

Government of Jammu & Kashmir



DISTRICT HEALTH ACTION PLAN

BANDIPURA

December 2007

District Health Society
District Bandipora
Jammu & Kashmir


Date: 30.11.2007

Certificate of Approval

This is to certify that the District Health Action for NRHM prepared by the district health authorities with active involvement of all stakeholders has integrated the health and health facility improvement needs of the district.

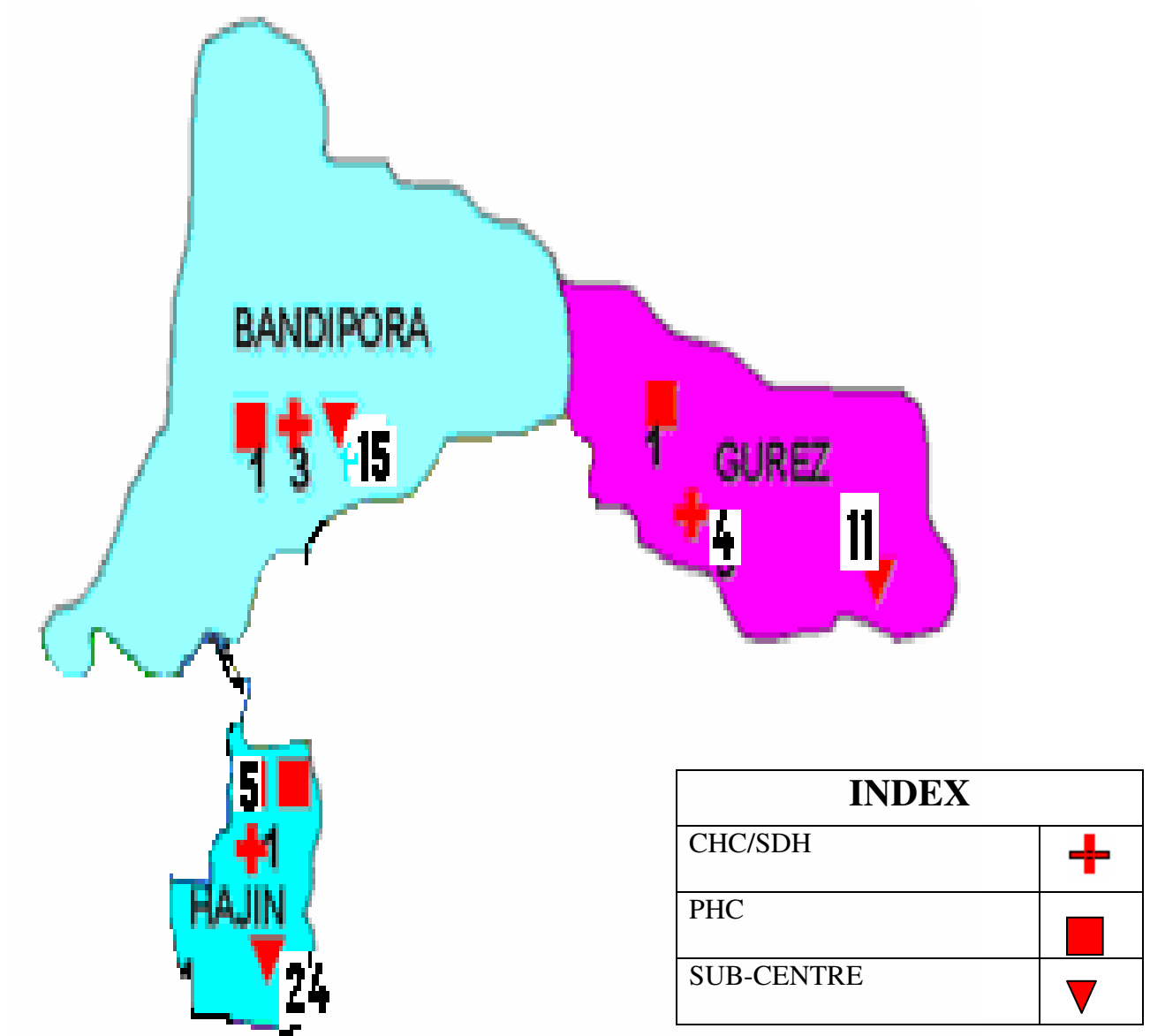
The participatory and decentralized approach in preparing the plan involved in preparation of village health action plans, block health action plans and health facility surveys. The results of these micro level plans and surveys have reflected the overall health improvement needs of the district and it has integrated into the district health action plan.

The plan was discussed in the district health society and suggestions were incorporated and approved.


21.11.07
**Development Commissioner
& Chairperson
District Health Society
District Bandipora**


30.11.07
Chief Medical Officer

Health Facility Map



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PREFEACE

The Hon'ble Prime Minister launched the NRHM on 12th April 2005 throughout the country with the basic objective of providing accessible, affordable and accountable health care in rural areas. Its primary focus is on making the public health system fully functional at all levels. While detailing the functioning of the NRHM, the present planning process initiated in the State provides the entire framework for making the Public Health System fully functional and standardized upto the Indian Public Health Standards at all levels. In doing so, it emphasizes the need for communitisation of the Public Health System, improved financing and management of public health, human resource innovations, and a long-term financial commitment to enable the state and districts to undertake programmes aimed at achieving the Mission goals.

National Rural Health Mission envisages the planning process to be participatory and decentralized starting with the Village. It seeks to empower the community by placing the health of the people in their own hands and determine the ways they would like to improve their health. This is the only way to ensure that health plans are local specific and need based. The State should facilitate the processes by providing enabling environment and required financial and technical support. NRHM was launched in April 2005 and is being implemented by the Department of Health and Medical Education, Government of Jammu & Kashmir.

In accordance with the National Rural Health Mission, Jammu & Kashmir. The district has constituted the District Health Mission and significant progress has been made since it's beginning. As per the NRHM guidelines, it has merged multiple societies at the district level. The District Action Plan was the most important aspect of the NRHM and to make District Plan more meaningful and address local health problems, preparation of Block Health Plans was considered essential. The decentralized planning process involved village consultations and preparation of Village Health Plans by the Village Health Water and Sanitation committees; followed by development of Block Action Plans through integration of Health Facility Surveys and block specific needs. The Block Action Plans were then integrated to form District Action Plan.

As result of this exercise, the district now has developed capacity for preparing the need based health action plans following participatory processes. A District Planning Team (DPT) was set up for this purpose in the month of November 2007 with representation from various sectors concerned with NRHM. This group was responsible for management of the entire planning process in the district and also for provision of the technical support. The DPT is the standing body and will take charge of ensuring implementation of the plan. Thus the DPT not only owns the plan but will also be responsible for monitoring the progress of implementation to achieve the objectives of the plan. The members of the DPT are:

S. No.	Name	Designation	Department
1	Mr. Shiekh Mushtaq Ahmad	DDC	Revenue
2	Dr. Ghulam Mohiuddin Wani	CMO	Health
3	Mr. Tariq Ahmad Zalgar	ACD & GPO	DC Office
4	Mr. Abdul Majeed Lone	CPO	DC Office
5	Dr. A. R. Wani	BMO	Health
6	Dr. Abdul Rasheed	ADMO ISM	Health
7	Mr. Masrat Hashim	PO- ICDS	Social Welfare
8	Mr. Mohammad Amin Wangnoo	CEO	Education
9	Dr. Mohammad Yousuf Mir.	DIO	Information
10	Mr. Zahoor Ahmad Chat	SE	
11	Mr. Ghulam Qadir Pintoo	Ex. Engineer	PHE

The orientation of DPT, facilitated by EPOS Health India, was held on 19th May 2007. This enabled the DPT members to not only understand NRHM approach, key components and strategies of NRHM, but also manage the planning process and develop the District Action Plan. The DPT met a number of times and the individual members reviewed the situation of their respective sectors/areas and collectively developed the strategic vision for improving the health status of the district population.

We the members of the DPT on behalf of the entire Core Group reiterate and certify that this District Action Plan has been prepared through participatory processes. It has been developed by integrating the Block Action Plans prepared by integrating health facility surveys and village health plans in each block of the District. This plan also incorporates the needs and plans from 51 Sub health centres, 12 PHCs and 03 CHCs in the District.

Name of Chief Medical Officer

Signature

Date

EXECUTIVE SUMMARY

Bandipora is one of the newest districts of the Kashmir area and was formed in April 2007. It has been carved out of the erstwhile Baramulla. The data regarding the various parameters in the district was quite scanty as the segregation had not been done. However, activities have been proposed based on needs expressed by community members at various levels and facility survey giving clear picture of gaps in infrastructure, equipment and human resources and considering IPHS standards.

As a newly formed district there is the opportunity to develop state-of-the-art health facilities, strategies and implementation arrangements that may make the district health facilities a model for others to emulate.

A peculiar problem faced by the district is the settling in of the tribal populations of shepherds who come down from the heights during the high snowfall months and tend to inhabit the lower plains areas along with their animals till the onset of favourable climate. This situation takes its toll of the available services and facilities of the district like water, sanitation and even health care. For the first time this plan envisages specific services in terms of deputing of MMU for diagnostic, curative and treatment services to these tribal settlers all through the four months of their sojourn in the district.

The district specific problems as envisaged during the formulation of the DAP were basically the low institutional deliveries and the almost negligible popularity of the family planning activities of the health department. This issue was widely discussed and it was brought out that the family limitation strategies would not work here but there is a great need for spacing methods and information regarding them as opposed to the termination of fertility. Also the care of the newborn through the establishment of neonatal corners and baby friendly hospitals would make for a better environment for the care of the mother and the child in the CHCs and PHCs.

There is a deep-seated belief in the Unani form of traditional system of healing among the people of the area. They are dependent for a large part on the cures and preventive measures advocated by the age-old unani practitioners. If this system of medicine could be integrated through IEC, joint working and ownership there would be better understanding of health issues in the region.

There is a large role to be played by the Rehbar-e-Sehat and Rebar-e-Taleem personnel who have been trained during the course of the plan formulation to take on much of the IEC and awareness generation activity component on their shoulders and ascertain the participation of the youth, women and elderly among the general population of the district.

The situation of unrest prevalent in the district is also of concern in terms of health and curative therapeutics as it is telling on the health of the population and the care providers alike. The scope of the implementation of the DAP would be limited by the fact also that there would be little community level participation due to a general lack of elected representatives. There are neither Sarpanches nor Panchayat set ups for taking up the initiatives on a community level where mobilization itself would have brought the programmes within the purview of the people. Thus innovative strategy has been evolved to enable the population to benefit from the vision of the mission.

In the year 2006, IIPS Mumbai ranked 593 districts in the country. This ranking is on children parity, contraceptive prevalence rate (CPR), under five child mortality and ANC. Because Kulgam is a new

district, its ranking is not available. However, ranking of its parent district Anantnag can give a sense of health status of Kulgam as well. The overall ranking of the district Anantnag is 275. It is 576 on the basis of percentage of women having three or more children; 11 on the basis of CPR; 332 for under five mortality rate and rank 101 for three or more ANC visits. In this ranking system, the lower is the rank, the better the district.

In terms of major challenges, the district needs to increase institutional deliveries and deliveries by skilled personnel which are currently at 30% and 52% respectively. The share of male participation in use of family planning methods is almost negligible. Prevalence of anaemia amongst pregnant women is quite high. These issues have to do both with demand and supply of health services. This is a district where average literacy levels are below 40%. It is abysmally low for women at 18 % and 56% for men, hence behaviour change communication (BCC) has to be strategically designed. Therefore, BCC has been envisioned as more than awareness intervention which requires specialised professional treatment in terms of strategy and material development. The plan has put emphasis on inter sectoral convergence. The highlight is convergence with education and women and child department for provision of life skills education to both in and out of school adolescent girls and boys. In the absence of existence of Panchayati Raj institutions, there is a component on community action through village health and sanitation committees.

On the supply side, 79 posts of ANM, 58 post of Nurse at PHCs, 15 posts of MO s, 3 posts of paediatrician and 3 posts of obstetricians/ gynaecologist are vacant. Over all 79 posts at SCs, 216 posts at PHC,s, and 45 posts at CHC level are vacant. Role Ob/Gyne and Paediatricians is crucial for comprehensive emergency obstetric care and high risk cases of neo natal health. To meet the above mentioned and many others crucial health indicators, the plan provides for filling gaps in the area of human resources by hiring key staff including medical doctors and specialists on contract and converging with AYUSH department.

The basic infrastructure in the district has many gaps. Out of total 82 sub centres, 66 are running in rented building. All the 82 SCs do not have water supply connection and toilets and electricity is not available at 74 SCs which adversely impacts utilization of services from SCs. There are total 23 PHCs but water supply is available only in 61% and electricity in 65%. Facility survey Report (Anex-1 & II) giving clear picture of gaps in infrastructure, equipment, drugs and human resources and considering IPHS standards. Construction of new buildings, expansion and repair of old ones has been proposed. For smooth logistics management and storage, development of logistics management information system and construction of a warehouse has been proposed.

Reproductive and Child Health is one of the priority programmes comprising Maternal health, Child health, Adolescent health including RTI / STI management and Family Planning. In order to increase institutional deliveries, which is a major concern, focus has been fixed on upgrading the PHCs to functioning 24x7 PHCs and also enhancing the EmOC skills of the medical personnel. In order to increase institutional delivery attention has been given to functioning of 24x7 PHCs in phased manner and construction of rented SC & PHC building with all facilities. A sum of Rs. **5171.324 lac** has been planned for activities under the RCH II.

Under NRHM special focus has been given to Village Health Water and Sanitation Committee, Rogi kalayan committee, upgradation of health facilities as per IPHS, selection and training of ASHA, functioning of quality assurance committee, infrastructure development etc. A total of Rs. **7060.09 Lac** has been planned for NRHM budget.

"National Disease Control Programme include RNTCP, leprosy control programme, Malaria control programme, Blindness control programme, vector born disease, integrated disease surveillance

and iodine deficiency disorder. The Revised National Tuberculosis Control Programme (RNTCP) aims to stop the spread of TB in the region as it is a rising concern among the rural population and have to be dealt with due to the large influx of tourists and pilgrims who may carry virulent strains into the immunological set up of the host population.

To have in place an effective surveillance system, the Integrated Disease Surveillance Programme has been introduced. It includes case detection and recording, compiling the weekly reports, report transmission, analysis and interpretation, taking appropriate action, investigation and confirmation of suspected cases and outbreaks if any, providing feedback and dissemination of results, and evaluation leading to improvement in the system. This is a very vital wing and the budget planned for it is Rs **49.3** lac. A total of Rs **413.1759** lac has been planned for the National Diseases Control Programme.

A total budget for district Kulgam for the plan period 2008-2012 has been proposed for Rs. **15072.4** lac. **(150 crores, 72 Lac and 4 thousand rupees)**

CRITICAL ISSUES AND PRIORITY ACTIONS

S. No	Thematic Area	Critical Issues of the District	Specific Priorities
1.	District & Block Health Programme Management:	<ul style="list-style-type: none"> ▪ Health programmes being run along parallel lines due to no integration of the various societies like TB, RNTCP etc., in the district. ▪ Support to CMO office ▪ Manpower ▪ Infrastructure ▪ Training ▪ Monitoring, Reporting and evaluation. 	<ul style="list-style-type: none"> ▪ As a newly formed district there is a need to set up the infrastructural and manpower inputs in the form that is planned for running the health programmes of the district smoothly. ▪ CMO office and DPMU office space to be contiguous to facilitate the day to day planning, process, implementation, monitoring and evaluation of activities. ▪ Integrate all district societies into District Health society essential for running all programmes from the DPMU. ▪ Development of total clarity amongst officials and Consultants about NRHM activities ▪ Recruitment of staff on contractual basis ▪ Procurement of essential requirements for office of DPMU and its functional units at the block level ▪ Training of newly recruited staff on all aspects of health services and NRHM vision and mission objectives besides the plan of the district. ▪ Capacity building of the DHS members for running the District Health Society. ▪ Training of district officials and Block SMOs ▪ Strengthening the CMO office ▪ Capacity building of the DPMU ▪ Development of HMIS ▪ Strengthening the registration of births and deaths as well as the sex ratio [CRS] ▪ Monitoring of health activities by health personnel only. ▪ Streamlining Financial management and systems

2	Reducing MMR and IMR	<ul style="list-style-type: none"> ▪ Increasing access to services ▪ Increasing awareness about availability of services ▪ Utilize the well entrenched AYUSH practitioners for enhancing health care for mothers and newborn ▪ Increasing Institutional deliveries ▪ Studying the causes of infant mortality and feasibility of ameliorative measures 	<ul style="list-style-type: none"> ▪ Recruitment of ASHA and promoting access to services through her approach ▪ Approaching the local practitioners of Unani for inputs on maternal, new-born and child care ▪ Involving them in the implementation, outreach activities and IEC ▪ Promoting PPP tie-ups with private sector ▪ Ensuring availability of personnel especially specialists and Public Health Nurses for the 24 hour PHC, CHC and ANMs at the sub centres ▪ Strengthen FRUs for Emergency Obstetric Care services along with minimum basic infrastructure, drugs and equipments. ▪ Operationalisation of 24X7 PHCs and SCs ▪ Increased coverage under JSY ▪ Construction of SCs and PHCs where ever required and service delivery for 24 hour in all PHCs ▪ To increase IEC/BCC activities to promote spacing and exclusive breastfeeding ▪ Disseminating the findings of the study and formulating strategy for enhanced neonatal care services
3	Family Planning	<ul style="list-style-type: none"> ▪ Offering services for spacing to promote health of mother and newborn ▪ Lack of awareness ▪ IEC for getting over mindset 	<ul style="list-style-type: none"> ▪ Increase awareness on benefits of spacing to promote the health of the mother and the children ▪ BCC material and activities to be made part of outreach services ▪ Increased awareness for Emergency Contraception and 10 yr Copper T ▪ Partner with private doctors for FP and RCH services ▪ Increasing Access to Emergency Contraception and spacing methods through Social marketing ▪ Promoting participation of the religious elements in spacing acceptance to improve health of the mother and child.
4	Adolescent Health	<ul style="list-style-type: none"> ◆ Adolescent boys are exposed to smoking, drug addiction, and 	<ul style="list-style-type: none"> ▪ Information, Education, Communication and BCC to be enhanced ▪ ASRH o increase the reach and spread

		<p>alcoholism.</p> <ul style="list-style-type: none"> ▪ Mental health is a major problem ▪ Teenage pregnancies emerging as a problem. Unsafe abortion & unsafe sex trend on the rise. ▪ Exploitative relationships are also on the rise and the high risk behaviour is apparent in some pockets of the district ▪ Tourism too has its darker side with high risk sexual behaviour being 'passe' for certain interactive 	<p>of knowledge levels of Adolescents on RH and Life skills</p> <ul style="list-style-type: none"> ▪ School health programme to incorporate features of ARSH ▪ Medical facilities to be more responsive to adolescent needs ▪ NGOs participation to be enhanced. ▪ Strict reporting of MTPs and risky abortions
5	Mobile Medical Units (MMUs)	<ul style="list-style-type: none"> ▪ Required essentially to increase outreach activities ▪ Remote population is not covered ▪ Sufficient staff and logistics. 	<ul style="list-style-type: none"> ▪ MMU to be procured ▪ MMU equipped with diagnostic services etc as per NRHM norms to provide medical services stet with a camp approach. ▪ Contract MOs and staff nurses for MMUs
6	Upgrading CHCs to IPHS	<ul style="list-style-type: none"> ▪ All the 3 CHC are housed in govt building however the condition of CHC needs to be upgraded as per IPHS standard. 	<ul style="list-style-type: none"> ▪ CHCs to be upgraded highlighted as per facility survey ▪ Additional 2 CHCs to be built as per population. ▪ Manpower be recruited ▪ Infrastructure be set up immediately (Detail in Anexure-II)
7	Upgrading	<ul style="list-style-type: none"> ▪ All 23 PHCs need to 	<ul style="list-style-type: none"> ▪ 9 PHC are functioning in rented building,

	PHCs for 24 hr Services and IPHS standards	<p>be upgraded to IPHS</p> <ul style="list-style-type: none"> ▪ 5 PHCs are working 24hrs. 	<p>require new building. (Detail in Annexure-II)</p> <ul style="list-style-type: none"> ▪ Additional 5 PHCs to be built as per population. ▪ As per Facility Survey all repairs, additions, alterations be taken up to have functional 24 hour PHCs. ▪ Manpower ▪ Equipments and drugs ▪ Well-equipped and staffed Labour rooms
8	Upgrading Sub Centres to IPHS standards	<ul style="list-style-type: none"> ▪ As per Facility survey the SCs to be repaired, altered and constructed should be taken up ▪ Also staff quarters to be built where required ▪ Additional SCs as per population to be built 	<p>66 SCs require new building. (Detail in Annexure-II)</p> <ul style="list-style-type: none"> ▪ 12 Scs need to repair. ▪ Additional 103 SCs to be built as per population. ▪ Relocation of SCs nearer population ▪ Delivery rooms in SCs for institutional deliveries ▪ Drugs and equipments as per IPHS ▪ Manpower
9	Immunisation	<ul style="list-style-type: none"> ▪ Efficient monitoring and supervision ▪ Gaps in difficult, flung areas & inaccessible areas ▪ Reporting and documentation ▪ Lack of awareness to mothers ▪ Alternate vaccine delivery ▪ Transhumance population of goatherds that moves down during the winters 	<ul style="list-style-type: none"> ▪ Close Monitoring and documentation of the progress ▪ Zero Polio cases and quality surveillance for Polio cases ▪ Enhancing the coverage of Immunization ▪ Alternative Vaccine delivery mechanisms in place ▪ Effective Cold Chain Maintenance upto sub centre level
10.	NDCP	<ul style="list-style-type: none"> ▪ TB a major concern 	<ul style="list-style-type: none"> ▪ IEC to be enhanced on screening for TB ▪ Popularization of the DOTS programme through NGOs, radio and other avenues

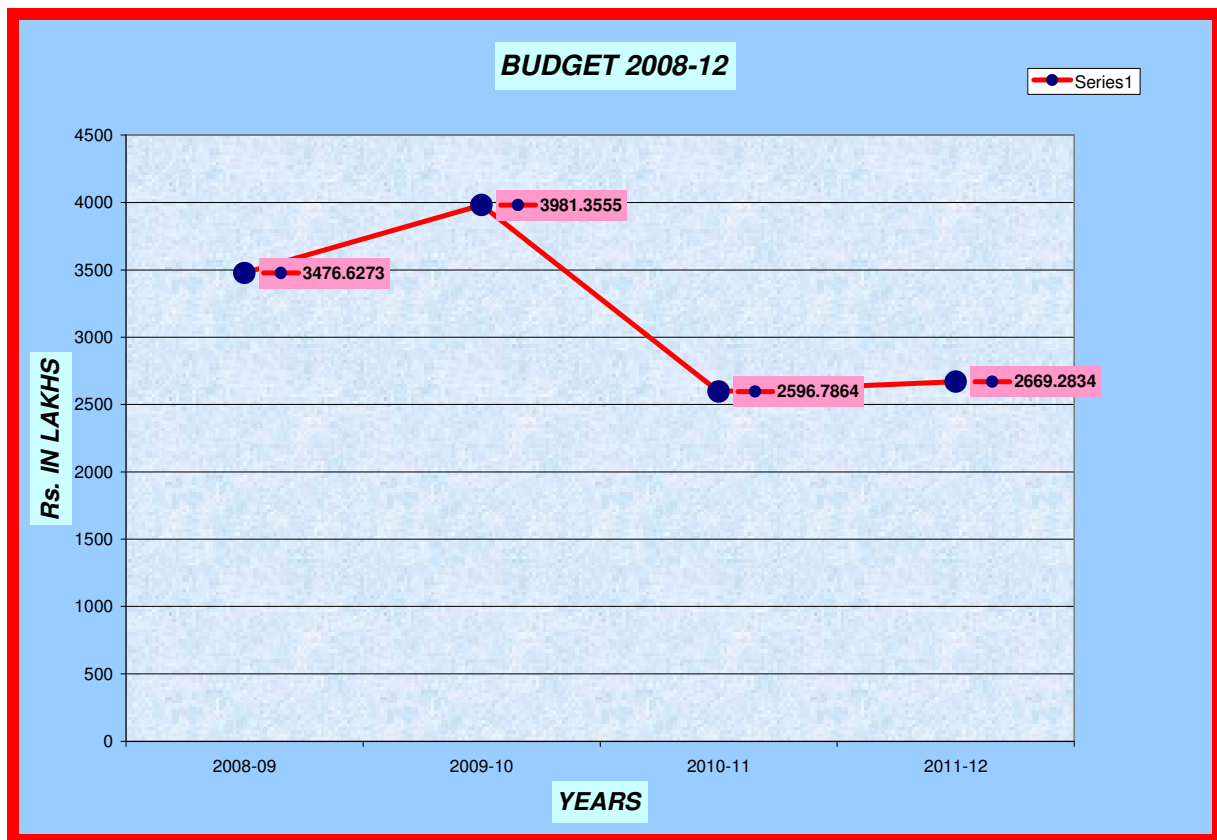
	Inter Sectoral Convergence	Promote coordination between ICDS and health department	<ul style="list-style-type: none"> ▪ Linkages to be developed between ICDS workers and health workers for timely diagnosis of malnourished children and their management
		Promote coordination between RDD and health department	<ul style="list-style-type: none"> • Promote & encourage cost effective construction of household latrine & their proper use. • Elimination of open defecation to minimise the risk of contamination of water source & food. • Awareness on sanitation and Hygiene • Covering of schools and AWCs under TSC • Planning for helath • Implementing health strategies • Monitoring and evaluating the health programmes being implemented
		Promote coordination between Education Department and the Health Department	<ul style="list-style-type: none"> • Education and sanitary habits among students • IEC on health and health determinants to be prepared and distributed
13	Human Resource	Lack of manpower to be recruited at all levels on contractual appointments from DPMU to the Sub centres	<ul style="list-style-type: none"> • Recruitment of staff on contract where vacancies • Recruitment of staff for new facilities as per the infrastructure requirements • Rational placement of Specialists and trained staff • Increased salaries for contractual doctors and Specialists • Special allowances for Regular staff • Allowing Specialists and MOs for developing special skills as per their needs by attending special courses anywhere in India. • Increase in the number of training centres for LHV, ANM, Staff Nurses, Lab Technicians • Proposal for Staff Nurse College and other Paramedical training college.

			<ul style="list-style-type: none"> • Computers at all PHC and for each MO and Specialist at the CHC • All staff to be in place as IPHS norms by 2012
14	Gender and Equity	Women accorded lesser status as compared to men	<ul style="list-style-type: none"> • Health and care of the mothers, girl children and female infants to be propagated through a well thought out strategy of IEC
15.	PPP	Private sector presence to be tapped for joint ventures	<ul style="list-style-type: none"> • Large business lobby dealing in tourism to be tapped for CSR and provision of facilities for improving the health indicators of the district • Provision of specialised health care to the pilgrims coming for the Amarnath yatra and also sightseeing • Provision of health care to the <i>bakarwals</i> or goatherds who come down to the planer areas during the severe winters. • Building alliances with other departments, PRIs, Private sector providers and NGOs

Note: Details of infrastructure facilities available and lacking at SC, PHC and CHC level is given with name in annexure-II.

