DISTRICT HEALTH ACTION PLAN SIWAN 2012 – 13

Name of the district : Siwan

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Foreword

National Rural health Mission was launched in India in the year 2005 with the purpose of improving the health of children and mothers and reaching out to meet the health needs of the people in the hard to reach areas of the nation.

National Rural Health Mission aims at strengthening the rural health infrastructures and to improve the delivery of health services. NRHM recognizes that until better health facilities reaches the last person of the society in the rural India, the social and economic development of the nation is not possible.

The District Health Action Plan of Siwan district has been prepared keeping this vision in mind. The DHAP aims at improving the existing physical infrastructures, enabling access to better health services through hospitals equipped with modern medical facilities, and to deliver the health service with the help of dedicated and trained manpower. It focuses on the health care needs and requirements of rural people especially vulnerable groups such as women and children. The DHAP has been prepared keeping in mind the resources available in the district and challenges faced at the grass root level. The plan strives to bring about a synergy among the various components of the rural health sector. In the process the missing links in this comprehensive chain have been identified and the Plan will aid in addressing these concerns. The plan has attempts to bring about a convergence of various existing health programmes and also has tried to anticipate the health needs of the people in the forthcoming years.

I am grateful to the Department of Health, Government of Bihar for providing the leadership in the preparation of this plan and also in the implementation of other health programmes. The medical personnel and staff of DH/PHCs/APHCs/HSCs gave vital inputs which were incorporated into this document.

I am sure the DHAP and its subsequent implementation would inspire and give new momentum to the health services in the District of Siwan.

(Lokesh Kumar Singh)
(IAS)
District Magistrate-Cum-
Chairperson, DHS, Siwan

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About the Profile

Even in the 21st century providing health services in villages, especially poor women and children in rural areas, is the bigger challenge. After formation of National Rural Health Mission, we are doing well in this direction. Launching Muskan- Ek Abhiyan we are try to achieve 100% immunization and Anti Natal Care. Janani Evam Bal Suraksha Yojana is another successful program that is ensuring safe institutional delivery of even poor and illiterate rural women. Like wise several other programs like RNTCP, Pulse Polio, Blindness control, Leprosy eradication are running and reaching up to last man of society. But satisfaction prevents progress. Still, we have to work a lot to touch miles stones. In this regard sometime, I personally felt that planning of any national plan made at center lacks local requirements and needs. That is why, despite of hard work, we do not obtain the optimum results. The decision of preparing District Health Action Plan at District Health Society level is good.

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

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

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

Dr. Chandrashekhar Kumar
Civil Surgeon Cum
Member Secretary, DHS,
Siwan

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Chapter I : Introduction

1.1 Introduction

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

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

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

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

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

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

Stakeholders in Process

- *Members of State and District Health Missions*
- *District and Block level programme managers, Medical Officers.*
- *State Programme Management Unit, District Programme Management Unit and Block Program Management Unit Staff*
- *Members of NGOs and civil society groups (in case these groups are involved in the DHAP formulation)*
- *Support Organisation – PHRN and NHSRC*

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

1.2 Planning Objectives

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

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

1.3 Approach to District Planning

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

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

The District Planning Core Group (DCG) provided technical insights and strategic vision as an integral part of the process of development of District Health Action Plan.

The members of the DCG had also taken the responsibility of contributing to the selected thematic areas such as RCH-2, newer initiatives under NRHM, Immunization etc. Assessment of overall situation of the District and the development of a broad framework for planning was done through a series of meetings of the DCG.

This District Action Plan has been prepared through a process of integration of Block Action Plans including Health Facility Surveys. An initial meeting was held in which the current status of the District Action Plan was presented and suggestions and feedback taken. The Membership and roles and responsibilities of DCG and the cauterization of the plans was discussed. Based on the inputs received from the Blocks, a draft of each chapter was developed after discussions. These were further improved upon through individual consultations with groups and nodal officers. Specific dates and times were fixed for this purpose. A date was also proposed for a meeting during which the individual chapters would be discussed and approved before the final DHAP was prepared for presentation to the District Health Society for approval. The Final DHAP was approved by the District

1.4 District Planning Process

⇨ 1.4.1 District Level Consultation Workshop:

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

After a through situational analysis of district health scenario this document has been prepared. In the plan, it is addressing health care needs of rural poor especially women and children, the teams have analyzed the coverage of poor women and children with preventive and promotive interventions, barriers in access to health care and spread of human resources catering health needs in the district. The focus has also been given on current availability of health care infrastructure in pubic/NGO/private

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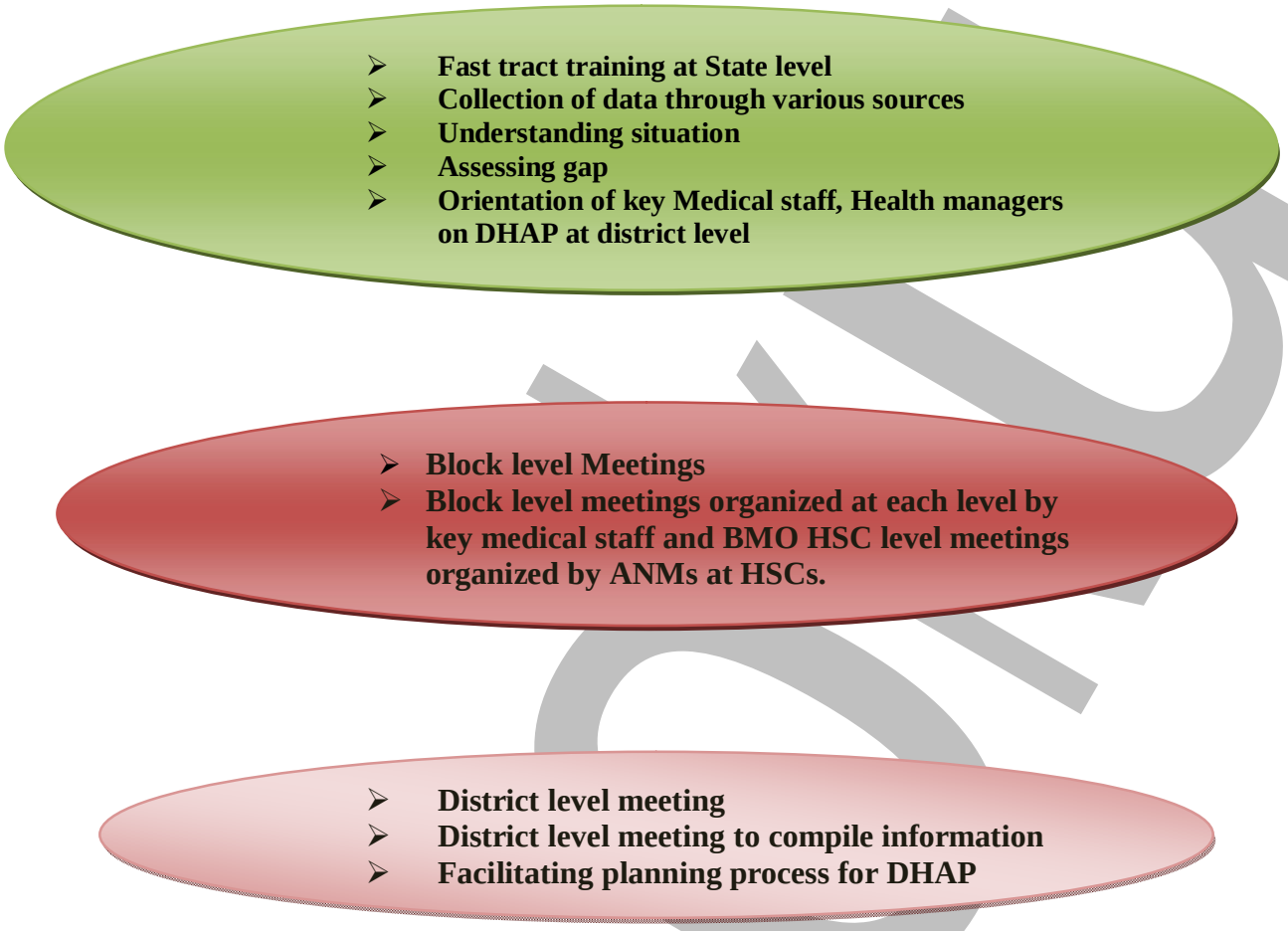
sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein command other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level



District Health Action Plan Planning Process

1.4.2 Tools and techniques

- **Preliminary Phase**

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

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- **Main Phase – Horizontal Integration of Vertical Programmes**

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

1. How adequate are the existing human and material resources at various levels of care (namely from sub – center level to district hospital level) in the state; and how optimally have they been deployed?
2. What factors contribute to or hinder the performance of the personnel in position at various levels of care?
3. What structural features of the health care system as it has evolved affect its utilization and the effectiveness?

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

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

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

1.4.3 Collection of basic data for planning

Primary Data:

All the Medical Officers, Block Health Managers, Block Account Manger were interacted During the District level meeting and their suggestion was welcome during the open discussion. Daily work process was observed properly and inputs were taken in account. District officials including CS, ACMO, DIO, DMO, DLO, DTO, RCHO and others were interviewed and their ideas were kept for planning process. For collection of data situational analysis and different formats have been developed foe gathering basic information regarding finalization of DHAP.

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Secondary Data:

Following books, modules and reports were taken in account for this Planning Process:

- RCH-II Project Implementation Plan
- NRHM operational guideline
- DLHS Report
- Report Given by DTC
- SRS Samples
- Report taken from different programme societies e.g. Blindness control, District
- Leprosy Society, District TB Center , District Malaria Office
- Census-2011
- National Habitation Survey-2003
- Population foundation Of India 2007
- Bihar State official website

Tools:

Main tools used for the data collection were:

- Informal In-depth interview
- Group presentation with different district level officials
- Informal group discussions with different level of workers and community representative Review of secondary data

1.5 Data Analysis and Plan Preparation:-

The data collected from blocks and Sub Centers were compiled at BHAP which was analyzed by Block Planning team for fixing their action plans regarding all the running programme. The data was also discussed in workshop with RKS members of every block. The outcome was a much tailored action plan as per the needs of blocks. This all plans from blocks were presented by all block teams at district level in front of district planning team for any comment and reforms. The suggestion from expert was incorporated in the block plan which was later sent to district for compilation of district plan. Thus this compiled action plan is again discussed for finalization of the next action plan of the district.

Primary Data:

Data analysis was done manually. All the interviews were recorded and there points were noted down. After that common points were selected out of that.

Secondary Data:

All the manuals books and reports were converted in to analysis tables and these tables are given in to introduction and background part of this plan.

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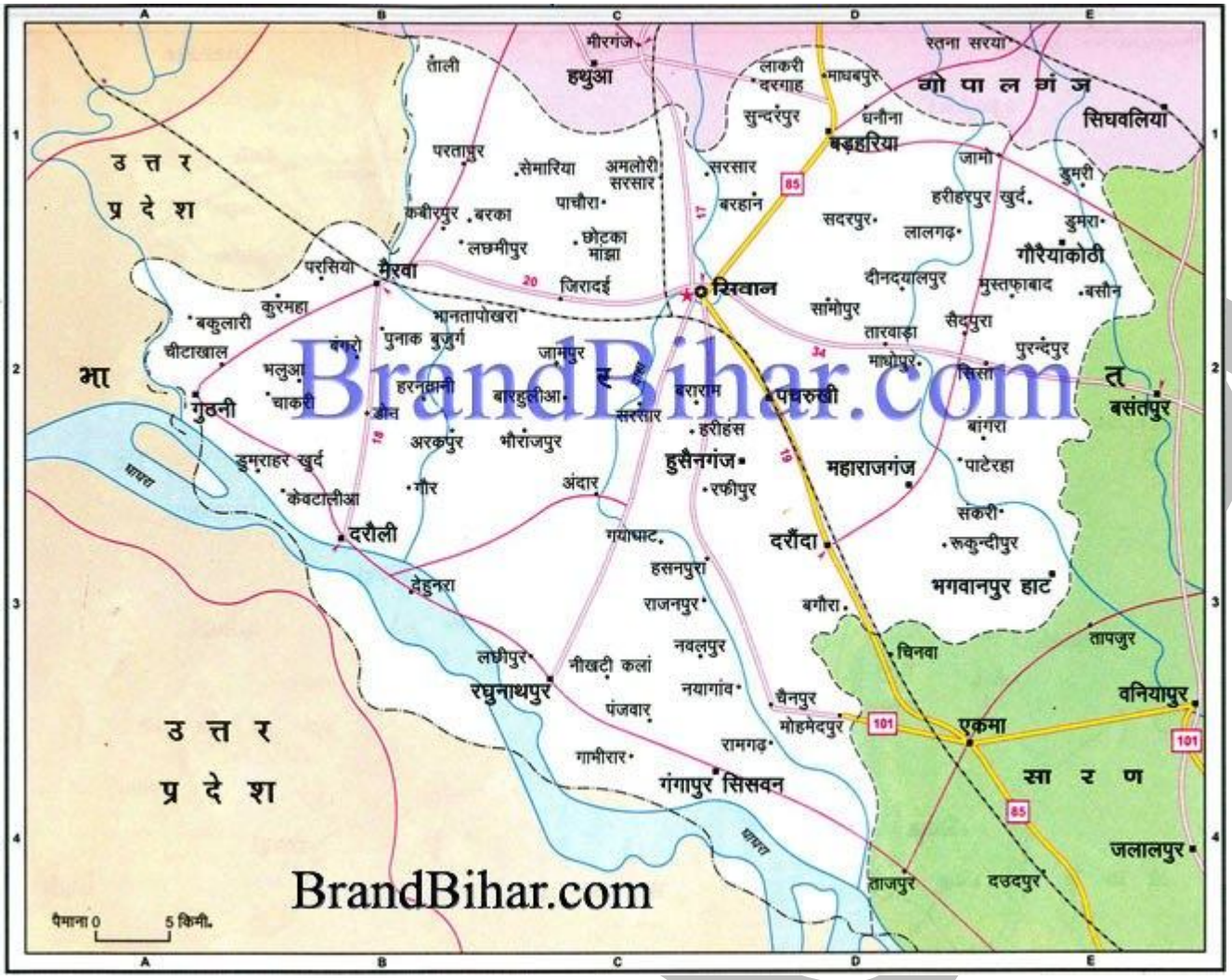
Chapter II: Profile of District



2.1 Historical Perspective

Siwan, situated in the western part of the State, was originally a sub-division of Saran District, which in ancient days formed a part of **Kosala Kingdom**. The present district limits came into existence only in 1972, which is **geographically situated at 25°35 North and 84°1 to 84°47 east**. The total area of the Siwan district is about **2219.00 Sq. Km**. with a population of **21,56,428** as per the **1991 census**. The district is bounded on the east by the Saran district, on the north by Gopalganj district and on the west and south by two districts of U.P. viz. Deoria and Balia respectively.

Siwan derived its name from **"Shiva Man"**, a Bandh Raja whose heirs ruled this area till Babar's arrival. **Maharajganj**, which is another subdivision of Siwan district, may have found its name from the seat of the Maharaja there. A recently excavated marvelous statue of Lord Vishnu at Village Bherbania from underneath a tree indicates that there were large numbers of followers of Lord Vishnu in the area. As the legend goes, **Dronacharya of Mahabharat** belonged to village **'DON'** in **Darauli**

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Block. Some believe Siwan to be the place where Lord Buddha died. **Siwan is also known as Aliganj Sawan after the name of Ali Bux**, one of the ancestors of the feudal lords of the area. Siwan was a part of Banaras Kingdom during 8th century. Muslims came here in the 13th century. Sikandar Lodi brought this area in his kingdom in 15th century. Babar crossed Ghaghra river near Siswan in his return journey. In the end of the 17th century, the Dutch came first followed by the English. After the battle of Buxar in 1765 it became a part of Bengal. **Siwan played an important role in 1857 independence movement**. It is famous for the stalwart and sturdy 'Bhoj-puries', who have always been noted for their martial spirit and physical endurance and from whom the army and police personnel were largely drawn. A good number of them rebelled and rendered their services to Babu Kunwar Singh. **The anti pardah movement** in Bihar was started by **Sri Braj Kishore Prasad** who also belonged to Siwan in response to the **Non Co-Operative movement** in 1920. A big meeting was organised at Darauli in Siwan District on the eve of the Kartik Purnima Mela under the leadership of Dr. Rajendra Prasad who had thrown away his lucrative practice as an advocate in the Patna High Court at the call of Gandhiji. In the wake of this movement Maulana Mazharul Haque, who came to stay with his maternal uncle Dr. Saiyyad Mahmood in Siwan, had constructed an ashram on the Patna-Danapur road which subsequently became **Sadaquat Ashram.**

The next phase of the Non co-operation movement known as the **Civil Disobedience movement** of 1930, was fully implemented in Siwan. In connection with the Satyagrah Movement Pt. Jawaharlal Nehru made a whirlwind tour of the different parts of Bihar. One of the famous meetings he addressed was at Maharajganj. A few persons of present Siwan District who played an important role in the attainment of independence were **Dr. Rajendra Prasad**, **Maulana Mazharul Haque**, **Shri Mahendra Prasad** the elder brother of Dr. Rajendra Prasad, **Dr. Sayyad Mohammad**, **Shri Braj Kishore Prasad** and **Shri Phulena Prasad**. **Uma Kant Singh** (Raman jee) of Narendrapur achieved martyrdom during the **Quit India Movement**. Jwala Prasad and Narmedshwar Prasad of Siwan helped Jai Prakash Narayan after his escape from Hazaribagh Central Jail. One of the most renowed literaturer of this country **Pandit Rahul Sankritayayana** started peasant Movement here between 1937 to 1938. During his visit to Champaran Mahatma Gandhi and Madan Mohan Malviya visited Siwan and Gandhiji even spent a night at Zeradei in the house of Dr. Rajendra Prasad. The chowki on which he slept then is still kept intact there.

CHANGES IN THE JURISDICTION OF THE DISTRICT

The major changes in the jurisdiction of the district were creation of Siwan as district and the changes resulting there from, and the implementation of **Trivedi Award on the 10th June, 1970** resulting in substantial alteration of jurisdiction. Siwan was being declared as a district in 1972 in which it was proposed to include 10 blocks of Gopalganj and 13 blocks of Siwan subdivisions. Two blocks **Bhagwanpur** and **Basantpur** of Siwan were declared to be added to the jurisdiction of proposed Marhaura subdivision. But after one year later in 1973 Gopalganj was made a separate district with it's 10 blocks included in Siwan earlier and thus Siwan constituted its original 15 blocks including Bhagwanpur and Basantpur blocks. Trivedi Award was implemented on 10th June 1970. Thereby fourteen villages of Siwan having an area of 13092 acres were transferred to U.P. and twelve villages of U.P. with an area of 6679 acres were transferred to Siwan. The basis of this transfer was the position of

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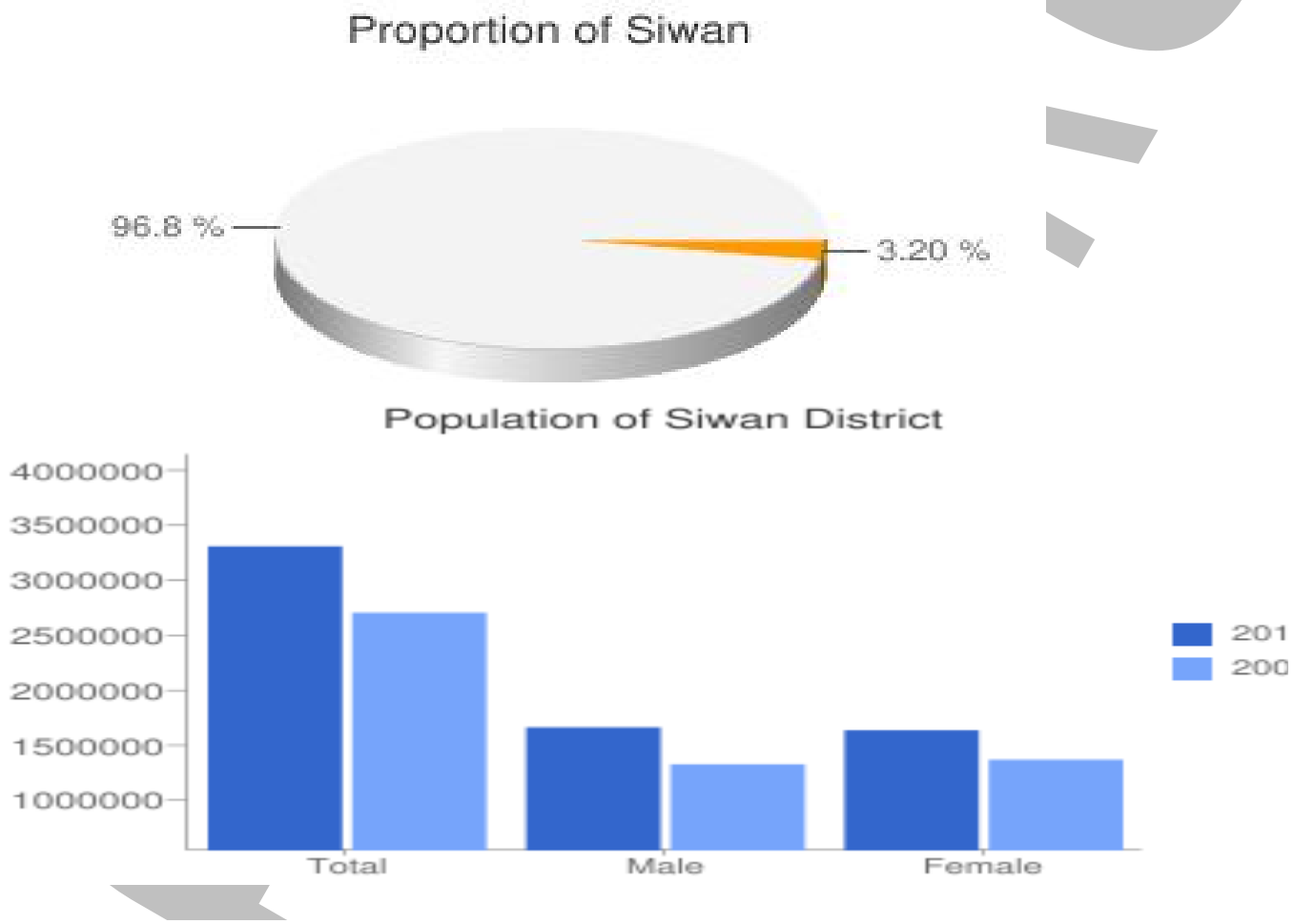
Ghaghara river in 1885. After 1885 the course of the river changed from time to time resulting in intermixing the areas of U.P. with those of Siwan. Hence the position of 1885 was taken to be the base and those transfer were made accordingly. Before the Trivedi Award the boundary of Siwan with U.P. was flexible changing with the course of the river. After the Award this boundary was fixed by installing pillars on the conspicuous points, the maintenance of which is done by Govt. of Utter Pradesh and the administration of Siwan as per the provisions of the Awards. Thus after this Awards, the so far flexible boundary of Siwan vis-a-vis U.P. on both banks of Ghaghara river was given a stability. Presently four more blocks have been created namely **Lakri Nabiganj**, **Nautan, Jiradei** and **Hasanpura** block. Out of these newly created blocks Lakri Nabiganj is functional and rests of the three are not functional. Thus there are **sixteen functional blocks** in the district Namely - Siwan, Mairwa, Darauli, Guthani, Hussainganj, Andar, Raghunathpur, Siswan, Barharia, Pachrukhi under Siwan subdivision and Maharajganj, Duraondha, Goreakothi, Basantpur, Bhagwanpur and Lakri Nabiganj under Maharajganj subdivision.

2.2 District Profile



An official Census 2011 detail on Siwan, a district of Bihar has been released by Directorate of Census Operations in Bihar. Enumeration of key persons was also done by census officials in Siwan District of Bihar.

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In 2011, Siwan had population of 3,318,176 of which male and female were 1,672,121 and 1,646,055 respectively. There was change of 22.25 percent in the population compared to population as per 2001. In the previous census of India 2001, Siwan District recorded increase of 24.78 percent to its population compared to 1991.

The initial provisional data suggest a density of 1,495 in 2011 compared to 1,223 of 2001. Total area under Siwan district is of about 2,219 sq.km.

Average literacy rate of Siwan in 2011 were 71.59 compared to 51.65 of 2001. If things are looked out at gender wise, male and female literacy were 82.77 and 60.35 respectively. For 2001 census, same figures stood at 67.26 and 36.88 in Siwan District. Total literate in Siwan District were 1,994,056 of which male and female were 1,155,972 and 838,084 respectively. In 2001, Siwan District had 1,118,027 in its total region.

With regards to Sex Ratio in Siwan, it stood at 984 per 1000 male compared to 2001 census figure of 1031. The average national sex ratio in India is 940 as per latest reports of Census 2011 Directorate.

Description	2011	2001
Actual Population	**3,318,176**	**2,714,349**
Male	1,672,121	1,336,283
Female	1,646,055	1,378,066
Population Growth	**22.25%**	**24.78%**
Area Sq. Km	2,219	2,219
Density/km2	**1,495**	**1,223**
Proportion to Bihar Population	3.20%	3.27%
Sex Ratio (Per 1000)	**984**	**1031**
Child Sex Ratio (0-6 Age)	934	934
Average Literacy	**71.59**	**51.65**
Male Literacy	82.77	67.26
Female Literacy	60.35	36.88
Total Child Population (0-6 Age)	**532,868**	**549,611**
Male Population (0-6 Age)	275,500	284,195
Female Population (0-6 Age)	257,368	265,416
Literates	**1,994,056**	**1,118,027**
Male Literates	1,155,972	707,675
Female Literates	838,084	410,352
Child Proportion (0-6 Age)	**16.06%**	**20.25%**
Boys Proportion (0-6 Age)	16.48%	21.27%
Girls Proportion (0-6 Age)	15.64%	19.26%

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Description	Rural	Urban
Population (%)	**94.51 %**	**5.49 %**
Total Population	**3,135,865**	**182,311**
Male Population	1,576,783	95,338
Female Population	1,559,082	86,973
Sex Ratio	**989**	**912**
Child Sex Ratio (0-6)	937	880
Child Population (0-6)	**508,332**	**24,536**
Male Child(0-6)	262,452	13,048
Female Child(0-6)	245,880	11,488
Child Percentage (0-6)	**16.21 %**	**13.46 %**
Male Child Percentage	16.64 %	13.69 %
Female Child Percentage	15.77 %	13.21 %
Literates	**1,864,407**	**129,649**
Male Literates	1,082,341	73,631
Female Literates	782,066	56,018
Average Literacy	**70.96 %**	**82.17 %**
Male Literacy	82.35 %	89.48 %
Female Literacy	59.55 %	74.21 %

In census enumeration, data regarding child under 0-6 age were also collected for all districts including Siwan. There were total 532,868 children under age of 0-6 against 549,611 of 2001 census. Of total 532,868 male and female were 275,500 and 257,368 respectively. Child Sex Ratio as per census 2011 was 934 compared to 934 of census 2001. In 2011, Children under 0-6 formed 16.06 percent of Siwan District compared to 20.25 percent of 2001. There was net change of -4.19 percent in this compared to previous census of India.

Siwan District population constituted 3.20 percent of total Bihar population. In 2001 census, this figure for Siwan District was at 3.20 percent of Bihar population.

All details regarding Siwan District have been processed by us after receiving from Govt. of India. We are not responsible for errors to population census details of Siwan District

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Table-1

No.	Variable	Data
1.	Total Area	2219 Sqr Km
2.	Total No. of Blocks	19
3.	Total No. of Gram Panchayats	293
4.	No. of Villages	1538
5.	No of PHCs	19
6.	No of APHCs	54
7.	No of HSCs	439 (370+69)
8.	No of Sub divisional hospitals	1
9.	No of Referral hospitals	3
10.	No of Doctors	85
11.	No of ANMs	615
12.	No of Grade A Nurse	17
13.	No of Para medicals	
14.	Total population	3,318,176
15.	Male population	1672121
16.	Female population	1646055
17.	Sex Ratio	1000/984
18.	No of Eligible couples	550770
19.	No. of Anganwadi centers	2618
20.	No. of Anganwadi workers	2618
21.	No of ASHA	3008
22.	No. of electrified villages	1228
23.	No. of villages having access to safe drinking water	1438
24.	No of villages having motorable roads	1333

Source: Census 2011

⇨ 2.2.1 District Health Administrative Setup

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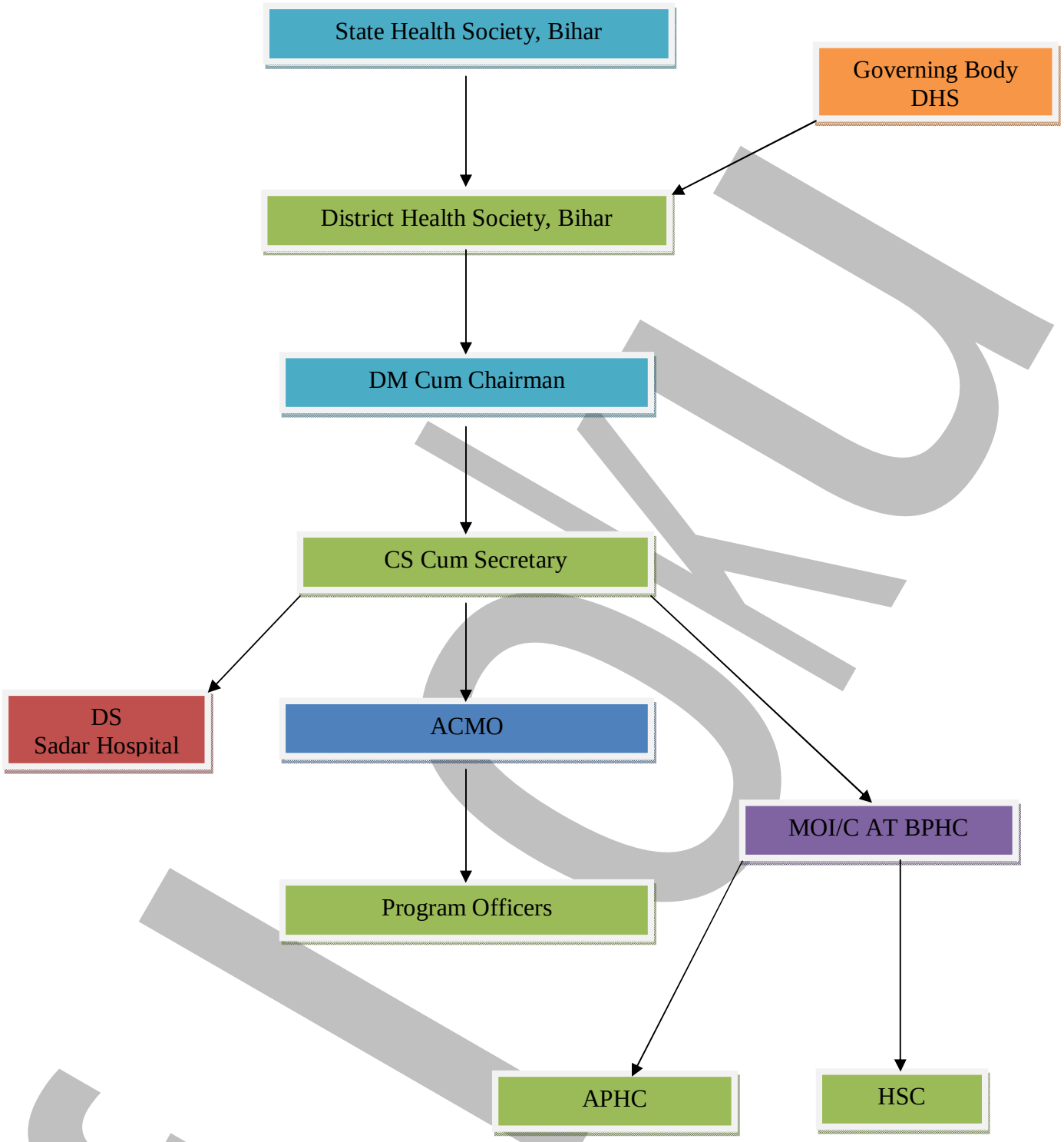

2.2.2 Demography and Development Indicators

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Social

- Siwan district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Siwan have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.
- 11.38% of the population belongs to SC and 0.51% to ST. Some of the most backward communities are *Mushahar, Turha,chamar* and *Dome*.

