FINAL

National Rural Health Mission

State Action Plan

Uttar Pradesh

(2008 - 2009)

Department of Family Welfare
Uttar Pradesh

Contents

Preface

The National Rural Health Mission is being implemented in the State with an aim to reduce infant mortality rate & maternal mortality ratio, ensuring population stabilization, prevention & control of communicable & non-communicable diseases and mainstreaming AYUSH for promotion of healthy life style.

Over 1.25 lac ASHAs, one of the key functionaries at the grassroot level, have been selected and imparted the first round of training. Integrated training on 2nd to 4th modules is in progress. Further, this year, an ASHA support system is proposed to be put in place to facilitate in her functioning.

The Comprehensive Child Survival Programme (CCSP) for bringing about reduction in infant and child mortality rates has been rolled out in 17 districts and is expected to bring good results. Further, the introduction of the Janani Suraksha Scheme (JSY) for promoting safe motherhood will go a long way in improving the proportion of institutional deliveries and reducing maternal mortality in the state. A scheme for promoting institutional deliveries through public-private partnership is also proposed to be implemented in the State.

A number of new innovations have been incorporated in this year's plan, such as, safe motherhood meetings, Saas Bahu Sammelans, pilots for addressing undernutrition and many more. Emphasis will also be laid on operationalising FRUs and deployment of manpower. A State level human resource development group is proposed to be constituted for rationalising posting of manpower within the districts and preparation of a training calendar. Quality of services will also be strictly monitored by placing State Quality Monitors at the division level, who would visit various districts in the division to monitor service quality. Other components, such as, improvement of health infrastructure, access to services, maternal health, child health, adolescent health, family planning, RTI/STI, involvement of NGOs, demand generation and capacity building would also continue.

The process for establishment of programme management units at State, Division District and Block levels has been initiated and I am confident that the proposed strategies will be implemented effectively thereby resulting in reduction of the mortality and morbidity rates and stabilizing the population growth of the state.

March 03, 2008

Nita Chowdhury
Principal Secretary
(Medical Health & Family Welfare)
Government of Uttar Pradesh

1. UTTAR PRADESH – PROFILE

Demographic Profile

Uttar Pradesh, with a population of around 166 million (Census 2001), is the most populous State of the Indian Union and accounts for approximately 16.17 percent of the country's population. Out of the total population of the State, more than 79 percent (13.15 crores) live in the rural areas, while the remaining 21 percent (3.45 crores) live in the urban areas. The population density of the State is 689 persons per sq. km, as against the national average of 324 persons per sq. km. The demographic indicators are summarized in the table ahead.

Demographic Profile of Uttar Pradesh

Indicator	Value
Population (Census 2001)	
Male	8.75 Crores
Female	7.85 Crores
Total	16.60 Crores
Population Density (Per Square Kilometre)	689
Annual Exponential Growth Rate (1991-2001)	2.30
Sex Ratio per Thousand Male (In 2001)	898
Female Literacy (2001) Percent	42.98

Out of the total population, 52.7 percent (8.75 crores) are males and 47.3 percent are females (7.85 crores). The sex ratio of the population is 898 females per 1000 males for the State, compared to 933 for all India (Census 2001). The population density is very high in the Eastern and Western regions and very low in Bundelkhand region. The literacy rate among those aged seven years and above is 70.23 percent among males and 42.98 percent among females. The life expectancy in the State is 65.48 years for males and 67.10 years for females, as compared to the national average of 65.63 years for males and 66.38 years for females.

For planning and development purposes, the State is divided into four distinct regions on the basis of homogeneity, contiguity and economic criteria. These regions are– Western, Central, Eastern and Bundelkhand. For administrative purposes, these regions are further divided into 17 divisions and 70 districts. These districts are further divided into tehsils (303) and developmental blocks (823). Each block consists of a number of villages (97,134), which is the smallest unit in the rural areas. There are approximately 700 urban local bodies, 8135 Nayay Panchayats, 52005 Gram Sabhas. There are around 631 cities and urban agglomerations in the State.

Health Infrastructure

The present public health infrastructure in the State, both in the urban and rural areas, is shown below:

Urban Areas	No. of Facilities	Rural Areas	No. of Facilities
Super Specialty Institute	5*	CHCs	426 + 91 (Construction completed, establishment under process)
Medical Colleges	7 - Govt. 2 – Central Govt. 3 –Private	BPHCs	397
District Male/Combined Hospitals	78	Additional PHCs	2837 (In Govt. Bldg.- 1527)
District Female Hospitals	53	Rural PPCs	147
Urban FW Bureau	5	Sub Centres	20521 (In Govt. Bldg.- 7000)
Urban FW Centres	61		
Health Posts	288		
District Level PPCs	63		

* *1 super specialty institute, SGPGI, is functional at Lucknow, 3 institutes at Lucknow and 1 at Saifai, Etawah are in the process of development*

Human Resources

The ratio of doctors per thousand population for U.P. is much below the national figure of 1 and although the ratio of beds is almost the same as the all India figure of 0.7, their geographical distribution is highly skewed in favour of the urban areas, depriving the rural masses.

Indian System of Medicine and Homeopathy

As per information made available by the Registrar, Indian Medical Council, Uttar Pradesh, 59,783 Ayurvedic & 14,905 Unani practitioners are currently registered and are expected to be practicing in the State. In addition, there are 27548 registered Homeopath doctors in the State.

Ayurveda

There are about 2200 Ayurvedic dispensaries and hospitals in the State and about 1.50 crore patients receive treatment in these dispensaries every year. The State Government has spent Rs.1.05 crore in 2003-04, Rs.1.08 crore in 2004-05 and

Rs.1.05 crore in 2005-06 on providing medicines to patients. However, there is scope to further improve the functioning of the Ayurvedic dispensaries and hospitals in the State. While the number of OPD patients receiving treatment in Ayurvedic hospitals and dispensaries is relatively better, the bed occupancy ratio in Ayurvedic Hospitals is very poor. This needs to be looked into.

Homeopathy

About 1.50 crore patients receive OPD treatment in Homeopathy dispensaries. The State Government has spent about Rs.87.91 lac in 2003-04, Rs.79.80 lac in 2004-05 and 2005-06 on medicines. At end of Ninth Plan there were 89 urban dispensaries and 1253 rural dispensaries in the State. Presently, there are 1342 Homeopathy dispensaries in the State. These include 126 dispensaries where no posts have so far been sanctioned.

2. LESSONS LEARNT

Following are the broad gaps and lessons learnt during implementation in previous years:

Institutional Mechanisms

- Currently, the institutional mechanisms are inadequate to ensure effective implementation of various interventions. Lack of programme management units and monitoring mechanisms have been a constraint in ensuring effective implementation of proposed activities.
- Limited capacities at district level in planning and monitoring.
- PRI mechanisms are weak – handholding support is required to orient and sensitize them on their roles and responsibilities in regard to health issues. Need to build capacities on local level planning, implementation and monitoring.
- NGO – institutional mechanisms for selection, monitoring, payments need to be established
- Coordination and convergence with other departments, PRI, local NGOs and health related interventions.

Strategic Inputs and Systems

- Lack of an integrated BCC strategy
- IEC bureau needs to revamped – currently involved only in replication & dissemination of previously developed messages or those developed by GoI.
- Limited number of District Health Education & Information Officers (DHEIOs) – do not have a proactive role, committed action plan or budget at their disposal
- Lack of an effective MIS
- Mismatch of resources (most deserving areas/manpower/equipments & machines)
- Procurement issues – Centralised procurement by GoI discontinued before State procurement systems were in place, which has adversely affected programme outcomes.
- Need to build capacities of State officers on procurement as per World Bank norms.
- In absence of an integrated training plan and systems to undertake training, parallel training programmes have been undertaken for same set of providers resulting in non-participation, conflict and inadequate outcome of training programmes.

Access to Services

- Janani Suraksha Yojana – The scheme is popular with the community at large. Beneficiaries generally in hurry to avail financial benefit without regard to status of their health and leave the institution at the earliest. This adversely affects the neonatal and maternal health outcomes.
- Mechanisms for implementation of JSY (monitoring, grievance redressal, etc.) need to be strengthened.
- Physical infrastructure of Sub-Centres (those in rented buildings) is inadequate for conducting deliveries.
- Facility wise monitoring of available services, gaps & feedback.
- Current compensation packages are not attractive enough to engage and retain skilled staff (Doctors, Staff Nurses) in rural areas.

Quality of Care and Monitoring

- Need to continuously assess and address skill gaps of service providers by undertaking various training programmes with inbuilt component of follow up & validation.
- No systems/tools to measure quality on a regular basis. External & internal monitoring tools need to be developed.
- Community & client feedback on expectation & gaps in quality of care required to be captured to improve service delivery.

Demand Generation

- Need to assess knowledge status & information need through KAP studies in relation to programme interventions.
- Lack of state specific integrated BCC strategy & implementation plan for healthy living
- Need to undertake regular research & evaluation for BCC interventions

Impact Assessment

- Need to establish system of concurrent & mid term evaluation for corrective action
- Concurrent audits required to be conducted

3. PROCESS OF PLAN PREPARATION

Initially, it was planned to develop District Health Action Plans (DHAPs) and consolidate DHAPs to develop state PIP. However, due to delay in initiating the exercise of DHAP preparation the mandated bottom-up procedure could not be followed in the strict sense. A participatory process has however been followed for preparation of the State PIP, as well as, the DHAPs.

In view of the limited expertise available at the district level, technical support was solicited from Medical Colleges and development partners, such as, SIFPSA and UPHSDP to facilitate preparation of the plans for the year 2008-09. Guidelines were shared with the technical support agencies and a one day orientation workshop for the functionaries of the technical support agencies was conducted by the Programme Officers at the State level.

These functionaries were responsible for facilitating the plan preparation at the district level. District planning teams were constituted in each district, having representation from various sectors concerned with NRHM. This group carried out a situational analysis of the district and identified priority areas. District Action Plans were developed by the district functionaries based on the inputs gathered through consultations. The technical agencies only played a facilitative role. The District Magistrates were also apprised of the DHAP preparation and all DHAPs have been approved and forwarded by the DMs of respective districts.

Plan from all 70 districts have been received at the state headquarter. A review of the district action plans was carried out at the State level and priorities common to most districts were identified for inclusion in the State PIP. Additionally, each district has been allocated funds ranging from Rs.15 lac to Rs.40 lacs for taking up local specific innovative interventions to achieve programme objectives.

It is envisaged to follow a decentralized planning process in subsequent years with a bottom up approach starting from the village. This would ensure that health plans developed are need based and the state plays a facilitative role in the process. Although a proposal for preparation of DHAPs was included in the PIP for 2007-08, the approval was only received in the month of February 08 and the amount could not be utilised. A budgetary requirement of Rs. 350 lacs at an average cost of Rs.5 lacs per district is being included under NRHM Additionalities for the year 2008-09.

4. GOALS & OBJECTIVES

Mission

Improved health status and quality of life of rural population with unequivocal and explicit emphasis on sustainable development measures.

Key Objectives (to be achieved by 2012)

- To reduce MMR to 258/ lac live births
- To reduce IMR to 36/1000 births
- To reduce TFR to 2.8
- Malaria mortality reduction rate by 60%
- Kala-azar mortality reduction rate by 100%
- Filaria/Microfilaria reduction by 80%
- Leprosy Prevalence Rate-Less than 1 per 10000
- Tuberculosis DOTS series- 85% cure rate & 70% detection of new sputum smear positive cases
- Upgrading all CHCs to IPHS
- Increase bed occupancy of FRUs >75%
- Engaging 1.23 lac ASHAs.
- Dengue mortality reduction by 50%
- Cataract operation - 42 lacs
- Under NBCP, objective is to reduce the prevalence rate from 1% to 0.5 by year 2012.
- To bring down Total Goitre Rate (TGR) to <10%.
- To ensure that >90% households consume iodized salt.
- To ensure availability of AYUSH by ensuring that at each block PHC, at least 2 MOs, one of them AYUSH practitioner, are available all the time.
- Safe drinking water and sanitation facilities to > 60% of villages.
- Reduction of malnourished children by half of present level.

CURRENT STATUS AND TARGETS

RCH II GOAL	UTTAR PRADESH				INDIA		
	Current status	Target			Current status	Target	
		07-08	08-09	09-10		07-08	09-10
MMR	517 per 1 Lac LB (SRS 01-03)	<460	<400	<360	301 (SRS 01-03)	200	<100
IMR	71 per 1000 LB (SRS 2006)	<65	<50	<45	57 (SRS 2006)	45	<30
TFR	3.8 (NFHS 3)	3.6	2.76	2.60	2.7 (NFHS 3)	2.3	2.1

CURRENT STATUS AND TARGETS

RCH OUTCOMES		CURRENT STATUS (NFHS-3, 2005-06)	TARGET		
			08 - 09	09-10	10-11
Maternal Health					
1.	% of pregnant women receiving full ANC coverage (3 ANC checks, 2 TT injections & 100 IFA Tablets)	26.3%	35%	50%	60%
1a.	% mothers who consumed IFA for 90 days or more during last pregnancy	8.7 %	30%	40%	50%
2.	% of pregnant women age 15-49 who are anaemic	51.6%	45%	40%	35%
3.	% of births assisted by a doctor/nurse/LHV/ANM/other health personnel	29.2%	45%	60%	70%
4.	% of institutional births	22%	40%	50%	60%
5.	% of mothers who received post partum care from a doctor/ nurse/ LHV/ ANM/ other health personnel within 2 days of delivery for their last birth	14.2%	20%	30%	40%
Child Health					
6.	% of neonates who were breastfed within one hour of life	7.2%	15%	25%	35%
7.	% of infants who were breastfed exclusively till 6 months of age	51.3%	60%	65%	70%
8.	% of infants receiving complementary feeds apart from breast feeding at 9 months	45.5%	50%	60%	70%
9.	% of children 12-23 months of age fully immunized	22.9%	40%	50%	60%
10.	% of children 6-35 months of age who are anaemic	85.1%	75%	65%	50%
11.	% of children under 5 years age who have received all nine doses of Vitamin A	7.3% (5 doses)	10%	20%	30%
12.	% of children under 3 years age with diarrhoea in the last 2 weeks who received ORS	12%	20%	30%	40%
13.	% of children under 3 years age who are underweight	47.3%	40%	35%	30%

RCH OUTCOMES		CURRENT STATUS (NFHS-3, 2005-06)	TARGET		
			08 - 09	09-10	10-11
Family Planning					
14.	Contraceptive prevalence rate (any modern method)	29.3%	35%	40	45
15.	Contraceptive prevalence rate (limiting methods)				
	Male Sterilization	0.2%	2%	5%	10%
	Female Sterilization	17.3%	25%	30%	40%
16.	Contraceptive prevalence rate (spacing methods)				
	Oral Pills	1.7%	3%	5%	10%
	IUDs	1.4%	5%	10%	15%
	Condoms	8.7%	15%	25%	30%
	Unmet need for spacing methods among eligible couples	21.9%	20%	18%	16%
	Unmet need for terminal methods among eligible couples	12.6%	12%	11%	10%

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Jan 2008)	TARGET					
			2008-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
Infrastructure								
1.	No. and % PHCs upgraded to provide 24X7 RCH services	300 36%	350 43%	500 61%	650 79%	823 100%	823 100%	823 100%
2.	No. and % of health facilities upgraded to FRUs, fulfilling the minimal criteria per the FRU guidelines (at least 3 critical criteria)							
	a. District/Combined Hospitals	38 60%	40 63%	44 70%	48 76%	53 84%	63 100%	63 100%
	b. Sub-district Hospitals	-	-	-	-	-	9 50%	18 100%
	c. CHCs	23 5%	50 12%	70 16%	80 19%	87 20%	110 26%	140 33%
	d. Block PHCs	-	-	-	-	-	-	-
3.	No. and % of functional Sub-Centres (ANM is posted and working out of the facility)	20521 100%	20521 100%	20521 100%	20521 100%	20521 100%	20521 100%	20521 100%
4.	No. and % of sampled FRUs following agreed infection control and health care waste disposal procedures	Not done	DHs-20 38% CHC-15 4%	DHs-25 47% CHC-30 7%	DHs-30 57% CHC-40 9%	DHs-35 66% CHC-50 12%	DHs-45 85% CHC-80 19%	DHs-53 100% CHC-100 23%
5.	No. and % of health facilities that have operationalised IMEP guidelines	-	-	-	DHs-20 38% CHC-40 9%	DHs-30 57% CHC-60 14%	DHs-45 85% CHC-90 21%	DHs-53 100% CHC-140 33%
Human Resources								
6.	No. and % of ANM positions filled (against required)	22533 95%	22533 95%	22533 95%	23000 97%	23000 97%	23656 100%	23656 100%
7.	No. and % of specialist positions filled at FRUs (against required)	40%	40%	50%	50%	55%	60%	70%
Programme Management								
8.	No. and % of state and districts having full time programme managers for RCH with financial & admin. powers delegated	Nil	70 distt. 100%	70 distt. 100%	70 distt. 100%	70 distt. 100%	70 distt. 100%	70 distt. 100%
9.	No. and % of sampled state & district programme managers whose performance was reviewed during the past 6 months	70 dist. (Dy. CMO) 100%	Nil	70 dist. 100%	70 dist. 100%	70 dist. 100%	70 dist 100%	70 dist 100%

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Jan 2008)	TARGET					
			2008-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
10.	% of district action plans ready	50 districts 71%	70 districts 100%	-	-	-	70 districts 100%	70 districts 100%
11.	% of sampled districts that are implementing M&E triangulation involving community	14 districts (4QA+10 IFPSQA) 20%	14 districts 20%	14 districts 20%	28 districts 40%	56 districts 80%	70 districts 100%	70 districts 100%
12.	SPMU in place with 100 % staff	-	50%	100%	100%	100%	100%	100%
13.	No. and % DPMU staff in place	-	50%	100%	100%	100%	100%	100%
Financial Management								
14.	% of districts reporting quarterly financial performance in time	90%	90%	100%	100%	100%	100%	100%
Logistics / Procurement								
15.	% of district not having at least one month stock of a. Measles vaccine b. OCP c. EC Pills d. Surgical Gloves	Nil	-	-	-	-	-	-
Training								
16.	No. and % of Medical Officers trained in							
	a. SBA (1 day orientation)	400	440	-	-	-	-	-
	b. Life-saving anaesthesia skills	Nil	20	-	-	20	40	40
	c. EmOC	Nil	-	48	-	48	96	-
	d. RTI/STI	-	-	-	-	-	-	-
	e. MTP using MVA	37	10	50	30	30	200	100
	f. MTP using other methods	-	-	-	-	-	-	-
	g. (i) CCSP-UP (IMNCI) ToT	127	199	271	-	-	-	-
	(ii) CCSP-UP (MOs)	29	153	306	459	612	-	-
	h. Facility Based Newborn care	-	100	100	70	70	-	-
	i. Care of sick children and severe malnutrition	Nil	-	34	50	36	-	-

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Jan 2008)	TARGET					
			2008-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
	j. NSV	21	14	20	20	28	85	102
	k. Laparoscopic sterilization	16	8	6	24	32	70	70
	l. Minilap	10	8	32	36	64	140	140
	m. IUD insertion	Nil	6	60	90	100	200	200
	n. ARSH	Included in Integrated Skill Based Training						
	o. IMEP	-	-	-	-	-	-	-
17.	No. and % Staff trained in SBA							
	a. ANM /LHV	20	150	150	125	125	290	-
	b. LHV	-	-	-	-	-	-	-
	c. Staff nurse	20	150	150	125	125	290	-
18.	No. and % Staff trained in CCSP-UP (IMNCI)							
	a. ANM	511	715	919	1123	1327	-	-
	b. LHV	34	-	312	312	312	312	-
	c. ASHA	1800	3500	5200	8600	12000	-	-
	d. Staff Nurse	Nil	-	-	86	-	-	-
19.	No. and % of Staff Nurses trained in Facility Based Newborn Care	Nil	-	-	40	40	-	-
20.	No. and % of ASHAs trained in Home Based Newborn Care	Nil	Subsumed under CCSP					
21.	No. and % Staff trained in IUD insertion							
	a. ANM/LHV	Nil	-	500 11%	1000 22%	1500 33%	3000 67%	4500 100%
	b. Staff Nurse	Nil	-	-	-	500 25 %	1250 63%	2000 100%
22.	No. and % of staff trained in ARSH							
	a. ANM	-	incl. in Int. Skill Based Training of RCH				-	-
	b. LHV	-	incl. in Int. Skill Based Training of RCH				-	-
	c. Staff Nurse	-	incl. in Int. Skill Based Training of RCH				-	-
	d. Prog. Managers	-		-	-		-	-
23.	No. and % of state and district programme managers trained on IMEP	Nil	-	-	100 17%	200 33%	400 67%	600 100%

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Jan 2008)	TARGET					
			2008-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
24.	No. and % of health personnel who have undergone Contraceptive Update/ISD Training	-	-	-	-	-	-	-
Maternal Health								
25.	% of ANC registrations in first trimester of pregnancy	25.7% (NFHS-3)	30%	35%	38%	40%	50%	60%
25b.	% mothers who consumed IFA for 90 days or more during last pregnancy	8.7 % (NFHS - 3)	15%	20%	25%	30%	40%	50%
26.	% of 24 hrs PHCs conducting minimum of 10 deliveries/month	56%	60%	65%	70%	80%	100%	100%
27.	% of Caesarean Sections in CEmONC centres	8.1% of total deliveries	10%	12%	15%	15%	15%	15%
28.	No. and % of health facilities providing RTI/STI services							
	a. DHs	53 100%	53 100%	53 100%	53 100%	53 100%	53 100%	53 100%
	b. SDHs	18 100%	18 100%	18 100%	18 100%	18 100%	18 100%	18 100%
	c. CHCs	50 12%	70 16%	100 23%	150 35%	200 47%	340 80%	340 80%
	d. PHCs	240 29%	240 29%	250 30%	260 32%	270 33%	300 36%	350 43%
29.	No. and % of health facilities providing MTP services							
	a. DHs	53 100%	53 100%	53 100%	53 100%	53 100%	53 100%	53 100%
	b. SDHs	8 44%	8 44%	10 55%	15 75%	18 100%	18 100%	18 100%
	c. CHCs	90 21%	110 26%	120 28%	135 32%	150 35%	300 36%	350 43%
	d. PHCs	50 6%	60 7%	75 9%	90 11%	100 12%	120 15%	150 184
30.	No. of districts where Referral Transport services are functional	-	-	10 15%	35 50%	70 100%	70 100%	70 100%
31.	No. and % of planned RCH outreach camps held	67 48%	35 25%	70 50%	105 75%	140 100%	140 100%	140 100%
32.	No. and % of planned Monthly Village Health and Nutrition Days held	702000 45%	3.5 lacs 25%	7 lacs 45%	10 lacs 65%	13 lacs 80%	15 lacs 100%	15 lacs 100%

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Jan 2008)	TARGET					
			2008-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
Child Health								
33.	No. of districts where CCSP logistics are supplied regularly	-	-	-	8 11%	17 24%	35 50%	35 50%
34.	No. and % of health facilities with at least one provider trained in Facility Based Newborn Care	-	17 DHs	17 DHs 17 CHCs	17 DHs 34 CHCs	17 DHs 68 CHCs	35 DHs 140 CHCs	35 DHs 140 CHCs
35.	No. and % of sampled outreach session where AD syringe use and safe disposal are followed	97%	98%	100%	100%	100%	100%	100%
36.	No. of districts and schools where School Health Programme is implemented	70 Dist. 7000 schools	70 Dist. 9000 schools	70 Dist. 9000 schools	70 Dist. 9000 schools	70 Dist. 9000 schools	70 Dist. 36000 schools	70 Dist. 36000 schools
Family Planning								
37.	No. and % of health facilities providing Female Sterilization services							
	a. DHs	43 81%	45 85%	47 89%	50 94%	53 100%	53 100%	53 100%
	b. SDHs	8 44%	8 44%	10 55%	15 75%	18 100%	18 100%	18 100%
	c. CHCs	90 21%	110 26%	120 28%	135 32%	150 35%	300 70%	350 82%
	d. PHCs	50 6%	60 7%	75 9%	90 11%	100 12%	120 15%	150 18%
38.	No. and % of health facilities providing Male Sterilization services							
	a. DHs	78 100%	78 100%	78 100%	78 100%	78 100%	78 100%	78 100%
	b. SDHs	8 44%	8 44%	10 55%	15 75%	18 100%	18 100%	18 100%
	c. CHCs	200 47%	200 47%	250 59%	250 59%	300 70%	426 100%	426 100%
	d. PHCs	-	-	-	-	-	-	-
39.	No. and % of health facilities providing IUD insertion services							
	a. CHCs	426 100%	426 100%	426 100%	426 100%	426 100%	426 100%	426 100%
	b. PHCs	150 100%	200 100%	250 100%	300 100%	350 100%	400 100%	500 100%
	c. Sub centres	7000	7000	7000	7500	8000	8000	8000

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Jan 2008)	TARGET					
			2008-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
40.	No. of accredited private institutions providing:							
	a. Female Steril. Services	10	-	-	32	34	100	120
	b. Male Steril. Services	10	-	-	32	34	70	85
	c. IUD Insertion Services	10	-	-	32	34	100	120
41.	% of districts with Quality Assurance Committees (QACs)	49 70%	-	50 71%	60 86%	70 100%	-	-
42.	% of district QACs having quarterly meetings	NA	-	50 71%	60 86%	70 100%	-	-
43.	% of planned Female Sterilisation camps held in the quarter	NA	-	75%	90%	95%	100%	100%
44.	% of planned NSV camps held in the quarter	NA	-	-	80%	90%	100%	100%
Adolescent Reproductive and Sexual Health								
45.	% of ANC registrations in first trimester of pregnancy for women < 19 years of age	NA	-	-	10%	25%	60%	70%
46.	No. and % of health facilities providing ARSH services							
	a. CHCs	42 10%	45 11%	65 15%	75 18%	90 21%	140 33%	180 42%
	c. PHCs	-	-	-	-	-	-	-
	d. Other Counselling centres	-	35 50%	70 100%	70 100%	70 100%	70 100%	70 100%
47.	No. and % of health facilities with at least one provider trained in ARSH	234 18%	234 18%	350 27%	500 38%	650 50%	1300 100%	1300 100%
Vulnerable Groups								
48.	No. and % of district plans with specific activities to reach vulnerable communities	70 100%	70 100%	70 100%	70 100%	70 100%	70 100%	70 100%

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Jan 2008)	TARGET					
			2008-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
Innovations/PPP/NGO								
49.	No. of districts covered under MNGO scheme	40	40	70	70	70	70	70
50.	No. of MNGO proposals under implementation	8						
Monitoring and Evaluation								
51.	% of districts reporting on the new MIES format on time	36%	36%	50%	75%	100%	100%	100%

5. RCH II PROGRAMME OBJECTIVES & STRATEGIES

The second phase of the Reproductive and Child Health (RCH) Programme started from April 2005 with necessary modifications based on the lessons learnt in the first phase, in the State. A comprehensive integrated Programme Implementation Plan (PIP) for RCH phase II has been approved by Government of India and the programme implementation virtually started from October '05 after the first release of funds from GoI.

Key Goals for RCH-II

Target Areas	Key Indicators	Status	Target 2010
Maternal Health	MMR	517 (SRS 01-03)	<360
Newborn & Child Health	IMR	71 (SRS 2006)	<45
Population Stabilization	TFR	3.8 (NFHS-3, 2005-06)	2.60

1. MATERNAL HEALTH

Objectives

- Increase ANC coverage
- Increase registration in 1st trimester
- Ensure TT injections to pregnant women
- Reduction of anaemia in women
- Increase in institutional deliveries
- Ensuring management of complications during pregnancy and delivery
- Ensuring post natal care

Major Strategies

Reproductive and child health programme encompasses all the major components of the complex framework to target maternal mortality, bearing in mind the limitation of resources. The first 4 objectives are leveraged with the strengthening of sub-centre to IPHS. The 5th and 6th objectives are leveraged with strengthening of PHCs, CHCs and District Women Hospitals to IPHS.

1.1 Birth Preparedness, Safe Motherhood and Antenatal Care

It induce behaviour change and positive approach, it is proposed to undertake safe motherhood meetings in every village every six months to emphasize, the need of birth preparedness plan and proper antenatal care. During the Village Health & Nutrition Day (VHND) sessions the ASHAs would bring together ANM//AWW/pregnant women/elderly members of the family of pregnant women. Discussions in these meetings will include ANC check-up schedule, services covered under ANC, sites of safe/institutional delivery, service providers and various government schemes available under the programme for community welfare.

Since the budget for VHNDs have been provisioned under the ASHA scheme no additional budgetary requirement is proposed.

1.2 Operationalisation of Facilities

1.1.1 Operationalisation of CHCs & District Women Hospitals (DWHs) as FRUs

Currently, there are 38 District Women's Hospital and 23 CHCs in State that are functioning as FRUs. Strengthening of infrastructure of remaining 15 DWHs and 27 CHCs is under process. Further, 50 CHCs have been identified for strengthening and facility survey is under process for identification of CHCs to be operationalised as FRUs. Accordingly, it is targeted operationalise the 53 DWHs and 87 CHCs, so as to ensure that at least two CHCs are functioning as FRUs (IPHS) in each district by end of 2008-09.
The State will adopt a sub-divisional approach for strengthening FRUs / IPHS facilities for equitable distribution of comprehensive maternal care. The sub-divisional CHCs/hospitals will be strengthened on priority, to provide integrated range of services covered under NRHM.

Availability of blood in emergency situations is being ensured through identification of one blood bank in the vicinity within the district, either at the district hospital or by establishing linkage with a private sector provider. The UP State AIDS Control Society (UPSACS) is currently establishing blood storage facility in 20 identified FRUs. Further, 50 blood storage units will also be established by UPSACS in 2008-09 in the identified FRUs.

To address manpower issues, it is proposed to hire Staff Nurses on contract. It is proposed to position 6 Staff Nurses at each CHC on contract, apart from the 3 regular staff nurses. It is also proposed to enter into contract with local private Gynaecologists for providing services on on-call basis. For ensuring availability of Anaesthetists at the CHCs, it is proposed to empanel Anaesthetists working at district hospitals/private sector to provide services on on-call basis. Paediatricians wherever required would be ensured through redeployment/ contract.

It is proposed to position the Specialists including Anaesthetists on team basis.

Details of human resources to be deployed and fund requirement has been provided in the section on 'Human Resources'.

Further, there is paucity of manpower at the district women hospital which is affecting care of referred maternal clients. It is proposed to hire additional manpower to augment services to referred clients from rural areas, which are often in need of emergency treatment and advanced care. Subject to vacancy/requirement and availability these would be hired on monthly contract or per case basis.

Sl.	Position	No. to be Positioned
1	Gynaecologist/ LMO	Upto 3
2	Paediatrician	1
3	Anaesthetist	1
4	Pathologist	1
5	Staff Nurses	Upto 9
6	Data Assistant	1
7	Cleaning Staff	2

The tentative requirement of staff has been detailed in the section on 'Human Resources'.

It is also proposed to provide a computer at the FRUs for maintenance of facility records, including details of reimbursement under JSY. Accordingly, it is proposed to procure computer system including UPS and printer for the FRUs that are proposed to be made functional. The budgetary requirement is provisioned under the head 'Infrastructure & Equipment'. Additionally, it also proposed to deploy a Computer Operator at the FRU, the cost of which has been budgeted under the section on 'Human Resources'. Budgetary provisions for stationery, consumables, etc. have been incorporated in the section on 'Institutional Strengthening'.

The State shall also initiate steps for appointing Hospital Managers in FRUs and hospitals having adequate client load to handle the complexities of activities related to hospital administration, including, equipment maintenance, procurement of consumables, assets and inventory management, human resource management, client conveniences, ambulance services, sanitation, public relations, etc.

Expenses towards upgradation and physical strengthening of CHCs, equipment and medicines including contractual manpower as detailed above, have been budgeted under the section on 'Infrastructure & Equipment'.

Compilation of facility level reports and reporting to CMO would be the responsibility of the Medical Superintendent. Expenses towards compilation of such reports would be met from funds available under RKS.

The monitoring of physical progress against the operationalisation plan would be done by the district authorities. However, field visit would also be done by State level officials. Other activities, such as, training etc. will be followed up at the State programme management level. Field visits at regular intervals would be conducted to monitor the quality of service delivery and utilization of service. A monitoring checklist has been developed for the purpose.

Strengthening Blood Transfusion Services at Referral Units (FRU/Other referral hospitals)

Haemorrhage is an important cause of maternal death. To address this issue blood transfusion services at the referral units need to be strengthened. Currently, these services are non-existent in the rural referral units. Accordingly, it is proposed to provide training to service providers. A 3-day training package is proposed to be developed in collaboration with SGPGI/KGMU, details of which have been incorporated in the 'Training Section.' 87 units at the CHCs (FRUs) will be made operational this year.

1.1.2 Operationalisation of CHCs & BPHCs to provide 24-hour services

At present there are around 200 CHCs and 100 BPHCs providing 24x7 delivery services and by March 2008 it is expected that at least 400 facilities will be functional. It is further proposed to make functional all the 426 CHCs and 397 Block PHCs by the end of 2008-09.

Provision of manpower, wherever vacancies exist, would be made through contractual arrangements. It is also proposed to have Lady Medical Officers (MBBS) at CHCs, lady ISM doctors at PHCs for 8 hour shifts during the day. In case of gaps in Staff Nurses, it is proposed to deploy Staff Nurses/General Nursing Midwives (GNMs) on contract.

Contracting of ISM lady doctors and GNMs was piloted in 20 districts of the State and in view of the encouraging results, it is proposed to upscale the activity in all the districts. Deployment of these ISMs, Staff Nurses & GNMs would be initiated for the BPHCs and once the block level facilities have been saturated, deployment would be done for the CHCs.

The estimated number of personnel to be hired and the budgeted expenses is detailed in the section on 'Human Resources'.

Sl.	Position	Additional Number Expected to be Available on Contract
1	Lady Medical Officer (MBBS)	At CHC -150
2	ISM Lady Doctor	At BPHC -500
3	Nurses	At CHC – 852 At BPHC -1000

1.1.3 Operationalise MTP services at health facilities

General Performance

At present (2007-08) MTP services are available only at limited facilities (53 district women hospitals and 150 CHCs). Thus, a total of 203 facilities are providing MTP services at present.

Proposal for the year 2008-09

It is proposed to strengthen the existing MTP services at these facilities and further operationalise MTP services in the remaining 276 CHCs. Accordingly, MTP services would be available at all the DWHs and CHCs by the end of 2008-09. Requisite training would be provided to the LMOs and procurement of MVAs and D&C kits would be done, which have been accordingly budgeted in the Training and Procurement sections of the PIP. It may be noted that D&C kits are not required for conducting a D&C procedure but instruments are to be used during MTP procedure through MVA.

A proposal for procurement of kits amounting to Rs.13.20 lacs had been proposed in the PIP for 2007-08, the approval for which has been received in the month of February 2008 and since no procurement was possible, it is proposed to utilize the amount in the year 2008-09.

1.1.4 Operationalise RTI/STI services at health facilities

At present RTI/STI services are being provided at 50 facilities. It is proposed to provide these services at 90 more facilities, one each at the identified FRUs for the year 2008-09. Facilities for confidential counselling would also be strengthened at these units, as well as, at the district hospitals. Provision for training of LMOs/Pathologists/Lab Technicians has been included in the Training component.

Further, weekly RTI/STI clinics will be conducted at Block PHCs for providing symptomatic treatment and referral services.

A requirement of Rs.22.40 lacs was proposed in the PIP for 2007-08, the approval of which has been received in the month of February 2008. This amount would be utilised in the year 2008-09 and no additional budgetary requirement is being made for the year 2008-09.

1.1.5 Introduction of pregnancy diagnostic kits

It is also proposed to introduce pregnancy test kits. Social marketing activities would be undertaken through a government undertaking to promote the use of rapid diagnostic test kits for pregnancy diagnosis. ASHAs would be involved in the social marketing activities.

1.3 Incentive for Promotion of Institutional Deliveries

A special incentive scheme for all the night deliveries taking place between 8 pm and 7 am has been operational in the State. A cash incentive of Rs.200/- to the Medical Officer, Rs. 100/- to the Staff Nurse/ANM and Rs.30/- for the cleaning staff was being paid for each night delivery. This scheme of Rs. 330/- per night delivery is proposed to be continued with certain modifications

Henceforth, the incentive will be payable against fulfilment of a minimum criteria i.e., the total number of deliveries at the BPHC should be more than 20 per month, of which at least 10 deliveries have been night deliveries. The incentive will be payable per night delivery over and above the minimum 10 deliveries.

In case of CHCs, the total number of deliveries per month should be at least 60, of which 30 deliveries must have been night deliveries. The incentive will be payable per night delivery over and above the minimum 30 deliveries.

It is expected that in the year 2008-09, around 823 units (426 CHCs & 397 BPHCs) would be performing night deliveries. Accordingly, a budgetary provision has been made.

Budgetary Requirement

Year	No. of 24 Hour Delivery Units	Expected No. of Night Deliveries per Year Qualifying for Incentive (CHC – 20 per mnth; BPHC- 5 p.m.)	Total Incentive @ Rs. 330/- per case per year
2008-09	823	126000	415.80 lacs

1.4 Provision of Referral Transport

Provision of referral transport would be done with support of NGOs/PPP. Funds for the activity will be met through the JSY, CCSP Programme and Rogi Kalyan Samitis at all the facilities

1.5 Integrated Outreach Services

General Performance

In the year 2007-08, outreach RCH camps were proposed for two most remote and underserved blocks in each district between October to March.

Proposal for the year 2008-09

This activity will be continued as per last year norms. Thus 280 camps would be conducted in 140 blocks covering all 70 districts. **Accordingly, total of Rs. 56.00 lacs @ Rs. 20,000 per camp will be required for year 2008-09 for this activity.**

Expected Outcome:

Each camp is expected to provide following outcome:

Sl. No.	Services	Beneficiaries
1	Female sterilization	20
2	NSV	10
3	ANC check up & care	20
4	IUD	10
5	Contraceptive counselling	30
6	RTI/STI	20
7	Child Immunization	20
8	Routine Treatment	50
9	Cataract and eye screening	20
10	Examination and treatment of T.B. cases	10
11	Malaria (Screening and treatment)	10
12	MTP	5
13	Post Natal Care	10

Further, in order to assess the functioning and impact of these RCH camps, it is proposed to undertake an evaluation exercise to study the effectiveness of such camps, extent of coverage of unserved/underserved areas, utilisation by marginalised populations and assess the perceived level of satisfaction of beneficiaries, perception of the community in regard to utility of RCH camps.

Also the reporting arrangements, monitoring arrangements, quality assurance system, and implementation bottlenecks will be analysed and necessary actions would be initiated to improve the efficiency and effectiveness of the camps. It is proposed to hire an external agency / take support of development partners for conducting the study. The budgetary requirement has been incorporated in the 'Monitoring & Evaluation' section.

1.6 Part-time Dais (voluntary workers)

There are 15343 part-time Dais positioned at the Sub-Centres. She is paid an honorarium of Rs. 200/- per month. As per communication received from Govt of India the funds requirement would be met from RCH flexipool. The budgetary requirements have been provided in the section on 'Human Resources'

1.7 Rent and Contingency for Sub-Centres

There are 12930 Sub-Centres in the State that are operating from rented buildings. As per communication received from GoI the funds requirement would be met from RCH flexipool. Accordingly, a provision of rent and contingency for all 20521 Sub Centres has been made under the head 'Infrastructure & Equipment'

1.8 Janani Suraksha Yojana (JSY)

The JSY scheme is being implemented in the State and is covered under NRHM Additionalities. Necessary guidelines have already been sent to the districts and funds are being disbursed regularly. Wide publicity of the scheme is also being ensured through hoardings, pamphlets, bus panels and through print and electronic media.

Establishment of JSY Cell

For maintaining a good reporting system, updation of records, fund management & monitoring it is proposed to establish JSY Cell at the SPMU/ Directorate level. The following contractual manpower would be deployed in the JSY cell:

- Data Entry Operator - 2
- Data Analyst - 1
- Financial Analyst - 1
- Accountant - 1
- Class IV - 1

For complaint redressal:

- Data Entry Operator - 1
- Office Assistant - 1

All expenditure for the above would be met from the 1% allocation for administrative expenses as per GOI norms.

Implementation of JSY

It is proposed to further strengthen the implementation of JSY in the State. The State has already issued instructions for making payments through bearer cheques to all JSY beneficiaries.
A circular has already been issued to retain all JSY beneficiaries at the facility for 48 hours after deliveries and in no case before 24 hours, so as to ensure care for post partum complications, neonatal resuscitation and initiation of colostrum feeding.

A grievance redressal system for JSY is also being established. This would be taken care of by operationalisation of Rogi Kalyan Samitis at the health facilities and facilitation by ASHA. A system of registering complaints at the facilities will be established and regular feedback through monitoring and redressal of complaints would be ensured.

Accreditation of private sector facilities has also been initiated. Guidelines have been prepared and will shortly be disseminated to districts for identification and accreditation of private facilities for provision of JSY benefits.

It is also proposed to establish quality assurance committees in each district for monitoring quality of service deliver under various components including JSY. These quality monitors will also assess the quality of service delivery.

Monitoring

It is proposed to establish a proper monitoring mechanism. This would become effective once the district and divisional PMUs are in place. Each facility would be instructed to maintain a list of beneficiaries to whom reimbursements have been made during the financial year so that monitors visiting the district can follow-up with the beneficiary on a sample basis.

Estimated Number of Beneficiaries for JSY for the year 2008-09

The total number of beneficiaries catered under JSY during the period April 07 to February 08 is 9.09 lac deliveries. It is estimated that by the end of the financial year the total number of beneficiaries under JSY would be around 11 lacs.

Also the bed occupancy rate at District Women Hospitals has increased from 40 % to more than 70% during the last quarter. Further, with the strengthening of facilities and accreditation of private hospitals/medical colleges the number of institutional deliveries is likely to increase substantially.

Accordingly, it is estimated that around 15 lac deliveries would be conducted under JSY during the year 2008-09. The estimation is based on the following:

Expected No. of Deliveries in Urban Area

Expected No. of Deliveries in District Women Hospital (@12 per day x 53 hospitals x 365 days)	232140
Expected No. of Deliveries In Other District level Hospitals (@10 per day x 10 hospitals x 365 days)	36500
Expected No. of Deliveries in Govt. Medical Colleges (@ 10 per day x 9 Colleges x 365 days)	32850
Expected No. of Deliveries in Pvt. Medical Colleges (@ 10 per day x 3 Colleges x 365 days)	10950
Total No. of Expected Deliveries under JSY in Urban Areas (A)	*312440*

Expected No. of Deliveries in Rural Areas

Expected No. of Deliveries in CHCs (@ 100 per month x 426 CHCs x 12 months)	511200
Expected No. of Deliveries In Block PHCs (@ 60 per month x 300 BPHCs x 12 months)	216000
Expected No. of Deliveries in Identified Addl. PHCs with Adequate Infrastructure (@ 10 per month x 1000 APHCs x 12 months)	120000
Expected No. of Deliveries in Identified Sub-Centres with Adequate Infrastructure (@ 8 per month x 4000 SCs x 12 months)	384000
Total No. of Expected Deliveries under JSY in Rural Areas (B)	*1231200*

Total No. of Deliveries (A+B) = 15,43,640

Therefore, the total number of expected deliveries under JSY for the year 2008-09 works out to 15.44 lacs. Accordingly, budgetary requirement for 15 lac deliveries is proposed as detailed ahead.

Budgetary Requirement for JSY for the year 2008-09

Budget head	Physical target			Rate (Rs./Unit)	Annual Amount (Rs. in Lacs)
	Unit of measure	Current Status	Estimated Target		
Implementation of JSY by districts					
(a) Beneficiaries *Home Deliveries (BPL)*	Per Benef.	-	150,000 beneficiaries	500/-	**750.00**
Institutional deliveries i) Urban	Per Benef.		300,000 beneficiaries	1200/-	**3600.00**
ii) Rural	Per Benef.		950,000 beneficiaries	2000/-	**19000.00**
(b) Caesarean Sections	Per benef.	-	100,000	1500/- per case	**1500.00**
Administrative Expenses					
A. At State level	-	-	-	(1%)	**248.50**
B. At District level	-	-	-	(4%)	**994.00**
Total					**26092.50**

Voucher Scheme for Transportation

The District Society / RKS at the block level will identify and accredit transport providers to facilitate transportation to BPL clients. It is proposed to provide vouchers to BPL clients, which will be distributed by ASHA. On reaching a health facility through an accredited private transporter, the driver/owner will be paid Rs.250/- at the health facility by the designated officer from the transportation component of the JSY funds. In this case the transportation amount will not be paid to either the client or the ASHA.

Budget Summary (Maternal Health) 2008 – 09

Sl.	Particulars	Amount (Rs. in lacs)
Maternal Health Interventions		
1	Incentive for Promotion of Institutional Deliveries	415.80
2	Integrated Outreach Camps	56.00
Sub-Total		*471.80*
Janani Suraksha Yojana		26092.50
Sub-Total		*26092.50*
Grand Total		**26966.58**

Procurement of Disposable Delivery Kits (DDKs), Kit A, Kit B and PHC Kits were proposed in the PIP for 2007-08, the approval of which has been received in the month of February 2008. The amount will be utilised in year 2008-09 and no additional budgetary requirement is being made for procurements.

2. CHILD HEALTH INTERVENTIONS

2.1 Comprehensive Child Survival Programme – UP (CCSP-UP)

For the reduction of under 5 mortality and neonatal mortality in particular, specific interventions have already been initiated and are to be implemented in a phased manner. In the first phase (2007-09), 17 selected districts, 1 from each division, have been taken up. The districts have been selected based on the IMR in the district and availability of minimum required infrastructure. Thereafter, in year 2009-10, additional 17 districts will be taken up and by the year 2012 all 70 districts will be covered.

This strategy was launched on 25th April 2007 at the State head quarter by the name of Comprehensive Child Survival Programme – UP (CCSP-UP).

Goals

- To reduce the Infant Mortality Rate from the present level (72 per 1000 live births, SRS 2004) to less than 30 per 1000 live births by the year 2010.
- To reduce the neonatal mortality rate in the pilot area by 50 percent from the existing level

Objectives

- Improve community & family practices for child care
- Improve access to quality institutional child care services
- Empower ASHA & grass root health functionaries in providing essential child care services in community
- Demand generation for quality child care services
- Improve uptake of services

Coverage

17 districts are being covered under the CCSP programme as under:

1. Aligarh	6. Banda	11.Jhansi	16.Moradabad
2. Pratapgarh	7. Faizabad	12.Lakhimpur Kheri	17.Saharanpur
3. Azamgarh	8. Bahraich	13.Kannauj	
4. Shahjahanpur	9. Varanasi	14.Bulandshahar	
5. Siddharthnagar	10.Gorakhpur	15.Mirzapur	

Implementation Plan

Assured Availability of Quality Services

- All CHCs and PHCs will plan self assessed workload for providing specific child care services, for which they will be given specific training and support in terms of equipments, consumables, medicines etc.

- All facilities will be continuously monitored on functional status in terms of availability of critical equipments, medicines, manpower and consumables.
- Services provided and uptake of services.
- Infection prevention practices and waste disposal.
- Client feedback.
- Referral ambulance services are proposed to be operationalised in under NRHM in all the 17 intervention districts to ensure referral. Provision of Rs.50/- for ASHA & Rs. 250/- for the family has been made for each sick child.
- All the functionaries trained on 10 days child survival package will have to make 3 mandatory visits to all the newborns, in their areas. They will have to observe the newborn, help mothers initiate breastfeeding within one hour after birth, weigh the child, counsel the mother for prevention of hypothermia & infection and look for any complications.
- There is provision of special incentive of Rs. 50/- to ASHA after completing 3 mandatory visits to a normal newborn baby & Rs. 100/- after completing 6 visits to all low birth weight babies within first four weeks of life.

Integrated Behaviour Change Communication & IEC

- Monthly village level meeting on health and nutrition day proposed under NRHM will be leveraged for promoting best practices in relation to preventive, promotive and curative child care practices.
- Quarterly meetings at gram panchayat level proposed under RCH-II state PIP as demand generation through gram panchayat will be utilized to involve local leadership in promotion of ownership of comprehensive child survival programme
- Community orientation workshop at each sub centre for community based new born care will be mainstreamed under the child survival programme, the areas of focus will be complete ANC care, Institutional deliveries, promotion of exclusive breast feeding, essential care of new born, timely identification of high risk new born and their timely referral to appropriate facility.
- Age of marriage, nutritional status of mother, care during pregnancy & delivery and gap between two pregnancies have important bearing on child health. These aspects will be part of communication activities.
- Child survival programme will be part of integrated state level multimedia activities.
- Local media activities in relation to wall writings, SHG/other group meetings, film shows, local cable TV, cinema slides and press notes.

Community management of services including facility audit, service audit, social/ death audit

- Under the NRHM Rogi Kalyan Samiti (RKS) are being made functional at district male and female hospitals, CHCs and PHCs. Village health and sanitation committees (VHSC) are involved with maintenance and functionality of sub centres. RKS and VHSCs are involved in maintaining linkages with the community, supervision of health care provided by the facilities, arranging outreach services, monitoring quality of care and getting feedback from service users. Thus they are actively involved in management of facilities with community perspective. A member nominated from the RKS/VHSC will be part of the team conducting death audit of under 5 children and disease burden in the community due to child illnesses.
- It is proposed that ASHA will be required to report every death of child under 05 years of age and it will be the responsibility of medical officer in charge to constitute a team consisting of a medical officer, LHV of the area and elected representative of the panchayati raj nominated by block Rogi Kalyan Samiti to compulsorily carry out death audit on a given format within 07 days reporting of death by ASHA. Rs. 300/- are being provided for each death audit out of which Rs. 50/- will be given to ASHA.

Public Private Partnership

- Private hospitals will be assessed and accredited for capacity to undertake comprehensive child survival training. Selected institutions will be supported by providing training for their staff, training aids, training logistics and other contingent expenditure. Token publicity support will be provided for these institutions. These hospitals will be strengthened accordingly in relation to infrastructure manpower, equipments and other logistics
- NGOs will be selected to facilitate training, supervision and monitoring. They will be made responsible for training management especially transportation, accommodation & food of trainees & other logistics.

Procurement

Assured availability of medicines, consumable and functional equipments are critical to success of programme.

- Equipments and its maintenance will be leveraged from strengthening of PHCs, CHCs and sub centres. Standard list for drug and consumables for SNCUs, CHCs and PHCs will be developed and funds will be provided to maintain the buffer stock at every facility under the programme.
- ANMs are already being provided Kit A and B which contains all the essential medicines for child survival, hence no separate provision is being made for sub centres.

Convergence with other NRHM Interventions

- Comprehensive child survival programme will be dovetailed with strengthening of FRUs / strengthening of health facilities to IPHS standard, sub centre kit, maternal care interventions under RCH-II, strengthening of various training facilities, contraceptive services, adolescent health, nutrition and services under ICDS and IEC activities.
- Routine immunization and PPI will be additional components contributing to child survival programme.
- The child health interventions proposed under state PIP for RCH-II except routine immunization and pulse polio immunization programme will be subsumed under comprehensive child survival programme.
- Integrated IEC for different component of NRHM will have a strong element of child survival programme.

MIS, Supervision and Monitoring

MIS

- Reporting formats will be developed to capture physical & financial progress in terms of training nominations, strengthening of training institutions, training progress, strengthening of health facilities, service delivery, logistics, payments to ASHA, social and death audit, service quality issues, IEC, contribution from private and NGO partner, NGO activities against expected workload.

Supervision and Monitoring

- One retired officer of the system will be trained & made responsible for extensive monitoring & supportive supervision. It will be further strengthened by supportive supervision will be ensured through NGOs active in the field, Self Help Groups, Mothers group, nominated community representative.
- One UNICEF coordinator is already placed in each division will facilitate the different interventions in the district.
- Chief Medical Officer and Superintendent (DWH) will be the district level monitors for the training
- Additional Director (Medical & Health) will monitor the activities at divisional level
- A state level Quality Monitors are proposed to be deployed. They will frequently visit the selected district and monitor the activities including trainings.

Programme Management

- Reporting formats have been developed for the training activities, implementation and supervision
- District, Division and State level monitoring cells will be developed for Data entry, analysis and documentation
- A baseline survey for important indicators is proposed to be carried out through an independent agency.
- Regular monitoring through Govt. and non Govt. sources will be ensured and findings will be evaluated for mid course changes.
- End line survey again through an independent agency is proposed.

2.1.1 Capacity building of health system in public & private sector

It has four major components

- Strengthening of training centres
- Development of training curriculum
- Training of service providers at facility, grass root workers & community
- Strengthening of health facilities

Progress during 2007-08 (as on January 08):

Sl.	Activity	Target	Progress
1	Development of Training Module for CCSP	-	Completed
2	Upgradation of Training Facilities	34	20
3	District ToTs Completed	17	17
4	Training of Medical Officers	612	221
4	Training of ANMs	4000	360 trained
5	Training of ASHAs	9000	2500 trained
6	IYCF State & District Workshops	1+70	1+70 Completed

The trainings for child health could only be initiated in the month of October 07, hence the achievement figures are low as compared to the targets. However, this year the proposed targets would be achieved.

2.1.2 Strengthening of Training Centres

KGMU, Lucknow and IMS Varanasi, BHU had been identified as resource centres for the training purposes in the year 2007-08. These institutions have been

strengthened. KGMU, Lucknow is providing training on facility based new born care and IMS Varanasi is conducting training of State level Trainers. 3 batches of Training of Trainers have been completed.

It is now proposed to strengthen 4 additional medical colleges – MLN Medical College, Allahabad; MLB Medical College, Jhansi; GSVM Medical College, Kanpur and SN Medical College, Agra. These medical colleges will be conducting training courses for Physicians.

An amount of Rs.19.90 lacs were released in 2007-08 for strengthening the Training Centres at KGMU, Lucknow and IMS Varanasi. This year an estimated amount of Rs. 12 lacs (@ Rs. 6 lac per Medical College) is proposed as recurring expenditure.

For the additional 4 medical colleges an amount of Rs.9.95 lacs per unit is proposed for strengthening training infrastructure and towards recurring expenses for nine months. Accordingly, an amount of Rs.39.80 lac is budgeted. Further, it is planned that one medical college would conduct 8 batches of training each year for the physicians training. The estimated cost per batch of training of 10 days is Rs. 2.19 lacs. Accordingly, of the training of physicians by these 4 colleges an amount of Rs. 70.08 lacs is budgeted

Thus, the total amount budgeted for the activity for the year 2008-09 is Rs.121.88 lacs. The funds for training of physicians amounting to Rs. 70.08 lacs have already been received and no additional funds are required. **The requirement for the additional component of strengthening the training institutions and meeting their recurring expenses is Rs. 51.80 lacs for the year 2008-09**

Trainings under CCSP

As has been proposed in the PIP for 2007-08, the ten days training for the functionaries will be continued. The training package has been finalised and trainings have been initiated. The District ToTs have been completed and training of ASHAs and ANMs is in progress.

Three days special clinical training package for district hospitals/CHC/PHC team for facility based care for sick children.

The TOT will be provided at KGMU in batches of 10 participants from each districts consisting of paediatricians & nurses who in turn will train district trainees.

It will be residential training focusing on management of seriously ill, premature, underweight and seriously malnourished children requiring indoor care & management. The training will be given to all the MOs, Staff Nurses & ANMs in the selected 17 districts by the core group.

2.1.4 Job Aids & Tools for ASHAs

To facilitate the ASHAs in their working, it is proposed to provide the ASHA with job aid and tools. These will be developed by a team of experts at the State level, supported by donor agencies. It is estimated that each kit would cost around Rs.150/-. **Accordingly, for an average of 1765 ASHAs per district a sum of Rs.45 lacs has been budgeted for the 17 CCSP districts.**

2.1.3 Procurement of child survival kits for ASHAs

Purchase of child survival kit for ASHA was proposed @ Rs. 1000/kit for 1765 kits per district. Accordingly, a sum of Rs. 300 lacs was budgeted. The approval for procurement has been received recently and the funds will be used in 2008-09.

A child survival kit for ASHA is being proposed @ Rs. 1000/kit. The components of kit are as under:

Contents of the kit

SN.	Item	Rate (In Rs.)
1.	Mucous extractor No. 10 per kit	130.00
2.	Towels - 2 Nos. (medium sized)	50.00
3.	ORS packets (for 1000 ml solution) - 10 per kit	100.00
4.	ORS packets (for 200 ml solution) - 20 per kit	100.00
5.	Cotton wool & Gauze	50.00
6.	Medicine kit	300.00
7.	DDK - 10 per kit	100.00
8.	Digital thermometer (sensitive for low temp.)	20.00
9.	Bag	150.00
Total		**1,000.00**

Cost of Medicine Kit

1	Syrup Amoxicillin/dispersible paediatric tab. 5 nos.	:	Rs.	90/-
2	Syrup Cotrimoxozole/ dispersible paediatric tab. 5 nos.	:	Rs.	60/-
3	Syrup Paracetamol/ dispersible paediatric tab. 5 nos.	:	Rs.	60/-
4	Betadine lotion 100 ml.	:	Rs.	30/-
5	Mercurochrome/gentian violet	:	Rs.	30/-
6	Dettol/Savlon soap - 2 nos.	:	Rs.	30/-
	Total	**:**	**Rs.**	**300/-**

Average Requirement : 1765 kits per district

Total No. of Kits Required : 1765 x 17 = 30,000 approx.

Funds required for these kits : Rs.1000/Kit x 30000 kits = **Rs. 3,00,00,000/-**

The approval for procurement has been received recently and the funds will be used in 2008-09.

2.1.5 Sensitization workshops at state, district and block and PHC levels

For sensitization of service providers, it is proposed to conduct workshops at State, district, block and at the PHCs (30,000 popn.) levels. **Accordingly, a budgetary provision of Rs. 40.70 lacs has been made as under**:

Sl.	Activity	Amount (Rs. in lacs)
1	State Workshop	5.00
2	District Workshops (17 workshops @ Rs. 15,000/- per wkshp.)	2.55
3	Block Workshops (221 workshops @ Rs. 5,000/- per wkshp.)	11.05
4	Workshops at PHCs (30,000 popn.) (1105 workshops (5 per block) @ Rs. 2,000/- per wkshp.)	22.10
Total		**40.70**

2.1.6 Establishment of Special New Born Care Units

It was proposed to establish full fledged special new born care units (SNCU) at district women hospitals. However, to non-availability of human resources, it will not be possible to effectively operationalise full fledged units. It is therefore proposed to provide certain basic minimum equipment, such as, resuscitation table, phototherapy unit, oxygen hood, paddle operated suction apparatus, resuscitation bag & mask, oxygen cylinders, endotracheal tubes and few important medicines at each District Women Hospital where one room can be converted to newborn care unit.

This unit will have at least one paediatrician, 2 medical officers and 6 staff nurses trained in paediatric care. In some of the district women hospitals, such as, Veerangana Avanti Bai Mahila Chikitsalya, Lucknow catering to a large load of pregnant women (Average of around 7000 deliveries annually) already have SNCU units, however, these are not well equipped and there is shortage of manpower. Such units, wherever available, would be strengthened on priority basis. Further, operationalisation of the units would be done in a phased manner.

During 2008-09 it is proposed to establish 4-5 such units. In the PIP for 2007-08, an amount of Rs.447.18 lacs for 17 units was proposed @ Rs. 15.8 lacs towards non-recurring expenses and Rs. 10.5 lacs as recurring expenses per unit, the sanction for which was received in the month of February 2008. However, during the year 2008-09, it is proposed to establish only 5 units, in view of the manpower constraints. In the PIP for 2007-08, an amount of Rs.447.17 lacs was budgeted. The sanctioned has been received in Feb. 2008. **Thus, the amount will be utilised in the year 2008-09, and no additional amount is required this year.**

2.2 Infant & Young Child Feeding (IYCF)

2.2.1 Promotion of colostrum feeding and early initiation of breastfeeding

Breastfeeding provides the best health benefits when started immediately after an infant's birth, continued exclusively (without introducing other foods, liquids, or water) for the first six months of life, and then continued along with suitable complementary feeding through age two or longer. Feeding infants colostrum during the first days after childbirth-as early as possible is important for a newborn's health. Colostrum contains high concentrations of carbohydrates, protein, and antibodies (acting like a vaccine to prevent infections) and will not irritate the newborn's intestines, as other liquids will.

It is therefore proposed to promote colostrum feeding and initiation of breastfeeding within one hour of birth. Social Behaviour Change Communication (SBCC) activities carrying messages promoting exclusive breastfeeding, appropriate complementary feeding and nutritional management during child's sickness will be conducted through various media channels.

Grassroot functionaries, such as, ASHA, AWW and ANMs who serve women in health care facilities and in communities will be trained in promoting appropriate breastfeeding practices. They will advise women on optimal breastfeeding, on the dangers of first giving the newborn liquids other than colostrum and of complementary feeding before six months and on dealing with discomfort or difficulties while breastfeeding.

A provision of incentive to ASHA for ensuring colostrum feeding and initiation of breastfeeding within one hour of birth has been incorporated in the incentive scheme for ASHAs. She would be paid Rs.50/- per child for the activity.

It is also proposed to promote breastfeeding through home based peer counsellors. Peer counsellors will be local mothers who will be trained to promote breastfeeding. During their visits, the counsellors will answer the mothers' queries and offer advice on the position of the baby during feeds and on nutrition and rest for the mothers. They will encourage exclusive breastfeeding and even counter family pressure to introduce early supplementary feeding. This activity will be implemented with support of NGOs and development partners working in the State.

2.2.2 Sensitization Workshops on IYCF

It was proposed to carry out State and District level workshops for promoting Infant & Young Child Feeding during the year 2007-08. The activity was conducted as proposed. It is now planned to expand the activity up to block and PHC level (30,000 popn.). Additionally, intensive IEC/BCC activities are planned through mass media and with support of civil society organizations. Brochure/pamphlets for sensitising service providers on initiation of early breastfeeding, exclusive breastfeeding and appropriate complementary feeding will be developed and distributed among service providers. Further, counselling by trained SBAs will be conducted. Mothers will be persuaded to stay at health facilities for 48 hours to ensure initiation of breastfeeding and perinatal care for improving child survival. The budgetary requirement for development of communication material would be met from the allocation under IEC/BCC. Circulars and guidelines will be issued to all CMOs, Addl./Dy. CMOs, Medical Officers to ensure effective implementation of the activities and 48 hours post delivery stay in the institution. Monitoring will be done through state and division level for the whole activity.

A training curriculum has been developed by BPNI for promotion of appropriate breastfeeding and complementary feeding practices. It is proposed to conduct training of Medical Officers, Staff Nurses, ANMs of public, as well as, private facilities with support of State BPNI. The training would be for duration of 3 days (2 days classroom & 1 day clinical). District level trainers would be developed for conducting the trainings in each district. The component of breastfeeding is included in the Integrated Skill Training, Skill Up-gradation trainings for MOs, Supervisors and grassroot functionaries, ASHA training and in CCSP training packages. Hence, no additional budgetary provision is being made.

Budgetary Requirement

Sl.	Activity	Amount (Rs. in lacs)
1	Development of Information Booklet & IEC Material	2.00
2	Printing of Booklet (3 lac copies @ Rs. 10 per copy) & IEC Material	35.00
3	State & District level workshops	40.00
4	Workshops at PHCs (@ Rs. 2,000/- per PHC for 3000 PHCs)	60.00
5	Promotion through mass media	50.00
6	Development & production of display boards for DWH, CHC & BPHC (2 each for 1262 facilities @ Rs. 1000 per set)	12.62
Total		**199.62**

A total budget of Rs. 199.62 lacs has been budgeted for IYCF activities for the year 2008-09

2.3 Management of Other Childhood Diseases

Diarrhoea

Management of diarrhoea has been included in the CCSP package. Further, Zinc tablets to be given 20mg/day for 14 days in case of persistent diarrhoea (on IMNCI lines). This will be implemented in 17 selected districts under CCSP-UP and scaled up in a phased manner. The requirement of zinc tablets and ORS for management of diarrhoea cases would be met from Kit A supplied to all 70 districts.

2.4 Addressing Undernutrition

2.4.1 Bal Swasthya Poshan Mah (BSPM) – Strategy for Addressing Micronutrient Malnutrition

A biannual strategy (fixed months six months apart – June and December) was developed and launched in the State jointly with ICDS. The strategy has proved effective and it is proposed to strengthen and ensure implementation in the entire State in an effective manner. Biannual vitamin A supplementation (VAS) along with intensive promotion of exclusive breastfeeding, complementary feeding, iodised salt consumption and referral of severely undernourished children will be organised in the two fixed months. These activities are linked to village wise routine immunisation sessions organised as per the immunization/outreach sessions microplan of ANM.

Detailed guidelines for implementation have been developed, clearly specifying the role of Health and ICDS. Since the strategy is implemented with support from ICDS, joint planning and dissemination meetings of Health and ICDS functionaries are required to be conducted at the State and district levels before and after each biannual round.

Requirement of vitamin A syrup would be ensured through Kit A and additional requirement of vitamin A would be met from state budget/donor agencies.

The budgetary requirement for the same is as under:

Sl.	Activity	Amount (Rs. in lacs)
1	Joint planning meeting of Health and ICDS Officers at State level (Rs. 25,000- per meeting x 2 meetings/year)	0.50
2	Printing of BSPM guidelines, reporting and monitoring formats	6.00
3	Joint planning meeting of Health and ICDS functionaries at District level (Rs. 5,000- per meeting x 2 meetings/year for 70 districts)	7.00
4	Dissemination Meetings at District level (Rs. 5,000- per meeting x 2 meetings/year for 70 districts)	7.00
Total		**20.50**

Accordingly, a budgetary provision of Rs. 20.50 lacs is being made

Further, as per Govt. of India policy regarding micronutrients - Iron & Folic Acid, children between 6 – 60 months have to be included in the programme as there is sufficient evidence that iron deficiency affects this age group also. Iron syrup/paediatric tablets are being provided in Kit A and supplementation needs for this age group will be met through this supply.

2.4.2 Pilot for Addressing Undernutrition in Selected Districts

It is proposed to carry out interventions in 20 vulnerable districts having poorest nutritional indicators. These districts have been identified on the basis of the percentage of severely undernourished female children, according to a study conducted by NIN and IASDS in 2004. The districts proposed to be covered are as follows:

Banda*	Fatehpur*	Badaun	Hamirpur*	Rae Bareilly*
Hardoi*	Aligarh*	Sultanpur	Bulandshahr*	Muzaffarnagar*
Varanasi	Pratapgarh	Bareilly	Rampur*	Basti
Gonda	Azamgarh*	Mainpuri*	Lalitpur	Barabanki*

** Proposed ICDS-IV districts*

Proposed Strategy

- Linkages to be developed between ICDS workers and health workers for timely diagnosis of malnourished children and their management.
- All the ANMs and AWWs to be trained for counselling regarding quality nutrition.
- IEC to be developed and disseminated to the community regarding food and nutrition.
- Establishment of nutrition rehabilitation corners at selected CHCs for management of cases of severely malnourished children
- Biannual strategy being implemented in close coordination with Unicef (BSPM) will be continued in the project period for timely identification and management of malnourished cases.
- Awareness campaign will be organized to sensitize the community regarding importance of balanced diet and importance of proper & adequate nutrition
- The Medical Officers at BPHC and CHC will be trained to manage the cases of moderate to severe malnutrition. This component has been included under facility based newborn care training under CCSP to be conducted by Paediatric Dept. KGMU, Lucknow.

- For proper management of malnourished cases, medicines and provision of supplementary nutrition will be made. It is estimated that on an average there would be around 10 cases per month at the identified facilities, these children would be provided with cooked meals, medicines, nursing care, etc.
- Involvement of developmental partners for monitoring and facilitating implementation.

Budgetary Requirement

Sl.	Description	Amount (Rs. in lacs)
1	Orientation Workshop at State and District Level (Rs. 2.0 lacs for State Workshop and Rs. 5000/- per District for 20 districts)	3.00
2	Development of Training and Local Resource Material for Feeding Demonstrator on Management of Severe Malnutrition	1.00
3	2 days Training of Medical Officers, Nurses & Feeding Demonstrators (25 persons per batch x 20 batches @ Rs. 25,000 per batch)	5.00
4	Programme Management Support at CHC @ Rs. 30,000/- per CHC per year	6.00
5	Contingency for medicines, dietary supplementation @ Rs. 4000/- per month per CHC for 20 CHCs	9.60
6	Funds to CHC for Referral to Tertiary Centres @ Rs. 5000/- per year per CHC	1.00
7	Operational Support (incl. Monitoring) to Programme through nearby Medical Colleges @ Rs. 10,000/- per year per CHC	2.00
Total		**27.60**

2.5 Strengthening School Health Programme

In the PIP for 2007-08, it was proposed to initiate bi-annual heath checkups in junior schools (classes 1 to 5). 100 schools were identified in underserved and remote rural areas & urban slums in each district for this activity. The activity is now proposed to be taken up in a campaign mode. A 'School Health Week' would be conducted during a fixed week in each quarter. Thus, 4 rounds of activity would be conducted each year. It is expected that each PHC would be able to conduct 2 visits to at least 10 schools in its jurisdiction each year. Thus, about 36,000 schools would be covered in the State each year under the school health programme.

The objective of the programme is to conduct medical examination of school children for early detection of anaemia, nutrition disorders, worm infestations, eye screening, dental caries, on site treatment for common illness (prophylactic administration of vitamin A, etc.) and referral of children requiring detailed examination & treatment.

The Medical Officers of Primary Health Centres and the paramedical staff shall constitute school medical teams and visit the schools in their area on a

predetermined definite programme under advance intimation to the school authorities. It is also proposed to rope in private practitioners, through associations like IAP and IMA during the campaign.

The team will provide health care check-up to each student at least twice a year. Height & weight measurements, eye screening and deworming (biannually) would be conducted. Students who require specialised treatment will be referred to health facilities where they can obtain treatment.
The students studying in higher classes will be identified to work as "Health Guides". These students will also identify the students with health problems and bring to the notice of the teachers, doctors and the visiting paramedical teams.

A Health appraisal register will be maintained at each school for recording different health status and morbidity conditions of the students examined.

The Block MOIC would prepare a plan for coverage of the schools in his area in coordination with education department officials. The Medical Officer of the Addl. PHC will be responsible for visiting all the schools under his jurisdiction in a year's time. An annual calendar of visits will be prepared in advance along with necessary logistics for procurement and transportation of supplies. Village level functionaries like, ASHA, AWW and Shiksha Mitras will support as per actual need. The report of such visits will be submitted to the VHSC, Education Department and Block PMU. The respective Block Officers will compile their report and send it to the District PMU where the district report would be compiled.

Provision of referral cards, health register and supply of deworming tablets would be ensured.

Sl.	Description	Amount (Rs. in lacs)
1	Procurement of Deworming Tabs. (1 tab. six monthly) @ Rs. 4/- per child for 72 lac children	2.88
2	Mobility to health team @ Rs. 100/- per schools x 36,000 schools x 2 visits per school	144.00
3	Printing of 3.50 lac referral cards @ Rs. 1/- per card	3.50
4	Printing of Registers, Height-Weight Charts, Eye Screening Cards (@Rs.500/- per school for 36,000 schools)	180.00
Total		**330.38**

2.6 IFA Supplementation for School Children

A School Health Programme as described above will be put into place, wherein apart from health check-ups biannual deworming would also be carried out. Further, in view of the poor nutritional status of children it is proposed to provide children (6-10 years) IFA supplementation in line with the Government of India

policy regarding micronutrients. Each child would be provided 30 mg elemental iron and 250 mcg folic acid per day for 100 days in a year.

Senior school children acting as 'Health Guides', NSS groups, as well as, ASHA will be involved in distribution and ensuring consumption of IFA supplement by school children twice a week. Detailed guidelines for implementation including coordination with the education department are being developed for the purpose. It is proposed to link the scheme with midday meals and also involve Village Education Committees (VECs) to ensure proper monitoring and implementation.

The budgetary requirement for procurement of IFA tablets is as follows:

Sl.	Description	Amount (Rs. in lacs)
1	Procurement of IFA Tabs. (30 mg elemental iron and 250mcg Folic Acid) @ Rs. 20/- for 100 tabs per child for 72 lac children	1440.00
Total		**1440.00**

2.7 Pilot for Addressing Malnutrition in Girl Child (Conditional Cash Transfer)

Despite improvements over the last two decades, child malnutrition remains a serious health problem in developing countries, and is the main contributor to child mortality. With a view to tackle the menace of undernutrition, as also to promote healthier girl child, given the skewed sex ratio in most of the districts of Uttar Pradesh, sincere efforts are needed to support the poor households in ensuring adequate nourishment to the girl child. Poverty alleviation programs over the years have taken a variety of forms. Social welfare programs provide transfers in cash and kind to people with incomes and assets below a specified level in most countries. Accordingly, under NRHM it is proposed to pilot a Conditional Cash Transfer (CCT) to those BPL households, who ensure that they have adequately maintained the nutritional status of their girl child/children for the first two years.

A district wise index of the nutritional status of girls, based on Gomez Grades, has been used to identify one district each from the Bundelkhand and Eastern regions of Uttar Pradesh for the CCT scheme. These regions face the gravest challenge in ensuring good health to the children on account of their economic backwardness resulting from factors, such as, inhospitable terrain and frequent exposure to natural calamities like, floods and drought. The two identified districts in these regions are Banda and Sonbhadra.

Implementation Modalities

The BPL households in the districts will be identified on the basis of their ration cards or the list available with the Gram Panchayats. ASHA will be the functionary

responsible for facilitating the scheme, by keeping track of the girls born in her catchments and bringing them to the health facility for annual growth check-ups for ascertaining their nutritional status. An amount of Rs.25/- will be payable to her as an incentive for her efforts, if the girl's nutritional status is found to be satisfactory. Similarly, the parents of the girl will receive Rs.100/- as incentive. Both these amounts will be payable one time at the completion of one year. On completion of 2 years of age, the eligible beneficiary will be paid a sum of Rs.500/- and ASHA would receive an amount of Rs.50/-. For being eligible for payments under the scheme, the girl child should weigh 10 kgs at the end of 1 year and 12 kgs at the end of 2 years. The parents will also be required to produce the following documents at the time of weight measurement.

a) The Birth Registration Certificate of the girl;
b) The Immunization Card of the girl with complete immunization against the six Vaccine Preventable Diseases (VPDs).

In the absence of these documents, even the ASHA will not receive any payments because the availability of these documents with the beneficiaries is one of her responsibilities.

The payment would be made at the Block PHCs after due verification of document and proper weighing. A register of details of the beneficiaries to whom payments are made would be maintained at the BPHC. Sample verification of 10% of cases would also be ensured through visits of PHC Medical Officers, Supervisors, NGOs. Publicity of the scheme would also be ensured through a proper publicity plan prepared in consultation with district officials. Support of SIFPSA / development partners working in these districts would be taken for the activity.

