DISTRICT HEALTH ACTION PLAN

2012-2013

DISTRICT HEALTH SOCIETY

KATIHAR

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I . Acknowledgements

Accepting the role & importance of Health in process of social & economical development of the nation & to make available health facilities to our citizens for improvement of living status of marginalize people, especially those who are living in rural area GOI launched National Rural Health Mission (2005-2012) in April-2005. It devours to change in old basic health delivery system for effective health care to rural population throughout the country, with special focusing on those state which are poor in respect of education, health facilities & infrastructure including 18 state &Bihar is one of the EAG state.

The goal of the mission is to provide better health facilities to poor, women & children specially vulnerable section who are living in rural area & the last general people of India. Far betterment health delivery system, NRHM has tried to bring the Indian system of medicine, in main stream of health system, is one of the objective of NRHM. The actual operational focal point for regulation of NRHM is district & therefore district plan is must needed for its successful operation and achieving the goal, we committed to formulate District Health Action Plan 2011-12.

During preparation of plan 2011-12 all issues from bottom to top is kept into consideration including Sub-centre / Village level plan, a comprehensive DHAP has been prepared. In the preparation of DHAP the views of the different departments that are directly or indirectly related to determinants of health, such as water, pollution, hygiene and sanitation, will lead to betterment of health care delivery, and to make this collaboration possible actions are to be outlined in the District Health Action Plan.

The development of a District Action Plan for Katihar entailed a series of Consultative Meetings with stakeholders at various levels, collecti data from various departments with their analysis. A series of District level Workshops are also organized, to identify district health problems & its solution, are also included in the DHAP.

I would like to acknowledge the cooperation extended by the District Magistrate (DM) and Deputy Development Commissioner (DDC) because without their support the conduct of the of district level workshop would not have been possible. I extends my thanks to All the Program and Medical officers of the district for their assistance and support from the inception of the project. The formulation of the plan is a participatory process I am also thankful to all the Medical officers and Block Health Managers, Accountants and HSC level ANM who played a vital role throughout the whole exercise in preparing the District Health Action Plan.

The role of the whole team of PHRN Bihar & State Health Society, Bihar, specially to State Data Officer Mr. Arvind Kumar, Mr.Ajit Kumar Singh State Facilitator(NRHM) NHSRC-Bihar & SPO Miss. Rashi Jaiswal as well as HMIS trainers and Training Materials / tricks supplied by SHSB, Patna which was very helpful to build the capacity of ANMs' to prepare her HSC level planning can't be ignored. And I am also thankful to all DHS Consultant, IDSP unit & Sri Mani Bhushan Jha, Health Manager, for their whole hearted support throughout the process of planning, preparation and finalization of the District Health Action Plan .

In the last I would like to appreciate the initiatives and support of all, to whom I am aware or not, for their whole hearted support, throughout the process of planning & preparation of DHAP.

Nirmal kumar
District Programme Manager

District Health Society, Katihar

(Dr. Yogendra Prasad)
Civil Surgeon cum Member Secretary
District Health Society, Katihar

II. Executive Summary

By the govt. of India, the National Rural Health Mission launched for aiming at providing integrated comprehensive primary health care services, especially to the poor and vulnerable sections of the society.

In order to make NRHM fully accountable and responsive, the District Health Action Plan (DHAP) 2012-13 has been prepared. This District Health Action Plan is one of the key instruments to achieve NRHM goals. This plan is based on basic health needs of the District.

The district level planning team prepared this plan particularly addressing health care needs of rural poor especially women and children. After a thorough situational analysis of district health scenario, this document has been prepared. In the plan, the teams have analyzed the coverage of poor women and children with preventive and primitive interventions, barriers in access to health care and spread of human resources catering health needs in the District. The focus has also been given on current availability of health care infrastructure in public/NGO/private sector, availability of wide range of providers.

The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programs, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centres into functional hospitals meeting Indian Public Health Standards.

As a first step towards planning process, identification of performance gaps in comparison with the last year plan was attempted by carrying out a situational analysis. It indicates that the last year proposed most plan of actions/activities are not implemented in the district till date because of this non-performance, the expenditure of the district is less than 30%, it is the matter of great concern and should be addressed promptly so that the Missions objectives are accomplished and the poor people of district have not been deprived with their health needs. I have great believe that the gaps of the last year should be accomplish in the forth coming months and it is possible only, when all the persons concern has given their 100 percent efforts towards the accomplishment of the objectives. At last but not the least the district of Katihar is a flood prone and Kala-azar prone district, so I am hopeful that this action plan incorporated the activities that encountered the above problems .

District Magistrate cum Chairperson
District Health Society, Katihar

III . SWOT Analysis of the District

STRENGTHS – WEAKNESSES – OPPORTUNITIES – THREATS :

❖ STRENGTHS

1. **Involvement of Civil Surgeon cum Member Secretary: - CS cum MS** personally takes interest in various programs like Family Planning Camp at PHC level, Muskan,VHSC, Untied Fund etc. program up to HSC level as well as guides in every activity of Health program and get personally involved. He properly review all programs blockwise by calling meeting of all Block officers & Accountant.

2. **Support from District Administration:-** District Magistrate cum Chairperson also take's interest in all the health program and actively participate in various activities. By calling a monthly review meeting of District Health Society he also review all programs & services personally. The District Administration provides administrative support as and when needed.

3. **Support from PRI (Panchayati Raj Institute) Members: -** Elected PRI members of Blocks & Panchayats are very co-operative. They take interest in every health programmes and support as and when required. They take lead roles in Rogi Kalyan Samitis' meeting as well as Zila Parisad quarterly meeting. They review quality of all running services personally. There is an excellent support from Members, Pramukh & Mukhias They actively participate in all health activities and monitor, it during their tour program.

4. **Effective Communication: -** Communication is easy with the help of internet facility at block level and land line & Mobile phone facility which is incorporated in PHCs .

5 .**Facility of vehicles: -** Under the Muskan Ek Abhiyan program/Pulse Polio Program PHC have the vehicles for monitoring in the field.

6. **Support from media: -** Local newspapers and channel are very co-operative for passing messages as and when required. They also personally take interest to project good and worse things which is very helpful for administration to take corrective measures.

❖ WEAKNESS

1. **Non availability of specialists at Block level: -** As per IPHS norms, there are vacancies of specialists in most of the PHCs. Many a times only Medical Officer is posted, they are busy with routine OPD and medico legal work only. So PHC doesn't fulfill the criteria of ideal referral centers and that cause force people to avail costly private services.

2. **Non availability of ANMs at APHCs to HSCs level: -** As per IPHS norms, there are vacancies of ANM in most of HSCs. Many HSCs' are being operated by Deputed ANMs. So HSC doesn't fulfill the criteria of ideal Health Sub Centre and that cause force people to travel up to PHCs to avail basic health services.

3. **Apathy to work for grass root level workers: -** Since long time due to lack of Monitoring at various level grass root level workers are totally reluctant for work. Even after repeated training, desired result has not been achieved. Most of the MO, Paramedics, Health Staffs & workers do not stay at HQ. Medical Officers, who are supposed to monitor the daily activity of workers, do not take any interest to do so. For that reason workers also do not deliver their duties regularly and qualitatively.
   Due to lack of monitoring & supervision some aim, object & program is suffering.

4. **Lack of proper transport facility and motarable roads in rural area :-** There are lack of means of transport and motarable roads in rural areas . Rural roads are ruled by 'Jogad', a hybrid mix of Motor cycle and rickshaw, which is often inconvenient mean of transport. The fact that it is difficult to find any vehicle apart from peak hours is still the case in numerous villages.

5. **Illiteracy and taboos:-**The literacy rate in rural area has still not reached considerable mark. Especially certain communities have constant trend of high illiteracy. This causes prevalence of various taboos that keep few communities from availing benefits of health services like immunization or ANC, institutional delivery…etc.

❖ OPPORTUNITIES

1. Health indicator in APHC/HSC is not satisfactory. Services like Complete Immunization, Family Planning, Complete ANC may require to be improved. So there is an opportunity to take the indicator to commendable rate of above by deploying more efforts and will.
2. **Involvement of PRIs: -** PRI members at Block and village level are very co-operative to support the programmes. Active involvement of PRI members can help much for acceptance of health care deliveries and generation of demand in community.
3. Improvement of infrastructure: -. With copious funds available under NRHM Scheme to DHS there is good opportunity to make each health facility neat and clean, Well Equipped and Well Nurtured.

❖ THREATS

1. Flow of information if not properly channeled to the grass root stakeholder

2. Natural calamities like every year flood adversely affects the progress of Health Program in flood affected areas

lll. The Planning Process

1. FORMATION OF DISTRICT PLANNING TEAM

District Planning Team was constituted Civil Surgeon cum Chief Medical Officer, DPM, DAM, Dist. Data Manager (IDSP) ,Deputed Assistant as well as Block Health Managers and District Program Officers like DIO, DMO, DTO, DLO etc.

1.1 SUB CENTER LEVEL PLANNING PROCESS

In each block, all the Health Sub-centers (HSC) were selected for this process. Situation analysis of the HSC has been done in the prescribed format that has been provided by the SHSB, Patna . Before of it All ANMs' & Data Operators has been trained on HMIS & Village / Sub-centre level plan following TOT of all MOICs' & BHMs'.
In lue of it gaps & challenges of sub-centre came in focus which is planned to overcome in coming FY 2012-13.

1.2 BLOCK LEVEL PLANNING PROCESS

On the basis of plans generated from these HSCs /villages, block level health plan were prepared. Facility survey was done for each facility available in the vicinity of block-. Block level workshops were organized to discuss proposed plans. Situation analysis helped them in finalizing their plan.
The people during the group discussions opined that frontline functionaries of different departments viz; water & sanitation, ICDS/WCD, ANMs, teachers, and field workers of NGOs could work together to help reducing risk factors from other determinants of health and make the health services available to them.

1.3 DISTRICT LEVEL PLANNING PROCESS AND AGGREGATION OF BLOCK HEALTH PLAN

The details for NRHM planning were collected from both Quantitative & Qualitative sources. The data was collected through facility survey, household survey and access to secondary data sources, compiled service statistics and also other published studies. The data collected were both of the primary & secondary type.

2. Techniques of Primary Data Collection:

The data of various PHCs' uploaded on HMIS web-portal is collected and then it is analyze then key indicators set to overcome the gaps for service available.

Then as the State, at the district level we also organize TOT of all MOICs', BHMs' & Health Educators to enhance their capacity about data and their collection process, they are also taught that how to improve their ANMs' & Data operator as well as computers' capacity to collect, report & compile data & related information. Then they organized two days capacity building workshop at their own block headquarters to improve their ANMs' & Data operator as well as computers' capacity & they are trained to report / load authenticated data on HMIS reporting format as well as web portal. Besides of this ANMs' also get capacity to prepare & submit her HSC (Health Sub-centre) level action plan to improve the existing facility. This whole process was supported by State Data Officer Mr. Arvind Kumar, Ajit Kumar Singh State Facilitator(NRHM)
NHSRC-Bihar & SPO Miss. Rashi Jaiswal as well as HMIS trainers and Training Materials / tricks supplied by SHSB, Patna.

Focused Group Discussion and Field Visit: The focused group discussion with Block Medical Officers and Block Health Managers were carried out from all the blocks. Field visits were made along with the village health information survey form and information was collected and filled in by the ANMs and cross -checked by the Block Health Managers of the respective blocks.
On the basis of block health plan from Sixteen (16) blocks of the district, which includes their all running HSCs' action plan, District health action plan was made. Thus it can be said that, this NRHM action plan is the compilation of the planned activities to be carried out at all level of care. The activities for a year is divided into four quarters and distributed accordingly. The first quarter of the year will start from the month of April. This plan is based on the past performance of the district. The budget is planned based on the past expenditure and the requirements for the future in the District.

3. Sources Of Secondary Data:

The data related to various national Health Programmes were collected from following Sources.
HMIS: The data of various PHCs' uploaded on HMIS web-portal is collected and then it is analyze then key indicators set to overcome the gaps for service available.
RCH: The RCH data was collected from DLHS –3 reports. The comparative figures of the state were taken from RCH II programme document of the state and socio economic survey reports..
RNTCP: The data was collected from the monthly reports of TB department.
NLEP: The data was collected from leprosy department.
NVBDCP: The data was collected from the reports of malaria department.
NBCP: The data on blindness was collected from Blindness Control Society of Katihar district.
IDSP: The data was collected from the weekly reports that the department sends to the state.
Demographic, Socio-economic & vital rates: The data was collected from NFHS-II, DLHS , SRS , Department of Health and Family Welfare , Statistical Branch etc.

IV. Profile of the District

Katihar is located at **25.53° N 87.58° E**. It has an average elevation of 20 metres. The main rivers of the District are mighty **Ganga** (southern boundary, 25 kilometers from Katihar Town), magnificent **Kosi** (western boundary, 30 kilometers from Katihar Town) and beautiful **Mahananda** besides many other small rivers like **Kari Kosi** (flowing by the side of Katihar town), **Kamla** etc. The **Kosi (Sorrow of Bihar)** merges with Ganga at the south-west boundary of Katihar District. This District shares boundary with two states i.e. **Jharkhand** at the southern side and **West Bengal** at the eastern side. The Bangla Desh lies around 80 km east of Katihar town and Nepal lies around 100 km north of Katihar Town. There is rail connectivity to both the borders from Katihar railway station. The hills of Jharkhand near the southern bank of Ganga is even visible from Katihar Town on a clear day. Its proximity to the Himalayas in the north, Jharkhand plateu in the south and a multiple of rivers combined with good rainfall gives it a distinct climate which can be termed more or less pleasant during most of the year. The rainy season flood is an annual feature. And on 2nd October 1973,Katihar acquired status of an independent district.

Headquarters: Katihar
Area: 3,057 sq km
Population: Total: 3068149 **Rural**: 2794765 **Urban**: 273384
Sub Divisions: Barsoi, Katihar Sadar, Manihari
Blocks: Katihar, Barsoi, Kadwa, Amdabad, Manihari, Balrampur, Korha, Falka, Azamnagar, Barari, Pranpur, Mansahi, Samaeli, Kursaila, Hasanganj, Dandkhora
Agriculture: Paddy, Makhana, Banana
Industry: Jute and Paper Mills
Rivers: Mahananda, Ganges, Koshi, Righa

1. Govt. Sadar Hospital, **Katihar** Address :- Kali Bari Road, Katihar-854105

2 . Pvt. Katihar Medical College and Hospital Address :- Sirsa , Katihar-854105

3 . Katihar Railway Hospital Address :- Barmasia , Katihar-85410

4. Nidan Hospital Address :- Binodpur Raj Hata, Katihar – 854105

Doctors :

Dr. N. K. Jha (Child Specialist), Dr. Sima Mishra (Gynecologist)

5. Katihar Sewa Sadan Address :- Sadar Hospital Road, Katihar-854105

Doctors :

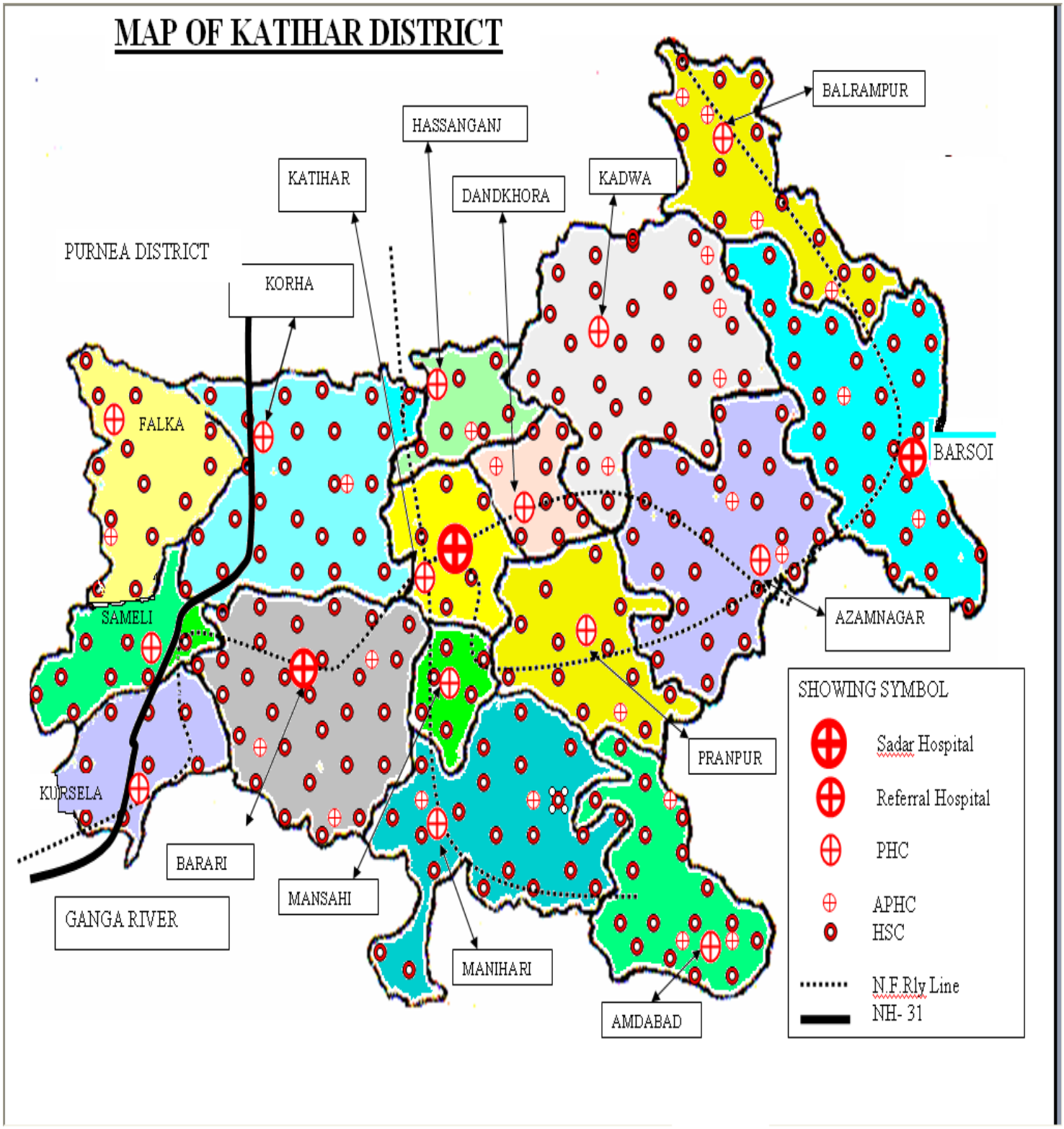
Dr. Ranjana Jha (Gynecologist), Dr. Ashutosh Kumar Jha (Orthopedic)

