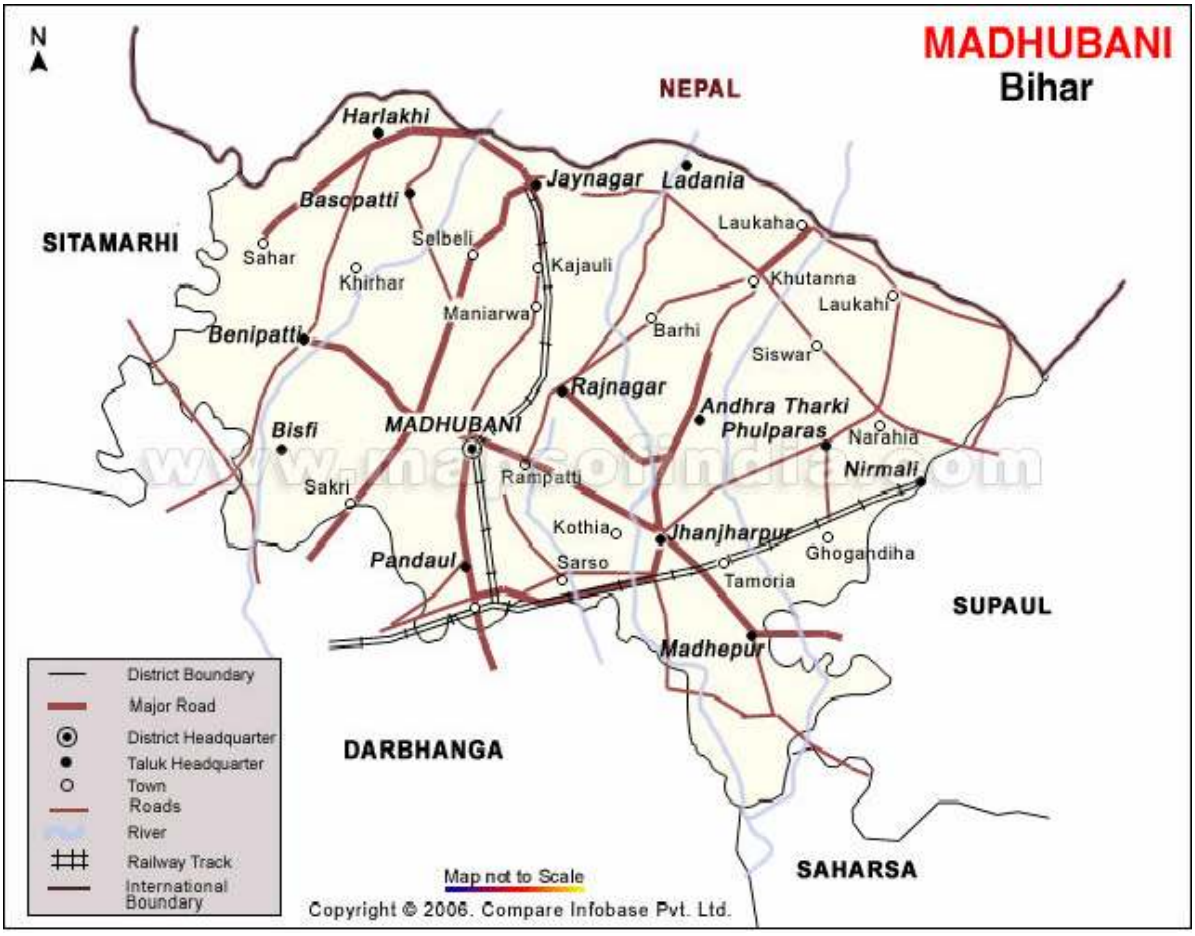
DISTRICT HEALTH ACTION PLAN 2011 – 12

Name of the district: Madhubani



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Preface

It is our pleasure to present the Madhubani District Health Action Plan for the year 2011-12. The District Health Action Plan seeks to set goals and objective for the district health system and delineate implementing processes in the present context of gaps and opportunities for the Madhubani district health team.

National Rural Health Mission was introduced to undertake architectural corrections in the public Health System of India. District health action plan is an integral aspect of National Rural Health Mission. District Health Action Plans are critical for achieving decentralisation, interdepartmental convergence, capacity building of health system and most importantly facilitating people's participation in the health system's programmes. District health Action planning provides opportunity and space to creatively design and utilise various NRHM initiatives such as flexi – financing, Rogi Kalyan Samiti, Village Health and Sanitation Committee to achieve our goals in the socio-cultural context of Madhubani.

I am very glad to share that all the BHMs and MOIC of the district along with key district level functionaries participated in the planning process. The plan is a result of collective knowledge and insights of each of the district health system functionary. We are sure that the plan will set a definite direction and give us an impetus to embark on our mission.

Dr. Ganesh Mahto

Civil Surgeon Cum Member Secretary

District Health Society, Madhubani

Acknowledgements

The commitment to bridge the gaps in the public health care delivery system, has led to formulation of District Health Action Plans. The collaboration of different departments that are directly or indirectly related to determinants of health, such as water, hygiene and sanitation, will lead to betterment of health care delivery, and to make this collaboration possible actions are to be outlined in the District Health Action Plan. Thus this assignment is a shared effort between the departments of Health and Family Welfare, ICDS, PRI, Water and Sanitation, Education to draw up a concerted plan of action. The development of a District Action Plan for Madhubani district of Bihar entailed a series of Consultative Meetings with stakeholders at various levels, collection of secondary data from various departments, analysis of the data and presentation of the existing scenario at a District-level workshop. The District level Workshop was organized to identify district specific strategies based on which the District Action Plan has been prepared by the District & Block Program Management Unit . Our thanks are due to All the Program officers and Medical officers of the district for their assistance and support from the inception of the project. The involvement of the all the Medical officers played a vital role throughout the exercise enabling a smooth conduct of consultations at block and district levels.

The present acknowledgement would be incomplete without mentioning the participation of representatives and officials from department of Integrated Child Development Services, Panchayati Raj Institution, Education and Water and Sanitation, who actively participated in consultations with great enthusiasm. Without their inputs it would not have been possible to formulate the strategic health action plan for the district. The formulation of this plan being a participatory process, with inputs from the bottom up, the participation of community members at village level proved very helpful. These consultations at grassroots level supplemented the deliberations at block and district levels, adding value to the planning process. Finally, we would like to appreciate the efforts and supports of all those including PHRN Bihar , Team who were associated with the team for accomplishment of this task and brought the effort to fruition.

Dist. Nodal M & E Officer D.H.S Madhubani	D.A.M D.H.S Madhubani	D.P.M D.H.S Madhubani	C.S Cum Member Secretary D.H.S Madhubani

Executive Summery

With the growing concerns for health of the community, National Rural Health Mission (NRHM) is seen as a vehicle to ensure that preventive and promotive interventions reach the vulnerable and marginalized through expanding outreach and linking with local governance institutions. NRHM envisages achievement of ascertained goals by promotion of intersectoral linkages, which is anticipated as imperative for its effective implementation. These linkages can be within the public health system such as RCH, Family Planning, Routine Immunization and National Disease Control programmes or with other departments like Women and Child Development, Education, PRI and Water and Sanitation. These linkages could also be with the NGOs, the private health sector and the corporate sector with the overall objective of improvement of services and fragmentation of efforts. For making NRHM fully accountable and to facilitate the responsiveness of NRHM, need for formulation of District Health Action Plan (2007-12) has been recognized. DHAP intends to provide a guideline to develop a liable public health delivery system through intensive monitoring and performance standard.

The process for formulation of DHAP required participatory approach at various levels. To make the plan more practicable and to ensure that grass root issues are voiced and heard, the initial stages of process of plan development included consultations at village and block level. As NRHM emphasizes community participation and need based service delivery with an improved outreach to disadvantaged communities, village and block level consultations provided vital information to guide the district health action plan. The consultations endeavored to reach a consensus on constraints at community level and feasible solutions/interventions strategies regarding a particular subject matter. Based on discussions on both demand and supply side concerns in the blocks the priorities were set and agreed. Further to share the findings of village and block level process with a larger stakeholder group and to finalize a strategic action plan district level workshop was conducted.

Following the consultations at village and block level, consultations at district level involving a large range of stakeholders from different levels, aimed at delineating strategies to achieve identified district plan objectives. For effective implementation of suggested approaches it has been endeavored to carve out specific activities for each strategy and assign the activities a tentative time frame so as to indicate when a particular activity can happen.

Prior to consultative meetings, an attempt has been made to identify the performance gaps within the framework of existing health system by conducting situational analysis. It has been found that the situation of public health infrastructure in the district is not appalling however major gaps are found in human resource situation with high number of vacant staff positions for male MPWs, ANMs, specialists and lab technicians. The situation of convergence of health department with ICDS is notable. At the community level close collaboration exists between the ANMs and the AWWs. The activities of the two departments are integrated, providing complementary job functions to ensure better accessibility and availability of health services. Involvement of PRI in issues of health through village health and sanitation

committees is limited. Though the committees are constituted in most of the villages their functionality is unconvincing.

With the vision to improve the reproductive and child health condition within the district, increase in female literacy has been anticipated as the foremost strategy. The challenge of providing quality services to the poorest and remotest areas can be achieved by developing pro-people partnerships with the non-government sector and promoting convergence with other concerned departments and agencies such as ICDS, panchayat and education. To ensure universal access to quality services, upgradation of facilities and strengthening of technical capacity of existing human resources, especially with regard to emergency obstetric care needs to be focused. Improved fund flow, timely procurement of goods and services, cadre management, planning and monitoring through infusion of managerial skills is envisaged as necessary in order to reach the objectives of the mission. Intensified IEC activities by local health workers, panchayat leaders, community societies/local NGOs will provide much needed support for behaviour change of community regarding maternal care during pregnancy, ANC, institutional deliveries, breastfeeding practices as well as family planning. Need for using health facilities for deliveries and other issues related to RCH, family planning, female education and gender equity would be the central point of counseling during interactions between health workers and pregnant women.

To promote access to improved health care at household level through ASHAs, induction trainings of ASHAs are still needed to be finished. With a view to bring about decentralization, encourage community participation, and improve health service delivery, establishment of RKSs have been suggested at all CHCs and PHCs. However, specific guidelines for functioning mechanism as well as trainings of members will ensure streamlined activities under RKS. Upgradation and strengthening of health infrastructure needs urgent recruitment of required number of gynecologists, anesthetists, pediatricians, staff nurses, ANMs, MPWs and lab technicians either on permanent or contractual basis, as well as assurance of adequate procurement and logistic supply. For upgrading standard of services, multi-skilling of doctors/ paramedics is envisaged by imparting refresher training courses. Increased outreach of services is also envisioned to be achieved by initiating medical mobile units, which will operate within the most vulnerable areas. To make MMUs functional there is need for deployment of staff, availability of conveyance, equipments and drugs. Further, since Ayurveda, Unani and Homeopathy system of medicine have had a long presence in the State, specially in the remote and rural areas it is suggested to use their potential for improving accessibility to health services by mainstreaming of AYUSH within the framework of primary health delivery.

With the objective of achieving the targets of child immunization there is a felt need for strengthening the service delivery mechanism by increasing manpower as well streamlined adequate supply of vaccines. Besides, regular in-service trainings can help build the capacity of health workers on various managerial aspects as well as improve the efficiency of delivery. In order to deal with the critical cultural issues, that might be hampering the performance of child immunization indicators, convergence with PRI through *gram panchayat*, other influential members of the community and local NGOs/CBOs is

considered significant. Involvement of panchayat to ascertain better coverage of immunization is envisioned through establishment and activation of VHSCs, which motivate community for higher acceptance of vaccination by organizing various innovative activities and by inter-personal communication.

As far as vector borne diseases are concerned, the risk of malaria is high in the district. To tackle the performance of indicators of malaria, institutional strengthening is suggested by upgradation of existing laboratories and increasing the number of laboratories for malaria microscopy. Need of filling up vacant posts for staff workers and lab technicians are highly recognized. Outreach of services delivery is expected to be achieved by co-opting with private institutions with the vision to increase slide collection rate. Intersectoral coordination between health department, ICDS, PRI, education dept, NGOs and water and sanitation department is primarily emphasized for IEC on issues related to general health and environmental hygiene.

For improvement in RNTCP indicators intensified case detection activities are proposed. To ensure high responsiveness from the community regarding acceptance of services, sensitization of community through PRI and collaboration with private practitioners is presumed. In addition to this availability of advanced diagnostic techniques with quality assurance are expected to build faith among the community members towards institutional health care services. For easy accessibility to treatment facility, increasing the number of DOTS providers is also proposed. In addition to this, the much needed behavioural change of staff members can be achieved by imparting trainings for orientation and better counseling skills.

Outreach of NBCP services can be attempted by increasing the number of outreach camps in un-reached and remote areas. For improving eye care delivery services there should be adequate supply of diagnostic equipments as well as drugs. Gaps in service delivery are felt due to non-posting of eye specialists at health facilities even in Sadar Hospital, Madhubani. Thus filling up vacancies for eye-surgeons and imparting refresher training courses on new techniques and interventions will help in accomplishment of required targets. In this regard, convergence with schools is envisaged for organization of school eye-screening camps.

With the view of reduction of leprosy regular surveys are proposed for case detection along with constant monitoring and reporting mechanism. Service delivery can be strengthened by recruitment of motivated and dedicated staff for field activities. To tackle the identified cases, it is important to convince community members for rebuttal of prevailing misconceptions associated with the disease. Initiatives on IEC and BCC can be attempted by collaboration of activities with panchayat, which is supposed to be the most efficient medium for sensitization of community.

However in order to expedite the process and to make it more effective, convergence at various levels require detailing of effective operational approaches, laying out clear roles and outcomes, and clear mechanism for joint planning and monitoring. This will not only ensure streamlining of strategies but also ensure accountability of the public health system of different departments, be it health

department, ICDS, PRI, education or water and sanitation. Continuous monitoring will keep a check on effective collaboration of services related to immunization and institutional delivery, AYUSH infrastructure, supply of drugs, upgradation of CHCs to IPHS, utilization of untied fund, and outreach services through operationalization of mobile medical unit.

❖ Process of Plan Prepration

The district received the situational analyses formats and planning formats from the SHS to base its planning process on. UNFPA helped district in facilitating the process of DPIP development. Under the overall leader ship of DHS, district PIP planning team was formed, which called a district level consultation (on 4th December, 2010), comprising of all block MOICs and BHMs, to formally initiate the process of 2011-12 DPIP formulation. This was the forum where DHS informed the blocks to form Block PIP planning teams and disseminated the process to be adopted in the blocks and timelines for the same. The situational analysis formats were shared with the blocks and a preliminary discussion took place on the same during this meeting. UNFPA was invited by the DHS to detail the process of block and district PIP formulation to the district and block PIP planning teams. In response to the same, in a second district consultation meeting (on 15-16th December 2010) UNFPA detailed not only the situational analysis formats but also customized the FMR based block and district planning templates and shared the same with the group, which was endorsed by the group. At the same time, UNFPA also shared an illustrative one-page report of block situation analysis which the PHCs can display as chart in their facilities to give visibility to the process of Block PIP formulation (this could be one way of using the information gathered by situational analysis and displaying the same). In the consultation, UNFPA also shared the concept and steps of block consultation to be conducted by each PHC / Block as an important step toward preparing the block PIPs. At the end of this meeting, deliverables that were given to the district and blocks were: 1. The DHS would get the calendar of block level consultations from each PHC, 2. The block will complete their situational analysis in a time bound fashion, 3. The blocks will develop a one page report of the situational analysis based on the template provided by UNFPA and stick / paste the same in their respective PHCs, 4. Each PHC / Block will complete the Planning template in a time bound fashion and submit the same to the DHS, 4. DHS will compile the block health plans into DPIP in the district planning templates and submit the same to the SHS.

Brief of Block Consultation: the purpose of the block consultation is primarily to take block / community perspective of the health care status in the block and to identify the health priorities / interventions needed in the block together with identifying geographies in the block which are left out in terms to receiving health care services and to focusing on the same to improve the access of health services there.

The District Health Action Plan of Madhubani has been prepared under the guidance of the Civil Surgeon Cum Member Secretary D.H.S, Madhubani with a joint effort of the District Program Manager, District Account Manager and District Nodal M & E Officer, the various Medical Officers and Health Managers of PHCs as well as other concerned departments under a participatory process. The field staff of the department have also played a significant role. Public Health Resource Network has provided technical assistance in estimation and drafting of various components of this plan.