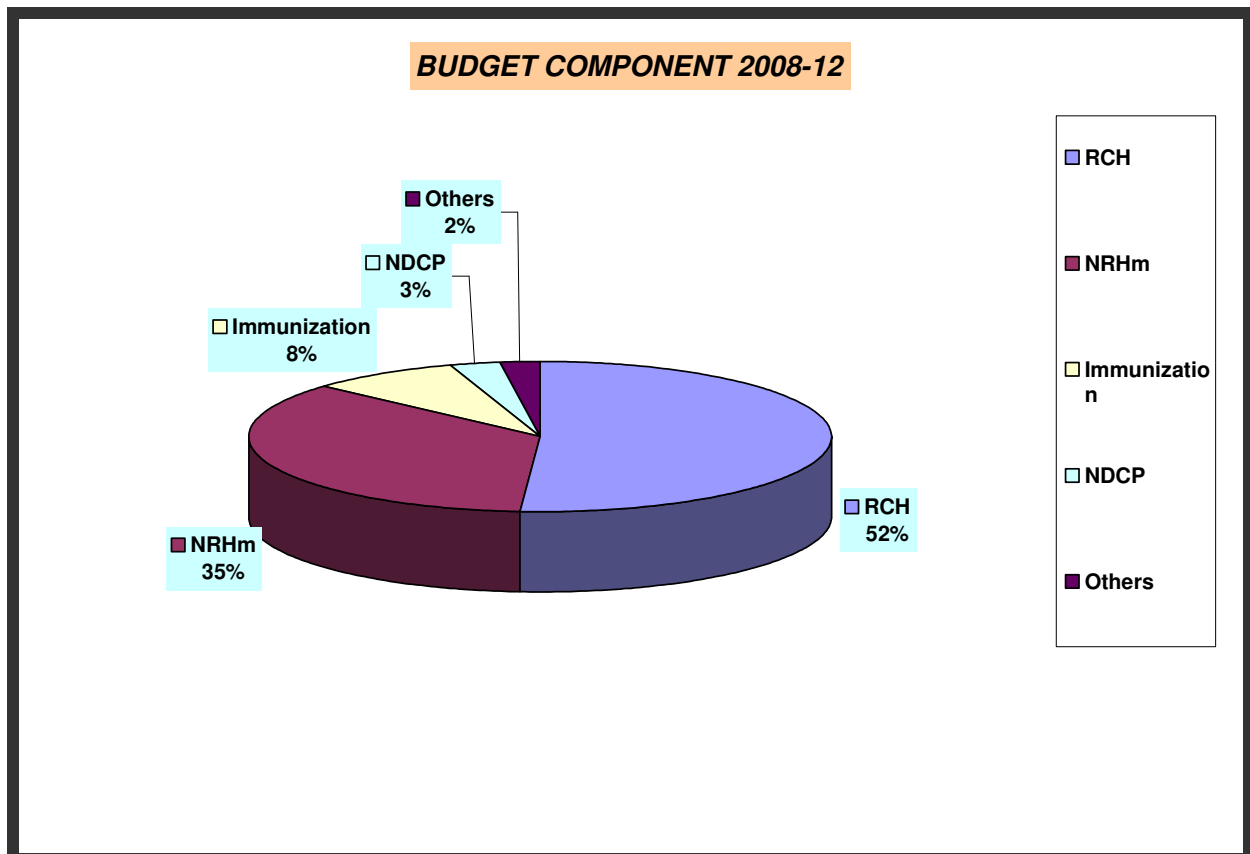
Budget Summary						
Component	Year wise Budget in Lakhs					
	2008-09	2009-10	2010-11	2011-12	Total	
A1- Strengthening of District Health Management Unit	17.48	8.032	4.889	5.181	35.582	
A2- District Program management unit	86.481	86.971	96.068	106.033	375.553	
A3- Maternal Health	220.273	163.226	172.519	188.3361	744.3541	
A-4. Newborn & Child Health	15.084	10.5	0	0	25.584	
A-5. Family Planning	37.1105	38.756	24.567	26.559	126.9925	
A-6. Adolescent Health	28.474	24.197	23.31	26.6	102.581	
B-1. ASHA – Accredited Social Health Activist	25.068	9.168	9.289	9.421	52.946	
B-2. Provision of Untied Funds at SCs	15.3	43.8	43.8	43.8	146.7	
B3- Provision of Untied Funds at CHCs	9	17.25	17.25	17.25	60.75	
B4- Provision of Untied Funds at PHCs	9.5	15.5	15.5	15.5	56	
B 5 Mobile Medical Units	72.71	23.71	23.71	23.71	143.84	
B6 Upgrading CHCs to IPHS	312.6148	341.72	26.317	27.084	707.7358	
B7 – Upgrading PHCs to 24 Hour Service	565.036	645.922	207.5216	190.016	1608.4956	
B 8-. Upgrading SCs	529.927	561.4	14.9	14.9	1121.127	
B9. VHWSC	10.25	11.275	12.4025	13.64275	47.57025	
C 1. Cold Chain Maintenance	46.7	38.35	16.8	16.8	118.65	
C 2. IEC and Social Mobilization	29.13	27.53	28.08	27.53	112.27	
C 3. Alternate Vaccine Delivery Mechanism	26.004	26.004	26.004	26.004	104.016	
C 4-Supervisory Support & Vaccine Transportation	0.91	0.91	1.3625	1.3625	4.545	
C 5 Data Monitoring & Support	18.4	22.58	18.18	18.18	77.58	
C 6 Supplies & Logistics	169.78	232.736	154.263	154.263	711.042	
D 1. RNTCP	40.71	36.739	40.43	44.47	162.349	
D 2. Leprosy	1.5	0	0	0	1.5	
D 3. National Malaria Control Programme	14.5	4.2	4.2	4.2	27.1	
D 4.Other Vector Borne Diseases	3.39	3.54	3.71	3.891	14.531	
D 5. Control Of Blindness	37.476	10.229	13.12	14.433	75.258	
D 6. Integrated Disease Surveillance Programme	26.602	14.072	11.534	12.371	64.579	
D 7. Iodine Deficiency Disorders	3.945	4.34	4.773	5.251	18.309	
8. Inter Sectoral Convergence	59.642	61.206	62.927	64.815	248.59	
9- Community Health Action	7.731	8.504	9.355	10.29	35.88	
10- Public Private Partnership	74.55	54.66	57.575	61.844	248.629	
11- Gender And Equity	43.64	31.404	34.545	37.879	147.468	

12- Capacity Building	42.89	68.53	43.53	43.53	198.48
13. Human Resource Plan	419.092	976.3223	976.3223	976.3273	3348.0634
14. Procurement & Logistics	125.81	5.908	4.19	4.618	140.526
15 Demand Generation - IEC	285.717	314.2892	345.717	380.291	1326.0142
16. School Health	8.25	9.075	9.9825	10.98075	38.28825
17. Financing Health Care	27.1	24.56	33.481	36.792	121.933
18. Bio medical waste management	8.85	4.24	4.662	5.128	22.88
TOTAL	3476.627	3981.356	2596.786	2669.2834	12724.2921



District Bandipura BUDGET - AT- A GLANCE (In Lakhs)						
#	Components	2008-09	2009-10	2010-11	2011-12	Total
A	RCH-II					
1	DHS	17.48	8.032	4.889	5.181	35.582
2	DPMU	86.481	86.971	96.068	106.033	375.553
3	Maternal health	220.273	163.226	172.519	188.3361	744.3541
4	Child Health	15.084	10.5	0	0	25.584
5	Family Welfare	37.1105	38.756	24.567	26.559	126.9925
6	Adolescent Health	28.474	24.197	23.31	26.6	102.581
7	Gender & Equity	43.64	31.404	34.545	37.879	147.468
8	Capacity Building	42.89	68.53	43.53	43.53	198.48
9	Human Resource	419.092	976.3223	976.3223	976.3273	3348.0634
10	IEC	285.717	314.2892	345.717	380.291	1326.0142
11	HMIS & Monitoring	18.4	22.58	18.18	18.18	77.58
	Total	1214.642	1744.808	1739.647	1808.916	6508.2522
B	NRHM					
1	ASHA	25.068	9.168	9.289	9.421	52.946
2	SC Untied Fund & Maintenance	15.3	43.8	43.8	43.8	146.7
3	PHC Untied Fund & Maintenance	9	17.25	17.25	17.25	60.75
4	CHC Untied Fund & Maintenance	9.5	15.5	15.5	15.5	56
5	MMU	72.71	23.71	23.71	23.71	143.84
6	Upgradation of CHC	312.6148	341.72	26.317	27.084	707.7358
7	Upgradation of PHC	565.036	645.922	207.5216	190.016	1608.4956
8	Upgradation of SC	529.927	561.4	14.9	14.9	1121.127
9	VHWSC	10.25	11.275	12.4025	13.64275	47.57025
10	Community Action Plan	7.731	8.504	9.355	10.29	35.88
11	PPP	74.55	54.66	57.575	61.844	248.629
12	Health Care Financing	27.1	24.56	33.481	36.792	121.933
13	Procurement & logistics	125.81	5.908	4.19	4.618	140.526
14	Biomedical Waste	8.85	4.24	4.662	5.128	22.88
	Total	1793.447	1767.617	479.9531	473.9958	4515.01265
C	Immunization					
1	Cold Chain Maintenance	46.7	38.35	16.8	16.8	118.65
2	IEC & Social Mobilization	29.13	27.53	28.08	27.53	112.27
3	Alternate Vaccine Delivery	26.004	26.004	26.004	26.004	104.016
4	Supervisory Support & Vaccine	0.91	0.91	1.3625	1.3625	4.545
5	Supplies and Logistics	169.78	232.736	154.263	154.263	711.042

	Total	272.524	325.53	226.5095	225.9595	1050.523
D	NDCP					
1	RNTCP	40.71	36.739	40.43	44.47	162.349
2	Leprosy	1.5	0	0	0	1.5
3	National Malaria Control Program	14.5	4.2	4.2	4.2	27.1
4	Other Vector Born Diseases	3.39	3.54	3.71	3.891	14.531
5	Blind Control Programme	37.476	10.229	13.12	14.433	75.258
6	Integrated Disease Surveillance	26.602	14.072	11.534	12.371	64.579
7	Iodine Deficiency Disorders	3.945	4.34	4.773	5.251	18.309
	Total	128.123	73.12	77.767	84.616	363.626
E	Others					
1	Inter Sectoral	59.642	61.206	62.927	64.815	248.59
2	School Health	8.25	9.075	9.9825	10.98075	38.28825
	Total	67.892	70.281	72.9095	75.79575	286.87825
	Grand total	3476.627	3981.356	2596.786	2669.283	12724.2921



1. SITUATION ANALYSIS

Profile of the District

Bandipora District is one of the districts of the State of Jammu & Kashmir. It has 3 medical blocks. It has 04 CD blocks. District headquarters is situated at Bandipora. The District Bandipora has population 398167 which lives in 189 villages and 90 Gram Panchayat.

Name of District		Bandipora
Name of District Headquarters		Bandipora
No. of CD Blocks in the District		04
No. of Villages		189
Size of Villages	1-500	77
	501-2000	101
	2001-5000	10
	5000+	1
Villages without motorable roads		NA
Villages without electricity		NA
No. of Towns		
Urban Local Bodies (ULB)	Municipal Corporation	
	Municipality	
	Notified Area Committee	
	Others	

Population of SC is negligible in the district. But Tribal population is very high in comparison to other district of valley. Gurez block has 100% tribal population and 12.5% is also in Sumbal block. Around 32% population is below poverty line.

Development Indicators of the District

SN	Indicators	State	District
1	Crude Birth Rate	18.9 (SRS 2005)	29/1000
2	Crude Death Rate	5.5 (SRS 2005)	7.0
3	Infant Mortality Rate	50 (SRS 2005)	60/1000
5	TFR	2.4 (SRS 2004)	2.5
6	Couple Protection Rate	54 (NFHS-III)	52
7	Sex Ratio (General)	948 SRS (892-Census 2001)	909/1000
8	Sex Ratio (0 – 6 years)	937(Census 2001)	818
9	Sex Ratio at birth	NA	909
10	Literacy rate (overall)	54% (Census 2001)	49 %
11	Literacy rate (male)	68.8	54.39%
12	Literacy rate (female)	44.7 SRS (41.9 Census 2001)	31.42%
13	Enrolment of students elementary education	NA	113514
		NA	57328
		NA	56186

Source: SRS-2005, Census, 2001; DLHS-RCH-II Survey, 2004

Socio Economic and Health Indicators of the District

Name of Health Blocks	Bandipora	Hajan	Gurez	Total for District
Demographic indicators				
Total Population	160329	209553	28290	398172
Population of males	81165	106872	14151	202188
Population of females	79164	102681	14139	195984
Population of children less than a year old	2942	6286	978	10206
Population of children in age group between 1 and 6 years	14647	27241	2868	44756
% Scheduled Castes	.05%	-	0%	0.16%
% Scheduled Tribes	12.5%	-	100%	37.5%
Number of Inhabited Villages	47	115	27	189
Socio-economic indicators				
No. of <2 children benefiting from the ICDS scheme	3840	NA	499	4339
No. of children aged 2 years and above benefiting from the ICDS scheme	2375	NA	1416	3791
No. of BPL households	7981	NA	2337	10318
No. of girls enrolled in primary schools last year	10192	NA	NA	10192
No. of girls dropping out of primary schools last year	429	NA	0	429
Number of overhead tanks or hand pumps	Nil	01	Nil	01
Number of functional hand pumps in sub centres	Nil	Nil	2	02
Number of wells currently being used for drinking water purposes	NA	Nil	Nil	NIL
Number of households with access to toilets	670	5013		5683
No. of private health facilities/clinicians	02	30	Nil	32
No. of women who have benefited through the JSY Scheme till now	150	NA	68	218
No. of girls who got married last year and were <18 years at the time of marriage	39	NA	Nil	39
No. of Tubectomies conducted in the last reporting year	NA	146		146
No. of IUD insertions done in the last reporting year	165	77	9	251
No. of vasectomies done in the last reporting year	Nil	11	NA	11
No. of pregnant women	NA	NA	824	824
No. of pregnant women registered for ANC during the last reporting year	4107	5095	798	10000

Name of Health Blocks	Bandipora	Hajan	Gurez	Total for District
No. of pregnant women who received both TT1 and TT2 during pregnancy in the last reporting year	1690	TT1=4679 TT2=4235	798	11402
No. of institutional deliveries in the last reporting year	411	277	233	921
No. of women operation of MTPs in the last reporting year	84	NA	Nil	84
No. of RTI/STI cases reported in the last reporting year	938	6750	Nil	7688
No. of children given measles vaccine in the last reporting year	4550	4744	1065	10359
No. of outpatients (monthly average)	6385	17621	4320	28326
No. of inpatients (monthly average)	274	161	190	625
Prevalent Diseases				
TUBERCULOSIS and LEPROSY				
No. of patients currently undergoing DOTS therapy in the block	150	15	23	188
Number of new leprosy cases reported in last reporting year	Nil	Nil	Nil	NIL
NVBDCP				
No. of slides examined for malaria in last reporting year	Nil	Nil	Nil	NIL
No. of notified malaria cases (last reporting year)	Nil	Nil	Nil	NIL
No. of new kala-azar cases in the block in the last reporting year	Nil	Nil	Nil	NIL
No. of microfilaria cases reported in the last reporting year	Nil	3551	Nil	3551
No. of JE cases reported in the last reporting year	NA	Nil	Nil	NIL
Blindness Control				
No. of cataract operations conducted in the block last year	NA	Nil	65	65
School Health Programme				
No. of schools covered under in the last reporting year	11	60	71	142

Health Institutions, Population Coverage Ratios and Health Functionaries in the District

Name of Block		Bandipora	Hajan	Gurez	Total for District
Name of Health Blocks					
Health Institutions					
No. of Speciality Hospitals		Nil	Nil	Nil	0
No. Referral Hospitals		1	Nil	01	02
No. of CHC/BPHCs		01	01	03	05
No. of Blood Banks		Nil	Nil	Nil	-
No. of CHCs (IPHS Standards)		Nil	01	01	-02
No. of Blood Storage Units		Nil	Nil	Nil	-
No. of PHCs in the Block		02	03	02	07
No. of MOs in Positions		08	16	13	37
No. of 24 hrs. PHCs		Nil	01	03	04
No. of MTP Centres		Nil	Nil	0	00
No. of Sub Health Centres		29	16	01	46
No. of ANMs in Position		11	12	06	29
No. of AYUSH Dispensaries		Nil	16	01	17
No. of Private Hospitals		Nil	Nil	Nil	-
No. of Beds in Govt. Institutions		40	NA	44	88
No. of Beds in Pvt. Institutions		30	NA	Nil	30
No. of Anganwari Centres		191	215	68	474
No. of Ultrasound Clinics	Govt.	01	Nil	01	02
	Pvt.	01	01	-	02
	Unregistered	Nil	NA	-	-
Population covered		NA	NA	32000	32000
No. of Sub-centres covering more than the current norm (5000)		10	04	-	14
No. of Obstetricians	Govt.	Nil	0	01	01
	Pvt.	Nil	0	-	-
No. of Gynaecologists	Govt.	Nil	0	01	01
	Pvt.	01	0	-	01
No. of Paediatricians	Govt.	Nil	0	-	-
	Pvt.	Nil	0	-1	-
No. of Surgeons	Govt.	01	02	01	04
	Pvt.	Nil	0	-	-
No. of Anaesthetists	Govt.	01	0	01	02
	Pvt.	Nil	0	-	-
No. of Orthopaedists	Govt.	Nil	0	-	00
	Pvt.	Nil	0	-	-
No. of Dentists	Govt.	Nil	01	-	01
	Pvt.	06	0	-	06

Name of Block		Bandipora	Hajan	Gurez	Total for District
Name of Health Blocks					
Health Institutions					
No. of Eye Surgeons		Nil	0	-	-
		Nil	0	-	-
No. of Gen. Physicians		01	16	-	17
		Nil	0	-	-
No. of Radiographers		01	0	-	01
		Nil	0	-	-
No. of Public Health Nurses		Nil	0	-	00
No. of Staff Nurses		06	07	-	13
No. of LHVs		Nil	01	-	01
No. of Pharmacists		25	23	14	58
No. of Lab. Technicians		04	03	02	09
No. X Ray Technicians		02	02	01	05
No of Ophthalmic Assts.		01	01	-	02
No. Dental Mechanics/Hygienists		01	01	01	03
No. of Male Health Supervisors		02	00	-	02
No. of ANMs		11	12	06	19
No. of Male Health Workers		03	01	02	06
No. of AW Workers		191	218	68	474
No. of UDCs		NA	03	-	03
No. of LDCs		NA	02	-	02
No. of Computer/Statistical Assts.		0	00	-	-
No. of Drivers		05	03	06	14
No. of ASHAs selected		83	178	25	286
No. of Trained Dais		28	20	10	58

Work force position in the district as per IPHS Norms:-

Table: 2		Identified Gaps of Manpower					
Name of Blocks		Hajjan	Bandipora	Gurez	No. Of Required Staff	No. of Existing Staff	Total Gaps
No. of Sub- Centres (51)	IPHS Norm	24	20	7			
ANM	2	35	25	10	102	32	70
N0. Of PHC's(12)		5	3	4		0	
MO	2	3	5	4	24	12	12
Pharmacist	1	-1	0	-1	12	14	-2
Nurse	3	12	8	12	36	4	32
Female Health Worker	1	2	2	4	12	4	8
Health Educator	1	4	3	4	12	1	11
Health Assistant	2	7	6	8	24	3	21
Clerks	2	6	4	7	24	7	17
Lab. Technician	1	3	3	3	12	3	9
Driver	—	2	3	2		7	-7
Class IV	4	6	4	7	48	31	17
TOTAL					204	86	118
No. of CHC's(3)		1	1	1			
A. CLINICAL MANPOWER							
General Surgeon	1	1	0	0	3	2	1
Physician	1	1	0	1	3	1	2
Obstetrician / Gynaecologist	1	1	1	0	3	1	2
Paediatrics	1	1	1	1	3	0	3
Anaesthetist	1	1	0	0	3	2	1
Public Health Programme Manager	1	1	1	1	3	0	3
Eye Surgeon	1	1	1	1	3	0	3
Other specialists (if any)							
General duty officers (Medical Officer)		0	5	6			
B. SUPPORT MANPOWER							
Nursing Staff	7+2						
Public Health Nurse	1	0	0	1	3	2	1
ANM	1	0	0	0	3	3	0
Staff Nurse	7	3	3	6	21	9	12
Nurse/Midwife							
Dresser	1	0	1	1	3	1	2
Pharmacist / compounder	1	-3	1	-3	3	8	-5
Lab. Technician	1	0	0	-1	3	4	-1
Radiographer	1	0	-1	-1	3	5	-2
Ophthalmic Assistant	1	1	0	1	3	1	2
Ward boys / nursing orderly	2	-2	-3	-7	6	18	-12
Sweepers	3	-3	1	1	9	10	-1
Chowkedar	1	-1	0	1	3	3	0
OPD Attendant	1	1	1	0	3	1	2
Statistical Assistant / Data entry operator	1	1	1	1	3	0	3
OT Attendant	1	0	0	1	3	2	1
Registration Clerk	1	0		0	3	3	0
Any other staff (specify)							
TOTAL					93	76	17
Note: (-) Surplus staff							

Status of Health Centre Buildings in the District

Sub-Centre (SC) Status:-

Sub Centres	No.	Overall Status
Sub-Centres in own building	08	
Sub-Centre in Panchayat Bldg / rented building	42	
SC without Electricity connection	51	
SC without Water Supply	51	
SC without Toilets	51	

Primary Health Centres:- (PLZ GIVE THE PHC DATA NAME WISE IN TABULAR FORM)

Status	Names of PHCs
24 hour PHC	PHC Hajan
Total beds	20
No. of OPD cases	96025
No. of indoor cases	305
Rogi Kalyan Samiti functioning	YES

Block Primary Health Centre (BPHC)/CHC

(BPHC)/CHC Status		Total
Total no. of beds		96
Total no of OPD cases		111812
Total no. of indoor admissions		6315
Bed occupancy rate		32%
Total no. of deliveries		653
Up gradation of SKS		NA
Vehicle/Ambulance		08
Ambulance with NGO partner		NIL
Rogi Kalyan Samiti functioning		Yes

Number of Institutions Requiring New Buildings

#	Category of Institution	Numbers
1	PHCs	06
2	SCs	42
3	CHCs	01

Source: CMO office

Number of Buildings Requiring Additions/Expansion (staff quarters)

#	Category of Institution	Numbers
1	PHCs	12
2	SCs	51
3	CHCs	03

Number of Buildings Requiring Repairs

#	Category of Institution	Numbers
1	PHCs	06
2	SCs	9
3	CHCs	03

Status of Staff Quarters attached to CHCs, PHCs and SCs in the District

Building	Staff Quarters	Condition (G: Good, NMR: Needs Minor Repairs, MR: Needs Major Repairs, NAD: Needs Additions)
CHC Bandipora	Yes	All these Quarters Need major repairs and additions
CHC Hajan	Nil	
CHC Gurez	Nil	
PHC Chintmulla	Nil	
PHC Astangoo	Nil	
PHC Walar Lake	Nil	
PHC Nowgain	Yes	MR
PHC Naid Khai	Nil	
PHC Hajan	Yes	MR
PHC Amchi Kondal	Nil	
PHC Ajas	Nil	
PHC Sheikhpora	Nil	
PHC Bagtora	Nil	
PHC Bamayee Tulail	Nil	
PHC Budingan Tulail	Nil	

Status of Staff Quarters attached to SCs in the District

Sub Centres	No. of SCs	Size in sq. mts.	Condition (see codes above)
SHCs having 2 staff Qtrs. in addition to clinic, examination and delivery room area	No		No
SHCs having 1 staff Qtr. in addition to clinic, examination and delivery room area	No		No
SHCs having no staff Qtrs	56		56

2. PLANNING PROCESS

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

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

The District Planning Team (DPT) provided technical oversight and strategic vision for the process of development of District Action Plan.

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

This District Action Plan has been prepared through a long 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 DPT and the chapterization plans were 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 DAP was prepared for presentation to the District Health Society for approval

HEALTH SERVICE INDICATORS FOR THE DISTRICT					
BASIC HEALTH SERVICES					
S. No	Indicator	Criteria			Goal Posts & SCORE
1	IMMUNIZATION COVERAGE < 3 YEAR OF AGE	No. <3 years	No. completely immunised	% of fully immunized children	Maximum 100% Minimum 0%
		NA	NA		
2	ESSENTIAL ANTENATAL CARE	Total no. of pregnant women	No of women who got full antenatal care as defined	% of women getting antenatal care as defined	Maximum 100% Minimum 0%
		NA	NA		
3	INSTITUTIONAL DELIVERY	Total no. of deliveries	Total no of women who had institutional delivery	% of pregnant women who had institutional delivery.	Maximum 100% Minimum 0%
		NA	NA		
4	WEIGHING OF NEWBORN WITH IN THREE DAYS	Total no. of births in the year	No. of newborn weighed within three days	Percentage of newborn weighed within three days	Maximum 100% Minimum 5%
		NA	NA		

HEALTH SERVICE INDICATORS FOR THE DISTRICT						
BASIC HEALTH SERVICES						
S. No	Indicator	Criteria				Goal Posts & SCORE
5	BREASTFEEDING IN FIRST HOUR	Total no of births in the last year	No of newborns who were breastfed in the first hour	Percentage of newborns who were breastfed within an hour		Maximum 100% Minimum 0%
		NA	NA			
6	REPORTING OF BLOOD SLIDE	Approx no of blood slides sent in last 3 months	Average time taken for reporting of blood slide			Maximum over 30 days Minimum 1 day
		NA	NA			
9	ACCESS TO STERILISATION SERVICES	No of target couples for sterilisation services (> 2 children)	Total no. of couples with at least one of them wanting FP operation:	No. who wanted to get FP operation done last year but could not	% of unmet demand for FP operation	Maximum 100% Minimum 0%
		-NA	-NA	-NA	-	
HEALTH RELATED SERVICES						
WATER & SANITATION						
15	USE OF DOMESTIC/ COMMUNITY TOILET	Total no. of families	Total no. of families where all members are using domestic/ community toilet	Percentage of families where all members are using domestic/ community toilet		Maximum : 50 % Minimum 0%
		-	-	-		
FOOD SECURITY RELATED						
16	ANGANWADI	Total no. of children eligible for anganwadi	Actual No. getting diet regularly	Percentage of Anganwadi beneficiaries		
		5895	2795	47%		
17	MIDDAY MEAL	Total no. of primary and middle schools	Total no. of schools giving cooked midday meals	Percentage of schools giving midday meals		
		NA	NA	-		
18	PDS FUNCTIONING	Total no. of BPL families eligible for lower cost grains	No. of families getting grains from PDS shop	Percentage of beneficiaries		
		9432	8597	91%		

HEALTH SERVICE INDICATORS FOR THE DISTRICT					
BASIC HEALTH SERVICES					
S. No	Indicator	Criteria			Goal Posts & SCORE
19	ANTYODAYA YOJNA	Total no. of BPL families eligible for free grains	No. of families getting free grains from PDS shop	Percentage of beneficiaries	
		3223	616	16%	
20	SCHOOL ENROLMENT	Total no. of children in 6-14 age group	No. of children in age group not going to school	Percentage of school going children	
		28794	669	98%	
HEALTH STATUS					
21	CHILD MALNUTRITION	Total no. of children below 3 with wt record.	no. of children with gr I or above malnutrition**	% of children malnourished	Max 200% Minimum 0%
		NA	NA		
22	LOW BIRTH WEIGHT	Total no. of newborn who were weighed last year	Total no. of babies with LBW	Percentage of babies with LBW	Max 100% Min 10%
		959	158	16%	
23	AGE OF MARRIAGE	Total no. of girls married last year	No. of girls married below 19 year of age	100% - % of married women below 19 year of age	Max 100% Mim 0%
		476	415	87%	-
24	SPACING	Total number of births last year which were second or > child	No. of children born with more than 36 months difference	% of unspaced second or third children born	Max 100% Minimum 0%
		687	485	70%	
25	INFANT DEATHS	Total number of births last year	Any deaths of any child below one year	% of infant deaths	Maximum 20% Minimum 0%
		1138	20	1.76%	
26	OUTBREAK OF WATER BORNE DISEASE	Diarrhoeal outbreaks(More than three cases of a disease in same week)	jaundice outbreaks (as defined)	Sum of water borne disease outbreaks	Maximum 4 Minimum 0
		2			0.9%

Health facilities as per Population Norms:-

Block:- Bandipora			Population census 2001- 1,31,661 Projected for 2012- 1,75,109	
Health Facility	Recommended	Required	Existing	Gap/ to be constructed
SC's	1/3000	58	20	38
PHC's	1/20000	8	3	05
CHC's	1/80000	2	01	01
Block:-Hajan			Population census 2001- 1,49,013 Projected for 2012- 1,98,187	
SC's	1/3000	66	24	42
PHC's	1/20000	10	05	05
CHC's	1/80000	02	01	01
Block:- Gurez			Population census 2001- 25,837 Projected for 2012: 34,363	
SC's	1/3000	12	07	05
PHC's	1/20000	02	04	00
CHC's	1/80000	00	01	00

3. PRIORITIES AS PER BACKGROUND AND PLANNING PROCESS

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

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

1. Providing services for the Un-reached population
2. Quality services at all level.
3. **Demand Generation, IEC/BCC:** Behaviour Change for utilization of services.
4. **Human Resources:** Vacant positions need to be filled as well as more staff needs to be recruited. To facilitate a higher retention of medical staff, staff residences must be constructed and special, attractive incentives given to attract medical practitioners. Availability of well trained ASHAs for each 1000 population.
5. **Capacity Building:** All new staff would require training while the current staff also needs regular training to both maintain and upgrade their skills. Thus capacity building of the staff is a grey area requiring attention. It is therefore essential to work out a strategy for capacity building suited to the district to ensure that maternal and child health improves effectively in the rural areas. An assessment of training needs is to be carried out for all staff categories against their job descriptions. Appropriate training programmes have to be developed and implemented in the near future. This training must include education to be given to adolescents and children to help shape healthier living patterns (i.e. awareness and information about alcohol, drugs, safe sexual practices, nutrition etc). Newer skills need to be developed in the staff to face up to the newer needs that are emerging in the health scenario of the district.
6. Improving the condition of the facilities as per the IPHS norms including provision of quarters for the personnel
7. Strengthening CMO office with good Infrastructure and technical assistance.
8. Strengthening the HMIS especially availability of correct data and its use. Data validation and networked, centralized computerized data availability up to PHCs with district linkages.
9. Improved monitoring for improved services
10. Improving the image of the health services within the community

Priorities gathered from the Village Action Plans of District Bandipora:

- 1. RCH/Maternal Health:** Complete awareness of ANC, Provision of Iron folic tablets, Calcium, Vit. A, at the sub-centres in adequate quantities. Facilities for institutional delivery at sub-centres and transportation for the pregnant ladies has also been suggested. Due to the undulating terrain there has been a **marked** lacuna in this area of health care delivery to the district. The dependence of the population on the government practitioners is almost total as there is very little private practitioner presence.
- 2. Child Health & Immunizations:** Improvement in Child Health component under NRHM by having required supply of vaccines at sub-centres, complete awareness about immunizations among the public. Provisions for cold chain maintenance and proper delivery system have also been strongly recommended.
- 3. Family welfare:** Stress on availability of preventive measures like contraceptives at the sub centres and there should be emphasis on increasing awareness and encouraging use of contraceptives among the people by all health personnel. As this a Muslim majority area there is a mindset against family limitation practices which is prevalent widely. However, the population and especially the women are agreeable to adopting spacing methods to improve the quality of life of themselves and their children. This aspect needs to be highlighted and addressed accordingly.
- 4. Adolescent health:** Vigorous awareness campaign has been suggested in the village plans and has been urged to be taken up seriously under the NRHM purview. Guidance, counselling facilities at sub centres, proper scrutiny of RTI/STI cases and awareness regarding Trish and STDs has also been recommended.
- 5. TB Control Programme:** As T.B is prevalent throughout the district recommendations for complete eradication of the disease by taking proper measures like wide-spread awareness generation, anti-tobacco campaign, personal hygiene, anti-pollution drives, highly organized DOTS programme, random checking of sputum and blood samples among the vulnerable group are also some of the suggestions made in the village plans.
- 6. Blindness Control:** Increasing the frequency of cataract and eye check-up camps which normally happen once in a year or two. Availability of Vit. A at sub centres has also been strongly recommended in the village plans.
- 7. NRHM Additionalities :**(ASHA) Definition of job role of the ASHAS, proper training, and provision of medicine kit and timely honorarium for their services has also been suggested.
- 8. JSY:** Timely remuneration to mothers at delivery was highlighted and it was repeatedly suggested that there should be proper monitoring of JSY funds at all levels. Other aspects like gender equity, IEC, Capacity building, inter-Sectoral convergence, untied funds to VWHSC was also taken up in the discussions for speedy and accurate implementation.
- 9. Adolescent Health:** The focus is on provision of Adolescent Reproductive and Sexual Health [ARSH] education to school children at the tender stages where they can obtain the maximum information and be aware besides awareness building on good health practices, responsible family life, and harmful effects of alcoholism. There is a tendency among the young males to succumb to depression which needs to be addressed immediately.
- 10. Anaemia.** A rampant occurrence among the poorer sections of the district and especially in the rural and tribal populations. There is needed to take care of this condition immediately.