Economic

- The main occupation of the people in Siwan is Agriculture, business and daily wage labour.
- Siwan is the first district in Bihar where 1700 crores rupees are in bank and the main source of income is gulf country where lots of people work.
- Almost 20% of the youth population migrates in search of jobs to the metropolitan cities like Kolkata, Punjab, Mumbai, Surat, Delhi etc.
- The main crops are Wheat, Paddy, Pulses, Oilseeds, Mango.
- Tobacco and sugar cane are the main cash crop of the community of the district.

⇨ 2.2.3 Topography

Siwan, situated in the western part of the State, was originally a sub-division of Saran District, which in ancient days formed a part of **Kosala Kingdom**. The present district limits came into existence only in 1972, which is **geographically situated at 25º35 North and 84º1 to 84º47 east**. The total area of the Siwan district is about **2219.00 Sq. Km**. with a population of **21,56,428** as per the **1991 census**. The district is bounded on the east by the Saran district, on the north by Gopalganj district and on the west and south by two districts of U.P. viz. Deoria and Balia respectively.

⇨ 2.2.4 Climate and Agro Ecological Situation

The district gets its place in the transitional zone of drier climatic condition of Uttar Pradesh and moist climatic condition of West Bengal, but nearness to U.P. gives way to experience comparatively drier climatic condition. The area observes hot westerly winds which start in March and last till May, but in April and May light, damp easterly winds blow intermittently and afternoon storms accompanied with rain take the place of the rainless dust storms of U.P. The summer season experiences 'Loo' during May and June having temperature above **100^0F (38^0C)**, Since the district is in transitional zone the Monsoon rain starts late here, but earlier than U.P., and persists till September. This period provides maximum rain to the area. July and August are the oppressive months due to heat intermixed with high humidity. The winter season is normally pleasant with low temperature. During this period western depressions sometimes give small quantity of rain, which intensifies the existing coldness into chill. The **average annual rainfall** for 51 years at Siwan is **120 centimeters (47 inches)**.

⇨ 2.2.5 Rainfall

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⇨ 2.2.6 Air temperature and humidity

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⇨ 2.2.7 Land and soil

The southern part of the district along river Ghaghara is marked by '**Draras'**, which are typical formation of the sand heaping with

Thin layer of clay and silt over them. **Alluvium** and **dilution Rae** the important works of river Ghaghara in this part, where by boundary problems are created leading to transfer of land to and from the district.

The district of Siwan falls in the area, which occupies an intermediary position between the **Bhanger plain** of Uttar Pradesh and **Khader plain** of West Bengal. 'Bhanger' (or Banger) is the older alluvium containing heavier soil with greater clay proportion, while Khader is the newer alluvial deposit by river floods, Both types of soils are found in the district, but Khader is limited to the vicinity of the rivers where it is periodically renewed by fresh deposits, especially in **"DIARA"** areas. **Khader** is locally termed as 'Domat' and 'Bhanger' as '**Balsundari**'. The Bhanger contains nodular segregations of carbonate of lime known as '**Kankar**'. The soil is in many places sulfurous and extraction of saltpeter has long been an important industry. The saltpeter industry has disappeared with the march of time and changing phase of development

⇨ 2.2.8 River system

The district is drained by few small rivers like Jharahi, Daha, Gandaki, Dhamati (Dhamahi), Siahi, Nikari and Sona. The southern boundary of the district is formed by **river Ghaghara**, the main stream of the area. Among these, Ghaghara is the only perennial river because of its Himalayan source and rest rivers bear different origins. The rivers of the district get inundated almost every year. The area is characterised by certain typical features like '**Chaurs',** some of which give birth to short length streams locally known as '**Nadi' or 'Sota**'. The rivers Jharahi and Daha are the tributaries of river Ghaghara, while Gandak and Dhamati are of river Gandak. The Siahi and Nikari streams drain to Jharahi, While Sona drains to river Daha. These streams play important role in carrying out excess water during rainy season. Siwan, the district headquarters, is located on the eastern bank of river Daha.

⇨ 2.2.9 Flora Fauna

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Siwan district is mainly a plain and fertile agricultural land. It has highest temperature in May and lowest temperature in January. The highest rainfall period is August and September. In summer it often faces, cyclones.

Plants and Herbs

First of all Mr. M. H. Hens who was then forest conservator collected plants but Siwan District does not appear in his articles. At that time it was a Sub-Division of the Saran District. The land of Siwan cannot be divided into botanical zones.

Crops

Crops are cultivated in the district as per the seasons. There are mainly two major crops .i.e. Khariff and Rabi.

Khariff — Its period is June to September and the main crops are Maize, Paddy, Sugarcane, and Millet etc.

Rabi — Its period is October to March and the, Main crops are Wheat, Grams, Peas, Mustards, Soya beans, Sunflower etc.

March - January - During this period mainly Kidney beans and summer paddy is grown.

Fruits

The main fruits are Mango, Guava, Banana, and Papaya. The other fruits that are grown are Pomegranate, big and small Lemon. Amla are also found in some places.

Vegetables

Vegetables are also grown according to the season.

Winter season : Potato, Cauliflower, Cabbage, Reddish, Spinach, Carrot, Brinjal, Tomato, Bottle gourd, Pumpkins etc are grown in this season.

Rainy Season : Ladyfinger, Bitter gourd, “Ghewara” etc are grown during this season.

Trees

The district has no forest area. The trees that are found in orchards and roadsides are Mango, Litchi, Eucalyptus, Pipal, banyan, Shisham. Neem, Ashok, Coconut, Palmyra etc.

Flowers

The flowers that are found are Rose, Fern & Cactus, various types of Croton, Jasmine, Lily, Christhemum etc.

⇨ 2.2.10 Language and culture:

Generally Bhojpuri is the speaking language of the district. Some people also used to speak Hindi and Urdu. But frequently Bhojpuri is speaking by the most of the people in the district.

➢ 2.3 Eminent personality of Siwan

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Dr. RAJENDRA PRASAD

Name	**: Dr. Rajendra Prasad**
Father's Name	**: Sri Mahadev Sahai**
Date of Birth	**: 3 Decemeber, 1884**
Birth Place	**: Zeradei, Siwan, Bihar**
Date of Demise	**: 28 February, 1963**

Dr. Rajendra Prasad, son of Mahadev Sahai, was born in **Zeradei, siwan, Bihar** on December 3, 1884. Being the youngest in a large joint family he was greatly loved. He was strongly attached to his mother and elder brother Mahendra. In Zeradei's diverse population, people lived together in onsiderable harmony. His earliest memories were of playing "Kabaddi" with his Hindu and Muslim friends alike. In keeping with the old customs of his village and family, he was married when he was barely 12 years old to Rajvanshi Devi.

He was a brilliant student; standing first in the entrance examination to the University of Calcutta, he was awarded a Rs.30/month scholarship. He joined the famed Calcutta Presidency College in 1902. His scholarship, ironically, would pose the first test of his patriotism. Gopal Krishna Gokhale had started the Servants of India Society in 1905 and asked him to join. So strong was his sense of duty toward his family and education that he, after much deliberation, refused Gokhale. But the decision would not rest easy on him. He recalled, "I was miserable" and for the first time in his life his performance in academia declined, and he barely cleared his law examinations.

Having made his choice, however, he set aside the intruding thoughts, and focused on his studies with renewed vigor. In 1915, He passed the Masters in Law examination with honors, winning a gold medal. Subsequently, he completed his Doctorate in Law as well.

As an accomplished lawyer, however, he realized it would be only a matter of time before he would be caught up in the turmoil of the fight for independence. While Gandhiji was on a fact finding mission in Chamaparan district of Bihar to address grievances of local peasants, he called on Dr. Rajendra Prasad to come to Champaran with volunteers. He rushed to Champaran. Initially he was not impressed with Gandhiji's appearance or conversation. In time, however, he was deeply moved by the dedication, conviction and courage that Gandhiji displayed. Here was a man alien of the parts, who had made the cause of the people of Champaran his own. He decided that he would do everything he could to help, with his skills as a lawyer and as an enthusiastic volunteer.

Gandhiji's influence greatly altered many of his views, most importantly on caste and untouchability. Gandhiji made Dr. Rajendra Prasad realize that the nation, working for a common cause, "became of one caste, namely co-workers." He reduced the number of servants he had to one, and sought ways to simplify his life. He no longer felt shame in sweeping the floor, or washing his own utensils, tasks he had all along assumed others would do for him.

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Whenever the people suffered, he was present to help reduce the pain. In 1914 floods ravaged Bihar and Bengal. He became a volunteer distributing food and cloth to the flood victims. In 1934, Bihar was shaken by an earthquake, which caused immense damage and loss of property. The quake, devastating by itself, was followed by floods and an outbreak of malaria which heightened misery. He dove right in with relief work, collecting food, clothes and medicine. His experiences here led to similar efforts elsewhere too. In 1935, an earthquake hit Quetta. He was not allowed to lend a hand because of Government restrictions. Nevertheless, he set up relief committees in Sind and Punjab for the homeless victims who flocked there.

Dr. Prasad called for non-cooperation in Bihar as part of Gandhiji's non-cooperation movement. He gave up his law practice and started a National College near Patna, 1921. The college was later shifted to Sadaqat Ashram on the banks of the Ganga. The non-cooperation movement in Bihar spread like wildfire. Dr. Prasad toured the state, holding public meeting fter another, collecting funds and galvanizing the nation for a complete boycott of all schools, colleges and Government offices. He urged the people to take to spinning and wear only khadi. Bihar and the entire nation was taken by storm, the people responded to the leaders' call. The machinery of the mighty British Raj was coming to a grinding halt. The British India Government utilized the one and only option at its disposal-force. Mass arrests were made. Lala Lajpat Rai, Jawaharlal Nehru, Deshbandhu Chittranjan Das and Maulana Azad were arrested. Then it happened. Peaceful non- cooperation turned to violence in Chauri Chaura, Uttar Pradesh. In light of the events at Chauri Chaura, Gandhiji suspended the civil disobedience movement. The entire nation was hushed. A murmur of dissent began within the top brass of the Congress. Gandhiji was criticized for what was called the "Bardoli retreat."

He stood by his mentor, seeing the wisdom behind Gandhiji's actions. Gandhiji did not want to set a precedent of violence for free India. In March 1930, Gandhiji launched the Salt Satyagraha. He planned to march from Sabarmati Ashram to Dandi seashore to break the salt laws. A salt Satyagraha was launched in Bihar under Dr. Prasad. Nakhas Pond in Patna was chosen as the site of the Satyagraha. Batch after batch of volunteers courted arrest while making salt. Many volunteers were injured. He called for more volunteers. Public opinion forced the Government to withdraw the police and allow the volunteers to make salt. He then sold the manufactured salt to raise funds. He was sentenced to six months imprisonment.

His service on the various fronts of the movement for independence raised his profile considerably. He presided over the Bombay session of the Indian National Congress in October 1934. Following the resignation of Subhash Chandra Bose as the President of the Congress in April 1939, He was elected President. He did his best to heal the rifts created between the incompatible ideologies of Subhash Chandra Bose and Gandhiji. Rabindranath Tagore wrote to him, "I feel assured in my mind that your personality will help to soothe the injured souls and bring peace and unity into an atmosphere of mistrust and chaos..."

As the freedom struggle progressed, the dark shadow of communalism which had always lurked in the background, steadily grew. To his dismay communal riots began spontaneously burst all over the

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nation and in Bihar. He rushed from one scene to another to control the riots. Independence was fast approaching and so was the prospect of partition. Dr. Prasad, who had such fond memories of playing with his Hindu and Muslim friends in Zeradei, now had the misfortune of witnessing the nation being ripped into two.

In July 1946, when the Constituent Assembly was established to frame the Constitution of India, he was elected its President. Two and a half years after independence, on January 26, 1950, the Constitution of independent India was ratified and he was elected the nation's first President. Dr. Prasad transformed the imperial splendor of Rashtrapati Bhavan into an elegant "Indian" home. He visited many countries on missions of goodwill, as the new state sought to establish and nourish new relationships. He stressed the need for peace in a nuclear age.

In 1962, after 12 years as President, Dr. Prasad retired, and was subsequently awarded the Bharat Ratna, the nation's highest civilian award. With the many tumults of his vigorous and accomplished life, he recorded his life and the decades before independence in many books, among the more noted of which are "Satyagraha at Champaran" (1922), "India Divided" (1946), his autobiography "Atmakatha" (1946), "Mahatma Gandhi and Bihar, Some Reminisences" (1949), and "Bapu ke Kadmon Mein" (1954).

Dr. Rajendra Prasad spent the last few months of his life in retirement at the Sadaqat Ashram in Patna. He died on February 28, 1963. In her first citizen, India had imagined a life of possibilities, and seen an unsurpassed dedication to making them real.

BRIJKISHOR PRASAD

	Name	**:**	**Brijkishor Prasad**
	Date of Birth	**:**	**1877**
	Birth Place	**:**	**Shrinagar**
	Date of Demise	**:**	**1946**

Brajkishore Prasad was born in 1877 in a prominent kayastha family in Shrinagar to Ramjivan Lal a zamindar now in Siwan district in Bihar. He had his early education in Chapra and Patna before moving to Presidency College in Calcutta where he completed his legal training. In between he was married to Phool Devi. He set up a roaring legal practise in Darbhanga and had two sons Vishwa Nath and Shiv Nath and two daughters, Prabhavati Devi and Vidyawati.Prabhavati Devi was married to Jayaprakash Narayan and Vidyawati to Mrityunjaya Prasad,son of Rajendra Prasad.

He met with Mahatma Gandhi in 1915 and was immediately taken in by him. He decided to get involved full time in the freedom struggle and gave up his legal practice. He was instrumental in Gandhi taking up the Champaran movement where Rajendra Prasad and [1]Anugrah Narayan Sinha were

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handpicked with him to successfully lead the movement . Gandhi was so impressed by his dedication that he set aside a full chapter on him in his autobiographical book, My experiments with truth called "The Gentle Bihari".

He remained at the forefront of the freedom struggle in Bihar and collaborating with several colleagues was instrumental is the setting up of Bihar Vidyapeeth. For the last ten years of his life he was severely infirmed and died in 1946.[2]

MAULANA MAZHARUL HAQUE

	Name	**:**	**Maulana Mazharul Haque**
	Date of Birth	**:**	**22 Decemeber, 1866**
	Birth Place	**:**	**Brahmpur, Brahmpur, Patna, Bihar, India**

Mulana Mazharul haque was born on 22 dec.1866 in village Brahmpur, Thana Maner of Patna district. He got lot of land donated to him by his relatives and settled in village Faridpur of district Siwan in 1900.

He constructed a home in the village and named it 'Ashiana'. Pandit Motilal Neharu in 1927, Smt. Sarojani Devi in 1928, Pt. Madan Mohan Malviya, K.F. Nariman, Maulana Abdul Kalam Azad visited his house 'Ashiana' in Faridpur. He was the only son among the three children's of Sheikh Amedullah. The names of his sister were Gafrunisha and Kaneej Fatma. His father was a rich landlord.

He got his primary education from a Maulvi at home. He passed his matriculation from Patna Collegiate in 1886. Then he went to Lucknow for higher studies and took admission in Cannigh College. But he could not adjust himself and left to England for studying law in 1886. He returned to India in 1891 after passing law and started practice at Patna. On the advice of his friend Willam Barket he joined the judicial service as Munsif. But he soon resigned following differences with the District & Session Judge and started practice at Chapra. Again he went to Patna in 1906 to practice law.

In 1906 he was elected as Vice Chairman of Bihar Congress Committee. He also stared a journal 'Motherland'. He took actively participated in Champaran Movement and was sentence to 3 month imprisonment. He was the founder of "Sadaquat Ashram" at Patna and "Bihar Vidyapeeth".

He was born in village **Ukhai, 6 k.m. from Siwan district** on 2nd August 1842 in his parental house.

KHUDA BAKSH KHAN

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	Name	**:**	**Khuda Baksh Khan**
	Date of Birth	**:**	**2 August 1842**
	Birth Place	**:**	**Ukhai, Siwan, Bihar, India**
	Date of Demise	**:**	**3 August 1908**

Khuda Baksha were in service of King Alamgir. They were doing the work of book keeping and writing records of the kingdom.

His father was a famous advocate in Patna. He was very fond of collecting hand written books and he was spending big part of his income on purchasing such books. His father brought Khuda Baksh to Patna from Ukhai. He passed his matriculation with very good marks from the Patna High School in 1859. His father sent him to Calcutta for higher studies. But he could not adjust himself to the new environment and he often had health problems. He returned to Patna and started studying law in Patna University. He completed his law education in 1868 and started practice at Patna. In short time, he became a well known advocate.

His father expired in 1876, but in his will he has asked his son to establish a public library with the collection of his books nearing around 1700 and making more contribution to the collection. His father aim was to benefit the people of his precious collection.

In 1877 he became the **1st Vice Chairman of the Patna Municipal Corporation.** For his contribution in the area of education and literature he was awarded the title of "Khan Bahadur" in 1891. In 1903 he was honored with the title of "C.I.B."

The biggest achievement of Khuda Baksh was creating a public library from the precious collections of his father and making his own valuable collection of books, which was later named as "Oriental Public Library" He started constructing a separate special building for the library, which was completed in two years. The library was inaugurated by the Lieutenant Governor of Bangal Sir Charles Elliot in 1891. At that time it was having around 4000 hand written books in the library.

In 1895, he was appointed as a Chief Justice of High Court of Nizam of Hyderabad. After staying there for about three years, he again returned to Patna and started the practice. But soon he suffered from the paralysis and he confined his activity only to the library. Due to his illness, he could not carry out his activities. He was given Rs. 8000 for paying his debts and made the secretary of the library and Rs. 200 was sanctioned as a pension to him. He couldnot recovered from the paralysis and the great son of Siwan died on 3rd August 1908.

2.4 Historical Places

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Amarpur

Amarpur is a village situated 3 Kms. West of Darauli, in this village ruins of mosque of red bricks on the bank of river Ghaghara are still available. This mosque was build during the reign of Mughal Emperor Shahjahan (1626-1658) under the supervision of the Naib Amar Singh but the work was left incomplete. The village derived its name from the builder of the mosque Amar Singh.

Faridpur

Faridpur situated just near Andar is the birthplace of Maulana Mazharul Haque who played an important role during the freedom movement. Sadaquat Ashram in Patna, which originally belonged to him. He was a symbol of Hindu Muslim unity.

Darauli

A block headquarter now is said to be have been founded after the name of Dara Shikoh the elder son of the Emperor Shahjahan. It name was Daras Ali, which later on was changed into Darauli. There is reminiscence of Mughal period ruins where a big mela is held every year on the Kartik Purnima.

Don

A village in the Darauli block where there are remnants of a fort, which is said to be connected with the famous hero of the Mahabharat, Acharya Dronacharya the guru of both Kaurav's and Pandav's.

Dona's stupa is a lesser-known but popular Buddhist pilgrimage site, despite its isolated location. The Buddhist traveler Hiuen Tsang mentions a visit to Don in his account of his travels in India. He describes the stupa as being in ruins. The account of Dona's distribution of Buddha's ashes and being given the vessel is a mentioned in the end of the Mahaparinibbana Sutta, which is described in Maurice Walsh's The Long Discourses. Presently Dona's stupa is a grassy hill and has a Hindu temple built over it, where a beautiful statue of Tara is worshipped as a Hindu goddess. This statue was carved in the 9th century. A.D. Tourists on a Buddhist Pilgrimage Tour are sure to appreciate the historic sight of the stupa at Don.

Don can be reached from Patna to Siwan via Chhapra. A day trip from Kusinagar via Gopalganj can also be arranged.

After the Buddha's cremation a dispute arose as to how his ashes should be divided. Eventually a brahmin named Dona was given the task and he did it to the satisfaction of all the eight claimants. As a

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reward for his services he was given the vessel in which the ashes had been collected and from which he had divided and he announced that he would enshrine this vessel in a stupa. This stupa later became a popular destination with pilgrims. When Hiuen Tsiang went there it was already in ruins but it still sometimes emitted a brilliant light. Today Dona's stupa is a large grassy mound with a Hindu temple on it just outside the village of Don. Nearby is an exceptionally beautiful statue of Tara now being worshipped as a Hindu goddess? This statue dates from the 9th century. To get to Don go from Patna to Siwan via Chhapra . Alternatively you can visit Don as a day trip from Kusinara via Gopalganj. Beyond Siwan the road is very bad. The story about Dona's division of the Buddha's ashes is in the last part of the Mahaparinibbana Sutta which can be found in Walshe's The Long Discourses. When you have finished in Patna cross the Ganges by the new Mahatma Gandhi Bridge and head north to Vesali via Hajipur.

Hasanpura

It is a village in the Hussainganj block. It is said that Makhdum Sayyad Hasan Chisti, a saint who came from Arabia to India and settled here, found it. He founded a Khankhah too.

Lakri Dargah

It is the place of pilgrimage for the Mohammedans. The village is so called because it contains the tomb (Dargah) of a Mohammedan saint, Shah Arjan of Patria, in which there is some good woodwork. The story runs that the saint, attracted by the solitude of the place, performed a Chila here, i.e., gave himself up to religious contemplation for 40 days. He also set up a religious establishment, which was endowed by the Emperor Aurangzeb. The anniversary of the saint's death is celebrated the 11th of Rabi-us-sani every year which attracts a large crowd.

Maharajganj

A block headquarters now, it was also called Basnauli Gangar. It is the largest bazar in the district. This was the place where great hero of Indian Independence Movement, Shri Phulena Prasad centralised his activity and fought against the Britishers.

Mairwa Dham

A block headquarters now, there is a celebrated Brahma Asthan, locally known as Hari Baba ka Asthan, the shrine having been built over the relics of the saint. There is also a mound called Chananriyam Dih from an Ahirni woman who is now worshipped in a shed built in front of the Dak bungalow which occupies the top of the mound. The shrine is on the bank of the Jharhi River and fairs are held in Kartik and Chaitra months. There is also a leper home at Mairwa known as Kustha Sevasram which is doing useful work.

Mehandar

A village in Siswan Blcok, where there is a temple of Lord Shiva & Lord Vishwakarma which is

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visited by the people of the locality on the Shivaratri day & Vishwakarma Puja (17 Sept) Day. It is known for its temple and a pond scatted over an area of more than 52 bighas. It is said that one Nepal king built these and took his bath in the pond and got his leprosy cured.

Ziradei

It is a village in the Hussainganj Blcok. Dr.Rajendra Prasad, the first President of the Indian Republic, belonged to this village.

Bhikhabandh

A village in Maharajganj Block, there is a big tree under the shade of which Bhaiya-Bahini temple is situated. The story runs that these brother and sister fought Mughal sepoys in the 14th century and died here in course of fighting.

Train & Transport Facility

Transport facilities in the district are not inadequate. Railways and roads are the two main media, previously there was problem due to inadequate metalled roads and interaction of different railway gauges. But conversion of metre-gauge into broad gauge from Gorakhpur have improved the condition .Addition to the metalled roads by P.W.D. , R.E.O. and District Board has improved the condition of road routes.

The North Eastern Railways crosses through Siwan district for 45 Kms. From little beyond Mairwa in the north in the North West to Daraundha in the south- east crossing through the stations of Mairwa , Ziradei ,Siwan, Pacharukhi and Darundha. There is also a short loop-line running from Darundha to Maharajganj. Siwan in an important railway station of the North Eastern Railway where main traffic dealt with are sugar and vegetable.

Although there was no state highway but now some road has been taken. There is a wide knot of important metalled roads serving as important routes for transport. There are Siwan - Mairwa Guthani road covering 31.5 kms Siwan Chapra road covering 65 kms. Siwan-Sarfara road covering 35 kms. Siwan- Raghunathpur road 27 kms. Siwan- Siswan road covering 37 kms, Siwan- Maharajganj road 19 kms. Siwan-Badali road 17 kms. Siwan -Mirganj 16 kms. Guthni -Chapra via Darauli and Raghunathpur 45 kms and Bhantapokhar Ziradei road 5 kms. On all these roads power propelled vechicle ply regularly carryring the passanger, Buses ply on Siwan-Patna, Siwan-Chapra, Siwan-Mirganj, Siwan-Gopalganj and Siwan-Mairwa-Guthani etc. roads buses ply regularly.

Up to 1969 there was no road link with eastern Utter Pradesh, It was after the construction of road bridge near Guthani over river Saryu that the flow of traffic to the neighbour state has shown considerable progress

Chapter III Health Profile

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3: Health Facilities in the District

Data below indicating the present status of HSC, APHC, PHC, CHC, Sub-divisional hospital & District Hospital.

Health Sub-centres

S.N.	Block Name	Population 2011 with growth	Sub-centres required Pop 5000 (IPH)	Sub-centers Present	Sub-centers sanctioned	Further sub-centers require	Status of building		Availability of Land (Y/N)
							Own	Rented	
1.	Ander	109635	19	11	0	8	5	6	
2.	Barhariya	321388	64	37	0	27	2	35	
3.	Basantpur	105091	17	11	0	6	2	9	
4.	Bhagwanpur	220352	33	19	0	14	3	16	
5.	Darauli	174122	27	20	0	7	1	19	
6.	Daraunda	172714	34	18	0	16	9	9	
7.	Goriakothi	220916	43	34	0	9	6	28	
8.	Guthani	128119	28	18	2	8	5	13	
9.	Hassanpura	149434	29	16	0	13	2	14	
10.	Hussaingunj	182497	23	19	0	4	2	17	
11.	Lakri Navigunj	122496	24	15	3	5	5	10	
12.	Maharajgunj	189953	36	28	1	8	12	16	
13.	Mairwa	113422	22	11	0	11	1	10	
14.	Nautan	90719	18	13	0	5	0	13	
15.	Pachrukhi	201722	42	30	0	12	2	28	
16.	Raghunathpur	157359	31	18	0	13	5	13	
17.	Siswan	154480	31	19	0	12	5	14	
18.	Siwan Sadar	205358	40	20	7	13	9	11	
19.	Siwan Urban	134458	NA	NA	NA	NA	NA	NA	
20.	Ziradei	163941	32	18	0	14	5	13	
	Total	**3318176**	**593**	**375**	**13**	**205**	**81**	**294**	

Additional Primary Health Centers (APHCs)

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S.N.	Block Name	Population 2011 with growth	Sub-centres required Pop 5000 (IPH)	Sub-centers Present	Sub-centers sanctioned	Further sub-centers require	Status of building		Availability of Land (Y/N)
							Own	Rented	
1.	Ander	109635	4	2	0	2	0	2	
2.	Barhariya	321388	10	3	1	6	0	3	
3.	Basantpur	105091	3	1	0	2	0	1	No
4.	Bhagwanpur	220352	7	2	1	4	0	2	
5.	Darauli	174122	6	3	0	3	1	2	
6.	Daraunda	172714	6	1	1	4	1	0	
7.	Goriakothi	220916	8	4	0	4	4	0	
8.	Guthani	128119	4	2	1	1	1	1	
9.	Hassanpura	149434	6	1	1	4	1	0	No
10.	Hussaingunj	182497	6	4	0	2	1	3	No
11.	Lakri Navigunj	122496	4	2	2	0	1	1	
12.	Maharajgunj	189953	6	3	0	3	0	3	No
13.	Mairwa	113422	3	2	0	1	0	2	
14.	Nautan	90719	3	3	0	0	1	2	
15.	Pachrukhi	201722	6	3	0	3	1	2	
16.	Raghunathpur	157359	5	2	0	3	1	1	
17.	Siswan	154480	5	3	0	3	1	1	
18.	Siwan Sadar	205358	7	3	4	0	1	3	
19.	Siwan Urban	134458	NA	NA	NA	NA	NA	NA	
20.	Ziradei	163941	5	4	0	1	1	3	
	Total	**3318176**	**104**	**48**	**11**	**46**	**16**	**32**	

Primary Health Centers

S.N.	Block Name/sub division	Population	BPHCs Present	PHCs required @ Pop 80000 – 120000 (IPH)	PHCs proposed
1.	Ander	109635	1	2	1
2.	Barhariya	321388	1	3	2
3.	Basantpur	105091	1	1	1
4.	Bhagwanpur	220352	1	2	1
5.	Darauli	174122	1	2	1
6.	Daraunda	172714	1	2	0
7.	Goriakothi	220916	1	2	1
8.	Guthani	128119	1	1	0
9.	Hassanpura	149434	1	2	1
10.	Hussaingunj	182497	1	2	1
11.	Lakri Navigunj	122496	1	1	0
12.	Maharajgunj	189953	1	2	1
13.	Mairwa	113422	1	1	0
14.	Nautan	90719	1	1	0
15.	Pachrukhi	201722	1	2	1
16.	Raghunathpur	157359	1	1	0
17.	Siswan	154480	1	2	1
18.	Siwan Sadar	205358	1	2	1
19.	Siwan Urban	134458	NA	NA	NA
20.	Ziradei	163941	1	1	0
	Total	**3318176**	**19**	**32**	**13**

CHC Required

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S.N.	Block Name/sub division	Population	CHCs Present	CHCs required @ Pop 1200000 and above (IPH)	CHCs proposed
1.	Ander	109635	0	0	0
2.	Barhariya	321388	0	2	2
3.	Basantpur	105091	0	0	0
4.	Bhagwanpur	220352	0	1	1
5.	Darauli	174122	0	1	1
6.	Daraunda	172714	0	1	1
7.	Goriakothi	220916	0	2	2
8.	Guthani	128119	0	1	1
9.	Hassanpura	149434	0	1	1
10.	Hussaingunj	182497	0	1	1
11.	Lakri Navigunj	122496	0	1	1
12.	Maharajgunj	189953	0	1	0
13.	Mairwa	113422	1	1	0
14.	Nautan	90719	0	0	1
15.	Pachrukhi	201722	0	2	1
16.	Raghunathpur	157359	1	1	0
17.	Siswan	154480	1	1	0
18.	Siwan Sadar	205358	0	2	1
19.	Siwan Urban	134458	0	1	0
20.	Ziradei	163941	0	1	1
	Total	**3318176**	**3**	**21**	**15**

Sub-Divisional Hospital

S.N.	Name of sub division	Population	Sub- Divisional Hospital Present	Sub- Divisional Hospital required	Sub divisional hospital proposed
1.	Maharajgunj	189953	1	0	0
	Total	**189953**	**1**	**0**	**0**

District Hospital

S.N.	Name of District	Population	District Hospital Present	District Hospital required	DH proposed
1.	Siwan	3318176	1	1	0
	Total	**3318176**	**1**	**1**	**0**

⇨ 3.1 Human Resources and Infrastructure

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Sub-centre database

No. of Sub center present	No. of Sub center required	Gaps in Sub centers	ANMs (R)/(C) posted formally	ANMs (R)/(C) posted required	Gaps in ANMs(R)/(c)	Building ownership (Govt)	Required Building (Govt)	Gaps in Buildings (Govt.)	ANM residing at HSC area (Y/N)	Condition of residential facility (+++/++/+/#)	Status of furnitures	Status of Untied fund
375	593	218	284	593/593	459/341	81	593	512	y	+++		

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

Additional Primary Health Centre (APHC) Database: Infrastructure

S. N.	No. of APHC present	No. of APHC required	Gaps in APHC	Building ownership (Govt)	Building Required (Govt)	Gaps in building	Building condition (+++/++/+/#)	Condition of Labour room (+++/++/#)	No. of rooms	No. of beds	Condition of residential facility (+++/++/+/#)	MO residing at APHC area (Y/N)	Status of furniture	Ambulance/ vehicle (Y/N)
1.	54	104	50	16	104	88	#	#	101	36	#	N	#	Y

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

Additional Primary Health Centre (APHC) Database: Human Resources

S. N.	No. of APHC	Doctors		ANM		Laboratory technician		Pharmacists / dresser		Nurses A Grade		Accnt/Peons/Sweeper/Night Guards	Availability of specialist
		Sanction	In Position	Sanction	In position	Sanction	In position	Sanction	In position	Sanction	In Position		
1	48	96	39	96	54	48	4	48	1	48	2	19	0

Primary Health Centres : Infrastructure

S. N.	No. of PHC present	No. of PHC required	Gaps in PHC	Building ownership (Govt)	Building Required (Govt)	Gaps in Building	No. of Toilets available	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. Places where rooms > 5	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/++/#)
1.	19	32	13	18	32	14	18	15	++	15	6/186	A	++	+

Good condition +++/ Needs major repairs++/Needs minor repairs-less that Rs10,000-+/ needs new building-#; Water Supply: Available –A/Not available –NA, Intermittently available-

Primary Health Centres: Human Resources

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S. N.	No. of PHC	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses		Specialists		S.Keeper, Peon, NG, Sw.
		Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1.	19	133	66	66	66	19	5	19	6	40	6	30	8	35