Summary Of The Planning Process
Training of district team for preparation of DHAP **Study and discuss the BHAP with district officials**
Preliminary meeting with Civil Surgeon and D.P.M along with other concerned officials
Data Collection for Situational Analysis - MOIC and BHM meeting chaired by DM and CS
Block level consultations with MOICs, BHMs and BCMs
Writing of situation analysis
District Planning workshop to review situation analysis and prepare outline of district health plan- the meeting was chaired by CMO. The workshop was attended by MOICs, BHMs and other key health functionaries at the district level.
District Consultations for preparation of 1st Draft
Preliminary appraisal of Draft
Final Appraisal
Final DHAP: Submission to DHS and State
Printing and Dissemination

❖ Tools and Techniques Used for DHAP Prepration

Methods for Stakeholder Consultations

For conducting stakeholder consultations at village and block level, multi-attribute utility method was used. The method helped to rank stakeholder's priorities on a set of dimensions that provided the combination of results across individuals. Multi-attribute utility method incorporates concept mapping and force-field analysis.

Concept Mapping

Concept mapping technique was used for obtaining a set of statements and concepts from participants. It helped to identify goals, measures, priorities or themes for the evaluation. The

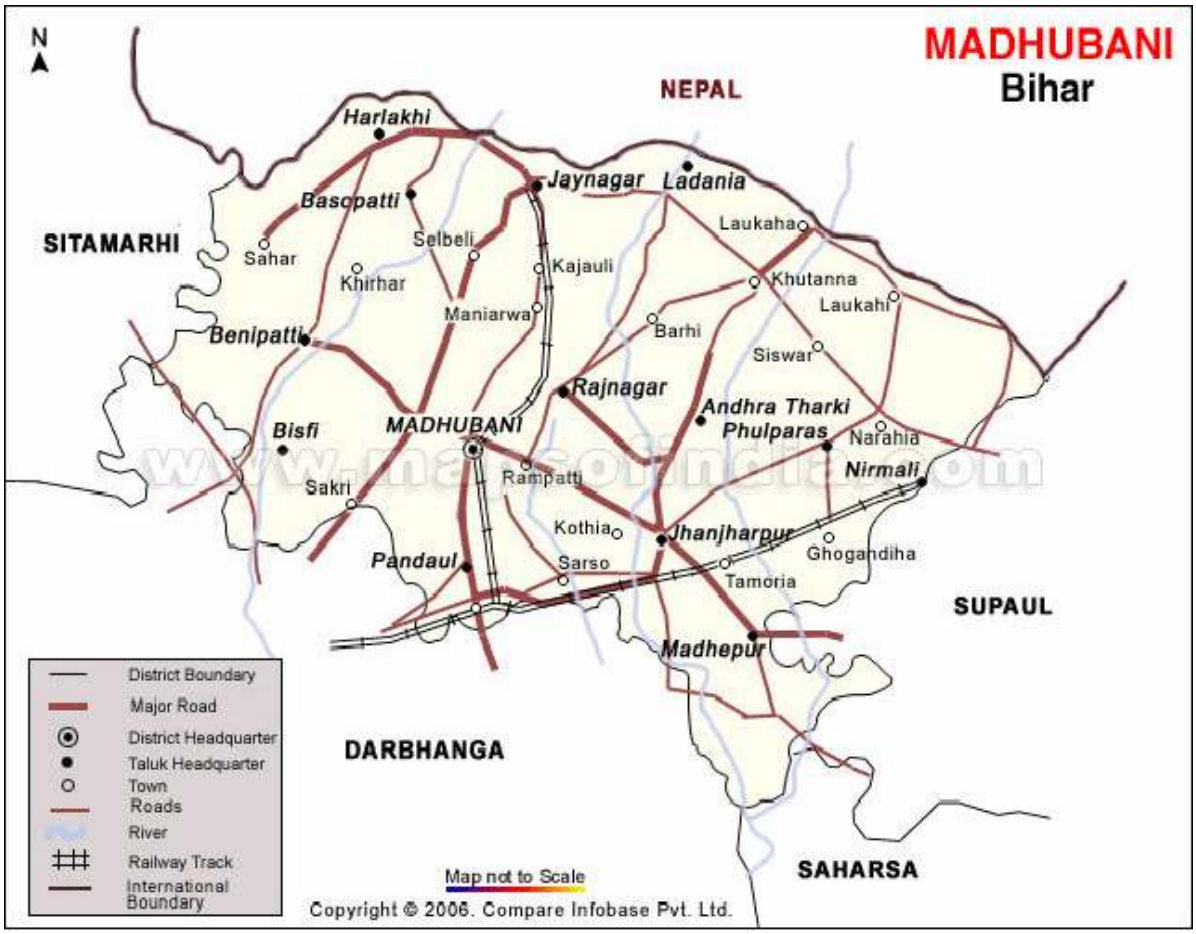
technique proved useful as through iterative inquiry, a priority list is generated about the issues that various groups would like to address.

Field Force Analysis

Field force analysis is a technique developed by Kurt Lewin, for diagnosing situations. In the present study field force analysis method was used to identify factors that are acting as driving and restraining forces for ensuring effective implementation. Driving forces are those forces affecting a situation that are pushing in a particular direction; they tend to initiate a change and keep it going. Restraining forces are acting to restrain or decrease the effect of driving forces. Low awareness, prevalence of misconceptions and poor access to services may be examples of restraining forces for improved health condition.

❖ District Overview

Madhubani is located at 26.37 degree north and 86.08 degree east. It occupies a total area of 3501 sq km. The district has a total population of 3,575.281 out of which rural population has a share of 3,450,736 and urban population has a share of 124,545 (2001 census). The district is surrounded on the north by a hill region of Nepal extending to the border of its parent district Darbhanga in the south, Sitamarhi in the west and Supaul in the east. Madhubani fairly represents the centre of the territory once known as Mithila and the district has maintained a distinct individuality of its own.



There are numerous streams and rivers which intersect the district. The main rivers are Kamla, Kareh, Balan, Bhutahi, Balan, Gehuan, Supen, Trishula, Jeevachh, Koshi and Adhwara. Whole District is under Earthquake Zone 5. The district has five Sub-divisions namely Madhubani, Jaynagar, Benipatti, Jhanjharpur and Phul Paraas. The district has twenty one blocks namely Jainagar, Pandaul, Rahika, Bisfi, Benipatti, Basopatti, Babubarhi, Rajnagar, Madhepur, Khutauna, Khajauli, Jhanjharpur, ghoghardiha, Ladania, Madhwapur, Harlakhi, Laukahi, Andharatharhi, Lakhnaur and Phulparas. The soil of the district is highly calcarious and contains mixture of clay and sand in varying proportions. Since it can retain moisture, it is suited to paddy cultivation. The district receives more rain than its adjoining district. Artificial irrigation is practiced but its full potential has not yet been realized. Tanks are used all over the

district for irrigation purpose. Apart from well Tube-wells and artesian wells are also being utilized for the purpose of artificial irrigation.

Madhubani Painting

The district is known for Madhubani painting. The "Madhubani" style of paintings derives its name from this region. The Madhubani Paintings has distinct identity because of its unique design and texture. These paintings are made using vegetable dyes, and the canvas is usually cloth or paper. Several of the well-known "Mahubani" paintings are used as motifs on bags, kurtas (an Indian garment for covering the upper-half of the body), and other materials produced using the hand-block painting technique. With ethnic-chic being in vogue, such products are all the rage, these days, not just with the Indians, but also in the export market. *Jitwarpur, Ranthi and, Mangrauni* are villages where the art form is practiced both for its aesthetic purpose as well as for commercial consumption. For commercial purposes, the painting is now being done on paper, cloth, canvas etc. Cotton wrapped around a bamboo stick forms the brush. Black colour is obtained by mixing soot with cow dung; yellow from turmeric or pollen or lime and the milk of banyan leaves; blue from indigo; red from the kusam flower juice or red sandalwood; green from the leaves of the wood apple tree; white from rice powder; orange from palasha flowers. The painting is a primary source of income for number of 10 families. The continuing market in this art throughout the world is a tribute to the resourcefulness of the women of Mithila who have successfully transferred their techniques of bhitti chitra or wall painting to the medium of paper. Similarly, another handicraft art form called *Sikki- Mauni*. With help of local grass people here prepare many items of daily use like jewelry box, doll etc. These are used traditionally for keeping grains and also the food items and other bamboo works are quite famous and attract people of various parts of the country.

Predominant Economic Activities

Agriculture, Makhana cultivation, Fisheries, Mithila Painting, Sikki and Mouni, Handicrafts and Weaving.

Natural Disaster(Flood)

Every year flood plays it havoc and makes the life of the people miserable and even disrupts the supply of basic needs. During the flood of 2007 total of 331 Panchayats were affected (110 were affected completely and 221 were partially affected). Total 836 villages were affected and 372599 families were affected. During flood people face problem related with health and sanitation in general and women in particular because of absence of toilet in houses. During the post-flood period many water borne diseases get spread in villages and afflict numerous problems to poor people and in many instances this also cost people life. In absence of shelter houses most of the time peoples' poultry and animal get washed out.

❖ District Profile

✓ Administrative set up

PARTICULARS	NUMBER
Number of Sub-Division	5
Number of Blocks	21
Number of Municipality	1
Number of Gram Panchayat	399
Number of Police Station	18
Number of Inhibited Villages	507
Number of Uninhibited Villages	604
Number of Villages	1111

✓ Demography and Development Indicators

Population	Male	Female	Total
Rural Population (in %)	52.9	47.1	4379716
Literacy Rate	56.79	26.25	41.97
SC Population (in %)	52.9	47.1	13.48
ST Population (in %)			0.04
BPL Population			
Sex Ratio	Females per 1000 males 942	(0 – 6 years) 939	
Population Growth (1991 – 2001)	26.08		
Population Density (person per sq km)	1022		
Number of Household	Total 656858	Rural 96.51	Urban 3.49
Household Size	5		
Type of house (%)	Pucca 28.2	Kuchha 61.5	
Per Capita Income			
Total workers (number)	1503556		
Main workers (number)	1074782		
Marginal workers (number)	429212		
Non – workers (number)	2875721		
Total workers to total population (%)	34.33		

Cultivators to total workers (%)	7.92
Agriculture laborers to total workers (%)	11.38
Workers in HH industries to total workers (%)	0.85
Main workers to total population (%)	34.32
Marginal workers to total population (%)	24.53
Non workers to total population (%)	65.65
Number of villages having drinking water facilities	1034
Number of villages having safe drinking water facilities	1033
Number of electrified villages	615
Number of villages having primary school	2206
Number of villages having middle schools	382
Number of villages having secondary/sr. secondary schools	119
Pupil Teacher Ratio (Primary School)	
Pupil Teacher Ratio (Middle School)	
Out of School children	
Number of villages having any health care facilities	522
Number of Health Sub Centre	429
Number of Additional Primary Health Centre	57
Number of Primary Health Centre	20
Number of Sub-divisional hospital	1
Number of hospitals/dispensaries per lakh population 2007 – 08	12
Number of beds in hospitals/dispensaries per lakh population 2007 – 08	9
Percentage of children having complete immunization 2007 – 08	33
Percentage of women having safe delivery 2007 – 08	12
Number of villages having post office facility	432
Number of villages having Paved approach road	545
Number of villages having mud approach road	986
Average size of operational holding	
Normal Rain Fall	1273.2 mm
Actual rain Fall	
Percentage of cultivable land to total geographical area 2006-07	63
Percentage of area under commercial crops to gross cropped area 2006-07	
Percentage of net area sown to geographical area 2006-07	
Cropping intensity	134.23

Percentage of gross irrigated area to gross area sown 2006-07	
Percentage of net irrigated area to net area sown 2006 – 07	
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	
Percentage of area under agahani crops	
Percentage of area under garma crops	
Percentage of area under rabi crops	
Length of highways and major district roads (mdrs) per lakh population (km) 31st march 2005	
Length of highways and major district roads (mdrs) per thousand sq km in area (km) 31st march 2005	
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	
Credit deposit ratio 2008	
Density of livestock per sq km 2003	
Density of poultry per sq km 2003	1022
Average livestock population served per veterinary hospital/dispensary 2003	
District wise fish production 2007 – 08	
Share of districts in total milk production 2007 – 08	

✓ Topography

The district of Madhubani was carved out of the old Darbhanga district in the year 1972 as a result of reorganisation of the districts in the State. This was formerly the northern subdivision of Darbhanga district. It consists of 21 Development Blocks. Bounded on the north by a hill region of Nepal and extending to the border of its parent district Darbhanga in the south, Sitamarhi in the west and Supaul in the east, Madhubani fairly represents the centre of the territory once known as Mithila and the district has maintained a distinct individuality of its own.

It is located at a **Longitude** of 25º-59' to 26º-39' East and the **Latitude** is 85º-43' to 86º-42' North.

Height from Sea

The Madhubani district is situated at height of 80 meters from Sea.

Boundary

North	South	East	West
Hill region of Nepal	Darbhanga District	Supaul District	Sitamarhi District

Area

- Madhubani occupies a total of 3501 sq. kms.
- Main Rivers are Kamla , Kareh, Balan, Bhutahi Balan, Gehuan, Supen, Trishula, Jeevachh, Koshi and Adhwara Group.
- High Flood Level is 54.017 m.
- Whole District is under Earthquake Zone 5.
- Total Cropped Area - 218381 Hect.
- Barren /Uncultivable Land - 1456.5 Hect
- Land under Non-agricultural use - 51273.24 Hect
- Cultivable Barren Land - 333.32 Hect
- Permanent Pasture - 1372.71 Hect
- Miscellaneous Trees - 8835.90 Hect
- Cultivable Land - 232724 Hect
- Cropping Intensity - 134.23 %

✓ **Climate and Agro Ecological Situation**

The climate of this district is generally healthy. There are three well marked seasons, viz, a pleasant cold season, a hot, dry summer and the rainy season. The cold weather begins in November and continues up to February, though March is also some- what cool. Westerly winds and dust storms begin to blow and the temperature goes up to about 42oC. Rains set in towards the middle of June when the temperature begins to fall and humidity rises. Though the rains continue till the end of September or the middle of October, these months are not so hot.

✓ **Rain Fall**

- Varies between 900mm and 1300 mm.
- Average Rainfall = 1273.2 mm.

Occupational Structure

The predominant occupation of the district is agriculture and majority of the population is involved in agriculture related activities. In addition to agriculture related activities part of the population is also involved in household industry. The pattern of occupation is broadly divided into cultivators, agricultural labourers, household industry workers and other workers. The table given below provides the details:

Indicators	Male/female	No.
Main workers		877,412
	Male	745,736
	Female	131,676
Cultivators		291,565
	Male	258,319
	Female	33,246
Agricultural labourers		416,627
	Male	334,264
	Female	82,363
Household industry workers		29,126
	Male	22,764
	Female	6,362
Other workers		140,094
	Male	130,389
	Female	9,705
Non-workers		2,347,558
	Male	961,880
	Female	1,385,678

Source: Census 2001.

