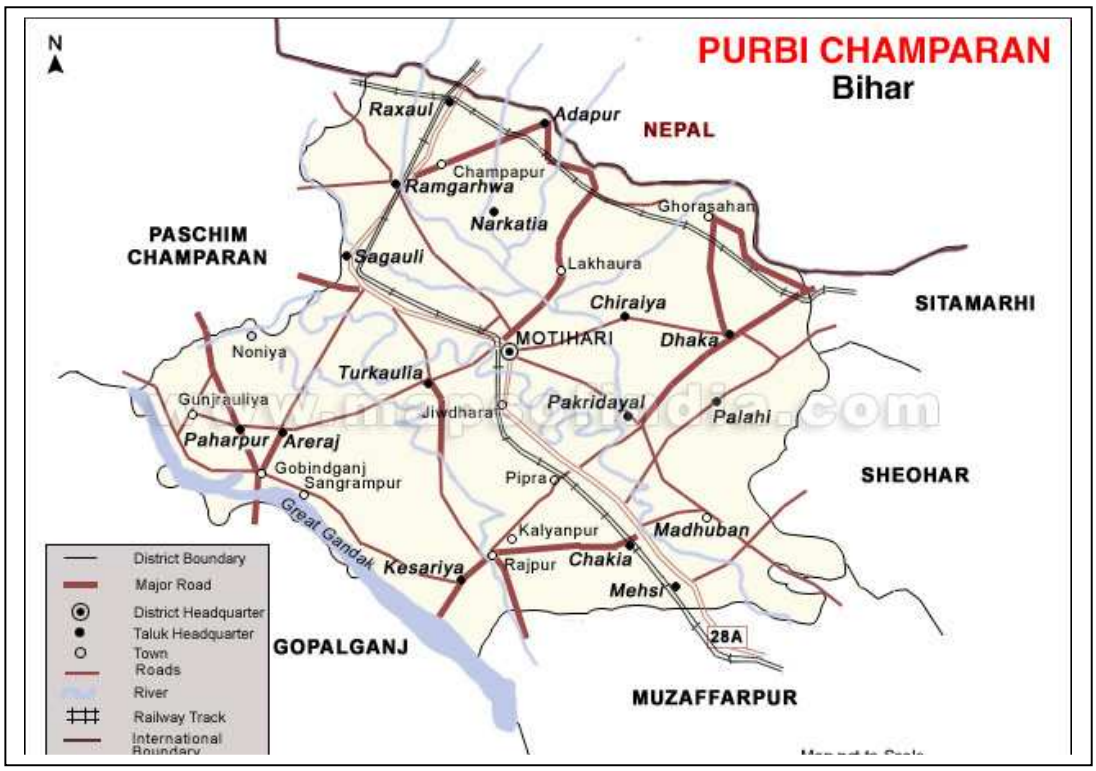
DISTRICT HEALTH

ACTION PLAN

2011 – 12

EAST CHAMPARAN



Map of East Champaran

Foreword

Recognising 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 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 rage 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 State Health Society,Bihar for its dynamic leadership of the health sector reform programme 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 to facilitate our Civil Surgeon, ACMO, MOICs,BHM regarding preparation the DHAP. The proposed location of HSCs, PHCs and its service area reorganized with the consent of ANM, 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.

RanaP.K.Solanki
District Programme Manager
District Health Society
East Champaran.

About the Profile

Under the National Rural Health Mission this District Action Plan of East Champaran district has been prepared. From this, the 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 and Block Health Managers of every block. I am grateful to the District Magistrate, D.P.M., ACMOs, MOICs, BHMs and ANMs and from their excellent effort we may be able to make this District Health Action Plan of East Champaran District.

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

(**Dr.Kameshwar Mandal**)
Civil Surgeon
East Champaran

EXECUTIVE SUMMERY

The District Health Society working for all Programs Implementations under State Health society/NRHM for the government of Bihar and committed to towards promoting the right of every citizen specially rural women and child to enjoy a life of health and equal opportunity and is making all round effort in this direction.
The District PIP based on the past experience for implanting the National Rural Health Mission at the all level.

Goal

The goal is to improve quality of life of the rural people by reducing the following:-

Table 1: RCH Outcomes in the District: Goals		
Outcomes Indicators	**State Current Status**	**District Goal 2011-12**
MMR1	**312**	**270**
IMR	**56**	**45**
NMR3	**42.1**	**30**
TFR4	**4.0**	**3**

These goals clearly indicate that the district is planning to drastically upscale avialbity and accessibility and utilization of RCH services .
The entire District Health Society East Champaran Team is working in Mission mood to achieve the goals set by the state and its trying to effectively deal with challenges. These strategies have impact on all the component of RCH viz. Maternal Health, Child Health, Family Planning etc where as specific core programm strategies have wider impact on the specific program component it has been recognized that all these strategies should converge and go hand in hand to achieve the program outcome. The district considers that strengthening institutional mechanisms, infrastructure development , insuring adequate and trained human resources etc are fundamental requirements for getting better program outcomes. Accordingly document is presented with backward linkages from core program strategies to institunational framework.

Trauma centre

As a result of economic development and motorization, the number of traffic accidents and the mortality rate from them have rapidly increased and accidents became the second leading cause of death. The district had a higher mortality rate from traffic injury. Reduction of traffic accidents and provision of quality service are emphasized.

Reduction of the mortality rate from injury depends largely on prevention of traffic accidents, timely provision of first aid and transport, appropriate care at health institutions. The project aims to bring about comprehensive improvement in these areas. As a result of traffic safety activities, the percentage of bike riders who wear a helmet and car drivers who wear a seat belt increased. The project trained emergency medical care and first aid staff members from district hospitals and volunteer organizations. They have promoted local health care by applying the acquired skills and knowledge at work. Therefore, effectiveness of the project is high.

There will be two Trauma Centres proposed in the East Champaran district. One on Sugauli Highway and second will be on Mehsi Highway.

Maternity Ward

30 Bedded Maternity ward Required at District Hospital to fulfill the need to 48 hour stay mother and child for better care.

Kalazar Ward

East Chapparan District is effected to Kala Azar and there are many Mahadalit Tola are not detected by the local Facilities. So, there are need to make some special Plan to detect the widely effected area to give special focus and provide them better services to eradicate it.

For this Purpose we have selected five Blocks on the basis past records and No. of patient registered in District Hospital and Concerned PHCs.

Such as:-

1. **KESARIA**
2. **CHAKIA**
3. **KALYANPUR**
4. **TURKAULIA**
5. **MOTIHARI SADAR BLOCK**

So, there are need to select Mahadalit Tola and to organize weekly health checkup camps and quarterly spry of DDT in such Tola.

NEEDS

1. Special vehicle to collect the patient from there door stop to concerned point.
2. Need five bed to each concerned point for Kalazar effected patient.
3. Loss of wages should be paid daily.
4. Required One Community mobilizer in each Mahadalit Tola.
5. One Special Doctor for the treatment of the Kalazar patient in above mentioned PHC.
6. Availability of the medicine & injection.

A 30 beded Kalazar Unit will be proposed in Sadar Hospital

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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

One of the main approaches of NRHM is to communities, which will entail transfer of funds, functions and functionaries to Village Health & Sanitation Commitee and also greater engagement of Rogi Kalyan Samiti (RKS), hospital. 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 principle instrument for planning, implementation and monitoring, formulated through a participatory and bottom to up planning process. NRHM-DHAP is anticipated as the cornerstone of all strategies and activities in the district.

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

Stakeholders in Process

- *Members of State and District Health Missions*
- *District and Block level programme managers of line departments i.e., Health and Family Welfare, Women and Child Development including Integrated Child Development Scheme (ICDS) and water/sanitation departments.*
- *State Programme Management Unit and District Programme Management Unit Staff*
- *Members of NGOs and civil society groups (in case these groups are involved in the DHAP formulation)*

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

1.2 Objectives of the Process

The aim of the present study is to prepare NRHM – DHAP based on the framework provided by State Health Society, Patna. 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 study comprised of review of reports collected from Sub Centre Level Planning Approved by V.H.& S.C.. Following this the research strategies, techniques and design of assessment tools were finalized. As a preparatory exercise for the formulation of DHAP secondary data were complied from different functionaries like; health, ICDS scheme, PRIs, Water and Sanitation department to perform a situational analysis.

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

The formation of a new state provides new opportunities. 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 a questionnaire based survey of facilities that was applied on all HSCs and PHCs of the East Champaran district. In addition, a number of field visits and focal group discussions, interviews with senior officials 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.

Initially when sufficient infrastructure and manpower were not available for management of major health problems, several vertical programmes, e.g. National Malaria Control Programme, National Leprosy Eradication Programme, were initiated. Subsequently, over the years a three-tier health care infrastructure has been established. As on date efforts are being made to integrate the existing vertical programmes at district level and ensure that primary health care institutions will provide comprehensive health and family welfare services to the population.

In this regard, 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 Plan document of East Champaran district has been prepared on the said context.

1.3.3 Preparation of DHAP

PLANNING PROCESS

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

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

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

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

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

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

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

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

SOURCES:-

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

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon, ACMO, all programme officers and the State level team formed for DHAP (District Health Action Plan) as well as the MOICs, ANMs, and community representatives 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 Block Health Managers. 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

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analysed 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 rage 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.

Chapter-2

District Profile

BRIEF HISTORY OF DISTRICT

First Creation of Champarn District : 1866

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

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

Origin of Name

Flower Champa

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

Ancient History

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

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

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

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

of the adventures counted the Saka dynasty of Bangal another, Nanyadeva, founded the Carnatic dynasty of Mithila with its capital at Siaraon on the Indo- Nepal border.

MEDIEVAL PERIOD

During 1211 and 1226 first Muslim influences was experienced when Ghyasuddin Iwaz the muslim governor of Bangal extended his a way over Tribhukti or Tirhut .It was however, not a complete conquest and he was only able to have Tirhut from Narsinghdeva a simyaon king, in about 1323 Gnyas-Uddip.Tughiar annexed irabhuk and placed it under Kameshwar Thakur established Sugaon or Thakur dynasty, As Harsinghdeo the last simraon king had taken shelter in Nepal Kameshwar Thakur a Brahmin Rajpandit was installed to regal status. The sugaon dynasty hold Tirabhukti as a tributary province for about a century after the capture of Harsinghdeo . The most famous of the dynasty was Raja Shiva Singh who was adorned by the immortal poet laureate Vidyapati, during the period of Lakshmi Nath Deva Tirabhukti was attached by Sultan Alleuddin Hussain Shah of Bengal and Sikender Lodi of Delhi . A treaty was concluded in 1499 according to which 'Tirahukti , left to Sikandar Lodi subsequently, Sikander Lodi attacked Tirabhukti and made the prince a tributary chief. However, in contravention of the treaty conducted by his father .Nasrat Shah, son of Allauddin Shah attacked Tirbhukti in 1530 annexed the territory, killed the Raja and thus put an end to the Thakur dynasty .

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

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

BRITISH PERIOD

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

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

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

In the beginning of 1857 movement the position of Britishers was precarious. Major Hoimes who was commanding the 12th Irregular cavalry, stationed at sugauli was apparently panicked and

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

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

Estate of Bettiah and Ramnagar gave lease of land to them on easy terms for cultivation of indigo. The arrangement made for the cultivation of indigo were (1) Zirat and (2)Tenkuthiya . Apparently, nothing went wrong by the introduction of both the systems. But actually, the peasants suffered a lot due to both the systems. The wages paid to laborers were extremely low and entirely inadequate. The were forced to labor hard and were severely punished for alleged slackness on their part Sri Raj kumar shukla, an indigo cultivator of the district having heard about the None Co-operation Movement had by Gandhijee in South Africa met and apprised him about miserable plight of indigo Cultivators in the Champaran District. He persuaded him to visit the district. Almost at same time;The Indian Nation congress in December ,1916 passed at Lucknow a resolution for requesting Government to appoint a committcd of both officials and non-officials to enquire into the agrarian trouble facing the district.

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

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

EAST CHAMPARAN DISTRICT PROFILE

ESTABLISHED

CHAMPARAN	1866
PURBI CHAMPARAN	1971

POLITICAL

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

GEOGRAPHICAL LOCATION

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

BOUNDARY

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

DISTANCE FROM

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

NATURAL

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

CLIMATE

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

ADMINISTRATIVE

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

AGRICULTURE (AS PER 2003-2004 DATA)

AREA	391401 Hectare
CULTIVABLE LAND	303923 Hectare
NON CULTIVABLE LAND	87478 Hectare
IRRIGATED LAND	176115 Hectare
NON IRRIGATED LAND	127808 Hectare
MAJOR CROPS	Rice Paddy (Basmati Rice), Sugar Cane, Jute, Lentis

DEMOGRAPHY (ACCORDING TO 2001 CENSUS)

URBAN	Male	135366
	Female	115720
	Total	251086

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RURAL	Male	1941681
	Female	1747006
	Total	3688687

Total

LITERACY (ACCORDING TO 2001 CENSUS)

MALE	49.3%
FEMALE	24.3%
AGGREGATE	37.5%

EDUCATION : NO OF SCHOOLS AND COLLEGES

PRIMARY

RURAL	1734
URBAN	31
TOTAL	1765

UPPER PRIMARY

RURAL	384
URBAN	21
TOTAL	405

HIGH SCHOOL

RURAL	83
URBAN	6
TOTAL	98

DEGREE COLLEGES

RURAL	11
URBAN	6
TOTAL	17

Chapter-3

Situational Analysis

District Health Action Plan

Name of the District… Champaran East

DISTRICT PROFILE

No.	Variable	Data
1.	Total area	3698 Sq. k.m
2.	Total no. of blocks	27
3.	Total no. of Gram Panchayats	421
4.	No. of villages	1634
5.	No of PHCs	20
6.	No of APHCs	48
7.	No of HSCs	319
8.	No of Sub divisional hospitals	0
9.	No of referral hospitals	03
10.	No of Doctors	91 (R) + 98 (C)
11.	No of ANMs	291 (R) + 110 (C)
12.	No of Grade A Nurse	17 (R) 38 (C)
13.	No of Paramedical	2210
14.	Total population	4725938
15.	Male population	2531960
16.	Female population	2270699
17.	Sex Ratio	1000/897
18.	No of Eligible couples	
19.	Children (0-6 years)	736733
20.	Children (0-1years)	143332
21.	SC population	624345
22.	ST population	4708
23.	BPL population	2667646
24.	No. of primary schools	1581

25.	**No. of Anganwadi centers**	**3897**
26.	**No. of Anganwadi workers**	**3897**
27.	**No of ASHA**	**2766**
28.	**No. of electrified villages**	**583**
29.	**No. of villages having access to safe drinking water**	**1445**
30.	**No of villages having motorable roads**	**1815**

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

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

Table 3.1: Health Indicators

Indicator	East Champaran	Bihar	India
CBR#			25.0
CDR#			8.1
IMR#			63.0
MMR#			301
TFR#			3.1

Internal MIS data

3.1 Availability of facilities and location of facilities

As per existing norms one HSC is planned for every 5000 population ,one PHC for every 100000 population.

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

Gaps in Health Infrastructure:

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

To ensure one progress of any district, it is important to ensure that its people are healthy and have round the clock easy access to adequate health infrastructure. Out of Twenty blocks in district East Champaran are proposed to be converted to CHCs but are still awaiting sanction from the state. Currently 20 PHCs, 49 APHCs and 319 HSCs are functioning in the district. Four referral hospitals are located in Dhaka,Pakridayal,Areraj and Chakia block. The building has damaged. The block wise details are as follows:

Table 3.2: Block wise health infrastructure details of East Champaran district

PHC

No	Block Name/sub division	Population	PHCs Present	PHCs required @ Pop 120000 and above	PHCs proposed
1	PATAHI	169618	1	2	1
2	PAKRIDEYAL	250000	1	2	1
3	PAHARPUR	16955	1	2	1
4.	CHAKIA	204504	1	2	1
5.	MEHSI	166514	1	2	1
6.	RAMGHARWA	183733	1	2	1
7.	HARSIDHI	241200	1	2	1
8.	CHAURADANO	154488	1	2	1
9.	KALYANPUR	307863	1	2	1
10.	DHAKA	312007	1	2	1
11.	ADAPUR	186426	1	2	1
12.	MADHUBAN	233118	1	2	1
13.	CHIRAIYA	262025	1	2	1
14.	GHORASAHAN	251377	1	2	1

15.	RAXAUL	202007	1	2	1
16.	ARERAJ	137335	1	2	1
17.	SUGAULI	189168	1	2	1
18.	KESARIA	147663	1	2	1
19.	TURKAULIA	346625	1	2	1
	MOTIHARI URBAN	763312	1	6	5
	Total	4725938	20	44	24

Section A: Health Facilities in the District

Sub-Divisional Hospital

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

Section A: Health Facilities in the District

District Hospital

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

Section B: Human Resources and Infrastructure

Sub-centre database

	No. of Sub center present	No. of Subcenter required	Gaps in Sub centers	ANMs (R)/(C) posted formally	ANMs (R)/(C) posted required	Gaps in ANMs(R)/(c)	Building ownership (Govt)	Required Building (Govt)	Gaps in Buildings (Govt)	ANM residing at HSC area (Y/N)	Condition of residential facility (+++/++/+/#)	Status of furniture's	Status of Untied fund

1	319	834	515	291/110	128/393	128/393	190	129	129	Y	+++	#	unexpended

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

Section B: Human Resources and Infrastructure

Additional Primary Health Centre (APHC) Database: Infrastructure

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

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

Section B: Human Resources and Infrastructure

Additional Primary Health Centre (APHC) Database: Human Resources

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

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

Section B: Human Resources and Infrastructure

Primary Health Centres : Infrastructure

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

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

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

B: Human Resources and Infrastructure
Section B: Human Resources and Infrastructure

Referral Hospital : Infrastructure

Referral Hospital : Human Resources

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

Section C: Equipment, Drugs and Supplies

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

Availability of Equipment

Procurement and Logistics Management for Drugs

No.	Name of facility	Drugs required	Stock outs last year	
			Name of Drug	Months
1	Family planning	Atropine, Catmin, Diagipam inj, Antibiotics etc.		
2	JBSY	Mathalzin inj & Tab., Antisparkodic inj. Etc.		
3	Immunization	Hub Cutter etc.		
4	Filareia	MDA, DEC		

Procurement and Logistics Management for Supplies

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

5				
6				

Section D: RKS, Untied Funds and Support Services

Rogi Kalyan Samitis

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

Untied Funds

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

Support Systems to Health facility functioning

No	Facility name	Services available								
		Ambulance	Generator	X-ray	Laboratory services O/I/ NA				Canteen	House keeping
		O/I/	O/I/	O/I/	Pathology	Malaria/	T		O/I/ NA	

		NA	NA	NA		kalaazar	B			
1	20 PHC LEVEL	O	O	O	O	I	I		NA	O/I
2	SADAR HOSPITAL	I	O	I/O	I	I	I		**NA**	O

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

Section E: Health Services Delivery

Name of the District:			
No.	**Service**	**Indicator**	**District Data**
1	***Child Immunization***	% of children 9-11 months fully immunized (BCG+DPT123+OPV123+Measles)	61.09%
		% of immunization sessions held against planned	85%
2	***Child Health***	Total number of live births	10485
		Total number of still births	288
		% of newborns weighed within one week	90%
		% of newborns weighing less than 2500 gm	20%
		Total number of neonatal deaths (within 1 month of birth)	85
		Total number of infant deaths (within 1-12 months)	51
		Total number of child deaths (within 1-5 yrs)	20
		Number of diarrhea cases reported within the year	453
		% of diarrhea cases treated	100%
		Number of ARI cases reported within the year	NA
		% of ARI cases treated	NA
		Number of children with Grade 3 and Grade 4 under nutrition who received a medical checkup	NA
		Number of children with Grade 3 and Grade 4 under nutrition who were admitted	334
		Number of undernourished children	NA
		% of children below 5 yrs who received 5 doses of Vit A solution	96%
3	***Maternal Care***	Number of pregnant women registered for ANC	37458
		% of pregnant women registered for ANC in the 1st trimester	60%

		% of pregnant women with 3 ANC check ups	56%
		% of pregnant women with any ANC checkup	95%
		% of pregnant women with anemia	12%
		% of pregnant women who received 2 TT injections	100%
		% of pregnant women who received 100 IFA tablets	96%
		Number of pregnant women registered for JBSY	37218
		Number of Institutional deliveries conducted	37218
		Number of home deliveries conducted by SBA	12358
		% of institutional deliveries in which JBSY funds were given	100%
		% of home deliveries in which JBSY funds were given	NIL
		Number of deliveries referred due to complications	1445
		% of mothers visited by health worker during the first week after delivery	98%
4	***Reproductive Health***	Number of MTPs conducted	NA
		Number of RTI/STI cases treated	NA
		% of couples provided with barrier contraceptive methods	50%
		% of couples provided with permanent methods	28.40%
		% of female sterilizations	34%
5	***RNTCP***	% of TB cases suspected out of total OP	2.85%
		Proportion of New Sputum Positive out of Total New Pulmonary Cases	55.06%
		Annual Case Detection Rate (Total TB cases registered for treatment per 100,000 population per year)	57.10%
		Treatment Success Rate (% of new smear positive patients who are documented to be cured or have successfully completed treatment)	90.99%
		% of patients put on treatment, who drop out of treatment	4.7%
6	***Vector Borne Disease Control Programme***	Annual Parasite Incidence	NA
		Annual Blood Examination Rate	NA
		Plasmodium Falciparum percentage	NA
		Slide Positivity Rate	NA
		Number of patients receiving treatment for Malaria	NA
		Number of patients with Malaria referred	NA
		Number of FTDs and DDCs	NA
7	***National Programme for Control of Blindness***	Number of cases detected	147520
		Number of cases registered	131053
		Number of cases operated	18640
		Number of patients enlisted with eye problem	42413

		Number of camps organized	65
8	***National Leprosy Eradication Programme***	Number of cases detected	678
		Number of Cases treated	678
		Number of default cases	03
		Number of case complete treatment	739
		Number of complicated cases	NIL
		Number of cases referred	NIL
9	***Inpatient Services***	Number of in-patient admissions	66253
10	***Outpatient services***	Outpatient attendance	865231
11	***Surgical Services***	No. of Major surgeries conducted	
		No. of Minor surgeries conducted	

All the existing PHCs are functioning in the Government building and based on their foundation, area covered electrification, water facility, etc. All PHCs are in average condition except . Each of them is having power supply 10 to 15 hours (average) and have water supply through hand pipe The telephone facility is available. All PHCs have sanitation facility but needs maintenance properly. Further more, almost all the PHCs are lacking in proper disposal of waste.
Further, the current health infrastructure is not supported by district hospital. A 100 bed hospital is essential at East Champaran and Four 100 bed hospitals are required at Chakia.Pakridayal,Raxaul and Dhaka because it is the sub – divisional head quarter.. So, there is need of CHC here.

In the district at least one CHC is required in each block as per the present population. Apart from the new CHCs that need to be built according to the norms. It is needed to upgrade the PHCs into CHCs and increase the bed strength to 30 at least in each of them immediately.

All the PHCs are having no vehicle services.
The gaps in accommodation are huge. PHCs do not have the required number of quarters for Doctors as well as nurses. Whatever the existing quarters are there, they are in a very sorry state. There is acute shortage of quarters for Paramedics and other staff at all the PHCs. In the campus residential accommodation for all staff is required not just for few is very necessary if we really want to have our CHCs working for 24 hours a day and 7 days a week.

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

As far as APHCs are concerned, 49 APHCs are functioning without any facilities with damaged building (Table annexed). They are either functioning in the rented building. Few APHCs are functioning in government buildings but building condition is very poor. All APHCs are devoid of electricity and lacking of water supply because Hand pumps are not functioning properly. There are no residential facilities for staff except one.

Apart from the new PHCs (all APHC will converted into PHC) that need to be built we need to construct building for the 49 APHCs as shown in the table no. 6 above or the existing building need to be taken over and upgraded according to the PHC norms. All PHCs mentioned in the above table which do not have facility for electricity should be immediately provided with the electricity. Existing PHCs, which do not have any kind of water supply need to be provided with a bore from where they can have their own water supply round the clock. Staff quarters need to be built for all the new 49 APHCs. This will definitely help

in the long run of a dream of PHCs functioning for 24 hours a day and 7 days a week. Most of the PHCs do not have a Well equipped labour room or any kind of privacy during delivery. Until and unless all the PHCs are equipped with the proper facilities and privacy facility there will never be support from the locals residing in the vicinity of the public facility for institutional delivery whatever else we do for achieving 100% institutional delivery.

319 existing Health Sub-Centre are running in Government or Rented building. Almost all the buildings are in poor conditions and immediately renovation / new constructions are required. As per population norms and geographical conditions 366 new more sub-centers are required to provide better health facility to the community.

3.2 Manpower Availability and Gaps in manpower

Gaps in staffing should be recalculated after planning for multi-skilling and redistribution of existing staff such that there are no redundant manpower. Secondary level data give us the detailed manpower status at all the levels viz. PHC, APHC and HSC. As there are 20 PHCs (yet to be sanctioned as CHC) there should be requirement of 120 posts for medical officers out of which at least 80 posts should be of specialist MOs and rest of the 40 should be of general MOs with MBBS qualification.

But the actual scenario in the 20 blocks of East Champaran district is pathetic in a sense because as we can see. PHCs do not have even 1 specialist doctor. we can also see that there is also an acute shortage of Paramedics in the PHC level. PHCs (yet to be sanctioned as CHC) have required 9 staff nurses wherein there is no staff nurses are with them.

No any PHCs have Radiographers with them. There should be at least 1 radiographer with each PHC. All of the Block PHCs have at least 1 Lab Technician with them which is not sufficient. There should be at least 3 Lab Technicians in each of them. There 1 BHE posted in each of the PHCs .
Most of the PHCs do not have the requisite number of LHVs with them. At PHC level, according to the staffing norms for PHCs there should be at least 1 specialist doctors (PG qualified) and 2 doctors with MBBS qualification which means that there should be at least 7 medical officers posted at the PHCs.
As there are 49 APHCs, we would require at least 49 Medical Officers. Only 56 Ayush are in position at present. Going by the staffing norms of PHCs there is an acute shortage of female as well male paramedical staff. Most of the already functioning PHCs are not having at least 1 female Paramedical staff as well as 1 male paramedical staff which according to the staffing norms are 95% less. A PHC by staffing norm should have at least 2 MOs, 3 female Paramedics (ANM/ LHV/ Staff Nurse), 3 Male paramedics (HA/ NMS/ NMA/ dresser/ compounder/ Lab technician etc.) and 2 class IV staff.

The total no. of existing & Proposed HSCs is 834. There are 319 functioning sub-centres in the whole of East Champaran district. According to the staffing norms at HSC level each sub - centre should have 1 MPW (M) and 2 ANMs.

3.3 Infrastructure: Current Status and Gap

Section A: Health Facilities in the District

Health Sub-centres

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

16.	ARERAJ	137335	27	18	22	0			N
17.	SUGAULI	189168	13	13	10	03	5	8	N
18.	KESARIA	147663	29	12	18	0			N
19.	TURKAULIA	346625	70	21	49	49			N
20.	MOTIHARI URBAN	763312	152	16	21	115	6	10	N
	Total	4725938	834	319	421	366	15	27	

Section A: Health Facilities in the District

PHC

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

18.	KESARIA	147663	1	2	1
19.	TURKAULIA	346625	1	2	1
	MOTIHARI URBAN	763312	1	6	5
	Total	4725938	20	44	24

Section A: Health Facilities in the District

Sub-Divisional Hospital

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

Section A: Health Facilities in the District

District Hospital

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

Section B: Human Resources and Infrastructure

Sub-centre database

	No. of Sub	No. of Subce	Gaps in Sub	ANMs (R)/(C)	ANMs (R)/(C)	Gaps in ANMs(	Buildin g	Requir ed	Gaps in Buildin	ANM residin	Condition of	Status of	Status of Untied

	center present	nter requir ed	centers	posted formally	posted required	R)/(c)	owners hip (Govt)	Buildin g (Govt)	gs (Govt)	g at HSC area (Y/N)	residential facility (+++/++/+ /#)	furnitur e's	func
1	319	834	515	291/110	128/393	128/393	190	129	129	Y	+++	#	unexpen ded

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

Section B: Human Resources and Infrastructure

Additional Primary Health Centre (APHC) Database: Infrastructure

No	No. of APHC present	No. of APHC require d	Gaps in APHC	Building ownership (Govt)	Building Required (Govt)	Gaps in building	Buildin g conditio n (+++ /++/ #)	Conditi on of Labour room (+++/+ +/#)	No. of rooms	No. of beds	Condition of residential facility (+++/++/+ /#)	MO residing at APHC area (Y/N)	Status of furniture	Ambulanc e/ vehicle (Y/N)
1	48	151	103	24	127	0	#	#	52	104	#	Y	NA	Y
Tot.	48	151	103	24	127	0	#	#	52	104	#	Y	NA	Y

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

Section B: Human Resources and Infrastructure

Additional Primary Health Centre (APHC) Database: Human Resources

No	No. of APHC	Doctors		ANM		Laboratory technician		Pharmacists / dresser		Nurses A Grade		Accnt/Peon s/Sweeper/ Night Guards	Availabilit y of specialist
		Sanc tion	In Positi on	Sanc tion	In posi tion	Sanc tion	In posi tion	Sanc tion	In posi tion	Sanc tion	In Posi tion		
1	48	02	0	0	0	0	0	0	0	2	0	0/1/1/0	0

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

Section B: Human Resources and Infrastructure

Primary Health Centres : Infrastructure

No	No.	No. of	Gaps in	Buildin	Buildin	Gaps in	No. of	Functio	Conditi	No.	No. of beds	Func	Conditio	Conditio

	of PHC present	PHC required	PHC	g ownership (Govt)	g Required (Govt)	Building	Toilets available	nal Labour room (A/NA)	on of labour room (+++/++/#)	Places where rooms > 5		tional OT (A/NA)	n of ward (+++/++/#)	n of OT (+++/++/#)
1	20	58	38	20	38	38	20	20	+++	20	6 (per PHC)	A	++	+

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

Section F: Community Participation, Training & BCC

Community Participation Initiatives

S.No	Name of Block	No. of GPs	No. VHSC formed	No. of VHSC meetings held in the block	Total amount released to VHSC from untied funds	No. of ASHAs	Number of ASHAs trained		Number of meetings held between ASHA and Block offices	Total amount paid as incentive to ASHA
							Round 1	Round 2		
1	PATAHI	16	14	-	-	146	113	-	12	NA
2	PAKRIDEYAL	15	14	-	-	81	8	-	12	NA
3	PAHARPUR	21	18	-	-	89	76	-	12	NA
4	CHAKIA	18	13	-	180000	189	165	-	8	NA
5	MEHSI	12	12	-	120000	99	99	-	12	36000
6	RAMGHARWA	16	16	-	-	128	107	-	12	NA
7	HARSIDHI	20	10	-	-	181	150	-	12	600000
8	CHAURADANO	15	15	-	150000	110	77	-	12	NA
9	KALYANPUR	27	00	-	-	185	151	-	12	NA
10	DHAKA	2	19	-	-	184	88	95	12	1864
11	ADAPUR	19	11	-	190000	93	63	-	12	NA
12	MADHUBAN	22	15	-	-	87	24	-	9	4320
13	CHIRAIYA	20	10	-	-	190	190	-	9	500000
14	GHORASAHAN	24	11	-	-	191	145	-	12	NA
15	RAXAUL	13	13	-	-	92	67	-	12	NA
16	ARERAJ	30	27	-	-	215	151	-	12	NA
17	SUGAULI	28	18	-	-	108	108	-	12	NA
18	KESARIA	17	00	-	-	76	76	-	12	NA
19	TURKAULIA	32	21	-	-	177	177	-	12	NA
20	MOTIHARI SADAR	19	00	-	-	145	145	-	12	NA
21	BANJARIA	11	-	-	-	-	-	-	-	-

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

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

Training Activities:

S.No	Name of Block	Rounds of SBA Trainings held	No. of personnel given SBA Training	Rounds of IMNCI Trainings held	No. of personnel given IMNCI Training	Any specific issue on which need for a training or skill building was felt but has not being given yet
1.	District level	3	4 per batch	1 round	24	Required more training for TOT and block level training to improve the quality of health worker.

BCC. ACTIVITY-

No.	Name of Block	BCC campaigns/ activities conducted
1	PATAHI	Community meetting, Mahila Mandal Meetting, I.E.C., etc.
2	PAKRIDEYAL	Do
3	PAHARPUR	Do
4	CHAKIA	Do
5	MEHSI	Do
6	RAMGHARWA	Do
7	HARSIDHI	Do
8	CHAURADANO	Do
9	KALYANPUR	Do
10	DHAKA	Do
11	ADAPUR	Do
12	MADHUBAN	Do
13	CHIRAIYA	Do
14	GHORASAHAN	Do

15	RAXAUL	Do
16	ARERAJ	Do
17	SUGAULI	Do
18	KESARIA	Do
19	TURKAULIA	Do
20	MOTIHARI SADAR	Do
21	BANJARIA	Do
22	BANKATWA	Do
23	KOTWA	Do
24	PHENHARA	Do
25	PIPRAKOTHI	Do
26	SANGRAMPUR	Do
27	TETARIA	Do

District and Block level Management

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

19	KESARIA	N	N	N
20	TURKAULIA	Y	N	N
21	MOTIHARI SADAR	Y	N	N
22	BANJARIA	N	N	N

B: Human Resources and Infrastructure

Section B: Human Resources and Infrastructure

Referral Hospital : Infrastructure

Referral Hospital : Human Resources

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

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

3.3.1 Infrastructure facilities at PHCs

East Champaran District has 20 PHCs. All the PHCs function from their own building.

All the facilities have electricity in all parts of the hospital.
None of the facility has OPD facilities for RTI/ STI except one. OPD facility for gynecology/ obstetric is not available.

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

Specific staff training of medical officer in PHCs

The post of obstetrician/ gynecologist is not filled in any PHCs. The post of RTI/STI specialist is not filled in any of the facilities. The post of PHN is not filled in any of the facilities, while the posts of laboratory technician, pharmacist and staff nurse are filled and unavailable.

3.3.2 Availability of specific facilities in Additional Primary Health Centres

APHCs in East Champarandistrict have not their own buildings. There are no facilities of toilet, water supply electricity, laboratory, vehicle, labour room in any APHCs.

3.3.3 Availability of specific facilities in Sub-centre

Of the Sub-centres surveyed in East Champaran district, only 190 HSCs function from government buildings and 129 is running rented building. 80% of then have at least well as the source of water, There is no facilities of electricity, toilet facility and quarters for the health worker. The ANMs is present in all SCs, but there is no any means of transportation.

At PHC level, there should be a provision for X-ray, laboratory and also transportation facilities like ambulance, jeeps, etc. PHC staff also needs to be trained how to use the instruments and what are they for. Even if they have the instruments, as they do not know what are they called or for what purpose they are used when generally asked they say they do not have the equipments. Major equipments needs to be fully provided to all the 20 PHCs so that they can function 24 hours a day. Same is the case at sub-centre level.

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

3.5 Training Need Assessment /Human resource development/ Capacity Building

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

There is an ANM Training Centre located in the District East Champaran which imparts trainings to ANMs. The following additional trainings for various levels need to be imparted in the coming years:

- Specialized management trainings (for BMOs, DPOs & DPM)
- Specialized communication trainings (for BEEs, NGOs & media officers)
- Awareness generation trainings (for ANMs, LHVs, MPW(M), AWWs, Sahiyya, SHG leaders & PRI members)
- Skilled birth attendant training for ANM, LHV and Grade “A” Nurse etc.

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

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

Multi-skilling for Paramedical:

Minimum Periodic Re-training: The training policy must specify that every two years at least 15 days training per MPW and health supervisor (male and female) must be received.

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

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

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

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

Trainings for Medical Officers:

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

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

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

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

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

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

There is an ANM Training Centre located in the District hospitalEast Champaranwhich imparts 18 months of trainings to ANMs. Table below depicts the various IST and SST trainings conducted from the year 2000 onwards. Though most of the ANMs & LHVs have been covered under these trainings but some feedback trainings also needs to done so that they retain what they have been taught.

3.6 Health Services:

There are 319 subcentres, 49 APHCs and 20 PHCs spread in the 20 blocks of East Champaran. The OPD situation, bed occupancy and hospital management related issues are not in a very good condition if compared to the potential and capacity of institutions. The quality of public health services has been described in concerned sections and here the analysis of the clinical services.

- PHCs have yet to start function on a 24 hour basis though roasters in this view have been prepared in all facilities.
- ANMs availability in the headquarters still is an issue.
- Though contractual appointments are given, the no. of doctors is not adequate.
- Neonatal care is also a problem area needs improvement. Equipments and nursery facility provided to improve this also needs to be properly installed and used in almost all those facilities.
- The management of severe and acute malnutrition is not at all taking place.
- Supervisors are neither in sufficient number nor trained enough for supervising the work of the ANMs.
- In many places post of sector supervisors are vacant and needs to be fulfilled
- There is a greater gap of man power, infrastructure and equipment's at subcentre level due to which Subcentres are not functioning with quality services.
- Continuing out of pocket expenditure by ANM on stationary and travel with lack of adequate arrangements for facilitating mobility also effects the proper functioning of the subcentres.
- Continuing gaps in the cold chain maintenance and supply of disposables needed to improve quality in immunization.

Creating Conducive environment: Service condition

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

Another basic service issue is accommodation. At no level is there adequate housing for all staff. The focus has been on developing government housing for doctors first. At the PHC level there is accommodation available, especially for doctors but it is seldom adequate to house even half the staff or even half the number of doctors. At the PHC, most do not have accommodation for doctors and only about half have usable accommodation for other categories of staff. In many of these locations, availability of basic quality rental accommodation is also a problem.

Laboratory Services

Laboratory services at the sub-centre are absent. By norms four basic tests-Blood pressure, weighing of pregnant women and children, blood haemoglobin estimation and urine testing for sugar and albumen (also ESR) are expected to take place here.

These above tests do no take in PHCs. That the PHC, as per norms, has a basic laboratory which can do about 20 basic diagnostic tests has almost been forgotten within the system. Even microscope availability is low. In the last three years there has been considerable movement forward in this area and now availability may approximate 30% of PHCs- still a low figure.