Expected Number of Beneficiaries

Based on the population figures of Census 2001, the expected number of beneficiaries in the two districts works out to around 1.46 lacs. Detailed figures are presented in the table below:

Expected No. of Beneficiaries for Conditional Cash Transfer Scheme (Y2008)

District	Population (2001)	Expected Popn. (2008) @ 2.05% annual growth rate	Sex Ratio (2001)	Expected No. of Girls	Expected No. of BPL Beneficiaries (@ 30% of total popn.)	Expected No. of Beneficiaries for CCT (30% of Total BPL Population)
Banda	15,37,334	17,71,982	860	8,19,304	2,45,791	74000
Sonbhadra	14,63,519	16,86,900	898	7,98,123	2,39,437	72000

Annual Budgetary Requirement

The annual budgetary requirement for the scheme works out to Rs. 182.50 lacs which would be met from NRHM Additionalities. The details are presented hereunder as-

SN	District	Expected No. of Beneficiaries for CCT	Cost @ Rs.125/- per Beneficiary
1	Banda	74,000	92.50 lacs
2	Sonbhadra	72,000	90.00 lacs
Total Cost Per Annum			**182.50 lacs**

Budget Summary (Child Health): 2008 – 09

Sl.	Particulars	Amount (Rs. in lacs)
Child Health Interventions		
1	Programme Implementation (Payment to ASHAs @ Rs.2000/- per year x 30,000 ASHAs)	600.00
2	Sensitization Workshops	40.70
3	Infant death audit	17.00
4	Promotion of Infant & Young Child Feeding (IYCF)	199.62
5	Implementation of *Bal Swasthya Poshan Mah*	20.50
6	Pilot for management of severely malnourished children	27.60
7	School Health Programme	327.50
8	Conditional cash transfer scheme for addressing undernutrition in girl child upto 2 years of age	182.50
9	Supervision of ASHAs through NGOs (Rs.300 per ASHA x 30,000 ASHAs)	90.00
10	Baseline survey & documentation	35.00
Sub-Total		*1540.42*
Training		
1	Strengthening of training institutions	51.80
2	Job Aids & Tools for ASHA	45.00
Sub-Total		*96.80*
Procurement		
1	Deworming Tablets for School Children (6-10 years)	2.88
2	IFA Tablets for School Children (6-10 years)	1440.00
Sub-Total		*1442.88*
Grand total		**3562.60**

3. FAMILY PLANNING

General Performance

Population stabilization strategy is enunciated in UP population policy 2000. However, implementation is has not been consistent as planned. RCH-II program is aimed at lowering population growth by reducing Total Fertility Rate (TFR) from 3.8 to 2.8. Current TFR is 3.8 (NFHS-III).

As per NFHS-III CPR due to modern method is 29.3%, sterilization 17.5%, spacing methods 11.8%. There has been a marginal decline in unmet need due to sterilization from 13.6% to 12.6% and in spacing methods from 11.8% to 9.3%.

The main gaps have been in the area of sterilization performance against set objectives which is declining since last 2 years.

The various reasons for declining sterilization performance are as under:-

- Non availability of skilled service providers in adequate numbers.
- Non availability of functional laparoscopes in adequate numbers.
- Additional spacing choices to rural clients.
- Increasing litigations.
- Limited number of facilities providing daily services.
- Revised norms for service providers of laparoscopic sterilizations as per Hon'ble Supreme Court orders.

Total budget of Rs. 3181.68 was approved in the PIP for the year 2007-08 against the proposal of Rs. 7261.68. The approval for the budget of Rs. 4080.00 lacs for compensation package for sterilization (Male and Female) has been received recently.

3.1. Terminal/Limiting Methods

3.1.1. Dissemination of manuals on sterilization standards & quality assurance of sterilization services

An amount of Rs. 28 lacs was budgeted for conducting dissemination workshops. Guidelines and funds for the same have been sent to the districts and the activity would be completed in the year. Hence, no further budgetary provision is required this year as the activity would be completed.

3.1.2. Prepare operational plan for provision of sterilization services across districts (including training, BCC/IEC, equipment, drugs and supplies, etc.)

The development of district level work plan for providing sterilization services has been prepared and incorporated in specific District Action Plans (DAPs). Hence, no budgetary provision is required for the activity.

3.1.3. Implementation of sterilization services by districts

3.1.3.1. Provide female sterilization services on fixed days at health facilities in districts

It is proposed to provide fixed day services in at least 3 facilities in every district, including the district female hospital/combined hospital/PPC and at 2 FRUs. In case there in only one functional FRU, a CHCs having either a surgeon or gynaecologist or an LMO would be selected for providing sterilization services (ligation/abdominal tubectormy) on two fixed days. Preferably, Tuesdays and Fridays would be fixed for such services. However, any other day may be fixed as per suitability in consultation with the CMO. Wide publicity of the fixed days would have to be ensured through wall painting, leaflet, brochures, etc. In case any of the service providers are untrained, they would be trained on female sterilization techniques.

A separate register would be maintained to record number of sterilizations conducted on fixed days, including the details of clients and the surgeon conducting the sterilization.

It is expected that there would be around 84,000 sterilization cases in these facilities during the 2008-09. Rs. 50.00 per sterilization would be provided for infection prevention materials, gloves, suture & other consumables. Other support will come from sterilization subsidy.

Accordingly, total Rs. 42 lacs will be required for year 2008-09 for this activity.

3.1.3.2. Provide NSV services on fixed days at health facilities in districts

3 facilities in each district including district male hospital/combined hospital and FRUs/CHCs will provide fixed day NSV services at their facility.

Preferably, Tuesdays and Fridays would be fixed for such services. However, any other day may be fixed as per suitability in consultation with the CMO. Wide publicity of the fixed days would have to be ensured through wall paintings, hoardings, distribution of leaflets, etc. In case any of the service providers are untrained, they would be trained on NSV techniques at the earliest.

A separate register would be maintained to record number of sterilizations conducted on fixed days, including the details of clients and the surgeon conducting the sterilization.

It is expected that about that there would be around 10,000 NSVs during the year 2008-09. Rs.50.00 per NSV will be provided infection prevention materials, gloves, suture & other consumables. Other support will come from sterilization subsidy.

Accordingly, total Rs. 10.50 lacs will be required for year 2008-09 for this activity.

3.1.3.3. Organize sterilization camps in districts

As per the revised compensation package for sterilisation Rs.10/- per case is available to be used for camp arrangements. Hence, no separate budget is required for this activity.

3.1.3.4. Organize NSV camps in districts

Male participation is critical to success of population stabilization efforts. With the availability of NSV services, a new opportunity can be explored for improving the male participation in population control. Govt. of India has developed a scheme to promote NSV services in the community. A detailed guideline for camp planning, human resources, IEC, service delivery and training service provider is available for implementation. A package of Rs.1,67,250.00 for each camp has been approved by Govt. of India.

It is proposed that 2 NSV camps per district will be organized between October and March. It is expected that 50 NSVs will be performed in each camp and thus 140 camps will be organized in the state during the year and 7000 NSVs will be performed in these camps.

Total of Rs 234.15 lacs will be required for organizing these camps in year 2008-09.

3.1.3.4 RCH Camp at Block PHCs/CHCs

It is proposed to organize 18 camps each year (1 camp each month from April to Sept. and 2 camps/month in each block during Oct. to March) as per the existing norms. Accordingly, a sum of Rs. 666.63 lacs has been budgeted for organising 18 camps/year in each of the 823 blocks @ Rs.4500/- per camp.

Cost

Over and above current level of support available to sterilizations services from GOI under FW program, following support will be required for conducting each RCH camp.

At MOI/C- PHC/CHC level

• Mobility for IEC	Rs.	50/-
• Camp Arrangement	Rs.	300/-
• Refreshment	Rs.	250/-
• Transportation to Sterilization clients	Rs.	750/-
• Administrative/communication cost	Rs.	50/-
• Soap detergent Kerosene oil	Rs.	100/-
• Miscellaneous	Rs.	100/-
• Reagents and consumables	Rs.	300/-
Sub-Total (A)	**Rs.**	**1900/-**

At CMO Level

- Mobility for surgical team — Rs. 700/-
- Medicine
  a) Anaemia & worms, IFA
  b) General Medicines
  c) RTI/STI — Rs. 1050/-
  d) Xylocaine 1%, Inj. Pentazocine /Inj. Phenargan, Inj. Atropine etc.
- Follow up cards for Ster. clients/adm.cost/comm.cost — Rs. 200/-
- Other consumables
  (surgical gloves, bleach, sutures, antiseptics (chlorohexadiene soln.), dressing material, reagents, syringes & needles, pregnancy test kits, etc) — Rs. 650/-

Sub-Total (B) — Rs. 2600/-

Total Cost per Camp (A+B) : Rs. 4500/- .

Therefore, total cost for conducting the camps in 823 blocks during the year 2008-09 will be Rs. 666.63 lacs.

Thus, the total budgetary requirement for the activity for the year 2008-09 is Rs.663.63 lacs.

3.1.3.5. Compensation for female sterilization

Upto December 2007, around 2.16 lacs sterilisations were performed. It is estimated that in the year 2008-09 around 3 lacs sterilisations would be performed.

Accordingly, as per the GOI approved compensation package an amount of Rs.3000 lacs @ Rs 1000/- per sterilization would be required for year 2008-09.

3.1.3.6. Compensation for male sterilization

Around 1201 male sterilizations were performed upto December 2007, the performance objective for year 2008-09 is proposed at 10,000. For which compensation package at GOI approved rate of Rs 1500/- sterilization.

Accordingly, Rs. 150 Lacs are proposed for year 2008-09

3.2. Spacing Methods

3.2.1 Implementation of IUD services by districts.

IUD services will be continued to be provided. During the year 2007-08, around 12.52 lacs IUD insertions were conducted and it is expected that around 15 lac clients would have been served. Accordingly, in the year 2008-09 about 20 lac clients are targeted to be reached. Therefore, as per the Govt. of India approved package of Rs. 20/- per client the budget required would be Rs. 400 lacs.

3.2.2 Provision of IUD services at health facilities in districts

Daily IUD 380-A services are being provided in 70 district women hospitals/PPC 426 CHCs and 397 block PHCs. For these counselling services, IUD kits, client cards, IEC, infection prevention, follow-up services and other consumables will be provided. For these activities Rs.50,000 per unit will be required for District Hospitals/PPCs, Rs.20,000/- for CHCs and Rs.15,000/- for BPHCs.

Sl.	Facility	No. of Facilities	Allocation Per Facility	Total Amount (In Lacs)
1	District Hospitals/PPCs	70	50,000/-	35.00
2	CHCs	426	20,000/-	85.2
3	BPHCs	397	10,000/-	39.70
Total				**159.90**

Accordingly a total need for the year 2008-09 will be 159.90 lacs.

3.2.2.2. Organize IUD camps in districts.

Like previous year monthly fixed day IUD 380-A camps will be organized at select 7000 sub-centres. Rs. 500 per camp will be required for camp arrangement as approved in RCH-II PIP for the state.

Accordingly a total need for the year 2008-09 will be 420.00 lacs.

3.3. Other strategies/activities

To achieve objective of population stabilization, it is proposed to involve private sector providers. It is proposed that private nursing homes or hospitals will be identified in each district particularly in the rural area if available, and geographical area of block attached to these institutions/providers for providing these services.

A mapping exercise will be carried out by the DPMU & the district nodal officer regarding provision of clinical contraceptive services and its uptake, further, a databank of private institutions and providers incorporating district wise details will be prepared. Private providers who wish to get themselves accredited will be identified during the mapping process and training needs will also be assessed and subsequently addressed. The identified facility will be accredited for provision of services through a standard checklist in terms of infrastructure and skills required. A checklist has already been developed and made available to the districts for the same.

For sterilisation, as per GoI scheme the private provider/facility will be paid Rs.1300/- per male sterilization and Rs. 1350/- for each female sterilization.

Further, Rs.200/- per male sterilization and Rs.150/- per female sterilization will be paid to the motivator.

For IUD insertion the accredited provider/facility will be paid Rs. 75/- (inclusive of cost of IUD) per case.

An amount of Rs. 50 lacs is being budgeted for the year 2008-09 for providing sterilisation and IUD services through private providers.

3.4 Procurement & Maintenance

In the PIP for 2007-08 procurement of Single Puncture Laparoscopes/ Laparocators, Double Puncture Laparoscopes, Double Puncture Training Laparoscopes, NSV kits and IUD insertion kits was proposed to be met from NRHM Additionalities as follows.

Sl.	Item	Quantity	Estimated Unit Cost per	Total Amount (In Lacs)
1	Single Puncture Laparoscope/Laparocators	1224	4.00 Lacs	4896.00
2	Double Puncture Laparoscope	140	4.50 Lacs	630.00
3	Double Puncture Training Laparoscope	38	5.50 Lacs	209.00
4	NSV kits	200	600.00	1.20
5	IUD Kits	5000	3000.00	150.00
Total				**5886.20**

The approval for procurement has been received in February 2008. However, since no procurement would be possible during the current financial year, procurement of these equipments will be done during the year 2008-09 and the sum of Rs.5886.20 lacs is being accordingly budgeted under NRHM Additionalities.

Further, around 400 Laparoscopes/Laparocators are in repairable condition. It is proposed to get these repaired for which an estimated cost of Rs.189 lacs is being budgeted. Further, for annual maintenance of 450 Laparoscopes around Rs.30 lacs would be required. Thus, a total of Rs.219 lacs would be required towards maintenance and repairs of Laparoscopes/Laparocators.

The budgetary requirement of Rs. 219 lacs for maintenance and repairs of Laparoscopes/ Laparocators has been provisioned under the section ‘Infrastructure & Equipment’.

3.5 Comprehensive Family Planning Service Plan

In order to achieve the objective of the year and address the bottleneck in the service delivery of family planning services following comprehensive family planning service plan is proposed. Focusing on the large unmet need and demand from the population, there is need to plan for both terminal and spacing method by which they can be substantial increase in Contraceptive Prevalence Rate (CPR). For the purpose of conducting various trainings, it is proposed to develop and strengthen 17 District Women Hospitals at Divisional headquarters as state of the art training sites which would be used for providing clinical trainings to various service providers in the State.

a. 17 Divisional district women hospitals/PPC will be strengthened to conduct all types of training.
b. Suitable existing room will be renovated or if necessary extension or a new training hall will be constructed.
c. Necessary equipments along with other training materials like tables, chairs, Blackboard, computer, LCD, screen and Video conferencing system etc. will be installed.
d. Qualified doctors & paramedical staff of 7 divisional Headquarter Women/PPC hospitals will be trained to conduct Laparoscopic trainings, for Abdominal Tubectomy 3 divisional HQ doctors/Paramedics will be trained. For IUCD doctors & paramedics of all the 17 DWH/PPC will be trained in these training centres.

Proposal for the year 2008-09

At present, FP services are offered on daily basis at 43 district women hospitals. At rest of the facilities (CHC/BPHCs) these services are provided through camp approach (Sterilization camps/ through RCH Camps), which is different from the fixed day approach where the service provider is placed at facility itself and every service is offered on weekly or bi-weekly basis, thus, making it more convenient for clients for availing the services. The facility fixed day approach is also cost effective, in view of the additional expenses that are incurred in organising camps, ensuring mobility of providers and IEC activities. It also helps in addressing the large unmet need of the population.

However, ensuring availability of services at the facilities is constrained because of shortage of trained service providers. At present there are about 150 trained providers available to provide abdominal Tubectomy (Minilap) and about 200 trained service providers in Laparoscopic sterilization. Further, because of the Supreme Court ruling laparoscopic service providers are limited, therefore there is need to focus more on abdominal tubectomy (including both interval and post partum). Also because with the increase in institutional delivery more demand is expected to come (through JSY) for postpartum abdominal tubectomy.

A district wise databank of trained service providers is being developed. This will be utilised to assess additional training needs with a view to provide at least 1 sterilisation provider at CHCs/PHCs and IUD provider at all the health facilities. The training needs will be reflected in the District Health Action Plans.

Proposal for Abdominal Tubectomy Training

Initially it is planned to make tubectomy services available at all FRUs and all the district women hospitals in a phased manner.

For abdominal tubectomy induction training, one medical college (SN Medical College, Agra) and 3 district women hospitals, namely Jhansi, Varanasi and Gorakhpur will be used as training sites where abdominal tubectomy is popular. It is proposed to train 140 medical officers across 70 districts. It is also proposed to train 140 district monitors, two for each district, who would act as district resource and act as mentors for new inductees.

For the purpose of trainings it is also proposed to strengthen the training sites. The budget details have been ahead.

Proposal for Laparoscopic Training

Abdominal tubectomy (Minilap) is a popular method of sterilization in 15 districts, it is therefore proposed to conduct laparoscopic trainings in 55 districts. For laparoscopic sterilization training, initially 3 medical colleges (Lucknow, Kanpur & Meerut) and 7 district women hospitals at divisional headquarters will be strengthened to provide the training. It is proposed to train 70 medical officers, fulfilling the criteria for laparoscopic training. It is also proposed to train 55 district monitors, one each for 55 districts, who would act as district resource and act as mentors for new inductees.

For the purpose of trainings it is also proposed to strengthen 7 District Women hospitals and 3 Medical Colleges as training sites including physical strengthening, facility for teleconferencing, training job aids, etc. The budget for the strengthening has been incorporated ahead.

Proposal for IUD Training

IUD services are offered in integrated manner on day to day basis upto the level of BPHCs. They are also offered on camp basis at 7000 sub centres (1 camp/month) which are in Govt. building. However, these services are not offered regularly at PHC level.

Repositioning IUD 380A

A pilot for repositioning IUD 380A was proposed in the PIP for 2007-08 and was planned to be implemented in 3 districts for which a budget of Rs. 27 lacs was proposed. The State level workshop and trainings have been completed and the

activity is being implemented in the three districts. It is now proposed to expand the activity to cover 14 additional districts.

Considering the large number of ANMs in the districts and in view of their client load and time involved in travelling and the convenience of motivating clients for IUCD insertion at their own facilities, it is proposed to conduct on site training by mobile team of trainers (team of 6 retired doctors/ PHNs per district). The trainer trainee ratio will be 2:4.

As an alternative arrangement a set of mannequins will also be provided to the mobile team for more hands on practice to trainees.

For the purpose of trainings it is also proposed to strengthen 4 additional training sites (CHCs/PHCs) other than the DWHs in 7 districts. Further, provision of facility for teleconferencing, training job aids, etc. would be made. The budget for the strengthening has been provided ahead.

Further, it is proposed to procure mannequins (female pelvic models) for training on various family planning techniques. At least 90 models would be required for this purpose. The estimated cost of each mannequin is Rs. 40,000/-. Accordingly, an amount of Rs. 36.0 lacs is being budgeted for the purpose. The budgetary provision has been incorporated under the section on 'Training'.

Proposal for NSV Training

To address the need for NSV, which is the simplest method of sterilization, it is proposed to train one provider in each district during NSV camps. There would be sufficient client load in these camps which provides opportunity to provide training to the service providers. The State Training Resource Centre – CSMMU, Lucknow will coordinate the training activities.

The details of the various trainings are shown in the table ahead.

Type of Service	Institutions providing fixed day/camp services			No. of trained providers available	Total No. required	Gap in No. of trained service provider	No. to be trained in 2008-09
	District Hospital	CHC/Block PHC	SC				
Abdominal Tubectomy (ML)	15 (Fixed day)	22 (On camp basis)	-	200	492	292	140
Lap. St.	43 (Fixed day)	426 (On camp basis)	-	300	492	192	70
IUD	53	426	7000	8000	9000	1000	1000

The budget for the trainings has been incorporated in the 'Training' section.

Budget Summary (Family Planning): 2008 – 09

Sl.	Description	Annual Amount (Rs. Lacs)
Family Planning Interventions		
1	Provision of female sterilization services on fixed days	42.00
2	Provision of NSV services on fixed days	10.50
3	NSV Camps in Districts	234.15
4	RCH Camps at BPHCs / CHCs	666.63
5	Implementation of IUD services	400.00
6	Provision of IUD services in districts	159.90
7	IUD Camps in districts	420.00
8	Family Planning services through private providers	50.00
Sub-Total		*2269.78*
Compensation		
1	Compensation for female sterilization	3000.00
2	Compensation for NSV Acceptance	150.00
Sub-Total		*3150.00*
Procurement & Maintenance of Equipment		
1	Maintenance and repair of Laparoscopes/ Laparocators	219.00
Sub-Total		*219.00*
Grand Total		**5638.78**

Additionally, an amount of Rs.5886.20 lacs towards procurement of laparoscopes/laparocators, NSV kits and IUD kits, is being budgeted under NRHM Additionalities.

4. ADOLESCENT HEALTH

Interventions envisaged in the PIP for 2007-08 could not be conducted due to various constraints, including procurement issues. A number of interventions have been implemented on smaller scales in various districts. However, on direction of Hon'ble Supreme Court, the adolescent strategy is being reviewed at the highest level. Once the review is final, activities will be undertaken in the State. The State proposes to implement an adolescent health strategy which includes the following:

- Development of a package of health services, apart from IFA supplementation, TT and deworming
- Sensitising community on adolescent health problems and role of various stakeholders – annual village health meetings are proposed through convergence with AIDS control programme
- Adolescent health meetings, separately for boys & girls, to make adolescents understand their needs, right approach, services available and risks involved in unsafe behaviour.
- Environment building and adolescent friendly counselling services at health facilities through properly oriented health service providers and community mobilizers (ASHA) and provision of services in sensitive and friendly manner.
- Improving knowledge of adolescents of availability of services and service delivery points.
- Development of MIS to capture gender and geographical disaggregated data on risky behaviours, sicknesses and utilization of services by adolescents.
- Regular monitoring of services

It is proposed to develop specific interventions in line with GOI guidelines and roll out the same in a phased manner.

4.1 State Level Workshop

It is proposed to conduct a workshop at the state level in which Addl. CMO (RCH) & Nodal Officers from all the districts will participate. The detailed guidelines related to adolescent health services will be disseminated to the participants in the workshop. Officers from the State Govt., state health & family welfare department, other departments like ICDS, PRI, Education and good NGOs working in the health sector will also participate in the workshop.

The total expenditure in this workshop is estimated to be Rs. 2.0 lacs.

4.2 Preparation of Operational Plans

An operational plan for the scheme will be developed at the state level and at the level of each district. It is proposed to spend Rs. 0.05 lacs at the state level and Rs. 0.01 lacs at each district for this activity.

Accordingly Rs.0.75 lacs will be spent for preparation of operational plans

4.3 Dissemination Workshops

It is proposed to hold district and block level dissemination workshops for orienting the functionaries. At block level, orientation workshops will be held in which effort will be made to reach out to adolescents and their parents for imparting necessary knowledge and information regarding various issues of the adolescent age group.

Some of the key issues to be addressed are:

- Physical, mental, psychological and social changes during adolescence
- Peer pressure and substance abuse
- Family Life Education including correct age of marriage
- Sexual harassment and violence and ways to cope with them
- Personal hygiene and health education (incl. RTI/STI & AIDS awareness)
- Magnitude and demerits of population explosion and the role of adolescents in population stabilization.

For the district level workshops an amount of Rs.10,000/- per district has been budgeted and for organizing block level workshops it is proposed to spend Rs.10,000 per block. Thus, a total of Rs. 89.30 lacs has been budgeted for the activity.

4.4 Adolescent Counselling Centres

At each block an adolescent centre will be established at a selected site where adolescents are expected to get together for various youth activities. These centres should have at least 2 separate rooms for male & female beneficiaries. At these centres counselling sessions will be conducted through NGOs to address various problems of the adolescents by psychologists / counsellors who can be PG in Psychology/Sociology/MSW but it should be ensured that one of the counsellors is a female. They will be paid an honorarium of Rs. 10,000/- each per month, with facility of Rs. 5000/- as rental for the centre & contingent amount of Rs. 5000/- for miscellaneous expenses per month. Thus, the monthly expense at each centre for 2 counsellors, rent & contingency expenses will be Rs. 0.30 lacs.

Adolescents found engaged in high risk behaviours will be counselled and referred to Integrated Counselling and Testing Centres (ICTCs). Convergence and necessary coordination would be maintained at State, district and field levels with the HIV/AIDS programme to promote safe reproductive health behaviours, prevention & management of RTI/STIs and counselling.

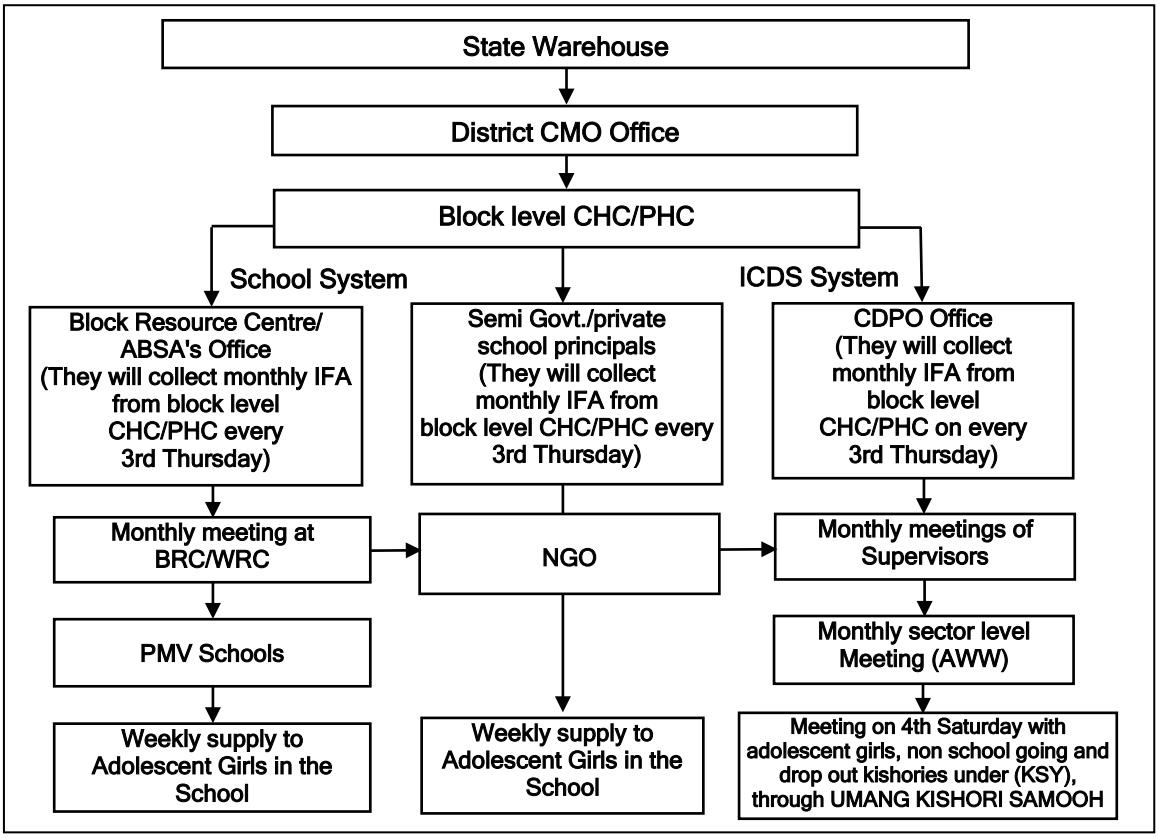
Accordingly, a sum of Rs. 252 lacs has been budgeted.

4.5 IFA Supplementation and Deworming

Adolescent girls constitute 10 percent of the total population & various surveys indicate that over 50 percent of adolescent girls suffer from anaemia, which

increases further with the onset of menstruation. Studies have further revealed that consumption of one adult tablet of IFA (Government Supply) once a week has tremendous improvement in haemoglobin level and well being of these girls. It is proposed that 25% of the adolescent girls, both school going and non-school going, will be provided one IFA tablet once a week through their school teachers or ASHA under the scheme. Thus, each beneficiary will be provided with 52 iron tablets in a year.

IFA Supply & Distribution



The total cost of procurement is estimated to be Rs. 474.24 lacs for 48 lacs adolescent girls and Rs. 192 lacs for biannual deworming tablets to all adolescent girls. The total amount of Rs. Rs. 666.24 lacs towards procurement had been budgeted in the PIP for the year 2007-08. The approval for the same has been received in the month of February 2008. This amount would be utilised in year 2008-09 and no additional amount is being budgeted.

Budget Summary (Adolescent Health) : 2008 – 09

Sl.	Description	Amount (Rs. in lacs)
Adolescent Health Interventions		
1	Orientation Workshop (State Level)	2.00
2	Preparation of Operational Plans	0.75
3	Dissemination Workshops (District & Block Level)	89.30
4	Adolescent Counselling Centres	252.00
Grand Total		**344.05**

5. URBAN RCH

Urban population constitute about 20% of the state population and likely to grow upto 30% in the next five years. The number of slums in the state is more than 6244, with a total population of more than a crore. Health indicators in slum areas are often even lower than in remote rural areas. The health infrastructure to address RCH needs of the slum areas is very weak and ineffective.

Exclusive female oriented health facilities particularly in slum areas have not found favour with community because majority of deliveries are taking place in homes. Facilities do not provide emergency services, decision making is done by males who are not comfortable with taking children to facility with females only & the staff does not encourage male clients. In these circumstances it is necessary to provide a facility that caters to health needs of both males and females in the urban deprived community.

To cater to RCH needs of urban areas particularly in slums establishing urban PHC concept was mooted in RCH-I but significant efforts could not be made.

Though D type health posts were created in big cities under urban revamping scheme but gaps in terms of adequate infrastructural support in terms of location, building, equipment and consumable support and monitoring the utilization and impact of these health posts remained insignificant.

Under European Commission assisted Sector Investment program (SIP) following new initiatives were undertaken to strengthen urban health services:

- Urban RCH project in Lucknow
- Urban RCH plan for 11 large cities
- Creation of new Urban Health Posts (UHPs) in remaining 58 districts
- PPP involvement in Varanasi

These interventions had following components:

Sr. No	Component	RCH Project Lucknow	RCH Plan for 11 Cities	New Urban Health Posts in 58 Cities	PPP Project at Varanasi
1	Urban RCH office	Y	Y	-	-
2	Contractual staff for maternity homes	Y	Y	Y	-
3	Setting up RCH nodal units (Health Posts) - Rent/maintenance - Contractual staff - Drugs & Consumables - IEC - Contingency & Misc.	Y	Y	Y	
4	Community linkages	Y			Y

Sr. No	Component	RCH Project Lucknow	RCH Plan for 11 Cities	New Urban Health Posts in 58 Cities	PPP Project at Varanasi
5	Referral linkages	Y			Y
6	IEC activities	Y	Y		Y
7	Inter-sectoral Coord., supervision & monitoring	Y			
8	Management training	Y			
9	Training	Y			
10	Strengthening existing UHPs		Y		
12	Mobile medical units		Y (10)		Y
13	NGO involvement		Y		
14	24 x 7 emergency delivery care		Y (2)		

Urban health services will be further strengthened through:

- Sustaining services & facilities created through SIP
- Mapping of the slum areas for identifying additional needs and available infrastructure
- Creation of additional 56 health posts in 56 districts
- It will be located in rented building, provided with contractual staff consisting of Lady MO, staff nurse 2, ANM 2, Ayah1,part time sweeper, arrangement for security, support for equipments & supplies, basic conveniences and IEC
- As far as feasible these health posts will be outsourced to NGO/ private sector
- To begin with it should have outdoor facility with provision for attending emergency care and providing referral services
- It will provide routine diagnostic, immunization and curative outdoor services to all while emphasizing on reproductive and childcare services.
- Link worker (ASHA) will be developed on basis of one per 1500 population
- Outreach workers (ANM) to provide outreach immunization, ANC, contraceptive distribution & counselling and referral RCH services in coordination with DUDA volunteers, AWW, link worker and other resources available in community
- Simultaneous TBA training will be done to promote assisted deliveries in the area and provision of institutional linkages with AWW, Balwadi centres of DUDA community and health posts to be maintained on regular basis.
- Provision of a community worker @ Rs. 5000/- per month from the locality on contractual basis to facilitate uptake of services by community.
- Provision of mechanism for fortnightly or monthly meeting of a team consisting of MMOH or Dy. CMO urban, MOI/C, one ANM, two community nominees of DM to monitor and record positive aspect of services available to community and gaps.

Outcomes

298 Urban Health Posts (UHPs) are providing integrated immunization ante/ post natal care, family planning, child health care, adolescent health services through outreach & outdoor services. In addition linkages with hospitals for institutional referral care to reduce maternal & child sickness and mortality rates have been established.

National Urban Health Mission (NUHM)

As per communication received from Government of India, vide DO No. L 19012/5/2007-UH dated 11th Feb. 2008, it is proposed to launch the National Urban Health Mission (NUHM) in order to effectively address the health concerns of the urban poor especially those living in urban slums. 14 cities with high slum population, namely, Kanpur, Lucknow, Agra, Varanasi, Meerut, Aligarh, Ghaziabad, Shahjahanpur, Saharanpur, Jhansi, Bareilly, Allahabad. Farrukhabad (incl. Fatehgarh) and Hapur have been identified in the State.

It is proposed to sign a tripartite MOU between the Centre, State and the urban local bodies followed by setting up of institutional arrangements and operationalisation of the Mission. This would be followed by conducting a city specific GIS mapping of resources (health facilities, both, public & private and slums – listed & unlisted).

In view of the above, the expenses for the urban RCH interventions in the 14 cities proposed to be covered by the NUHM have been budgeted for a period of 6 months only under this proposal.

A. Urban RCH Project in Lucknow City

Under this initiative, a city plan for Lucknow urban area was approved by the Ministry of Health & Family Welfare, Government of India in the year 2001. After successful launch of Urban RCH project in Lucknow city, the first roll-over plan was approved by the Government of India in year 2002. The second roll-over plan was approved by the State Sector Reform Cell on 26.04.05 Following were the major interventions undertaken in the project –

1. Strengthening of existing Urban Health Posts
2. Linkage with DUDA and establishing RCH nodal units
3. Reorganisation and reallocation of sanctioned staff of Urban Family Welfare Centres
4. Strengthening of Bal Mahila Chikitsalya evam Prasuti Griha (Maternity Homes) and converting them into operational First Referral Units (FRUs)
5. Establishing functional Neonatal Intensive Care Units (NICUs)
6. Selection and training of Community Health Workers (CHWs)

7. Service delivery in inaccessible areas through NGOs
8. Strengthening of diagnostic services at BMC & PG
9. Creating Swasthya-Ghars in the community

It is now proposed to sustain the successful interventions initiated under the project. The budgetary requirement for Lucknow City urban RCH interventions is as follows:

Details of Activity	Calculation	Total (Rs. in lacs)
(A) Support for Urban RCH Office		
Cont. Class-IV	Rs. 3500/-X1X12	0.42
Cont. Computer Operator	Rs. 7000/-X1X12	0.84
Cont. Care-taker (for Office & Meeting Hall)	Rs. 3300/-X1X12	0.40
Cont. Security Guard	Rs. 3,500/-X3X12	1.26
Cont. Part-time Sweeper	Rs. 1,500/-X1X12	0.18
Telephone / Electricity Bills	Rs. 20,000/-X12	2.40
AMC of Xerox / FAX / EPABX /	Rs. 15,000/-X12	1.80
Computer Peripherals/Aqua Guard/Water Cooler/ Electronic Typewriter	Rs. 20,000/-X12	2.40
Contingency & Miscellaneous	Rs. 25,000/-X12	3.00
(B) Misc. Contingencies		
Misc. Exp. For Maint., Sewer, Safe Water Supply etc. (For all 8 BMC & PGs @2500/- per month X 8)	Rs. 2500/-x8x12	2.4
(C) Contractual Staff at BMC & PG		
Cont. Gynaecologist PG (Rs. 12000/-)	Rs. 12000/- X19X12	27.36
Cont. Paediatrician (Rs. 12000/-)	Rs. 12000/- X16X12	23.04
Cont. Staff Nurse (Rs. 6500/-)	Rs. 6500X31X12	24.18
Anaesthetist (on call) (Rs. 600/- per LSCS Operation)	Rs. 600/-X500 Cases	3.00
Cont. Security Guard (for all 8 BMC & PGs)	Rs. 3500/-X8X12	2.10
Cont. Sweeper / Sweepress (Full-time)	Rs. 3000/-X19X12	6.84
Cont. Lab Assistant (for NICU, Aliganj & Indira Nagar)	Rs. 5000/-X2X12	1.20

Details of Activity	Calculation	Total (Rs. in lacs)
Cont. Class-IV for 2 NICU	Rs. 3000/-X4X12	1.44
POL & Maintenance of Generator (at 8 BMC&PG)	Rs. 3000/-X8X12	2.88
Strengthening with Contingency/Emergency Drugs (Existing Rates @Rs. 10,000/-) per month	Rs. 7000/-X10X12 (10 Units)	8.40
Streng. With Ambulance on hire basis (Driver, POL, Maint.)	Rs. 22000/-X8X12	21.12
(D) Contractual Staff for RCH Nodal Units		
Cont. Full-time Medical Officer - Urban RCH Nodal Units)	Rs.12000/- X14X12	20.16
Cont. Specialist PTMO-Gynaecologist	Rs. 12000/-X1X12	1.44
Provision for Full-time Workers for Existing RCH Nodal Units Staff Nurse (1 For PHC, Gudamba) @Rs. 6,000/- X 1 Nos. X 12 Months	Rs. 42,000.00	0.78
Sweeper @Rs. 1500/-X 7 Nos.X 12 Months	Rs. 126,000.00	1.26
Ward Ayah @Rs. 1500/-X 7 Nos.X 12 Months	Rs. 126,000.00	1.26
Medicines & Logistics Support	Rs. 10000/-X7X12	8.40
Misc. expenditure (Electricity bills, Mobility, Sanitation, Curtains Cloth, Screen & Stationary etc. for 12 RCH Nodal Units, Sahadatganj & Gudamba) @Rs. 3500/- p.m.	Rs. 3500/-X12X12	5.04
Rent for 4 RCH Nodal Units	Rs. 5500/-X4X12	9.24
(E) Community Linkage		
Honorarium to Community Health Volunteers (CHV) – Benchmark	Rs. 530400.00	5.30
Contingent/Mobility Expenditure to NGOs for Coordinators and CHVs for Implementation of Project in Slums)	Rs. 800000.00	8.00
Supply of DD Kit (10000 Kits)	Rs. 150000.00	1.50
(F) IEC Activities		
RCH Stall in Annual Exhibitions, Lucknow Mahotsav and Laxman Mela etc.	Rs. 200000.00	2.00
Film Shows in Slums (Prov. Of Projector/ Mobility/ TV/ VCR)	Rs. 200000.00	2.00
Grand Total (A to F)		**203.04**

Since Lucknow would be covered under the National Urban Health Mission, activities would be sustained for only 6 months under NRHM. Accordingly, the budgetary requirement works out to Rs.101.70 lacs

B. Urban RCH Interventions in Other Large Cities (12 cities)

Urban RCH interventions in the 3 cities, which are not proposed to be covered under the Urban Health Mission, will be continued. Further, for the 12 cities that are to be covered under NUHM the activities would be sustained for the initial six months only. The following recurring expenditure will be supported:

1. Operational Expenses of UHPs (Contractual staff, drugs & consumables)
2. IEC Activities for demand generation
3. Involvement of NGO for service deliveries
4. Mobile medical units

Budgetary Requirement for 3 Cities

Sl.	District Name	No. of UHPs requiring support	Component & Estimated Expenses (Rs. in lacs)				
			Contractual Staff for UHPs	Drugs & Consumables	Other Expenses	IEC Support	Total
1	Faizabad	6	27.48	9.36	6.54	0.90	**50.28**
2	Gorakhpur	15	55.44	23.40	18.00	2.25	**114.09**
3	Moradabad	18	63.42	28.08	18.30	2.70	**130.50**
Total Amount		**39**	**146.34**	**60.84**	**42.84**	**5.85**	**294.87**

Budgetary Requirement for 12 Cities under NUHM

Sl.	District Name	No. of UHPs requiring support	Component Description				Total for 1 year (Rs. in lacs)
			Contractual Staff for UHPs	Drugs & Consumables	Other Expenses	IEC Support	
1	Agra	16	56.76	24.96	15.24	2.40	**119.42**
2	Aligarh	11	40.56	17.16	9.90	1.65	**84.33**
3	Allahabad	8	18.84	12.48	5.64	1.20	**50.22**
4	Bareilly	9	25.32	14.04	10.14	1.35	**63.91**
5	Ghaziabad	14	47.22	21.84	13.50	2.10	**102.72**
6	Jhansi	7	28.68	10.92	7.74	1.05	**59.45**
7	Kanpur City	16	38.58	24.96	13.26	2.40	**99.26**
8	Meerut	15	60.48	23.40	14.04	2.25	**119.23**
9	Saharanpur	5	24.78	7.80	2.70	0.75	**45.09**
10	Varanasi	7	30.48	10.92	7.74	1.05	**61.25**
11	Shahjahanpur	1	4.92	1.56	1.20	0.15	**8.83**
12	Farrukhabad	1	4.92	1.56	1.20	0.15	**8.83**
Total Amount		**110**	**381.54**	**171.60**	**102.30**	**16.50**	**822.54**

Accordingly, for 6 months the budgetary requirement would be Rs. 411.27 lacs for the 12 cities.

C Interventions in remaining 54 cities

One Urban Health Post in each district has been created from EC-SIP funds last year. It is proposed to sustain the interventions initiated in these cities and also establish one additional new health post in these cities to meet the growing demand. The budget details are provided ahead:

Description	Support to 22 Old UHPs	Support to 54 UHPs established under EC-SIP	Support for 54 new UHPs	Total
Contractual Staff for UHPs	108.24	265.68	265.68	**639.6**
Drugs & Consumables	34.32	84.24	84.24	**202.80**
Other Expenses	11.88	64.80	64.80	**141.48**
IEC Support	3.30	8.10	8.10	**19.50**
One time Expense for Establishment of 54 new UHPs	-	-	54.00	**54.00**
Total	**157.74**	**422.82**	**476.82**	**1057.38**

Thus, the total requirement for urban RCH interventions in 54 cities is Rs.1057.38 lacs

E. Partnership with Ramakrishna Mission Home of Service for Urban RCH Proposal in Varanasi City

Ramakrishna Mission Home of Service, Varanasi, has been implementing a Mobile Medical and Community Health Services Project in urban slums and rural areas since the year 2002. The project began with initial grant assistance (cash and kind) from World Health Organization (WHO), Sir Dorabji Tata Trust, Tata Consultancy Services, British Medical Association, BHEL and other private donations.

In late 2003, Government of UP (GoUP) sanctioned an amount of Rs. 67.00 lac to support the project over a 3-year period under the European Commission assisted Sector Investment Programme (SIP). The project is already established on a very solid footing, with various equipments and personnel resources in place, and the delivery of primary health care & RCH services in selected slum areas identified has also had a very positive impact in the slums.

It is proposed to support the implementation of the project. The services being delivered presently cover the areas of Primary Health Care, Ante-Natal Care,

Family Planning Services (especially spacing methods), and complete immunization. Not only are the immediate slum-dwellers taking full advantage of these services, but also economically-deprived families from distances as far away as 50km away.

In view of the above community needs, it is deemed necessary to continue these services as well as the health awareness programme at least till such time as when alternate high-quality services become conveniently available and affordable.

The current proposal aims to continue the activities in 8 slums and extend it further to cover 4 additional slums of Varanasi

Budgetary requirement for Dt. Varanasi

(I). Urban Mobile Medical Outreach Services

Description	Rate	Amount (Rs. in lacs)				
		Q 1	Q 2	Q 3	Q 4	Total
Doctors (2 per unit)	Rs. 12,000/pm	0.720	0.720	0.720	0.720	2.880
Pharmacists (1 per unit)	Rs. 8,000/pm	0.240	0.240	0.240	0.240	0.960
Compounder (1 per unit)	Rs. 6,000/pm	0.180	0.180	0.180	0.180	0.720
Nurse (2 per unit)	Rs. 7000/pm	0.420	0.420	0.420	0.420	1.680
Community Health Worker (4 per unit)	Rs. 6,000/pm	0.720	0.720	0.720	0.720	2.880
Drivers (1 per unit)	Rs. 5,000/ pm	0.150	0.150	0.150	0.150	0.600
Field Assts (2 per unit)	Rs. 4,500/pm	0.270	0.270	0.270	0.270	1.080
Drugs	-	1.350	1.350	1.350	1.350	5.400
Consumables	-	0.030	0.030	0.030	0.030	0.120
POL Maintenance	Rs. 25000/pm	0.750	0.750	0.750	0.750	3.000
Contingency	@ 8% of the total Expenses	0.386	0.386	0.386	0.386	1.546
Total		**5.216**	**5.216**	**5.216**	**5.216**	**20.866**

(II). Office Management (for Urban RCH Varanasi and Rural Mobile Medical Outreach & Community Services in Dt. Mirzapur)

Description	Rate	Amount (Rs. in lacs)				
		Q 1	Q 2	Q 3	Q 4	Total
Office Manager/Coordinator	Rs. 12000/pm	0.360	0.360	0.360	0.360	1.440
Cash and Account	Rs. 8000/pm	0.240	0.240	0.240	0.240	0.960
Computer Operator	Rs. 6500/pm	0.195	0.195	0.195	0.195	0.780
Computer Operator	Rs. 6500/pm	0.195	0.195	0.195	0.195	0.780
Electricity	Rs. 6000/pm	0.180	0.180	0.180	0.180	0.720
Phone	Rs. 3000/pm	0.090	0.090	0.090	0.090	0.360
POL for Generator and Maintenance	Rs. 15000/pm	0.450	0.450	0.450	0.450	1.800
Post & Courier	Rs. 2000/pm	0.060	0.060	0.060	0.060	0.240
Stationery	Rs. 7500/pm	0.225	0.225	0.225	0.225	0.900
Internet	Rs. 1500/pm	0.045	0.045	0.045	0.045	0.180
Contingency	@ 8% of the total Expenses	0.163	0.163	0.163	0.163	0.653
Total		**2.203**	**2.203**	**2.203**	**2.203**	**8.813**

Total Budgetary Requirement for Urban RCH Varanasi is Rs. 26.68 lacs

Budget Summary (Urban RCH) – 2008-09

Sl.	Description	Annual Amount (Rs. Lacs)
A	Urban RCH Lucknow (for 6 months)	101.70
B	Urban RCH intervention in 3 large cities	294.87
	Urban RCH intervention in 12 large cities (for 6 months)	411.27
C	Urban RCH intervention in 54 cities	1057.38
D	Urban RCH interventions in Dt. Varanasi	26.68
Grand Total		**1891.90**

6. INFRASTRUCTURE AND EQUIPMENT

6.1 Rent and Contingency for Sub-Centres

There are 12930 Sub-Centres in the State that are operating from rented buildings. Accordingly, a provision of rent @ Rs. 250/- per month is being made. Thus, the requirement for the year 2008-09 is Rs. 387.90 lacs.

Further, a provision for contingency for 20521 Sub Centres @ Rs. 2000/- per year is being made. Accordingly, a budgetary requirement of Rs. 410.42 lacs is being proposed for the year 2008-09.

Thus, the total budget for sub-centre rent and contingency is Rs. 798.32 lacs.

6.2 One-time Major Repairs of Sub-Centres

Currently, there are 20521 established in the State, which provide MCH services, immunization, institutional delivery, FP services and other medical facilities. In 2007-08, in the supplementary PIP, major repair of 500 Sub-Centres was proposed for which a budget of Rs. 875 lacs was proposed at an average cost of Rs. 1.75 lacs per Sub-Centre. The approval for the same has been received recently from GoI and it is proposed to take up the activity in 2008-09. No additional fund requirement is being proposed.

6.3 Maintenance and repair of Laparoscopes/Laparocators

Apart from the above, around 400 Laparoscopes/Laparocators are available which require repairs. The estimated cost of repair for the above is Rs. 189 lacs. Further, for annual maintenance of 450 Laparoscopes around Rs. 30 lacs would be required. Thus, a total of Rs. 219 lacs would be required to maintenance and repairs of Laparoscopes/Laparocators.

Budget Summary (Infrastructure & Equipment): 2008 – 09

Sl.	Description	Annual Amount (Rs. Lacs)
1	Rent and Contingency for Sub-Centres	798.32
2	Maintenance & Repair of Laparoscopes/Laparocators	219.00
Grand Total		**1017.32**

7. HUMAN RESOURCES

Non-availability of key personnel in public health facilities due to vacancies or shortage against prescribed norms and absenteeism, is often consider as the main reason for under utilization of public health facilities. Apart from the shortfall of personnel, management of existing human resources is also a key issue.

Organisational Review & Development & HR Policy Development

A number of activities have been initiated by UP Health Systems development Project (UPHSDP) in this regard. UPHSDP has contracted IIM Lucknow for carrying out an organizational review and development of a human resource management policy. It is proposed to take necessary action as per the findings and recommendation of the study.

Human Resource Development Group

In order to rationalise the deployment of manpower, assess training needs of officers and preparation of a training calendar for the district level officers, it is proposed to constitute a State level group of officers who would visit the districts and carry out the microplanning exercise in collaboration with the district and divisional officers. The activity would be carried out once each year in the month of June-August.

Further, for proper deployment of manpower, assessment of training needs of officers and preparation of a training plan for the district level officers, it is proposed to constitute a State level group of officers who would visit the districts and carry out the microplanning exercise in collaboration with the district and divisional officers. The activity would be carried out each year in the month of June-July.

The group would include experienced individuals taken up on contract, departmental officers, PMU Consultants incharge of training. Orientation and training of these state level officers would be conducted. Teams would then be formed from this pool of officers for conducting the proposed activity at the district level. A set of guidelines and formats would be developed for the purpose, which would be circulated to the district before the visit of the team. Fund requirement for the activity would be met from NRHM Additionalities and have accordingly been detailed under the head.

Deployment of ISM Practitioners

It is proposed to deploy 3 ISM practitioners at each Block PHC. The activity would be implemented in a phased manner.

There are a large number of ISM practitioners who are working in the rural areas under their respective departments in the State. However, the infrastructure facilities available for these practitioners, is in very poor condition in most of the places. In the first phase, it is therefore proposed to co-locate these ISM

practitioners, who do not have proper infrastructure to function, at the Block PHCs. Also ISM practitioners who are operating from rented/donated buildings in the vicinity would be co-located to the block PHCs.

These practitioners would be provided with a separate room and a store and would practice their respective pathies. A process of identification of such practitioners and Block PHCs having adequate space has already been initiated. Such Block PHCs would also be identified where adequate space is not available and it would be required to construct additional rooms to accommodate the ISM practitioners. Subsequent to identification of such facilities requiring infrastructure strengthening, operational plans would be prepared for ensuring provision of ISM practitioners. It is estimated that additional construction would be required in around 500 facilities (Block and Addl. PHCs) for which an estimated average amount of Rs.10.0 lacs per facility (including provision of furniture fixtures) would be required. In year 2008-09, it is proposed to take up construction activities in around 100 facilities for which an amount of Rs. 1000 lacs would be required. This requirement of Rs. 1000 lacs would be met from funds received from the Department of AYUSH, Govt. of India.

Hospital Management

The State shall also initiate steps for appointing Hospital Managers in FRUs and hospitals having adequate client load to handle the complexities of activities related to hospital administration, including, equipment maintenance, procurement of consumables, assets & inventory management, human resource management, client conveniences, ambulance services, sanitation, public relations, etc. Accordingly, the training issues will also be addressed. With a view to improve facility management and quality of care, a component of capacity building of mid level officers of the health department who would assuming the role of facility administrators in the near future, is also proposed. Details have been provided in the section on 'Training"

7.1 Part Time Dais for Sub Centres

As already mentioned in the section on 'Maternal Health' a part-time dai is positioned at the 15,343 Sub Centres. She is paid an honorarium of Rs. 200/- per month. **Accordingly, a budgetary provision of Rs. 368.23 lacs is being made for year 2008-09.**

7.2 ANMs for Sub Centres

At present 537 ANMs are working on contract, apart from this there still exists a vacancy for 1223 ANMs. Although there is a vacancy of 1223 ANMs, it is not expected that more than 300 ANMs additionally would actually be available on contract. Accordingly, budgetary provision for hiring 837 ANMs (537 existing and additional 300) on contract is being made.

Budgetary requirement

Post	No. proposed to be deployed	Rate	Amount (Rs. In lacs)
ANMs	837	Rs.7000/- pm	703.08
Total			**703.08**

7.3 Manpower Requirement for 24 Hour PHCs

Sl.	Position	Addl. Number Expected to be deployed	Honoraria per month (Rs.)	Est. Annual Expense (Rs. in lacs)
1	ISM Lady Doctor	500	10,000/- pm	600.00
2	Nurses	1000	9,000/- pm	1080.00
Total				**1680.00**

7.4 Manpower Requirement for CHCs/FRUs

Sl.	Position	Addl. Number Expected to be deployed	Honoraria per month (Rs.)	Est. Annual Expense (Rs. in lacs)
1	Specialists (Gynaecologist, Paediatrician, Anaesthetist, Eye Surgeon, Public Health Specialist)	500	18,000/- pm	1080.00
2	Staff Nurses	852	9,000/- pm	920.16
3	Laboratory Technicians/Optometrist	426	8,000/- pm	408.96
Total				**2409.12**

For ensuring availability of Anaesthetists at the CHCs, it is proposed to empanel Anaesthetists working at district hospitals/private sector to provide services on on-call basis. Paediatricians wherever required would be ensured through redeployment/ contract.

7.5 Manpower Requirement for District Hospitals

Sl.	Position	Number Required	Rate/ Monthly Honoraria (Rs.)	Estimated No. of Cases Annually	Est. Annual Expense (Rs. in lacs)
1	Gynaecologist	Per case basis	Rs.1,000/- per case	5000	50.00
2	Staff Nurses	150	Rs.9,000/- pm	-	162.00
3	Anaesthetists	Per case basis	Rs. 1000/- per case	5000	50.00
4	Data Assistant	53	Rs.8000/- pm	-	50.88
Total					**312.88**

Budget Summary (Human Resources) 2008 – 09

Sl.	Description	Annual Amount (Rs. Lacs)
1	Part Time Dais for Sub-Centres	368.23
2	ANMs for Sub-Centres	703.08
3	Manpower Requirement for PHCs	1680.00
4	Manpower Requirement for CHCs	2409.12
5	Manpower Requirement for District Women's Hospital	312.88
Grand Total		**5473.31**

8. INSTITUTIONAL STRENGTHENING

8.1 Strengthening Logistic Management

It is an ongoing activity, already approved in the RCH-II PIP. The intervention provides for hiring contractual staff, security at the State Logistic Management Cell and at the 11 Regional Warehouse, including contingency support for payment of electricity charges, telephone, POL for DG sets, stationery and miscellaneous expenditure. A total amount of Rs.131.75 lacs has been budgeted for the year 2008-09.

8.2 Decentralized Fund for Transportation of Supplies

A provision of funds for hiring transport at local level was made at the PHC/CHC/District and Divisional levels for transportation of supplies and contraceptives right from the State Logistic Management Cell down to the Sub-centres. These funds will be continued to be made available as per the requirement given below:

Budgetary Requirement

Expenditure Description	No. of Locations	Amount per Location (Rs.)	Amount (Rs. in lacs)
Divisional Level (Additional Directors)	17	50,000.00	8.50
District Level (Chief Medical Officers)	70	30,000.00	21.00
Block Level – CHC/PHC (Medical Officer Incharge)	823	12,000.00	98.76
Total			**128.26**

8.3 Waste Management

The need:

Nosocomial, or Hospital-associated infections (HAI) are seen to affect approximately 5% of hospitalized patients. Hospitals are reservoirs for strains of bacteria that are multi drug resistant strains. There are however effective interventions for reducing the occurrence of HAIs. Studies have demonstrated that these infections are a reason of prolonged hospitalization and therefore increased costs adding to the patient's bill burden. Patients with hospital born infections have to pay higher bills for laboratory investigations and antibiotics & had a higher financial burden than those who were not affected. Cost effective interventions such as regular hand washing, skin disinfections, use of gloves, fumigation of

wards and OTs and an active microbiological surveillance system have proven to be effective in reducing these infections. Due to cost and time constraints these interventions are often overlooked. In addition hospital waste is highly infectious & toxic & proper disposal is essential for prevention of cross infection to all.

Prevention of hospital born infection & infection prevention measures are integral component of Quality Assurance Program. With the advent of Antibiotic Era & continuous availability of newer & potent antibiotics, more virulent, pathogenic & resistant bacteria are making appearance which may be difficult to treat & cause serious illnesses. Infection prevention practices & hospital waste management systems need to be in place for assured quality of care. It has been accorded top priority by Government of U.P.

UP Health System Development Project is assisting state to modernize & upgrade health care in the state. UPHSDP has undertaken an integrated project to install waste management disposal system in public health facilities from tertiary care facilities up to BPHCs in first phase.

Objectives

- Reduce hospital born infections
- Scientific disposal of hospital waste

Strategy

- Improve infection prevention practices
- Develop hospital waste management plan
- Through PPP route
- Capacity building
- Monitor hospital born infections
- Coordination with private sector for cost sharing
- Improve community practices
- Outcome evaluation

Implementation plan:

- UPHSDP is the nodal agency for the intervention
- Setting up of TAG (already done)
- Undertake need assessment (already done)
- State has been divided into 10 zones named as Combined Treatment Facility (CTF) as per GOI notification & CPCB norms. These facilities have been identified at regional level in Meerut, Lucknow, Bareilly, Agra, Jhansi, Kanpur, Gonda/ Faizabad, Allahabad, Gorakhpur, Varanasi. as per the guideline of the

CPCB. Hospital Waste is to be collected within the radius of 150 KM from Combined Treatment Facility covered.

- Each Combined Treatment Facility has the technology like incinerator with air Pollution Control System, Autoclave, Shredder and ETP plant complete with all other accessories which are required for disposal of the bio-medical waste as per the latest CPCB norms.
- Follows UP Pollution Control Board (UPPCB) norms & guidelines (already done)
- Development of technical specifications & its approval from GOUP (already done)
- Implementation through PPP process
- Creation of Hospital Waste Management Unit at State Level with following members:
  - In charge of the Hospital Waste Management Joint Director (HWM)
  - Assistant Engineer (Elect/HWM)
  - Environmental Engineer/ Specialist/ experience in ETP activities
  - Junior Engineer (Elect/HWM)
  - Computer Operator
  - Accountant / Account Officer
- Role of private partner
  - Supply of equipments and consumables i.e. is red, yellow and blue colour bins, bags black container and non perforating polycarbonate jars, needle cutters, trolleys, wheel barrows, personal protecting equipments like gloves, masks, goggles boots non metal helmets and aprons, weighing machines, chemical disinfectants, daily waste collection records, biomedical waste manifest form
  - Training of the Doctors, Surgeons and all paramedical staff of the hospital regarding the essentiality of Hospital Waste Management, hazardousness of the hospital waste, and segregation of hospital waste as per the guidelines of the Government of India of Gadget 1998.
  - Providing of IEC materials regarding the HWM activity as per the direction given by the project management unit and directorate of medical and health time to time and as per the norms of the CPCB.
  - Transportation of segregated hospital waste from the hospital to combined treatment facility in closed vehicles as per the norms of the CPCB.
  - Incineration, shredding, autoclaving of the transported hospital waste in the CTF as per the norms and guide line of the CPCB.
  - Daily waste collection record at CTF level

- Verification of supplied consumable other equipments as mentioned in the bidding document on the established Performa by the concerned in charge of the hospitals.
- Verification report of incinerated, shredded and autoclaved hospital waste collected from different hospital as per CPCB norms dully counter signed by the Technologist / Assistant Engineers of the concerned region where the CTF has been installed.

- Role of Hospital
  - Segregation of hospital waste as per the guidelines of the Government of India gazette 1998 in yellow, blue, red bins as per the nature of the waste.
  - Collection of the waste from different wards, Operations Theatres, and other places and to carry out it up to hospital waste room situated in the hospital premises and put it down to hospital waste room yellow, red and blue boxes made in the waste room.
  - Participation in the training program organized by the service provider time to time regarding HWM activities.
  - The hospital authorities would ensure the proper segregation of the hospital waste and training of each and every hospital staff in the HWM rules and regulations and segregation process as prescribed by the CPCB.
  - The hospital authorities would review/monitor the hospital waste management activities being performed in the hospital at every fortnight.
  - The in charge of the hospitals will authorize a competent person for performing the HWM activities & person will be responsible for the all activities of HWM.

- Development of bidding document (already done)

- Undertaking bidding process (WB approved national competitive bidding process, already done)

- Selection of service provider/ bidders (already done)

- Award of contract to selected CTFs (already done, 4 agencies covering all 10 CTFs)

- Work contract includes:
  - Supply of equipments & consumables as per specification included in bids
  - Printing & distribution of training manual for the staff developed by UPHSDP
  - Recurrent Training to concerned staff
  - Collection, Transportation to their Combined Treatment Facility
  - Treatment, Disinfections

- Final Disposal of BIO-MEDICAL Waste as per Govt. of India Gadget of 1998 on Bio-medical Waste Management & Handling rules & latest CPCB guidelines
- IEC messages at facility developed by UPHSDP
- Coverage in first phase includes all the District Hospital (Male & Female), Community Health Centres (CHC) and up to Block Primary Health Centres (BPHC) Level Hospitals in the entire state

- Facility staff to segregate hospital waste & deposit in common waste storage room, constructed in the facility by UPHSDP
- In the first phase only disposal of solid hospital waste will be undertaken
- Disposal of liquid hospital waste & sub block facility will be undertaken in subsequent phase

Community mobilization plan

- Community messages for general cleanliness , & proper disposal of domestic & waste of sick family members
- Through wall writing, wall paintings & hoardings
- PRI/ village meetings

MIS

- Pre & post evaluation format for training
- Monthly self assessment format at facility & CTF
- Monthly format for Physical & financial progress

Monitoring

- Nodal officer nominated by facility in charge to monitor segregation & transport of collected waste to waste store room
- Log book to record uptake of hospital waste by CTF
- Incineration & final disposal at CTF by A.E/ technologist posted at A.D. office at divisional head quarters
- Inspection, analysis of air, water & other discharges of CTF by regional pollution officer of UPPCB, giving a copy of report to UPHSDP
- Inspection by head quarter/ UPHSDP staff

Evaluation:

- Through UP Pollution Control Board (UPPCB)

Budgetary Requirement:

The estimated expenditure for the activities is around Rs.12 crores annually. The expenditure to be incurred is currently being shared by UPHSDP and GoUP. After the first year the entire budget would be borne by the State government. Therefore no budget requirement is being proposed in the PIP.

8.4 Quality Assurance Cell

QA committees for FP services have been established to ensure good quality family planning services. These committees will further monitor quality of maternal and child health services. Further, State Quality Monitors in each division are proposed to be put in place for monitoring quality on regular basis.

Additionally, a QA strategy is being implemented in 10 districts by SIFPSA. QA Committees have been constituted at district level and one round of district-level workshops have been conducted. The QA strategy will be replicated in other districts in phased manner.

Budget Summary (Institutional Strengthening) 2008 – 09

Sl.	Description	Annual Amount (Rs. Lacs)
1	Strengthening Logistic Management	131.75
2	Decentralized Fund for Transportation of Supplies	128.26
Grand Total		**260.01**

9. TRAINING

To achieve the goals of NRHM, skilled and committed human resource is required to deliver the services in an enabling environment. In Uttar Pradesh SIHFW has been identified and designated as Collaborating Training Institute (CTI) to coordinate with directorates and other training institutions and agencies for design and implementation of trainings all over the state. The training plan for year 2008-2012, with support of CTI, Medical Colleges and SIFPSA, proposes various categories of trainings, their time frame and resources needed for implementation.

9.1 Categories of Trainings

Trainings have been designed to target specific intervention areas and goals. Various intervention areas identified are:

a. *Trainings related to Maternal Health.*
b. *Trainings related to Child Health*
c. *Trainings related to Population Stabilization.*
d. *Training to Improve Programme Management*
e. *Trainings to improve quality of services, service utilization etc.*
f. *Trainings related to Human Resource Development*

9.2 Strengthening of Training Infrastructure

Uttar Pradesh has vast network of training infrastructure. The state has a State Institute of Health and Family Welfare (SIHFW) which is the apex training institute for Medical & Health and Family Welfare departments. Besides this, there are 11 Regional Health and Family Welfare Training Centres, 40 ANMTCs, 4 LHV training centres and 1 PHN training centre. For district level trainings 30 District Peripheral Training Teams (DPTT) also exist in the State.

These training centres are in the process of being strengthened in terms of civil work, training & teaching aids, mess/hostel renovation and equipment. The state government is working towards filling all the vacancies in these training centres to make them functional.

A plan to provide additional human resource support to support planning, implementation and monitoring of vastly distributed training activities was approved under RCH 2 PIP. Budgetary support to this Training Management unit was provided under RCH 2 PIP 20-05-06 and subsequently also under NRHM PIP for year 2007-08. As establishment of Training Management unit has not taken place yet, a revised fund proposal has been included in the PIP 2008-09.

PROPOSED ORGANOGRAM FOR TRAINING MANAGEMENT UNIT AT SIHFW

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in lacs)
1	Consultant Clinical Training	1	MBBS, PG in Gynaecology or Paediatrics with 2 years experience	25,000	3.00
2	Consultant Public Health	1	MBBS, PG in Public Health with 2 years experience	25,000	3.00
3	Accounts Manager	1	Graduation in Accountancy with 5 years experience in accounting	15,000	1.80
4	Data Analyst cum Computer Typist	3	Computer Proficiency - A level course from any govt. recognized institution, 2 years experience in data entry and analysis	10,000	3.60
Expenses towards recruitment and institutional overheads					3.60
Total					**15.00**

9.3. Progress Details & Plan for 2008-09

1. Skilled Birth Attendant (SBA) Training

This training is most important among various trainings planned to reduce maternal mortality. It was planned to cover staff nurses, LHVs and ANMs posted at 24X7 delivery centres with this training so that quality of services could be improved at these centres. At present there are 300 centres providing 24X7 delivery services in the state and 2 staff nurses,1LHV and 1 ANM is posted at these centres to look after labour rooms. According to latest GoI guidelines ANMs / LHVs / Staff Nurses posted at PHCs have to be given uniform 3 weeks training in a batch of max. 4 at selected training centres which have sufficient case load. Last year only 16 district female hospitals were identified as training centres in the state. This year additional 21 centres have qualified this criterion as delivery load has increased immensely under JSY. At present Trainers team from these 37 district women hospitals is being trained and One day orientation to the entire MO I/Cs of these centres to enable them to understand the concept and train their workers on basic core skills will also continue to this financial year 2008-09. ANM/LHV/SN team will start from Feb. 08 and continue in this year. The effort will be to cover presently functional 300 centres this year.

2. Life Saving Anaesthesia Skill Training

FRUs are being strengthened to provide Emergency obstetric care, for which anaesthetists are being trained at the facility. Five Medical colleges were identified and strengthened to conduct 18 wks training for medical officers posted at various FRUs. & district hospitals. 4 doctors will be trained in a batch. 2 such batches of 18 weeks duration will be conducted in this year in each medical college.

3. Emergency Obstetric Care

This 16 weeks training with support of FOGSI has been started for selected lady medical officers posted at FRUs. In UP two Medical colleges (KGMU Lucknow and JNMS Aligarh) have been identified to impart initial 6 weeks training and 9 district level female hospitals have been identified for rest of the 10 weeks training. A team of master trainers is available in the state that has been trained at Vellore by FOGSI. Training of district level teams of 8 participants per batch is in progress.

4. Short Term CEmOC Refresher Training

A 2 week refresher training is proposed for MBBS doctors who have been doing LSCS previously and have stopped now. Similarly this training will be given to those DGO/MS/MD specialists who find themselves ill confidant to perform operative procedures. 5 training sites will be identified at district female hospitals of 5 KAVAL towns in the state and a batch of 4 will be sent for 2 weeks attachment training to these hospitals.

5. Blood Transfusion training

It is proposed that service providers posted at Blood storage units being made functional at District and FRU level will be provide a 3 days training at SGPGI. NACO guidelines will be followed. 1 MO and 1 LT will be training from 70 blood storage units will be trained in the year 2008-09.

6. CCSP (Comprehensive Child Survival Programme - UP)

Various training for child survival has been merged and a comprehensive training package for healthy and sick children in the name of Comprehensive Child Survival Programme has been developed. The details have been included in the section on ‘Child Health’.

7. MTP Training

MTP training using MVA techniques has been planned. The procurement and supplies of MVA kits includes all district female hospitals and 140 FRUs. This year the training plan will include 2 doctors from each of the sites equipped with the MVA kits. The training sites will be developed at 5 big district hospitals which will later cover all 70 districts among themselves.

8. IUCD Training

For IUCD trainings, it is proposed to establish 17 Centres for conducting Training of Trainers. SIFPSA would also support in this endeavour. Details provided in the section on 'Family Planning'.

9. Training on Sterilization Techniques

Details provided in the section on 'Family Planning'.

10. RTI/STI Training

This training is being undertaken by SIFPSA in 10 districts. Similar training package will be provided the Lab Technicians posted at RTI/STI clinics.

11. Skill Up-gradation Training for RCH-II & NRHM

The purpose is to upgrade overall skills in imparting health service delivery and programme management at various levels. This training will have largest coverage in terms of manpower and categories.

A. **Skill up-gradation for Basic Health Worker (Female) and Supervisors:** To update the knowledge and skills of ANMs and LHV, a 12 days refresher training course has been planned and started in 37 districts last year in which NRHM and RCH-II services , RTI / STI, Adolescent health, contraceptive update etc components are included. The remaining 33 district will be taken up this year so that this comprehensive training package is delivered uniformly all over the state. District Female / Male Hospitals have been taken on board to cover the skill component incorporated in the training.

B. **Skill up-gradation for Basic Health Worker (Male) and Health Supervisor:** Male health workers and supervisors are being trained for 6 days for refreshing their knowledge and skills on NRHM and RCH services, supervision and co-ordination ability etc. More emphasis has been given on management of a very important component of NRHM i.e. National Disease Control Programmes and disease surveillance. From this year this training will cover all 70 districts.

12. Managerial Skill Development Training

Three categories of trainings have been started for enhancement of managerial capacity of health managers at various levels-

a. Managerial skill upgradation training for districts level managers- A 5 days training package is being implemented for ADs, CMOs, Additional CMOs and Dy. CMOs in collaboration with various management institutes in the state. Programmatic, financial and human resource management issues are being addressed through this training.

b. Managerial skill upgradation training for hospital managers- A comprehensive package of 5 days is being imparted for CMSs, and MSs posted at district male and female hospitals and FRUs. Exposure on hospital autonomy, hospital automation, hospital waste management and infection prevention techniques has been included along with management of emergency services, various schemes and programmes under NRHM focussed at hospitals.

c. Skill upgradation for medical officers- This 12-days comprehensive package including basic management skills along with programme management skills has been started for mid level managers posted at PHCs and CHCs. Programme management includes all NRHM components including financial management. Few components of specialized skill e.g. RTI /STI, Adolescent health, IMEP guidelines, IPHS guidelines, contraceptive update, national disease control programmes have also been included in the package so that medical officers are not required to leave their place of posting for more than one time.

13. VHSC Awareness Generation Training

A 2-day orientation programme has been started to orient all 52000 Village health and sanitation committees of Panchayat Raj in the state on NRHM and related health issues. The very grass-root level workers from other supporting line departments like Education, Health, ICDS and sanitation functionaries have also been included in this training programme.

It is also planned to give them an over-view on planning and monitoring of village level health activities through village health planning. A manual was developed for the purpose last year. A self assessment tool has now been added to the manual. State level and block level trainers have been trained and field level training of 1500 VHSCs will be completed till March 08. Rest has been planned in the next year.

14. Development of Trainers skills

A 5 day training course is being conducted to develop and upgrade trainers skills in a pool of trainers posted in the districts and also at all the training institutions. The package includes systematic approach to training, different training methodologies and use of different training and teaching aids. This training will continue this year also.

15. Training of Dais for Promotion of RCH services

This training is focussed on the changing role of Dais as family advisors, and catalyst to avail RCH services and schemes. The package includes components of Family based new born care, PNDT, JSY, ASHA Scheme and Birth / Death registration responsibilities. This 10 days training is being imparted at District

Womens Hospital and some selected FRUs having enough case load to give them sufficient opportunity for hands on skill development. 10270 dais are expected to be trained by end of March 08. For the year 2008-09, it is planned to train additional 22000 Dais.

16. BCC Officers orientation training

A 5 day training course had been designed for communication officers placed at block and district level in the state, but only 29 communication officers were left in the cadre. This year approximately 500 officers will be joining through regular appointment. These officers will have major responsibility of formulating geographically specific BCC strategy in their work areas to target positive behavioural change and service utilization. It has been decided that A 12 days induction course is needed to orient them in formulation of a BCC strategy, use of various communication tools and methods, emphasis on interpersonal communication skill. This training will serve the purpose of induction training for newly joining officers.

17. Logistic Management Course

To ensure proper management of logistics, their procurement and inventory control, training for all the concerned functionaries (SMO, PMA, Pharmacist etc.) working at District level stores and warehouses etc will be trained for 3 days. This training will be designed this year through TNA by state level resource pool and will cover available staff this year.

18. PMU Staff Training

A 5 days training will be organized for staff deployed in state, divisional, district and block level Project Management Units after these units come on board. A tentative budget plan has been included in the PIP.

9.4 Other Activities (Monitoring , Evaluation, Meetings, Seminars, Study Tours and Research etc. for quality improvement

To ensure quality of training activities, monitoring is necessary from state as well as divisional and district levels. A provision has been made in the PIP for organizing study tours, meetings, seminars and facilitates exposure visits for programme managers and planners. A provision for operational research on ongoing activities under NRHM & RCH-II interventions has also been included.