Land Use Pattern

The land use in the district is highly dependent upon the traditional agriculture practice. As a result productivity of land is not at the expected level. The average size of the holding is small and fragmented. It is also one of the reasons that has not led to dent of technical agriculture practice in the agriculture sector. In addition poverty amongst farmer has always prohibited them to use the technology to upgrade the productivity. The details are given below:

S. No	Type of land	Area in hectare
1	Total Cropped Area	218381 Hect.
2	Barren /Uncultivable Land	1456.5 Hect
3	Land under Non-agricultural use	51273.24 Hect
4	Cultivable Barren Land	333.32 Hect
5	Permanent Pasture	1372.71 Hect
6	Miscellaneous Trees	8835.90 Hect
7	Cultivable Land	232724 Hect
8	Cropping Intensity	134.23 %
9	Area brought under HYV seeds	Nil

Source: http://madhubani.bih.nic.in/

Industry

Being a predominantly agrarian economy industry sector has failed to realize its significance. One of the major constrains for the growth of industry is infrastructural poverty and the level of urbanization which is merely 3.65%. Overall composite index of development of the district is only 96.8 as compared to highest index values of 224.53 for Patna district (Madhubani District Potential Linked Credit Plan 2008-09, NABARD). Most of the industries present in the district are small scale like Mithila painting, chura, rice and printing. Infact Mithila painting has also miserably failed to receive the support of administration and its recognition is gradually decreasing. The table given below provides details of industry:

S. No	Type of Industry	Number
1	Mithila painting registered	76
2	Registered furniture industry	13
3	Steel industry	03
4	Chura industry	03
5	Rice industry	01
6	Printing industry	03
7	Small scale industry	3000

Dairy Industry

S. No	Particulars	No
1	No of Government committees	30
2	No. of government chilling centre	01
3	No. of private chilling centres	00
4	No of government milk production centres	30
5	No of private milk production centres	00
6	Total production of milk by cow	150 ltrs.
7	Total production of milk by buffalo	50 ltrs
8	Total Milk production	200 ltrs

Animal Husbandry

The district has potential in this sector but due to lack of infrastructure the allied industries have not been able to develop in the district. The table given below provides details related with animal husbandry:

S. No	Institutions	Number
1	Artificial Insemination Centre	16
2	Veterinary sub-centre	70
3	Veterinary centre	35
4	Veterinary hospital/dispensary	1

Education

The district performance at the education front is abysmally poor. The literacy rate is only 41.97% and the literacy among female is only 26.54%. Moreover the poor progress on the education front is also due to lack of infrastructure. The table given below provides details and also details of Bihar Education Project under the Sarva Siksha Abhiyan:

S. No	Particulars	No.
1	Primary school (Govt.)	2116
2	Upper Primary School (Govt)	745
3	Enrollment of Boys	332603
4	Enrollment of girls	282016
5	Primary teachers	8669
6	Middle Schools	745
7	Enrollment of Boys	109702
8	Enrollment of girls	85682
9	Teachers in middle school	6649
10	S.C Registered Male students (6-14 years)	73373
11	S.C registered female students	58892
12	S.C unregistered male students	1800
13	S.C Unregistered female students	836
14	S.C drop out male students	3915
15	S.C drop out female students	3526
16	S.T registered male students	225
17	S.T Registered Female students	171
18	ST Unregistered male students	14

19	ST unregistered Female students	08
20	ST Drop out male students	180
21	ST Drop out female students	173
22	No of Minorities registered male students	81889
23	No of minority registered female students	67346
24	No. of unregistered male minority student	2410
25	No. of unregistered female minority students	1882
26	No. of drop out male minority students	6470
27	No. of Drop out female students	5934
28	No of Schools do not have toilet facility	1591
29	No of Schools do not have drinking water facility	556
30	No of Schools do not have separate toilet facility for boys and girls	2193
31	Number of primary school without building	287
32	Number of classrooms that require repairing	1288
33	Number of upper primary school required*	28

Current Status Of Outcome

Current FY Achievement

Maternal Health

	SN	Indicator	2009-10	April-Sep 2010	Source
ANC	1	No. of Pregnant women (PW) registered for ANC	71,330	40,929	HMIS
	2	% PW registered for ANC in I trimester	58.25%	53.76%	HMIS
	3	% PW with 3 ANC checks	30%	15%	HMIS
	4	% PW with any ANC checks	59%	30%	HMIS
	5	% PW with Anaemia	3%	2%	HMIS
	6	% PW receiving 2 TT injections	60%	56%	HMIS
	7	% PW receiving 100 IFAs	16%	17%	HMIS
Safe delivery	8	No. of PW registered for JBSY	30,638	21,479	HMIS
	9	No. of Institutional deliveries conducted	39,213	22,227	HMIS
	10	No. of Home deliveries conducted by SBA	10216	930	HMIS
	11	% of deliveries conducted as CS	6%	0	HMIS
PNC	12	% of new mothers given PNC within 48 hrs after delivery	37%	29%	HMIS

Child Health

SN	Indicator	2009-10	April-Sep 2010	Source
1	% of 12-23 months fully immunised	83%	59%	HMIS
2	% of planned immunisation sessions held	72%	63%	HMIS
3	No. of children aged 9 months and 5 years who received at least 1 dose of Vitamin A			HMIS

4	Total number of live births	42,672	21,739	HMIS
5	Total number of still births	345	106	HMIS
6	No. of newborns who were weighed immediately after birth			HMIS
7	No. of newborns who were less than 2500 gm at the time of birth (LBW)			HMIS
8	No. of diarrhoea cases reported	608	1212	HMIS
9	No. of measles / ARI cases reported			HMIS

Family Planning

SN	2009-10				April – November 2010					
	Minilap	NSV	Vasect	Total	Minilap	NSV	Vasect	Total	IUCD	Oral Pills
	14780		5	14785	2936		1	2937	2850	14281

*. Upto 11-Dec-2010, 1855 no of female sterlization completed

Patients Services

SN	**Indicator**	**2009-10**	**April-Dec 2010**	**Source**
1	Total Outdoor Patients	1190912	746576	HMIS
2	Total Indoor Patients			HMIS
3	Total Midnight Count	27638	18402	HMIS
4	Major Operation	1511	122	HMIS
5	Minor Operation	39636	24978	HMIS

DLHS-3

Population and Household Characteristics, 2007-08				
Background Characteristics	**DLHS - 3**		**DLHS - 2**	
	Total	**Rural**	**Total**	**Rural**
Percent total literate Population (Age 7 +)	53.0	53.1	-	-
Percent literate Male Population (Age 7 +)	69.1	69.5	-	-
Percent literate Female Population (Age 7 +)	40.0	40.1	-	-
Percent girls (age 6-11) attending Schools	97.7	97.7	-	-
Percent boys (age 6-11) attending Schools	98.6	98.6	-	-
Have Electricity connection (%)	17.9	17.8	4.9	3.9
Have Access to toilet facility (%)	12.0	12.1	9.5	8.4
Use piped drinking water (%)	0.7	0.7	6.3	6.3
Use LPG for cooking (%)	2.2	2.2	2.8	2.0
Live in a pucca house (%)	8.9	9.0	8.9	8.0
Own a house (%)	98.6	98.6	-	-
Have a BPL card (%)	25.3	25.5	-	-
Own Agriculture Land (%)	48.7	49.9	-	-
Have a television (%)	6.3	6.4	7.1	6.4
Have a mobile phone (%)	13.9	14.2	-	-
Have a Motorized Vehicle (%)	4.7	4.9	4.0	3.5
Standard of Living Index				

Low (%)	88.4	88.3	86.9	87.9
Medium (%)	8.2	8.1	11.2	10.9
High (%)	3.4	3.5	1.9	1.2
* Number of Females per 1000 Males				

Indicators	DLHS - 3		DLHS - 2	
	Total	Rural	Total	Rural
Marriage and Fertility, (Jan 2004 to 2007-08)				
Percentage of girl's marrying before completing 18 years	39.5	39.9	69.1	70.2
Percentage of Births of Order 3 and above	53.1	53.2	53.7	53.6
Sex Ratio at birth	99	102	-	-
Percentage of women age 20-24 reporting birth of order 2 & above	72.4	72.8	-	-
Percentage of births to women during age 15-19 out of total births	96.3	96.4	-	-
Family planning (currently married women, age 15-49)				
Current Use :				
Any Method (%)	34.9	35.1	29.0	28.8
Any Modern method (%)	30.5	30.9	28.7	28.6
Female Sterilization (%)	28.2	28.6	24.4	24.3
Male Sterilization (%)	0.0	0.0	0.2	0.2
IUD (%)	0.6	0.6	0.6	0.6
Pill (%)	1.0	1.0	2.7	2.7
Condom (%)	0.5	0.4	0.6	0.6

Unmet Need for Family Planning:				
Total unmet need (%)	40.3	40.1	33.7	33.8
For spacing (%)	17.3	16.9	15.7	15.7
For limiting (%)	23.0	23.2	18.0	18.1
Maternal Health:				
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	29.5	29.9	-	-
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	35.6	36.3	14.5	14.4
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)#	75.2	76.1	30.7	30.4
Institutional births (%)	16.0	16.5	5.8	5.6
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	4.0	4.1	5.8	5.6
Mothers who received post natal care within 48 hours of delivery of their last child (%)	10.4	10.7	-	-
Child Immunization and Vitamin A supplementation:				
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)	42.1	42.8	17.2	17.2
Children (12-23 months) who have received BCG (%)	81.7	83.3	48.9	45.7
Children (12-23 months) who have received 3 doses of Polio Vaccine (%)	57.6	59.0	26.9	28.7
Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	54.5	55.8	34.0	27.7
Children (12-23 months) who have received Measles Vaccine (%)	51.2	52.5	26.7	21.3
# It is adjusted according to DLHS-3 definition				

DLHS-3	Madhubani			
Indicators	DLHS - 3		DLHS - 2	
	Total	Rural	Total	Rural
Child Immunization and Vitamin A supplementation: (Contd...)				
Children (9-35 months) who have received at least one dose of Vitamin A (%)	47.6	48.3	-	-
Children (above 21 months) who have received three doses of Vitamin A (%)	8.4	8.8	-	-
Treatment of childhood diseases (children under 3 years based on last two surviving children)				
Children with Diarrhoea in the last two weeks who received ORS (%)	7.1	7.2	5.5	5.1
Children with Diarrhoea in the last two weeks who were given treatment (%)	84.0	84.2	70.2	70.6
Children with acute respiratory infection/fever in the last two weeks who were given treatment (%)	85.7	85.3	-	-
Children had check-up within 24 hours after delivery (based on last live birth) (%)	12.2	12.3	-	-
Children had check-up within 10 days after delivery (based on last live birth) (%)	11.9	12.0	-	-
Child feeding practices (Children under 3 years)				
Children breastfed within one hour of birth (%)	7.9	8.2	-	-
Children (age 6 months above) exclusively breastfed (%)	4.9	5.1	-	-
Children (6-24 months) who received solid or semisolid food and still being breastfed (%).	79.9	80.6	-	-
Knowledge of HIV/AIDS and RTI/STI among Ever married Women (age 15-49)				
Women heard of HIV/AIDS (%)	22.6	22.0	24.4	24.2
Women who knew that consistent condom use can	27.8	29.4	14.9	14.6

reduce the chances of getting HIV/AIDS (%)				
Women having correct knowledge of HIV/ AIDS (%)	86.8	86.9	-	-
Women underwent test for detecting HIV/ AIDS (%)	2.8	2.5	-	-
Women heard of RTI/STI (%)	37.0	36.6	69.1	68.9
Knowledge of HIV/AIDS among Un-married Women (age 15-24)				
Women heard of HIV/AIDS (%)	30.3	31.2	-	-
Women who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)	24.2	24.2	-	-
Women having correct knowledge of HIV/ AIDS (%)	98.6	99.5	-	-
Women underwent test for detecting HIV/ AIDS (%)	0.0	0.0	-	-
Women heard of RTI/STI (%)	9.5	10.0	-	-
Women facilitated/motivated by ASHA for				
Ante-natal Care (%)	1.2	1.3	-	-
Delivery at Health Facility (%)	1.1	1.1	-	-
Use of Family Planning Methods (%)	0.7	0.8	-	-

Situational Analysis

Sl. No.	Name Of The Post	Post Sactioned	In - Position
1.	Medical Officer (Regular)	213	**70**
2.	Medical Officer (Contractual)	81	**54**
3.	“A” Grade Nurse (Regular)	34	**14**
4	“A” Grade Nurse (Cont.)	114	**10**
5	Block Extension Educator	19	**2**
6	Health Educator	41	**9**
7	Lady Health Visitor	39	**9**
8	Ophthalmic Assistance	8	**7**
9	Public Health Nurse	1	**0**
1	Statistical Assistance	1	**0**
11	Pharmasist	84	**17**
12	Laboratory Technician	64	**14**
13	X-Ray Technician	4	**3**
14	Sanitary Inspector	19	**2**
15	Clerk	115	**115**
16	ANM(Regular)	584	**371**
17	ANM (Cont.)+ANM R	429	**162+41**
18	Computer	18	**15**
19	B.H.W	153	**151**
20	F.W.W	54	**44**
21	Driver	41	**21**
22	IV Grade Staff	379	**228**
23	O.T Assistance	4	**0**

24	Dresser	83	**69**
25	B.H.M	21	**13**
26	Accountant(Cont.)	21	**11**
27	Data Centre	28	**16**
28	**BCM**	**21**	**12**
29	**AYUSH**	**83**	**66**

❖ **District Program Management Unit**

Designation	Sanction	In-Position	Vacant
Dist. Program Manager	**1**	**1**	**0**
Dist. Account Manager	**1**	**1**	**0**
Dist. Nodal M & E Officer	**1**	**1**	**0**
Dist. Community Mobilizer(ASHA)	**1**	**1**	**0**
Dist. Data Assistance(ASHA)	**1**	**1**	**0**
District Planning Coordinator	**1**	**0**	**1**

❖ **Block Program Management Unit**

Designation	Sanction	In-Position	Vacant
Block Heath Manager	**21**	**13**	**5**
Block Accountant	**21**	**11**	**6**
Block Community Mobilizer	**21**	**12**	**6**

❖ Health Sub Centres

S.N	Block Name	Population	Sub-centres required	Sub-centers Present	Sub-centers proposed	Further sub-centers required	Status of building		Availability of Land (Y/N)
							Own	Rented	
1	LADANIA	**185382**	35	18	9	8	14	4	
2	MADHAWAPUR	**152396**	28	12	24	4	8	4	
3.	JAYNAGAR	**191214**	36	16	15	5	7	9	Y-12 N-3
4	BENIPATTI	**356612**	62	35	25	2	19	16	N/A
5	JHANJHARPUR (PHC)	**134755**	20	14	20	6	12	2	N/A
6.	KHUTAUNA	**219678**	33	18	15	NIL	N/A	N/A	N/A
7	BISFFI	**359068**	59	35	24	59	11	15	N/A
8	BABUBARHI	**222964**	41	21	6	14	N/A	N/A	N/A
9	KHAJAULI	**126201**	24	15	4	5	4	10	4
10	KALUAHI	**126476**	24	11	2	11	5	6	2
11	GHOGHARDIHA	**167019**	31	13	17	1	0	13	Y-17 N-13
12.	PHULPARAS	**138137**	26	12	11	3	0	12	Y-12 N-11
13.	JHANJHARPUR (ONLY FOR PANCHAYET)	**29773**	5	4	3	0	2	2	Y-3 N-4
14.	RAJNAGAR	**241376**	45	22	19	04	13	9	N/A
17	BASOPATTI	**162532**	30	16	5	9	3	13	NO
18	PANDAUL	**260116**	49	31	5	13		31	
19	ANDHRARTHARI	**175280**	33	18	5	10	12	0	Y
20	HARLAKHI	**194873**	16	16		5	8	8	Y-8 N-8
21	LAUKAHI	**210706**	50	25	11	14	8	10	N
22	RAHIKA	**245264**	46	29	11	6	8	21	N/A
22	MADHEPUR+LAKHANUR	**479895**	73	35					
	Total	**4379717**	766	429	231	179	134	185	

❖ Additional Primary Health Centres

S.N	Block Name	Population	APHCs required	APHCs Present	APHCs proposed	Further APHCs required	Status of building		Availability of Land (Y/N)
							Own	Rented	
1	LADANIA	**185382**	8	3	1	3	1	2	QUEIRY
2	MADHAWAPUR	**152396**	7	2	2	5	2		YES
3	JAYNAGAR	**191214**	8	1	2	5	1		Y-2
4	BENIPATTI	**356612**	10	2	8	-	2	-	NO
5	JHANJHARPUR (PHC)	**134755**	NO	3	2	2	3	0	NO
6	KHUTAUNA	**219678**	6	3	3	3	1	1	Y-1 N-2
7.	BISFFI	**359068**	8	3	4	7	1	2	
8.	BABUBARHI	**222964**	7	3	3	-	2	1	
9.	KHAJAULI	**126201**	4	0	4	0	-	-	NO
10	KALUAHI	**126476**	4	1	1	3	1	-	2
11	GHOGHARDIHA	**167019**	8	4	1	3	0	4	5
12	PHULPARAS	**138137**	6	3	1	2	2	1	Y-3 N-1
13	JHANJHARPUR (ONLY FOR PANCHAYET)	**29773**	1	0	1	0	1	0	1
14	RAJNAGAR	**241376**	8	4	4				
17	BASOPATTI	**162532**	4	2	1	-	N.A	N.A	
18	PANDAUL	**260116**	8	5	3	Nil	4	1	
19	ANDHRARTHARI	**175280**	8	3	1	4	3	0	Yes
20	HARLAKHI	**194873**	3	2	3	2	1	-	YES
21	LAUKAHI	**210706**	7	5	2	2	5		YES
22	RAHIKA	**245264**	8	2	4	1	2		N/A
15	MADHEPUR	**479895**	9	5	-	-	4	1	
	Total	**4379717**	122	57	51	42	36	21	

