STATE ACTION PLAN
UTTAR PRADESH

FINAL

2010 - 2011

National Rural Health Mission

Department of Family Welfare, Uttar Pradesh

Preface

The year 2009-10 has seen a paradigm shift in the Health and Family Welfare sector in Uttar Pradesh. The initiatives of NRHM have been fully integrated with the day-to-day working of the Medical and Family Welfare Departments. This year the PIP of 2010-11 is the result of a participative effort of the state doctors from almost all districts. The State Government has brought in a special focus on this sector with major recruitment drives and incentives to doctors.

There has been a significant rise in institutional deliveries from 1.68 lacs in the year 2006-07 to 15.63 lacs in the year 2008-09 and institutional deliveries have already crossed 15.23 lacs upto December 2009 against a target of 18 lacs in the year 2009-10. Rural Uttar Pradesh is now developing a culture of getting young pregnant mothers to institutions for delivery.

A major area of concern remains the high rates of IMR/MMR. Uttar Pradesh has done a detailed analysis of IMR/ MMR with a special focus on neonatal deaths and these strategies have been incorporated in the PIP, specifically addressing the neonatal deaths in the community and at the facilities. One important fact of that has emerged is the prevalence of practices which are detrimental to neo-natal health care and a concentrated IEC programme appears necessary to compliment state efforts. This component includes immediate care after birth, home based new born care and facility based new born care. Establishment of new born care corners at all 24x7 units, neonatal intensive care units (NICU) at FRUs and sick new born care units (SNCU) at designated District Women's Hospitals is being undertaken.

Related to immunization, the State has had a DLHS level of 30 percent fully immunized children which is the lowest in the country. A specific programme for spreading awareness of immunization and ensuring a genuine 90 percent level of immunization is being detailed out and incorporated in the PIP. This has evolved with active participation of district level doctors with important inputs from the GOI team lead by Dr. Padmanabhan.

The State has responded to a felt need of more supportive supervision of ANMs by introducing a tier between the PHC and ANM, of trained ISM doctors, who will be supervising the ANM and their activities and targets on a full time basis.

The State has looked at initiatives undertaken in other states like the SNCUs, NRCs and MMUs and has also incorporated these in the PIP. A major thrust in the PIP has been the development of district level plans and the encouragement to the districts to propose specific area interventions. After a series of workshops, many of these proposals have been selected and have been included as a new innovations section.

The State Government has continued with its proposals which were included as an amendment of the PIP 2009-10 that is

a. Upgradation of district hospitals should take place for all old hospitals of the state;
b. Funds for repair are not needed under NRHM since these are provided as Non Planned Budget of the State.
c. MMUs in a Block do not replace a PHC but can only supplement the facilities being provided by a PHC by providing two doctors, once a week, at six designated places in the Block, which are not being served effectively by the CHCs/PHCs.

The PIP for 2010-11 of Uttar Pradesh is also distinctive because of the thrust of training and a comprehensive program for training is included in the proposal.

We are sure that these programmes and innovations of National Rural Health Mission will provide the much needed impetus to the Health Sector in the State leading to better health for all, especially the vulnerable population.

Pradeep Shukla
Principal Secretary, Medical Health and Family Welfare
Government of Uttar Pradesh

Preface

The State of Uttar Pradesh has seen a major shift in Medical Health& Family Welfare services under NRHM with the State Government going in for major structural changes. To begin with the State has implemented the recommendations of the 6th Pay Commission giving the benefit of salary at par with the Center to all doctors for the first time. There have been over 3,000 promotions of doctors this year. 682 doctors were recruited in 2009-10 and the Uttar Pradesh Public Service Commission is recruiting another 5014 doctors to fill the vacancies in the cadre. In PPP model; 292 MBBS doctors and 74 Specialists are working on contractual basis under RCH programme. About 628 ISM lady doctors and 284 male ISM doctors are deployed under AYUSH in the RCH programme.

For the first time internal assessment has been done for MMR, IMR, and polio cases occurring in the State and we have gone into details to analyse the reasons for high death rates. For MMR/IMR, in spite of rigorous training of ASHAs, there are many socio-cultural traditions which are detrimental for IMR /MMR in the State. Therefore the PIP for the year 2010-11 includes specific action points focusing on reducing IMR and MMR together with a detailed and comprehensive IEC strategy.

The most spectacular performance has been the rise in the institutional deliveries. With the launch of JSY these have gone up from 1.68 lacs in the year 2006-07 to 15.63 lacs in the year 2008-09 and 15.23 lacs upto December 2009 against a target of 18 lacs in the year 2009-10. Rural Uttar Pradesh is developing a culture of getting young pregnant women to the institutions for delivery. IEC interventions are proposed focused on the importance of institutional deliveries for the safety of mother and baby so that under JSY the community is motivated to bring the mothers to the facilities.The Department has also planned an extensive process of micro management to address the client load.

Specific incentive based program have been incorporated in the PIP after many rounds of discussions and interaction with district service providers and State officials.

DLHS shows 30% immunization coverage in UP which is lowest in the country. There is a need of a specific focused scheme (as per JSY model) It is being proposed that there should be some incentive for each of the 5 rounds of RI. This proposal has come after intensive interaction with district service providers (doctors and field officers) . This will help in increasing immunization coverage upto 90%.

The purchase and availability of medicines has been put on the internet in each districts. Department has, for the first time, come up with clinical targets and procedures to be established in all 71 districts, planning norms for minimal clinical achievements. Accordingly districts have been divided into three categories on the basis of clinical criteria.

The State has responded to a felt need of more supportive supervision of LHVs /ANMs by introducing a tier between the PHC and ANM, of trained ISM doctors, who will be supervising the ANM and their activities /targets on a full time basis.

The PIP for 2010-11 of Uttar Pradesh is also distinctive because of the thrust of training. Tapping the enthusiasm of doctors during DAP meetings a comprehensive training program has been included in the proposal. We are thankful to the valuable suggestions of Dr.Padmanabhan. His untiring efforts have enhanced our DAPs proposals . Training of 1000 doctors is planned to expose them to current medical education(CMEs) and to enable them to implement best clinical practices.

The State is proposing a new thrust with a new look at its existing feature and more participation of male family members.The Departments are also planning to make the procurement process fully transparent.The Departments have approached experts like Mr.T.V.Anthony and Mr. Purnalingam to provide guidance under NRHM.We are sure that these programmes and innovations under NRHM will provide much needed impetus to the medical infrastructures and systems in the State leading to better health for all, especially the vulnerable populations.

Dr. C.B Prasad
Director general,
Directorate of Family Welfare
Uttar Pradesh.

Dr. R.R Bharti
Director general,
Directorate of Medical and Health,
Uttar Pradesh.

ABBREVIATIONS

AMG	Annual Maintenance Grant
ABER	Annual Blood Examination Rate
ANM	Auxiliary Nurse and Midwife
ANMTC	ANM Training Centres
ANC	Ante-Natal Care
ACMO	Additional Chief Medical officer
ASHA	Accredited Social Health Activist
APHC	Additional Primary Health Centre
ARSH	Adolescent Reproductive and Sexual Health
ARI	Acute Respiratory Infections
AWC	Aanganwari Centre
AWW	Aanganwari Worker
AYUSH	Ayurveda Unani Siddha and Homoeopath
AES/JE	Acute Encephalitis Syndrome
API	Annual Parasite incidence
AFB	Acid Fast bacilli
ACSM	Advocacy, Communication and Social Mobilization
AIR	All India Radio
ASOM	Acute Suppurative Otitis Media
ARSH	Adolescent Friendly Reproductive and Sexual Health services
BCC	Behaviour Change Communication
BPHC	Block Primary Health Centre
BPL	Below Poverty Line
BHW	Block Health Worker
BSPM	Bal Swasthya Evam Poshan Mah
BEO	Block Education Officer
CBR	Crude Birth Rate
CCSM	Child Survival and Safe Motherhood program
CSMMU	Chhatrapati Sahuji Maharaj Medical University
CDR	Crude Death Rate
CHC	Community Health Centre
CCSP	Comprehensive Child Survival Programme
CEmOC	Comprehensive Emergency Obstetrics Care
CMO	Chief Medical Officer
CMS	Chief Medical Superintendent
CRM	Common Review Mission
CTI	Collaborating Training Institute
CUG	Closed User Group
CTFs	Combined Treatment Facilities
CME	Continuous Medical Education
CSOM	Chronic Suppurative Otitis Media
CDPO	Child Development Project Officer
CBO	Community Based Organisations

DAP	District Action Plan
DDK	Disposable Delivery Kit
DLHS	District Level Health Survey
DALYs	Disability-adjusted life Year
DIO	District Immunisation Officer
DHEIO	District Health Education Officers
DHM	District Hospital Male
DPO	District Program Officer
DHAP	District Health Action Plan
DHF	District Hospital Female
DCH	Diploma in Child Health
DCM	District Community Mobiliser
DH	District Hospital
DPMU	District Project Management Unit
DPTT	District Peripheral Training ----------
DOTS	Directly Observed Treatment Shortcourse
DWH	District Women Hospital
DDT	Di-chloro di phenyl trichloro ethene
DBS	District Blindness Society
DTO	District Tuberculosis Officer
DOT	Directly Observed Treatment
DMC	District Microscopy Centre
DRS	Drug Resistance Surveillance
DTC	District Tuberculosis Centre
DOTS	Direct Observed Therapy Short-Term
DLO	District Leprosy Officer
DPMR	Disability Prevention and Medical Rehablitation
DLO	District Leprosy Officer
DEO	District Education officer
DSU	District Surveillance Unit
DSO	District Surveillance Officer
DMHP	District mental Health Programme
DCTC	Divisional Clinical Training Centres
ECPs	Emergency Contraceptive Pills
EMTS	Emergency Medical Transport Services
EmOC	Emergency Obstetric Care
EQA	External Quality Assurance Protocol
EDC	Eye Donation Camps
ELISA	Enzyme-Linked Immunosorbent Assay
ENT	Ear Nose Throat
FBNC	Facility Based Newborn Care
FAQs	Frequently Asked Questions
FFHC	Family Friendly Hospital Certification
FFH	Family Friendly Hospital
FP	Family Planning
FW	Family Welfare
FWC	Family Welfare Counselor

FRU	First Referral Unit
FOGSI	Federation of obstetricians and Gynecologists Societies of India
FTK	Field Testing Kits
FCTC	Framework Convention on Tobacco Control
FHI	Family Health International
GOI	Government of India
GoUP	Government of Uttar Pradesh
GIA	Grant In Aid
HRG	High Risk Groups
HS	Health supervisor
HIS	Health Information System
HE	Health Education
ICDS	Integrated Child Development Scheme
IDSP	Integrated Disease surveillance Programme
IDA	Iron deficiency Anaemia
IDD	Iodine Deficiency Disorder
IEC	Information Education Communication
IFA	Iron and Folic Acid
IMR	Infant Mortality Rate
IMEP	Infection Management Environmental Protection
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IIPS	International Institute for Population Sciences
ISM	Indian System of Medicines
IPHS	Indian Public Health Standards
IUD	Intra Uterine Device
ITAP	Innovations in Technical assistance Project
IYCF	Infant &Young Child Feeding
IYCFP	Infant &Young Child Feeding Practices
IDSP	Integrated Disease Surveillance Project
ITN	Insecticide Treated Nets
IRS	Indoor Residual Spray
IRL	Intermediate reference Laboratory
ISTC	International Standard of TB Care
IMA	Indian Medical Association
IOL	Intra Ocular Lenses
ITAP	Innovations in Family Planning Services Technical Assistance Agency
IRH	Institute for Reproductive Health
JSY	Janani Suraksha Yojana
JE	Japanese Encephalitis
LA	Local Anaesthesia
LSAS	Life Saving Anesthesia Skill Training
LBW	Low Birth Weight
LHV	Local Health Visitor
LMO	Lady Medical Officer
MBBS	Bachelor of Medicine Bachelor of Surgery
MDR	Maternal Death Review
MH	Medical Health

MIES	Management Information and Evaluation System
MMR	Maternal Mortality Rate
MMU	Medical Mobile Unit
MNGO	Mother Non Government Organization
MOIC	Medical Officer In-Charge
MO	Medical Officer
MOCH	Medical officer Child Health
MPW	Multi purpose worker
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
MDA	Multi drug Administration
MNCH	Maternal, Newborn and Child Health
NBCP	National Blindness Control Program
NBCC	New Born Care Corner
NICU	Neonatal Intensive Care Unit
NABH	National Accreditation Board for Hospitals
NFHS	National family Health Survey
NHSRC	National Health System Resource Center
NIDDP	National Iodine Deficiency disorder Control Programme
NNACP	National Nutritional Anaemia Control Programme
NIHFW	National Institute of Health and Family Welfare
NGO	Non Government Organization
NMR	Neonatal Mortality Rate
NSSK	Navjat Shishu Suraksha Karyakram
NRHM	National Rural Health Mission
NRC	Nutritional Rehabilitation Centre
NSV	No Scalpel Vasectomy
NUHM	National Urban Health Mission
NVBDCP	National vector Borne Disease Control Program
NSP	New Sputum Positive
NTF	National Tuberculosis Force
NPCB	National Programme for Control of Blindness
NIV	National Institute of Virology
NICD	National Institute of Control of disease
NIDDCP	National Iodine Deficiency Disorder Control Programme
NTCP	National Tobacco Control Programme
NSV	Non Scalpel Vasectomy
OCP	Oral Contraceptive Pills
ORS	Oral Rehydration Solution
OPD	Out Patient Department
OT	Operation Theatre
PCPNDT	Pre Conception Pre Natal Detection Technique
PHN	Public Health Nurses
PHFI	Public Health Foundation of India
PIP	Project Implementation Plan
PPP	Public Private Partnership
PPH	Postpartum Hemorrhage

PMU	Project Management Unit
PNC	Post Natal Care
PRI	Panchayati Raj Instituitions
PROMIS	OPERATIONALISATION OF PROCUREMENT AND HEALTH MIS
Pf	Plasmodium falciparum
PWBs	Patient Wise Boxes
PP	Private Practitioners
PSU	Private Sector Units
PCR	Polymerase Chain Reaction
PMOA	Para medical ophthalmic assistant
PDO	Project Development Objectives
PRI	Panchayti Raj Institutions
QAC	Quality Assurance Committee
RCH	Reproductive and Child Health
RI	Routine Immunization
RKS	Rogi Kalyan Samiti
RHFWTC	Regional Health and Family Welfare Training Centres
RSBY	Rashtriya Swasthya Bima Yojana
RTI	Reproductive Track Infection
RNTCP	Revised National Tuberculosis Control Programme
SACH	Scheme for Adolescent Counseling for Health
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendent
SHRC	State Health Resource Centre
SHP	School Health Program
SRS	Sample Registration System
SIHFW	State Institute of Health and Family Welfare
SIFPSA	State Innovations in family Planning Projects Agency
SNCU	Sick Neonatal Care Unit
SSKY	Saloni Swastha Kishori Yojana
SPMU	State Programme Management Unit
STI	Sexually Transmitted Infection
SPR	Slide Positivity rate
SFR	Slide falciparum Rate
STLS	Senior TB Laboratory Supervisor
STS	Senior Treatment Supervisor
STF	State Task Force
SDS	State Drug Store
SLO	State Leprosy Officer
SSU	State surveillance Unit
SHS	Second Hand Smoke
SHG	Self Help Groups
SHP	School health Programme
SSKY	Saloni Swasthya Kishori Yojna
STI	Sexually Transmitted Infection
STD	Sexually Transmitted diseases
TBA	Traditional Birth Attendent

TBHV	Tuberculosis Health Visitor
TEN	Tracking Every Newborn
TFR	Total fertility Rate
TGR	Total Goitre Rate
ToT	Training of Trainers
TO	Tuberculosis Officer
TU	Tuberculosis Units
TRG	Total Goiter Rate
UNOPS	United Nations Office for Project Services
UPSACS	Uttar Pradesh State AIDS Control Society
UPHSDP	Uttar Pradesh Health System Development Project
UHP	Urban Health Post
UT	Union Terretories
UPSACS	Uttar Pradesh State AIDS Control Society
UHI	Urban health Initiative
VAD	Vitamin A Deficiency
VAS	vitamin A supplements
VHSC	Village Health and Sanitation Committee
VHND	Village Health and Nutrition Day
VHIR	Village Health Index Register
VHSC	Village Health and Sanitation Committee
WHO	World Health Organization
ZTF	Zonal Task Force

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CONTENTS

UTTAR PRADESH - A PROFILE

Socio-Demographic Profile

Uttar Pradesh with a population of 166 million that accounts approximately 16 percent of the country's population is the most populous state in India (Registrar General of India, 2001). The decadal growth rate of the state was 25.85 during 1991-2001 as against the country growth rate of 21.54. The projected current population of the state is 197 million (Registrar General of India, 2009-10). Geographically with an area of 0.24 million sq. kms, the state accounts for approximately 7 percent of the total landmass of the country. The state is divided into four distinct regions on the basis of homogeneity, contiguity and economic criteria for the purpose of better planning and development. These regions are - Western, Central, Eastern and Bundelkhand. These regions are further subdivided in 18 divisions and 71 districts. The districts are divided into tehsils (311) and developmental blocks (820).

As per Census 2001, the population density (per square kilometre) in the state has increased from 548 in 1991 to 689 in 2001. The population density is very high in the Eastern and Western regions and very low in Bundelkhand region. More than one-fifth of the people (21 percent) come under Scheduled Caste category and less than one percent (0.10 percent) is Scheduled Tribes. Furthermore, Hindus constitute about 80 percent of the state's population. According to Census 2001, the literacy rate in the state (57 percent) is lower than national figure (67 percent). In the state, the male and female literacy rate is about 70 percent and 43 percent, which is lower than the national average (75 percent for males and 54 percent for females). Also, there exists wide variation among those urban and rural inhabitants as far as literacy rate is concerned. Seventy percent of the urban people are literates as compared to 53 percent of their rural counterparts. The variations in the literacy rate imply high inequality in terms of access to education by sex and place of residence. The sex ratio as well as child sex ratio (0-6 age group) of the state is 898 and 916, which is much below the corresponding national figures of 933 and 927, indicating the prevailing gender norms in the state.

Socio-Demographic Profile of Uttar Pradesh vis-à-vis India		
Indicators	**Uttar Pradesh**	**India**
Population (in millions)	**166**	**1028**
Decadal growth rate	**25.85**	**21.54**
Population Density	**689**	**324**
Sex Ratio	**898**	**933**
Child Sex Ratio	**916**	**927**
Literacy Rate (Male)	**70.2**	**75.3**
Literacy Rate (Female)	**42.9**	**53.7**
Scheduled Caste	**21.1**	**16.2**
Scheduled Tribe	**0.1**	**8.2**
Percent Hindus	**80.6**	**80.5**
Percent Muslim	**18.5**	**13.5**

Source: Registrar General of India, 2001.Census of India 2001

Rural Scenario

As per the 2001 census, there are 107,452 villages in the state, 97,942 of which are inhabited. Approximately 27 percent villages in the state had a population of less than 500 and another 26 percent villages had population in the range of 500-999. The average population per village in the state is only 1,344. A large number of small villages scattered all over the state is a major obstacle to development of infrastructure facilities and development sector-related service delivery. Moreover eight out of every 10 people in the state live in rural areas. However, districts like Lucknow, Ghaziabad, Meerut, Agra and Kanpur have relatively large urban populations.

Urbanization and Urban Health

Uttar Pradesh has undergone rapid urbanization over the past fifty years. Census 2001 states that nearly 34 million people that accounts almost one-fifth of the population, reside in urban areas. The corresponding figure in 1951 was merely 8 million accounting 13.7 percent of the population. During the same period, number of Urban Agglomeration and towns has increased from 410 to 670.

Trends of Urbanization

Census Year	Urban Population	Percent of Urban Population	No. of UA and towns	Decadal growth Rate
1951	8225068	13.65	410	21.86
1961	8983900	12.81	215	9.23
1971	11653740	13.90	256	29.72
1981	18749979	17.83	598	60.89
1991	25971891	19.68	631	38.52
2001	34512624	20.78	670	32.88

Less than 17 percent birth among urban poor takes place in any health facilities in the State. Only 15 percent children in urban poor were completely immunized. Nearly half the children are underweight among urban poor and infant mortality rate is around 86 per thousand live births which is quite high with respect to U.P (73 percent). Whether this is due to an individual reason or is a combination of lack of information, accessibility to services and general unawareness remains to be evaluated.

Factors further affecting the health of the urban poor are issues related to water and sanitation. Only one in ten urban poor households have access to piped water supply at home and nearly half of urban poor households do not have access to toilets.

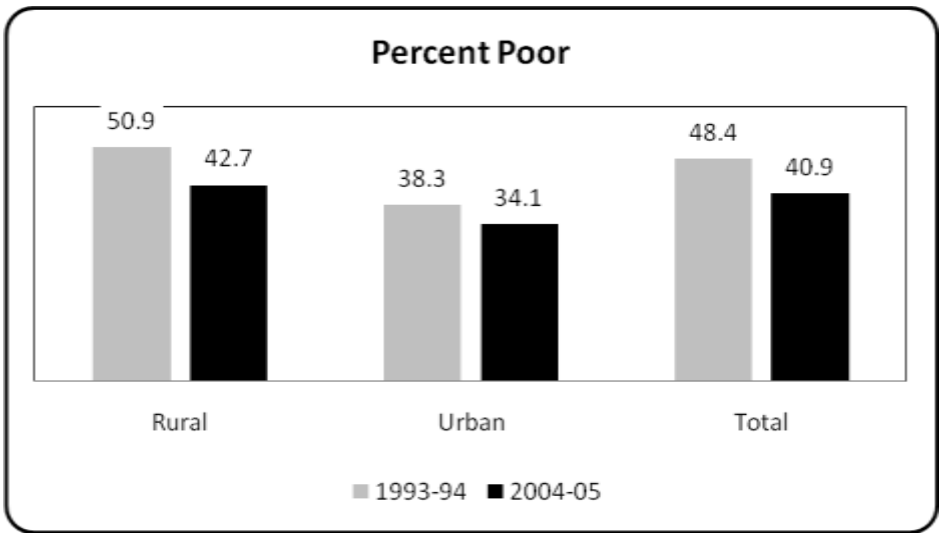
Key Indicators for Urban Poor					
Indicators (in percent)	**Urban Poor**	**Urban Non Poor**	**Overall Urban**	**Overall Rural**	**State Total**
Births in health facilities	**16.7**	**52.3**	**39.5**	**15.8**	**20.6**
Family Planning by any modern method	**24.4**	**49.4**	**42.4**	**25.3**	**29.3**
Children completely immunized	**15.3**	**42.9**	**33.0**	**20.8**	**23.0**
Children who are underweight	**48.5**	**27.1**	**34.9**	**44.1**	**42.4**
Neonatal Mortality	**50.0**	**35.5**	**40.7**	**49.4**	**47.6**
Infant Mortality	**86.2**	**51.9**	**64.2**	**74.8**	**72.7**
Under 5 Mortality	**110.1**	**66.1**	**82.4**	**100.0**	**96.4**
Households with access to piped water supply at home	**11.5**	**40.9**	**32.2**	**1.2**	**9.0**
Women who had at least one contact with a health worker in the last three months	13.6	6.4	8.2	18.5	15.9

Source: NFHS-III (2005-06)

Increasing urbanization, among other factors, tends to put pressure on the health services delivered in the catchment area leading to poor services.

Poverty

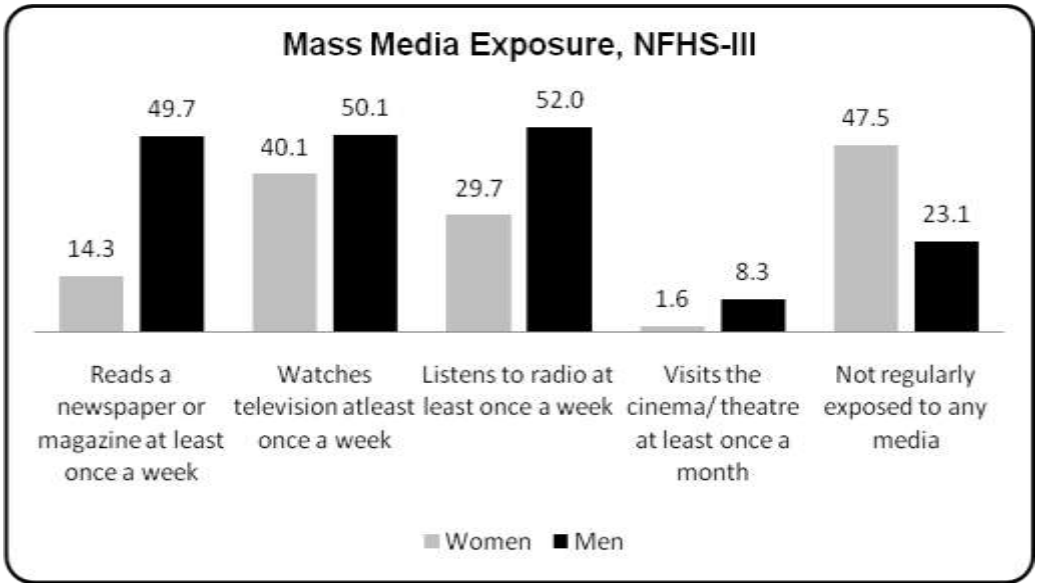
According to the Planning Commission (2009), Uttar Pradesh is the 6th poorest state of India. Nearly 40.9 percent of the people in the state were poor in 2004-05 compared to 48.4 percent in 1993-94; a change of 7.5 percent during 11 years. Moreover, there exist wide rural-urban differences in the percentage of poor; 42.7 percent in rural area as against 34.1 percent in urban area.



Additionally, NFHS-3 reveals that a quarter of the population in the state is in the lowest wealth quintile and only 14 percent of the population is in the highest wealth quintile.

Agriculture is the primary occupation of the people in the state. Again, only 17 percent of the women in the state are working as against 47 percent of the men (RGI, 2001).

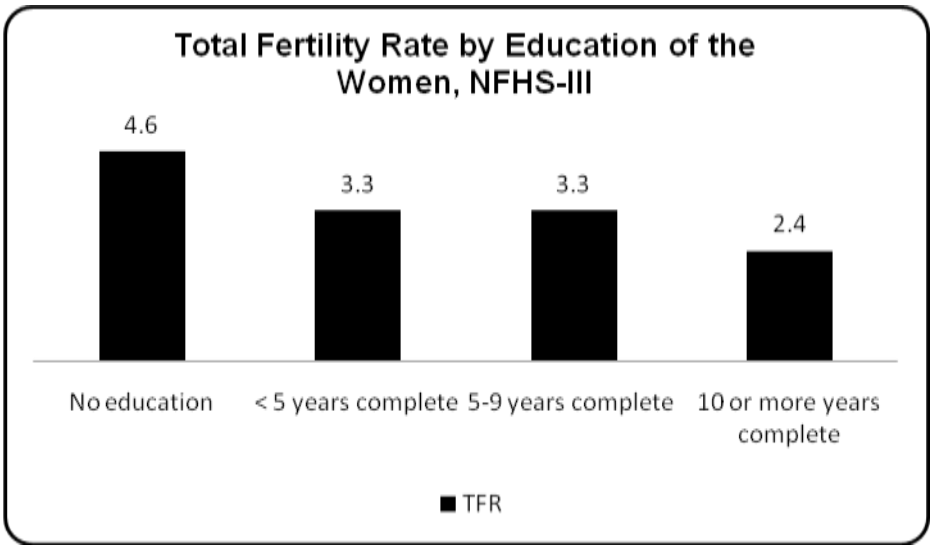
Mass Media Exposure



NFHS -3 divulges that 14 percent of the women aged 15-49 years compared to 50 percent of the men in the same age group in Uttar Pradesh read newspaper or magazine at least once a week. Additionally, four out of every 10 women and five out of every 10 men watch television at least once a week. Further 30 percent and 52 percent respectively of the women and men listen to radio at least once a week. Exposure to cinema/ theatre is very minimal in the state. As may be seen only two percent of the women and eight percent of the men visit the cinema/ theatre at least once a month. However, nearly half of the women and more than a fifth of the men aged 15-49 are not regularly exposed to any media.

Fertility and Mortality

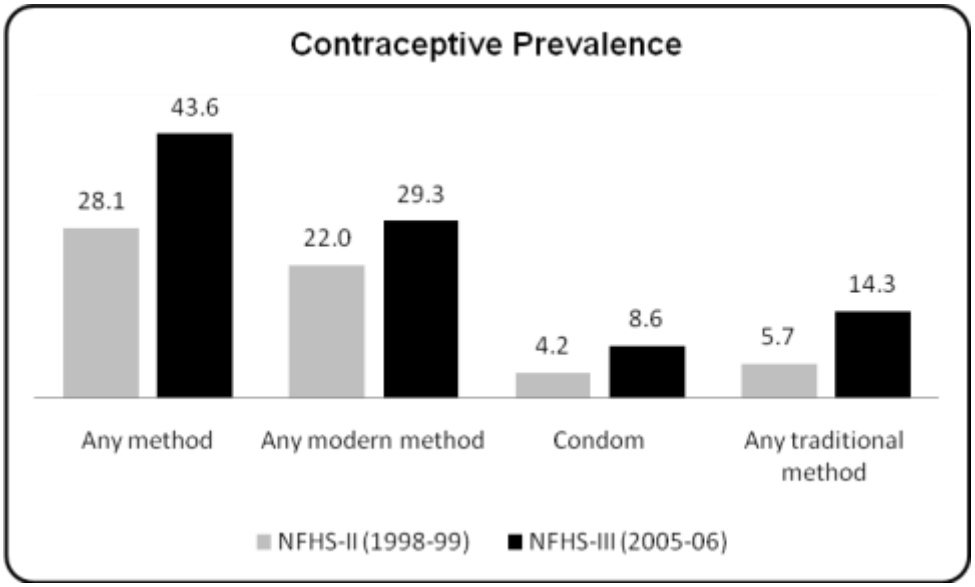
Age at marriage is considered as an important proximate determinant of fertility. As per DLHS-3 (2007-08), the mean age at marriage for boys is 22 years as against 18 years for the girls in the state. The crude birth rate (CBR) was 44.9 in 1971 and steadily declined to 29.5 in 2007. In rural areas, the CBR declined from 46.3 in 1971 to 30.5 in 2007, and in urban areas from 34.7 in 1971 to 25.5 in 2007 (SRS). The total fertility rate (TFR) has been estimated to be 3.8 (NFHS-3); much higher than the national figure of 2.7. There are substantial rural-urban differences with regard to the TFR. The age-specific pattern of fertility reveals a peak in the age group of 20-24 years for both urban and rural areas. A large proportion of births (47 percent) are of third or higher order. A large proportion of these births is unwanted, as reported by mothers themselves, and could have been avoided. Differentials in fertility based on education and wealth are quite remarkable (NFHS-3). For women with no education, the TFR is 4.6 and for those with more than 10 years of education, the TFR is 2.4. TFR in the lowest wealth quintile is 4.9 and that in the highest quintile is 2.3.



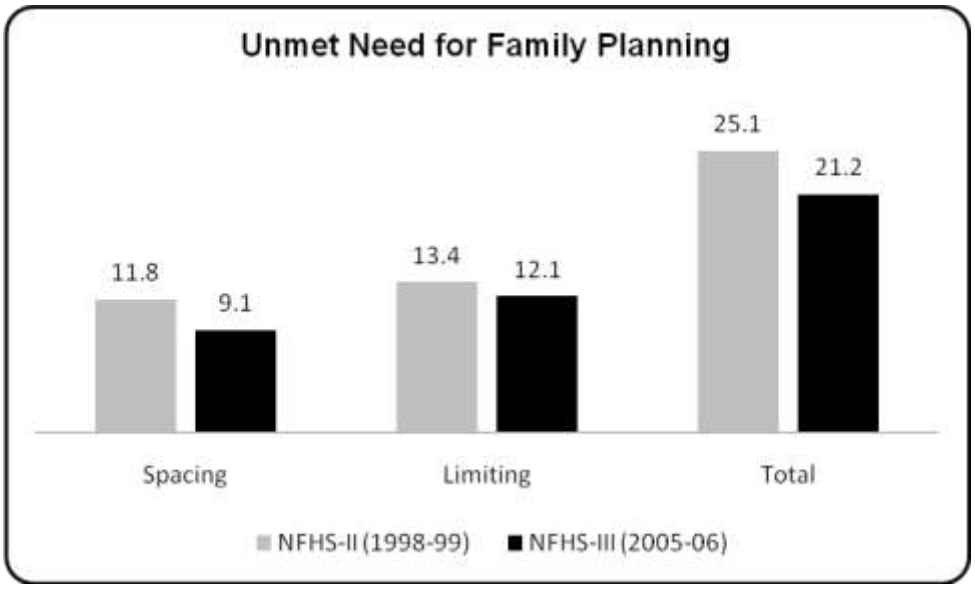
The death rate declined sharply over the same period of time. In 1971, the estimated crude death rate (CDR) for the state was 20.1, decreased to 8.4 in 2008. In rural areas, the death rate declined from 21.1 to 8.8, and in urban areas from 13.1 to 6.6 (SRS). Much of this decline was due to a decrease in the infant mortality rate (IMR), particularly after 1990. The infant mortality rate (IMR) for the state was 182 per 1,000 live births in 1971, declining to 114 in 1990 and further to 67 in 2008 (SRS). Nearly two-thirds of infant deaths occur during the neonatal period. The under-five mortality rate has significantly declined from 126 in 1998-99 to 96 in 2005-06. This is still higher than the national estimate of 74 (NFHS). Further, the neonatal mortality rate (NMR) of 48 and maternal mortality ratio (MMR) of 440 in the state is much higher than the national average (NMR-36 and MMR-254). The life expectancy at birth increased from 43 in 1970-75, to 57 years in 1992-96, to 60 in 2002-2006. The life expectancy at birth was 45.4 for males and 40.5 for females in 1970-75, increasing to 57.7 for males and 56.4 for females in 1992-96. This further increased to 60.3 for males and 59.5 for females in 2002-06 (SRS).

Contraception and Unmet Need

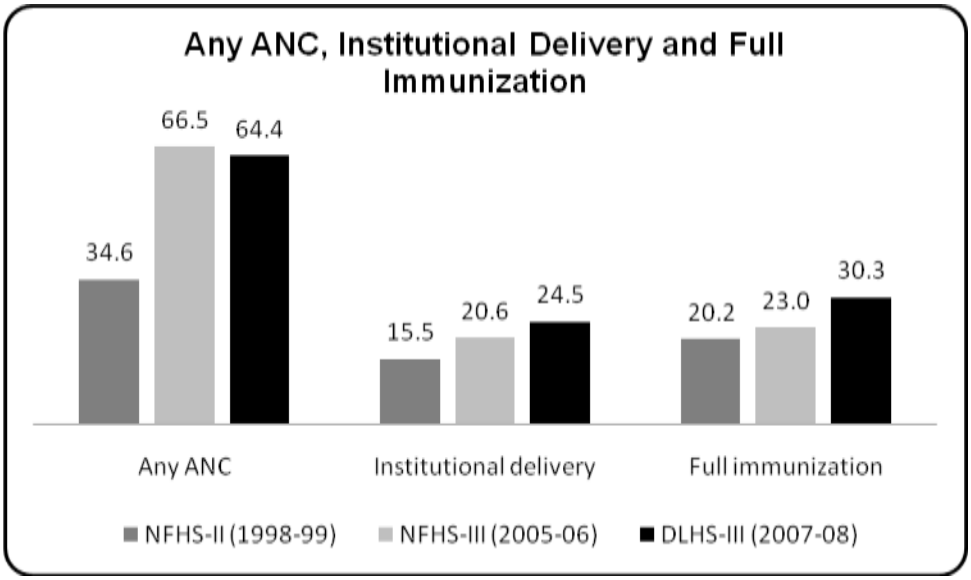
The use of any method of contraception increased from 28 percent in 1998-99 (NFHS-2) to 44 percent in 2005-06 (NFHS-3) - an increase of nearly 61 percent over a period of seven years. While usage of traditional methods has increased substantially, among modern methods, the major contribution has been an increase in condoms from 4 percent in 1998-99 to 9 percent in 2005-06. There are major differentials in contraceptive use in urban and rural areas. In urban areas, 56 percent used any method of contraception in 2005-06 as compared to 40 percent in rural areas.



Unmet need for family planning is a measure of the extent to which married women desire to space or limit the number of children, but often do not do so because of factors such as non-availability of easily affordable and readily accessible quality services and lack of consensus within the family. The unmet need for spacing methods has increased from 9 percent in 1998-99 to 12 percent in 2005-06. The unmet need for limiting methods has marginally declined from 13 percent in 1998-99 to 12 percent in 2005-06 (NFHS-3).



Maternal and Child Health



Antenatal care is an important component of the maternal as well as child health status. The utilization of any antenatal care services has increased from 34.6 in NFHS-2 to 66.5 in NFHS-3. Thus, still about one-third of the currently married women aged 15-49 years have not received any antenatal care services during their last pregnancy. Again, only one-fifth of the children are delivered in a health facility in 2005-06 (NFHS-3), which has increased to nearly one-fourth in 2007-08 (DLHS-3). Overall, 35 percent of women in the state are mildly anaemic, 14 percent are moderately anaemic and two percent are severely anaemic. Exploring the immunization status of children, merely 23 percent of the children have received all the basic vaccinations viz. BCG, measles, and three doses of polio vaccine (NFHS-3). The same is 30 percent according to DLHS-3. Among children aged 6-35 months, 25 percent are mildly anaemic, 56 percent are moderately anaemic and 5 percent are severely anaemic. However, there is no significant difference in nutritional status between male and female children (NFHS-3).

Health Profile of Uttar Pradesh vis-à-vis India

Indicators	Uttar Pradesh	India
Total Fertility Rate1	3.82	2.68
Crude Birth Rate2	29.1	22.8
Crude Death Rate2	8.4	7.4
Infant Mortality Rate2	67	53
Neo -natal Mortality3	48	36
Maternal Mortality Ratio4	440	254
Life Expectancy at Birth5	60.0	63.5
Contraceptive Prevalence Rate1	43.6	56.3
Unmet Need1	21.2	12.8
Any ANC1	66.6	77.2
Institutional Delivery1	20.6	38.7
Full Immunization1	23.0	43.5

Sources:

1 International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3) 2005-06: India; Volume 1. Mumbai: IIPS.

2 Registrar General of India. 2009. Sample Registration System Bulletin Volume 44. No 1

3 Registrar General of India. 2007. Sample Registration System Annual Statistical Report.

4 Registrar General of India. 2009. Sample Registration System Special Bulletin On Maternal Mortality In India 2004-06.

5 Registrar General of India. SRS based Abridged Life Table 2002-06.

Health Infrastructure

Availability and accessibility of the health infrastructure is the key to utilization of services. The existing public health infrastructure in the state is shown below:

Health Infrastructure in Uttar Pradesh

Urban Areas	No. of Facilities	Rural Areas	No. and status of Facilities
Super Specialty Institute	5	CHCs	• 438-Functional • 419-With 24 hrs Electricity and water supply • Gynaecologist available in 142, anaesthetist in 123, Paediatrician in 275 & General Surgeon in 226 facilities • Out of these 413 are functional as 24x7 units • Additional 82 CHCs are under construction.
Medical Colleges	7 - Govt. 2 – Central Govt. 9–Private	BPHCs	• 470-Functional • 458- With 24 hrs Electricity and water supply • 460 MOICs, 391 MO2, 121 MOCH in these facilities. • Out of these 401 are functional as 24x7
District Male Hospitals	61	Additional PHCs	• 2680-Functional • 1915 In Govt. Building. • 765 in hired building • 1677 With 24 hrs Electricity 1985 with 24 hrs water facilities • 2050 MOs, 503 ISM, 73 Staff Nurses, Phy 1388, LHVs 924, ANMs 2116, LA 977, • Out of these 32 are Functional as 24x7
District Female Hospitals	53		
Combined Hospitals	20	Sub Centres	• 20,621-Funcional (In Govt. Bldg.- 9947)
Urban FW Bureau	5		
Urban FW Centres	62	-	-
Health Posts	243 (121 NRHM+122 State)		
District Level PPCs	140		

Source: HMIS Cell, SPMU, 2009

There are five super speciality institutes and 18 medical colleges. There are 61 district male hospitals, 53 district female hospitals and 20 combined hospitals. Out of 438 functional CHCs, 413 CHCs are functioning as 24x7 units. There are 470 functional BPHs, 2680 functional additional PHCs and 20621 sub-centres.

The ratio of doctors per thousand populations in Uttar Pradesh 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 . Many of the required health facilities along with the required human resources are not in position. The considerable difference between "required" and "in position" facilities is reflected in the present health status of the people in the state.

Manpower Situation			
Particulars	**Sanctioned Posts**	**In position**	**Vacancies**
Sub-centre	26344	20621	5723
Primary Health Centre	4390	3150	1240
Community Health Centre	1097	438	659
Multipurpose worker (Female)/ANM at Sub Centres & PHCs	23570	21024 (regular) 813 (contractual)	2546
Health Worker (Male) MPW(M) at Sub Centres	8857	2160	6697
LHV at PHCs	3690	3509	181
Doctor at PHCs/ CHCs/ DHM/ DHF/ DCH	14103	8482	5621
MOCH posted at PHCs		1110	
Obstetricians & Gynaecologists at DHs + CHCs	134+438	310 + 140	65
Anaesthetists at DHs + CHCs	134+438	202 + 122	191
Paediatricians at DHs + CHCs	134+438	250 + 281	(16)
Surgeons at DHs + CHCs	268+438	260 + 227	1573
Radiographers at DHs + CHCs	134+438	49 + 62	404
Chief Pharmacists	1363	1363	0
Pharmacist	5222	4269	953
Pharmacy Incharge	82	62	20
Senior Laboratory Technician	170	170	0
Laboratory Technicians	4205	316 + 467	3422
X-Ray Technician	633	531	102
Dark room Assistants	193	108	85
BCG Technician	291	221	70
Staff Nurse	4948	4708	240

Source: MIS Cell, Directorate of Medical and Health, UP and HMIS cell, State Programme Management Unit, UP, December 2009

Indian System of Medicine and Homeopathy

As per information made available by the Registrar, Indian Medical Council, 59,783 Ayurvedic & 14,905 Unani practitioners are currently registered and are expected to be practicing in the state. In addition, there are 27,548 registered Homeopath doctors in the state.

Ayurveda

There are about 2,200 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.

S.N	Unit	No.
1	Ayurvedic Medical Colleges & Hospitals	8
2	District Ayurvedic Hospitals	141
3	Ayurvedic Dispensaries	1967
4	Medical officers Ayurved	1974/2053
5	Unani Dispensaries	251
6	Medical officers Unani	265

Source: Directorate of Ayurveda and Unani, UP and HMIS cell, State Program Management Unit, UP, December 2009

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. Present position of staff has been indicated in the table below:

S.N	Unit	No.
1	Homeopathy Medical College & Hospitals	7
2	District Urban Homeopathy Hospitals	121
3	Homeopathic dispensaries	1575
4	Homeopathic doctors	1117/1610
5	Homeopathic Compounders	1128/1572
6	Homeopathic dispensary attendants	1682/2334

Source:
Directorate of Homeopathy, UP and HMIS cell, State Program Management Unit, UP, December 2009

Chapter 2

KEY ACHIEVEMENTS AND AREAS FOR IMPROVEMENT ON THE BASIS OF LESSONS LEARNT

Significant progress has been made in terms of implementation of various activities during last 2 years. One of the key achievements has been the establishment of programme management units. PMUs have been established at the State, division, district and block levels. An induction training of the contractual staff for these units was carried out to orient them towards the NRHM programme and explain to them their role and responsibilities. A six day training programme for District and Block PMU staff was conducted at the State Institute of Health and Family Welfare (SIHFW) at Lucknow.

During last 3 years number of institutional deliveries has increased tremendously due to Janani Suraksha Yojana and the number of beneficiaries has increased to about 10 folds during this period. To provide quality care to the pregnant women and new born, the efforts have been made to upgrade and strengthen facilities. The number of functional FRUs and 24x7 units has increased during this period. At present there are 137 FRUs and 707 units functional as 24x7. Further, 140 units of blood storage facility have been provided to the districts. Procurement of Laparoscopes for the districts has been another laudable achievement in the current year.

The implementation of the Comprehensive Child Survival Programme (CCSP) in the 17 districts for reduction of infant and neo-natal mortality has also gained momentum. During the year 2009-10 additional 19 districts have been added to the programme. Now on the basis of lessons learned, it is being upscaled to whole of the State. Facility based new born care has also been added to the activity to address increased number of sick new borns being referred to the facilities. Further, the efforts have been made to operationalize Sick Newborn Care Units in 7 districts (Lalitpur, Lucknow, Saharanpur, Shahjahanpur, Azamgarh, Aligarh & Pratapgarh) of the State. All these SNCUs are likely to be functional by March, 2010. Further, in the year 2010-11, five additional SNCUs are being proposed in under served districts.

The school health scheme was launched in the month of October, 2008 and 40 schools are being covered twice a year in each block. Thus, around 32,000 rural schools are being covered across the State thereby reaching out to 50 lac school children. The activities at the school level include a health check-up, referral, IFA supplementation, biannual deworming and free spectacles to needy children. The training of school teachers has also been added during the year 2009-10, so as to improve the screening process by them. On the basis of positive response, the scheme is being expanded to 49000 schools to reach 73 lacs children.

Adolescent health interventions for school going adolescent girls are also being implemented in the State. The Saloni Swasth Kishori Yojana for school going adolescent girls is covering around 6500 junior girls' high schools. Interventions under the adolescent health include family life education, weekly IFA supplementation and

biannual deworming. It also includes conduction of Saloni Sabhas every month to create awareness regarding personal hygiene, healthy nutritional practices and women empowerment. As per the feedback received from field the training on ARSH is also being included this year.

To provide patient friendly services, strengthening of all the district level hospitals is being done during the year 2010-11 with provision of 24 hours electricity and water supply, improving toilet facilities, provision of safe drinking water, outsourcing cleaning, upkeep and laundry services at district hospitals and hospital waste management system. Further, all the district hospitals and identified CHCs have been surveyed by an independent agency for upgradation as per IPHS. The designing and architecture work has almost been completed and construction work has been initiated at identified places.

Procurement of various items and various drug kits, at the State and district level has either been completed or is under progress. Procurement of items at the State level, such as, IFA tablets, laparoscopes, IUD kits, NSV kits and Blood storage equipments has been done through UNOPS.

Training of functionaries at various levels is also being conducted. There have been some constraints and the desired targets have not been achieved. However, in case of ASHAs, training of all selected ASHAs on 2nd to 4th modules has been completed and training on fifth module on BCC is going on and will be completed by March 2010.

A comprehensive BCC strategy for NRHM in the State has already been formulated, approved by GoI and is being implemented accordingly.

Under routine immunization, efforts have been made to strengthen the programme through various interventions like-alternate vaccine delivery system, special focus on urban underserved areas, block level microplanning and intensive monitoring of the planned sessions. New immunization card has been developed for tracking, as well as, for IEC. Further, a system of preparing name wise tally sheet of beneficiaries has also been initiated. Training of Health Workers for RI is almost complete and that of Medical Officers is underway.

Even with these interventions, the RI coverage in the State is not up to the mark and DLHS-III survey has reported only 30 percent completely immunized children in the State. To improve this, an incentive based plan is being proposed this year in the present PIP.

Chapter 3

PREPARATION OF DAPs AND STATE PIP – THE PROCESS

A participatory process has been followed for preparation of the State PIP, as well as, the District Health Action Plans (DHAPs). A number of orientation meetings and workshops were organised at the State HQ for the Divisional and District Programme Managers and Project Management Units. Further, guidelines were developed at the State PMU and a one day review and orientation workshop for the district level functionaries was organised at the Family Welfare Directorate during the month of November 09.

National Health Systems Resource Centre, Govt of India, New Delhi under the chairmanship of Dr. Padmnabhan has supported the planning process for the State through orientation meetings, workshops and group works at the State level. The districts have been guided to go through the process of situational analysis, understanding the required norms and identifying the gaps, so that to prepare their District Specific Action Plan.

After the orientation workshops, district planning meetings were organised by the districts. Divisional PMUs provided support to the District PMUs in developing the district action plans. Each district developed Block level plans and compiled them to develop a District level Action Plan. In addition every district has developed a few sample village health plans, which have been compiled separately and the State has about 1000 such plans ready for implementation.

Plan from all 71 districts have been received at the state headquarter. A review of the district action plans is being carried out at the State level through various expert agencies like-SIFPSA and ITAP and priorities common to most districts have been identified for inclusion in the State PIP. There are 44 high focus districts in the State, which have some specific challenges to address and the solution and strategy has been incorporated in the chapter "Challenges and Ways to Overcome in High Focus Districts" of the State PIP.

Nodal officers from the Medical Health and Family Welfare Directorates and programme managers from the State PMU participated in all the meetings and workshops chaired by Principal Secretary-Medical Health and Family Welfare and Director General-F.W./M.H. Directorates. Work groups were constituted to discuss key issues and recommend strategies. Based on the deliberations during various workshops and meetings at various levels, the State Action Plan has been prepared.

Chapter 4

NRHM OBJECTIVES AND TARGETS

Mission

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

Objectives of the Mission

- Access to integrated comprehensive primary health care.
- Universal access to Public services for food, nutrition, sanitation, hygiene & public health care services.
- Reduction in maternal & child mortality.
- Prevention & control of communicable & non communicable diseases.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.

Expected Outcomes (2005-2012)

- Increase bed occupancy of FRUs from 43% (2006) to 75%
- Upgrading CHCs to IPHS— >50%
- To reduce MMR from 440/100000 live births (SRS 2004-06) to 258/ 100000 live births
- To reduce IMR from 67 /1000 live births (SRS,2008) to 36/1000 live births
- To reduce TFR from 3.9 (SRS,2007) to 2.8
- Malaria mortality reduction rate by 60%
- Leprosy Prevalence Rate from 5/1000 to less than 1 per 10000
- Tuberculosis DOTS series- 85% cure rate & 70% detection of new sputum smear positive cases.
- Total no. of cataract operations—42 Lakhs in NRHM period (2005-2012)
- Under NBCP, objective is to reduce the prevalence rate from 1% to 0.5 by year 2012.
- To bring down Total Goiter Rate (TGR) in the range of 11 to 53 in 29 endemic districts to <10%.
- Reduction of malnourished children from 42.3 % (NFHS-3, 2005-06) to less than 25%
- To reduce unmet need from 25% (DLHS-3, 2007-08) to 15%

➢

Current Status and Targets for Year 2010-11-12

Goals	Uttar Pradesh			India	
	Current Status 09-10	Target		Current Status	Target
		10-11	11-12		11-12
MMR	440/ Lac LB (SRS 04-06)	<350	<258	254 (SRS 04-06)	<100
IMR	67/ 1000 LB (SRS ,2008)	<58	<36	53 (SRS 2008)	<30
TFR	3.8 (NFHS 3)	3.5	2.8	2.7 (NFHS 3)	2.1
Functional FRUs	136 53 DWH +9DCH+74 CHCs	180 53 DWH +20DCH+107 CHCs	230 72DH+18 SDH+140 CHCs	-	-

Status of Key Indicators

Sl.	Indicator	Status Jan 2009	Target 2009-10	Status up to Jan 2010
1	**No. and % BPHCs/CHCs upgraded to provide 24X7 RCH services**	**630**	**823**	**707**
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	**59**	**65**	**62**
	b. CHCs	**61**	**75**	**75**
3	**No. and % of functional Sub-Centres (ANM is posted and working out of the facility)**	**20102**	**20521**	**20221**
4	**No. and % of sampled FRUs following agreed infection control and health care waste disposal procedures**	**Not Done**	**134 DHs**	**Is being done**
5	**No. and % of health facilities that have operationalised IMEP guidelines**	**-**	**-**	**Could not be taken up**
Human Resources				
6	**No. and % of ANM positions filled (against sanctioned)**	**22533/23570**	**23000**	**20347 (1905 under training which will be complete by March, 2010)**
7	**No. and % of specialist positions filled at FRUs (against required)**	**40%**	**55%**	**50%**
Programme Management				

Sl.	Indicator	Status Jan 2009	Target 2009-10	Status up to Jan 2010
8	No. and % of state and districts having full time programme managers for RCH with financial & admin. powers delegated	Nil	71 100%	71 100%
9	No. and % of sampled state & district programme managers whose performance was reviewed during the past 6 months	Nil	71 100%	71 100%
10	% of district action plans ready	70/ (100%)	71/ (100%)	71/ (100%)
11	SPMU in place with 100 % staff	80%	100%	90%
12	No. and % DPMU staff in place	90%	100%	90%
Financial Management				
13	% of districts reporting quarterly financial performance in time	90%	100%	90%
Logistics / Procurement				
14	% of district not having at least one month stock of			
	a. Measles vaccine	Nil	Nil	Nil
	b. OCP	Nil	Nil	Nil
	c. EC Pills	Nil	Nil	Nil
	d. Surgical Gloves	Nil	Nil	Nil
Child Health				
15	No. of districts where CCSP logistics are supplied regularly	-	17	17
16	No. and % of health facilities with at least one provider trained in Facility Based Newborn Care	-	36 district 144 units	25 district 50 units
17	No. and % of sampled outreach session where AD syringe use and safe disposal are followed	97%	100%	100%
18	No. of districts and schools where School Health Programme is implemented	70 districts 7000 schools	71 districts 32000 schools	71 districts 15000 schools
Family Planning				
19	No. and % of health facilities providing Female Sterilization services			
	a. DHs	53	53	53
	b. CHCs	150	226	220
	c. PHCs	70	100	75
20	No. and % of health facilities providing Male Sterilization services			
	a. DHs & Combined	81	81	81
	b. CHCs	250	300	300
21	No. and % of health facilities providing IUD insertion services			
	a. CHCs	426	426	426

Sl.	Indicator	Status Jan 2009	Target 2009-10	Status up to Jan 2010
	b. PHCs	250	350	350
	c. Sub centres	7500	10000	8500
22	No. of accredited private institutions providing:			
	a. Female Steril. Services	40	60	52
	b. Male Steril. Services	40	60	52
	c. IUD Insertion Services	40	60	52
Monitoring and Evaluation				
23	% of districts reporting on new MIES format	78%	100%	90%

Current Status and Targets

RCH OUTCOMES		CURRENT STATUS (DLHS-3, 2007-08)	TARGET		
			09–10	10–11	11–12
Maternal Health					
1.	% of mothers who had received three or more ANC	21.9%	50%	60%	70%
1a.	% mothers who consumed 100 IFA Tablets	7.7 %	40%	50%	60%
2.	% of pregnant women age 15-49 who are anaemic	51.6%	40%	35%	30%
3.	% of births assisted by a doctor/nurse/LHV/ANM/other health personnel (safe delivery)	30.1%	60%	70%	75%
4.	% of institutional delivery	24.5%	50%	60%	70%
5.	% of mothers who received post natal care within two weeks of delivery	33.8%	30%	40%	50%
Child Health					
6.	% of children under 3 years who were breastfed within one hour of birth	15.4%	25%	50%	70%
7.	% of children age 6 – 35 months receiving exclusively breastfed for at least 6 months	8.2%	25%	50%	70%
8.	% of infants (6-9 months)receiving solid/semi solid food and breast milk	54.5%	60%	70%	75%
9.	% of children 12-23 months of age fully immunized	30.3%	50%	70%	90%

RCH OUTCOMES		CURRENT STATUS (DLHS-3, 2007-08)	TARGET		
			09–10	10–11	11–12
10	% of children 6-35 months of age who are anaemic	85.1% (NFHS-3,2005-06)	65%	50%	40%
11	% of children (age 9 months and above) who have received at least one dose of Vitamin A supplement	32.2%	50%	70%	90%
12	% of children with diarrhoea in the last 2 weeks who received ORS	17.3%	30%	40%	50%
Family Planning					
13	Contraceptive prevalence rate (any modern method)	26.7%	40%	45%	50%
14	Contraceptive prevalence rate (limiting methods)				
	Male Sterilization	0.2%	5%	10%	15%
	Female Sterilization	16.5%	30%	40%	50%
15	Contraceptive prevalence rate (spacing methods)				
	Oral Pills	1.7%	5%	10%	15%
	IUDs	1.0%	10%	15%	20%
	Condoms	7.1%	25%	30%	35%
	Unmet need for spacing methods among eligible couples	11.6%	18%	16%	12%
	Unmet need for limiting methods among eligible couples	22.2%	11%	10%	8%

RCH Intermediate Indicators - Status and Target

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Estimated Mar 2010)	TARGET				
			2010-11 (quarter-wise)				11-12
			Q1	Q2	Q3	Q4	
Infrastructure							
1.	No. and % Block level PHCs / CHCs upgraded to provide 24X7	675	690	720	740	750	823 100%

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Estimated Mar 2010)	TARGET				
			2010-11 (quarter-wise)				11-12
			Q1	Q2	Q3	Q4	
	RCH services						
2.	No. and % Addl. PHCs upgraded to provide 24X7 RCH services	32	35	40	60	100	200
3.	No. and % of health facilities upgraded to FRUs, fulfilling the minimal criteria as per the FRU guidelines (at least 3 critical criteria)						
	a. District/Combined Hospitals	62	62	65	68	73	73 100%
	b. Sub-district Hospitals	1	1	3	5	0	18 100%
	c. CHCs	74	74	80	90 1	107	140 27%
	d. Block PHCs	-	-	-	-	-	-
4.	No. and % of functional Sub-Centres (ANM is posted and working out of the facility)	20221 100%	20521 100%	20621 100%	20621 100%	20621 100%	20621 100%
5.	No. and % of sampled FRUs following agreed infection control and health care waste disposal procedures	District Level Facilities-134 (61+53 + 20)	134	134	134	134	134
6.	No. and % of health facilities that have operationalised IMEP guidelines	Not taken up	-	-	50	50	100

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Estimated Mar 2010)	TARGET				
			2010-11 (quarter-wise)				11-12
			Q1	Q2	Q3	Q4	
Human Resources							
7.	No. and % of ANM positions filled (against sanctioned)	20347/ 23570	22929	22929	22929	22929	25000
8.	No. and % of specialist positions filled at FRUs (against required)	50%	50%	55%	55%	60%	70%
Programme Management							
9.	No. and % of state and districts having full time programme managers for RCH with financial & admin. powers delegated	71 distt. 100%	71 distt. 100%	71 distt. 100%	71 distt. 100%	71 distt. 100%	71 distt. 100%
10.	No. and % of sampled state & district Prog. Mgrs. whose performance was reviewed during the past 6 months	71 dist. 100%	71 dist. 100%	71 dist. 100%	71 dist. 100%	71 dist. 100%	71 dist. 100%
11.	% of district action plans ready	71 district 100%	71 district 100%	-	-	-	71 district 100%
12.	% of sampled districts that are implementing M&E triangulation involving community	5	5 districts	10 districts	15 districts	18 districts	36 district 50%
13.	SPMU in place with 100 % staff	90%	90%	90%	100%	100%	100%
14.	No. and % DPMU staff in place	90%	90%	100%	100%	100%	100%

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Estimated Mar 2010)	TARGET				
			2010-11 (quarter-wise)				11-12
			Q1	Q2	Q3	Q4	
Financial Management							
15.	**% of districts reporting quarterly financial performance in time**	**90%**	**90%**	**100%**	**100%**	**100%**	**100%**
Logistics / Procurement							
16.	**% of district not having at least one month stock of** **a. Measles vaccine** **b. OCP** **c. EC Pills** **d. Surgical Gloves**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**
Training							
17.	**No. and % of Medical Officers/staffs trained in**						
	a. SBA (21 days training) Trainers MOs SNs/LHVs/ ANMs	**423 1350 912**	**750**	**750**	**750**	**750**	**3000**
	b. Life-saving anaesthesia skills	**33+19 under training**	**---**	**24**	**24**	**24**	**72**
	c. EmOC training – ToT at Vellore (10 days)		**12**	**12**	**6**		**30**
	d. EmOC training 16 weak	**27+12 under training**	**16**	**16**	**16**	**16**	**64**
	e. Short terms refresher C EmOC training 14 days TOT			**10**			**10**
	f. Short				**20**	**20**	**40**

RCH INTERMEDIATE / MOU INDICATOR	CURRENT STATUS (Estimated Mar 2010)	TARGET				
		2010-11 (quarter-wise)				11-12
		Q1	Q2	Q3	Q4	
terms refresher C EmOC training 14 days						
g. RTI/STI (MOs & LTs)	-	-	24	50	50	124
h. MTP using MVA (21 days training)	16	-	-	-	-	
i. MTP using MVA (ToT)			15	15		30
j. MTP using MVA (6 days refresher training)	-	30	30	30	30	120
k. (i) CCSP-UP (IMNCI) ToT	114	72	72	72	72	288
(ii) CCSP-UP (MOs)	400	300	300	300	300	1200
l. Facility Based Newborn Care (ToT)	108	60	90-	-	-	150
m. Facility Based Newborn Care (MOs & S.Ns)	90	250	500	500	738	1938
n. Care of sick children & severe malnutrition	90	250	500	500	738	1938
o. NSV centres	48	50	55	60	65	80
p. Laparoscopic steriliz.	66	66	70	73	75	100
q. Minilap	20	30	35	45	55	70
r. IUD insertion	1300	1350	1400	1450	1500	1800

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Estimated Mar 2010)	TARGET				
			2010-11 (quarter-wise)				11-12
			Q1	Q2	Q3	Q4	
	s. FLE ToT 5 days			50	50		100
	t. BCC/IPC 5 days	-	-	50	50	50	150
	u. FW Counsellors training (7days)		100	100			200
18.	No. and % Staff trained in SBA						
	ANM /LHV/SN	912	750	750	750	750	3000
19.	No. and % Staff trained in CCSP-UP (IMNCI) (1 batch of 4 LHV/ANM and 20 ASHAs)						
	a. ANM/ LHV/ HS	4550	1550	1550	1550	1670	6320
	b. ASHA	24150	8000	8000	8000	8180	32180
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	-	2064	2064	2064	2736	12000
	b. Staff Nurse	-	688	688	688	912	5000
22.	No. and % of staff trained in ARSH						
	State TOTSIHFW/ DGFW/SPMU-3 days		25	-	-	-	25
	TOT for Regional trainers		60				60
	MOs (3 days)		-	600	616	600	1816
	ANM (5 days)				2000	2262	4262
23.	No. and % of state and district programme managers trained on IMEP	Nil	-	11	10	50	71 100%
Maternal Health							

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Estimated Mar 2010)	TARGET				
			2010-11 (quarter-wise)				11-12
			Q1	Q2	Q3	Q4	
24	% of ANC registrations in first trimester of pregnancy	25.1 % (DLHS-3)	40%	44%	47%	50%	60%
25	% mothers who consumed 100 IFA tablets	7.7 % (DLHS -3)	30%	32%	35%	40%	50%
26	% of 24 hrs PHCs conducting minimum of 10 deliveries/month	56%	60%	65%	70%	100%	100%
27	% of Caesarean Sections in CEmONC centres	8 % of total delv.	10%	12%	15%	15%	15%
28	No. and % of health facilities providing RTI/STI services						
	a. DHs/ Combined Hosp.	73	73	73	73	73	73 100%
	b. SDHs	18	18	18	18	18	18 100%
	c. CHCs	200	250	300	350	438	438 100%
	d. PHCs	100	150	300	400	470	470 100%
29.	No. and % of health facilities providing MTP services						
	a. DHs	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%
	c. CHCs	58 11%	70 14%	80 16%	90 17%	100 19%	140 27%
	d. Block PHCs	50	55	60	65	70	100
30	No. of districts where Referral Transport services are functional	-	-	10 15%	35 50%	71 100%	71 100%

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Estimated Mar 2010)	TARGET				
			2010-11 (quarter-wise)				11-12
			Q1	Q2	Q3	Q4	
31.	No. & % of planned RCH camps held	14000	3500	3500	3500	3500	14000
32.	No. and % of planned Monthly Village Health and Nutrition Days held	702000 97%	1.8 lacs 25%	3.6 lacs 50%	5.4 lacs 75%	7.2 lacs 100%	7.2 lacs 100%
Child Health							
33.	No. of districts where CCSP logistics are supplied regularly	17	17	36	36	36	36 50%
34.	No. and % of health facilities with at least one provider trained in Facility Based Newborn Care	25 district 50 units	36 district 60 units	36 district 70 units	36 district 80 units	36 district 108 units	36 district 144 units
35.	No. and % of sampled outreach session where AD syringe use and safe disposal are followed	25%	30%	40%	50%	60%	80%
36.	No. of districts and schools where School Health Programme is implemented	71 Dist. 32000 schools	71 Dist. 25000 schools	71 Dist. 25000 schools	71 Dist. 50000 schools	71 Dist. 50000 schools	71 Dist. 60000 schools
Family Planning							
37.	No. and % of health facilities providing Female Sterilization services						
	a. DHs	53	53	53	53	53	53 100%
	b. SDHs	18	18	18	18	18	18 100%
	c. CHCs	240	240	300	350	380	400
	d. PHCs	100	125	150	175	200	250 49%

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Estimated Mar 2010)	TARGET				
			2010-11 (quarter-wise)				11-12
			Q1	Q2	Q3	Q4	
38.	No. and % of health facilities providing Male Sterilization services						
	a. DHs	72	72	72	72	78	78 100%
	b. SDHs	8	8	10	15	18	18 100%
	c. CHCs	400	400	400	405	410	410 100%
39.	No. and % of health facilities providing IUD insertion services						
	a. CHCs	400 97%	400 100%	425 100%	425 100%	425 100%	500 100%
	b. PHCs	350 65%	350 65%	375 81%	400 81%	400	400
	c. Sub centres	2000	2000	2500	3000	3500	3500
40.	No. of accredited private institutions providing:						
	a. Female Steril. Services	10	30	50	75	100	140
	b. Male Steril. Services	10	5	10	10	10	70
	c. IUD Insertion Services	10	50	75	100	150	200
41.	% of districts with Quality Assurance Committees	49 70%	71	71	71	71	71
42.	% of district QACs having quarterly meetings	71	71	71	71	71	71
43.	% of planned Female Sterilisation camps held in the quarter	18camp/ block/	1camp/ block /m	1camp / block/ m	2camp/block /m	2camps/block/ m	18camps/ block/y
44.	% of planned NSV camps held in the quarter	350	50	50-	100	200	400
Adolescent Reproductive and Sexual Health							
45.	% of ANC registrations in 1st trimester of pregnancy for women <19 yrs of age	NA	-	-	10%	25%	50%

RCH INTERMEDIATE / MOU INDICATOR		CURRENT STATUS (Estimated Mar 2010)	TARGET				
			2010-11 (quarter-wise)				11-12
			Q1	Q2	Q3	Q4	
46.	No. and % of health facilities providing Adolescent Health Services						
	a. CHCs/BPHCs	Nil	Nil	2	4	4	10
	b. Other Counselling centres	Nil	Nil	14	28	28	70
47.	No. and % of health facilities with at least one provider trained in ARSH	Nil	Nil	14	28	28	70
Vulnerable Groups							
48.	No. and % of district plans with specific activities to reach vulnerable communities	44	44	44	44	71 100%	71 100%
Innovations/PPP/NGO							
49.	No. of districts covered under MNGO scheme	-	-	-	-	-	-
50.	No. of MNGO proposals under implementation	-	-	-	-	-	-
Monitoring and Evaluation							
51.	% of districts reporting on the new MIES format on time	90%	90 %	95%	100%	100%	100%

Chapter 5

ENSURING SUSTAINABLE AND QUALITY HEALTH CARE

The National Rural Health Mission (NRHM) is aimed at ensuring effective and quality healthcare, especially to the poor and vulnerable sections of the society. It is being implemented in the State with the aim of reducing infant mortality rate & maternal mortality ratio, ensuring population stabilization, prevention & control of communicable & non-communicable diseases and bringing AYUSH to the mainstream for promotion of healthy life style. Given the status of public health infrastructure in the State, it will not be possible to provide the desired services till the infrastructure is sufficiently upgraded. The Mission seeks to establish functional health facilities in the public domain through revitalization of the existing infrastructure and fresh construction or renovation wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in human resource planning, as well as, infrastructure strengthening. The mandate for NRHM therefore includes the following areas for concerted action:

As per guidelines mentioned on page no. 17 of the NRHM Framework for Implementation (2005-2012), Govt. of India, the following actions are proposed.

1. Ensuring Patient Friendly Functional facilities - Establishing fully functional CHCs/ Sub-Divisional/District Hospitals, which includes:

   - Infrastructure/equipments
   - Management support
   - Streamlined fund flows
   - Contractual appointment and support for capacity development
   - Pooling of staff/optimal utilization
   - Improved MIS
   - Local level flexibility
   - Community / PRI/ RKS for accountability / M&E

2. Increasing and improving human resources in rural areas for which the following has been undertaken during the year 2009-10:

   - Contractual appointments at facilities to overcome short term gaps.
   - Outsourcing of non-clinical functions, such as, cleaning, upkeep, laundry waste disposal, etc.
   - Multi-skilling of doctors / paramedics and continuous skill upgradation
   - Convergence with AYUSH

3. Accountable health delivery is being done:

   - Referral chain from village to hospital
   - Management of health facilities by Rogi Kalyan Samitis (RKS)
   - Budget to be managed by PRIs / RKS

4. Effective decentralisation and flexibility for local actions is under implementation:

   - Untied fund and flexibility for innovations
   - Management by Rogi Kalyan Samitis

5. Reducing maternal & child deaths and population stabilization:

   - Functional public health system including CHCs as FRUs, PHC as 24X7, Sub Centres, Sub Divisional hospital, District Hospitals
   - Under NRHM, training of locally recruited ANMs at 16 identified centres is under progress-1905 ANMs will complete their training by March, 2010 and will be available for posting at sub centres.
   - Promoting institutional delivery
   - Improving quality of services at the facilities
   - Thrust on Skilled Birth Attendants training of Medical Officers, LHVs and ANMs at identified centres.
   - Training of ASHAs-Basic 19 days (7+12) training is complete for almost all the ASHAs. Training of fifth module is underway.
   - New born care for reducing neo natal mortality. The CCSP programme in 36 districts of the State is under progress, where all the ASHAs, ANMs and LHVs are being trained;
   - Expanding facilities to provide FP services
   - Active Village Health and Sanitation Committees;
   - Training of Panchayat members.
   - Expanding the ANM work force especially in remote areas and in larger villages and semi-urban areas.
   - Planned synergy of ANMs, AWWs and ASHAs

6. Actions for preventive and promotive health:

   - Untied fund for local action
   - Convergence with other departments / institutions
   - Capacity building
   - Improved School Health Programme involving primary & middle schools
   - Common approach to IEC for health
   - Involvement of PRIs

7. Disease surveillance:

   - Horizontal integration of programmes through VHSC, SC, PHC, CHC.
   - Initiation and Integration of IDSP at all levels

8. Health Information System:

   - A fully functional two way communication system leading to effective decision making and corrective actions.

9. Planning and monitoring with community ownership:

   - Community monitoring (piloting and scale up in a phased manner)
   - Involvement of NGOs/PRIs

NRHM is an opportunity for the State of Uttar Pradesh to uplift the face of existing health services. It empowers the State with the vision to improve health infrastructure, quality of services and accessibility of these services by the larger section of the community. The overall objective is to have the highest attainable standards of services at the public health institutions coupled with the recent technical advances in terms of well equipped facilities and adequate skilled manpower at every level. In the last few years the credibility of public sector has gone down and it is very necessary that the district/sub district government hospitals are re-strengthened to provide patient friendly services in a congenial environment.

It is a well known fact that good hospital services are pivotal for well ordered and humane community and will definitely be the recipients of societal resources. It is of prime importance for the Government of Uttar Pradesh to provide quality delivery of health services at all levels. The health care delivery system has remained fragmented and ill-equipped for decades and the growing demand of the community calls for better hospital services and quality assurance mechanisms. In fact, the focus of the state will be, not merely on providing minimum acceptable standards, but to set forth a system of constant improvement in the hospitals by providing quality patient care which is translated into reality by greater efficiency, accountable and responsible governance in the hospitals and congenial friendly atmosphere which tempts the community to accept government health services.

Ensuring Quality Care - The hospitals are being strengthened with all the signs and indications well displayed in such a way that when a patient reaches there, he/she knows where he has to go for the registration, consultation, investigation or admission etc. Most of the district hospitals are well equipped for simple routine tests but with up-gradation as per IPHS they will be provided recent and modern investigative facilities as well. The reporting mechanism will also be streamlined. This will be done through State budget as well as budget available under NRHM.
Availability of medicines is another area which is of prime importance for the patients. Government of Uttar Pradesh is fully committed to provide all essential medicines, absolutely free of cost for poor people and the State budget has been increased tremendously during the last few years. However, the gaps will be filled with the budget available under NRHM.

Availability of adequate human resource, which is well trained, skilled and patient friendly is another crux of NRHM mandate this year. All the districts / sub districts hospitals and CHCs which are identified as FRUs will be provided with skilled manpower at every level. Special management, skill up-gradation and behaviour communication training programmes will be organized for them.

Road Map to IPHS - To achieve the objectives of reducing infant and maternal mortality rates, the state has been working on operationalising health facilities as FRUs. In the end of financial year 2007-08, only 38 district women hospitals and 23 CHCs were functional as FRUs (where caesarean sections are being performed and all mandatory requisites are available excepting for blood bank facilities, though definite linkages have been developed).

During the year 2008-09, a vast exercise was executed to deploy the available human resource and 119 units (all 53 district women hospitals, five combined hospitals and 61 CHCs) were made functional as FRUs. Further, 140 blood storage units have been installed at identified sites to make these units fully functional during the year 2009-10. All the districts / combined hospitals have the accessibility to a blood bank (license renewal processed sped up) and all CHCs at identified FRUs either have a blood storage refrigerator or linkages with a blood bank.

This year we plan to operationalise 127 CH / CHCs as FRUs in addition to 53 district women hospitals. There are 27 medical officers have been recently trained and 12 are under training on EmOC. Similarly, 33 Medical Officers have completed short term anaesthesia training and 19 are being trained to be posted at earmarked CHCs. Thus, additional facilities will be functioning as FRUs. At these centres posting of contractual staff nurses, and other paramedics have been planned accordingly. Meanwhile, strengthening of infrastructure, provision of equipments, and blood storage facility will be ensured.

All the facilities which are already functional as FRUs have to be strengthened as per IPHS standards. It is proposed to strengthen all the districts male / female / combined hospitals and identified CHCs as per IPHS standards in a phased manner. The infrastructure at the health facilities at different levels has to be geared up and must be well equipped to take up all complicated & difficult cases of medicine, surgery, gynaecology, paediatrics, orthopaedics, trauma, ophthalmology, etc. In the State of Uttar Pradesh, most of the CHCs are not well-equipped to tackle complicated cases, except for gynaecology & paediatrics; hence the district level facilities function as first referral units for the purpose. Therefore, it is necessary to upgrade & strengthen these facilities, so as to provide comprehensive emergency health care to the community.

Focus Areas under State Plan for 2010-11

1. Strengthening of CHCs & FRUs to provide optimal health services as per IPHS

As per IPHS guidelines for CHCs / FRUs, Govt of India, strengthening of facilities is being done and includes the following. Most of the activities are under progress and few have been outsourced like-Cleaning, upkeep & laundry services.

- Physical infrastructure strengthening--entrance zone, OPD, Indoor, Treatment room, Ancillary rooms, OT, Labour rooms, Sterilization rooms, Labs, Offices & Stores etc.
- Ensuring 24 hrs water supply, emergency lighting & telephone facilities.
- Human resource- Clinical specialists, paramedics, nursing staff & other support man power.
- Ensuring availability of equipments, consumables & medicines.

- Capacity building & multi-skilling of medical & paramedical staff.
- Quality assurance in service delivery.
- Blood storage facility & essential laboratory services.
- Referral communication services for timely referral & management.
- Cleaning, upkeep & laundry services.

3. Strengthening to Provide Optimal Health Services at Block/APHC level

- Untied Fund/ Annual Maintenance Grant/ RKS fund at Block & APHCs.
- Provision of Inverters (1 KVA) at 24 x 7 Addl. PHCs & select Sub centres for 500 units.
- Relocation of AYUSH practitioners
- Contractual appointment of MBBS doctors at all Block level facilities
- Contractual appointment of AYUSH lady doctors at all Block PHCs
- Contractual appointment of AYUSH male doctors at PHCs
- Contractual appointment of AYUSH Pharmacists at PHCs

4. Strengthening to Provide Optimal Health Services at Sub Centre level

- Construction of Sub Centres (3000 nos. from Mission Flexipool)
- Major Repairs of 1000 Sub Centres @ Rs. 2 lacs/unit.
- Electricity connections at 1000 Sub Centres.
- Contractual appointment of 2500 ANMs.
- Untied grants & AMG at Sub centres.
- Capacity building of ANMs.
- Provision of performance based incentive for trained TBAs to promote safe institutional deliveries.
- Various IEC activities (wall writing/display boards/posters etc.) at Sub centres.
- Inverters are being provided at facilities operating out of own building, having adequate space, 24 hours water supply, ANM staying at the facility and there is electricity supply for more than 8 hours

5. Strengthening of Health Services at Community Level

- ASHA Scheme
  - *Training on 5th Module is underway.*
  - *Operationalisation of ASHA Support System*
  - *Replenishment of ASHA Kits*
  - *ASHA Award Scheme*
  - *Annual ASHA Sammelan/Melas*
  - *Newsletter for ASHAs*
- Untied grants for each revenue village (1,07,164) through VHSCs
- Biannual Orientation of PRIs during BDC Meetings
- Saas Bahu Sammelans – District & Block level.
- Mobile medical units -1 per block in all 71 districts.
- Community monitoring activities in selected districts.

6. Strengthening Training

- Training Support for BHW (M) & BHW (F) — Pre-service training of ANMs & Male Workers.

- Physical strengthening of training institutes (RHFWTCs, ANMTCs, DPTTs, LHV/PHN Trg. Centres)
- Capacity Building for District Action Planning and development of DAPs with support of NHSRC.

7. Strengthening Drug Warehouses

- Maintenance of State & Regional Drug Warehouses.
- Operationalization of District Drug Warehouses
- Operational expenses for existing district drug warehouses (24 nos.)—contractual human resource, electricity, telephone facility, other contingent items.

8. Other Activities

- Closed User Group (CUG) network for Health Department functionaries up to ANMs
- Concurrent audit system
- Scheme for Medical Officers for Pursuing Post-Graduation in Public Health/ Family Medicine/Professional Development Course
- Capacity Building for District Action Planning and development of DAPs

The activities proposed for achieving the above have been detailed under the relevant sections in various chapters.

RCH FLEXIPOOL (PART – A)

1. MATERNAL HEALTH

Maternal mortality in the state continues to remain high for many decades but with introduction of various programme packages during nineties, such as Child Survival and Safe Motherhood programme (CSSM), RCH I, RCH II and now National Rural Health Mission (NRHM), Maternal Mortality Ratio (MMR) has started declining. However, there is a long way to go to achieve the defined objectives for the state.

Year	1997	2001-03	2004-06	Goal (NRHM) by 2012
MMR	707	517	440	258

Source: Sample Registration System (SRS) Bulletin, 1997, 2001-03,2004-06

Since the implementation of NRHM focussed interventions such as Janani Suraksha Yojana (JSY) has helped in promoting institutional deliveries and bringing down the MMR. Further to improve the quality of care and meet with increasing load of JSY beneficiaries, more facilities are being operationalised as FRUs and 24X7 PHCs/CHCs. Accreditation of sub centres is also being undertaken. More emphasis is being laid for 48 hours stay after the delivery at the facility. State is strategically planning and implementing various clinical training programmes for increasing skills of a large cadre of skill service providers for provision of quality services as per standard protocols

Major Strategies

1.1 Operationalisation of Facilities for Institutional Deliveries

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

To bring about a reduction in maternal mortality, it is imperative that our health units are equipped to handle complicated cases of pregnancy and ensure safe delivery. Currently, there are 53 district hospitals, 7 combined Hospitals and 77 CHCs, thus a total of 137 units are functioning as FRUs against a target of operationalising 180 units by 2009-1. Of these FRUs, caesarean sections are being conducted in 122 facilities. Efforts at this stage are to consolidate and achieve quality at these centres. While the State is proposing 180 FRUs for the year 2010-11, it will be endeavoured to surpass these objectives to reach 200.

Year wise implementation of **FRUs** is mentioned in the table below:

Year	No of DWH	Combined Hospital	CHCs	Cumulative Total
2007 -08	38	-	23	**61**
2008 -09	53	5	61	**119**
2009 -10	53	7	77	**137**
2010-11 (proposed)	**53**	**20**	**107**	**180**

Achievements (at FRUs):

Year	Status of deliveries		
Type of Deliveries	**Normal**	**Assisted**	**Caesarean Section**
2008 -09	3,33,570	23,066	**30,717**
2009-10 (till Dec.09)	**2,91,819**	**33,385**	**24,685**

Target for the year:
It is proposed to operationalise 30 CHCs and 13 Combined Hospitals as FRUs this year. Thus, 180 facilities will be functioning as FRUs by the end of year 2010 – 2011.

Human Resource:
Rationalization in redeployment of human resources is being done and hiring of Specialists on contract or 'on-call basis' and Staff Nurses on contract will be continued (Annexure). The tentative requirement of the staff has been detailed in the section on Human Resources in Mission Flexipool.

For upgrading the skills of the service providers and to meet the shortage of trained service providers-27 medical officers trained in EmOC and 33 trained for short term anaesthesia have been posted at earmarked CHCs/DWH. 12 more medical officers are under training for EmOC, and 19 for short term anaesthesia. Additional human resources will be posted at these FRUs either on contractual basis or the Medical Officers trained under EmOC/ LSAS will be posted at these units. The State has indented 5000 Medical Officers from Public Service Commission which includes specialists in Gyne/ Obs, Pediatrics and Anesthesia. Already 2800 applications have been received which are being sorted out at the level of Commission and DG – MH. It is likely that we will be able to select and appoint required Human Resources at earmarked FRUs.

Further, as per training plan for 2010-11, to fill gaps in trained human resource, 4 more centres for providing EmOC training are being identified in the state(FOGSI model – 6 weeks in medical college and 10 weeks in DHF). Around 60 medical officers will be trained in short term Anaesthesia training and 64 in EmOC training. Thus, additional units will be made functional as First Referral Units.

At these centres posting of contractual staff nurses and other paramedics have been planned accordingly. Meanwhile, strengthening of infrastructure, provision of equipments, and blood storage facility will be ensured.

Operational Cost for FRU*
Support services at all the DWH and DCH (73) have been outsourced through processes centralised at the State level. At facilities where support services (such as communications, security, sanitation, gardening, waste disposal, referral and computerisation) are not outsourced, it is proposed to make available an additional sum

of Rs. 25000 per month. **There are 107 such facilities and the total cost for this activity is Rs. 321 lacs for the year 2010-11**.

At the DWHs/ DCHs, as per the feedback received from the CMSs, there are many gaps like equipments, linen and POL for generator which have to be addressed immediately. The amount sanctioned under RKS funds are not sufficient and the senior doctors and have requested for additional amounts in the State level meeting. Hence an amount of Rs. 5 lacs for these 73 units is being proposed. **Rs. 365 lacs had been proposed for the year 2010-11.**

*** Financial assistance has not been approved and GoI has directed to meet the expenses through various untied funds. A proposal to GoI for reconsideration has been sent.**

Blood Bank and Blood storage units

All the Districts / Combined Hospitals have accessibility to a blood bank and have either a blood storage refrigerator or linkages with a blood bank.

There are 51 existing blood banks in the State and 20 districts are being strengthened for 2010-11. The detailed proposal is included in Strengthening of Infrastructure under Mission Flexipool.

During the FY 2009 – 2010, a total of 140 blood storage refrigerators have been procured and distributed to FRUs. These blood storage refrigerators have been sent to pre identified units in the districts in 2009, with information and guidelines to the CMO for installation at the facility. The process is underway and will be completed by March 2010. A total of 60 Medical Officers and 74 Laboratory Technicians have been trained till date by UPSACS. In those facilities where blood storage units were not available till now, linkages had been established with district level government/ private blood banks. The complete list is available at Annexure X. During the year 2010-11, 40 additional blood storage units will be operationalised and the same will be procured through UNOPS. **It is estimated that 40 unit @ Rs. 90,000 will be required and the amount has been budgeted under Mission Flexipool.** It would be ensured that existing units have proper licensing and in places where blood storage units have not been established, proper linkages with government blood banks are available.

Drugs and Supplies

With facility of investigations and blood transfusion, provisions have been made for ensuring the availability of essential life saving medicines which are not available through the routine State government supplies, such as, anti Rh sera, misopristol, antibiotics for resistant cases of sepsis, etc. for the management of related conditions. It is expected that out of the total institutional deliveries covered under JSY; 50 percent of the women delivering at the DWH and CHCs have the facility of being diagnosed for Rh grouping. Of these 0.5 percent are likely to be Rh negative, needing Rh anti D sera injection. Accordingly for expected number of 2,625 women (0.5 percent of the delivered cases) the budgetary requirement of Rs. 52.50 lacs is being made for the

procurement of Rh anti D sera. This has been budgeted under Procurement in Mission Flexi pool.

1.1.2 Operationalisation of CHCs & BPHCs to provide 24 X 7 delivery services

At present there are 372 CHCs, 303 BPHCs and 32 APHCs that are providing 24X7 delivery services. It is expected that in the year 2010-11, additional 28 CHCs, 47 BPHCs and 68 APHCs will be functional to provide 24X7 services for delivery. Thus a total of 850 facilities will be operationalised to provide 24 hour BEmOC services.

Year wise coverage of 24X7 sites

Year	CHCs	BPHCs	Add. PHCs	Total
2008 -09	346	294	-	**640**
2009 -10	372	303	32	**707**
2010-2011 (proposed)	**400**	**350**	**100**	**850**

Achievements:

Year	Deliveries at CHCs	Deliveries at BPHCs	Total
2008 -09	2,52,474	4,35,506	**6,87,980**
2009-10 (up to Dec. 09)	**5,00,060**	**4,86,247**	**9,86,307**

Human Resources

Additional human resource is also proposed to be made available through contractual arrangements. At the District Women Hospitals, two Lady Medical Officer (MBBS) would be deployed for helping and sharing case load of institutional deliveries due to JSY. It is proposed to have one Medical Officer (MBBS) at CHCs and Block PHCs. These doctors would be responsible for public health services and would ensure implementation, supervision and monitoring of various interventions proposed under NRHM.

During the year 2009 –10, one ISMP LMO at each block level PHCs/CHCs were hired on contractual basis to promote institutional delivery. At present 525 ISMP LMOs are working at these units. It is proposed that during 2010 –11, at every block level PHC/ CHC (excluding FRU units) and 100 additional PHC one ISMP lady doctor would be deployed on contract basis for providing institutional delivery services. Additional nurses would also be deployed on contract basis to meet the gap of paramedical staff.

These doctors will be recruited by the District Health Society, under the chairpersonship of District Magistrate incase of DWH and CHCs. The concerned CMS/ SIC/ Superintendant will be member of the selection committee. In case of BPHC/ APHCs, CMO will be a member of the selection committee.

Operational Cost for 24x7*

Funds from RKS are inadequate to meet all the operational costs at the BPHCs operational as 24x7 and therefore an amount of Rs 10,000 per month is proposed for undertaking activities such as security, sanitation and communication. **There are 743 (excluding 107 FRU CHCs) such facilities and the total cost for this activity is Rs. 891.60 lacs for the year 2010-11**.

*** Financial assistance has not been approved and GoI has directed to meet the expenses through various untied funds. A proposal to GoI for reconsideration has been sent**

Monitoring

In 2010-11, to ensure monitoring of each woman, a name based mother and child tracking system will be instituted where all pregnant women will be tracked for ANC as well as PNC and children will be tracked for immunization. This is further detailed under the "Innovations in Maternal Health" section.

Budget:

The estimated number of personnel to be hired and the budgeted expenses are detailed in the section on 'Human Resource'

1.2 Ante Natal and Post Natal Care

In the State, while nearly 65 percent of women receive any ANC (DLHS-III), the percentage of women receiving full ANC is only 22 percent. Further analysis of the DLHS data indicates that of the ten districts performing poorly on the indicator of atleast 3 ANC visits, six have the poorest indicators for institutional delivery as well. These districts will be high focus districts for the state for all ANC, institutional delivery as well as PNC related activities.

Table: Percentage of mothers who had atleast three ANC visits during the last pregnancy

SN	District	Atleast 3 ANC visits	Institutional delivery
1	BADAUN	8	10.9
2	ETAH	8	20
3	HARDOI	9.1	13.4
4	FARRUKHABAD	9.8	13.4
5	SHAHJAHANPUR	11	8.9
6	KANNAUJ	11.3	14
7	AURAIYA	13.4	14.4
8	LAKHIMPUR KHERI	14.8	14.5
9	BAHRAICH	15.4	7
10	FATEHPUR	15.4	15.6

Source: DLHS III, 2007-2008

However, with concerted efforts in the field and inclusion of ante natal and post natal care into the JSY package, the uptake of these services has been encouraging. The

concurrent evaluation of the JSY scheme in selected state by GoI in 2008[1] reports that among the JSY beneficiaries, 95 percent were registered for ANC, more than 82 percent had atleast 3 checkups, 83 percent consumed atleast 100 IFA tablets and 84 percent received post natal care.

To further strengthen ante natal and post natal care services, ASHAs have been trained to promote early registration of pregnancies; provide three ANC check ups during VHNDs with ANMs; and ensure TT coverage and consumption of iron and folic acid. ASHAs in turn mobilise communities and motivate them for availing complete ante natal services. Micro birth plans for registered births are being developed by the ASHA with the support of ANMs. An amount of Rs. 100 per month has been budgeted for meetings with pregnant women conducted by ASHAs to emphasise on the need for complete ante, natal and post natal care. Provision for referring complications in ANC has also been provided and an amount of Rs. 200 has been included in the ASHA incentive. ASHAs have been trained in identifying high risk pregnancies and new borns for timely management of cases. These referred complications are verified as genuine cases by the attending doctor at the facility, who counter signs the voucher.

For institutional deliveries, guidelines have been issued to DWHs and FRUs for 48 hours stay at the facility to ensure first PNC follow up check up. In addition, detailed guidelines issued to ASHAs elaborate their role in following up for post natal complications within first seven days of delivery. Incase of any complications, these are reported to the ANMs or MOs of CHC/ PHC for appropriate management.
For home deliveries, ASHAs and ANMs conduct follow up PNC visits. An incentive of Rs. 50 has been proposed for the ASHA for PNC, care of the newborn and colostrum feeding.

All fund requirements have been included under ASHA scheme in Mission Flexipool.

[1] May 2009, Concurrent Assessment of Janani Suraksha Yojana (JSY) Scheme in Selected States of India, 2008, accessed from www.mohfw.nic.in

1.3 Village Health & Nutrition Days (VHNDs)

Village Health and Nutrition Days (VHNDs) sessions involving the ASHAs, AWWs and ANMs are being organised in the State. Detailed guidelines have already been issued to the districts. The activity will be continued this year. It is estimated that during 2010-11 about 1,37,000 sessions per month (a total of 16,45,000 sessions through the year) would be organised across the state . An amount of Rs. 250 will be made available from VHSC funds for organising the VHND to establish a festive environment for the event. The expenses would be met from the incentive budgeted under 'Mission Flexipool'.

The monthly VHND is planned in UP as a day where health services will be made available in the morning and community mobilisation activities will be held in the afternoon. The VHNDs will be conducted as per the detailed RI micro plan available in Part C.

Suggested Event Schedule of Activities for VHND[2]

Khushali Diwas - Village Health & Nutrition Day		
Mobilization	**Step 1:** ASHA prepares list of RI, ANC and PNC beneficiaries; list of beneficiaries for group meetings by topic	
	Step 2: 4-5 pairs of Bal Chetaks ensure that most infants in the village are brought for the RI session.	
Service Delivery at the village level	**10:00 – 11:30 am**	**Routine Immunization:** Infants + children for Vitamin A dose (about 15-20 children) 5-6 school children to mobilize; ANM to give immunization
	11.30 to 1.00 pm	**ANC check up + IFA+TT+BCC** (about 12-15 ANCs)+ **PNC check up**
	1.00 to 2.00 pm	**Refreshments**
	3.00 to 4.00 pm	**Group Meeting by ANM**
Community Event	**5.00 to 6.30 pm**	**Local community Event (to be organized by VHSC and MPW)** • Felicitation of ANM / ASHA / Role Models • Panel discussion

BCC & Outreach services during VHND	
1. Routine Immunization	**2. Contraceptive services**
3. ANC and PNC check ups	**4. DOTS for TB**
5. Local events as planned by village health and sanitation committee	**6. BCC through group meetings**
7. Child-community activities: Bal Chetaks responsible for ensuring complete immunization of infants; and booster shots and Vitamin A for older children; identification of mal nourished children and nutrition counselling.	

[2] Adapted from UP Communication Strategy

Regular reports of VHND session are being received from all the districts and as per an independent study 86 percent VHNDs had been conducted against planned till September 2009.

To increase the efficiency and quality of VHNDs, the following activities are planned:

1. Sensitization of PRI by MOIC in monthly meetings
2. Integrate VHND session in the training curriculum being developed to train the new VHSC to be formed
3. Quarterly review convergence at District level DHS meeting by District Magistrate
4. Skilled birth attendant (SBA) training for ANMs and Staff Nurse who will be involved in the VHNDs to ensure quality of ANC and PNC care.

Provision of Rs. 250 will be made from VHSC funds for organising VHNDs. Funds for local events to be organised in the second half will be met from VHSC funds. ASHA incentive of Rs. 150 for social mobilization has been incorporated in Part C in Routine immunisation (RI)).

A 1.4 Janani Suraksha Yojana (JSY) for Institutional Delivery (FMR Code A1.4)

While the NFHS and DLHS data provide an overview of the health status in the State, these are quite dated (2005-06 and 2007-08 respectively), with the implementation of JSY, there has been an increase in institutional delivery in the State from 2007-08 onwards. Thus, there is a need for re-evaluating the present MMR and percent of institutional deliveries in the revised context.

The concurrent evaluation of the JSY scheme in selected states by GoI in 2008[3] indicates that:

- 48 percent of the deliveries in the State were institutional deliveries whereas DLHS III conducted just a year before reports it as 24.6, an increase of 23 percent points in a year which is commendable.
- Of these women nearly 60 percent women are staying for 24 hours or more at the place of delivery.
- Out of the total JSY beneficiaries, more than 60 percent are from SC/SCT and other vulnerable groups.
- Among the JSY beneficiaries, 95 percent were registered for ANC, more than 82 percent had atleast 3 checkups, 83 percent consumed atleast 100 IFA tablets, 84 percent post natal care, 96 percent babies received BCG and 88 mothers who delivered at facilities were advised for exclusive breast feeding.

In addition to the districts identified for intensive ante natal and post natal care services, the districts of Balrampur (8.6), Siddharthnagar (9.7), Shravasti (11.2) and

[3] May 2009, Concurrent Assessment of Janani Suraksha Yojana (JSY) Scheme in Selected States of India, 2008, accessed from www.mohfw.nic.in

Kaushambi (14.3) will also be prioritised for institutional delivery activities based on indicators from DLHS III.

The JSY scheme is being implemented successfully across all the districts in the State. Necessary guidelines have already been sent to the districts and funds are being disbursed regularly. Wide publicity of the scheme is being ensured through hoardings, pamphlets, bus panels, print media and electronic media. Identification of private sector health facilities is being undertaken for the provision of JSY benefits and the facilities will be accredited as per Government of India norms. The activities will be continued during the next year and efforts will be made to increase institutional deliveries. **Beneficiaries will be encouraged to stay for at least 48 hours after delivery.** Further, the ANMs and ASHAs would ensure proper birth planning to ensure timely antenatal check-ups and institutional delivery.

The various important issues like quality of care, Family Friendly Hospitals, Facility Based Maternal Death Audit, injection of iron sucrose to anaemic mothers and other initiatives have been incorporated in the PIP under Innovations in Maternal Health section.

Estimated Number of Beneficiaries of JSY for the year 2010 - 2011

JSY scheme is being implemented from the year 2005-06. JSY scheme has given a boost in the deliveries being conducted at institutions. Based on progress reports from districts and reported by DGFW, 48 percent of the deliveries conducted in the State are institutional deliveries.

Following table shows the cumulative progress of institutional deliveries since JSY was launched in 2006-07:

Table: Number of Institutional Deliveries since 2006-07

Year	No. of institutional Deliveries (in lacs)
2006-07	**1.68**
2007-08	**9.64**
2008 -09	**15.63**
2009 -10	**18.63**

Source: Progress Report (2006-09), JSY, DG-FW

It is estimated that by the end of the financial year 2009 -2010 the total number of beneficiaries under JSY would be around 19 to 20 lacs. Further break up of these deliveries by the facility at which services were availed in presented in the following table:

Table: Number and Percentage of Deliveries by Type of Facility

S.No	Description	Nos.	Percentage
1	Total Institutional deliveries till Dec 09	15,23,532	84.64% (against target of 18 lacs)
2	BPL deliveries at home	37,245	2.44%
3	Deliveries at Sub Centres	2,00,403	13.15%
4	Deliveries at PHCs	4,86,247	31.91%
5	Deliveries at CHCs	5,00,060	32.82%
6	Deliveries at DHs including Medical Colleges	2,99,577	19.66%

Source: Progress Report (2009), JSY, DG-FW

At present about 33 percent institutional deliveries are taking place at public health facilities. It is proposed to increase the percentage of institutional deliveries at public health facilities to 37 percent. To meet the increasing demand under JSY, 137 FRUs, having atleast one LMO and two Staff Nurses round the clock and remaining team on call basis, have been operationalised. Further, during the year 2010 -11, 43 more units will be made functional as FRUs, as already discussed under the section on operationalisation of FRUs above. Also mapping of facilities would be done to ensure that JSY load is distributed as per bed strength & bed occupancy.

In the year 2010-11, 707 units (24x7) have been strengthened with 2-3 staff nurses and AYUSH lady doctors available round the clock at Block PHCs. During the year 2010-2011 it is proposed to increase 24 hr. units to 850 units (including 100 APHCs). The strengthening of CHCs as per IPHS norms is under process and deployment of additional human resources to meet the demand will help meet the additional work load. Accordingly, with the strengthening of health facilities and deployment of additional human resources, it is estimated that around 21.00 lac (2,170,820) beneficiaries would be covered under JSY during 2010 - 2011. The estimation is based on the following:

Expected No. of Rural Deliveries (Institutional)-

Expected No. of Rural Deliveries in Urban Facilities Deliveries at Gyne/ Obs Department of government and private medical colleges (9+9), DWH (53) and women's section of DCH (20)	168000 (12%)
Expected No. of Deliveries in CHCs (438)	693000 (32%)
Expected No. of Deliveries In Block PHCs (470) and identified APHCs	672000 (33%)
Expected No. of Deliveries in Identified Sub-Centres with Adequate Infrastructure	273000 (13%)
Total No. of Expected Deliveries under JSY in Rural Areas (A)	***1806000***

Expected No. of Urban Deliveries (Institutional)

Expected No. of Deliveries in District Level Hospitals, Government Medical Colleges, Pvt. Medical Colleges (DWH & Combined)	252000 (8%)
Total No. of Expected Urban Deliveries under JSY in (B)	***252000***

Expected No. of Rural Deliveries (Home)

Total Expected No. of Home Deliveries in BPL Families (C)	**42000 (2%)**

Total No. of Deliveries (A+B+C) = 21 Lacs.

Implementation of JSY

It is proposed to further strengthen the implementation of JSY in the State, for which additional support is required at the State level. A support cell, having two functionaries, has already been established at the Family Welfare Directorate. However, this cell requires additional strengthening in view of the enormous data being received from the districts and for redressal of complaints, as well as, for effective monitoring.

Strengthening of JSY Cell

For maintaining a good reporting system, updating of records, fund management & monitoring JSY Cell at the Directorate level has been formed. The following contractual manpower has been deployed in the JSY cell for programme management, monitoring and complaint redressal during the year 2009 to 2010:

- Programme Assistant - 2
- Data Entry Operator - 2
- Data Analyst - 1
- Accountant - 1
- Class IV - 1

All expenditure for the above would be met from the 1 percent allocation for administrative expenses at State level as per GOI norms. The budgetary requirement for the estimated 21 lacs deliveries is detailed below.

Budgetary Requirement for JSY for the year 2010 – 2011

Budget head	Physical target			Rate (Rs./Unit)	Annual Amount (Rs. in Lacs)
	Unit of measure	Current Status	Estimated Target		
Implementation of JSY (a) Beneficiaries					
A1.4.1 *Home Deliveries (BPL)*	Per Benef.	-	42000	500/-	**210.00**
Institutional deliveries **A1.4.2.2** Urban			252000	1000/-	**2520.00**
A1.4.2.1 Rural			1444800	2000/-	**28896.00**
			361200*	1650/- (1400/- +250)*	**5959.80**
(b) **A1.4.2.3** Caesarean Sections (Private Facility/ Provider)	Per benef.	-	30,000	1500/- per case	**450.00**
Sub-Total					**38035.80**

It is estimated that around 20 percent of the beneficiaries reach independently at the health facility, without the support of any mobiliser. Hence, no incentive is payable and the budgetary estimation has been done accordingly.

The total amount approved for JSY in the year 2010-11 is Rs. 38035.80 lacs.

A 1.4.3 Other Activities-

Administrative expenses at State level @ 1% of total amount and at district level @ 4%, totalling to Rs 1901.79 lacs (FMR Code A 1.4.3). This amount will be utilized for various administrative activities as per GoI norms.

1.4 Saubhagyawati Surakshit Matretva Yojana (FMR Code A 8.2)

A scheme for improving institutional deliveries, with the involvement of the private sector institutions, similar to the Chiranjeevi scheme in Gujarat, has been launched in the State during the year 2008 – 09. The scheme would be continued this year. At present 128 (as of December, 2009) Private Nursing Homes functional in peri-urban and rural areas have been accredited in 71 districts. The accreditation criteria, as per national guidelines, along with the complete list of nursing homes is being attached as annexed. Each nursing home is given an amount of 1.85 lacs for conducting 100 normal as well as complicated deliveries of BPL clients. The decreasing trend in the number of institutions is due to the withdrawal of incentives to clients or ASHAs during year 2009 -10. This contribution can go up in a big way if this barrier is removed.

Achievements:

	2008-09 (implemented for 8 months)	2009-10 (up to December 2009 9 months)
No. of Nursing Homes	158	**128**
Normal Delivery	12,291	**5754**
Caesarean Section	1,252	**693**
Complicated Deliveries	**597**	**166**

The budgetary support amounting Rs. 391.90 Lacs has been provided under the section 'Public Private Partnerships'.

1.6 Provision of Referral Transport for Pregnant Women

There is an inbuilt mechanism of Referral Transport facility under JSY. ASHA or the client gets Rs. 250.00 for reaching the facility. The facility for delivery is identified by the ASHA, with the family members of the beneficiaries, in the last trimester of the pregnancy and local transport for reaching the facility is identified. To make the referral transport amount readily available to the pregnant woman's family incase of an emergency, the ANM is issued an imprest amount of Rs. 1000 and she further provides an advance of Rs. 250 to the concerned ASHA.

Further, many districts have proposed to outsource referral to local NGOs/ agency for carrying the pregnant woman on no benefit basis. This component has been budgeted under District Innovations (for 22 districts as per their DHAPs) under Mission Flexipool. For referral transport from facility to facility, most CHCs and DHs have their own ambulances, procured through UPHSDP/ State budget. Operationalisation of these ambulances, including costs for drivers and POL, is being met through the State budget. At the CHC level an additional provision for referral has been included in the monthly operational costs. Additoinally, a scheme for Referral Transport through Ambulance (108) is being planned by the State and may be considered for the year 2011-12.

1.7 Rent for Sub-Centres (FMR code A 10.4)

There are 10,674 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 @ Rs. 250/- per month for 10,674 Sub Centres, amounting to Rs.320.22 lacs has been made for the year 2010-11 incorporated in the section on 'Infrastructure & Human Resource'.** Additionally, Rs.250/- p.m. would be utilized from untied grant at Sub Centre, in case a proper (minimum two rooms) rented building is available and can be used for providing better services including deliveries.

1.8 Performance based Incentive to Helper of ANM at Sub Centres

There are a large number of women in the State who have been conducting deliveries at homes or helping ANMs at the Sub Centre. It is proposed to encourage them for counselling the pregnant woman to deliver at the facility and ensuring essential newborn care. The following incentives are proposed:

Incentive for assisting ANM at Sub Centre for ensuring colostrum feeding within one hour after delivery, maintaining warmth and essential new born care
(Rs.100/- per delivery x 2 deliveries per month) - Rs.200/-

For assisting the ANM in conducting immunisation clinics at Sub Centre, assisting in her field visits and upkeep of Sub Centre premises
(Rs. 25/- per clinic day x 4 days / month) - Rs.100/-

Accordingly, a helper will be able to earn a maximum incentive of Rs.300/- per month. **The payment to helpers would be made from the Untied Funds at Sub centre level under Mission Flexipool.**

1.9 Providing Safe Abortion Services

Abortions have been legal in India, for a broad range of indications, for over three decades now by virtue of The MTP Act, 1971. Despite this, unsafe abortions contribute to a significant percentage of maternal deaths in the country. The Sample Registration Survey, 2000, estimates that 8.9 percent of all maternal deaths in India are related to complications of unsafe abortions. While most causes of maternal mortality are not predictable, unsafe abortion is predictable and therefore, easily preventable, if women have access to safe abortion care.

Operationalisation of MTP services at health facilities

At present MTP services are available only at 180 facilities (53 District Women Hospitals, 20 combined hospitals and around 107 CHCs). Thus, a total of around 273 facilities are providing MTP services. The table below shows the MTP achievement for the last 3 years:

Table: Year wise number of MTP cases

Year	**No of MTPs**
2007 -08	**89194**
2008 -09	**81644**
2009 – 2010 (Dec.)	**53908**

Source: Progress report, 2007-09, DG FW

It is proposed to strengthen the existing MTP services at these facilities and further operationalise MTP services by training more service providers in the existing facilities. Requisite training would be provided to the LMOs. This year the focus is on provision of safe abortion services upto the level of FRUs. Thus, a total of 180 facilities would be providing comprehensive safe abortion services including MVA, EVA and MA.

MVA Procurement: (FMR Code B 19.1)
It is proposed to procure 433 MVAs syringes(219 @ 3 per District Women Hospital & Combined Hospital and 214 @2 per functional CHCs) at the rate of Rs.2501/syringe during the year **2010 – 2011. A total of Rs. 10.83 lacs has been approved from Mission Flexipool.**

MTP Training:
In the year 2009-10, 10 Comprehensive Abortion Care (CAC) training sites were identified for MTP training at District Women Hospitals (Ghaziabad, Bulandshahar, Firozabad, Allahabad, Varanasi, Lucknow, Baharaich, Hamirpur, Unnao & Lucknow,) where 20 LMOs were trained as District trainers in CAC. Each of the 10 training sites were strengthened, with technical assistance from development partners, to provide CAC training to Ob-Gyns and MBBS doctors posted in the public health facilities. In addition to the clinical skill strengthening, the training curriculum also focussed on sensitizing the trainees towards importance of secrecy and confidentiality of the women undergoing MTP. This is expected to increase the acceptability of safe MTP services at the public healthcare facilities. Three types of training are being conducted: a) Training of Trainers in which 26 Master Trainers have been trained; b) Certified providers training on new and recommended safe abortion technologies like MVA and MMA for Ob-Gyns, DGO and all service providers approved under the MTP Act; c) Certification training for MBBS doctors in which the trainees perform 25 cases, of which five cases have to be performed independently. In the trainings, certified and certification, medical methods of abortions is covered in addition vacuum aspiration, MVA & EVA. In the Certification Training, the doctors are not trained in 2nd trimester abortion procedure since as per MTP act, MBBS doctors are not permitted to perform 2nd trimester abortions.

However, due to shortage of service providers, the state is facing difficulty in deputing the LMOs for the CAC training. Consequently, only 18 LMOs were trained against the target of 90. Presently the State has a total of 127 trained service providers.

For the year 2010-11, it is proposed to identify and strengthen 15 additional training sites. Thirty additional district level Master Trainers will be trained, a refresher training for Master Trainers conducted and certified and certification training of providers conducted such that a trained provider is available at 180 DWH/ CH/ CHCs. More details are available in the section on Training and funds have been budgeted in the same section.

Operationalization of District Level Committees

District Level Committee (DLCs) under the chairmanship of the CMO has been empowered to approve private sector facilities for providing MTP services. The DLCs in all 71 districts will be operationalized and information on the need for private sector site approval will be circulated to all facilities through press releases.

Strengthening Reporting and Activation of State and District MTP Cell

As per the MTP Act, data on all MTPs performed in a district during the month has to reach the CMO. Each CMO needs to compile the data for his district and forward it to the state MTP cell for onward reporting in the NRHM MIS. Availability of MTP admission registers, consent and opinion forms and monthly reporting format at all facilities will be ensured.

Orientation of DPMs/ BPMs/ ANMs/ ASHAs

Orientation of service providers and managers at district and sub district level will be undertaken along with the PCPNDT orientation (proposed in section of PCPNDT).

1.10 Operationalisation RTI/STI services at health facilities (FMR code A 1.1.4)

RTI/ STI clinics have been established in each district in a phased manner. Presently 86 RTI/STI clinics are functional at district level (including clinics in Medical Colleges). UPSACS has trained 175 Medical Officers and 97 Staff Nurses/ LT in these clinics. Counsellors have been appointed in these units and they have undergone eleven day training for various activities. Presently, 76 counsellors are working in these units. In addition, under RCH II, RTI/ STI clinics were established at 50 identified CHCs where Medical Officers and Laboratory Technicians (LTs) were trained through SIFPSA.

Establishment of RTI/STI clinics up to Block level (FMR code A 1.1.4)

It is being proposed to establish RTI/STI clinics at all 908 Block level PHCs/CHCs. A separate room for the purpose will be identified with all necessary furniture, examination couch, partition for male and female patients anda sign board to be displayed for availability of specialists. These will be in line with the National guidelines. **An estimated budget of Rs 0.50 lacs for setting up such clinics had been proposed. A total of Rs. 454.00 lacs for 908 such clinics has been approved by GOI.**

Training of Service Providers (FMR code A 11.3.5)*

It would be mandatory to train one medical officer & one LT from all 820 blocks to operationalise RTI/STI clinics at these facilities. This activity will be implemented in close coordination with UP State AIDS Control Society.

The TOT for the same will be conducted at CSMMU where 2 master trainers from each district will be trained for 3 days in batches of 30 participants. NACO identified national level experts will train State/ district trainers according to the National Guidelines for Prevention, Management and Control of RTI/ STI infections. To train 142 master trainers, 5 batches will be organized with an approximate cost of Rs.3 lacs per batch. **Thus, a total of Rs. 15 lacs will be required for the purpose.**

District level training will be conducted at district male/women hospitals in 60 batches (30 participants/batch) for 3 days. Thus to train 1646 participants, an estimated cost @Rs. 50,000/- per batch is required. **A total of Rs. 30.00 Lacs is being budgeted.**
*** Rs 50.69 lacs has been approved for 70 batches.**

Drugs and Consumables (FMR code A 13.2.1)
Earlier the funds for diagnostic and drug kits were provided by GoI, which were directly dispersed to the districts with guidelines and list of medicines and consumables. In 2009-10, GoI in its NPCC comments has conveyed that these will be provided directly by NACO through UPSACS. However, these essential items were not received, affecting provisioning of RTI/ STI services at the facility level. **Financial requirement for 908 RTI/STI drug kits & consumables kits of Rs. 317.80 lacs @ Rs 35000 per facility per year had been proposed and approved by GOI under RCH Flexipool Procurement Budget.** The Kits will be provided to the facilities as per their need. This includes provision for reagents, consumables and drug kits.

1.11 RCH Camp at CHCs/Block PHCs and Additional PHC (FMR code A 1.3)
It is proposed to organize 12 camps each year at the CHCs/ Block PHCs and at Additional PHCs having a proper building and a functional OT. Almost 30 percent of the camps would be organised at the Additional PHC level and remaining camps at the CHCs/Block PHCs. One camp each month from April to March, per block as per existing norms, are being planned. Plans would be prepared by the district to conduct these camps between 1st and 20th of the month @ Rs.4500 per camp. Since these RCH camps are planned at the facilities, normal services are not disrupted. ANMs and ASHAs mobilised beneficiaries in advance for availing services during these camps. Family Planning services are also being provided during these camps.

1.11	**A.1.3**	**RCH Camps**				
	A.1.3.1	*RCH camps at facilities*	820	4500	12	442.80
	A.12.3.1	*IEC for RCH camps*	820	6720	1	55.10
		Sub Total				**497.90**

Break up for RCH Camp
Thus, the total budgetary requirement for the activity for the year 2010 - 2011 is Rs. 497.90 lacs and has been approved by GOI .