4. GOALS

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

PL MENTION THE SOURCE OF THE DATA

INDICATOR	Current	Goals				
		07-08	08-09	09-10	10-11	11-12
Reduction in Infant Mortality Rate (IMR)	60	58	53	45	38	31
Reduce Neo-natal Mortality Rate (NMR)	38	36	32	25	18	14
Reduction Maternal Mortality Ratio (MMR)	300	290	250	210	170	140
Reduction in Birth Rate	29	28	26	23	19	16
Reduction in Total Fertility Rate	2.6	2.6	2.5	2.4	2.3	2.2
Reduction in Death Rate	.7	.7	.7	.6	.6	.6
Increase Ante-Natal Care as defined	60	65	70	77	83	88
Increase Proportion of Women getting IFA tablets	20	25	60	70	80	90
Increase Proportion of Women getting 2 TT Injections	40	45	55	65	75	83
Increase Institutional Deliveries	28%	30	35	45	57	69
Increase Delivery by Skilled Birth Attendants	70%	72	80	90	100	100
Increase Contraceptive Prevalence Rate	32.5	35	40	45	52	59
Increase Complete Immunisation of Children (12-23 month of age)	60	62	65	73	80	86
Increase Proportion of Children Exclusively Breastfed	15%	17	25	35	44	57
Reduce Prevalence of STI/RTI	7%	7	6	6	5	4

5. TECHNICAL COMPONENTS
PART A: Reproductive and Child Health (RCH) II

A-1. Strengthening of Health Management	
Situation Analysis	DPMU is to be Established.
Objectives Benchmarks	To establish District Health management Unit and implementation of all national health programme by providing technical support in planning & in its implementation with proper financial management
Strategies	<ol style="list-style-type: none"> 1. Functional Integration of all the vertical Societies 2. Capacity building of the members of the District Health Mission and District Health Society regarding the programme, their role, various schemes and mechanisms for monitoring and regular reviews and also on GOI / GOI J&K guidelines for running the District. Health & FW Society 3. Strengthening the functioning of the DHS 4. Establishing Monitoring mechanisms
Activities	<ol style="list-style-type: none"> 1. Developing systems for proper management, governance and functioning through: <ul style="list-style-type: none"> • Effective Planning – Annual, quarterly, monthly and as per needs • Supervision mechanisms • Convergence systems • Procedures, • Reporting systems, • Regularity of meetings, • Agenda of meetings, Maintaining minutes and its timely circulation • Decentralisation, • Delegation of decision-making power • Rational decision making 2. Orientation Workshop of the members of the District health Mission and society. 3. Issue based orientation in the monthly Review and Planning meetings as per needs. 4. Ensuring provision of Technical Assistance at the district and block levels and their ongoing capacity building. 5. Exposure visits of members of the District health Society in two states 6. Improving the Review and planning meetings through a holistic review of all the programmes under NRHM and proper planning. 7. Formation of a monitoring Committee from all departments. 8. Development of a Checklist for the Monitoring Committee.

	9. Arrangements for travel of the Monitoring Committee					
	10. Sharing of the findings of the committee during the Field visits in each Review Meeting with follow-up of the recommendations.					
	11. Vehicles for DHMU & CMO & contractual appointment of two drivers					
Support required	State to provide support for building the capacity of the DHS through participation in DHS meetings					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Developing systems	x				
	Orientation Workshop of the members	x	x	x	x	
	Issue based orientation	x	x	x	x	
	Ensuring provision of Technical Assistance at the district, block level.	x	x	x	x	
	Exposure visits of DHS members		x	x		
	Formation of a monitoring Committee from all departments.	x				
	Development of a Checklist for the Monitoring Committee.	x				
	Two vehicles for DHMU & CMO					
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Orientation Workshop	0.55	0.605	0.666	0.732	2.553
	Exposure visit	3.1	3.41	0.000	0.000	6.51
	Issues based Workshops	0.55	0.605	0.666	0.732	2.553
	Mobility for Monitoring	1.32	1.452	1.597	1.757	6.126
	Vehicle @ 5.lac * 2	10.00	0.00	0.00	0.00	10
	POL for 2 vehicles @ 50000/ per vehicle/ year	1.00	1.00	1.00	1.00	4
	Salary for 2 drivers @ 4000/M	0.96	0.96	0.96	0.96	3.84
	Total	17.48	8.032	4.889	5.181	35.582

Detailed Calculations

#	Description	Amount
Exposure Visit		
1	Airfare and travel expenses (Taxi, Bus, etc;)	200000/-
2	Lodging, Boarding, Food	100000/-
3	Misc.	10000/-
	Total	3,10,000/-

A- 2 District Programme Management Unit	
Current Status	<p>In NRHM a large number of activities have been introduced with very definite outcomes. The cornerstone for smooth and successful implementation of NRHM depends on the management capacity of District Programme officials. District programme management unit will be operational very soon.</p> <p>In order to strengthen the district PMU, three skilled personnel i.e. Programme Manager, Accounts Manager and Data Assistant have being provided in each district. These personnel are there for providing the basic support for programme implementation and monitoring at district level.</p> <p>At present there is no DPMU staff at District Head Quarters. There is no computers and peripherals available with the DPMU, Bandipora, which is one of the utmost need for HMIS in the district.</p> <p>There is a need for providing more support to the CMO office for better implementation especially in light of the increased volume of work in NRHM, monitoring and reporting especially in the areas of Maternal and Child Health, Civil works, Behaviour change and accounting right from the level of the Sub centre.</p>
Objectives	To make District Programme Management Unit functional and strengthened.
Strategies	<ol style="list-style-type: none"> 1. Support to the CMO for proper implementation of NRHM. 2. Capacity building of the personnel 3. Development of total clarity at the district and the block levels amongst all the district officials and Consultants about all activities 4. Provision of infrastructure for the personnel 5. Training of district officials and MOs for management 6. Use of management principles for implementation of District NRHM 7. Streamlining Financial management 8. Strengthening the CMO office 9. Strengthening the Block Management Units 10. Convergence of various sectors
Activities	<ol style="list-style-type: none"> 1. Support to the CMO for proper implementation of NRHM through involvement of more consultants for support in data analysis, trends, timely reports and preparation of documents for the day-to-day implementation of the district plans so that the CMO and the other district officers: <ul style="list-style-type: none"> • Finalizing the TOR and the selection process • Advertisements for Management unit team members and consultants, one each for Maternal Health, Civil Works, Child health, and Behaviour change. If properly qualified and experienced persons are not available then District Facilitators to be hired which may be retired persons. • Selection of the DPMU/BPMU staff and consultants. • Provision of dealing assistant NRHM in DHS chairman office for better coordination between Chairman, Management Units and other allied departments of DHS. 2. Capacity building of the personnel <ul style="list-style-type: none"> • Joint Orientation of the District officers and the consultants • Induction training of the DPM and consultants • Training on Management of NRHM for all the officials • Review meetings of the District Management Unit to be used for orientation

	<p>of the consultants.</p> <p>3. Development of total clarity in the Orientation Workshops and review meetings at the district and the block levels amongst all the district officials and Consultants about the set of activities:</p> <p>4. Provision of infrastructure for officers, DPM, DAM, DDM and the consultants of the District Project Management Unit and Provision of office space with furniture and computer facilities, photocopy machine, printer, Mobile phones, digital camera, fax etc.</p> <p>5. Use of Management principles for implementation of District NRHM</p> <ul style="list-style-type: none"> • Development of a detailed Operational manual for implementation of the NRHM activities in the first month of approval of the District Action Plan including the responsibilities, review mechanisms, monitoring, reporting and the time frame. This will be developed in participatory consultative workshops at the district level and block levels. • Financial management training of the officials and the Accounts persons • Provision of Rs. 500,000 as untied funds at the district level under the jurisdiction of the CMO. • Compendium of Government orders for the DC, CMO, district officers, hospital, CHCs, PHCs and the Sub centres need to be taken out every 6 months. Initially all the relevant documents and guidelines will be compiled for the last two years. <p>6. Strengthening the Block Management Unit: The Block Management units need to be established and strengthened through the provision of :</p> <ul style="list-style-type: none"> • Block Programme Managers (BPM), Block Accounts Managers (BAM) and Block Data Assistants (BDA) for each block. These will be hired on contract. For the post of BPM and the BAM retired persons may also be considered. • Office setup will be given to these persons • Accountants on contract for each PHC since under NRHM Sub centres have received Rs 10,000 also the village committees will get Rs 10,000 each, besides the funds for the PHC. • Provision of Computer system, printer, Digital Camera with date and time, furniture. <p>7. Convergence of various sectors at district level</p> <ul style="list-style-type: none"> • Provision of Convergence fund for workshops, meetings, joint outreach and monitoring with each CMO. ▪ Monitoring the Physical and Financial progress by the officials as well as independent agencies. ▪ Yearly Auditing of accounts
Support required	<ol style="list-style-type: none"> 1. State should ensure delegation of powers and effective decentralization. 2. State to provide support in training for the officials and consultants. 3. State level review of the DPMU on a regular basis. 4. Development of clear-cut guidelines for the roles of the DPMs, DAM and District Data Manager. 5. Developing the capacities of the CMOs and other district officials to utilize the capacities of the DPM, DAM and DDA fully.

	<p>6. Each of the state officers Incharge of each of the programmes should develop total clarity by attending the Orientation workshops and review meetings at the district and the block levels for all activities.</p> <p>7. If qualified persons for the posts of DPM, DAM are not available then State should allow the appointment of facilitators or Coordinators or retired qualified persons by the District Health Society.</p>					
Time Line			2008-09	2009-10	2010-11	2011-12
	Activity					
	Establishment of DPMU and Consultants	x	x	x	x	
	Infrastructure, furniture, computer systems, fax, UPS, Printer, Digital Camera	x				
	Workshops for development of the operational Manual at district and Block levels	x	x	x	x	
	Compendium of Govt orders	x	x	x	x	
	Joint Orientation of Officials and DPM, DAM, DDM	x	x	x	x	
	Management training workshop of Officials					
	Establishment of BPMU	x				
	Training of DPM and Consultants	x	x	x	x	
	Review meetings	x	x	x	x	
	Computer systems with printer and Digital Camera & furniture for DPMU, BPMUs, District, block personnel	x				
Monitoring of the progress	x	x	x	x		

**Budget
(In Lakhs)**

Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
Honorarium DPM,DAM,DDA and Consultants	32.34	35.57	39.13	43.04	150.08
Travel Costs for DPMU @ Rs 10,000/ per month x 12 mths	1.32	1.452	1.597	1.757	6.126
Infrastructure costs, furniture, computer systems, fax, UPS, Printer, Digital Camera,Telephone.	5	0.000	0.000	0.000	5
Workshops for development of the operational Manual at district and Block levels	1.1	1.21	1.33	1.46	5.1
Untied Fund	6	7.000	8.000	9.000	30
Compendium of Govt orders	0.550	0.605	0.666	0.732	2.553
Joint Orientation of Officials and DPM, DAM, DDM	0.275	0.303	0.333	0.366	1.277
Management training workshop of Officials	0.55	0.605	0.666	0.732	2.553
Personnel for BPMU	22.57	24.83	27.31	30.04	104.75
Training of DPM and Consultants	0.75	1.000	1.250	1.500	4.5
Review meetings @ Rs 1000/ per month x 12 months	0.132	0.145	0.160	0.176	0.613
Office Expenses @ Rs 10,000/month x 12 months for DPMU	1.3	1.5	1.6	1.8	6.2

Computer systems (5) with printer and Digital Camera and furniture for DPMU, BPMUs and District and block personnel	3	0.000	0.000	0.000	3
Annual Maintenance Contract for the equipment	0.594	0.653	0.719	0.791	2.757
Travel costs for BPMU	7.92	8.71	9.58	10.54	36.75
Monitoring of the progress by independent agencies	1.100	1.210	1.331	1.464	5.105
Office expenses for Blocks @ Rs 5000 x 3 blocks	1.98	2.178	2.396	2.635	9.189
Total	86.481	86.971	96.068	106.033	375.553

Detailed calculation for Personnel at DPMU for one year

Details	Units	Unit Cost	Amount for 12 months
Personnel at District level			
District Programme manager	1	18000	216000
District Accounts Manager	1	15000	180000
District Data Assistant	1	12000	144000
Consultant for Maternal Health	1	40000	480000
Consultant for Child Health	1	40000	480000
Consultant for Civil Works	1	40000	480000
Consultant for HMIS	1	40000	480000
Consultant for Behaviour Change	1	40000	480000
Sub Total			2940000
Personnel at Block level			
Block Programme manager	3	15000	540000
Block Accounts Manager	3	12000	432000
Block Data Assistant	3	10000	360000
Part Time Accountant at PHC	12	5000	720000
Sub Total			2052000
Hiring of vehicles at block level @ Rs 2000 x 10days /mth x3blocksx12 mths	3	20000	720000
Office Automation with Furniture, Computer system, Camera, Printer, etc	3 for BPMU 1 for DPM 1 for DAM	60,000	300000

A-3. MATERNAL HEALTH			
Situation Analysis	Indicator		
	No of Pregnancies (Estimated)	10,037	
	Maternal Deaths(April-06 to March. 07)		
	ANC registration During first Trimester		%
	Full ANC coverage as defined		30
	TT -1	7158	72
	Institutional Deliveries	921	19
	Deliveries by skilled birth attendant		
	Home deliveries 1651	Skilled	Unskill ed
			835
	No. of pregnancy related complications referred to FRU level		
Anemia			
Objectives	<ol style="list-style-type: none"> 1. Decrease in the Maternal Mortality ratio 2. 100% ANC coverage by 2012 3. 100% pregnant women administered two doses of TT by 2012 4. 80% pregnant women to consume 100 IFA tablets by 2010 and 100% by 2012 5. 65% Institutional deliveries by 2010 and 80% by 2012 6. 75% deliveries to be carried out by trained /Skilled Birth Attendant by 2010, 100% by 2012 7. 100% women to get improved Postnatal care by 2010 8. 50 % increase the safe abortion services by 2010 9. Reduction in Anaemia to less than 20 per cent by 2012 		
Strategies	<ol style="list-style-type: none"> 1. Provision of quality Antenatal and Postpartum Care to all pregnant women 2. Increase in Institutional deliveries 3. Provision of Quality services in the health facilities and availability of Emergency Obstetric Care services 4. Availability of safe abortion services at all CHC and PHC 5. Increased coverage under JSY 6. Strengthening the Village Health Day 7. To increase awareness among mothers and communities about the importance of institutional deliveries 8. Improved behaviour practices in the community 9. Increase accessibility to services 		
Activities	<ol style="list-style-type: none"> 1. Identification of all pregnancies through house-to-house visits by AWWs, ASHAs and TBAs 2. Operationalizing the Village Health Day <ul style="list-style-type: none"> • Once a week ANC clinic at all PHC and CHC • Weekly ANCs at all AWCs wherever possible • Development of a micro plan for the ANM's in a participatory manner with the ICDS at the level of PHC to cover all the AWCs. In the beginning it is expected that there should be 100% coverage at the population covered by the AWCMO and later each hamlet need to develop its microplan. • Wide publicity regarding the VHD day by AWWs and ASHAs and their 		

A-3. MATERNAL HEALTH

	<p>services</p> <ul style="list-style-type: none">• A day before the VHD day the AWW and the ASHA should visit the homes of the pregnant women needing services and motivate them to attend the VHD day• If the pregnant women do not attend the VHD day then they should be brought from their homes to the AWC• 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 at each of the mother's meetings <p>3. Improving accessibility to care</p> <ul style="list-style-type: none">• Monthly Outreach sessions at each difficult area villages• Pooling of resources at the PHC for conducting sessions for all services• Team to consist of MO PHC, LS, LHV, ANM, AWW, ASHA• Wide publicity for these outreach sessions by the ANMs/ AWWs/ ASHAs <p>4. Postnatal Care</p> <ul style="list-style-type: none">• 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. There is a need to train the AWWs intensively since initially till the posts are filled the ANM cannot do joint visits <p>5. Active involvement of TBAs:</p> <ul style="list-style-type: none">• Training to all TBAs focussing on their involvement in VHD days, motivating clients for registration, ANC, institutional deliveries, safe deliveries, postnatal care, care of the newborn & infant, prevention and cure of anaemia and family planning , on the 5 cleans, danger signs and timely referral• Delivery kits to be given to all TBAs• TBA to be attached with the ANM• Incentive of Rs 100 per delivery should be given to TBAs for promoting safe and institutional delivery through Skilled Birth Attendant• The recruitment of new ASHAs should be from the TBA taskforce. <p>6. Reduction of Anaemia</p> <ul style="list-style-type: none">• Wider distribution of IFA tablets and overseeing their consumption• ASHAs to be developed as depot holders for IFA tablets• ASHA to ensure that all pregnant women take 100 IFA tablets• Promotion of kitchen gardens to promote intake of iron rich vegetables.• Attractive packaging and Ayurvedic preparations of Iron and Folic Acid as an alternative to persons not consuming IFA tablets for increasing acceptance• Availability of IFA tablet. <p>7. Tracking bags</p> <ul style="list-style-type: none">• Provision of tracking bags for all the Pregnant mothers• Training of ANM and AWWs for the use of Tracking bags <p>8. Provision of Weighing machines to all Subcentres and AWCs</p> <p>9. Provision of twenty four hours heating arrangement for six months from</p>
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A-3. MATERNAL HEALTH

- November to April for all S/Cs for which one gas Bokhari with Gas cylinder is needed for the time being.
10. Training of personnel for Safe motherhood and Emergency Obstetric Care (Details in Component on Capacity building)
 11. Training for skilled birth attendant
 12. Developing the CHC and PHC for quality services and IPHS standards (Details in Component Upgradation of CHC& PHC and IPHS Standards)
 13. Increase accessibility of 24-hour delivery services (BEmoC) in all PHC. Repairs and renovations of PHC to be carried out.
 14. Availability of Blood at the CHC
 - Establishing Blood storage units at all CHC
 - Certification of the Blood Storage centres
 15. Improving the services at the Subcentres (Details in Component on Upgradation of Subcentres and IPHS)
 16. Behaviour Change Communication (BCC) efforts for awareness and good practices in the community (Details in Component on IEC)
 17. Increasing the Janani Suraksha coverage
 - Wide publicity of the scheme (Details in Component on BCC)
 - Advance Funds for JSY should be available with the ANMs
 - Timely payments to the beneficiary should be ensured
 18. Provision of Mobile Phones to all PHC MOs and CHC personnel
 - Display of the Mobile numbers at all Subcentres, AWCs, Panchayat Ghar, PHC and CHC
 - Plan of Rs. 225 per month of BSNL, which includes facility for 50 free calls
 19. Provision of Safe Abortion:
 - Provision of MTP kits and necessary equipment and consumables at all PHC
 - 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.
 20. Development of a proper referral system with referral cards
 21. Improvement of supervision and monitoring of ANM tour programme, Fixed VHD days, outreach sessions, payment of JSY, EmOC services, referral
 - Fixed VHD days and Tour plan of ANM to be available at the PHC 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
 22. Use of the Village Chowkidar and Numberdar as Social Mobilizers for getting data on Maternal deaths, abortions, Pregnancies
 23. Involvement of Rehbar-e-Sehat teachers for IEC, reporting and community mobilization
 - Training of RIS teachers
 - Regular meetings for progress and follow-up
 - Increase of emoluments to Rs 500 per month for motivation of families,

A-3. MATERNAL HEALTH

	giving some safe drugs, promotion of good health practices and disease control 24. RCH Camps: These will be organized monthly to provide specialist services especially for RTI/STD cases. Build public-private partnership in this area.
Support Required	<ol style="list-style-type: none">1. Issue of joint letters from Health & WCD department for joint working and ensuring its implementation2. Ensuring availability of personnel especially specialists and Public Health Nurses for the 24 hour PHC, CHC and two ANM at the subcentres3. Ensuring availability of formats and funds with the ANM for JSY and timely payments4. Certification of PHC as MTP centres5. Ensuring smooth flow of Blood from the Blood Bank at District Hospital to the Blood Storage units

A-3. MATERNAL HEALTH

Time Line		2008-09	2009-10	2010-11	2011-12
Identification of all pregnancies through house-to-house visits		x	x	x	X
Operationalizing the VHDs		x	x	x	X
Once a week ANC clinic at	All PHC and CHC				
Weekly ANCs	All AWCs wherever possible				
Microplan for ANMs		x	x	x	X
Monthly Outreach sessions	All difficult villages				
Delivery kits to be given to all TBAs		189	189	189	189
Incentive for TBA referral @Rs 100 per referral		3000	4000	5000	6000
Incentive to RIS teachers @ Rs 500/mth		x	x	x	X
Provision of tracking bags for all the AWCs & SC		530	609		609
Provision of Weighing machines to all Subcentres and AWCs		530			
Regular meetings for progress and follow-up		x	x	x	X
Establishing Blood storage units at all CHC		2CHC	2 CHC		
Increasing the Janani Suraksha coverage		8000	9000	10000	11000
Provision of Mobile Phones		12 PHC & 4CHC MOs			
Provision of MTP kits and necessary equipment and consumables at all PHC		X	X	X	X
Training of the MOs in MTP		x	x	x	X
RCH Camps		12	12	12	12
Training of personnel for Safe motherhood and Emergency Obstetric Care		x	x	x	x
Training of the MOs in MTP		x	x	x	X
Training for skilled birth attendant		x	x	x	X
Training of RIS teachers		x	x	x	X
Training to all TBAs		x	x	x	X
Training of ANM and AWWs for the use of Tracking bags		x	x	x	

A-3. MATERNAL HEALTH**Budget**

Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
Consultancy support for developing Microplan for Village health Day	1.1	1.21	1.331	1.464	5.105
Tracking Bags @ Rs 300/ bag x 530 AWCs & SCs	1.749	2.043	2.247	2.472	8.511
Adult Weighing machines @ Rs 800 per machine x 530 AWCsand SCs & Maintenance(10% cost of machine)	4.664	5.359	5.359	5.359	20.741
Monthly special outreach session in 50 difficult villages@2000/session	1.1	1.21	1.331	1.4641	5.1051
Blood Storage @ Rs 3 lakhs per unit	4.5	4.5	0	0.000	9
Referral Cards @ Rs 2 per card x 20,000	0.4	0.484	0.532	0.586	2.002
MTP kits @ Rs 15000 Per kit	1.98	2.178	2.396	2.635	9.189
One day training workshop on Tracking bags at the district level and each block/ sector	1.1	1.210	1.331	1.464	5.105
JSY beneficiaries @ Rs 1400/person	112	126.000	140.000	154.000	532
Mobile phone instrument @ Rs 2000	1.02	1.90	0.000	0.000	2.92
Mobile Phones recurring cost @ Rs 2700	1.377	3.942	3.942	3.942	13.126
Delivery kits to TBA's@3000and reffeling @ 1000	7.56	7.56	7.56	7.56	
Insentives to TBA @ 100 per deliveryby skilled birth attendent	1.5	2	2.5	3	30.24
RCH Camps @ Rs 25000 per camp x 12	3.3	3.63	3.99	4.39	9
Total	220.273	163.226	172.519	188.3361	744.3541

A-4. NEWBORN & CHILD HEALTH

Situation Analysis	Sl. No.	Indicator	No.	Rate /%	
	1	Live Births			
	Sex Differentials		F	M	
	2	Neonatal Deaths	NA	NA	
	3	Infant Deaths	NA	NA	
	4	Child Deaths	NA	NA	
	5	Still birth in the last year	NA	NA	
	6	Low birth weight newborns (less than 2.5 kgs.)	NA	NA	
	7	Child Vaccination: completed (12-23 months age)	NA	NA	
	8	Severely malnourished children (Grade III & IV)	NA	NA	
	9	ARI cases in the last year	NA	NA	
	10	Deaths in the last year due to pneumonia in children	NA	NA	
	11	Diarrhoea cases in the last year	NA	NA	
	12	Deaths in last year due to Diarrhoea in children	NA	NA	
Objectives	Goals: 1. To reduce IMR. 2. To reduce child malnutrition level. Objectives:				
Strategies & Activities	1) Special drive for increasing institutional deliveries. 2) 100% immunization coverage with proper cold chain facilities availability as per need 3) Prompt & appropriate community level care for all sick children & neo-nantal. 4) Adequate referral transport for sick children & neo nantal. 5) Reducing cost of care so as to favourable impact on poverty level. 6) Regular house visit & counselling by community level care gives for preventive & promotive health of children & reduction of child malnutrition.				
Support required	For maintenance of cold chain, logistics of vaccine monitoring system, integration with Ayush, NGOs.				
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12
	Promoting (IMNCI)	x	x	x	x
	IMNCI training	x	x	x	x
	Assessment of FRUs with reference to IPHS for NB Care	x	x		
	Newborn corners – All CHC	3 CHC	2CHC		
	Malnutrition Corners – DH and all CHC	3 CHC	DH , 2CHC		
	Education on early and exclusive breast feeding and Colostrum	x	x	x	x

A-4. NEWBORN & CHILD HEALTH

	Promotion of health seeking behaviour for sick children	x	x	x	x	
	Improving newborn care at the household level	x	x	x	x	
	Training on the home based Care IMNCI of ASHA/AWW/ANM/MOs	x	x	x	x	
	Training of MO in CEmOC, IMNCI	x	x	x	x	
	Training of LHV, AWW and ANM on IMCI including referral, Tracking Bags	x	x	x	x	
	Wide publicity regarding VHD days	x	x	x	x	

Budget

Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
Newborn Corner furnished with equipment @ Rs 2 lakh per facility	6.00	6.00	0	0	12.00
Examination table, chair, stool, table, other equipment @ Rs. 3000 x No of AWCs	1.422	0	0	0	1.422
Infant Weighing Machines@Rs. 800/AWCx No of AWCs	3.792	0	0	0	3.792
Foetoscope @ Rs.50 x No AWCs	2.37	0	0	0	2.37
Malnutrition Corners @ Rs 50,000 per CHC and District Hospital	1.5	2.5	0	0	4
	15.084	8.5	0	0	23.584

