District Health Action Plan

2011-2012

District Health Society
Munger

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Foreword

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system.

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

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

The goals of the Mission are to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

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

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

KULDIP NARAYAN
(DM, Munger)

About the Profile

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

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

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

Dr. Aabid Hussain
ACMO
Munger

Dr. Mukesh kumar
Civil Surgeon
Munger

Chapter-1

Introduction

1.1 Background

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

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

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

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

For effective program implementation NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the need for situation analysis, stakeholder involvement in action planning, community mobilization, inter - sectoral convergence, partnership with Non Government Organizations (NGOs) and

private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving program functionaries and community representatives at district level.

Stakeholders in Process

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

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

1.2 Objectives of the Process

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

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

1.3 Process of Plan Development

1.3.1 Preliminary Phase

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

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

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

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

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

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

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

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

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

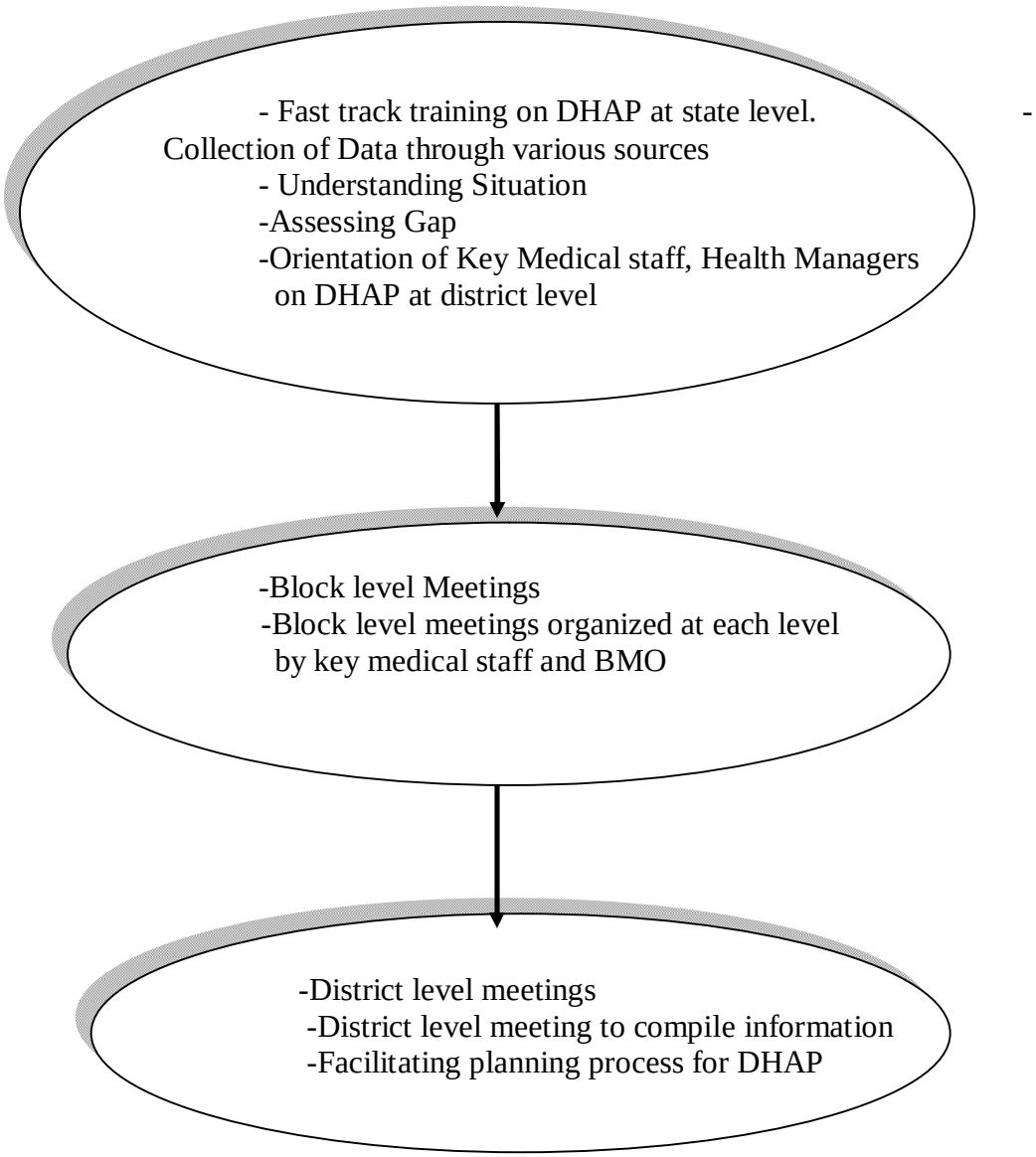
This Integrated Health Action Plan document of Munger district has been prepared on the said context.

1.3.3 Preparation of DHAP

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

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

District Health Action Plan Planning Process



MUNGER – Historical Pointers

The territory included within the district of Munger (famously Monghyr) formed pent of the Madhya-desa as "Midland" of the first Aryan settlers. It has been identified with Mod-Giri a place mentioned in the Mahabharata, which was the capital of a kingdom in Eastern India near Vanga and Tamralipta. In the Digvijaya Parva of Mahabharata, we find the mention of Moda-Giri, Which seems similar to Moda-Giri. Digvijaya Parva suggests that it was a monarchical state during early times. A passage in the Sabha-Parva describes Bhima's conquest in Eastern India and says that after defeating Karna, king of Anga, he fought battle at Modagiri and killed its chief. It was also known as Maudal after Maudgalya, a disciple of Buddha, who converted a rich merchant of this place into Buddhism. Buchanan says that it was the hermitage of Mudgala Muni and this tradition of Mudgal Risi still persists. Munger is called "Modagiri" in the Monghyr copperplate of Devapala. The derivation of the name Munger (Monghyr) has found the subject of much speculation. Tradition arcribes the foundation of the town to Chandragupta, after whom it was called Guptagars a name which has been found inscribed on a rock at Kastaharni Ghat at the north-western corner of the present fort. It is insisted that Mudgalrisi lived there. Tradition ascribes the composition of various suktar of the 10th Mavdala of the Rigveda to Rishi Mudgal and his clan. However, General Cunnigham had strong suspicicion when he connects this original name with Mons as Mundas, who occupied this part before the advent of the Aryans. Again Mr. C.E.A. oldham, ICS, a farmer collector suggests the possibility of Munigiha, ie , the abode of the Muni, without any specification which later corrupted to Mungir and later became Munger.

At the dawn of history, the present site of the town was apparently comprised within the Kingdom of Anga, with the capital Champa near Bhagalpur. According to Pargiter, Anga comprises the modern districts of Bhagalpur and Munger commissionary. The Anga dominion at one time included Magadha and the Shanti-Parva refers to an Anga king who sacrificed at Mount Vishnupada. In the epic period Modagiri finds mention as a separate state. The success of the Anga did not last long and about the middle of the sixth century B.C. Bimlisara of Magadha is said to have killed Brahmadatta, the last independent ruler of ancient Anga. Hence the Anga became an integral part of the growing empire of Magadh. As epigraphic evidence of the Gupta period suggests that Munger was under the Guptas. To the reign of Buddhagupta (447-495 A.D) belongs a copper plate of A.D. 488-9 originally found at Mandapura in the district.

HIUEN TSIANG'S ACCOUNT: However the first historical account of the district appears in the Travels of HIUEN TSIANG, who visited this area towards the close of the first half of the seventh century A.D. Hiuen Tsiang observed "The country is regularly cultivated and rich in produce flowers and fruit being abundant, the climate is agreeable and manners of the people simple and honest. There are 10 Buddhist monartries with about 4,000 priests and few Brahminical temples occupied by various sectaries". The pilgrim's "I-lan-ha-po-fa-to"country is identified as this area. He had to pass through thick forest and strange mountains into the country of Hiranayaparvat. The capital Hiranayaparvat, lay, on the southern bank of Ganga, and closed to it stood mount Hiranya, which "belched masses of smoke and vapour that obscured the light of the sun and the moon". The position of this hill is determined from its proximity to the Ganga, to be Munger and though no smoke now comes from any peak, the numerous hot springs in the hills point to famous volcanic action. These hot spring are also mentioned in Hiuen Tsiang's Account. General Cunningham identified the hot springs being those of Bhimbandh and its offshoots. Other authorities refer it as Uren in present Lakhisarai District.

Unfortunately, there is a historical gap of almost two centuries when we find its fresh mention in the Munger copper plate of Devapala discovered at Munger about 1780. We learn from this copper plate about Dharampala (c.770-810) who preceded far beyond Kanauj in his military campaigns. It refers to a campaign of Dharampala along the foot of the Himalayas. Tripartite struggle between the Palas, Rashhtrakutas and Gurjar-Pratihars for subermacy over Kanauj was a dominant factor in the history of northern India. We find mention of Pala king Gopal, his son Dharampala & Devapala. Munger prominence is also corroborated by the Nawlagarth inscriptions of Begusarai. The Bhagalpur plate of Narayan pala, executed at Munger, shows their policy of religious tolerance and there patronage to the worshipers of Shiva & Sakti cults.

Till the advent of the Turkish rule in India. Munger was under sway of the Karnataka dynasty of Mithila. However Bakhiyar Khilji took possession of Territory any of Munger in AD1225. Thus Munger in possession of the Khilji ruler Gyasuddin. After a tussle and aftermath a peace treaty Munger came under the control of Sultan of Bengal between 1301-1322, which is corroborated by the Lakhisarai Inscription. Munger came under the possession of Muhammad Bin Tugular who annexed Munger to Delhi for some time. In 1342 the whole of north India witnessed the turmoil and Late Spasmodic Illyas Shah of Bangal taking advantage of the opportunities established his sway over Bihar. An interesting description of the Bengal sultan still exists in Lakhisarai. Inscription bearing a date corresponding to 1297 which mentions Rakmuddin Kalawao (c1296-1302) and a Governor round Ferai Hitagim. During thus conflict between the Tugulaqs of Delhi and Bangal Sultan some portions of then Munger came under the possession of the Sharqils of Jaunpur.

Some inscriptions found in Munger speaks of the conflict between the Jampur rules and the Bangal Sultan which resulted in farmer's defeat and finally resulted in peace. Here we came across the name of prince Danyal who held the post of Governor of Bihar. It was prince Danyal who had repaired the fortification of Munger and built in 1497 the voult over the shrine of Shah Nafah. This is also known by the insemination but up by Danyal on the eastern wall of the Dargah just within the southern gate of the fort.

Nasrat Shah succeeded Hussain Shah in Bengal in 1590. His brother-in-law Makhdun Alam took possession of Munger Fort and entrusted its responsibility to one of his general named Kutub Khan who made Munger the head quarters of Bihar army of the rulers of Gaur. Bahar in his memoir mention that when he invaded Bihar, Munger was under the change of a prince. After the Battle of ghagra, Babar sent envoys to Nusarat Shah later Kutub Khan was defeated and killed by Shur Shah. In 1534 again a powerful army in command of Ibrahim Khan moved out to Munger, The battles took place in the narrow plains of Surajgarha in which Ibrahim Khan was routed and slain and Sher Shah firmly placed himself to Kingshlip. Thus during the Humayun-Sher Shah conflict Munger pardoner strategic gamed. During the subsequent war between Sher Shah and Humayun Munger was the seat of battle between, the Afghan and the Empires in which Sher Shah captured Dilawar Khan son of Daulat Khan Lodi. Mughal rule was substituted for Afghan rule. During Akbar's period when the great Bengal military revolts started. Munger was for some time the headquarters of Akbar's officers in their expeditions against the rebels. It was in this year that Raja Todarmal took possession of Munger and tried to deal with three refractory powerful semi-independent Zamindars of

Akbar's time viz. Raja Gajapati of Hajipur, Raja Puran Mal of Ghidhaur and Raja Sangram Singh of Kharagpur. The last two belonged to the district of Munger. Gajapati was totally ruined. After the final occupation of Bihar, Raja Man Singh was appointed as the Governor and on the basis of Akbarnama. It can be said that Raja Man Singh succeeded well in his administration. Kharagpur at that time was a great principality extending from the south of Munger to the south of Bhagalpur and Santhal Paragans. Sangram Singh remained loyal to the Mughal rule till Akbar's death in 1605. But the accession of Jahangir and the rebellion of Prince Khusru led him to make a final attempt to recover his independence. He collected his forces, which, according to Jhangir's memoirs, consisted of about four thousand horses and a large army of foot soldiers.

The Mughal army under Jahangir's Kuli Khan Lala Beg, Governor of Bihar, valiantly opposed him and a gun shot in 1606 killed Sangram Singh. Sangram Singh's son succeeded in gaining favour of Jahangir but had to wait till 1615 when, on his conversion to Islam, he was allowed to return to Bihar. He known in history as Rozafzun (ie. Daily growing in power). He remained faithful to the Emperor and in 1628 when Jahangir died he was a commander of 1500-foot soldiers and 700 horses. When Shahjahan became the Emperor, Rozafzun entered into active Mughal services and accompanied Mahabat Khan in his Kabul expedition. He was a brave soldier and had to his credit his participation in the Siege of Parendah and was promoted to the higher ranks and became the commander of 2000-foot soldiers and 1000 horses.He died in 1635 and was succeeded by his son Raja Bihruz who was also a great fighter and held the rank of 700-foot soldier and 700 horses, under Shahjahan. He extended his territory, got many grants specially the Chakla Midnapur, in which he built a town and named it Kharagpur. A ruined palace built by him is there; adjoining it is a three-domed mosque. There is still a marble slab, which gives the date of building in 1656 A.D. But this brave Kharagpur ruler died in 1656. During the civil (1657-58) amongst the sons of Shahjahan, Shah Shuja, the second son of the Emperor was governor of Bengal. On hearing of the serious illness of his father in 1657 he raised the standard of revolts and claimed the throne. Though his capital was at Rajmahal, Munger the centre from which he direct his preparations and here he returned in 1658 after his defeat. In June 1658, Auranzeb made an attempt to conciliate Shuja by granting him the province of Bihar in addition to Bengal. Munger came into great prominence during this period of the civil war. Prof. Quanungo writes that after the March of Imperial Army Shuja wrote to Dara asking for the grant of Munger, which formed the part of Dara's province of Bihar. Dara was also prepared to give away the Fort of Munger on the condition that the present fortress was dismantled and Shuja's son did not reside there. We also get a reference of Murad's letter in which the designs of Dara to deprive Shuja of Munger has been hinted at. Shuja took shelter at Munger to face the Imperialists. In course of this conflict Dara was compelled to send urgent letters to his son to make peace with his uncle. As a result of this treaty of 1685 Munger was added to Shuja's viceroyalty but he was not allowed to reside there. In 1659 Daud Khan took charge of the province of Bihar. Mir. Jumla and Prince Muhammad pursued Shuja up to Munger. Shuja was forced by the treachery of Raja Bihruz Khan of Kharagpur and Khaza Kamal of Birbhum to abandon Munger in 1659. It was in this connection that Raja Bihruz was made In charge of the whole area of Munger. We also find a mention of a Aevastative famine during the reign of the Governor, Ibrahim Khan which continued from 1670-72. The Dutch traveller, De Graafe, who travelled from Munger to Patna in November 1670 gives a graphic picture of the horrible sccnes. Marshall also mentions very interesting details about Munger. He inspected Shah Suja place built on the west side of the Fort. He describes it, "as a very large house where the king (Suja) lived, walled next to the river, for about one and half Kos with bricks and stones, with a wall fifteen yards high". He entered the first gate but was stopped at the other within which he saw two elephants carved in stone and very large and handsomely". The inside palace was so strictly guarded that two Dutch men De Graafe and Oasterhoff were imprisoned for their antiquarian interest as they were taken as spies. They were released after seven weeks of imprisonment in November , 1670 by paying a fine of one thousand rupees to the Nawab of Patna. Marshall found a great garden and, at the south end, he saw several thatched and many tombs and mosques.