1.12 Trainings for Maternal Health
The following trainings have been planned for maternal health and detailed under the training section:

- Skilled Birth Attendant's training
- Life Saving Anesthesia Skills
- Emergency Obstetric Care training
- Short term refresher CEmOC training
- Comprehensive Abortion Care training

1.13 Quality Assurance, Supervision and Monitoring of Maternal Health Activities

A detailed guideline has been developed by the State for monitoring of field level activities and have been issued to ACMO – RCH, Superintendant –CHC, Medical Officer – BPHC, District PM, District Community Mobiliser, District Accounts Manager (DAM) and Block Manager (HEO). A checklist suggesting an itinerary and specific areas of observation such as, visiting beneficiaries of JSY, verification of IUD cases, School Health Programme, Saloni Swasthya Kishori Yojana and visit to one VHND have been included.

Eight State Quality Monitors have been appointed at the Divisional level in 2009-10. Additional 10 SQMs will be recruited in 2010-11, making an SQM available at each division. These SQMs are responsible for monitoring quality of NRHM activities and they submit detailed inspection reports based on which their monthly reimbursement and honorarium is released. Their detailed TOR is attached as Annexure.

Ante Natal Care and Post Natal Care

To ensure that the guidelines issued to ASHAs and ANMs are followed, a detailed format is available with the ASHAs to be verified by the ANM and compiled at block level. This format is detailed under Mission Flexipool and attached as Annexure. While this format provides information for incentives for each ASHA, it also provides necessary service uptake data, including details of ANC, complications during ante natal period, PNC, institutional delivery, immunisation, among others. Progress in service uptake is being compiled and verified using these reports. Any grievances are addressed by the Medical Officer I/C in a monthly meeting with the ASHAs.

Ensuring 48 hour stay under JSY

As per guidelines issued to the districts, the beneficiaries have to be motivated to stay upto 48 hours after delivery. Keeping the operational constraints in mind, this is a challenge which is being overcome by including arrangement of fresh meals and making the facility family friendly.

In facilities where there is a very high case load and the facility is constrained in keeping the beneficiaries for 48 hours, an extra JSY ward is being proposed under Infrastructure Strengthening in Mission Flexipool.

Tracking ANC and Micro Birth Planning

The name wise tracking system proposed under Innovations will provide client based information for each service availed by the woman. During the monthly meeting at the BPHC, the MO I/C will provide a list of beneficiary to the respective ANM, who will then ensure that the beneficiary attends the VHND and avails ANC/ PNC services. Those beneficiaries in their last trimester of pregnancy will be accompanied by family members, and will plan with the ANM/ ASHA on referral transport, facility to be accessed and funds for an emergency.

Janani Suraksha Yojana

For ensuring that JSY implementation is according to guidelines from national level, the following monitoring activities have been instituted:

- Analysis of reporting formats: The Chief Minister of UP reviews the performance of NRHM on a monthly basis. Uptake of JSY, RI and FP services are indicators included for this review. The data for JSY is collected in the State Government formats as well as Departmental formats for review. The figures received from districts are validated between formats, analysed and reviewed. Feedback is provided to districts and those with low uptake are identified to resolve issues with CMOs.
- Bearer cheque payment to beneficiaries: All beneficiaries are reimbursed the JSY amounts through bearer cheques.
- Listing of all JSY beneficiaries at PHC and CHCs: A list of the beneficiaries who have availed JSY benefits is displayed at the PHCs and CHCs and is updated on a quarterly basis. Any discrepancy can be brought to the notice of the concerned authority.
- Grievance redressal: The District Magistrate addresses grievances on *tehsil diwas* once a month. At the district level, MO I/C will be responsible for conducting meetings with ASHAs once a month to address any issues regarding payment.
- Monitoring through State Quality Monitors: State Quality Monitors have been appointed at the division level with specified terms of reference. These SQMs will also conduct site visits including site visits and field visits to activities such as VHNDs, ASHA trainings, school health programmes, that are scheduled for the same days.

INNOVATIONS IN MATERNAL HEALTH FOR IMPROVING QUALITY OF SERVICE DELIVERY

1.14 Family Friendly Hospital Initiative (FFHI) Programme
(FMR Code A 8.4)

"A Family Friendly Hospital is a healthcare facility where the service providers offer quality care by following evidence based protocols and check lists for all the beneficiaries with special focus on women and babies to ensure patient safety. The hospital environment will be made conducive for the beneficiaries to stay comfortably in the institution. The institution will also provide enabling environment for the service providers to practice quality standards"

Rationale

Access to public health services has witnessed tremendous improvement since the inception of National Rural Health Mission. But the Hospitals are not implementing the evidence based labour room and operation theatre protocols. If these protocols are implemented, they would bring down the maternal and neonatal mortality and morbidity substantially in addition to improving the quality of maternal and newborn care and enhancing patient safety. For example, implementation of active management of labour protocol alone would cut down the PPH incidence by 40 percent thereby reducing the maternal deaths due to PPH. The standard protocols, safe child birth check lists, safe surgery check lists already available are to be put into use by training the service providers.

The ambience and the environment of the hospital has to be improved by providing clean environment, which is garbage free, has no overflowing drains and overall sanitation of the facility is maintained. Further improvements by way of a garden and improving the maintenance of the facility can also be attempted.

Client friendly services in the wards should aim at providing privacy during examination, mosquito screens for windows and doors, clean linen, clean blankets and no rusted cots or damaged mattresses, no cobwebs, no broken windows, with provision of purified drinking water, hot water, clean toilets with running water and provision of food. These efforts would encourage women who have just delivered and their families/ attendants to stay in the institutions for 48 hours. Mother and child are encouraged to stay for 48 hours for observation since 60 percent complications occur in mother and baby duo during that period.

The health facilities should have the essential drugs and equipments to provide basic care and to provide first aid in case of complications. It will also be ensured that standard treatment and infection control protocols are available and the staff is trained to use the protocols. FFH certification would assess the competency of the service providers in implementation of standard protocols.

The certification of Family Friendly Hospital (FFH) will provide a formal acknowledgement to the service standards already available at those facilities. The FFH do not focus on the major infrastructure support or additional human resources immediately. FFH mainly focus on the effective utilization of the available resources e.g. RKS funds, maintenance grants etc. and building capacity among the service providers to deliver quality services. Since the procedure for certification of family friendly hospitals does not take long, many health facilities can get certified within a short period. These certified hospitals can move to next higher level of accreditation for IPHS/ ISO/ NABH at a later date. The FFH certification would cut down the preparatory period for ISO certification and would encourage certified Family Friendly Hospital to opt for ISO certification.

The Family Friendly Hospital certification is one of the ways to ensure improvement in quality services. The certification process will not only create quality institutions but also ensure sustenance of the services offered, once certified. The active participation of all the service provider in the gap analysis, preparation of action plan, and implementation of quality protocols for FFH certification would create ownership, accountability and pride which will be a driving force for the sustenance of quality standards in the FFH certified institutions.

Additional funding support and autonomy to the Family Friendly Hospitals would encourage more CHCs and hospitals to opt for certification programme. Initially the certification may be on voluntary basis and after two years it would be mandatory for all the public hospitals to improve the quality standards by way of FFH certification.

The number of certified institutes in a district could also be a criterion for computing district ranking which would create healthy competition among the District health managers.

State Quality Assurance Cell has been established in the State Directorate. Formation of 'FFH Support Groups' within it would provide constant mentoring support to the institutions to ensure quality standards.

The proposal for the year 2010 - 2011

1. Orientation of field functionaries

A one day orientation at the State level will be conducted with two representatives from each facility. This orientation will provide an overview of the concept of FFH initiative to the health managers.

This will be followed by a five day training TOT to be conducted by the National Health Systems Resource Centre (NHSRC) trainers at SIHFW, Lucknow. The Divisional Programme Managers and a representative from the divisional HQ hospital will participate in this training. These Divisional PMs will train the district level health functionaries and further supervise the implementation of FFH activities in districts in their division.

S.No	Activity	Rate per Unit	Total (in Rs. Lacs)	Remarks
1.	State level orientation (200 participants @ Rs. 2000 each)	Rs. 1000	4.00	**RCH Flexipool**
2.	Five day TOT for Divisional teams (50 participants @ Rs. 12,000 each) at SIHFW	Rs. 12000	6.00	**Training budget – RCH Flexipool**
3.	District level trainings (Rs. 20,000 for each district)	Rs. 20000	14.20	**Training budget – RCH Flexipool**
	Total		**24.20**	

Of this total amount, Rs. 4.00 lacs is being budgeted under Innovations/ PPP/ NGO and Rs. 20.20 lacs has been budgeted under Training for the year 2010-11.

2. Process for making facility 'A Family Friendly Hospital'

- To get the hospital ready for certification team effort is required. Everyone in the hospital should participate in the problem identification/ gap analysis and work towards rectification of deficiencies within a time frame. It is desirable for each hospital staff to voluntarily accept the responsibility for some of the tasks for improvement.
- It is preferable to convene a hospital staff meeting in which all the staff including the outsourced service staff participate.
- The objective of Family Friendly hospitals is explained to all staff and gap analysis form is discussed during the meeting. A core team is formed that will go round the hospital and identify gaps by using the gap analysis form. This will be followed by development of strategies, along with timelines, by a core team. Each staff may be assigned with specific task.
- Periodical reviews will be conducted every week to monitor the progress of interventions. Every one of the staff member who participate in this process of quality improvement should feel ownership and self esteem and pride.

3. The hospitals/ facilities selected to participate in the programme

It is proposed that FFHI will be applicable to 53 District Women Hospitals and 17 Combined Hospitals. During the financial year 2009 – 2010, an amount of Rs. 10.00 lacs per District Women Hospital including Combined Hospitals has been released for ensuring infrastructural strengthening. Hence total of 70 District Women Hospitals are considered for FFHI. Also 70 CHCs which are functional as FRUs are proposed to be covered under FFHI in phased manner. Hence a total of 140 facilities are targeted for FFHI for year 2010 -11-12 as this initiative has immense benefits in the improvement of quality of service delivery. **In the first phase, 50 DWHs and 30 CHCs will be made Friendly Hospitals during the year 2010 – 2011.** The remaining 60 facilities will be operationalised as FFHIs in the year 2011-12.

C. Process of inspection for certification

(i) **Support team:** A Quality Assurance Cell exists in the Directorate of Family Welfare to provide support for this initiative and closely monitor the implementation. Initially the FFHI will be promoted as a voluntary initiative.

(ii) **Training:** A team of quality experts from NHSRC will train Master Trainers at the divisional level, who will in turn facilitate the training of four personnel from each district on FFH quality processes. This team will be responsible for conducting gap analysis at each of the facilities, prepare an action plan with timelines and supervise implementation of action plan. The process of upgradation to the FFHI standards does not require major structural changes in the facility or procurement of costly equipment and therefore should not take more than three months for completing the process.

(iii) **Readiness**: Once the hospital intimates about the readiness, preliminary visit will be made by the Quality Assurance Cell to check readiness for accreditation and visit by the certification team. The Certification Committee will be formed at the State level consisting of senior professor of obstetrics and gynaecology, reputed NGO nominated by State Govt and a Programme Officer, which will visit the institution and carryout the assessment of the institution on a prescribed format.

(iv) Based on the satisfactory inspection report, the Certification Body will release the Family Friendly Hospital certificate to the District Magistrate. District Magistrate would organize a small public function for handing over the certificate to the CMS/ Medical Superintendent of the facility, in which the VHSC, RKS members and elected representatives would participate.

(v) The certificate would be displayed at the entrance of the hospital. The quality assurance message with the list of improved quality of services will be displayed under which all service providers would affix their signature.

D. Period for the facility to qualify for certification

If the hospital team follows the process suggested by the certification body systematically, certification can be obtained within 3 to 6 months.

a. Validity of certification

The certificate is valid for 3 years. Every year, one surprise inspection will be made by the team. For any major deficiency noticed during the inspection, feedback would be provided to the concerned authorities so that the necessary action can be conducted. If the gaps are not corrected the certification will be cancelled. The Programme Officers and the CMS should take corrective action and apply for certification afresh.

b. **Responsibility of Support Team:**

The team will support the facilities in getting the certification.

E. Supportive Supervision

The Master Trainers at the divisional level will be responsible to support the facilities in their transition as a Family Friendly Hospital. They will support the facility in development of their transition plan, implementation of the plan, obtaining certification and visit every alternate month to assess whether the facility is meeting the criteria of

FFHI and Baby Friendly Hospital (this is an initiative described in the Child Health section). The plans developed at the facility level will be submitted to the Quality Assurance Cell at the State level to enable follow up of any constraints in implementation.

Budget:

Additional budget for improving the quality of services is proposed to those facilities especially selected for providing 24X 7 institutional delivery services including care of new born during hospital stay. The certification criteria do not envisage major structural alteration in the hospital or procurement of costly equipment.

The budget is provided in MCH budget head of PIP

SN	No of Facilities	Budget @ Rs. In lacs/Unit per year.	Amount (In lacs)
	30 CHCs working as FRUs.	5.00	**150.00**
	Renovation and strengthening of OPD with proper signage and glow signs	*2.00*	
	Facility of safe drinking water (Aquaguard with water cooler)	*0.50*	
	Furniture, benches, fans, coolers, TV/ DVD player for patients in OPD, indoor area	*1.50*	
	Repair and renovation of toilets with geysers (3 nos.)	*1.00*	
		TOTAL	**150.00**

GOI has approved the activity with the budgetory support of Rs.159.00 lacs under Innovation/PPP/NGO (FMR Code A.8.4).

1.15 Operational Plan for Pregnant women and Child Tracking System (FMR Code A 10.3)

It has been decided to have name-based tracking system whereby pregnant women and children can be tracked for their ANCs and immunization along with a feedback system for the ANM, ASHA etc to ensure that all pregnant women receive their Ante-Natal Checkups and post-natal care and further children receive their full immunization.

Data capturing of pregnancies detected/being registered from 1st Dec 09 and births occurring from 1st Dec 2009 will be captured in the system by ANM. The flow of data will be from Sub Centre to Block PHC to district to GoUP to GOI.

To strengthen the system action plan will be prepared at the following level

- State Level: Sensitize the District CMOs on the urgency and need for the name based tracking of pregnant women and immunization of children.
- District Level: Hold discussions with the Block Medical Officers to sensitize them on the initiative
- Block Level: To sensitize the ANM/ASHA/Block Level officials/Block programme management Unit/LHW and develop modalities for getting the primary information on name based tracking of pregnant women and immunization of children and subsequent reports on services provided.
- ANM/ASHA Level : Report the services delivered to the pregnant women and children based on the stipulated dates as per the ANC schedule and immunization schedule

The ID number would be generated by the system and would be available at the time of next updating on the computer system.

The state may entrust a training institution in the State say, the SIHFW, RHFWTC, and SHSRC or at the district level to take up the responsibilities for imparting training

Potential benefits are as follows:

1. Better control on estimates of infant and maternal mortality
2. Off-take of JSY benefits
3. Improved supply chain management of vaccines and drugs
4. Focused deployment of personnel based on the case load
5. Improvement in Registration of births
6. Used a basis for ICDS, Primary education, Adolescent health

Budget:

SN	Activity	Units	unit cost	Ant. Rs in lacs
1	State workshops	1	Rs.1.00lac	1.0
2	District and downwards workshops/orientation training	71	Rs 1.00 lac	71.00
3	Format printing	6 lacs formats	Rs. 2.00	12.00
4	Monitoring & Evaluation at State Level	1 at State	9.00	09.00
			TOTAL	93.00

Total budget amounting Rs. 93.00 lacs is required which has been approved by GOI under RCH Flexi pool under FMR Code A.10.3.

1.16 Early detection of pregnancy using pregnancy test kit

(FMR Code B 19.1)

The maternal mortality rate may be reduced significantly by early detection of pregnancy and taking care of pregnant women accordingly. Under the 'Mother (pregnant women) and child tracking system' early diagnosis of pregnancy by user's friendly pregnancy kit by ASHA & ANM will be highly beneficial for the scheme. This will also help in generating the faith of the beneficiaries in the system. Accordingly the Nischay pregnancy kit was introduced in the State in 2009-10 to ANMs and ASHAs. A one day training has also been provided to these service providers on using these kits. These kits have received a positive response in the field.

Orientation Training: To scale up this activity, all CHC/Block level MOI/Cs will be oriented to the testing technique and how to plan one day orientation training at their respective facilities for ANMs and ASHAs. MOI/Cs will be provided with supply of pregnancy kits for further distribution to ANMs/ASHAs.

One pregnancy kit will be for one beneficiary. The estimated number of deliveries in UP is about 55 Lacs. Considering 50 percent of women reach government facilities for various facilities and 50 percent reach in the first trimester, a total of 15 lac kits will be required. **The unit cost of the kit is Rs. 10/- and the total requirement of budget amounts to Rs. 150 lacs.** The estimated proposed budget will be met from Mission Flexi Pool under procurement head. It will be ensured that the shelf life of the test kits is more than one and a half year at the time of supply.

Budget required:

SN	Item	Unit price @ Rs	Amt. Rs. In Lacs
1	Pregnancy Kit	Rs. 10/ per kit	150.00
Total			**150.00**

Procurement of pregnanany test kits for Rs. 150 lacs has been approved by GOI under Mission Flexi-pool Procurement head (FMR Code B.19.1).

1.17 Reduction of Maternal Mortality and morbidity and neonatal mortality by management of severe Anaemia among pregnant women (FMR Code B 19.1)

Anaemia is prevalence in pregnant women is more than 51.6 percent in UP. (NFHS III). Studies have proved that iron deficiency is responsible for > 95 percent of the anaemia during pregnancy. The factors responsible for iron deficiency precede pregnancy and include diet poor in iron content, menstrual loss, poor oral intake of iron supplements and increasing demand of the foetus during pregnancy. Anaemia directly contributes to 8 percent mortality and indirectly to 22 percent mortality of the total maternal mortality rates. It also contributes to high foetal losses and increased incidence of LBW babies and consequent infant mortality.

Every second adolescent girl is anaemic. About 49 percent women weigh less than 45 kgs. Iron deficiency anaemia continues through the life cycle of girls into their adolescence and adulthood. 57 percent of children born to undernourished mothers are under weight. (Ref. – Planning Department UP, 2005 Report – 'A note on the Health Sector', pg 17)

Oral iron is given in the form of Iron Folic Acid tablets to combat anaemia both as a therapeutic and preventive measure. To correct severe anaemia with Hb percent less than 8 gms the women need parentral iron. Though studies proved that parental iron and oral iron have the same benefits; various factors like poor compliance, poor absorption etc result in poor outcomes among severely anaemic women.
In the high focus states often women are seen in the hospitals with complications of anaemia and the Haemoglobin levels are around 3-4 gm percent. When the haemoglobin levels of these women are to be improved within shorter time either blood transfusion or intravenous iron therapy is recommended. As the availability of blood transfusion facility is limited, therefore intravenous iron sucrose is the next best alternative. Reports of haemoglobin rise of 2.5 gm percent per week have been reported.

Iron sucrose is administered as IV drug for the management of severe anaemia. The advantage with this drug is the near absence of side effects. The second important advantage is the rapidity in the correction of anaemia which occurs within 5 weeks (Bangladesh study) and hence can be administered even in advanced stages of pregnancy say 30- 32 weeks.

Uniform Guidelines for the implementation

It is also important to develop uniform guidelines as per national guidelines which can be implemented across the state in all the selected institutions so that the benefit of iron therapy reaches the targeted population of the pregnant women.
Accordingly guidelines have been developed for the administration of iron sucrose in all the medical institutions. All the pregnant women who attend antenatal clinics in CHCs/BPHCs, FRUs and district hospitals with Hb percent levels less than 8 gms may be administered with Intravenous Iron Sucrose as per the protocol. The ANMs would screen the women for severe anaemia, refer women to CHCs, FRUs and for treatment

with Intravenous iron Sucrose. As per State guidelines, all pregnant women are being provided with a tablet of deworming during the second trimester of pregnancy to prevent anemia due to worm infestation.

A technical group will be formed with the senior specialist in Obstetrics, officer in charge of maternal health in State Health Society and state programme officer and other experts will prepare the state specific guidelines including method of administration of Iron Sucrose injection.
Guide lines:

a. Compulsory Hemoglobin estimation at 14 weeks, 20th weeks and 32 weeks of pregnancy for all pregnant mothers.
b. De worming at 20th week of gestation (Second Trimester).
   (Tablet Albendazole, 400 mg – single dose.)
c. Iron in the form of Ferrous Sulphate is the best choice. Preventive and therapeutic form of Iron to be started after deworming.
   (Preventive dosage of Iron – 100 mg. of elemental iron- FST 0.5 mg. Folic acid once daily for 100 days. Therapeutic dosage of Iron – 100 mg. of elemental iron – FST 0.5 mg. folic acid twice daily for 100 days).

Coverage:
It is proposed that IV iron injection therapy will be given to pregnant women with severe anaemia (1 percent of the JSY targeted (21 lacs) pregnant women/ deliveries)i.e. out of 21 lakhs deliveries conducted in the institutions around 21000 women delivered under JSY treated at FRU level may seek care during the antenatal period . It is expected that 50 percent will be utilized.

BUDGET:
Cost of one ampoule of IV Iron Sucrose inje**ct** is Rs.125/-. A severely anaemic woman requires 6 amp. of IV Iron Sucrose injections. Total amount of Rs 78.75 lacs would be required for procurement of IV Iron Sucrose injections. **This amount has been approved under the Procurement Head of Mission Flexi pool (FMR Code B.19.1).**

1.18 Strengthening of JSY accredited Sub centres (FMR Code A1.1.5)

There is a felt need for quality management and quality assurance in health care delivery system so as to make the same more effective, economical and accountable to the masses. The launching of NRHM has provided the opportunity for framing Indian Public Health Standards for Sub-centres also.
Minimum Services requirement to be provided on assured basis by a Sub Centre are listed below:

Sub-centres are expected to provide promotional, preventive and few curative primary health care services as below:

- Maternal and Child Health: (i) Antenatal care (ii) Intra-natal;(iii) Postnatal care
- Child Health: (i) Basic Newborn Care; (ii) Promotion of exclusive breast-feeding (iii) Full Immunization (iv) Vitamin A supplements, (v) Prevention and control of childhood diseases like malnutrition, infections, ARI, Diarrhoea, Fever, etc.

- Family Planning and Contraception, Counselling, services up to IUD insertion/removal and appropriate referral for other services.
- Adolescent health care:

JSY is one of the prime scheme in rural areas aiming at promoting institutional deliveries, therefore contributing directly in reducing Maternal Mortality and there by reducing neonatal & Infant Mortality as well. On implementation of JSY scheme, sub centres became very vital unit as the Institutional delivery encompasses those deliveries conducted at sub centres also. The achievement for 3 years show the increasing trend of deliveries at the sub centres and decreasing trend of domiciliary deliveries.

SN	Year	Sub centres Deliveries	BPL Home deliveries
1	2006 – 2007	No report as format was not in use	-
	2007 – 2008		75566 (partial regn.)
	2008 – 2009	22552	151011
	2009– 2010 (Up to Dec. 09)	178110	37245
		169296	

District wise list of the sub centres providing institutional deliveries is mention at the end of this intervention. Thus it is essential that at least 2300 sub centres as reported till Dec 2009 to be equipped with essential instruments consumables for providing quality services and conducive environment for the pregnant women coming for delivery at sub centres

In order to increase the accessibility to the sub centres attempt would be made at the district level to cover 700 more Sub Centers running in Govt building for conducting institutional deliveries. Hence they are also covered under this component. The proposed target is accreditation of total 3000 sub centres during year 2010 – 2011.

There are certain standards prescribed for accreditation of sub centres which is mentioned below:

- Sub centres should be functioning in government building
- ANM should be residing even at night in sub centre building
- Sufficient arrangement of light and water.

Strategy:

2300 + 700 (proposed for year 2010 – 11), total 3000 sub centres fulfilling the above standards are accredited under JSY in the state during 2010 – 2011. District Health Society has identified certain items for strengthening the sub centres and these items have been proposed under this intervention. Each centre will be provided an amount for upgradation based on its needs.

Budget:

Strengthening of Accredited Sub Centers: Allocated Budget				
SN.	**Activities**	**Quantity**	**Unit cost in Rs.**	**Amt in Rs.**
1	**Dissemination Meeting in each of the selected districts**	**71**	**5000**	**355000**
2	**Instruments/Equipments**			
2.1	Delivery Table with mattress	**3000**	**8200**	**24600000**
2.2	Examination Table	**3000**	**4500**	**13500000**
2.3	Foot step	**3000**	**750**	**2250000**
2.4	Weighing Machine (Both Type)	**3000**	**1500**	**4500000**
2.5	B.P. Instruments	**3000**	**900**	**2700000**
2.6	Stove	**3000**	**450**	**1350000**
2.7	IUCD Insertion Kit	****	**0**	**0**
3	**Electric Arrangement**			
3.1	Inverter	**3000**	**15000**	**45000000**
3.2	Emergency Lantern	**3000**	**1000**	**3000000**
4	**Furniture**			
4.1	Steel Hospital Bed	**3000**	**4200**	**12600000**
4.2	Mattress with Rexene cover	**3000**	**2200**	**6600000**
5	**Furnishing**			
5.1	Bed Sheet	**3000**	**160**	**480000**
5.2	Blanket	**3000**	**500**	**1500000**
5.3	Pillow	**3000**	**100**	**300000**
5.4	Bench for Waiting place	**3000**	**950**	**2850000**
5.5	Almirah	**3000**	**4400**	**13200000**
6	**Running Water**			
6.1	**Water Tank (200 Ltr.)***	**3000**	**3000**	**0**
6.2	**fitting of water tank & plumbing***	**3000**	**3000**	**0**
6.3	**Tullo Pump**	**3000**	**3000**	**9000000**
6.4	**Covered Bucket with Tape, Tub (20 Ltr.)****	**3000**	**0**	**0**
7	**White Washing & Minor Repair****	**3000**	**0**	**0**
8	**Sign Board**	**3000**	**750**	**2250000**

Strengthening of Accredited Sub Centers: Allocated Budget				
SN.	**Activities**	**Quantity**	**Unit cost in Rs.**	**Amt in Rs.**
9	**Wall Painting of Immunization Schedule**	**3000**	**750**	**2250000**
10	**Impact assessment Study**	**1**	**100000**	**100000**

Depending on the gap analysis by the Divisional/ District PMU, an amount in the range of Rs. 20,000 to Rs. 60,000 will be provided to the DHS for releasing to respective facilities. The monitoring of implementation will be undertaken by the MO I/C and DHS.

DHS further proposes that an impact assessment study of this activity to be commissioned in the third quarter of the FY 2010 – 2011 which has been included in the above budget.

A total sum of Rs. 1083.55 lacs has been approved by GOI under operationalisation of facilities head (FMR code. A.1.1.5).

Other Strategies /Activities (A1.5)

1.19 Maternal Death Audit
(FMR Code A 1.5.1)

1.19.1 Facility Based Maternal Death Audit

To accelerate the pace of decline of MMR and in order to achieve the NRHM & MDG goals Maternal Death Review (MDR) as a strategy has been spelt out clearly in the RCH II National Programme Implementation Plan document. It is an important strategy to reduce MMR as well as Maternal Morbidity as it gives detailed information on various factors affecting maternal deaths at community, facility, district, region and national level. This information, when used to inform programmes, provides critical inputs on design and implementation issues. Based on GOI guidelines 'Facility Based Maternal Death Audit System" has been developed in consultation with the Technical Support Group for maternal health. It is proposed that these guidelines be implemented in the State in 2010 – 2011. Strategy for the Facility or Institutional Based Maternal Death Audit, along with associated activities, is given in the table below:

SN	Activities	**Action taken / proposed**
1	Selection of institutions	**Proposed institutes for intervention are FRUs (District Women Hospitals, CHC –FRUs 137 units (53 DWH + 4DCH and 77 CHC as FRUs) and 9 medical Colleges. Total = 146 facilities and During II phase 862 Facilities providing 24X 7 service delivery would be covered.**
2	Training	**State level training of District trainers team (3 each from 57 DWH + CDHs + 9 Medical colleges total = 66 units. And 198 trainees would be trained)**
		District level Training: of FRU – CHCs =77 (7 participants from each of the FRU, total of 539 participants)
3	Medical Audit Review Committees	**Vide GOUP order no. 858/5 -9/2004 -9 (15)/2004 dated 12 March, 2004 state has issued orders for formation of various level Committees.**
4	Formats for Maternal Death Audit	**Based on GOI Guide lines formats for the use have been developed.**
5	Printing of the formats and a booklet on strategy of MDA	**Budget is proposed for the printing of formats, a booklet on Guideline on MDA.**
6	**Review meetings**	**The facility level MDA Committees will meet as per the following schedule** **1. Medical Colleges: Once a month** **2. District Hospital/FRUs: Quarterly**

In the event of a maternal death, the Facility Based Audit Committees will assess the following:

1. Circumstances under which the death took place;
2. Cause of maternal death – direct or indirect obstetric causes and non obstetric causes;
3. Whether death was preventable;
4. What steps are required to address first and second delays; and
5. Management interventions.

The Committee will map any particular pattern in occurrence of deaths in the facility such as

1. Death occurring on particular week days
2. Any pattern in timing of death.
3. Any pattern in relation to staff deployment

State Programme Officer – SIHFW will conduct all the training programmes in consultation with SPMU concern officer. State Programme officer will organize yearly review meetings at state level to review all institutional level maternal deaths and status on follow up actions.

S.No	Activities	No. of Units	Rate per Unit (in Rs.)	Frequency	Total (in Rs. Lacs)
	Maternal Death Audit				
	One day district level orientation of DHs	3	191650	1	5.74
	One day orientation for FRUs and 24x7 units	143	4100	1	5.99
	Review Meetings	1	150000	1	1.50
	Printing of forms, booklets and annual report	1	500000	1	5.00
	Sub Total				**18.11**

1.19.2 Community Based Maternal Death Audit

In addition to the Facility Based Maternal Death Audit, there is a need to conduct audits at the community level to understand reasons for maternal death and factors hindering access to health services. The following activities will be undertaken in 2010-11:

- Guidelines, in accordance with the national level guidelines, will be developed in 2010-11;
- State level orientation for CMO/ ACMOs/ DPMs/ DCMs;
- District level orientation of Block level MO I/Cs – CHC/ PHC, CDPOs, BDOs and ABSAs;
- Block level orientation of HEOs/ ANMS/ HVs, selected ASHAs and selected members of VHSCs;
- Capacity building for reporting and conducting verbal autopsy through State Level Trainers trained at PGI, Chandigarh will be done for CMSs (included in facility based death audit training);
- Revision of existing formats through Technical Support Group on Maternal Health and ensuring distribution of these formats upto ANM level;
- Committees already existing at block, district and State will be revived;
- These Committees will facilitate the process of verbal autopsy and they will compile, discuss and provide feedback to health facilities;
- Discussion of reasons for death and means to prevent future maternal mortality and morbidity will be discussed by the Committee at the community level;
- District Magistrates will be responsible for conducting quarterly meetings at district level and analysing causes of maternal deaths and addressing them.
-

S.No	Activities	No. of Units	Rate per Unit (in Rs.)	Frequency	Total (in Rs. Lacs)
	Community Level Death Audit				
	One day state level orientation	1	300000	1	3.00
	One day district level orientation	71	15000	1	10.65
	Block Level Orientation	820	3000	1	24.60
	Printing of formats	820	2	12	0.20
	Meetings for audit activities	820	200	4	6.56
	Sub Total				**45.01**

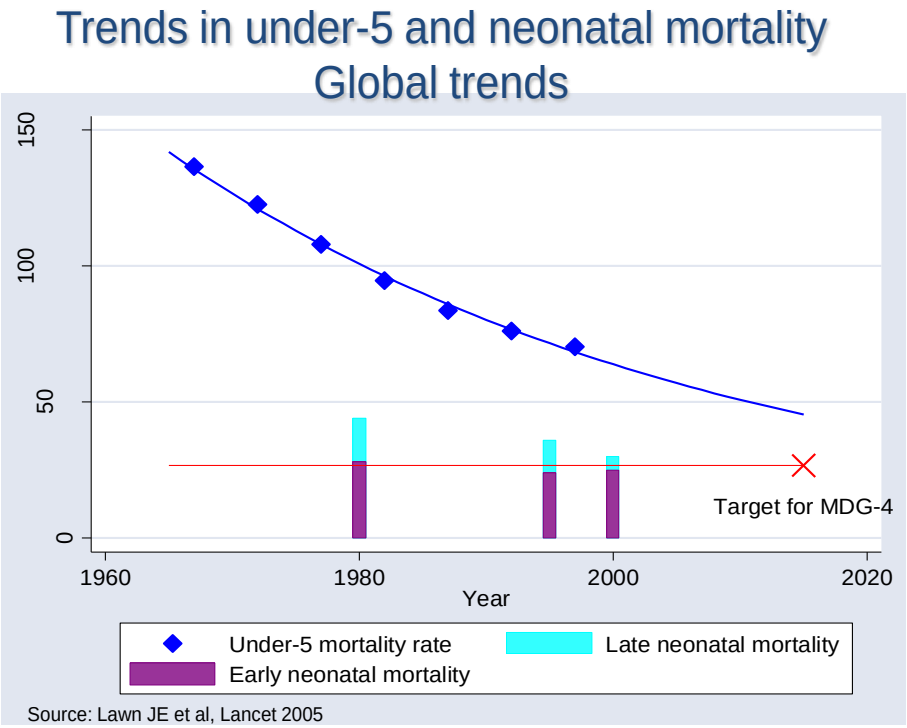
The total amount Rs. 63.12 lacs has been approved by GOI (FMR Code A.1.5.1).

BUDGET SUMMARY

FMR S.No	Activities	No. of Units	Rate per Unit (in Rs.)	Frequency	Total (in Rs. Lacs)
A 1	**MATERNAL HEALTH**				
A.1.1.4	**Operationalise RTI/STI services**	908	50000	1	**454.00**
A.1.1.5	**Operationalize sub centres (Accreditation under JSY)**				**1,083.55**
A.1.3	**RCH Camps**	820	4500	12	**442.80**
A.1.4	**Janani Suraksha Yojana**	2130000			**38,035.80**
A 1.4.3	**Other activities-**5% administrative espenses for JSY				**1901.79**
A 1.5.1	**Maternal Death Audit**				
	Facility Based Death Audit				**18.11**
	Community Based Maternal Death Audit				**45.01**
	PROGRAMME SUB TOTAL				**41,981.06**
A.12.3.1	**IEC for RCH Camps**	820	6720	1	55.10
A. 10	**Institutional Strengthening – Tracking of pregnant women and children**				94.00
A.1.1.4	**Training – RTI/ STI**				45.00
A 11.9	**Training –FFHI**	50	12000	1	20.20
A 10.4	**Infrastructure Strengthening –Rent for Sub Centre**	250	10674	12	320.22
	PPP/Innovations				
A 8.2	Saubhagyawati Yojana	1	39190000	1	391.90
A 8.4	Family Friendly Hospital Initiative				159.00
	Procurement - Mission Flexipool				609.88
	SUB TOTAL FOR MATERNAL HEALTH				**43676.36**

2. CHILD HEALTH INTERVENTIONS

Although the State has made consistent progress in improving the child health indices during the last 3 decades, the indicators are still a cause of concern for us. Child mortality rate & infant mortality rate are still very high in comparison to national average. The IMR was as high as 181 per 1000 live births in 1971, which has come down to present level to 67 per 1000 live births, but the decline is mainly in the post neonatal period where as neonatal period mortality has not declined significantly. Globally also, the trends are similar. The graph below clearly shows that though the infant mortality rate has come down from 150/1000 live births in 1960s, the neonatal mortality (first 4 weeks of life) is still quite high. Similarly, it shows that the reduction in early neonatal period (first week of life) is almost negligible and the reduction in late neonatal period (2nd to 4th week of life) is also not up to the mark.

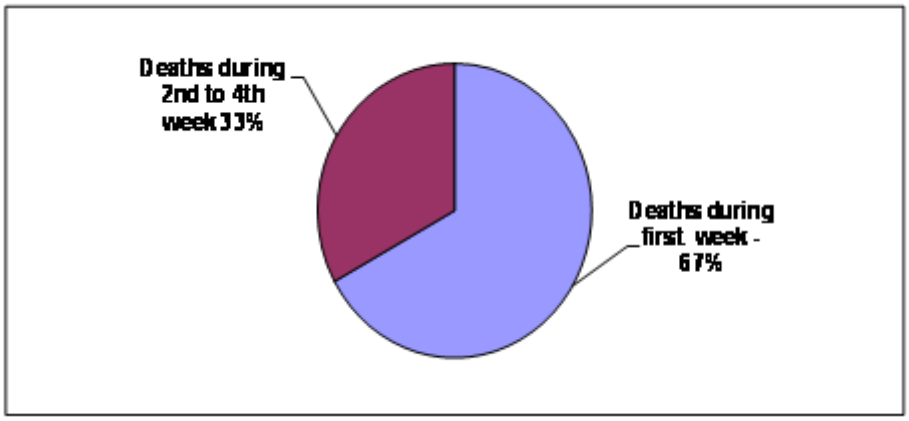


At the time of inception of NRHM, the Infant Mortality Rate was 73/1000 live births (SRS 2005), which has come down to 67/1000 live births (SRS 2008) but it is still high as compared to the national average of 53/1000 live births. Similarly, under 5 mortality stood at 96 per 1000 live births (NFHS-3 2005-06), compared to the national average of 74.

This calls for a concerted effort to address the causes of deaths in neonatal period, which may be medical causes and/or multiple social factors leading to improper practices and behaviours in the community. A study has been carried out to understand the prevalent behaviours and practices for new born care in various regions of the State and right behaviours and practices have been identified to be added to the training and IEC/BCC material developed specifically for child health interventions.

2.1 NEONATAL MORTALITY - Our biggest concern

More than 67% deaths occur in the first 28 days of life and 33% deaths are occurring in the rest 11 months of the first year of life. As per NFHS-3 (2005-06), Neonatal mortality of the State is as high as 48 per thousand live births and immediate interventions are needed to address it. In the first 28 days, the first week is most crucial because two-thirds of the neo-natal deaths occur in the first week itself as shown in the pie diagram below:-

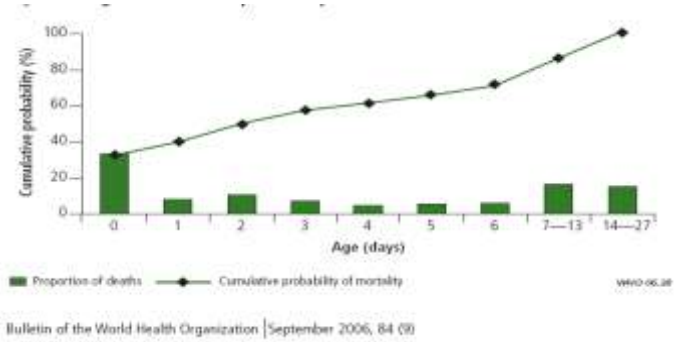


Though the IMR has declined significantly during the last decade, the reduction in neo natal mortality has not kept pace with it. The main causes of deaths during the Neo Natal period are:-

- Asphyxia (Inability to establish respiration immediately after birth).
- Hypothermia (Reduction in body temperature due to various prevalent customs and traditions in the community).
- Infections (custom of putting oil/ghee/mud/other local material on umbilical stump and other infections due to unhygienic practices, myths and beliefs).
- Low birth weight babies (>33% as per NFHS-III reports) are highly susceptible to asphyxia, hypothermia and infections leading to maximum number of Neo Natal deaths in low birth weight and pre term babies.

  The New Born needs immediate care after birth, which can be provided best at the facility level, because Day-1 is the most crucial for a new born as shown in the graph below:-

Timing & Cumulative probability of neonatal deaths in UP



Bulletin of WHO-September, 2006, 4(9)

Though with intervention of JSY, there is a huge rise in number of institutional deliveries, but still about 45 percent births are taking place at home and immediate care after birth should be available both at the facility as well as at home. The need for training all the staff nurses, ANMs and ASHAs in resuscitation emerged from this fact. The component is being addressed through following interventions:-

- Training of ASHAs under Comprehensive Child Survival Programme (CCSP) to make them understand the magnitude of problem and their role in motivating the community to practice right behaviours. They motivate the families to ensure colostrums feeding within one hour after birth, exclusive breast feeding for the first six months of the life, maintain the warmth of the baby by postponing bathing for 6 days and practicing hygienic behaviours.
- Trained ASHAs are visiting each new born 3/6 times during the first month of life, identify high risk newborns and ensure their referral if needed. Each new born is being visited on the 1st, 3rd and 7th day of life compulsorily and ASHAs are being paid cash incentive for each visit and referral through an established system.
- All the ANMs and Staff Nurses are being trained to resuscitate the new born and provide her essential new born care.
- All the medical officers are being trained to provide essential new born care to a normal baby and treatment to a sick new born under facility based new born care training.

2.1.1 Strategies to address neonatal mortality in the State

1. Community mobilization and home based care– through ASHA. Empowerment of ASHA by Comprehensive Child Survival Training Programme (IMNCI Plus).
2. Capacity building of ANMs - Comprehensive Child Survival Training Programme (IMNCI Plus).
3. Capacity building and improving skills of Medical Officers of CHC/PHC through F-IMNCI.
4. Capacity building and improving skills of Staff Nurses of CHC/PHC through F-IMNCI
5. Training and Skill up-gradation of MOs & Staff Nurses for Management of Neonatal asphyxia, hypothermia and infections through 'Nawjat Shishu Surachha Karyakram' for staff posted at 24 x 7 hours facilities and FRUs (NSSK Training).
6. Ensuring Newborn Care corner at each CHC/BPHC.
7. Establishing Sick Newborn Care in each Divisional Hospital (where there is no Medical College).
8. Management of Diarrhoea and Pneumonia through ASHA/ANM and at facility.
9. Ensuring wide publicity regarding proper behaviour and practices for breastfeeding, prevention of hypothermia and infection prevention. This will be done during breastfeeding week, newborn care week and various workshops, seminars etc.
10. To increase public awareness, audio-visual aids are being provided in each post-natal ward where relevant massages, information and entertaining educative films will be shown throughout the day.
11. Supporting supervision and hand holding of ASHA with the support of Medical Colleges and reputed institutions.

In 2009-10, Uttar Pradesh has undertaken a detailed study of infant mortality cases with special focus on neonatal mortality. With this the Family Welfare Department has also conducted several rounds of discussions and deliberations regarding what will actually work at the ground level. This has come out with a consensus that specific messages and wide publicity by using different IEC interventions are also necessary to supplement the State machinery as many traditions and customs with the public psyche, which are detrimental to the neonatal and infant health. The State is implementing multipronged strategy to address deaths in the early neonatal period, which are mainly due to infections, prematurity, hypothermia and asphyxia in the new born.

These are being addressed by –

- Creating awareness in the community regarding importance of institutional delivery, giving colostrums in the first hour after birth, postponement of bathing for first 6 days, keeping the baby warm and practicing hygienic behaviour with exclusive breastfeeding up to the age of 6 months.
- Training of ASHAs for motivating mothers for institutional deliveries, providing complete care to the newborn and identifying high risk babies for referral and management.

- Training of ANMs and staff nurses for providing essential newborn care to all and treatment to sick babies.
- Training of medical officers for providing facility based newborn care to referred children.
- Wide IEC activities for creating awareness in the masses and motivating them to practice right and appropriate behaviours.

To ensure complete essential new born care to all the deliveries at facility following is being done:-

1. New Born Care Corner (NBC Corner) at all 24x7 facilities where all the essential equipments and medicines are being provided The staff posted here is being trained to use them.
2. Neonatal Intensive Care Unit (NICU) at all FRUs where essential equipments including Phototherapy Units, Radiant warmers, pedal operated suction apparatus, oxygen hood and Ambu bag is being made available. All the medical officers and staff nurses posted at these facilities are being trained under ongoing 3 days Facility Based New Born Care Training in the State. Futher it has been decided to provide latest equipments including neonatal respirator, which is easy to operate even by a trained staff nurse at all distirct women hospitals which function as district level training site for FBNC. These sites will be strengthened for provision of quality services to newborns and training as well. The same is being budgeted under the site strengthening component of FBNC.
3. Sick New Born Care Unit (SNCU) at 7 identified places in the State. The SNCU at Lalitpur is fully functional and remaining 6 at Lucknow, Saharanpur, Shahanjahanpur, Pratapgarh, Aligarh and Azamgarh are almost complete and will be fully functional from April, 2010.

2.1.2 Essential newborn care corners

Child health is directly linked to the educational and health status of mother, care during pregnancy, safe delivery, post delivery care of the new born & management of early childhood illnesses. To address these issues, a component of essential newborn care is being implemented all over the State at district hospitals, CHCs and Block PHCs. The Medical Officers along with paramedical staff have been trained for essential newborn care designed for skill development of the functionaries.

All the CMOs, CMSs and MO I/Cs have been provided a check-list for Newborn Care (NBC) Corners in the labor rooms of respective facility. They have been given instructions to supervise the operationalization of these NBC corners in each delivery. If there is any gap in availability of specific equipment, medicines or skills, they have to identify it and corrective measures have to be taken immediately either through RKS funds or by arranging training for personnel.
ASHAs, ANMs and LHVs are being trained to provide essential newborn care through various training courses being run throughout the state like – ASHAs in their basic

training course of 2nd phase and ANMs/LHVs during 12 days Integrated Skill Based training specifically designed for these functionaries and SBA training.

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

An integrated approach, focusing on the family, community and facility level care of the mother and the new born, supported by the institutional mechanism for health care delivery, is required. For this a multi- pronged strategy has been envisaged which is being implemented in a phased manner from the year 2007-08 in the State of Uttar Pradesh.

The goals and objectives of the programme were kept as follows:

2.2.1 Goals

- To reduce the Infant Mortality Rate from 73 per 1000 live births (SRS 2005) to less than 36 per 1000 live births by the year 2012 in Intervention areas.
- To reduce the neonatal mortality rate in the pilot area by 30 percent from the existing level

2.2.2 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, identification of high risk new borns , their timely referral and management.
- Demand generation for quality child care services through efficient IEC/BCC
- Improve uptake of services through effective counselling.

2.2.3 Components of CCSP

- Birth preparedness and complete antenatal care
- Immediate care after birth
- Home Based Newborn Care
- IMNCI package
- Strengthening of referral linkages
- Facility Based New Born Care –Trg. of all MOs & S/Ns posted at PHC/CHC/FRU/DWH
    - This component is also being addressed by GoI from this year only as Navjat Shishu Suraksha Karyakram where training of Pediatricians, MOs and Staff Nurses is being done specifically for care of newborns immediately after births).
- Establishing SNCUs
- Strengthening community mobilization and BCC (Behavior Change Communication) network. Celebration of breastfeeding and Newborn care week
- Infant Death Audit
- Intensive supervision, monitoring and evaluation

Comprehensive Child Survival Programme – UP (CCSP-UP) was launched during the year 2007-08. The programme was initiated in 17 selected districts (one district in each division with high IMR and availability of minimum basic infrastructure). However, during 2007-08 only the regional orientation workshops and National ToTs could be completed and actual training of functionaries could only be initiated from 2008-09. Good progress has been made in these 17 districts in regard to training, implementation and reporting.
Additionally 19 districts have been taken in the year 2009-10 where state and district TOTs are almost complete and few of the districts have also initiated 10 days training for ASHAs/ANMs/LHVs. The training envisaged under CCSP programme is very extensive, and implementation in the field needs lot of support and handholding for ASHAs together with intensive monitoring and supervision.

Since the programme seems to have very good response in the community and ASHAs have gained lots of confidence, it has been decided to scale it up in all 71 districts of the State in the year 2010-11..

2.2.4 Coverage in the First Phase (2008-09)

Under CCSP, one district from each division was selected with high IMR (DLHS-II) and which also had the minimum infrastructure to implement the programme. The first phase of the programme is being implemented in 17 districts as listed below:

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	

2.2.5 Coverage in the Second Phase (2009-10)

In year 2009-10 one additional district in each division was added to the scheme, as per the plan for phased expansion.

Previously, Lalitpur district was taken as a pilot for IMNCI supported by Unicef during the year 2005-06 and 2006-07. Medical Officers, Health Supervisors and ANMs had been trained together with AWWs. Hence, Lalitpur was also covered under CCSP for ASHAs training.

19 Second phase districts in which the programme was initiated in the year 2009-10 are listed below—

1. Allahabad
2. Badaun
3. Barabanki
4. Basti
5. Bhadohi
6. Bijnor
7. Chitrakoot
8. Etah
9. Farrukhabad
10. Ghaziabad
11. Gonda
12. Jalaun
13. Jaunpur
14. Lalitpur
15. Maharajganj
16. Mathura
17. Mau
18. Muzaffarnagar
19. Unnao

2.2.6 Expansion of CCSP in all the remaining districts.

It was planned to cover 25 % every year in increasing manner, when the programme was launched in the year 2007-08. Thus 17 districts were covered in the yr.2008-09, another 19 Districts were added in the yr.2009-10 and it was planned to add 18 further in the Yr. 2010-11. But, since it is an extensive, time taking training, it has been decided to start the programme in all the 35 remaining districts, so that all the functionaries may be trained by the end of 2012.

The work load calculated in these Districts comes to 1461 LHV, 10061 ANMs and 61028 ASHAs to be trained in the next 2-3 yrs. The total no. of training Batches to be conducted is 580 for the yr. 2010-11 which will cover approximately 20% of the functionaries.

2.3 Status of Training

2.3.1 The present status of trainings in 17 first phase districts is as under:

Sl.	Description	Total work load for 17 districts	Target to be achieved by 2009-10	Achievement till Dec. 09	Expected achievement by March, 10	Remaining work load 2010-11
1	Training of Trainers	270	270	270	270	--
2	Training of Medical Officers (Physicians Training)	1262	1100	217	400	862**
3	Training of ANMs	5200	5200	3500	3800	1400
4	Training of LHVs/HS	1400	1400	400	500	900
5	Training of ASHAs	34000	30000	22300	23150	10850
6	TOT for FBNC (19 districts x 6)	114	114	118	118	--
7	Training of MOs & Staff Nurses in FBNC(140 units x 6) X3 days training	840 For (17 +1) district	840	114 (19 batches)	510 (85 batches) 5 batch/district	330
8	TOT for Supervisors	68	68	59	68	--
9	Supervisory training (ANMs and LHVs)	7287	2672	576	1088	6199

**If FIMNCI is finalized, then total Load will be treated for FIMNCI

2.3.2 Status in the Second Phase districts

The present status of trainings in 19 second phase districts is as under:

Sl.	Description	Total work load for 19 districts	Target to be achieved by 2009-10	Achievement till Dec. 09	Expected achievement by March, 10	Remaining work load 2010-11-12
1	Training of Trainers (ToT state level)	190	114	72	114	76
2	District TOT Batches	31	19	7	19	12
3	Training of ANMs/LHVs/HS (4 participants per batch)	7340	1600	60	250	7090
4	Training of ASHAs (20 participants per batch)	37000	7000	240	1000	36000
5	TOT for FBNC (18 districts x 6 participants) (12 participants per batch)	108 (9 batches)	108	25 (2 batches)	108 (18 districts x 6 participants)	--

Sl.	Description	Total work load for 19 districts	Target to be achieved by 2009-10	Achievement till Dec. 09	Expected achievement by March, 10	Remaining work load 2010-11-12
6	Training of MOs & Staff Nurses in FBNC(143 units x 6 participants)	858 For 19 districts	858	0	90 (15 batches)	768
7	TOT for Supervisors-4 from each district (32/batch)	76	76	0	32 (1 batch)	44
8	Supervisory training (ANMs and LHVs) 16/batch	7340	912	0	128 (1 batch each in 8 districts)	7212
9	Site strengthening for CCSP	35	23	7	23	12
10	Site strengthening for FBNC	19	19	0	19	-

2.3.3 Involvement of various Medical Colleges under Child Health Trainings

Seven Medical Colleges have been involved in various types of child health trainings. Paediatrics and SPM department of IMS, BHU, Varanasi is supporting TOT for CCSP master trainers. As of now 9 batches of such TOTs have been completed by the institute and it will continue the support in future.

Neonatology section of Paediatrics department of CSMMU, Lucknow has been involved in imparting TOT for facility based new born care training in the State. TOTs of 17 first phase districts have been completed and those of second phase are going on. The districts are conducting training of Medical Officers and Staff Nurses after completion of ToTs. The centre will also be utilized for imparting FBNC training to Medical Officers and Staff Nurses of the neighbouring CCSP districts.

The Medial Officers (Physicians training) of 10 days which was initiated in first phase 17 districts is being conducted with support from 4 State Medical Colleges, namely, **MLN Medical College, Allahabad; MLB Medical College, Jhansi; GSVM Medical College, Kanpur** and **SN Medical College, Agra.** These Medical colleges have been strengthened for training and each college has started the training programme. In addition, JN Medical Colleges A.M.U. Aligarh will be included for the TOT of CCSP/F-IMNCI and Physicians training. Strengthening of JN Medical Colleges, AMU Aligarh is proposed for the year 2010-11.

As per guidelines from Govt. of India, the training programme initiated in these Medical Colleges will now be an amalgamation of facility based new born care and CCSP (F-IMNCI & CCSP) training for Uttar Pradesh. The revised budget is being included in the proposed plan and the training will be of 11 days after getting approval from GOI.

The recurring cost for each medical college (7 in Nos.)is around Rs.5 lacs per annum. The Non recurring cost (one time) for JN Medical Colleges will be Rs.3.95 lacs
Thus, an amount of Rs.38.95 lacs is being budgeted for 7 Medical Colleges.

2.3.4 Training Plan for 2010-11 (CCSP + FBNC) (FMR Code A 11.5.1 + A 11.5.2)

SN	Description	Total work load for 36 districts 2010-11-12	Target to be achieved by 2010-11	Remaining work load for 2011-12	No. of batches proposed	Estimated budget *(Rs. In lac)*
1	Training of Trainers	76	76	0	Nil	0
2	District TOT (1st/2nd phase districts) (Rs.2.39 lacs per batch)	384	384	0	16 (4 for 1st & 12 for 2nd)	38.24
3	Training of Medical Officers (F-IMNCI) (Rs.2.97 lac for trg. & Rs.4400/- for sup.-25 % of 13 batches)	2086 862(17 districts)+1224 (19 districts)	1200** (10 batches in each Med. Colleges)	886	50	149.072
4	Training of ANMs/LHVs/HS (55 sites will be made functional during 2010-11)	9390 (2300 of 1st phase+7090 of 2nd phase)	4000 (1000 batch. x 4)	5390	1000 (24 part.) @Rs.1.65 lac	1650.00
5	Training of ASHAs (55 sites will be made functional during 2010-11)	46850 (10850 of 1st phase+ 36000 of 2nd phase)	20000	26850		
6	Training of MOs & Staff Nurses in FBNC(283 units x 6) *(Rs.12000/- per batch) for trg*	1098 (330+768)	1098	0	183 (6 part.)	21.96
	Supervision of 48 batches- (about 25 % of batches organized) @ Rs.3200/- per batch				48	1.54
7	TOT for Supervisors	44	44	0	2	Will be supported by UNICEF
8	Supervisory training (ANMs and LHVs) *(Rs.24,500/- per batch for trg & sup of 100 batches- 25 % @ Rs.3200/- per batch)*	13411 (6199+ 25% of 7212)	8002 (6199+1803) (All 387 batches in 1st phase & 113 in 2nd phase	5409	500	122.50

SN	Description	Total work load for 36 districts 2010-11-12	Target to be achieved by 2010-11	Remaining work load for 2011-12	No. of batches proposed	Estimated budget *(Rs. In lac)*
	Supervision of 100 batches-(about 25 % of batches organized) @ Rs.3200/- per batch		Distt.)		100	3.20
9	Site strengthening for CCSP (@ Rs.2.15 lacs per site)	16	16	0	NA	34.40
10	Site strengthening for CCSP/FBNC @ Rs.2.5 lacs for 36 (1^{st}/2^{nd}) phase districts, which will include neo-natal respirators of latest technology but easy to handle. These funds will be released as per need & training of staff to use these eqipments and also for maintenance and repair etc.	36	36	0		90.00)
Total						**2116.06**

**If F-IMNCI is finalized, then total load will be treated for F-IMNCI

The details of the training load, plan for the yr.2010-11 and estimated budget is shown in the table below.

2.3.5 Training Plan for New 35 Districts 2010-11 (CCSP) (FMR code A 11.5.1)

Sl.	Description	Total work load for new 35 districts 2010-11-12	Target to be achieved by 2010-11	Remaining work load for 2011-12	No. of batches proposed	Estimated budget *(Rs. In lac)*
1	Training of Trainers (ToT State level)	280	280	0	12 (Appx. 24 part.)	UNICEF support
2	District TOT (New 35 districts) (Rs.2.39 lacs per batch)	840	840	0	35 (1 batch per district)	83.65
3	Training of ANMs/LHVs/HS	11522	2320 (580 batch. x 4)	9202	580 (Appx. 24 part.) @Rs.1.65 lac	957.00
	Training of ASHAs	61028	12180 (580 batch. x 21)	48848		
4	TOT in FBNC (35 x 6) (@Rs.57,500/- per batch)	210	150	60	15	8.63
5	Training at districts of MOs & S/Ns on FBNC (Av. 4 batches in each of the 35 districts) *(Rs.12000/- per batch for trg & sup of 35 batches-25 % @ Rs.3200/- per batch*	2472 (412 units-377 bl+35 dt)	840	1632	140	16.80
	Supervision of 35 batches-(about 25 % of batches organized) @ Rs.3200/- per batch				35	1.12
6	Site strengthening for CCSP (@ Rs.2.15 lacs per site)	35	35	0	35 (1 site per district)	75.25
7	Additional funds for site strengthening @ Rs.2.5 lacs per district, which will include neo-natal respirators of latest technology but easy to handle. These funds will be released as per need & training of staff to use these eqipments and also for maintenance and repair etc.	35	35	0	NA	87.50
Total						**1229.95**

Thus the total budget of Rs. 1229.95 lacs will be required for site strengthening, District TOT and 20% of training of functionaries (ASHA/ANM/LHV) during the Yr.2010-11 in remaining 35 districts.

Since the training norm is revised by GoI, but the State has not been implemented the revised norm as yet because it will be implemented only after getting approval from the committee formed for this purpose. Till that period, the existing norm will be applicable. However, to meet out the enhanced norm after implementation of the revised norm, an additional amount of Rs. 90.00 lacs (about 5 % of the training cost) has been proposed in the child health training component.

Thus an additional amount of Rs.90.00 lacs has been budgeted for Yr.2010-11.

2.3.6 Printing of Training Modules

An amount of Rs.50.00 lacs was asked for printing of training module for approximately 20,000 functionaries in the year 2009-10. However, the printing process got delayed and the modules are under process of printing and will be available by March 2010. These modules will be utilized for training of 20,000 functionaries planned for year 2010-11. Additionally training modules will be required for about 20,000 functionaries (15,000 from new 35 districts and 5,000 from old 36 districts).

Hence, an amount of Rs.50.00 lacs is being budgeted for printing of 20,000 sets of training modules for the financial year 2010-11.

2.4 Procurement

2.4.1 Procurement of child survival kits for ASHAs (FMR code B19.1)

A child survival kit is being provided to the ASHAs after completion of training which is around Rs. 1000/-, as detailed below:

Contents of Child Survival Kit for ASHAs

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**

Details 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/-**

In the year 2009-10, an amount Rs.200.00 lacs was proposed and approved for procurement of 20000 child survival kits for distribution to trained ASHAs. However, the training got delayed and only about 1000 ASHAs will be trained by the end of current year. The procurement process is in progress and 20000 kits will be supplied to the districts from March 2010 onwards. Zinc sulphate tablets were provided to ASHAs in 2008-09, but since now GoI is supplying it in Kit A, it is not being budgeted separately.

Now , the programme is being expanded to all the remaining 35 districts of the State and as per estimation , about 20% ASHAs will be trained during the yr. 2010-11 , it is being proposed to procure child survival Kits for 12,000 ASHAs @ Rs.1000 per Kit and the total budget required will beRs.120.00 lacs.

The replenishment of various items for ASHAs trained in the 17 districts taken up during the first phase was required and the following items are proposed for replenishment:

Items for Replenishment in Child Survival Kit for ASHAs (FMR Code B 19.1)

SN.	Item	Rate (In Rs.)
1.	Mucous extractor (5 per kit)	65.00
2.	Towels – 1 No. (medium sized)	25.00
3.	ORS packets (for 1000 ml solution) – 5 per kit	50.00
4.	ORS packets (for 200 ml solution) – 10 per kit	50.00
5.	Cotton wool & Gauze	25.00
6.	Medicine kit	300.00
7.	Digital thermometer (sensitive for low temp.)	20.00
Total		**535.00**

A sum of Rs.27.75 lacs was proposed and approved for replenishment of 5000 kits in the year 2009-10. Further it is estimated that around 20,000 more kits will require replenishment. Accordingly, a sum of Rs. 107.00 lacs will be required.

Thus, a total sum of Rs.107.00 lacs will be required for replenishment of kits during the year 2010-11.
The total funds required for the purpose will be Rs. 227.00 lacs. The expenditure has been budgeted under the head 'Procurements'

2.4.2 Procurement of Weighing Scales for Trained ASHAs (FMR Code B 19.2)

It is to be ensured that each newborn is weighed and home visit is done accordingly. With increase in the institutional deliveries due to JSY, the newborns delivered at facility are mostly weighed but those born at home or at sub centres are not being weighed. Hence, it is being proposed to provide Salter Weighing Scale (Spring Balance) to all the trained ASHAs. An estimated cost of Rs.350.00 per such scale is being proposed for 60,000 ASHAs who would be trained by the end of year 2010-11.
Thus, an amount of Rs. 210.00 lacs. is being budgeted under "Procurement head".

2.4.3 Job Aids & Tools for ASHAs*

Job aid and tools are being provided to facilitate the ASHAs in their working. These have been developed by a team of experts at the State level, supported by donor agencies. The cost of each kit is around Rs.150/- as detailed ahead**.** All the ASHAs of first phase districts have been provided with these job aids and tools and they are utilizing it in the community.

Sl.	Item	Purpose	Qty.	Estimated Cost (Rs.)
1	Home-visit Leaflet (Checklist) on newborn and postpartum maternal care for ASHA	Aid ASHAs during home visits to newborns and lactating mothers to provide need based 95ounseling and referral for services	2	2.00
2	Pictorial flip chart for ASHA on home-based newborn care practices/behaviours	For use in interpersonal 95ounseling during home visits and community meetings	1	22.00
3	Pictorial flip chart to help ASHA promote and negotiate Infant &Young Child Feeding practices (IYCF)	To improve understanding of ASHA on infant and child feeding and nutrition issues to be able to resolve related day to day problems faced while dealing with mothers and families	1	20.00
4	A compendium of frequently asked questions (FAQs) on breastfeeding & compl. Feeding practices	Develop understanding of practical field situations and behaviours observed and faced with in the field and respond accordingly.	1	22.00
5	A compendium of frequently asked questions (FAQs) on routine immunization	Develop understanding of practical field situations and behaviours observed and faced in the field and respond accordingly	1	22.00

Sl.	Item	Purpose	Qty.	Estimated Cost (Rs.)
6	Calendar with NBC messages for ASHA (6 leaves)	As a reminder on newborn care practices	1	50.00
7	Formats for record keeping and supervision	To ensure proper record keeping and reporting	1 set	10.00
Total				**148.00**
A	Checklist for ASHA facilitators	To review ASHAs work at monthly ASHA meetings (review of VHI register, organization of VHNDs, JSY, Postnatal home visits, review of supplies, infant deaths, planning for next month, etc)	2	2.00
Total Cost per ASHA				**150.00**

The funds approved for the second phase districts will be utilized by the end of this financial year as the process of printing is in progress. Hence funds will be used in the Yr.2010-11 as committed liability.

Since 35 new districts are being covered and about 20% ASHA (about 12000 ASHAs)will be trained in the year 2010-11, therefore budget for the same of Rs.18.00 lacs is being proposed and is being budgeted under Infrastructure and Human Resources.

***Not approved in ROP. Proposal sent for reconsideration.**

2.5 Payment to ASHAs for Programme Implementation

After completion of 10 days training ASHAs are visiting the families according to birth weight of the baby. If the newborn weighs < 2.5 kgs, they visit on day 1st, 3rd, 7th, 14th, 21st and 28th day and fill up the format provided for the purpose. If the baby weighs ≥ 2.5 kgs, the visit is proposed on day 1st, 3rd and 7th day of the child birth. During the visit they have to counsel the mother and the family regarding exclusive breastfeeding, keeping the baby warm and infection free. Each ASHA is paid Rs. 100/- for conducting 6 visits to each Low Birth Weight (LBW) newborn and Rs. 50/- for 3 visits to each normal weight newborns. It is estimated that on an average each ASHA would be required to visit 9 LBWs and about 21 normal infants in a year. Accordingly, she would be able to earn an amount of Rs.2,000/- (Rs.900/- for visits to LBW newborns and Rs. 1100/- for visits to normal infants). For 60,000 (48,000 for 1st/2nd phase & 12,000 from new districts) ASHAs who will be trained by 2010-11, **an amount of Rs. 1200.00 lacs will be required as incentive. This activity has not been approved in the ROP. Proposal has been sent to GOI for reconsideration.**

Though, the programme is newer and supervision-monitoring of ASHAs is not up-to the mark as ASHA support system is not in place as yet, the reports are being received from 17 first phase districts on prescribed formats and the level of implementation is as below (April to December 2009):

SN	Particulars	Performance	Remarks
1	ASHAs trained by Dec 2009	22732 (62.2 %)	ASHA training is in progress. Hopefully, more than 80 % will be trained by March 2010.
2	% ASHA reporting on prescribed format	60.8	Reporting has been started this year only. Supervision and monitoring will improve the reporting.
3	Total births reported in 17 CCSP districts (Apr-Dec 09)	2,45,289 (2.1 births per ASHA per month)	The number is for 61 % of the expected births reported.
4	% births visited by ASHA 3/6 visits	89.0	Being the 1st year of implementation, the report is quite satisfactory. Handholding is needed to improve the quality.
5	% Newborns identified as < 2.5 Kgs.(LBW) by ASHA	17.1	ASHAs don't have a weighing scale. At many facilities (in case of institutional deliveries) the weighing scales are not functional.
6	Number of Newborns referred out of visited	2660	Referral will increase with improvement in quality treatment at identified facilities (FBNC)
7	No. of deaths reported (Apr-Dec 09)	2078	Extensive supervision and monitoring needed.

2.6 Navjat Shishu Suraksha Karyakram (NSSK). (FMR Code A 11.5.5)

NSSK is an initiative from GoI to reduce neonatal mortality all over the country. Four specialists (2 Paediatricians + 2 Gynaecologists) will be trained from each district as district trainers. In March 2010, this activity will be conducted with the help of IAP team at 4 identified medical colleges of the state which are already involved in child health training. Further, it is being proposed to train all the medical officers and staff nurses involved in delivery of the new born in 35 non CCSP districts of the state, to avoid duplicity and confusion in the functionaries.
There are 383 blocks in these 35 districts and one batch of 24 participants will be trained at district level for two days. Thus the training will be completed in about 4-6 months time by the district trainers in each district. Each district will have to organize 3-4 such batches.

The average cost of one batch has been calculated as Rs. 50,000/- and the total cost for estimated 150 batches will be Rs.75.00 lacs. The printing cost of the module is being calculated @ Rs. 100 per module costing a total of Rs. 3.60 lacs for about 3600 functionaries. State level meetings, sensitization workshops, contingency and other expenses are being estimated to be about 6.40 lacs. The supervision and monitoring of the training programme will be done through district and state level programme officer, the budget for which has been built in.

Thus a total of Rs. 85.00 lacs are being budgeted for the programme.

2.7 Reporting Formats

Detailed reporting formats have been developed for reporting by the ASHAs which are to be filled during home visits. These reports are countersigned by the beneficiary and verified by ANM for release of incentive. These reports are compiled at the Block PHCs on monthly basis and payment is made accordingly to the ASHAs. Printing of formats for reporting will be required. Around Rs.100/- per trained ASHA is proposed in the budget for about 60,000 ASHAs (28000 trained by Mar 10 & 20000+12000 of new districts) will be trained in 2010-11.
The total budget required for the formats will be 60.00 lacs. It has not been approved in ROP. Proposal has been sent to GOI for reconsideration.

2.8 Supervision of ASHA through Recognized Institutions (FMR Code A 10.3)

The programme is very ambitious one and needs intense handholding of ASHAs in the field. For supportive supervision and monitoring, it is essential that each ASHA is contacted at least once a month by skilled personnel. At present, ANM and LHVs are being trained for the purpose but an independent supervisor is most essentially needed for improved supervision. It is being proposed to intensify supervision through reputed institutions in the state like SPM departments of Medical Colleges and Social Work Departments of Universities. 9 such institutions have been identified and districts are being allocated to these Institutions. Initial discussions have been completed and it is

being proposed on a pilot basis for one year to have the Institute appoint one block level supervisor in the districts allotted who will contact each ASHA of his/her area at least once in a month. The PG students will conduct block level meeting every month with block supervisor, ANMs/LHVs and sample ASHAs. The Nodal institution will be overall in-charge of districts assigned to it for selection and placement of Block level Supervisor, supervision, monitoring and evaluation of the programme. One such pilot being undertaken in Aligarh with the support of UNICEF and the results are encouraging.

An honorarium of Rs.5000 per month with mobility support of Rs.3000/= per month will be paid to the supervisor by the Institution and is being budgeted for one block level supervisor who will be a graduate and will be trained by the institution on standard format. In addition, the institution will be provided Rs.5000/- per district per month for mobility, communication, compilation of reports etc.

In these districts, 1 facilitator for every 20 ASHAs will be placed through ASHA support system who will coordinate with Block level supervisor for handholding of CCSP and ASHA scheme.

Budget Requirement

S. No.	Category	Rate (Rs.)	Number	Total Amount (Rs.in lacs)
1	Honorarium to Supervisors	5000/- per month for 12 months = Rs.60,000/- per year	450 blocks (223+227)	270.00
2	Mobility to Supervisors	3000/- per month for 12 months = Rs.36,000/- per year	450 blocks (223+227)	162.00
3	Support to Institutions	5000/- per month for 12 months = Rs.60,000/- per year	36 districts	21.60
Total				**453.60**

Thus an amount of Rs. 453.60 lacs is required for extensive supervision and monitoring of the programme through 9 independent reputed institutions.

2.9 Infant Death Audit (FMR Code A 2.8)

Infant death audit was proposed in the PIP 2009-10 in two blocks of 2 selected districts. The districts identified are Aligarh and Banda, where more than 80% ASHAs have been trained. The standard protocols and modalities have been prepared with the support of UNICEF and other developmental partners working in the field. These will be finalized by end January, 2010 and training for reporting and investigations is proposed to be started from February, 2010 with the help from experts from PGI-Chandigarh. The amount approved for the year 2009-10 will be used for these activities. All efforts would be made to establish a system of Infant Death Audits in the next year. It is proposed to implement the scheme in all the blocks of these 2 districts.

The ASHA would report any infant death occurring in her area to the BPHC. She would be paid Rs.50/- for reporting each infant death and Rs. 250/- would be paid to the facility for conducting verbal autopsy and reporting to the State as per prescribed format. It is estimated that 25 infant deaths/block would be reported in a year. An additional amount of Rs.1500/- per block for a year is proposed for development and printing of formats and other communication. Thus, an amount of Rs. 10,000/- per block is being budgeted for the year 2010-11. There are total 20 blocks in these 2 districts, which will cost around 2.0 lacs for the purpose including development and printing of formats and communication. Additionally an amount of Rs. 1 lac is being proposed at State level for various activities including monitoring and reporting.
Accordingly, a budgetary provision of Rs. 3.00 lacs is being made this year.

2.10 Establishment of Sick New Born Care Units (SNCU). (FMR Code A2.2 and A 9.2.1)

It was proposed to establish full fledged Sick New Born Care Units (SNCU) at district women hospitals. However, due to non-availability of human resources, it was not possible to effectively operationalise full-fledged units.

At present only SNCU at Lalitpur is fully functional. As per reports received from the unit, total no. of newborns admitted till, December, 09 is 1025, out of which 837 have been cured completely, 34 were referred to higher facilities, 14 left and 140 newborns have been reported dead. The SNCU unit at Veerangana Avanti Bai Mahila Chikitsalya, Lucknow catering to a large load of pregnant women (an average of around 7000 deliveries annually) has also been operationalised through funds from NRHM in the year 2009-10.

In addition, SNCU in 5 district women hospitals in Shahjahanpur, Aligarh, Pratapgarh, Saharanpur and Azamgarh have been developed, where civil works has been completed during the year and equipments have been installed with UNICEF support. Human Resource was to be recruited and as of now Saharanpur, Shahjahanpur. Azamgarh and Aligarh have completed the activity. The training of staff at these sites is under way. It is expected that the remaining unit at Pratapgarh shall also complete recruitment and training by March 2010 and will be fully functional by April 2010.

Rupees 20 lacs per unit was demanded and approved during the year 2009-10 which has been utilized partially due to late recruitments and functionality of the units. It is expected that during the year 2010-11, these units will be fully functional and an amount of Rs. 25.00 lacs would be required to support the human resource (3 Paediatrician/trained doctors and 6 staff nurses) requirement and recurring expenses towards medicines, drugs, etc. for each such units.

Further SNCU Lalitpur being fully functional and catering to a good workload has demanded for recruiting 6 more Staff Nurses. Hence it is proposed that additional Staff Nurses may be deployed as per work load.

Further, it is being proposed to establish one SNCU in each division specially where there is no Medical College. Thus 1 SNCU in Banda, Faizabad, Basti , Moradabad and Mirzapur are to be established in the Yr.2010-12. Since an amount of about Rs.30.00 lac was spent in civil works in previous SNCUs, the same is being asked for the purpose. Hence an amount of Rs. 150.00 lac is being proposed for renovation/ construction/civil works in these 5 designated DWH for SNCU. The support regarding equipment installation will be taken from UNICEF as before.

Thus a budget of Rs.150.00 lacs is being asked for new Five SNCUs (FMR Code A 9.2.1) and Rs 175.00 lacs (FMR Code A 2.2)would be required towards operational expenses for 7 existing units. Total Budget required under the head will be Rs. 325.00 lacs.

At all FRUs a unit is being developed for **intensive care of the newborns (NICU)** where all the essential equipments like resuscitation bag and mask, phototherapy unit, oxygen hood, radiant warmer, pedal operated suction apparatus and baby weighing machine among others has been provided during the year 2004-05 (Kit N of RCH I). Further, all the Medical Officers and Staff Nurses posted at these units are being trained to utilise these equipments under facility based new born care. The gaps will be identified and met with RKS funds.

2.11 IEC for CCSP/FBNC/SNCU/NSSK activities

Wide IEC activities are proposed for the programme to create awareness in the community- especially for neonatal issues.

- Hoardings of 10 fit x 8 fit will be placed in each block and 2 hoardings at district head quarters in district female hospital/railway station/Collectorate/any other important place.
- Posters of poly vinyl (foam) will be developed and pasted at sub centers, New PHCs, Block PHCs, CHCs and district hospitals.
- Flyers/leaflets will be devolved and printed for workers and community.
- Protocols for new born care are being developed and will be placed at all the labour rooms, new born care corner of the facility and postnatal ward of each 24x7 facility and FRUs of the State.
- Audio visual material will be designed and developed through a reputed agency with clear messages for masses regarding benefits of institutional delivery, colostrum feeding, postponing bathing for 6 days, keeping the baby warm and skin to skin contact with mother, applying nothing on the umbilical stump, hygienic behaviour to prevent infections and importance of timely immunization of the baby. The developed material will be distributed to all the districts through DVD/CD/Cassettes to be played regularly in the waiting area and post natal wards of all 24x7 facilities. The arrangement for T.V./DVD/VCD players will be done through RKS funds.

- Bal Chetak (identified students from local schools studying in class 5-8) will be our messengers to be families for right behaviours and practices and will be incentivised in kind and the scheme is being included under IEC/BCC section.
- Each new born delivered at the facility will be provided with a vest (baniyan) printed on both the side with messages of exclusive breast feeding and routine immunization at the time after the delivery. This vest will propagate the correct messages in the community and shall remind the mother for timely immunization. On an estimated cost of Rs. 10/- per such printed vest an amount of Rs. 210.00 lacs is being budged for (estimated 21 lacs institutional deliveries under JSY) the purpose under Neonatal campaigns in IEC/BCC section.
- Funds will be met from IEC/BCC Head.

2.12 Quality Maintenance under CCSP

Comprehensive Child Survival Programme (CCSP-UP), which if properly implemented by ensuring quality of training and implementation, will bring down the neo-natal mortality of the State. To ensure quality of implementation, all 36 districts have 1 Nodal Officer for Child Health designated in the district who is responsible for organizing trainings, logistic management and implementation of activities with proper supervision and monitoring. They are supported by Divisional Health, Nutrition, Sanitation Technical Coordinator (DHNSTCs) recruited through UNICEF. At the State level, in addition to the Joint Director – RCH at the Directorate and General Manager – Child Health at the SPMU, a Consultant-cum-Manager ensures quality implementation of activities. This position of Consultant cum Manager was created in May 2008 and is presently supported by USAID through ITAP and will be continued in 2010-11.

Since till date, only 2 districts in a division are covered under CCSP, it was easy for these DHNSTCs to monitor and supervise the programme. With the expansion of activities in all 71 districts of the State in 2010-11, it is extremely essential to improvise the supportive supervision and monitoring of various activities, especially the quality of training and implementation by the functionaries at the field level.

It is proposed to establish a 'Child Health Cell' in the Directorate of Family Welfare where a Joint Director level officer, preferably a child specialist with experience in CCSP, should head the unit, assisted by an Assistant Director (level-III) and a Medical Officer (level II/I) both preferably paediatricians or public health specialist. The unit should have 1 Data Analyst and 2 Programme Assistants to help in compiling data received from the field. The later 3 will be contractual personnel through NRHM funds in line with equal level functionaries under Programme Management section of PIP.

Further, since SPMU has a major role in planning, monitoring and supervision of the programme, it is proposed to have four Regional Managers, 1 Data Analyst and 1 Programme Assistant. It is assumed that the Regional Managers (preferably Master in Social Sciences with field experience of minimum 5 years in health sector) will be responsible for 17-18 districts of their region and will make at least 1 visit per month in each district allotted to them. The Consultant-cum-Manager will coordinate with all the Regional Managers, district Nodal Officer Child Health (each district has one designated

ACMO/Dy. CMO) and DPMUs for regular reporting and feedback. He/she will also make at least 2 visits per week as per information/problems received from the district. The Senior Manager-cum-consultant will be responsible for producing monthly reports of training, implementation activities, SNCUs and infant death audits from all the districts. S/he will also coordinate with the Medical Colleges and identified reputed institutions involved in the programme. The proposed budget for the purpose is as below:

S.No.	Position	Minimum Qualification	Minimum Experience	No.	Amount per month	Amount for the year
1	Regional Manager**	Master's Degree in public health /Social Science	5 years	4	21,000/-	10,08,000/-
2	Data Analyst (1 at SPMU & 1 at DGFW)**	Graduate with good computer knowledge	2 years	2	21,000/-	5,04,000/-
3	Programme **Assistant (1 at SPMU & 2 at DGFW)	Graduate with good computer knowledge	2 years	3	17,000/-	6,12,000/-
4	TA/DA for field visits *	-	-	12	50,000/-	6,00,000/-
5	State/ Divisional level Quarterly review meeting*			4	1,50,000/-	6,00,000/-
Total (Rs.)						**33,24,000/-**

***FMR code A 2.1**
****FMR Code A 14.1**

2.13 Infant & Young Child Feeding (IYCF) (FMR Code A 2.5)

Early and exclusive breast feeding is the most cost effective intervention to reduce Infant Mortality Rate. A two pronged approach is being adopted for promoting optimal infant and young child feeding practices, which includes creating awareness through the integrated State BCC strategy and enhancing the counselling skills of ASHAs and AWWs.. Promotion of infant & young child feeding has also been taken up as a component under the integrated State BCC strategy. A number of IEC and BCC interventions are planned to be implemented. Additionally, appropriate infant & young child feeding practices would be promoted by the ANMs and ASHAs.

The skill-based training for family welfare counsellors posted at District Hospitals, CHCs and Block PHCs is proposed for counselling of mothers and positive behaviour changes in the community. The training will be of 7 days, for which the module has already been developed and it has a major component of Infant and Young Child Feeding. The same has been budgeted under the head "Maternal Health".

Further all the ASHAs, ANMs, LHVs and Medical Officers are being trained to promote breast feeding in CCSP districts. ASHAs in these districts are being provided with job aids and tools, which also has a specific booklet regarding breast feeding and one flip book regarding feeding of young children.

An amount of Rs. 5 lacs is being budgeted for State level workshop and other activities during World Breastfeeding Week and Rs. 0.50 lacs per district for various activities during the week. Breastfeeding promotion campaigns are also proposed under IEC/BCC section.

Baby Friendly Hospital Initiative (BFHI) was launched in UP in the year 1994-95 and staff (MOs, SNs & other para-medic functionaries) were trained in all 53 District Women Hospital and 25 Private Nursing Homes. Training was also imparted to Gynaecological and Obstetrics department of all State Medical Colleges. The assessment of these hospitals was carried out through nominated teams and 24 hospitals were declared Baby Friendly by State Task Force and National Task Force upto 1999-2000.
To refresh and update the knowledge, a re-orientation workshop is proposed for organizing at the state level in the year 2010-11. It is proposed to organize 4 workshops (participants of 18 districts in one workshop) to cover all the 71 districts of the state. The Assessment and Evaluation Committees under Family Friendly Hospital Initiative will also assess the facility for baby friendliness. The fund requirement for each workshop will be about Rs.1.50 lacs.

For 4 workshops an amount of Rs.6.00 lacs has been budgeted. The district level workshop will be clubbed with the workshop organized at the districts under IYCF programme.

Thus a total of Rs. 46.50 lacs is being budgeted under the head.

2.14 Management of Other Childhood Diseases

2.14.1 Diarrhoea

Diarrhoea is still the biggest killer for under 5 children. Management of diarrhoea has been included in the CCSP package with Zinc tablets to be given 20mg/day for 14 days in case of persistent diarrhoea (on IMNCI lines). This is being implemented in 36 selected districts under CCSP-UP and scaled up in a phased manner. Strategies to address these include:

- Training of all functionaries for ORS administration
- ORS Procurement
- Zinc sulphate tabs. and pilot ORT corners in CCSP districts
- IEC for identification for severely dehydrated children and their referral
- Management of severely dehydrated children at facilities

The requirement of ORS for management of diarrhoea cases would be met from Kit A supplied to all 71 districts. It will be made mandatory to discuss about availability of ORS packets and management of diarrhoea in each meeting called by MOI/C at CHC/BPHC with ASHA and ANMs

2.14.2 ARI Management

For ARI management, training of functionaries for identification and standard case management of pneumonia and bronchiolitis cases would be carried out. This training package is being included with that of diarrhoea management and a common training of Medical Officers and Staff Nurses will be conducted. The training module includes both the components. Further, IEC activities to improve knowledge about home management of cough & cold and recognition of early danger signs for seeking appropriate medical care will be carried out.

All the ASHAs and ANMs in CCSP districts are being trained to identify Pneumonia cases, their treatment and referral in case of complications. The package under the programme includes audio visual clippings of Pneumonia and Bronchiolitis cases, cases with wheezing and clinical visits in the paediatric wards.

A training package for Staff Nurses and Medical Officers posted at District Hospitals, Block PHCs and CHCs has been developed under F-IMNCI programme which will be applicable for all the Medical Officers and Staff Nurses.

2.15 Pilot for Addressing Under-Nutrition in Selected Districts (FMR Code A 2.6)

Severe acute malnutrition is defined by a very low weight for height (below -3 SD WHO growth standards), by visible severe wasting, or by the presence of nutritional oedema. In children aged 6–59 months, an arm circumference less than 115 mm is also indicative of severe acute malnutrition. A child with severe acute malnutrition undergoes physiological and metabolic changes which includes reduction in functional capacity of

organs and slowing of cellular activities. These profound changes put severely malnourished children at particular risk of death due to hypoglycaemia, hypothermia, electrolyte imbalance, heart failure. In the absence of a standard protocol, mortality of children suffering from SAM admitted to hospital can range between 20 to 30% with the highest levels (50-60%) among those with oedematous malnutrition. With modern treatment regimes and improved access to treatment, case-fatality rates can be reduced to less than 5% both in the community and in facilities.

As per the NFHS-3 (2005-06) 7% of children below three years suffer from severe acute malnutrition (SAM). In absolute numbers it means that in the state there are over 10 lac children below 3 years who suffer from severe acute malnutrition. Considering the size of the problem, it is proposed to explore the feasibility and effectiveness of an integrated community and facility based model for providing quality care to 1000 children with severe acute malnutrition. The integrated model will be implemented with support from UNICEF and state Medical Colleges.

The overall aim of the Nutrition Rehabilitation Centre is to provide quality health and nutritional care to children with severe acute malnutrition. Specifically, the project will work towards the following:

1. Jointly with Health and Women and Child Development department develop standard guidelines for improving quality and access of special care to children with severe acute malnutrition.
2. Training of Health and ICDS functionaries for malnutrition management and counselling at hospital and community setting.
3. Providing full time nutrition expert support for inpatient care, follow up and rehabilitation.

Convergence will be established with the ICDS Department for early identification of malnourished children, their counselling and referral. Joint training of ICDS and Health functionaries would be conducted in the intervention area. The Medical Officers at the CHCs and Block PHCs will also orient CDPOs, AWWs and ASHAs during their monthly meetings for timely diagnosis of malnourished children and their management, as well as, referral of severely malnourished children. A joint review on the nutrition status of children will be conducted every month.

In the PIP for 2009-10 establishment of **Nutritional Rehabilitation Centres** in 4 CCSP districts had been proposed, in convergence with ICDS. In these districts the Village Health and Nutrition Days were to be strengthened to promote growth monitoring and counselling for growth promotion. It was proposed to allocate 2 beds at one CHC (FRU) in each district and 4 beds in the paediatric department of the district male hospital for severely malnourished children. The districts have been identified for the purpose depending upon IMR, Nutritional index of the children and presence of SNCU in the neighbourhood. The districts identified are Banda, Badaun, Pratapgarh, and Gonda. The initial activities have been completed, detailed guidelines have been sent to the districts and it is likely that the Nutritional Rehabilitation Centres will be established in all 4 districts by March, 2010 based on the successful example of Talbehat PHC, Lalitpur.

Efforts are being made to mobilize the services of the Paediatric and SPM Departments of adjacent Medical Colleges to boost the success of the programme.
Further, provision of weighing scales, height measurement stand, etc. would be made since availability of functional weighing scales, etc. is a constraint. It is also proposed to appoint one counsellor at each CHC for counseling on appropriate feeding.
The operationalization cost per annum for these centres has been estimated to be Rs. 10.00 lac.

2.16 School Health Programme - UP

A school health programme has been launched successfully in the State. School Health Program is envisaged as an important tool for preventive, promotive and curative health services to the population. The programme started in October, 2008 and covers 40 schools (classes 1 to 5) per block, and is reaching out to around 50 lac children of 6-10 years of age in the State. Till December 09 visits of medical teams to 14,600 schools has been completed and by March 10 about 30,000 schools will be covered.
This year 20 more school per block will be added, thus covering about 49000 schools and about 73 lacs children in the State. It is estimated that on an average every primary school has around 150 children enrolled on the basis of which the target of 73 lacs children has been calculated. It is proposed to cover all Government primary schools in a phased manner in coming years.

2.16.1 Components of the Program:

Health services:

- **Screening, health care and referral:**
    - Screening of general health, assessment of anaemia/nutritional status, visual acuity & colour vision, hearing problems, dental check up, common skin problems, physical disabilities, learning disorders,behaviorproblems.
    - Referral Cards for priority services at CHCs/District hospitals.

- **Micronutrient (Iron & Folic Acid) management:**
    - Weekly supervised distribution of Iron-Folate tablets coupled with education about the issues of anaemia.

- **De-worming**
    - As per national guidelines
    - Biannually supervised schedule
    - Cooks of Mid- day deal to be also covered.

- **Health Promotion at Schools**
    - Counseling for nutrition and personal hygiene.
    - Regular practice of physical education & health education
    - **Capacity building** of teachers and involved health personnel

- **Monitoring & Evaluation**
  - Monitoring by officials and supervisors of health department, ABSA and Supervisor of Education Department is integral part of the programme.
  - District magistrate to nominate senior officers for conducting surprise inspections.
  - Mid term evaluation is proposed through independent agency.

2.16.2 Programme Implementation

The school health programme is being implemented with collaboration of primary education department at every level in each district. A detailed blockwise microplane has been prepared indicating the date of visit a medical team as well as the members included in the team like-Medical Officer, Paramedic (Staff Nurse/Pharmacist/ LHV/ANM). There will be a refrectionist or dental hygienist in the team as per availability. Under the programme every shool has been provided with register on which detail information of the students is being entered by the teachers prior to Medical Team visit. After medical check-up the doctor mentions the findings and treatment on the register. A health card is being issued to each child with the detail findings signed by the doctor which has to be counter signed by the parents. In case of referral a referral slip is being issued by the doctor and the sick child is directed to go to the nearest BPHC/CHC/DH. Instructions have been issue to the districts to give priority to these referred children. Along with appropriate treatment spectacles are also being given free of cost to children with reflective errors.

After the visit of the medical team the school teachers will screen the children at interval of 6 months. District Nodal Officers with support of District Programme Mangers and Community Mobilizers will conduct a two days training of three trainers from each block. These trainers will in turn train the school teachers. Two teachers from each school would be imparted two days training on the various components of the programme. These teachers will be guided to provide bi annual de-worming and bi weekly IFA tablets to the children identification of various common ailments occurring in children, refractive errors, colour vision defects, measurement of height and weight etc. and refer the students to the nearest health facility (CHC/Block PHC) for detailed medical examination and treatment as per requirement. Teachers will also be made responsible for making children aware regarding proper personal hygiene and importance of nutrition. The training module has been developed and is under printing process. The training will start from the end of February, 2010.

Under National Blindness control programme the component of school eye screening is incorporated for the target age group is 8-14 years but under school health programme the target age group is 6-10 years. Hence, budget for provision of spectacles is being inbuilt under the programme. This year approximately 16000 additional schools are being covered targeting about 24 lacs children. It is estimated that out of children examined around 5-7% will be suffering from refractive errors.
Hence, budget is being included for 1 lac children @ Rs. 200/child.

As suggested by Principal Secretary, Basic Education and Director-SSA it is proposed that a sensitization workshop is conducted at State Head Quarter where concerned officers and workers of the department, representatives of other partner government departments, representatives of developmental partners, NGOs etc will be involved to give them complete information regarding the programme. In a similar manner a sensitization workshop is also being planned at each district head quarter.

For State workshop a budget of Rs. 5.00 lacs and for district workshop a budget of Rs. 15,000/district is being included.
Further, a school health programme is being taken up for school going adolescent girls. The details have been mentioned under the 'Adolescent Health' component.

2.16.3 Budgetary Requirement ((FMR Code A 2.4)

SN	Description	Amount (Rs. in lacs)
1.	Sensitization workshop at State Head Quarter	5.00
2.	Sensitization workshop at each District Head Quarter (Rs. 15,000x71)	10.65
3	Honoraria to Resource Person (@ Rs.350/- per person for 3 persons x 71 districts x 2 days)	1.49
4	Training of Block Trainers (@ Rs.400/- per person [Hon. Rs.200/-, T.A.-Rs.100/- Refresh.-Rs.50/-, Stat. – Rs.30, Contin.-Rs.20] x 3 persons per block x 820 blocks)x2 days	19.68
5	Honorarium to block resource person Rs. 300/- (Hon Rs.250/- + Refreshment Rs.50/-) x 3 persons x 2 days x 820 blocks	14.76
6	Training of Teachers at Block level (@ Rs.250 per person [Hon. Rs.100/-, Refresh.-Rs.50/-, TA- Rs.50/-, Stat. – Rs.30, Contin.-Rs.20] x 2 persons per school x 49,200 schools x 2 days)	492.00
7	Contingency for Printing of Health Card, Referral card, Registers etc. (@ Rs.500/- per school x 49,200 schools)	246.00
8	Mobility to health team (@ Rs. 300/- per visit x 49,200 schools x 1 visit per school)	147.60
9	Weighing scale, Ht. measuring stand, eye chart, measuring tape, etc. (@ Rs.1000/- per school x 20 sets per block (40 sets have already been provided to each block during the year 2008-09 & 2009-10)*	164.00
10	Printing of training module for 20 new schools/block	15.00
Sub-Total		1116.18
An amount of Rs.240.96 lacs is already available with the districts for training and Rs. 30.90 lacs is with the State for printing of training modules developed at SPMU. Hence, an additional amount of Rs. 730.211 lacs (Rs. 1002.131 -240.96-30.96) is required.		844.26
Procurement of Supplies *B 19.2		0.00

SN	Description	Amount (Rs. in lacs)
1.	Sensitization workshop at State Head Quarter	5.00
2.	Sensitization workshop at each District Head Quarter (Rs. 15,000x71)	10.65
3	Honoraria to Resource Person (@ Rs.350/- per person for 3 persons x 71 districts x 2 days)	1.49
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11	Procurement of IFA Tabs. (30 mg elemental iron and 250mcg Folic Acid) @ Rs.14/- for 100 tabs per child for 73.80 lac children	1033.20
12	Procurement of De-worming Tabs. (1 tab. six monthly) @ Rs. 2/- per tab. x 2 tabs per child x 73.80 lac children	295.20
13	Procurement of spectacles (Rs. 200x1 lac children)	200.00
Sub-Total		**1328.40**
Total budget for 2010-11		**Rs.2058.611**

2.17 Bal Swasthya Poshan Mah(Biannual Child Health and Nutrition Months) Strategy for addressing Micronutrient Malnutrition (FMR Code A 2.7)

Under nutrition occurs when the demands of the body for one or more nutrients are not met. This can be either due to inadequate dietary intake of the nutrients and/or due to non availability of these nutrients to the body due to frequent infections or metabolic causes.

Undernutrition can also occur due to the deficiency of micronutrients or nutrients required by the body in very small quantities such as vitamin A, B, C etc. or minerals such as iron, iodine, zinc and calcium etc. The deficiency of one or more micronutrients in the body is referred to as Micronutrient Malnutrition.
The three commonly prevalent micronutrient deficiencies are

- Vitamin A Deficiency (VAD)
- Iodine Deficiency Disorder (IDD)
- Iron deficiency Anaemia (IDA)

Prevalence of micronutrient malnutrition in children in UP

Iron Deficiency Anaemia (IDA)

85% children 6 months to 36 months children are anaemic in the state as reported by NFHS-3

Vitamin A Deficiency (VAD)

According to DLHS-3 only 32.2% children have received one dose of vitamin A supplement (VAS)

Iodine Deficiency Disorders (IDD)

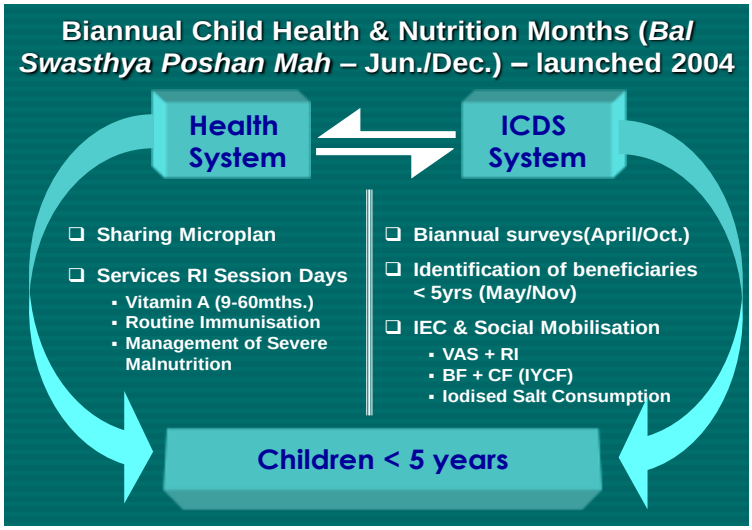
IDD is widespread in UP. As per NFHS-3, only 36% households consume adequately iodized salt in the state despite the legal ban on sale of non-iodized salt for edible purposes being in position in U.P

The prevention and control of micronutrient malnutrition is an integral part of NRHM. Micronutrient programmes comprise of National prophylaxis programme for preventive of Blindness due to Vitamin A Deficiency, National Iodine Deficiency disorder Control Programme (NIDDP) and National Nutritional Anaemia Control Programme. In Uttar Pradesh, Vitamin A supplementation is being done through a special biannual initiative known as Bal Swasthya Poshan Mah(BSPM).

BSPM Strategy:

Biannual strategy (fixed months six months apart- June and December) was developed and launched initially in 18 districts of UP, jointly by Health and ICDS with UNICEF support. As part of the biannual strategy, every year in June and December, vitamin A is administered along with a complement of other services, which are considered to be crucial for child survival and development. This package of services includes immunization; advice on breastfeeding and complementary feeding; screening and referral for severely malnourished children and education and demand generation for iodized salt.

Under the BSPM strategy, two months viz., June and December, six months apart, have been identified as health and nutrition months. During these months, health sector is assigned with the task of providing immunization and other services to the beneficiaries while ICDS sectors responsible for beneficiaries using the services by organizing intensive social mobilization and IEC activities. These biannual months have been linked to village-wise routine immunization sessions organized as per the immunization/ outreach session's micro plan of ANMs. Since its inception, these months are being organized in June and December because of frequent Pulse Polio rounds.



Lessons Learnt

- Biannual fixed months strategy, six months apart, is effective not only for reaching children 9-60 months or administration of vitamin A supplements (VAS) but also for intensive promotion of community practices pertaining to consumption of iodized salt, appropriate infant and young child feeding practices as well as for conducting special drives for identification and management of severely undernourished. It also acts as a catch up round for Routine immunization especially measles.
- Defining roles and responsibilities of health and ICDS sectors facilitates effective teamwork and convergence of actions on fixed immunization days (as per the Routine immunization –RI micro plans). It also facilitates improved management and delivery of quality health and nutrition service

Detailed guidelines for implementation have been developed, clearly specifying the role of Health and ICDS.

Result

Following four rounds of BSPM (2004-2005), VAS coverage in these districts increased to 64% in 2 years. A remarkable increase was also recorded on development of micro plan for Routine immunization (from 65%to 94.4%). The success of this initiative was evident in the data of DLHS-2 also which shows that Vita A supplementation with at least one dose of Vitamin A increased from 11.2% DLHS 2 (2002-04) to 32.2% DLHS 3 (2007-08). The recent compiled data from the districts reflect following findings-

- **Dec 2008:**
  - A total of 109 lakhs children were covered with one dose of Vita A against the state target of 251 lakhs children between 9months -5 years(43%)
- **June 2009 round:**
  - A total of 133 lakhs children were covered with one dose of Vita A against the state target of 254 lakhs children between 9months -5 years(53%)
- **December 2009 round:** While the results for the round are awaited, following initiatives were taken for strengthening the rounds in the state
  - Pre round joint planning meeting of Health and ICDS done in all the 71 districts with support of nine Medical colleges and UNICEF

- Orientation of approximately 1600 MOICs and CDPOs in all the 71 districts. Block teams created in 15 UNICEF supported districts
- Timely availability of Vitamin A syrup to the ANMs.
- IEC supply for booth visibility with support from UNICEF

- **Planning for Year 2010:**
  - State level joint planning meeting of DIOs and DPOs
  - Block level planning meeting of Medical Officers of Additional PHCs ,Health and ICDS supervisors on Health and ICDS survey and linking enumeration of beneficiaries to microplan and coverage
  - Joint orientation of Health and ICDS grass root functionaries (ANMs and AWWs) prior to the rounds.
  - Piloting linking of deworming with vitamin A administration in 4 districts.
  - Provision of salt testing kits to ANMs to facilitate demonstration of presence of iodine in salt during the biannual rounds

Support of developmental partners will be taken for strengthening Health and ICDS survey, Microplan sharing, coverage reporting and supportive supervision in the districts.

Pilot administration of pediatric iron and deworming with vitamin A:

GOI guidelines recommend de-worming to be an important intervention for reducing prevalence of anaemia and malnutrition in children. GOI guidelines also mention that mega doses of vitamin A offer a good opportunity for administration of deworming. As both malnutrition and anaemia prevalence is high in UP, it is proposed that six monthly de-worming and weekly pediatric iron tablet be linked with biannual BSPM rounds where vitamin A is administered along with a complement of other health and nutrition interventions. The pediatric iron tablet has been provided by GoI in Kit A and ANM will ensure that mothers of children covered under the scheme are provided with four tablets of pediatric iron for weekly consumption on VHNDs to be administered on a fixed day. ASHA of the area will visit the families on a sample basis and follow up. It is proposed that the intervention be piloted in selected four districts, fine tuned on the basis of implementation learning and then feasibility of scale up explored.

As the western UP and north eastern UP districts are grappling with polio and Japanese encephalitis respectively, it is suggested that districts from central and bundelkhand regions with reported high vitamin A coverage be selected for piloting. In the first phase, therefore, it is suggested that deworming linked to biannual vitamin A supplementation round be piloted in children less than 5 yrs of age in 4 districts of the state– namely Lalitpur, Kaushambi, Auriya and Bhadohi. The cost of this intervention would be as follows:-

District	Total population (in Lacs)	Children 2-5 yrs @9%of the total population (In Lacs)	Total quantity needed (total children 2tablet (in Lacs)	Wastage (5%) (In Lacs)	Total quantity needed (total quantity+ wastage)(InLacs)
Bhadohi	15.88	1.4	2.9	0.1	3.0
Lalitpur	11.47	1.0	2.1	0.1	2.2
kaushambi	15.16	1.4	2.7	0.1	2.9
Auriya	13.84	1.2	2.5	0.1	2.6
Total		**5.1**	**10.1**	**0.5**	**10.7***

Budget estimate is given below:

Budget Allocation for the year 2010-11

S.no	Activity	Rate	Amount in Lacs
1	Joint planning meeting of DIOs and DPOs at State Level	@ Rs 2000/participant X 142 participants X 2 meetings/year	5.68
2	Joint planning meeting of Health and ICDS at District level	@ Rs 5000/-per meeting X 2 meetings/District/year X 71 districts	7.1
3	Joint planning meeting of Health and ICDS at Block level	@ Rs 2000/-per meetingX 2 meetings/Block/yearx 823 blocks	32.92
4	Joint orientation of ANMs and AWW at sector level	@ Rs 25/-participant X 2 meetings /yearX 1.7 lacs ANM and AWW	85.00
5	Booth visibility (booth banner)	@ Rs 200/-Banner/Vaccinator X 25000 banners	50.00
6	Printing of BSPM guideline, monitoring and reporting formats	@ Rs 2000/block/round X 2 rounds/Block/year x 823 blocks	32.92
7	Dissemination meeting at District level	@ Rs 5000/-per meetingX 2 meetings/District/year x 71 districts	7.1
8	Coverage evaluation	@ Rs 10 lacs/year	10.00
	Media Plan	Media plan is important for increasing visibility .Media plan would be a part of larger Child health BCC strategy and will be included in IEC/BCC head	
	Total		**230.72**

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	Total		**230.72**

Budget for Procurement for BSPM for the Year 2010-11

S.no	Activity	amount	Remark
1	Procuring Salt testing kits for ANMs	25000 kits	To be procured from budget available under Mission Flexipool

GOI has approved a budgetary allocation of Rs. 3.75 lacs for procurement salt testing kits for ANM @ Rs 15 per kit.

Budget Summary –Child Health

FMR S.No	Activities	Total (in Rs. Lacs)
A. 2	**CHILD HEALTH**	
A.2.1	**Integrated Management of Neonatal & Childhood Illness (IMNCI)**	**12.00**
A.2.2	Facility Based Newborn Care/FBNC - SNCU	**175.00**
A.2.4	**School Health Programme**	**680.32**
A.2.5	**Infant and Young Child Feeding**	**46.50**
A.2.6	**Care of Sick Children and Severe Malnutrition - NRCs**	**10.00**
A.2.7	**Management of Diarrhoea, ARI and Micronutrient Malnutrition**	**230.72**
A.2.8	**Other Strategies/activities – Infant Death Audit**	**3.00**
	SUB TOTAL FOR CHILD HEALTH	**1157.54**
A 11.5	**TRAININGS**	3,604.80
A 9.2.1	**HR AND INFRASTRUCTURE –SNCU**	150
A 10.3	**INSTITUTIONAL STRENGTHENING – Supervision of ASHA thro reputed institutions**	453.60
A 14.1	**PROGRAMME MANAGEMENT Quality Maintenance under CCSP - HR**	**18.60**
B19	**PROCUREMENT OF DRUGS**	**2153.55**
	SUB TOTAL FOR CHILD HEALTH	**7538.09**

The total budget approved is Rs. 7538.09 lacs for the year 2010-11

3. FAMILY PLANNING

The Total Fertility Rate (TFR) of Uttar Pradesh has declined from 4.1 to 3.8 (NFHS 2 and NFHS 3). However, the rates are still very high compared to the national average of 2.7. As per the projections in the Population Policy of UP (2000), to reach the policy objectives of a replacement levels of TFR of 2.1 by 2016, 12.1 lac couples should be provided limiting methods of family planning and 48.4 lac couples should be provided spacing methods in the year 2010. The Contraceptive Prevalence Rate for limiting and spacing should be 31 percent and 13.1 percent respectively. Against these objectives, the FP performance for the State is as shown in the table below:

Methods	2007 -08	2008 -09	2009 -10(till Dec 09)	Expected by March 2010
Vasectomy	5,940	11,132	6,603	25,000
Tubectomy	4,65,951	4,68,381	2,17,809	5,30,000
Total Limiting	4,71,891	4,79,513	2,24,416	5,55,000
IUCD	19,43,474	21,05,501	10,59116	22,00,000
MTP	89,194	81,644	53,098	70,000
C C users	16,88,583	15,25,458	9,74,393	16,00,000
OP users	8,21,883	8,58,137	7,47,506	8,60,000
Total Spacing	25,99,660	45,70,740	28,34,113	47,30,000

The FP situation is especially poor in the following ten districts identified using DLHS-III data FP efforts including IEC/ BCC efforts will have to be intensified in these districts:

Table: Percent women using any family planning method

1	BALRAMPUR	8.5
2	SHRAVASTI	12.5
3	BAHRAICH	14
4	BADAUN	18.2
5	GONDA	18.5
6	SIDDARTHNAGAR	20.1
7	FIROZABAD	23.5
8	SITAPUR	24.8
9	ETAH	26
10	FATEHPUR	27.1

Source: DLHS-III, 2007-08

The above indicates a lack of thrust on FP in the State. Some of the reason/ factors for poor performance are:

- Non availability of skilled service providers, as per government norms for limiting methods;
- Non functional and inadequate number of laparoscopes for sterilisations;
- Increasing litigations;
- Limited number of facilities providing daily FP services;
- Inadequate counselling of post partum, post abortion and high fertility families;

- Additional spacing choices not reaching consistently to rural clients;
- Preference for the male child; and
- Revised norms as per Hon'ble Supreme Court orders, permitting only DGO, MD Obs and Gynae & MS general surgery to perform Laparoscopy Ligation Training and provide services.

While some of these issues are related to readiness of the facilities and availability of the human resource, others require extensive IEC for community mobilisation and behaviour change for adopting small family norms.

The following strategies have been planned for 2010-11:

3.1 Family Welfare Situational Assessment

In continued efforts to provide appropriate and effective assistance for quality FP services in UP, GoUP has planned a rapid assessment of FP services with support from USAID/ SIFPSA. The objectives of assessment are to have an overview of the current status (quality, availability of FP services) as delivered at various levels of public and private sector, including at the facility and community level.

The assessment will include: a) district field visits; b) review of existing documents and policies; c) facility preparedness; d) availability of human resources; e) service delivery using standardised assessment tools; f) observation of services at RCH camps and facilities; and g) collecting information on FP trainings (in services and pre service) including the number of staff trained. The assessment is planned between February 10-22, 2010 and the results will be disseminated by end of February, 2010. Recommendations made from the dissemination will be implemented in the State during 2010-11.

3.2 Terminal/Limiting Methods

3.2.1 State level workshops for district orientation (FMR Code A 3.1.1)

The activity envisages organizing 4 state level workshops for key programme officers of the districts. This orientation will include performance based strategic action plan, sterilization norms and also include quality standards as per GOI guidelines as mentioned in the Quality Assurance Manual for Sterilization Services. It is proposed to conduct 4 batches of workshops (approx. 18 districts/ batch @ Rs. 50,000/- per batch). **Thus total of Rs. 2.00 lacs is being budgeted for this activity.**

3.2.2 Dissemination on sterilization standards & quality assurance of sterilization services (FMR Code A 3.1.1)

With the objective of orienting the district functionaries regarding sterilization standards and quality of sterilization services (keeping in mind frequent transfers of the programme officers), it is proposed to conduct one day dissemination workshops at the district level. Service quality standards for sterilization approved by Govt. of India will be disseminated along with service quality protocols and steps for organising sterilization services.

An amount of Rs. 0.40 lacs per district is being budgeted. **Accordingly, an amount of Rs.28.40 lacs will be required for conducting this activity.**

3.2.3 Deployment of Family Welfare Counsellors at District Hospitals to Enhance Uptake of Post Partum Uptake of Family Planning Services (FMR Code A 9.1.5)

As a strategy to promote post partum contraception at the district level, it is proposed to position Family Welfare Counselors (FWCs) at District Women Hospitals and Combined Hospitals. These FWCs would counsel eligible mothers for adopting sterilization or IUD and would also promote colostrum feeding, early initiation & exclusive breastfeeding.

During 2009 – 2010 provision of one Family Welfare Counselor per District Women Hospital and Combined Hospitals totalling to 73 positions was made in the PIP. Retired trained ANMs or Lady Health Visitors or Staff Nurses were eligible as FWCs. As it was difficult to find candidates with above qualifications, this year it is proposed that candidates with a graduation degree in MSW/Post graduate degree Social Sciences or Psychology or MA Sociology, may also be considered for the position.

In view of above consideration, this year 180 posts of FWCs are proposed at the FRU level @ Rs 9,000 per month as honoraria. Taking the opportunity of large number of institutional deliveries under JSY scheme, these counselors will have the opportunity to reach all the mothers coming to the facility with information about family planning options available, addressing their concerns about small family norms. These FWCs will also be responsible for counselling the women coming to the facilities for ante natal check ups and for adoption of post partum family planning methods.

Performance of these FWCs will be assessed on the basis of increase in the number of beneficiaries adopting post partum family planning methods at the facility.

A total of Rs. 194.40 lacs is budgeted for the year 2010-11 for honoraria for these FWCs.

For the capacity building of these FWCs a manual, handbook and an MIS system has been developed in 2009-2010. The first round of training will be completed by March 2010. The details of the training plan for FWCs is detailed under training section.

3.2.4 Implementation of sterilization services by districts

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

Provision of Fixed day sterilization services (ligation/abdominal tubectomy) would be continued at all district women hospitals (DWH)/ combined hospital/ PPCs and CHCs. Thus it would be available at 180 functional FRUs. At present all our DWH & combined hospitals (73) are providing female sterilization services for six days per week and fixed day sterilization services (ligation/abdominal tubectomy) on two fixed days will be continued to be provided at CHCs (107) having either a surgeon or gynaecologist or an LMO. 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.

. **No additional budget is required as the same has been included in the revised compensation package.**

Provision of chemical sterilisation solution for laparoscopes is made for 180 proposed FRUs @Rs. 750 per bottle x 48 bottles per facility per year totalling to Rs 64.80 lacs and is being budgeted under procurement
(FMR Code B 19.1)

3.2.4.2 Provide NSV services on fixed days at health facilities in districts

Provision of fixed day NSV services at each District Male Hospital/ Combined Hospital and FRUs/CHCs will continue. 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. Rs.50.00 per NSV will be provided infection prevention materials, gloves, suture & other consumables. Wide publicity of the fixed days would be ensured through wall writings, leaflet, brochures, etc. In case any of the service providers are untrained, they would be trained on NSV at the earliest.

No additional budget is required as the same has been included in the revised compensation package.

3.2.4.3 Organize NSV camps in districts (FMR Code A 3.1.3)

Male participation is critical to success of population stabilization efforts. With the availability of NSV services, a new opportunity can be explored for improving male participation in population stabilisation. 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.

However, it has been observed that sufficient caseload is not available when these camps are organised at such large scale. Hence; such camps do not remain cost effective. It is therefore proposed to hold smaller NSV camps at the district level. In each district, 6 camps will be organized each year between October and March. Each camp would cost around Rs.35,000/-. It is expected that around 426 camps will be organized in the State during the year, 100 NSVs will be performed in each camp and around 42,600 NSVs will be performed in these camps. Compensation package will also be applicable to these beneficiaries.