A-5. FAMILY PLANNING						
Situation Analysis	Indicators	No. or Rate				
	Eligible Couple					
	Couple Protection Rate					
	Female Sterilization operations during last year	146				
	Vasectomies during the last year	11				
	Couples using temporary method					
Objectives Benchmarks	Goal: Objectives: Reducing the unmet demand for contraception both spacing & limiting.					
Strategies & Activities	1) Increasing the number of Govt./Pvt. Institutions providing limiting methods of contraception. 2) Availability of spacing methods of gross rot level 3) Training of staff in IUD insertion at Sc's 4) Training of doctors/paramedic in safe abortions. 5) Training of doctors/paramedic in Laproligations 6) Holding of laproligation camps in PHC/CHC 7) Massive IEC campaign for family planning especially among male for popularising NSV 8) Involvement of ICDS workers, ASHA's in programme by providing incentive					
Support required	For IEC/BCC, purchase of logistics in case of non availability organising different training & quality services.					
Time line	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Training of MOs for NSV	12 MOs	12 MOs	11MOs	11MOs	
	Training of MOs for Minilap	4 MOs	4 MOs	4 MOs	4 MOs	
	Training of Specialists for Laparoscopic Sterilization	3CHC DH	2 CHC			
	Development of Static Centres at General hospitals and all CHC	3 CHC DH	2 CHC			
	Sterilization camps (Persons)	600	600	600	600	
	NSV Camps	6 camp	6 camp	6 camp	6 camp	
	Supply of Copper T – 380	3000	3000	3000	3000	
	Emergency Contraception	3000	3000	3000	3000	
	Laparoscopes	3 CHC DH	2 CHC			
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	NSV camps @ Rs. 386250/camps/block	11.5875	12.746	14.021	15.423	53.7775
	Sterilization Camps @ 738.5 X600 cases	4.873	5.36	5.896	6.486	22.615
	Development Static Centres@Rs 1 lakh	4.00	2.00	0	0	6.00
	Copper T-380 @ Rs 45 / piece	1.35	1.35	1.35	1.35	5.4

A-5. FAMILY PLANNING						
	Emergency Contraception@Rs10/2 tabs	0.3	0.3	0.3	0.3	1.2
	Laparoscopes 3per CHC&DH @ Rs3.00 lakhs/laparoscopes	12.00	6.00	0	0	18.00
	NSV Incentives 100 cases/block@1000/case	3.00	3.00	3.00	3.00	12.00
	Total	37.1105	30.756	24.567	26.559	118.9925

Detailed Calculations

Calculations per Case of NSV

S.No	Head	Unit Cost
1.	Payment to NSV acceptor	1000
2.	Mobilization/Transport cost	50
3.	Payment to Service Provider	50
4.	Payment to IEC advocate/Motivator	25
5.	Payment to Assistant/OT Nurse etc;	10
6.	Drugs and Dressing	27.5
	Total	1162.5

Requirements for organizing one camp (600 cases)

S.No	Head	Unit	Unit Cost	2008-09	2009-10	2010-11	2011-12	Total
1	District Workshop	1	4000	4000	4400	4840	5324	18564
2	Block workshops	4	7500	52500	57750	63525	69877.5	243653
3	TA/DA for NSV surgeons	5	2000	10000	11000	12100	13310	46410
4	IEC activities			93250	102575	112832.5	124115.75	432773
5	TA to Acceptor for Semen Analysis	600	50	30000	35000	40000	50000	155000
6	Payment to NSV Advocate/motivator, Drugs & Dressings	600	1162.50	196500	229250	262000	327500	1015250
	Total			386250	439975	495297.5	590127.25	1911650

Budget for IEC activities for NSV camp

S.No	Head	Unit	Unit Cost	Amount
1.	Hand Bills	100000	0.15	15000
2.	NSV booklets	10000	2	20000
3.	Banners	250	54	13500
4.	Posters	11000	2.50	27500
5.	DA for Driver & 2 persons	45 Mondays	50	2250
6.	Electronic Media Publicity for 15 days			5000
7.	Wall writing & publicity			1000
8.	Other Innovative activities			9000
9.	Total			93250

Budget for sterilization per case

S.No	Head	Unit Cost (Rs)
1.	Payment to acceptor	500
2.	Mobilization/Transport cost	50
3.	Payment to Service Provider	50
4.	Payment to IEC advocate/Motivator	35
5.	Payment to Assistant/OT Nurse etc;	10
6.	Drugs and Dressing	93.5
	Total	738.5

A-6. ADOLESCENT HEALTH						
Situation Analysis	No specific programme to address the adolescent health High prevalence of Anaemia & malnutrition Lack of adequate information regarding one's own body, its requirement, hygiene practices.					
Objectives Benchmarks	Reduce malnutrition & Anaemia especially adolescent girls. Reduce percentage of marriage in this group Increase awareness regarding pitfall of early marriage and child bearing. Increase awareness of one's own body including fertility control & safe sexual practices.					
Strategies & Activities	IEC/BCC. Mass screening of Anaemia. Training programme for adolescent with provision for booklets. Adolescent health service particularly distribution of IFA tablets to all unmarried girls, Reproductive health counselling, health facility based care etc.					
Support required	For screening & management of Anaemia & Malnutrition, school health programme, IEC campaign through print & local cables, involvement of NGO's.					
Time line	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Research					
	Awareness generation	x	X			
	Formation of Adolescent Mentoring Group					
	Workshop of all the partners	x	x			
	Training a district pool of Master trainers					
	Selection of Peer Educators	2Blocks	1 block			
	Counsellor through NGOs	x	x	x	x	
	Training of Peer Educators	250	130			
	Retraining of Peer Educators	100	150	380	380	
	Orientation of the Health personnel	x	x			
	Three day health camps for Adolescents	x	x			

A-6. ADOLESCENT HEALTH**Budget**

Activity	2008-09	2009-10	2010-11	2011-12	Total
Research	5.00	0.000	0.000	0.000	5
Awareness generation @ Rs 2000 per village x 189 villages	4.158	4.574	5.031	5.534	19.297
Workshop of all the partners	0.55	0.605	0.666	0.732	2.553
Training of Adolescent Mentoring Group and other expenses@1 Lakh	1	1.000	1.000	1.000	4
<u>Counsellors@ Rs 8000 per month x2x3CHCs x12 mths</u>	6.336	6.970	7.667	8.433	29.406
Training of Peer Educators @ Rs 100 per person x 3 days xNo of Peer Educators	2.381	1.372	0.000	0.000	3.753
ReTraining of Peer Educators @ Rs 100 per person x 3 days x peer Educators	1.134	1.247	1.372	1.509	5.262
Orientation & Reorientation Health personnel	0.275	0.303	0.333	0.366	1.277
Counselling sessions @ Rs 1000/yr/peer Educator	3.78	3.78	3.78	3.78	15.12
Counselling Clinics renovation, furnishing and Misc expenses @ Rs 10000.00	0.66	0.726	0.799	0.878	3.063
Health camps for Adolescents once per quarter x 4 x Rs 50000 per camp	2.2	2.42	2.662	2.928	10.21
Joint Evaluation by an agency & Govt	1.00	1.200	0.000	1.440	3.64
	28.474	24.197	23.31	26.6	102.581

PART B: New NRHM Initiative

B-1. ASHA – Accredited Social Health Activist						
Situation Analysis	<p>The Sub Centre caters to a population of approximately 3000 spread over an average of 5-7 villages. Hence keeping in view the difficulties faced by the ANM to provide health and family welfare services in all the villages and also carry out effective community contact, under NRHM a village level community based functionary has been brought in all villages and will be trained for meeting the health-related demands of people and will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services indicators in the villages.</p> <p>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 Janani Suraksha Yojana, motivation for sterilization, DOTS provider, etc.). It is conceived that she will be able to earn about Rs. 1,000.00 per month.</p> <p>In district Bandipora 286 ASHAs have been selected and have received training in module 1. At present every ASHA is being paid an incentive of Rs.150 per month for mobilizing the children for immunization. Besides these they are also entitled for Rs.600. for escorting a pregnant to near by Health Institution for delivery and rest of the activities supposed to performed by the a trained ASHA is not being paid any incentives</p> <p>Total ASHAs approved by DRHS=286 No. of ASHAs needs to be approved= 115.</p>					
Objectives Benchmarks	<ol style="list-style-type: none"> 1. Availability of a Community Resource, service provider, guide, mobilize 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 & Activities	<p>Training to the ASHAs. Follows ups to the different activities undertaken by ASHAs. Other facility to ASHA like uniform & study material.</p>					
Support required	<p>Quarterly training to ASHAs in different health related issues</p>					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Training of new & untrained ASHAs	115	0	0	0	
	Training of ASHAs for module2,3,4	283				
	Reorientation of the ASHAs		283	283	283	
	ASHA Performance Diaries	398	398	398	398	
	District ASHA Mentoring group	x	x	x	x	

B-1. ASHA – Accredited Social Health Activist						
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Training & kit @ Rs 10000/ New ASHA+ Kit @ 1000/ Trained ASHA	14.33	0	0	0	14.33
	Training of ASHA in Module II,III,IV @ 2000/ASHA	5.66	0	0	0	5.66
	Reorientation @ Rs 1000/ ASHA	0	3.98	3.98	3.98	11.94
	Expenses for the District mentoring group – meetings, travel @ Rs 5000 per month x 12 months	0.66	0.726	0.799	0.878	3.063
	ASHA Performance Diary @ 100/ASHA	0.438	0.482	0.53	0.583	2.033
	Compensation to ASHA @1000/ASHA	3.98	3.98	3.98	3.98	15.92
	Total	25.068	9.168	9.289	9.421	52.946

B-2. Provision of Untied Funds at Sub Centres						
Situation Analysis/	Till NRHM was launched there was no provision for any fund for the subcentres for maintenance, electricity, water, any fund for consumables and cleanliness of the subcentre. Rs 2000 was given as contingency funds, which were totally inadequate to meet any demands. Due to this the Subcentres were in a pathetic condition and the ANM worked alone for deliveries sometimes helped by the family members. A number of equipment needed some repair due to which they were lying unutilized. The Gram Panchayat members were never involved in any activities of the Subcentre. Keeping in view the remoteness, backwardness and isolated situation of this tribal border district and heavy cost factor of construction and others the amount need to be increased to the tune of Rs.30,000/-per S/Centers (Rs 10000 for untied fund + Rs 20000 for annual maintenance grant)					
Objectives	Sub centre Upgradation & increase in untied funds yearly by 20%. Maintenance of PHC					
Strategies & Activities	Expansion in terms of construction. Major repair of buildings. Basic facility availability. Provision of phone & ambulance					
Support required	Support required from Govtt. Communication facilities. Logistics & supply & human resources.					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Untied Fund of Rs 10000/subcentre	51	136	136	136	
	Annual Maintenance grant of Rs 20000/SC	51	136	136	136	
	Plan for maintenance to be developed and approved by Gram Panchayat	x	x	x	x	
	Plan for use of untied funds	x	x	x	x	
	Gram Panchayat to identify mode of construction and repair	x	x	x	x	
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Untied Fund of Rs 10000/subcentre + 85 new SCs from 2010	5.10	13.60	13.60	13.60	45.9
	Annual Maintenance grant of Rs 20000/SC+ 85 new SCs from 2010	10.20	27.20	27.20	27.20	91.8
	Total	15.3	40.8	40.8	40.8	137.7

B-3. Provision of Untied Funds at PHC						
Situation Analysis/	Till NRHM was launched there was no provision for any fund for the PHC for maintenance, electricity, water, any fund for consumables, telephone, hiring transport in emergencies and cleanliness PHC. Due to this the PHC were in a bad shape. They were unable to provide services as per the needs of the patients. A number of equipment needed some repair due to which they were lying unutilized.					
Objectives	1. Strengthening of the PHC through financial support					
Strategies & Activities	1. Provision of Untied funds of Rs 25000 each year to the PHC at the disposal of the Rogi Kalyan Samities 2. Provision of an Annual Maintenance grant of Rs 50,000 to the PHC					
Support required	ECG, USG, X ray plants and fully fledged lab.					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Untied Fund of Rs 25000/PHC	12 PHC	22 PHC	22 PHC	22 PHC	
	Annual Maintenance grant of Rs 50000/PHC	12 PHC	22 PHC	22 PHC	22 PHC	
	Plan for maintenance to be developed and approved by the Rogi Kalyan Samitis	x	x	x	x	
	Plan for use of untied funds	x	x	x	x	
	Rogi Kalyan Samitis to identify mode of construction and repair	x	x	x	x	
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Untied Fund of Rs 25000/PHC + 10 new PHC from 2010	3.00	5.50	5.50	5.50	19.50
	Annual Maintenance grant of Rs 50000/PHC x 12 PHC+ 10 new PHC from 2010	6.00	11.00	11.00	11.00	39.00
Total		9.00	16.50	16.50	16.50	58.50

B-4. Provision of Untied Funds at CHCs						
Situation Analysis	Though the untied fund for CHC is not available .Enough to meet out all the expenditure of all the related and necessary repairs and Upgradation and maintenance of PHC's.					
Objectives	Upgradation of CHC as speciality hospital. Upgradation of CHC's Internet facility of all CHC's.					
Strategies & Activities	On line reporting system by BPMS. Staff Strengthening Expansion and Upgradation different facility.					
Support required	Sufficient funds to meet out all these expenditure's.					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Untied Fund of Rs 50000/CHC	3	2	2	2	
	Annual Maintenance grant of Rs 100000/CHC	3	2	2	2	
	Plan for maintenance to be developed and approved by the Rogi Kalyan Samitis	x	x	x	x	
	Plan for use of untied funds	x	x	x	x	
	Rogi Kalyan Samitis to identify mode of construction and repair	x	x	x	x	
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Untied Fund of Rs 50000/CHC + 2new CHC from 2010	1.5	2.50	2.50	2.50	9.00
	Annual Maintenance grant of Rs 100000/CHC+ 2new CHC from 2010	3.00	5.00	5.00	5.00	18.00
	Annual Maintenance grant of Rs 500000/ DH	5.00	5.00	5.00	5.00	20.00
	Total	9.5	12.5	12.5	12.5	47.00

B- 5. Mobile Medical Units						
Situation Analysis	No govt. mobile medical unit is existing.					
Objectives	To start at least two mobile medical unit in the district during the year 2007-2008.					
Strategies & Activities	Hiring of staff. Purchase of mobile medical unit specialized ambulance. Separate budget for mobile medical unit. Rent & building.					
Support required	Staff Mobile ambulance. Supply & logistics.					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Operationalizing the MMU	1				
	Orientation of the staff	x	x	x	x	
	Wide Publicity	x	x	x	x	
	Strengthening the MMU	x	x	x	x	
	Addition of services	x	x	x	x	
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	One unit of Mobile van for the staff @ 7 Lakhs	7.0	0.000	0.000	0.000	7.00
	One mobile unit with essential accessories @ 18.25 Lakhs	18.25	0	0	0	18.250
	One mobile unit with diagnostic facilities @23.75 Lakhs	23.75	0	0	0	23.750
	Recurring expenditure of mobile unit @ 23.71 Lakhs	23.71	23.71	23.71	23.71	94.84
Total		72.71	23.71	23.71	23.71	143.84

B – 6. Upgrading CHCs to IPHS						
Situation Analysis	So far no CHCs have been upgraded to IPHS standard. The target to be achieved in future is 3 CHC's which needs to upgrade as per IPHS.					
Objectives	Upgradation of 3 CHC's as per IPHS standards.					
Strategies & Activities	Construction as expansion of CHC's. All diagnostics facility. Additional referral facilities. Blood bank & child born care.					
Support required	Sufficient release of fund at right time.					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Repair /alterations/additions of CHC	3 CHCs				
	Construction of CHC building	2 CHCs				
	Construction of Staff Quarters	2 CHC	2 CHC			
	Furniture	3 CHC	2 CHC			
	Generator	3 CHC	2CHC			
	Computer	3 CHC	2 CHC			
	Maintenance	x	x	x	x	
	Addition & Repairing of DH	X				
Budget (in lacs)	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	CHC Building Repair, Alteration and Edition @ 10 Lakh	30.00	00.00	00.00	00.00	30.00
	Construction of CHC build.40.00lacs(RS.1000/SFT) * 2	80.00	0.00	00.00	00.00	80.00
	Up gradation Of CHC Bandipora to DH.	10.00	00.00	00.00	00.00	10.00
	Repairing of DH	0.00	50.00	00.00	00.00	50.00
	Staff quarters for Dist. Hospital	27.2	27.2	00.00	00.00	54.40
	Staff Quarter S.Q for MO No. of CHC @48.00 lac (Rs 1000/ Sft.) * 4	96.00	96.00	00.00	00.00	192.00
	Staff Quarter S.Q for staff nurses No. of CHC @40 lac (Rs. 1000/ Sft.) * 4	80.00	80.0	00.00	00.00	160.00
	S.Q for chowkedar @4.00 lac* 5 CHCs	10.00	10.00	00.00	00.00	20.00

	Furniture 5%CHC building Cost-% available 5% of 40.0lac - 47% (2.00-47%)x3 + 2New CHC	3.18	4.00	00.00	00.00	7.18
	Computer ,printer ,fax No. of CHC @50000 (3x50000) + 2 New CHC	1.5	1.00	00.00	00.00	2.50
	Mechanical laundry @ 50000 / CHC (50000X3) +2 New CHC	1.5	1.00	00.00	00.00	2.50
	Ambulance for DH	15.00	00.00	00.00	00.00	15.00
Recurring	Purchase of generator sets @ 0.6 lakh x No of CHCs	1.8	1.20	00.00	00.00	3.00
	Recurring & Maintenance cost of generator sets Rs. 140 X 30 days X 12 months X No. of CHCs	1.512	2.52	2.772	3.049	9.853
	Travelling allowance @ 75 / day X 24 visits / mon.X No. of CHCs (75X24X12X3) + 2 New CHC	0.7128	1.08	1.188	1.3068	4.2876
	Telephone @ 2000 / mon. / CHC (2000X12X3) +2New CHC	0.792	1.20	1.32	1.452	4.764
	Internet @ 500/ mon./ CHC (500X3X12)+ 2 New CHC	0.198	0.30	0.33	0.363	1.191
	Other expenses @ 4000 / Môn. / CHC (4000X3X12)+ 2 New CHC	1.44	2.40	2.64	2.904	9.384
	Maintenance grant of CHC (water, electricity) @ 10000 / Môn. / CHC (10000X12X3) +2 New CHC	3.60	6.00	6.60	7.26	23.46
	Staff for Mech. Laundry 2 persons/ CHC @4000 / mon. (6X4000X12)+ 2 New CHC	2.88	4.80	5.28	5.808	18.768
Total		367.3148	288.7	20.13	22.1428	698.2876

B – 7. Upgrading PHCs for 24 hr Services						
Situation Analysis	Only one PHC's have been upgraded as 24 hours service					
Objectives	To improve health care & reduce MR & work load on state hospital.					
Strategies & Activities	All types of facility available. Consultation of specialists to made available. Referral & communication facility. Expansion & construction.					
Support required	Funds to be realized well in time.					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Upgradation of PHCs as 24 X7	08	08	06		
	Repair/ additions/ alterations of PHC	07				
	Construction of PHCs	05	10			
	Staff Quarters at PHC	12	10			
	Furniture	12	10			
	Computer System	12	10			
	Vehicle	09	10			
	Invertors	12	10			
	Washing Machines	12	10			
	Maintenance & Others	X	X	X	X	
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
Non recurring	All PHCs to be upgraded to 24X7 as per IPHS PHC @ 25%of building cost 15lac (375000),8 PHCs in 08-09,08 PHCs in 09-10,06 PHCs in 10-11	30.00	30.00	22.50	0.00	82.50
	Construction of PHCs in rented buildings 05 PHCs @ 15lac/ PHC (Rs. 1000/ Sft.) * 5 PHCS	75.00	00.00	0.00	0.00	75.00
	Construction of 10 new PHCs buildings @ 15lac/ PHC (Rs. 1000/ Sft.) * 10PHCS	75.00	75.00	0.00	0.00	150.00
	Staff Quarters for 22 PHCs @48.00lac/PHC (Rs. 1000/ Sft.)	528.00	528.00	0.00	0.00	1056.00
	Furniture 5% of building cost X no. of PHC- % available (5% of 15lacX 12)- 45% (75000X12-45%)	4.95	0.00	0.00	0.00	4.95

	Invertors for staff quarters @15000/PHC	1.8	0.00	0.00	0.00	1.80
	Computer@40000/PHC	4.8	0.00	0.00	0.00	4.8
	Vehicle 09 PHCs @ 3lac/per vehicle	27.00	0.00	0.00	0.00	27.00
	Washing machines 1/PHC@10000 12X10000	1.2	0.00	0.00	0.00	1.2
Recurring	24X7 PHC Extra Man Power for 1 PHC / CD Block as per IPHS (1 MO / block @21000/M) (2 Nurses / Block @ 12800 / M)	44.736	89.472	123.024	123.024	380.256
	Telephone expenses@2000/month/PHC 2000X12X12	2.88	2.88	2.88	2.88	11.52
	Internet expenses @500/month/PHC 500X12X12	0.72	0.72	0.72	0.72	2.88
	Electricity charges 5000X12X12	7.2	7.2	7.2	7.2	28.8
	POL 0cases/year/PHC@300/Case 80X12X300	2.88	2.88	2.88	2.88	11.52
	Driver 1/PHC @4000/month 07X4000X12	3.36	3.36	3.36	3.36	13.44
	Laundry staff 1/PHC @4000/month 4000X12X12	5.76	5.76	5.76	5.76	23.04
	Maintenance & other expenses 10000/moth/PHC	14.4	14.4	14.4	14.4	57.6
Exp.For new PHCs 11	Furniture @ 75000 * 10	0.00	7.5	0.00	0.00	7.5
	Invertors for staff quarters @15000/PHC * 10	0.00	1.50	0.00	0.00	1.50
	Computer@40000/PHC * 10	0.00	4.00	0.00	0.00	4.00
	Vehicle 10 PHCs @ 3lac/per vehicle	0.00	30.00	0.00	0.00	30.00
	Washing machines 1/PHC@10000 10X10000	0.00	1.0	0.00	0.00	1.00
	Telephone expenses@2000/month/PHC 2000X12X10	0.00	2.40	2.40	2.40	7.20
	Internet expenses @500/month/PHC 500 X 12 X 10	0.00	0.60	0.60	0.60	1.80

	Electricity charges 5000 X 12 X 10	0.00	6.00	6.00	6.00	18.00
	POL 80cases /year/ PHC @ 300 /Case 80 X 10 X 300	0.00	2.40	2.40	2.40	7.20
	Driver 1 / PHC @ 4000 / month 10 X 4000 X 12	0.00	4.80	4.80	4.80	14.40
	Laundry staff 1 / PHC @ 4000 / month 4000 X 12 X 10	0.00	4.80	4.80	4.80	14.40
	Maintenance & other expenses 10000 / moth / PHC * 10	0.00	12.0	12.00	12.00	36.00
	Total	829.686	836.672	215.724	193.224	2075.306

B – 8. Upgrading Sub Centres						
Situation Analysis	Upgradation of sub centre's.					
Objectives	To met out the health care in rural areas & improve the detorated services.					
Strategies & Activities	Building for sub centre & referral facility. Sanitation & electricity for sub Centre's. Staffs strengthen of sub centres. Maintenance & supplies.\					
Support required	Logistics & maintenance support for govt.					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	New buildings with quarters, equipment and Furniture for existing centres -128	64	64	-	-	
	Two staff Quarters -136	68	68	-	-	
	Furniture	51	85	-	-	
	Electric wringing, Sanitary toilets, Water supply	51	85	X	X	
Budget (in Lacs)	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Construction of Sc's in rented building & new SCs ac. To population norms @ 4.00 lacs / SCs (43 existing & 85 New Scs) (Rs.1000/Sft.)	256.00	256.00	0.00	0.00	512.00
	Staff quarter for Existing & new SCs (Existing 51 SCs & 85 New SCs 7.50 lac (Rs. 1000 / sft.)	510.00	510.00	0.00	0.00	1020.00
	Furniture 5% of Building cost X no. of SCs - % available 5% of 4.00 X51- 22%	7.956	0.00	0.00	0.00	7.956
	Travelling allowance @ 100/visit X10 visits /SC * 51	0.51	0.51	0.51	0.51	2.04
	Electricity charges & other Expenses @1000/month/ SC	6.00	6.00	6.00	6.00	24.00
	Voluntary worker @ 1200/SC 1200X51	0.60	0.60	0.60	0.60	2.40
	Furniture @ 20000/ SC * 85	0.00	17.00	0.00	0.00	17.00
Recurring	Voluntary worker @1200/SC * 85	0.00	1.02	1.02	1.02	3.06
	Travelling & other expenses @ 7000/SC * 85	0.00	5.95	5.95	5.95	17.85
Total		781.066	797.08	14.08	14.08	1606.306

B-9 Untied Funds and Incentive Fund for the Village Health and Water Sanitation Committees					
Situation Analysis/ Current Status	<p>NRHM has placed a lot of stress on Community involvement and formation of Village Health & Water Sanitation Committees (VHWSC) in each village. These committees are responsible for the health of the village. In District Bandipora these committees have been formed but need strengthening to improve their functioning. The selection of ASHA, her working, progress of the village is part of the responsibilities of the Gram Panchayat.</p> <p>In Bandipora there are 77 villages with population less than 1500. There are 101 villages with population between 1500 and 3000. There are 10 villages with population more than 3000 & 1 village with the population more than 5000. Hence these amount to 77 units of 1500 population.</p>				
Objectives	Strengthening the Village Health & Water Sanitation Committees through financial support				
Strategies	<ol style="list-style-type: none"> 1. Provision of annual Untied funds of Rs 10000 each year to the villages upto a population of 1500 2. Provision of Rs 5000 as permanent advance fund for Incentives for ASHA 				
Activities	<ol style="list-style-type: none"> 1. Provision of Annual Untied funds of Rs 10000 each year to the villages' upto a population of 1500. Villages with more than 1500 population upto 3000 will get twice the funds. Villages with population more than 3000 will get three times the funds. Hence there will be 77 units of population 1500 or less to get the funds annually of Rs 10,000.00. This untied fund is to be used for household surveys, health camps, sanitation drives, revolving fund etc; 2. Orientation of the MPHWF for the utilization of the untied funds and she in turn will orient the Village, Health & Water Sanitation committee. 3. Provision of Rs 5000 as permanent advance fund for Incentives for ASHA based on performance norms. 4. Monthly meetings of the VHWSC for reviewing the funds and activities. This is to be facilitated by the MPHWF 5. Monthly review at the PHC level regarding the VHWSC functioning and utilization of funds. 				
Support required	<ol style="list-style-type: none"> 1. State should ensure the orientation procedure for the VHWSC 2. Funds to be transferred on time to the MPHWF 3. PRIs to ensure proper usage and accounts 				
Timeline		2008-09	2009-10	2010-11	2011-12
	Untied Fund of Rs 10000/unit for Pop 1500/unit x 77 units	x	x	x	x
	Orientation and reorientation of the VHWSC	x	x	x	x
	Provision of Rs 5000 as permanent advance for incentives to ASHA	x	x	x	x
	Monthly meetings of the VHWSC	x	x	x	x
	Review of the VHWSC functioning at PHC level	x	x	x	x

Budget	Activity / Item	2008-09	2009-10	2010-11	2011- 12	Total
	Untied Fund of Rs 10000/unit 1500Population/unit x 77units	7.7	8.47	9.317	10.2487	35.7357
	Permanent Advance to VHWSC for ASHA incentive @ Rs5000/SC	2.55	2.805	3.0855	3.39405	11.8345 5
	Total	10.25	11.275	12.4025	13.64275	47.5702 5
	Untied Fund of Rs 10000/unit 1500Population/unit x 77units	7.7	8.47	9.317	10.2487	35.7357

PART C: Immunisation

C-1. Cold Chain Maintenance						
Situation Analysis	Non-availability of cold chain store at the district level.					
Objectives	To make cold chain system functional with regard to storage & workshop					
Strategies & Activities	1) Construction of cold chain rooms for stores, workshop, and demonstration room. 2) Purchase & distribution of cold chain centres especially Gurez. 3) Making cold chain workshop functional. 4) Supply of gen-sets & provision for POI maintenance.					
Support required	For financing the construction work, establishing workshop & monitoring the cold chain by DIO.					
Timeline	3 years					
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
Non recurring	District Hospital: DG set @ 1Lac	1.00	0.00	0.00	0.00	1.00
	ILR @ 20000	0.20	0.00	0.00	0.00	0.2
	Deep freezer @ 15000	0.15	0.00	0.00	0.00	0.15
	Stabilizer @ 20000	0.20	0.00	0.00	0.00	0.2
	CHC; DG set @ 1 Lac /CHC 1 lac X 3 + 2 new CHC	3.00	2.00	0.00	0.00	5.00
	One I LR @ 20000 X 3+ 2 new CHC	0.60	0.40	0.00	0.00	1.00
	Stabilizer @ 10000x3+ 2 new CHC	0.30	0.20	0.00	0.00	0.50
	Deep freezer@15000x3+ 2 new CHC	0.45	0.30	0.00	0.00	0.75
	PHC:G.Set @45000/PHC(45000x12)+ 10 new PHCs	5.40	4.50	0.00	0.00	9.90
	I LR@20000X12PHC's)+ 10new PHCs	2.4	2.00	0.00	0.00	4.40
	Stabilizer@10000x12PHC's)+ 10new PHCs	1.2	1.00	0.00	0.00	2.20
	Sc's: I ILR at one SC/Block @20000x3 blocks	0.6	0.00	0.00	0.00	0.6
	Ice pack boxes 1/SC@ 9lac / district	9.00	0.00	0.00	0.00	9.00

	Construction of cold chain maintenance room with air condition at CHC @ 5lac /CHC (5lac x 3) + 2 new CHCs	15.00	10.00	0.00	0.00	25.00
	Staff for C.C.M: CCM engineer at CHC @15000/month/CHC(15000x12x3)	5.4	5.40	9.00	9.00	28.80
	Annual maintenance ; 5000x12x3	1.8	1.80	3.00	3.00	9.60
Total		46.7	27.6	12.00	12.00	98.3