CURRENT STATUS AND TARGETS FOR TRAINING

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS	TARGET					
		(2007-08)	08-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
Maternal Health Training								
I	**Skilled attendance at Birth**							
	Setting up of SBA Training Centres	16	Selected 37 districts have been identified					
	TOT for SBA training centres	180	-	-	-	-	-	-
	SBA (One Day Orientation of MOs)	800	800	-	-	-	-	-
	Training of Staff Nurses in SBA	20	150	150	125	125	290	-
	Training of ANMs / LHV	20	150	150	125	125	290	-
II	**Life-saving Anaesthesia skills**							
	Setting up of life saving Anaesthesia Skills Training Centres	5 Medical Colleges have been Identified						
	TOT for Anaesthesia skills training	Nil	-	10	-	-	-	-
	Training of Medical Officers in life saving Anaesthesia skills	Nil	20	-	-	20	40	40
III	**EmOC**							
	Setting up of EmOC Training Centres	Two Medical Colleges have been identified KGMU Lucknow and JNMC Aligarh						
	TOT for EmOC	8		16	-	16	32	-
	Training of Medical Officers in EmOC (Short term)	Nil		48	-	48	96	-
	Refresher CEmOC for existing specialists	District Women Hospitals at 5 KAVAL towns will be identified for 2 weeks training						
	Gynaecologists(DGO/MS) in the system not performing LSCS will be training in batches of 4	Nil	20	40	20	-	40	40
IV	**Blood storage unit operationalisation**	3 days training will be given at SGPGI on NACO guidelines						
	1 MO & 1 LT posted at each FRU blood storage units	Nil	20	60	60	-	-	-
V	**RTI / STI Training**							
	TOT for RTI/STI training	Nil	-	-	-	-	-	-
	Training of laboratory technicians in RTI/STI	Nil	30	30	-	-	-	-

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS	TARGET					
		(2007-08)	08-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
Child Health Training								
I	**Comprehensive Child Survival Programme (CCSP)**							
	CCSP Training (pre-service)	Process initiated for inclusion in pre-service training of ANM, MPW(M), Staff Nurses and Medical Officers						
	CCSP Master Trainers (10 Days Integrated Child Survival Trg.)	127	199	271	-	-	-	-
	CCSP (10 Days Integrated Child Survival Trg. For MOs)	29	153	306	459	612	-	-
	CCSP (10 Days Integrated Child Survival Trg. for ANMs)	511	715	919	1123	1327		
	CCSP (10 Days Integrated Child Survival Trg. for LHVs)	34	-	312	312	312	312	
	CCSP Training for Anganwadi Workers	523	-	-	-	-	-	-
	CCSP (10 Days Integ. Child Survival Trg. for ASHAs)	1800	3500	5200	8600	12000		-
	CCSP (10 Days Integ. Child Survival Trg. for Staff Nurses)	Nil	-	-	86	-	-	-
II	**Facility Based Newborn care**							
	Facility Based Newborn care TOT (3 Days)	20	48	-	-	-	-	-
	Facility Based Newborn care Trg for MOs	-	100	100	70	70	-	-
	Facility Based Newborn care Trg for Staff Nurse	Nil	-	-	40	40	-	-
	Care of sick children and severe malnutrition (for 17 Dist.+34 FRUs)	Nil	-	34	50	36	-	-
Family Planning Training								
I	**MTP**	**Training sites 5 DWHs of KAVAL towns**						
	TOT on MTP using MVA	-	10	-	-	-	-	-
	MTP using MVA	37	10	50	30	30	200	100
II	**NSV**							
	TOT on NSV	1	-	1	1	1	3	3
	NSV Trg for MOs	21	14	20	20	28	85	102

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS	TARGET					
		(2007-08)	08-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
III	**Laparoscopic Sterilization**							
	TOT Laparoscopic sterilization	7	10	15	10	-	35	35
	District monitors training	0	0	25	35	50	55	55
	Laparoscopic sterilization Trg. for MOs	16	8	6	24	32	70	70
	Refresher training for lap ligation	12	6	6	18	20	50	50
IV	**Minilap**							
	TOT for Minilap	0	7	14	0	0	21	21
	District monitors training	0	0	30	60	50	70	70
	Minilap Trg. for MOs	10	8	32	36	64	140	140
V	**IUD Insertion**	7 divisional HQ districts (SIFPSA) + 10 divisional HQ districts(DFW)						
	TOT for IUD insertion	18	110	102	60	17	-	-
	Training of Medical Officers in IUD insertion	Nil	50	100	75	80	200	200
	Training of Staff Nurses/LHVs in IUD insertion	Nil	100	110	150	150	300	300
	Training of ANMs in IUD insertion	Nil	100	300	500	800	1500	1500
Other Trainings								
I	**VHSC Awareness Generation Trg.**							
	TOT	6840	-	-	-	-	-	-
	Field training	50000	30000	30000	30000	37000	172000	170000
II	**Dai Training for promotion of RCH services**							
	TOT	135	-	-	-	-	-	-
	Dai training	10000	5000	7000	5000	5000	15000	-
III	**Development of Trainer's Skill**	140	25	50	50	25	100	-
IV	**Managerial Skill Training**							
	Addl. CMO	71	25	50	50	25	150	100
	CMS	100	50	50	25	25	150	100
	MOs (12 Days)	44	125	125	125	125	500	500

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS	TARGET					
		(2007-08)	08-09 (quarter-wise)				09-10	10-11
			Q1	Q2	Q3	Q4		
V	**Skill Upgradation Training**							
	Skill Upgradation Training for ANM	391	750	750	750	750	3000	4000
	Skill Upgradation Training for LHV	163	40	35	75	75	300	450
	Skill Upgradation Training for HW (M)	149	50	50	25	25	50	100
	Skill Upgradation Training for HS (M)	140	50	50	25	25	50	100
VI	**IEC / BCC Officers Orientation**	50	50	50	50	50	300	-
VII	**Logistic Management Training**	Nil	25	75	50	50	250	-
VIII	**Programme Management Training**							
	Training of SPMU staff	Nil	50	-	-	-	-	-
	Training of DPMU/ BPMUs staff	Nil	50	250	500	500	700	-

Budgetary Requirement for Strengthening Training Sites in 17 Districts

Description	Number of Sites		Estimated Cost per Site (Rs. in lacs)	Total Amount (Rs. in lacs)
	New	Old	New	
A. Physical Strengthening of Training Sites				
Medical Colleges	-	4	0.500	2.00
District Women Hospitals/PPC	17	-	5.000	85.00
CHCs/BPHCs	68	-	0.015	1.02
Sub-total				*88.02*
B. Equipment & Training Aids for Trainings in Family Planning				
Teleconferencing facilities for 10 districts	10	-	2.50	25.00
For Abdominal Tubectomy	3	-	1.00	3.00
For Laparoscopic Training	7	-	1.00	7.00
For IUD Training	17		1.00	17.00
CHCs/BPHCs	68	-	0.012	0.82
Mannequins for IUD Training	90		0.60	54.00
Sub-total				*81.82*
Grand Total				**169.84**

Budgetary Requirement for Child Health Trainings

Sl.	Description	Amount (Rs. in lacs)
1	Expenses towards strengthening training sites	51.80
2	Job Aids and tools for ASHA for Child Health	45.00
Total		**96.80**

Summary of Budgetary Requirement for Trainings

Sl.	Training Type	Coordinating Institution	Financial Plan for 2007-08	Expected Expenditure in Year 2007-08	Proposal for the year 2008-09
1	**Strengthening of Training Institutions (SIHFW, ANMTCs, etc.)**	SIHFW/CTI			
	Contractual Manpower at SIHFW/CTI	SIHFW	28.47	0.81	**15.00**
	Strengthening of Training Sites in 17 Districts	DFW	-	-	**88.02**
	Equipment & training aids for Family Planning Trainings	DFW	-		**81.82**
	Strengthening of training sites for Child Health Trainings	DFW	-		**51.80**
	Job Aids and tools for ASHA for Child Health	DFW	-		**45.00**
2	**Development of Training Packages**	DFW	10.00	-	
3	**Skilled Attendance at Birth**	SIHFW/CTI			
	Setting up of SBA Training Centres		16.00	16.00	**102.90**
	TOT for SBA Training Centres		2.49	6.66	
	SBA (1 Day Orientation for MOs)			2.00	
	Training of Staff Nurses in SBA		105.92	2.00	
	Training of ANMs / LHVs				
4	**Life-saving Anaesthesia Skills**	DFW	61.00	nil	**61.00**
5	**EmOC**	DFW	41.95	nil	**41.95**
6	**Short-term Refresher CEmOC Training**				**8.03**
7	**Blood Storage Unit Training**				**4.33**
8	**RTI / STI Training**	SIHFW/CTI	4.50	nil	**2.00**
9	**Comprehensive Child Survival Programme (CCSP)**	DFW	1437.00	135.37	**-**
10	**Facility Based Newborn Care**	DFW	95.00	10.00	**-**
11	**Family Planning Training**				
	MTP	SIHFW/CTI	5.43	-	**11.00**
	NSV	SIFPSA	49.81	-	**290.00**
	Laparoscopic sterilization	SIFPSA			
	Minilap (Abdominal Tubectomy)	SIFPSA			
	IUD insertion	SIFPSA			
12	**VHSC Awareness Generation Trg.**	SIHFW/CTI	1160.00	159.69	**549.00**
13	**Dai Training**	SIHFW/CTI	500.00	335.00	**493.70**
14	**Development of trainer's skill**	SIHFW/CTI	7.80	5.00	**5.85**
15	**Managerial Skill Training**				
	AD / CMO	SIHFW/CTI	5.85	3.60	**5.85**
	CMS	SIHFW/CTI	1.95	4.00	**5.85**
	MOs (12 Days)	SIHFW/CTI	29.04	2.00	**36.20**
16	**Skill Upgradation Training RCH 2**	SIHFW/CTI	237.57	30.00	**157.01**
17	**IEC / BCC Officers Orientation**	SIHFW/CTI	19.50	1.77	**13.42**
18	**Logistic Management Training**	SIHFW/CTI	17.80	nil	**6.00**
19	**Programme Management Training**	SIHFW/CTI	15.53	nil	**56.47**
20	**Other Activities (M&E, Meetings, Seminars, Study Tours, Research, etc.**	-	65.00	nil	**20.00**
Total			**3920.61**	**713.90**	**2152.20**

10. PUBLIC PRIVATE PARTNERSHIPS (PPP)

10.1 PPP for Improving Institutional Deliveries

It is proposed to implement a scheme on safe motherhood, involving private sector institutions for improving institutional deliveries similar to the Chiranjeevi scheme being implemented in Gujarat. Certain modifications have been made in the Chiranjeevi scheme to suit the state.

The scheme would be applicable to BPL population in both rural and urban areas. Each private agency/provider will be required to select a geographical area of one or more blocks on the basis of first come first served principle. Not more than two agencies will be empanelled for a single block. Agency performing less than 50 deliveries a quarter would be debarred from the scheme. These agencies/providers would follow service delivery protocols approved by GoUP/GoI. Selection/accreditation will be done as per checklist approved by GoUP/GoI.

25 percent of beneficiaries will be verified by an independent agency as per direction of DRHM. In case of fake reporting/ gap in service will draw a financial penalty as per State guidelines. Three continuous defaults would result in automatic blacklisting of the agency/provider.

It is proposed to reimburse the empanelled private partner a total sum of Rs.1.80 lacs for conducting 100 deliveries.

The package has been worked on the following estimate:

Sl.	Description	Amount (Rs.)
1	Normal Deliveries (@ Rs. 1200/- per delivery for 80 deliveries)	96000.00
2	Complicated delivery not requiring surgical intervention (@ Rs. 1500/- per delivery for 10 deliveries)	15000.00
3	Caesarean section (@ Rs. 5000/- per delivery for 10 deliveries)	50000.00
4	Predelivery visits (@ Rs. 50/- per case for 100 cases)	5000.00
5	Investigations (@ Rs. 50/- per case for 100 cases)	5000.00
6	Sonography (@ Rs. 150/- per case for 40 cases)	6000.00
7	Blood Transfusion (@ Rs. 1,000/- per case for 3 cases)	3000.00
Total		**180000.00***

** The benefits accruing under JSY to be paid by respective RKS on production of client card showing details of services received duly signed by the private facility incharge where services have been received.*

A panel of private providers would be created to whom families covered under the scheme could be referred. Identification and empanelment of the private gynaecologists/hospital will be done by the MOICs of the Block PHCs. After the private practitioner agrees to join the scheme, a Memorandum of Understanding is signed between him/her and the district health authorities. An advance payment of Rs.25,000/- would be made to the empanelled provider to start providing services and would be replenished regularly.

The District Programme Management Unit (DPMU) will handle all documentation work for the scheme and would also be custodians of all the documents. The DPMU would also be responsible for making the payments to the empanelled Gynaecologists. The Nodal Officer RCH will be responsible for reporting the progress of the scheme to the State headquarter.

To bring public sector facilities at par, a similar incentive can be considered for identified public sector facilities. Such public sector facilities would be eligible to receive an amount of Rs. 50,000/- per 100 deliveries as per the package. The payment would be held with the RKS and would be utilized for upgradation of the residential facilities (e.g. Minor repairs, provision of power back-up, 24 hr water supply, coolers, DTH TV, Internet facility, transportation for school going wards) in the institution to address quality of life issues in rural areas.

Budgetary Requirement

It is expected that an average of 2 private providers/facilities would be able to perform 200 deliveries/ year in each district in 70 districts. Therefore, around 70 providers would be conducting an average of 200 deliveries per year. Similarly, about 200 public facilities across the State would be able to conduct 100 deliveries per year under the scheme. Accordingly, the budgetary requirement would be as follows:

Sl.	Description	Amount (Rs. in lacs)
1	Expenses towards survey & empanelment of private providers (@ Rs.10,000/- per district for 70 districts)	7.00
2	Reimb. of funds to private provider/facility (@ Rs. 3.6 lacs per provider per 200 deliveries x 140 providers)	504.00
3	Reimb. of funds to public facility (@ Rs. 50,000/- per facility for 200 facilities)	100.00
4	Expenses towards monitoring and verification (@ Rs. 10,000/- per district for 70 districts)	7.00
Total		**618.00**

10.2 PPP for Rural Outreach Services in Districts Varanasi & Mirzapur

Under the European Commission's Sector Investment Programme, support was being provided to Ram Krishna Mission, Varanasi for creating health awareness in rural areas of district Varanasi. It is now proposed to expand the Outreach and Community Primary Health Care and Reproductive and Child Health Services to a population of more than 80,000 villagers spread in 13 blocks of Mirzapur district in the village clusters of Araziline, Bami, Bharuhana, Chaksari, Gaura, Hayatnagar, Khajuraul, Lohara, Majhawan, Manikpur, Naugawa, Patewar, Ramnagar Sikari where the Mission has trained and equipped 60 Community Health Facilitators and 40 Traditional Birth Attendants and is currently providing mobile medical services once in a month through its other funds. The services provided here will be the same as those being provided in the Varanasi city slums and will include immunization, antenatal care, and family planning especially spacing methods.

Budgetary Requirement for Rural Mobile Medical Outreach & Community Services

Description	Rate	Amount (Rs. in lacs)				
		Q 1	Q 2	Q 3	Q 4	Total
Doctors (2 per unit)	Rs. 12,000/pm	0.720	0.720	0.720	0.720	2.880
Pharmacists (1 per unit)	Rs. 8,000/pm	0.240	0.240	0.240	0.240	0.960
Compounder (1 per unit)	Rs. 6,000/pm	0.180	0.180	0.180	0.180	0.720
Nurse(2 per unit)	Rs. 7000/pm	0.420	0.420	0.420	0.420	1.680
Community Health Facilitator (40 per unit)	Rs. 750/pm	0.900	0.900	0.900	0.900	3.600
Drivers (1 per unit)	Rs. 5,000/ pm	0.150	0.150	0.150	0.150	0.600
Field Assts (2 per unit)	Rs. 4,500/pm	0.270	0.270	0.270	0.270	1.080
Drugs		1.350	1.350	1.350	1.350	5.400
Consumables		0.030	0.030	0.030	0.030	0.120
POL Maintenance	Rs. 25000/pm	0.750	0.750	0.750	0.750	3.000
Contingency	@ 8% of the total Expenses	0.386	0.386	0.386	0.386	1.546
Total		**5.396**	**5.396**	**5.396**	**5.396**	**21.586**

10.3 Support to NGOs

A number of NGOs are being supported by donor agencies in the State to implement various health service interventions. A number of initiatives had also been initiated by the health department for promotion of RCH services. It is proposed to further strengthen NGO interventions. Funds are already available and no additional fund requirement is proposed.

10.4 Other NGO/PPP Initiatives in the State

Apart from the above, a number of initiatives are being taken in the State under the UP Health Systems Development Project and SIFPSA. The concept of Public-Private-Partnership as a part of healthcare system is being developed to make it an integral part of the healthcare delivery system in the state Current focus of PPP in health is to develop strategies to achieve the following:

1. Utilizing untapped resources and strengths of Private sector.
2. Enhancing the capacity to meet growing health needs.
3. Reducing financial burden of government.
4. Reducing geographic disparity in provision of services and its access.
5. Reaching remote areas; target specific group of populations.
6. Improving efficiency through evolving new management structures.

The various ways by which participation of the private sector is being embedded in the delivery of healthcare services in the state are as under:

- Contracting-out of public healthcare facilities to private organizations
- NGOs to Provide limited curative and preventive health care services in the remote and underserved areas
- Hospital Waste Management in Govt. Hospitals on Turn-key basis
- Hiring of Service Agency for Providing Contractual IT Staff
- Outsourcing of Non-clinical Services
- Pioting Voucher Scheme in Bahraich, Agra & Kanpur districts

Budget Summary (PPP) 2008-09

Sl.	Description	Annual Amount (Rs. Lacs)
1	PPP for Promoting Institutional Deliveries	618.00
2	PPP for Outreach Services in Dt. Varanasi & Mirzapur	21.59
Grand Total		**639.59**

11. PCPNDT & SEX RATIO

11.1 Operationalize PCPNDT Cell

General Performance

There was no regular institutional mechanism to implement and monitor PCPNDT Act in the state. Joint Director (Family Welfare) was carrying out related activities without required support system till lately. Now PCPNDT cell has been formed. Presently cell has two contractual staff against the proposed post of three contractual staff (Data Assistant-1, Social Scientist-1 and Legal Assistant-1).

Proposal for the year 2008-09

This year following budget is proposed for the continuation of PCPNDT Cell as per RCH-II norms:

Sl.	Description	Annual Requirement (Rs. in lacs)
1	Payment of honoraria to 3 contractual staff @ Rs. 12,000/- pm	4.32
2	Contingency	0.40
	Total	**4.72**

Accordingly Rs. 4.72 lacs will be required for the PCPNDT cell at State level for the year 2008-09.

11.2 Orientation of programme managers and service providers on PCPNDT Act

As proposed in the previous year, it is proposed to continue organising State and District level workshops for creating publicity regarding the need to address, discrimination against girl child yet there is wide spread lack of specific knowledge on provisions of PCPNDT Act.

The cost of state workshop is proposed at Rs. 5.00 lacs and district workshop at Rs. 0.5 lacs, thus total Rs. 40.00 lacs will be required for the year 2008-09.

11.3 Monitoring of Sex Ratio at Birth

Monitoring of sex ratio will also be undertaken through existing registration in service data system at the time of delivery. Further, integrated concurrent evaluations are planned for various components in RCH-II and NRHM. Sex ratio will also be one of the components of independent annual evaluation process.

Gender disaggregated data on births and deaths will be collected through ASHA. Block level compilation would be done and analysed to detect adverse ratios. The data would be reviewed in quarterly meeting of District Mission and meetings of CMO. Status, gaps and follow-up action would be discussed during the meetings

Accordingly, wherever required media advocacy efforts would be strengthened and also efforts would be made for ensuring implementation of laws, policies and programmes that protect the right of the girl child. Steps would also be taken to promote community based inter-sectoral actions to address adverse sex ratio.

IEC and behaviour change material, such as, posters and brochures will be developed and printed to sensitise the masses on gender issues. The brochures would contain sensitization messages and the role and responsibilities of various stakeholders in this regard.

11.4 Other PCPNDT activities

For effective implementation of PCPNDT, Govt. of India has already directed to undertake extensive efforts are required in area of IEC, facilitation of legal cases and regular review meeting at district and state level.

It is proposed to provide funds to the district for local IEC, stakeholder meeting, regular sensitization, workshops and school and communities, local media, cable TV and Cinema Slides, sting operations, review meetings and for facilitation of court cases.

Districts have been categorised based on the number of genetic centres in the districts and accordingly budgetary allocation are proposed for each district.

Sl.	Category according to registered genetic centres	No. of Districts	Proposed Amount to be Released per District
1	0 - 16	25+1 (DDMS)	Rs. 25,000/-
2	17 - 25	10	Rs. 35,000/-
3	26 - 50	17	Rs. 50,000/-
4	51 - 100	6	Rs. 75,000/-
5	Above 100	12	Rs. 100,000/-

Rs. 35.00 lacs will be required for the districts. Further, meetings and extensive multi media activities will be taken up by the IEC Bureau for which an amount of Rs. 100.00 lacs is budgeted. For activities at the State level, such as, stakeholder meetings, monitoring, etc. an amount of Rs. 5.00 lacs is budgeted.

Additionally, it is proposed to hold rallies for creating mass awareness in 20 identified districts having poor sex ratio. For this an amount of Rs.20.00 lacs is budgeted @ Rs.1.00 lac per district.

The various communication interventions will be integrated with the State BCC strategy and districts will be asked to reflect PCPNDT local media interventions in their District Health Action Plans (DHAPs)

Accordingly, total amount of Rs.160 lacs will be required for the year 2008-09.

Budget Summary (PCPNDT): 2008 – 09

Sl.	Description	Annual Amount (Rs. Lacs)
1	Operationalisation of PCPNDT Cell	4.72
2	Orientation of Programme Managers and Service Providers	40.00
3	Other PCPNDT Activities	160.00
Grand Total		**204.72**

12. BEHAVIOUR CHANGE COMMUNICATION (BCC)

Information Education & Communication and Behaviour Change Communication are the backbone of the NRHM programme. Given the objectives of the National Rural Health Mission, the following key areas have been identified for communication interventions in a phased manner under the NRHM:

1. Maternal Health
2. Child Health
3. Reproductive Health & Family Planning services
4. Safe Drinking Water & Environmental Sanitation
5. Tuberculosis eradication
6. Vector Borne Diseases
7. Blindness Control Programmes

The key endeavour is to develop a communication strategy that is integral, holistic and comprehensive to serve as a strong foundation for multiple and integrated communication interventions.

12.1 Development of BCC Strategy

Education and information significantly increase utilization of basic health care. However, while traditional IEC methods focus on giving information and creating awareness among the community, Behaviour Change Communication (BCC) is characterized by its direct approach to changing behaviour. A carefully planned and managed BCC strategy ensures that the behaviour identified for change is feasible within the social and cultural context in which people live.

It is therefore proposed to develop an integrated BCC strategy for the State relevant to the overarching NRHM mandate. Since the manpower and technical expertise available within the department is limited, it is proposed to outsource the activity to a professional agency. The agency would need to understand the nature of health issues and barriers to change in the context of Uttar Pradesh. Key issues to be addressed include assessing the existing communication resources, concurrent behaviour research, evaluating program policies, audience segmentation, media penetration and media approaches. Some suggestive activities to be carried out would include:

- Analysis
- Strategic design
- Development of content inclusive of production, revision and pre-testing
- Management, implementation and monitoring
- Planning for continuity and sustainability

A lump sum provision of Rs. 40 lacs for the activity is being made.

12.2 Communication Strategies for 2008-09

Till such time that an integrated BCC strategy is put into place the following activities will be initiated during the year 2008-09.

A. Maternal Health

1. Imparting maternal health knowledge including utilization of cultural practices through integrated approach to media and IPC.
2. Promoting institutional deliveries by increasing utilization of services through ASHA under the *Janani Suraksha Yojana*
3. Awareness creation regarding diseases (e.g. Hepatitis E, Rubella, Herpes, etc.) which have adverse effect on foetus, as well as, on mothers if contracted during pregnancy.

B. Child Health

1. Gateway behaviour approach to introduce breast feeding and other healthy practices around newborn survival.
2. Integrated communication to stimulate demand for Routine Immunization services

C. Family Planning

1. Integrated communication to stimulate demand for and improve quality of FP spacing methods and related services.
2. Integrated communication to stimulate demand for and improve quality of FP limiting methods and related services.
3. Male participation for support and use of family planning methods.

A. MATERNAL HEALTH

The purpose of identified maternal health strategies is to reduce maternal and neonatal morbidity and mortality in UP. With the introduction of Janani Suraksha Yojana, institutional deliveries are registering an upward increase under the NRHM. However, due to the recent implementation of the scheme, information gaps about the benefits accruing to the client and the service providers exist.

Three main strategies have been identified for addressing key maternal and neonatal health issues.

Campaign 1: Imparting maternal health knowledge including utilization of cultural practices through integrated approach to media.

Rationale:

One of the root causes of women not seeking health care during and post pregnancy for themselves is a lack of awareness about the benefits of Ante-natal care. In addition, women do not consider it important to pay attention to their own

health and gender inequity within the community perpetuates and allows for this passive acceptance of not taking care of one's health during pregnancy. The overall strategic approach, therefore, promotes the concept of celebrating womanhood to help women (at the individual level) understand the importance of taking care of their health during pregnancy, child birth and postnatal period. The concept will also influence social norms to create a conducive environment for sustained behaviour change. The strategy uses cultural practices as opportunities to reach audiences in a socially acceptable manner. For example, the common ritual of *godh bharai* with the pregnant woman, a cultural practice usually observed in the seventh month of pregnancy, can easily be used as a platform to convey messages about birth preparedness, safe delivery and post natal care.

Audience and Expected behaviour outcomes:

- Primary audience: Women in the reproductive age. Women will contact service provider the moment she knows that she is pregnant, will take care of nutritional needs, avail at least three antenatal check ups, recognize danger signs during pregnancy and post natal care, and initiate early breastfeeding.
- Secondary audience: Older women are the secondary audience who will communicate the benefits of ANC, proper nutrition, and breastfeeding to their daughter in law, daughters, and families, recognize danger signs, and accompany the woman for prenatal, during delivery and post delivery periods to health service.

Activities and Media Channels

- Primary Audience (Women of reproductive age):
  - Women will attend community group meetings to discuss maternal health issues
  - Mass media will be used to create social norms around maternal health in the community

- Secondary Audience (Older women):
  - Mass media will role model how mothers in law can support daughters in law in practicing healthy maternal health behaviours.
  - *Saas Bahu Sammelans* where mothers in law and daughters-in-laws are encouraged to communicate and participate in follow up facilitated discussions on key maternal health issues in the radio program

- Tertiary Audience (ANMs and Health Providers):
  - ANMs, ASHAs, TBAs will coordinate the formation of women's discussion or health clubs.

- They will be trained in facilitating group discussions in listeners groups where women listen to radio drama program which addresses key maternal health issues and behaviours.
- Health providers will be trained to use print materials and interactive games, organize song competitions in the group to ensure an entertainment education and participatory approach to discussing maternal health behaviours and issues.

Campaign 2: Promoting institutional deliveries by increasing utilization of services through ASHA under the *Janani Suraksha Yojana*

Rationale:

Under the NRHM, one of the key objectives is to reduce by half the maternal mortality rate from the current rate. The key strategies for reducing the maternal and infant mortality is to promote institutional deliveries in both urban and rural areas.

The Janani Suraksha Yojana has been implemented in the state recently under which the deliveries conducted in the hospitals have been incentivized. The ASHA is the key motivator at the village level to persuade the pregnant women and their family members to undergo institutional deliveries. As the scheme has been recently introduced, there is a large information gap in the minds of the client and the service provider about the JSY benefits.

Audience and Expected behaviour outcomes:

- Primary audience: Pregnant women will contact the ASHA/ health worker for identification of service site for delivery and will opt for institutional delivery. She will know the benefits available under the JSY scheme.
- Secondary audience: ASHAs, ANMs and other Health Providers. They will educate and motivate the pregnant women and their family members to avail of the benefits under the JSY scheme

Activities and Media Channels:

- Primary Audience (Women of reproductive age):
  - Women will attend community group meetings to discuss maternal health issues
  - Mass media will be used to create social norms around maternal health in the community
  - Wall Paintings and hoardings at service sites to inform the community about the monetary benefits of the JSY
  - Radio Drama series to educate and inform the women about the benefits of institutional deliveries and JSY.

- Secondary Audience (Older women):
  - Mass media will role model how ASHAs and service providers promote safe deliveries at the hospitals and contribute to ensuring the well being of the community.
  - ASHAs and other service providers will hold community group meetings to discuss maternal health issues and benefits of hospital based deliveries.
  - Wall Paintings and hoardings at service sites to inform the community about the monetary benefits of the JSY

Campaign 3: Awareness creation regarding diseases (e.g. Hepatitis A,B,C and E, Rubella, Herpes, etc.) which have adverse effect on foetus, as well as, on mothers if contracted during pregnancy.

Rationale

Altered liver function test in third trimester may signify a physiological change due to pregnancy, otherwise it may signify distressing disorder with itching such as intrahepatic cholestasis of pregnancy or a potentially fatal disorder like acute fatty liver of pregnancy, HELLP syndrome or acute viral E hepatitis (which has high mortality when it occurs in third trimester). Differentiating the various disorders in the last trimester is crucial as certain disorders require immediate termination of pregnancy.

A study on prevalence and severity of acute viral hepatitis in north India[1] revealed that Hepatitis E virus (HEV) infection alone is responsible for 47.4% of the cases of viral hepatitis in pregnant females in the third trimester. This is corroborative with the fact that HEV infection accounts for 50-70% of all patients with sporadic viral hepatitis in India.[2] In pregnant females in third trimester with viral hepatitis, the prevalence of HEV infection is reportedly between 40-57%. HAV infection was less common (0% vs 5.2%) and HBV infection more common (34.6% vs 7.2%) in central India. HCV infection was not seen in any case as was also observed by other groups. This is explained by the low prevalence of high risk factors for HCV transmission in the study group. Seventy five percent of the FHF cases were HEV positive. Thus, HEV was the most common hepatotrophic virus associated with FHF. Among the HEV positive pregnant females, the mortality rate was 39.1%. The mortality rate is in the range of 30-45% and may be as high as 70%. Majority of the cases die undelivered. Two of the five (40%) HAV positive patients expired out of which one had co-infection with HEV. One pregnant female who died had co-infection with HBV and HEV. Five of the 46 (10.8%) patients in non A-E group expired. Thus, HEV was associated with a high mortality rate among pregnant women.

[1] Beniwal et al - Prevalence and severity of acute viral hepatitis and fulminant hepatitis during pregnancy: A prospective study from North India

[2] Aggarwal R, Krawczynski K. Hepatitis E: An overview and recent advances in clinical and laboratory research. J Gastroenterol Hepatol 2000;15:9-20.

B. CHILD HEALTH

The purpose of identified child health strategies is to reduce infant mortality rate in UP. The areas for communication interventions that have been identified are

1. Neonatal health
2. Child Immunization

47.6% of the deaths in children are attributable to neonatal deaths (NFHS-3). Generally, 20% of the neonatal deaths can be prevented if the deaths on the 1st day are reduced. Therefore, the strategy emphasizes becoming aware of dangers signs and taking immediate action for neonates, providing skin to skin care, and feeding colostrum to decrease the chances of neonatal mortality in the initial days after birth. There has been stagnation in the rates for routine immunization in the state with only 22.9 % of children under 1 being completely immunized (NFHS-3). RI is therefore an important priority for the state.

Campaign 1: Gateway behaviour approach to introduce breastfeeding and other healthy practices regarding the newborn

Rationale: Many newborn deaths could be avoided if the community and the parents would have proper knowledge of providing warmth and immediate breastfeeding to new born babies. Certain cultural practices act as barriers to adopting healthy behaviours. Colostrum, for example, is considered inappropriate for the newborn. In other cases, babies are kept separated from their mothers, many times in the cold, as the family awaits the appropriate community member to perform a ceremony that ensure an auspicious beginning for the new born. Promote the concept of 'good mother' who provides colostrums to her newborn child and warmth immediately after birth.

Audience and expected behaviour outcomes:

- Primary audience: The primary audience comprises of mothers, mother-in-law, and caretakers. Mothers will breastfeed new born baby within the first 2 hours after delivery and hug the baby within the first hour of the birth to provide warmth (skin to skin care). Mother in law will support the mother in these two behaviours.
- Secondary audience: The secondary audience is service providers and community leaders. Providers will counsel mother in laws and women about importance of colostrum feeding, importance of providing warmth to the baby through skin to skin care, and address myths and misconception about colostrum and immediate hugging. Community leaders will support health providers in promoting these healthy behaviours.

Activities and Media channels:

- Primary Audience (Caretakers/ mothers/ mothers-in-law):
  - Mass media (Radio, TV, Press) will be used to create social norms around skin to skin care and importance of providing warmth to the baby right after birth.
  - Partner with private sector to include these messages on beauty products used by mothers and mothers in law

- Secondary Audience (Service providers and community leaders):
  - Train health care providers in IPC to reinforce messages on immediate colostrums breastfeeding and skin to skin care
  - Identify mothers practicing these behaviours and mothers in law supporting the behaviour and train them to become advocates in their communities and as role models through mass media.

Campaign 2: Integrated communication to stimulate demand for Routine Immunization services

Rationale: As per NFHS – 3, the percentage of fully immunized children is only 22.9. However BCG is 61 %. Polio is 87.5%, DPT is 30% and measles is 37.5 and Vitamin A is 7.3%. In 2007 there was renewed thrust on routine immunization through RI weeks, where immunization of children 0-1 year was undertaken through a campaign mode at the village level.

Efforts are being made to increase the awareness and sense of responsibility amongst the parents to ensure the complete immunization of all children below one year. The responsible parents will undertake action to save their children from the six vaccine preventable diseases like TB, Diphtheria, Pertussis, Tetanus, Polio & Measles.

Under NRHM routine immunization campaign is being undertaken centrally over national television and satellite channels.

Audience and expected behaviour outcomes:

- Primary audience: Caretakers of children in the age group of 0-1 years who will ensure that their children are immunized according to the immunization schedule so that they fulfil their responsibilities as responsible parents
- Secondary audience: Health care providers who will use IPC to mobilize and ensure immunization of all eligible children.
- Tertiary audience: Community members who will create an enabling environment by educating caretakers about the importance of complete immunization.

Activities and Media channels:

- Primary Audience (Caretakers):
  - Women will attend community group meetings to learn about benefits of complete immunization
  - Mass media will be used to inform caretakers about the dates, place & time for immunization and the need to ensure the complete immunization
  - Immunization cards for maintaining the complete immunization status of the child
- Secondary Audience (Health Providers):
  - Mass media will role model good provider –client communication
  - At the service delivery level, providers (ANMS, AWWs, and ASHAs) will be trained to counsel clients through IPC/C on immunization.
  - Print support materials such as posters, and handbills will serve as counselling aides for health providers.
- Tertiary Audience (Community Members):
  - At the community level, the responsibility of the community to ensure that all children under one year of age are completely immunized
  - Mass media will be linked to community level interventions such as community group meetings with mothers, mothers in law and elderly women.

C. Family Planning / Reproductive Health in Uttar Pradesh

A life cycle approach addresses specific family planning needs across three age groups (those below 18, 18-24, and 25 and above) with a specific focus on men and women of reproductive age group of 18-30 years. A pattern of early marriage combined with low use of contraceptives between the ages of 15-24 provides an opportunity to reach out to young married couples (married adolescents and youth) regarding family planning.

A comprehensive three pronged strategy to stimulate demand for family planning methods, improve quality of services, create a norm for joint decision making among couples, and increase method mix for spacing and limiting based on the life cycle approach.

Campaign 1: Integrated communication strategy to stimulate demand for and improve quality of FP spacing methods and related services

Rationale:

Of currently married women of reproductive age, about a third (35%) are currently users of any method; over a quarter (27%) are current users of any modern method of which 17% is attributable to sterilization and only 9% to modern spacing methods (condoms, pills, and IUDs). Cultural beliefs such as the desire for male child and the social norm to prove fertility promote the practice of bearing children

soon after marriage. The high discontinuation rates is due to clients not being informed about the various side effects of pills within the first three months or/ and the lack of technical knowledge and counselling from the provider.

In order to make spacing methods a social norm among couples, the strategy attempts to help couples realize that birth spacing is the right thing for them to do right after they get married. The strategy employs the "Ask" approach which encourages and provides clients with the skills to ask their provider relevant questions about specific spacing methods.

Audience and Expected behaviour outcomes:

- Primary audience: Eligible couples with women between the ages of 18-30. "Eligible" being defined as those couples who are either, newly married, have only one child, and /or are interested in using spacing methods.

  Expected behaviour: They will seek advice from ASHA/ health provider, ask questions about available methods and procure appropriate methods. Satisfied clients will advocate for the method they are using and continue using the method.

- Secondary audience: Health care providers which include ASHAs and AWW; ANMs, doctors from the public and private sector, including NGO clinics.

  Expected behaviour: They will give correct and complete information on all available methods to their clients. ASHAs and AWWs will refer clients for further counselling and services in a timely manner and dispel FP and particularly method-specific myths and misconceptions.

Activities and Media Channels:

- Primary Audience (Couples and specifically women between ages 18-24 – married):
  - Mass media: TV and Radio will promote individual methods to increase knowledge of target audience about specific methods and motivate them to seek more information from health service providers.
  - Radio drama serial for the general public will aim to increase method specific knowledge and address myths and misconceptions
  - Reminder Media: Wall paintings & hoardings will act as reminder media for seeking more information from health providers and promoting service sites
  - Community level media: Video van and pre-recorded folk media performances can be used to inform clients about FP methods available in pharmacies and other commercial outlets.

- Secondary Audience (ASHAs, ANMs and other Health Providers):
  - ANMs, ASHAs, TBAs will coordinate the formation of women's discussion or health clubs at the village level during group meetings to be conducted by the ASHAs.
  - Health providers will be trained through training, distance learning radio programs, and listeners groups to improve their technical knowledge and IPC skills. They will use printed materials to address rumours and misconceptions with clients.
  - Mass media will role model good client –provider communication IPC

Campaign 2: Integrated communication strategy to stimulate demand for and improve quality of FP limiting methods and related services.

Rationale:

As couples move from being spacers to limiters, not wanting more children or not wanting children for a long time, they should know that there is a range of birth limiting methods available to them which are more secure and definite than spacing methods. This strategy will focus on NSV & Female Sterilization along with IUD as limiting methods.

The primary audience is couples with women in the age group of 25-49 years with focus on 25-35 years as approximately 65% of the entire market consists of those within the age group of 25-35. By establishing social norm among this audience, the strategy aims to create a ripple effect and also reach those who are between the age of 36-45.

Audience and expected behaviour outcomes:

- Primary audience: Couples with women in the age group of 25-49.

  Expected behaviour: They will seek advice from health provider or go to a health clinic and ask questions about birth limiting methods specially NSV and IUD, procure appropriate methods. Satisfied users of NSV and IUD will advocate for the method to others.

- Secondary audience: Health care providers which include ASHAs and AWW; ANMs, doctors from the public and private sector, including NGO clinics.

  Expected behaviour: They will give correct and complete information on all available methods to their clients. They will refer clients interested in birth limiting methods and dispel myths and misconceptions.

Activities and Media Channels:

- Primary Audience (Couples with women in the age group of 30-49):
  - Mass media such as TV, radio, and press will promote individual methods to increase knowledge of target audience about specific methods and about trained sources of information- health service providers or clinics.
  - Community level activities like group meetings, A/V shows role modelling client- provider communication and motivating clients to seek information and services for limiting methods
  - Wall paintings and hoardings will act as reminder media for seeking more information from health providers and promoting service sites

- Secondary Audience (ANMs and Health Providers):
  - Health providers will be trained through training, distance learning radio programs, and listeners groups to improve their technical knowledge and IPC skills. They will use printed materials to address rumours and misconceptions with clients.
  - Mass media will role model good client –provider communication IPC

Campaign 3: **Male participation for support and use of family planning method**

Rationale:

Male sterilization accounts for 0.4% of total modern method use (26.7%) in UP while female sterilization accounts for a total of 17% of the modern method use in UP. Men have a voice in their family to influence existing social norms and behaviours related to family planning decision, however, they have very little interaction or involvement in matters related to family planning.

The proposed interventions, therefore, aim to increase communication between couples regarding FP and demonstrate ways in which men may support their spouses in FP decision making, therefore aiming to create a new social norm. The strategy uses a male-focused approach to encourage couple decision making in order to provide men their own space for questioning, understanding and practicing relevant behaviours. Furthermore, it was discussed that respected male opinion leaders in the communities can powerfully role model these behaviours for the younger men, therefore creating a social norm of discussing reproductive health and gender related issues between fathers, brothers, and young men- a social norm and practice that is more common among women then men.

Audience and expected behaviour outcomes:

- Primary audience: Males in the reproductive age group.

  Expected behaviour: Men will talk with their spouse and relatives about FP, support spouse in choosing appropriate method for family planning, accompany spouse to clinic, agree to use male sterilization as contraceptive method, use condoms, talk with one another about using FP.

- Secondary audience: Male opinion leaders of the community.

  Expected behaviour: Opinion leaders will advocate for use of family planning methods, hand out information in meetings about methods, refer potential users to health providers, advocate for supporting spouse in selecting appropriate method, dispelling myths and misconceptions about NSV.

Activities and Media Channels:

- Primary Audience (Men in reproductive age group):
  - Mass media: TV, radio, and press will promote what it means to be a 'good husband'. Mass media will also be used to publicly recognize those who are practicing the modelled behaviours of a good husband.
  - Community Level: Men's groups such as chaupals will have facilitated discussions where men will talk about what it means to be a good husband and how they may support their wife in sharing FP responsibility-specifically NSV use.
  - Men who are practicing these behaviours will become advocates and encourage their peers and younger men to be 'good husbands'.

- Secondary Audience (Male opinion leaders):
  - Opinion leaders will facilitate group discussions about what it means to be a good husband and supporting wife in FP use, and specially taking the responsibility for FP by opting for NSV. Opinion leaders will dispel myths and misconceptions about NSV.
  - Training and materials for opinion leaders as facilitators of group meetings with men.
  - Community meetings interlinked with folk media, games, and mass media events where opinion leaders are recognized

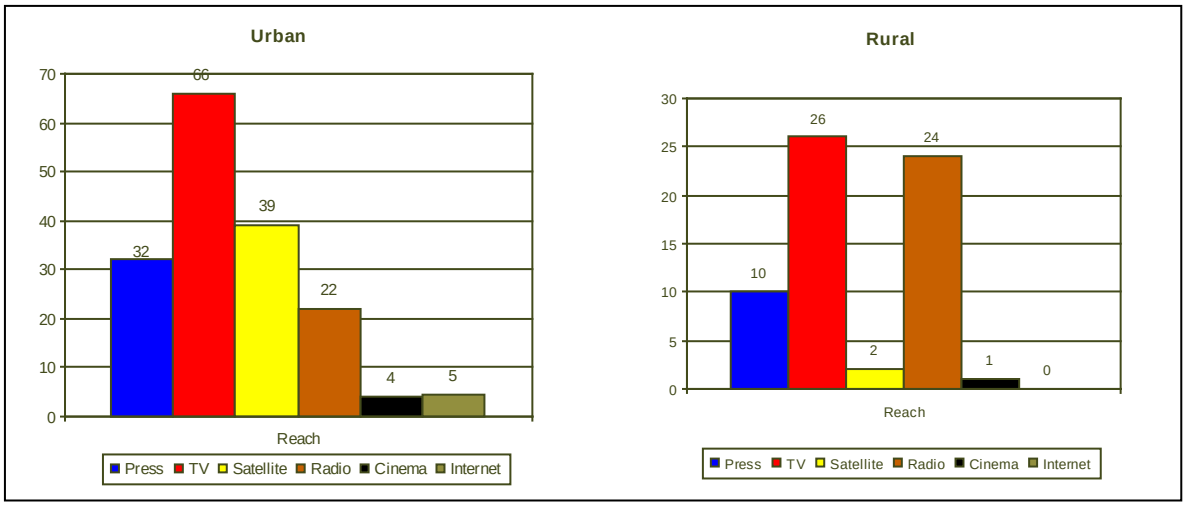
Family Planning: Media Planning and Budget Criteria

Research has continuously proven the existing positive association between media exposure and campaign effect on behaviour[3]. As a result, interventions proposed in this plan have to meaningfully reach defined target audience to generate positive behaviour change. The campaign has to provide messages that are understood, relevant, credible, trusted by the audience and that are expressed in straightforward, domesticated terms[4].

[3] Synder, L., Diop-Sidibé, N., Badiane, L. "A Meta-analysis of the Effectiveness of Family Planning Campaigns in Developing Countries", Paper presented to the Health Communication Division of the Annual Conference of the International Communication Association, New York, May 2003

[4] Cleland, J., Watkins, S., " The key lesson of family planning programs for HIV/AIDS control", AIDS 2006, Vol 20 No 1

One defining characteristic of Uttar Pradesh is that the state has important populations located in "media dark" areas. The Television reach[5] in the urban areas is approximately 66% whereas in the rural areas it drops to 26%. Satellite TV reach is high in urban areas at 39% but extremely poor at only 2% in rural. Reach of Radio in urban UP is around 22% and is higher in rural areas at 24%.



Source: Indian Readership Survey R1 2007

With male literacy[6] at 70.2% and female literacy at 42.9%, the reach of the print medium in the state is comparatively lower than TV and Radio at 32% in the urban areas and 10% in the rural areas[7].

Budget Criteria

- To ensure that at least the media exposed population gets adequate mass media exposure, media reach is targeted at 95% to 97%, with a frequency that goes from 3.5 to 6. The scheduling strategy would be pulsed with high intensity during launch (3 to 4 months) with maintenance periods of 3 months, alternated with "silence" periods of 2 to 3 months.
- Budget allocation should be 65% Mass Media and 35% to IPC and community based activities.
- Based on proposed strategies the suggested resource assignment is as follows:
    1. Strategy 1 (spacing methods) 45%
    2. Strategy 2 (limiting methods), 35%
    3. Strategy 3 (male involvement), 20%

[5] Indian Readership Survey R1 2007
[6] Census-2001
[7] Indian Readership Survey R1 2007

Estimated Budget for Campaigns

	Activity	Level of Activity	Rate (approx) in Rs.	Total for 1 Campaign (in Rs. Lacs)	Total for 3 Campaigns (in Rs. Lacs)
A	**Mass Media**				
	TV	State	LS	150.00	450.00
	Radio	State	LS	80.00	240.00
	Press	State / District	LS	45.00	135.00
	Local cable for all 3 campaigns	District	50000	35.00	35.00
B	**Local Media**				0
	Hoardings 2 per district	District	15000	21.00	63.00
	Community Level activities				0
	Group meetings (Men) biannual per Gram Sabha	Village	50	59.00	59.00
C	**Print Materials**				0
	Posters Spacing *	State	15	10.00	30.00
	Posters Limiting *	State	15	10.00	30.00
	Posters Male Involvement *	State	15	10.00	30.00
	Leaflets Spacing	State	LS	5.00	15.00
	Leaflets Limiting	State	LS	5.00	15.00
	Leaflets Male Involvement	State	LS	5.00	15.00
	Booth Banner for RI campaign	District	LS	100.00	100.00
	Sub Total				**1217.00**
D	**Integrated Media activity for NRHM**				
	Radio Drama Series	State	LS	-	50.00
	Radio Distance Learning Program for Health service providers	State	LS	-	50.00
	Wall Paintings	Block	Rs.12,000/- per block	-	98.76
E	**Production cost (TV, Radio, Prototypes, Duplication of CDs etc.)**	State	LS	-	150.00
	Sub Total				**348.76**
	Grand Total				**1565.76**

Apart from implementing the campaigns described above, wide publicity for various interventions would be ensured. Special events would also be organised on special occasions WHO Day, Women's Day, Breastfeeding Week, World Population Day, etc.

12.3 Communication Mobilization and Behaviour Change

Mahila Samakhya Uttar Pradesh is a unique initiative. A government programme, started in 1989 under the National Education Policy 1986. Mahila Samakhya Uttar Pradesh is committed to empower each woman to attain equality and their just place in family, society and governance.

Towards this Mahila Samakhya Uttar Pradesh strives to ensure establishment of women rights, access to qualitative education, health and economic opportunities as well as capacities to utilise them. Mahila Samakhya in 17 years long journey has been able to engage Sangha women in many developmental activities, their learning about rights, finance, banking has given them new sense of self worth.

Currently, the Samakhya is functioning in 16 districts of the State. It is proposed to involve Mahila Samakhya in community mobilisation and promoting behaviour change in areas of maternal health, child health, adolescent health and family planning through their women's groups.

An amount of Rs.0.50 lacs per district for 16 districts is being budgeted under this head. Accordingly, an amount of Rs.8.0 lacs would be required for the year 2008-09.

Budget Summary (IEC/ BCC Activities) 2008-09

Sl.	Activities	Budgetary Requirement for 2008-09 (Rs. in Lacs)
1.	Development of Comprehensive BCC Strategy	40.00
2.	Special Campaigns	1565.76
3.	Publicity through mass media (Advertisement through newspapers, flex hoardings at block/ district level, cinema slide, electronic media – Radio, TV Doordarshan, ETV (UP), Sahara TV, CCTV.)	200.00
4.	Activities on Special Occasions	25.00
5.	Contingency for IEC Bureau	3.00
6	Expenses towards community mobilization and behaviour change	8.00
TOTAL		**1841.76**

13. MONITORING & EVALUATION

13.1 Monitoring

For the purpose of monitoring various interventions being implemented under NRHM, it is proposed to establish an M&E cell within the PMU having adequate manpower which includes a senior manager with expertise in M&E, technical consultants to monitor specific components, such as, child health, maternal health, training, etc. Support staff namely, programme assistants and data analyst have been proposed. While State level interventions will also be monitored by the Programme Officers concerned, monitoring of district level interventions would be ensured through the programme management units at the Divisional level.

Additionally, it is proposed to place State Quality Monitors, one person at each division for monitoring availability and quality of services in the various districts of the division. People from outside the government system, preferably retired government department officers, having requisite experience of functioning of health sector would be deployed.

Monitoring activities would look into the following aspects:

- Implementation progress
- Gaps in implementation
- Uptake of services
- Utilisation of inputs
- Availability and utilisation of manpower & services
- Quality of care
- Equitable access to services, with focus on marginalised populations
- Financial inputs & physical outcomes
- Fund utilisation against set target
- Timely settlement of pending liabilities

Appropriate reporting formats consistent with the program interventions are being developed and a regular reporting arrangement involving the district and divisional programme management units will be established.

13.1.1 Development of Web based MIS

National Informatics Centre (NIC) has already been contracted for development of web based MIS software, consistent with GOI reporting guidelines. This is being done in coordination with UP Health Systems Development Project (UPHSDP). Further, certain activities are being undertaken by UPHSDP for strengthening decision support systems. A number of initiatives in collaboration with the NIC have already been made by the Project in this regard, namely, Health Management Information System HMIS), Personnel Information System (PIS), Financial Management Information System (FMIS) and Hospital Information System (HIS) – that would help in policy planning, informed decision making and

effective monitoring. Development of software, piloting some of these at the district level has been completed. The Project is now focussing on improving the models already developed, operationalizing the systems state-wide and testing further innovations. Training of State and district level functionaries is also planned.

Further, procurement of hardware, provision of internet connectivity, development of web based softwares as proposed under NRHM Additionalities in the PIP for 2007-08, have been initiated and would be completed shortly. Coordination is being maintained with UPHSDP for training of district functionaries and operationalising the web based MIS.

13.1.2 State Quality Monitors at Division Level

It is proposed to place one person at each division for monitoring availability and quality of services in the various districts of the division. People from outside the government system, preferably retired government department officers, having requisite experience of functioning of health sector would be deployed.

An advertisement for hiring the monitors on contract would be released in the leading local newspaper and a screening of applications would be done by a panel of officers constituted for the purpose by the Addl. Director of the Division. Three candidates would be shortlisted in each division and the names would be sent to the Mission Director for final selection on one candidate.

The monitors would be paid fixed honoraria, DA and travel expense and will be expected to conduct at least 6 days field visits and cover 2 districts each month. The monitoring would be done based on a checklist developed in consultation with programme officers.

The District PMUs/CMO would ensure availability of all related information/ records. The Addl Director's office shall provide secretarial assistance to the monitors who would submit his visit report and recommendations within 7 days of completion of their tour to the Mission Director, with a copy to the Addl. Director.

The budgetary provisions for the above have been included in the section on 'Programme Management' and would be met from the Mission flexipool.

13.1.3 Monitoring by Divisional Officers & State Programme Officers

Apart from having State Quality Monitors, the Addl. Director at the Division level will be responsible for monitoring implementation of the programme in the districts within the division. He would assign responsibility to his Jt. Director either for monitoring all activities in particular districts or particular components in all districts. Monthly review meetings of Addl. Directors at the State headquarter is already being conducted. Further, State programme officers would also undertake field visits to monitor implementation as well as, quality of services on a regular basis.

13.1.4 Video conferencing facility

Further, in order to facilitate effective monitoring across the State, videoconferencing facility will be installed at the SPMU. This facility will equip the officials in the State capital and doctors / officials in the districts to confer with each other on a regular basis provide updates and feedback, discuss problems, etc. without incurring travel expenses or other losses such as time, ignoring of patients etc. which is presently associated with face to face meetings.

The district officials would utilise the NIC infrastructure available in the districts.

13.1.4 Ensuring priority to NRHM by District Collectors

It is proposed to ensure regular meetings of State & District Health Missions so as to review the progress made under the programme. District Magistrates have already been appraised regarding the programme and all DHAPs have been approved by DMs and forwarded to the State. It is also proposed to have periodic communications sent to the District Magistrates by the Chief Secretary, as well as, by Mission Director so as to ensure commitment & leadership at the district level.

13.2 Evaluation

While goals will be assessed for impacts through evaluations conducted by GOI on a national basis (NFHS, SRS, DLHS), the process indicators and intermediate indicators will be tracked through periodic surveys by external agencies. Intervention specific evaluation will also be undertaken for measuring impacts and gaps. Findings of the evaluations will be utilized for bringing in the required changes in strategy and implementation plan.

Budget Summary (M&E Activities) 2008-09

Sl.	Activities	Requirement for 2008-09 (Rs. in Lacs)
1	Development of Formats	1.50
2	Operationalising Video Conferencing facility	2.50
3	Monitoring Surveys	100.00
4	Consultancies & Research Studies	50.00
5	Evaluation Studies (RCH Camps, Implementation of JSY, CCSP, IEC campaigns, etc.)	125.00
TOTAL		**279.00**

14. PROCUREMENT

14.1 Establishment of Procurement Cell

For procurement of various items (drugs and equipment) under NRHM, it is proposed to establish a procurement cell at the State PMU/ Directorate of Family Welfare. The cell would follow the norms laid down by Govt. of India in case of specific programs. The cell would undertake the following tasks:

- Deciding procurement strategy including technical specifications
- Mode of procurement
- Preparation of tender documents
- Advertisement of the tenders
- Issue of tender documents
- Opening of the tender
- Evaluation of the tender
- Award of contract
- Notification of delivery to consignee
- Inspection and testing
- Resolution of disputes, if any

The cell would be manned by contractual personnel as detailed below :

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Procurement Manager	1	MBA with relevant experience of atleast 5 yrs	26,000	**3.12**
2.	Asst. Procurement Manager	1	MBA with relevant experience of upto 2 yrs	20,000	**2.40**
3.	Accounts Officer	1	MFC/M.Com/CA Inter/ ICWA Inter	15,000	**1.80**
4.	Computer Operator	1	BCA/ BSc. with Computer Science	10,000	**1.20**
5.	Class-IV	1	-	4,500	**0.54**
Total					**9.06**

Budgetary Requirement (incl. in Programme Management)

Sl.	Activities	Amount (Rs. in Lacs)
1.	Payment to Contractual Staff	9.06
2.	Provision for hiring of technical experts on assignment basis	2.50
3.	Establishment of Office (computer system, telephone, furniture, etc.)	2.50
4.	Miscellaneous & Contingency	1.20
TOTAL		**15.26**

14.2 Procurement of Drug Kits

Details regarding procurement have been provided under the relevant component. Various procurements were proposed in the PIP for the year 2007-08, the approvals for which were received in the month of February 2008. These procurements would be completed during the year 2008-09. Additional budget required towards procurement during the year 2008-09 is summarised below:

Budget Summary (Procurement) 2007 – 08

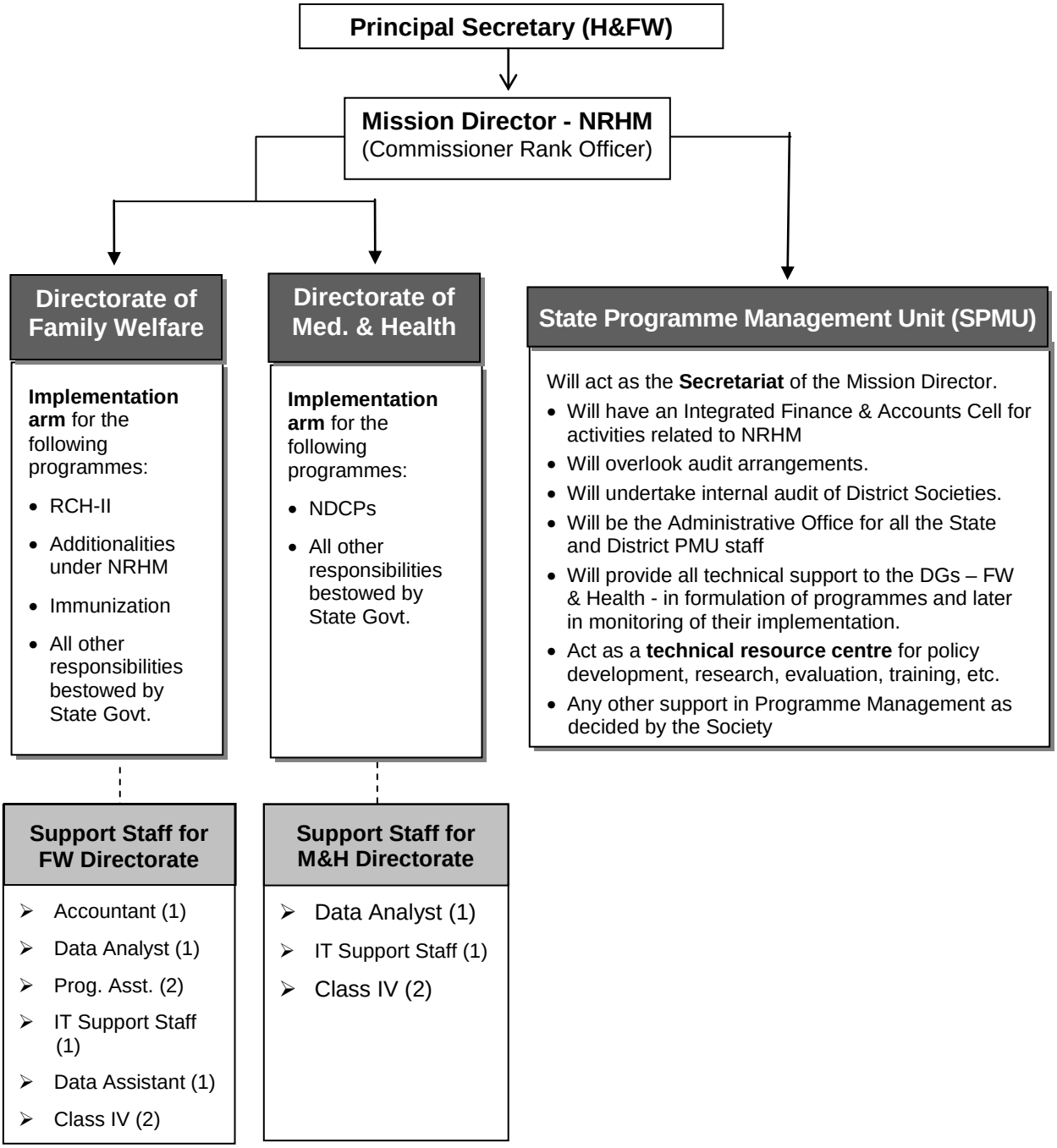
Sl.	Particulars	Amount (Rs. in lacs)
1	**Expenses towards Procurement Cell**	15.26
2	**Procurement for Child Health Interventions**	
	Deworming Tablets for School Children (6-10 years)	2.88
	IFA Tablets for School Children (6-10 years)	1440.00
Grand Total		**2342.92**

15. PROGRAMME MANAGEMENT

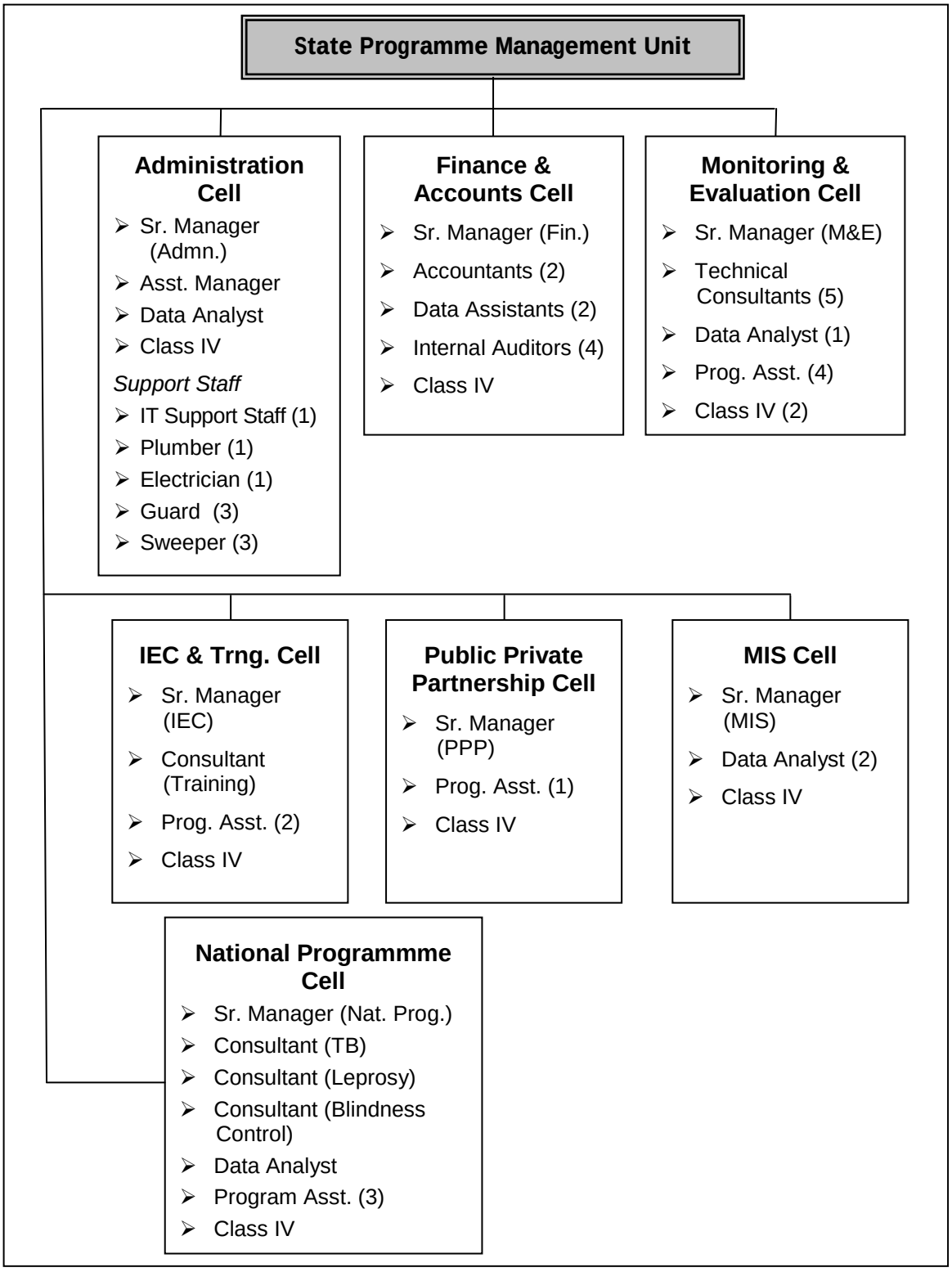
15.1.1 State PMU

The State PMU under NRHM would be established at the FW Directorate to look after RCH-II, as well as, other components of NRHM. It is further proposed to strengthen the programme management under RCH-II and at the Medical & Health Directorate. Additionally, for the effective implementation of the NRHM programme and considering the large geographic size of the State, additional units at the Division and Block levels are proposed to be established.

PROPOSED ORGANOGRAM FOR NRHM IMPLEMENTATION AT STATE LEVEL



STRUCTURE OF STATE PROGRAMME MANAGEMENT UNIT (SPMU)



A. Support Staff for Family Welfare Directorate

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Accountant	1	MFC/M.Com/CA Inter/ ICWA Inter	15,000	**1.80**
2.	Data Analyst	1	MCA/PGDCA	15,000	**1.80**
3.	Data Assistant	1	BCA/ BSc. With Computer Science	12,000	**1.44**
4.	IT Support Staff	1	Graduate with Dip. In Hardware Maintenance	10,000	**1.20**
5.	Programme Assistant	2	Masters Degree with Experience in Health Sector	12,000	**2.88**
6.	Class-IV	3	-	4,500	**1.62**
7.	Class-IV (Sweeper)	1	-	4,500	**0.42**
Total					**11.16**

B. Support Staff for M&H Directorate

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Data Analyst	1	MCA/PGDCA	15,000	**1.80**
2.	IT Support Staff	1	Graduate with Dip. In Hardware Maintenance	10,000	**1.20**
3.	Class-IV	2	-	4,500	**1.08**
Total					**4.08**

C. Staff for NRHM PMU

1. Administration Cell

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Sr. Manager (Administration)	1	MBA (HR) with 5+ yrs. Experience	26,000	**3.12**
2.	Asst. Manager	1	MBA with 2 yrs experience	20,000	**2.40**
3.	Data Analyst	1	MCA/PGDCA	15,000	**1.80**
4.	Class-IV	1	-	4,500	**0.54**
Support Staff for Housekeeping					
5.	IT Support Staff	1	Graduate with Dip. In Hardware Maintenance	10,000	**1.20**
6.	Plumber	1	-	5,000	**0.60**
7.	Electrician	1	-	5,000	**0.60**
8.	Guard	3	-	5,000	**1.80**
9.	Sweeper (Class-IV)	3	-	3,500	**1.26**
Total					**13.32**

2. Finance & Accounts Cell

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Sr. Manager (Finance)	1	CA/MBA (Finance)	26,000	**3.12**
2.	Accountant	2	MFC/M.Com/CA Inter/ ICWA Inter	15,000	**3.60**
3.	Data Assistant	2	BCA/ BSc. With Computer Science	12,000	**2.88**
4.	Internal Auditors	4	B. Com/ CA Inter/ ICWA Inter	10,000	**4.80**
5.	Class-IV	1	-	4,500	**0.54**
Total					**14.94**

3. Monitoring and Evaluation Cell

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Sr. Manager (M&E)	1	MBA (Operations Research) / PG in Statistics / Demo-graphy/ Popn. Sc.	26,000	**3.12**
2.	Technical Consultant (Maternal Health)	1	MBBS with Degree/Diploma in Obs. & Gynae.	25,000	**3.00**
3.	Technical Consultant (Child Health)	1	MBBS with Degree/Diploma in Paediatrics	25,000	**3.00**
4.	Technical Consultant (Quality Assurance)	1	Degree/Diploma in Hospital Management	25,000	**3.00**
5.	Consultant (Cold Chain)	1	Mechanical Engg. In Refrigeration	25,000	**3.00**
6.	Consultant (Procurement)	1	PG in Materials Mgmt. with at least 5 yrs experience	25,000	**3.00**
7.	Data Analyst	1	MCA/PGDCA	15,000	**1.80**
8.	Programme Assistant	4	Masters Degree with Experience in Health Sector	12,000	**5.76**
9.	Class-IV	2	-	4,500	**1.08**
Total					**26.76**

4. IEC & Training Cell

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Sr. Manager (IEC)	1	PG in Mass Comm.	26,000	**3.12**
2.	Consultant (Training)	1	MD (Preventive & Social Medicine) with experience in designing of curriculum & training materials	25,000	**3.00**
3.	Programme Assistant	2	Masters Degree with Experience in Health Sector	12,000	**2.88**
4.	Class-IV	1	-	4,500	**0.54**
Total					**9.54**

5. Public Private Partnership Cell

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Sr. Manager (PPP)	1	PG with at least 5 yrs experience in	26,000	**3.12**
2.	Programme Assistant	1	Masters Degree with at least 2 yrs. Experience of working with NGOs/PPP	12,000	**1.44**
4.	Class-IV	1	-	4,500	**0.54**
Total					**5.10**

6. MIS Cell

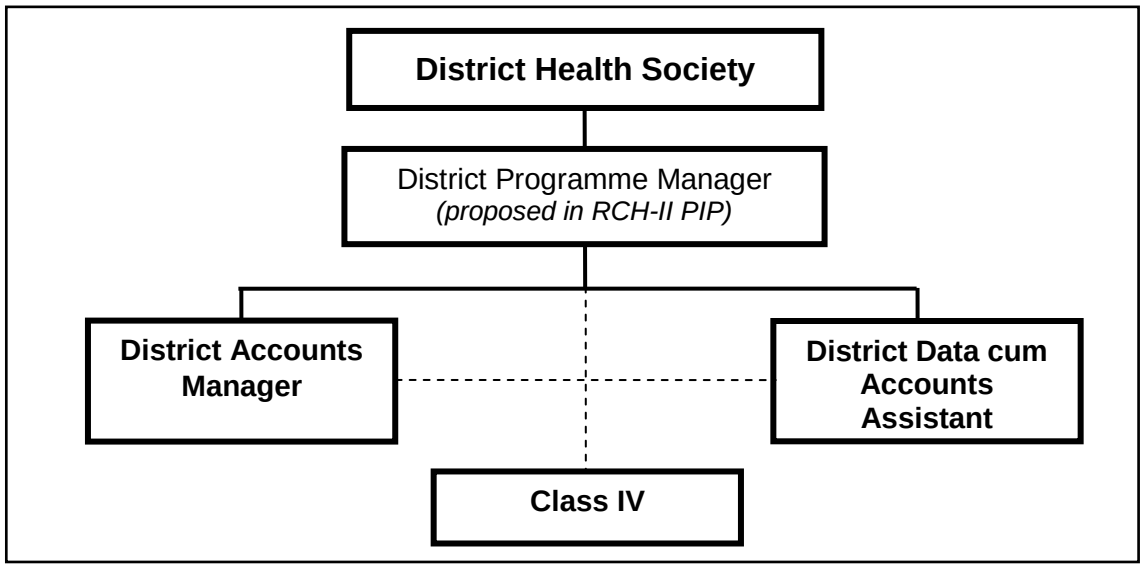
Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Sr. Manager (MIS)	1	Graduate in Software Engineering with 5+ yrs. Experience	26,000	**3.12**
2.	Data Analyst	2	MCA/PGDCA	15,000	**3.60**
3.	Class-IV	1	-	4,500	**0.54**
Total					**7.26**

7. National Programme Cell

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1	Sr. Manager	1	MBBS with Advanced Degree in Community Med.	26,000	**3.12**
2.	Technical Consultant (TB)	1	MBBS	25,000	**3.00**
3.	Technical Consultant (Blindness Control)	1	MBBS	25,000	**3.00**
4.	Technical Consultant (Leprosy)	1	MBBS	25,000	**3.00**
5.	Data Analyst	1	MCA/PGDCA	15,000	**1.80**
6.	Programme Assistant	3	Masters Degree with Experience in Health Sector	12,000	**4.32**
7.	Class-IV	2	-	4,500	**1.08**
Total					**19.32**

15.1.2 District PMU

For management of the programme interventions at the district level District PMUs would be established in all the 70 districts, the structure of which is shown below:

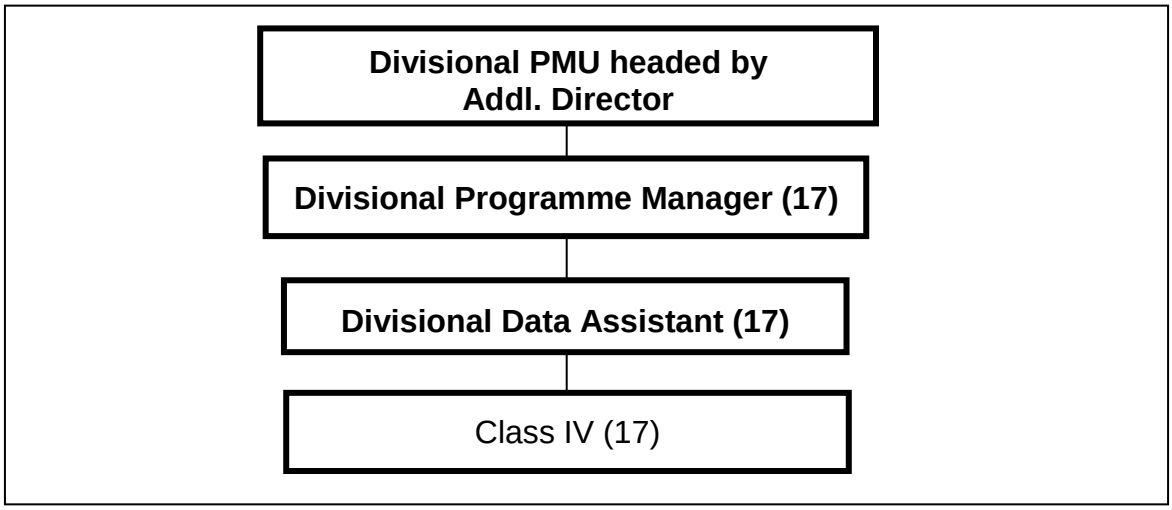


Budget :

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in lacs)
1.	Programme Manager	70	MBA/MBBS	20,000	**168.00**
2.	Accounts Manager	70	CA-Inter/ ICWA / MBA-Finance	15,000	**126.00**
3.	Data cum Accounts Assistant	70	B.Com / ICWA Inter with Computer Skills	10,000	**84.00**
4.	Class-IV	70	-	4,500	**37.80**
Total					**415.80**

15.1.3 Divisional PMU

A proposal for establishment of a Divisional Programme Management Unit at each division headed by the Additional Director was proposed and approved by GoI, the structure of which is shown below:



It has been decided by the State that the District Units that were constituted under SIFPSA would be reorganised to set-up the Divisional Unit in each division. This will speed by the process of establishment of these units and accordingly actions have also been initiated. The budgetary requirement mentioned in the PIP is as per the approval received form GoI. In case additional expenses are required to be incurred the same would be borne by SIFPSA.

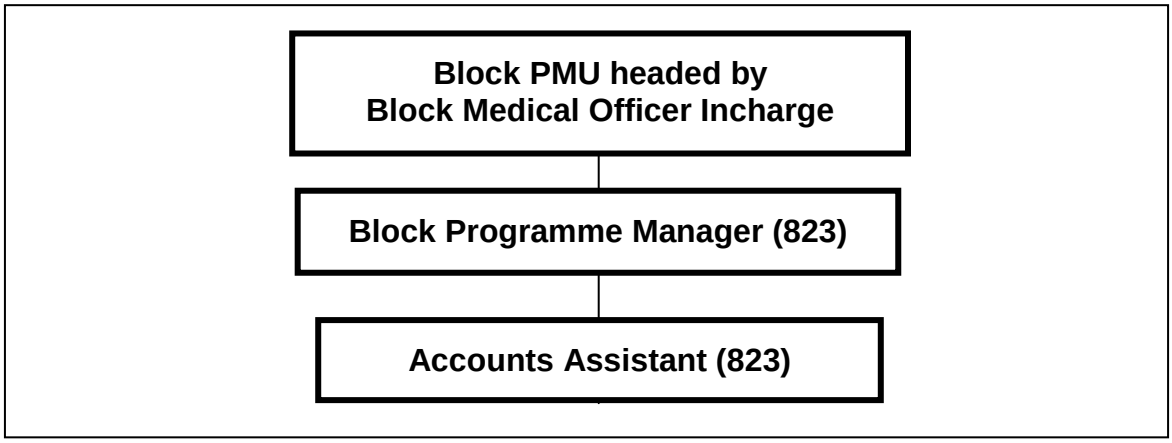
Budget for Divisional PMU:

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Programme Manager	17	MBA/MBBS	20,000	**40.80**
2.	Data Assistant	17	BCA/BSc. Comp.Sc	12,000	**24.48**
3.	Class-IV	17	-	4,500	**9.18**
Total					**74.46**

15.1.4 Block Level Units

At block level, two positions are recommended:

1) Block Programme Manager; and
2) Accounts Assistant.