❖ Infrastructure HSCs

S No	Block Name	HSC			Building Status			Building Condition				Assured running water supply			Cont. power supply		
		Total	Functional	Non-Functional	GOVT	Rent	PAN	(+++)	(++)	(+)	(#)	NA	A	I	NA	A	I
1	ANDHRATHADI	18	18	0	5	12	1	5	0	0	0	0	0	0	0	0	0
2	BABUBARHI	21	21	0	10	11	0	5	5	0	11	21	0	0	21	0	0
3	BASOPATTI	16	15	1	9	5	2	1	1	14	0	16	0	0	16	0	0
4	BENIPATTI	37	35	2	20	13	4	8	10	12	7	37	0	0	37	0	0
5	BISFI	35	35	0	11	15	9	0	11	0	207	35	0	0	35	0	0
6	GHOGHARDIHA	17	17	0	5	16	0	5	0	0	16	17	0	0	17	0	0
7	HARLAKAHI	16	16	0	8	8	0	0	8	0	0	16	0	0	16	0	0
8	JAINAGAR	16	16	0	7	9	_	1	4	1	10	16	_	_	16	_	_
9	KALUAHI	11	11	0	5	2	4	5	0	0	6	10	1	0	10	1	0
10	KHAJAULI	15	15	0	5	7	3	5	0	0	10	14	1	0	15	0	0
11	KHUTAUNA	18	18	0	5	0	0	3	2	0	13	18	0	0	18	0	0
12	LADANIA	18	18	2	9	4	3	2	2	8	4	18	0	0	18	0	0
13	LAKHNAUR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	LOUKAHI	25	18	7	12	6	0	11	0	1	6	18	0	0	18	0	0
15	MADHEPUR	66	56	10	2	54	0	0	2	0	54	66	0	0	66	0	0
16	MADHWAPUR	12	12	0	7	5	0	6	2	2	2	7	5	0	12	0	0
17	PANDAUL	31	31	0	0	31	0	0	0	0	8	31	0	0	31	0	0
18	PHULPARAS	12	12	0	3	9	0	3	0	0	9	12	0	0	12	0	0
19	RAHIKA	29	29	0	9	11	9	0	0	0	9	0	0	0	0	0	0
20	RAJNAGAR	22	22	0	12	3	7	0	0	0	0	0	0	0	0	0	0
21	JHANJHARPUR	14	14	0	13	1	0	10	3	0	1	0	0	0	0	0	0
Total		449	429	22	157	222	42	70	50	38	373	352	7	0	358	1	0

❖ Infrastructure APHCs

S No	Block Name	APHC			Building Status			Building Condition				Assured running water supply			Cont. power supply		
		Total	Functional	Non-Functional	GOVT	Rent	PAN	(+++)	(++)	(+)	(#)	NA	A	I	NA	A	I
1	ANDHRATHADI	3	3	0	2	0	0	0	2	0	0	2	0	0	2	0	0
2	BABUBARHI	3	3		3	0	0		3			3	0	0	3	0	0
3	BASOPATTI	1	1	0	1	0	0	0	0	1	0	1	0	0	1	0	0
4	BENIPATTI	2	2	0	2	0	0	0	0	2	0	2	0	0	2	0	0
5	BISFI	3	3	0	1	2	0	0	0	4	2	3	0	0	2	1	0
6	GHOGHARDIHA	4	4	0	1	3	0	0	1	0	3	4	0	0	4	0	0
7	HARLAKAHI	2	2	0	2	0	0	0	0	2	0	2	0	0	2	0	0
8	JAINAGAR	1	1	0	1	0	0	_	1	_	_	1	_	_	1	_	_
9	KALUAHI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	KHAJAULI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	KHUTAUNA	3	3	0	1	1	0	1	0	0	2	3	0	0	3	0	0
12	LADANIA	3	3	0	3	0	0	0	0	1	2	3	0	0	3	0	0
13	LAKHNAUR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	LOUKAHI	5	5	1	5	0	0	4	0	1	0	5	0	0	5	0	0
15	MADHEPUR	14	10	4	3	1	0	0	3	0	3	10	0	0	10	0	0
16	MADHWAPUR	2	2	0	2	0	0	0	1	1	0	2	0	0	2	0	0
17	PANDAUL	6	6	0	6	0	0	0	0	0	0	0	6	0	0	2	0

18	PHULPARAS	3	3	0	2	1	0	2	0	0	1	3	0	0	3	0	0
19	RAHIKA	2	2	0	2	0	0	0	++	0	0	NA	0	0	NA	0	0
20	RAJNAGAR	3	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0
21	JHANJHARPUR	3	3	0	3	0	0	1	1	1	0	0	0	0	0	0	0
Total		63	59	5	43	8	0	8	12	13	13	44	6	0	43	3	0

❖ **Infrastructure PHCs/Refferals/SDHs/DHs**

No	PHC/ Referral Hospital/SDH/DH Name	Building ownership (Govt/ Pan/ Rent	Building condition (+++/ ++/#)	Assured running water supply (A/NA/I)	Continuous power supply (A/NA/I)	Toilets (A/NA/I)	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. of rooms	No. of beds	Functional OT (A/ NA)	Condition of ward (+++/ ++/#)	Condition of OT (+++/++/#)
1	ANDHRATHADI	Govt	+++	NA	A	A	A	+++	13	30	A	++	++
2	BABUBARHI												
3	BASOPATTI	Govt	+++	A	A	A	A	+++	2	6	NA	++	++
4	BENIPATTI	Govt	+++	A	A	A	A	#	12	9	A	#	#
5	BISFI	Govt	+++	A	A	A	A	+++	14	28	A	+++	+++
6	GHOGHARDIHA	Govt	+++	A	A	A	A	+++	8	10	A	+++	+++
7	HARLAKAHI	Govt	+++	A	A	A	A	+++	6	6	A	+++	+++

8	JAINAGAR	Govt	#	I	A	A	A	+	16	7	A	+	++
9	KALUAHI	Govt	++	NA	NA	NA	NA	#	6	6	NA	#	#
10	KHAJAULI	Govt	++	A	A	A	A	#	10	12	A	#	+++
11	KHUTAUNA	Govt	++	A	A	A	A	++	17	18	NA	+++	#
12	LADANIA	Govt	+++	NA	A	A	A	+++	4	8	A	+++	+++
13	LAKHNAUR	Govt	#	-	-	-	-	-	-	-	-	-	-
14	LOUKAHI	Govt	+++	A	A	A	A	+++	13	11	A	+++	+++
15	MADHEPUR	Govt	++	A	A	A	A	++	17	10	A	++	++
16	MADHWAPUR	Govt	+++	A	A	A	NA	+++	5	6	NA	+	#
17	PANDAUL	Govt	+++	A	A	A	A	+++	7	20	A	+++	+++
18	PHULPARAS												
19	RAHIKA	Govt	++	A	A	A	A	++	7	6	NA	++	#
20	RAJNAGAR	Govt	++	A	A	A	A	+++	10	18	A	++	+++
21	Sub-Div. JHANJHARPUR	Govt	++	NA	A	A	A	++	20	50	A	+++	+++
	Total												

❖ Village Health Sanitation Comity , ASHA

S.No	Name of Block	No. of GPs	No. VHSC formed	Total amount released to VHSC from untied funds	No. of ASHAs	Number of ASHAs trained	
						Round 1	Round 2
1	ANDHRATHADI	18	18	4,40,000.00	147	139	0
2	BABUBARHI	20	20	5,90,000.00	172	172	0
3	BASOPATTI	15	12	3,00,000.00	122	122	32
4	BENIPATTI	33	33	9,90,000.00	267	266	0
5	BISFI	28	18	5,30,000.00	253	228	0
6	GHOGHARDIHA	5	5	4,90,000.00	290	130	0
7	HARLAKAHI	17	16	4,00,000.00	151	142	18
8	JAINAGAR	15	15	1,80,000.00	132	45	0
9	KALUAHI	11	1	4,60,000.00	180	171	34
10	KHAJAULI	14	14				23
11	KHUTAUNA	18	18	4,30,000.00	167	167	0
12	LADANIA	15	13	2,40,000.00	137	137	0
13	LOUKAHI	18	15	6,20,000.00	151	137	0
14	MADHEPUR+LAKHNAUR	43	12	12,20,000.00	183	160	0
15	MADHWAPUR	13	13	3,90,000.00	110	110	0
16	PANDAUL	26	26	7,10,000.00	218	217	0
17	PHULPARAS	31	31	3,80,000.00	0	0	0
18	RAHIKA	22	21	7,70,000.00	170	137	0
19	RAJNAGAR	25	23	6,00,000.00	191	191	0
20	JHANJHARPUR	13	13	6,50,000.00	115	106	0
TOTAL		400	337	**1,03,90,000.00**	3156	2777	107

❖ **Man Power In Block**

Man-Power Status In Block

Sl. No	DH/SDH/REFF PHC Name	Doctors			ANM			Laboratory Technician			Pharmacists			Dresser			Nurses A Grade		
		Senction	In Position		Sencti on	In Position		Senction	In Position		Senction	In Position		Sencti on	In Position		Sencti on	In Position	
		Reg	Reg	Cont	Reg.	Reg.	Cont.	Reg.	Reg.	Cont.	Reg.	Reg.	Cont.	Reg.	Reg.	Cont.	Reg.	Reg.	Cont.
1	ANDHRATHADI	10	4	3	20	13	4	5	0	2	5	1	0	2	0	0	3	1	0
2	BABUBARHI	7	2	2	42	21	12	2	0	2	2	0	0	2	0	0	4	0	0
3	BASOPATTI	6	2	3	16	12	3	2	0	2	2	0	0	2	0	0	4	0	0
4	BENIPATTI	28	3	2	70	30	8	1	0	0	1	1	0	1	1	0	0	0	1
5	BISFI	9	2	6	43	23	6	4	1	0	4	0	0	4	3	0	0	0	0
6	GHOGHARDIHA	10	2	3	38	15	16	8	0	1	8	1	0	8	3	0	18	0	1
7	HARLAKAHI	9	3	4	41	15	3	1	0	0	3	0	0	3	1	0	3	0	1
8	JAINAGAR	5	3	3	32	15	2	2	0	0	1	0	0	1	0	0	_	0	1
9	KALUAHI	3	2	0	22	9	1	1	0	1	1	0	0	1	0	0	2	0	0
10	KHAJAULI	7	3	2	28	14	10	1	0	0	1	0	0	1	1	0	3	0	0
11	KHUTAUNA	10	2	5	26	15	5	3	0	2	4	1	0	4	2	0	0	0	0
12	LADANIA	4	2	3	1	4	0	1	0	0	1	0	0	1	1	0	0	0	1
13	LAKHNAUR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	LOUKAHI	14	2	1	40	7	11	6	0	1	6	0	0	6	1	0	6	0	0
15	MADHEPUR	32	2	4	44	24	16	11	0	1	11	1	0	11	2	0	10	0	1
16	MADHWAPUR	10	2	7	30	17	5	3	0	0	3	1	0	3	1	0	3	0	0
17	PANDAUL	8	4	4	62	34	8	3	0	3	2	1	0	2	2	1	2	0	0

18	PHULPARAS	6	2	2				1	0	0	2	0	0	1	0	0	0	0	0
19	RAHIKA	7	3	3	29	29	1	0	0	0	1	1	0	4	3	0	0	0	0
20	RAJNAGAR	11	3	2	50	25	5	5	0	0	5	1	0	5	0	0	6	0	2
21	Sub-Div. JHANJHARPUR	8	4	2	0	0	0	1	0	1	2	1	0	2	2	0	6	1	0
22	SADAR HOSPITAL	22	10	6	2		2	4	1	0	2	2	0	4	0	0	18	4	2
23	JHANJHARPUR	4	2	2	15	10	9	5	0	2	6	1	0	6	3	0	16	1	2
TOTAL		213	64	69	584	332	163	70	2	18	73	13	0	74	26	1	104	7	12

❖ Activity & Analysis

Maternal Health & JBSY

The district is conducting normal deliveries only at PHCs and not at any sub centre or APHC. Caesarean sections happen only at the district hospital. There are several blocks, which are more than 20 km. away from the district headquarters. According to the norms, there has to be one facility per 500,000 population providing CS services. There are 2 gynaecologists. As per DLHS III, only 16% deliveries were happening at institutions and only 4% of home deliveries were attended by SBAs; on ANC, only 30% pregnant women were registered in their first trimester and only 36% received at least 3 ANCs. PNC within 48 hrs. post delivery was 10%.

Taking population of Madhubani as 35,71,000 (census 2001) and birth rate as 28.9 / 1000 (for Bihar, Census 2001) population, and pregnancy wastage as 10%, approximately, 113,522 pregnancies happens in Madhubani district per year. Not all deliveries happen at government facilities, yet as per the service data (source: HMIS Madhubani), 39213 deliveries happened at govt. facilities in 2009-10, out of which -71330 women were registered for ANC (of this 58% were registered in the 1st Trimester). 30638 women were registered for JBSY (-29% of PW). 39213 delivery happened at institutions and 17558 happened at home. Of all home deliveries reported, 10,216 were attended by SBAs. As per the service data, only 30% pregnant women had 3 ANC checks, 16% got 100 IFA tablets, and 60% received 2TT injections. 6% of all deliveries were conducted as caesarean. The information also showed that 37% deliveries were given post-natal visits within 48 hrs. following birth. The figures from DHS also show that no MTP was performed in the last year and no training was provided on MTP to any doctor and/or SN/ANM. 29 and 19 cases of RTI/STI were treated in year 2009-10 and April – September 2010 respectively.

Objectives	1. 100% pregnant women to be given two doses of TT 2. 90% pregnant women to consume 100 IFA tablets by 2010 3. 70% Institutional deliveries by 2010 4. 90% deliveries by trained /Skilled Birth Attendant by 2010 5. 95% women to get improved Postnatal care by 2010 6. Increase safe abortion services from current level to 80 % by 2010
Strategies	1. Provision of quality Antenatal and Postpartum Care to pregnant women 2. Increase in Institutional deliveries 3. Quality services in the health facilities 4. Availability of safe abortion services at all APHC and PHC 5. Increased coverage under JBSY 6. Strengthening the Maternal, Child Health and Nutrition (MCHN) days 7. Improved behavior practices in the community **8. To construct New 100 Bedded Maternity Ward in Sadar Hospital Madhubani & 30 Bedded Maternity Ward in PHC Babubarhi and Phc Benipatti.**
Activities	1. Identification of all pregnancies through house-to-house visits by ANMs, AWWs and ASHAs 2. Fixed Maternal, Child Health and Nutrition days • Once a week ANC clinic by Health Worker at all PHCs and CHCs • Development of a microplan for ANMs in a participatory manner • Wide publicity regarding the MCHN day by AWWs and ASHAs and their services • A day before the MCHN day the AWW and the ASHA should visit the homes of the pregnant women needing services and motivate them to attend the MCHN day • Registration of all pregnancies • Each pregnant woman to have at least 3 ANCs, 2 TT injections and 100 IFA tablets • Nutrition and Health Education session with the mothers 3. Postnatal Care • The AWW along with ANM will use IMNCI protocols and visit neonates and mothers at least thrice in first week after delivery and in total 5 times within one month of delivery. They will use modified IMNCI charts to identify problems, counsel and refer if necessary 4. Tracking bags • Provision of tracking bags for the left outs and the dropout Pregnant mothers • Training of ANMs and AWWs for the use of Tracking bags 5. Provision of Weighing machines to all Subcentres and AWCs 6. Availability of IFA tablets • ASHAs to be developed as depot holders for IFA tablets • ASHA to ensure that all pregnant women take 100 IFA tablets 7. Training of personnel for Safe motherhood and Emergency Obstetric Care (Details in Component on Capacity building) 8. Developing the APHC and PHC for quality services and IPHS standards (Details

	in Component Upgradation of APHC & PHCs and IPHS Standards) 9. Availability of Blood at the General Hospital and PHC • Establishing Blood storage units at GH and PHC • Certification of the Blood Storage centres 10. Improving the services at the Subcentres (Details in Component on Upgradation of Subcentres and IPHS) 11. Behaviour Change Communication (BCC) efforts for awareness and good practices in the community (Details in Component on IEC) 12. Increasing the Janani Suraksha coverage • Wide publicity of the scheme (Details in Component on BCC …) • Availability of advance funds with the ANMs • Timely payments to the beneficiary • Starting of Janani Suraksha Yojana Helpline in each block through Swasthya Kalyan Samitis 13. Training of TBAs focussing on their involvement in MCHN days, motivating clients for registration, ANC, institutional deliveries, safe deliveries, post natal care, care of the newborn & infant, prevention and cure of anaemia and family planning 14. Safe Abortion: • Provision of MTP kits and necessary equipment and consumables at all PHCs • Training of the MOs in MTP • Wide publicity regarding the MTP services and the dangers of unsafe abortions • Encourage private and NGO sectors to establish quality MTP services. • Promote use of medical abortion in public and private institutions: disseminate guidelines for use of RU-486 with Mesoprestol 15. Development of a proper referral system with referral cards 16. Improvement of monitoring of ANM tour programme and Fixed MCHN days • Fixed MCHN days and Tour plan of ANM to be available at the PHCs with the MOs • Checklist for monitoring to be developed • Visits by MOs and report prepared on basis of checklist filled • Findings of the visits by MOs to be shared by MO in meetings 17. RCH Camps: These will be organized once each quarter through NGOs/Rotary/Lions clubs to provide specialist services especially for RTI/STD cases.

Newborn & Child Health

Breast feeding: As per DLHS 2003, only 7.9% mothers breastfeed their children within two hours of birth and 4.8% children were breastfed exclusively for stipulated period of 4 months. There is lack of knowledge regarding the significance of colostrums and the socio-cultural factors associated with it.