Chapter 4

Health Sub Centers:

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

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

Indicators	Gaps	Issues	Strategy	Activities
Infrastructure	1) Sub centers present – 319; Sub centers proposed – 834; Sub centers required – 1153 2) The district needs 319 +834= 1153 HSCs to start and make functional 3) 58.09 (183 out of 319) HSCs are on rent and rent is outstanding science 5 years and above. 4) Building conditions are very poor. Out of 319 existing HSCs, 218 needs new buildings and rest needs major/ minor repairs. 5) All HSCs lacks	1) To increase the number of HSCs (319 to 1153) 2) To make functional 315+472 = 787 HSCs 3) Repairing of Old buildings 4) New buildings with residential facilities, clinical rooms, labour rooms, examination rooms, toilets, drinking and running water facility at the appropriate location 5) To assure land availability for proposed and newly	Short Term Strategy: 1) To optimize the use of existing resources by their repairing and upgrading 2) To hire buildings if required 3) Short term measures to enhance the infrastructure requirements 4) Resolution of local or political issues and handover of buildings	Short Term: 1. Repairing of existing building and infrastructure 2. Where repairing is not possible, hire buildings on rent for one year. Advertise it through local news paper. 3. Allotment of Mobile phone at each HSCs. Advertise the number in local news paper 4. Vehicle of APHC should be used for related HSC 5. Solar System for power supply 6. Water supply: tube well 7. Purchase of furniture from

	proper residential facilities, drinking and running water supply, toilets etc according to IPHS. 6) Lands are not available for new buildings 7) Lack of continuous power supply, telephone, transport facility etc at all the HSCs 8) Lack of drugs, equipment's & furniture as per IPHS Norms 9) Non availability of HMIS formats/ registers and stationary 10) Unavailability of labor rooms, clinic rooms, examination rooms, toilets 11) Lack of display boards, visiting schedule of ANM, complain/suggestion box 12) No residential accommodation facility	proposed HSCs. 6) To assure fund availability for construction of new building and payment of rent. 7) To assure proper power supply for 24 hours at HSCs 8) To assure availability for equipment's, drugs and furniture's according to IPHS norms. 9) To facilitate HSCs with telephone and transport facility for hard to reach areas.	Long Term Strategy: 1) Development of proposed HSC 2) Sanctioned of further required HSC Monitoring:	untied fund 8. Equipment and Drugs should be made available from PHC/ DHS 9. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings Long Term: 1) Land Availability with support of local community and administration 2) Construction of new buildings according to IPHS norms. Assure completion within one year. 3. Community mobilization for promoting land donations at accessible locations. 1. Biannual facility survey of HSCs through local NGOs as per IPHS format 2. Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 3. Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4. Training of VHSC/Mothers

				committees/VECs/Others on technical monitoring aspects of construction work. 5. Monthly Meeting of one representative of VHSC/ Mothers committees on construction work.
Human Resource	1) Only one ANM is posted at one HSC. Required HSC =834 Existing HSC = 319 Total ANM = 1153 Total HW = 2) Lack of Male and Female Health Workers and volunteers at HSC 3) Lack of Skilled ANM and HW 4) Below standard record keeping and reporting	1) To hire 344 ANM required 2) To post at least one Male Health Worker at each HSC 3) To train ANM and Health Workers 4) Continuous training at local level by Medical Officers in the block 5) To focus on record keeping and reporting system at HSC level	Short Term: 1) Effectively and efficiently use the existing human resource – Proper Placement and Transfer 2) Local Training for improvement of Knowledge, Skill and Attitude 3) Performance based incentive/ punishment plans Long Term: 1) Recruitment and Selection 2) Training and Development	Short Term: 1) Bimonthly review and training programs at PHC/ APHC level to the existing ANM and HW by MO/ MOIC or BHM 2) Bimonthly meeting/ review of all ASHA and AWW at HSC with ANM and BHM 3) Monitoring and evaluation of work at HSC level by MO/ BHM 4) Mobile team for uncovered areas including one MO, one ANM and one HW. Weekly visit plan to that uncovered areas. 5) More focus on weekly meeting at PHC level. Long Term: 1) Staff recruitment 2) Capacity building 3) Strengthening of ANM training school 4) Public – private partnership for HR development

Drug kit availability	1) No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, 2) Irregular supply of drugs	Indenting Logistics	Strengthening of reporting process and indenting through form 2 and 6 and delegating the purchase power from District to PHC level. Couriers for vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through ANMs account 4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage
Service performance	1) Unutilized untied fund at all HSC 2) No institutional delivery at HSC level 3) Hard to reach areas (12 blocks are flood affected 4) Antenatal Care	1) Operationalization of Untied fund. 2) Lack of delivery room and other facilities at sub centre level. 3) Improvement in quality of services like ANC, NC and	Capacity building of account holder of untied fund Renovation of HSC, through construction of delivery room & supply of equipments.	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at

	1. Early registration of pregnant women (only 18.7%) 2. Minimum three antenatal checkups (only 32.2%) 3. Other associated services (one TT inj. during pregnancy 69.7%) 5) Intra-natal and post natal care (Institutional birth 24.9%)(Mother who receive post natal care within 48 hr of delivery 9.5%) 6) Child Health: Children fully immunized 30.2% Children who receive BCG 76.2% Children who receive 3 doses of Polio 39.7% Children who receive 3 doses of DPT 45.3% Children who receive measles Vaccine 40.4% 7) Field Visits: Poor Tour Plans not followed 9) Community Need Assessment: Poor 10) Curative Services : Not available at HSC 11) Training, coordination and monitoring	PNC, Immunization, in Hard to reach areas in rainy season. 4) Integration of disease control programs at HSC level. 5) Family Planning services at HSC level 6)To improve reporting system from HSC to PHC regarding community needs and disease survillence 7) Need to develop ANM and Health Workers as a trainer to train ASHA and AWW	Phase wise strengthening of HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through HSC level Community focused Family Planning services Convergence	PHC level for managing accounts at HSCs untied fund 1. Establishment of a task force & Training of his staffs for working in drastic conditions 2. Give some addl. Remuneration/ incentives. 3. Arrangement of Boats/Vehicles for movement in Hard to reach areas 4. Involvement of community leaders / PRI. 1 Gap identification of HSCs through facility survey 2.strengtheing one HSC per PHC for institutional delivery in first quarter 3.Owning first delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.

				1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. 2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues

Additional PHC:

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

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

	APHCs only 40 are having own building Existing 25 buildings are not properly maintained Nonpayment of rent of 6 APHCs for long period. 128 APHC need new building construction All Existing APHC Need Major repair Running water supply is not available Non availability of Labour room. None of the APHC has Power Supply. All Existing APHC require new construction of toilet Lack of equipments, Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries	constructed building. Lack of community ownership.	Strengthening of Infrastructure and operationalizatio n of construction works in Three phase Monitoring	RKS **A. Strengthening of APHCs having own buildings** A.1Rennovation of APHCs buildings A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries **B. Strengthening of APHCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund/ RKS from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new APHC buildings as standard layout of IPHS norms. C1. Preparation of PHC wise priority list of APHCs

				according to IPHS population and location norms of APHCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New APHC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed APHCs buildings. 4 Biannual facility survey of APHCs through local NGOs as per IPHS format 4.1 Regular monitoring of APHCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.

Human Resource	Out of 46 APHCs have 92 doctor is required but only 8 doctors posted, Out of 184 grade A Nurse only 24 grade A Nurse has been appointed , but they are deputed at PHC or district Hospital Out of 184 Male Health Worker only 80 have been posted.	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	1.Selection and recruitment of ….Doctors/Grade A nurse/ANMs 2.Selection and recruitment of …male workers 3. Sending back the staffs to their own APHCs. 1. Training need Assessment of APHC level staffs 2. Training of staffs on various services 3. EmoC Training to at least one doctor of each APHC 1. Analyzing gaps with training school 2. Deployment of required staffs/trainers 3. Hiring of trainers as per need 4. Preparation of annual training calendar issue wise as per guideline

				of Govt of India. 5. Allocation of fund and operationalization of allocated fund
Drug kit availability	No drug kit as such for the APHCs as per IPHS norms. (Kit A, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs) and contraceptives, Only need based emergency supply Irregular supply of drugs	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 2 and 6 Couriers for vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	1.Weekly meeting of APHC staffs at PHC for promoting APHC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the APHC to PHC(First reminder-Red, Second reminder-Blue, Third reminder-Yellow) 3.1 Hiring of couriers as per need 3.2 Payment of courier through APHC account 4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and

				drug storage
Service performance	RKS has not been formed at any of the APHC. Unutilized untied fund at APHC level No institutional delivery at APHC level OPD for 2days only in most of the APHC No inpatient facility available No ANC, NC and PNC and family planning services. No lab facility 6 Ayush practitioner posted No rehabilitation services No safe MTP service No OT/ dressing and Cataract operation services. Approx 80% of APHC staffs not reside at place of	Formation of RKS Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps. Integration of disease control programs at APHC level. Family Planning services Convergence Operational issues	Capacity building of account holder of untied fund Phase wise strengthening of 16 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms. Mobile Medical Units (MMUs) to be operationalized Implementation of disease control programs through APHC level where APHC will work as a resource center for HSCc. At present the same is being done by PHC only.	1.Training of signatories on operating Untied fund / RKS account, book keeping etc 2. Assigning PHC RKS accountant for supporting operationalization of APHC level accounts 2. Timely disbursement of untied fund/ seed money for APHCs RKS. 3. 1 Gap identification of 16 APHCs through facility survey 2.strengtheing one APHC per PHC for institutional delivery in first quarter 3.Owneringfirst delivered baby and ANM Medical Care: 1. OPD (40/day/doctor) 2. 24 hr emergency services 3. Referral services 4. inpatient services 6 beds 1 Review of all disease control programs APHC wise in existing

	posting Lack of counseling services Problem of mobility during rainy season Lack of convergence at APHC level Operational gaps: There is no link between HSCs and APHCs and the same way there is no link between APHC and PHC		Community focused Family Planning services PPP Convergence	Tuesday weekly meetings at PHC with form 6 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 5.Weekly meeting of the staffs of concerned HSCs (as assigned to the APHC) 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1.Outsourcing services for Generator, fooding, cleanliness and ambulance i 1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC.

				2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues 3. Arrangement of Hand Pump through PHED 4. Electricity connection through local electricity department 5. Telephone connection.

Staff Position in APHCs as per IPHS norms

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

Primary Health Centers:(30 beaded)				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	The district altogether needs 27 PHCs but there are only 20 functioning PHC. 7 PHC are required to be formed. All 20 PHCs are having own building All 20 PHCs are running with only six bed facility. **Delivery** : At present only 20 PHC's is conducting	Available facilities are not compatible with the services supposed to be delivered at PHCs. Quality of services Community participation.	Up gradation of PHCs into 30 bedded facilities. ISO certification of selected PHCs in the district. Strengthening of BMU	1.Need based (Service delivery)Estimation of cost for up gradation of PHCs 2. Preparation of priority list of interventions to deliver services. 1. Selection of any two PHCs for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail.

	delivery.0020 At an average of 5 delivery per day Out of which only 14 PHC having an average of 10 delivery per day. **Family Planning** 20 PHC's are conducting at an average of 3 Family Planning Operation per week. OPD / Minor operation/ Emergency is 185 per day This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also underutilized equipments. Lack of appropriate furniture Non availability of		Ensuring community participation. Strengthening of Infrastructure and operationalization of construction works	1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers in rest of the vacant place & Accountants in all institutions. 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community representatives on erecting boundary, beautification etc, 2. Nukkad Nataks on Citizen's charter of HSCs as per IPHS 1.1 Monthly meetings of VHSCs, Mothers committees **3A.Strengtheing of HSCs having own buildings** A.1Rennovation of HSCs A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries **3B. Strengthening of HSCs running in rented buildings.** B1. Estimation of backlog rent and

	HMIS formats/registers and stationeries Operation of RKS: Lack in uniform process of RKS operation. Lack of community participation in the functioning of RKS. Lack of facilities/ basic amenities in the PHC buildings		Monitoring	facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new HSCs C1. Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings. 4 biannual facility survey of HSCs through local NGOs as per IPHS format 4.1 Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of

				VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.
Human Resource	Doctors : Existing 20 PHC district have 138 sanctioned post of regular doctor only 80 (r) + 91 (c) are working . Grade A Nurse : Out of 26 sanctioned post only 2 are working. ANM :- Out of 428 sanctioned post only 291 are working. Lab Technician :- Out of 52 sanctioned post only 17 are working. Pharmacist :- Out of 52 sanctioned post only 20 are working. Block Extension Educator :- Out of 12 sanctioned post only 11 are working. Health Educator :- Out of 32 sanctioned post only 29 are working. L.H.V :- Out of 29 sanctioned post only 22 are working. Out of 20 BHM & Accountant but at present all are	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	1. Selection and recruitment of ….ANMs 2. Selection and recruitment of …male workers 1. Training need Assessment of HSC level staffs 2. Training of staffs on various services 1. Analyzing gaps with training school 2. Deployment of required staffs/trainers 3. Hiring of trainers as per need 4. Preparation of annual training calendar issue wise as per guideline of Govt of India. 5. Allocation of fund and operationalizatio n of allocated

	vacant.			fund
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time. Only … % essential drugs are rate contracted at state level . Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system Phase wise strengthening of APHCs for vaccine / drugs storage	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all PHCs 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store

				keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	1.Exessive load on PHC in delivering all services i.e. 10 delivery per day, Family Planning operation/emergency operation and 185 OPD per day in each PHC. Lack of counseling services Problem of mobility during rainy season Lack of convergence	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization, Family Planning services Convergence	Capacity building of account holder of untied fund Phase wise strengthening of 30 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through HSC level	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts at HSCs untied fund 1 Gap identification of 30 HSCs through facility survey 2.strengtheing one HSC per PHC for institutional delivery in first quarter 3.Owneringfirst delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC

				with form 6.(four to five HSC per week)
			Community focused Family Planning services	2.Strengthening ANMs for community based planning of all national disease control program
			Convergence	3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1. Fixed Saturday for meeting day of ANM, AWW, ASHA, with VHSCs rotation wise at all villages of the respective HSC. 2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition

				and sanitation issues
Operational				

S.No.	Indicators	Present Status (10-11)	% Availability	Availability as per DLHS 3	%age Availability
1	PHC having Residential Quarter for Medical Officer	20 (Repairable)	100%	19	95%
2	PHC having separate Labour Room	20 (Repairable)	100%	11	55%
3	PHC having Personal Computer	0	0	0	0
4	PHC having Normal Delivery Kit	12	60%	12	60%
5	PHC having Large Deep Freezer	6	30%	6	30%
6	PHC having regular water supply	20	100%	21	105%
7	PHC having Neonatal Warmer (Incubator)	0	0	2	10%
8	PHC having Operation Theater with Boyles Apparatus	3	15%	3	15%
9	PHC having Operation Theater with anaesthetic medicine	1	5%	9	45%

Sub divisional / Referral Hospital				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**

Infrastructure	The district has been requiring 5 sub divisional Hospital but there are no any functioning. The district has 3 Referral Hospital are functioning. Referral Hospital have own building but not adequate space. Require additional building **Delivery** : At present normal delivery is 10 cesarean or other operation 3 Conducting per day **Family Planning** Family Planning Operation 3 per week. OPD / Minor operation/ Emergency is 185 per day This huge workload is not being addressed with only 30 beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms The comparative analysis of facility survey(08-09) and DLHS3 facility	Available facilities are not compatible with the services supposed to be delivered at Referral Quality of services Community participation.	Upgradation of Referral into 100 bedded facilities. ISO certification of selected Referral in the district. Strengthening of BMU Ensuring community participation. Strengthening of Infrastructure and operationalizatio n of construction works	1.Need based (Service delivery)Estimation of cost for upgradation of Referral 2.Preparation of priority list of interventions to deliver services. 1.Selection of any one Referral for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers, Accountants in these institutions 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community representatives on erecting boundary, beautification etc, **3A.Strengtheing of Sub div./Referral hospital having own buildings** A.1Rennovation of building. A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats

	survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also underutilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries Operation of RKS: Lack in uniform process of RKS operation. Lack of community participation in the functioning of RKS. Lack of facilities/ basic amenities in the existing buildings		Monitoring	and purchase of stationeries **3B. Construction of new of Sub div./Referral hospital** B1. Preparation of priority list of Sub div./Referral hospital according to IPHS population and location norms. B2. Community mobilization for promoting land donations at accessible locations. B3. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed of Sub div./Referral hospital 4.2 Monitoring of renovation/construction works through RKS members. 4.3 Training of Members of RKS committees/ Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of RKS committees on construction work.

Human Resource	Doctors : Lack of Obstetrician & Gynecologist, Anesthetist Lack of Grade A Nurse, O.T Assistant, Ward Boys, Sweeper, Chowkidar, Ophthalmic Assistant	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	* Recruitment of Doctors like Obstetrician & Gynecologist, Anesthetist 1. Selection and recruitment of Grade A Nurse 2. Selection and recruitment of male workers like O.T Assistant, Ward Boys, Ophthalmic Assistant 3. Training need Assessment of Sub div. level staffs 4. Training of staffs on various services 5. Deployment of required staffs/ trainers 6. Hiring of trainers as per need 7. Preparation of annual training calendar issue wise as per guideline of Govt of India. 8. Allocation of fund and operationalizatio n of allocated fund

Drug kit availability	Irregular supply of drugs because of improper assessment and improper supply and centralized distribution. Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 8 Strengthening of drug logistic system Phase wise strengthening of A Referral for vaccine / drugs storage	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all Referral 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	1.Exessive load on Referral Hospital in delivering all services i.e. 10 delivery per day, Family Planning operation/emergency operation and 185 OPD per day in each Hospital. Lack of counseling services Problem of mobility during rainy season Lack of convergence	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization,	Capacity building of account holder of untied fund Phasewise strengthening of Institutional delivery and fix a day for ANC as per IPHS norms. Community focused Family Planning services Convergence	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund form DHS Strengtheing Sub Div. Hospital for institutional delivery in first quarter Submission of reports of all programs by the supervisors duly signed by the respective Head. 1. Ensuring supply of contraceptives with three month's buffer stock at Sub Div. Hospital 3. Training of staffs on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1. Fixed Saturday for meeting day of ANM,

				AWW, ASHA
Operational				

District Hospital

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

i. To provide comprehensive secondary health care (specialist and referral services) to the community through the District Hospital.
ii. To achieve and maintain an acceptable standard of quality of care.
iii. To make the services more responsive and sensitive to the needs of the people of the district and the hospitals/centers from which the cases are referred to the district hospitals

Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	1) Size of Hospital: Number of beds is 100 which are far less than the requirement. Standard is 500 beds. 2) Building and Space Requirement: Poor building conditions need minor repairing Number and conditions of toilets are poor. 3) Ambulatory Care Area (OPD): No general or subsidiary waiting space/ room for patients Diagnostic Services: No ultrasound, radio-diagnosis facility Clinical Laboratory: Outsourced Blood Bank:	To increase number of beds up to 500 Repairing and Maintenance of Old Building New buildings for RCH, wards, diagnostic services, waiting space etc Need of new toilets Expantion of delivery wards to make it 60 bedded ward One ward of 30 beds for Family Planning Operation New building for	Repairing of existing buildings and infrastructures Repairing of boundary wall Hand-over of buildings already completed Timely completion of work in progress Construction of new buildings needed One water tank One separate transformer for power supply Upgradation into 500 beded facilities. Strengthening of BMU	1.Need based (Service delivery)Estimation of cost for upgradation of Referral 2.Preparation of priority list of interventions to deliver services. 1.Selection of any two Referral for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers, Accountants in institutions 3. Training to the RKS signatories for account

	4) Intermediate Care Area (Inpatient Nursing Units): 5) Critical Care Area (Emergency Services): 6) Therapeutic Services: Toilet condition poor Sanitation, waste disposal poor Physiotherapy: Need separate building 7) Hospital Services: Hospital Kitchen: Central sterile and supply department: Hospital Laundry: Mortuary: Medicine and General Store 8) Engineering and Services: Electric engineering: Generator and lighting Call Bells: Mechanical Engineering: AC, Room Heating Public Health Engineering: Water Supply: Drinking Water: Drainage and Sanitation: Poor Waste disposal System: 9) Fire Protection: 10) Telephone and Intercom: Parking:	laundry, kitchen, mortuary etc Repairing of water tank. Installation of new tube wells (5 at least) New buildings for residential quarters and community hall. Not Functioning General Wards need Minor repair . Not independent of OPD OT: Not according to IPHS Delivery Suit Unit: No distinct antenatal and postnatal wards Need new building	Community participation Strengthening of Infrastructure and operationalizatio n of construction works Monitoring	operation. 4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community representatives on erecting boundary, beautification etc, 2.Monthly meetings of DHS, RKS A.1Rennovation of **buildings** A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries 3C. Construction of new **buildings** according to IPHS norms 3.1 Monitoring of renovation/construction works through DHS/RKS members.

	Committee room: Residential Quarters:	Storage Condition is poor Continuous Water Supply – not continuous for 24 hours Not available. Dependent on tube well. No separate parking area No separate committee room		Need minor repairs Insufficient, more quarters are needed (7 for doctors, 6 for paramedical staffs)

Human Resource	Doctors: Only 13 doctors. Sanctioned 14 Standard 25 Paramedical: Only 7 Nurses. Sanctioned 8 Standard is 100-150 lab technician: Sanctioned 3 Pharmacist: Only 1 Sanctioned 1 Standard 5 Dresser: Only 3 Sanctioned 3 No O.T Assistant: Sanctioned 1 Standard 5 Other Staffs are also insufficient and not according to the norms of IPHS	Appointment of new Doctors and Paramedical Staffs Use of Contractual Staffs and Outsourcing for different services	Staff recruitment Capacity building Strengthening of ANM training school	Selection and recruitment of Doctors and Paramedical Staffs Selection and recruitment of …male workers Training need Assessment of Dist. level staffs Training of staffs on various services Analyzing gaps with training school Deployment of required staffs/trainers Hiring of trainers as per need Preparation of annual training calendar issue wise as per guideline of Govt of India. Allocation of fund and operationalization of allocated fund
Drug kit availability	(A) Drugs 1) OPD Drugs: Only 37 OPD Standard is 104 2) IPD Drugs: Only 57 IPD Drugs Standard is 107 (B) Equipments 1) Imaging Equipments: No Dental X-ray Machine, No Ultra sonogram, No C.T. Scan 2) X-Ray room accessories: Not according to IPHS 3) Cardiac Equipment: ECG 1 Not according to IPHS 4) Labor Ward & Neo Natal Equipments: Lacking weighing	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 8 Strengthening of drug logistic system	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all Referral 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of drugs

	machines, baby incubators, phototherapy unit, etc as according to IPHS			with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	Blood Bank ECG Nonfunctioning of RKS 6. Essential Services (Minimum Assured Services) Services include OPD, indoor, emergency services. Secondary level health care services regarding following specialties will be assured at hospital: Consultation services with following specialists: General Medicine General Surgery O&G services Pediatrics including Neonatology Emergency (Accident & other emergency) Critical care Anesthesia Ophthalmology ENT Dermatology and Venerology (Skin & VD) RTI/STI	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization, Integration of disease control programs at Dist. level. Family Planning services	Capacity building of account holder of untied fund Community focused Family Planning services	It provides effective, affordable healthcare services (curative including specialist services, preventive and promotive) for a defined population, with their full participation and in co-operation with agencies in the district that have similar concern. It covers both urban population (district headquarter town) and the rural population in the district. 2. Function as a secondary level referral centre for the public health institutions below the district level such as Sub-divisional Hospitals, Community Health Centres, Primary Health Centres and Sub-centres. 3. Technical and administrative support and education and training for primary health care

	Orthopedics Radiology including ultrasonologist Radiotherapy Dental care Public Health Management Psychiatry Plastic Surgery Allergy Super Specialties Cardiology Cardio-thoracic Vascular Surgery Gastro-entomology Surgical Gastro-entomology Nephrology Urology Neurology Neurosurgery Oncology Endocrinology/Metabolism Diagnostic and other Para clinical services regarding: Laboratory services Imaging services CT Scan services Pornography ECG EEG Echocardiogram Endoscopy Angiography Echocardiography Pathology Physiotherapy Dental Technology (Dental Hygiene) Drugs and Pharmacy Ancillary and support services: Following ancillary services shall be ensured:			

	Medico-legal /postmortem Ambulance services Dietary services Laundry services Security services Waste management Counseling services for domestic violence, gender violence, adolescents, etc. Gender and socially sensitive service delivery be assured. Ware housing/ central store Maintenance and repair Electric Supply (power generation and stabilization) Water supply (plumbing) Heating, ventilation and air-conditioning Transport Communication Medical Social Work Nursing Services Sterilization and Disinfection Horticulture (Landscaping) Lift and vertical transport Refrigeration Administrative services (i) Finance* (ii) Medical records (Provision should be made for computerized medical records with anti-virus facilities whereas alternate records			Outsourcing of services like laundry, ambulance, dietary, housekeeping and sanitation, waste disposal etc. to be arranged by hospital itself. Manpower and outsourcing work could be done through local tender mechanism Medical Superintendent to be authorized to incure and expenditure up to Rs.25.00 lakhs for repair/upgrading of impaired equipments/instruments with the approval of executive committee of RKS. Financial powers of Head of the Institution Financial accounting and auditing be carried out as per the rules along with timely submission of SOEs/UCs.

	should also be maintained) (iii) Procurement (iv) Personnel (v) Housekeeping and Sanitation (vi) Education and training (vii) Inventory Management Services under various National Health and Family Welfare Programmes Epidemic Control and Disaster Preparedness			No equipment/instruments should remain non-functional for more than 30 days. It will amount to suspension of status of IPHS of the concerned institutions for absence period.

Non-Governmental Organization [NGOs]

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

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

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

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

INFRASTRUCTURE PLANNING

Facility	Existing	2011-12
Projected Population	4853538	
General Hospital	One at District	One
PHC/APHC	0	50
PHC	20	50
Subcentre	319	834

3. PRIORITIES AS PER BACKGROUND AND PLANNING PROCESS

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

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

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

SPECIFIC PRIORITIES OF THE DISTRICT

1. **Gender & Equity:** Implementation of PNDT Act 1995 through regular monitoring of Ultrasound Clinics and regular meetings of advisory committee. Increase in BCC/IEC activities for awareness of PNDT Act.

2. **Maternal Health:** Well managed system of institutional deliveries through Delivery huts and Emergency Obstetric Care services, JSY extended to all poor categories of persons, Blood Storage Units at all PHCs, All PHCs to be developed as FRUs, PHCs to be developed as 24x7 facilities, good referral mechanisms. Ensure complete Ante antal and Post natal coverage.

3. **Neo Natal and Child Health:** Provision of Neonatal services at PHCs, PHCs, Training on IMNCI and IMCI, addressing Anaemia and Malnutrition. Preparation of School Health Plan.

4. **Family Planning:** Improving the coverage for Spacing methods and NSV

5. **Immunization:** Total coverage for immunization

6. **Adolescent Health:** The focus is on provision of Adolescent Reproductive and Sexual health education through schools and also awareness building on good health practices, responsible family life, and harmful effects of Alcoholism.

7. **National Disease Control Programmes:** Prevention of Mosquito transmitted diseases and increase case detection rate of NSP cases up to 70% and maintaining cure rate of 85%.

8. **Demand Generation, IEC/BCC:** Nutrition, Health & RCH Education to Adolescents, Behaviour Change in the difficult Populations and for improving the adverse sex ratio. Health Plan for each village through Village Health Committee of the Panchyat.

9. **Programme Management:** Better functioning of the District Health Society and a strengthened Civil Surgeon's Office and establishing BPMU.

10. **Infrastructure**: Increase in the number of Subcentres, PHCs, PHCs and Urban Health centres for the slums and urbanized population

11. **Human Resources:** Filling of the vacancies as per the population based norms for the year 2009-10, increased mobility, motivational issues, provision of quarters at all facilities, Availability of well trained ASHAs for each 1000 population

12. **Capacity Building:** Focussed capacity building in Emergency Obstetric Care, Continuous skill building of all personnel as per needs expressed and also the new job responsibilities under NRHM. Training and capacity building of Panchayati Raj Institutions to establish decentralized and participative planning and training of all ASHAs.

13. **Procurement and Logistics:** Construction of a scientific Warehouse for Drugs

14. **Monitoring and Evaluation:** Data validation and computerized data availability upto PHCs with district linkages

15. **Intersectoral Convergence:** Fixing Responsibilities of each sector for their accountability and hence better Intersectoral Coordination and ensure Inter Sectoral convergence with nutrition, Drinking water & sanition programme to derive synergies.

16. **Public-Private Partnership:** Increase in the number of private facilities for accreditation with the Government for providing services

4. GOALS

The District will strive to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children and will achieve the following goals:

INDICATOR	Current		Goals for District
	Bihar	East Champaran	11-12
Reduction in Infant Mortality Rate (IMR)	57 (SRS 07)	57	50
Reduction Maternal Mortality Ratio (MMR)	162 (NFHS III)	162	140
Reduction in Birth Rate	23.9 SRS 07)	19.56*	16
Reduction in Total Fertility Rate	2.69 (SRS 07)	2.69	2.5
Reduction in Death Rate	6.5 (SRS 07)	5.04*	4.8
Increase in Couple Protection Rate	62 (DLHS 07-08)	62	70
% of Pragnant receiving full ANC	58.8 (NFHS III)	35.9%** DNA *	70%
Increase % of Women getting IFA tablets	28.3%(NFHS III)	82%* 11%**	90%
Increase Institutional Deliveries	39.4 (NFHS III)	60.2%* 36.8**	65%
Increase Delivery by Skilled Birth Attendants	54.2 (NFHS III)	83.5% 48.7%**	
Increase Complete Immunisation of Children (12-23 month of age)	65.3 (NFHS III)	90% 58.7%**	
Increase in Annualized NSP CDR (TB)		50/L*	
Decrease in API of Malaria (NVBDCP)		.34*	
Pravelance rate (Leprosy)			
Sex Ratio	861 (Census 01)	873*	

Note:

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

indicators along with the expected target sets that are projected for period of next five years (2007-12).

period of next five year plan period. In order to attain the set goals certain strategies are laid out against each indicator.

PART A: Reproductive and Child Health (RCH) II

A-1. MATERNAL HEALTH

Situation Analysis/ Current Status

Indicator	**No.**			
No of Pregnant women	137052			
Maternal Deaths	6 As per C.S.O. report			
ANC registration	No. 37458		% 88%	
Full ANC coverage	DNA		7.10% (DLHS02)	
Full ANC coverage (3 ANC)	DNA			
Institutional Deliveries (In the last reporting year)	40394		60.2%	
Deliveries by skilled birth attendants	40394		83.5%	
Home deliveries (Total No.): 6986	Skilled		Unskilled	
	No.	%	No.	%
	4049	58	2937	42
No. of pregnancy related complications referred to FRU level	DNA			

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

ANC: 88% pregnant women in the last reporting year were registered for ANC checkups. The data regarding Full ANC is not available. As per DLHS 2002, only 7.1 % of the pregnant women had received full ANC care that is three doses of TT, required number of IFA tablet and at least 3 ANC checkups during their pregnancy. The reasons for low ANC coverage are the shortage of staff, sociocultural beliefs, large areas and populations unreached and the unmotivated staff.

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

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

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

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

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

Janani Surakha Yojana: The JSY scheme has been launched in Haryana and 3426 women

	have benefited till date. This low uptake has been due to poor awareness in the people and non availability of regular funds from the government at the health facilities. **Janani Suvidha Yojna:** **Services:** The Community does not have enough confidence in the government facilities since the personnel are not always available especially Lady MOs and also adequate infrastructure, equipment and drugs. There is a dearth of facilities as per the population norms for facilities. A large number of the women use private facilities. The government has started intensive efforts to improve the facilities through delivery huts, 24 hour PHCs, development of PHCs as per IPHS standards. At present there are 31 delivery huts are functional with special facilities for institutional deliveries. The Delivery huts should be at all the Subcentres. **Fixed Maternal, Child Health and Nutrition Days** (MCHN days) are being organized but there is little awareness amongst the community about the days when these are held and also regarding the services being provided. **RCH Camps:** RCH camps would be organized in each block in each year to reach the community and provide services at the doorsteps. These camps provide specialist services with simple diagnostic tests. They also serve for screening of RTI and STDs.
Objectives	1. 100% pregnant women to be given two doses of TT 2. 90% pregnant women to consume 100 IFA tablets by 2011 3. 70% Institutional deliveries by 2011 4. 90% deliveries by trained /Skilled Birth Attendant by 2011 5. 95% women to get improved Postnatal care by 2011 6. Increase safe abortion services from current level to 80 % by 2011
Strategies	1. Provision of quality Antenatal and Postpartum Care to pregnant women 2. Increase in Institutional deliveries 3. Quality services and free medicines to all the deliveries in the health facilities. 4. Availability of safe abortion services at all PHCs and PHCs 5. Increased coverage under Janani Suraksha Yojna & Janani Suvidha Yojna. 6. Strengthening the Maternal, Child Health and Nutrition (MCHN) days 7. Improved behaviour practices in the community 8. Referral Transport 9. EmOC at PHCs 10. Organizing RCH Camps. 11. Oprationalization of FRU 12. Skill Development of Human resources 13. Community mobilization for strengthening the services
Activities	1. Identification of all pregnancies through house-to-house visits by ANMs, AWWs and ASHAs

2. Fixed Maternal, Child Health and Nutrition days

- Once a week ANC clinic by contract LMO at all PHCs and PHCs
- Development of a microplan for ANMs in a participatory manner
- Wide publicity regarding the MCHN day by AWWs and ASHAs and their services
- A day before the MCHN day the AWW and the ASHA should visit the homes of the pregnant women needing services and motivate them to attend the MCHN day
- Registration of all pregnancies
- Each pregnant woman to have at least 3 ANCs, 2 TT injections and 100 IFA tablets
- Nutrition and Health Education session with the mothers

3. Postnatal Care

- The AWW along with ANM will use IMNCI protocols and visit neonates and mothers at least thrice in first week after delivery and in total 5 times within one month of delivery. They will use modified IMNCI charts to identify problems, counsel and refer if necessary

4. Provision of Weighing machines to all Subcentres and AWCs

5. Establishing Delivery Huts for all the Subcentres alongwith provision of additional ANMs in all these Delivery huts for 24 hour deliveries.

6. Availability of IFA tablets

- ASHAs to be developed as depot holders for IFA tablets
- ASHA to ensure that all pregnant women take 100 IFA tablets

7. Training of personnel for Safe motherhood and Emergency Obstetric Care (Details in Component on Capacity building)

8. Developing the PHCs for quality services and IPHS standards (Details in Component Upgradation of PHCs and IPHS Standards)

9. Availability of Blood Bank at the General Hospital and Blood Storage Unit at PHC

- Establishing Blood storage units at PHCs along with sadar hospital
- Certification of the Blood Storage Centres

10. Improving the services at the Subcentres (Details in Component on Upgradation of Subcentres and IPHS)

11. Behaviour Change Communication (BCC) efforts for awareness and good practices in the community (Details in Component on IEC)

12. Increasing the Janani Suraksha Yojna & Janani Suvidha Yojna coverage

- Wide publicity of the scheme (Details in Component on BCC …)
- Availability of advance funds with the ANMs
- Timely payments to the beneficiary
- Starting of Janani Suraksha Yojana Helpline in each block through Swasthya Kalyan Samitis
- Increase in the No. of Private Health Providers in Urban Areas for JSY.
- Regular IEC Activities in the Urban Slum Areas for Janani suvidha Yojna

13. Training of TBAs focussing on their involvement in MCHN days, motivating clients for registration, ANC, institutional deliveries, safe deliveries, post natal care, care of the newborn & infant, prevention and cure of anaemia and family planning

14. Safe Abortion:

- Provision of MTP kits and necessary equipment and consumables at all APHCs
- Training of the MOs in MTP
- Wide publicity regarding the MTP services and the dangers of unsafe abortions
- Encourage private and NGO sectors to establish quality MTP services.
- Promote use of medical abortion in public and private institutions: disseminate guidelines for use of RU-486 with Mesoprestol

15. Development of a proper referral system with referral cards and arrangement of referral facilities to the complicated deliveries at all APHCs/PHCs.

16. Improvement of monitoring of ANM tour programme and Fixed MCHN days

- Fixed MCHN days and Tour plan of ANM to be available at the PHCs with the MOs
- Checklist for monitoring to be developed
- Visits by MOs and report prepared on basis of checklist filled
- Findings of the visits by MOs to be shared by MO in meetings

17. RCH Camps: These will be organized once each block per year to provide specialist services especially for RTI/STD cases and Maternal & Child Health.

18. Provision of free medicines to all the patients of deliveries.

19. Blood bank
20. Neo natal care facility
21. Facility for C- section

	22. Equipments and drug logistics 23. Mapping of Human Resources 24. Training on EmOc , CmOc, LSAS and Neonates Care and Skilled birth Logistic management, hospital management and Human resource management 25. Asha/ AWW/ ANM training on identification of danger sign & symptom of pregnant women . Mass communication on FRU service availability to the community 26. Referral transport planning and management.
State support	1. Issue of joint letters from Health & WCD department for joint working 2. Ensuring availability of personnel especially specialists and Public Health Nurses for the 24 hour PHCs, APHCs and two ANMs at the subcentres 3. Ensuring availability of formats and funds with the ANM for JSY and timely payments 4. Certification of PHCs as MTP centres 5. The State should closely monitor the progress of all the activities
MTP services at health facilities	
Gaps	MTP services are not available in Public sectors IEC Service providers are not aware about legal dimension of. Eligible private practitioners should be involved. Legal awareness about PC-PNDT & MTP Act.
Strategie	Strengthening of comprehensive abortion care (Safe abortion , Family planning)services at all Facilities such as :- Sadar Hospital, Referral Hospital, PHCs & APHCs. Training
Activity	selection of facilities for provision of safe abortion services Location of facility availability of trained service provider, space, equipments. 2. To Provide appropriate equipments at all facilities and MVA syringes. 3.Putting the trained doctors at appropriate facilities to commence the services 4. Training of Medical officers and Para medical staffs on Safe abortion services training including awareness about legal aspects of MVA/ EVA and Medical abortion by IPAS . 5. Formation of district level committee (DLC) to accredit private sites as per GOI guide line . Develop reporting system of MTP services in private and public secter. 6. Through training program make the govt doctors skilled to perform MTP in the approved sites. 1. To Involve community to aware about location of services , process and legal aspects of MTP services through - AWW, ASHA & ANM, LRG and mass media. The services of Pregnancy testing should be strengthen and it should be linked with MTP services. 2. NGO's and local Practitioner should be involved for counseling and information of facility 3. Assurance of privacy and link with family welfare services counseling at all facility. Linkage with MTP services with NGOs (PPP) those who are working in Safe abortion services. and create one modal center at district and PHC level. Training of ASHA on medical abortion.
RTI/STI services at health facilities	

Gaps	No regular clinic at all PHCs & APHCs.
Activity	Trained service provider on syndrome management of RTI/STI (As per GOI guide line) up to APHC level. Logistics of setting of clinics and free drugs availability 1. Integrated Counseling services in four public sector facilities by trained personnel . 2. IEC/BCC for awareness available RTI/STI services at all health facilities.
Operationalise Sub-canters Referral Transport	
Gaps	Non availability of Ambulance in as per the norms one ambulance/1lac population Pickup Service of pregnant women is not available
Activity	Ambulance should be available 24x7 for safe referral of patients /Pregnant women in time. Free transport for Pregnant women to reach them to government facility and cost should be reimbursed from RKS fund. In panel all existing Ambulance services provider.
Integrated RCH camps	
Strategie	Coverage of Slums & Maha Dalit Tola.
Activity	1. Identifying Socially Backward, Slums & Maha Dalit Tolas. 2. Hiring trained alternate vaccinator/ retired ANMs and Medical officer .hiring vehicle for fixed day out reach camps with drugs. Fixed day OPD clinics at APHC level and adjoining HSC of respective APHCs. with dedicated MO and support staff. 3. To make calendar for camps with date and identified areas. Community based reporting system through SMS. involve PRI members and training on reporting and Camp approach.
Monthly Village Health and Nutrition Days	
Gaps	1Fixed day AN clinic not conducted at any level - Early 2.registration is not done of pregnant women during “Muskan Ek Abhiyan”.
Strategie	Immunization Day could be use as VHND Community based monitoring
Activity	1. AWC should be develop Hub of activities (VHND) 2. Develop an activity plan calendar for VHND as seasonality. 4. Registration, Immunization, ANC, weighing of PW and Children, Feeding of PW, Demonstration of food preparation, health &sanitation practices etc. 6. Soft ware activity- Counseling of mothers on ANC, preparation for delivery, PNC, child care ,STI/RTI, and AYUSH, adolescent Health 7. Meeting of VHSC and preparation for area specific epidemiological planning and community based monitoring. 8. Skill development training is required to ANM , ASHA & AWW and Dular (LRG) Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourish children ,New born, DOTs and other services SMS reporting system of conducting VHND and ANM collect Data from field level and compile it in weekly/Monthly meeting. Fixed day AN clinic at APHC/RH/SDH/DH 9- EDD date of Pregnant women should be recorded by ASHA/ ANM for compulsory three

	ANC checkups and institutional delivery. Training of AHSA on identification of danger sign of obstetric complications, post partum family planning /sterilization
Janani Suraksha Yojana / JSY	
Gaps	1- Tracking of pregnant women from first Trimester is not done form the register. 2- Pregnancy Test Kit is not adequately available. 4- To much documentation process.
Activity	1- Review of early registration with 3 AN checkup ,two TT.100/200 IFA Tab. in ASHA Diwas. 2- Incentive of ASHA should be linked with above activity @ Rs 50 per AN mother for ASHA. 2- Direct transfer of funds from district to PHC through core banking 4. Home Delivery should be conducted by SBA trained Staff Nurse or ANM. 5. "MAMTA" should be appointed at PHC level like Sadar Hospital. Make APHC as 24x7 with three Para medical workers.
Home Deliveries	
Gaps	1.Home Delivery is still prevailing through untrained traditional Dai's 2. Reporting of home delivery is not done so the PNC is not provided
Activity	1. Provision of Dai Delivery kit(DDK) to TBA where institution access is poor. And it should be supervised by ANM for home deliveries. 2. Delivery kit (equipment, medicine)for ANM should be supplied 3. Number of delivery Kits as per number of deliveries conducted in home. Reporting of home delivery is responsibility of ASHA and she should report to ANM and
Institutional Deliveries	
Gaps	1. C- Section deliveries are not conducted in institution. 2. infection control protocols is not at all maintain at all facilities 3. Welcome PW at Institution and PHC level. 4. Reporting of maternal death Maternal death reporting is usually not reported by worker . 5. Biomedical waste management is not properly taken care off at all institution 6. Complicated delivery cases are not being attained at any facilities. 7. Needy PW should be provided free blood and medicine. 8. Importance of Maternal death reporting
Strategie	Strengthen C- section services with infection control protocol in phases wise manner in district. Strengthen Record keeping Grading institution as per women and child friendly services at facilities. provide free of cost Blood for pregnant women who need blood transfusion for severe anemia / PPH Strengthening MMR reporting through ASHA
Activity	MIS for HR Mapiing of specialists/ multiskilled MOs Training load assessment A.1 EMOC for labour room. A.2 Specialist should be posted at Sadar Hospital/PHC. A.3 Incentive for c-section. A.4 Trained personnel at O.T level. A.5 Need based Equipments and drugs in O.T and Labour room. A.8. Incentives may be considered for the nurses / ANMs for the deliveries beyond a fixed number.