C-2. IEC & Social Mobilisation						
Situation Analysis	No. of IEC session conducted last year. Average No. of participants per Session.					
Objectives Benchmarks	Widespread awareness regarding the good health practices Knowledge on the schemes, Availability of services					
Strategies & Activities	1. Information Dissemination through various media, 2. Interpersonal Communication 3. Promoting Behaviour change					
Support required						
Timeline						
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
Recurring	IEC programme for 15-49 women (Maternal, child health& family welfare One programme/ village/month @100 1X189X12X100	2.27	2.27	2.27	2.27	9.08
	Adolescent health One prog. /SC/month @500 1X51X12X500(136SCs from 2010)	3.06	8.16	8.16	8.16	27.54
	Drama & film shows @10000/block 10000X3	0.3	0.3	0.3	0.3	1.2
	Local T.V Ads. @60000/district	0.6	0.6	0.6	0.6	2.4
Non recurring	LCD player @ 1 lac/dist	1.00	0.00	0.00	0.00	1.00
Non recurring	VCD player @ 5000/PHC 5000X10	0.60	0.50	0.00	0.00	1.10
Recurring	News paper messages 12 messages per year @ 10000 12X10000	1.20	1.20	1.20	1.20	4.80
	Establishment of IEC unit At district level ICE prog. Manager @20000/month 20000X12	2.40	2.40	2.40	2.40	9.60
	Artists Two @15000/mnoth 2X15000X12	3.6	3.6	3.6	3.6	14.4
	Educators Four @ 10000/month 4X10000X12	4.8	4.8	4.8	4.8	19.2
	ICE activity RNTCP & VBD @ 3 lac/ block 3X3lac	9.00	9.00	9.00	9.00	36.00
Total		28.83	32.83	32.33	32.33	126.32

C-3. Alternate Vaccine Delivery Mechanism						
Situation Analysis	Vaccine delivery vehicle available without separate drivers & POL					
Objectives Benchmarks	To shift the vaccines from provisional stores to district stores, to block stores through vaccine carriers to maintain cold chain during transportation.					
Strategies & Activities	1) Engagement of drivers on contractual basis for vaccine carriers vehicle. 2) Provision of MOU. 3) POL for vaccine carrier. 4) Payment for delivering vaccine from blocks headquarters' to sub-centres & for out reach sessions @ Rs. 50/ sessions.					
Support required	By authorising the society, to engage the drivers & involvements of community for the said purpose with sufficient For MOV, supervision & for vaccine delivery mechanism.					
Timeline	1 & half year					
	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	POI for vehicles @ 200/session/SC 200X52X51 (136 SCs from 2010)	5.304	14.144	14.144	14.144	47.736
Budget	Incentives to ASHAs @100/session/ASHA 100X52X398	20.70	20.70	20.70	20.70	82.80
	Total	26.004	34.844	34.844	34.844	130.536

C-4. Supervisory Support and Vaccine Transportation						
Situation Analysis	Poor supervisory support & no proper vaccine transportation mechanism from district headquarter to block & subsequently in fields.					
Objectives Benchmarks	To provide potent vaccine from provincial stores to district stores to block stores & subsequently to the places of its utilization in sub-centres & at out reach sessions in villages.					
Strategies & Activities	Distribution of vaccine to block headquarters' through cold chain vehicle. Distribution of vaccine to cold chain centres in blocks through cold chain boxes. Distribution of vaccines to peripheries through departmental vehicle/hired vehicle. Cost of POL for district/block vehicle to be used for vaccine transportation/ supervisory support Hiring of vehicle in case of non-availability of departmental vehicle.					
Support required	Approval of the component along with financial support.					
Timeline	Three years					
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Testing of vaccine strengthening at site after transportation (provision for POL to MO in charge immunization or someone specially trained @ 60000/ district.	0.60	0.60	0.60	0.60	2.4
	Training of Health worker / ANM @ 250/H. W / ANM 250X110	0.275	0.7175	0.7175	0.7175	2.4275
	Total	0.875	1.3175	1.3175	1.3175	4.8275

C-5. HMIS, Monitoring and Evaluation

Situation Analysis	<p>HMIS is a monitoring tool for the performance that provides information to support planning, decision-making and executive control for managers in the Health & FW department.</p> <p>The basis of HMIS is the data collected by the ANM who is over burdened with a substantial amount of her time being spent on surveillance related activities. Presently the data is collected on some printed format on monthly basis it does not cover the information on nutrition, community participation and community Health Information .</p> <p>The BMO submit the consolidated data during the monthly meeting with CMO at the Distt.H/Q. Some BMOs during winter send the same by post which takes long time to reach at the Distt.H/Q and creates problem for compilation</p> <p>There is no horizontal integration of surveillance activities of existing disease control programmes. Absence of clear case definitions and poor supervision or crosschecking of the data collected hampers the quality of reporting. Non-Communicable diseases are not included in surveillance even though the burden due to them is high. Absence of formats for reporting diseases also affects quality of the data collect.</p> <p>There is lack of coordination between departments. Discrepancy between the data of the Health department and the ICDS. There is large gap between reported and evaluated coverage. The District administrative system not able to make use of the health data.</p> <p>Specific HMIS software needs to design which fulfil the basic information requirement of the district. In the first phase all the Block Headquarters needs to be linked with the District Health Quarter through NIC Net centre, Kargil for better communication, All CHCs and PHCs should be computerised for better data collection and reporting. A V sets needs to be installed at the district Health headquarters for better and prompt communication services.</p>					
Objectives Benchmarks	<ol style="list-style-type: none"> 1. Integration of several parallel running programme software 2. HMIS is used for decision making on regular basis 3. Inclusion of RCH indicators monitoring 4. Linkage to decision making at Central level 5. Refresher training 6. Make it more useful for State level officials 					
Strategies & Activities	<ol style="list-style-type: none"> 1. Research on various issues related to RCH to get a correct baseline <p>Improvement in the CNAA Computerized HMIS</p>					
Support required	<p>Govt. support, Govt. institutions like revenue, social welfare, NGOs etc.</p>					
Timeline	Activities	2008-09	2009-10	2010-11	2011-12	

	Survey for practices, coverage, behaviour etc through independent agency	x				
	Software development	x				
	Data Entry of each household	x	x			
	Internet connectivity	x	x			
	Provision of computers for each CHC and PHC	x				
	AMC for computers	x	x	x	x	
	GIS for the district, training and updation	x	x	x	x	
	Printing monitoring Charts	x	x	x	x	
Budget	Activities	2008-09	2009-10	2010-11	2011-12	Total
	Survey for practices, coverage, behaviour etc through independent agency	15.00	0.00	0.000	0.000	15.00
	Software development	20.00	0.000	0.000	0.000	20.00
	Data Entry of each household's health card @ Rs 2 per card x 90000 cards (aprox.)	1.80	0.40	0.800	1.200	4.200
	Internet connectivity @ Rs 900 /mth x No of facilities x12 mths	1.620	2.916	3.2076	3.528	11.2716
	provision of computers for each CHC and PHC @ Rs 60,000/computer system with UPS and printer	9.00	7.20	0.00	0.000	16.200
	AMC for computers @ Rs 5000 /computer /year x 20 computers	0.75	1.35	1.485	1.6335	5.2185
	Consumables for computers @ Rs 4000/mth/facility x 12 mths	7.20	12.96	14.256	15.6816	50.0976
	GIS for the district, training and updation	12.00	0.50	0.500	0.500	13.50
	Printing monitoring Charts @ Rs. 5 per monitoring chart	0.10	0.125	0.150	0.175	0.550
Total		67.47	25.451	20.3986	22.7181	136.0377

C-6. Supplies and Logistics						
Situation Analysis	<ul style="list-style-type: none"> • Presently the supplies are received from Govt of India and State Provincial Stores and in case of emergencies through local purchase out of Hospital Development Fund. The distribution of the supplies is made keeping in view the status/workload of the institution. The supplies are being stored by the existing staff. However the annual supplies are inadequate as per the workload. • Insufficient Vaccine Supply. • No IFA tablets supplied for last two years. • Vitamin A tablets not being supplied for last two years. • Insufficient supply of Disposable Syringes during School Visits 					
Objectives Benchmarks	<ul style="list-style-type: none"> • Procurement of supplies. • Proper storage of supplies. • Proper distribution of supplies as per the needs. • To keep the buffer stock for emergency purposes • Availability of sufficient amount of vaccines for covering maximum children. • Increase in Immunization sessions to cover maximum population. • Coverage of 100% habitations for immunization along with hilly and tribal pockets • Potent Vaccines. • Provision of Iron and Vitamin Supplements to needy children and Pregnant Women 					
Strategies & Activities	<ul style="list-style-type: none"> • At each Health Institution construction of separate stores for drugs and Gas Cylinders for proper and risk free storage. • Separate staff must be engaged for maintenance of the stores, they must be trained in material management. • Sufficient refrigerators be provided for storage of specific drugs. • The stores must be supervised by a Medical Officer trained in material management. • Separate vehicle at District Headquarter purpose of drugs with provision of POL & driver. • Construction of Mechanical Laundry at each CHC and District Hospital & Block Headquarters. • Engagement of proper staff for operation of mechanical laundry. • The stock of supplies needs to be kept in a manageable position for which a computer is needed at District Headquarter and each other Health Institution. 					
Support required						
Timeline						
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
Non recurring	Equipments at district hospital @22.19lac	22.19	0.00	0.00	0.00	22.19

	Equipment at CHC's Total amount X no. of CHC's - % available 22.19lacX3- 18% + 2 new CHC	54.59	44.38	0.00	0.00	98.97
	Equipments at PHC's T. amt. X no. Of PHC's - % available X T. amt. 111500X12-21% + 10 new PHCs	10.57	11.15	0.00	0.00	21.72
	Equipments at Sc's T, amt. X no. of Sc's - % Available 25680X56- 21%+(85new Sc's X T.amt. from 2009)	11.36	21.828	0.00	0.00	33.188
Recurring	Maintenance for equipments @ 20000/ block200000X3	0.6	0.6	0.6	0.6	2.40
	Drugs at district hospital @ 10.00 lac	10.00	10.00	10.00	10.00	40.00
	Drugs at CHC T. amt. X no. of CHC's - % available10.00 lac X 3- 33% + 2 new CHCs	20.1	50.00	50.00	50.00	170.10
	Drugs at PHC T. amt. X no. of PHC's - % available + 3.0lac X12 – 11% + 10 new PHCs	32.04	66.00	66.00	66.00	230.04
	Drugs at SC T. amt. X no. of Sc's - % available 18135X56- 18% +(new Sc's 85 X 18135 from 2009	8.33	24.663	24.663	24.663	82.319
Total		169.78	228.621	151.263	151.263	700.927

PART D: National Disease Control Program

D-1. RNTCP						
Situation Analysis	Indicators	No. / Rate				
	New Sputum Positive cases (ACDR)					
	Annual total cases					
	Total new pulmonary TB cases					
	Proportion of new sputum positive out of total new pulmonary cases					
	Cure rate					
	Smear Conversion Rate					
	Treatment success rate					
	Defaulter cases					
	Failure cases					
	DMCs (designated microscopic centres) are examining the patients. Patients are taking treatment at DOT centres.					
Objectives	To achieve & maintain cure rate of 85%. To achieve case deduction of rate of 70%.					
Strategies & Activities	1 Provision for one extra lab Assistant for each DMC. 2 Provision Of one four wheeler for each TU for effective supervision (4TU's) 3 involvements of private practioner's & private lab Assistants. 4 Involvement of NGO. 5 strong IEC activities as per Local needs. 6 Involvement of education and ICDS departments for DOT services. 7 Un inter reputed good quality drugs. 8 Easy accessible & expectable DOT centres. 9 Training and retraining of staff.					
Support required						
Timeline	Activities	2008-09	2009-10	2010-11	2011-12	
	Improving the DTC building, MC Centres and TC centres	x				
	Increasing the DOT providers through ASHAs	x	x	x	x	
	Training to RNTCP staff and ASHA	x	x	x	x	
	Awareness drives	x	x	x	x	
	Mask Provision					
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Civil Works					
	DTC building 1.5 lakhs	1.5	0	0	0	1.5
	MC 0.28/MC	4.76	0	0	0	4.76
	TU 0.35/Tu	1.05	0	0	0	1.05
	except DTC					
	Material and supplies	1.32	1.45	1.6	1.76	6.13
	Laboratory material	1.1	1.21	1.33	1.46	5.1
	Training	16.24	17.864	19.65	21.615	75.369
Awareness drive on World TB	1	1.1	1.21	1.33	4.64	

day						
IEC activities	1	1.1	1.21	1.33	4.64	
Vehicle hiring for STS/STLS in winter @ 1 lakh	1	1.1	1.21	1.33	4.64	
Salaries of contractual staff	8.76	9.636	10.6	11.66	40.656	
Vehicle maintenance inc POL 4 wheeler	1	1.1	1.21	1.33	4.64	
Hiring of vehicle DTO MO TC @ Rs 0.42lakh/yr	1.7	1.87	2.06	2.27	7.9	
Equipment and maintenance Microscope @ Rs1000/yr/microscope Computer@ Rs 5000/yr Photocopier/Fax Rs2500/ machine	0.085	0.094	0.103	0.113	0.395	
Miscellaneous – TA/DA, Telephone, Meetings, Electricity repair etc	0.195	0.215	0.247	0.272	0.929	
Total	40.71	36.739	40.43	44.47	162.349	

**Detailed Calculations
Training in RNTCP**

Personnel	Unit Cost	Units	2007-08
DTO	State		
MOTC	23320	3	69960
MO	15580	40	623200
STS	6726	2	13452
STLS	16720	2	33440
LT	5972	20	119440
ANM	2875	266	764750
			1624242

Personnel RNTCP

Personnel	Unit Cost	Units	Months	Amount
TB health visitor	6750	3	12	243000
STS	7000	2	12	168000
STLS	7000	2	12	168000
LT	6500	2	12	156000
Data Entry Operator	6000	1	12	72000
Accountant	1250	1	12	15000
Driver	4500	1	12	54000
Total				876000

D-2. LEPROSY											
Situation Analysis	Balance Cases at beginning of year		New cases detected in year		Cases Discharged in year		Balance Cases at end of year		Per 10,000 Population		Proportion of Deformity Ratio among cases
	PB	MB	PB	MB	RFT	O.D	PB	MB	PR	NCDR	
Objectives	To achieve elimination of Leprosy.										
Strategies & Activities	Integrate leprosy services in the general health. Services to improve access to treatment. Capacity building of general health care staff. Adequate supply of MDT health centre IEC activity To ensure high cure rate through flexible & patient freely drug delivery system. Monitoring to keep track of progress towards elimination.										
Time line											
Budget	Activity / Item				2008-09	2009-10	2010-11	2011-12	Total		
	IEC activity for Leprosy @ 50000/block				1.5	0.00	0.00	0.00	1.5		
Total	Total				1.5	0.00	0.00	0.00	1.5		

D-3. NATIONAL MALARIA CONTROL PROGRAMME

Situation Analysis	Issues	No.	%			
	Total Blood Slides Examined (BSE)	NA	NA			
	Total Positive Cases:	NA	NA			
	Plasmodium Vivax (Pv):					
	Plasmodium Falciparum (Pf):	NA	NA			
	Slide Positivity Rate (SPR)	NA	NA			
	Slide Positive plasmodium falciparum Rate (PFR)	NA	NA			
	Annual Blood Examination Rate (ABER)	NA	NA			
Deaths	NA	NA				
Source: CMO office						
Objectives	To educate community about anti malaria operation.					
Strategies & Activities	IEC activities public awareness & involvement. Anti malarial activities must be increased. Active supervision, active & passive surveillance Fogging & survey supervision during summer. Fogging of entire village during summer.					
Support required	Fogging machines for each block. Jeep for biologist with POL					
Timeline						
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Fogging machine for each block & D.H @ 10.00lac/ district	10.00	0.00	0.00	0.00	10.00
	Two spray machines for each block @ 5000/ block 5000X2X3	0.30	0.00	0.00	0.00	0.30
	Staff 2 persons/block @ 5000/ month 2X3X5000X12	3.60	3.60	3.60	3.60	14.40
	Phenyl @ 20000/block	0.60	0.60	0.60	0.60	2.40
	Total	14.5	4.20	4.20	4.20	27.10

D-4. OTHER VECTOR BORNE DISEASES						
Situation Analysis	Other VBDs	No.				
	Kalazaar	NIL				
	Dengue					
	Lymphatic Filariasis	NIL				
	Japanese Encephalitis	NIL				
Objectives	No incidence of Dengue by 2012 Prevention of JE, Chikungunya and other new infections					
Strategies	<ol style="list-style-type: none"> 1. Reduction of vector density 2. Mosquito-man contact reduction 3. Community awareness 					
Activities	<ol style="list-style-type: none"> 1. Reduction of vector density <ul style="list-style-type: none"> • Identification of breeding sites • Fogging and spraying • Covering of any breeding sites 2. Preparedness for new infections <ul style="list-style-type: none"> • Increase in Manpower • Training of personnel for identification of new infections • Preparation of Laboratories in the district and State to diagnose the new diseases • Preparedness of dealing with the epidemic outbreak 3. Community awareness as part of the IEC for Malaria and IDSP <ul style="list-style-type: none"> • Group meetings • Pamphlets/ handbills • Public announcements • Kala Jathas 4. One jeep for Entomologist (already covered in malaria budget) 5. One truck for shifting manpower and drums /equipment (in malaria budget) 					
Support required	Support from State Laboratory and the NICD for diagnosing Dengue, Chikungunya, JE etc; Support from District Administration, PRIs, WCD, PHEd,					
Time Frame	Activity / Item	2008-09	2009-10	2010 - 11	2011-12	
	Fogging and Spraying	x	x	x	x	
	Pamphlets	x	x	x	x	
	Kala Jathas for Malaria, Dengue and Chikungunya	x	x	x	x	
Budget	Activity / Item	08-09	09-10	10-11	11-12	Total
	Unforeseen expenses	0.5	0.55	0.61	0.67	2.33
	Pamphlet, poster @1lakh	1	1.1	1.21	1.331	4.641
	Kala Jathas for Malaria, Dengue and Chikungunya @ Rs 1000 per village x 189	1.89	1.89	1.89	1.89	7.56
	Total	3.39	3.54	3.71	3.891	14.531

D-5. BLINDNESS CONTROL PROGRAMME						
Situation Analysis	Indicators	No.				
	Total Cataract surgery performed	NA				
	Cataract surgery with IOL	NA				
	School going children screened	NA				
	Children detected with refractive error	NA				
	Children provided with free corrective spectacles	NA				
	Villages having no register	NA				
Objectives	<ul style="list-style-type: none"> ▪ To establish health care facility for every 5 lac. People. ▪ To develop human resource for eye care service or PHC, CHCs, sub- district hospitals. ▪ To improve quality of service delivery. ▪ To ensure participation of civil society & private sector. 					
Strategies & Activities	<ol style="list-style-type: none"> 1) Strengthening service delivery. 2) Develop human resource for eye care. 3) Promoting outreach activities & public awareness. 4) Develop institutional capacity. 5) Cataract operation. 6) Involvement of NGOs 7) Unit work. 8) Training. 9) IEC. 10) School eye screening programme. 11) Monitoring of evaluation. 					
Support required	State level					
Time Line						
Budget	Activity / Item	08-09	09-10	10-11	11-12	Total
	Health Mela @50000 / CHC	1.50	2.50	2.75	3.025	9.775
	IEC @1lakh	1.0	1.1	1.21	1.331	4.641
	School Eye Screening @1000 X100 school	1.0	1.1	1.21	1.331	4.641
	Blind Register	0.386	0.425	0.467	0.514	1.792
	Observance of Eye Donations	0.15	0.17	0.19	0.21	0.72
	Cataract Camps @ Rs 20000 per camp x 12PHC	2.4	2.64	4.6	5.06	14.7
	POL fro Eye Camps @ Rs 2000/camp x12	0.24	0.264	0.46	0.506	1.47
	House to house survey for vision defects @ 10 lakhs	10.00	0	0	0	10.00
	Training of School teachers @ Rs 100/head x 100	0.1	0.11	0.121	0.133	0.464
	Training of PRIs @ Rs 100/head x 200	0.2	0.22	0.242	0.266	0.928
	Repair and purchase of equipment and maintenance	20.00	2.00	2.20	2.42	26.62
	Total	36.976	10.529	13.45	14.796	75.751

D-6. Integrated Disease Surveillance Programme

<p>Situation Analysis/</p>	<p>The programs with major surveillance components include:</p> <ul style="list-style-type: none"> • The National Anti-Malaria Control Program • National Leprosy Elimination Program • Revised National Tuberculosis Control Program • Nutritional Surveillance • National AIDS Control Program • National Polio Surveillance Program as part of the Polio eradication initiative • National Programme for Control of Blindness (Sentinel Surveillance) <p>Surveillance activities of all these vertical programs of Malaria, Tuberculosis, Polio, HIV are functioning independently leading to duplication of Surveillance efforts. Surveillance has been ineffective due to</p> <ul style="list-style-type: none"> ▪ There are a number of parallel systems existing under various programs which are not integrated. ▪ The existing programs do not cover non-communicable diseases. ▪ Medical colleges and large tertiary hospitals in the private sector are not under the reporting system as well as for utilization of laboratory facilities. ▪ The laboratory infrastructure and maintenance is very poor ▪ Presently, surveillance is sometimes reduced to routine data gathering with sporadic response systems thereby leading to slow response to Epidemics, ▪ Information technology has not been used fully for information and to analyze and sort data so as to predict epidemics based on trends of the reported data. <p>In response to these issues the Integrated Disease Surveillance Programme was launched in J & K to provide essential data to monitor progress of on going disease control programs and help in optimizing the allocation of resources.</p> <p>IDSP includes 15 diseases/ conditions (Malaria, Acute diarrhoeal disease-Cholera, Typhoid, Jaundice, Tuberculosis, Acute Respiratory Infection, Measles, Polio, Road Traffic Accidents, Plague, Yellow Fever, Meningoencephalitis /respiratory distress, etc., HIV, HCB, HCV)) and 5 state specific diseases (Thyroid diseases, Cutaneous Leishmaniosis, Acid Peptic Diseases, Rheumatic Heart Diseases).</p> <ul style="list-style-type: none"> ▪ Establishing of District Surveillance unit ▪ Upgradation of 1 PSU Labs ▪ Water testing labs are in place ▪ V-Sat is been installed but training is required ▪ Rapid response teams are being established at District levels. ▪ DSUs (District Surveillance Units) are being established in all districts ▪ One Computer, Printer and Scanner has been received
<p>Objectives</p>	<ol style="list-style-type: none"> 1. Improving the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors. 2. Establishing a decentralized state based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the country at the state and national level. 3. Improving the efficiency of the existing surveillance activities of disease

	control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.					
Strategies & Activities	1) Upgradation of Labourites (renovation, furnishing/ supply of lab. Equipments, lab. Material & supply). 2) Computer hardware & office equipments, software for surveillance, leasing of wide area networking. 3) Consulting /contract staff, training .IEC. 4) Monitoring and evaluation.					
Support Required						
Time line	Activity / Item	2008- 09	2009-10	2010-11	2011-12	
	Renovation of Labs with provision of equipment, furnishings, material	1 District Hosp, 3 CHC	PSU at 4 CHC			
	Training	x	x	x	x	
	Contractual staff					
	Software for DSU & training of staff	x	x	x	x	
	WEN connectivity	x	x	x	x	
	Sensitization of Community			x	x	
	Meetings with SHGs	x	x	x	x	
	Meetings with teachers	x	x	x	x	
	Meetings with Numberdar and Chowkidars	x	x	x	x	
Budget						
	Activity / Item	08-09	09-10	10-11	11- 12	Total
	Renovation of Labs at CHCs a@ Rs 20,000	0.8	0.8	0	0	1.6
	Renovation of Lab at District Hospital @ Rs 140,000 and maintenance	1.51	0.18	0.2	0.22	2.11
	Equipment for Lab at PSU at CHC and @ Rs 40,000	1.6	1.6	0	0	3.2
	Equipment for Lab at District @ Rs 850,000	8.5	0	0	0	8.5
	Computer and Accessories at CHC @50000	1.5	1.00	0	0	2.5
	Office for PSU at Maintenance CHC @ Rs 10,000 per unit	1.1	1.2	1.2	1.2	4.7
	Office Maintenance for DSU @ Rs 10,000	0.1	0.1	0.1	0.1	0.4
	Software for DSU@ Rs 335000	3.35	0	0	0	3.35
	Furnishing of Lab at PSU at CHCs and @ Rs 10,000	0.4	0.4	0.6	0.2	1.6
	Furnishing of Lab at DSU @ Rs 60,000	0.6	0	0	0	0.6
	Material and supplies at Lab at PSU at CHCs @ Rs 8,000	0.24	0.24	0.36	0.36	1.2
	Material and supplies at Lab at DSU @ Rs 75,000	0.75	0.83	0.91	1	3.49
	Contract Staff at District level @ 200000/yr for 4 staff yr wise	2	2.2	2.92	3.71	10.83
	IEC activities	1.00	1.1	1.21	1.33	4.64

Training and retraining	0.902	1.36435	1.50	165	4.696
WEN connectivity	0.5	0.55	0.61	0.67	2.33
Operational costs at PSU for Surveillance @ Rs 15000/year x 3	0.45	0.45	0.45	0.45	1.8
Operational costs at DSU for Surveillance @ Rs 130000/year	1.3	1.43	1.573	1.73	6.033
Total	26.602	13.44435	11.633	12.62	64.29935

Detailed Budget for Trainings

Personnel	Unit Cost	Units for 2007-08	Amount for 2008-09	Units for 2009-10	Amount for 2008-09
MPW	785	12	9420	23	18055
Lab Assistant at CHC	905	3	2715	4	3620
Lab Assistant at District	3110	2	6220	2	6220
MOs	1835	24	44040	44	80740
DST 4 members	6950	4	27800	4	27800
			90195		136435

D-7. Iodine Deficiency Disorders						
Situation Analysis	Iodine is one of the essential micronutrients. Minimum requirement is 150 microgram per day. The main source of Iodine is from soil and water. Iodine is taken from food grown in iodine rich soil. At present there is a depletion of Iodine in the soil due to which there is a deficiency of Iodine. Deficiency result in a variety of disorders ranging from Abortion, stillbirths, Goitre, impaired mental function, retarded growth. In J & K the National Iodine Deficiency Programme is being implemented. People in J & K consume rock Salt and crystal salt					
Objectives/	<ol style="list-style-type: none"> 1. Prevention of Iodine Deficiency diseases 2. Consumption of Iodized salt by 100% families 					
Strategies	<ol style="list-style-type: none"> 1. Supply/monitor quality of Iodized salt 2. Assessment of the magnitude of the problem 3. Laboratory Monitoring of Iodized salt and urine samples 4. Health Education 					
Activities	<ol style="list-style-type: none"> 1. Supply/monitor quality of Iodized salt <ul style="list-style-type: none"> • Monitoring is done through Food Inspectors who collect two samples of salt per month per district and send it to a laboratory. • The Health workers have been supplied with Kits to test samples at least five per month. • Review is done in the monthly meetings • Monitoring through School health programme – Testing of samples and awareness • Supply of Testing kits to AWCs, Schools, SHGs 2. Assessment of the magnitude of the problem This will be done by the Central Survey team 3. Laboratory Monitoring of Iodized salt and urine samples 4. Health Education: An IEC strategy is essential to promote the consumption of Iodized salt through AWWs, PRIs, NGOs, ASHA, SHGs etc; Demonstration of Iodized salt by school children through testing, Rallies, sensitisation of shopkeepers for keeping Iodized salt. 5. Testing of salt at shops and homes 					
Support required	<ol style="list-style-type: none"> 1. Regular Supply of Testing Kits 2. Regular Supply of Iodized salt 3. Regular supply of IEC material 					
Timeline	Activity / Item	08-09	09-10	10-11	11-12	
	Large Village meetings for awareness on IDD and consumption of Iodized salt	x	x	x	X	
	Programme in schools – 100 Primary, Upper Primary, Secondary- Govt and Private by School health team	x	x	x	X	
	Awareness programme with the SHGs and shopkeepers	189 villages	189 villages	189 villages	189 villages	
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Large Village meetings for awareness on IDD and consumption of Iodized salt	1.00	1.100	1.210	1.331	4.641

	Programme in schools – 100 Primary, Upper Primary, Secondary- Govt and Private by School health team	2.00	2.200	2.420	2.662	9.282
	Awareness programme with the SHGs and shopkeepers @ Rs 500 per village x 189 villages	0.945	1.040	1.143	1.258	4.386
	Total	3.945	4.34	4.773	5.251	18.309

6:INTER-SECTORAL CONVERGENCE

6.1 Partnership with AYUSH department

In District Bandipora there are --- ISM (AYUSH) Dispensaries in which --- dispensaries are sanctioned & --- dispensaries are working with internal arrangements. Majority of the dispensaries are situated in far-flung areas & along with actual line of control.

ISM doctors are fully trained & competent to conduct deliveries & can contribute a lot in implementing the concept of institutional deliveries .But it is unfortunate that these services are not being utilized maybe out of bias or some other reasons. Without any special facility the ISM Doctors are conducting deliveries where they are posted & no alternative facility is available with the people. For implementation of national programme hundred all ISM (AYUSH) staff is involved in the field. But there is no cold chain facility, lab facility & other incentives.