He further writes "the town stands upon an ascent, the river bank by it being 8 or 10 yards high, the brick wall by the river side at the south end of Munger was about 5 yards high and 20 yards long with a little tower at each end and each wall is a fortification to place the gun on it. Towards the close of the 18th Century we find that Munger was merely station of "Power Magazine" established there…." For most vivid lightning often about Munger attracted by the iron ore which abounds in the neighboring hills and if it fell upon the magazine, the while Fort could certainly be destroyed by the explosion". We find mention in the travel account of R.Heber in his book "Narrative of Journey Through the Upper Province of India (1827)" that Munger was noted for its good climate and Warren Hastings also speaks of the delightful change of atmosphere from that of Bengal. Heber further wrote "Munger presents an imposing appeardance…. The Fort is now dismantled. Its gates, its battlements etc. are all of Asiatic architecture and very much similar to the Khitairagorod of Moscow." Miss Emily Eden was also much struck by the inland tables and boxes and expressed surprise on such curious workmanship (Miss Eden-Up the Country quoted in Munger Gazetteer 1960). The remark of Miss Eden is also attested in the writing of Fanny Parkes who wrote "Among the articles manufactured here the black vases for flowers turned into while wood and lacquered whilst in the Lathe with scaling wax are pretty". Joseph Hooker also speaks highly of Munger, "By far the prettiest town, Munger was celebrated for its iton manufacture, especially of muskets, in which respect it is the Burmingham of Bengal".

When we come down to the early Mughal period we get a few references to the district in the famous book "Ain-I-Akbari" prepared by Abul Fazl. According to it Sarkar Munger consisted of 31 mahals or Parganas, paying a revenue of 10,96,25 981 dams (40 dams equal to One Akbar Shahi rupee). It is also mentioned that Sarkar Munger furnished 2150 horses and 50,000 foot soldiers. Raja Man Singh who is said to have reconqucred Bengal and Orissa had for some time Munger as his residenoc.During the reign of Aurangzed we find mention of Munger inconnection with the death and burial at Munger of the poet Mulla Mohammad Saiyed, who wrote under the nom-de-plume of Ashraf. The poet Ashraf stood in high favour with prince Azim-Us-Shah, Aurangzeb's grand son, who happened to be the Governor of Bihar. The poet Ashraf had also been for a long time the teacher of Zebunissa Begum, Aurangzeb's daughter who was herself a poetcss of rupute. It 1704 while on his way from Bengal to Mecca, the poet died at Munger where his tomb is still pointed out. Nicholas Graafe, a Dutch physician who visited in the beginning of the century was struck with admiration at the sight of its white wall, towers and minarets. But by 1745 when Mustafa Khan, a rebellious General of Alivardi Khan advanced against it in his march northwards the fort was a ruinous fortification which the Governor and his little garrison tried to put up some Defence but failed miserably.

The besieger got upon the wall and scized the fort though the leader was killed by a stone that fell upon him. Mustafa Khan, however, following the custom of those days, had music played to celebrate his success, he also took some guns and ammunition from the fort and after a halt for a few days marched off towards Patna. During the period of the disintegration of Mughal Empire Munger had to witness new changes. Bihar came to be joined to the Suba of Bengal, which had practically become independent of Delhi. Alivardi, who was the Fauzdar of Rajmahal had now become the District Governor of Munger.

Munger was politically and strategically so important that it did not escape even the Maratha expendition. The second Maratha invasion under Raghujee Bhonsla occurred in 1743.

Balaji Maratha entered into Bihar and advancing through Tekari, Gaya, Manpur, Bihar and Munger. It is also mentioned that during the 4th Maratha invasion in 1744 Raghuji passed through the hills of Kharagpur. When British force was pursuing Jean Law, the French adventurer and partisan of siraj-ud-duala, who was flying northwards after the Battle of Plassey, Major Coote reached Munger late at night on 20th July, 1757 and requisitioned a number of boats which the Governor of Munger supplied. But Munger Fort was in such a good condition that he was not allowed to enter the Fort and when he approached the walls he found that garrison was ready to fire. Coote wisely resumed his march without any attempt to enter the Fort. Nearly three years after in the spring of 1760 the army of Emperor Shah Alam marched out of the District when he was being pursued by Major Caillaud and miran. The Emperor had been defeated by Caillaud and Miran at sirpur on the 22nd February, 1760. This time Johan Stables, who had succeeded Caillaud was given charge of Munger. It was he who directed to attack the Kharagpur Raja who had openly defied the authority of the new Nawab, Kasim Ali Khan.

The modern history of Munger came again into Prominence in 1762 when Kasim Ali Khan made it his capital instead of Murshidbad in Bengal. The new Nawab removed his treasure, his elephants and horses and even the gold and silver decorations of the Imam Bara from his old capital. He favored General Gurghin (Gregory) Khan, an Armenian of Ispahan, re-organized the army and had it drilled and equipped after English model. He also established and arsenal for the manufacture of fire-arms and it is from this time that Munger can trace back its importance for the manufacture of guns. Even today that glorious tradition is being carried on by hundreds of families who specialize in the manufacture of guns.

Two days a week he sat in a public hall of audience and personally dispensed justice. He listened Patiently to the complaints and grievances of everyone and gave his impartial order. The Nawab, indeed, was a terror both to his enemies and to wring doors. He also honored learning and the learned and welcomed scholars and savants to his court and he surely earned the respect and admiration of both friends and foes alike. Unfortunately, however, destiny did not help him and Mir Kasim Ali soon came into confrontation with the English.

MIR KASIM AND HIS CONFICT WITH THE ENGLISH: The first quarrel appears to have been caused by the tactless conduct of Mr. Ellis, who was in incharge of an English factory at patna. Mr. Ellis had received a vague report that two English deserters were concealed at Munger. A long dispute followed and it was finally compromised by Mr. Ironsides, the Town Major of Calcutta , who conducted the search of the Fort with the due permission of the Nawab. No deserters were found inside the Fort, the only European in the place being an old French invalid. In April, 1762 Warren Hastings was sent from Calcutta to arrange the terms between the Nawab and Mr.Ellis. The Nawab received him well but Ellis refused to meet Warren Hastings and stayed in his house at Singhia, 15 miles away from Munger. Beside this personal rancor, serious trade disputes arose between the Nawab and East India Company. The East India Company had been enjoying exemption frm heavy duty transit levied on inland trade. After the battle of Blassey the European servants of the Company began to trade extensivdy on their own account and to claim a similar exemption for all goods passing under company's flag and covered by Dastak or certificate signed by the Governor or any agent of the factory. Great abuses followed when the English in some cases lent their names to Indians for a consideration and the latter used the same Dastak over and over again or even began forging them.

Warren Hastings in 1762 says that every boat he met on the river bore the company's flag and became aware of the oppression of the people by the Gumashtas and the Company's servant. Mir Kasim bitterly complained that his source of revenue had been taken away from him and that his authority was completely disregarded. Eventually in Octuber, 1762, Mr. Vansittart, the Governor left Calcutta in order to try and conclude a settlement between the two parties. He found the Nawab of Munger smarting under the injuries and insults he had received. But at length it was agreed that servants of the company should be allowed to carry on the inland private trade, on payment of a fixed duty of 9% on all goods- a rate much below that paid by the other merchants. The dastak also remained with a new provision that it should also be countersigned by the nawab's collector. Mir Kasim agreed to these terms but, of course, very unwillingly. Sair-ul-Mutakharin gives a detailed account of the visit of Vansittart. The Nawab advanced six miles to meet vansittart and arrange for his residence in the house which Gurghin Khan had crected on hill of Sitakund (Pir Pahar).

Vansittart returned to Calcutta in January 1763 after a week long stay at Munger but he was sorry to find that the agreement concluded with the Nawab has been repudiated. The Nawab, however, had honestly sent the copies of the Governor's agreement to all of his officrs for its immediate implementation. The result was that English goods then in transit, were stopped and duty caimed upon them. The English council reacted sharply and wanted that the English dastak should pass free of duty. The Nawab on the other hand protested at this breach of faith and passed orders abolishing all transit duty and thereby, throwing open the whole inland trade free from any custom duty. The English regarded this as an act of hostility and preparations for war began but English decided first to send a deputation headed by Messrs. Amyatt and Hay to arrange fresh tersm with the Nawab.Mr. Ellis was also informed of this development and was warned not to commit any act lof aggression even if the mission failed and Amyatt and Hay were well out of the Nawab's power.

The members of the mission reached Munger on the 14th may, 1763 and opened up negotiations, but it was soon found that they were undocked. The Nawab who was offended at the rough and over bearing manner in which he was addressed by the English linguist and refused to speak to him. At subsequent interviews also the Nawab tried to avenge the English insult and refused to come to any terms. The Envoys were kept under strict supervision and when some of the party wished to ride out from Munger they found their way barred by the Nawab's soldiers with lighted matches ready to fire. Just at this tenses moment English cargo boats for Calcutta were detained at Munger and 500 Muskets intended for the factory at Patna were found out hidden under the cargo. The Nawab, naturally, became suspicious of the English move which might have been to seize the fort and the city at Patna. He wanted , therefore, a thorough check-up by his own troops otherwise he would declare war. In the mean time he permitted Mr. Amyatt and others of the party to leave for Calcutta, but detained Mr. Hay and Mr. Gulson as hostages for the safety lof his officers who had been arrested by the English.

As regardes the final rupture between the English and Bengal Nawab it was precipitated by the action of Mr. Ellis who believed that war was in any case inevitable, and seized the city of Patna on hearing the news that the detachment was advancing from Munger to reinforce the Nawab's garrison. The Nawab also retaliated promptly, reinforcements were hurried up and the Fort quickly recaptured. This news of the success gave Kasim Ali the keenest delight. Even though it was mid-night, he immediately ordered music to strike and awakened the whole town of Munger. At day-break the doors of the public halls were thrown open and every one hastened to offer him congratulations. He , now, proclaimed the outbreak of war and directed his officers to put the English to sword wherever they were found. In pursuance lof this general order Mr. Amayat was killed at Murshidabad and the factory at Cossim (Kasim) Bazar was stormed. The survivorsw surrendered and were sent to Munger to join their unfortunate companions from patna.

The British force under Major Adams quickly advanced against the nawab and defeated his troops at Suti. On Hearing of his defeat, he sent his Begums and children to the fort at Rohtas and set out himself accompanied by Gurgin khan to join his army that was now concentrated on the banks of the Udhua Nullah near Rajmahal. Before leaving Munger, however, he pur to death a number of his prisoners including Raja Ram Narayan, till lately Deputy Governor of Bihar, who was thrown down into the river below the fort with a pitcher filled with sand bound to his neck. Gurgin Khan not satisfied with this butchery also urged the Nawab to kill his English prisoners but this the Nawab refused to do. Jagat set Mahtab Rai and Sarup Chand, two rich bankers of Murshidabad who had been brought from that place by Mir Kasim Ali as they were believed to favour the British cause also appears to have escaped. Though as the tradition says they were also drowned at the same time. This story is, however, contradicted by the author of Sair-UI-Mutakharin who says that they were hacked to pieces at Barth. The exact location of the tower of castle of Munger from where Jagat Seth and others were thrown down has not yet been located.

Before the Nawab could join his army at Udhua Nullah he heard of a second decisive defeat that he had sustained and thereafter returned to Munger. He stayed there only for two or three days and marched to Patna with his prisoners like Mr. Hay, Mr. Ellis and some others. On the way Mr. Kasim halted on the bank of Rahua Nullah, a small stream near Lakhisarai. It was here that Gurgin Khan met his death and was cut down by some of his own troopers who were demanding arrears of their pay. A scene of wild confusion followed. Makar, another Armenian General, fired off some guns, the thought that the English were upon them and fled in terror, Mir Kasim himself flying on an elephant. There was great confusion in the army because of this false alarm but Mir Kasim marched on the next day to Patna.

In the meantime the British army moved on rapidly towards Munger and at this time Munger was placed under the command of Arab Ali Khan, who was a creature of Gurgin Khan. On the first of October 1763 the main body of the army arrived on batteries that had been thrown up and were immediately opened. For two days heavy fire was maintained but in the evening the Governor capitulated and surrendered himself and his garrison. The English at once set to work to repair the breaches and improve the defences.

The Fort was left under the command of Captain John White who was further directed to raise locally another battalion of sepoys. This news of the capture of Munger infuriated the Nawab who as soon as he heard of it gave order that his English prisoners at Patna should be put to death. This order was carried out by the infamous Samru and is known in history, as the 'Massacre of Patna'.

There years later in 1766 there was a mutiny of the European officers of Bengal army because of the reduction of *"bhatta"* which was an extra monthly sum to cover the increased expenses when the soldiers were on active military duty. After the battle of Plassey Mir Jafar Khan had granted an extra-allowance, called "double bhatta" which had continued during the role of Mir Kasim also. But the Directors of the companies now passed order that this allowance should be abolished except for the grant of half-bhatta to the troops stationed at Patna and Munger. This curtailment was bitterly resented by the army officers and on the first of May, 1766 a memorandum to this effect was signed by officers of the first brigade stationed at Munger under Sir Robert Fletcher who transmitted it to Lord Clive at Murshidabad.

Clive lost no time and proceeded to Munger in person by forced marches and in the mean time sent forward some officers to deal with the situation as well as they could. When arrived at Munger late at night on the 12th May, the army heard too much of drums beating and going further to Robert Fletcher's quarter they found the European regiment drinking, singing and beating drums. Next morning two of them went to Kharagpur and returned with two battalions to Munger. But we learn that on 14th the European battalion broke out in open mutiny and Captain Smith seized the saluting batteries which were situated upon hillock. The hillock was known as Karn Choura hill. Captain Smith gained possession of the hill and was successful in suppressing the rebellion. In short, Munger was recaptured by the prompt and brave action of Caption Smith and sir Robert Fletcher.

Clive hadd already reached Munger and he held a parade of troops. He explained the circumstances under which the "bhatta" had been withdrawn and he further applauded the loyal conduct of the sepoys and condemned the conspiracy of some officers. They were further threatened that the ring leaders would get the severest penalties under Martial Law. After his address, the brigade gave their hearty cheers and marched off quietly to the barracks and the lines. Thus, the rebellion of the British officers at Munger was successfully suppressed. For some time John Maccabe was a Deputy Commissioner, Government of Munger before 1789.

The subsequent history of the district is uneventful with the extension of the British dominions, the town of Munger ceased to be an important frontier post. There was no arsenal, no regular garrison was kept up and no attempt was made to bring the fortification up-to-date. Munger, however, was still important for its fine situation and salubrious air and was used as a sanatorium for the British troops. So great a resort that it was the journey up the Ganga followed by a stay was regarded of as healthy as a sea voyage. We find that a trip to Munger was prescribed for the wife of Warren Hastings when she was in ill health and in 1781 when Warren Hastings was on his way to meet Chait Singh at Banaras he left his wife here for the benefit of her health. But during the early part of the 19th century Munger was degraded to a lunatic asylum for sepoys where there was also a depot for army clothing and it became an invalid station for British soldiers.

Munger District is located in the southern part Bihar and its headquarters are located on the southern bank of river Ganges. The district is spread over 1419.7 Sq. km. accounting for 3.3% of the area of Bihar . It lies between 24^0 22 N to 25^0 30 N latitude and 85^0 30 E to 87^0 3 E longitude. From administrative and development point of view,Munger is divided into three subdivisions namely Munger,Kharagpur, and Tarapur. There are nine developmental blocks namely Munger, Bariarpur, Jamalpur, Dharahara, Kharagpur, Tetia Bambar,Tarapur Asarganj and Sangrampur. There are about 903 villages in the district. The Munger district on an average is 30 to 65 mtrs above sea level. The average annual rainfall is 1231 mm.

FORMATION OF THE DISTRICT

The existence of Munger as a separate executive centre dates from the year1812, It appears from a letter dated the 15th July of that year, that Mr. Ewing was appointed to have charge of Munger Criminal Court, called the court of Joint Magistrate of Munger and that he was made subordinate to the Magistrate of Bhagalpur and worked like a sub-divisional officer.

A letter also from Mr. Dowdeswell, Secretary to the Government, dated the 22nd October, 1811 proves that at that time no magisterial authority exited at Munger except that of the Magistrate of Bhagalpur to whom it was addressed : "I am directed", it runs, to acquaint you that his Excellency the Vice-President in council considers it of importance that you should revert to the practice which formerly existed holding the Kachari during a part of the year at Munger, and that he desires that you will make necessary arrangement for the purpose". But the extent of the Munger jurisdiction is not mentioned in the local records till September, 1814 when it is clearly stated to comprised five Thanas or police divisions, viz. Munger, Tarapur, Surajgarha, Mallepur and Gogri.

No change seems to have been made in the powers or jurisdiction of the Munger court till 1832 when it was made revenue-receiving Centre under the name of a Deputy Collectorship. This new office was conferred on the joint Magistrate. Form this time officer exercised most of the power of a full Magistrate-Collector. He had now power to correspond directly with the chief Executive and the Revenue authority as an independent authority.