	Procurement of blood bank equipments, Licensing blood storage / blood bank Meeting infrastructure requirements as per norms Training of MO and lab tech/ staff nurse blood storage grouping /cross matching and management of transfusion reactions stabilized linkages with mother blood bank. Planning across the district to operationalize FRUs A.9 Blood Transfusion facility should be started. A.10 Functional Lab Facilities at c-section level. A.16 Direction can be issued from SHS to provide free of cost Blood for pregnant women who need blood transfusion for severe anemia/ PPH on prescribed through RKS Fund Procurement of equipment As per example Introduce color coded buckets for facilities as per IMEP established common treatment plant for safe disposal of biomedical waste Training of staff Monitoring of biomedical waste management develop protocol of monitoring Procurement of equipment As per example Introduce color coded buckets for facilities as per IMEP established common treatment plant for safe disposal of biomedical waste Training of staff Monitoring of biomedical waste management develop protocol of monitoring Procurement of equipment As per example Introduce color coded buckets for facilities as per IMEP established common treatment plant for safe disposal of biomedical waste Training of staff Monitoring of biomedical waste management develop protocol of monitoring Procurement of equipment As per example Introduce color coded buckets for facilities as per IMEP established common treatment plant for safe disposal of biomedical waste Training of staff Monitoring of biomedical waste management develop protocol of monitoring Organize Blood camp at all institution and mobilize community for voluntary blood donation A.11 Provision of food for the delivered mothers and mothers under gone in tubectomy in all the health facilities. A.12 Mobilize community Resources for providing Free food for PW at Institution. A.14 Strengthen first ten facility as per facility survey of institution for the women and child friendly . 1.Training of ASHA & ANM on reporting of Maternal deaths and conduct Verbal Autopsy 2.Incentives for maternal death reporting by ASHA @ Rs 50/-per maternal death 3. Reporting line should be in five columns – name of mother, place of death, date of death,

	cause of death and no. of birth. Institution and urban center also to report Maternal death to the district CS/CMO. 4. Maternal Death should be reported by ASHA AWW, ANM Staff Nurse & Doctors to the district data center . Investigation of maternal death by district team. and third party review(District magistrate) training of ASHA and investigation team objective and process of investigation and review of maternal death .
Adolescent Heath	
Reproductive and sexual health	
Gaps	1. No training programme for adolescent particularly health and sex. 2. Preventions of anemia younger's. 3. Marriage before legal age. 4. Preventions of teen age pregnancy and abortion. 6. Preventions of addiction in boys. 7. Limited interventions for empowering adolescent girls 8. AWCs are not equipped to promote activities for girl empowerment
Activity	Multipurpose counselor can be used for adolescent care. Adolescent pregnancy should be addressed with priority care(eclampsia, 3 ANC, anemia, 100 IFA, 100% institution delivery, low birth Wight baby, Brest feeding.PNC with in 48 hours. Family counseling for adolescent pregnancy tracking on above mention through ASHA and AWW. State to develop and issue guidelines for implementation of Kishori MandalsFormation of Kishori Mandals by registration of all girls (11-18 yrs) Prepare a monthly plan of activities for one dayper week 1. Counseling nutrition, health and social issues every week at AWCs 2. Weekly distribution of IFA Tablets to out-of-school girls at AWCs 3. Distribution of Deworming tablets every 6 months 4. Arrange and facilitate training on income generation skills and Family life education Initiate family schools for learning child care , safe mother hood life skills and Family life education 1. Initiate family life education through special training 2. Income generation skills and support for marketing outlet 3. Adolescent girls kit-sanitary napkins to be included in medical kit that is made available at the AWC 4. Kishori Mandals to be involved in community level events and train them as Master trainer to support AWC services Provision of minimum supply and storage place in AWCs
Child Health	
IMNCI	
Gaps	1.Inadequate monitoring of this activity at field level 2. 75% of doctors and majority of ANM & Staff Nurse not trained. 3.No ASHA is trained on IMNCI 3. Non availability of "MAMTA" at PHC level. 4 .Not Recognizing early sign and symptoms of illness of new born babies. 5. Neonatal Care Unit not up to mark.

	7. Early breast feeding not encouraged. Monitoring Training Drugs availability PNC Referral 8. NSU and SNCU
Strategie	Monitoring through Supervisors Capacity building of front line workers on case management skill Strengthening of overall health system for effective management of IMNCI. Awareness generation among mothers, families and community on IMNCI issue.
Activity	1 Tearing load Incorporate ASHA in training team 2 Monitoring system 3. community based monitoring system through LRG ASHA kit regular supply. 1.Incentives for supervisors 2. Care of babies by "MAMTA" and ANM. 3. Encouraging mother regarding child care. 4. Frequent checkup of babies by Pediatrician. 5.fixing a day in a week for IMNCI related work at HSC level 6.Training to ANMs/doctors on operating baby warmer machines
Facility Based Newborn Care/FBNC	
Gaps	1.No PHC has baby warmer machines. 2. .ANMs and Doctors are not trained to operate these machines There is no provision of stay of mothers of neonates at PHC.he mothers neonates Capacity building Space and equipments
Strategie	Strengthening of NSU at PHC level and SNCU at district level. Counseling of mothers at institution.
Activity	1. All PHC and Referral should be equipped baby warmer machines. 2. Training of Doctors and ANM to operate baby warmer machine. 3. Provide new born care equipments for PHCs, referrals and district hospital with new born ward. 4. Organize training programme for newborn care for the nurses in the district hospitals.
Home Based Newborn Care/HBNC	Under IMNCI program home based new born care is also addressed.
School Health Programme	
Gaps	1. No Pre School Health checkup & complete Immunization card. 2. No training of school teacher for basic health care and personnel hygiene. 3. No regular health checkup camp at school. 4. No Training & Screening of school's teacher for eye sight test. 5. No other specific program has been formulated in the district.
Strategie	Coordination Non priority Strengthening of block level coordination committee,

	Designing visible plans to start work with schools.
Activity	1. Half yearly health checkup camp for children in schools should be organized. 2. Training of school teacher by the medical personnel with support administrative person. 3. Quarterly meetings of VEC representatives. School health anemia control programme should be strengthen with bi annually de worming . 4. Organizing competitions/Debates/Painting competitions/Essay/demonstration and model preparation of nutritional food and health. 5. Half yearly Health checkups and health card of all school going children. 6. Films shows on health, sanitation and nutrition issues 7. Social Lab activities. 8. Rally and Prabhat Phery in epidemic areas. (Kala-azar & Malaria) Referral system for the school children for higher medical care.
Infant and Young Child Feeding/IYCF	
Gaps	Non awareness of breast feeding and proper diet of young children. Poor knowledge regarding new born care and child feeding practices. Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding. Lack of awareness on importance of appropriate and timely IYCF
Strategie	Training of Health and ICDS
Activity	Colostrum feeding and breast feeding inclusively for six months. Through IMNCI program. Baby friendly hospital Accreditation of nursing home and facility according to norms of baby friendly hospital. 1. Development of BCC activities 2. IEC material developed for LRP 3. Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA 4. Linking JBSY with colostrums feeding Maternal benefit scheme to provide incentive to mothers during pregnancy, for 3 ANCs, TT immunization and CF and BF. Counselling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries Folk performance to promote exclusive breast feeding Uniform message on radio from state head quarter 1. Organize social events ▪ Strengthening of Mahila Mandal meetings- fortnightly with involvement of adolescent girl ▪ Organize healthy baby shows, healthy mother / pregnant woman. ▪ Appreciation and reorganization of positive practices in community. ▪ Celebration of “Annaprashan Day” at AWC Demonstration of recipes.
Care of Sick Children and Severe Malnutrition	
Activity	Establish nutrition rehabilitation center in district hospital, FRU and one PHC .
Management of diarrhea, ARI and Micronutrient	

Malnutrition	
Activity	Procurement of ORS with Zinc , Bi annual Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup. And fortified micronutrient supplementation for 6m to 2 years children in shattu at AWC. 2. Provision of three eggs to all pre school children at least one per week through AWC.
Other strategies/activities	
Activity	1. Involvement of ICDS, school teachers and PRI for mentoring an evolution.
FAMILY PLANNING	
Terminal/Limiting Methods	
Goal	Lack of knowledge of small family norms.
Activity	Ensure one MO trained on on minilep and NSV up to PHC Training of nurses and ANMs on IUD and other spacing methods Ensure availability of contra septic (indenting , logistic management) .
Dissemination of manuals on sterilization standards & quality assurance of sterilization services	
Activity	Quality assurance committee formed and regular meeting been held as per GOI guide line . Translation of GOI guideline IN Hindi. Printing of Guide line.
Female Sterilization camps	
Gaps	Laparoscopy surgery not done.
Activity	Trained doctors on laparoscopy. Procure Laparoscopy equipments for trained docters.
NSV camps	
Gaps	Trained doctors are not available.
Activity	Training of doctors needed. Procurement of equipment.
Compensation for female sterilization	
Activity	Immediate disbarment of incentive after sterilization camps. Logistic planning is needed before organizing camps. Block Health manager could be hire one support staff for disbursement for logistic support.
Compensation for male sterilization	Immediate disbarment of incentive after sterilization camps. Logistic planning is needed before organizing camps. Block Health manager could be hire one support staff for disbursement for logistic support.
Activity	Immediate disbarment of incentive after sterilization camps. Logistic planning is needed before organizing camps. Block Health manager could be hire one support staff for disbursement for logistic support.
Accreditation of private providers	

for sterilization services	
Gaps	No Accreditation of private nursing home.
Activity	Accreditation of private nursing home. As per GOB guide line.
Spacing Methods	
IUD camps	
Gaps	Camps not held.
Activity	Training of ANM & staff nurse for IUD insertion. Procurement of IUD. Equipments for IUD insertion.
IUD services at health facilities	
Accreditation of private providers for IUD insertion services	
Gaps	No accreditation of private providers for IUD insertion services.
Activity	Accreditation of private providers for IUD insertion services. As per GOI guide lines.
Social Marketing of contraceptives	
Activity	Social marketing of need based OC & IUD. Increasing access to contraceptive through communities based distribution system free of cost.
Contraceptive Update seminars	
Gaps	Not being held.
Activity	seminars for MO and other through Professional bodies (FOGSI. BMA, Nursing association etc..on Copper-t 380-A should be popularized. Awareness for emergency contraceptive.
Other strategies/activities	
INNOVATIONS/ PPP/ NGO	
PNDT and Sex Ratio	
Gaps	No registration of ultra sound clinic.
Activity	Registration and monitoring of ultra sound clinic. MTP clinic should be watched for termination of pregnancy following USG. IEC on PNDT act.
Public Private Partnerships	
Activity	District /PHC level managers should be aware about the TOR of PPP which is finalized at State level. Build the capacity of manager to manage contracts of PPP Reimbursement of service charges of BPL family from RKS.
NGO	

Programme Gaps	Non involvement of NGO in F.P programme, Institutional delivery, Blindness control programme.
Activity	Networking with all NGOs working in the district. for strengthening communalization process of Health in the dis Devlop directory of all NGOs ASHA Programme manager could be facilitated Networking with NGOs. Capacity building training programme for NGOs office bearer with the help of professionals on system straignthening .component. Mentoring Group at district level. Participatory Reporting mechanism should be develop of NGOs work in the district. Co-ordination with community based orgnisation as SHG, LRG, VEC, VHSC,PRI etc.
Other innovations (if any)	
INSTITUTIONAL STRENGTHENING	
Human Resources Development	
Activity	Expose visit of DPM/BHM /ASHA and to other state where facility is comparatively working better. Action 1 can be copied.
Logistics management/ improvement	
Activity	Indenting of medicine through form 6 should be strengthening and training of ANM on indenting process. Drugs chapter on HSC pest Need based procurement and distribution of ANM Kit through Form 6. Decentralization of Medicine purchasing at the PHC as per Central purchasing committee list.
Monitoring & Evaluation / HMIS	
Activity	Training of District and PHC level Mangers on New HMIS formate. Translation of HMIS formate in Hindi All Pursing formate should be linked with line formate. As muskan reporting format data should be linked with HIMS format and review of HSC and PHC based on HIMS format Monthly meeting of MOIC and BHM should be conducted on the basis of HIMS format and Power point presentation is mandatory in meeting. HIMS data could be validated by BHM on four indicator (accessibility, availability, coverage, adequate coverage, effective coverage.) Training of BHM on Validation component. and use data for decision making .
Behaviour change communications/IEC	

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

Timeline

Activity	**2011-2012**
Strengthening of the Fixed MCHN days	x
Developing the PHCs for EmOC	All PHCs
Blood Storage Units	PHCs&APHCs
Developing Delivery huts	40
Developing MTP centres	All PHCs
JSY beneficiaries	3000
Promoting Medical Abortion	All PHCs
RCH Camps	At all PHCs/APHCs

Budget

Activity / Item	**2011-12**
Consultancy for support for developing Microplan for MCHN days	20000
Adult Weighing machines @ Rs 1500 per machine x 772 AWCs & Maintenance	1158000
31 Delivery Huts @ Rs 62500 /hut	1937500
Recurring cost of 31 Delivery Huts @ Rs 136250 per year	4223750
Blood Storage Unit @ Rs 3.5 lakhs per unit	350000

	Referral Cards @ Rs 5 per card x 20,000	100000
	MTP kits @ Rs 18750 Per kit at GH & PHCs/APHCs	1312500
	JSY beneficiaries @ Rs 2000/person X 137052	274104000
	RCH Camps @ Rs 250000 per camp x 7	1750000
	Hiring of vehicle for referral at every PHC@15000x 12monthx20	3600000
	Total	**288555750**

Recurring Costs per Delivery Hut for one year

S.No	Head	Unit	Unit Cost	Amount
1.	O.C	1 year	43500	43500
2.	Material and supply	1 year	62500	62500
3.	Motor Vehicles	12 mths	1875	22500
4.	Honorarium for TBA	12 mths	625	7500
	Total			**136000**

A-2. NEWBORN & CHILD HEALTH

Situation Analysis/ Current Status

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

* CS Office

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

Childhood illnesses

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

Pneumonia: The District data shows that 19.13 % of children suffered from Pneumonia. There is a need to create awareness regarding the danger signs of Pneumonia since only half of the women are aware of danger signs of pneumonia as per DLHS 2002.

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

School Health: In district there are 540 schools and 56596 students enrolled there. Up to Nov. 2008 358 school were visited and 34660 students were examined by the health staff. 5206 students were found ailing mainly with anemia, defective vision, poor orodental hygiene and skin disease.

Objectives

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

	7. To strengthen school health services.
Strategies	1. Improving feeding practices for the infants and children including breast feeding 2. Promotion of health seeking behaviour for sick children 3. Community based management of Childhood illnesses 4. Improving newborn care at the household level and availability of Newborn services in all PHCs & hospitals 5. Enhancing the coverage of Immunization 6. Zero Polio cases and quality surveillance for Polio cases 7. Preaperation of operational plan and guidelines for School Health. 8. Regular Monitoring and supervision. 9. Monitoring through Supervisors 10. Capacity building of front line workers on case management skill 11. Strengthening of overall health system for effective management of IMNCI. 12. Awareness generation among mothers, families and community on IMNCI issue.
Activities	**1.** Improving feeding practices for the infants and children including breast feeding • Education of the families for provision of proper food and weaning • Educate the mothers on early and exclusive breast feeding and also giving Colostrum • Introduction of semi-solids and solids at 6 months age with frequent feeding • Administration of Micronutrients – Vitamin A as part of Routine immunization, IFA and Vitamin A to the children who are anaemic and malnourished • Growth Monitoring by ANM/AWW and Health Staff for early detection of Malnutrition. **2.** Promotion of health seeking behaviour for sick children and Community based management of Childhood illnesses • Training of LHV, AWW and ANM on IMNCI including referral • BCC activities by ASHA, AWW and ANM regarding the use of ORS and increased intake of fluids and the type of food to be given • Availability of ORS through ORS depots with ASHA • Identification of the nearest referral centre and also Transport arrangements for emergencies with the PRIs and community leaders with display of the referral centre and relevant telephone numbers in a prominent place in the village **3.** Improving newborn care at the household level

- Adaptation of the home based care package of services and scheduling of visits of all neonates by ASHA/AWW/ANM on the 1st, 2nd, 7th, 14th and 28th day of birth.
- In case of suspicion of sickness the ASHA /AWW must inform the ANM and the ANM must visit the Neonate
- Referral of the Neonate in case of any symptoms of infection, fever and hypothermia, dehydration, diarrhoea etc;
- Supply of medicine kit and diagnosis and treatment protocols (chart booklets) for implementation of the IMNCI strategy
- Strengthening the neonatal services and Child care services in General hospital Narnaul, General hospital East Champaran and all PHCs : This will be done in phases
- In all of these units, newborn corners would be established and staff trained in management of sick newborns and immediate management of newborns.
- The equipment required for establishing a newborn corner would include Newborn Resuscitation trolley, Ambubag and masks (newborn sizes), Laryngoscopes, Phototherapy units, Room warmers, Inverters for power back-up, Centralized oxygen and Pedal suctions
- Training of staff in Newborn Care, IMNCI and IMCI (MOs, Nurses, ANM, AWW, ASHA) including the management of sick children and severely malnourished children.
- Availability of Paediatricians in all the General hospitals and PHCs
- Ensuring adequate and free supply of drugs for management of Childhood illnesses.

4. Strengthening the Fixed Maternal and Child health days (Also discussed in the component on Maternal Health)

- Developing a Microplan in joint consultation with AWW
- Organize Mother and Child protection sessions twice a week to cover each village and hamlet at least once a month
- Tracking of Left-outs and dropouts by ASHA, AWW and contacting them a day before the session
- Information of the dropouts to be given by ANM to AWW and ASHA to ensure their attendance
- Wide publicity regarding the MCHN days

5. Strengthening Immunization (Discussed in Component C)

6. School Health Programme

- Preparation and dissemination of guidelines for School Health
- Monthly visit by Deputy Civil Surgeon (School Health).
- Coordinatiion and covergence with education department.
- Training to School Teachers on Health Activities.

7 . Tearing load
8. Incorporate ASHA in training team
9. Monitoring system
10. community based monitoring system through LRG
ASHA kit regular supply.
a. Incentives for supervisors
b. Care of babies by "MAMTA" and ANM.
c. Encouraging mother regarding child care.
d. Frequent checkup of babies by Pediatrician.
e. Fixing a day in a week for IMNCI related work at HSC level
f. Training to ANMs/doctors on operating baby warmer machines

Support required

1. Availability of trained staff including Paediatricians
2. Technical Support for training of the personnel
3. Timely availability of vaccines, drugs and equipment
4. Good cooperation with the ICDS, Edu. Deptt. and PRIs
5.

Timeline

S.No	Activity	2011-12
1.	Health Education of the families and the mothers on breast feeding, weaning and good practices, ORS by the ASHA/ANM/AWW	**x**
2.	Identification of the malnourished children	**x**
3.	Administration of Micronutrients – Vitamin A, IFA	**x**
4.	Availability of ORS at ORS depots with ASHA	**x**
5.	Identification of the nearest referral centre with yearly updation	**x**
6.	Transport arrangements for emergencies by the PRIs and community leaders	**x**
7.	Display of the referral centres and relevant telephone numbers in a prominent place	**x**
8.	Training on IMNCI & IMCI of ASHA/AWW/ANM/MO/LHV on the home based Care package	**x**
9.	Supply of medicine kit & diagnosis and treatment protocols (chart booklets) for the IMNCI strategy	**x**
10.	Development of Referral system & referral cards	**x**
11.	Establishing Newborn Corner in hospitals and PHCs with equipment medicines and supplies and also Malnutrition Corners	20PHCs

	12.	Equipment and drugs for management of Childhood illnesses	**x**
	13.	Provision of Large Invertor	All PHC/PHC
	14.	Preparation and dissemination of School Health Plan	
	15.	Monitoring and supervision of School Health Activities by Deputy Civil Surgeon (School Health)	
	16.	Training to School Teachers	1000

Budget	**Activity / Item**	**2011-12**
	Newborn Corner furnished with equipment @ Rs 250000 lakh per facility	250000
	Provision of Invertor @ 31250 x 23	718750
	Examination table, chair, stool, table, other equipment @ Rs. 6250 x 772AWCs	4825000
	Infant Weighing Machines@Rs. 1500/AWCx 772	1158000
	Referral cards @ Rs 5 x 25000	125000
	Free availability of medicines	1000000
	Monitoring of School Health Activities @ 12500 pm x 12 months	150000
	Training of Teachers @ 250 x 1000 teachers	250000
	Supply of Medicines, glasses, hearing aids	500000
	Total	**8976750**
	Training on IMNCI and IMCI of LHV/ASHA/AWW/ANM/MOs on the home based Care package and management at facilities	Component on training
	Supply of Diagnosis and treatment protocols (chart booklets) for IMNCI & IMCI strategy	
	Supply of medicine kit for IMNCI	State

4.3.1.2 Child Health and Immunization

Data is not available of infants delivered weighed below 2.5 kg. Poor outcomes in the child health due to the following reasons:

- Workers not following the 8/8 quality ante-natal care norms
- Poor nutritional habits
- Early marriages
- Illiteracy among rural masses esp. tribals
- Poverty
- Less no. of institutional deliveries

Table 4.2: Child health indicators

A. Percentage of women who started breastfeeding immediately/within 2 hours of the birth to their children	36.3
B. Percentage of women who gave exclusive breast milk for at least 4 months to their children	57.3
(i) BCG	72.6
(ii) DPT (Three injections)	52.2
(iii) Polio (Three doses)	52.0
(iv) Measles	44.7
(v) Complete immunizations (BCG + 3 DPT + 3 Polio + measles)	36.2

The block wise immunization performance within the district seems to be satisfactory. But when this data is compared with the external data like that of SRS there seems to be large variance. Possible reason for this can be that the internal data is taken out of vaccine utilization whereas the external data represents the actual service delivery.

Constraints for poor quality of immunization:

- Unavailability of vaccines on time
- Lack of staff
- Far-away sub-centres and improper transportation
- Illiteracy

Suggestions for improving the quality of immunization:

- Vacant staff positions should be filled-in
- At least two months stock of all the vaccines at CHC level
- Proper transportation facilities
- Maximum IEC coverage so that people should know about the date and venue of immunization

4.3.1.3 Family Planning

In all the blocks of districtEast Champaranthe achievement with respect to target in case of Family Welfare is quite satisfactory.

<table>
<tr><th colspan="2">A-3. FAMILY PLANNING</th></tr>
<tr><td>Situation Analysis/ Current Status</td><td>
<table>
<tr><th>Indicators</th><th>No. or Rate</th></tr>
<tr><td>Eligible Couple</td><td>277996</td></tr>
<tr><td>Couple Protection Rate</td><td></td></tr>
<tr><td>Female Sterilization operations in 2009-10</td><td>9226</td></tr>
<tr><td>Vasectomies in 209-10</td><td></td></tr>
<tr><td>Couples using temporary method in 2009-10</td><td></td></tr>
</table>
The awareness regarding contraceptive methods is high except for the emergency contraception. This is because of inadequate IEC carried out for Emergency Contraception
Currently 27274 couples are using temporary methods of contraception and 2631 have permanant sterlization (mainly Female sterilization). In temporary methods commonest use is of Condom, which has a high failure rate. Use of Copper –T is low. The community prefers female sterilization since there is gender imbalance and limited male involvement. Women also do not have decision-making power.
The reasons for the low use of permanent methods and Copper -T are due to inadequate motivation of the clients, inadequate manpower, limited skills of the ANMs for IUD insertion and also their irregular availability. The rejection rate is high since proper screening is not done before prescribing any spacing method.
Copper T-380 – 10 year Copper T has been recently introduced but there is very little awareness regarding its availability. There is a need to promote this 10 yr Copper T
Some socio-cultural groups have low acceptance for Family Planning.
Promotion efforts for Vasectomy have been very infrequent and only 222 men have undergone Vasectomy.
The current number of trained providers for sterilization services is insufficient.</td></tr>
<tr><td>Objectives</td><td>1. Reduction in Total fertility Rate from 2.5 to 2.4
2. Increase in Contraceptive Prevalence Rate to 70 %
3. Decrease in the Unmet need for modern Family Planning methods to 0%
4. Increase in the awareness levels of Emergency Contraception from 60% to 80%</td></tr>
<tr><td>Strategies</td><td>1. Training of MOs in NSV & Female Sterlization.
2. Availability of all methods and equipments at all places
3. Increasing access to terminal methods of Family Planning
4. Promotion of NSV</td></tr>
</table>

	5. Increased awareness for Emergency Contraception and 10 yr Copper T 6. Decreasing the Unmet Need for Family Planning 7. Expanding the range of Providers 8. Increasing Access to Emergency Contraception and spacing methods through Social marketing & Training of ANMs for IUD Insertions. 9. IEC/BCC activities for Family Planning Methods.
Activities	1. Each PHC and PHC will have one MO trained in any sterilization method. • All the PHC/PHC will have at least one MO posted who can be trained for abdominal Tubectomy. This method does not require a postgraduate degree or expensive equipment. • Similarly MOs will be trained for NSV • Specialists from District hospitals and PHCs will be trained in Laparoscopic Tubal Ligation. • At PHCs, one medical officer will be trained in NSV • Each PHC will be a static center for the provision of sterilization services on regular basis. The Static centers will be developed as pleasant places, clean, good ambience with TV, music, good waiting space and clean beds and toilets. 2. About 4 -7 PHCs come under the catchments area of PHCs and the camps will be organized on fixed days in each of the PHCs. • Equipments and supplies will be provided at PHCs and PHCs for conducting sterilization services. • A systemic effort will be made to assess the needs of all facilities, including staff in position and their training needs, the availability of electricity and water, Operation theatre facilities for District hospitals/PHCs/PHCs, Inventory of equipment, consumables and waste disposal facilities and the condition, location and ownership of the building. • At least three functional Laparoscopes will be made available per team, as will the equipment and training necessary to provide IUD and emergency contraception services. The existing Laparoscopes need to be replaced. For effective coverage 4 teams are required with minimum three Laparoscopes for each team. 3. Training in Spacing methods, Emergency Contraceptives and interpersonal communication for dissemination of information related to the contraceptives in an effective manner. • Supply of Emergency Contraceptives to all facilities

- Access for the quality IUD insertion improved at all the 117 subcentres.
- All the ANMs at 117 subcentres will be given a practical hands on training on insertion of IUD
- IUD 380-A will be used due to its long retention period and can be used as an alternative for sterilization.

4. IEC/BCC

- Awareness on the various methods of contraception for making informed choices
- Discussed in the Component on IEC
- Increasing male involvement in family planning through use of condoms for safe sex and also in Vasectomy.
- BCC activities to focus on men for Vasectomy.

5. Inter Sectoral convergance

- A detailed action plan will be produced in co-ordination with the ICDS department for involvement of the AWWs and their role in increasing access to contraceptive services.
- Staff of ISM department will be trained in communication and non-clinical methods to promote and increase the availability of FP methods.
- Engaging the private sector and provide incentives and training to encourage them to provide quality family planning services
- Training private lady doctors in IUD insertion and promoting the provider will help to expand coverage of these services increase the total use of IUCD.
- Training for the private sector will be provided as above, and approved, monitored providers will be promoted and eligible for discounted supplies.
- Accreditation of private hospitals and clinics for sterilization and NSV
- Creating an enabling environment for increasing acceptance of contraceptive services Innovative schemes will be developed for reaching out to younger men, women, newly married couples and resistant communities.

6. Role of ASHAs:

- Training for provide counselling and services for non-clinical FP methods such as pills, condoms and others.
- Act as depot holders for the supplies of pills and condoms by the ANMs for free distribution
- Procurement of pills and condoms from social marketing agencies and

	provide these contraceptives at the subsidized rate • Provide referral services for methods available at medical facilities Assist in community mobilization and sensitisation. 7. Formation of District implementation team consisting of DC, CS, District MEIO, Distt NSV trainer • One day Workshop with elected representatives, Media, NGOs, departments for sensitisation and implementation strategy, fixing pre-camp, camp and post-camp responsibilities • Development of a Microplan in one day Block level workshops • NSV camp every quarter in all hospitals initially and then PHCs and PHCs • IEC for NSV • Trained personnel • Follow-up after NSV camp on fixed days after a week and after 3 months for Semen analysis • Access to non-clinical contraceptives increased in all the villages • AWWs and ASHAs as Depot holders 8. Ensure one MO trained on on minilep and NSV up to PHC Training of nurses and ANMs on IUD and other spacing methods Ensure availability of contra septic (indenting , logistic management) .
Support required	• Availability of a team of master trainers/ANM tutors and RFPTC trainers for follow up of trained LHVs and ANMs after one month and six months of training and provide supportive feedback to the service providers • A training cell will be created in the medical college for the training of the medical officers in the area of various sterilization methods • Availability of equipment, supplies and personnel

Timeline		2011-12
	Training of MOs for NSV	10 MOs
	Training of MOs for Minilap	5 MOs
	Training of Specialists for Laparoscopic Sterilization	3 MOs
	Development of Static Centre at General hospital	GH NNL, PHC M/Garh
	Sterilization Camps (Persons)	5000
	NSV Camps	24
	Accreditation of private institutions for sterilization	10
	Supply of Copper T – 380	5000
	Emergency Contraception	3000
Budget	**Activity / Item**	**2011-12**
	NSV camps @ Rs. 292275 per 2 camps x 12	3507300
	Sterilization Camps @ 1000 & 650 for 5000 cases	8250000
	Copper T-380 @ Rs 65 / piece x 5000	325000
	Emergency Contraception @ Rs15/2 tabs x5000	75000
	Development Static Centres@Rs 2 lakh	250000
	NSV Equipment @ Rs 1000 x 5 GH & 20PHCs	25000
	Laparoscopes @ Rs 350000	350000
	Total	**12782300**

Detailed Calculations

Calculations per Case of NSV

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

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

S.No	Head	Unit	Unit Cost	Amount
1.	District Workshop	1	9375	9375
2.	Block workshops	1	9375	9375
3.	IEC activities @ 5000 per camps/PHC	1	5000	100000
4.	TA to Acceptor for Semen Analysis	60	75	4500
5.	Payment to NSV Advocate/motivator, Drugs & Dressings	60	2000	120000
	Total			**243250**

Budget for IEC activities for NSV per camps

S.No	Head	Unit	Unit Cost	Amount
1.	Hand Bills	100000	.50	50000
2.	NSV booklets	10000	3.00	30000
3.	Banners	250	75	18750
4.	Posters	10000	5	50000
5.	DA for Driver & 2 persons	36 Mandays	100	7200
6.	Electronic Media Publicity for 15 days			5000
7.	Wall writing & publicity			1875
8.	Other Innovative activities			12500
9.	**Total**			**175325**

Budget for Vasectomy sterilization per case

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

Budget for sterilization camps benefiting 5000 cases

S.No	Head	Unit	Unit Cost	Amount
1.	Per Case BPL @ Rs 1000	500	1000	500000
2.	Per Case Non-BPL @ Rs 650	4500	650	2925000
3.	IEC activities			125000
4.	Other activities and Office Expenses			375000
	Total			**3925000**

A-4. ADOLESCENT HEALTH	
Situation Analysis	The adolescents are very vulnerable since out of 4227 girls married last year 47 were married before the age of 18 years. The awareness levels for various issues of RCH are low. As per DLHS 2002, 42.5% girls got married before the age of 18 years and had one child before the specified 19 years. It has been observed that the adolescents especially the boys are exposed to smoking, addictions, and peer pressure and there is no one to counsel them. Alcoholism and drug addiction is becoming a major problem and there is no de-addiction centre There is no intervention with the boys. NYK has done some awareness generation exercises with the out-of-school adolescents. No efforts have been made for any counselling of the adolescents. There is hence a great lacuna in the knowledge of the Adolescents. Data regarding the perceptions and practices of girls and boys is lacking especially in the context of rural setting, urbanized villages and urban slums. Lack of awareness regarding AIDS/HIV among the adults.
Objectives	1. Increase the knowledge levels of Adolescents on RH and HIV/AIDS 2. Enhance the access of RH services to all the Adolescents 3. Improvement in the levels of Anaemia to 50% by 2012
Strategies	1. Awareness amongst all the adolescents regarding Reproductive health and HIV/AIDS. 2. Provision of Adolescent Friendly Health & counselling services
Activities	The Adolescent Health package will consist of the following activities: 1. Formation of District Partnership for Adolescent Health (DPAH) consisting of representatives of: Health department, Education department, Social Welfare department, ICDS, NGOs, PRIs, National Service Volunteers, Nehru Yuva Kendra Sangathan, other youth organizations, local chapters of Indian Academy of Paediatrics and other stakeholder groups. 2. Workshop to develop an understanding regarding the Adolescent health and to finalize the operational Plan 3. Provision of Adolescent friendly health services at PHCs, PHCs, FRUs and district hospitals in a phased manner. Training of the MOs, ANMs on the needs of this group, vulnerabilities and how to make the services Adolescent friendly. 4. Adolescent Health Clinics will be conducted at least twice in a month by the MO to provide Clinical services**,** Nutrition advice, Detection and treatment of anaemia, Easy and confidential access to medical termination of pregnancy, Antenatal care and advice regarding child birth, RTIs/STIs detection and treatment, HIV detection and

	counselling, Treatment of psychosomatic problems, De-addiction and other health concerns 5. Awareness building amongst the PRIs, Women's groups, ASHA, AWWs 6. Provision of IFA tablets to all Adolescents, deworming every 6 months, Vitamin A administration and Inj TT. 7. Carrying out the services at the fixed MCHN days. 8. Involvement of NGOs for Environment building. One NGO per Block will be selected. NGO will select the counsellor in the villages.

PART B: New NRHM initiatives

Budget	**Activity**	**2011-12**
	Awareness generation @ Rs 2500 per village	3362500
	Workshop of all the partners	100000
	Training a district pool of Master trainers	100000
	Training of Councellors at every PHC @ 10000/batch x 25	250000
	Orientation & Reorientation Health personnel	50000
	Counselling sessions @ Rs 1250/per month/per PHC/PHC	25000
	Counselling Clinics renovation, furnishing and Misc expenses @ Rs 12500 x all PHCs/APHCs	862500
	Joint Evaluation by an agency & Govt	100000
	Total	**4850000**

4.3.2 Health Infrastructural Indicators

The performance with respect to certain key activities under NRHM shows that infrastructure related issues needs to be sorted out to ensure a successful implementation of plan. Next section details out probable strategies and activities:

Suggested Strategies and Activities:

Two female MPWs in each sub centre: Sub centers may plan for two MPWs, preferably both women. The job description and workload of the MPW (F) needs to be lessened and made realistic. Along with this, workload rationalization would be achieved by equal sharing of the work between the two persons posted at the sub centre. In the first stage this achieved by redefining of the male MPWs work to be identical with the female MPWs. Except or institutionalization delivery and IUCD insertion, every task currently done by women can be done by men also. And in the second stage by ensuring that the second person in the HSC is also a female MPW i.e. converting the male MPW post to a female MPW post. In effect this would mean that the population per MPW- female norm currently at 1 : 5000

Multi skilling all PHC paramedical: The PHC staffing pattern needs restricting to ensure utilization of manpower and better functioning of the facility. PHCs may plan for having two or three male multi-skilled employees with a male multi-skilled supervisor and three female multi-skilled workers (including the section incorporated in the sector) and a female multi-skilled supervisor. There would also be one medical officer in every PHC (preferably two). These multi-skilled workers must be skilled in dressing, drug dispensation (the compounder's) and first contact curative care and in basic laboratory package as well as in RCH. Between them they should be able to keep the PHC functional for 24 hours, provide institutional delivery and the other services as proposed in the service delivery norms. Though the immediate step is only multi-skilling and revising job descriptions, cadre restricting may follow this. In this process of transition no one has to be dropped unless they are unwilling for multi-skilling. New recruitments would be into the multi-skilled category and many existing cadre would die away. Some like staff nurses would function as multi-skilled staffs when posted in a PHC and can play the role of staff nurse when posted in CHC and district hospitals. We estimate that such retraining and redeployment would solve a substantial part of the manpower vacancy problem. Each PHC may also have two staff at class IV qualifications.