Childhood illnesses

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

Pneumonia: There is a need to create awareness regarding the danger signs of Pneumonia since only half of the women are aware of danger signs of pneumonia as per DLHS 2002.

Newborn and Neonatal Care: There is very little data available for the newborns and the neonates. The District data shows that a negligible percentage of newborns and neonates died which is doubtful. Reporting regarding these deaths is not done properly. The various health facilities also are poorly equipped to handle newborn care and morbidity. The TBAs and the personnel doing home deliveries are unaware regarding the neonatal care especially warmth, prevention of infection and feeding of colostrum.

1. Reduction the IMR.
2. Increased proportion of women who are exclusively breastfed for 6 months to 100%
3. Increased in Complete Immunization to 100%
4. Increased use of ORS in diarrhea to 100%
5. Increased in the Treatment of 100% cases of Pneumonia in children
6. Increase in the utilization of services to 100%

1. Improving feeding practices for the infants and children including breast feeding
2. Promotion of health seeking behavior for sick children
3. Community based management of Childhood illnesses
4. Improving newborn care at the household level and availability of Newborn services in all PHCs & hospitals
5. Enhancing the coverage of Immunization
6. Zero Polio cases and quality surveillance for Polio cases

1. Improving feeding practices for the infants and children including breast feeding
- Study on the feeding practices for knowing what is given to the children
- Education of the families for provision of proper food and weaning
- Educate the mothers on early and exclusive breast feeding and also giving Colostrums
- Introduction of semi-solids and solids at 6 months age with frequent feeding
- Administration of Micronutrients – Vitamin A as part of Routine immunization, IFA and Vitamin A to the children who are anemic and malnourished

2. Promotion of health seeking behavior for sick children and Community based management of Childhood illnesses
   - Training of LHV, AWW and ANM on IMCI including referral
   - BCC activities by ASHA, AWW and ANM regarding the use of ORS and increased intake of fluids and the type of food to be given
   - Availability of ORS through ORS depots with ASHA
     Identification of the nearest referral center and also Transport arrangements for emergencies with the PRIs and community leaders with display of the referral center and relevant telephone numbers in a prominent place in the village
3. Improving newborn care at the household level
   - Adaptation of the home based care package of services and scheduling of visits of all neonates by ASHA/AWW/ANM on the 1st, 2nd, 7th, 14th and 28th day of birth.
   - In case of suspicion of sickness the ASHA /AWW must inform the ANM and the ANM must visit the Neonate
   - Referral of the Neonate in case of any symptoms of infection, fever and hypothermia, dehydration, diarrhea etc;
   - Training on IMNCI of ASHA/AWW/ANM/MOs on the home based Care package
   - Supply of medicine kit and diagnosis and treatment protocols (chart booklets) for implementation of the IMNCI strategy
   - Strengthening the neonatal services and Child care services in Sadar hospital Madhubani and all PHC. This will be done in phases.
   - In all of these units, newborn corners would be established and staff trained in management of sick newborns and immediate management of newborns. For all the equipment for establishing newborn corners, a five year maintenance contract would be drawn with the suppliers. The suppliers would also be responsible for installing the equipment and training the local staff in basic operations
   - The equipment required for establishing a newborn corner would include Newborn Resuscitation trolley, Ambubag and masks (newborn sizes), Laryngoscopes, Photo therapy units, Room warmers, Inverters for power back-up, Centralized oxygen and Pedal suctions
   - Training of staff in Newborn Care, IMNCI and IMCI (MOs, Nurses) including the management of sick children and severely malnourished children.
   - Availability of Pediatricians in all the District hospital and PHCs
   - Ensuring adequate drugs for management of Childhood illnesses.
4. Strengthening the fixed Maternal and Child health days (Also discussed in the component on Maternal Health)
   - Developing a Micro plan in joint consultation with AWW
   - Organize Mother and Child protection sessions twice a week to cover each village and hamlet at least once a month
   - Use of Tracking Bag
   - Tracking of Left-outs and dropouts by ASHA, AWW and contacting them a day before the session
   - Information of the dropouts to be given by ANM to AWW and ASHA to ensure their attendance
   - Wide publicity regarding the MCHN days
5. Strengthening Immunization

1. Availability of trained staff including Pediatricians 2. Technical Support for training of the personnel 3. Timely availability of vaccines, drugs and equipment 4. Good cooperation with the ICDS and PRIs

Routine Immunization

Situation Analysis/ Current Status	
Objectives/ Milestones/ Benchmarks	Reduction in the IMR 100 % Complete Immunization of children (12-23 month of age) 100 % BCG vaccination of children (0-12 month of age) 100% DPT 3 vaccination of children (12-23 month of age) 100% Polio 3 vaccination of children (12-23 month of age) 100% Measles vaccination of children (12-23 month of age) 100% Vitamin A vaccination of children (12-23 month of age)
Strategies	1. Strengthening the District Family Welfare Office 2. Enhancing the coverage of Immunization 3. Alternative Vaccine delivery 4. Effective Cold Chain Maintenance 5. Zero Polio cases and quality surveillance for Polio cases 6. Close Monitoring of the progress

Activities	1. Strengthening the District Family Welfare Office • Support for the mobility District Family Welfare Officer (@ Rs.3000 per month towards cost of POL) for supervision and monitoring of immunization services and MCHN Days • One computer assistant for the District Family Welfare Office will be provided for data compilation, analysis and reporting @ Rs 4500 per month. 2. Training for effective Immunization Training for all the health personnel will be given including ANMs, LHVs, FPWs, Cold chain handlers and statistical assistants for managing and analyzing data at the district. 3. Alternative vaccine delivery system (mobility support to PHCs for vaccine delivery) a. For Alternative vaccine delivery, Rs. 50 to per courier or Rs. 100 to per HRA courier will be given per session. It is proposed to hold two session per week per HSC area. b. Mobility support (hiring of vehicle) is for vaccine delivery from PHC to MCH days site where the immunization sessions are held for 8 days in a month 4. Incentive for Mobilization of children by Social Mobilizers • Incentive will be given to Social Mobilizers for each session site for mobilization number of children and pregnant woman. • 6. Contingency fund for each block • Rs. 1000/ month per block will be given as contingency fund for communication. 7. Disposal of AD Syringes • For proper disposal of AD syringes after vaccination, hub cutters will be provided by Govt. of India to cut out the needles (hub) from the syringes. Plastic syringes will be separated out and will be treated as plastic waste. Regarding the disposal of needles, Pits will be formed at PHCs as per CPCB guidelines. For construction of the pits at PHCs a sum of Rs. 2000/ PHC has been provisioned. 8. Outbreak investigation • Rapid Action Team for epidemics will be formed • Dissemination of guidelines • Training of Rapid Action Team for investigating outbreaks who will in turn orient the ANMs during Sector meetings 9. Adverse effect following Immunization (AEFI) Surveillance: • Standard Guidelines have been developed at national level and will be disseminated to the district officials and block levels in Review meetings. 10. IEC & Social Mobilization Plans Discussed in details in the Component on IEC 11. Cold Chain • Repairs of the cold chain equipment @ 750/- per PHC will be given each year • For minor repairs, Rs. 10,000 will be given per year.

	• Electricity & POL for Genset & preventive maintenance (Running Cost) of 500 per day. • Payment of electricity bills for continuous maintenance of cold chain for the PHCs @ 400 per month PHCs (vaccine distribution centers) has been budgeted under this head. POL & maintenance of vaccine delivery van 5000/- per month. @ Rs. 1500/month for maintenance and POL for Vaccine delivery van for regular supply of vaccine to the PHCs.
Support required	State to ensure the following: • Regular supply of vaccines and Auto disable syringes • Reporting and Monitoring formats • Monitoring charts • Cold Chain Modules and monitoring formats • Temperature record books • Polythene bags keep vaccine vials inside vaccine carrier • Polythene bags(Red & Black) keep into use syringe and vials • Training of Cold Chain handlers • Training of Mid level managers • Extra budget for cold chain handler for vaccine delivery two days in a week

Population Stabilization Family Planning

Situation Analysis/ Current Status	The awareness regarding contraceptive methods is high except for the emergency contraception. This is because of inadequate IEC carried out for Emergency Contraception Currently 23% couples are using temporary methods of contraception and 17% have permanent sterilization (mainly Female sterilization). In temporary methods commonest use is of Condom, which has a high failure rate. Use of Copper –T is low. The community prefers female sterilization since there is gender imbalance and limited male involvement. Women also do not have decision-making power. The reasons for the low use of permanent methods and Copper -T are due to inadequate motivation of the clients, inadequate manpower, limited skills of the ANMs for IUD insertion and also their irregular availability. The rejection rate is high since proper screening is not done before prescribing any spacing method. Copper T-380 – 10 year Copper T has been recently introduced but there is very little awareness regarding its availability. There is a need to promote this 10 yr

	Copper T Some socio-cultural groups have low acceptance for Family Planning. The current number of trained providers for sterilization services is insufficient.
Objectives	1. Reduction in Total fertility Rate. 2. Increase in Contraceptive Prevalence Rate to 70 % 3. Decrease in the Unmet need for modern Family Planning methods to 0% 4. Increase in the awareness levels of Emergency Contraception
Strategies	1. Increased awareness for Emergency Contraception and 10 yr Copper T 2. Decreasing the Unmet Need for Family Planning 3. Availability of all methods at all places 4. Increasing access to terminal methods of Family Planning 5. Promotion of NSV 6. Expanding the range of Providers 7. Increasing Access to Emergency Contraception and spacing methods through Social marketing 8. Building alliances with other departments, PRIs, Private sector providers and NGOs
Activities	• **1.** Expanding the range of Public Sector providers for Terminal methods • Each APHC and PHC will have one MO trained in any sterilization method. • All the APHC/PHC will have at least one MO posted who can be trained for abdominal Tubectomy. This method does not require a postgraduate degree or expensive equipment. • Similarly MOs will be trained for NSV • Specialists from District hospitals and PHCs will be trained in Laparoscopic Tubal Ligation. • At PHCs, one medical officer will be trained in NSV • Each PHC will be a static center for the provision of sterilization services on regular basis. The Static centers will be developed as pleasant places, clean, good ambience with TV, music, good waiting space and clean beds and toilets. • At selected PHCs where the EmOC intervention is undertaken, the medical officer will be trained for NSV. • Equipments and supplies will be provided at APHC and PHC for conducting sterilization services. • A systemic effort will be made to assess the needs of all facilities, including staff in position and their training needs, the availability of electricity and water, Operation theatre facilities for District hospitals/PHC/APHC, Inventory of equipment, consumables and waste disposal facilities and the condition, location and ownership of the building. • At least three functional Laparoscope's will be made available per team, as will the equipment and training necessary to provide IUD and emergency contraception services. The existing Laparoscope's need to be replaced. For effective coverage 4 teams are required with minimum three Laparoscope's

	for each team. • Vacant positions will be filled in on a contractual basis. • Access to Terminal Family Planning methods • Provision of Sterilization services every day in all the hospitals • Organization of Sterilization camps on fixed days at all PHC • NSV • **2.** Formation of District implementation team consisting of DM, CS, District MEIO, Distt NSV trainer • One day Workshop with elected representatives, Media, NGOs, departments for sensitization and implementation strategy, fixing pre-camp, camp and post-camp responsibilities • Development of a Micro plan in one day Block level workshops • NSV camp every quarter in all hospitals initially and then PHCs and APHCs • IEC for NSV • Trained personnel • Follow-up after NSV camp on fixed days after a week and after 3 months for Semen analysis • Access to non-clinical contraceptives increased in all the villages • AWWs and ASHAs as Depot holders • **3.** Training in Spacing methods, Emergency Contraceptives and interpersonal communication for dissemination of information related to the contraceptives in an effective manner. • Supply of Emergency Contraceptives to all facilities • Access for the quality IUD insertion improved at all the 27 subcentres. • All the ANMs at 27 subcentres will be given a practical hands on training on insertion of IUD • Diagnosis and treatment of RTI/STI as per syndromic approach. The various screening protocols related to the IUD insertion enabling her to screen the cases before the IUD insertion. This will result in longer retention of IUDs. • Counseling of the cases • Repair of subcentres so that the IUD services can be provided and ensuring privacy and confidentiality. • IUD 380 A will be used due to its long retention period and can be used as an alternative for sterilization. • Awareness on the various methods of contraception for making informed choices • Discussed in the Component on IEC • **5.** Increasing the gender awareness of providers and increasing male involvement • Empowering women • Increasing male involvement in family planning through use of condoms for safe sex and also in Vasectomy. • BCC activities to focus on men for Vasectomy. • Gender sensitization training will be provided for all health providers in the

	CHC/PHC and integrated into all other training activities. • Service delivery sites for male methods by training health providers in NSV and conventional vasectomy will be expanded so that each CHC and Block PHC in the district has at least a provider trained in NSV. • **6.** Improving and integrating contraceptives/RCH services in PHCs and Sub-centers • Skill-based clinical training for spacing methods including IUCD insertion and removal, LAM, SDM and EC of Lady Health Visitors (LHVs) and Auxiliary Nurse Midwives (ANMs). • They will also be trained in infection prevention, counselling and follow up for different family planning methods. • MIS training will also be given to the health workers to enable them to collect and use the data accurately. • Their supervisors will be trained for facilitative supervision and MIS. • Follow up of trained LHVs and ANMs after one month and six months of training and provide supportive feedback to the service providers • **7.** Strengthening linkages with ICDS programme of women and child development department and ISM (Ayurveda) • A detailed action plan will be produced in co-ordination with the ICDS department for involvement of the AWWs and their role in increasing access to contraceptive services. • Department of health officials and ICDS officers will be orientated to the plan. • AWWs and their supervisors will receive technical training and training in communication skills and record keeping by Medical Officer of the PHC and LHV. • Staff of ISM department will be trained in communication and non-clinical methods to promote and increase the availability of FP methods. • **8.** Engaging the private sector to provide quality family planning services • Incentives and training to encourage private providers to provide sterilization services • Training private lady doctors in IUD insertion and promoting the provider will help to expand coverage of these services increase the total use of IUCD. • Detailed plan will be developed in consultation with the private sector for determining the amount and mode of payment, the regulation and monitoring frameworks necessary, and safeguards to ensure equity of access. • Training for the private sector will be provided as above, and approved, monitored providers will be promoted and eligible for discounted supplies. • Accreditation of private hospitals and clinics for sterilization and NSV • Role of ASHAs: • Training for provide counseling and services for non-clinical FP methods such as pills, condoms and others. • Act as depot holders for the supplies of pills and condoms by the ANMs for free distribution

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Procurement of pills and condoms from social marketing agencies and provide these contraceptives at the subsidized rate
Provide referral services for methods available at medical facilities
Assist in community mobilization and sensitization.
Building partnerships with NGOs
Creating an enabling environment for increasing acceptance of contraceptive services Innovative schemes will be developed for reaching out to younger men, women, newly married couples and resistant communities.
These will be and scaled up as appropriate.