There are no guidelines for conducting of joint meetings between ISM (Ayurvedic/ Unani) & allopathic at District & block levels. However an informal meeting is held once in a year. There is no binding by way of govt. orders from the higher authorities. The status IEC strategy for Ayurveda & allopathic should be jointly prepared & planned by director ISM & Director health (Allopathic).The IEC funds & material should be jointly shared & should be at the disposal of director ISM & director Health separately.

1. Constitution of RKS in ISM
2. CHC and PHC will provide AYUSH services
3. Involvement of Ayurvedic dispensaries in implementation of national health programmes.

Issues / Areas	Areas of cooperation	Areas of convergent action
Curative ; Patient care, Surveillance referral	<p>In order to provide medicare facilities to the masses there is a vast potential for cooperation with health department so as to implement all the national programmes like National Malaria eradication Programme, T.B. control programme (DOTS), HIV / Aids awareness programme, implementation of institutional deliveries.</p> <p>The cooperation is also needed from the department of social welfare, (ICDS) Anganwari centres located in the areas where the ISM dispensaries are functioning by the way that the staff of these centres (Anganwari workers) can bring the unvaccinated children to the nearest ISM institutions so that their complete vaccination should be</p>	<p>The ISM doctors are providing the health Medicare facilities by the way of providing Ayurvedic / Unani medicine but as the dispensaries of AYUSH are located in the Isolation / far flung areas where there is no existence of any health facility (Allopathic) in the form of primary health centres / community health centres or even allopathic dispensaries. Here people come across emergencies which are supposed to be attended by Ayurvedic / Unani doctors or staff. Therefore there is dire need of emergency drugs, life saving drugs, bandaging material, antiseptic lotions, antibiotics which are not supplied in ISM dispensaries. Due to non availability of these drugs in some cases precious lives are lost and wrath of people falls on the staff of ISM institutions. Therefore life saving</p>

	done. Old routine is that medical officer of the concerned ISM institution visits the Anganwari centre once in a month should be started for general health check up of the children of Anganwari centres.	drugs, antiseptic lotions & dressing materials need to be supplied to avoid suffering of the ailing masses.
Preventive; Immunization, Prophylaxis services Promotive, IEC	Health department's cooperation is needed in providing ILR, Deep freezers to the ISM dispensaries. One ISM dispensary is functioning along with sub centre. Rest of the ISM Dispensaries are without immunization facility as these are lacking cold chain facility , so twelve ISM dispensaries which are working in Pacca buildings having electric supply should be immediately provided cold chain facility in the form of ILR's & deep freezers .	As the facility of cold chain in the form of ILR's & deep freezers is provided to ISM institutions. Routine vaccination as well as out reach vaccination camps should organised easily in remotest & far flung areas. For IEC funds should be kept at the disposal of the Asstt. District. Medical officer so as it should be used for awareness Programmes.
Specific issues in Implementation of national programmes Maternal care	Health Department to assist ISM institutions & to provide kits of iron Folic acid tablets directly to the dispensaries through the Asstt. District. Medical officer. All ASHAs operational in the areas of ISM institutions should be given training on providing emergency health care services.	As Kits of Iron folic acid tablets are provided to ISM institutions. ISM Doctors can treat Pregnant women as well as cases of iron deficiency anaemia is better way. In present situation only Ayurvedic / Unani medicines which contain iron are given to pregnant women for deficiencies of Iron
Child care	Health department should cooperate with Assistant District. Medical officer Bandipora & kits containing Iron small & folic acid, Septran (paed) & Antihelminthics tabs should be supplied to ADMO office & then it is supplied to all the ISM institutions. As far as social welfare department is concerned Anganwadi workers can bring unvaccinated children to the dispensaries.	As it contains Iron, Septran (Paed) & Antihelminthics tabs be provided ISM dispensaries better care of children suffering from iron deficiency anaemia, worm infestation & other diseases. As Anganwadi workers / helpers bring the children to the ISM Dispensaries on a fixed date of immunization through this goal of 100 % immunization could be achieved.
Adolescent health	Health department & education department organised camp for the awareness of adolescent health age group. Ayurvedic / Unani doctors should be invited to give awareness lectures & these camps should be organised at ISM institution also. Education department can cooperate with ISM institutions in a particular areas & through chief education officers or Zonal education officers, it	Some funds should be kept at the disposal of the concerned ADMO for procuring IEC materials like banners / posters etc. for organising awareness camps. With this people living in remotest & far flung areas particularly adolescent age groups children can be benefited from this awareness campaign as most of the ISM institutions are in remotest & far flung areas.

	should be made mandatory that medical officer of that area should visit schools & give awareness lectures to the adolescent children on different issues.	
School Health	Education department's help is needed for the health check up of children as done as a routine matter few years back.	When approached by the concerned chief education officer/ Zonal education officers, the ISM Doctors are willing to provide these services for general health check up of children of different schools.
Leprosy	Cooperation from health department is needed to train ISM doctors/ Paramedical staff. All ISM doctors, paramedical staffs should be given training to address sensitive health issues like Leprosy.	After diagnosis of a case of leprosy the anti-Leprotic drugs should be made available directly to ISM institution so that patients can avail the medicines from the nearest dispensary
IDD	Health department cooperation is needed	Only IEC activities are done on our own to aware the masses about the iodine deficiency diseases.
Tuberculosis	Health department should cooperate with ISM department & all ISM doctors /paramedical staff should be trained through regular training / workshop from to time laboratory facility with laboratory technician should be provided	Anti tuberculosis drugs Dots therapy should be provided directly to ISM dispensaries so that patient of Tuberculosis can avail the facility from the nearest dispensary as in some far flung areas. There is no existence of allopathic institutions & only ISM institutions are catering the health needs of the areas
HIV/AIDS	Cooperation from health department is needed for training of ISM Doctors / Paramedical staff for AIDS. Regular workshops training Programmes should be organised so that knowledge of the staff is updated about the disease.	Funds for AIDS awareness camps should be kept at the disposal of Asstt. District. Medical officer at District. Level so that IEC material like Banners , pamphlets etc should be disturbed to the masses so that exact cases of the disease its sign & symptoms are known to the people or IEC material from health (allopathic) department should be supplied to the ADMO's
Water borne diseases	PHE department & health departments' cooperation is needed. As water born diseases are due to the infected water chlorine tablets should be supplied.	If the cases of the particular disease on particular area rises. In order to check it chlorine tablets & other drugs should be supplied to the ISM institutions so that Medical officers / officials can treat the cases. IEC materials for water born diseases should be kept at the disposal of ADMO .So that according to need it should be distributed about the masses & awareness camps about the

		staff drinking water should be organised as in rural areas major source of drinking water is well, springs, & the water is often polluted in rainy season.
RTI/ STI	Health department to provide medicines, antibiotics as to check RTI / STI. One laboratory technician with laboratories should be given to dispensaries	As antibiotics are provided to ISM institutions, Medical officers of these institutions can treat the patients of RTI /STI in a better way & by providing laboratory facilities in these institutions which are situated in remotest areas , the diagnosis of diseases Is made in initial stage that helps in treatment of the patient.

6.2 ICDS projects

Issues / Areas	Areas of cooperation	Areas of convergent action
Coordination with allied departments	<p>Linkages to be developed between ICDS workers and health workers for timely diagnosis of malnourished children and their management.</p> <p>Health Department</p>	<p>AWW share information/records of pregnant mothers and newborns with ANMs</p> <p>AWW help in tracking beneficiaries and bring them for immunization</p> <p>They keep community informed of next session's date of health checkup camp and immunization.</p> <p>AWW should reports disease outbreaks in the village to ANM.</p> <p>IEC to be developed and disseminated to the community regarding food and nutrition.</p> <p>For proper management of malnourished cases, medicines will be supplied along with the PHC and CHC drug kits annually.</p>

6.3 Rural Development Department

Issues / Areas	Areas of cooperation	Areas of convergent action
During the initial base line survey conducted in the district for assessment of the hygienic behaviour and knowledge about sanitation in the rural population, it was observed that barely 5% of the rural population has basic sanitary related facilities like household toilets & rest of the	<p>Linkages to be developed between the Health Department and the Rural Development department</p> <ul style="list-style-type: none"> Improving the health standard & general quality of life of rural community. Awareness on sanitation/ 	<ul style="list-style-type: none"> Demand driven approach with increased emphasises on awareness Subsidy for individual household units replaced by incentive the poorest of poor household. Rural school

<p>population nearly 95% go for open defecation. The (KAP) study conducted revealed that the basic hygiene behaviour of the general public in the district was very poor.</p> <p>Since inception of the total sanitation campaign project in the district rigorous (IEC) campaign has been taken up in all the community development block in district Bandipora .as a result as of today the basic hygiene behaviour of the public improved considerably. As a result of sustain (IEC) campaign around 19000 families including BPL 4000 & APL 15000 have been motivated to use & constructed house hold toilet (3618). Also around three hundred no of school toilets (276) have been constructed under the project</p>	<p>Hygiene & health education.</p> <ul style="list-style-type: none"> • Covering of school / Anganwari in rural areas with sanitation facilities & promote Hygiene education & sanitary habits among students. • Promote & encourage cost effective construction of household latrine & their proper use. • Elimination of open defecation to minimise the risk of contamination of water source & food. 	<p>sanitation is major component for wider acceptance of children who can encourage their parents for sanitation environment.</p> <ul style="list-style-type: none"> • Awareness generation amongst the A.P.L families for construction of toilet by their own. • Amount of Rs Four thousand Per school toilet to be added from NRHM as the twenty thousand is not sufficient for construction of school toilet in hilly belt. • Anganwadi toilet in private houses with a cost of Rs Five thousand for each Anganwadi • Toilet facility at PHC, CHC, DH, • Services of doctor & paramedical staff for awareness for sanitation condition & environment. • For IEC of Rs 12.6 lakhs • For Solid Waste Disposal in towns and cities: Rs 8.4 lakhs
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6.4 Public Health department

Issues / Areas	Areas of cooperation	Areas of convergent action
<ul style="list-style-type: none"> ▪ People of the district Bandipora are still dependant on traditional water sources, in certain areas water from hand-pumps is perceived to be unfit for consumption, and water availability is falling short of requirement. ▪ The practice of boiling water for drinking purpose is not prevalent ▪ 	<p>Health and ICDS Departments</p>	<ul style="list-style-type: none"> ▪ Bleaching powder and chlorine tablets will be provided by IPH and distributed by field functionaries to households ▪ Joint communication strategy. ▪ Copy of water quality monitoring reports generated by IPH department will be shared with the Health Department at block, district and state levels ▪ Community based organisations formed under

		various programmes/sectors will be engaged by a team of frontline workers – health, ICDS and IPH departments.
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6.5 PRIs

Issues / Areas	Areas of cooperation	Areas of convergent action
<p>The PRIs have been envisaged to play a very important role in NRHM</p> <p>At the village level they are part of the VHWSC.\</p> <p>At the Gram Panchayat level they are part of the Gram Panchayat health committee. Similarly at the Block and the District they are part of the Block and District health mission.</p> <p>At the Subcentre the Sarpanch is the joint signatory to the bank account for the operation of the Untied funds of Rs 10000.</p> <p>In the Gram Panchayat meetings held twice each month the PRIs review the activities of the health department along with the ICDS</p>	<p>Motivating the community</p> <p>Availability of personnel and services</p> <p>Participation in the VH Days</p> <p>Giving importance to issues of health in the Gram Panchayat meetings</p>	<p>Joint plans</p> <p>Joint review and monitoring</p> <p>Mobilization of the community for action on health care issues, safe drinking water and sanitation.</p> <p>Advocacy at village, Gram panchayat, block and district level.</p>

Education Department

Issues / Areas	Areas of cooperation	Areas of convergent action
<p>There are --- schools, -- EGS centres and --- private schools covering ----- children.</p> <ol style="list-style-type: none"> For regular check up of school children there should be a provision for a doctor (physician specialist) & expert team which will assist the doctor. Mid day meal in school is being successfully carried. Cooks are engaged at Rs -----/mth. The message of balanced diet is not being successfully carried out. School health education programme is not taking place regularly. There is no Adolescent Health programme in the district. 	<p>Co-operation with health department PHED, RDD, ICDS department.</p>	<ol style="list-style-type: none"> Strengthening of school health programme. Promotion of yoga in the school. Launching of Adolescent Health programme Regular school health programmes

Convergence –PRI system and capacity building, NGO coordination, Public Private Partnership, Training and Meetings of committee members	
Problem Identified & Core Issues.	<ol style="list-style-type: none"> 1. Non Existence of PRI and systems. 2. Lack of quality conscious private health service providers for partnership 3. Need for strengthening Village health, water and sanitation committees and training them 4. Difficult to communitise health services due to non-availability of good NGOs and community organisations. 5. Lack of formal institutional mechanisms for convergent actions with NRHM related sectors
Solutions proposed (Activity plan)	<ul style="list-style-type: none"> • PRI systems need to be in place • PPP need to be developed and CME to be provided to private providers • All the members especially the members of PRIs need to be imparted training in primary health care delivery system, which can be imparted at the PHC/ CHC level by the block MO or Medical Officers. • For joint efforts, monthly meetings of the committee as constituted above must be held and the meeting should be fixed in advance and the local panjayath leaders and MPHWS of the sub centres should arrange the meeting at sub centres. The local Medical Officer and Health Supervisors can also attend the monthly meeting. • MNGOs scheme need to be strengthened to communitise health services. • At the policy level formal mechanisms need to be put in place for convergent actions with other NRHM sectors
Support needed for implementing changes	Policy and funding support
Time needed to implement changes	<ul style="list-style-type: none"> • PPP initiative (Chiranjeevi) has been proposed under RCH • For training of PRI and VHWS committee members: Rs. 10 Lakhs • For regular monthly meetings: Rs.- 2 Lakhs • Educational materials-Rs 2 lakhs • Total Rs. 14 lakhs for one year and Rs 56 lakhs for 4 years
Sustainability of the changes	Three months after constitution of the committees.
Benchmark(s) derived from this component	capacity of the committee members with decentralised powers.

Inter Sectoral Convergence	
Situation Analysis/ Current Status	<p>Health is a social responsibility and is not the domain of the health department only. Unfortunately the total responsibility has fallen on the health department. The various departments have been involved in the Pulse Polio campaign which has led to the massive mobilization and success of the campaign.</p> <p>The District Health Society has been formed consisting of members of various departments. Block health societies will be formed and also at the sector, and village level. At the Gram Panchayat level under the Sarpanch Gram Panchayat committees have been formed consisting of various sectors. The Village health and Water Sanitation Committees also consist of various sectors and the community.</p> <p>In reality these committees need to be strengthened since they are not functional. All the various sectors are working separately although for the same cause. Hence there is a lot of duplication and wastage of resources.</p> <p>Although orders have been issued for convergence but other sectors do not participate readily. Joint working of the ICDS and health is happening on the Fixed Maternal Child Health and Nutrition day. This needs to be strengthened and streamlined. The community is not aware regarding this day.</p> <p>The forum of the fixed health day each week has a lot of potential and has not been used properly.</p>
Objectives	<ol style="list-style-type: none"> 1. Providing Primary and basic quality health care services at the village level 2. Providing quality RCH services 3. Optimal utilization of RCH services by community especially women 4. Empowering women to facilitate them to seek and demand quality RCH services.
Strategies	<ol style="list-style-type: none"> 1. Strengthening the various Committees and Societies 2. Strengthening the VHD days 3. Joint action for various issues
Activities	<ol style="list-style-type: none"> 1. Joint workshops for Planning and Review at all levels <ul style="list-style-type: none"> • Orientation programmes • Monthly meetings 2. Strengthening the VHD days <ul style="list-style-type: none"> • Wide participation of all the sectors in preparation of the community and in the actual activities, in health education • Each Wednesday during Immunization sessions joint orientations by all sectors and problem solving for each of the sectors 3. Joint Action for Sanitation, provision of safe water, provision of services and personnel at facilities 4. Joint review at the Gram Panchayat meetings 5. Joint efforts for education of the girls, improving the sex ratio, raising age of marriage, improving the nutritional status, identifying the correct BPL families, income generation. 6. Joint CNAA to determine the needs and thereby developing the plans jointly 7. Realignment of the Health and the ICDS sectors for common data and common work boundaries.. 8. At the CHC level monthly meetings are organized. This should be jointly organized with the ICDS 9. At the monthly meetings of the CMO, the officers of all the departments should come

	<p>10. Annual action Plans to be developed jointly through meetings at the village, Gram Panchayat, Sector and culminating in Block workshops and District workshops</p> <p>11. Chiranjeevi Scheme to involve PRIs for promoting safe deliveries for rural BPL women through PPP initiative by involving the private sector</p> <p>12. Upgrading Ayush at all levels from PHC to DH.</p> <p>13. Involvement of the RDD for construction of toilets in all health facilities and public places</p>
Support required	<p>Govt orders for intersectoral coordination with clear roles and responsibilities and If the various sectors do not attend the meetings then the decisions will be taken and will be binding for all the sectors.</p> <p>Strict follow-up at the State level for ensuring coordination.</p>

Timeline

Activity / Item	2008-09	2009-10	2010-11	2011-12
Meetings of the Block Committees	x	x	x	x
Meetings of the Village groups	x	x	x	x
Joint CNA training (474 AWW, 287 ANM, 398 ASHAs, 44 Supervisors, 44 MOs, 04 CDPOs)	x	x	x	x
Joint monitoring at the sector level	x	x	x	x
Hiring of vehicle	x	x	x	x
Joint monitoring at the block level	x	x	x	x
Yearly joint Planning Workshops at the Block level for development of the Action Plans	x	x	x	x
Yearly joint Planning Workshops at the District level for development of the Action Plans	x	x	x	x
Yearly joint Workshops to consolidate the plans from the village to the Gram Panchayats to the Sectors and then Blocks at the Block level for Annual Action Plans	x	x	x	x

Budget

Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
Meetings of the Block Committees @ Rs 1000 /meeting x 3blocks x 12 months	0.36	0.396	0.436	0.479	1.671
Meetings of the Village groups @ Rs 100 per village x 189 villages x 12	2.268	2.495	2.744	3.019	10.526
Joint CNA training @ Rs 200 per person (474 AWW, 287 ANMs, 398 ASHAs, 44 Supervisors, 44 MOs, 4 CDPOs) x 1251	2.502	2.7522	3.02742	3.330	11.852
Joint monitoring at the sector level					
Hiring of vehicle @ RS 1200/ day x 5 days/month x 3 blocks x 12 months	2.16	2.376	2.614	2.875	10.025
Joint monitoring at the block level					
Hiring of vehicle @ RS 1000/ day x 5 days/month x 3 blocks x 12 months	1.8	1.98	2.178	2.396	8.354

Yearly joint Planning Workshops at the Block level for development of the Action Plans @ Rs 0.5 lakhs per block x 3 blocks	1.5	1.65	1.815	1.997	6.962
Yearly joint Planning Workshops at the District level for development of the Action Plans @ Rs 1.00 lakh	1.0	1.1	1.21	1.33	4.64
Yearly joint Workshops to consolidate the plans from the village to the Sectors and then Blocks at the Block level for Annual Action Plans @ Rs 1.00 lakhs per block x 3 blocks	3.0	3.3	3.63	3.99	13.92
Yearly joint Workshops to consolidate the findings at the block levels at the District level for development of the Action Plans @ Rs 1.00 lakh	1.0	1.1	1.21	1.33	4.64
Training of PRIs/,VHWS committee members under Chiranjeevi Scheme @22 lakhs	22.00	22.0	22.0	22.0	88
Regular monthly meetings under Chiranjeevi Scheme @12 lakhs	12.00	12.0	12.0	12.0	48
Development of Education material and hands on training under Chiranjeevi Scheme @ 10 lakhs	10.0	10.0	10.0	10.0	40
Total	59.59	61.1492	62.86442	64.746	248.59

7.COMMUNITY ACTION PLAN

Community Health Action	
Situation Analysis	<p>Health is a social responsibility and is not the domain of the health department only. Unfortunately the total responsibility has fallen on the health department. The various departments have been involved in the Pulse Polio campaign which has led to the massive mobilization and success of the campaign.</p> <p>The District Health Society has been formed consisting of members of various departments. Block health societies will be formed and also at the sector, and village level. At the Gram Panchayat level under the Sarpanch Gram Panchayat committees have been formed consisting of various sectors.</p> <p>The Village health and Water Sanitation Committees also consist of various sectors and the community.</p> <p>In reality these committees need to be strengthened since they are not functional. All the various sectors are working separately although for the same cause. Hence there is a lot of duplication and wastage of resources.</p> <p>Although orders have been issued for convergence but other sectors do not participate readily. Joint working of the ICDS and health is happening on the Fixed Maternal Child Health and Nutrition day. This needs to be strengthened and streamlined. The community is not aware regarding this day. The forum of the fixed Village health day each week has a lot of potential and has not been used properly</p>
Objectives	<ol style="list-style-type: none"> 1. Providing Primary and basic quality health care services at the village level 2. Providing quality RCH services 3. Optimal utilization of RCH services by community especially women 4. Empowering women to facilitate them to seek and demand quality RCH services.
Strategies	<ol style="list-style-type: none"> 1. Strengthening the various Committees and Societies 2. Strengthening the VHD days 3. Joint action for various issues
Activities	<ol style="list-style-type: none"> 1. Joint workshops for Planning and Review at all levels <ul style="list-style-type: none"> • Orientation programmes • Monthly meetings 2. Strengthening the VHD days <ul style="list-style-type: none"> • Wide participation of all the sectors in preparation of the community and in the actual activities, in health education • Each Wednesday during Immunization sessions joint orientations by all sectors and problem solving for each of the sectors 3. Joint Action for Sanitation, provision of safe water, provision of services and personnel at facilities 4. Joint review at the Gram Panchayat meetings 5. Joint efforts for education of the girls, improving the sex ratio, raising age of marriage, improving the nutritional status, identifying the correct BPL families, income generation. 6. Joint CNAA to determine the needs and thereby developing the plans jointly 7. Realignment of the Health and the ICDS sectors for common data and common work boundaries. 8. ASHA to participate in all the meetings of the ICDS held between the 20th and 22nd of each month.

	<p>9. At the CHC level monthly meetings are organized. This should be jointly organized with the ICDS</p> <p>10. At the monthly meetings of the CMO the officers of all the departments should come</p> <p>11. Annual action Plans to be developed jointly through meetings at the village, Gram Panchayat, Sector and culminating in Block workshops and District workshops</p>					
Support required	<p>Govt orders for inter-sectoral coordination with clear roles and responsibilities and If the various sectors do not attend the meetings then the decisions will be taken and will be binding for all the sectors.</p> <p>Strict follow-up at the State level for ensuring coordination.</p>					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Formation of Block Committees					
	Orientation of Committee members at all levels					
	Joint Community action	x	x	x	x	
	Joint Annual Action Plan	x	x	x	x	
	Sector Alignment	x				
	Reorientation of the Committees and Societies	x	x	x	x	
	Strengthening the Gram Panchayat meetings and Gram Sabhas	x	x	x	x	
Budget	Activity / Item	2008-09	2009-10	2010-11	2008-12	Total
	Training of the VHWSC @ Rs 200 per person x 15 persons/village x189 villages	5.76	6.336	6.970	7.667	26.733
	Meetings of the VHWSC @ Rs 50 per village x 189 villages x 12 months	1.134	1.247	1.372	1.509	5.262
	Meetings of Women SHG @ Rs 100 per year x 189 villages	0.189	0.208	0.229	0.252	0.878
	Honorarium for MOs for promoting Community health Action @ Rs 1000 pm and travel charges Rs 800 pm	0.648	0.713	0.784	0.862	3.007
	Total	7.731	8.504	9.355	10.29	35.88

8. PUBLIC PRIVATE PARTNERSHIP

Public Private Partnerships	
Situation Analysis/ Current Status	<p>The private sector includes NGOs, Private Practitioners, Trade and Industry Organisations, Corporate Social Responsibility Initiatives.</p> <p>The private sector is the major provider of curative health services in the country. 43% of the total IUD clients obtain their services from the private sector. Engaging with it to provide family planning services has the potential to significantly expand the coverage of quality services. Public-private partnerships can stimulate and meet demand and have a synergistic impact of the RCH. To ensure efficient services of good quality from the private and public sectors, robust monitoring and regulatory mechanisms need to be developed so that the private sector can come forward and cooperate in all the National programmes and also in sharing its resources.</p> <p>At present, no any Public Private Partnership activity is going on in the District. MNGO is J & K Ex-Services league. FNGOs are Jamola Nehru Club, Tiger Club, Friends Youth and Cultural Club. No initiatives taken under Public Private Partnership.</p>
Objectives	<ol style="list-style-type: none"> 1. Increasing the coverage of the health services and also increasing the accessibility for health services 2. Widening the scope of the services to be provided to the clients
Strategies	Incentives and training to encourage private providers to provide sterilization services
Activities	<p>Involve private players including NGOs/Trusts by providing a conducive environment for accessing quality and affordable health care services to the community.</p> <ul style="list-style-type: none"> ▪ Partnership for Services for Training: Lot of capacity building activities are envisaged under NRHM, but departments neither have that much of expertise nor sufficient time to carry out the capacity building activities properly. Therefore, all such training programme will be outsourced to a capable agency selected by the DHS. ▪ Partnership for Services for IEC: For implementing and managing IEC activities (mela, shows, campaign, rally, Village Contact Drives etc) including designing and printing of IEC material, a technical and Technical Support Agency will be hired. ▪ Partnership for Services for Transportation: One agency will be hired for getting services of vehicles with drivers for field monitoring by the officers at District and below level, for transportation of drugs, equipment, linen and others up to the Sub Centre level. Drivers for department's vehicles and ambulances will also be hired from such agency. Annual contract will be done for this purpose. <p>This kind of partnership will much effective for the unreached and far flung areas where there no motorable roads available. Alternate transport like Mules can be hired from the private sector.</p> <ul style="list-style-type: none"> ▪ Partnership for Services for conducting Studies, survey and evaluations: For understanding the trends of diseases, impact of programs being implemented, assessing the health scenario, a technical support agency will be hired for conducting surveys, evaluation, Data analysis, HMIS etc.