24 hour Multi-Skilled Paramedical Based Service in al PHCs: We recommend that in all PHCs irrespective of category, 24 hour service with emphasis on institutional delivery be insisted on by multi-skilling and deploying paramedical. The multi-skilled paramedical worker should also be trained in emergency care management at primary level.

Strengthening BAMS Doctor's role while keeping Medical Officers Option open: The use of medical officers with BAMS (AYUSHcheme) to fill up vacancies where no medical officers are currently available is welcome. However all the service issues discussed equally affect their functionality. Moreover currently they would be unable to deliver the notified services of the PHC level and special training would be needed to close the gaps.

Strengthening of PHCs

Appointment of Six Medical Officers at Least, four of whom at least are specialist or within them have the required four – skill (physician, paediatrician, surgeon, gynecologist) mix. If there are a number of APHCs not having doctors to be looked after with visits, the number posted here may increase further.

B-1. ASHA – Accredited Social Health Activist

Situation Analysis

ASHA is an honorary worker and will be reimbursed on performance-based incentives and will be given priority for involvement in different programmes wherever incentives are being provided (like Institutional Delivery, 3 ANC & PNC Registration, Death & Birth registration, Safe MTP, Motivation for Sterlization etc. She will be able to earn about Rs. 1,000 per month
In district East Champaran 3578 ASHAs have been selected and 225 have received training.

Objectives

1. Availability of a Community Resource, service provider, guide, mobilizer and escort of community
2. Provision of a health volunteer in the community at 1000 population for healthcare
3. To address the unmet needs

Strategies

1. Selection and capacity building of ASHA.
2. Constant mentoring, monitoring and supportive supervision by district Mentoring group

Activities

1. Strengthening of the existing ASHAs through support by the ANMs and their involvement in all activities.
2. Reorientation of existing ASHAs
3. Selection of new ASHAs to have one ASHA in all the villages and in urban slums
4. Training of all remaining ASHAs who have not received any training regarding the related other modules.
5. Provision of a kit to ASHAs
6. Formation of a District ASHA Mentoring group to support efforts of ASHA and problem solving
7. Review and Planning at the Monthly sector meetings
8. Periodic review of the work of ASHAs through Concurrent Evaluation by an independent agency

Support required

1. Timely Payments to ASHA
2. Advance of Rs. 5000 always with ASHA for prompt payments to the women

Activity	**2011-12**
Selection of additional ASHAs	330
Total ASHAs	3578
Training of new & untrained ASHAs	330
Reorientation of the initial ASHAs	330

	District ASHA Mentoring group	x
Timeline		

Budget	**Activity / Item**	**2011-12**
	Kit @ Rs 2500/ ASHA	8945000
	Reorientation @ Rs 1250/ ASHA	4472500
	Expenses for the District mentoring group – meetings, travel @ Rs 62500 per month x 12 months	750000
	Incentive for ASHAs	3692496
	Total	**9809496**

Activities	Approval by State for ASHA as counsellor and training of all Male & Female person of all villages, and training of all the health personnel in the Subcentres, PHCs and PHC in block 10. There will be equal number of Male and Female counsellors and will alter between two PHCs – one week the male counsellor is in one PHC and the fe counsellor in the other and they switch PHCs in the next week so that both the boys girls benefit. The counsellor will be • Facilitating group meetings • Organizing Counselling session once per week at the PHCs with publicity regarding the days of the sessions. • Collecting data and information regarding the problems of Adolescents 11. Close monitoring of the under 18 marriages, pregnancies, prevalence of RTI/STD
Support required	Involvement of ASHA as counsellor and one male & female school Manpower and funds

Timeline	**Activity**	**2010-11**
	Awareness generation	x
	Workshop of all the partners	x
	Training a district pool of Master trainers	x
	Selection of Councellors through NGOs	x
	Training of Councellers and followup re-orientation	x
	Orientation of the Health personnel	x
	Counselling Clinics	All PHCs

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

Situation Analysis/ Current Status	Rs. 10000 as Untied Fund for each Sub Centre is available. Rs. 1020000 is available for 102 Sub Centers. Rs. 10000 is also provided for Annual Maintenance Grant for Sub Centers. Rs. 1020000 is also available as Annual Maintenance Grant for all the Sub Centers in the District. The most of Sub Centers are in very pathetic condition A number of equipment needed some repair due to which they were lying unutilized. The Gram Panchayat members were never involved in any activities of the Sub centre.
Objectives	1. Strengthening of the Sub centre to provide basic health care, Ante natal care & post natal care and safe deliveries at Sub center level.

<table>
<tr><td>Strategies</td><td>1. Provision of Untied funds of Rs 10000 each year to the Sub centers at the disposal of the ANM for local needs
2. Provision of Rs 10000 for Annual maintenance Grant for Sub Centres.</td></tr>
<tr><td>Activities</td><td>1. Each Sub centre would be given an untied support of Rs. 10,000 per annum. The fund would be kept in a joint account to be operated by the ANM and the local Sarpanch.
2. Rs 10000 will be given as Annual Maintenance Grant to each Subcentre. This will be under the mandate of the Gram Panchayat SHC Committee for undertaking construction and maintenance. This will bring in greater community control and the sub-centres would be brought fully under the Panchayati Raj framework.
3. Activities suggested for the untied funds include minor modifications, cleanliness of premises, transport of emergencies, transport of samples, purchase of consumables, etc;
4. This fund will not be used for salaries, vehicle purchase and recurring expenses of Gram Panchayat
5. Monthly and quarterly expenditure statement will be submitted alongwith UC</td></tr>
<tr><td>Support required</td><td>1. Fund flow process to be made easier
2. Sarpanch to ensure proper usage and accounts</td></tr>
<tr><td>Timeline</td><td>
<table>
<tr><th></th><th>2011-12</th></tr>
<tr><td>Untied Fund of Rs 10000/subcentre</td><td>3190000</td></tr>
<tr><td>Annual Maintenance grant and repair of Rs 10000/SC</td><td>X</td></tr>
<tr><td>Plan for maintenance to be developed and approved by Gram Panchayat</td><td>X</td></tr>
<tr><td>Plan for use of untied funds</td><td>X</td></tr>
<tr><td>Gram Panchayat to identify mode of construction and repair</td><td>X</td></tr>
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</td></tr>
<tr><td>Budget</td><td>
<table>
<tr><th>Activity / Item</th><th>2011-12</th></tr>
<tr><td>Untied Fund of Rs 10000/SC</td><td>3190000</td></tr>
<tr><td>Annual Maintenance grant and repair of Rs 10000/SC</td><td>3190000</td></tr>
<tr><td>Total</td><td>6380000</td></tr>
</table>
</td></tr>
</table>

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

Situation Analysis/ Current Status

Rs 375000 are available as Untied Fund for 20 PHCs @ 25000 for each APHC. Rs 750000 are available as Maintainance grant for 20 PHCs @ 50000 per APHC and Rs 1500000 is available to the PHC's SKS to provide additional facilities to the Patients for 15 PHCs @ 100000 per PHC. A number of equipment needed some repair due to which they were lying unutilized.

Objectives

1. Strengthening of the PHC through financial support

Strategies

1. Provision of Untied funds of Rs 25000 each year to the APHCs at the disposal of the Swasthya Kalyan Samities
2. Provision of an Annual Maintenance grant of Rs 50,000 to the PHCs
3. Provision of fund of Rs 100000 for providing additional facilities to the Patients

Activities

These funds will be routed through the Swasthya Kalyan Samitis who will approve the yearly activities and the related budgets and also undertake and supervise improvement and maintenance of physical infrastructure.

1. An untied fund of Rs 25000 will be provided each year for activities as per the local needs including minor modifications, cleanliness of premises, transport of emergencies, transport of samples, purchase of consumables, etc;

This fund will not be used for salaries, vehicle purchase and recurring expenses of Gram Panchayat or any other facility.

2. An Annual Maintenance grant of Rs 50,000 will be given to the PHCs for water, toilets, maintenance of building.
3. An Annual Grant of Rs 100000 will be given to the PHCs for providing additional facilities to the Patients.
4. Monthly and quarterly expenditure statement will be submitted alongwith UC

Support required

1. Timely release of funds
2. Meetings of the Swasthya Kalyan Samitis to be regularly held

Timeline

Activity	2011-12
Untied Fund of Rs 25000/PHC	500000
Annual Maintenance grant of Rs 50000/PHC	1000000
Plan for maintenance to be developed and approved by the V.H.& S.C.	X
Plan for use of untied funds	X
V.H.& S.C. to identify mode of construction and repair	X
Special Fund to give facilities to the patients @100000/PHC	2000000

Budget

Activity	2011-12
Untied Fund of Rs 25000/APHC	1225000
Annual Maintenance grant of Rs 50000/PHC	1000000
Annual Fund to give facilities to the paients of Rs 100000/PHC	2000000
Total	**4225000**

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

Situation Analysis/ Current Status

Rs. 300000 is available for 6 PHCs as Untied Fund for local health action @ 50000 per PHC. Rs. 600000 is available for 6 PHCs as Improvement and Maintenance of physical infrastructure of the PHC @ 100000 per PHC and Rs. 600000 is available to the SKS for providing additional facilities to the patients. A number of equipment needed some repair due to which they were lying unutilized.

Objectives

1. Strengthening of the PHC through financial support

Strategies

1. Provision of Untied funds of Rs 50000 each year to the PHCs at the disposal of the Village Health & Sanitation Committee Provision of an Annual Maintenance grant of Rs 100,000 to the PHCs
2. Provision of an Annual fund of Rs 100000 for providing additional facilities to the patients to the PHCs.

Activities

These funds will be routed through the Swasthya Kalyan Samitis who will approve the yearly activities and the related budgets and also undertake and supervise improvement and maintenance of physical infrastructure.

1. An untied fund of Rs 50000 will be provided each year for activities as per the local needs including minor modifications, cleanliness of premises, transport of emergencies, transport of samples, purchase of consumables, etc;

This fund will not be used for salaries, vehicle purchase and recurring expenses of Panchayat or any other facility.

2. An Annual Maintenance grant of Rs 100,000 will be given to the PHCs for water, toilets, maintenance of building.
3. An annual fund of Rs 100000 is provided for providing additional facilities to the patients to the PHCs.
4. Monthly and quarterly expenditure statement will be submitted alongwith UC

Support required

3. Timely release of funds
4. Meetings of the Village Health and Sanitation Committee to be regularly held

Timeline

Activity	2011-12
Untied Fund of Rs 50000/PHC/APHC	3450000
Annual Maintenance grant of Rs 100000/PHC	2000000
Plan for maintenance to be developed and approved by the Village Health and Sanitation Committee	X
Plan for use of untied funds	X
V.H.& S.C.to identify mode of construction and repair	X
Annual grant for the facilities to the patients Rs 100000/PHC	X

Budget

Activity / Item	**2011-12**
Untied Fund of Rs 50000/PHC/APHC x 20PHCs/49APHCs	3450000
Annual Maintenance grant of Rs 100000/PHC	200000
Annual grant for the facilities to the patients of Rs 100000/PHCs	200000
Total	**3850000**

B- 5. Mobile Medical Units

Situation Analysis/ Current Status	There is only one mobile dispencery is available in East Champaran Hospital. But most of the time the vehicle is busy in some other activities. As per the NRHM guideline there is no Mobile medical unit exist.
Objectives/	Meeting the unmet health needs of the people residing in difficult and underserved areas, through provision of healthcare at their doorstep
Strategies	Operationalizing a Medical Mobile Unit (MMU)
Activities	1. Joint meeting of the District Health Society and the Swasthya Kalyan Samiti (SKS) to decide the appropriate modality for Operationalization of the MMU. 2. Formation of a Monitoring Committee 3. The SKS will operate the MMU for long-term sustainability of the intervention. 4. Staff will be hired on contract by the SKS. 5. Need Analysis to be carried out for determining the areas of MMU. 6. Development of a monthly roster for operationalizing MMU 7. MMU with essensial accessories, basic laboratory facilities, semi-auto analyser and generator etc. 8. Wide publicity before the arrival of the MMU 9. Periodic Review.
Support required	Govt Order from the State for exemption of the Regular Staff from providing services in the MMU, Funds for purchase of MMU and its maintenance. Manpower
Timeline	

	2010-11
Operationalizing the MMU	**1**
Orientation & reorientation of the staff	**X**
Wide Publicity	**X**
Strengthening the MMU	**X**
Addition of services	**X**

Budget	**Activity / Item**	**2011-12**
	Hiring staff	1650000
	Orientation of the staff	50000
	Joint Workshop for finalizing modalities	50000
	Cost of Vehicle, equipment and accessories	3000000
	Recurring Cost of Drivers, Drugs, supplies, Mobile phones, POL, Maintenance	400000
	Total	**5150000**

Detailed Calculations

Budget for Vehicles, Equipment and Accessories

S.No	Head	Unit Cost
1.	Cost of Vehicle for staff to MMU	625000
2.	Cost of Vehicle for carrying A/V aids, equipment etc	2250000
3.	Prefabricated tents & Furniture	187500
4.	Equipment	2,50,000
5.	Mobile Phone (one for each Driver)	1250
	Total	**3313750**

Budget of Personnel

S.No	Head	Unit	Unit Cost	Amount
1.	Emoluments to MOs -1	12 mths	35000	420000
2.	Emoluments to Specialists –2 (Part time)	12 mths	45000	540000
3.	Lab Technician	12 mths	9375	112500
4.	Pharmacist	12 mths	9375	112500
5.	Nurse	12 mths	11250	135000
	Total			**1320000**

Budget for Recurring Expenses

S.No	Head	Unit	Unit Cost	Amount
1.	Salary of Drivers	12 mths	10000	120000
2.	Drugs			125000
3.	POL & Maintenance of Vehicles			125000
4.	Maintenance of equipment			25000
5.	Mobile Phone bill -2	12 mths	500	12000
	Total			**407000**

B – 6. Upgrading PHCs to IPHS		
Situation Analysis/ Current Status	There are 20 PHCs in the Distt. are under process to be as per the IPH Standards. There is shortage of Staff & Specialists in all PHCs. Rs 20 lakhs was provided for each PHC for IPHS Up gradation and 2 specialists were hired under IPHS in the district for each PHC for providing Specialists services to the people.	
Objectives	Upgrading the General hospitals and the PHCs to IPHS standards	
Strategies	1. Availability of all personnel as per IPHS 2. Proper building 3. Adequate Laboratory, Blood Storage Unit, Equipment and Drugs	
Activities	1. Hiring of additional staff as per IPHS with 7 Specialists and MOs, in each of the facilities, 10 staff nurses, 1 PHN, 1 Computer clerk, 1 Dresser, 1 Pharmacist, 1 Lab Technician, 1 BEE, 1 Radiographer, 1 UDC, 1 Accountant, 1 Clerk, 1 Epidimiologist and ancillary staff like Aya, Chowkidar, Dhobi, Sweepers, Peon and filling of Vacancies 2. Repair of PHCs 3. Equipment as per IPHS norms	
Support required	State to sanction posts as per IPHS Allowing Contractual Personnel at Market Rates	
Timeline	As FRUs, Contractual Specialists and equipments by 2010-11	
Budget	**Activity/ Items**	**2011-12**
	Building for PHC	
	New Building for APHC	
	Furniture	300000
	Equipment	5547500
	Vehicle /Ambulance	500000
	Recurring cost for existing PHCs	591250
	Recurring costs of additional PHCs	
	Repair of building for PHCs	4000000
	Total	**10938750**

B – 7. Upgrading PHCs for 24x7, IPHS and others requirements of PHCs	
Situation Analysis/ Current Status	20 PHCs were developed for 24 x 7 PHCs but staff is inadequate and neither is the equipment. The Staff quarters need to be built so that all the staff can stay and be available. None of the PHCs are near the IPHS standards. As per the population norms at least 25 PHCs will be required by 2010-11 and there are only 18. Only 34 Staff quarters are available.10 PHCs don't have any staff quarters
Objectives	To establish 4 no. of PHCs for 24x7 and IPHS To increase the number of PHCs to 20 by 2010-11

Strategies	1. Availability of all personnel as per IPHS 2. Proper building with staff quarters in all PHCs 3. Adequate Laboratory, Equipment and Drugs 4. Additional PHCs	
Activities	Hiring of additional staff as per IPHS with 2 MOs(maybe Ayush), in each of the facilities, 3 staff nurses, 1 PHN, 1 Lab Technician, Part time Pharmacist, 1UDC, 1 Accountant, and Class IV and filling of Vacancies Building addition /Expansion of 09 PHCs and Repairing of 11 PHCs. Construction of staff quarters for the existing PHCs Upgrading the Laboratory for tests necessary for 24 hour PHCs Furniture, Drugs and Equipment as per IPHS norms Identification of sites for 2 new PHCs and developing them as per IPHS. Staff quarters for the existing PHCs	
Support required	State to sanction posts as per IPHS Allowing Contractual Personnel at Market Rates	
Timeline and	Increase the no. of PHCs and 24x7 PHCs by 2011-12	
Budget	**Activity / Item**	**2011-12**
	New Buildings for 18 PHCs with equipment, Drugs and Furniture and quarters as per IPHS	56700000
	Equipment and furniture for existing facilities as per IPHS	1500000
	Repair/Additions of PHCs	62500
	Staff Quarters as per IPHS	
	Recurring costs of the additional PHCs	3816250
	Total	**62078750**

B – 8. Upgrading Sub Centres and Additional Subcentres	
Situation Analysis/ Current Status	Out of the existing 117 Subcentres, 95 Subcentres are in their own buildings and 6 are in Panchayat buildings and 1 are in rented buildings. Electricity is required in 50 buildings and Water supply in 43 Subcentres. Toilets are present in 71 Subcentres, needing minor repairs and 31 do not have toilets. Out of 95 Subcenters running in their own building 55 SCs are in very bad condition and need major repair. Rest Subcdenters also need some minor repaires. There are no staff Quarters in 7 Subcentres, 59 Subcentres have one quarter. Also looking at the projected population for 2009-10 at 9.29 lakhs, it will be essential to plan for these new Subcentres. In those Subcentres where there are Delivery huts, there are 2 ANMs. As per IPHS norms each Subcentre should have 2 ANMs.
Objectives	1. Upgrading of Subcentres as per IPHS standards 2. Quarters for the ANMs 3. Opening Additional Subcentres to cater to the entire population
Strategies & Activities	Building new buildings for 30 Subcentres Quarters for the Subcentres

	Provision of Electricity to 50 Subcentres Provision of Water connection to 43 Subcentres Provision of toilets to 31 Subcentres	
Support required	State to sanction posts as per IPHS Allowing Contractual Personnel at Market Rates	
Timeline	**Activity / Item**	**2011-12**
	New buildings with quarters, equipment and Furniture (10)	22
	Repair of SCs (55)	30
	2 Staff Quarters (7)	7
	1 Staff Quarter (59)	30
	Electricity connections	50
	Water Connections	43
	Toilets	31
	New Subcentres	
Budget	**Activity / Item**	**2011-12**
	New buildings with quarters	135762500
	New Subcentres	7585000
	Repair of SCs	1875000
	2 Staff Quarters	2625000
	1 Staff Quarter	4612500
	Recurring Costs	1250000
	Total	**153710000**

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

B-9 Untied Funds and Incentive Fund for the Village Level Committees

Situation Analysis/ Current Status

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

In East Champaran there are 17 villages with population less than 500. There are 144 villages with population between 2001 and 5000. There are 16 villages with population more than 5000.

Objectives

1. Strengthening the Village Level Committees through financial support

Strategies

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

Activities

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

   This untied fund is to be used for household surveys, health camps, sanitation drives, revolving fund etc;
2. Orientation of the ANMs for the utilization of the Untied Funds and she in turn will orient the Village Level committee.
3. Monthly meetings of the VLC for reviewing the funds and activities. This is to be facilitated by the ANMs
4. Monthly review at the PHC level regarding the VLC functioning and utilization of funds.

Support required

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

Timeline

	2011-12
Untied Fund of Rs 10000/unit for Pop 2000/unit x 186 units	
Orientation and reorientation of the VHWSC	
Provision of Rs 5000 as permanent advance for incentives to ASHA	
Monthly meetings of the VHWSC	
Review of the VHWSC functioning at PHC level	

Budget

Activity / Item	**2010-11**
Untied Fund of Rs 10000/unit 1500/unit x 186 units	1860000
Untied Fund of Rs 20000/unit 3000/unit x 144 units	2880000
Untied Fund of Rs 30000/unit 5000/unit x 16 units	480000
Total	**5220000**

PART C: Immunisation

C-1. Strengthening Immunization	
Situation Analysis/ Current Status	As per the District data immunization coverage is 100%. But for complete immunization data is not available. Complete Immunization is present only in 58.7% children in the age group 24-35 months and 11.4% did not receive any vaccine, as per DLHS 2002 data. The dropout rate is also high. The availability of health facilities in villages definitely affected and increased the immunization of children. 50 percent were immunized at government health facility and rest of them at private health facility. Regarding Vitamin A supplement 21 % of the children got at least one dose of Vitamin A. The reasons for children not being Immunized are related to the ignorance of the mothers on the importance of immunization, the place and time of Immunization sessions and fear of side effects. The community perceives that the Polio drops given repeatedly at the time of Pulse Polio campaign are equivalent to the complete immunization. The ANMs have to take the vaccines from the PHC headquarters resulting in them not reaching the hamlets and also the difficult areas and also the Pulse Polio campaign. Supervision is not done properly at PHC level. Also there is large gap between reported and evaluated coverage. There are 25 Nos. of Deep Freezers, 31 ILR and 28 Cold Boxes are available in the district. There is need of these above said cold chain equipments.
Objectives/ Milestones/ Benchmarks	Reduction in the IMR to 49 100 % Complete Immunization of children (12-23 month of age) 100 % BCG vaccination of children (12-23 month of age) 100% DPT 3 vaccination of children (12-23 month of age) 100% Polio 3 vaccination of children (12-23 month of age) 100% Measles vaccination of children (12-23 month of age) 100% Vitamin A vaccination of children (12-23 month of age)
Strategies	1. Strengthening the Deputy Civil Surgeon (Immunization) 2. Enhancing the coverage of Immunization 3. Alternative Vaccine delivery 4. Effective Cold Chain Maintenance 5. Zero Polio cases and quality surveillance for Polio cases 6. Close Monitoring of the progress
Activities	1. Strengthening the Deputy Civil Surgeon (Immunization) office. • Support for the mobility Deputy Civil Surgeon (Immunization) (@ Rs.5000 per month towards cost of POL) for supervision and monitoring of immunization services and MCHN Days

- One Computer assistant for Deputy Civil Surgeon (Immunization) @7500 pm

2. Training for effective Immunization

Training for all the health personnel will be given including ANMs, LHVs, MPWs, Cold chain handlers and statistical assistants for managing and analyzing data at the district.

3. Alternative vaccine delivery system (mobility support to PHCs for vaccine delivery)

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

b. Mobility support (hiring of vehicle) is for vaccine delivery from PHC to MCHN days site where the immunization sessions are held for 8 days in a month

4. Incentive for Mobilization of children by Social Mobilizers

- Rs.100 per month will be given to Social Mobilizers for each village for mobilization of children to the immunization session site. This money will be provided to ASHA wherever possible but if there is no ASHA then it will be given to someone nominated from the village by the PRIs.

6. Contingency fund for each block

- Rs. 1000/ month per block will be given as contingency fund for communication.

7. Disposal of AD Syringes

- For proper disposal of AD syringes after vaccination, hub cutters will be provided by Govt. of India to cut out the needles (hub) from the syringes. Plastic syringes will be separated out and will be treated as plastic waste. Regarding the disposal of needles, Pits will be formed at PHCs as per CPCB guidelines. For construction of the pits at PHCs a sum of Rs. 2000/ PHC has been provisioned.

8. Outbreak investigation

- Rapid Action Team for epidemics will be formed
- Dissemination of guidelines
- Training of Rapid Action Team for investigating outbreaks who will in turn orient the ANMs during Sector meetings
- Hiring of vehicle for Extension of Immunization at brock kilns in the field every month.

9. Adverse effect following Immunization (AEFI) Surveillance:

- Standard Guidelines have been developed at national level and will be disseminated to the district officials and block levels in Review meetings.

10. IEC & Social Mobilization Plans

Discussed in details in the Component on IEC

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	11. Cold Chain • Repairs of the cold chain equipment (@ 750/- per PHC & PHC will be given each year • For minor repairs, Rs. 10,000 will be given per year. • Payment of electricity bills for continuous maintenance of cold chain for the PHCs @ 300 per month PHCs (vaccine distribution centres) has been budgeted under this head. • Availability of cold chain equipments at all PHCs/PHCs
Support required	State to ensure the following: • Regular supply of vaccines and Autodestruct syringes • Reporting and Monitoring formats • Monitoring charts • Cold Chain Modules and monitoring formats • Temperature record books • Polythene bags to keep vaccine vials inside vaccine carrier • Polythene for the vaccines to avoid labels being damaged • Training of Cold Chain handlers

Timeline

Activity	**2011-12**
Alternative Vaccine delivery	
Mop up Round	
IEC activities	
Tracking bags	
Orientation on Tracking bags	
Purchase & Maintenance of Cold Chain Equipments	
Provision of Large Invertor with Battery	

Budget

Activity	**2011-12**
Mobility Support for Deputy-Civil Surgeon (Immunization) as POL @ 6250	75000
Salary of Computer Assistant for Dy.C.S.(Immunization) @ 10000 pm	120000
Mobility support for alternative vaccine delivery Rs. 50 per session for 1 planned sessions per week at each Subcentre village for 12 months = Rs. 50x1 sessionsx4 weeks/mthx12 months x 319 SCs	1531200
Mobility Support Mop up campaign @ Rs 12500 per PHC (Including travel, vaccine delivery, IEC) x 6 rounds/ year x PHCs	1500000
Mobilization of Children by Social Mobilizers @ Rs. 100/ session x4 sessions per month X 319 units x12month	1531200

	Contingency fund for each block @ Rs.1000/month x 20 blocks x 12 months	240000
	Printing of Immunisation cards @ 5 per card x 30000 cards each year	150000
	Tracking Bags to ANMs (and @ Rs. 200 per tracking bag x 534	106800
	Supply of Cold Chain Equipments: Deep Freezer-8, ILR- 7, Cold Boxes- 10	State
	Maintenance of Cold Chain Equipments (funds for major repair) (@ Rs.750 per PHC/PHC per month and Rs 50,000 annual for minor repairs	230000
	POL & maintenance for Vaccine delivery van at district level @ Rs.18750/month x 12 mths	225000
	Provision of Large Size Invertor with battery at all facilities upto PHC/PHC @ 31250 x 25	781250
	Running cost of ILRs & Deep Freezers (for electricity bill) (@ Rs 500 per month for PHCs/PHCs x 20 x 12 mths	72000
	Hiring of vehicle for extension of immunization at brick kilns @ Rs 1000pm/PHC	240000
	Total	**6802450**

Priorities and Activities for RNTCP

District –

D-1. RNTCP

Gaps	Priority Areas	Activity planned under each priority area
• Lack of proper monitoring and supervision at TU and District Level • Proper counseling of patients by the DOTS provider and by the STS is not being done. • Schedule of Follow-up is not being maintained • Regular intake of drugs is not being ensured	**Increase Cure-rate* (56%(DTO) to 85%)**	**(a) Effective monitoring and supervision to ensure the follow-up sputum smear examinations done according to guidelines** **(b) Ensure that every dose of medication is observed during the intensive phase of treatment and at least one dose per week in the continuation phase.** **(c) Ensure return of empty blister packs during weekly collection of drugs** **(d) Participation of ASHAs and AWWs for providing DOTS so as to reach services close to the patients for decrease default rate.** **(e) Ensure proper counseling of the**

		patient by the health workers.
2.	**Increase Case-detection (29%(DTO) to 70%)**	**(a) Organizing awareness campaign and community meetings to aware people about the TB and DOTS.** **(b) Sensitization of MOTCs/MOs at the Peripheral health facilities to ensure every TB suspect undergo Sputum Smear examination (at least 2% of Total New OPD patient)** **(c) Sensitization of all Lab Technician for Correct Sputum Smear Microscopy(5%-15% positivity is expected among patients examined for diagnosis)** **(d) Ensuring 3 sputum smear examinations for TB patients**
3.	**Ensure Quality of DOTS** • **Lack of dispensing medication properly as per technical guidelines in district. ANMs providing DOTS at HSCs do not visit Center on DOTS day.** • **Regular intake of Drugs is not being conducted by DOTS providers** • **Delay in initiation of Treatment of NSP Patient within a weak** • **Follow-up sputum smear**	**(a) Participation of ASHA and Community Volunteers to provide effective DOTS.** **(b) Incentive to ASHA and Volunteers for timely Sputum smear microscopy Collection and follow-up.** **(c) Initiation of treatment of New Smear Positive (NSP) patients within a weak of diagnosis. To control spared of infection in Group.** **(d) Proper Monitoring/Supervision to ensure regular and interrupted DOTS as per guidelines.** **(e) Proper counseling of patients by the DOTS provider and supervisory staffs.**

	microscopy examination at the end of Intensive Phase and at the end of the treatment is not done in many cases	
4	**Provide Quality DMC services** • **Microscopes of many DMCs are defective or dysfunctional** • **Proper space with electricity connection for keeping microscopes and proper water supply in the DMCs is not available** • **Poor maintenance of microscopes** • **Irregular supply of Lab consumables i.e., Slides, sputum containers and chemicals**	**(a) Maintenance/Replacement of defective Binocular microscopes.** **(b) Establishment of new DMC as per need and repairing/renovation of closed DMCs with proper electricity connection and water supply.** **(c) Refreshment training of Lab Staffs specially Lab Technician for maintenance of microscopes.** **(d) Ensure regular and adequate supply of laboratory consumables to DMCs from |District TB Center(DTC)**
5	**HR Issues** • **Lack of staffs i.e., Lab Technician(LT), STS, STLS, TBHV and**	**(a) Recruitment of Counselor at PHC level** **(b) Active participation of community specially ASHA and AWW.** **(c) Capacity building of ASHA**

	other Staffs • **Operational Issues:** **Lack of coordination between ASHA, AWW and ANMs.**	**(d) Remuneration to ASHA/Community volunteer for providing DOTS will be paid timely.** **(e) New recruitment for lacks in staffs i.e., Lab Technician, STS, STLS, TBHV and other staffs.**

***Cure-rate*: No. of cured NSP cases/Total No. of NSP cases X 100**
***Cured Cases*: Initially sputum smear-positive patient who has completed treated and had negative sputum smears, on two occasions, one of which was at the end of treatment.**

PART D: National Disease Control Programme

D-2. RNTCP

Situation Analysis/ Current Status

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

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

Objectives

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

<table>
<tr><td>Strategies</td><td>1. Improvement in the infrastructure
2. Improvement in the quality of the intervention
3. Increasing the outreach of the programme
4. Increasing the awareness regarding Tuberculosis</td></tr>
<tr><td>Activities</td><td>1. One more DMC as per norms
2. Improvement in the quality of testing of sputum
• Training to the RNTCP staff in the district
• Equipment maintenance – Microscope, Computer and Others
• Adequate supply of drugs
3. Increasing the outreach of the programme by Increasing the DOTS providers through involvement of ASHAs who will be paid Rs. 250 per caser for providing services. She will be oriented regarding DOTS. Also the AWH should be involved in reporting suspicious cases. Training will be given to ASHA for identifying the suspects.
4. Increasing the awareness regarding the various issues of Tuberculosis through involvement of Rotary clubs and the Lions clubs and NGOs. Special drive for detection of cases on World TB day through the involvement fo all departments
5. DOTS regime to be strictly monitored through the VHWSC, the PRIs and the PHC MO</td></tr>
<tr><td>Support required</td><td>Timely supply of medicines</td></tr>
<tr><td>Timeline</td><td>2010-11
1. One New DMC in TU Narnaul
2. Increasing the DOT providers through ASHAs
3. Training to RNTCP staff and ASHA
4. Awareness drives
5. Involvement of the AWW</td></tr>
<tr><td>Budget</td><td><table>
<tr><td>Activity / Item</td><td>2011-12</td></tr>
<tr><td>Civil Works</td><td>375000</td></tr>
<tr><td>Laboratory Material</td><td>212500</td></tr>
<tr><td>Honorarium</td><td>137500</td></tr>
<tr><td>IEC/Publicity</td><td>92500</td></tr>
</table></td></tr>
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	Equipment maintainance	55000
	Training	231250
	Vehicle Maintainence	75000
	Vehicle Hiring	300000
	NGO/PP support	115000
	Contractual Services	1812500
	Printing	171250
	Procurement Vehicle	125000
	Procurement Equipment	37500
	Miscellaneous	312500
	Total	**4052500**

Salaries of Contractual Staff

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

D-3. LEPROSY

Situation Analysis/ Current Status

Balance Cases at beginning of year		New cases detected in year (April 08 to Nov 08)		Cases Discharged in year		Balance Cases at end of year		Per 10,000 Population		Proportion of Deformity Ratio among cases
PB	MB	PB	MB	RFT	O.D	PB	MB	PR	NCDR	
203	241	487	191	729	10	174	209	.82	1.85	1.03

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

Objectives

Eradication of Leprosy

Strategies & Activities

1. Detection of New cases
2. House to House visit for detection of any cases
3. IEC for awareness regarding the symptoms and effects of Leprosy
4. Prompt treatment to all cases
5. Rehabilitation of the disabled persons
6. Distribution of Medicine kit and rubber shoes
7. Honorarium to ASHA for giving MDT
8. Block leprosy awarkers coupaign- 3 Block

Support required

Availability of regular supply of drugs
(Preduisolace)

Objective

Bulde up capacity Building of MIS & General Health staff.

Activities

1. Training of Medical officer- 150
2. Training of General Health staff- 300
3. ASHA'S Training – 500
4. Health Mela-
5. School Quiz in 100 school
6. Urban Leprosy programme-
7. Raily & Bkker (Leprosy day)
8. Patiuf welfare-

Timeline

1. BLAC (Black leprosy awareness campaign)- in Four P.H.C. April 2009 to May 10.
2. School quiz in hundred schools by (N.H.A.)- 100 school- June 2009 & July 2010

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	3. ASHA Training- Aug 2010 4. Training of MDS & General Health staff- Sept. 2010 5. Urban Leprosy programme- Oct. 2010 6. Raily & Banner (Leprosy day) 30th Jan 2011. 7. Health Mela- Jan. 10 & Feb. 11 8. Patient welfare- 30th Jan 2011	
Budget	**Activity / Item**	**2011-12**
	Salary to Contractual Staff	46200
	Office Expenditure	12500
	Account work	4800
	Contagious	15000
	Audit fee	4000
	Vehicle reparing (Two vehicle)	75000
	POL & Maintenance 4000/vehicle	100000
	Supporting maintenance	18750
	Patient welfare	10000
	Raily & Leprosy day	6000
	School Quiz in (100 school)	50000
	Health Mela	4000
	Oneday orientation training MOS & General Health staff	171000
	Urban Leprosy programm	47000
	BLAC (4 PHC)	460000
	Total (nine lac eighty three thousand only)	**983000**
DUES Year 2007-08 & 2008-09	**Note- 1. Rs. 59925.00 (fifty nine thousand nine hundred twenty five) dues of BLACK programm of 07-08** **2. Rs. 50050.00 payment of confractual staff (Driver) due for the year 08-09** **3. Rs. 2500.00 (Two thousand five hundred) dues of office expenditure** **Total dues- 112475.00 (one lac twenlve thousand foru hundred seventy five)**	

D-4. NATIONAL MALARIA CONTROL PROGRAMME

Situation Analysis/ Current Status

Issues	No.	%
Total Blood Slides Examined (BSE)	112815	
Total Positive Cases: Plasmodium Vivax (Pv): Plasmodium Falciparum (Pf):	311	
Slide Positivity Rate (SPR)		.27
Annual Parasite Index (API)		0.34
Slide Positive plasmodium falciparum Rate (PFR)	DNA	
Deaths:	0	

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

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

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

The main bottlenecks are related to shortage of manpower especially for the remote areas.

There are 22 posts of MPHS (LHV) and only 10 are in position. There are 29 posts of MPHS (M) and only 12 are in position.

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

Objectives

Reduction in SPR, API, PFR death rate

Strategies

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

Activities

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

The MOs, Laboratory Technicians, MPHWs and MPHS, ANMs, ASHAs will be trained in various techniques relating to the job

3. Strengthening of Malaria clinics
   - Provision of Proper equipment and reagents – Fogging machines, sprayers,
   - Provision of Jeep, Truck,
4. Addressing Disease outbreak
   - District Outbreak teams will be created at the district headquarter
   - In the team MO, LT, one MPHW, one field worker
   - Provision of mobility, Lab equipments, spray equipment
5. Health education to the community through the ANMs, AWW, ASHAs, RMPs, Ayush personnel
6. Involvement of Private sector: The private practitioners will be closely involved
7. Innovative methods of Mosquito control: Promotion of Gambusia fish needs to be done at every facility. The Civil Surgeon's office should have a hatchery and at each PHC level storage tank full of Gambusia, which can be easily distributed by any of the personnel.

Support required

- Availability of supplies
- Filling up of vacancies
- Supply of health Education material
- Regular Supply of Gambusia fish

Timeline

Activity / Item	**2010-11**
Hiring Contractual Staff	x
Purchase of Jeep and Trucks	x
Fogging & Spraying	x
Hoardings	20 PHCs 1 GH 49 APHCs
Hatcheries for Gambusia Fish	20 PHCs & 1GH,
IEC activities	X

Budget

Activity / Item	**2011-12**
Salary Contractual staff	4821000
Travel expenses @ Rs 7500 per month x 12 months	90000
Office expenses @ Rs 6250 per month x 12	75000
Jeep and maintenance	60000

	Trucks – 3 and maintenance	300000
	4 small Fogging machines for each PHC @ Rs 1.00 lakh and one at District HQ Pulse Fog Machines @ Rs.8.00 lakh per unit and maintenance	2900000
	Training	1145500
	Misc @ Rs 1Lakh per GH and Rs 20000 per PHC, and for PHC Rs 10000	1694000
	Board hoarding: 8'x 12' at 20 sites initially at the PHCs and General hospitals @ Rs 25,000/-	500000
	Board hoarding: 5'x3' at 20 sites initially at the PHCs@ Rs 10,000/-	200000
	POL @ Rs 150,000/- per vehicle jeep and truck for 12 months x 4	**7200000**
	Hatchery in all PHCs for Gambusia fish @ Rs 1.00 lakh per PHC, General Hospitals and Civil surgeon's office	2200000
	Total	**21185500**

Training

	Personnel	**Unit Cost**	**Units**	**Amount**
	DTO	State		
	MO	19475	50	973750
	LT	6000	2	12000
	MPH	1925	20	38500
	MPW	2875	48	138000
	ANM	2875	100	287500
	ASHA	500	200	100000
				1511635

Salaries of Contractual Staff

	Personnel	**Unit Cost**	**Units**	**Months**	**Amount**
1	MPHW Male	7000	21	12	1764000
2	MPHS Male	10000	18	12	2160000
3	Spray and Fogging staff	4000	4	12	192000
4	LT	6500	2	12	156000
5	Data Entry Operator	6000	1	12	72000
6	Accountant	12500	1	12	150000
7	Driver	4500	1	12	54000
	Total				**4548000**

D-5. OTHER VECTOR BORNE DISEASES			
Situation Analysis/ Current Status	Other VBDs	No.	
	Kalazaar	00	
	Dengue	00	
	Lymphatic Filariasis	00	
	Japanese Encephalitis	00	

	Others	
Objectives	Decrease in incidence of Dengue to nil Prevention of JE, Chikingunya and other new infections	
Strategies	1. Reduction of vector density 2. Mosquito-man contact reduction 3. Community awareness	
Activities	1. Reduction of vector density • Identification of breeding sites • Fogging and spraying • Covering of any breeding sites 2. Mosquito-man contact reduction • Use of Insecticide coated mosquito nets • Promotion of the mosquito nets 3. Preparedness for new infections • Increase in Manpower • Training of personnel for identification of new infections • Preparation of Laboratories in the district and State to diagnose the new diseases • Preparedness of dealing with the epidemic outbreak 4. Community awareness as part of the IEC for Malaria and IDSP • Group meetings • Pamphlets/ handbills • Public announcements	
Support required	Support from State Laboratory and the NICD for diagnosing Dengue, Chikingunya, JE etc; Support from District Administration, PRIs, WCD, PHEd,	
Timeline	One jeep for Entomologist (already covered in malaria budget) One truck for shifting manpower and drums/equipment (in malaria budget)	
Budget	**Activity / Item**	**2011-12**
	Budgeted in Malaria	
	IEC and awareness to the people	100000
	Unforeseen expenses	75000
		175000

D-6. BLINDNESS CONTROL PROGRAMME

Situation Analysis / Current Status

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

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

Data is not available regarding this from Private sector.