Budget for Block level Units:

Designation	Number	Monthly Honoraria (Rs.)	Total Yearly Budget (Rs. in Lacs)
Programme Manager	823	12,000	**1185.12**
Accounts Assistant cum Data Entry Operator	823	8,000	**790.08**
Total			**1975.20**

15.1.5 Support Staff for Mission Director

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in Lacs)
1.	Executive Assistant	1	MBA	26,000	**3.12**
2.	Data Assistant	1	BCA/BSc. Comp.Sc	12,000	**1.44**
3.	Class-IV	1	-	4,500	**1.08**
Total					**5.64**

15.1.6 Recruitment Process

For the purpose of recruitment of Consultants and Sr. Mangers it is proposed to hire a recruitment agency of repute, which would carry out the initial short listing process, conduct a written screening test and preliminary interviews. A list of recommended candidates for various positions would be prepared by the agency and forwarded to the State. A panel of interviewers would be constituted who would conduct interviews and shortlist the final candidate.

For positions such as Data Assistants, Computer Operators and Class IV staff, local manpower providing agencies would be contracted.

It is expected that the hiring of programme management staff at various level would be completed by the end of the first quarter and necessary induction and follow-up training will be provided to the hired staff.

15.2 Strengthening of Directorate of Medical & Health, Directorate of Family Welfare and Divisional Offices

The strengthening of physical infrastructure (civil works) and office automation of the Family Welfare Directorate and State PMU is nearing completion. An amount of Rs.300 lacs had been budgeted in the PIP for 2007-08 for strengthening of the Medical & Health Directorate. The activity is in progress and the allocated funds would be utilised in 2008-09, hence no additional requirement is budgeted.

It was also proposed to carry out physical strengthening and refurbishment, including office automation, of Divisional Offices in the 17 Divisions of the State and accordingly a budget of Rs. 170 lacs @ Rs. 10 lacs per division was budgeted in the PIP for 2007-08. However, the activity was not approved. It is once again requested to sanction the amount of Rs.170 lacs for the above activity.

15.3 Operational Expenses

a) Operational Expenses for State FW Directorate

An amoun of Rs.162 lacs has been budgeted for various miscellaneous expenses (telephone, fax, stationery, consumables, program managers travel expense, housekeeping, etc.)

Expenditure Head	Amount (Rs. in lacs)
Audit fees, concurrent audits, etc.	30.00
Telephones/Fax/Mobile Phones/Other communication methods/maintenance @ Rs. 100,000 pm	12.00
Electricity Bills/Electrician on contract/A/C maintenance/ gensets etc. @ Rs. 100,000 pm	12.00
Stationary/Photo Copier Bills/AMC etc. @ Rs. 1,00,000 pm	12.00
Computer/AMC/CDs/Floppies/Internet etc. @ Rs. 50,000 pm	6.00
Vehicle Hire/POL etc. @ Rs.1,00,000 pm	12.00
Field visits/Meetings at GoI for the officers as per norms @ Rs.1 lac pm	12.00
Office equipments/ furniture/ painting/ maintenance etc.	50.00
Library/research/surveys/study tours/seminars & workshops	10.00
Contingency support/imprest money/office daily expenditures etc. @ Rs.50,000 p.m.	6.00
Total Expenditure	**162.00**

b) Operational Expenses for District PMUs

Sl.	Description	Annual Expense (Rs. in lacs)
1	District PMU (@ Rs. 40,000/- per month x 12 months x 70 units)	336.00
Total		**336.00**

c) Operational Expenses for Divisional and Block PMUs

Sl.	Description	Annual Expense (Rs. in lacs)
1	Divisional PMU (@ Rs. 50,000/- per month x 12 months x 17 units)	102.00
2	Block Units (@ Rs. 6,000/- per month x 12 months x 823 units)	592.56
Total		**694.56**

d) Operational Expenses for Support Unit of Mission Director

Sl.	Description	Annual Expense (Rs. in lacs)
1	Contingency Expenses (@ Rs. 10000/- per month x 12 months)	1.20
Total		**1.20**

15.4 Mobility support for Directorate Staff, Divisional Officers and District Programme Managers

For the purpose of improving programme management, monitoring & supervision, at the State and district levels, an amount of Rs.415.12 lacs has been budgeted.

Sl.	Description	Annual Expenditure (Rs. in lacs)
1.	Mobility support to State Level functionaries (incl. maintenance of government vehicles & POL) @ Rs. 7,50,000/- pm	90.00
2.	Mobility support to Divisional Level functionaries @ Rs. 10,000/- pm for 17 divisions	20.40
3.	Mobility Support to CMOs @ Rs. 8,000/- pm for 70 districts	67.20
4.	Mobility Support to Addl./Dy. CMOs @ Rs.5,000/- pm for 4 officers (excl. Nodal Officers for RCH and UIP) for 70 districts	168.00
5.	Mobility Support to Medical Officer Incharge at CHC/ BPHCs for 823 units (@Rs. 5000/- per month)	41.15
6.	Mobility Support to Medical Officers PHCs (30,000 popn) for 2837 units (@Rs. 1000/- per month)	28.37
Total		**415.12**

15.5 State Quality Monitors at Division Level

As already described in the section on 'Monitoring and Evaluation', it is proposed to place one person at each division for monitoring availability and quality of services in the various districts of the division. The budgetary requirement for the same would be as follows and would be met from the Mission flexipool::

Budgetary Requirement

Sl.	Description	No. of Days	No. of Persons	Monthly Expense (Rs.)	Annual Expense (Rs. in lacs)
1	Honoraria (@ Rs.1000/- per day)	6	1	6,000.00	0.72
2	Boarding & Lodging (@ Rs. 2000/- per day)	6	1	12,000.00	0.36
3	TA	-	1	3,000.00	0.36
4	Contingency	-	-	500.00	0.06
Total per Division per month				**17000.00**	**2.04**
Annual Expense for 17 Divisions					**34.68**
One-time recruitment expenses (@ Rs. 0.20 lacs per division)					**3.40**
Total Requirement for 2008-09					**38.08**

15.6 Human Resource Development Group

As already mentioned in the section on 'Human Resources' it is proposed to constitute a Human Resource Development Group in order to rationalise the deployment of manpower, assess training needs of officers and preparation of a training calendar for the district level officers. The budgetary requirement will be as under and will be met from the Mission flexipool:

Budgetary Requirement

Sl.	Description	Annual Amount (Rs. Lacs)
1	Expenses towards development of formats guidelines, state level training & orientation	2.00
2	Expenses towards District Visit (@ Rs.12,000/- per district for 70 districts) Honoraria @ Rs. 1000/- per day – Rs. 3000/- Lodging & Lodging @ Rs. 1500 per day x 3 days – Rs. 4500/- TA – est. 2000/- (as per actuals) Contingency - Rs. 2500/-	8.40
Grand Total		**10.40**

Budget Summary (Programme Management to be met from RCH Flexipool)

Sl.	Description	Annual Amount (Rs. Lacs)
1	Honoraria to State PMU Staff	111.48
2	Honoraria to District PMU Staff	415.80
3	Strengthening of Divisional Offices	170.00
4	Operational Expenses of FW Directorate	162.00
5	Operational Expenses of District PMUs	336.00
6	Provision of equipment/furniture and mobility support for SPMU Staff, Divisional Officers and District Programme Managers	415.12
7	Establishment & Operational Expenses of Procurement Cell	6.20
8	Honoraria to Procurement Cell Staff	9.06
Grand Total		**1625.66**

Programme Management Expenses to be met from Mission Flexipool

Sl.	Description	Annual Amount (Rs. Lacs)
1	Honoraria to Divisional PMU staff	74.46
2	Honoraria to Block PMUs staff	1975.20
3	Honoraria to Mission Director's Support Staff	5.64
4	Operational Expenses for Support Unit of Mission Director	1.20
5	Operational Expenses of Divisional and Block Units	694.56
6	State Quality Monitors at Division Level	38.08
7	Human Development Resource Group	10.40
Grand Total		**2799.54**

16 ADDITIONAL COMPONENTS

16.1 Health and Family Welfare Mela

It is proposed to organise 3-day health melas in each parliamentary constituency @ Rs. 8.00 lac per mela as per GOI norms.

Accordingly, for holding such melas in 80 constituencies an amount of Rs.640 lacs is budgeted for the year 2008-09.

6. BUDGET SUMMARY (PART A - RCH FLEXIPOOL)

(Rs. in lacs)

Sl.	Component	Funds Disbursed to Districts Earmarked for Utilisation	Approvals Received in 2007-08 to be Utilised in 2008-09	Proposed Budget for 2008-09	Total Funds to be Utilised in 2008-09
1	Maternal Health			471.80	471.80
2	Janani Suraksha Yojana			26092.50	26092.50
3	Child Health			1540.42	1540.42
4	Family Planning			1983.18	1983.18
5	Family Planning Compensation			3150.00	3150.00
6	Adolescent Health			344.05	344.05
7	Urban RCH			1891.90	1891.90
8	Infrastructure & Equipment			1017.32	1017.32
9	Human Resources			5473.31	5473.31
10	Institutional Strengthening			260.01	260.01
11	Training	2366.93		2152.20	4519.13
12	Public Private Partnership (PPP)			639.59	639.59
13	PPNDT & Sex Ratio			204.72	204.72
14	IEC/BCC			1841.76	1841.76
15	Monitoring & Evaluation			279.00	279.00
16	Procurement		6297.02	1442.88	7739.90
17	Programme Management			1625.66	1625.66
18	Health & Family Welfare Melas			640.00	640.00
Total (RCH Flexipool)		**2366.93**	**6297.02**	**51050.30**	**59714.25**
19	Routine Immunization			4634.41	4634.41
Total (RCH Flexipool & RI)		**2366.93**	**6297.02**	**55684.71**	**64348.66**

(Rs. in lacs)

Budget Head	06-07 (Actual expenditure)	07-08 (Actual/ estimated expenditure)	08-09								
			RCH II						NRHM	Others	Total
			Qtr I	Qtr II	Qtr III	Qtr IV	Total				
							Rs. lacs	%			
1. Maternal Health											
(a) JSY			6523.13	6523.13	6523.13	6523.13	26,092.50	51.1%			26,092.50
(b) Others			117.95	117.95	117.95	117.95	471.80	0.9%			471.80
Sub total			6641.08	6641.08	6641.08	6641.08	26,564.30	52.0%			26,564.30
2. Child Health			348.98	351.33	331.43	508.68	1,540.42	3.0%			1,540.42
3. Family Planning											0.00
(a) Sterilisation Compensation			500.00	500.00	1,000.00	1,000.00	3,000.00	5.9%			3,000.00
(b) NSV acceptance			18.00	25.00	44.00	63.00	150.00	0.3%			150.00
(c) Others			381.71	381.71	609.89	609.89	1,983.18	3.9%			1,983.18
Sub total			899.71	906.71	1,653.89	1,672.89	5,133.18	10.1%			5,133.18
4. Adolescent Reproductive and Sexual Health			63.00	113.90	104.15	63.00	344.05	0.7%			344.05
5. Urban RCH			513.48	459.48	459.48	459.48	1,891.90	3.7%			1,891.90
6. Tribal RCH			0.00	0.00	0.00	0.00	0.00	0.0%			0.00
7. Vulnerable groups			0.00	0.00	0.00	0.00	0.00	0.0%			0.00
8. Innovations / PPP/ NGO			134.68	180.68	252.18	276.77	844.31	1.7%			844.31
9. Infrastructure and Human Resources			1,567.91	1,567.91	1,567.91	1,567.91	6,271.63	12.3%			6,271.63

Budget Head	06-07 (Actual expenditure)	07-08 (Actual/ estimated expenditure)	08-09								
			RCH II						NRHM	Others	Total
			Qtr I	Qtr II	Qtr III	Qtr IV	Total				
							Rs. lacs	%			
10. Institutional Strengthening (HRD practices, logistics, M&E/ HMIS, QA)			119.00	165.00	130.00	125.02	539.01	1.1%			539.01
11. Training			618.05	506.12	519.15	508.88	2,152.20	4.2%			2,152.20
12. BCC/ IEC			781.51	632.25	534.00	534.00	2,481.76	4.9%			2,481.76
13. Procurement			1,661.88	0.00	0.00	0.00	1,661.88	3.3%			1,661.88
14. Programme Management			537.67	362.67	362.67	362.67	1,625.66	3.2%			1,625.66
TOTAL	12212.96	27199.00	13,886.93	11,887.11	12,555.92	12,720.36	51,050.30	100.0%			51,050.30

7. BUDGET DETAILS (PART A - RCH FLEXIPOOL)

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
1. MATERNAL HEALTH										
1.1. Operationalise facilities										
1.1.1. Operationalise Block PHCs/CHCs/ SDHs/DHs as FRUs	CHC/ DWH	50	70							Included under NRHM (upgradation as per IPHS)
1.1.1.1. Organise dissemination workshops for FRU guidelines										
1.1.1.2. Prepare plan for operationalisation across district	District plan		-							
1.1.1.3. Monitor progress against plan; follow up with training, procurement, etc	Per Facility									Included under NRHM (upgradation as per IPHS)
1.1.1.4. Monitor quality of service delivery and utilisation including through field visits.	Covered under 1.1.3			Covered under 1.1.3						
1.1.1.5. Innovative project (Promoting institutional deliveries through ISM/GNMs at selected PHCs.										
1.1.2. Operationalise PHCs to provide 24-hour services										
1.1.2.1. Incentive for night deliveries at CHCs/BPHCs	Per Facility	240	CHCs-426 PHCs- 397	Rs. 330/- per delv.	103.95	103.95	103.95	103.95	**415.80**	For expected 126000 deliveries at 823 facilities
1.1.2.2. Monitor progress against plan; follow up with training, procurement, etc	District Monitoring									

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
1.1.2.3. Monitor quality of service delivery and utilisation including through field visits.	PHC/CHC									Quality will be leveraged and monitored by Area Dy CMO / ACMO during sterilisation/RCH camp/ other monitoring activities
1.1.3. Operationalise MTP services at health facilities	CHC/DWH	53 DWHs + 150 CHCs	53 DWHs + 426 CHCs							
1.1.3.1. Prepare plan for operationalisation across districts (including training, equipment, drugs & supplies, etc.)	District	0	70	0						integrated with preparation of single plan document for all activities in the district
1.1.3.2. Monitor progress against plan; follow up with training, procurement, etc	District	-	NA	NA						linked with other monitoring activities
1.1.3.3. Monitor quality of service delivery and utilization including through field visits.	District	-	NA	NA						
1.1.4. Operationalise RTI/STI services at health facilities	CHC/DWH	50	70							
1.1.4.1. Prepare plan for operationalisation across districts (including training, equipment, drugs & supplies, etc.)	District	50	70							

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
1.1.4.2. Monitor progress against plan; follow up with training, procurement, etc	District	-	NA	NA						linked with other monitoring activities
1.1.4.3. Monitor quality of service delivery and utilisation including through field visits.	District	-	NA	NA						
1.1.5. Operationalise sub-centres										
1.1.5.1. Prepare plan for operationalising services at sub-centres (for a range of RCH services including antenatal care and post natal care)	District	0	70							
1.1.5.2. Monitor quality of service delivery and utilisation including through field visits	District/Block	0								LHV- 2 visits/week
1.2. Referral Transport										
1.2.1. Prepare and disseminate guidelines for referral transport for pregnant women and sick newborns / children	District	0	70							Leveraged through untied fund with RKS
1.2.2. Implementation by districts	Block	0	70							
1.3. Integrated outreach RCH services										
1.3.1. RCH Outreach Camps in un-served/ under-served areas										
1.3.1.1. Implementation by districts of RCH Outreach Camps in un-served/ under-served areas	Each camp	0	2 blocks /distt.	Rs. 20000.00	14.00	14.00	14.00	14.00	**56.00**	Identified 2 blocks/distt. X 2 camps/yr.
1.3.1.2. Monitor quality of services and utilisation.	Per camp	0								Each Camp to be supervised & monitored by area deputy CMO for quality & utilization thru' checklist

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
1.3.2. Monthly Village Health and Nutrition Days at Anganwadi Centres										
1.3.2.1. Implementation by districts of Monthly Village Health and Nutrition Days at Anganwadi Centres	AWC	0		Rs. 100/- per meeting x 2 meetings/ AWC per month						Already built under ASHA incentive scheme under NRHM
1.3.2.2. Monitor quality of services and utilisation	AWC	0								Linked with RI monitoring
1.4. Janani Suraksha Yojana / JSY (details of IEC/BCC in section 12)										
1.4.1. Dissemination of JSY guidelines to districts and sub-districts.	State-level	-	-							
1.4.2. Implementation of JSY by districts.										
1.4.2.1. Home deliveries	per benef.		1.5 lac		187.50	187.50	187.50	187.50	**750.00**	
1.4.2.2. Institutional deliveries	per benef.		Urban - 2.50 lacs Rural - 8.50 lacs		5650.00	5650.00	5650.00	5650.00	**22600.00**	
1.4.2.3. Caesarean Deliveries	per benef.		20,000		375.00	375.00	375.00	375.00	**1500.00**	
1.4.3. Monitor quality and utilisation of services.	State	contd.	MIS/Review meetings/WS		310.63	310.63	310.63	310.63	**1242.50**	
1.5. Other strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)										
1.5.1 Birth Preparedness, Safe Motherhood & ANC Meetings	per meeting	-	135000							Expenses incorporated under ASHA Incentive

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
2. CHILD HEALTH										
2.1. **Comprehensive Child Survival Programme for U.P.**(*IMNCI (details of training, drugs and supplies, under sections 11 and 13)*	17 districts	-								
2.1.1. Prepare detailed operational plan for IMNCI (CCSP-UP) across districts	State +17 districts	-			7.55	33.15			**40.70**	Sensitization Workshops
2.1.2. Implementation of CCSP-UP (including IMNCI activities in districts)	State & 17 Distt.	-	-	Average Rs.35.29 Lacs/ distt	150.00	150.00	150.00	150.00	**600.00**	Incentive for mandatory visits.
2.1.3. Monitor progress against plan:	State + 17 Divisions + 17 Distt.	-	Monitoring by state/Div./Distt levels	Review meetings to be organized by Unicef.					**0.00**	
2.1.3.1 Supportive supervision & monitoring through NGOs:	17		at least 2-3 NGOs in place in 17 distt.	Average Rs.5.29 Lac/distt.	22.50	22.50	22.50	22.50	**90.00**	
2.1.4. Evaluation & Infant Death Audit	17 distt.	-			20.00	7.00	10.00	15.00	**52.00**	
2.2. Facility Based Newborn Care/FBNC (details of training, drugs and supplies, under sections 11 & 13)										
2.2.1. Prepare and disseminate guidelines for FBNC.									**0.00**	
2.2.2. Prepare detailed operational plan for FBNC across districts (including training, BCC/IEC, drugs and supplies, etc.).& Implementation of FBNC activities in districts.									**0.00**	

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
2.2.3. Monitor progress against plan; follow up with training, procurement, etc.	State + 17 Divisions + 17 Distt.	-	35	Built in with CCSP prog.						
2.3. Home Based Newborn Care/HBNC (details included under Child survival programme for UP)	**The component is included under Child survival programme for UP)**									
2.3.1. Prepare and disseminate guidelines for HBNC.										
2.3.2. Prepare detailed operational plan for HBNC across districts (including training, BCC/IEC, drugs and supplies, etc.).										
2.3.3. Implementation of HBNC activities in districts.										
2.3.4. Monitor progress against plan; follow up with training, procurement, etc.										
2.4. School Health Programme										
2.4.1. Prepare and disseminate guidelines for School Health Programme.										
2.4.2. Prepare detailed operational plan for School Health Programme across districts.										
2.4.3. Implementation of School Health Programme by districts.	Per district		36000 schools		81.88	81.88	81.88	81.88	**327.50**	
2.4.4. Monitor progress and quality of services.										
2.5. Infant and Young Child Feeding/IYCF (details of training, drugs & supplies, under sections 11 and 13)										
2.5.1. Prepare and disseminate guidelines for IYCF.									**0.00**	
2.5.2. Prepare detailed operational plan for IYCF across districts (including training, BCC/IEC, drugs and supplies, etc.).	State & all 70 distt.		71							

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
2.5.3. Implementation of IYCF activities in districts.	71	Included under RCH-II regular	Seminars/ WS at State/Distt	**State-2.0 Lacs, Rs. 0.25 Lac/distt**	49.91	49.91	49.91	49.91	**199.62**	
2.5.4. Monitor progress against plan; follow up with training, procurement, etc.	State								**0.00**	
2.6. Care of Sick Children and Severe Malnutrition at FRUs										
2.6.1. Prepare and disseminate guidelines.	**Included under facility based care of sick children**									
2.6.2. Prepare detailed operational plan for care of sick children and severe malnutrition at FRUs, across districts (including training, BCC/IEC, drugs and supplies, etc.).	17									
2.6.3. Implementation of activities in districts.	20				6.90	6.90	6.90	6.90	**27.60**	
2.6.4. Monitor progress against plan; follow up with training, procurement, etc.										
2.7. Management of Diarrhoea, ARI and Micronutrient malnutrition	70				10.25		10.25		**20.50**	
2.8. Other strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)										
2.8.1 Pilot Conditional Cash Transfer Scheme for Addressing undernutrtion in Girl Child upto 2 yrs	2 distts.							182.50	**182.50**	
3. FAMILY PLANNING										
(Details of training, IEC/BCC, equipment, drugs and supplies in sections 11, 12 and 13)										
3.1. Terminal/Limiting Methods										
3.1.1. Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
3.1.2. Prepare operational plan for provision of sterilisation services across districts (including training, BCC/IEC, equipment, drugs and supplies, etc.).										
3.1.3. Implementation of sterilisation services by districts										
3.1.3.1. Provide female sterilisation services on fixed days at health facilities in districts	Per Facility (DWHs, Combined hospitals, PPCs, Other Female Hospitals & CHCs with trained service providers=200 Facilities)	0	500*210=105000 Sterilization	Rs. 50.00/sterilization	10.50	10.50	10.50	10.50	**42.00**	Daily Sterilization services at 210 identified facilities, the funding is being proposed for infection prevention materials, gloves, suture & other consumables. Other support to come from sterilization subsidy.
3.1.3.2. Provide NSV services on fixed days at health facilities in districts	Per Facility (District Male Hospitals, CHCs/BPHCs with trained service providers=3 Facilities/district)	0	210*3*12=7560	Rs. 50.00/ sterilization	2.63	2.63	2.63	2.63	**10.50**	Weekly sterilization services at 210 identified facilities, funding is being proposed for infection prevention materials, gloves, sutures &

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
										other consumables. Other support to come from sterilization subsidy. Exp. outcome 3 NSVs/ facility/week
3.1.3.4. Organise NSV camps in districts.	Camps (2 camps per distt. per yr)	0	140	Rs.167,250			117.08	117.08	**234.15**	2 camps per district between Oct. to Feb.
3.1.3.4(a) RCH Camp at Block PHCs/CHCs	Facility	14814	823*18=14814	Rs. 4500 + IEC	111.11	111.11	222.21	222.21	**666.63**	
3.1.3.5. Compensation for female sterilisation	Clients	216000	500000	Rs.1,000	500.00	500.00	1000.00	1000.00	**3000.00**	
3.1.3.6. Compensation for NSV Acceptance	Clients	1201	12000	Rs.1,500	18.00	25.00	44.00	63.00	**150.00**	
3.1.3.7. Incentive to AWW/ASHA									**0.00**	This will be met out from specific intervention subsidy eg sterilization, IUD etc
3.1.4. Monitor progress, quality and utilisation of services										Every block will be visited thrice in month by either Dy. CMO/ Addl. CMO/ CMO or other designated official

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
3.2. Spacing Methods										
3.2.1. Prepare operational plan for provision of spacing methods across districts (including training, BCC/IEC, drugs and supplies, etc.)	District & block workshop	0	1+ no. of blocks	incl. in Dissemination Workshop						
3.2.2. Implementation of IUD services by districts.	District	0	400000	Rs. 20.00	100.00	100.00	100.00	100.00	**400.00**	
3.2.2.1. Provide IUD services at health facilities in districts.	District Women Hospital, CHCs/PHCs, Joint Hospital, PPCs	0	823+70=893	Rs. 100000.00	39.98	39.98	39.98	39.98	**159.90**	
3.2.2.2. Organise IUD camps in districts.	Camp	7000 SC	7000*3=21000	Rs. 500.00	105.00	105.00	105.00	105.00	**420.00**	
3.2.3. Social Marketing of contraceptives										
3.2.3.1. Set up CBD Outlets										
3.2.4. Organise Contraceptive Update seminars for health providers										
3.2.5. Monitor progress, quality and utilisation of services.										
3.3. Other strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)					12.50	12.50	12.50	12.50	**50.00**	
4. ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH										
(Details of training, IEC/BCC in sections 11 and 12)										
4.1. Adolescent friendly services										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
4.1.1. Disseminate ARSH guidelines.	State-level Workshop		2 (1 W/S for 35 districts)			2.00			**2.00**	
4.1.2. Prepare operational plan for ARSH services across districts	State/District			State- Rs.5000/- Dist - Rs.1000/-		0.75			**0.75**	
4.1.3. Dissemination Workshops	District		70 districts	Distt. Rs. 0.1 lac/distt.		7.00			**7.00**	
4.1.4. Orientation Workshops	Block		823	Rs. 0.1 lac/block		41.15	41.15		**82.30**	To be organised at block headquarter to orient adolescent & their parents.
4.1.5. Implement ARSH services in districts by establishing adolescent counselling centres (1 in each district) thru NGOs	District		70 districts	0.20 lacs pm per centre /distt.	63.00	63.00	63.00	63.00	**252.00**	
4.2. Other strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)										
5. URBAN RCH										
5.1. Urban RCH Services										
5.1.1. Identification of urban areas / mapping of urban slums										
5.1.2. Prepare operational plan for urban RCH (including infrastructure and human resources, training, BCC/IEC, equipment, drugs and supplies, etc.).										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
5.1.3. Implementation of Urban RCH plan/ activities	District				506.81	452.81	452.81	452.81	**1865.22**	
5.1.3.1. Recruitment and training of link workers for urban slums										
5.1.3.2. Strengthening of urban health posts and urban health centres										
5.1.3.3. Provide Maternal Health services (please specify)										
5.1.3.4. Provide Child Health services (please specify)										
5.1.3.5. Provide Family Planning services (please specify)										
5.1.3.6. Provide ARSH services (please specify)										
5.1.4. Monitor progress, quality and utilisation of services.										
5.2. Other Urban RCH strategies/activities (please specify – PPP/ Innovations/NGO to be mentioned under section 8)					6.67	6.67	6.67	6.67	**26.68**	Thru RK Mission, Varanasi
6. TRIBAL RCH										
6.1. Tribal RCH services										
6.1.1. Mapping of tribal areas										
6.1.2. Prepare operational plan for tribal RCH (including infrastructure and human resources, training, BCC/IEC, equipment, drugs and supplies, etc.).										
6.1.3. Implementation of Tribal RCH activities										
6.1.3.1. Provide Maternal Health services (please specify)										
6.1.3.2. Provide Child Health services (please specify)										
6.1.3.3. Provide Family Planning services (please specify)										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
6.1.3.4. Provide ARSH services (please specify)										
6.1.4. Monitor progress, quality and utilisation of services.										
6.2. Other Tribal RCH strategies/activities (please specify – PPP/ Innovations/NGO to be mentioned under section 8)										
7. VULNERABLE GROUPS										
Specific health activities targeting vulnerable communities such as SCs, STs, and BPL populations living in urban and rural areas (not covered by Urban and Tribal RCH)										
7.1. Services for Vulnerable groups										
7.1.1. Mapping of vulnerable groups										
7.1.2. Prepare operational plan for vulnerable groups (including infrastructure and human resources, training, BCC/IEC, equipment, drugs and supplies, etc.).										
7.1.3. Implementation of activities										
7.1.3.1. Provide Maternal Health services (please specify)										
7.1.3.2. Provide Child Health services (please specify)										
7.1.3.3. Provide Family Planning services (please specify)										
7.1.3.4. Provide ARSH services (please specify)										
7.2. Other strategies/activities (please specify – PPP/ Innovations/NGO to be mentioned under section 8)										
8. INNOVATIONS/ PPP/ NGO										
8.1. PNDT and Sex Ratio										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
8.1.1. Operationalise PNDT Cell	State	0	1	Rs. 4.72 lacs	1.18	1.18	1.18	1.18	**4.72**	
8.1.2. Orientation of programme managers and service providers on PC & PNDT Act	State/District	0	70	District - Rs. 0.50 lac/Dist. State - Rs. 5.00 lacs	10.00	10.00	10.00	10.00	**40.00**	
8.1.3. Monitoring of Sex Ratio at Birth	District								**0.00**	
8.1.4. Other PNDT activities (please specify)	State/District	0	71	District - Rs. 1 lac per and State - Rs. 30 lacs	40.00	40.00	40.00	40.00	**160.00**	Sting operation, IEC, facilitation of legal cases & review mtgs. at state & district level
8.2. Public Private Partnerships	District		70		80.00	125.00	195.00	218.00	**618.00**	
8.3 NGO Programme	District		2		3.50	4.50	6.00	7.59	**21.59**	Dt. Mirzapur & Varanasi, outreach thru RKM
8.4. Other innovations(if any)										
9. INFRASTRUCTURE AND HUMAN RESOURCES										
9.1. Contractual Staff & Services										
9.1.1. ANMs recruited and in position		537	837	7,000/- pm	175.77	175.77	175.77	175.77	**703.08**	
9.1.2. Laboratory Technicians recruited and in position			426	8,000/- pm	102.24	102.24	102.24	102.24	**408.96**	
9.1.3. Staff Nurses recruited and in position			PHC- 1000 CHC- 852 DWH -150	9,000/- pm	540.54	540.54	540.54	540.54	**2162.16**	

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
9.1.4. Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians) recruited and in position			500	18,000/- pm	270.00	270.00	270.00	270.00	**1080.00**	
			Anaes-5000 cases Gynae - 5000 cases	Rs. 1000/- per case	25.00	25.00	25.00	25.00	**100.00**	
9.1.4.1 ISM lady Doctors			500	10,000/- pm	150.00	150.00	150.00	150.00	**600.00**	
9.1.5. Part time Dais for Sub Centres			15343	2,400/- pm	92.06	92.06	92.06	92.06	**368.23**	
9.1.6 Data Assistant for DWHs			53	8,000/- pm	12.72	12.72	12.72	12.72	**50.88**	
9.2. Major civil works (New constructions/ extensions/additions)										
9.2.1. Major civil works for operationalisation of FRUS										
9.2.2. Major civil works for operationalisation of 24 hour services at PHCs										
9.2.2.1 Major civil works for operationalisation of Subcentre										
9.2.2.2 Major civil works for operationalisation of Main centre										
9.3. Minor civil works (New constructions/ extensions/additions)										
9.3.1. Minor civil works for operationalisation of FRUS										
9.3.2. Minor civil works for operationalisation of 24 hour services at PHCs										
9.3.2.1 Minor civil works for operationalisation of Subcentre										
9.3.2.2 Minor civil works for operationalisation of Main centre										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
9.4. IMEP Operationalise Infection Management & Environment Plan at health facilities (details of training, equipment, drugs and supplies, under sections 11 and 13)										
9.4.1. Organise dissemination workshops for IMEP guidelines										
9.4.2. Prepare plan for operationalisation across districts (including staffing, infrastructure, training, equipment, drugs & supplies, etc.)										
9.4.3. Monitor progress against plan; follow up with training, procurement, etc										
9.4.5 Rent & Contingency for Sub Centre	Sub Centre		Rent - 12930 Cont. - 20521	Rent - Rs.250 Cont. - Rs.2000	199.58	199.58	199.58	199.58	**798.32**	
10. INSTITUTIONAL STRENGTHENING										
10.1. Human Resources Development										
10.1.1. HR Consultant(s) recruited and in position										
10.1.2. Mapping of human resources done										
10.1.3. Transfer and cadre restructuring policy developed										
10.1.4. Performance appraisal and reward system developed										
10.1.5. Incentive policies developed for posting in under-served areas										
10.1.6. Management Development Programme for Medical Officers										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
10.1.7. Other activities (please specify)										
10.2. Logistics management/ improvement										
10.2.1. Logistics consultant(s) recruited and in position										
10.2.2. Review of logistics management system done										
10.2.3. Training of staff in logistics management										
10.2.4 Logistic management at state/div. level	state/div.	1+11	12		32.94	32.94	32.94	32.94	**131.75**	
10.2.5. Decentralised fund for transportation of supplies			71		32.06	32.06	32.06	32.08	**128.26**	
10.3. Monitoring & Evaluation / HMIS										
10.3.1. *Strengthening of M&E Cell*										
10.3.1.1. M&E consultant(s) recruited and in position										
10.3.1.2.Provision of equipment at state & district levels										
10.3.1.3. Communication & Mobility support to State/Div. and District										
10.3.2. *Operationalising the new MIES format*										
10.3.2.1. Review of existing registers										
10.3.2.2. Printing of new forms										
10.3.2.3. Training of staff										
10.3.3. Other M&E activities (concurrent evaluation)					54.00	100.00	65.00	60.00	**279.00**	
11. TRAINING										
11.1. Strengthening of Training Institutions (SIHFW, ANMTCs, etc.)										
11.1.1. Carry out repairs/ renovations of the training institutions										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
11.1.1.1 Strengthening training Sites for Child Health Trainings					40.00	11.80			**51.80**	
11.1.1.2 Strengthening training Sites										
11.1.2. Provide equipment and training aids to the training institutions					80.00	35.84			**115.84**	17 district training sites
11.1.2.1 Job Aids & Tools for ASHA for Child Health					45.00				**45.00**	
11.1.2.2 Equipment & Training Aids for Family Planning trainings					54.00				**54.00**	
11.1.3. Contractual staff recruited and in position	SIHFW				6.45	2.85	2.85	2.85	**15.00**	
11.1.4. Contractual staff recruited and in position at Directorate Training Cell	State level									
11.1.4. Other activities (pl. specify)										
11.2. Development of training packages										
11.2.1. Development/ translation and duplication of training materials										
11.2.2. Specialised training equipment (for skills trainings) provided										
11.2.3. Other activities (pl. specify)										
11.3. Maternal Health Training										
11.3.1. *Skilled Attendance at Birth / SBA*										
11.3.1.1. Setting up of SBA Training Centres										
11.3.1.2. TOT for SBA					35.00	25.00	20.00	22.90	**102.90**	
11.3.1.3. Training of Medical Officers in SBA										
11.3.1.4. Training of Staff Nurses in SBA										
11.3.1.5. Training of ANMs / LHVs in SBA										
11.3.2. *EmOC Training*										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
11.3.2.1. Setting up of EmOC Training Centres	2			3.79 lacs						
11.3.2.2. TOT for EmOC	8 trainers trained at Vellore from 2 identified Medical Colleges.									
11.3.2.3. Training of Medical Officers in EmOC	2 Med. Colleges (8 trainees per batch)	nil	1 batch/facility	8.5 lacs/batch	8.50	8.50	8.50	16.45	**41.95**	
11.3.2.4. Short Term CEmOC Training						2.50	2.50	3.03	**8.03**	
11.3.3. *Life saving Anaesthesia skills training*										
11.3.3.1. Setting up of Life saving Anaesthesia skills Training Centres	1	nil	5							
11.3.3.2. TOT for Anaesthesia skills training	1		5	6.1 lac/batch					**0.00**	
11.3.3.3. Training of Medical Officers in life saving Anaesthesia skills	1 batch (4 MOs)		10		6.10	18.30	18.30	18.30	**61.00**	
11.3.4. *MTP training*										
11.3.4.1. TOT on MTP using MVA					2.00	3.00	3.00	3.00	**11.00**	
11.3.4.2. Training of Medical Officers in MTP using MVA										
11.3.4.3. Training of MOs in MTP using other methods (pl. specify)										
11.3.5. *RTI / STI Training*										
11.3.5.1. TOT for RTI/STI training										
11.3.5.2. Training of laboratory technicians in RTI/STI										
11.3.5.3. Training of Medical Officers in RTI/STI										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
11.3.5.4. Training of Staff Nurses in RTI/STI							1.00	1.00	**2.00**	
11.3.5.5. Training of ANMs / LHVs in RTI/STI										
11.3.6. *Orientation of Dai / TBAs on safe delivery*										
11.3.7. Other maternal health training (please specify)										
11.4. IMEP Training / Workshop										
11.4.1. TOT on IMEP										
11.4.2. IMEP training for state and district programme managers										
11.4.3. IMEP training for medical officers										
11.4.4 Training of Medical Offr. & LTs on Blood Storage						2.33	2.00		**4.33**	
11.5. Child Health Training										
11.5.1. CCSP-UP (IMNCI) Training (pre-service and in-service)										
11.5.1.1. TOT on Child survival package (pre-service and in-service)	3/distt. * 17 distt.	-	51	Rs. 2.364/unit					**0.00**	
11.5.1.2. CCSP-UP IMNCI Training for Medical Officers (Physicians)	3/distt. * 17 distt.		51	Rs. 2.416 lacs/unit					**0.00**	
11.5.1.3. CCSP-UP IMNCI Training for ANMs / LHVs / ASHA	17	-	Ongoing process	72.24 Lacs/distt.					**0.00**	
11.5.1.4. CCSP-UP IMNCI follow up Training	-	-	-	-						
11.5.1.5. Training material for IMNCI + HBNBC = CCSP	17	-	17	6.0 Lacs					**0.00**	
11.5.1.6 Development of Training module for CCSP	At State level		1	2.0 Lacs					**0.00**	

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
11.5.2. ***Facility Based Newborn Care / FBNC***										
11.5.2.1. TOT on FBNC (State Level)	10 Batches	-	10	Rs. 1.0 Lac/batch					**0.00**	
11.5.2.2. Training on FBNC for Medical Officers	17	-	17	2.0 Lacs					**0.00**	
11.5.2.3. Training on FBNC for SNs/ANMs	17	-	17	3.0 Lacs					**0.00**	
11.5.3. ***Home Based Newborn Care / HBNC***										
11.5.3.1. TOT on HBNC (Included in child survival package)	(Included in Comprehensive Child Survival Training Package)									
11.5.3.2. Training on HBNC for ASHA (Included in child survival package- 3 days Trg.)										
11.5.4. *Care of sick children and severe malnutrition at FRUs*	(Included in Facility Based Sick Child care)									
11.5.4.1 Development & printing of module for Care of sick children and severe malnutrition at FRUs- 3 days Trg. Package.	State level									
11.5.4.2. TOT on Care of sick children and severe malnutrition at FRUs	State level									
11.5.4.3. Training on Care of sick children and severe malnutrition for Medical Officers	17 distt.									
11.5.5. Other child health training (please specify)	-									
11.6. Family Planning Training										
11.6.1. *Laparoscopic Sterilisation Training*										
11.6.1.1. TOT on laparoscopic sterilisation										
11.6.1.2. Laparoscopic sterilisation training for medical officers					50.00	100.00	100.00	40.00	**290.00**	
11.6.2. *Minilap Training*										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
11.6.2.1. TOT on Minilap										
11.6.2.2. Minilap training for medical officers										
11.6.3. *Non-Scalpel Vasectomy (NSV) Training*										
11.6.3.1. TOT on NSV										
11.6.3.2. NSV										
11.6.4. *IUD Insertion*										
11.6.4.1. TOT for IUD insertion										
11.6.4.2. Training of Medical officers in IUD insertion										
11.6.4.3. Training of staff nurses in IUD insertion										
11.6.4.4. Training of ANMs / LHVs in IUD insertion										
11.6.5. Contraceptive update/ISD Training										
11.6.6. Other family planning training (please specify)										
11.7. ***Adolescent Reproductive and Sexual Health/ARSH Training***										
11.7.1. TOT for ARSH training										
11.7.2. Orientation training of state and district programme managers										
11.7.3. ARSH training for medical officers										
11.7.4. ARSH training for ANMs/LHVs										
11.7.5. ARSH training for AWWs										
11.8. Programme Management Training										
11.8.1. Training of SPMSU staff									**0.00**	
11.8.2. Training of DPMSU staff									**0.00**	
11.9. Other training (pl. specify)										
11.10 Other Activities (M&E, Meetings, Seminars, Study Tours and Research, etc.)					2.00	5.00	6.00	7.00	**20.00**	

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
11.13.1 AGT - TOT									**0.00**	
11.13.2 VHSC Orientation training					100.00	100.00	150.00	199.00	**549.00**	
11.14 Dai Training					150.00	100.00	110.00	133.70	**493.70**	
11.15 DTS									**0.00**	
11.16 Management Development Trainings										
11.16.1 AD/CMO						2.00	2.00	1.85	**5.85**	
11.16.2 CMS						2.00	2.00	1.85	**5.85**	
11.16.3 MOs						12.00	13.00	11.20	**36.20**	
11.16.4 Programme Mgmt Trainings					10.00	20.00	20.00	6.47	**56.47**	
11.17 Skill Development Trainings										
11.17.1 ANM					25.00	50.00	50.00	32.01	**157.01**	
11.17.2 LHV										
11.17.3 HW (Male)										
11.17.4 HS (Female)										
11.17.5 Staff nurse										
11.17.6 MO										
11.18 IEC Managers Induction					2.00	3.00	4.00	4.42	**13.42**	
11.19 Logistic Management					1.00	1.00	2.00	2.00	**6.00**	
11..20 Development of Trainers Skill					1.00	1.00	2.00	1.85	**5.85**	
12. BCC / IEC										
12.1 Strengthening of BCC/IEC Bureaus (state and district levels)										
12.1.1 Contractual staff recruited and in position										
12.1.2 Other activities (pl. specify)	0	0	0	0						
12.2 Development of State BCC strategy					40.00				**40.00**	
12.3 implementation of BCC strategy										
12.3.1 BCC/IEC activities/campaigns for	0	0	0	0						

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
maternal health										
12.3.1.1 BCC/IEC activities for maternal health intervention (except JSY)	State Level				127.00	122.00	80.00	80.00	**409.00**	
12.3.1.2 BCC/IEC activities for JSY	State Level									
12.3.1.2 BCC/IEC activities for JSY (distt. Level)	Distt. Level									
12.3.2 BCC/IEC activities/campaigns for child health	State/Distt Level				204.00	155.00	125.00	125.00	**609.00**	
12.3.3 BCC/IEC activities/campaigns for family planning	State/Distt Level				191.51	136.25	110.00	110.00	**547.76**	
12.3.4 BCC/IEC activities/campaigns for ARSH										
12.4 Any other activities (please specify)										
12.4.1 Publicity through mass media					50.00	50.00	50.00	50.00	**200.00**	
12.4.2 Activities on special occasions					7.00	7.00	7.00	7.00	**28.00**	
12.4.3 Community mobilization through Mahila Samakhya	Distt. Level		16 districts		2.00	2.00	2.00	2.00	**8.00**	
12.5 Health & Family Welfare Mela in MP constituencies	MP constituencies	0	80	Rs. 8.0 lacs/mela	160.00	160.00	160.00	160.00	**640.00**	
13. PROCUREMENT										
13.1. ***Procurement of Equipment***										
13.1.1. *Procurement of equipment for Maternal Health*										
13.1.1.1. Procurement of equipment of skills based services (anaesthesia, EmOC, SBA)	Included under NRHM under the component of upgradation of facilities as per IPHS									
13.1.1.2. Procurement of equipment of blood storage facility										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
13.1.1.3. Procurement of MVA/EVA equipment for health facilities										To be done from available funds of 2007-08
13.1.1.4. Procurement of RTI/STI equipment for health facilities										
13.1.1.5. Procurement of RTI/STI drug kits for selected 70 RTI/STI clinics										
13.1.1.6. Procurement of RTI/STI drugs for all BPHC/CHC										
13.1.1.7. Procurement of Kit A and Kit B										
13.1.1.8. Procurement of Kits for ASHA										
13.1.2. *Procurement of equipment for Child Health*										
13.1.2.1. Procurement of equipment for CCSP-UP IMNCI (Child survival kit for ASHA)										
13.1.2.2. Procurement of equipment for facility based newborn care & care of sick children and severe malnutrition										
13.1.3. *Procurement of equipment for Family Planning*										
13.1.3.1. Procurement / repair of Laparoscopes / Laprocators				Repair-400 AMC-450	219.00				**219.00**	
13.1.3.2. Procurement of NSV kits										
13.1.3.3. Procurement of IUDs/IUD Kits										
13.1.3.4. Procurement of operating microscopes/accessories for recanalisation services										
13.1.4. *Procurement of equipment for IMEP*										
13.2. Procurement of Drugs and supplies										
13.2.1. Procurement of drugs and supplies for maternal health										
13.2.2. Procurement of drugs and supplies for child health (Buffer stock of key drugs)										

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
13.2.3. Procurement of key supplies (Other than drugs: recording formats/ Registers & weighing scales) for child health										
13.2.4. Drugs for Care of sick children and severe malnutrition at CHC/PHC										
13.2.3. Procurement of drugs and supplies for family planning										
13.2.4. Procurement of supplies for IMEP										
13.2.5. Procurement of general drugs and supplies for health facilities										
13.3. Other procurement (please specify)										
13.3.1 Medicines kit for MTP										
13.3.1 DDKs										
13.3.4 Procurement of IFA for School Children					1440.00				**1440.00**	
13.3.4 Procurement of deworming tabs for School Children					2.88				**2.88**	
14. PROGRAMME MANAGEMENT										
14.1. ***Strengthening of State society/State Programme Management Support Unit (details of training under section 11)***										
14.1.1. Contractual Staff for SPMSU recruited and in position					27.87	27.87	27.87	27.87	**111.48**	
14.1.2. Provision of equipment/furniture for SPMSU staff (Strengthening of Directorate incl.)									**0.00**	
14.1.3 Operational Expenses for State FW Directorate (Contingency Support for miscellaneous activities)					40.5	40.5	40.5	40.5	**162.00**	
14.1.4. Provision of equipment/furniture for Divisional PMU staff	Division	0	17	Rs.10 lacs	170				**170.00**	

Budget Head	Physical Target			Rate (Rs./unit)	2008 - 09				Annual Amount (Rs. Lacs)	Remarks
	Unit of measure	Base-line (current status)	Target for the year		Q1	Q2	Q3	Q4		
14.2. ***Strengthening of District society/District Programme Management Support Unit (details of training under section 11)***										
14.2.1. Contractual Staff for DPMSU recruited and in position					103.95	103.95	103.95	103.95	**415.80**	
14.2.2. Provision of equipment/furniture and mobility support for SPMU Staff/ District Prog. Mgrs.					103.78	103.78	103.78	103.78	**415.12**	
14.2.3 Operational Expenses for State FW Directorate (Contingency Support for miscellaneous activities)					84.00	84.00	84.00	84.00	**336.00**	
14.3. ***Strengthening of Financial Management systems***										
14.3.1. Training in accounting procedures										
14.3.2. *Audits*										
14.3.2.1. Annual audit of the programme										
14.3.2.2. Concurrent audit										Under NRHM Addl.
14.3.3. Operationalise E-banking system upto district levels										
14.4 Other activities- Expenses towards procurement cell					7.565	2.565	2.565	2.565	**15.26**	
Total					**13,886.93**	**11,887.11**	**12,555.92**	**12,720.36**	**51,050.30**	

8. WORK PLAN (PART A - RCH II)

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
1.	**MATERNAL HEALTH**								
1.1.	*Operationalise facilities (details of infrastructure & human resources, training, IEC/BCC, equipment, drugs and supplies in sections 9, 11, 12 and 13)*								
1.1.1.	*Operationalise Block PHCs/CHCs/SDHs/DHs as FRUs*								
1.1.1.1.	Organize dissemination workshops for FRU guidelines	Completed							
1.1.1.2.	Prepare plan for operationalisation across districts (including staffing, infrastructure, training, equipment, drugs & supplies, etc.)	Y	Y	Y	Y	Y	Y	State/District	NRHM
1.1.1.3.	Monitor progress against plan; follow up with training, procurement, etc	Y	Y	Y	Y	Y	Y	District	NRHM
1.1.1.4.	Monitor quality of service delivery and utilization including through field visits.	Y	Y	Y	Y			State/District	NRHM
1.1.2.	*Operationalise PHCs to provide 24-hour services*								
1.1.2.1.	Prepare plan for operationalisation across districts (including staffing, infrastructure, training, equipment, drugs & supplies, etc.)	Y	Y	Y	Y	Y	Y	State/District	RCH
1.1.2.2.	Monitor progress against plan; follow up with training, procurement, etc	Y	Y	Y	Y	Y	Y	District	RCH
1.1.2.3.	Monitor quality of service delivery and utilization including through field visits.	Y	Y	Y	Y	Y	Y	State/District	RCH
1.1.3.	*Operationalise MTP services at health facilities*								
1.1.3.1.	Prepare plan for operationalisation across districts (including training, equipment, drugs & supplies, etc.)	Y	Y	Y	Y	Y	Y	District	RCH
1.1.3.2.	Monitor progress against plan; follow up with training, procurement, etc	Y	Y	Y	Y	Y	Y	District	RCH
1.1.3.3.	Monitor quality of service delivery and utilization including through field visits.	Y	Y	Y	Y	Y	Y	State/District	RCH
1.1.4.	*Operationalise RTI/STI services at health facilities*								

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
1.1.4.1.	Prepare plan for operationalisation across districts (including training, equipment, drugs & supplies, etc.)	Y	Y	Y	Y	Y	Y	District	RCH
1.1.4.2.	Monitor progress against plan; follow up with training, procurement, etc	Y	Y	Y	Y	Y	Y	District	RCH
1.1.4.3.	Monitor quality of service delivery and utilization including through field visits.	Y	Y	Y	Y	Y	Y	State/District	RCH
1.1.5.	*Operationalise sub-centres*								
1.1.5.1.	Prepare plan for operationalizing services at sub-centres (for a range of RCH services including antenatal care and post natal care)	Y	Y	Y	Y	Y	Y	District	RCH
1.1.5.2.	Monitor quality of service delivery and utilization including through field visits	Y	Y	Y	Y	Y	Y	State/District	RCH
1.2.	***Referral Transport***								
1.2.1.	Prepare and disseminate guidelines for referral transport for preg. women & sick newborns/ children	Y	Y					State	RCH
1.2.2.	Implementation by districts	Y	Y	Y	Y	Y	Y	District	RCH
1.3.	***Integrated outreach RCH services***								
1.3.1.	*RCH Outreach Camps in un-served/under-served areas*								
1.3.1.1.	Implementation by districts of RCH Outreach Camps in un-served/ under-served areas	Y	Y	Y	Y	Y	Y	District	RCH
1.3.1.2.	Monitor quality of services and utilization.	Y	Y	Y	Y	Y	Y	District	RCH
1.3.2.	*Monthly Village Health and Nutrition Days at Anganwadi Centres*								
1.3.2.1.	Implementation by districts of Monthly Village Health and Nutrition Days at Anganwadi Centres	Y	Y	Y	Y	Y	Y	District	RCH
1.3.2.2.	Monitor quality of services and utilization	Y	Y	Y	Y	Y	Y	District	RCH
1.4.	***Janani Suraksha Yojana / JSY (details of IEC/BCC in section 12)***								
1.4.1.	Dissemination of JSY guidelines to districts and sub-districts.	Completed							
1.4.2.	Implementation of JSY by districts.	Y	Y	Y	Y	Y	Y	District	RCH

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
1.4.3.	Monitor quality and utilization of services.	Y	Y	Y	Y	Y	Y	State/District	RCH
1.5.	*Other strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)*								
2.	**CHILD HEALTH**								
2.1.	*CCSP (IMNCI) (details of training, drugs and supplies, under sections 11 and 13)*								
2.1.1.	Prepare detailed operational plan for CCSP (IMNCI) across districts (including training, BCC/IEC, drugs and supplies, etc.).	Completed						State/District	RCH
2.1.2.	Implementation of CCSP (IMNCI) activities in districts	Y	Y	Y	Y	Y	Y	District	RCH
2.1.3.	Monitor progress against plan; follow up with training, procurement, etc.	Y	Y	Y	Y	Y	Y	District	RCH
2.1.4.	Pre-service CCSP (IMNCI) activities in medical colleges, nursing colleges, and ANMTCs								
2.2.	*Facility Based Newborn Care/FBNC (details of training, drugs and supplies, under sections 11 & 13)*								
2.2.1.	Prepare and disseminate guidelines for FBNC.	Completed						State	RCH
2.2.2.	Prepare detailed operational plan for FBNC across districts (including training, BCC/IEC, drugs and supplies, etc.).	Completed						District	RCH
2.2.3.	Implementation of FBNC activities in districts.	Y	Y	Y	Y	Y	Y	District	RCH
2.2.4.	Monitor progress against plan; follow up with training, procurement, etc.	Y	Y	Y	Y	Y	Y	State/District	RCH
2.3.	*Home Based Newborn Care/HBNC (details of training, drugs and supplies, under sections 11 and 13)*								
2.3.1.	Prepare and disseminate guidelines for HBNC.	Completed						State	RCH
2.3.2.	Prepare detailed operational plan for HBNC across districts (including training, BCC/IEC, drugs and supplies, etc.).	Completed						District	RCH
2.3.3.	Implementation of HBNC activities in districts.	Y	Y	Y	Y	Y	Y	District	RCH

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
2.3.4.	Monitor progress against plan; follow up with training, procurement, etc.	Y	Y	Y	Y	Y	Y	State/District	RCH
2.4.	*School Health Programme*								
2.4.1.	Prepare and disseminate guidelines for School Health Programme.	Y						State	RCH
2.4.2.	Prepare detailed operational plan for School Health Programme across districts.	Y						District	RCH
2.4.3.	Implementation of School Health Programme by districts.	Y	Y	Y	Y	Y	Y	District	RCH
2.4.4.	Monitor progress and quality of services.	Y	Y	Y	Y	Y	Y	District	RCH
2.5.	*Infant and Young Child Feeding/IYCF (details of training, drugs and supplies, under sections 11 and 13)*								
2.5.1.	Prepare and disseminate guidelines for IYCF.	Y							
2.5.2.	Prepare detailed operational plan for IYCF across districts (including training, BCC/IEC, drugs and supplies, etc.).	Y						District	RCH
2.5.3.	Implementation of IYCF activities in districts.	Y	Y	Y	Y	Y	Y	District	RCH
2.5.4.	Monitor progress against plan; follow up with training, procurement, etc.	Y	Y	Y	Y	Y	Y	State/District	RCH
2.6.	*Care of Sick Children and Severe Malnutrition at FRUs*								
2.6.1.	Prepare and disseminate guidelines.	Y						State	RCH
2.6.2.	Prepare detailed operational plan for care of sick children and severe malnutrition at FRUs, across districts (including training, BCC/IEC, drugs and supplies, etc.).	Y						District	RCH
2.6.3.	Implementation of activities in districts.	Y	Y	Y	Y	Y	Y	District	RCH
2.6.4.	Monitor progress against plan; follow up with training, procurement, etc.	Y	Y	Y	Y	Y	Y	State/District	RCH
2.7.	*Management of Diarrhoea, ARI and Micronutrient malnutrition*	Y	Y	Y	Y	Y	Y	District	RCH

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
2.8.	*Other strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)*								
3.	**FAMILY PLANNING**								
	(Details of training, IEC/BCC, equipment, drugs and supplies in sections 11, 12 and 13)								
3.1.	***Terminal/Limiting Methods***								
3.1.1.	Dissemination of manuals on sterilization standards & quality assurance of sterilization services.	Completed						State	RCH
3.1.2.	*Prepare operational plan for provision of sterilization services across districts (including training, BCC/IEC, equipment, drugs and supplies, etc.).*	Y						District	RCH
3.1.3.	*Implementation of sterilization services by districts*								
3.1.3.1.	Provide female sterilization services on fixed days at health facilities in districts	Y	Y	Y	Y	Y	Y	District	RCH
3.1.3.2.	Provide NSV services on fixed days at health facilities in districts	Y	Y	Y	Y	Y	Y	District	RCH
3.1.3.3.	Organize female sterilization camps in districts.	Y	Y	Y	Y	Y	Y	District	RCH
3.1.3.4.	Organize NSV camps in districts.	Y	Y	Y	Y	Y	Y	District	RCH
3.1.4.	*Accreditation of private providers to provide sterilization services*	Y	Y	Y	Y				
3.1.5.	*Monitor progress, quality and audit of services through Quality Assurance Committees*	Y	Y	Y	Y	Y	Y		
3.2.	***Spacing Methods***								
3.2.1.	*Prepare operational plan for provision of spacing methods across districts (including training, BCC/IEC, drugs and supplies, etc.).*	Y						State	RCH
3.2.2.	*Implementation of IUD services by districts.*								
3.2.2.1.	Provide IUD services at all health facilities in districts.	Y	Y	Y	Y	Y	Y	District	RCH
3.2.2.2.	Organize IUD camps in districts.	Y	Y	Y	Y	Y	Y	District	RCH
3.2.2.3.	Repositioning IUD 380A	Y	Y	Y	Y	Y	Y	District	RCH

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
3.2.3.	*Social Marketing of contraceptives*								
3.2.3.1.	Set up CBD Outlets								
3.2.4.	*Organize Contraceptive Update seminars for health providers*								
3.2.5.	*Monitor progress, quality and utilization of services.*	Y	Y	Y	Y	Y	Y	State/District	RCH
3.3.	***Other strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)***								
4.	**ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH**								
	(Details of training, IEC/BCC in sections 11 and 12)								
4.1.	***Adolescent friendly services***								
4.1.1.	Disseminate ARSH guidelines.	Y						State	RCH
4.1.2.	Prepare operational plan for ARSH services across districts (including training, BCC/IEC, equipment, drugs and supplies, etc.).	Y						District	RCH
4.1.3.	Implement ARSH services in districts.		Y	Y	Y	Y	Y	District	RCH
4.1.3.1.	Setting up of Adolescent Clinics at health facilities.	Y	Y					District	RCH
4.1.4.	Monitor progress, quality and utilization of services.	Y	Y	Y	Y	Y	Y	State/District	RCH
4.2.	***Other strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)***								
5.	**URBAN RCH**								
5.1.	***Urban RCH Services***								
5.1.1.	Identification of urban areas / mapping of urban slums	Y	Y					District	RCH
5.1.2.	Prepare operational plan for urban RCH (including infrastructure and human resources, training, BCC/IEC, equipment, drugs and supplies, etc.).	Y	Y					District	RCH

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
5.1.3.	Implementation of Urban RCH plan/ activities	Y	Y	Y	Y			District	RCH
5.1.3.1.	Recruitment and training of link workers for urban slums	Y	Y	Y	Y			District	RCH
5.1.3.2.	Strengthening of urban health posts and urban health centres		Y	Y				District	RCH
5.1.3.3.	Provide Maternal Health services (ANC, Spacing methods)	Y	Y	Y	Y	Y	Y	District	RCH
5.1.3.4.	Provide Child Health services	Y	Y	Y	Y	Y	Y	District	RCH
5.1.3.5.	Provide Family Planning services (ANC, TT))	Y	Y	Y	Y	Y	Y	District	RCH
5.1.3.6.	Provide ARSH services (please specify)								
5.1.4.	Monitor progress, quality and utilization of services.	Y	Y	Y	Y	Y	Y	District	RCH
5.2.	*Other Urban RCH strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)*								
6.	**TRIBAL RCH**								
6.1.	*Tribal RCH services*								
6.1.1.	Mapping of tribal areas								
6.1.2.	Prepare operational plan for tribal RCH (including infrastructure and human resources, training, BCC/IEC, equipment, drugs and supplies, etc.).								
6.1.3.	Implementation of Tribal RCH activities								
6.1.3.1.	Provide Maternal Health services								
6.1.3.2.	Provide Child Health services								
6.1.3.3.	Provide Family Planning services								
6.1.3.4.	Provide ARSH services								
6.1.4.	Monitor progress, quality and utilization of services.								
6.2.	*Other Tribal RCH strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)*								

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
7.	**VULNERABLE GROUPS**								
	Specific health activities targeting vulnerable communities such as SCs, STs, and BPL populations living in urban and rural areas (not covered by Urban and Tribal RCH)								
7.1.	***Services for Vulnerable groups***								
7.1.1.	Health Posts in Urban Slums	Y	Y	Y	Y	Y	Y	District	RCH
7.1.2.	Prepare operational plan for vulnerable groups (including infrastructure and human resources, training, BCC/IEC, equipment, drugs and supplies, etc.).								
7.1.3.	Implementation of activities	Y	Y	Y	Y	Y	Y	District	RCH
7.1.3.1.	Provide Maternal Health services	Y	Y	Y	Y	Y	Y	District	RCH
7.1.3.2.	Provide Child Health services	Y	Y	Y	Y	Y	Y	District	RCH
7.1.3.3.	Provide Family Planning services	Y	Y	Y	Y	Y	Y	District	RCH
7.1.3.4.	Provide ARSH services								
7.2.	***Other strategies/activities (please specify - PPP/ Innovations/NGO to be mentioned under section 8)***								
8.	**INNOVATIONS/ PPP/ NGO**								
8.1.	***PNDT and Sex Ratio***								
8.1.1.	Operationalise PNDT Cell	Completed						State	RCH
8.1.2.	Orientation of programme managers and service providers on PC & PNDT Act	Y	Y					State	RCH
8.1.3.	Monitoring of Sex Ratio at Birth	Y	Y	Y	Y	Y	Y	State	RCH
8.1.4.	Other PNDT activities	Y	Y	Y	Y	Y	Y	State/District	RCH
8.2.	***Public Private Partnerships***	Y	Y	Y	Y	Y	Y	State/District	RCH
8.3.	***NGO Programme***	Y	Y	Y	Y	Y	Y	State/District	RCH
8.4.	***Other innovations(if any)***								

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
9.	**INFRASTRUCTURE AND HUMAN RESOURCES**								
9.1.	***Contractual Staff & Services***								
9.1.1.	ANMs recruited and in position	Y	Y					District	RCH
9.1.2.	Laboratory Technicians recruited and in position	Y	Y	Y	Y			District	NRHM
9.1.3.	Staff Nurses recruited and in position	Y	Y	Y	Y			District	NRHM
9.1.4.	Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians) recruited and in position	Y	Y	Y	Y			District	RCH
9.1.5.	Others (specify) recruited and in position								
9.2.	***Major civil works (New constructions/ extensions/additions)***								
9.2.1.	Major civil works for operationalisation of FRUS	-	Y	Y	Y	Y	Y	Distt.	NRHM
9.2.2.	Major civil works for operationalisation of 24 hour services at PHCs	-	-	-	-	-	-	-	-
9.2.2.1	Major civil works for operationalisation of sub centre	Y	Y	Y	Y		-	Distt.	NRHM
9.2.2.2	Major civil works for operationalisation of main centre		Y	Y	Y			Distt.	NRHM
9.3.	***Minor civil works***								
9.3.1.	Minor civil works for operationalisation of FRUs	Y	Y	Y	Y				
9.3.2.	Minor civil works for operationalisation of 24 hour services at PHCs	Y	Y	Y	Y				
9.3.2.1	Minor civil works for operationalisation of sub centre	Y	Y	Y	Y				
9.3.2.2	Minor civil works for operationalisation of main centre	Y	Y	Y	Y				
9.4.	***Operationalise Infection Management & Environment Plan at health facilities (details of training, equipment, drugs and supplies, under sections 11 and 13)***								
9.4.1.	Organize dissemination workshops for IMEP guidelines		Y	Y	Y			State	RCH
9.4.2.	Prepare plan for operationalisation across districts (including staffing, infrastructure, training, equipment, drugs & supplies, etc.)			Y	Y			District	RCH
9.4.3.	Monitor progress against plan; follow up with training, procurement, etc		Y	Y	Y			State/District	RCH

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
9.5.	Other activities (pl. specify)								
10.	**INSTITUTIONAL STRENGTHENING**								
10.1.	***Human Resources Development***								
10.1.1.	HR Consultant(s) recruited and in position								
10.1.2.	Mapping of human resources done								
10.1.3.	Transfer and cadre restructuring policy developed		Y	Y					State
10.1.4.	Performance appraisal and reward system developed	Y	Y						State
10.1.5.	Incentive policies developed for posting in under-served areas								
10.1.6.	Management Development Programme for Medical Officers								
10.1.7.	Other activities								
10.2.	***Logistics management/ improvement***								
10.2.1.	Logistics consultant(s) recruited and in position								
10.2.2.	Review of logistics management system done								
10.2.3.	Training of staff in logistics management			Y	Y			State	RCH
10.2.4.	Construction of Drug warehouse at district level	Y	Y	Y	Y	Y	-	District	NRHM
10.2.5.	Other logistics activities								
10.3.	***Monitoring & Evaluation / HMIS***								
10.3.1.	*Strengthening of M&E Cell*								
10.3.1.1.	M&E consultant(s) recruited and in position	Y						State	RCH
10.3.1.2.	Provision of equipment at state and district levels	Y	Y					State/District	RCH
10.3.2.	*Operationalizing the new MIES format*								
10.3.2.1.	Review of existing registers								
10.3.2.2.	Printing of new forms		Y					State	RCH
10.3.2.3.	Training of staff		Y	Y				State	RCH
10.3.3.	Other M&E activities								

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
11.	**TRAINING**								
11.1.	***Strengthening of Training Institutions (SIHFW, ANMTCs, etc.)***								
11.1.1.	Carry out repairs/ renovations of the training institutions	Y	Y	Y				State	RCH
11.1.2.	Provide equipment and training aids to the training institutions	Y	Y					State	RCH
11.1.3.	Contractual staff recruited and in position	Y	Y	Y				State	RCH
11.1.4.	Other activities (pl. specify)								
11.2.	***Development of training packages***								
11.2.1.	Development/ translation and duplication of training materials	Y	Y	Y				State	RCH
11.2.2.	Specialized training equipment (for skills trainings) provided	Y	Y					State	RCH
11.2.3.	Other activities (pl. specify)								
11.3.	***Maternal Health Training***								
11.3.1.	*Skilled Attendance at Birth / SBA*								
11.3.1.1.	Setting up of SBA Training Centres	Y						State	NRHM
11.3.1.2.	TOT for SBA	Y	Y	Y	Y			State	NRHM
11.3.1.3.	Training of Medical Officers in SBA	Y	Y	Y	Y	Y	Y	State	NRHM
11.3.1.4.	Training of Staff Nurses in SBA	Y	Y	Y	Y	Y	Y	State	NRHM
11.3.1.5.	Training of ANMs / LHVs in SBA	Y	Y	Y	Y	Y	Y	State/District	NRHM
11.3.2.	*EmOC Training*								
11.3.2.1.	Setting up of EmOC Training Centres	Completed							
11.3.2.2.	TOT for EmOC	Completed						State	RCH
11.3.2.3.	Training of Medical Officers in EmOC	Y	Y	Y	Y	Y	Y	State	RCH
11.3.3.	*Life saving Anaesthesia skills training*								
11.3.3.1.	Setting up of Life saving Anaesthesia skills Training Centres	Y							
11.3.3.2.	TOT for Anaesthesia skills training	Y	Y						
11.3.3.3.	Training of Medical Officers in life saving Anaesthesia skills	Y	Y	Y	Y	Y	Y	State	RCH

Strategy / Activity	Timeline						Responsibility State/District	Source of funds (Pls. specify)
	2008-09				2009-10	2010-11		
	Q1	Q2	Q3	Q4				
11.3.4. *MTP Training*								
11.3.4.1. TOT on MTP using MVA	Y	Y						
11.3.4.2. Training of Medical Officers in MTP using MVA	Y	Y	Y	Y	Y	Y	State	RCH
11.3.4.3. Training of MOs in MTP using other methods	Y	Y	Y	Y	Y	Y	State	RCH
11.3.5. *RTI / STI Training*	Included in skill upgradation training.							
11.3.5.1. TOT for RTI/STI training								
11.3.5.2. Training of laboratory technicians in RTI/STI		Y	Y	Y	Y	Y	State	RCH
11.3.5.3. Training of Medical Officers in RTI/STI		Y	Y	Y	Y	Y	State	RCH
11.3.5.4. Training of Staff Nurses in RTI/STI								
11.3.5.5. Training of ANMs / LHVs in RTI/STI								
11.3.6. Orientation of Dai / TBAs on safe delivery	Y	Y	Y	Y			State	RCH
11.3.7. Other maternal health training								
11.4. ***IMEP Training***								
11.4.1. TOT on IMEP		Y					State	RCH
11.4.2. IMEP training for state and district programme managers		Y					State	RCH
11.4.3. IMEP training for medical officers			Y	Y			State	RCH
11.5. ***Child Health Training***								
11.5.1. *IMNCI Training (pre-service and in-service)*							State	RCH
11.5.1.1. TOT on IMNCI *(pre-service and in-service)*	Completed						State	RCH
11.5.1.2. IMNCI Training for Medical Officers		Y	Y	Y			State	RCH
11.5.1.3. IMNCI Training for staff nurses					Y		State/District	RCH
11.5.1.4. IMNCI Training for ANMs / LHVs	Y	Y	Y	Y	Y	Y	State/District	RCH
11.5.1.5. IMNCI Training for ASHAs	Y	Y	Y	Y	Y	Y	State/District	RCH
11.5.2. *Facility Based Newborn Care / FBNC*								
11.5.2.1. TOT on FBNC	Y	Y					State	RCH
11.5.2.2. Training on FBNC for Medical Officers		Y	Y				State	RCH
11.5.2.3. Training on FBNC for SNs		Y	Y				State	RCH
11.5.3. *Home Based Newborn Care / HBNC*								
11.5.3.1. TOT on HBNC								
11.5.3.2. Training on HBNC for ASHA (2nd & 3rd Trg. PCG)			Y	Y	Y	Y	State	RCH

Strategy / Activity	Timeline						Responsibility State/District	Source of funds (Pls. specify)
	2008-09				2009-10	2010-11		
	Q1	Q2	Q3	Q4				
11.5.4. *Care of sick children and severe malnutrition*								
11.5.4.1. TOT on Care of sick children and severe malnutrition		Y	Y				State	RCH
11.5.4.2. Training on Care of sick children and severe malnutrition for Medical Officers		Y	Y				State	RCH
11.5.5. Other child health training								
11.6. ***Family Planning Training***								
11.6.1. *Laparoscopic Sterilization Training*								
11.6.1.1. TOT on laparoscopic sterilization	Y	Y					State	RCH
11.6.1.2. Laparoscopic sterilization training for medical officers		Y	Y	Y	Y	Y	State	RCH
11.6.2. *Minilap Training*								
11.6.2.1. TOT on Minilap	Y	Y					State	RCH
11.6.2.2. Minilap training for medical officers		Y	Y	Y	Y	Y	State	RCH
11.6.3. *Non-Scalpel Vasectomy (NSV) Training*								
11.6.3.1. TOT on NSV		Y					State	RCH
11.6.3.2. NSV training for MOs			Y	Y	Y	Y	State	RCH
11.6.4. *IUD Insertion*								
11.6.4.1. TOT for IUD insertion	Y	Y	Y	Y			State	RCH
11.6.4.2. Training of Medical officers in IUD insertion	Y	Y	Y	Y	Y	Y	State	RCH
11.6.4.3. Training of staff nurses in IUD insertion	Y	Y	Y	Y	Y	Y	State/District	RCH
11.6.4.4. Training of ANMs / LHVs in IUD insertion	Y	Y	Y	Y	Y	Y	State/District	RCH
11.6.5. *Contraceptive Update/ISD Training*								
11.6.6. Other family planning training								
11.7. ***Adolescent Reproductive & Sexual Health/ARSH Training***								
11.7.1. TOT for ARSH training								
11.7.2. Orientation training of state and district programme managers		Y	Y				State	RCH

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
11.7.3.	ARSH training for medical officers								
11.7.4.	ARSH training for ANMs/LHVs								
11.7.5.	ARSH training for AWWs								
11.8.	***Programme Management Training***								
11.8.1.	Training of SPMSU staff	Y	Y					State	RCH
11.8.2.	Training of DPMSU staff	Y	Y	Y	Y			State	RCH
11.9.	Other training (pl. specify) Mgmt. Trg. details annexed separately.								
12.	**BCC / IEC**								
12.1	***Strengthening of BCC/IEC Bureaus (state & district)***								
12.1.1	Contractual staff recruited and in position	Y						State	RCH
12.1.2	Other activities (pl. specify)								
12.2	***Development of State BCC strategy***	Y	Y					State	RCH
12.3	***Implementation of BCC strategy***								
12.3.1	*BCC/IEC activities/campaigns for maternal health*	Y	Y	Y	Y	Y	Y	State/District	RCH
12.3.1.1	BCC/IEC activities for maternal health interventions (except JSY)	Y	Y	Y	Y	Y	Y	State/District	RCH
12.3.1.2	BCC/IEC activities for JSY	Y	Y	Y	Y	Y	Y	State/District	RCH
12.3.2	*BCC/IEC activities/campaigns for child health*	Y	Y	Y	Y	Y	Y	State/District	RCH
12.3.3	*BCC/IEC activities/campaigns for family planning*	Y	Y	Y	Y	Y	Y	State/District	RCH
12.3.4	*BCC/IEC activities/campaigns for ARSH*	Y	Y	Y	Y	Y	Y	State/District	RCH
12.4	Any other activities								
13.	**PROCUREMENT**								
13.1.	***Procurement of Equipment***								
13.1.1.	*Procurement of equipment for Maternal Health*								
13.1.1.1.	Procurement of equipment of skills based services (Anaesthesia, EmOC, SBA)	Y	Y	Y				State	RCH
13.1.1.2.	Procurement of equipment of blood storage facility		Y	Y				State	RCH

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
13.1.1.3.	Procurement of MVA/EVA equipment for health facilities	Y	Y					State	RCH
13.1.1.4.	Procurement of RTI/STI equipment for health facilities	Y	Y					State	RCH
13.1.2.	*Procurement of equipment for Child Health*								
13.1.2.1.	Procurement of equipment for IMNCI	Y	Y					State	RCH
13.1.2.2.	Procurement of equipment for facility based newborn care	Y	Y					State	RCH
13.1.2.3.	Procurement of equipment for care of sick children and severe malnutrition	Y	Y					State	RCH
13.1.3.	*Procurement of equipment for Family Planning*								
13.1.3.1.	Procurement / repair of Laparoscopes / Laparocators	Y	Y					State	RCH
13.1.3.2.	Procurement of NSV kits	Y	Y					State	NRHM Addl.
13.1.3.3.	Procurement of IUDs	Y	Y					State	NRHM Addl.
13.1.3.4.	Procurement of operating microscopes/accessories for recanalisation services								
13.1.4.	*Procurement of equipment for IMEP*								
13.2.	***Procurement of Drugs and supplies***								
13.2.1.	Procurement of drugs and supplies for maternal health	Y	Y					State	RCH
13.2.2.	Procurement of drugs and supplies for child health	Y	Y					State	RCH
13.2.3.	Procurement of drugs and supplies for family planning	Y	Y					State	RCH
13.2.4.	Procurement of supplies for IMEP				Y			State	RCH
13.2.5.	Procurement of general drugs and supplies for health facilities	Y	Y					State	GoUP
13.3.	Other procurement								
14.	**PROGRAMME MANAGEMENT**								
14.1.	***Strengthening of State society/State Programme Management Support Unit (details of training under section 11)***								
14.1.1.	Contractual Staff for SPMSU recruited and in position	Y	Y					State	NRHM
14.1.2.	Provision of equipment/furniture and mobility support for SPMSU staff	Y	Y					State	NRHM

Strategy / Activity		Timeline						Responsibility State/District	Source of funds (Pls. specify)
		2008-09				2009-10	2010-11		
		Q1	Q2	Q3	Q4				
14.2.	***Strengthening of District society/District Programme Management Support Unit (details of training under section 11)***								
14.2.1.	Contractual Staff for DPMSU recruited and in position	Y	Y	Y				District	NRHM
14.2.2.	Provision of equipment/furniture and mobility support for SPMSU staff	Y	Y					District	NRHM
14.3.	***Strengthening of Financial Management systems***								
14.3.1.	Training in accounting procedures		Y	Y				State	NRHM
14.3.2.	*Audits*								
14.3.2.1.	Annual audit of the programme				Y	Y	Y	State	NRHM
14.3.2.2.	Concurrent audit	Y	Y	Y	Y	Y	Y	State	NRHM
14.3.3.	Operationalise E-banking system upto district levels	Done							
14.4	Other activities								

9. DISTRICT-WISE ALLOCATION (PART - A)

Districts will be allocated funds based on the estimates incorporated for various interventions in the State Action Plan. Further, District Health Action Plans (DHAPs) have been prepared by the districts wherein district specific interventions have been proposed. Accordingly, districts would be provided additional funds for such district specific interventions after a review of their detailed action plan at the State level by concerned programme officers. A tentative provision ranging from Rs.10 lacs to Rs.15 lacs per district has been made under the Mission flexipool. Tentative districtwise allocation under RCH is as under:

Sl.	District	Allocation (Rs. in lacs)
1	Agra	775.28
2	Aligarh	728.10
3	Allahabad	970.21
4	Ambedkarnagar	501.81
5	Auraiya	406.68
6	Azamgarh	1124.90
7	Badaun	877.31
8	Baghpat	362.70
9	Bahraich	638.76
10	Balia	840.56
11	Balrampur	512.32
12	Banda	557.74
13	Barabanki	745.48
14	Bareilly	757.78
15	Basti	677.57
16	Bhadohi	288.07
17	Bijnor	619.25
18	Bulandshahar	811.79
19	Chaundoli	413.97
20	Chitrakoot	315.56
21	Deoria	751.44
22	Etah	743.47
23	Etawah	377.94
24	Faizabad	622.78
25	Farrukhabad	406.91

Sl.	District	Allocation (Rs. in lacs)
26	Fatehpur	646.30
27	Ferozabad	460.86
28	Gautambudhnagar	236.10
29	Gaziabad	469.21
30	Ghazipur	836.78
31	Gonda	772.98
32	Gorakhpur	1099.11
33	Hamirpur	370.93
34	Hardoi	911.82
35	Hathras	375.93
36	Jalaun	471.29
37	Jaunpur	1018.06
38	Jhansi	478.52
39	JP Nagar	330.96
40	Kannauj	391.27
41	Kanpur (Dehat)	518.83
42	Kanpur (Nagar)	600.54
43	Kaushambi	483.68
44	Kushinagar	737.02
45	Lakhimpur Khiri	855.70
46	Lalitpur	333.63
47	Lucknow	656.00
48	Maharanganj	601.18
49	Mahoba	246.26
50	Mainpuri	458.77
51	Mathura	522.84
52	Mau	507.42
53	Meerut	642.62
54	Mirzapur	673.52
55	Moradabad	827.32
56	Muzzafarnagar	751.31
57	Pilibhit	427.90
58	Pratapgarh	879.49
59	Raibareilly	817.88

Sl.	District	Allocation (Rs. in lacs)
60	Rampur	389.29
61	Saharanpur	666.80
62	Sant Kabir Nagar	366.98
63	Shahjahanpur	795.15
64	Shrawasti	371.85
65	Siddharthanagar	657.64
66	Sitapur	972.07
67	Sonbhadra	503.02
68	Sultanpur	987.98
69	Unnao	772.61
70	Varanasi	574.87
Total		**43298.67**

The absorptive capacity of funds at the district level is currently limited, however, in view of the proposed establishment of divisional & district PMUs, provision of manpower on contract and support of development partners the absorptive capacity is expected to increase.