6. Y.F.A Eye Hospital and Research Institute

Address :- Naya tola , Katihar-854105

Phone no. – 06452-241878

MAP OF KATIHAR DISTRICT



Demographic profile of the Katihar

Katihar

Area	3,057 Sq.Kms.
Population	3068149
SC Population	287575
ST Population	172906
Male Population	1601158
Female Pupulation	1466991
Sex Ratio	919/1000
Literacy Combined	50.92
Male literacy	58.55
Female literacy	42.52
No. of Sub Divisions	03
No. of Blocks	16
No. of Nagar Nigam	01
No. of Gram Panchayats	239
No. of Revenue Villages	1548

Health Related Data

Following are the State Government Health System available in the District-:

No. of Primary Health Centre	16
No. of Referral Hospitals	04
No. of District Hospital	01
No. of Additional Primary Health Centre	45
No. of Health Sub Centre	345

V. Situational Analysis-

Availability of facilities and location of facilities

As per existing IPHS norms one HSC is planned for every 5000 population and for tribal areas the 3000 population, one PHC for every 30,000 population and for tribal area 20,000 population one CHC for every 1, 20,000 population. For tribal areas the norm is one CHC per 80,000 populations.
The number of gap is in the number of sectors without HSCs, without PHCs, we have major gap in CHCs where in practice the norm followed is one CHC per administrative block. There is no CHC in the Katihar district . 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:

Out of 16 blocks in Katihar district are proposed to be converted to CHCs. Currently 16 PHCs, 4 referral hospitals, 45 APHCs and 345 HSCs are functioning in the district. District hospital is located at Katihar block.

Health Sub-centres

S.No	Block Name	Population	Sub-centres required	Sub-centers Present	Sub-centers proposed	Sub-centers Sanctioned	Further sub-centers required	Status of building	
								Own	Rented
1	Amdabad	164741	31	17	9	7	5	7	4
2	Azamnagar	308229	59	30	19	8	10	6	5
3	Balrampur	152794	29	13	12	7	4	4	2
4	Barari	275700	52	28	16	7	8	7	3
5	Barsoi	327461	62	27	25	5	10	7	5
6	Dandkhora	67417	13	8	3	2	2	4	2
7	Falka	151604	29	14	10	6	5	4	2
8	Hasanganj	53316	10	6	3	3	1	2	1
9	Kadwa	335598	64	27	27	8	10	9	7
10	Katihar(R)	250212	18	5	10	6	3	1	0
11	Korha	262838	50	25	17	7	8	11	5
12	Kursela	65944	13	8	3	2	2	4	1
13	Manihari	186150	35	22	8	5	5	4	0
14	Mansahi	77912	15	7	6	5	2	3	2
15	Pranpur	140388	27	11	12	6	4	2	2
16	Sameli	83757	16	9	4	4	3	4	1
	Total	3068149	523	257	184	88	82	79	42

Additional Primary Health Centers (APHCs)

Sl. No.	Block Name	Population	APHCs required	APHCs present	APHCs Sanctioned	Further APHCs required
1.	Amdabad	164741	6	3	0	2
2.	Azamnagar	308229	12	4	05	5
3.	Balrampur	152794	5	4	0	1
4.	Barari	275700	11	5	0	3
5.	Barsoi	327461	13	4	0	2
6.	Dandkhora	67417	2	2	1	0
7.	Falka	151604	5	3	0	2
8.	Hasanganj	53316	2	1	1	0
9.	Kadwa	335598	13	6	0	3
10.	Katihar (R)	93487	4	2	0	1
11	Korha	262838	11	3	0	2
12	Kursela	65944	2	1	0	1
13	Manihari	186150	6	3	0	2
14	Mansahi	77912	3	1	0	1
15	Pranpur	140388	5	2	0	1
16	Sameli	83757	3	1	0	2
	Total	**2911414**	**103**	**45**	**7**	**26**

As per the IPHS norms still 16 CHCs (existing PHCs will be converted into CHCs) and 62 more PHCs (including existing 45 APHCs will be converted into PHCs) are required to be setup. As in case of HSCs, total HSCs are required 523. Katihar district has 345 existing HSCs. So, Katihar district need 174 more HSCs than the existing numbers.

All the existing CHCs (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 Sameli , Dandkhora and Falka . PHC Katihar has no building (Own building) .

CHC/ Block PHC	Building		Building Condition	Power Supply (in hrs)	Gen set	Water Supply	Tele phone	Sanitation (Toilet / Bath)		No. of Beds	Waste Management
	Govt.	Rented						Patient	Staff		
Amdabad	1	0	Poor	24	1	OHT	Y	Y	Y	6	N
Azamnagar	1	0	Average	24	1	OHT	Y	Y	Y	6	N
Balrampur	1	0	Average	24	1	OHT	Y	Y	Y	6	N
Barari	1	0	Average	24	1	OHT	Y	Y	Y	30	N
Barsoi	1	0	Good	24	1	OHT	Y	Y	Y	100	N
Dandkhora	1	0	Good	24	1	OHT	Y	Y	Y	6	N
Falka	1	0	Good	24	1	OHT	Y	Y	Y	6	N
Hasanganj	1	0	Average	24	1	OHT	Y	Y	Y	6	N
Kadwa	1	0	Good	24	1	OHT	Y	Y	Y	6	N
Katihar	1	0	Average	24	1	OHT	Y	Y	Y	6	N
Korha	1	0	Average	24	1	OHT	Y	Y	Y	6	N
Kursela	1	0	Good	24	1	OHT	Y	Y	Y	6	N
Manihari	1	0	Good	24	1	OHT	Y	Y	Y	6	N
Mansahi	1	0	Average	24	1	OHT	Y	Y	Y	6	N
Pranpur	1	0	Good	24	1	OHT	Y	Y	Y	6	N
Sameli	1	0	Good	24	1	OHT	Y	Y	Y	6	N

In the every PHCs are having power supply up to 24 hours (average) and Every PHCs have water supply through Over head tank as well as Hand Pump also. The telephone facility is available in each and every PHC along with their Data Centre. Every PHCs have sanitation facility but needs maintenance properly. Further more, almost all the PHCs are lacking in proper disposal of waste

Only 4 PHCs having Government vehicle services and Government ambulance services are available in only 4 PHCs other PHCs having outsourced ambulance (PPP) . So, there is requirement of ambulance in 12 PHCs and there is requirement of vehicles in 12 PHCs.

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 stage. 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 PHCs 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, All the 45 APHCs are functioning without any facilities with damaged building .Building condition is very poor. All APHCs are devoid of electricity, lacking of water supply because Hand pumps are not functioning properly. There are no residential facilities for staff.

Existing building need to be taken over and upgraded according to the IPHS norms. All APHCs , which do not have facility for electricity should be immediately provided with the electricity. Existing APHCs, 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 Existing APHCSs and Proposed 26 APHCs. This will definitely help in the long run of a dream of APHCs functioning for 24 hours a day and 7 days a week.

Out of 345 existing Health Sub-Centre 79 HSCs are have own building , 42 HSCs are running in rented building . Almost all the Government buildings are in poor conditions and immediately need renovation / new constructions are required. Rennovation/ Constructions works is going on at 36 HSCs.
As per IPHS norms 174 new more sub-centers are required to provide better health facility to the community.

Manpower Availability and Gaps in manpower

There are major gaps in Human resource in Health sector in Katihar District . As Per IPHS norms there are 4 specialist and 01 Physician at every PHC(CHC) . As per norms in Katihar for 16 PHCs there are 78 post of Contractual MOs is sanctioned , out of which 67 are specialist MOs and rest of the 11 should be of general MOs . Out of 78 MOs there are only 29 MOs are posted , out of which only 01 is specialist MO and rest of the MOs are general MBBS who has been appointed as stop gap arrangement due to non availability of Specialist MOs.

Slno.	Name of the Post	Sanctioned Post	Posted	Vaccant
1	Medical Officers (R)	120	64	56
2	Medical Officers (C)	78	35	43
3	Grade – A Nurse (R)	28	16	12
4	Grade – A Nurse (C)	104	72	32
5	LHV	63	28	35
6	Pharmacists	46	2	44
7	Lab Technicians	42	3	39
8	X- Ray Technicians	4	4	0
9	Sanitation Inspector	12	2	10
10	ANM (R)	362	325	37
11	ANM (C)	345	220	125
12	Computer	11	9	2
13	Store Keeper	3	2	1
14	O.T Assistant	3	01	2
15	Driver	11	8	3
16	BHW	43	32	11
17	BHI	11	2	9
18	HW	48	1	47
19	Dresser	42	11	31
20	MWA	43	36	7
21	FWA	35	27	8
22	BEE	12	0	12
23	HE	19	17	2

Indian Public Health Standard (I.P.H.S.) :

Although a large number of Sub-centres, Primary Health Centres and Community Health Centres have been established to provide comprehensive promotive, preventive and curative services to the rural people in the country, most of these institutions, at present are not able to function up to the level expected of them due to varied reasons. National Rural Health Mission (NRHM), launched by the Hon'ble Prime Minister on 12 April 2005, envisages getting these institutions raised to the level of optimum availability of infrastructure, manpower, logistics etc. to improve the quality of services and the corresponding level of utilization. Through wide consultation with various stakeholders, Indian Public Health Standards (IPHS) for these centres have been framed. The key aim of the Standards is to underpin the delivery of quality services which are fair and responsive to clients' needs, which should be provided equitably and which deliver improvements in health and well being of the population. Each PHC and CHC, as part of IPHS, is required to set up a Rogi Kalyan Samiti / Hospital Management Committee, which will bring in community control into the management of public hospitals with a purpose to provide sustainable quality care with accountability and people's participation along with total transparency.

To bring these centres to the level of Indian Public Health Standards, is no doubt, a challenge for most of the States and also may require a detailed institution specific facility survey to find out the gaps. Planning is done so that all the health institutions work on the basis of IPHS. Health care delivery in India has been envisaged at three levels namely primary, secondary and tertiary. The secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral Units (FRUs) and the district hospitals. The CHCs were designed to provide referral health care for cases from the primary level and for cases in need of specialist care approaching the centre directly. 4 PHCs are included under each CHC thus catering to approximately 80,000 populations in outreach / hilly areas and 1, 20,000 population in plain areas. CHC is a 30-bedded hospital providing specialist care in medicine, Obstetrics and Gynaecology, Surgery and Paediatrics. These centres are however fulfilling the tasks entrusted to them only to a limited extent.

Under the NRHM, the Accredited Social Health Activist (ASHA) is being envisaged in each village to promote the health activities. With ASHA in place, there is bound to be a groundswell of demands for health services and the system needs to be geared to face the challenge. Not only does the system require up gradation to handle higher patient load, but emphasis also needs to be given to quality aspects to increase the level of patient satisfaction. In order to ensure quality of services, the Indian Public Health Standards are being set up for CHCs so as to provide a yardstick to measure the services being provided there. This document provides the requirements for a Minimum Functional Grade of a Community Health Centre.

Sub – Centre

Conduct a facility survey and identify the gaps, which have been done to ensure that all the existing Sub-centres should be posted with one ANM immediately. The vacant post may be filled up on contractual basis. There should be an in-built plan to take care of vacancies arising out of retirements, long leave, and other emergency situation so that the services of ANM are available without any interruption.

The appointment of second ANM as envisaged in the IPHS for each Sub-centre is to be made locally on contractual basis as per the demand, phase wise. The services of a Male Health Worker (MPW-M) are also necessary at the Sub centre. The arrangement has been made for utilization of untied fund for strengthening the functioning of Sub-centres. All the existing Sub-centres buildings should be made environment friendly, with a good source of water supply, electricity / solar power / other alternative energy sources. This can be ensured with the help of Panchayat and related sectors. Utilization of Annual Maintenance Grant for strengthening of infrastructure and basic necessities of the Sub-centres will also be taken care of. Health Sub Center is the first line service deliverable institutions from where different types of services are provided to women and children. The objectives of IPHS for Sub-Centre's are :

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

Health Sub Centre is very important part of entire Health System. It is first available Health facility nearby for the people in rural areas. We are trying to analyze the situations at present in accordance with Indian Public Health Standards.

1. Infrastructure for HSCs: (IPHS Norms) :

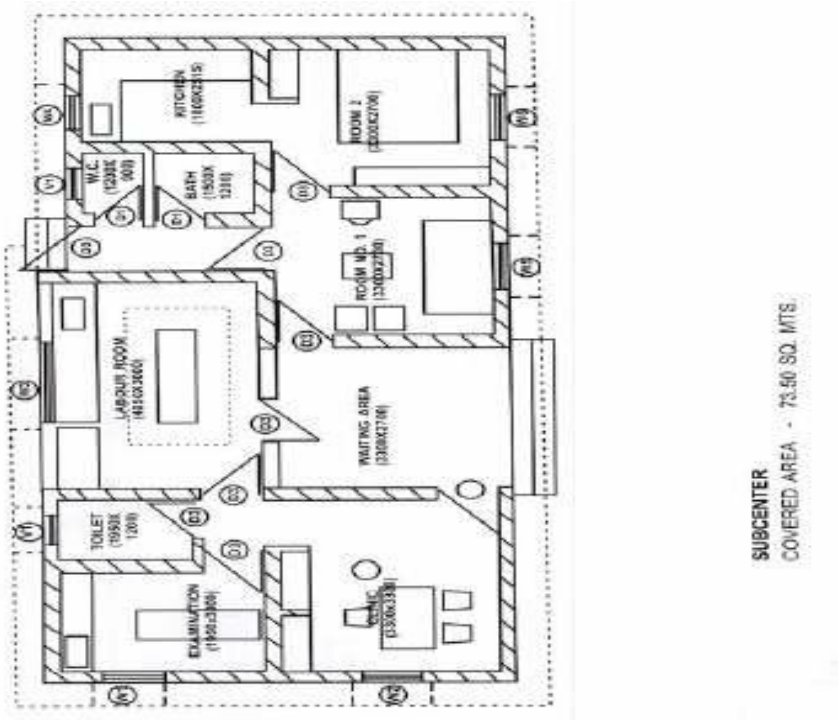
I. Location of the centre : The location of the centre should be chosen that:

a. It is not too close to an existing sub centre/ PHC
b. As far as possible no person has to travel more than 3 Km to reach the Sub centre
c. The Sub Centre Village has some communication network (Road communication/Public Transport/Post Office/Telephone)
d. Accommodation for the ANM/Male Health Worker will be available on rent in the village if necessary.

For selection of village under the Sub Centre, approval of Panchayats as may be considered appropriate is to be obtained.

II. The minimum covered area of a Sub Centre along with residential Quarter for ANM will vary from 73.50 to 100.20 sq mts. depending on climatic conditions(hot and dry climate, hot and humid climate, warm and humid climate), land availability and with or without a labour room. A typical layout plan for Sub-Centre with ANM residence as per the RCH Phase-II National Programme implementation Plan with area/Space Specifications is given below.

Typical Layout of Sub- Centre with ANM Residence



Waiting Area : 3300mm x 2700mm
Labour Room : 4050mm x 3300mm
Clinic room : 3300mm x3300mm
Examination room : 1950mm x 3000mm
Toilet : 1950mm x 1200mm
Residential accommodation: this should be made available to the Health workers with each one having 2 rooms, kitchen, bathroom and WC. Residential facility for one ANM is as follows which is contiguous with the main sub centre area.

Room -1 (3300mm x 2700mm), Room-2(3300mm x 2700mm)
Kitchen-1(1800mm x 2015mm)
W.C.(1200mm x 900mm)
Bath Room (1500mm x 1200mm)
One ANM must stay in the Sub-Centre quarter and houses may be taken on rent for the other/ANM/Male Health worker in the sub centre village. This idea is to ensure that at least one worker is available in the Sub-Centre village after the normal working hours. For specifications the "Guide to health facility design" issued under Reproductive and Child Health Program (RCH-I and II) of Government of India, Ministry of Health and Family Welfare may be referred.