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

There is no Eye Bank or Eye donation centre in District East Champaran. The nearest Eye Bank is at Rohtak Medical College.

Objectives

1. Reduction in the Prevalence Rate of blindness to 0.5 %
2. Decrease in the Prevalence Rate of Childhood blindness to 0.6 % per 1000 children by 2010
3. Usage of IOL in 95% of Cataract operations

Strategies

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

Activities

1. Determining the prevalence of Cataract through a study by an external agency.
    - One time house-to-house survey for study of prevalence of vision defects and Cataract of entire population leading to referrals and appropriate case management including cataract surgeries
2. Increasing the number of Ophthalmologists either by hiring or through involvement of Private Sector.
3. Training in IOL to Ophthalmologists
4. Training of Paramedical staff and Teachers, NGOs, Patwaris and AWW for screening of school children and IEC activities.

5. AMC for all equipment will be done.
6. Equipment
   - Repair of Synaptophore and Operating Microscope
   - Purchase of Ophthalmic Chair, Slit Lamp, Operating Microscope, Synaptophore, A Scan biometry, Keratometer, Direct and Indirect Ophthalmoscope
7. Construction of Eye Unit in Hospitals and later PHCs
8. Supply of basic Eye medicines like eye drops, eye ointments and consumables for Primary Eye Care in PHCs/PHCs.
9. All PHCs and PHCs to be developed for vision screening and basic eye care

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

10. Blind Register to be filled up by the AWW, together with PRIs
11. Eye Camps with the involvement of Private sector and NGOs
12. School Eye Screening sessions
13. IEC activities

Support required

Procurement of latest equipment for hospitals by GOI
Timely Repair of equipment

Timeline

2011-12
Health Mela
Development of PHCs as Vision Centres
Development of Sadar Hospital Motihari as Eye Unit
School Screening
Cataract Camps

Budget

Activity / Item	**2011- 12**
Health Mela	125000
IEC	6250
School Eye Screening	50000
Blind Register	87500
Observance of Eye Donations	18750
Cataract Camps @ Rs 60000 per camp x 10	600000
NGO and Eye Bank @ Rs 750/IOL x 300, 30 cases for Corneal transplant	225000
POL for Eye Camps @ Rs 6000/camp x10	60000

	Survey of Factory workers/Roadways	12500
	Training of School teachers @ Rs 100/head x 410	41000
	Training of PRIs @ Rs 100/head x 410	41000
	Repair and purchase of equipment and maintenance	1500000
	Total	**2767000**

D-7. Integrated Disease Surveillance Programme

Situation Analysis/ Current Status

The **programs with major surveillance components** include:

- The National Anti-Malaria Control Program
- National Leprosy Elimination Program
- Revised National Tuberculosis Control Program
- Nutritional Surveillance
- National AIDS Control Program
- National Polio Surveillance Program as part of the Polio eradication initiative
- National Programme for Control of Blindness (Sentinel Surveillance)

Surveillance activities of all these vertical programs of Malaria, Tuberculosis, Polio, and HIV are functioning independently leading to duplication of Surveillance efforts. Surveillance has been ineffective due to

- There are a number of parallel systems existing under various programs which are not integrated.
- The existing programs do not cover non-communicable diseases.
- Medical colleges and large tertiary hospitals in the private sector are not under the reporting system as well as for utilization of laboratory facilities.
- The laboratory infrastructure and maintenance is very poor
- Presently, surveillance is sometimes reduced to routine data gathering with sporadic response systems thereby leading to slow response to Epidemics,
- Information technology has not been used fully for information and to analyze and sort data so as to predict epidemics based on trends of the reported data.

In response to these issues the Integrated Disease Surveillance Programme was launched in Haryana in 2005 to provide essential data to monitor progress of on going disease control programs and help in optimizing the allocation of resources

IDSP includes 15 diseases/ conditions (Malaria, Acute diarrhoeal disease-Cholera, Typhoid, Jaundice, Tuberculosis, Acute Respiratory Infection, Measles, Polio, Road Traffic Accidents, Plague, Yellow Fever, Meningoencephalitis /respiratory distress, etc., HIV, HCB, HCV)) and 5 state specific diseases (Thyroid diseases, Cutaneous Leishmaniosis, Acid Peptic Diseases, Rheumatic Heart Diseases).

- Establishing of District Surveillance unit
- Upgradation of 2 PSU Labs
- Water testing labs are in place
- V-Sat has been installed but training is required
- Rapid response teams have been established at District levels.
- DSUs (District Surveillance Units) has been established in all districts
- 1 Data entry operators and 1 Data Entry Manager have been appointed on contract.
- 1 Computer has been installed the software provided by GoI has not been received

	▪ Regional Lab has been proposed fro specialized test
Objectives	1. Improving the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors. 2. Establishing a decentralized state based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the country at the state and national level. **3.** Improving the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.
Strategies	1. Strengthening data quality, analysis and links to action; 2. Improving the laboratories 3. Training of all the stakeholders in disease surveillance and action 4. Coordinating and decentralizing surveillance activities 5. Intersectoral Coordination and involvement of communities and the private sector
Activities	1. Strengthening of the District Surveillance Unit (DSU), established under the project, • Training of the Unit Incharge for epidemiology – {DMO) • Hiring of Administrative Assistant • Training of contract staff on disease surveillance and data analysis and use of IT • Providing support for collection and transport of specimens to laboratory networks • Provision of computers and accessories • WEN connectivity to be operationalized • Provision of software of GOI 2. Setting up of Peripheral Surveillance Units at GH Narnaul 3. Sensitizing the Community for • Notifying the nearest health facility of a disease or health condition

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selected for community-based surveillance

- Supporting health workers during case or outbreak investigations
- Using feedback from health workers to take action, including health education and coordination of community participation.
- Meetings with the SHGs, school teachers, Numberdar and Chowkidars for sensitisation and prompt reporting of cases

4. Improvement in the Laboratories at the district and at PHCs through provision of equipment and consumables

Support required

Timely trainings for the Nodal persons
Government Order for involvement of teachers in Disease Surveillance

Timeline

Activity / Item	**2011-12**
Renovation of Labs with provision of equipment, furnishings, material	1Gen Hosp, + 20 PHCs
Training	X
Contractual staff	X
Software for DSU & training of staff	X
WEN connectivity	X
Sensitization of Community	
Meetings with SHGs	X
Meetings with teachers	X

Budget

Activity / Item	**2011-12**
Renovation of Labs at20 PHCs and general hospitals@ Rs 31250 x 21	656250
Renovation of Lab at District @ Rs 187500 and maintenance	187500
Equipment for Lab at PHC and general hospitals @ Rs 62500	1312500
Equipment for Lab at District @ Rs 5,00,000	625000
Computer and Accessories at PHC and general hospitals @500000	1050000
Computer and Accessories at DSU@630000	630000
Office Equipment for at PHC and general hospitals @ Rs 12500 per unit	262500
Office Equipment for DSU @ Rs 10,000	10000
Software for DSU@ Rs 350000	350000
Furnishing of Lab at PHCs and general hospitals @ Rs 12500	262500
Furnishing of Lab at DSU @ Rs 60,000	75000
Material and supplies at Lab at PHCs and general hospitals @ Rs 12500	262500
Material and supplies at Lab at DSU @ Rs 75,000	75000

	Contract Staff at District level @ 200000/yr for 4 staff	200000
	IEC activities	100000
	Training and retraining	186000
	WEN connectivity	50000
	Operational costs at PSU for Surveillance @ Rs 15000/year x 5	75000
	Operational costs at DSU for Surveillance @ Rs 130000/year	130000
	Total	**6499750**

Detailed Budget for Trainings

Personnel	Unit Cost	Units	Amount
ANM	900	443	398700
Lab Assistant at PHCs	1000	20	20000
Lab Assistant at Distt	3500	2	7000
MOs	2000	189	378000
		Total	**803700**

D-8. Iodine Deficiency Disorders	
Situation Analysis/ Current Status	Iodine is one of the essential micronutrients. Minimum requirement is 150 microgram per day. The main source of Iodine is from soil and water. Iodine is taken from food grown in iodine rich soil. At present there is a depletion of Iodine in the soil due to which there is a deficiency of Iodine. Deficiency result in a variety of disorders ranging from Abortion, stillbirths, Goitre, impaired mental function, retarded growth. In Haryana the National Iodine Deficiency Programme is being implemented since 1986. There is a ban on the sale on non Iodized salt in Haryana. In district East Champaran no case of Iodine deficiency disorders has been identified**.**
Objectives	Prevention of Iodine Deficiency diseases Consumption of Iodized salt by 100% families
Strategies	1. Supply/monitor quality of Iodized salt 2. Assessment of the magnitude of the problem 3. Laboratory Monitoring of Iodized salt and urine samples Health Education
Activities	1. Supply/monitor quality of Iodized salt • Monitoring is done through Food Inspectors who collect two samples of salt per month per district and send it to a laboratory. • The Health workers have been supplied with Kits to test samples at least five per month. • Review is done in the monthly meetings • Monitoring through School health programme – Testing of samples and awareness

<table>
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- Supply of Testing kits to AWCs, Schools, SHGs

2. Assessment of the magnitude of the problem & done by the Central Survey team

3. Laboratory Monitoring of Iodized salt and urine samples

The samples are collected by MPHW and sent for analysis.

4. Health Education: An IEC strategy is essential to promote the consumption of Iodized salt through AWWs, PRIs, NGOs, ASHA, SHGs etc; Demonstraion of Iodized salt by school children through testing, Rallies, sensitisation of shopkeepers.

5. Testing of salt at shops and homes

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

1. Regular Supply of Testing Kits

2. Regular Supply of Iodized salt

Regular supply of IEC material

</td></tr>
<tr><td>Timeline</td><td>

2009-10

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

</td></tr>
<tr><td>Budget</td><td>
<table>
<tr><th>Activity / Item</th><th>2010-11</th></tr>
<tr><td>Large Village meetings for awareness on IDD and consumption of Iodized salt</td><td>100000</td></tr>
<tr><td>Programme in schools 1581 Primary by School health team</td><td>500000</td></tr>
<tr><td>Awareness programme with the SHGs and shopkeepers @ Rs 500 per village x 1634villages</td><td>817000</td></tr>
<tr><td>Total</td><td>1417000</td></tr>
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6. Inter-Sectoral Convergence

6.1 Partnership with AYUSH department

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

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

6.2 ICDS projects

Issues / Areas	Areas of cooperation	Areas of convergent action
Maternal and child health care, complete immunization Anemia and Malnutriton	• Fixed MCHN days • Joint CNAA • Data Validation • Common sectors • Out reach to	• Training for counselling clients, • Provision of spacing methods including oral pills, condoms, LAM and SDM and community mobilization. • Convergence of services at the grassroots would ensure increasing the access to and demand for services • Provision of Examination table and Infant

	children and pregnant women	weighing machine to all AWCs • Joint sector meetings, block and district meetings • DDCs • DOTS providers • Diseases Surveillance

Rural Development Department

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

Public Health department

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

Issues / Areas	Areas of cooperation	Areas of convergent action
The PRIs have been envisaged to play a very important role in NRHM At the village level they are part of the VLC.\ At the Gram Panchayat level they are part of the Gram Panchayat health committee. Similarly at the Block and the	Motivating the community Availability of personnel and services	Joint plans Joint review and monitoring Mobilization

District they are part of the Block and District health mission. At the Subcentre the Sarpanch is the joint signatory to the bank account for the operation of the Untied funds of Rs 10000. In the Gram Panchayat meetings held twice each month the PRIs review the activities of the health department alongwith the ICDS	Participation in the MCHN days Giving importance to issues of health in the Gram Panchayat meetings	of the community for action on health care issues, safe drinking water and sanitation. Advocacy at village, Gram panchayat, block and district level.

Education Department

Issues / Areas	Areas of cooperation	Areas of convergent action
Literacy rate of females is 55.82%. Malnutrition and anemia management in school going children Prevention and control of drug addiction in adolescent Family life education	In Pulse Polio campaign School health programme Member of Village, health and Water Sanitation Committee Proper implementation of mid day meal program Support in various IEC campaigns organised by health dept.	IEC activities School health Education Screening of children for health problems, vision defects DOTS provider Motivating Community members Diseases Surveillance

Inter Sectoral Convergence	
Situation Analysis/ Current Status	Health is a social responsibility and is not the domain of the health department only. Unfortunately the total responsibility has fallen on the health department. The various departments have been involved in the Pulse Polio campaign which has led to the massive mobilization and success of the campaign. The District Health Society has been formed consisting of members of various departments. Block health societies will be formed and also at the sector, and village level. At the Gram Panchayat level under the Sarpanch Gram Panchayat committees have been formed consisting of various sectors. The Village health and Water Sanitation Committees also consist of various sectors and the community. In reality these committees need to be strengthened since they are not functional. All the various sectors are working separately although for the same cause. Hence there is a lot of duplication and wastage of resources. Although orders have been issued for convergence but other sectors do not participate readily. The forum of the fixed health day each week has a lot of potential and has not been used properly.
Objectives	1. Providing Primary and basic quality health care services at the village level 2. Providing quality RCH services 3. Optimal utilization of RCH services by community especially women 4. Empowering women to facilitate them to seek and demand quality RCH services.
Strategies	1. Strengthening the various Committees and Societies 2. Strengthening the MCHN days 3. Joint action for various issues
Activities	1. Joint workshops for Planning and Review at all levels • Orientation programmes • Monthly meetings 2. Strengthening the MCHN days • Wide participation of all the sectors in preparation of the community and in the actual activities, in health education • Each Wednesday during Immunization sessions joint orientations by all sectors and problem solving for each of the sectors 3. Joint Action for Sanitation, provision of safe water, provision of services and personnel at facilities 4. Joint review at the Gram Panchayat meetings 5. Joint efforts for education of the girls, improving the sex ratio, raising age of

	marriage, improving the nutritional status, identifying the correct BPL families, income generation. 6. Realignmant of the Health and the ICDS sectors for common data and common work boundaries. 7. ASHA to participate in all the meetings of the ICDS held between the 20th to 22nd of each month. 8. At the PHC level monthly meetings are organized. This should be jointly organized with the ICDS 9. At the monthly meetings of the Civil Surgeon the officers of all the departments should come 10. Annual action Plans to be developed jointly through meetings at the village, Gram Panchayat, Sector and culminating in Block workshops and District workshops	
Support required	Govt orders for inter-sectoral coordination with clear roles and responsibilities and If the various sectors do not attend the meetings then the decisions will be taken and will be binding for all the sectors. Strict follow-up at the State level for ensuring coordination.	
Timeline	**2010-11** Formation of Block Committees Orientation of Committee members at all levels Joint Community action Joint Annual Action Plan Sector Alignment Strengthening the Gram Panchayat meetings and Gram Sabhas	
Budget	**Activity / Item**	**2011-12**
	Meetings of the Block Committees @ Rs 2500 /meeting x 27 blocks x 12 months	810000
	Meetings of the Village groups @ Rs 125 per village x 1634 villages x 12	2451000
	Joint monitoring at the sector level Hiring of vehicle @ RS 1250/ day x 5 days/month x 20 sectors x 12 months	1500000
	Joint monitoring at the block level Hiring of vehicle @ RS 1250/ day x 5 days/month x 27 blocks x 12 months	2025000
	Yearly joint Planning Workshops at the Block level for development of the Action Plans @ Rs 10000 per block x27 blocks	270000
	Yearly joint Planning Workshops at the District level for development of the Action Plans @ Rs 25000	25000
	Yearly joint Workshops to consolidate the findings at the block levels at the District level for development of the Action Plans @ Rs 25000	25000
	Total	**7106000**

7. COMMUNITY ACTION PLAN

Community Health Action	
Situation Analysis/ Current Status	Constitution of Village Health Water and Sanitation Committees (VHWSC) has been done and now these committees are the part of Village Level Committees formed by the Women & Child Development Department but subsequently no activities have been carried out leading to dysfunctional committees. No efforts have been carried out nor did any monitoring done by the District authorities to keep these Committees function. Monthly meetings of the SMS groups are held but these need to be more focussed and also with specific actions. They can also be linked to the SHGs. Community health action is thereby very limited.
Objectives	Ensuring availability of quality health services to the community Motivating the community for good health seeking behaviour
Strategies	Formation and Strengthening the VLC and the Gram Panchayat meetings Monitoring the progress of the Village health Action Plan and also the village morbidity and mortality
Activities	1. Facilitation of the process with the support of an external agency 2. Trainings of the VLC 3. Regular meetings of the committee, once a month, shall be held. 4. Regular meetings of the SMS Groups with linking with the SHGs and formation of Emergency Fund through the collections. Also developing a microplan for the SMS Groups. 5. Local Gram Panchayat shall review the functioning of VHSC Based on village plans; sub-centre action plan shall be formulated. 6. Tour plan of ANM to be shared with local Gram Panchayat 7. Verbal autopsy fo Maternal and Child deaths by the members for each mortality 8. Organization of Health Camps in every Sub Health Centre feeder area 9. Organization of a Public hearing in every cluster (PHC area) within a block 10. Formation of Block level team for holding health camps and public hearings. 11. District level team to support household survey and survey of health facilities
Support required	1. Zila Pramukh and the District Collector to ensure that meetings of Gram Panchayats are held and to review what issues of health are being discussed. 2. State officials to provide the capacity building of the District officials for village health action 3. State to develop the training module for the members of VHSC and also the TOTs

	4. District Authorities have to ensure the monthly meetings of VLCs and SMS Groups.	
Timeline	**2010-11** Training of Village Level Committees Review of Village health action Plans Formation of Emergency Fund and development of Microplan for the SMS Public hearing in every cluster Health camps Strengthening the Block health committee	
Budget	**Activity / Item**	**2010-11**
	Training of the VH&SC @ Rs 200 per person x 15 persons/Committee x1634 villages	4902000
	Meetings of the VLC @ Rs 250 per village x 1634 villages x 12 months	4902000
	Meetings of SMS @ Rs 100 per month x 1634 villages	163400
	Total	**9967400**

8. Public Private Partnerships

Public Private Partnerships	
Situation Analysis/ Current Status	The private sector includes NGOs, Private Practitioners, Trade and Industry Organisations, Corporate Social Responsibility Initiatives. The private sector is the major provider of curative health services in the country. 43% of the total IUD clients obtain their services from the private sector. Engaging with it to provide family planning services has the potential to significantly expand the coverage of quality services. Public-private partnerships can stimulate and meet demand and have a synergistic impact of the RCH. To ensure efficient services of good quality from the private and public sectors, robust monitoring and regulatory mechanisms need to be developed so that the private sector can come forward and cooperate in all the National programmes and also in sharing its resources. There is no policy on Public Private Partnership in Haryana Unless there are incentives for the private sector to venture into this area, its involvement is unlikely.
Objectives	1. Increasing the coverage of the health services and also increasing the accessibility for health services 2. Widening the scope of the services to be provided to the clients
Strategies	Incentives and training to encourage private providers to provide sterilization services
Activities	**1. Accreditation of facilities for specialized treatment** **2. Provision of fixed payments for clients** • Developing the clinical skills of private doctors will be developed in vasectomy, abdominal tubectomy and laparoscopy. Training private lady doctors in IUD

insertion and promoting the provider will help to expand coverage of these services increase the total use of IUCD.

3. Hiring of Specialists for providing services

- Gynaecologist @ Rs 1875 per visit
- Anaesthetists @ Rs 1250 per visit
- Paediatrician @ Rs 750 per visit

4. Encouraging the use of public facilities by private doctors on a fee-sharing basis

Private doctors will be allowed to use public facilities on a fee sharing basis, e.g. in the evening when PHC/PHC s are normally closed. This will optimise the utilization of the existing infrastructure of public health facilities and make services more accessible, especially to day labourers.

- Local private doctors will be identified and invited to participate through consultative meetings, and assist in drawing up a partnership action plan
- A detailed plan will be developed in consultation with the private sector for determining the amount and mode of payment, the regulation and monitoring frameworks necessary, and safeguards to ensure equity of access.
- Training for the private sector will be provided as above, and approved, monitored providers will be promoted and eligible for discounted supplies

5. **Arogya Kosh** to continue

6. **PPP- Various Schemes under RNTCP**

Support required

1. State to agree for allowing the private sector to use facilities
2. State to develop the Public Private Policy
3. Finalization of Incentives for the Private sector for various services
4. Private providers should get payment on a monthly basis

Timeline

Activity	**2011-12**
Increasing the partnership with Private partners by their involvement in RCH	20
Accreditation to private facilities	5
Inviting Private providers for using Govt facilities, putting in specialized equipment in the Govt hospitals	**x**
Outsourcing facilities to private providers	**x**
Involvement of private Specialists in Govt facilities	**x**
Training to the Private providers	**X**

Budget	**Activity / Item**	**2011-12**
	Arogya Kosh	375000
	Hiring of specialists-2 @ 37500 pm	900000
	Training of NGO personnel and the Private sector @ Rs 625 for 2 days per person x 40 persons	50000
	Workshop for involvement of the Private sector	62500
	Total	**1387500**

9. GENDER AND EQUITY

Gender and Equity	
Situation Analysis/ Current Status	Gender discrimination is a common phenomenon. It has a direct bearing on the health status of women and children. Some of the parameters are the Sex Ratio, Age at marriage, enrolment of girls in schools, Male sterilization. The main reason is dowry. The **Sex Ratio** shows a bad picture in district East Champaran. The Sex Ratio as per Census of 2001 was 918.The Sex Ratio for 0-6 years as per 2001 census was 817. Now the Sex Ratio is 873. It seems that there a large number of bachelors and that crime has increased in this area. But still a lot has to be done. Advisory committees have been constituted in all the districts and their meetings are held periodically. The topics of PNDT Act, Gender issues and Declining Sex ratio have been included in RCH training for Medical Officers conducted at SIHFW. The **Age at marriage** for boys is 21.8 and 17.8 for girls as per DLHS 2002. 42.8% of girls in the rural areas were married below 18 years. As per the block data out of 4227 girls who got married last year 47 were less than 18 years. There is no specific data on **Gender Based Violence** but women take it as part of marriage and hence undermine the facts. **Male involvement in Family Welfare** is minimal since there are very few Vasectomies as against Tubectomies. The **indicators for morbidity and mortality** also show differential values for boys and girls. The service providers are also not **gender sensitive**.
Objectives	1. Empowering women 2. Increasing male involvement in RCH activities 3. Addressing adverse Sex Ratio 4. Sensitizing the personnel on issues of Gender 5. Implementation of PNDT Act 1995.
Strategies &	1. Addressing Adverse Sex ratio

Activities	• Workshops with private providers, IMA members, Religious leaders, Caste leaders, PRIs, MLAs • Early registration of pregnancies through TBAs, ASHAs, AWWs, Numberdar and Chowkidar and any of these to get Rs 50 per case for early registration of pregnancy • Rallies in all schools and colleges and generating discussions in schools and colleges through debates • Regular advertisements in the newspapers • Swearing-in-ceremonies at the time of marriages regarding female foeticide • Regular meetings of the Appropriate Authorities • Registration of all Ultrasonography machines • Review of the monthly format to be filled by the Ultrasonography machines providers 2. Increasing male involvement in family planning • Use of condoms for safe sex • Vasectomy and NSV are safer and easier to perform in primary health centres than Tubectomy. • BCC activities to focus on men for Vasectomy. Service delivery sites for male methods by training health providers in NSV and conventional vasectomy will be expanded so that each PHC and Block PHC in the district has at least a provider trained in NSV. • Demand for male contraceptive methods, men's reproductive health services through designing and implementing male-focused BCC activities. 3. A Research Study on the effect on bachelors in District East Champaran due to the shortage of girls and also the ill effects in Society. 4. Gender sensitization training will be provided for all health providers in the PHC/PHC and integrated into all other training activities so that they will have greater awareness of factors that influence women's decision making and thereby help them respond better to the needs of women and support her in exercising her choice. 5. Increasing the age of marriage • IEC activities for the harmful effects of early marriage • Registration of marriages • All the printing press people who print wedding cards should send one card to the Civil Surgeon's office 6. Health card would be provided to all girl children upto the age of 18 years. 7. Improving the Literacy status and promotion of education upto 10th standard. The

Panchayats shall be granted incentives for ensuring 100 percent enrolments of girls in the age group of 6-14 years in schools.

8. Treatment of anaemia in girls and also improving their nutritional status through Supplementary food at the AWCs
9. Reporting of Gender Based Violence cases by all the departments
10. Promotion of Samoohic Vivahs
11. Affidavit in court should be given regarding the dowry given to prevent false cases.
12. Implementation of PNDT Act in the District by proper and routine check up of Ultrasound Clinics in the district.

Support required

Strict enforcement of the PCPNDT Act
Support from other departments as mentioned under intersectoral convergence

Timeline

Activity	**2010-11**
Workshops with all stakeholders	x
Incentives for early registration of Pregnancy	x
Promoting male involvement through Vasectomy	x
Study on the plight of bachelors	x
Developing strategies to publicize the problem of the bachelors	
IEC for Vasectomy	x
Health Card for girl Child	x
Advisory group meetings	x

Budget

Activity / Item	**2011-12**
Workshops with private providers, IMA members, Religious leaders, Caste leaders, PRIs, MLAs in every block and Gram Panchayat and with SHGs	250000
Incentive for Early registration of pregnancies @ Rs 50 per case x 20000 pregnancies	100000
Rallies in all schools and colleges and generating discussions in schools and colleges through debates	200000
Regular advertisements in the newspapers	120000
Health Card for Girl Child @ Rs 2 /card x 10,000 cards	20000
Price for the panchyats for three best sex ratio in the district @ 100000, @ 50000 & @ 20000	170000
Price for the panchayat where the girls age group 6-14 years 100% enrollement in the schools @ 20000	100000
Monitoring and meetings of advisory committee	100000
Computer and other asseceries	50000
Total	**2540000**

10. CAPACITY BUILDING

Trainings	
Status	Training is an essential part of human development. Although the personnel have the basic skills necessary for carrying out their duties there is a need to upgrade the skills as well as to keep pace with the new developments under NRHM. There is a skill gap for managing safe deliveries, Abortions, Newborn Care, managing Childhood illnesses, Obstetric and Paediatric emergencies, morbidity and epidemics. There is no system for continuing education of the personnel. The management skills are also lacking resulting in poor management of programmes including financial management. Most of the personnel are unable to use computers and internet. The trainings are carried out by the SIHFW alongwith the Regional training centres and the district training centres. There is a shortage of staff and also rapid turnover. The specialists leave very rapidly since the payment to the specialists is very low as compared to Delhi and Punjab. The staffs who have received trainings are not placed in the facilities where they can utilize their skills. The monitoring of the trainings is not done hence the quality of trainings is in question. Also there is no monitoring of the work output of the personnel for which they have received the trainings. 225 ASHAs have been trained. Some of the skill birth attendants are already trained and rest are required training in plan period
Objective	Reduction in the MMR and IMR Fully skilled personnel at all levels in the Health sector, ICDS, PRIs, NGOs and private sector for provision of services
Strategy	1. Development of training plan and methodology for all the personnel on various issues of RCH to reduce the Maternal and Neonatal mortality, meeting the unmet needs, building Gender perspective, good programme management and managing various components of NRHM 2. Ensuring the quality of trainings
Activity	**1. Capacity building for the reduction in Maternal and Neonatal mortality** • TBA training for 15 days in the concept of clean deliveries, danger signs, early referral, Newborn care and family planning, communication, • MTP training on MVA to all PHC MOs for 15 days. In 2009-10, 10 Lady MOs will be trained. Refresher trainings on MVA to be given • Training in Obstetric management & skills for operationalization of 24x7 PHCs for 16 weeks • Training in skilled Birth attendants (ANM for 21 days & LHV, SN for 14 days) • IMNCI training to ANM/LHV, SN, MO, CDPO for 8 days in the area covering the 24 x 7 PHCs • Integrated skill training for Urban Medical Officers for 12 days at Rohtak Medical

College

- Training on Blood transfusion for MOs and Lab Technicians for CEmOC centres with Blood storage facilities for 3 days
- Training in Life saving/Anaesthesia for EmOC at FRUs for MOs for 18 weeks
- Integrated skill training of all SN
- Integrated skill training for ANMs
- Training of ASHAs
- Training in management of newborns and sick children at Medical College Rohtak of the MOs, SN,
- Training in BCC for MOs, LHVs, ANMs
- Training of Ayush personnel on issues of RCH and reporting for 3 days

2. Capacity building to meet the unmet needs

- Training on NSV for MOs for 5 days
- Training for Laproscopic Sterilization for Surgeons, Gynaecologists, SN, OT attendants for 12 days
- Skill upgradation of ANMs & LHVs for 5 days
- Orientation on contraceptive devices for MOs of Govt facilities as well as private facilities

3. Training on Medico-legal aspects

4. Capacity building for Gender equality

- Orientation on Gender equality & PCPNDT Act for DCs, CSs, doctors both Govt and private, members of District Appropriate authority NGOs

5. Capacity building for good programme management

- Professional Development course for District Programme Managers, Senior district officials, SMOs for 10 weeks
- Management Development course for MOs for 5 days
- General and Financial rules (G & FR) for the district officials, MOs, clerical staff for 3 days
- Financial management training for Accounts Officers, Accountants for 3 days
- Computer training to all the MOs, Clerical staff, accounts personnel

6. Capacity building for managing the other components of NRHM

RNTCP

- Reorientation Training of DOT providers for 1 day

	• Orientation of MOs on revised Paediatric & PWBs under Paediatric management for 1 day • Training of newly appointed MOs (1) under RNTCP – MO TU, M/Garh for 10 days Convergence for Sanitation and hygiene under NRHM • One day orientations of VHWSCs for total sanitation **Disease Control Programme** – Blindness Control, Malaria, IDSP, IDDM • MPW • LT training PRIs • Training on NRHM and their roles of the members of the Zila Parishad, Panchayat Samitis, Gram Panchayat members, VHWSCs for 1 day NGOs • Training in BCC • Training of Field NGOs Private Sector Training on Family Planning issues, PCPNDT Act, Reporting **7. Ensuring the quality of trainings** • A district quality training team will be formed to ensure the organization of trainings as per schedule, arrangements and monitoring the quality of all the trainings on the basis of checklists to be developed by the state. • They will ensure the availability of trainers and the staff at the District Training Centre. • The team will also monitor the work output of the trained personnel and give recommendations regarding improvements in the training and the future requirements. • A list of Resource persons will be developed from the State for specialized issues.
State Support	• SIHFW to develop the training calendar and organize the trainings as per schedule • Medical colleges to be prepared for providing trainings on EmOC, MTP, Neonatal Care • Monitoring by the State the quality of trainings and the work output through the development of a format and checklist • Placement of the personnel trained in various specialized issues at the right facilities • Ensuring staff at the District training centre

Timeline	**Activity**	**2011-12**
	SBA training for 95 MOs x 2 batches for 14 days	20
	MVA MTP training to all PHC MOs for 14 days x 38 MOs x 5 batches	15

	Training on Blood transfusion for MOs and Lab Technicians for EmOC centres with Blood storage facilities for 3 days	1MO 1LT
	Training in Obstetric management & skills for 24x7 PHCs for 16 weeks	2 MOs/2 SN
	Training in skilled Birth attendants for 14 days for LHV & SNs and for 21 days for ANMs x 9 batches for ANMs and 4 batches for LHV/SNs	52
	IMNCI training to ANM/LHV, SN, ASHA for 8 days x 9 batches	225
	IMNCI training to MOs x 1 batch	22
	Integrated skill training for Urban MOs for 12 days at Rohtak Medical College	5 MOs
	Integrated skill training of all SN	10 SNs
	Integrated skill training for ANMs	20ANMs
	Integrated skill training for MOs	5 MOs
	Training of MOs, SN in Mgt of Newborns & sick children at Medical College Rohtak	2 MOs 2 SN
	Training in BCC for MOs, LHVs, ANMs, x 5 days	12 MOs, 5 LHVs 25 ANMs
	Training on NSV for MOs at NSV camps	4 MOs
	Training on Minilap x 12 days x 15 persons	15
	Training for Laproscopic Sterilization for MOs x 12 days	15
	Orientation on contraceptive devices for MOs - Govt and private facilities	150
	Training on Medico-legal aspects to MOs,	30 MOs & SMOs
	Training on IUD for MOs x 5 batches	4
	Training on IUD for SN/ANMs/LHV x 20 batches	100
	Orientation on PCPNDT Act for DCs, CSs, doctors both Govt and private, members of District Appropriate authority NGOs in a workshop	x
	Training of NGOs in BCC @ Rs 300 per person x 6 days	20 persons
	Professional Development course for District Programme Managers, Block Programme Managers, Senior district officials, SMOs for 10 weeks	Mgrs 5. Distt Officials 4, SMO 3
	Training in Life saving/Anaesthesia for EmOC at FRUs for MOs for 18 weeks	0
	Training of ASHAs	Discussed in the respective chapters
	Disease Control Programme – Blindness Control, malaria, IDSP, IDDM, RNTCP	
	Training for **Urban Health** Centres	
Budget	**Activity**	**2011-12**
	SBA training for 95 ANMs x 2 batches for 21 days	2600000
	MVA MTP training to all PHC MOs for 14 days x 38 MOs x 21630 x 5 batches	5753600
	Training on Blood transfusion for MOs and Lab Technicians for EmOC centres with Blood storage facilities for 3 days	-
	Training in Obstetric management & skills for 24x7 PHCs for 16 weeks	-
	Training in skilled Birth attendants for 14 days for LHV & SNs and for 21 days for ANMs x @ 41855 x 9 batches for 49 ANMs	1845800

	IMNCI training to ANM/LHV, SN, ASHA for 8 days x 105650 x10 batches	105700
	IMNCI training to MOs x 117900 x 1 batch	118000
	Integrated skill training for Urban MOs for 12 days	
	Integrated skill training of all SN @ 4200 x 10 persons	42000
	Integrated skill training for ANMs @ 2100 x 443 persons	930000
	Integrated skill training for MOs @ x 3700 x 5 persons	18500
	Training of MOs, SN in Mgt of Newborns & sick children	-
	Training in BCC for MOs, LHVs, ANMs, MOs: Rs 500/MO x 5 days LHVs & ANMs x 200 x5 days	500000
	Training on NSV for MOs at NSV camps	-
	Training on Minilap x 12 days x 15 persons	-
	Training for Laproscopic Sterilization for MOs x 12 days @21630x5 batch	108150
	Orientation on contraceptive devices for MOs - Govt and private facilities	-
	Training on Medico-legal aspects to MOs,	-
	Training on IUD for MOs x @11713x 5 batches	58565
	Training on IUD for SN/ANMs/LHV x @9556 x 20 batches	191120
	Orientation on PCPNDT Act for DCs, CSs, doctors both Govt and private, members of District Appropriate authority NGOs in a workshop	-
	Training of NGOs in BCC @ Rs 300 per person x 6 days	21600
	Professional Development course for District Programme Managers, Block Programme Managers, Senior district officials, SMOs for 10 weeks	-
	Training in Life saving/Anaesthesia for EmOC at FRUs for MOs for 18 weeks	-
	Training of ASHAs @ 38194 x 8 batches	305552
	Block training Facilitator @ 51321 x 1 batch	51321
	Total	**12649908**

11. HUMAN RESOURCE PLAN

Human Resource Plan	
Situation Analysis/ Current Status	The Human Resources in district East Champaran are grossly inadequate. There is a 40 % turnover of doctors' inspite of the fact that contractual doctors are being hired. The fast urbanization and unparalleled growth in the nearby villages will have to look at the health facilities which are unable to cope with the demands today. In 2012 the population will be around 10 lakhs at least with the slum population increasing five fold. There is no motivation for the doctors to work and promotions are hard to happen. Due to the increased urbanization the doctors prefer to work in Private facilities. **Subcentre level** • The number of subcentres including urban centres will have to be increased from 117 to 132 • The requirement of ASHAs will be around 1000 including the urban[norm of one for 1000 population] • The requirement of ANMs will be around 264 in Government as per IPHS norms of 2 ANMs per Subcentre. • Delivery huts will be required for each of these subcentres. At present there are 31

	delivery huts. In 2009-10, 40 will be required. • There are 16 villages having population coverage more than 5000, these villages needs additional ANMs **PHC level** • The PHCs required in 2009-10 will be around 25 • HR Requirement is reflected in gaps identified in Facility survey. **PHC Level** • The PHCs required in 2009-10 will be around 7 and at least 2 General hospitals.
Objectives	To equip health system with adequate manpower especially as per IPHS to meet the NRHM goals.
Strategies & Activities	1. Rational placement of Specialists and trained staff 2. Recruitment of staff on contract where vacancies 3. Approval of staff for new facilities including Urban facilities 4. Motivational measures to retain staff 5. Rs 10000 per month as hardcore allowances to all the doctors
Support required	1. The State must approve and give sanctions for the necessary personnel for each facility before actually starting the facilities. 2. Contractual staff should be allowed recruitment as and when required. Permission from State should not be taken each time.