10. NRHM ADDITIONALITIES (PART -B)

1. ASHA SCHEME

The scheme is being implemented under following components:

i) Selection and Training of ASHAs

The implementation of the ASHA scheme is progressing satisfactorily. Selection and first round of training is almost complete. Against a target of 1.35 lac ASHAs to be selected, 1.29 lac have been selected and 1.20 lacs ASHAs have been trained on the first module.

Further, instructions have been given that non-performing ASHAs may be identified and weeded out. It is estimated that around there would be around 10% attrition, hence, in areas of drop-outs, the selection and training of additional ASHAs would be required to be trained on the first module. This is likely to be a continuous process and the identification, selection & training activity would be conducted annually. The expenses will be met from the overall savings in the training component.

The existing ASHAs would now undergo training on 2nd to 4th modules. The training on Village Health Index Register (VHIR) has been clubbed with this training. The integrated training duration is of 12 days. The district ToT has been completed and the process of field training has been initiated. About 10,000 ASHAs would be trained within this year for which an expense of Rs.212 lacs is estimated. The remaining would be trained in the year 2008-09. **The expense for the training the remaining the 1.10 lac ASHAs in year 2008-09 is estimated to be Rs. 2523 lacs.**

ii) ASHAs Kits

As per GoI norms every ASHA is to be provided with drug kit. Tentatively, each kit would contain the following items:

i.	DDK	-	20
ii.	IFA Tablets (large)	-	1000
iii.	Tab Punarvadumandur (Iron)	-	1000
iv.	ORS packet (WHO)	-	100 packets
v.	Tab. Paracetamol	-	100 tabs
vi.	Tab Dicyclomine	-	50 tabs
vii.	Povidine Ointment	-	2 tubes
viii.	Thermometer	-	2
ix.	Cotton Absorbent Roll (500gm)	-	1
x.	Bandage (4 cm x 4 mt.)	-	10
xi.	Tab. Chloroquine*	-	50 tabs
xii.	Condoms*	-	500
xiii.	Oral Pills (in cycles)*	-	300

** From existing stock at Sub Centre/PHC under Malaria and FW programmes.*

Estimated Cost of Drug Kit is Rs. 500/- per kit

Therefore, total requirement for 1.35 lac ASHA Kits is Rs. 675 lacs.

iii) Flipbook to ASHAs

To facilitate ASHAs in discharge their services, it is proposed to provide them with a flipbook. A flipbook has been developed by SIFPSA and has been found useful. Some quantities have already been printed and distributed by SIFPSA. An additional quantity of 50,000 would be required to be printed.

Accordingly, for the year 2008-09, a sum of Rs. 25 lacs is being budgeted for the year 2008-09.

iv) Identity Cards to ASHAs

ASHA has to network with the PRI and health functionaries at various health facilities in relation to client specific needs. In absence of identification document she faces difficulty in effectively introducing herself and facilitation of services for her clients. It is therefore proposed to provide each ASHA with an identity card which she would wear during her work. The district PMU, with approval of the District Mission, would ensure printing and issuance of the cards to ASHA.

Accordingly, a budgetary provision for procurement of 1.35 cards @ Rs. 10/- per card, an amount of Rs. 13.50 lacs is being made.

v) Incentive to ASHAs

ASHA being a voluntary worker, her sustenance is dependent on incentives earned by her. The State has approved an incentive scheme for ASHAs, outside the interventions where the incentive is built-in into the scheme. The details of the approved scheme are as under:

Sl.	Activities	Activities Expected During the Year	Rate
1	Janani Suraksha Yojna	30 Delivery Per 1000	Rs. 600/-
2	Tubectomy	20 Case Per Year	Rs. 150/-
3	Pulse Polio	8 rounds	Rs. 50/-
4	Routine Immunization Campaign	4 rounds	Rs. 150/-
5	TB Control	2-3 Cases	Rs. 250/-
6	PNC, care of the newborn & colostrum feeding	30 Delivery Per 1000	Rs. 50/-
7	On taking Complicated Pregnancy Cases or New Born Cases to the Health Facility	3 Cases	Rs. 200/-

Sl.	Activities	Activities Expected During the Year	Rate
8	Complete Immunization of children upto 1 year of age and Vitamin A Supplementation	30 Children	Rs. 100/-
9	Completion of Village Health Register	Once a Year	Rs. 500/-
10	Birth-Death Registration	30 Births & 9 Deaths	Rs. 5/-
11	Group Meetings in Village	24 Meetings (2 Meetings Per Month)	Rs. 100/-
12	Vision testing of children upto 15 years of age (40% per thousand)	Of 150 Children, 15 Children with weak eyesight	Rs. 25 per Children
13	After post-operative follow-up of Cataract Patients	Per case	Rs. 50/-
14	Leprosy Treatment	Passive Bacillary Multi Bacillary	Rs. 50/- Rs. 100/-

It is expected that about 1 lac ASHAs will be able to earn on an average Rs.500/- per month other than JSY and National Programmes where incentives are already built in the scheme.

Accordingly, an amount of Rs.6000.00 lacs for 1 lac ASHAs is being budgeted.

vi) ASHA Award Scheme

To motivate the ASHAs, it is proposed to reward the best performing ASHA in each block. The activities conducted by her during the year would be evaluated and the best performers would be identified. The minimum eligibility criteria for the award would be as follows:

- 80% children (<1 year) in her area have been fully immunised
- 80% of the deliveries in her area conducted at institutions
- More than 3 sterilizations conducted in her area
- Village Health Index Register (VHIR) is fully updated
- Annual Village Action Plan has been prepared

The District Mission would make the final selection based on the overall performance under various programmes. The winners would be felicitated publicly and would be eligible to receive a certificate of appreciation and cash prizes of Rs.5,000/-.

Accordingly, for 823 ASHAs an amount of Rs. 41.15 lacs would be required.

vii) Annual ASHA Sammelan/Mela

It is proposed to organise an annual programme for the ASHAs in each district. The key achievements, constraints, etc. would be discussed during these meetings. The best performing ASHA in the district would also be felicitated in these meetings.

It is expected that around 60 percent ASHAs would participate in these meetings. A budget of Rs. 250/- per ASHA is being budgeted. **Therefore, for around 81,000 ASHAs, an amount of Rs. 202.50 lacs is being budgeted.**

viii) Newsletter for ASHAs

It is proposed to publish quarterly newsletters for ASHAs for promotion of ASHAs, depicting their roles, success stories, government schemes, progress under various components of ASHA scheme and recognition of good performance and creation of enabling environment. It is proposed to publish around 1.50 lac copies each quarter.

Therefore, for printing of 6.0 lac newsletters @ Rs. 15/- per newsletter, an amount of Rs.90 lacs will be required for the year 2008-09.

ix) ASHA Support System

GoI has recommended setting up of an ASHA support system at State and District levels for facilitating and streamlining the functioning of ASHA scheme.

The recommendation for State level includes setting up of an ASHA resource centre at State Health System Resource Centre or State PMSU. For States with more than 20000 ASHAs the recommendation includes a Project Manager (MBA), a Deputy Project Manager (MSW), a Statistical Assistant (Graduate in Statistics), a Data Assistant and an Office Attendant. The recommended outlay for ASHA resource centre is Rs. 17.556 lacs.

At district level, there is provision of Data Assistant at District level, who will work at District PMU. The provision for district component is 2.76 lacs per district.

At the block level, the Block Manager would act as the Nodal Officer, in absence of a Block Manager, an officer nominated by the Block Medical Officer will act as a Nodal Officer. To begin with, the state has decided to have one female block facilitators (ASHA Facilitator) for twenty ASHAs. It is proposed to hire NGOs for facilitating this function. The NGOs would be selected by the District Mission and allotted specific blocks based on their individual strengths. The team to be deployed by the NGO will be approved by the District Mission. The NGOs would deploy female graduates as ASHA Facilitators, however, in case of non-availability of a suitable female candidate, a male facilitator may be deployed, subject to approval by the District Mission. These NGOs/ASHA facilitators would report to the Block Nodal Officer.

Training of ASHA Facilitators

It is proposed to conduct 6 day training at the district level on the concept and activities under NRHM, role & responsibilities of ASHA, role & responsibilities of the Facilitator, supervision, verification of services, reporting, community mobilisation, convergence with other departments, such as, ICDS, PRI, Education, etc. A training

module will be developed for the same. Each batch of training would have 25-30 participants.

It is proposed to conduct these trainings through state level NGOs/ Medical Colleges/ professional training institutions. The estimated budget for the training activity is as under:

Sl.	Description	Amount (Rs.)
A. Development of Training Module		
1	Expenses towards development of training module	2,00,000.00
2	Printing of Training Module (10,000 copies @ Rs. 200/- per copy)	20,00,000.00
Total		**22,00,000.00**
B. Expenses towards Training (1 Batch)		
1	TA to Trainees (@ Rs. 100/- per trainee x 30 trainees)	3000.00
2	DA to Trainees (@ Rs. 100/- per trainee/day x 30 trainees x 6 days)	18,000.00
3	Expenses towards Boarding of Trainees (@ Rs. 150/- per trainee/day x 30 trainees x 6 days)	27,000.00
4	Kit Material to Trainees (@ Rs. 100/- per trainee x 30 trainees)	3,000.00
5	Honoraria to Resource Persons (@ Rs. 500/- per person/day x 3 persons x 6 days)	9,000.00
6	DA to Resource Persons (@ Rs. 100/- per person/day x 3 persons x 6 days)	6,000.00
7	Expenses towards Boarding of Resource Persons (@ Rs. 800/- per person/day x 3 persons x 6 days)	14,400.00
8	Miscellaneous & Contingency expenses (Audio-visual aids, etc)	2500.00
9	Expenses towards 1 day Field Visit	3000.00
Total per Batch		**85900.00**

Accordingly, for training 6750 ASHA Facilitators around 225 batches of training will be required to be conducted. Thus, the total expense towards training works out to Rs. 215.28 lacs.

Monitoring and Supervision

A monthly reporting format will be developed which would be submitted by the ASHA Facilitators to the block Nodal Officer with a copy to the District Nodal Officer.

Budgetary Requirement for ASHA Support System

Sl.	Description	Amount (Rs. in Lacs)
1	State Level ASHA Resource Centre	17.56
2	District Level Support System (@ Rs.2.76 lacs per district x 70 districts)	193.20
3	Block level Support System	
	(i) ASHA Facilitators (6750 x Rs. 150/ day x 20 days/month)	2430.00
	(ii) Contingency for stationery and meetings (@ Rs.12,000/- per block for 823 blocks)	98.76
	(iii) Contingency Allowance to Block Nodal Officer for purchasing journals, magazines, etc. (@ Rs.12,000/- per block for 823 blocks)	97.76
4	PHC Level Support	
	(i) Honoraria to LHV for meetings, trainings and attending at least 5 VHND sessions (3660 x Rs. 500 pm x 12 months)	219.60
	(ii) Honoraria to ICDS Block Supervisor for monitoring at least 5 VHND sessions (3660 x Rs. 500 pm x 12 months)	219.60
	(iii) Funds for serving tea, snacks, refreshments, etc. for conducting monthly meetings (3660 x Rs. 9000/- per annum)	329.40
5	Training of ASHA Facilitators	215.28
Total		**3821.16**

Although the total requirement for operationalising the ASHA scheme is 3821.60 lacs, however, during the year 2008-09 it is expected that about 50 percent of the ASHA facilitators would be trained and deployed. Accordingly, a requirement of only Rs. 2000 lacs is being proposed for the year 2008-09

x) Grievance Redressal

For addressing grievance issues of the ASHA it is proposed to put in place a grievance redressal system. For any complaints of the ASHA she would have the option of lodge a complaint at the Block PHC. A register would be maintained at the Block PHC for registering complaints made by ASHA. The register would have provision for recording the name of the ASHA, village where she is working, nature of complaint, action taken, date of disposal of complaint and remarks if any. The MOIC would attend to the complaints lodged and ensure speedy disposal.

The Medical Officer would send a report to the CMO each month detailing the number of complaints received, actions taken and details of pending complaints including reasons for pendency. The CMO would take necessary action, wherever required for ensuring disposal of complaints.

The review of complaints received, actions taken and pending issues would be included in the agenda for monthly meeting of RKS, monthly meeting of Medical Officers of PHC and in meetings of District Health Society.

Further, the issue of grievances of ASHA would be included in agenda of Tehsil Diwas.

Summary of Budgetary Requirement for ASHA Scheme

Sl.	Description	Amount (Rs. in Lacs)
1	Training of 1,30,000 ASHAs on Modules 2 to 4 & VHIR	2523.00
2	Kits for ASHAs	675.00
3	Flipbook to ASHAs	25.00
4	Identity Card for ASHAs	13.50
5	Incentive to ASHAs	6000.00
6	ASHA Award Scheme	82.30
7	Annual ASHA Sammelan/Melas	202.50
8	Newsletter for ASHAs	90.00
9	ASHA Support System	2000.00
Total		**11611.30**

2. VILLAGE HEALTH INDEX REGISTER (VHIR)

As mentioned in the PIP for the year 2007-08, in view of integrated nature of NRHM it was proposed that every revenue village will have a Village Health Index Register that would include apart from basic family details, utilization of RCH and other health services, status of nutrition, water supply & sanitation. The VHIR would form the basis of annual planning. It will be dynamic register and will be concurrently updated for vital events, disease status, services & other health related inputs & services utilization. One register would be used for three years.

It was also proposed to enter the VHIR data into the computer and a pilot study in four blocks was proposed to be undertaken and later on expanded to other areas in phased manner. However, at this point of time the computerisation activity is being postponed and would be considered later on.

The proposal for VHIR was approved in the NRHM PIP of year 2006-07 for Rs.3075.06 lacs out of which Rs. 106.00 lacs were released by Govt. of India. The printing of VHIR is in process and would be completed before the end of the financial year 2007-08. As already mentioned, the training component has been integrated with the 2nd to 4th modules, hence no additional budget for training is proposed in this head. It is estimated that in year 2008-09, additional 50,000 VHIRs would be required, to be printed @ Rs.80/- each.

Outcome

- Village health index register developed depicting health status and need of health care for the village.
- VHIR used for planning and implementation of village health plan.

Therefore, a total of Rs.40 lacs for printing of 50,000 registers would be required in the year 2008-09.

3. PRE SERVICE TRAINING

A) Training Program for ANMs

Need

ANMs (Basic Health Worker - Female) are primarily midwifery service providers and community does not receive skilled attendance at birth without her presence in the sub centre. Therefore, under NRHM it has been proposed to post one additional ANM at each sub-centre so that one ANM stays at the sub-centre all the time to provide midwifery and new born care services. This is very crucial to reduce IMR and MMR in the State.

Present Situation

We have 20,521 sub-centres positioned in the rural areas of Uttar Pradesh. All the sub-centres are manned by one ANM. Under the proposal mentioned-above the state will require 20,521 ANMs more to have two ANMs posted at sub-centres. In addition to this, the state envisages 7,000 more sub-centres to be created in the next five years in order to accommodate growth of population. These additional 7,000 sub-centres will also require 14,000 ANMs to be posted at the norm of two ANMs per sub-centre in the coming years. Accordingly, we have a **gap of broadly 34,000 ANMs** to fill in the coming five years time. Availability of trained ANMs in the state is almost negligible as the training centres have not been conducting training since 1992. Therefore, we require assessment and revitalization of the training institutions/ facilities existing in the State to start producing fresh ANMs to fill this wide gap.

Status of training capacity of the State

Pre-service training of ANMs was not taking place between the years 1992-2004. Realizing the ANMs vacancies at the sub-centres and non-availability of trained

ANMs in the state, efforts were made to start the training again in the year 2004. At present the training capacity of the state is as follows:-

1. ANMs Training Centres (ANMTCs): 40
   These centres conduct 18 months pre-service training of ANMs. 30 centres have been made partially functional although the problem of availability of PHN Tutors affects the quality of training. The capacity of these centres is maximum 60 per batch.

2. District Training Centres : 30
   These centres are non-functional at present. Their capacity is to house 30 participants. They are proposed to be used as pre-service training centres of MPW (Males) and ANMs but they will require strengthening in terms of civil work and contractual manpower to function as above. 10 centres will be used as ANM training centres with the capacity of 30 trainees per batch. 20 centres would be used for MPW training with the similar capacity per centre.

Strategy- To increase availability through pre-service training

Accordingly, if we utilize these centres to the fullest and run a batch of 60 participants at 40 ANMTCs and run a batch of 30 participants at **10 DPTs** we can produce maximum 2700 BHWs in 18 months time. The State realizes that this will not be enough therefore, the proposal is:

1. **Activate 10 District Training Centres (Achal Prashikshan Kendras) as ANMTCs-** This will need physical strengthening and placement of staff on contractual basis. These centres can accommodate 30 students per year, provided they are given all the facilities that are given to the ANMTCs. 2 PHN tutors and one clerical staff along with support staff will be hired to make these centres active. The budgetary proposal is given below.

2. **Partnership with Private Sector Nursing Training Centres -** There are as many as 62 nursing training centres functional in the private sector that have been established and approved by State Nursing Council and approved by the state government to run three-and-a-half year training programme for diploma nurses. State medical faculty will be requested to invite proposals from these centres to run batches of **BHWs** along side nurses. The state medical faculty will complete the process of approval of these centres by the state government to run a approved number of trainees per batch. 30-50 of these approved centres will then be invited to enter into a MOU with the state Health Society to run at least **3 batches of 18 months BHWs training** for state government. These centres will be given financial support under NRHM. The financial norms will be proposed by the governing body of State Medical Faculty for conducting. The basic structure of financial support will be such that students studying in private and government training centres have more or less comparable financial burden during training.

3. **Financial support-** Each of the student trainee will receive Rs 1000.00 per month as stipend to bear the cost of boarding and examination etc.. Students studying in the government centres don't have to bear the cost of tuition fee, lodging cost therefore for private centres financial support will be provided in the form of tuition fee and lodging cost on a per student basis. An additional contingency support will also be provided to all the centres (both private and government). Besides this no other support will be provided to the private sector centres e.g. salaries, wages, transport, training/teaching aids etc.

Sl.	Training Centre	No. of training centres	Capacity per centre	Total capacity per 18 months
1	ANMTCs	40	60	2400
2	Dist. Training Centres	10	30	300
3	Approved Nursing Training Centres in Private Sector	40	60	2400
Total		**90**	**-**	**5100**

B) Training Program for MPW(Male)

(1) **RHFWTCs** – The state has 11 RHFWTCs with a capacity of 60 students per batch. 1 year pre-service training of Male Health Workers is being conducted at RHFWTCs. At present 11 RHFWTCs are functional in the state. All the centres are at different level of functionality. They will be provided additional staff of 2 PHNs, 1 Clerk and 5 support staff to facilitate training.

(2) **Achal Prashikshan Kendra (DPTT**) - Pre-service training of Male Health Workers is proposed to be conducted in 20 DPTTs with a capacity of 30 students per training centre. These centres will also be provided manpower support and used for MPW training.

Sl.	Training Centre	No. of training centres	Capacity per centre	Total capacity per 12 months
1	RHFWTCs	11	60	660
2	DPTT	20	30	600
Total		**31**	**-**	**1260**

Budgetary Requirement

1. **Annual maintenance grant-** is being provided for each of the peripheral centre to enable them to maintain their teaching blocks, hostels, vehicles.
2. **Hiring of vehicles** - A plan for hiring buses and vehicles to each of the training centre for transportation of students to rural training sites and clinical hospitals has been incorporated in the plan
3. **Contractual manpower** – Achal Prashikshan Kendras (DPTTs) will be provided 2 PHN, 1 clerk and at least 5 support staff (mess staff and female attendant) on contract basis.
4. **Training support-** It is planned that 5100 ANMs (BHW) and 1260 MPW (Male) will be trained in each batch. They will be given per month stipend of Rs.1000 to bear the cost of boarding etc. A fixed amount of contingency support is being provided to each of the training centre to enable them communication, vehicle hiring, stationary and repair and maintenance of teaching/training equipments and other facilities. They can also arrange for resource persons for teaching and training from this fund. The State Institute of Health & Family Welfare acts as Apex Training Institute for technical supervision of all the divisional and district level pre-service training centres mentioned above. It has been designated Collaborating Training Institute (CTI) for NRHM and RCH-2 programme. A provision for maintaining mess, Hostel and security services through service provider agency and hiring vehicles through travel agency had been made previously, which will be continued this year.

1. Annual Maintenance

Sl.	Training Centre	No of Centres	Unit Rate (Rs. in lacs)	Amount (Rs. in lacs)
1.1	ANMTCs	40	2	80.00
1.2	DPTTs for BHW (Female) training	10	2	20.00
1.3	RHFWTCs	11	2	22.00
1.4	DPTTs for MPW (Male) training	20	2	40.00
1.5	LHVTCs	4	2	8.00
1.6	SIHFW	1	-	100.00
Total				**270.00**

2. Support for Hiring of Vehicles

Sl.	Training Centre	No of centres	Unit Rate (Rs. in lacs)	Amount (Rs. in lacs)
2.1	ANMTCs	40	1	40.00
2.2	DPTTs for BHW(female) & MPW(Male) training	30	1	30.00
2.3	RHFWTCs (1bus+1jeep)	11	1	11.00
2.4	LHVTC	4	1	4.00
2.5	PHNTC	1	1	1.00
Total				**86.00**

3. Budget for Contractual Manpower

Sl.	Training Centre	No of centres	Unit rate p.m.	Annual Requirement (Rs. in lacs)	Requirement for 2nd, 3rd, & 4th Qtrs (Rs. in lacs)
3.1	PHNs (2 each at DPTTs)	30	15000	9.00	7.50
3.2	Clerical support (1 each at ANMTC, RHFWTC, DPTT)	81	8000	6.48	4.86
3.3	Support staff (driver, mess staff, hostel attendant) 5 each at ANMTC, RHFWTC, DPTT	81	4500	18.23	13.67
Total				**33.71**	**26.03**

4. Budget for Pre-Service Training

Sl.	Training Centre	No of Centres	Unit rate / Trainee/mnth	Annual Requirement (Rs. in lacs)	Requirement for 2nd, 3rd, & 4th Qtrs (Rs. in lacs)
4.1	Stipend to 6360 student BHW(F)+MPW(M)	121	1000	763.20	572.4
4.2	Lodging support for private centres (2400)	40	1000	288.00	216.00
4.3	Tuition fee for private trainees (2400)	40	15000	432.00	324.00
4.4	Contingency support to all 121 (40+30+11+40) training centres	121	5000/ Centre/ Mnth	72.60	54.45
4.5	SIHFW (labour agencies+ travel + contingency)	1	2,50,000	30.00	24.00
Total				**1585.80**	**1190.85**
Total Requirement for 2008-09 (1+2+3+4)					**1572.03**

4. STRENGTHENING OF NURSES TRAINING

In year 2006-07, the proposal to set-up 6 nurses training schools in the State was proposed at the cost of Rs. 2652 lacs, which was approved and the first instalment of Rs.920 lacs was released. Due to policy and process related constraints, the strategy is being revised and it is proposed to implement the same through Public Private Partnership. The available amount of Rs.920 lacs would be utilized in the year 2008-09 hence, no additional demand is being made.

5. STRENGTHENING OF CHCs & DWHs TO IPHS NORMS

During the year 2005-06, Rs.5600 lacs and in year 2006-07 Rs. 2120 lacs were received for strengthening CHCs to IPHS @ Rs. 20 lacs per CHC.

CHC should provide

- → Comprehensive EmOC and New Born Care (NBC)
- → Blood transfusion service

- → Emergency infant and child care services.
- → General emergency clinical care
- → RTI/STI services.
- → Referral Transport Services.

Strategies

1. Strengthening of the infrastructure including proper O.T. design.
2. Capacity building of the service providers.
3. Redeployment/outsourcing to meet the gaps in human resource.
4. Community oriented services managed through RKS.
5. Focus on quality of care.
6. Maintenance of proper cold chain.
7. Improved monitoring and evaluation

Implementation Plan

Survey of 167 CHCs has been completed under EC-SIP. Further, 347 facilities have been surveyed by development partners. Facility survey is also being conducted under DLHS-3. It is proposed to carry out an analysis of all the surveys and identify gaps to take up additional survey of facilities as required. The available reports are already being analysed for preparation of a priority list of facilities to be upgraded to IPHS.

It is then proposed to outsource the facility survey to a competent agency. Approximately 140 facilities would be required to be surveyed for which an amount of Rs. 100 lacs is being budgeted.

Physical upgradation of 50 CHCs is complete. It is now proposed to first functionalise these FRUs, as well as, focus efforts on ensuring availability of services at the remaining CHCs before taking up additional civil works. Constraints of manpower, equipment and supplies would be resolved first and identification of needs for physical upgradation would be carried out in the current year.

This year the focus will be ensuring that at least 2 CHCs in each district are functioning as FRU and providing entire range of services.

1.1 Place a team of qualified service providers including obstetrician and gynaecologist, paediatrician, anaesthetist, radiologist, LTs, optometrists and staff nurses. In case of vacancies at specific facilities contractual appointment will be made to fill the gaps. However, the funding of human resource under this component will be budgeted through RCH flexipool.

1.2 Refurbishing and maintenance of fully equipped Labour room, O.T. and neonatal resuscitation space, pre and post operative ward with assured running water & power supply.

1.3 Capacity building of existing service providers.

1.4 The facility will be linked to at least two blood banks in the district or nearby districts for assured availability of blood transfusion services. The necessary manpower and equipment will be procured out of the budgeted amount.

1.5 Ensured availability of referral transport.

1.6 Checklist to monitor quality of care.

1.7 A team consisting of departmental officials, community representatives and other stake holders to monitor and manage the health facilities.

1.8 Upgraded MIS for uptake, quality, cost effective services.

Budgetary Requirement

Sl. No.	Component	Physical		Financial (In lacs)		
		Ongoing	New	Ongoing	New	Total
1	Equipment & Furnishings	50	34 CHC 38 DWHs	750.00	1080.00	**1830.00**
2	Consumables	50	34 CHC 38 DWHs	35.00	50.40	**85.40**
3	Security staff	50	34 CHC 38 DWHs	63.00	90.72	**153.72**
4	Procurement of Office Automation Equipment	-	34 CHC	-	51.00	**51.00**
5	Support services (Computer Operator, Telephone, Stationery, Sanitation, etc.)	50	34 CHC	125.00	85.00	**205.00**
6	Facility Survey	-	140	-		**100.00**
Grand Total						**2425.12**

For the year 2008-09, the fund requirement under this component is Rs. 2425.12.

Expected Outcome

- 140 CHCs made functional with round the clock availability of EmOC & NBC apart from routine health care delivery.
- 10% increase in number of institutional deliveries, caesarean operations, neonatal services at the site
- Reduced maternal and neonatal mortalities.
- Proper cold chain maintenance.

6. UNTIED GRANT TO HEALTH FACILITIES

Govt. of India has already approved provision of untied grant @ Rs. 0.50 lac per year per facility for CHCs, @ Rs. 0.25 lacs per PHC through Rogi Kalyan Samiti and @ Rs 0.10 lac for each sub centre through Village Health Sanitation Committee and @ Rs. 0.10 lac for Village Health & Sanitation Committee. As per GoI norms the total allocation works out to Rs. 8274.10 lacs.

However, Uttar Pradesh has two categories of primary health centres, the Block PHCs which cater to a population of 1 to 1.5 lacs and Additional PHCs (APHCs) which are situated at sub-block level and are supposed to cater to a population of 30,000. The physical size, staffing pattern, population catered are different for the both these kinds of facilities. Therefore, the quantum of funds required for the two facilities is different. Accordingly, the untied funds are proposed to utilized in the following manner:

Sl.	Facility	Financial (In lacs)		
		No.	Rate	Total
1	CHCs	426	0.50	213.00
2	Block PHCs	397	0.50	198.50
3	PHCs	2837	0.15	425.55
4	Sub centre	20521	0.10	2052.10
5	VHSCs	52005	0.10	5200.50
Grand Total				**8089.65**

Total requirement for the year 2008-09 is Rs. 8089.65 lacs.

At the Additional PHC (APHC) level, there is difficulty in operating the RKS, therefore the untied funds for the APHCs would be retained with the RKS of the Block PHC, within whose jurisdiction the APHC falls. The RKS would release funds to the APHCs and would have the flexibility to issue additional funds over and above the allocation of the APHC, if the Committee is convinced that the requirement of funds is well justified. However, the additional funds released would have to come from the total pool of untied funds available with the Block PHC.

7. ANNUAL MAINTENANCE GRANT (AMG)

Govt. of India has already approved provision of AMG @ Rs.1.00 lac per year per facility for CHCs, @ Rs.0.50 lacs per PHC through Rogi Kalyan Samiti and @ Rs.0.10 lac for each sub centre through Village Health Sanitation Committee. The allocation as per GoI norm works out to Rs. 2788 lacs.

However, as already explained in the section on 'Untied Grants', the State has two kind of primary health centres which vary in physical size, staffing pattern,

population catered, etc., accordingly, the AMG funds are proposed to be allocated in the following manner:

Budgetary Requirement

Sl. No.	Facility	Financial Requirement (Rs. in lacs)		
		No.	Rate	Total
1	CHCs	426	1.00	426.00
2	BPHCs	397	0.75	297.75
3	APHC	1527	0.20	305.40
4	Sub Centre	7000	0.10	700.00
Grand Total				**1729.15**

Accordingly, for the facilities in the government buildings the total requirement for year 2008-09 is Rs. 1729.15 lacs.

8. ANNUAL ASSISTANCE TO ROGI KALYAN SAMITIS (RKS)

Govt. of India provides assistance to RKS @ Rs. 5 lacs to district level hospitals & @ Rs. 1 lac for CHCs/PHCs according to which the allocation works out to Rs.4315 lacs. However, due to difference in the sizes, population catered, etc. the allocation has been reworked for the State as under:

Sl. No.	Component	Numbers	Financial (in Lacs)	
			Rate	Total
1	District Hospitals	78+53	5.0	655.00
2	CHCs	426	3.0	1278.00
3	Block PHCs (BPHCs)	397	2.0	794.00
4	Additional PHCs (APHCs)	2837	0.20	567.40
Grand Total				**3294.40**

Total requirement for year 2008-09 is Rs. 3294.40 lacs.

9. CAPACITY BUILDING OF ROGI KALYAN SAMITIS (RKS)

Rogi Kalyan Samitis have been constituted at the designated health facilities. However, the concept is new and it is important that members of the RKS understand their roles, responsibilities and processes for functioning of the RKS.

Accordingly, it is proposed to undertake capacity building of RKS members in the following areas:

- Resource Mobilization
- Quality Assurance
- Material and Equipment Management
- Financial Management
- Human Resource Management
- Community Participation / Public Relations
- Legal / Ethical aspects of Hospital Management

However, before embarking on development of any training program, a situation analysis would be carried out to identify the bottlenecks in functioning of the Samitis and related shortcomings in capacities within them. Only then it would be possible to develop an effective training program to address the problems being faced by the RKS and to equip them to perform as envisaged. Other than developing the Training Materials and conducting the trainings, an 'Operations Manual' for the Rogi Kalyan Samitis would be developed which would serve as guidelines for these bodies.

It is proposed to hire services of any external agency having adequate experience in conducting similar training needs assessments, developing materials and conducting training for carrying out the following activities:

- Review functioning of the Rogi Kalyan Samitis (RKSs) and identify the bottlenecks in their proper functioning
- Prepare a situational analysis report
- Develop an Operations Manual for the RKSs in the State
- Develop 'Performance Monitoring & Evaluation Standards' in conformity with the laws and bye-laws of the RKSs
- Develop training module, training manual, and conduct the training programs for the RKS members and other key District/State level functionaries
- Develop Monitoring & Evaluation tools for reviewing performance of RKS

The Divisional and District PMUs would monitor the functioning of the RKS. During the year 2008-09, it is proposed to conduct training of RKS members at the district hospitals and at the CHCs and block PHCs. Two day training programmes will be organised at the district and would include 5 participants from each facility. Accordingly, for training participants from 1380 facilities (DHs Male/Combined-78, DWHs-53, CHCs-426, BPHCs-823) around 276 training batches will be conducted during the year at an estimated expense of Rs.45,000/- per batch.

Budgetary Requirement

Sl.	Description	Amount (Rs. in Lacs)
1	Review of functioning of RKS and development of Operations Manual	15.00
2	Printing of Operations Manual	5.00
3	Training of RKS members	124.20
Total		**144.20**

Total requirement for year 2008-09 is Rs. 144.20 lacs.

10. CAPACITY BUILDING OF VILLAGE HEALTH & SANITATION COMMITTEES

Village Health & Sanitation Committee (VHSC) is the key agency for developing the village health plan and monitoring implementation of the village level interventions.

Therefore it is proposed to undertake capacity building of these VHSCs to enable them to understand their roles and responsibilities and build their capacities in planning, problem solving and monitoring health interventions.

It is proposed to identify local level functionaries of various departments, such as, health, ICDS, Education, PRI, Rural Development, NGOs, etc. and orient and equip them to facilitate VHSCs in their functioning. Around 300 functionaries in each district would be identified and they would be oriented & trained during a one day workshop at the district. These local functionaries would be responsible for conducting meetings with two Committees each year and orient them about their roles and responsibilities, support in preparation of Village Health Plans, listing of activities to be undertaken, proper utilization of untied funds. They would also provide a feedback to relevant departments on the constraints and problems being faced by the Committees.

Two district level workshops would be organised each year, during the month of April and October. An amount of Rs.50,000/- per workshop is being budgeted. Accordingly, for two workshops in each of the 70 districts an amount of Rs. 70 lacs is being budgeted for the year 2008-09

11. CONSTRUCTION OF NEW SUB-CENTRES

In the supplementary PIP of 2007-08 construction of 1000 Sub Centres was proposed at an average cost of Rs. 8 lacs per Sub Centre. The approval has been received recently and the activity would be taken up in 2008-09. It may be noted that new sub-centres are proposed to be constructed wherever sub-centres are

operating in rented buildings. However, in view of the increased population there are areas where no sub-centre is available and such large pockets of unserved areas would be provided with sub-centres on priority basis.

12. DRUG WAREHOUSES AT DISTRICT LEVEL

In the year 2007-08, a proposal was made for operationalising 24 District Warehouses at a cost of Rs. 118.56 lacs. This was approved with comments that the manpower component should be included from the State funds. It is proposed that the activity be continued during the 11th plan period and could be transferred to the State after the end of the 11th plan. By this time these drug warehouses would be functioning smoothly and can be sustained from the State budget.

The budget is required for provision of contractual staff and operating expenses. Each warehouse will have a contractual accountant, computer operator, forklift operator cum mechanic, electrician cum generator operator, loader, sweeper, gardener and security personnel.

Budgetary Requirement

S.No.	Item	Unit cost (Lac Rs)	Quantity	Total cost (Rs in lacs)
1	Contractual Staff	2.94	24	70.56
2	Contingent Expenditure	2.00	24	48.00
	Total			**118.56**

Accordingly a budget of Rs.118.56 lacs is proposed.

13. PROVISION OF BACK-UP POWER AT 24 HR. FACILITIES

The availability of power in rural areas of the State is extremely poor, accordingly it is proposed to provide Inverters (1 KVA capacity) at block level PHCs and CHCs, especially for conducting deliveries at night. Accordingly, a budgetary provision @ Rs. 12,000/- for purchase of Inverter (Including battery) is being made 823 facilities. **Therefore, a total requirement of Rs. 98.76 lacs is proposed for the year 2008-09.**

14. PURCHASE OF GENERATOR SETS

Most of the generators available at the CHCs and Block PHCs are in very poor condition. The cost of maintenance of these gensets is very high and it would be prudent to replace these generator sets. Accordingly it is proposed, to procure 100 gensets of 10 KVA, to be distributed to 100 CHCs and 100 gensets of 7.5 KVA for distribution to 100 Block PHCs. It is estimated that each generator of 10 KVA and

7.5 KVA would cost about Rs. 2.50 lacs and Rs. 1.60 lacs respectively. **Therefore, a total requirement of Rs. 410 lacs is proposed for the year 2008-09.**

15. SAAS BAHU SAMMELAN

Lack of communication within the family is one of the issues that needs to be addressed, so that the health perspective of daughters-in-law is understood by elder members of the family. Both mothers-in-law, as well as, daughters-in-law need to understand each others perspective and arrive at a proper decision with full knowledge of services available through various programmes and benefits thereof. It is therefore very essential to make these opinion leaders understand the significance of safe motherhood and newborn & infant care. A component of counselling has been included under the behaviour change module.

Additionally, for the purpose joint meetings of daughters-in-law, mothers-in-law, elderly ladies of the family, female PRI members, ICDS functionaries, NGOs, and women's groups are proposed to be organised. These meetings titled as '**Saas Bahu Sammelans**' would be organised to bring these stakeholders on a common platform and would be held once every year at the district and block levels.

This activity has been undertaken in Azamgarh, Meerut and Agra districts and encouraging feedback has been received. Further, during the preparation of DAPs, the demand for the inclusion of the activity has been received from many districts.

At the district level, the Addl. CMO (RCH or Maternal Health) and at the block level the MOIC would be responsible for organising such meetings in coordination with ICDS staff. An agenda for the same would be prepared well in advance.

During these meetings, women health issues, role of various family members, harmful social practices & beliefs, significance of nutrition, information of various programmes and schemes, role of other stakeholders in improving health practices in the community. The meetings would be videographed and useful feedbacks would be documented which would help in refining communication strategies, development of communication material and interventions.

Budgetary Requirement

Sl.	Description	Amount (Rs. in Lacs)
1	District level Meetings (@ Rs. 1 lac per district for 70 districts)	70.00
2	Block level Meetings (@ Rs. 15,000/- per block for 70 districts)	123.45
Total		**193.45**

16. SCREENING & VACCINATION OF PREGNANT WOMEN AT RISK OF HEPATITIS A, B, C & E

Liver Foundation of India recommends screening of all pregnant women be screened for Hepatitis virus during last trimester of pregnancy.

To initiate action in this direction it is proposed that all District Women's Hospital in the State where, pregnant women on clinical examination are found to be having liver dysfunction will be screened for detection of viral hepatitis A, B, C and E. If confirmed and need for preventive vaccination is justified, they would be vaccinated for hepatitis A, B, C and E. For this a budgetary provision of Rs.1 lac is being made for testing of hepatitis and vaccination thereof. **Accordingly, an amount of Rs. 70 lacs is being proposed for the year 2008-09.**

In addition, extensive communication activities will be leveraged for imparting knowledge and behaviour change in relation to risks of hepatitis during pregnancy and services available under the programme.

17. MOBILE MEDICAL UNITS

During the year 2006-07, a proposal for operating 70 mobile medical units at a total cost of Rs.2611 lacs was approved. Total funds of Rs. 1995 lacs was released during 2006-07 and further Rs. 711.20 lacs was released in 2007-08

Procurement bottlenecks have impeded the implementation of the activity. It is proposed to complete the operationalisation of this activity in 2008-09. No additional funds are required.

18. REFERRAL TRANSPORT SERVICES FOR MOTHER AND CHILD CARE

Timely access to emergency institutional care is critical to reduction of MMR, IMR & CMR. Non-availability of transport facility and lack of minimal medical care during transportation needs to be addressed. The states of Tamil Nadu and Andhra Pradesh have taken lead in addressing the problem. Considering limited number of facilities in Uttar Pradesh this support is even more vital for the state. The state model is based on the experiences of the two States.

A proposal for operationalising referral transport services in 23 districts at a cost of Rs. 4740.16 was included in the PIP. GoI approved the activity in principle with comments to develop a transparent system of selecting NGOs and output & outcome indicators in place before any release. UPHSDP is in the process of developing the systems for the intervention by the end of the current financial year which will be shared with GoI. However, during the year 2008-09, it is proposed to operationalise the services in 7 CCSP districts, namely, Kannauj, Mirzapur, Siddharthanagar, Shahjahanpur, Lakhimpur Khiri, Pratapgarh and Azamgarh (2

districts, Bahraich & Banda, are being taken up by UPHSDP), thus, saturating 50 percent of the Comprehensive Child Survival Programme (CCSP) districts. Thereafter, in year 2009-10, additional 8 CCSP districts will be taken up and by year 2012 all 70 districts will be covered.

In every block of the identified district one ambulance @ Rs. 13.00 lacs will be made operational through NGOs. The ambulance will be equipped with a standard list of medicines equipments and personnel including 03 drivers and 06 paramedics @ Rs. 5.40 lacs per annum per unit.

A control room will be setup in every district for coordinating calls of the service and the ambulance drivers @ Rs. 1.30 lacs per annum per unit in non-recurring component and @ Rs. 0.60 lacs per unit per annum as recurring component. In addition the ambulance network will be facilitated by cellular connections among control room, ambulances and clients. The cost of communication @ Rs. 0.03 lacs in non-recurring components and Rs.0.06 lacs per unit per annum as recurring expenses. Accordingly the total requirement is detailed ahead:

Sl.	Component	Physical	Budget (Rs. in lacs)
1	Capital cost of equipped ambulance	7 districts (99 Units)	1287.00
2	Contractual staff	-	534.60
3	Control Room	7	13.30
4	Communication	-	8.91
Total			**1843.81**

It is therefore proposed to include the amount of Rs. 1843.81 lacs in the year 2008-09 for operationalising the scheme.

19. INCENTIVE PACKAGE

In the year 2007-08, an innovative scheme for providing incentive to contractual staff was proposed for improving uptake of facility services with a budget of Rs.1279.24 lacs. The scheme remained under consideration of GoI subject to placement of an effective appraisal system. It is now proposed to have a single scheme for both contractual, as well as, regular staff.

Eligibility Criteria

Institutional deliveries

- CHCs conducting more than 60 deliveries per month

Caesarean Operations

- For every caesarean above 6 caesarean at CHCs conducting at least 60 deliveries per month

Child Survival

- Every child hospitalised (other than those delivered at the institution) for more than 24 hours in the facility

Laboratory Services

- Every examination for blood grouping & matching
- Every laboratory examination conducted for hospitalised patients.

Critically Ill

- For more than 10 IPD cases attended per month

Incentive Scheme

1. Institutional Delivery – (Caesarean Section) Package Rs. 1320.00 /delivery

PERSONNEL	INCENTIVE MONEY
Gynaecologist	Rs. 600.00
Anaesthetist	Rs. 400.00
Staff Nurse (3x50.00)	Rs. 150.00
ANM	Rs. 150.00
Ward Aya+Sweeper	Rs. 10.00+10.00

2. Child Survival - Package Rs. 220.00/ patient

PERSONNEL	INCENTIVE MONEY
Paediatrician	Rs. 100.00
Staff Nurse (2x50.00)	Rs. 100.00
WB+Sweepers	Rs. 10.00+10.00

3. Lab. Services (MP Hb & Urine Albumin Sugar excl.) Package Rs. 30.00/ test

PERSONNEL	INCENTIVE MONEY
Laboratory Technician	Rs. 25.00/ test
Attendant/ Sweeper	Rs. 5.00/ test

4. Critically Ill - Package Rs. 420.00/ IPD Case

PERSONNEL	INCENTIVE MONEY
Physician	Rs. 300.00
Staff Nurse (2X50.00	Rs. 100.00
Ward Boy + Sweepers	Rs.10.00+10.00

Budgetary Requirement for Incentive Scheme:

SN	Components	Physical		Financial (in lacs)
		Exp. Number	Rate (Rs.)	Total
1	Caesarean Operation	12000	1320.00	158.40
2	Child Survival	60000	220.00	132.00
3	Laboratory Services	201600	30.00	60.48
4	Critical ill	80640	420.00	338.68
Total				**689.56**

The incentive will be given on team basis and distributed to all officials contributing to delivery of service as per departmental/government order.

The incentive scheme will be implemented by the Rogi Kalyan Samiti. The Addl. CMO/ Dy. CMO for Maternal Health will be the nodal officer for monitoring and facilitating the scheme. A monthly report depicting the number of institutional deliveries, caesarean operations, children admitted for over 24 hours, investigations conducted for indoor patients and critically ill will be placed before the RKS by the MOIC. The report will also clearly mention the individual performances of the staff, which will form the basis of deciding the amount of incentive and its recipient.

The District Mission will review the progress on quarterly basis and will form an agenda point in the quarterly meetings.

The appraisal will be done on the following criteria:

- 24 hour availability of full component of essential qualified staff approved by State Mission at the facility (Anaesthetist may be on call basis)
- Functional labour, room, OT, laboratory, indoor ward as per checklist.
- Availability of essential medicines and consumables as per checklist.
- Availability of functional client conveniences, such as, toilet, water supply, electricity, fan.
- Incentive will be given on the basis of submission of duly completed cards, showing the details of investigations, services provided, complications (if any) and outcome of the services.

20. SWASTHYA PURASKAAR YOJANA

To encourage the good performers in the field, a 'Swasthya Puraskaar Yojana' was proposed in the PIP for 2007-08, however, the scheme could not be implemented, due to lack of effective benchmarks and an appropriate appraisal system. Certain modifications have been made in the scheme and would be applicable to both regular, as well as, contractual staff. An appraisal system would also be put in place for the same. The details of the scheme are as under:

Benchmarks for eligibility based on performance during last 12 months

For ANMs :

1. At least 85 Immunisation/MCH sessions conducted in villages on fixed days
2. 90% immunization of pregnant women.
3. Conducted/assisted more than 60 institutional deliveries at main/sub centre.
4. Identified and referred at least 20 complicated pregnancy cases.
5. Motivated 20 sterilisation and 50 new IUCD users

For Medical Officers PHC (30,000 popn)

1. At least 150 deliveries conducted at PHC
2. 300 referred children treated for ARI/Diarrhoea/LBW/undernutrition.
3. Number of infant deaths in the area is less than 30
4. 85 percent infants in the area completely immunised
5. 30 new sputum positive cases detected and 85 percent patients completed DOTS treatment
6. 90 cases of cataract operated in the area and 600 school-going children provided corrective glasses through school eye screening programme
7. 95 percent of malaria positive cases given radical treatment
8. As per monthly report and supervisor checklist critical equipment sickness and critical logistics stock-out < 7days.

For Addl./Dy. CMOs (Programme Officers)

1. At least 70 % of total budget received has been utilized.
2. 80 percent of updated physical progress of the programme submitted on time to the District/state.
3. At least 1 meeting per month held with the MOICs & Supdt. CHC/FRU.
4. At least 100 MCH/RI sessions/Field visits for RCH activities monitored.

District Nucleus under Leprosy Programme

1. No. of defaulters is lowest in the district
2. Maximum no. of reconstructive surgeries at DPMR programme
3. Prevalence Rate < 1
4. Treatment Completion Rate

For CMOs

1. At least 70 % of total budget received has been utilized.
2. 100% updated physical & financial progress report of the programme submitted on time to the State.
3. At least 1 meeting per month held with the MOICs & Supdt. CHC/FRU.
4. At least 2 FRUs fully functional & 75 percent PHCs operationalised as 24x7
5. At least 10 percent improvement in sterilisation performance

6. Piloted at least 1 innovative project in the district
7. Attended at least 3 State/National level training programmes/seminars
8. At least 10 percent improvement in cataract & IOL operation, sputum positive case detection, completion of DOTS therapy
9. At least 10 percent reduction in vector borne disease cases
10. At least 95 percent of RI sessions held
11. At least 75 percent reduction in detection of polio cases.
12. At least 150 MCH/RI sessions/field visits for RCH activities monitored.

For Divisional ADs / Jt. Directors

1. At least 70 % of total budget received in the division has been utilized.
2. 100% updated physical & financial progress of the programme submitted on time by the districts to the State.
3. At least 1 meeting per month held with the CMOs, Addl. CMOs and CMSs.
4. At least 50 field visits conducted for monitoring of various NRHM activities.

For State Programme Officers

1. More than 75% disbursement of total budget received from GoI
2. Timely submission of at least 50% utilization certificate to GoI.
3. Updated physical progress of the project submitted to GoI regularly.
4. At least 1 monthly meeting held with the ADs, and 6 meetings with CMOs & Addl./Dy. CMOs.
5. At least 12 field visits for monitoring of various NRHM activities.
6. Attended at least 3 National level training programmes/seminars
7. Represented State in at least 3 International/Inter-State/National meetings/ workshops
8. Special contribution in development of training package/ programme interventions related to concerned programme
9. Organised at least 2 state level events related to the programme

For Best Block PHC

1. At least 300 deliveries conducted at BPHC
2. 500 referred children treated for ARI/Diarrhea/LBW/undernutrition.
3. Number of infant deaths in the area is less than 120
4. Number of maternal deaths in the area is less than 100
5. At least 85 percent infants in the area completely immunised
6. At least 100 new sputum positive cases detected and 85 percent patients completed DOTS treatment
7. At least 350 cases of cataract operated in the area and 2500 school-going children provided corrective glasses through school eye screening programme
8. At least 95 percent of malaria positive cases given radical treatment

9. As per monthly report and supervisor checklist critical equipment sickness and critical logistics stock-out < 7days.

For Best CHC/FRU

1. At least 500 deliveries including 60 caesareans conducted at CHC/FRU
2. 600 referred children including 100 sick newborns treated for ARI/ Diarrhea/ LBW/ undernutrition.
3. 150 new sputum positive cases detected and 85 percent patients completed DOTS treatment
4. At least 95 percent of malaria positive cases given radical treatment
5. As per monthly report and supervisor checklist critical equipment sickness and critical logistics stock-out < 7days.
6. 100% submission of UCs of last quarter.

*Norms for utilization of performance award fund for BPHC/ CHC

The funds received as award can be utilized by BPHC/CHC personnel for any of the purposes as detailed ahead. The RKS would be authorized to take the decision for utilization of the funds.

- Refurbishment, such as, repairs, whitewash etc. of residential complex at CHC
- Provision of amenities, such as, water supply arrangements, power (generator/inverter/solar panel), furniture, room coolers, security arrangements.
- Transportation facility for sending children to schools

For Best District Hospital

District Women Hospital

1. At least 2000 deliveries conducted in the facility.
2. At least 600 complicated cases of pregnancy attended/treated/referred.
3. At least 300 caesarean sections done.
4. Newborn care unit functional and at least 300 sick newborns Attended/ Treated/Admitted/Referred.
5. As per monthly report and supervisor checklist critical equipment sickness and critical logistics stock-out < 7days.

District Hospital Male

1. At least 500 IOL surgeries conducted in the facility.
2. At least 100 NSVs carried out
3. At least 750 under-5 yrs children admitted and treated for ARI/ Diarrhoea/ undernutrition.
4. As per monthly report and supervisor checklist critical equipment sickness and critical logistics stock-out < 7days.

***Norms for utilization of performance award fund for District Hospital**

The funds received as award can be utilized by district hospital personnel for any of the purposes as detailed ahead. The RKS would be authorized to take the decision for utilization of the funds.

- Refurbishment, such as, repairs, whitewash etc. of residential complex at district hospital
- Provision of amenities, such as, water supply arrangements, power (generator/inverter/solar panel), furniture, room coolers, security arrangements.
- Transportation facility for sending children to schools

The eligibility criteria for Specialists at CHCs and Paramedical staff working under various national programmes, such as, Tuberculosis, Leprosy, Vector Borne Diseases are being developed and would also be considered under the award scheme.

Budgetary Estimate for Incentive for Exceptional Services

Sl.	Category	Total No. of Prizes	Calculations	Expected Amt. (Rs. in lacs)
1	ANMs	1st , 2nd & 3rd prize in all 70 districts – Total 3 prizes in each district	10,000 X 70 *(1st Prize - Rs.5,000/- 2nd Prize - Rs.3,000/- 3rd Prize - Rs.2,000/-)*	7.00
2	Staff Nurse at CHCs	1st , 2nd & 3rd prize in all 70 districts – Total 3 prizes in each district	15,000 X 70 *(1st Prize - Rs.7,000/- 2nd Prize - Rs.5,000/- 3rd Prize - Rs.3,000/-)*	9.0
3	Medical Officers at PHC	1st , 2nd & 3rd prize in every category in all 70 districts – Total 3 prizes in each district	23,000 X 70 *(1st Prize - Rs.10,000/- 2nd Prize - Rs.8,000/- 3rd Prize - Rs.5,000/-)*	16.10
4	Supdt. CHC	1st , 2nd & 3rd prize in all 70 districts – Total 3 prizes in each district	Rs.23,000x70 *(1st Prize - Rs.10,000/- 2nd Prize - Rs.8,000/- 3rd Prize - Rs.5,000/-)*	16.10
5	Specialists	1st , 2nd & 3rd prize in all 70 districts – Total 3 prizes in each district	Rs.23,000x70 *(1st Prize - Rs.10,000/- 2nd Prize - Rs.8,000/- 3rd Prize - Rs.5,000/-)*	16.10
6	Technical Staff	1st , 2nd & 3rd prize in all 70 districts – Total 3 prizes in each district	Rs.10,000x70 *(1st Prize - Rs.5,000/- 2nd Prize - Rs.3,000/- 3rd Prize - Rs.2,000/-)*	7.00
7	District Programme Officers	1st , 2nd & 3rd prize – Total 3 prizes in State	*(1st Prize - Rs.15,000/- 2nd Prize - Rs.12,000/- 3rd Prize - Rs.10,000/-)*	0.37
8	Medical Officers District Hospitals Male &Female	1st , 2nd & 3rd prize – in 5 categories in State (Gynae, Paed, Anaes, Eye, NSV)	23,000 X 5 *(1st Prize - Rs.10,000/- 2nd Prize - Rs.8,000/- 3rd Prize - Rs.5,000/-)*	1.15

Sl.	Category	Total No. of Prizes	Calculations	Expected Amt. (Rs. in lacs)
9	Chief Medical Officers	1st , 2nd & 3rd prize - Total 3 prizes in State	*(1st Prize - Rs.15,000/- 2nd Prize - Rs.12,000/- 3rd Prize - Rs.10,000/-)*	0.37
10	State Programme Officers	1st , 2nd & 3rd prize	*(1st Prize - Rs.15,000/- 2nd Prize - Rs.12,000/- 3rd Prize - Rs.10,000/-)*	0.37
11	Best PHC	1 Prize in the State	Rs. 2,00,000/-	2.00
13	Best CHC	1 Prize in the State	Rs. 3,00,000/-	3.00
14	Best DWH	1 Prize in the State	Rs. 5,00,000/-	5.00
15	Best DHM	1 Prize in the State	Rs. 5,00,000/-	5.00
Total				**88.56**

21. RCH MELA AT DISTRICT & BLOCK LEVELS

In view of the health communication needs of the people and popularity of health and family welfare melas, it is proposed to organized RCH melas in district and block once in a year. The focus of these melas will be on RCH & Adolescent health issues. They will impart knowledge on desirable health practices and behaviour for healthy life apart from providing clinical and counselling services. The services available in these melas will improve ANC, gynaecological check-up, IFA, TT, sterilization and spacing services, immunization services, RTI/STI, post natal check-up. Average cost of per mela at district level is proposed at Rs.1.50 lacs per district and Rs. 0.50 lac for each block.

Accordingly Rs. 516.50 lacs will be required for the year 2008-09.

22. ESTABLISHING CLOSED USER GROUP (CUG) NETWORK

The proposal was included in the PIP for 2007-08 at a cost of Rs. 470 lacs. GoI partially approved the project and released Rs. 100 lacs with observation that hardware and its maintenance should be undertaken by the user and only monthly rental cost of Rs. 225/- per month may be reimbursed in limited areas.

This activity could not be undertaken in 2007-08, it is proposed to initiate the activity in the 17 districts that are being covered under CCSP in 2008-09 and scale it up in subsequent years. The available funds would be utilized in the year 2008-09 and no fund requirement is being proposed.

23. ESTABLISHING CONCURRENT AUDIT SYSTEM FOR NRHM

A concurrent audit system was proposed in the PIP for 2007-08 and a budget of Rs. 51.56 lacs was approved. Salient feature of the interventions proposed are as under:

- A senior CA firm will engaged for developing the model for the state including concurrent audit will be carried out.
- Appointment of consultant reporting directly to Mission Director for development of formats, norms and reports on monthly audit.
- Monthly implementation of monthly audit system and providing support and guidance to district units, coordinating with district level auditors.
- Setting up of the feedback mechanism.
- Sensitization of field officers and units, orientation training for PMU officials.

The implementation process has been developed and terms of references are being finalised. It is expected that activities would begin in 2008-09. Accordingly, an amount of Rs.51.56 lacs is being budgeted for 2008-09.

24. STRENGTHENING OF MIS

A proposal for strengthening MIS was proposed in the PIP for 2007-08 for Rs.129.36 lacs, of which only Rs. 79.36 lacs were approved for hardware components at State level. The process for acquiring the hardware is in progress and is likely to be completed within the year.

It is now proposed to strengthen the HMIS system right from block to State levels. A web based software is already being developed by NIC, which would integrate reporting for all health programmes. All block and district facilities, CMO Office and PMUs would be provided with computers, back-up power and personnel for ensuring timely entry of data and reporting. A budgetary requirement of Rs. 1200 lacs is being for the year 2008-09.

Sl.	Description	Annual Amount (Rs. Lacs)
1	Expenses towards procurement of servers, computer system, printer, back-up power, furniture, networking, development of software, etc.	1000.00
2	Training of Staff	80.00
4	Recurring Expenses incl. contractual staff for 6 months	120.00
Grand Total		**1200.00**

25. DISTRICT INNOVATIONS

Districts have proposed area specific interventions in their District Action Plans for 2008-09. A brief list of some of the interventions is provided below:

- Performance rating of PHCs/CHCs
- Display of Immunization Schedule in All villages
- Birth companionship programme
- Sanitation Day on 2nd October

- Outsourcing of sanitation facilities, diet services, security at district hospitals
- Camps during Magh Mela and Magh Mela Exhibition in Allahabad
- Prevention of occupational diseases, such as, Silicosis in stone quarries/ crushers in District Allahabad, Sonbhadra
- Health camps in Arsenic affected blocks in Dt. Ballia and Lakhimpur Kheri
- Special health camps for weavers in Dt. Sonbhadra, Bhadohi & Mirzapur
- Activities for prevention of Flurosis in Dt. Unnao, Agra and Firozabad
- Training adolescent girls to mobilize the community for increased utilization of MCH services
- Provision of BPL community coordinators at district male/female hospitals and CHCs
- Half yearly safe motherhood meeting in every village
- Outreach blood donation camps
- Inter and intra departmental meetings at s/c and block level for convergence
- Half yearly safe motherhood meeting in every village
- Improved access to maternal and child health care for BPL rural/ urban population through voucher system
- Child Health and Nutrition Mela through ICDS

The implementation plan for innovative interventions submitted by the districts would be reviewed by concerned Program Officers at the State headquarter and releases to the districts would be made accordingly. **An amount of Rs.2100.00 lac is being proposed for the year 2008-09.**

26. DISTRICT ACTION PLANS (DAPS)

In the Supplementary PIP for 2007-08 a proposal for Rs. 700 lacs was made for preparation of District Action Plans. It was proposed to follow a bottom-up approach as suggested by GoI, including preparation of village health plans, their consolidation at the block level for preparing the DAPs. The approval for the proposal has been received in February 2008. It is proposed to implement this activity in 2008-09. The process would be initiated in the first quarter itself by hiring external agencies/partnering with donor agencies and Medical Colleges. As per revised estimates an amount of Rs. 5 lacs per district is being budgeted. Accordingly, a requirement of Rs.350 lacs is being proposed for the year 2008-09.

27. RASHTRIYA AROGYA NIDHI (RAN)

In order to provide financial assistance to BPL patients for receiving medical treatment for major life threatening diseases at any of the super-specialty hospitals/institutes under the government, the Rashtriya Arogya Nidhi (RAN) would be utilized.

The referrals under Rashtriya Arogya Nidhi will be made through Rogi Kalyan Samiti under NRHM at district level and patients will be attended by any of the 4

tertiary care institutions i.e. Balrampur Hospital, Lucknow; Dr. Ram Manohar Lohia Hospital, Lucknow; SGPGI Lucknow & KGMU, Lucknow.

Committees would be constituted by the hospital/ institution management, having five members including two technical persons, one finance person, one management person and one non-government member of the RKS or a non-government nominee of the Director, SGPGI to approve releases to individual patients under the scheme.

The Committee at the referral hospitals/institute would be authorised to sanction upto Rs.50,000/- for the treatment of any deserving BPL patient. For cases where reimbursement is upto Rs.1.5 lacs, such cases would be forward to the State Technical Committee for approval. State would release the financial assistance to patients living in the State up to Rs.1.5 lacs in an individual case and forward all such cases to RAN, where the quantum of financial assistance is likely to exceed Rs. 1.5 lacs.

The Technical Committee at the State level will screen the applications and make recommendations to the Managing Committee for approval of reimbursements and will also advise on technical matters, such as, nature of illnesses to be covered for assistance under the scheme and other ancillary issues. The committee will comprise of the following:

- Director – Balrampur Hospital, Lko
- Director (Medical Care)
- Nominee of Director, SGPGI / KGMU

At the State level, the RAN will be managed by a committee consisting of the following members:

- Minister (Medical & Health) - Chairman
- Principal Secretary, Medical Health & Family Welfare - Member
- Mission Director - Member
- DG (M&H) - Member Secretary
- Director, Balrampur Hospital -Members
- Finance Controller - Treasurer
- Two prominent doctors - co-opted as non official members

The BPL applicant will fill a form to avail the assistance. The form will be available in each department of the hospital/ institute. The MO Incharge of the case and hospital, where the patient is receiving the treatment will also fill a form to certify the diagnosis and recommending the total amount required for treatment, which will duly signed by the HoD and then the amount approved/sanctioned by Medical Superintendent of the hospital.

A quarterly statement of the number of applications received and sanctioned will be prepared by the referral hospitals and submitted to the State Management Committee and also send a copy to the concerned district society.

At the state level the Grant in Aid would be to the extent of 50% of the contribution made by the state government to the state fund / society subject to a maximum of Rs.5.0 crores. Hence the state would contribute Rs.5 crores and Rs.5 crores would contributed by GOI under the scheme. It is proposed to release a sum of Rs.50 lacs/year as corpus fund to each referral hospital. The remaining will be held with the State Committee. In Uttar Pradesh SGPGIMS, Lucknow & CSMMU, Lucknow have already received Rs.10 lac from the GOI as corpus fund under RAN.

The annual review of the funds received from the RAN will be done by State Managing Committee and all the expenses made from the corpus by the hospital will be reimbursed accordingly.

Financial Assistance is not admissible to the patients under the following circumstances:

(i) Government Servants (Central/State Government & PSUs Employees) are not eligible to receive financial assistance out of the Rashtriya Arogya Nidhi.
(ii) Re-imbursement of expenditure already incurred is not admissible.
(iii) The sanction of grant is restricted to patients taking treatment in Govt. hospitals, no assistance is provided for treatment in private hospital.
(iv) Financial assistance is not admissible for disease of common nature where treatment is not expensive.
(v) If the patient is above poverty line.

List of ailments covered under the scheme

- Cardiology & cardiac surgery
- Cancer - Radiation treatment & chemotherapy,
- Urology/Nephrology - dialysis and surgical procedures in urology and gastroenterology.
- Orthopaedics - artificial prosthesis for limb, implants and total hip & knee replacement, external fixaters and AO implant used in the treatment of bone diseases and fractures.
- Miscellaneous- Intraocular lens implants, hearing aids and shunts for hydrocephalous
- Investigations - ultrasound, doppler, radio nucleoside scans, CT Scan, mammography, angiography for all organs, MRI, EEG, EMG, Urodynamic Studies
- Drugs - immunosuppressive drugs, anti TB drugs, Anti D, Anti Haemophilic globulin, erythropoietin, blood & blood products, plasma for patients of burn.
- Other major illness considered appropriate for assistance by medical superintendent /committee of doctors could be added to the list.

28. NRHM HELPLINE

There is widespread lack of knowledge, confusion regarding the NRHM objectives, components, interventions, role of various departments, civil society organisations, PRIs etc. To address demand of specific knowledge to various information seekers across the State, it is proposed to set-up an NRHM helpline ant the SPMU/State Family Welfare Directorate. The helpline will be functional during normal working hours with a dedicated line. An instrument for recording details of incoming calls will also be installed. For queries that cannot be responded immediately, the call details will be recorded on a register along with details of the query will be recorded on a register and will be responded to within 24 hours.

Further, a provision of seeking information through the internet would be available for which a module will be built in the department's website. The helpline staff would respond to the queries received over the net. For publicity of the helpline an annual budget of Rs. 6.0 lacs is being proposed. Further, the publicity of the helpline would also be integrated along with the publicity activities for other interventions wherever, relevant and possible.

The helpline would be manned by a contractual staff, who would preferably be a retired person of the Health/ Family Welfare Department not below the rank of Joint Director having knowledge of NRHM interventions. He would be supported by a secretarial staff who would handle calls in his absence and will also respond to the net queries.

Budgetary Requirement

Sl.	Description	Annual Amount (Rs. Lacs)
1	Expenses towards procurement of computer system, printer installation of telephone line, call detail recording machine, office furniture etc.	1.0
2	Honoraria to Helpline Officer (@ Rs. 20000/ per month)	2.40
3	Honoraria to Helpline Assistant (@ Rs. 8000/ per month)	0.96
4	Recurring Expenses (telephone stationery, etc.) for Helpline Unit (@ Rs. 5000/ per month)	0.60
5	Expenses towards publicity	6.0
Grand Total		**10.96**

29. TELEMEDICINE PROJECT

One of the main objectives of NRHM is to provide the rural population access to health care services. In this context telemedicine can play a vital role, especially in hard to reach areas and also in providing advanced level of healthcare services where only some services exist. With the objective of providing access to advanced medical facility, it is proposed to pilot a telemedicine project in 10 districts of the State, with support of SGPGI, Lucknow. In each selected district Level -1 facilities (i.e. 2 selected FRUs/CHCs and 1 BPHC) and Level-2 (District

Hospital) will be connected to a state level hospital, SGPGI (i.e. Level-3). The districts will be selected on the basis of distance from tertiary care facilities, remoteness & inaccessibility of specialised care either in govt. of private sector.

Government of India as developed technical & financial norms for infrastructure and manpower for implementing a telemedicine project. Based on these norms the proposal is being presented for consideration.

Expenses towards establishment of Telemedicine Unit at State Level (Level-3)

A. Fixed Cost

Sl. No.	Item Description	Estimated Value (In Rupees)	Remarks
1.	Hardware / Software (including PC, servers, etc.)	11,00,00	
2.	Telemedicine Consulting Centre (TCC) Software	7,50,000	May vary, Interactive Client is assumed. Web-based module may be cheaper.
3.	Telemedicine Server Software	5,00,000	
4.	Video Conferencing Kit	8,50,000	
5.	Terrestrial IP (2 mbps) scalable	10,000	May vary, broadband setup charge assumed.
6.	Training costs	1,00,000	To be provided by vendor, hospital bears cost of its staff.
7.	Installation & Commissioning	2,00,000	To be conducted by various vendors.
Total		**35,10,000**	

B. Annual Recurring Costs

Sl. No.	Item Description	Approximate Cost (Rs)	Remarks
1.	Site Administrator + Technician	3,50,000	Administrator = Rs. 2,00,000 Technician = Rs. 1,50,000
2.	Medical staff incentive / allowance	1,08,000	Doctors (01 nos) = 5000/month Medical staff (02 nos) = 2000/month
3.	Annual Maintenance Charges Hardware/Software per node	3,39,000	Assuming 15% of Equipment costs + s/w subscription / update
4.	Annual Update / Support Charges of Telemedicine software	2,50,000	Assuming 20% of costs
5.	Annual bandwidth cost per year per node	1,50,000	Assumed Broadband
6.	Electricity other consumables, etc.	0	To be provided by the hospital
Total (with incentives)		**11,97,000**	
Total (without incentives)		**10,89,000**	

Expenses towards establishment of Telemedicine Unit at District Hospital Level-2

Fixed Cost

Sl. No.	Item Description	Estimated Value (In Rupees)	Remarks
1.	Recommended Medical Equipment	6,00,000	
2.	Hardware / Software (including PC, servers, etc.)	11,50,00	
3.	Optional Storage Server + Backup	8,00,000	
4.	Telemedicine Consulting Centre (TCC) Software	7,50,000	May vary, Interactive Client is assumed. Web-based module may be cheaper.
5.	Telemedicine Server Software	5,00,000	
6.	Video Conferencing Kit	8,50,000	
7.	Terrestrial IP (2 mbps) scalable	10,000	May vary, Broadband setup charge assumed.
8.	Land, building, furniture electrical fittings, fixtures or any other non electronic item	0	To be provided by the hospital concerned
9.	Training costs	1,00,000	To be provided by vendor, hospital bears cost of its staff.
10.	Installation & Commissioning	2,00,000	To be conducted by various vendors.
Total (with optional items)		**49,60,000**	
Total (without optional item)		**41,60,000**	

Annual Recurring Costs

Sl. No.	Item Description	Approximate Cost (in Rupees)	Remarks
1.	Site Administrator + Technician	3,50,000	Administrator = Rs. 2,00,000 Technician = Rs. 1,50,000
2.	Medical staff incentive / allowance	1,08,000	Doctors (01 nos) = 5000/month Medical staff (02 nos) = 2000/month
3.	Annual Maintenance Charges Hardware/Software per node	5,56,500	Assuming 15% of Equipment costs + s/w subscription / update
4.	Annual Update / Support Charges of Telemedicine software	2,50,000	Assuming 20% of costs
5.	Annual bandwidth cost per year per node	1,50,000	Assumed Broadband
6.	Electricity other consumables, etc.	0	To be provided by the hospital
Total (with incentives)		**14,14,500**	
Total (without incentives)		**13,06,500**	

Expenses towards establishment of Telemedicine Unit at CHC/ FRU/PHC Level-1

Fixed Cost

Sl. No.	Item Description	Estimated Value (In Rupees)	Remarks
1.	Recommended Medical Equipment	6,00,000	
2.	Hardware / Software (including PC, servers, etc.)	3,50,000	
3.	Telemedicine Consulting Centre (TCC) Software	2,00,000	May vary, Interactive Client is assumed. Web-based module may be cheaper.
4.	Video Conferencing Kit	2,50,000	
5.	Terrestrial IP (2 mbps) scalable	10,000	May vary, Broadband setup charge assumed.
6.	Land, building, furniture electrical fittings, fixtures or any other non electronic item	0	To be provided by the hospital concerned
7.	Training costs	50,000	To be provided by vendor, hospital bears cost of its staff.
8.	Installation & Commissioning	1,00,000	To be conducted by various vendors.
Total (with optional items)		**15,60,000**	

Annual Recurring Costs

Sl. No.	Item Description	Approximate Cost (in Rupees)	Remarks
1.	Site Administrator + Technician	3,50,000	Administrator = Rs. 2,00,000 Technician = Rs. 1,50,000
2.	Medical staff incentive / allowance	1,08,000	Doctors (01 nos) = 5000/month Medical staff (02 nos) = 2000/month
3.	Annual Maintenance Charges Hardware/Software per node	2,00,000	Assuming 15% of Equipment costs + s/w subscription / update
4.	Annual Update / Support Charges of Telemedicine software	40,000	Assuming 20% of costs
5.	Annual bandwidth cost per year per node	50,000	Assumed Broadband
6.	Electricity other consumables, etc.	0	To be provided by the hospital
Total (with incentives)		**7,48,000**	
Total (without incentives)		**6,40,000**	

Budget Summary

Sl.	Description	No. of Units	Amount (Rs. in lacs)		
			One time Cost	Recurring Expenses	Total
1	Telemedicine Unit at State Level	1	35.10	11.97	47.07
2	Telemedicine Unit at District Hospital	10	49.60	14.15	637.50
3	Telemedicine Unit at CHC/FRU/PHC	10	15.60	7.48	230.80
Total					915.37

Accordingly, a total sum of Rs. 915.37 lacs for 10 districts for the year 2008-09 is being budgeted.