Item	IPHS Norms	Maximum requirement	Present Status	Gaps	Task for 2012-13	Budget for (2012-13)
Physical Infrastructure	The minimum covered area of a Sub Center along with residential Quarter for ANM will vary from 73.50 to 100.20 sq meters.	66 (Max. HSC as per IPHS)	27 (Already having building)	39	25	25X1300000 = 3,25,00000
Waste Disposal	Waste disposal should be carried out as per the GOI guidelines, which is under preparation	Nothing to do because GOI guideline is not prepared				
Furniture	Examination Table 1 Writing table 2 Armless chairs 3 Medicine Chest 1 Labour table 1 Wooden screen 1 Foot step 1 Coat rack 1 Bed side table 1 Stool 2 Almirahs 1 Lamp 3 Side Wooden racks 2 Fans 3 Tube light 3 Basin stand 1	1X 27 = 27 2X 27 = 54 3X 27 = 81 1X 27 = 27 1X 27 = 27 1X 27 = 27 1X 27 = 27 1X 27 = 27 1X 27 = 27 2X 27 = 54 1X 27 = 27 3X 27 = 81 2X 27 = 54 3X 27 = 81 3X 27 = 81 1X 27 = 27	27 HSC are sanctioned that need all these Furniture. Some HSC have some furniture but worth deposable.			

VII. Strengthening Infrastructure and Human Resource

Health Sub Center

Issues in Planning	Current status	Activities to be under taken	Out put to be achieved	Time frame for 2011-12
To make all the HSCs functional	Out of 345 HSC only 85 having own building & 42 are in rented.	Running water facility by using untied funds	All the 257 HSCs have running water facility	1st and 2nd Quarter
Lack of equipments	All the HSCs have not adequate equipment as per IPHS norms	Procurement of equipment as per IPHS norms	All the HSC s equipped with prescribed equipment	1st and 2nd Quarter
Lack of Human resources	Out of 345 sanctioned post of ANM (R) 164 post are vaccant	Recruitment process of ANMs' should be easier.	All the Vaccant post of ANM are filled.	1st quar.
Lack of Nursing skill	All the ANMs lacks the nursing skills	Training of all ANMs on SBA, IMNCI, ANC & Immunization	All the ANMs are trained on these skills	1st , 2nd and 3rd quar.
Construction/ Rennovation of Existing HSCs and proposed 184 HSCs	Unavailability of Land only 18 HSCs have availability of land	Involvement of opinion leader, and PRIs for Community mobilization for land donations .	Land available for atleast 88 proposed HSCs in the next two years	1st and 2nd quar.
		Meeting with C.O/B.D.O in the chairmanship of District Magistrate for availability of land		
Irregular/non payment of rent of 42 rented building	No disbursement of fund by DHS	Timely disbursement of fund by DHS	Rent of all the rented HSCs paid timely.	1st ,2nd ,3rd and 4th quar.
Irregular presence of staffs	Lack of Staff quarter at HSC level	Community mobilization/ Social audit	At least 90 % attendance secured	1st ,2nd ,3rd and 4th quar.
		Construction of Staff Quarter	All the HSCs have Staff quarter .	1st ,2nd ,3rd and 4th quar.

ADDITIONAL PRIMARY HEALTH CENTERS

Issues in Planning	Current status	Activities to be under taken	Out put to be achieved	Time frame for 2011-12
Lack of proper building and infrastructure	Out of 45 APHC 42 having functioning	Make all APHCs functional using untied funds	All the 45 APHCs functional.	1st and 2nd Quarter
Lack of equipments	All the APHCs have not adequate equipment as per IPHS norms	Procurement of equipment as per IPHS norms	All the APHCs equipped with prescribed equipment	1st and 2nd Quarter
Lack of Human resources	Out of 104 sanctioned post of grade A-Nurse 33 are vacant	Recruitment of grade A-nurse	All the Vacant post of contractual Grade- A nurse has been filled	1st quar.
	Out of 50 sanctioned post of ANM (regular) 15 Post are vacant	Recruitment of Regular ANM	All the 15 Vacant post of regular ANM are filled	2nd quar.
	Out of 50 sanctioned post of Medical officers 31 posts are vacant	Recruitment of Medical officers	All the 31 vacant post of Medical officers are filled	2nd quar.
Lack of Nursing skill	All the contractual Nurses lacks the nursing skills	Training of Nurses on SBA , IMNCI, ANC & Immunisation	All the contractual Nurses are trained on these skills	1st , 2nd and 3rd quar.
Construction of 34 Proposed APHCs	Unavailability of Land	Involvement of opinion leader, and PRIs for Community mobilization for land donations .	Land available for atleast 20 proposed APHCs in the next two years	1st and 2nd quar.
		Meeting with C.O/B.D.O in the chairmanship of District Magistrate for availability of land		

Primary Health centers: There are 16 PHCs in Katihar district, 03 Referral hospitals and a District hospital. Out of 03 Referral Hospital Manihari Referral Hospital is not functional and the Barari and Barsoi PHC are too, not functional because they are situated within distance of one K.M from their respective Referral Hospital. Primary Health Center , Katihar, Sadar Block only rendered the services of OPD.

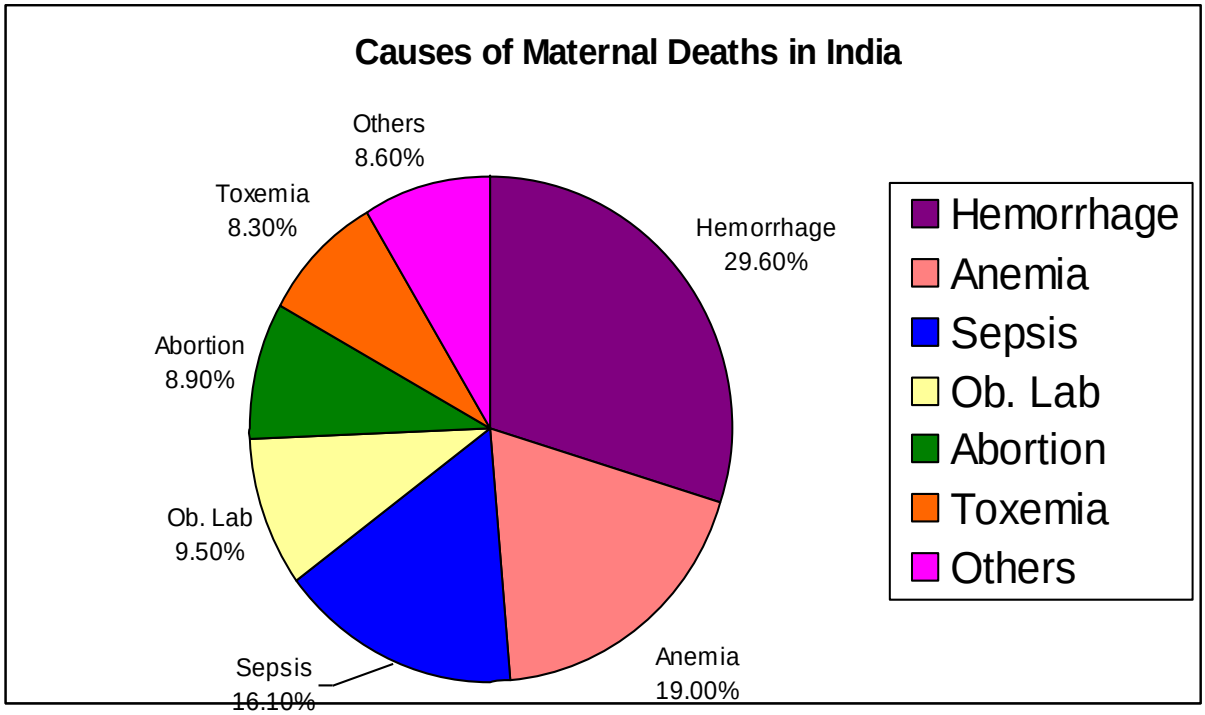
Issues in Planning	Current status	Activities to be under taken	Out put to be achieved	Time frame for 2011-12
Up gradation of PHCs into 30 bedded CHCs in phase wise	All the 16 PHCs are 06 bedded	Selection of of PHCs which has been up graded into CHCs in phase wise manner	04 PHCs has been upgraded into CHCs	3rd and 4th quar.
Lack of equipments	All the 16 PHCs lacks the equipments as per IPHS norms	Procurement of equipment as per IPHS norms	All the 16 PHCs have well equipped with appropriate equipments as per IPHS norms	2nd & 3rd quar.
Lack of Human resource at PHCs level	Out of 67 sanctioned post of Contractual Specialist Doctors only 02 Specialist MO Posted	Recruitment and selection of Human resource	All the vacant post of Medical officers to be filled	1st quar. .
		Empanelling Pvt. Gynaecologists for PHCs to provide ANC/PNC services at fixed day	Increase in ANC and PNC at PHCs level	1st,2nd ,3rd, & 4th quarter
		Hiring Pediatrician for PHCs to OPD services at fixed day.	Increase in Child OPD	1st,2nd ,3rd, & 4th quarter
	Out of 46 sanctioned post of Pharmacists 45 post are vacant, out of 42 post of Lab. Tech. 39 are vacant .	Appointment of Pharmacists and Lab. Technician on contract basis	All the vacant post of 45 pharmacist and Lab . Tech. to be filled	2nd Quar.
Construction/ Renovation of Existing PHCs	Delay/ performance of works is very slow by Public Work Department (Building Division)	Constitution of Separate Engineering department for construction/renovation of Health facilities	Appointment of Civil Engineers.	1st quar.
Promotion of Social audit	Lack of knowledge and level of awareness about the service delivery system amongst the masses	IEC/BCC activities to increase the level of awareness .	Every block have organize BCC/ IEC activities	1st and 2nd quarter
		Displaying all the services (Citizen's charter) provided by the PHCs at centre as well as prominent places of the villages	All the 16 PHCs displayed citizens charter	1st quarter

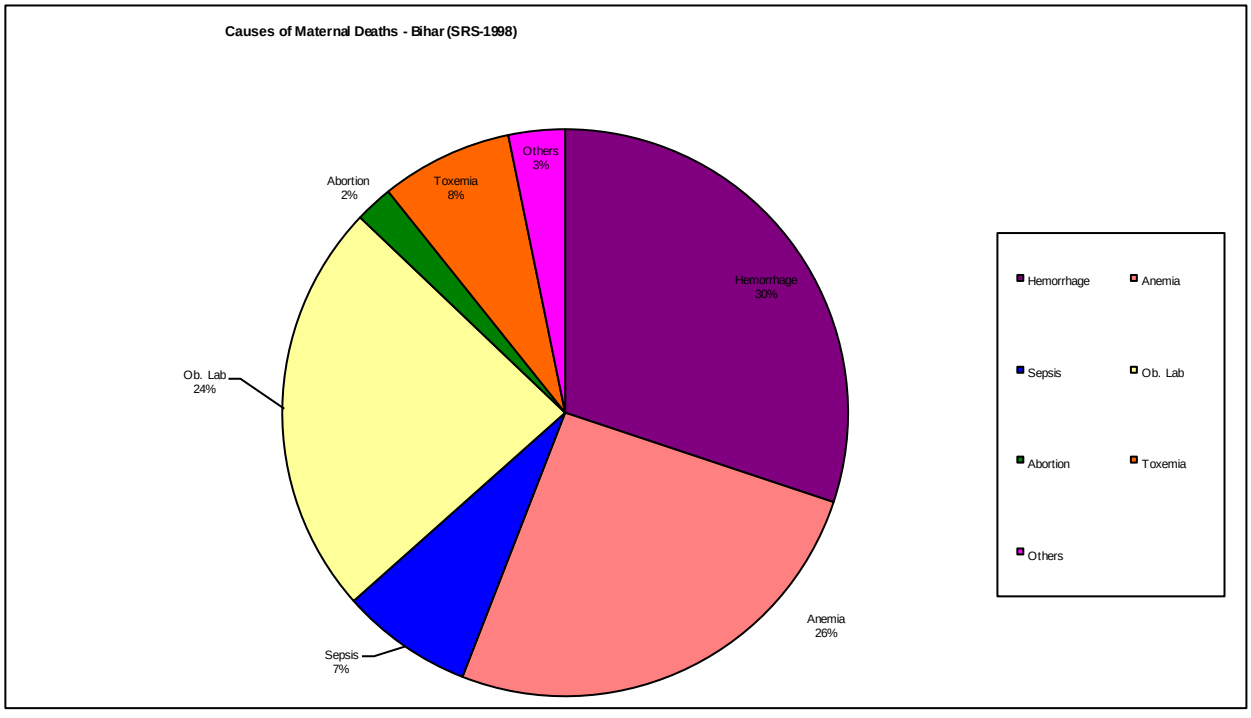
REPRODUCTIVE AND CHILD HEALTH

A.1 Maternal Health

The RCH program covers all aspects of women's reproductive health across their reproductive cycle, from puberty to menopause are covered. RCH program addresses the needs that have emerged over years of implementing Family Welfare Program.

Under this Program the emphasis shifted to decentralize planning at district level based on assessment of community needs and implementation of program at fulfillment of these need. New interventions such as control of reproductive tract infection, gender issues, male participation and adolescent health and the Family welfare program are also taken.





Goal : Reduce MMR from present level 312 (SRS 2007-08) to less than 100

Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
1. To improve coverage of 03 ANC to 32.5 % to 75 by 2012.	Only 32.5 % of women receive 03 ANC during their pregnancy period.	Awareness generation about importance of ANC at Community level	• Increase in ANC • Increase in reported cases of pregnancy	1st and 2nd quar.
Lack of awareness about importance of ANC		Social mobilization to create demand in the community for ANC clinics		
		Use of local resources in terms of ASHA , AWC to track the pregnancy inform the ANMs	Increase in reported cases of pregnancy	1st and 2nd quar
No ANC at HSC level	HSC have not provided the ANC services	Organising Regular ANC clinics at Health Centers level	50 % of the HSC organize regular weekly ANC clinics	1st ,2nd ,3rd & 4th quar.
To provide out reach maternal care		Organizing ANC clinic sessions in remote areas through mobile health units.	25 % cases of MMU OPD should be ANC	1st ,2nd ,3rd & 4th quar
Lack of Human Resources	All the 16 post contractual Gynaecogists are vacant	Empanelling Gynaecologists for gynaecology OPD in under or un served areas	Increase in ANC cases upto 75 %	1st ,2nd ,3rd & 4th quar
Lack of service delivery system	ANMs are not trained in SBA	Training of ANM & Grade-A on ANC and SBA	100 % ANM & Grade- A trained in ANC and SBA	1st ,2nd ,3rd & 4th quar
	Apathy behaviour of health personnel towards the beneficiary	BCC and counselling sessions for service providers	User friendly environment	1st quar.
To strengthen PHC s for providing maternal care	Lack of staff and specialist MOs	Empanelling Gynaecologists for gynaecology OPD in PHC.	Increase in ANC cases at PHCs upto 50 %	1st ,2nd ,3rd & 4th quar
Providing the ANC services at their door steps	No VHND at AWC	Organizing Monthly Village Health and Nutrition Days in each Aaganwadi Centres	100 % coverage of VHND at AWC .	1st ,2nd ,3rd & 4th quar
To increase the institutional deliveries to 16.6% to 75 % by 2011	Only 16.6 % of deliveries are institutional deliveries	Make all the existing 25 APHCs functional for 24*7 Delivery services	All the 25 APHCs are functional and providing delivery services	1st quar.

Lack of infrastructure /Facility at APHC and PHCs	All the 16 post contractual Gyn. are vacant. 168 post of ANM and 33 post of grade'A' nurse are vacant.	Recruitment and availability of Staff nurses & ANM to all PHCs/APHCs.	100% of vacant post of contractual manpower should be filled	1st quarter and 2nd quarter
		Hiring retired ANM for ANC and institutional deliveries	300 retired ANM are recruited	
Lack of Maternal health care center at urban area	Except District Hospital katihar , there is no urban health center	Construction of urban health center for every 10000 population	4 urban health centers constructed	2nd and 3rd quarter
Lack of equipments in labour room	All the 16 PHCs including D.H lack the labour room equipments as per IPHS norms	Procurement of Labour room equipment as per IPHS norms.	All the 17 health facilities equipped with labour room equipment	1st and 2nd quarter
Lack of drugs at labour room	As per IPHS norms there are acute shortage of drugs at labour room	Strengthen the Procurement and supply of drugs policies at district level	All the 17 health facilities have adequate amount of drugs in labour rooms	1st and 2nd quarter.
Strengthen FRUs and PHCs for CEmOC services	At Katihar ,Govt. health facilities have not at all any infrastructure at all in terms tackle CEmOC	Ensuring adequate and safe blood supplies by strengthening existing blood banks /storage or opening new blood banks/storage in the district.	Operationalisation of 02 blood storage units at FRUs	1st and 2nd quarter.
Lack of Human resources to tackle CEmOC		Empanelling Gynecologists and anesthetic on CALL BASIS for conducting institutional deliveries, providing Essential and Emergency Obs Care at government facilities	10 Gynecologists and 10 anesthetic will be empanelled	1st and 2nd quarter.
Poor monitoring of services		Monitoring & evaluation by MOs and Block Health Managers	Improved quality of services	1st , 2nd 3rd & 4th quar.