Referral Hospital/CHC : Infrastructure

S. N.	No. of Referral/CHC present	No. of Referral/ CHC required	Gaps in Referral/CHC	Building ownership (Govt)	Building Required (Govt)	Gaps in Building	No. of Toilets available	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. Places where rooms > 5	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/++/#)
1.	3	19	16	3	19	16	2	3	++	0	84	A	++	++

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

Referral Hospital: Human Resources

S. N.	No. of /Referral/ CHC	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses		Specialists		Storekeeper
		Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1.	3	26	6	7	5	3	3	5	0	14	1	11	2	0

District Hospital: Infrastructure

S. N.	No. of Sadar Hospital present	No. of Sadar Hospital require	Gaps in Sadar	Building ownership (Govt)	Building Required (Govt)	Gaps in Building	No. of Toilets available	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/++/#)
1.	1	1	0	govt	0	0	16	A	#	100	A	+	+

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

District Hospital: Human Resources

S. N.	No. of DH	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses		Specialists		Storekeeper
		Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	1	13	10	1	0	2	1	2	2	4	4	5	4	1

3.3 ACHIEVMENTS: STATUS OF PREGRESS IN DIFFERENT HEALTH PROGRAMMS

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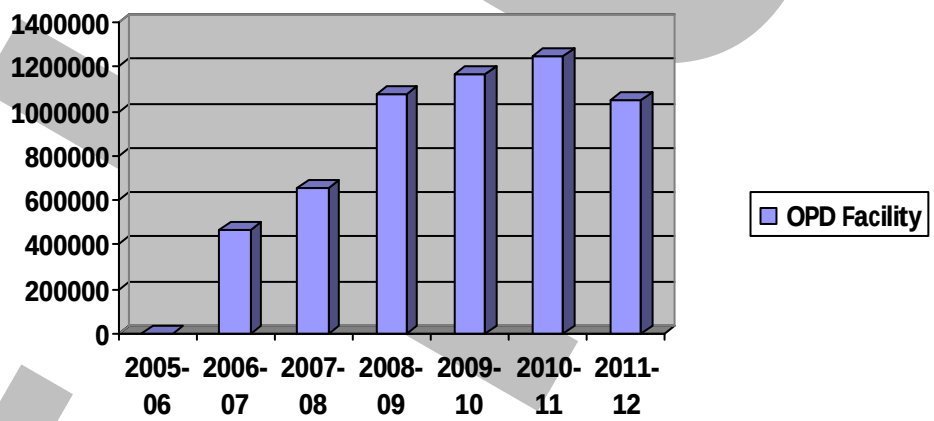
S. N.	Program	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12 (Till Nov 11)
01.	OPD facilities	NA	469279	654921	1078200	1163819	1245084	1047589
02.	JBSY	NA	3514	22639	35597	36966	39676	29608
03.	FP Operation	2810	3722	8816	13920	9643	18304	8862
04.	Full immunized child	55691	77683	93007	76831	70986	63542	42399
05.	Leprosy	663	749	731	914	770	739	454
06.	Kala-azar	268	293	508	676	675	752	539
	TB	483	581	2314	3992	3395	2859	1740
08.	Blindness	1926	2025	855	5954	4628	4251	3683
09.	Vitamin A	93669	110424	112256	63292	69964	58440	34260
10.	AIDS	289	314	165	191	175	180	159
11.	Epidemic (Diarrhea / Dysentery)	250	250	803	1517	2350	2526	1578
12.	Filarial	315	365	2686	8747	6369	5570	3267

OPD facilities



JBSY facilities

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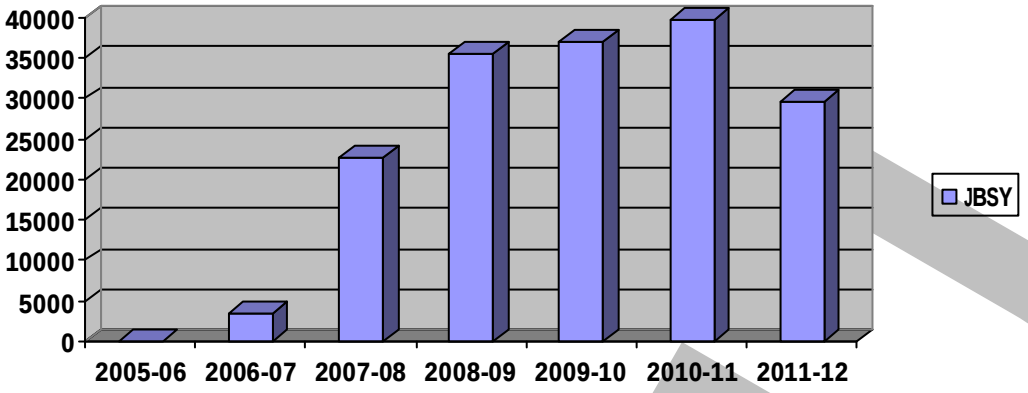
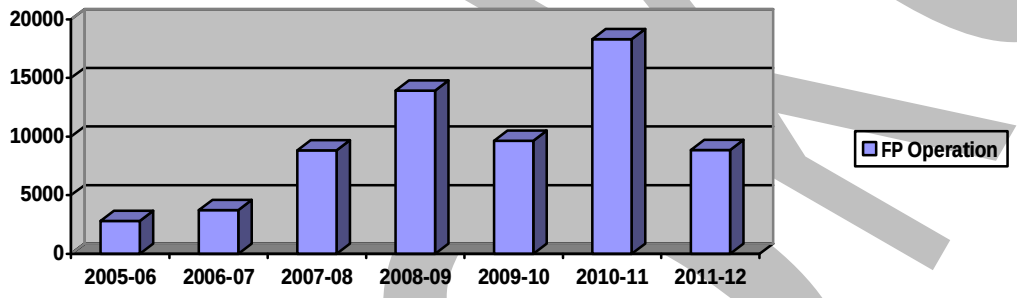
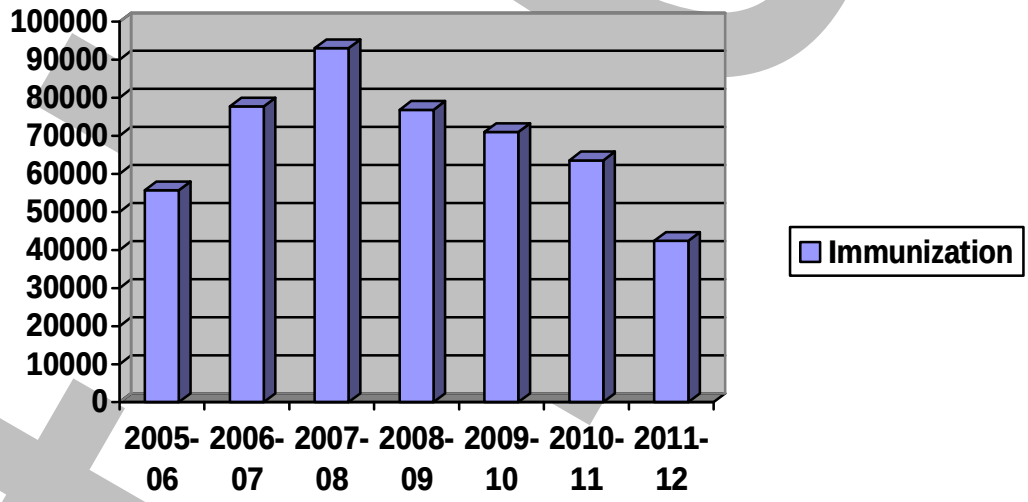


FP Operation



Full immunized child



Leprosy

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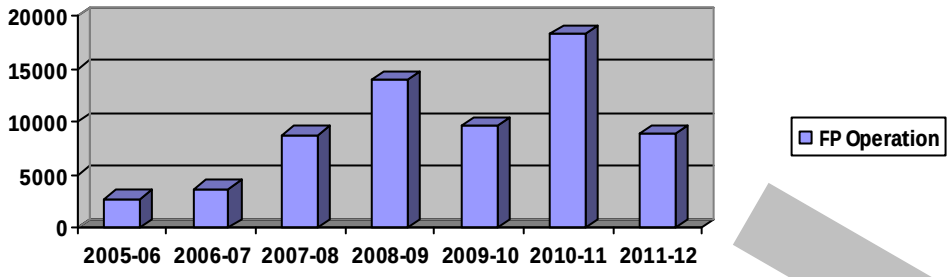
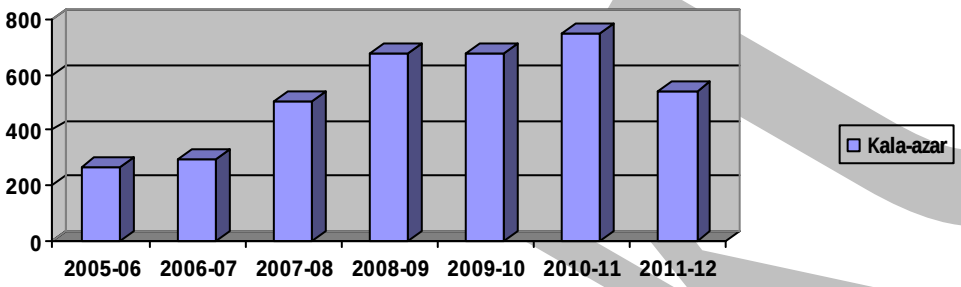
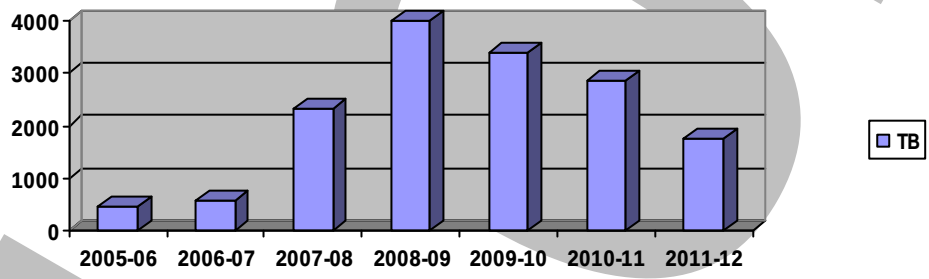


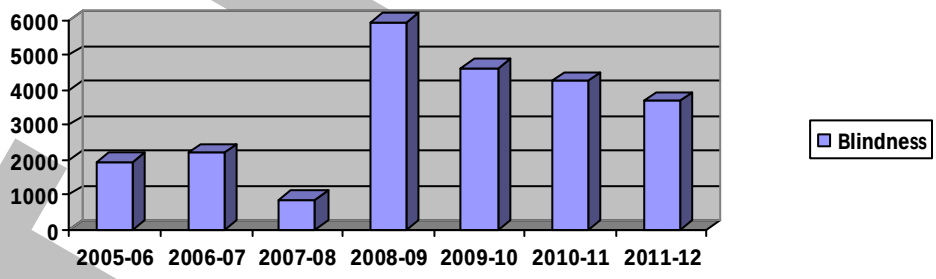
Kala-azar



TB



Blindness



Vitamin A

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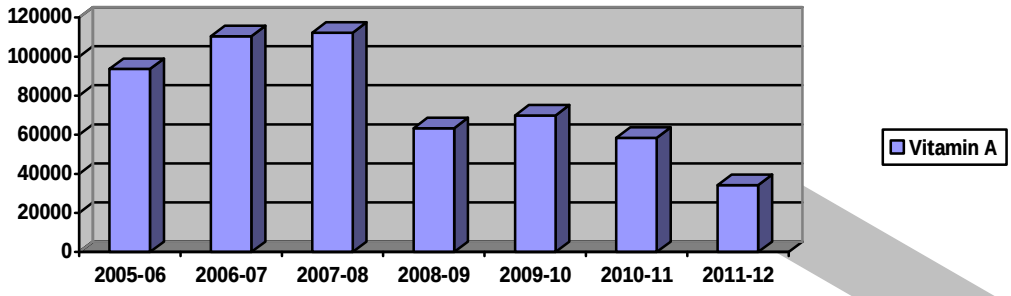
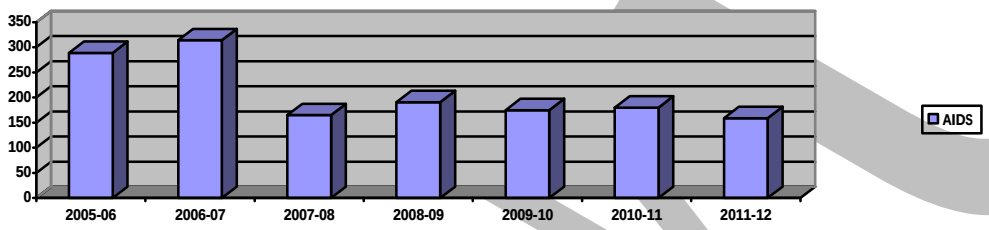
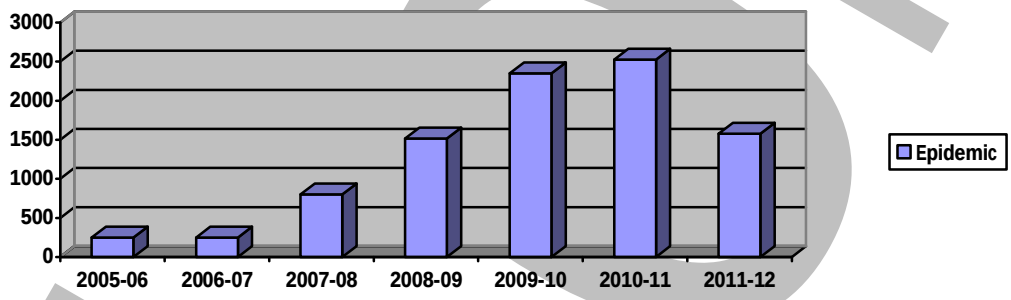


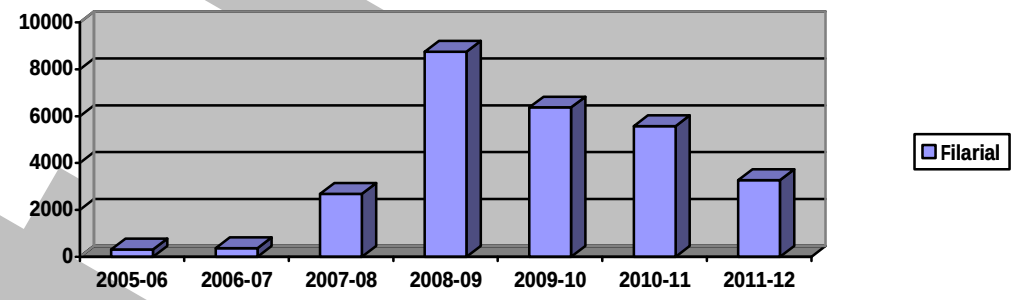
AIDS



Epidemic (Diarrhea / Dysentery)



Filarial



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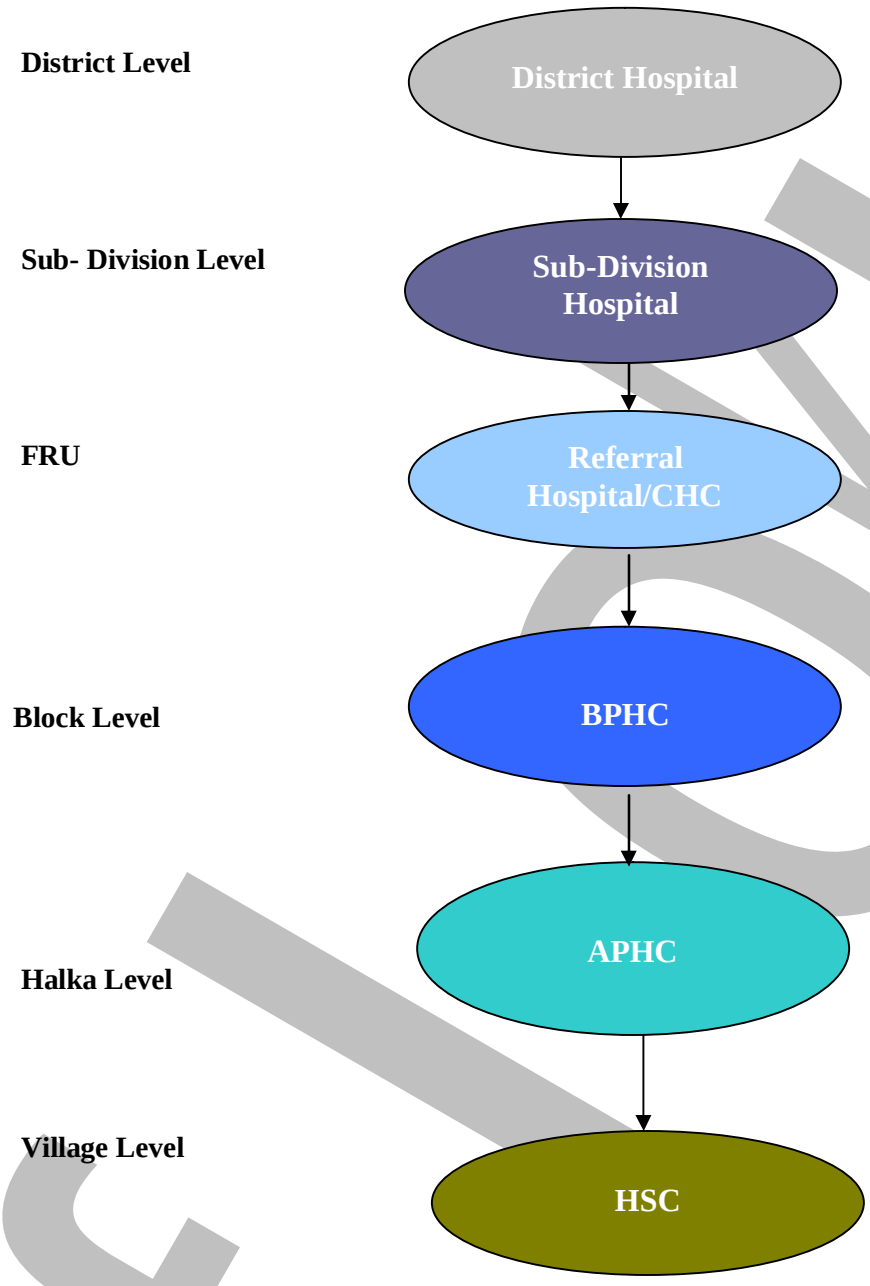
Chapter IV: Situation Analysis For HSC, APHC, BPHC & DH

On different level, there are various institutions in the health system from where health facilities are being provided to the people. The IPH standard specifies the properties, requirements and service specifications of all institutions. In the network of health system of a district, there are following hierarchy of institutions at different level :-



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In the present situational analysis of Siwan district, we will try to find out answer of the following questions-

- Is there sufficient no. of HSC, APHC, BPHC, CHC, Sub-divisional hospital & District Hospital sanctioned as per IPH standard?
- What are the gaps between no. of required and sanctioned institutions?
- Whether all institutions have resources, manpower and infrastructure as per IPH norms or not?
- Whether all institutions are providing the health services as per IPH norms or not?
- Is there sufficient fund allotment for institutions and programs?
- What are the activities that will improve the quality of services and will make it more reliable?

The situation analysis on the basis of no. of institutions, infrastructure, manpower, services and budget is given below

4.1 Health Sub Center:

Health Sub Center is the first line service deliverable institutions from where different type of services is provided to women and children. The objectives of IPHS for Sub-Centre 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.

No. of Institutions (Health Sub Center)

As per IPH standard at every 5000 population one HSC has to be established.

District Population (2011)	Maximum HSC required as per IPH Norms @ 5000 people	No. of Sub center already sanctioned/established	Gaps in No. of HSC
3318176	**593**	**375**	**218**

To obtain 100% IPH standard -: Need to sanction 218 new HSC to achieve 100% IPH standard.
Task for 2012-13 -:

- **Out of 375 sanctioned Some HSC are not established so far. So, in financial year 2012-13, the first priority should be given to these non-functional HSC.**
- **25% of gaps i.e 54 HSC can be sanctioned more to minimize the gaps.**

4.1.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task 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.	**593 (Max. HSC as per IPHS)**	**81 (Already having building)**	**512**	**25% of gaps =128**
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			

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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 593 = 593 2X 593 = 1186 3X 593 = 1779 1X 593 = 593 1X 593 = 593 1X 593 = 593 1X 593 = 593 1X 593 = 593 1X 593 = 593 2X 593 = 1186 1X 593 = 593 3X 593 = 1779 2X 593 = 1186 3X 593 = 1779 3X 593 = 1779 1X 593 = 593	**375 HSC are sanctioned that need all these furniture. Some HSC have some furniture but worth disposable.**	**593**	All sanctioned/e stablished HSC i.e.375
Equipment	Basin Kidney 825 ml Tray instrument Jar Dressing Hemoglobin meter ForcepsTissue160 mm Forceps sterilizer Scissors surgical Reagent strips for urine Scale, Infant metric Sterilization kit Vaccine Carrier Ice pack box Forceps Suture needle straight Suture needle curved Syringe Disposable gloves Clinical Thermometer Torch weighing (baby) weighing (Women) Stethoscope	2X593=1186 1X593=593 1X593=593 1X593=593 1X593=593 1X593=593 1X593=593 1X593=593 2X593=1186 8X593=4744 20X593=11860 12X593=7116 12X593=7116 12X593=7116 20X593=11860 1X593=593 20X593=11860 1X= 593 1x 593= 593 1X593= 593 1X593= 593 1X593= 593	**375 HSC are sanctioned that need all these equipments.**	**593**	All sanctioned/e stablished HSC i.e. 375

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Drugs	**Kit A** ORS IFA Tab. (large) IFA Tab. (small) Vit. A Solution(100 ml) Cotrimoxazole Tab(child) **Kit B** Tab. Methylergometrine Maleate (0.125 mg) Paractamol (500 mg) Inj.Methylergometrine Maleate Tab.Mebendazole(100 mg) Tab.Dicyclomine HCl. (10 mg) Ointment Povidone Iodine 5% Cetrimide Powder Cotton Bandage Absorbant Cotton (100 gm each)	150X593= 15000X593= 13000X593= 6X593= 1000X593= 480X593= 500X593= 10X593= 300X593 180X593= 5X593= 125X593= 120X593= 10X593=	**375 HSC are sanctioned that need all these drugs.**	**593**	All sanctioned/e stablished HSC i.e 375
Laboratory	Minimum facilities like estimation of haemoglobin by using a approved **Haemoglobin Colour Scale**, urine test for the presence of protein by using **Uristix,** and urine test for the presence of sugar by using **Diastix** should be available. **Haemoglobin Colour Scale** **Uristix** **Diastix**	1X593=593 1X593=593 1X593=593	**375 HSC are sanctioned that need all these equipments.**	**593**	All sanctioned/e stablished HSC i.e 375
Electricity	Wherever facility exists, uninterrupted power supply has to be ensured for which inverter facility / solar power facility is to be provided. Solar power set	1X593=593	**375 HSC are sanctioned that need Solar power sets.**	**593**	All sanctioned/e stablished HSC i.e 375
Water	Potable water for patients and staff and water for other uses should bein adequate quantity. Towards this end, adequate water supply should be ensured and safe water may be provided by use of technology like filtration, chlorination, etc. as per the suitability of the center.	Safe water available everywhere			

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Telephone	**Where ever feasible, telephone facility / cell phone facility is to be provided. Mobile phone**	1X593=593	**375 HSC are sanctioned and need Mobile Phone**	**593**	All sanctioned/established HSC i.e 375

⇨ 4.1.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2012-13
Health worker (female)	2	2 X 593=1186	793	393	375x2=750 56x2=112
Health worker (male)	1 (funded and appointment by the state government)	1 X 593=593	0	593	375

⇨ 4.1.3 Services And others

Sub Heads	Gaps	Issues	Strategy	Activities
Infrastructure	**Out of 375 only 81 HSC have its own building, remaining are running in rented building.**	**1**. Non payment of rent **2.** Land availability for new building	**1.** Ensuring payment of rent till own buildings are not constructed. **2.** Involve DM to arrange land.	**1.** Budget to construct 143 HSC is given above. Construction of building is time taking process. So, timely payment of rent is needed **2.** DM should instruct the CO to arrange land for HSC.
	Lack of Equipments, Drugs, Furniture , Power	**HSC are working but without resources**	Purchasing Equipments, Drugs, Furniture, Power etc. as per IPH standard.	No, excuse. There is no other way except purchasing all required resources.
	Formats/Registers and Stationeries **(Untied fund)**	**Always it is found that HSC is lacking stationeries**	Arrangements of fund for these miscellaneous expenses.	Untied fund are available but problem in chandelling. Untied fund is operated jointly by ANM & PRI people but they have no proper knowledge to handle it. Only one PRI e.i Mukhiya (Pradhan) should be authorized for joint account and then proper orientation should be given them.

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Services of HSCs	**No institutional delivery at HSC level**	Skilled staff to perform institutional delivery is available but lacking resources.	Arrange all required resources to perform institutional delivery.	Purchase Drug, equipments, furniture as per IPHS. Arrangement of Ambulance at APHC & PHC level to quickly send patients in bigger hospital in case of complications.
	Poor ANC	1. In compare to delivery there are poor percentage of pregnant women registration. 2. Minimum three antenatal check-ups	1. Make community aware about the merit of ANC 2. Make system more reliable.	1. Need to aware village women through orientation program. Regular supply of TT & IFA. 2. Ensure availability of drug and equipments necessary for check up
	Poor Post Natal Care	1.A minimum of 2 postpartum home visits 2. Initiation of early breast-feeding within half-hour of birth 3. Counseling on diet & rest, hygiene, contraception, essential new born care, Infant and young child feeding.	Ensuring minimum 2 postpartum visit at home. Ensuring counseling on early breath feeding, on diet & rest, hygiene, contraception, essential new born care	Strict rule to compel ANM to visit at home. Orientation & Training program of ANM over early breath feeding, on diet & rest, hygiene, contraception, essential new born care
	Family Planning and Contraception	1. Education, Motivation and counseling to adopt appropriate Family planning methods 2. Provision of contraceptives such as condoms, oral pills, emergency contraceptives. 3. IUD insertions	Increase No. of FP operation & promotion of the use of contraceptives	1.Tubectomy operation is going good but to increase the no. of vasectomy operation counseling of male are necessary. 2. Ensure the availability contraceptives such as condoms, oral pills, emergency contraceptives 3. Training of ANM on IUD insertion is required.
	No MTP	Counseling and appropriate referral for safe abortion services (MTP) for those in need.	Start MTP Services at HSC level.	First purchase the essential equipments and drugs listed above. Training/refreshing course of suitable ANM.

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Services of HSCs	**RNTCP**	Eradication of TB	Easy availability of drugs & referral of patients.	Referral of suspected symptomatic cases to the PHC/Microscopy center • Provision of DOTS at Subcentre and proper documentation and follow-up
	AIDS, Blindness, Leprosy, Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics	Eradication & Control	Making people aware about these disease	IEC activities to enhance awareness and preventive measures about AIDS, Blindness, Leprosy, Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics
	Child Immunization	1. No 100% child immunization 2. Drop out cases 3. Shortage of vaccine.	Working at various level to obtain 100 % child immunization.	1. Preparation of micro plan at PHC level. Special Plan for hard to reach area. 2. Proper monitoring. 3. Filling up immunization card to follow up. 4. Vaccine is supplied from state that is irregular. So, ensure availability of all vaccine to increase reliability. 5. To control drop out cases if possible new vaccine like **Easy 5** and **MMR** should supply.

➢ 4.2 Additional Primary Health Center (APHC) :

Additional Primary Health Center are the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-center for curative, preventive and promotive health care. A typical Primary Health Center covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with 4-6 indoor/observation beds. It acts as a referral unit for 6 sub-center and refer out cases to PHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level.
The objectives of IPHS for APHCs are:

i. To provide comprehensive primary health care to the community through the Additional Primary Health Center.
ii. To achieve and maintain an acceptable standard of quality of care.
iii. To make the services more responsive and sensitive to the needs of the community.

No. of Institutions (Additional Primary Health center)

As per IPH standard at every 30,000 population one APHC has to be established.

District Population (2011)	Maximum APHC required as per IPH Norms @ 30,000 people	No. of APHC already sanctioned/established	Gaps in No. of APHC
3323360	**104**	**54**	**50**

To obtain 100% IPH standard -: Need to sanction 51 new APHC to achieve 100% IPH standard.

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Task for 2012-13 :-

- Out of 54 sanctioned APHC Some APHC are not established so far. So, in financial year 2012-13, the first priority should be given to these non-functional APHC.
- 25% of gaps i.e. 13 APHC can be sanctioned more to minimize the gaps.