30. ESTABLISHMENT OF ONCOLOGY UNIT AT BALRAMPUR HOSPITAL

The number of cancer cases has been growing in the State, however, oncology facilities only exist at SGPGI and CSMMU, Lucknow. Therefore, for timely detection of various cancerous conditions, including Melanoma, and their treatment/referral, a proposal has been submitted to State government for establishment of an Oncology Unit at Balrampur Hospital, Lucknow which is functioning as a super-speciality hospital in government sector. Once the unit is established subsequent strengthening/upgradation would be taken-up. Proposal for which will be prepared accordingly and included in NRHM in subsequent years.

31. COMMUNITY MONITORING ACTIVITIES

Community monitoring is one of the core strategies under NRHM. It is proposed to operationalise community monitoring activities with support from GOI, development partners and NGOs. Detailed plans would be prepared in consultation with the Advisory Group on Community Action (AGCA) at GOI and final plan would be shared with GOI. A tentative budgetary provision of Rs.100 lacs for initiating community monitoring activities is proposed for the year 2008-09.

32. PILOT FOR NUTRITION COMPONENT UNDER RNTCP

Patients suffering from Tuberculosis are in weak health. To increase their resistance, it is proposed to give them protein rich foods, such as, egg, milk, etc. as supplement diet. It is justified to provide them Rs. 600/- each for first two months of intensive treatment i.e. Rs.10/- per day.

It is proposed to pilot the activity in one district and measure the outcome. Accordingly, an amount of Rs.50 lacs is being budgeted for the year 2008-09.

33. PILOT FOR TREATMENT OF MDR CASES UNDER RNTCP

It is proposed to pilot an activity on treatment of MDR cases in one district and measure the outcome, details have been provided in the chapter on 'Revised National Tuberculosis Control Programme'. Accordingly, an amount of Rs.50 lacs is being budgeted for the year 2008-09.

34. RI COMPONENT

Details have been provided in the chapter on 'Routine Immunisation'. An amount of Rs.840.98 lacs is being budgeted under Mission flexipool for the year 2008-09.

35. PROGRAMME MANAGEMENT

As already described in Part A (RCH-II) of the PIP, the following programme management expenses would be met from NRHM Additionalities.

Programme Management Expenses to be met from NRHM Additionalities

Sl.	Description	Annual Amount (Rs. Lacs)
1	Honoraria to Divisional PMU staff	74.46
2	Honoraria to Block PMUs staff	1975.20
3	Honoraria to Mission Director's Support Staff	5.64
4	Operational Expenses for Support Unit of Mission Director	1.20
5	Operational Expenses of Divisional and Block Units	694.56
6	State Quality Monitors at Division Level	38.08
7	Human Development Resource Group	10.40
Grand Total		**2799.54**

11. BUDGET SUMMARY (PART B – MISSION FLEXIPOOL)

Sl	Component	Approvals Received in 2007-08 to be Utilised in 2008-09 (Rs. in lacs)	Proposed Budget for 2008-09 (Rs. in lacs)	Total Funds to be Utilised in 2008-09 (Rs. in lacs)
1	ASHA Scheme		11611.30	11611.30
2	Village Health Index Register (VHIR)		40.00	40.00
3	Pre-service Training		1572.03	1572.03
4	Strengthening of CHCs to IPHS Norms		2425.12	2425.12
5	Untied Grant at Various levels		8089.65	8089.65
6	Annual Maintenance Grant (AMG)		1729.15	1729.15
7	Annual Assistance to Rogi Kalyan Samitis		3294.40	3294.40
8	Capacity Building of RKS Members		144.20	144.20
9	Capacity Building of VHSCs		70.00	70.00
10	Drug Warehouses at District Level		118.56	118.56
11	Provision of back-up power at 24 Hr. Facilities		98.76	98.76
12	Purchase of Generator Sets		410.00	410.00
13	Saas Bahu Sammelan		193.45	193.45
14	Screening of pregnant women for Hepatitis A, B, C & E		70.00	70.00
15	Referral Transport Services for Mother & Child Care		1843.81	1843.81
16	Incentive Package		698.56	698.56
17	Swasthya Puraskaar Yojana		88.56	88.56
18	RCH Mela at District and Block Levels		516.50	516.50
19	Strengthening HMIS		1200.00	1200.00
20	District Innovations		2100.00	2100.00
21	Rashtriya Arogya Nidhi (RAN)		500.00	500.00
22	NRHM Helpline		10.96	10.96
23	Telemedicine Project		915.37	915.37
24	Programme Management		2799.54	2799.54
25	District Action Plans (DAPS)		350.00	350.00
26	Strengthening Nurses Training	920.00		920.00
27	Mobile Medical Unit	2611.20		2611.20

Sl	Component	Approvals Received in 2007-08 to be Utilised in 2008-09 (Rs. in lacs)	Proposed Budget for 2008-09 (Rs. in lacs)	Total Funds to be Utilised in 2008-09 (Rs. in lacs)
28	Establishing Closed Users Group Network	100.00		100.00
29	Concurrent Audit System	51.56		51.56
30	Construction of Sub Centres	8000.0		8000.00
31	Procurement of Laparoscopes/Laparocators/NSV & IUD Kits	5886.20		5886.20
32	Major Repairs of Sub Centre Buildings	875.00		875.00
33	Electrification of 1000 Sub Centres	150.00		150.00
34	Community Monitoring		100.00	100.00
35	Nutrition Component under RNTCP		50.00	50.00
36	Treatment of MDR Cases under RNTCP		50.00	50.00
37	Routine Immunisation Component		840.98	840.98
Total		**18593.96**	**41930.90**	**60524.86**

12. RCH II (PART C) RI COMPONENT - UIP PLAN

A. ROUTINE IMMUNISATION PROGRAMME

1. Summary of recent initiatives

- **State Level Task Force for Strengthening RI**

  The State has an established Task Force under the chairmanship of Principal Secretary, Medical, Health & Family Welfare, Govt. UP. This task force meets once every quarter to review the RI program. Besides different wing representatives of Health & Family Welfare Dept., the members include Secretaries of other Departments, such as, ICDS, Panchayati Raj, Education, Urban development authorities, representatives of NPSP(WHO), UNICEF, CARE, Rotary, SIFPSA, IMA, IAP others.

- **Core Group**

  Core group at State level under the chairmanship of Director General (National Program, Monitoring & Evaluation) provides technical support as well as monitors the progress made on a regular basis. The members of the Core group include Director (FW), AD UIP, AD MCH, AD IEC, AD RCH, CCO, Partner agencies – UNICEF and NPSP (WHO). The Core group meets every month to discuss and review the implementation strategies, monitoring results and suggest new strategies for improvement.

- **Funds and Norms for distribution to Districts under RCH II (Part C)**

  Districts have been provided provisional funds for Sept to Nov 05 with directives/norms for proper utilization of these funds. Checks and balances at all levels have been taken into account, for example - voucher has been designed for payment by ANM to Social Mobilizer.

- **RI Monitoring**

  Monitoring of RI sessions is taking place for the last 3 years by Govt, UNICEF and NPSP. This is further being strengthened through intensive efforts by Government and partner agencies. At present the State is monitoring RI sessions on a standardized RI monitoring format, which is in the process of revision & developed by the State with assistance from UNICEF & NPSP. The compilation of data for each district is being done by NPSP district SMO units and being forwarded to the NPSP (WHO) State RI Cell for analysis and corrective actions.

  Revised Monitoring and Supervision

  The state is in the process of developing revised monitoring formats for regular RI sessions and revised monitoring compilation tool to be used by NPSP field units. This will be shared with GOI once they are finalized by the state. The revised monitoring formats upon analysis will generate substantial quality indicators of sessions for timely action at various levels of intervention - block, district and state.

2. Partnerships with other Agencies / Organisations.

Involvement of ICDS

- Anganwadi centres are being used as session sites
- AWW share information/records of pregnant mothers & newborns with ANMs
- AWW help in tracking beneficiaries and bring them for immunization
- They keep community informed of next session's date
- AWW reports disease outbreaks in the village to ANM

Involvement of Panchayat Raj Institutions and Department of Education in RI needs revamping.

Involvement of other partners in RI and their role

Organization like WHO /NPSP ,UNICEF, Immunization BASICS, CARE , ADRA Etc supports the state in providing technical and logistics supports in their own capacities .The principal activities carried out by major partners like WHO /NPSP and UNICEF is detailed below.

WHO/NPSP

- Monitoring of RI sessions during Regular RI days and Immunisation Weeks
- Compilation of Monitoring formats, Analysis and Feedback to State and Districts every month
- Technical support in Implementation and Strengthening of Routine Immunisation Monitoring Software (RIMS)
- State and District Level Technical Assistance in Strengthening Recording and Reporting mechanism, RI micro planning, Training of Health Workers and Capacity Building of Program Managers, Medical Officers and IO/ICC, AEFI investigation and VPD outbreak investigation.

UNICEF

- RI microplan effective implementation by providing mobility support
- Social mobilization to create awareness.
- Effective supervision by providing mobility support
- ANM training regarding use of AD syringes and supply of AD syringes
- Establishment of programme management units at District level in 10 districts
- Medical officers training regarding Routine Immunizations in 26 districts.
- Cold Chain support in terms of repair of cold chain equipments all over the State.

Vitamin A Supplementation Programme

UNICEF is providing technical and financial help in 18 districts of the State. The USAID funded Micronutrient and Child Blindness Program, A2Z, aims to save and improve the lives of vulnerable people through micronutrient and child blindness control, prevention and treatment interventions. They are providing support to the VAS programme in 6 districts of the state. CARE is also providing support in some districts terms of IEC, training and evaluations in these districts.

3. New Initiatives:

- New Immunisation card with four folds in the process with one portion each to be retained by ANM, ASHA and AWW apart from the portion given to beneficiaries.

  Status: Four fold immunization cards have already been distributed in field and their use has been seen during the ongoing Immunization Weeks and regular RI sessions.

- Availability and use of AD syringes have been around 99% in the session sites, indicating the replacement of glass syringes thereby ensuring safe injection practices.
- Construction and functioning of Immunisation waste disposal pit have been done in majority of the PHCs/CHCs
- Session wise record keeping by ANM and Joint Monitoring by Health and ICDS Supervisor proposed

  Status: Sessions wise tally sheets to record name of beneficiaries vaccinated in RI sessions has been initiated during immunization weeks and will be shortly implemented during regular RI sessions.

- Provision of special support to 16 Districts of UP for organizing RI sessions in difficult to reach area through special teams.
- Training for RIMS - Training of newly inducted Computer Assistants on RIMS has been planned in the month of March and batch-wise orientation of Computer Assistants has been planned in three regions of UP during 2008-2009.

4. Assessment of critical bottlenecks for full coverage

1. Availability

The main constraints in supply and distribution of vaccine are as follows:

- The flow of vaccine from GoI needs to be regular and sufficient as per State target with timely prior information.
- Vaccine supply from Govt. of India is limited to only 3 Depots. Timely and sufficient Supply of vaccine from these depots to divisional stores and further down to districts at times becomes difficult.

- Erratic power supply at block level hampers maintenance of cold chain for storage of vaccines.
- For rising up to expectations for cold chain our districts are to be provided with sufficient and timely funds for POL for gensets. At present average availability of power supply (not continuous) in districts at block level is about 4-6 hours.
- Also that more than 10 year running gensets should be replaced.

2. Accessibility

The main barriers include

- Alternate Vaccine Delivery system needs to be sustained over time for better accessibility of services through flow of funds from GOI
- Monitoring of session by Medical Officers and district level officers is also not adequate.
- Shortage of service providers.
- There is no well-defined infrastructure and micro plan for urban areas.

3. Utilization / Adequate Coverage

- Lack of awareness about Vaccine Preventable Diseases in Community.
- Lack of Coordination between ANM, Anganwadi Worker and ASHA
- Planning for missed sessions still not functional
- Poor MIS and record keeping leading to high drop outs which ANM is not able to track.

Action Plan

In the state of Uttar Pradesh, the RI sessions are held for **2 days in a week – Wednesdays and Saturdays, thus with the possibility of 8 sessions per sub centre per month**. The state proposes to hold 4 - 8 session in a month for any sub-centre as required according to its population, for effective service delivery to fill the huge gap in service delivery.

The components of Alternative Vaccine Delivery, Mobilization of Children for RI at session sites by ASHA/Non ASHA, hiring service provider in urban slums and underserved areas will be done as was done and proposed in previous year. For strengthening monitoring and supervision and surveillance, funds will be provided to DIOs, MO I/C of PHCs and APHC for monitoring and supervision of RI sessions. Review meetings for DIOs at the State level and also similar meetings at the District levels will be held for review of RI activities.

Key Areas of Initiatives for UP:

- Train all field staff immediately on current UIP policies, guidelines and skills with special emphasis on micro planning, injection safety, waste disposal, record maintenance and reporting; Training of Health Workers and MOs will be taken up according to GOI module
- Strengthen monitoring and supervision at all levels.
- Better coordination between ANM, ASHA and AWW for effective conduct of quality sessions and reducing the drop outs in a particular village.
- Involve other departments (ICDS, Railway, Education, PRI, etc.) and partners (NGOs, Private Sector & Medical Colleges) more actively to communicate messages and provide services.
- Additional support to difficult to reach or hard to reach areas for providing outreach area services.
- Develop a vaccine management system where vaccine requirements are based on accurate target population (from community level surveys) and working Cold Chain storage capacity.
- Replacement of Cold Chain Equipments which needs immediate replacement.

Budgetary Requirement

Total budgetary requirement for routine immunisation activities is Rs.5475.39 lacs of which Rs.4634.41 lacs are proposed to be met from RCH flexipool and Rs.840.98 lacs from Mission flexipool.

Additional funds/ commodity assistance would have to be provided by GOI for replacement of cold chain equipments and training of cold chain handlers.

ACTIVITIES & BUDGETARY REQUIREMENT FOR ROUTINE IMMUNIZATION (2008-09)

S.No.	Activity Head	Budget	Requirement (2008-2009)
C. 1	**Routine Immunization Strengthening :**		
C 1.1	**Mobility support for Supervision and Monitoring:**		
C 1.1.1	Mobility for State Officers for Supervision and monitoring	@ Rs. 100,000/annum	100,000.00
C 1.1.2	POL for mobility of ACMO/DIO for Supervision & Monitoring @ 4000 / month / district	Rs. 50000/ District X 70 districts	3,500,000.00
Sub total (Mobility support for supervision and monitoring)			**3,600,000.00**
C 1.2	**Alternate Vaccine Delivery :**		
C 1.2.1	Alternate Vaccine delivery support to sessions in rural areas	Rs. 50 / session X 8 sessions / Month X Number of sub centers (20521) - 4217 no. of sub centres (Special plans for 16 Districts, refer C.1.6.4) X 12 months	78,259,200.00
C 1.2.2	Alternate Vaccine Delivery support for session in urban slums and underserved areas	Rs. 50 / Session X 1800 urban slum clusters X 4 sessions/month/urban slum X 12 months	4,320,000.00
C 1.2.3	Alternate Vaccine delivery support for sessions in urban areas of big cities (11 big cities in UP @ 50 special sessions/city/month)	Rs. 50/ Session X 50 sessions/city X 11 cities X 12 Months	330,000.00
Sub total (Alternate Vaccine Delivery to session sites)			**82,909,200.00**
C 1.3	**Special provisions for underserved and urban slum areas**		
C 1.3.1	Honorarium of alternate vaccinators and contingency expenses for sessions in Urban Slums and Underserved areas	Rs. 350 / session (Rs. 300/- as honorarium + Rs. 50/- as contingency) X 1800 clusters X 4 session/month X 12 months	30,240,000.00
C 1.3.2	For Special sessions in urban areas of big cities	Rs. 350/ session (Rs. 300/- as honorarium + Rs. 50/- as contingency) X 50 sessions/month/city X 11 cities X 12 months	2,310,000.00

S.No.	Activity Head	Budget	Requirement (2008-2009)
C 1.3.3	Special sessions by alternate vaccinators in vacant rural sub centres	Rs. 350 / session X 300 vacant sub centers X 8 sessions / month / sub center X 12 months	10,080,000.00
Sub total (special provisions for underserved and urban areas)			**42,630,000.00**
C 1.4	**Social Mobilization**		
C 1.4.1	For ASHA/ Link workers in rural areas	Rs. 150/session X 20521 sub centres X 8 sessions/month X 12 months	295,502,400.00
C 1.4.2	For Special sessions in urban areas of big cities	Rs 150/session X 50 sessions/month/city X 11 cities X 12 months	990,000.00
Sub total (Social Mobilization)			**296,492,400.00**
C 1.5	**Computer support to State and Districts**		
C 1.5.1	Honorarium of Contractual Computer Assistants for DIOs	Rs. 7000 / assistant / month X 70 districts X 12 months	5,880,000.00
C 1.5.2	Honorarium of Contractual Computer Assistants at State level for AD(UIP) and State Cold Chain Officer	Rs. 7000 / assistant / month X 2 assistants X 12 months	168,000.00
Sub total (Computer support to State and Districts)			**6,048,000.00**
C 1.6	**State specific activities**		
C 1.6.1	Review of District and block level Routine Immunisation Microplan	Rs. 500/ block & district in 2nd year X (823 blocks + 70 districts)	446,500.00
C 1.6.2	Preparation of RI Microplanning CDs for dissemination to districts and blocks	Rs. 40/ CD X 400 pieces	16,000.00
Sub total (State Specific activities)			**462,500.00**
C 1.7	**Training Activities**		
C 1.7.1	Training of MOs on RI (Including TOT) + Fund for AEFI Orientation and Training	Rs. 50000/ Batch X 150 batches + Rs. 50000/ Batch X 3 batches	7,650,000.00
C 1.7.2	Training of Male Health Workers in batches of 20 participants on RI	Rs. 23090/ Batch X 300 Batches	6,927,000.00

S.No.	Activity Head	Budget	Requirement (2008-2009)
C 1.7.3	Orientation training on RIMS for CA's of DIOs	Rs. 200000/ Batch X 3 Batches	600,000.00
C 1.7.4	Training on RIMS for newly inducted CA's of DIOs	Rs. 200000/ Batch X 1 Batch	200,000.00
Sub total (Training component)			**15,377,000.00**
C 1.8	**Printing Activities**		
C 1.8.1	Printing of Vaccine Stock Register standardized by GOI	Rs. 110/ register X 1000 cold chain storage units	110,000.00
C 1.8.2	Printing of Vaccine distribution and Session Wise Consumption register	Rs. 110/ register X 1000 cold chain storage units	110,000.00
C 1.8.3	Printing of Session wise ANM tally sheets and reporting format	Rs.0.5/sheet X 2 copies X Total No. of sessions/ month (171918) X 12 months +10% wastage	2,269,317.60
C 1.8.4	Printing of UIP Monthly reporting format for Blocks and Districts to send report from Blocks to Districts and from Districts to State	Rs. 1 / format X 2 copies X (823 blocks + 70 Districts) X 12 months + 10% Buffer	23,575.20
C 1.8.5	Printing of Hired Service provider (for urban and rural vacant sub center areas) payment receipt (3 copies with carbon for each provider)	Rs 1 / copy X 3 copies X 184896 sessions/year	554,688.00
C 1.8.6	Printing of Hired Service provider payment receipt for special sessions in 11 major cities of UP (3 copies with carbon for each provider)	Rs. 1 / copy X 3 copies X 6600 sessions	19,800.00
C 1.8.7	Printing of ASHA/Mobilizer payment receipt book (2 voucher books each with receipts in triplicate per ANM on approved format design by GOUP of 50 sessions)	Rs. 85 / book X 16000 books (total of 13500 ANMs + 2500 Alternate vaccinators in UP)	1,360,000.00
C 1.8.8	Printing of Monitoring formats for Govt officials & partner agencies (NPSP (WHO), UNICEF, CORE, ADRA, CARE etc.)	Rs. 0.5/ format X 7,00,000	350,000.00
C 1.8.9	Printing of EPI newsletter on quarterly basis	Rs. 3 / newsletter X 50000 copies X 2 times every year	300,000.00
Sub total (Printing activities)			**27,597,380.80**

S.No.	Activity Head	Budget	Requirement (2008-2009)
C 1.9	**Operational Expenses for strengthening service delivery**		
C 1.9.1	Purchase of Hypochlorite solution @ 20 litre / vaccine distribution point / year	Rs. 3 / litre X 20 litres / vaccine distribution point / year X 1000 vaccine points	60,000.00
C 1.9.2	Purchase of Sieve and bucket for syringe disinfection @ 1 set / vaccine storage point	Rs. 70 / set X 100 vaccine storage points	7,000.00
C 1.9.3	Pits for disposal of immunisation waste	Rs. 2500 X 100 vaccine storage points	250,000.00
C 1.9.4	Plastic bags (red and black for each site) for disposal of used syringes	Rs. 2/ bag X 2 bags/ session X 171918 sessions/month X 12 months + 10% WASTAGE	9,077,270.40
C.1.9.5	Purchase of small Polythene bags to keep Vaccine in Vaccine carriers	Rs. 0.5 / polythene bag X 180000 (171918 sessions/month + 10% wastage) X 12 months	1,080,000.00
Sub total (Operational expenses for strengthening service delivery)			**10,474,270.40**
C 1.10	**Review meetings and feedback**		
C 1.10.1	Organization of State Review meetings for district level official to be organized once every six months	Rs. 1250 / participant X 3 participants / district X 70 districts X 2 times / year	350,000.00
Sub total (Review meetings and feedback)			**350,000.00**
Total (Routine Immunisation Strengthening)			**463,440,751.20**

ACTIVITIES & BUDGETARY REQUIREMENT FOR RI (2008-09) TO BE MET FROM MISSION FLEXIPOOL

S.No.	Activity Head	Budget	Requirement (2008-2009)
C. 1	Routine Immunization Strengthening :		
C 1.1	Mobility support for Supervision and Monitoring:		
C 1.1.1	POL as mobility support for Divisional Additional Director for Supervision and Monitoring of RI sessions @ Rs. 2000/ District / annum	Rs. 2000 X 70 districts	140,000.00
C 1.1.2	POL as mobility support for New PHC MOs for Supervision and Monitoring of RI sessions @ Rs.1000 / Month	Rs. 1000 X 2610 New PHCs' (in UP) X12 months	31,320,000.00
Sub total (Mobility support for supervision and monitoring)			31,460,000.00
C 1.2	State specific activities		
C 1.2.1	Special support to (4 Mandals /Divisions: Gorakhpur ,Mirzapur, Chitrakoot ,Bundelkhand (14 Districts)+ Chandauli and Ballia = 16 Districts for Mobility and Vaccine Delivery Support for organising RI sessions through Special Teams in Difficult to reach areas such as river belts, scattered habitations in forest areas, construction sites etc.	Rs. 800/ Vehicle / Block X 170 blocks X 4 vehicles/ session X 8 sessions/month X 12 months	52,224,000.00
Sub total (State Specific activities)			52,224,000.00
C 1.3	Review meetings and feedback		
C 1.3.1	Organization of Mandal Wise Review meetings for district level official to be organized once every Three Months	Rs. 300 / participant X 3 participants / district X 70 districts X 4 times / year	252,000.00
C 1.3.2	Operational Expenses for RI cell at State for report generation of RIMS and etc.	Rs. 1000/ month X 12 months	12,000.00
C 1.3.3	Fund for AEFI and Vaccine Preventable Disease Outbreak Investigation	Rs. 1500 / event X 100 events	150,000.00
Sub total (Review meetings and feedback)			414,000.00
Total required from NRHM			84,098,000.00

Requirement for Replacement of Cold Chain Equipment from CFC to CFC-Free

S.No	Name of Equipment	Specification	Qty. for Replacement (CFC to CFC free)	Additional Qty. required under the expansion plan	Total Requirement	Approx Cost per Unit	Total Fund Required (Rs. in Lacs)
1	Walk-in-Cooler	32 Cu. Mtr. Prefabricated having two cooling units 3 phase 440 volt along with10 KVA Genset, AMF Panel, Temp. Recording System based on CFC Free refrigerant	11	5 (including Genset & Servo Voltage Stabilizer of 10 KVA)	16	18 Lac per Unit (including installation and other necessary work to bring in operation)	288.00
2	Walk-in-Freezer	32 Cu. Mtr. Prefabricated having two cooling units 3 phase 440 volt along with 10 KVA Genset, AMF Panel, Temp. Recording System based on CFC Free refrigerant	2	1 (including Genset & Servo Voltage Stabilizer of 10 KVA)	3	25 Lac per unit (including installation and other necessary work to bring in operation)	75.00
3	Deep Freezer (Large) 300-310 Ltr.	220 volt AC/50 Hz. storage capacity approx 275 ltr. CFC Free hold overtime during power cut approx. 18 hours	350	1500 (For Pulse Polio) including 1 KVA Voltage Stabilizer	1850	Rs. 20,000/- each	370.00
4	Ice Lined Refrigerator (ILR) Large 300-310 Ltr.	220 volt AC/50 Hz. Storage capacity approx. 275 ltr. CFC Free hold overtime during power cut approx. 48 hours	500	100 (including 1 KVA Voltage Stabilizer)	600	Rs. 26,000/- each	156.00

S.No	Name of Equipment	Specification	Qty. for Replacement (CFC to CFC free)	Additional Qty. required under the expansion plan	Total Requirement	Approx Cost per Unit	Total Fund Required (Rs. in Lacs)
5	Ice Lined Refrigerator (ILR) (Small) 140-145 Ltr.	220 volt AC/50 Hz. Strong capacity CFC Free hold overtime during power cut approx. 48 hours	2000	500 (For established Vaccine Store at new PHCs including 1 KVA Voltage Stabilizer)	2500	Rs. 15000/- each	375.00
6	Deep Freezer (Small) 140-145 Ltr.	220 volt AC/50 Hz. strong capacity approx 375 ltr. CFC Free hold overtime during power cut approx. 18 hours	2000	500 (For established Vaccine Store at new PHCs including 1 KVA Voltage Stabilizer)	2500	Rs. 15000/- each	375.00
7	1 KVA Voltage Stabilizer	Suitable for WHO standard ILR/DF to be attached with one twin set of small ILR & DF	2000	500	2500	Rs. 3000/- each	75.00
8	Tool Kit	for 70 Refrigerator Mechanics	35	35	70	Rs. 70000/- each	49.00
9	Cold Box (Large) 22 ltr. + 50 Ice Packs	Vaccine storage capacity 15 ltr Polyurethane lining material LLDPE Hinged insulation thickness 60 mm Ice Pack type E5/21, E5/09 of WHO approved specification.	2000	500	2500	Rs. 7000/- each	175.00
10	Cold Box (Small) 5 ltr. + Ice Packs of WHO specification	Vaccine storage capacity 5 ltr Polyurethane lining material LLDPE Hinged insulation thickness 60 mm Ice Pack type E5/21, E5/09 of WHO approved specification.	3000	1000	4000	Rs. 5000/- each	200.00

S.No	Name of Equipment	Specification	Qty. for Replacement (CFC to CFC free)	Additional Qty. required under the expansion plan	Total Requirement	Approx Cost per Unit	Total Fund Required (Rs. in Lacs)
11	Vaccine Carrier + 4 Ice Packs	Vaccine storage capacity 2 ltr Polyurethane lining material LLDPE Hinged insulation thickness 60 mm Ice Pack type E5/12, E5/19 of WHO approved specification @ 2 Vaccine Carrier per ANM	50000	50000 (for Pulse Polio)	100000	Rs. 600/- each	600.00
12	Spare Ice Pack	Suitable for Vaccine Carrier E 5/12, E5/19 of WHO approved specification	250000	200000	450000	Rs. 20/- each	90.00
TOTAL							**2828.00**

B. PULSE POLIO IMMUNIZATION PROGRAMME

Goals & Objectives

The goal of the Global Polio Eradication Initiative is to ensure that no child will ever again know the crippling effects of polio. Polio is a highly infectious disease caused by a virus (poliovirus). This virus lives & multiplies only in intestinal tract of human beings. There are 3 types of wild polio viruses P1, P2 and P3. It invades the nervous system and can cause total paralysis in a matter of hours. It can strike at any age, but affects mainly children under three. Polio is mainly passed through person-to-person (i.e., faecal-oral) contact, and infects persons who do not have immunity against the disease. There is no cure for polio, but the disease can be prevented by immunization with polio vaccine. Oral polio vaccine (OPV) was developed in 1961 by Dr Albert Sabin; OPV is an effective, safe and inexpensive vaccine, and has been used in all countries of the world to achieve polio eradication

The primary strategies for achieving eradication are:

· *Attaining high routine immunization:* immunize every child aged <1 year with at least 3 doses of oral poliovirus vaccine (OPV). Paralytic polio can be caused by any of 3 closely-related strains (serotypes) of poliovirus. Trivalent OPV (OPV3) provides immunity against all 3 types. Three routine OPV doses should be received by infants at ages 6, 10 and 14 weeks.

· *National Immunization Days (NIDs):* Conduct Pulse Polio Immunization (PPI) programme by providing additional OPV doses to every child aged <5 years at intervals of 4-6 weeks. The aim of NIDs/PPI is to "flood" the community with OPV within a very short period of time, thereby interrupting transmission of virus throughout the community. Intensification of the PPI programme is accomplished by the addition of extra immunization rounds, adding a house-to-house "search and vaccinate" component in addition to providing vaccine at a fixed post. The number of PPI rounds conducted during any particular year is determined by the extent of poliovirus transmission in the country. In recent years, several rounds have been conducted throughout the year in the state, which have carried a heavier burden of poliovirus – in an attempt to break the last chains of transmission. Intensification of PPI requires meticulous programme planning, intensive supervision, monitoring & extensive social mobilization.

· *Surveillance of acute flaccid paralysis (AFP)* to identify all reservoirs of wild poliovirus transmission. This includes AFP case investigation and laboratory investigation of stool specimens collected from AFP cases, which are tested for polioviruses in specialized laboratories.

· *"Mopping-up" immunization:* when poliovirus transmission has been reduced to well-defined and focal geographic areas, intensive house-to-house, child-to-child

immunization campaigns are conducted over a period of days to break the final chains of virus transmission.

Activities

Strategy for Immunization:

- Booth on day 1 followed by
- House-to-house visits to search and vaccinate all children from 0 - 5 years
  - A teams to cover all houses in 5-6 days
  - B teams to immunize children in X marked house
- Vaccination teams to cover transit and congregation sites
- Mobile teams to cover brick kilns, construction sites, hard to reach areas etc

Prioritizing Areas:

- High Risk Areas (HRAs)are given special attention for all operational issues
- Prioritization of these areas is based on
  - Surveillance data
    - Wild virus cases during recent years
  - SIA quality
    - Number of missed houses during recent SIAs
    - Unimmunized children on street survey
    - Any other problem
  - Qualitative feedback of poor quality during recent SIAs
  - Community profile – under served communities

Special strategies to reduce "X" houses:

- X houses were to be converted by teams / supervisors the same day / next day
- Biphasic activity has been strengthened by making teams stay in the field till late evening to cater to children returning late.
- Lists of "Repeated X houses" of last 3 rounds are made to be specially visited to immunize the children.

Budgetary Requirement

No of Districts	-	70
No of Blocks	-	944
No of Booths	-	108139
No of Vaccinators Booth	-	324417
No of Supervisors Booth	-	21628
No of H-t-H Team Days	-	305044
No of Teams (1 team per 5 team days)	-	61009
No of Vaccinators H-t-H	-	183027
No of Supervisors H-t-H	-	20336
No of Transit Team Days	-	91833
No of Mobile Team Days	-	9674

Activity wise Budget		Amount (Rs. In Lacs)
Booth Budget		
Supervisors Per Diem	Rs. 50/- per supervisor for 1 day	10.81
Supervisors Mobility	Rs. 75/- per supervisor for 1 day	16.22
Booth Mobility	per 10 booth 1 vehicle @Rs. 800/- for 1 day	86.51
Per Diem Vaccinators	Rs. 50/- per vaccinator for 1 day	162.21
Supplies & Logistics	Rs. 40/- per booth for 1 day.	43.26
Total Booth Budget		**319.01**
House to House Budget		
District Mobility	Rs. 1500/- per block	14.34
Block Mobility	per 13 team days, 1 vehicle @ Rs. 800/-	187.72
Supervisor Mobility	Rs. 100/- per supervisor for 5 days	101.68
Per Diem Vaccinators H-t-H	Rs. 50/- per vaccinator for 5 days	457.57
Per Diem Supervisor	Rs. 75/- per supervisor for 5 days	76.26
Back-up Team	Backup team: Per 50 X houses 1 B team (having 2 members) is to be made. Mobility @Rs. 100/- per team and per diem @ Rs. 50/- per member will be given. In addition to this 4 vehicles per block @ Rs. 800/- for one day's activity has been provided	156.64
District Support Personnel	Rs 50/- per day per worker for 5 workers for 6 days	1.05
Block Support Personnel	Rs. 50/- per day per worker for 3 workers for 6 days.	8.51
Supplies & Logistics	Rs. 30/- per team per day for 5 days.	91.51
District Level Genset	Rs.9000/- per district	6.30
Block Level Genset	Rs 7000/- per block	66.22
Mobility for MOs at Add/ New PHCs	Per block @Rs 100/- for 4 persons for 6 days	22.66
Mobility for Revenue Staff	30000/- per district	21.00
Pulse Polio Rally	25000/- per district	18.90
Divisional A.D. Mobility	Rs. 3000/- per district	2.10
Total House to House Budget		1232.45
Transit Team Budget		0.00
Supervisors Per Diem	Per 5 team day 1 supervisor day @Rs. 75/-	13.77
Supervisors Mobility	Per 5 team day 1 supervisor day @Rs. 100/	18.37
Per Diem Vaccinators	2 Vaccinators per team @Rs. 50/- per vaccinator	91.83
Supplies & Logistics	Rs 15/- per team day	13.77
Total Transit Team Budget		137.75

Activity wise Budget		Amount (Rs. In Lacs)
Mobile Team Budget		0.00
Supervisors Per Diem	Per 5 team day 1 supervisor day @Rs. 75/-	1.45
Supervisors Mobility	Per 5 team day 1 supervisor day @Rs. 100/	1.93
Vehicle Mobility	Rs. 50/- Per team day	4.84
Per Diem Vaccinators	2 Vaccinators per team @Rs. 50/- per vaccinator	9.67
Supplies & Logistics	Rs 15/- per team day	1.45
Total Mobile Team Budget		19.35
IEC Activities		**200.00**
State Head Quarter (Observer's TA / DA and Contingency)		**0.50**
Total (Booth + H-t-H + Transit + Mobile)		**1909.05**
(i) Expected Rounds in 2008 – 2009 - 9 Rounds (2 NIDs + 7 SNIDs)		**17181.48**
(ii) Mop-up Round (approx 25 districts) 2 Mop-up rounds @ Rs. 700 lacs per round		**1400.00**
Grand Total (i+ ii)		**18581.48**

Budgetary Requirement for Training on Cold Chain, Vaccine Issues & Other Operational Expenses

S.No.	Activity	Budget Norms	Requirement	Rate	Budget Requirement (Rs. in lacs)	Remarks
1	One day training for Vaccine Cold Chain handlers posted at PHC, District and Division Level vaccine store person	2000 total person to be trained @ 1,000/- per person (100 batches of 20 persons per batch including the expenses of Trainer)	Rs. 2000 per person (conducting 100 batches of 20 Trainees and 2 trainers for TA/DA and honorarium fixed norms in NRHM and other expenses born for arrangement of Training)	2000 x 2000	40.00	Most of the staff has either been transferred, retired or promoted. New comers need to be trained
2	Two days training of Vaccine & Cold Chain logistics management for DIOs posted at District & officer responsible at Division H.Q.	100	Rs. 3000 per person (for conducting 5 batches of training 20 trainees and 3 trainers per batch)	3000 x 100	3.00	Most of the officers have either been transferred, retired or promoted. New comers need to be trained
3	Printing of Training Module	3500	One for each participant	3500 x 100	3.50	
4	Printing of Temp. Log Book	7000	One book per each electric operated cold chain equipment	7000 x 25	1.75	
5	Printing of Genset Log Book	1000	One Log Book per each Genset	1000 x 50	0.50	
6	AMC of repair of WIC/WIF	30000/- per Unit		30000 x 21	6.30	
7	Maintenance of repair of Cold Chain Equipment (electric operated)	500/- per Cold Chain Equipment		7000 X 500	35.00	

S.No.	Activity	Budget Norms	Requirement	Rate	Budget Requirement (Rs. in lacs)	Remarks
8 (a)	Repair maintenance of Genset & other expenses of Vaccine Store	100,000/- per District		100000 x 70	70.00	
8 (b)	Repair maintenance of Genset & other expenses of Vaccine Store	25000/- per Division		25000 x 17	4.25	
9	POL for Genset	10 lit POL per Genset per day for working 5 hrs. per day Rs. 300/- (Approx) for 365 days per Cold Chain Point		1000 x 300 x 365	1095.00	
TOTAL					**1259.30**	

Summary of Budgetary Requirement for Pulse Polio Immunization (PPI) and Cold Chain Maintenance

Sl	Description	Amount (Rs. In lacs)
1	Pulse Polio Immunization	18581.48
2	Training, Maintenance & Operational Expenses	1259.30
Grand Total		**19840.78**

13. NATIONAL DISEASE CONTROL PROGRAMMES (PART D)

1. NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

During the year 2007-08 a proposal was made for Rs. 5173.25 lacs, which was approved but total amount released was Rs 3407.26 lacs. The opening balance during the year was to the tune of 429.75 lacs and total availability of fund during the year was 3837.01 lacs.

The component wise status of implementation is as under:-

Sl.	Intervention	Targets	Achievement till Dec-07	Expected achievement by Mar-08	Remarks
1	Cataract Operation	550000	284966 (265523 IOL)	6,50,000	The targets will be achieved till March because maximum operations are to be held in winter season.
2	School eye Screening	5833333	1760981	30,00,000	In view of Hon'ble Supreme Court orders, teachers should not be involved in other works.
3	Free Spectacles for BPL Children	122500	45525	90,000	Due to lack of funds up to Dec-07. Now funds are released, the activity has geared up.
4	Corneal Collection	2000 (500 GOI)	175	250	Due to lack of public awareness and less co-operation of peoples.
5	Vision Centre	50	50	-	All Functional
6	Eye donation Centre	5	0	-	After full functioning of eye banks it will take off gradually.

During the year there were liabilities of Rs. 1269.12 lacs previous years which was cleared totally. Thus total available funds for activities this year was Rs 2567.89 lacs against which Rs. 170.48 lacs are available in State Society and remaining has been disbursed in the districts.

Major bottlenecks in Programme Implementation

- School Eye Screening Programme:- Against requirement of Rs. 153.00 lacs the funds available were Rs. 25 lacs in July 2007 which affected the implementation of the programme.
- As regards proposal of non recurring grant for up gradation for 5 NGOs, one NGO has been sanctioned grant. Four more proposals are under consideration.
- IEC components have been sluggish; steps have been initiated to utilize the available funds.

- Training of Ophthalmic Assistant.
- Strengthening of the State Cell as per norms.
- Eye Donation Centre. Lack of response from the field.

Input from the State

- Procurement of Equipment for District hospitals and 151 IOL centres have been undertaken from state funds.

Strategy for the year 2008-09

- Improve the performance of the cataract surgery and quality assurance.
- Improve the school eye screening performance and distribution of free spectacles.
- Improve the performance of eye banks and corneal collection.
- Operational diabetic retinopathy clinic.
- Integrated IEC.

Magnitude of the Problem

India was first country to launch the National Programme for Control of Blindness in 1976. The goal of the programme was to reduce the prevalence of blindness. Out of the total estimated 45 million blind people (3/60) in the world, 7 million are in India and 1.85 million in Uttar Pradesh. This is due to the large population base and increased life expectancy. Every year 0.3% of the population, which means about 5.5 lac blind persons, are added to the total blind population. Out of 5.5 lacs total blind 3.5 lacs become blind every year due to cataract.

As the prevalence of cataract is reducing, blindness due to degenerative diseases like diabetes and glaucoma and injuries related corneal opacities are increasing. The programme has to tackle emerging challenges.

Objectives of the Programme

At present U.P. has blindness prevalence rate of 1.0%, it is committed to reduce this rate from 1.0% to 0.3% by the end of year 2020, 0.5% by the end of 2012 and 0.9% by the end of 2008-09

Main Activities of the Programme

a. Cataract Surgery
b. School Eye Screening
c. Corneal Blindness (Eye Banking)
d. Diabetic Retinopathy
e. Glaucoma screening programme

1. Cataract Operation Activities

At present about 11.50 lacs cataract blindness cases exist in the state. To this almost 3.5 lacs new cases are added every year. If 5.5 lacs cataract surgeries are conducted every year, back log of 11.50 lacs will be cleared in 6 years. If 7.5 cataract surgeries are conducted every year the back log will be cleared in next 4 years. And the resources could be deployed to address other degenerative causes of blindness.

a. Target of Cataract Operations for the year 2008-2009:

Sl.	Year	Target (In lacs)	Cataract Surgical Rate Achieved	Achievements
1	2006-07	5.20	351	6.36 lacs
2	2007-08	7.52	360	6.50 lacs (expected)
3	2008-09	7.52	400	-

b. Target of IOL Operations for the year 2008-2009:

Sl.	Year	Percentage Achievement of IOL Operations against total Cataract Operations
1	2006-07	85.35%
2	2007-08	93.00% (expected)
3	2008-09	95.00%

Strategies to Achieve the Targets of 2008-09

1. Primary Screening by ASHA, MPW to identify with visual impediments.
2. Case selection by eye surgeon at screening camps, base & Distt Hospital.
3. Transportation of Cataract Blind to base hospital for IOL Surgery, free for all.
4. Follow up of operated cases carrying out refraction and providing best corrected glasses.
5. Training of eye surgeons in IOL, SICS and Phaco.
6. Promotion of good & high technical NGOs.
7. Extended IEC programme by electronic media, print media and local agencies, AIR & National Channels to approach rural and remote area supported by local IEC.

As an estimate among the total target of cataract surgeries 30% will be done by Govt agencies and 30% will be done by NGOs and 40% will be done by private sector. Thus, @ Rs. 500 / cataract operation will cost (50% of target 7.52 lacs i.e. 3.76) Rs 1550 lacs. The cost of IOL and Suture @ Rs.250 has not been included in it because this will be supplied from state society for which 200 lacs for 2 lacs IOLs and 50 lacs for 10-0 suture will be required.

But as per the funds available in pipeline, a lump sum of Rs.1550 lacs are required for this activity.

2. School Eye Screening Activities

It is estimated that 5-7% of School going children aged 8-14 yrs have problems with their eye sight effecting their participation and learning at school. This can be corrected by a pair of spectacles.

All school having children in the age group of 8 -14 years are expected to under take eye screening activities. With the school teachers not available for the activity, it is proposed that this activity will be under taken by ASHA/ MPW (Male). These workers will be trained for under taking screening process and making referral for refraction to block PHCs. DBCS will supply the refractive glass to eligible students.

a. Target of Screening of 50 lacs Children of aged 8-14 years in the year 2008-09

b. Target of Free Distribution of 1.22 lacs spectacles to poor children in year 08-09

Strategies to Achieve the Targets of 2008-09:

a. Training of ASHA, MPWs at primary level.
b. Suspected refractive error children referred to PHC/CHC/NGO Hospitals/ trained Optometrist for proper refraction.
c. Provide free spectacles to poor children.
d. Involvement of NGO's in Screening of Children having low Vision for non school going children..
e. Development of 100 VISION CENTRES at PHC/CHC level with the equipment & furniture and fixture in the year 2008-09. The concept of vision centre arises from fact that one time provision of equipments and supportive material hardly ever gets replaced resulting into non functional facility. It is proposed that in next 4 years all block health facility will have a vision centre each centre requires Rs. 25000 for replacing obsolete and non-functional equipments / material.
f. Through local IEC all schools will have wall painting/writing in relation to eye screening programme.
g. For providing free spectacles to 1.22 lacs students @ Rs 125 each total sum required is Rs 152.50 lacs.
h. Wall paintings depicting need for eye screening, deworming, nutrition, drinking water and sanitation will be undertaken in every school. Wall painting @ of Rs 10 / sq.ft. for 25 sq.ft. at 40 thousands schools would be done. Thus, Rs.100 lacs are required to undertake this activity.
i. For setting up 100 vision centres sum required is Rs 25 lacs (@ Rs 25000 each).

Total amount required is Rs 277.50 lacs for this activity.

3. Corneal Blindness Activities

The prevalence of corneal blindness is about 1% of total blindness. There are about 18000 people in need of corneal transplant. The lack of corneal donation and functional institutions are major bottlenecks to address corneal blindness.

Target of 2000 Corneal Transplantation in the year 2008-09

Objective

1. Vitamin A Solution Programme.
2. Collection of Donated eye & providing Keratoplasty Services in all Medical Colleges and registered Eye Banks.

Strategies to Achieve the Targets of 2008-09

1. Primary eye care medicines will be available at PHC/CHC level.
2. Vitamin A Cap. & solution distribution at village level by ASHA.
3. 13 Eye Banks are already registered in 2007-2008 and nearly 10 eye banks will be registered in 2008-2009.
4. As per GOI norms 11 eye banks will be provided non recurring grant of Rs. 10 lacs /per bank In addition all 13 eye banks will also receive recurring grant of Rs. 1 lacs as collection centre. A lumpsum of 50.00 lacs will required for this activity.
5. Lump sum provision of Rs. 25 lacs for undertaking electronic and local media interventions.

Total amount required for this activity is Rs 75 lacs.

4. Diabetic and Glaucoma related blindness

About 10% of total blindness is due to diabetes and glaucoma. Currently there are no mechanism to address this category of blind persons which is gradually increasing. It is proposed to setup screening clinic in every district hospital and treatment centre at every divisional hospital and medical colleges. Equipment for diagnosis diabetes related problem by Govt. of UP. Only indirect ophthalmoscopes are required to undertake screening process for both diseases.

Strategies to achieve targets:

1. All known diabetics to be examined by eye surgeon /ophthalmic asstt.
2. Tonometry, fundoscopy and indirect ophthalmoscope will be done at weekly clinic at all district hospitals.
3. Medical Management of diabetic retinopathy and surgical management of glaucoma at divisional level hospital.

4. For surgical intervention patients referred to medical colleges for diabetic retinopathy.
5. For operation of equipments optometrist should trained at medical colleges by state govt.
6. Eye surgeons to be trained in diabetic retinopathy and Glaucoma by central government.

Financial requirement

1. An indirect and a direct ophthalmoscope for each district hospital will cost (Rs.50,000 X 70= Rs 35.00 lacs)
2. An auto perimeter, green laser, retinal angiography and slit lamp for each divisional level hospital will cost (50 lacs X 3 Div. Hosp= 150 lacs only)

Total amount required is Rs 185.00 lacs for this activity.

5. Human Resource Development:

In order to bring about improvement in quality of services following substantial efforts have been made:

Training PMOA (Eye Asstt./Optometrist), PHC-Medical Officer and Staff Nurse :-

To be trained by State Level in Refraction & instrumentation, Community Ophthalmology and Ophthalmic Nursing in 4 training centres namely - Medical College, Lucknow, Meerut, Agra and Allahabad.

S.No.	No. of Trainees	Name of Training	Duration	Cost
1	200 PMOAs	Refraction & Instrument Management	5 Days	5.00 lacs

Total amount required for this activity is Rs 5.00 lacs.

6. Strengthening State Blindness Control Cell

GoI has recommended staff and financial norms for strengthening State Blindness Control Society Cell at Directorate. Fund for this activity is available. With the integration of the Blindness Control Society with NRHM Society, the strengthening component will be integrated with the State Programme Cell. The fund requirement for 2008-09 is provided ahead:

S.No.		Staff on Contract Basis	Monthly Rate	Annual Requirement (Rs. in lacs)
A.	1	Budget & Finance Officer	13000	1.56
	2	Administrative Officer	11000	1.32
	3	Computer Programmer	9000	1.08
	4	Data Entry Operator	6500	0.78
	5	Administrative Assistant	5500	0.66
	6	Driver	3500	0.42
	7	Peon	3000	0.36
		Sub-Total		**6.18**
B.	1	TA/DA to Staff	8000	0.96
	2	POL and Vehicle maintenance	5000	0.60
	3	Stationery & Consumables	5500	0.66
	4	Quarterly Review Meeting	15000	0.60
		Sub-Total		**2.82**
C.		**Support for District Nodal Office for 70 Districts** (Computer & accessories – Rs 50,000/- ; Honoraria as per GoI norms to District Nodal Officer – Rs.2000/- pm; Honoraria as per GoI norms to Support Staff – Rs.1500/- per month; Contingency – Rs.1000/- per month)	**One time Expense – Rs. 0.50 lacs** **Recurring - Rs.0.54 lacs pm**	**72.80**
Total				**81.80**

7. Infrastructure Development

In the year 2008-09 following new Centres will be added for eye care services.

Sl.	Level	Infrastructure to developed in 2008-09	Funds required
1	Up gradation of 5 NGO Hospitals	5 NGO hospitals will be provided non-recurring grant of Rs. 25.00 lacs for the strengthening /up-gradation of their Hospital.	125.00 lacs.

Summary of Financial Requirement for NPCB (NRHM) for the Year 2008-2009

Sl.	Description	Total Requirement (Rs. In lacs)
1	Cataract Operation	1550.00
2	School Eye Screening	277.50
3	Corneal Blindness activity	75.00
4	Diabetic and Glaucoma related blindness	185.00
5	Human Resource Development	5.00
7	State Programme Cell	81.80
8	Infrastructure Development (Up-gradation of NGO Hospitals)	125.00
Total		**2299.30**
For Clearing liabilities of Mission Flexipool		**2456.51**

During the year 2007-08 a proposal was made for Rs. 5173.25 lacs which was approved but total amount released was Rs 3407.26 lacs. The opening balance during the year was to the tune of 429.75 lacs and total availability of fund during the year was 3837.01 lacs.

Additionally, there were pending liabilities amounting to Rs.24,56,50,758/- under the NPCB programme. NPCB received the amount from Mission Flexipool for clearing the previous pending liabilities of Rs.1200.56 lacs, Rs.1102.80 lacs current year activities of 2007-08 of Cataract Operation and Rs.153.13 lacs for current activities of school eye screening. Hence, an amount of Rs 2456.51 lacs are required to reimburse the same in Mission Flexipool account. The requirement is over and above the proposal of Rs.2299.30 lacs.

2. REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

RNTCP in Uttar Pradesh : In Uttar Pradesh RNTCP was launched in Lucknow as a pilot project and then subsequently extended to 8 districts. With the assistance of the World Bank the programme was extended to 40 districts in 2004. By December 2005 entire state has been fully covered under the programme with access to DOTS services for 18.39 Crore population. . In Uttar Pradesh about 257 new cases are expected per Lac annually, out of which 95 per Lac per year are New Smear Positive cases.

1. Objectives

1. *To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases, and*
2. *To achieve and maintain detection of at least 70% of such cases in the population*

General Information about the State

1	State Population – Projected 2008	1908.9 Lacs
2	Number of districts in the State	70
3	Urban population	360 Lacs
4	Tribal population	13 Lacs
5	Hilly population	14 Lacs
6	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums, etc.)	Approx. 12.0 Lacs

2. Overview of the Project in year 2007-08

a. Financial Details - Financial Status for Year 2007-08

(Amount in Lacs)

Activity	Proposal Sent and approved outlay	Releases Received from GOI	Released from State to Districts	Fund Utilization	Projected Expenditure January to March 2008	Total Projected Expenditure April 2007 to March 2008
RNTCP	4082	2425	2378	1964	1292	3256

b. General Performance

Year	Population Covered (in Lacs)	Annualised CDR (Lac/Yr)	New Sputum +Ve Detection Rate (lac/Yr)		Conversion Rate (%)	Cure Rate (%)
		Target >180	Target >67 (70%)		Target >90%	Target >85%
2005	1820	119	47	49%	90	84
2006	1839	122	50	53%	89	84
2007	1874	131	53	56%	90	83

c. Key Achievements

- Annualised case detection rate is increased to 131 from 122 of 2006.
- New sputum +ve detection rate is increased to 56% from 53% of 2006.
- Maintaining conversion rate 90% and cure rate is 83% near target of 85%.

d. Major Bottlenecks in Implementation

a. TB suspects are not being referred to DMCs from PHIs as per indicator i.e. 2% to 3% of total adult OPD.

b. Untrained DTOs and MOTCs because of frequent transfers.

c. No. of TUs and DMCs are not as per Population norms.

d. Medical colleges are not involved to the extent, they should be. They are reporting only 2 to 3% cases in place of 15 to 20%.

e. Lack of supervision and monitoring by district officials.

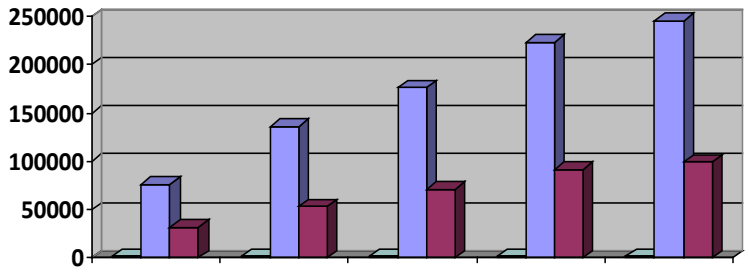
f. Lack of referral feedback.

g. Lack of awareness generation in slums, SC dominated areas, densely populated areas and urban slums.

h. Non involvement of private practitioners.

2. Situation Analysis and Trends

Total Cases/ NSP treated under RNTCP in U.P.



Year	2003	2004	2005	2006	2007
Total treated Cases Of TB	76026	136632	176022	223811	245106
Treated NSP Cases	32006	53505	71203	91302	99606

Total population of the State is being covered under RNTCP. There is an increasing trend in detection of total cases of tuberculosis and new smear positive cases & their treatment.

3. Components of the Programme

1. Civil Work
2. Laboratory Consumables
3. Honorarium
4. IEC/Publicity Activities
5. Equipment Maintenance
6. Training
7. POL &Vehicle Maintenance
8. Vehicle Hiring
9. NGO/PP Support
10. Miscellaneous Activities
11. Contractual Services
12. Printing
13. Research & Studies
14. Medical Colleges
15. Procurement of Vehicle
16. Procurement of Equipment
17. Nutrition Support
18. NSP Detection, Conversion & Cure

4. Proposal for year 2008-09

No. of districts without DTC - 3 (Agra, Hathras, Bagpat).

No. of districts that submitted annual action plans, which have been consolidated in this state plan: **70**

Organization of services in the state:

Status of TU s & DMCs as on 30th Sept 07

Sl.	District	Popn. (lacs)	No. of Govt. TUs	No. of Pvt. TU s	No. of NGO TU s	Total TUs/ No. to be planned FY 08-09	No. of Govt. DMCs	No. of Pvt. DMCs	No. of NGO DMCs	Total DMCs/ No. to be planned FY 08-09
1	AGRA	41	8	0	0	8/0	30	0	3	33/4
2	ALIGARH	34	7	0	0	7/0	29	3	0	32/2
3	ALLAHABAD	56	10	0	0	10/1	44	0	11	55/5

Sl.	District	Popn. (lacs)	No. of Govt. TUs	No. of Pvt. TU s	No. of NGO TU s	Total TUs/ No. to be planned FY 08-09	No. of Govt. DMCs	No. of Pvt. DMCs	No. of NGO DMCs	Total DMCs/ No. to be planned FY 08-09
4	AMBEDKAR_NAGAR	23	4	0	0	4/1	17	0	0	17/3
5	AURAIYA	13	3	0	0	3/0	12	0	0	12/2
6	AZAMGARH	45	8	0	0	8/0	37	0	0	37/5
7	BAGHPAT	13	3	0	0	3/0	11	0	0	11/0
8	BAHRAICH	27	6	0	0	6/0	26	0	0	26/2
9	BALLIA	31	6	0	0	6/1	28	0	0	28/1
10	BALRAMPUR	19	4	0	0	4/0	16	0	1	17/3
11	BANDA	17	4	0	0	4/0	17	0	0	17/0
12	BARABANKI	30	7	0	0	7/0	31	0	0	31/4
13	BAREILLY	41	7	0	1	8/1	33	2	2	37/3
14	BASTI	23	4	0	0	4/1	22	0	0	22/1
15	BIJNOR	35	6	0	0	6/1	26	0	1	27/10
16	BUDAUN	35	6	0	0	6/1	28	5	0	33/1
17	BULANDSHAHAR	33	6	0	0	6/1	26	0	0	26/7
18	CHANDAULI	19	4	0	0	4/0	17	0	0	17/2
19	CHITRAKOOT	9	3	0	0	3/0	8	0	0	8/1
20	DEORIA	31	5	0	0	5/0	26	0	0	26/14
21	ETAH	31	6	0	0	6/0	25	1	0	26/4
22	ETAWAH	15	3	0	0	3/0	14	0	0	14/0
23	FAIZABAD	24	3	0	0	3/1	13	0	0	13/3
24	FARRUKHABAD	18	3	0	0	3/0	13	0	0	13/3
25	FATEHPUR	26	5	0	0	5/0	17	0	1	18/5
26	FIROZABAD	23	5	0	0	5/0	20	0	0	20/4
27	G. .B NAGAR	13	2	0	0	2/1	9	1	2	12/5
28	GHAZIABAD	37	7	0	0	7/1	26	2	5	33/12
29	GHAZIPUR	34	6	0	0	6/0	29	0	1	30/5
30	GONDA	31	5	0	0	5/1	20	0	0	20/9
31	GORAKHPUR	43	7	0	0	7/0	23	1	4	28/15
32	Hamirpur-UP	12	2	0	0	2/0	10	0	0	10/0
33	HARDOI	38	7	0	0	7/1	32	0	0	32/7
34	HATHRAS	15	3	0	0	3/0	7	0	1	8/0
35	JALAUN	16	3	0	0	3/0	15	0	0	15/3
36	JAUNPUR	44	8	0	0	8/1	37	0	4	41/5
37	JHANSI	20	4	0	0	4/0	17	0	2	19/1
38	J. P.NAGAR	17	3	0	0	3/0	13	0	2	15/2
39	KANNAUJ	16	3	0	0	3/0	13	0	0	13/1
40	KANPUR_DEHAT	18	3	0	0	3/1	15	0	0	15/1
41	KANPUR_NAGAR	47	7	0	1	8/3	40	1	4	45/0
42	KAUSHAMBI	15	3	0	0	3/0	12	0	1	13/2
43	KHERI	36	6	0	0	6/1	24	1	0	25/5
44	KUSHINAGAR	33	6	0	0	6/0	26	0	0	26/5
45	LALITPUR	11	2	0	0	2/0	10	0	0	10/0
46	LUCKNOW	42	8	0	0	8/1	31	0	7	38/6

Sl.	District	Popn. (lacs)	No. of Govt. TUs	No. of Pvt. TU s	No. of NGO TU s	Total TUs/ No. to be planned FY 08-09	No. of Govt. DMCs	No. of Pvt. DMCs	No. of NGO DMCs	Total DMCs/ No. to be planned FY 08-09
47	MAHARAJGANJ	24	4	0	0	4/0	18	0	1	19/7
48	MAHOBA	8	3	0	0	3/0	8	0	0	8/1
49	MAINPURI	18	3	0	0	3/1	14	0	0	14/2
50	MATHURA	23	4	0	0	4/1	17	1	6	24/5
51	MAU	21	4	0	0	4/0	19	1	0	20/0
52	MEERUT	34	7	0	0	7/0	24	0	7	31/9
53	MIRZAPUR	24	5	0	0	5/0	22	1	0	23/2
54	MORADABAD	42	8	0	0	8/1	31	2	3	36/8
55	MUZAFFARNAGAR	40	7	0	0	7/1	29	0	0	29/7
56	PILIBHIT	19	4	0	0	4/0	19	0	0	19/0
57	PRATAPGARH	31	5	0	0	5/1	18	0	0	18/8
58	RAE_BARELI	32	6	0	0	6/1	25	0	0	25/8
59	RAMPUR	22	5	0	0	5/0	20	0	2	22/0
60	SAHARANPUR	32	6	0	0	6/1	24	0	2	26/7
61	SANT_KABIR_NAGAR	16	3	0	0	3/0	14	0	0	14/2
62	SANT_RAVIDAS_NGR	15	3	0	0	3/0	16	0	1	17/0
63	SHAHJAHANPUR	29	5	0	0	5/1	21	0	0	21/1
64	SHRAVASTI	13	2	0	0	2/0	10	0	0	10/0
65	SIDDHARTHNAGAR	23	4	0	0	4/1	20	0	0	20/0
66	SITAPUR	41	6	0	1	7/2	25	0	1	26/12
67	SONBHADRA	17	5	0	0	5/0	24	1	2	27/3
68	SULTANPUR	36	6	0	0	6/1	27	0	1	28/7
69	UNNAO	30	6	0	0	6/0	20	0	0	20/0
70	VARANASI	36	7	0	0	7/0	24	0	12	36/13
Total		**1874**	**349**	**0**	**3**	**352/30**	**1484**	**23**	**90**	**1597/272**

**Public Sector includes Medical Colleges, Govt. health department, other Govt. department and PSUs i.e. as defined in PMR report*

^ Similarly, Private Sector includes Private Medical College, Private Practitioners, Private Clinics/Nursing Homes and Corporate sector

RNTCP Performance Indicators:

Sl.	Name of district	Popn. (Lacs)	Ann. total case detection rate(4Q06 to 3Q07)	Ann. NSP case detection rate (4Q06 to 3Q07)	% NSP detection (4Q06 to 3Q07)	Smear conversion rate of NSP at 3 months (4Q06 to 3Q07)	Cure rate of NSP (4Q05 to 3Q06)
			(Expected > 180/Lac/yr)	(Expected > 95/Lac/yr)	(Expected > 70%)	(Expected > 90%)	(Expected > 85%)
State Average		**1874**	**128**	**52**	**55%**	**89%**	**83%**
World Bank Districts							
1	AGRA	40.8	168	47	49%	87%	82%
2	ALIGARH	33.7	183	76	80%	92%	87%
3	ALLAHABAD	55.8	144	48	51%	78%	67%
4	BAGHPAT	13.1	157	77	82%	94%	89%
5	BAHRAICH	30.7	160	59	63%	90%	88%
6	BARABANKI	34.5	138	62	65%	89%	82%
7	BAREILLY	40.6	180	70	74%	90%	84%
8	BASTI	23.3	147	49	52%	91%	86%
9	BIJNOR	35.3	92	47	49%	89%	83%
10	BUDAUN	34.6	153	73	77%	92%	84%
11	BULANDSHAHAR	33	174	67	70%	95%	90%
12	ETAH	31.5	132	60	63%	92%	86%
13	ETAWAH	15.1	148	58	61%	83%	79%
14	FAIZABAD	19	110	45	47%	92%	87%
15	FATEHPUR	26	108	38	40%	89%	79%
16	FIROZABAD	23.1	160	51	53%	81%	65%
17	G. B. NAGAR	13.4	215	71	75%	91%	86%
18	GHAZIABAD	37.1	245	94	99%	93%	90%
19	GONDA	31.2	116	45	48%	85%	78%
20	HAMIRPUR-UP	11.8	150	42	44%	89%	84%
21	HATHRAS	15	113	56	59%	92%	86%
22	JAUNPUR	44.1	144	45	48%	92%	85%
23	JHANSI	19.7	130	60	63%	88%	82%
24	J.P. NAGAR	16.9	129	65	68%	90%	82%
25	KANPUR_NAGAR	46.7	142	53	56%	88%	79%
26	KHERI	36.1	144	61	64%	88%	83%
27	LUCKNOW	41.5	177	68	71%	86%	84%
28	MAINPURI	18	116	55	58%	92%	87%
29	MATHURA	23.4	131	58	61%	90%	89%
30	MEERUT	33.9	184	80	85%	93%	89%
31	MIRZAPUR	23.9	128	63	67%	89%	91%
32	MORADABAD	42.3	143	62	65%	86%	76%
33	MUZAFFARNAGAR	40	120	56	59%	88%	84%
34	PILIBHIT	18.5	146	57	60%	92%	79%
35	PRATAPGARH	30.8	76	30	31%	83%	73%
36	RAE_BARELI	32.4	142	66	70%	85%	78%

Sl.	Name of district	Popn. (Lacs)	Ann. total case detection rate(4Q06 to 3Q07)	Ann. NSP case detection rate (4Q06 to 3Q07)	% NSP detection (4Q06 to 3Q07)	Smear conversion rate of NSP at 3 months (4Q06 to 3Q07)	Cure rate of NSP (4Q05 to 3Q06)
			(Expected > 180/Lac/yr)	(Expected > 95/Lac/yr)	(Expected > 70%)	(Expected > 90%)	(Expected > 85%)
37	RAMPUR	21.7	162	65	69%	86%	84%
38	SAHARANPUR	32.1	186	72	75%	91%	87%
39	SHAHJAHANPUR	28.8	92	40	42%	84%	75%
40	SITAPUR	40.8	156	62	66%	90%	86%
41	SULTANPUR	36	90	38	40%	88%	82%
42	UNNAO	30.5	152	56	59%	90%	83%
43	VARANASI	35.5	155	66	70%	91%	86%
	WB Average	**1292.3**	**146**	**59**	**62%**	**89%**	**83%**
GFATM funded Districts							
1	AZAMGARH	44.6	81	35	37%	91%	87%
2	BALLIA	31.1	71	22	24%	89%	82%
3	BALRAMPUR	19	72	42	44%	91%	85%
4	BANDA	16.9	112	46	48%	84%	72%
5	DEORIA	30.8	52	18	19%	88%	77%
6	FARRUKHABAD	17.8	129	62	65%	92%	85%
7	GHAZIPUR	34.4	65	27	28%	89%	82%
8	GORAKHPUR	42.7	54	20	21%	82%	77%
9	HARDOI	38.3	134	56	59%	91%	86%
10	JALAUN	16.4	152	59	62%	89%	83%
11	KANNAUJ	15.6	85	38	40%	92%	85%
12	KANPUR_DEHAT	17.9	106	46	49%	86%	72%
13	KUSHINAGAR	32.6	63	28	29%	91%	87%
14	LALITPUR	11	148	73	77%	90%	84%
15	MAHARAJGANJ	24.5	62	23	24%	92%	87%
16	MAHOBA	8	119	60	63%	91%	88%
17	MAU	20.9	94	21	22%	90%	83%
18	ST_RAVIDAS_NAGAR	15.3	154	56	59%	97%	91%
19	SIDDHARTHNAGAR	23	74	30	32%	89%	87%
20	SONBHADRA	16.5	75	47	50%	96%	90%
21	AMBEDKAR_NAGAR *	22.9	64	32	34%	92%	86%
22	AURAIYA*	13.3	140	62	65%	91%	85%
23	CHANDAULI*	18.5	76	35	37%	86%	86%
24	CHITRAKOOT*	9	134	52	55%	82%	61%
25	KAUSHAMBI*	14.6	106	38	40%	87%	74%
26	SANT_KABIR_NAGAR*	16.1	66	28	29%	88%	76%
27	SHRAVASTI*	9.5	83	41	43%	86%	80%
	GFATM Average	**581.2**	**88**	**37**	**39%**	**89%**	**84%**

** Districts started implementation in 4th Qtr 2005.*

Section B – Priority areas at the State level for achieving the objectives planned :

S.No.	Priority areas	Activity planned under each priority area
1	Improvement in case detection activities	1 a) Improvement in referral of TB suspects from PHIs to DMCs; Continued emphasis on repeat sputum examination and sputum examination of symptomatic contacts
		1 b) Micro planning in urban slums/hilly /densely populated/SC dominated areas with focussed plan of action in 19 districts.
		1 c) Improving quality of microscopy services by monitoring under EQA by IRL Lucknow and STDC Agra.
		1 d) Further strengthening of other sectors: Medical College, ESI, Railway, Corporate, CGHS etc.
		1 e) Support to IMA-GFATM-RNTCP-PPM partnership project under IMA to increase NSP detection.
		1 f) Monitoring referral of chest symptomatics from VCTC & vice versa for TB and HIV Co-ordination.
		1 g) Opening new TU s/DMCs to meet population norms
2	Case holding activities	2 a) Further strengthening of DOT network by involvement of ASHA, AWW and general health staff.
		2 b) Retrieval of defaulting patients by general health staff & ASHA ; Monitoring default through MO-PHIs.
		2 c) Minimising initial default by strengthening inter district/inter state referral feedback mechanism through Nodal referral centres, developed in DTCs of Medical College districts
		2 d) Continued involvement of NGOs, DUDA workers, ASHA in default retrieval
		2 e) Emphasis on patient provider & community meetings
		2 f) Training of staff for good IPC by improving motivational skills
3	Supervision & Monitoring	3 a) Divisional review by State officials/Additional Directors
		3 b) Intensified monitoring of the districts by state level teams
		3 c) Regular special review of poor performing districts at state level
		3 d) Regular monitoring of the programme through NRHM at all levels
		3 e) Filling up all contractual staff under RNTCP at each level
		3 f) Ensuring movement of DTOs & MO TCs as per guidelines
		3 g) Intensifying supervision at all levels
		4 a) Training of untrained DTOs, TOTs & MO TCs at National & state level

S.No.	Priority areas	Activity planned under each priority area
4	Trainings	4 b) Update training of MOs under revised modules & re orientation
		4 c) Ongoing training activities in Medical colleges
		4 d) Training of MOs from other sectors
		4 e) Training of >50% of MPW & MPHS, Paramedical staff
5	Strengthening of IRLs and DRS study	5 b) Further strengthening of IRL at Lucknow & STDC Agra for future DST & DOTS plus.
		5 e) Trainings under DRS study of western U.P., to be conducted by JALMA, in co ordination with STDC Agra.
6	Implementation of EQA	6) Implementation of EQA by 1st Qtr 08 in all remaining districts of eastern U.P.
7	Implementation of TB-HIV co ordination programme	7 a) Constitution of State & Distt. TB-HIV Co ordination committees
		7 b) Training of staff at all levels under TB-HIV co ordination programme
		7 c) Cross referral to VCTC & vice versa & reporting under standard formats
8	IEC activities	8 a) School awareness programme
		8 b) Sensitization of NGOs & involvement in IEC activities
		8 c) General awareness in the community by community about the facilities available for free diagnosis & treatment under DOTS. Emphasis on community meetings and continuous Patients Providers Interaction Meetings
		8 d) More community Meetings in urban slums/densely populated/SC dominated areas
		8 e) Recruitment of State IEC Officer & communication facilitators to promote IEC activities at Distt. level
		8 f) Sensitization of PPs and other influential persons

Priority Districts for Supervision and Monitoring by State during the 2008-09

Low NSP Ann. Case detection rate(< 50%) 4Q06 to 3Q07		Expected achievement 2008				Low Cure rates (<80%) 4Q05 to 3Q06		Expected achievement 2008			
		1st Qtr	2nd Qtr	3rd Qtr	4th Qtr			1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
DEORIA	19	31	43	55	67	CHITRAKOOT	61%	70%	75%	80%	85%
GORAKHPUR	21	33	44	56	67	FIROZABAD	65%	70%	75%	80%	85%
MAU	21	33	44	56	67	ALLAHABAD	67%	75%	80%	85%	85%
BALLIA	23	34	45	56	67	KANPUR_DEHAT	72%	75%	80%	85%	85%
MAHARAJGANJ	23	34	45	56	67	BANDA	72%	80%	85%	85%	85%
GHAZIPUR	27	37	47	57	67	PRATAPGARH	73%	80%	85%	85%	85%

SANT_KABIR_ NAGAR	28	38	48	58	67	KAUSHAMBI	74%	80%	85%	85%	85%
KUSHINAGAR	28	38	48	58	67	SHAHJAHANPUR	75%	80%	85%	85%	85%
PRATAPGARH	30	40	49	58	67	MORADABAD	76%	85%	85%	85%	85%
SHRAVASTI	30	40	49	58	67	SANT_KABIR_ NAGAR	76%	85%	85%	85%	85%
SIDDHARTH NAGAR	31	40	49	58	67	DEORIA	77%	85%	85%	85%	85%
AMBEDKAR_ NAGAR	33	42	50	59	67	GORAKHPUR	77%	85%	85%	85%	85%
AZAMGARH	35	43	51	59	67	RAE_BARELI	78%	85%	85%	85%	85%
CHANDAULI	36	44	52	60	67	GONDA	78%	85%	85%	85%	85%
FATEHPUR	38	46	53	60	67	KANPUR_ NAGAR	79%	85%	85%	85%	85%
SULTANPUR	38	46	53	60	67	PILIBHIT	79%	85%	85%	85%	85%
KANNAUJ	39	46	53	60	67	ETAWAH	79%	85%	85%	85%	85%
KAUSHAMBI	39	46	53	60	67	FATEHPUR	79%	85%	85%	85%	85%
SHAHJAHANPUR	40	47	54	61	67						
HAMIRPUR-UP	42	49	55	61	67						
BALRAMPUR	43	49	55	61	67						
FAIZABAD	45	51	56	62	67						
JAUNPUR	45	51	56	62	67						
GONDA	45	51	56	62	67						
BANDA	46	52	57	62	67						
BIJNOR	47	52	57	62	67						
AGRA	47	52	57	62	67						
KANPUR_ DEHAT	47	52	57	62	67						

MIS

All the Districts & State TB Cell are connected under Server of Govt. of India, CTD. All information from District TB Cells to State TB Cell and then to CTD and vice-versa passes through the system. The funds are also transferred by e-transfer mode.

Monitoring &Evaluation Plan

a) Divisional review by state officials/additional directors.

b) Intensified monitoring of the districts by state level teams.

c) Regular special review of poor performing districts at state level.

d) Regular monitoring of the programme through NRHM at all levels.

e) Ensuring movement of DTOs & MOICs as per guidelines.

f) Intensifying supervision at all levels.

g) Internal evaluation by teams of other states

h) Internal evaluation supervision & monitoring by a team comprising of WHO Consultants & DTOs of neighbouring districts.

i) Evaluation by WHO Consultants and by CTD

Financial requirement for FY 2008-09 under RNTCP

Budget has been consolidated on the basis of Action Plans received from distt.