POST PARTUM CARE

PNC withing 48 hours of delivery on the other hand 61.9 % of women got atleast one TT injection during their pregnancy it reveals that services given to pregnant women in this regards are much higher than PNC and for that the cause could be poor home visits by the ASHA/AWW/ANMs

Objective - To increase coverage of post partum care to 15.3 % to 60%.by 2012

Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
Low % of PNC	At Katihar 93 % of the pregnant mother leave the health institution immediately after the bith of baby	Provision for at least 48 Hours stay at health institutions after delivery	60 % PNC coverage	1st and 2nd quarter
		Availability of bed and other facilities for the mother and neonates	100 % bed availability	1st and 2nd quarter
		Recruitment of MAMTA for PNC & Neo Natal care at every PHCs/ Referal Hospital.	No. of MAMTA recruited	1st quarter.
Lack of follow up of cases		Follow-up Monitoring and follow up of cases by ASHA/LHV and ANM during their home visits especially for post natal care (PNC) using IMNCI protocols and visit neonates and mothers within three days and six weeks of delivery.	50 % of delivery cases follow up by ASHA / LHV	All the 4 quar.

SAFE ABORTION SERVICES

The outcomes of pregnancy are live births, stillbirths, spontaneous abortion and induced abortion. There were out of total reported pregnancies. About 90 percent of these ended as live births. The percentages of pregnancies that ended in spontaneous and induced abortions were five each, while the rest resulted in stillbirths. The incidence of pregnancy wastage in the absence of external intervention is more among women in the age group of 20-29 and 35-39 and many times it leads to maternal mortality and life time risk to the mother. To reduce this , a fully equipped MTP centre should be available at every PHC & CHC level.

Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
Lack of MTP services at health facilities	At present MTP services provided at D.H only	Ensure availability of MTPs in all FRU and PHCs	MTPs services provided in all the 17 health facilities	1st quarter
Lack of training about the MTP technique	5 % of ANMs trained on MTP	Capacity building of Health personnel on MTP	50 % of ANM trained on MTPs	1st and 2nd quarter
Lack of equipments	MTPs equipment available at only D.H	Procurement of essential equipment such as Vacuum extractor & Manual Vacuum aspirator	Availability of MTPs equipment in all 17 health facilities.	1st quarter
Lack of knowledge about the legal status of MTP	Only 10 % people have the knowledge about the laglity of MTPs	Disseminate information regarding the legal status of MTP and its availability by CBV, FHW, ANM, and ASHA by one to one meeting and group meeting .	50 % of the population aware about the legality of MTPs services	Through out the year
		Establishment of hoarding at prominent places displaying the information regarding the legal status of MTP	17 hoarding established	1st and 2nd quarter

A.2 Child Health

Ongoing major intervention programs in child health include:- Essential new born care. Programs for reducing mortality due to ARI and diarrhea and Immunization to prevent morbidity and mortality due to vaccine preventable diseases; E food and micronutrient supplementation programs aimed at improving the nutritional status; Improved access to immunization, health care and nutrition programs have resulted in substantial decline in IMR over the last five decades. However it is a matter of concern that the decline in prenatal and neonatal mortality has been very slow.

The major killers of children are – acute respiratory infections, dehydration due to diarrhea, measles and neonatal tetanus and in some areas malaria. The high prevalence of malnutrition contributes to over 50% of child deaths. In India, a significant proportion of child deaths (over 40% of under-five Mortality and 64% of infant mortality) take place in the neonatal period. About one-third of the newborns have a birth weight less than 2500 gram (low-birth weight). A significant proportion of mortality occurs in low-birth weight babies

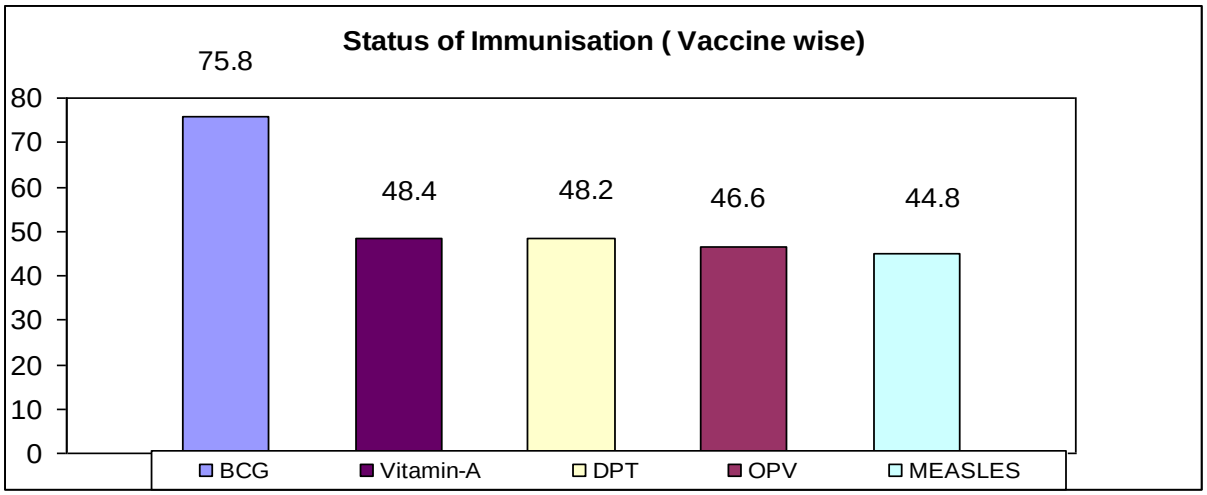
Goal- To bring down the Infant Mortality Rate (IMR) from the present level of 60 per thousand live births to less than 30 per thousand live births by 2012.

Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
To increase % of colostrums feeding from 13.8% to 75 % within 1 hr of birth	Myths and misconception about the colostrums & breast feeding	BCC activities by ASHA/ MAMTA and ANM for colostrums feeding	Colostrums feeding increased from 13.8% to 75 %	All the 4 quarters
To increase exclusive breastfeeding among 0-6 month children from 14.8% to 75 %	Myths and misconception about the breast feeding	One to one meeting by ASHA/ LHV/AWW worker with mother for promoting Breast feeding Dissemination of information about importance of breast feeding during VH&N	▪ 25000 one to one meeting held by ASHA/ AWW ▪ Breast feeding increased up to 75%	All the 4 quarters
Providing Essential New Born Care at Facility level	Lack of training of Health personnel on New born care	Capacity building of Health personnel on New born care especially on danger signs	50 % of the available health personnel trained on New born Care	1,2,3 and 4th quar
	Lack of Infrastructure and necessary guidelines at health facilities for new born care at all the facilities including D.H	Construction of FBNCC at PHCs, FRUs and D.H	17 FBNCC will be constructed	1,2,3 and 4th quar
		Procurement of logistics and dissemination to health facilities	All the newly constructed 17 FBNCC will be fully equipped with equipments	1,2,3 and 4th quar.

Providing Essential New Born Care at Community Level/Home based	Lack of Knowledge about the neo natal care care amongst the health personnel	Training of AWWs/ ASHA /ANMs/LHVs on neo natal care	75 % of the health personnel will be trained on NNC	1,2,3 and 4th quar.
		Training on Identifying danger signs of hypothermia, hypoxia and sepsis to ASHA, AWW .	75 % of the ASHA/ AWW will be trained on danger signs	1,2,3 and 4th quar
		Educating the community about danger signs	25000 mothers will be educated on danger signs	1,2,3 and 4th quar
		Support for Pediatrician on call basis	No. of Pediatrician empanelled for on call basis	1st quarter .
Management of Diarrheal and ARIs		To increase ORS distribution from 32.6 % to 75%	No. of ORS packets & Cotrimoxazole tablets distributed through AWWs	.2nd & 3rd quar.
		To increase treatment of diarrheal from 80.9% to 100% within two weeks	No. of Referral cases of sick child to higher level	1,2,3 and 4th quar

A.2.1 IMMUNISATION

To Strenghten/accelarate the Immunisation programme the GOB launches **MUSKAN EK ABHIYAN** programme in the year 2007 . And this programme has a very positive impact on immunisation .. But when we compare this progress to State and National level we find that we are far behind and we have to do lot of hard work to achieve 100% full immunisation .



Drop out rate between BCG & Measles

Generally the gaps between BCG and measles were up to 5% but according to the above chart (Dlhs-3) it raises up to 31 %. It's a very high and the matter of great concern. The reason behind it is

- The beneficiaries of BCG were migrate to other places.
- Poor service delivery
- unavailability of vaccines
- myths and misconception of community about the immunization
- Hard to reach immunization sites

It is necessary to break the gap between BCG and Measles. So we will look in matter in deep and try to provide all the children BCG vaccine as well as Measles including all vaccine in between like DPT, OPV etc.

Goal - To reduce the mortality of children (0 to 6 yr) of vaccine prevented diseases

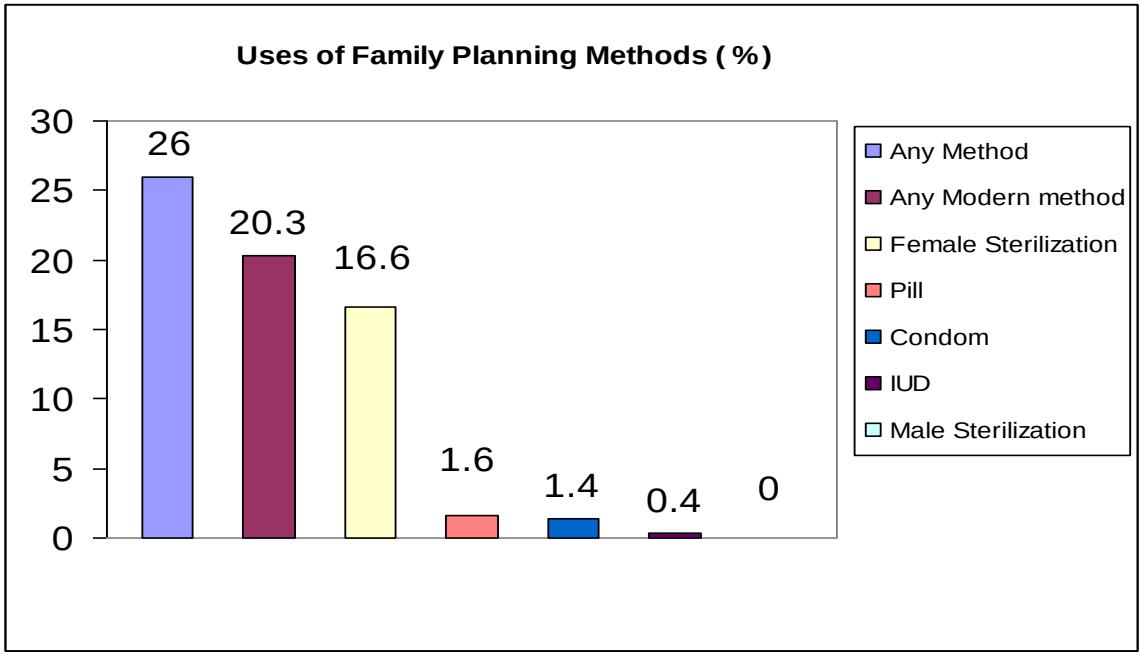
Issues in Planning	Current Status	Activities	Out put to be achieved	Time frame
To Increase in percentage of fully protected children in 12-23 months as per national immunization schedule to 32.6 % to 75 %	Human resource shortage at all levels	Recruitment of Health personnel	All the vacant post to be filled	1st and 2nd quarter
		Hired retired ANMs for holding immunization sessions in remote areas	300 retired ANMs hired	2nd quarter
	Hard to reach areas, Poor transportation	Providing Interest free loans to ANM to purchase Moped/Scooty for immunization in hard to reach areas	200 moped loans given to ANM	1st and 2nd Quar.
Shortage of vaccines & cold chain equipments	Inconsistent delivery of Vaccines & syringes to district	Streamline the procurement and supply chain of vaccines	All the facility have vaccines and cold chain equipments available for through the year	1st and 2nd
		Fund for Local Annual Maintenance contract for Cold Chain equipment	100 % maintenance of cold chain equipments	1,2,3 and 4th quarter
Poor monitoring		Involvement of CDPO& Health Managers for Monitoring	100 % session site will be monitored by CDPOs and BHM	
Myths and misconception about the immunization	Some communities have misconception about the immunization they boycott the Immunisation	One to one meeting by ASHA/AWW with parents of the child	80 % increase in Immunization rate	1,2,3 and 4th quarter
		Involvement of opinion leader, religious leader and PRIs		
		Advertisement through local cable channels		
		Wall writing , street play , Hoardings		
To strengthen the Muskan Ek Abhiyan Program	Inconsistent Payment of incentive money to ASHA/AWW/ANM	Consistent payment of incentive money to ASHA/AWW/ANM	100 % payment will be made to ASHA/AWW/ANM	1,2,3 and 4th quarter
	Low motivation			
To Strengthen immunization in Urban areas	Inadequate health infrastructure in urban areas	Establishment of Urban Health center/Programme	10 urban health centers will be established	1st and 2nd quarter.
	Poor Coordination	PPP with Pvt. Clinics/NGO Hospital	PPP with 25 NGOs for immunization	1st and 2nd quarter.

A.3 Family Planning

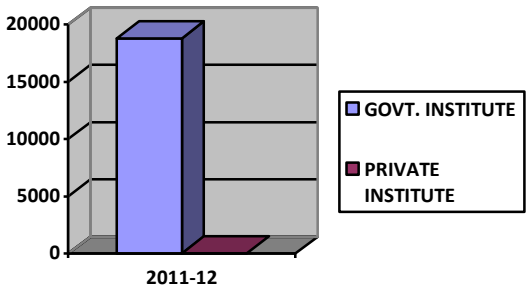
The availability of family planning does more than enable women and men to limit family size. It safeguards individual health and rights, preserves our planet's resources, and improves the quality of life for individual women, their partners, and their children. In all the blocks of Katihar district the achievement with respect to target in case of Family Planning is not quite satisfactory.

Total sterilization for the **FY-2010-11** is **18803** which is likely to 80% of the total target but male NSV is only 7. While in current year **(2010-2011)** total sterilization up to **Nov'10 is 3855** having **NSV** is only **4**.

The sterilization services are largely limited to district and Referral hospitals. There is unmet need exits in the state for limiting the family, which is around 10 %. To increase access to sterilization services, it is planned that at least one facility in each of the 16 blocks will be developed for regular sterilization services. This facility will provide complete range of family planning services like conventional vasectomy, traditional tubectomy, laparoscopic sterilization, non scalpel vasectomy and safe abortion services along with IUD, Oral pills Emergency contraception pills, and non clinical contraceptives. These services will be made available on all days as per the clients need.



FAMILY PLANNING OPERATION



Goal - To stabilize district population by reducing Total Fertility Rate (TFR) from 3.5 to 2.96 by the end of 2012 , In order to achieve this, reduce current unmet need for FP by 75%.

Issues	Current Status	Activities	Out put to be achieved	Time frame
To reduce Unmet Need for Spacing	Poor performances by the out reach Blocks.	Develop at least one facility in each block to provide all FP services including terminal methods on a regular basis.	All 24 x 7 PHCs provide regular clinical contraceptive services including IUD insertions	Through out the year
		IUD insertion at HSC level through out the year	345 HSCs will be provided the services of IUD insertion .	Through out the year
		Organizing IUD camps at Block level	300 IUD camps will be organized at Block level .	Through out the year
		Training of service providers on Minilap, NSV & IUD insertion	No. of Doctors & ANMs get trained on Minilap , NSV and IUD insertion	Through out the year
		Upgrading facilities for sterlisation services	17 health facilities has been upgraded for sterilization services	Through out the year
Lack of equipments for Minilap , NSV and IUD insertion kit	All the health facilities lacking the required amount of above equipments	Need based procurement of drugs, equipment and instruments	All the health facilities have required no. of instruments	1st and 2nd quarter
To reduce unmet Need for Terminal Methods	Poor Accessibility of sterilization services	Accrediation of private providers for providing sterilization Services at their facility.	20 Private providers accredited for sterilization services.	1st ,2 ,3 and 4th quarter
			6000 sterilization will be done at Pvt. Accredited Hospitals	
To Increase	Poor male participation.	PHCs / Referal / District Hospital to provide fixed day female sterilization services.	No. of PHCs / Referal / District Hospital to provide fixed day female sterilization services.	Through the year
		Promotion of postpartum sterilization	1000 postpartum sterlisation.,	Through out the year
		Female sterlisation camp	500 camps has been organized	Through out the year
	Poor IEC on NSV/	Organizing Fixed day	200 NSV camps organized .	Through out

NSV cases 0 % to 20 % (DLHS-3)	Family planning services	NSV camp	2000 NSV cases	the year
		Area wise BCC / IEC on NSV	No. of BCC/IEC activities to be done	Through out the year
		One to one meeting with eligible couple by ASHA/LHV	No. of one to one meeting conducted by AHSA/LHV	Through out the year
		Block level PRI orientation on availability of F.P Services	16 Block level orientation will be organized	1st and 2nd quarter
	Lack of knowledge on **standards & quality assurance of sterilisation services**	Block level ICDS orientation on availability of F.P Services	16 Block level orientation will be organized	1st and 2nd quarter
		Block level SHG orientation on availability of F.P Services	16 Block level orientation will be organized	2nd and 3rd quarter
		Block level ASHA/AWW orientation on availability of F.P Services	16 Block level orientation will be organized	2nd and 3rd quarter
		AWC level mothers & adolescents meeting at village level	2301 AWC level meeting will be organized .	Through out the year
		Organizing health mela focusing on MH, FP , child health	16 health melas will be organized.	2nd and 3rd quarter
To ensure quality of services		**Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services**	No. of Manuals printed and disseminated	1st quarter
Monitoring & evaluation of Services		Monitor quality of services & utilization	Quarterly visit of accrediated facility by QAC.	Through out the year
			Quarterly visit of District Hospital/Ref. Hospital and PHCs for monitoring of quality of services provided	Through out the year

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAM

B.1 Revised National T.B Control Programme

Tuberculosis (TB) is a communicable disease caused by Mycobacterium Tuberculosis, which spreads from a diseased person to a healthy one. Germs of TB spread through air when untreated patients cough or sneeze. TB mainly affects the lungs; but it can also affect other parts of the body (Brain, Bones, Glands, etc.).