</td></tr>
<tr><td>Support required</td><td>

Availability of a team of master trainers/ANM tutors and RFPTC trainers for follow up of trained LHVs and ANMs after one month and six months of training and provide supportive feedback to the service providers
A training cell will be created in the medical college for the training of the medical officers in the area of various sterilization methods
Availability of equipment, supplies and personnel

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<tr><td>Timeline</td><td>
<table>
<tr><td></td><td>2011-12</td></tr>
<tr><td>Training of MOs for NSV</td><td>10 MOs</td></tr>
<tr><td>Training of MOs for Minilap</td><td>10 MOs</td></tr>
<tr><td>Training of Specialists for Laparoscopic Sterilization</td><td>10 MOs</td></tr>
<tr><td>Sterilization Camps (Persons)</td><td>15000</td></tr>
<tr><td>Accreditation of private institutions for sterilization</td><td>2</td></tr>
<tr><td>Supply of Copper T – 380</td><td>10000</td></tr>
<tr><td>Emergency Contraception</td><td>6000</td></tr>
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ASHA

<table>
<tr><td>Situational Analysis</td><td>ASHA is an honorary worker and will be reimbursed on performance-based incentives and will be given priority for involvement in different programmes wherever incentives are being provided (like institutional delivery being promoted under JBSY, motivation for sterilization, DOTS provider, etc.). It is conceived that she will be able to earn about Rs. 1,000.00 per month

In district Madhubani 3034 ASHAs have been selected and 2751 have received training.</td></tr>
<tr><td>Objectives</td><td>1. Availability of a Community Resource, service provider, guide, mobilizer and escort of community
2. Provision of a health volunteer in the community at 1000 population for healthcare
3. To address the unmet needs</td></tr>
<tr><td>Strategies</td><td>1. Selection and capacity building of ASHA.
2. Constant mentoring, monitoring and supportive supervision by district Monitoring group</td></tr>
<tr><td>Activities</td><td>1. Strengthening of the existing ASHAs through support by the ANMs and their involvement in all activities.
2. Reorientation of existing ASHAs
3. Selection of new ASHAs to have one ASHA in all the villages and in urban slums
4. Provision of a kit to ASHAs
5. Formation of a District ASHA Mentoring group to support efforts of ASHA and problem solving
6. Review and Planning at the Monthly sector meetings
7. Periodic review of the work of ASHAs through Concurrent Evaluation by an independent agency</td></tr>
<tr><td>Support required</td><td>1. Timely Payments to ASHA
2. Proper training.</td></tr>
<tr><td>Timeline</td><td>
<table>
<tr><th>Activity</th><th>2011-12</th></tr>
<tr><td>Selection of additional ASHAs</td><td>844</td></tr>
<tr><td>Total ASHAs</td><td>4046</td></tr>
<tr><td>Training of new & untrained ASHAs</td><td>1296</td></tr>
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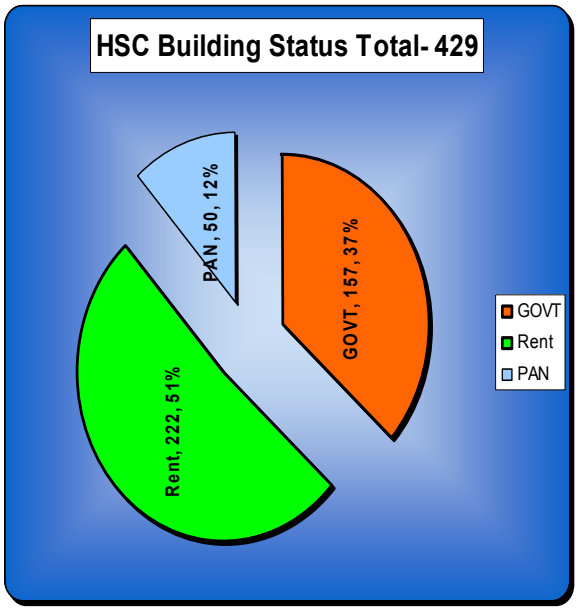
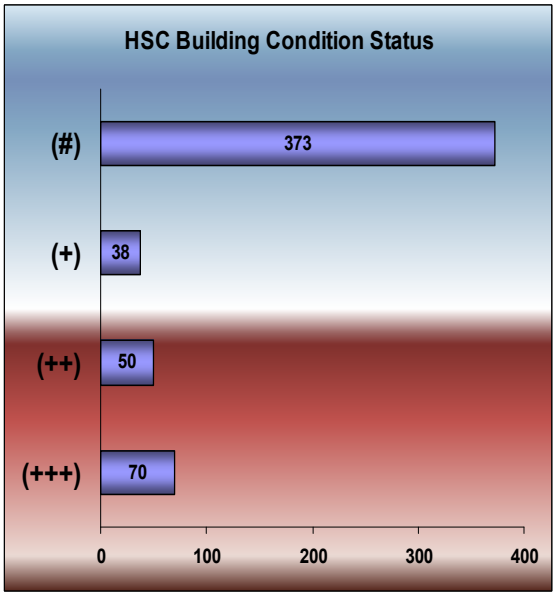
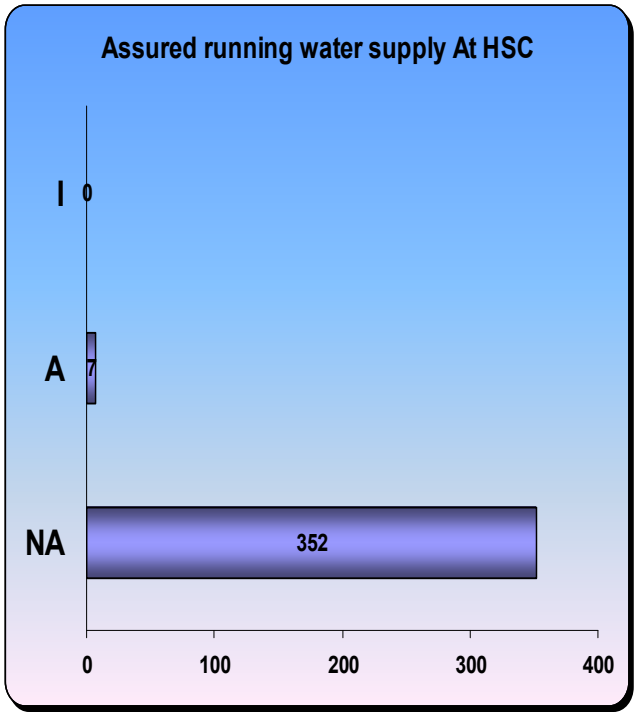
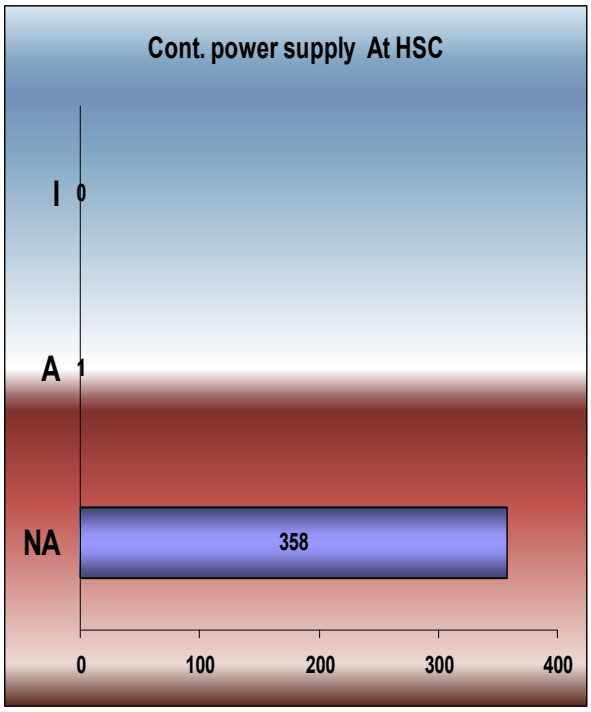
</table>

HSCs Analysis

As per IPHS norms a sub center provides interface with the community at the grass root level providing all the health care services. Of particular importance are the practices/ packages of services such as immunization, ANC, NC and PNC, prevention of malnutrition and common childhood diseases, family planning services and counseling. They also provide elementary drugs for minor ailments such as ARI, diarrhea, fever, worm infestation etc. And carry out community need assessment. Besides the above, government implements several national health and family welfare programs which again are delivered through these frontline workers.

Sub Heads	Gaps	Issues	Strategy	Activities
Current Status				
				


Assured running water supply At HSC
I
0
A
7
NA
352
0
100
200
300
400


Cont. power supply At HSC
I
0
A
1
NA
358
0
100
200
300
400

Service performance	Unutilized untied fund at HSC level	Operationalization of Untied fund.	Capacity building of account holder of untied fund	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts
	No ANC at HSC level	Improvement in quality of services like ANC, NC and PNC, Immunization	Strengthening one HSC per PHC for institutional delivery in first 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 the list prepared 4.Honouring first delivered baby and ANM
	Poor PW registered in first trimester PW with three ANCs is also poor	Improvement in quality of services like ANC, NC and PNC, Immunization and family planning	1. Phase wise strengthening of HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. 2. Community focused family planning services	1 Gap identification HSCs through facility survey 2. Eligible Couple Survey 3. Ensuring supply of contraceptives with three month's buffer

	Family Planning Status:			stock at HSCs. 4. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 5. Training of ANMs on IUD insertion

	Lack of counseling services	Training	Training	1. Training to ANMs on ANC, NC and PNC, Immunization and other services.
	HSC unable to implement disease control programs	Integration of disease control programs at HSC level.	Implementation of disease control programs through HSC level	1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6. (four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.
	80% of the HSC staffs do not reside at place of posting	Absence of staffs	Community monitoring	1. Submission of absentees through PRI
	Problem of mobility during rainy season	Communication and safety		1.Purchasing Life saving jackets for all field staffs 2. Providing incentives

				to the ANMs during rainy season so that they can use local boats.

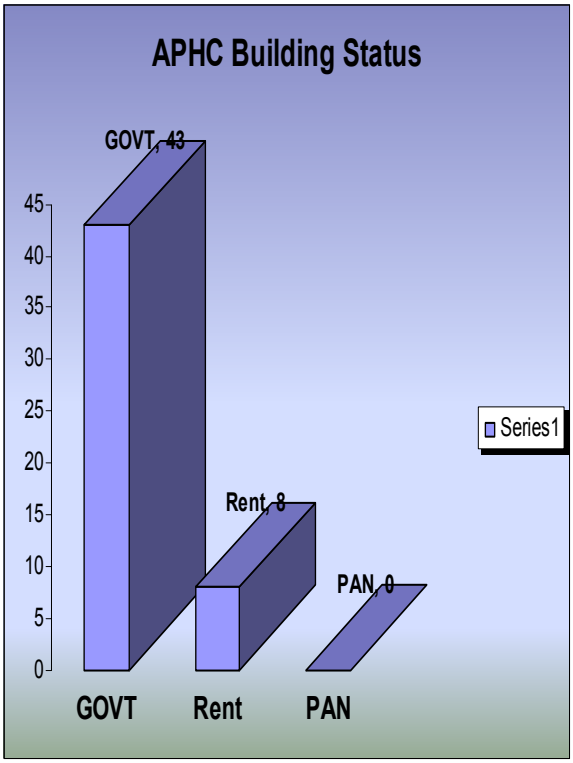
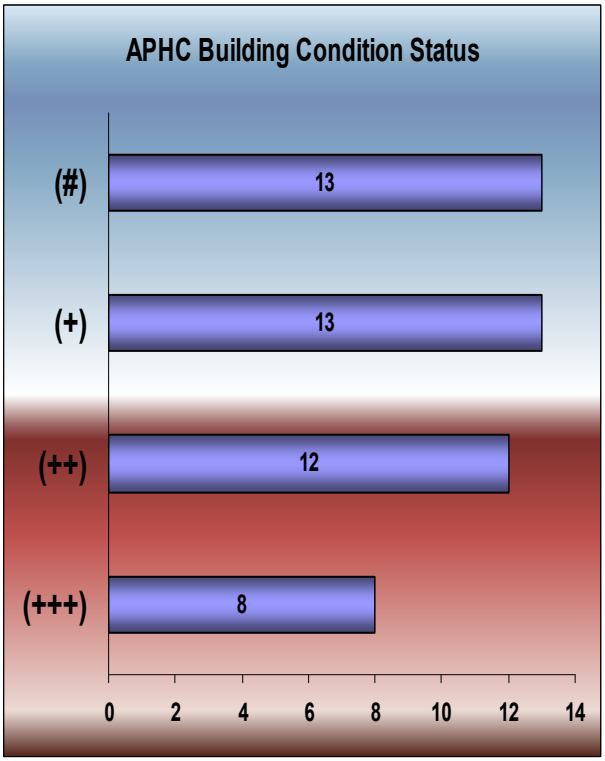
Sub Heads	Gaps	Issues	Strategy	Activities
Human Resource	Out of 429 seats 295 seats of contractual ANM®, are vacant. Out of 248 seats of Staff Nurses 146 seats are vacant.	Filling up the staff shortage	Staff recruitment	1.Selection and recruitment of required ANMs 2. Selection and recruitment of required staff nurse.
	All 429 contractual ANMs needs training on different services.	Untrained staffs	Capacity building	1.Training need Assessment of HSC level staffs 2.Training of staffs on various services
	The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities	Training	Strengthening of ANM training school	1.Analyzing gaps with training school 2.Deployment of required staffs/trainers 3.Hiring of trainers as per need 4.Preparation of annual training calendar issue

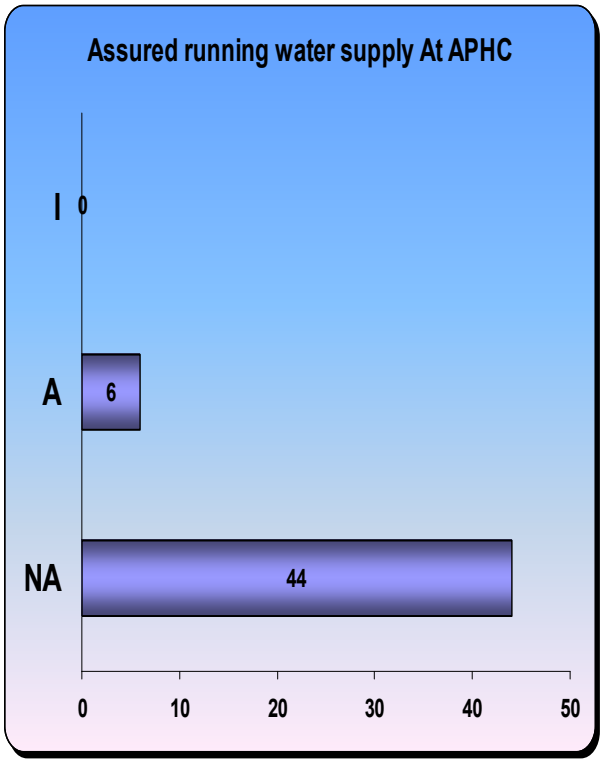
				wise as per guideline of Govt of India. 5.Allocation of fund and perationalization of allocated fund
	Only need based emergency suuply Irregular supply of drugs	Logistics		1.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.Hiring vehicles for supply of drug kits through untied fund. 3.Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)
		Operationalization	Couriers for vaccine and other drugs supply	1 Hiring of couriers as per need 2 Payment of courier through

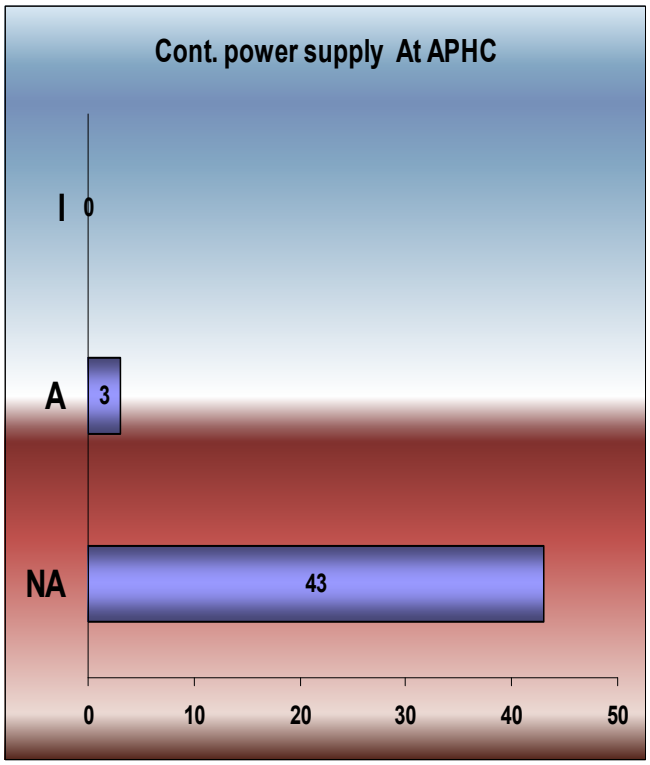
				ANMs account
			Phase wise strengthening of APHCs for vaccine / drugs storage	1.Purchasing of cold chain equipments as per IPHS norms 2. training of concerned staffs on cold chain maintenance and drug storage

APHCs Analysis

Additional PHCs

Current Status	
	





Sub Heads	Issues	Strategy	Activities
Infrastructure	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	1.“Swasthya Kendra Chalo Abhiyan” to strengthen community ownership 2.Nukkad Nataks on Citizen’s charter of APHCs as per IPHS 3. Registration of RKS 4.Monthly meetings of VHSCs, Mothers committees and RKS **A.Strengtheing of APHCs having own buildings** A.1Rennovation of APHCs buildings A.2 Purchase of Furniture A.3 Prioritizing the equipment list

		operationalization of construction works in Three phase	according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries Purchase of equipments as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new APHC buildings as standard layout of IPHS norms. C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New APHC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed APHC 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

			Monitoring	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.
	Gaps	**Issues**	**Strategy**	**Activities**
Human Resource	Lack of doctors, Lack of ANMs, Lack of A Grade nurses, Lack of Pharmacists. Untrained	Filling up the staff shortage Untrained staffs	Staff recruitment	1.Selection and recruitment of 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

	ANMs and male workers The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities Most of the APHC staffs are deputed to respective PHC hence APHC are defunct		Capacity building Strengthening of ANM training school	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 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	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 2 and 6 Couriers for	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)

	Irregular supply of drugs		vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	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

Primary Health Centers:(30 bedded)

Indicators	Gaps	Issues	Strategy	Activities
Infrastructure	All PHCs are running with only six bed facility. The huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 100% of facilities are not adequate as per IPHS norms.(written below) 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 the area of improvement. Lack of equipments as per IPHS norms	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	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