1. Civil Work :

Activity	No. required as per the norms in the state	No. already upgraded/ present in the state	No. planned to be upgraded during next financial year	Norms	Estimated Expenditure on the activity (Rs.)
	(a)	(b)	(c)	(d)	(e)
SDS	4	4		Minor Civil Work @2800/- Per SDS	11200
DTCs	70	67	3	@ 400000/- Per DTC	1200000
Maintenance of DTCs		58		Old DTCs @4500/- per DTC	261000
TUs	388	358	30	For new TUs as per Pop. Norms @ 35000/- Per TU	1050000
Maintenance of old TUs		358		Old TUs @300/- Per TU	465400
DMCs	1922	1650	272	For new DMCs as per Pop. Norms and Excess DMCs Required for Hilly & Tribal area. @ 30000 /-per DMC	8160000
Maintenance of old (Govt.) DMCs		1447		(Old Govt. DMCs as per 3rd Qtr 07)@1000/-per DMC	1447000
TOTAL					**12594600**

2. Lab Materials (Norms-Rs.1.5 lac/million pop).

Activity	Amount permissible as per the norms in the state	Amount actually spent in the last 4 quarters	Estimated Expenditure 2008-09 (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(d)	(e)
Purchase of Lab Materials by Districts	28631998	21831179	28197682	Enhanced price & expected increase in referral of TB suspects
Lab materials for EQA activity at STDC	177600	0	160000	IRI Lucknow, STDC Agra
Total	**28809598**	**21831179**	**28357682**	-

3. Honorarium to DOT providers*

Activity	Amount permissible as per the norms in the state	Amount actually spent in the last 4 quarters	Estimated Expenditure 2008-09 (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(d)	(e)
Honorarium	29940500	3205296	**29201375**	Honorarium permissible:(Estimated value- Rs. 250 X 50% of total cases

***** *These community volunteers are other than salaried employees of Central/State government and are involved in provision of DOT e.g. Anganwadi workers, trained dais, village health guides, ASHA, other volunteers, etc*

4. IEC Activities planned at State Level (Norms - Rs.75000 /million pop.) for 2008-09

Target Group/ Objective	Activity	No. of activities held in last 4 quarters	No. of activities proposed in next financial year (Qtr wise)				Total activities proposed during 2008-09	Estimated Cost per Activity Unit	Total expenditure for the activity during 2008-09
			Apr-Jun	July-Sep	Oct-Dec	Jan-Mar			
Patients and General public for Awareness Generation & Social Mobilization									
Outdoors	- Wall paintings	1552	1618	2567	2539	1520	8245	350	2885750
	- Hoardings	1354	86	106	95	57	344	7000	2408000
	- Tin plates	2833	1982	2903	2589	1909	9383	170	1595110
	- Banners	3084	502	706.5	548	463	2219	225	499275
	- Others	1736	329.5	1877	340.5	1739	4285	214	916990
	- Wall Charts	0	700	700	700	600	2700	75	202500
	- Mela Kits	27	27	0	0	0	27	10000	270000
Outreach Activities	Patient provider interaction meetings	2033	1399	1719	1556	957	5630	300	1689000
	Community meetings	2043	909	1103	989.5	633.5	3635	300	1090500
	Mike publicity	589	389	483	445	314	1631	800	1304800
	Others – Event Support material	25	81	106	93	51	331	500	165500
	Puppet Shows / Street/ Plays	93	236	314	269	122	941	450	423450
	School activity	251	551	698	605	354	2166	300	649800
Print publicity	Posters	61850	33238	37119	33653	18541	140751	10	1407510
	Pamphlets	394223	142832	156109	148522	123862	571325	3	1713975
	Others- handbills	35002	24163	34216	33843	16428	108650	3	325950
	Others- DOT directory	0	0	2000	0	0	2000	250	500000
	Misc. print mat.	7000	0	0	0	0	0	250	0
Media activity	Media activities on cable	33	90	99	95	68	352	2000	704000
	Radio FM-Rainbow-2 spots(30 sec. each)	0	0	0	0	0	0	2000	0
	Other activities	2014	13	18	15	6	52	1480	76960

Target Group/ Objective	Activity	No. of activities held in last 4 quarters	No. of activities proposed in next financial year (Qtr wise)				Total activities proposed during 2008-09	Estimated Cost per Activity Unit	Total expenditure for the activity during 2008-09
			Apr-Jun	July-Sep	Oct-Dec	Jan-Mar			
Patients and General public for Awareness Generation & Social Mobilization									
Opinion leaders/ NGOs for advocacy	Sensitization meetings- Communication Facilitators/NGOs	80	131	169	151	79	538	1000	538000
	Media activities	1027	55	73	61	42	236	2000	472000
	Power point Presentations / one to one interaction	1003	51	59	54	38	202	1800	363600
	Information Booklets-	4620	9414	5826	6305	3109	19654	50	982700
	NGOs Schemes- 2 fold Leaflet	0	0	0	0	0	0		0
	World TB Day activities	199	0	0	0	215	215	3903	839145
	Press Conference	27	27	0	0	0	27	1000	27000
	Rally	17	124	0	0	0	124	1000	124000
	Meet	18	124	0	0	0	124	1000	124000
	Any other public event	10	327	75	65	28	495	300	148500
	CMEs	40	225	291	254	130	900	500	450000
	Interaction meetings	94	168	197	181	126	672	500	336000
	one to one interaction meetings	630	193	204	198	177	772	300	231600
	Information Leaflet/Brochure 3 Fold RNTCP	620	375	1441	903	1278	3997	50	199850
	Any other - PP Scheme Leaflets/Brochure	20	854	903	874	779	3410	300	1023000
	Newsletter (Hindi)	200	20	15	15	10	60	900	54000
	Total- Districts		221234	252097	235958	173636	896093	9753	24742465
	State								1000000
	Comm. Facilitators								1400000
	Grand Total for IEC								**27142465**

5. Equipment Maintenance
(Norms-Rs.30000 per year per district & Rs.1500 per microscope per year)

Item	No. actually present in the state	Amount actually spent in the last 4 quarters	Estimated Expenditure for 2008-09 (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(d)	(e)
Computer (maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)	69	3643721	1721050	
Photocopier (incl. AMC, toner etc.)	71		958500	
Fax	21		42500	
OHP	48		78500	
Binocular Microscopes	1746	404773	2713140	
Total			**5513690**	

6. Training (Norms - Rs.55000/ million pop.)

Consolidation of Training data	No. in the district	No. already trained in RNTCP	No. planned to be trained in RNTCP during each quarter of next FY (c)				Expenditure (in Rs) planned for current financial year	Estimated Expenditure for 2008-09 (Rs.)	Justification/ remarks
			Q1	Q2	Q3	Q4			
Training of DTOs (at National level)	70	23	20	10	0	0	100000	200000	
Training of MOTCs	388	244	83	40	20	0	80000	290000	
Training of MOs (Govt + NonGovt)	6706	4021	881	739	490	428	5652335	5341028	
Training of LTs of DMCs Govt + Non Govt	1862	1544	126	99	47	72	728630	533990	
Training of MPWs	19193	5273	1306	1690	1837	1160	3076236	4070173	
Training of MPHS, pharmacists, nursing staff, BEO etc	6248	2450	872	929	843	361	2384962	2167139	
Training of Comm. Volunteers	8189	5894	1463	1619	1050	897	1696630	1542020	
Training of Pvt Practitioners	8040	785	626	787	881	691	1505600	2270580	
Re training of MOs	2438	1161	412	512	385	352	1202849	1586578	
Re Training of LTs of DMCs	1818	861	217	447	433	213	605910	1093926	
Re Training of MPWs	1639	994	345	420	448	255	498736	373750	
Re Training of MPHS, pharmacists, nursing staff, BEO	5878	1992	736	952	866	614	935181	970648	

Consolidation of Training data	No. in the district	No. already trained in RNTCP	No. planned to be trained in RNTCP during each quarter of next FY (c)				Expenditure (in Rs) planned for current financial year	Estimated Expenditure for 2008-09 (Rs.)	Justification/ remarks
			Q1	Q2	Q3	Q4			
Re Training of CVs	3762	1593	349	434	435	238	425409	399564	
Retraining of Pvt Practitioners	1742	67	125	160	243	183	113825	301560	
Provision for Update Training at Various Levels #	0	0	0	0	0	0	500000	500000	
Review Meetings at State Level	0	0	0	0	0	0	200000	200000	
TB/HIV Training of MOs	6852	0	2933	1728	1628	573	216678	3323000	
TB/HIV Training of STLS, LTs , MPWs, MPHS, Nursing Staff, Community Volunteers etc	16137	0	0	4000	4000	4000	0	3000000	
TB/HIV Training of STS	365	9	120	185	60	0	31816	121500	
Provision for Update Training at Various Levels # Districts Accountants, etc	4851	0	2000	1400	1251	200	185912	1188280	
Review Meetings at State Level	0	0	0	0	0	0	0	200000	
Any Other Training Activity	464	100	41	80	75	35	1532721	262100	
Total							**21673430**	**29935836**	

7. POL & Vehicle Maintenance (Norms–Rs.25000 per year for 2 wheeler and Rs.1.25 lac per year for 4-wheeler)

Type of Vehicle	Number permissible as per the norms in the state	Number actually present	Amount spent on POL and Maintenance in previous 4 quarters	Estimated Expenditure for 2008-09 (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(e)	(f)
Four Wheelers	13	13		1305000	9 RNTCP vehicles incl. State TB Cell & STDC, rest from state Govt:
Two Wheelers	382	356	7638550	9550000	
TOTAL				**10855000**	

8. Vehicle Hiring Norms–Rs 700/day for DTO upto 25 days & Rs 700/day upto 7 Days (in case of Hilly & Tribal Areas it is Rs. 850/day)

Hiring of Four Wheeler	Number permissible as per the norms in the state	Number actually requiring hired vehicles	Amount spent in the previous 4 quarters	Estimated Expenditure for 2008-09 (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(e)	(f)
For STC/ STDC	3	3	10672407	600000	
For DTO	70	61		11239600	
For MO-TC	368	367		14833200	
Urban TB Co-ordinator	6	6		540000	
TOTAL				27212800	

9 - NGO/ PPP Support

Norms:
Scheme 1 - Rs 25000/year per 10 lac pop.
Scheme 2 - Rs 20000/year per 1 lac pop.
Scheme 3 - Rs 20000/year
Scheme 4 - Rs 50000/year
Scheme 5 - Rs 4.8 lac in first year & Rs 3.4 lac per year in subsequent years

Activity	No. of currently involved in RNTCP in the state	Additional enrolment planned for this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for 2008-09 (Rs.)	Justification / remarks
	(a)	(b)	(c)	(d)	(e)	(f)
NGOs involvement scheme 1	6	12	3082525	245000	450000	
NGOs involvement scheme 2	32	38	0	943700	2400000	
NGOs involvement scheme 3	0	0	0	0	0	
NGOs involvement scheme 4	70	25	0	3750000	4750000	
NGOs involvement scheme 5	1	0	0	340000	550000	
NGOs involvement unsigned	77	4	0	480000	250000	
Private practitioners scheme 1	75	177	0	558000	760000	
Private practitioners scheme 2	45	166	0	480650	668100	
Private practitioners scheme 3	3	21	0	75000	487500	
Private practitioners scheme 4	4	36	0	525000	1050000	
TOTAL					11365600	

10. Miscellaneous (Norms - Rs.1.5 lac/million pop.)

Activity*	Amount permissible as per the norms in the state	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure 2008-09 (Rs.)	Justification/ remarks
	(a)	(b)	(d)		(e)
IRL	NA			800000	Telephone bills, Internet, TA/DA of staff, Postage for referral & other correspondence, stationary & miscellaneous activities-
State Level	600000	417300	300000	1300000	
District Level	28631987	12227856	27011963	28047000	
Total				**30147000**	

11. Contractual Services

Category of Staff	No. permissible as per the norms in the state	No. actually present in the state	No. planned to be additionally hired this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current fin. year	Estimated Expenditure for the next financial year (Rs.)	Justification/ remarks
	(a)	(b)	(c)		(e)	(e)	
TB/HIV Coord.	1	0	1	142216267	0	216000	
Urban TB Coord.	6	6	0		1152000	110400	* Incl. 5% annual hike
MO-STCS	2	1	1		453600	486000	* Incl. 5% annual hike
State Acctt	2	2	0		378000	405000	* Incl. 5% annual hike
State IEC Officer	1		1		180000	207000	* Incl. 5% annual hike
Pharmacist	4	4	0		428400	459000	* Incl. 5% annual hike
Secretarial Asst	1	1	0		88200	96600	* Incl. 5% annual hike
State DEO	1	1	0		88200	96600	* Incl. 5% annual hike
MO-DTC	11	1	8		979200	1728000	* Incl. 5% annual hike
STS	388	336	52		35005500	39595500	* Incl. 5% annual hike
STLS	388	329	59		34992000	39595500	* Incl. 5% annual hike
TBHV	312	189	123		28193850	28993950	* Incl. 5% annual hike
DEO	70	70	0		5282200	5698800	* Incl. 5% annual hike
Accountant - part time	57	44	13		1472400	1540800	* Incl. 5% annual hike
Contractual LT	839	685	154		74881800	74548500	Contractual sanctioned is 50% for UP i.e.50% of total existing + planned DMCs= 1869/2 =935
Driver	7	7	0		396900	552000	* Incl. 5% annual hike
Other contractual post approved under RNTCP:							
Microbiologist	1	0	1		0	360000	for IRL
Administrative Officer	1	0	1		0	132000	Required in state TB Cell for Admn. Works
Class-4 for State TB Cell	1	0	1		0	60000	Required in state TB Cell for misc. activities
Total						**194881650**	

12. Printing (Norms - Rs.1.5 lac/million pop.)

Activity	Amount permissible as per the norms in the state	Amount spent in the previous 4 Qtrs	Estimated Expenditure for 2008-09 (Rs.)	Justification/ remarks
	(a)	(b)	(d)	(e)
Printing- State level and Districts. Level:*	28631987	10142147	27601363	Printing of modules, reporting formats, referral registers & forms etc. Treatment cards, I cards, TB & Lab registers, referral forms & registers, sp. Forms, c & s forms, EQA forms& registers, reporting formats, etc.

13. Research & Studies: Rs. 832006.00

(*for DRS Study which is being undertaken by Jalma Institute, Agra.)

14. Medical Colleges

Activity	Amount permissible as per norms	Estimated Expenditure for the next financial year (Rs.)	Justification/ remarks
	(a)	(b)	(c)
Contractual Staff: ▪ MO-Medical College (Total approved in state - 10) ▪ STLS in Medical Colleges (Total no in state- 2) ▪ LT for Medical College (Total no in state -15) ▪ TBHV for Medical College (Total no in state - 13)	4549755	4549755	Staff for Medical Colleges approved by CTD
Research and Studies: ▪ Thesis of PG Students ▪ Operations Research*	328000	328000	
Travel Expenses for attending STF/ZTF/NTF meetings	193000	188000	
IEC: Meetings and CME planned	250000	250000	
Equipment Maintenance at Nodal Centres	0	0	
Total		**5315755**	

15. Procurement of Vehicle (Norms: for 2-Wheeler Rs 50000 each)

Equipment	No. actually present in the state	No. planned for procurement this year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)
4-wheeler	-	-	-	-
2-wheeler	350	65	3250000	30 For new TUs+ 35 for old vehicles > 6 years
Total			3250000	

16. Procurement of Equipment (Norms - Rs. 60,000 for Computer)

Equipment	No. actually present in the state	No. planned for this year (only as per norms)	Estimated Expenditure for 2008-09 (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)
Computer	69	5	300000	* 1 for Budaun (Theft), 3 for SDS, 1 Laptop for STO.
Photocopier	71	2	200000	1 for Lucknow (Old district, unserviceable) & 1 for State TB Cell
OHP	50	7	199000	
Total			699000	

17. Nutrition

Patients suffering from Tuberculosis are in weak health. To increase their resistance, it is proposed to give them protein rich foods, such as, egg, milk, etc. as supplement diet. It is justified to provide them Rs. 600/- each for first two months of intensive treatment i.e. Rs.10/- per day.

It is proposed to pilot the activity in one district and measure the outcome. For which an amount of Rs.50 lacs is being budgeted for the year 2008-09. The budgetary requirement would be met from Mission flexipool.

18. Treatment of MDR Cases

As per the guidelines provided for treatment of MDR cases in the interim period till such time that the RNTCP-DOTS Plus services are being extended across the state, following estimates have been calculated for one year for the treatment of MDR cases in the State.

a) Case load: Approx. 3% of NSP are estimated to be MDR. As per ARTI 1.9 for the state, approx. 5600 MDR cases are estimated annually out of NSP only. MDR in retreatment cases will further increase the figure. 318 registered MDR cases have been reported from JALMA Institute Agra only.

b) Treatment cost: Excluding Pyrazinamide & Ethambutol, which may be provided from loose drugs supplied by CTD, the average treatment cost per patient for one day is estimated as Rs. 150.00.

It is proposed to pilot the activity in one district and measure the outcome. For which an amount of Rs.50 lacs is being budgeted for the year 2008-09. The budgetary requirement would be met from Mission flexipool

MIS

All the Districts & State TB Cell are connected to the Server of Govt. of India, CTD. All information from District TB Cells flows to State TB Cell, then to CTD is through the system and from upwards to downwards. The budget is also transferred by e-transfer system.

Monitoring & Evaluation Plan

a) Divisional review by State officials/Additional Directors.

b) Intensified monitoring of the districts by state level teams.

c) Regular special review of poor performing districts at state level.

d) Regular monitoring of the programme through NRHM at all levels.

e) Ensuring movement of DTOs & MO TCs as per guidelines.

f) Intensifying supervision at all levels.

g) Internal Evaluation by teams of Other States

h) Internal Evaluation Supervision &Monitoring by a Team comprising of WHO Consultants & DTO's of neighbouring Districts.

i) Evaluation by WHO Consultants by CTD

Summary of Proposed Budget for the State (WB & GFATM)

Category of Expenditure	Budget estimate for the coming FY 2008 - 2009 (To be based on the planned activities and expenditure in Section C)		
	World Bank 43 districts	*GFATM 27 districts*	*Total State*
1. Civil works	9159300	4090830	**13250130**
2. Laboratory materials	19497682	8860000	**28357682**
3. Honorarium	23560375	5641000	**29201375**
4. IEC/ Publicity	15151358	11991107	**27142465**
5. Equipment maintenance	3760440	1753250	**5513690**
6. Training	19426241	10509595	**29935836**
7. Vehicle maintenance	7880000	2975000	**10855000**
8. Vehicle hiring	21812800	5400000	**27212800**
9. NGO/PP support	8551600	2814000	**11365600**
10. Miscellaneous	20865500	9281500	**30147000**
11. Contractual services	148746150	46135500	**194881650**
12. Printing	19255863	8345500	**27601363**
13. Research and studies	832006	0	**832006**
14. Medical Colleges	4880600	435155	**5315755**
15. Procurement - vehicles	2700000	550000	**3250000**
16. Procurement - equipment	699000	0	**699000**
Total	**327128915**	**118782437**	**445561352**

3. NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

THE VISION

1. To provide effective health care to the rural population
2. To implement effective village health plan under the head of the village health and sanitation committee
3. To improve public health indicators and weak infrastructure
4. Training of Paramedics, ASHA and others to improve health care delivery system.

GOALS

1. Reduction in morbidity and mortality of all vector borne diseases
2. Prevention and Control of Vector Borne Diseases by giving area wise specific priorities.
3. Universal access to public health services and promotion of health life styles with the help of Integrated Vector Management.

NRHM OBJECTIVES

- Malaria mortality reduction rate 50% upto 2010, additional 10% by 2012.
- Elimination of Filaria by 2015, 70% by 2010 and 80% by 2012.
- Elimination of Kala-azar by 2010.
- Reduction in JE mortality rate by 50% by 2010.
- Reduction in Dengue mortality rate by 50% by 2010.
- Effective Control over Chikungunya morbidity.

Components of the Programme

- Malaria Control Programme
- Filaria Control Programme
- Kala-azar
- Japanese Encephalitis
- Dengue

PRESENT STATUS OF VECTOR BORNE DISEASES IN UTTAR PRADESH

S. No.	Year	MALARIA			FILARIA		JE		DENGUE		KALA-AZAR	
		TOTAL	Pf	Death	Disease	Mf	Cases	Death	Cases	Death	Cases	Death
1	2004	85868	2142	0	7999	1088	1030	228	7	0	36	2
2	2005	105302	3149	0	7613	619	5581	1593	121	4	68	2
3	2006	91566	1875	0	5738	725	2073	476	617	14	83	0
4	2007	81580	1989	0	5791	637	2675	577	130	2	69	1

Pf = Plasmodium falciparum (species causing cerebral malaria)

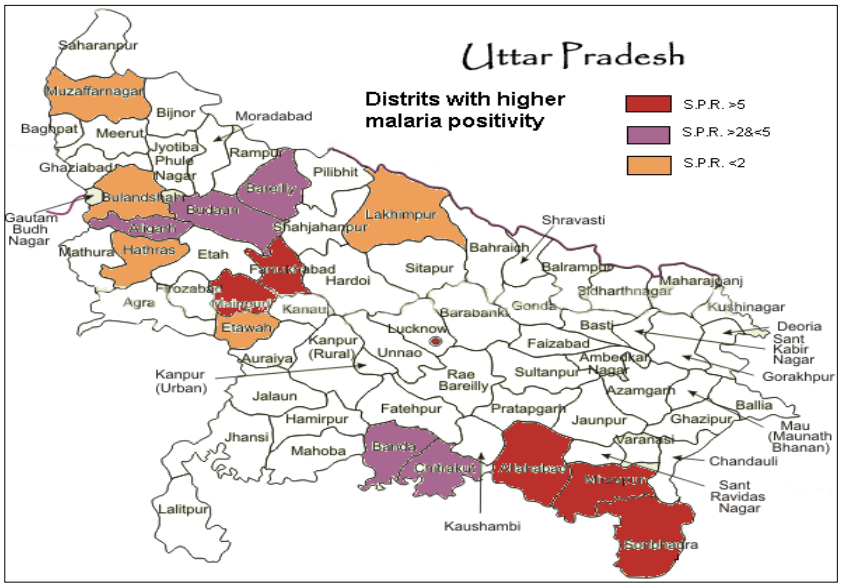
Mf = Micro filariae (stage of filaria parasite detected in blood examination)

MALARIA

1. Situational Analysis of Malaria

Malaria is present throughout the state of Uttar Pradesh. The great challenge with malaria is that it is unstable, appears suddenly and at other times disappears suddenly but the spray programme is implemented in about 50 districts on the basis of norms laid down by Govt. of India. The endemicity is persisting in interstate border districts. The ABER is inadequate due to shortfall of resources i.e. man, money & material.

Distribution of High Risk Districts



Identified High Risk Districts

Status of 15 Most Malaria affected Districts of U.P. during 2007									
S.No.	District	Population	B.S. Examed.	Malaria Positive	P.f. Positive	ABER (%)	SPR (%)	P.f. %	A.P.I.
1	Sonbhadra	1553044	104525	34415	335	6.73	32.93	0.97	22.16
2	Mirzapur	2144298	167100	8850	0	7.79	5.30	0.00	4.13
3	Allahabad	4943970	111448	7283	48	2.25	6.53	0.66	1.47
4	Mainpuri	1690372	57404	4021	708	3.40	7.00	17.61	2.38
5	Banda	1592080	60184	1775	15	3.78	2.95	0.85	1.11
6	Muzaffarnagar	3558748	120792	1692	129	3.39	1.40	7.62	0.48
7	Budaun	3257107	47062	1577	0	1.44	3.35	0.00	0.48
8	Bareilly	3618970	63467	1417	5	1.75	2.23	0.35	0.39
9	Aligarh	3173424	58216	1196	105	1.83	2.05	8.78	0.38
10	Farrukhabad	1673777	20325	1182	30	1.21	5.82	2.54	0.71
11	Hathras	1414985	29548	474	140	2.09	1.60	29.54	0.33
12	Kheri	3396011	74822.0	597	56	2.20	0.80	9.38	0.18
13	Bulandshahar	3102219	59743	560	44	1.93	0.94	7.86	0.18
14	Chitrakoot	849595	22515	816	37	2.65	3.62	4.53	0.96
15	Etawah	1422052	20100	363	33	1.41	1.81	9.09	0.26
A	Total 15 Distts	37390651	1017251	66218	1685	2.72	6.51	2.54	1.77
B	Total Whole State	173303539	3390604	81580	1989	1.96	2.41	2.44	0.47
Percent contribution of these 15 districts to total malaria cases of the state		21.58 % of the State's Population	30.00 % of the State's Surveillance	81.17 % of the State's Positives	84.72 % of the State's P.f.cases	1.39 times of State's Average	2.71 times of State's Average	1.04 times of State's Average	3.76 times of State's Average

Annual Blood Examination Rate	1.96%
Slide Positivity Rate	2.41
Pf	2.44
Annual Parasite Index	0.47

2. Specific Constraints for implementation of Programme

Active Surveillance is not being conducted effectively due shortage of Multi Purpose Workers (Male). The population has also increased, relative to which infrastructure has not been strengthened. Presently, ANMs (Basic Health Worker - Female) are not able to fully contribute in Vector Borne Diseases Control Programme because of other programmes.

3. Prioritization of the areas including the criterion of prioritization

The 15 districts - Sonbhadra, Mirzapur, Allahabad, Mainpuri, Banda, Muzaffarnagar, Badaun, Bareilly, Aligarh, Earrukhabad, Hathras, Lakhimpur Khiri, Bulandshahar, Chitrakoot and Etawah are high-risk because of high API & high SPR and Pf percentage.

Mirzapur & Sonbhadra Districts show Pf resistance to Chloroquine.

4. Strategy and Innovations proposed

The Strategy is

- **Surveillance**
- **Early Diagnosis and Treatment**
- **Vector Control**: anti-larval and anti-adult measures and control of mosquitoes breeding by vector management.
- **Capacity Building**

  Training of ASHAs in making blood smear
  Training of ASHA in using Rapid Diagnostic Kits by Medical Officer Incharge of specified PHCs. Training of Lab Technicians of PHCs in identifying malaria parasite by expert Pathologists and LTs. Training of health workers and supervisors in making solution of insecticides and in using spray pumps and fogging machines by District Malaria Officer and Malaria Inspector. The Medical Officers should also be well conversant with equipments and techniques and in precautions to be taken.

- **BCC/IEC activities**

  Health Education material to be supplied to ASHA & village Health Society for proper display at proper places and also to be distributed in
  Meetings at block level. Educating people for getting blood examined in fever. Educating for sanitation, proper drainage, getting all pits and other places of water stagnation filled up.
  Information, Education & Communication before Spraying and fogging operations and about precautions to make it successful.

- **Involvement of ASHA and remuneration through ASHA incentives and through Village Health & Sanitation Society.**

As Active surveillance is unsatisfactory because of shortage of MPW male worker so it is proposed to involve ASHA and to give her remuneration. As per the strategy being implemented under NVBDCP, the fever cases are to be screened through blood slide collection and examination for the presence of malaria parasites. The surveillance is primarily done by multipurpose health workers (M) and to some extent the female workers and ANMs are also involved. The patients going to the primary health centres or hospitals are also screened by the lab. Technicians placed at PHCs. Under NRHM ASHAs have been engaged at village level for improvement in service delivery mechanism in various health programmes. ASHA gets performance based incentives and it is proposed that for strengthening the surveillance and treatment the ASHAs may be involved. NVBDCP has also issued instructions for incentives to ASHA for high malaria endemic districts in North-eastern states and hard core pf predominant states. On the same principle, it is requested that the proposal for involvement of ASHA in malaria surveillance and prompt treatment may be allowed and **if the assistance is not met from NVBDCP cash assistance, it may be met from NRHM Additionalities from the funds available with Village Health and Sanitation Committee.**

5. Requirement for commodity as per technical norms and considering balance of stores, consumption capacity and justification

1-Commodity requirement for Malaria & Filaria

Item	Technical Requirement	Stock available	Net requirement
Chloroquin Tablets	30000000	43942000	
Primaquine 2.5mg	300000	958000	
Primaquine 7.5 mg	600000	362000	238000
Artesunate Tab		5100	
Inj Quinine	400		400
Tab Quinine	1500		1500
ASP Tabs	20000		20000 (In the state of Uttar Pradesh, Pf resistance has been noticed in one district namely Mirzapur and to tackle the pf resistance alternate drug i.e. ASP has been proposed)
Tab DEC	333000000		333000000
DDT	2100 MT		2100
Malathion Technical	15 MT		
Temephos	10000 litres	2830 litres	7170
Pyrethrum	10000 litres	1500 litres	8500
M.L.O.	35000 litres		35000
ITN Bed nets	600000		600000 (For BPL families of Banda, Sonbhadra & other districts with high API)
Rapid Diagnostic Kits	1000000		100000 (for Mainpuri & Hathras & other districts with high Pf % having remote and inaccessible areas, labourer's settlement to be used By ASHAs who will be trained by MOs.)

Rapid Diagnostic Kits: We fully acknowledge that adequate numbers of Blood Slides are not getting prepared because of shortage of man power. There is delay in reporting and in administration of Radical Treatment. The present generation of Lab technicians are also not so competent in detecting malaria parasite and are also involved in other programmes. We are trying to improve the situation.

As Falciparum Malaria is fatal condition and demands immediate treatment, therefore it is requested that rapid Diagnostic Kits be provided for areas having high percentage of falciparum cases. These kits will be supplied to ASHA who will be trained for it. Thus some deaths due to Falciparum Malaria could be prevented.

6. **Cash assistance required from Centre and unspent balance available with state**

The Centre is giving Commodity assistance in Malaria.
The State expects it to consider incentive of Rs 5 to ASHA for Blood Slide Collection and Total assistance **Remuneration to ASHA Rs 685 lacs. (**There 137000 ASHAs working and each expected to make 100 slides per annum. Maximum Rs 500 per ASHA per annum.

7. **Assistance for Capacity building and IEC/BCC/PPP activities**

IEC **Rs. 2000000**

Health Education material to be supplied to ASHA & village Health Society for proper display at proper places and also to be distributed in Meetings at block level. Educating people for getting blood examined in fever. Educating for sanitation, proper drainage, getting all pits and other places of water stagnation filled up. The Village & Health Society will arrange Health Education campaign and fairs in the village. Health Education material will be displayed at schools, bus stations, markets and marts.

Training of Medical & Paramedicals **Rs. 2400000**

Training of ASHAs in making blood smear
Training of ASHA in using Rapid Diagnostic Kits by Medical Officer Incharge of specified PHCs. Training of Lab Technicians of PHCs in identifying Malaria Parasite by expert Pathologists and LTs Training of health workers and supervisors in making solution of insecticides and in using spray pumps and fogging machines by District Malaria Officer and Malaria Inspector. The Medical Officers should also be well conversant with equipments and techniques and in precautions to be taken.

General Vector Control Strategy:

Main strategy for Control of Vector Borne diseases is Vector Management.

- To control conditions promoting Mosquitoes Breeding
- One Week day – Saturday to be made Dry Day
- Larvicide - Temephos in open drains
- Two Rounds of DDT- IRS
  In PHCs having Falciparum death, SPR double of last three years but not less than 4%, SPR more than 5% in average of last 3 years or SPR 3% or more having more than 30% of Pf cases. Population 13245000 of 15 malaria affected districts meeting the above criteria.
- DDT Focal Spray or Pyrethrum
  Malaria Positive
  Dengue Positive
  JE/AES cases

- Fogging by Malathion Technical
  To control outdoor mosquitoes density in villages affected with JE/AES
  (Larvicide in the morning)
  Fogging at Dusk and Dawn
- **Information, Education & Communication before Spraying and fogging operations and about precautions to make it successful.**

Budget Proposals from State Share

1. Surveillance: (Block PHCs 823)

Logistics (chemicals, glass ware, stationery, glass slides, cotton swabs, spirit, disposable pricking needles etc)

176 PHCs of highly endemic 15 Districts Rs. 3000 per PHC	**Rs. 528000**
647 PHCs of remaining 55 Districts Rs. 2000 per PHC	**Rs. 1294000**

2. Vector Control

• **Spray wages for DDT 2100 MT**	**Rs. 23100000**
• **Space Spray Pyrethrum 2% extract** Cost of K oil	**Rs. 1900000**
• **Malathion Technical Fogging for 15 MT operation cost**	**Rs. 8400000**

3. Monitoring & Evaluation

Mobility 15 Districts @ Rs 20000 per distt	**Rs. 300000**
Monitoring & Evaluation Mobility 55 Districts @ 10000 per distt	**Rs. 550000**

4. Sonbhadra package

District Sonbhadra is most affected district having tribal population and inaccessible areas. It needs special attention.

ITN Bed Nets 100000	**Rs. 10000000**
Rapid Test Kits 20000	**Rs. 1000000**
Total state Share	**Rs. 47072000**

(The spray wages 23100000 will be paid by Village Health & Sanitation Society, and the remuneration of ASHA Rs. 68500000 is requested)

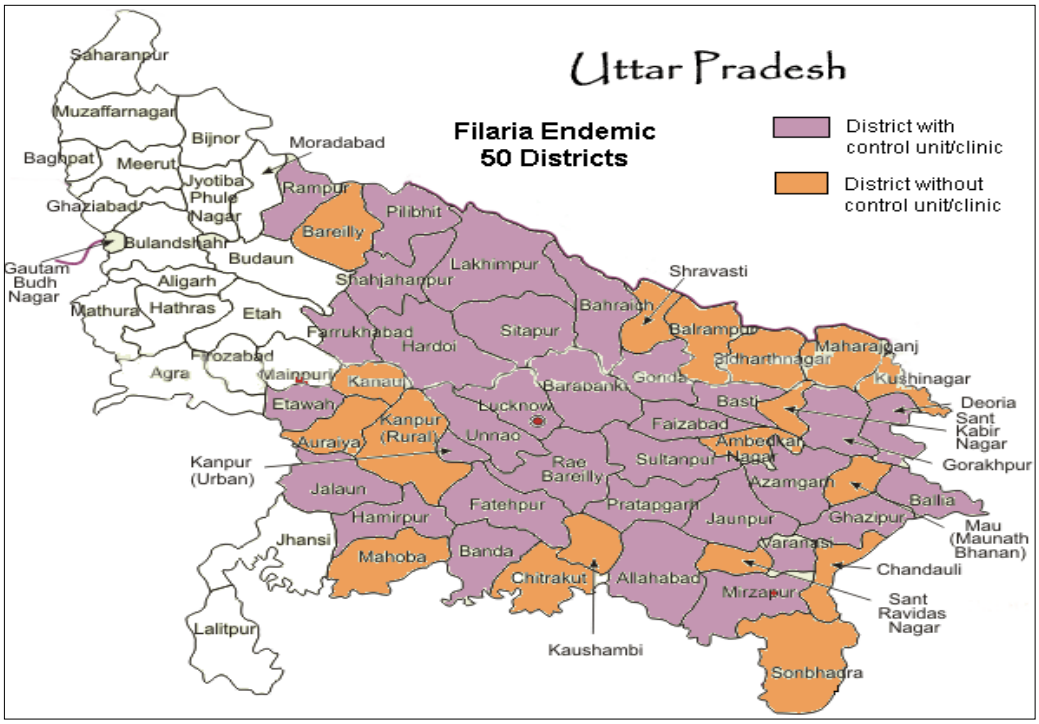
FILARIA

1. Situational Analysis:

Filaria is endemic in 50 districts with present Mf rate 1.50%. The great challenge is to eliminate filaria and to bring down Mf Rate <10%.

Year	Cases	mf positive
2004	7999	1088
2005	7613	619
2006	5738	725
2007	5791	637

Filaria Endemic Districts



In year 2006, in MDA survey, 145584 lymphoedema cases and 41463 hydrocoele cases were detected.

2. Specific constraints in implementation of Programme

Apart from this disability management is the great challenge to remove social stigma from the population suffering from the disease. Filaria is mainly the urban disease and due to rapid urbanization disease cases increasing to many folds. No method for detecting the parasite at early stage of infection. Resources are inadequate and insufficient due to 29 Filaria Units and 2 Filaria Clinics.

MDA is expected to be successful. Intensive health education and inter-sectoral cooperation is needed.

3. **Prioritization of the areas including the criterion of prioritization**

50 Districts

4. **Strategy and Innovations proposed**

- Mass Drug administration
- Morbidity Management

5. **Requirement for commodity as per technical norms and considering balance of stores, consumption capacity and justification**

6. **Cash assistance required from Centre and unspent balance available with state**

District level Officers Training	Rs.	50000
IEC	Rs.	1250000
MDA Assessment through Medical Colleges/ICMR institutions	Rs.	450000
POL/Mobility	Rs.	250000

District level Activities

IEC including DCC meetings sensitization	Rs.	12500000
Training of MOs including Govt & Pvt doctors	Rs.	3000000
Training of Paramedical staff at PHC HQ	Rs.	2500000
Night Blood Survey	Rs.	2350000
POL/Mobility	Rs.	2500000
Training of Drug Distributors	Rs.	15000000
Honorarium to Drug Distributors	Rs.	30000000
Honorarium to Drug Supervisor	Rs.	3500000
Morbidity management includes listing & mapping, hydrocele operation and demonstration of home based management	Rs.	2000000
Total	**Rs.**	**75350000**

The State has 29 filaria control units, and 31 clinics. These institutions were implementing the National Filaria control Programme in the specified area of urban localities for antilarval operations, detection and treatment and delimitation survey in non-endemic districts. After the World Health Assembly resolution 1997, the Lymphatic filariasis has been targeted for elimination. Initially the pilot project was started in selected districts in which 2 districts of Uttar Pradesh namely Varanasi and Gorakhpur were also selected. As per National Health Policy-2002, the national goal for elimination of Lymphatic filariasis has been set for the year 2015.

The total requirement for the population of 133409468 in 50 filaria endemic districts will be 333523670 no. of DEC tablets

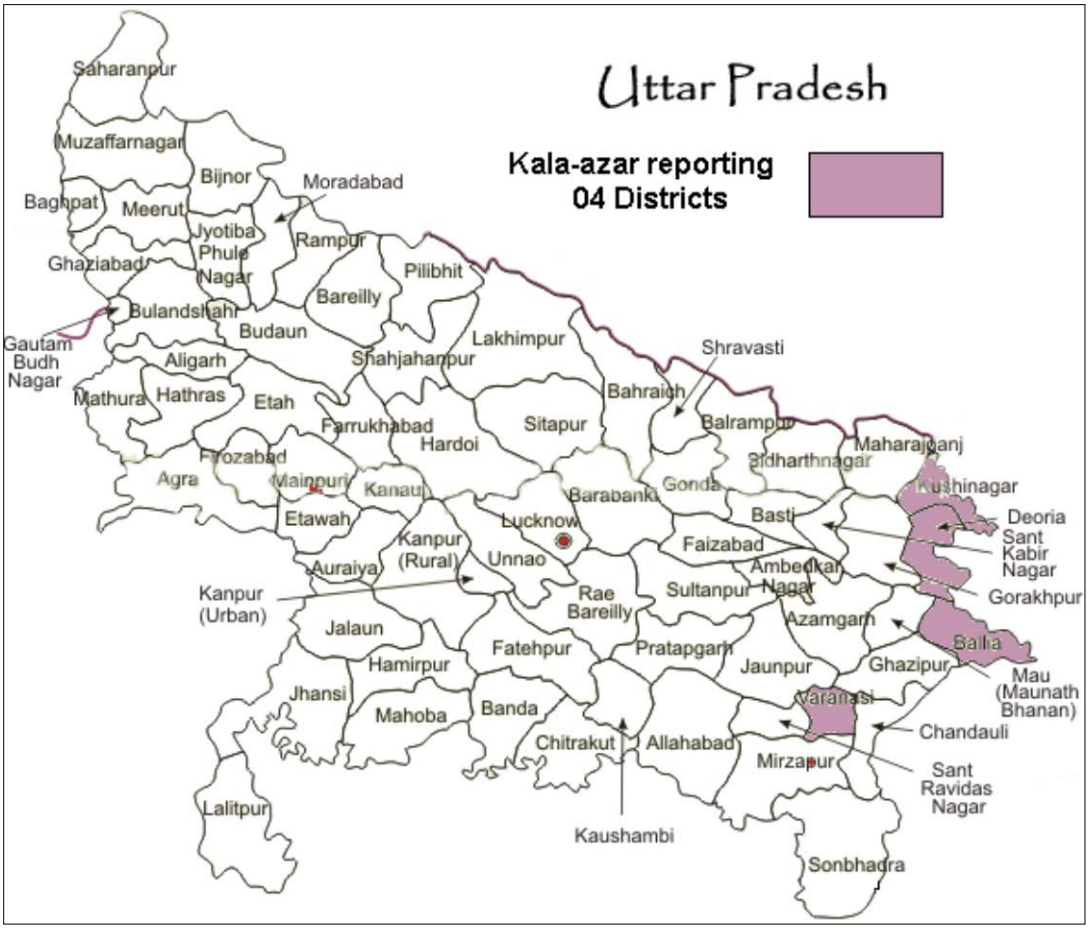
KALA-AZAR

Situational Analysis of Disease

Kala-azar is endemic in 10 districts of eastern U.P. bordering Bihar state. Among these 0.4 districts are hyper-endemic i.e. Kushinagar, Deoria, Ballia, Varanasi. The principles of elimination are anti adult measures and complete treatment of the patient. The disease is not detectable at early stage and patients receiving incomplete treatment. Incubation period is very long.

Year	Cases	Deaths
2004	36	2
2005	68	2
2006	83	0
2007	69	1

Kala-azar is endemic in eastern districts, the 4 border districts bordering with Bihar- Kushinagar, Deoria, Ballia and Varanasi are hyper-endemic.
The cases are of sporadic occurrence in 95 villages spread over in 23 PHCs of these 4 districts.



2. **Specific constraints in implementation of Programme**

The disease has long incubation period and not detectable in early stages. The economical, simple to perform and reliable Kits not available. The houses of affected population are Kachcha

3. **Prioritization of the areas including the criterion of prioritization**

4 districts bordering Bihar - Kushinagar, Deoria, Ballia and Varanasi.
Population 25 Lacs BPL 1.74 Lacs

4. **Strategy and Innovations proposed**

- Complete Treatment of Cases
- Behaviour Change Communication
- Vector Control

5. **Requirement for commodity as per technical norms and considering balance of stores, consumption capacity and justification**

rK39 Kits	200000 tests for BPL families (not received so far)
DDT	187.5 MT (Technical requirement)
Inj SSG	2100 vials
Tab. Miltefosine	19600 (not supplied earlier)

6. **Cash assistance required from Centre and unspent balance available with state**

1. Spray wages	110.80
2. Kala-azar Survey	3.48 Lacs
3. Kala-azar Fortnight campaign	9.66 Lacs
4. BCC/IEC	15.06
5. Training	11.00
6. Total	150 Lacs

7. **Assistance for Capacity building and IEC/BCC/PPP activities**

Capacity Building: Training of Health Workers and supervisors in Case detection. Training in making solution of insecticides and in use of pump and in changing nozzle and in doing minor repair. The MOs should also be well conversant.
IEC: The poor people to be educated that their wages will be compensated in case they are admitted and get injections outdoor.

Information, Education & Communication before spraying operations and about precautions to make it successful.

Details of Kala-azar affected Districts

S. No.	District	Total PHCs	KA Affected			
			PHCs	Village	Population	Names of PHCs
1.	Deoria	15	7	45	12.60 lacs	Bankata, Bhapaparrani, Bhatni Lar, Majhganwa, Patthar Deva, Rampur Karkhana
2.	Kushinagar	14	7	28	4.40 lac	Fazinagar, Vishunpu, Tamkuhi, Taraiya Sujan, Kasya, Dudahi, Sukrauli
3.	Ballia	17	3	05	4.00 lac	Dubhad, Sonwani, Reoti
4.	Varanasi	08	6	17	4.00 lac	Sewapuri, Arajiline, Cholapur Chiraigaon, Kashi Vidya Peeth Ramnagar
TOTAL		**54**	**23**	**95**	**25.00 lac**	

Survey Campaign in Kala-azar affected districts

S. No.	District	Affected Population	BPL Families	Surveyor days for families surveyed @ 50 no/day	Total Remuneration for surveyor @ Rs. 100/day (Rs. Lac)
1.	Deoria	12.60 lac	0.90 lac	1800	1.80
2.	Kushinagar	4.40 lac	0.30 lac	600	0.60
3.	Ballia	4.00 lac	0.28 lac	560	0.56
4.	Varanasi	4.00 lac	0.26 lac	520	0.52
Total		25.00 lac	1.74 lac	3480	**Rs. 3.48 lac**

Survey Campaign in Kala-azar affected districts

S. No.	Activity Particulars	Amount per PHC (Rs. Lac)	No. of PHCs	Total Amount (Rs. Lacs)
1.	Camp organization (Tent, furniture, mike etc.)	0.20	23	4.60
2.	Mobility for camp	0.02	23	0.46
3.	Contingency (Stationary & misc. items)	0.20	23	4.60
Total				**Rs. 9.66 lac**

GOI has allocated 252.22 lacs (150 as cash + 102.22 lacs for commodity)

JAPANESE ENCEPHALITIS (JE)

1. Situation Analysis of Disease

Year	Cases	Deaths
2004	1030	228
2005	5581	1593
2006	2075	476
2007	2675	577

2. Specific constraints in implementation of Programme

The pigs play role of amplifying hosts and pig rearing is means of livelihood for many people in affected region. The Vector breeds in paddy fields and paddy is main agricultural product of the region. Hon'ble High court has instructed to remove piggeries from human habitation. Concerned Departments requested for implementation.

3. Prioritization of the areas including the criterion of prioritization

Eastern region-Gorakhpur, Basti, Faizabad, Devipatan and Azamgarh mandals and Saharanpur, Muzaffarnagar districts of West are affected and where 90% of cases are found.

4. Strategy and Innovations proposed AES/ JE Intervention measures

- Early diagnosis and Treatment
- Vector Control
- Immunization against JE
- Behaviour Change Communication
- Rehabilitation Centre for the treatment of physically handicapped patients has been established at Gorakhpur.
- Establishment of 15 Sentinel Labs- CSMM University Lucknow and 14 District Hospitals.
- Strengthening of Treatment facilities at periphery.
- Establishment of Epidemic Ward at BRD Medical College Gorakhpur
- Vaccination of Children 1 to 15 years with SA 14-14-2 vaccine. 18 districts have been covered. This year, 9 Districts will be covered.

JE Vaccination had been done in 18 most affected districts. Next 9 districts will be covered this year. Nodal Centre established at DG Medical & Health. Epidemic Ward at Gorakhpur medical College. Viral research Centre is being established by NIV Pune.

5. Requirement for commodity as per technical norms and considering balance of stores, consumption capacity and justification

1. Diagnostics
   Procurement of JE Kits 55 kits@ 8000 Rs 440000

2. Vector Control:
   Fogging Machine 10 @ 40000 Rs 400000
   Insecticides Malathion Technical 8 MT Rs. 800000

6. Cash assistance required from Centre and unspent balance available with state

7. Assistance for Capacity building and IEC/BCC/PPP activities may be incorporated

Behaviour Change Communication (BCC/IEC) Rs. 2050000

Educating public that treatment facilities are available at nearest Community Health Centre and patient will be transported free by Govt. vehicle to the District Hospital if need arises.

Educating public to keep piggeries away from human habitation, to get these covered by wire screen and to keep these clean and insecticides sprayed. Educating public to get protected from mosquito bite.

Information, Education & Communication before Spraying and fogging operations and about precautions to make it successful.

Capacity Building Rs. 1910000

Total : Rs. 5600000

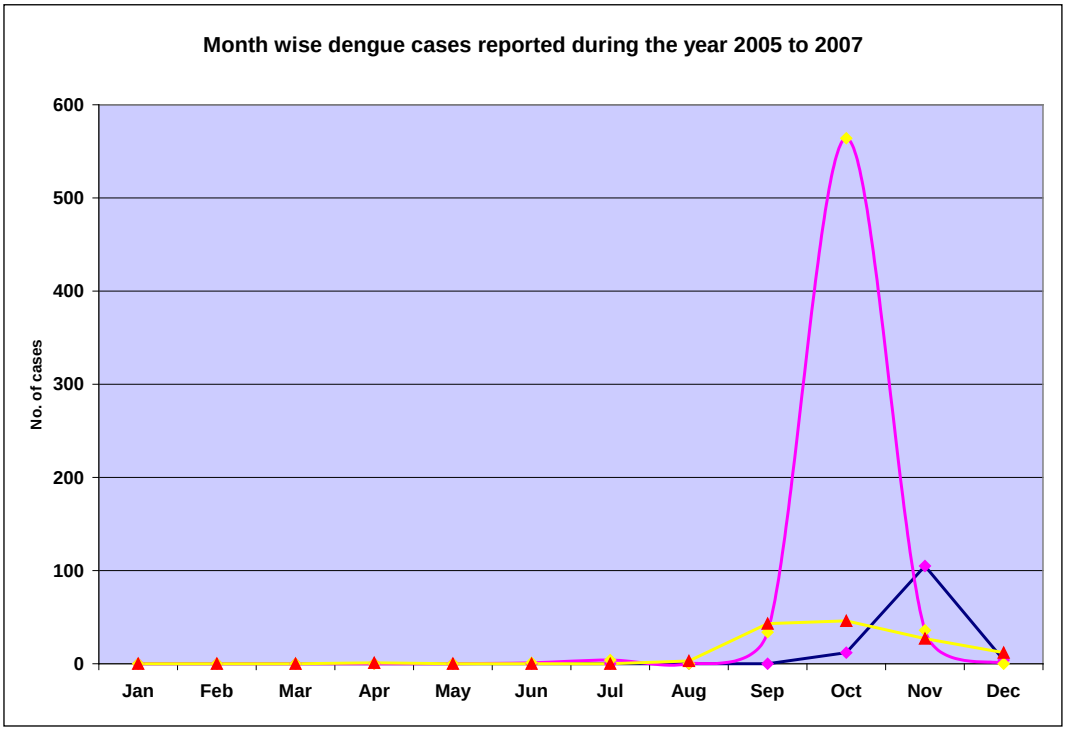
State Contribution
ITN bed nets for BPL families in JE affected Districts
For 100000 ITN Bed nets Rs. 1000000

DENGUE

A. DENGUE

In 2003 738 cases and 8 deaths were reported of which maximum no. of cases reported from Ghaziabad district (272) followed by Lucknow (248), Kanpur (105). In 2004 only 8 cases were reported with nil death. Again in 2006 upsurge of cases reported from various districts of the state. Total 639 cases and 14 deaths were reported. The maximum no of effective districts were Lucknow (186 cases & 3 deaths), Gautambudhnagar (86 cases & nil death), Ghaziabad (66 cases & 1 death). Similarly, in 2007, total 131 cases and 2 deaths were reported. Month wise analysis of the Dengue cases reported during the last 3 years (2005 to 2007) has revealed that

transmission of this disease takes place through out the year, but post monsoon period reports the maximum cases as can be seen from the following graph:



The disease tends to follow seasonal pattern, i.e., the cases peaking after monsoon and it is not uniformly distributed over the years.

The factors contributing to the transmission of the dengue is mainly rapid urbanization, life style changes and deficient water management including improper water storage practices in urban, peri-urban and rural areas, leading to proliferation of mosquito breeding sites. The districts adjacent to Delhi has revealed rise in no of cases. In 2007, 57.5 % were reported by only two districts namely, Ghaziabad and G.B.Nagar which are included in the National Capital Region (NCR).

The various factors responsible for high endemicity of dengue in these districts are unprecedented human population growth; unplanned and uncontrolled urbanization; inadequate waste management; improper water supply; lack of effective public health infrastructure in addition to man-made ecological and lifestyle changes.

As per the guidelines of GOI, the state has established 9 Sentinel Surveillance Hospitals with laboratory facility for enhancing the diagnostic facility of Dengue in the state. For back up support these institutes were linked with SGPGI, Lucknow which has been identified as one of the Apex Referral Laboratories in the country with advanced diagnostic facility. Dengue

IgM ELISA test kits are being provided by GoI to these institutes through NIV Pune. The name of the Sentinel Surveillance Hospitals are as under:

1. Regional Lab. Swasthya Bhawan, Lucknow.
2. District Hospital, Ghaziabad,
3. LLRM, Medical College, Meerut,
4. MLB Medical College, Jhansi,
5. MLN Medical College, Allahabad.
6. Institute of Medical Sciences, BHU, Varanasi.
7. SN Medical College, Agra.
8. GSVM Medical College, Kanpur.
9. CSMMU, Lucknow.

The sentinel hospitals will collect blood samples from the suspected patients with viral syndrome and process to detect the presence of specific IgM antibody. They will maintain line-listing of dengue positive cases. As soon as a dengue case is confirmed by serological test (IgM Capture ELISA Test), the respective district vector borne Disease Control Officer/ District Chief Medical Officer or Municipal Health Officer is intimated so that he/she can immediately initiate remedial measures in respect of vector control in the affected area(s).

B. CHIKUNGUNYA:

Chikungunya fever is a viral disease, caused by an arbovirus of the family Togaviridae, genus Alphavirus and transmitted by *Aedes aegypti* mosquito. It is a debilitating, but non-fatal viral illness and occurs principally during the rainy season. The disease resembles dengue fever and is characterized by severe, sometimes persistent, joint pain (arthiritis), as well as fever and rash. It is rarely life-threatening. Chikungunya is diagnosed by blood tests (ELISA). Since the clinical appearance of both Chikungunya and dengue is similar, laboratory confirmation is important. The disease has re-appeared in the country after a quiescent of almost 30 years. In India, a major epidemic of Chikungunya fever was reported during the last millennium. During 2006, the state has reported only 4 cases of Chikungunya, out of which 3 were reported from Jhansi district and 1 was from Kanpur district. Similarly, in 2007 also 4 imported cases (native of Kerala state) were reported by SGPGI, Lucknow.

There were no vaccines or drug available for Dengue and Chikungunya. Therefore, the prevention and control of the vector mosquito is crucial for containment of these diseases. Further the transmission occurs mainly at home, therefore community participation and co-operation is of paramount importance for successful implementation of programme strategies for prevention and control of both Dengue and Chikungunya. Therefore,

considerable efforts have been made through advocacy and social mobilization for community education/awareness. For effective community participation, people are informed about Chikungunya and the fact that major epidemics can be prevented by taking effective preventive measures by community itself.

The same vector Aedes aegypti is involved in the transmission of both dengue and Chikungunya therefore, the strategy of prevention and control is similar for both the disease.

1. Situation Analysis of Dengue

Year	Cases	Deaths
2001	21	0
2002	2	0
2003	708	8
2004	7	0
2005	121	4
2006	639	14
2007	132	2

2. Specific Constraints for implementation of Programme

The public need to be educated to control breeding of mosquitoes. One weekday-Saturday to be made Dry Day to empty all water stored in pots, tyres and coolers etc. intensive IEC measures will be undertaken.

3. Prioritization of the areas including the criterion of prioritization

National Capital Region districts-Ghaziabad and Gautam Buddha Nagar. The Joint Hospital Noida to be developed as sentinel Surveillance Hospital.

4. Strategy and Innovations proposed

1. BCC/IEC
2. Strengthening of sentinel Surveillance Labs- immediate testing and reporting positive cases immediately to concerned CMO.
3. Immediate anti-Vector measures on getting report of Positive Cases

5. Requirement for commodity as per technical norms and considering balance of stores, consumption capacity and justification

Ig M ELISA Kits of Dengue and Chikunguniya to all 9 Sentinel Labs.

6 Cash assistance required from Centre and unspent balance available with state

a.	Apex Referral Lab		
	Grant	Rs.	1000000
	Recurrent	Rs.	100000
b.	9 Sentinel Surveillance Hospital @ Rs 50000	Rs.	450000
c.	Monitoring & Evaluation and Rapid response @ Rs 75000		
	43 Districts	Rs.	3225000
d.	Epidemic Preparedness (logistics & Operational Costs)	Rs.	5500000
e.	Fogging Machines 35 @ 40000	Rs.	1400000
f.	Operational Research	Rs.	700000

7. Assistance for Capacity building and IEC/BCC/PPP activities Rs. 400000

Training of Medical Officers in diagnosis and management of Dengue by Physician
Training of Medical Officers in performing Tourniquet Test by Physician
Training of Lab Technicians in doing Platelets Count

8. IEC Social Mobilization @Rs 60000 Rs. 2580000

Educating public for consulting doctors of Govt Hospitals if patient has fever, bodyache, rashes, bleeding or shock

Educating public to observe one week day-Saturday as Dry Day

Information, Education & Communication before Spraying and fogging operations and about precautions to make it successful.

Total Rs. 15355000

ROLE OF VILLAGE HEALTH & SANITATION SOCIETIES

1- Sanitation and keeping mosquitoes breeding controlled by covering the drains, cleaning the drains, putting kerosene oil or burnt mobil oil in open drains, to keep water flowing in the drain by de-silting and correcting the gradient, filling the pits.

2- To arrange health education camps, discussions and fairs. To display health education material at proper places.

3- To pay spray wages.: About Rs 5000 per year per village

4- To pay remuneration to ASHAs for making blood slides.: maximum Rs 500 per annum to one ASHA

5- To remove piggeries or to keep these covered by wire screen and get cleaned and disinfected.

6- Information, Education & Communication before Spraying and fogging operations and about precautions to make it successful.

The total plan of NVBDCP works out to be :

Activity	GOI		State
	Cash	Commodity	
Malaria		1923.75	The State to bear all infrastructure cost on salary and TA and DA
Training/IEC	44		
Kala-azar	150	102.22	
ELF	753.50		
AES/JE	56		
Dengue/Chikungunya	153.55		
Total	**1157.05**	**2025.97**	

Total GOI Rs. 3868.02 lacs (3183.02 + 685 lacs)

State Contribution 570.72 lacs

Additional demand of Rs 685 lacs for remuneration to ASHA has been requested from GOI.

BUDGET RECEIVED FROM GOI IN YEAR 2007-08		
1	Drug Distributors Honoraria	44721100
2	MOs Training	854075
3	Paramedical Training	2493410
4	District Coordination committee	700000
5	IEC	5600800
6	POL	1837015
7	Night Blood Survey	1260000
8	Line listing	1473600
9	Hydrocoelectomy	1330000
10	Evaluation (assisted by Medical Colleges)	450000
11	Balance	6383000
Total Received		**67103000**

BUDGET SUMMARY (2008-09)

NATIONAL VECTOR BORNE DISEASES CONTROL PROGRAMME

Item/Activity	Requirement from GOI		State Cont.
	Commodities	Cash	
MALARIA			
Primaquine 7.5 mg	238000		
Inj Quinine	400		
Tab Quinine	1500		
ASP tab	20000		
DEC	333000000		
DDT 5%	2100 MT		
Malathion Technical	15 MT		
Temephos	7170 Litres		
MLO	35000 Litres		
ITN	600000		
RDKits	100000		
ASHA remuneration			685000
IEC		2000000	
Capacity Building		2400000	
Logistics 176 PHCs@ 3000			528000
Logistics 647 PHCs @ 2000			1294000
DDT Spray Wages			23100000
Malathion Technical Fogging Operation Cost			8400000
Synthetic Pyrethrum K Oil			1900000
Mobility 15 Districts @ 20000			300000
Mobility 55 Districts @ 10000			550000
Sonbhadra Package			
ITN			10000000
RD Kits			1000000
TOTAL MALARIA			*47072000*
FILARIA			
District level officers Training		50000	
IEC		1250000	
MDA Assessment		450000	
POL		250000	
Distt IEC		12500000	
Training MOs		3000000	
Training Paramedicals		2500000	
Night Blood Survey		2350000	
POL		2500000	
Training Drug Distributors		15000000	
Honorarium Drug Distributors		30000000	
Honorarium Drug Supervisors		3500000	
Morbidity Management		2000000	
TOTAL FILARIA		*75350000*	

Item/Activity	Requirement from GOI		State Cont.
	Commodities	Cash	
KALA-AZAR			
Commodities			
rK39 kits	200000		
DDT 5%	187.5 MT		
Inj SSG	2100 vials		
Tab Miltefosine	19600		
Spray Wages		11080000	
Kala-azar Survey		348000	
Fortnight Camp		966000	
BCC		1506000	
Capacity Building		1100000	
TOTAL KALA-AZAR		*15000000*	
JAPANESE ENCEPHALITIS			
JE Kits		440000	
Fogging Machines		400000	
Malathion Technical		800000	
BCC		2050000	
Capacity Building		1910000	
ITN			10000000
TOTAL JE		*5600000*	
DENGUE			
Apex Referral Lab			
Grant		1000000	
Recurrent		100000	
9 labs		450000	
Monitoring & Evaluation 43 Districts		3225000	
Epidemic Preparedness		5500000	
Fogging Machines		1400000	
Operational Research		700000	
Training		400000	
IEC		2580000	
TOTAL DENGUE		*15355000*	
Total		**115705000**	**57072000**
ASHA INCENTIVES		**68500000**	
Grand Total		**386802000**	
State contribution of Rs 570.72 lacs includes Spray Wages proposed to be paid by VHSCs			

During the year 2007-08 an amount of Rs.4,40,90,518/- for JE and further Rs.2,04,99,000/- for implementation of activities under NVBDC programme, was taken on loan basis from Mission flexipool. This loan amount of Rs.6,45,89,518/- will have to be repaid. The requirement is over and above the proposal of Rs.3868.02 lacs.

4. NATIONAL LEPROSY ERADICATION PROGRAMME

1. Overview of the project in year 2007-08

a) Financial Details.

For the year 2007-08 a proposal of Rs. 629.01 lacs had been sent to Government of India and Government of India has sanctioned an amount of Rs.478.87 lacs towards sustained activities and to eliminate leprosy from State, District and Block level and released a fund of Rs. 202.78 lacs out of which Rs.32.87 is towards Cash Assistance, and a opening balance of Rs. 192.11 lacs was available at the beginning of the year 2007-08. Against total availability of fund Rs.394.89 during the current and expenditure of Rs.236.10 lacs has been incurred upto January 2008.

Financial Position of NLEP in last 3 Years

(Rupees in Lacs)

Details		2005-2006	2006-2007	2007-2008 (Upto Jan08)
1	Balance at the beginning of the financial year	212.00	198.00	192.11
2	Funds received from GOI	216.00	391.00	169.91
3	Expenditure during the year	286.31	398.45	234.47
4	Balance at the end of the financial year	198.00	192.11	127.23
5	Balance at State level at the end of January 2008			37.73
6	Balance at the District level at the end of January 2008			89.50
7	TOTAL Balance available in the state at the end of January 2008			127.23

b. General Performance :

During XIth Five Year Plan National Leprosy Elimination Programme was launched in the State with the National Objective to achieve elimination level i.e. 01 patient per 10,000 population. The vertical leprosy services were maintained up to year 2002-03 and thereafter the leprosy services were integrated in the General Health Care system, so that the persons suffering from leprosy feel themselves as general patients and the diagnosis & treatment work of leprosy has been started in all Hospitals, Community Health Centres and Primary Health Centres. The following outcomes have been visualized after systematic and concerted efforts of leprosy elimination :-

S.No.	Particular	At the end of March, 2007	At the end January, 2008
1.	Total recorded patients	18,104	19,603
2.	Prevalence Rate of leprosy	0.95/10,000	1.03/10,000
3.	Deformity Rate among new cases	1.15 %	1.43
4.	Child Rate among new cases	5.80 %	5.82

c. Key Achievements.

Under Deformity Prevention and Medical Rehabilitation scheme 110 Major Reconstructive Surgery have been given to deformed leprosy patients by Chatrapati Shahuji Maharaj Chiktsa Vishwavidyalaya, Lucknow with the collaboration of Rotary Club.

Detail of district according Prevalence Rate of Leprosy

Prevalence Rate	Period-wise Detail of Districts	
	In 31-3-2007	In 31-01-2008
< 1	36	32
> 1 - 2	34	38
> 2 - 5	0	0
> 5	0	0

d) Major bottlenecks in implementation

- Prevailing social stigma about leprosy among the society.
- Integration of leprosy vertical staff in the primary health care system, create lack of proper care of leprosy patients.
- No full functional integration of primary health care staff in the leprosy work.
- Fund available under cash assistance is merger for full mobilization of field staff in the field.

2. Situation analysis and trends.

The programme epidemiological assessment of last 5 years is as under:

Year	Popn (In lacs)	New cases detected during the year	Cases discharged	Balance cases at the end of the year	ANCDR per 10,000 popn.	PR per 10,000	Deformity proportion among new cases %	Child proportion%	MB proportion%
2002-03	17.40	90586	103764	71647	5.17	4.10	1.51	8.32	44.1
2003-04	17.80	80323	91515	61634	4.50	3.50	1.32	7.64	46.8
2004-05	18.18	48110	75934	33884	2.64	1.86	1.24	7.51	42.5
2005-06	18.60	36409	48590	21761	1.96	1.17	1.02	6.10	41.9
2006-07	19.03	32413	36070	18104	1.70	0.95	1.15	5.80	39.4
2007-08	19.03	26018	23889	19603	1.64	1.03	1.43	5.82	40.7

The above table shows the decreasing trends of the following of last five years :

- Annual New Cases Detection Rate decreases from 5.17 to 1.64 per 10,000 population.
- Prevalence Rate decreases from 4.10 to 1.03 per 10,000 population.
- Deformity Rate decreases from 1.51 to 1.43 %
- Child rate among new cases decreases from 8.32 to 5.82 %
- M.B. proportion decreases from 44.1 to 40.7 % among new cases.

3. Components of the programme.

(1) Further reduce the burden of leprosy - To achieve the goal of elimination i.e. Prevalence rate less than 01 patient per 10,000 population from district level to block level.

(2) High Quality Services - To improve the quality of diagnosis and treatment the Medical & Para Medical Staff of General Health Care system will be given Orientation and Re-orientation training.

(3) Enhance Disability Prevention and Medical Rehabilitation - Prompt vigils will be kept on primary stage of disability, reaction and relapse by Health worker and the same will be reported to Medical Officer for efficient treatment. The Medical Rehabilitation will be provided for correction of deformity.

(4) To cut down the quantum of Social Stigma - To cut down the quantum of social stigma the effective measures will adopted through IEC.

4. Proposal for year 2008-09

The main goal of the programme to bring down the prevalence rate of disease less than 01 per 10,000 population at district level and block level.

Milestones at the end of 31st March 2009

Sl.	Particulars	At the end of January, 2008	At the end of March, 2009
1	Prevalence Rate of leprosy	1.03/10,000	0.90/10,000
2	Deformity Rate among new cases.	1.43%	1.00%
3	Child rate among new cases.	5.82%	4.00%
4	Female patients rate	30.54%	40.00%

(1) **Reduction of burden of leprosy**: To reduce the burden of leprosy the regular and intensified supervision & monitoring will be made by the District Nucleus. The Epidemiological Status of SIS indicator will be monitored. The Health worker will be made more mobile in the field by providing them adequate incentive like TA & DA

(2) **High Quality Leprosy Services**: To create capacity building and calibre among the Medical & Para Medical Staff of General Health Care System, Orientation and Re-orientation training will be imparted to 6,000 Medical Officer, 3,700 Pharmacist, 7,000 Health Supervisors and 25,000 Health Workers. Out of total 40% will be trained in the year 2007-08.

(3) **Enhance Disability Prevention and Medical Rehabilitation:** The Grade-I deformity, reaction and relapse will be promptly reported by Health Workers to Medical Officer and the same will be efficiently treated by the Medical Officer. For Medical Rehabilitation the selection of cured deformed patients will be made by

District Nucleus and selected patients will be sent to Physical Medicine and Rehabilitation Institution. 300 Reconstructive Surgery Operations will be performed in a year. For social and vocational rehabilitation Community Opinion leaders of the area will be involved, just like ASHA and Village Health and Sanitation Committee.

(4) **To cut down the quantum of Social Stigma:** To cut down the quantum of social stigma Quiz In School & colleges, Workshop of Community Opinion Leaders will be organized at block level. Workshop of Non Government Organization will be organized, Rallies at Block and district level will be organized, leprosy message will be spread through Folk Shows like, Bhajan, Allha, Lok Geet, Short Play, Magic Show etc., Display Board will be displayed in each service centre and Hoarding will be displayed Hospitals, Community Health Centres, Primary Health Centres, Tehsil campus, Block Campus, Mandi Campus etc. Messages relating to Leprosy will also be spread through wall painting, Bus Panel etc.

(5) **Monitoring & Evaluation:** For effective monitoring and Evaluation each District Nucleus will be provided Computer and Internet facilities. For field mobilization Provision of Maintenance of Vehicle & Oil purchase will be provided for two vehicles per district.

(6) **Maintenance of Contractual Services:** The contractual Services of 2006-07 will be maintained up to 2007-08.

(7) **Co-operation of NGOs**: The co-operation of Non Governmental Organizations working under Modified SET Scheme till 2007-08 as per norms of Government of India will be continued during the year 2008-09.

Components

a) HRD and Training:

Since 1.4.2003 the vertical leprosy services had been integrated in the primary health care system and the facilities of leprosy diagnosis and treatment have been made available at each Hospitals, Community Health Centres and Primary Centres like a general disease so that the leprosy patients think himself as general patient. For the full functional integration of leprosy programme among the primary health care system training is integral part of the programme.

Training

- 4 days Technical cum DPMR Training of 1500 PHCs Medical officers is proposed in the batch of 30 trainees @ Rs. 28,000/= per batch the total cost will Rs. 14.00 lacs.
- 4 days Technical cum DPMR Training of 1500 Health Workers is proposed in the batch of 30 trainees @ Rs. 28,000/= per batch the total cost will Rs. 11.20 lacs.
- 2 days Technical cum DPMR Re-orientation Training of 350 District Nucleus Staff in the batch of 30 trainees @ Rs. 16,000/= per batch the total cost will Rs. 1.87 lacs.
- 2 days Technical cum DPMR Training of 3000 PHCs Medical officers is proposed in the batch of 30 trainees @ Rs. 16,000/= per batch the total cost will Rs. 16.00 lacs.
- 2 days Technical cum DPMR Training of 1800 Pharmacist is proposed in the batch of 30 trainees @ Rs.16,000/= per batch the total cost will Rs. 9.60 lacs.
- 5 days Smear Technology Training of 524 Laboratory Technicians (2 from each District Hospital and 1 from each Community Health Centre) is proposed in the batch of 30 trainees @ Rs. 16,000/= per batch the total cost will Rs. 9.60 lacs.
- 2 days Technical cum DPMR Training of 2570 Leprosy Vertical Staff is proposed in the batch of 30 trainees @ Rs. 16,000/= per batch the total cost will Rs. 13.70 lacs.

- Half day training of ASHA for preliminary recognition and follow-up of leprosy cases in batches of 30 to be given during basic training courses.

Management Information System

For the proper monitoring, evaluation, supervision and guidance in each district a District Nucleus is functioning which required a Desk Top Computer duly connected with Internet connection is required.

Monitoring and Evaluation Plan.

For monitoring, evaluation and guidance of programme activities the following components are functioning in the programme.

- WHO has posted on State NLEP Co-ordinator at state level supported with two Zonal NLEP Co-ordinator
- Under ILEP support Neither Land Leprosy Relief Association and The Leprosy Mission have taken 34 and 36 districts respectively for monitoring and supervision of programme activities by posting of Leprosy Programme Advisors.
- At State level Quarterly Review Meeting of District Leprosy Officer are organised at the end of each quarter.
- At district level Quarterly Inter Departmental Review cum Coordination meeting will be held at the end of each quarter to seek the collaboration of Social Welfare department, Education Department, Local Bodies, etc.