⇨ 4.2.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2012-13
Physical Infrastructure	It should be well planned with the entire necessary infrastructure. It should be well lit and ventilated with as much use of natural light and ventilation as possible. The plinth area would vary from 375 to 450 sq. meters depending on whether an OT facility is opted for.	**104 (Max. APHC as per IPHS)**	**16 (Already having building but requires renovation)**	**50**	**25% of gaps = 13**
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 3 Writing tables with table sheets 5 Plastic chairs 6 Armless chairs 8 Full steel almirah 4 Labour table 1 OT table 1 Arm board for adult and child 4 Wheel chair 1 Stretcher on trolley 1 Instrument trolley 2 Wooden screen 1 Foot step 5 Coat rack 2 Bed side table 6 Bed stead iron 6 Baby cot 1 Stool 6 Medicine chest 1 Lamp 3 Shadowless lamp light (for OT and Labour room) 2 Side Wooden racks 4 Fans 6 Tube light 8 Basin 2 Basin stand 2 Sundry Articles including Linen: Buckets 4 Mugs 4	Maximum APHC is 104 so requirement is accordingly	**54 APHC are sanctioned that need all these furniture. Since almost all APHC are non-functional so, everywhere these furniture are required.**	**50**	All sanctioned/ established APHC i.e 50

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	LPG stove 1 LPG cylinder 2 Sauce pan with lid 2 Water receptacle 2 Rubber/plastic shutting 2 meters Drum with tap for storing water 2 I V stand 4 Mattress for beds 6 Foam Mattress for OT table 1 Foam Mattress for labour table 1 Macintosh for labour and OT table 4 metres Kelly's pad for labour and OT table 2 sets Bed sheets 6 Pillows with covers 8 Blankets 6 Baby blankets 2 Towels 6 Curtains with rods 20 metres				
Equipment	• Normal Delivery Kit • Equipment for assisted vacuum delivery • Equipment for assisted forceps delivery • Standard Surgical Set • Equipment for New Born Care and Neonatal Resuscitation • IUD insertion kit • Equipment / reagents for essential laboratory investigations • Refrigerator • ILR/Deep Freezer • Ice box • Computer with accessories including internet facility • Baby warmer/incubator. • Binocular microscope • Equipments for Eye care and vision testing • Equipments under various National Programmes • Radiant warmer for new borne baby • Baby scale • Table lamp with 200 watt bulb for new borne baby • Phototherapy unit • Self inflating bag and mask-neonatal size • Laryngoscope and Endotracheal intubation tubes (neonatal) • Mucus extractor with suction tube and a foot operated suction machine • Feeding tubes for baby 28 • Sponge holding forceps - 2	**Maximum APHC is 104 so requirement is accordingly**	**54 APHC are sanctioned that need all these equipments.**	**104**	All sanctioned/ established APHCs i.e. 54

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	• Valsellum uterine forceps - 2 • Tenaculum uterine forceps – 2 • MVA syringe and cannulae of sizes 4-8 • Kidney tray for emptying contents of MVA syringe • Trainer for tissues • Torch without batteries – 2 • Battery dry cells 1.5 volt (large size) – 4 • Bowl for antiseptic solution for soaking cotton swabs • Tray containing chlorine solution for keeping soiled instruments • Residual chlorine in drinking water testing kits • H2S Strip test bottles				
Drugs	Paracetamol Tab- 500mg per Tab. Paracetamol Syrup- 125mg/5ml-60ml Atropine - Inj. 0.6 mg per 1ml amps Ciprofloxacin - Tab 500mg/Tab Co Trimoxazole Tab 160 + 800 mg Tab Gentamycin - Inj M.D. vial (40 mg/ml)-30ml vial Oxytocin - Inj-Amp 1 ml (5i.u./ml) 5% Dextrose 500 ml bottle B Complex Tab Gentamicin - Ear/Eye Drop 5 ml Promethazine - Inj-Amp. 2ml amps (25 mg/ml) Pentazocine Lactate Inj. Inj-Amp.- 1 ml (30 mg/ml) Diazepam - Inj-Amp. 2ml amps (5mg/ml) Cough Expectorant 100 ml pack Ampicillin 250mg Capsule Ampicillin 500mg Capsule Cetrizine Tablet - 10mg Doxycycline Capsule-100mg Etophylline & Theophylline Inj.- 2ml Fluconazole Tablet – 200mg Dicyclomine Tablets -20mg Dexamethasone	**Maximum APHC is 104 so requirement is accordingly**	**54 APHC are sanctioned that need all these equipments.**	**104**	All sanctioned/established APHC i.e 50

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	Inj.- 4mg/ml- 10ml Vial Atropine Inj. 0.6mg/ml - 1ml Ampoule Lignocaine Solution 2% Solution 2%- 30ml Vial Diazepam Tablet- 5mg Chlorpheniramine Maleate - Tablet- 4mg Cephalexin) - Capsule- 250mg Metronidazole - Tablet- 200mg Ranitidine Hydochloride - Tablet 150mg Metoclopramide - Tablet- 10mg Diethylcarbamazine - Tablet- 50mg Paracetamol Dicyclomine - Tablet (500mg+20mg) Fluconazole - Tablet 50mg Diethylcarbamazine - Tablet- 100mg Xylometazoline - Drops - 0.1% (Nasal) 10ml vial. A.R.V. Theophyline IP Combn. 25.3mg/ml Aminophyline Inj. IP 25mg/ml Adrenaline Bitrate Inj. IP 1mg/ml Methyl Ergometrine Maleate 125mg/Tablet, Injection Amoxycilline Trilhydrate IP 250mg/Capsule Amoxycilline Trilhydrate IP 250mg/Dispersible Tab. Phenoxymethyl Penicillin 130mg/ml Vit K3 (Menadione Inj.) USP 100mg/ml Nalidixic Acid Tabs. 100mg/Tab Phenytoin Sodium Inj. IP 50mg/2ml Chlorpromazine Hydrochloride 25mg/ml Cephalexin /Ceptrofloxin 250mg/Tablet Sodium Chloride Inj. IP I.V. Solution 0.9w/v Gama Benzine hexa Chloride As decided by CS Plasma Volume Expander As decided by CS Inj. Magnesium Inj. 50% preparation Hydralazine Misoprostol 200mg/Tablet				

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Laboratory	1. Routine urine, stool and blood tests 2. Bleeding time, clotting time, 3. Diagnosis of RTI/ STDs with wet mounting, Grams stain, etc. 4. Sputum testing for tuberculosis (if designated as a microscopy center under RNTCP) 5. Blood smear examination for malarial parasite. 6. Rapid tests for pregnancy / malaria 7. RPR test for Syphilis/YAWS surveillance 8. Rapid diagnostic tests for Typhoid (Typhi Dot) 9. Rapid test kit for fecal contamination of water 10. Estimation of chlorine level of water using ortho-toludine reagent	**Maximum APHC is 104 so requirement is accordingly**	**54 APHC are sanctioned that need all these equipments.**	**104**	All sanctioned/established APHC i.e 50
Electricity	Wherever facility exists**,** uninterrupted power supply has to be ensured for which Generator and inverter facility is to be provided.	**Maximum APHC is 104 so requirement is accordingly**	**54 APHC are sanctioned that need power supply.**	**104**	All sanctioned/established APHC i.e 50
Water	Potable water for patients and staff and water for other uses should be in adequate quantity. Towards this end, adequate water supply should be ensured and safe water may be provided by use of technology like filtration, chlorination, etc. as per the suitability of the center.	Safe water available everywhere			
Telephone	Where ever feasible, telephone facility / cell phone facility is to be **provided.**	**Maximum APHC is 104 so requirement is accordingly**	**54APHC are sanctioned that need Telephone facility.**	**104**	All sanctioned/ established APHC i.e

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Transport	The APHC should have an ambulance for transport of patients. **This may be outsourced.**	**Maximum APHC is 104 so requirement is accordingly**	**54 APHC are sanctioned that need Telephone facility.**	**104**	All sanctioned/established APHC i.e
Laundry and Dietary facilities	Laundry and Dietary facilities for indoor patients: **these facilities can be outsourced**.	**Maximum APHC is 104 so requirement is accordingly**	**54APHC are sanctioned that need Telephone facility.**	**104**	All sanctioned/established APHC i.e

⇨ 4.2.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2012-13
Medical Officer MBBS – 1 Ayush - 1	2	2X104=208	35 (Ayush)	173	54 x2=104
Pharmacist	1	1X104=104	1	103	1 x54=54
Nurse-midwife (Staff Nurse)	3	3X104=312	2	310	3x54=162
Health workers (F)	1	1X104=104	1	103	1x54=108
Health Educator	1	1X104=104	23	81	1x54=108
Health Asstt (Male & Female)	2	2X104=208	35	173	2x54=108
Clerks	2	2X104=208	30	178	2x54=108
Laboratory Technician	1	1X104=104	1	103	1x54=54
Driver	Outsourced				
Class IV	4	4X104=416	33	383	4x54=216

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⇨ 4.2.3 Services and others

Sub Heads	Gaps	Issues	Strategy	Activities
Infrastructure	**Out of 54 only 16APHC have its own building, remaining are running in rented building.**	**1**. Nonpayment of rent **2.** Land availability for new building	**1.** Ensuring payment of rent till own buildings are not constructed. **2.** Involve DM to arrange land.	**1.** Budget to construct APHC is given above. Construction of building is time taking process. So, timely payment of rent is needed **2.** DM should instruct the CO to arrange land for HSC.
	Lack of Equipments, Drugs, Furniture, Power	**APHC are working but without resources**	Purchasing Equipments, Drugs, Furniture, Power etc. as per IPH standard.	No, excuse. There is no other way except purchasing all required resources.
	Formats/Registers and Stationeries (Untied fund)	**Always it is found that APHC is lacking stationeries**	Arrangements of fund for these miscellaneous expenses.	Untied fund provision under control of RKS.
Services of APHC	**No institutional delivery at APHC level**	**No services of delivery**	Arrange all required resources and manpower to start institutional delivery.	▪ Purchase Drug, equipments, furniture as per IPHS. ▪ Hire required manpower to support this service. ▪ Arrangement of Ambulance at APHC level to quickly send patients in bigger hospital in case of complications.
	Medical care	**Non Functional**	▪ OPD Services ▪ 24 hours emergency services ▪ Referral services ▪ In-patient services (6 beds)	▪ hours in the morning and 2 hours in the evening ▪ Minimum OPD attendance should be 40 patients per doctor per day. ▪ Appropriate management of injuries and accident, First Aid, Stabilization of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions ▪ Ambulance Service to support referral ▪ Provision of diet, light, laundry etc to start indoor service.

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	Maternal and Child Health Care	**Non functional**	▪ Antenatal care ▪ Intra-natal care ▪ Postnatal Care ▪ New Born care ▪ Care of the child	▪ start immunization properly. ▪ start JBSY at APHC level ▪ Establish lab for minimum investigations like hemoglobin, urine albumin, and sugar, RPR test for syphilis ▪ Nutrition and health counseling ▪ Promotion of institutional deliveries ▪ Conducting of normal deliveries ▪ Assisted vaginal deliveries including forceps / vacuum delivery whenever required ▪ Manual removal of placenta ▪ Appropriate and prompt referral for cases needing specialist care. ▪ Management of Pregnancy Induced hypertension including referral Pre-referral management ▪ A minimum of 2 Postpartum home visits, first within 48 hours of delivery, 2nd within 7 days through Sub-center staff. ▪ Initiation of early breast-feeding within half-hour of birth ▪ Education on nutrition, hygiene, contraception, **essential new born care.**
	Family Planning, Contraception & MTP	**No FP operation at APHC level.**	1. Start FP operation 2. Distribution of contraceptives such as condoms, oral pills, emergency Contraceptives. 3. IUD insertions	▪ Education, Motivation and counseling to adopt appropriate Family planning methods. ▪ Provision of contraceptives such as condoms, oral pills, emergency Contraceptives, IUD insertions. ▪ Permanent methods like Tubal ligation and vasectomy / NSV. ▪ Follow up services to the eligible couples adopting permanent methods Counseling and appropriate referral for safe abortion services (MTP) for those in need. Counseling and appropriate referral for couples having infertility.
	RNTCP	**No DOT center at APHC**	Treatment and Distribution of drug.	▪ All APHCs to function as DOTS Centers to deliver treatment as per RNTCP treatment guidelines through DOTS providers and treatment of common complications of TB and side effects of drugs, record and report on RNTCP activities as per guidelines.

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	Integrated Disease Surveillance Project (IDSP)	No IDSP	Need to start IDSP	▪ APHC will collect and analyze data from sub-center and will report Information to PHC surveillance unit. ▪ Appropriate preparedness and first level action in out-break situations. ▪ Laboratory services for diagnosis of Malaria, Tuberculosis, Typhoid and tests for detection of faucal Contamination of water (Rapid test kit) and chlorination level.
	National Program for Control of Blindness (NPCB)	**No NPCB program**	Need to start NPCB Program	▪ Diagnosis and treatment of common eye diseases. ▪ Refraction Services. ▪ Detection of cataract cases and referral for cataract surgery.
	National AIDS Control Program		Starting AIDS control program at APHC level	▪ IEC activities to enhance awareness and preventive measures about STIs and HIV/AIDS, Prevention of Parents to Child Transmission ▪ Organizing School Health Education Programme (c) Screening of persons practicing high-risk behavior with one rapid test to be conducted at the APHC level and development of referral linkages with the nearest VCTC at the District Hospital level for confirmation of ▪ HIV status of those found positive at one test stage in the high prevalence states. ▪ Risk screening of antenatal mothers with one rapid test for HIV and to establish referral linkages with CHC or District Hospital for PPTCT services. ▪ Linkage with Microscopy Center for HIV-TB coordination. ▪ Condom Promotion & distribution of condoms to the high risk groups. ▪ Help and guide patients with HIV/AIDS receiving ART with focus on Adherence.

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	Leprosy, Malaria, Kala- azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics	Eradication & Control	Making people aware about these disease and providing treatments	▪ IEC activities to enhance awareness and preventive measures about AIDS, Blindness, Leprosy, Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics ▪ Starting treatment of patients if reported. ▪ Referral facilities for better treatment.

➢ 4.3 Primary Health Center (PHC):

Primary Health Centers exist to provide health care to every citizen of India within the allocated resources and available facilities. The Charter seeks to provide a framework which enables citizens to know.

- what services are available?
- the quality of services they are entitled to.
- the means through which complaints regarding denial or poor qualities of services will be addressed.

Objectives

- to make available medical treatment and the related facilities for citizens.
- to provide appropriate advice, treatment and support that would help to cure the ailment to the extent medically possible.
- to ensure that treatment is best on well considered judgment, is timely and comprehensive and with the consent of the citizen being treated.
- to ensure you just awareness of the nature of the ailment, progress of treatment, duration of treatment and impact on their health and lives, and
- to redress any grievances in this regard.

No. of Institutions (Primary Health center)

As per IPH standard at every 1,00,000 population one PHC has to be established.

District Population (2009)	Maximum PHC required as per IPH Norms @ 1,00,000 people	No. of PHC already sanctioned/established	Gaps in No. of PHC
3318176	**32**	**19**	**13**

To obtain 100% IPH standard :- Need to sanction 13 new PHC to achieve 100% IPH standard**.**

Task for 2012-13 :-

- Out of 19 sanctioned PHC all 19 PHC are established and functioning. So, in financial year 2012-13, 25% of gaps i.e. 3 PHC can be sanctioned more to minimize the gaps.

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⇨ 4.3.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2012-13
Physical Infrastructure	The PHC should have 30 indoor beds with one Operation theatre, labour room, X-ray facility and laboratory facility. It should be well lit and ventilated with as much use of natural light and ventilation as possible. The plinth area would vary from 375 to 450 sq. meters depending on whether an OT facility is opted for.	**32 (Max. PHC as per IPHS)**	**19 PHC are functional out of which 1 have no building. (Existing buildings require renovation)**	**13**	**1 new building**
Waste Disposal	Waste disposal should be carried out as per the GOI guidelines, which is under preparation	Nothing to do because GOI uideline is not prepared			
Furniture	Examination table 3 Writing tables with table sheets 5 Plastic chairs 6 Armless chairs 8 Full steel almirah 4 Labour table 1 OT table 1 Arm board for adult and child 4 Wheel chair 1 Stretcher on trolley 1 Instrument trolley 2 Wooden screen 1 Foot step 5 Coat rack 2 Bed side table 6 Bed stead iron 6 Baby cot 1 Stool 6 Medicine chest 1 Lamp 3 Shadowless lamp light (for OT and Labour room) 2 Side Wooden racks 4 Fans 6 Tube light 8 Basin 2 Basin stand 2 Sundry Articles including Linen: Buckets 4 Mugs 4 LPG stove 1 LPG cylinder 2 Sauce pan with lid 2	Working PHC is 19 so requirement is accordingly	**19 PHC are sanctioned that need all these furniture.**	**13**	All sanctioned/established PHC i.e 19

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	Water receptacle 2 Rubber/plastic shutting 2 meters Drum with tap for storing water 2 I V stand 4 Mattress for beds 6 Foam Mattress for OT table 1 Foam Mattress for labour table 1 Macintosh for labour and OT table 4 metres Kelly's pad for labour and OT table 2 sets Bed sheets 6 Pillows with covers 8 Blankets 6 Baby blankets 2 Towels 6 Curtains with rods 20 metres				
Equipment	• Normal Delivery Kit • Equipment for assisted vacuum delivery • Equipment for assisted forceps delivery • Standard Surgical Set • Equipment for New Born Care and Neonatal Resuscitation • IUD insertion kit • Equipment / reagents for essential laboratory investigations • Refrigerator • ILR/Deep Freezer • Ice box • Computer with accessories including internet facility • Baby warmer/incubator. • Binocular microscope • Equipments for Eye care and vision testing • Equipments under various National Programmes • Radiant warmer for new borne baby • Baby scale • Table lamp with 200 watt bulb for new borne baby • Phototherapy unit • Self inflating bag and mask-neonatal size • Laryngoscope and Endotracheal	**Working PHC is 19 so requirement is accordingly**	**19 PHC are sanctioned that need all these equipments.**	**19**	All sanctioned/established PHC is 19

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	intubations tubes (neonatal) • Mucus extractor with suction tube and a foot operated suction machine • Feeding tubes for baby 28 • Sponge holding forceps - 2 • Valsellum uterine forceps - 2 • Tenaculum uterine forceps – 2 • MVA syringe and cannulae of sizes 4-8 • Kidney tray for emptying contents of MVA syringe • Trainer for tissues • Torch without batteries – 2 • Battery dry cells 1.5 volt (large size) – 4 • Bowl for antiseptic solution for soaking cotton swabs • Tray containing chlorine solution for keeping soiled instruments • Residual chlorine in drinking water testing kits • H2S Strip test bottles				
Drugs	Paracetamol Tab- 500mg per Tab. Paracetamol Syrup- 125mg/5ml-60ml Atropine - Inj. 0.6 mg per 1ml amps Ciprofloxacin - Tab 500mg/Tab Co Trimoxazole Tab 160 + 800 mg Tab Gentamycin - Inj M.D. vial (40 mg/ml)-30ml vial Oxytocin - Inj-Amp 1 ml (5i.u./ml) 5% Dextrose 500 ml bottle B Complex Tab Gentamicin - Ear/Eye Drop 5 ml Promethazine - Inj-Amp. 2ml amps (25 mg/ml) Pentazocine Lactate Inj. Inj-Amp.- 1 ml (30 mg/ml) Diazepam - Inj-Amp. 2ml amps (5mg/ml) Cough Expectorant 100 ml pack	**Maximum PHC is 19 so requirement is accordingly**	**19 PHC are sanctioned that need all these equipments.**	**13**	All sanctioned/established PHC i.e 19

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	Ampicillin 250mg Capsule Ampicillin 500mg Capsule Cetrizine Tablet - 10mg Doxycycline Capsule-100mg Etophylline & Theophylline Inj.- 2ml Fluconazole Tablet – 200mg Dicyclomine Tablets -20mg Dexamethasone Inj.- 4mg/ml- 10ml Vial Atropine Inj. 0.6mg/ml - 1ml Ampoule Lignocaine Solution 2% Solution 2%- 30ml Vial Diazepam Tablet- 5mg Chlorpheniramine Maleate - Tablet- 4mg Cephalexin) - Capsule- 250mg Metronidazole - Tablet- 200mg Ranitidine Hydochloride - Tablet 150mg Metoclopramide - Tablet- 10mg Diethylcarbamazine - Tablet- 50mg Paracetamol Dicyclomine - Tablet (500mg+20mg) Fluconazole - Tablet 50mg Diethylcarbamazine - Tablet- 100mg Xylometazoline - Drops - 0.1% (Nasal) 10ml vial. A.R.V. Theophyline IP Combn. 25.3mg/ml Aminophyline Inj. IP 25mg/ml Adrenaline Bitrate Inj. IP 1mg/ml Methyl Ergometrine Maleate 125mg/Tablet, Injection Amoxycilline Trilhydrate IP 250mg/Capsule Amoxycilline Trilhydrate IP				

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	250mg/Dispersible Tab. Phenoxymethyl Penicillin 130mg/ml Vit K3 (Menadione Inj.) USP 100mg/ml Nalidixic Acid Tabs. 100mg/Tab Phenytoin Sodium Inj. IP 50mg/2ml Chlorpromazine Hydrochloride 25mg/ml Cephalexin /Ceptrofloxin 250mg/Tablet Sodium Chloride Inj. IP I.V. Solution 0.9w/v Gama Benzine hexa Chloride As decided by CS Plasma Volume Expander As decided by CS Inj. Magnesium Inj. 50% preparation Hydralazine Misoprostol 200mg/Tablet				
Laboratory	1. Routine urine, stool and blood tests 2. Bleeding time, clotting time, 3. Diagnosis of RTI/ STDs with wet mounting, Grams stain, etc. 4. Sputum testing for tuberculosis (if designated as a microscopy center under RNTCP) 5. Blood smear examination for malarial parasite. 6. Rapid tests for pregnancy / malaria 7. RPR test for Syphilis/YAWS surveillance 8. Rapid diagnostic tests for Typhoid (Typhi Dot) 9. Rapid test kit for fecal contamination of water 10. Estimation of chlorine level of water using ortho-toludine reagent	**Maximum PHC is 19 so requirement is accordingly**	**19 PHC are sanctioned that need all these equipments.**	**13**	All sanctioned/established PHC i.e 19

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Electricity	Wherever facility exists**,** uninterrupted power supply has to be ensured for which Generator and inverter facility is to be provided.	**Maximum PHC is 19 so requirement is accordingly**		**13**	All sanctioned/established PHC i.e. 19
Water	Potable water for patients and staff and water for other uses should be in adequate quantity. Towards this end, adequate water supply should be ensured and safe water may be provided by use of technology like filtration, chlorination, etc. as per the suitability of the center.	Safe water available everywhere			
Telephone	Where ever feasible, telephone facility / cell phone facility is to be provided.	**19 PHC is existing so requirement is accordingly**	**15 existing PHC have telephone.**	**13**	4 Newly PHC requires new connection
Transport	The APHC should have an ambulance for transport of patients. **This may be outsourced.**	**19 PHC is existing so requirement is accordingly**	**19 existing PHC have Ambulance.**	**13**	All sanctioned/established PHC
Laundry and Dietary facilities	Laundry and Dietary facilities for indoor patients: **these facilities can be outsourced**.	**19 PHC is existing so requirement is accordingly**	**All sanctioned PHC requires this facility.**	**13**	All sanctioned/established PHC i.e.

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⇨ 4.3.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2012-13
General Surgeon	1	19X1=19	4	15	15
Physician	1	19X1=19	2	17	17
Obstetrician/ Gynecologist	1	19X1=19	2	17	17
Pediatrics	1	19X1=19	1	18	18
Anesthetist	1	19X1=19	0	19	19
Health Manager	1	19X1=19	17	2	2
Eye surgeon	1	19X1=19	0	19	19
Nurse-midwife	9	19X9= 171	46	125	125
Dresser	1	19X1=19	3	16	16
Pharmacist/ compounder	1	19X1=19	2	17	17
Lab. Technician	1	19X1=19	5	14	14
Radiographer	1	19X1=19	0	19	19
Ophthalmic Assistant	1	19X1=19	0	19	19
Ward boys/ nursing orderly	2	19X2= 38	0	38	38
Sweepers	3	19X3= 57			
Chowkidar	1	19X1=19	0	19	19
OPD attendant	1	19X1=19			
Statistical Assistant/ Data entry operator	1	19X1=19	19	0	0
OT attendant	1	19X1=19	0	19	19
Registration clerk	1	19X1=19	0	19	19
Accountant	1	19X1=19	18	1	1

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⇨ 4.3.3 Services and others

Sub Heads	Gaps	Issues	Strategy	Activities
Infrastructure	**Out of 19 only 18 PHC have its own building, remaining are running in rented building.**	**1**. Non payment of rent **2.** Land availability for new building	**1.** Ensuring payment of rent till own buildings are not constructed. **2.** Involve DM to arrange land.	**1.** Budget to construct 4 PHC is given above. Construction of building is time taking process. So, timely payment of rent is needed **2.** DM should instruct the CO to arrange land for HSC.
	Lack of Equipments, Drugs, Furniture, Power	**PHC are working but without resources**	Purchasing Equipments, Drugs, Furniture, Power etc. as per IPH standard.	No, excuse. There is no other way except purchasing all required resources.
	Formats/Registers and Stationeries (Untied fund)	**Always it is found that HSC is lacking stationeries**	Arrangements of fund for these miscellaneous expenses.	Untied fund provision under control of RKS.
Services of PHC	**Delivery at PHC level**	**Delivery services but with poor resources**	Arrange all required resources and manpower to improve the quality of institutional delivery.	▪ Purchase Drug, equipments, furniture as per IPHS. ▪ Hire required manpower to support this service.
	Medical care		▪ Care of routine and emergency cases in surgery ▪ Care of routine and emergency cases in medicine ▪ New-born Care ▪ 24 hours emergency services ▪ Referral services ▪ In-patient services (6 beds)	▪ hours in the morning and 2 hours in the evening ▪ Minimum OPD attendance should be 40 patients per doctor per day. ▪ Appropriate management of injuries and accident, First Aid, Stabilization of the condition of the patient before referral, Dog bite/snake bite/ scorpion bite cases, and other emergency conditions ▪ Ambulance Service to support referral ▪ Provision of diet, light, laundry etc to start indoor service.

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	Maternal and Child Health Care	**Non functional**	▪ 24-hour delivery services including normal and assisted deliveries ▪ Essential and Emergency Obstetric Care ▪ Antenatal care ▪ Intra-natal care ▪ Postnatal Care ▪ New Born care ▪ Care of the child	▪ improve quality of JBSY at PHC level ▪ Establish lab for minimum investigations like haemoglobin, urine albumin, and sugar, RPR test for syphilis ▪ Nutrition and health counseling ▪ Promotion of institutional deliveries ▪ Conducting of normal deliveries ▪ Assisted vaginal deliveries including forceps / vacuum delivery when ever required ▪ Manual removal of placenta ▪ Appropriate and prompt referral for cases needing specialist care. ▪ Management of Pregnancy Induced hypertension including referral ▪ Pre-referral management ▪ A minimum of 2 Postpartum home visits, first within 48 hours of delivery, 2nd within 7 days through Sub-center staff. ▪ Initiation of early breast-feeding within half-hour of birth c) Education on nutrition, hygiene, contraception, **essential new born care**

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	Family Planning, **Contraception & MTP**	**FP operation at PHC level.**	1. Full range of family planning services including Laparoscopic Services 2. Safe Abortion Services 3. Distribution of contraceptives such as condoms, oral pills, emergency contraceptives. 4. IUD insertions	▪ Education, Motivation and counseling to adopt appropriate Family planning methods. ▪ Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions. ▪ Permanent methods like Tubal ligation and vasectomy / NSV. ▪ Follow up services to the eligible couples adopting permanent methods ▪ Counseling and appropriate referral for safe abortion services (MTP) for those in need. ▪ Counseling and appropriate referral for couples having infertility.
	RNTCP	**DOT center at PHC**	Treatment and Distribution of drug.	▪ All PHC function as DOTS Center to deliver treatment as per RNTCP treatment guidelines through DOTS providers and treatment of common complications of TB and side effects of drugs, record and report on RNTCP activities as per guidelines.
	Integrated Disease Surveillance Project (IDSP)	No IDSP	Need to start IDSP	▪ PHC will collect and analyze data from sub-center and will report information to PHC surveillance unit. ▪ Appropriate reparedness and first level action in out-break situations. ▪ Laboratory services for diagnosis of Malaria, Tuberculosis, Typhoid and tests for detection of faucal contamination of water (Rapid test kit) and chlorination level.

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	National Program for Control of Blindness (NPCB)	**No NPCB program**	Need to start NPCB Program	▪ Diagnosis and treatment of common eye diseases. ▪ Refraction Services. ▪ Detection of cataract cases and referral for cataract surgery.
	National AIDS Control Program		Starting AIDS control program at PHC level	▪ IEC activities to enhance awareness and preventive measures about STIs and HIV/AIDS, Prevention of Parents to Child Transmission ▪ Organizing School Health Education Programme (c) Screening of persons practicing high-risk behavior with one rapid test to be conducted at the PHC level and development of referral linkages with the nearest VCTC at the District Hospital level for confirmation of HIV status of those found positive at one test stage in the high prevalence states. ▪ Risk screening of antenatal mothers with one rapid test for HIV and to establish referral linkages with District Hospital for PPTCT services. ▪ Linkage with Microscopy Center for HIV-TB coordination. ▪ Condom Promotion & distribution of condoms to the high risk groups. ▪ Help and guide patients with HIV/AIDS receiving ART with focus on Adherence.
	Leprosy, Malaria, Kala- azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics	Eradication & Control	Making people aware about these disease and providing treatments	▪ IEC activities to enhance awareness and preventive measures about AIDS, Blindness, Leprosy, Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics ▪ Starting treatment of patients if reported. ▪ Referral facilities for better treatment.

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4.4 District Hospital:

District Health System is the fundamental basis for implementing various health policies and delivery of healthcare, management of health services for define geographic areas. District hospitals is an essential component of the district health system and functions as a secondary level of health care which provides curative, preventive and promotive healthcare services to the people in the district.

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

i. To provide comprehensive secondary health care (specialist and referral services) to the community through the District Hospital.

ii. To achieve and maintain an acceptable standard of quality of care. To make the services more responsive and sensitive to the needs of the people of the district and the hospitals/centers from which the cases are referred to the district hospital

No. of Institutions (Sadar Hospital)

As per IPH standard one District Hospital at every district.

District Population (2011)	Maximum DH required as per IPH Norms	No. of DH already sanctioned/established	Gaps in No. of DH
3318176	**1**	**1**	**0**

Task for 2012-13 :-

- **Need to provide required manpower, resources, drugs and equipments to minimize the gaps.**

⇨ 4.4.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2012-13
Physical Infrastructure	An area of 65-85 m^2 per bed has been considered to be reasonable. The area will include the service areas such as waiting space, entrance hall, registration counter, etc. In case of specific requirement of a hospital, flexibility in altering the area is kept.	**1**	**1**	**0**	**500 beds hospital is already proposed so need to complete it.**

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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	Doctor's chair Doctor's Table Duty Table for Nurses Table for Sterilization use Long Benches Stool Wooden Stools Revolving Steel Cup-board Wooden Cup Board Racks -Steel – Wooden Patients Waiting Chairs Attendants Cots Office Chairs Office Table Foot Stools Filing Cabinets (for records) M.R.D. Requirements (record room use) Pediatric cots with railings Cradle Fowler's cot Ortho Facture Table Hospital Cots Hospital Cots Pediatric Wooden Blocks Back rest Dressing Trolley Medicine Almirah Bin racks ICCU Cots Bed Side Screen Medicine Trolley Case Sheet Holders with clip Bed Side Lockers Examination Couch Instrument Trolley Instrument Trolley Mayos Surgical Bin Assorted Wheel Chair Stretcher / Patience Trolley Instrument Tray Assorted Kidney Tray Assorted Basin Assorted Basin Stand Assorted Delivery Table Blood Donar Table	For working 1 District Hospital as per requirement	**1 DH is sanctioned and working and need all these furniture.**	**1**	All sanctioned/ established PHC i.e 1

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	O2 Cylinder Trolley Saline Stand Waste Bucket Dispensing Table Wooden Bed Pan Urinal Male and Female Name Board for cubicals Kitchen Utensils Containers for kitchen Plate, Tumblers Waste Disposal - Bin / drums Waste Disposal - Trolley (SS) Linen Almirah Stores Almirah Arm Board Adult Arm Board Child SS Bucket with Lid Bucket Plastic Ambu bags O2 Cylinder with spanner ward type Diet trolley - stainless steel Needle cutter and melter Thermometer clinical Thermometer Rectal Torch light Cheatles forceps assortted Stomach wash equipment Infra Red lamp Wax bath Emergency Resuscitation Kit-Adult Enema Set				

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Equipment	**As per IPHS norms** • Imaging Equipment • X-ray room accessories • Cardiac equipments • Labor ward equipments • Equipment for New Born Care and Neonatal Resuscitation ▪ ENT equipment ▪ Eye equipment ▪ Dental Equipment ▪ Laboratory equipments ▪ OT equipment ▪ Surgical equipment ▪ Physiotherapy equipments ▪ Endoscopes equipments ▪ Anesthesia equipments • IUD insertion kit • Equipment / reagents for essential laboratory investigations • Refrigerator • ILR/Deep Freezer • Ice box • Computer with accessories including internet facility • Baby warmer/ incubator. • Binocular microscope • Equipments for Eye care and vision testing • Equipments under various National Programmes • Radiant warmer for new borne baby • Baby scale • Table lamp with 200 watt bulb for new borne baby • Photo therapy unit • Self inflating bag and	**Working DH is 1 so requirement is accordingly**	**1 DH is sanctioned that need all these equipments.**	**1**	One sanctioned/established DH

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	mask-neonatal size • Laryngoscope and Endotracheal intubations tubes (neonatal) • Mucus extractor with suction tube and a foot operated suction machine • Feeding tubes for baby 28 • Sponge holding forceps - 2 • Valsellum uterine forceps - 2 • Tenaculum uterine forceps – 2 • MVA syringe and cannulae of sizes 4-8 • Kidney tray for emptying contents of MVA syringe • Trainer for tissues • Torch without batteries – 2 • Battery dry cells 1.5 volt (large size) – 4 • Bowl for antiseptic solution for soaking cotton swabs • Tray containing chlorine solution for keeping soiled instruments • Residual chlorine in drinking water testing kits • H2S Strip test bottles				
Drugs	Dicyclomine Inj- Atropine - Inj. Norfloxacin- Tab Ciprofloxacin - Tab Ciprofloxacin - Tab Co Trimoxazole Tab Amoxicillin- Cap Gentamycin - Inj Albendazole Alprazolam - Tab Ranitidine - Inj Oxytocin - Inj-Amp Methyl Ergometrine Glibenclamide 5% Dextrose 5% Dextrose + 0.9%				

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	B Complex Silver Sulphadiazine oint - Promethazine - Inj-Amp. Pentazocine Lactate Inj. Diazepam - Inj-Amp. Cough Expectorant Ampicillin Ciprofloxacin Thiopentone Cetrizine Doxycycline Ampicillin & Cloxacilin Etophylline & Theophylline Dopamine Hydrochloride Adrenaline Sodium Bicarborate Tinidazole Fluconazole Clotrimazole Cream Dicyclomine Tablets Dexamethasone Digoxin Metformin Atropine Lignocaine Solution 2% Cetrimide Concenterated Diazepam Diclofenac Sodium Carbamazepine Carbamazepine Cephalexin Metronidazole Metronidazole Cefotaxime Atenolol Furosemide Ranitidine Hydochloride Metoclopramide Isosorbide Dinitrate Diethylcarbamazine Ciprofloxacin Metronidazole Cefotaxime Enalapril Enalapril Chloramphenicol Alprazolam Tramadol Dexamethasone Cefotaxime Amlodipine Erythromycin Stearate Cetrizine Omeprazole Prednisolone Diethylcarbamazine Ampicillin Sodium Atenolol Hydroxy progesterone acetate Xylometazoline Prednisolone Betamethasone				

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	Chloram Phenicol Bupivacaine Hydrochloride Succinyl Choline Intermediate acting insulin Lente/NPH Insulin Insulin injection (Soluble) - Inj. 40IU/ml premix insulin (30/70 Human) A.S.V.S. ARV				
Electricity	Wherever facility exists**,** uninterrupted power supply has to be ensured for which Generator and inverter facility is to be provided.	**1 District Hospital**	**Power supply is available.**		All sanctioned/e stablished DH i.e 1
Water	Potable water for patients and staff and water for other uses should be in adequate quantity. Towards this end, adequate water supply should be ensured and safe water may be provided by use of technology like filtration, chlorination, etc. as per the suitability of the center.	Safe water available everywhere			
Telephone	Where ever feasible, telephone facility / cell phone facility is to be **provided.**	**3 Telephone connections required**	**1 telephone is existing .**	**2**	2 new connection required
Transport	The APHC should have an ambulance for transport of patients. **This may be outsourced.**	**3 ambulance & 1 Vehicle required**	**1 ambulance existing.**	**1**	
Laundry, Dietary and Cleaning facilities	Laundry, Dietary and cleaning work can be outsourced.	**For 1 existing District Hospital**	**One existing DH requires this facility.**	**1**	

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⇨ 4.4.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2012-13
Hospital Superintendent	1	1X1=1	1	0	0
Medical Specialist	3	3X1=3	0	3	3
Surgery Specialists	3	3X1=3	1	2	2
O&G specialist	6	6X1=6	1	5	5
Psychiatrist	1	1X1=1	0	1	1
Dermatologist / Venereologist	1	1X1=1	0	1	1
Pediatrician	3	3X1=3	1	2	2
Anesthetist (Regular / trained)	6	6X1= 6	1	5	5
ENT Surgeon	2	2X1=2	1	1	1
Ophthalmologist	2	2X1=2	2	0	0
Orthopedic an	2	2X1=2	0	1	1
Radiologist	1	1X1=1	0	1	1
Casualty Doctors / General Duty Doctors	20	20X1= 20	7	13	13
Dental Surgeon	1	1X1=1	2	0	0
Hospital Manager	1	1X1=1	1	0	1
AYUSH Physician	4	4X1=4	0	4	4
Pathologists	2	2X1=2	0	2	2
Staff Nurse	20	20X1=20	3	17	17
Hospital worker (OP/ward +OT+ blood bank)	20	20X1=20	7	13	13
Ophthalmic Assistant	2	2X1=2	4	0	0
ECG Technician	1	1X1=1	0	1	1
Laboratory Technician (Lab + Blood Bank)	4	4X1=4	1	3	3
Maternity assistant (ANM)	4	4X1=4	1	3	3
Radiographer	2	2X1=2	0	2	2
Pharmacist[1]	6	6X1=6	2	4	4
Physiotherapist	2	2X1=6	0	2	2
Statistical Assistant	1	1X1=1	0	1	1

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Chapter V: SWOT ANALYSIS OF THE DISTRICT:

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

District: Part A,B,C,D

Part A

Strength	Weakness	Opportunity	Threat
• Decentralized Planning from HSC to District level. • Huge pool of Human Resource working at ground level as ANM, Asha and Anganwadi workers. • Provision of incentive money for Asha, ANM according to their performance in mobilizing community for institutional delivery ,FP etc. • Provision of Incentive money for beneficiary under JBSY, Family Planning. • Extension of emergency facilities in remote rural areas and posting of skilled doctors. • Regular training program of doctors and other medical staffs for skill up gradation.	• All PHCs are with only six bedded facility.50-60% of facilities are not adequate as per IPHS norms for providing emergency care. • Lack of doctors and other human resource in the remote areas medical facilities • Achievement of target is not up to the mark . • Slow pace of most of training like SBA and IMNCI. • Monthly VHND is not operational as yet. • Institutional delivery is still less than 50% in the district. • No NRC has been made operational in the district. • Seat for contractual medical officer and specialist, ANM and Asha are still vacant.	• Always support from state health society for all financial and logistics requirements for program implementation • Scope for involving Private partner like Surya clinic for timely achievement of targets. • Scope of getting full support from people through their participation in RKS and VHSC. • Favourable political and administrative environment for program implementation • Increasing literacy and awareness among public to support Family planning and institutional deliveries. • Better coordination and support from other	• Due to illiteracy some fraction of population are not availing available facilities • Poverty becomes the cause of nutritional deficiency leading to health problems in society. • In case of remaining without practice for long time health staff training become useless. • Extending services in remote rural areas is still a challenge in achieving targets of MCH and FP, RI. • Traditional and religious attitude of public is hindrance for increasing Institutional deliveries, Family planning etc. • Vulnerable section of society are still not availing the available services.