	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 Lack of Maternity beds in PHSc Babubarhi and Benipatti.		BMU Ensuring community participation.	RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community representatives on erecting boundary, beautification etc, 2. Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS. **Strengtheing of PHCs** 1.Rennovation of PHCs 2.Purchase of Furniture 3. Prioritizing the equipment list according to service delivery and IPHS norms. 4. Purchase of equipments 5. Printing of formats and purchase of stationeries

			Strengthening of Infrastructure and operationalization of construction works Monitoring	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. 3. Construct 30 bedded maternity ward in PHC babubarhi & Benipatti.
Human Resource	As per IPHS norms each PHC requires clinical staffs	Staff shortage Untrained staffs	Staff recruitment	1.Selection and recruitment of Doctors 2.Selection and recruitment of ANMs/ male workers 3.Selection and recruitment of paramedical/

			Capacity building	support staffs 4.Appointment of Block Health Managers in all institutions) 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 programs.
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time. Only 70 % essential drugs are rate contracted at state level .	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7	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

	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.		Strengthening of drug logistic system	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 each PHC. 2. Total 85 seats of Regular and 22 seats of contractual doctors in the	Optimun Utilization of Human Resources	Quality improvement in residential facility of doctors/ staffs.	1. Hiring of rented houses from RKS fund for the residence of doctors and key staffs. 2. Incentivizing doctors on their

	district is vacant. 3. All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less 4. lacking of 24 hrs new born care services. 5. 4 Lab services provided by PPP services have fled away. 6.Health facility with AYUSH services is not being provided 7. Lack of maintenance of ambulances 8. Shortage of ambulances 9. Quality of food, cleanliness (toilets,Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC. 10. In serving emergency cases, there are maximum chances of	Epidemic outbreaks and Need based intervention in epidemic areas.	Recruitment Proper and timely information of outbreaks	performances especially on OPD, IPD, FP operations, Kala-azar 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 information of outbreaks 4. Purchasing folding tents, beds and equipments and medicines to organize camps in

	misbehave from the part of attendants, so staffs are reluctant to handle emergency cases. 11. Several cases of theft of instruments, computers, and submersible pumps etc at PHCs. 12. No guidance to the patients on the services available at PHCs. 13. Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular. 14. Lack of inpatient facility for kala-azar patients. 15.Lack of counseling services 16.Problem of mobility during rainy season 17. Lack of convergence 18. Lack of timely reporting and delay	Service Load centered at PHC Availability of AYUSH pathy. Insecurity (Staff	Strengthening of equipments and services and increase in the number of ambulances. Strengthening of AYUSH services at PHC level in the first level. Confidence building measures	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.

	in data collection	and Properties) Govts existing services like lab, x-ray, generator, fooding and cleanliness services.	Strengthening of the Govts existing services like lab, x-ray, generator, fooding and cleanliness services. Creating friendly environment HMIS and strengthening of reporting process	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

Sdar Hospital Madhubani

Indicators	Gaps	Issues	Strategy	Activities
Infrastructure	1.There are 150 beds in the Sadar hospital which is not adequate as per the requirement. **Ward** — **No of Beds** Male Medical Ward — 20 Female Medical Ward — 20 Children Ward — 10 Cholora Ward — 10 Kala-Azar Ward — 40 Male Surgical Ward — 20 Meternity Ward — 10 Eye & Ent Ward — 20 **Total** — **150**	Lacks in infrastructure	Strengthening of infrastructure	1. Purchase of required beds. 2. Listing of required equipments as per IPHS norms and their purchase. 3. Listing of required furniture and their purchase. 4. Simplifying process of RKS operation. 5. Renovation of drainage system and leveling of internal area up to the level of outer area. 6. Construction of enquiry counters at the gate.

	2. Lack of equipments as per IPHS norms and also under utilized equipments. 3.Lack of appropriate furniture 4.Operation of RKS: Delayed process of operation. Delay in disbursement of fund 5. Heavy water logging during rainy season. 6.Buildings for ICU, Causality ward are ready but lack of trained HR this is not work properly. 7. No use of paying wards. 8.No enquiry counter as such for the patients. 9.No residential facilities for doctors and staffs. 10. No canteen facility 11. No sufficient Maternity ward.			7. Construction of new residential buildings. 8.Tender for canteen facility. 9. Construct a 100 bedded maternity ward.
Drug kit availability	1. Irregular supply of drugs because of lack of fund disbursement on time. 2. Only 70% essential drugs are rate contracted at state level. 3. There is no clarity on the guideline for need based drug procurement and	Improper Supply and logistics	Capacity building and strengthening of reporting process and indenting through form 7	1.Training of store keepers on invoicing of drugs 2.Implementing computerized invoice system 4. Enlisting of equipments for safe storage of drugs.

	transportation. 4. Lack of proper space, furniture and equipments for drug storage	Lack in storage facility		5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store keeper.
Service performance	1.Exessive load in delivering all services 2. Blood storage unit is present but not utilized 3.No 24hrs Lab facility 4.Health facility with AYUSH services is not being provided 5. 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 ambulances d. Shortage of ambulances 6. No guidance to the patients on the services available at DH. 7.Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.	Workload Lack in infrastructure	Motivation building Strengthening of infrastructure	1. Incentivizing doctors/ staffs on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment. 2. Purchase of equipments for Blood storage unit, 3. IEC on blood storage unit. 4. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day 5. Repairing of all defunct Ambulances 6. Hiring of ambulances as per need. 7. Appointment of one AYUSH practitioner and

				Yoga teacher 8. Purchase of equipments/ instruments for strengthening lab. 9. Wall writing on every section of the building denoting the facilities 10. Name plates of doctor 11. Displaying Roster of doctors with their details. 12. Gardening 13. Apron with name plates with every doctors 14. Presence of staffs with uniform and name plates.

IDSP

PIP of IDSP Madhubani-2011-12						
Sub-activity	**Tasks**		**Unit Cost**	**No. of Units**	**2011-12**	**Remarks**
1. Staff Salary	1.1	Epidemiologists	42000	12	42000*12=504000	
	1.2	Microbiologists	0	0	0	N/A
	1.3	Entomologist	0	0	0	N/A
	1.4	Consultant (Finance)	0	0	0	N/A
	1.5	Consultant (Training)	0	0	0	N/A
	1.6	State Data Manger	0	0	0	N/A
	1.7	District Data Manager	32000	12	32000*12=3,84,000	
	1.8	Data Entry Operator	8500	12	8500*12=102000	New post
	1.9	Accountent (Part Time)	4000	12	4000*12=48000	New post
	1.1	Peon	3000	12	3000*12=36000	New post
		Sub Total			**1074000**	
2. Training	2.1	Training of Hospital Doctors	30000	20 (Per batch)	20000*1=20000	N/A
	2.2	Training of Hospital Pharmasist / Nurses (Reporting Person)	20000	20 (Per batch)	15000*1=15000	N/A
	2.3	Training of Data Managers	0	0	0	N/A
	2.4	Training Health Manager & Data Operator	15000	20 (Per batch)	15000*1=15000	N/A
		Sub Total			**65000**	
3. Operational Cost	3.1	Mobility Support for IDSP and RR Team	12500	1	12500*12=150000	Vehical for IDSP office & RRT
	3.2	Office Expenses	5000	1	5000*12=60000	Stationary 2000*12, News Paper for News Allerts 500*12=6000, Contegency 1000*12=12000 & Others Expences 1500*12=18000
	3.3	ASHA incentives for Outbreak reporting	100	1	100*10*12=12000	Estimated to get 10 informations per month from volunteers a total of 120 such information in a year per district. Each informant to be given an incentive of Rs.100/-
	3.4	Consumables for District Labs	50000	1	50000*1=50000	Consumables items for District Labs
	3.5	Collection & transportation of samples	10000	1	10000*1=10000	Collection & transportation of samples from field to lab

	3.6	IDSP reports including alerts	0	0	0	N/A
	3.7	Post card for Out break Information & alerts (Hard to Reach area)	2	1	2*1000=2000	Rs 2 per post card with printig of all mater & office Address (one time in year)
	3.8	Printing of Reporting Forms	10000	1	10000*1=10000	Printing of Reporting Forms at HQ
	3.9	Outgoing Phone & Broadband Expenses	2000	1	2000*12=24000	Phone & Broadband Expenses @ Rs 2000 par month
	3.1	Out Sourcing Vehicle for District Surveillance Unit	15000	1	15000*12=180000	Vehicle for Field Visit & Outbreak
	3.11	Out Sourcing Generator for District Surveillance Unit	8000	1	8000*12=96000	Generator for Vedio Conferencing & Data Centre.
	3.12	IEC by Radio Prasaran	3500	1	3500	Advertisement
	3.13	IEC by Poster Banner	2000	1	2000	Advertisement
	3.14	Mobile Expences	500	2	500*2*12=12000	
		Sub Total			**611500**	
4. New Innovations	4.1	TA For Pvt Instituation	100	15	50*15*52=39000	Per visit for weekly reports Rs 50 for 15 Reporting units X 52 weeks
	4.2	Social Mobilization and Intersectoral co-ordination	1000	10	1000*10*12=120000	Social Mobilization and Intersectoral co-ordination in 10 block @ Rs 1000 per month
	4.3	Integration of Medical Colleges (Per Month in SSU)	0	0	0	N/A
	4.4	Community based surveillance	0	0	0	N/A
	4.5	Case based study reports	500	1	500*1=500	Per case 500
	4.6	Furniture for IDSP VC cum Training Hall	100000	1	100000*1=100000	Stablisment of VC cum Training hall with Round table & 30 Chairs
		Sub Total			**259500**	
		TOTAL			**2010000**	

Section-A – General Information about the District

1	Population (please give projected population 2010)	**42,10,052**
2	Urban population	**84,343**
3	Tribal population	-
4	Hilly population	-
5	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums)	-

(These population statistics may be obtained from Census data /District Statistical Office)

ORGANIZATION OF SERVICES IN THE DISTRICT:

S. No.	Name of the TU	Population (in Lakhs)	Please indicate if the TU is-		No. of MCs		
			Govt	NGO	Govt	NGO	Private
1	DTC- Madhubani	5.55	√	X	5	X	X
2	Add TB Centre, Jhanjharpur	6.04	√	X	5	X	X
3	PHC, Ghoghardiha	6.36	√	X	5	X	X
4	PHC, Babubarhi	6.78	√	X	5	X	X
5	PHC, Ladania	6.43	√	X	5	X	X
6	PHC, Jaynagar	4.41	√	X	5	X	X
7	PHC, Bisfi	5.95	√	X	5	X	X
	DISTRICT	**41.53**			**35**	**X**	**X**

RNTCP performance indicators:

Important: Please give the performance for the last 4 quarters i.e. ***July'09*** *to* ***June'10***

TB Unit	Total number of patients put on treatment	Annualized total case detection rate (per lakh pop)	No of new smear positive cases put on treatment	Annualized New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year		Proportion of TB patients tested for HIV
						Annualized NSP CDR	Cure rate (85%)	
DTC- Madhubani	461	78.12	247	44.75	76.77%	70%	80-85%	0
Add TB Centre, Jhanjharpur	341	56.78	229	38.11	85.65%	60%	80-85%	0
PHC, Ghoghardiha	497	78.51	270	42.65	87.98%	65%	80-85%	0
PHC, Babubarhi	314	46.58	229	33.96	63.41%	60%	80-85%	0
PHC, Ladania	508	79.47	337	52.72	85.80%	70%	80-85%	0
PHC, Jaynagar	424	96.66	264	60.17	93.18%	80%	80-85%	0
PHC, Bisfi	438	73.97	278	46.95	67.62%	70%	80-85%	0
District:-	**2983**	**71.51**	**1854**	**44.89**	**80.06 %**	**70%**	**80-85%**	0

Section B – List Priority areas for achieving the objectives planned:

S.No.	Priority areas	Activity planned under each priority area
1.	Strengthening of General System	a. To establish a TU (Sanctioned)
		b. To reorganize the DMCs in view of patients accessibility.
		c. To make all DMCs functional.
2.	Involvement of NGOs and PPs	a. Enlisting of Private Practioners and NGOs.
		b. Organize CMEs & Sensitization of PPs with IMA GFATM R 9.

3.	IEC/ ACSM activity	a. Community meetings with PRIs/SHGs
		b. Posters and Wall Painting.
		c. Patients providers Meeting.
		d. Slide Show in Cinema Halls.
5.	Training/ re-training & Sensitization	MOs/ MPWs/ DOT providers
6.	TB/HIV Co-ordination	Formation of Committee
7.	MDR TB	Line listing of MDR suspects and transportation of samples to IRL

1 Section C – Plan for Performance and Expenditure under each head:

2

Civil Works

3	Activity	4	No. required as per the norms in the district	5	No. actually present in the district	6	No. planned for this year	7	Pl provide justification if an increase is planned (use separate sheet if required)	8	Estimated Expenditure on the activity	9	Quarter in which the planned activity expected to be completed
10		11	(a)	12	(b)	13	(c)	14	(d)	15	(e)	16	(f)
17	DTC	18	1	19	1	20	X	21	Building Repair, Electric wiring & Maintenance	22	1,00,000	23	2Q & 3Q 11
24	TUs	25	8	26	7	27	1	28	As per population norm	29	44,100	30	2nd Qtr '11
31	DMC	32	42	33	35	34	7	35	As per population norm	36	2,45,000	37	2,3 & 4th Qtr '11
								38	**Total**	**39**	**3,89,100**	40	

Laboratory Materials

41	Activity	42	Amount permissible as per the norms in the district	43	Amount actually spent in the last 4 quarters	44	Procurement planned during the current financial year (in Rupees)	45 46	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	47	Justification / Remarks for (d)
48		49	(a)	50	(b)	51	(c)	52	(d)	53	(e)
54	Purchase of Lab Materials	6,30,000		55	1,53,327	56	6,15,000	**57**	**5,00,00**	**58** **59**	**Plan to make all 35 DMCs functional & 7 new DMCs with CDR 100/lac**

Honorarium

60	Activity	61	Amount permissible as per the norms in the district	62	Amount actually spent in the last 4 quarters	63	Expenditure (in Rs) planned for current financial year	64 65	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	66	Justification/ Remarks for (d)
67		68	(a)	69	(b)	70	(c)	71	(d)	72	(e)
73	Honorarium for DOT providers (both tribal and non tribal districts)	74	7,45,750	75	91,000	76	1,14,800	**15,00,000**		**77**	**Total no. of patients put on Community Volunteer DPs & Backlog to be cleared since 2008**
78	Honorarium for DOT providers of Cat IV patients	**79**	**NA**	**NA**		**NA**		**NA**		**80**	

Annual Action Plan Format Advocacy, Communication and Social Mobilization (ACSM) for RNTCP

1) Information on previous year's Annual Action Plan
   a) Budget proposed in last Annual Action Plan: …**7,85,925**
   b) Amount released by the state: ……**Nil**…..
   c) Amount Spent by the district- …… **Nil** ……
2) Permissible budget as per norm : ……..**3,15,750**
3) Budget for next financial year for the district as per action plan detailed below: ……

Program Challenges to be tackled by ACSM during the Year 2011-12	**WHY** **ACSM Objective**	**For WHOM** **Target Audience**	**WHAT** **ACSM Activities**		**When** **Time Frame**				**By WHOM**	**Monitoring and Evaluation**		**Budget**
Based on existing TB indicators and analysis of communication challenges ***(Maximum 3 Challenges)***	Desired behavior or action (make **SMART:** specific, measurable, achievable, realistic & time bound objectives)		Activities	Media/ Material Required	Q 1	Q 2	Q3	Q 4	Key implementer and RNTCP officer responsible for supervision	Outputs; Evidence that the activities have been done	Outcomes: Evidence that it has been effective	Total expenditure for the activity during the financial year
Challenge 1.	**To achieve annual CDR rate of 60 %**											
Advocacy Activities												
To increase CDR rate	To achieve 90% CDR rate instead of 71.5 % at presen	MO-ICs & MOs	Sensitization of MO-ICs & MOs	Course material for sensitization training	40	X	40	40	DTO	It will help to increase CDR rate	Increased CDR rate	96,000
					-	-	-	-				-
					-	-	-	-				-
					-	-	-	-				-

	t											
Communication Activities												
-do-	-do-	DOTS Provider	Sensitization of DOTS Providers	-do-	50	50	50	50	MO-TCs & STS/ STLS	”	”	72,000
					-	-	-	-		-		-
					-	-	-	-		-		-
					-	-	-	-		-		-
Social Mobilization activities												
-do-	-do-	Community People	Community meeting	Organizational Expanses	12	12	12	12	DTO, MO-TCs & STS/ STLS	”	”	30,000
					-	-	-	-		-	-	-
					-	-	-	-		-	-	-
Challenge 2:												
Advocacy Activities												
To increase CDR rate	To achieve 90% CDR rate instead of 71.5 % at present	PRIs/SHGs/Religious Heads	Sensitization Meeting	-	3	3	3	3	DTO, MOTC & STS/STLS	Increased Referrals	Increased CDR	20,000
Advocacy at the	World TB Day Celebr	District Authorities, Civil Society	-	-	1	-	-	-	-	Advocacy	Increased Refer	25,000

district level	ation	MOs & PPs	-		-	-	-	-	-		rals	-
Social Mobilization												
-	-	-	-	-	-	-	-	-	-	-	-	-
Challenge 3:-												
Advocacy activities												
-	-	-	-	-	-	-	-	-	-	-	-	-
Communication activities												
-	-	-	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-	-	-	-
Social Mobilization Activities												
-	-	-	-	-	-	-	-	-	-	-	-	-
										TOTAL BUDGET:-		**2,43,000**