Activity / Item	Current Status	2010-11 Proposed	2011-12
			Required
Sub Center	**315**	**472**	**229**
ANM (R) ANM (C)	291 152		128 351
Health worker Male	6	60	54
ASHA	2686	3689	1003
PHC	**20**	**30**	**50**
MO (R) MO (C)	91 98	128	30
Pharmacist			
Staff Nurse (R) Staff Nurse (C)	17 30	165	7 135
Health Educator/Male supervisor	30	31	1
LHV	17	43	26
UDC/ Computer Clerk	20	40	20
LDC	89	109	20
Lab Tech	5	42	37
Class IV	231	306	75
SMOs	2	4	2
Staff Nurse	12	70	58
PHN	0	7	7
Computer cleark	3	7	4
Dresser	0	7	7
Pharmasist	7	7	0
Lab Tech	4	7	3
BEE	2	7	5
Radiographer	3	7	4
UDC/ Computer Clerk	5	7	2
LDC	9	14	5
Epidemiologist	0	7	7
Total Class IV	18	**70**	52
LMO (for PHC)	3	**18**	15
LMO (for PHC)	1	**7**	6
Accountant for PHC	0	**18**	22
Accountant for PHC	7	**7**	0

Budget for Contractual Staff	Activity / Item	Unit Cost(per year)in lacs	2010-11	2011-12	
	Sub Center		**319**	**512**	
	ANM	136260	33	4496580	
	Health worker Male	118800	46	5464800	
	PHC		**20**	0	
	MO	252660	8	2021280	
	Pharmacist	153720	7	1076040	
	Staff Nurse	153720	49	7532280	
	ANM	136260	6	817560	
	Health Educator/Male supervisor	153720	10	1537200	
	LHV	171180	11	3081240	
	PHN	171180	18	3081240	
	UDC/ Computer Clerk	118800	18	2138400	
	LDC	91330	18	1643940	
	Lab Tech	118800	16	1900800	
	Class IV	69330	46	4431180	
	PHC		**0**	0	
	SMOs	3152250	5	15761250	
	Staff Nurse	153720	58	8915760	
	PHN	171180	7	1198260	
	Computer cleark	91330	4	639310	
	Dresser	69330	7	485310	
	Pharmasist	153720	0	153720	
	Lab Tech	118800	3	356400	
	BEE	153720	5	768600	
	Radiographer	118800	4	475200	
	UDC/ Computer Clerk	1933680	2	3867360	
	LDC	798060	5	3990300	
	Epidemiologist	2758220	7	19307540	
	Total Class 4	693300	50	34665000	
	LMO (for PHC)	252660	15	3789900	
	LMO (for PHC)	252660	6	1515960	
	Accountant for PHC	96000	22	2112000	
	Accountant for PHC	120000	0	120000	
	Hard core allowance to all Doctors	120000	71	8520000	
			Total	**143939410**	

IEC/BCC	
Status	There is lack of awareness and good practices amongst the community due to which they neither avail the services nor take any positive action. There is lack of awareness regarding the services, schemes including the Fixed Health days. The following issues need special focus: • Spacing methods, ideal interval between births, no scalpel vasectomy, information about FP facilities and MTP facilities available at different levels • Importance of 3 visits for ANC, advantages of institutional delivery, Post

	natal care, availability of skilled birth attendants, balanced diet during pregnancy, anaemia, misgivings about IFA, kitchen garden • Importance of complete immunization, disadvantages of drop outs, nutritional requirements of infants and children, malnutrition, exclusive breastfeeding • Problems of adolescents, drugs addiction, malnutrition, problems of sexuality, age at marriage, tendency to take risks in sexual matters • DOTS programme for TB, location of microscopy centres, cardinal symptoms of TB, • High risk behaviour in the community in relation to water born diseases, heart diseases and lung diseases, and HIV/AIDS, STDs • Evil of drugs addiction affecting adolescents, • High prevalence of RTIs, including STDs, • Issues of malaria spread and prevention and also other diseases • JSY, Fixed Health days , availability of services The personnel have had no training on Interpersonal communication.
Objective	Widespread awareness regarding the good health practices Knowledge on the schemes, Availability of services
Strategy	1. Information Dissemination through various media, 2. Interpersonal Communication 3. Promoting Behaviour change
Activity	1. Awareness on • Fixed MCHN days • JSY • Services available 2. Designing of BCC messages on exclusive breast feeding and complimentary feeding, ANC, Delivery by SBA, timely referral, PNC, FP, Care of the Newborn, Gender, hygiene, sanitation, use of toilets, male involvement in the local language 3. Consistent and appropriate messages on electronic media – TV, radio 4. Use of the Folk media, Advertisements, hoardings on highways and at prominent sites 5. Training of ASHA/AWW/ANM on Interpersonal communication and Counselling on various issues related to maternal and Child health 6. Display of the referral centres and relevant telephone numbers in a prominent place

	in the village 7. Promoting inter-personal communication by health and nutrition functionaries during the Fixed health & Nutrition days 8. Orientation and training of all frontline government functionaries and elected representatives 9. Integration of these messages within the school curriculum 10. Kit for the newly married and during first pregnancy to be given at the time of marriage and during pregnancy 11. Mothers meeting to be held in each village every month to address the above mentioned issues and for community action 12. Kishore Kishori groups to be formed in each village and issues relevant to be addressed in the meetings every month 13. Meetings of adult males to be held in each village to discuss issues related to males in each village every month and for community action. 14. Village Contact Drives with the whole staff remaining at the village and providing services, drugs , one to one counselling and talks with the Village Health & Water Sanitation Committee and the Mother's groups 15. Developing Nirdeshika for holding Fixed Health & Nutrition days to be distributed to all MOs, ANMs,AWWS, LS, PRIs, 16. Monthly Swasthya Darpan describing all the forthcoming activities and also what happened in the month alongwith achievements 17. Bal Nutrition Melas 4 times at each Subcentre 18. Wall writings 19. Pamphlets for various issues packed in an envelope
State Support	State to give guidelines for the good practices and also training module on BCC
Timeline and Budget	**Activities** / **2011-12** Finalizing the messages / x Advertisements / x TV spots / x Folk Media shows x 286 villages / x Hoardings on highways and prominent places / 100 Display boards / 90 Pamphlets x / 10,000

	Developing Nirdeshika for holding Fixed Health & Nutrition days	4000
	Monthly Swasthya Darpan	4000
	SMS meetings in each village	x
	Bal Nutrition Melas in each SC	x
	Kishori Shakti meetings in each village	x
	Opinion leaders workshops	100
	Wall writings	x
Budget	**Activities**	**2011-12**
	Finalizing the messages	50000
	Advertisements	250000
	TV spots	125000
	Folk Media shows @ Rs 1000/1634 village	**1634000**
	Hoardings @ Rs 10000/hoarding x 100 hoardings	1250000
	Display boards @ Rs 2500/board x 160 Display boards	400000
	Pamphlets @ Rs 5/pamphlets x 100000 pamphlets	500000
	Nirdeshika for Fixed Health Nutrition days @ Rs 20/ Nirdeshika	80000
	Swasthya Darpan @ Rs.20 /copy/month	480000
	Bal Nutrition Melas @ Rs 300 x 4 times x No of 319 HSCs	382800
	Opinion leaders workshops @ Rs 300 /person x 100	30000
	Wall writings @ Rs 500 x 1634 villages	817000
	Total	**5998800**

Procurement and Logistics

Situation Analysis/ Current Status	In district East Champaran there is no proper Warehouse. There are rooms in which drugs are stored but it is not a scientific Warehouse. Most of the drugs are supplied by the State but some drugs are locally procured. Inventory Management is not very scientific and the records are not computerized. There is no system of wastage control, replacements, transfer of stocks from one centre to the other. Record Keeping is done manually. There is one storekeeper in the General hospital and two in the District Malaria Office. Requirements are also not made scientifically.	
Objective	Development of a Scientific Warehouse system.	
Strategies	1. Developing a Warehouse 2. Capacity building of the personnel for stores and also record keeping 3. Computerization of all the stocks	
Activities	1. Construction of a scientific Warehouse 2. Procurement of software and computer hardware for the Warehouse from TNMSC 3. Proper Equipment and hardware 4. Availability of Pharmacist, Assistant Pharmacist, Packers 5. Training of personnel Appointment of an agency for Operationalization of the Scientific Warehouse	
Support required	State to develop a scientific and transparent Procurement, Logistics and Warehousing system with quality control	
Timeline	**Activity / Item**	**2011-12**
	Construction of Warehouse	x
	Software	x
	Computer system with UPS, Printer, Scanner,	x
	Equipment & Hardware	x
	Pharmacist @ Rs 9000/mth	
	Assistant Pharmacist @ Rs 5000/mth	
	Packers -2 @ Rs 4000/mthx2	
	Security Staff @ Rs 6000/mth	
	Training of personnel	
	Consultancy to agency for Operationalization of the Warehouse	x
Budget	**Activity / Item**	**2011-12**
	Construction of Warehouse	2500000
	Software	25000
	Computer system with UPS, Printer, Scanner,	70000
	Equipment & Hardware	1000000

	Pharmacist @ Rs 9000/mth	108000
	Assistant Pharmacist @ Rs 5000/mth	60000
	Packers -2 @ Rs 4000/mthx2	96000
	Security Staff @ Rs 6000/mth	72000
	Training of personnel	
	Consultancy to agency for Operationalization of the Warehouse	200000
	Total	**4131000**

13. PROGRAMME MANAGEMENT

Strengthening of District Health Management

Situation Analysis/ Current Status	The District Health Mission and Family Welfare Society have formed been registered in East Champaran. The Society is reconstructed and with these following members and the Deputy Commissioner as the Governing board President. The members are all the Programme Officers, Education, SDM, IMA president, ICDS, PWD. The Governing body meetings are held monthly under the chairmanship of the Deputy Commissioner. Although the DH&FWS formed and meetings conducted regularly but still they are not focused on health issues and need proper training on planning and management.
Objectives/ Milestones/ Benchmarks	District Health & Family Welfare Society to make functional and empower to plan, implement and monitor the progress of the health status and services in the district.
Strategies	1. Capacity building of the members of the District Health Mission and DH&FW Society regarding the programme, their role, various schemes and mechanisms for monitoring and regular reviews. 2. Establishing Monitoring mechanisms 3. Regular meetings of Society.
Activities	1. Orientation Workshop of the members of the District health Mission and Society on strategic management, financial management & GoI/GoH Guidelines. 2. Monthly Review and planning meetings. 3. Improving the Review and planning meetings through a holistic review of all the programmes under NRHM and proper planning. 4. Formation of a monitoring Committee from all departments. 5. Development of a Checklist for the Monitoring Committee. 6. Arrangements for travel of the Monitoring Committee Sharing of the findings of the committee during the Field visits in each Review Meeting with follow-up of the recommendations.

Support required	1. Technical and financial assistance needs to be imparted for orientation and integration of societies. 2. A GO should be taken out that at the district level each department should monitor the meetings closely and ensure follow-up of the recommendations. 3. Instructions & directions from GoH for proper functioning of the societies and monitoring committee. 4. Funds to maintain society office & staff.	
Timeline	2010-11 1.Orientation Workshops of the members of the District Health Mission and District Health & Family Welfare Society 2. Monthly Review and Planning Meetings will be organized. 3. Formation of the monitoring Committee and will start the monitoring visits. 4.Strengthening of the Monitoring Committee	
Budget **In Lakhs**	**Activity / Item**	**2011-12**
	Orientation Workshop	62500
	Monthly Meetings	15000
	Mobility for Monitoring	144000
	Total	**221500**

District Programme Management Unit	
Status	In NRHM a large number of activities have been introduced with very definite outcomes. The cornerstone for smooth and successful implementation of NRHM depends on the management capacity of District Programme officials. The officials in the districts looking after various programmes are overworked and there is immense pressure on the personnel. There is also lack of capacities for planning, implementing and monitoring. The decisions are too centralized and there is little delegation of powers. In order to strengthen the district PMU, three skilled personnel i.e. Programme Manager, Accounts Manager and Data Assistant have being provided in each district. These personnel are there for providing the basic support for programme implementation and monitoring at district level under DH&FW Society. The District Programme Manager is responsible for all programmes and projects in district under the umbrella of NRHM and the District Accounts Manager (DAM) is responsible for the finance and accounting function of District RCH Society including grants received from the state society and donors, disbursement of funds to the implementing agencies, preparation of submission of monthly/quarterly/annual SoE, ensuring adherence to laid down accounting standards, ensure timely submission of UCs, periodic internal audit and conduct of external audit and implementation of computerised FMS. The District Data Assistant (DDA) has to work in close consultation with district officials, facilitate working of District RCH Society, maintain records, create and maintain district resource database for the health sector, inventory management,

	procurement and logistics, planning and monitoring & evaluation, HMIS, data collection and reporting at district level. There is a need for providing more support to the Civil Surgeon office for better implementation especially in light of the increased volume of work in NRHM, monitoring and reporting especially in the areas of Maternal and Child Health, Civil works, Behaviour change and accounting right from the level of the Subcentre. The Civil surgeon's office is located in the premises of the only General hospital in the district. The office of all the Deputy Civil Surgeons is also in hospital premises.
Objectives	Strengthened District Programme Management Unit
Strategies	1. Support to the Civil Surgeon for proper implementation of NRHM. 2. Capacity building of the personnel 3. Development of total clarity at the district and the block levels amongst all the district officials and Consultants about all activities 4. Provision of infrastructure for the personnel 5. Training of District Officials and MOs for management 6. Use of management principles for implementation of District NRHM 7. Streamlining Financial management 8. Strengthening the Civil Surgeon's office 9. Strengthening the Block Management Units 10. Convergence of various sectors

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

	consultant of the District Project Management Unit. 5. Provision of office space with furniture and computer facilities, photocopy machine, printer, Mobile phones, digital camera, fax, etc; **6. Use of Management principles for implementation of District NRHM** • Development of a detailed Operational manual for implementation of the NRHM activities in the first month of approval of the District Action Plan including the responsibilities, review mechanisms, monitoring, reporting and the time frame. This will be developed in participatory consultative workshops at the district level and block levels. • Financial management training of the officials and the Accounts persons • Provision of Rs. 500000 as Untied funds at the district level under the jurisdiction of the Civil Surgeon 7. **Strengthening the Block Management Unit**: The Block Management units need to be established and strengthened through the provision of : • Block Programme Managers (BPM), Block Accounts Managers (BAM) and Block Data Assistants (BDA) for each block. These will be hired on contract. For the post of BPM and the BAM retired persons may also be considered. • Office setup will be given to these persons • Accountants on contract for each PHC since under NRHM Subcentres have received Rs 10,000; also the village committees will get Rs 10,000 each, besides the funds for the PHCs. • Provision of Computer system, printer, Digital Camera with date and time, furniture **8. Convergence of various sectors at district level** • Provision of Convergence fund for workshops, meetings, joint outreach and monitoring with each Civil Surgeon 9. **Monitoring the Physical and Financial progress** by the officials as well as independent agencies 10. **Yearly Auditing** of accounts
Support from state	1. State should ensure delegation of powers and effective decentralization. 2. State to provide support in training for the officials and consultants. 3. State level review of the DPMU on a regular basis.

4. Development of clear-cut guidelines for the roles of the DPMs, DAM and District Data Manager.

5. Developing the capacities of the Civil Surgeons and other district officials to utilize the capacities of the DPM, DAM and DDA fully.

6. Each of the state officers Incharge of each of the programmes should develop total clarity by attending the Orientation workshops and review meetings at the district and the block levels for all activities.

7. If qualified persons for the posts of DPM, DAM are not available then State should allow the appointment of facilitators or Coordinators or retired qualified persons by the District Health Society.

Time Frame

2010-11

- Selection of District level consultants, their capacity building and infrastructure
- Development of an operational Manual 2011-12
- Selection of Block Management Units and provision of adequate infrastructure and office automation
- Capacity building up of District and Block level Management Units
- Training of personnel
- Reorientation of personnel

Budget in Lakhs

Activity	**Year 2011-12**
Honorarium DPM,DAM,DDA and Consultants	3000000
Travel Costs for DPMU @ Rs 12,000/ per month x 12 mths	144000
Infrastructure costs, Furniture, computer systems, fax, UPS, Printer, Digital Camera	100000
Workshops for development of the operational Manual at district and Block levels	100000
Untied Fund	50000
Joint Orientation of Officials and DPM, DAM, DDM	25000
Management training workshop of Officials	50000
Personnel for BPMU	7560000
Training of DPM and Consultants	500000
Review meetings @ Rs 1000/ per month x 12 months	12000
Office Expenses @ Rs 10,000/month x 12 months for district	120000
Annual Maintenance Contract for the equipment	
Travel costs for BPMU @ Rs 5000 per month per 27 block	135000
Monitoring of the progress by independent agencies	100000
Hiring of vehicles at block level @ Rs 800x 5 days /mth x 20 PHC/APHCsx12 mths	960000
Office expenses for Blocks @ Rs 5000 x 27 blocksx 12	1620000
Total	**14476000**

Detailed calculation of Budget for Personnel at DPMU for one year

S.No	Details	Units	Unit Cost	Amount for 12 months
	Personnel at District level			
	District Programme manager	1	23000	276000
	District Accounts Manager	1	18000	216000
	District Data Assistant	1	15000	180000
	Consultant for Maternal Health	1	40000	480000
	Consultant for Child Health	1	40000	480000
	Consultant for Civil Works	1	40000	480000
	Consultant for HMIS	1	40000	480000
	Consultant for Behaviour Change	1	40000	480000
	SubTotal			**3072000**
	Personnel at Block level			
	Block Health manager	20	15000	300000
	Block Accounts Manager	20	12000	240000
	Block Data Operator	20	10000	200000
	Subtotal			**3812000**
	Hiring of vehicles at block level @ Rs 800x 5 Days x27 blocks x12 months	20	4000	**1296000**
	Office Automation with Furniture, Computer system, Camera, Printer, etc	20for BPMU 1 for DPM 1 for DAM	100000	**2200000**
	Gross Total			**7308000**

14. FINANCING OF HEALTH CARE

Financing Health Care		
Situation Analysis/ Current Status	For sustainability and needs based care, health financing is the key. In District East champaran Rogi Kalyan Samiti(RKS) have been formed in each of the hospitals,and PHCs. These are hospital autonomous societies which are allowed to take user fees for services provided at the facilities. Formation of these RKS has resulted in great satisfaction amongst the patients and also the staffs since now funds are available with the facilities to care for the people. No trainings have been given for the skill building of the Incharges of these facilities. There is no standardized reporting format and information regarding these RKS is available.	
Objectives	Availability of sufficient funds for meeting the needs of the patients	
Strategies	1. Generation of funds from User charges 2. Donations from individuals 3. Efficient management of the RKS 4. Provision of Seed money to each RKS	
Activities	1. Generation of funds from User charges: User charges are taken for Registration, IPD, Laboratory investigations from persons who can afford to pay. 2. Donations from individuals: Donations are to be generated from individuals. For the betterment of hospitals, equipment, additions to the buildings, etc 3. Efficient management of the RKS: Training will have to be given for efficient management and utilization of the funds for activities that generate funds. Computerization of data and all the parameters need to be carried out preferably through customized software. Trainings can be organized with the help of SIHFW Bihar who have developed modules and conducted trainings for the management of these Societies. **4.** Provision of Seed money to each RKS at PHCs and PHCs of Rs 100000 each year for repair, purchase of new equipment, additions, alterations, etc'; **5.** Development of customized software and training of staff for the use of this software **6.** Regular filling of formats	
Support required	1. Timely meetings of Rogi Kalyan Samitis **2.** Trainings on the management of the RKS	
Timeline	**Activity**	**2011- 12**
	Provision of Seed money @ Rs 1 lakh per PHC @ Rs 1.00 lakhs	**2000000**
	Training of the Incharges and second in command @ Rs 800 per person	**16000**
Budget	**Activity**	**2011- 12**
	Provision of Seed money @ Rs 1 lakh per PHC @ Rs 1.00 lakhs	**200000**
	Training of the Incharges and second in command @ Rs 800 per person x 1 day	**16000**
	Total	**216000**

15. HMIS, MONITORING AND EVALUATION

HMIS	
Status	HMIS is a monitoring tool for the performance that provides information to support planning, decision-making and executive control for managers in the Health & FW department. In this sector Data collection is ongoing for more than 60-90 different conditions. The basis of HMIS is the data collected by the ANM who is over burdened with a substantial amount of her time being spent on surveillance related activities. Each year a CNAA exercise is carried out but the set procedures under the CNAA are generally not followed in development of annual action plans and in their utilization in planning the activities of health workers. The action plans are prepared more as a normative exercise rather than as a management tool for estimation of service needs and monitoring the programme outputs. There is no horizontal integration of surveillance activities of existing disease control programmes. Absence of clear case definitions and poor supervision or crosschecking of the data collected hampers the quality of reporting. Non-Communicable diseases are not included in surveillance even though the burden due to them is high. Absence of formats for reporting diseases also affects quality of the data collect. The data from the ANMs is sent upto the district level with no analysis done at any of the higher levels. There is no system of feedback to the lower levels in the health system. The transmission of data is affected by poor communication facilities available. Data is not collected from private practitioners, private laboratories and private hospitals both in rural and urban setting. Data collected during emergencies and epidemics is of better quality The response system at the District level is activated only in times of outbreaks. There is lack of coordination between departments. Discrepancy between the data of the Health department and the ICDS. There is large gap between reported and evaluated coverage. The District administrative system not able to make use of the health data. There is inadequate understanding regarding the classification of diseases. HMIS software consisting of all the data collected right from the Sub-centres with online facilities is not available Computers have been supplied upto the PHCs. The HMIS Software is developed by health department on their Web Portal and monthly reports are sending through the Software.
Objective	Integration of several parallel running programme software HMIS is used for decision making on regular basis Inclusion of RCH indicators monitoring Linkage to decision making at Central level Refresher training Make it more useful for State level officials
Strategy	1. Proper implmentation of RCH HMIS performa up to the SC level 2. Improvement in the CNAA

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

Activities	**2011-12**
Internet connectivity	x
AMC for computers	20 comp.
Consumables for computers	x
Training for Data Entry and all other related staff	x
Printing monitoring Charts	2000
Provision of MIS Officer for the district	1

Budget	**Activities**	**2011-12**
	Internet connectivity @ Rs 1000 /mth x No of facilities x12 mths	12000
	AMC for computers @ Rs 5000 /computer /year x No of computers	60000
	Consumables for computers @ Rs 2000/mth/facility x 12 mths	24000
	Training of Staff related to HMIS up to SC Level @ 200 x2x 534 persons	213600
	Printing monitoring Charts @ Rs. 5 per monitoring chart	5000
	Salary to MIS Officer @ 12000 pm x 12 months	144000
	Honorarium for Data Center @ Rs 15000/ mth	180000
	Mobility support to M&E Officer @12000/mth	144000
	Every 4 BPHC one Resource person for hands on training of ANM @4 Days in one BPHC @ Rs 1000/day Hon, Rs 1000/ logistic and Rs 800/ per day travel	14000

	Data Back-up external hard disc	4000
	Total	**800600**

Monitoring

Situation Analysis/ Current Status	Monitoring is an important aspect of the programme but it is not happening effectively and regularly. Each officer and the PHC Incharges, MO PHCs are supposed to make regular visits and monitor the progress and check on the activities and also the data provided by the ANMs. The reports have to be submitted and discussed in the monthly review meetings at the entire forum. The District Health Society is not monitoring the progress and neither are the committees at the Block and Gram Panchayat levels. No proper Check-lists exist for monitoring. Also analysis is not done of the visits and any data collected No Verbal Autopsies (Maternal, Neo-natal, Infant & Child Death audits) are carried out any levels. The Role & Functioning of the Subcentre level Committee, PHC level Committee, SKS at PHC, PHC, and VLC need to be clearly defined. There is no system of concurrent Evaluation by independent agencies so that the district officials are aware regarding the progress and the lacunae.
Objectives	Effective Monitoring and Evaluation system
Strategies	1. Developing the system for visits, reporting and review 2. Developing a system of Concurrent Evaluation
Activities	1. Fixing the dates for visits, review meetings and reports 2. Development of Checklist for Monitoring 3. Software for the checklist and entry of the findings in the checklist 4. Each official and PHC MO to make at least 5% facility visits and also of the villages 5. Quality assessment of all health institutions. 6. Maternal Mortality Audit by MO and by involving LW/AWW for reporting of maternal deaths, **7.** Mobility for monitoring at all levels and with the use of district monitors
Support required	Appointment of Agencies for Concurrent Evaluation Monitoring by State from time to time State officials to attend Review meetings

Timeline

Activity / Item	**2011-12**	
Review meetings	x	
Mobility support for Deputy Civil Surgeon (Family Welfare & Immunization)	x	
Mobility support for monitoring MCHN days	x	
Quality assessment	All	
Trainings of all the committee members	x	
Maternal and Child death Audit	300	

Budget	Activity / Item	2011-12
	Review meetings @ Rs 1250/mtg x2 facilities x 12 mths	30000
	Mobility support for Deputy C.S. (Immunization and Family Welfare) for Monitoring for POL	60000
	Mobility support for monitoring MCHN days @ Rs. 800 X 5 days X 4 monitors X 12 months	192000
	Quality assessment of all health institutions each year @ Rs 2000/inst	40000
	Trainings of all the committee members	100000
	Maternal, Child death Audit @ Rs 1000/death	300000
	Total	**722000**

16 Bio-Medical Waste Management

Bio-Medical Waste Management	
Situation Analysis / Current Status	As per the Bio-Medical Waste Rules, 1998, indiscriminate disposal of hospital waste was to be stopped with handling of Waste without any adverse effects on the health and environment. In response to this the Government has taken steps to ensure the proper disposal of Biomedical waste from all Nursing homes, hospitals, Pathological labs and Blood Banks. The District Health Officer is the Nodal Person in each district for ensuring the proper disposal of Biomedical Waste. Trainings to the personnel for sensitizing them have been imparted, Pits have been dug, Separate Colour Bins/containers and Segregation of Waste is taking place though has to be done more systematically. Proper Supervision is lacking. GOI has sanctioned a Plasma Pyrolysis Plant. Plasma Pyrolysis is a state-of-the-art technology for safe disposal of medical waste. It is an environment friendly technology, which converts organic waste into commercially useful by-products in a safe and reliable manner. The plant will soon be installed and training will be imparted to two persons from the district.
Objectives	1. Stopping the indiscriminate disposal of hospital Waste from all the facilities by 2012 2. Ensuring proper handling and disposal of Biomedical Waste in each Facility
Strategies	1. Capacity Building of personnel 2. Proper equipment for the disposal and disposal as per guidelines 3. Strict monitoring and Supervision
Activities	1. Review of the efforts made for the Biomedical Waste Interventions 2. Development of Microplan for each facility in District & Block workshops

3. Capacity Building of personnel

- One day reorientation workshops for District & Block levels
- Training to two persons for Plasma Pyrolysis Plant. The company persons will impart this training.
- Biomedical Waste management to be part of each training in RCH and IDSP

4. Proper equipment for the disposal

- Plasma Pyrolysis Plant to be installed
- Installation of the Separate Colour Bins/containers and Plastic Bags for the bins

5. Segregation of Waste as per guidelines

6. Partnering with Private providers for waste disposal

7. Proper Supervision and Monitoring

- Formation of a Supervisory Committee in each facility by the MOs and the Supervisors

Timeline

Activity	**2011-12**
Orientation and Reorientation for the personnel for Biomedical Waste Management at District and Block levels	x
Consumables	x
Maintenance of the Plasma Pyrolysis plant	x
Payment for the incinerators	393

Budget

Activity	**2011-12**
Orientation and reorientation for Biomedical Waste Management at District and Block levels	150000
Consumables	100000
Maintenance of the Plasma Pyrolysis plant	350000
Payment for incinerators@ Rs. 8 per bed 12 mths	11520
Total	**611520**

17. ANNUAL WORK PLAN

Objectives:

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

Sr. No.	**Activity Indicators**	**Planned for 2011-12**	
		No.	**%**
1	ANC registration during the first trimester increased to	36418	60%
2	Complete ANC coverage increased to	19000	95%
3	Institutional Deliveries increased to	14000	70%
4	Deliveries by skilled birth attendants increased to	16000	80%
	No. of women benefited under JSY	2000	
5	Low birth weight new born reduced by	DNA	25 %
6	Complete Child Vaccination(in 12-23 months age) increased to	22000	95%
7	Severely malnourished (III & IV) decreased by	0	0 %
8	Increase CPR		70%
9	Female sterilization operations to be performed during the year	5000	
10	Vasectomies to be performed in the year	600	
11	Leprosy – Detection of new cases	0	0%
12	Tuberculosis – Detection of NSP cases	67/L	70%
13	Tuberculosis- No. of defaulters reduced to	<5	<5 %
14	No. of Malaria Deaths reduced to	00	100%

18. BUDGET AT-A-GLANCE (In Lakhs)		
S. N	**Components**	**2011-12**
A	**RCH-II**	
1	DHS	
2	DPMU	**7308000**
3	Maternal health	**288555750**
4	Child Health	**8976750**
5	Family Welfare	**12782300**
6	Adolescent Health	**4850000**
7	Gender & Equity	**2540000**
8	Capacity Building	**12649908**
9	HR	**143939410**
10	IEC	**5998800**
11	HMIS	**800600**
12	Monitoring	**722000**
	Total	
B	**NRHM**	
1	ASHA	**9809496**
2	SC Untied Fund & Maintenance	**6380000**
3	PHC Untied Fund & Maintenance	**4225000**
4	PHC Untied Fund & Maintenance	**3850000**
5	MMU	**5150000**
6	Upgradation of PHC	**10938750**
7	Upgradation of PHC	**62078750**
8	Upgradation of SC	**153710000**
9	VLC	**5220000**
10	Community Action Plan	**9967400**
11	PPP	**1387500**
12	Health Care Financing	**216000**
13	Logistics	**4131000**
14	Biomedical Waste	**611520**
	Total	
C	**Immunization**	
1	Immunization	**6802450**
D	**NDCP**	
1	RNTCP	**4052500**
2	Leprosy	**983000**
3	Malaria	**21185500**
4	Vector Borne	**175000**
5	Blindness Control	**2767000**
6	IDSP	**6499750**
7	IDD	**1417000**
8	Vitamin A	**2910000**
	Total	**807091604**
E	**Others**	
1	InterSectoral	**7106000**
	Grand total	**814197604**

Strengthing of D.P.M.U. & BPMU

Post	Salary per month per unit (in Rupees)
DPM	45000
DAM	35000
M & E.O	25000
BHM	24000
BAM	15000
DATA OPERATOR	12000

Other Office Expenses

Stationary	Per Yearr. per Unit **(in Rupees)**
Mobile	10000
Stationary	1 Lakh
Vehicle	180000

One time investment to strengthen DPMU & BPMU

Phone & Fax	**Rs. 5 Lakh (Aprox)**
Photo State (Machine)	
Water Cooler	
Furniture's	
Laptop	
Renovation of Office	

DISTRICT HEALTH SOCIETY,EAST CHAMPARAN

BUDGET FOR 2011-2012

Sl.	Name of Activities	Opening balance as on01.04.08	Fund Received during the year	Total fund available on 31.12.08	Total Expenditure during the year 31.12.08	Closing Balance as on 31.12.08	Demand for the year 09-10
1	Janani evam bal suraksha yojna	20031736	20000000	40031736	25819000	14212736	24000000
2	Family Planning	11776330	0	11776330	3817550	798780	0
3	Female Sterlization camp	252000	0	252000	0	252000	0
4	Blood storage centre	244600	400000	644600	0	644600	480000
5	In land letter	18750	0	18750	0	18750	
6	A.N.M. ('R') Honorarium	6142500	912600	7055100	659000	6396100	1095120
7	Training of A Grade Nurse	450000	0	450000	0	45000	0
8	Contractual A.N.M. Honorarium	52650	0	52650	0	52650	0
9	S.B.A. Training	231520	0	231520	208508	23012	0
10	I.M.N.C.I. Training	924624	0	924624	0	924624	0
11	Health worker Training for R.I.	188050	0	188050	188050	0	0

12	A.N.M. Instrument	238249	0	238249	0	238249	0
13	Drug Kit-A & Kit -B			9945000			
14	RCH/PHC/FRU Kit						
15	Fund for Different Kit's	9945000	0		3154359	6790641	0
16	ASHA Drug Kit	786680	0	786680	0	786680	0
17	ASHA Bag	117750	0	117750	0	117750	0
18	Health Mela	6000	0	6000	0	6000	0
19	IEC (Laminated Board)	160	0	160	0	160	0
20	IEC (Health realated Publicity)	713177	100000	813177	95276	717901	120000
21	District Flexi Pool fund	1798712	0	1798712	290674	1508038	0
22	Grant to Rogi Kalyan Samiti	300000	100000	400000	300000	100000	120000
23	District Action Plan	50000	0	50000	0	50000	0
24	Untied fund for sub centre	1650000	0	1650000	0	1650000	0
25	ASHA Identity Card	14634	0	14634	0	14634	0
26	ASHA Divas	743520	664020	1407540	385200	1022340	796824
27	ASHA Training	2513744	0	2513744	0	2513744	0
28	Construction of 2 M.O. Qtr at Areraj.	954450	0	954450	763560	190890	0
29	Rennovation of HSC Bulding	1317844	0	1317844	366600	951244	0
30	Rennovation of ICU	0	0	0	0	0	0
31	Vehicle for D.M.O.	30000	0	30000	30000	0	0
32	D.P.M.U. Salary	61259	636000	697259	0	697259	763200
33	State Management Fund	5360137	0	5360137	289992	5070145	0
34	ORS Purchase	343233	0	343233	0	343233	0
35	Routine Immunization Programme	4071823	2302199	6374022	899373	5474649	2762639
36	Pulse Polio Programme	222207	11737103	11959310	11675303	284007	14084523
37	Muskan Ek Abhiyan	10474500	0	10474500	3715760	6758740	0
38	Data Center at District Level	1369941	0	1369941	48000	1321941	0
	Total	**83395780**	**36851922**	**120247702**	**52706205**	**67541497**	**44222306**

PROGRAMME WISE FUND UTILIZATION AGAINST ALLOTMENT AND REQUIREMENT OF ALLOTMENT FOR 2010-11

Sl. No.	Name of Activities	Budget Alloted during 2009-10	Expenditure during this year up to Nov. 09	Fund Required for F.Y 2010-11
1	NRHM- A (RCH-II)	95884733	68507230	119855916
2	NRHM- B (RCH-II)	222586495	12223743	244845144
3	NRHM-C (Puls Polio)	25522151	22025699	25522151
4	NRHM-C (R.I.)	10210140	2261938	11231154
	Total	**354203519**	**105018610**	**401454365**

Chepter-

Maternal And Child Health

Name of the District:-East Champaran											
				Level-I & II				HR			
			Delivery Status	Staff in Place in numbers				Staff required in numbers(indicate : Regular/Contractual)			
Name of Block	Name and place of facility	Type of facility (Sub-Center/ APHC/NPHC any other)	Average Monthly Institutional Deliveries (Based on Jan to June 2010)	MO**, *** (please specify whether MBBS/ AYUSH/ Specialization)	SN	ANM	LT	MO	SN	ANM	LT*
ARERAJ	SANGRAMPUR	APHC	0	1 AYUSH	0	2	0	1	1	0	1
CHIRAIYA	SHIKARGANJ	APHC	0	1 AYUSH	0	1	0	1	1	1	1
DHAKA	PANCHPAKRI	APHC	0	1 AYUSH	0	2	0	1	1	0	1
KALYANPUR	KATHWALIA	APHC	0	1 AYUSH	0	1	0	1	1	1	1
HARSIDDHI	MATHARIA	APHC	0	1 AYUSH	0	2	0	1	1	0	1
MADHUBAN	TETARIYA	APHC	0	1 AYUSH	0	1	0	1	1	1	1
MEHSI	RAJEPUR	APHC	0	0	0	0	0	2	1	2	1
PAHARPUR	PAKARIA	APHC	0	1 AYUSH	0	1	0	1	1	1	1
TURKAULIA	SEMRA	APHC	0	1 AYUSH	1	2	0	1	0	0	1
PAKRIDAYAL	SHEKHPURWA	APHC	0	0	0	1	0	1	1	1	1
PATAHI	BARA SHANKAR	APHC	0	1 AYUSH	0	1	0	1	1	1	1
RAXAUL	BHELAHI	APHC	0	2	0	1	0	0	1	1	1
CHAURADANO	BELA	APHC	0	0	0	1	0	1	1	1	1
SUGAULI	RAGHUNATHPUR	APHC	0	0	1	1	0	1	0	1	1
PAKRIDAYAL	PHENHARA	APHC	0	1 AYUSH	0	2	0	1	1	0	1
TURKAULIA	BANJARIA	APHC	0	1 AYUSH	0	4	0	1	1	0	1
TURKAULIA	KOTWA	APHC	0	1 AYUSH	0	2	0	1	1	0	1
CHAKIA	CHINTAMANPUR	HSC	0	0	0	1	0	1	1	1	1

GHORA SAHAN	SAMANPUR	HSC	0	0	0	1	0	1	1	1	1
RAMGA DHWA	PAKHNAHI YA	HSC	0	0	0	1	0	1	1	1	1
Total for Diistrict			**0**	**2**	**2**	**28**	**0**	**20**	**18**	**14**	**20**

Level 1			Training Status and Requirment									
BLOCK	Name and place of facility	Type of facility (SC/ APHC/ NPHC/ ccredited pvt.)	Training status	MO (In Numbers)				ANM/ SN (In Numbers)				
				BeM OC	IUCD	NSSK	Others	NSS K	SBA	F-IMNCI	IMNCI	IUCD
ARERAJ	SANGRAMPUR	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
CHIRAIYA	SHIKARGANJ	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
DHAKA	PANCHPAKARI	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
KALYANPUR	KATHWALIYA	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
HARSIDDHI	MATHARIA	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
MADHUBAN	TETARIYA	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
MEHSI	RAJEPUR	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
PAHARPUR	PAKARIYA	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
TURKAULIA	SEMRA	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
PAKRIDAYAL	SEKHPURWA	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
PATAHI	BARA SHANKAR	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
RAXAUL	BHELAHI	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
CHAURADANO	BELA	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
SUGAULI	RAGHUNATHPUR	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3

PAKRIDAYAL	PHENHARA	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
TURKAULIA	BANJARIA	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
TURKAULIA	KOTWA	APHC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
GHORASAHAN	SAMANPUR	HSC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
RAMGADHWA	PAKNAHIA	HSC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
CHAKIA	CHINTAWANPUR	HSC	Completed	0	1	0	0	0	0	0	0	0
			Required	0	0	1	0	3	3	1	2	3
			Total required	0	0	20	0	60	60	20	40	60

Name of the District:- East Champaran
Infrastructure Status Level 1 & 2

Name of Block	**Name and place of facility**	**Type of facility (SC/ APHC/ NPHC/ Accredited pvt.)**	**Status (Specify numbers wherever applicable)**	**Staff Quarters**	**Number of beds**	**Labour Room**	**New Born Care Corner**	**Toilets**	**Other Infrastructures required(Water/ Electricity/others)**	**Equipment (Adeq/Inadequate)**	Existing refferal mechanism (see code below A to E)
ARERAJ	SNAGRAMPUR	APHC	**Existing**	**0**	**0**	**0**	**0**	**1**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**1**	**1**	**1**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	1	**Water**		E
CHIRAIYA	SIKARGANJ	APHC	**Existing**	**0**	**0**	**0**	**0**	0	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**1**	**1**	2	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	**1**	**Water**		E
DHAKA	PANCHPAKRI	APHC	**Existing**	**0**	**0**	**0**	**0**	0	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**1**	**1**	2	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	0	**Water**		E
KALAYANPUR	KATHAULIA	APHC	**Existing**	**0**	**0**	**1**	**0**	**1**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**0**	**1**	**1**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	1	0	1	**Water**		E
HARSIDHI	MATHARIA	APHC	**Existing**	**0**	**0**	**1**	**0**	**1**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**0**	**1**	**1**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	1	0	1	**Water**		E
MADH	TETARIA	APHC	**Existing**	**0**	**0**	**1**	**0**	1	[redacted]	**Inadequa**	E