Tuberculosis (TB) remains a major public health problem in India. Every year approximately 18 lakh people develop TB and about 4 lakh die from it. India accounts for one fifth of global incidence of TB and tops the list of 22 high TB burden countries. Unless sustained and appropriate action is taken, approximately 20 lakh people in India are estimated to die of TB in next five years.
TB kills more adults in India than any other infectious disease.

In India, EVERY DAY:

- More than 40,000 people become newly infected with the tubercle bacilli
- More than 5000 develop TB disease
- More than 1000 people die of TB (i.e. 1 death every 1½ minutes)

The best way to diagnose lung TB is by examining the sputum under a Binocular Microscope.
Germs of TB can be seen with a Binocular Microscope.

Despite the existence of a National Tuberculosis Control Programme since 1962, the desired results had not been achieved. On the recommendations of an expert committee, a revised strategy to control TB was pilot tested in 1993 in a population of 2.35 million, which was then increased in phased manner

The Revised National Tuberculosis Control Programme (RNTCP) aims to stop the spread of TB by curing patients. The key of this strategy is to cure TB through Directly Observed Treatment at a time and place convenient to the patient.

A full-fledged programme was started in 1997 and rapidly expanded in a phase manner with excellent results.

By March 2004 , Katihar district has been covered under RNTCP

The RNTCP is an application in India of the WHO-recommended Directly Observed Treatment, Short Course (DOTS) the most effective strategy to control TB.

Role of the District TB Control Society/District TB Centre

The TB programme will provide orientation, training, technical assistance, quality assurance of laboratory services, and supervision and monitoring of activities. It will also refer tuberculosis patients with serious complications who require hospitalization.
First time Katihar district is under Target zone after RNTCP launched. The cure rate is increased upto 85 %. That is due to good performance of all the TUs. They maintain the track records of High Detection and High cure rate upto 85 %.
Katihar District maintained the NSP case detection rate through out the years and improved it cure rate. The percent of positive cases detection is increased and also the cure rate has improved .

At every 500000 Population there is a provision to establish one Tuberculosis unit
There are 04 Tuberculosis unit in the district

1. Manihari
2. Barari
3. Barsoi
4. Korha

Annual Plan for Programme Performance & Budget for the year

1st April 2012 to 31st March_2013___

Section-A – General Information about the District

1	Population (in lakh) please give projected population (as on July 1st 2009)	
2	Urban population	3068149
3	Tribal population	Not Significant
4	Hilly population	
5	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums)	

(These population statistics obtained from /District Statistical Office)

Does the district have a DTC_____

Organization of services in the district:

S. No.	Name of the TU	Population (in Lakhs)	Please indicate if the TU is-		No. of MCs		
			Govt	NGO	Govt	NGO	Private
1.	Katihar DTC	628528	01		06		01
2.	Manihari	344703	01		03		
3.	Barsoi	734340	01		05		
4.	Korha	563334	01		03		
5.	Barari	546524	01		06		
	Total	2817429	05		23		01

RNTCP performance indicators:

Important: Please give the performance for the last 4 quarters i.e. Oct _08 to September _09__

Name of the TU (also indicate if it is predominantly urban / rural / hilly / special group	Total number of patients put on treatment	Annualised total case detection rate (per lakh pop.)	No of new smear positive cases put on treatment	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year	
						Annualized NSP case detection rate	Cure rate
TU 1 KATIHAR	724	56.5	364	88.4	71.3	90%	>85%
TU 2 BARARI	496	44.7	304	73.9	78.2	75%	>85%
TU 3 MANIHARI	287	41.2	185	72.0	78.4	75%	>85%
TU 4 BARSOI	549	36.5	407	73.4	78.6	75%	>85%
TU 5 KORHA	410	35.9	197	47.2	77.0	70%	>85%
TU 6							
District (total)	2466	43.0	1457	71.0	76.7	>77%	>85%

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

Sl.No.	Priority areas	Activity planned under each priority area
1	IEC	1 a) Wall Panting in all DMC & Market hat. Place on sings and symptoms of TB and the location on near DMC.
		1 b)hoardings
		1 c)pamplets & media coverage.
2	Improving Quality of Dots	2 a) Timely disbursement of remuneration of DOT Provider
		2 b) Strengthening monitoring & supervision of DOTS.
3	Starting of New DMCs	3 a) New LTs have been appointed & DMCs are in the process of operationalization.
		3 b) Propopsals for starting of new DMCs are in the pipeline.
4	Improving of Case detection	4 a) Population of Katihar District is 2817429, As per RNTCP population norms opening of 3 more DMCs are Proposed.
		4 b)Training of MOs & Community DOTs providers
5	Involvement of other sector need one more LT Medical College and N.F. Railway Hospital.	5 a)N. F. Railway Hospital and Katihar Medical College KMCH / ESI Hospital.
		5 b)

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

Civil Works

Activity	No. required as per the norms in the district	No. actually present in the district	No. planned for this year	Pl provide justification if an increase is planned (use separate sheet if required)	Estimated Expenditure on the activity	Quarter in which the planned activity expected to be completed
	(a)	(b)	(c)	(d)	(e)	(f)
DTC upgradation	01	01			Rs 4500/-	2q11
No. of TUs upgraded	05	05			Rs 6500/-	3q11
No. of MCs upgraded along with establishment of new DMCs	28	24	03	New DMC as per the population	1, 15000	2q11
Upgradation of district drug store for storing 2nd line drugs	1	0	1	For storing 2nd line drugs	30,000/-	2q11
				TOTAL	1,56,000	

Laboratory Materials

Activity	Amount permissible as per the norms in the district	Amount actually spent in the last 4 quarters	Procurement planned during the current financial year (in Rupees)	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
Purchase of Lab Materials	450000	219041	350000	450000	As per the rate approval by SHS Patna

Honorarium

Activity	Amount permissible as per the norms in the district	Amount actually spent in the last 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
Honorarium	740779	221000	435500	500000	Involment NGO, CV, AWW & Asha
Honorarium for successful completion of Tt of MDR cases.		nil	nil	25000/-	Estimated expenditure for 10 pts.
Total-				5,25,000/-	

	No. presently involved in RNTCP	Additional enrolment proposed for the next fin. year
Community volunteers	1495	1600

IEC/Publicity:

Permissible budget as per Norms:

Budget for next financial year proposed as per action plan detailed below:

Target Group/ Objective	Activities Planned at District Level						Total activities proposed during next fin. Year	Estimated Cost per activity unit	Total expenditure for the activity during the next fin. Year
	Activity (All activities to be planned as per local needs, catering to the target groups specified)	No. of activities held in last 4 quarters	No of activities proposed in the next financial year, quarterwise						
			Apr-Jun	July-Sep	Oct-Dec	Jan-Mar			
Patients and General public / for awareness generation and social mobilization	Outdoors: - wall paintings - Hoardings - Tin plates - Banners - others	 0 0 0 2	 0 0 0 20	 14/25 0 0 0	 30 0 0 4	 30 0 0 0	 90 0 0 24	 150 0 0 300	 13500 0 0 72000
	Outreach activities: - Patient provider interaction meetings - Community meetings - Mike publicity - Others	 0 0 0	 24 24 4	 24 24 4	 24 24 4	 24 24 4	 96 96 16	 100 100 200	 9600 9600 3200

	Puppet shows/ street plays/etc.								
	School activities	0	3	3	3	3	12	300	36000
	Print publicity - Posters - Pamphlets - Others								
	Media activities on Cable/local channels Radio	0	0	3	3	3	9	1000	9000
	Any other activity								
Opinion leaders/NGOs for advocacy	Sensitization meetings								
	Media activities								
	Power point Presentations / one to one interaction								
	Information Booklets/ brochures								
	World TB Day activities	0	0	0	0	1	1	12000	12000
	Any other public event						1	3000	3000
Health Care providers – public and private	- CMEs - Interaction meetings - one to one interaction meetings								
	- Information Booklets - Any other	0	2000	0	0	0	2000	1000	20000
Any Other Activities proposed	Zonal Meeting	0	1	1	1	1	4	1000	4000
								Total Budget	**191900/-**

Equipment Maintenance:

Item	No. actually present in the district	Amount actually spent in the last 4 quarters	Amount Proposed for Maintenance during current financial yr.	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
Computer (maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)	01	12660	40,000	40,000	
Photocopier (includes AMC, toner etc.)					
Fax					
OHP					
Binocular Microscopes	26		24000	39,000	
			TOTAL	79000/-	

Training:

Activity	No. in the district	No. already trained in RNTCP	No. planned to be trained in RNTCP during each quarter of next FY (c)				Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
			Q1	Q2	Q3	Q4			
	(a)	(b)					(d)	(e)	(f)
Training of MOs	96	80		1	1		0	10000	
Training of LTs of DMCs- Govt + Non Govt	25	25							
Training of MPWs									
Training of MPHS, pharmacists, nursing staff, BEO etc	429							35000	
Training of Comm Volunteers	1495			1	1		2210		
Training of Pvt Practitioners	400	270						5000	
Other trainings #									
Re- training of MOs	96	80						40000	
Re- Training of LTs of DMCs	25	25						15000	
Re- Training of MPWs									
Re- Training of MPHS, pharmacists, nursing staff, BEO									
Re- Training of CVs	1495	1495		1	1			46000	
Re-training of Pvt Practitioners	400	270						10000	
TB/HIV Training of MOs	96	96						75250	
TB/HIV Training of STLS, LTs , MPWs, MPHS, Nursing Staff, Community Volunteers etc	2349							100000	
TB/HIV Training of STS									
Traing of MOs & other category of staff on PMDT.								10,000/-	
Training of doctors at medical college(KMCH)	1			1		1		40,000/-	
Provision for Update Training at Various Levels #									
Any Other Training Activity #									

 # Please specify

TOTAL ___386250/-_____

Vehicle Maintenance:

Type of Vehicle	Number permissible as per the norms in the district	Number actually present	Amount spent on POL and Maintenance in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
Four Wheelers	01	01	5000	0	100000	
Two Wheelers	05	05	20351	150000	150000	
				TOTAL	250000	

Vehicle Hiring:

Hiring of Four Wheeler	Number permissible as per the norms in the district	Number actually present	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
For DTO		01	0			
For MO-TC		05	0	294000	315000	
				TOTAL	315000	

NGO/ PP Support:

Activity	No. of currently involved in RNTCP in the district	Additional enrolment planned for this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
NGOs involvement scheme 1						
NGOs involvement scheme 2						
NGOs involvement scheme 3						
NGOs involvement scheme 4						
NGOs involvement scheme 5						
NGOs involvement unsigned						
Private practitioners scheme 1						
Private practitioners scheme 2A						
Private practitioners scheme 2B						
Private practitioners scheme 3						
Private practitioners scheme 4						
ACSM Scheme				**TOTAL**		

Miscellaneous:

Activity*	Amount permissible as per the norms in the district	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)
TA/DA for DTO , MOTC & OTHER STAFFS	500000	51610	150000	4,00,000	
Travel cost of MDR pts to DTC & DOT plus site		nil	nil	1,00,000	
			TOTAL	5,00,000	

** Please mention the main activities proposed to be met out through this head*

Contractual Services:

Activity	No. required as per the norms in the district	No. actually present in the district	No. planned to be additionally hired during this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)		(d)	(e)	
Medical Officer-DTC	Not to be filled						
STS	05	05			756000	792000	
STLS	05	04			604800	792000	
TBHV	02	01			109800	219600	
DEO	01	01			109800	105600	
Accountant – part time	01	01			37800	39600	
Contractual LT	Not to be filled	17			1392300	1795800	
Recruitment of DOT PLUS/TB/HIV supervisor	1	0	1	0	0	1,80,000	
				2234008	**TOTAL**	39,24600/-	

Printing:

Activity	Amount permissible as per the norms in the district	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)
Printing*****	450000	51948	150000	257000	

** Please specify items to be printed*

Research and Studies:

Any Operational Research project planned (Yes/No) _____
(If yes, enclose annexure providing details of the Topic of the Study, Investigators and Other details)

Whether submitted for approval/ already approved? (Yes/No) _____
Estimated Budget (to be approved by STCS).____

Medical Colleges

Activity	Amount permissible as per norms	Estimated Expenditure for the next financial year(Rs.)	Justification/ remarks
	(a)	(b)	(c)
Contractual Staff: ▪ MO (In place: Yes/No) ▪ STLS (In place: Yes/No) ▪ LT (In place: Yes/No) ▪ TBHV (In place: Yes/No)	 1 1 1	 1,44,000 1,02,000 96,000	As per RNTCP guidelines.
Research and Studies: ▪ Thesis of PG Student ▪ Operations Research*	1 1	20,000 5,00,000	
Travel Expenses for attending STF/ZTF meetings	2,00,000	2,00,000	For attending STF/ZTF meeting & conferences.
IEC: Meetings and CME planned	15000	40000	
	Total	11,02000/-	

** Expenditure on OR can only be incurred after due approvals of STF/ STCS/ZTF/CTD (as applicable)*

Procurement of Vehicles:

Equipment	No. actually present in the district	No. planned for this year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)
4-wheeler **				
2-wheeler	5	4	2,00,000	Vehicle is more than 7yrs old so need new one

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

Procurement of Equipment:

Equipment	No. actually present in the district	No. planned for this year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)
Computer			20,000	Old one has to be replaced.
Photocopier			20,000	
OHP				
Any Other			20,000	
total		60,000	60,000	

Section D: Summary of proposed budget for the district –

Category of Expenditure	**Budget estimate for the coming FY 2011- 2012** *(To be based on the planned activities and expenditure in Section C)*
1. Civil works	156,000
2. Laboratory materials	450000
3. Honorarium	525000
4. IEC/ Publicity	191900
5. Equipment maintenance	79000
6. Training	386250
7. Vehicle maintenance	250000
8. Vehicle hiring	315000
9. NGO/PP support	0
10. Miscellaneous	500000
11. Contractual services	3924600
12. Printing	257000
13. Research and studies	0
14. Medical Colleges	1102000
15. Salaries of regular staff**	0
16. **Procurement – drugs**	0
17. Procurement –vehicles	200000
18. Procurement – equipment	60000

8396750/-

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

NATIONAL LEPROSY ERADICATION PROGRAMME

B.2 National Leprosy Elimination Programme

Leprosy is a chronic infectious disease caused by M. Leprae, an acid-fast, rod shaped bacillus. The disease mainly affects the skin, the peripheral nerves, mucosa of the upper respiratory tract and also the eyes, apart from some other structures. Leprosy has afflicted humanity since time immemorial. It once affected every continent and it has left behind a terrifying history and human memory of mutilation, rejection and exclusion from society.

PRIORITY AREAS:

Objective	Strategies	Activity
Increase awareness among the community about the disease	BCC to motivate patients having suggestive symptoms to go for self reporting	Using ASHA and AWW to disseminate information during VH&N day
	IEC activities to reduce the social stigma	Interpersonal communication by health workers
		IPC Training (4 batch of 40 each)
	Involving Village committee as link agencies	Orientation of village Health & Sanitation committee
		Orientation of community leaders on village & health committees
To develop BCC plan to mitigate stigma	Involvement of Panchayat for motivation to patients	Development of BCC material
		Development of IEC material
To provide the quality treatment	Quality diagnosis and treatment	Quality diagnosis and treatment indicators to be finalized
	Intense monitoring for regular supply of drugs	Intense monitoring during sub centre days

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

B.3 National Vector Borne Disease Control Programme

The NVBDCP was initiated in the year 2003-2004. It is an umbrella programme for prevention and control of vector borne diseases including Malaria, Filaria, Kala-azar and Dengue. Under the program comprehensive and multi sectoral public health activities are implemented. Districts teams should review incidence and prevalence data available for these diseases in the district through surveillance activities and plan as per national strategy adapted to address local needs. Vector borne diseases like Malaria, Kala-azar, Dengue and Japanese encephalitis are outbreak prone diseases and therefore during formulation of the district health plan, epidemic response mechanism should also be outlined.

The main objectives of NVBDCP are:

To reduce mortality and morbidity due to Malaria

To reduce percentage of PF cases.