Equipment Maintenance:

81 Item	82 No. actually present in the district	83 Amount actually spent in the last 4 quarters	84 Amount Proposed for Maintenance during current financial yr.	85 Estimated Expenditure for the next financial year for which plan is being submitted (Rs.) 86	87 Justification/ Remarks for (d)
88	89 (a)	90 (b)	91 (c)	92 (d)	93 (e)
94 95 Office Equipment (Maintenance includes computer software and hardware upgrades, repairs of photocopier, fax, OHP etc)	96 1	97 1,650	98 30,000	99 30,000	**100 Computer software, photocopier & maintenance**
101 Binocular Microscopes (RNTCP)	102 26	103 Nil	104 60,000	105 39,000	106
			107 Total:-	**108 69,000**	109

Vehicle Maintenance:

110	Type of Vehicle	111	Number permissible as per the norms in the district	112	Number actually present	113	Amount spent on POL and Maintenance in the previous 4 quarters	114	Expenditure (in Rs) planned for current financial year	115	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	117	Justification/ remarks
118		119	(a)	120	(b)	121	(c)	122	(d)	123	(e)	124	(f)
125	Four Wheelers	126X		127X		128X		129X		130X		131	
132	Two Wheelers	133	8	134	7	135	96,198	136	2,00,000	137	2,00,000	138	
								139	**Total:-**	**140**	**2,00,000**	141	

Vehicle Hiring:

142 143	Hiring of Four Wheeler	144	Number permissible as per the norms in the district	145	Number actually present	146	Amount spent in the previous 4 quarters	147	Expenditure (in Rs) planned for current financial year	148	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	149	Justification/ remarks
150		151	(a)	152	(b)	153	(c)	154	(d)	155	(e)	156	(f)
157	For DTO	158	1	159	1	160	1,80,899	161	2,10,000	162	2,52,000	163	
164	For MO-TC	165	8	166		167		168	4,70,400	169	4,70,400	170	
								171	**Total:-**	**172**	**7,22,400**	173	

174	Activity	175	Amount permissible as per norms	176	Estimated Expenditure for the next financial year(Rs.)	177	Justification / remarks
178		179	(a)	180	(b)	181	(c)
182	Contractual Staff: ▪ MO (In place: Yes/No) ▪ STLS (In place: Yes/No) ▪ LT (In place: Yes/No) ▪ TBHV (In place: Yes/No)		NA		NA		NA
183	Research and Studies: ▪ Thesis of PG Student ▪ Operations Research*		NA		NA		NA
184	Travel Expenses for attending STF/ZTF meetings		NA		NA		NA
185	IEC: Meetings and CME planned		NA		NA		NA
186			**187**		**188**	189	

Procurement of Vehicles:

190	Equipment	191	No. actually present in the district	192	No. planned for this year	193	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	194	Justification/ remarks
195		196	(a)	197	(b)	198	(c)	199	(d)
200	4-wheeler **	201	Nil	202	Nil	203	Nil	204	
205	2-wheeler	206	7	207	1	**208**	**20,000**	209	RS 40,000 as balance

** Only if authorized in writing by the Central TB Division

Procurement of Equipment:

210	Equipment	211	No. actually present in the district	212	No. planned for this year	213	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	214	Justification/ remarks
215		216	(a)	217	(b)	218	(c)	219	(d)
220	Office Equipment (computer, modem, scanner, printer, UPS etc)	221	1 Each	222	1 Monitor	223	10.000	224	Problem in the monitor & UPS
225	Any Other	226	X	227	X	228	X	229	

230 ***Section D: Summary of proposed budget for the district –***

S.No.	Category of Expenditure	Budget estimate for the coming FY 2011- 12 *(To be based on the planned activities and expenditure in Section C)*
1	Civil works	3,89,100
2	Laboratory materials	5,00,000
3	Honorarium	15,00,000
4	IEC/ Publicity	2,43,000
5	Equipment maintenance	69,000
6	Training	2,18,200
7	Vehicle maintenance	2,00,000
8	Vehicle hiring	7,22,400
9	NGO/PP support	1,68,000
10	Miscellaneous	6,30,000
11	Contractual services	48,38,400
12	Printing	6,30,000
13	Research and studies	-
14	Medical Colleges	-
15	Procurement –vehicles	20,000
16	Procurement – equipment	10,000
	TOTAL:-	**1,01,38,100**

*** Only if authorized in writing by the Central TB Division*

LEPROSY

Situation Analysis/ Current Status	
Objectives	Eradication of Leprosy
Strategies & Activities	1. Detection of New cases 2. House to house visit for detection of any cases 3. IEC for awareness regarding the symptoms and effects of Leprosy 4. Prompt treatment to all cases 5. Rehabilitation of the disabled persons 6. Distribution of Medicine kit and rubber shoes 7. Honorarium to ASHA for giving MDT
Support required	Availability of regular supply of drugs
Timeline	**2011-12** House to house detection Wide publicity Rigorous follow-up

NATIONAL MALARIA & KALA-AZAR CONTROL PROGRAMME

Situation Analysis/ Current Status	Now the Malaria program is known as National Vector Borne Disease Control programme. Under this District malaria Working Committee has been constituted and representatives from various departments are there but there is very little help from these departments. Malaria program is in maintenance phase in Madhubani district. The mosquito density of Anopheles Culifacies was found mainly from May to October whereas Anopheles Aegepti and Anopheles Stephensai were found throughout the year with a peak from April to Nov. The main bottlenecks are related to shortage of manpower especially for the remote areas. Following are the descriptions of man power status.
Objectives	Reduction in SPR, API, PFR death rate
Strategies	1. Provision of additional Manpower 2. Training of personnel 3. Strengthening of Malaria clinics 4. Addressing Disease outbreak 5. Health education 6. Involvement of Private sector **7.** Innovative methods of Mosquito control
Activities	1. Provision of additional Manpower • Hiring of personnel till regular staff in place 2. Training of personnel The MOs, Laboratory Technicians, ANMs, ASHAs will be trained in various techniques relating to the job 3. Strengthening of Malaria clinics • Provision of Proper equipment and reagents – Fogging machines, sprayers, • Provision of Jeep, 4. Addressing Disease outbreak • District Outbreak teams will be created at the district headquarter • In the team MO, LT, one field worker • Provision of mobility, Lab equipments, spray equipment 5. Health education to the community through the ANMs, AWW, ASHAs, RMPs, Ayush personnel 6. Involvement of Private sector: The private practitioners will be closely involved

Support required	• Availability of supplies • Filling up of vacancies • Supply of health Education material

BLINDNESS CONTROL PROGRAMME

BLINDNESS CONTROL PROGRAMME	
Situation Analysis	Eye Care is being provided through the Sadar Hospital, There are 1 phthalmic Assistants in the district posted at Sadar Hospitals and BPHC don't have Ophthalmologists. The norm for GOI is 1 eye surgeon for a population of one lakh. Hence in this district at least 45 Eye Surgeons are required. The numbers of surgeries need to be at least triple to tackle the blindness due to Cataract. There is no Eye Bank or Eye donation center in District Madhubani. The nearest Eye Bank is at PMCH Patna.
Objectives	1. Reduction in the Prevalence Rate of blindness to 0.5 % **2.** Decrease in the Prevalence Rate of Childhood blindness to 0.6 % per 1000 children by 2010 **3.** Usage of IOL in 95% of Cataract operations
Strategies	1. Provision of high quality Eye Care 2. Expansion of coverage 3. Reduce the backlog of blindness 4. Development of institutional capacity for eye care services
Activities	1. Determining the prevalence of Cataract through a study by an external agency. • One time house-to-house survey for study of prevalence of vision defects and Cataract of entire population leading to referrals and appropriate case management including cataract surgeries 2. Increasing the number of Ophthalmologists either by hiring or through involvement of Private Sector. 3. Training in IOL to Ophthalmologists 4. Training of Paramedical staff and Teachers, NGOs, Patwaris and AWW for screening of school children and IEC activities. 5. AMC for all equipment will be done. 6. Equipment • Repair of Synaptophore and Operating Microscope • Purchase of Ophthalmic Chair, Slit Lamp, Operating Microscope, Synaptophore, A Scan biometry, Keratometer, Direct and Indirect Ophthalmoscope

<table>
<tr>
<td></td>
<td>
7. Construction of Eye Unit in Hospitals and later PHCs
8. Supply of basic Eye medicines like eye drops, eye ointments and consumables for Primary Eye Care in PHCs/CHCs.

9. All PHCs and CHCs to be developed for vision screening and basic eye care

<table>
<tr><td>Eye Care centre</td><td>Vision Centre</td><td>Screening</td></tr>
<tr><td>Eye Surgeon</td><td>Primary Eye Care</td><td>Identify Blind</td></tr>
<tr><td>Treatment of eye conditions and follow-up</td><td>Vision Test</td><td>Maintain Blind Register</td></tr>
<tr><td>Training</td><td>Screening Eye Camps</td><td>Motivator</td></tr>
<tr><td>Supervision</td><td>Referral for surgery</td><td>Referral</td></tr>
</table>
10. Blind Register to be filled up by the AWW, together with PRIs
11. Eye Camps with the involvement of Private sector and NGOs
12. School Eye Screening sessions
13. IEC activities
</td>
</tr>
<tr>
<td>Support required</td>
<td>Procurement of latest equipment for hospitals by GOI

Timely Repair of equipment</td>
</tr>
</table>

BUDGET

PART-A		
FMR HEAD	**ACTIVITY**	**BUDGET**
A.1.1.1	Operationalise Block PHCs/ CHCs/ SDHs/ DHs as FRUs	432000
A.1.1.2	Operationalise 24x7 PHCs (Organise workshops on various aspects of operationalisation of 24x7 services at the facilities @ Rs. 25,000 / year / district)	50000
A.1.3.1	RCH Outreach Camps in un-served/ under-served areas	453973
A.1.3.2.	Monthly Village Health and Nutrition Days at AWW Centres	529000
A.1.4.1	Home deliveries (500/-)	296250
A.1.4.2.1	Rural (A) Institutional deliveries (Rural) @ Rs.2000/- per delivery for 10.00 lakh deliveries	134900000
A.1.4.2.2	Urban (B) Institutional deliveries (Urban) @ Rs.1200/- per delivery for 2.00 lakh deliveries	1239600
A.1.4.2.3	Caesarean Deliveries (Facility Gynec, Anesth & paramedic) 10.3.1 Incentive for C-section(@1500/-(facility Gynec. Anesth. & paramedic)	750000
A.1.4.3	Other Activities(JSY) 1.4.3. Monitor quality and rganizers of services and Mobile Data Centre at HSC and APHC Level and State Supervisory Committee for Blood Storage Unit	2700000
A.2.1	Integrated Management of Neonatal & Childhood Illness/IMNCI (Monitor progress against plan; follow up with training, procurement, review meetings etc) 2.1. IMNCI (details of training, drugs and supplies, under relevant sections) 2.1.1. Monitor progress against plan; follow up with training, procurement, review meetings etc	168750
A.2.2	Facility Based Newborm 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.)	189224
A.2.4	School Health Programme (Details annexed)	6963000
A.2.6.	Care of sick children & severe malnutrition	3092700

A.2.7.	Management of Diarrhoea, ARI and Micro nutrient	361000
A.3.1.1.	Dissemination of manuals on rganizers on standards & quality assurance of rganizers on services	50000
A.3.1.2	Female Sterilisationcamps	570000
A.3.1.3 3.1.2.2.	NSV camps (Organise NSV camps in districts @Rs.10,000 x 500 camps)	770000
A.3.1.4	Compensation for female rganizers on 3.1.2.3. Compensation for female rganizers on at PHC level in camp mode 3.1.2.1. Provide female rganizers on services on fixed days at health facilities in districts (Mini Lap)	26795000
A.3.1.5 3.1.2.4	Compensation for male slerilisation 3.1.2.4. Compensation for NSV Acceptance @50000 cases x1500	1500000
A.3.1.6 3.1.3.1	Accreditation of private providers for rganizers on services 3.1.3.1 Compensation for sterilization done in Pvt.Accredited Hospitals (1.50 lakh cases)	11898750
A.3.2.1	IUD Camps	637500
A.3.2.2	IUD services at health facilites/compensation	668386
A.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)	169337
A.3.3	POL for Family Planning for 500 below sub-district facilities	405000
A.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)	550000
A.9.1.2	Laboratory Technicians	468000
A.9.1.3	Staff Nurses	16416000
A.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	840000
A.9.1.6	Incentive/Awards etc. 8.2.1 Incentive for ASHA per AWW center (80000x200 per month) and Incentive toANMs per Aganwari	28255000

	Centre under Muskan Programme (@80000 x Rs.150 Per Month	
A.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	100000
A.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	2100000
A.10.3.1	Up gradation & Maintenance of Web Server(25000/- per annum) and Database backup(4000/- per month)	73000
A.10.3.2	HMIS HR(Every 4 BPHC one resource person for hands on training of ANM @ 4days in one BPHC)	28800
A.10.3.3	Printing of Revised HMIS formats prescribed under NRHM	14208
A.10.3.4	HMIS Training	473714
A.10.3.5	Mobility for M & E officers	144000
A.10.4	Sub-centre rent and contingencies @ 1770 no. x Rs.500/- x 60 months	1332000
A.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/-	1850310
A.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)	6894000
A.11.6.2	Minilap Training12.3.2.1. Minilap training for medical officers/staff nurses (batch size of 4)	210720
A.11.6.3	NSV Training 12.3.3 Non-Scalpel Vasectomy (NSV) Training	67800
A.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/-	137500
A.12.1	Strengthening of BCC/IEC Bureaus (State and District Levels)	515625
A.13.2.1	Drugs & Supplies for MH	4695720

A.13.2.5	General drugs & supplies for health facilities	44762500
A.14.2	Strengthening of District Society/DPMU 16.2.1. Contractual Staff for DPMSU recruited and in position	2732000
A.14.3	Strengtheningof Financial Management Systems	668200
A.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/-	840000
TOTAL PART-A		**309758567**

PART-B

FMR HEAD	Activities	ACTIVITY
B.1.12	ASHA Support System at District Level	1215484
B.1.13	ASHA Support System at Block Level	3024000
B.1.15	ASHA Trainings	1730800
B.1.16	ASHA Drug Kit & Replenishment	9583111
B.1.18	Motivation of ASHA	2972625
B.1.2	ASHA Divas	5583840
B.1.21	Untied Fund for Health Sub Center, Additional Primary Health Center and Primary Health Center	5560000
B.1.22	Village Health and Sanitation Committee	10730000
B.1.23	Rogi Kalyan Samiti	4400000
B.2.1	Construction of HSCs (315 No.)	65394000
B.2.2	Construction of PHCS (Residential Qtr & APHC)	114000006
B.2.3	Up gradation of CHCs as per IPHS standards	8000000
B.2.4	Infrastructure and service improvement as per IPHS in 48 (DH & SDH) hospitals for accreditation or ISO : 9000 certification	2000000
B.2.5	Upgradation of ANM Training Schools	5000000
B.2.6	Annual Maintenance Grant	4400000
B.3.2	Block Programme Management Unit	12214440
B.3.4.A	Additional Manpower for NRHM Hospital Manager in FRU	600000

B.4.4	Referral Transport in District	4368000
B.9	Outsourcing of Pathology and Radiology Services from PHCs to DHs	2598214
B.10	Operationalising MMU	5616000
B.11	Monitoring and Evaluation (State , District & Block Data Centre)	3780000
B.14	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	1800000
B.15	Mainstreaming Ayush under NRHM	25320000
B.18.2	Procrument of SCNU equipments for DH & Newborn Corner equipments for PHCs	865000
B.19	Preparation of District Health Action Plan (Rs. 2 lakhs per district x 38)	100000
B.21	ANM®	41184000
B.22	Intersectoral Convergenence(Incentive for AWW under Muskan Project	8565600
TOTAL PART-B		**350605120**
TOTAL (A + B)		**660363687**