Total of Rs.149.10 lacs will be required for organizing these camps during the year 2010 – 2011

3.2.5 Plan to scale up NSV services:

Although tubectomy gained popularity in the state, NSV acceptance is not up to the desired level and constitutes about 2.3 percent of total sterilizations in Uttar Pradesh. Therefore, increasing awareness, acceptance of and access to NSV services are important components of the UP State's Family Welfare Programme. The aim of the NSV programme is to increase the contribution of NSV to total sterilizations to 7.5 percent by 2012.

A Centre of Excellence for Male Contraception (NSV) has been strengthened in the Department of Urology, CSMMU, Lucknow in the year 2005-06 with support from SIFPSA. This Centre was established with the objective of providing quality NSV training and providing NSV services at static sites. The COE also conducts camps, imparts training, generates training material and IEC material together with conducting promotional activities, including research and studies for improving quality of service delivery, developing and maintaining data base, etc. The project has been very successful and has been providing NSV services and training to doctors on regular basis. The centre is now able to generate 15-20 clients per day for NSV. The center is conducting TOTs to develop trainers of NSV. Till now the COE center has trained a large number of Surgeons. Since inception total number of seven trainers and 144 service providers have been trained under the project.

During 2009 - 2010 the model was replicated to establish satellite centres in 3 additional Medical Colleges (Meerut, Allahabad & Kanpur). Budget of Rs.10 lacs has been released to each Medical college for strengthening, for conducting master trainers training and induction training. Communication related efforts have to be initiated in the catchment area to generate adequate client load for training and service provisioning.

In addition, it is proposed to scale up NSV services with USAID supported technical assistance agency for ensuring male participation. The following activities are planned:

A. Follow up of NSV providers who are trained in the Centers of Excellence

The Centers of Excellence at Allahabad, Kanpur, Meerut and Lucknow will train selected medical officers from their divisions as NSV service providers. The trainings will be as per GOI norms. After completion of the training, the trained medical officers are expected to provide NSV services in their facilities. In the absence of backstopping by a NSV expert, some of the medical officers may not develop the confidence and comfort level to carry out NSV surgery independently in their respective facilities.

The technical agency will support the Satellite Centres by providing NSV trainers to backstop/ follow up the trained medical officers at the facility/ district level. The backstopping and follow ups will be provided till the medical officers develop confidence and become comfortable doing NSV independently.
The monitoring of these follow ups will be conducted by the District Quality Assurance Committees.

B. Organize training of doctors on NSV

Till Centers of Excellence start rolling out clinical training of doctors on NSV, it is proposed that young male doctors especially newly recruited MBBS doctors be trained on NSV skills during existing NSV camps. Wherever sufficient client load and NSV trainer are available the NSV clinical trainings may be organized. Where qualified NSV trainers are not available, the services of national level trainers through external technical support agencies may be availed. The doctors from the technical assistance agency will support the NSV camps being organised in each district and provide trained service providers and trainers.

C. Orientation of facility staffs and outreach workers on NSV

The paramedical and support staff in the health facilities, and outreach workers are generally not aware of the advantages of NSV. Many of them have misconceptions about the procedure and they are not confident in giving appropriate messages to eligible couples. They lack counseling skills. It is proposed to orient staff of those facilities where NSV services are provided (through camps, VHNDS, monthly meetings at facilities or on fixed days). The orientation would focus on explaining the simplicity of the procedure, dispelling myths and misconception on NSV and the messages to be given to target couples. Counseling skills of the staffs would be strengthened. To minimize disruption to routine functioning of these facilities, the orientations would be organized onsite and whole-site for few hours duration on the days of monthly meetings. The facilitators would visit the health facilities and conduct the trainings onsite.

D. Increase demand for NSV by strengthening IEC/ BCC activities

The States BCC Strategy calls for a multimedia approach to include 1) interpersonal communication, 2) community engagement, and 3) mass media. The COE have existing IPC materials which they have been using in the field with good results from communities. This strategy will include using these materials and will focus on community based approaches while using mass media to create an enabling environment. Community based approaches to BCC include home visits, group meetings and working with existing local structures and community groups. The healthcare staff need to be oriented to use the IEC/ BCC materials appropriately and effectively.

E. Conduct formative research

A systematically designed formative research will help to better understand what motivates the clients to undergoing NSV and their long term satisfaction; what are the barriers in availing NSV services. The effectiveness of different communication models and materials can be compared. It is proposed to conduct a formative research to assess the existing status regarding NSV and how it can be promoted.

As mentioned earlier, monitoring of these activities will be through DQAC and budget for the same is available in Mission Flexipool.

3.2.7 Compensation for Sterilization

3.2.7.1. Compensation for female sterilization (FMR Code A 3.1.4)

Female sterilisation has declined this year. Till December 2009, around 2.17 lacs sterilisations were performed. It is expected that there will be around 5 lac sterilisations will be performed till March 2010 since the maximum number of female sterilisations are conducted in the last quarter. With the procurement of Laparoscopes and training of providers, it is now estimated that in the year 2010 -11 around 7 lac sterilisations would be performed.

An amount of Rs. 7000 lacs @ Rs.1000/- per sterilization would be required for the year 2010 -11

3.2.7.2. Compensation for male sterilization (FMR Code A 3.1.5)

6607 male sterilizations have been performed upto December 2009, the performance objective for year 2010 -11 is proposed at 45,000 provided the incentive for beneficiaries is approved.

An amount of Rs. 675 lacs @ Rs.1500/- per sterilization would be required for the year 2010 -11

3.2.8 Training

The following trainings for permanent methods are planned for FP initiatives in the State:

- **Post Partum Abdominal Tubectomy Training**

Post partum abdominal tubectomy training will be provided along with the short term Comprehensive Emergency Obstetrics Care (CEmOC) refresher training It is observed that although post partum abdominal tubectomy is a simple procedure which can be performed soon after delivery (within 48 hours), service providers are reluctant to offer these services to beneficiaries in absence of current practice. During the course of this training, there will be an opportunity to refresh their skills on post partum clients who opt for abdominal tubectomy. This training will be coordinated by SIHFW.

- **Post Partum Abdominal Tubectomy (PPAT) Refresher Training for MBBS LMOs**

Presently, MBBS LMOs are providing all the obstetric services at DWH/ CHs. In service they have gained skills in all obstetrical procedures (major and minor surgeries, including LSCS) but currently they are not providing post partum abdominal tubectomy services due to lack of emphasis on post partum family planning services. Therefore, to refresh their skills for provision of PPAT it is proposed to give them a refresher training of three days at 17 divisional training centres. It is proposed to train 85 doctors (LMOs) in the year 2010-11. The services of master trainers of abdominal tubectomy will be used to impart this training. The training will be coordinated by SIHFW.

In addition to the above, NSV training in Centres of Excellence, laparoscopic sterilisation training and abdominal tubectomy training will be conducted. Details of these are available in the training section.

3.2.9 Monitoring of Sterilization Services (FMR Code A 3.1.1)

To ensure provision of sterilization services, it is proposed to adopt a provider-wise monitoring of sterilization cases conducted through already established District QACs. Regular review of performance would be conducted and a reporting mechanism would accordingly be established. District and Divisional trainers (of NSV, Laparoscopic & minilap tubectomy) would be involved in providing supportive supervision and followup of newly trained service providers. They will also give immediate feedback so that the corrective measures can be adopted for the service provision as well as facility readiness for the sterilization services. They will be paid TA/DA and Honoraria according to norms, which will be met from this head. **Accordingly a sum of Rs 25 lacs is being budgeted for this activity.**

3.3 Spacing Methods

3.3.1 IUD Services:
Implementation of IUD services by districts: (FMR Code A 3.2.2)

Upto the month of December 09, around 10.59 lac IUD insertion were done and it is expected that around 18 lacs clients will have IUD inserted by the end of March 2010. Accordingly for the year 2010-11 about 22 lacs clients are expected to be provided IUD insertion services. Therefore as per the Govt. of India approved package of Rs. 20/- per client the budget required would be Rs. 440/- lacs.

An amount of Rs.440 lacs @ Rs.20/- per client would be required for the year 2010 -11

3.3.1.2. Provision of IUD services at District Hospitals/CHCs/Block PHCs: Daily IUD 380-A insertion services are being provided in 73 District Hospitals (Women, Combined & PPCs), 438 CHCs and 470 block PHCs at present. It is proposed to ensure provision of fixed day services at each of these facilities and expand to remaining CHCs and Block PHCs. IUD services at the Sub Centres would be continued to be provided at 2300 accredited sub centers on fixed days. Preferably, Mondays (ANC clinic days) would be the day for IUD services also.

However, funds would be required for: (i) client cards, IEC activity - This component is budgeted under BCC section; and (ii) infection prevention services from the RCH flexi pool.

For these activities Rs.15,000 per unit will be required for District Hospitals/PPCs, Rs.6,000/- for CHCs and Rs.3,000/- for BPHCs as shown in the table below is proposed

Sl.	Head Name	At District Hospital/PPC	At CHCs	At BPHCs
1	Client Card	Rs. 2500/-	Rs. 1000/-	Rs. 500/-
2	IEC Activity	Rs. 5000/-	Rs. 2000/-	Rs. 1000/-
3	Infection prevention & other consumables*	Rs. 7500/-	Rs. 3000/-	Rs. 1500/-
	Total	**Rs. 15,000/-**	**Rs. 6,000/-**	**Rs. 3,000/-**

*Includes chlorhexadine, solution for chemical sterilisation and surgical handscrub

Accordingly, the total requirement works out as follows:

Sl.	Facility	No. of Facilities	Allocation Per Facility	Total Amount (In Lacs)
1	District Hospitals/PPCs	73	15,000/-	10.95
2	CHCs	438	6,000/-	26.28
3	BPHCs	470	3,000/-	14.10
Total				**51.33**

The total amount needed for the year 2010-11 is Rs. 51.33 lacs (FMR Code A12.3.3) out of which Rs. 24.76 lacs (FMR Code B 19.1)is for procurement of infection prevention items and other consumables has been budgeted under Mission Flexi pool.

3.3.1.3. IUD services at Sub Centres

IUD services at the Sub Centres would be continued to be provided on fixed days. Preferably, Mondays (ANC clinic days) would be the day for IUD services also. Expenses towards infection prevention etc. would be met from the untied grant and there is no additional budgetary requirement. IEC activities will also be implemented to popularise the clinic day.

3.3.1.4. Post Partum IUD Experiences

SIFPSA has piloted the PPIUCD training in technical assistance with USAID support at three sites in UP namely, Lucknow, Allahabad and Jhansi. The Obs. & Gynae Department of CSMMU has been strengthened as a training site for PPIUCD. The training materials are presently being finalised to suit the needs of the State. In addition, standardisation of follow up systems, demand generation and reporting systems are being strengthened to ensure complete care and counselling for a beneficiary. It is expected that PPIUCD trainings and activities will be consolidated by September 2010, post which SIFPSA will initiate scale up activities. Since this activity will be supported by USAID, no additional funds are being requested.

3.3.2 Social Marketing

Social Marketing is being implemented in all C and D category villages(with population between 2000 and 5000) in 71 districts of the State with USAID support. Condoms and OCPs are being made available through conventional and unconventional retail outlets. Independent studies show that socially marketed condoms and pills are available in atleast one retail outlet in 58 percent of 44000 villages in C and D category villages. Gram Panchayat meetings, community meetings, Market town Activities (MTAs) in rural *haats*, van activities, health baby events, retailer meetings and Anganwadi worker meetings are being conducted. Anganwadi workers are being encouraged to become Community Based Depot (CBD) holders.

Condom promotion activities are also being conducted through the Technical Support Group of National AIDS Control Organisation (NACO).

Support will be sought from both organization to continue support for social marketing activities to increase the availability of condoms and pills in the State.

3.3.3 Training

The following family planning trainings for spacing methods will be provided to strengthen capacities of service providers:

- **IUD training**

Training for staff nurses/ LHVs/ PHN is proposed in the year 2010-11 and is detailed in the training section. The training in IUD 380 A for the year 2010-2011 has been proposed for 668 doctors, 1376 Staff Nurses/LHVs and 3870 ANMs.

- **Contraceptive Technology Update**

It is proposed that the contraceptive technology update training is included in the ANM and LHV skill training so that service providers are well aware of latest options available for family planning.

Details of the training along with the budget are given in the training section.

3.3 Other strategies/activities – FP services through Private Providers (FMR Code A 3.1.1)

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

This exercise was proposed to be facilitated by DPMUs which are fully fnctional now, this activity will be carried out this year. 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 database 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, training needs 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 norms, 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, Govt. of India provides for a payment of Rs.75/- to an accredited provider/facility for each case of IUD insertion (inclusive of cost of IUD). It is proposed that two private facilities will be accredited in each of the 71 districts of UP (depending on availability of Pvt. Nursing Homes or hospitals)

It is estimated that around 500 NSVs, 2600 female sterilizations and 5000 IUD insertions would be conducted by the private providers. **Following table shows the budget requirement for the activity.**

SN	FP Method	Proposed @ Rs. per sterilization	Expected workload	Amt. in lac Rs
1	Female Sterilisation (FMR Code. A.3.1.6)	1500	2600	39.00
2	NSV (FMR Code A.3.1.6)	1500	500	7.50
3	IUD (FMR Code A 3..2.3)	75	5000	3.75

Accordingly, an amount of Rs. 50.25 lacs is being budgeted for the year 2010-11 for providing sterilisation and IUD services through private providers/NGOs.

3.5 Advocacy for Family Planning

Advocating family planning with district level bureaucrats provides the necessary fillip to the family planning program at the District level. It is proposed to invite District Magistrates and local leaders for the Saas Bahu Sammelans, ASHA Sammelans and Pradhan Sammelans to garner support for family planning as well as identify solutions to local level problems/ issues around FP.

3.6 Delaying Age at Marriage

Delaying age at marriage has been identified as a key priority behaviour to be changed for the State. This will address many RCH concerns of the State. DLHS III data indicates that the following districts have the poorest indicators for age at marriage.

Table: Percent of girls marrying before completing 18 years

1	SHRAVASTI	82.8
2	BAHRAICH	70.7
3	BALRAMPUR	66.5
4	GONDA	63.4
5	SIDDARTHNAGAR	63.1
6	MAHARAJGANJ	62.4
7	LALITPUR	58.9
8	BADAUN	55.7
9	KUSHINAGAR	52.7
10	CHANDAULI	49.4

Source: DLHS – III, 2007-08

Delaying age at marriage is seen as a key strategy for reduction of total fertility. Saloni Swasth Kishori Yojana (SSKY), SACH and ARSH include delaying age at marriage as a key behavioural outcome and will be addressing the issue through meetings with adolescent girls. Special emphasis in the above districts have been suggested in the District Action Plans to address the issue of early age at marriage through local community based vents and community mobilisation.

3.7 Quality Assurance for Family Planning

District Quality Assurance Committees (DQACs) have been set up in all districts of the State. These DQACs submit monthly reports to the Directorate and are actively involved in verifying sterilisation cases for insurance claims. They also ensure that standards of male and female sterilisation are being followed at district level. In addition, these DQACs will also be involved in orientation workshops at state and district level workshops for (activity3.21&3.2.2) & FFHI and they will also ensure quality of delivery services at public health facilities.

3.8 Procurement & Maintenance (FMR Code B 19.2)

During the year 2008-09 orders for procurement of Single Puncture Laparoscopes/ Laparocators, NSV kits and IUD insertion kits have been placed. However, due to the fluctuation in rates the desired quantity could not be procured. Against a requirement of 1224 single puncture laparoscopes only 724 could be procured. These laparoscopes are presently being distributed in the field. There is a need for these equipment and kits, which is being budgeted as under:

Sl.	Item	Quantity	Estimated Unit Cost	Total Amount (In Lacs)
2	IUD Kits (for Sub Centres)	2000	Rs.4500.00	90.00
3	NSV kits @ 2 Kit per CHC	1000	Rs.2500.00	25.00
Total				**115.00**

The above budget requirement of Rs. 115 lacs would be met from the Mission Flexipool and has been provided for accordingly under the head 'Procurements' in Mission Flexipool.

Budget Summary

SN	FMR S.No	Activities	No. of Units	Rate per Unit (in Rs.)	Frequency	Total (in Rs. Lacs)
3		**FAMILY PLANNING**				
3.2	**A 3.1.1**	**Meetings/ Sensitisation/ Orientation**				**30.40**
3.3	**A 3.1.3**	**Special Camps for Limiting Methods – NSV Camps**	426	35000	1	**149.10**
	A.3.1.4	Compensation for Female Sterilisation	1000	700000	1	**7,000.00**
	A.3.1.5	Compensation for Male Sterilisation	1500	45000	1	**675.00**
3.8		**Accreditation of Private Provider for sterilisation**				
	A 3.1.6	*Female Sterilisation*	2600	1500	1	39.00
	A 3.1.6	*NSV*	500	1500	1	7.50
		Sub Total				**46.50**
	A 3.2.3	**Accreditation of private providers for IUD insertion**	5000	75	1	**3.75**
	A 3.2.2	**Wage loss compensation for IUD insertion**	20	2200000	1	**440.00**
		FAMILY PLANNING SUB TOTAL				**8,344.75**
	A 12.3.3	**IEC/BCC for Provision of IUD Services at Facilities**				**51.33**
	A 11.6	**Training – Laparoscopic, minilap, NSV and IUD**				**141.24**
		Infrastructure and HR				
		Honoraria for Family Welfare Counselors at DHs and CHCs	180	9000	12	194.40
		Institutional Strengthening				
3.5		*Monitoring of Sterilisation Services*	1	2500000	1	25.00
		Sub Total				**25.00**
3.9	**B 19.2**	**Procurement**				
		Consummables for sterilsation camps at facilities on fixed days	180	750	48	64.80
		Infection prevention consummables for IUD services				24.76
		IUD Kits	2000	4500	1	90.00
		NSV Kits	1000	2500	1	25.00
		Sub Total				**204.56**
		SUB TOTAL FOR FAMILY PLANNING				**8741.88**

4. PCPNDT(A.8.1)

Sex ratio is an important indicator to measure gender equity. The rapidly decreasing sex ratio in the state is likely to create severe gender imbalance that can destroy the social fabric. It should also viewed both as child right issue (girls are killed either through sex selective abortions or die prematurely due to violence and neglect). Figures below indicate the trend in sex ratio over the years of India and Uttar Pradesh.

Yrs	1901	1911	1921	1931	1941	1951	1961	1971	1981	1991	2001
India	972	964	955	950	945	946	941	930	934	927	933
UP	942	916	908	903	907	908	907	876	882	876	898

But the results about the sex ratio among the children between ages 0 to 6 years has decreased remarkably at national as well as state level.

Year	India	UP
1991	945	927
2001	927	916

It is seen that the status of eastern districts is better than western districts. Census 2001 indicates that Shahjahanpur (838), Mathura (841), Badaun (841), GB Nagar (842), Hardoi (843), Etah (847), Jalaun (847), Baghpat (848), Firozabad (851), Agra (852), Hamirpur (852), Mainpuri (855), Hathras (856), Etawah (856), Auraiya (856), Kanpur Dehat (856) and Shravasti (859) are the 17 worst affected districts with the sex ratio lower than 860.

The 'Civil Registration Data' clearly shows that the sex ratio is declining in most of the commercially viable districts where ultrasonography centers are in abundance indicating a direct correlation. Consequently, strategies will focus on these districts. Data from the CMO office of 69 districts indicate that there are 172 ultrasound machines in the government sector and 3467 machines in the private sector. It is well known that it is difficult to regulate the private sector and therefore initiatives to monitor the implementation of the PC PNDT Act becomes even more essential.

Given the above scenario, effective implementation of the PCPNDT Act together with social reform efforts including enhancing the value of a daughter is a significant step towards the prevention of female feticide.

State level Activities

4.1.1 State PCPNDT Cell (FMR Code A.14.1)

A PCPNDT cell has been established at the FW Directorate. Two positions for which recruitment was not undertaken will be done by Marc 2010. The following budget is proposed for the continuation of PCPNDT Cell:

Sl.	Description	Amt.(Rs. in lacs)
1	Procurement of computer peripherals	0.05
2	Payment of honoraria to 3 contractual staff @ Rs. 17,000/- pm (data Assistant, Legal Assistant&Social scientist)	6.12
3	Contingency	0.60
Total		6.77

Accordingly Rs. 6.77 lacs will be required for the PCPNDT cell at State level for the year 2010-11. The expense has been budgeted under the head 'Programme Management'

4.1.2 State Inspection & Monitoring Committee

A State level Inspection & Monitoring Committee has been established, which will undertake inspection of ultrasound centres in 10 worst districts. It is estimated that for each inspection visit around Rs.10,000/- would be incurred for 2 visits per district. **Accordingly, for visits to 10 districts, an amount of Rs.2.00 lac is being budgeted for the year 2010 -2011.**

4.1.3 Orientation Training of District Nodal Officers and Data Assistants

A PNDT website has been created by Govt. of India and there is a system of online data updating. One round of training on the system of reporting was conducted at Lucknow for district Nodal Officers and Data Assistants. In the year 2009-10, CMOs have started reporting on the PCPPNDT provisions. However, there is a need to conduct a reorientation since there have been many transfers. This will also give the CMOs an opportunity to share and discuss specific issues in their districts regarding implementation of the Act and their role and responsibilities. It is therefore proposed to provide one round of orientation training to the CMOs/ ACMOs and Data Assistants to orient them on the various procedures to be followed, maintenance of records, updating of data, etc.

Four batches of training would be required to be conducted, each batch having around 40 participants. The cost of each batch of training would be around Rs.25,000. **Thus, for 4 batches of training an amount of Rs.1.0 lac would be required for the year 2010 - 2011**

4.1.4 Review Meetings at State level

It is proposed to review the activities conducted by districts for implementation of the PCPNDT Act. Nodal Officers from the district would participate in these meetings. A one-day meeting would be conducted every six month at the State headquarter for the purpose. Two batches of meetings would be required to be conducted to cover all the 71 districts. The budgetary requirement for each meeting would be as follows:

Sl.	Description	Annual amt. (Rs. in lacs)
1	Venue expenses (Audio/video, etc.)	0.02
2	Expenses towards refreshments, etc.	0.07
3	Stationery, etc.	0.04
3	Contingency	0.02
Total for one batch		0.15
Total for 2 meetings of 2 batches		0.60

4.1.5 State Level Meeting of Boards/Committees

Three Committees/Boards have been constituted at the State level under the PCPNDT Act. These committees would meet at regular intervals to review the activities under PCPNDT and suggest necessary actions to be taken, if required. The budgetary requirement for the various meetings would be as follows:

Sl.	Description	No. of Meetings to be organized	Estimated expense per meeting	Annual Requirement (Rs. in lacs)
1	Meeting of State Supervisory Board under the Chairmanship of Hon'ble Minister of Medical & Health	3	Rs.15,000/-	0.45
2	Meeting of State Appropriate Authority under the Chairmanship of DG (FW)	6	Rs.300-/	0.018
3	State Advisory Committee	6	Rs.1,000/	0.06
Total				0.53

4.1.6 State Level Sensitization Workshop

A sensitisation workshop was conducted in 2009-10 with the active participation of leading gynecoogists who gave their perspective. A detailed documentation of the meeting is being sent to GoUP for further action. This workshop provided an appropriate platform for discussion and detailing of documentation required for PCPPNDT. It is proposed that this workshop be conducted this year also involving different stakeholders including government doctors, District Magistrates, NGOs, representative from the legal field, social welfare department, women and child welfare department, women and human right groups, district administration and PRIs. In the

second session, the participants will be members from IMA, nursing home associations, gynaecologists, radiologists, ultrasonologists, and members from FOGSI association. **A budgetary provision of Rs. 3 lacs is being made**.

4.1.7 State level IEC Activities

IEC activities for generating awareness regarding the provisions of the PCPNDT Act are being conducted by the IEC Bureau in the State. It is proposed to continue the IEC activities through the IEC bureau. The activity plan would be prepared by the IEC Cell and discussed with the members of the State Advisory Committee and the State Appropriate Authority. After approval of the same the IEC activities will be implemented. **A lumpsum provision of Rs.100 lacs is being made for the year 2010 - 2011**

4.2 Divisional Level Activities

4.2.1 Orientation of Members of the District Advisory Committee

District level Advisory Committees have been constituted. The members of the Committees are required to be oriented regarding their role and responsibilities. Accordingly, it is proposed to conduct one day orientation meeting of these functionaries. The meetings will be organised at the division level. It is estimated that the average cost of each meeting would be around Rs.10,000/-. Thus, the budgetary requirement for conducting one meeting in each of the 18 divisions works out to Rs.1.80 lacs.

4.3 District Level Activities

4.3.1 District Inspection & Monitoring Committee

Under the PCPNDT Act, District level Inspection & Monitoring Committees have been constituted, for inspection and monitoring of ultrasound centres. The Committee will undertake at least two inspection and monitoring visits every month and will send quarterly report to the State PNDT Cell. An amount of Rs.10,000/- is being budgeted for monitoring activities in each district. Accordingly, for 71 districts, an amount of Rs.7.10 lac is being budgeted for the year 2010 - 2011. In addition, the Divisional PMUs will be involved in monitoring the implementation of the PCPPNDT Act and submitting regular reports.

4.3.2 District Level Sensitization Workshops

After the State-level sensitization workshop has been conducted, one-day district level workshops would be organised for creating publicity regarding the need to address discrimination against girl child and creating awareness regarding the provisions of PCPNDT Act and its enforcement. Necessary guidelines and literature on the subject would also be provided to the participants. Accordingly, various stakeholders in the districts would be sensitised. Two sessions would be organised as follows:

First session - for Medical Officers, NGOs, Officials from the Department of Women & Child Development, Social Welfare, Panchayati Raj, Human Rights Commission, etc.
Second session - for Representatives of IMA, Nursing Home Associations, FOGSI, Gynaecologists, Radiologists, Ultrasonologists, etc.
An amount of Rs.40,000/- would be allocated to each district for the same. **Accordingly, an amount of Rs.28.40 lacs is being budgeted for 71 districts.**

4.3.3 Organizing Competitions at Inter/Degree Colleges

As a part of awareness generation, it is proposed to organise various competitions, such as, debate, essay writing, poster competition etc. in intermediate/degree colleges on issues related to female foeticide, gender discrimination. Such events would be conducted in 3 institutions in each district. The budgetary requirement will be as follows:

Sl.	Description	Annual amt.(Rs.)
1	Prizes for students @ Rs.1800/- per school x 3 schools	5400.00
2	Expenses towards refreshments, etc. @ Rs.1000/- per school x 3 schools	3000.00
3	Miscellaneous	1600.00
Total for one District		10000.00
Total for 71 Districts		710,000.00

Accordingly, for 71 districts, an amount of Rs.7.10 lac is being budgeted for the year 2010-11.

4.3.4 IEC Activities at District Level

Districts can utilize funds being collected from registration/renewal of Centres under the PCPNDT Act for IEC activities. However, additional funds are proposed to be provided to the districts to undertake local level IEC for generating awareness regarding the provisions of the PCPNDT Act through wall paintings, posters, hoardings, local media, cable TV, etc. Names of the members of the District Advisory Committee and phone numbers for lodging complaints will be displayed at prominent places and printed on pamphlets, forms etc. for distribution.
Districts have been categorized based on the number of genetic centers in the districts and accordingly budgetary allocation is proposed for each district.

Sl.	Category according to registered genetic centres	No. of Districts	Budget for IEC per District	Contingency per District	Total Amt Rs. in Lacs
1	0 - 16	26	Rs. 25,000/-	Rs. 2,000/-	7.02
2	17 - 25	10	Rs. 35,000/-	Rs. 3,000/-	3.80
3	26 - 50	17	Rs. 40,000/-	Rs. 4,000/-	7.48
4	51 - 100	5	Rs. 50,000/-	Rs. 5,000/-	2.75
5	Above 100	13	Rs. 60,000/-	Rs. 6,000/-	8.58
Total					**29.63**

4.3.5 TA/DA to District Level Staff for Attending Meetings, Workshops, trainings, etc. outside District HQ

Regular review meetings and refresher trainings, etc. have been planned for district nodal officers, dealing clerks and members of advisory committee. A lumpsum provision of Rs.20,000/- per district is being made towards reimbursement of travel and DA to the district staff for attending meetings, trainings, etc. outside the district HQ. **Thus, a total budgetary provision of Rs.14.20 lacs is being made.**

BUDGET SUMMARY (PCPNDT): 2010 -2011

SN	FMR S.No	Activities	No. of Units	Rate per Unit (in Rs.)	Frequency	Total (in Rs. Lacs)
4	**A 8.1**	**PCPNDT**				
4.1.2	**A 8.1**	**State Monitoring and Inspection Committee – Monitoring Visits**	10	10000	2	**2.00**
4.1.4	**A 8.1**	**Review Meetings at State Level**				**0.60**
4.1.5	**A 8.1**	**State level Meeting**				**0.53**
4.1.6	**A 8.1**	**State level sensitisation workshop for providers**	1	300000	1	**3.00**
4.2.1	**A 8.1**	**Orientation of Members of District Advisory Committee**	18	10000	1	**1.80**
4.3	**A 8.1**	**District Level Activities**				**42.60**
	A 8.1	**PCPNDT SUB TOTAL**				**50.53**
		Training				
4.1.3		Refresher Training of District Nodal Officers and Data Assistants	4	25000	1	**1.00**
		Programme Management – Operationalising PCPNDT Cell				**20.97**
4.1.7	**A 12.4**	**IEC/ BCC**				**129.63**
		SUB TOTAL FOR PCPPNDT				**202.13**

Of the total budget of Rs. 202.13 lacs, a budget of Rs. 50.53 is proposed under PCPNDT for the year 2010-11.

5. ADOLESCENT HEALTH

Nearly 25 percent of the population of Uttar Pradesh are adolescents (415 lacs). As per NFHS-III (2005-06) about 25 percent are boys and 23 percent are girls. Adolescent girls who marry at less than 18 years of age are 59 percent and 38 percent begin child bearing when less than 19 years. As per NFHS-III teenage pregnancy is 14.3 percent and unmet need for contraception is 21 percent. Adolescent taking treatment at health facilities is only 31 percent. There is poor awareness in this age group regarding different problems occurring in adolescents such as RTI/STIs and ways to address them. NFHS III data also indicates that there is poor knowledge regarding problems of unsafe sex and protected sex. Only 33 percent of girls in age group of 15-19 knew that condom can prevent HIV/AIDS and 36 percent males had heard of STDs.

Given the above scenario there is an urgent need for influencing the health seeking behaviour of adolescents which will determine mortality, morbidity, population growth and health in the community. This will also influence adolescents for delaying the age at marriage, reducing teenage pregnancy, meeting unmet need of contraceptive, reducing incidents of RTI/STIs and reducing maternal deaths in this age group. *To meet these needs of adolescents in the State, it is planned to conduct trainings for service providers and operate adolescent friendly centres.*

In addition, severe anemia has been identified as a major health challenge. Data from NFHS-III indicates that nearly 49 percent of adolescent girls in the age group of 15-19 years are anemic and prevalence of anemia continues to remain at 52 percent during pregnancy. Adolescent pregnancy and anemia contribute to the high prevalence of low birth weight and subsequent under nutrition among Indian children. Iron deficiency during adolescence, with or without anemia, result in poor physical work capacity, poor concentration, and low school achievement. Targeting adolescent girls will help prevent iron deficiency during pregnancy and its consequences. *To address these issues, school going as well as non-school going adolescent girls will be reached through specific programmes* proposed in sections below.

5.1 Orientation and Training on ARSH (FMR Code A 4.2)

Under RCH-II Programme some components of ARSH modules were incorporated in the training programmes of doctors and workers being conducted by SIHFW, but extensive trainings as per national guidelines on ARSH were not conducted. Keeping the scenario of health status of adolescents in UP in mind, it is proposed to incorporate a re-orientation programme for medical officers and health workers on ARSH in a phased manner.

Planning Meeting – A planning meeting will be conducted at State HQ with GoI officials to plan in detail the modalities of training and issues of printing of modules. For this a budget of Rs 25000 is being included.

State Sensitization Workshops: It is planned to conduct a sensitization workshop at State Head Quarter in which all the programme officers of the Department, district representatives, officers of other partner departments like-Education, PRI, ICDS, Rural Development etc., representatives of NGOs, developmental partners and media will

participate. Advocacy for implementing adolescent health activities, which includes development of materials, will also be undertaken during this workshop. For this a budget of Rs. 5.00 lacs is being proposed.

Similarly, district level sensitization workshops will be conducted at each District H.Q. for which a budget of Rs. 25000/district is being proposed.

These workshops will be followed by TOT for master trainers of the State. A pool of 25 master trainers will be trained for 3 days with support from concerned officials from GoI. The group will comprise of senior officers from Directorate of Family Welfare - UP, SIHFW, SPMU, NGOs, etc. This will be followed by a TOT for district officers that will be conducted at SIHFW in two batches in which 3 officers from each district of divisional HQ will be trained to conduct training of medical officers and LHV/ANM in a phased manner at the district. A detailed training plan is being enclosed for which budget will be included in the training section.
The Facilitators Guide and handouts for medical officers have been developed by GoI in English which will be used for the training programme in the State. It is requested that GoI provide the same to the State in required numbers. The Facilitators Guide and handouts for LHV/ANMs have to be translated in Hindi for our state. In case the modules for MOs cannot be provided by GoI, then a budget of Rs.10 lacs is being proposed for printing of Facilitators Guide and handouts for MOs and LHVs/ANMs.

5.2 Implementing ARSH: Scheme for Adolescent Counseling for Health (SACH) project

Information and Health services can play an important role in helping adolescents to stay healthy and to complete their journey to adulthood; supporting young people who are looking for a route to good health, treating those who are ill, injured or troubled and reaching out to those who are at risk.

SIFPSA in coordination with MAMTA has developed SACH (Scheme for Adolescent Counseling for Health) project to be implemented in two blocks of Allahabad and Meerut districts, on the pattern of ARSH.

The goal of SACH is to equip adolescents with emphasis on out of School with information and skills for developing as healthy individuals.

The SACH kendras (youth friendly health centres) will be established at three levels starting from Sub Centre and moving up to the district. At the Sub Centre level, the SACH Kendra will have infotainment as their prime focus. At the block and district level it will have and additional component of counseling for personal hygiene and RH issues and provision of health care services will also be integrated with existing health systems and other programmes of SACS, NYKS and Yuvak Mangal Dals so as to avoid verticality.

The ARSH training programme which is being included for MOs/HVs and ANMs will ultimately support and synergise the SACH scheme under which YFHC are being opened at different levels with support from SIFPSA.

SACH project has been approved in two districts of Allahabad and Meerut as a pilot. One center each at the district level, four centers in urban areas of each district, centers at two blocks per district and 14 centers at sub centre level in each district are proposed to be established.

The technical resource institute—MAMTA is supporting the scheme by developing information material to be displayed at these centres. Also games have been developed which will provide information and knowledge regarding issues of reproductive and sexual health which will be made available at these centres. Mobilization of both boys and girls in adolescent age group to these centres will be ensured by peer educators, ASHA, NGOs for which training is also being included in SACH programme. At the YFHC at block level counsellors will be appointed on contractual basis and they will tackle the referred cases and ensure proper treatment or guidance by the block medical officers. For further investigations or treatment the beneficiary will be referred to the district ICTC centre as needed.

Based on learning from the pilot, SIFPSA will scale up the implemention to four additional districts in the year 2010-11. No additional budget is required from NRHM.

SN.	FMR No.	Activities	Unit Cost (Rs)	Total Cost (Rs. in lacs)	Remarks
1	A.4.2	Planning Meeting at State level	25000	**0.25**	**ARSH – RCH Flexipool**
2	A.4.2	State Level Orientation by GOI for 200 participants*	500000	**5.00**	**ARSH – RCH Flexipool**
3	A.4.2	District Sensitisation Workshop 71 District @ Rs.25000/- per District*	25000	**17.75**	**ARSH – RCH Flexipool**
4	A.11.7	Development and Printing of Module for Facilitator/MOs/LHV/ANM (Lumpsum)	1000000	**10.00**	**Training – RCH Flexipool**
5	A.11.7	State TOT for SIHFW/DGFW/SPMU Trainers and Monitors (25 Participants) for 3 days in one batch**	135650	**1.36**	**Training – RCH Flexipool**
6	A.11.7	State TOT for Regional level Trainer and Monitor (30 Participants) for 3 days in 2 batch = 60 participants**	151325	**3.03**	**Training – RCH Flexipool**
7	A.11.7	Training of Medical Officers for 3 days RHFWTC, 1816 MOs in 96 Batches (25 Participants per batch)**	85275	**81.86**	**Training – RCH Flexipool**
8	A.11.7	Training of ANM & LHV for 3 days at District level Training Centre, 128 batches 4262 participants (15% of Total training Load) (30 Participants per batch)	71000	**90.88**	**Training – RCH Flexipool**
TOTAL				**210.13**	

A total budget of Rs. 210.13 lacs is required under the ARSH component of adolescent health. Of this, a total of Rs. 187.13 is being budgeted under Training component of RCH Flexipool (FMR Code A 11.7). An amount of Rs. 23 lacs has been budgeted under ARSH (FMR Code A.4.2)

5.3 Intervention for school going adolescent girls addressing anemia: Saloni Swasth Kishori Yojana (FMR codeA 4.1)

Adolescent health interventions under the name *Saloni Swasth Kishori Yojana,* have been launched for school going adolescent girls. The interventions include family life education, counselling on nutrition and personal hygiene, weekly IFA supplementation and biannual deworming. The component for school going adolescent girls is covering around 8000 girl's junior high schools (10 schools per block). The programme was launched in December 2008. Under the programme the Medical teams, comprising of AYUSH lady doctors, HV/ ANM visit each school every six months to provide IFA, deworming tablets, FLE, counselling on nutrition and personal hygiene.

In each school, Saloni Sabha is organized once in a month with support of trained teachers in which debates, folk activities, skits, discussions regarding nutritious food/proper dietary habits/ personal hygiene issues etc. are organized on the basis of monthly themes provided to the schools. In each school, 3 girls are identified as Saloni Adhyaksha, Saloni Upadhyaksha and Saloni Treasurer, who have been made accountable for organizing Saloni Sabha in their schools regularly. A budget of Rs. 300/Sabha per month has been incorporated in the scheme. The scheme has shown good results as there is involvement of girls in Saloni Sabha, who feel confident and empowered. There is good feed back from the district officials, programme managers and local NGOs working in the field that the scheme has had impact on the adolescent girls of the targeted schools. Also, there is a recommendation to implement the programme to non school going adolescent community, which is being incorporated for year 10-11.

In the year 2008-09 two teachers from each selected school were trained at the block by medical officers who were given training at State Head Quarter. On the recommendations of the district officials a reorientation programme is being incorporated for the year 2010-11, where two teachers from each school will be trained at Block level. Teachers' guidelines have been developed with support from ITAP which also include themes for organizing Saloni Sabhas at the schools. A Saloni Diary has also been developed to be maintained by each adolescent girl in which she has to keep record of herself, her likes and dislikes, achievements and future plans, dietary habits etc. The topics of Saloni Diary are in concurrence with the chapters of teacher's guidelines. The budget for training and printing of training material is being given in detail. The scheme will improve the girl's confidence level and empower them for many activities thus, finally bringing a behaviour change in them. Hence, it has been decided to continue the interventions in an improved way. **A total budget of Rs. 685.78 lacs is required under Saloni Swasth Kishori Yojana component of Adolescent Health. Out of this, an amount of Rs. 288 lacs is being requested for the year 2010-11. The rest of the amount has been budgeted in PPP and Innovations section of RCH Flexipool**.

5.4 Intervention for non-school going adolescent girls addressing anemia

A large percentage of adolescents in our states do not go to the schools and are often in a more disadvantageous situation than those, who attend school. They are often in a poor socio economic group, and are not in institutional environment where there is contact with teachers and peers. Hence, it is important that weekly Iron Folic Acid supplementation, bi annual De-worming and Family Life Education-with counselling on nutrition & personal hygiene should be incorporated for non school adolescent girls in the community under the adolescent health programme this year.

To implement the programme in the villages, it is planned to take the help of local NGOs which are actively working in identified villages. With the help of district functionaries about 10,000 villages have been identified having a presence of NGO worker. At the block level, MO and Programme Managers who have already been trained under Saloni Swasth Kishori Yojana for school going girls will impart a one day training to these NGO workers regarding the concept of the programme and its implementation. Block level representative of the concerned NGO will also be involved and made responsible for implementation of the activities. Alongwith the NGOs, training will be imparted to ASHAs and Anganwadi workers of these identified villages, who will provide services to the adolescent girls in the community and counsel them regarding personal hygiene, nutrition and family life education. Similar to adolescent health programme for school going adolescents, monthly Saloni Sabha will be conducted in each identified village with the support of ASHA and NGO volunteer. Also 5 dynamic girls will be nominated as Saloni Sakhi who will be responsible to ensure that their peer adolescent girls take weekly IFA tablets regularly. In the long run, these Saloni Sakhis will be networked with the YFHCs and mobilise adolescents for availing ARSH services there.

Thus, in 10,000 identified villages, about 20,000 NGOs/ASHAs/AWWs will be trained for which **a budget of Rs. 25 lacs is being proposed**.

There are about 50 non school going adolescent girls in a population of 1000 requiring IFA supplementation. For 10,000 villages with approximate population of 150 lacs, the total adolescent girl population to be covered is approximately 7.50 lacs. In ASHA kit Iron Folic Acid Tablets are being provided for age group of 15-45 years of women, which will cover the adolescent girls of her area as well. So, a budget for provision of de-worming tablets only is being incorporated under the programme. **A budget of Rs. 30 lacs is being proposed under Procurement section of Mission Flexipool.**

BUDGET SUMMARY FOR ADOLESCENT HEALTH

S.No	FMR S.No	Activities	No. of Units	Rate per Unit (in Rs.)	Frequency	Total (in Rs. Lacs)
5		**ADOLESCENT HEALTH**				
5.1	**A4.2**	**Orientation and Training on ARSH**				**23.00**
5.2	**A4.1**	**Saloni Swasth Kishori Yojana**				
		Medical team visit to schools	8000	300	2	48.00
		Saloni Sabhas	8000	300	10	240.00
		Sub Total				**288.00**
		ADOLESCENT HEALTH SUB TOTAL				**311.00**
5.5	**A 13.2.5.**	**Procurement – deworming tablet for school going and non school going, IFA tablets,**				**158.64**
5.6	**A12.3.4**	**IEC**				**27.60**
5.3	**A 8.4**	**Innovations/ PPP**				**190.54**
		Training				
	A11.7	**ARSH**				**187.13**
	A 11.7	**Saloni Teacher's Training**				**50.99**
5.7	**A 11.7**	**Training for ASHAs, ANMs and AWWs for non-school going adolescents**	1	2500000	1	**25.00**
						950.91

6. URBAN RCH

Urban RCH

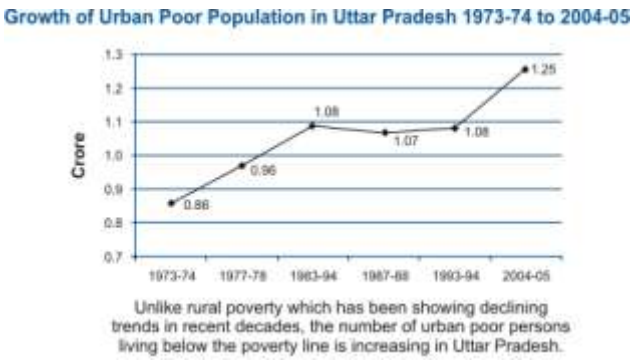
The current PIP has taken into account the guidelines as per the RCH II norms. If National Urban Health Mission is launched by GoI in the due course of time, the planning and budget will be modified as per the NUHM guidelines.

Urban Health Scenario in UP

The Urban Population in Uttar Pradesh has been increasing rapidly in recent decades along with rapid urbanization .As per 2001 census 3.45 crore persons were residing in towns and cities of Uttar Pradesh .It is estimated that 1.17 crore person comprises 30.6 percent of Urban Population of the State lives below the poverty line. The urban population in Uttar Pradesh grew by 33 per cent during the decade 1991-2001 compared with 26 per cent for the overall population growth rate.

The health status of people in Uttar Pradesh is amongst the lowest in the country, especially for the urban poor. The health indicators among urban poor are significantly lower than in rural areas of the state. Urban areas reported a high rate of home deliveries and low rates of immunization of children .A significant percentage of the population in the cities of UP live in slum areas, thus even more prone to sickness and disease. Many of them are migrants from the rural areas or from neighbouring states, living below poverty line, and unable to afford the high cost of private medical care

Place of Residence	Number of Poor Persons (in crores)	% of Pop below poverty line
Urban	1.17	30.6
Rural	4.73	33.4
Total	5.90	32.8



State Details		**2009 – 10**
Total population of State		19.2 Crore
% of Urban Population		30%
Urban Slum population (taking Urban Population as Demoninator)		4.41 crores (projected for 2011)*
Total no of Cities / Iurban Areas with population between 1- 10 lacs (Pl add		51**
Out of these cities no. of cities / urban areas covered under Urban RCH		13 large cities of UP and all disctrict HQ except for Mathura and Chanduali
Total urban slum population of covered cities		11,34,677**
Total no. of Urban health centers in covered cities	Functional	All
	Non - Functional	

***As per NFHS-3 (2005-06) Reanalysis on SLI by UHRC, New Delhi**
**** As per NUHM draft Document.**

Situational analysis:

Primary health care services are provided by 122 Urban Health Post (UHP) state funded established in different Districts .Though, initially planned for a population of 50,000, due to migration there has been a substantial increase in slum and poor population. Increasing population pressure along with shortage of staff has rendered large areas of the city as either underserved or unserved areas and slums. Keeping in view in 2007, 122 New Urban Health Posts were established now those are funded by NRHM. In 2009-10 according to need 8 new urban health posts were established in Lucknow, Unnao, Sitapur, Azamgarh ,Etah and Chanduali and 2 Urban health posts were discontinued in District Kanpur Dehat and Shrawasti depending upon urban slum population

Slum Population and Decadal Growth Rate in major Cities of UP

City	Total Population (2001)	Slum Population (2001)	% Slum Population (2001)	Decadal growth rate	Comments
Kanpur	2,532,138	367,980	14.53	34.73	Taken in the 1st phase of NUHM
Lucknow	2,207,340	179,176	8.12	36.33	
Agra	1,259,979	121,761	9.66	41.29	
Varanasi	1,100,748	137,977	12.53	18.06	
Meerut	1,074,229	471,581	43.9	42.51	
Aligarh	667,732	304,126	45.55	38.96	
Ghaziabad	968,521	258,255	26.66	113.26	
Saharanpur	452,925	161,971	35.76	20.80	
Jhansi	383,248	158,482	41.35	22.25	
Bareilly	699,839	156,001	22.29	18.48	
Allahabad	990,298	126,646	12.79	22.79	

As per the NUHM draft document

Health indicators of Urban Poor in Uttar Pradesh

Key Indicators	Urban Poor	Rural	State Total
Marriage and Fertility			
Women age 20-24 married by age 18 (%)	60	61.2	53.1
Total fertility rate (children per woman)	4.25	4.13	3.82
Birth Interval (median number of months between current and previous birth)	29	29	29
Maternal Health			
Maternity care			
Mothers who had at least 3 antenatal care visits (%)	20.7	22.5	26.6

Mothers who received tetanus toxoid vaccines (minimum of 2) (%)	61.6	61.1	64.5
Mothers who received complete ANC (%)	1.8	2.4	4.1
Births in health facilities (%)	16.7	15.8	20.6
Births assisted by doctor/nurse/LHV/ANM &other health personnel (%)	23.6	21.5	27.2
Anaemia among women			
Women age 15-49 with anaemia (%)	55.3	50.3	49.9
Family Planning (Currently Married Women, age 15–49)			
Any modern method (%)	24.4	25.3	29.3
Permanent sterilization method rate (%)	13.3	16.9	17.5
Child Health & Survival			
Child immunization and vitamin A supplementation			
Children completely immunized (%)	15.3	20.8	23
Children left out from UIP (Children not receiving DPT 1) (%)	58.2	45.7	44.3
Children dropping out from UIP (DPT 1 to DPT 3) (%)	23.5	26.4	25.7
Child feeding practices			
Children under 3 year's breastfed within one hour of birth (%)	4.6	7	7.3
Children age 0-5 months exclusively breastfed (%)	34	55.8	51.5
Children age 6-9 months receiving solid or semi-solid food and breast milk (%)	42.9	44.9	46.1

Source: NFHS-3 (2005-06)

This reflects:

a) Poor availability and utilization of health services
b) Delay in recognition of early warning signs and prompt treatment of childhood ailments (owing to lack of awareness) and
c) Continued deprivation of resources to secure normal growth as well as catch up growth in cases of low birth weight, which is common occurrence among the urban poor.

Among the urban poor households in Uttar Pradesh only one sixth have access to pipe water supply while only one third have access to a private sanitary facility. The pressure on the limited resources escalates with the increasing number of urban poor.

Environmental Conditions	**Urban Poor**	**Rural**	**State Total**
Households with access to piped water supply at home (%)	11.5	1.2	9
	84.6	90.7	84.4

Household using a sanitary facility for the disposal of excreta (flush / pit toilet) (%)	53.5	16	33.1
Infectious Diseases			
Prevalence of medically treated TB (per 100,000 persons)	532	468	425
Women (age 15-49) who have heard of AIDS (%)	41.9	35.8	45.2
Access to Health Service			
Children under age six living in enumeration areas covered by an AWC (%)	24.9	88.2	76.2
Women who had at least one contact with a health worker in the last three months (%)	13.6	18.5	15.9

Source: NFHS-3 (2005-06)

Goals and Objectives- To improve the health status of the urban poor community by provision of quality Primary Health Care services and decentralized health facilities by ensuring one urban health post (UHP) per 50,000 populations in the city (including existing infrastructure and manpower)

Challenges- Increasing urbanization tends to put pressure on the health services delivered in the catchments area resulting a gap in the delivery of RCH services as it largely depends upon the community linkages and adoption of community based strategy. Ineffective Referral System from the community level to the second tier is another challenges leading towards the dilution of the trust of community and also the loss of manpower which accompanies the patients. To address these challenges, the Urban RCH component has been included under NRHM for the State. Human resources for operationalisation of health facilities formed a major component of the plan and were included in the PIP for 2009-10. However, due to delays in recruitment, these activities could not be initiated, resulting in low utilisation of budgets.

Solutions and Prioritized strategies – While there has been a delay in recruitment in the year 2009-10, now 92 UHPs out of 128 are functional and will continue implementation of activities throughout the year. Some of the key strategies that can be prioritized to increase the access of quality health services and address challenges faced by urban population groups:

- Sustaining the State Urban Cell under Directorate of Family Welfare, Go UP at the state level.
- Sustaining existing 128 Urban Health Posts in 67 Districts being funded by NRHM. 5 new Urban Health Posts are planned to establish in Kanpur according to Urban Population and two Urban Health Posts has been discontinued by the recomondation of CMO on the basis of Urban Population. These districts are Chanduali and Mathura.
- Capacity Building of the existing urban health human resources to delivery quality of services.
- Awareness campaign and programs to sensitize the people living in slums and generate need to utilize the health care services.

- Maximum utilisation of existing facilities by strengthening, reorganizing and redeployment.
- Organize monthly health and family planning outreach camps to strengthen forums of convergence in each city.
- Referral Protocols
- Partnership with Private Hospitals, Faith Based Organization and NGOs for improving the health status of urban poor (as a pilot in Lucknow).

Thus it is proposed to support a total of 131 health posts in State by NRHM. These health posts are distributed as follows:

- 14 health posts in Lucknow City under Lucknow Urban RCH Program
- 13 large cities (excluding Lucknow as there is a separate program being implemented in the city) of the State consists of 55 health posts
- 55 health posts located in 53 Districts (except District Chanduali and Mathura.

Type of Services - Out patient services and referral service

Target Population – Poor & Under Served Population

- Inaccessible and Migrating Populations
- People with limited economic means & with less access to resources
- People live in temporary shelters
- People working in construction sites
- BPL people

Key challenges, Solutions and Prioritized strategies identified are:

Increasing Urbanization tends to put pressure on the health services delivered in the catchments area. The result of which there is a gap in the delivery of RCH services as it largely depends upon the community linkages and adoption of community based strategy. Ineffective Referral System from the community level to the second tier is another challenge. This leads to dilution of the trust of community and also the loss of manpower which accompanies the patients.

Some of the key strategies that can be prioritized to increase the access of quality health services and address challenges faced by urban population groups:

- Sustaining the State Urban Cell under Directorate of Family Welfare, GoUP at the state level.
- Sustaining existing 131 Urban Health Posts being funded by NRHM
- Capacity Building of the existing urban health human resources to delivery quality services.
- Awareness campaign and programs to sensitize the people living in slums and generate need to utilize the health services..
- Maximum Utilisation of Existing Facilities by Strengthening, Reorganizing and Redeployment.
- Organize monthly health and family planning outreach camps to strengthen forums of convergence in each city.
- Referral Protocols

- Partnership with Private Hospitals, Faith Based Organization and NGOs for improving the health status of urban poor (as a pilot in Lucknow)

Key activities proposed to strengthen the Urban RCH program in 2010 – 2011.

1. **Strengthening of the State Urban Cell under Directorate of Family Welfare**
   During the course of implementation of the Urban RCH components it has been observed that there is a need to build a MIS system so as to properly monitor the urban health activities at the directorate level.
   This enhanced capacity will help in smooth implementation of urban health activities in the state.

Budget for Strengthening of Urban Cell at Directorate of Family Welfare, Lucknow ------ (FMR Code A 14.4)

a) Hiring of Contractual Staff

	Particular	No.	Honorarium	No. of Month	Total Amount in Lacs
1	Data Assistant	1	Rs. 17000	12	2.04
2	Computer Operator	1	Rs. 17000	12	2.04
3	Program Assistant	1	Rs. 17000	12	2.04
4	Office Attendant	1	Rs. 6500	12	0.78
Subtotal Total					**6.90**

b) Operational expenses

	Particulars	Total Amount in Lacs
1	Telephone & Internet Bill @ Rs. 3000/- pm	0.36
2	Computer Peripherals (Cartridge etc.) @Rs. 5000/- pm	0.6
3	Stationary @ Rs. 5000/- pm	0.6
4	Contingency Miscellaneous @Rs. 5000/- pm	0.6
Subtotal		**2.16**
Total Annual Requirement (a+b)		**9.06**

Rs 9.06 lakhs have been budgeted for Strengthening of Urban Cell at Directorate of Family Welfare, Lucknow in Programme Management.

2. Lucknow Urban RCH Programme (FMR A 5.1)

Existing MCH Care infrastructure in Lucknow city was established for the population of only 8 lacs which has more than doubled since then. In continuation of Urban RCH Project, re-organization of the urban health units and redeployment of manpower is being proposed.

Some of the specific strategies suggested in the Lucknow Urban project are:

1. Strengthening of Urban RCH Office/meeting hall
2. Strengthening SIP Approved & Established UHPs(14 Urban Health Posts)
3. Additional support to Bal Mahila Chikatsalaya (8)
4. MCH services in outreached slum area by NGO: Growth in urban population is found to be very high and it is found to be difficult to increase public health facilities in such a speed. On the other hand this City is having numerous presence of private sector/NGO who are either providing or can provide primary, secondary and tertiary level health services for urban slum population. Some of the NGOs are also having a good presence and rapport within the communities.
    - Partnership for community mobilization
    - Partnership for referrals (for critical illness/delivery etc)
    - Partnership for FP camps/RCH camps

Budget proposed for Urban RCH Lucknow (FMR A 5.1)

C	Honorarium @ Per Month	No.	No. of Months	Total Amount (in Lacs)
1	2	3	4	5
A 1.Urban RCH Office Staff				
Sr. Computer Operator-cum-Asst.	12000	1	12	1.44
Office Assistant	8000	1	12	0.96
Office Boy	4500	1	12	0.54
Caretaker-cum-Storekeeper	7000	1	12	0.84
Security Guard	4000	3	12	1.44
Sweeper (Full-time)	3500	1	12	0.42
Peon	4500	1	12	0.54
Sub total				**6.18**
A 2.Miscellaneous Heads at Urban RCH Distt. H. Q.				
Telephone	3000	3	12	1.08
POL/Conveyance Allowance for Office Staff	5000	1	12	0.6
AMC of Fax/EPABX	5000	1	12	0.6
AMC of Comp. Peri./Aqua Guard/Water Cooler etc.	5000	1	12	0.6
Contingency & Miscellaneous	5000	1	12	0.6
Streng. & Ref of URCH Office hall	100000	1	1	1
Wall Painting (in Local Catchment Area)	100000	1	1	1
Hoarding	10000	22	1	2.2
Pamphlets, Brochures, Handbills etc.	10000	22	1	2.2
Referral Cards, OPD Slips	8000	22	1	1.76
Stall in Annual Exhibitions & Major Festivals	200000	1	1	2
RCH Camps & Film Shows in Slums	100000	1	1	1

C	Honorarium @ Per Month	No.	No. of Months	Total Amount (in Lacs)
Sub total				**14.64**
A 3.Staff at BMC & PGs				
Gynaecologist	25000	16	12	48
Paediatrician	25000	12	12	36
Anaesthetist (on call-apprx. 25 calls per BMCX8 BMC)	1000	200	12	24
Staff Nurse	15000	21	12	37.8
Ward Aya	4500	17	12	9.18
Ward Boy	4500	11	12	5.94
Security Guard	4000	16	12	7.68
Sweepers (Full-time)	3500	16	12	6.72
Computer Operator-cum-Data Assistant	8000	8	12	7.68
Ambulances (for BMC&PGs & on call avail. to UHPs)	25000	8	12	24
Telephone	1000	8	12	0.96
Sub total				**207.96**
A 4.Streng. of SIP Approved & Established UHPs				
Rent	7000	7	12	5.88
Lady Medical Officer (MBBS)	24000	14	12	40.32
Staff Nurse	15000	14	12	25.2
ANM	9000	28	12	30.24
Security Guards	4000	28	12	13.44
Ayaha	4000	14	12	6.72
Sweeper(Full-time)	3500	14	12	5.88
Peon-cum-Dak Runner	4000	14	12	6.72
Bi-cycle for Peon-cum-Dak Runner	3500	14	1	0.49
Telephone Bills	1000	14	12	1.68
For strengthening of newly established UHP	100000	12	1	12
IEC	10000	14	1	1.4
Sub total				**149.97**
A 5.MCH services in slum areas	5400000			**54**
Sub total				**54**
Grand Total				**432.75**

The total cost Rs 432.75 lacs for programme expenses and Rs 43.92 for drugs and consumables

2. Urban RCH Interventions in 13 Large Districts. (62 Urban Health Posts) (FMR Code A 5.1)

It is proposed to sustain various activities in the 13 large districts that will be providing following package of services at the facility. These include:

- Complete MCH services
- Family Planning and meeting contraception needs
- Immunization, Vitamin A supplement
- Medical care of all illnesses coming to the OPD
- Management of RTIs and STIs
- Counselling on delivery and neonatal practices – safe delivery practices, antenatal care, post natal care (including breastfeeding), prevention and management of child illnesses - Respiratory infections, Diarrhea– hand washing, soap availability, use of ORS, management and prevention of malnutrition
- Coordination point for other national programs – TB, Leprosy & Blindness

It is proposed that the UHPs will be providing health care services from its fixed location and will also plan and execute regular outreach services (for immunization/ANC/PNC/FP) to cover 100% slum population

Implementation of Urban RCH Plan/Activities in NUHPs of 13 Districts funded by NRHM

S.No	Name of District	Total No.of NUHP	Building		Manpower												Other Expenses)				IEC @10000/year/ center+Establishment of New UHPs	Total/ month
			Rent @Rs 7000/month/center)		Doctor @24000/-pm/center		Staff Nurse @ Rs15000/-pm/ center		ANM @Rs 9000/- per ANM/pm/center		Security Guards@Rs 4000/-Per Guard/pm/center		Ayah(Rs4000/-pm)/center		Sweeper(Rs 2000/pm) /center		Tel bill (1000/month/center	Electricity(Rs 1000/month/center)	Refilling of LPG gas(400/month/center)	Misc. Rs. 1000/month /Center		
			No.	Amt (Lakhs)	No.	amt	No.	amt	No.	amt	No.	amt	No.	amt	No.	amt						
1	AGRA	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
2	ALIGARH	5	5	4.2	5	14.40	5	9.00	10	10.80	10	4.80	5	2.40	5	1.20	0.60	0.60	0.24	0.60	0.50	49.34
3	ALLAHABAD	2	2	1.68	2	5.76	2	3.60	4	4.32	4	1.92	2	0.96	2	0.48	0.24	0.24	0.10	0.24	0.20	19.74
4	BAREILLY	3	3	2.52	3	8.64	3	5.40	6	6.48	6	2.88	3	1.44	3	0.72	0.36	0.36	0.14	0.36	0.30	29.60
5	GHAZIABAD	5	5	4.2	5	14.40	5	9.00	10	10.80	10	4.80	5	2.40	5	1.20	0.60	0.60	0.24	0.60	0.50	49.34
6	JHANSI	3	3	2.52	3	8.64	3	5.40	6	6.48	6	2.88	3	1.44	3	0.72	0.36	0.36	0.14	0.36	0.30	29.60
7	KANPUR	10	10	8.4	10	28.80	10	18.00	20	21.60	20	9.60	10	4.80	10	2.40	1.20	1.20	0.48	1.20	1.00	98.68
8	MEERUT	6	6	5.04	6	17.28	6	10.80	12	12.96	12	5.76	6	2.88	6	1.44	0.72	0.72	0.29	0.72	0.60	59.21
9	SAHARANPUR	5	5	4.2	5	14.40	5	9.00	10	10.80	10	4.80	5	2.40	5	1.20	0.60	0.60	0.24	0.60	0.50	49.34
10	VARANASI	6	6	5.04	6	17.28	6	10.80	12	12.96	12	5.76	6	2.88	6	1.44	0.72	0.72	0.29	0.72	0.60	59.21
11	MORADABAD	5	5	4.2	5	14.40	5	9.00	10	10.80	10	4.80	5	2.40	5	1.20	0.60	0.60	0.24	0.60	0.50	49.34
12	FIAZABAD	5	5	4.2	5	14.40	5	9.00	10	10.80	10	4.80	5	2.40	5	1.20	0.60	0.60	0.24	0.60	0.50	49.34
13	GORAKHPUR	6	6	5.04	6	17.28	6	10.80	12	12.96	12	5.76	6	2.88	6	1.44	0.72	0.72	0.29	0.72	0.60	59.21
	Total	**62**	**62**	**52.08**	**62**	**178.56**	**62**	**111.60**	**114**	**133.92**	**114**	**59.52**	**62**	**29.76**	**62**	**14.88**	**7.44**	**7.44**	**2.93**	**7.44**	**6.20**	**611.82**

A Budget Rs. 611.82 Lakhs has proposed and approved for programme expenses (FMR Code A.5.1)and Rs 96.72Lacs for drugs and consumables MR Code B 19.1)for the purpose.

3. Urban RCH Interventions in 53 Districts. (55 Urban Health Posts) (FMR Code A5.1)

Keeping in mind the urbanization and migration it is proposed to continue support the existing UHPs in the state and has been envisioned to provide the following package of services at the facility. In Kanpur Dehat, Shravasti UHPs have not been proposed as the urban population is less than 1 lacs. In Chanduli & Mathura the UHPs has been discontinued as CMO has proposed not to continue the posts.

These include:

- Complete MCH services
- Family Planning and meeting contraception needs
- Immunization, Vitamin A supplement
- Medical care of all illnesses coming to the OPD
- Management of RTIs and STIs
- Counselling on delivery and neonatal practices – safe delivery practices, antenatal care, post natal care (including breastfeeding), prevention and management of child illnesses - Respiratory infections, Diarrhea– hand washing, soap availability, use of ORS, management and prevention of malnutrition
- Co**.**ordination point for other national programs – TB, Leprosy & Blindness

A Budget Rs. 547.79 Lakhs is proposed for programme expenses and Rs 88.92 Lacs for drugs and consumables in this regard.

DISTRICT WISE Urban RCH Interventions in NUHPs of 53 Districts funded by NRHM

S.No	Name of District	Total No.of UHP	Building		Manpower										Other Expenses)				IEC @10000/year/center Amt (Lakhs)	Total Budget (in Rs.) for 2010 -11 Amt (Lakhs)
			Rent @Rs 7000/month/ center)		Doctor @24000/- pm/center		Staff Nurse @ Rs15000/- pm/ center		ANM @Rs 9000/-per ANM/pm/center		Security Guards@Rs 4000/Guard/ month/center		Ayah(Rs4000 /person/mon th/center)		Sweeper(Rs 2000/person month/center)		Telephone (1000/month/center)	Electricity(Rs 1000/month/center)Am	Heating of LPG gas(400/month/center)	Misc. Rs. 2000/ month/UHP Amt		
			No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)						
1	AURAIYA	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
2	AMBEDKARNAGAR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
3	AZAMGARH	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	1.10	10.87
4	BADAUN	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.15	9.92
5	BAGPAT	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
6	BAHRAICH	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
7	BALIA	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
8	BALRAMPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
9	BANDA	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
10	BARABANKI	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.1	0.1	0.0	0.1	0.10	9.87

S.No	Name of District	Total No.of UHP	Building		Manpower												Other Expenses)				IEC @10000/year/center Amt (Lakhs)	Total Budget (in Rs.) for 2010 -11 Amt (Lakhs)
			Rent @Rs 7000/month/ center)		Doctor @24000/- pm/center		Staff Nurse @ Rs15000/- pm/ center		ANM @Rs 9000/-per ANM/pm/center		Security Guards@Rs 4000/Guard/ month/center		Ayah(Rs4000 /person/month/center)		Sweeper(Rs 2000/person month/center)		Refresh (1000/month/center)	Electricity(Rs 1000/month/center)Am	Heating or LPG gas(400/month/center)	Misc.Rs 2000/ month/UHP Amt		
			No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)						
																	2	2	5	2		
11	BASTI	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
12	BHADOHI	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
13	BIJNOR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
14	BULANDSHAHAR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
15	CHITRAKOOT	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
16	DEORIA	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
17	ETAH	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	1.10	10.87
18	ETAWAH	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
19	FATEHPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
20	FIROZABAD	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.1	0.1	0.0	0.1	0.10	9.87

S.No	Name of District	Total No.of UHP	Building		Manpower												Other Expenses)				IEC @10000/year/center Amt (Lakhs)	Total Budget (in Rs.) for 2010 -11 Amt (Lakhs)
			Rent @Rs 7000/month/ center)		Doctor @24000/- pm/center		Staff Nurse @ Rs15000/- pm/ center		ANM @Rs 9000/-per ANM/pm/center		Security Guards@Rs 4000/Guard/ month/center		Ayah(Rs4000 /person/month/center)		Sweeper(Rs 2000/person month/center)		Refuse (1000/month/center)	Electricity(Rs 1000/month/center)Am	Heating or LPG gas(400/month/center)	Misc. Rs. 2000/ month/UHP Amt		
			No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)						
																	2	2	5	2		
21	G.B.NAGAR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
22	GHAZIPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
23	GONDA	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
24	HAMIRPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
25	HARDOI	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
26	HATHRAS	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
27	J.P.NAGAR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
28	JALAUN	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
29	JAUNPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
30	KANNOJ	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.1	0.1	0.0	0.1	0.10	9.87

S.No	Name of District	Total No.of UHP	Building		Manpower												Other Expenses)				IEC @10000/year/center Amt (Lakhs)	Total Budget (in Rs.) for 2010 -11 Amt (Lakhs)
			Rent @Rs 7000/month/ center)		Doctor @24000/- pm/center		Staff Nurse @ Rs15000/- pm/ center		ANM @Rs 9000/-per ANM/pm/center		Security Guards@Rs 4000/Guard/ month/center		Ayah(Rs4000 /person/month/center)		Sweeper(Rs 2000/person month/center)		Refuse (1000/month/center)	Electricity(Rs 1000/month/center)Amt	Heating or LPG gas(400/month/center)	Miscellaneous 2000/ month/UHP Amt		
			No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)						
																	2	2	5	2		
31	KAUSHAMBHI	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
32	KHERI	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
33	KUSHINAGAR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
34	LALITPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
35	MAHARAJGANJ	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
36	MAHOBA	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
37	MAINPURI	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
38	MAU	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
39	MIRZAPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
40	MUZAFFARNAGAR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.1	0.1	0.0	0.1	0.10	9.87

S.No	Name of District	Total No.of UHP	Building		Manpower												Other Expenses)				IEC @10000/year/center Amt (Lakhs)	Total Budget (in Rs.) for 2010 -11 Amt (Lakhs)
			Rent @Rs 7000/month/ center)		Doctor @24000/- pm/center		Staff Nurse @ Rs15000/- pm/ center		ANM @Rs 9000/-per ANM/pm/center		Security Guards@Rs 4000/Guard/ month/center		Ayah(Rs4000 /person/month/center)		Sweeper(Rs 2000/person month/center)		Ref on (1000/month/center)	Electricity(Rs 1000/month/center)Am	Heating or LPG gas(400/month/center)	Misc. Rs. 2000/ month/UHP Amt		
			No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)						
																	2	2	5	2		
41	PILIBHIT	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
42	PRATAP GARH	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
43	RAIBAREILLY	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
	RAMPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
45	S.KABIR NGR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
46	SIDHARTHNAGAR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
47	SITAPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
48	SONBHADRA	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
49	SULTANPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
50	UNNAO(incl.Shukla	3	3	2.52	3	8.64	3	5.40	6	6.48	6	2.88	3	1.44	3	0.72	0.3	0.3	0.1	0.3	2.30	31.60

S.No	Name of District	Total No.of UHP	Building		Manpower												Other Expenses)				IEC @10000/year/center Amt (Lakhs)	Total Budget (in Rs.) for 2010 -11 Amt (Lakhs)
			Rent @Rs 7000/month/ center)		Doctor @24000/- pm/center		Staff Nurse @ Rs15000/- pm/ center		ANM @Rs 9000/-per ANM/pm/center		Security Guards@Rs 4000/Guard/ month/center		Ayah(Rs4000 /person/month/center)		Sweeper(Rs 2000/person month/center)		Tea Urn (1000/month/center)	Electricity(Rs 1000/month/center)Am	Heating of LPG gas(400/month/center)	Misc.Rs. 2000/- month/UHP Amt		
			No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)	No.	Amt (Lakhs)						
	Ganj)																6	6	4	6		
51	KASHIRAMNAGAR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	1.10	10.87
52	SHAHJAHANPUR	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
53	FARRUKHABAD	1	1	0.84	1	2.88	1	1.80	2	2.16	2	0.96	1	0.48	1	0.24	0.12	0.12	0.05	0.12	0.10	9.87
	TOTAL Rs.	**55**	**55**	**46.20**	**55**	**158.40**	**55**	**99.00**	**110**	**118.80**	**110**	**52.80**	**55**	**26.40**	**55**	**13.20**	**6.60**	**6.60**	**2.64**	**6.60**	**10.55**	**547.79**

S5. Preparatory activities for National Rural Health Mission:

- **Baseline Survey of Health Facilities & Slums (both listed and unlisted) in 14 NUHM cities.**

As a preparatory activity, this initiative has been proposed to continue this year, accordingly, a total sum of Rs.70.00 Lacs is being budgeted @ Rs. 5 lacs per district. **FMR Code A 5.2**

- **Health facility assessment and preparation of assessment reports for the 14 large cities of the State**

It is proposed to continue the health facility(funded by State and NRHM) assessment that has been initiated in the financial year 2009 – 10. The existing technical agencies working on urban health will be supporting the NRHM and directorate to accomplish this activity. This document will be served as a city and state level planning tool.

BUDGET FOR HEALTH FACILITY ASSESSMENT OF 14 CITIES UNDER NUHM

SN	Particulars	Nos.	Amount (Rs.)
1	Honourarium to Field Investigators @Rs. 1500 /day/person, Travel of Field investigators, Development of Questionnaries, Data entry, Final Report @ Rs. 50000/ city	14	7.00
2	Contengency for 14 cities		3.00
	TOTAL BUDGET (Rs.)		**10.00**

A budget Rs. 10 Lakhs is being made for the said activity . FMR Code A 5.2

- **Sensitization Workshop and follow up meetings at State and City / district level for organizational set up at State and City / district level. (FMR Code A 5.2)**

There are very less evidences available on strategies and interventions in urban slum areas. It is found essential in previous years that the city level officials and other stakeholders require orientation and sensitization on urban health issues. In order to sensitize various stakeholders at State and city / district level on NUHM, it is proposed to conduct a series of workshops and follow up meetings with the officials at both State and city / district level. The agencies working on urban health within the state and having technical expertise on the subject would be supporting this activity at city and state level.

BUDGET FOR SENSITIZATION WORKSHOP FOR STATE AND CITY/ DISTRICT LEVEL OFFICIALS

SN	Description	No.	Unit Amount	Amount
1	State Level W/s	2	0.25	0.50
3	City/ District level workshops 2 in each city	14	0.10	1.40
Total (Rs.)				**1.90**

Accordingly budget provision of Rs. 1.90 Lacs is being made in the regards for FY 2010 - 2011

IEC / BCC

- Migratory trends need to be considered while planning RCH services. Specific communication strategies should be designed for such populations and health providers should be mandated to provide services to temporary and new residents in addition to population in their service records.
- Demand generation activities in the form of display of posters, billboards and other audio and video materials, street play, cable transmission in the various facilities be planned and budgeted under IEC/BCC head.
- Urban areas report a high rate of home deliveries and low rates of immunization of children. A significant percentage of the population in the cities of UP live in slum areas, thus even more prone to sickness and disease. There is an urgent need to connect the services with the demand and publicize the RCH services available at the Urban Health Posts.
- Local district specific activities are being proposed to direct the demand to the services. Signages / hoardings at the UHP will be displayed prominently. Local cable channels with strip ads with locations of UHPs, schedule of services will be undertaken. Additionally, demand will be generated by street plays and IPC by the home visits being proposed through the RI Link workers.

Activities proposed under Urban RCH & RI related campaigns		
IPC : HHs and community level	**Mid Media / Local media**	**Mass Media**
Household Level • Identification of clients for spacing/limiting; RI through household visit by RI link worker **Facility Level** • Counseling of pregnant women on PPFP/ RI during ANC, delivery and PNC visits by ANM, FWCs, MO/IC	• Wall Paintings / Hoardings at Urban Health Posts on benefits of small family/ right age at marriage/ NSV/ IUCD • Signages and on-site communication • Handbills for community • Folk performances on FP / IUCD/ PCPNDT / Male participation by trained troupes • Street plays for NSV • Street plays for PCPNDT (district level) • Competitions at Inter/ Degree colleges for PCPNDT	• TV and Radio. Spots / programs and Print Media (Press ads and articles) are planned to highlight benefits of birth spacing and encouraging men participation in family planning • Radio series for general public addressing various issues among complete subset of family planning. • NSV local press and radio ads • Local cable channels

Budget is proposed Rs 10000/year for Health post visibility and an additional Budget has been proposed in IEC/BCC head.

MCH services in outreached slum area by NGO in District Lucknow (Annexure)

Project Goal: To provide quality family planning and reproductive health services in one block urban Lucknow of district Lucknow.

Project Objectives: The objectives of the study are as follows-

- To increase complete ANC coverage
- Promote institutional deliveries
- To increase complete immunization
- To increase contraceptive use in the project area.

(c) Demographic profile of the identified area:

S. No.	Name of Ward	Name of slum	Population
1	Faizullaganj	Ward I & Ward II	60000
2.	Jankipuram		24828
		Khalilabad	378
		Rampur	361
		Madiyav	2728
		Gudiyan purwa	268
		Gaddiyan purwa	421
		Sikandarpur	1183
		Sitapurroad (engineering college to Tedipulia)	15300
		Pahadpur	1234
		Chawdhrainpurwa	318
		Sultanpur	219
Grand Total			**107238**

(d) Major components

This project will incorporate a number of new strategies designed to:

- Increase access to clinical methods and respond to the quality RCH services to the community by organizing monthly health camps in the villages at fixed sites.
- Further utilize the available private and public infrastructure i.e. communication channels, outreach sites, extension programme, women's leadership, to build a sustainable village-based family welfare programme.
- To increase use of reproductive health & Family Planning services by improving demand for RCH products & access to quality reproductive health services including incresses of awareness level on RCH among adolescents.

(e) Services:

- Immunization with help of ANM/Nurse
- Distribution of ORS packets and IFA Tablets
- Comprehensive health and Counselling (CHACS)
    - Counselling services
    - Counselling for pregnant mothers
    - PNC mothers
    - Counseling for FP client
- Adolescent Care
- Non-Clinical Services through Link Person
- Follow-up care
- Project outreached services
- IEC
    - Inter Personnel Counseling (IPC)
    - Group Meetings

- Wall writings with geru
- Folk media:

(f) <u>Expected outcome:</u>

- To increase 5 percent CPR of all ECs in the block.
- ANC Services**:** ANC services will be given to all pregnant women. At least 80 percent women would likely to receive two doses of TT and 66 percent women will get 100 IFA tablets in the project area.
- All pregnant women would counsel and promote for institutional deliveries.
- Child Immunization**:** Complete immunization will be given to 60 percent children in the age group of (0-1 year) in the project area.

S.No	FMR S.No	Activities	Total (in Rs. Lacs)
6		**URBAN RCH**	
6.1	**A.5.1**	**Lucknow Urban RCH (14 Urban Health Posts and 8 BMCs)**	432.85
	A.5.1	**Activities in NUHPs in 13 big districts (62 Urban Health Posts)**	611.82
	A.5.1	**Activities in NUHPs in 53 districts (55 Urban Health Posts)**	547.79
	A.5.2	**Baseline survey for 14 cities under NUHM**	70.00
	A.5.2	**Health facility assessment for 14 cities under NUHM**	10.00
6.2	**A5.2**	**Sensitisation workshop at State and City/ district level**	1.90
		URBAN RCH SUB TOTAL	**1674.36**

7. TRAINING

Training is an important component of capacity building of the personnel in the State to provide quality services. Training of providers and community level volunteers also becomes essential to ensure that consistent messages reach communities and the community volunteers are available to follow up the health needs of the community. The Training Policy of the State is to enhance the knowledge and skills of each and every category of health personnel as per latest technology to enable them to provide quality and efficient health services as well manage health programmes.

The State Institute of Health and Family Welfare (SIHFW) is the Collaborating Training Institute for the State and conducts clinical as well as management related trainings. State Innovations in Family Planning Services Agency (SIFPSA) conducts family planning related trainings in the State. Both agencies and concerned departments also collaborate with Medical Universities and Medical Colleges as training sites for conducting clinical trainings.

There are 87 training facilities in the State, of which SIHFW is the apex institute at the State level, 11 are Regional Health and Family Welfare Training Centres (RHFWTCs), 40 are ANM Training Centres (ANMTCs), 30 are DPTT (*Achal Prashikshan Kendra),* four are LHV training centres (health schools) and one PHN training centre. Each of these facilities is located in State owned buildings. These include class rooms, hostels, furniture, audio visual equipment. In DPTT audio-visual equipments are not available.

For capacity building of staff, "Development of Trainer's Skills" training was conducted for all existing staff of operational training centres. This training built capacities of these staff on comprehensive and systematic approach to training. 385 trainers of RHFWTCs, ANMTCs, DPTTs and LHVTCs were trained over the last three years.

While conducting trainings, the State ensures quality by:

- Developing detailed modules, in consultation with Technical Support Groups and in line with national modules, which are then made available to trainers;
- Selection of subject specific experts as trainers and specific terms of reference discussed with them;
- Pre and post training checklists developed, administered and analysed;
- Feedback from trainees on course content, relevance of subjects, training methodology and training facilities collected in formats and analysed for feedback to trainers and training organisers; and
- Mentoring of trainers at district level training facilities to ensure quality of training

Training in 2009-10

Most training planned in 2009-10 have been initiated. However their initiation was delayed (thus affecting utilisation of budgets) because of a) the delay in appointment of Director – SIHFW leading to administrative delays in sanction of budgets; and b) unavailability of IUCD kits and Zoe models. Details of total numbers trained are attached in the Training Plan. Since, these issues have been addressed, trainings are now being conducted and will continue in 2010-11.

Implementation Plan for 2010-11

For the year 2010-11, State Institute of Health & Family Welfare has been identified and designated as a nodal body to coordinate with Directorates and other training institutions and agencies for design and implementation of trainings all over the state. In addition, there exists State Innovations in Family Planning Services Agency (SIFPSA) which has been providing trainings in the State on especially family planning related issues. The State has also collaborated with institutions such as National Institute of Health and Family Welfare (NIHFW) for conducting specific trainings and will explore possibilities with Public Health Foundation of India (PHFI). Specifically for Child Health related trainings, linkages have been established with Medical Colleges and their functionaries.

This section includes details of the trainings planned for the year as well as a comprehensive training plan.

Specific actions that will be taken for strengthening training capacities in 2010-11 are:

- Collaboration with NIHFW for inclusion of latest trainings in training calendar.
- Identifying national level expert faculty and including them as trainers in suggested programmes, at their rates.
- Boarding and lodging of participants will be outsourced to private partners at regional level to enhance capacities of RHFWTCs. This will facilitate the training of MPW.
- Flexible funds for facilities for need based infrastructure strengthening.
- There are three posts of medical cadre (1 Principal, 1 Medical Lecturer cum Demonstrator (MLCD) and 1 Epidemiologist) at each of the RHFWTCs. Vacant posts at these RHFWTCs will be filled to make the functioning smooth.
- At DPTTs, staff transferred to other locations from training sites will be reassigned to their training jobs.
- Retired personnel to be taken on contract for augmenting the manpower shortage at DPTTs, ANMTCs and RHFWTCs

The training programmes planned for the year 2010-11 by the training agencies are included in the sections below. Besides the above, State Health Resource Centre will also be established in the year 2010-11.

7.1 State Institute of Health and Family Welfare (SIHFW)

7.1.1 Maternal Health Trainings

a) Skilled Birth Attendants' (SBA) Training Programmes: Training of Trainers (TOT)

Two day SBA TOT has been held for 423 trainers at SIHFW, U.P., but due to the transfer/ retirement of trainers or some other causes, this number has come down. Hence, there is a need to train new trainers. In the year 2010-11, SBA TOTs will be conducted for 90 trainers.

Skilled Birth Attendants' (SBA) Training Programmes: Training of ANMs/LHVs /SNs

Similarly under the National Rural Health Mission (NRHM), a basic objective is to provide safe and qualitative delivery services at First Referral Units to minimize the MMR. For this, the ANMs/ LHVs/ SNs (on contract & regular) are to be provided quality training in Maternal and New Born Care. The Government of India has designed a 21 days Skilled Birth Attendants' Training Programme at District Women Hospitals (DWH). For this training, Hindi Translation of the module, "Guidelines for Ante Natal Care and Skilled Attendance at Birth by ANMs and LHVs" is being used to train LHVs/ANMs and Staff Nurses. In the first phase of training in 2008-2009, 37 Districts (training sites) with about 150 deliveries per month were chosen, where a batch of 4 ANMs/ LHVs/ SNs was given residential training for Maternal and New Born Care on the guidelines given by the Government of India. In this phase, about 1000 ANMs/ LHVs/ SNs received Skilled Birth Attendants' Training.

In Phase –2 in 2009-10 district sites have been extended and FRUs have also been selected. So this year the training is to be extended to 82 sites. Budget has been sent to the districts and training has started. By the end of March 2010, 656 more ANMs/ LHVs/ SNs are expected to be trained. But as the training has started late in 2009-10, the remainder of its numbers will be carried over to the year 2010-11.

There is provision of 18 new sites where the number of deliveries are more than 60 per month in the year 2010-11. The Government of India has approved a grant of Rs. 40,000 per training site. Thus, besides strengthening amount of Rs. 15,000 per site, a sum of Rs. 40,000 for all 100 sites is proposed for the year 2010-11. This will include furnishing of classroom and drugs/ supplies required for training.

Target for Year 2010-11 : 3000 Trainees (LHV/ANM/SNs)

b) Life Saving Anaesthesia Skill Training (LSAS)

Under the National Rural Health Mission (NRHM), a basic objective is to provide safe and qualitative delivery services at First Referral Units (FRUs) to minimize the MMR. For this, LSAS training is being provided in five Medical Colleges of Uttar Pradesh, viz: The Chatrapati Shahu Ji Maharaj Medical University (Lucknow), S.N. Medical College (Agra), LLRM Medical College (Meerut), GSV Medical College (Kanpur) and Maharani Laxmi Bai Medical College (Jhansi). Each Medical College provides 18 weeks LSAS Training (12 weeks Training at Medical College + 6 weeks, Field Attachment Training preferably at DWH) to 4 MBBS Medical Officers of the Provincial Medical Services in each batch.

In the year 2009-10 the number of batches that received training has been less and up to March 2010 only two batches would have received training. To fulfil this gap in the year 2010-11, there is a plan to raise the number of participants from 4 to 6 in each batch.

A total of 33 MOs have been trained and 19 are under training for LSAS training at 5 Centres and 20 more MOs will be provided training in the year 2009-10. Chatrapati Shahu Ji Maharaj Medical University (CSMMU), Lucknow became a Training Institution from the second batch. During 2010-11, these trainings will continue at 6 centres (2 batches at each centre).

Target for Year 2010-11 : 72 participants (in 12 batches)

Training of Trainers

The Trainers of these Medical Officers are the Anaesthetists of the DWH, where they are attached. In this phase, the Medical Officers are usually attached to a training site near their place of posting. A two day Training of Trainers is conducted at the Medical Colleges where the LSAS training is going on. For this purpose the budget is inbuilt in the training budget of the Medical Colleges.

This year the target for TOT is : 20 Trainers

The present 5 Life Saving Anaesthesia Skill Training centres need to be strengthened and a new centre at Allahabad is also to be initiated. **For the strengthening of these centres, a sum of Rs. 18 lacs is budgeted for this activity for the year 2010-11.**

c) Emergency Obstetrics Care (EmOC) Training

Under the National Rural Health Mission (NRHM), a basic objective is to provide safe and qualitative delivery services at First Referral Units to minimize the MMR. For this end the important training being run in the Department of Obstetrics & Gynaecology of two Medical Colleges of Uttar Pradesh- The Chatrapati Shahu Ji Maharaj Medical University (Lucknow), Jawahar Lal Nehru Medical College, Aligarh Muslim University (Aligarh). Each Medical College provides 16 weeks Emergency Obstetrics Care (EmOC) Training - 6 weeks Training at Medical College + 9 weeks' Field Attachment Training at DWH + 1(last) week's Training at Medical College to 8 MBBS Medical Officers of the Provincial Medical Services.

During 2008-2009 a total of 27 Medical Officers received Emergency Obstetrics Care (EmOC) training at two centres. In Batch-3, 12 Medical Officers have completed the training. Due to some administrative problems the training started late in the Budget Year 2009-10.

It has been observed that most of the female candidates for EmOC training prefer nearer sites for EmOC training due to mobility issues, so there is lack of nominations for this training. Central Review Mission which visited Uttar Pradesh recently gave suggestion to increase the number of training sites. To this end, the State Institute of Health & Family Welfare has initiated the process by contacting the Medical Colleges of U.P. for conducting such trainings. In response to this, Medical Colleges at Agra, Allahabad,

Meerut, Kanpur, Jhansi and BHU have given consent for such trainings and it is still under process.

After consultations with the representatives of the GOI, two new training sites at Allahabad and Meerut Medical Colleges are being included in this year's PIP.

Training of Trainers

10 Medical Specialists (7 from the Provincial Medical Services, 2 from CSMMU (Lucknow) and 1 from Aligarh have received Training of Trainers for EmOC training at Vellore and Surat centres organized by FOGSI. This year a total of 8 candidates will receive training as EmOC Trainers at these or other centres chosen by the FOGSI/AVNI. These candidates will be from new sites and the existing medical colleges (sites).

The Trainers from the PMS are the specialists posted at DWHs where the EmOC participants are being attached. As per the guidelines of FOGSI, 8 DWHs are attached to a Medical College. In view of the above, the number of trainers for the year 2010-11 is to be increased to 30 to include trainers from the new proposed sites.

Target for Year 2010-11 : 30 Master Trainers
64 MOs (in 8 batches)

Earlier the Operational expenses for the centres had not been budgeted. **So a sum of Rs. 13 lacs is being proposed for running the centre, monitoring and certification costs in 2010-11.**

d) Short Term Comprehensive Emergency Obstetrics Care (CEmOC) Refresher Training

Training of Trainers
A sensitisation training of CEmoC will be conducted at SIHFW, UP for trainers of EmOC. The trainer of EmOC training will also be a trainer of the Short Term Comprehensive Emergency Obstetrics Care (CEmOC) Refresher Training.

Training of Gynaecologists for CEmOC
In the Provincial Medical Services it has been observed that there are a number of Doctors, who are specialists (MS/MD (Gyn.)/DGO) but do not perform caesarean section either because they are posted in an area where such opportunity is not available or because they lack confidence to do so. Under the National Rural Health Mission, there is a provision of a Short Term Comprehensive Emergency Obstetrics Care (CEmOC) Training for 2-3 weeks for such specialist doctors.

Together with this it is also proposed to refresh the skills of these service providers in post partum abdominal tubectomy. It is observed that although post partum abdominal tubectomy is a simple procedure which can be performed soon after delivery (within 48 hours), service providers are reluctant to offer these services to beneficiaries in absence

of current practice. During the course of this training, there will be an opportunity to refresh their skills on post partum clients who opt for abdominal tubectomy.

This training is to be organized at 10 District Women Hospitals which have caesarean operation load of more than 60. This 14 days training will be held in the first week of March 2010. At each site there will be a batch of 2 MOs, who would be attached to a near by DWH to perform caesarean operation.

Target in Year 2009-2010 : 30 Gynaecologists

Target for Year 2010-11 : 40 Gynaecologists

e) MTP Training

In the year 08-09, training was planned on MTP using MVA technique. 10 DWHs based on their MTP case load have been identified as training sites. After training, CMOs of the district will be responsible for approval of new sites and service providers under MTP Act. Upto December 15, 2009 a total of 20 LMOs have been trained. Due to social barrier it is not possible to train MOs (Male).

In the year 2010-11, to strengthen DWHs and FRUs, it is proposed to conduct a 5 day refresher training (using MVA technique) for 120 LMOs in batches of 3 each at DWH. Two additional batches for TOT (15 participants in each batch) on MTP using MVA will be conducted in SIHFW.

f) RTI/STI Training of Medical Officers and Lab Technicians

62 Medical Officers and 62 Lab Technicians from selected First Referral Units (FRUs) will be provided 3 days training on RTI/STI. The training will be held at SIHFW in 5 batches.

g) Training for Family Welfare Counsellors (FWCs)

In the year 2009-10, it was proposed to organise training for Family Welfare Counsellors who were to be posted at the District Women Hospital in each district. The criterion for FWCs was retired PHNs/ Staff Nurses/ LHV/ ANM, etc. Only 18 FWCs could be recruited. In the year 2010-11 a revision in qualifications has been made and it is proposed that one FWC will be posted at 180 facilities (53 DWH + 20 CHs+ 107 FRUs). These FWCs will be provided a seven days training. The budget for training is Rs. 35.68 lacs, contingency to SIHFW is Rs. 0.15 lacs and printing of the module/handbook Rs. 1.35 lacs. These trainings will focus on updating information on family welfare issues and enhancement of counselling and communication skills. Further details are available in the Family Planning section.

A total sum of Rs. 37.18 lacs is being budgeted for the activity in 2010-11.

SUMMARY OF TRAININGS TO BE CONDUCTED BY SIHFW

Training Activities		Implementing Agency	Current Status	Target-2010-11				
				Q1	Q2	Q3	Q4	Total
Maternal Health Training								
1	**Skilled Attendance at Birth**							
	Setting up of SBA Training Centres		**82 centres are functional, 18 to be established this year**					
	TOT for SBA training centres	**SIHFW**	**423**	**30**	**30**	**30**	**-**	**90**
	Training of Staff Nurse/ ANM/ LHV/ in SBA	**DWH & FRUs**	**1000**	**750**	**750**	**750**	**750**	**3000**
2	**Life saving Anaesthesia skills (18 weeks training - 12 weeks in Medical college + 6 weeks in DWH**	**SIHFW + 5 medical colleges**						
	Setting up of life saving Anaesthesia skills training centres		**One centre to be established**					
	TOT for Anaesthesia skills trainings		**7**	**10**	**10**			**20**
	Training of Medical Officers in life saving Anaesthesia skills		**52**		**6/36**		**6/36**	**12/72**
3	**EmOC (FOGSI) (16 weeks trainings – 6 weeks in medical college + 10 weeks in DWH**	**SIHFW + 2 medical colleges**	**2 new centres to be established in 2010-11** Negotiations are on with other Medical Colleges to include them as additional training sites					
	TOT for EmOC		**8**	**18**	**6**	**6**		**30**
	Training of Medical Officers in EmOC (Short Term)		**39 (27+ 12)**	**16**	**16**	**16**	**16**	**64**
4	**Refresher CEmOC for existing specialists (14 days training)**	**SIHFW**						
	TOT		**8**	**10**				**10**
	Gynaecologists (DGO/MS/Other		**30**	**10**	**10**	**10**	**10**	**40**

Training Activities		Implementing Agency	Current Status	Target-2010-11				
				Q1	Q2	Q3	Q4	Total
	subject MS) in the system not performing LSCS will be trained for 3 weeks in btch of 2							
5	**MTP using MVA**	**SIHFW**						
	TOT on MTP using MVA	**SIHFW**	**20**	**1/15**	**1/15**	**-**	**-**	**2/30**
	MTP refresher using MVA	**DWH**	**16**	**6/18**	**8/24**	**12/36**	**14/42**	**40/120**
6	**RTI/STI Training for MOs and LTs**	**SIHFW**		**2/50**	**1/25**	**1/25**	**1/24**	**5/124**
7	**Trainings for FWCs (7 days)**	**SIHFW**			**2/50**	**3/65**	**3/65**	**8/180**

COMPREHENSIVE TRAINING PLAN (SIHFW)- PIP 2010-11

S.No	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
A	**RCH RELATED TRAININGS**									
1	**Post Partum Abdominal Tubectomy**	Medical Officers	3 Days	17	RHFWTC & DWH	Skill training for Post Partum Abdominal Tubectomy	17	5	85	7.39
2	**Skilled Birth Attendant's training**									
2.1	Setting up of SBA Training Centres (18 new Centres)				37 Old Sites+20 New(DWH)+25 FRUs					2.70
2.2	Training of Trainers (TOT)	CMS(DWH), Gyae., Paed.,Staff Nurses	2 Days	1	State Institute of Health & Family Welfare, U.P.	This TOT is for Trainers of District Women Hospitals & FRUs who impart training to Field Operatives	3	30	90	3.34
2.3	Training of staff Nurse/ ANM/ LHV/ in SBA	ANMs/LHVs/Staff Nurses	21 Days	100	District Women Hospitals & First Referral Units	It provides knowledge & skills about safe delivery with introduction of Partographs	750	4	3000	828.23

S.No	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
						and use of Mag Sulph, Misoprestrol etc.				
2.4	One Time Grant for Strengthening of Sites (100 centres)					Grant of Rs.40000 per centre has been earmarked by the GOI for strengthening of Training Sites				40.00
3	**Life Saving Anaesthesia Skills**									
3.2	Training of Trainers (TOT)	Anaesthetists	2 Days	6	Medical Colleges of Lucknow, Agra, Meerut, Kanpur, Jhansi	This TOT is for Anaesthetists of District Women Hospitals who will work as Trainers (budget is built in training budget to Medical Colleges)	4	5	20	109.08
3.2	Life Saving Anaesthesia Skills (Field Training)	MBBS Medical Officers	18 Weeks	6	Medical Colleges of Lucknow, Agra, Meerut, Kanpur, Jhansi.	Out of 18 weeks' 12 weeks' LSAS Training is provided at respective	12	6	72	

S.No	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
					This year a new LSAS site is proposed at Medical College, Allahabad	Medical Colleges & then Trainees are attached to a DWH for practical training for 6 weeks followed by an exam..				
3.3	One Time Grant for Strengthening of Sites (6 centres)									18.00
4	**Emergency Obstetric Care (EmOC) Training**									
4.1	Training of Medical Officers in EmOC	Gynaecologists	10 Days	2	Medical Colleges decided by FOGSI (such as CMC Vellore, Gandhigram, Surat etc.)	Trainers for Emergency Obstetrics Care & Short Term Emergency Obstetrics Care	5	6	30	18.00
4.2	Field Training	MBBS Medical Officers	16 Weeks	4	Medical Colleges of Lucknow , Aligarh, Meerut and Allahabad have been included in PIP 2010-11.	Out of 16 weeks, 6 weeks Training at Medical College + 9 weeks practical training in DWH + last	8	8	64	172.94

S.No	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
						week in their respective medical colleges				
5	**Short term refresher CEmOC**									
5.1	Training of Trainers (TOT)	Trainers of EmOC Training	1	1	SIHFW	1 Day Sensitization Training regarding CEmOC to Trainers of EmOC Training	1	10	10	1.00
5.2	Field Training	Specialist MOs (DGO/MS/MD)	14 Days	10	District Women Hospitals with Caesarean load of 60	Specialist MOs who have no exposure to conduct Caesarean Section.	20	2	40	12.56
6	**MTP using MVA**									
6.1	Training of Trainers (TOT)	Pool of Trainers from Dist. Male & Female Hospitals & Training Centres.	4 Days	1	SIHFW in Collaboration with Female Hospitals	20 trainers are available and 30 new trainers will be trained	2	15	30	2.18
6.2	Field Training	Medical Officers (Female)	5 Days	10	District Women Hospitals	Refresher Training with MVA Method	40	3	120	8.00
7	**RTI/STI Training for MOs and LTs**	Medical Officers & Lab Technicians	3 Days	62	Sub District Level	MOs & Lab Technicians of CHCs will be	5	25	124	5.69

S.No	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
						trained on RTI/STI				
8	**Family Welfare Counsellors' Trg.**	Family Welfare Counsellors	7 Days	1	SIHFW	The FWC to be appointed at DWH will be given training on Counselling & Communication Skills	8	20-25	180	37.18
9	**Adolescent Health Training (ARSH)**									
9.1	**State TOT**	Trainers &monitors of SIHFW/DGFW/SPMU	3 Days	1	SIHFW	Capacity Development of Trainers & monitors regarding Adolescent health	1	25	25	1.36
9.2	**State TOT**	Trainers of RHFWTC&Dh	3 Days	1	SIHFW	Capacity Development of Trainers regarding Adolescent health and module printing	2	30	60	13.03
9.3		Medical Officers	3 Days	11	RHFWTC	Adolescent health component as per GOI module	96	19	1816	81.86

S.No	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
9.4		ANM	5Days	71	District Level Training Centre/facility	Adolescent health component as per GOI module	128	33	4262	90.88
										1453.42

The total budget for trainings proposed by SIHFW is Rs. 1453.42 lacs for the year 2010-11 under RCH Flexipool

The above calculations (related to SIHFW training) have been made as per the letter no A 11033/101/2007/trg dated 17 Nov 2009 giving the following norms for SIHFW related training:

1. Perdiem to trainees (Group A and B) Rs. 700.00
2. Perdiem to trainees (Group C and D) Rs. 400.00
3. Honorarium to State level facility Rs. 1000.00
4. Honorarium to District and sub District level facility Rs. 600.00
5. Food arrangements (per day/ per participant) Rs. 150.00
6. Contingency (per day/ trainees) Rs. 100.00
7. Institutional overhead 10% of training cost
8. Venue arrangement Rs. 1000.00 per day or actual cost
9. TA as per State government norms (actuals)
10. Eminent faculty with subject specialisation will be invited for trainings at their rates

7.2 State Innovations in Family Planning Services Agency (SIFPSA)

SIFPSA has been designated as nodal agency for Clinical Family Planning Trainings. The funds for NSV, Laparoscopic, Abdominal Tubectomy, IUCD Training, and SBA for Medical Officer training have been released from NRHM. Due to unavoidable circumstances fund release for activities proposed in year 2009-10 were delayed, accordingly the objectives of trainings were revised.

a) NSV Satellite Centres (Medical College Meerut, Allahabad & Kanpur)

Based on experience and success of Centre of Excellence (COE) for NSV at department of Urology at CSSMU, the surgery department of three medical colleges have been strengthened as NSV Satellite Centres for static service delivery on regular basis & induction & refresher training of medical officers. Since the training of doctors depends upon client load, gradual increase quarter-wise has been proposed in the year 2010-11. The induction training for 99 doctors and refresher training to 67 doctors has been proposed in three medical colleges.

b) NSV Centre of Excellence (COE CSMMU, Lucknow)

In the year 2010-2011, Training of Trainers (TOT) to 8 trained NSV doctors who have performed atleast 50-100 cases will be provided. Induction training to 99 doctors and refresher training to 27 doctors has been proposed.

c) Laparoscopic Sterilization

The State has an objective of having atleast one trained provider on laparoscopic tubal ligation at each CHC. In the year 2009-10, a total of 11 doctors and 11 staff nurses have been trained till Jan, 2010 and the training in 7 DCTCs is ongoing.

In the year 2010-2011, Training of Trainers (TOT) has been proposed for 36 doctors and 12 staff nurses for six new Divisional Clinical Training Centres. Induction trainings at 13 DCTCs for 168 Medical Officers and 112 staff nurses have been proposed. Refresher training to 72 doctors has also been proposed.

d) Abdominal Tubectomy training

The State has the objective of atleast one trained Abdominal Tubectomy provider at each block (823). In the year 2009-10, a total of 9 doctors and 7 staff nurses have been trained till Jan, 2010 and the training in 3 DCTCs is ongoing.

The Training of Trainers (TOT) for the year 2010-2011 has been proposed for 12 doctors and 6 staff nurses of two new Divisional Clinical Training Centres viz Banda and Gorakhpur. Induction training at 5 DCTCs for 99 Medical Officers and 66 staff nurses has been proposed. Refresher training for 45 doctors has been proposed.

e) IUCD Insertion Training

Objective of training service providers in IUCD insertion technique is to provide at least one provider at each subcentre, PHC, Block PHC and CHC in the state.

In the year 2009-10, the activity could not be initiated due to unavailability of appropriate ZOE models.

In view of expansion of training to 8 new Divisional Clinical Training Centres (DCTC) the Training of Trainers (TOT) has been proposed for 24 doctors and 24 Staff Nurses/ Lady Health Visitor/PHN. Similarly, TOTs for district trainers have been proposed for 61 doctors & 61 Staff Nurses/ Lady Health Visitor/PHN. Induction training for the year 2010-2011 has been proposed for 668 doctors, 1376 Staff Nurses/LHVs and 3870 ANMs.

f) Post Partum IUCD Training

SIFPSA has piloted the PPIUCD training with the assistance from a USAID supported technical agency at three sites in UP. Obst. & Gynae Department of CSMMU has been strengthened as training site for PPIUCD. Training material, PPIUCD standards and job aids have been developed in consultation with the technical agency and are in the process of finalisation. Seven faculty members of OBGY department have been trained as master trainers. PPIUCD training for service providers of two DCTCs were initiated in July 09 and so far 4 medical officers and 4 staff nurses were oriented. There are around 300 PPIUCD acceptors in the State. Since, this was the pilot activity at these 3 sites, the training will be scaled up after strengthening and standardisation of follow up system, demand generation, reporting system and training material with support of the technical agency.

g) Skilled Birth Attendant (SBA) Training for Medical Officers

Objective of the State is to provide at least one trained doctor on SBA skills at each 24 x 7 facility in the state.

The SBA training for medical officers has been initiated in two govt. medical colleges. In the year 2009-10 this training is being expanded to 4 govt. medical colleges i.e Gorakhpur, Jhansi, Meerut and Agra. The objective of training 336 medical officers has been kept for the year 2010-2011. The medical officers posted at 24 x 7 facilities (MBBS government doctors having 3-5 years of service will be trained). Priority will be given to those doctors in nominations, where the SBA training for paramedical is completed or ongoing.

TRAINING PLAN AND DETAILS FOR SIFPSA

RCH INTERMEDIATE / MOU INDICATOR		Implementing agency	TARGET AS PER NRHM PIP 09-10	TARGET (Revised) (2009-10)	ACHEIVEMENT (2009-10) AS ON 31/12/09	TARGET 10-11 (quarter-wise) Q1	Q2	Q3	Q4	Total	Expected Expenditure up to March, 20(Rs. in Lacs)10	CARRY OVER BUDGET OF 2009-2010 TO 2010-2011 (Rs. in Lacs)	ADDITIONAL BUDGET FOR 2010-(Rs. In Lacs)11	REMARKS
Maternal Health Training														
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*
1	**NSV Satellite Centre**													
	TOT	**Medical College, Allahabad, Kanpur, Meerut**	9	9		0	0	0	0	**0**	**15.56**	**14.43**	**19.98**	
	Induction		36	9		9	18	30	42	**99**				
	Refresher		0	0		0	9	27	27	**63**				
2	**NSV COE**													
	TOT on NSV	**Urology Deptt., CSMMU, Luckow**	8	2		2	2	2	2	**8**	**6.36**	**8.03**	**10.15**	
	NSV Trg for MOs		108	36		21	24	27	27	**99**				
	NSV Refresher		24	9		6	3	6	6	**21**				
3	**Laparoscopic Sterilization**													
	TOT Laparoscopic sterilization	**SIC/CMS of 7 old DCTCs & 6**	54	0		48	0	0	0	48	**17.15**	**20.24**	**58.63**	

RCH INTERMEDIATE /		Implementing	TARGET	TARGET	ACHEIVEMENT	TARGET					Expected	CARRY	ADDITIONAL	REMARKS
	Laparoscopic sterilization Trg. for MOs & Staff Nurses	new DCTCs	190	70		45	70	100	65	280				
	Refresher training for lap ligation		36	12		9	6	18	39	72				
4	**Abdominal Tubectomy**													
	TOT for AT	SIC, CMS of 3 old DCTCs & 2 new DCTCs	30	0		18	0	0	0	**18**	**7.55**	**9.60**	**31.62**	
	AT Trg. for MOs and SN		145	30		20	45	50	50	**165**				
	AT Refresher		48	18		9	6	15	15	**45**				
5	**IUD Insertion**													**1. Project deferred in PAC by Principal Secretary, MH&FW with the direction to ensure IUCD kits & Zoe Models by Directorate, FW/SPMU to concerned districts followed by approval from PAC.2. Proposed targets will be met only after the availability of Zoe & IUCD kit**
	TOT for IUD insertion (Divisional Trainer)	Veerangna Avanti Bai, Mahila Chikitsalya, 10 old +8 new DCTCs, District Women Hospitals of 30 districts, Block Level CHCs/BPHCs of 43 districts	42	0	0	12	24	12	0	**48**	**0**	**230.77**	**13.47**	
	TOT for IUD insertion (District Trainer)		248	0	0	0	16	48	48	**112**				
	Training of Medical Officers in IUD insertion		1388	0	0	0	172	258	258	**688**				
	Training of Staff Nurses/LHVs in IUD insertion		2976	0	0	0	344	516	516	**###**				
	Training of ANMs in IUD insertion		8928	0	0	0	774	1548	1548	**###**				

	RCH INTERMEDIATE /	Implementing	TARGET	TARGET	ACHEIVEMENT	TARGET					Expected	CARRY	ADDITIONAL	REMARKS
														in the districts
6	**SBA Training of doctors**													
	SBA Training of doctors	**2 old & 4 new Medical Colleges**	295	**60**	**0**	78	114	72	72	**336**	**27.25**	**59.51**	**40.64**	**1. File for approval of project is at Chief Secretary, considering approval in first week of Jan,10, targets and expenditure in year 09-10 are being proposed.**
	Grand Total										**73.88**	**342.58**	**174.49**	

A total of 174.49 lacs is proposed under training for SIFPSA for the year 2010-11.

7.3 Maternal Health

As detailed in the Section on Maternal Health, trainings will be conducted for RTI/ STI Training and Family Friendly Hospitals (FFH). RTI/ STI trainings will be conducted in close coordination with NACO and with CSMMU, Lucknow. A budget of Rs 45 lacs has been proposed for RTI/ STI trainings.

For FFH, orientations at State level will be conducted with two representatives from each facility. This orientation will provide an overview of the concept of FFH initiative to the health managers. This will be followed by a five day training TOT to be conducted by the National Health Systems Resource Centre (NHSRC). The Divisional Programme Managers and a representative from the divisional HQ hospital will participate in this training. These Divisional PMs will train the district level health functionaries and further supervise the implementation of FFH activities in districts in their divisions.

S.No	FMR S.No	Activities	No. of Units	Rate per Unit (in Rs.)	Frequency	Total (in Rs. Lacs)
		Training				
1	**A.1.1.4**	*State level training on RTI/STI*	5	300000	1	15.00
2	**A.1.1.4**	*District level training on RTI/ STI*	60	50000	1	30.00
3	**A 11.9**	*FFHI-Five day TOT for Divisional teams (50 participants @ Rs. 12,000 each)*	50	12000	1	6.00
4	**A 11.9**	*FFHI- District level trainings (Rs. 20,000 for each district)*	71	20000	1	14.20
		Sub Total				**65.20**

A total of Rs. 65.20 lacs are proposed for the year 2010-11 for trainings for Maternal Health.

7.4 Child Health Trainings

Seven Medical Colleges have been involved in various types of child health trainings. Paediatrics and SPM department of IMS, BHU, Varanasi is supporting TOT for CCSP master trainers. As of now 9 batches of such TOTs have been completed by the institute and it will continue the support in future.

Neonatology section of Paediatrics department of CSMMU, Lucknow has been involved in imparting TOT for facility based new born care training in the State. TOTs of 17 first phase districts have been completed and those of second phase are going on. The districts are conducting training of Medical Officers and Staff Nurses after completion of TOTs. The centre will also be utilized for imparting FBNC training to Medical Officers and Staff Nurses of the neighbouring CCSP districts.

The following trainings have been proposed under Child Health Section:

Budget Summary (Child Health): 2010 – 11

Sl.	Particulars	Amount (Rs. in lacs)
Training (2.2.6)		
1	Printing of training module (for approx. 20,000 functionaries)	50.00
2	Support to Medical Colleges for operational expenses (@Rs. 5 lacs/ College for 7 Medical Colleges) and non recurring to JN MC, AMU Aligarh	38.95
3	Training of Physicians at Medical Colleges	149.07
4	Training of Functionaries under CCSP @ Rs. 1.65 lacs per batch)x1000 batches for 36 district	1650.00
5	Training of Functionaries under CCSP @ Rs. 1.65 lacs per batch)x 580 batches for new 35 district	957.00
6	District level ToT for 36 CCSP districts	38.24
7	District level ToT for 35 new CCSP districts	83.65
8	Training of Supervisors on CCSP for 36 districts	125.70
9	Training on facility based care for sick children in CCSP districts (including TOT & for 36 old and 35 new CCSP districts)	50.04
10	Strengthening of District level training sites for CCSP/ FBNC	287.15
11	Navjat Shishu Surksha Karyakaram(NSSK) (2.2.11)	85.00
12	Since the training norm is revised by GOI, but the state has not been implemented the revised norm as yet because it will be implemented only after getting approval from the committee formed for this purpose. Till that period the existing training norm will be applicable. However, to meet out the enhanced norm after implementation of the revised norm, an additional amount of Rs.90.00 lacs (about 5.00 % of the training cost) has been proposed in the child health training component.	90.00
Sub-Total		***3604.80***

The total budget proposed for child health trainings for the year 2010-11 is Rs. 3604.80 lacs.

7.5 Adolescent Health Trainings

As mentioned in Section 5.3, under the Adolescent Health component on Intervention for school going adolescent girls addressing anaemia: Saloni Swasth Kishori Yojana, a budget of Rs. 50.99 lacs is being proposed for organising State, District and Block level trainings for teachers. Similarly, in Section 5.4, under the component - Intervention for non-school going adolescent girls addressing anaemia, a budget of Rs. 25 lacs is being proposed for training 20,000 NGOs/ASHAs in 10,000 identified villages.

	Adolescent Health - Saloni Teacher's Training	**No. of Units**	**Rate per Unit (in Rs.)**	**Frequency**	**Total (in Rs. Lacs)**
	State level training	6	6200	1	0.37
	District level training	41	14200	1	5.82
	Block level training	400	11200	1	44.80
5.7	Training for ASHAs, ANMs and AWWs for non-school going adolescents	1	2500000	1	25.00
	Sub Total				**75.99**

The total budget proposed for trainings for addressing anaemia in school going and non-school going adolescent girls for the year 2010-11 is Rs. 75.99 lacs.

SUMMARY BUDGET

SN	**Activities**	**Total (in Rs. Lacs)**
7.1	**TOTAL FOR SIHFW**	**1453.42**
7.2	**TOTAL FOR SIFPSA**	**174.49**
7.3	**TOTAL FOR MATERNAL HEALTH TRAINING**	**65.20**
7.4	**TOTAL FOR CHILD HEALTH TRAINING**	**3604.80**
7.5	**TOTAL FOR ADOLESCENT HEALTH TRAINING**	**75.99**
	TOTAL FOR TRAINING	**5374.91**

The total budget for training under RCH Flexipool is Rs. 5374.91 lacs for the year 2010-11.