To control other vector borne diseases like Kala azar , Dengue, Filaria, Chikungyniea etc.

Katihar is a Kala- azar & Malaria prone district of Bihar. The tribal and under privileged community of the society is vulnerable to these diseases because they have deprived of basic habitation facility and they have poor living conditions.

Goal- To reduce mortality and morbidity due to Malaria

Objectives	**Constraints**	**Strategies**	**Activities**
Early Case Diction and Prompt Treatment	Lack of Knowledge about malaria prone areas	Identify pockets populations at risk to have increased access to early diagnosis and prompt treatment	House to house survey by ASHA/AWW/MHW etc
	Lack of HR such as Malaria inspector & L.T.	Appointment of L.T and Malaria inspector on Contract	Recruitment & selection of H.R
	Lack of FTDs & DDC	Complete surveillance of fever cases identification and treatment, role of FTDs and DDCs are very important	Appointment & training of Malaria link workers on contract
			Establishment of Fever Testing depots at every 5000 Population
			Establish the Drug distribution center at every 5000 Population.
		Follow MAP treatment policy	Strictly follow the MAP treatment guidelines for diagnosis & treatment of malaria cases
			Procurement of Rapid diagnosis sticks for PF cases.
			Procurement and timely supply of necessary drugs, equipments and lab reagents.
Preventive Vector Control measure	**Lack of Biological control (Hatchery)**	**Establishment of hatchery at every block**	Establishment of hatchery for larvivours fishes at block level.
			Introduction of fishes at breeding places at least once in every six months
	Improper and poor spraying	**Indoor Residual Spray**	Timely and proper IRS in high risk area according to MAP guidelines

		To reduce man mosquito contact	To reduce man mosquito contact distribution of Impregnated Mosquito Net in high risk area.
To increase the knowledge about the sign, symptoms and treatment of Malaria	**Lack of awareness and knowledge about the malaria in masses**	Emphasize upon Behavioral Change communication and social mobilization	Awareness generation towards adopting personal prophylactic measures to control Malaria
			Awareness towards service delivery centers for treatment of Malaria
			Awareness generation towards the spray

B.3.2 Kala-Azar

Katihar is a Kala-azar prone area in the State. Studies reveals that the ST and SC community especially Mushhar community are vulnerable towards the epidemic due to their poor living conditions.

Goal

To contribute to improving the health status of vulnerable groups and at-risk population living in kala-azar-endemic areas by the elimination of Kala-azar so that it is no longer a public health problem.

Targets

To reduce the annual incidence of Kala-azar to less than one per 10,000 population at district by 2011-12.

- Reduce case fatality rates
- Prevent the emergence of Kala-azar/HIV/AIDS, and TB co-infections

Objectives	Constraints	Strategies	Activities
Early Case Diction and Prompt & complete Treatment	Lack of Knowledge about Kala-azar prone areas	Identify pockets populations at risk to have increased access to early diagnosis and prompt treatment	House to house survey by ASHA/AWW/MHW etc
	Lack of Human resources such as Lab Technician	Appointment of L.T on Contract basis	Publication of vacancies
			Recruitment & selection of H.R
	Lack of FTDs & DDCs	For complete surveillance of Kala-azar cases identification and treatment, role of FTDs and DDCs are very important. Use of FTDs and DDCs of Malaria for Kala-azar cases	Appointment of link workers on contract basis
			Training of link workers
			Establishment of Fever Testing depots at every 5000 Population
			Establishment of Drug distribution center at every 5000 Population.
	Lack of equipment & Drugs, reagents	**Timely diagnosis and treatment**	Strictly follow the treatment guidelines for diagnosis & treatment of Kala-azar cases
			Procurement of K-39 testing kits .
			Procurement and timely supply of necessary equipments and lab reagents
			Procurement & supply of essential drugs
Provide better living condition	**Lack of Pucca houses for vulnerable community**	Convergence to welfare and DRDA for availability of pucca houses under Indira Awas Yojna	Meeting with public representatives and PRIs
			Meeting with DDC and DRDA director
			Meeting with Block program officer (DRDA)

To make preventive measures to eradicate Kala-azar	**Improper & poor spraying of DDT**	**Indoor Residual Spray**	Timely IRS in high risk area and vulnerable area.
			Monitoring of spraying by MOIC & Block Health Manager
			Capacity building program for sprayer for DDT spray to ensure that every corner of the house is properly spray up to height of six feet from the ground level.
		To reduce man mosquito contact	To reduce man mosquito contact by distribution of Impregnated Mosquito Net in high risk area and vulnerable community/people
	Myths and misconception about the spray	To conduct IEC/BCC activities	Awareness generation about the DDT Spray for Kala-azar
			FGD with vulnerable people about the spraying
			One to one meeting by ASHA with vulnerable households on spraying
		Emphasize upon Behavioral Change communication and social mobilization	Awareness generation towards adopting personal prophylactic measures to control Kala-azar
			Awareness towards service delivery centers for treatment of Kala-azar
			Awareness generation towards the spray

B.4 NATIONAL BLINDNESS CONTROL PROGRAMME

Blindness is a major public health problem in most developing countries where eye care facilities are still limited. Cataract is the leading cause accounting for 50% to 70 % of total blindness.
India is the first country in the world to launch blindness prevention related program as early as 1963 i.e. National program for trachoma control. After few changes in the names, this program was re-designated, since 1976 as "National program for Control of Blindness" (NPCB)

The National program for control of blindness was launched in year 1976 with a goal for reduction in prevalence of blindness from 1.4 percent to 0.3 percent. The four-pronged strategy refers to strengthening service delivery, developing human resources for eye care, outreach activities and developing institutional capacities. All school children in the age group of 10-14 years should be screened for refractive errors. Percentage of children detected with refractive errors should be 5-7%.

Objectives	Constraints	Strategies	Activities
To increase cataract surgery rate	**Lack of eye surgeon & opthalmist in the district**	Strengthening service delivery	Filling vacant posts of eye specialists
			Organizing outreach camps in rural areas & extremely backward classes tola
		Target older age groups	Identification of cases
			Increase treatment acceptance
			Follow up to treated cases
To Increase the surgery rate with IOL	**Lack of equipments and drugs**	Procurement, distribution and assurance of quality equipment and drugs	Operational mobile units (procurement of ambulance, microscope etc
			Ensure adequate supply of medicines
			Continuous availability of vitamin A
	Lack of knowledge about the new technology	**In-service training program**	Refresher training course for eye surgeons & opthalmists for skill up gradation (new techniques)

School Eye Screening: children in the age group of 10-14 years should be screened for refractive errors	**Lack of awareness about the refractive errors**	**School health camps** Number of School Going Children Eye Screened number in FY-2011-12 - 13073	Organization of camps for identification of children with refractive errors and prohibition of free spectacles
			Training to teachers in schools
			Snellen's Vision Box for schools
		Promoting outreach activities and public awareness	Effective communication about outreach camps
			Awareness regarding eye-care
Oral Health Screening for - Community - School children		**Promotion of Vitamin A supplementation through AWW , ANM and ASHA**	Promotion of Vitamin A supplementation
			IEC campaigning about eye donation

B.5 NATIONAL IODIEN DEFICIENCY CONTROL PROGRAM & Vit.-A PROGRAM :

Introduction: Iodine Deficiency Disorders(IDD) affect a large number of population living in all the continents of our planet. Iodine is an essential micronutrient which is required at 100-150 micrograms daily for normal human growth and development. There is an evidence of wide-spread distribution of environmental iodine deficiency not only in the Himalayan region but also in plains, riverine areas and even the coastal regions. Iodine deficiency starts its impact from development of foetus to all ages of human beings. It could result in abortion, still-birth, mental retardation, deaf-mutism, squint, dwarfism, goitre of all ages, neuromotor defects etc. Iodine deficiency thus directly affects the "Human Resource Development" and which in turn greatly affects the human productivity as well as country's development.

Magnitude of the Problem: About 200 million people are at the risk of IDD in our country. The survey conducted by the Central & State Health Directorates, ICMR and medical Institutes have clearly demonstrated that not even a single State/UT is free from the problem of Iodine Deficiency Disorders. It is estimated that 71 million population are suffering from goitre and other iodine deficiency disorders. Samples surveys have been conducted in 25 States and 4 Union - Territories of the country which revealed that out of 275 districts surveyed so far IDD is a major public health problem in 235 districts where prevalence is more than 10 per cent.

Control Program: Realizing the magnitude of the problem the Government of India launched a 100 per cent Centrally assisted National Goitre Control Program(NGCP) in 1962 with the following objectives:

(i) Initial surveys to assess the magnitude of the Iodine Deficiency Disorders.

(ii) Supply of iodated salt in place of common salt.

(iii) Health Education & Publicity.

(iv) Resurveys to assess the impact of iodated salt after every 5 years.

(v) Laboratory monitoring of iodated salt and urinary iodine excretion.

*** Major challenges & activities to overcome these in the field are -**

Objectives	Constraints	Strategies	Activities
Program planning for inter departmental coordination	**No coordination between departments like Railway, District Admin.**	Dist. level IDD cell should be developed.	Monthly review meeting under Civil Surgeon.
			Monthly reporting format should be maintained.
		Special incentive & support from State level to Dist. Nodal & Focal Person.	Funds for maintenance of IDD cell.
Education & Publicity about Iodine deficiency.	**Lack of general awareness.**	Awareness generation activities among school children, salt traders and retailers, field functionaries of health.	Awareness camp & Quiz should be organize on inter-school basis.
			Salt traders as well as retailers should be rewarded per annum.
			Relevant IEC material to each district for awareness generation and used during IDD month.
	Lack of interest of ASHA	Awareness generation activities ICDS and community members	Half yearly Orientation should be organize.
			Reporting from ASHA should be maintained fortnightly on PHC level.

* Vitamin–A supplementation Program

Vitamin – A is an essential micronutrient which is fat soluble. It is essential for growth & various other physiological functions.

Physiological Functions of Vitamin-A

- Keeps eyes healthy
- Important for vision in dim light (Prevents night blindness)
- Prevents nutritional blindness.
- Increases immunity against infections.
- Helps proper development of bones & teeth.
- Helps proper growth of the body.
- Helps to maintain healthy skin.
- Good for nerve & bone.

*** Major Activities for better outcome-**

Objectives	Constraints	Strategies	Activities
Better Program conduction.	**Lack of general awareness.**	Awareness generation activities among school children, pregnant & lactating women.	Should be added in Mahila Mandal meeting on AWC & in VHND.
			Relevant IEC material to each district for awareness generation and used during round.
Better coverage to target population	**Delayed distribution of Vitamine-A Solution.**	Proper planning & channel should be adopted for distribution.	Solution should reach at district headquarter at least 2days before of round date.
			Date of round should be Announced one month before.
			Strategy of supplementation should start form 1st day house to house then 2nd day on site.
	Lack of interest of ASHA	Awareness generation activities ICDS and community members	Half yearly Orientation should be organized at least one month before.

NRHM_D

B.5 INTEGRATED DISEASE SURVEILLANCE PROJECT

Goal : To reduce the burden of morbidity and mortality due to various diseases in the district.

Objective :

- Establishing a sustainable decentralized system of disease surveillance for timely and effective public health action.
- Integration of disease surveillance activities to avoid duplication and facilitate sharing of information across all disease control programs so that valid data are available for appropriate health decision.
- Proper allocation of Health resources where they are needed.
- Integration of private sector for reporting under IDSP.
- Integration of Non Communicable Disease Surveillance under IDSP.

Epidemic branch deals with Communicable Diseases, i.e. Waterborne Diseases such as Cholera, Gastroenteritis, Typhoid and Infective hepatitis, Zoonotic Diseases like, Plague and Leptospirosis, Arthropod borne diseases like, Dengue fever, Kala-azar and Malaria , Air borne disease like Meningococcal Meningitis and provides health relief services in the wake of natural calamities like heavy rain, floods, draught, cyclone etc. to prevent post calamity disease outbreak. The collection and a good analysis of data analysis of this data gives us the indication when to apply what method to stop epidemic and control it.

Strategies adopted

- Operationalization of norms and standards of case detection, reporting format.
- Video Confrencing cum training Cell
- Streamlining the MIS system- Establishing Web based & channels for data collection within the district and transmission mechanisms to state level.
- Analyzing line listing of cases and Geographical Information Systems (GIS) mapping approach Preparation of graphs & charts on the basis of reports for planning strategies during epidemic outbreak.
- Training to all the grass root level workers, MO's & CHC staff in Data Collection,

- **Human Resources (IDSP) :**
  - **ACMO cum District Surveillance Officer.**
  - **District Epidemiologist.**
  - **District Data Manager**

- Establishment of IDSP unit: A proper guideline is needed from SHSB to Civil Surgeon cum CMO & DM cum Chairperson District Health Society .It leads to very soon IDSP establishment.

- A Separate Vehicle is must needed for IDSP (DSU) for proper monitoring and supervisory visit of PHC, Private Rural & Urban Sentinel site, private reporting and Rapid movement of RRT team and DEIT, because neither ACMO have any vehicle nor DHS provide any vehicle for IDSP work.

- It should be mandatory to all District ESI , Railway ,Police Hospital ,to reporting under IDSP and a letter should be given to them for the same from the state level.

- A proper guideline is needed from SHSB to Civil Surgeon cum CMO & DM cum Chairperson District Health Society regarding integration of Private Rural & Urban Sentinel site & private reporting unit.

DISTRICT HEALTH ACTION PLAN
2011-2012

DISTRICT HEALTH SOCIETY

KATIHAR

Annual Budget Plan 2012-13
District Surveillance Unit (IDSP)
District Health Society, Katihar

Prupose

Sl No.	Remuneration	Number	Proposed Amount	Total Annual Amo	Remark
1	Epidemilogist	1	40000*12	480000.00	33% hike on existing salary
2	District Data Manager	1	19750*12	237000.00	43% hike on existing salary
3	Data entry opreator	1	10000*12	120000.00	33% hike on existing salary
4	Class IV	1	5000*12	60000.00	
	Training		**Batch**	**Proposed Amount**	
1	Medical Officer	100	3	45000.00	
2	Nursh/Pharmacist	318	16	75000.00	
3	Sensitization workshop ASHA	2549	20	50980.00	
4	Sensitization workshop Aganwari	2271	16	48000.00	
	Oprational cost		**Proposed Amount**		Remark
1	Mobillity support		20000/- * 12 month	240000/-	surveillance activity is a field job and success of programm depende upon the active surveillance. Neither DSO/ACMO has any vehicle nor DHS provide vehicle for surveillance activity to IDSP. Surveillance activity e.g. community based surveillance, case based study report evaluation of caused of epidemic and integration of private sector with IDSP all are depend upon the mobability of the IDSP personal. The moment of RRT/DIET is also valuable for the success of the project. Transpotation of lab sample from peripheri to district is still related to mobility, so independent vehicle is must needed for success of IDSP.
2	Office expenses(Stationary & miscellanious		5000*12 month	60000.00	
3	ASHA Incentives for outbreak		12*1000	12000.00	
4	Consumable for Districts Lab			75000.00	
5	Collection & Transportation of Samples			20000.00	
6	IDSP Report including alert			7200.00	
7	Printing of Reporting Forms			7200.00	
8	Broadband expenses		2000*12month	24000.00	**Outgoing facility is needed**
9	Social Mobilization and Intersectoral co-ordinatior			16000.00	
10	Community based surveillance			180000.00	
11	Case base Study			6000.00	
		Total Amount		**1742380.00**	

B. 6 ASHA (Accredited Social Health Activist)

ASHA will take steps to **create awareness** and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services. She will counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child. ASHA will mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government. She will work with the Village Health & Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan. She will arrange escort/accompany pregnant women & children requiring treatment/admission to the nearest pre- identified health facility i.e. Primary Health Centre/Community Health Centre/ First Referral Unit (PHC/CHC/FRU).

ASHA will provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Program. She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit will be provided to each ASHA Emphasizing evidence base decentralized village and district level health planning and management is going to be accomplished through appointment of Accredited Social Health Activist (ASHA).

The general norm was **'One ASHA per 1000 population'.** The criteria for selection were women preferably eighth pass and married/widowed of same village. She should be 'Bahu' of that particular village.

About the work & incentive of ASHA, Hon'ble Executive Director have also written a letter by greeting them for their work & service given to the community.

Selection of ASHA

Out of revised target of 2549 ASHA selection of 2534 ASHA has been selected and 1779 ASHA has been trained on 1st Module & 2284 ASHA has been trained on 2,3 & 4 module. Rest of selection and Training of remaining ASHA will be completed in the year 2012-2013.
District training team for module-1 had received TOT in the year 2006. They are responsible for giving training at the block level. The TOT members who received the training will train the ASHA at the block level.

The main Constraints in proper implementation of ASHA are following :

- Poor coordination between the MOIC and Mukhias on selection.
- Lack of interest in ASHA selection amongst PRIs members
- In present situation DCM (ASHA) & DDA (ASHA) will facilitate the whole process of training to ASHA. They are also responsible for the issues related to ASHA.