The earliest record of value in the collectorate appears to be the letter from the

CENSUS OF INDIA 2001

State/District/C.D Block	Literacy rate								
	Total			Rural			Urban		
	Persons	males	females	Persons	males	females	Persons	males	females
MUNGER DISTRICT	60.11	70.7	47.97	53.35	65.3	39.69	76.87	84	68.64
Munger	67.97	75.7	58.96	54.66	63.9	43.72	75.44	82.2	67.48
Bariarpur	53.84	65.40	40.07	53.84	65.40	40.07	--	--	--
Jamalpur	75.09	83.6	65.36	63.93	73.8	52.59	84.39	91.7	75.98
Dharhara	50.98	63.5	36.73	50.98	63.5	36.73	--	--	--
Kharagpur	51.39	64.4	36.74	50.28	64.10	34.79	57.83	66.2	48.19
Asarganj	52.00	62.7	39.71	48.68	59.8	35.88	81.44	88.6	73.34
Tarapur	53.34	66.1	39.44	53.34	66.1	39.44	--	--	--
Tatia Bombar	51.00	64.9	34.75	51.00	64.9	34.75	--	--	--
Sangrampur	53.66	65.8	40.01	53.66	65.8	40.01	--	--	--

Commissioner of Bhagalpur to the Secretary to the Sadar Board of Revenue. At Fort William, dated the 29th May, 1850. He writes-"It appears from the record that the native town and Bazar of Munger have for a long period been considered government property. This though constituting one Mahal, was divided into 13 Tarafs, Viz. (1) Bara Bazar, (2) Deochi Bazar, (3)

Goddard Bazar, (4) Wellesly Bazar, (5) Munger Bazar, (6) Gorhee Bazar, (7) Batemanganj Topekhana Bazar, (8) Fanok Bazar, (10) Dalhatta Bazar, (11) Belan Bazar, (12) Rasoolganj and (13) Begampur".

Population, Literacy Rate Blockwise.

CENSUS OF INDIA 2001

State/District/C.D Block		Population		Child population in the age - group 0-6			Literates			
		Persons	males	females	Persons	males	females	Persons	males	females
MUNGER DISTRICT	Total	1135499	604662	530837	197144	102928	94216	564043	354611	209432
	Rural	818913	435774	383139	150156	78809	71347	356799	233051	123748
	Urban	316586	168888	147698	46988	24119	22869	207244	121560	85684
Munger	Total	296950	159243	137707	48399	25084	23315	168940	101494	67446
	Rural	109639	58869	50770	20323	10555	9768	48817	30891	17926
	Urban	187311	100374	86937	28076	14529	123547	120123	70603	49520
Bariarpur	Rural	92431	49632	42799	17015	8630	8385	40604	26816	13788
Jamalpur	Total	181571	96522	85049	28735	14829	13906	114768	68267	46501
	Rural	84912	45260	39652	15447	8079	7368	44411	27434	16977
	Urban	96659	51262	45397	13288	6750	6538	70357	40833	29524
Dharhara	Rural	103919	55197	48722	19601	10295	9306	42986	28509	14477
Kharagpur	Total	181008	96183	84425	30683	16619	14064	77249	51253	25996
	Rural	154098	81942	72156	25872	14196	11676	64470	43428	21042
	Urban	26910	14241	12669	4811	2423	2388	12779	7825	4954
Asarganj	Total	59562	31620	27942	11276	5832	5444	25108	16175	8933
	Rural	53856	28609	25247	10463	5415	5048	21123	13876	7247
	Urban	5706	3011	2695	813	417	396	3985	2299	1686
Tarapur	Rural	84341	44060	40281	16311	8531	7780	36289	23470	12819
Tatia Bombar	Rural	57622	30869	26753	10796	5586	5210	23882	16395	7487
Sangrampur	Rural	78095	41336	36759	14328	7522	6806	34217	22232	11985

Geography & Economy

Physical Features and Natural Resources

The district of Munger is hemmed among the Ganges in the north, Bhagalpur district in the east, Barh district in the west and the district of Jamui in the south. It covers almost 14 Development Blocks. The total area is 3301.70 Km^2 and the total population is 1,924,317, vide 1991 census. The density of population per Km^2 was 583 in 1991.

Relief Feature

Plain Lands in the North:

The Northern plain of Munger district has two facets of landscape i.e. diaras north of the Gangatic levee and tal lands south of the levee. Some of the Gangetic levee and tal lands south of the levee. Some of the important diaras are Maheshpur, Heru, Bahadurpur,

Kalarampur, Budhwa and Taufir diaras. These diaras suffer from annual inundation along with the erosion and deposition of soils. This is the area of bood hazards with the sedimentary rocks.

The area south of the Gangetic levee is known as Tal lands. Some of the important tals are Barhiya tal, Mainma tal, Bilya tal, Bariarour tal and others. Some of the important rivers e.g. Kiul Harohar, Dakranal and Baduar deposit soil in their flood plains. Tal lands also suffer from annual inundation, water loggings and deposition of soil.

Mineral Water

Munger district has long been famous for its mineral waters and hot water springs, There is a belt of thermal springs along a Zone from the Kharagpur hills to the Rajgir hills of the Patna district. There are altogether seven groups of thermal springs in this district. These are:-

1. Bharari (Chormara Group)
2. Bhimbandth Group
3. Hingania Group
4. Remeshwar-Lakshmishwar –Bhowrah Kunds groups.
5. Rishikund groups.
6. Sitakund – Phillips-kund group and
7. Sringirishi group

CLIMATE

Munger district is a part of Zone – III with sub-zone in South Bihar Plains. The zone is located on south of river Ganges and comprises districts of Munger, Bhagalpur, Gaya, Aurangabad, Rothas, Bhojpur, Patna and Nalanda. It is sub humid and much drier as compared to zone-I and III. It has monsoon sub-tropical climate ranging from sub-dry and sub-humid conditions. There are three district seasons in this zone viz., summer, monsoon and winter.

SUMMER (MARCH TO MAY)

The summer season is characterized by gradual rise in temperature, occasional thunder showers and hail storm, high velocity westerly during this season is very dry resulting in sunstroke deaths at times. The maximum temperature rises up to 45o C.

MONSOON (JUNE TO SEPTEMBER)

It starts from middle of June and continues up to end of September. Monsoon is characterized by cloudy weather, high humidity, frequent rains and weak variable surface wind. Maximum rainfall occurs during July and August.

WINTER (OCTOBER TO FEBRUARY)

Winter season is characterized by gradual decrease in temperature which comes to a minimum in the first week of January. Thereafter, the temperature starts increasing. The minimum temperature varies from 3.50 C to 90 C.

RAINFALL

The rainfall under this zone is mainly influenced by the south-west monsoon which sets in the second week of June and continues up to end of September. Sometimes cyclonic rain also occurs. The average annual rainfall of this zone is 1078.7 mm. The rainfall distribution is marked seasonal in character. Greatly limiting water availability in certain times of the year and requiring disposal of excess water in some weeks during monsoon also occur. The average annual rainfall of Munger district is 1146.4mm (53year average), out of which 80% is received during monsoon season and the rest (more than5%)in summer season. In case of Munger district, the temporal variation annual rainfall was recorded at a maximum of 2181.6 mm in 1971 and a minimum of 481.6 mm in 1972 with annual coefficient of variation of 27.2%. July

and August received maximum monthly rainfall in the district. The monthly co-efficient of variation of rainfall for monsoon from June to September was 68.5%, 44.3% and 51.8% respectively for Munger.

SOIL

Soil of Munger district is grey to dark grey in color, medium to heavy in texture, slightly to moderately alkaline in reaction, cracks during summer (1) cm to more than 5 cm wide and more than 50 cm deep) becomes shallow with onset of monsoon, with clay content nearly 40% to 50% throughout the profile. Slicken side along with the wedge shaped structural aggregates absorb soil are found in level land or depression. Soil becomes bonding during summer and remains inundated rains. The clay minerals found are smectites followed by hydrous mica. The soil has a good fertility status. Diara land soils are light textured and well drained with free calcium carbonate (CaCO3) that varies between 3% to 8% but seldom exceeds 10% particularly no genetic low zone gives a coarse stratification micro relief, udic moisture regime clay. Minerals found are hydrous mica, smectite, kaolonite and chloride. The nature of sediments deposited in Diara land can be generally stated as those near the streams are coarser in texture i.e., sand which gradually becomes finer with distance a grade to heavy texture of clay in the central part of the meander, these being always layers of sand at varying department which generally do not go deeper than 40 cm to 60 cm of surface deposited as a result of changing course of the current. These Diaras are either:

Islands between river streams or

The place of the abandoned Dhar in the flood plains.

4.4Chid Health							
Logical Framework							
Sl.	Goal	Sl.	Impact indicators				
1		1.1	Reduction in IMR				
	To improve Child health & achieve child survival	1.2	Child performance in the school - enrolment, attendence and dropout				
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
1	To increase ORS distribution from 51%(DLHS3) to 80%	1.1	% increase of ORS distribution .	1.1 .1			% of PHC initiated IMNCI and HBNC training.
2	To increase treatment of diarrohoea from 77.1% to 90% within two weeks		% increase of treatment of diarrohoea within two weeks				
3	To increase treatment of ARI/Fever in the last two weeks from 82.2%(DLHS3) to 95%		% increase of treatment of ARI/Fever in the last two weeks		*IMNCI,Home Based Newborn Care/HBNC*		
4	To increase of infant care with in 24hr of delivery from 29.7%(DLHS3) to 50%		% increase of infant care with in 24hr of delivery .		Strengthening of Facility Based Newborn Care/FBNC and trained workers on using equipments.		No of PHC initiated FBNC with trained MAMTA on facility based new born care..
5	To increase % of breastfeeding from 33.8% to 70% within 1 hr of birth		% increase of breastfeeding within 1 hr of birth .	1.1 .2			No of training orgnised in PHC on IYCF
6	To increase intiation of complimentry feeding among 6 month of children from 88.3% to 90%		% increase of complimentry feeding among 6month of children.				
7	To increase exclusive breastfeeding among 0-6 month of children from 36.4% to 80%		% increase of exclusive breastfeeding among 0-6 month of children .				
8	To increase immunization coverage from 53.3% to 70%		% increase of full immunization coverage .		Infant and Young Child Feeding/IYCF		
9	To increase vit A coverage of received atleast one dose (9month to 35 months) from 67.3% to 80% and include up to 5 years.		To increase Vit A reported adequte coverage among (9m to 5ys)	1.1 .3	Management of diarrhea, ARI and Micronutrient Malnutrition through Child srvival months		Two round of Child survival Month organised in one financial year.
10	To decrese Malnutrition form 58%(NFHS III state) to 30% of the age group of (0 to 5 yrs)		% of decrese Malnutrition age group of (0 to 5 yrs)	1.1 .4	Care of Sick Children and Severe Malnutrition and strenthen VHND at all AWCs		No of VHND orgnised vs Planned.
		2.1		2.1 .1	School Health Programme		No Of school health programme orgnised in the PHC
Sl.	Strategy		Gaps		Activities	Unit Cost	Budget
	IMNCI,Home Based Newborn Care/HBNC		*Training Gaps(AWW-2328/2476,ASHA-0,ANM-377/401,MPW-*		*Assessment of Training load and prepare calendar of training*	NA	0

			11/83,MO-47/146,CDPO-05/16,ICDS Super-05,Health supervisors-27,NGOs-06) *No ASHA is trained on IMNCI*		*Incorporate ASHA in IMNCI training team*	NA	0
					ASHA kit regular supply and incorporate use of ASHA Kit in training curriculum.		
					Division of area among all trained supervisors for revision of IMNCI activity in their area.	NA	0
					BHM will be responsible for review of health supervisor sand LS(ICDS)on given format .Unicef staff will support in developing review mechanism in PHC.	NA	0
					Incorporate IMNCI reports in HIMS format	NA	0
			Inadequate monitoring of this activity at field level		*Encouraging mother regarding child care.in VHND*	NA	0
					Frequent checkups of babies by Pediatrician. *Distribute telephone number to AWW and ANM of respective doctors those who are supervising them in the field.*	NA	0
					Wednesday could be fixed a day for IMNCI relateed work at HSC level	NA	

					Community based Monitoring support system develop with SHG in one PHCTraining of Group membersseed money to SHG for referral services and other need based services.	Rs 100000 for one PHC	100000
	Facility Based Newborn Care/FBNC		only eight institutions have baby warmer machines but maintenance of machine is not up to the mark and district having referral six bedded SNCU		All PHCs should be equipped with baby warmer machines.	Mobilizing nine units from UNICEF	0
			ANMs and Doctors are not trained to operate these machines		Training of Doctors and ANMs to operate baby warmer machine.	Rs 5000/- for demonstration at District level	5000
			There is no provision of stay of mothers of neonates at PHC.		Organize training program for newborn care for the nurses in the district hospitals	One Nurse from each PHC Cost will be 5000/-	5000

			Neonatal Care Unit not up to mark.		District level Supporting supervisory team should be developed with the responsibility of nonfunctioning of neonatal care unit. Training of team on monitoring of NCU	Rs. 5000/-for one time training	5000
			Non availability of "MAMTA" at PHC level.		*Training of Mamta and staff nurse on logistics of Newborn Care units. By district level supervisory Team.*	Rs 1500 for team members for each PHC per month	342000
	Infant and Young Child Feeding/IYCF		Non awareness of breast feeding and proper diet of young children.		Colostrums feeding and breast feeding inclusively for six months. Through IMNCI Training.	NA	0
					Baby friendly hospital Training of one doctor from each Nursing hospital at District Level	Rs. 20000 for training programme	20000
					Two days training of one staff nurse from each private hospital on counseling skill.	Rs 20000/- for training programme	20000

					Accreditation of nursing home and facility according to norms of baby friendly hospital initiatives	NA	0
			Poor knowledge regarding new born care and child feeding practices		Development and Printing of BCC materials	Rs 5 per unit for 10000 units	50000
					Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA	NA	0
					Linking JBSY with colostrums feeding	NA	0
			Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding		Counseling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries in mothers meetings and VHSCs meetings	NA	0
					Folk performance to promote exclusive breast feeding	Included in maternal health	0
					Uniform message on radio from state head quarter	State budget	0
			Lack of awareness on importance of appropriate and timely		Organize social events through VHSCs	NA	0

			IYCF		Strengthening of *Mahila Mandal* meetings- fortnightly with involvement of adolescent girl	NA	0
					Organize healthy baby shows, healthy mother / pregnant woman.	Rs 2000 per month per PHC	456000
					Appreciation and reorganization of positive practices in community. For this purpose hiring a documentation specialist.	Rs 100000 for the whole district on community wise sample basis	100000
					Celebration of "*Annaprashan(Muhjutthi) Day*" at AWC	NA	0
					Demonstration of recipes.	Rs 250 per month per AWC(Under MUSKAN program)	0

					Exposure visits to existing NRCs to observe different models in the country	Rs 50000 for the district	50000
	Care of Sick Children and Severe Malnutrition		There is not a single unit in the district where severly malnurished children could be treated.		Establish rehabilitation center in district hospital, FRU and one PHC and promote locally available food formula for nutritional Therapy as Hadrabad Mix	Rs 1000000 per unit	4000000
	Management of diarrhea, ARI and Micronutrient Malnutrition		There is high prevalence of PEM and anemia among children because of Child nutrition is least priporty among service providers.		Procurement of ,ORS , Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup.	100000 ORS packets at the rate of Rs 5 per packet. (If ORS is not provided in Kit A) IFA syrup for 800000 children at rate of Rs	3700000

						4 per children	
					Include coverage of Vitamin A and IFA,children in New HIMS format.	NA	0
					Insure two round of Vitamin A and deworming for the age group of (9m to 5 yrs) & (2 yrs to 5 yers) respectively in the month of April And Oct as per GOI guide line.	Rs 1500000 per round into two rounds (If Vit A is not provided in Kit A)	3000000
					Involvement of ICDS, school teachers and PRI for monitoring and evolution	NA	0
			No Pre School Health checkup & complete Immunization card.		Half yearly health checkup camp for children in schools should be organized.	Rs 2000 per PHC	38000
	School Health Programme		No training of school teacher for basic health care and personnel hygiene.		Training of school teacher by the medical personnel with support of administrative person.	Budget incorporated in adolescent	0

						he alth	
			No regular health checkup camp at school.		Quarterly meetings of VEC representatives by attending existing meetings of VECs representatives at block level by the concerned MOICs and BHMs.	NA	NA
			No Training & Screening of school's teacher for eye sight test.		Linking existing 7 opthalmic paramedics with this program and developing school wise calendar.	Mobility support of Rs 10000 per PHC for moving other blocks and hard to reach areas.	190000
			No other specific program has been formulated in the district.		School health anemia control programme should be strengthened with biannually de worming .	Budget incorporated in adolescent he alth	0

					Organizing competitions/Debates/Painting competitions/Essay/demonstration and model preparation of nutritional food and health.	Rs 20000 per PHC	380000
					Half yearly Health checkups and health card of all school going children.	Printing of Health Card at the rate of Re 1 per card for the children of class 6 to 10	100000
					Films shows on health, sanitation and nutrition issues	Use LCD projector in this activity.	0
					Social science Lab activities.	Included in adolescent health	0

					Rally and Prabhat Phery in epidemic areas. (Kala-azar & Malaria)	Local contribution/ Untied Fund/ VHSC	0
					Referral system for the school children for higher medical care.	From RKS fund	0
					Total		**12561000**

Ministry of Health and Family Welfare
Government of India

District Level Household and Facility Survey under Reproductive and Child Health Project (DLHS-3)

District Fact Sheet 2007-08

Bihar
Munger

International Institute for Population Sciences
(Deemed University)
Mumbai – 400 088

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About DLHS - 3:

The District Level Household Survey (DLHS) was initiated in 1997 with a view to assess the utilization of services provided by government health care facilities and people's perception about the quality of services. The District Level Household Survey (DLHS -3) is the third in the series of district surveys, preceded by DLHS-1 in 1998-99 and DLHS-2 in 2002-04. As in DLHS-3, the International Institute for Population Sciences (IIPS) was the nodal agency to conduct DLHS-1 and DLHS-2. DLHS-3, like other two earlier rounds, is designed to provide estimates on important indicators on maternal and child health, family planning and other reproductive health services. In addition, DLHS-3 provides information on important interventions of National Rural Health Mission (NRHM). Unlike other two rounds in which only currently married women age 15-44 years were interviewed, DLHS -3 interviewed ever-married women (age 15-49) and never married women (age 15-24).