SUMMARY BUDGET FOR TRAINING

S.No	FMR S.No	Activities	Total (in Rs. Lacs)
7		**TRAINING-SIHFW**	
7.1		**Maternal Health Training**	
a	**A. 11.3.1**	**Skilled Attendance at Birth (setting up training centres, TOT, training and one time grant for site strengthening)**	**874.27**
b	**A.11.3.3**	**Life saving Anesthesia skills(One time grant for site strengthening, training of MOs)**	**127.08**
c	**A.11.3.2**	**EmOC (FOGSI)(TOT and training of MOs, running of centre cost certification and monitoring, and refresher)**	**204.50**
e	**A 11.3.4**	**MTP(MVA) Refresher Training**	**10.18**
f	**A.11.3.5**	**RTI/STI Training for MOs and LTs**	**5.69**
g	**A.11.3.7**	**Family welfare counselors training (7 days) (inclusive of course material and contingency)**	**37.18**
i	**A.11.6.2**	**Post Partum Abdominal Tubectomy Training**	**7.39**
j	**A.11.7**	**Adolescent Health (module, State TOT, State TOT for regional trainers, training of MOs and training of ANMs and LHVs)**	**187.13**
		TOTAL FOR SIHFW	**1,453.42**
		TRAINING- SIFPSA	
7.6 & 7.7	**A.11.6.3**	**NSV (Satellite Centre and COE)**	**30.13**
7.8	**A.11.6.1**	**Laparoscopic Sterilisation (TOT, training and refresher)**	**58.63**
7.9	**A.11.6.2**	**Abdominal Tubectomy (TOT, Training and refresher)**	**31.62**
7.10	**A.11.6.4**	**IUD Insertion (TOT at division and district, and training of MOs, staff nurses, LHVs and ANMs)**	**13.47**
7.1	**A.11.3.1**	**SBA Training of Doctors**	**40.64**
		TOTAL FOR SIFPSA	**174.49**
		Maternal Health Training	
	A.11.3.5	RTI/ STI at State nd district level	45.00
	A.11.3.7	FFHI(TOT at divisional level and district level training)	20.20
		Maternal Health Sub Total	**65.20**

S.No	FMR S.No	Activities	Total (in Rs. Lacs)
		Child Health Training	
	A.11.5.1	**Printing of Modules**	**50.00**
	A.11.5.1	**10 days CCSP Training (District TOT and training in 71 districts)**	**2,728.89**
	A.11.5.1	**Supervisory Training**	**125.70**
	A.11.5.1	**Site Strengthening for 36 districts and 35 new districts**	**287.15**
2.1	**A.11.5.2**	**Operational costs of Medical Colleges for conducting trainings (recurring for all and non recurring for JMMC)**	**38.95**
	A.11.5.2	**Training of MOs (Physicians/F-IMNCI) at Medical Colleges and supervision costs**	**149.07**
	A.11.5.2	**FBNC Training (TOT, training and supervision in 36+35 districts)**	**50.04**
2.4	**A.11.5.5**	**NSSK (Training, printing costs of modules and ensitization workshop**	**85.00**
	A.11.5.5	***Pool for meeting changed GoI norms***	**90.00**
		CHILD HEALTH TOTAL	**3,604.80**
		PCPNDT	**1.00**
	A.11.7	***Adolescent Health Training (State level training and non school going adolescents)***	**75.62**
		TOTAL FOR TRAINING	**5373.54**

8. BEHAVIOUR CHANGE COMMUNICATION (BCC)

Behaviour change communication is a process that makes communities understand new required behaviours and adopt those to make a difference in quality of their lives. A carefully planned and managed BCC programme ensures that the behaviours identified for change are feasible within the social and cultural context in which people live.

To guide the overall BCC efforts under NRHM, the BCC strategy has been developed for Uttar Pradesh. The BCC plan presented here is guided by the approved BCC strategy for the state and is in correlation with the activities which have already been initiated under the NRHM in 2009-2010.

The state BCC strategy proposes a two-pronged approach to circumvent the dilemma of addressing too many care seeking and household behaviours at one time. The approach includes:

- Selection of priority behaviours for promotion through Mass Media and
- Promoting specific behaviours through interpersonal communication (IPC) and community based BCC approaches.

Specific behaviours related to each National Health Programme will be addressed at the facility, household and community level using IPC tools that enable need specific BCC. Need based BCC at the household level, focuses on establishing dialogue and motivating change that can be easily assimilated within the socio-cultural milieu of communities in Uttar Pradesh.

14 Core Trigger Behaviours[4]	
1	Age at marriage > 18 yrs; Delay first pregnancy till 21 years for girls
2.	Eat three times a day (women and adolescent girls); eat 3-4 times a day (pregnant women)
3.	Early registration <12 weeks; 3 ANC check ups
4.	Institutional Delivery; Stay in the hospital for 48 hrs after delivery
5.	Immediate health seeking behaviour on recognition of danger signs in mother and newborn
6.	Immediate and exclusive breast feeding within one hour of birth and continue exclusive breast feeding up to six months
7.	New born care- Keep the newborn warm with skin to skin care; Cord care
8.	Complete Immunization/ Booster / Vit A
9.	Complementary feeding from six months 4-5 times a day in addition to breast feeding
10.	Wash hands with soap after defecation and prior to feeding child under three years
11.	Increase birth interval to three years
12.	Adopt any limiting method after two children even if both are girls

[4] Source: NRHM BCC strategy for Uttar Pradesh

Note: Priority behaviors across all NRHM programmes have been selected based on the following criteria:

1. *Evidence of association of the behaviors to prevent outcomes such as maternal mortality, neonatal and child mortality, anaemia, TB, vector borne diseases etc.*
2. *Expert opinion of the core group committee guiding the development of the NRHM BCC strategy in UP.*
3. *Magnitude of the behavioral problem and potential for change through BCC approaches.*

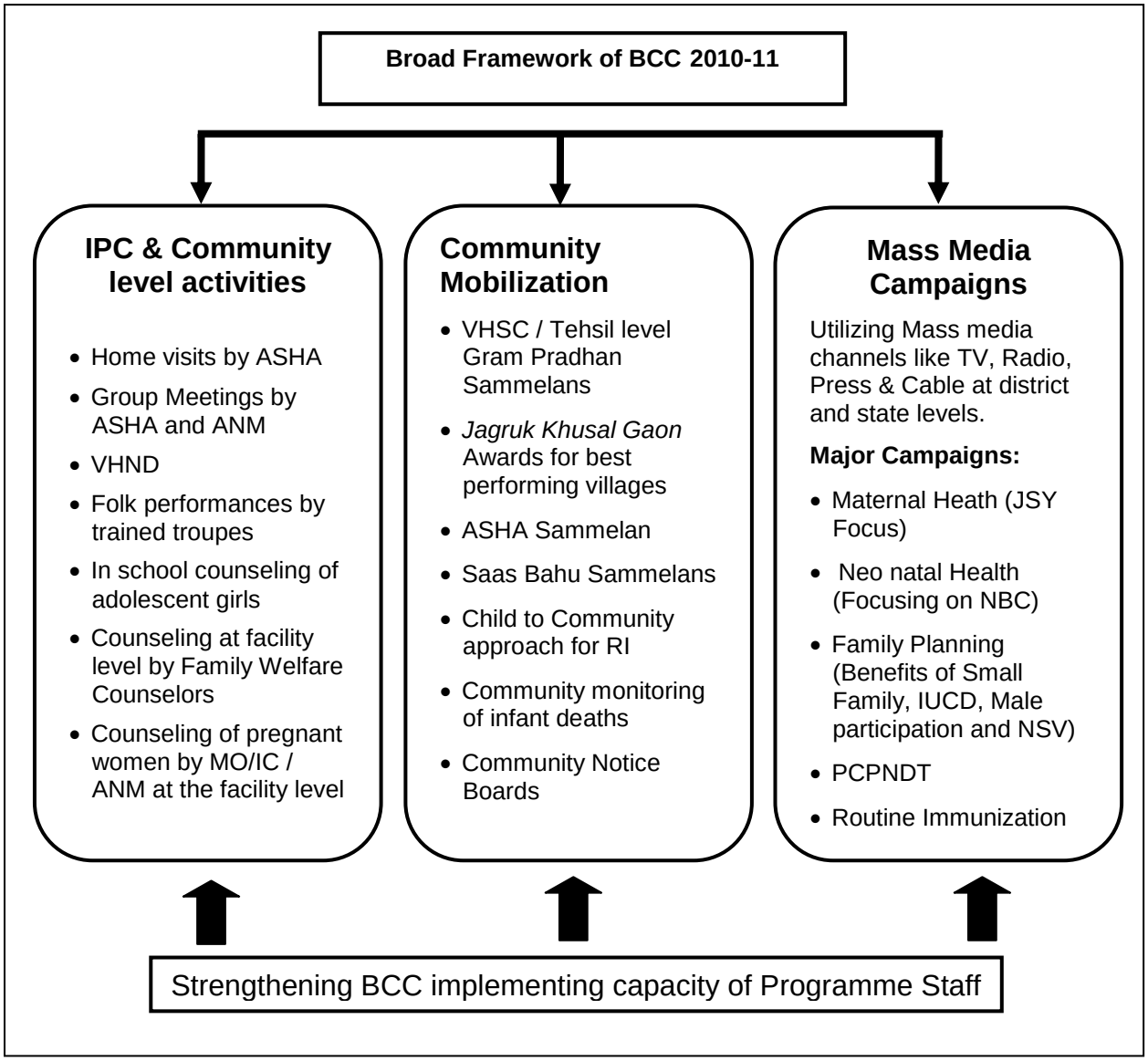
13.	Early detection of TB
14.	Empty and dry water containers once a week

The priority areas selected for BCC activities for the year 2010 – 2011 in accordance with the above core behaviours are**:**

BCC Campaigns	**Priority Behaviours**	**Target Audiences**	
		Primary	**Secondary**
Maternal and Newborn Health	Complete ANC: 3 ANC checkups, 100 IFA, 2 injections TT	Married women of childbearing age	Husbands, Older women in households
	Institutional deliveries and stay in hospital for 48 hours (Focus on *Janani SurakshaYojana*)	Pregnant Women and their Husbands	Decision makers in households –Mother in-laws
	Essential New born care (skin to skin care, cord care, immediate & exclusive BF)	All married women of childbearing age	ASHA, AWW, Older women in family
Child Health	Routine Immunization; biannual supplementation of Vitamin A	Men and women of childbearing age	ASHA, AWW, Older women in family
	Exclusive breastfeeding for 6 months	Pregnant and postpartum women	
	School health Programme	School children and teachers	Caregivers, General community
Family Planning	Increase birth intervals (with focus on Cu 380 A-IUCD and PPIUCD)	Couples with spacing needs (counselling at pregnancy and continuing till post partum period)	ASHAs, AWW, ANMs, Community influentials, Mothers-in-law
	Increasing men participation in Contraception.	Married Men	VHSC & Community influentials, ASHAs, ANMs,
	Use of Limiting methods (with focus on NSV)	Couples achieving desired family size	ASHAs, AWWs, ANMs, Community influentials, Mothers-in-law
	PCPNDT- selective sex determination	Couples in reproductive age; Service Providers; Private clinics	General community, community influentials
Adolescent Health (Saloni Swasth Kishori Yojna)	Health, Hygiene, Nutrition, Age at marriage, negotiation/ life skills.	Adolescent girls; Teachers	Parents of adolescent girls, general community, community influentials ANM, AWW ,ASHA

The NRHM BCC strategy for Uttar Pradesh proposes interventions at the State, Facility/institution, Local/village-slum and Household/family levels. These interventions are linked together by a common strategic plan that includes a planned focus on a set of priority behaviours as stated above.

To facilitate this there are three overarching strategies: (1) Interpersonal communication (IPC) and community level BCC, (2) Community level mobilization (3) Mass media. The purpose of presenting the all three broad strategies together is to underscore the need to work with all three approaches instead of the singular focus on mass media. Each of the broad strategies is considerably strengthened if implemented synergistically and simultaneously.



A. MATERNAL AND NEWBORN HEALTH BCC CAMPAIGN

Increasing awareness about institutional deliveries: Under the NRHM, one of the key objectives is to reduce by half the maternal mortality rate. The key strategies for reducing the maternal and infant mortality is to promote 3 ANC check ups and institutional deliveries in both urban and rural areas.

While there has been an increase in demand for institutional deliveries by the introduction of *Janani Suraksha Yojna* with over 15.40 lac JSY deliveries till December 2009, there is still a need to focus on increasing the demand for JSY to achieve the target of 21.00 lac JSY deliveries being proposed for 2010-11.

There will be a special multi-media campaign using mass media, interpersonal communication, local and mid media to increase awareness of *Janani Suraksha Yojna* and with emphasis on safe motherhood and need for complete Ante natal care and postnatal care.

Exclusive and immediate breast feeding & adoption of appropriate new born practices to prevent neonatal mortality: Neonatal mortality is as high as 48/1000 live births in the state. 67% of the deaths in children are attributable to neonatal deaths in the first 28 days of life (NFHS-3). Generally, 20% of the neonatal deaths can be prevented if the deaths on the 1st day are reduced. The situation is complicated by harmful socio-cultural practices like not feeding the neonate colostrum, bathing the new born, applying oil/ ghee/mud to the freshly cut umbilical cord

An exhaustive evidence review was carried out with the help of development partners which highlighted the importance of using inter-personal communication for changing behaviours and integrating BCC efforts across multiple platforms using the continuum of care approach to deliver key messages consistently. Actively involving the community leads to results and community based groups are a good platform to deliver BCC messages.[5]

This calls for urgent action through an integrated intensive approach to educate the community about harmful practices and to promote the correct newborn care practices.

- ***COMMUNITY LEVEL (NBC CONTACT 1):*** *Neo natal care messages to be given to the community during the Saas Bahu Sammelans*

As the harmful neonatal practices are deeply rooted in socio-cultural practices, it is necessary not only to educate the woman but also the mother-in-law about the adverse effects / dangers to the infant's life through the existing practices but also to inform them about the correct appropriate neo-natal behaviours. The *Saas Bahu Sammelans* are already being implemented in the state and have wide social acceptability.

A special module with interactive games will be added to the existing activity with focus on saving newborn lives.

- ***FACILITY LEVEL (NBC CONTACT 2):*** *Counselling of pregnant woman & family members during third trimester at the Godbharai ceremony*

[5] Community-based interventions that improve newborn health outcomes: A review of evidence in South Asia.; VISTAAR, Evidence Review Series 5, March 2008

A new initiative of "*Godhbharai* ceremony" involving blessing of the pregnant woman in the third trimester is being planned. The ceremony will use the existing cultural practices and the opportunity provided by the ceremony to counsel the pregnant woman and family members at the facility about nutrition and general care, the expected date of delivery (EDD), the 3 delays that could jeopardize the lives of the mother and the unborn child, danger signs and help in the birth planning for each pregnant woman.

Counselling of the woman and the mother-in-law by the MO/IC and ANM about appropriate neo-natal practices would be initiated during the pregnancy at the *Godbharai* ceremony being proposed at the facility level. A Pregnancy / MNH guide will be handed to the woman focussing on nutrition, care during pregnancy, importance of institutional delivery, Immediate & exclusive breast feeding, prevention and management of hypothermia, appropriate cord care and immunization.

- ***FACILITY LEVEL (NBC CONTACT 3):*** *Stay at the hospital for 48 hours*

As the Day 1 has the highest infant mortality in the state, there is need to ensure hospital stay of minimum of 48 hours. It is recommended that the JSY payment be given to the beneficiaries only after 48 hours to promote the stay in hospital for 48 hours after delivery.

This would also provide the opportunity for counselling of the parents and the family especially the women family members. The immediate & exclusive breast feeding behaviours can be supervised by the providers at the facility along with behaviours related to cord care and prevention and management of hypothermia.

24x7 facilities are being equipped with audio visual sets (TV & DVD players) in maternity wards through funds from RKS funds. A set of 4-5 minute short films on maternal and child health / care is being proposed which will be available for viewing in the wards.

- ***FACILITY LEVEL (NBC CONTACT 4)****: Counselling of the mother & family members on correct new born practices by Family Welfare Counsellors; giving of "Badhai Kit"*

Counselling at the facility level on exclusive and immediate breast feeding and essential new born care, follow up by ASHAs to identify danger signs in neonates will be the main thrust of the awareness generation activities.

A "*Badhai*" kit consisting of a vest (*baniyain* printed with NBC messages) and IPC material like the MNH guide will be given to the parents of new borns along with counselling by the Family Welfare Counsellors.

- ***HOUSEHOLD LEVEL (NBC CONTACT 5&6)****: Two home visits by ASHAs and AWW for PNC and monitoring of new born*

There is evidence to show that convergence between the ICDS and the Department of Health produce "better results". The ASHAs and the AWWs will play a crucial role in monitoring the mother and the new born child through the post natal home-visits.

The ASHAs and AWWs will be provided training in identification of danger signs in neo-nates so as to counsel the family members and the mother. The first PNC would be delivered by the ASHA & AWW within 7 days followed up by the second PNC visit within 21 days. The ASHA/

AWW would monitor the health of the new born and re-emphasize the exclusive breast feeding and behaviours related to management of hypothermia and cord care.

- ***INTEGRATION WITH PULSE POLIO:*** *Infant monitoring*

Every opportunity for infant monitoring should be utilized to emphasize the importance of adopting appropriate new born behaviours. The Pulse Polio house- to -house teams will be trained to identify danger signs in newborns and to reiterate the priority new born behaviours

- ***COMMUNITY AUDIT & AWARD :*** *Infant death audit; Community Notice boards*

Communities play a vital role in changing socio-cultural practices and acceptance of new practices. Community ownership / involvement may require a focus on more than new born care (broader heath issues)[6].

Infant death audits are being proposed in the programme to sensitize the community to the infant deaths and to provide an opportunity for introspection and debate within the community. This would be coordinated by the ANM with support from the VHSC. The infant death audit guidelines would be detailed in the VHSC advocacy booklet being proposed.

Quarterly reporting and monitoring of the village performance on 5 indices is proposed through village level community notice boards at the Panchayat Ghars (1) Number of Infant Deaths; (2) Number of Maternal Deaths; (3) Number of children < 5 fully immunized/ Total number of >5 children; (4) Number of NSV acceptors (5) Number of acceptors of female sterilization.

An annual Award & Certificate for the best performing village (*Jagruk Khushal Gaon*)/ Block would be awarded at the Tehsil Level *Gram Pradhan* Sammelans. Rs 1000/- per block is for purchase of Awards and printing certificates is being provided in the IEC/BCC budget.

MASS MEDIA & MID MEDIA ACTIVITIES:

An intensive burst of mass media and mid media activity across the state level is planned to build an enabling environment for promoting awareness about appropriate new born practices. Folk performances would be used to convey NBC messages to media dark villages to support the mass media campaign.

- ***MEDIA ADVOCACY EFFORTS:***

Activities are being planned around special days like the Safe Motherhood Day (April 13), Breast feeding week (August 1-8) and the New Born Care Week (Nov 14 -21) to give added impetus to the multimedia campaign on Maternal Health and JSY.

Media advocacy would be used strategically to generate awareness, dialogue and support dissemination of priority behaviours related to Maternal and Newborn health through mass media channels by ensuring valuable editorial space.

These are being planned as new campaigns which will require material development and production for the campaign. Small scale formative research to identify and help in developing key messages will be undertaken. The services of an advertising agency for material development will be utilized and media planning agency for development of a professional media plan for effective and cost efficient media buying.

[6] Ibid

Activities being planned under the MNH campaigns		
Inter personal Communication HHs and community level	**Mid Media / Local media**	**Mass Media**
Household Level • Home Visits by ASHA for need based counseling (IPC tools & leaflets for community) • 2 PNC visits by ASHA & AWW for infant monitoring and New Born Care **Village Level:** • VHND for ANC / PNC service provision **Community Level:** • Saas Bahu Sammelan • Group Meetings by ASHA / ANM on monthly themes • Community infant death audit • *Jagruk Kushal Gaon* Awards **Facility Level**: • Counselling of pregnant women by FW Counsellor • Godbharai ceremony: Counselling of pregnant women in third trimester at the facility on EDD, 3 Delays, Danger signs, Nutrition, EBF, PNC & PPFP Counselling of mother & family members on New Born Care practices and *Badhai Kit*	• Wall paintings with details of JSY, Exclusive BF, New born care, Complete ANC ○ ASHA home ○ Sub centers ○ PHCs ○ District Hospitals • Posters (4 types on JSY, EBF, NBC & ANC & PNC) • Standard treatment & Protocol charts at facility level • Folk performances on MNH by trained troupes • Community notice boards for monitoring village level performance on 5 parameters: ○ Infant deaths ○ Maternal deaths ○ Immunization status ○ Acceptance of NSV ○ Acceptance of female sterilization	**State / District Level** • TV & Radio spots on JSY • TV & Radio spots on New Born Care • Newspaper ads • Doctors interviews and content on TV & Radio programmes • TV and Radio spots on immediate and exclusive breastfeeding and complementary feeding at six months. • Media sensitization meets on maternal health and New born care on the occasion of special days: ○ New Born Care Week (Nov 14 -21) ○ Safe motherhood Day (April 13) ○ Breast feeding week (August 1-8)

B. FAMILY PLANNING BCC CAMPAIGN

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.

Promoting small family norm: In order to make spacing methods a social norm among couples, a mix of IPC and community based activities at the village level will be undertaken to promote healthy spacing and timing of pregnancies. This will be supported by a mass media campaign promoting the small family norm and basket of contraceptive choices.

Demand generation for IUCD: There is a renewed emphasis on promotion of IUCDs in the state by increasing numbers of trained providers for IUCD. Divisional level clinical training centers are being established at the 18 divisional headquarters of the state. In light of the increased availability of the trained providers, a special campaign focused on promotion of the IUCD will be undertaken by modifying the creatives developed by SIFPSA for promotion of IUCD 380 A *(*modification of *SUVIDHA campaign).*In addition IUCD will also be promoted as a post partum long acting contraceptive method through local activity in districts having trained providers for PPIUCD.

Demand generation for NSV: Non Scalpel Vasectomy (NSV) commonly known as the "no cut, no suture" method (*Bina chira, bina tanka*) is characterized by less pain, fewer complications and quicker return to sexual activity than conventional vasectomy.

Misconceptions of vasectomy causing weakness both physically and sexually and requiring long periods of rest following the procedure are common. Many providers including ANMs have little information on the details of the procedure and are reluctant to counsel on it. There is also little awareness about the incentive scheme for NSV both for the acceptor and the motivator.

Given the programme emphasis on establishing the training centers for NSV providers, it is proposed to promote NSV in the local media to generate client load for the trained NSV providers. Local media activities featuring names, addresses and contact numbers of trained providers will be implemented. Activities will include local radio channels, local newspapers, street plays, signages, posters, banners and pamphlets.

Preventing female foeticide (PCPNDT):

Declining sex ratio and preference for a male child has adversely impacted the reproductive health of women leading to multiple pregnancies and high maternal mortality and morbidity. Ironically the declining sex ratio is more prevalent in the more prosperous western districts of UP (greater emphasis on districts bordering Haryana & Rajasthan) with higher literacy rates and better health indices.

IEC activities for generating awareness and community participation for building consensus and social sanction against female foeticide amongst the community and service providers have been planned at the state level and at the district level and are explained in detail in the section on PCPNDT. State level sensitization workshops, district specific activities for awareness generation like rallies, competitions at Inter/ Degree colleges, local radio, cable and press, wall paintings, hoardings and signages will be planned.

Activities proposed under FP related campaigns		
Inter personal communication HHs and community level	**Mid Media / Local media**	**Mass Media**
Household Level • Identification of clients for spacing and limiting through household visit by ASHA • Home visit by ASHA to promote birth planning. **Village Level** • VHND - Counselling of pregnant women by ANM on PPFP during ANC visit **Community Level** • Monthly group meetings for promotion of small family norm by ASHA & ANM as per monthly themes • Saas Bahu Sammelan • Group discussions / meeting through the VHSC for encouraging male participation in FP decision making **Facility Level** • Counselling of pregnant women on PPFP during ANC, delivery and PNC visits by ANM, FWCs, MO/IC	• Wall Paintings on benefits of small family/ right age at marriage/ NSV/ IUCD: o ASHA home o Sub Centre o PHCs / CHCs o District hospitals • Folk performances on FP / NSV / IUCD/ PCPNDT / Male participation by trained troupes • Street plays for NSV • Street plays for PCPNDT (district level) • Competitions at Inter/ Degree colleges for PCPNDT • Workshops at Panchayat level for community felicitation of men as positive role models for spacing and/or limiting • Posters for IUCD, NSV, FP (basket of contraceptives) • IPC materials for use by ASHA during home visits and group meetings: o FP guide for spacing and limiting o NSV Pamphlets & IUCD Handbill	• TV and Radio. spots/programmes and Print Media (Press ads and articles) are planned to highlight benefits of birth spacing and encouraging male participation in family planning • Radio series for general public addressing various issues among complete subset of family planning. • NSV local press and radio ads
1. *IPC activities done by ASHA and Saas Bahu Sammelan are being budgeted under ASHA Budget* 2. *Wall paintings planned under 2009-10 PIP are currently under implementation* 3. *Family welfare counsellor being recruited for the district level facilities. FWC IPC training module developed, TOT planned under 2009-10 activities* 4. *New creatives to be developed.* 5. *Material development cost is proposed under Mass Media budget*		

C. CHILD HEALTH AND ROUTINE IMMUNIZATION BCC CAMPAIGN

The areas for communication interventions that have been identified are child nutrition and routine immunization.

Increasing Routine Immunization: There has been stagnation in the rates for routine immunization in the state with only 30.3 % of children under 1 being completely immunized (DLHS-3).

Some of the barriers to complete and timely immunization are lack of awareness about services, immunization schedules, prevailing myths and misconceptions, high dropout rate, low parental motivation and lack of community ownership of the immunization programme.

A high visibility and an intensive BCC campaign is being proposed for promotion of parental responsibility for ensuring **complete immunization** of the children. The campaign will use mass media channels like Radio, Television, Print for dissemination of the messages. It will be supported by IPC by ASHAs, AWWs during the VHND and the RI sessions at the village level and counseling of parents of newborns about the importance of complete immunization at the facility level. A new colour coded BCC immunization card (based on the *Indradanush* colour coded RI strategy for ensuring minimum of 5 contacts in the first year) which has been developed and field tested is being proposed to complement the RI campaign.

Bal Chetak Strategy for RI: In addition, a child to community intervention for community mobilization *Bal Chetak* strategy (Alert Child Guardian intervention) will be piloted in one district for increasing immunization coverage. Piloting the intervention in one district will provide the evidence for scale up and for understanding the logistical issues associated with the intervention.

Involving coordination and convergence with the Department of Basic Education, the *Bal Chetak* is a child volunteer (10-14 years) working in pairs to track the immunization status of 4-5 infants in their neighborhood. The *Bal Chetak* will maintain a diary with names of the children, provide a home visit two days prior to the immunization session to inform parents, follow up visit on immunization day to ensure participation by the infant's care giver. The motivation for the *Bal Chetak* is planned through public awards & certificates at the Block & District level. ASHAs, School teachers or village volunteers would be enlisted to provide supportive supervision to the *Bal Chetaks*.

Child Health and Nutrition Months (Bal Swasth Poshan Mah - BSPM): It is proposed to support the BSPM by IEC campaigns in June & December as in the previous years through extensive IEC and media advocacy efforts on mass media like Television, Radio and Dailies supported by IPC and local media like posters and handbills.

School Health Programme: The programme is being scaled up to 48,000 schools this year. IEC support is being planned for the School Health Programme through wall paintings, handbills for distribution to the students & non-tearable foam Posters on health & hygiene. The Bal swasth cards being provided are budgeted in the programme budget.

Activities proposed under Child Health related campaigns		
Inter personal communication HHs and community level	**Mid Media / Local media**	**Mass Media**
Household Level • Identification & tracking of beneficiaries for RI through household visit by ASHA per session **Village Level** • VHND - Counseling of pregnant/ mothers of new borns by ANM on importance of complete immunization during ANC / PNC visit **Community Level** • Monthly group meetings for demand generation for RI activities ASHA & ANM as per monthly themes • Saas Bahu Sammelan **Facility Level** • Counselling of pregnant women/ mothers of newborns on RI during ANC, delivery and PNC visits by ANM, FWCs, MO/IC	• Wall Paintings on RI & BSPM: o ASHA home o Sub Centre o PHCs / CHCs o District hospitals • Folk performances on Child health and parental responsibility by trained troupes • Rallies by School children for BSPM months • IPC materials for use by ASHA during home visits and group meetings: o VHND/ RI handbill o Advocacy book for VHSC members • VHND and RI Flex banners • BSPM Posters • School Health Programme Posters, wall paintings and handbills	• TV and Radio spots on RI and Bal Swasth Poshan Mah (BSPM) • Media advocacy efforts through interviews and talk shows, Doctors interviews and content on popular TV & Radio programmes like Kalyani, Hello Sehat
1. *IPC activities done by ASHA are being budgeted under RI programme budget* 2. *Wall paintings planned under 2009-10 PIP are currently under implementation* 3. *Family welfare counsellor being recruited for the district level facilities. FWC IPC training module developed, TOT planned under 2009-10 activities* 4. *New creatives to be developed.* 5. *Material development cost is proposed under Mass Media budget*		

D. ADOLESCENT HEALTH BCC CAMPAIGN

The *Saloni Swasth Kishori Yojna* (SSKY) was launched by the State Government of Uttar Pradesh under the National Rural Health Mission in October 2008. SSKY targets school going adolescent girls in the age-group of 11-19 years and is being scaled up in FY 2010-11 to over 8000 schools across the state covering approximately 12,00,000 adolescent girls.

The SSKY seeks to address the problem of acute anaemia in adolescent girls through observed oral therapy of providing weekly IFA through DOTS approach and bi annual de-worming and medical examination of girls. Complemented by monthly sessions for in-school counselling on health, nutrition and hygiene through the Saloni Sabhas, SSKY proposes to bring about sustainable changes in dietary and hygiene behaviours of adolescent girls and increase awareness and knowledge on RH issues.

The Saloni Sabhas have been conceptualized as monthly group counselling sessions at the school covering topics like health, nutrition, how to detect anaemia, healthy food habits, how to build negotiating skills, self confidence and team building, female reproductive organs, personal & menstrual hygiene (including how to prepare homemade sanitary pads), correct age of marriage, delaying of the first pregnancy etc. The lecture would be followed by group activity for which there is a monthly provision of Rs 300/- per school. The group activities would cover interactive games, role-plays, demonstrations of recipes, making sanitary pads, hand washing and personal hygiene

The key behavioural outcomes for the SSKY to be promoted through the monthly Saloni Sabhas are:

1. Increase frequency/ nutritional value of food intake to 3 times/day for adolescent girls
2. Maintain Personal hygiene and menstrual hygiene
3. Delay age at marriage to 18 years for girls and 21 years for boys
4. Delay first pregnancy till woman is 21 years of age
5. Increase detection of symptoms of RTIs
6. Increase treatment seeking for RTIs

BCC Activities proposed under *Saloni Swasth Kishori Yojna*		
IPC	**Mid Media / Local media**	**Mass Media**
Household Level • Reinforcement of behaviours and record keeping by adolescent girls through Saloni Diaries **School Level** • In School monthly counselling sessions on health, hygiene & nutrition through Saloni Sabhas • Weekly IFA through DOTS approach • Biannual medical examination and de-worming by team of	• Set of 3 wall paintings on key behaviours related to health, hygiene and nutrition at the selected Saloni school • Saloni sabhas • Saloni Handbills for parental consent / information Materials developed for SSKY: • Teachers Guide for monthly in-school Saloni sessions: ○ ***Session 1:*** *SSKY & Me* ○ ***Session 2:*** *What is Anaemia? What can I do about it?* ○ ***Session 3*** : *Balanced Diet and my role* ○ ***Session 4***: *Self confidence and my role in improving my diet* ○ ***Session 5***: *Hand washing with soap after defecation*	• No activity in mass media channels is currently proposed for SSKY

medical doctors	○ ***Session 6***: *Female reproductive organs, Menstrual cycle & hygiene* ○ ***Session 7***: *Importance of personal Hygiene* ○ ***Session 8***: *Correct age at Marriage* ○ ***Session 9***: *The underage mothers and the right age for first child* ○ ***Session 10***: *Saloni group, my diary and the change in me.* • Corresponding Saloni Diary for adolescent girls for record keeping and for session review. • Press Ad ; Poster	
**The communication package including the Teachers guide and the Saloni Diary have been developed by Johns Hopkins Bloomberg School of Public Health/ Center for Communication Programmes under the ITAP project funded by USAID.*		

A detailed facilitation guide for the teachers has been developed along with a capacity building / training plan which is detailed under the programme section on the Saloni Swasth Kishori Yojna. A corresponding Saloni Dairy for the adolescent girls for record keeping and session review has also been developed. An important innovation of SSKY, the diary will also enable the documentation of the process of empowerment in the girls. The materials are being evaluated and field tested in Hardoi and will be ready for scale up in the year 2010 -2011.

E. URBAN HEALTH CAMPAIGN

Urban areas report a high rate of home deliveries and low rates of immunization of children. A significant percentage of the population in the cities of UP live in slum areas, thus even more prone to sickness and disease. There is an urgent need to connect the services with the demand and publicize the RCH services available at the Urban Health Posts.

Local district specific activities are being proposed to direct the demand to the services. Signages / hoardings at the UHP will be displayed prominently. Local cable channels with strip ads with locations of UHPs, schedule of services will be undertaken. Additionally, demand will be generated by street plays and IPC by the home visits being proposed through the RI Link workers.

Activities proposed under Urban RCH & RI related campaigns		
IPC : HHs and community level	**Mid Media / Local media**	**Mass Media**
Household Level • Identification of clients for spacing/limiting; RI through household visit by RI link worker **Facility Level** • Counselling of pregnant women on PPFP/ RI during ANC, delivery and PNC visits by ANM, FWCs, MO/IC	• Wall Paintings / Hoardings at Urban Health Posts on benefits of small family/ right age at marriage/ NSV/ IUCD • Signages and on-site communication • Handbills for community • Folk performances on FP / IUCD/ PCPNDT / Male participation by trained troupes • Street plays for NSV • Street plays for PCPNDT (district level) • Competitions at Inter/ Degree colleges for PCPNDT	• TV and Radio. Spots / programmes and Print Media (Press ads and articles) are planned to highlight benefits of birth spacing and encouraging men participation in family planning • Radio series for general public addressing various issues among complete subset of family planning. • NSV local press and radio ads • Local cable channels

MONITORING AND EVALUATION:

Monitoring of implementation of such a vast BCC plan is mandatory to effective implementation of planned activities. Behavioural tracking and monitoring of BCC activities need to be strengthened.

Four strategies for strengthening behavioural monitoring and evaluation are proposed: (1) Tracking priority behaviours (2) Monitoring BCC inputs (3) Formative research for campaign planning and (4) Systematic evaluation of pilot interventions and innovations.

- **Tracking NRHM Priority Behaviours**

At least 6 of the 14 priority behaviours proposed under the BCC strategy are not being tracked through either SRS or DHLS surveys. These behaviours need to be included in SRS and DHLS surveys or any other surveys. District level data should be available for all the priority behaviours. The following six behaviours need to be included in tracking surveys:

1. Stay in the hospital for 48 hrs after delivery
2. Eat three times a day (women and adolescent girls); eat 3-4 times a day (pregnant women)
3. Keep the newborn warm with skin to skin care
4. Wash hands with soap after defecation and prior to feeding child under three years
5. Early detection of TB
6. Empty and dry water containers once a week

- **Monitoring BCC Inputs**

It is important to monitor BCC inputs at the community level. These include home visits, group meetings and community events (*Swaasthya Melas*; *Saas Bahu Sammellan, Godhbharai* ceremony etc.). These inputs can be monitored routinely if they are incorporated into the existing MIS. It is proposed to examine the existing HMIS developed by some of the development partners for adaptation to the NRHM needs along with a review of the existing MIS.

- **Formative Research**

Formative research that can inform media campaigns and community BCC inputs is needed and is being budgeted. In addition, a number of formative research studies for family planning are being planned by some of the development partners for Urban health. Findings from these will also feed into developing/ assessing of existing materials. In addition, formative research for Maternal and Child health will be undertaken to inform the development of the BCC campaigns.

- **Systematic evaluation of pilot interventions and innovations**

The PIP includes several pilot BCC interventions and innovations such as the Bal Chetak strategy for RI. These pilot interventions should have a summative evaluative component with a good study design to enable a systematic assessment of impact.

A lump sum of Rs. 25 lacs is being budgeted for Monitoring and Evaluation as well as mid term impact assessment of BCC activities under this proposed plan.

Proposed Implementation and monitoring processes:

The implementation of activities being proposed in the PIP requires institutional capacity within the NRHM for implementation of the BCC activities and support by professional advertising agencies for development of mass media and IPC material for the proposed campaigns.

Increasing BCC planning capacity at the state level: One of the major reasons for inadequate implementation of BCC activities in 2009-10, was the lack of professionally qualified IEC/BCC experts for programme implementation. A separate IEC /BCC cell with qualified professionals is being proposed at the Family Welfare Directorate to be headed by the Director IEC and supported by Joint Director and 4 professional IEC experts one each in strategic planning, mass media planning, community mobilization and monitoring and evaluation. This IEC cell would be technically supported by GM IEC and an IEC consultant at the SPMU. Apart from developing the institutional capacity, there is extensive support for IEC/ BCC activities by the development partners especially by USAID funded technical assistance projects like ITAP and by SIFPSA.

Building BCC implementation capacity at the District and the Block level: To develop the implementation capacity of the Health Education Officers at the block level and the District Project officers and the District Community Mobilizers, extensive capacity building courses are being planned. The detailed curriculum of the 5 day BCC course has already been developed by Johns Hopkins University Bloomberg School of Public Health Center for Communication Programmes through the ITAP project. As a first step, over 1000 officers (Div PMs, DPMs, DCMs, BHEOs) will be oriented to the BCC strategy for the state, learn to undertake situational and audience analysis, frame specific BCC objectives at the Block level and develop strategic communication plans. The curriculum will also lay special emphasis on developing monitoring & evaluation

skills at the Block level for effective monitoring and quality assurance of the household and village level IPC and community activities being planned in this PIP.

Campaign Planning and implementation support by Advertising and Media Planning agencies: It is proposed to procure the services of reputed advertising and media planning agencies for the development of the creative software for the different IEC campaigns being planned. Support by development agencies like UNICEF and USAID would be sought in the procurement of professional services.

Monitoring mechanisms for BCC activities:

Well planned supervision and monitoring are necessary for large scale implementation of the BCC campaigns and for implementing BCC activities at the community level. The systematic implementation of BCC strategies will be largely dependent on the establishment of effective supervision and monitoring systems.

Detailed campaign implementation guidelines will be provided to the block and district level BCC implementation staff for effective implementation and supervision. Photo verification of large scale community level activities like folk performances, saas bahu sammelans and Tehsil level Gram Pradhan Sammelans will be planned. Photo verification of local media activity such as wall paintings and hoardings will be sought from agency. Post plan evaluation of mass media releases will be sought from media planning agency for evaluation of mass media activity.

Apart from the above, the following monitoring mechanisms will be institutionalized for regular monitoring of BCC activities:

- Monitoring of Output indicators:

	BCC Output Indicators	Level of monitoring	Frequency	Level of supervision
1.	Number of Home visits implemented / planned	Village Level	Monthly	Block level Health Education Officer (BHEO)
2.	Number of group meetings implemented/ Planned	Village Level	Monthly	Block level Health Education Officer (BHEO)
3.	Number of folk performances implemented / planned	Village Level	Monthly	Block level Health Education Officer (BHEO)
4.	Number of VHND held	Village Level	Monthly	Block level Health Education Officer (BHEO)
5.	Community Notice Boards	Village Level	Monthly	Block level Health Education Officer (BHEO)
6.	Saas Bahu Sammelans held/ planned	District Level	Quarterly	District Programme Manager (DPM)
7.	Tehsil level Gram Pradhan Sammelan held/planned	Tehsil Level	Quarterly	District Programme Manager (DPM)

- **Methods of random supervision:** Methodology proposed to be used for random supervision of BCC includes random surprise checks on work of frontline workers. Doing household visits along with ASHA to observe her skills of conducting home visits and counseling and providing supportive supervision. Attending group meetings on randomly selection basis to observe that these are being conducted according to the themes and protocol decided in the plan. Checking and verifying registration of people attending group meetings time to time.

STRENGTHENING BCC IMPLEMENTATION:

To implement the BCC Annual action plan, State realizes the need of establishing a IEC/BCC cell under Family Welfare Directorate. At SPMU level it is proposed to have one GM (IEC), one communication officer with one support staff to coordinate with IEC/BCC cell under FW directorate to implement IEC/BCC plan.

A lump sum budget of Rs 25.00 lacs is being proposed for the setting up of a new IEC/BCC cell at the Family Welfare Directorate under the Director IEC. The cell would have the professional manpower recruited from the market or on deputation with expertise and requisite experience in IEC/ BCC. The logistic support required for infrastructure including purchase of furniture, colour printers, fax machines and photocopiers are being budgeted.

The plan proposes following structure for IEC/BCC cell under Family Welfare directorate.

IEC/BCC Cell under Family Welfare Directorate	
Overall Leadership	Director, IEC/BCC Cell (From GoUP / Directorate FW)
	Joint Director IEC/ BCC (From GoUP / Directorate FW)
Support Staff	• Sr. Communication Officer: Strategic Planning & implementation (Deputation / Contractual) • Communication Officer: Mass Media Planning and Execution (Deputation / Contractual) • Communication Officer: IPC, Community Mobilization & Training (Deputation / Contractual) • Communication Officer: Monitoring and Evaluation (Deputation / Contractual) • MIS support staff (Contractual)
IEC/BCC Cell under SPMU	
	• General manager IEC (Deputation / Contractual) • Communication Officer (Deputation / Contractual) • MIS support staff (Contractual)

BUILDING BCC CAPACITY FOR IMPLEMENTATION AT DISTRICT AND BLOCK LEVELS:

Improving BCC planning and implementation skills at the divisional and district levels will be one of the focus areas for 2010-11.

It is proposed to orient the Divisional, district and block level officers directly associate with implementation with the BCC activities with the detailed BCC strategy for the state. District level BCC planning and implementation skills will be built in Divisional Programme Managers, District Programme Managers, District Community Mobilizers and Block Health Education Officers. A 5 day capacity building course is planned. The objectives of the BCC district planning and implementation course are:

- Identifying block and district level priority behaviours needs to be addressed through BCC based on DHLS data and to conduct an analysis to identify barriers to these priority behaviours.
- Developing broad district level BCC strategy
- Developing a district plan related to block and PHC level implementation
- Developing a district plan related to district level BCC functions

This course is expected to build the district level planning skills to enable them to do effective planning, implementation of BCC activities and understand the need for supportive supervision of the village level / frontline workers. It is expected that the total number of participants for the course will around 1015 participants as per the following details:

Participants for District level BCC planning and implementation Course		
Sr No	**Trainees**	**Number**
1.	NRHM Divisional Managers	17
2.	NRHM District Managers	70
3.	NRHM District Community Mobilizers	70
4.	Block level health education officers	540
5.	Medical Officers, LHVs, etc.	300
	Total Participants	1015

***Details of the training plan / budgetary requirements are detailed in training section of the State PIP.*

DETAILED IEC / BCC BUDGET BREAKUP
Quarter wise estimated expenditure

	Activity	Qtr 1 (Apr - Jun)	Qtr 2 (Jul - Sep)	Qtr 3 (Oct - Dec)	Qtr 4 (Jan - Mar)	Total	Remarks
1	Setting up and development of IEC / BCC unit of the state Level	0.00	15.00	10.00	0.00	25.00	Establishing of the IEC /BCC cell at the FW Directorate as outlined in the state BCC strategy.
2	Meeting manpower requirements at the state level	0.00	0.00	0.00	0.00	0.00	In built in Programme Management budget
3	Formative research to identify barriers and key messages	0.00	30.00	0.00	0.00	30.00	
4	Develop BCC strategy	0.00	0.00	0.00	0.00	0.00	Already developed in 2009 -2010
5	Media planning agency hiring charges	0.00	5.00	0.00	0.00	5.00	
6	Advertising Agency hiring charges	0.00	10.00	0.00	0.00	10.00	
7	Material Design & Development	0.00	5.00	5.00	5.00	15.00	
8	**Media Mix**						
A.	**Interpersonal Communication (IPC)**						
i	Monthly Group Meetings	0.00	0.00	0.00	0.00	0.00	Inbuilt in ASHA scheme budget @ Rs100 x 2 x 12 months x 136812 ASHAs (ASHA Scheme Mission Flexipool)

	Activity	Qtr 1 (Apr - Jun)	Qtr 2 (Jul - Sep)	Qtr 3 (Oct - Dec)	Qtr 4 (Jan - Mar)	Total	Remarks
ii	Home Visits by ASHA for PNC through Comprehensive Child Survival Programme (CCSP)	0.00	0.00	0.00	0.00	0.00	Inbuilt in CCSP scheme budget @ Rs 50 & Rs 100/- per visit x CCSP districts
iii	In-school monthly Saloni Sabhas for counselling of adolescent girls on Health, Nutrition & Hygeine	0.00	0.00	0.00	0.00	0.00	Inbuilt under Saloni Adolescent Health Programme budget @Rs 300/sabha x 8000 schools x 10 sessions
B	**Community Awareness & Mobilization**						
i	Tehsil level Gram Pradhan Sammelan	0.00	0.00	0.00	0.00	0.00	Inbuilt in Mission Flexipool budget Part B
ii	Panchayat level felicitation of men as positive role models for adoption of FP (spacing / limiting) in selected districts	0.00	0.00	5.00	0.00	5.00	
iii	Awards for *Jagruk Khusal Gaon* @ 823 x Rs 1000 for procuring awards for the Tehsil Level Gram Pradhan Sammelan	0.00	8.23	0.00	0.00	8.23	
iv	Mobilization of RI beneficiaries through ASHA @Rs 150/- per session x 8 sessions/month x 20621 subcenters	0.00	0.00	0.00	0.00	0.00	Inbuilt in RI programme budget Part C
v	Social mobilization by urban RI link worker in 11 selected cities @150/- per session x	0.00	0.00	0.00	0.00	0.00	Inbuilt in RI programme budget Part C
vi	Godhbharai ceremony for felicitation of pregnant women in the last trimester at the facility level	0.00	0.00	0.00	0.00	0.00	Inbuilt in JSY programme budget
vii	Annual ASHA sammelan	0.00	0.00	0.00	0.00	0.00	Inbuilt in ASHA scheme budget Rs 204.25 lacs (ASHA Scheme Mission Flexipool)
viii	Saas, Bahu Sammelan	0.00	0.00	0.00	0.00	0.00	Inbuilt in Mission Flexipool budget @Rs 150000 / district x 71 districts
					Subtotal	**13.23**	
C	**Community Media (Folk Media)**						
i	Folk performances @ 25 performances per 823 block per year @ Rs 2500/- per performance approx	0.00	171.46	171.46	171.46	514.38	Troupes trained on NRHM messages. Activity to be coordinated by SIFPSA
ii	Street Plays for NSV @Rs 3000/- x1000 shows at selected districts/ locations x 2 rounds	0.00	30.00	0.00	30.00	60.00	
iii	Street plays for Urban RCH @ 3000/- x 24 performances per UHP per year x 69 Urban Health Posts	0.00	16.56	16.56	16.56	49.68	Troupes trained on NRHM messages. Activity to be coordinated by SIFPSA
					Subtotal	**624.06**	
D	**Outdoor Media**						
i	VHND / RI Wall Paintings	0.00	0.00	182.03	21.65	203.68	
ii	NSV; VHND /RI Flex Banners	0.00	8.14	150.00	8.14	166.28	
iii	CCSP, NSV, UHP / RI Hoardings/ Signages	0.00	555.49	182.61	1.61	739.71	
iv	Community Notice Boards	0.00	260.01	0.00	0.00	260.01	
					Subtotal	**1369.68**	
E	**Mass Media**						

	Activity	Qtr 1 (Apr - Jun)	Qtr 2 (Jul - Sep)	Qtr 3 (Oct - Dec)	Qtr 4 (Jan - Mar)	Total	Remarks
E.1	**Campaign 1 JSY (Maternal & Neonatal Health)**						
i	Television / Radio	0.00	0.00	0.00	0.00	0.00	Inbuilt in JSY Scheme Maternal Health programme budget
ii	Print	0.00	0.00	0.00	0.00	0.00	
iii	Development of films, spots & campaign materials	0.00	0.00	0.00	0.00	0.00	
iv	District level @50,000/ - per district x 71 (*Godhbhari ceremony* : Counseling of pregnant woman at PHC in last trimester)	0.00	0.00	0.00	0.00	0.00	Inbuilt in JSY Scheme Maternal Health programme budget
v	Block Level @ 50,000/- per block x 820 blocks (*Godhbhari ceremony:* Counseling of pregnant woman at PHC in last trimester)	0.00	0.00	0.00	0.00	0.00	
					Subtotal	**0.00**	
E.2	**Campaign 2 Family Planning (Generic)**						
i	Television / Radio	0.00	52.50	52.50	0.00	105.00	
ii	Print	0.00	22.50	22.50	0.00	45.00	
iii	Development of films, spots and campaign materials	0.00	10.00	10.00	10.00	30.00	
					Subtotal	**180.00**	
E.3	**Campaign 3 PCPNDT**						
i	Television / Radio	0.00	0.00	0.00	0.00	0.00	Inbuilt in PCPNDT programme budget (Rs 100 lacs for awareness campaign in specific districts).
ii	Print	0.00	0.00	0.00	0.00	0.00	
					Subtotal	**0.00**	
E.4	**Campaign 4 IUCD**						
i	Television / Radio	0.00	15.00	35.00	55.00	105.00	
ii	Print	0.00	15.00	15.00	15.00	45.00	
iii	Development of films, spots and campaign materials	0.00	0.00	10.00	10.00	20.00	
					Subtotal	**170.00**	
E.5	**Campaign 5 NSV**						
i	Radio	0.00	15.00	30.00	25.00	70.00	
ii	Print	0.00	25.00	0.00	25.00	50.00	
iii	Development of radio spots and campaign materials	0.00	10.00	0.00	0.00	10.00	
					Subtotal	**130.00**	
E.6	**Campaign 6 Child Health (BSPM) & Routine Immunization**						
i	Television / Radio	0.00	50.00	50.00	50.00	150.00	
ii	Print	0.00	20.00	20.00	20.00	60.00	
iii	Child to community approach for RI for community mobilization (Pilot in one district)	0.00	5.00	5.00	5.00	15.00	
iv	Development of films, spots and campaign materials	0.00	10.00	10.00	10.00	30.00	
					Subtotal	**255.00**	
E.7	**Radio Drama Series for General Public**	0.00	30.00	30.00	0.00	60.00	
					Subtotal	**60.00**	
E.8	**Campaign 7 URBAN RCH**						
i	Cable strip ad @ 50000 x 14 cities x 2 rounds	0.00	7.00	0.00	7.00	14.00	
ii	District Level @ 1,00,000/- per district x 14 cities selected under Urban PIP (Pamphlets printing, referral cards, local press ads / radio)	0.00	14.00	0.00	0.00	14.00	

	Activity	Qtr 1 (Apr - Jun)	Qtr 2 (Jul - Sep)	Qtr 3 (Oct - Dec)	Qtr 4 (Jan - Mar)	Total	Remarks
					Subtotal	**28.00**	
F.	**POS / Print media**						
i	Jobaids and IPC Tools CCSP district ASHA Flipbook @ Rs 150 x 39000 ASHAs	0.00	0.00	0.00	0.00	0.00	Inbuilt in CCSP programme budget for 19 districts
ii	ASHA IPC home visit tool for MNH @ Rs 20 x 150000	0.00	0.00	30.00	0.00	30.00	
iii	Asha Newsletter @ Rs 12 x 150000	0.00	0.00	0.00	0.00	0.00	Inbuilt in ASHA Scheme budget
iv	Counselling tools for Family Welfare Counsellors @ Rs 500 x 600	0.00	3.00	0.00	0.00	3.00	
v	Foam Posters (20"x30")**IUCD** @ 18 x 60000 x 2 times (at trained sites)	0.00	0.00	21.60	0.00	21.60	
vi	Foam Posters (20"x30")**MNH** @ 18 x 40000 x 4 numbers (BF / NBC / JSY / PNC)	0.00	28.80	0.00	0.00	28.80	
vii	Foam Posters (20"x30")**FP(Basket of choice)** @ 18 x 160000 x 1 time (for distribution to ASHAs/ FWCs / Sub centers)	0.00	28.80	0.00	0.00	28.80	
viii	Paper Posters (20"x30") Campaign **BSPM (CH)** @Rs 4 x 170000 x 2 rounds	0.00	6.80	0.00	6.80	13.60	
ix	Foam Posters - Campaign CCSP **(NBC & CH)** @ Rs 18 x 60000 (For placement at ASHA's homes)	0.00	10.80	0.00	0.00	10.80	
x	Foam Posters - **School Health Programme** @ Rs 18 x 48000 schools	0.00	8.64	0.00	0.00	8.64	
xi	Paper Posters **NSV** @ Rs 4 x 200000	0.00	8.00	0.00	0.00	8.00	
xii	VHSC advocacy book for Pradhans & ASHAs including information on **VHND/ RI & NSV** and other programmes @Rs 15 x 150000	0.00	0.00	22.50	0.00	22.50	
xiii	Foam Posters **Standard treatment & protocol charts for NBC, growth & EmOC** in ANC areas, LR & PNC wards @Rs18 x 5000 x 4 types	0.00	1.80	0.00	1.80	3.60	
xiv	One fold Pamphlets **FP guide Spacing / Limiting** @ 1.00 x 30 leaflets x 150000 (ASHAs + extra)	0.00	45.00	0.00	0.00	45.00	
xv	One fold Pamphlets **Maternal guide MNH** @ 1.00 x 30 leaflets x 150000 (ASHAs + extra)	0.00	45.00	0.00	0.00	45.00	
xvi	Single leaf Handbill **VHND (RI)** @0.30p	0.00	19.80	19.80	19.80	59.40	Inbuilt in State innovation activity budget Part C for Routine Immunization (Incentive based Scheme)
xvii	BCC Immunization cards	0.00	0.00	0.00	0.00	0.00	
xviii	Single leaf Handbill **Saloni Swasthya Kishori Yojna** @0.30p x 2 times x 150 students x 8000 schools	3.60	0.00	3.60	0.00	7.20	
xix	Single leaf Handbill **School Health Programme** @0.30p x 1 time x 170 students x 48000 schools	24.48	0.00	0.00	0.00	24.48	Inbuilt in School Health Programme budget
xx	Bal Swasth card / referral slip x 150 children x 48000 schools	0.00	0.00	0.00	0.00	0.00	Inbuilt in School Health Programme budget
xxi	One fold Pamphlet **NSV** @ Rs1.00 x 5,00,000 x 2 rounds	5.00	0.00	5.00	0.00	10.00	
xxii	Single leaf Handbill **IUCD** @ Rs 30p x 30 leaflets x 150,000 ASHAs + extra	0.00	0.00	13.50	0.00	13.50	

	Activity	Qtr 1 (Apr - Jun)	Qtr 2 (Jul - Sep)	Qtr 3 (Oct - Dec)	Qtr 4 (Jan - Mar)	Total	Remarks
xxiii	Saloni Teachers guide @ Rs15 x 19000 (18500 teachers + extra)	0.00	0.00	0.00	0.00	0.00	Inbuilt in Saloni Swasthya Kishori Yojna Programme budget
xxiv	Saloni Diary for adolescent girls@ Rs15 x 1265000 (1252890 girls + extra)	0.00	0.00	0.00	0.00	0.00	Inbuilt in Saloni Swasthya Kishori Yojna Programme budget
					Subtotal	**383.92**	
G.	**Special Celebrations (Days/ Week)**						
	Breast Feeding week @ LS (50 lacs) **(August 1-8)**	0.00	50.00	0.00	0.00	50.00	
ii	World Population Day@ 50,000 x 71 districts **(July 11)**	0.00	35.50	0.00	0.00	35.50	
iii	New born care week @ 50,000 x 71 districts **(Nov 14 -21)**	0.00	0.00	35.50	0.00	35.50	
iv	Safe motherhood day @ 50,000 x 71 districts **(April 13)**	35.50	0.00	0.00	0.00	35.50	
v	Republic Day **(January 26)**	0.00	0.00	0.00	1.50	1.50	
vi	Others	0.00	0.00	0.00	25.00	25.00	
					Subtotal	**183.00**	
9	**Capacity Building and training of manpower**						
i	Capacity building of staff	0.00	0.00	0.00	0.00	0.00	12 day training(7+5) module for Programme Managers / Service Providers budgeted under Training Component
ii	Internal workshops	0.00	0.00	0.00	0.00	0.00	
iii	Specialized training	0.00	0.00	0.00	0.00	0.00	
					Subtotal	**0.00**	
10	**Monitoring and Evaluation**						
i	Midterm monitoring	0.00	0.00	25.00	0.00	25.00	
	Quarterwise Subtotals	**68.58**	**1,707.82**	**1,189.16**	**541.32**	**3,486.88**	

Outdoor Media (Detailed Breakup)						
Wall Paintings						
1 wall painting (RI) at 20621 Sub centers size 3'x5' @ Rs 7 psf	0.00	0.00	0.00	21.65	21.65	RI/VHND
6 wall paintings each at 134 District Hospital size 10'x10' @ Rs 7 psf	0.00	0.00	5.63	0.00	5.63	JSY / FP / IUCD / NSV / RI / PCPNDT
SHP: 3 Wall paintings School Health Programme 3'x5' x 48,000 SHP schools @ Rs 7 psf	0.00	0.00	151.20	0.00	151.20	Health Behaviours
SSKY: 3 wall paintings Saloni 3'x5' at 8000 schools @ Rs 7 psf	0.00	0.00	25.20	0.00	25.20	Nutrition/Hygiene Behaviour
WALL Paintings Sub Total	**0.00**	**0.00**	**182.03**	**21.65**	**203.68**	
Banners						
VHND/RI Flex Banners (Fixed banners: 30000 x 5'x3' x Rs 15.50; Folding Banners 50000 x 4'x2.5' x Rs 15.50)	0.00	0.00	150.00	0.00	150.00	
NSV Banners (5' x 3') @ Rs 15.50 psf 4 banners each x1750 facilities	0.00	8.14	0.00	8.14	16.28	
BANNERS Sub Total	**0.00**	**8.14**	**150.00**	**8.14**	**166.28**	
Hoardings / Signages						
CCSP Hoardings / Signages @ Rs 18100 x 1000	0.00	0.00	181.00	0.00	181.00	
RI Hoardings@Rs 18100 x 3000 (District level hospitals; Tehsils, Blocks, railway stations, bus-stands)	0.00	543.00	0.00	0.00	543.00	RI Hoardings@Rs 18100 x 3000 (District level hospitals; Tehsils, Blocks, railway stations, bus-stands)
Glow sign boards for NSV sites (5' x 3') Rs 215 psf x100 trained providers	0.00	0.00	1.61	1.61	3.23	
Glowsign Sign boards/ Site information boards / print material for 131 UHP@ Rs 15000 x 131 UHP per year	0.00	0.00	0.00	0.00	0.00	Inbuilt into Urban RCH budget from RCH Flexipool
1 hoarding / signage per 69 Urban Health Posts (UHP) @ Rs 18100/- per hoarding	0.00	12.49	0.00	0.00	12.49	
HOARDINGS Subtotal	**0.00**	**555.49**	**182.61**	**1.61**	**739.71**	
Notice Board						
Community Notice Board(Black board with painting & installation) to be placed at AWW center 5'x3' blackboard @Rs 500/- x 52,002 gram sabhas	0.00	260.01	0.00	0.00	260.01	

IEC/BEHAVIOUR CHANGE COMMUNICATION-BUDGET SUMMARY
(FMR Budget Head A.12.3)

SN	Activity	Proposed Budget in Lacs	Budget approved by GoI for BCC/IEC strategy
1	Setting up and development of IEC / BCC unit of the state Level	25.00	**Rs. 2000.00 lacs has been approved by GoI for this activity.** **No activitywise breakup of the approved budget has been given by the Govt. of India. Hence, it is left with the State to decide which activities are to be undertaken in the year 2010-11**
2	Formative research to identify barriers and key messages	30.00	
3	Media planning agency hiring charges	5.00	
4	Advertising Agency hiring charges	10.00	
5	Material Design & Development	15.00	
6	Media Mix		
7	Community Awareness and Mobilization activities	13.23	
8	Community Media (Folk Media)	624.06	
9	Outdoor Media	1,369.68	
10	Campaign 2 Family Planning (Generic)	180.00	
11	Campaign 4 IUCD	170.00	
12	Campaign 5 NSV	130.00	
13	Campaign 6 Child Health (BSPM) & Routine Immunization	255.00	
14	Radio Drama Series for General Public	60.00	
15	Campaign 7 URBAN RCH	28.00	
16	POS / Print media	383.92	
17	Special Celebrations (Days/ Week)	183.00	
18	Monitoring and Evaluation	25.00	
	Total	**3,506.89**	**2000.00**

IEC/BCC activities, which has been budgeted in the various programme heads.

(Rs. in lacs)

S.N.	FMR Budget Head	Activity detail	Approved Budget	Remarks
1.	A.12.3.1	BCC/IEC activities for Maternal Health	55.10	IEC activities for 820 RCH camps
2.	A.12.3.3	BCC/IEC activities for Family Planning	51.33	Printing of cards for 73 District Hospitals, 438 PHCs and 470 BPHCs
3.	A.12.3.4	BCC/IEC activities for ARSH	27.60	Wall paintings and leaflets for ARSH activities
4.	A.12.4	Other activities	129.63	IEC activities for PC and PNDT
Total			**263.66**	

S.No	FMR S.No	Activities	Total (in Rs. Lacs)
1	**A.12**	**BCC/IEC**	
2	**A12.3**	**Implementation of BCC/IEC strategy**	2000.00
3	**A.12.3.1**	**BCC/IEC activities for MH**	55.10
4	**A.12.3.3**	**BCC/IEC activities for FP**	51.33
5	**A.12.3.4**	**BCC/IEC activities for ARSH**	27.60
6	**A.12.4**	**Other activities (PCPNDT)**	129.63
		SUB TOTAL BCC/IEC	**2263.66**

9. PUBLIC PRIVATE PARTNERSHIPS (PPP) / INNOVATIONS AND NGO

9.1 PUBLIC PRIVATE PARTNERSHIPS (PPP)

The State has been innovating with various Public Private Partnerships for improving access to quality health services. Some of these initiatives along with status are:

- **Saubhagyawati Yojana:** A conditional cash transfer scheme called Soubhagyavati Yojana was initiated in the second quarter of 2008-09 and was fully implemented in the year 2009-10. In this scheme, service providers in the private sector were accredited using guidelines. Those facilities which met these criteria were included under the scheme and were reimbursed for services provided to BPL families for delivery, pre and post natal visit, and delivery related complications. In addition, BPL beneficiaries going to these facilities could also avail JSY benefits. This scheme provided an opportunity to pregnant women and their families to access institutional delivery at a facility of their choice and at the same time share the case load between the public and private sector. At present 128 (December 09) Pvt Nursing Homes are involved in 71 districts. Each Nursing Home is being given an amount of 1.85 lacs for conducting 100 normal as well as complicated deliveries of BPL clients. However, with the withdrawal of JSY benefits in the private sector by GoI, the number of deliveries in the private sector has reduced. GoUP has requested GoI to reinstate these benefits so that the utilisation of this scheme is enhanced.
-

	2008-09 (implemented for 8 months)	2009-10 (upto December 2009 9 months)
No. of Nursing Homes	158	128
Normal Delivery	12,291	5754
Cesarean Section	1,252	693
Complicated Deliveries	597	166

It is also proposed that facilities that are a part of the Social Franchising project being implemented by SIFPSA (described in next section) be included in the scheme to generate higher number of accredited facilities in a PPP mode. In the year 2010-11, these facilities are likely to increase to 50, thus increasing the total number of accredited facilities under Soubhagyawati Joyana to 178. It is assumed that all nursing homes accredited would be paid Rs. 1.85 lacs for conducting deliveries in a year as per calculations below.

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
8	Primipara Cases (@ Rs. 500/- per case for 10 cases)	5000.00
Total		**185000.00**

According to reports received, of the 178 accredited hospitals, there are 30 nursing homes that are conducting about 200 deliveries and will be requiring two instalments of the fixed amount for of Rs. 1.85 lacs each.

Sl.	Description	Amount (Rs. in lacs)
1	Reimb. of funds to private provider/facility (@ Rs. 1.85 lacs per 100 deliveries x 152 instalments)	384.80
2	Expenses towards monitoring and verification (@ Rs. 10,000/- per district for 71 districts)	7.10
Total		**391.90**

Sl.	Description	Amount (Rs. in lacs)
1	PPP for Promoting Institutional Deliveries (Saubhagyawati Yojana)	391.90
Grand Total		**391.90**

- **Mother NGO scheme:** Under the Mother NGO Scheme operationalised by Government of India, 35 MNGOs have been selected in the State, of which 8 MNOs have 65 FNGOs. These NGOs were selected by GoI. Selection for another 27 MNGOs is pending. In addition, SIFPSA was selected as the Regional Resource Centre (RRC) to provide technical support to these NGOs in fulfilling their objectives. The objectives of this programme are to address gaps in information or RCH services; build institutional capacities; and generate advocacy and awareness. However, there is a need to provide stimulus to this network and operationalise it. It is proposed to select all NGOs, identify gaps requiring their support in the field and support this network in implementation. Coordination with GoI will be initiated towards this objective.

- **Voucher System in KAVAL towns:** A voucher system was operationalised in Agra and Kanpur Nagar by SIFPSA using PPP models. These vouchers were made available to pregnant women from vulnerable families so that they could access ante natal care, delivery services, post natal care, family planning services and RTI/ STI services from accredited private providers. Rates were pre negotiated with these private providers and contracts were signed with them. These private providers were then reimbursed by a Voucher Management Unit for the services provided, verifiable by the vouchers received. Based on the success of the voucher system in the two areas, the voucher system in now being scaled up to urban slums of all KAVAL towns, namely, Kanpur, Agra, Varanasi, Allahabad and Lucknow. However, financial support for this scheme is available through SIFPSA and USAID and no financial assistance is being requested.
- **Social Franchising in 21 districts:** The franchising model is being used in the State to supplement the services being provided through the public health systems. This network of facilities, branded as Merrygold Health Network, has nearly 200 facilities in 21 districts and a referral network of 5000 community based members providing reproductive and child health services. The facilities provide services at fixed prices, inclusive of medicines and hospital stay, which are more than 50 percent less than market prices. Linking this network with the State level schemes makes it possible for vulnerable populations to access quality health care. A key feature of this network is that it is self sustaining after an initial set up phase. Since this project is being funded by USAID through SIFPSA, no additional funds are required
- **Involvement of Private Sector for Management of Health Systems:** Department of Health and Family Welfare, Government of Uttar Pradesh (GoUP) embarked upon involving the private sector in preventive, promotive and curative health care with the objective of drawing upon the management acumen and efficiencies of the private sector, and also to augment infrastructure and resources. During 2008-09, Public Private Partnership (PPP) initiatives at the primary, secondary and tertiary level were explored. GoUP had engaged transaction advisors empanelled by Department of Economic Affairs, Government of India to assist the health department in working out the most effective arrangements for inviting private sector participation for the proposed PPP projects and in managing all the processes leading up to the selection and contracting with the selected private partners. The proposed models along with the selected Transaction Advisors were:
    - Establishment and management of Mobile Medical Units (MMU) and Emergency Transportation by PriceWaterhouse Coopers (PWC)
    - Management of Urban Health Centres by PriceWaterhouse Coopers (PWC)
    - Management and expansion of Primary Health Centres, Community Health Centres and District Hospitals by EPOS Health India (EPOS)
    - Management of Diagnostic Services at regional level and below by Grant Thornton (GT)
    - Establishment of Super Speciality Hospitals

  A Committee headed by the Industrial Development and Establishment Commissioner was established which included Principal Secretary – Finance, Principal Secretary - Law and Principal Secretary – Medical Health and FW as core members. Transaction Advisors selected for developing framework and activities

and timelines. It was decided at a later date that MMU initiative would be undertaken by a tender process rather than by PPP (detailed in Mission Flexipool).

Design of the Emergency Medical Referral Transport system has been finalised, and will be proposed in PIP of 2011-12.

The framework for management and expansion of PHCs, CHCs and DHs has been approved by the Honorable Cabinet. Four hospitals, viz., Allahabad, Kanpur, Firozabad and Basti will be contracted to private providers for the next 33 years. Eight CHCs, 30 PHCs and 219 associated Sub Centres will also be operated by the private provider. Framework for Regional Diagnostic Centre is almost final and operatinalised this year.

- **PPP Initiatives at Facility Level:** Guidelines were developed for Hospital Waste Management in Govt. Hospitals on turn-key basis and outsourcing of cleaning, upkeep and laundry services at district hospitals. Facilities are taking up initiatives at their level.
- **Accreditation for Family Planning in the Private sector:** As detailed in the section of FP, private sector involvement in sterilisation and IUDs is being reemphasised to improve FP services uptake.

Budget Summary (PPP) 2009-10

Sl.	Description	Amount (Rs. in lacs)
1	PPP for Promoting Institutional Deliveries (Saubhagyawati Yojana)	391.90
Grand Total		**391.90**

9.2 INNOVATIONS

9.2.1 Innovations in Maternal Health: Family Friendly Hospital

The FFHI initiative detailed out in the Maternal Health section is an innovation for improving quality of health services. The following activities and budgets have been included in the Innovations section:

FMR No.	ACTIVITY	NO. OF UNITS	RATE PER UNIT	FREQ.	TOTAL (Rs. IN LACS)
A.8.4	**Family Friendly Hospital Initiative**				
	State level orientation (200 participants @ Rs. 2000 each)	200	2000	1	4.00
	State level function for certification	1	500000	1	5.00
	Funds for strengthening facility as FFH				

FMR No.	ACTIVITY	NO. OF UNITS	RATE PER UNIT	FREQ.	TOTAL (Rs. IN LACS)
	Renovation and strengthening of OPD with proper signage and glow signs	30	200000	1	60.00
	Facility of safe drinking water (Aquaguard with water cooler)	30	50000	1	15.00
	Furniture, benches, fans, coolers, TV/ DVD player for patients in OPD, indoor area	30	150000	1	45.00
	Repair and renovation of toilets with geysers (3 nos.)	30	100000	1	30.00
	Sub Total				**159.00**

9.2.2 Interventions for School going Adolescent Girls: Saloni Swasth Kishori Yojana

Adolescent health interventions under the name *Saloni Swasth Kishori Yojana,* have been launched for school going adolescent girls. The interventions include family life education, weekly IFA supplementation and biannual deworming. The component for school going adolescent girls is covering around 8000 girl's junior high schools (10 schools per block).

A training programme is being included under the scheme, where two teachers from each school wilL be trained at Block level, or which teachers guidelines have been developed with support from ITAP which also include themes for organizing Saloni Sabha at the schools. A Saloni Diary has also been developed to be maintained by each adolescent girl in which she has to keep record of herself, her likes and dislikes, achievements and future plans, dietary habits etc. The topics of Saloni Diary are in concurrence with the chapters of teacher's guidelines. The budget for training and printing of training material is being given in detail.

Under the programme the Medical teams, comprising of AYUSH doctors, HV/ ANM will visit each school every six months to provide IFA, deworming tablets, counselling on nutrition and personal hygiene. It is proposed to continue the scheme, the details for which are proposed in the tables below:

Printing Cost of Teacher's Training Manual and Saloni Diary							
	Number of Teachers Training Manuals Required	Unit Cost	Cost of Required Manuals (A) (Rs.)	Number of Saloni Diaries Required	Unit Cost	Cost of Required Diaries (B) (Rs.)	Total Cost (A+B) (Rs. In lacs)
State Level	240	15	3600	240	15	3600	**0.07**
Dist Level	1650	15	24750	1650	15	24750	**0.50**
Block Level	16000	15	240000	16000	15	240000	**4.80**
School Level	Nil		0	1234500	15	18517500	**185.18**
	17890		268350	1252390		18785850	**190.54**

Cost of Training Programme												
	State Level - (Trainees ACMO-71,DivPM17,DPMs-71,DCMs-71)	Refreshment to the trainees /day	Refreshment to the trainees /batch size of 40 (A)	Honourarium to the trainers//day	Number of Trainers /batch	Honourarium to the trainers/batch (B)	Support Staff Cost/day (C)	Contingency (D)	Total cost of Training of 1 Batch (A+B+C+D)	Number of trainees	Approx no. of required Batches	Cost of the required number of Batches
I	1 day training	100	4000	500	4	2000	200	0	6200	230	6	37,200
	District Level (Trainees MO BPHC - 820,HEO/BPM -820)	TA/DA and Refreshment to the trainees /day(100 TA+50 Refreshment)	TA/DA and Refreshment to the trainees for the batch of 40	Honourarium to the trainers/day (250 Honorarium+50 Refreshment)	Number of Trainers /batch	Honourarium to the trainers/batch (B)	Support Staff Cost/day (C)	Contingency (D)	Total cost of Training of 1 Batch (A+B+C+D)	Number of trainees	Approx no. of required Batches	Cost of the required number of Batches
II	2 day training	150	12000	300	2	1200	0	1000	14200	1640	41	5,82,200
	Block Level (Trainees - saloni School Teachers, 2Teachers/8000schools)	TA/DA and Refreshment to the trainees /day(75 TA+50 Refreshment)	TA/DA and Refreshment to the trainees for the batch of 40	Honourarium to the trainers/day (200 Honorarium+50 Refreshment)	Number of Trainers /batch	Honourarium to the trainers/batch (B)	Support Staff Cost/day (C)	Contingency (D)	Total cost of Training of 1 Batch (A+B+C+D)	Number of trainees	Approx no. of required Batches	Cost of the required number of Batches
III	2 day training	125	10000	250	2	1000	0	200	11200	16000	400	44,80,000
	Total cost of Deployment of Trainings (I+II+III)											**50,99,400**

The total budget for adolescent health proposed for 2010-11 is Rs. 241.536 lacs only

SUMMARY BUDGET FOR PPP/INNOVATIONS/ NGO FOR 2010-11

SN	FMR S.No	Activities	No. of Units	Total (in Rs. Lacs)
1	**A 8.1**	PCPNDT (details incl. in Chapt.4)		50.53
	A.8.2	Soubhagyawati (*Reimbursement of funds for 208 private provider/ facility @185000) and Rs. 7.1 lakhs for monitoring*	208 facilities + 7.1 lakhs for monitoring	391.90
	A.8.4	Family Friendly Hospital Initiative		159.00
2	**A.8.4**	Adolescent Health (Teacher's manual and Saloni diaries) **TOTAL FOR INNOVATION/PPP/NGO**		190.54 791.97

10. HUMAN RESOURCES AND INFRASTRUCTURE

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. An exercise was undertaken to map the availability of specialists and service providers across health facilities. The specialists were then rationalised and redeployed to make the maximum number of facilities functional as per the IPHS norms. It is proposed to hire contractual staff to meet the gaps in human resources at all levels. Consultants and specialists will be recruited through the District Health Societies with the Commissioner and Additional Director also being responsible to ensure staffing. Positions of Multi Purpose Workeres (MPWs) – Male are being hired by the Directorate at state level through an agency. However, recruitment for positions of ANMs/ Paramedics/ Staff Nurses/ Class III/ Class IV/ AYUSH are being recruited through the DHS, which in turn may recruit from the open market or through an agency. Skilled personnel from outside the State are also being considered to meet the shortfall. At the State level for SPMU, personnel will be deputed to suitable positions and additional staff hired through open market or through recruitment agencies.

HUMAN RESOURCES

10.1 ANMs for Sub Centres

At present 685 ANMs are working on contract, apart from this there still exists a vacancy for 1315 ANMs. As per NRHM mandate, every sub centre should have two ANMs, so that one ANM does the delivery work at the Sub centre and the other conducts the outreach activities. There is a clause from GoI that the number of second ANMs allowed will be same as that of male workers being paid by State budget. Presently, there are about 2054 male workers working in the State and another 473 are under training which will be completed by March 2010. Accordingly, budgetary provision for hiring 2500 ANMs (existing, as well as, additional) on contract is being made.

Budgetary requirement

Sl.	Post	No. Proposed to be deployed	Rate	Amount (Rs. In lacs)
1	ANMs	2500	Rs.9,000/- pm	2700.00
Total				**2700.00**

10.2 Human Resource Requirement for 24*7 Units

As already mentioned in the section on 'Maternal Health', it is proposed to deploy MBBS doctors at the Block PHCs for implementation of NRHM interventions.

Sl.	Position	No. Proposed to be Deployed	Honoraria per month (Rs.)	Annual Expense (Rs. in lacs)
1	ISM lady Doctors at 331 non FRU CHCs+470 BPHCs+100 APHCs	901	24,000/- pm	Mission Flexipool
2	Staff Nurse @ 1 per unit**	720 (BPHC/APHC)	15,000/- pm	864.00
Total				**864.00**

10.3 Human Resource Requirement for CHCs

Sl.	Position	No. Proposed to be Deployed	Honoraria per month (Rs.)	Est. Annual Expense (Rs. in lacs)
1	MBBS Doctors (preferably LMO) at non-FRU CHCs	200	30,000/- pm	720.00
2	Specialists at FRU CHCs (MD, MS, MDS)	180	Rs. 40,000 pm	864.00
2	Specialists at FRU CHCs** (Diploma Holder/ BDS)	180	Rs 35,000 pm/ Rs. 30,000 pm	567.00
3	Specialist on call at CHC	5000 in year	Rs. 1,000 call	50.00
	Other Staff			
4	Staff Nurses 1 per non FRU CHC	331	Rs. 15,000 pm	595.80
5	Staff Nurses 2 per FRU CHC	214	Rs. 15,000 pm	385.20
6	Family welfare Counsellors at FRU CHCs	107	Rs.9,000pm	115.56
7	Laboratory Technicians/Optometrist/ Physiotherapist etc	438	Rs 9,000 pm	473.04
Total				**3770.60**

** BDS Doctors may be deployed at FRUs, however, in such a case, payment will be made @ Rs.30,000/- p.m.*

****** calculation made for 9 months

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.

10.4 Human Resource Requirement for District Hospitals

Sl.	Position	No. Proposed to be Deployed	Monthly Honoraria/ Rate (Rs.)	Est. Annual Expense (Rs. In lacs)
1	Specialists at DMH* (MD,MS,MCH,DM, MDS, etc)	122	Rs.40,000/- per month	439.20
2.	Specialists (Diploma Holders/ BDS) at DMH*	122	Rs. 35,000 per month	384.30
3	Specialists on call basis (Orthopaedician, Ophthalmologist, Urologist, Cardiologist, Plastic Surgeon, etc) @ avg. 100 calls per yr for Dist. Male Hosp. and Comb. Hosp.	10,000 calls	Rs.1000/- per call	100.00
	Other Staff			
4	MBBS/ DGO/ MS Lady Doctors for DWH & DCH @ 2 per unit	146	Rs.30,000/- pm	394.20
5	Anaesthetist/ Paediatrician/Radiologist/pathologist for DWH&DCH @2/unit	146	Rs.30,000/- pm	394.20
6	Family welfare Counsellors at DWH/DCH	73	Rs.9000/-pm	78.84
7	Staff Nurses at all District Hospitals @ 3 per hospital	402	Rs.15,000/- pm	723.60
8	Paramedic Staff (LTs, X-Ray Tech., Optometrist, ECG Tech. Dental hygienist, etc.)	146	Rs.9,000/- pm	157.68
9	Data Assistant (All DHs)	134	Rs.8000/- pm	128.64
Total				**3807.16**

10.5 Deployment of Family Welfare Counsellors at District Hospitals and CHCs

As a strategy to promote post partum contraception at the district level, it is proposed to position Family Welfare Counsellors (FWCs) at District Women Hospitals and Combined Hospitals where deliveries are taking place. These FWCs would counsel eligible mothers for adopting sterilization or IUD and would also promote colostrum feeding, early initiation & exclusive breastfeeding. During 2009 – 2010 provision of one Family Planning Counsellor per District Women Hospital and Combined Hospitals totalling to 73 positions was made in the PIP. Retired trained ANMs or Lady Health Visitors or Staff Nurses were eligible as FWCs. But as per CMOs report, it was difficult to get candidates of the proposed qualification. Hence this year it is proposed that candidates with a graduation degree in MSW/Post graduate degree Social Sciences or Pschycology or MA Sociology, may also be considered for the position.

It is now proposed to make a FWC available at 180 FRUs, in the first phase; in view of large number of institutional deliveries taking place at CHCs due to the JSY Scheme. This provides an opportunity to reach all the mothers coming to the facility with information about family planning options available, addressing their concerns about adoption of a family planning method and follow up.

The counsellors would be paid fixed honoraria of Rs.9000/- and their performance will be judged on the basis of number of acceptors of family planning methods in the particular facility. A budgetary provision @ Rs.9, 000/- per month per Counsellor is proposed for total of 180 FWCs (53 DWHs + 20 CHs + 107 CHCs).

Accordingly, an amount of Rs.194.40 lacs will be required towards salary of the counsellors for the year 2010-11.

10.6 Payment to ASHAs for Programme Implementation

After completion of 10 days training ASHAs are visiting the families according to birth weight of the baby. If the newborn weighs < 2.5 kgs, they visit on day 1st, 3rd, 7th, 14th, 21st and 28th day and fill up the format provided for the purpose. If the baby weighs ≥ 2.5 kgs, the visit is proposed on day 1st, 3rd and 7th day of the child birth. During the visit they have to counsel the mother and the family regarding exclusive breastfeeding, keeping the baby warm and infection free. Each ASHA is paid Rs. 100/- for conducting 6 visits to each Low Birth Weight (LBW) newborn and Rs. 50/- for 3 visits to each normal weight newborns. It is estimated that on an average each ASHA would be required to visit 9 LBWs and about 21 normal infants in a year. Accordingly, she would be able to earn an amount of Rs.2,000/- (Rs.900/- for visits to LBW newborns and Rs. 1100/- for visits to normal infants). For 60,000 (48,000 for 1st/2nd phase & 12,000 from new districts) ASHAs who will be trained by 2010-11, **an amount of Rs. 1200.00 lacs will be required as incentive. GOI has not given the approval , however request has been send to GOI for reconsideration.**

10.7 Human Resources and Operational Expenses to Operationalise Seven Sick New Born Care Units (SNCUs)

For the seven Sick New Born Care Units to be operationalised in Lalitpur, Lucknow, Shahjahanpur, Aligarh, Pratapgarh, Saharanpur and Azamgarh, it is expected that recruitment and training will be completed and the units fully functional by April 2010.

Rupees 20 lacs per unit was demanded and approved during the year 2009-10 which has been utilized only partially due to late recruitments and functionality of the units. It is expected that during the year 2010-11, these units will be fully functional and an amount of Rs. 25.00 lacs would be required to support the human resource (3 Pediatrician/trained doctors and 6 staff nurses) requirement and recurring expenses towards medicines, drugs, etc. for each such units.

Further SNCU Lalitpur being fully functional and catering to a good workload has demanded for recruiting 6 more Staff Nurses. Hence it is proposed that additional Staff Nurses may be deployed as per work load.

Thus total budget of Rs.175.00 lacs would be required towards operational expenses for 7 units.

Budget Summary (Human Resources) 2010 – 11

Sl.	Description	Annual Amount (Rs. in lacs)
1	ANMs for Sub-Centres	2700.00
2	Human Resource Requirement for Block PHCs	864.00
3	Human Resource for CHCs	3770.60
4	Family Welfare Counselors at DHs and CHCs	194.40
5	Human Resource for District Hospitals	3807.16
6	Human Resources and Operational Expenses for Seven SNCUs	175.00
Grand Total		**11511.16**

*Not approved as yet as per RoP, sent again for reconsideration

INFRASTRUCTURE

Infrastructure has been planned based on categorisation of facilities as difficult, most difficult and inaccessible. While complete lists of functional FRUs and health facilities for each district is attached as Annexure, GoI has suggested a mapping of facilities at various levels with number of beds and staffing at each facility. This exercise is time consuming and information is presently being collected as per the formats from GoI and will be shared soon.

Other activities for strengthening infrastructure for RCH programme related components are as below:

10.8 Establishment of Sick New Born Care Units (SNCU)

It is proposed in the Child Health section to establish one SNCU in each division, especially in those where there is no Medical College. These SNCUs will be established in Banda, Faizabad, Basti, Moradabad and Mirzapur in the Yr.2010-12. Based on previous experience an amount of Rs.30.00 lac is budgeted for each SNCU. **Hence an amount of**

Rs. 150.00 lac is being proposed for renovation/ construction/civil works in these 5 designated DWH for SNCU. The support regarding equipment installation will be taken from UNICEF as before.

10.9 Rent of Sub Centres

There are 10,674 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 @ Rs. 250/- per month for 10,674 Sub Centres, amounting to Rs.320.22 lacs, is being made for the year 2010-11.** Additionally, Rs.250/- p.m. would be utilized from untied grant at Sub Centre, in case a proper (minimum two rooms) rented building is available and can be used for providing better services including deliveries.

SUMMARY BUDGET FOR HR AND INFRASTRUCTURE FOR 2010-11

S.No	FMR No.	Activity	No. of Units	Rate per unit (in Rs.)	Freq	Total (in Rs. Lacs)
	A.9	**HUMAN RESOURCES AND INFRASTRUCTURE**				
	A.9.1.1	ANMs for Sub Centres	2500	9000	12	2700.00
	A.9.1.2	Laboratory Technicians at District Hospitals	438	9000	12	473.04
	A.9.1.3	Staff Nurses (470 @BPHC, 331@ non FRU CHCs, 214@107 FRU CHCs and 402 @134 DHs)	1417	15000	12	2550.60
	A.9.1.4	Doctors and Specialists 470 MBBS @ Rs. 30000 pm at BPHC, 100 Specialist (MD/MS/BDS) @Rs 40000 pm at CHC, 150 Specialist (Diploma Holder/ BDS) @Rs 35000 pm at CHC, Specialist on call at CHC for total 5000 visits @Rs. 2000 per visit, 50 Specialist (MD/MS/BDS) @Rs 40000 pm at DH, 100 Specialist (Diploma Holder/ BDS) @Rs 35000 pm at DH, Specialist on call at DH for total 10000 visits @Rs. 2000 per visit, 73 MBBS/DGO/MS@ Rs. 30000 pm				**4024.80**
	A.9.1.5	Other contractual staff (146 Paramedic Staff for DHs @Rs. 9000 pm, 134 Data Assistants at DHs @Rs. 8000 pm, 180 Family Welfare Counsellors at DHs and CHCs @ Rs. 9000 pm)				480.72
	A. 9.1.6	Renovation/ construction of 5 new SNCUs	5	3000000	1	150.00
		SUB TOTAL FOR HR AND INFRASRUCTURE				**10379.16**

11. Institutional strengthening

Strengthening of institutions at various levels is being proposed as below:-

11.1 Operational Expenses of Drug Warehouses at District Level

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. An amount of Rs. 118.56 lacs was proposed and approved in the PIP for the year 2008-09 and 2009-10. The expenses will continue to be met from NRHM funds; accordingly the following budgetary requirement is proposed.

S.No.	Item	Unit cost (Rs in lacs)	Quantity	Total cost (Rs in lacs)
1	Contractual Staff	2.94	53	155.82
2	Contingent Expenditure	2.00	53	106.00
Total				**261.82**

The budgetory support has been provided under Mission Flexi pool (FMR B.21)

11.2 Strengthening Logistic Management

This activity had been proposed for the year 2009-2010. However, since it could not be implemented in the previous financial year, it is being proposed for the year 2010-2011. 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.

At each warehouse an Accountant, Computer Operator, Folk Lift Operator cum Mechanic, Fourth Class/Loader, Generator Operator cum Electrician, Security staff and class-IV staff will be deployed. The budget details are as under:

Sl.	Warehouse	Elect. Charges	Telephone Charges	POL for DG Set	Stationery	Contin-gencies	Salary to Cont. Staff *	Total (Rs. In lacs)
1	State WH (LMC)	130000	18000	10000	30000	200000	633672	**10.22**
2	Agra	110000	10000	9000	15000	200000	571788	**9.16**
3	Allahabad	110000	10000	9000	15000	200000	571788	**9.16**
4	Azamgarh	110000	10000	9000	15000	200000	571788	**9.16**
5	Bareilly	110000	10000	9000	15000	200000	571788	**9.16**
6	Banda	110000	10000	9000	15000	200000	571788	**9.16**
7	Gorakhpur	110000	10000	9000	15000	200000	571788	**9.16**
8	Faizabad	110000	10000	9000	15000	200000	571788	**9.16**

Sl.	Warehouse	Elect. Charges	Telephone Charges	POL for DG Set	Stationery	Contin-gencies	Salary to Cont. Staff *	Total (Rs. In lacs)
9	Kanpur	110000	10000	9000	15000	200000	571788	**9.16**
10	Lucknow	110000	10000	9000	15000	200000	571788	**9.16**
11	Meerut	110000	10000	9000	15000	200000	571788	**9.16**
12	Varanasi	110000	10000	9000	15000	200000	571788	**9.16**
Total		**1340000**	**128000**	**109000**	**195000**	**2400000**	**6203329**	**110.98**
Renovation of LMC Road								**9.77**
Grand Total								**120.75**

**** Contractual Staff***

Sl.	Position	Basis of Calculation	Amount (Rs.)
1	Accountant	12 persons x Rs. 6000/- x 12 months	864000/-
2	Computer Operator	12 persons x Rs. 6000/- x 12 months	864000/-
3	Folk Lift Operator cum Mechanic	12 persons x Rs. 5000/- x 12 months	720000/-
4	Fourth Class/Loader	12 persons x Rs. 5000/- x 12 months	720000/-
5	Generator Oper. Cum Electrician	12 persons x Rs. 3000/- x 12 months	432000/-
6	Sweeper	12 persons x Rs. 3000/- x 12 months	432000/-
7	Armed Guards	12 persons x Rs. 6335/- x 12 months	912240/-
8	General Guards	25 persons x Rs. 5157/- x 12 months	1547100/-
9	Gardener	12 persons x Rs. 3000/- x 12 months	432000/-

Accordingly, a total amount of Rs.120.75 lacs has been budgeted for the year 2010-2011. Further, these warehouses were constructed in 2001-02 and are in poor physical condition. Physical strengthening of these warehouses is also proposed, the funds for the same will be met from Mission Flexipool.

11.3 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 next:

Expenditure Description	No. of Locations	Amount per Location (Rs.)	Amount (Rs. In lacs)
Divisional Level (Additional Directors)	18	50,000.00	9.00
District Level (Chief Medical Officers)	71	30,000.00	21.30
Block Level – CHC/PHC (Medical Officer Incharge)	823	12,000.00	98.76
Total			**129.06**

Budget Summary (Institutional Strengthening) 2010 - 2011

Sl.	Description	Annual Amount (Rs. in lacs)
1	Strengthening Logistic Management	120.75
2	Decentralized Fund for Transportation of Supplies	129.06
Grand Total		**249.81**

TOTAL AMOUNT OF RS. 249.81 LACS IS BEING BUDGETED FOR INSTITUTIONAL STRENGTHENING UNDER LOGISTIC MANAGEMENT. GOI HAS APPROVED UNDER FMR CODE A.10.2.

SUMMARY BUDGET FOR INSTITUTIONAL STRENGTHENING FOR 2010-11

S.No	FMR No.	Activity	No. of Units	Rate per Unit (in Rs.)	Freq	Total (in Rs. Lacs)
11	**A.10**	**INSTITUTIONAL STRENGTHENING**				
	A.10.2	Logistic management & improvement				249.81
	A.10.3	Name based women and childtracking system (incl. impact assessment)				94.00
	A.10.3	Supervision of ASHAs				453.60
	A.10.3	Child Health – BSPM				42.92

	A.10.3	Monitoring of Sterilisation Services (FP)	1	2500000	1	25.00
	A.10.4	Rent for Sub Centre	250	10674	12	320.22
		Sub Total for Instl. Strengthening				**865.33**

Total budget approved for Institutional Strengthening is Rs. 865.33 lacs for the year 2010-11.

12. PROGRAMME MANAGEMENT

The State PMU for NRHM has been established. Programme Managers, designated as General Manager have been deployed. Most of the staff has been hired on contract, some have been brought on deputation and some staff is on loan basis from SIFPSA. As the State Health Resource Centre (SHRC) has not been established till date for UP, SPMU is functioning as both Secretariat to Mission Director as well as SHRC. Hence, the structure of the State PMU is designed as shown in the following page.

Proposed Staffing of Finance Cell

Sl.	Post	No.	Qualification / Source of Appointment
1	Finance Controller	1	From UP Finance and Accounts Services
2	Sr. Manager Finance	1	On deputation from UPFS/Open Market Minimum experience of 10 yrs or CA/ICWA with 10 yrs experience from open market
3	Manager Finance	3	AO or AAO with minimum 10 yrs experience in Govt or semi-govt org. or CA Inter/ICWA Inter with min. 5 yrs experience from open market
4	Accountant	3	B.Com/B.Com with computer knowledge and 10 years experience in Government or Semi Government
5	Internal Auditor	2	Accountants/Auditors with min. 10 yrs experience in govt or semi-govt org. or B.Com/CA Inter, ICWA Inter from open market
6	Data Analyst	1	Masters Degree in Statistics/Computer Science with relevant experience of min. 5-7 yrs.
7	Secretary	1	Graduate, good speed in shorthand typing. Must be proficient in computers (MS Word, Excel, Power Point, Internet etc.) with min. 5 yrs experience from open market.

Proposed Staffing of HR Cell (Admin and Programme Management)

Sl.	Post	No.	Monthly Honoraria	Qualification
2	HR Specialist	1	Rs.28,000	Senior HR professional having MBA/PGDM with specialisation in HR and experience of at least 3 years from reputed organisation
3	Data Assistant	1	Rs.17,000	BCA/ B.Sc. with computer science from open market with min. 3-5 years of experience

Proposed Staffing of IEC Cell

Sl.	Post	No.	Monthly Honoraria	Qualification
1	Technical Consultant (IEC) (Non Medical)	1	Rs. 33,000	IEC Expert having post graduate qualifications in Mass Communication having experience of preparing media plans and communication strategy with work experience of at least 5 years
2	Programme Assistant	1	Rs. 17,000	Masters Degree in related subject with relevant experience of min. 5 yrs.

Proposed Staffing for M&E Cell

Sl.	Post	No.	Monthly Honoraria	Qualification
1	Technical Consultant (M &E) (Non Medical)	1	Rs.33,000/-	PG in Statistics/Demography/Pop. Sc. with min. 5-8 yrs experience .
2	Data Analyst	1	Rs.21,000	Masters Degree in Statistics/Computer Science with relevant experience of min. 3 yrs.

Proposed Staffing for MIS Cell

Sl.	Post	No.	Monthly Honoraria	Qualification
1	Data Analyst	1	Rs. 21,000	Masters Degree in Statistics/Computer Science with relevant experience of min. 3 yrs
2	Data Assistant	2	Rs.17,000	BCA/ B.Sc. with computer science from open market with min. 3 years of experience
3	MIS Officer	3		Salary born by SIFPSA

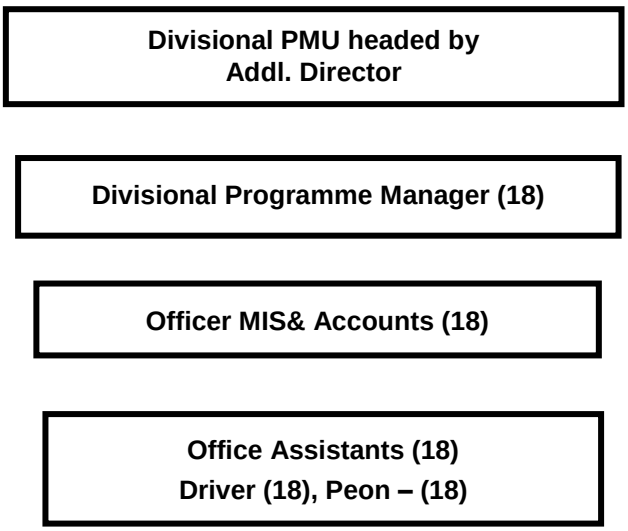
Proposed Staffing for Quality Maintenance under CCSP

Sl.	Post	No.	Monthly Honoraria	Qualification
1	Technical Consultant (Non Medical)	1	Rs.33,000/-	Master degree in social science/science/public health with min of 5-8 years experience .
2	Regional Manager	4	Rs.21,000	Master degree in social science/science/public health with min of 3-4 years experience
2	Data Analyst	1	Rs.21,000	Masters Degree in Statistics/Computer Science with relevant experience of min. 3 yrs.
3	Data Assistant	1	Rs. 17,000	BCA/ B.Sc. with computer science from open market with min. 3 years of experience

12.1.2 Divisional PMU

Divisional Programme Management Units have been established in 18 divisions. These units have been placed under the Additional Director of the Division and each unit has a Programme Manager who is assisted by an Officer responsible for MIS and accounting activities. The structure of the divisional PMU is shown below:

Structure of the Divisional PMU

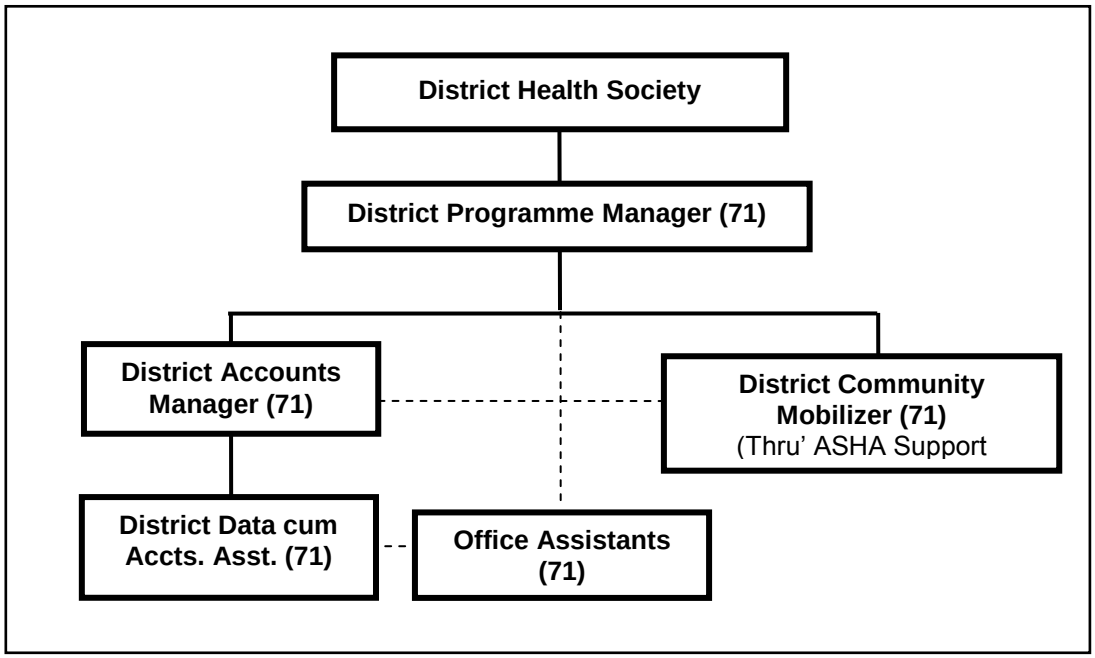


The Divisional PMUs are mentoring the District PMUs and assisting in NRHM programme implementation

12.1.3 District PMU

For management of the programme interventions at the district level, District PMUs have been established in 71 districts, the structure of which is shown below:

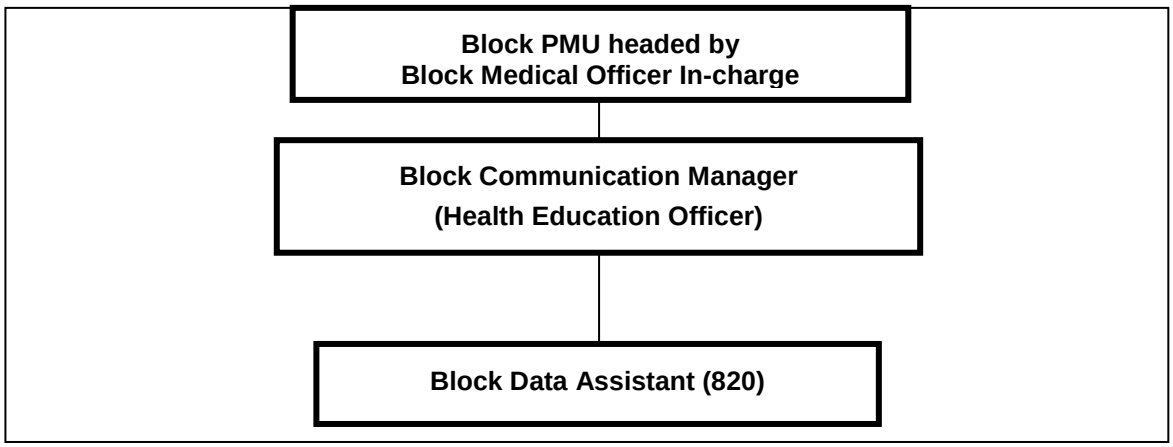
Structure of the District PMU



12.1.4 Block PMUs

At the block level, the Block MOIC would be head of the Block PMU and would be supported in his function by the Block Programme Manager/Health Education Officers, appointed by the State government, and Data Assistants hired on contract under NRHM. The block level structure is as shown below:

Structure of Block PMUs



12.2 Human Resource Plan for SIHFW/CTI

A plan to provide additional human resource to support planning, implementation and monitoring of training activities was approved under NRHM PIP for year 2009-10. A Training Management unit will be placed this year as a part of human resource plan under NRHM, this unit will work under chart society established at SIHFW which is functioning as CTI (Collaborating Training Institute) for NRHM.

Sl.	Designation	No.	Essential Qualification	Monthly Honorarium (Rs.)	Total Yearly Budget (Rs. in lacs)
1	Seniour Consultant Clinical Training	1	MBBS, PG degree preferably in Gynaecology or Paediatrics with minimum 10 years of experience	40,000	4.80
2	Seniour Consultant Public Health	1	MBBS, PG degree in Public Health with minimum 10 years experience	40,000	4.80
3	Accounts Manager	1	Graduation in Accountancy with 5 years experience in accounting	21,000	2.64
4	Data Assistant	2	BCA/ B.Sc. with computer science from open market with min. 3 years of experience	17,000	2.04
5	Support staff	2		6,500	0.78
Expenses towards recruitment and institutional overheads and travel					5.00
Total					**20.06**

12.3 Operational Expenses

a) Expenses towards honoraria and allowances to SPMU Staff

Sr. No:	Designation	Total Staff	Honoraria (Rs.)/month	Annual (in Lacs)
1	**GM (on deputation)**	**8**	**84000**	**80.64**
2	**DGM (on deputation)**	**2**	**63000**	**15.12**
3	**FC (on deputation from UPFS)**	**1**	**84000**	**10.08**
4	**Sr. Manager-Finance (on deputation from UPFS/Open Market)**	**1**	**56000**	**6.72**
5	**Manager – Finance**	**3**	**36500**	**13.14**
6	**HR Specialist**	**1**	**36500**	**4.38**
7	**Technical Consultants (non-medical)**	**6**	**33000**	**23.76**
8	**Consultant (Medical)**	**3**	**35000**	**12.6**
9	**Regional Manager**	**4**	**21000**	**10.08**
10	**Accountant**	**3**	**21000**	**7.56**
11	**Data Analyst**	**5**	**21000**	**12.60**
12	**Data Assistant**	**5**	**17000**	**10.20**

Sr. No:	Designation	Total Staff	Honoraria (Rs.)/month	Annual (in Lacs)
13	**Program Assistant**	**12**	**17000**	**24.48**
14	**Internal Auditors**	**2**	**14000**	**3.36**
15	**Secretary/ Steno Typist**	**4**	**21000**	**10.08**
16	**Office Coordinator**	**1**	**21000**	**2.52**
17	**Guard**	**3**	**4500**	**1.62**
18	**Sweeper**	**3**	**4500**	**1.62**
19	**Electrician**	**1**	**7000**	**0.84**
20	**Office Attendant**	**13**	**6500**	**10.14**
	Total			**261.54**

b) Expenses towards Support to Directorate Staff

(as per approved PIP of 2009-10)

Sl.	Designation	Nos.	Amount (Rs.) Per Month	Annual (Rs. in lacs)
1	Accountant	1	21,000	2.52
2	Data Analyst	1	21000	2.52
3	Data Assistant	2	17,000	4.08
4	Programme Assistant	2	17,000	4.08
	PCPNDT Cell			
1	Procurement of Computer peripherals			0.05
2	Programme Assistant/Data Assistant/LA/SS	3	17,000	6.12
3	Contingency			0.60
	Urban Cell			
1	Data Assistant (GIS)	1	17,000	2.04
2	Computer Operator	1	17,000	2.04
3	Programme Assistant	1	17,000	2.04
4	Office Attendant	1	6,500	0.78
	Quality maintenance under CCSP			
1	Data Analyst	1	21,000	2.52
2	Data Assistant	2	17,000	2.04
Total				**33.47**

Expenses towards Support to IEC Bureau (Directorate staff)

Sl.	Designation	Nos.	Amount (Rs.) Per Month	Annual (Rs. in lacs)
1	Consultant	2	33,000	7.92
2	Programme Assistant	2	17,000	4.08
Total				**12.00**

c) Other Operational Expenses for FW Directorate & SPMU

An amount of Rs.287.01 lacs has been budgeted for various miscellaneous expenses (telephone, fax, stationery, consumables, program managers travel expense, housekeeping, etc.)

Expenditure Head	**Amount (Rs. in lacs)**	
	DFW	**State PMU**
Rent for State PMU (@ Rs.1.44 lacs per month)	-	17.28
Annual audit and Concurrent audit fees etc.	-	65.00
Telephones/Fax/Mobile Phones/Other communication methods/maintenance	6.00	15.00
Electricity Bills/Electrician on contract/AC maintenance/ gensets etc.	10.00	10.35
Stationary/Photo Copier Bills/AMC etc.	8.00	15.00
Computer/AMC/CDs/Floppies/Internet etc.	6.00	10.00
Vehicle Hire/POL etc.	15.00	50.00
Field visits/Mtngs at GoI/for Officers as per norms (include CRM/JRM visit)	10.00	20.00
Field visit of Senior Manager/Regional Manager under CCSP (Quality Maintance)	-	6.00
Office equipments/ furniture/ painting/ maintenance etc.	5.00	8.00
Library/research/surveys/study tours/seminars & workshops	2.00	30.00
Contingency support/imprest money/office daily expenditures etc.	6.00	10.00
Advertisement	-	5.00
Renovation of SPMU Basement	-	30.00
Operating expenses for Urban RCH cell	2.16	-
Operating expenses for Routine Immunisation & Cold Chain	7.50	-
T.A/D.A for PCPNDT cell staff	14.20	
Total Expenditure	**91.86**	**291.63**

d) Operational Expenses for Divisional PMUs (to be met from Mission Flexipool)

Sl.	**Description**	**Annual Expense (Rs. in lacs)**
1	Operating Expenses of Divisional PMUs (@ Rs. 125,000/- per month x 12 months x 18 units)	270.00
Total		**270.00**

g) Operational Expenses for Divisional ADs (to be met from Mission Flexipool)

Sl.	Description	Annual Expense (Rs. in lacs)
1	Mobility Support for monitoring & supervision (@Rs. 2500 p.m. per district)	21.30
2	Contingencies (Rs. 5,000 per month x 18 Divisions)	10.80
Total		**32.10**

h) Operational Expenses for District PMUs

Sl.	Description	Annual Expense (Rs. in lacs)
1	Honoraria to District PMU Staff • District Programme Manager (Rs. 27,000/- per month) • District Community (thru ASHA Supp Sys-Rs.22,000 • District Accounts Manager (Rs. 22,000/- per month) • District Data cum Accts. Assistant (Rs. 17,000/- per month) • Class - IV (Rs. 6500/- per month) Total (@ Rs. 94,500/- per month x 12 months x 71 units)	805.14
2	Other Operating Expenses of District PMUs (@ Rs. 60,000/- per month x 12 months x 71 units)	511.20
Total		**1316.34**

i) Operational Expenses for Block Units (to be met from Mission Flexi pool)

Sl.	Description	Annual Expense (Rs. in lacs)
1	Honoraria to Block Unit Staff • Block Data Assistant (Rs. 8,000 per month) (@ Rs. 8,000/- per month x 12 months x 820 units)	787.20
2	Other Operating Expenses of Block Units • Communication Support to Block Prog. Manager (Rs. 500 per month) • Contingencies (Rs. 1,000 per month to be met from ASHA Support system)	49.20
Total		**836.40**

j) Operational Expenses for Mission Director Support (to be met from Mission Flexipool)

Sl.	Description	Annual Expense (Rs. in lacs)
1	Operating Expenses • Contingencies (Rs. 15,000 per month)	1.80
Total		**1.80**

12.4 Mobility Support for Monitoring & Supervision

For the purpose of improving programme management, monitoring & supervision, at the district and block levels, the proposal has been included in Mission Flexipool.

12.5 State Quality Monitors

In the PIP 2009-10, 18 state quality monitors were proposed for monthly quality monitoring of services under NRHM. People from outside the government system, preferably retired government officers, of Joint Director and above rank, having requisite experience of functioning at district/ state level in health sector would be deployed.

Presently, eight State Quality Monitors are working. This year it is proposed to ensure all the 18 SQMs (one SQM per division).

Budgetary Requirement

S.No	Description	No. of Days	No. of Districts/ Division	Monthly Expense (Rs.)	Annual Expense (Rs. In lacs)
District Visits (2 days per district/ month)					
	Honoraria (@Rs.1000 per day	2	71	2000	17.04
	Boarding and Lodging (@Rs 2500/- per trip)				21.30
	Travel Expenses (HQ to District and Local Vehicle Hiriing)				17.04
Expenses per SQM					
	Contingency (@ Rs. 1,000/- per Division per month)				2.16
	Monthly Visits to State HQ (DA – Rs. 1500/-, TA-Rs. 2000/-, Inc. Rs. 250/-)				8.10
Recruitment of 10 remaining SQMs					0.50
Orientation workshop					0.50
Quarterly review meeting @ 50,000 per quarter					2.00
Total					**68.64**

Programme Management Expenses to be met from Mission Flexipool

Sl.	Description	Annual Amount

		(Rs. Lacs)
1	Operational Expenses of Divisional Units	270.00
2	Operational Expenses for Divisional AD Offices	32.10
3	Honoraria to Block PMUs staff	787.20
4	Operational Expenses of Block Units	49.20
Grand Total		**1138.5**

SUMMARY BUDGET
RCH FLEXIPOOL 2010-11

SN	COMPONENT	APPROVED BUDGET 2010-11 (Rs.in Lacs)
1	Maternal Health (excl. JSY)	2043.47
2	Janani Suraksha Yojana	39937.59
3	Child Health	1157.54
4	Family Planning	30.40
5	Family Planning Compensation	8314.35
6	Adolescent Health/ARSH	311.00
7	Urban RCH	1674.36
8	Training	5373.54
9	IEC/BCC	2263.66
10	Innovations/ PPP/ NGO/PCPNDT	791.97
11	Infrastructure and HR	10379.16

12	Institutional Strengthening	1185.55
13	Procurement	476.44
14	Programme Management	2210.10
	TOTAL	**76149.13**

MISSION FLEXIPOOL (PART –B)

ASHA SCHEME

The State has currently selected 136,182 ASHAs against the proposed number of 136,263. To train these ASHAs, capacities have been built of 12 State Trainers, 401 District Trainers and 4207 Block Trainers. 128,250 (95 percent) ASHAs have been trained up to the fourth module. All ASHAs have been supplied with drug kits. An independent concurrent assessment of JSY in selected states of India conducted in 2008 indicated that for UP 79 percent ASHAs arranged for TT injections for beneficiaries, 69 percent arranged for atleast three check-ups, 78 percent arranged for registration of pregnant woman and 76 percent ASHAs accompanied the pregnant woman for delivery. The same study also reports that only 1.7 percent of the ASHAs had not received any training at all.

Issues in Planning in ASHA	Current Status as per evidence from data triangulation	Activities to be undertaken to achieve targets	Outputs to be achieved	Time Frame for 2010-11
Streamlining delay in payment/full payment of performance incentives to ASHAs.	The CRM and JRM indicate that the ASHAs are receiving their payment regularly. The Concurrent Assessment of JSY in UP indicates that 55.2 percent ASHAs receive their payment regularly.	At block level and district level performance payment voucher and master payment disbursement register system has been introduced and being vigorously monitored from the state to the block level, including soliciting the support of AMG members for their support and feedback. In monthly meetings at Block level payments under Mission Flexipool is being made through cheques	Regular, timely and full payment with complete validation and transparency ASHA with full motivation to perform in the community	Already under implementation since July 1, 2009
Regular upgradation of skill/ completion	-Proposal approval obtained from the concerned authorities for 5th module training, adaptation	Starting from the 2 day orientation of the district ASHA nodal officers up to the block trainers and	Prescribed Induction training of 23 days of all the	The 5th module training will continue till July 2010.