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• Strong provision of IEC and BCC activity under the programs for effective program implementation and sensitizing people. • Decentralized implementation process of the entire program. • Involvement of people in uplifting health facilities through RKS and VHSC.	• Achievements in Family Planning and IUD insertation are far less than targets. • Insensitivity of Doctors and other health staffs for patients. • Unavailability of doctors and staffs in hospital at the time of duty. • No timely procurement of equipments and drug in the remote health facilities.	line departments like ICDS, Municipality etc • Good opportunity to rapport building with community member. • Through ICC/IEC methods awareness generation can be promote. • Proper coordination and communication is important for implementation and success of any programme.	• In rural areas adolescent girls are not so frank to discuss with ANM and ASHA • Marginalised section of the society is losing their faithna due to service provider people like ANM,ASHA stubborn nature. • Backlog payment of ASHAs is the big challenge for service provider. • Unavailability of medicine or ignorance of ANM.

Part B

Strength	Weakness	Opportunity	Threat
• ASHAs is working from bottom to top level and their involvement in all programme . • Trained professional working in the district which help in successfulness of programme • Untied funds are available at every level. • No. of AYUSH Doctor-39. • Asha support system with DCM and BCM	• Inadequate training of ASHAs. • Requirement of trained Professional in some blocks • Untied fund is not utilize properly • Requirement of AYUSH Doctor as per APHC. • Asha Selection is not 100% complete • RKS is not function in any APHC. • Utilization of untied fund in most of the health centers is very less.	• ASHAs would be trained in all module , Fully participation by Ashas in all health programme, • Fulfill all Vacant post so that use for health programme. • It would be utilize untied fund properly at every level. • It would be used AYUSH Doctor in Health Programme. • Participation of Mukhiyas and	• Corruption and ill intention in construction of buildings and selection process of employees. • Lack of people interest and support for proper maintenance of health infrastructure and quality of services. • Less knowledge and sensitivity for work among Asha and other

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has been made functional in the district. • Motivational program for Asha like Umbrella distribution is completed in time. • Formation of VHSC has been completed in most villages of the district. • Deployment of BHM and Hospital Managers is complete at all the vacant places in the district. • Services of advanced life saving ambulance (108) is started in the district • Contractual AYUS doctors have been placed in APHC. • Decentralized planning at HSC level has been started from this year in the district	• Replenishment of Asha kit and drugs is not timely and complete. • Construction of HSC, APHC, PHC buildings and staff quarters moving with very slow pace. • ISO certification process of health facilities is still to start in the district. • Pathology and Radiology services under PPP initiatives are not properly functional at most of the health facilities. • Lack of orientation among members of RKS regarding their scope of works for Health facilities	Surpanch in Asha selection process to expedite the process and also proper and complete utilization of Untied fund for health facility development. • Favorable administrative and political condition for program implementation. • Availability of fund from both NRHM and State funding for development of health infrastructure.	contractual employees.

Part C

Strength	Weakness	Opportunity	Threat
• Increasing coverage of immunisation from bottom to top level.	• Hard to reach area .	• To encourage community to avail opportunity of immunisation.	

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6.6.1 Maternal Health & JBSY	
Objectives	1. 100% pregnant women to be given two doses of TT 2. 90% pregnant women to consume 100 IFA tablets by 2013 3. 70% Institutional deliveries by 2013 4. 90% deliveries by trained /Skilled Birth Attendant by 2013 5. 95% women to get improved Postnatal care by 2013 6. Increase safe abortion services from current level to 80 % by 2013
Strategies	1. Provision of quality Antenatal and Postpartum Care to pregnant women 2. Increase in Institutional deliveries 3. Quality services in the health facilities 4. Availability of safe abortion services at all APHC and PHC 5. Increased coverage under JBSY 6. Strengthening the Maternal, Child Health and Nutrition (MCHN) days 7. Improved behavior practices in the community
Activities	1. Identification of all pregnancies through house-to-house visits by ANMs, AWWs and ASHAs 2. Fixed Maternal, Child Health and Nutrition days • Once a week ANC clinic by contract LMO at all PHCs and CHCs • Development of a microplan for ANMs in a participatory manner • Wide publicity regarding the MCHN day by AWWs and ASHAs and their services • A day before the MCHN day the AWW and the ASHA should visit the homes of the pregnant women needing services and motivate them to attend the MCHN day Registration of all pregnancies • Each pregnant woman to have at least 3 ANCs, 2 TT injections and 100 IFA tablets • Nutrition and Health Education session with the mothers 3. Postnatal Care • The AWW along with ANM will use IMNCI protocols and visit neonates and mothers at least thrice in first week after delivery and in total 5 times within one month of delivery. They will use modified IMNCI charts to identify problems, counsel and refer if necessary 4. Tracking bags • Provision of tracking bags for the left outs and the dropout Pregnant mothers • Training of ANMs and AWWs for the use of Tracking bags 5. Provision of Weighing machines to all Subcentres and AWCs 6. Availability of IFA tablets • ASHAs to be developed as depot holders for IFA tablets • ASHA to ensure that all pregnant women take 100 IFA tablets 7. Training of personnel for Safe motherhood and Emergency Obstetric Care (Details in Component on Capacity building)

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	8. Developing the APHC and PHC for quality services and IPHS standards (Details in Component Up gradation of APHC & PHCs and IPHS Standards) 9. Availability of Blood at the General Hospital and PHC • Establishing Blood storage units at GH and PHC • Certification of the Blood Storage centre 10. Improving the services at the Sub centre (Details in Component on Up gradation of Sub centre and IPHS) 11. Behaviour Change Communication (BCC) efforts for awareness and good practices in the community (Details in Component on IEC) 12. Increasing the Janani Suraksha coverage • Wide publicity of the scheme (Details in Component on BCC …) • Availability of advance funds with the ANMs • Timely payments to the beneficiary • Starting of Janani Suraksha Yojana Helpline in each block through Swasthya Kalyan Samitis 13. Training of TBAs focussing on their involvement in MCHN days, motivating clients for registration, ANC, institutional deliveries, safe deliveries, post natal care, care of the newborn & infant, prevention and cure of anaemia and family planning 14. Safe Abortion: • Provision of MTP kits and necessary equipment and consumables at all PHCs • Training of the MOs in MTP • Wide publicity regarding the MTP services and the dangers of unsafe abortions • Encourage private and NGO sectors to establish quality MTP services. • Promote use of medical abortion in public and private institutions: disseminate guidelines for use of RU-486 with Mesoprestol 15. Development of a proper referral system with referral cards 16. Improvement of monitoring of ANM tour programme and Fixed MCHN days • Fixed MCHN days and Tour plan of ANM to be available at the PHCs with the MOs • Checklist for monitoring to be developed • Visits by MOs and report prepared on basis of checklist filled • Findings of the visits by MOs to be shared by MO in meetings RCH Camps: These will be organized once each quarter through NGOs/Rotary/Lions clubs to provide specialist services especially for RTI/STD cases.
State support	1. Issue of joint letters from Health & ICDS department for joint working 2. Ensuring availability of personnel especially specialists and Public Health Nurses for the 24 hour PHCs, APHC and two ANMs at the subcenter 3. Ensuring availability of formats and funds with the ANM for JBSY and timely payments 4. Certification of PHCs as MTP centres 5. The State should closely monitor the progress of all the activities

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6.6.2 Newborn & Child Health	
	Breast feeding: As per DLHS 2002, only 11.9% mothers breastfeed their children within two hours of birth and 4.8% children were breastfed exclusively for stipulated period of 4 months. There is lack of knowledge regarding the significance of colostrums and the socio-cultural factors associated with it. **Childhood illnesses** Diarrhea: Under nutrition is associated with diarrhea, which further leads to malnutrition. According to the DLHS 2002 although three fourths of the women were aware of what was to be done when a child got diarrhea but in practice very few women gave Oral Rehydration Solution (ORS) to the child and a negligible percentage gave more fluids to drink. This shows that there is a need for more knowledge regarding the use of ORS and increased intake of fluids and the type of food to be given. **Pneumonia:** There is a need to create awareness regarding the danger signs of Pneumonia since only half of the women are aware of danger signs of pneumonia as per DLHS 2002. **Newborn and Neonatal Care:** There is very little data available for the newborns and the neonates. The District data shows that a negligible percentage of newborns and neonates died which is doubtful. Reporting regarding these deaths is not done properly. The various health facilities also are poorly equipped to handle newborn care and morbidity. The TBAs and the personnel doing home deliveries are unaware regarding the neonatal care especially warmth, prevention of infection and feeding of colostrums.
	1. Reduction the IMR. 2. Increased proportion of women who are exclusively breastfed for 6 months to 100% 3. Increased in Complete Immunization to 100% 4. Increased use of ORS in diarrhea to 100% 5. Increased in the Treatment of 100% cases of Pneumonia in children 6. Increase in the utilization of services to 100%
	1. Improving feeding practices for the infants and children including breast feeding 2. Promotion of health seeking behavior for sick children 3. Community based management of Childhood illnesses 4. Improving newborn care at the household level and availability of Newborn services in all PHCs & hospitals 5. Enhancing the coverage of Immunization 6. Zero Polio cases and quality surveillance for Polio cases
	1. Improving feeding practices for the infants and children including breast feeding • Study on the feeding practices for knowing what is given to the children • Education of the families for provision of proper food and weaning • Educate the mothers on early and exclusive breast feeding and also giving Colostrums • Introduction of semi-solids and solids at 6 months age with frequent feeding • Administration of Micronutrients – Vitamin A as part of Routine immunization, IFA and Vitamin A to the children who are anemic and malnourished **2.** Promotion of health seeking behavior for sick children and Community based management of Childhood illnesses • Training of LHV, AWW and ANM on IMCI including referral

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

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6.6.3 Family Planning

Situation Analysis/ Current Status	Indicators	No. or Rate
	Eligible Couple	550770
	% of Female Sterilization operations DLHS-03	17.2%
	% of male Sterilization operations DLHS-03	0.2%
	% of Couples using temporary method DLHS-03	24%
	• The awareness regarding contraceptive methods is high except for the emergency contraception. This is because of inadequate IEC carried out for Emergency Contraception • Currently 24% couples are using temporary methods of contraception and 17.4% have permanent sterilization (mainly Female sterilization). In temporary methods commonest use is of Condom, which has a high failure rate. Use of Copper –T is low. The community prefers female sterilization since there is gender imbalance and limited male involvement. Women also do not have decision-making power. • The reasons for the low use of permanent methods and Copper -T are due to inadequate motivation of the clients, inadequate manpower, limited skills of the ANMs for IUD insertion and also their irregular availability. The rejection rate is high since proper screening is not done before prescribing any spacing method. • Copper T-380 – 10 year Copper T has been recently introduced but there is very little awareness regarding its availability. There is a need to promote this 10 yr Copper T • Some socio-cultural groups have low acceptance for Family Planning. • Promotion efforts for Vasectomy have been very infrequent and only 222 men have undergone Vasectomy. • The current number of trained providers for sterilization services is insufficient.	
Objectives	1. Reduction in Total fertility Rate. 2. Increase in Contraceptive Prevalence Rate to 70 % 3. Decrease in the Unmet need for modern Family Planning methods to 0% 4. Increase in the awareness levels of Emergency Contraception	
Strategies	1. Increased awareness for Emergency Contraception and 10 yr Copper T 2. Decreasing the Unmet Need for Family Planning 3. Availability of all methods at all places 4. Increasing access to terminal methods of Family Planning 5. Promotion of NSV 6. Expanding the range of Providers 7. Increasing Access to Emergency Contraception and spacing methods through Social marketing 8. Building alliances with other departments, PRIs, Private sector providers and NGOs	
Activities	**1.** Expanding the range of Public Sector providers for Terminal methods • Each APHC and PHC will have one MO trained in any sterilization method. • All the APHC/PHC will have at least one MO posted who can be trained for abdominal Tubectomy. This method does not require a postgraduate degree or expensive equipment. • Similarly MOs will be trained for NSV • Specialists from District hospitals and PHCs will be trained in Laparoscopic Tubal Ligation. • At PHCs, one medical officer will be trained in NSV • Each PHC will be a static center for the provision of sterilization services on regular basis.	

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	The Static centers will be developed as pleasant places, clean, good ambience with TV, music, good waiting space and clean beds and toilets. • At selected PHCs where the EmOC intervention is undertaken, the medical officer will be trained for NSV. • Equipments and supplies will be provided at APHC and PHC for conducting sterilization services. • A systemic effort will be made to assess the needs of all facilities, including staff in position and their training needs, the availability of electricity and water, Operation theatre facilities for District hospitals/PHC/APHC, Inventory of equipment, consumables and waste disposal facilities and the condition, location and ownership of the building. • At least three functional Laparoscope's will be made available per team, as will the equipment and training necessary to provide IUD and emergency contraception services. The existing Laparoscope's need to be replaced. For effective coverage 4 teams are required with minimum three Laparoscope's for each team. • Vacant positions will be filled in on a contractual basis. • Access to Terminal Family Planning methods • Provision of Sterilization services every day in all the 3 hospitals • Organization of Sterilization camps on fixed days at all PHC • NSV **2.** Formation of District implementation team consisting of DM, CS, District MEIO, Distt NSV trainer • One day Workshop with elected representatives, Media, NGOs, departments for sensitization and implementation strategy, fixing pre-camp, camp and post-camp responsibilities • Development of a Micro plan in one day Block level workshops • NSV camp every quarter in all hospitals initially and then PHCs and APHCs • IEC for NSV • Trained personnel • Follow-up after NSV camp on fixed days after a week and after 3 months for Semen analysis • Access to non-clinical contraceptives increased in all the villages • AWWs and ASHAs as Depot holders **3.** Training in Spacing methods, Emergency Contraceptives and interpersonal communication for dissemination of information related to the contraceptives in an effective manner. • Supply of Emergency Contraceptives to all facilities • Access for the quality IUD insertion improved at all the 75 subcentres. • All the ANMs at 75 subcentres will be given a practical hands on training on insertion of IUD **4.** Diagnosis and treatment of RTI/STI as per syndromic approach. The various screening protocols related to the IUD insertion enabling her to screen the cases before the IUD insertion. This will result in longer retention of IUDs. • Counseling of the cases • Repair of subcentres so that the IUD services can be provided and ensuring privacy and confidentiality. • IUD 380 A will be used due to its long retention period and can be used as an alternative for sterilization. • Awareness on the various methods of contraception for making informed choices • Discussed in the Component on IEC

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	5. Increasing the gender awareness of providers and increasing male involvement • Empowering women • Increasing male involvement in family planning through use of condoms for safe sex and also in Vasectomy. • BCC activities to focus on men for Vasectomy. • Gender sensitization training will be provided for all health providers in the CHC/PHC and integrated into all other training activities. • Service delivery sites for male methods by training health providers in NSV and conventional vasectomy will be expanded so that each CHC and Block PHC in the district has at least a provider trained in NSV. **6.** Improving and integrating contraceptives/RCH services in PHCs and Sub-centers • Skill-based clinical training for spacing methods including IUCD insertion and removal, LAM, SDM and EC of Lady Health Visitors (LHVs) and Auxiliary Nurse Midwives (ANMs). • They will also be trained in infection prevention, counselling and follow up for different family planning methods. • MIS training will also be given to the health workers to enable them to collect and use the data accurately. • Their supervisors will be trained for facilitative supervision and MIS. • Follow up of trained LHVs and ANMs after one month and six months of training and provide supportive feedback to the service providers **7.** Strengthening linkages with ICDS programme of women and child development department and ISM (Ayurveda) • A detailed action plan will be produced in co-ordination with the ICDS department for involvement of the AWWs and their role in increasing access to contraceptive services. • Department of health officials and ICDS officers will be orientated to the plan. • AWWs and their supervisors will receive technical training and training in communication skills and record keeping by Medical Officer of the PHC and LHV. • Staff of ISM department will be trained in communication and non-clinical methods to promote and increase the availability of FP methods. **8.** Engaging the private sector to provide quality family planning services • Incentives and training to encourage private providers to provide sterilization services • Training private lady doctors in IUD insertion and promoting the provider will help to expand coverage of these services increase the total use of IUCD. • Detailed plan will be developed in consultation with the private sector for determining the amount and mode of payment, the regulation and monitoring frameworks necessary, and safeguards to ensure equity of access. • Training for the private sector will be provided as above, and approved, monitored providers will be promoted and eligible for discounted supplies. • Accreditation of private hospitals and clinics for sterilization and NSV **9.** Role of ASHAs: • Training for provide counseling and services for non-clinical FP methods such as pills, condoms and others. • Act as depot holders for the supplies of pills and condoms by the ANMs for free distribution

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	• Procurement of pills and condoms from social marketing agencies and provide these contraceptives at the subsidized rate • Provide referral services for methods available at medical facilities • Assist in community mobilization and sensitization. • Building partnerships with NGOs • Creating an enabling environment for increasing acceptance of contraceptive services Innovative schemes will be developed for reaching out to younger men, women, newly married couples and resistant communities. • These will be and scaled up as appropriate.
Support required	1. Availability of a team of master trainers/ANM tutors and RFPTC trainers for follow up of trained LHVs and ANMs after one month and six months of training and provide supportive feedback to the service providers 2. A training cell will be created in the medical college for the training of the medical officers in the area of various sterilization methods 3. Availability of equipment, supplies and personnel

Timeline	**Indicators**	**2012-13**
	Training of MOs for NSV	10 MOs
	Training of MOs for Minilap	5 MOs
	Training of Specialists for Laparoscopic Sterilization	3 MOs
	Sterilization Camps (Persons)	15000
	Accreditation of private institutions for sterilization	10
	Supply of Copper T – 380	5000
	Emergency Contraception	3000

6.6.4 Adolescent Reproductive and Sexual Health

The World Health Organization (WHO) defines adolescence as the period between 10 and 19 years of age, which broadly corresponds to the onset of puberty and the legal age for adulthood. Commencement of puberty is usually associated with the beginning of adolescence. In some societies, adolescents are expected to shoulder adult responsibilities well before they are adults; in others, such responsibilities come later in life.

Although it is a transitional phase from childhood to adulthood, it is the time that the adolescents experience critical and defining life events – first sexual relations, first marriage, first childbearing and parenthood. It is a critical period which lays the foundation for reproductive health of the individual's lifetime. Therefore, adolescent reproductive and sexual health involves a specific set of needs distinct from adult needs. The reproductive health needs of adolescents as a group has been largely ignored to date by existing reproductive health services. Many adolescents in India face reproductive and other health risks. Poor nutrition and lack of information about proper diets increase the risk of iron-deficiency anemia for adolescent girls. Young women and men commonly have reproductive tract infections (RTIs) and sexually transmitted infections (STIs), but do not regularly seek treatment despite concerns about how these infections may affect their fertility. India also has one of the highest rates of early marriage and childbearing, and a very high rate of iron deficiency anemia. The prevalence of early marriage in India poses serious health problems for girls, including a significant increase of maternal or infant mortality and morbidities during childbirth. The following facts will help understand the situation objectively.

- The median age of marriage among women (aged 20 to 24) in India is 16 years.
- In rural India, 40 percent of girls, ages 15 to 19, are married, compared to only 8 percent of boys the same age.
- Among women in their reproductive years (ages 20 to 49), the median age at which they first gave birth is 19.
- Nearly half of married girls, ages 15 to 19, have had a least one child.

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• India has the world's highest prevalence of iron-deficiency anemia among women, with 60 percent to 70 percent of adolescent girls being anemic.	
Objectives	• Improve sex ratio 1000 > 1000 • Increase the knowledge levels of Adolescents on RH and HIV/AIDS • Enhance the access of RH services to all the Adolescents. • Improvement in the levels of Anaemia.
Strategies	• Raise awareness and knowledge among adolescents about Reproductive Health and Family Planning services with emphasis on late marriage and childbearing. • Improve micronutrient service for adolescents primarily to reduce anaemia. • Awareness amongst all the adolescents regarding Reproductive health and HIV/AIDS. • Provision of Adolescent Friendly Health & counselling services
Activities	• Create conducive environment to promote adolescent health needs among health service providers and community at large. • Targeted BCC campaign using multiple channels to raise awareness about safe reproductive health practices and Family Planning among adolescents. • Partnerships with key stakeholders and major networks to promote safe reproductive health practices and Family Planning among adolescents. • Provide RTI/STI curative services for adolescents through expanded network of health facilities and frontline health workers. • Targeted BCC campaign using multiple channels to promote good nutritional practices and micronutrients such as Iron Folic Acid and Iodine among adolescents. • Increase availability and distribution of micronutrient Workshop to develop an understanding regarding the Adolescent health and to finalize the operational Plan. • Supplements to adolescents at grassroots level primarily through health and education networks. • Provision of Adolescent friendly health services at HSCs, APHCs PHCs, CHCs, FRUs and district hospitals in a phased manner. Training of the MOs, ANMs on the needs of this group, vulnerabilities and how to make the services Adolescent friendly. • Adolescent Health Clinics will be conducted at least twice in a month by the MO to provide Clinical services**,** Nutrition advice, Detection and treatment of anemia, Easy and confidential access to medical termination of pregnancy, Antenatal care and advice regarding child birth, RTIs/STIs detection and treatment, HIV detection and counseling. • Treatment of psychosomatic problems, De-addiction and other health concerns. • Awareness building amongst the PRIs, Women's groups, ASHA, AWWs. • Provision of IFA tablets to all Adolescents, deworming every 6 months, • Vitamin A administration and Inj. TT. • Carrying out the services at the fixed MCHN days. • Involvement of NGOs for Environment building. One NGO per Block will be selected. NGO will select the counsellor in the villages. • Involvement of ASHAs as counsellor and one Male & Female person of all the villages, and training of all the health personnel in the Sub centres, PHCs and CHC in the block • There will be equal number of Male and Female counsellors and will alternate between two PHCs – one week the male counsellor is in one PHC and the female counsellor in the other and they switch PHCs in the next week so that both the boys and girls benefit. • Facilitating group meetings. • Organizing Counselling session once per week at the PHCs with Wide publicity regarding the days of the sessions.

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	• Collecting data and information regarding the problems of Adolescents Close monitoring of the under 18 marriages, pregnancies, prevalence of RTI/STD

6.6.5 Urban Health

Urban health is an innovative approach to cover the un-served population. As till date the maternal and child health components were mainly concentrated in the rural areas, the urban sector remained un-served. There are sub-centers and PHC in the rural areas to provide health services. But in urban area there is no such system. Municipal Authorities is no providing health services, There the people are deprived of basic health facilities. Moreover, there is not such facility available to cover the un-served urban areas. With this objective urban health was initiated to cover the urban areas especially the urban slums.

As per the guidelines there is provision of one female health worker for every 2000 population. For the state a total of 998 female health workers have to be involved in the urban health program. They will carry out the same activity as performed in rural health programs. There is also provision of 62 Public Health Nurse to support primarily the urban health programs. But there is restriction that, for every 25000 population, it can be done so. The whole program is to be handled by urban health officer. There is provision of one urban health officer for every 50,000 population

Action Plan for Urban Health Programs

Goal	• To improve the health status of the urban poor community by provision of quality integrated (Primary Health Care Services)
Objective	• To provide integrated and sustainable system for primary health care services in the urban areas, with focus on urban poor living in slums and other vulnerable groups. • Making all the Urban Health Centers functional through hiring of one Urban Health Officer. It is needless to mention that due to lack of officer it is difficult to monitor the activities performed by the CBHVs from the head quarter. We can strengthen the urban services by hiring retired BHOs or retired MOs on contractual basis. They will sit in the respective BHOs office and manage the programmes. They will monitor of the activities by the health workers. • Capacity building of all the selected staff batch wise. Training is very important to build there capacity on regular basis. Training approach has to be participatory to enhance their communication skills. Post training assessment of the workers, if found in-effective replacement with other interested health worker. • Monthly meeting of all selected leaders with UHOs. In addition monthly meeting of all the selected leaders in their own urban center with female health workers. After collection of all reports they will discuss health topics which will help in their development. The meeting has to be organized in each of the centers on regularly. • DPHN and DIO/RCHO will arrange regular meeting with the workers to assess monthly progress on reproductive and child health issues and immunization. If required review meeting of Urban Health Officer with CDHO, ADHO, RCHO and DPMU team to fill up the identified gaps.

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Urban Health

Urban health care has been found wanting for quite a number of years in view of fast urbanization leading to growth of slums and population as more emphasis is given in rural areas. Most of the Cities and Towns of Bihar have suffered due to lack of adequate primary health care delivery especially in the field of family planning and child health services.

Objectives:	1. Improve delivery of timely and quality RCH services in urban areas of Bihar 2. Increase awareness about Maternal, Child health and Family Planning services in urban areas of the state At present, there are 12 Urban Health Centres (UHC) in the state which are non-functional. However, as per the GoI guidelines, there should be one UHC for 50,000 population (outpatient). The Urban Health Centre are required to provide services of Maternal Health, Child Health and Family Planning. The infrastructure condition of the Urban Health Centres is not up to the mark and requires some major renovation work. The staff at each UHC should comprise of 1 Medical Officer (MO), 1 PHN/LHV, 2 ANMs, 1 Lab Assistant and 1Staff clerk with computer skills.

NUTRITIONAL REHABILITATION CENTRE

Introduction--NRC is the Nutritional Rehabilitation centre or a facility based care for children with severe acute malnutrition that are given residential medical treatment along with special feeding and care till the childs physical condition is stabilized.

NRC was established in 2011 at Sadar Hospital campus Siwan with collaboration with Gyan bharti siksha and prashichhan sansthan patn. Till now the 4th batch has been successfully completed and 5th batch is going on.NRC is the positive hope for poor people in the district there malnourished children will be treated.

Objective of NRC

- To reduce severe and acute malnutrition rate in the age group between 6 month to 60 month.
- Capacity building of mother and family on health, hygiene and nutrition.

Out comes

- Successfully 4batch has been completed and 79 children has been treated till now.(23.1.2012)
- 5th batch is going on.

6.6.6 Monitoring and Evaluation

One of the major weaknesses of the RCH program in the Bihar is the absence of an effective Monitoring and Evaluation system that would provide accurate and reliable information to program managers and stakeholders and enable them to determine whether or not results are being achieved and thereby assist

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them in improving program performance. A triangulated process of Monitoring and Evaluation would enable cross checking and easy collection, entry, retrieval and analysis of data.

Activities

- Strengthening and up gradation of monitoring and evaluation cell
- Mobility support
- Equipping and furnishing demographic cells
- Conducting survey and concurrent evaluation
- Formation of Databank
- Revised CNAA for all levels would be persuaded and guidelines for preparation district plans
- Web/internet based computer software for use at district and state level
- Reporting formats for providing requisite information

6.6.7 Synergies with NRHM Additional ties

The NRHM is an effort to bring about the architectural change to overall program management to enable rationalization of resources and simultaneously to augment then limited resources so that equity in health is ensured. The commonality of initiatives in the following areas would be complementing the similar efforts under NRHM;

- Infrastructures for facility development,
- Manpower recruitment,
- Capacity building through training, program management, institutional strengthening, organizational development,
- Communitization,
- Promotional efforts for demand generation and
- Improved monitoring & evaluation systems developed under RCH II
- Public Private Partnership
- Convergence & Coordination

The convergence approach which was mooted earlier now finds a clear policy initiative and procedural development by health and all health determinants sectors so that a joint effort is made in tandem from planning to impact evaluation / outcome to ensure investments in health reach the poor /unnerved/underserved/excluded segment of the population. These common efforts would also strengthen gender equity through adolescent and other initiatives of both RCH & NRHM to provide a safety net to young women and girl children.

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Part B

NRHM

AdditionAlities

TIOKU

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6.6.8 Decentralization

For effective decentralization in principle as well as practice, health societies have been established at all levels of the healthcare delivery structure. Systematic involvement of various stakeholders at all levels through these societies has helped make healthcare delivery responsive to the needs of the people via participatory planning and removal of bottlenecks at implementation levels. State Health Society provides overall guidance and supervision for effective planning and implementation, and also coordinates activities across the board. The

State Health Mission, the Governing Body and the Executive Committee meet at regular intervals and take decisions regarding all matters. District level activities are taken care of through the District Health Society.