The sample size among the districts in the country varies according to their performance in terms of Ante-Natal Care (ANC), institutional delivery, immunization, etc. and it was fixed based on information related to such indicators from DLHS-2. For low performing districts, 1500 Households (HHs), for medium performing districts, 1200 HHs and for good performing districts, 1000 HHs were fixed as sample size. In case of Munger, sample size was 1000 households with 10% additional HHs to take care of non-response/refusal, etc.

The survey used two-stage stratified random sampling in rural and three-stage stratified sampling in urban areas of each district. The information from 2001 Census was used as sampling frame for selecting primary sampling units (PSUs). In rural areas, all the villages in the district were stratified into different strata based on population /HH size, percentage of SC/ST population, female literacy (7+), etc. The required number of villages from each strata was selected with probability proportional to size (PPS). In selected primary sampling units (villages), household listing was done and required numbers of households were selected using systematic random sampling.

For larger villages (more than 300 HHs) segmentation was carried out. In case of 300 to 600 HHs, two segments of equal size were made and one was selected using PPS. For PSUs having more than 600 HHs, segments of 150 HHs were created depending on the size and then two segments were selected using PPS. In case of urban areas, number of wards were selected using PPS at first stage. In a selected ward, one enumeration block from 2001 census was selected again using PPS. Procedure for segmentation, household selection, etc, was same as in the case of rural PSUs.

The uniform bilingual questionnaires, both in English and in local language, were used in DLHS-3 viz., Household, Ever Married Women (age 15-49), Unmarried Women (age 15-24), Village and Health facility questionnaires.

In the household questionnaire, information on all members of the household and the socio-economic characteristics of the household, assets possessed, number of marriages to usual members of the household since January 2004 and deaths in the household since January 2004 etc. was collected. In case of female deaths, attempts were made to assess maternal death. The household questionnaire also collected information on respondent's knowledge (seen/read/ heard) about messages related to various government health programmes being spread through media and other sources.

The ever married women's questionnaire consisted of sections on women's characteristics, maternal care, immunization and child care, contraception and fertility preferences, reproductive health including knowledge about HIV/AIDS.

The unmarried women's questionnaire contained information on her characteristics, family life education and age at marriage, reproductive health-knowledge and awareness about contraception, HIV / AIDS, etc.

The village questionnaire contained information on availability of health, education and other facilities in the village and whether the health facilities are accessible throughout the year.

For the first time, population-linked facility survey has been conducted in DLHS-3. In a district, all Community Health Centres (CHCs) and District Hospital (DH) were covered. Further, all Sub-centres (SC) and Primary Health Centres (PHC) which were expected to serve the population of the selected PSU were also covered. There were separate questionnaires for SC, PHC, CHC and DH. They broadly include questions on infrastructure, human resources, supply of drugs & instruments, and performance.

Note:

DLHS-2: information is based on data collected from currently married women 15-44 years.

DLHS-3: information is based on data collected from ever married women 15-49 years.

DLHS-2: In total percentage is adjusted for indicators considering over sampling of urban PSUs in DLHS-2. This adjustment is done in those districts where urban percentage is less than 30.

DLHS-2: includes tap (inside residence/yard/plot), tap (shared/public), hand pump/borewell, well-covered.

DLHS-3: includes pipe into dwelling, piped to yard/plot, public tap/standpipe.

Unmet need for spacing

Unmet need for spacing includes the proportion of currently married women who are neither in menopause or had hysterectomy nor are currently pregnant and who want more children after two years or later and are currently not using any family planning method. The women who are not sure about whether and when to have next child are also included in unmet need for spacing.

Unmet need for limiting

Unmet need for limiting includes the proportion of currently married women who are neither in menopause or had hysterectomy nor are currently pregnant and do not want any more children but are currently not using any family planning method.

Unmet need

Unmet need refers to unmet need for limiting and spacing.

Correct knowledge of HIV/AIDS

The women who heard about HIV/AIDS and have correct knowledge about transmission of HIV/AIDS and knowledge of prevention from HIV/AIDS.

Bihar	DLHS-3	District : Munger

District Indicators, Munger, (2001 Census)

Indicators	Census 2001
Population (in thousands)	1136
Decadal Growth Rate (1991-01)	20.3
Sex Ratio*	878
Percent Urban population	27.9
Percent SC population	16.7
Percent ST population	2.3
Female Literacy Rate (7 years and above)	48.0
Male Literacy Rate (7 years and above)	70.7

Sample outcome, DLHS -3, 2007-08

Category	No. covered	Response Rate
Households	1024	93.1
Ever Married Women (15-49 years)	1033	88.4
Unmarried Women (15-24 years)	214	83.6
Sub Centres (SC)	27	84.4
Primary Health Centres (P H C)	9	100.0
Community Health Centres (C H C)	1	100.0
District Hospital (D H)	1	100.0

Population and Household Characteristics, 2007-08

Background Characteristics	DLHS - 3		DLHS - 2	
	Total	Rural	Total	Rural
Percent total literate Population (Age 7 +)	70.5	65.8	-	-
Percent literate Male Population (Age 7 +)	80.5	76.9	-	-
Percent literate Female Population (Age 7 +)	60.1	54.7	-	-
Percent girls (age 6-11) attending Schools	99.1	98.8	-	-
Percent boys (age 6-11) attending Schools	99.5	99.6	-	-
Have Electricity connection (%)	53.2	43.1	25.4	15.8
Have Access to toilet facility (%)	40.4	25.5	40.4	28.6
Use piped drinking water (%)	1.7	0.3	6.3	0.9
Use LPG for cooking (%)	16.6	3.5	13.3	8.4
Live in a pucca house (%)	26.4	15.9	27.6	17.3
Own a house (%)	95.2	97.9	-	-
Have a BPL card (%)	23.2	28.2	-	-
Own Agriculture Land (%)	35.0	43.4	-	-
Have a television (%)	30.6	18.6	30.0	21.6
Have a mobile phone (%)	28.3	21.9	-	-
Have a Motorized Vehicle (%)	9.0	6.9	11.3	9.4
Standard of Living Index				
Low (%)	61.7	75.3	57.5	68.0
Medium (%)	18.9	15.1	26.5	23.3
High (%)	19.3	9.6	16.1	8.7

* Number of Females per 1000 Males

Bihar	DLHS-3	District :	Munger

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	30.5	32.6	50.4	61.2
Percentage of Births of Order 3 and above	42.6	44.4	50.0	51.4
Sex Ratio at birth	125	135	-	-
Percentage of women age 20-24 reporting birth of order 2 & above	61.5	66.2	-	-
Percentage of births to women during age 15-19 out of total births	15.6	17.2	-	-
Family planning (currently married women, age 15-49)				
Current Use :				
Any Method (%)	41.4	39.6	38.6	36.8
Any Modern method (%)	33.9	33.2	30.7	28.4
Female Sterilization (%)	30.3	29.7	26.4	25.8
Male Sterilization (%)	0.4	0.5	0.1	0.2
IUD (%)	0.9	0.9	0.7	0.4
Pill (%)	1.2	1.3	0.7	0.3
Condom (%)	1.1	0.8	2.6	1.5
Unmet Need for Family Planning:				
Total unmet need (%)	31.6	32.9	35.3	35.1
For spacing (%)	14.9	15.4	16.1	16.5
For limiting (%)	16.7	17.5	19.3	18.6
Maternal Health:				
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	39.6	35.3	-	-
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	36.8	35.8	22.5	17.3
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)*	75.2	78.5	38.0	29.3
Institutional births (%)	48.6	43.5	38.8	29.8
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	10.5	10.9	14.4	11.2
Mothers who received post natal care within 48 hours of delivery of their last child (%)	46.7	46.8	-	-
Child Immunization and Vitamin A supplementation:				
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)	36.3	34.7	27.6	21.6
Children (12-23 months) who have received BCG (%)	84.3	84.0	51.9	44.6
Children (12-23 months) who have received 3 doses of Polio Vaccine (%)	50.1	49.5	36.8	31.1
Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	60.2	59.7	41.0	29.7
Children (12-23 months) who have received Measles Vaccine (%)	60.6	63.9	37.7	33.8

* It is adjusted according to DLHS-3 definition

Bihar	DLHS-3	District :	Munger

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 (%)	64.2	67.4	-	-
Children (above 21 months) who have received three doses of Vitamin A (%)	11.2	10.6	-	-
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 (%)	33.0	19.1	47.1	46.0
Children with Diarrhoea in the last two weeks who were given treatment (%)	73.8	69.4	100.0	100.0
Children with acute respiratory infection/fever in the last two weeks who were given treatment (%)	72.4	68.5	-	-
Children had check-up within 24 hours after delivery (based on last live birth) (%)	41.6	40.6	-	-
Children had check-up within 10 days after delivery (based on last live birth) (%)	42.1	40.6	-	-
Child feeding practices (Children under 3 years)				
Children breastfed within one hour of birth (%)	19.3	19.5	-	-
Children (age 6 months above) exclusively breastfed (%)	14.2	13.5	-	-
Children (6-24 months) who received solid or semisolid food and still being breastfed (%).	82.3	81.6	-	-
Knowledge of HIV/AIDS and RTI/STI among Ever married Women (age 15-49)				
Women heard of HIV/AIDS (%)	53.6	45.8	36.7	26.9
Women who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)	24.5	22.2	20.2	21.1
Women having correct knowledge of HIV/ AIDS (%)	92.6	92.9	-	-
Women underwent test for detecting HIV/ AIDS (%)	4.4	3.5	-	-
Women heard of RTI/STI (%)	58.6	49.4	96.7	95.9
Knowledge of HIV/AIDS among Un-married Women (age 15-24)				
Women heard of HIV/AIDS (%)	79.0	74.5	-	-
Women who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)	31.5	29.2	-	-
Women having correct knowledge of HIV/ AIDS (%)	95.6	93.9	-	-
Women underwent test for detecting HIV/ AIDS (%)	0.0	0.0	-	-
Women heard of RTI/STI (%)	51.5	43.0	-	-
Women facilitated/motivated by ASHA for				
Ante-natal Care (%)	8.0	9.8	-	-
Delivery at Health Facility (%)	12.1	14.9	-	-
Use of Family Planning Methods (%)	2.5	3.5	-	-

Bihar	DLHS-3	District : Munger

Village (N=36)

Indicators	Number
Villages that have implemented Janani Suraksha Yojana (JSY)	34
Villages with Health & Sanitation Committee	0
Villages with Rogi Kalyan Samiti (RKS)	9
Villages where PRI aware of untied fund by Government	2
Health facility within village-ICDS (Anganwadi)	31
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-ICDS (Anganwadi)	2
Health facility within village- Sub-Centre	15
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Sub-Centre	16
Health facility within village- PHC	0
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-PHC	30
Health facility within village- Block PHC	0
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Block PHC	29
Health facility within village- Govt. Dispensary	2
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Government. Dispensary	18
Health facility within village- Private Clinic	3
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Private Clinic	28
Health facility within village- AYUSH Health Facility	1
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-AYUSH Health Facility	28

Facility Survey

Community Health Centre (CHC) N = 1

Indicators	Number	Indicators	Number
Infrastructure :		**Performance :**	
CHC having Personal Computer	0	In-patients admission in last one month	294
CHC having Operation Theatre	1	Referred cases for serious ailments from CHC to higher centre during last one month	4
CHC having Labour Room	1	Deliveries performed in last one month	184
CHC having Blood Storage Facility	0	Blood transfusion done in last one month	0
CHC having large deep freezer	0	Sterilization conducted in last one month	243
CHC prepared a CHC plan for the current year	1		
CHC having water supply for 24 hours	1		
CHC having Ambulance on road	1		

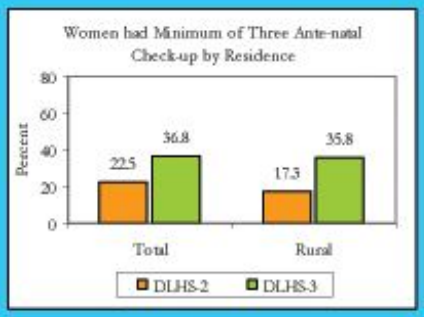
Facility Survey

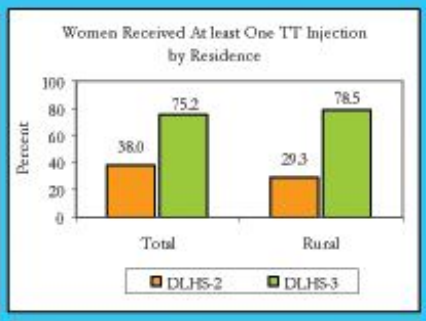
Indicators	Number	Indicators	Number
Community Health Centre (CHC) (Contd...)			
Human Resource :		**Supply :**	
CHC having General Surgeon	0	CHC with 24 hours normal delivery services	1
CHC having Obstetrician/ Gynecologist	1	CHC with 24 hours New born care	1
M.O. received training of Non-Scalpel Vasectomy (NSV) during last five years	3	CHC recognized as Integrated Counseling and Testing Centre (ICTC)	0
M.O. received training for Prevention, Care and Support for HIV/AIDS during last five years	0		
M.O. received training of basic Emergency Obstetric Care during last five years	1		
M.O. received training of Integrated Management of Neonatal and Childhood illness during last five years	1		
Primary Health Centre (PHC) N= 9			
Infrastructure :		**Performance :**	
PHC having Residential Quarter for Medical Officer	5	Haemoglobin tests (TLC/DLC) conducted during last one month	0
PHC having separate Labour Room	3	Blood smear examinations for malaria parasite conducted during last one month	54
PHC having Personal Computer	0	In-patient admissions during last one month	1,517
PHC having Normal Delivery Kit	6	Referral cases for serious ailments from PHC to higher centres during last one month	219
PHC having Large Deep Freezer	2	Deliveries performed during last one month	657
PHC having regular water supply	6	Beneficiaries of JSY during last one month	534
PHC having Neonatal Warmer (Incubator)	0	Women provided with post-natal care services during last one month	521
PHC having Operation Theater with Boyles Apparatus	0	New born care provided during last one month	508
PHC having Operation Theater with anaesthetic medicine	3	Infants and children immunized during last one month	6,522
		Condoms distributed during last one month	2,552
		PHC prepared the PHC plan for current year	9