Issues in Planning in ASHA	Current Status as per evidence from data triangulation	Activities to be undertaken to achieve targets	Outputs to be achieved	Time Frame for 2010-11
of 5th Module training	completed -18 State trainers and 55 Zonal trainers have been trained for the fifth module. - Identification and selection of State, Zonal and block trainers as per the prescribed criteria under process -Necessary audio-visual support in the form of films on IPC, Event organization and community meeting conduction completed	ultimately ASHA training at the block levels shall be undertaken. The programme is under process.	136182 ASHAs shall be completed	
The timely and sustainable availability of drug kits to the ASHAs	In 2009-10 only one medicine kit was given to each ASHA. Replenishment was, in most of the cases, not done properly and timely	For 2010-11, 2 medicine kits will be provided at an interval of 6 months.	Regular and sufficient availability of common drugs with the ASHA	June 2010
Supervisory structure for ASHAs	At the state level State ASHA Mentoring Group has been constituted and 3 meetings of the body have already been conducted ASHA support mechanism in terms of nomination of 2 facilitators from NHSRC has also been provided District level ASHA Mentoring Groups have also been constituted in all the 71 districts with the conduction of 2 meetings at a particular period to ensure universality and uniformity among the districts and sequencing between the district and the state Regular monitoring and supervisory support to ASHAs, as of now, is being provided by the ANMs and LHVs At District level along with Nodal officer One District Community mobilizer has been recruited. At Block level Health Education Officer has been designated as ASHA Nodal Officer.	At Block level, one data assistant is to be placed for which process is under way. To facilitate ASHAs one facilitator for every 20 ASHAs have to be identified.	Regular and frequent individualized supervisory support to ASHAs Smooth and transparent incentive payment mechanisms in place.	June 2010
Ensuring Sustainability, regularity and constructiveness of the ASHA monthly meeting and discussions	Irregular, less representative, without well defined agenda No accountability or responsibility at the block level	Detailed fresh guidelines have been issued for organising meetings at block level and in that meeting payment of ASHAs and local issues are to be addressed along with continued education.	Regular and more representatives attending meetings and regular payment and capacities of ASHAs strengthened.	Already under implementation
Launching of the 2 day, once in 2 months, periodic			Regular refreshment of the skills	July 2010 onwards

Issues in Planning in ASHA	Current Status as per evidence from data triangulation	Activities to be undertaken to achieve targets	Outputs to be achieved	Time Frame for 2010-11
refresher training of ASHAs			transmitted to the ASHAs through the 23 day induction training and its translation on the field	

The scheme is being implemented under following components:

1.1 Training of ASHAs (FMR Code B 1.1)

The implementation of the ASHA scheme is progressing satisfactorily. The second phase training of ASHA of 12 days on 2nd to 4th modules have almost been completed. 128,250 ASHAs have been trained against 136,182 till December 31, 2009. As on March 2010, 128,434 (94%) have been trained.

As per Government Order of GoUP there is a provision of periodic training for two days every two months as refresher trainings on selected topics identified through training needs assessment. The State Institute of Health and Family Welfare (SIHFW) has been working as coordination and implementing agency in the State of Uttar Pradesh for all categories of trainings under NRHM. All trainings under ASHA scheme will be organised by SIHFW in partnership with ASHA Resource Centre (SPMU) and NGOs. **Two days periodic training of all ASHAs on selected topics will be organised for which 2400.58 lacs have been proposed.**

The fifth module trainings, which were planned for the year 2009-2010, have been initiated in the month of January 2010 and will continue in 2010-2011. The available budget of Rs. 1685.70 lakhs for this training will be used as a committed liability.

1.2 Replacement of ASHAs

Nearly 5-6 percent of the identified ASHAs are no longer providing their services since they are now employed as AWWs, school teachers, among others. Feedback from the nodal officer of districts and district community mobiliser is being collected about such ASHAs. The process of identifying replacements for such ASHAs will be initiated this year. The selection and the training will be met with the expenditure under the training head.

1.3 ASHAs Drug Kits and Replenishment (FMR Code B 1.2)

As per GoI norms every ASHA is to be provided with drug kit. During the year 2009-2010, kits have been provided to all trained ASHAs. However, the items would be required to be replenished. The following items would be provided to each ASHA:

i.	DDK	-	10
ii.	IFA Tablets (large)	-	1000
iii.	Tab Punarvadumandur (Iron)	-	1000
iv.	ORS packet (WHO)	-	100 packets
v.	Tab. Paracetamol	-	200 tabs
vi.	Tab. Dicyclomine	-	50 tabs

vii.	Povidine Ointment	-	2 tubes
viii.	Cotton Absorbent Roll (500gm)	-	1
ix.	Bandage (4 cm x 4 mt.)	-	10
x.	Tab. Chloroquine*	-	50 tabs
xi.	Condoms*	-	500
xii.	Oral Pills (in cycles)*	-	300

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

Estimated Cost of Kit is Rs. 500/- per kit. This kit will be provided every six months. 95 percent of 135,190 selected ASHAs will be given this drug kit. **Therefore, total requirement for 1.29 lac ASHA Kits *Rs. 500 * 2 = Rs. 1293.73 lacs.**

Further, the medicines available with the ANM may be provided to the ASHA as per her need and some medicines will be stocked with the ASHA as a depot holder.

1.4 Incentive to ASHAs (FMR Code B 1.3)

The sustenance of the ASHA, a voluntary worker, depends 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 additional incentives that are not covered under other programmes are as under:

Sl.	Activities	Activities Expected During the Year	Rate
1	PNC, care of the newborn & colostrum feeding	30 Delivery Per 1000	Rs. 50/-
2	On taking Complicated Pregnancy Cases or New Born Cases to the Health Facility	3 Cases	Rs. 200/-
3	Complete Immunization of children upto 1 year of age and Vitamin A Supplementation	30 Children	Rs. 100/-
4	Completion of Village Health Register	Once a Year	Rs. 500/-
5	Birth-Death Registration	30 Births & 9 Deaths	Rs. 5/-
6	Group Meetings in Village	24 Meetings (2 Meetings Per Month)	Rs. 100/-
7	Vision testing of non-school going children upto 15 years of age (40% per thousand)	Of 150 Children, 15 Children with weak eyesight	Rs. 25 per child
8	After post-operative follow-up of Cataract Patients	Per case	Rs. 50/-

It is expected that about 85 percent of the ASHAs (approx. 1.15 lac nos.) 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.

An amount of Rs.6945.30 lacs for 1.15 lac ASHAs was proposed and Rs 6945.28 lacs has been approved by GOI.

1.5 ASHA payment vouchers and registers (FMR Code B 18.3.2)

As per the feedback from the districts and discussion with ASHAs, ASHA payment vouchers have been introduced. The format for the voucher is enclosed as Annexure in the PIP. These vouchers are submitted in duplicate by the ASHAs and duly verified by the area ANM to be submitted to the Medical Officer in the monthly block level meeting. The payment against these vouchers is made in the subsequent month. The cost of the booklet of vouchers is estimated @Rs. 25 per booklet. For this activity Rs. 34.13 Lacs has been sanctioned by GOI.

At the block level a master payment register has been introduced. The format is enclosed in the Annexure. In this register all type of monthly payments are recorded with details of payment made to each ASHA and their areas of operation. On non-receipt of payments by an ASHA for more than 2-3 months, she is contacted for resolution of any grievances and to motivate her towards her services. The cost of the master payment register is estimated @ Rs. 100 per register per block. A budgetary provision of Rs 0.85 lacs has been made by GOI for this activity.

The total amount for payment voucher & register is Rs. 34.98 lacs.

1.6 Mobility Support for Attending Monthly Meetings (FMR Code B 1.1)

Apart from the incentive payable to ASHA, she would be paid an amount of Rs. 30/- towards conveyance for attending the monthly meeting at the PHC once a month. **Therefore, an amount of Rs. 465.74 lacs for 1.29 lac ASHAs has been sanctioned.**

1.7 ASHA Award Scheme (FMR Code B1.1)

To motivate the ASHAs, a reward scheme for the best performing ASHA in each block was proposed. The activities conducted by her during the year would be evaluated and the best performers would be identified. This scheme would be continued in this year. It is expected that the selection of ASHAs as per the criteria given below will be based on their performance in her targeted population. 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

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 820 ASHAs an amount of Rs. 41.00 lacs was proposed and same has been approved by GOI.

1.8 Annual ASHA Sammelan/ Diwas (FMR Code B1.1)

The ASHA scheme was launched in the State on August 23, 2005. An annual programme for the ASHAs is organised in each district on the same date. These programmes were organised in 2009 and a positive feedback has been received. It is proposed to continue the activity this year. Separate guidelines for conducting the ASHA sammelan shall be provided to all the districts at appropriate time.

It is expected that around 60 percent ASHAs would participate in these meetings. A budget of Rs. 250/- per ASHA has been budgeted. **Therefore, for around 81,709 ASHAs, an amount of Rs. 204.27 lacs was proposed and same has been approved by GOI.**

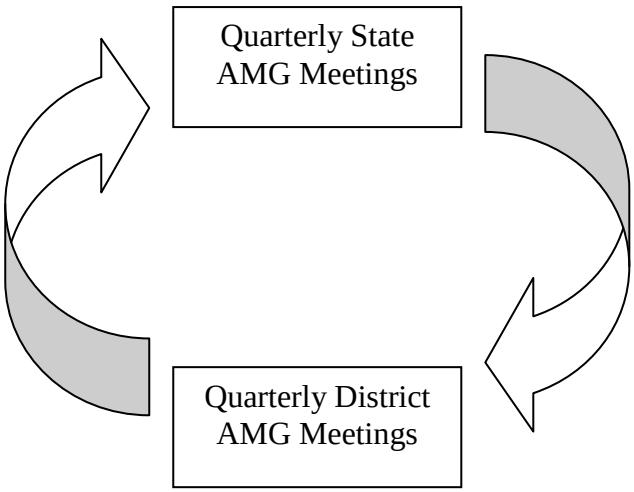
1.9 Newsletter for ASHAs (FMR Code B1.1)

Newsletters for ASHAs is being published and distributed every quarter. The newsletter depicts their roles, success stories, government schemes, progress under various components of ASHA scheme, etc. It is proposed to continue publishing of around 1.50 lac copies each quarter.

Therefore, for printing of 6.0 lac newsletters @ Rs. 11.67/- per newsletter, an amount of about Rs.70.02 lacs was proposed and same has been approved by GOI.

1.10 ASHA Mentoring Group (AMG) Meeting – District & State (FMR Code B1.1)

To support the ASHA scheme, an ASHA Mentoring Group has been constituted at the State and District levels. This Group at the State level meets quarterly to discuss feedback received from District AMG meetings. Major feedback and decisions are conveyed to the district level and form the agenda for their next quarterly AMG meeting. The State level AMG also conveys a 15 day time frame within which all districts should conduct their AMG meetings. Minutes of meeting are compiled and analysed at the State level, providing inputs for agenda for the next State level meeting. Two State level AMG meetings and three District level AMGs have been conducted till end February 2010. For the meeting of this group and field visits a provision of Rs.10,000 per district is being made for 71 districts. Further, an amount of Rs.2.90 lacs has been provisioned for the State level. **Thus, a total amount of Rs. 10 lacs (7.10 lacs for districts & 2.90 lacs for state) has been sanctioned.**


Quarterly State
AMG Meetings
Quarterly District
AMG Meetings

1.11 ASHA Support System

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

At the State level, though support is being provided through NHSRC two additional personnel is also required for better functioning of ASHA Resource Centre. At district level, District Nodal Officers and District Community Mobilizers have been positioned. At the block level, Block MOIC and the Block Health Education Officer under the State cadre, designated as Block Managers under NRHM, would act as the Nodal Officers. In absence of a Block Manager, an officer nominated by the Block Medical Officer will act as a Nodal Officer. A Data Assistant is being positioned at the block level to support the Nodal Officer under the Block Programme Management Unit.

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. In areas where no NGOs are available support would be sought from HVs and ICDS Mukhya Sevikas.

Training of ASHA Facilitators (FMR Code B1.1)

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 (State level) (@ Rs. 500/- per person/day x 3 persons x 6 days)*	9,000.00
6	DA to Resource Persons (Local) (@ 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**

* At the time of training prevailing rates will be applicable

Accordingly, for training 6600 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. During the year 2009-10, it is expected that around 80 percent of the trainings will be possible. Hence, only 180 batches of training has been budgeted. **For this activity an amount of Rs.175.10 lacs has been sanctioned.**

State Level ASHA Resource Centre , Monitoring and Supervision (FMR Code: B1.1)

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. The vouchers and payment registers will be compiled at the block level, at the district level and then at the state level. At State level, selection and training is being monitored at SPMU alongwith the payment up to ASHA in various activities.

Summary of Budgetary Requirement for ASHA Support System (FMR Code B1.1)

Sl.	Description	Amount (Rs. in Lacs)
1	State Level ASHA Resource Centre (for workshops, meetings, seminars, exposure visits, etc.)	2.00
2	1 Programme Assistant and 1 Office Assistant will be hired at State level	3.00
3	District Level Support System for District Community Mobiliser	150.00
4	Block level Support System	0.00
	(i) ASHA Facilitators (6500 x Rs. 150/ day x 20 days/month)	1822.50
5	Training of ASHA Facilitators	175.10
Total		**2152.60**

Summary of Budgetary Requirement for ASHA Scheme

Sl.	Description	Amount (Rs. in Lacs)
1	Refresher training (periodic training)	2400.58
2	Replenishment of Kits for ASHAs	1293.73
3	Incentive to ASHAs	6945.28
4	Mobility Support for Attending Monthly Meetings	465.74
5	ASHA Award Scheme	41.00
6	Annual ASHA Sammelan/Diwas	204.27
7	Newsletter for ASHAs	70.02
8	Meetings of ASHA Mentoring Group	10.00
9	ASHA payment voucher and registers	34.98
10	ASHA Support System	2152.60
Total		**13618.20**

2. OTHER ACTIVITIES

2.1 VILLAGE HEALTH INDEX REGISTER (VHIR) (FMR CODE B18.3.2)

A Village Health Index Register has been developed and provided to most of the ASHAs. Training on filling up and maintenance of records on the same has also been conducted. The register includes, apart from basic family details, utilization of RCH and other health services, status of nutrition, water supply & sanitation. It is concurrently updated for vital events, disease status, services & other health related inputs & services utilization and can be used for annual planning.

For year 2010-11, 140,000 VHIRs will be printed @Rs. 80, for which Rs. 112 lacs has been sanctioned.

3. VILLAGE HEALTH AND SANITATION COMMITTEE (VHSC)

There are 52,002 Gram Sabhas in UP of which 51,943 VHSCs have been constituted and have an operational bank account. These VHSCs consist of Gram Sabha Pradhan as the Chairperson, ANM of the area as Co-Chairperson, six nominated members from the Gram Panchayat constituted under the PRI Act (and must include from scheduled castes and scheduled tribes, other backward castes and woman representatives) and the ASHA as the Executive Secretary. The VHSC can also have upto seven special invitees from local NGOs, SHGs or nominees from revenue village hamlet who do not have voting rights. Each VHSC is given an untied fund of Rs. 10,000 per revenue village (total no. of revenue villages is 1, 00,422 as per reports received from districts).

3.1 Orientation of VHSC Members on Their Roles and Responsibilities under NRHM

VHSCs are resources available at the village level and when effectively engaged can mobilise communities to solve their health related problems. To engage these VHSCs meaningfully, 394 master trainers at district level and 4851 trainers at block level have trained 55278 Panchayat members till July 2009. This process is continuing and the activity will continue in the year 2010-11. In addition, a leaflet with guidelines for operating VHSCs has been prepared and disseminated to all members.

Issues in Planning for VH&SC	Current Status as per evidence from data triangulation	Activities to be undertaken to achieve targets	Outputs to be achieved	Time Frame for 2010-11
A. The constitution of the Village Health and Sanitation Committee	There are 52,002 VHSCs constituted, in each Gram Sabha, of which 51,943 have opened a separate bank account.			
B. The capacity of the PRIs for Village Level Planning	Two days orientation training of members of VH&SC is planned and the programme is under process.	Remaining 2 day orientation of the VHSCs shall be undertaken	More intensive engagement of PRI members in formation of village health plans incorporating health related issues of the village	Training will continue this year also.
C-Appropriate and adequate quality use of VHSC funds	While funds have been released to VHSCs, field visits indicate that their utilisation is not as per prescribed guidelines.	Capacity building of VHSC members for identification and addressing village health related problems in village health plans and developing strategies to address these problems using VHSC funds. Pradhan Sammelan at Tahseel level will be organized to acquaint them about the roles and responsibilities envisaged in NRHM Framework Implementation document.	Quality utilization of the VHSC funds towards addressing specific health related issues of their village	Ongoing

Orientation of VHSC members was proposed under RCH Flexipool in the PIP for the year 2008-09. However, the activity was suspended as the committees were still being formed and their accounts were being opened. This year we have a strong network of managers at divisional, district, block level and also District Community Mobilizers hired and placed in each district to supervise community processes. Therefore it is planned that during the year 2010-11, members from 50 percent VHSCs formed will be oriented for 2 days on their roles and responsibilities under NRHM. As already detailed earlier in this section, TOTs have been completed this year and all levels of PMU managers are trained on NRHM programme implementation to facilitate this field level training. The training programme is under process and will continue in year 2010-11. **Hence for this year no additional budget has been demanded.**

3.2 Tehsil Level Pradhan Sammelan (FMR Code B8.2)

A tehsil level annual Pradhan Sammelan shall be organised to educate and orient the Pradhans about their roles and responsibilities for functioning of the VHSCs. 312 Tehsil level Pradhan Sammelans will be organised in 2010-11 with intensive IEC activities. In this Sammelan, they will also be oriented regarding the health program under NRHM and the utilisation of services by the community. For this Rs. 40,000 per Sammelan is budgeted. **An amount of Rs. 124.80 lacs has been sanctioned.**

4. ROGI KALYAN SAMITI (RKS)

A rapid qualitative assessment of RKS was conducted in eight districts which were selected using simple random sampling. These districts were Bijnor and Shahjahanpur from Western region; Fatehpur and Unnao from Central region; Bahraich and Ghazipur from Eastern region and Hamirpur from Bundelkhand region. The assessment covered 42 facilities including all district level hospitals, two block level hospitals (CHCs) and two PHCs from each of the selected districts. The assessment noted that RKS funds were being utilised for various activities depending on the need of the facility such as small upgradation of facilities such as construction of boundary wall, white wash and minor repairs; housekeeping, display boards and gardening; and utilities such as electricity including POL for generators, water and toilets; boarding and lodging facilities. Forty one of the 42 facilities had separate RKS accounts.

However, the study reflected a need for reorientation of RKS members and clarity on guidelines. Accordingly guidelines were revised and disseminated to all health units. Also, to increase the resources available at the facility and to facilitate better planning, the RKS funds, annual maintenance grant (AMG) and user charges were pooled together at the disposal of the RKS. These funds can be utilised for medical waste disposal management, procurement of emergency drugs, procurement of essential equipment, repair and maintenance of equipment, facility maintenance, arrangements for regular electricity supply, arrangements for drinking water, ambulance, communication, annual audit and any other that the RKS may deem fit.

4.1 ANNUAL ASSISTANCE TO RKS (FMR CODE: B6)

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.4313 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 (DHM, DWH, DHC) (FMR CODE B6.1)**	145	5.0	725.00
2	**CHCS(FMR CODE B6.2)**	438	1.0	438.00
3	**BLOCK PHCS (BPHCS) (FMR CODE B6.3)**	470	1.0	470.00
4	**ADDITIONAL PHCS (APHCS) (FMR CODE B6.4)**	2680	1.0	2680.00
Grand Total				**4313.00**

* In Combined Hospitals, Male and Female units have been taken separately for RKS purposes

Total amount sanctioned for RKS is Rs. 4313.00 lacs.

4.2 CAPACITY BUILDING OF RKS (FMR CODE B.8.2)

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. A training component was proposed in the PIP of 2008-09 and trainings have been conducted in the districts. However, not all the functionaries could be trained and it is proposed to continue the training activity in this year also. The capacity building of RKS members covers 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

A budgetary support of Rs. 15.08 lacs for TOT and Rs. 47.03 lacs for field training (total Rs. 62.11 lacs) has been sanctioned in the training budget.

5. UNTIED GRANT TO HEALTH FACILITIES (FMR CODE B2)

Govt. of India has 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. 13228.30 lacs.

During the year 2008-09, around 52002 VHSCs at Gram Panchayat level were established and accounts were opened. However, the revenue villages are 107,164. Accordingly, the fund requirement is being proposed for this year is as under:

Sl.	Facility	Financial (In lacs)		
		No.	Rate	Total
1	**CHCS(FMR CODE B2.1)**	438	0.50	219.00
2	**BLOCK PHCS(FMR CODE B2.2)**	470	0.50	235.00
3	**PHCS (ADDITIONAL PHCS) (FMR CODE B2.2)**	2680	0.25	670.00
4	**SUB CENTRE (FMR CODE B2.3)**	20621	0.10	2062.10
5	**VHSCS (52002) REVENUE VILLAGES 100422 (FMR CODE B2.4)**	100422	0.10	10042.20
Grand Total				**13228.30**

Total amount of Rs. 13,228.30 lacs is sanctioned under untied grants to facilities and VHSCs.

At the additional PHC (APHC) level, there is difficulty in operating RKS. Therefore the untied funds for the APHCs would be retained with the RKS of the Block PHC which falls in its jurisdiction. 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.

6. ANNUAL MAINTENANCE GRANT (AMG)- ONLY FOR GOVERNMENT BUILDINGS) (FMR CODE 4)

Govt. of India has 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. 2860.20 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 allocated in the following manner:

Budgetary Requirement

Sl.	Facility	Financial Requirement (Rs. in lacs)		
		No.	Rate	Total
1	CHCS(FMR CODE B4.1)	438	1.00	438.00
2	BPHCS (FMR CODE B4.2)	470	1.00	470.00
3	APHC (GOVERNMENT BUILDING) (FMR CODE B4.2)	1915	0.50	957.50
4	SUB CENTRE (GOVERNMENT BUILDING) (FMR CODE B4.3)	9947	0.10	994.70
Grand Total				**2860.20**

A total amount of Rs 2860.20 has been sanctioned for AMG (only for health facilities functioning in government buildings)

7. OTHER COMMUNITY BASED ACTIVITIES

7.1 SAAS BAHU SAMMELANS

With a view to improve communication within the family in relation to the health of daughters-in-law, it was proposed to organise '**Saas Bahu Sammelans**' at the district levels. These joint meetings of daughters-in-law, mothers-in-law, elderly ladies of the family, female PRI members, ICDS functionaries, NGOs, and women's groups were organised during the year. 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 are discussed.
It is proposed to organise such meetings this year also. These meetings will be organised once a year at the District level.

Accordingly, at the district level, an amount of Rs.1.50 lac per meeting (Rs.1 lac for organising the meeting incl. stalls and Rs. 0.50 lacs towards transportation of participants) has been budgeted. **Thus, for organising 71 district meetings a total sum of Rs.106.50 lacs has been sanctioned.**

8. OPERATIONALISING HEALTH INFRASTRUCTURE (FMR CODE B5)

The NRHM seeks to provide accessible, affordable and quality health care to the population, especially the vulnerable sections. Given the status of public health infrastructure in the State, it will not be possible to provide the desired services till the infrastructure is sufficiently upgraded. The Mission seeks to establish functional health facilities in the public domain through revitalization of the existing infrastructure and fresh construction/renovation or strengthening wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in human resource planning, as well as, infrastructure strengthening.

Infrastrucutre has been planned based on categorization of facilities as difficult, most difficult and inacceseabile. While comptle list of functional FRUs and health facilties for each disitricts is attached as annexure, GoI has suggested a mapping of facilties at various levels with number of beds and staffing at each facility. This exerice is time consuming and information is presently being collected as per the formats from the GoI and will be shared soon.

A facility survey was conducted in 2009-10 in 134 District Hospitals and 100 CHCs which is under completion. Detailed findings will be available shortly.

8.1 Construction of New Sub-Centres (FMR CODE B 5.3)

Out of the 20,621 sub centres in the State, about 9,947 are operating in own buildings and another 7000 Sub Centres are under construction (3000 from budget received under 2009-10 PIP and 4000 from State budget). There are nearly 3000 Sub centres will be functioning from hired buildings. With the increased number of deliveries due to JSY, operationalisation of sub centres in their own building is imperative to cater to the increased load of beneficiaries. Accordingly, another 1800 sub centres are proposed for the year 2010-11 at an average cost of Rs. 8 lacs per Sub Centre. **Thus an amount of Rs. 14400.00 lacs has been sanctioned for this activity.**

8.2 Rent of Sub Centres (FMR Code A. 10.4)

There are 10,674 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 @ Rs. 250/- per month for 10,674 Sub Centres, amounting to Rs.320.00 lacs, is being made for the year 2010-11 under RCH Flexipool. Additionally, Rs.250/- p.m. would be utilized from untied grant at Sub Centre, in case a proper (minimum two rooms) rented building is available** and can be used for providing better services including deliveries.

8.3 Strengthening of PHC

There are 470 Block PHCs and 2680 Additional PHCs. All the Block PHCs are being upgraded as CHCs in a phased manner. All Block PHCs are functional as 24x7 and strengthening of the building has been done during last two years including minor repairs, electricity, water supply and equipments. In the year 2010-11, all 24x7 units at block level are being provided an amount of Rs. 10,000 per month for maintaining support services (telephone, referral, computer operator, security and cleanliness). Additionally all these facilities will be provided with untied, AMG and RKS funds as per norms. Keeping in mind the shortage of manpower and the increasing JSY case loads, 1 male MBBS doctor is being provided on contract basis during the year 2010-11. Additionally, one male ISM and one female ISM is also being provided at this level. Two Staff Nurses on contract are being provided at each Block PHC to facilitate 24x7 delivery services.

All Additional PHCs are getting untied, AMG and RKS as per norms. Fifty percent PHCs do not have regular doctors. To resolve this situation, one male ISM doctor is being provided at each of the APHCs with Pharmacist of respective pathy.

In the year 2009-10, it was proposed to operationalise 50 Additional PHCs as 24x7 where ANM is residing and monthly case load of deliveries is more than 30. Out of these 47 units are functional as 24x7. This year it is proposed to operationalise 50 more Additional PHCs thus making 100 units as 24x7. These units will be entitled to get the privilege of having one ISM lady doctor on contract and support services @ Rs 10,000 per month in line with the provisions for other 24x7 units. One Staff Nurse will be provided additionally to each 24x7 Additional PHC. This amount has been budgeted under Maternal Health.

8.4 Establishment of JSY ward in Block PHCs *

Due to high acceptability of JSY in the community, there is increased load at Block PHCs. There is a need to expand the ante natal and post natal ward. It is proposed to establish a new JSY ward with space for six beds, other necessary furniture and accessories, two toilets cum bathroom, TV and DVD players and god furnishing. The cost has been calculated @ Rs 7.70 lacs per unit for 470 block level PHCs in the State. The same has been sancetioned in year 2009-10 with 942 units at PHCs.

8.5 Equipments for FRUs and CHCs

FRU /CHC kits are an essential requirement for a functional facility. For this activity a total cost of Rs. 3100 lacs was proposed and approved for the year 2009-10. Orders for purchase of kits and equipments have been placed and the same will be available at the units by February 2010. These will be utilised in the year 2010-11, and no additional budget is required.

Blood Storage facility at 140 Identified Units has been provided during the year 2009-10. The equipments are being installed at the site and the staffs are being trained for the purpose. Proposal for another 40 such units have been included in the maternal health PIP.

8.6 Upgradation of Selected District Hospitals & CHCs to IPHS (FMR Code B3.2)

In order to upgrade District Hospitals and CHCs as per the IPHS standards an amount of Rs. 25095.57 lacs was budgeted in 2009-10. Under this activity it was proposed to upgrade 40 selected District Level Hospitals apart from physical strengthening of all district hospitals. Infrastructure strengthening also included increasing number of beds for expansion of wards, especially at District Women Hospitals to cope with the increasing load of delivery due to JSY.

An amount of Rs. 16000.00 lacs has been approved for upgradation of 40 District Level Hospitals at the rate of Rs. 400 lacs/hospital. The work has been allocated to the State Public Sector Construction Agency, U.P. Project Corporation Ltd. and consultancy work was assigned to consultants like-EPOS Health India Private Limited. The facility survey and detailed proposal for up-gradation taking into account local factors and merger with existing hospitals has been completed by the consultants and approved by the Directorate of Family Planning/Health and construction work has started. Further it is being proposed to upgrade all the remaining 89 District Level Hospitals (DH NOIDA to be managed by NCR and four hospitals will be implemented using PPP models) during the year 2010-11. Since the construction and upgradation work as per IPHS takes about 20 months, it is proposed that an amount Rs. 100 lacs per unit being budgeted. Remaining amount will be proposed in the following year. **Hence, a total amount of Rs. 8900.00 lacs has been approved by GOI.**
An amount of Rs. 8795.57 lacs was budgeted in 2009-10 for strengthening of 50 selected CHCs. The work is in progress and will be completed during 2010-11.

Sl.	Facility	Nos.	Estimated Cost per Unit	Total Amount (Rs. In lacs)
1	Upgradation of DHs as per IPHS	89	100 lacs	8900.00
Total				**8900.00**

The total fund of Rs. 8900.00 lacs has been sanctioned for this activity.

8.7 Outsourcing of Cleaning, upkeep and Laundry Services at District Hospitals (FMR Code B 3.2)

The performance of the healthcare services is greatly influenced by the effectiveness of non-clinical services such as laundry, security, sanitation & housekeeping, gardening, etc. The UP Health Systems Development Project had supported outsourcing hospital cleaning (housekeeping) and gardening services in selected district hospitals which had yielded good results. This activity has been replicated in all district level hospitals in the state and funds have been released for the last quarter of financial year 2009-10. The remaining funds will be sufficient for the next two quarters of the financial year 2010-11. Additional funds will be required for two quarter. **Accordingly, a budgetary provision of Rs. 2700 lacs was made but GOI has approved for 50% of the proposed amount of Rs 1350.00 lacs. The balance amount is to be provided on submission of details.**

8.8 Hospital Waste Management System (FMR Code B 3.2)

A PPP model for management of hospital waste is being implemented by UPHSDP. Combined Treatment Facilities (CTFs) have been set up by private operators and contracts have been signed with them for collection and disposal of solid hospital waste. The facilities covered are District Hospital (Male/Female), Combined Hospitals, Community Health Centre and Block Primary Health Centre of entire state. The Project has also developed Performance Monitoring Indicators for the hospital units and service providers which will be used during monitoring of the CTFs. Considering the success of the CTFs, it is proposed to sustain healthcare waste management activity through NRHM. The activity has been taken over by NRHM since 2009-10 and **an amount of Rs.1300 lacs was proposed and approved by GOI.**

8.9 Mobility Support to DWH & DCH Staff (FMR Code B 27.8)

With the objective of improving monitoring, supervision and quality of services, it is proposed to provide mobility support to Officers at the District Women Hospitals and Combined Hospitals for conducting field visits. Hired vehicles are proposed to be used for the purpose. A budgetary provision of Rs.2.50 lacs per annum for each hospital was made. An amount of Rs. 182.50 lacs was released to the districts for 73 facilities with detailed guidelines. **An amount of Rs. 182.50 lacs was proposed and has been approved by GOI.**

Further, provision of essential medicines, reagents, consumables, X-ray plates and equipment that are not being met through State budget will be ensured from RKS funds. Dietary arrangements for patients, maintaining proper quality standards, would be done through State budget.

8.10 Vehicle for Specialists (FMR Code B 27.8)

It is a challenge in the health systems for communities to avail specialist services at sub district health facilities. However, if these services could be provided, only patients requiring higher levels of care will reach the District Hospitals, thus rationalising the patient loads at these facilities. To facilitate the availability of Specialists, it is proposed that transportation arrangements be made available to them, so that teams can visit sub district facilities once a week on a fixed day on rotation basis.

On an average one vehicle will be allotted for five blocks. These vehicles will operate on fixed route-fixed day-fixed time approach. 164 vehicles will be required for the State @ Rs. 18000 per month. **Thus a total of Rs. 354.24 lacs was proposed and approved by GOI.**

8.11 Diesel for Generators at District Hospitals and Functional CHCs (FMR Code B 28)

The availability of electricity in Uttar Pradesh is poor affecting the functionality of the health facility. In some areas, there is less than four hours of electricity available

throughout the day. Therefore, various funds available at facilities for the purpose are inadequate. It is proposed that an additional amount of Rs. 1 lac per month per district level facility and Rs. 0.35 lac per month per fully functional CHC and Rs 0.14 lacs for CHCs which are still functional in Block PHC building , be provided to the facilities to overcome the shortage of electricity. **A total amount of Rs. 4237.20 lacs is being proposed for the activity for the year 2010-11.**

Activity	No. of Units	Rate per Unit	Freq.	Total (in Rs. Lacs)
Diesel for generators				
For District Hospitals	**134**	**100000**	**12**	**1608.00**
For fully Functional CHCs	**438**	**35000**	**12**	**1839.60**
For CHCs which are functional in Block PHC building	**470**	**14000**	**12**	**789.60**
				***4237.20**

Rs 4236.00 Lacs approved as per ROP.

8.12 Establishment and Strengthening of Blood Banks (FMR Code B.3.2) and Blood Storage Units (FMR Code B 5.6)

Most of the district hospitals and CHC level FRUs do not have blood bank facility. As most of these hospitals cater to complicated referred cases from the periphery, including delivery, accidental and other complicated cases requiring immediate blood transfusion, there is an urgent need to establish and strengthen blood banks at each district level hospital (as per prescribed norms) and blood storage facility at CHC level FRUs.

Up-gradation of all the district level hospitals is being done to bring them to IPHS, it becomes mandatory to strengthen all the existing blood banks and to establish at remaining places.

It is being proposed to strengthen these units by providing all the essential equipments and human resource etc to make these units functional. An amount of Rs. 2473.45 lacs is being proposed for the same.

For the districts where no blood bank is functional, the establishment cost needed is Rs. 1837.35 lacs and for the remaining districts the strengthening cost has been estimated to be Rs. 636.10 lacs. The detailed estimates are annexed.

For further 40 additional blood storage units, it is proposed to budget Rs. 90,000 per unit. The procurement of equipment for this will be done through UNOPS.

A total amount of Rs. 2473.45 lacs (FMR Code B 3.2) was proposed & approved for Establishment and Strengthening of Blood Banks and Rs. 36 lacs (FMR **Code B 5.6)** had **been proposed and approved for procurement and operationalisation of blood Storage Units.**

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8.13 Construction of Regional Drug Warehouses (fmr code b 8.16)

There are 11 Regional Drug warehouses existing in the State which are fully functional. It is proposed to construct seven Regional Drug Warehouses in the year 2010-11 so that each division has one Regional Drug Warehouse.

With these 18 Regional Drug warehouses and the existing 53 District Drug warehouses, there will be a total of 71 Drug Warehouse making one Drug warehouse available in each district. Each warehouse is estimated to cost Rs 164.11 lacs. **Thus, an amount of Rs.1148.77 lacs was budgeted and approved by GOI.**

8.14. Operationalisation of District Drug Warehouses (FMR CODE B.21)

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. An amount of Rs. 118.56 lacs was proposed and approved in the PIP for the year 2008-09 and 2009-10. The expenses will continue to be met from NRHM funds; accordingly the following budgetary requirement is proposed.

S.No.	Item	Unit cost (Rs in lacs)	Quantity	Total cost (Rs in lacs)
1	Contractual Staff	2.94	53	155.82
2	Contingent Expenditure	2.00	53	106.00
Total				**261.82**

The budgetory support has been provided under Mission Flexi pool (FMR B.21)

8.15 Strengthening Logistic Management (FMR CODE B. 21)

This activity had been proposed for the year 2009-2010. However, since it could not be implemented in the previous financial year, it is being proposed for the year 2010-2011. 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.

At each warehouse an Accountant, Computer Operator, Folk Lift Operator cum Mechanic, Fourth Class/Loader, Generator Operator cum Electrician, Security staff and class-IV staff will be deployed. The budget details are as under:

Sl.	Warehouse	Elect. Charges	Telephone Charges	POL for DG Set	Stationery	Contin-gencies	Salary to Cont. Staff *	Total (Rs. In lacs)
1	State WH (LMC)	130000	18000	10000	30000	200000	633672	**10.22**
2	Agra	110000	10000	9000	15000	200000	571788	**9.16**
3	Allahabad	110000	10000	9000	15000	200000	571788	**9.16**
4	Azamgarh	110000	10000	9000	15000	200000	571788	**9.16**
5	Bareilly	110000	10000	9000	15000	200000	571788	**9.16**
6	Banda	110000	10000	9000	15000	200000	571788	**9.16**
7	Gorakhpur	110000	10000	9000	15000	200000	571788	**9.16**
8	Faizabad	110000	10000	9000	15000	200000	571788	**9.16**
9	Kanpur	110000	10000	9000	15000	200000	571788	**9.16**
10	Lucknow	110000	10000	9000	15000	200000	571788	**9.16**
11	Meerut	110000	10000	9000	15000	200000	571788	**9.16**
12	Varanasi	110000	10000	9000	15000	200000	571788	**9.16**
Total		**1340000**	**128000**	**109000**	**195000**	**2400000**	**6203329**	**110.98**
Renovation of LMC Road								**9.77**
Grand Total								**120.75**

**** Contractual Staff***

Sl.	Position	Basis of Calculation	Amount (Rs.)
1	Accountant	12 persons x Rs. 6000/- x 12 months	864000/-
2	Computer Operator	12 persons x Rs. 6000/- x 12 months	864000/-
3	Folk Lift Operator cum Mechanic	12 persons x Rs. 5000/- x 12 months	720000/-
4	Fourth Class/Loader	12 persons x Rs. 5000/- x 12 months	720000/-
5	Generator Oper. Cum Electrician	12 persons x Rs. 3000/- x 12 months	432000/-
6	Sweeper	12 persons x Rs. 3000/- x 12 months	432000/-
7	Armed Guards	12 persons x Rs. 6335/- x 12 months	912240/-
8	General Guards	25 persons x Rs. 5157/- x 12 months	1547100/-
9	Gardener	12 persons x Rs. 3000/- x 12 months	432000/-

Accordingly, a total amount of Rs.120.75 lacs has been budgeted for the year 2010-2011. Further, these warehouses were constructed in 2001-02 and are in poor physical

condition. Physical strengthening of these warehouses is also proposed, the funds for the same will be met from Mission Flexipool.

Decentralised Funds for Transportation

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 next:

Expenditure Description	No. of Locations	Amount per Location (Rs.)	Amount (Rs. In lacs)
Divisional Level (Additional Directors)	18	50,000.00	9.00
District Level (Chief Medical Officers)	71	30,000.00	21.30
Block Level – CHC/PHC (Medical Officer Incharge)	823	12,000.00	98.76
Total			**129.06**

Budget Summary (Institutional Strengthening) 2010 – 2011

Sl.	Description	Annual Amount (Rs. in lacs)
1	Strengthening Logistic Management (FMR Code B.21)	120.75
2	Decentralized Fund for Transportation of Supplies (FMR B.27.8)	129.06
Grand Total		**249.81**

TOTAL AMOUNT OF RS. 249.81 LACS IS BEING BUDGETED FOR INSTITUTIONAL STRENGTHENING UNDER LOGISTIC MANAGEMENT. GOI HAS APPROVED UNDER FMR CODE A.10.2.

9. **Improving Access To Health Services Using Mobile Medical Units (Mmu)** (Fmr Code B 11)

There is an acute shortage of Government Doctors and Para-medical staff in Uttar Pradesh because of which basic health care services cannot be ensured through the existing public health care delivery systems. To ensure the delivery of health care facilities in the remote and inaccessible areas, it is proposed to operationalise MMU in 15 districts of the state which have been identified as difficult to reach or left wing extremist effected areas.

Under the scheme it is proposed that one MMU will provide one unit of service per day for a period of 8 hours and work 6 days in a week. The MMU will visit the selected villages/ habitations once a month. Accordingly, one MMU will approximately cover 6 centres/ villages in a month. It is proposed to position the MMUs at common points like large villages or local weekly bazaars on this monthly regular schedule basis. This way at medical facilities will be available at 6 points in a development Block (besides the Block Headquarters) as per a definite weekly schedule.

This would mean that in the select villages/ centres there would be availability of service of this MMU or moving Hospitals which is proposed to be named *"Chalit Aspatal".* With due publicity and regularity these *"Chalit Aspatals"* can become a special feature in rural Uttar Pradesh and villagers can come to the Mobile Medical Units for treatment on systematic basis. Each MMU will serve at a pre-dedicated centre for 8 hours. The name of the selected districts are given below:-

S.N.	Name of District (Left wing extremist)	S.N.	Name of District (Difficult to reach)
1.	Sonbhadra	9.	Banda
2.	Mirzapur	10.	Chitrakoot
3.	Chandauli	11.	Hamirpur
4.	Gazipur	12.	Mahoba
5.	Kushinagar	13.	Jalaun
6.	Deoria	14.	Jhansi
7.	Mau	15.	Lalitpur
8.	Ballia		

It is proposed to provide one MMU at each Block accept District Head Quarter Block. Thus, a total of 135 MMUs will be operationalized. The budgetary estimates are as under:-

S.N.	Activity	No.	Unit cost (in lacs)	Total cost (in lacs)
1.	Capital Expenditure Cost of MMU Cost of office setup	 135 15	 13.28 3.00	 1792.80 45.00
2.	Operational Cost	135	18.00 per year	2430.80
	Total			4267.80

A budgetory support of Rs.4268.6 lacs has been approved by GOI for opeartionalisation of MMU.

10. EMERGENCY MEDICAL TRANSPORT SERVICES (EMTS) (FMR CODE B 12)

In view of the importance of access to ambulance services for reducing delays in access to care during emergencies, it was proposed to have emergency transport services in all districts. Thus, with the objective of providing immediate response during emergencies the ambulance service would provide basic first aid to the patient and transport them to the nearest facility. This activity was proposed to be done in partnership with the private sector. There was a provision for a control room (call centre) for receiving calls for the service through a toll free number. A district control room was to be established in each district for coordinating from the call centre and the ambulance provider. There was a provision for two types of ambulances, one having basic life support services and another having advanced life support services. This provision was made in the PIP for the year 2009-10. GoI had given the permission and sanctioned the fund of Rs. 7309.45 lacs to operationalise such kind of service in 12 selected districts through 315 ambulances. There was a rider from GoI that only the cost of ambulance is admissible under NRHM. The operating cost during first year is to be born by the State. However, due to certain bottlenecks the scheme of Emergency Medical Transport Services could not be operationalised in the year 2009-10.

However, in the year 2010-11 Government of Uttar Pradesh proposes to start the above mention service throughout the State. One ambulance will be provided to each 820 blocks and 13 Districts Head Quarters having a population more than 10 lacks will be provided 4 ambulances and rest other 58 District Head Quarters wil be provided 2 ambulances each. Thus, a total of 988 ambulances will be operated. All the ambulances will be having only the Basic Life Support System (BLESS). 1 ERC and 71 DCC will be established. The detail cost analysis is given below:-

Sl.	Description	Physical	Estimated Unit Cost (Rs.)	Total Budget (Rs. in lacs)
One –time Expenditure				
1.	Capital cost of Basic Life Support Systems Ambulances	988 units	10.00 lacs	9880.00
2.	Establishment of Emergency Response Centre (ERC)	1 unit	650 lacs	650.00
3.	Establishment of District Coordination Centres (DCCs)	71 units	5 lacs	355.00
Sub Total				***10885.00***
Recurring Expenditure for 10 months				
1.	For BLS Ambulances	988 units	0.72	7113.60
2.	ERC	1 unit	16 lacs	160.00
3.	DCC	71 units	1.50 lacs	1065.00
Sub Total				***8338.60***
60 % of the Operational Cost				5003.16

Based on the discussions with Government of India official's entire capital expenditure and only 60% of the operational cost is being budgeted for operationalising Emergency Medical Transport Services in the State. 40% of of the operational cost will be born by State Government.

Thus, a total sum of Rs. 15888.16 lacs was budgeted and approved by GOI for the year 2010-11

11. HUMAN RESOURCE

11.1 DEPLOYMENT OF CONTRACTUAL AYUSH DOCTORS AT 24 HOUR NON-FRU CHC AND PHC (FMR Code B 14.4 and B 14.1)

As already mentioned under the section on 'Human Resource' under RCH Flexipool, it is proposed to continue with the deployment of ISM practitioners, the cost of which would be met from Mission Flexipool.

Additionally, as mandated under NRHM for deployment of additional AYUSH practitioners at PHCs, it is proposed to deploy 1 male AYUSH doctor at each Additional PHC where no regular AYUSH doctor is posted on contract @ Rs. 24,000/month for graduates and Rs. 28000/month for post graduates. Further 1 post graduate AYUSH doctor may be posted at CHCs where AYUSH clinic may be run on regular basis. These AYUSH doctors undergo extensive four years study and clinical training (BAMS, BUMS and BMHS) and are trained for providing services required at the APHCs/ BPHCs/ CHCs.

Under NRHM, AYUSH Ministry is committed to providing infrastructure strengthening, training, equipments and medicines @ Rs.3 lac per unit every year, if human resources are provided through Mission Flexipool. It is proposed to strengthen 1570 identified Additional PHCs by providing AYUSH doctors and trained AYUSH Pharmacists of respective pathies at these facilities. Since AYUSH Pharmacists are available only in Ayurveda/ Unani, and as per information received from Directorate of Homeopathy, no training courses are run for Homeopathic Pharmacists, only about 1000 Pharmacists will be placed with Ayurveda/ Unani doctors. Thus, budgetary provision for deployment of 1000 AYUSH Pharmacist @ Rs. 9000/- per month is being made.

Fund requirement for the deployment of ISM Lady Doctor, male doctor, and Pharmacist is given below-

Sl.	Position	No. Proposed to be Deployed	Honoraria per month (Rs.)	Annual Expense (Rs. in lacs)*
1	ISM Lady Doctor at 24x7 units **(FMR Code B 14.4)**	901 (CHC-331, BPHC-470, APHC-100)	24,000/- pm	1946.16
2	AYUSH Male Doctor at CHC/ APHC **(FMR Code B 14.4)**	1500	24,000/- pm	3240.00
3	AYUSH Pharmacist **(FMR Code B 14.1)**	1000	9,000/- pm	810.00
Total				**5996.16**

*Calculations for nine months

An amount of Rs. 5996.16 lacs was proposed for this activitity but GOI has given approval for Rs. 5956.16 lacs.

12. INFRASTRUCTURE AND MANPOWER REQUIREMENT THAT ARE ESSENTIAL FOR IMPLEMENTATION OF UIP BUT NOT PERMISSIBLE UNDER PART C.

For improving the performance of immunization in the state, the following human resource is being proposed. This kind of deployement of human resource under the Part C budget of NRHM and hence with consent of RI programme division, GOI, the budgetary provision are being proposed in Mission Flexipool Part **B.**

FMR Code B.14.1 Human resource:

State has a State cold chain Officer as UP is a large State should need assistant cold chain officer

Monitoring and Evaluation Officer/Accounts manager is needed at state for monitoring of programme and regular flow of funds and SOE

There is need of personnel like semiskilled cold chain helpers to be available for 24 electricity and contingency plan to maintain cold chain.

Apart from Govt. persons additional requirement of Technician, Store keeper and Driver for Vaccine Van has been projected in PIP

FMR Code B.26.5 Infrastructure

Strengthening of RI and cold chain under Programme Management Head

Expansion of cold chain store rooms at State ,Divisional and District level is also needed

10 New places for installation of WIC/WIC

Mobile workshop in Regional Vaccine store.

Computers with internet are required at Regional depot for proper record keeping and flow of vaccine and logistic

FMR Code B.26.5 Review Meetings: Review meeting of refrigerators and vaccine store keepers are essential for proper feedback about vaccine, logistic and equipment status.

FMR Code B.26.5 Mobility support to blocks: Beside the regular funds for AVD, additional funds for mobility to block to cover vacant sub centre and “Mobile Sessions” for hard to reach area have been proposed.

Mobility support to Blocks to cover vacant Subcentre : There are shortage of 2546 ANMs in the state and approximately 244416 sessions/year will be planned and one vehicle will cover 4 sessions/day hence about 61104 vehicles/year will be required to cover vacant subcentre . Sessions will be covered by team approach in these areas.

No. of Vacant subcentres = 2546

No. of sessions planned /year = 244416/year (2546*8*12)

No. of vehicles required /year= 61104 (one vehicle will cover 4 sessions/day)

FMR Code B.26.5 In most of the places the separate connection of electricity has been taken for WIC locations & there no provision for the payment of electric bill to electricity board, Resultant the users are facing the problem for running the cold chain equipment at their division. Therefore some amount for the payment of electricity charges has been added in PIP 2010-11.

FMR Code B.18.3.2 Printing of ASHA payment slips, vaccine & genset log book and MCH register : Printing of MCH register are required for proper recording of pregnant women

and children and ASHA payment slips for payment to ASHA for mobilization of beneficiaries
FMR Code B.18.3.2 Districts innovation: "Arogayam" project scaling up in 5 Districts J.P.Nagar, Moradabad, Rampur, Bijnor and Baghpat the detailed writeup is provided in earlier section . **(Budget Sheet Enclosed after Page No 257 as page 257-A)**

13. PRE SERVICE, MANAGEMENT AND SPECIALIST TRAINING

A partnership is being developed with national level public health management institute for enhancement of managerial capacity of district and block level health programme managers. NRHM programme requires knowledge and skills for planning district action plans, monitoring and evaluation of the schemes for mid course correction and also optimal utilization of funds for maximum health benefit. Three categories of trainings have been planned for health managers at various levels-

13.1 State Institute of Health and Family Welfare (SIHFW)

13.1.1 State Level Interventions for Program Management & Human Resource Development

a) Orientation of VHSC members

Orientation of VHSC members on their roles & responsibilities under NRHM. This year this orientation could not be started so for in the year 2008-09 about 55278 members from 5527 VHSC were trained. It is planned that in the year 2010-11 members from 24000 VHSCs (240000 members) will be oriented for 2 days on their roles and responsibilities under NRHM. TOTs have been completed this year and all levels of PMU Managers have been trained on NRHM programme implementation to facilitate this field level training.

b) NRHM Managerial Skill Development Training (FMR Code B 16.3.3)

A partnership is being developed with national level public health management institutes for enhancement of managerial capacity of district and block level health programme managers. NRHM programme requires knowledge and skill for planning district action plans, monitoring and evaluation of the schemes for mid course correction and also optimal utilization of funds for maximum health benefit. Three categories of trainings have been planned for health managers at various levels :

- **Programme management training for districts level managers**

A training package has been planned for year 2010-11 for Additional CMOs/ Dy.CMOs who are looking after NRHM in the districts. The course contents include more knowledge and hands on practice for planning and implementation of NRHM schemes and guidelines. A plan to train 200 district programme managers (at least 3 from each of the 71 districts) has been planned.

Routine Immunization Strengthening under Mission Flexipool for year 2010-11

S.No	FMR-Budget Head	Activities	No. of Units	Rate per Unit	Freq.	Total (in Rs. Lacs)
12	**B14**	**INFRASTRUCTURE STRENGTHENING AND MANPOWER REQUIREMENT FOR IMPLEMENTATION OF UIP**				
12.1	**B14.1**	**Human Resources**				
	B14.1	State level				
	B14.1	*Assistant Cold Chain Officer*	1	30000	12	3.60
	B14.1	*Monitoring and Evaluation Officer*	1	30000	12	3.60
	B14.1	*Cold Chain Handlers*	5	8000	12	4.80
	B14.1	Regional/ Divisional				
	B14.1	*Programmers cum computer assistants*	18	12000	12	25.92
	B14.1	*Cold-chain handlers*	18	8000	12	17.28
	B14.1	*Technician*	9	15000	12	16.20
	B14.1	*Vaccine Store Keeper*	9	20000	12	21.60
	B14.1	*Drivers for van*	5	15000	12	9.00
	B14.1	District level				
	B14.1	*Cold Chain Handlers*	71	8000	12	68.16
	B14.1	*Technician*	12	15000	12	21.60
		Sub Total				**191.76**
12.2	**B26.5**	**Infrastructure**				
	B26.5	Expansion of cold chain workshop (71 district level and 15 for divisional level)	1	1000000	1	10.00
	B26.5	Mobile workshop (for regional depot Agra, Varanasi, Meerut and Lucknow)	4	400000	1	16.00
	B26.5	Renovation and electrification of WIC/WIF rooms going to be isntalled in 10 locations @100000/ location	10	100000	1	10.00
	B26.5	Expansion of cold chain workshop (71 district level and 15 for divisional level)	86	50000	1	43.00
	B26.5	Computers for Regional Depot	4	60000	1	2.40
		Sub Total				**81.40**
		Review Meetings				
	B26.5	Training of Cold Chain handlers	100	750	1	0.75
	B26.5	*Vaccine store keepers*	18	1500	4	1.08
	B26.5	*Refrigerators technicians*	89	1500	4	5.34
		Sub Total				**7.17**
12.3	**B26.5**	**Mobility Support to Block (1 hired vehicle @ Rs 800 for 4 sessions per day (there are 2546 vacant sub centres so total 244416 session have been planned in these areas)**	244416	200	1	488.83
		Sub Total				**488.83**
12.4		**Printing Activities**				
		ASHA payment slips	25000	45	3	33.75
		Vaccine log book	1000	30	1	0.30
		Genset log book	1000	30	1	0.30
	B18.3.2	MCH register	110000	70	1	77.00
		Sub Total				**111.35**
12.5	**B18.3.2**	**IVRS Systems for trackingof beneficiaries**	5			190.00
		Sub Total				**190.00**
	B26.5	Electricity bills for WIC/WIF				
	B26.5	*At State HQ/ Divisional HQ*	2	150000	1	3.00
	B26.5	*Regional Depot and Divisional HQ*	18	150000	1	27.00
		Sub Total				**30.00**
		TOTAL FOR INFRASTRUCTURE AND MANPOWER FOR UIP				**1,100.51**

- **Programme management training for block programme managers**

Similarly a course is being planned for block level managers (Senior Medical Officers). This training will be conducted at the state level by a team of state level programme managers. It is planned to cover 200 block managers in for the year 2010-11.

- **Hospital Management Training**

Hospital Management Training for CMS's of Male & Female District hospital and M.S. Male & Female of CHC of the district. This course for hospital managers has been developed at the State Institute of Health & Family Welfare (SIHFW). The contents of 5 days training would include Human Resource Management, Ward Management, Record Keeping, Clinical Services Management etc. A 5 days package has been planned for hospital managers from hospitals with less than 100 beds, similarly, a 11 days training package has been designed for hospital managers from hospitals with more than 100 beds. A total of 100 doctors, 50 in each category, at various managerial posts will be trained on these packages. 4 batches with duration of 5 days for 25 participants would be conducted at State Institute of Health & Family Welfare (SIHFW).

- **Five days Administrative Management Training for CMS**

For giving information on administrative and financial procedures (rules and regulations) 100 CMS (male and female) will be trained in 4 batches (25 participants in each batch). Duration of the training will be five days.

- **Five days training on Disaster Management for Medical Officers**

Many of the districts in Uttar Pradesh are disaster prone. Flood is almost a regular phenomenon in Uttar Pradesh mainly in Terai districts. Besides, earthquakes and other natural calamities occur very frequently in the state. Role of health department becomes very crucial in the time of disaster. Considering this, 5 days trainings for the medical officers will be held on disaster management. The focus of the training will be on the disaster preparedness of health department and its role during and after calamities.

In the financial year 2010-2011, Total 200 Medical officers will be trained on disaster management. The trainings will be held at State Institute of Health & Family Welfare (SIHFW) in 8 batches (25 participants in each batch). Medical officers from disaster prone districts of the state will be called for these trainings. Experts of the subject will be invited for facilitating sessions of these trainings.

- **Five days BCC trainings for District Program Management Units**

All District Program Managers, District Community Mobilizers, NGO personnel of NRHM have been provided induction training organized by State Institute of Health & Family Welfare (SIHFW). A five day training has been planned for them in the year 2010-2011. Around 1000 participants will be trained in 16 batches.

- **Orientation of District Administrative Officers (DAOs) on NRHM**

5 days orientation workshops will be organized for the DAOs and District Health Education Officers (DHEIOs) of all the districts. Nearly 75 participants will be trained in 3 batches. The orientation will be held at State Institute of Health & Family Welfare (SIHFW). These officers are looking after the NRHM activities at the district levels.

- **Training Programme on Gender Sensitivity & Gender Equity for Health Professionals**

Women play an important role in health status of the entire family, but they have been kept outside health and development process. In most cases, women are in a position of socio economic disadvantage that negatively effects their health and it is thus necessary to promote interventions that seek to improve women's disadvantageous situation. Therefore until equity is achieved, it requires a gender approach to give special focus to women's situation. It is also required that health professionals do understand the relationship between gender health and development

The focus of this training programme would be to enhance gender sensitivity and also sensitize the health professionals so that they are able to conceptualizes gender about issues related to gender, in-equalities issues and integrate them into developmental process. The contents to be covered Gender, Gender Inequalities, Gender Equity, Gender Budgeting, PCPNDT Act, & MTP Act, Gender and HIV, AIDS vulnerability, Domestic Violence and Health consequences and action plan. During this training medical officers of PHCs/CHCs would be trained on a 5 days training package.

- **Family Life Education**

Girls & Boys, when they reach the reproductive age group, require some kind of family life education. This is the time when they need to know about reproductive health, child bearing, family planning, RTI & STI and child rearing etc. They also need to know the right age for marriage, child rights and their reproductive rights.
Teachers of Government Inter colleges are required to be trained on the above mentioned topics so that they can disseminate this information to their students. 4 batches of 5 days duration have been planned for the year 2010-11 Each batch would consist of 25 participants.

- **Five Days training on Behavior Change Communication (BCC) for District Public Health Nurses (PHN), District Health Visitors and Tutors**

Five days trainings on Behavior Change Communication will be organized for District Public Health Nurses and District Health Visitors. Total 150 participants will be trained in 6 batches. The training will be held at SIHFW.

c) Twelve days foundation course for newly appointed Health Education Officers (HEOs)

Health Education Officers were recruited through UP Public Service Commission in Year 2008. These officers have been designated as Block Program Managers of NRHM as well.

In the financial year 2010-2011, a 12 days foundation course is proposed for newly appointed officer. Out of approximately 502 HEOs, a total of 200 officers will be trained

in 8 batches. The foundation course will be organized by State Institute of Health & Family Welfare (SIHFW). The course curriculum will include roles and responsibility of HEOs, Government servant's conduct rules, structure of the department, demographic indicators and public health issues of India and Uttar Pradesh, Orientation on NRHM and its components, Inter – sectoral and Inter-departmental coordination, Financial management, Supportive supervision, Management skills, Community participation and mobilization etc.

d) Two day's trainings for Rogi Kalyan Samities (RKS) members (FMR Code B 8.2)

Two rounds of trainings have already been organized for the members of Rogi Kalyan Samitis. In the year 2010-2011, 2 days training is planned for selected members of RKSs.

About 2300 RKS members will be trained in 95 batches held at district level. Besides, State Institute of Health & Family Welfare (SIHFW) will organize two days ToTs for the district level trainers (300).

This round of RKS training will focus on community participation for better hospital services.

e) Integrated Skill Upgradation training for paramedicals (12 days) (FMR Code B 16.3.1)

Skill upgradation training for ANMs and LHVs (12 days) at ANMTCs, logistics management training for pharmacists and store keepers (3 days) at RHWTCs and five days training for Statistical Officers and ICC at RFWTCs will be conducted. A TOT for 5 days for the above courses will be organised at SIHFW.

- **ANMs and LHVs training:** Training for ANMs and LHVs is proposed to develop core skills as per need identified & NRHM Programme Management. The Training will cover ANM & LHVs of 71 districts of U.P. At district level the duration of training will be 12 working days. This year (2010-11) it is proposed to train 7155 ANMs & LHVs. At SIHFW 250 trainers will be trained in 10 batches.

Logistics Management Training for Store Keeper & Pharmacist (3 days): (FMR Code B 16.3.3)

Training for Store Keeper and Pharmacists will be organised to train basic NRHM & associated required skills regarding logistics. Trainings will be conducted at Regional Health & Family Welfare Training Centres (RHFWTCs), during 2010-11. Three days' training will be conducted in 44 batches to train 660 participants.

Statistical officers & Investigator cum computers (ICC) (5 days) (FMR Code B 16.3.3)

Statistical Officers & Investigator cum computers (ICC) at PHC/CHC so that they will be able to keep the record at PHC/CHC, This training will enable them to handle all statistical figures and make available to higher level as & when required. Trainings will be conducted at Regional Health & Family Welfare Training Centres (RHFWTCs), during 2010-11. Five days training will be conducted in 22 batches to trained 550 participants.

f) Training of ENT Specialists for updated knowledge and recent developments regarding hearing impaired (FMR Code B 16.3.3).

ENT Specialists are usually posted in the District Hospitals and Community Health Centers. There is rarely a provision of training for them to acquire recent knowledge and skills being used in higher centers like Chatrapati Shahu ji Maharaj Medical University, Lucknow. So a 5 Day training is being planned for ENT Specialists at Lucknow in collaboration with the ENT Specialists of Chatrapati Shahu ji Mahraj Medical University, Lucknow. This training will upgrade their knowledge in field of Ear, Nose & Throat to enable better service to hearing impaired.

g) Hospital Waste Management Training (FMR Code B 16.3.3)

It is observed that quality of sanitation and hygiene depends on the skills of concerned staff of the hospital. It is proposed that after giving two days TOT at SIHFW to the concerned officer of the hospital this 3 days training will be conducted at district hospital concerned. This officer will act as a trainer to train the ward boys and sweepers of district hospital concerned. At SIHFW 6 batches of 2 days TOT will be conducted and thereafter a three day training of 142 batches of 25 participants each will be organized at the district hospital concerned. A total of 3550 participants will be trained.

h) Pre Service Training of Male and Female Health Worker (FMR Code B 16.3.2)

Pre-service training of health workers is essential so that these male and female health workers have a basic understanding of health. The State has already advertised for the positions of Male Health Workers and 4960 workers will be trained. The training for these workers is for one year and will be conducted in the Regional Health and Family Welfare Training Centres (RHFWTCs) and District Peripheral Training Teams – *Achal Prashikshan Kendra* (DPTTs). Training for the batches exceeding the capacity of the RHFWTCS will be outsourced.
It is proposed that 1911 Female Health Workers will be trained in 2010-11. The duration of their training will be 1.5 years. These trainings will be conducted at the 40 ANMTCs in 40 batches.

For improving the quality of training and maintenance of training facilities support will be provided in following areas.

- Hiring of vehicles and POL – A plan for hiring vehicles or arrangement for POL at each of the training centre for transportation of students to rural training sites and clinical hospitals has been incorporated in the plan.
- Contractual manpower – All the training centres will be provided tutors, chowkidars, part time clerk and warden/ caretaker as per their requirement.
- Contingency – A fixed amount of contingency support will be provided to each of the training centres to enable them communication, stationary and repair and maintenance of teaching/training equipments and honorarium to guest faculty.
- Mannequins: The pre-service as well as in-service training will be imparted at all 40 ANMTCs and 30 DPTTs which are being strengthened to equip them with training tools. It is proposed to procure 70 mannequins @ Rs. 1.50 lacs which will help trainees to practice hands on training and gain skill proficiency. These mannequins will be used for all the comprehensive training like SBA, IUD training, and female sterilisation trainings. Rs. 105.00 lacs are being budgeted for procurement of these mannequins in the year 2010-11.

National Institute of Health and Family Welfare (NIHFW) (FMR Code B 16.3.3)

NIHFW is the apex institute for training in the country. To get an exposure to national and international best practices in training, it is proposed that SIHFW will collaborate with them to organise trainings. Trainings identified are:

- **Training on latest technology and skills for medical and health:** NIHFW will conduct a three weeks training programme for one batch (25 participants) in which the participants will be exposed and trained on latest technology and skills available in the field of health.

- **Training course PPPs in Health sector:** Public Private Partnerships in healthcare is an emerging area and there are many examples of national as well as international best practices which could be adapted in the State. Therefore, a decision was taken that training on PPP be organised with NIHFW to expose health professionals in the State to these innovations. Doctors and Administrators, in two batches (25 participants each), will be trained on PPPs by NIHFW.

- **Specialised skill training in the area of cardiology, ENT, ortho and neuro:** This training will be organised through NIHFW at prestigious clinical institutes of our country. A lumpsum budget for 30 lacs has been proposed for this training. NIHFW will be providing details of the hospitals and number of trainees in above different speacialities subsequently.

- **Specialised skill training:** It is proposed that NIHFW will coordinate with Medical Colleges in other States to enable skill based training of 400 participants in specialisation areas such as opthamology, ortho, intensive care and emergency life saving skills. A detailed training plan will be developed with NIHFW for this training.

- **Training on Public Health Management:** Doctors will be trained on public health management issues and latest hospital practices and procedures. A class based

training combined with exposure visit to state specific models in the country implementing innovative best practices will be undertaken. The curriculum and training plan will be developed by SIHFW and NIHFW.

SIHFW Strengthening (FMR Code B.16.1)

As a measure for strengthening of SIHFW, following activities have been planned-

- To ensure quality of training activities, monitoring is necessary from the State Institute of Health & Family Welfare (SIHFW), Directorate of Family Welfare and Health and State Programme Management Unit (SPMU) officers at the state level. A provision is being made in the PIP for organizing study tours, meetings and 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. The financial norms will be same as approved for both the Directorates and SPMU.

- Strengthening of classrooms proper furniture, mess utensils, Lenin for hostels and various kinds of teaching aids are to be arranged in order to give the quality training to the participants.
- There is a need of contractual manpower for security, classrooms and hostel attendants, mess support staff consultants, data entry operators and other support staff for the smooth conduction of training. For various field visits, transportation support in the form of fuels, POL and maintenance of vehicle, communication is also required. There is a need to strengthen the library also.
- **Extension of classrooms**- The various kinds of training activities have been planned for the current years. There are only two classrooms and one meeting hall in the institute. It is highly desirable to have more classrooms and extension of the existing classrooms. For this activity a budgetary provision Rs. 300 Lacs have been made and approved by GOI.

COMPREHENSIVE TRAINING PLAN (SIHFW)- PIP 2010-11

SN	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
B	**Programme Management and Human Resources Development**									
1	**Orientation of VHSC Members**	VHSC Members	2 Days	820	Block Head Quarters	TOT has been completed, 5245 trainers trained, 55278 members already trained. Rest of members will be trained	8000	30	240000	1056.00
2	**NRHM Skill Development Training**									
2.1	**Programme Management training for district level managers**	ACMO/Dy.CMO	5 Days	1	SIHFW	Training on NRHM related programmes and activities	8	25	200	16.22
2.1.1	**Hospital Management Training**	CMS (Male & Female)	5 Days	1	SIHFW		4	25	100	10.14
2.2	**Programme Management Training for block programme managers**	Senior Medical Officers	5 Days	1	SIHFW	Training on NRHM related programmes and activities.	8	25	200	16.22
2.3	**Administrative training for CMS**	CMSs	5 Days	1	SIHFW	Admin& Financial rules, regulations, Hospital Management etc.	4	25	100	8.11
2.4	**BCC trainings for District**	DPMs/DCMs & NGO Personnel	5 Days	1	SIHFW	Knowledge about Behaviour change	16	25	400	32.44

SN	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
	Programme Management Units					communications for implementation of NRHM Programme				
2.5	**Orientation of District Administrative Officers in NRHM**	Administrative Officers of districts	5 Days	1	SIHFW	NRHM Activities & NRHM Financial Rules & Regulations	3	25	75	4.85
2.6	**Disaster Management Training**	Medical Officers of CHC	5 Days	1	SIHFW	Preparedness in Hospitals & PHC/CHC in case of Disasters	8	25	200	16.22
2.7	**Gender Sensitization Training**	Medical Officers	5 Days	1	SIHFW	Gender planning, gender budgeting & knowledge about PCPNDT Act.	4	25	100	10.14
2.8	**Family Life Education**	Principals & Teachers of GICs	5 Days	1	SIHFW	To sensitize the principals of GICs about NRHM activities to propagate the issues in their colleges & civil society	4	25	100	8.11
2.9	**BCC/IPC trainings**	Tutors/DPHN/DHV	5 Days	1	SIHFW	To train on IPC/BCC . These trainers will impart training to ANMs	6	25	150	9.69
2.11	**Foundation Training**	HEOs	12 Days	1	SIHFW	Training on roles & responsibilities, Govt. Servant conduct rules, financial rules etc	12	25	300	27.56
3	**RKS Training**									
3.1	TOT	Trainers of SIHFW	2 Days	1	SIHFW	Capacity Development of RKS Members	12	25	300	15.08

SN	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
3.2		RKS Managers	2 Days	13	RHFWTC	Capacity Development of RKS Members	95	24	2300	47.03
5	**Integrated Skill Upgradation Training for Para Medicals**									
5.1	Training of Trainers	Trainers of RHFWTC /ANMTC/DH/	5 Days	1	SIHFW	These trainers will form Pool of Trainers to conduct training at Division or District Level	10	25	250	20.28
5.2	Skill Upgradation	ANMs/LHVs	12	51	RHFWTC & ANMTCs	The ANMs/LHVs who don't receive SBA training will receive this training for Core Skills including IUD.	446	15	6690	740.58
5.3	Skill Upgradation	Store Keepers & Pharmacists	3 Days	11	RHFWTC	Their Roles & Responsibilities in NRHM	44	15	660	20.43
5.4	Skill Upgradation	Statistical Officers & Computers	5 Days	11	RHFWTC	Their Roles & Responsibilities in NRHM, Different formats regarding FMIS	22	25	550	30.25
6	**Hospital Waste Management Training**									
6.1	TOT	Clincians from DH	2 Days	1	SIHFW	Training on Different Types of Waste, Disposal of Waste in	12	25	300	5.53

SN	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
						Hospital				
6.2	Field Training	Ward Boys & Support Staff	3 Days	71	District Hospitals	Different Types of Waste, Disposal of Waste in Hospital	142	25	3550	71.00
1	**Cardiology**				In collaboration with NIHFW	Training programmes to be organised for specialists/Clinicians of PMS				445.6
1.1	**2 D Eco/TMT Refresher**	Cardiologists	1 Week		In collaboration with NIHFW		1	25	25	
1.2	**Cath Lab**	Cardiologists	6 Months	1	In collaboration with NIHFW		1	5	5	
1.3	**ICCU Refresher**	Cardiologists & Clinicians	15 Days		In collaboration with NIHFW		4	10	40	
2	**Trauma Management**	Medical Officers of CHC/ DHs			In collaboration with NIHFW		10	10	100	
3	**Emergency Management**	Doctors/Technicians/SN & Others			In collaboration with NIHFW		15	5	75	
4	**Bronchoscopy Refresher**	Chest Specialists	15 Days		In collaboration with NIHFW		10	10	100	
5	**Harmone Analysis**	Pathologists	15 Days		In collaboration with NIHFW		10	10	100	
6	**Colcoscopy Training**	Surgeons/Gynaecologist	15 Days	1	In collaboration with NIHFW		3	10	30	
7	**Ear, Nose, Throat(ENT)**	ENT Specialists of Districts	5 Days	1	SIHFW In Collaboration with CSMMU, Lko	Latest development on techniques in field of ENT	3	25	75	6.08
7	**Pre Service Training**									
7.1		Male Health Worker	1 Year	11+	11 RHFWTC & Other Recognised institutions	Advertisement publisehed on 11 Jan., 2010 for the post.	83	60	4960	2070.00

SN	Area & Name of Training	Category of Trainees	Duration	No. of Sites	Details of Training Sites	Comments	Total Batches	Number of Trainees/batch	Total Number of Trainees	Estimated Budget (in Lacs)
7.2		ANMs / LHVs	1.5 Years	40	ANMTCs	Advertisement publisehed on 11 Jan., 2010 for the rerverve category posts.	32	60	1911	512.00
8	**Monitoring & Evaluation**	Training related M &E activities, planning & review meetings, seminars, workshop and study tour and research etc. for quality improvement								20.00
9	**SIHFW Strengthening (include Renovation)**									505.04

SCHEME FOR MEDICAL OFFICERS AND NURSES FOR PURSUING POST GRADUATION (FMR Code B 16.3.3)

It is a well established fact today that the limited success of the various health programs/interventions in the State is the result of poor program management rather than the programs having inherent flaws per se. The need for imparting systematic education in public health therefore gains importance. To meet this need and also to provide and incentive to young Medical Officers in the cadre, it is proposed to sponsor candidates each year for pursuing post graduation in Public Health from reputed institutions in the country. Further, there are courses for professional development and on Family Medicine, etc. that are being run by reputed institutions. Medical Officers would also be sponsored for studying such courses. Also nurses, who are interested in pursuing M.Sc. Nursing or to attend Speciality Nursing Courses, would be sponsored. **A total budgetary provision of Rs.50 lacs is being made for the same.**

SUMMARY OF TRAININGS – 2010-11

FMR-Budget Head	Activities	No. of Units	Rate per Unit	Total (in Rs. Lacs)
	NRHM Managerial Skill Development Training			
B16.3.3	*Addl. CMO/ Dy. CMO (5days)*	8	202750	16.22
B16.3.3	*Senior MOs(5 days)*	8	202750	16.22
B16.3.3	*Administrative Management Training for CMS Famale & Male (5 Days)*	4	202750	8.11
B16.3.3	*Disaster Management(5 days)*	8	202750	16.22
B16.3.3	*BCC training for DPM. DCM/ DAM and NGO*	16	202750	32.44
B16.3.3	*NRHM Management Trainings for Dist. Administrative Officers (5 days)*	3	161500	4.85
B16.3.3	*Gender Sensitization to MOs(5 days)*	5	202750	10.14
B16.3.3	*Family Life Education for Principals(5 days)*	4	202750	8.11
B16.3.3	*BCC Trainings for DPHN, DHV/ Tutors(5 days)*	6	161500	9.69
	Sub Total			**121.99**
B16.3.3	**Foundation Training for HEO(12 days)**	8	344550	**27.56**
	RKS			
B8.2	*RKS TOT(3 days)*	12	125650	15.08
B8.2	*Dist RKS Members' Field Training (2 Days)*	95	49500	47.03
	Sub total			**62.10**
	Integrated Skill Refresher Training for ANM and LHV			
B16.3.1	*TOT (5 Days)*	10	202750	20.28
B16.3.1	*ANM and LHV(12 days)*	446	165950	740.58
B16.3.3	*Logistic Management Training for Pharmacists & Store Keepers (3 Days)*	44	46440	20.43
B16.3.3	*Statistical Officer & ICC (5Days)*	22	137480	30.25
	Sub total			811.54
B16.3.3	**Training of ENT specialist**	3	202750	**6.08**
	Hospital Waste Management Training			
B16.3.3	*TOT (2 Days)*	6	92100	5.53
B16.3.3	*Field Training (3 Days)*	142	50000	71.00
	Sub total			**76.53**
	Pre service Training			
B16.3.3	**Preservice Training of MHWs(duration 1 year**	1	2070.00	2,070.00

FMR-Budget Head	Activities	No. of Units	Rate per Unit	Total (in Rs. Lacs)
	with 5000 participants)			
B16.3.2	**Preservice Training of FHWs (duration 1.5 years, no. of participants 2400)**	40	1280000	512.00
	Sub Total			**2,582.00**
	Training course to be organised through NIHFW			
B16.3.3	Training on latest technology & skills for medical health	25	400,000	100.00
B16.3.3	Training course on Health sector	25		20.00
B16.3.3	Specialised skill trg. In cardiology,ENT,Otho, Neuro (outside UP)			30.00
B16.3.3	Training of specialised skill in specialised areas (outside the state)	400		195.60
B16.3.3	Training on public health management and current procedures/hospital practices with exposure to different states (ouside UP)	220		100.00
	Sub Total			445.60
	SIHFW Strengthening			
B16.1	*Training related M & E activities, planning and review meetings, seminars, workshops and study Tours and Research etc. for quality improvement*	1	2000000	20.00
B16.1	*Strengthening of SIHFW (Class Room Furniture, Mess Utensils, Linen for Hostels, Teaching Aids)*	1	15000000	150.00
B16.1	*Contingency Support to SIHFW(Transportation, POL, Maintenance of vehicles Communication, Library)*	1	600000	6.00
B16.1	*Hiring of Security Guards, Class Room & Hostel Attendants & Mess Support Staff*	1	2400000	24.00
B16.1	*Contractual Man Power – Consultants-3, Data Entry Operator-2, Support Staff-2*	1	2504000	25.04
B16.1	*Extension of classroom*	1	30000000	300.00
	Sub Total			**525.04**
	TOTAL FOR SIHFW + NIHFW			**5,714.44**
B16.3.3	**Scheme for MOs and Nurses for pursuing PG**	1	5000000	**50.00**
	TOTAL FOR TRAINING			5764.44

The above calculations (related to SIHFW training) have been made as per the letter no A 11033/101/2007/trg dated 17 Nov 2009 giving the following norms for SIHFW related training:

11. Perdiem to trainees (Group A and B) Rs. 700.00
12. Perdiem to trainees (Group C and D) Rs. 400.00
13. Honorarium to State level facility Rs. 1000.00
14. Honorarirum to District and sub District level facility Rs. 600.00
15. Food arrangements (per day/ per participant) Rs. 150.00
16. Contingency (per day/ trainees) Rs. 100.00
17. Institutional overhead 10% of training cost
18. Venue arrangement Rs. 1000.00 per day or actual cost
19. TA as per State government norms (actuals)
20. Eminent faculty with subject specialisation will be invited for trainings at their rates

The total budget for training of Rs. 5764.44 lacs is sanctioned by GOI.

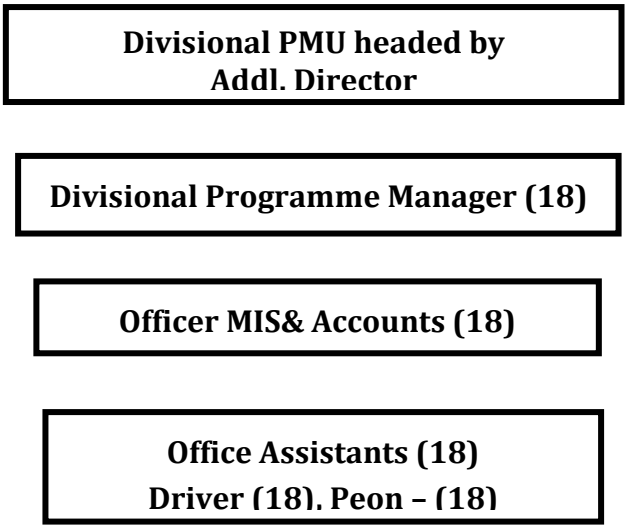
14. PROGRAMME MANAGEMENT

A detailed note on the structure of SPMU and programme management units at the State, division, district and block level has been detailed in the Programme Management section of RCH Flexipool. Considering the high population and number of districts in the State, there was a need to establish units at the block as well as division level for efficient management. Components of operational expenses have been included under the Mission Flexipool budget.

14.1.1 Divisional PMU

Divisional Programme Management Units have been established in 18 divisions. These units have been placed under the Additional Director of the Division and each unit has a Programme Manager who is assisted by an Officer responsible for MIS and accounting activities. The structure of the divisional PMU is shown below:

Structure of the Divisional PMU

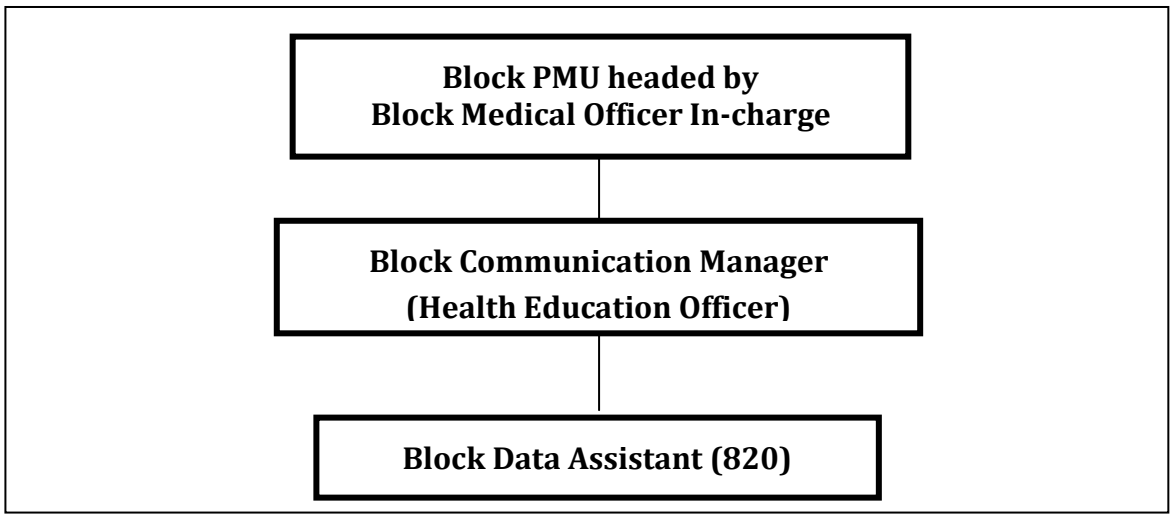


The Divisional PMUs are mentoring the District PMUs and assisting in NRHM programme implementation

14.1.2 Block PMUs

At the block level, the Block MOIC would be head of the Block PMU and would be supported in his function by the Block Programme Manager/Health Education Officers, appointed by the State government, and Data Assistants hired on contract under NRHM. The block level structure is as shown below:

Structure of Block PMUs



a) Operational Expenses for Divisional PMUs from Mission Flexipool (FMR Code B 27.6)

Sl.	Description	Annual Expense (Rs. in lacs)
1	Operating Expenses of Divisional PMUs (@ Rs. 125,000/- per month x 12 months x 18 units)	270.00
Total		**270.00**

b) Operational Expenses for Divisional ADs (FMR Code B 27.6) (to be met from Mission Flexipool)

Sl.	Description	Annual Expense (Rs. in lacs)
1	Mobility Support for monitoring & supervision (@Rs. 2500 p.m. per district)	21.30
2	Contingencies (Rs. 5,000 per month x 18 Divisions)	10.80
Total		**32.10**

c) Operational Expenses for Block Units (FMR Code B 27.1) (to be met from Mission Flexi pool)

Sl.	Description	Annual Expense (Rs. in lacs)
1	Honoraria to Block Unit Staff • Block Data Assistant (Rs. 8,000 per month) (@ Rs. 8,000/- per month x 12 months x 820 units)	787.20
2	Other Operating Expenses of Block Units • Communication Support to Block Prog. Manager (Rs. 500 per month) • Contingencies (Rs. 1,000 per month to be met from ASHA Support system)	49.20
Total		**836.40**

Budget Summary (Programme Management) 2010-11

S.No	FMR-Budget Head	Activities	No. of Units	Rate per Unit	Freq.	Total (in Rs. Lacs)
14		**DIVISIONAL/ BLOCK PROGRAMME MANAGEMENT UNIT**				
		Programme Management Expenses				
	B27.6	*Operational Expenses of Divisional Units*	18	125000	12	270.00
	B27.6	*Operational Expenses of Divisional AD Offices*				32.10
	B27.1	*Honoraria to Block PMUs staff*	820	8000	12	787.20
	B27.1	*Operational Expenses to Block Units*				49.20
		TOTAL FOR PROGRAMME MANAGEMENT				**1,138.50**

15. STATE HEALTH RESOURCE CENTRE (SHRC) (FMR Code B 25)

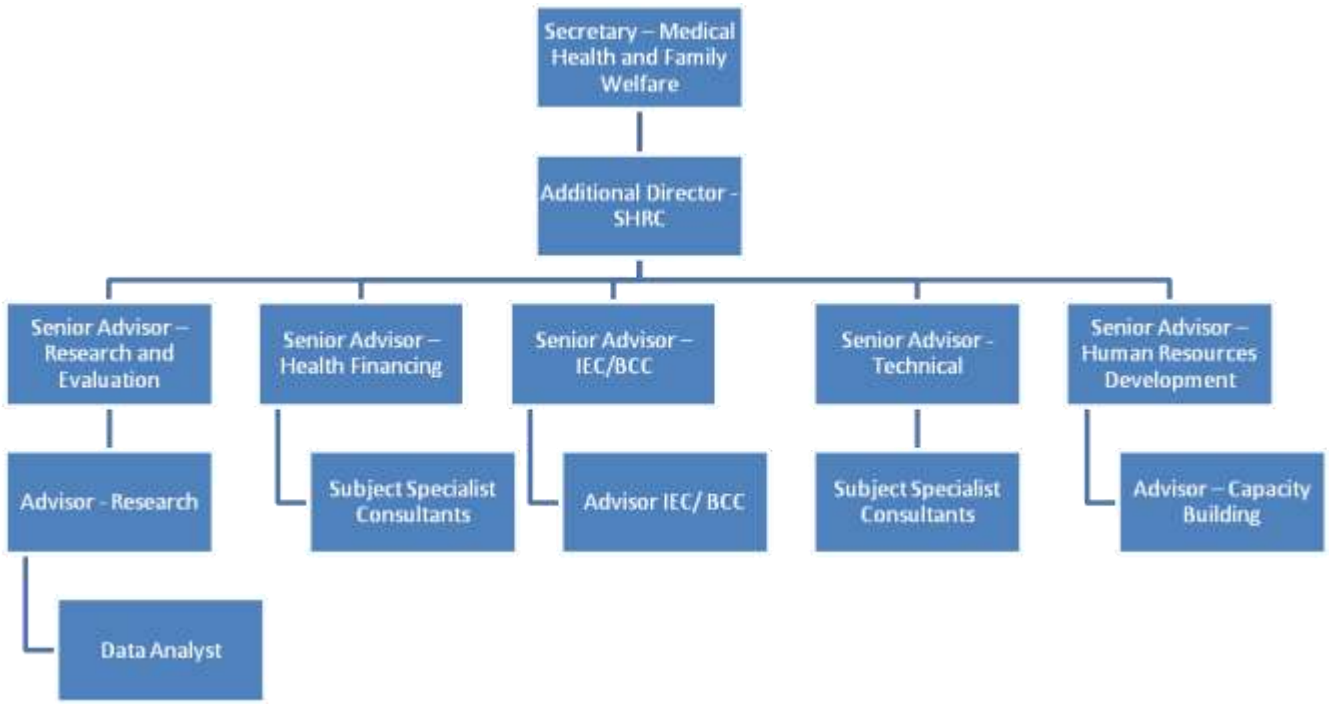
The NRHM mandates that each State set up a State Health Resource Centre along with the SPMU. Despite various discussions on the subject, the State has not been able to operationalise such a unit as yet. It is planned that the SHRC would be set up in the year 2010-11.

The State Health Resource Centres will act as the 'think-tank' for the State in implementing the NRHM and providing technical assistance for improving health systems in the State. Specifically its role will be to:

- Conduct high quality research and surveys, rapid assessments and appraisals in selected areas and on identified topics that contribute to understanding of programme issues and results achieved, impact made by programmes, and areas that need to be strengthened;

- Document and disseminate best practices and successful experiences of other states as well as countries to different stakeholders;
- Provide technical support to the Directorate on BCC strategy implementation plan, development of materials and media plans, design of BCC campaigns and study of impact of these campaigns on improved awareness and knowledge and behaviour change;
- Identifying capacity building need, develop training modules and innovate on capacity building methodologies, including exploring satellite centres for distant learning;
- Development of an evaluation plan, design evaluation studies to assess programme performance in identified areas, empanel research agencies for conducting these evaluations, identification of research agencies, training of investigators, monitoring the study in field, finalization of reports, documenting and disseminating findings and identifying areas for strengthening programme implementation;
- Development of standardised protocols and tools for ensuring minimum quality standards in health care service delivery; and
- Designing innovative public private partnership models, conducting operations research by piloting them, documenting lessons learnt and designing scale up plans for successful models.

Based on the above role for SHRC, it has been designed as a top heavy and responsive organisation. Since the SHRC will be required to provide very technical and specialised input, provision has been made to hire subject specialists and experts for short durations.



Since this unit will have to established in the State, linkages and tie ups with existing structures would be explored for functioning of the unit under the leadership of Secretary Medical Health and Family Welfare. An estimated budget for the unit has been calculated in the table below:

S.No	Activities	No. of Units	Rate per Unit	Frequency	Total (in Rs. Lacs)
15	**STATE HEALTH RESOURCE CENTRE (FMR Code B25)**				
1	**Personnel**				
	Secretary -Medical Health and FW	-	-	-	
	Additional Director - SHRC	1	125000	12	15.00
	Senior Advisor- Research and Evaluation	1	100000	12	12.00
	Senior Advisor - Health Financing	1	100000	12	12.00
	Senior Advisor- IEC/ BCC	1	100000	12	12.00
	Senior Advisor - Technical	1	100000	12	12.00
	Senior Advisor - Human Resource Development	1	100000	12	12.00
	Advisors (Research, IEC and Capacity Building	3	75000	12	27.00
	Data Analyst	1	50000	12	6.00
	Longterm Consultants (4 consultants for 88 days each)	4	6000	88	21.12
	Short term consultants (6 consultants or 20 days each)	6	8000	20	9.60
2	**Operational Expenses**	1	500000	12	60.00
3	**Activities**				0.00
	Retainer for empanelled advertising agency	2	500000	12	120.00
	Hiring agencies for conducting research	10	1000000	1	100.00
	Books and periodicals	5	1000	12	0.60
	Library set up costs	1	1000000	1	10.00
	Exposure and field visits	5	10000	72	36.00
	Setting up hardware for distance education	1	10000000	1	100.00
4	**One time set up costs**	1	10000000	1	100.00
	SUB TOTAL FOR SHRC				**665.32**

The total budget proposed for SHRC is Rs 665.32 lacs and same has been approved by GOI.

16. DISTRICT ACTION PLAN (FMR Code B 7)

Decentralised planning is an elaborate process for a State with 71 districts. However, based on guidelines received from Government of India, guidelines were issued to each of the districts with formats to provide information on specific indicators in November 2009. Four regional meetings were convened from December 8 to 11, 2009 by Directorate General – Family Welfare with CMOs, ACMO (NRHM) and District Program Managers (DPMs). Preliminary instructions for preparing the DHAPs were shared with these representatives. Four consecutive workshops were conducted at State Programme Management Unit (SPMU) with the support of National Health Systems resource centre (NHSRC) with representatives from each of the divisions and districts in which the planning processes were discussed in detail. A planning meeting was conducted under the leadership of Divisional PMUs at district and block level to identify district specific health needs. Capacity building of Block Medical Officers and Block Managers was part of this meeting in which village health planning processes were elaborated and clarified. Each Block Medical Officer prepared atleast one Village Health Plan with the respective VHSC members and the Block Health Plan. These were then compiled at the district level for the District Health Action Plan. Seventy one DHAPs and more than 1000 Village Health Action Plans have been developed for the State and a team of Divisional PMU has been constituted at the State level to review these plans and develop district specific innovative activities to improve health service delivery.

District level variations and district specific needs have been addressed and included in the State PIP. Evidence from high focus districts including flood affected areas, drought affected areas, JE/ AES affected areas, minority communities, tribal areas, fluorosis/ silicosis affected areas, left wing extremist affected areas, Bundelkhand has been considered while designing strategies. Specific issues like poor literacy, sex discrimination, high TFR, etc. have also been considered for developing the district level strategies and innovative activities.

To conduct this exercise next year for developing the District Action Plans, for year 2011-12 an amount of Rs. 200.00 lacs has been approved by GOI.

17. DISTRICT SPECIFIC INTERVENTIONS (FMR Code B 22)

As mentioned earlier, each of the 71 districts had prepared a detailed District Health Action Plan, depending on their local needs. Government of India has provided the State with a list of 44 backward districts and for these districts a detailed plan has been developed through consultative processes involving Divisional Programme Management Units and District Programme Management Units. Depending on the area specific problem, solutions were suggested by the District identifying vulnerable groups and possible interventions. A team of SPMU/ Directorate/ Divisional PMU and District PMU officers identified areas of intervention from each of the District Health Action Plans. Areas of emphasis include those affected by Japanese Encephalitis, left wing extremist activities, hard to reach areas, flood affected areas, drought affected areas, vulnerable groups, minority groups, ravine belt, early age of marriage and high female feticide districts. The remaining District Action Plans (27) were also reviewed for their

specific need based interventions and have been included for the purpose of budgeting. Some interventions suggested by the districts and being operationalised throughout the State, such as the mobile medical units, health melas, NSV camps, etc. have not been included in this section. In addition, a separate plan has been prepared, based on proposals received from districts, to provide better health services to people residing in left wing extremist affected areas.

17.1 **Strengthening of JSY Accredited Centres:** Under the NRHM, there is an effort to make institutional delivery services available at the sub centre level. Thus women will be able to avail maternity services in the presence of a trained provider. This emerged as a strong need in the village and district action plans. This activity is being scaled up and it is proposed that 3800 sub centres will be accredited for providing natal services. This activity has been included in detail under the Maternal Health section of RCH Flexipool.

17.2 **Public Private Partnership:** While the School Health Programme reaches school going children for regular check ups, there is no provision for conducting check ups for non-school going children. A collaboration between public and private sectors for conducting health camps and eye screening for non-school going children has been proposed by five districts of Gorakhpur, Deoria, Kushinagar, Basti and Sant Kabir Nagar. Budget is proposed for corrective glasses for these children @ Rs. 6.43 lacs per district. **Rs 28.91 lacs has been approved by GOI for this activity.**

17.3 **Programme Support through NGOs:** Involving NGOs for community mobilisation and community level support has been planned in fifteen districts. These NGOs will be working with the community level institutions such as VHSCs and RKS for empowering communities to access health services. In addition, capacity building of ASHAs as an agent of change is envisaged to enhance the quality of service delivery. Mobilisation through community level activities is planned in these districts. This initiative is supported through USAID funded projects in eight districts. Budgets have been proposed as per the need of each district under the table for district specific intervention. **Rs 32.28 lacs has been approved by GOI for this activity.**

17.4 **Family Friendly Hospitals:** Districts have responded to the need for quality services and patient care by proposing Family Friendly Hospital initiative. However, this activity will be implemented in 80 FRUs at the outset and details of the initiative have been included under the section on Maternal Health under RCH Flexipool.

17.5 **Training of VHSC Members on Development of Village Health Plans:** Capacity building activities of VHSCs for development of village health plans has been proposed in 11 districts. Gorakhpur and Ballia have suggested implementing the VHSC strengthening model developed by SIFPSA. This model involves training and mentoring the VHSCs through handholding of these VHSCs. **Rs 65.87 lacs has been approved by GOI for this activity.**

17.6 **JE/ AES Control Programme**: Intensive activities in JE/ AES affected areas has been planned in seven endemic districts. Activities to ensure 100 percent vaccination of vulnerable populations, capacity building of ASHAs to prepare slides, incentive to ASHA for JE vaccination and follow up, spraying in and around piggeries, repair and maintenance of fogging machines and intensified disease surveillance are activities proposed at the district and block level . **Rs 86.50 lacs has been approved by GOI for this activity.**

17.7 **ASHA Performance Tracking System and Regular Recognition:** Detailed criteria have been established for identifying ASHAs and recognising their efforts. These criteria have been detailed out in the section on incentives to ASHAs under Mission Flexipool. Computerised systems for data entry, collation, identification of good performaers and regular recognition have been proposed in seven districts of Gorakhpur, Deoria, Kushinagarm Maharajganj, Basti, Sant Kabir Nagar and Siddharthnagar @ Rs 0.40 lacs each. **Rs 2.8 lacs has been approved by GOI for this activity.**

17.8 **Mahotsav/ Sammelans and Workshops:** Community level activities to encourage positive behaviours have been planned by 14 districts. Adarsh Dampatti Sammelans in which couples with spacing between children and acceptors of family planning methods will be felicitated. It is proposed to identify 100 such ideal couples in four districts of Ambedkar Nagar, Faizabad, Sultanpur and Barabanki @ Rs. 3000 for each couple felicitation has been proposed.

Nav Dampatti Sammelans to encourage delay of first child have been proposed in three districts. Newly wed couples will be invited to these gatherings along with their family members to emphasise the need for delay of the first child and spacing between children. Information on the complete basket of contraceptive choices will also be available for the couple. This will be conducted in a festive environment making the event enjoyable for the couples.
Sensitisation workshops for key stakeholders, workshops with PRI members and participation is large health melas has been included under this head.

Rs 32.5 lacs has been approved by GOI for this activity.

17.9 **Medical Bridge Facility:** An innovative model of Medical Bridge Facility will be initiated on a pilot basis in Lucknow division. The objectives of the model are:

- To provide a choice of providers to patients on referral and specialised health services available in their reach within the government as well as the private sector;
- To facilitate linkages between patients and the medical centres of their choice;
- To provide information on cost-effective and suitable medicines to patients; and
- Facilitate availability of cost effective and suitable medicines on a sustained basis

This model has been **developed and patented by an NGO** and will be implemented by them initially in Lucknow. Through this a database of all service providers and health facilities in the area along with their area of specialisation will be established. Linkages

will also be established with these facilities/ providers for referral of patients. While information on ANMs and PHCs will be included in the database, no linkages for referrals will be established with them. Database for government and private operators for transportation as well as willing pharmaceutical suppliers will also be developed. Services will be provided on paid-for basis.

This initiative will take three years to get established. For the year 2010-11, the agency will be hired, hardware installation completed, personnel recruited, detailed business plan developed and database developed and available in an easily retrievable format. **An initial setting up cost of Rs. 70 lacs is being budgeted for 2010-11.**

17.10 **Integrated Voice Recording Systems**: An Intergrated Voice Recording System (IVRS) had been established in JP Nagar for follow up and tracking of pregnant women for ante and post natal care and children for visit specific immunisation. A database with details of each family is generated and any information on child births is updated based on information received from reports submitted by ANMs. Reminder calls are automatically generated for ANC visits and immunisation for these rural beneficiaries. Callers can also dial in for queries related to RCH services. On the supply side, a list of beneficiaries for tracking is generated and handed to the ANMs as per their field visit plan. Information on beneficiary specific services provided is updated at the end of the day. This system will be implemented in JP Nagar, Moradabad, Rampur, Bijnor and Baghpat as pilots and budget has been included in the Routine Immunisation section. **Call Centre Facility :**This system will be implemented in Kanpur Nagar for which an amount of Rs 35 lacs has been approved by GOI. This system will help the community to access right facility, right human resource at particular point of time and place.

17.11 **Rewards and Incentives:** Recognition of efforts of community level institutions and service providers go a long way in motivating them. While the ASHA newsletter shares achievements of ASHAs and recognises their contribution, it is proposed that rewards at the community level to exemplary Gram Panchayats and service providers have been proposed. **An amount of Rs. 4.08 lacs has been approved for the year 2010-11.**

17.12 **Adolescent Health:** Block level adolescent activities involving ASHAs, adolescents, influencers and gate keepers will be planned. Ambedkar Nagar, Faizabad and Sultanpur have proposed these meetings **at block level (42 nos.) @ Rs. 5000 per meeting, totalling to Rs 2.10 lacs.** These meetings will provide fillip to the Adolescent Health programmes in the districts. The same amount has been approved by GOI.

17.13 Gender Awareness Programme: In addition to the awareness activities conducted under PCPNDT section, seven districts, namely Meerut, Baghpat, Gautam Bhudh Nagar, Bulandshahar, Ghaziabad, Saharanpur and Muzaffarnagar, have proposed rallies and seminars to promote awareness for Saving the Girl Child. These districts are also those identified as districts with poor sex ratio as per DLHS III. **Two programme per district @ Rs. 1 lac each totalling to Rs. 14 lacs has been approved by GOI.**

17.14 Public Health Library: District of Banda has establishment and operationalisation of public health library in the district. This will include subscriptions to journals and public health materials for ready reference. These materials will be available for reference by Division/ District/ Block level functionaries for latest information and technical updates related to health. **An amount of Rs. 4.00 lacs has been approved by GOI.**

17.15 **Study/ Survey/ Research:** Studies and assessments have been planned for providing feedback on implementation of community level activities. Suggested assessments include: a) functioning of Village Health and Sanitation Committees (VHSCs) and utility of village health fund under NRHM; b) ASHA and their role in influencing maternal health; and c) Rogi Kalyan Samitis as a means for community empowerment and patient welfare. These studies will be conducted as rapid assessments at district level and findings will be shared at the district as well as State level. **An amount of Rs 9 lacs has been approved for six districts of Gorakhpur, Maharajganj, Deoria, Kushinagar, Basti and Sant Kabir Nagar for the year 10-11**.

17.16 **Tracking of Pregnant Women and Children for Immunisation:** Monitoring systems to track each pregnant woman of natal care and child for immunisation are dependant on updated information on each beneficiary. To ensure timely data entry strengthening of district level data centre is being proposed with an earmarked data entry operator at block level. In those blocks where block level computers are not fully functional, the activity could also be outsourced for updating records on a fortnightly basis. An amount of Rs 1000 per month per block has been proposed and includes costs of computer peripherals and consumables, communication charges, printing of formats and incentives for block and district personnel to send updated records to the State level. Rs. 106.0 lacs has been approved by GOI. This amount will be pooled at State level for Jachha Bachha Suraksha Abhiyan to be implemented through out the State for Tracking of Pregnant Women and Children.

17.17 **Operationalisation of Health Facility:** Specific needs of health facilities for improving quality of health services have been proposed by districts in their DAPs. Construction of a facility for lodging of ASHAs at 24x7 facilities has emerged as a strong need from many districts. Provision for construction of these ASHALAYA's @ Rs. 1.50 lacs each has been made in 36 facilities across 15 districts.

In addition, districts have suggested arrangements for fresh food for mother after delivery at identified sites. These initiatives will lead to increased number of institutional deliveries and encourage women to stay for atleast 48 hours after the delivery. These arrangements have been proposed for 15 sites on pilot basis @ Rs. 2.88 lacs per site.

Other facility specific requests for equipment and machines have also been included in the section. All these initiatives will enhance the quality of service delivery.**. Rs. 143.28 lacs has been approved by GOI.**

17.18 **Malnutrition and Anemia Care Clinic:** An amount of Rs. 8.46 lacs for each district has been proposed for Malnutrition and Anemia Care Clinics by Kanpur Nagar and Kanpur Dehat. **Rs. 16.92 lacs** have **been approved by GOI.**

17.19 **Promotion of Family Planning:** Proposal for condom vending machines (CVM) has been submitted by Meerut district in which 25 CVMs will be installed in locations where footfalls are high. The district of Pratapgarh has submitted a proposal for promotion of non scalpel vasectomy (NSV) in which local activities building on the state level campaign for male sterilisation will be conducted. **Rs. 7.5 lacs has been approved by GOI.**

17.20 **Mobile Health Units:** The State is operationalising 465 Mobile Medical Units (MMUs) to meet the needs of hard to reach rural areas and those affected by natural extremities. The proposals of districts for mobile health units have been considered while planning allocations of MMUs in the State.

17.21 **Special Camps:** Camps have been proposed in arsenic affected areas, fluorosis prone area and for silk industry workers. Five districts of Ballia, Ghazipur, Pratapgarh, Varanasi and Mau have been identified through the DAPs for conducting these special health camps. These camps will be conducted for workers of bangle making units and carpet industry. Convergence with concerned departments will be planned at the district level to ensure reaching maximum number of beneficiaries. **Rs. 22.0 lacs has been approved by GOI.**

For all above mentioned activity, a total sum of Rs. 682.74 lacs have been approved by GOI.

Details of District Specific Interventions and Backward District Interventions are presented in following tables:

DISTRICT SPECIFIC INTERVENTIONS

Issues/ Category	Backward Districts	Challenges/Gaps	Strategies planned
Japanese Encephalitis Prone area	Kushinagar, Maharajganj, Basti, Siddharthnagar, Santkabirnagar, Bahraich, Balrampur.	***General***: - Inadequate HR at different levels. - Shortage of vehicle for surveillance, monitoring & supervision - No separate funding for district to undertake intervention for JE control - Regular vaccination. ***Facility Level***: - Timely transport of patients. - Availability of drugs. - Child Intensive care unit at selected CHCs - Ventilator at DHs - Availability of Microscope ***Community Level:*** - Shortage of BHW (M). - Lab Strengthening - Training of LTs - Surveillance materials (slides, pricking needles, sprit, stain, surveillance bag, MF-2) ***Spraying & fogging*** - Strip Pumps & its spare parts - Insecticides - Pulse Fog machine & accessories - Melatheone Technical - Larvisides ***IEC/BCC*** Group meetings ,IEC Materials	***State Level***: - Sensitization meeting before monsoon season. - Procurement of Drugs, Fogging machines, Insecticide & timely supply to districts. - AMC of fogging machines and instruments. ***Division Level:*** - Training of Paramedical staff, - Regular funding for sentinel surveillance lab. - Rehabilitation centers for physical handicapped patients. - Water testing through NIV for highly affected villages. ***District/block Level:*** - Provision of separate funding for districts to identify and implement district specific JE control activities. - Early diagnosis and treatment - Vaccinations to ensure 100% coverage of vulnerable group. - Conversion with concerned department for shifting piggeries from human habitation. - Spraying in and around piggeries - Incentive to ASHA for JE Vaccination and follow up. - Surveillance in affected area - Capacity building of ANM/ASHA for making slides and provision for Incentive to ANM/ASHA. - Repair & maintenance of fogging machine at regular interval - Replacement of non-functional fogging machines - Mass media campaign - Mobility for fogging & spraying - Program management support (DMO)

Issues/ Category	Backward Districts	Challenges/Gaps	Strategies planned
Left wing extremist affected area	Sonbhadra, Chandauli, Ghazipur, Deoria, Kushinagar and Mirzapur	- Security problems to health staff. - Transportation. - Lack of community support. - Problem in developing health infrastructures.	- Special drives with security backup. - Mobile Medical Team in affected block. - Involvement of local people on incentive basis for programme support. - Provision of Sub health center on per 1000 population & NPHC per 10000 populations. - Incentive to staff posted in effected area.
Hard to reach areas	Sonbhadra, Siddharthngar, Shrawasti, Khiri, Pilibhit, Chitrakoot, Mahoba	- Poor condition of roads - Lack of transportation - Lack of willingness among health staff. - Poor communication.	- Convergence with development department. - Mobile Medical Unit - Involvement of local people on incentive basis for programme support. - Close user group mobile connection to staff.
Flood affected areas	Maharajganj Kushinagar, Siddharthnagar, Basti, Bahraich,Gonda, Balrampur, Sitapur, Khiri	- Connectivity during flood. - Lack of Preparedness - Controlling communicable diseases. - Providing safe drinking water during flood.	- Convergence with Disaster Management unit at district. - Adequate availability of Bleaching powder, chlorine tablets, ORS packet & other medicines - Supply of safe drinking water with support of development organization. - Special health check-up for epidemic affected area and counseling session - Arrangement of Spraying and dusting - Formation of rapid response team. - Availability of ARV/ASV - Establish temporary Health post in every flood affected area by giving incentive to staff on duty.
Minority Group	Badau, Khiri, Sahjahanpur, Moradabad, Rampur, J.P. Nagar, Barreily, Pilibhit, Bahraich, Shrawasti, Balrampur, Siddharthnagar	- Myths and misconceptions - No concept of birth preparedness - Lack of faith in health Facilities - Lack of ownership of PRI/ Opinion leader in health related issues - Lack of support to service providers - Cultural Practices - Socio economic conditions - Religious prohibition for accepting contraceptive use	- IEC on socio cultural myths & misconceptions particularly prevailing among them - Involvement of PRI/ Opinion leader members in management and with some responsibility for uptake of services and improvement in services. - Behavior change communication. - Promoting spacing methods of family planning among this community.
Ravine belt	Fatehpur, Etah, Farukhabad,	- Too far health facilities - Poor transportation facility	- Establishment of separate sub health center for such area. - Incentive for ANM and other staff

Issues/ Category	Backward Districts	Challenges/Gaps	Strategies planned
	Mainpuri, Badaun, Shahjahanpur.	- Unavailability of ANM at sub health center	- Mobile Medical Unit - Arrangements for transportation - Convergence for Rehabilitation,
Early age of Marriage	Shrawasti, Bahraich Balrampur, Gonda, Siddharthnagar, Maharajganj, Lalitpur, Badun, Kushinagar	- Social customs - Early age pregnancy causing probability of high mortality - Longer fertility period	- Awareness generation specially in rural community. - Effective implementation of Law with the support of Gram Chokidar by giving incentive to him. - Mass media campaign showing adverse affect of early age marriage
Female Foeticide	Agra, Badaun, Etah, Farukhabad, Hardoi, Jalaun, Mathura, Sahjahanpur.	- Social custom - Unlawful use of ultrasound service providers	- Effective implementation of PPNDT Act. - IEC
Bundelkhand area and drought affected	Jhansi, Lalitpur, Mahua, Chitrakoot, Banda, Jalaun and Hamirpur	- Difficult terrain - Dacoit affected - Low literacy - Land not fertile, causing poverty and lack of employment - Tribal - Sparsely populated - Malnutrition	- Fixed date-fixed venue approach for outreach teams - Special campaign for mal nutrition - Early diagnosis and treatment of malnutrition at NRC,Talbehat, Lalitpur - SNCU at Lalitpur District women's Hospital - Five districts covered under CCSP - MMU operated
Vulnerable Groups	Kushinagar	- Karols and Moosahars tribes - Very abnormal beliefs and customs - Unhygienic eating habits - Do not believe in modern healthcare	- MMU operationalised - Widespread awareness campaigns - Inter personal communication through folk media and ASHAs - Fixed date-fixed venue approach for outreach teams - RCH camps and Health Melas -
Tribals	Lakhimpur Kheri, Shrawasti, Bahraich, Sonbhadra, Gonda Jhansi and Lalitpur	- Nomads leading to poor health indicators and immunization status - Poor FP uptake due to existing practices - Existing practices and beliefs regarding healthcare - Poor literacy, poverty and poor hygiene	- MMU operationalised - Inter personal communication through folk media and ASHAs - Fixed date-fixed venue approach for outreach teams - RCH camps and Health Melas -
- Malaria	Sonbhadra, Mirzapur,	- Dense forest areas	- Fever Surveillance of at least 10% of population.