Rogi Kalyan Samitis at APHC, PHC, CHC, Sub Divisional Hospitals and District Hospitals have been set up. The formation of societies under NRHM has given a new direction to management and overall functioning of the health department towards the achievement of its goals

6.6.9 ASHA (Accredited Social Health Activist)

Situation Analysis	ASHA is an honorary worker and will be reimbursed on performance-based incentives and will be given priority for involvement in different programmes wherever incentives are being provided (like institutional delivery being promoted under JBSY, motivation for sterilization, DOTS provider, etc.). It is conceived that she will be able to earn about Rs. 1,000.00 per month. In district Siwan 2820 ASHAs have been selected and 2327 have received training.
Objectives	1. Availability of a Community Resource, service provider, guide, mobilizer and escort of community 2. Provision of a health volunteer in the community at 1000 population for healthcare 3. To address the unmet needs
Strategies	1. Selection and capacity building of ASHA. 2. Constant mentoring, monitoring and supportive supervision by district Mentoring group
Activities	1. Strengthening of the existing ASHAs through support by the ANMs and their involvement in all activities. 2. Reorientation of existing ASHAs 3. Selection of new ASHAs to have one ASHA in all the villages and in urban slums 4. Provision of a kit to ASHAs 5. Formation of a District ASHA Mentoring group to support efforts of ASHA and problem solving 6. Review and Planning at the Monthly sector meetings 7. Periodic review of the work of ASHAs through Concurrent Evaluation by an independent agency

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Support required	1. Timely Payments to ASHA 2. Proper training.	
Timeline	**Activity**	**2012-13**
	Total target of ASHAs	3008
	Total Working ASHAs	2820
	Selection of ASHAs to be completed in 2012-13	220
	Reorientation of the initial ASHAs	
	District ASHA Mentoring group	X

6.6.10 Untied Funds for Health Sub-Centre, APHC & PHCs

The objective of the activity is to facilitate meeting urgent yet discrete activities that need relatively small sums of money at Health Sub Centers.
The suggested areas where Untied Funds can be used mentioned below:

- Cover minor modifications to sub center-curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level;
- Ad hoc payments for cleaning up sub center, especially after childbirth; transport of emergencies to appropriate referral centers;
- Purchase of consumables such as bandages in sub center;
- Purchase of bleaching powder and disinfectants for use in common areas of the village;
- Labour supplies for environmental sanitation, such as clearing/ larvicidal measures for stagnant water
- Payment/reward to ASHA for certain identified activities.
- Untied fund for HSC-10000,APHC-50000 PHC-25000.

6.6.11 Village Health & Sanitation Committee

Government of Bihar has decided to merge "Village Health and Sanitation Committee" with ***"Lok Swasthya Pariwar Kalyan and Gramin Swaschata Samiti"*** constituted by Department of Panchayat Raj in Bihar. The committee will observe the ongoing activities in the HSC and committee will also monitor the Village Health Sanitation and nutrition Day activity.

6.6.12 Rogi Kalyan Samiti

Aims and Objectives

The objectives of the RKS is :

- Upgrade and modernize the health services provided by the hospital and any associated outreach services
- Supervise the implementation of National Health Programme at the hospital and other health institutions that may be placed under its administrative jurisdiction
- Organize outreach services / health camps at facilities under the jurisdiction of the hospital
- Monitor quality of hospital services; obtain regular feedback from the community and users of the hospital services
- Generate resources locally through donations, user fees and other means

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Functions of the RKS

To achieve the above objective, the Society utilizes it's resources for undertaking the following activities/initiatives:

- Acquire equipment, furniture, ambulance (through, donation, rent or any other means) for the hospital
- Expand the hospital building, in consultation with and subject to any guidelines that may be laid down by the Gob Make arrangements for the maintenance of hospital building (including residential buildings), vehicles and equipments available with the hospital
- Improve boarding/lodging arrangements for the patients and their attendants
- Enter into partnership arrangement with the private sector (including individuals) for the improvement of support services such as cleaning services, laundry services, diagnostic facilities and ambulatory services etc
- Develop/lease out vacant land in the premises of the hospital for commercial purposes with a view to improve financial position of the Society
- Encourage community participation in the maintenance and upkeep of the hospital
- Promote measures for resource conservation through adoption of wards by institutions or individuals
- Adopt sustainable and environmental friendly measures for the day-to-day management of the hospital, e.g. scientific hospital waste disposal system, solar lighting systems, solar refrigeration systems, water harvesting and water re-charging systems etc.

6.6.13 Infrastructure Plan

NRHM aims to ensure HSC facility on the Govt. of India population norms of 01 per 5000 population in general areas and 01 per 3000 populations in tribal areas. As per 2011 Census, population of the Siwan District is approximately 3318776 Existing no of HSCs are 371.As per IPHS norms total requirement of HSCs are 637.To facilitate the above population the state requires additional ….HSCs had been approved by state health society Bihar to achieve the total target. It is proposed to be created next five years. In SPIP 2010-11 State Health Society Bihar sanctioned fund for Building construction of 8 HSC @ Rs.9.50 lakhs per HSC. The initiatives have been taken by the DHS for the construction work HSC through Building Department.

6.6.14 UPGRADATION OF COMMUNITY HEALTH CENTRE (CHC)

NRHM aims to ensure CHCs on the Govt. of India population norm of 1 per 1.20 Lakhs populations. The Govt.of Bihar plans to upgrade all its PHCs and Referral Hospitals below the headquarter level to CHC as per IPHS standards. In the district Siwan total no of existing PHCs are 19 and the no of Referral Hospital is 3 (inclusive of 03 PHC). Hence a total of 15 units are needed to be upgraded to CHC standard and converted to 30-bedded hospitals. The State Health Society Bihar had Sanctioned Rs. 1.60 crore in SPIP 2009-10 for 4 PHC @Rs. 40Lakhs. The work of upgradation is under progress. The costs also include provision of equipment at these hospitals either as per IPHS standard or as required.

6.6.15 PPP Initiatives

The private sector includes NGOs, Private Practitioners, Trade and Industry Organisations, Corporate Social Responsibility Initiatives.

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The private sector is the major provider of curative health services, Mobile health services and Referral transport services as well as Radiology and pathology, Generator and meals services in the distric. Engaging with it to provide family planning services has the potential to significantly expand the coverage of quality services. Public-private partnerships can stimulate and meet demand and have a synergistic impact of the RCH. To ensure efficient services of good quality from the private and public sectors, robust monitoring and regulatory mechanisms need to be developed so that the private sector can come forward and cooperate in all the National programmes and also in sharing its resources. There is no policy on Public Private Partnership in Haryana Unless there are incentives for the private sector to venture into this area, its involvement is unlikely.

Objectives

- Increasing the coverage of the health services and also increasing the accessibility for health services widening the scope of the services to be provided to the community.
- Provide emergency referral transport services.

6.6.16 Services of Hospital waste treatment and Disposal in all Government Health facilities upto PHCs in Bihar (IMEP)

- As per the Bio-Medical Waste Rules, 1998, indiscriminate disposal of hospital waste was to be stopped with handling of Waste without any adverse effects on the health and environment. In response to this the Government has taken steps to ensure the proper disposal of biomedical waste from all Nursing homes, hospitals, Pathological labs and Blood Banks.
- The District Health Officer is the Nodal Person in each district for ensuring the proper disposal of Biomedical Waste.
- Trainings to the personnel for sensitizing them have been imparted, Pits have been dug, Separate Colour Bins/containers and Segregation of Waste is taking place though has to be done more systematically. Proper Supervision is lacking.
- GOI has sanctioned a Plasma Pyrolysis Plant. Plasma Pyrolysis is a state-of-the-art technology for safe disposal of medical waste. It is an environment friendly technology, which converts organic waste into commercially useful by-products in a safe and reliable manner.
- The plant will soon be installed and training will be imparted to two persons from the district.

Objectives

- Stopping the indiscriminate disposal of hospital Waste from all the facilities by 2011-12

Strategies

- Capacity Building of personnel
- Proper equipment for the disposal and disposal as per guidelines
- Strict monitoring and Supervision

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Activities

- Review of the efforts made for the Biomedical Waste Interventions
- Development of Micro plan for each facility in District & Block workshops

Capacity Building of personnel

- One day reorientation workshops for District & Block levels
- Training to two persons for Plasma Paralysis Plant. The company persons will impart this training.
- Biomedical Waste management to be part of each training in RCH and IDSP
- Proper equipment for the disposal
- Plasma Paralysis Plant to be installed
- Installation of the Separate Colour Bins/containers and Plastic Bags for the bins
- Segregation of Waste as per guidelines
- Partnering with Private providers for waste disposal
- Proper Supervision and Monitoring
- Formation of a Supervisory Committee in each facility by the MOs and the Supervisors

6.6.17 Main streaming AYUSH under NRHM

The Indian systems of medicine have age old acceptance in the communities in India and in most places they form the first line of treatment in case of common ailments. Of these, Ayurveda is the most ancient medical system with an impressive record of safety and efficacy. Other components such as Yoga, Naturopathy are being practised by the young and old alike, to promote good health. Now days, practice of Yoga has become a part of every day life. It has aroused a world wide awakening among the people, which plays an important role in prevention and mitigation of diseases. Practice of Yoga prevents psychosomatic disorders and improves an individual's resistance and ability to endure stressful situation. Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) are rationally recognised systems of medicine and have been integrated into the national health delivery system. India enjoys the distinction of having the

largest network of traditional health care, which are fully functional with a network of registered practitioners, research institutions and licensed pharmacies. The NRHM seeks to revitalize local health traditions and mainstream AYUSH (including manpower and drugs), to strengthen the Public Health System at all levels. It is decided that AYUSH medications shall be included in the drug kit of ASHA, The additional supply of generic drugs for common ailments at SC/PHC/CHC levels under the Mission

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shall also include AYUSH formulations.

At the CHC level two rooms shall be provided for AYUSH practitioner and pharmacist under the Indian Public Health Standards (IPHS) model. At the same time, it has been decided to place or provision one Ayush doctor on contract at the APHCs for the purpose and to ensure complete coverage of the population.

Activities Improving the availability of AYUSH treatment faculties and integrating it with the existing Health Care Service.

S**trategies**

- Integrate and mainstream ISM &H in health care delivery system including National Programmes.
- Encourage and facilitate in setting up of Ayush wings-cum-specialty centres and ISM clinics.
- Facilitate and Strengthen Quality Control Laboratory.
- Strengthening the Drug Standardization and Research Activities on AYUSH.
- Develop Advocacy for AYUSH.
- Establish Sectoral linkages for AYUSH activities Delivery System

1. Integration of AYUSH services in 1234 APHC with appointment of contractual AYUSH Doctors.
2. Appointment of paramedics where AYUSH Doctors shall be posted.
3. Strengthening of AYUSH Dispensaries with provision of storage equipments.
5. Making provision for AYUSH Drugs at all levels.
6. Establishment of specialized therapy centers/yush wings in District Head Quarter Hospitals & Medical Colleges.
7. AYUSH doctors to be involved in all National Health Care programmes, especially in the priority areas like IMR, MMR, JSY, Control of Malaria, Filaria, and other communicable diseases etc.
8. Training of AYUSH doctors in Primary Health Care and NDCP.
9. All AYUSH institutions will be strengthened with necessary infrastructure like building, equipment, manpower etc.
10. Yoga trainings were held in various District hospitals to provide Yogic therapy for specific diseases and also as a synergistic therapy to all other systems of treatment.

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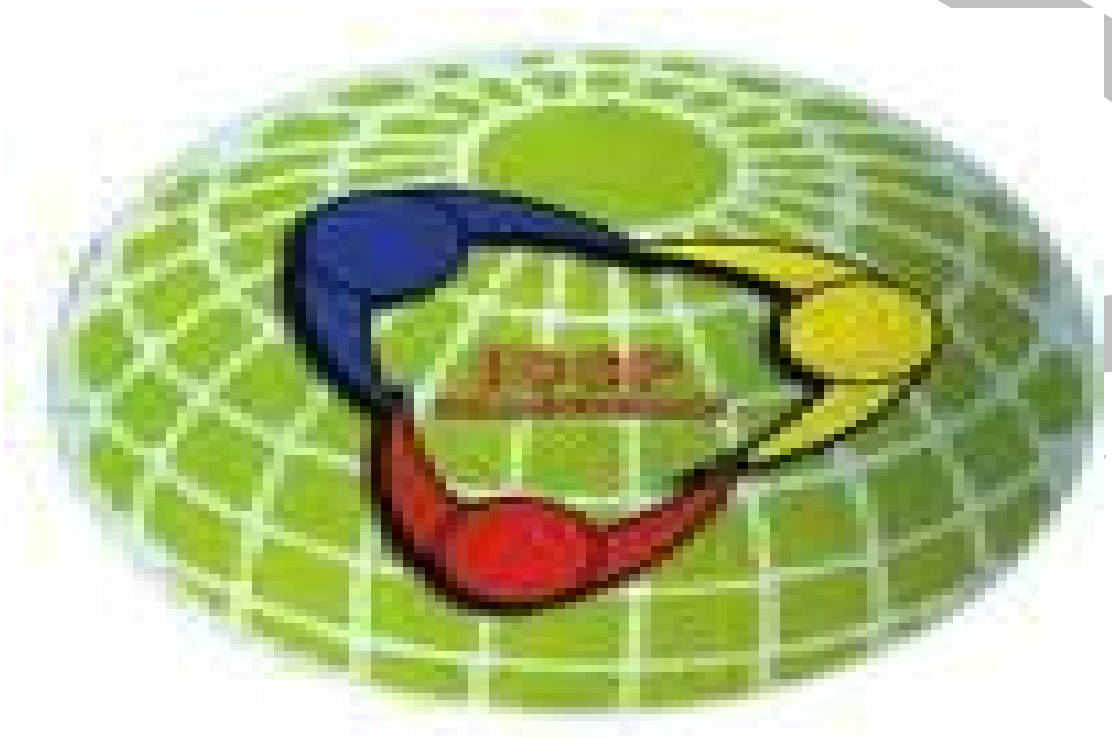
INTEGRATED DISEASE SURVEILLANCE PROJECT

(IDSP)



DISTRICT SURVEILLANCE UNIT

SIWAN (BIHAR)

INTRODUCTION

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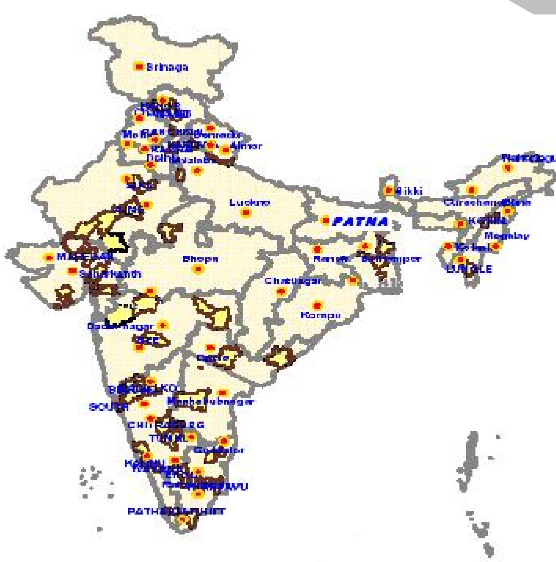
Integrated Disease Surveillance Project (IDSP) was launched by Ministry of Health, Government of India in November 2004, in response to a long felt need expressed by various expert committees. IDSP is a decentralized, state based surveillance project in the country. It is intended to detect early warning signals of impending outbreaks and help initiate an effective response in a timely manner. Major components of the project are:

(1) Integrating and decentralization of surveillance activities;

(2) Strengthening of public health laboratories;

(3) Human Resource Development – Training of State Surveillance Officers, District Surveillance Officers, Rapid Response Team, other medical and paramedical staff; and

(4) Use of Information Technology for collection, collation, compilation, analysis and dissemination of data. This national program is to accomplish these goals by working with the states to improve the completeness, reliability and timeliness of information collected at the peripheral levels of the health care systems.



As a part of the component of strengthening public health laboratories, initially IDSP aimed to support laboratories at 5 different levels starting from the Primary Health Centre. However, implementation experiences showed that due to limitations in availability and capacity of human resources, laboratory strengthening as envisaged was not possible. Many revisions in laboratory strengthening plan happened since then which resulted in confusion and incorrect comprehension at state levels. The laboratory cell of CSU has been pro-actively engaging the states for the final revision of the laboratory component, concentrating on basic and feasible actions. Currently, the laboratory component focuses on a two- pronged approach consisting of reinforcing the capacity of 50 priority public health labs at district level in the country and establishing a referral network in seven priority states through partnering with existing and functioning laboratories. Both strategic orientations will integrate a competency based strengthening of human capacities and reinforce quality assurance standards at all levels. To ensure success of the implementation, it will be crucial that the project reinforces capacity at central, state and district level, defines guidelines, develop performance specifications for rapid test (antigen or antibody) kits, obtains laboratory test results useful for surveillance (e.g. outbreak confirmation, diagnosis of key IDSP diseases difficult to diagnose on clinical grounds), and assures continuous handholding at state and district level. Another important aspect of IDSP is to strengthen reporting of laboratory confirmed data using L form. Efforts are required at the state and the district level to establish L form reporting from as many laboratories as possible in the state.

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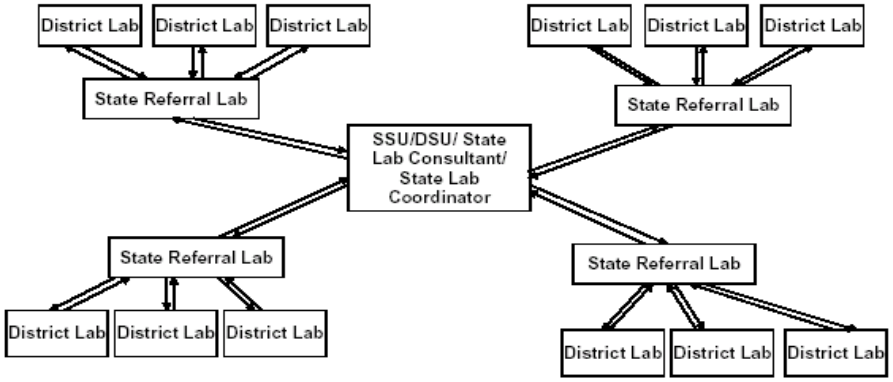
STATE REFERRAL LAB NETWORK – A MODEL
(Existing Medical colleges, Number variable)



IDSP aims to strengthen the quality of lab results by integrating competency based strengthening of technical capacities of the lab personnel and quality assurance activities. Nationwide, district and state level microbiologists recruited under IDSP will be imparted training in techniques and quality assurance systems. Therefore, the Quality assurance for public health laboratory testing will be supported by developing standard operating procedures, the external quality assessment system, biomedical waste management, development of guidelines for quality of kits as well as sample collection, transportation and handling.

IDSP (Integrated Disease Surveillance Project):-

- Launched in Nov. 2004 with World Bank Assistance.
- Initially, CSU located at Nirman Bhawan.
- Shifted to NICD in 2006.
- Major Objectives:
  - Early Detection & response to Outbreaks.
- Major Components:
  - Integration and Decentralization of Surveillance activities.
  - Strengthening of public Health Laboratories.
  - Human Resource Development.
  - Use of Information Technology for Data Management.

Phasing of IDSP (State)

Bihar was included in the Third phase i.e. from 2005.

I Phase (Nine State) (2004-2005):-Andhra Pradesh, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharastra, Uttarakhand, Tamilnadu, Mizoram, Kerala

II Phase (Fourteen State) (2004-2005):-Chhatisgarh, Goa, Gujaraat, Haryana, Rajasthan, West Bengal, Manipur, Meghalaya, Orissa, Tripura, Chandigarh, Pandichery, Delhi, Nagaland.

III Phase (Twelve State) (2004-2005):- Uttar Pradesh, **Bihar**,Jammu-Kashmir,Jharkhand ,Punjab, Auranchal Pradesh, Assam, Sikkim, A & N Nicobar, Daman & Deu, Lakshweep

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IDSP 24 x 7 Call Centre

- Information about outbreaks Received on a toll free no- 1075
- Information referred to State/District surveillance officer verification/ Action.

Video Conferencing Facility

- The Video Conferencing facility is being utilized regularly for discussion of outbreaks and alert and Documentation of investigation reports by District and State RRTs.
- Training of Data Mangers and Data Entry Operators has begun using the VC facilities.

Data Collection: activities (Disease Surveillance)

- Date Collection - Data being colleted and transferred electronically. Data analysis and feedback being given to districts. Data are being validated for its use.
- The Data are being collected manually from Government and Private Sector on the prescribed formats.
- The reports are being received on weekly basis, analyzed and feedbacks are being given to districts.
- Information flow is through internet from district to state and state to Central Surveillance unit.

Strength of IDSP

- Functional Integration of Surveillance component of vertical programmes
- Reporting of suspect, probable and confirmed cases
- Strong IT component for data Analysis
- Trigger level for gradated response
- Action Component in the reporting formats
- Streamlined flow of funds to the district.

Diseases under Surveillance

CORE diseases Regular surveillance

1. Vector Borne disease – Malaria
2. Water borne diseases – Acute diarrhoeal disease (Cholera) Typhoid
3. Respiratory disease – Tuberculosis
4. Vaccine preventable Disease — Measles
5. Disease under eradication — Polio
6. Other conditions — Road traffic Accidents
7. Other international commitments – Plague, Yellow fever
8. Unusual clinical syndromes — Meningoencephalitis, Respiratory (causing death / hospitalization distress, Hemaorrhagic fever

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6.6.19 RNTCP (Revised National Tuberculosis Control Programme)

Situation Analysis/ Current Status

Indicators	No. / Rate
New Sputum Positive cases (NSP)	1291
Annualized new case detection rate per one lakh population	42.10/Lakhs
Total No. of patient put on treatment	3462
Annual total case detection rate per one lakh population	113/Lakhs
Cure rate of New Smear Positive cases	68%
Smear Conversion Rate	81%
Defaulter cases	6%
Failure cases	1%
Source : DTO Office	

To fight Tuberculosis the Revised National Tuberculosis Control Programme based on the DOTS regime was launched in 2006 in Siwan. Under this programme in District Siwan Tuberculosis Unit at microscopic centers were setup.

Objectives

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

Strategies

1. Improvement in the infrastructure
2. Improvement in the quality of the intervention
3. Increasing the outreach of the programme
4. Increasing the awareness regarding Tuberculosis

Activities

1. One more DMC as per norms
2. Improvement in the quality of testing of sputum
   - Training to the RNTCP staff in the district
   - Equipment maintenance – Microscope, Computer and Others
   - Adequate supply of drugs
3. Increasing the outreach of the programme by Increasing the DOTS providers through involvement of ASHAs who will be paid Rs. 250 per caser for providing services. She will be oriented regarding DOTS. Also the AWH should be involved in reporting suspicious cases. Training will be given to ASHA for identifying the suspects.
4. Increasing the awareness regarding the various issues of Tuberculosis through involvement of Rotary clubs and the Lions clubs and NGOs. Special drive for detection of cases on World TB day through the involvement fo all departments
5. DOTS regime to be strictly monitored through the VHWSC, the PRIs and the PHC MO

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Support require	Timely supply of medicines
Timeline	2010-11 1. Increasing the DOT providers through ASHAs 2. Training to RNTCP staff and ASHA 3. Awareness drives 4. Involvement of the AWW

RNTCP performance indicators:

Important: Please give the performance for the last 4 quarters i.e. ***Oct 2010 to Sep 2011***

TB Unit	Total number of patients put on treatment	Annualized total case detection rate (per lakh pop)	No of new smear positive cases put on treatment	Annualized New smear positive case detection rate (per lakh pop)	Success rate for cases detected in the last 4 corresponding quarters	Plan for the next year		Proportion of TB patients tested for HIV	No. of MDR TB suspects identified and subjects to C/DST of sputum	No. of MDR TB cases diagnosed & put on treatment
						Annualized NSP CDR	Success rate %			
Siwan_DTC	575	74	148	19	86	75	87	0	0	0
Basantpur	612	96	208	33	96	97	97	0	0	0
Daraundha	517	95	159	29	91	96	93	0	0	0
Mairwa	335	68	140	28	82	69	84	0	0	0
Raghunathpur	740	99	282	38	96	99	97	0	0	0
District-Siwan	2779	87	937	29	91	88	93	0	0	0

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

S.No.	Priority areas	Activity planned under each priority area
1	Case Finding	Upgrade Hasanpura, Chainpur, Nautan, Ziradei and Lakri Naviganj PHIs as DMCs
		Started Sputum Collection Centres at Tarwara, Jamo Bazar, Sarsar, Bharthue, Baletha, Narendrapur and Madarpur
		Intensify Case finding efforts in High risk groups like- Prison, Slum, Mahadalit Tola and High density populated area.
		Focus on referral, Defaulter and Missed patients.
		Training/Re-training Lab Staff, DOTs Provider, Community Volunteer, ANM and Medical Officers.
2	Case Holding	Clear Honorarium Backlog.
3	Supervision and Monitoring	Regularize Payment of POL.
		Regularize Monthly meeting with MOTCs, STSs, STLSs and Quarterly meeting with Lab Technicians.
		Fill existing (2 STLS, 6 LTs, 1 TBHV) and newly created (1 STS, 1 STLS) vacancies.
		Upgrade Drug Stores at Siwan_DTC and Ander
4	Intensified TB-HIV Package	Formation/regularization of DCC meeting every quarter.
		Regularize Monthly meeting of NACP Staff with RNTCP
		Co-ordinate Training in Intensified Package.
5	PMDT	Upgrade Drug Store for SLD Storage at District-level
		PMDT Training to 1 MO per DMC and all Lab Technicians

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6.6.20 LEPROSY

Leprosy is a chronic infectious disease caused by the bacteria known as Mycobacterium leprae. The disease mainly affects the peripheral nerves, skin, and occasionally some other structures. All systems and organs can be involved in leprosy except the Central Nervous System. Leprosy, with long incubation period between 9 months to 20 years after infection can affect all age groups. The signs and symptoms many vary between PB to MB depending upon the degree of patient's immunity to M. leprae, the causative agent. Nevertheless, 95% of the people in our community are immune to Leprosy. Since the Leprosy bacilli affect the peripheral nerves, and if not properly cared, the patients lose sensation by and large, in their hands, feet and eyes, and injuries to these insensitive parts may lead to disfigurement, which is the main consequence of this disease that generates fear and stigma. The early detection and prompt treatment of Leprosy with prescribed MDT not only cures Leprosy but also interrupts its transmission to others.

Objectives	Eradication of Leprosy
Strategies & Activities	1. Detection of New cases 2. House to house visit for detection of any cases 3. IEC for awareness regarding the symptoms and effects of Leprosy 4. Prompt treatment to all cases 5. Rehabilitation of the disabled persons 6. Distribution of Medicine kit and rubber shoes 7. Honorarium to ASHA for giving MDT
Support required	Availability of regular supply of drugs
Timeline	**2012-13** House to house detection Wide publicity Rigorous follow-up

NATIONAL VECTOR BORN DISEASE CONTROL PROGRAMME

6.6.21 Kalazar

Situation analysis/Current status:

Kala azar is a slow progressing indigenous disease caused by a protozoan parasite of genus leishmania. It is transmitted by a vector i.e sand fly (*Phlebotomus argentipes*). PKDL is a condition when the *L.donovani* invades skin cells, reproduces and develops there & manifests as dermal lesions.

For the control of kala azar, NVBDCP,MOH &FW Govt.of India is proving free rapid diagnostic kits(Rk39)and drug(SSG-Sodium stibogluconate)in the district. For the vector control we had conducted two round IRS(Ist round(1st feb-30mar2011) &IInd round(15th july-30thjuly 2011)) in the kala azar affected villages in the district.

Issues	**No**
Total No of Kala azar & PKDL	**743(Till Nov.2011)**
Total No of Deaths	**0**

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6.6.22 NATIONAL MALARIA CONTROL PROGRAMME

Situation Analysis/ Current Status

Issues	No.	%
Total Blood Slides Examined (BSE)	15183	
Total Positive Cases: Plasmodium Vivax (Pv): Plasmodium Falciparum (Pf):	0	
Deaths:	0	

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

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

The main bottlenecks are related to shortage of manpower especially for the remote areas. Folloing are the descriptions of man power status.

Post Name	Sanctioned	In position	Vacant	Remarks
DMO	**1**	**1**	**0**	**All these posts come under state cadre**
AMO	**1**	**0**	**1**	
Malaria Inspector	**6**	**1**	**5**	
Lab Technician	**15**	**1**	**14**	
Clerk	**2**	**1**	**1**	
BHI	**15**	**2**	**13**	
BHW	**53**	**6**	**47**	
Driver	**2**	**0**	**2**	
Mechanic	**1**	**0**	**1**	
Motor Cleaner	**2**	**0**	**2**	
SFW	**2**	**1**	**1**	
FW	**4**	**0**	**4**	
Peon	**2**	**1**	**1**	
Sweeper	**1**	**1**	**0**	

Objectives

Reduction in SPR, API, PFR death rate

Strategies

1. Provision of additional Manpower
2. Training of personnel
3. Strengthening of Malaria clinics
4. Addressing Disease outbreak

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	5. Health education 6. Involvement of Private sector **7.** Innovative methods of Mosquito control
Activities	1. Provision of additional Manpower • Hiring of personnel till regular staff in place 2. Training of personnel The MOs, Laboratory Technicians, ANMs, ASHAs will be trained in various techniques relating to the job 3. Strengthening of Malaria clinics • Provision of Proper equipment and reagents – Fogging machines, sprayers, • Provision of Jeep, 4. Addressing Disease outbreak • District Outbreak teams will be created at the district headquarter • In the team MO, LT, one field worker • Provision of mobility, Lab equipments, spray equipment 5. Health education to the community through the ANMs, AWW, ASHAs, RMPs, Ayush personnel 6. Involvement of Private sector: The private practitioners will be closely involved
Support require	• Availability of supplies • Filling up of vacancies • Supply of health Education material
Timeline	

Activity / Item	**2012-13**
Hiring Contractual Staff	X
Purchase of Jeep	X
Fogging & Spraying	X
Hoardings	19 PHC, 1 SH 54 APHC
IEC activities	X

Dengu & Chikungunya

6.6.22 JAPANESE ENCEPHLITIS

JE is a serious and disabling illness caused by the Japanese Encephlitis virus. The Virus enters the body through the bite of Culex vishnoi & Culex pseudovishnoi mosquito and infects brain, causing inflammation & swelling which may result in long lasting brain damage or death. The mosquito picks up the virus from the animals(most commonly the pigs & water birds)and transmit to Humans. NVBDCP , MOH & FW, Govt. of India has monitored the JE in country since 1978. The children below 15 years are at higher risk than adults.

JE is the most Fatal disease causing havoc in the Siwan district in the recent years. Starting from 16th april 2011 a twenty day JE vaccination programme held by PATH, in which children from 1-15yrs age group were vaccinated.

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Target Population (1-15yrs age)	Achievement	%
1070702	936167	87.43

JE must be taken as a serious issue in the district on seeing the figure below:

Issues	No.
Total No. of JE +ve cases	19
Total No of deaths	6

Action taken by District:
The District malaria office is going for technical malathion fogging in the JE affected villages.

Support Required :

- There is no any facility for diagnosis of JE in the District.
- There is no any facility for treatment of JE in the district.
  Task to complete in 2012-13
  - Establishment of Special ward for JE patients
  - Establishment of diagnosis cell or centre test for testing of JE infected.

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Technical support of DFID_SWASTH Team in District Health Action Plan and Activities - Siwan

Program	Activities planned	Support of DFID_SWASTH
VHSND	Capacity building of ANM,ASHA,AWW along with Block officials like MOIC,BHM,BCA,CDPO,LS, EE, BC and DC of TSC. Assessment and procurement of medicines and equipments. Strong monitoring plan at district to Block level with PHED, ICDS and others development partners.. Monthly Convergence meeting and feedback sharing with ICDS, PHED, Administration and partner agencies at district and PHC level.	Technical support in planning to orientation. Monitoring support through support supervision and feedback sharing. Support through planning and feedback sharing during meeting.
JBSY	Agenda /data based structure meeting during ASHA Diwas and ANM monthly/weekly meeting and planning for next target.	Technical support
Hospital management	Planning meeting and capacity building of block officials at district level and service providers ASHA, MAMTA,ANM etc at PHC level to strengthen Labor Room and NBCC.	Technical support, Support supervision and feedback sharing support
NRC	Dissemination through IEC counseling through health and nutrition worker.	Technical support
Kala Azar	Capacity building of service providers	Support in planning and need based.
Bachpan Diwas	Planning and discussion in convergence meeting	Technical support/Support supervision and feedback sharing support.