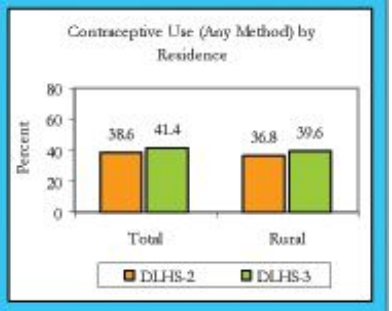
Facility Survey

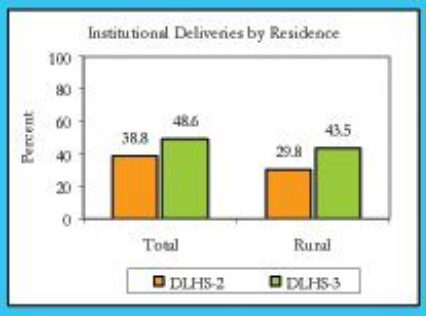
Indicators	Number	Indicators	Number
Primary Health Centre (PHC) (Contd...)			
Human Resource :		**Supply :**	
PHC having Lady Medical Officer (LMO)	3	PHC that received the untied fund in previous financial year	9
PHC having Laboratory Technician	4		
PHC organized any training programme in their PHC during last year	9		
PHC having at least one MO, who received Integrated Skill Development Training for 12 days during last five years	7		
PHC having at least one MO, who received IMNCI training during last five years	4		
Sub Centre (SC) N = 27			
Infrastructure :		**Performance :**	
Sub Centre located in government building	11	Number of Infants and children immunized	3,403
Sub Centre having communication facility	0		
Sub Centre having separate labour room	0		
ANM staying in Sub Centre village	5		
Sub Centre having staff quarter for ANM	0		
Sub Centre having regular water supply	15		
Human Resource :		**Supply :**	
Sub Centre where Male Health Worker in position	4	Sub-Centre having auto-disposible syringes	24
ANM had Integrated Skill Development Training in last 5 years	10	Sub-Centre reporting IFA tablets out of stock for more than 10 days during last one month	17
ANM ever been trained in Integrated Skill Development Training	21	Sub-Centre reporting Vitamin A out of stock for more than 10 days during last one month	8
ANM trained in integrated management of neonatal and childhood Illnesses (IMNCI) in last 5 years	13	Sub-Centre reporting ORS packets out of stock for more than 10 days during last one month	21
ANM ever been trained in integrated management of neonatal and childhood Illnesses (IMNCI)	19	Sub-Centre that received untied fund in previous financial year	16
ANM who attended Skilled birth attendant (SBA) training	6		

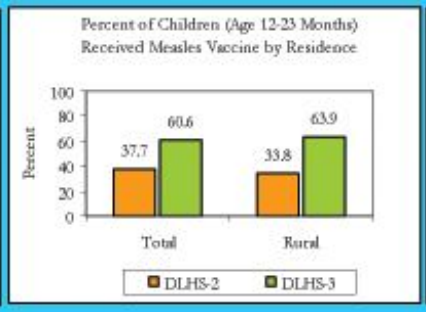
Performance at a Glance

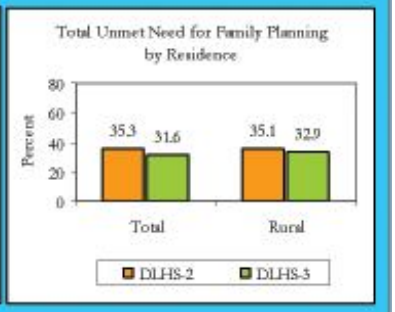












Situation Analysis for District Health Action Plan

No	Variable	Data
1	Total Area	1419.
2	Total no. of Block	9
3	Total no of Gram Panchayats	101
4	No. of Villages	866
5	No of PHCs	9
6	No. of APHCs	19
7	No. of HSCs	155
8	No. of Sub divisional hospitals	Nil
9	No. of referral hospitals	Nil proposed -1
10	No of Doctors	C-30(27 M, 3 F),R-46 (42 M, 4F)
11	No. of ANMs	R-165,C-137
12	No. of Grad A Nurse	C-26,R-20
13	No. of Paramedicals	
14	Total Population	1383495
15	Male Population	736722
16	Female Population	646773
17	Sex Ratio	878f/1000m
18	No. of Eligible couples	257834
19	Children (0-1 years)	39000
20	Children (0-6 years)	
21	SC Population	187323
22	ST Population	22412
23	BPL Population	136619
24	No. of Primary School	1069
25	No of Anganwari centers	1074
26	No of Anganwari workers	863
27	No of ASHA	961 (945 working but)
28	No. of Electrified villages	689
29	No. of villager having access to safe drinking water	NIL
30	No of villages having motorable roads	821

Section A : Health Facilities in the District

Health Sub – Centers

S.No	Block Name	Population	Sub-centres required(After including HSCs)	Sub centers Present	HSCs Proposed	Sub centers required	Status of building		Avalability of Land	
							own	Rented	Y	N
1	Sadar. Munger	361805	28	23	5	5	6	17		No
2	Jamalpur	221227	20	16	4	4	8	8	8	8
3	Dhrarhra	126615	19	17	2	2	5	5	5	5
4	H.Kharagpur	220541	30	26	4	4	4	6	5	5
5	Bariyarpur	112616	14	14	0	0	4	6	6	
6	Tarapur	102762	19	18	1	1	7	5	13	5
7	Asarganj	72571	11	11	0	0	3	7	7	3
8	Sangrampur	95151	23	19	4	4	5	8	7	12
9	Tetiyabamber	70207	12	11	1	1	3			
Total		**1383495**	**176**	**155**	**21**	**21**	**45**	**62**	**51**	**38**

Section A : Health Facilities in the District

Additional Primary Health centers (APHCs)

S.No	Block Name	Population	APHCs required (After including APHCs)	APHCs Present	APHCs Proposed	APHCs required	Status of building		Avalability of Land	
							own	Rented	Y	N
1	Sadar. Munger	361805	4	0	4	4	NA	NA		no
2	Jamalpur	221227	3	2	1	1	1	NA	2	1
3	Dhrarhra	126615	4	3	1	1	….	…	yes	
4	H.Kharagpur	220541	4	4	0	0	3	NA	Yes	
5	Bariyarpur	112616	2	1	1	1	NA	2		no
6	Tarapur	102762	2	2	0	0	2	1	Yes	
7	Asarganj	72571	2	2	0	0		Yes	Yes	1
8	Sangrampur	95151	3	3	0	0		Yes		1
9	Tetiyabamber	70207	2	2	0	0	Yes	NA	Yes	
Total		1383495	26	19	7	7				

Section A : Health Facilities in the District

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

S.No	Block Name/sub division	Population	PHCs/Referral/SDH/DH present	PHCs required (After including referral / DH/SDH	PHCs proposed
1	Sadar. Munger	361805	PHC	NA	NA
2	Jamalpur	221227	PHC	NA	NA
3	Dhrarhra	126615	PHC	NA	NA
4	H.Kharagpur	220541	PHC	NA	NA
5	Bariyarpur	112616	PHC	NA	NA
6	Tarapur	102762	PHC	NA	NA
7	Asarganj	72571	PHC	NA	NA
8	Sangrampur	95151	PHC	NA	NA
9	Tetiyabamber	70207	PHC	NA	NA
Total		1383495			

Name of the PHC/Referral Hospital/SDH/DH 1st April 2010 to 30 November 2010			
No	Service	Indicator	Data
1	Child Immunizations	% of children 9-11 month fully immunized (BCG+DPT1+OPV123+Measled)	41.29%
		% of Immunization sessions held against planned	97%
2	Child Health	Total number of live births	18436
		Total number of still births	351
		% of newborns weighed within one week	NA
		% of newborns weighing less than 2500 gm	3.6% (658)
		Total number of neonatal deaths (within 1 month of birth)	03
		Total number of infant deaths (within 1-12 months)	01
		Total number of child deaths (within 1-5 yrs)	04
		Number of diarrhea cases reports reported within the year	952
		% of diarrhea cases treated	952
		Number of ARI cases reported within the year	324
		% of ARI cases treated	100%
		Number of children with Grade 3 and Grade 4 undernutrition who were admitted	NA
		Number of undernourished children	NA
		% of children below 5 yrs who received 5 doses of vit A solution	587
3	Maternal care	Number of Pregnant woman register for ANC	19286
		% of pregnant woman registered for ANC in the 1st trimester	51.74
		% of Pregnant woman with 3 ANC check up	61.85
		% of Pregnant woman with any ANC checkup	
		% of Pregnant woman with received 2 TT injections	97.31
		% of Pregnant woman who received 100 IFA tablets	69.28
		Number of institutional deliveries conducted by SBA	15293
		% of c- sections conducted	0.01
		% of Pregnancy complications managed	2.69
		% of institutional deliveries in which JBSY fund were given	76.74 (11736)
		% of home deliveries in which JBSY funds were given	0%
		Number of deliveries referred due to complications	nil
		% of mothers visited by health workers during the first week after delivery	80%
		Number of Maternal Deaths	01
4	Reproductive Health	Number of MTPs conducte at public institution	35
		Number of MTPs conducted at accredited	161
		Number of RTI/STI case treated	M-44,F-41
		% of couples provided with barrier contraceptive methods	80097
		% of couples provided with permanent methods	

		% of female sterilizations	1034
5	RNTCP	% of TB cases suspected out of total OP	3.39%
		Proportion of New sputum positive out of total New pulmonary cases	1014-1722
		Annual case detection Rate (total TB cases registered for treatment per 100,000 (% population per year .	117.91%
		Treatment success Rate (% of new smear positive patients who are document to be cured or have successfully completed treatment	91.37%
		% of patients put on treatment who drop out of treatment.	3.39%
6	Vector Borne Disease Control Programme	Annual Parasite Incidence	0.35
		Annual Blood Examination Rate	0.33
		Plasmodium Falciparum percentage	91%
		Slide Positivity Rate	10.76
		Number of Patients receiving treatment for Malaria	494
		Number of Patients with Malaria referred	0
		Number of FTD and DDCs	18&50
7	National Programme for control of Blindness	Number of cases detected	618
		Number of cases operated	618
		Number of patients enlisted with eye problem	NA
		Number of camps organized	NA
8	National Leprosy Eradication Programme	Number of cases detected	MB- 73,PB-108
		Number of cases treated	MB-73,PB-108
		Number of default cases	MB-4,PB-0
		Number of cases complete treatment	MB-52,PB-95
		Number of complicated cases	MB-25,PB-17
		Number of cases referred	0
9	Inpatient Services	Number of in-patient admissions	29708
10	Outpatient services	Outpatient attendance	624294
11	Surgical Services	Number of major surgeries conducted	686
		Number of minor surgeries conducted	5625

Section F: Community Participation, Training & BCC

Community Participation Initiatives

S.no.	Name of Block	No. of GPs	No. of VHSC formed	No. of VHSC meeting held in the block	Total amount released to VHSC from untied funds	No. of ASHAs	Number of ASHAs trained	Number of meeting held between ASHA and Block officers	Total amount paid as incentive to ASHA
						Round 1	Round 2		
1	Sadar. Munger	13		78	100000	105		NA	NA
2	Jamalpur	10	34	34	340000	98		NA	NA
3	Dhrarhra	13	93	1	930000	103		NA	NA
4	H.Kharag pur	18	18	18	890000	10		NA	NA
5	Bariyarpur	11	11	39	320000	92		NA	NA
6	Tarapur	12	0	40	510000	100		NA	NA
7	Asarganj	7	45	7	450966	71		NA	NA
8	Sangramp ur	10	19	19	610000	92		NA	NA
9	Tetiyabam ber	7	7	24	460000	34		NA	NA

Training Activities:

S.No	Name of Block	Rounds of SBA Trainings held (2009-10)	No. of Personnel given SBA Training	Rounds of IMNCI Training held (2009-10)	No. of Personnel given IMNCI Training	Any specific issue on which need for a training of skill building was felt but has not being given yet
1	Sadar. Munger	4	23ANM+LHV	4	23 (ANM+LHV) +22(ANMC)	NA
2	Jamalpur	1	22	39	39	NA
3	Dhrarhra	…..	……	2	24	NA
4	H.Kharagpur	2	30	2	30	NA
5	Bariyarpur	1	4	3	22	NA
6	Tarapur	2	0	2	0	NA
7	Asarganj	1	3	1	12	NA
8	Sangrampur	4	4	3	23	NA
9	Tetiyabamber	1	5	1	1	NA

Name of the District ,Munger

Section B : Human Resources and Infrastructure

PHC Sub-center database

Name of PHC	Sub center	Pop	No of G.P at/villages served	ANM/R/C in position		Building ownership (Govt/Pan/Rent			Building condition (+++/++/+/)			Assured running water supply (A/NA/I)			Cont. power supply (A/AN/I)			ANM residing at HSC area (Y/N)		Condition of residential facility(+++/++/+)			Status of furniture's		Status of Untied fund	
				R	C	Govt	Pan	rent																			
Sadar. Munger	23	361805		18	22	10	1	13	3	3	18≠		24			24		2	22		2	22≠	1	23	24	23
Jamalpur	16	221227		18	17	8		8	1	6	9≠	1	15			16		8	8	1	7	8≠	8	8	16	13
Dhrarhra	17	126615		19	21	10		15			9+		25			25			25			25≠	NA	25	25	NA
H.Kharagpur	26	220541		30	21	2		8			10≠		10			10			10			10≠	10	NA	10	NA
Bariyarpur	14	112616		17	13	5		5		5	5≠		10			10		4	6			10≠	10	NA	10	10
Tarapur	18	102762		19	13	8		9		8	9≠	1	16		1	16			17			17≠	NA	17	17	NA
Asarganj	11	72571		11	6	4		7			11≠	1	10			11			11			11≠	6	5	6	6
Sangrampur	19	95151		15	15	5		14		7	12≠		19			19			19			19≠	13	6	19	13
Tetiyabamber	11	70207		13	6	7		4	1	5	5≠		11			11		3	8	1	1	9≠	NA	11	11	4
Total	155	1383495		160	134																					

Civil Surgeon cum Member Secretary,
District Health Society, Munger

Section B : Human Resources and Infrastructure

Name	APHC & PHC		Doctors				ANM				Laboratory technician				Pharmacists/dresser				Nurse A Grade				Accent/peons/Sweeper/Nights Guards		Availability of specialist	
	Sanc	Inposi	Sanc		Inpos		Sanc		Inpos		Sanc		Inpos		Sanc		Inpos		Sanc		Inpos		Sanc	Inpos		
	PHC	APHC	PHC	APHC	PHC	APHC	PHC	APHC	PHC	APHC	PHC	APHC	PHC	APHC	PHC	APHC	PHC	APHC	PHC	APHC	PHC	APHC	PHC	APHC	PHC	APHC
Sas	1	NA	2	NA	2	NA	19	NA	18	NA	NA	NA	NA	NA	NA	NA	NA	NA	1	NA	1	NA	4	NA	PHC	APHC
Jmp	1	2	4	6	4	2	4	6	4	2	1	3	1	NA	1/1	3/3	1/1	1/1	1	6	NA	3	4	8	NA	NA
Dha	1	3	8	8	8	3	4	6	2	6	1	3	1	1	1/1	3/3	1/NA	1/NA	4	9	NA	2	8	8	3	NA
Kha	1	4	8	8	4	7	4	8	2	7	2	4	2	NA	2/2	4/4	0	2/NA	2	8	0	7	8	6	3	NA
Bar	1	1	8	4	3	0	3	4	3	2	1	2	NA	NA	2/2	1/1	1/NA	1/NA	4	1	4	1	2	12	1	NA
Tar	1	2	8	4	8	0	11	4	11	2	1	2	1	NA	2/2	1/1	1/NA	1/NA	4	1	3	1	8	2	NA	NA
Asa	1	2	4	4	4	1	3	4	3	2	1	2	NA	NA	1/1	2/2	1/NA	1/NA	1	4	NA	3	6	2	NA	NA
Sag	1	3	8	2	6	2	34	20	30	1	2	1	1		1/1	1/1	1/NA	NA	1	2	1	NA	6	4	NA	NA
Tbam	1	2	4	4	3	2	3	4	2	2	1	2	0	0	1/1	1/1	1/NA	NA	1	4	1	3	8	2	4	NA

Civil Surgeon cum Member Secretary,
District Health Society, Munger

Sr. NO	STRATEGIES	Activities	Component Code (only at state level)	Output 2012	Activity Plan										Budget Plan								
					2010-2011FY				2011-2012 FY						2010-2011 FY					2011-2012 FY			
					Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised {Y x (A)} = D	under or over-utilised Budget {(B~D} =E	Tentative Unit Cost (2010-11)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
											Q 1	Q 2	Q 3	Q 4									
A		RCH																					