Issues/ Category	Backward Districts	Challenges/Gaps	Strategies planned
	Badau, S.R. Nagar, Mahoba, Fatehpur, Barreily, Farukhabad.	- Hilly area leading to water storing. - Poor Surveillance due to lack of manpower. - Delayed diagnosis, treatment & follow-up - Lack of strip pumps for spray. - Low capacity of ANM/ASHA in slide preparation. - Lack of awareness.	- Early diagnosis and treatment. - Radical treatment. - Vector Control. - Capacity building of ANM/ASHA for making slides and provision for Incentive to ANM/ASHA. - Procurement of Rapid Diagnostic kits & drugs. - BCC/IEC Activities & development of Educational materials. - Involvement of community. - Distribution of bed nets. - PPP model for high focused district Sonbhadra.
- Filaria	Maharajganj, Kushinagar, Basti, Santkabir Nagar, Siddharthnagar, Chandauli Mirzapur.	- Inadequate arrangement for diagnosis at block level. - Prevention of disability through morbidity management. - Lack of awareness.	- Strengthening Block facilities for diagnosis. - Provision for Morbidity management. - Regular Hydrocile operation camps. - Registration of affected clients. - Training of Manpower for morbidity management & prevention - Special Incentive for preparing slides during nights - Surveillance in highly affected area. - Multi drug therapy. - Awareness campaign
- Fluorosis	Unnao, Raibareili, Agra, Sonbhadra and Mirzapur	- High level of fluoride & other harmful elements in drinking water	- Survey of affected areas - water sampling and testing - Identification of affected villages. - Regular health check-up by mobile health team. - Rehabilitation of all identified people. - Awareness campaign among villagers - Consistent system of reporting of affected area & Incentive to ANM/ASHA for proper reporting
- Silicosis	Sonbhadra, Mirzapur and Firozabad	- Un registered Bangle making centers	- Convergence with concerned departments - Special Health Check-up camps for workers of Bangle making centers and referrals.
- Muscular Dystrophy	Mirzapur (Lalganj)	- Deficiency of calcium among people	- Referral services to higher institutions for victims - Free treatment facility for victims.
Difficult terrain	Sonbhadra	-	- Decreasing distance between two sub centers up to one sub center/1000 population
Low Immunization coverage	Badaun, Bahraich, Balrampur, Banda,	- Lack of awareness among community.	- IEC and BCC among community - Placing a system of client tracking with all details like, name, address,

Issues/ Category	Backward Districts	Challenges/Gaps	Strategies planned
	Chitrakoot, Etah, Farukhabad,Khiri, Pilibhit, Shrawasti, Sitapur, Chandauli, Fatehpur, Gonda, Mathura, Moradabad, Sahjahanpur, Sant Ravidasnagar	- No comprehensive data of eligible clients. - No proper mechanism for tracking of drop out children. - Hard to reach area. - Large area to be covered by ANMs - Supportive supervision.	etc. - Provision of Vehicle for covering out reach area/village - Incentive to client in form of NSC or cash, - Incentive to VHSC, Kshetra Panchayat, PHC/CHC, sub Center in case of acheiving more than 90% coverage - Strengthen vaccine delivery system - Strengthen Cold Chain maintenance system.
Low Institutional Delivery	Auraiya, Badaun, Bahraich, Balrmapur, Banda, Bareilly, Chitrakoot, Farukhabad, Gonda, Fatehpur, Hardoi, Kannauj, Khiri, Kaushambi, Unnao Maharajganj,Pilibhit, Shrawasti, Siddharthnagar, Shahjahanpur,	- Less no. of sub health centers providing institutional delivery services. - Lack of infrastructure & SBA training personal - People's Faith in health facilities - Low health seeking behavior - Poor involvement of Pvt. set-up	- Increasing the number of sub health centers providing institutional deliveries - Increasing SBA trained personal at level of health facilities. - BCC and IEC. - Involvement of Private institutions for institutional delivery.
Low F.P. users (any modern methods)	Agra, Badaun, Bahraich, Balrampur, Etah, Farukhabad, Fatehpur, Firozabad, Gonda, Santkabir Nager, Shahjahanpur, Sharwasti, Siddharthnagar & Sitapur	***General***: - Preference for male child - Children considered as social security - Religious prohibition for contraceptive use - Myths and misconceptions - Early age of marriage hence higher reproductive span - Low literacy ***Service Delivery:*** - Lack of service providers - Lack of supportive supervision and monitoring - Quality FP service	- Skill up gradation of medical & paramedical staff on sterilization techniques - Involvement of private nursing homes / hospitals for sterilization & spacing services - logistic management and system of buffer stock, and logistic transport system - Local IEC activities for promotion and up-take of services - Contraceptive social Marketing. - Monitoring by state at regular interval. - Involvement of political leaders. - Updating State Population Policy
(A) Infrastructure		- IPD space for JSY beneficiaries at	Construction additional ward

Issues/ Category	Backward Districts	Challenges/Gaps	Strategies planned
IPD space Electricity Shelter	All 44 backward districts	BPHC - 24 Hrs electricity - Shelter	Providing new generator, & Budget for POL Construction of Rain Basera at each BPHC/CHC
(B) H R			
- Lack of HR			- Recruitment HR either on regular or contractual basis. - Special incentive to service providers working in difficult area. - Separate HR Policy including Reward Policy
- Lack of skilled/ trained HR			- Operationalization of all training centers across the state like, SIHFW, RHFWTC, ANMTC, etc - Training of personal on regular basis - Training on SBA, CTU, EmOc, MTP, RTI/STI, LSAS, etc.

Budget Summary Dist. Specific Interventions (FMR Code B22)

To respond to the above challenges following interventions have been suggested:

Intervention	Name of Intervention	No. of District	Budget Proposed
Int-1	Public Private Partnership	5	28.91
Int-2	Program support through NGO	15	32.28
Int-3	Village Health Plan/Training of VHSC members	16	65.87
Int-4	JE/AES Control Program	7	86.50
Int-5	ASHA Performance Tracking System	7	2.80
Int-6	Mahotsav/ Sammelans/ Workshops	14	32.50
Int-7	Medical Bridge Facility	6	70.00
Int-8	IVRS/ Call Centre/	1	35.00
Int-9	Rewards & Incentives	7	4.08
Int-10	Adolescent Health	3	2.10
Int-11	Gender Awareness Program	7	14.00
Int-12	Public Health Library	1	4.00
Int-13	Study/Survey/Research	6	9.00
Int-14	Tracking of pregnant women & children for Immunization to be used from State Level under Jachha Bachha Suraksha Abhiyan	71	106.00
Int-15	Operationalization of Health Facility	22	143.28
Int-16	Malnutrition and Anemia Care clinic	2	16.92
Int-17	Family Planning	2	7.50
Int -18	Special Camps	5	22.00
		Grand Total	**682.74**

Details of Intervention proposed under District Specific Innovations of NRHM PIP (2010-11)

S.No.	Name of Intervention	District		Activities proposed under that intervention	Unit/No.	Unit Cost/ Dist	Amount (in Lac)
Intervention -1	Public Private Partnership	1	Gorakhpur	Eye screening & Corrective glasses for non school going children with refractive error	1	642500	6.43
		2	Deoria	Eye screening & Corrective glasses for non school going children with refractive error	1	642500	6.43
		3	Kushinagar	Eye screening & Corrective glasses for non school going children with refractive error	1	642500	6.43
		4	Basti	Eye screening & Corrective glasses for non school going children with refractive error	1	642500	6.43
		5	Santkabir nagar	Eye screening & Corrective glasses for non school going children with refractive error	1	321250	3.21
						Sub Total(Int- 1)	**28.91**
Intervention -2	Program support through NGO	1	Basti	Strengthening of Comm. level activities with support of NGO	14	54000	7.56
		2	Siddharth Nagar	Strengthening of Comm. Level activities with support of CHAI Organization*	7	0	0.00
		3	Deoria	Strengthening of Community Level activities with support of NGO	8	54000	4.32
		4	Sitapur	NGO Involvement in RI, VHSC and VHND	5	54000	2.70
		5	Ballia	Strengthening of Comm. level activities with support of NGO	5	54000	2.70
		6	Varansi	Capacity building of ASHA, Facilitator, IEC Activities, Logistic support for strengthening of VHND, VHSC, IYCF, CCSP. ASHA mentoring *	Whole Dist.	0	0.00
		7	Saharanpur		Whole Dist.	0	0.00
		8	Banda		Whole Dist.	0	0.00
		9	Azamgarh		Whole Dist.	0	0.00
		10	Bulandsahar		Whole Dist.	0	0.00
		11	Gonda	Capacity building of ASHA, Facilitator, IEC Activities, Logistic support for strengthening of VHND, VHSC, IYCF, CCSP. ASHA mentoring *	Whole Dist.	0	0.00
		1	Kaushambi		Whole	0	0.00

S.No.	Name of Intervention	District		Activities proposed under that intervention	Unit/No.	Unit Cost/ Dist	Amount (in Lac)
		2			Dist.		
		13	Chitrkoot		Whole Dist.	0	0.00
		14	Pratapgarh	Strengthening of Comm. level activities with support of NGO in two blocks	2	500000	10.00
		15	Chandauli	PPP Initiative In Naugarh Block	1	500000	5.00
						Sub Total(Int- 2)	**32.28**

**** The cost of the activity will be borne by development partner agencies.***

Intervention -3	**Village Health Plan/Training of VHSC members**	1	Gorakhpur	Developing of Village Health Plan	1233	400	4.93
			Gorakhpur	VHSC strengthening through DIFPSA on SIFPSA Model	5	400000	20.00
		2	Deoria	Developing of Village Health Plan	1007	400	4.03
		3	Kushinagar	Developing of Village Health Plan	956	400	3.82
		4	Maharajganj	Developing of Village Health Plan	777	400	3.11
		5	Basti	Developing of Village Health Plan	1047	400	4.19
		6	Sant kabir Nagar	Developing of Village Health Plan	648	400	2.59
		7	Siddharth Nagar	Developing of Village Health Plan	1015	400	4.06
		8	Mahoba	Developing of Village Health Plan	247	400	0.99
		9	Hamirpur	Developing of Village Health Plan	314	400	1.26
		10	Etah	Developing of Village Health Plan	500	400	2.00
		11	Bahraich	Training of VHSC members*	1337	0	0.00
		12	Bahraich	Developing of Village Health Plan	600	400	2.40
		13	Bijnaur	Training of VHSC members*	959	0	0.00
		14	Kannuj	Orientation of VHSC*	250	0	0
		15	Ballia	VHSC strengthening through NGO on SIFPSA Model	833	1500	12.50

S.No.	Name of Intervention	District		Activities proposed under that intervention	Unit/No.	Unit Cost/ Dist	Amount (in Lac)
		16	Farukhabad	Orientation of VHSC*	512	0	0
						Sub Total(Int- 3)	**65.87**

Intervention -4	**JE/AES Control Program**	1	Gorakhpur	JE/AES Control programe at District & NIV level	1	2650000	26.50
		2	Deoria	JE Control programe at District level	1	1000000	10.00
		3	Kushinagar	JE Control programe at District level	1	1000000	10.00
		4	Maharajganj	JE Control programe at District level	1	1000000	10.00
		5	Basti	Prevention and Control of JE	1	1000000	10.00
		6	Sant kabir Nagar	Prevention and Control of JE	1	1000000	10.00
		7	Siddharth Nagar	Prevention and Control of JE	1	1000000	10.00
						Sub Total(Int- 4)	**86.50**

Intervention - 5	**ASHA Performance Tracking System**	1	Gorakhpur	ASHA Performance Tracking system & Regular recognition	1	40000	0.40
		2	Deoria	ASHA Performance Tracking system & Regular recognition	1	40000	0.40
		3	Kushinagar	ASHA Performance Tracking system & Regular recognition	1	40000	0.40
		4	Maharajganj	ASHA Performance Tracking system & Regular recognition	1	40000	0.40
		5	Basti	ASHA Performance Tracking system & Regular recognition	1	40000	0.40
		6	Sant kabir Nagar	ASHA Performance Tracking system & Regular recognition	1	40000	0.40
		7	Siddharth Nagar	ASHA Performance Tracking system & Regular recognition	1	40000	0.40
						Sub Total(Int- 5)	**2.80**
Intervention -6	**Mahotsav/ Sammelans/ Workshops**	1	Ambedkar Nagar	Adarsh Dampatti sammelan	100	3000	3.00
		2	Faizabad	Adarsh Dampatti sammelan	100	3000	3.00
		3	Sultanpur	Adarsh Dampatti sammelan	100	3000	3.00
		4	Barabanki	Adarsh Dampatti sammelan	100	3000	3.00
		5	Basti	Experience sharing workshops with stakeholders	1	50000	0.50
		6	Sant kabir Nagar	Experience sharing workshops with stakeholders	1	50000	0.50
		7	Siddharth Nagar	Experience sharing workshops with stakeholders	1	50000	0.50
		8	Banda	Sensitization of IMA and AYUSH	3	20000	0.60
		9	Banda	Sensitization of PRI members*	5000	0	0.00
		10	Agra	Paticipation in Taj Mahotsav	1	500000	5.00
		1	Allahabad	Nav Dampatti Sammelan	10	400	4.00

		1				00	
		12	Pratapgarh	Nav Dampatti Sammelan	6	40000	2.40
		13	Lucknow	Paticipation in Lucknow Mahotsav	1	500000	5.00
		14	Khiri	Nav Dampatti Sammelan	5	40000	2.00
						Sub Total(Int- 6)	**32.50**
		**** Already taken up separately in Part-B***					
Intervention -7	**Medical Bridge Facility**	1	Sitapur	Establishment of medical bridge facility through call centre	1		**Funds to be released to DHS-LKO for operation alisation**
		2	Lakhimpur Kheri	Establishment of medical bridge facility through call centre	1		
		3	Hardoi	Establishment of medical bridge facility through call centre	1		
		4	Unnao	Establishment of medical bridge facility through call centre	1		
		5	Rai Bareilly	Establishment of medical bridge facility through call centre	1		
		6	Lucknow	Establishment of medical bridge facility through call centre	1		
						Sub Total(Int- 7)	**70.00**
Int.- 8	**IVRS/ Call Centre**	1	Kanpur Nagar	Establishment of call centre.	1		35
						Sub Total(Int- 8)	**35.00**
Intervention -9	**Rewards & Incentives**	1	Ambedkar Nagar	Rewards to Best Gram Panchayat	1	22500	0.23
		2	Faizabad	Rewards to Best Gram Panchayat	1	22500	0.23
		3	Sultanpur	Rewards to Best Gram Panchayat	4	10000	0.40
		4	Barabanki	Rewards to Best Gram Panchayat	1	22500	0.23
		5	Jhansi	Recognisition of Good Performance	1	100000	1.00
		6	Auraiya	Recognition for service provider	1	100000	1.00
		7	Khiri	Recognition for service provider	1	100000	1.00
						Sub Total(Int- 9)	**4.08**

Intervention -10	**Adolescent Health**	1	Ambedkar Nagar	Block lelvel Saloni Swasthay Sammelan	9	5000	0.45
		2	Faizabad	Block lelvel Saloni Swasthay Sammelan	11	5000	0.55
		3	Sultanpur	Block lelvel Saloni Swasthay Sammelan	22	5000	1.10
						Sub Total(Int- 10)	**2.10**
Intervention -11	**Gender Awareness Program**	1	Merrut	Save Girl Child Campaign (Rallies, Seminar, etc.)	2	100000	2.00
		2	Sharanpur	Save Girl Child Campaign (Rallies, Seminar, etc.)	2	100000	2.00
		3	Muzaffarnagar	Save Girl Child Campaign (Rallies, Seminar, etc.)	2	100000	2.00
		4	Bhaghpat	Save Girl Child Campaign (Rallies, Seminar, etc.)	2	100000	2.00
		5	Gautambudh nagar'	Save Girl Child Campaign (Rallies, Seminar, etc.)	2	100000	2.00
		6	Bulandsahar	Save Girl Child Campaign (Rallies, Seminar, etc.)	2	100000	2.00
		7	Ghaziabad	Save Girl Child Campaign (Rallies, Seminar, etc.)	2	100000	2.00
						Sub Total(Int- 11)	**14.00**
12	**Public Health Library**	1	Banda	Establishment of Library at 3 block & Dist.	4	100000	4.00
						Sub Total(Int- 12)	**4.00**
Intervention -13	**Study/Survey/Research**	1	Gorakhpur	Functioning of VHSC, & utility of village health fund under NRHM	1	150000	1.50
		2	Maharajganj	Functioning of ASHA and its effect on maternal health	1	150000	1.50
		3	Deoria	Functioning of Rogi Kalyan Samiti & utility of sub center untied fund	1	150000	1.50
		4	Kushinagar	Functioning of Rogi Kalyan Samiti & utility of sub center untied fund	1	150	1.50

						000	
		5	Basti	Functioning of VHSC, & utility of village health fund under NRHM	1	150 000	1.50
		6	Santkabirnagar	Functioning of Rogi Kalyan Samiti & utility of sub center untied fund	1	150 000	1.50
						Sub Total(Int- 13)	**9.00**
Intervention-14	**Tracking of pregnant women & children for Immunization**	i	All District	Tracking of pregnant women & children for immunization	53	200 000	106.00
			The activity is being under taken for all 71 districts under Jachha Bachha Suraksha Abhiyan to be implemented from State Level. Hence the budget is pooled at State Level to be utilized for various activities.				
						Sub Total(Int- 14)	**106.00**
Intervention -15	**Operationalization of Health Facility**	1	Kanshiram Nagar	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150 000	3.00
			Kanshiram Nagar	Sanitary Napkins, Sterilized towel, Baby cloths for JSY clients	1	190 800 0	19.08
			Kanshiram Nagar	Ultrasound Machine & other isntruments for Kasganj FRU	1	500 000	5.00
		2	Jhansi	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150 000	3.00
		3	Gonda	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150 000	3.00
		4	Shrawasti	Procurement of Ultra Sound Machine at FRU Eikauna	1	400 000	4.00
		5	Ghaziabad	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150 000	3.00
		6	Allahabad	Arrangement of fresh food for mother after delivery at 4 sites (Out source)	5	288 000	14.40
		7	Muradabad	Arrangement of fresh food for mother after delivery at 4 sites	4	288 000	11.52
		8	Mau	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150 000	3.00
		9	Maharajganj	Arrangement of fresh food for mother after delivery at CHC-Partawal	1	288 000	2.88

		10	Gorakhpur	Arrangement of fresh food for mother after delivery at CHC-Sahjanwa	1	288000	2.88
		11	Merrut	construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150000	3.00
		12	Bhaghpat	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150000	3.00
		13	Gautambudh Nagar	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150000	3.00
		14	Bulandshahar	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150000	3.00
		15	Saharanpur	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150000	3.00
		16	Muzaffarnagar	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	2	150000	3.00
		17	Varanasi	Strengthening of SSPG Divisional Hospital	1	1500000	15.00
		18	Jaunpur	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	4	150000	6.00
		19	Lucknow	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	4	150000	6.00
		20	Azamgarh	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	4	150000	6.00
		21	Ballia	Construction of ASHA Staying Facility (ASHALAYA) at two 24x7 sites	4	150000	6.00
		22	Kanpur Nagar	Arrangement of fresh food for mother after delivery at 4 sites	4	288000	11.52
						Sub Total(Int- 15)	**143.28**
Int. 16	**Malnutrition and Anemia Care clinic**	1	Kanpur Nagar	Malnutrition and Anemia Care clinic	3	282000	8.46
		2	Kanpur Dehat	Malnutrition and Anemia Care clinic	3	282000	8.46
						Sub Total(Int- 16)	**16.92**
Int -17	**Family Planning**	1	Meerut	Condom vending machines in Red Light Areas	25	10000	2.50
		2	Pratapgarh	Promotion of NSV	1	500000	5.00

						Sub Total(Int- 17)	**7.50**
Intervention -18	**Special Camps**	1	Ballia	Health camps in arsenic affected area & IEC	1	500 000	5.00
		2	Ghazipur	Health camps in arsenic affected area & IEC	1	500 000	5.00
		3	Varansi	Health camps in arsenic affected area & IEC	1	500 000	5.00
		4	Mau	Health camps for silk industry workers	1	500 000	5.00
		5	Pratapgarh	Health camps for Fluorosis prone Areas	2	100 000	2.00
						Sub Total(Int- 18)	**22.00**

Budget for 44 Backward Districts Specific Interventions under NRHM for year 2010-11

Issues/ Category	Backward Districts	Strategies planned
Japanese Encephalitis Prone area	Kushinagar, Maharajganj, Basti, Siddharthnagar, Santkabirnagar. Bahraich, Balrampur.	
		Sensitization meeting of AD,CMO, CMS and BRD Representative from Medical collage Gorakhpur.
		Procurement of Drugs, Fogging machines.
		Division Level:-
		Training of Paramedical staff at AD office Gorakhpur level.
		Regular funding for sentinel surveillance lab.
		Rehabilitation centers for physical handicapped patients at Gorakhpur.
		Water testing in highly affected villages through NIV Gorakhpur
		District/block Level:-
		Separate funding for districts to identify and implement district specific JE control activities.
		Vaccines for immunization*
		Convergence meeting with concerned department.
		Spraying in and around piggeries
		Incentive to ASHA for JE Vaccination and follow up.**
		Surveillance in affected area (in addition to budgets available in NVDCP)
		Capacity building training of ANM/ASHA for making slides.
		AMC and maintenance of fogging machines
		Mass media campaign
		Mobility for fogging & spraying
		Program management support to DMO.
Left wing extremist affected area	Sonbhadra, Chandauli, Ghazipur, Deoria, Kushinagar and Mirzapur	Special drives with security backup.
		Mobile Medical Team.
		Involvement of local people on incentive basis for programme support.

		Incentive to staff posted in effected area.
Hard to reach areas	Sonbhadra, Siddharthngar, Shrawasti, Khiri, Pilibhit, Chitrakoot, Mahoba	Convergence meeting with development department.
		Mobile Medical Unit.
		Involvement of local people on incentive basis for programme support @ Rs. 0.25 lac per block and rest at district level.
		Close user group mobile connection to staff.
		Referral transport facility by outsourcing in identified blocks
		Incentive for staff on duty at Health posts in Flood efected area.
Flood affected areas	Maharajganj Kushinagar, Siddharthnagar, Basti, Bahraich,Gonda, Balrampur, Sitapur, Khiri	Convergence meeting with Disaster Management unit.
		Additional Procurement of Bleaching powder, chlorine tablets, ORS packet & other medicines
		Special health check-up for epidemic affected area and counseling session
		Arrangement of Spraying and dusting
		Additional Procurement of ARV/ASV
		Referral transport facility by outsourcing in identified blocks
		Incentive for staff on duty at Health posts in Flood efected area.
Bundelkhand/ Drought affected areas	Banda, Mahoba, Jalaun, Chitrakoot, Lalitpur, Hamirpur and Jhansi	SNCU
		Nutritional Rehabilitation Centres at Lalitpur and Banda
		Referral transport facility by outsourcing in identified blocks
		Fixed day-fixed venue camps (47 blocks twice a month)
Vulnerable Group	Kushinagar,	MMU operationalised
		- Widespread awareness campaigns

		- Inter personal communication through folk media and ASHAs
		- Fixed date-fixed venue approach for outreach teams
		- RCH camps and Health Melas
Minority Group	Badaun, L Khiri, Sahjahanpur, Moradabad, Rampur, J.P. Nagar, Barreily, Pilibhit, Bahraich, Shrawasti, Balrampur, Siddharthnagar	IEC on socio cultural myths & misconceptions particularly prevailing among them
		Involvement of PRI/ Opinion leaders
		Behavior change communication.
		IEC for promoting spacing methods of family planning among this community.
Ravine belt	Fatehpur, Etah, Farukhabad, Mainpuri, Badaun, Shahjahanpur.	Incentive for ANM and other staff
		Mobile Medical Unit*
		Referral transport facility by outsourcing in identified blocks
		Convergence for Rehabilitation
Early age of Marriage	Shrawasti, Bahraich Balrampur, Gonda, Siddharthnagar, Maharajganj, Lalitpur, Badun, Kushinagar	Awareness generation campaign
		Effective implementation of Law with the support of Gram Chowkidar and Panchayat Secretary by giving incentive to him for reporting each case of early marriage
		Mass media campaign showing adverse affect of early age marriage
Female Foeticide	Agra, Badaun, Etah, Farukhabad, Hardoi, Jalaun, Mathura, Sahjahanpur.	Meeting/Seminar for effective implementation of PC PNDT Act.
		Organization of Quiz, Debate, Rally.(Addl.budget required)
		IEC Activities.(Additional budget required)
Endemic Diseases-		

Malaria	Sonbhadra, Mirzapur, Badaun, S.R. Nagar, Mahoba, Fatehpur, Barreily, Farukhabad	BCC/IEC Activities & development of Educational materials.
		Involvement of community.
Filaria	Maharajganj, Kushinagar, Basti, Santkabir Nagar, Siddharthnagar, Chandauli Mirzapur	Strengthening Block facilities for diagnosis.
		Registration of affected clients.
		Surveillance in highly affected area.
Fluorosis	Unnao, Raibareili, Agra, Sonbhadra and Mirzapur	Survey of affected areas
		Water sampling and testing
		Identification of affected villages.
		Awareness campaign among villagers
		Consistent system of reporting of affected area & incentive to ANM/ASHA for proper reporting
Silicosis	Sonbhadra, Mirzapur, Firozabad	Convergence with concerned departments
		Special Health Check-up camps for workers of Bangle making centers and referrals.
		Special campaign among carpet workers and bangle workers
Muscular Dystrophy	Mirzapur (Lalganj)	Referral services to higher institutions for victims
Low Immunization coverage	Badaun, Bahraich, Balrampur, Banda, Chitrakoot, Etah, Farukhabad,Khiri, Pilibhit, Shrawasti, Sitapur, Chandauli, Fatehpur, Gonda, Mathura, Moradabad, Sahjahanpur, Sant Ravidasnagar	IEC and BCC among community
		Placing a system of client tracking with all details like, name, address, etc. (to be converged with new born tracking systems)
		Provision of Vehicle for covering out reach area/village (incl in RI)
		Incentive to client in form of NSC or cash, @Rs.500/- per client
		Incentive to VHSC, Kshetra Panchayat, PHC/CHC, Sub Center in case of acheiving more than 90% coverage
		Strengthen vaccine delivery system
		Strengthen Cold Chain maintenance system.

Low FP	Agra, Badaun, Bahraich, Balrampur, Etah, Farukhabad, Fatehpur, Firozabad, Gonda, Santkabir Nager, Shahjahanpur, Sharwasti, Siddharthnagar & Sitapur	Additional Local IEC activities for promotion and up-take of services
		Contraceptive Social Marketing.
		Monitoring by state at regular interval.
		Involvement of political leaders.
		Updating State Population Policy by state (formation, printing, dissemination at various level
IPD space	All Districts	Construction additional ward
Electricity	All Districts	Proving new generator, & Budget for POL
Shelter	All Districts	Construction of Rain Basera at each BPHC/CHC
Meeting Hall for ASHAs	All Districts	Construction of meeting hall for ASHAs monthly meetings and training courses in selected BPHCs where space is available (incl furniture)
Lack of HR	All Districts	Recruitment HR either on regular or contractual basis. Giving additional incentives
	All Districts	Special incentive to service providers working in difficult area.
Lack of skilled/ trained HR	All Districts	Operationalization of all training centers across the state like, SIHFW, RHFWTC, ANMTC, etc
	All Districts	Training of personnel on regular basis
	All Districts	Training on SBA, CTU, EmOc, MTP, RTI/STI, LSAS, etc.

Compiled Budget Provision for Backward and Dist. Specific Interventions under NRHM
(Year 2010-11) (FMR B 22)

SN	Name of Division	Name of District	Budget (In Lakhs)		
			Backward Dist.Interventions (Budget includes proposals for Distt. Specific Interventions)	Dist. Specific Interventions	Total Budget
1		Agra	60.92	0	60.92
2		Firozabad	46.49	0	46.49
3		Mainpuri	44.5	0	44.5
4		Etah	72.42	0	72.42
5	Agra	Mathura	50.6	0	50.6
6		Aligarh	38.5	0	38.5
7		Kanshiram Nagar	0	34.08	34.08
8	Aligarh	Hathras	33.5	0	33.5
9		Fatehpur	75.82	0	75.82
10		Allahabad	0	25.4	25.4
11		Pratapgarh	0	26.4	26.4
12	Allahabad	Kaushambi	33.5	0	33.5
13		Banda	80.33	0	80.33
14		Chitrakoot	84.33	0	84.33
15		Hamirpur	41.49	0	41.49
16	Banda	Mahoba	77.81	0	77.81
17		Lalitpur	81.23	0	81.23
18		Jhansi	46.23	0	46.23
19	Jhansi	Jalaun	73.83	0	73.83
20		Bareilly	40	0	40
21		Badaun	78.42	0	78.42
22		Pillibhit	70.1	0	70.1
23	Bareli	Shahjahanpur	74.42	0	74.42
24		Basti	78.78	0	78.78
25		Sant Kabir Nagar	79.12	0	79.12
26	Basti	Sidharth nagar	94.08	0	94.08
27		Barabanki	41.73	0	41.73
28		Faizabad	0	10.78	10.78
29		Ambedkar Nagar	0	10.68	10.68
30	Faizabad	Sultanpur	0	11.5	11.5
31		Bahraich	81.95	0	81.95
32		Balrampur	73.52	0	73.52
33		Gonda	73.92	0	73.92
34	Gonda	Shrawasti	73.42	0	73.42
35	Gorakhpur	Kushinagar	85.37	0	85.37

36		Gorakhpur	0	66.64	66.64
37		Deoria	0	31.68	31.68
38		Maharajganj	72.59	0	72.59
39		Auraiya	34.5	0	34.5
40		Etawah	33.5	0	33.5
41		Kanpur Nagar	0	53.98	53.98
42		Kanpur Dehat	0	10.46	10.46
43		Farrukhabad	65.92	0	65.92
44	Kanpur	Kannauj	33.5	0	33.5
45		Hardoi	35.6	0	35.6
46		Lucknow	0	73	73
47		Lakhimpur Khiri	57.2	0	57.2
48		Raibarely	35	0	35
49		Sitapur	71.12	0	71.12
50	Lucknow	Unnao	35	0	35
51		Moradabad	51.02	0	51.02
52		J.P. Nagar	42.5	0	42.5
53		Bijnaur	0	12	12
54	Moradabad	Rampur	37.5	0	37.5
55		Mirzapur	48.17	0	48.17
56		Sant Ravidas Nagar	46.5	0	46.5
57	Mirzapur	Sonbhadra	34.27	0	34.27
58		Chandauli	53.5	0	53.5
59		Varansi	0	27	27
60		Ghazipur	0	14	14
61	Varanasi	Jaunpur	0	13	13
62		Shaharanpur	0	12	12
63	Shaharanpur	Muzaffarnagar	0	13.47	13.47
64		Merrut	0	14.5	14.5
65		Gautambuddh Nagar	0	15.42	15.42
66		Baghpat	0	16	16
67		Bulandsahar	0	16.5	16.5
68	Meerut	Ghaziabad	0	16.5	16.5
69		Azamgarh	0	13	13
70		Mau	0	15.56	15.56
71	Azamgarh	Ballia	0	23.19	23.19
	State/Div. Level		64	106	170
		Grand Total	**2737.72**	**682.74**	**3420.46**

Note:- The various proposals submitted by the districts for backward and/or district specific interventions in DAPs have been included in the comprehensive budget of the districts as above**.**

17.21 Left Wing Extremist Affected Areas (FMR Code B 22)

There is infiltration of Naxalites in certain areas of Uttar Pradesh. The worst affected districts are Sonbhadra, Chandauli, Mirzapur, Gazipur, Deoria and Kushinagar. These districts have poor road connectivity, educational & health services, problems of safe drinking water supply, electricity and public distribution system.

From the data available from the District Level Household and Facility Survey (DLHS II & III and NFHS-II & III), the following key aspects emerge.

i) The LWE affected districts are predominantly rural.
ii) More than 3/4th of the people living in these districts have a low standard of living index. (The low standard of living index was a composite index worked out as a part of District Level Household Survey Phase-III).
iii) Less than 1/4th of the population lives in pucca houses.
iv) Less than 1/3rd have electricity connection.
v) Female literacy for most districts is below the national average.
vi) Most districts have substantial scheduled tribe/caste population.

District wise indicators and their status are being annexed.

The NRHM has provided an opportunity to validate the image of democratic government as proactive and caring, through its numerous initiatives in these areas primarily through:-

- A cadre of supportive & caring ASHAs-holds great potential to stem alienation in these areas.
- Bridging infrastructure and human resource gaps.
- Appointment of resident health worker through local criteria.
- Organizing outreach (mobile medical units, camp based approach)
- Incentivizing health workers and block pooling of resources.
- Cluster Based development.

Proposed Interventions

17.21.1 Human Resource Development

a) Recruitment of staff based on local criteria.
b) Incentives to Govt. workers posted in these areas and special honorarium to those posted on contractual basis.
c) Multi skilling of existing staff to increase the range of services provided.

17.21.2 Strengthening District Hospitals, Construction of New PHCs and Sub Centres In Affected Areas to Improve Quality of Care

It has been proposed to construct sub centres and PHCs in areas where no such facilities exist. For e.g. in Sonbhadra, construction of 4 PHCs with a budget of Rs. 308.72 lacs and 45 new Sub centres with a budget of Rs. 402.30 lacs have been proposed. These sub

centres are basically scattered in 8 blocks of the districts. Human resource and establishment has been proposed with the annexed detailed proposal from Sonbhadra.

17.21.3 Enhanced Availability of Drugs

Bi monthly Swasthya Melas are proposed in every block with sufficient amount of medicines and surgical facilities. Additional medicines, vaccines and injections have been provisioned for all these districts as mentioned below.

17.21.4 Four ANM/District Training Centres Strengthening

Of these identified districts, ANM training centres are present in Mirzapur and Deoria whereas, District Training Centres are present in Gazipur, Sonbhadra and Deoria. Those districts which do not have a training centre have been tagged to adjoining districts for training purposes. Under NRHM, during the year 2009-10, ANM trainings has been started in 16 training centres, where ANMs have been selected from the village and block level and all these districts have been covered under the scheme. With the capacity of 60 per batch, 960 ANMs are being trained and will be available from April, 2010 to be posted in the districts.

17.21.5 Community Based Care

Since outreach services are hampered due to various reasons, ASHAs are being provided extra incentives in these districts especially in affected blocks. To reduce infant and maternal mortality rate ASHAs have been trained to provide community based care and through inter personal communication they are trying to develop health seeking behavior in the community. Further, it is being proposed to incentivize ASHAs and ANMs of these areas by providing additional facilities as mobility support and security

17.21.6 Improved Out-Reach Services, Transport and Referral

Mobile Medical Units are proposed to be provided in each block of all districts, which will be parked at "fixed date, fixed site" approach with adequate medicines and human resource. The same is being budgeted in the chapter under "Mobile Medical Units" under Mission Flexipool.

Strengthening referral-In case of emergency or complications the pregnant women, sick children or sick adults must get proper treatment and management at suitable sites. For this special referral support is being budgeted for these districts.

Estimated Budget

(Rs. in lacs)

SN	Name of the District	Proposed activity	Unit cost	Number	Total estimated cost
1.	Sonbhadra (affected block- Nadwa,	Construction of sub centres	8 lacs	45	402.30
		Construction of PHCS	77.18 lacs	04	308.72
		Sub centre establishment	12000/- per month	45	64.80 l

SN	Name of the District	Proposed activity	Unit cost	Number	Total estimated cost
	Chatura, Babhani, Mayurpur, Budhhi, Chopan, Ghorawal & Nadwa)	Human resource for New PHCs	76,000/- per month	4 MOs, Pharma, ANM, Ward boy, Sweeper	10.56
		Awareness meetings at SCs	1000/- per meeting	93 SCs (1 meeting /SC/month)	11.16
		Communicable Diseases control programme			11.00
		Vector Borne Disease Control Programme -Purchase of insecticides, labour charges, IEC & mosquito net etc.	-	-	261.63
		Sub Total			**1005.37**
2.	Gazipur (affected block- Jamaniya, Bhadora & Gondor)	-Enhanced availability of drugs	10,000/- month/affected block	3	3.60
		-ANM/district training centres strengthening	2 lacs/centre	1	2.00
		-Community based care	-	-	
		-Outreach services referral transport	250/- per referral	100/month	3.00
		-Incentivizing human resource	1000/- per month to ANM & 250/- per month to ASHA	20 ANMs & 80 ASHAs	14.40
		Sub Total			**23.00**
3.	Chandauli (affected block- Navgarh, Chakiya, Barhani, Sahebganj & Chandauli Sadar)	-Enhanced availability of drugs	10,000/- month/affected block	5	6.00
		-ANM/district training centres strengthening	NA	NA	0
		-Community based care	-	-	
		-Outreach services referral transport	250/- per referral	100/month	3.00
		-Incentivizing human resource	1000/- per month to ANM & 250/- per month to ASHA	20 ANMs & 80 ASHAs	24.00
		Sub Total			**33.00**
4.	Mirzapur (affected block- Jamalpur, Rajgarh, Patehara, Halia & Lalganj)	-Enhanced availability of drugs	10,000/- month	5	6.00
		-ANM/district training centres strengthening	2 lacs/centre	1	2.00
		-Community based care	-	-	
		-Outreach services referral transport	250/- per referral	100/month	3.00
		-Incentivizing human resource	1000/- per month to ANM & 250/- per month to ASHA	20 ANMs & 80 ASHAs	24.00
		Sub Total			**35.00**
5.	Deoria	-Enhanced availability of	10,000/- month	2	2.40

SN	Name of the District	Proposed activity	Unit cost	Number	Total estimated cost
	(affected block-Bankata &Bhatpur)	drugs -ANM/district training centres strengthening -Community based care -Outreach services referral transport -Incentivizing human resource	2 lacs/centre - 250/- per referral 1000/- per month to ANM & 250/- per month to ASHA	2 - 100/month 20 ANMs & 80 ASHAs	4.00 3.00 9.60
		Sub Total			**19.00**
6.	Kushinagar (affected block-Fazil Nagar)	-Enhanced availability of drugs -ANM/district training centres strengthening -Community based care -Outreach services referral transport -Incentivizing human resource	10,000/- month/affected block NA - 250/- per referral 1000/- per month to ANM & 250/- per month to ASHA	1 NA - 100/month 20 ANMs & 80 ASHAs	1.20 0 0 3.00 4.80
		Sub Total			**9.00**
		Grand Total			**1124.37**

- Mobile Medical Units are being provided all over the State in the NRHM PIP 2010-11.
- Provision of RCH camps-18/block has been made all over the State.
- Provision of Health Melas-once a month/block has been made all over the State.
- NSV camps will be organized on priority basis in every district.'
- VHSC training is being organized at block level all over the State.
- National disease control programmes are addressing the local district specific problems

A total amount of Rs 1124.37 lacs has been proposed and has been approved by GOI for this activity.

18. INNOVATIONS

18.1 Mobile sessions to cover Hard to reach areas and Award/Iincentive shceme for ASHA, ANM, VHSC etc. under RI strengthening (FMR Head B 17.2)

1. FMR Code B.17.2 Incentive/Award Scheme for Routine Immunization:

- "Award Scheme" is the new strategy has been planned to ensure 100 % registration of Pregnant Women and immunization of children in the rural areas of the State. ANM, AWW, ASHA and VHSC members are involved to mobilize the beneficiaries to get registration, health checkup and immunization of pregnant women and childrens. This scheme will increase the registration of PW, tracking of women for their health check-up , fully immunization of children , awareness and responsibility of community.
- IEC material will be prepared on immunization programme for Village Health Sanitation Committee , community . budget has been proposed in IEC/BCC head.
- In the State, approximately 66 Lacs women will be Pregnant in a year and out of that 40 lacs will be in rural araes. In rural areas ANM, AWW and ASHA coordinate with each other and work as team for registration of PW and Routine Immunization In PIP Rs 40.16 Crores have been approved for Incentive/Awards scheme for ASHA, ANM and VHSC under Mission Flexipool (FMR code no.17.2). In this Rs 3900.00 Lacs for Incentive/Awards scheme for ASHA, ANM and VHSC under RI strengthening and Rs 116.00 for Mobility support for Hard to reach areas. After discussion with District Project Officers (FW) and Divisional & District Programme Management unit following strategy has been decided.
- Incentive to ASHA and AWW for registration of P.W.: - Main role of ASHA and AWW is to mobilize pregnant women and get them registred by ANM. ASHA and AWW are working in the same areas (approx.1000-1500 population) in the rural areas. To strengthen tracking and registration of pregnant women, it is being proposed to incentivize each ASHAs and AWW.ASHA and AWW will get Rs 30/-on every registration especially with in 3 months of pregnancy for completion of tracking up to 3 ANC checkups. It has been expected that Approx. 30 lacs (75% Pregnant Women from the rural areas) will be registred by ASHA and AWW.
- Budget estimation to ASHA and AWW:
- Incentive to ASHA on 30 lacs registration of PW from rural araes=30,00,000X Rs 30=Rs 9,00,00,000 =900.00 Lacs
- Incentive to AWW on 30lacs registration of PW from rural araes=30,00,000X Rs 30=Rs 6,00,00,000 =900.00 Lacs
- Total Budget for ASHA and AWW: Rs 1800.00 Lacs
- Award to ANM: ANMs will be awarded on the basis of no. of registration of pregnant women in their areas which will be also ensured through incentive of ASHA and AWW. In state 20621 Subcentre are in position and approximatly 20000 ANMs are working in these Subcentres covering about 8000 population/Subcentre. It has been estimated that in each subcentre approx. 240 women will be pregnant in a year. It has been also estimated that approx. 5000 ANMs will register 50 pregnant women /year , 5000 ANMs will register 100 pregnant women/year , 5000 ANMs will

register 150 pregnant women/year and 5000ANMs will register 200 pregnant women/year .

- It has been calculated that ANMs wiil get Rs 500/- for 50 registartions/Year, Rs 1000/- for 100 registrations/Year, Rs 2000/- for 150 registrations/year and Rs 2500 /- for 200 registrations/year in their areas budget estimation is as follow-
- Budget estimation for ANMs :-
- 50 registrations/year of PW: 5000 ANMs X Rs 500= Rs 25, 00,000=Rs 25.00 Lacs
- 100 registrations/year of PW: 5000 ANMsX Rs 1000= Rs 50, 00,000=Rs 50.00 Lacs
- 150 registartions/year of PW: 5000 ANMs X Rs 2000= Rs1, 00, 00,000=100.00 Lacs
- 200 registartions/year of PW: 5000 ANMs X Rs 2500= Rs1, 25, 00,000=125.00 Lacs
- Total Budget for ANMs = Rs 300.00 = Rs 300.00 Lacs
- Award to Gram Sabhas: Total 52000 Gram Sabhas are active in our State and It is estimated that 25000 Gram Sabhas (Pradhans) will help in getting registration of 100% PW and full immunization of children (0-1 year) in their areas and it has been decided each Gram Sabha (Pradhan) will get a momento of Rs 4000/- along with certificate after completion of 100% registration of PW and full immunization of children (0-1 year) in their areas.Estimation of registration of pregnant women for the purpose of awards to Pradhan, the cut of month will be decided at State level and the guide line will be issued shortly.
- Budget estimation: 25000X Rs 4000= Rs10, 00, 00,000=Rs 1000.00 Lacs
- Award to Block Pramukh: It is astimated on an average in each Block area around 60 Gram Sabha are there.All Gram Sabha can not register 100% PW some or the other region hence Award to Block Pramukh is calculated on the basis of percentage of fully registerd GramSabha.
- In this scheme 400 Block Pramukh will be awarded if 50 % Gram Sabha will achieve 100% of PW and full immunization of Children (0-1 year) in their areas. Block Pramukh will get a momento of Rs 25000/- after completion of 50% Gram Sabha in their areas.
- Award to Block Pramukh= 400X Rs 25000=1, 00, 00,000=Rs 100.00 Lacs
- Award to Jila Panchayat Addayachhya, District magistrate and Chief Development Officer: It has been estimated that approimatly 1/3rd of the total Districts (working area of Jila Panchayat Addayachhya, District magistrate and Chief Development Officer) will get Award if 50 % Gram Sabha will achive 100% registration of PW and full immunization of children . Jila Panchayat Addayachhya, District magistrate and Chief Development Officer will be awarded a momento of Rs 50,000/- to each Officer.
- Budget estimation: 25X3X 50,000 = Rs 37, 50,000=Rs 37.50 Lacs
- Division level: It has been estimated that 1/3rd of total Divisions will achieve the target .It has been calculated 40% of GramSabha complete 100% registration of PW and full immunization of children in the Division. It has been decided that Divisional Commissioners will be awarded by a momento of Rs 1,00,000
- Budget estimation for Division = 6X1, 00,000= Rs 6, 00,000=Rs 6.00 Lacs

Detail about Incentive/Award Scheme

B 17.2	Incentive/ Award Scheme			
Sl.No	Awards and Incentive	Units	Rate	Amount in Lacs
1	Incentive to ASHA	3000000	Rs.30 per Registration	900.00
2	Incentive to AWW	3000000	Rs30 per Registration	900.00
3	Award to ANM	20000		300.00
4	Award To Gramm Sabha	25000	Rs.4000/-Gram Sabha	1000.00
5	Award To Block Pramukh	400	Rs.25000/-Block	100.00
6	Award to Jila Panchayat Adhayachaya,DM,CDO	25	Rs 50000/- District	37.50
7	Award to Divisional Commissioner	6	Rs 100000/-Division	6.00
8	At State level			656.50
	Total			3900.00

- Total Budget: Rs 3900.00 Lacs has been approved for Incentive/Award Scheme under Mission Flexipool FMR code no .17.2
- FMR Code B.17.2 Mobile sessions to cover Hard to reach areas: There are some areas which have got scanty population or they are away from the subcentre and not covered by ANM regularly. There are some areas which are not connected by all-weather road and they are out of during the rainy season. “Mobile Sessions” will be planned for all above areas on quarterly basis with team approach. Approximately 1677 subcentre and 14000 villages are such which have to cover by “Mobile Sessions”. Areas will be identified and planning will be done in such a way that one vehicle will cover 4 sessions and no. of vehicles will be required as per no. of mobile sessions planned.
- No of Hard to reach Areas= 1677
- No. of sessions= 13416 or 14000 sessions (approx. 8 sessions /area)
- No. of sessions planned to cover these areas= 14000 (4 times in a year)
- No of additional vehicles required=14000 (1 vehicle will cover3- 4 sessions in a day)
- Budget requirement = 14600*800= 116 Lacs
- FMR code no. B.17.3 IEC under RI: The draft PIP of the State for 2010-11 submitted to Govt. of India had a proposal of Rs. 17770.75 lacs for new initiative to strengthen routine immunization (an incentive based strategy to beneficiaries) apart from incentive there was a provision of extensive IEC activities to popularize the scheme and other support system. During sub group and NPCC meeting and discussions the incentive based strategy was not approved. The State was asked to redraft the proposal. The revised proposal was sent as mentioned above.
- Govt. of India has approved the award shcme but at the same time approved the IEC activities of the original incentive strategy which amounts to Rs. 1121.25 lacs. The details are given below.
- (FMR B 17.3)

S.no	Name of Activity	Rate	Amount (in Lacs)	Remark
1	**Sensitization Meeting**			
a	At state level(CMO and DIO/Nodal Officer)	Rs 2500/- per participant X 142	3.55	Sentization meeting required to give clear guideline about incentive base scheme
b	At District level(all MOs)	Rs 150/-per Participant X 5000	7.50	
c	At Block level(ANMs and Health workers and Supervisors	Rs 100/-per Participant X 25000	25.00	
	Subtotal		**36.05**	
2	**Human resource**			
a	Outsourcing for data uploading	@ 10000/-Block for 3 months	85.20	
	Subtotal		**85.20**	
3	**IEC**			
a	Print media		Approx. 800.00	comprehensive ICC/BCC required for this scheme
b	TV/Radio			
c	Hoardings			
d	Banner/Poster			
e	Handbills	Rs 2/- Brochures or handbill x1,00,00,000	200	
	Subtotal		**1000**	
	Total		**1121.25**	

18.2 Maintaining Closed User Group (CUG) Network

This was an innovation initiated in 2009-10 through which 1000 functionaries were connected together through a CUG at a cost of Rs. 640 per month per user. The total amount proposed in 2009-10 was Rs 76.80 lacs. This network has been activated in the third quarter of 2009-10 and therefore funds available will be sufficient to maintain the network. **No additional funds are being requested in 2010-11.**

18.3 Swasthya Parikshan Yojana (Health Melas) (FMR CODE B 10.1)

More than 80 percent of UP resides in rural areas where accessibility to health services is very poor. This is aggravated by the fact that there is a huge shortfall in human resources available at government facilities in rural and is almost negligible in hard to reach areas. The planned outreach services such as routine immunisation, ante natal and post natal care coverage, counselling for family planning services is less than 50 percent. NFHS III shows that awareness is high in rural areas for family planning and maternal health services.

To address these issues, two day Health Melas were initiated as a pilot in second quarter using RKS funds in once a month in every block where all specialists and

paramedics go on a predecided date with adequate drugs, equipments, instruments and manpower. Pre camp publicity in nearby areas is conducted extensively to ensure demand generation for these services. A total of 3557 Health Melas have been conducted during this period reaching nearly 42.5 lac beneficiaries. Of these, 72411 high risk cases were referred to health facilities, 26000 IUD inserted, 1831 male vasectomies and 19501 tubectomies conducted, 4306 new leprosy cases identified, 1015 leprosy cases registered for restructuring surgery and 31319 cataract operations conducted. With this tremendous response from communities and it is planned to scale up this activity

To implement this activity, a fixed site – fixed date approach will be used, in which 50 percent of the blocks will be covered on the first and second of the month and the remaining on the 15th/ 16th of the month. As already mentioned, each camp will be pre publicised and will be self sufficient to include all personnel, equipment, supplies and drugs.

All district hospital and CHCs have been issued a notification that the Health Mela beneficiaries should be given preference for follow up and post surgical management. ANMs would be required to conduct home visits for follow up of the vasectomy, tubectomy and IUD insertion clients.

It is proposed to conduct one Health Mela of two days duration in each block every month.

The CMO/ ACMOs/ Deputy CMOs are physically present during the Health Mela. MO I/C from the Block PHC is involved in all pre and post event activities.
At the State level, Additional Director – Health and Family Welfare has been nominated as the Nodal Officer for the activity. He is responsible for sending all State level guidelines to the districts and ensuring that all logistics are available at the district. Computerised reports from districts are received at State level within 48 hours after the event, which includes provision for qualitative feedback on how the project is functioning.

S.No	Activity	Unit Cost	Number	Total Amount (in lacs)
1	Organisation of Mela (incl. tent, furniture, IEC, refreshments for functionaries and audio systems)	Rs. 20,000	820	1968.00
	Vehicle arrangement	Rs. 600 per day	2 buses per mela for 820 blocks	118.08
	Planning and monitoring at State level	Rs. 10,000 per month	12 months	1.20
	Medicines/ X-ray plates/ ECG rolls/ reagents etc.		From State budget	0.0
	Total			**2087.28***

Government of India has approved an amount of Rs. 2087.28 lacs for organization of health melas as mentioned above in the table.

18.4 Ensuring Quality Health Care through Government Health Facilities. (FMR CODE B 18.2)

- The Government of Uttar Pradesh is committed to provide affordable, quality health services to people of the state specially to those belonging to lower socio-economic strata. The Govt health facilities are providing a wide range of services ranging from preventive, curative services ranging from primary, to tertiary care. To create confidence among the people toward Public Health Facilities the Govt. is trying to get it's facilities accredited to NABH (National Accreditation Board of Hospitals) standard in a phased manner. Moving ahead in the same direction it is proposed to get 29 units (16 district level hospitals and 13 Community Health Centres) accredited to NABH standards. The name of the hospitals and CHCs are as below:

S.N	Dstrict Hospitals	S.No.	CHC
1	UHM Hospital, Kanpur	1	Mohanlal Ganj, Lucknow
2	Balrampur Hospital, Lucknow	2	Lalganj, Raebareilly
3	Dr. S.P.M. Hospital, Lucknow	3	Chandausi, Moradabad
4	Pt. D.D. Upadhyay Hospital, Varanasi	4	Sambhal, Moradabad
5	District Hospital, Moradabad	5	Toondla, Firozabad
6	District Hospital, Saharanpur	6	Khairagarh, Agra
7	District Hospital, Bahraich	7	Sardhana, Meerut
8	District Hospital, Gorakhpur	8	Sidhauli, Sitapur
9	District Hospital, Banda	9	Faridpur, Bareilly
10	District Hospital, Faizabad	10	Ujhani, Badaun
11	District Hospital, Mathura,	11	Lalganj, Pratapgarh
12	District Hospital, Agra	12	Mauranipur, Jhansi
13	District Hospital, Jhansi	13	Khalilabad, Santkabirnagar
14	T.B. Sapru Hospital, Allahabad		
15	District Hospital, Bareilly		
16	Avanti Bai Female Hospital, Lucknow		

- To get the accreditation of NABH for the above mentioned facilities a sum of Rs. 954.5 lakhs is required towards technical fee (@ Rs. 7.5 lakhs/hospital), administrative charges (30% of technical fee), Govt. taxes (10.3%) and infrastructure strengthening (based on gap analysis) of the selected CHCs (@ Rs. 50 lakhs/unit). For infrastructure strengthening of the District Hospitals budgetary provision has already been made in the PIP. The amount Rs. 954.5 lacs was budgeted for accreditation of the hospitals. Government of India has approved the activity for same amount.

- Charges for the accreditation fee and other expenses will be budgeted in the PIP of the next year i.e. 2011-12, which is likely to be Rs. 60 lakhs.

19. SUPERVISION, MONITORING AND EVALUATION

19.1 Community Based Monitoring (CBM) (FMR Code B 18.1)

Community monitoring is one of the core strategies under NRHM. It was proposed to operationalise community monitoring activities with support from GOI, development partners and NGOs during the year 2009-10 as a pilot in 5 districts. An official exposure visit was undertaken to Pune to understand the modalities and systems needed for implementing community based monitoring systems. Based on field observations, community monitoring is effective in situations where supply side requirements are adequately met, namely, staffing is almost 100 percent with adequate supply of drugs and appropriate infrastructure.

A pilot would be initiated along these lines in five districts with three BPHCs covering 15-20 villages in each district. Under this activity, it will be endeavoured that the community should emerge as active rather than passive participants in the public health system, ensuring service availability and quality of services availed.

Community based monitoring will promote community ownership and decentralized planning from village to district level. It will also provide community feedback to the local health authorities for improving Public Health Delivery Systems, which will be further monitored using verifiable indicators. The CBM activity will be initiated with the support of Advisory Group on Community Action (AGCA)/ Population Foundation of India (PFI), such as development of ToRs for NGOs and processes of CBM.

S.No	Activities	No. of Units	Rate per Unit (in Rs.)	Frequency	Total (in Rs. Lacs)
1	**NGO Costs**				
	Personnel				
	Coordinator	5	15000	12	9.00
	Capacity Building Officer	5	10000	12	6.00
	Block Community Supervisor	15	7500	12	13.50
	Honorarium to Village facilitator	225	2500	12	67.50
	Sub Total				**96.00**
	Travel of Personel				
	Travel Allowance to personnel	25	300	240	18.00
	Sub Total				**18.00**
	Workshops and Meetings				

	Workshop of NGO personnel on CBM guidelines	15	2500	1	0.38
	Workshop for orientation of all CBM Committees	300	500	1	1.50
	Jan Sunvayi meetings	225	250	2	1.13
	Sub Total				**3.00**
	Printing of Materials				
	Posters	200	10	1	0.02
	Flip books	200	40	1	0.08
	Handouts for CBM personnel	500	10	1	0.05
	Information boards at village level	75	4000	1	3.00
	Development and printing of reporting formats	2500	25	1	0.63
	Sub Total				**3.78**
	NGO Overheads				**6.04**
	Total NGO Costs				**126.81**

The following activities are planned for CBM in 2010-11:

- Identification of five districts for implementation of CBM activities (to be initiated in February 2010)
- Development of guidelines for implementation of CBM in identified districts to be developed, finalised and approved at SPMU;
- Development of ToRs for NGOs with support from Advisory Group on Community Action (AGCA)/ Population Foundation of India (PFI) and selection of NGOs for facilitation and supervision of CBM;
- Establishment of CBM Committees at block level and district level in identified districts with guidelines on its constitution and clearly defined roles, responsibilities and authority;
- Guidelines will also specify linkages between RKS, VHSC and CBM Commitees;
- Development of training materials and training of NGO personnel on CBM and related activities will be completed;
- Training of CBM Committees will be conducted which will include community involvement, rapid appraisals, obtaining feedback from communities regarding health services and initiating action at local level with flexible funds available through NRHM;
- Village health mapping involving communities will be developed for all villages and development of Village Health Plans;
- Initiating public dialogue (*Jan Sunvai)* to be chaired at the block and district level chaired by the local and district health authority respectively;
- Printing of IEC materials for mobilisation of communities and for information sharing with them; and
- Development of information systems to manage the implementation of CBM.

The activities detailed above will lead to empowerment of VHSCs to influence public health systems to meet needs of their communities.

CBM Activity will be initiated CBM will be implemented in five selected district for which about Rs.100.00 lacs is required per district. **A total sum of Rs. 500 lacs has been approved by Govt. of India for this activity.**

19.2 ANM Supervision and Monitoring Systems (FMR Code B 18.3.2)

There are more than 21000 ANMs who are functional in the State posted in 20,600 Sub centres and PHCs. Each ANM was catering to a population of 5000, however, on an average each ANM is covering a population of 8000-10000. In her area she is supposed to provide, immunization, ante natal checkups, delivery at sub centre, post natal care, family planning counseling, IUCD insertions and counseling regarding nutrition and hygiene. These ANMs also provide their services in the Pulse Polio campaigns, which in UP is at a monthly frequency. As per NRHM mandate there should be two ANMs at each sub centre, one for service provisioning and the other for outreach.

In the years before 1992, there was a surplus of trained ANMs which could not be employed by the State. Many Court cases were filed by ANMs and at that time the Court directed to suspend ANM trainings. This has led to a shortage of trained ANMs, as reported by various assessments.

The ANM trainings have been reinitiated in 2008-09 and presently 1905 ANMs are under training which will be completed by March 2010. These ANMs will be available for providing services, thus addressing the human resource gap through 40 ANMTCs. These trainings have now been institutionalized and regular trainings will continue.

Since these ANMTCs have a capacity of 60 trainees per batch, the maximum capacity available is of 2400. There are 11 Regional Family Welfare Training Centres and 30 District Training Centres (DPTT) for male workers training. All the training centres have been strengthened during 2008-09 and 2009-10. The State is also exploring various PPP models to enhance the training capacity for male and female workers.

As per the existing structure, the Lady Health Visitor (LHV) is supposed to supervise and monitor ANMs works. One LHV has to supervise four ANMs. But the number of LHVs in position are around 2000 only and this is almost a dying cadre in the State. The existing LHVs are not performing their duties and responsibilities, leading to negligible supervision of ANMs. This led to a consultation of field officer, departmental heads, and program officers, SPMU officers and representatives of various developmental partners to develop an ANM monitoring and supervision structure.

In 2009-10, four male AYUSH doctors were proposed to be posted at Additional PHCs where no Medical Officers were available. There was an overwhelming response to the position advertised and most of the places have been recruited. These male AYUSH doctors are fresh blood in the health system and are performing their duties with enthusiasm and vigour. Based on this experience, one male AYUSH doctor is being proposed in 2010-11 this year. Presently there are about 1110 AYUSH doctors posted at block / below block level from regular posting and 725 on contract under NRHM.

Further Public Service Commission has published list of 2500 MBBS doctors which have been recently selected. It is being planned that 1 doctor from this list will be posted at CHCs specifically for supervision purposes. Thus, at each block there will be 3 medical officers (2 from AYUSH and from freshly recruited MBBS doctors) who will be responsible for extensive supervision of ANM activities in the field. It is being proposed to revise the present roster of ANM and now, to give maximum emphasis to routine immunization activities, these ANMs will be conducting VHND / immunization sessions on all 6 days of the week on a rotational basis. These doctors will be designated as nodal officers for ANM supervision and monitoring and will be mandated to conduct field visits on all days of the week to monitor the activities of ANMs. During these visits the doctor will visit VHND sessions and some beneficiaries for client feedback. In addition, these doctors will also visit ANC clinics being conducted by ANMs at Sub Centres. They will also monitor the provisioning of IUD services as well.

Provision will be made for vehicle hiring to enable the mobility of these doctors for a month @ Rs. 18000 per vehicle for 820 blocks in the state. Thus, the budget for the same for compelte one year is being budgeted as Rs. 18000 X 820 blocks X 12 months = 1771.20 lacs. These doctors will submit their advance tour plan to MOI/C Block PHC and will prepare a report in a prescribed format on each visit undertaken. These reports would be compiled at the block PHC by MO I/C Block PHC.

A sum of Rs. 1771.20 lacs has been approved by Govt. of India for this activity.

19.3 Mobility Support for Monitoring & Supervision (FMR Code B 18.3.2)

A detailed monitoring and supervision guideline was prepared in 2009-10 to make monitoring visits effective. Sites for visits at each level were defined for all functionaries along with checklists for monitoring each activity. Frequency of visits by each level of supervisors/ officers was defined in the guidelines. Detailed reporting formats were sent to SPMU on a monthly basis. These reports are reviewed and compiled for feedback and corrective action.

Sl.	Description	Annual Exp. (Rs. in lacs)
1	Mobility Support to District Communication Manager (@Rs.800/- per day x 8 days/month) for 71 districts	54.53
2	Mobility Support to District Accounts Manager (@Rs.800/- per day x 6 days/month) for 71 districts	40.90
3	Mobility Support to District Programme Managers (@Rs. 800/- per day x 8 days/ month) for 71 districts	54.53
Total		**149.96**

For the purpose of improving programme management, monitoring & supervision, at the district and block levels, an amount of Rs. 149.96 lacs has been approved by Govt. of India.

19.4 State Quality Monitors

In the PIP 2009-10, 18 state quality monitors were proposed for monthly quality monitoring of services under NRHM. People from outside the government system, preferably retired government officers, of Joint Director and above rank, having requisite experience of functioning at district/ state level in health sector would be deployed.

Presently, eight State Quality Monitors are working. This year it is proposed to ensure all the 18 SQMs (one SQM per division) are appointed for each division. This has been budgeted under **Human Resources under RCH Flexipool.**

19.5 Technical Support Groups

The State has formulated Technical Support Groups to ensure that quality services are provided effectively through various programmes. These groups influence policy decisions at State level, provide strategic direction to programme implementation and review programmes for any course correction needed. The TSGs consist of representatives from Directorate, donor partners, local implementation partners and technical experts. The following TSGs, with their constitution are as follows:

S.No	Technical Support Group	Members
1	Maternal and Child Health	Nodal Officer: Director, MCH Members: UNICEF, PATH, IntraHealth, JHU, WHO and Vatsalya
2	Family Planning	Nodal Officer: Director, FP Members: SIFPSA, ITAP, CARE, FPAI, PFI, PSS and HLFPPT
3	Nutrition	Nodal Officer: Joint Director- Family Welfare Members: CARE, IntraHealth, AtoZ, CRS, UNICEF, representative from ICDS
4	Adolescent Health	Nodal Officer: Joint Director- NRHM

		Members: SIFPSA, CARE, MAMTA and BETI Foundation
5	IEC/ BCC	Nodal Officer: Additional Director-UIP Members: SIFPSA, CARE, UNICEF and ITAP
6	Improved Programme Management and Implementation (incl. logistics)	Nodal Officer: Joint Director- Training Members: SIFPSA, ITAP, JHU and UPHSDP
7.	Other National Programmes (incl.	Nodal Officer – Director – National Programmes Members: Water Corporation/ Water Works, Rural Development Division, Social Welfare Division, CAPART, Sulabh International and SPM departments of CSMMU

These TSGs are mandated to meet quarterly and the minutes of the meetings are submitted to the Mission Director, NRHM who may participate in any specific meeting, twice a year. There will also be a meeting convened under the chairpersonship Principal Secretary, Medical Health and Family Welfare or Mission Director, NRHM, twice a year, to review progress. These meetings are being conducted regularly and some of the major decisions and strategies include:

- Development of protocols for Essential New Born Care at facilities
- Development of job aids and tools to be utilized by ASHAs in CCSP districts
- Decision and designing of one day orientation training for ASHAs
- Development of Maternal Death Audit protocol and formats
- Development of Infant Death Audit protocols, formats and design of training programmes for investigators and research team
- ASHA Mentoring Group meeting at State
- Recruitment of Family Welfare Counselors at district hospitals, their roles and responsibilities and design and development of modules for training programmes of FWCs
- Establishment of Nutritional Rehabilitation Centres in selected districts
- Designing training materials and review of modules for adolescent health and school health programme (SACH, Saloni and Ashirwad)
- Finalisation of guidelines for VHSCs and RKS fund utilisation

These Technical Support Groups will continue to provide technical assistance to the implementation of all programmes in the State.

19.5 Annual Survey to Measure Performance of Poor Performing Districts and Incentives for Improved Performance (FMR Code B 18.3.2)

Based on DLHS III findings, the poorest performing districts have been identified for intensive programming for each thematic area. The specific indicators identified are:

- Maternal Health
  - Percent women receiving atleast three ANC checkups
  - Percent women availing institutional delivery
- Child Health

    - Percent children completely immunised
- Family Planning
    - Any modern method usage

It is proposed that a fixed time annual survey be established and conducted by external agencies in the identified districts for each theme. These agencies will be reputed national level agencies that have been sub-contracted in the past for conducting DLHS. Questionnaire from DLHS will be used for each theme. While the survey results will provide the overview of critical indicators for each theme, the indicators mentioned above will be the measure of performance of the district.

A randomly selected sample of 1000 per poorly performing district will be taken for obtaining district wise indicators (approximately 25000 samples). Districts will be encouraged to identify their weak pockets, identify challenges and resolve them to enhance services uptake. DLHS III data will serve as the baseline and districts will be given a reward on improving their indicator to three times that of the baseline.

While GoI is developing an Annual Health Survey providing indicators on a district and regional basis, the above survey will provide inputs as per State timelines to ensure timely incentives to the districts. It is proposed that the agency will be selected by August to enable training and field work in November/ December, data entry and analysis in January, report finalisation in February and dissemination of results to districts in March. These surveys will be conducted on a continuous basis.
The following budget has been approved for this activity

Component	No. of Units	Rate per Unit	Freq.	Total (in Rs. Lacs)
Annual Survey for Poor Performing Districts	25000	500	1	125.00
FMR Code B 18.3.2		**Total**		**125**

An amount of Rs. 125 lacs is proposed for conducting the surveys in the year 2010-11.

Each district enhancing their performance to three times that of the baseline, will be given an incentive of Rs. 5 lacs, for utilisation as per needs of the district. It is expected that ten of the poorly performing districts will be able to achieve objectives of enhanced performance. **Accordingly a budget of Rs. 50 lacs (FMR Code B 24) will be required for the year 2010-11. In addition, an amount of Rs. 5 lacs (FMR Code B 24) will be required for a State level function for felicitation** of the district and encourage even better performance next year.

For the activity, a total amount of Rs. 180 lacs has been approved by Govt. of India.

19.6 Concurrent Evaluation of Programme Activities (FMR Code B 24)

In addition to the GoI Annual Health Survey, concurrent evaluation of programme implementation activities will be conducted through independent agencies/ reputed Medical Colleges to provide inputs into programme planning:

- CCSP Programme: It is proposed to conduct a survey in 17 districts where the CCSP programme implementation was initiated in 2009-10. The survey will provide estimates for IMR/ NMR to assess progress in these districts and will also ask programme related questions for feedback. To obtain reliable district wise estimates, a sample of 1000 to 1500 will be taken, depending on the size of the district, and it is expected that a total sample of 20000 will be required. **A total amount of Rs. 100 lacs is proposed for the activity in 2010-11.**
- School Health/ Adolescent Health Programme: To assess the impact of the adolescent health intervention on:
    - Reduction in anaemia and under nutrition (as measured by BMI) in adolescent girls.
    - Early detection and treatment seeking for symptoms of reproductive tract infections in adolescent girls
    - Improved menstrual hygiene behaviours in adolescent girls
    - Intention to marry after 18 years and intention to postpone child bearing to after 19 years

  The Saloni evaluation will be conducted in two parts: formative and summative. The methodology for the formative evaluation will include pretest of the materials, training feedback and assessment of changes in knowledge and behaviours of adolescents as well as service providers.
  The summative evaluation will be done using a randomized cluster trial design. **A total amount of Rs. 11 lacs has been proposed for the year 2010-11.**

To monitor programme implementation in the field, a detailed log frame has been developed with verifiable indicators and means of verification. These indicators along with the indicators identified by GoI through their MIS will provide information on programme implementation.

20. CONCURRENT AUDIT SYSTEMS FOR NRHM (FMR Code B 27.5)

A concurrent audit system is functional in the State in which District Health Society (DHS) accounts are being audited and the system has been appreciated at GoI. The salient features of the interventions proposed are as under:

- A Chartered Accountant / CA Firm is engaged to ensure that all formats developed for audit and monthly audit activities are carried out;
- Implementation of monthly audit system, providing support and guidance to district units and coordinating with district level auditors.
- Feedback mechanism.
- Support in statutory audit
- Sensitization of field officers and units, orientation training for PMU officials.

This year it is proposed to strengthening the concurrent audit system by deploying finance professionals on contract. Accordingly, one Chartered Accountant, an Accounts

Assistant and support staff will continue operationalising the system. Audit of district health society accounts would be continued. The budgetary requirement is as shown in the table ahead.

S.No.	Description	Total cost (Rs in lacs)
1	Contractual Staff and operational expenses @ Rs. 60,000 per month	7.20
2	Audit of District Society Accounts through External Auditors @ Rs.4000 per month / district	34.08
Total		**41.28**

Accordingly, an amount of Rs. 41.28 lacs has been approved.

21. OPERATIONALISATION OF HMIS AND PROMIS (PROCUREMENT MANAGEMENT INFORMATION SYSTEM) (FMR Code B 18.3.1)

In state PIP 2009-10, a budgetary requirement of Rs. 1200 Lacs was proposed under Mission Flexipool, sub-head Operationalization of Health MIS (HMIS). Under this proposal, 823 block PHCs and 128 district hospitals were proposed for computerisation and implementation of Health MIS. In order to strengthen financial accounting system at state, district and block level, implementation of tally (ERP 9.0) software was also proposed in PIP 2009-10 under this activity.

Against the above sanction in PIP 2009-10, procurement of computer hardware for all 823 block PHCs/CHCs and 128 district hospitals(Men, Women & Combined) along with procurement of tally ERP multiuser for 71 districts and tally single user accounting software for 515 Block PHCs/CHCs is under process and is expected to be implemented before 31 March, 2010. Total expenditure upto 31st,December, 2009 is about Rs. 1041 Lacs and would likely be completed 100% upto 31st March,2010.

At present, Health management information system(HMIS) is successfully implemented upto district level. The periodical reports are being uploaded from all 71 districts in the state and nodal officers at all levels have also been nominated for Health MIS. Guidelines for effective monitoring of various activities under NRHM programmes by officers at different level as per the defined checklist provided by SPMU have already been issued by higher authority. Monthly consolidated data of HMIS is compiled by Investigation-cum-Computer (ICC) and is uploaded by HMIS operator at district level. The status and quality of uploaded data is monitored by state nodal officers with their support staff of NRHM, divisional programme managers and district programme managers. R&D activities are being proposed by academic institutions in order to analyse the HMIS data and derive important facts.

The computer hardware is expected to available at block level before 31st March 2010. The HMIS data at block units(PHCs/CHCs) will be compiled by ICCs posted at block

units and will be uploaded by Block data assistants. District account manager(DAM) and district data and account assistant (DDAA) will maintain the data related to financial accounting system at district level.

For monitoring and evaluation, detailed guidelines have already been sent to the districts by SPMU according to which CMOs have to take corrective actions. The compiled report of programme officers is put-up in district health societies meetings. Apart from this all the programme officers of additional Director level at the office of DG family welfare and DG medical health are responsible for implementing and monitoring their concerned programme activities for which they have been made fully accountable. These officers monitor their programmes in the field regularly and submit their reports to DGs for corrective actions. Apart from these there is provision of state quality monitor at every division in Uttar Pradesh. At present total eight state quality monitors are working. They are monitoring the activities of their concerned division.

Training on HMIS at all level will be required to enhance data quality of HMIS. The persons included for training are computer operators, ICCs, district programme managers, divisional programme managers, additional CMOs, Dy.CMOs, block ICCs and Block data assistants.

In order to maintain Health MIS upto block level during 2010-11, a budgetary requirement of **Rs. 890 lacs** is proposed. This will include activities such as printing of Health MIS formats for Health facilities, training on M&E for staff at state, district & block level, provisioning of contractual staff for data uploading, reports printing, internet access and other recurring expenses including computer consumables etc. Out of 908 CHCs/Block PHCs 823 CHCs/Block PHCs were proposed for computerisation in state PIP 2009-10. Remaining 85 CHCs(other than 823 block PHCs/CHCs) are also proposed for computerisation during 2010-11. Apart from this, implementation of tally ERP single user for remaining 308 Block PHCs/CHCs is also proposed during 2010-11 so that uniform financial system could be placed across all 823 block PHCs/CHCs in the state.

A web based Procurement Management Information System(ProMIS), has been introduced at MoHFW in order to computerize the complete procurement process i.e. Procurement management, Warehouse Management and Stock Recording facility. This computerised system could enhance transparency, competitiveness, timely supplies, record keeping, complaint handling and decision making in drug warehouses at state, regional and district level. In order to implement this Procurement MIS(ProMIS) in all 10 regional drug warehouses (Varanasi, Bareilly, Meerut, Gorakhpur, Faizabad, Azamgarh, Agra, Kanpur, Allahabad and Banda) including one state drug warehouse at Lucknow and 24 district drug warehouses, a budgetary requirement of **Rs. 196 lacs** is proposed for PIP 2010-11. This will include the procurement of desktop computers for state, regional and district drug warehouses, printing of input formats, barcode tags, training for staff, provisioning of contractual staff for data uploading, reports printing, internet access and other recurring expenses including computer consumables etc. Nodal officers will be nominated at state, regional and district level to monitor the data

entry in ProMIS. Training on ProMIS to these nodal officers and other support staff will be required, so as to implement this system successfully during 2010-11.

Thus, total budgetary requirement of Rs. 1086 lacs (Rs. 890 lacs for health MIS and Rs. 196 lacs for procurement MIS) **has been approved by Govt. of India.** The details are given in the table below :

MONITORING & EVALUATION ACTIVITIES IN STATE PIP FOR 2010-11

Major Head	Minor Head	Code	Budget in Rs.Lacs	Details	Remarks
Strengthening of M&E/HMIS	Salaries of M&E, MIS & Data Entry Consultants	1.1	260.00	Salaries for 38 computer operators at state level, 121 computer operators for district level health units already approved for 2009-10 and salaries for 85 operators for CHCs/Block PHCs being proposed for computerisation during 2010-11	@12000-15000 per month for state level & @8000-10,000 per month for districts
	Mobility for M&E officers	1.2	125.00	Mobility for HMIS Nodal officers posted at state,district and block level	
	Workshops/Training on M&E	1.3	5.00	Training on M&E at state level	
	M&E studies	1.4	2.50	R&D activities based on HMIS data	R&D activities are proposed to be done by academic Institutions
	Others (specify)	1.5	12.50	Hiring of IT related services from external agencies in case of any contingency	
Procurement of HW/SW and other equipments	Hardware/Software procurement	2.1	150.00	Computer hardware procurement for remaining 85 CHCs/Block PHCs to be computerised during 2010-11. This includes procurement of computers,printers,ups, Software & other electronics equipments including furniture for state level units and CHCs.	

Major Head	Minor Head	Code	Budget in Rs.Lacs	Details	Remarks
	Internet connectivity	2.2	60.00	Broadband internet connections at health facility level	Rs. @400 per month per computer basis
	Annual Maintenance	2.3	25.00	Annual maintenace of H/W & equipments which are already procured during 2008-09 and 2009-10	
	Printing & computer stationery	2.4	60.00	Consumables for computers,printers and computer stationery	Rs. @400 per month per computer basis
	Others	2.5	90.00	Procurement of Tally (ERP 9.0) accounting software singe user for remaining 308 block PHCs and provision of wireless internet access to the remote health units.	Tally procurement is to be made as per the guidelines of GOI
Operationalising HMIS at subdistrict level	Review of existing registers - to make compatible with National HMIS	3.1	10.00	Review of existing registers/formats and redesign in order to make compaitable with national HMIS	
	Printing of new Registers/Forms	3.2	15.00	Printing of registers/input formats for health units	
	Training of staff	3.3	75.00	Training on M&E at division, district and block level	
	TOTAL		**890.00**		

IMPLEMENTATION OF PROMIS IN STATE PIP FOR 2010-11

Major Head	Minor Head	Code	Budget in Rs.Lacs	Details	Remarks
Monitoring & Evaluation	Salaries of Nodal officers/Logistics Managers/Data Entry Operators	1.1	60.00	4 operators for state drug warehouse, 20 operators for regional drug warehouses and 24 operators for district drug warehouses	Salary for 48 computer operators at drug warehouses at all level @8000-10,000 per month per person.
	MIS reports/publications or research/Statistical data etc. based on ProMIS	1.2	2.50	R&D activities based on ProMIS data	R&D activities are proposed to be done by academic Institutions. It also includes printing of analystical reports/books.

Major Head	Minor Head	Code	Budget in Rs.Lacs	Details	Remarks
	Workshops/Training on ProMIS Warehouse Information System	1.3	5.00	Training on ProMIS Warehose Information System at state level staff	Four session of one day training is to be conducted at state level for warehouse storekeepers/pharmacist and other related state/district level officers. 2 session of training for serior management is also included.
	Workshops/Training on ProMIS Management Information System	1.4	5.00	Training on ProMIS Management Information System at state level staff	
	Others	1.5	12.50	Hiring of IT related services from external agencies in case of any contingency	
Procurement of HW/SW and other equipments	Hardware/Software procurement	2.1	50.00	Procurement of computer hardware for state,regional and district drug warehouses. This includes computers,printers, UPS, software and other electronics equipments including furnitures	4 desktop computers including all accessories for state drung warehouse, 2 for each regional(total 10) and one for each district drug warehouse(total 24). Thus, total 48 desktop computers with monitor,CPU, printer and UPS are proposed to procure with unit price about @60,000/- per computer system.
	Internet connectivity	2.2	5.00	Broadband internet connections at all warehouses	Rs. @400 per month per computer basis at drug warehouses at state,regional and district level.
	Annual Maintenance	2.3	0.00	Maintenance of existing computer hardware	Included in Sub-head 2.2
	Printing & computer stationery	2.4	0.00	Consumables for computers,printers and computer	Included in Sub-head 2.2

Major Head	Minor Head	Code	Budget in Rs.Lacs	Details	Remarks
				stationery	
	Others	2.5	25.00	Procurement of barcode readers & thermal Printers and barcode tags	
Operationalising ProMIS till the district level	Training of staff	3.1	3.00	Training of staff at regional and district ware houses	Training of State/District level warehouse managers and store keepers/pharmacists for 3 days training for 5 batches of 30 persons per batch @ Rs. 60,000 per batch
	Rearrange/Reorganize warehouses to facilitate dispatch & receipts strictly as per FEFO for data entry in ProMIS	3.2	1.75	Rearrange/Reorganise warehouses to facilitate dispatch & recipts	Labour charges for 5 un-skilled labourers for 7 days @ Rs.140 per day per person in each warehouse
	Modernization of warehouses/building new warehouses	3.3	0.00	Modernisation of warehouses	Already included in PIP
	Printing of revised formats of Expiry & stock registers	3.4	1.25	Printing of revised formats of expiry & stock registers	Printing of about 20 stock registers for each drugwarehouse @Rs.150 per register
	Others	3.5	25.00	Printing of input formats including barcode tags	
	TOTAL		**196.00**		

22. PROCUREMENT

Under RCH I, supply of certain drugs and kits such as Drug Kit A and B and contraceptives were supplied by the Central Government. In 2007-08, this procurement was decentralized to the States. However, due to impediments in procurement, these drugs could not be supplied to the field level. In 2009-10, supply from Government of India was revived and now Kit A and Kit B are being received, including contraceptives, medicines and kits.

For other medicines, procurement was done through CMSD using open contract, State rate contract and DGS and D rate contracts. However, UNOPS has been retained by the State for complete procurement since 2008-09 and all major procurements are done by them using transparent systems and processes.

22.1 Establishment of Procurement Cell

Establishment of a procurement cell was proposed in the PIP for the year 2008-09, however, the same could not be established. It is proposed to put the procurement cell in place during this year. 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 Hon. (Rs.)	Annual Budget (Rs. in Lacs)
1.	Procurement Specialist	1	BE/B.Tech./MBA with relevant expr. 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**

Total Budgetary Requirement (incl. in Prog. Management under Mission Flexipool)

Sl.	Activities	Amount (Rs. in Lacs)
1.	Payment to Contractual Staff	9.06
2.	Hiring of consultancy services for preparation of ToRs, bid documents, etc.	100.00

3.	Establishment of Office (computer system, telephone, furniture, etc.)	2.50
4.	Miscellaneous & Contingency	1.20
TOTAL		**112.76**

22.2 Procurement of Drugs & Equipment

Details regarding procurement have been provided under the relevant component. Various procurements proposed during the year 2010-11 is summarised below and the expenditure would be met from Mission Flexipool. In addition, a letter has been sent to GoI for diversion of funds from major repairs, Mobile Medical Units, Emergency Medical Referral Transport (EMRT) to various construction/ strengthening / expansion works of SIHFW /RFPTC/ ANMTC, etc..The letter also has a proposal for procurement of normal delivery kits, IUD insertion kits, life saving emergency medicines and emergency resuscitation kits amounting to Rs. 5886.92 lacs. If this diversion of funds is not approved vide the letter and earlier proposal, it may be considered under this PIP. This is being requested because under twelth finance commission a grant of Rs. 238.70 lacs has been sanctioned for various family welfare activities under repair & maintenance heads and an amount of Rs. 10783.00 lacs for variouos activities under medical health directorate for the year 2009-10. This is under state non-plan budget and has to be used for various repairs and maintenance activities.

Budget Summary (Procurement) 2010-11

S.No	FMR-Budget Head	Activities	No. of Units	Rate per Unit	Freq.	Total (in Rs. Lacs)
		Maternal Health				
	B19.1	*MVA Procurement*	433	2500	1	10.83
	B19.1	*Procurement of pregnancy test kits*	1500000	10	1	150.00
	B19.2	*Procurement of Rh anti D sera injection*	2625	2000	1	52.50
	B19.1	*IV Sucrose injections*	10500	125	6	78.75
		Sub Total				**292.08**
		Child Health				
	B19.1	*Procurement of new drug kits*	12000	1000	1	120.00
	B19.1	*Replenishment of Child Survival Kits for ASHAs @ Rs. 535/- per kit*	20000	535	1	107.00
	B19.2	*Weighing Scales for 60000 trained ASHAs @Rs 350 per scale*	60000	350	1	210.00
	B19.1	*Deworming Tablets for School Children (6-10 years)*	7380000	2	2	295.20
	B19.1	*IFA Tablets for School Children (6-10 years) (30 mg elemental iron + 250 mcg folic acid)*	7380000	14	1	1033.20

S.No	FMR-Budget Head	Activities	No. of Units	Rate per Unit	Freq.	Total (in Rs. Lacs)
	B19.3	*Procuring salt testing kits fr ANMs*	25000	15	1	3.75
	B19.2	*Weighing scale for school health programme*	16400		1	164.00
	B19.2	*Procurement of spectacles*	100000		1	200.00
		Sub Total				**2133.15**
		Family Planning				
	B19.1	*Consummables for sterilsation camps at facilities on fixed days*	180	750	48	64.80
	B19.1	*Infection prevention consummables for IUD services*	0	0	0	24.76
	B19.2	*IUD Kits*	2000	4500	1	90.00
	B19.2	*NSV Kits*	1000	2500	1	25.00
	B19.1	***Sub Total*** **Procurement of drugs for Urban Health**				**204.56**
		Lucknow				43.90
		13 big cities				96.70
		53 cities				88.90
		Sub Total				**229.50**
		TOTAL FOR PROCUREMENT AND EXPENSES				**2859.29**

A sum of Rs. 2859.29 lacs has been approved for procurement under Mission Flexipool

23. RASHTRIYA SWASTHYA BIMA YOJANA (RSBY)

Various analysis indicate that out of pocket expenditure on health in UP is very high, there is an increasing trend to access health services in the private sector and that this trend is also seen among the rural poor. To make services in the private sector more accessible a health insurance scheme has been developed for families living below the poverty line. The Central Government pools 75 percent of the annual premium and State contributes the remaining 25 percent. Under the scheme, cashless health insurance cover upto Rs. 30,000 is provided to all BPL families. Presently nearly 18 lac vulnerable families in 40 districts have been covered under the RSBY and it is aimed to cover 100 lac families by the end of the year in all 71 districts. No funds are required in this PIP to continue this scheme.

24. SUPPORT FOR RNTCP (FMR CODE B26.3)

Based on the discussions held during the NPCC meeting held in Delhi on 05.03.2010, following activities were identified as essential for the success of RNTCP programme. Central TB division has shown its inability to provide the funds for these activities through its own resources. Hence, with the consent of CTD these are being budgeted under the Mission Flexipool. The details of the activities are given below:-

1. Continuation phase of the treatment of MDR cases who were put under treatment last year under an interim plan, for which the budget was provided in the PIP year 2008-09. A sum of Rs. 25.00 lacs are required to complete the continuation phase of treatment for MDR cases.

2. Renovation of hostel and training hall in state TB demonstration centres (STDC) cum intermediate reference lab (IRL) at Agra with a sum of Rs. 22.65 lacs.

3. Construction of a training hall in the campus of TB hospital Thakurganj, Lucknow. The training hall will be utilized for various kind of state level training and workshops under RNTCP. A sum of Rs. 34.73 lacs are required for the activity.

4. Additional instrument for intermediate reference lab (IRL) Lucknow to deal with increased load for culture and DST for MDR TB suspects and DOTs Plus. A sum of Rs. 40.00 lacs are being budget for this activity.

For implementation of all the above mentioned activities a total sum of Rs. 122.38 lacs are being budgeted under Mission Flexipool as support to RNTCP. Govt. of India has approved a budgetary allocation of Rs. 82.40 lacs only.

25. Support to NLEP for RCS Camps (FMR Code B26.2)

Based on the discussion during NPCC meeting, held in Delhi on 05-03-2010, budgetary provision are being made for organization of RCS camps from Mission Flexipool because Leprosy cell of Government of India showed its inability to sanction any budget for RCS camps. The state Leprosy officer pleaded that RCS camps are very important activity where cured Leprosy patients are identified for reconstructive surgeries, hence the required fund for arranging RCS camps be provided from Mission Flexipool. Mission Director GoI agreed with the view of State Leprosy Officer.

Hence an amount of Rs. 36.00 lacs had been budgeted under Mission Flexipool for organization of RCS camps and other expenditures. Govt. of India has approved the activity for the same amount.

BUDGET SUMMARY OF MISSION FLEXIPOOL

S.No	ACTIVITIES	PROPOSED 2010-11 (in Rs. Lacs)
1	ASHA SCHEME	13618.20
2	VILLAGE HEALTH INDEX REGISTER	112.00
3	VILLAGE HEALTH AND SANITATION COMMITTEES (Tehsil Level Pradhan Sammelan)	124.80
4	ANNUAL ASSISTANCE TO ROGI KALYAN SAMITIS	4313.00
5	UNTIED GRANTS TO FACILITIES	13228.30
6	ANNUAL MAINTENANCE GRANT (ONLY FOR GOVERNMENT BUILDINGS)	2860.20
7	SAAS BAHU SAMMELAN	106.50
8	OPERATIONALISING HEALTH INFRASTRUCTURE	34538.35
9	MOBILE MEDICAL UNITS	4268.60
10	EMTS	15888.16
11	HUMAN RESOURCES	5956.16
12	INFRASTRUCTURE STRENGTHENING AND MANPOWER REQUIREMENT FOR IMPLEMENTATION OF UIP	1,100.51
13	TRAINING	5083.09
14	DIVISIONAL/ BLOCK PROGRAMME MANAGEMENT UNIT	1138.50
15	STATE HEALTH RESOURCE CENTRE	665.32
16	DISTRICT ACTION PLAN	200.00
17	DISTRICT SPECIFIC INTERVENTION	3420.46
17.2	Left Wing Extremist Affected Area	1124.37
18	INNOVATIONS	8297.43
19	MONITORING AND SUPERVISION	2712.16
20	HMIS	890.00
21	PROMIS	196.00
22	CONCURRENT AUDIT SYSTEMS	41.28
23	PROCUREMENT	2859.29
24	NPPCD	4.22
25	NVBCD	352.31
	TOTAL FOR MISSION FLEXIPOOL	**123099.21**

Routine Immunization (Part -C)

Introduction:

Routine Immunization is the single most successful child survival strategy the world over and also reduces morbidity to great extent. Immunization is one of the most cost-effective health interventions known to mankind over the last three decades. An effective National Immunization strategy can help decrease childhood morbidity and mortality and help in achieving the MDG-4 i.e. reducing child mortality by 2/3rd between 1990 and 2015. In India Expanded Programme on Immunization (EPI) was started in 1978 and renamed Universal Immunization Programme (UIP) in 1985. In 2005 GoI has launched Multi Year Plan (MYP) to strengthen routine immunization and routine immunization is now a part of NRHM. Under NRHM improved access to Universal Immunization through induction of AD syringes, Alternate Vaccine Delivery and improved mobilization services under the programme

Situational Analysis of the State Implementation Programme:

1. Current Scenario of Implementation of Immunization Programme:

In the state of Uttar Pradesh, the RI sessions are held for 2 days in a week – Wednesdays and Saturdays, thus 8 sessions per sub center per month are presumed to be held. The state proposes to hold 4 - 8 session in a month for any sub-centre as required according to its population and beside this immunization sessions are also being held in District Hospital, PPC, Urban Health Posts and outreach sessions in slums of big cities .These sessions are being supervised by LHVs, Medical officers and other partner agencies. 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 / Link Worker and hiring service provider/Alternate Vaccinator in urban slums and underserved areas are being emphasized in all districts of UP. District Immunization is the Nodal officer at district level.

Basic Information related to Immunization:

S.no	Beneficiaries	Target		
		2008-09	2009-10	2010-11
1	Pregnant Women	6591559	6543526	6603279
2	0-1 Year(Infants)	5554886	5538203	5600781
3	1-2 Years	5233115	5217398	5276351
4	2- 5 Years	-	-	-
5	5 years	4678927	4664874	4717584
6	10 years	4532477	4518864	4569924
7	16 years	3737921	3726694	3768803

Source: Directorate FW, UP, 2009

Sessions Planned /Held

S.no	Routine Immunization Sessions	2008-09	2009-10 (upto Dec-09)	2010-11
1	Sessions planned in urban Areas		48000	42384
2	Sessions planned in Rural Areas		1970016	1965000 (outreached sessions 1645000/year and fixed sessions at facilities 320000/year)
3	Total Sessions Planned	1881714	1455860 (2018016)	2007384
4	Total Sessions held	1515057	1204828	
5	No.of sessions with Hired Vaccinators		7200	42384
6	No of Hired Vaccinators		353	340

Source: Directorate FW, UP, 2009

a. Implementation Status:

Manpower

The status of health immunization staff is provided in the following table

Particulars	Sanctioned	In position	Required
State Immunization Officer(AD UIP)	1	1	0
State Cold Chain Officer	1	1	0
Technical Assistant	1	1	0
District Immunization Officers	64	64	7
State and District Computer assistants	-	73(contractual)	0
Refrigerators Mechanics	69	67	22
Cold chain Store Keepers	9	9	9
Multipurpose worker (Female)/ANM at Sub Centres & PHCs	23570	21024	2546

Health Worker (Male) MPW(M) at Sub Centres	20521	2097	18424
Health Assistant (Female)/LHV at PHCs	3690	3509	181
Health Assistant (Male) at PHCs	3690	4294	-

Source: Directorate FW, UP, 2009

Cold Chain Infrastructure:

In the state, wide network of cold stores have been created. At present 1 state, 4 regional, 14 divisional and districts and block level cold chain storage points are currently functional.

18 WIC and 4 WIF are currently functional at state, regional and divisional headquarter and 3170 ILRs and 3167 DFs functional at district and block headquarter and supplying the vaccines as per need on recommended temperature. The detail about the cold chain stores is also provided in following tables**.**

Existing Support to the State from GOI

S.No	Cold chain Equipment	Stock(functional as on 31st Dec 09)	Requirement			Remark
			2009-10	2010-11	2011-12	
a)	**WIC**	**18**		**19**		
b)	**WIF**	**4**		**5**		
c)	**ILR**	**3170**		**2448**		
d)	**DF**	**3167**		**3167**		
e)	**Cold Boxes**	**6500**		**5700**		
f)	**Vaccine Carrier**	**118000**		**65000**		
g)	**Ice Packs**	**-**				
h)	**Vaccine Van**	**78**		**90**		

Vaccines and logistics

The vaccines and logistics are being supplied by GOI as per demand and store in different cold chain stores at different level. Cold chain management system has been established. The stock and requirement of vaccines and logistics is reflected in the following table.

S.No	Item	Stock(functional	Requirement	Remark

		as on 31st Dec 09)				
1	Vaccines		2009-10	2010-11	2011-12	
a)	TT	9659186				
b)	BCG	4564990				
c)	OPV	4857809				
d)	DPT	11391881				
e)	Measles	3481604				
f)	HepB					
g)	JE (Routine)	1600000				
2	Syringes including wastage of 10% and 25% buffer					
a)	0.1 ml	1765300				
b)	0.5ml	6999726				
c)	Reconstitution syringe	134312				
3	Hubcutters	25000(50% working)				

Training

Health Workers: 2 days training was organized for BHWs to strengthen the RI and batches were held against the released fund during 2007-08 and 2009-10. The status of training is provided below. The rest 7677 of the BHWs and Supervisors are to be trained during financial year 2010-11**.**

Name of District	Total in position (ANM+LHV+BHW male	Total Trained in 2007-08	Proposed Training in 2009-10	Total Trained	Remining	Total Batch to be Trained in 10-11
Agra	625	250	100	350	275	14
Mathura	308	180	20	200	108	5
Mainpuri	238	191	100	291	0	0
Firozabad	245	220	80	300	0	0
KashiramNagar	117	110	0	110	7	0
Hathrus	144	165	0	165	0	0
Aligarh	288	297	20	317	0	0
Etah	175	110	80	190	0	0
Allahabad	585	231	100	331	254	13
Fatehpur	363	277	60	337	26	1
Kaushambi	248	160	20	180	68	3

Name of District	Total in position (ANM+LHV+BHW male	Total Trained in 2007-08	Proposed Training in 2009-10	Total Trained	Remining	Total Batch to be Trained in 10-11
Pratapgarh	494	303	120	423	71	4
Azamgarh	572	161	100	261	311	16
Ballia	476	100	100	200	276	14
Mau	242	180	60	240	2	0
Baduan	426	322	60	382	44	2
Bareilly	488	340	100	440	48	2
Pilibhit	221	180	20	200	21	1
Shahjahanpur	354	221	120	341	13	1
Basti	395	363	0	363	32	2
Sant Kabir Nagar	225	180	20	200	25	1
Siddarthanagar	332	261	20	281	51	3
Banda	268	263	0	263	5	0
Chitrakoot	170	119	20	139	31	2
Hamirpur	256	200	20	220	36	2
Mahoba	156	154	0	154	2	0
Bahraich	403	158	60	218	185	9
Balrampur	250	200	20	220	30	2
Gonada	433	280	100	380	53	3
Shrawasti	150	120	0	120	30	2
Ambedkarnagar	346	242	20	262	84	4
Barabanki	451	180	80	260	191	10
Faizabad	315	160	60	220	95	5
Sultanpur	526	120	100	220	306	15
Deoria	402	140	80	220	182	9
Gorakhpur	650	338	60	398	252	13
Maharajganj	326	240	60	300	26	2
Kushinagar	517	100	60	160	357	18
Jaulon	353	149	0	149	204	11
Jhansi	364	273	80	353	11	1
Lalitpur	210	160	20	180	30	2
Auriaya	203	87	100	187	16	1
Etawah	209	172	20	192	17	1
Farrukhabad	235	99	100	199	36	2
Kannauj	237	141	60	201	36	2
Kanpur Dehat	266	180	60	240	26	2
Kanpur Nagar	438	232	120	352	86	5
Hardoi	572	300	60	360	212	11
Lakhimpur.khiri	523	277	60	337	186	10
Lucknow	576	361	0	361	215	11
Raibareilly	542	240	80	320	222	11

Name of District	Total in position (ANM+LHV+BHW male	Total Trained in 2007-08	Proposed Training in 2009-10	Total Trained	Remining	Total Batch to be Trained in 10-11
Sitapur	623	235	80	315	308	16
Unnao	534	300	100	400	134	7
Baghpat	200	100	60	160	40	2
Bulandshar	402	190	60	250	152	8
G.B.Nagar	145	75	40	115	30	2
Ghaziabad	368	136	60	196	172	9
Meerut	334	227	80	307	27	1
Bhadohi	210	160	0	160	50	3
Mirzapur	429	242	60	302	127	6
Sonbhadara	179	164	0	164	15	1
Bijnor	684	241	120	361	323	17
J.P. Nagar	204	144	60	204	0	0
Moradabad	794	336	80	416	378	19
Rampur	453	179	20	199	254	13
Muzzafarnagar	396	250	60	310	86	4
Saharanpur	471	321	40	361	110	6
Chandauli	333	199	60	259	74	4
Ghizipur	506	339	120	459	47	2
Jaunpur	571	289	0	289	282	14
Varanasi	476	237	100	337	139	7
Total	26355	14851	4000	18851	7677	384

Medical Officers: 3 TOTs of medical officers held in NIHFW, New Delhi. The training of 69 batches of Medical officers will be conducted in Division Moradabad, Gorakhpur, Jhansi, Allahabad , Lucknow, Bareilly and Varanasi and funds have been released for the same

TRAINING OF MEDICAL OFFICERS ON R I - UTTAR PRADESH (2010-2011)

Sl. No.	Division	No. of Medical Officers	No of Medical Officer will be trained 09-10	No of Medical Officer to be trained	Training load for Year 10-11(50% of the total)	No of Batches to be trained 10-11
		In Position				
1	**Agra & Aligarh**	**702**	**0**	**702**	**351**	**18**
2	**Allahabad**	**552**	**0**	**552**	**276**	**14**
3	**Azamgarh**	**354**	**0**	**354**	**177**	**9**
4	**Bareilly**	**399**	**160**	**239**	**120**	**6**
5	**Basti**	**289**	**0**	**289**	**145**	**7**
6	**Devipatan**	**285**	**0**	**285**	**143**	**7**

Sl. No.	Division	No. of Medical Officers	No of Medical Officer will be trained 09-10	No of Medical Officer to be trained	Training load for Year 10-11(50% of the total)	No of Batches to be trained 10-11
		In Position				
7	Faizabad	470	0	470	235	12
8	Gorakhpur	446	160	286	143	7
9	Chitrakoot	247	0	247	124	6
10	Jhansi	282	120	162	81	4
11	Kanpur	538	240	298	149	7
12	Lucknow	1287	400	887	444	22
13	Meerut	525	0	525	263	13
14	Moradabad	366	140	226	113	6
15	Saharanpur	273	0	273	137	7
16	Mirazapur	255	0	255	128	6
17	Varanasi	556	160	396	198	10
Total		7826	1380	6446	3223	161

Cold chain handlers: This activity was proposed in 09-10 but due to non availability of modules this training could not be conducted. This training will be taken this year.

Block level data handlers by DIO and District Cold chain Officer

District RI Computer Assistants on RIMS/HMIS and Immunization formats under NRHM

b. District wise coverage levels of all antigens for 2008-09, 2009-10(till Dec, 09)

S. No	DISTRICT/ DIV.	Yearly Target				Coverage									
		Yearly Target 2008-09		Yearly Target 2009-10		BCG (in numbers)		OPV-1 (in numbers)		OPV-3 (in numbers)		DPT-1 (in numbers)		DPT-3 (in numbers)	
		Infants	Pregnant Women	Infants	Pregnant Women	2008-09	2009-10 (Till Dec.09)	2008-09	2009-10 (Till Dec.09)	2008-09	2009-10 (Till Dec.09)	2008-09	2009-10 (Till Dec.09)	2008-09	2009-10 (Till Dec.09)
1	AGRA	120994	143575	120632	142528	122216	96017	114752	82581	122211	81569	105221	88838	121023	89761
2	FEROZABAD	68620	81426	68414	80834	69643	57607	69274	54232	68809	52874	69243	54494	68841	53093
3	MAINPURI	53389	63352	53228	62890	55140	42059	56039	38693	54820	23678	55720	40368	54963	47870
4	MATHURA	69352	82296	69144	81696	69372	50635	73140	53025	69417	50952	73995	53487	70798	50952
	AGRA	**312355**	**370649**	**311418**	**367948**	**316371**	**246318**	**313205**	**228531**	**315257**	**209073**	**304179**	**237187**	**315625**	**241676**
5	ALIGARH	100000	118662	99699	117797	106000	77931	99299	254786	105577	65943	101561	64563	105574	73468
6	ETAH	50355	59753	50204	59317	51205	38022	53736	39798	50732	38028	53736	39798	50732	38028
7	HATHRAS	44667	53002	44532	52616	44670	35286	40073	32225	45431	34334	40073	32225	45431	34334
8	KANSHIRAM NAGAR	42895	50900	42766	50530	43725	33982	44884	32961	43465	32520	44884	34223	43465	32520
	ALIGARH	**237917**	**282317**	**237201**	**280260**	**245600**	**185221**	**237992**	**359770**	**245205**	**170825**	**240254**	**170809**	**245202**	**178350**
9	ALLAHABAD	164984	195774	164490	194348	149129	112948	156824	116787	151022	112342	128575	110329	130131	106211
10	FATEHPUR	77131	91526	76899	90859	72983	62052	67156	53806	65514	54550	58154	55400	56045	56758
11	KAUSHAMBI	43215	51280	43085	50905	41820	33319	46290	25452	36507	30091	46290	31452	36507	30091
12	PRATAPGARH	91278	108312	91003	107523	84020	69740	78564	70279	80043	68495	73648	70279	80016	68495
	ALLAHABAD	**376608**	**446892**	**375477**	**443635**	**347952**	**278059**	**348834**	**266324**	**333086**	**265478**	**306667**	**267460**	**302699**	**261555**
13	AZAMGARH	131689	156265	131294	155126	137427	112936	141450	106328	126598	103205	114950	106250	115793	102915
14	BALLIA	92320	109549	92043	108751	91711	71787	91564	73035	91564	65833	87081	73035	84994	65833
15	MAU	61970	73535	61783	72999	61598	77326	61991	50845	61638	49438	61873	50241	61648	49564
	AZAMGARH	**285979**	**339349**	**285120**	**336876**	**290736**	**262049**	**295005**	**230208**	**279800**	**218476**	**263904**	**229526**	**262435**	**218312**

16	BADAUN	102578	121722	102270	120835	94714	80367	94615	69929	94639	76876	94170	71163	95055	76830
17	BAREILLY	120952	143524	120588	142478	120957	91998	131627	98470	119000	90969	125554	99689	118797	91816
18	PILIBHIT	54981	65241	54816	64766	54903	44288	54476	39107	50326	39877	54850	40961	50665	41858
19	SHAJAHANPUR	85162	101056	84907	100319	88878	63736	81588	56770	80509	58783	82114	59512	81680	60887
	BAREILLY	**363673**	**431543**	**362581**	**428398**	**359452**	**280389**	**362306**	**264276**	**344474**	**266505**	**356688**	**271325**	**346197**	**271391**
20	BASTI	69692	82697	69481	82094	71396	58440	74878	59810	69732	52439	74856	59810	69714	52439
21	SANT KABIR NGR	47456	56313	47314	55903	49425	35511	49845	36069	45100	32719	38831	36069	36346	32719
22	SIDDARTH NGR	68183	80908	67979	80318	67645	56454	74677	45981	51725	49968	64173	57457	41471	50942
	BASTI	**185331**	**219918**	**184774**	**218315**	**188466**	**150405**	**199400**	**141860**	**166557**	**135126**	**177860**	**153336**	**147531**	**136100**
23	BANDA	51373	60961	51219	60517	55114	40130	48349	35628	50253	38554	47323	35627	49755	38489
24	CHITRAKOOT	25602	30380	25525	30159	30958	23183	27857	21219	27314	21221	27857	21219	27314	21221
25	HAMIRPUR	34888	41399	34783	41097	30930	26392	30544	25390	29435	24826	29458	25390	29439	24826
26	MAHOBA	23658	28073	23587	27868	23664	18614	27638	19358	23662	18013	27634	19358	23662	18013
	CHITRAKOOT	**135521**	**160813**	**135114**	**159641**	**140666**	**108319**	**134388**	**101595**	**130664**	**102614**	**132272**	**101594**	**130170**	**102549**
27	BAHARAICH	79583	94435	79344	93747	86503	57604	94625	72794	91564	58639	94625	72794	84994	58639
28	BALRAMPUR	56221	66713	56052	66227	58180	41740	61051	42829	58862	42153	58015	42440	56597	42058
29	GONDA	92462	109716	92184	108916	92981	72014	70956	71577	90148	65278	99230	72894	89059	66920
30	SRAWASTI	39312	46649	39194	46309	39422	29389	39282	24762	39377	29272	39282	24762	39377	29272
	DEVIPATAN	**267578**	**317513**	**266774**	**315199**	**277086**	**200747**	**265914**	**211962**	**279951**	**195342**	**291152**	**212890**	**270027**	**196889**
31	AMBEDKAR NGR	67747	80389	67543	79803	68810	52340	74931	58128	67857	51270	74931	58128	67857	51276
32	BARABANKI	89361	106038	89093	105266	90651	74077	92908	70255	89616	69542	92908	70255	89616	69542
33	FAIZABAD	69818	82848	69608	82244	74615	58151	69136	54347	69136	53221	69136	54347	67783	53221
34	SULTANPUR	107453	127507	107131	126578	107630	79059	102493	77949	107517	74920	98129	79635	108039	74962
	FAIZABAD	**334379**	**396782**	**333375**	**393891**	**341706**	**263627**	**339468**	**260679**	**334126**	**248953**	**335104**	**262365**	**333295**	**249001**
35	DEORIA	90673	107593	90401	106808	90371	73262	93917	67894	90122	66504	91728	71267	87698	66498
36	GORAKHPUR	125996	149510	125617	148421	129209	94509	134605	105261	126437	93719	125993	106094	126003	94501
37	KUSHINAGAR	96688	114733	96398	113897	100232	83780	113928	79929	100077	65516	108112	78777	96849	65314

38	MAHARAJGANJ	72664	86225	72446	85597	72982	56945	80876	57269	73913	54664	75353	57269	73707	54664
	GORAKHPUR	**386021**	**458061**	**384862**	**454723**	**392794**	**308496**	**423326**	**310353**	**390549**	**280403**	**401186**	**313407**	**384257**	**280977**
39	JALAUN	48598	57668	48452	57247	49457	37965	51771	35190	51069	33776	51741	35185	50069	33776
40	JHANSI	58320	69204	58145	68700	59106	47486	63444	48507	58391	45640	63444	48507	58391	45640
41	LALITPUR	32690	38790	32592	38508	33290	25162	29752	21906	32954	24125	29642	21896	32951	24125
	BUNDELKHAND	**139608**	**165662**	**139189**	**164455**	**141853**	**110613**	**144967**	**105603**	**142414**	**103541**	**144827**	**105588**	**141411**	**103541**
42	AURAIYA	39439	46799	39322	46457	40642	29227	39937	30343	39936	30637	39937	30343	39936	30637
43	ETAWAH	44751	53103	44617	52716	44767	34839	42514	31870	44783	35040	38272	32418	44769	35040
44	FARRUKHABAD	52473	62265	52315	61812	53661	43695	46398	36477	52514	39329	46398	36477	52514	39329
45	KANNAUJ	46428	55092	46288	54691	46791	34944	46995	34443	45470	34554	46995	34493	45470	34769
46	KANPUR (N)	139312	165311	138893	164106	146676	110380	144369	96158	140667	103258	137715	107054	138194	103378
47	KANPUR(D)	52247	61998	52090	61546	53979	43027	51083	39121	51028	40230	50398	39417	50071	40281
	KANPUR	**374650**	**444568**	**373525**	**441328**	**386516**	**296112**	**371296**	**268412**	**374398**	**283048**	**359715**	**280202**	**370954**	**283434**
48	HARDOI	113569	134763	113228	133782	120598	90182	65622	83891	113921	83429	115972	83891	113617	84129
49	L.KHERI	107186	127189	106864	126262	111919	88457	101352	86851	97078	82185	98839	86429	97094	82285
50	LUCKNOW	121924	144678	121558	143624	131711	98765	128450	89199	124485	90191	128450	89199	124485	90191
51	RAIBAREILLY	95998	113913	95710	113083	97159	74884	105642	74134	100951	72391	99569	77592	97285	74477
52	SITAPUR	120994	143575	120630	142528	134265	103249	12641	105947	120998	95126	114851	103852	111465	94588
53	UNNAO	90249	107092	89978	106311	95824	76082	86866	70230	81545	67096	81868	69551	78492	66962
	LUCKNOW	**649920**	**771210**	**647968**	**765590**	**691476**	**531619**	**500573**	**510252**	**638978**	**490418**	**639549**	**510514**	**622438**	**492632**
54	BAGHPAT	38902	46164	38785	45828	38914	29101	40546	29683	38902	29088	39956	29703	38903	29088
55	BULANDSHR	97365	115535	97072	114693	99623	70783	99649	68649	97492	72829	99397	69500	97449	72817
56	G.B.NAGAR	40172	47669	40053	47321	42335	30627	39284	27571	44568	29332	39284	27571	44568	29332
57	GHAZIABAD	110004	130533	109673	129582	117481	88211	102197	72382	108685	78422	96536	78896	106616	79329
58	MEERUT	100169	118862	99868	117996	104408	76374	119969	76594	103185	70614	119158	81041	102688	74309
	MEERUT	**386612**	**458763**	**385451**	**455420**	**402761**	**295096**	**401645**	**274879**	**392832**	**280285**	**394331**	**286711**	**390224**	**284875**
59	BADOHI	45256	53705	45120	53315	47157	33590	45957	33540	45877	34965	45317	33540	47994	34965
60	MIRZAPUR	70720	83918	70508	83306	65806	53447	66788	55401	65343	52590	59800	54485	60428	52520

61	SONBHADRA	48936	58069	48789	57645	47244	38713	33552	35992	50015	37472	31291	35763	39814	28464
	MIRZAPUR	**164912**	**195692**	**164417**	**194266**	**160207**	**125750**	**146297**	**124933**	**161235**	**125027**	**136408**	**123788**	**148236**	**115949**
62	BIJNOR	104678	124213	104363	123308	102298	73267	104564	75340	102472	73292	100048	75453	102700	73310
63	J.P.NAGAR	50105	59456	49955	59023	49125	36406	49188	36910	47287	36478	49296	36806	47284	36481
64	MORADABAD	127377	151149	126995	150047	121632	96633	111789	91989	110051	90478	111089	92115	110308	90614
65	RAMPUR	64309	76310	64115	75754	53319	43380	53165	45449	52511	43378	53720	45827	52442	43383
	MORADABAD	**346469**	**411128**	**345428**	**408132**	**326374**	**249686**	**318706**	**249688**	**312321**	**243626**	**314153**	**250201**	**312734**	**243788**
66	M.NAGAR	118416	140515	118060	139491	118425	87173	92593	65472	118468	84829	85979	70263	118468	84842
67	SAHARANPUR	96829	114900	96539	114063	96916	71246	96809	69884	96868	68473	96809	71623	96868	69725
	SAHARANPUR	**215245**	**255415**	**214599**	**253554**	**215341**	**158419**	**189402**	**135356**	**215336**	**153302**	**182788**	**141886**	**215336**	**154567**
68	CHANDAULI	54910	65158	54745	64685	55036	45641	58017	45022	51664	41586	56776	44627	51690	41503
69	GHAZIPUR	101535	120484	101230	119606	89953	83168	86744	80846	73778	79470	86744	80846	69610	79470
70	JAUNPUR	130745	155145	130352	154014	132004	109865	135593	106339	118073	97895	100268	107174	87047	98042
71	VARANASI	104918	124497	104603	123590	102767	80032	110333	76026	105832	78294	105037	78638	105917	78246
	VARANASI	**392108**	**465284**	**390930**	**461895**	**379760**	**318706**	**390687**	**308233**	**349347**	**297245**	**348825**	**311285**	**314264**	**297261**
	TOTAL UP	**5554886**	**6591559**	**5538203**	**6543526**	**5605117**	**4369631**	**5383411**	**4352914**	**5406530**	**4069287**	**5329862**	**4230074**	**5253035**	**4112847**

		Coverage		Coverage		Coverage		Coverage					
								Hep. B (Wherever applicable)					
		MEASLES		TT-2 + Booster		JE (Wherever applicable)		2008-09			2009-10 (Till Dec. 09)		
S.No.	DISTRICT/DIV.	2008-09	2009-10 (Till Dec.09)	2008-09	2009-10 (Till Dec.09)	2008-09	2009-10 (Till Dec.09)	1st	2nd	3rd	1st	2nd	3rd
1	AGRA	121842	85761	144187	101034								
2	FEROZABAD	68624	49995	57009	52260								
3	MAINPURI	51943	40135	65102	45059								
4	MATHURA	69388	50559	82377	59964								
	AGRA	**311797**	**226450**	**348675**	**258317**								
5	ALIGARH	104328	74370	107143	62151								
6	ETAH	50551	37421	49785	44344								
7	HATHRAS	45105	34434	49349	42301								
8	KANSHIRAM NAGAR	43598	33157	48197	39254								
	ALIGARH	**243582**	**179382**	**254474**	**188050**								
9	ALLAHABAD	135808	103108	127257	111762								
10	FATEHPUR	68333	57562	66898	58593								
11	KAUSHAMBI	41395	29745	31232	30661								
12	PRATAPGARH	81143	68497	81743	74281								
	ALLAHABAD	**326679**	**258912**	**307130**	**275297**		**0**						
13	AZAMGARH	121744	98191	125229	104961		42797						
14	BALLIA	84959	63260	83852	61609		14529						
15	MAU	61594	46609	54587	46179		25897						
	AZAMGARH	**268297**	**208060**	**263668**	**212749**		**83223**						
16	BADAUN	86702	76320	93468	74832								
17	BAREILLY	118105	89112	137784	85812		Not Reported						
18	PILIBHIT	49496	40920	51062	40217								
19	SHAJAHANPUR	77891	60604	88565	65855								

	BAREILLY	**332194**	**266956**	**370879**	**266716**								
20	BASTI	69698	51170	68508	57468		34500						
21	SANT KABIR NGR	45672	33895	43406	30039		37352						
22	SIDDARTH NGR	53404	49791	51563	45499		44641						
	BASTI	**168774**	**134856**	**163477**	**133006**		**116493**						
23	BANDA	51244	38785	57413	35103								
24	CHITRAKOOT	25841	20421	23145	18463								
25	HAMIRPUR	30045	24812	30108	27593								
26	MAHOBA	23670	18156	28076	19871								
	CHITRAKOOT	**130800**	**102174**	**138742**	**101030**								
27	BAHARAICH	85409	57048	98124	72302		5543						
28	BALRAMPUR	57450	51881	62993	49365		13015						
29	GONDA	82479	67066	81221	61899		39774						
30	SRAWASTI	39499	29279	41422	41932		6826						
	DEVIPATAN	**264837**	**205274**	**283760**	**225498**		**65158**						
31	AMBEDKAR NGR	67614	50169	75349	55205		Not Reported						
32	BARABANKI	89433	67307	95464	71495		12539						
33	FAIZABAD	65988	51237	76202	58190		9419						
34	SULTANPUR	96575	74718	88636	79650		17383						
	FAIZABAD	**319610**	**243431**	**335651**	**264540**		**39341**						
35	DEORIA	87789	65307	98683	71449		60551						
36	GORAKHPUR	127018	93711	149555	112435		61760						
37	KUSHINAGAR	96696	61580	92436	66889		Not Reported						
38	MAHARAJGANJ	72794	54261	75979	52661		23505						
	GORAKHPUR	**384297**	**274859**	**416653**	**303434**		**145816**						
39	JALAUN	49800	33099	51434	36325								
40	JHANSI	58410	45048	53730	49884								
41	LALITPUR	32613	24211	33071	23884								
	BUNDELKHAND	**140823**	**102358**	**138235**	**110093**								

42	AURAIYA	40191	30415	34403	30687								
43	ETAWAH	44757	34307	51946	35893								
44	FARRUKHABAD	52623	39241	37768	37388								
45	KANNAUJ	44872	34161	48545	36224								
46	KANPUR (N)	138701	105476	161286	126459			44076	37705	33576	50665	45193	43107
47	KANPUR(D)	50366	39733	52300	42745								
	KANPUR	**371510**	**283333**	**386248**	**309396**		**0**						
48	HARDOI	113610	83058	116337	89374		27101						
49	L.KHERI	96581	78442	88176	92090		19200						
50	LUCKNOW	117216	92466	121311	93912		13674	24530	15901	12473	51101	37299	33339
51	RAIBAREILLY	96630	71470	92908	72522		27253						
52	SITAPUR	100966	90757	130682	110809		Not Reported						
53	UNNAO	80085	62802	75983	65232		15785						
	LUCKNOW	**605088**	**478995**	**625397**	**523939**		**103013**						
54	BAGHPAT	39073	29126	52754	34561								
55	BULANDSHR	97387	72834	99214	66099								
56	G.B.NAGAR	41574	28569	36968	29070								
57	GHAZIABAD	113169	83765	104291	74774								
58	MEERUT	103359	74054	116895	84209								
	MEERUT	**394562**	**288348**	**410122**	**288713**								
59	BADOHI	45428	33838	52212	38242								
60	MIRZAPUR	54676	53899	69601	60062								
61	SONBHADRA	37866	36108	47963	45292								
	MIRZAPUR	**137970**	**123845**	**169776**	**143596**								
62	BIJNOR	103953	73243	122196	83103								
63	J.P.NAGAR	46991	35579	55446	30947								
64	MORADABAD	115044	96480	113677	88069								
65	RAMPUR	60451	43412	44723	32996								
	MORADABAD	**326439**	**248714**	**336042**	**235115**								
66	M.NAGAR	118455	84821	101782	72612		8923						

67	SAHARANPUR	96848	68205	106709	71314		20159						
	SAHARANPUR	**215303**	**153026**	**208491**	**143926**		**29082**						
68	CHANDAULI	51593	41144	40689	30818								
69	GHAZIPUR	74996	73865	84243	78384								
70	JAUNPUR	120473	98061	126151	116914								
71	VARANASI	104161	77322	119300	81209								
	VARANASI	**351223**	**290392**	**370383**	**307325**								
	TOTAL UP	**5293785**	**4069365**	**5527803**	**4290740**		**582126**						

Note: There are 26 Districts and out of these 23 Districts are reporting for JE vaccination. Only in District Kanpur Nagar and Lucknow vaccination for Hep B is being implemented.

c. Reporting and incidence of VPD: VPD surveillance has been improved in last year.