ISSUES FOR ASHA PROGRAM-

Sl. No.	Issues in Planning in ASHA	Current Status as per evidence from data triangulation	Activities to be undertaken to achieve targets	Outputs to be achieved	Time Frame for 2012-13
1	Working of ASHA	Out of 2537 ASHA 111 ASHA is non working.	Block mobilizer should be trained for motivation of non-working ASHA	100% working	1st Quarter
2	ASHA Selection	2549	2537 Selected	Target selection to be completed	1st Quarter
3	1. ASHA Trainings - Lagging and Qualitative Issues **2.** Technical backstopping in Training	Total 2284 ASHA has been trained in 2,3 & 4 module but only 1779 in module 1. As well as training of 2,3 & 4 module is not up to the mark. While most of ASHA who received training for module-1 have dropped or currently not in work.	Creation of training Pool at the District and Block Levels 1. Develop user friendly training methodology and the training modules. 2. Print the modules in prescribed time, 3. Disseminate the modules from District to block. 4. Work on the training modalities 6. Provide the supportive supervision to maintain quality checks and control at Block level.	Completion of Module 1, 2, 3 and 4 trainings and rolling out of Module 5 training	1st, 2nd and 3rd Quar
4	ASHA Drug Kit- Incompetent Kit bags/ Non availability of Kit bags and Drugs	- Kit bag available to ASHAs not adequate	- Provision of Drug Kit Bag to ASHAs (Kits provided earlier are not designed to keep medicines) through tender after designing. - Strengthening of processes with the Facilitate the procurement process and supply it to ASHA. Develop the mechanism to maintain at least two months stock of medicines with ASHA. - Training of ASHAs	- Better health Care of the community - Self- Help Mechanism will be developed	1st quarter

BUDGET-2012-13

Annexure 2

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)		Unit of measure (in words)	Physical Target (where applicable)										Unit Cost (in Rs.)	Q1		Q2		Q3		Q4		Total Annual proposed budget (in Rs.)		Committed Fund requirement (if any in Rs.)	Responsible Agency (State/ SHSB/ Name of Development Partner)	REMARKS
					Q1		Q2		Q3		Q4		Total no of Units															
		HFD*	State Total		HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total		HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total			
A.1.1	MCH Centre																200000								200000			
1.2	Organise workshops on various aspects of operationalisation of 24x7 services at the facilities @ Rs. 25,000 / year / district																25000		0		0		0		25000			
1.3.1	RCH outreach camps																224000								224000			
1.3.2	VHSND	23530		2352													319605		319605		319605		319605		1278420			
1.4.1	Home deliveries			2000													10000000		10000000		10000000		10000000		40000000			
1.4.2	(A) Institutional deliveries (Rural) @ Rs.2000/- per delivery	160000		fifty thousand													20000000		200000000		300000000		300000000		1000000000	600000000		
	(B) Institutional deliveries (Urban) @ Rs.1200/- per delivery	82000		eight thousand four hundred													25000000		25000000		25000000		25000000		100000000			

	incentive for C-section(@1500/-(facility Gynec. Anesth. & paramedic)			**six hundred**												**4968957.75**		**4968957.75**		**4968957.75**		**4968957.75**		**19875833**			
1.4.3	**Incentive for MAMTA @ Rs. 100 per delivery**															**13750000**		**13750000**		**13750000**		**13750000**		**55000000**			
1.4.4	**Monitor quality and utilisation of services@**															**1244642.25**		**1244642.25**		**1244642.25**		**1244642.25**		**4978557**			
	Total Maternal Health															**8264965**		**2581596 5**		**3581596 5**		**3581596 5**		**1237128 60**			
	2. Child Health																										
	IMNCI																										
2.1.1	**Monitor progress against plan; follow up with training, procurement, review meetings etc**															**15000**		**15000**		**15000**		**15000**		**60000**			
2.2	**Facility Based Newborn Care**															**100000**		**0**		**0**		**0**		**100000**			
2.4	**Home Based Newborn care**															**5000000**		**5000000**		**5000000**		**5000000**		**20000000**			
2.5	**School Health Program (Details annexed)**															**1135936.2**		**1135936.2**		**1135936.2**		**1135936.2**		**4543744.8**			
2.6	**New Born Care centre (NRC)**															**1108884**		**1108884**		**1108884**		**1108884**		**4435536**			
2.7	**Care of sick children & severe malnutrition**															**10000000**		**10000000**		**10000000**		**10000000**		**40000000**			
2.8	**Management of Diarrhoea, ARI and Micro nutrient**															**12500000**		**12500000**		**12500000**		**12500000**		**50000000**			
	Total Child Health															**5109820.2**		**5009820.2**		**5009820.2**		**5009820.2**		**20139280.8**			

	3. Family Planning																									
3.1.1	**Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services**															**25000**		**25000**		**25000**		**25000**		**1000000**			
3.1.2	**Provide female sterilisation services on fixed days at health facilities in districts (Mini Lap)**															**7289355.5**		**7289355.5**		**7289355.5**		**7289355.5**		**2915742**			
3.1.3	**Organise NSV camps in districts**															**4000000**		**4000000**		**4000000**		**5000000**		**17000000**			
3.1.4	**Compensation for female sterilisation at PHC level in camp mode**															**35000000**		**35000000**		**65000000**		**65000000**		**2000000000**			
3.1.5	**Compensation for NSV Acceptance**															**1000000**		**1000000**		**1000000**		**2000000**		**5000000**			
3..1.6	**Compensation for sterilization done in Pvt. Accredited Hospitals cases)**															**20000000**		**20000000**		**50000000**		**50000000**		**1400000000**			
3.1.7	**Monitor progress, quality and utilisation of services**															**2740.75**		**2740.75**		**2740.75**		**2740.75**		**10963**			
3.5.4	**IUD Camps**															**600000**		**600000**		**600000**		**600000**		**24000000**			
3.11	**Organise Contraceptive Update seminars for health providers**															**0**		**25000**		**25000**		**0**		**50000**			
3.12	**NSV Training**															**750000**		**750000**		**0**		**0**		**1500000**			
3.13	**IUD insertion Training**															**1000000**		**1000000**		**0**		**0**		**2000000**			

3.14	**Minilap Training**															**1250000**		**1250000**		**0**		**0**		**2500000**			
3.15	**Block level PRI orientation on Availability of FP services**															**1000000**		**1000000**		**0**		**0**		**2000000**			
3.16	**Block level ICDS orientation on Availability of FP services**															**1250000**		**1250000**		**0**		**0**		**2500000**			
3.17	**Block level SHG orientation on Availability of FP services**															**1250000**		**1250000**		**1250000**		**1250000**		**5000000**			
3.18	**Block level ASHA/AWW orientation on Availability of FP services**															**2500000**		**2500000**		**2500000**		**0**		**7500000**			
3.19	**AWC level mother & adolescents meeting at village level**															**10000000**		**10000000**		**10000000**		**11000000**		**41000000**			
3.2	**Organising health melas focusing on MH FP and child health**															**2500000**		**2500000**		**2500000**		**2500000**		**10000000**			
	Total Family Planning															**8966676.3**		**8991676.25**		**14466676.25**		**14491676.3**		**4691676705**			
	4. Adolescent Reproductive and Sexual Health																										
4.1	**Disseminate ARSH guidelines.**															**25000000**		**25000000**		**40000000**		**25000000**		**115000000**	**200000000**		
4.2	**Conducting ARSH Camp in 10% of Sub centres across the state (as Village ARSH Week)**															**1000000**		**1000000**		**1000000**		**1000000**		**4000000**			
	Total ARSH															**26000000**		**26000000**		**4010000000**		**26000000**		**1190000000**			
	6. Vulnerable Groups																										

6	**Health Camps in Maha-Dalit Tola**															**300685**		**300685**		**300685**		**300685**		**1202740**			
	Total Vulnerable Groups															**300685**		**300685**		**300685**		**300685**		**1202740**			
	7. Innovations																										
	PNDT and Sex Ratio																										
7	**Orientation programme of PNDT activities, Workshop at District and Block Level**															**67612.75**		**67612.75**		**67612.75**		**67612.75**		**2704051**			
	8. Infrastructure and Human Resource																										
8.1.1	**ANMs, Staff Nurses Salary**															**195900000**		**195900000**		**195900000**		**195900000**		**783600000**			
8.1.2	**Loboratory Technicians/MPW (LT in Blood Banks)**															**36000000**		**36000000**		**36000000**		**36000000**		**14400000**			
8.1.5	**Medical Officers at CHCs/PHCs (Salary of MOs in Blood Banks)**															**16800000**		**16800000**		**16800000**		**16800000**		**67200000**			
8.1.7	**Others – Computer Assistants/ BCC C0-ordin ator etc (FP Counsellors)**															**7650000**		**7650000**		**7650000**		**7650000**		**30600000**			
8.1.8	**Incentive / Awards etc. to SN, ANMs etc (Muskaan Programme-Incentive to ASHA**															**38328000.00**		**38328000.00**		**38328000.00**		**38328000.00**		**95820000.00**			
	Salary of 3106 MPWs @Rs.2950/- x 60 months (since 2005)															**35400**		**0**		**0**		**0**		**35400**			

	Hiring of 1000 Retired ANMs or ANMs from other states for out reach services @ Rs. 5000 / month / ANM															**3750000**		**3750000**		**3750000**		**3750000**		**15000000**				
	Hiring Specialists															**14848891**		**14848891**		**14848891**		**14848891**		**59395564**				
	Facility improvement for establishing New Born Centres - @ Rs. 50,000 / per FRU															**50000**		**0**		**0**		**0**		**50000**				
	Facility improvement for New Born Centres at PHCs across the state - @ Rs. 25,000 / per PHC															**1500000**		**0**		**0**		**0**		**1500000**				
	Total Infrastructure and Human Resources															**27730291**		**27494891**		**27494891**		**27494891**		**97254964**				
	9. Training																											
9.1	**Strengthening of existing SBA Training Centres**															**0**		**4000000**		**0**		**0**		**4000000**				
9.3.1	**Training of ANMs / LHVs in SBA (Batch size of four)**															**0**		**3933333**		**3933333**		**3933333**		**11799999**				
	Training of nurses/ANMs in safe abortion															**4250000**		**0**		**0**		**0**		**4250000**				
	Training of Medical Officers in safe abortion															**250000**		**0**		**0**		**0**		**250000**				
9.5.1	**TOT on IMNCI for Health and ICDS worker**															**1596000**		**1596000**		**1596000**		**1596000**		**6384000**				
9.5.1	**IMNCI Training for Medical Officers (Physician)**															**0**		**13081161.66**		**13081161.66**		**13081161.66**		**39243498**				

9.5.1	**IMNCI Training for all health workers**																									
9.5.1	**IMNCI Training for ANMs / LHVs/AWWs**															**17095000**		**17095000**		**17095000**		**17095000**		**68380000**		
9.5.5.3	**NSSK Training**															**1454750**		**1454750**		**1454750**		**1454750**		**5819000**		
9.6.2	**Minilap Training**															**702400**		**0**		**702400**		**0**		**1404800**		
9.6.3	**NSV Training**															**33900**		**0**		**0**		**0**		**33900**		
9.6.4.1	**IUD Insertion Training**															**29425**		**29425**		**29425**		**29425**		**1177000**		
9.6.4.2	**PPIUCD Clinical training**															**384960**		**2406000**		**0**		**0**		**6255600**		
9.7	**One Day ARSH Orientation by the MOs of 25% ANMs**															**21250**		**21250**		**21250**		**21250**		**850000**		
9.7.1	**One Day ARSH Orientation of PRI by the MOs of50% ANMs**															**42500**		**42500**		**42500**		**42500**		**1700000**		
9.8.2	**Training of DPMU staff**															**250000**		**250000**		**250000**		**250000**		**1000000**		
9.11.3.2	**Community Visit for students and teachers**															**500000**		**500000**		**500000**		**500000**		**2000000**		
																31218500		**33474944.66**		**27771344.66**		**27068944.66**		**11953373.98**		
A.10 PROGRAM/NRHM MANAGEMENT COST																										
10.1.5	**Mobility support District malaria Office**															**1500000**				**1500000**				**3000000**		
10.2.1	**Contractual Staff of DPMU**															**4912227**		**4912227**		**4912227**		**4912227**		**19649088**		
10.2.2	**Mobility Support and Equipment Furniture**															**10000000**		**5000000**		**5000000**				**20000000**		
10.3	**Strengthening of BPMU**															**3916640**		**3916640**		**3916640**		**3916640**		**15666560**		

10.4.1	Tally Upgradation DPMU &BPMU															3240000							3240000				
10.4.3	AMC															1012500		1012500		1012500		1012500		4050000			
10.4.5	Training on Tally															4250000							4250000	Block level			
10.4.9	Management Unit at FRU	4		four												3795000		3795000		3795000		3795000		15180000	For 4-FRU HMand 1-Accountant		
10.5.1	Annual Audit																					10000		10000			
10.6	Concurrent Audit															600000		600000		600000		600000		2400000			
	Total															68476177		54486177		55986177		49586177		22853468			
																6300095177		7907676 1.86		1316314 01.9		9344616 1.9		3362038 42.8			
	PART-B																										
	Mission flexible pool																										
B.1	ASHA																										
B1.1.1	Selection& Training of ASHA	2549		twothousandfivehundredfortynine												2946219		2946219		2946219		2946219		11784877			
B1.1.2	Procurement of ASHA and Replacement															6372500,00				6372500				12745000			
1.1.3	Other incentive & TA,DA for ASHA Diwas															11000000		11000000		11000000		11305688		44305688	150000000		
1.1.4a	Best performance Award															500000							500000				

	to ASHA																										
1.1.4c	Identity Card	2549		twothousandfivehundredfortynine												50980								50980			
1.1.5	Asha resource Centre															8952550		8952550		8952550		8952550		35810000			
	TOTAL															50424449		49414469		55787719		49720037		21717925			
B2.UNTIED FUND																											
2.1	Untied fund for SDH/CHC	4		four												2000000								2000000	2-SDH		
2.a	Untied fund for PHC	16		sixteen												8000000								8000000			
2.b	Untied fund for APHC	45		fortеen												22500000								22500000			
2.3	Untied fund for HSC	345		threefortyfive												8625000								8625000			
2.4	Untied fund for VHSC	1506		onethousandfivehundredandsix												150600000								150600000	revenue Village 1506		
																26935000		0		0		0		26935000			
B.3	Annual maintenance Grants																										
3.1	CHC	4		four												320000000								320000000			
3.1.a	SDH	2		two												150000000								150000000			
3.2	PHC	16		sixteen												320000000								320000000			
3.2.a	APHC	45		fortyfive												450000000								450000000			
3.3	Sub Centre	345		threefortyfive												8625000								8625000			
																21		0		0		0		21			

																02 50 00								02 50 00			
B. 4	**HOSPITAL STRENTHNING**																										
4. 1. 1a	**Construtio n of SNCU**	**1**		**one**												**64 00 00 00**								**64 00 00 00**			
4. 1. 1. b	**Up gradation of DH**	**4**		**fou r**												**50 00 00 00**								**50 00 00 00**			
4. 1. 2. a	**Installatio n of solar water system**	**4**		**fou r**												**65 45 00**								**65 45 00**			
4. 3	**Sub Center Rent and Contingen cies**	**2 4 9**		**two fort yni ne**												**74 70 00**		**74 70 00**		**74 70 00**		**74 70 00**		**29 88 00 0**	**rs. 10 00 pe r m on th**		
																12 80 15 00		**74 70 00**		**74 70 00**		**74 70 00**		**15 04 25 00**			
B. 5	**New Construction / Renovation and Setting up**																										
B. 5. 2a	**Constructi on APHC(PH C)**			**nin e**												**54 00 00 00 00**								**54 00 00 00 00**	**fo r 9 A P H C**		
B. 5. 2b	**Constructi on of residential quarters for Doctor & Staff Nurses**	**1 6**		**sixt een**												**26 46 16 00 0**								**26 46 16 00 0**			
B. 5. 2c	**Strengthen ing of Cold Chain**															**16 00 00 0**								**16 00 00 0**			
5. 3	**SHCs/Sub Centers**																	**22 00 00 00 00**						**22 00 00 00 00**	**fo r 20 H S C**		
5. 10 .2	**ANM Training School**			**one**														**22 00 00 00 00**						**22 00 00 00 00**			
																32 02 16 00 0		**44 00 00 00 00**		**0**		**0**		**36 42 16 00 0**			
B.6 Corpus Grants to HMS/RKS																											
B. 6. 1	**DH**															**50 00 00**								**50 00 00**	**0**		
6. 2	**SDH/REF**															**90 00 00 0**								**90 00 00 0**	**S D H - 2 & R E**		

																								F-1		
6.3	PHCs			sixten												16000000								16000000			
6.4	Other APHC			fortyfive												45000000								45000000			
																15600000		0		0		0		15600000			
B.7 District Action Plans (Including Block, Village)																										
B.7	District Action Plans (Including Block, Village)															881500								881500			
B.8 Panchayati Raj Initiative																										
b.8.1	Constitution and orientation of Community Leader & of VHSC,SHC,PHC,CHC etc															357000								357000			
8.2	Orientation workshop training and capacity building of PRI at DHS/CHC/PHC															157100								157100			
																514100		0		0		0		514100			
B.9																										
main streaming of AYUSH																										
9.1	AYUSH Specialist															22200000		22200000		22200000		22200000		88800000			
9.3.1	Training of AYUSH and Paramedical staffs															10000000		10000000		10000000		10000000		40000000			
																23200000		23200000		23200000		23200000		92800000			
B.10	IEC/BCC																									
10.1	development of state IEC/BCC															60000000		60000000		60000000				180000000			
10.3	Health Mela															10000000		10000000		10000000		10000000		40000000			
																70000000		70000000		70000000		10000000		220000000			
B.11 MMU																										