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PIP of District Health Society, Siwan (2012-13) 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)				Financial Requirement (in Rs.)				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	Q1	Q2	Q3	Q4				
		HFD *		HFD	HFD	HFD	HFD	HFD	HFD	HFD	HFD	HFD			
A	**RCH Flexipool**														
A.1	**MATERNAL HEALTH**														
A.1.1	**Operationalise Facilities**														
A.1.1.1	**Operationalise FRUs-**														
A.1.1.1.2	Monitor Progress and Quality of Service Delivery		4	1	1	1	1	12500	12500	12500	12500	50000			
A.1.1.2	Operationalise 24x7 PHCs (Mch Center-APHC)		19	5	4	5	5	125000	100000	125000	125000	475000			
A.1.1.3	MTP Services at Health Facilities		20	4	5	6	5	100000	125000	150000	125000	500000			
A.1.1.4	RTI/STI Services at Health Facilities		20	4	5	6	5	100000	125000	150000	125000	500000			
A.1.1.5	Operationalise Sub-Centres (MCH Center-HSC)		2	0	1	1	0	0	50000	50000	0	100000			
A.1.2	***Referral Transport***											0			
A.1.3	**Integrated Outreach RCH Services**											0			
A.1.3.1	RCH Outreach Camps/ Others		38	10	10	10	8	70000	70000	70000	56000	266000			
A.1.3.2	Monthly Village Health and Nutrition		2660	Y	Y	Y	Y	Y	Y	Y	Y	1401300		NRHM	

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	Days													
A.1.4	**Janani Suraksha Yojana / JSY**										0			
A..1.4.1	Home Deliveries		1000	250	250	250	250	125000	125000	125000	125000	500000			
A_1.4.2	**Institutional Deliveries**										0			
A.1.4.2.A	Institutional Deliverie-Rural		60000	15000	15000	15000	15000	30000000	30000000	30000000	30000000	120000000	15000000		
A.1.4.2.B	Institutional Deliveries-Urban		1000	250	250	250	250	300000	300000	300000	300000	1200000			
A.1.4.2.C	Institutional Deliveries-C-Sections		600	150	150	150	150	225000	225000	225000	225000	900000			
A.1.4.3	Administrative Expenses		1	Y	Y	Y	Y	399570	399570	399570	0	1198710			25% increased of Budget
A.1.5	Maternal Death Review		209	50	50	59	50	37500	37500	44250	37500	156750			
A.1.6	Other Strategies/Activities (ICTC for HIV Testing of ANC Cases)							0	0	0	0	0			
A.2	**CHILD HEALTH**							0	0	0	0	0			
A.2.1	**IMNCI**		1	Y	Y	Y	Y	12500	12500	12500	12500	50000			
A.2.1.1	Implementation of IMNCI Activities in Districts		1	1	0	0	0	50000	0	0	0	50000			
A.2.1.3	Incentive for HBNC to ASHA/AWWs(State Iniative) 3 PNC for Normal Baby		11425	2856	2856	22856	2856	285625	285625	285625	285625	1142500			
A.2.1.4	Incentive for HBNC to ASHA(State Iniative) 6PNC for Low Birth Baby		7000	2800	2800	2800	2800	560000	560000	560000	560000	2240000			
A.2.2	Facility Based Newborn Care/FBNC (Operationalise 40 NBSUs)		1	1	0	0	0	775000	0	0	0	775000			

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A.2.3	Home Based Newborn Care/ HBNC							0	0	0	0	0			
A.2.4	Infant and Young Child Feeding/ IYCF							0	0	0	0	0			
A.2.5	Care of Sick Children and Severe Malnutrition														
A.2.6	Management of Diarrhoea, ARI and Micronutrient Malnutrition (Nutritional Rehabilitation Centres)	1.00	2	0	1	0	0	1083000	1083000	1083000	1083000	4332000		NRHM	1 NRC is functional and need 1 more NRC for SDH
A.2.7	Other Strategies/activities (,Vitamin A Biannual Round)		2 (Round	1	0	1	0	358049	0	358050	0	716099		NRHM	
A.2.8	Infant Death Audit		0					0	0	0	0	0			
A.3	**FAMILY PLANNING**							0	0	0	0	0			
A.3.1	**Terminal/ Limiting Methods**							0	0	0	0	0			
A.3.1.1	Dissemination of Manuals on Sterilisation Standards & QA of Sterilisation Services		1	0	1	0	0	0	20000	0	0	20000			
A.3.1.2	Female Sterilisation Camps		500	150	100	100	150	750000	500000	500000	750000	2500000			
A.3.1.3	NSV Camps		20	6	3	4	7	30000	15000	20000	35000	100000			
A.3.1.4	Compensation for Female Sterilisation		19000	4750	4750	4750	4750	4750000	4750000	4750000	4750000	19000000			
A.3.1.5	Compensation for Male Sterilisation (Compensation for NSV Acceptance)		445	75	100	150	120	112500	150000	225000	180000	667500			
A.3.1.6	Accreditation of Private Providers for Sterilisation Services		3558	889	889	889	891	1333500	1333500	1333500	1336500	5337000			

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A.3.2	**Spacing Methods**							0	0	0	0	0			
A.3.2.1	IUD Camps		200	50	50	50	50	75000	75000	75000	75000	300000			
A.3.2.2	IUD Services at Health Facilities							0	0	0	0	0			
A.3.2.3	Accreditation of Private Providers for IUD Insertion Services							0	0	0	0	0			
A.3.2.5	Contraceptive Update Seminars							0	0	0	0	0			
A.3.3	POL for Family Planning (for District Level + State Level Monitoring)		19	19	19	19	19	80750	80750	80750	80750	323000			**Rs.17000/- Per PHC for FP camp (Rs.12000/- per PHC & Rs.5000/- District will be spent per PHC wise.**
A.3.4	Repairs of Laparoscopes							0	0	0	0	0			
A.3.5	**Other Strategies/ Activities**							0	0	0	0	0			
A.3.5.1	State Level Worshop/Review for FP							0	0	0	0	0			
A.3.5.2	Orientation							0	0	0	0	0			
A.3.5.3	Family Planning Incentive/Award to Best Performer District/other Personel							0	0	0	0	0			
A.3.5.4	Provide IUD Services at Health Facility (IUD Camps)		58	10	20	15	13	15000	30000	22500	19500	87000			
A.3.5.5	Social Marketing ofContraceptives							0	0	0	0	0			

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A.4	**DOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH**							0	0	0	0	0			
A.4.1	Adolescent Services at Health Facilities (ARSH Corners in 3 DHs and PHCs)							0	0	0	0	0			
A.4.2	School Health Programme/ NPSGK	1	1	Y	Y	Y	Y	2208000	2208000	2208000	2208000	8832000			
A.4.3	Other Strategies/ Activities (Menstrual Hygiene)							0	0	0	0				
A.5	**URBAN RCH**							0	0	0	0	0			
A.5	URBAN RCH(Urban Health Center Through PPP)							0	0	0	0	0			
A.6	**TRIBAL RCH**							0	0	0	0	0			
A.6	TRIBAL RCH							0	0	0	0	0			
A.7	**PNDT & Sex Ratio**	1	1	1	1	1	1	25000	25000	25000	25000	100000			
A.7.1	Support to PNDT Cell							0	20000	40000	40000	100000			
A.7.2	Other PNDT Activities (Monitoring of Sex Ratio at Birth)							0	0	0	0	0			
A.8	**INFRASTRUCTURE (Minor Civil Works) & HUMAN RESOURCES (Except AYUSH)**														
A.8.1	**Contractual Staff & Services**							0	0	0	0	0			
A.8.1.1	ANMs, Staff Nurses, Supervisory Nurses (Salary of Contractual ANM/ Contractual SN)	278	549	Y	Y	Y	Y	21745500	21745500	21745500	21745500	86982000			110 Grade A nurse+439 ANM®=549

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A.8.1.2	Laboratory Technicians/(LT in Blood Banks)	3	3	Y	Y	Y	Y	90000	90000	90000	90000	360000			
A.8.1.5	Medical Officers at CHCs / PHCs (Salary of MOs in Blood Banks)	1	1	Y	Y	Y	Y	105000	105000	105000	105000	420000			
A.8.1.7	Others - FP Counsellors		1					90000	90000	90000	90000	360000			State has appointed till now
A.8.1.8	Incentive/ Awards Etc. to SN, ANMs Etc. (Muskaan Programme-Incentive to ASHA and ANM)		43275	10818	10818	10818	10821	645879	645879	645879	645880	2583517	3141600		25% increment of budget
A.8.1.9	Human Resources Development (Other Than Above)							0	0	0	0	0			
A.8.1_10	Other Incentives Schemes (Pl. Specify)							0	0	0	0	0			
A.8.2	**Minor Civil Works**							0	0	0	0	0			
A.9	**TRAINING**														
A.9.3	**Maternal Health Training**							0	0	0	0	0			
A.9.3.1	Skilled Attendance at Birth	6	12	3	3	3	3	264330	264330	264330	264330	1057320			
A.9.3.2	Comprehensive EmOC Training (Including C-Section)														
A.9.3.3	Life Saving Anaesthesia Skills Training														
A.9.3.4	MTP Training		6	1	2	2	1	43470	86940	86940	43470	260820			
A.9.3.5	RTI / STI Training							0	0	0	0	0			
A.9.3.6	BEMOC Training							0	0	0	0	0			

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A.9.3.7	Other MH Training (Any Integrated Training, Etc.)- Training of MOs and Paramedics at Sub-District Level (Convergence with BSACS)		2	1	1	0	0	115000	115000	0	0	230000			
A.9.4	IMEP Training							0	0	0	0	0			
A.9.5	**Child Health Training**							0	0	0	0	0			
A.9.5.1	IMNCI	18	60	15	15	15	15	2321160	2321160	2321160	2321160	9284640			15% increment of budget
A.9.5.3	Home Based Newborn Care							0	0	0	0	0			
A.9.5.4	Care of Sick Children and Severe Malnutrition A.9							0	0	0	0	0			
A.9.5_5	**Other CH Training (Pl. Specify)**							0	0	0	0	0			
A.9.5.5.1	TOT on FBNC							0	0	0	0	0			
A.9.5.5.2	Training on FBNC for Medical Officers							0	0	0	0	0			
A.9.5.5.3	NSSK Training (SN/ANM)		6	0	2	2	2	0	105800	105800	105800	317400			
A.9.6	**Family Planning Training**							0	0	0	0	0			
A.9.6.1	Laparoscopic Sterilisation Training							0	0	0	0	0			
A.9.6.2	Minilap Training		1	0	1	0	0	0	70237	0	0	70237			
A.9.6.3	NSV Training		1	0	0	1	0	0	0	33900	0	33900			
A.9.6_4	**IUD Insertion Training**							0	0	0	0	0			
A.9.6.4.1	Training of Medical Officers in IUD Insertion		1	0	1	0	0	0	55289	0	0	55289			
A.9.6.4.2	Training of ANMs / LHVs/SN in IUD		3		1	1	1	0	29425	29425	29425	88275			

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	Insertion														
A.9.6.5	Contraceptive Update							0	0	0	0	0			
A.9.6_6	**Other FP Training (Pl.SSpecify)**							0	0	0	0	0			
A.9.6.6.2	Training of Family Planning Counsellors							0	0	0	0	0			
A.9.7	ARSH Training (MOs, ANM/Nurses, Nodal Officers)							0	0	0	0	0			
A.9.8	**Programme Management Training**							0	0	0	0	0			
A.9.8.1	SPMU Training							0	0	0	0	0			
A.9.8.2	DPMU Training	2	1	1	0	0	0	50000	0	0	0	50000			
A.10.1.5	Mobility Support (District Malaria Office)		1	Y	Y	Y	Y	60000	40000	40000	40000	180000			
A.10.1.6	Strengthening of Directorate							0	0	0	0	0			
A.10.2	**Strengthening of DHS/ DPMU (Including HR, Management Cost, Mobility Support, Field Visits)**							0	0	0	0	0			
A.10.2.1	Contractual Staff for DPMU Recruited and in Position	4	4	Y	Y	Y	Y	370944	370944	370944	370944	1483776			
A.10.2.2	Provision of Equipment/furniture and Mobility Support for DPMU Staff & HR Consultant		1	Y	Y	Y	Y	308125	308125	308125	308125	1232500			25% increment of total budget
A.10.3	Strengthening of Block PMU	35	38	Y	Y	Y	Y	119796	119796	119796	119796	479184			
A.10.3.1	Recurring Expense for BPMU(Mobility and Office Expense)		19					21375000	21375000	21375000	21375000	85500000			25% increment of total budget
A.10.3.1(A)	Laptop for BHM		19	19	0	0	0	0	0	0	0	722000			

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A.10.4	**Strengthening (Others)**														
A.10.4.2	Renewal (Upgradtion)		1	0	1	0	0	0	8100	0	0	8100			
A.10.4.3	AMC (State, Regional & DHS)		1	0	1	0	0	0	22500	0	0	22500			
A.10.4.9	Management Unit at FRU (Hospital Manager & FRU Accountant)	2	4	Y	Y	Y	Y	1020000	1020000	1020000	1020000	4080000			
A.10.5	**Audit Fees**														
A.10.5.1	Annual Audit of the Programme (Statutory Audit)		19	Y	Y	Y	Y	171000	0	0	0	171000			
A.10.5.2	Internal Auditor	1	1	Y	Y	Y	Y	60000	60000	60000	60000	240000			
A	RCH Flexipool														
Total										Grand Total		**3698923 17**			

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Part – B

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PIP of District Health Society, Siwan (2012-13)

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.)	Financial Requirement (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		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)			
		HFD *		HFD	HFD	HFD	HFD	HFD		HFD	HFD	HFD	HFD	HFD			
B	**Mission Flexible Pool**																
B.1	**ASHA**							0		0	0	0	0	0			
B.1.1.1	Selection & Training of ASHA	2822	3008	1003	1003	1002	0	3008	4623.33	4637199	4637199	4632577	0	13906975			
B.1.1.2	Procurement of ASHA Drug Kit & Replenishment	2822	3008	1504	1504	0	0	3008	312	938496	938496	0	0	1876992	550000		
B.1.1.3	Other Incentive to ASHAs (TA/DA for ASHA Divas)	2822	3008	Y	Y	Y	Y	3008	1284	965568	965568	965568	965568	3862272			25% increment of tentative unit cost
B.1_1.4	**Awards to ASHA's/Link Workers**																
B.1.1.4.A	Best Performance Award to ASHAs at District Level		19	19	0	0	0	19	2500	47500	0	0	0	47500			25% increment of tentative unit cost
B.1.1.4.B	Rechargeable Torch to ASHA		3008	3008	0	0	0	3008	250	752000	0	0	0	752000			25% increment of tentative unit cost
B.1.1.4.C	Identity Card to ASHA		3008	3008	0	0	0	3008	30	90240	0	0	0	90240			
B.1.1.5	ASHA Resource Centre/ASHA Mentoring Group	160	164	0	0	0	0	164	3527140	10581420	10581420	10581420	1.1E+07	42325680			10% hike salary of DDA,BCM,AF
B.2	**Untied Funds**																
B.2.1	Untied Fund for SDH/CHC		1	1	0	0	0	1	50000	50000	0	0	0	50000			
B.2.2.A	Untied Fund for PHCs		19	19	0	0	0	19	25000	475000	0	0	0	475000			

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B.2.2.B	Untied Fund for APHC		54	54	0	0	0	54	25000	1350000	0	0	0	1350000			
B.2.3	Untied Fund for Sub Centres		370	0	370	0	0	370	10000	0	3700000	0	0	3700000			
B.2.4	Untied Fund for VHSC		1538	1538	0	0	0	1538	10000	15380000	0	0	0	15380000	15380000		
B.3	**Annual Maintenance Grants**							0		0	0	0	0	0			
B.3.1	CHCs		3	1	2			3	300000	300000	300000	300000	0	900000			
B.3.1.A	SDH		1	1	0	0	0	1	300000	100000	100000	100000	0	300000			
B.3.2	PHCs		19	9	5	5		19	200000	950000	950000	950000	950000	3800000			
B.3.2.A	APHC		47	20	20	7	0	47	100000	1700000	1000000	1000000	1000000	4700000	1100000		
B.3.3	Sub Centres		370	125	125	100	20	370	10000	1250000	1250000	1000000	200000	3700000			
B.4	**Hospital Strengthening**		1	1	0	0	0	1	500000	125000	125000	125000	125000	500000			
B4.1	**Up Gradation of CHCs, PHCs, Dist. Hospitals to IPHS)**							0		0	0	0	0	0			
B.4.1.1	**District Hospitals**							0		0	0	0	0	0			
B.4.1.1.A	Construction of SNCU in District Hospitals	1	1	0	0	0	0	0		0	0	0	0	0	600000		Construction of SNCU has been completed and equipments has also purchased(30% Amount of SNCU equipment has to pay Apprx=600000)
B.4.1.1.B	Up Gradation of 05 DHs by Increase Number of Beds 900							0		0	0	0	0	0			
B.4.1.2	CHCs (Hospital Strengthening)							0		0	0	0	0	0			
B.4.1.3	PHCs (Construction of 4 Doctors & 8 Staff Nurse Quarters in 38 PHCs)\							0		0	0	0	0	0			
B.4.1.4	Sub Centres(Hospital Strengthening)							0		0	0	0	0	0			

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B.4.1.5	Others (Up Gradation of 2 Health Facilities (Rajendra Nagar) Eye Hospital & Lok Nayak Jay Prakash Narayan Hospital) Into Super Speciality As Per IPHS							0		0	0	0	0	0			
B4.2	Strengthening of Districts, Sub-Divisional Hospitals, CHCs, PHCs							0		0	0	0	0	0			
B4.2.A	Installation of Solar Water System in 25 SDH, 10 RH and 150 PHC	5	14	5	5	4	0	14	38500	192500	192500	154000	0	539000			
B.4.3	Sub Centre Rent and Contingencies									7500000	7500000	7500000	7500000	30000000	4000000		Rent is pending for a long time
B.5	**New Constructions/ Renovation and Setting Up**																
B.5.1	Construction of 1 New office and DPMU Quarter		1	Y	Y	Y	Y	1	1.2E+07	11900000	Y	Y	Y	11900000			Fund required as per IPHS norms
B.5.1.2	Construction of 1 bathrooms, 1 Hall,Drainage, 1 New labour room,and 1 ASHA waiting room in Sadar Hospital		5	5	0	0	0	5	8400000	8400000	0	0	0	8400000			Fund required 4 Lakh for New construction of 1 bathroom . 40 Lakhs for 1 New Hall,20 Lakhs for Drainage, 12 Lakh for 1 New Labour room,8 Lack for 1 New ASHA waiting room and shade
B.5.1.3	Renovation of wards. OT. Labour Room and Bathroom and Oxygen pipe lining(central Oxygen System)		5	5	0	0	0	5	3400000	3400000	0	0	0	3400000			Renovation of wards. OT.Labour room=1000000.Renovation of Bathroom=4 Lakh Oxygen pipelining C main consele=2000000
B.5.1.4	Upgradation of CHCs as per IPHS standards		14	Y	Y	Y	Y	14	9000000	Y	Y	Y	Y	126000000			Fund required as per IPHS norms

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B.5.1.5	**Construction of Boundry wall for 8 PHCs**		8	4	4	0	0	8	1260@per feet	10080000	10080000	0	0	20160000			Construction of Boundry wall for 8 PHC and every PHC has approximately 2000 Sq. Per Sq feet is @1260 (1260x16000=20160000)
B.5.2.	Construction of PHCs		4	4	0	0	0	4	2037000					81228000			Fund required as per IPHS norms
B5.2.1.	Construction of APHC		6	4	2	0	0	6	7599000	30396000	1519000	0	0	31915000			Fund required as per IPHS norms
B.5.2.A	Construction of HSCs		82	Y	Y	Y	Y	82	1557000	Y	Y	Y	Y	127674000			Fund required as per IPHS norms
B.5.2.A.A	Construction of Residential Quarters for DS,Manager,Doctors and Staff		3	3	0	0	0	3	8000000	24000000	0	0	0	24000000			
B5.2.B	Construction of Residential Quarters for Doctors & Staff Nurses in Old APHC		2	0	2	0	0	2	7599000	0	15198000	0	0	15198000			Fund required as per IPHS norms
B5.2.C	Strengthening of Cold Chain (Refurbishment of Existing Cold Chain Room for District Stores and Earthing and Wiring of Existing Cold Chain Rooms in All PHCs		1	0	1	0	0	1	800000	0	800000	0	0	800000			
B5.2.1.C	Strengthening of Cold Chain (Refurbishment of Existing Cold Chain Room for District Stores and Earthing and Wiring of Existing Cold Chain Rooms in All PHCs		19	5	5	5	4	19	100000	5000000	50000	500000	400000	1900000			
B5.4	Setting Up Infrastructure Wing for Civil Works (9 Executive Eng, 38 Asst. Eng & 76 JE Under Bihar Medical Services and Infrastructure Corporation																

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	Ltd)																
B5.5	Govt. Dispensaries/ Others Renovations																
B5.6	Construction of BHO, Facility Improvement, Civil Work, BemOC and CemOC Centers\																
B.5.7	Major Civil Works for Operationalisation of FRUS																
B.5.8	Major Civil Works for Operationalisation of 24 Hour Services at PHCs																
B.5.9	Civil Works for Operationalising Infection Management & Environment Plan at Health Facilities																
B.5.10	**Infrastructure of Training Institutions**																
B.5.10.1	Strengthening of Existing Training Institutions/Nursing School(Other Than HR)-Strengthening of Nursing Education- at IGIMS Bihar																
B.5.10.2	New Training Institutions/School(Other Than HR)																
B.6	**Corpus Grants to HMS/RKS**							0		0	0	0	0	0			
B6.1	District Hospitals		1	1				1	500000	500000	0	0	0	500000			
B6.2	CHCs (SDH)		2	2	0	0	0	2	100000	200000	0	0	0	200000			
B6.3	PHCs - RKS		19	19	0			19	100000	1900000	0	0	0	1900000			
B6.4	Other (APHC)		47	47		0	0	47	100000	4700000	0	0	0	4700000	4700000		
B.7	**District Action Plans (Including Block, Village)**	1	1					1	30000	0	30000	0	0	30000			50% hike of budget

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B.7.1	**HSC level planning**	370	370						1500	0	370	0	0	555000			
B.7.1.1	**BHAP**	19	19						6250	0	19	0	0	118750			25% hike of budget
B.7.1.2	**SDH Planning**		1						6250	0	1	0	0	6250			
B.7.1.3	**Other expenses for DPC(Mobile Recharge)**		12	3	3	3	3	12	500	1500	1500	1500	1500	6000			Rs 500 PM for mobile recharge
B.7.1.4	District Action Plans (for two workshop)		2	0	1	1	0	2	25000	0	25000	25000	0	50000			
B.7.1.5	Planning Cell at distrcit level(1 computer assistant)		1	1	0	0	0	1	6000	3	3	3	3	72000			
B.7.1.6	Laptop for DPC		1	1	0	0	0	1	38000	38000	0	0	0	38000			
B.8	**Panchayati Raj Initiative**																
B8.1	Constitution and Orientation of Community Leader & of VHSC,SHC,PHC,CHC Etc		293	74	74	74	71	293	1725	127650	127650	127650	127650	510600			15% increment of budget
B.8.2	Orientation Workshops, Trainings and Capacity Building of PRI at State/Dist. Health Societies, CHC,PHC		293+19=312	78	78	78	78	312	713	12765	47394	47394	47394	222456			15% Increased of Budget
B.9	**Mainstreaming of AYUSH**																
B.9	**Medical Officers at DH/CHCs/ PHCs (Only AYUSH)**																
B.9.1	Medical Officers at DH/CHCs/ PHCs (Only AYUSH)	35	54	Y	Y	Y	Y	54	22000	3564000	3564000	3564000	3564000	14256000			
B_9.3	**Activities Other Than HR**																
B.9.3.1	Training of AYUSH Doctors & Paramedical Staffs W.R.T AYUSH Wing and Establishment of Head Quarter Cost																
B_10	**IEC-BCC NRHM**																

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B.10	**Strengthening of BCC/IEC Bureaus (State and District Levels)**																
B.10.1	Development of State BCC/IEC Strategy		20	Y	Y	Y	Y	20		550000	550000	550000	550000	2200000			**Rs.300000/- for Dist Level & 100000/- for PHC**
B_10.2	**Implementation of BCC/IEC Strategy**																
B.10.3	Health Mela (Leprosy)		1	0	1	0	0	1	6000	0	6000	0	0	6000			50% Increment of total budget
B.10.4	Creating Awareness on Declining Sex Ratio Issue.																
B.10.5	Other Activities																
B_11	**Mobile Medical Units (Including Recurring Expenditures)**																
B_11	Mobile Medical Units (Including Recurring Expenditures)		1	3	3	3	3	12	468000	1404000	1404000	1404000	1404000	5616000			
B_12	**Referral Transport**																
B.12.1	**Ambulance/ EMRI/Other Models**																
B.12.1	Ambulance/ EMRI/Other Models																
B.12.2	**Operating Cost (POL)**																
B.12.2.A	Emergency Medical Service/102-AmbulanceService																
B.12.2.B	1911- Doctor on Call & Samadhan																
B.12.2.C	Advanced Life Saving Ambulance (Call 108)		1	Y	Y	Y	Y	0	130000	390000	390000	390000	390000	1560000			
B.12.2.D	Referral Transport in Districts		18	Y	Y	Y	Y	0	15000	810000	810000	810000	810000	3240000			15000 PM for Per ambulance
B_13	**PPP/ NGOs**																
B.13.1	**Non-Governmental Providers of Health Care RMPs/TBAs**																

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B.13.2	Public Private Partnerships																
B_13.3	**NGO Programme/ Grant in Aid to NGO**																
B.13.3.B	Outsourcing of Pathology and Radiology Services From PHCs to DH	11	20	3	2	2	2	20	300000	150000	150000	150000	150000	6000000			
B.13.3.C	Outsourcing of HR Consultancy Services							0		12765	0	0	0	12765			
B.13.3.D	IMEP(Bio-Waste Management)		23	7	8	8	0	23	75827	436000	436000	436000	436000	1744000			
B_14	**Innovations**																
B.14.A	Innovations(If Any) (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls Or SABLA)\																
B.14.B	YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services		913	229	229	229	226	913	460	104995	104995	104995	104995	419980			15% Incresed of tentative unit cost
B_15	**Planning, Implementation and Monitoring**																
B .15.1	**Community Monitoring (Visioning Workshops at State, Dist, Block Level)**																
B15.1.1	State Level																
B15.1.2	District Level (Purchase of 830 Mobile Handsets From BSNL/By Tender Process)																
B15.1.3	Block Level																
B15.1.4	Other																
B.15.2	**Quality Assurance**																
B15.2	Quality Assurance																
B.15.3	**Monitoring and Evaluation**																

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B.15.3.1	**Monitoring & Evaluation/HMIS/MCTS (State, District , Block & Divisional Data Centre)**																
B15.3.1.A	State, District, Divisional, Block Data Centre	20	20	Y	Y	Y	Y	20	8250	495000	495000	495000	495000	1980000			
B15.3.1.B	CBPM																
B.15.3.2	**Computerization HMIS and E-Governance, E-Health (MCTS, RI Monitoring, CPSMS)**	83	83					83	824	17109	17109	17109	17109	68437			15% increased of total budget
B.15.3.2.A	MCTS and HRIS							0			517000	0	0	517000			15% increased of total budget
B.15.3.2.B	RI Monitoring		19	5	5	5	4	19	7868	37375	37375	37375	37375	149500			
B.15.3.2.C	CPSMS							0		0	25000	0	0	25000			
B.15.3.2.D	Hospital Management System, Telemedicine and Mobile Based Monitoring							0		0	0	0	0	0			
B.15.3.3	**Other Activities (HMIS)**							0		0	0	0	0	0			
B.15.3.3.A	Strengthening of HMIS (Up-Gradation and Maintenance of Web Server of SHSB)		1		1			1	4000	0	4000	0	0	4000			
B15.3.3.B	Plans for HMIS Supportive Supervision and Data Validation							0	32600	815000	815000	815000	815000	326000			
B_16	**PROCUREMENT**																
B.16.1.1	**Procurement of Equipment of MH (Labour room) PHC**		21	21	0	0	0	21	130519	2740899	0	0	0	2740899	2740899		10% increased of budget
B.16.1.2	**Procurement of Equipment of SNCU**		1	1	0	0	0	1	2265258	2265258	0	0	0	2265258	2265258		
B.16.1.3	**Procurement of Equipment: FP**		132	33	33	33	33	132	5435	179355	179355	179355	179355	717426			
B16.1.3.A	Procurement of Minilap Set (FP)		95	24	24	24	23	95	3000	72000	72000	72000	69000	285000			
B16.1.3.B	Procurement of NSV Kit (FP)		5	0	3	2	0	5	1100	0	3300	2200	0	5500			

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B16.1.3.C	Procurement of IUD Kit (FP) (PHC Level)		1	0	1	0	0	1	15000	0	15000	0	0	15000			
B16.1.4	Procurement of Equipment: IMEP																
B16.1.5	**Procurement of Others**																
B16.1.5.A	Dental Chair Procurement		23	23	0	0	0	23	283500	5103000	0	0	0	5103000	1357894		
B16.1.5.B	Equipments for 1 New Blood Banks		1	0	0	0	0	1	890000	0	0	0	0	890000			
B16.1.5.C	A.C. 1.5 Ton Window for 28 (Running Blood Banks)		1	0	1	0	0	1	25000	0	25000	0	0	25000			
B16.1.5.E	POL for Vaccine Delivery From State to District and to PHC/CHC																
B.16.1.1	Procurement of Equipment: MH (Labour Room)																
B.16.1.1A	Procurement of Bed, ANC Instrument and ARI Timer																
B 16.1.2	Procurement of Equipment : CH (SCNU-NBCC)																
B 16.2	**Procurement of Drugs and Supplies**																
B16.2.1	**Drugs & Supplies for MH**																
B16.2.1.A	Parental Iron Sucrose (IV/IM) As Therapeutic Measure to Pregnant Women with Severe Anaemia		1	0	1	0	0	1	500000	0	500000	0	0	500000			
B.16.2.1.B	IFA Tablets for Pregnant & Lactating Mothers		134859	33714	33714	33714	33714	134859		479323	479323	479323	479323	1917292			
B16.2.2	**Drugs & Supplies for CH**																
B.16.2.2.A	Budget for IFA Small Tablets and Syrup for Children (6 -59 Months)		419561	1E+05	104890	1E+05	104890	419561	5.68	711087	711087	711087	711087	2844350			
B16.2.2.B	IMNCI Drug Kit		7872	1968	1968	1968	1968	7872	250	492000	492000	492000	492000	1968000			
B16.2.3	Drugs & Supplies for FP																

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B.16.2.5	General Drugs & Supplies for Health Facilities		3E+06	8E+05	829544	8E+05	829544	3318176	4.33	3591925	3591925	3591925	3591925	14367702			
B_22	**Support Services**																
B.22.1	Support Strengthening NPCB																
B.22.2	Support Strengthening Midwifery Services Under Medical Services																
B.22.3	Support Strengthening NVBDCP																
B.22.4	Support Strengthening RNTCP		19	5	5	5	4	19	18000	90000	90000	90000	72000	342000			
B.22.5	Contingency Support to Govt. Dispensaries																
B.22.6	Other NDCP Support Programmes																
B_23	**Other Expenditures (Power Backup, Convergence Etc)-**																
B.23.A	Payment of Monthly Bill to BSNL		20	Y	Y	Y	Y	20	3405	204300	204300	204300	204300	817200			
B	Mission Flexible Pool																
												Part B=Grand Total		**662668024**			

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Part – C

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		C.1Mobility Support for Supervision & Monitoring at District level (Rs. 50000 per year per district	C.2Cold chain maintenance (Maintenance of Cold Chain equipments ILR & DFs Rs. 12000/- per districts & Rs. 3000/- per PHCs)

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SL No.	Name of District	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance
1	Siwan	50000	12500	12500	12500	12500	0	63000	0	63000	0	0	0

C.3Alternative vaccine delivery to Session Sites

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C.3.1-Alternative vaccine delivery in NE States, Hilly terrains & geograhically from vaccine delivery point, river crossing etc.hard to reach areas in per month @ Rs. 100 per session for 12 months						C.3.2-Alternative Vaccine Deliery in other areas @ Rs. 50 per session sites for Approx 14000 Session sites in a month & AVD for Urban Areas					
Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance
58800	14700	14700	14700	14700	0	2912000	728000	728000	728000	728000	0

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C.4Focus on slum & underserved areas in urban areas:											C.5 Social Mobilization of Children through ASHA/ Link workers & paid mobilizers for Under served areas & Hard to Reach area @ Rs 200/- per month for mobilization (for 12 months)					
C.4.1-for 3645 slums @ Rs. 200 per month per Mobilizer per session						C.4.2 Alternate vaccinators honorarium for urban @ Rs 1400 per month for 12 months for under served areas										
Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance

ftlOKU

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0	0	0	0	0	0	168000	42000	42000	42000	42000	0	235200	58800	58800	58800	58800	0

f1 OKU

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C. 6. Computer Assistants support							C. 7. Printing & Dissemention
C. 6.1 Computer Assistants support at State Level	C. 6.2 Computer Assistants support for District level @ Rs.10000 per person per month for one computer assistant in each 38 districts						
Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)