UBAN			**Required: New**	**4**	**6**	**0**	**1**	1	**Outsource Generator**	**te**	E
			or Rennovation	**0**	**0**	1	0	**1**	**Water**		E
MEHSI	RAJEPUR	APHC	**Existing**	**0**	**0**	**1**	**0**	**1**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**0**	**1**	**1**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	1	0	1	**Water**		E
PAHARPUR	PAKARIA	APHC	**Existing**	**0**	**0**	**0**	**0**	**0**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**1**	**1**	**2**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	0	**Water**		E
TURKAULIA	SEMRA	APHC	**Existing**	**0**	**0**	**1**	**0**	**1**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**0**	**1**	**1**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	1	0	1	**Water**		E
PAKRIDAYAL	SEKHPURWA	APHC	**Existing**	**0**	**0**	**1**	**0**	**0**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**0**	**1**	**2**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	1	0	0	**Water**		E
PATAHI	BARA SHANKAR	APHC	**Existing**	**0**	**0**	**0**	**0**	**0**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**1**	**1**	**2**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	0	**Water**		E
RAXAUL	BHELAHI	APHC	**Existing**	**0**	**0**	**0**	**0**	**0**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**1**	**1**	**2**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	0	**Water**		E
CHAURADANO	BELA	APHC	**Existing**	**0**	**0**	**0**	**0**	**0**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**1**	**1**	**2**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	0	**Water**		E
SUGAULI	RAGHUNATHPUR	APHC	**Existing**	**0**	**0**	**0**	**0**	**0**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**1**	**1**	**2**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	0	**Water**		E
PAKRIDAYAL	PHENHARA	APHC	**Existing**	**0**	**0**	**1**	**0**	**1**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**0**	**1**	**1**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	1	0	1	**Water**		E
TURKAULIA	BANJARIA	APHC	**Existing**	**0**	**0**	**1**	**0**	**1**	[redacted]	**Inadequate**	E
			Required: New	**4**	**6**	**0**	**1**	**1**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	1	0	1	**Water**		E
TURKA	KOTWA	APHC	**Existing**	**0**	**0**	**1**	**0**	**1**	[redacted]	**Inadequa**	E

ULIA			**Required: New**	**4**	**6**	**0**	**1**	**1**	**Outsource Generator**	**te**	E
			or Rennovation	**0**	**0**	1	0	1	**Water**		E
CHAKIA	CHINTAMAPUR	HSC *APHC not available	**Existing**	**0**	**0**	**0**	**0**	**0**	[redacted]	**Inadequate**	E
			Required: New	**3**	**2**	**1**	**1**	**2**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	0	**Water**		E
GHORASAHAN	SAMANPUR	HSC *APHC not avialable	**Existing**	**0**	**0**	**0**	**0**	**0**	[redacted]	**Inadequate**	E
			Required: New	**4**	**2**	**1**	**1**	**2**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	0	**Water**		E
RAMGADHWA	PAKNAHIA	HSC *APHC not avialable	**Existing**	**0**	**0**	**0**	**0**	**0**	[redacted]	**Inadequate**	E
			Required: New	**3**	**2**	**1**	**1**	**2**	**Outsource Generator**		E
			or Rennovation	**0**	**0**	0	0	0	**Water**		E
		Total New		**78**	**108**	**11**	**20**	**31**			
		Total Rennovation		**0**	**0**	**9**	**0**	**10**			
	Refferal Mechanisim										
	A	Own Ambulance									
	B	EMRI Model									
	C	Other PP model									
	D	Hiring Private Vehicle									
	E	Private Vehicle but difficult to manage									
* For APHC amubulances will be hired and for the two HSCs nearest facility ambulance will be used for referral											

Annual Budget: Level - I

Budget Head	Additional Requirement	Unit Cost (in Rs.)	Amount in Rs.	Amount by State	Additional amount from Centre	Remarks
Human Resource						
Medical Officer	Redeployment	30000	0			
Staff Nurse	18	144000	2592000			Calculated @ 12000 per month
LT	Redeployment		0			
ANM	Redeployment	8000	0			
Supportive Supervision [Clinical supervisor + Nonmedical supervisor]	0	0.00	0.00			Supervised by Block MOIc. & BHM weekly one days each
Mobility support for supervision	20	96000.00	1920000.00			Hiring Private Vehicle maxium @ Rs. 800/- per Day to minimun 10 Days for 12 months
One Fourth grade & one Sweeper	40	36000.00	1440000.00			one fourth grade & one Sweeper for each Facility Centre @ Rs. 3000/ Month to 12 Month
Security Guard	60	36000.00	2160000.00			3 guards per facility X 12 months @3000 per month
Sub-total 1:			**8112000**			
Training						
SBA	60	28000.00	1680000			28000/ nurse
BEmOC (MO)	0	15000.00	0			15000/ doctor
NSSK	80	117050.00	9364000			For 32 participants
F-IMNCI	20	288250.00	288250.00			288250 for a batch of 16 people
IMNCI	40	100800.00	201600			100800/ for a batch of 24 people
IUCD	60	211550.00	634650			211550 for 20 participants
Any Other (Please Specify)		0.00	0			
Sub-total 2:			**12168500**			

Infrastructure						
Staff Quarters : New	78	750000.00	0			
Repair /Rennovation	0	200000.00	0			
Beds for patient: New	108	8200.00	885600			
Repair /Rennovation	0	0.00	0			
Labour Room: New	11	400000.00	4400000			
Repair /Rennovation	9	0.00	0			
New Born Corner: New	to be supplied by state	0.00	0			
Repair /Rennovation	0	0.00	0			
Toilets: New	31	40000.00	1240000			
Repair /Rennovation	10	20000.00	200000			
Equipments	to be supplied by state		0			
Delivery Drug + Delivery Kit	20	87000.00	522000000.00			Delivery Kit + Dilivery Drug for per Benificiaries @ Rs. 290 X 25 Benificiaries X 12 Month
Outsourcing of Generator for Electricity	20	180000.00	3600000.00			It is @ 15000 per mnth for 1 year
Any Other (Please Specify)			0			
Subtotal 3:			**6725600**			
Grand Total			**27006100**			

Name of the District:									Name of the Block:				
Level 2			Facility and HR Status Sheet										
		Delivery Status	Staff in Place in numbers						Staff required in numbers(indicate : Regular/Contractual)*				
Name and place of facility	Type of facility (24x7 PHC/CHC/ Pvt./Others	Average Monthly Institutional Deliveries (Based on Jan to June 2010)	Specialist/PG MO /MO-Multiskilled (OBG,PAED , ANAESTH)	MO	SN *	ANM	LHV/PHN	LT	MO	SN	ANM	LHV/PHN	LT
Ada pur	PHC	83	0	2	2	2	1	0	3	1	0	0	1
Areraj	PHC	62	0	2	2	2	1	0	3	1	0	0	1
Chakia	PHC	217	0	2	2	2	1	0	3	1	0	0	1
Chauradano	PHC	259	0	2	2	2	1	0	3	1	0	0	1
Chiraiya	PHC	175	0	2	2	2	1	0	3	1	0	0	1
Dhaka	PHC	80	0	4	2	2	1	0	1	1	0	0	1
Ghorasahan	PHC	175	0	1	2	2	1	0	4	1	0	0	1
Harsiddhi	PHC	238	0	1	2	2	1	0	4	1	0	0	1
Kalyanpur	PHC	85	0	4	2	2	1	0	1	1	0	0	1
Kesaria	PHC	68	0	3	2	2	1	0	2	1	0	0	1
Madhuban	PHC	224	0	2	2	2	1	0	3	1	0	0	1
Mehsi	PHC	134	0	1	2	2	1	0	4	1	0	0	1
Pahar Pur	PHC	64	0	2	2	2	1	0	3	1	0	0	1
Pakri Dayal	PHC	89	0	3	2	2	1	0	2	1	0	0	1
Patahi	PHC	98	0	2	2	2	1	0	3	1	0	0	1
Ramgadhwa	PHC	142	0	2	2	2	1	0	3	1	0	0	1
Raxaul	PHC	311	0	4	2	2	1	0	1	1	0	0	1
Sugauli	PHC	142	0	2	2	2	1	0	3	1	0	0	1
Turkaulia	PHC	76	0	4	4	0	2	2	3	0	2	0	0
Total				45	40	36	20	2	52	18	2	0	18
* The number of staff nurses should be increased to 5 once the BeMoc services, stabilization units and 30 beds are made functional at the designated CHCs													

** All specialists (Gyane, Ananes, Paeds) should be relocated to Level 3 facilities as speciality services are not being provided at Level 2 facilities

There should be only 5 Mos at any Level 2 facility and the remaning should be relocated to other facilities

Name of the Disctrict: Name of the Block: (MCH Level 2) Training Status and Requirment

Name and place of facility	Type of facility (24x7 PHC/CHC/Pvt. /Others	Training status	MO(In Numbers)								LHV/ANM/SN (In Numbers)					
			BeMOC	MTP/MVA	NSV	NSSK	F-IMNCI	Mini-Lap	IUCD	Laproscopy	NSSK	SBA	F-IMNCI	IMNCI	IUCD	Other
Ada pur	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Areraj	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Chakia	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Chauradano	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Chiraiya	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Dhaka	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Ghorasahan	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Harsiddhi	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Kalyanpur	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Kesaria	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Madhub	PHC	Compl	0	0	0	0	0	0	0	0	0	0	0	0	0	

an		eted													
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Mehsi	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Paharpur	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Pakridayal	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Patahi	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Ramgadhwa	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Raxaul	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Sugauli	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	6	6	3	2	6	
Turkaulia	PHC	Completed	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Required	2+3	2	2	5	5	2	0	1	8	8	6	2	8	
		Total Required	95	38	38	95	95	38	0	19	116	116	60	38	116	0

Name of the District:		Name of the Block: Status Level II										Infrastructure	
Name and place of facility	**Type of facility (24x7 PHC/CHC/Pvt./Others**	**Status (Specify numbers wherever applicable)**	**Staff Quarters**	**Number of beds**	**Labour Room**	**Child stablization Unit**	**New Born Care Corner**	**Toilets**	**Other Infrastructures required(Water/ Electricity /others)**	**Equipment(Adeq/Inadequate)**	**Equipments for Maintanence of Cold Chain (ILR/DF)**	**Existing refferal mechanisim* (see code below A to E)**	
Adapur	PHC	**Existing**	**0**	**6**	**1**	**0**	**0**	**1**		**INADEQUETE**	**ILR/DF**		
		Required: New	**8**	**24**	**0**	**1**	**1**	**3**	**Not required**				
		or Rennovation	**0**	**0**	1	0	0	0					

		Existing	**0**	**6**	**1**	**0**	**0**	**1**				
		Required: New	**8**	**24**	**0**	**1**	**1**	**3**	**Not required**	**INADEQUETE**	**ILR/DF**	
Areraj	PHC	**or Renovation**	**0**	**0**	1	0	0	0				
		Existing	**0**	**6**	**1**	**0**	**0**	**1**				
		Required: New	**8**	**24**	**0**	**1**	**1**	**3**	**Not required**	**INADEQUETE**	**ILR/DF**	
Chikaia	PHC	**or Renovation**	**0**	**0**	1	0	0	0				
		Existing	**0**	**6**	**1**	**0**	**0**	**1**				
		Required: New	**8**	**24**	**0**	**1**	**1**	**3**	**Not required**	**INADEQUETE**	**ILR/DF**	
Chauradano	PHC	**or Renovation**	**0**	**0**	1	0	0	0				
		Existing	**0**	**6**	**1**	**0**	**0**	**1**				
		Required: New	**8**	**24**	**0**	**1**	**1**	**3**	**Not required**	**INADEQUETE**	**ILR/DF**	
Chiraiya	PHC	**or Renovation**	**0**	**0**	1	0	0	0				
		Existing	**0**	**6**	**1**	**0**	**0**	**1**				
		Required: New	**8**	**24**	**0**	**1**	**1**	**3**	**Not required**	**INADEQUETE**	**ILR/DF**	
Dhaka	PHC	**or Renovation**	**0**	**0**	1	0	0	0				
		Existing	**0**	**6**	**1**	**0**	**0**	**1**				
		Required: New	**8**	**24**	**0**	**1**	**1**	**3**	**Not required**	**INADEQUETE**	**ILR/DF**	
Ghorasahan	PHC	**or Renovation**	**0**	**0**	1	0	0	0				
		Existing	**0**	**6**	**1**	**0**	**0**	**1**				
		Required: New	**8**	**24**	**0**	**1**	**1**	**3**	**Not required**	**INADEQUETE**	**ILR/DF**	
Harsiddhi	PHC	**or Renovation**	**0**	**0**	1	0	0	0				
		Existing	**0**	**6**	**1**	**0**	**0**	**1**				
		Required: New	**8**	**24**	**0**	**1**	**1**	**3**	**Not required**	**INADEQUETE**	**ILR/DF**	
Kalyanpur	PHC	**or Renovation**	**0**	**0**	1	0	0	0				
		Existing	**0**	**6**	**1**	**0**	**0**	**1**				
		Required: New	**8**	**24**	**0**	**1**	**1**	**3**	**Not required**	**INADEQUETE**	**ILR/DF**	
Kesaria	PHC	**or Renov**	**0**	**0**	1	0	0	0				

		ation										
Madhuban	PHC	Existing	0	6	1	0	0	1	[redacted]	INADEQUETE	ILR/DF	
		Required: New	8	24	0	1	1	3	Not required			
		or Renovation	0	0	1	0	0	0				
Mehsi	PHC	Existing	0	6	1	0	0	1	[redacted]	INADEQUETE	ILR/DF	
		Required: New	8	24	0	1	1	3	Not required			
		or Renovation	0	0	1	0	0	0				
Paharpur	PHC	Existing	0	6	1	0	0	1	[redacted]	INADEQUETE	ILR/DF	
		Required: New	8	24	0	1	1	3	Not required			
		or Renovation	0	0	1	0	0	0				
Pakridayal	PHC	Existing	0	6	1	0	0	1	[redacted]	INADEQUETE	ILR/DF	
		Required: New	8	24	0	1	1	3	Not required			
		or Renovation	0	0	1	0	0	0				
Patahi	PHC	Existing	0	6	1	0	0	1	[redacted]	INADEQUETE	ILR/DF	
		Required: New	8	24	0	1	1	3	Not required			
		or Renovation	0	0	1	0	0	0				
Ramgadhwa	PHC	Existing	0	6	1	0	0	1	[redacted]	INADEQUETE	ILR/DF	
		Required: New	8	24	0	1	1	3	Not required			
		or Renovation	0	0	1	0	0	0				
Raxaul	PHC	Existing	0	6	1	0	0	1	[redacted]	INADEQUETE	ILR/DF	
		Required: New	8	24	0	1	1	3	Not required			
		or Renovation	0	0	1	0	0	0				
Sugauli	PHC	Existing	0	6	1	0	0	1	[redacted]	INADEQUETE	ILR/DF	
		Required: New	8	24	0	1	1	3	Not required			
		or Renovation	0	0	1	0	0	0				
Turkaulia	PHC	Existing	0	6	1	0	0	1	[redacted]	INADEQUETE	ILR/DF	
		Required: New	8	24	0	1	1	3	Not required			

		or Rennovation	**0**	**0**	1	0	0	0				
		Total Required New	152	456	0	19	19	57				
		Total Required Rennovation	0	0	19	0	0	0				
*Refferal Mechanisim												
A	Own Ambulance											
B	EMRI Model											
C	Other PP model											
D	Hiring Private Vehicle											
E	Private Vehicle but difficult to manage											

Annual Budget at a Glance Level II						
Budget Head	**Additional Requirement**	**Unit Cost (in Rs.)**	**Amount in Rs.**	**Amount by state**	**Extra from Centre**	**Remarks**
Human Resource						
Medical Officer	Redeployment	0.00	0			
ANM	Redeployment	8000.00	0			
Staff Nurse	18	144000.00	2592000			
LHV / PHN	0	0.00	0			
LT	Redeployment	0.00	0			
Supportive Supervision [Clinical supervisor + Nonmedical supervisor]	3	480000.00	1440000			Clinical Supervision by Mobile Trainer one each for 5- 6 blocks @ 40000 per month & Non-Clinical Supervision by DPC for 10 days a month
Mobility support for supervision	3	180000(additional requirement)+ 96000	636000			Hiring Private Vehicle maxium @ Rs. 800/- per Day for minimun 10 Days in Month and 15000 per month for mobile trainer
Any Other (Please Specify)						
Sub-total 1:			**4668000**			
Training						
SBA	116	28000.00	3248000			
BEmOC (MO)	95	15000.00	1425000			For Particeipent @15000/-
MTP	38	95795.00	957950			Rate 95795 for 4 doctors
NSSK	211	117050.00	819350			For 7 batches
F-IMNCI	155	288250.00	2882500			For 12 batches
IMNCI	38	100800.00	201600			For 2 batches
Mini-Lap	38	71240.00	712400			71240 for 4 participants
Laparoscopy	19	71240.00	356200			71240 for 4 participants
NSV	38	32600.00	293400			32600 for 4 participants
IUCD	116	211550.00	1269300			211550 for 20 participants
Any Other (Please Specify)	0	0.00	0			

Sub-total 2:			**12165700**			
Infrastructure						
Staff Quarters : New	152	750000.00	114000000			
Repair /Rennovation	0	200000.00	0			
Beds for patient: New	456	8200.00	3739200			
Repair /Rennovation	0	0.00	0			
Toilets: New	57	40000.00	2280000			
Repair /Rennovation	0	20000.00	0			
Labour Room: New	0	400000.00	0			
Repair /Rennovation	19	130000.00	2470000			
Stabilisation Unit: New	to be supplied by state	0.00	0			
Repair /Rennovation	0	0.00	0			
New Born Corner: New	to be supplied by state	0.00	0			
Repair /Rennovation	0	0.00	0			
Cold chain equipments-ILR/ DF	**to be supplied by state**	**0.00**	0			
Equipments	to be supplied by state	0.00	0			
Any Other (Please Specify)		0	0			
Subtotal 3:			**122489200**			
Grand Total			**139322900**			

Name of the District: **Name of the Block:**

Level III **Facility and HR Status Sheet**

		Delivery Status		Staff in Place in numbers						Staff required in numbers(indicate : Regular/Contractual)*					
Name and place of facili	Type of facility DH/SDH/ AH/FRU/ CHC/Pvt. /Others	Average Monthly Institutional Deliveri	C-Section	Specialist/PG MO /MO-Multiskilled	MO	SN	ANM	LHV/PHN	LT	Specialist (Indicate type)	MO	SN	ANM	LHV/PHN	LT

ty		**es (Based on Jan to June 2010)**		**(OBG, PAED , ANAESTH)**											
MOTIHARI	DH	431	YES	5 Gynae , 5 GS, 1 LSAS, 1 Peads	10	6	10	3	2	0	0	14	0	0	0
Total															
* Number of staff nurses may be increased to 20 once the facility is converted to a 100 bedded facility in the ratio of 5:1															
# There should be only 4 MO's at a level 3 facility and the remaining should be reallocated. The specialists may be provided as per norms															

Training Status and Requirment (MCH Level III) **Name of the District:**
Name of the Block

Name and place of facility	**Type of facility DH/SDH/AH/FRU/CHC/Pvt./Others**	**Training status**		**MO (In Numbers)**									**LHV/ANM/SN (In Numbers)**					
			LSAS	**EMOC**	**MTP**	**NSSK**	**F-IMNCI**	**Mini-Lap**	**Laproscopy**	**NSV**	**IUCD**	**Others**	**NSSK**	**SBA**	**F-IMNCI**	**IMNCI**	**IUCD**	Other
MOTIHARI	**DH**	**Completed**	**1**	**2**	0	**0**	**0**	**0**	**5**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
		Required	**0**	**0**	**2**	**4**	**4**	**2**	**0**	**0**	**0**	**0**	**30**	**30**	**20**	**10**	**30**	0
		Total Required	**0**	**0**	**2**	**4**	**4**	**2**	**0**	**0**	**0**	**0**	**30**	**30**	**20**	**10**	**30**	**0**

Name of the District:	**Name of the Block:** **Status Level III**	**Infrastructure**

Name and place of facility	Type of facility DH/SDH/AH/FRU/CHC/Pvt./Others	Status (Specify numbers wherever applicable)	Staff Quarters	Number of beds	OT	Labour Room	SNCU/ Child stablization Unit	New Born Care Corner	Blood Storage/ Blood Bank	Toilets (M/F)	Other Infrastructures required (Water/ Electricity/others)	Equipment (Adeq/ Inadequate)	Equipments for Maintanence of Cold Chain (ILR/DF)
MOTIHARI	DH	**Existing**	**8**	**100**	**2**	**1**	**0**	**0**	**0**	**0**		**INAD.**	**Not Required**
		Required: New	**6**	**0**	**0**	**0**	**1**	**1**	**1**	**6**	**Not Required**		
		or Renovation	**2**	**0**	**2**	1	0	0	0	0			
		Total New	**6**	**0**	**0**	**0**	**1**	**1**	**1**	**6**			
		Total Renovation	**2**	**0**	**2**	**1**	**0**	**0**	**0**	**0**			

Annual Budget at a Glance Level III

Budget Head	Additional Requirement	Unit Cost (in Rs.)	Amount in Rs.	Amount by state	Extra from Centre	Remarks
Human Resource						
Specialists:	0	0.00	0			
Obs. / Gynaec.	0	0.00	0			
Anaesthetist	0	0.00	0			
Paediatrician	0	0.00	0			
Medical Officer	redeployment	0.00	0			
ANM	redeployment	0.00	0			
Staff Nurse	0	0.00	0			
LHV / PHN	0	0.00	0			
LT	redeployment	0.00	0			
Supportive Supervision [Clinical supervisor + Nonmedical supervisor]	0	0.00	0			Supervised by Supritendent. & Hospital manager
Mobility support for supervision	0	0.00	0			not required
Trainer for skill lab	1	480000.00	4800000			nurse @ 40000 per month
Sub-total 1:			**4800000**			
Training						

SBA	30	28000.00	840000			
LSAS	0	136000.00	0			
CEmOC	0	138000.00	0			
MTP	2	95795.00	95795.00			Rate 95795 for 4 doctors
NSSK	30	117050.00	117050.00			117050 for 32 people
F-IMNCI	24	288250.00	288250.00			288250 for a batch of 16 people
IMNCI	10	100800.00	100800.00			100800/ for a batch of 24 people
Mini-Lap	2	71240.00	71240.00			71240 for 4 participants
Laparoscopy	0	71240.00	0			71240 for 4 participants
NSV	0	32600.00	0			32600 for 4 participants
IUCD	30	211550.00	423100			211550 for 20 participants
Any Other (Please Specify)	0		0			
Sub-total 2:		1290525.00	**1936235**			
Infrastructure						
Staff Quarters : New	6	750000.00	4500000			
Repair /Rennovation	2	200000.00	400000			
Beds for patient: New	0	8200.00	0			
Repair /Rennovation	0	0.00	0			
Toilets: New	6	40000.00	240000			
Repair /Rennovation	0	20000.00	0			
OT: New	0	0.00				
Repair /Rennovation	2	0.00				
Labour Room: New	0	400000.00	0			
Repair /Rennovation	1	130000.00	130000.00			
Child Stabilisation Unit: New	To be supplied by state	0.00	0			
Repair /Rennovation	0	0.00	0			
New Born Corner: New	To be supplied by state	0	0			
Repair /Rennovation	0	0				
SNCU: New	1	3400000	3400000			
Repair /Rennovation	0	0				
Blood Bank: New	1	294000	294000			
Repair /Rennovation	0	0	0			
Blood Storage (BSU):	0	294000	0			

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New						
Repair /Rennovation	0	0	0			
Cold chain equipments-ILR/ DF	To be supplied by state		0			
Equipments	To be supplied by state		0			
Skill Lab to be established at the District Hospital	1	1500000.00	1500000.00			
Subtotal 3:			**10464000**			
Grand Total			**17200235**			

CHAPTER-VII

BUDGET

A-1. Maternal Health

Budget	Activity / Item	2011-12
	Consultancy for support for developing Microplan for MCHN days	20000
	Adult Weighing machines @ Rs 1500 per machine x 772 AWCs & Maintenance	1158000
	31 Delivery Huts @ Rs 62500 /hut	1937500
	Recurring cost of 31 Delivery Huts @ Rs 136250 per year	4223750
	Blood Storage Unit @ Rs 3.5 lakhs per unit	350000
	Referral Cards @ Rs 5 per card x 20,000	100000
	MTP kits @ Rs 18750 Per kit at GH & PHCs/APHCs	1312500
	JSY beneficiaries @ Rs 2000/person X 137052	274104000
	RCH Camps @ Rs 250000 per camp x 7	1750000
	Hiring of vehicle for referral at every PHC@15000x 12monthx20	3600000
	Total	**288555750**

A-2. NEWBORN & CHILD HEALTH

Budget	Activity / Item	2011-12
	Newborn Corner furnished with equipment @ Rs 250000 lakh per facility	250000
	Provision of Invertor @ 31250 x 23	718750
	Examination table, chair, stool, table, other equipment @ Rs. 6250 x 772AWCs	4825000
	Infant Weighing Machines@Rs. 1500/AWCx 772	1158000
	Referral cards @ Rs 5 x 25000	125000
	Free availability of medicines	1000000
	Monitoring of School Health Activities @ 12500 pm x 12 months	150000
	Training of Teachers @ 250 x 1000 teachers	250000
	Supply of Medicines, glasses, hearing aids	500000
	Total	**8976750**

A-3. FAMILY PLANNING

Budget	Activity / Item	2011-12
	NSV camps @ Rs. 292275 per 2 camps x 12	3507300
	Sterilization Camps @ 1000 & 650 for 5000 cases	8250000
	Copper T-380 @ Rs 65 / piece x 5000	325000
	Emergency Contraception @ Rs15/2 tabs x5000	75000
	Development Static Centers @Rs 2 lakh	250000
	NSV Equipment @ Rs 1000 x 5 GH & 20PHCs	25000
	Laparoscopes @ Rs 350000	350000
	Total	**12782300**

A-4. ADOLESCENT HEALTH

Budget	Activity	2011-12
	Awareness generation @ Rs 2500 per village	3362500
	Workshop of all the partners	100000
	Training a district pool of Master trainers	100000
	Training of Counselors at every PHC @ 10000/batch x 25	250000
	Orientation & Reorientation Health personnel	50000
	Counseling sessions @ Rs 1250/per month/per PHC/PHC	25000
	Counseling Clinics renovation, furnishing and Misc expenses @ Rs 12500 x all PHCs/APHCs	862500
	Joint Evaluation by an agency & Govt	100000
	Total	**4850000**

B-1. ASHA – Accredited Social Health Activist

Budget	Activity / Item	2011-12
	Kit @ Rs 2500/ ASHA	8945000
	Reorientation @ Rs 1250/ ASHA	4472500
	Expenses for the District mentoring group – meetings, travel @ Rs 62500 per month x 12 months	750000
	Incentive for ASHAs	3692496
	Total	**9809496**

B-2. Untied Funds and Annual Maintenance grant for Sub Centers

Budget	Activity / Item	2011-12
	Untied Fund of Rs 10000/SC	3190000
	Annual Maintenance grant and repair of Rs 10000/SC	3190000
	Total	**6380000**

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

Budget	Activity	2011-12
	Untied Fund of Rs 25000/APHC	1225000
	Annual Maintenance grant of Rs 50000/PHC	1000000
	Annual Fund to give facilities to the paients of Rs 100000/PHC	2000000
	Total	**4225000**

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

Budget	Activity / Item	2011-12
	Untied Fund of Rs 50000/PHC/APHC x 20PHCs/49APHCs	3450000
	Annual Maintenance grant of Rs 100000/PHC	200000
	Annual grant for the facilities to the patients of Rs 100000/PHCs	200000
	Total	**3850000**

B- 5. Mobile Medical Units

Budget	Activity / Item	2011-12
	Hiring staff	1650000
	Orientation of the staff	50000
	Joint Workshop for finalizing modalities	50000
	Cost of Vehicle, equipment and accessories	3000000
	Recurring Cost of Drivers, Drugs, supplies, Mobile phones, POL, Maintenance	400000
	Total	**5150000**

B – 6. Upgrading PHCs to IPHS

Budget	Activity/ Items	2011-12
	Building for PHC	
	New Building for APHC	
	Furniture	300000
	Equipment	5547500
	Vehicle /Ambulance	500000
	Recurring cost for existing PHCs	591250
	Recurring costs of additional PHCs	
	Repair of building for PHCs	4000000
	Total	**10938750**

B – 7. Upgrading PHCs for 24x7, IPHS and others requirements of PHCs

Budget	Activity / Item	2011-12
	New Buildings for 18 PHCs with equipment, Drugs and Furniture and quarters as per IPHS	56700000
	Equipment and furniture for existing facilities as per IPHS	1500000
	Repair/Additions of PHCs	62500
	Staff Quarters as per IPHS	
	Recurring costs of the additional PHCs	3816250
	Total	**62078750**

B – 8. Upgrading Sub Centres and Additional Subcentres

Budget	Activity / Item	2011-12
	New buildings with quarters	135762500
	New Subcentres	7585000
	Repair of SCs	1875000
	2 Staff Quarters	2625000
	1 Staff Quarter	4612500
	Recurring Costs	1250000
	Total	**153710000**

B-9 Untied Funds and Incentive Fund for the Village Level Committees

Budget	Activity / Item	2010-11
	Untied Fund of Rs 10000/unit 1500/unit x 186 units	1860000
	Untied Fund of Rs 20000/unit 3000/unit x 144 units	2880000
	Untied Fund of Rs 30000/unit 5000/unit x 16 units	480000
	Total	**5220000**

PART C: Immunisation

C-1. Strengthening Immunization

Budget	Activity	2011-12
	Mobility Support for District immunization officer as POL @ 6250	75000
	Salary of Computer Assistant for District immunization officer @ 10000 pm	120000
	Mobility support for alternative vaccine delivery Rs. 50 per session for 1 planned sessions per week at each Subcentre village for 12 months = Rs. 50x1 sessionsx4 weeks/mthx12 months x 319 SCs	1531200
	Mobility Support Mop up campaign @ Rs 12500 per PHC (Including travel, vaccine delivery, IEC) x 6 rounds/ year x PHCs	1500000

	Mobilization of Children by Social Mobilizers @ Rs. 100/ session x4 sessions per month X 319 units x12month	1531200
	Contingency fund for each block @ Rs.1000/month x 20 blocks x 12 months	240000
	Printing of Immunisation cards @ 5 per card x 30000 cards each year	150000
	Tracking Bags to ANMs (and @ Rs. 200 per tracking bag x 534	106800
	Supply of Cold Chain Equipments: Deep Freezer-8, ILR- 7, Cold Boxes- 10	State
	Maintenance of Cold Chain Equipments (funds for major repair) (@ Rs.750 per PHC/PHC per month and Rs 50,000 annual for minor repairs	230000
	POL & maintenance for Vaccine delivery van at district level @ Rs.18750/month x 12 mths	225000
	Provision of Large Size Invertor with battery at all facilities upto PHC/PHC @ 31250 x 25	781250
	Running cost of ILRs & Deep Freezers (for electricity bill) (@ Rs 500 per month for PHCs/PHCs x 20 x 12 mths	72000
	Hiring of vehicle for extension of immunization at brick kilns @ Rs 1000pm/PHC	240000
	Total	**6802450**

PART D: National Disease Control Programme

D-2. RNTCP		
Budget	**Activity / Item**	**2011-12**
	Civil Works	375000
	Laboratory Material	212500
	Honorarium	137500
	IEC/Publicity	92500
	Equipment maintainance	55000
	Training	231250
	Vehicle Maintainence	75000
	Vehicle Hiring	300000
	NGO/PP support	115000
	Contractual Services	1812500
	Printing	171250
	Procurement Vehicle	125000
	Procurement Equipment	37500
	Miscellaneous	312500

	Total	**4052500**

D-3. LEPROSY

D-3. LEPROSY		
Budget	**Activity / Item**	**2011-12**
	Salary to Contractual Staff	46200
	Office Expenditure	12500
	Account work	4800
	Contagious	15000
	Audit fee	4000
	Vehicle reparing (Two vehicle)	75000
	POL & Maintenance 4000/vehicle	100000
	Supporting maintenance	18750
	Patient welfare	10000
	Raily & Leprosy day	6000
	School Quiz in (100 school)	50000
	Health Mela	4000
	Oneday orientation training MOS & General Health staff	171000
	Urban Leprosy programm	47000
	BLAC (4 PHC)	460000
	Total (nine lac eighty three thousand only)	**983000**

D-4. NATIONAL MALARIA CONTROL PROGRAMME

D-4. NATIONAL MALARIA CONTROL PROGRAMME		
Budget	**Activity / Item**	**2011-12**
	Salary Contractual staff	4821000
	Travel expenses @ Rs 7500 per month x 12 months	90000
	Office expenses @ Rs 6250 per month x 12	75000
	Jeep and maintenance	60000
	Trucks – 3 and maintenance	300000
	4 small Fogging machines for each PHC @ Rs 1.00 lakh and one at District HQ Pulse Fog Machines @ Rs.8.00 lakh per unit and maintenance	2900000
	Training	1145500
	Misc @ Rs 1Lakh per GH and Rs 20000 per PHC, and for PHC Rs 10000	1694000
	Board hoarding: 8'x 12' at 20 sites initially at the PHCs and General hospitals @ Rs 25,000/-	500000
	Board hoarding: 5'x3' at 20 sites initially at the PHCs@ Rs 10,000/-	200000
	POL @ Rs 150,000/- per vehicle jeep and truck for 12 months x 4	**7200000**
	Hatchery in all PHCs for Gambusia fish @ Rs 1.00 lakh per PHC, General Hospitals and Civil surgeon's office	2200000
	Total	**21185500**

D-5. OTHER VECTOR BORNE DISEASES

Budget	Activity / Item	2011-12
	Budgeted in Malaria	
	IEC and awareness to the people	100000
	Unforeseen expenses	75000
		175000

D-6. BLINDNESS CONTROL PROGRAMME

Budget	Activity / Item	2011- 12
	Health Mela	125000
	IEC	6250
	School Eye Screening	50000
	Blind Register	87500
	Observance of Eye Donations	18750
	Cataract Camps @ Rs 60000 per camp x 10	600000
	NGO and Eye Bank @ Rs 750/IOL x 300, 30 cases for Corneal transplant	225000
	POL for Eye Camps @ Rs 6000/camp x10	60000
	Survey of Factory workers/Roadways	12500
	Training of School teachers @ Rs 100/head x 410	41000
	Training of PRIs @ Rs 100/head x 410	41000
	Repair and purchase of equipment and maintenance	1500000
	Total	**2767000**

D-7. Integrated Disease Surveillance Programme

Budget	Activity / Item	2011-12
	Renovation of Labs at20 PHCs and general hospitals@ Rs 31250 x 21	656250
	Renovation of Lab at District @ Rs 187500 and maintenance	187500
	Equipment for Lab at PHC and general hospitals @ Rs 62500	1312500
	Equipment for Lab at District @ Rs 5,00,000	625000
	Computer and Accessories at PHC and general hospitals @500000	1050000
	Computer and Accessories at DSU@630000	630000
	Office Equipment for at PHC and general hospitals @ Rs 12500 per unit	262500
	Office Equipment for DSU @ Rs 10,000	10000
	Software for DSU@ Rs 350000	350000
	Furnishing of Lab at PHCs and general hospitals @ Rs 12500	262500
	Furnishing of Lab at DSU @ Rs 60,000	75000
	Material and supplies at Lab at PHCs and general hospitals @ Rs 12500	262500

	Material and supplies at Lab at DSU @ Rs 75,000	75000
	Contract Staff at District level @ 200000/yr for 4 staff	200000
	IEC activities	100000
	Training and retraining	186000
	WEN connectivity	50000
	Operational costs at PSU for Surveillance @ Rs 15000/year x 5	75000
	Operational costs at DSU for Surveillance @ Rs 130000/year	130000
	Total	**6499750**

D-8. Iodine Deficiency Disorders

Budget	**Activity / Item**	**2011-12**
	Large Village meetings for awareness on IDD and consumption of Iodized salt	100000
	Programme in schools 1581 Primary by School health team	500000
	Awareness programme with the SHGs and shopkeepers @ Rs 500 per village x 1634villages	817000
	Total	**1417000**

D-9. Vitamin A

Budget	**Activity / Item**	**2011-12**
	Awareness on Vitamin A Programme.	1000000
	IEC activities	200000
	Programme in Blocks for Vitamin A	1000000
	Training of field functionaries	400000
	Site Management	280000
	Additional site Management	30000
	Total	**2910000**

Inter Sectoral Convergence

Budget	**Activity / Item**	**2011-12**
	Meetings of the Block Committees @ Rs 2500 /meeting x 27 blocks x 12 months	810000
	Meetings of the Village groups @ Rs 125 per village x 1634 villages x 12	2451000
	Joint monitoring at the sector level Hiring of vehicle @ RS 1250/ day x 5 days/month x 20 sectors x 12 months	1500000

	Joint monitoring at the block level Hiring of vehicle @ RS 1250/ day x 5 days/month x 27 blocks x 12 months	2025000
	Yearly joint Planning Workshops at the Block level for development of the Action Plans @ Rs 10000 per block x27 blocks	270000
	Yearly joint Planning Workshops at the District level for development of the Action Plans @ Rs 25000	25000
	Yearly joint Workshops to consolidate the findings at the block levels at the District level for development of the Action Plans @ Rs 25000	25000
	Total	**7106000**

7. COMMUNITY ACTION PLAN

Community Health Action

Budget	**Activity / Item**	**2011-12**
	Training of the VH&SC @ Rs 200 per person x 15 persons/Committee x1634 villages	4902000
	Meetings of the VLC @ Rs 250 per village x 1634 villages x 12 months	4902000
	Meetings of SMS @ Rs 100 per month x 1634 villages	163400
	Total	**9967400**

8. Public Private Partnerships

Public Private Partnerships

Budget	**Activity / Item**	**2011-12**
	Arogya Kosh	375000
	Hiring of specialists-2 @ 37500 pm	900000
	Training of NGO personnel and the Private sector @ Rs 625 for 2 days per person x 40 persons	50000
	Workshop for involvement of the Private sector	62500
	Total	**1387500**

9. GENDER AND EQUITY

Gender and Equity

Budget	**Activity / Item**	**2011-12**

	Workshops with private providers, IMA members, Religious leaders, Caste leaders, PRIs, MLAs in every block and Gram Panchayat and with SHGs	250000
	Incentive for Early registration of pregnancies @ Rs 50 per case x 20000 pregnancies	100000
	Rallies in all schools and colleges and generating discussions in schools and colleges through debates	200000
	Regular advertisements in the newspapers	120000
	Health Card for Girl Child @ Rs 2 /card x 10,000 cards	20000
	Price for the panchyats for three best sex ratio in the district @ 100000, @ 50000 & @ 20000	170000
	Price for the panchayat where the girls age group 6-14 years 100% enrollement in the schools @ 20000	100000
	Monitoring and meetings of advisory committee	100000
	Computer and other asseceries	50000
	Total	**2540000**