NGO Support

NGO	Staff	Activities
I WHO	3 Officers	TECHNICAL SUPPORT - Support at State and District level in Planning, Implementation, Supervision, Monitoring, Training. NO FINANCIAL SUPPORT
	1 State NLEP Co-ordinator	
	Zonal NLEP Co-ordinator-Bareilly	
	Zonal NLEP Co-ordinator-Bareilly	
II ILEP		
a) Netherlands Leprosy Relief	5 Leprosy Advisors along with Driver and a vehicle	Cover 34 Districts. TECHNICAL SUPPORT - Support at State and District level in Planning, Implementation, Supervision, Monitoring, Training + FINANCIAL SUPPORT
b) The Leprosy Mission	Technical Resource Units (TRUs) having 1 MO, 1 NMS, 1PTT & 1 Driver each along with vehicle	Cover 36 Districts. TECHNICAL SUPPORT - Support at State and District level in Planning, Implementation, Supervision, Monitoring and Training. + FINANCIAL SUPPORT

Total financial Support by ILEP – Rs. 10.45 lacs

Activity -wise Break-up of Budgetary Requirement

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
A	Infrastructure & Manpower	District Leprosy Officer - 70 Posts						
		Dy. District Leprosy Officer-70 Posts						
		Health Educator -71						
		Non Medical Supervisor - 548						
		Non Medical Assistant - 2686						
		Physiotherapy Technician - 47						
		Urban Hospital - 162						
		Community Health Centre - 384						
		Block Primary Health Centre - 813						
		Sector Primary Health Centre – 2990						
i	Strength	Functional Integration in place in the state and all health facilities of govt. providing leprosy services						
ii.	Weakness	Posts of District Leprosy Officers lying vacant in 17 high priority districts viz. Kanpur Nagar, Azamgarh, Mau, Gonda, Sitapur, Maharajganj, Jaunpur, Chandauli, Fatehpur,Banda, Chitrakoot, Hamirpur, Kannauj, Moradabad, JP Nagar, Badaun, Basti	Posts of DLO & Deputy DLO to be filled in the priority districts					
iii.	Threat	Complacency among programme officers & staff after achieving elimination	Sustain quality of leprosy services in health services					
iv	Opportunity	Availability of ASHAs in leprosy work	Involvement of ASHAs in leprosy work					

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
		Man power of trained and motivated vertical leprosy staff still eager to render leprosy services	Continue to take services of trained and motivated vertical leprosy staff for providing leprosy services					
	Suggestion:	Present POL provision is Rs. 40,000/= per vehicle for two vehicles per district is found not adequate due to poor condition of vehicles. For field mobility of Staff there is no provision of TA & DA.	POL etc budget be increased to Rs. 60,000/= per vehicle for Districts & for State HQ Vehicles Rs. 80,000/= per vehicle for three vehicle be provided considering the vastness of the state. DPMR activity shall need extra mobility at state & District level					
B	**Training & Capacity Building**	**Expected Outcome: Early Case Detection by trained field staff & Quality diagnosis and treatment & Prevention of Disabilities. BUDGET Rs.4032000**						
		All trainings to be integrated with trainings of NRHM						
	4 Days Technical Cum DPMR Training of Medical Officers	3 days Technical cum IEC training - 900 Medical Officer trained during 2007-08 in batches of 30 trainees each	**4 days Technical cum DPMR training -** for 600 untrained Medical Officers in batches of 30 trainees	June to September, 2008	600	28000	560,000	NRHM (NLEP)- District Health Society
	4 Days Technical Cum DPMR Training of Health Workers	3 days Technical cum IEC training - 540 Health Workers trained during 2007-08 in a batch of 30 trainees.	**4 days Technical cum DPMR training -** for 600 untrained Health Workers (Male & Female) in a batches of 30 trainees.	June to September, 2008	600	28000	560,000	NRHM (NLEP) District Health Society

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
	Reorientation Training							
	Reorientation Training	3 Days Technical Training given to newly posted District Nucleus members in 2007-2008 - 31 District Leprosy Officers, 29 Dy. District Leprosy Officers, 7 Non Medical Supervisors and 4 Physiotherapy Technicians have been imparted	**2 days Technical and DPMR orientation training** to be given to all District Nucleus staff (5 members from each District) in batches of 30	July to October, 2008	350	16000	186,667	NRHM (NLEP) District Health Society
	Orientation Training of Medical Officers.	One day refresher training given to 1996 Medical Officers in 2007-08	**Two days Orientation Technical & DPMR training - 2100** Medical Officer (Male & Female) of Primary Health Care system of high priority 38 Districts in batches of 30	July to October, 2008	2100	16000	1,120,000	NRHM (NLEP) District Health Society
	Orientation Training of Pharmacist.	One day refresher training given to 2293 Pharmacist in 2007-08	**One day orientation training** to 600 Pharmacists to be given during 2007-08 in batches of 30 trainees	July to September, 2008	600	8000	160,000	NRHM (NLEP) District Health Society
	5 days Training of Laboratory Technicians.	Lab Technicians not trained in 2007-2008	5 **days Training of Laboratory Technicians in Skin Smear Examination - 70** Laboratory Technicians from District Hospitals and 1 Laboratory Technician from each Community Health Centre (384)	October, 2008	70	16000	74,667	NRHM (NLEP) District Health Society

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
	2 days Technical cum DPMR training of Leprosy Staff.	Such training has not been imparted during the year 2007-08.	**Two days Orientation Technical & DPMR training of Leprosy Staff** - for selection of deformed leprosy cases for RCS and their post operative care. 470 Non Medical Supervisors, 2100 Non Medical assistants and Physiotherapy Technicians in batches of 30	June to August, 2008	2570	16000	1,370,667	NRHM (NLEP) District Health Society
	Half Day Training of ASHA	Such training has not been imparted during the year 2007-08.	**Half Day Training of ASHA** for preliminary recognition and follow-up of leprosy cases in batches of 30- To be given during basic training courses for ASHA	June to August, 2008				NRHM
C	**Community Education (IEC) and Advocacy Efforts**	**Expected Outcome: Create Awareness about leprosy among masses, Encourage early case detection by voluntary reporting. Reduce stigma in Society, Social & Vocational Rehabilitation of Leprosy affected persons. BUDGET: Rs.12875000**						
		The following IEC activities have been carried out during the year 2007-08	Planned IEC activities for 2008-2009 are as under					
	i.	**Installation of Hoarding -** one each in 239 Community Health Centres are being done	**Hoardings** for public places	September, 2008 to November, 2008	300	10000	3,000,000	NRHM (NLEP)- State Health Society

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
	ii.	**Display Board in 453 Block level Primary Health Centres** are being done	**Display Boards** are proposed to be provided at New Primary Health Centres of endemic districts.	September, 2008	500	2700	1,350,000	NRHM (NLEP) State Health Society
	iii.	**Posters** are being provided @ 100 Posters per Block at Primary Health Centres. Total 80,500 Posters will be made.	**Posters** are required for spreading knowledge of Leprosy and DPMR activities to the public	September, 2008	100000	5	500,000	NRHM (NLEP) State Health Society
	iv.	**Diagnostic Cards** @ 50 per block are being provided. Total 40,250 Diagnostic Cards to be made.	**Diagnostic cards** are required for distribution to ASHAs, School / Colleges teachers for spreading knowledge to communities and students.	September & October, 2008	100000	5	500,000	NRHM (NLEP) State Health Society
	v.	**Folk Shows-** 1360 Magic Shows, 1190 Short Plays, 53 Nukkad Natak and 85 Puppet shows have been organised during the year 2007-08	**Folk Shows** - Magic shows, puppet shows & cultural programmes for spreading knowledge of leprosy. It is proposed that 20 Magic Shows, 20- Puppet shows and 20 Cultural Programmes to be organized in high endemic districts at intervals during the year	August, 2008, October, 2008 and January, 2009	1400	4000	5,600,000	NRHM (NLEP) State Health Society
	vi	**Rallies** -140 have been organised @ two Rallies per district	**Two large Rallies** - One to be organised on 2nd October 2008 & one on 30th January 2009	October, 2008 and January, 2008	140	5000	700,000	NRHM (NLEP) District Health Society

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
	vii.	**140 Quiz have** been organised @ two Quizzes per district in School/college.	**2 Quiz programmes** in each district	October, 2008 and January, 2009	140	1000	140,000	NRHM (NLEP) District Health Society
	viii.	**70 IPC workshops of Medical Officer & Health Workers** have been organized @ one workshop per district.	**70 IPC Workshops** to be organised in each district	January, 2009	70	3000	210,000	NRHM (NLEP) District Health Society
	ix.	**140 Orientation Camps of Non Government organization** have been organised.	**Orientation Camp for NGOs.** - two camps for each district	August, 2008, November, 2008	140	2500	350,000	NRHM (NLEP) District Health Society
	x	665 **Public Opinion Leader's workshop** e.g. Gram Pradhan, Sarpanch, BDC Members and Block Pramukh were organised in Block PHC Head quarters	**One Public Opinion Leaders' workshop** is proposed per district at Block Level	October, 2008	140	2500	350,000	NRHM (NLEP) District Health Society
	xi	**Two Health Melas** have been organised in each district.	**One Health Mela for awareness** and selection of cases for RCS to be organised	September & October, 2008	70	2500	175,000	NRHM (NLEP) District Health Society
D	**DPMR Activity**	**Expected Outcome: Prevention of Disabilities, prevention of deterioration of existing deformities, Medical & Social Rehabilitation of Leprosy Affected Persons, Mobilization of operable cases for Reconstructive surgeries at Tertiary Hospitals of State. BUDGET : Rs.2,250,000**						
	RCS in ILEP Supported Institutions	The Leprosy Mission Hospital & Home, Naini, Allahabad and at Motinagar, Faizabad are conducting RCS operations	Selected deformed leprosy affected persons to be referred for RCS to The Leprosy Mission Hospital & Home at Naini (Allahabad) and at Motinagar (Faizabad)	July, 2008 to February, 2009				The Leprosy Mission

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
	RCS by Central Govt. Institutions	Central Jalma Institute for Leprosy, Agra is conducting RCS operations	Selected deformed patients of Western U.P. districts will be sent for RCS operation at Central Jalma Instt. For Leprosy, Agra.	July, 2008 to February, 2009				JALMA
	RCS by Identified Medical College	King George Medical University, Lucknow has been identified as Physical Medicine and Rehabilitation Institution for the state during the year 2007-08 and 110 Major RCS operations have been performed there.	Selected deformed patients of Lucknow Division will be sent for Major RCS to CSMMU, Lucknow.	July, 2008 to February, 2009				
	Physical Medicine and Rehabilitation Institution	Physical Medicine and Rehabilitation Center of King George Medical University, Lucknow has been identified by GOI for strengthening RCS services	Physical Medicine and Rehabilitation Center of King George Medical University, Lucknow to provide RCS services	July, 2007 to March, 2008				
	Provision for Major RCS Operation Cost.	There was no provision of fund for Major R.C.S. Operations. Surgeries were financed by Rotary Club, Lucknow.	For conducting major R.C.S. Operations at CSMU College, Lucknow, the cost for 200 operations per year @ Rs. 6,500/= per operation.	July, 2008 to March, 2009	200	5000	1,000,000	NRHM (NLEP)-State Health Society
	Compensation for loss of wages to RCS patients	There was no provision of fund for Major R.C.S. Operation.	To mobilize deformed leprosy affected persons for RCS, those belonging to Below Poverty Line category compensation for loss of wages shall be provided.	July, 2008 to March, 2009	100	5000	500,000	NRHM (NLEP)-State Health Society

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
	MCR footwear	MCR footwear have been provided to Grade-1 deformity patients	500 pairs of MCR footwear to be provided @ Rs. 300/- per pair	July, 2007 to March, 2008	500	300	150,000	NRHM (NLEP) District Health Society
	Aids & Appliances	Crutches & Splints have been provided to deformity patients	Aids and Appliances to be given to Deformity patients for 200 patients @Rs.3000	July, 2007 to March, 2008	200	3000	600,000	NRHM (NLEP)- State Health Society
E	**URBAN LEPROSY CONTROL**		**Expected Outcome : Increase urban coverage by involvement of Health Facilities in Urban areas e.g. ESI, Railway, Municipality, Industrial, Private , NGO etc. BUDGET : Rs.1839100**					
	Urban Leprosy Control	Under Urban Leprosy Project 52 Projects were implemented. Mega City-1, Metropolitan City-1, Medium City-9 and Urban Township's-41 were included	**52 Projects** to be continued in the state and expenses are as per heads below:	April 08 to March 09				
			Supportive Medicine includes Prednisolone, & Dressing materials					NRHM (NLEP) District Health Society
			Mega City		1	40000	40,000	
			Metropolitan City		1	36000	36,000	
			Medium City		9	18000	162,000	
			Township		41	9000	369,000	
			MDT Delivery services and follow up of under treatment patients.					NRHM (NLEP) District Health Society

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
			Mega City		1	56500	56,500	
			Metropolitan City		1	56500	56,500	
			Medium City		9	28200	253,800	
			Township		41	11300	463,300	
			Monitoring, supervision and Coordination which includes periodic meetings and mobility.					NRHM (NLEP) District Health Society
			Mega City		1	24000	24,000	
			Metropolitan City		1	24000	24,000	
			Medium City		9	12000	108,000	
			Township		41	6000	246,000	
F.	**Procurement Plan**	**Expected Outcome: Provide medicines (other than MDT), splints, crutches, MCR Footwear, welfare items for leprosy affected persons. Printing of Report & Record proformas. BUDGET : Rs.23,10,000**						
	Drugs Material & Supplies	MDT Supply has been received from Govt. of India free of cost.	MDT for about 15,000 MB and 18,000 PB cases will be required during the year.	April 2008 to March 2009				
	Supportive Medicines	Supportive medicines procured at District level	Procurement of Supportive Medicines at District level	Jul-08	70	15000	1,050,000	NRHM (NLEP) District Health Society
	Splints and Crutches	Splints and Crutches have been provided to deformity patients.	Splints and Crutches will be provided to deformity patients.	August 08	70	4000	280,000	

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
	Patients Welfare	Needy patients have been provided help as per their needs.	Needy patients will be provided help as per their needs.	Sept 08	70	6000	420,000	
	Printing of Records	Printing of SIS formats and other records has been done at District level	Printing of modified SIS Formats and records	June to August, 2008	70	8000	560,000	NRHM (NLEP) District Health Society
G.	**Contractual Services :**	**Expected Outcome : Efficient functioning of SLO & DLO Offices for monitoring & supervision of NLEP BUDGET Rs. 60,90,000**						
		SLS Staff :		Apr. 08 to Mar. 09				NRHM (NLEP) State Health Society
		Budget & Finance Officer-1	Bgt. & Finance Officer-1		1	14300	171,600	
		Data Entry Operator-1	Data Entry Operator - 2		2	7150	171,600	
		Driver-1	Driver - 1		1	3850	46,200	
		Peon-1	Peon - 1		1	3300	39,600	
		TA/DA for Epidemiologist & SLO for attending leprosy conferences.	TA/DA for Epidemiologist & SLO for attending leprosy conferences.		1	10000	120,000	
		TA/DA for Contractual Drivers of DLS			70	500	420,000	
	Office Equipment	Mobile Phone Rental for SLO	Mobile Phone Rental for SLO		1	2500	30,000	
			Laptop for SLO		1	30000	30,000	
			LCD Display Unit		1	61000	61,000	
			Desktop Computer with complete assembly		1	50000	50,000	
	Telephone/FAX/Internet Charges for SLS		Telephone/Fax/Internet		1	10000	120,000	

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
	Contractual Services :	**DLS Staff :**		Apr. 08 to Mar. 09				NRHM (NLEP) District Health Society
		Driver-100 (Not more than 2 in any district)	Drivers on Contract 70		70	3850	3,234,000	
		Honorarium for Accountants of DLS	Honorarium for Accountants of DLS		70	400	336,000	
	Telephone/FAX/Internet Charges for DLS		Telephone/Fax/Internet charges for DLS		70	1500	1,260,000	
H.	**NGO Services :**	**Expected Outcome: Generate Community awareness for early case detection, Provide Ulcer care, POID services to affected persons and Case follow-up of cases under treatment. BUDGET : Rs 60,63,440**						
	Funding under SET SCHEME		NGOs already working to continue work but their role shall be redefined - IEC, Surveillance, Prevention of Deformity & Ulcer Care, case follow-up, absentee retrieval etc.	April, 2008 to March, 2009				NRHM (NLEP)- State Health Society
			a) Gramya Vikas Sansthan,Lucknow (Mohammadi Tahsil, Kheri)	2008-09			460,000	NRHM (NLEP)- State Health Society
			b) Jawahar Lal Nehru Sewa Sansthan, Deoria (Bhatni &Bhulouni Block)	2008-09			680,480	NRHM (NLEP)- State Health Society
			c) Mahila Avam Bal Vikas Samiti, Naini Lar, Deoria (Kopa & Ghosi Block, Mou)	2008-09			500,000	NRHM (NLEP)- State Health Society

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
			d)Maksad, Chandan Chouki, Paliyakalan, Kheri (Palia Tahsil, Kheri)	2008-09			510,060	NRHM (NLEP)-State Health Society
			e) Nehru Youya Chetana Kendra, Deoria (Deoria & Baharaj Bajar Block Deoria)	2008-09			502,660	NRHM (NLEP)-State Health Society
			f) Poorvanchal Sewa Sansthan, Deoria (Dasai Deoria, Kasiya Block Deoria)	2008-09			796,620	NRHM (NLEP)-State Health Society
			g) Poorvanchal Sewa Sansthan, Deoria (Siswa & Nichloul, Maharajganj)	2008-09			436,000	NRHM (NLEP)-State Health Society
			h) Sanjay Gandhi Sewa Sansthan, Deoria (Rudrapur, Gouri Bazar, Deoria)	2008-09			753,660	NRHM (NLEP)-State Health Society
			i) Swargiya Lal Bhadur Shastri Sewa Kusht Sewa Ashram, Azamgarh (Tarwa Firozpur Block)	2008-09			432,060	NRHM (NLEP)-State Health Society
			j) Tripurari Sewa Avam Shiksha Sansthan, Goura Deoria (Brahmpur, Sardar Nagar Bolck, Gorakhpur)	2008-09			496,000	NRHM (NLEP)-State Health Society

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
			k) Trinity Association for Social Service, St. Kabir Nagar (Brijmanganj & Noutanwa Block, Mahrajganj)	2008-09			495,900	NRHM (NLEP)- State Health Society
I	ASHA	**Expected Outcome: Creating awareness about the early signs of leprosy among the people and ensure timely treatment completion. BUDGET : Rs19,00,000**						
		No incentive has been provided to ASHA during the year 2007-08	ASHA has to play an important role in creating awareness about the early signs of leprosy among the people and ensure timely treatment completion. Incentive to be given to ASHA after patient is cured					NRHM (NLEP) District Health Society
			For MB Cases incentive to be given @ Rs.500 per patient	2008-09	2000	500	1,000,000	
			PB Cases incentive to be given @ Rs.300 per patient	2008-09	3000	300	900,000	
J.	NLEP Monitoring & Review	**Expected Outcome : Improvement in quality of services BUDGET : Rs.10750000**						
	District Level :	The programme activities are being monitored by Chief Medical Officers very month.	District level - Qtly Review Meeting of progress made in NLEP in coordination with members of other Depts. e.g. Social Welfare, Handicapped Welfare, Education	April, 2008 to March, 2009	4 X 70	2000	560,000	NRHM (NLEP) District Health Society

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
	State Level	At State level one day review meeting have been organised in the month of August, 2007 & January, 2008 and 1 review meeting to be held in March, 2008.	Qtly. Review meeting of DLOs - 4 Meetings in a year. Participants include District Officers, State Officers, GOI Guests, WHO Coordinators, & Medical College teachers other NGO members. (Study material, LCD Hiring (if LCD Projector not procured in 2008-09), working lunch & refreshments etc.)	April, 2008, July, 2008, October, 2008 & January, 2009	4	25000	100,000	NRHM (NLEP)-State Health Society
K.	Vehicles Operation & Hiring	v.	SLS @ Rs. 80,000/= per year per vehicle for 3 vehicles.		2	85000	170,000	NRHM (NLEP)-State Health Society
		vi.	DLS @ Rs. 50,000/= per year per vehicle for 2 vehicles each districts.		140	50000	7,000,000	NRHM (NLEP) District Health Society
L.	Office Operation & Maintenance.	i.	SLS @ Rs. 60,000/= per year	April 2008 to March 2009	1	60000	60,000	SLS
		ii.	DLS @ Rs. 20,000/= per year		70	20000	1,400,000	NRHM (NLEP) District Health Society

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs.)	Source of Funds
1	2	3	4	5	6	7	8	9
	Consumables	iii.	SLS @ Rs. 60,000/= per year for stationary		1	60000	60,000	NRHM (NLEP)- State Health Society
		iv.	DLS @ Rs. 20,000/= per year for stationary		70	20000	1,400,000	NRHM (NLEP) District Health Society
M	Special IEC Campaign	Expected Outcome : Awareness generation in high priority areas for early case detection				BUDGET : Rs.2485000		
		Block level Awareness Campaign carried out in 30 blocks of 17 Districts	Block level Awareness Campaign to be carried out in 20 blocks		20	100000	2,000,000	
		Urban Leprosy Sensitization and Awareness Campaign in 6 Urban areas	**Urban Leprosy Sensitization and Awareness Campaign** in 10 Urban areas		5	97000	485,000	
Total Fund Required							50,594,540	

Budget Summary for 2008-09

Sl.	Heads	Budget allocated in 2007-2008 (in Rs.)	Budget proposed in 2008-2009 (in Rs.)	Expected Outcome
A	Training & Capacity Building	3,062,000	4032000	Early Case Detection by trained field staff & Quality diagnosis and treatment & Prevention of Disabilities. Budget
B	Community Education (IEC) and Advocacy Efforts	13,854,000	12875000	Create Awareness about leprosy among masses, Encourage early case detection by voluntary reporting. Reduce stigma in Society, Social & Vocational Rehabilitation of Leprosy affected persons.
C	DPMR Activity	-	2250000	Prevention of Disabilities, prevention of deterioration of existing deformities, Medical & Social Rehabilitation of Leprosy Affected Persons, Mobilization of operable cases for Reconstructive surgeries at Tertiary Hospitals of State .
D	Urban Leprosy Control	3,251,000	1839100	Increase urban coverage by involvement of Health Facilities in Urban areas e.g. ESI,Railway, Municipality, Industrial, Private , NGO etc.
E	Procurement Plan	3,940,000	2310000	Provide medicines (other than MDT), splints, crutches, MCR Footwear, welfare items for leprosy affected persons. Printing of Report & Record proformas.
G	Contractual Services	6,513,000	6090000	Efficient functioning of SLO & DLO Offices for monitoring & supervision of NLEP
J	N.G.O. Services	10,487,000	6063440	Generate Community awareness for early case detection, Provide Ulcer care, POID services to affected persons and Case follow-up of cases under treatment.
K	ASHA	-	1900000	Creating awareness about the early signs of leprosy among the people and ensure timely treatment completion .
L	NLEP Monitoring & Review Meetings	-	660000	Improvement in quality of services
M	Vehicles Operation & Hiring	5,700,000	7170000	For improved monitoring & Supervision

Sl.	Heads	Budget allocated in 2007-2008 (in Rs.)	Budget proposed in 2008-2009 (in Rs.)	Expected Outcome
N	Office operation & Consumables	1,080,000	2920000	Efficient record keeping & reporting by SLO & DLO Offices
M	Special IEC Campaign	-	2485000	Awareness generation in high priority areas for early case detection
Total Budget		**47,887,000**	**50,594,540**	Efficient delivery of Leprosy Services in the state

During the year 2007-08 an amount of Rs 100 lacs for implementation of activities was taken on loan basis from Mission flexipool. This loan amount of Rs.100 lacs will have to be repaid. The requirement is over and above the proposal of Rs.505.95 lacs.

5. INTEGRATED DISEASE SURVEILLANCE PROJECT

In the PIP for year 2007-08, State had proposed a plan for Rs.3426.76 lacs. The proposal was approved in principle, subject to authorization to programme division to communicate activity-wise approvals with defined budget lines.

Though there was allocation of Rs.510 lacs from GoI, however, no release was communicated to State. Therefore the activities have not been initiated.

The MoU between GoI and GoUP has been signed and the activities are proposed to be undertaken in 2008-09.

In the PIP for year 2008-09, State proposes a plan for Rs.316.90 lacs for implementing IDSP in 5 districts – Kanpur, Agra, Varanasi, Allahabad & Lucknow against GOI has allocation of Rs 268 lacs for UP for this year. District Allahabad will be developed as a Model district for IDSP.

Detailed Proposal for 2008-09

1. Background

The GOI has initiated the decentralized, state based Integrated Disease Surveillance Project. The project would enable State to detect early warning signals of impending outbreak and initiate an affective response in timely manner. It is also expected to provide essential data to monitor progress of ongoing disease control programmes and to allocate health resources accordingly.

2. Objectives

- To improve the information available to the govt. health services and private health care providers on a set of high priority diseases and risk factors with the view to improving the responses to such diseases and risk factors.
- To establish a decentralized state based system of surveillance for communicable and non communicable diseases to ensure timely and effective public health action in response to health challenges in the country at the state and national level.
- To improve the efficiency of existing surveillance system and facilitate sharing of relevant information with the health administration, community and other stake holders so as to detect disease trend and evaluate control strategies.

3. Components

- Establish state and district level disease surveillance unit.
- Strengthening of data quality, analysis and linkages to action
- Improve laboratory support system.

- Train stakeholder in disease surveillance and action
- Coordinate and decentralize surveillance activities
- Integrate disease surveillance at all level and involve communities and other stake holders.

Diseases/Conditions under the Surveillance Programme

a. Regular surveillance

Vector Borne Diseases	1. Malaria
Water Borne Diseases	2. Acute Diarrhoeal Disease (Cholera)
	3. Typhoid
Respiratory Diseases	4. Tuberculosis
Vaccine Preventable Diseases	5. Measles
Diseases under Eradication	6. Polio
Other conditions	7. Road Traffic Accidents
Other International commitments	8. Plague
Unusual Clinical Syndrome (causing death/ hospitalization)	9. Menigoencephalitis/ Respiratory distress, hemorrhagic fevers, other undiagnosed conditions

b. Sentinel Surveillance

Sexually Transmitted Diseases/ Blood Borne Other conditions	10. HIV/ HBV, HCV
	11. Water quality
	12. Out door air quality(Large urban centres)

c. Regular Periodic Surveys

NCD risk factors	13. Anthropometry, Physical Activity, Blood Pressure, Tobacco Nutrition Blindness

d. State Priorities Disease

	14. Japanese Encephalitis
	15. Dengue/ DHF
	16. Filaria
	17. Kala-azar

4. Phasing

The Integrated Disease Surveillance Project was implemented by GoI in the entire country in phase manner. Uttar Pradesh was to be taken up in Phase-III commencing from 2007-08. The state proposal was submitted through NRHM PIP, however no financial releases were received by the state.

5. Key performance indicators

The performance of surveillance system will be assessed using following indicators.

- No. and %age of districts providing monthly surveillance report on time.
- No. and %age of responses to disease specific triggers on time.
- No. and %age of responses to disease specific triggers assessed to be adequate.
- No. and %age of laboratories providing adequate quality of information.
- No. of districts in which private providers are contributing to disease information.
- No. of reports derived from health care providers.
- No. of reports derived from private laboratories.

6. Expectations

It is expected that IDSP will avert a sufficient number of disease outbreak and epidemics and reduce human suffering and improve the efficiency of all existing health programme. This programme will also allow monitoring of resource allocation and form a tool to enhance equity in health delivery.

7. Strategy

The four main strategies for implementation of IDSP are -

1. Information Technology and Networking
2. Laboratory Upgradation
3. Human Resource Development
4. Disease Surveillance and Response Mechanism

8. Existing Surveillance Mechanism

Reporting units - *Rural*

a. Medical Officer Block PHC (BPHC)/ CHC - 1249
   i. PHC
   ii. CHC

b. Informers at community level (Rumour registry)
   i. Village Pradhan
   ii. MPW (Male/ Female)
   iii. Health Supervisors
   iv. ASHA
   v. Anganwadi Worker
   vi. NGO Worker
   vii. Newspapers

Reporting units - *Urban*

a. **District Level Hospitals, Health Posts, etc.** (during outbreaks)
b. **Medical Colleges** (during outbreaks)
c. **Informers at the community level (Rumour registry)**
   i. Ward members
   ii. News papers

Currently, Director-Communicable and Vector Borne Diseases assisted by Joint Directors looks after disease surveillance programme. It mainly compiles report received from the districts and initiates action in case of out break of diseases.

At present there is no system of Integrated Disease Surveillance in the state. However, the surveillance for individual diseases is being done under different programme, vertically. For example- Surveillance of malaria is being done actively and passively by Male Multi Purpose Workers and PHCs, CHCs & hospitals respectively and is being monitored at the district level by the District Malaria Officer and at the state level by the Additional Director, Malaria, U.P. Surveillance of Tuberculosis is being done passively at PHCs and is being monitored by the DTO and at the state level by Joint Director (TB). Surveillance of Polio is being done at the PHCs and CHCs level by the Medical Officers and at the district level by the DIO and SMO on the guidelines of the WHO and the state level it is being monitored by the Additional Director (UIP).

9. Intervention Plan

9.1 Establish state and district level disease surveillance unit.

To undertake mandate of IDSP, state head quarter needs to be strengthened with a properly staffed and equipped State Surveillance Unit (SSU). At district level one of the Addl. CMO, who looks after the disease surveillance component. A disease surveillance unit (DSU) needs to be established at district level.

GoI has provided the physical and financial norms for setting of state and district surveillance unit. The same has been taken into consideration for the developing proposal for setting up of these units at state and district level.

9.1.1 State Surveillance Unit (SSU)

SSU has been set up under Director General of Medical and Health Services, U.P. with the following Members.

State Surveillance Officer	-	Joint Director level-IV (from existing staff of State Govt.)
Dy. State Surveillance Officer	-	Level-III Medical Officer (from existing staff of State Govt.)

Public Health Consultant (2)	-	Experienced Medical Graduate on contractual basis
Consultant, Technical & Training	-	On contractual basis
Consultant, Finance	-	On contractual basis
Data Manager	-	On contractual basis
Data entry operator (2)	-	On contractual basis
Assistant	-	On contractual basis
Helper	-	On contractual basis

SSU will have the following responsibilities –

- The collection and analysis of all data being received from the districts and transmitting the same to the central surveillance unit.
- Coordinating the activities of the rapid response teams and dispatching them to the field whenever the need arises.
- Monitoring and reviewing the activities of the district surveillance units including checks on validity of data, responsiveness of the system and functioning of the laboratories.
- Coordinating the activities of the state public health laboratories and the medical college laboratories.
- Sending regular feedback to the district units on the trend analysis of data received from them.
- Coordinating all training activities under the project.
- Coordinating meetings of the state surveillance committee, which is referred to in later paragraphs

9.1.2 State Surveillance Committee

A State Surveillance Committee has been set up under the chairmanship of the Secretary, Medical & Health Department to oversee all the surveillance activities in the state and will be administratively responsible for implementation of the programme.

The members of the committee will consist of the following:

Chairperson : Secretary, Medical & Health, Govt. of U.P.
Co-Chairperson : Director General, Medical & Health
Member Secretary : State Surveillance Officer
Members :

1. Director, Health, GoUP
2. Programme Officers (TB, Malaria, Polio, AIDS, Blindness Control, Leprosy Eradication)
3. Representative nominated by the Principal Secretary, Home, Govt. of U.P.
4. Representative from Pollution Control Board, U.P.

5. In-charge State Public Health Lab.
6. State Representative of IMA
7. Representative of State Medical College
8. Representative of Health related NGOs

The state surveillance committee would meet at least twice in a year and as and when required.

9.1.3 Manpower Requirement at State HQ

Sl.	State Unit	District Unit
1	Jt. Director (State Surveillance Officer-SSO)*	Dy. CMO (District Surveillance Officer-DSO) *
2	Consultant (Technical and Training)	Accountant -1
3	Consultant (Finance and Procurement)	Data Entry Operator-2
4	Data Manager	Administrative Assistant-1
5	Data Entry Operator-2	
6	Office Assistant-1	
7	Class IV-1	

* *These posts are available in the system, others will be filled up on contractual basis as per GoI norms.*

Manpower Expenses at State Level

Title	Type	No.	Monthly Fees (Rs.)	Annual Cost (Rs. In Lac)	Procedure
Consultant Finance/ Procurement	Full Time	1	10000	1.20	Consultancy
Consultant Training/ Technical	Full Time	1	10000	1.20	Consultancy
Data Manager	Full Time	1	10000	1.20	Consultancy
Data Entry Operator @ 6000/- per month	Full Time	2	12000	1.44	On contract
Assistant	Full Time	1	5000	0.60	On contract
Helper	Full Time	1	3000	0.36	On contract
TOTAL		**7**	**50000**	**6.00**	

The unit cost for personnel required for SSU on GoI norms is Rs. 6.00 lac per year.

Operational Cost of SSU

Activity	Annual Unit Cost Rs.	Procedure	No. of units	Annual Cost (Rs. In Lac)
Travel cost, POL, Maintenance and Hiring of vehicles	100000	Hiring by direct contracting	1	1.00
Office expenses on telephone, fax, electricity	60000	Paid by SSU	1	0.60
Office stationery and other consumable items	60000	Local purchase	1	0.60
DA to officers and staff engaged under IDSP	80000	Paid by SSU	1	0.80
Miscellaneous including contingency	50000	Paid by SSU	1	0.50
SUB-TOTAL	**350000**		**1**	**3.50**

Additional components for setting up SSU include civil works, lab., computerisation, web-connectivity and operational support.

9.1.4 Administrative Structure at District Level

1. District Surveillance Committee :

Constitution of the committee as follows :

Chairperson : District Magistrate

Co-Chairperson : Chief Medical Officer.

Member Secretary : District Surveillance Officer

Members :

1. Programme Officers (TB, Malaria, Polio, AIDS, Blindness Control, Leprosy Eradication)
2. Representative of Senior Superintendent of Police
3. Superintendent of Police
4. Representative of Jal Nigam
5. Representative of NGOs
6. Chairman, Distt. Panchayat
7. In-Charge District Public Health Lab.

The District Surveillance Committee will meet once a month regularly and as often as needed during an epidemic. A routine report of this meeting should be forwarded to the State Surveillance office to give a feedback on the progress and problems in various districts. Reports of these meeting will be forwarded to the National Surveillance cell once in three months.

9.1.5 District Surveillance Unit (DSU)

Constitution of the DSU will be as follows :

District Surveillance Officer (1)	-	Nominated by the Chief Medical Officer
Consultant Public Health (2)	-	Medical Graduates on contractual basis
Accountant (1)	-	On contractual basis
Data entry operator (2)	-	On contractual basis
Administrative Assistant (1)	-	On contractual basis

District Surveillance Units

Title	Type	No.	Monthly Fees (Rs.)	Annual Cost (Rs. In Lac)	Procedure
Accountant	Full Time	1	7000	0.84	On contract
Data Entry Operator @ 6000/- per month	Full Time	2	12000	1.44	On contract
Administrative Assistant	Full Time	1	5000	0.60	On contract
TOTAL		**4**	**24000**	**2.88**	

Operational Cost of DSU

Activity	Annual Unit Cost (Rs. In Lac)	Procedure	No. of units	Annual Cost (Rs. In Lac)
District Level				
Travel cost, POL, Maintenance and Hiring of vehicles	40000	Hiring by direct contracting	5	2.00
Office expenses on telephone, fax, electricity	20000	Paid by DSU	5	1.00
Office stationery and other consumable items	20000	Local purchase	5	1.00
D.A. to officers and staff engaged under IDSP	30000	Paid by DSU	5	1.50
Miscellaneous including contingency	20000	Paid by DSU	5	1.00
SUB-TOTAL	**130000**		**5**	**6.50**
Peripheral Level				
Travel cost, POL, Maintenance and Hiring of vehicles	5000	Hiring by direct contracting	38	1.90
Office expenses on telephone, fax, electricity	4000	Paid by DSU	38	1.52

Activity	Annual Unit Cost (Rs. In Lac)	Procedure	No. of units	Annual Cost (Rs. In Lac)
Office stationery and other consumable items	2000	Local purchase	38	0.76
D.A. to officers and staff engaged under IDSP	3000	Paid by DSU	38	1.14
Miscellaneous including contingency	1000	Paid by DSU	38	0.38
SUB-TOTAL	**15000**		**38**	**5.70**
TOTAL				**15.70**

9.1.6 Outbreak Response

There will be District Outbreak Investigation Team **(DOIT)** in each district to look after the various aspects of an outbreak composition of the team will be as follows -

1. Nodal Officer(Epidemiologist)
2. Clinician(Physician or Paediatrician)
3. Micro Biologist
4. District Administrative nominee (not below the rank of Tehsildar)
5. One member of surveillance consultant of DSO
6. Health Assistant

At the state level there will be three state level Rapid Response Teams to investigate at the time of out break of epidemic. Members of the team is as follows -

1. State Surveillance Officer/ Nominee
2. Micro Biologist
3. Nodal Officer In charge of disease control programme in the state
4. Consultant Epidemiologist
5. Representative of Medical College

9.2 Strengthening of data quality, analysis and linkages to action

Main activities under this head

- Online entry, management and analysis of surveillance data through use of computer and internet and WWW
- Reporting surveillance data using standard software including GIS, with flexibility with new system
- E-mail services between state head quarter, district, blocks, laboratories and GoI.
- Linkages with institution and personnel involved in public health.
- Using feedback from health worker/community to take action

- Rapid dissemination of health alerts to public health staff and civil societies
- Quality Assurance surveys of laboratory information.

The main activities to be undertaken for this component includes computerisation at State, district and programme support units at CHCs, generation of feedback through softwares, and web-enabled reporting system between District and State. In the first phase it is proposed to undertake computerisation and connectivity between State, District HQ and all CHCs to improve data quality and follow-up action. Provision of computer and software at CHCs is not being provisioned under the programme. It is proposed that computer and manpower provided under FRU/ CHC upgradation will be utilised for the programme. For this the expenditure to be incurred is as follows:

Procurement of Computer Hardware including Server & Accessories

Sites	Total No.	Total Cost (in lacs)
District Surveillance Unit @ Rs.6.60 lac	5	33.00
State Surveillance Unit @ Rs.19.15 lac	1	19.15
Total		**52.15**

Procurement of Computer Software

Sites	Total No.	Total Cost (in lacs)
District Surveillance Unit @ Rs.3.05 lac	5	15.25
State Surveillance Unit @ Rs.6.10 lac	1	6.10
TOTAL		**21.35**

Cost of web enabled connectivity

Web enabled connectivity at district level

No. of units	LAN & ISP connectivity (One time) @ 50000/- per location	ISP connectivity charges @ Rs.0.50 lac per year (Rs. in lacs)
5	2,50,000	2.50
Web enabled connectivity at State level		
1	50000	0.50

9.3 Improve laboratory support system.

Correct diagnosis of the communicable and non-communicable disease is crucial to dispel rumours and undertake scientific interventions. Currently, laboratory services are rudimentary in nature. These need to be revamped and strengthened.

Under the IDSP project GoI has provided norms to strengthen laboratory support system. For Uttar Pradesh following units need to be strengthened

- State laboratory at State HQ and SSU
- District lab at every district head quarter
- Peripheral labs at all CHCs

Strengthening norms of above units includes components of

i. Civil Works
ii. Procurement of laboratory equipment
iii. Consumables
iv. Office equipments
v. Furniture and fixtures.

Financial norm given by GOI, are as under:

- State lab. - Rs. 15.1 lac
- District lab - Rs. 12.85
- CHC - Rs. 0.98 lacs per unit.

For the year 2008-09 it is proposed to take up 5 KAVAL towns having 38 CHCs under the IDSP project as per the budget allocation under NRHM.

(i) Civil Works

Activity	Total No.	Total (lacs.)
Renovation of peripheral labs at CHCs @ Rs.0.20 lac per lab	38	0.76
Renovation of District Lab at District Hospital @ Rs.1.40 lac per lab	5	7.00
Renovation of District Surveillance Unit at Dist. HQ @ Rs.1.40 lac per lab	5	7.00
Renovation of State Laboratory at State HQ @ Rs.1.40 lac per lab	1	1.40
Renovation of State Surveillance Unit at State HQ @ Rs.1.40 lac per lab	1	1.40
TOTAL		**17.56**

(ii) Procurement of Laboratory Equipments

Activity	Total No.	Total Cost (in lacs)
Labs at CHCs @ Rs.0.40 lac	38	15.20
Labs at District Level @ Rs.8.50 lac	5	42.5
Lab at State HQ and SSU @ Rs.8.50 lac per unit	1+1	17.00
TOTAL		**74.7**

(iii) Procurement of Office Equipments

Sites	Total No.	Total Cost (in lacs)
Labs at CHCs @ Rs.0.10 lac	38	3.8
Labs at District Level @ Rs.1.00 lac	5	5.00
Lab at State HQ and SSU @ Rs.2.50 lac	1+1	5.00
TOTAL		**13.8**

(iv) Furniture and Fixtures

Sites	Total No.	Total Cost (in lacs)
Labs at CHCs @ Rs.0.10 lac	38	3.8
Labs at District @ Rs.0.60 lac	5	3.0
District Surveillance Unit @ Rs.0.60 lac	5	3.0
Lab at State @ Rs.0.60 lac	1	0.60
State Surveillance Unit @ Rs.0.60 lac	1	0.60
TOTAL		**11.00**

(v) Material & Supplies for Laboratories

Sites	Total No.	Total Cost (in lacs) Per Yr.
Labs at CHCs @ Rs.0.08 lac/yr	38	3.04
Labs at District Lab @ Rs.0.75 lac/yr	5	3.75
Lab at State Lab @ Rs.1.50 lac/yr	1	1.50
TOTAL		**8.29**

9.4 Train stakeholders in disease surveillance and action

To improve knowledge, understanding of program objective & guidelines, role of other support personnel and units, skills, application and commitment is essential for effective implementation of the program. To this end intensive capacity building/ training are to be undertaken under the program. The details of the training program are as under:

- The training components include epidemiology, laboratory, data management, quality assurance
- It will be three tier training process, state and district level trainer 10 at each level will be trained by GoI at identified institutions. Who intern will train block level trainer who intern will trained the sub block staff and community members
- Training material will be provided by GoI
- For training two levels of trainers have been identified. Level-2 trainers (State and district) who have been trained by Level-1 trainer (National level). They will in turn train district and sub district personnel.
- State/district level training will be undertaken by the GoI at national institute.
- Peripheral level training will be given by the block Medical Officer at the sub block level.
- Total no. of trainees will be include MPWs (male & female), state surveillance team, medical officer, peripheral worker, lab technicians/ assistants, data managers, district surveillance team and ASHAs.

Total cost involve in training would be Rs. 13.747 lac as detailed below:

Unit Cost for Training Courses under IDSP

Training under IDSP	No. of Trainees	No. of Batches	Unit Cost Per Batch (Rs.)	Total Cost (in lac)
MPW (including NMAs)	2500	15	15700	2.355
LAB ASST.	40	2	18100	0.362
MO	290	15	36700	5.50
LAB TECH.	45	2	62200	1.24
DATA MANAGERS	6	1	62200	0.62
DST	20	1	139000	1.39
SST	5	1	228000	2.28
TOTAL				**13.747**

9.5 Integrate disease surveillance at all levels and involve communities and other stakeholders.

The success of any programme depends upon the participation of stakeholders, maintaining of regular linkage, coordination, hand-holding, sharing of information and feedback. The various stakeholders under the programme are as under:

- Under IDSP the stakeholders at periphery would be medical officer PHC, sentinel private practitioners, participating laboratories
- At district peripheral level member of district surveillance unit, district public health lab, cantina private hospitals, programme officer of different disease control programme, medical colleges
- At state level all members of SSU, state disease control programme officer, state laboratories, medical colleges in the state.
- Coordination between all the stakeholders will be insured by the SSU through IT networking.

10. Surveillance Mechanism (Proposed under IDSP)

Reporting units - *Rural*

a. Medical Officer Block PHC (BPHC / CHC)
    i. Blocks
    ii. PHC
    iii. CHC

b. Sentinel Private Practitioners

c. Informers of Medical department
    i. MPWs including the Leprosy worker (Non Medical Assistant)
    ii. ASHA

d. Informers at community level (Rumour registry)
    i. Village Pradhan
    ii. Teachers
    iii. Anganwadi members
    iv. Self help group
    v. News papers

In the rural area the training will be provided to MPWs, NMAs and ASHA who will work as informer in the project. If the disease occurs in the village the ASHA/ Male MPW will immediately inform to the PHC Medical Officer for confirming the disease and take the action accordingly.

Reporting units - *Urban*

a. Hospital
b. Medical Colleges
c. Sentinel Private Practitioners/ Sentinel Private Hospitals/Private Lab
d. Specialty Hospitals
    i. Infectious disease
    ii. Tuberculosis
    iii. Children
e. Municipal Corporation
    i. Hospitals
    ii. Dispensaries / Health Posts
f. Employees State Insurance Scheme (ESI)
    i. Hospitals
    ii. Dispensaries
g. Central Government Health Scheme
    i. Hospitals
    ii. Dispensaries
h. Railways
    i. Hospitals
    ii. Dispensaries
i. Informers in the municipal areas
    i. Sanitary Inspectors
    ii. Filaria Inspectors
    iii. Malaria Inspectors
    iv. SFW/ Field Workers
    v. Insect Collectors
j. Informers at the community level (Rumour registry)
    i. Ward members
    ii. Anganwadi workers
    iii. Youth groups
    iv. News papers

Special Units

b. NGOs doing surveillance activities
c. State Water Pollution Control Board
d. Regional/ State Air Pollution Control Board
e. District Police Information System

Frequency of Reporting

It is suggested that each of the Sentinel Private Practitioners (SPP)/ Sentinel Private Hospitals (SPH) report at weekly intervals. Since at each PHC there will be atleast10 SPPs this will mean at least one report per day from each region and three to four reports per day at the Block PHC. In addition, if there is any untoward case or a sudden increase noted, additional reports may be sent. Emergency telephone numbers will be made available to contact MO PHC / Health worker.

Flexibility will be provided in the method of reporting by the SPPs. Each PHC may choose an optimal method that is suitable in the situation. Any of the following methods may be used:

- Telephone followed by mailing of IDSP format by hard copy
- Fax
- Electronic mailing
- Courier
- Office of the DSO / CHC
- Direct contact with Health Worker if necessary
- Private Courier can be contracted

Telephonic reports will be encouraged during epidemic situations so as to avoid delay. MO Block PHC / computer entry person / District Surveillance Officer will be able to receive information from the periphery. Routine reporting will be facilitated by the health worker visiting the SPPs in the rural areas on specific days assigned for reporting. In urban areas, telephones can be used or the health workers can collect reports from SPPs as done in the polio program.

11. Information, Education and Communication

People's knowledge and participation is crucial for the success of the programme. Different sections of the service providers and community groups should be given specific role and tool to facilitate their contribution in the programme and understand role of other group of workers and community to facilitate smooth action at the ground level.

Toward this end a robust BCC intervention is proposed to be undertaken on regular basis to facilitate the process of understanding cooperation and coordination in respect of various components of the program, The communication may focus on specific needs of target audience, expected outcomes and progress made from time to time. The interpersonal communication material be developed and used by leveraging through community mobilization activities under RCH-II or other programmes. Convergence with other BCC interventions under NRHM would also be ensured.

The component-wise financial requirements are shown in the tables ahead.

A. State Level

Activity	Annual Unit Cost (Rs. in lacs)	No. of units	Cost for one year (in lacs)	Procedure
1. Development of communication material	10.00	1	10.00	By SSU
2. Sensitization workshops	1.00	1	1.00	By SSU
3. Review meeting of State Committee/ DSUs	0.50	1	0.50	By SSU
4. Press Advertisement	1.50	1	1.50	By calling 3 or more proposal from 3 newspapers
5. Print Media (Pamphlets, brochures etc.)	1.50	1	1.50	By calling 3 or more proposal from 3 newspapers
6. Telecasting of TV spots	4.00	1	4.00	Quality & Cost based selection
7. Broadcasting on Radio	1.50	1	1.50	Quality & Cost based selection
TOTAL	**20.00**	**-**	**20.00**	

B. Peripheral & District Level

Activity	Annual Unit Cost (Rs. in lacs)	No. of units	Cost for one year (in lacs)	Procedure
1. Organization of sensitization of work shops	0.30	5	1.5	By DSU
2. Review meeting of District Committee	0.10	5	0.5	By DSU
3. Press advertisement	0.20	5	1.0	By calling 3 or more proposal from 3 news papers
4. Print Media (Pamphlets, brochures etc.)	0.20	5	1.0	By calling 3 or more proposal from 3 news papers
5. Other media incl. indigenous methods	0.20	5	1.0	Single source
TOTAL	**1.00**	**5**	**5.0**	

Summary of Expenditure (In Lacs)

The total estimated expenditure for 2008-09 will be Rs. 3385.84 lacs as summarised below:

Summary of Budget Proposal	One Time Expenditure (in Lacs)	Recurring Expenditure	Total Cost
		1 Year	
(i) Civil Work(renovation of labs and surveillance units):	17.56	-	17.56
(ii) Procurement of laboratory equipments:	74.70	-	74.70
(iii) Procurement of Computer Hardware & Accessories:	52.15	-	52.15
(iv) Procurement of Office Equipments:	13.80	-	13.80
(v) Procurement of Computer Software:	21.35	-	21.35
(vi) Furniture and Fixtures:	11.00	-	11.00
(vii) Material & Supplies for Laboratories:	-	8.29	8.29
(viii) Individual consultants / contractual personnel to be hired:			
A. District Surveillance Unit	-	2.88	2.88
B. State Surveillance Unit	-	6.00	6.00
(ix) Information, Education and Communication:			
A. Peripheral & District Level	-	5.00	5.00
B. State Level	10.00	10.00	20.00
(x) Cost for training courses under IDSP:	62.47	-	62.47
(xi) Cost of web enabled connectivity:			
Web enabled connectivity at district level	2.50	2.50	5.00
Web enabled connectivity at State level	0.50	0.50	1.00
(xii) Operational cost for implementing IDSP:			
Peripheral Level	-	5.70	5.70
District Level	-	6.50	6.50
State Level	-	3.50	3.50
TOTAL	**266.03**	**50.87**	**316.90**

6. NATIONAL IODINE DEFICIENCY DISORDERS CONTROL PROGRAMME

Iodine is an important micronutrient for the health of human beings. A lack of iodine in the diet can lead to iodine deficiency disorders, ranging from miscarriage, cretinism, retarded psychomotor development and goitre. Iodine deficiency is the single most important and preventable cause of mental retardation worldwide. Iodine deficiency leads to a much wider spectrum of disorders, commencing with the intrauterine life and extending through childhood to adult life.

In 1966 National Goitre Control Programme was launched in U.P. and surveys were undertaken. Out of 70 districts 44 districts are surveyed in a phased manner & 24 districts were found to be endemic. For effective control of IDD the Govt. took a decision to universalize iodization of all edible salt. Govt. of U.P. under PFA Act has banned entry of uniodised salt from 2nd Oct. 1987. In 1992 programme was renamed as National Iodine Deficiency Disorder Control Programme (NIDDCP).

NIDDCP focuses on the following

- Survey & resurvey to know IDD prevalence.
- Supply of only iodized salt for human consumption (salt having 15ppm Iodine at consumer level)
- Creating demand by consumers for iodized salt.

General Performance

Recent Surveys

- Total Districts in U.P. : 70
- Total Districts surveyed : 54
- Total Districts found endemic : 24 (Goitre rate above 10%)

Districts	Year	Goitre %
Kushinagar	2004-05	5.67
Balrampur	2004-05	0.59
Jhansi	2004-05	2.6
Gazipur	2005-06	awaited
Kanpur Dehat	2005-06	0.11
Sonbhadra	2005-06	awaited
Sant Ravidas Nagar	2005-06	0.18
Ballia	2006-07	6.6
Shravasti	2006-07	0.5
Jaunpur	2006-07	3.6
Faizabad	2006-07	0.4
Moradabad	2006-07	0.6
Pratapgarh	2006-07	0.3

Structure of NIDDCP

IDD Cell: This cell was established in the Nutrition Wing of state Health Institute, Lucknow in 1987. Additional Director, state Health Institute is the programme officer of NIDDCP in U.P. The Additional Director is working under the Director General, Medical & Health Services.

Main Activities of IDD Cell

- To monitor the supply and distribution of iodized salt in the state.
- Monitoring the complete ban on the sale of non-iodized salt.
- IEC activities implementation.
- To coordinate the IDD surveys conducted by various agencies of GoI, medical colleges.
- Training of PHC Lab. Tech. for estimation of iodine content in iodized salt.
- Receive salt samples collected from districts and analyze them quantitatively at state IDD Lab.
- Organize state, divisional and district level IDD workshops.
- Meeting of state coordination committee.
- Monitor the activities of district level coordination committee.

IDD Lab

The lab works under the IDD Cell and is manned by an LT & LA. Presently officers, lab technicians and staff of nutrition wing of SHI are working in IDD Cell & IDD Lab.

Goal

To bring down Total Goitre Rate (TGR) to less than 10%.

Objective

- To ensure 90% households consume iodized salt. (15ppm at consumer level)
- Supply of iodized salt through PDS.

Strategy

Supply & use of Iodized salt is an effective programme strategy in preventing Iodine deficiency. The work plan would simultaneously concentrate on increasing demand of iodized salt as well as supply of only iodized salt (preferably powdered packet salt). Creation of demand would be through multi-sectoral agencies such as anganwadi, medical health workers, panchayat members, school teachers & children, NGOs.

The district monitoring system is to be strengthened. The involvement of Public Distribution System (PDS) would also be advocated for ensuring supply through the network of fair price shops.

For the strategy, it is necessary to train and create awareness among the various health functionaries, ICDS functionaries, block officers, teachers, panchayat members and the beneficiaries.

Surveys would be conducted to assess the magnitude of the Iodine Deficiency Disorders. Resurvey after every 5 years to assess the extent of Iodine Deficiency Disorders. Laboratory testing of iodised salt would be continued.

Activities

1. Strengthening of IDD Cell

Presently staff of State Health Institute is working in this programme. For proper functioning of IDD Cell & IDD Lab. adequate staff is required. Post of Technical Officer, SA, LDC, LT & LA are to be filled during 2008-09. These posts are sanctioned on regular basis by GOI but are lying vacant. Contractual staff (Computer Operator-1, Data Analyser-1, Record Keeper-1, Driver-2, IVth Class-2) are also required in this programme.

2. Establishment & Maintenance of IDD lab

There is a provision to establish divisional level IDD labs. In 2008-09, it is proposed to establish 5 labs., one each at Gorakhpur, Agra, Meerut, Varanasi & Allahabad division. These Labs will test salt samples from the division & they will send the report to the HQ.

3. Survey

In 2008-09 surveys would be carried out in 10 districts. Resurvey in 5 districts - Agra, Pilibhit, Saharanpur, Sultanpur, Lakhimpur Khiri. New Survey in 5 districts - Kaushambi, Hamirpur, Mahoba, Barabanki, Baghpat. These surveys will be conducted by Medical Colleges in the State.

4. Health, Education & Publicity

IDD Day on 21st. Oct will be celebrated at the State HQ and in 24 endemic districts. IDD Day will be celebrated by involving schools. IEC activities are the main stay of the programme. It is proposed to print publicity material. It will be distributed and displayed at CHCs, PHCs, Anganwadi Centres, etc. Iodine in salt will be tested at the consumer level through rapid Salt Testing Kits (STKs). This is a very good tool for awareness creation & monitoring. STKs will be provided by GOI for testing of salt at field level

5. Monitoring of the Programme

Monitoring will be done through joint efforts of Medical & Health department, ICDS, Medical Colleges, PRI, NGOs. At village and district levels by MOIC, Supdt., CMO, Addl. CMO will be responsible. At division level monitoring will be done by AD

(Division). At state level the programme officer would monitor the programme. It would be reviewed time to time by the Mission Director.

6. Procurement

Rapid Salt Testing Kits for testing salt samples are required for monitoring the programme progress. Kits are proposed to be provided by GOI and will be distributed to grass root level workers of M&H, ICDS, PRI & NGOs. 70,000 kits (average 1000 kits per district) would be required.

Some IEC material will be supported by Unicef. Additional provision has also been made in the proposal for 2008-09.

Budgetary Estimate for 2008-09

Sl.	Activity	Amount (Rs. in lacs)
1	IDD Cell	6.00
2	Estab. & Maintenance of IDD Lab. at Division level ▪ Establishment of 5 labs @ Rs.50,000/- per lab. – Rs. 2.50 lacs ▪ Maintenance of Labs @ Rs.20,000/- per lab. – Rs. 1.00 lac	3.50
3	Survey @ Rs. 25,000/- per district for 10 districts (*New Survey* - Kaushambi, Hamirpur, Mahoba, Barabanki, Baghpat) (*Resurvey* - Agra, Pilibhit, Sultanpur, Saharanpur, Lakhimpur Khiri)	2.50
4	Health Education, Workshops & Training ▪ Division Level (3) – Rs. 75,000/- per division ▪ District Level (4) – Rs. 50,000/- per district ▪ IDD Day H.Q.(Lko.) – Rs. 50,000/- ▪ IDD Day in Endemic Districts (24) – Rs. 20,000/- per district ▪ Printing of publicity material (folders, pamphlets, stickers, etc.) - Rs. 2,45,000/-	12.00
Total Amount		**24.00**

During the year 2007-08 an amount of Rs. 5 lacs for implementation of activities was taken on loan basis from Mission flexipool. This loan amount of Rs.5 lacs will have to be repaid. The requirement is over and above the proposal of Rs.24 lacs.

7. NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF DEAFNESS

Over 50% of hearing impairments are preventable, including, hearing loss caused by infections of the ear (ASOM, CSOM), secretary otitis media, traumatic, rubella deafness, noise induced hearing loss and ototoxicity. 30% of deafness, though not preventable is treatable. Thus, a total of 80% of all deafness is avoidable by medical or surgical methods while other patients can be rehabilitated with the use of hearing aid, speech and hearing therapy. This strongly indicates the need to strengthen ear & hearing care services.

The common causes leading to all degrees of hearing loss are:

Sl.	Disease	% of population suffering
1.	Ear Wax	15.9%
2.	Chronic Supurative Otitis Media	5.2%
3.	Serous Otitis Media	3%
4.	Dry perforation	0.5%
5.	Congenital Deafness	0.2%
6.	Non infectious & other unknown causes (Presbyacusis, NIHL, Ototoxicity)	10.3%

7.1 General Information about the State

State Population – Projected 2008	1908.9 Lacs
Number of districts in the state	70
Urban population	360 Lacs
Tribal population	13 Lacs
Hilly population	14 Lacs
Other groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban, slums, etc.)	Approx. 12.0 Lacs

7.2 Objectives of the Programme

1. To prevent the avoidable hearing loss on account of disease or injury.
2. Early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness.
3. To medically rehabilitate persons of all groups, suffering with deafness.

4. To strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme, for persons with deafness.
5. To develop institutional capacity for ear care services by providing support for equipment and material and training personnel.

Long term objective: To prevent and control major causes of reversible hearing impairment and deafness, so as to reduce the total disease burden by 25% of the existing by the end of Eleventh Five Year Plan.

7.3 Summary of the Programme

The project was launched in two pilot districts, namely, Barabanki and Gorakhpur, in the year 2007-08.

Progress under Pilot Projects

- In the Ist phase ENT surgeons of respective districts were given training at CSSMU, Lucknow by experts of ENT department Lucknow and Govt. of India.
- Senior ENT surgeons of Barabanki & Gorakhpur are the District Nodal Officers for the pilot in their district.
- Paediatrician and Obstetrician of the district hospital and CHC, PHC were given one day training by CSMMU & ENT Surgeon of District and State Nodal Officers.
- ENT surgeon of Barabanki Gorakhpur are extending awareness campaign training to doctors, health worker, ASHA, NGOs, teachers of their respective district.
- Process of purchasing of ENT equipment and audiometry and basic constructed of sound proof treated room is in progress.
- Equipment for Barabanki and Gorakhpur CHC, PHC also in process.

Problem Areas

- Inconsistent results of surgery for hearing improvement in contrast with cataract surgery, which has more or less predictable results. The results of myringoplasty and tympanoplasty are highly operator dependant.
- For specialized surgery and regularly quality services ENT surgeons need to be trained at National Level Institute V.Y. Nayar Hospital Mumbai.
- Cochlear implants for recovering the deafness may also be required.
- State requires minimum two Centres of high excellence for updates surgery and training centre that is not available at present.
- Sufficient number of ENT surgeons for routine hospital services and ENT emergencies not available.
- Non-availability of qualified audiologists even at divisional headquarters hence outsourcing may be considered.

7.3 Plan for 2008-2009 (Extension Phase)

Six district hospital in the State have been identified for the expansion phase in the East, West, and Central regions :

1. Lucknow
2. Banda
3. Moradabad
4. Agra
5. Saharanpur
6. Varanasi

Strategy

1. Capacity building of District Hospital, Community Health Centre and Primary Health Centre.
2. Identification of potential District hospital/large hospital to provide preventive/screening/curative service on daily basis.
3. To provide above services there is need for
    a. Strengthening of district hospital in terms of equipment/instrument
    b. Soundproof room for audiometry
    c. Posting of manpower in adequate number (one ENT specialist and one Audiologist atleast at District level)
    d. Skill development of service provider and paramedics
    e. IEC for dissemination of information about availability of services/site/ importance etc.
4. Sensitization of service providers and paramedics PHN, MPW, CDPO, AS, ASHA, Teachers about of NPPCD through workshops/training
5. Awareness generation in community through NGO, VHC etc. through sensitization workshop with supported IEC support
6. Involvement of schools and ICDS for screening of children upto 14 years

Interventions

1. The existing health infrastructure would be utilized for the project. The District will be the nodal point for the actual implementation of the programme. The government and private doctors, as well as, audiologists will be involved. The District Hospital would be strengthened with the provision of equipment to enable diagnostic as well as therapeutic and rehabilitation exercises to be carried out here.

2. The Primary Health Centres and Community Health Centres will be involved. The doctors here will be given training as well as the basic diagnostic equipment, to enable them to diagnose, treat and refer the patients with hearing and ear diseases.

3. The MPWs and the grass root functionaries will be sensitized regarding the programme and their specific roles in the programme.

4. The school health system will play a very important role in the programme. The school teachers of the primary section would be required to conduct a survey based on a questionnaire for the primary children. Those found to be positive, will undergo an ear check up by the school health doctor who would have received training in this aspect. The school health doctors will be able to identify, treat and refer the children with ear and hearing problems.

5. BCC activities would be an important and essential part of the programme.

6. Training done in the first phase will be followed by screening and diagnosis in the second phase. Third phase will see the conduct of surgical camps and the provision of rehabilitative services as well as hearing aid provision.

7. The State Medical College would be the Centre of Excellence which will support the programme in the state with provision of expertise for training, as well as, patient care and referral.

8. One screening camp per month at District Hospital, CHC/PHC for early detection and control of deafness would be conducted by district nodal officer and local ENT surgeon. NGOs would be deployed as facilitators for this propose.

9. For audiometry and other proposes services of audiologist/ audiologist assistant would be on contractual basis.

10. In year 2008-2009 to develop institutional capacity for ear services same programme will be extended in other district where ENT surgeons are available.

11. Monitoring and review will be done periodically.

1. Expenditure for Activities in 6 New Proposed Districts for 2008-2009

a) Training of Paediatrician and Obstetrician of DH/CHC/PHC

S. No.	District	IEC Activities Training of Paediatrician and Obstetrician of DH/CHC/PHC	Total One Day Training
1.	Lucknow	50,000 @1225x16-CHC 725x20-DH	50,000.00
2.	Banda	50,000 @1225x16-CHC 725x20-DH	50,000.00
3.	Moradabad	30,000 @1225x16-CHC 725x10-DH	30,000.00
4.	Agra	30,000 @1225x16-CHC 725x10-DH	30,000.00
5.	Saharanpur	30,000 @1225x16-CHC 725x10-DH	30,000.00
6.	Varanasi SSPG	30,000 @1225x16-CHC 725x10-DH	30,000.00
Total			**220,000.00**

b) Expenditure One Day Training of Obstetrician and Paediatrician at District Hospital For 6 New Proposed District

S.No.	Activities		Cost	Total Cost
1.	TA+DA	Local Consultant	500x6	3,000.00
		Medical College Consultant	1500x6	9,000.00
2.	Honorarium	Local Consultant	1000x6	6,000.00
		Medical College Consultant	1500x6	9,000.00
3.	Photographic Record		300x6	1,800.00
4.	IEC Material (WHO Booklet)		225x300	67,500.00
5.	Flex Banner (2 Nos.)		600x6	3,600.00
Total				**99,900.00**

c) Screening Camp

Sl.	District	Screening Camp One camp per month	Total
1.	Lucknow	Doctor 1000 x 12 NGO 10,000 x 12	12,000.00 1,20,000.00
2.	Banda	Doctor 1000 x 12 NGO 10,000 x 12	12,000.00 1,20,000.00
3.	Moradabad	Doctor 1000 x 12 NGO 10,000 x 12	12,000.00 1,20,000.00
4.	Agra	Doctor 1000 x 12 NGO 10,000 x 12	12,000.00 1,20,000.00
5.	Saharanpur	Doctor 1000 x 12 NGO 10,000 x 12	12,000.00 1,20,000.00
6.	Varanasi SSPG	Doctor 1000 x 12 NGO 10,000 x 12	12,000.00 1,20,000.00
Total			**7,92,000.00**

d) Capacity Building CHC/PHC

S. No.	District	No. of Units	Rate per Unit	Total Amount (Rs.)
1.	Lucknow	44	Rs.10,000	4,40,000.00
2.	Banda	53	Rs.10,000	5,30,000.00
3.	Moradabad	60	Rs.10,000	6,00,000.00
4.	Agra	68	Rs.10,000	6,80,000.00
5.	Saharanpur	60	Rs.10,000	6,00,000.00
6.	Varanasi SSPG	48	Rs.10,000	4,80,000.00
Total				**33,30,000.00**

Summary of Expenditure for Activities in 6 New Proposed Districts for 2008-2009

Sl.	Activities	Costing
a.	IEC Activities Training of Paediatrician and Obstetrician of DH/CHC/PHC	2,20,000.00
b.	Audiovisual TA+DA, WHO Booklet for Paediatrician and Obstetrician Training	99,900.00
c.	Screening Camp	7,92,000.00
d.	Capacity Building CHC/PHC Staff	33,30,000.00
e.	Capacity Building District Hospital Staff (@Rs.9.5 lacs per district)	57,00,000.00
f.	Audiologist Salary (Rs.10,000/- pm x 12 months x 6 audiologists)	7,20,000.00
Total		**1,08,61,900.00**

2. Salary Expenses for Audiologist of existing pilot project district

Sl.	District	Audiologist Contractual	Total
1.	Barabanki	10,000x12	1,20,000.00
2.	Gorakhpur	10,000x12	1,20,000.00
Total			**2,40,000.00**

3. Expenses for District Nodal Officer

S. No.	Heads	Present status	Activities planned	Time Schedule	No. Required	Rate per Month	Costs (In Rupees)
1..	Telephone/Fax/ Internet Charges	Communication	NPPCD	2008-09	8	2000x12x8	1,82,000.00
2.	Mobility Fund	Monitoring of the programme	NPPCD	2008-09	8	2000x12x8	1,82,000.00
3.	Desk Top computer with UPS with 4in1 Fax Photocopier and Printer, Scanner	E-mail and Monitoring Programme	NPPCD	2008-09	8	50,000x8	4,00,000.00
4.	Contingency and Miscellanies	Programme	NPPCD	2008-09	8	500x12x8	48,000.00
Total							**8,12,000.00**

4. Budget for training of ENT Surgeons of Six New District at Medical College

S. No.	ENT Surgeons	Coasting of Five Days training - Material TA+DA +Food Honorarium	Total Cost
1.	15	60,000.00/Actual Cost	60,000.00/Actual Cost
2.	25	IEC Material WHO Booklet and CD 25x300	7,500.00
Total			**67,500.00**

5. Fund Required for Training of Doctors/PHN/MPH/CDPO, ASHA, Teachers Activities through NGO for year 2008-09

S.No.	District	Amount Required for One year 2008-2009	Total
1.	Lucknow	4,12,000.00	4,12,000.00
2.	Banda	4,12,000.00	4,12,000.00
3.	Agra	4,12,000.00	4,12,000.00
4.	Moradabad	4,12,000.00	4,12,000.00
5.	Saharanpur	4,12,000.00	4,12,000.00
6.	Varanasi	4,12,000.00	4,12,000.00
Total			**24,72,000.00**

6. Costing for Establishment office and Staff required For State Nodal Officer at Medical & Health Directorate

S.N.	Expected Outcome: Efficient functioning of State Nodal Officer April, 2008-09					
	State Nodal Officer Staff		Present Status	No	Cost per month	Cost 2008-09
1.	Administrative Officer-1	Administrative Officer-1	Nil	1	12100	1,45,200.00
2.	Data Entry Operator-1	Data Entry Operator-1	Nil	1	7150	85,800.00
3.	Epidemiologist-1	Epidemiology Work	Nil		7150	85,800.00
4.	Driver-1	Driver-1	Nil	1	3850	46,200.00
5.	Peon-1	Peon-1	Nil	1	3300	39,600.00
6.	TA/DA for SNO/ Epidemiologist	TA/DA for SNO/ Epidemiologist	Nil	1	10000	1,20,000.00
7.	Vehicle for day to day in touring activities	Study reliable long route convenience-Travera	Nil	1	5,75,000	5,75,000.00
8.	POL		Nil		-	50,000.00
9.	Office Furniture		Nil	-	-	1,00,000.00
10.	Office contingency		Nil	-	-	1,00,000.00
11.	Office Phone+ Internet		Nil		2,500	30,000.00
12.	Desktop Computer with UPS+4in1 Printer	HP-Pentium -4	Nil	1		50,000.00
13.	20CPM A3 Size Photocopier		Nil	1	-	1,25,000.00
14.	Lap Top Computer	HP Intel Duo core	Nil	1	-	60,000.00
15.	Mobile Phone to SNO	Mobile Phone to SNO	Nil	1	1000	12,000.00
16.	Miscellaneous		Nil		-	50,000.00
17.	Publicity work for all 8 district	Wall Painting (8'x3'), Hording(15'x8')/ Posters (2'x1.5')	Nil	8	2,5000	2,00,000.00
Total						**18,74,600.00**

Budget Summary for NPPCD Programme for 2008-09

Sl.	Activity	Total Cost (Rs. in lacs)
1.	For New Proposed District Hospital & CHC/PHC for capacity building, IEC and Audiologist salary	108.62
2.	Audiologist Salary for all Eight district including existing pilot project district Barabanki & Gorakhpur	2.40
3	For District Nodal Officer	8.12
4.	Training of ENT Surgeons at Medical College	0.675
5.	For NGO	24.72
6.	State Nodal Officer	18.746
Total		**163.28**

14. BUDGET SUMMARY (PARTS A to D)

(Rs. in Lacs)

Sl.	Scheme	GoI Allocation (2008-09)	State Proposal (2008-09)	GOUP Contribution
1	RCH	42800.00	51050.30	23520.00
2	Routine Immunization		4634.41	
3	NRHM Additionalities	37300.00	41930.90	
4	PPI	19300.00	19840.78	
Sub-total		99400.00	117456.39	
5	National Disease Control Programmes			
	RNTCP	4278.00	4455.61	
	NLEP	510.00	505.95	
	IDSP	226.00	316.90	
	NIDDCP	24.00	24.00	
	NPCB	2000.00	2299.30	
	NVBDCP	3183.00	3868.02	
	NPPCD	-	163.28	
Sub-total		10221.00	11633.06	23520.00
6	Funds through Treasury Mechanism	38300.00	38300.00	-
Total		*147921.00*	*167389.45*	*23520.00*

15. INTERSECTORAL CONVERGENCE (PART E)

Inter-sectoral coordination is a key strategy that can lead to cost-effective results and sustain them over the long run. Hence, if relevant sectors can work in close coordination with each other to bring about a common objective to be achieved, then outcomes can be achieved in a shorter span of time and in a cost-effective manner. Inter-sectoral coordination, especially between the Departments of Health, Department of, Women and Child Development, AYUSH, Panchayat Raj Department, Water & Sanitation, Education, is critical for increasing the coverage of the health programmes and improving implementation.

Many of the programme components have been designed with the clear understanding that they will be implemented in close convergence and coordination with other departments and agencies within the State and outside that are working in the same area.

15.1 Mainstreaming of AYUSH :

Mainstreaming of AYUSH is one of the key strategies under the National Rural Health Mission (NRHM) under which it is envisaged that all PHCs/CHCs would be provided AYUSH facilities under the same roof. It is proposed to position AYUSH practitioners at PHCs, arranged either by relocation of AYUSH doctors from existing dispensaries or from contractual hiring of AYUSH doctors.

AYUSH lady medical officers and General Nursing Midwives are also being deployed at the PHCs to promote institutional deliveries. A pilot was implemented in 20 districts in phased manner over the past two years and was found to be successful. It is now proposed to scale the same in the entire State. Training modules have been prepared and these practitioners are imparted training before deployment.

Further, financial support will be sought from AYUSH department for providing physical infrastructure at PHCs for AYUSH practitioners wherever adequate space is not available. Process of identification of facilities has been initiated. It is proposed to ensure provisioning of space and infrastructure at 1000 PHCs.

15.2 Convergence with Department of Women & Child Development:

The Departments of Health & Family Welfare is closely working at the village level through the Anganwadi system to bring about better nutrition outcomes of women, children and adolescents in the villages through ICDS. Better nutrition and reduction in anaemia can have a direct impact on the pregnancy related complications, reduce maternal mortality and infant & child mortality and can bring about better health outcomes.

Convergence of services with the Department of Women and Child Development include involvement of the anganwadi workers in identification of pregnant women, weighing babies as soon as possible after delivery, improving the coverage of Vitamin A in children and in improving the compliance of IFA among pregnant women, identification of undernourished pregnant women and lactating mothers and pre-school children to ensure they get priority in food supplementation programs under the ICDS and appropriate health care from the ANMs and doctors, etc.

Village Health and Nutrition Days are being organized on every Saturdays at Anganwadi Centre in the State. Department of Health and Department of Women & Child Development have initiated actions for facilitating the activity by fixing roles and responsibilities of all the three grass root level functionaries (ANM AWW and ASHA).

The objective of organizing this VHND is to provide impetus to the efforts towards increasing early registration, ANC checkups, institutional deliveries, counselling on Infant & Young Child feeding (IYCF), Family Planning, Immunization, Counselling on Nutrition, Safe drinking water, Sanitation, etc.

15.3 Convergence with Panchayti Raj Department:

Government Orders have been issued for convergence between Health and PRI, to ensure well coordinated implementation of NRHM.

Village Health and Sanitation Committees comprising members from the community and some of the prominent persons like school teacher, ANM, Anganwadi worker, ASHA etc. will be developing a holistic plan for a village covering health, sanitation and other relevant health related aspects.

This will not only help them in planning and organizing things in a more realistic manner but will also help them in facilitating the identification of the problems, priorities, possible solutions, and implementation and obviously to plan out the budget and expenditure processes. Under NRHM these VHSCs are supposed to receive an untied fund of Rs.10,000/- for such activities.

15.4 Convergence with Development Partners:

A number of international agencies and reputed NGOs are working in the State. Their active role is envisaged in implementation of NRHM. Brief details of working of the agencies are provided below:

a) Uttar Pradesh Health System Development Project (UPHSDP)

The first phase of the UP Health Systems Development Project (UPHSDP) commenced on 26th July, 2000. It was launched in 28 districts and covered 110

facilities with the chief goal of improving the overall health care delivery system in the State. The Project Development Objective was enunciated as –

"To establish a well managed health system in Uttar Pradesh which delivers more effective services through policy reform, institutional and human resource development, and investment in health services."

The Project made a significant contribution towards improving the utilization of health facilities in the State. It implemented several systems and training programs, including the development of Quality Circles, improving the FMS, PIS and HMIS, and NGO contracting in rural areas. These impacted in a positive manner the efficiency and quality of health services delivery in the State. The Project also succeeded in drawing the attention of policy makers towards a number of salient policy issues that need to be addressed in the State.

The first phase was followed by a two year extension. During this extension phase, apart from implementing district innovative strategies, it was planned to continue those project activities that had been found to have been making a significant positive impact on the efficiency and quality of health services delivery in the State.

It is further proposed to launch the expansion phase of the World Bank assisted Uttar Pradesh Health Systems Development Project (2008-2012). The expansion phase (UPHSDP-2) would have a pro-poor and equity focus as its underlying philosophy and it would strive to provide a renewed thrust to the existing health system in the State, in order to meet the goals of NRHM as well as the MDGs 4, 5, and 6 related to child health, maternal health and prevention of infectious/communicable diseases respectively.

b) State Innovations in Family Planning Services Agency (SIFPSA)

The Innovations in Family Planning Services (IFPS) Project was designed to serve as a catalyst for the Government of India in reorienting and revitalizing the country's family planning services. In light of this thinking the IFPS Project Agreement came into being as a joint endeavour of Government of India and USAID on 30th September, 1992. The project structure envisaged that all activities would be implemented by a registered society, 'State Innovations in Family Planning Services Project Agency' (SIFPSA).

The IFPS Project has been a large and complex project with elements of services, training, logistics, contraceptive marketing and research & evaluation. However, the four major components are:-

- Public sector activities
- NGO based activities
- Contraceptive social marketing programme
- Research & evaluation activities related to key strategic and programmatic areas

SIFPSA has also been nominated as Regional Resource Centre under the MNGO Programme, which is also a part of RCH-II Programme. Hence, their expertise will be utilized in all the fields as required

c) UNICEF & Other Agencies

UNICEF is providing technical support in various areas which includes:

- Support in implementation of RI activities and biannual Vitamin A supplementation
- Social mobilization to create awareness.
- Effective supervision by providing mobility support
- ANM training regarding use of AD syringes and supply of AD syringes
- Establishment of technical support units at division level
- Medical officers training regarding Routine Immunization
- Cold Chain support in terms of repair of cold chain equipments all over state.

Other agencies such as, WHO, CARE, PATH – Sure Start Project, AED-A2Z, IntraHealth – Vistaar Project and some reputed NGOs are supporting the State in various areas of health, such as, pulse polio programme, micronutrient supplementation, community mobilization, evidence reviews, demonstration & learning projects, advocacy and capacity building.

A development partners group has been constituted which meets at regular intervals and due convergence is being ensured between the partners.

15.4 Convergence with Education Department:

A school health programme is proposed to be implemented in the State for which due coordination will be established with the education department at State, district and block levels. Participation of concerned education department functionaries would be ensured before finalising school related activities.

15.5 Convergence with AIDS Control Programme:

Due convergence is being maintained with the AIDS Control programme in the State. SACO is ensuring provision of blood storage units at FRUs (CHCs). It is also proposed to establish referral linkages for counselling of adolescents and testing for suspected cases.

15.6 Institutional Arrangements for Convergence at the District Level:

Convergence in program implementation at the district level is also envisaged. The District Magistrate is the chairperson of the District Mission that is entrusted with monitoring and review of the various interventions being implemented. District Action Plans have been prepared in a consultative manner which shall help in achieving the required convergence in program implementation at the district level.