A.1		**1. Maternal Health**													0							
	A.1.1	**1.1Operationalise facilities (dissemination, monitoring & quality) (details of infrastructure & human resources, training, IEC / BCC, equipment, drug and supplies in relevant sections)**													0							
	A.1.1.1	**1.1.1 Operationalise Block PHCs/ CHCs/ SDHs/ DHs as FRUs**			2	1	1	lack of lab technician	2		y	y	y	y	360000	720000	684000	?	?	360000	720000	NRHM	
	A.1.1.1.1	**1.1.1 Operationalise FRUs (Diesel, Service Maintenance Charge, Misc. & Other costs) 1.1.1.1 Operationalise Blood Storage units in FRU**			1	1	0		2		y	y	y	y	96000	96000	96000	?	?	120000	240000	NRHM	

	A.1.1.2	**1.1.2 Operationalise 24x7 PHCs (Organise workshops on various aspects of operationalisation of 24x7 services at the facilities @ Rs. 25,000 / year / district)**			0	0	0	No budgetary provision was planned for FY 10-11	9	Workshop at all PHCs has been planned during FY 2011-12	y	y	y	y	25000	0	0	0	0	25000	225000	NRHM	
	A.1.1.3	**MTP services at health facilities**	?	?	?											#VALUE!	#VALUE!		#VALUE!		#VALUE!		
	A.1.1.4	**RTI/STI srvices at health facilities**			0	0	0		1	To open an OPD at Sadar Hospital for providing RTI/STI Services	y	y	y	y	0	0	0	0	0	420000	420000	NRHM	A Medical officer (Skin Specialist) shall be appointed on contractual basis @Rs. 35,000/- per month
	A.1.1.5	**Operationalise Sub-centres**														0	0		0		0		
	A.1.2	**1.2 Referral Transport**														0	0		0		0		

	A.1.2.1	**1.2.1. To develop guidelines regarding referral transport of the pregnant women and sick new born / children and dissemination of the same @ Rs. 50,000 for the state**													0	0		0		0		
	A.1.2.2	**1.2.2. Payment to Ambulances for all PHCs @ Rs. 200 / case of pregnancy for Jehanabad district (Pilot basis)**													0	0		0		0		
	A.1.3.	**1.3. Integrated outreach RCH services**													0	0		0		0		
	A.1.3.1	**1.3.1. RCH Outreach Camps in un-served/ under-served areas**			216	0	216	Report not completed by PHC	60		Y	Y	Y	Y	833	179928	180000	0	179928	833	49980		
	A.1.3.2.	**1.3.2. Monthly Village Health and Nutrition Days at AWW Centres**													0	0		0		0		

	A.1.4	**1.4. Janani Evam Bal Suraksha Yojana/JBSY**													0	0		0		0		
	A.1.4 .1	**1.4.1 Home deliveries (500/-)**			148	0	148	Not Expent by PHC	200		y	y	y	y	500	74000	74000	0	74000	500	100000		
	A.1.4 .2	**1.4.2 Institutional Deliveries**					0									0	0		0		0		
	A.1.4 .2.1	**1.4.2.1 Rural (A) Institutional deliveries (Rural) @ Rs.2000/- per delivery for 10.00 lakh deliveries**			19200	10514	8686	Due to Backlog decrease	31686		y	y	y	y	2000	38400000	38400000	15500000	22900000	2000	40472000		
	A.1.4 .2.2	**1.4.2.2 Urban (B) Institutional deliveries (Urban) @ Rs.1200/- per delivery for 2.00 lakh deliveries**			3073	0	3073		4000		y	y	y	y	1200	3687600	3687600	0	3687600	1200	1112400		
	A.1.4 .2.3	**1.4.2.3 Caesarean Deliveries (Facility Gynec, Anesth & paramedic) 10.3.1 Incentive for C-section(@1500/- (facility Gynec. Anesth. & paramedic)**			100	0	100	Not clear guideline	200		y	y	y	y	1500	150000	150000	0	150000	1500	150000		

	A.1.4.3	**1.4.3 Other Activities(JSY) 1.4.3. Monitor quality and utilisation of services and Mobile Data Centre at HSC and APHC Level and State Supervisory Committee for Blood Storage Unit**									0	y	y	0	540000	540000	540000	14560	525440	540000	540000		
		Total (JSY)					0									0	0		0		0		
	A.1.5	**1.5 Other strategies/activities**					0									0	0		0		0		
	A.1.5.1	**1.5.1 Maternal Death Audit 1.1.3 Survey on maternal and perinatal deaths by verbal autopsy method (in two districts) @ 850 per death**					0									0	0		0		0		
A.2		**2. Child Health**					0									0	0		0		0		

	A.2.1	**2.1. Integrated Management of Neonatal & Childhood Illness/IMNCI (Monitor progress against plan; follow up with training, procurement, review meetings etc) 2.1. 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**			1	0	1	Expenditure report not given by RCH Office	135000	2	y	y	y	y	135000	135000	135000	0	135000	135000	135000		
	A.2.2	**2.2 Facility Based Newborn Care/FBNC in districts (Monitor progress against plan; follow up with training, procurement, view meeting etc.) 2.2.1. Implementation of FBNC activities in districts. (Monitor progress against plan; follow up with training, procurement, etc.)**			1	0	1	Expenditure report not given by RCH Office	2		y	y	y	y	38000	38000	38000	0	38000	38000	38000		

	A.2.3.	**2.3 Home Based New born care/HBNC**				0									0	0		0		0		
	A.2.4	**2.4 School Health Programme (Details annexed)**			484	0	484	Due to DM stay	984		y	y	y	y	3000	1452000	1451645	0	1452000	3000	1500000		
	A.2.5.	**2.5 Infant and Young Child Feeding/IYCF**					0									0	0		0		0		
	A.2.6.	**2.6 Care of sick children & severe malnutrition**			1	0	1	Due to not established	2		y	y	y	y	1758070	1758070	1758070	0	1758070		1758070		
	A.2.7.	**2.7 Management of Diarrhoea, ARI and Micro nutrient**					0				y	y	y	y		240435	240435	16000	224435		240435		
A.3		**3.Family Planning**					0									0	0		0		0		
	A.3.1.	**3.1.Terminal/Limiting Methods**					0									0	0		0		0		
	A.3.1.1.	**3.1.1. Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services**			1	0	1	Workshop not held	2		y	y	y	y	22000	22000	22000	0	22000	22000	22000		
	A.3.1.2	**3.1.2 Female Sterilisationcamps**			216	0	216	Data not available	400		y	y	y	y	1000	216000	216000	0	216000	1000	184000		

	A.3.1.3 3.1.2.2.	**3.1.3 3.1.2.2. NSV camps (Organise NSV camps in districts @Rs.10,000 x 500 camps)**			20	0	20	Data not available	40		y	y	y	y	10000	200000	200000	0	200000	10000	200000		
	A.3.1.4	**3.1.4 Compensation for female sterilisation 3.1.2.3. Compensation for female sterilisation at PHC level in camp mode 3.1.2.1. Provide female sterilisation services on fixed days at health facilities in districts (Mini Lap)**			6602	274	6328		12828		y	y	y	y	1000	6602000	6601550	306604	6295396	1000	6532604		
	A.3.1.5 3.1.2.4	**3.1.5 Compensation for male slerilisation 3.1.2.4. Compensation for NSV Acceptance @50000 cases x1500**			345	3	342		542		y	y	y	y	1500	517500	518175	0	517500	1500	295500		
	A.3.1.6 3.1.3.1	**3.1.6 Accreditation of private providers for sterilisation services 3.1.3.1 Compensation for sterilization done in Pvt.Accredited Hospitals (1.50 lakh cases)**			1971	391	1580		3580		y	y	y	y	1500	2956500	2956500	1312450	1644050	1500	3725950		

	A.3.2	**3.2. Spacing Methods**					0									0	0		0		0		
	A.3.2 .1	**3.2.1. IUD Camps**			200	0	200		400		y	y	y	y	1500	300000	300000	0	300000	1500	300000		
	A.3.2 .2	**3.2.2 IUD services at health facilites/compensation**			5066		5066		10066		y	y	y	y	50	253300	253283	0	253300	50	250000		
	A.3.2 .3	**Accreditation of private providers for IUD insertion services**					0									0	0		0		0		
	A.3.2 .4	**Social Marketing of contraceptives**					0									0	0		0		0		
	A.3.2 .5 3.2.2.	**3.2.5 3.2.2. Contraceptive Update Seminars (Organise Contraceptive Update seminars for health providers (one at state level & 38 at district level) (Anticipated Participants-50-70)**			1	0	1		2		y	y	y	y	64215	64215	64170	0	64215	64215	64215		
	A.3.3	**3.3 POL for Family Planning for 500 below sub-district facilities**			1	0	1		2		y	y	y	y	145800	145800	162000	0	145800	145800	145800		
	A.3.4	**3.4 Repair of Laproscopes (Rs. 5000 x 40 nos.)**					0									0	0		0		0		

	A.3.5	3.5 Other strategies/activities 3.1.4. Monitor progress, quality and utilisation of services 3.5. Establishing Community Based Condom and OCP Distribution Centres (pilot in one district/1 PHC)														0	0		0		0		
A. 4		4. Adolescent Reproductive and Sexual Health (ARSH)														0	0		0		0		
		(Details of training, IEC/BCC in relevant sections)														0	0		0		0		
	A.4.1	Adolescent services at health facilites. 4.1.1. Disseminate ARSH guidelines.4.1.2. Establishing ARSH Cells in Facilities 4.1.2.1. Developing a Model ARSH Cell for the facilities 4.1.2.2. Establishing ARSH Cell at Patna District Hospital 4.1.2.3. Establishing ARSH Cell is 50% PHCs of Patna District 4.2 Conducting ARSH Camps at all PHCs for a week (as ARSH Week) 4.2.2 Establishing Youth friendly health clinics in Urban Area/ Universities			0	0	0									0	0	0	0		0		

		Campus / Market Place																					
	A.4.2	**4.2 Other strategies/activities**					0									0	0		0		0		
A. 5		**5. Urban RCH**					0									0	0		0		0		
	A.5.1	**5.1. Urban RCH Services (Development of Micro-plans for each urban area already mapped for delivery of RCH services, both outreach and facility based through private agencies/institutions/organisations- 50lakhs & Operationalising 20 UHCs through private clinics @540000/- pm**					0									0	0		0		0		
A. 6		**6 Tribal Health**					0									0	0		0		0		

	A.6.1	**Tribal RCH services**					0									0	0		0		0		
	A.6.2	**Other strategies/activities**					0									0	0		0		0		
A.7		**7. Vulnerable Groups**					0									0	0		0		0		
	A.7.1	**7.1 Services for Vulnerable groups**					0									0	0		0		0		
	A.7.1	**7.1 Services for Vulnerable groups**					0									0	0		0		0		
	A.7.2	**7.2 Other strategies/activities**					0									0	0		0		0		
A.8		**8. Innovations/PPP/NGO**					0									0	0		0		0		
	A.8.1	**8.1.PNDT and Sex Ratio** **8.1.1. Orientation programme of PNDT activities, Workshop at State, District and Block Level (1+38+533) (amount Rs.50 Lakhs) 8.1.2 Monitoring at District level and Meetings of District level Committee (100 Lakhs)**			19	0	19		38		y	y	y	y	25000	475000	475000	0	475000	25000	475000		

	A.8.2.	**Public Private Partnerships**					0									0	0		0		0		
	A.8.3	**NGO Programme**					0									0	0		0		0		
	A.8.4	**Other innovations (if any)**					0									0	0		0		0		
A.9		**INFRASTRUCTURE & HR**					0									0	0		0		0		
	A.9.1	**Contracutal Staff & Services**					0									0	0		0		0		
	A.9.1.1	**9.1.1 ANMs 10.1.1.2. Hiring of 1000 Retired ANMs or ANMs from other states for out reach services @ Rs. 5000 / month / ANM**				0	0				y	y	y	y		0	0	0	0		0		
	A.9.1.2	**9.1.2 Laboratory Technicians**			6	3	3		9		y	y	y	y	58500	351000	351000	117000	234000	78000	468000		
	A.9.1.3	**Staff Nurses**			26	26	0		38		y	y	y	y	144000	3744000	3744000	2327580	1416420	144000	5472000		

	A.9.1.4	9.1.4 Doctors and Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians) Hiring Specialists 1.1.1.1 Operationalise Blood Storage units in FRU -Salary of Medical Officer - 1,82,40,000/-; 10.1.2.1. Empeanelling Gynaecologists for gynaecology OPD in under or un served areas @ Rs. 1000/- week x 52 weeks ; 10.1.2.3. Empanelling Gyaneocologists for PHCstoprovide OPD services @ Rs. 300/- weekx 52 weeks; 10.1.2.4 Hiring Anaesthetist positions @ Rs.1000 per case x 120000; 10.1.2.5. Hiring Paediatrician for facilities where there are vacant Paediatricians positions @ Rs. 35,000/- month (2 per district); 10.1.2.6 Hiring Gynaecologists for facilities that have vacant positions @ Rs. 650 per case x 75000 cases			2	1	1		3		y	y	y	y	420000	840000	840000	120000	720000	420000	840000		

	A.9.1.5	Other contractual Staff 9.1 Fast-Track Training Cell in SIHFW 9.2 Filling Vacant Position at SIHFW/Hiring Consultant at SIHFW 10.1.1 Honorarium of Voluntary Workers @ of 1200/- PA x 3106 No.					0								0	0		0		0		
	A.9.1.6	Incentive/Awards etc. 8.2.1 Incentive for ASHA per AWW center (80000x200 per month) and Incentive toANMs per Aganwari Centre under Muskan Programme (@80000 x Rs.150 Per Month									y	y	y	y		5275800	5276000	4031725	1244075		5689800		
	A.9.2	9.2. Major civil works (new construction/extension/addition)																					
	A.9.2.1	9.2.1 Major Civil works for operationalisation of FRUS					0									0	0	0	0		0		

	A.9.2.2	**9.2.2 Major Civil works for operationalisation of 24 hour services at PHCs**					0									0	0		0		0		
	A.9.3	**9.3 Minor Civil Works**					0									0	0		0		0		
	A.9.3.1	**9.3.1 Minor civil works for operationalisation of FRUs 10.4.1 Facility improvement for establishing New Born Centres at 76 FRUs across the state - @ Rs. 50,000 / per FRU**			2	0	2		2		y	y	0	0	50000	100000	100000	0	100000	100000	100000		
	A.9.3.2	**9.3.2 Minor civil works for operationalisation of 24 hour services at PHCs 10.4.2. Facility improvement for establishing New Born Centres at PHCs across the state - @ Rs. 25,000 / per PHC**			9	0	9		18		y	y	y	y	100000	900000	900000	0	900000	100000	900000		
	A.9.4	**9.4 Operationalise IMEPat health facilites**														1394316	1394316	0	1394316		1394316		
	A.9.5	**9.5 Other Activities**																					

A. 10		**10. Institutional Strengthening**																					
	A.10. 1	**10.1 Human Resource Development**																					
	A.10. 2	**10.2 Logistics management/improvement**																					
	A.10. 3	**10.3 Monitoring Evaluation/HMIS 11.3 Monitoring & evaluation through monitoring cell at SIHFW**													469980	469980	0	469980		484380			
	A.10. 4	**10.4 11.4 Sub-centre rent and contingencies @ 1770 no. x Rs.500/- x 60 months**			5	0	5		30		y	y	y	y	30000	150000	150000	43200	106800	30000	750000		
	A.10. 5.	**10.5. Other strategies/activities TA & DA for the 30 days contact programme**																					
A. 11		**11 Training**					0								0	0		0		0			

	A.11.1	**11.1 Strengthening of Training Institutions**				0								0	0		0		0			
	A.11.2	**11.2 Development of training packages**				0								0	0		0		0			
	A.11.3	**11.3 Maternal Health Training**				0								0	0		0		0			
	A.11.3.1	**11.3.1 Skilled Birth Attendance /SBA 12.1.2 Skilled Attendance at Birth / SBA--Two days Reorientation of the existing trainers in Batches 12.1.3 Strengthening of existing SBA Training Centres 12.1.4 Setting up of additional SBA Training Centre- one per district 12.1.5 Training of Staff Nurses in SBA (batches of four) 12.1.6 Training of ANMs / LHVs in SBA (Batch size of four) 20 batches x 38 districts x Rs.59,000/-**			2	1	1		6		y	y	y	y	88110	176220	176220	61100	115120	88110	440550		

	A.11.3.2	**EmOC Training 12.1.3 EmOc Training of (Medical Officers in EmOC (batchsize is 8)**					0									0	0		0		0		
	A.11.3.3	**11.3.3 Life Saving Anaesthesia Skills training 12.1.5 Training of Medical Officers in Life Saving Anaesthesia Skills (LSAS)**					0									0	0		0		0		
	A.11.3.4	**11.3.4 MTP Training 12.1.6.1 Training of nurses/ ANMs in safe abortion 12.1.8 Training of Medical Officers in safe abortion**			1	0	1		2		0	y	0	y	80000	80000	80000	0	80000	80000	80000		
	A.11.3.5	**11.3.5 RTI/STI Training**																					
	A.11.3.6	**Dai Training**																					