	<ul style="list-style-type: none"> ▪ Partnership for School Health Programme: For covering all the primary schools both government and private and strengthening School Health Programme private organisations specially local NGOs will be involved. ▪ Partnership for Security: As Poonch district is highly affected with the militancy, security of health personals and institutions is a major concern of the district. For providing security to all PHC and some selected Subcentres, Ex-servicemen council or committees can be hired. Annual contract will be done for this purpose. <p>The following activities will be carried out:</p> <ul style="list-style-type: none"> • To conduct Feasibility study for various PPP options in the district. • To develop detailed operational framework and schemes for various feasible options in the district. • To identify technical support agency for studies on above activities • To initiate one pilot innovative intervention based on the priority in each block of district. under PPP • To prepared resource directory of all active NGOs involved in health and development issues in the district. • To prepared a list of all private health care providers including Practitioners of alternative system of medicine in the district. • To conduct training need assessment (TNA) for all the identify private partners • To orient all identified privet partners on NRHM and various national health programmes • To develop detailed framework or monitoring and evaluation of various PPP • To collaborate with aviation agency for providing helicopter services for the district for six month. The helicopter will be hired for four days in a month for six month interventions • To conduct exit polls at General and Civil hospitals CHC, PHC from OPD IPD patients to improve the condition of the health facilities • Workshops for involvement of the Private sectors (one each with NGOs/Trusts/Private institutions; Media; Ex-servicemen association, transportation ,HR agencies) • Sharing Workshops with Private players 																																								
Support required	Support required form the State to allow PPP; to develop a conducive environment by formulating a workable PPP Policy.																																								
Timeline	<table border="1"> <thead> <tr> <th data-bbox="375 1457 1084 1528">Activity / Item</th> <th data-bbox="1084 1457 1182 1528">2008 -09</th> <th data-bbox="1182 1457 1279 1528">2009 -10</th> <th data-bbox="1279 1457 1377 1528">2010 -11</th> <th data-bbox="1377 1457 1482 1528">2011 -12</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1528 1084 1562">Feasibility study</td> <td data-bbox="1084 1528 1182 1562"></td> <td data-bbox="1182 1528 1279 1562"></td> <td data-bbox="1279 1528 1377 1562"></td> <td data-bbox="1377 1528 1482 1562"></td> </tr> <tr> <td data-bbox="375 1562 1084 1596">Operational Frame work</td> <td data-bbox="1084 1562 1182 1596"></td> <td data-bbox="1182 1562 1279 1596"></td> <td data-bbox="1279 1562 1377 1596"></td> <td data-bbox="1377 1562 1482 1596"></td> </tr> <tr> <td data-bbox="375 1596 1084 1629">Operationalization of PPP</td> <td data-bbox="1084 1596 1182 1629">x</td> <td data-bbox="1182 1596 1279 1629">x</td> <td data-bbox="1279 1596 1377 1629">x</td> <td data-bbox="1377 1596 1482 1629">x</td> </tr> <tr> <td data-bbox="375 1629 1084 1663">Innovative interventions</td> <td data-bbox="1084 1629 1182 1663">x</td> <td data-bbox="1182 1629 1279 1663">x</td> <td data-bbox="1279 1629 1377 1663">x</td> <td data-bbox="1377 1629 1482 1663">x</td> </tr> <tr> <td data-bbox="375 1663 1084 1772">Advertisement for hiring technical support agency for assisting for achievement of objective of PPP mentioned above</td> <td data-bbox="1084 1663 1182 1772"></td> <td data-bbox="1182 1663 1279 1772"></td> <td data-bbox="1279 1663 1377 1772"></td> <td data-bbox="1377 1663 1482 1772"></td> </tr> <tr> <td data-bbox="375 1772 1084 1806">Establishing technical support agency</td> <td data-bbox="1084 1772 1182 1806"></td> <td data-bbox="1182 1772 1279 1806"></td> <td data-bbox="1279 1772 1377 1806"></td> <td data-bbox="1377 1772 1482 1806"></td> </tr> <tr> <td data-bbox="375 1806 1084 1871">Preparation of directories of resource agencies and privet partners</td> <td data-bbox="1084 1806 1182 1871"></td> <td data-bbox="1182 1806 1279 1871"></td> <td data-bbox="1279 1806 1377 1871"></td> <td data-bbox="1377 1806 1482 1871"></td> </tr> </tbody> </table>	Activity / Item	2008 -09	2009 -10	2010 -11	2011 -12	Feasibility study					Operational Frame work					Operationalization of PPP	x	x	x	x	Innovative interventions	x	x	x	x	Advertisement for hiring technical support agency for assisting for achievement of objective of PPP mentioned above					Establishing technical support agency					Preparation of directories of resource agencies and privet partners				
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	TNA for private partners				
	Capacity building NGOs, CBOs, ToT 2 batches x 25per batch on national health programme	x	x	x	x
	Training of pvt. Health care providers 2 batches x 25per batch on national health programme	x	x	x	x
	Capacity building of PRIs, VHWSC, SHGs and other field functionaries	x	x	x	x
	Area specific training modules				
	Monitoring and evaluation of PPP initiative	x	x	x	x

Budget

Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
Feasibility study on PPP issues	10.00	0.00	0.00	0.00	10.00
Innovative activities based on the study	20.00	20.00	20.00	20.00	80.00
Capacity Building of NGOs	0.50	0.500	0.00	0.500	1.500
Establishing Tech. Support Agency	2.00	2.2	2.420	2.662	9.282
Capacity Building of PRIs, SHGs, VHWSCs	0.5	0.55	0.605	0.666	2.321
Area specific Modules	0.5	0.000	0.000	0.000	0.5
Exit poles	2	2.2	2.420	2.662	9.282
Feasibility study on PPP issues	10	0	0.000	0.000	10
5 Workshops for involvement of the Private sectors (one each with NGOs/Trusts/Private institutions; Media; Ex-servicemen association, transportation ,HR agencies) @ 25000 per workshop	2.5	0	0	0	2.50
Sharing Workshops with Private players	0.55	0.61	0.67	0.74	2.57
Admin and overhead Charges for hiring the agencies	2.00	2.2	2.42	2.67	9.29
Hiring of helicopter for six month @ 1lakh/visitX 4 visitX 6 month	24	26.4	29.04	31.944	111.384
TOTAL	74.55	54.66	57.575	61.844	248.629

9. GENDER AND EQUITY

Gender and Equity	
Situation Analysis	<p>Gender discrimination is a common phenomenon. It has a direct bearing on the health status of women and children. Some of the parameters are the Sex Ratio, Age at marriage, enrolment of girls in schools, Male sterilization. The main reasons are dowry.</p> <p>Advisory committees have been constituted in the district and their meetings are held periodically. The orientation of various stake holders has taken place last year for sensitisation on PC-PNDT act</p> <p>There is no specific data on Gender Based Violence but women take it as part of marriage and hence undermine the facts. Male involvement in Family Welfare is minimal since there are very few Vasectomies as against Tubectomies. The indicators for morbidity and mortality also show differential values for boys and girls. The service providers are also not gender sensitive.</p>
Objectives	<ol style="list-style-type: none"> 1. To improve the decline in sex ratio in 0-6 years of age group 2. To reduce the domestic violence 3. To empower women in all age groups for gender equity 4. To enhances male participations in ensuring the gender balance and equity in the community 5. To develop capacities of various stake holder in Govt. and privet sectors on gender issues and various laws and acts related to establishing gender balance in the society 6. To ensure implementations of PC-PNDT and MTP act in the district. 7. To establish strong mechanism for monitoring of sex ratio and implementations of various acts to ensure gender balance and equity in the society
Strategies	<ol style="list-style-type: none"> 1. Addressing Adverse Sex ratio 2. Increasing male involvement in family planning 3. Increasing male involvement in family planning 4. Gender sensitization
Activities	<ol style="list-style-type: none"> 1. Addressing Adverse Sex ratio <ul style="list-style-type: none"> • Workshops with private providers, IMA members, Religious leaders, Caste leaders, PRIs, MLAs • Early registration of pregnancies through TBAs, ASHAs, AWWs, Numberdar and Chowkidar and any of these to get Rs 50 per case for early registration of pregnancy • Rallies in all schools and colleges and generating discussions in schools and colleges through debates • Regular advertisements in the newspapers • Swearing-in-ceremonies at the time of marriages regarding female foeticide • Regular meetings of the Appropriate Authorities • Registration of all Ultrasonography machines • Review of the monthly format to be filled by the Ultrasonography machines providers 2. Increasing male involvement in family planning <ul style="list-style-type: none"> • Use of condoms for safe sex • Vasectomy and NSV are safer and easier to perform in primary health centres than Tubectomy. • BCC activities to focus on men for Vasectomy. <p>Service delivery sites for male methods by training health providers in NSV and</p>

	<p>conventional vasectomy will be expanded so that each CHC and Block PHC in the district has at least a provider trained in NSV.</p> <ul style="list-style-type: none"> • Demand for male contraceptive methods, men's reproductive health services through designing and implementing male-focused BCC activities. <ol style="list-style-type: none"> 3. A Research Study on the sex ratio to understand the increase in the sex ratio for 0-6 yrs age. 4. Gender sensitization training will be provided for all health providers in the CHC/PHC and integrated into all other training activities so that they will have greater awareness of factors that influence women's decision making and thereby help them respond better to the needs of women and support her in exercising her choice. 5. Health card would be provided to all girl children upto the age of 18 years. 6. Improving the Literacy status and promotion of education upto 10th standard. 7. Treatment of anaemia in girls and also improving their nutritional status through Supplementary food at the AWCs 8. Reporting of Gender Based Violence cases by all the departments 9. Affidavit in court should be given regarding the dowry given to prevent false cases. 10. Preparation of GIS maps as planning tool to monitor and control decline sex ratio 11. IEC activities to raise the awareness regarding gender discrimination 12. Development of training modules 					
Support required	Strict enforcement of the PCPNDT Act					
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Research study for the increase in sex ratio for 0-6 years					
	Preparation of GIS maps as planning tool to monitor and control decline sex ratio					
	Up gradation of GIS	x	x	x	x	
	IEC campaign through print audio visual and folk media	x	x	x	x	
	Capacity building	x	x	x	x	
	Orientation of public and Pvt health care providers including NGOs on various laws related to health specially PC-PNDT & MTP act	x	x	x	x	
	Reorientation	x	x	x	x	
	Development/procurement training modules					
	Monitoring	x	x	x	x	
	Periodic advisory committee meeting and field monitoring @ Rs.5000 x 4(this includes meeting, travel and other contingencies)	x	x	x	x	
	Panchayat level vigilance committees to check decline in sex ratio and violence against women	x	x	x	x	
	Training of all MOs, ANMs on gender issues	x	x	x	x	
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Research Study	10.00	0	0	0	10.00
	Preparation of GIS maps for	5.00	1.0	1.0	1.0	8.00

monitoring					
IEC Campaign @2000 X189 villages	3.78	4.158	4.574	5.031	17.543
Periodic Advisory committee meetings @ 5000	0.2	0.22	0.242	0.266	0.928
Development of Trg. Modules	1.00	0	0	0	1.00
Training of MO's &, ANMs	2.00	2.2	2.42	2.662	9.282
Panchayat level vigilance committees @1000X160	1.6	1.76	1.936	2.13	7.426
Workshops with private providers, IMA members, Religious leaders, Caste leaders, PRIs, MLAs in every block and Gram Panchayat and with SHGs	10.0	11.0	12.1	13.31	46.41
Rallies in all schools and colleges and generating discussions in schools and colleges through debates	5.00	5.5	6.1	6.7	23.3
Regular advertisements in the newspapers	5.00	5.5	6.1	6.7	23.3
Health Card for Girl Child @ Rs 2 /card x 3000 cards	0.06	0.066	0.073	0.08	0.279
Total	43.64	31.404	34.545	37.879	147.468

10. CAPACITY BUILDING

Capacity Building						
Situation Analysis	<p>Training is an essential part of human development. Although the personnel have the basic skills necessary for carrying out their duties there is a need to upgrade the skills as well as to keep pace with the new developments under NRHM. There is a skill gap for managing safe deliveries, Abortions, Newborn Care, managing Childhood illnesses, Obstetric and Paediatric emergencies, morbidity and epidemics. There is no system for continuing education of the personnel. The management skills are also lacking resulting in poor management of programmes including financial management. Most of the personnel are unable to use computers and internet.</p> <ol style="list-style-type: none"> 1. Trainings of M.O in IMNCI is going and there is a need for more such trainings for MOs and other staff including refresher trainings 2. Orientation of TBAs is going on under RCH but there is a need for refresher training 3. Some of the Skill Birth Attendants are already trained and rest are required to be trained <p>The trainings are carried out by the RIHFW along with the Regional training centres and the district training centres. There is a shortage of staff and also rapid turnover.</p> <p>The monitoring of the trainings needs to be done for the quality of trainings. Also monitoring of the work output of the personnel for which they have received the trainings should also be done.</p>					
Objectives	<ol style="list-style-type: none"> 1. Reduction in the MMR and IMR from baseline to 50% of baseline by 2012 2. Fully skilled personnel at all levels in the Health sector, ICDS, PRIs, NGOs and private sector for provision of services 					
Strategies & Activities	<ol style="list-style-type: none"> 1. Development of training plan and methodology for all the personnel on various issues of RCH to reduce the Maternal and Neonatal mortality, meeting the unmet needs, building Gender perspective, good programme management and managing various components of NRHM 3. Ensuring the quality of trainings 					
Support required	From govt. & govt. Agencies Respectable people of the society Imams, people of the society, wealthy donors & social workers.					
Timeline						
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Construction of training hall @ 50 lac	25.00	25.00	0.00	0.00	50.00
	Trainings: VHWSC 2000/ committee X 51+ 85 new VHWSC from 2010	1.02	2.72	2.72	2.72	9.18
	ANMS @ 2000/ ANM (112) + 170 new ANM's from 2010	2.24	5.68	5.68	5.68	19.28
	Nurses @ 2000/ nurse (57)+ 135 new nurses for PHC (30) & CHC(30)	1.14	3.84	3.84	3.84	12.66

	& DH (75)					
	MO @ 20000/ MO(24) & 20 for new PHCS	4.80	8.80	8.80	8.80	31.2
	Specialists @ 20000/ specialists (21) & 69 new for CHC & DH	4.20	18.00	18.00	18.00	58.2
	Lab. Technician (26)@ 10000/L.t.	2.6	2.6	2.6	2.6	10.4
	TBA @ 1000/TBA(189)	1.89	1.89	1.89	1.89	7.56
	Total	42.89	68.53	43.53	43.53	198.48

11. HUMAN RESOURCE PLAN

Human Resource Plan						
Situation Analysis	The Human Resources in district Bandipora is not as per IPHS norms. There is no motivation for the doctors to work and promotions are hard to happen. No doctors and Specialists want to work in the rural areas.					
Objectives Benchmarks	<ol style="list-style-type: none"> 1. All staff to be in place as IPHS norms by 2012 2. Increased salaries for contractual doctors and Specialists 3. Special allowances for Regular staff 4. Increase in the number of training centres for LHV, ANM, Staff Nurses, Lab Technicians 					
Strategies & Activities	<ol style="list-style-type: none"> 1. Rational placement of Specialists and trained staff 2. Recruitment of staff on contract where vacancies 3. Recruitment of staff for new facilities as per the infrastructure requirements 4. Computers at all PHC and for each MO and Specialist at the CHC 5. Allowing Specialists and MOs for developing special skills as per their needs by attending special courses anywhere in India. 6. Proposal for Staff Nurse College and other Paramedical training college. 					
Support required						
Timeline						
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	CHC Staff					
	Obs/Gyn 2@ 26270 per month	6.3	6.3	6.3	6.3	25.2
	General surgeon 1 @ 26270 per month	3.15	3.15	3.15	3.15	12.6
	Paediatrician (3@ 26270/month)	9.46	9.46	9.46	9.46	37.84
	Physician 2@26270/M	6.3	6.3	6.3	6.3	25.2
	Anaesthetic (1@ 26270 / Môn.)	3.15	3.15	3.15	3.15	12.6
	Public health P M (3@26270 / Môn.)	9.46	9.46	9.46	9.46	37.84
	Eye surgeon (3@26270/ Môn.)	9.46	9.46	9.46	9.46	37.84
	Public health nurse (1@ 14265/ Môn.)	1.71	1.71	1.71	1.71	6.84
	Staff nurse (12@ 12800/ Môn.)	18.43	18.43	18.43	18.43	73.72
	Ophthalmic assistant 2@9900 /M	2.38	2.38	2.38	2.38	9.52
	Dresser (2@5777/mon.)	1.39	1.39	1.39	1.39	5.56
	Sweeper, Chokidar, OPD & OT Attendant (2@5777/ Môn.)	1.39	1.39	1.39	1.39	5.56

	Statistical assistant (3@ 7610/ Môn.)	2.74	2.74	2.74	2.74	10.96
Staff for 2 new CHCs from 2010						
	14 Specialists @ 26270 /M (G. Surg., Phy., O/G., Paed., Anaes., PHPM., Eye Surg.,	0	44.133 6	44.133 6	44.133 6	132.400 8
	Staff nurse 20@ 12800 /M	0	30.72	30.72	30.72	92.16
	Public health nurse 2@ 14265/M	0	3.4236	3.4236	3.4236	10.270
	Dresser 2@5777/M	0	1.3864	1.3864	1.3864	4.1593
	Pharmacist 2 @ 12800/M	0	3.072	3.072	3.072	9.216
	Lab. Tech. 4 @ 9900 /M	0	2.376	2.376	2.376	7.128
	Radiographer 2 @ 9900/M	0	2.376	2.376	2.376	7.128
	Sweeper, Chokidar,OPD & OT Attendant (16 @5777/ Môn.)	0	8.3188	8.3188	8.3188	24.9565
	UDC 4@ 8057 /M	0	3.8673	3.8673	3.8673	11.6020
	LDC 2@ 6650 /M	0	1.596	1.596	1.596	4.788
	Epidemiologist 2 @7661 /M	0	1.8386	1.8386	1.8386	5.5158
PHC :-----						
	MOs 12 @ 21000/ month	30.24	30.24	30.24	30.24	120.96
	Staff nurse 32 @ 12800	49.15	49.15	49.15	49.15	196.6
	Lab . Tech. 9@9900/M	10.69	10.69	10.69	10.69	42.76
	Clerks 17@7610/M	15.52	15.52	15.52	15.52	62.08
	Class IV 17 @ 4000/M	8.16	8.16	8.16	8.165	32.645
Staff for new 10 PHCs from 2010						
	MOs 20 @ 21000/M	0	50.40	50.40	50.40	151.20
	Pharmacists 10 @ 12800 /M	0	15.36	15.36	15.36	46.08
	Ayush Pharmacists 10 @ 12800 /M	0	15.36	15.36	15.36	46.08
	Nurses 30 @ 12800/M	0	46.08	46.08	46.08	138.24
	Clerks 20 @ 8000/M	0	19.20	19.20	19.20	57.60
	Lab. Tech 10 @ 9900/M	0	11.88	11.88	11.88	35.64
	Class IV 40 @ 4000/M	0	19.20	19.20	19.20	57.60
Sub Centres :-----						
	ANMS 70 @ 11355 70X11355X12	95.382	95.382	95.382	95.382	381.528
New 85 Sub Centres :-----						
	ANM's for new 85 Sc's from 2010 @ 11355/ month	0	231.64 2	231.64 2	231.64 2	694.926
DISTRICT HOSPITAL :-						
	Hospital Superintendent ¹ 1@ 28000/ month	3.36	3.36	3.36	3.36	13.44
	Medical Speciality 1 @ 26270/M	3.15	3.15	3.15	3.15	12.6
	Surgery Specialists 1 @ 26270/M	3.15	3.15	3.15	3.15	12.6

Dermatologist / Venereologist 1@ 26270/ month	3.15	3.15	3.15	3.15	12.6
Paediatrician 1 @ 26270/ M	3.15	3.15	3.15	3.15	12.6
Ophthalmologist 1 @ 26270/ month	3.15	3.15	3.15	3.15	12.6
ENT surgeon 1 @ 26270/ M	3.15	3.15	3.15	3.15	12.6
Orthopadician 1 @ 26270/ M	3.15	3.15	3.15	3.15	12.6
Radiologist 1@ 26270 / M	3.15	3.15	3.15	3.15	12.6
Casualty Doctors / General Duty Doctors 7@ 21000/ M	17.64	17.64	17.64	17.64	70.56
Forensic expert 1 @ 26270/ M	3.15	3.15	3.15	3.15	12.6
Dental Surgeon 1@ 26270/ month	3.15	3.15	3.15	3.15	12.6
AYUSH physician 2 @ 26270/ M	6.3	6.3	6.3	6.3	25.2
Staff nurse 17 @ 12800/ month	26.11	26.11	26.11	26.11	104.44
OT blood bank/opd attendant 5@ 7610 / M	4.57	4.57	4.57	4.57	18.28
Ophthalmic Assistant / Refractionist 1@9900/M	1.19	1.19	1.19	1.19	4.76
Sanitary worker 5 @ 5777/ M	3.47	3.47	3.47	3.47	13.88
ECG technician 1 @ 9900/M	1.19	1.19	1.19	1.19	4.76
Lab. Technician 5 @ 9900/ M	5.94	5.94	5.94	5.94	23.76
Lab. Attendant 2 @ 5777/ M	1.39	1.39	1.39	1.39	5.56
Pharmacist ISM 3 @ 12800/ M	4.61	4.61	4.61	4.61	18.44
Matron 1 @ 8000/ M	0.96	0.96	0.96	0.96	3.84
Physiotherapist 1 @ 15000/ M	1.8	1.8	1.8	1.8	7.2
Statistical Assistant 1 @ 7610/ M	0.91	0.91	0.91	0.91	3.64
Medical record officer 1@ 15000/M	1.8	1.8	1.8	1.8	7.2
Electrician Plumber 2@9900/M	2.38	2.38	2.38	2.38	9.52
Superintendent 1@ 10000/ M	1.2	1.2	1.2	1.2	4.8
Accountant 2@ 10000/M	2.4	2.4	2.4	2.4	9.6
Computer Operator 6@6000/ M	4.32	4.32	4.32	4.32	17.28
Driver1@4000/M	0.48	0.48	0.48	0.48	1.92
Peon Staff,Scurity, 4@4000 / M	1.92	1.92	1.92	1.92	7.68
O.T,Staff Nurse 2@ 12800/M	3.07	3.07	3.07	3.07	12.28
O.T Assistant 2 @ 7610/M	1.83	1.83	1.83	1.83	7.32
O.T. Sweper 1 @ 3000/M	0.36	0.36	0.36	0.36	1.44
Blood Bank Staff Nurse 1@12800/M	1.54	1.54	1.54	1.54	6.16
MNA/FNA 1@7000/M	0.84	0.84	0.84	0.84	3.36
Blood Bank Tech. 1 @ 9900/M	1.19	1.19	1.19	1.19	4.76
Sweeper 1@3000/M	0.36	0.36	0.36	0.36	1.44
Total	419.09	931.32	931.32	931.32	3213.06
	2	23	23	73	3

12. PROCUREMENT AND LOGISTICS

Procurement and Logistics						
Situation Analysis/ Current Status	In district Bandipora there is no proper Warehouse. There are rooms in which drugs are stored but it is not a scientific Warehouse. Most of the drugs are supplied by the State but some drugs are locally procured. Inventory Management is not very scientific and the records are not computerized. There is no system of wastage control, replacements, transfer of stocks from one centre to the other. Record Keeping is done manually.					
Objectives	Development of a Scientific Warehouse system by 2009					
Strategies	1. Developing a Warehouse 2. Capacity building of the personnel for stores and also record keeping 3. Computerization of all the stocks					
Activities	1. Construction of a scientific Warehouse 2. Procurement of software and computer hardware for the Warehouse from TNMSC 3. Proper Equipment and hardware 4. Availability of Pharmacist, Assistant Pharmacist, Packers 5. Training of personnel 6. Appointment of an agency for Operationalization of the Scientific Warehouse					
Support required	State to develop a scientific and transparent Procurement, Logistics and Warehousing system with quality control					
Time Line	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Construction of Warehouse	x				
	Software	x				
	Computer system with UPS, Printer, Scanner,	x				
	Equipment & Hardware	x				
	Pharmacist @ Rs 9000/mth	x				
	Assistant Pharmacist @ Rs 5000/mth	x				
	Packers -2 @ Rs 4000/mthx2	x				
	Security Staff @ Rs 6000/mth	x				
	Training of personnel	x				
	Consultancy to agency for Operationalization of the Warehouse	x	x			
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Construction of Warehouse	85.00	0.00	0.00	0.00	85.00
	Software	0.25	0.00	0.00	0.00	0.25
	Computer system with UPS, Printer, Scanner,	0.6	0.00	0.00	0.00	0.6
	Equipment & Hardware	34.5	0.00	0.00	0.00	34.5
	Pharmacist @ Rs 9000/mth	1.08	1.19	1.31	1.44	5.02
	Assistant Pharmacist @ Rs 5000/mth	0.6	0.66	0.726	0.799	2.785
	Packers -2 @ Rs 4000/mthx2	0.96	1.056	1.162	1.278	4.456

	Security Staff @ Rs 6000/mth	0.72	0.792	0.871	0.968	3.351
	Training of personnel	0.1	0.11	0.121	0.133	0.464
	Consultancy to agency for Operationalization of the Warehouse	2	2.1	0.00	0.00	4.1
	Total	125.81	5.908	4.19	4.618	140.526

13.DEMAND GENERATION – IEC

IEC	
Status	<p>There is lack of awareness and good practices amongst the community due to which they neither avail the services nor take any positive action. There is lack of awareness regarding the services, schemes including the Fixed Village Health days.</p> <p>The following issues need special focus:</p> <ul style="list-style-type: none"> • Spacing methods, ideal interval between births, no scalpel vasectomy, information about FP facilities and MTP facilities available at different levels • Importance of 3 visits for ANC, advantages of institutional delivery, Post natal care, availability of skilled birth attendants, balanced diet during pregnancy, anaemia, misgivings about IFA, kitchen garden • Importance of complete immunization, disadvantages of drop outs, nutritional requirements of infants and children, malnutrition, exclusive breastfeeding • Problems of adolescents, drugs addiction, malnutrition, problems of sexuality, age at marriage, tendency to take risks in sexual matters • DOTS programme for TB, location of microscopy centres, cardinal symptoms of TB, • High risk behaviour in the community in relation to water born diseases, heart diseases and lung diseases, and HIV/AIDS, STDs • Ill effects of drugs addiction affecting adolescents, • High prevalence of RTIs, including STDs, • Issues of malaria spread and prevention and also other diseases • JSY, Fixed Health days , availability of services <p>The personnel have had no training on Interpersonal communication.</p>
Objective	<p>Widespread awareness regarding the good health practices Knowledge on the schemes, Availability of services</p>
Strategy	<p>4. Information Dissemination through various media, 5. Interpersonal Communication 6. Promoting Behaviour change</p>
Activity	<p>1. Awareness on</p> <ul style="list-style-type: none"> • Fixed VHD days • JSY • Services available <p>2. Designing of BCC messages on exclusive breast feeding and complimentary feeding, ANC, Delivery, PNC, FP, Care of the Newborn, Gender, male involvement in the local language</p> <p>3. Consistent and appropriate messages on electronic media – TV, radio</p> <p>4. Use of the Folk media, Advertisements, hoardings on highways and at prominent sites</p> <p>5. Training of ASHA/AWW/ANM on Interpersonal communication and Counselling on various issues related to maternal and Child health</p> <p>6. Display of the referral centres and relevant telephone numbers in a prominent place in the village</p> <p>7. Promoting inter-personal communication by health and nutrition functionaries during the Fixed health & Nutrition days</p> <p>8. Orientation and training of all frontline government functionaries and elected representatives</p> <p>9. Integration of these messages within the school curriculum</p>

	<p>10. Kit for the newly married and during first pregnancy to be given at the time of marriage and during pregnancy</p> <p>11. Mothers meeting to be held in each village every month to address the above mentioned issues and for community action</p> <p>12. Kishore Kishori groups to be formed in each village and issues relevant to be addressed in the meetings every month</p> <p>13. Meetings of adult males to be held in each village to discuss issues related to males in each village every month and for community action.</p> <p>14. Village Contact Drives with the whole staff remaining at the village and providing services, drugs, one to one counselling and talks with the Village Health & Water Sanitation Committee and the Mother's groups. The whole district administration will get geared up for 33 days quarterly to carry out this massive drive in which registration of birth, death, Immunization of each child, ANC of each pregnant woman, growth monitoring of each child, disinfection of wells, spraying of houses and fogging, treatment of the stagnant water sites, detection of TB and Leprosy, treatment of all ailments, eye conditions through massive publicity. This will be carried out in each village through Rath Yatra.</p> <p>15. Monthly Swasthya Darpan describing all the forthcoming activities and also what happened in the month along with achievements</p> <p>16. Wall writings Pamphlets for various issues packed in an envelope</p>					
State Support	State to give guidelines for the good practices and also training module on BCC					
Timeline	Activities	2008-09	2009-10	2010-11	2011-12	
	Finalizing the messages	x	x	x	x	
	Advertisements	x	x	x	x	
	TV spots	x	x	x	x	
	Radio Jingles	x	x	x	x	
	Folk Media shows	x	x	x	x	
	Hoardings on highways and prominent places	x	x	x	x	
	Display boards	x	x	x	x	
	Pamphlets	x	x	x	x	
	Developing Nirdeshika for holding VHD days		x			
	Monthly Swasthya Darpan	x	x	x	x	
	Orientation & training of all frontline govt functionaries and elected representatives					
	VCD in each village quarterly	x	x	x	x	
	Bal Nutrition Melas	x	x	x	x	
	Adolescent meetings	x	x	x	x	
	Opinion leaders workshops	x	x	x	x	
	Wall writings	x	x	x	x	
Budget	Activities	2008-09	2009-10	2010-11	2011-12	Total

Hiring of an agency for carrying out the intensive IEC & behaviour change activities	40.00	44.00	48.4	53.24	185.64
Finalizing the messages in local language	1	1.1	1.21	1.331	4.641
Advertisements	5	5.5	6.05	6.655	23.205
TV spots	1	1.1	1.21	1.331	4.641
Radio Jingles in local language	1	1.1	1.21	1.331	4.641
Folk Media shows @ Rs 1000/village	1.89	2.079	2.287	2.516	8.772
Hoardings @ Rs 10000/hoarding	10	11	12.1	13.31	46.41
Display boards @ Rs 2000/board	1.8	1.98	2.178	2.396	8.354
Pamphlets @ Rs 10/pamphlets x 30000	3	3.3	3.63	3.993	13.923
Nirdeshika for Fixed Health Nutrition days @ Rs 20/ Nirdeshika x 8000	1.6	1.76	1.936	2.13	7.426
Swasthya Darpan @Rs.10 /copy/mth x 8000	0.8	0.88	0.968	1.065	3.713
Orientation of elected rep and PRIs@ Rs 200 x 2000 persons x1 day	4	4.4	4.84	5.324	18.564
Village campaign @ Rs 69.132 lakhs per Campaign x 4 times in a year	207.17 2	227.88 92	250.67 8	275.746	961.4852
Bal Nutrition Melas @ Rs 300 x 4 times x AWCs	5.688	6.257	6.882	7.571	26.398
Adolescent meetings @ Rs 100 per group x 189 villages	0.189	0.208	0.229	0.252	0.878
Community and religious leaders workshops @ Rs 300 /person x 100 x 4 times	1.2	1.32	1.452	1.597	5.569
Wall writings @ Rs 200 x 189 villages	0.378	0.416	0.457	0.503	1.754
Total	285.71 7	314.28 92	345.71 7	380.291	1326.014