S.no	Diseases	2009	
		Cases	Death
1	Measles	1018	19
2	Whooping Cough	0	0
3	Diptheria	21	3
4	Neonatal Tetanus	6	2
		2009	
		Cases	WPV
5	AFP	14534	419

d. Trend of IMR of the State for last 5 years: Infant Mortality Rate is gradually decreasing in the State.

S.No	Year	IMR of the State(SRS data)
1	**2004**	**72**
2	**2005**	**73**
3	**2006**	**71**
4	**2007**	**69**
5	**2008**	**67**

Source: Office of Registrar General, 2005-2009, SRS Bulletin, Vol 39-44, No (1)

e. AEFI committee and cases reported: 54 Districts have reported that committee has been formed in their Districts.

AEFI cases details (as on 14/01/2010)				
	2008		2009	
	Cases	Death	Cases	Death
AEFI	24	21	22	13

2. Supervision and Monitoring

Various activity have been planned to monitor the activities of Routine Immunization

I. **Core Group meeting** 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, and GM & DGM from SPMU, Partner agencies – UNICEF, NPSP (WHO) and immunization Basic

(MCHIP). The Core group meets every month to discuss and review the implementation strategies, monitoring results and suggest new strategies for improvement**.**

a. Provides technical support by identifying key barriers in improving full immunization coverage and recommend strategies to address gaps.
b. Monitoring and Supervisory visits by the members in these districts.
c. Review District wise progress and identify High priority Districts
d. **Micro plan:** Review of RI microplan in all 71 Districts has been done last year with the help of Core group .This microplans include Rural, urban and hard to reach areas.

Urban RI strengthening initiated in selected 11 districts with large urban population:

For strengthening of Routine Immunization in Urban Areas of Uttar Pradesh 11 Districts have been selected .Districts are Kanpur Nagar ,Lucknow, Agra, Varanasi, Ghaziabad, Aligarh, Bareilly, Meerut, Moradabad, Gorakhpur& Allahabad .Programme has been started from the month of Nov08. Detailed microplans have been prepared .Total sessions planned 39600 /year covering approximately 65 lakhs slum population (34% of total urban population in these cities).

It is recommended that in addition to Govt. Vaccinators (regular) contractual & Hired vaccinators will do immunization services in slums areas of these 11 Districts. Vaccinators will be hired in Districts Agra & Allahabad (for 600 sessions) and for rest of the 9 Districts. It is planned that two ANM s will be posted in each Urban Health Posts on contractual basis under NHRM and they will cater to the RI services of the urban slums in the area

e. Vaccine and logistics management Logistic (vaccine and others) and financial management upto the level of village

f. Cold Chain Review infrastructure facilities and maintenance of cold chain and provide feedback for timely corrective ac

g Injection safety and waste disposal

h. Recording and reporting (coverage data, Vaccines and logistics, VPD, AEFI)

II. **Monitoring and data analysis:** Additional Director (UIP) is a nodal officer at state level for implementing and monitoring the Immunization activities under Director General Family Welfare One District Immunization Officer is supervising the RI activities at District level. Monitoring of RI sessions is taking place for the last 4 years by Govt, and supported by Development Partners as WHO/NPSP and UNICEF and others. Revised RI monitoring formats are being used. Monitoring formats are compiling at District NPSP office and after analysis compilation at State level .Feedback is being shared by State and District and Block level officials for corrective action. For strengthening monitoring and supervision, funds have been provided to DIOs, MO I/C of PHCs.Total 111251 sessions have been monitored from Oct 08-Sept09 .ANMs preasence is 93.9 %, availability of all 4 primary vaccine is 93-94%,presence of ASHA mobilizer is 86%.

III. **Review Meeting:** DIO review meeting are being regularly held & minutes of meeting have also been shared. Review meetings for DIOs at the State level and also similar meetings at the District levels are been held for review of RI progress by State and Divisional Officials. The Core group represents to the State/district level review meetings to highlight achievements and strategize ways to overcome shortcomings also analyzes data and provides feedback to help blocks to regularly plan and improve RI activities

3. Integration of J.E. Vaccine in Routine Immunization in 34 Districts : JE vaccine has been integrated in Routine Immunization in 34 Districts in the endemic Districts where campaign has been completed .Districts are Deoria, Maharajganj, Gorakhpur, L.Khiri, Kushinagar, Sant Kabir Nagar, Siddarthanagar, Ambedkarnagar, Bahraich, Balrampur, Barabanki, Basti, Gonda,Mau,Raibareilly, Saharanpur,Sitapur,Shrawasti,Hardoi, Unnao, Lucknow, Sultanpur, Faizabad, Azamgarh, Balia, Bareilly, Muzzaffarnagar,Pratapgarh,Fatehpur,Allahabad,Kanpurnagar,Sahajahanpur,Gazipur and Jaunpur. Target of 1-2 Year children in these 34 Districts is 30.73 Lacs and annual dose requirement will be 40.87 Lacs doses.

4. Status of RIMS implementation: RIMS - an important monitoring tool developed by the Government of India **.**Monitoring on new revised monitoring format reporting in RIMS and HMIS format has been started .Out of 71 Districts 59 Districts have regular reporting of RIMS and they have been instructed to report

regularly on RIMS and HMIS format. Regular training on RIMS and HMIS formats is required to orient RI Computer Assistants. District wise RIMS uploading status is as follows:

DISTRICT	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
AGRA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FEROZABAD	No	No	No	No	No	No	No	No	No	No	No	No
MAINPURI	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MATHURA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
ALIGARH	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ETAH	No	No	No	No	No	No	No	No	No	No	No	No
HATHRAS	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BAGPAT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
BULANDSHAHAR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
G.B.NAGAR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
GHAZIABAD	No	No	No	No	No	No	No	No	No	No	No	No
MEERUT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MUZAFFARNAGAR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
SHAHARANPUR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BIJNOR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
J.P.NAGAR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MORADABAD	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
RAMPUR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ALLAHABAD	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FATEHPUR	Yes	Yes	No	No	No	No	No	No	No	No	No	No
KAUSHAMBHI	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
PRATAPGARH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
BANDA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
CHITRAKOOT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
HAMIRPUR	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
MAHOBA	Yes	Yes	No	No	No	No	No	No	No	No	No	No

AZAMGARH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BALLIA	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No
MAU	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
BADOHI	No	No	No	No	No	No	No	No	No	No	No	No
MIRZAPUR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
SONBHADRA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CHANDAULI	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
GHAZIPUR	No	No	No	No	No	No	No	No	No	No	No	No
JAUNPUR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
VARANASI	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BADAUN	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No
BAREILLY	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
PILIBHIT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
SHAHJAHANPUR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ETAWAH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
AURIAYA	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FARRUKHABAD	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
KANNAUJ	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
KANPUR(DEHAT)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
KANPUR(NAGAR)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
JALAUN	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
JHANSI	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
LALITPUR	Yes	Yes	No	Yes	Yes	No	No	No	No	No	No	No
HARDOI	No	No	No	No	No	No	No	No	No	No	No	No
KHERI	No	No	No	No	No	No	No	No	No	No	No	No
LUCKNOW	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
RAEBARELI	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
SITAPUR	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
UNNAO	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
AMBEDKAR NAGAR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BARABANKI	No	No	No	No	No	No	No	No	No	No	No	No

FAIZABAD	Yes	Yes	No	No	No	No	No	No	No	No	No	No
SULTANPUR	No	No	No	No	No	No	No	No	No	No	No	No
BAHRAICH	No	No	No	No	No	No	No	No	No	No	No	No
BALRAMPUR	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
GONDA	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
SRAWASTI	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BASTI	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
SANTKABIR NAGAR	No	No	No	No	No	No	No	No	No	No	No	No
SIDDHARTHNAGAR	No	No	No	No	No	No	No	No	No	No	No	No
DEORIA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
GORAKHPUR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
KUSHINAGAR	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No
MAHARAJGANJ	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No

5. Coordination with partners (ICDS, Public Private Partnerships, other agencies)

- ***Involvement of ICDS*:-**
  - Anganwadi centres are being used as session sites
  - AWW share information/records of pregnant mothers and 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
- The presence of the Development Partners who support Routine Immunization as their thematic areas of operation has been a great strength to the State. The development partners are WHO/NPSP and UNICEF provide day-to-day technical inputs and other operational support to the State RI cell.

NPSP/WHO support

- Technical support in training of computer assistants in data entry of the revised monitoring system
- Establishing a system of tracking of children in Routine Immunization:
    - WHO/NPSP proposes to pilot a system of tracking of identified newborns in Polio SIA activities in Routine Immunization through manual process in eight RI supported districts in selected blocks
    - Sharing the results of the same with GoUP for scaling in other blocks of the state with logistic support by State.
    - The initial results of the same process with computerized tracking of newborn piloted in one block each of WHO/NPSP supported districts have been shared with GoUP
- Establishing a system of recording and reporting system in the state:
    - WHO/NPSP proposes to develop a system of recording and reporting mechanism in the state
    - In order to maintain better transparency of the reported coverage figures in the state, WHO/NPSP proposes to develop a systematized reporting system using session wise reporting and compilation process of the same at the block and district level.
    - The process so developed will be shared with GoUP for scaling up at all levels

      WHO/NPSP will continue to provide Technical Assistance in Routine Immunization areas at State Level and at designated District level in the field of:
    - Analysis of RI data; Coverage and Monitoring data
    - Routine Immunization Micro planning Support in AEFI
    - Support in Training of Health Workers and Medical Officers

TA in VPD surveillance including specific outreach investigations as desired

<u>Routine Immunization- Activities, included in UNICEF Rolling Work plan 2010-11</u>

1. Updation of Routine immunization microplans and digitalization of data in the June 2009 appointed 15 districts[7] as well as in the districts[8] where UNICEF had been working primarily.

[7] Kheri, Baireicj\h, Shrivasti, Sitapur, Balgrampur, Philibhit, Chitrakoort, Farukabad, Agra, Kaushambi, Lalitpur, Kushinagar, Maharajganj, Sonabhadra and Siddhartnagar.
[8] Saharanpur, Meerut, Varanasi, Moradabad, Bareilly, Lucknow, Kanpur, Faizabad, Azamghar, Gonda, Basti, Ghorakpur, Mirzapur, Banda, Allahabad, Badohi and Jaunpur

2. Technical and financial support of RI Supportive supervision (SS) + corrective actions implemented in the June 2009 appointed 15 districts as well as in the districts where UNICEF had been working primarily.
3. Gaps assessment of cold-chain
4. Comprehensive RI strengthening in Lalitpur and Agra through Village Health Nutrition Days – VHND strengthening, AVD (Alternate Vaccine Delivery) for difficult to reach areas, PRI involvement, community mobilization, mass media and outdoor media etc.
5. Techno managerial support in planning and conduction of
    - Health workers training on communication skills and RI
    - Medical Officers training
    - Cold chain handlers training

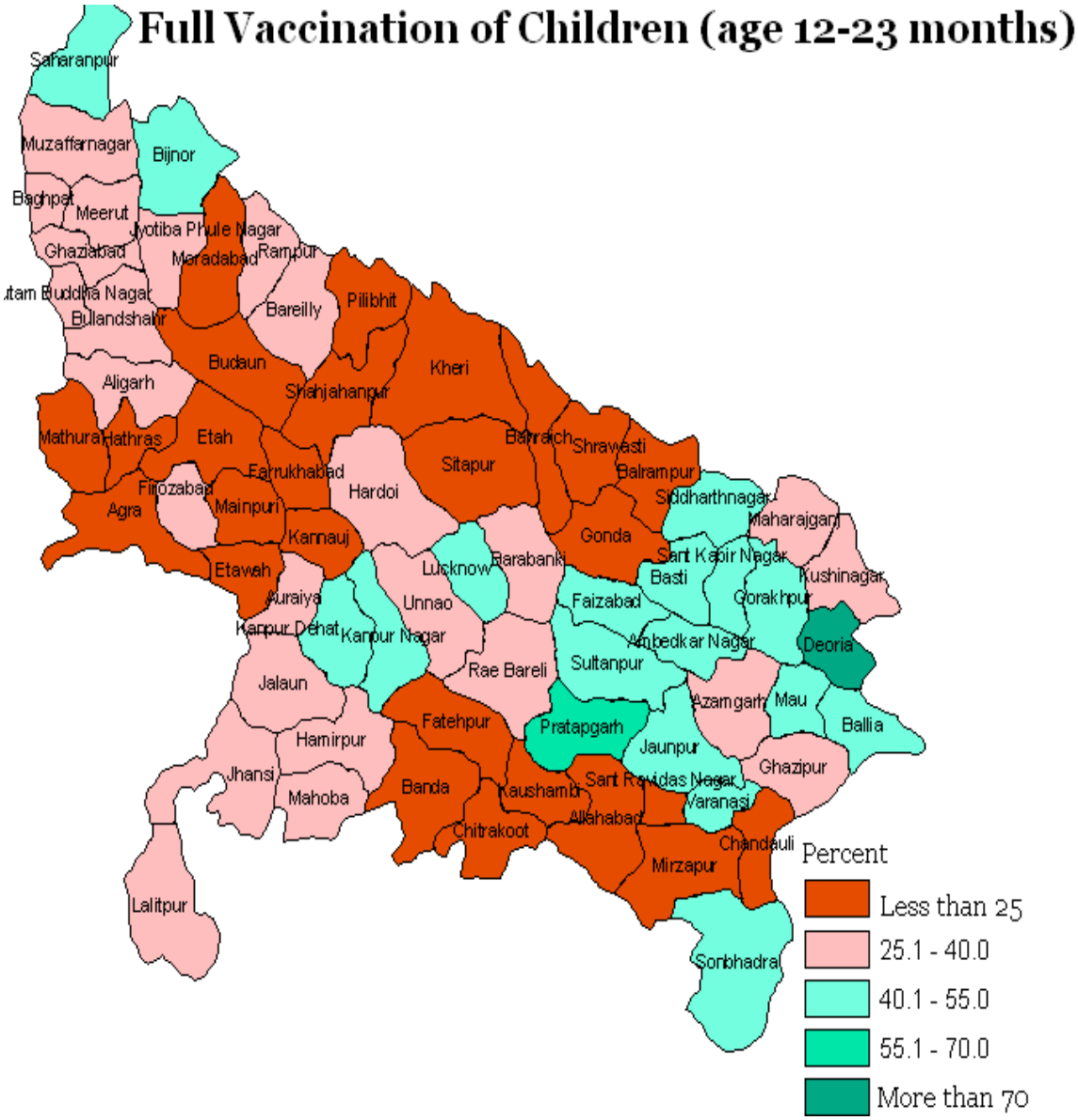
***USAID/Maternal and Child Health Integrated Program (MCHIP*) Activities are proposed at State and 3 Districts.**

***At State headquarter*:**

- Technical support in planning, implementation and monitoring of UIP.
- Developing need based tools and job aids addressing various program components and assisting in advocacy and implementation of the same.
- Supporting in periodic review of the program and feedback sharing for corrective actions.
- Supportive supervision in priority districts with participation of govt officials and partners
- Providing support in development of State Program Implementation Plan

6. Strategies for further improving Routine Immunization:

Map of Uttar Pradesh showing Status of Evaluated Coverage - DLHS 3 data (2007-08)



Division Name	District Name	Fully Immunized %	Ranking	Children (12-23 months) who have received BCG (%)	Children (12-23 months) who have received 3 doses of Polio Vaccine (%)	Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	Children (12-23 months) who have received Measles Vaccine (%)	Children (9-35 months) who have received at least one dose of Vitamin A (%)
AGRA	ETAH	11.6	69	48.5	25.1	16.5	23.6	17.3
AGRA	MATHURA	20.6	57	72.9	30.7	31.1	31.8	19.1
AGRA	HATHRAS	22.5	53	69.0	30.7	34.3	48.4	27.8
AGRA	AGRA	23.2	51	71.9	28.6	25.3	35.7	26.1
AGRA	MAINPURI	23.4	49	70.5	37.3	38.5	39.6	29.1
AGRA	ALIGARH	27.1	43	74.2	39.3	32.0	45.9	30.2
AGRA	FIROZABAD	29.3	39	67.4	46.0	35.1	41.2	32.5
AGRA Average		**22.5**		**67.8**	**34.0**	**30.4**	**38.0**	**26.0**
ALLAHABAD	FATEHPUR	22.0	55	76.1	28.6	30.9	45.9	29.8
ALLAHABAD	ALLAHABAD	22.9	52	53.8	38.8	31.2	37.4	36.8
ALLAHABAD	KAUSHAMBI	23.4	48	57.7	22.8	23.1	33.0	24.4
ALLAHABAD	PRATAPGARH	54.8	2	85.3	62.7	63.8	61.4	47.9
ALLAHABAD Average		**30.8**		**68.2**	**38.2**	**37.3**	**44.4**	**34.7**
AZAMGARH	AZAMGARH	35.3	21	76.9	45.2	46.9	55.1	28.2
AZAMGARH	BALLIA	44.5	13	76.3	52.5	54.2	62.3	22.4
AZAMGARH	MAU	44.7	12	81.3	52.2	51.6	65.0	26.8
AZAMGARH Average		**41.5**		**78.2**	**50.0**	**50.9**	**60.8**	**25.8**
BAREILLY	BADAUN	10.6	70	61.1	22.3	15.4	30.5	21.6
BAREILLY	PILIBHIT	19.0	62	72.3	30.0	28.2	43.7	25.7
BAREILLY	SHAHJAHANPUR	20.3	58	64.6	28.0	26.1	38.9	17.8
BAREILLY	BAREILLY	32.2	33	66.9	37.5	36.9	44.5	33.3
BAREILLy Average		**20.5**		**66.2**	**29.5**	**26.7**	**39.4**	**24.6**
BASTI	SIDDARTH NAGAR	44.1	14	72.4	49.3	49.7	50.4	34.0
BASTI	SANT KABIR NAGAR	51.1	5	77.2	55.3	55.8	58.6	39.9
BASTI	BASTI	53.9	3	85.8	59.3	58.9	68.2	46.1
BASTI Average		**49.7**		**78.5**	**54.6**	**54.8**	**59.1**	**40.0**
CHITRAKOOT	BANDA	13.7	68	58.4	31.2	21.9	34.0	26.7

CHITRAKOOT	CHITRAKOOT	19.1	61	70.8	34.6	34.0	44.2	25.8
CHITRAKOOT	MAHOBA	32.2	32	89.7	43.0	40.7	59.9	41.8
CHITRAKOOT	HAMIRPUR	32.5	30	94.5	51.7	51.8	61.7	37.4
CHITRAKOOT Average		**24.4**		**78.4**	**40.1**	**37.1**	**50.0**	**32.9**
DEVIPATAN	BAHRAICH	15.0	66	67.8	19.1	19.2	30.0	15.5
DEVIPATAN	SHRAWASTI	16.0	65	59.4	19.9	19.2	30.0	18.1
DEVIPATAN	BALRAMPUR	18.0	63	54.0	24.9	25.6	25.2	15.1
DEVIPATAN	GONDA	20.1	59	60.7	28.7	28.7	31.5	22.0
DEVIPATAN Average		**17.3**		**60.5**	**23.2**	**23.2**	**29.2**	**17.7**
FAIZABAD	BARABANKI	31.1	36	66.7	36.6	37.7	36.1	28.1
FAIZABAD	AMBEDKAR NAGAR	45.0	11	85.8	61.1	54.7	64.0	49.0
FAIZABAD	SULTANPUR	45.0	10	84.7	54.5	54.4	58.9	43.2
FAIZABAD	FAIZABAD	47.2	7	75.4	52.5	52.8	57.2	42.6
FAIZABAD Average		**42.1**		**78.2**	**51.2**	**49.9**	**54.1**	**40.7**
GORAKHPUR	KUSHI NAGAR	31.5	34	75.1	40.6	40.2	45.4	32.8
GORAKHPUR	MAHARAJGANJ	33.9	24	82.5	49.4	48.0	52.0	36.4
GORAKHPUR	GORAKHPUR	46.3	8	92.8	67.4	61.0	66.1	47.2
GORAKHPUR	DEORIA	71.6	1	93.2	76.8	72.9	66.3	45.3
GORAKHPUR Average		**45.8**		**85.9**	**58.6**	**55.5**	**57.5**	**40.4**
JHANSI	JALAUN (ORAI)	28.0	40	75.1	34.1	36.5	44.7	27.4
JHANSI	LALITPUR	31.3	35	82.1	33.4	33.0	56.3	45.5
JHANSI	JHANSI	32.4	31	94.9	49.3	43.4	67.4	43.2
JHANSI Average		**30.6**		**84.0**	**38.9**	**37.6**	**56.1**	**38.7**
KANPUR	FARUKKHABAD	19.7	60	62.7	45.9	23.1	37.3	23.5
KANPUR	ETAWAH	24.3	47	79.9	38.7	40.1	49.3	37.4
KANPUR	KANNAUJ	24.3	46	69.6	34.0	37.3	44.1	30.3
KANPUR	AURIYA	32.9	28	72.5	42.7	38.7	47.0	29.3
KANPUR	KANPUR NAGAR	41.0	18	88.0	63.4	57.3	78.2	58.4
KANPUR	KANPUR DEHAT	45.7	9	82.5	49.1	47.5	63.3	54.4
KANPUR Average		**31.3**		**75.9**	**45.6**	**40.7**	**53.2**	**38.9**
LUCKNOW	LAKHIMPUR KHERI	14.1	67	56.8	17.7	17.7	29.2	21.3
LUCKNOW	SITAPUR	17.5	64	56.7	24.4	23.8	31.3	18.3
LUCKNOW	HARDOI	26.5	44	60.3	31.7	29.0	40.4	26.6
LUCKNOW	RAEBARELI	33.1	27	81.6	45.6	47.0	54.5	43.0

Coverage

LUCKNOW	UNNAO	39.1	20	84.0	45.9	48.5	52.2	38.7
LUCKNOW	LUCKNOW	51.1	4	85.8	66.1	64.2	69.1	37.7
LUCKNOW Average		**30.2**		**70.9**	**38.6**	**38.4**	**46.1**	**30.9**
MEERUT	BAGPAT	26.3	45	65.9	35.2	34.3	43.7	36.1
MEERUT	BULANDSHAR	27.2	42	79.3	31.2	39.4	52.4	34.5
MEERUT	G.B.NAGAR	27.2	41	79.3	31.2	39.4	52.4	40.9
MEERUT	GHAZIABAD	32.5	29	74.5	34.0	38.8	47.6	44.5
MEERUT	MEERUT	34.8	23	77.8	45.1	41.6	62.7	52.2
MEERUT Average		**29.6**		**75.4**	**35.3**	**38.7**	**51.8**	**41.6**
MIRZAPUR	BHADOHI	21.5	56	65.7	34.6	38.3	40.5	29.7
MIRZAPUR	MIRZAPUR	23.3	50	51.1	28.9	29.6	30.9	28.5
MIRZAPUR	SONEBHADRA	43.7	15	73.8	49.2	50.9	49.0	30.7
MIRZAPUR Average		**29.5**		**63.5**	**37.6**	**39.6**	**40.1**	**29.6**
MORADABAD	MORADABAD	22.0	54	74.6	31.4	34.7	46.6	35.3
MORADABAD	J.P. NAGAR	29.7	38	71.7	36.6	34.0	47.6	25.3
MORADABAD	RAMPUR	30.4	37	67.7	33.0	32.9	49.7	35.5
MORADABAD	BIJNOR	40.2	19	76.8	42.3	41.4	57.2	38.7
MORADABAD Average		**30.6**	71	**72.7**	**35.8**	**35.8**	**50.3**	**33.7**
SAHARANPUR	MUZAFFAR NAGAR	34.9	22	77.2	46.9	41.8	50.1	33.6
SAHARANPUR	SAHARANPUR	41.1	17	79.1	45.2	44.2	57.3	40.6
SAHARANPUR Average		**38.0**		**78.2**	**46.1**	**43.0**	**53.7**	**37.1**
VARANASI	CHANDAULI	33.7	26	71.9	40.5	40.3	54.1	33.3
VARANASI	GHAZIPUR	33.7	25	71.9	40.5	40.3	54.1	33.3
VARANASI	JAUNPUR	41.9	16	72.4	54.3	53.8	49.3	39.3
VARANASI	VARANASI	47.2	6	86.7	63.1	62.9	65.2	45.7
VARANASI Average		**39.1**		**75.7**	**49.6**	**49.3**	**55.7**	**37.9**
State Average		**30.3**		**73.4**	**40.4**	**38.9**	**47.0**	**32.2**

Evaluation DLHS-3 (2007-08)

SITUATIONAL ANALYSIS:

The improvement in BCG coverage from 57.4 % (DLHS-2) to 73.6 % (DLHS-3) reflects an increase in access to the immunization services and coverage of other antigen also improved

- According to DLHS 3 coverage of fully immunized children is only 30%. There are 33 districts in the state having coverage below state average (less than 30%) Baduan, Etah, Banda, LakhimpurKhiri, Bahriach, Shrawasti, Sitapur, Balrampur, Pilibhit, Chitrakoot, Farrukhabad, Gonda, Shahajahanpur, Mathura, Bhadohi, Fatehpur, Moradabad, Hathras, Allahabad, Agra, Mirzapur, Mainpuri, Kaushambi, Etawah, Kannuaj, Baghpat, Hardoi ,Aligarh, Bulandshar, G.B.Nagar, Jaluan, Firozabad, J.P.Nagar.

- There are 35 districts with coverage of 30-50% and 3 districts (Basti-53%, Pratabgargh-55%. Deoria-72%) with more than 50 % coverage in the state.

- Although DLHS Data show individual antigen is good but fully immunization coverage is low because of assessment based on low antigen coverage.

Assessment of critical bottlenecks for full coverage

1. Availability:

- Shortage of ANMs is 2546 ANMs in the state and it is around 10.8 % and population catered by ANM is around 8000-9000 (only one ANM available per Subcentre) . 35 Districts are having > 10 % shortage of ANMs (see annexure1)
- The number of polio rounds every year is affecting the amount of time and resources available for other health-related activities including routine immunization.
- The flow of vaccine needs to be regular and sufficient as per State target with timely prior information.
- 10 year running gensets need replacement.
- Hub-cutters required for having fully functional injection safety can be maintained only if adequate numbers are supplied by GOI

- Vaccine Carriers required for maintaining the cold chain in the field needs replacement.

Steps taken to improve availability

- To compansate the shortage of ANMs there is provision of hiring the contractual ANMs however only 853 could be hired last year. 1905 Regular ANMs are under training and with in short time they will start working
- Equipments and gensets are urgently required from GOI for strengthening the cold chain.

2. Accessibility

- The State continues to have dual problem of poor accessibility to immunization coverage as well as high dropout from BCG to DPT 3. As per the DLHS3 report 24.0% children have "No Immunization" i.e., they did not receive even a single antigen
- DLHS 3 data shows BCG coverage in the State is 73.4%, while 38.9% children are being reached with DPT 3 doses with the dropout of 47%
- If we compare BCG coverage with Measles coverage, the measles coverage is 47.0 with the dropout of 36%
- 100% planned sessions are not being held.
- Due-lists for beneficiaries are not being prepared
- Regular and timely fund is not reaching to State for alternate vaccine delivery
- Due to shortage of MO at BPHC and New PHC sessions are not monitored regularly
- Reporting and recording needs strengthening.
- Coordination with ICDS needs improvement at District and state level.
- Role of ANM under NRHM has increased with involvement of finance of record keeping has hampered her routine work.

Steps taken to improve accessibility:

- State has planned
  - **fixed sessions** at facilities District Hospital (Male and Female), Combined Hospitals , CHCs, PHCs and Additional PHCs (320000 sessions/year)
  - **Outreach sessions** 1645000 sessions /year in outreach areas
  - **Focus on Urban Slums areas of 11 big cities** (42384 sessions/year)
  - **Mobility support for vacant subcentre** (244416sessions/year)

- **" Mobile sessions**" to cover hard to reach areas(14000 sessions/year) have been planned to cover vacant subcentre and hard to reach areas by team approach
- **Catch-up rounds strategy:** Besides all above strategy CHCs/PHCs will identify the gaps where sessions could not be held because of any reason .They will enlist the area-wise unimmunized beneficiaries and will plan catch-up rounds for missed sessions in the month of Oct, Nov and Dec10 after analysing status of immunization in the areas.

3. To reduce dropouts: (reasons and steps taken to improve)

- The DLHS-3 data provides a base that if the children reached with BCG vaccine are being tracked subsequently in RI sessions in a systematized way then we can reduce the drop-out rate significantly and thereby having more fully Immunized children with attainment of MDG-4 goals.
- Enlisting of all beneficiaries by "Pregnant Woman and Child Tracking Strategy" by ASHA, AWW and ANM
    - ANM will collect relevant data in respect of all cases of pregnant women registered and children
    - The Tracking Every Newborn (TEN) initiative, which tracks newborn infants for routine immunization in the state of Uttar Pradesh (UP) India, is beginning to show promising results.
    - The computerization of all beneficiaries at district level by outsourcing external agency
    - Maintaining of MCH registers and use of counter file
    - Name wise Tally Sheet for beneficiaries started in all RI sessions

4. Utilization / Adequate Coverage

- Lack of awareness about Vaccine Preventable Diseases in Community.
- Lack of Coordination between ANM, Anganwadi Worker and ASHA
- List of beneficiary is incomplete in the most of the places

Steps taken to improve coverage:

- Regular payment to ASHA for social mobilization of Rs 150/- session and for complete immunization under ASHA scheme Rs 100/- beneficiaries.
- **Comprehensive IEC/BCC strategy** through VHSC , ICDS , mass media /print media etc to create community awareness and demand

- TV/ Radio, Print media and other mass media systems are effective strategies for raising awareness and influencing behaviour.
- Inter-personal communication (IPC) with families and communities is also critical in bringing about the desired change in attitude and behaviour of service users.
- IPC through ANMs, AWWs, ASHAs, local mobilizers and influential persons; IEC material for providers as well as clients
- IPC with pregnant mothers during TT immunization contact shall be the focus of the communication for enhancing coverage and reducing the drop-out rate.
- Local IEC/social mobilization methods (flock media) will be adapted and developed for demand generation (not just mass media; press/radio and television).
- AWW and ASHA will be partnered for effective demand generation and information
- Anganwadi centres will also be used as immunization sites and fixed immunization days displayed with the name of the ANM.
- Strengthening of Village Health and Nutrition Days (VHND) through VHSC.

Action Plan: Key areas of initiatives for 2010-11

1. **Monitoring and Supervision for RI:** Monitoring and supervision is a key component of RI and for this mobility support is needed Uttar Pradesh being a large state with 71 districts, amount of Rs. 1,00,000/- is inadequate to ensure mobility of State officials on regular basis. Therefore Rs. 2, 00,000 have been requested herein and Rs 50000/- per District level officers. Mobility for other Officers like ACMO, MOIC, MOs and DPM has been proposed under Mission Flexipool.

   Supportive supervision: There is proposal to hire AYUSH doctor for New PHC for better supervision. The doctors will be trained and they will provide monthly supportive supervision.

2. **Cold Chain Maintenance:** To minimize the distance for transportation of vaccines for PHC to Sub-centre or immunization site the additional vaccine

storage points were planned to be established in new PHCs and equipments were supplied for the same, so maintenance is required for 3500 equipments and budget has been projected for the same.

3. **Focus on slum and underserved areas in Urban Areas:** For strengthening of Routine Immunization in Urban Areas of Uttar Pradesh 11 Districts have been selected .Districts are Kanpur Nagar ,Lucknow, Agra, Varanasi, Ghaziabad, Alligarh, Bareilly, Meerut, Moradabad, Gorakhpur& Allahabad .Programme has been started from the month of Nov08. Detailed microplans have been prepared .Total sessions planned 42384 sessions/-year have been planned to covering approximately 65 lakhs slum population (34% of total urban population in these cities). It is recommended that apart from Govt. Vaccinators ,vaccinators will be hired to cover urban slum population ,for this budget has been projected
4. **Mobilization of beneficiaries through ASHA/RI mobilizer:** ASHA is a link worker between Service provider and community and she play a key role in mobilizing the beneficiaries for RI.ASHA is being provided Rs 150/- for social mobilization under Part C and Rs 100/- for fully immunized children under Mission Flexi pool. Total sessions planned in the state are 2007384; they are at facilities (fixed sessions 320000/year, in rural areas 1645000/year and urban slums of 11 big cities 42384/year.
5. **Alternate Vaccine Delivery (AVD):** Alternate vaccine delivery @ Rs 50/-session have been proposed for 1645000session /year in rural areas and 42384 session /year urban slums of 11 big cities. This amount will be provided only for 1st quarter of the year. After that arrangement of 2 vehicles/block for 8 days in a month (Wednesdays and Saturdays) will be done at the block level for 12 months .Thus total amount required will be 843.69 Lacs.
6. **Support for Computer Assistant:** For RI reporting and Data analysis 2 Computer assistant at State level and 71 Computer assistants for Districts have been appointed .There is provision for 10 % increase in salary so budget has been proposed for this.
7. **Printing and dissemination of Immunization card, tally sheet and monitoring format:** four fold immunization cards are being used for last 1 year and cards are printed centrally at state level so Rs 5/beneficiaries has been proposed for this .

8. **Review Meetings:** 4 State level review meeting DIOs along with Cold chain officer and DPMs have been planned .Participants from distance District have to spend more amount in travel therefore Rs 1500/Participant has been requested. Quarterly District level meeting for exclusive for RI with MOIC, CDPO and other stakeholder have been planned .Block orientation of ANM with ASHA is also planned.
9. **Training:** Comprehensive traing plan for Medical Officers, Health Workers, cold chain handlers, Data handlers, and Computer assistants has been planned.

Comprehensive Training Plan

SNo	Name of the Training	Participants	Traing load	To be Trained 09-10	Venue	Training load for 2010-11	No of participant /batch	No of Batches	Budget/Batch	Total in Lacs	Time line
1	2 days orientation ANMs,Multi purpose Workers,Supervisors	ANMs,MPWs male,LHV	26335	18851	District HQ	7677	20 participants/Batch	384	Rs 67300/-Batch	258.43	Mar-11
2	3 Days training of Medical Officers on RI	Medical Officers	7826	1380	RFPTC	3223	20 participants/Batch	161	Rs 145000/-Batch	233.45	Mar-11
3	1 day refresher training of District and State level Computer assistants on RIMS and HMIS	State and District level Computer assistants	73	73	State HQ	73	25 Participant/batch	3	Rs 75000/batch	2.25	Mar-11
4	1 Day cold chain handlers training	District and Block level cold chain handlers	900	900	District HQ	900	15-20Participants/batch	45		40.00	Mar-11
5	1 day traing of Data Handlers	District and Block level Data Handlers	823	823	District HQ	823	-	-	Rs 300/-Participant	2.47	Mar-11

10. **Microplanning:** Review of RI microplans on software in 09 Feb has been completed and Budget for this year 2010-11 has been projected.
11. **POL for Vaccine delivery from State to District and from District to PHCs/CHCs:** Budget has been planned for POL for transporting the vaccine from State, District and to PHC/CHC and also for maintenance of Vehicle
12. **Injection safety**: Budget has been planned to purchase red and black polythene bags, buckets , bleaching powder and construction of pits.

Innovations carried out in the State:

Many innovations have been done in the state of UP to reduce and establish systems to address the existing problems in Routine Immunization and work in the line of proposed strategies in the state. Both the below innovations (Arogayam and TEN in J.P.Nagar and Baghpat) have resulted in encouraging results in terms of reach to the beneficiaries in a systematic manner. Both the systems have few strong points, which needs to be integrated for further scaling up of the initiatives in the states to strengthen the RI in the state and to address the critical bottlenecks for achieving better FI coverage in the state. After reviewing the progress of Arogyam programme along with Previous Districts J.P.Nagar and Baghpat three more Districts Moradabad.Bijnor and Rampur will be piloted in 2010-11 .Beside this to ensure 100% immunization in Moradabad Division Commissioner Moradabad has taken initiative to supervision of the prgramme by third party.

a. The **"Aarogyam Project**" was initiated in the district J.P Nagar by District Magistrate with the objective to establish a technology - based delivery system to track every beneficiary (Pregnant Women and Infant) for health services. The project was later adopted with the same concept by District Baghpat. The project has been implemented at Block level at J.P. Nagar while at Baghpat; it is being operated from District level. The "Aarogyam Project" envisages:
    i. Generation of unique Identification (ID) number for each beneficiary and generate awareness in community on health services and visions to improve the community & service provider linkages.
    ii. Principally works through I.V.R.S (Interactive Voice Recording System) application with an overview that a replicable model of technology based intervention in health care delivery may be developed in near future in the state.
    iii. Additional sub-sets associated with Aarogyam Project are that it gathers health specific data with respect to Childhood immunization, Institutional delivery, JSY, ANC/PNC details.
    iv. This also has in itself a "Helpline Number" where beneficiaries can lodge health related complaints. Complaints are then forwarded to concerned ANM and Medical Officer in charges. This project

provides educative support to various other health campaigns like Pulse Polio Campaigns, Gender Equality, and JSY etc.

b. The **"Tracking Every Newborn (TEN)"** Initiative was initiated by WHO/NPSP in eight blocks of RI Supported eight NPSP district for tracking every newborn through computerized name based database.This initiative utilizes the newborn data generated through polio SIA as well as other sources to have a comprehensive list. It also aims at establishing best practices at block level for using computerized health records for health and non health related programs. The Tracking Every Newborn Initiative:

   i. Collect and collate newborn data from all sources including polio SIA and establish a comprehensive computerized name based database at block level.
   ii. Provide complete list of beneficiaries to ANM in advance of immunization session to facilitate tracking of all newborn for immunization.
   iii. Continuously update data base for any newborn identification as well as immunization after every session.
   iv. Establish a practice of immunization reporting following each session with all the names.
   v. Generate sub-center wise performance indicators for the analysis and subsequent corrective actions.

c. **To ensure 100% Rountine Immunization (RI) in Moradabad Division:** The entire Moradabad division is high risk area in the view of the low Rountine Immunization coverage and persistance of Polio virus. This proposal has been prepared under the supervision of **Commissioner, Moradabad Division** in the background of non eradication of Polio from the region even after a persistent drive of more than 15 years .The main reasons for this persistant significant constraints in Pulse Polio Programme and challenges affecting the efficacy of the OPV being cited are as follows:

   i. Population living in access –compromised areas

ii. Perception of poor quality vaccine persists because people see some children getting polio after taking 10-12 doses of OPV.
iii. Instance of community resistance
iv. Sanitation, Nutritional status
v. Weak RI coverage

The challenges of **"Weak Immunization Programme in HR areas"** like in Moradabad Division calls for immediatly fixing of the problem , not only for ensuring eradication of Polio virus at the erliast ,but is also required to keep the region and country free after this programme ends.

Proposal: Keeping in view the above situation analysis and innovations taken up in the state by GoUP, it is proposed that a system of tracking of children and introduction of third party to run the monitoring system in the Division needs to be adopted.

1 Survey for the eligible beneficiaries in the area will be conducted by ASHA with support of AWW utilizing the ANM of that particular sub centre. The data generated in the field will be entered in Block Level Computers. Block ICC will support the data entry process at the block level and subsequently will take over the role of data entry and provide computerized due list to each ANM on the session day.

2. For scaling up the benefits of both Aarogyam and Tracking Every Newborn initiatives, software may be developed with the support from NIC which will capture the benefits above innovations. The responsibility of developing a programme which can capture this real time data input and issue a red flag in case a child has been left unimmunized on or till due date will be given to a third party.They will be responsible for updating the information being supplied by the ANMs at the end of of each week of immunization work.
3. Session-wise beneficiary tally sheet will be entered into the software and this will generate the monthly report for the block which will be transmitted to the District for preparing the monthly report for the district.
4. The list of unimmunized till due date will be generated at the end of each week and supplied to the PHC/CHC in charge .The unimmunized children will be covered by team approach. A list of unimmunized children even after lapse of 15 days will be generated every fortnight by the third party and sent to Commissioner Moradabad from where District level team will visit the child,

home and immunize and get the record updated at PHC/CHC. This will be accompanied with a memo for the PHC/CHC in - charge and concerned field officer

5. To maintain the sustainability of the programme, daily / monthly operational support for the scaled up project may be integrated in the PIP of the state.
6. A monitoring system will have to be inbuilt using the Block Medical Officers and District Medical Officer supervision and monitoring, so that the system can be sustained.

Total budget for above Innovations in 5 Districts (Moradabad Division and District Baghpat) is Rs 190.00 lacs proposed under Mission flexi pool.

7. Routine Immunization- Part 'C' - Programme Implementation Plan
Directorate of Family Welfare, Govt. of Uttar Pradesh, Lucknow
Budgetary Requirement for year 2010-11

Services Delivery	Norms*	Expenditure & Achievement									Remark
		2005-06	2006-07	2007-08	2008-09		2009-10		2010-11		
		Expenditure	Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Funds requirement in Lacs	Target	
Mobility support for supervision : Supervisory visits by state and district level officers for monitoring and supervision of RI	Rs 50,000 per District for district level officers (this includes POL and maintenance) per year	11.41	11.83	19.99	15.86	No of sessions Supervised	30.35	No of sessions Supervised	35.50	No of sessions Supervised	AS PER THE STANDARD NORM Rs. 50,000/ district X 71 districts
	By state level officers @ Rs.100,000 /year	0.01	0.73	0.10	1.00	No of districts visited for RI review	2.00		2.00	No of districts visited for RI review	Uttar Pradesh being a large state with 71 districts, amount of Rs. 1,00,000/- is inadequate to ensure mobility of State officials on regular basis. Therefore Rs. 2,00,000 have been requested herein.
SUB TOTAL		**11.42**	**12.56**	**20.09**	**16.86**		***32.35***		**37.50**		
Cold Chain maintenance	@ Rs 500 per PHC/CHC per year District Rs 10,000 per year					% Funds used	20.03	% Funds used	24.6		AS PER THE STANDARD NORM Rs. 500/ PHC/CHCper year X 3500 CHC/PHC/AddlPHC Rs. 10,000 / district / year X 71 districts
SUB TOTAL							**20.03**		**24.6**		

Focus on slum & underserved areas in urban areas:	Hiring an ANM @ Rs.300/session for four sessions/month /slum of 10000 population and Rs.200/- per month as contingency per slum of i.e. total expense of Rs. 1400/- per month per slum of 10000 population.	34.72	46.81	40.31		No of sessions with hired vaccinators	56.8	No of sessions with hired vaccinators	148.34		AS PER THE STANDARD NORM Rs. 350 (Rs. 300/- as honorarium and Rs. 50/- as contingency) / session for maximum 4 sessions/month in a slum of 10000 population .Total 42384 sessions/year have been planned
SUB TOTAL		**34.72**	**46.81**	**40.31**			**56.8**		**148.34**		
Mobilization of children through ASHA/mobilizers	**@ Rs 150/session (for all states/UT.s)**	977.56	1392.91	1819.75	1496.25	No. of sessions with ASHA	2575.15	No. of sessions with ASHA	2531.08		AS PER THE STANDARD NORM Total session in rural areas = 2007384 /year Fixed session at facilities = 320000/year for this no funds needed Outreached sessions=1645000 funds proposed @Rs 150/session sessions in Urban areas of big cities =42384 and funds proposed Rs 150/session so budget has been proposed for total sessions 1687384sessions/year

SUB TOTAL		**977.56**	**1392.91**	**1819.75**	**1496.25**		**2575.15**		**2531.08**		
Alternative Vaccine Delivery:	Geographically hard to reach areas (eg.Sessions site > 30 Kms from vaccine delivery points river crossing etc) @Rs 100per session					No of sessions with AVD		No of sessions with AVD	budget has been proposed for 160992 mobile sessions in Mission Flexipool	No of sessions with AVD	AS PER THE STANDARD NORM Total session in rural areas = 2007384 /year Fixed session at facilities = 320000/year for this no funds needed Outreached sessions=1645000 funds proposed @Rs 50/session sessions in Urban areas of big cities =42384 and funds proposed Rs 50/session so budget has been proposed for total sessions 1687384sessions/year
	NE States, Hilly terrains @ Rs.100 per session										
	For RI session in other areas @ Rs.50 per session.	335.91	487.93	660.35	616.15		856.9		843.69		
SUB TOTAL		335.91	487.93	660.35	616.15		856.9		**843.69**		
Support for Computer Assistant for RI reporting (with annual increment of 10% wef from 2010-11	State @Rs 12,000- 15,000 p.m.	0.21	0.84	0.80	1.10		1.54		3.17		AS PER THE REVISED STANDARD NORM State level CA - @ Rs. 13200/month for 2 CAs' X 12 months District level CA - @ Rs. 8800/month X 71 districts X 12 months
	Districts @ Rs 8000- 10,000 p.m	6.37	27.53	52.37	47.15	No of CA in position	66.3	No of CA in position	74.98	No of CA in position	
SUB TOTAL		**6.58**	**28.37**	**53.17**	**48.25**		**67.84**		**78.14**		

Printing and dissemination of immunization cards, tally sheets, monitoring forms, etc.	@ Rs 5 per beneficiary	3.25	8.94	62.30	70.89		324.35		330.16		AS PER THE STANDARD NORM Rs. 5/beneficiary X 6603280 pregnant women beneficiaries +10% wastage In UP four fold immunization is being used for last 1 year
SUB TOTAL		**3.25**	**8.94**	**62.30**	**70.89**		**324.35**		**363.18**		
Review Meetings	Support for Quarterly State level Review Meetings of district officers @ Rs 1250/participant/day for 3 persons (CMO/DIO/Dist Cold Chain Officer)	1.29	1.49	0.74	1.91	No of meetings held	1.41	No of meetings held	10.65		Rs. 1250/participant X 3 participants/district X 71 districts X 4 times/year.
	Quarterly Review & feedback meeting for exclusive for RI at district level with one Block MO.s, ICDS CDPO and other stakeholders @ Rs 100/- per participant for meeting expenses (lunch, organizational expenses)					No of meetings held	5.97	No of meetings held	9.88		AS PER THE STANDARD NORM Rs. 100/participant X 3 participants/block X 823 blocks X 4 times/year

	Quarterly review meeting exclusive for RI at Block level @Rs 50/-pp as honorarium for ASHAs (travel) and Rs 25 per person at the disposal of MO-I/C for meeting expenses(refreshments, stationery and misc. expenses)					No of meetings held	160.2	No of meetings held	217.50		AS PER THE STANDARD NORM Maximum Rs. 50/Asha participant X (137000 ASHA) X 4 times/year Rs. 25/- participants 137000 ASHA+24000 ANMs X 4 times/year
SUB TOTAL		**1.29**	**1.49**	**0.74**	**1.91**		**166.17**		**238.03**		
Trainings	District level orientation training for 2 days of ANM, Multi Purpose Health Worker (Male), LHV, Health Assistant (Male / Female), Nurse Mid Wives, BEEs & other specialist (as per revised RCH norms)					No of persons trained	26.18	No of persons trained	258.43	No of persons trained	7677 ANMs and male health workers and Supervisors are remaining who have not received 2 day training on immunization. 384 batches of trainings will be organized this year .@ Rs. 67300/batch X 384 batch with 20 participants in each batch
	Three day training of Medical Officers on RI using revised MO training module					No of persons trained	26.61	No of persons trained	233.45	No of persons trained	Trainings of Medical Officers (3 days) will be organized this year in 161 batches following training of trainers in 4 batches in year 2009-10. .@ Rs. 145000/batch X 161batches of MO training

	One day refresher training of District RI Computer Assistants on RIMS/HMIS and Immunization formats under NRHM					No of persons trained	0	No of persons trained	2.25	No of persons trained	Refresher training will be organized this year in 3 batches @ Rs. 75000/-. The training requires arrangement for hired computers and other logistics.
	One day cold chain handelers training for block level cold chain handlers by state and district cold chain officers for a batch of 25-30 per batch, for 410 cold chain handlers					No of persons trained	0	No of persons trained	40.00	No of persons trained	As per RCH revised Norms
	One day Training of block level data handlers by DIO and District Cold chain Officer to train about the reporting formats of Immunization and NRHM					No of persons trained	1.3	No of persons trained	2.47	No of persons trained	One day training will be organized for block level data handlers of all 823 blocks of the State. .@ Rs. 300/participant
SUB TOTAL							54.09		**536.60**		
Microplanning : To devlop sub-center and PHC microplans	@ Rs 100/- per subcentre (meeting at block level, logistic)						15.75	100% of SC/PHC/CHC /Districts have updated microplans	20.62	100% of SC/PHC/CHC/ Districts have updated microplans	AS PER STANDARD NORM Block level meeting : Rs.

using bottom up planning with participation of ANM, ASHA, AWW	For consolidation of microplan at PHC/CHC level @ Rs 1000/- block & at district level @ Rs 2000/- per district	3.80	1.08	0.15	3.15		8.78	every year	9.65	every year	100/meeting/subcenter X 20621/subcenters Consolidation of Microplan : Rs. 1000/block X 823 blocks Rs. 2000/district X 71 districts
SUB TOTAL		**3.80**	**1.08**	**0.15**	**3.15**		**24.53**		**30.27**		
POL for vaccine delivery from State to District and from district to PHC/CHCs	.@ Rs. 100,000/ district/year			4.30		% Funds used	51.21	% Funds used	71.00	% Funds used	AS PER STANDARD NORM Rs. 1,00,000/district/year X 71 districts
SUB TOTAL							**51.21**		**71.00**		
Consumables for computer including provision for internet access for RIMS	@ 400/ - month/ district						2.83		3.41		AS PER STANDARD NORM Rs 400/- month has been proposed
SUB TOTAL							**2.83**		**3.41**		
Red/Black Plastic bags etc	@ Rs 2/bags/session	0.20	2.54	1.52	24.29	% funds used	75.64	% funds used	80.30	% funds used	AS PER STANDARD NORM Rural : Rs. 2/bag/session X 2 bags/session X 2007380 in Uraban and Rural and Fixed sessions
Bleach/Hypochlorite solution	@ Rs 500 per PHC/CHC per year	0.71	0.82	0.46	0.78	% funds used	3.82	% funds used	5.00	% funds used	AS PER STANDARD NORM Rs. 500/vaccine storage point/year X 1000 vaccine storage points

Twin bucket @ Rs 400 per PHC/CHC per year				0.47	1.64	% funds used	3.65	% funds used	4.00	% funds used	AS PER STANDARD NORM Rs. 400/set X 1000 vaccine storage points
SUB TOTAL		0.91	3.36	2.45	26.70		**83.11**		**89.30**		
STATE SPECIFIC ACTIVITIES											
Injection Safety											
Funds for preparing disposal pit for disposal of sharp immunization waste.	Rs. 2500/pit X 500 vaccine storage points		0.85	4.24			10.01		17.50		Reason : funds have been released for 50% construction of pits Therefore funds are requested this year for preparing pits in 50% of vaccine storage points. Rs 3500
Funds for purchase of small polythene zipper bags to keep vaccines in the vaccine carriers	Rs. 0.5/polythene bag X total number of sessions/year +10% wastage	6.20	44.47	5.20	7.35		10.69		10.04		AS PER STANDARD NORM Rural : Rs. 0.5 polythene bag X 2007380 in Uraban and Rural and Fixed sessions
SUB TOTAL		6.20	45.32	9.44	7.35		**20.7**		**27.54**		
Strengthening of Cold Chain System in the State											
Operational expenses at divisional vaccine storage	Rs. 25000/divisional store/year X 18 divisional stores						2.41		4.75		Reason : Separate ear marked funds are required for repair and maintenance of Generator set and other expenses at

points											Divisional Vaccine Storage points
Operational expenses at district vaccine storage points	Rs. 20000/district store/year X 71 districts						9.76		00.00		Reason : Separate ear marked funds for repair and maintenance of Generator set and other expenses at District Vaccine Storage points
Funds for annual maintenance contract of WIC/WIF	Rs. 40,000/unit/year X 21 units of WIC and WIF						2.41		8.40		
SUB TOTAL							12.17		**27.35**		
Grand Total		**1380.36**	**2027.28**	**2668.01**	**2285.61**		**4348.23**		**5002.81**		

1. **Infrastructure and Manpower requirement that are essential for implementation of UIP but not permissible under Part C –**budget has been proposed in Mission Flexipool. Please see the Part B under Mission Flexi pool for the detail.

2. **IEC plan for strengthening UIP: Detail and budget has been proposed in ICC/BCC head**.

A high visibility and an intensive BCC campaign is being proposed for promotion of parental responsibility for ensuring complete immunization of the children. The campaign will use mass media channels like Radio, Television and Print for dissemination of the messages. It will be supported by IPC by ASHAs, AWWs during the VHND and the RI sessions at the village level and counseling of parents of new borns about the importance of complete immunization at the facility level. A new colour coded BCC immunization card (based on the Indradanush colour coded RI strategy for ensuring minimum of 5 contacts in the first year) which has been developed and field tested is being proposed to complement the RI campaign.

In addition, a child to community intervention for community mobilization Bal Chetak strategy (Alert Child Guardian intervention) will be piloted in one district for increasing immunization coverage. Involving coordination and convergence with the Department of Basic Education, the Bal Chetak is a child volunteer (10-14 years) working in pairs to track the immunization status of 4-5 infants in their neighborhood. The Bal Chetak will maintain a diary with names of the children, provide a home visit two days prior to the immunization session to inform parents, follow up visit on immunization day to ensure participation by the infant's care giver. The motivation for the Bal Chetak is planned through public awards & certificates at the Block & District level. ASHAs, School teachers or village volunteers would

be enlisted to provide supportive supervision to the Bal Chetaks.

Activities proposed under Child Health related campaigns		
IPC : HHs and community level	**Mid Media / Local media**	**Mass Media**
Household Level • Identification & tracking of beneficiaries for RI through household visit by ASHA per session **Village Level** • VHND - Counseling of pregnant/ mothers of new borns by ANM on importance of complete immunization during ANC / PNC visit **Community Level** • Monthly group meetings for demand generation for RI activities ASHA & ANM as per monthly themes • Saas Bahu Sammelan **Facility Level** • Counseling of pregnant women/ mothers of new borns on RI during ANC, delivery and PNC visits by ANM, FWCs, MO/IC	• Wall Paintings on RI & BSPM: o ASHA home o Sub Centre o PHCs / CHCs o District hospitals • Folk performances on Child health and parental responsibility by trained troupes • Rallies by School children for BSPM months • IPC materials for use by ASHA during home visits and group meetings: o VHND/ RI handbill o Advocacy book for VHSC members • VHND and RI Flex banners • BSPM Posters	• TV and Radio spots on RI and Bal Swasth Poshan Mah (BSPM) • Media advocacy efforts through interviews and talk shows, Doctors interviews and content on popular TV & Radio programs like Kalyani, Hello Sehat

3. Strengthening of Cold Chain and Vaccine Logistic Management (CCVLM)

Rationale:

- Since the inception of UIP a wide network of cold chain stores have been created
- Introduction of AD syringes
- Frequent polio rounds –more equipments and persons needed to maintain vaccine
- Equipment and management failure at storage level can destruction of large quantity of vaccine

Cold chain and vaccine management strengthening; Cold chain system available in State has been given in annexure

a. The requirement of cold chain equipment (for replacement as well as expansion) was projected in past PIP 2008-09.The CFC equipment are very old and CFC refrigerators is not available in market as the use of R-12 is banned. Therefore this equipment is urgently required for replacement, similarly the number beneficiaries of routine immunization are increased due to increasing the population and new vaccine (J.E & HIP-B) has been included in routine immunization.

b. The pulse polio immunization campaign is continuing for last about 10 years. The demand of Deep Freezers is being sent regularly but against the demand of 1500 Deep Freezers (Large) only few D/F (S) have been provided to states of U.P. The main reason for high sickness rate of Deep Freezer is overloading being used for freezing the ice packs. The position of freezing capacity in state is as under.

c. To minimize the distance for transportation of vaccines for PHC to Sub-centre or immunization site the additional vaccine storage points are to be established in new PHCs, where electricity is available & running in Govt. Building For this purpose, The demand of ILR/DF has been projected as additional requirement of Cold Chain equipment.

d. The demand of vaccine carriers and cold boxes are regularly is being sent to GOI. During the polio campaign approx. 125000 vaccine carriers are used and one lack vaccine carriers were demanded but only 35000 vaccine carriers have been supplied in last month only. The demand of remaining 65000 vaccine carriers has been projected in PIP 2010-11

Equipments:

The requirement for this year is provided in the table below and is expected that procurement would be done by Govt.of India

Requirement of Cold Chain Equipment PIP 2010-11 (including the demand of 2009-10)

S.No.	Name of Equipment	Requirement for Replacement against CFC to Non CFC	Additional Requirement for expansion	Total Requirement	Equipments supplied (in pipeline)	Total requirement
1	Walk in Cooler	11	8	19	0	19
2	Walk in Freezer	2	3	5	0	5
3	Deep Freezer (Large)	350	1500 (for pulse polio)	1850	425	1425
4	Ice Lined Refrigerator (ILR Large)	500	100	600	200	400
5	Ice Lined Refrigerator (ILR Small)	2000	500	2500	452	2048
6	Deep Freezer (Small)	2000	500	2500	758	1742
7	Genset 10 KVA for District, PHC/CHC with KNOP	896	100	996	0	996
8	1 KVA Voltage Stabilizer (For Float Assembly)	2000	500	2500	0	2500
9	Tool Kit	35	1	36	0	36
10	Cold Box (large + ice pack)	2000	500	2500	800	5700

11	Cold Box (Small)	3000	1000	4000		
12	Vaccine Carrier(4 ice pack)	100000	_	100000	35000	65000
14	Hub Cutter for each ANM		25000	25000	0	25000
13	Electronic Data Logger(For ILR and DF and transportation of vaccine)			6000	0	6000
14	Freezer Indicator			3500	0	3500
15	Vaccine van insulated for all (71) Distt. ,Eighteen Division & State H.Q.	87	3	90	0	90
16	Refrigerator Van			5	0	5

Note: There is urgent requirement of above equipments and to be supplied by Govt. of India

Cold chain depot at Additional PHCs (New PHCs)

A. To maintain cold chain in the area of Block other than Block PHC, State will identify Additional PHCs which have got Govt. building and electric supply and we will install ILR along with the generator backup support.

B. We will also explore the Additional PHC where we can establish a cold chain depot to deliver vaccine in the remote areas of the PHC. In these depot vaccine will be transferred in the cold boxes along with icepacks one day prior the session.

Our focus will be to create 1-2 extra cold chain points in each Block at additional PHC

BUDGET SUMMARY FOR IMMUNISATION

S.no	Head	Amount proposed for 2010-11(in Lacs)
1	Part C	5002.81
2	Programme management head	7.50
3	Mission Flexipool	
a	RI and Cold chain Strengthening	1100.51
b	Mobility support to Hard to reach areas and Award Scheme	4016.00
	Total	10126.82

ANNEXURE

Position of ANMs in U.P.

Sl. No.	District Name	Approved Post	Filled post	Vacant
1	Agra	478	337	141
2	Mainpuri	225	223	2
3	Firozabad	242	214	28
4	Mathura	256	225	31
5	Aligar	394	288	106
6	Hathras	201	144	57
7	Ata	210	175	35
8	Kashiram Nagar	183	117	66
9	Partapgarh	431	426	5
10	Kaushambhi	204	161	43
11	Fatehpur	347	330	17
12	Allahabad	666	594	72
13	Shahjahanpur	344	323	21
14	Bareli	505	428	77
15	Badaun	425	363	62
16	Pilibhit	219	187	32
17	Jalaun	325	276	49
18	Jhansi	374	249	125
19	Lalitpur	218	155	63
20	Hamirpur	249	205	44
21	Chitarkoot	159	121	38
22	Mahoba	169	118	51
23	Bana	306	225	81
24	Sultanpur	472	457	15
25	Ambedkar Nagar	308	305	3
26	Faizabad	292	281	11
27	Barabanki	409	387	24
28	Gonda	381	376	5
29	Sharwasti	141	86	55
30	Bahraich	371	348	23
31	Balrampur	239	191	48
32	Balia	426	416	10
33	Azamgarh	552	530	22
34	Mau	244	244	0
35	Gorakhpur	545	539	6
36	Derio	384	381	3
37	Maharajganj	299	290	9
38	Kushinagar	418	406	12

Sl. No.	District Name	Approved Post	Filled post	Vacant
39	Santkabir Nagar	204	200	4
40	Sidharth Nagar	279	259	20
41	Basti	317	314	3
42	Kannauj	209	200	9
43	Kanpur dehat	250	228	22
44	Kanpur Nagar	433	369	64
45	Etawah	190	183	7
46	Auriya	184	168	16
47	Farukhabad	224	214	10
48	Raibareilly	481	475	6
49	Lucknow	387	378	9
50	Sitapur	495	469	26
51	Unnao	402	389	13
52	Hardoi	488	466	22
53	L. Khiri	440	383	57
54	Baghpat	200	157	43
55	G.B. Nagar	145	109	36
56	Ghaziabad	368	312	56
57	Meerut	334	310	24
58	Bulandshahr	402	311	91
59	Saharnpur	406	341	65
60	Mujaffar Nagar	470	402	68
61	Bijnor	400	356	44
62	Moradabad	454	390	64
63	J.B. Nagar	194	125	69
64	Rampur	244	180	64
65	Sonbhadhar	197	139	58
66	Mirzapur	317	299	18
67	Bhadhohi	182	162	20
68	Varanasi	365	363	2
69	Chandauli	282	267	15
70	Gazipur	472	454	18
71	Jaunpur	544	531	13
	Total	**23570**	**21024**	**2546**

Recommendation of Standing Committee on Health and Family Welfare for catch-up rounds/special immunization weeks

In reference to GOI letter no. H.11013/2010-CC&V dated on 21.01.10 concerned with recommendation of Parliamentary Standing Committee on Health and Family Welfare to improve the immunization coverage in the poor performing districts as per DLHS-III data to ensure effective reduction in unimmunized /partially immunized children.

As mentioned earlier, each of the 71 districts had prepared a detailed District Health Action Plan, depending on situational analysis. Government of India has provided a list of 44 backward districts where a detailed plan has been developed through consultative processes involving Divisional Programme Management Units and District Programme Management Units.

After RI review meetings at State level gaps have been identified and Districts specific innovations have been incorporated in PIP for year 10-11 to strengthen Routine Immunization Programme in identified 18 Districts (Budaun, Etah, Banda, Kheri Lakhimpur, Bahraich, Shrawasti, Sitapur, Balrampur, Pilibhit, Chitrakoot, Farrukhabad, Gonda, Shajahanpur, Mathura, Moradabad, SantRavidas Nagar, Chanduali, Fatehpur) (Refer to PIP page no. 286).

Health Infrastructure and gaps identified:

S.n	Name of the District	No of Blocks	No of Subcentre	Sanctined posts of ANMs	Shortage of ANMs	% Fully Immunized Children(DLHS-III)
1	**Baduan**	18	366	425	62	10.6
2	**Etah**	8	178	210	35	11.6
3	**Banda**	8	285	306	81	13.7
4	**Khiri Lakhimpur**	15	386	440	57	14.1
5	**Bahriach**	14	310	371	23	15.0
6	**Shrawasti**	5	126	141	55	16.0
7	**Sitapur**	19	468	495	26	17.5
8	**Balrampur**	9	206	239	48	18.0
9	**Pilibhit**	7	199	219	32	19.0
10	**Chitrakoot**	5	139	159	38	19.1
11	**Farrukhabad**	7	185	224	10	19.7
12	**Gonda**	16	338	381	5	20.1

13	**Shajahanpur**	15	299	344	21	20.3
14	**Mathura**	10	215	256	31	20.6
15	**SantRavidasNaga**	6	155	182	20	21.5
16	**Moradabad**	13	416	454	64	22.00
17	**Fatehpur**	13	324	347	17	22.0
18	**Chanduali**	9	248	282	15	33.7

Gaps identified and steps taken to improve coverage:

1. Availability:

1. Shortage of ANMs: Shortage of ANMs shows clear co-relation with poor coverage. To overcome this problem ANMs will be hired this year however 1905 regular ANMs are under training and they will join this year.
2. Strengthen vaccine delivery system by regular funds for AVD
3. Strengthen Cold Chain maintenance system. There is urgent requirement of equipments like ILRs, DFs, Cold box, Vaccine carrier and hub cutters etc from GOI.

2. Accessibility and to reduce dropouts:

a. 100% planned sessions not held: to overcome this problem State has planned
   i. **fixed sessions** at facilities District Hospital (Male and Female) Combined Hospitals , CHCs, PHCs and Additional PHCs
   ii. **Outreach sessions** (in SCs and villages)
   iii. **Focus on Urban Slums araes** (in 11 big cities)
   iv. **Mobile sessions** for vacant subcentre have been planned to cover vacant subcentre and hard to reach areas by team approach
   v. **Catch-up rounds strategy**: Besides all above strategy CHCs / PHCs will identify the gaps where sessions could not be held because of any reason. They will enlist the area-wise unimmunized beneficiaries and will plan catch-up rounds for missed sessions in the month of Oct, Nov and Dec10 after analysing status of immunization in the areas.

b. **Hard to reach areas:** Microplan review and Mobile sessions by team approach
c. **Due list of beneficiaries not available:** Tracking of baneficiaries and computerization of data
d. **Poor recording** : Printing of MCH registers, name wise tally sheets
e. **Poor monitoring :** monitoring on new revised formats by Govt Medical officers and AYUSH doctor (Proposal of hiring of AYUSH doctors for ANMs supervision)
f. **Poor coordination with PRI,ICDS :** Coordination meetings at all level

2. **Utilization and adequate coverage :**
   a. Lack of awareness about Vaccine preventable disease
   b. Lack of cordination between ASHA,AWWand ANM

Steps to improve:

i. Regular payment to ASHA after assessing her progress
ii. Comprehensive IEC/BCC strategy
iii. Training of Health workers,Medical Officers,Cold chain handlers and data handlers
iv. Incentive to VHSC, Kshetra Panchayat, PHC/CHC, sub Center in case of acheiving more than 90% coverage
v. Training of ASHA on Vth Module (concept of VHND has been included in this module)

3. **Role of Partener agency :**
   - District Lakhimpur Kheri, Baireich, Shrivasti, Sitapur, Balrampur, Philibhit, Chitrakoort, Farrukhabad have been alloted to UNICEF by planning division and District Baduan has been allotted to NPSP/WHO to improve the coverage.

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME (NVBDCP)

COMPONENTS OF THE PROGRAMMES

- Malaria Control Programme
- Filaria Control Programme
- Kala-azar
- Japanese Encephalitis
- Dengue & Chikungunya

GOALS

- Reduction in morbidity and mortality of all vector borne diseases.
- Prevention and Control of vector borne diseases by giving area wise specific priorities.
- Universal access to public health services and promotion of health life styles with the help of Integrated Vector Management.

NRHM Objectives

- Malaria morbidity & mortality reduction rate 50% up to 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 J.E. mortality rate by 50% by 2010.
- Reduction in Dengue mortality rate by 50% by 2010.
- Effective Control over Chikungunya morbidity

Present Status of Vector Borne Disease in Uttar Pradesh

(Reporting Calendar Year)

		Positive	P.*f.*	Death	Disease	M.*f*	Cases	Death	Cases	Death	Cases	Death
	2004	85868	2142	0	7999	1088	1030	228	7	0	36	2
	2005	105302	3149	0	7613	619	5581	1593	121	4	68	2
	2006	91566	1875	0	5738	725	2073	476	617	14	83	0
	2007	83019	2132	0	5791	637	2675	577	130	2	69	1
	2008	93383	2310	0	5134	477	2730	486	51	2	26	0
	2009	53204	641	0	2815	452	3061	555	161	2	17	1

P.*f.* = *Plasmodium falciparum(species causing cerebral malaria)*
M.*f.* = *Micro f ilariae(stage of filarial parasite detected in blood examination)*

A. MALARIA

Situational Analysis of Malaria

Malaria is present throughout the state of Uttar Pradesh. The interstate border districts are endemic for Malaria.

Specific Constraints for implementation of Programme

Sr. No.	Problems	Reasons
1	Poor surveillance	Lack of manpower Malaria is not a priority issue for available manpower(ANM,MPW,FHW)
2	Inadequate ABER	lack of infrastructure (man money and material), technicians are not very competent
3	Of and on appearance of the disease in non endemic area	Seasonal variations

Priority districts - 20 districts in UP are priority districts for malaria control programme - Aligarh, Hathras, Mainpuri, Firozabad, Bareilly, Badaun, Bijnore, Mirzapur, Sonbhadra, St.Ravidas Nagar, Allahabad, Fatehpur, Kanpur Dehat, Farrukhabad, Jhansi, Banda, Hamirpur, Mahoba, Bulandshahar, Muzaffarnagar .

Criterion for prioritisation- 1) High A.P.I. , 2) High S.P.R. , 3) P.*f.* percentage, and
4) Resistance to Chloroquine.
In Sonbhadra district P.*f.*is resistance to Chloroquine.

Identified High Risk Districts (2009-10, till dec 2009)

S. N	Name of Districts	Population	Blood Slide Examination	Malaria Positive	P.*f.*	ABER	SPR	Pf %	A.P.I
1	Aligarh	3489328	37907	620	12	1.09	1.64	1.94	0.18
2	Hathras	1402730	25720	770	130	1.83	2.99	16.88	0.55
3	Mainpuri	1645529	42729	908	4	2.60	2.13	0.44	0.55
4	Firozabad	2055306	33595	708	8	1.63	2.11	1.13	0.34
5	Bareilly	2834071	73010	908	3	2.58	1.24	0.33	0.32
6	Badaun	3111144	50815	1051	1	1.63	2.07	0.10	0.34
7	Bijnore	3598867	124508	1022	13	3.46	0.82	1.27	0.28
8	Mirzapur	2459717	126509	6317	2	5.14	4.99	0.03	2.57
9	Sonbhadra	1784065	89431	10020	52	5.01	11.2	0.52	5.62
10	St.Ravidas Nagar	2059434	29423	1252	0	1.43	4.26	0.00	0.61
11	Allahabad	4878373	96810	4071	31	1.98	4.21	0.76	0.83
12	Fatehpur	2441900	53081	918	2	2.17	1.73	0.22	0.38
13	Kanpur Dehat	1660564	58208	2597	30	3.51	4.46	1.16	1.56
14	Farrukhabad	1747849	31029	927	2	1.78	2.99	0.22	0.53
15	Jhansi	1641360	62645	1265	52	3.82	2.02	4.11	0.77
16	Banda	1629551	55656	906	18	3.42	1.63	1.99	0.56
17	Hamirpur	1078893	52202	1479	19	4.84	2.83	1.28	1.37

18	**Mahoba**	**848101**	**41415**	**1213**	**10**	**4.88**	**2.93**	**0.82**	**1.43**
19	**Bulandshahar**	**2853300**	**147288**	**870**	**8**	**5.16**	**0.59**	**0.92**	**0.30**
20	**Muzaffar Nagar**	**3947542**	**133837**	**2082**	**53**	**3.39**	**1.56**	**2.55**	**0.53**
	TOTAL	**47167624**	**1365818**	**39904**	**450**	**2.90**	**2.92**	**1.13**	**0.85**

High Risk Areas for Indoor Residual Spray in 2010 with DDT

S. No	Name of the Districts	Populaton for Malaria	DDT Req. (MT)	Rounds	No. of Labour	No. of Days	Labour Rate (Rs. Per man Per day)	Total Labour Charges (in Rs.)
1	Aligarh	212360	31.85	2	60	150	100.00	900000
2	Kashiram Nagar	90000	13.50	2	24	150	100.00	360000
3	Hathras	350000	52.50	2	102	150	100.00	1530000
4	Mathura	70000	10.50	2	18	150	100.00	270000
5	Mainpuri	200000	30.00	2	60	150	100.00	900000
6	Etah	90000	13.50	2	24	150	100.00	360000
7	Firozabad	90000	13.50	2	24	150	100.00	360000
8	Bareilly	99388	14.91	2	30	150	100.00	450000
9	Badaun	142202	21.33	2	42	150	100.00	630000
10	Moradabad	101272	15.19	2	30	150	100.00	450000
11	J.P.Nagar	60791	9.12	2	18	150	100.00	270000
12	Bijnore	212347	31.85	2	64	150	100.00	960000
13	Kheri	125000	18.75	2	36	150	100.00	540000
14	Sultanpur	70000	10.50	2	18	150	100.00	270000
15	Gonda	50000	7.50	2	12	150	100.00	180000
16	Bahraich	70000	10.50	2	18	150	100.00	270000
17	Basti	50000	7.50	2	12	150	100.00	180000
18	Chandauli	70000	10.50	2	18	150	100.00	270000
19	Ghazipur	60000	9.00	2	18	150	100.00	270000
20	Mirzapur	723000	108.45	2	216	150	100.00	3240000
21	Sonbhadra	1038000	155.70	2	306	150	100.00	4590000
22	St.R.D.Nagar	115000	17.25	2	30	150	100.00	450000
23	Allahabad	667000	100.05	2	198	150	100.00	2970000
24	Fatehpur	180000	27.00	2	54	150	100.00	810000
25	Pratapgarh	32480	4.87	2	6	150	100.00	90000
26	Kanpur Nagar	100000	15.00	2	30	150	100.00	450000
27	Kanpur Dehat	200000	30.00	2	60	150	100.00	900000
28	Farrukhabad	350000	52.50	2	102	150	100.00	1530000
29	Kannauj	70000	10.50	2	18	150	100.00	270000
30	Jhansi	110360	16.55	2	30	150	100.00	450000
31	Jalaun	90000	13.50	2	24	150	100.00	360000

32	Lalitpur	162173	24.33	2	48	150	100.00	720000
33	Chitrakoot	100000	15.00	2	30	150	100.00	450000
34	Banda	110000	16.50	2	30	150	100.00	450000
35	Hamirpur	223000	33.45	2	66	150	100.00	990000
36	Mahoba	38118	5.72	2	12	150	100.00	180000
37	Bulandshahar	173000	25.95	2	48	150	100.00	720000
38	Saharanpur	190000	28.50	2	54	150	100.00	810000
39	Muzaffar Nagar	200000	30.00	2	60	150	100.00	900000
TOTAL		7085491	1062.82		2050			30750000

Areas for Focal spray

S. No	Name of the Districts	Labour	Total Transportation + Labour Charges (in Rupees)
1	**Agra**	6	50000
2	Pilibhit	6	50000
3	Shahjahanpur	6	50000
4	Rampur	6	50000
5	**Lucknow**	6	50000
6	Unnao	6	50000
7	Rae-Bareli	6	50000
8	Sitapur	6	50000
9	Hardoi	6	50000
10	**Faizabad**	6	50000
11	Ambedkar Nagar	6	50000
12	Barabanki	6	50000
13	Balrampur	6	50000
14	Shravasti	6	50000
15	**Azamgarh**	6	50000
16	Jaunpur	6	50000
17	Kaushambi	6	50000
18	Etawah	6	50000
19	Auraiya	6	50000
20	**Meerut**	6	50000
21	Bagpat	6	50000
22	Ghaziabad	6	50000
23	G.B.Nagar	6	50000
TOTAL		**138**	**1150000**

- **Early diagnosis and treatment**- Involvement of ASHAs and training of medicals and para medicals.
- **Vector Control** : Anti larval and anti adult measures and control of mosquitoes breeding by vector management. Main strategy for control of vector borne diseases is vector management
- Control conditions that promote mosquito breeding
- one week day- Saturday to be made dry day
- Larvicide- Temephos in open drains . Currently beimg implemented in 42 district of
- Two rounds of DDT – IRS in high risk districts as per guide lines of GOI
- DDT Focal Spray or Pyrethrum in other than high risk districts but having p.f. case
- Fogging by Malathion Technical at dusk and dawn- in dengue and JE/AES positive areas

- Public awareness- **before spraying and fogging operations and about precaution to make it successful.**

Innovations

- 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. As State is short of manpower and will have MPWs appointed only after 2 years, we have planned to involve ASHAs in malaria activity.

  GOI has approved involvement of ASHAs in 10 most malaria sensitive districts of Uttar Pradesh on pilot basis. Total incentive of Rs 69 lacs has been sanctioned for this activity. The activity can be extended further to other districts, based on the experience gained in the 10 pilot districts.

  For all 10 most malaria sensitive districts in Uttar Pradesh- ASHAs will be involved in making blood slides of suspected cases, considering incentives of Rs.5/- to ASHA per blood slide collection and total assistance remuneration to ASHA Rs.6900000/-.

  NVBDCP has also issued instructions for incentives to ASHA for high malaria endemic district in North Eastern states and hard core P.f. predominant states. It is requested to accept the proposal for involvement of ASHA in malaria surveillance and prompt treatment.

- **Cash assistance sanctioned from GOI for ASHA incentives— Rs.6900000/-**

Capacity Building

- Training of ASHAs in using Rapid Diagnostic Kits by Medical Officer Incharge of specified PHCs.
- Training of LTs of PHCs in identifying Malaria parasite by expert pathologist and LTs.
- Training of Health Workers and Supervisors in making solution of Insecticides and in using spray pumps and fogging machines by District Malaria Officers and Malaria Inspectors.
- The Medical Officer will also be made well conversent with equipments and with techniques and should know about precaution to be taken.

IEC /BCC Activities

- Health Education material to be supplied to ASHA and 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. Education about sanitation, proper drainage, getting all pits and other places of water stagnation filled up.

- Information, education and communication before spraying and fogging operation and about precautions to be taken to make it successful.

Commodity requirement for Malaria

Item	Technical Requirement	Stock available	Net requirement
Chloroquine Tablets	40000000	11664000	28336000
Primaquine 2.5mg	1500000	143000	1357000
Primaquine 7.5mg	2000000	10000	1990000
Inj. Quinine	1000	0	1000
Tab. Quinine	2000	1000	1000
Artesunate Sulphadoxine Pyremethamine Tabs	5000	0	5000 (in the state of U.P., P.f. resistance has been noticed in one districts namely Sonbhadra and to takely the P.f. resistence alternate drug i.e. ASP has been proposed.)
Tab DEC	280000000	50000000	230000000
Albendazole Tab.	115600000	0	115600000
DDT	1060 MT	705 MT	355MT
Malathion Technical	10 MT	0	10 MT
Temephos	10000 Litres	1500 Litres	8500 Litres
Pyrethrum	10000 Litres	275 Litres	9725 Litres
M.L.O.	35000 Litres	0	35000 Litres
ITN Bed nets	600000		600000 (for BPL families of Banda, Sonbhadra and other districts with high API)
Rapid Diagnostic Kits	1000000	0	1000000 (for Mainpuri and Hathras and other districts with high P.f. % having remote and inaccessible areas, labourer's settlement to be used by ASHAs who will be trained by M.O.s.)

Cash assistance required from centre and unspent balance available with state (Malaria)

Activities	Requirement (in Rs.)	Remark
BCC/IEC	1,41,45,000.00	All are Vector Borne Diseases which

		includes observation of Anti Malarial Month, Kala-azar fortnight and community awareness in AES/JE, Dengue & Chikungunya as well as intersectoral conversions and social mobilization in Lymphatic Filariasis.
ASHA Incentive	69,00,000.00	For 10 most malaria sensitive districts on pilot basis.
ASHA Training	**5,75,000.00**	**For 10 most malaria sensitive districts.**
Monitoring & Suprevision	**40,25,000.00**	**Improvement in monitoring & supervision at field level for affective implementation of malaria programme.**
Total Malaria	**2,56,45,000.00**	

Budget proposals from state share

(Figures in Rs.)

1	**Surveillance: (Block PHCs 823)**	
	Logistics (Chemicals, glasswares, stationery, glass slides, cotton swabls, spirit, disposable pricking needles etc.)	
	230 PHCs of highly endemic 20 districts	
	Rs. 10000 per PHC	2300000.00
	593 PHCs of ramining 51 districts	
	Rs. 5000 per PHC	2965000.00
2	**Vector Control**	
	Spray wages for DDT 1060MT	31800000.00
	Space spray Pyrethrum 2% ext.	
	Cost of K.Oil	1900000
	Malathion Technical Fogging	
	for 15 MT operation cost	6650000
3	**Monitoring and Evaluation**	
	Mobility 20 distt. @ Rs.20000/- per districts	400000
	Monitoring and evaluation mobility 51 districts @ Rs.10000/- per districts	510000
4	**Sonbhadra package**	

	District Sonbhadra is most affected district having tribal population and inaccessible areas. It needs special attention	
	ITN Bed nets 100000	10000000
	Rapid Test Kits 20000	1000000
Total State Share		**Rs.5,75,25,000**

B. FILARIA

☞ **Proposed date of M.D.A. 11th November, 2010**

Situational Analysis

Year	Cases	Mf Positive
2004	7999	1088
2005	7613	619
2006	5738	725
2007	5791	637
2008	5134	477
2009	2815	452

Filaria is endemic in 50 districts with present M*f* rate 1.50%. The great challenge is to eliminate filarial and to bring down M*f* rate less than 10%.
The state has 29 Filaria Control units and 31 Filaria Clinics. These institutions were implementing the National Filaria Control Programme in the specified area of urban localities. The activities of National Filaria Control Program are-

- Anti larval operations
- Detections 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 2 selected districts namely Varanasi and Gorkhpur of U.P., which is now being scaled up in all 50 endemic districts.
GOAL -As per national health policy-2002 the national goal for elimination for lymphatic filariasis has been set for the year 2015.

Specific constraints for 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 diseases cases increasing to manifolds. No method for detecting the parasite at early stage of infection.

Resources are inadequate and insufficient due to 29 Filaria Units and 02 Filaria Clinics.

- MDA is expected to be successful. Intensive Health Education and intersectoral co-operation is needed.

Priority Districts--50districts- Gorakhpur, Maharajgunj, Deoria, Kushi Nagar, Basti, St.Kabir Nagra, Siddharth Nagar, Azamgarh, Mau, Ballia, Varanasi, Chandauli, Ghazipur, Jaunpur, Mirzapur, Sonbhadra, St.Ravidas Nagar, Faizabad, Ambedkar Nagar, Sultanpur, Barabanki, Bahraich, Shravasti, Gonda, Balrampur, Allahabad, Kaushambi, Pratapgarh, Fatehpur, Banda, Chitrakoot, Mahoba, Jalaun, Hamirpur, Kanpur Nagar, Kanpur Dehat, Etwah, Auraiya, Farrukhabad, Knnauj, Bareilly, Pilibhit, Shahjahanpur, Rampur, Lucknow, Rae-Bareli, Unnao, Hardoi, Kheri, Sitapur.

Criterion of prioritization- high Mf rate

Strategy and Innovations proposed

- Meeting at State H.Q.- Of district programme officers, annually.
- Meeting at district level- Under chairmanship of DM with other departments
- Training- drug distributor and other staff involved in preparing slides
- Identification of volunteers/ Drug distributors
- Composition of Rapid Response Team
- Preparation at village and sub-centre level by involving NRHM institutions like- Village Health and Sanitation Committee and Rogi Kalyan Samittees.
- Media sensitization at district and block level
- IEC activities at local level

Requirement for commodity from GOI

The total requirement for the population of 115540608 in 50 filaria endemic districts is given below—

Sr No.	Requirement	Amount
1	DEC tablets	280000000
2	Albendazole Tablets	115600000

Cash assistance required from centre and unspent balance available with state

S. No.	Activity Proposed	Amount Approved	Remark
1	Capacity building at state, district and PHC level of Medical & Paramedicals for MDA	70,96,000.00	Training at state level- 50000, Training of MOs-1763104 Training of Para Medicals- 5282896
2	Micro Filaria Survey, Mobility support & Morbidity Management	77,35,000.00	Night Survey – 2350000 POL/ Mobility- 2795000 Morbidity Management- 2590000

3	Sensitization & Honorarium to Drug Distributors including Supervisors	4,42,75,000.00	Training of Drug Distributors-10775000 Honorarium to Drug Distributors- 30000000 Honorarium to Supervisors- 3500000
TOTAL		**5,91,06,000.00**	

Details

District level officers training	Rs.50000
IEC *(funds provided under MALARIA IEC/BCC Activity)*	Rs.14145000
MDA Assessment through Medical Colleges / ICMR institutions	0
POL/ Mobility	0
District Level Activities	
IEC including DCC meetings sensitization	Rs.12500000
Training of MOs including Govt. and Pvt. Doctors	Rs.1763104
Training of Paramedical staff at PHC HQ	Rs.5282896
Night Blood Survey	Rs.2350000
POL/ Mobility	Rs.2795000
Training of Drug Distributors	Rs.10775000
Honorium to Drug Distributors	Rs.30000000
Honorium to Drug Supervisors	Rs.3500000
Morbidity Management this includes line listing and mapping, hydrocele operation and demonstration of home based management	Rs.2590000
TOTAL	**Rs.73251000**
Unspent balance	Rs.3100000

C. KALA-AZAR

Situational Analysis of Disease

Kala-azar is endemic in 10 districts of Eastern U.P. bordering Bihar State. Among these 4 districts are hyper endemic i.e. KushiNagar, Deoria, Ballia, Varanasi. The principles of elimination are anti adult measures and complete treatment of the patients. The disease is not detectable at early stage and patient are not able to get treatment at right time. Incubation period is very long.

Year	Cases	Deaths
2004	36	2
2005	68	2
2006	83	0
2007	69	1
2008	26	0
2009	17	1

The cases are sporadic in 18 villages of 4 hyperendemic districts covering 12 PHCs. Details are mentioned in the table given below-

S. No.	Districts	Total PHCs	KA Affected		
			PHCs	Villages	Names of PHCs
1	Deoria	15	2	2	Bankata Bhapaparrani
2	Kushinagar	14	4	7	Ramkola, Fajil Nagar, Dudahi, Kubernath
3	Ballia	17	2	4	Reoti, Dubahar
4	Varanasi	8	4	5	Kashividdyaphit ,Chiraigaoe, Harhua, Cholapur
TOTAL		**54**	**12**	**18**	

Specific Constraints for implementation of Programme

- The disease has long incubation period and not detectable in early stages.
- The economical, simple to perform and reliable kits(RK-39) not available.
- The disease mainly affects people living in lower socioeconomic status ,who live in kachcha houses which is a favourable breading site for vector.

Priority Districts-4 districts bordering Bihar-Kushinagar, Deoria, Ballia and Varanasi.

Criterion of prioritization- High case detection

Strategy and innovations proposed

Early detection and treatment

- rK-39 kits for early case detection
- Complete treatment of cases in PHCs/CHCs
- Active surveillance- convergence with IDSP

IEC/BCC-

- Kalazaar fortnight is being observed in hyperendemic district.
- The poor people to be educated that their wages will be compensated in case they are admitted and get injections out door.
- Public awareness before spraying operations and about precaution to make it successful.

Vector control-

- DDT-IRS spray as per GOI norm

Capacity building:

- Training of Health Workers and Supervisors in case detection, 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.

Requirement for commodity as per technical norms

S. No	Name of District	Population	Name of Items			
			rK-39	SSG Inj. (vials)	DDT 50% (in MT)	Wages for spray (in Rs.)
1	Varanasi	100000	150	150	15	292500
2	Deoria	300000	450	100	45	585000
3	Ballia	180000	300	300	27	585000
4	Kushi Nagar	300000	450	150	45	253500
TOTAL		**880000**	**1350**	**700**	**132**	**1716000**

Net Requirement considering Balance-

Sr. no.	Item	Technical requirement	Available	Net Requirement
1	rK-39	1350	00	1350
2	**Inj. SSG**	700 vials	875 vials	nil
3	**DDT**	132MT	100MT	32 MT
4	**Tab.Miltefosine**	19,600	nil	19,600

Cash assistance required from centre and unspent balance available with state

(Figures in Rs.)

Sr. no.	Activities	Cash assistance
1	Spray wages	1716000
2	Kala-azar survey	348000
3	Kala-azar fortnight campaign*	980000
4	BCC/ ICC	1956000
Total		**5000000**

Details of Survey campaign in Kala-azar hyperendemic districts on Kalazaar fortnight

S. No.	*Activity Particulars*	*Amount per PHC (Rs. Lakh)*	*No. of PHCs*	*Total Amount (Rs. Lakh)*
1	*Camp Organization (Tent, furniture, mike ets.)*	*0.4*	*12*	*4.8*
2	*Mobility for camp*	*0.02*	*12*	*0.24*
3	*Contingency*	*0.4*	*12*	*4.8*
4	*(Stationary & misc. items)*			
TOTAL				***9.84***

D. JAPANESE ENCEPHALITIS/A.E.S.

The disease is prevalent in 34 districts in Uttar Pradesh. In Eastern region of U.P., Districts of Gorakhpur, Basti, Azamgarh, Devipatan divisions and in western region, districts of Saharanpur division are affected. Approximately 90% of cases are reported from rural and periurban areas of these districts. The present death rate due to the disease is 20% as is evident from the following table-

A. Situation Analysis of the disease-

Year	Cases	Deaths
2004	**1030**	**228**
2005	**5581**	**1593**
2006	**2075**	**476**
2007	**2675**	**577**
2008	**2730**	**483**
2009(upto 31st Dec.)	**3061**	**555**

After vaccination of children of 1-15 years age group, the JE cases declined considerably but the number has started increasing from 2009.

B. Strategy and Innovations proposed

- **Early diagnosis and treatment-** Early Diagnosis and prompt treatment will be ensured by strengthening the diagnostic facilities in 15 district labs of highly sensitive districts & HQ lab., each of which will be equipped with one ELISA reader, deep freezers, and supplementary material. District of Gorakhpur division contribute maximum number of cases. The reduction in mortality will be ensured by arranging adequate amount of medicines in all treating centers in the JE sensitive districts. Gorakhpur, kushinagar and Deoria are already having ventilators. These ventilators will be made fully functional.

- **Vector Control-** Antivector measures will be exercised by undertaking fogging operations in villages of highly affected PHCs for which 10 MT Malathion technical will be required.
  The vector is of exophagic and exophilic in nature, the high density built up of population and house/ human dwelling inward movement of vector species may increase the risk of disease transmission during rainy period, hence indoor residual spray(IRS) with Malathion 25% wdp will be done in the rural population assuming 50 houses coverage in each case. The spray will be done in two rounds in 14 JE sensitive districts of 45 days each i.e. first round starting from June 15th to July 31st, 2010 and second round from August 1st to September 15th.

- **IEC/BCC**- IEC will be done in AES/JE affected districts to change the behaviour of the public for ensuring treatment at nearby state government hospital/treatment centers without a delay, isolation of pigs, away from human habitation or wire gauging / screening of piggeries and protection from mosquito bites . The AES/JE affected districts will require funds for IEC/BCC as mentioned below.

Sr. No.	Districts	Rate/Unit	Amount required
1	For JE sensitive districts(14)	@ Rs.100000/district	14.00 lacs
2	For rest of the JE affected districts(20)	@ Rs.50000/districts	10.00 lacs
3	Total (34 districts)		24.00 lacs

- **Rehabilitation Centres** for the treatment of physically handicap patients has been established at Gorakhpur.

- **Sentinel Surveillance Labs-** Strengthening of already functioning Sentinel Surveillance Labs.
- Strengthening of treatment facilities at periphery.
- For strengthening of surveillance, diagnosis and treatment facilities etc GOI has sanctioned Rs.17.25 lacs.

- **Establishment of epidemic ward** - Epidemic Ward is functioning at BRD Medical College, Gorakhpur. Viral research Centre, Pune's field unit has been established at BRD Medical College, Gorakhpur.
- **Vaccination of children 1 to 15 years with SA-14-14-2 vaccine** - J.E. vaccination had been done in affected districts. Nodal Centre is established at D.G. Medical and Health
- Ensuring safe drinking water supply and sanitary latrine in affected communities.
- **Supervision and monitoring** –
  As directed by GOI last year, State has designated a separate Programme officer for AES/JE in the State. State cell comprises of Director, AES/JE and Joint Director, AES/JE.
  Core committee for supervision and monitoring will be constituted this year which comprises of–
  Chair man- DG Medical & Health Services
  Member 1- Director, AES
  Member 2- Director, Medical Care
  Member 3- Joint Director, AES/State Programme Officer JE
  The budget of 9.2 lacs has been sanctioned for monitoring and supervision of AES/JE.

- **Capacity Building –**To enhance the skills of treating physicians GOI has sanctioned Rs. 8.05 lacs .

C. Specific Constraints for implementation of Programme

- Disease affected districts mainly practice paddy cultivation as means of livelihood due to which exophylic and exophagic vector mosquito species of the disease JE get widespread breeding sites and institution of anti-vector control operations is very difficult. Larvivorous fish hatcheries & rearing not properly managed by the local people.
- The pigs are also means of livelihood of poor communities and three pigs acting as amplifying host. Hon'ble High Court has instructed to remove piggeries from human habitation, but the concerned department so far could not comply the orders of the Hon'ble Court. Moreover, veterinary based sero-surveillance of reservoir as well as amplifying host is lacking.
- The ardied birds, which are reservoir of JE virus, also prevalent in the area.
- Transmission cycle of complex nature.The treatment facilities available at district hospitals, CHCs & PHCs are not fully utilized by the public due to lack of confidence & faith, arisen by the severity of the disease.
- Inadequate human resource at different levels.
- Delayed reporting of the seizures at treatment centres i.e. hospitals, CHCs & PHCs.
- Shortage of vehicles required for mobility of staff for undertaking intervention measures, surveillance, monitoring, supervision etc.

Budget Proposal for year 2010-11

		(Rs. In lakhs
S. No.	**Activities**	**Amount**
Budgetory support under Mission Flexipool (Part-B)		

1	14 Sentinel Surveillance labs. (Equipments etc. for labs.)	
a.	Computer (one each at sentinel lab and HQ) @ 30000/- per unit	4.50
b.	Data Operator (one each at sentinel lab and HQ) @ 7500/- per month	13.50
c.	Elisa Reader @ 4.00lakh (for 14 sentinel lab and HQ)	60.00
d.	Deep freezers @ Rs.3.00lakh for 14 labs (one each at sentinel lab and HQ)	42.00
e.	Consumable @ Rs.30000/- for 14 sentinel labs and HQ	4.50
2	Vaccination	
a.	Honorarium for 15303 ASHA for enumeration of children @ Rs.500/- per ASHA	76.52
3	Anti Vector measures for (8.5lakh population)	
a.	Diesel for fogging	72.00
b.	Labour Wages	4.25
	Sub-Total	**277.27**
Budgetory Support under National Disease Control programe (Part - D)		
4	Strengthing of Surveillance Treatment facilities	12.60
5	Strengthing of Surveillance diagnosis JE lab facilities	4.65
6	Capacity building / Traiging	8.05
7	Monitoring and Supervision	9.20
	Sub Total	**34.50**
	GRAND TOTAL	**311.77**

- Rs. 34.50 lacs approved by GoI in JE/AES section—For strengthening of surveillance, diagnosic & treatment facilities (17.25 lacs), capacity building (8.05 lacs) & monitoring and supervision 9.20 lacs.
- Rs. 24.00 lacs for IEC/BCC approved with Malaria Programme.
- Rs. 277.26 lacs approved under Mission Flexi-pool for strengthening of surveillance units, diagnostic & treatment facilities.

E. DENGUE/ CHIKUNGUNYA

Dengue Situation analysis

Year	Cases	Death
2001	21	0
2002	2	0
2003	738	8
2004	8	0

2005	121	4
2006	639	14
2007	131	2
2008	51	2
2009	162	2

In 2003, 738 cases of dengue and 08 deaths were reported of which maximum number of cases reported from Ghaziabad district (272) followed by Lucknow (248), Kanpur (105). In 2004 only 08 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 number of affected districts were Lucknow(186 cases and 03 deaths), G.B.Nagar (86 cases and nil death), Ghaziabad(66case and 01 death). Similarly in 2007, total 131 cases and 02 deaths were reported. Month-wise analysis of the Dengue cases reported during the last three years (2005-2007) has revealed that transmission of this disease takes places throughout the year, in the Year 2008, 51 cases & 2 deaths and in 2009, 161 cases & 02 deaths are reported.

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. S.N. Medical College, Agra
8. GSVM Medical College, Kanpur
9. CSMMU, Lucknow
10. Distt.Hospital, G.B.Nagar(Proposed)

Specific Constraints for implementation of Programme

- The disease tends to follow seasonal pattern i.e. the cases peaking after mansoon and it is not uniformaly distributed over the years.
- The factors contributing the transmission of the Dengue is mainly rapid urbanization, lifestyle 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 number of cases.
- 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.

Chikungunya
Situation analysis

During 2006 the state has reported only 4 cases of Chikungunya ,out of which 3 were reported from Jhansi districts and 1 was from Kanpur district. Similarly, in 2007 also 4 imported cases (Native of Kerala state) were reported by SGPGI, Lucknow.

Specific Constraints for implementation of Programme

- 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.

Priority Districts- National Capital Region districts-Ghaziabad and Gautam Buddha Nagar.

Criterion of prioritization – High case detection rate

Strategy and innovations proposed (Dengue/Chikunguniya)

Training

- Training of Medical Officers in diagnosis and management of Dengue by Physician
- Training of Medical Officers in performing Tourniquet Test by Physician
- Training of L.Ts in doing platelet count
- Total amount sanctioned from GOI is Rs. 4.35 lacs for trainings/workshops.

IEC social mobilization (Budget sanctioned common for all VBDs)

- Educating public for seeking treatment from hospitals if patient has fever, bodyache, rashes, bleeding or shock.
- Educating public to observe one day a week , Saturday as Dry Day.
- **Information, Education and Communication before spraying and fogging operations and about precautions to make it successful.**

Sensitisation of Village Health & Sanitation Commitees

- Sanitation and keeping control on mosquitoes breeding 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 desilting and correcting the gradient, filling the pits.

- To arrange health education camps, discussions and fairs. To display health education material at proper places.
- To pay spray wages: about Rs.5000/- per year per village.
- To pay remuneration to ASHAs for making blood slides.: maximum Rs.500/- per annum to one ASHA.(as given in malaria section)
- To remove piggeries or to keep these covered by wire screen and get cleaned and disinfected.
- Information, Education & communication before spraying and fogging operations and about precaution to make it successful.

Strengthening of sentinel Surveillance Labs-

- Immediate testing and reporting positive cases immediately to concerned CMO.
- The Joint Hospital Noida to be developed as sentinel Surveillance Hospital.

Requirement for commodity from GOI

Ig M ELISA Kits of Dengue and Chikungunya to all 10 sentinel Labs.

Cash assistance required from Centre and unspent balance available with state

(Figures in Rs.)

1	**Apex Referral Lab @ 1.00lakh**	**100000**
2	10 Sentinel Surveillance Hospital @ Rs.50,000/-	500000
3	Monitoring and evaluation and Rapid Response @ Rs.80,000/- for 43 districts	From NRHM additionality
4	Epidemic preparedness (logistic and operational cost)	2760000
5	Fogging machines 15 @ 40,000/-	0
6	Training Workshop	435000
TOTAL		**3795000**
Unspent Balance		1480000

Expenditure (Financial Performance) - Budget Proposal

(Rs. in lakhs)

	2009-10 (Expenditure)	**2010-11 (Proposed)***	**Support to be met from NVBDCP/GoI or state resources or NRHM flexi fund**
Malaria			
DBS	**Rs. 2300000**	**Rs.4400000**	GOI
MPW			
ASHA			
Operational Cost including spray wages(IRS)			
Spray wages(IRS)	0	Rs. 3,18,00,000.00	State Resources

Fogging	0	6650000	State Resources
Space spray (pyrethrum)	0	1900000	State Resources
NAMMIS	0	Rs. 36,00,000.00	GOI
IEC,BCC &PPP(DBS)	Rs. 20,00,000.00	Rs. 20,00,000.00	GOI
Training(DBS)	Rs. 3.,00,000.00	Rs. 24.,00,000.00	GOI
Additional support under World Bank (if applicable)	NA	NA	
Human Resource			
Capacity building in project areas			
Mobility support			
Additional support under GFATM (if applicable)	NA	NA	
Capacity Building			
Establishment State Society			
Human Resource			
Monitoring & Evaluation			
BCC/PPP/Soc.Mkt.			
Drugs			
Chloroquine phosphate tablets	29492000 tablets	28400000 tablets	GOI
Primaquine 2.5 mg tablets	1733000 tablets	2000000 tablets	GOI
Primaquine 7.5 mg tablets	171000 tablets	1350000 tablets	GOI
Quinine sulphate tablets	1000 tablets	5000 tablets	GOI
Quinine Injections	500 vials	1000 vials	GOI
Artisunate+Sulphadoxine + Pyremethamine tablets	2752 tablets	5000 tablets	GOI
Diagnostics			
Rapid diagnostic kit	0	**Rs.**1000000	State resource
Survillance	0	**Rs. 5265000**	State resource
ASHA Incentive	0	Rs.69100000	GOI
IRS			
Monitoring & Evaluation	0	**Rs.**910000	State resource
Bednet			
Impregnated mosquito nets	0	**Rs.100**00000	State resource
LLIN	0	0	
Insecticides			
DDT 50% wdp	220 M.T.	460 M.T.	GOI
Synthetic Pyrethroid	N.A.	4.5 M.T.	State Resources
Malathion 25%/Technical	20 M.T.	10 M.T.	GOI
UMS – Larvicides			
For polluted water (M.L.O.)	N.A.	35000 Litre	GOI
For non-polluted water (Temophos)	3450 Litre	8500 Litre	GOI

Pyrethrum extract 2%	2000 Litre	9725 Litre	GOI
Total Malaria	**Rs. 23,00,000.00**	**Rs. 139025000**	
Filaria			
State level –			
Training of district level officers at state head quarter	**Rs.**50000	**Rs.**50000	GOI
IEC		**Rs.**1250000	GOI
MDA assessment by medical colleges /ICMR institute @ 9000/dist	0	Rs.450000	GOI
POL/Mobility	0	Rs.250000	GOI
District level-			
IEC	**Rs.**12500000	**Rs.**12500000	GOI
Training of MO including govt & private doctors	**Rs.**1646375	**Rs.**3000000	GOI
Training of paramedical staff	**Rs.**2493410	**Rs.**2500000	GOI
Night blood survey	**Rs.**1600000	**Rs.**2350000	GOI
POL/mobility	**Rs.**1444000	**Rs.**2500000	GOI
Training + honorarium of drug distributors	**Rs.**44816147	**Rs.**45000000	GOI
Honorarium to supervisors	**Rs.**2801000	**Rs.**3500000	GOI
Morbidity management	**Rs.**800000	**Rs.**2000000	GOI
Drugs (by GoI) DEC100mg	225792882 tablets	230000000 tablets	GOI
Albendazole	0	115600000 tablets	GOI
Total (Filaria)	**Rs. 68150932**	Rs. 75350000	
Dengue/Chikungunya			GOI
Grant in respect of Dengue and Chikungunya Strengthening surveillance (As per GOI approval) ➢ Apex Referral Labs recurrent @ Rs/ 1.00 lakh ➢ Sentinel surveillance Hospital recurrent @ Rs. 0.50 lakhs	100000(apex referral lab)500000(10 sentinel surveillance hospital)	100000(apex referral lab)+500000(10 sentinel surveillance hospital)	GOI
Monitoring/Supervision and Rapid Response	2150000	2150000	GOI
Epidemic Preparedness/social mobilization(logistics +operational cost)	2000000	2000000	GOI
Fogging machine	0	480000	GOI
IEC			
Training/Workshop	500000	500000	GOI
Total Dengue/Chikungunya	**Rs.** 4750000	**Rs.** 5730000	GOI

JE			
14 Sentinel Surveillance labs. (Equipments etc. for labs.)			
Computer (one each at sentinel lab and HQ) @ 30000/- per unit		450000	GOI
Data Operator (one each at sentinel lab and HQ) @ 7500/- per month		1350000	GOI
Elisa Reader @ 4.00lakh (for 14 sentinel lab and HQ)		6000000	GOI
Deep freezers @ Rs.3.00lakh for 14 labs (one each at sentinel lab and HQ)		4200000	GOI
Consumable @ Rs.30000/- for 14 sentinel labs and HQ		450000	GOI
Misc. contingencies @ 20000/- for 14 sentinel labs and HQ		300000	GOI
BCC/ IEC activity		2400000	GOI
Vaccination			
Logistic support for 8 distt. Totally by GOI			
Honorarium for 15303 ASHA for enumeration of children @ Rs.500/- per ASHA		7652000	GOI
Contingency @ Rs.20/- per ASHA		350000	GOI
Data entry for survey of 1-15 years children @ Rs.0.50 / entry		340000	GOI
Anti Vector measures for (8.5lakh population)			
Diesel for fogging		7200000	GOI
Labour Wages		4250000	GOI
Insecticide for IRS		25500000	GOI
Fogging Machines (150 small portable)		10700000	GOI
Malathion Technical 10 MT		1900000	GOI
Total JE		**Rs76950000** 73042000	**GOI**
Kala-azar (only for 4 states)			GOI
Kalazaar forte night campaign	**Rs.980000**	**Rs.980000**	
IRS(DDT)	27MT	27MT	GOI
SSG	700vial	0(875 vial balance)	GOI
Amphotericin-B	00	0	GOI
Miltefosine	0	19600 tabs	GOI
RK39	0	1500	GOI
Lab strengthening	0	0	GOI
Case search **(Kalazaar survey)**	**Rs.**348000	**Rs.**348000	GOI
Spray Pumps			GOI
Operational cost	**Rs.**1716000	**Rs.**1716000	GOI
Mobility & supervision	0	0	GOI
Capacity building	0	0	GOI

IEC/BCC	**Rs.**1956000	**Rs.**1956000	GOI
Monitoring & evaluation	0	80000	GOI
Kala-azar Total	**Rs.** 5000000	**Rs.** 5080000	
Grand Total		**Rs. 193296000**	

*** Any activity not listed and if required may be shown in separate row.**

Outstanding balance…20.34 lakhs. (as on previous month of submission of PIP).
Committed expenditure ……nil…….. (till March, 2010).
Balance expected…20.34 lakhs (on 1.04.2010).
This is most important as cash releases are based on the funds availability with state in totality and not head wise**.**

EXECUTIVE SUMMARY

In the state Uttar Pradesh vector borne diseases are major public health problem. Malaria in endemic in 71 districts.

- Filaira is endemic in 50 district viz; Gorakhpur, Maharajgunj, Deoria, Kushi Nagar, Basti, St.Kabir Nagra, Siddharth Nagar, Azamgarh, Mau, Ballia, Varanasi, Chandauli, Ghazipur, Jaunpur, Mirzapur, Sonbhadra, St.Ravidas Nagar, Faizabad, Ambedkar Nagar, Sultanpur, Barabanki, Bahraich, Shravasti, Gonda, Balrampur, Allahabad, Kaushambi, Pratapgarh, Fatehpur, Banda, Chitrakoot, Mahoba, Jalaun, Hamirpur, Kanpur Nagar, Kanpur Dehat, Etwah, Auraiya, Farrukhabad, Knnauj, Bareilly, Pilibhit, Shahjahanpur, Rampur, Lucknow, Rae-Bareli, Unnao, Hardoi, Kheri, Sitapur.
- Kala-azar is endemic in 04 districts viz; Varanasi, Deoria, Kushi Nagar and Ballia.
- AES including JE is endemic in 28 districts
- Dengue is endemic in 39 districts

The requirement for programme implementation has been indicated in detail and the summary is indicated below :

(Rs. In lakhs)

Disease	Cash assistance from GOI	Balance from previous years	Committed expenditure	Net requirement (approved in PIP)	State resources
Malaria					
a. DBS	256.45	0	0	256.45	575.25
b. World Bank for project states	-	-	-	-	-
c. GFATM for project states	-	--	-	-	-
Filaria	622.06	31.00	0	591.06	0
Kala-azar	63.16	13.16	0	50.00	0
AES including JE	34.5	0	0	34.5	0

Dengue/ Chikungunya	52.75	14.8	0	37.95	0
Total	**1028.92**	**58.96**	**0**	**969.96**	**575.25**

National Iodine Deficiency Disorder Control Programme (NIDDCP)

A. BACKGROUND

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 54 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).

B. MAGNITUDE OF THE PROBLEM IN UP

- National Goitre Control Programme launched in 1966. (only in Uttarakhand districts)
- Out of 71 districts 54 districts are surveyed in a phased manner and 24 districts are endemic.
- Govt. of U.P. under P.F.A.Act has banned entry of uniodised salt from 2nd Oct.1987.
- In 1992 programme was renamed as National Iodine Deficiency Disorder Control Programme.

C. GOALS & OBJECTIVES OF STATE NIDDCP

- To bring down total Goitre rate (TGR) less than 10%
- To ensure 90% household consume Iodised salt by 2012. (15ppm Iodine at consumer level) (Presently 77% of the households are consuming Iodised salt, only 36% households use adequately iodised salt).
- Supply of Iodised salt through Public Distribution System

D. COMPONENTS OF THE PROGRAMME

- **Surveys** to assess the magnitude of the Iodine Deficiency Disorders.
- **Supply of Iodised salt** throughout the state to be ensured.
- **Resurvey after every 5 years** to assess the extent of Iodine Deficiency Disorders & the impact of Iodised salt.
- **Laboratory monitoring of Iodised salt**.
- **Health, Education & Publicity**.