11	**MMU including recurring expenditures**															**14040000**		**14040000**		**14040000**		**14040000**		**56160000**	**14040000**		
B.12	**Referral Transport**																										
12.2.a	**102 Ambulance**	**16**		**sixteen**												**66300000**		**66300000**		**66300000**		**66300000**		**26520000**			
12.2.c	**Call 108**															**4542427**		**4542427**		**4542427**		**4542427**		**18169099**			
12.2.d	**Referral Transport in District**			**sixteen**												**2730000**		**2730000**		**2730000**		**2730000**		**10920000**			
																73572227		**73572227**		**73572227**		**73572227**		**29428909**			
	B.13																										
B.13.3a	**setting of Ultra Modern Diagnostic Center**															**87500000**		**87500000**		**87500000**		**87500000**		**350000000**			
B.13.3.b	**Out sourcing of pathology and radiology for PHCs to DH**	**19**		**NINETEEN**												**37500000**		**37500000**		**37500000**		**37500000**		**150000000**			
B.13.3.d	**Hospital Bio-Medical Waste Treatment management**			**seventeen**												**3880000**		**3880000**		**3880000**		**3880000**		**15520000**			
																12888000		**12888000**		**12888000**		**12888000**		**20052000**			
B.14 Innovations																											
B14.a	**Innovations (if any) (rajiv Gandhi Scheme for Empowerment of Adolescent Girls or SABLA)**															**40000000**		**15000000**		**15000000**		**15000000**		**85000000**			
14.b	**YUKTI Yojana**	**10**		**ten**												**20000000**		**20000000**		**20000000**		**20000000**		**80000000**			
																60000000		**35000000**		**35000000**		**35000000**		**165000000**			
B15 Planning Implementation and Monitoring																											
B.15.3	**State , District , Divisional , Block Data Center**															**54000000**		**54000000**		**54000000**		**54000000**		**216000000**			
15.3.2.a	**MCTS and HRIS**															**1271991**		**1271991**		**1271991**		**1271991**		**5087964**			

B.153.2.b	**RI Monitoring**															**89000**		**89000**		**89000**		**89000**		**3560000**			
15.3.2.c	**CPMS**															**0**											
15.3.3.a	**HMIS**															**12000**								**12000**			
15.3.3.b	**Plan for HMIS**															**82500**		**82500**		**82500**		**82500**		**3300000**			
																850691		**838691**		**838691**		**838691**		**3366764**			
B.16	**Procurement**																										
16.1.1	**Procurement of equipment**															**1517886**				**1517886**				**3035772**	**commited-2400000000**		2-HSC & 4-APHC LABOUR ROOM STRENGTHNING
16.1.2	**SNCU/NBCC equipment**															**34359555**				**34359555**				**68719110**			
16.1.3.a	**Procurement of Minilap set**															**1800000**				**1800000**				**3600000**			
16.1.3.b	**Procurement of NSV kit**															**55000**								**55000**			
16.1.3.c	**Procurement of IUD kit**															**60000**								**60000**			
16.1.5.a	**Dental Chair**	**17**		**seventeen**												**1493683**				**1493683**				**2987366**			
16.1.5.b	**New Blood Banks**															**252727**								**252727**			
16.1.5.c	**A.C 1.5 ton window**	**2**														**70000**								**70000**			
16.2.1.a	**Parental Iron Sucros for pregnent women**	**62500**		**sixtytwo thousa**												**10000000**								**10000000**			

				ndfi fe hun dre d																							
16 .2. 1. b	IFA tablet for pregnant mother	1 3 8 7 2 1		one thir tyth ous and seve n hun dre dtw ent yon e												19 87 85 7								19 87 85 7			
16 .2. 2. a	IFA tablet & syrup for children	4 5 9 3 5 3		fou r lks fifty nin e tho usa nd thre ehu ndr ed fifty thre e												27 11 14 2								27 11 14 2			
16 .2. 2. b	IMNCI drug kit															18 12 00 0								18 12 00 0			
16 .2. 5	General drug and supply															16 57 85 00				16 57 85 00				33 15 70 00			
	Procureme nt of Bed equipment for DH/PHC/ RH/ SDH															10 00 00 00				10 00 00 00				20 00 00 00			
																41 15 47 50		0		33 20 60 24		0		74 36 07 74			
B. 22	Support services																										
22	RNTCP															20 99 18 7. 5		20 99 18 7. 5		20 99 18 7. 5		20 99 18 7. 5		83 96 75 0			
	B.23																										
B. 23 .a	Payment of monthly bill of BSNL															10 00 00		57 88 5						15 78 85			
	G.Total															47 10 85 40 5		76 29 94 59 .5		66 08 48 48 .5		31 67 21 42 .5		61 42 79 10 7			
	PART-C –RI & PP																										
C. 1. a	RI Strengthen ing project ,review meeting,m obilty															10 80 00				10 80 00				21 60 00			

	support & other services etc																									
C. 1. c	**Printing and Dissemination of Immunization card,Tally sheet, monitoring format**															**50 00 00**				**50 00 00**				**10 00 00 0**		
C. 1. e	**Quarterly review meeting at District level**															**70 00**		**70 00**		**70 00**		**70 00**		**28 00 0**		
C. 1.f	**Quarterly review meeting at Block level**															**63 75 0**		**63 75 0**		**63 75 0**		**63 75 0**		**25 50 00**		
C. 1. g	**Focus on urban slum and Undeserved area**															**37 20 00**		**37 20 00**		**37 20 00**		**37 20 00**		**14 88 00 0**		
C. 1. h	**Social Mobilization by ASHA/Link worker/paid mobilizer**															**15 29 40 0**		**15 29 40 0**		**15 29 40 0**		**15 29 40 0**		**61 17 60 0**		
C. 1.i & C. 1.j	**Alternate vaccine delivery to session site**															**81 44 70**		**81 44 70**		**81 44 70**		**81 44 70**		**32 57 88 0**		
C. 1. k & C. 1.l	**Devlop micro plan at sub centre level and consolidation block level**															**52 50 0**								**52 50 0**		
C. 1. m	**Pol for vaccine delivery from District and PHC/CHC level**															**43 80 0**				**43 80 0**				**87 60 0**		
C. 1. n	**Consumables for Computer/ Internet**															**30 00**		**30 00**		**30 00**		**30 00**		**12 00 0**		
C. 1. o	**Injection safety**															**84 32 2**				**84 32 2**				**16 86 43**		
C. 1. p	**Injection safety (Bleaching powder/Hypochlorite/ etc)**															**86 40 0**								**86 40 0**		
C. 1. q	**Safety pits**															**26 38 5**								**26 38 5**		
C. 1. r	**Generator fuel for Cold chain**															**27 00 00**		**27 00 00**		**27 00 00**		**27 00 00**		**10 80 00**		

																							0			
C.2.b	Salary of Contractual Staff															3000000		3000000		3000000		3000000		12000000			
C.3.a	District level Orientation Training of ANM/LHV															3279112		3279112		3279112		3279112		13116649			
C.3.d	One day Cold chain handler training																	18400						18400			
C.3.e	One day Block data handler training at district level																	18400						18400			
C.4	Cold chain maintenance															42500				42500				850000			
																43614439		34543332		41961544		34175532		154294457			
	6.CPP																										
CPP.6	Honorarium of Vaccinator															3920635		3920635		3920635		3920635		15682500			
	Honorarium of Supervisor															5741425		5741425		5741425		5741425		22965000			
	Honorarium of Depo holder															1305000		1305000		1305000		1305000		5220000			
	Vehicles															7458775		7458775		7458775		7458775		29835000			
	Cold chain Holder at PHC and District															53125		53125		53125		53125		2212550			
	Mobility support to supervisor															7650000		7650000		7650000		7650000		30600000			
	IEC material															1442550		1442550		1442550		1442550		5770000			
	Ice Pack															5303110		5303110		5303110		5303110		21212240			
	Social mobilization															3000000		3000000		3000000		3000000		12000000			
	Contingency &Stationery															862500		862500		862500		862500		3450000			
	Vaccine Lifting															5000000		5000000		5000000		5000000		20000000			
	Walk in cooler and vaccine maintenance															7500		7500		7500		7500		300000			
	AFP case															10				10				21			

	visit																500				500				000			
																	70487070		70375770		70487070		70375770		28179990			
	G.Total																11409509		10491902		11242424		10455102		43609447			
E	Integrated Disease Surveillance Project (IDSP)																											
21.1	Salary of Staff/Consultant																											
E.2.1	Dist. Epidemiologist	1															1200000		1200000		1200000		1200000		4800000			33% increment
E3.2	Dist. Data Manager	1															59251		59251		59251		59251		2370004			43% increment
E.3.3	Data Operator	0		three													30000		30000		30000		30000		1200000			
	Class IV			three													15000		15000		15000		15000		6000000			
E1	Training																54745		54745		54745		54745		2189880	500000		
	Mobility																600000		600000		600000		600000		2400000			
	Broadband																6000		6000		6000		6000		240000			
	Office Expenses & Other																45350		45350		45350		45350		1814000			
	Miscellaneous																50500		50500		50500		50500		2020000			
	Renovation																		5000000						5000000			
_	Total																4408046		9408046		4408046		4408046		22633844			
	G.Total																4408046		9408046		4408046		4408046		22633844			
_																												
	13 .National Leprosy elimination Programme																											
	Drivers honorarium																13500		13500		13500		13500		540000			
	Audit fee @ Rs. 500/Month																1500		1500		1500		1500		6000			
	Honorarium for accountant for account works @400/pm																1200		1200		1200		1200		4800			

	DLS (leprosy) for rent telephone, electricity etc. Rs. 18000/Pm															**4500**		**4500**		**4500**		**4500**		**18000**			
	Photo copy and stationery															**3500**		**3500**		**3500**		**3500**		**14000**			
	Hiring of Vehicle/ POL/ maintenance															**18750**		**18750**		**18750**		**18750**		**75000**			
	Supportive medicine															**12500**		**12500**		**0**		**0**		**25000**			
	Regeants & Laboratory equipments															**6000**		**6000**		**0**		**0**		**12000**			
	Patients welfare															**6000**		**0**		**0**		**0**		**6000**			
	Organisation of School quiz @ 10 Quiz/blocks															**16250**		**16250**		**16250**		**16250**		**65000**			
	Meeting with PRI Members @ Rs. 4000 / Block															**16000**		**16000**		**16000**		**16000**		**64000**			
	Organisation of Health Melas															**5000**		**0**		**0**		**0**		**5000**			
	Training of New Mos on Leprosy															**0**		**27300**		**0**		**0**		**27300**			
	Reorientation training of Mos															**0**		**27300**		**0**		**0**		**27300**			
	Training of ASHA @ Rs. 3200 Per batch . Per batch of 40 ASHA 20 batch															**0**		**32000**		**32000**		**0**		**64000**			
	Aids & Appliances															**12500**		**0**		**0**		**0**		**12500**			
	Urban leprosy control Programme															**15000**		**30000**		**15000**		**15000**		**75000**			
	Total of NLEP															**1322000**		**2103000**		**1222000**		**902000**		**5549000**			
	14. National Vector Borne Disease Control Programme																										
	Kala-azar																										

	Wages for SFW @ Rs. 113 per SFW for 60 days															**21 01 80**				**21 01 80**		**0**		**42 03 60**			
	Wages for FW @ Rs. 92 per SFW for 60 days															**10 65 78 0**				**0**		**10 65 78 0**		**21 31 56 0**			
	Office expenses															**23 25**				**23 25**		**23 25**		**93 00**			
	Construction of office for DMO															**95 00 00**				**0**		**0**		**95 00 00**			
	Construction of Hatchery at block @ Rs. 50000.00 / Hatchery for 16 blocks															**20 00 00**				**20 00 00**		**0**		**80 00 00**			
	Contigency															**23 25**				**23 25**		**23 25**		**93 00**			
	Transportation of DDT (District to PHC)															**40 00**				**60 00**		**20 00**		**18 00 0**			
	Transportation of DDT (PHC to Village)															**15 00**				**20 00**		**15 00**		**90 00**			
	Repair of spray equipments															**30 00**				**32 00**		**0**		**62 00**			
	Purchase of Spray equipments															**16 00 0**				**88 00**		**0**		**24 80 0**			
	Mobility support for DMO															**27 15 0**				**27 15 0**		**0**		**54 30 0**			
	Mobility support for MO (PHC)															**13 50 0**				**13 65 0**		**0**		**27 15 0**			
	Daily Allowance for supervision of Spray															**10 80 0**				**0**		**72 00**		**18 00 0**			
	I.E.C															**10 80 0**				**0**		**72 00**		**18 00 0**			
	Incentive to ASHA for Complete treatment of Kala-azar cases															**16 25 0**				**16 25 0**		**16 25 0**		**65 00 0**			
	Loss of Wages for Kala-Azar patients during their treatment period for 30 days @ Rs. 50 Per															**24 37 50**				**24 37 50**		**24 37 50**		**97 50 00**			

	day																									
	Strengthing of PHC for Kala-azar Patients 10 bed per PHC/DH/ Ref. Hos. @ rs. 1000 with mattress															**18000**				**0**		**0**		**18000**			
	Mobility support for DMO @ Rs. 10000.00 / PM for 8 months															**20000**				**20000**		**20000**		**80000**			
	Mobility support for Malaria Inspector Purchase of 02 Motorcycle @ Rs. 50000.00 each															**10000**				**0**		**0**		**10000**			
	POL for Motor cycle @ 30 liter per months @ Rs. 50 /lit. for 12 months															**9000**				**9000**		**9000**		**36000**			
	Emphoteracin storage in District @ Rs. 500 per month for 12 months															**1500**				**3000**		**0**		**6000**			
	Treatment card for Kala-azar patients @ Rs. 2.50 / treatment card															**3250**				**0**		**0**		**3250**			
	Register for line listing for listing of loss fo wages for kala-azar patients 02 register for per effec. PHCs@ Rs. 50 / Register															**900**				**0**		**0**		**900**			
	Hiring of ware house for storage of DDT @ Rs. 5000 per month for 12															**15000**				**15000**		**15000**		**60000**			

	months																									
	Kala-azar forthnight program @ Rs. 4000/ PHC														**18000**				**18000**		**18000**		**72000**			
	Monthly emoulments of KTS-6 @ Rs. 10000.00 /PM for 12 months														**1800000**				**1800000**		**1800000**		**7200000**			
	Procurement of impregnated bed nets														**2500000**				**2500000**		**0**		**10000000**			
	Total														**33930110**		**0**		**12306630**		**15903330**		**77941220**			
	G.Total														**33930110**		**0**		**12306630**		**15903330**		**77941220**			
	14.1 Filaria																									
	District Coordination meeting 02 meeting @ 7500.00														**7500**				**7500**		**0**		**15000**			
	IEC on Filaria elimination														**200000**				**100000**		**0**		**400000**			
	Training for MO														**550000**				**0**		**0**		**550000**			
	Training for Para medical staff														**400000**				**0**		**0**		**400000**			
	Night Blood survey														**16698**				**0**		**0**		**16698**			
	POL for mobility support														**8000**				**8000**		**8000**		**330000**			
	Training of Drug distributor @ Rs. 92 each														**192740**				**192740**		**192740**		**770960**			
	Honorarium to DD @ Rs. 92/pm														**192740**				**192740**		**192740**		**770960**			
	Training of Supervisor														**47347**				**0**		**0**		**94694**			
	Honorarium for Supervisor														**2367 3.5**				**2367 3.5**		**2367 3.5**		**94694**			
	Total of NVDCP														**39967085**				**16652835**		**20074835**		**97251256**			
	15. National Blindness control																									

	Programme																									
	Grant in Aid for cataract operation														**750000**								**30000000**			
	Grant in Aid for School eye screening														**25000**								**1000000**			
	Total of NBCP														**775000**								**31000000**			
	16. IDD																									
	Training on IDD														**17000**								**17000**			
	Awareness campaign on IDD														**2000**								**8500**			
	Awareness campaign on IDD in school														**4000**								**17000**			
	Activities at AWC & Communities														**2000**								**8500**			
	IEC Material														**7397**								**7397**			
	Total of IDD														**32397**								**58397**			

SUMMARY OF BUDGET

Slno.	**Budget Head**																Amount
1	Maternal Health																**39835780**
2	Child Health																**15628631.8**
3	Family Planning																**34048195**
4	ARSH																**57125**
5	Vulnerable group programme																**1202743.5**
6	Innovation																**18055675.44**

7	Infrastructure & Human Resource																**7674971**
8	Training																**3280345.09**
9	BCC/IEC																**3038213.73**
10	Procurement of equipments																**8017433.6**
11	Programme Management																**2298958**
12	RNTCP																**8396750**
13	NLEP																**554900**
14	NVBDCP																**9725126**
15	NBCP																**3100000**
16	IDD																**58397**
17	VITAMIN-A																**441203**
18	ASHA																**17261250**
19	Institutional strengthing																**214369604**
20	Routine Immunisation & Pulse polio																**42084716.25**
21	IDSP																**2242380**