14. FINANCING HEALTH CARE

Financing Health Care						
Situation Analysis/ Current Status	For sustainability and needs based care, health financing is the key. In District Bandipora Rogi Kalyan Samitis (RKS) have been formed in each of the hospitals, CHC and PHC. These are hospital autonomous societies which are allowed to take user fees for services provided at the facilities. Formation of these RKS has resulted in great satisfaction amongst the patients and also the staffs since now funds are available with the facilities to care for the people. No trainings have been given for the skill building of the Incharges of these facilities. There is no standardized reporting format and information regarding these RKS is not there.					
Objectives	Availability of sufficient funds for meeting the needs of the patients					
Strategies	<ol style="list-style-type: none"> 1. Generation of funds from User charges 2. Donations from individuals 3. Efficient management of the RKS 4. Provision of Seed money to each RKS 					
Activities	<ol style="list-style-type: none"> 1. Generation of funds from User charges: User charges are taken for Registration, IPD, Laboratory investigations from persons who can afford to pay. 2. Donations from individuals: Donations are to be generated from individuals. For the betterment of hospitals, equipment, additions to the buildings, etc 3. Efficient management of the RKS: Training will have to be given for efficient management and utilization of the funds for activities that generate funds. Computerization of data and all the parameters need to be carried out preferably through customized software. 4. Provision of Seed money to each RKS at CHC and PHC of Rs 100000 each year for repair, purchase of new equipment, additions, alterations, etc'; 5. Development of customized software and training of staff for the use of this softw 					
Support required	<ol style="list-style-type: none"> 1. Timely meetings of Rogi Kalyan Samitis 					
Timeline	Activity	2008-09	2009-10	2010-11	2011-12	
	Provision of Seed money @ Rs 1 lakh per CHC and PHC	x	x	x	x	
	Training of the Incharges and second in command	x	x	x	x	
	Development of Software for RKS with training of personnel on the use	x	x	x	x	
Total	Activity	08-09	09-10	10-11	11-12	Total
	Provision of Seed money @ Rs 1 lakh per CHC and PHC @ Rs 1.00 lakhs	15.00	27.00	29.70	32.67	104.37
	Training of the Incharges and second in command @ Rs 1000 per person x 1 day	1.10	1.21	1.331	1.452	5.093
	Development of Software for RKS with training of personnel on the use	5.00	0.25	0.25	0.25	5.75
	Total	21.1	28.46	31.281	34.372	115.213

15. SCHOOL HEALTH

SCHOOL HEALTH						
Situation Analysis	<ul style="list-style-type: none"> ▪ At present school health checkups are being carried out by existing medical staff where in addition to health checkups the health education activities are being also carried out. ▪ Treatment of minor ailments, referrals, dental checkups and refractions are also being carried out. ▪ The work done reports are submitted on monthly basis to Block Headquarters and then to District Headquarters. 					
Objectives Benchmarks	<ul style="list-style-type: none"> ▪ Healthy and Intelligent School Child. ▪ Early identification of abnormalities. ▪ Reduction in Child Mortality rate. 					
Strategies & Activities	<ul style="list-style-type: none"> ▪ Engagement of separate contractual staff in order to conduct the health check ups of all the school children on monthly basis under supervision of District Programme Manager because the existing staff cannot carry out the school health activities in all educational institutions on regular basis. ▪ Provision of drugs, supplies and transport facilities. ▪ Provision of IEC material <ul style="list-style-type: none"> • Posters, pamphlets, hand bills and audio visual aids for carrying out Health education activities particularly regarding <ul style="list-style-type: none"> • Nutrition • Hygiene • Sanitation • Adolescent health • Drug Addiction • Immunization • National Health Programmes ▪ Provision of supplementary nutrition ▪ Training of doctors / paramedics regarding school health. ▪ Provision of spectacles for children having refractive errors. ▪ Training of teachers in batches for carrying out health education regarding preventive measures for both communicable and non communicable diseases. ▪ Signs and symptoms of common health problems prevalent in school children and their referral. ▪ Extensive school health camps. ▪ Provision of Vehicles for logistic support. ▪ Usage of Mobile Medical Unit and appointment of staff thereto for exclusive school health team. ▪ On spot diagnosis and corrections. ▪ Follow up of Identified abnormal children through ASHAs/ANMs ▪ Making one Health Checkup compulsory before joining a new class. 					
Support required						
Timeline	Activity / Item	2008-09	2009-10	2010-11	2011-12	
	Health checkups	X	X	X	X	
	Supply of sanitary pads for girls 12 above age	X	X	X	X	

	IEC programme	X	X	X	X	
	Training of teachers	X	X	X	X	
	School health camps	X	X	X	X	
Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Health checkups @ 25000 / block	0.75	0.825	0.9075	0.99825	3.48075
	Supply of sanitary pads for girls 12 above age @ 1.00 lac / block	3	3.3	3.63	3.993	13.923
	IEC programme @ 1.00 / block	3	3.3	3.63	3.993	13.923
	Training of teachers @ 25000/ block	0.75	0.825	0.9075	0.99825	3.48075
	School health camps @ 25000 / block	0.75	0.825	0.9075	0.99825	3.48075
	Total	8.25	9.075	9.9825	10.98075	38.28825

16. BIO- MEDICAL WASTE MANAGEMENT

Bio-Medical Waste Management						
Situation Analysis / Current Status	<p>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.</p> <p>The District Health Officer is the Nodal Person in each district for ensuring the proper disposal of Biomedical Waste.</p> <p>For effective disposal of Biomedical waste in the district; Trainings to the personnel for sensitizing them, Pits. Segregation of Waste is taking place though Separate Colour Bins/containers it has to be done more systematically. Proper Supervision is lacking.</p> <p>The treatment (incineration) of waste is suppose to handled by a company selected at the State level but till date the company has not been selected.</p>					
Objectives	<p>Stopping the indiscriminate disposal of hospital Waste from all the facilities by 2008</p> <p>Ensuring proper handling and disposal of Biomedical Waste in each Facility</p>					
Strategies	<p>Capacity Building of personnel</p> <p>Proper equipment for the disposal and disposal as per guidelines</p> <p>Strict monitoring and Supervision</p>					
Activities	<p>Review of the efforts made for the Biomedical Waste Interventions</p> <p>Development of Microplan Plan for each facility in District & Block workshops</p> <p>Capacity Building of personnel.</p> <p>Biomedical Waste management to be part of each training in RCH and IDSP</p> <p>Proper equipment for the disposal</p> <p>Installation of the Separate Colour Bins/containers and Plastic Bags for the bins</p> <p>Segregation of Waste as per guidelines</p> <p>Partnering with Private providers for waste disposal</p> <p>Proper Supervision and Monitoring</p> <p>Formation of a Supervisory Committee in each facility by the MOs and the Supervisors</p>					
Timeline	Activity	2008-09	2009-10	2010-11	2011-12	
	Orientation and reorientation for Biomedical Waste Management at District and Block levels	X	X	X	X	
	Consumables	X	X	X	X	
	Payment for incinerators@ Rs. 8 per bed 12 mths	X	X	X	X	
Budget	Activity	2008-09	2009-10	2010-11	2011-12	Total
	Orientation and reorientation for Biomedical Waste Management at District and Block levels	1.65	1.82	2.00	2.2	7.67
	Consumables	2.2	2.42	2.662	2.928	10.21
	Payment for incinerators@ Rs. 8 per bed 12 mths	5.00	00.00	00.00	0.00	5.00
Total		8.85	4.24	4.662	5.128	22.88

**Annexure
Facility Survey**

Table:1	Percentage Availability of Infrastructure				
District: Bandipora					
	Indicators	SC (51)	PHC (12)	CHC(3)	DH
1	Building (Govtt. + Donated)	16	55	100	
2	Building (Rented)	84	45	0	
3	Condition of Building (Good + Fair)	35	NA	Na	
4	Water Supply (Tap, bore well/ hand pump / tube well, well)	27	40	100	
4.1	Tap water supply	Na	36	100	
5	Electricity	2	50	100	
5.1	In all parts of hospital	Na	30	100	
5.2	Electricity supply (power generation stabilization)	Na	NA	Na	
6	Separate Toilet	0	40	100	
6.1	Sep. Toilet with running water	Na	NA	33	
7	Furniture	20	45	60	
8	Labour Room	0	30	100	
8.1	Aseptic labour room	Na	NA	66	
9	Avail. of Quarter for staff	0	22	33	
10	Number of beds available (Average)		7	23	
11	Laboratory		9	100	
12	Operation Theatre		0	100	
13	Waste Disposal (Burnt + Dump)		64	66	
14	Availability of incenerator		NA	33	
15	Telephone		9	100	
16	Computer		0	0	
17	Generator/Invertors		27	100	
18	Vehicle		27	33	
19	Emergency Room / Casualty			100	
20	Separate wards for males and females (66	
21	No. of beds : Male			13	
22	No. of beds : Female			10	
23	Availability of ECG facilities			100	
24	X-Ray facility			100	
25	Ultrasound facility			100	
26	Cardiac Monitor for OT			100	
27	Blood Storage Unit available			0	
29	Other Investigative Facility				
30	Heating ventilation & air conditioning				
31	Lift & vertical transport				
32	Refrigeration				
Na = Not applicable					

Table: 2		Identified Gaps of Manpower					
District- Bandipora							
Name of Blocks		Hajjan	Bandipor ^a	Gurez	No. Of Required Staff	No. of Existing Staff	Total Gaps
No. of Sub- Centres (51)	IPHS Norm	24	20	7			
ANM	2	35	25	10	102	32	70
N0. Of PHC's(12)		5	3	4		0	
MO	2	3	5	4	24	12	12
Pharmacist	1	-1	0	-1	12	14	-2
Nurse	3	12	8	12	36	4	32
Female Health Worker	1	2	2	4	12	4	8
Health Educator	1	4	3	4	12	1	11
Health Assistant	2	7	6	8	24	3	21
Clerks	2	6	4	7	24	7	17
Lab. Technician	1	3	3	3	12	3	9
Driver		2	3	2		7	-7
Class IV	4	6	4	7	48	31	17
TOTAL					204	86	118
No. of CHC's(3)		1	1	1			
A. CLINICAL MANPOWER							
General Surgeon	1	1	0	0	3	2	1
Physician	1	1	0	1	3	1	2
Obstetrician / Gynaecologist	1	1	1	0	3	1	2
Paediatrics	1	1	1	1	3	0	3
Anaesthetist	1	1	0	0	3	2	1
Public Health Programme Manager	1	1	1	1	3	0	3
Eye Surgeon	1	1	1	1	3	0	3
Other specialists (if any)							
General duty officers (Medical Officer)		0	5	6			
B. SUPPORT MANPOWER							
Nursing Staff	7+2						
Public Health Nurse	1	0	0	1	3	2	1
ANM	1	0	0	0	3	3	0
Staff Nurse	7	3	3	6	21	9	12
Nurse/Midwife							
Dresser	1	0	1	1	3	1	2
Pharmacist / compounder	1	-3	1	-3	3	8	-5
Lab. Technician	1	0	0	-1	3	4	-1
Radiographer	1	0	-1	-1	3	5	-2
Ophthalmic Assistant	1	1	0	1	3	1	2
Ward boys / nursing orderly	2	-2	-3	-7	6	18	-12
Sweepers	3	-3	1	1	9	10	-1
Chowkedar	1	-1	0	1	3	3	0
OPD Attendant	1	1	1	0	3	1	2

Statistical Assistant / Data entry operator	1	1	1	1	3	0	3
OT Attendant	1	0	0	1	3	2	1
Registration Clerk	1	0		0	3	3	0
Any other staff (specify)							
TOTAL					93	76	17
Note: (-) Surplus staff							

****NO DISTRICT HOSPITAL IN DISTRICT BANDIPURA**

Table:3		Percentage Availability of Equipments			
District: Bandipora					
Name of Blocks		Hajjan	Bandipora	Gurez	Avg. %age of District
No. of SC's (51)	IPHS Norm	24	20	7	
kit- C	56	15.0	15.0	33.0	21.0
No. of PHC's (12)		5	3	4	
Suggested equipments	36	25.0	17.0	8.0	16.7
Operational labour room	10	0.0	0.0	30.0	10.0
Pap Smear	11	55.0	36.0	66.0	52.3
Laboratory Reagents	10	3.0	0.0	60.0	21.0
Glassware and other equipment	7	33.0	29.0	100.0	54.0
Furniture	25	0.0	2.0	62.0	21.3
TOTAL	99				29.2
No. of CHC's(3)		1	1	1	
Standard Surgical Set-1	32	59	18.8	46.9	41.7
Standard Surgical Set - II	33	33	15.2	15.2	21.2
IUD Insertion Kit	19	16	5.3	0.0	7.0
Standard Surgical Set - III	17	6	17.6	23.5	15.7
Normal Delivery	12	58	33.3	0.0	30.6
Standard Surgical Set - IV	16	25	18.8	12.5	18.8
Standard Surgical Set - V	21	0	9.5	19.0	9.5
Standard Surgical Set - VI	11	0	18.2	18.2	12.1
Equip. for Anaesthesia	17	35	17.6	5.9	19.6
Equip.for Neo-natal Resuscitation	10	0	0.0	0.0	0.0
Materials Kit for Blood trans.	15	0	0.0	6.7	2.2
Equip. for OT	11	18	18.2	54.5	30.3
Equip. for Labour room	13	8	46.2	23.1	25.9
Equip. for Radiology	9	44	0.0	0.0	14.8
TOTAL	236	22	15.6	16.1	17.8

Table: 4		Percentage Availability of Medicine			
District: Bandipora					
Name of Blocks		Hajjan	Bandipora	Gurez	Average % of the District
Sc's (51)	IPHS Norm	24	20	7	
Kit- A	5	0	0	0	0
Kit- B	9	6	0	11	6
Drugs required by ANMs and LHVs	6	0	0	50	17
Other Drugs & Vacci.	8	15	36	13	21
Med. Req.for NDCP	7	2	0	43	15
Contracep. Req.for F.Plang.	4	12	10	75	32
Drug List for AWC	12	13	39	50	34
Total	51	7	12.1	34.6	17.86
PHC's (12)		5	3	4	
Essen. & emerg. obstetrics care drugs	38	0	7.0	95	34
Antidots	4	0	0.0	100	33
Anticonvulsant./ Antiepileptic	4	0	0.0	0	0
Anti-infective Medicines	5	20	20.0	20	20
Antifilarials	1	0	0.0	0	0
Antibacterial	16	0	13.0	13	9
Dermatological medicine	14	0	7.0	0	2
Antilep.& Antitubercular	2	100	50.0	0	50
Antifungal medicine	4	0	0.0	25	8
Antiprotozoal medicine	5	7	20.0	20	16
Blood Products and Plasma Substitutes	13	0	0.0	0	0
Antiseptics	6	6	0.0	0	2
Disinfectants	3	0	0.0	33	11
Diuretics	2	0	50.0	50	33
Gastrointestinal	22	0	0.0	5	2
Hormones, Endocrine & Contraceptives	10	0	0.0	0	0
Ophthalmic. preparation	12	33	0.0	0	11
Psychotic Disorders	15	0	0.0	20	7
Solns. correcting water Electrolyte & Acid-	9	0	11.0	0	4
Vitamins & Minerals	3	0	0.0	0	0
Drugs under RCH	1	0	0.0	0	0
Product Strength formulation Units	31	0	13.0	6	6
RTI / STI Drugs	10	0	10.0	60	23
Drugs & Consumable for MVA	6	0	17.0	0	6
TOTAL	236	6.9	9.1	18.6	11.5
CHC's (3)					
Essential drugs	70	22	0	77	33

Annexure – II
Detailed Infrastructure

Table: 1 A		Block: Bandipora							District: Bandipora						
	Name of SC	Ownership of the Building	Condition of the Building	Water supply	Electricity	Separate toilet	Labor room	Staff Quarter							
1	Soniwani	Rent	Poor	N	N	N	N	N							
2	Dobn	Rent	Good	N	N	N	N	N							
3	Kulhama	Rent	Poor	Y	N	N	N	N							
4	Gamroo	Rent	Poor	N	N	N	N	N							
5	Aragam	Govt	Poor	Y	N	N	N	N							
6	Lahorwahpora	Rent	Good	N	N	N	N	N							
7	Lawpora	Rent	Poor	N	N	N	N	N							
8	Chatti Badi	Govt	Good	Y	N	N	N	N							
9	Pazalpora	Rent	Poor	N	N	N	N	N							
10	Garrora	Govt	Poor	Y	N	N	N	N							
11	Aloosa	Govt	Poor	Y	N	N	N	N							
12	Watapora	Rent	Poor	N	N	N	N	N							
13	Athwattoo	Rent	Poor	N	N	N	N	N							
14	Malungam	Rent	Poor	N	N	N	N	N							
15	Ahmed Shrief	Rent	Poor	N	N	N	N	N							
16	Naidhal	Rent	Poor	N	N	N	N	N							
17	Kutsun	Rent	Poor	N	N	N	N	N							
18	Bankote	Govt	Poor	N	N	N	N	N							
19	Binlipora	Rent	Poor	N	N	N	N	N							
20	Dardpora	Rent	Poor	N	N	N	N	N							

Table: 1 B		Block: Bandipora															District: Bandipora														
	Name of PHC/CH C	Ownership of the Building	Water supply	Electricity/ In all Parts	Separate toilet /with running water	Labor room / Aseptic labor room	Staff Quarar	Labo ratory	Operat ion Theater	Waste disposal/ inciliator	Tele phone	Generator	Vehicle	Emerg./Causu ality Room	USG	ECCG / USG	X-RAY	Cardiac Monitor	Blood storage unit												
1	Chintimula	Rent	N	N/N	N	N	N	N	N	Trench	N	N	N																		
2	Astango	Rent		N/N	Y	N	N	N	Burnt	N	N	N																			
3	A/D Walar Lake	Rent	Y	N/N		N	N	N	Trench	N	N	N																			
1	CHC Bandipora	Govt	Y	Y/ Y	Y/N	Y/N		Y	Y	Y	Y	Y	Y	Y	Y/Y	Y	Y	Y	N												

Table: 1 A		Block: Hajan District: Bandipora						
	Name of SC	Ownership of the Building	Condition of the Building	Water supply	Electricity	Separate toilet	Labor room	Staff Quarter
1	Saderkot Balla	Rent	Poor	N	N	N	N	N
2	Shadipora	Rent	Poor	Y	N	N	N	N
3	Banyari	Rent	Poor	Y	N	N	N	N
4	Shahgund	Rent	Poor	Y	Y	N	N	N
5	Goshbugh	Rent	Good	N	N	N	N	N
6	Ganasthan	Rent	Poor	Y	N	N	N	N
7	Hakbora	Govt	Good	Y	N	N	N	N
8	Trigam	Rent	Poor	N	N	N	N	N
9	Zalpora	Rent	Good	N	N	N	N	N
10	Preng	Rent	Good	N	N	N	N	N
11	Chonderhana	Rent	Poor	N	N	N	N	N
12	Gund Jhangir	Govt	Poor	N	N	N	N	N
13	Dangerpora	Rent	Poor	Y	N	N	N	N
14	Malikpora	Rent	Poor	N	N	N	N	N
15	Sadnora	Rent	Good	N	N	N	N	N
16	Mukhdamyari	Rent	Good	Y	N	N	N	N
17	Asham	Rent	Good	Y	N	N	N	N
18	Panzinara	Rent	Good	N	N	N	N	N
19	S.K.Payeen	Rent	Poor	N	N	N	N	N
20	Madwan	Govt	Good	N	N	N	N	N
21	Chewa	Rent	Good	N	N	N	N	N
22	Nesbal	Rent		Y	N	N	N	N
23	Vigpora	Rent	Good	N	N	N	N	N
24	Bazipora	Rent		N	N	N	N	N

Table: 1 B		Block: Hajan District: Bandipora																
	Name of PHC/CHC	Ownership of the Building	Water supply	Electricity/ In all Parts	Separate toilet /with running water	Labor room / Aseptic labor room	Staff Quarter	Laboratory	Operation Theater	Waste disposal/ Incinerator	Telephone	Generator	Vehicle	Emergency/Causality Room	ECG / USG	X-RAY	Cardiac Monitor	Blood storage unit
1	Nowgain	Rent	N	Y/N		N	Y	N	N	Dustbin	N	N	Y					
2	Naid Khai	Govt	N	Y/Y	N	N	N	N	N	Dump	N	N	N					
3	Hajan	Govt	Y	Y/Y	Y	Y	Y	Y	N	Dumping	Y	Y	Y					
4	A/D Amchi Kondal	Rent	Y	Y/Y	N	N	N	N	N	Dumping	N	Y	N					
5	A/D Ajas	Govt	N	Y/N		N		N	N	Dump	N	N						
1	CHC Hajan	Govt	Y	Y/Y	Y/Y	Y/Y	Y	Y	Y	Dump/N	Y	Y	Y	Y	Y/Y	Y	Y	N

Table: 1 A		Block: Gurez							District: Bandipora
	Name of SC	Ownership of the Building	Condition of the Building	Water supply	Electricity	Separate toilet	Labor room	Staff Quarter	
1	Tarbal	Rent	Poor	N	N	N	N	N	
2	Kanzalwan	Rent	Poor	N	N	N	N	N	
3	Gujran Telil	Govt	Poor	N	N	N	N	N	
4	Hussangam	Rent	Good	N	N	N	N	N	
5	Budoub	Rent	Good	N	N	N	N	N	
6	Badwam	Rent	Good	N	N	N	N	N	
7	Chorwan	Rent	Good	N	N	N	N	N	

Table: 1 B		Block: Gurez													District: Bandipora				
	Name of PHC/CHC	Ownership of the Building	Water supply	Electricity/ In all Parts	Separate toilet /with running water	Labor room / Aseptic labor room	Staff Quarter	Laboratory	Operation Theater	Waste disposal/ incinerator	Telephone	Generator	Vehicle	Emergency/Causality Room	USG	ECG /	X-RAY	Cardiac Monitor	Blood storage unit
1	Sheikpora	Govt	Y	N/N	Y	Y	N	N	N		N	Y	N						
2	Bagtora	Govt		N/N	Y	N/N	N	N	N	River	N	N	Y						
3	Bamayee Tulail	Govt	Y	N/N	N	N	N	N	N	Burn	N	N	N						
4	Budguam Tulail	Govt	N	N/N	Y	Y	N	N	N	Burn	N	N	N						
1	CHC Gurez	Govt	Y	Y/Y	Y/N	Y/Y		Y	Y	Y	Y	Y	Y	Y	Y/Y	Y	Y	Y	N

**Annexure – III
Criteria Appraisal**

**Assessment of District Health Action Plan (DHAP)
Appraisal Criteria to be used by State & District Planning & Appraisal Team**


Sl. No.	Criteria	Remarks Yes/ No
A. OVERALL		
1	Has the DHAP been reviewed in detail by the District authorities to ensure internal consistency? If yes, by whom? This means that Situation analysis, goals, strategies, activities, work plan budget are in line with the proposed interventions and are evidence based.	Yes
2	Has Account Person from the Department reviewed the budget in detail?	Yes
3	Executive summary /At a Glance have been enclosed in the beginning of the document.	Yes
4	Has plan developed in all inclusive and participatory process by involving representatives of health, water and sanitation, ISM, ICDS, Rural Development, NGOs and community members?	Yes
5	Funds requirement matches with the absorption capacity and has judicious increase over the years (The planning should be based on past experiences in implementing interventions and realistic time frame/ workplan)	Yes
6	The Plan caters needs of vulnerable groups (SC/ST, BPL, Women and Children, others) (Activities proposed to cover SC/ST population for Immunization coverage, JSY scheme etc.)	Yes
7	Inter-department coordination and convergence mechanism is clearly mentioned for multi-sectoral inputs/elements. (Planned joint sector ,block and dist level meetings with ICDS, education and local self Govt. etc and joint circulars for implementing intervention)	Yes
8	The findings of the facility survey/ assessment has been integrated in the Plan	Yes
9	Plan has been approved by appropriate district authority District (District Health Society)	Yes
11	Training Plan The training strategy to strengthen existing HR. The training plan has indicated target groups (e.g. MO, ANM, ASHAs, AWW etc), training load and broad details e.g. duration, quality assurance for training, etc	Yes
12	BCC /IEC strategy A service oriented BCC strategy based on assessment of the current status of issues with MMR, IMR, TFR, awareness of PNDT, etc. has been narrated in the plan	Yes
13	Work Plan Is the work plan consistent with stated components/objectives, strategies and activities? And whether the proposed phasing of activities would lead to increase in delivery/utilization of services?	Yes
14	COSTS/BUDGET Key criteria are:	

Sl. No.	Criteria	Remarks Yes/ No
	Does the budget follow the prescribed formats?	Yes
	The justification column has break-up of total amount	Yes
	1. Absorptive capacity: If very ambitious utilization of funds is envisaged compared to performance of 05-06/06-07, then key steps have been proposed to achieve plan expenditure?	Yes
B RCH-II PROGRAM		
PROGRAM MANAGEMENT ARRANGEMENTS		
1	Steps to establish financial management system including fund flow mechanisms to blocks and downward level and accounting system including timely reporting expenditure	Yes
2	Steps to establish quality assurance committees/system in the district.	Yes
3	Step to ensure systems for holistic monitoring (Outputs, activities, costs) against DHAP .(Dist level review meeting and DHS meetings)	Yes
4	Strengthening of HMIS with emphasis on timely availability of reliable and relevant information at appropriate level e.g. community, SC, PHC, Block and district, analysis and feedback system, steps to ensure implementation of revised HMIS system.	Yes
5	Provision of logistics management of drugs and medical supplies in order to ensure continuous availability of essential supplies at S/C, PHC and CHC level.	Yes
TECHNICAL STRATEGIES		
A. Reproductive & Child Health		
1	Maternal Health A. Interventions for 100% ANC coverage, B. 24x7 for EmOC services at selected institutions C. Skill birth attendance during labour (ANM) D. Provision for availability of safe blood in FRUs/CEmOCs, E. Intervention for anesthesia training for MOs, F. Provision of Safe abortion services and, G. Management of RTI/STI Cases H. Provision for Janani Suraksha Yojana	Yes
2	Child Health A. Organizing MCHN days for complete immunization coverage, B. Interventions for IMNCI services (Optional) C. Provision for new born care at institutions and, D. Promotion of breast feeding E. School Health Programme	Yes
3	Family Planning	

Sl. No.	Criteria	Remarks Yes/ No
	<p>A. Interventions to provide regular FP services in everyh block facilities,</p> <p>B. Increase number of service providers for vasectomy, NSV, Tubectomy, and Laproligation ,</p> <p>C. Intervention to improve quality of camps,</p> <p>D. Quality IUD insertion services,</p> <p>E. Increased availability of OP, Condoms through community workers, ASHA, AWW, NGOs</p>	Yes
4	ARSH	
	<p>A. Intervention for training of MOs, paramedic for ARSH services (optional)</p> <p>B. Provision of AFHS services at selected institutions (optional)</p>	Yes
5	Gender Mainstreaming	
	Activities planned for awareness generation of gender, PCPNDT Act and strengthening implementation of PCPNDT Act.	Yes
B	NRHM ADDITIONALITIES Whether provision made for-	Yes
1	ASHA Training in the district	Yes
2	PRI Trainings (Block/Village health & Sanitation Committees)	Yes
3	Untied Funds at SC & Untied funds to RKS at PHC/CHC/District Hospitals	Yes
4	Civil Works as per IPHS (CHC/PHC/SC) Hospital Building- Staff Quarters	Yes
5	Strengthening Field Monitoring and Supervision (Enhance the provision of POL, Maintenance and of vehicle)	Yes
6	Need assessment done for-Procurements as per IPHS CHC/PHC/SC)	Yes
7	Appropriate provision made for-Programme Management Units at Divisional, District and Block levels-Adequate salary and OE provisions (District PMU is a part of RCH II and Block level PMUs are part of NRHM)	Yes
8	Adequate provision made for-Additional Manpower Specialists at CHCs ANMs at SCs Divisional/Block Programme Managers	Yes
9	Provision made for-Drug Kits at different institutions	Yes
10	Plan for management of Mobile Medical Units at districts	Yes
11	No of Ambulances available and required	Yes,
	District specific innovative activities to address local needs have been incorporated	Yes
12	Public private partnerships (optional)	Yes
12	Provision of hiring of vehicle for BMOs (as per requirements)	Yes
C	IMMUNIZATION PROGRAM Whether provision made for-	
1	Social mobilization	Yes

Sl. No.	Criteria	Remarks Yes/ No
2	Alternative vaccine delivery	Yes
3	Cold Chain Maintenance	Yes
4	PoL & Maintenance requirement for vehicles	Yes
D	National Disease Control Programme	
1	Water Borne Diseases Clear strategy prepared for combating Water Borne Diseases like Malaria, dengue etc	Yes
2	TB	
	Whether Separate section on TB with operational details and budget prepared	Yes

Sl. No.	Criteria	Remarks Yes/ No
3	Leprosy Separate section on Leprosy with detailed operational guidelines and budget	Yes
4	Blindness 1. Separate section on Blindness Central with detailed targets and budget 2. Monitoring mechanism for NGO	Yes Yes
F	INTER DEPARTMENTAL COORDINATION Whether interventions in the following areas have been planned	
1	ISM Integration Activities	Yes
2	Department of Social Welfare (ICDS)	Yes
3	PHLD	Yes
G	Miscellaneous	
1.	Whether Five year perspective plan with one year detailed budget prepared	Yes
2.	List of NGOs working in health sector the district	Yes
3.	Listing of private health facilities in the district. Block wise list of all private hospitals in the district	Yes
4.	Comprehensive note on overview of the District Hospitals	Yes
5.	Whether Plan presented in the District Health Society -Date of presentation and approval (Documentary evidence)	Yes


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