	A.11.3.7	**Other MH Training**					0									0	0		0		0		
	A.11.4	**IMEP Training**					0									0	0		0		0		
	A.11.5	**11.5 Child Health Training**					0									0	0		0		0		
	A.11.5.1	**11.5.1 IMNCI 12.2.1.1. TOT on IMNCI for Health and ICDS worker 12.2.1.2. IMNCI Training for Medical Officers (Physician) 12.2.1.3. IMNCI Training for all health workers 12.2.1.4. IMNCI Training for ANMs / LHVs/ AWWs 12.2.1.6 Followup training (HEs,LHVs)**									y	y	y	y		6413220	6413220	1419266	4993954	134760	1617120		
	A.11.5.2	**11.5.2 Facility Based Newborn Care 12.2.2.1 SNCU Training 12.2.2.2.NSU (TOT)**									y	y	y	y		692300	692300	0	692300		105500		

	A.11.5.3	**11.5.3 Home Based Newborn Care**																						
	A.11.5.4	**11.5.4 Care of Sick Children and severe malnutrition**																						
	A.11.5.5	**11.5.5 Other CH Training (Pl. Specify)**																						
	A.11.6	**11.6 Family Planning Training**																						
	A.11.6.1	**12.6.1 Laproscopic Sterilisation Training**																						
	A.11.6.2	**11.6.2 Minilap Training12.3.2.1. Minilap training for medical officers/staff nurses (batch size of 4)**			1	1	0		1				y		70240	70240	70240	0	70240	70240	70240			

	A.11.6.3	**11.6.3 NSV Training 12.3.3 Non-Scalpel Vasectomy (NSV) Training**			1	0	1		2			y			33900	33900	33900	0	33900	33900	33900		
	A.11.6.4	**11.6.4 IUD InsertionTraining 12.3.4 IUD Insertion (details in Annexure) 12.3.4.1 State level (TOT for the districts) 12.3.4.2 District level training (one district total) 12.3.4.3 PHC level training (for one district only)**			2	0	2		4			y	y		84725	169450	169450		169450	84725	169450		
	A.11.6.5	**Contraceptive Update Training**																					
	A.11.6.6	**Other FP Training**																					
	A.11.7	**11.7 ARSH Training 12.4.1 ARSH training for medical officers 12.4.3 One Day ARSH Orientation by the MOs of 25% ANMs 12.4.4 One Day ARSH Orientation of PRI by the MOs of50% ANMs**																					
	A.11.8	**11.8 Programme Management Training**																					

	A.11.8.1	**11.8.1 SPMU Training 12.5.4 State PMU to be trained/attend workshops in various areas like HR, Procurement & Logistics, PPP, FRU review and/or undertake study of various programmes in one good and one poor performing districts**																					
	A.11.8.2	**11.8.2 DPMU Training 12.5.1 Training of DPMU staff @ 38 x Rs.10,00012.5.2. Training of SHSB/DAM/BHM on accounts at Head Quarter level @ 6x1500x12=1,08,000/- + DAM=38x1500x4 + BHM=538x1500x4 12.5.3 Training for ASHA Help Desk to DPMs (38), Block level organisers (533) and MOICs (533), @ 1104 x 1000/-**			1	0	1		2		y	y	y	y	66000	66000	66000	0	66000	66000	66000		

	A.11.9	**Other Training**					0									0	0		0		0			
	A.11.9.1	**11.9.1 Continuing Medical & Nursing Education 11.2 Training of 20 (for total state) regular Government doctors in Public Health at Public Health Institute, Gujarat or at Wardha institute or Vellore institute to increase their administrative skills @ Rs.50,000/-**					0									0	0		0		0			
A.12		**12. BCC/IEC (for NRHM Part A, B & C)**																						
	A.12.1	**12.1 Strengthening of BCC/IEC Bureaus (State and District Levels)**																						

	A.12.2	12.2 Development of State BCC/IEC strategy 13.3 Concept and material development workshops by State BCC/IEC Cell 13.8 Establishment cost of the State BCC/IEC Cell 13.10 Technical support at District level																							
	A.12.3	12.3 Implementation of BCC/IEC stretegy																							
	A.12.3.1	12.3.1 BCC/IEC activities for MH																							
	A.12.3.2	BCC/IEC activities for CH																							
	A.12.3.3	12.3.3 BCC/IEC activities for FP																							
	A.12.3.4	12.3.4 BCC/IEC activities for ARSH																							

	A.12.4	12.4 Other activities 13.4 State Level events 13.5 District Level events (Radio, TV, AV, Human Media as per IEC strategy dissemination) 13.6 Printed material (posters, bulletin, success story reports, health calendar,Quarterly magazines & diaries etc) 13.7 Block level BCC interventions (Radio, kalajattha and for IEC strategy dissemination) 13.11 Media Advertisements on various health related days 13.12 Various advertisements/tender advertisements/EOIs in print media at State level 13.13 Developing Mobile Hoarding Vans and A V Van for State and District 13.14 Hiring an IEC Consultancy at state level for operationation of BCC Strategy. (@ Rs. 50000 x 1 x 12) 13.16 Implementation of specific interventions including innovations of BCC strategy/plans block level 13.17 Implementation of specific interventions including innovations of BCC strategy/plans District level (Rs.									y	y	y	y		272500	272500	133318	139182		300000		

		5000 x 38 x 12) 13.18 Implementing need based IEC Activities in Urban Areas (Support for Organization of need based IEC Activities in Urban Areas) (Rs.50000 x 9 x 2) 13.19 Capacity building of frontline functionaries (ANM, ASHA) in IPC skills building 13.20 Research, M&E, IEC prototypes etc																						
		Sub-total IEC/BCC																						
A. 13		**Procurement**																						

	A.13.1	**13.1 Procurement of Equipment**																					
	A.13.1.1	**13.1.1 Procurement of equipment 14.2. Equipments for EmOC services for identified facilities (PHCs, CHCs) @ Rs 1 Lac / facility / year (in two districts - kishanganj and jehanabad) 14.4. Equipments / instruments for Blood Storage Facility / Bank at facilities 14.6. Equipments / instruments, reagents for STI / RTI services @ Rs. 1 Lac per district per year**			2	0	2		4			y	y		18600	37200	37200	0	37200	18600	37200		
	A.13.1.2	**13.1.2 Procurement of equipment : CH**																					
	A.13.1.3	**13.1.3 Procurement of equipment : FP**																					
	A.13.1.4	**13.1.4 Procurement of equipment : IMEP**																					

	A.13.2	**13.2 Procurement of Drugs & supplies**																					
	A.13.2.1	**13.2.1 Drugs & Supplies for MH**														35340	35340	0	35340		35340		
	A.13.2.1.3	**13.2.1.3 SBA Drugs kits for MH**														30620	30620	0			30620		
	A.13.2.1.5	**13.2.1.5 IFA tab for Adolescents**														1029613	1029613	776034	253579		1029613		
	A.13.2.2	**13.2.2 Drugs & Supplies for CH**														47480	47480	0	47480		47480		
	A.13.2.3	**13.2.3 Drugs Supplies for FP**																					
	A.13.2.3.1	**13.2.3.1 Procurement of Minilap sets**														135000	135000	0			135000		
	A.13.2.4	**13.2.4 Supplies for IMEP**																					
	A.13.2.5	**General drugs & supplies for health facilities**														23328133	23328133	0	23328133		25000000		
A.14		**14. Prog. Manag-ement**																					

	A.14.1	**Strengthening of State Society/SPMU** **16.1. Strengthening of State society/State Programme Management Support Unit** **16.1.1. Contractual Staff for SPMU recruited and in position 16.5.1. Last pay drawn – Pension = Approx exp of Rs.20,000/-PM @ 20,000x6x12**																				
	A.14.2	**14.2 Strengthening of District Society/DPMU** **16.2.1. Contractual Staff for DPMSU recruited and in position**			12	12	0		12		y	y	y	y		1961120	1961120	557881	1403239		3052908		DPM @35420x1x12M=425040/- DAM @33541x1x12M=402492/- DNM&EO@29948x1x12M=359376/- DEO @8500x3x12M=306000/- Peon @4000x2x12=96000/- Office Assist

																						ant@ 10000 x2x12 =2400 00/-
	A.14. 3	**14.3 Strengtheningof Financial Management Systems 16.3.1.Training in accounting procedures 16.3.2. Audits 16.3.2.1. Audit of SHSB/ DHS by CA for 2009-10 16.4 Appointment of CA 16.4.1 At State level 16.4.2 At District level 16.5 Constitution of Internal Audit wing at SHSB**			12	12	0		12		y	y	y	y	20000	240000	240000	1000 00	1400 00	20000	240000		Mobilit y suppo rt to DPMU staff@ 20000 x2x12 M=48 0000/- Office Rent @600 0x1x1 2M=7 2000/- Telep hone @600 0x1x1 2M=7 2000/- Gener ator@ 20000 x1x12 M=24 0000/- Statio nary @200

																							00x1x 12M= 240000/- Contigency for TA/DA etc. @10000x1x 12M= 120000/-
	A.14.4	**14.4 Other activities (Programme management expenses,mobility support to state,district, block) 16.1.2. Provision of mobility support for SPMU staff @ 12 months x Rs.10.00 lakhs Updgration of SHSB Office 16.2.2.Provision of mobility support for DPMU staff @ 12 months x 38 districts x Rs.69945.17/-**			12	12	0		12		y	y	y	y	69945	839340	839340	839340	0	102000	1224000		
		Total Prog. Mgt.					0									0			0		0		
A.15		**Others/Untied Funds**					0									0			0		0		

		Total RCH II Base Flexi Pool					0									0			0		0		
		Total JSY, Sterilisation and IUD Compensation, and NSV Camps					0									0			0		0		
		Grand Total RCH II					0									#VALUE!	#VALUE!	27676058	#VALUE!		#VALUE!		

Sr. NO		**Code (only at state**	**Output 2012**	**Activity Plan**		**Budget Plan**	
				2010-2011FY	**2011-2012 FY**	**2010-2011 FY**	**2011-2012 FY**

		Activities			Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised {Y x (A)} = D	under or over-utilised Budget {(B~D} =E	Tentative Unit Cost (F)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
											Q 1	Q 2	Q 3	Q 4									
B																							

B.1	**Decentrlisation**																							
	B.1.11	**ASHA Support system at State level**																						
	B.1.12	**ASHA Support System at District Level**				**2**	**2**	**0**		**2**		**2**	**2**	**2**	**2**	**43550**	**706707**	**706707**	**0**	**706707**	**47050**	**1107014**		BP =4 Month salary of FY 10-11 and 12 month salary of FY11-12 and two times of ASHA Sammelan
	B.1.13	**ASHA Support System at Block Level**				**9**	**0**	**9**	**Not joined by candidates**	**18**		**9**	**9**	**9**	**9**	**96000**	**864000**	**864000**	**0**	**864000**	**158400**	**1425600**		
	B.1.14	**ASHA Support System at Village Level**																						
	B.1.14	**ASHA Trainings**				**0**	**0**	**0**								**0**	**0**	**0**		**0**		**0**		
	B.1.15	**ASHA Drug Kit & Replenishment**				**961**	**0**	**961**	**Agency name not given by SHSB**	**1922**		**961**		**961**		**1895.3**	**1821383**	**1821383**	**0**	**1821383**	**1895.3**	**1821383.3**		
	B.1.16	**ASHA Motivation-Saree & Umbrella**				**961**	**632**	**329**		**1290**		**y**	**y**	**y**	**y**	**see remark**	**714725**	**714725**	**79000**	**635725**	**see remark**	**714725**		saree+umb=725 &Prize=2000 each block
	B.1.17	**Emergency Services of ASHA**																						

	B.1.18	**ASHA Divas**				**961**	**63**	**898**		**153**		**72**	**27**	**27**	**27**	**1032**	**991752**	**991752**	**239000**	**752752**	**1032**	**991752**		
	B.1.19	**Capacity Building/Academic Support programme**																						
	B.1.2	**Untied Fund for Health Sub Center, Additional Primary Health Center and Primary Health Center**				**H-123, A-13 & P-9**	**H-123, A-13 & P-9**	**0**		**H-155, A-19 &P-9**		**y**	**y**	**y**	**y**	**see remark**	**1813000**	**1813000**	**329000**	**1484000**	**see remark**	**2812500**		**HSC-10000,APHC-25000&PHC-25000 pu/pa (HSC-144,Aphc-17, phc-9)**
	B.1.22	**Village Health and Sanitation Committee**				**525**	**525**	**0**		**530**		**Y**	**y**	**Y**	**Y**	**10000**	**5272500**	**5272500**	**1372000**	**3900500**	**10000**	**5322500**		**vhsc-10000 per village &Rs-2500 per PHC**
	B.1.23	**Rogi Kalyan Samiti**				**11**	**11**	**0**		**20**		**y**	**y**	**y**	**y**	**see remark**	**1600000**	**1600000**	**394000**	**1206000**	**see remark**	**2500000**		**DH-1,RH-1,PHC-9&APHC-9**
B.2		**Infrastrure Strengthening**						**0**									**0**	**0**		**0**		**0**		
	B.2.1	**Construction of HSCs (315 No.)**				**0**	**0**	**0**		**20**		**0**	**y**	**y**	**y**		**0**	**0**	**0**	**0**	**1557000**	**31140000**		
	B.2.2	Construction of residential quarters of old APHCs for staff nurse				**0**	**0**	**0**		**3**			**y**	**y**	**y**		**0**	**0**	**0**	**0**	**3000000**	**9000000**		

	B.2.2	**Construction of building of APHCs where land is available (5315000/APHCs)**				**0**	**0**	**0**		**2**			**y**	**y**	**y**		**0**	**0**	**0**	**0**	**7599000**	**15198000**		
	B.2.3	**2.3 Up gradation of CHCs as per IPHS standards**				**0**	**0**	**0**		**4**			**y**	**y**	**y**		**0**	**0**	**0**	**0**	**23700000**	**94800000**		
	B.2.4	**Infrastructure and service improvement as per IPHS in 48 (DH & SDH) hospitals for accreditation or ISO : 9000 certification**				**0**	**0**	**0**		**1**			**y**	**y**	**y**		**0**	**0**	**0**	**0**	**13850000**	**13850000**		
	B.2.5	**Upgradation of ANM Training Schools**				**1**	**0**	**1**		**2**			**y**	**y**	**y**	**535000**	**535000**	**535000**			**0**	**0**		
	B.2.6	**Annual Maintenance Grant**				**10**	**10**	**0**		**10**		**y**	**y**	**y**	**y**	**see remark**	**1500000**	**1500000**	**452000**	**1048000**	**see remark**	**1500000**		DH-500000,RH-100000 &PHC-100000
B.3		**TOTAL INFRASTRUCTURE strengthening**						**0**									**0**	**0**		**0**		**0**		
	B.3	**Contractual Manpower**						**0**									**0**	**0**		**0**		**0**		
	B.3.1 A	**Incentive for PHC doctors & staffs**				**52**	**0**	**52**		**62**		**y**	**y**	**y**	**y**	**8711**	**452972**	**452972**	**0**	**452972**	**9000**	**105028**		
	B.3.1 B	**Salaries for contractual Staff Nurses**				**860**	**504**	**356**		**576**		**y**	**y**	**y**	**y**	**7500**	**6450000**	**6450000**	**544393**	**1006607**	**12000**	**5905393**		

	B.3.1.C	**Contract Salaries for ANMs**				**1320**	**1320**	**0**		**2280**		y	y	y	y	**6000**	**7920000**	**7920000**	**7920000**	**0**	**8000**	**18240000**		
	B.3.1.D	**Mobile facility for all health functionaries**				**750**	**0**	**750**		**800**		y	y	**0**	**0**	**1500**	**1125000**	**1125000**	**0**	**1125000**	**2000**	**475000**		
	B.3.2.	**Block Programme Management Unit**				**9**	**9**	**0**		**9**		y	y	y	y	**49734 0**	**4476060**	**4476060**	**1967000**	**2509060**	**70173 6**	**6315624**		**BHM@23958x9x12=2587464/- BA@14520x9x12=156816 0/- Mobility,Office&TA/DA@20000x9x12=2160000 -**
	B.3.4.	**Addl. Manpower for NRHM**								**see remark**		y	y	y	y	**6685 7**	**0**	**0**	**0**	**0**	**29880**	**3585600**		**HM2x27500x12=660000 ,Rpmu(RPM-47300x12=567600 RAM-38500x12=462000,RM&EO=33000x12=396000,Office exp&Mobility-100000x12=1200000 &Meeting-25000x12=300000) Total Rs=3585600**
B.4		**PPP Initiativs**						**0**									**0**	**0**		**0**		**0**		
	B.4.1	**102-Ambulance service (state-806400) @537600 X 6 Distrrict**																						