10. CAPACITY BUILDING

Trainings

Budget	**Activity**	**2011-12**
	SBA training for 95 ANMs x 2 batches for 21 days	2600000
	MVA MTP training to all PHC MOs for 14 days x 38 MOs x 21630 x 5 batches	5753600
	Training on Blood transfusion for MOs and Lab Technicians for EmOC centres with Blood storage facilities for 3 days	-
	Training in Obstetric management & skills for 24x7 PHCs for 16 weeks	-
	Training in skilled Birth attendants for 14 days for LHV & SNs and for 21 days for ANMs x @ 41855 x 9 batches for 49 ANMs	1845800
	IMNCI training to ANM/LHV, SN, ASHA for 8 days x 105650 x10 batches	105700
	IMNCI training to MOs x 117900 x 1 batch	118000
	Integrated skill training for Urban MOs for 12 days	
	Integrated skill training of all SN @ 4200 x 10 persons	42000
	Integrated skill training for ANMs @ 2100 x 443 persons	930000
	Integrated skill training for MOs @ x 3700 x 5 persons	18500
	Training of MOs, SN in Mgt of Newborns & sick children	-
	Training in BCC for MOs, LHVs, ANMs, MOs: Rs 500/MO x 5 days LHVs & ANMs x 200 x5 days	500000
	Training on NSV for MOs at NSV camps	-
	Training on Minilap x 12 days x 15 persons	-

	Training for Laproscopic Sterilization for MOs x 12 days @21630x5 batch	108150
	Orientation on contraceptive devices for MOs - Govt and private facilities	-
	Training on Medico-legal aspects to MOs,	-
	Training on IUD for MOs x @11713x 5 batches	58565
	Training on IUD for SN/ANMs/LHV x @9556 x 20 batches	191120
	Orientation on PCPNDT Act for DCs, CSs, doctors both Govt and private, members of District Appropriate authority NGOs in a workshop	-
	Training of NGOs in BCC @ Rs 300 per person x 6 days	21600
	Professional Development course for District Programme Managers, Block Programme Managers, Senior district officials, SMOs for 10 weeks	-
	Training in Life saving/Anaesthesia for EmOC at FRUs for MOs for 18 weeks	-
	Training of ASHAs @ 38194 x 8 batches	305552
	Block training Facilitator @ 51321 x 1 batch	51321
	Total	**12649908**

11. HUMAN RESOURCE PLAN

Human Resource Plan

Budget for Contractual Staff	Activity / Item	Unit Cost(per year)in lacs	2010-11	2011-12	
	Sub Center		**319**	**512**	
	ANM	136260	33	4496580	
	Health worker Male	118800	46	5464800	
	PHC		**20**	0	
	MO	252660	8	2021280	
	Pharmacist	153720	7	1076040	
	Staff Nurse	153720	49	7532280	
	ANM	136260	6	817560	
	Health Educator/Male supervisor	153720	10	1537200	
	LHV	171180	11	3081240	
	PHN	171180	18	3081240	
	UDC/ Computer Clerk	118800	18	2138400	
	LDC	91330	18	1643940	
	Lab Tech	118800	16	1900800	
	Class IV	69330	46	4431180	
	PHC		**0**	0	
	SMOs	3152250	5	15761250	
	Staff Nurse	153720	58	8915760	
	PHN	171180	7	1198260	
	Computer cleark	91330	4	639310	
	Dresser	69330	7	485310	
	Pharmasist	153720	0	153720	
	Lab Tech	118800	3	356400	
	BEE	153720	5	768600	
	Radiographer	118800	4	475200	
	UDC/ Computer Clerk	1933680	2	3867360	
	LDC	798060	5	3990300	
	Epidemiologist	2758220	7	19307540	
	Total Class 4	693300	50	34665000	
	LMO (for PHC)	252660	15	3789900	
	LMO (for PHC)	252660	6	1515960	
	Accountant for PHC	96000	22	2112000	
	Accountant for PHC	120000	0	120000	
	Hard core allowance to all Doctors	120000	71	8520000	
			Total	**143939410**	

IEC/BCC

Budget	Activities	2011-12
	Finalizing the messages	50000
	Advertisements	250000

	TV spots	125000
	Folk Media shows @ Rs 1000/1634 village	**1634000**
	Hoardings @ Rs 10000/hoarding x 100 hoardings	1250000
	Display boards @ Rs 2500/board x 160 Display boards	400000
	Pamphlets @ Rs 5/pamphlets x 100000 pamphlets	500000
	Nirdeshika for Fixed Health Nutrition days @ Rs 20/ Nirdeshika	80000
	Swasthya Darpan @ Rs.20 /copy/month	480000
	Bal Nutrition Melas @ Rs 300 x 4 times x No of 319 HSCs	382800
	Opinion leaders workshops @ Rs 300 /person x 100	30000
	Wall writings @ Rs 500 x 1634 villages	817000
	Total	**5998800**

Procurement and Logistics

Budget	**Activity / Item**	**2011-12**
	Construction of Warehouse	2500000
	Software	25000
	Computer system with UPS, Printer, Scanner,	70000
	Equipment & Hardware	1000000
	Pharmacist @ Rs 9000/mth	108000
	Assistant Pharmacist @ Rs 5000/mth	60000
	Packers -2 @ Rs 4000/mthx2	96000
	Security Staff @ Rs 6000/mth	72000
	Training of personnel	
	Consultancy to agency for Operationalization of the Warehouse	200000
	Total	**4131000**

13. PROGRAMME MANAGEMENT

Strengthening of District Health Management

Budget	**Activity / Item**	**2011-12**

	Orientation Workshop	62500
	Monthly Meetings	15000
	Mobility for Monitoring	144000
	Total	**221500**

District Programme Management Unit

Budget in Lakhs	**Activity**	**Year 2011-12**
	Honorarium DPM,DAM,DDA and Consultants	3000000
	Travel Costs for DPMU @ Rs 12,000/ per month x 12 mths	144000
	Infrastructure costs, Furniture, computer systems, fax, UPS, Printer, Digital Camera	100000
	Workshops for development of the operational Manual at district and Block levels	100000
	Untied Fund	50000
	Joint Orientation of Officials and DPM, DAM, DDM	25000
	Management training workshop of Officials	50000
	Personnel for BPMU	7560000
	Training of DPM and Consultants	500000
	Review meetings @ Rs 1000/ per month x 12 months	12000
	Office Expenses @ Rs 10,000/month x 12 months for district	120000
	Annual Maintenance Contract for the equipment	
	Travel costs for BPMU @ Rs 5000 per month per 27 block	135000
	Monitoring of the progress by independent agencies	100000
	Hiring of vehicles at block level @ Rs 800x 5 days /mth x 20 PHC/APHCsx12 mths	960000
	Office expenses for Blocks @ Rs 5000 x 27 blocksx 12	1620000
	Total	**14476000**

Detailed calculation of Budget for Personnel at DPMU for one year

S.No	**Details**	**Units**	**Unit Cost**	**Amount for 12 months**
	Personnel at District level			
	District Programme manager	1	23000	276000
	District Accounts Manager	1	18000	216000
	District Data Assistant	1	15000	180000
	Consultant for Maternal Health	1	40000	480000
	Consultant for Child Health	1	40000	480000

	Consultant for Civil Works	1	40000	480000
	Consultant for HMIS	1	40000	480000
	Consultant for Behaviour Change	1	40000	480000
	SubTotal			**3072000**
	Personnel at Block level			
	Block Health manager	20	15000	300000
	Block Accounts Manager	20	12000	240000
	Block Data Operator	20	10000	200000
	Subtotal			**3812000**
	Hiring of vehicles at block level @ Rs 800x 5 Days x27 blocks x12 months	20	4000	**1296000**
	Office Automation with Furniture, Computer system, Camera, Printer, etc	20for BPMU 1 for DPM 1 for DAM	100000	**2200000**
	Gross Total			

14. FINANCING OF HEALTH

Financing Health Care

Budget	**Activity**	**2011- 12**
	Provision of Seed money @ Rs 1 lakh per PHC @ Rs 1.00 lakhs	**200000**

	Training of the Incharges and second in command @ Rs 800 per person x 1 day	**16000**
	Total	**216000**

15. HMIS, MONITORING AND EVALUATION

HMIS

Budget	**Activities**	**2011-12**
	Internet connectivity @ Rs 1000 /mth x No of facilities x12 mths	12000
	AMC for computers @ Rs 5000 /computer /year x No of computers	60000
	Consumables for computers @ Rs 2000/mth/facility x 12 mths	24000
	Training of Staff related to HMIS up to SC Level @ 200 x2x 534 persons	213600
	Printing monitoring Charts @ Rs. 5 per monitoring chart	5000
	Salary to MIS Officer @ 12000 pm x 12 months	144000
	Honorarium for Data Center @ Rs 15000/ mth	180000
	Mobility support to M&E Officer @12000/mth	144000
	Every 4 BPHC one Resource person for hands on training of ANM @4 Days in one BPHC @ Rs 1000/day Hon, Rs 1000/ logistic and Rs 800/ per day travel	14000
	Data Back-up external hard disc	4000
	Total	**800600**

Monitoring

Budget	**Activity / Item**	**2011-12**
	Review meetings @ Rs 1250/mtg x2 facilities x 12 mths	30000
	Mobility support for Deputy C.S. (Immunization and Family Welfare) for Monitoring for POL	60000
	Mobility support for monitoring MCHN days @ Rs. 800 X 5 days X 4 monitors X 12 months	192000
	Quality assessment of all health institutions each year @ Rs 2000/inst	40000
	Trainings of all the committee members	100000
	Maternal, Child death Audit @ Rs 1000/death	300000
	Total	**722000**

16 Bio-Medical Waste Management

Bio-Medical Waste Management

Budget	Activity	2011-12
	Orientation and reorientation for Biomedical Waste Management at District and Block levels	150000
	Consumables	100000
	Maintenance of the Plasma Pyrolysis plant	350000
	Payment for incinerators@ Rs. 8 per bed 12 mths	11520
	Total	**611520**

Structured approaches for State/ District/ Block PIP planning
National Rural Health Mission
Strategy & Activity Plan with budget
Name of the District:- EAST CHAMPARAN

	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
				1	2	3		5	6					8	9		11	12		13		15
				0	0	0				Q1	Q2	Q3	Q4									
A	**RCH**																					
A.1	**MATERNAL HEALTH**																					
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**														0	684000						
A.1.1.1.1	**1.1.1 Operationalise FRUs (Diesel, Service Maintenance Charge, Misc. & Other costs)** **1.1.1.1 Operationalise Blood Storage units in FRU**			2	1	1	Functional at Sadar Hospital,East Champaran	2		y	y	y	y	342000	684000	684000	176036	507964	408000	1323964	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	20	Workshop at all PHCs has been planned during FY 2011-12	y	y	y	y	0	0	0	0	0	25000	500000	NRHM	
A.1.1.3	**MTP services at health facilities**			0	0	0		66							0	0		0		0		
A.1.1.4	**RTI/STI srvices at health facilities**			0	0	0		2	To open an OPD at Sadar Hospital and Raxaul for providing RTI/STI Services	y	y	y	y	0	0	0	0	0	420000	840000	NRHM	A Medical officer (Skin Specialist) shall be appointed on contractual basis @Rs.35,000/- per month
A.1.1.5	**Operationalise Sub-centres**			834	319	515		515							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		45							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)**			20	20	0		20						150000	3000000	3000000		3000000		-3000000		
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**			31	0	31		31	delivery huts at outreach areas	Y	Y	Y	Y	62500	1937500	460000		1937500	62500	0		
A.1.3.2.	**1.3.2. Monthly Village Health and Nutrition Days at AWW Centres**			4000	4000	0		4000						200	800000	427480		800000	250	200000		
A.1.4	**1.4. Janani Evam Bal Suraksha Yojana/JBSY**			30000	30000			137052						2000	60000000	133600000		60000000	2000	214104000		
A.1.4.1	**1.4.1 Home deliveries (500/-)**			0	0	0		5000		y	y	y	y	500	0	255500	0	0	500	2500000		
A.1.4.2	**1.4.2 Institutional Deliveries**					0		137052							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			22890	22890	0	Wrong Calculation by SHSB, Bihar	137052		y	y	y	y	2000	45780000	133600000	45780000	0	2000	274104000		
	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	1000000	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)			1200	1000	200		3600		y	y	y	y	1500	1800000	600000	0	1800000	1500	3600000		
	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			48	0	48		48	FOR APHC	0	y	y	0	1741	83568	600000	0	83568	2000	12432		
		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		2600							0	0		0	850	2210000		
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			0		0		4	EVERY REFERAL UNIT					0	0	135000		0		0		
	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.)			20	0	20		20		y	y	y	y		0	152000	0	0	1000	20000		
	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)			773	553	220		773		y	y	y	y	1500	1159500	5890403	0	1159500	2199	540327		
	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	1	0		4	FOR REFERAL						0	3093600		0		0		
	A.2.7.	2.7 Management of Diarrhoea, ARI and Micro nutrient			0	0	0		319							0	0		0		0		
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		20		y	y	y	y	25000	25000	22000	0	25000	25000	475000		
	A.3.1.2	3.1.2 Female Sterilisationcamps			80	20	60		80							0	552000		0		0		
	A.3.1.3 3.1.	3.1.3 3.1.2.2. NSV camps (Organise NSV camps in districts @Rs.10,000 x 500 camps)			80	20	60		80		y	y	y	y	10000	800000	440000	0	800000	10000	0		
	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)			80000	80000	0		100000		y	y	y	y	1000	80000000	22530400	4909615	75090385	1000	24909615		
	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			360	32	328		380		y	y	y	y	1500	540000	1778400	48000	492000	1500	78000		
	A.3.1.6 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)			1185	0	1185		2000		y	y	y	y	1500	1777500	10752000	0	1777500	1500	1222500		
	A.3.2	3.2. Spacing Methods			57708	50	57658		57708							0	0		0		0		
	A.3.2.1	3.2.1. IUD Camps			319	319	0		365	HSC & APHC	y	y	y	y	24000	7656000	660000	0	7656000	24000	1104000		
	A.3.2.2	3.2.2 IUD services at health facilites/compensation					0		365							0	647280		0		0		

	A.3.2	reditation of private providers for IUD tion services					0									0	0		0		0		
	2.4	Social Marketing of contraceptives					0									0	0		0		0		
	A.3.2.5 3.2	5 3.2.2. Contraceptive Update eminars (Organise Contraceptive Update seminars for health providers (one at state level & 38 at district level) (Anticipated Participants-50-70)					0									0	163990		0		0		
	A.3.3	3.3 POL for Family Planning for 500 below sub-district facilities			462	100	362		500		y	y	y	y	650	300300	388800	65000	235300	800	164700		
	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		0		
A.4		4. Adolescent Reproductive and Sexual Health (ARSH)					0									0	0		0		0		
		(Details of training, IEC/BCC in relevant sections)					0									0	0		0		0		
	A.4.1	Adolescent services at health facilites. 4.1.1. Disseminate ARSH guidelines.4.1.2. Establishing ARSH Cells in Facilities 4.1.2.1. Developing a Model ARSH Cell for the facilities 4.1.2.2. Establishing ARSH Cell at Patna District Hospital 4.1.2.3. Establishing ARSH Cell is 50% PHCs of Patna District 4.2 Conducting ARSH Camps at all PHCs for a week (as ARSH Week) 4.2.2 Establishing Youth friendly health clinics in Urban Area/ Universities Campus / Market Place			20	0	20		20		y	y	0	0	25000	500000	500000	0	500000	25000	0		
	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		2						480000	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)			2	0	2		2		y	y	y	y		0	450000	0	0	25000	50000		
	A.8.2.	Public Private Partnerships			21	4	17		27							0	0		0		0		
	A.8.3	NGO Programme					0									0	0		0		0		
	A.8.4	Other innovations (if any)					0									0	45000		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			503	242	261		261		y	y	y	y	5000	2515000	2515000	0	2515000	8000	-427000		
	A.9.1.2	9.1.2 Laboratory Technicians			6	0	6		6		y	y	y	y	78000	468000	351000	0	468000	78000	0		
	A.9.1.3	Staff Nurses					0									0	13248000		0		0		

	A.9.1	9.1.4 Doctors and Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians) Hiring Specialists 9.1.1 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			1	0	1		2		y	y	y	y	3487300	3487300	840000	0	3487300	3487300	3487300		
	A.9.1.5	Other contractual Staff 9.1 Fast-Track Training Cell in SIHFW 9.2 Filling Vacant Position at SIHFW/Hiring Consultant at SIHFW 10.1.1 Honorarium of Voluntary Workers @ of 1200/- PA x 3106 No.					0									0	0		0		0		
	A.9.1.6	Incentive/Awards etc. 8.2.1 Incentive for ASHA per AWW center (80000x200 per month) and Incentive toANMs per Aganwari Centre under Muskan Programme (@80000 x Rs.150 Per Month			1	1	0		1		y	y	y	y	5185860	5185860	10610000	5185860	0	5185860	5185860		
	A.9.2	9.2. Major civil works (new construction/extension/addition)					0									0	0		0		0		
	A.9.2.1	9.2.1 Major Civil works for operationalisation of FRUS					0									0	0	0	0		0		
	A.9.2.2	9.2.2 Major Civil works for operationalisation of 24 hour services at PHCs			18	0	18		20							0	0		0		0		
	A.9.3	9.3 Minor Civil Works			46	0	46		46							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	0	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			20	0	20		20		y	y	y	y	25000	500000	0	0	500000	25000	0		
	A.9.4	9.4 Operationalise IMEPat health facilites					0									0	0		0		0		
	A.9.5	9.5 Other Activities					0									0	0		0		0		
A.10		10. Institutional Strengthening					0									0	0		0		0		
	A.10.1	10.1 Human Resource Development					0									0	0		0		0		
	A.10.2	10.2 Logistics management/improvement					0									0	0		0		0		
	A.10.3	10.3 Monitoring Evaluation/HMIS 11.3 Monitoring & evaluation through monitoring cell at SIHFW					0									0	670529		0		0		
	A.10.4	10.4 11.4 Sub-centre rent and contingencies @ 1770 no. x Rs.500/- x 60 months			319	0	319		140		y	y	y	y	60000	19140000	378000	0	19140000	60000	-10740000		
	A.10.5.	10.5. Other strategies/activities TA & DA for the 30 days contact programme					0									0	0		0		0		
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		

		.1 Skilled Birth Attendance /SBA 12.1.2 ed Attendance at Birth / SBA--Two s Reorientation of the existing trainers atches 12.1.3 Strengthening of isting 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/-			116	36	80		80		y	y	y	y	42504	4930464	88110	425040	4505424	59000	214576		
	A.11.3.2	EmOC Training 12.1.3 EmOc Training of (Medical Officers in EmOC (batchsize is 8)			20	2	18		18							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)			22	0	22		22							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			22	0	22		38		0	y	0	y	25000	550000	60000	0	550000	25000	400000		
	A.11.3.5	11.3.5 RTI/STI Training			22	0	22		2		0	y	0	y	0	0	0	0	0	96900	193800		
	A.11.3.6	Dai Training					0		150	mamta						0	0		0		0		
	A.11.3.7	Other MH Training					0									0	0		0		0		
	A.11.4	IMEP Training					0									0	0		0		0		
	A.11.5	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)			0	0	0		38		y	y	y	y	113900	0	6413220	1787100	-1787100	113900	6115300		
	A.11.5.2	11.5.2 Facility Based Newborn Care 12.2.2.1 SNCU Training 12.2.2.2.NSU (TOT)			0	0	0		2		y	y	y	y	0	0	692300	0	0	143750	287500		
	A.11.5.3	11.5.3 Home Based Newborn Care					0									0	0		0		0		
	A.11.5.4	11.5.4 Care of Sick Children and severe malnutrition			0	0	0		2							0	0		0		0		
	A.11.5.5	11.5.5 Other CH Training (Pl. Specify)					0									0	0		0		0		
	A.11.6	11.6 Family Planning Training					0									0	0		0		0		
	A.11.6.1	12.6.1 Laproscopic Sterilisation Training			0	0	0		19							0	0		0		0		
	A.11.6.2	11.6.2 Minilap Training12.3.2.1. Minilap training for medical officers/staff nurses (batch size of 4)			0	0	0		38		y	y	y	y	0	0	70240	0	0	28000	1064000		
	A.11.6.3	11.6.3 NSV Training 12.3.3 Non-Scalpel Vasectomy (NSV) Training					0		38							0	33900		0		0		
	A.11.6.4	11.6.4 IUD InsertionTraining 12.3.4 IUD Insertion (details in Annexure) 12.3.4.1 State level (TOT for the districts) 12.3.4.2 District level training (one district total) 12.3.4.3 PHC level training (for one district only)					0		116						32600	0	169450		0		0		
	A.11.6.5	Contraceptive Update Training					0									0	0		0		0		
	A.11.6.6	Other FP Training					0									0	0		0		0		
	A.11.7	11.7 ARSH Training 12.4.1 ARSH training for medical officers 12.4.3 One Day ARSH Orientation by the MOs of 25% ANMs 12.4.4 One Day ARSH Orientation of PRI by the MOs of50% ANMs			0	0	0		20		y	y	y	y	0	0	0	0	0	8350	167000		
	A.11.8	11.8 Programme Management Training					0									0	0		0		0		
	A.11.8.1	11.8.1 SPMU Training 12.5.4 State PMU to be trained/attend workshops in various areas like HR, Procurement & Logistics, PPP, FRU review and/or undertake study of various programmes in one good and one poor performing districts					0									0	0		0		0		

		.2 DPMU Training 12.5.1 Training of U staff @ 38 x Rs.10,00012.5.2. ing of SHSB/DAM/BHM on accounts ead Quarter level @																						
	A.11.8.2	1500x12=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/-			21	0	21		21		y	y	y	y	8750	183750	138000	0	183750	8750	0		
	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)					0									0	0		0		0		
	A.12.1	12.1 Strengthening of BCC/IEC Bureaus (State and District Levels)					0									0	468500		0		0		
	A.12.2	12.2 Development of State BCC/IEC strategy 13.3 Concept and material development workshops by State BCC/IEC Cell 13.8 Establishment cost of the State BCC/IEC Cell 13.10 Technical support at District level			1	0	1		2		y	0	0	0	12500	12500	12500	0	12500	25000	37500		
	A.12.3	12.3 Implementation of BCC/IEC stretegy					0									0	0		0		0		
	A.12.3.1	12.3.1 BCC/IEC activities for MH			0	0	0		1		y	y	y	y	0	0	0	0	0	25000	25000		
	A.12.3.2	BCC/IEC activities for CH			0	0	0		1		y	y	y	y	0	0	0	0	0	25000	25000		
	A.12.3.3	12.3.3 BCC/IEC activities for FP			0	0	0		1		y	y	y	y	0	0	0	0	0	25000	25000		
	A.12.3.4	12.3.4 BCC/IEC activities for ARSH			0	0	0		1		y	y	y	y	0	0	0	0	0	25000	25000		
	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			74	0	74		105		y	y	y	y	10027	741998	741998	0	741998	10027	310837		
		Sub-total IEC/BCC					0									0	0		0		0		
A.13		Procurement					0									0	0		0		0		
	A.13.1	13.1 Procurement of Equipment					0									0	0		0		0		
	A.13.1.1	13.1.1 Procurement of equipment 14.2. Equipments for EmOC services for identified facilities (PHCs, CHCs) @ Rs 1 Lac / facility / year (in two districts - kishanganj and jehanabad) 14.4. Equipments / instruments for Blood Storage Facility / Bank at facilities 14.6. Equipments / instruments, reagents for STI / RTI services @ Rs. 1 Lac per district per year			20	0	20		20		y	y	0	0	132895	2657900	37200	0	2657900	132895	0		
	A.13.1.2	13.1.2 Procurement of equipment : CH					0									0	191280		0		0		
	A.13.1.3	13.1.3 Procurement of equipment : FP			21	0	21		21		y	y	0	0	0	0	0	0	0	25000	525000		
	A.13.1.4	13.1.4 Procurement of equipment : IMEP					0									0	0		0		0		
	A.13.2	13.2 Procurement of Drugs & supplies					0									0	0		0		0		
	A.13.2.1	13.2.1 Drugs & Supplies for MH					0									0	0		0		0		
	A.13.2.2	13.2.2 Drugs & Supplies for CH					0									0	0		0		0		
	A.13.2.3	13.2.3 Drugs Supplies for FP					0									0	5500		0		0		
	A.13.2.4	13.2.4 Supplies for IMEP					0									0	0		0		0		
	A.13.2.5	General drugs & supplies for health facilities					0									0	0		0		0		
A.14		14. Prog. Manag-ement					0									0	0		0		0		

	.14.1	ngthening of State Society/SPMU Strengthening of State society/State amme Management Support Unit 1. Contractual Staff for SPMU recruited d in position 16.5.1. Last pay drawn – Pension = Approx exp of Rs.20,000/-PM @ 20,000x6x12					0								0	0		0		0		
	A.14.2	14.2 Strengthening of District Society/DPMU 16.2.1. Contractual Staff for DPMSU recruited and in position			0	0	0		0		y	y	y	y	61598	0	1961120	1252383	-1252383	139740	1252383		DPM@35420x1x12M=425040/- DAM@27720x1x12M=332640/- DNM&EO@23100x1x12M=277200/- DEO@8500x3x12M=306000/- Peon@4000x2x12=96000/- Office Assistant@10000x2x12=240000/-
	A.14.3	14.3 Strengtheningof Financial Management Systems 16.3.1.Training in accounting procedures 16.3.2. Audits 16.3.2.1. Audit of SHSB/ DHS by CA for 2009-10 16.4 Appointment of CA 16.4.1 At State level 16.4.2 At District level 16.5 Constitution of Internal Audit wing at SHSB			1	0	1		1		y	y	y	y	20000	20000	240000	120000	-100000	20000	120000		Mobility support to DPMU staff@20000x2x12M=480000/- Office Rent@6000x1x12M=72000/- Telephone@6000x1x12M=72000/- Generator@20000x1x12M=240000/- Stationary@20000x1x12M=240000/- Contigency for TA/DA etc. @10000x1x12M=120000/-
	A.14.4	14.4 Other activities (Programme management expenses,mobility support to state,district, block) 16.1.2. Provision of mobility support for SPMU staff @ 12 months x Rs.10.00 lakhs Updgration of SHSB Office 16.2.2.Provision of mobility support for DPMU staff @ 12 months x 38 districts x Rs.69945.17/-			20	0	20		20		y	y	y	y	69945	1398900	0	839340	559560	102000	1480440		
		Total Prog. Mgt.					0									0			0		0		
A.15		Others/Untied Funds			319	300	19		19							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									252422640	363047700	60588374	191834266		535945434		

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Structured approaches for State/ District/ Block PIP planning

National Rural Health Mission

Strategy & Activity Plan with budget

Name of the State/ UT:_____

Sr. NO		Activities		Component Code (only at state level)	Output 2012	Activity Plan										Budget Plan								
						2009-2010 FY				20010-2011 FY						2009-2010FY					2010-2011FY			
						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)	{X x (A)} = Budget Planned B	Budget received B or C or > than planned)	Budget utilised {Y x (A)} = D	{(B~D) under or over-utilised Budget =E	Tentative Unit Cost (F)	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
												Q1	Q2	Q3	Q4									
B																								
B.1	Decentrlisation																							
	B.1.11	ASHA Support system at State level																0						
	B.1.12	ASHA Support System at District Level				2	2	0		1		y	y	y	y	4000	8000	1110507	0	8000	4000	-4000		
	B.1.13	ASHA Support System at Block Level				20	17	3		10		y	y	y	y	12500	250000	2592000	0	250000	12500	-125000		
	B.1.14	ASHA Support System at Village Level				3908	0	3908		3908		y	y	y	y	150	586200	0	0	586200	150	0		
	B.1.15	ASHA Trainings				3908	3578	330		330		y	y	y	y	0	0	0		0	400	132000		
	B.1.16	ASHA Drug Kit & Replenishment				3908	3578	330		330		0	y	0	0	314	1227112	8199068	0	1227112	600	-1029112		
	B.1.17	Emergency Services of ASHA				0	0	0		3908		y	y	y	y	0	0	0	0	0	100	390800		
	B.1.18	Motivation of ASHA				3908	0	3908		3908		y	y	0	0	710	2774680	3190350	0	2774680	725	58620		
	B.1.19	Capacity Building/Academic Support programme				0	0	0		26		0	y	y	0	0	0	0	0	0	1000	26000		
	B.1.2	ASHA Divas				240	240	0		240		y	y	y	y	920	220800	4464432	200000	20800	930	202400		
	B.1.21	Untied Fund for Health Sub Center, Additional Primary Health Center and Primary Health Center				385	385	0		385		y	y	y	y		5015000	4950000	2189824	2825176	12076	1824084		for 27 phc @ 25000, 46 aphc @25000, 319 sub center @ 10000
	B.1.22	Village Health and Sanitation Committee				410	283	127		410		0	y	0	0	10000	4100000	12847500	2430000	1670000	10000	2430000		
	B.1.23	Rogi Kalyan Samiti				21	21	0		27		y	y	0	0	100000	2100000	4300000	1300000	800000	155556	3400012		1 lakh for phc, 2 lakh for SDH, 5 lakh for DH
B.2		Infrastrure Strengthening						0									0	0		0		0		
	B.2.1	Construction of HSCs (315 No.)				129	0	129		129		0	y	y	y	1575000	203175000	0	0	203175000	950000	-80625000		
	B.2.2	Construction of residential quarters of old APHCs for staff nurse				24	0	24		24		y	y	y	y	3000000	72000000	0	0	72000000	3000000	0		

	B.2.2	Construction of building of APHCs where land is available (5315000/APHCs)				24	0	24		24		y	y	y	y	7599000	182376000	0	0	182376000	5315000	-54816000		
	B.2.3	2.3 Up gradation of CHCs as per IPHS standards				6	2	4		5		y	y	y	y	2000000	12000000	0	4000000	8000000	2000000	2000000		
	B.2.4	Infrastructure and service improvement as per IPHS in 48 (DH & SDH) hospitals for accreditation or ISO : 9000 certification				1	0	1		1		y	y	y	y	0	0	0	0	0	400000	400000		
	B.2.5	Upgradation of ANM Training Schools				1	0	1		1								2500000						
	B.2.6	Annual Maintenance Grant				21	20	1		21		y	y	y	y	175000	3675000	0	1400000	2275000	175000	1400000		
B.3		TOTAL INFRASTRUCTURE strengthening						0									0			0		0		
	B.3	Contractual Manpower						0									0	13428180		0		0		
	B.3.1 A	Incentive for PHC doctors & staffs				20	0	20		20		y	y	y	y	8711	174220	0	0	174220	9000	5780		
	B.3.1 B	Salaries for contractual Staff Nurses				583	293	290		583		y	y	y	y	7500	4372500	0	5443393	-1070893	12000	8066893		
	B.3.1.C	Contract Salaries for ANMs				503	242	261		503		y	y	y	y	6000	3018000	0	7920000	-4902000	8000	8926000		
	B.3.1. D	Mobile facility for all health functionaries				81	37	44		44		y	y	0	0	1500	121500	0	0	121500	2000	-33500		
	B.3.2.	Block Programme Management Unit				20	17	3		20	Acountant selection pending	y	y	y	y	775988	15519760	13428180	2500000	13019760	857850	4137240		
	B.3.4.	Addl. Manpower for NRHM				0	0	0		20		y	y	y	y	66857	0	0	0	0	104000	2080000		
B.4		PPP Initiativs				20	4	16									0	0		0		0		
	B.4.1	102-Ambulance service (state-806400) @537600 X 6 Distrrict				20	20	0		27		y	y	y	y	156000	3120000	0	0	3120000	11042	-2821866		
	B.4.2	1911- Doctor on Call & Samadhan				0	0	0		0							0	0	0	0		0		
	B.4.3	Addl. PHC management by NGOs				0	0	0		0		y	y	y	y	0	0	0	0	0	75500	0		
	B.4.5	SHRC						0									0	0		0		0		
	B.4.6	Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP)				20	0	20		20		y	y	y	y	0	0	0	0	0	200000	4000000		
	B.4.7	Dialysis unit in various Government Hospitals of Bihar				1	0	1		1							0	0		0		0		
	B.4.8	Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar						0									0	0		0		0		
	B.4.9	Providing Telemedicine Services in Government Health Facilities						0									0	0		0		0		
	B.4.10	Outsourcing of Pathology and Radiology Services from PHCs to DHs				21	4	17		27		y	y	y	y	0	0	2078571	0	0	375000	10125000		
	B.4.11	Operationalising MMU				1	1	0		1		y	y	y	y	468000	468000	5616000	2808000	-2340000	468000	2808000		
	B.4.14	Monitoring and Evaluation (State , District & Block Data Centre)				21	21	0		28		y	y	y	y	101250	2126250	2700000	0	2126250	150000	2073750		
	B.4.15	Generic Drug Shop				20	0	20		27							0	0		0		0		
	B.4.16	Nutritional Rehabilitation Centre				1	1	0		1		y	y	y	y	126904800	126904800	126904800	0	126904800	205600	-126699200		
	B.4.17	Hospital Maintenance				20	0	20		20							0	0		0		0		

	B.4.18	Providing Ward Management Services in Government Hospitals 3000000/-						0		1							0	0		0		0			
	B.4.19	Provision for HR Consultancy services						0									0	0		0		0			
	B.4.2	Advanced Life Saving Ambulance				4	1	3		3		y	y	y	y	0	0	0	0	0	989000	2967000			
		TOTAL PPP INITIATIVES						0									0	0		0		0			
B.5	B.5	Prourement of supplies						0									0	0		0		0			
	B.5.1	Delivery kits at the HSC/ANM/ASHA (no.200000 x Rs.25/-)				4150	0	4150		7132		y	0	y	0	25	103750	0	0	103750	25	74550			
	B.5.2	SBA Drug kits with SBA-ANMs/ Nurses etc (no.50000 /38x Rs.245/-)				291	0	291		359		0	y	0	0	245	71295	71295	0	71295	245	16660			
	B.5.3	Availability of Sanitary Napkins at Govt. Health Facilities @25000/district/year				1	0	1		1		y	y	y	y	25000	25000	0	0	25000	25000	0			
	B.5.4	Procurement of beds for PHCs to DHs				456	220	236		236		y	y	0	0	7590	3461040	0	546480	2914560	8000	-1026560			
		TOTAL PROCUREMENT OF SUPPLIES						0									0	0		0		0			
B.6		Procurement of Drugs						0									0	0		0		0			
	B.6.1	Cost of IFA for Pregnant & Lactating mothers (Details annexed)				0	0	0		2752622		y	y	0	0	10.5	0	0	369490	-369490	110	303157910			
	B.6.2	Cost of IFA for (1-5) years children (Details annexed)				12632	12632	0		4587703		y	y	0	0	50	631600	0	631600	0	50	229385150			
	B.6.3	Cost of IFA for adolescent girls (Details annexed)				5267	5267	0		1908484		y	y	0	0	10.5	55303.5	0	0	55303.5	110	209877936.5			
		TOTAL PROCUREMENT OF DRUGS						0									0	0		0		0			
B.7		Mobilisation & Management support for Disaster Management						0									0	0		0		0			
B.8		Health Management Information System				0	0	0		800600		y	y	y	y	0	0	0	0	0	7500	6004500000			
B.9		Strenthening of Cold Chain (infrastrcure strengthening)				20	0	20		20							0	800000		0		0			
	B.9.1	Refurbishment of existing Warehouse for R.I. as well as provision for hiring external storage space for (during Immunization Campaigns) Logistics at State HQ @Rs 1500000/-				1	0	1		1		y	y	y	y	87500	87500	0	0	87500	87500	0			
	B.9.2	Refurbishment of existing Cold chain room for district stores in all districts with proper electrification,Earthing for electrical cold chain equipment and shelves and dry space for non elecrtical cold chain equipment and logistics @Rs 300000 Lakhs per district x 38 districts				0	0	0		1		y	y	0	0	0	0	0	0	0	300000	300000			
	B.9.3	Earthing and wiring of existing Cold chain rooms in all PHCs @Rs 10000/- per PHC x 533 PHCs				20	0	20		27		y	y	y	y	10000	200000	200000	70000	130000	10000	140000			
B.10		Preparation of Action Plan				20	20	0		27							0	0		0		0			

	B.10.1	Preparation of District Health Action Plan (Rs. 2 lakhs per district x 38)				1	1	0		1		0	0	y	y	100000	100000	100000	50000	50000	100000	50000		
	B.10.2	Preparation of State Health Action Plan @ 5 lakhs						0									0	0		0		0		
B.11		Mainstreaming Ayush under NRHM				62	62	0		30		y	y	y	y	456000	28272000	11940000	0	28272000	456000	-14592000		
B.12		Continuing Medical & Nursing Education				0	0	0		2						100000	0	0		0		0		
B.13		RCH Procurement of Equipments						0									0	0		0		0		
	B.13.1	Procurement of Equipments/instruments for Anesthesia				0	0	0		1		y	y	0	0	0	0	0	0	0	244000	244000		
	B.13.2	Equipment for ICU				1	0	1		1		y	y	0	0	1705263	1705263	0	0	1705263	1705263	0		
	B.13.3	Equipments/instruments for ANC at Health Facility (Other than SubCentre) @ 50,000 per district per year				48	0	48		48		y	y	0	0	0	0	0	0	0	50000	2400000		
	B.13.4	Equipments for the Labour Room				20	20	0		20		y	y	0	0	0	0	0	2044240	-2044240	255530	7154840		
	B.13.5	Equipments for SNCU &NSU				4	0	4		4														
	B.13.5.A	SNCU for 23districts unit cost of Rs. 2377258				1	0	1		1		y	y	0	0	2377258	2377258	2377258	2377258	0	2377258	2377258		
	B.13.5.B	NSU for 530 PHCs unit cost of Rs. 139492				20	0	20		27		y	y	0	0	139492	2789840	2789840	0	2789840	139492	976444		
	B.13.6	NSV Kits				20	0	20		27		y	y	0	0	1100	22000	22000	0	22000	1100	7700		
	B.13.7	IUD insertion kit				385	0	385		385		y	y	0	0	15000	5775000	5775000	15000	5760000	15000	15000		
	B.13.8	Minilap sets				21	0	21		21		y	y	0	0	3000	63000	63000	0	63000	3000	0		
B.14		Additionalitiesfor NVBDCP under NRHM				21		21		28							0	0		0		0		
		Total for Equipment Procurement						0									0	0		0		0		
	B.14	Drugs Procurement																						
	B.14.1	Drugs				0	0	0		1		y	y	y	y	0	0	0	0	0	20000000	20000000		
	B.14.2	Manpower/logistics for drugs procurement @ 10000x 2x12M=240000/-				0	0	0		2		y	y	y	y	0	0	0	0	0	120000	240000		
	B.14.3	Rent for drug store@10000x12M=120000/-				0	0	0		1		y	y	y	y	0	0	0	0	0	60000	60000		
		Grand Total NRHM-B																				6556662790		