TIOKU

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	120000	30000	30000	30000	30000	0	

C. 8 Review Meetings		
C.8. 1 State Level Review meetings	**C.8.2 Quarterly review meetings exclusive for RI at district level with one Block Mos, CDPO, and other stake holders @ Rs. 100 per participants for 5 participants per per PHCs 100**	**C. 8.3 Quarterly review meetings exclusive for RI at block level @ Rs. 50/- PP as honorarium for ASHAs and Rs. 25 per persons for meeting expenses for 789600ASHAs**

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Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance
	38000	9500	9500	9500	9500	0	789600	197400	197400	197400	197400	0

C.9 Trainings (separate annexure attached with details)

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C. 9. 1 District level orientation for 2 days for ANMs MPHW, LHV Health Assistants Nurse, Mid wife Bees and other specialist as per traning norm of RCH for 9000 persons in 600 batches						C.9.2 MO's training	C.9.3 One day training for Computer Assistant on RIMS/HMIS	C.9.4 One day cold chain handlers training for block level cold chain hadlers for 542 + 38 Sadar Hosp. cold chain handlers						C.9.5 One day training of block level data handlers for 533 person.					
Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance
0	0	0	0	0	0			20470	0	20470	0	0	0	19493	0	19493	0	0	0

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C.10 Microplanning											C.11 POL for vaccine delivery					
C.10.1 To develop microplan at sub-centre level @ Rs 100/- per sub - centre						C.10.2 For consolidation of microplans at block level @ Rs. 1000 per block/ PHC(20) and at district level @ Rs. 2000 per district for1 districts.						C.11 POL for vaccine delivery from State to district and from district to PHC/CHCs (@ Rs. 20000/- per WIC/WIF point & Rs. 20000/- per Districts + Rs. 5500/- for each PHC per year),					
Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance

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46100	0	46100	0	0	0	21000	0	21000	0	0	0	124500	31125	31125	31125	31125	0

C.12 Consumables	C. 13 Injection safety	C.14 Catch-up Campaign
C.12 Consumables for computer including provision for internet access for RIMs Rs. 400 per month per district for 38districts.	**C.13 1- Red & 1-Black plastic bags etc. @.90 paise per session for 12 months**	

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Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)
4800	1200	1200	1200	1200	0	54389	0	54389	0	0	0	

C. 16 For major AEFI cases investigation for every district in a	**Total Part C-RI**

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year. @Rs 1000/- for mobility in the field and @ 5000/- for specimen shipment to lab including travel cost, lodging & fooding etc.											
Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (In Rs Rupees)	Q1	Q2	Q3	Q4	Varience
15000	0	15000	0	0	0	4740352	1125225	1364677	1125225	1125225	0

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Part – D

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Sl. No.	District	Under SHS(Leprosy) NLEP contractual services (staff)									Services through ASHA (performance based Incentive to ASHA)											
		Driver's Remuneration @ Rs. 4500/- per month (one driver / District)						DEO at State Leprosy Cell @ Rs.8000/-	Administrative Assisstant in Leprosy Cell @ Rs. 7000/-	SMO (Surveillance Medical Officer) @ Rs. 20000/- per month	Services through ASHA (performance based Incentive to ASHA @ Rs. 500/- for MB & Rs.300/- for PB)						Sensitisation of ASHA (half day @ Rs. 2800/- per Batch of 40 Participant) at district level					
		Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance				Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance
1	Siwan	54000	13500	13500	13500	13500	0				57000	0	57000	0	0	0	210000	0	210000	0	0	0
Total		**54000**						**0**	**0**	**0**	**57000**		**57000**				**210000**					

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Office Expenses & Consumbale											
DLS(leprosy) for rent,telephone,electricity, P & T charges, miscellaneous(includes Rs.500/- per month honarrium for Account work)@ Rs.18000/- per district/ year						Consumable Expenses (Stationery & etc.) @ Rs. 14000/- per year					
Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance
18000	4500	4500	4500	4500	0	14000	0	14000	0	0	0
18000						**14000**					

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Capacity building																
2 days modular training of new entant Mos @ Rs. 24,750/- per Batch for 1 batches						1 day Orientation training of MOs @ Rs. 18625/- per Batch of 30 MOs for 3 batches						Refreshal training for one day for Health Supervisors/LHV/Pharmacists @ Rs. 7025/- per batch of 30 for 2 batches					
Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance
24750	0	24750	0	0	0	55275	0	55275	0	0	0	14050	0	14050	0	0	0
24750						**55275**		55275				**14050**					

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Behavioral Changes and Communication																						
School Quiz @ Rs. 500/- per quiz (7 quiz per block for 19 PHCs / Blocks)						Health Melas @ Rs. 4000/- per mela (one health mela per district)						Sensitization meetings with PRI members @ Rs. 3965/- per meeting at PHC / block level						Leprosy Day Function					
Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance
66500	0	66500	0	0	0	4000	0	4000	0	0	0	75335	0	75335	0	0	0	10000	0	10000	0	0	0
66500						**4000**						**75335**						**10000**					

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POL / Vehicle Operation & hiring						DPMR																							
Vehicle Operation / hiring, POL & Maintenance @ Rs. 75000/- per vehicle / district						MCR & other footwears- 250 pairs @ Rs.250/- per pair						Aids & appliances- Rs.7000/- per district						Welfare allowance for RCS patients @ 5000/- per patient for 25 patients						Incentive to institution for RCS Rs.5000/- per RCS for 100 RCS					
Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total Distrct annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance
75000	0	75000	0	0	0	62500	62500	0	0	0	0	7000	0	7000	0	0	0	12500	0	12500	0	0	0	0	0	0	0	0	0
75000						**62500**						**7000**						**12500**						**0**					

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Drugs, Materials & Supplies																	
Supportive medicines @ Rs. 25000/- per year						Laboratory reagents & equipments @ Rs. 11840/- per year						Printing of forms/DPMR registers etc					
Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance
25000	0	25000	0	0	0	11840	0	11840	0	0	0	0	0	0	0	0	0
25000						**11840**						**0**					

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Urban Leprosy Control Programme						Supervision, Monitoring & Review Review meetings and Travel Expenses						Cash Assistance	G. Total	Q1	Q2	Q3	Q4	Veriance
Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance	Total District annual allocation 2012-13	Q1	Q2	Q3	Q4	Variance							
50000	0	50000	0	0	0	12000	0	12000	0	0	0		858750	80500	742250	18000	18000	0
50000						**12000**						**0**	858750					

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ANNUAL PLAN FOR PROGRAMME PERFORMANCE & BUDGET FOR THE YEAR 1ST APRIL 2012 TO 31ST MARCH 2013

District - ___SIWAN_ ___ State -___BIHAR ___

This action plan and budget have been approved by the DTCS.

Signature of the DTO

Name - DR. NIRBHAY KUMAR JAIN Designation - D.T.O.

Section-A – General Information about the District

1	Population (in lakh) please give projected population for next year	3283345
2	Urban population	206719
3	Tribal population	0
4	Hilly population	0
5	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums)	0

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

Does the district have a DTC_____YES_____

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ORGANIZATION OF SERVICES IN THE DISTRICT:

S. No.	Name of the TU	Population (in Lakhs)	Please indicate if the TU is-		No. of DMCs		
			Govt	NGO	Govt	NGO	Private
1	Siwan_DTC	798766	YES		4		
2	Basantpur	656749	YES		3		
3	Daraundha	561670	YES		3		
4	Mairwa	511525	YES		3		
5	Raghunathpur	754634	YES		6		
	DISTRICT	**3283345**	YES		**19**		

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RNTCP performance indicators:

Important: Please give the performance for the last 4 quarters i.e. ***Oct 2010 to Sep 2011***

TB Unit	Total number of patients put on treatment	Annualized total case detection rate (per lakh pop)	No of new smear positive cases put on treatment	Annualized New smear positive case detection rate (per lakh pop)	Success rate for cases detected in the last 4 corresponding quarters	Plan for the next year		Proportion of TB patients tested for HIV	No. of MDR TB suspects identified and subjects to C/DST of sputum	No. of MDR TB cases diagnosed & put on treatment
						Annualized NSP CDR	Success rate %			
Siwan_DTC	575	74	148	19	86	75	87	0	0	0
Basantpur	612	96	208	33	96	97	97	0	0	0
Daraundha	517	95	159	29	91	96	93	0	0	0
Mairwa	335	68	140	28	82	69	84	0	0	0
Raghunathpur	740	99	282	38	96	99	97	0	0	0
District-Siwan	2779	87	937	29	91	88	93	0	0	0

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

S.No.	Priority areas	Activity planned under each priority area
1	Case Finding	Upgrade Hasanpura, Chainpur, Nautan, Ziradei and Lakri Naviganj PHIs as DMCs
		Started Sputum Collection Centres at Tarwara, Jamo Bazar, Sarsar, Bharthue, Baletha, Narendrapur and Madarpur
		Intensify Case finding efforts in High risk groups like- Prison, Slum, Mahadalit Tola and High density populated area.
		Focus on referral, Defaulter and Missed patients.
		Training/Re-training Lab Staff, DOTs Provider, Community Volunteer, ANM and Medical Officers.
2	Case Holding	Clear Honorarium Backlog.
3	Supervision and Monitoring	Regularize Payment of POL.
		Regularize Monthly meeting with MOTCs, STSs, STLSs and Quarterly meeting with Lab Technicians.
		Fill existing (2 STLS, 6 LTs, 1 TBHV) and newly created (1 STS, 1 STLS) vacancies.
		Upgrade Drug Stores at Siwan_DTC and Ander
4	Intensified TB-HIV Package	Formation/regularization of DCC meeting every quarter.
		Regularize Monthly meeting of NACP Staff with RNTCP
		Co-ordinate Training in Intensified Package.
5	PMDT	Upgrade Drug Store for SLD Storage at District-level
		PMDT Training to 1 MO per DMC and all Lab Technicians

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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	*1*	*1*	*0*	*Up gradation of DTC.*	*4500.00*	
District Drug Store (up gradation for storage of second line drugs)	*2*	*0*	*2*	*One Drug Store for DTC and One for DOTs Plus*	*65000.00*	
TUs	*6*	*5*	*1*	One new TU Planned and upgrade 5 TUs	*41500.00*	
DMC	*32*	*19*	*3*	*Three DMC Planned and 16 DMCs maintained*	*109000.00*	
				Total	***220000.00***	

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)*

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	(a)	(b)	(c)	(d)	(e)
Purchase of Lab Materials	480000.00	*210492.00*	*200000.00*	***300000.00***	

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 for DOT providers (both tribal and non tribal districts)	*900000.00*	*43750.00*	*30000.00*	1200000.00	***Amount due from 2008 to 2011***
Honorarium for DOT providers of Cat IV patients	*2500/per patients*	*0*	*0*	30000.00	
Actual Fares for Public transport to MDR TB patients (on DOTS-Plus Treatment) and 1 attendant for travel to DTC/DOTS Plus site/IRL for follow up examination.					
				1230000.00	

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

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1) Information on previous year's Annual Action Plan
   a) Budget proposed in last Annual Action Plan: - **2,40,000.00**
   b) Amount released by the state: - **60,000.00**
   c) Amount Spent by the district- **195680.00**
2) Permissible budget as per norm : 247500.00……
3) Budget for next financial year for the district as per action plan detailed below: ……137000.00…….

Program Challenges to be tackled by ACSM during the Year 2012-13	**Objective**	**Target Audience**	**ACSM Activities**		**Time Frame**				**By WHOM**	**Monitoring and Evaluation**		**Budget**
			Activities	Media/ Material Required	Q1	Q2	Q3	Q4		Outputs(Evidence that the activities)	Outcomes(Evidence that)	
Challenge 1. Law Suspect Referral												
Advocacy Activities												
Poor Suspect referral	To obtain support so as to increase referrals	Private Practitioners	One to one meeting	Diary	X				STS/STLS / TBHV	Purchase Vouchers	Increase in referrals from private sector	10000.00
				Table-top Material			X			Purchase Vouchers		5000.00
Communication Activities												
Poor Suspect	To spread awareness	Patients attending		Messages related to	X				Painter	Voucher	Increase in referrals	5000.00

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referral	about symptoms of TB and about RNTCP services	OPD		symptoms of TB, its diagnosis and treatment							from OPD	
		Community		Radio Jingle	X	X	X	X	Radio Channel	Advertisement on Radio	Increase in self reported referral	50000.00
		Community (World TB Day)	Rally	Banner				X	STS/STLS/ TBHV	Voucher/ Photographe	None	2000.00
		Community (World TB Day)	Rally	Pamphlet				X	STS/STLS/ TBHV	Voucher/ Sample	None	5000.00
Challenge 2: Irregular Treatment												
Communication Activities												
Poor compliance with DOT and follow-ups	To motivate patients for regular treatment and timely follow-ups	Patients		Patients Information Booklet	X	X	X	X	LT/DOT Provider	Voucher/ Sample booklet	Reduction in default rates; Improvement in follow-up rates	20000.00

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	To motivate Community DOT Providers so as to ensure regular	Community DOT Provider		Cloth Bags with RNTCP logo Printed	X	X	X	X		Voucher/ Sample Bags		40000.00
										TOTAL BUDGET		**137000.00**

Comments, if any:-

Prepared by:-

Equipment Maintenance:

Item	*No. actually present in the*	*Amount actually spent in the last 4*	*Amount Proposed for Maintenance during*	*Estimated Expenditure for the next financial year for which plan*	*Justification/ Remarks for (d)*

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	district	*quarters*	*current financial yr.*	*is being submitted* *(Rs.)*	
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Office Equipment *(Maintenance includes computer software and hardware upgrades, repairs of photocopier, fax, OHP etc)*	*1*	*19985.00*	*20000.00*	*30000.00*	
inocular Microscopes (RNTCP)					
				30000.00	

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*
			(c)						
	(a)	*(b)*	*Q1*	*Q2*	*Q3*	*Q4*	*(d)*	*(e)*	*(f)*
Re- training of MOs			*20*1=20*	*20*1=20*	*20*1=20*	*20*1=20*		*32000.00*	*2 days per batch*
Re- Training of LTs of DMCs			*8*3=24*	*X*	*8*3=24*	*X*		*12000.00*	*2 days per batch*
Re- Training of CVs			*25*5=125*	*25*5=125*	*25*5=125*	*25*5=125*		*50000.00*	
TB/HIV Training of MOs									*To be funded by BSACS*

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TB/HIV Training of STLS, LTs , MPWs, MPHS, Nursing Staff, Community Volunteers etc									*To be funded by BSACS*
Training of MOs in PMDT			*X*	*X*	*X*	*20*1=20*		*12000.00*	
Training of Para medicals in PMDT			*X*	*X*	*X*	*10*2=20*		*8000.00*	
								114000.00	

 # Please specify

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	*0*	*0*	*0.00*	*0.00*	*0.00*	
Two Wheelers	*6*	*5*	*137291.00*	*150000.00*	*150000.00*	*One more TU in Proposal*
					150000.00	

Vehicle Hiring:

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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	1	0	195000.00	225000.00	225000.00	
For MO-TC	6	5	0	365000.00	365000.00	
					590000.00	

NGO/ PP Support: (New schemes w.e.f. 01-10-2008)

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	Justification/ remarks

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					(Rs.)	
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
ACSM Scheme: TB advocacy, communication, and social mobilization	*x*	*x*	*x*	*x*	*x*	
SC Scheme: Sputum Collection Centre/s	*x*	*x*	*x*	*x*	*x*	
Transport Scheme: Sputum Pick-Up and Transport Service	*x*	*x*	*x*	*x*	*x*	
DMC Scheme: Designated Microscopy Cum Treatment Centre (A & B)	*x*	*x*	*x*	*x*	*x*	
LT Scheme: Strengthening RNTCP diagnostic services	*x*	*x*	*x*	*x*	*x*	
Culture and DST Scheme: Providing Quality Assured Culture and Drug Susceptibility Testing Services	*x*	*x*	*x*	*x*	*x*	
Adherence scheme: Promoting treatment adherence	*x*	*x*	*x*	*x*	*x*	
Slum Scheme: Improving TB control in Urban Slums	*x*	*x*	*x*	*x*	*x*	
Tuberculosis Unit Model	*x*	*x*	*x*	*x*	*x*	
TB-HIV Scheme: Delivering TB-HIV interventions to high HIV Risk groups (HRGs)	*x*	*x*	*x*	*x*	*x*	
				TOTAL		

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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)*
	480000.00	*94999.00*	*480000.00*	*380000.00*	*TA, DA, Almirah, Table, Chair and Telephone Expencess for office. Travel Support to MDR TB Patients. etc*
				380000.00	

** 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*	-	-		-	-	

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STS	*6*	*5*				*957600.00*	
STLS	*6*	*3*				*928800.00*	
TBHV	*2*	*1*				*224700.00*	
DEO	*1*	*1*	*0*	*2582314.00*	*3843500.00*	*113700.00*	
Accountant – part time	*1*	*1*				*41400.00*	
DOTs Plus Supervisior		*1*				*180000.00*	
Contractual LT		*7*				*1433100.00*	
						3879300.00	

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**	*480000.00*	*0*	*480000.00*	***50000.00***	

- *Please specify items to be printed*
-

Research and Studies:

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Any Operational Research project planned (Yes)

(Post Graduate grant for one research paper from each Medical College)

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)*	X	X	*X*
Research and Studies: ▪ Thesis of PG Student ▪ Operations Research*	X	X	*X*
Travel Expenses for attending STF/ZTF meetings	X	X	*X*
IEC: Meetings and CME planned	X	X	*X*

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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 ***	*0*	*0*	*0*	*0*
2-wheeler	*5*	*6*	***300000.00***	*One for the new TU, and the 5 existing bikes needs to be replaced*

** 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)*
Office Equipment (computer, modem, scanner, printer, UPS etc)	*Computer-1, modem-1, scanner-1, UPS-1, Fax-1*	*UPS-1, Computer Monitor-1*	*25000.00*	
Air Conditioner for Second Line Drug Store	*1*	*0*	*30000.00*	
Any Other				
			55000.00	

Section D: Summary of proposed budget for the district – Siwan

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S.No.	Category of Expenditure	Budget estimate for the coming FY 2010- 11 *(To be based on the planned activities and expenditure in Section C)*
1	Civil works	**220000.00**
2	Laboratory materials	**300000.00**
3	Honorarium	**1230000.00**
4	IEC/ Publicity	**137000.00**
5	Equipment maintenance	**30000.00**
6	Training	**114000.00**
7	Vehicle maintenance	**150000.00**
8	Vehicle hiring	**590000.00**
9	NGO/PP support	**0.00**
10	Miscellaneous	**380000.00**
11	Contractual services	**3879300.00**
12	Printing	**50000.00**
13	Research and studies	**0.00**
14	Medical Colleges	**0.00**

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15	Procurement –vehicles	**300000.00**
16	Procurement – equipment	**55000.00**
	TOTAL	**7435300.00**

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

- **Additionality Funds from NRHM-**Details of the activities for which Additionality Funds are proposed to be sought.
- **Sputum Collection and Transportation:**

n collection centres are being proposed at Tarwara, Jamo Bazar, Sarsar, Bharthue, Baletha, Narendrapur and Madarpur in FY 2012-13. Sputum samples for diagnosis and follow-up of TB Suspects/cases will be collected at these centres by existing health staff. Collected samples will be transported to nearby Designated Microscopic Centre (DMC), again by an existing health staff. Travel allowance as per actual expenses will be paid to the concerned staff through Rogi Kalayan Samiti. An amount of Rs. 21000.00 is being requested under NRHM additionality from District Health Society at the rate of Rs. 3000 per collection centre for a period of 1 year.

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Dengu & Chikungunya Dist.Wise Plan 2012-2013 Annex. I					
Sl.No.	Name of Institution	Sentinal Surveillance Hospital	Monitoring , Evaluation ,Rapid Response & Epidemic Preparedness (Logistic +Operational Cost)	Training & Workshop	Grand Total
1	PMCH,Patna	100000	0	0	100000
2	State Level	0	250000	50000	300000
Total		**100000**	**250000**	**50000**	**400000**

	Quarter Wise Activity (2012-2013)					
	Activity	Ist Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
1	Sentinal Surveillance Hospital	100000	0	0	0	100000
2	Monitoring , Evaluation ,Rapid Response & Epidemic Preparedness (Logistic +Operational Cost)	50000	50000	50000	100000	250000
3	Training & Workshop	0	50000	0	0	50000
Grand Total		**150000**	**100000**	**50000**	**100000**	**400000**

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Revised JE Dist.Wise Plan 2012-2013 Annex. I (Part I)							
Sl.No.	Name of Dist.	Diagnostics & Management @ Rs. 15.0 Lakhs Per District	IEC At State Level	Technical Malathion Fogging	Monitoring , Evaluation,Rapid Response & Epidemic Prepardness&Logistics +Operational Cost.	Lab Support	Grand Total
		Total district Annual allocation 2012-13	Total district Annual allocation 2012-13	Total district Annual allocation 2012-13	Total district Annual allocation 2012-13	Total district Annual allocation 2012-13	Total district Annual allocation 2012-13
1	ANMMCH Gaya	100000	0	0	0	0	100000
2	PMCH Patna	100000	0	0	0	0	100000
3	SKMCH, Muzaffarpur	100000	0	0	0	0	100000
4	State Level	0	500000	200000	800000	207000	1707000
	Total	**300000**	**500000**	**200000**	**800000**	**207000**	**2007000**

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IDSP-Budget sheet for 35 States/UTs				
Activity	**Sub-activity**	**cost**	**No of units**	**Proposed Budget for 2012-13**
1. Training	One day training of Hospital Doctors	as per NRHM guidelines	20	50000
	One day training of Hospital Pharmacist / Nurses	as per NRHM guidelines	20	30000
	One day training of Medical College Doctors	as per NRHM guidelines		
	One day training Data entry and analysis training for Block Health Team	as per NRHM guidelines	20	20000
	One day training of DM & DEO	as per NRHM guidelines	20	20000
	SUB TOTAL			**120000**
2. Human Resources	**Remuneration***			
	State/district Epidemiologists (1 at State HQ-SSU and 1 each at district HQs - DSUs)		1×12×35000	420000
	State/ district Microbiologists (1 at State/UT HQ- SSU and 1 each at identified district priority labs)		1×12×30000	360000
	Veterinary Consultant (1 at State/UT HQ - SSU)**			
	Entomologist (1 at State/UT HQ - SSU)			
	Consultants Finance (1 at State/UT HQ - SSU)			
	Consultants Training (1 at State/UT HQ - SSU)			
	Data Managers (1 at State/UT HQs - SSUs and 1 each at district HQs - DSUs)		1×12×25000	300000

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	Data Entry Operators (1 at State/UT HQs - SSUs, 1 each at district HQs - DSUs and 1 at identified Medical Colleges/Other institutions viz. ID Hospitals)identified under IDSP		1×12×15000	180000
	* The State Health Societies may fix the remuneration as per IDSP guidelines or less as per State Policy.			
	** One additional contractual position for a veterinary (consultant) at State level is proposed to improve inter-sectoral coordination (Subject to approval with the same remuneration as the medical epidemiologist)			
3. Operational Expenses	**SUB TOTAL**			**960000**
	Operational Costs			60000
	Transport	Rs 2,40,000/- per district per annum and Rs 5,00,000/- per State HQ/SSU per annum.		
	Office Expenses, Broadband Expenses, ICT equipment maintainence, State weekly alert bulletin, monthly meeting,Annual Reports, collection and transportation of samples and other misc.expenses (to be specified)			240000
	SUB TOTAL			**300000**
	SUB TOTAL (Human Resources i.e. Remuneration + Operational costs)			**1260000**
4. Laboratory support	Consumables and kits for Priority district labs	Not more than Rs 4,00,000/- per priority district lab per annum *(applicable only for functional IDSP district priority labs and where manpower and equipment has been provided under NRHM). Budget to be modified according to the expected sample workload.*		
	culture-media & reagents			
	diagnostic kits			
	glass ware			
	miscellanious required items			375000

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-	**Referral lab network services (Mapping of districts with Govt. Medical Colleges)**			
-	Reimbursement-based payments for tests (10 categories of tests.With each category priced individually)Cost of test to be reimbursed to be decided by the State	Not more than Rs 3,00,000/-per referral lab per annum (Identified No. of already approved labs in States are as follows: Andhra Pradesh-9, Gujarat-8, Karnataka-8, Maharashtra-10, Punjab-4, Rajasthan-6, Tamil Nadu-8, Uttarakhand-3, West Bengal-9) A total of *25 labs (Govt. Medical College) are proposed to be included into the network in this year from Kerala - 5, Haryana - 2, Bihar - 6, Orissa - 3, J&K - 3, Assam - 3, Tripura - 2, Manipur - 1. (Subject to approval)*		
-	ELISA /rapid test for leptospirosis			
-	ELISA for Dengue			
-	ELISA for Viral Hepatitis			
-	ELISA for Measles			
-	Rapid test for Meningococci			
-	Blood culture for Typhoid			
-	Diptheria culture			
-	Cholera culture			
-	other (state specific diseases)			280000
-	Minor laboratory operating expenses (consumables, reagents, kits, office expenses, part-time staff costs, transport costs, minor repairs, etc)	Not more than Rs 2,00,000/-per referral lab per annum (Identified No. of already approved labs in States are as follows: Andhra Pradesh-9, Gujarat-8, Karnataka-8,		180000

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		Maharashtra-10, Punjab-4, Rajasthan-6, Tamil Nadu-8, Uttarakhand-3, West Bengal-9). *A total of 25 labs (Govt. Medical College) are proposed to be included into the network in this year from Kerala - 5, Haryana - 2, Bihar - 6, Orissa - 3, J&K - 3, Assam - 3, Tripura - 2, Manipur - 1. (Subject to approval)*		
5. ID Hospitals	Office Expenses, Broadband Expenses, ICT equipment maintainence, monthly/weekly alert bulletin, monthly meeting, Annual Reports, collection and transportation of samples and other misc.expenses (to be specified)	Not more than Rs 3,00,000/- per year per site (Kasturba Hospital, Mumbai; Communicable Disease Hospital, Chennai; Sir Ronal Ross Tropical and Infectious Disease Hospital, Hyderabad; Infectious Disease Hospital, Delhi; Beleghata General & Infectious Disease Hospital, Kolkata; Infectious Disease Hospital, Ahmedabad; Infectious Disease Hospital, Bangalore).		

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6. Surveillance in Metro Cities	Office Expenses, Remunerations, Broadband Expenses, ICT equipment maintainence, monthly/weekly alert bulletin, monthly meeting, Annual Reports, collection and transportation of samples and other misc.expenses (to be specified). Funds to be released through the State Surveillance Unit.	Not more than Rs 10,00,000/- per year per city (Mumbai, Chennai, Kolkata).		
7. New Districts	Expenses on account of newly formed Districts which are not yet under IDSP	Not exceeding Rs 3,50,000/- per newly formed district on account of non-recurring costs (Computer Hardware & Accessories etc).		
	Total			**2215000**

National Iodine Deficiency Disorder Control Programme

ROP/FMR Budget Code No.(as per ROP 2012-13): Part- D

ROP/FMR Budget Head : National Iodine Deficiency Disorder Control Programme

SL No	Name of District	No. of PHC	ROP approved amount allocation (in Rs. lakhs)	Total District Annual Allocation (FY 2012-13) (in Rs. lakhs) (All activities of IDD budgetet in quarter 3)
1	Siwan	19	64165	64165

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Quarter Wise Fund Allocation Of Revised Malaria Control Programme ,(State & District Level) - 2012-2013

Sl. No.	Name of Districts	First Quarter				Second Quarter					Third Quarter							Forth Quarter		All Four Quarter
		IEC District & State Level	IEC During IRS	Expenditure on vehicle for supervision during IRS	Total Of First Quarter	MPW Contractual Salary	Incentive for ASHA	NAMMIS (For Detail pl.follow NAMMIS Annex.)	NAMMIS Training	Total Of Second Quarter	MPW Contractual Salary	Incentive for ASHA	Training of ASHA	Training Of ACMO,DMO & MI, State Level	Training of LT(5 Days)	Training of MPW(BHW,SFW &SI)	Total Of Third Quarter	Incentive for ASHA	Total Of Forth Quarter	Grand Total
1	**Siwan**	18,000	-	-	18,000	-	-	36,100	-	36,100	-	-	-	-	-	-	-	-	-	54,100

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		1(b)						2(b)						3(b)					
Sl. NO.	**District**	ROP/FMR Budget Code No.(as per ROP 2012-13) : Part D no. 1 (Recurring GIA and Eye Donation)						ROP/FMR Budget Code No.(as per ROP 2012-13) : Part D no. 2 (For vision Centre)						ROP/FMR Budget Code No.(as per ROP 2012-2013 : Part D no. 3 (Non-recurring GIA for Eye Bank)					
		Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Q1	Q2	Q3	Q4	Variance
1	Siwan	0	0	0	0	0	0	300000	0	300000	0	0	0	0	0	0	0	0	0

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4(b)						8 & 9(b)						11(b)					
ROP/FMR Budget Code No.(as per ROP 2012-13) : Part D no. 4 (Recurring GIA for Eye Donation)						ROP/FMR Budget Code No.(as per ROP 2012-13 : Part D no. 8 & 9 9For Cataract Operation and School Eye Screening Program)						ROP/FMR Budget Code No.(as per ROP 2012--13) : Part D no. 11(Setting up of RIOs)					
Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Q1	Q2	Q3	Q4	Variance
0	0	0	0	0	0	2650000	662500	662500	662500	662500	0	0	0	0	0	0	0

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12(b)						13(b)						14(b)					
ROP/FMR Budget Code No.(as per ROP 2011-12) : Part D no. 12 (GIA for strenthening of Medical colleges)						ROP/FMR Budget Code No.(as per ROP 2012-13) : Part D no. 14 (Strenthening of District Hospitals)						ROP/FMR Budget Code No.(as per ROP 2012-13) : Part D No. 15 (Recurring GIA to District Health Societies)					
Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Q1	Q2	Q3	Q4	Variance	Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Q1	Q2	Q3	Q4	Variance
0	0	0	0	0	0	2000000	0	2000000	0	0	0	500000	0	250000	250000	0	0

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5(b)	6(b)	7(b)	10(b)									
ROP/FMR Budget Code No.(as per ROP 2012-13) : Part D no.	ROP/FMR Budget Code No.(as per ROP 2012-13) : Part D no. 6	ROP/FMR Budget Code No.(as per ROP 2012-13) : Part D no. 7	ROP/FMR Budget Code No.(as per ROP 2012-13) : Part D no. 10	Procurement of ophthalmic equipments	Operating microscope	Ascan Biometer	Auto Refractor with kareto meter	Slept lamp	Hording & Hanging	Tin Plate Poster & Wall painting	IEC activities	Total
Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)	Total District Annual Allocation (FY 2012-13) (in Rs. lakhs)									
0	0	0	0		577800	558750	47600	879100	50000.00	190000	100000	7255150

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		PART -A												
S. No	Name of Dist	No. of PHC/Dist. H.Q	No. of Mos	Training of Dist officer & state	Training for MOs Trainer @ Rs. 300 Each Trainee @ Rs. 200 Each	Training for Paramedical staff & PHC Level Rs. 2500 per PHC & Dist. H.Q	Coordination meeting (two round) at state H.Q. @ Rs. 10,000 per meeting & Dist Level @ Rs. 5000 per meeting	IEC activity @ Rs. 2500 PHC & one Dist. H.Q+State H.Q. 20,00000.00	Line listing @ 2500 PHC + Dist H.Q.	Night blood survey @ 2500 PHC & Dist. H.Q.	State Level 100000 and PHC Dist. HQ. @Rs. 500 Each	Mislla nious Head	State Level 25000 & PHC + Dist. HQ @ 500 + 1000 PHC & Each District Office Expenditure	Total (A)
1	Siwan	19+1=20	51	0	10400	47500	10000	47500	47500	47500	13000		10500	233900

State & District Wise Fund Allocation - Kala-Azar, Bihar
2010-2011 First Quarter to Four Quarter (April'201 to March'2013)

	Name of Districts	Total Budget	QI	Q2(From Annex.V)	Q3(From Annex.V)	Q4(From AnnexII &.IV)	Total Q1to Q4	Variance
1	**Siwan**	5,869,950	572,967	572,967	572,967	4,151,050	5,869,950	-

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