	B.4.2	**1911- Doctor on Call & Samadhan**																							
	B.4.3	**Addl. PHC management by NGOs**																							
	B.4.4	**Referral Transport in District**				**9**	**7**	**2**		**9**		**y**	**y**	**y**	**y**	**156 000**	**1553 000**	**1553 000**	**0**		**18000 0**	**16200 00**		
	B.4.5	**SHRC**																							
	B.4.6	**Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP)**																							
	B.4.7	**Dialysis unit in various Government Hospitals of Bihar**																							
	B.4.8	**Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar**				**1**	**0**	**1**		**1**		**y**	**y**	**y**	**y**		**2400 000**	**2400 000**		**2400 000**		**24000 00**		

	B.4.9	Providing Telemedicine Services in Government Health Facilities																							
	B.4.10	Outsourcing of Pathology and Radiology Services from PHCs to DHs				10	4	6		10		y	y	y	y		5388889	5388889	804000	4584889		5500000			
	B.4.11	Operationalising MMU				12	0	12		30		y	y	y	y	468000	5616000	5616000	0	5616000	468000	14040000			
	B.4.14	Monitoring and Evaluation (State , District & Block Data Centre)				12	10	2		14		y	y	y	y	140000	1680000	1680000	372000	1308000	154000	1848000			
	B.4.15	Generic Drug Shop																							
	B.4.16	Nutritional Rehabilitation Centre																							
	B.4.17	Hospital Maintenance																							
	B.4.18	Providing Ward Management Services in Government Hospitals 3000000/-																							

	B.4.19	Provision for HR Consultancy services																							
	B.4.2	Advanced Life Saving Ambulance																							
		TOTAL PPP INITIATIVES																							
B.5	B.5	Prourement of supplies																							
	B.5.1	Delivery kits at the HSC/ANM/ASHA (no.200000 x Rs.25/-)																							
	B.5.2	SBA Drug kits with SBA-ANMs/ Nurses etc (no.50000 /38x Rs.245/-)																							
	B.5.3	Availability of Sanitary Napkins at Govt. Health Facilities @25000/district/year																							
	B.5.4	Procurement of beds for PHCs to DHs								140		y	y	0	0	9000	0	0	0	0	9000	1260000			

		TOTAL PROCUREMENT OF SUPPLIES																						
B. 6		**Procurement of Drugs**																						
	B.6.1	**Cost of IFA for Pregnant & Lactating mothers (Details annexed)**																						
	B.6.2	**Cost of IFA for (1-5) years children (Details annexed)**																						
	B.6.3	**Cost of IFA for adolescent girls (Details annexed)**																						
		TOTAL PROCUREMENT OF DRUGS																						
B. 7		**Mobilisation & Management support for Disaster Management**																						
B. 8		**Health Management Information System**																						

B.9		Strenthening of Cold Chain (infrastrcure strengthening)				1	0	1		2		y	y			800000	800000	800000		800000	1300000	1300000		
	B.9.1	Refurbishment of existing Warehouse for R.I. as well as provision for hiring external storage space for (during Immunization Campaigns) Logistics at State HQ @Rs 1500000/-																						
	B.9.2	Refurbishment of existing Cold chain room for district stores in all districts with proper electrification,Earthing for electrical cold chain equipment and shelves and dry space for non elecrtical cold chain equipment and logistics @Rs 300000 Lakhs per district x 38 districts								1		y	y	0	0	0	0	0	0	0	300000	300000		

	B.9.3	Earthing and wiring of existing Cold chain rooms in all PHCs @Rs 10000/- per PHC x 533 PHCs				9	0	9		18		y	y	y	y	10000	90000	90000	0	90000	10000	90000		
B.10		Preparation of Action Plan																						
	B.10.1	Preparation of District Health Action Plan (Rs. 2 lakhs per district x 38)				1	1	0		1		0	0	y	y		505000	505000	0	505000		505000		
	B.10.2	Preparation of State Health Action Plan @ 5 lakhs																						
B.11		Mainstreaming Ayush under NRHM										y	y	y	y		9841200	9841200	0	9841200		13831200		
B.12		Continuing Medical & Nursing Education																						
B.13		RCH Procurement of Equipments																						
	B.13.1	Procurement of Equipments/instruments for Anesthesia																						
	B.13.2	Equipment for ICU				1	0	1		1		y	y	0	0		0	0	0	0	1705263	1705263		

	B.13.3	Equipments/instruments for ANC at Health Facility (Other than SubCentre) @ 50,000 per district per year										y	y	y	y							50000		
	B.13.4	Equipments for the Labour Room										y	y	0	0							500000		
	B.13.5	Equipments for SNCU &NSU																						
	B.13.5.A	SNCU for 23districts unit cost of Rs. 2377258				1	0	1		2		y	y	0	0		2661991	2661991	158000	2503991		2000000		
	B.13.5.B	NSU for 530 PHCs unit cost of Rs. 139492				9	0	9		18		y	y	0	0	0	0	0	0	0	139492	1255428		
	B.13.6	NSV Kits																						
	B.13.7	IUD insertion kit																						
	B.13.8	Minilap sets																						
B.14		Additionalitiesfor NVBDCP under NRHM																						
		Total for Equipment Procurement																						

	B.14	**Drugs Procurement**																							
	B.14.1	**Drugs**																							
	B.14.2	**Manpower/logistics for drugs procurement @ 10000x 2x12M=240000/-**																							
	B.14.3	**Rent for drug store@10000x12M=120000/-**																							
	B.21	**ANM®**				**135**	**106**	**29**		**194**		**y**	**y**	**y**	**y**	**8000**	**10800000**	**10176000**	**4845000**	**3765000**	**8000**	**18624000**		
	B.22	**Isectoral Converence(Incentive for AWW under muskan)**				**1074**	**861**	**213**		**1074**		**y**	**y**	**y**	**y**	**1200**	**1288800**	**1288800**	**608000**	**680800**	**1200**	**1288800**		
		Grand Total NRHM-B																				**40778 1296**		

Sr. NO	STRATEGIES	Activities	Component Code (only at state level)	Output 2012	Activity Plan										Budget Plan							
					2010-2011Y				2011-2012 FY						2010-2011 FY					2011-2012 FY		
					Activity planned (X)	Activity Executed (Y)	Variance (X~Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised {Y x (A)} = D	under or over-utilised Budget {(B~D} =E	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
											Q1	Q2	Q3	Q4			-					
	C	IMMUNISATION										0							0	-		
	C.1	Pulse Polio operating costs									3,186,348.00	3,186,348.00	3,186,348.00	3,186,348.00					0	-		
	C.2	Routine Immunization										0							0	-		

	C.2.1	Mobility support for Supervision and Monitoring at districts and state level.									30,000.00	30,000.00	**30,000.00**	**30,000.00**					**0**	**-**		
	C.2.2	Cold chain maintenance										55,000.00	**55,000.00**						**0**	**-**		
	C.3.1	Alternate Vaccine Delivery to Session sites, Hard to Reach Area									60,000.00	60,000.00	**60,000.00**	**60,000.00**					**0**	**-**		
	C.3.2	Alternate Vaccine Delivery to Session sites, Other Site									237,500.00	237,500.00	237,500.00	237,500.00								
	C.4.1	**Focus on Slum Mobility cost**									51,600.00	51,600.00	**51,600.00**	**51,600.00**					**0**	**-**		
	C.5	**Social Mobilization of children**									37,500.00	37,500.00	37,500.00	37,500.00								
	C.6.2	Computer Assistants support at district level									37,500.00	0	**0**	**0**					**0**	**-**		
	C.8.2	Qly Revew Meeting at dist Level										10000	**10000**	**10000**								
	C.8.3	Quarterly review meeting at block level									-	100,000.00	**100,000.00**	**100000**					**0**	**-**		
	C.9.1	District level Orientation for 2 days ANMs, MPHW,LHV										150,000.00	**150000**						**0**	**135,400.00**		
	C.9.4	One day cold chain handlers trainings									-	20000							**0**	**12,500.00**		

	C.9.5	One day training of block level date handlers									-	15000							**0**	**15,000.00**	
	C.10.1	To develop micro plan at sub-centre level									-	71500							**0**	**25,000.00**	
	C.10.2	For consolidation of micro plan at block level									-	22000							**0**	**15,000.00**	
	C.11	POL for vaccine delivery from state to District and PHC/CHCs									30,000.00	30000	**30000**	**30000**					**0**	**90,000.00**	
	C.12	Consumables for computer including provision for internet access									3,000.00	3000	**3000**	**3000**					**0**	**4,800.00**	
	C.13	Red/Black bags, twin bucket, bleach/hypochlorite solution									-	20,000.00	-	**-**					**0**	**6,000.00**	
	C.16	Major AEFI Cases										15000	**15000**	**15000**					**0**	**25,000.00**	
		Grand Total of Immunizationn(R.I)									**487,100.00**	**928,100.00**	**779,600.00**	**574,600.00**					**0**	**328,700.00**	
	NIPPI	**NIPPI**										0							**0**	**-**	
	1	Mamta Incentive									168,750.00	168,750.00	**168,750.00**	**168,750.00**					**0**	**-**	**1800000**
		Salary to DCHM									-	-	**-**	**-**						**-**	
		Salary To JCHM																		**-**	

		Salary to Dy. Child Health Sup									22,500.00	22,500.00	**22,500.00**	**22,500.00**						-	
	3	Untied Fund										-	**-**	**-**					**0**	**500,000.00**	
		Others										0	**0**	**0**						**500,000.00**	
		HBNC										0							**0**	**-**	
		Total																	**0**	**1,000,000.00**	
	D	Maleria Division									250,000.00	250000	**250000**	**250000**					**0**	**-**	
		Kala-Azar									312,500.00	312500	**312500**	**312500**							
		Dengue									250,000.00	250000	**250000**	**250000**							
		Total Maleria									812,500.00	812500	**812500**	**812500**					**0**	**812,500.00**	
		Blindness									362,796.00	362796	**362796**	**362796**					**0**	**362,796.00**	
		Total Blindness									**362,796.00**	**362796**	**362796**	**362796**					**0**	**362,796.00**	

																		0	**-**		
		RNTCP																**0**	**-**		
		Civil Work									**68,750.00**	68750	**68750**	**68750**				**0**	**75,000.00**		
		Laboratary Materials									46,875.00	46,875.00	46,875.00	46,875.00				**0**	**85,000.00**		
		Honorarium									12500	12500	12500	12500				**0**	**200,000.00**		
		IEC/Publicity									**23440**	**23440**	**23440**	**23440**				**0**	**75,000.00**		
		Equipment Maintainance									**6250**	**6250**	**6250**	**6250**				**0**	**38,000.00**		
																		0			
		Tranning									**8000**	**8000**	**8000**	**8000**				**0**	**25,000.00**		
		Vehicle Maintainance									**46875**	**46875**	**46875**	**46875**				**0**	**50,000.00**		
		Proc. Of Vehicle									**46875**	**46875**	**46875**	**46875**				**0**	**200,000.00**		
		Proc. Of Equipment									**12500**	**12500**	**12500**	**12500**							

		NGO/PPP Support								**46875**	**46875**	**46875**	**46875**					**0**		
		Misscellanious								**25000**	**25000**	**25000**	**25000**					**0**	**75,000.00**	
																		0		
		Contractual Services								**1031250**	**1031250**	**1031250**	**1031250**					**0**	**693,000.00**	
		Printing								**12500**	**12500**	**12500**	**12500**					**0**	**-**	
		Total RNTCP								**1,387,690.00**	**1387690**	**1387690**	**1387690**					**0**	**1,516,000.00**	
		IDSP								388,400.00	388,400.00	388,400.00	388,400.00							
		Total of IDSP								**388,400.00**	**388,400.00**	**388,400.00**	**388,400.00**							
		IDD								10,000.00	10,000.00	10,000.00	10,000.00							
		Total of IDD								**10,000.00**	**10,000.00**	**10,000.00**	**10,000.00**							

		Filaria																		
	Mass drug administration	Taraining of M Os									**6000**		**6000**							
		Training of Paramedical Staff									**15000**		**15000**							
		Coordination Meeting									**6250**		**6250**							
		IEC Activity								**7,500.00**	**7,500.00**	**7,500.00**	**7,500.00**							
		Line Listing								**7,500.00**	**7,500.00**	**7,500.00**	**7,500.00**							
		Night Blood Survey								**7,500.00**	**7,500.00**	**7,500.00**	**7,500.00**							
		PHC Dist HQ								**2,000.00**	**2,000.00**	**2,000.00**	**2,000.00**							
		Dist Office Expenditure								**1,750.00**	**1,750.00**	**1,750.00**	**1,750.00**							
		Total of Filaria								**26,250.00**	**53500**	**26250**	**53500**							

	Leprocy																			
	Service through ASHA								**7,500.00**	**7,500.00**	**7,500.00**	**7,500.00**								
	Sensiotisation of ASHA									**6000**	**7000**	**7000**								
	DLS Rent, Telephone, Electricity Etc.								**6,000.00**	**6000**	**6000**	**6000**								
	Consumable Expenditure								**5,000.00**	**5,000.00**	**5,000.00**	**5,000.00**								
	2 Days modular training of new entant mos									**10,000.00**	**10,000.00**	**10,000.00**								
	1 Days Orientation training of new entant mos									**15000**		**15000**								
	Refreshal training of one day for health Supervisor/LHV/Pharmacists									**5000**	**5000**	**5000**								
	School Quiz										**25000**									
	Health Melas											**5000**								
	Sensiotisation meeting of PRI											**40000**								
	Leprosy Day Function										**15000**									

	POL/ Vehicle Operation & hiring								**23,500.00**	**23,500.00**	**23,500.00**	**23,500.00**								
	Aids & Appliances									**10000**							**0**	**-**	**#REF!**	
	Supportive Medicine								**7500**	**7500**	**7500**	**7500**								
	Laboratory reagents & equipments								**5000**	**5000**	**5000**	**5000**								
	Urban Leprosy control programme								**15625**	**15625**	**15625**	**15625**								
	Review meeting & travel expenses								**3750**	**3750**	**3750**	**3750**								
	Total Of Leprocy								**73,875.00**	**119,875.00**	**135,875.00**	**155,875.00**								

PIP of IDSP Munger District - 2011-12

Sub-activity	Tasks		Unit Cost	No. of Units	2011-12	Remarks
1. Staff Salary	1.1	Epidemiologists	42000	1	42000*12=504000	40% increage from last year salary
	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	24300	1	24300*12=291600	80% increage from last year salary
	1.8	Data Entry Operator	8500	1	8500*12=102000	New post
	1.9	Accountent (Part Time)	4000	1	4000*12=48000	Proposed new post
	1.1	Peon	3500	1	3500*12=42000	Proposed new post
		Sub Total			**987600**	
2. Training	2.1	Training of Hospital Doctors	20000	20 (Per batch)	20000*1=20000	N/A
	2.2	Training of Hospital Pharmasist / Nurses (Reporting Person)	15000	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			**50000**	
3. Operational Cost	3.1	Mobility Support for IDSP and RR Team	12000	1	12000*12=144000	Vehicle for IDSP office & RRT
	3.2	Office Expenses	5000	1	5000*12=60000	Stationary 2000*12, News Paper for News Allarts 500*12=6000, Contengency 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	Phone & Broadband Expenses	1500	1	1500*12=18000	Phone & Broadband Expenses @ Rs 1500 par month
	3.10	Mobile Expences	500	2	500*2*12=12000	Mobile Expenses Epidemiologist & Data Manager
		Sub Total			**318000**	
4. New Innovations	4.1	TA For Pvt Instituation	50	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	9	1000*9*12=108000	Social Mobilization and Intersectoral co-ordination in 9 block @ Rs 1000 par month
	Tasks		**Unit Cost**	**No. of Units**	**2011-12**	**Remarks**
	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	2	500*2=1000	Per case 500
	4.6	Farniture for IDSP VC cum Training Hall	50000	1	50000*1=50000	Stablishment of VC cum Training hall with Round table & 20 Chairs
		Sub Total			**198000**	
	TOTAL				**1553600**	