E. PRESENT STATUS

- **Surveys** conducted in last 3 years of 13 Distt. show some very encouraging results.
- Goitre rate is coming down below 10% in children aged 6-12 years.
- The **availibilty & consumption of Iodised salt** by the community is on increase.
- **Salt Supply has also increased as mentioned in the table-**

Year	Allotment (Tonnes)	Supply (Tonnes)
2007-08	933034	753277
2008-09	777528	677934
2009-10	777528	389261(till Aug, 09)

Note: - For 2009-10 reports up to Aug. 2009 is available as it is send by Salt Commissioner, GOI.

- **IEC Activities of 2009-10**
  - 344 Salt Traders of U.P. identified
  - Workshop of Salt Traders organized on 19-12-2009
  - IDD day meeting on 21st Oct. in all 71 Distt.
  - Awareness workshop with Unicef organised by Kalyani,Doordarshan & talk on IDD on AIR
  - Involvement of PRI in the programme

- **Salt Monitoring at District Level**

Year	Total Samples	>15 ppm	<15 ppm	<15 ppm %
2007-08	13817	11364	2453	17.76
2008-09	33248	20919	12329	37.81
2009-10	12006	8452	3554	29.60

- **State Public Analyst (PFA ACT)**

Year	Total Samples	>15 ppm	<15 ppm	<15 ppm %
2007-08	1155	1139	16	1.39
2008-09	843	832	11	1.31
2009-10	564	558	06	1.07

- **Salt Monitoring- IDD LAB**

Year	Total Samples	>15 ppm	<15 ppm
2007-08	44	44	0

2008-09	64	64	0
2009-10	31	31	0

F. MAJOR BOTTLENECKS IN IMPLEMENTATION

- Budget is not released in time.
- There is no provision of budget for the Distt.
- There is a need of completion of IDD surveys & resurveys in the Distt.
- Posts under IDD Cell & IDD Lab have to be filled.
- Intensive Training of Medical & Paramedical personnel is necessary.
- Awareness workshops at various level could not be held due to unavailibility of funds.

G. STRATEGY FOR YEAR 2010-11

I. IEC PLAN

IEC activities are the main stay for NIDDCP.

- IEC material is to be printed in form of Tin plates, Hoardings, Printed publicity materials such as Folders, Stickers, Pamphlets etc. This material will have all the information regarding the programme & importance of usage of Iodised salt to prevent Iodine Deficiency Disorders.
- Field Testing Kits serve two purposes. One is testing the salt & the other is to create awareness among people to use Iodised salt only.
- Main emphasis will be on rural population which uses crystal salt after washing it. This practice is to be stopped.
- Multi sectoral approach will be adopted for IEC activities.
- Grass root level workers such as ANMs, Anganwadi & representative of PRI will promote usage of Iodised salt at village level. They will also ensure availability of Iodised salt to the remotest village of the state.
- They will also promote usage of Iodised salt in all the village level meetings.
- MO/ ICs are instructed to promote usage of Iodized salt in every block level meetings.
- Side by side the workers will test the salt samples by FTK at village level & report it to CHCs & PHCs.
- Gram Pradhans will be provided with all the IEC material & will make sure that only Iodised salt is sold in their village.
- PRI personnel & grass root level workers will be trained about the programme by State Institute of Rural Development. SIRD has submitted a project regarding training of PRI to UNICEF. Training will start soon.
- NGO & Medical Colleges support will be taken in IEC activities.
- Each ANM is instructed to test 10 samples per month.
- Various level workshops are proposed at district, CHC, PHC level.

II. MIS PLAN

- For monitoring the programme proforma has been developed.
- ANMs, Anganwadi & PRI will test the samples & do the IEC activities & report it to MO/ Ic,Supdt. of PHC & CHC every month.
- MO/ Ic & Supdt. will compile the report,review & discuss in monthly meetings & send it to Addl.CMO (Immunization, who is nodal officer for IDD at district level) of the district.
- Addl.CMO will review the report & compile it & finally send it to State Health Institute.
- CMO will also review the programme in the monthly meeting & give the feed back.
- SHI will review the programme every month & send report of the total state to D.G. & Dir.NRHM.
- Finally the programme will be reviewed by Director NRHM & GOI.
- Work done by NGOs & Medical Colleges will be reviewed by the programme officer & their activities will be reviewed from time to time.

III. MONITORING & EVALUATION PLAN

MIS plan for all 71 districts of U.P.

Level	Person Responsible	Responsibilities
Village:	ANM, Anganwari, PRI	• Conduct testing of salt in the village (10 samples /month from pregnant women, mother of infants & households • IEC activities
Block	MO I/c of PHC/Sup. Of CHC	• Data compilation • Discussion in monthly meeting
District	Additional CMO(IMM) in coordination with Food Inspectors	• Compilation of reports • Feed back to traders through Food Inspectors & DSOs • Coordinating committee every six months
State:	IDD Cell, SHI, Luck now with State NGOs, Medical Colleges & ICDS	• Review reports

H. EXPECTED OUTCOME

- Able to control prevalance rate below 10% by 2012.
- More & more use of Iodised salt by the society.

- 90% of the households will use Iodised salt by 2012.
- Effective salt monitoring at various levels.
- Effective implementation of distribution & sale of Iodised salt under PFA.
- Awareness generation among people & demand creation for Iodised salt.
- Multisectoral envolvement in the programme.

I. BUDGET PROPOSAL FOR YEAR 2010-2011

I. Establishment of IDD Control Cell

- Post of Technical Officer, S.A., L.D.C., L.T. & L.A. are to be filled on contractual basis as advised by Dr.B.K.Tiwari, Advisor (Nutrition) GOI during 08-09.
- Presently staff of SHI is working in this programme. Amount of Rs.6,00,000=00 is allocated by GOI for the salary & allowances of the staff for the year 2010-11.

II. Establishment of IDD Monitoring Lab

- For the maintenance & purchase of lab equipments for the state lab budget an amount of Rs.3.50 lac is allocated by GOI for the year 2010-11.

III. Survey

- In 2010-11, 5 districts are to be surveyed & Rs. 50,000=00 / distt. is allocated.
- These surveys will be conducted by Medical Colleges of U.P.
- Therefore Rs.2,50,000=00 is allocated for surveys in 2010-11.

IV. Health, Education & Publicity

- On 21st Oct., IDD Day will be celebrated in Lucknow (State level) for which Rs.50,000=00 is proposed.
- IEC activities are the main stay of the programme.
- For the year 2010-11 Rs.12,00,000=00 is sanctioned from GOI for printing of various IEC materials.
- To create awareness among general public it becomes necessary to print these IEC material. These are to be distributed & display at CHC's, PHC'c, Anganwadi Kendra, Block.
- Iodine in salt will be tested at the consumer level through FTK. This is a very good tool for awareness creation & monitoring. For ASHA GOI has already allotted the kits & entry permit is to be issued by the State Govt.
- Strengthening IEC activities through AIR,Doordarshan,Print Media etc.

Summary of Proposed Budget for 2010-2011(GOI Allocation)

(Figures in Rs.)

S N	Activity	Amount Proposed
1	Establilshment of IDD Control cell	**600000.00**
2	Estb. & Maintenance of IDD Lab	**350000.00**
3	• Health Education & Publicity • Salt testing supplied by GOI(5,68,000No)	**1200000.00**
4	Survey	**2.50000.00**
5	**Total Amount**	**2400000.00**

The budget sanctioned from GOI for the year 2010-11 is Rs. 24 lacs.
Note: ***The budget allocated by GOI under this programme is released through treasury route.***

J. HRD & TRAINING

The posts under IDD Cell & IDD Lab are to be filled on contractual basis as proposed by GOI.
All the Addl.CMOs (Immunization) who are also the nodal officer of the programme at Districts were trained in 2007-08 , therefore further training is required for new persons in position.

K. PROCUREMENT

Field Testing Kit for salt testing is required in the programme for monitoring of salt. This will be supplied by GOI. 7,10,000 kits GOI will supply for ASHA's. Road permit is awaited.
25,000 kits (one kit will be provided to each ANM) are to be procured. Kits will be distributed to grass root level workers of M&H.

L. ADDITIONAL FUNDS REQUIRED FOR IDD ACTIVITIES FROM NRHM

Background

NIDDCP is 100% funded by GOI. Govt. of India allocate budget for NIDDCP's activities under 4 heads which are already mentioned. In addition to money allocated in this programme by GOI, there are certain activities which cannot be performed from this budget. Hence if NRHM provides funds for organising these activities the programme will get a boost. It is proposed that selected activities be under NRHM for awareness generation & demand creation for usage of Iodised salt.

Issues

- Iodine Deficiency Disorders continue to be one of the major public health problems in India with around 200 million people estimated to be at risk.

Uttar Pradesh with a population of 190 million is known to be at risk & no district in the state is reported to be free from IDD.

- Iodine deficiency can be prevented by using salt that has been fortified with Iodine. Iodine deficiency is particularly damaging during early pregnancy as it retards foetal brain development resulting in a range of intellectual, motor & hearing defects.
- As per the NFHS-3 in U.P. while 77% of households are using iodised salt only 36% households use adequately iodised salt. Furthermore 23% of the population in the state is using non-iodised salt, thus over 12 lacs out of 50 lacs children born every year in the state are at a greater risk of not reaching their physical & mental development potential.

M. PIP 2010-11 (requirement)

Specific interventions targeted along the continuum i.e. from pregnancy till two years & beyond will help in reducing deficiency in the most vulnerable group. These may include:-

- **ANC counselling**- Sensitization of lady doctors of all FRUs & CHCs/Block PHCs on role of Iodine & its importance in pregnancy. The sensitization meetings can be organized at divisional level. A tool kit may be provided to all the lady doctors & ANMs for use during antenatal counselling.
- **Provision of salt testing kits to ANMs**- One kit each may be provided to ANM with instructions to use it for demand generation & demonstration purposes. The kit may also be used during the biannual rounds (BSPM) on Village Health Nutrition Days for dialogue & advocacy with village stakeholders.
- **Regional Level Media Workshop** – These meetings can be organized in 4 regions of the state namely central. Western Bundelkhand & eastern for reaching both the supply (salt traders & retailers) & demand sides (community) with messages on importance of iodised salt.
- **CMO Level Expenses**- GOI does not provides any funds for District level because they only provide budget under 4 heads. Because of this CMO is unable to send salt samples for analysis to IDD Lab & they feel difficulty in organising IDD Day on 21st Oct. Hence this demand is made.

Budget to be included in NRHM State PIP 2010-11 :-

(Figures in Rs.)

Activity	Budget required
ANC Counselling Sensitisation meeting @ Divisional Level (18) at Divisional Head Quarter Rs.30,000=00 x 18	540000.00

25,000 Iodine Field Testing* Kits (Rs.15/kit)	375000.00
Regional Level Media Workshops 4x50,000=00	200000.00
Counselling toolkit for use in antenatal clinics	2500000.00
**@ Rs.100/toolkit x 25,000 toolkits	
Funds to CMO Rs.20,000 per distt./year	1420000.00
20,000x71 distt.	
Total	5035000.00
*Subcentres, Block PHCs, CHCs, District hospitals.	
**Subcentres, Block PHCs, CHCs, District hospitals.	

National Programme for Prevention and Control of Deafness (NPPCD)

A. INTRODUCTION

National Programme for Prevention and Control of Deafness is newly introduced Programme which has been launched to prevent hearing impairments found in children in the form of Pilot Project at present.

The burden of deafness is proportionately high in India with respect to world scenario.

As per estimated prevalence is 291 per lac population severe profound hearing loss were found. 26.4 million of children in India are suffering from hearing loss which adversely effect their educational performance during their studies. Over 50 % causes of hearing impairment are preventable and 80 % of all deafness is avoidable by medical or surgical method.

In the 2007-08 two district Barabanki and Gorakhpur and in 2008099 district Varanasi, Banda and Lucknow have been brought under coverage of the programme facilities. To prevent the avoidable hearing loss and to medically rehabilitation the programme is launched and action is in progress to sensitize the ENT Surgeon, other Medical and Para Medical Personnel's as well as Health Workers.

B. STRENGTHENING AND CAPACITY BUILDING

During the year 2007-08 an amount Rs. 43.40 lacs and in 2008-09 an amount of Rs. 64.39 have been sanctioned by Government of India towards capacity building of Examination and treatment of hearing impairment and ailments at district hospital ,Community Health Centres and Primary health by supply of equipments, hearing aid equipment, Sound proof room at district hospital as well as capacity and capability building in the Medical, Para Medical and Health Workers of Primary Health Care system.

During the year 2010-11 three new districts namely Agra, Saharanpur and Moradabad are being taken under the programme facility.

C. SITUATION ANALYSIS

- To reduce the burden of deafness is disproportionately high in Indian context and requires immediate action.
- Severe loss of productivity adversely affects the physical and economic progress.
- As NSSO estimated prevalence of 291n per lacs population of severe to profound hearing loss.
- Over all high prevalence i.e. 6.3 % in Indian population, as per WHO estimates.
- Of the 420 million children in India, it is estimated that about 264 million suffer from hearing impairments, which is of a magnitude and nature that it hinders their acquisition of communication skills and academic capabilities.
- Inadequate existing health resources related to hearing and speech in terms of manpower and infrastructure.

Over 50 % of the causes of hearing impairment are preventable including hearing loss caused by infections of the ear (ASOM, CSOM), Secretary Otitis Media, Traumatic, Rubella deafness. Noise induced hearing loss and Ototocity 30 % of deafness, through not preventable is treatable and curable. Thus a total 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 Action Plan 2010-11 (NPPCD)

The Common causes leading to all degrees of hearing loss are:

S.No.	Disease	% of population suffering
1-	Ear Wax	15.9 %
2-	Chronic Supurative Otitis Medical	5.2 %
3-	Serious Otitis Media	3 %
4-	Dry perforation	0.5 %
5-	Congenital Deafness	0.2 %
6-	Non infectious & other unknown causes (Presbycausis, NIHL, Ototocitty)	10.3 %

D. 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 linkage for continuity of the rehabilitation programme for persons with deafness.
5. To develop institutional capacity for ear care services by providing support for equipments and material and training personnel.

Long term objective: To prevent and control major causes of 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.

E. DISTRICT IN THE PROJECT

- YEAR 2007-2008- Gorakhpur & Barabanki
- YEAR 2008-2009- Banda , Varansi and Lucknow.
- YEAR 2010-2011- Agra ,Saharanpur and Moradadabad (Proposed)

S N	District	Status	Mid year Population In lakhs	Name of Hospital	ENT Surgeon	Audiologist/ Audiologist Assistant
1	Barabanki	Existing Pilot Project District	32.06	District Hospital Barabanki	3	NIL
2	Gorakhpur	Existing Pilot Project District	45.39	District Hospital Gorakhpur	2	NIL
3	Banda	Existing Pilot Project District	17.99	District Hospital Banda	1	NIL

4	Varanasi	Existing Pilot Project District	37.75	District Hospital Varanasi	1	NIL
5	Lucknow	Existing Pilot Project District	44.15	District Hospital Lucknow	2	NIL
6	Agra	New Proposed District	44.31	District Hospital Agra	2	NIL
7	Saharanpur	New Proposed District	34.16	District Hospital Shrawasti	1	NIL
8	Moradabad	New Proposed District	44.97	District Hospital Moradabad	1	NIL

Number of CHC/PHC / Navin PHC of 3 proposed District

S.No.	District	CHC	PHC	NPHC	Total
1	Agra	8	15	46	69
2	Saharanpur	10	11	44	65
3	Moradabad	8	12	43	63

F. STRATEGY

- Capacity building of District Hospital, Community Health Centre and Primary Health Centre.
- Identification of potential District hospital/ large hospital to provide preventive/screening / curative service on daily basis.
- To provide above services there is need for
  - Strengthening of district hospital in terms of equipment / instrument
  - Sound proof room for audiometry
  - Posting of manpower in adequate number (one ENT specialist and one Audiologist at least at District level)
  - Skill development for service provider and paramedics
  - IEC for dissemination of information about availability of services / site/importance etc.
- Sensitization of service providers and paramedics PHN,MPW,CDPO, AS , ASHA, teachers about of NPPCD through workshops/ training.
- Awareness generation in community through NGO, VHSC etc. through sensitization workshop with supported IEC support
- Involvement of schools and ICDS for screening of children up to 14 years

G. SUMMARY OF PROGRAMME

- 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 exercise to be carried out here.

- The Primary Health Centre and Community Health Centers 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.
- The MPWS and the grass root functionaries will be sensitized to the programme and to their specific roles in the programme.
- The School Health system will pay 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 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 health doctors will be able to identify, treat and refer the children with ear and hearing problems.
- IEC activities would be an important and essential part of the programme.
- Training will be done in the first phase 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 will as hearing aid provision.
- 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 will as patient care and referral.
- The pilot project is being taken up in two district of the state in year 2007-08 - Barabanki, 2- Gorakhpur.
- In Ist phase ENT Surgeon of respective district were given trainig at Lucknow Chatrapati Sahu Ji Mahraj University by expert of ENT department lko and Govt. of India.
- Senior ENT surgeon if Barabanki Gorakhpur is District Nodal Officer.
- ENT Surgeon of Barabanki Gorakhpur extending awareness campaign training to doctors, health worker, Asha, Teacher of their respective district NGO.
- Paediatrician and obstetrician of the district hospital and CHC, PHC were given one day training by Prof. CSMMU & ENT Surgeon of District and state Nodal Officers.
- Process of purchasing of ENT equipment and audiometry and basic constructed of sound Prof. Treated Room is in progress.
- Equipment for Barabanki and Gorakhpur CHC, PHC also in process.
- Screening camp one 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 for this propose facilitator would be NGO.
- For Audiometry an other proposes services of audiologist / audiologist assistant would be a contractual basis.
- In year 2010-2011 to develop institutional capacity for ear services same programme will be extended in other district where ENT surgeon is available.
- Monitoring and auditing of the programme would be done periodically and review.

H. BUDGET REQUIREMENT FOR YEAR 2010-11

A- Expenses for Establishment of Office and Staff required for State Nodal Officer at Medical & Health Directorate

For Expected Outcome : Efficient functioning of State Nodal Officer April 2009-2010						
S.No.	State Nodal Officer Staff	Present status	No.	Cost per month	1 Year Cost	NRHM (NPPCD) State Health Society
1	Administrative Officer-1	NIL	1	15000	180000	
2	Data Entry Operator-1	NIL	1	12000	144000	
4	Driver-1	NIL	1	7000	84000	
5	Peon-1	NIL	1	5500	66000	
6	TA/DA for SNO	NIL	1	5000	60000	
7	Vehicle Study reliable long route convenience Travera	NIL	1	575000	575000	
8	POL	NIL		6000	72000	
9	Office Furniture	NIL		100000	100000	
10	Contingency Office	NIL		5000	60000	
11	Office Phone+Internet	NIL		5000	60000	
12	Desktop Computer UPS+4 in1 printer HP-Pentium - 4	NIL	1	50000	50000	
13	20 CPM A3 Size Photocopier	NIL	1	175000	175000	
14	Lap top Computer HP Intel Duocore	NIL	1	60000	60000	
15	Mobile Phone to SNO on rental charge	NIL	1	2000	24000	
16	Miscellaneous	NIL	1		50000	
S.No	**State Nodal Officer Staff**	**Present status**	**No.**	**Cost per month**	**1 Year Cost**	**NRHM (NPPCD) State Health Society**
17	Publicity work for 3 district wall printings(8'X3') Hoarding (15'X8')	NIL	3	25000	75000	

	Total				**1769000/-**	

Total= 17,69,000 /-
(Total Rupees in words: Seventeen Lakh, Sixty nine thousand only)

B- Expenses for the District Hospital Capacity Building /etc. (As per standard of GOI)

S N	Items	Rate each	Req No.	Total Amount
1.	Construction of Sound proof room in District Hospital	Rs. 1,65,000	3	Rs. 4,95,000
2.	Audio equipments	Rs. 5,00,000	3	Rs. 15,00,000
3.	PHC Kits	Rs. 7,000	197	Rs. 13,79,000
4.	IEC Activities	Rs. 2,00,000	3	Rs. 6,00,000
5.	Screening camps at PHC level	Rs.10,000	197	Rs. 19,70,000
	Total			Rs. 59,44,000

C- Expenses for the 3 New District Hospital Staff (As per standard of GOI)

S.No.	Name of Post	Remuneration/per month	Required No.	Total Amount per annum
	Audiometric Assistant	Rs. 7,500	3 X 12	Rs.2,70,000
	Instructor	Rs. 7,500	3 X 12	Rs. 2,70,,000
	Total Amount			**Rs. 5,40,000**

D- Expenses for Establishment of office of District Nodal office at 3 New District level

S.No.	Name of Post	Rate per Annum	Req No.	Total Amount per annum
1-	Honorarium	Rs. 60,000	3	Rs.1,80,000
2-	Office operation and maintenance of records	Rs. 60,000	3	Rs.1,80,000
3-	Telephone, Fax, Internet, and Postal charges etc.	Rs. 30,000	3	Rs. 90,000
4-	Vehicle operation and hiring of vehicle	Rs. 70,000	3	Rs. 2,10,000
5.	Maintenance of equipments and furniture etc.	Rs. 30,000	3	Rs. 90,000
	Total			**Rs. 7,50,000**

E- Training expenses of 3 Newly inducted districts at Medical College and district level

S.No.	Name of Post	Rate per Annum	Req No.	Total Amount per annum
1-	Training of ENT Surgeon, Pediatrician, Gynecologist etc. at Medical College	48,450	3	Rs. 1,45,350
2-	Training of Medical, Para Medical & Health Workers at District Hospital	24,000	197	Rs. 47,28,000
	Total			Rs. 48,73,350

F- Expenses for the District Hospital Capacity Building /etc continuous phase for 5 district

S.No.	Details	Rate/PHC	Req. No.	Total Amount
1-	Screening Camps at PHC level to detect Hearing impairment persons	Rs. 10,000	330	33,00,000
2-	Hearing Aids BTE type	Rs. 7,000	330	23,10,000
3-	IEC	Rs. 10,000	330	33,00,000
	Total			89,10,000

G- Expenses for the District Hospital Staff (As per GOI) continues phase for 5 District

S.No.	Name of Post	Remuneration/per month	Required No.	Total Amount per annum
	Audiometric Assistant	Rs. 7,500	5 X 12	Rs. 4,50,000
	Instructor	Rs. 7,500	5 X 12	Rs. 4,50,000
	Total Amount			**Rs. 9,00,000**

H- Expenses for Establishment of office of District Nodal office at 5 District level

S N	Name of Post	Rate per Annum	Required No.	Total Amount per annum
1-	Honorarium	Rs. 60,000	5	Rs. 3,00,000
2-	Office operation and maintenance of records	Rs. 60,000	5	Rs. 3,00,000
3-	Telephone, Fax, Internet, and Postal charges etc.	Rs. 30,000	5	Rs. 1,50,000
4-	Vehicle operation and hiring of vehicle	Rs. 70,000	5	Rs. 3,50,000
5.	Maintenance of equipments and	Rs. 30,000	5	Rs. 1,50,000

	furniture etc.			
	Total			**Rs. 12,50,000**

I- Grand expenses required for NPPCD Programme (Year 2010-2011)

S N	Activity	Cost	Total Cost
A	Expenses for Establishment of Office and Staff required for State Nodal Officer at Medical & Health Directorate	17,69,000	1.22
B	Expenses for the District Hospital and supply of equipment of 3 newly introduced districts. (As per standard of GOI)	59,44,000	42.55
C	Expenses for the District Hospital Staff for 3 newly introduce distt. (As per standard of GOI)	5,40,000	14.40
D	Expenses towards establishment of District Nodal Office for 3 districts for 3 newly introduced districts.	7,50,000	00.00
E	Expenses towards training of Core trainer and Medical, Para Medical, Health Workers training of 3 newly introduced districts. (As per GOI)	48,73,350	24.00
F	Expenses for Capacity building at district under continuing phase of 5 districts.	89,10,000	45.52
G	Expenses for District Hospital Staff of continuing phase for 5 districts	9,00,000	00.00
H	Expenses towards District Nodal Office of 5 continuing phase District	12,50,000	00.00
	Grand Total	**2,49,36,350**	**130.69**

The budget sanctioned from GOI for the year 2010-11 is Rs. 130.69 lacs

National Programme for Control of Blindness (NPCB)

A. BACKGROUND:

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 number of cataract patient is reducing because of clearance of backlog, blindness due to degenerative diseases like diabetes and glaucoma and injuries related corneal opacities are increasing. The programme has to tackle emerging challenges.

B. GOAL:

Prevalence rate of blindness in Uttar Pradesh is 1.0% (Survey-2004). Goal of the programme is to reduce prevalence rate of blindness to -

- 0.5% by the end of 2012 and

- 0.3% by the end of year 2020

C. ACTIVITIES TO ACHIEVE GOAL:

I. Main Activities

a. Cataract Surgery.
b. School Eye Screening.
c. Eye banking for keratoplasty to treat Corneal Blindness.

II. Innovations taken up last year:

a. Management of diseases other than Cataract (Diabetic Retinopathy, Glaucoma management, Laser Techniques, Corneal Transplantation, Vitreoretinal Surgery and treatment of Childhood blindness)

INTEGRATE DISEASE SURVEILLANCE PROJECT (IDSP)

A. BACKGROUND

IDSP was started in 2004 with support from World Bank, to improve and Integrate Disease Surveillance in pursuance of recommendations by high powered committees like Public Health System Committee, Technical advisory committee and committee of secretaries on Environmental Sanitation.
In2007 with Avian Influenza outbreak human and animal components were added along with additional budget.

Following assumptions were made at the time of launch of project about infrastructure at state and district level

1. Units have adequate skills, resources and authority to respond.
2. Communities and private sector have adequate incentive to participate.
3. Good quality of lab information is available in timely manner and integrated into surveillance system.

But these were not found to be fully correct, so the objectives could not be achieved as well as fund utilization was low.
In Jan 2009 after detailed analysis of the situation, World Bank agreed to restructure the project and extend it for 2 years focusing on what can be achieved by the end of two years.
Keeping this in mind PDOs (Project Development Objectives) were revised and a proposal for restructuring and extension of IDSP up to 2012 has been prepared.

B. ORIGINAL PROJECT DEVELOPMENT OBJECTIVES

- To improve the information available to the Govt Health Services and Pvt. Health care providers on a set of high priority diseases and risk factors, so as to improve the responses towards them.
- To establish a decentralized state based system of surveillance for diseases to ensure timely and effective health response towards health challenges at all level.
- To put greater emphasis on building the links between the collection and analysis of information and ground intervention by public or private sectors.

The project was to assist the Govt to

1. Survey a limited number of health conditions and risk factors.
2. Strengthen the linkages, data quality & analysis.
3. Improve lab support.
4. Train stakeholders in disease surveillance and action.
5. Coordinate and decentralize surveillance activities
6. Integrate Disease Surveillance at state and district level and involve communities specially Pvt. Sectors.

C. PROPOSED CHANGES

Modified Project Development Objectives (PDOs) for 2010-2012: To improve and integrate disease surveillance compliant with the IHR 2005 requirement by:-

1. Supporting a nation-wide effort for surveillance preparedness for immediate reporting of outbreaks, regular surveillance and weekly reporting with emphasis on provisional diagnosis by medically trained staff from public and private sectors to generate early warning signals for appropriate and timely public health actions.
2. Demonstrating establishment and operation of decentralized surveillance systems, meeting performance standards (timeliness, improved quality of outbreak investigation including various sample collection for confirming the

diagnosis by laboratory net work, strengthening analysis and use of surveillance data &response).

D. DETAILED PROJECT DESCRIPTION

Various Components are:-

Component 1: Nationwide improvement in surveillance preparedness.

Component 2: Timeliness and improved quality of outbreak investigation and response in all states.

Component 3: Strengthening quality data analysis and assessing analytic quality of outbreak investigation.

Component 4: Supporting human health related activities under India's avian influenza pandemic control programme.

Component 1: Nationwide improvement in surveillance preparedness

- Enhancing the quality and frequency of use of communication network. Improvement in quality and content of video conferencing.
- Frequency of outbreak investigation, availability and use of lab confirmation would be done by CSU.
- Analytical capacity of districts will be improved by training epidemiologists and data managers on use of portal.
- To improve the quality and timeliness of reporting modified form P and L have been up loaded in portal.

Component 2: Timeliness and improved quality of outbreak investigation and response in all states

- CSU would monitor the data collected and intervene if there are problems with timeliness of reporting or lab confirmation.
- Important source of outbreak information the 1075 call centre will be publicized to health professionals.
- The media scanning service would be important in areas where surveillance infrastructure is still under development.
- CSU would ensure collaboration between epidemiologists, microbiologists /state lab coordinators at national and state levels.
- Outbreaks reported by IDSP would be assessed for competency by tools developed for this purpose.
- Medical colleges would be involved in disease surveillance and response.

Component 3: Strengthening quality data analysis and assessing analytic quality of outbreak investigation

- Epidemiologists would use suitable assessment tools created to review a sample of outbreak.
- CSU epidemiologist would undertake analyses of IDSP data to better understand data contained in the system.
- Effective communication of key findings and issues to IDSP sub units, state and national policy leaders and public would be done and for this support from other disciplines like communication etc would be taken.
- Interesting and well conducted outbreak investigation would be displayed as model in IDSP write-ups, in presentations and videoconferencing.

Component 4: Supporting human health related activities under India's avian influenza pandemic control programme

- This component aided the reference labs for prompt confirmation of human A1 cases and H1N1 cases and also re established seasonal influenza surveillance system for India building on network established by DHR, the dept of health research.
- In the proposed A1 lab network NCDC Delhi would take care of some critical issues such as (a) strict compliance with the definition of influenza like illness. (b) Training of epidemiologist and lab personnels to ensure quality in sample collection, transport and testing. (c) Use of standardized testing strategy developed in consultation with national institute of virology (NIV) Pune and WHO.

E. ACTIVITIES AGREED UNDER DIFFERENT COMPONENTS

I. Surveillance Preparedness

- Training of Epidemiologist, Microbiologist and Entomologist by NHSRC. It would be done regionally by drawing the faculty from the resource group, facilitated by NCDC.
- Training of District Surveillance team in specially phase III states.
- Additional training for reporting and analysis for health supervisors, block health team, pharmacists etc.
- Ensuring fully functional IT systems in place :-
  a. Mechanism to enhance data integration and flow from telephone, Email, and Fax will be developed.
  b. Decentralization of recruitment of DM and DEOs to SSU and DSU.
  c. Revision of renumeration to bring these at par with other national projects.
  d. SSU and DSU will be authorized to have broadband connectivity through BSNL and also to disburse their broad band bills.
  e. Training schedule and module for training of DM and DEOs has been prepared.
  f. Bandwidth capacity of EDUSAT has been upgraded from 512 Kbps to 1 Mbps.
  g. The issues of toll free number are being analyzed, investigated and solved.
  h. To promote the use of toll free services, the number will be publicized amongst the private and public sectors by advertisement, bulletins etc.
  i. The SMS Syndromic reporting model of is being assessed to be incorporated in other priority states.
  j. CSU will develop guidelines and provide training for developing Media Scanning and verification system using already existing infrastructure at SSU/DSU
- For priority district labs:-
  a. Rigorous monitoring will be done for procurement of equipment by the states.
  b. Development of specimen collection centre within the district.
  c. Placements of new medical and nonmedical microbiologists at districts and state labs under IDSP.

d. Training of new microbiologists by identifying 3 additional training institutes.
e. To prepare and distribute SOP manuals for the district priority labs (biowaste management guidelines and internal quality controls.)
f. Regular monitoring of functioning of district priority labs.
g. Implementation of guidelines for procurement of quality kits
h. To organize EQAS (External Quality Assessment Scheme) when district priority lab becomes functional for 3months

- For Entomological Surveillance:-
  a. Training of Entomologist.
  b. Entomologist in consultation with NVBDCP Programme officer and DMO will do mapping, monitoring of entomological density and bionomics and sensitivity to insecticides.
  c. They will also do entomological investigations during vector borne disease out break
  d. This year vaccine preventable diseases –diphtheria, pertusis and measles are going to be covered in IDSP Survillance. H1N1 has already been included in the programme.

. **Outbreak Investigation and Response**

- 25% of outbreaks detected by system within 1 week of first case diagnosis.
- 60% outbreak/rumors reported by other systems/ media verified within 48 hrs.
- 25% of outbreaks for which adequate specimen reached labs.
- Full documentation of 25% of reported out breaks should be available on IDSP Portal.

II. Analysis and Use of Data

- 50% of districts undertaking weekly surveillance analysis of data including graphs for trends and maps for incidence.
- 60% of districts providing monthly feedback to sub unit, policy makers and general public by using 1 page bulletin or news letter.

Outcome Indicators for Each Component

Components	Indicators for each component
Surveillance preparedness	• 60% of district have full time epidemiologists • 60% of districts have fully functional IT • System with online data entry and analysis. • 60%of districts have systems for SOS reporting like Toll free number, Media Scanning etc. • 25% of districts have referral labs &priority labs undertaking routine lab surveillance. • 25% of districts have referral labs meeting the EQAS standards.
Outbreak	• 25% of outbreaks detected within 1 week of

investigation & Response	• Detection of first case. • 60% of outbreaks /rumors reported by other • Systems verified within 48 hrs. • 25% of outbreaks for which adequate specimens reached in labs. • 25% of reported outbreaks for which first and final investigation reports are available with CSU IDSP.
Analysis & use of data	• 60% of districts undertaking weekly surveillance analysis data including graphs for trends over time and maps for incidence by area. • 60% districts providing monthly feedback to sub units, policy makers and general public.

The State presented its PIP for year 2008-2009 initiating this programme in 5 districts- Kanpur, Agra, Varanasi, Allahabad and Lucknow. In PIP of 2009-2010 the programme was extended to all districts of UP and State Head quarter.

F. ACHIEVEMENTS in 2009-10

1. SSU & 71 DSU Established.
2. State surveillance committee established.
3. 71district surveillance committee established.
4. State & 71 Districts RRT Formed.
5. Video conferencing and IT Equipment established in all 71 districts.
6. EDUSAT Installation completed in all districts.
7. Data Managers have been recruited in 71 districts.
8. Appointment of contractual staff is in process in all districts.
9. Epidemiologists and Microbiologists have been recruited and joined in 52 districts. All Epidemiologists and Microbiologists have been trained by Govt. of India. 19 districts still do not have Epidemiologist. The post of Entomologist is also lying vacant.
10. IDSP Portal has been started .On line entry of SPL Forms have been started.
11. Lab Supply- File and RFT has been sent to CMSD
12. Three Tier Training is proposed .1st level is being completed for DSOs and in process for RRT.
13. Screening for Swine flu at various entry points was strictly done, as a result we were able to restrict the number of Swine Flu cases and resultant mortality due to it at a very low level as compared to other states.

G. Targets for 2010 -11

1 This Year Vaccine preventable disease - Measles, Pertussis, Diphtheria and other diseases like Influenza A H1N1 and Malaria and other communicable diseases are going to be covered in IDSP Surveillance.

2 All Medical Colleges of the State are going to be involved actively in data collection and disease surveillance.

3 Private sector Hospitals and Nursing Homes are to be involved in disease surveillance.

4 Appointment of remaining vacant posts of Data Entry Operators in the district.
5 Appointment of remaining posts of Epidemiologist / Microbiologist and Entomologist in Uttar Pradesh.
6 Ensure training of Data Managers and Data Entry operators of all 71 Districts of Uttar Pradesh.
7 Strengthening of State Priority Labs of IDSP (Regional Lab Swasthya Bhawan and district Lab Ghazi bad).
8 To improve the Surveillance of Epidemic Prone Diseases of U.P. especially AES / JE and Dengue.
9 To improve the existing I.T. networking system
10 To ensure the online Data Entry from all districts of U.P.

H. INTERVENTION PLAN

- **Administrative Structure at State Level**

State surveillance unit-
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.)
Consultant, Technical & Training	-	On contractual basis
Consultant, Finance	-	On contractual basis
Data Manager	-	On contractual basis by GOI
Data entry operator (2)	-	On contractual basis
Assistant	-	On contractual basis
Helper	-	On contractual basis

Responsibilities of SSU –

- The collection and analysis of all data 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.

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

❖ *Administrative Structure at District Level*

District Surveillance Unit (DSU)

Constitution of the DSU is 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
Outbreak Response		

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 Sentinel Private Practitioners
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 meets once a month regularly and as often as needed during an epidemic. A routine report of this meeting is forwarded to the State Surveillance office to give a feedback on the progress and problems in various districts. Reports of these meeting are forwarded to the National Surveillance cell once in three months.

District Outbreak Investigation Team (DOIT) in each district looks after the various aspects of an outbreak composition of the team is as follows -

1. Nodal Officer(Epidemiologist)
2. Clinician(Physician or Paediatrician)
3. Microbiologist
4. District Administrative nominee (not below the rank of Tehsildar)
5. One member of surveillance consultant of DSO
6. Health Assistant

Rapid Response Team- At the state level there are 3 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

I. Strengthening of data quality, analysis and linkages to action

Main activities

1. Online entry, management and analysis of surveillance data through use of computer and internet
2. Reporting surveillance data using standard software including GIS, with flexibility with new system
3. E-mail services between state head quarter, district, blocks, laboratories and GoI.
4. Linkages with institution and personnel involved in public health.
5. Using feedback from health worker/community to take action
6. Rapid dissemination of health alerts to public health staff and civil societies
7. Quality Assurance surveys of laboratory information.

J. 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

- Regional laboratory at State HQ (SSU)
- District lab at Ghaziabad

K. Training of 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
- 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).
- State/district level trainings are being undertaken by the GoI at national institute.

L. Integrate disease surveillance at all levels and involves 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.

M. 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.

N. Contribution of SSU and DSUs in other programmes

Besides regular on-line entry of Form S, Form P and Form L, the District Surveillance Unit will submit following reports regularly to State for State level compilation and onward submission:

1. Weekly Outbreak Report through e-mail
2. Weekly Epidemic Prone Diseases through Courier
3. Monthly Statement of Institutional cases and Deaths due to Communicable Diseases. CBHI Performa
4. Monthly Statement of Institutional cases and Deaths due to Non-Communicable Diseases. CBHI Performa

O. INNOVATIONS

As the Microbiologist and the Technician have been trained at B.J. Medical College Pune and NCDC New Delhi respectively, we now wish to update the Regional Lab at Swasthya Bhawan Lucknow. Keeping in mind the diseases being presently covered under IDSP (Cholera, Dengue, Typhoid Fever, and Leptospirosis) the following equipments and related material is required.

S N	Particulars	Quantity Present	Quantity Required
1	Bio- Safety Cabinet	Nil	1
2	Binocular Microscope (Motic / Olympus)	Nil	1
3	ELISA Plate reader & washer	Nil	1
4	Multichannel (Octa Channel)	Nil	1
5	Micropipettes (0.1- 5 ul)	Nil	1
6	Micropipette (50 ul)	Nil	1
7	Micropipette (100 ul)	Nil	1
8	Thermometer • 0 degree Celsius to -70 degree Celsius • 10 degree Celsius to -30 degree Celsius • degree Celsius to -20 degree Celsius • 0 degree Celsius to -50 degree Celsius	Nil	1 each
9	Deep freezer (-70 oC)	Nil	1
10	Needle destroyer	Nil	1

Following kits are required

1 Dengue IgM ELISA kit (Short incubation)
2 Typhoid kit
3 Leptospirosis Rapid Test kit (leptochek)
4 Cholera antisera (poly O1 ; O139)
5 Reagents for Gram stain

P. Budget Requirement for year 2010-11

1. **IDSP Staff Salary**

		STATE (SSU)	DISTRICT (DSU)	Total

Sr No	STAFF SALARY	STATE (SSU) (Per Month)	Annual Fee	DISTRICT (DSU) (Per month for 71 Units / districts)	Annual Fee for 71 District	Total (SSU+ DSU)
1	Epidemiologist	-	-	1497500	17970000	17970000
2	Microbiologist	40000	480000	20000	240000	720000
3	Entomologist	20000	240000	0	0	240000
4	Consultant Finance	14000	168000	0	0	168000
5	Consultant Training	28000	336000	0	0	336000
6	State Data manager	14000	168000	0	0	168000
7	District Data Manager	0	0	958500	11502000	11502000
8	Data Entry Operator 1 in each district	8,500	102000	603500	7242000	73,44,000
9	Data entry operators in10 Medical College 1Each @ Rs. 8500/-			85000	1020000	1020000
	Total	124500	1494000	3164500	37974000	39468000
Total staff salary for 1 S.S.U. + 71 D.S.U.+10 Med.Colleges for 2010-2011 is Rs 39468000.00						

2. Training-

Training IDSP 2010-2011	Total	No of Batch	Training Cost
Training of Hospitial Doctors @ Rs. 1100 per head+other expenses @ 11000/- per batch (10 Participant each batch)	710	71	781000
Training of Hospitial Pharmacists / Nurses @ Rs. 750 per head+other expenses @ 15000/- per batch (20 Participant each batch)	1420	71	1065000
Training of Data Managers and Data Entry Operators in SSU and DSU @ Rs. 1600 per head+other expenses @ 31000/- per batch (20 Participant each batch)	154	7.7	238700

Total	**1913**	**97**	**2084700**

Note: As the norms of training budget sent from GOI were not found suitable for the State, the budget has been calculated as per requirement of State (1 batch per district).

3. Operational Cost-

For Surveillance Unit (1 SSU+71 DSU)					
Sr No		**State Annual**	**District (Unit Cost) Annual**	**for 71 Districts Annual**	**Total SSU+DSU**
3.1	Mobility Support	0	48000	3408000	3408000
3.2	Office Expenses	60000	24000	1704000	1764000
	Total	60000	72000	5112000	5172000
Total operational Cost for 1 S.S.U. + 71 D.S.U. for 2010-2011 is Rs 5172000.00					

Outbreak investigation and response					
Sr No		State Annual	District (Unit Cost) Annual	for 71 Districts Annual	Total SSU+DSU
3.3	Asha Incentives for Outbreak reporting	0	12000	852000	852000
3.4	Consumables & Kits for Lab	200000	200000	200000	400000
3.5	Collection & Transportation Of Samples	0	6000	426000	426000
	Total	200000	218000	1478000	1678000
Total Cost for 1 S.S.U. + 71 D.S.U. for 2010-2011 is Rs 1678000.00					

Analysis and use of data						
Sr No		**State Annual**	**District (Unit Cost) Annual**	**For 71 Districts Annual**	**For 10 Med.College Annual**	**Total SSU+DSU**
3.6	State IDSP Weekly Alert Bulletin	30000	0	0	0	30000
3.7	Printing Of Reporting Form	0	10000	710000	100000	810000
3.8	Broadband Expenses	12000	12000	852000	120000	984000
	Total	42000	220000	1562000	220000	1824000

Total Cost for 1 S.S.U. + 71 D.S.U.+10 Medical College for 2010-2011 is Rs 1824000.00

1. Total Budget for IDSP 2010-2011

	SSU	DSU (71)	Med. College	Total(in Rs.)
Total Staff Salary 2010-2011	1494000	3797400	1020000	39468000
Training				2084700
Operational Cost	425000	5112000		5172000
Outbreak investigations and response	200000	1478000		1678000
Analysis and use of data	42000	1562000	220000	1824000
Total	2321000	53260000	1240000	50226700

NATIONAL LEPROSY ERADICATION PROGRAMME(NLEP)

INTRODUCTION

During XI th Five Year Plan the National objective of NLEP is to achieve elimination level i.e. < 01 patients per 10,000 population, at state level, at district and block level and sustain the level of elimination achieved.

Objective of year 2010-11-

(1) Further reduce the burden of leprosy

(2) High Quality Services

(3) Enhance Disability Prevention and Medical Rehabilitation

(4) To reduce Social Stigma associated with disease

Targets to be Achieved by 31st March, 2011 for Uttar Pradesh

S.No.	Particular	At the end of March, 2009	At the end of March, 2011
1	Prevalence Rate of leprosy	0.81/10,000	0.70/10,000
2	Deformity Rate among new cases.	2.01 %	1.00 %
3	Child Rate among new cases.	6.27 %	4.00 %
4-	Female patients Rate	31.78	40.00 %

A. SITUATION ANALYSIS:

I. Infrastructure		II. Manpower	
Urban Hospital	162	District Leprosy Officer	Regular in 41 Districts
CHC	368	Dy DLO	15 Districts
Block PHC	445	In charge	15 Districts
APHC	3690	HE	58
Sub Centre	20521	NMS	517
		NMA	1920
		PTT	44

III. Achievements

S.No.	Particular	At the end of March, 2009	At the end December, 2009

1.	Total recorded patients	16,206	19,309
2.	Prevalence Rate of leprosy	0.81/10,000	0.97/10,000
3.	Deformity Rate among new cases	2.01 %	0.97 %
4.	Child Rate among new cases	6.27 %	6.17 %

Prevalence Rate of Leprosy in districts

Prevalence Rate	Period wise detail of Districts		
	2007-2008	2008-2009	2009-2010(till 31st dec 2009)
< 1	39	52	43
1 - 2	31	19	28
2 - 5	0	0	0
> 5	0	0	0

III. Strength, Weakness, Threat and Opportunities

S.No.	Heads	Present Status	Activities planned
I	Strength	Functional Integration in place in the state and all health facilities of govt. providing leprosy services. Elimination level achieved in 43 Districts by the end of Dec. 2009	Capacity Building & Training of GHS Staff for quality services
ii.	Weakness	Late detection of cases. All cases with disabilities report after developing the disability. Reaction cases not managed satisfactorily due to shortage of Prednisolone at PHC and lack of skills in recognizing neuritis and reaction	Promote Early Case Detection and Efficient & Prompt management of cases with neuritis & reaction
iii.	Threat	Complacency among Programme Managers & staff after achieving elimination	Sustained and quality services for leprosy
iv	Opportunity	Availability of ASHAs in leprosy work	Involvement of ASHAs in referral of suspects and follow up of patients

		Man power of trained and motivated vertical leprosy staff still eager to render services to Leprosy affected	Continue to take services of trained and motivated vertical leprosy staff for providing leprosy services and utilize them as experts for GHS staff

B. PERFORMANCE UNDER NLEP

Sr. No.	Indicators	2006-07	2007-08	2008-09	2009-10 at end of Dec. 2009
1	Annual New Case Detection Rate (per 1,00,000 population)	17	15.94	13.8	14.8
2	Prevalence Rate per 10,000 population at the end of year	0.95	0.94	0.81	0.97
3	Grade II Deformity Rate (%)	1.15	1.52	2.01	2.00
4	Treatment Completion Rate (%)	90.41	91.32	94.11	
5	Reconstructive Surgery conducted		610	476	342

C. INFRASTRUCTURE

	Contractual Services :	Expected Outcome : Efficient functioning of SLO & DLO Offices (Contractual Services- At State HQ 5,46,000 + At District HQ 34,44,000 Total BUDGET Rs 39,90,000)							
SN	**Heads**	**Present Status**	**Activities planned**	**Time Schedule**	**No. Required**	**Rate (In Rs.)**	**Costs (In Rs)**	**Source of cost**	**Total Budget Head wise**
	Contractual Services :	At State HQ							546000
i		SLO Office (Rs. 5,22,000)	Budget & Finance Officer cum Administrative Officer 1 @ Rs. 18000 per month		1	18000	216,000	NRHM (NLEP) State Health Society	
ii			Data Entry Operator 1 @Rs 12000 per month		1	12000	144,000		
iii			Contractual Driver 1 @ Rs 7000 per month		1	7000	84,000		
iv			TA/DA Driver @ Rs 1000 per month		1	1000	12,000		
v			Contractual Peon 1 @ Rs 5500 per month		1	5500	66,000		
			Conveyance to staff for attending office on holidays and outside office hours		4	500	24,000		
	Contractual Services :	At District HQ							3444000
		DLO Office	Contractual Driver @ Rs 7000 per month		41	7000	3,360,000	NRHM (NLEP) District Health Society	

D. TRAINING PLAN

	Training & Capacity Building	Expected Outcome: Early Case Detection by trained field staff & Quality diagnosis and treatment & Prevention of Disabilities. (At State HQ Rs 1,00,00 + At District HQ 59,04,000) BUDGET Rs. 60,04,000 (Training will be imparted in a batch						
SN	**Heads**	**Activities planned**	**Time Schedule**	**No. Requi**	**Rate (In**	**Costs (In Rs)**	**Source of cost**	**Total Budget**

					red	Rs.)			Head wise
		All trainings to be integrated with trainings of NRHM at State HQ							**1,00,000**
i	**5 days Training of Laboratory Technicians by State HQ at TLM Naini, Allahabad**	5 days Training of Laboratory Technicians in Skin Smear Examination - 17 Laboratory Technicians from District Hospitals have been trained in 2009-10 at TLM , Allahabad	**5 days Training of Laboratory Technicians in Skin Smear Examination - 25 Laboratory Technicians from District Hospitals to be trained at The Leprosy Mission Hospital & Training Centre, Allahabad**	October to December, 2010	25	4000	**100,000**	State Health Society	
	At District							**59,04,000**	
ii	**4 Day Refresher Technical cum DPMR Training of Newly appointed MO (rural & urban)**	4 days Technical and DPMR orientation training have neen given to newly recruited Medical Officers.	**4 days Technical and DPMR orientation training will be given to newly recruited Medical Officers of rural/urban area.**	July to October, 2010	900	28000	**840,000**	District Health Society	
iii	**2 Days Refresher Technical cum DPMR Training of Medical Officers at District HQ**	2 days Technical and DPMR orientation training given to 1980 Medical Officers(Male & Female) of Primary Health Care Services of high priorirty 38 Districts in batches of 30	**2 Day Refresher Technical cum DPMR Training at District HQ to 3600 Medical Officers of New Primary Health Centres**	July to October, 2010	3000	16,000	**16,00,000**	District Health Society	
iv	**3 Days Refresher Training of newly appointed Health Workers at District HQ**	Two days Orientation Technical & DPMR training of 2580 Health Workers & Leprosy Staff in batches of 30 completed in 2008-2009	**3 days Refresher Technical and DPMR training of newly appointed Health Workers for selection of deformed leprosy cases for RCSand their post operative follow-up.**	July to September, 2010	390	24000	**312,000**		
v	**2 Days Refresher Technical cum DPMR Training of Health Workers at District HQ**	2 days Technical and DPMR orientation training given to 1980 Medical Officers(Male & Female) of Primary Health Care Services of high priorirty 38 Districts in batches of 30	**2 Day Refresher Technical cum DPMR Training at District HQ to 5910 Health Workers of New Primary Health Centres**	July to October, 2010	5910	16000	**3,152,000**	District Health Society	

E. IEC

SN	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs)	Source of cost	Total Budget

									Head wise
	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 . (Top priority will be given in display of Hoarding, Display Board, Posters, Diagnostic cards to Blocks having PR > 1 like previous year in the year 2010-11 and more attention will be given to involve School & Colleges by providing diagnostic cards to teachers for senstization of teachers.) (State - Rs. 75,30,000 + Districts - 24,85,000 Total Rs. 1,00,15,000/=)**							
	STATE HQ	The following IEC activities have been carried out during the year 2009-10	**Planned IEC activities for 2010-2011 are as under**						**75,30,000**
i	By State HQ	Installation of Hoarding - 200 are under process	**Hoardings 150 for public places**	November, 2010 to January, 2011	150	15500	**2,325,000**	NRHM (NLEP) State Health Society	
ii	By State HQ .	Display Board 500 in priority Block level Primary Health Centres are being done	**Display Board 300 are proposed for public places in priority Districts**	November, 2010 to January, 2011	300	2700	**8,10,000**	NRHM (NLEP) State Health Society	
iii	By State HQ	Posters 100000 procurement is under process.	**Posters -1,00,000 to be provided to Districts on basis of leprosy problem and density of DPMR work.**	December, 2010	100000	6	**600,000**	NRHM (NLEP) State Health Society	
iv	By State HQ	100000 Diagnostic cards to be distributed to districts for for distribution to ASHAs, School / Colleges teachers for spreading knowledge to communities and students.	**Diagnostic cards** are required for distribution to ASHAs, School / Colleges teachers for spreading knowledge to communities and students.	September, 2010	100000	6	**600,000**	NRHM (NLEP) State Health Society	
v	By State HQ	Folk Shows-1400 Magic Shows, Short Plays,Nukkad Natak and Puppet s will be orgasnised subject to released of fund from GOI.	**Folk Shows-Magic Shows, Puppet Shows and Cultural Programmes for spreading knowledge of leprosy. It is proposed that 17 Magic Shows, 17-Puppet shows or 17 Cultural Programmes to be organized in high endemic districts**	August, 2009 to January, 2010	1065	**3000**	**3,195,000**	NRHM (NLEP) State Health Society	
	By District								**2485000**

	HQ								
vi	By District - at District level	Rallies -140 Rallies organized @ 2 per District	**2 Rallies @ Rs 5000 each on 2nd October 2010 & 30th Jan 2011**	October, 2010 ,January, 2011	71	10000	**710,000**	NRHM (NLEP) DHS	
vii	By District - at Block level	10 Quiz have been organised @ ten Quiz per district in School/college.	**10 High School Level Quiz @ Rs. 1000 each in each district**	January, 2010	71	10000	**710,000**	NRHM (NLEP) DHS	
viii	By District - at Block level	142 IPC workshops of Medical Officer & Health Workers have been orgainsed @ two workshop per district.	**Two IPC workshops of ASHAs in each of the 71 districts @ Rs. 5000/= each workshop**	October 2010 - January, 2011	71	10000	**710,000**	NRHM (NLEP) DHS	
xi	By District - at Block level	Two IPC workshops/Heal th Melas have been organised in each district.	**For IEC in Health Melas,Local Festivals, Melas,Asha Sammelan, Saas-Bahu Sammelan etc @ Rs5000 depending on population of Districts**	July 2010 to December 2010	71	5000	**355,000**	NRHM (NLEP) DHS	

F. DPMR PLAN

S.No.	Heads	Present Status	Activities planned	Time Schedule	No. Required	Rate (In Rs.)	Costs (In Rs)	Source of cost	Total Budget Head wise
	D.P.M.R. Activity	**Expected Outcome : Prevention of Disabilities, prevention of deterioration of existing deformities by specialist Care at Referral Units at District Hospitals, Medical & Social Rehabilitation of Leprosy Affected Persons, Mobilization of operable cases for Reconstructive surgeries at Tertiary Hospitals of State (State HQ - Rs. 58,00,000 + District HQ - 12,00,000) Budget - Rs. 70,00,000/=**							
	BY State HQ								**5800000**
i	**RCS in ILEP Supported Institutions**	Selected deformed leprosy affected persons have been referred for RCS operations to The Leprosy Mission Hospital & Home, Naini, Allahabad and at Motinagar, Faizabad	**Selected deformed leprosy affected persons to be referred for RCS to The Leprosy Mission Hospital & Home at Naini (Allahabad) and at Motinagar (Faizabad)**	April 2010 to February, 2011				The Leprosy Mission	
ii	**RCS by Central Govt. Insitutions**	Central Jalma Institute for Leprosy, Agra is not conducting R.C.S. operation due to renovation of Operation Theater since April, 2009 to till date.	**Selected deformed patients of Western U.P. districts shall be sent for RCS operation to Central Jalma Instt. For Leprosy, Agra.**					JALMA	

iii	**RCS by Medical College ,Lucknow & DDU Hosp., Varanasi under State HQ**	CSM Medical University, Lucknow has been identified as Physical Medicine and Rehabilitation Institution for the state during the year 2009-10. For Major R.C.S. Operations at CSMU College, Lucknow, Rs. 5000/= per operation is being provided in 2009-2010	**Selected deformed patients shall undergo Major RCS at Medical College, Lucknow & Pandit Deen Dayal Upadhyay Hospital Varanasi. Cost of Major RCS Operation shall be reimbursed to the Departments by State HQ. After repair of O.T. of JALMA, Agra addl. RCS**	April 2010 to February, 2011	200	5000	**1,000,000**	NRHM (NLEP)- State Health Society	
iv	**Compensation for loss of wages to RCS patients by State HQ**	To mobilize deformed leprosy affected persons for RCS , those belonging to Below Poverty Line category compensation for loss of wages has been provided @ Rs5000 per patient.	**Leprosy affected persons belonging to Below Poverty Line category ,undergoing RCS , compensation for loss of wages shall be provided @ Rs5000 per patient.**	April 2010 to February, 2011	500	5000	**2,500,000**	NRHM (NLEP)- Distt. Health Society	
v	**Compensation to patient's attendant for bearing food and travel cost etc. by State HQ**	This is first time proposed to mobilized the LAP's for RCS operation and found assistance from friends and relatives.	**Compensation to patient's attendant @ Rs. 3,000/= per patients.**	April 2010 to February, 2011	500	3000	**1,500,000**		
vi	**Supportive Medicines Aids & Appliances to RCS institutions by State HQ**	Crutches & Splints have been provided to deformity patients. Aids and Appliances have been given to Deformity patients for 200 patients @Rs.3000	**Supportive Medicines ,Crutches & Splints, Aids and Appliances, Footwear are to be provided to leprosy patients (to 100 patients @ upto Rs.2000 each)**	April 2010 to February, 2011	150	2000	**300,000**	NRHM (NLEP)- State Health Society	
vii	**Procurement of MCR Footwear**	MCR Footwear provided to Leprosy Affected Persons	**MCR Footwear to be procured for Grade-1 deformity patients, 200 pairs of MCR footwear per district @ Rs. 250 - per pair**	April 2010 to February, 2011	2000	250	**500,000**	NRHM (NLEP) State Health Society	
	By District HQ								**1200,000**
viii	**Screening Camp for RCS**	Screening Camps are being organized to mobilized patients for RCS operations	**Mobility for Organizing Screening Camp for Disabled for Reconstructive Surgery & Self Care Education**	June 2010 to December 2010	40	10000	**400,000**	NRHM (NLEP) District Health Society	
		Misc. expenses are being incurred.	**Misc. expenses for organising Secreening camp including Patient's Welfare items**	June 2010 to December 2010	40	10000	**400,000**	NRHM (NLEP) District Health Society	
ix	**Self Care Kits for LAP**	Self Care Kits are being provided	**Self Care Kits-4485 for Disability Grade 1 & 2 cases @ Rs 200**	April 2010 to March 2011	2000	200	**400,000**	NRHM (NLEP) District Health Society	

G. URBAN LEPROSY CONTROL

	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.18,39,100						
By District HQ									1839100
S N	**Heads**	**Present Status**	**Activities planned**	**Time Schedule**	**No. Required**	**Rate (In Rs.)**	**Costs (In Rs)**	**Source of cost**	**Total Budget Head wise**
	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 2010 to March 2011					
i			Supportive Medicine includes Prednisolone, & Dressing materials					NRHM (NLEP) District Health Society	
			Mega City(Popn.>20 lakhs)		1	40000	40,000		
			Metropolitan City (Popn 20lakhs)		1	36000	36,000		
			Medium City (Popn.10lakhs)		9	18000	162,000		
			Township (Popn.5lakhs)		41	9000	369,000		
ii			MDT Delivery services and follow up of under treatment patients					NRHM (NLEP) District Health Society	
			Mega City		1	56500	56,500		
			Metropolitan City		1	56500	56,500		
			Medium City		9	28200	253,800		
			Township		41	11300	463,300		

iii			Monitoring, supervision and Coordination which includes periodic meetings and mobility					NRHM (NLEP) District Health Society	
			Mega City		1	24000	24,000		
			Metropoliton City		1	24000	24,000		
			Medium City		9	12000	108,000		
			Township		41	6000	246,000		

H. LEPROSY COLONIES

S N	Heads	Present Status	Activities planned	Time Schedule	No. Required
i		No. of leprosy colonies			72
ii		No. of persons living in colonies -			2282
		Male			1263
		Female			1019
iii		No. of persons with grade II disability			1823
iv		Number of cases with ulcer			117
Services to be provided during the year					
i			Free health check up and medicine is being done by Medical Officer of nearest Primary Health Centres		
ii			Dressing material - Self care kits are being provided by the District Leprosy Nucleus regularly under procurement items.		
iii			MCR foot wear is being provided by District Leprosy Nucleus regularly for the care of feet under procurement items.		
iv			Civic amenities like provision of electricity, water supply and sanitation are being solved by District Leprosy Officer with the collaboration of local authorities.		

I. PROCUREMENT PLAN

	Procurement/ Material & Supplies Plan at District HQ	**Expected Outcome : Provide medicines (other than MDT) , splints, crutches, MCR Footwear, welfare items for leprosy affected persons & Printing of Forms/Records. (State - Rs. 0 + District - Rs. 32,66,000) BUDGET : Rs. 32,66,000/=**							**3266000**
S N	**Heads**	**Present Status**	**Activities planned**	**Time Schedule**	**No. Required**	**Rate (In Rs.)**	**Costs (In Rs)**	**Source of cost**	**Total Budget Head wise**
i	**MDT Drugs**	MDT Supply has been received from Govt. of India free of cost.	**MDT Drugs to be supplied by GOI free of cost on Quarterly Indenting as per case load**	April 2010 to March 2011					
ii	**Supportive Medicines**	Supportive medicines procured at District level	**Procurement of Supportive Medicines at District level @ avg Rs15000 per district**	Jul-10	71	15000	**1,065,000**	NRHM (NLEP) District Health Society	
iii	**Splints and Crutches**	Splints and Crutches & Items for Deformed Leprosy affected Persons have been provided	**Splints and Crutches, Items for Deformed Leprosy affected Persons will be provided to deformity patients @ avg Rs 6000 per Distict**	April 2010 to December 2010	71	6000	**426,000**	NRHM (NLEP) District Health Society	
iv	**Patients Welfare**	Needy patients have been provided help as per their needs.	**Needy patients will be provided help as per their needs @ avg Rs 10000 per District**	April 2010 to December 2010	71	10000	**710,000**	NRHM (NLEP) District Health Society	
v.	**Printing of Form & Records**	Adequate number of printing of forms and registers have been done.	**For printing of Forms and Records & Registers etc. amount of Rs. 15,000/= is proposed per district.**	April 2010 to December 2010	71	15000	**1,065,000**	NRHM (NLEP) District Health Society	

J. NGO SERVICES

	Expected Outcome : Generate Community awareness for early case detection, effective Surviellence of cured cases, provide Ulcer Care & Deformity Prevention and Ulcer care. Budget - Rs. 51,00,000						
Present Status	**Activities planned**	**Time Schedule**	**No. Required**	**Rate (In Rs.)**	**Costs (In Rs)**	**Source of cost**	**Total budget head wise**
	Following NGOs are working under Modified SET Scheme for which Govt. of India has not sanctioned GIA for the year 2009-10. Hence to clear the pending liabilities of GIA of NGOs the following amount is being proposed.	**October to November, 2010**				NRHM (NLEP)- State Health Society	**5100000**
	a) Gramya Vikas Sansthan,Lucknow (Mohammadi Tahsil, Kheri)	**2010-11**	**1**	**396,000**	**396,000**		
	b) Jawahar Lal Nehru Sewa Sansthan, Deoria (Bhatni &Bhulouni Block)	**2010-11**	**1**	**620,000**	**620,000**		
	c) Mahila Avam Bal Vikas Samiti, Naini Lar, Deoria (Kopa & Ghosi Block, Mou)	**2010-11**	**1**	**450,000**	**450,000**		
	d)Maksad, Chandan Chouki, Paliyakalan, Kheri (Palia Tahsil, Kheri)	**2010-11**	**1**	**400000**	**400,000**		
	e) Nehru Youya Chetana Kendra, Deoria (Deoria & Baharaj Bajar Block Deoria)	**2010-11**	**1**	**502000**	**502,000**		
	f) Poorvanchal Sewa Sansthan, Deoria (Dasai Deoria, Kasiya Block Deoria)	**2010-11**	**1**	**700000**	**700,000**		
	g) Sanjay Gandhi Sewa Sansthan, Deoria (Rudrapur, Gouri Bazar, Deoria)	**2010-11**	**1**	**700000**	**700,000**		
	i) Swargiya Lal Bhadur Shastri Sewa Kusht Sewa Ashram, Azamgarh (Tarwa Firozpur Block)	**2010-11**	**1**	**432000**	**432,000**		
	j) Tripurari Sewa Avam Shiksha Sansthan, Goura Deoria (Brahmpur, Sardar Nagar Bolck, Gorakhpur)	**2010-11**	**1**	**450000**	**450,000**		
	k) Trinity Association for Social Service, St. Kabir Nagar (Brijmanganj & Noutanwa Block, Mahrajganj)	**2010-11**	**1**	**450000**	**450,000**		

K. INCENTIVE FOR ASHA

		Expected Outcome : Creating awareness about the early signs of leprosy among the people and ensure timely treatment completion with support of ASHAs . BUDGET : Rs. 26,00,000/=							**2600000**
S N	**Heads**	**Present Status**	**Activities planned**	**Time Schedule**	**No. Required**	**Rate (In Rs.)**	**Costs (In Rs)**	**Source of cost**	**Total Budget Head wise**
		ASHAs have been trained in Leprosy and started referral of suspect cases	ASHA has to create awareness about the early signs of leprosy in her village and ensure timely treatment completion of cases in her village.					NRHM (NLEP) District Health Society	
		For M.B. Cases incentive given @ Rs.500 per patient	For M.B. Cases incentive to be given @ Rs.500 per patient				2,600,000		
		P.B. Cases incentive given @ Rs.300 per patient	P.B. Cases incentive to be given @ Rs.300 per patient						

L. NLEP MONITORING AND REVIEW PLAN

		Expected Outcome : Improvement in quality of services BUDGET : Review Meetings At State HQ Rs 1,80,000 + At District HQ Rs 12,78,000 TOTAL -Rs. 14,58,000/=							1458000
S N	**Heads**	**Present Status**	**Activities planned**	**Time Schedule**	**No. Required**	**Rate (In Rs.)**	**Costs (In Rupees)**	**Source of cost**	**Total Budget Head wise**
		At State HQ	4 Quarterly Review Meetings of DLOs at State HQ @ Rs 35,000	April, 2010 to March, 2011	4	45000	180000	NRHM (NLEP) State Health Society	
		At District HQ	Monthly Review Meetings of MOs / Staff at District / Block level @ Rs 1500/= per meeting i.e. Rs. 18,000/- Per year per district.	April, 2010 to March, 2011	284	4500	1278000	NRHM (NLEP) District Health Society	

M. VEHICLE OPERATION AND HIRING

		Expected Outcome : Improvement in quality of services through field level Monitoring ,Supervision and Guidance. BUDGET : POL Mobility & Hiring Vehicle At State HQ Rs 1,70,000 + At District HQ Rs. 53,25,000 Total Rs 54,95,000)							**5495000**
S N	**Heads**	**Present Status**	**Activities planned**	**Time Schedule**	**No. Required**	**Rate (In Rs.)**	**Costs (In Rs)**	**Source of cost**	**Total Budget Head wise**
		At State HQ	Vehicle Operation & Hiring for Vehicles @ Rs. 85,000 per year	April, 2010 to March, 2011	2	85,000	1,70,000	NRHM (NLEP) State Health Society	
		At District HQ	Vehicle Operation & Hiring for one Vehicles @ Rs. 75,000/= P.A.	April, 2010 to March, 2011	71	750,000	53,25,000	NRHM (NLEP) District Health Society	

N. OFFICE EXPENDITURE AND CONSUMABLES

		Expected Outcome : Efficient functioning of SLO & DLO Offices (Office Maintenance- State HQRs.2,89,000 + District HQ Rs 51,12,000 Total BUDGET Rs. 54,01,000)							**54**,01,000
S N	**Heads**	**Present Status**	**Activities planned**	**Time Schedule**	**No. Required**	**Rate (In Rs.)**	**Costs (In Rs)**	**Source of cost**	**Total Budget Head wise**
At State HQ								NRHM (NLEP) State Health Society	289000
i		SLO Office	Telephone/ Fax/ Internet/ Postal charges etc.				125,000		
ii			Office Operation & Maintenance				60,000		
iii			Consumables Stationary				80,000		
iv			Mobile Phone Rental for SLO @ Rs2000 per month		1	24000	24,000		
At District HQ								NRHM (NLEP) District Health Society	**5112000**
vii		DLO Office	Telephone /Fax/Internet/Communication @ Rs. 15,000 per year		71	15000	1,065,000		

viii			Office Operation & Maintenance @ Rs. 18,000 per year		71	18000	1,278,000		
ix			Consumables Stationary @ Rs. 24,000 per year		71	24000	1,704,000		
x			Maintenance of Office Equipment & Furniture etc. @ Rs 15000 for the year		71	15000	1,065,000		

O. BUDGET SUMMARY

Total	*Cash Assistance*	*Grand Total*
52168100	**5000000**	**57168000**

	BUDGET SUMMARY	**(Rs. In lakhs)**
S.No.	**Activity approved**	**Amount Approved**
1)	**Contractual Services**	
	State - SMO,BFO cum AO, DEO, Administrative Assistant, Driver, Peon.	40.00
	District - Drivers.	
2)	**Services through ASHA/USHA**	
	Honararium to ASHA, Sensitization of ASHA	26.00
3)	**Office expenses & Consumables**	54.00
4)	**Capacity building**	
	2 days refresher training of District Nucleus staff at State HQ	60.00
	5 days training of newly appointed Lab. Technician by State HQ	
	2 days refresher training of MO at district HQ	
	2 days refresher training health workers /Leprosy staff at district HQ	
5)	**Behavioral Change Communication**	
	Quiz,Folk show, IPC workshop, Meeting of Opinion leaders, Health Melas	100.00
	Posters, Diagnostic Cards, Hoardings, Display Board, Wall Painting etc.	
6)	**POL/Vehicle operation & hiring**	
	2 vehicles at State Level & 1 Vehicle at district	55.00
7)	**DPMR**	
	MCR Footwear, Aids and Appliances, Welfare allowance to BPL patients for RCS, Support to Govt. Institutions for RCS	70.00
8)	**Material & Supplies**	
	Supportive drugs, Lab. Reagents & Equipments and Printing of Forms/Records	33.00
9)	**Urban Leprosy Control**	18.40
10)	**NGO - SET Scheme**	51.00
11)	**Supervision, Monitoring & Review**	
	Review meetings and travel expenses	14.60
12)	Cash Assistance	50.00
	Total	**572.00**

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

A. BACKGROUND

In Uttar Pradesh RNTCP as a pilot project was launched in Lucknow 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 18.74 Crore population. All districts have District TB Centres manned by a team of qualified & trained key personnel's viz. DTO's, Dy. DTOs, STS, STLS, TBHVs, TO's, Lab Technicians & X-ray Technicians. The State TB Officer is overall responsible for the Revised National TB Control Programme in the state.

Two Intermediate Reference Labs at STDC Agra and Dept. of Microbiology, CSSM University, Lucknow have been developed by the State for continuous monitoring and quality improvement of the microscopy activities in Uttar Pradesh by EQA (External Quality Assurance Protocol) methodology.

The programme has been decentralized up to sub district level to ensure better diagnostic and treatment facilities to tuberculosis patients. In Uttar Pradesh, services are available in all the districts through 1778 Microscopy centres & >32000 DOT centres. Services are also available through all the Medical colleges of the state.

B. ACTIVITIES UNDER RNTCP

- Under RNTCP all persons who have cough of 2 weeks duration or longer are referred for sputum smear examination (AFB). 2 samples are tested in two days.
- Diagnosed TB patient are put on DOTS (Directly Observed Treatment Short course). A Trained DOT Provider ensures that patient actually swallow the medicines in front of him. The drugs of individual patients are kept in a box bearing the name of the patient.
- All TB drugs including supportive medicines are provided free of cost under the programme.
- Paediatric Wise Boxes have also been provided for paediatric patients under DOTS.
- Under the programme training programmes are conducted from time to time for DTOs, Medical Officers, Lab Technicians, Senior Treatment Supervisors, Senior Treatment Lab supervisor and DOT Providers.
- The programme has also contributed to strengthening the TB surveillance systems in the state significantly by means of:
    - Upgradation of 376 TB Units and 1778 sub-district level laboratories (DMCs) in the State
    - Upgradation of District TB Centres
    - Sound training materials with modular contents for all category of staff
    - Supply of good quality microscopes for the labs
    - Effective drug logistic management system established
    - Development and use of Patient Wise Boxes (PWBs) including paediatric boxes, leading to uninterrupted drug supply for individual patient
    - Electronic connectivity in District TB Centres established for effective MIS

C. PROGRAMME ACHIEVEMENTS

Year wise physical performance under RNTCP:

Year	Population covered (in lacs)	New Sputum Positive (NSP) Detection & treatment under RNTCP	Treatment Success rate of NSP (%)
2007	1874	56%	86
2008	1909	66%	87

2009(1st & 2nd Qtr)	1944	71%	88
2009 (3rd Qtr)	1944	67%	88

D. MAJOR ACTIVITIES/ ACHIEVEMENTS

Under Revised National TB Control Programme (Uttar Pradesh) in 2009:

1. Rising case detection trends in U.P: To meet the objectives of the programme (NSP detection >70% and Cure rate of NSP > 85%) by taking Initiatives by the state such as:
   - Opening DMCs/DOT centres in Dist. Hospitals,
   - Increase No. of functional DMCs (Currently 1778 DMCs & 376 TUs are functional as per 3rd Qtr 09 reports
   - Increased involvement of NGO/ PPs, involvement of Medical Colleges etc.
2. Innovative improvement in the referral feedback process: by developing 12 nodal referral centres in the state at DTCs of Medical College situated districts leading to reduction of initial defaulters
3. Regular monitoring of the programme by state through innovative intensive monitoring of poorly performing districts by state level teams.
4. DRS (Drug Resistance Surveillance) in the state is being done by JALMA institute, Agra in co ordination with STDC Agra.
5. IRL & EQA implementation: STDC Agra & Deptt. of Microbiology, CSMMU, Lucknow have been developed as IRL for monitoring 35 districts each.
6. Drug management: All 4 state drugs stores operational, improvement in the state capacity for effective drug management
7. Trainings: Trainings are being conducted at state & district level as per the training calendar.
8. Internal Evaluations conducted in 2009 for Distt. Pilibhit & Sant Kabir Nagar
9. Involvement of Medical Colleges: DMC/DOT centre in all (except 4 new) Medical Colleges, Medical College reporting initiated w.e.f. 2nd Qtr 07 onwards from all medical colleges. Constant monitoring of Medical Colleges through regular 4 quarterly STF (State Task Force) meetings, ZTF (Zonal Task Force) meeting for north Zone Medical Colleges held in Srinagar on 7th & 8th Oct09.
10. IMA-GFATM-RNTCP-PPM project: launched in state & monitored by 3 regional IMA headquarters, located at Ghaziabad, Moradabad & Varanasi. Regular CMEs & training programmes are being conducted in all districts of the state.

E. FUTURE STEPS

- Strengthening inter-sectoral collaboration: build/strengthen partnerships with Medical colleges, NGOs, PPs, ESI, Railways, TB hospitals etc
- Mobilizing community participation
- Improving quality of implementation in the urban areas

F. IMA-GFATM-RNTCP PROJECT 2007-2012

- Developed as "Umbrella Model" where Public Sector will be working together under one roof to reduce scourge of TB till it becomes a public health problem.
- There is high level of consistent IMA commitment. Project is consistent with ISTC (International Standard of TB Care) and will fill up gaps in service delivery areas.

G. ANNUAL PLAN FOR RNTCP PROGRAMME

Performance & Budget for UP State for the year 1st April 2010 to 31st March 2011

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*

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

Section A – General Information about the State

1	State Population (in lakh)	1978.78 Lacs
2	Number of districts in the State	71
3	Urban population	612.55
4	Tribal population	85.36
5	Hilly population	19.71
6	Any other known groups of special population for specific interventions (E.g. nomadic, migrant, industrial workers, urban slums, etc.)	80.60

No. of districts without DTC -2

No. of districts that submitted annual action plans, which have been consolidated in this state plan – 71

Organization of services in the state:

SN	DISTRICT	TOTAL POPULATION	Number of TUs of each type		No. of DMCs of each type in the district		
			Govt	NGO	Public Sector*	Private Sector^	NGO
1	AGRA	42.28	8		37	0	3
2	ALIGARH	35.01	7		29	1	0
3	ALLAHABAD	57.85	11		36	0	8
4	AMBEDKAR NAGAR	23.71	4		21	0	0
5	AURAIYA	13.81	3		12	0	0
6	AZAMGARH	46.25	9		45	1	1
7	BAGHPAT	13.63	3		11	3	1
8	BAHRAICH	31.36	6		26	0	2
9	BALLIA	32.22	6		30	0	0
10	BALRAMPUR	19.72	4		21	0	1
11	BANDA	17.56	4		18	0	0
12	BARABANKI	31.00	6		28	0	0
13	BAREILLY	42.13	8		41	3	1
14	BASTI	24.22	5		23	0	0
15	BIJNOR	36.65	6		26	0	1
16	BUDAUN	35.93	7		33	4	0
17	BULANDSHAHAR	34.22	7		29	0	0
18	CHANDAULI	19.20	4		17	0	0
19	CHITRAKOOT	9.37	3		9	0	0
20	DEORIA	31.96	6		31	0	0
21	ETAH	18.00	3		16	1	0
22	ETAWAH	15.69	3		14	0	0
23	FAIZABAD	25.00	4		20	0	0
24	FARRUKHABAD	18.46	3		13	0	0

25	FATEHPUR	26.99	5		19	0	1
26	FIROZABAD	23.95	5		22	0	0
27	GAUTAM BUDH NAGAR	13.95	2		9	0	2
28	GHAZIABAD	38.51	8		27	5	4
29	GHAZIPUR	35.70	6		28	0	0
30	GONDA	32.38	6		29	0	1
31	GORAKHPUR	44.31	9		33	0	3
32	HAMIRPUR-UP	12.20	2		11	0	0
33	HARDOI	39.77	8		37	0	0
34	HATHRAS	15.61	3		13	0	1
35	JALAUN	17.04	3		16	0	0
36	JAUNPUR	45.79	9		41	0	4
37	JHANSI	20.45	4		17	0	2
38	JYOTIBA PHULE NAGAR	17.55	3		15	0	2
39	KANNAUJ	16.22	3		16	0	0
40	KANPUR DEHAT	18.54	3		14	0	0
41	KANPUR NAGAR	48.44	10		34	1	4
42	KANSHIRAM_NAGAR	15.00	3		9	0	0
43	KAUSHAMBI	15.16	3		16	0	3
44	KHERI	37.46	7		25	0	0
45	KUSHINAGAR	33.85	7		33	0	0
46	LALITPUR	11.44	2		10	0	0
47	LUCKNOW	43.10	8		33	0	10
48	MAHARAJGANJ	25.37	5		24	0	1
49	MAHOBA	8.30	3		10	0	0
50	MAINPURI	18.65	4		14	0	0
51	MATHURA	24.23	5		24	0	7
52	MAU	21.65	4		19	0	1
53	MEERUT	35.14	7		30	0	6
54	MIRZAPUR	24.76	5		21	1	0
55	MORADABAD	43.90	8		32	2	8
56	MUZAFFARNAGAR	41.46	8		34	0	1
57	PILIBHIT	19.24	4		20	0	0
58	PRATAPGARH	31.93	6		25	0	2
59	RAE BARELI	33.62	6		24	1	0
60	RAMPUR	22.51	5		20	0	2
61	SAHARANPUR	33.34	7		26	0	3
62	SANT_KABIR_NAGAR	16.68	3		16	0	0
63	SANT_RAVIDAS_NAGAR	15.83	3		16	0	2
64	SHAHJAHANPUR	29.85	6		29	0	0
65	SHRAVASTI	10.31	2		10	0	0
66	SIDDHARTH NAGAR	23.86	4		22	0	0
67	SITAPUR	42.34	6	1	26	0	1
68	SONBHADRA	17.13	5		22	0	3
69	SULTANPUR	37.35	7		35	0	1
70	UNNAO	31.61	6		26	0	0
71	VARANASI	36.85	7		30	0	14
	Total	**1944.17**	375	1	1648	23	107

**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

Important: Please give the performance for the last 4 quarters i.e. Oct 2008 to September 2009.

SN	Name of the District (also indicate if it is notified hilly or tribal district	Total number of patients put on treatment*	Annualised total case detection rate (per lakh pop.)	No of new smear positive cases put on treatment *	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year		Proportion of TB patients tested for HIV	No. of MDR TB suspects identified and subjects to C/DST of sputum	No. of MDR TB cases diagnosed & put on treatment
							Annualized NSP case detection rate	Cure rate			
1	Agra	8738	207	2763	65	85%	>70%	>85%	NA	NA	NA
2	Aligarh	6446	184	2589	74	88%	>70%	>85%			
3	Allahabad	8347	144	3553	61	78%	>70%	>85%			
4	Ambedkar Nagar	2173	92	1235	52	88%	>70%	>85%			
5	Auraiya	2239	162	1114	81	85%	>70%	>85%			
6	Azamgarh	4918	106	2056	44	81%	>70%	>85%			
7	Baghpat	2079	153	1004	74	88%	>70%	>85%			
8	Bahraich	5421	173	2462	79	87%	>70%	>85%			
9	Ballia	3157	98	1556	48	79%	>70%	>85%			
10	Balrampur	2388	121	1102	56	85%	>70%	>85%			
11	Banda	2244	128	849	48	86%	>70%	>85%			
12	Barabanki	5251	169	2537	82	87%	>70%	>85%			
13	Bareilly	7078	168	2922	69	84%	>70%	>85%			
14	Basti	3579	148	1192	49	84%	>70%	>85%			
15	Bijnor	4389	120	2423	66	85%	>70%	>85%			
16	Budaun	5809	162	3085	86	87%	>70%	>85%			
17	Bulandshahar	7117	208	2688	79	87%	>70%	>85%			
18	Chandauli	1932	101	998	52	86%	>70%	>85%			
19	Chitrakoot	1500	160	559	60	84%	>70%	>85%			
20	Deoria	2393	75	1188	37	84%	>70%	>85%			
21	Etah	4518	251	2145	119	86%	>70%	>85%			
22	Etawah	2757	176	1235	79	86%	>70%	>85%			
23	Faizabad	2868	115	1318	53	86%	>70%	>85%			
24	Farrukhabad	2587	140	1087	59	86%	>70%	>85%			
25	Fatehpur	3686	137	1701	63	80%	>70%	>85%			
26	Firozabad	3931	164	1503	63	84%	>70%	>85%			
27	Gautam Budh Nagar	3618	259	1242	89	88%	>70%	>85%			
28	Ghaziabad	10357	269	3651	95	87%	>70%	>85%			
29	Ghazipur	3002	84	1627	46	80%	>70%	>85%			
30	Gonda	4200	130	1747	54	87%	>70%	>85%			
31	Gorakhpur	3684	83	2015	45	85%	>70%	>85%			
32	Hamirpur	1802	148	707	58	87%	>70%	>85%			
33	Hardoi	7413	186	3102	78	86%	>70%	>85%			
34	Hathras	2179	140	1111	71	85%	>70%	>85%			
35	Jalaun	2708	159	1066	63	84%	>70%	>85%			
36	Jaunpur	7597	166	2586	56	87%	>70%	>85%			
37	Jhansi	2980	146	1492	73	87%	>70%	>85%			

38	Jyotiba Phule Nagar	2098	120	1346	77	89%	>70%	>85%			
39	Kannauj	2062	127	1076	66	91%	>70%	>85%			
40	Kanpur Dehat	2331	126	1309	71	87%	>70%	>85%			
41	Kanpur Nagar	7669	158	2931	61	83%	>70%	>85%			
42	Kanshi Ram Nagar	465	124	211	56	86%	>70%	>85%			
43	Kaushambi	2824	186	1274	84	92%	>70%	>85%			
44	Kheri	4872	130	2169	58	83%	>70%	>85%			
45	Kushinagar	2921	86	1677	50	89%	>70%	>85%			
46	Lalitpur	1666	146	748	65	81%	>70%	>85%			
47	Lucknow	7787	181	3107	72	82%	>70%	>85%			
48	Maharajganj	2256	89	1257	50	86%	>70%	>85%			
49	Mahoba	1172	141	563	68	83%	>70%	>85%			
50	Mainpuri	2109	113	1084	58	88%	>70%	>85%			
51	Mathura	3834	158	1749	72	85%	>70%	>85%			
52	Mau	1966	91	781	36	81%	>70%	>85%			
53	Meerut	6763	192	3077	88	90%	>70%	>85%			
54	Mirzapur	3098	125	1385	56	90%	>70%	>85%			
55	Moradabad	6096	139	3538	81	84%	>70%	>85%			
56	Muzaffarnagar	6371	154	3223	78	86%	>70%	>85%			
57	Pilibhit	3190	166	1490	77	82%	>70%	>85%			
58	Pratapgarh	3954	124	1492	47	84%	>70%	>85%			
59	Rae Bareli	5300	158	2244	67	81%	>70%	>85%			
60	Rampur	3906	174	1759	78	87%	>70%	>85%			
61	Saharanpur	5297	159	2295	69	87%	>70%	>85%			
62	Sant Kabir Nagar	1846	111	766	46	90%	>70%	>85%			
63	Sant Ravidas Nagar	2845	180	1116	70	90%	>70%	>85%			
64	Shahjahanpur	3961	133	2113	71	84%	>70%	>85%			
65	Shravasti	1023	99	627	61	86%	>70%	>85%			
66	Siddharthnagar	2208	93	1039	44	87%	>70%	>85%			
67	Sitapur	6867	162	2521	60	76%	>70%	>85%			
68	Sonbhadra	1903	111	1187	69	86%	>70%	>85%			
69	Sultanpur	4295	115	2148	58	86%	>70%	>85%			
70	Unnao	5276	167	2258	71	91%	>70%	>85%			
71	Varanasi	6067	165	2468	67	85%	>70%	>85%			
	Total	283383	146	125238	64	85%	>70%	>85%			

***** *Patients put on treatment under DOTS regimens only are to be included.*

Section B – List Priority areas at the State level for achieving the objectives planned

SN	Priority areas	Activity planned under each priority area
1	To sustain & further improvement in case detection activities	• Further improvement in referral of TB suspects from PHIs to DMCs by strengthening of health system, Encourage referral of TB suspects through ASHA • Awareness about free diagnostic & treatment services by effective ACSM activities • Thrust on involving more NGO & PPs in revised schemes under the programme • Further improving quality of microscopy services by monitoring under EQA by both IRLs (Lucknow & Agra) • Further strengthening & monitoring of other sectors: Medical College, ESI, Railway, Corporate, CGHS etc. • Support to IMA-GFATM-RNTCP-PPM partnership project under IMA • Support to CBCI initiative project in the state, involving all CBCI institutions in the programme. • Implementation of TB-HIV collaborative activities in all districts & monitoring referral of chest symptomatic from ICTC & vice versa. • Opening new TU s/DMCs to meet population norms
2	MDR & DOTS plus	• Action plan for DOTS plus submitted by the State to CTD.DOTS Plus

		activities will be initiated with assistance from JALMA institute Agra, followed by IRL Lucknow & Agra
3	Case holding activities	• Further strengthening of DOT network by involvement of ASHA, AWW and general health staff • Retrieval of defaulting patients by general health staff & ASHA; Monitoring default through MO- PHIs • Minimising initial default by strengthening inter district/inter state referral feedback mechanism through Nodal referral centres, developed in DTCs of Medical College districts • Thrust on involvement of NGOs in DOTS adherence schemes under the programme • Emphasis on patient provider & community meetings • Intersectoral collaboration between various departments
4	Supervision & Monitoring	• Divisional review by State officials/Additional Directors • To continue "Intensified monitoring strategy" of the districts by state level teams • Internal Evaluations of 2-3 districts in each quarter • Regular monitoring of the programme through NRHM at all levels • Ensuring movement of DTOs & MO TCs as per guidelines • Intensifying supervision at all levels
5	Trainings	• Filling up the posts of DTOs/Dy. DTOs, MOTCs, • Training of untrained DTOs, TOTs & MO TCs at National & state level • Refresher trainings of MOs & other staff • Drug and logistics management workshops for the SDS (Pharmacists and JD) and all the DTC (DTO and pharmacist) • Ongoing training activities in Medical colleges • Training of MOs from other sectors • Training of >50% of MPW & MPHS, Paramedical staff
6	Strengthening of IRLs & Lab network	• Further strengthening of IRL at Lucknow & STDC Agra for future DST & DOTS plus. Microbiologist appointment in IRL • Increase in the visits by IRL teams & all components of EQA to be monitored by IRL • Accreditation of IRL Lucknow & Agra
7	Implementation of TB-HIV co ordination programme	• Regular reviews & feedbacks for District Co-ordination Committees by State Co-ordination Committee on Quarterly basis • Provision for CPT during treatment under RNTCP
8	ACSM activities	• School awareness programme • Involving more NGOs in revised ACSM schemes • General awareness in the community about the facilities available for free diagnosis & treatment under DOTS. Emphasis on community meetings and continuous Patients Providers Interaction Meetings • Strengthening of DOTS services in the urban slums involving NGOs • Optimum utilization of Communication Facilitators to promote IEC activities at Dist. Level • Sensitization of PPs with active participation of IMA • Awareness about free diagnostic & treatment services in Masjids, Gurudwara, & other religious places regularly

Priority Districts for Supervision and Monitoring by State during the next year

SN	District	Reason for inclusion in priority list
1	**Mau**	Lower case detection & cure rates
2	**Deoria**	Lower cases detection
3	**Siddharthnagar**	Lower cases detection
4	**Azamgarh**	Lower cases detection
5	**Gorakhpur**	Lower cases detection
6	**Ghazipur**	Lower case detection & cure rates
7	**Sant Kabir Nagar**	Lower cases detection
8	**Pratapgarh**	Lower cases detection
9	**Ballia**	Lower cases detection & cure rates
10	**Banda**	Lower cases detection
11	**Basti**	Lower cases detection
12	**Kushinagar**	Lower case detection
13	**Maharajganj**	Lower cases detection
14	**Sitapur**	Low cure rate of NSP
15	**Allahabad**	Low cure rate of NSP

Section C – Consolidated Plan for Performance and Expenditure under each head, including estimates submitted by all districts, and the requirements at the State Level

1. *Civil Works:*

Financial Norms:

a. Initial Establishment/Refurbishment costs One Time Costs

- DMC- Up to Rs 30,000 per DMC
- TU – Up to Rs 35,000 per TU
- DTC – Up to Rs 1.5 lakhs per DTC
- New DTC (where no DTC exists) up to Rs 4 lakhs per DTC which includes the above provision of Rs 1.5 lakhs per DTC
- STO Office up to Rs 50,000
- State Drug Store – up to Rs 4 Lakhs
- IRL – up to Rs 10 lakhs for Laboratory and Monitoring unit
- DOTS Plus Site-up to Rs. 10 Lakhs

b. Maintenance of Civil works:

- DMC: Rs. 1000 per year
- TU: Rs 1300 per year
- DTC: Rs 4500 per DTC per year
- State TB Office, IRL/STDC, SDS, DOTS Plus Site: Rs 75000 per year

The maintenance amount for DMCs and TUs may be pooled at district level and repairs are undertaken where necessary. In addition, one time provision of Rs. 1.5 lakhs per SDS and Rs 30,000 per District Drug Store to improve storage capacity for 2nd line drugs for DOTS Plus.

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	Pl provide justification if an increase is planned in excess of norms (use separate sheet if required)	Estimated Expenditure on the activity	Quarter in which the planned activity expected to be completed
	(a)	(b)	(c)	(d)	(e)	(f)
STC/STDC/ IRL	2	2	0	Maintenance, as per norms	75000	
SDS	4	4	2	For DOTS Plus for 2nd line drugs at two DP sites, SDS Agra & SDS Lucknow, As per revised norms	300000	
DOTS Plus site	2	0	2	As per State DOTS Plus Action Plan (Revised norms)	2000000	
Dist. Drug stores at DOTS Plus sites	3	0	3	For 2nd line drugs at two DP sites in 3 DTCs, STDC/DTC Agra, DTC Lucknow & DTC Barabanki, as per revised norms	90000	
DTCs	71	69	2	At JP Nagar & Varanasi	800000	
TUs	395	382	7		245000	
DMCs	1958	1840	118		3540000	
Maintenance total DTC, TU, DMC	All DTC, TU & DMCs > 1year old	-	-	For all DTC,TU & DMCs > 1year old, may be clubbed at Distt. level	2638100	
TOTAL					9688100	

2. Laboratory Materials:

District Level: Rs. 1.5 Lakh/million Populations. If the case detection is more, the consumption of laboratory consumables is higher & costing enhanced proportionately.

Activity	Amount permissible as per the norms in the state	Amount actually spent in the last 4 quarters	Procurement planned during the current financial year (in Rs)	Estimated Expenditure for the next financial year for which plan is being submitted (in Rs)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
Purchase of Lab Materials by Districts	33353824.67	23970538.00	29776000.00	33604312.00	
Lab materials for EQA activity at STDC (e.g. Lab consumables for trainings, preparation of Panel slides etc)	2916000	48992	2300000.00	2250000.00	For C & DST in IRLs for DOTS Plus & EQA (Financial norms at State Level: Rs. 0.15 lakh/million population at State level for procument of lab material for states performing culture and DST activities.)
Lab materials & consumables for Culture/DST activity at IRL and other Accredited Culture & DST labs in Govt. sector including Medical Colleges					
Total				35854312.00	

3. *Honorarium:*
    a. Honorarium permissible: [Estimated Rs. 250 * 75% of 283383 (total registered cases)]
    b. Rs. 2500.00 per case for MDR cases under DOTS Plus

Activity	Amount permissible as per the norms in the state	Amount actually spent in the last 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
Honorarium for DOT providers (both tribal and non tribal districts)	53134313	17662206	20000000	53134313	
Honorarium for DOT providers of Cat IV patients	100 X 2500	0	0	250000.00	As per DOTS Plus action plan
Total				53384313	

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

- Information on previous year's Annual Action Plan

a) Budget proposed in last Annual Action Plan (2009-10) - Rs. 20090000.00
b) Amount released by the state - Rs. 5791245.00 released to state & districts in Oct 2009/Dec2009. The expenditure will be reflected in SOE of 31.12.09
c) Amount Spent by the state & districts - Rs. 8321821.00 (01.10.08 to 30.09.09 - last 4 Qtrs)

- Permissible budget as per norm: Rs. 10859302.00 (including urban population) + 1000000.00(State with > 30 Million pop.)+14,00,000.00 (Communication Facilitator) = Rs. 13259302.00

- Budget for next financial year for the district as per action plan detailed below: Rs. 17465750.00 (Dist.) + 5000000.00 (State level WB & GFATM large state > 190 Million Pop.)+ 1400000.00 (Communication facilitators) = 23865750.00

ogram Challenges to be tackled by ACSM during the Year 20010-11	WHY ACSM Objective	For WHOM Target Audience	WHAT ACSM Activities		When Time Frame				By WHOM	Monitoring and Evaluation		Budget	
Based on existing TB indicators and analysis of communication challenges (Maximum 3 Challenges)	Desired behavior or action (make SMART: specific, measurable, achievable, realistic & time bound objectives)		Activities	Media/ Material Required	Q1	Q2	Q3	Q4	Key implementer and RNTCP officer responsible for supervision	Outputs; Evidence that the activities have been done	Outcomes: Evidence that it has been effective	Total expenditure for the activity during the financial year	
Challenge 1. Low case detection													
Advocacy Activities													
			1.One to one meeting district authorities		71	71	71	71	Dist. TB officer				No cost involved
			2.Sensitization meeting		75	75	75	75					300000
			3.Briefing Meetings		65	65	65	65					130000
			4.Program information	-poster in local language	16800	16800	16800	16800					806400

			5.Factsheets/ pamphlets	-Fact sheets	92500	92500	92500	92500	Distt. TB officer			1110000
			6.World TB Day	-success stories	18	18	18	17	Distt. TB officer			575000
Communication Activities												
			Participate in the biannual health mela	Booklet/Flip Book, Posters, Stickers, Banners, Pamphlet, Patient information booklet	36	35	36	35				426000
			Wall painting on TB	Cost of wall painting	2099	2098	2098	2098				3357200
			Audio Visual aid material for increasing public awareness in TB	Hoardings	64	63	64	63				2032000
				Tin Plates	2328	2327	2328	2327				1862000
				Banners	422	421	421	421				421250
				Mike publicity	274	273	273	273				874400
				Sticker	15550	15550	15550	15550				311000
Social Mobilization activities												

			Community Meeting	Meeting material	1468	1467	1468	1467				1761000
			Celebration of World TB day	Budgeted above								
			Exhibitions /Mela's / Popular Events in District.	Cost of Hiring of place and display material & cost interactive games, prizes etc	36	35	36	35				284000
			Drawing & Quiz Competitions		285	284	284	282				567500
			TB Sessions during NSS caps in school and college, Drawing & Quiz Competitions	Drawing material etc	141	141	143	140				281500
			OTHERS (HAAT, ETC)		643	642	643	642				257000
			Any other /Need Based Activities		178	177	178	177				710000
Challenge 2: Poor case holding/High default rate												
Advocacy Activities												
			1.Interaction Meetings		550	550	550	550				660000
			2.One to One Interaction Meetings	(no cost for one-to one IPC)	71	71	71	71				
			3. Use of Information Booklet	Cost of patient information booklet (Will be budgeted from state level for cost effectiveness)								
Communication Activities												
			Sharing of experience of									

			cured patients / Patients during Treatment.									
			Interpersonal communication with patients	(no cost for one-to one IPC)								
Social Mobilization												
			Sensitization of Departments Social welfare schemes	Cost of one meeting no of meetings	40	40	40	39				79500
			Interaction meetings	Cost of such meetings	550	550	550	550				660000
TOTAL BUDGET												**17465750**

4. Equipment Maintenance:

Computers/Photocopier /Fax – Rs 30,000/per year per district and per State • Binocular Microscope -Rs. 1500 per microscope per Year for AMC • Culture and DST equipment - 15% of cost of C&S equipment per Year The maintenance funds will be pooled at state or district level and arrangements made for responsive maintenance of equipment for least down time.

Item	No. actually present in the state	Amount actually spent in the last 4 quarters	Amount Proposed for Maintenance during current financial yr.	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
Computer (maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)	68	1660678	7000000	2064000.00	
Computer/photocopiers at state level/SDS/STDC	8			240000.00	

(maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)					
Binocular Microscopes (RNTCP)	1981	Expenditure Committed, released in Oct 09*		5943000.00	Since CMC OF BM's is planned
STDC/ IRL Equipment	2			560000.00	Two for STDC/IRL Agra & IRL Lucknow Culture and DST equipments - 15% of cost of C&S equipment per Year (Cold rooms & Incubators) including generator running & maintenance cost
Any Other (pl. specify)					
TOTAL				8807000.00	

Training to be planned as Initial Training, Retraining and Update training. **District level:** The year-wise costs for training and review meetings at district level are Rs. 55,000 per million population. **State Level:** The year-wise costs for training at state level are Rs. 15,000 per million population. *During training programmes the norms for lunch, refreshment and TA/DA costs would be as per approved norms under NRHM/State Health Society. (**Therefore the norms enhanced proportionately).*** **Review meetings (State level):** The cost for review meetings at state that include quarterly meetings of DTOs and half-yearly meetings of key policy makers are as under: • Rs. 2 lakh/year for states with >30 million population.

5. Training

Activity	**No. in the state**	**No. already trained in RNTCP**	**No. planned to be trained in RNTCP during each quarter of next FY (c)**				**Expenditure (in Rs) planned for current financial year**	**Estimated Expenditure for the next financial year (Rs.)**	**Justification/ remarks**
			Q1	Q2	Q3	Q4			
TB/HIV Training of MO-TCs and MOs	1243	33	24					21800	
TB/HIV Training of STLS, LTs , MPWs, MPHS, Nursing Staff, Community Volunteers etc	13703	1213							
TB/HIV Training of STS									
Training of MOs and Para medicals in DOTS Plus for management of MDR TB								277200	
Provision for Update Training at Various Levels #								700000	Update Misc. trainings at district level
Any other training activity- Medical College training plan through STF								1100000	Govt. MC @ 75000/- per Med. Col; Pvt Colloege @50000/- per MC
Any other training activity- State level Trainings of MOTC/MO/STS/STLS; budget for TA/DA for trainings paid through DHS in districts								1994000	
State level trainings for MOTC/STS/STLS/Drug management trainings/DOTS Plus Etc								3103888	
Review Meetings at State Level								400000	Enhanced from norms due to >190 Million population,

Activity	**No. in the state**	**No. already trained in RNTCP**	**No. planned to be trained in RNTCP during each quarter of next FY (c)**				**Expenditure (in Rs) planned for current financial year**	**Estimated Expenditure for the next financial year (Rs.)**	**Justification/ remarks**
	(a)	(b)	Q1	Q2	Q3	Q4	(d)	(e)	(f)
Training of DTOs (at National level)	71	71	20	10	10	10	14000000 (Total planned)	800000	
Training of MO-TCs									Included in State level trainings budget
Training of MOs (Govt + Non-Govt)	**371**	290	349	349	349	349		**5304800**	
Training of LTs of DMCs- Govt + Non Govt	**1993**	**1767**	73	72	72	72		**997050**	
Training of MPWs			366	366	366	366		**1156560**	
Training of MPHS, pharmacists, nursing staff, BEO etc	27496	13410	252	251	251	251		**793950**	
Training of Community Volunteers	**50089**	20849	1409	1408	1408	1408		**2310350**	
Training of Pvt Practitioners	**7578**	**1329**	157	157	157	157		**709640**	
Other trainings #									
Re- training of MOs	**2929**	**1305**	460	459	459	459		**3233120**	
Re- Training of LTs of DMCs	**880**	441	222	221	221	221		**1528350**	
Re- Training of MPWs	**5806**	**2561**	333	332	333	332		**591850**	
Re- Training of MPHS, pharmacists, nursing staff, BEO	**1274**	**552**	167	166	166	166		**295925**	
Re- Training of CVs	**4104**	**2313**	467	466	466	466		**764650**	
Re-training of Pvt Practitioners	**719**	**7**	32	31	31	31		**141250**	

6. *Vehicle Maintenance:*

Cost of POL and maintenance has been taken as: • 2 wheelers – Rs. 25,000 per year • 4 wheelers – Rs. 1.25 lakh per year • 4 wheeler of State TB cell/STO-Rs 2.00 lakh per year In case of 4 wheelers, funds for vehicle operation are only provided to districts which have jeeps rather than hired vehicles.

Type of Vehicle	**Number permissible as per the norms in the state**	**Number actually present**	**Amount spent on POL and Maintenance in the previous 4 quarters**	**Expenditure (in Rs) planned for current financial year**	**Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)**	**Justification/ remarks**
	(a)	(b)	(c)	(d)	(e)	(f)
Four Wheelers		13	8649536	12775000	1375000.00	
Four Wheelers (State level STO/STDC)	2	2			400000.00	
Two Wheelers	389	389			9950000.00	Including 7 new proposed TUs
				TOTAL	11725000.00	

7. *Vehicle Hiring*:*

MOTC for 7 days a month up to Rs 750/day (up to Rs 850 / day for in tribal and hilly areas) **DTO** (where not provided with Jeeps) Up to 25 days a month, Rs 750/ day

Hiring of Four Wheeler	**Number permissible as per the norms in the state**	**Number actually requiring hired vehicles**	**Amount spent in the prev. 4 qtrs**	**Expenditure (in Rs) planned for current financial year**	**Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)**	**Justification/ remarks**
	(a)	(b)	(c)	(d)	(e)	(f)
For STC/ STDC/IRL	5	5	13440671.00	34900000.00	1125000.00	Two State MO`s, 1 TB-HIV co ordinator, Two IRL
For DTO	58	58			12850000.00	
For MO-TC	389	389			24318000.00	Including 7 new proposed TUs
				TOTAL	38293000.00	

** Vehicle Hiring permissible only where RNTCP vehicles have not been provided*

8. NGO/ PP Support:

Activity	No. of currently involved in RNTCP	Additional enrolment planned for this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
ACSM Scheme: TB advocacy, communication, and social mobilization	42	69	4237684.00	4000000	16115000	
SC Scheme: Sputum Collection Centre/s	36	155			11460000	
Transport Scheme: Sputum Pick-Up and Transport Service	24	149			4152000	
DMC Scheme: Designated Microscopy Cum Treatment Centre (A & B)	96	32			19200000	
	0	96			4800000	
LT Scheme: Strengthening RNTCP diagnostic services	0	20			2272000	
Culture and DST Scheme: Providing Quality Assured Culture and Drug Susceptibility Testing Services	0	0			0	
Adherence scheme: Promoting treatment adherence (NGO)	33	64			3880000	
Adherence scheme: Promoting treatment adherence (PP)	79	290			3690000	
Slum Scheme: Improving TB control in Urban Slums	12	48			3000000	
Tuberculosis Unit Model	2	2			1878000	
TB-HIV Scheme: Delivering TB-HIV interventions to high HIV Risk groups (HRGs)	3	6			1080000	
Total	**327**	**931**			**71527000.00**	

9. Miscellaneous:

State level: Population of >30 million – Rs 7 lakhs **District level:** • Rs. 1.5 lakh/million population /year in RNTCP districts. *TA/DA would be as per approved norms under NRHM.* Only costs not covered by State/Districts budgets will be provided under project funds.

Activity* e.g. TA/DA, Stationary, etc	**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 for the next financial year (Rs.)**	**Justification/ remarks**
	(a)	(b)	(c)	(d)	(e)
For IRL Lucknow	3,00,000.00	80821.00	120000.00	200000	
For STDC Agra	3,00,000.00	213515.00	200000.00	200000	
SDS				1700000	For Drug Transportation
Preparatory Activities For DOTS Plus				170000	----Sputum Transportation to Jalma ,Agra Rs.140000 ---Printing of Forms, Rs.30000, Registers for DOTS Plus
State Level	7,00,000.00	923828.00	1500000.00	1500000	Large state with 71 districts
District Level	**29681699**	16683891.00	25300000.00	29589037	
			TOTAL	33359037	

10. *Contractual Services:*

Contractual Staff (State Level): The costs of each category of contractual staff is as under: • *Asst.Program Officer/ Epidemiologist –Rs 40,000 p.m. • Medical officer - Rs 30,000 p.m. • TB-HIV Coordinators – Rs 35,000 p.m. • Urban TB Coordinators – Rs. 20,000 p.m. • DOTS Plus Site Sr. Medical Officer – Rs. 30,000 p.m • DOTS Plus Site Statistical Assistant – Rs. 15,000 p.m • Microbiologist (IRL)– Rs 40,000 p.m* • Sr. LT (IRL)-Rs.15,000 p.m • IEC Officer – Rs. 18,000 p.m • Accounts Officer/ State Accountant – Rs.18,000 p.m • Secretarial Assistant – Rs.8500 p.m • Pharmacist/Storekeeper– Rs 12,000 p.m. • Store Assistant (SDS)– Rs. 8000 p.m • DEO (State TB Cell)– Rs.10,000 p.m • DEO (IRL) – Rs.10,000 p.m • Driver Rs.7000 p.m* Contractual Staff (District Level) The cost for each category for each contractual staff is as under: • *Medical Officer (District) Rs. 28,000 p.m • Sr. DOT Plus & TB-HIV Supervisor–Rs.15000 p.m. • STS /STLS (each)- Rs. 12,000 p.m • LT - Rs. 8500 p.m • TBHV -Rs. 8000 p.m* In addition a fixed TA of Rs 750 p.m is also payable, against appropriate travel documentation • *DEO -Rs. 8500 p.m • Accountant (Part Time) -Rs. 3000 p.m • Driver -Rs. 7000 p.m* A fixed allowance of Rs 1000 per month will be given to contractual STS/STLS/LT at TU/DMCs in notified tribal areas as per the tribal action plan. DA (daily allowance for travel) is only to be released against appropriate travel documentation. Where eligible such DA may be paid under State Government rules from the miscellaneous head. All new recruits will commence at above basic rate of remuneration. All contracts will be for one year. Contracts will be renewed by the society based on satisfactory performance. In the renewed contract the remuneration would be enhanced by up to 5% each year. Enhancement will be calculated over the basic rate and not the remuneration in the previous year.

Category of Staff	**No. permissible as per the norms in the state**	**No. actually present in the state**	**No. planned to be additionally hired during 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)		(d)	(e)	
TB/ HIV Coord.		1		14.71 Cr.	18.72 Cr.	420000	
Urban TB Coord.		6				1440000	
MO-STCS			2			720000	
State Accountant		2				432000	
State IEC Officer		1				216000	
Pharmacist		4				576000	
Secretarial Asst		1				102000	
MO-DTC		11				3696000	

STS	388	382	6			55872000	
STLS	388	382	6			55872000	
TBHV	247	195	52			23712000	
DEO (including DEO at IRL)	74	72	2			7548000	
Accountant – part time	71	71				2556000	
Contractual LT	782	686	86			78744000	
Driver		8				672000	
Asst Programme Officer/Epidemiologist			1			480000	
DOTS Plus Site Sr. Medical Officer			2			720000	
DOTS Plus site Statistical Assistant			2			360000	
Sr. DOTS Plus& TB/HIV Supervisor (district level)			2			360000	
Sr. LT at IRL			2			360000	
Store Assistant (State Drug Store)		4				384000	
Any other contractual post approved under RNTCP			1			480000	
					TOTAL	235722000	

11. Printing:

Rs.1.50 lakh/million population, including printing undertaken at State and District levels

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 for the next financial year for which plan is being submitted (Rs.)**	**Justification/ remarks**
	(a)	(b)	(c)	(d)	(e)
Printing-State level:*	2997000.00	3157960	5000000	10900000.00	
Printing- Distt. Level:*		8966256	7500000	19056170.00	

Total				**29956170.00**	

** Please specify items to be printed in this column*

12. Research and Studies (excluding OR in Medical Colleges):

Research proposals up to Rs 5 Lakhs may be approved by the ZTF (for medical colleges) or OR committee of the STCS. Proposal above Rs 5 lakhs will be forwarded to CTD. CTD may approve proposals upto Rs 15 lakhs and proposals above Rs 15 lakhs will be forwarded to the Central OR Committee.

Any Operational Research projects planned (Yes/No) _____Yes, DRS Study by JALMA Institute, Agra_____
Estimated Total Budget _____**20,74,000.00**_____

13. Medical Colleges:

The Medical colleges can be provided with the contractual staff (MO, LT and TB HV) as per requirement. . Rates of contract are same as for similar staff at district level. Provision has been made for need based training of resident doctors of all departments in RNTCP. It is expected that 50 residents/year/medical college would require this training. A thesis grant of Rs 20,000 for research on RNTCP priority areas will be approved by STF at one thesis per medical college per year. Provision is also available for support to Conferences, symposiums, panel discussions and workshops organized at National and state levels and at level of Medical college.

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 __12_) ▪ STLS in Medical Colleges (Total no in state __2_) ▪ LT for Medical College (Total no in state ___11) ▪ TBHV for Medical College (Total no in state_12__)		MO 12 4032000 STLS 2 288000 LT 11 1122000 TBHV 12 1152000 Total 6594000	
Research and Studies: ▪ Thesis of PG Students ▪ Operations Research*	22 X 20000.00 500000.00 X 5	440000.00 2500000.00	1 per Med. Col. X 22 Med. Colleges
Travel Expenses for attending STF/ZTF/NTF meetings	20000.00 per meeting 5000.00 X 12 for touring of STF	140000.00	

	chairperson		
IEC: Meetings and CME planned	35000.00 per STF meeting	140000.00	
Equipment Maintenance at Nodal Centres	30000.00	30000.00	
Total		9844000.00	

14. *Procurement of Vehicles:*

Equipment	No. actually present in the state	No. planned for procurement this year (only if permissible as per norms)	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)
4-wheeler **			0	
2-wheeler	300	81	4050000.00	Old two wheelers to be replaced

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

15. *Procurement of Equipment:*

Equipment	No. actually present in the state	No. planned for this year (only as per norms)	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)
Office Equipment (Computer, modem, scanner, printer, UPS etc.)		10	600000.00	For replacement of old computers
Office Equipment for SDS, IRL & two DOTS Plus sites (Computer, modem, scanner, printer, UPS etc.)		7	420000.00	3 for state & SDS, 1 each for two IRLs, 1 each for two DOTS Plus sites
Total			1020000.00	

Section D: Summary of Approved Budget for 2010-11

Category of Expenditure	*(Rs. in lacs)*
1. Civil works	96.90
2. Laboratory materials	286.80
3. Honorarium	373.70
4. IEC/ Publicity	167.10
5. Equipment maintenance	74.90
6. Training	180.00
7. Vehicle maintenance	93.80
8. Vehicle hiring	191.50
9. NGO/PP support	214.60
10. Miscellaneous	233.50
11. Contractual services	2357.20
12. Printing	179.70
13. Research and studies	20.74
14. Medical Colleges	75.00
15. Procurement –vehicles	40.50
16. Procurement – equipment	10.20

TOTAL	**4596.14**

- **Additionality Funds from NRHM-**Details of the activities with justification for which Additional Funds are proposed to be sought.

1. Budget for continuation phase treatment of old MDR cases who are under treatment under Interim plan from budget provided in previous year; Re. 25 Lacs
2. Renovation of hostel & training hall in STDC cum Intermediate Reference Lab (IRL) at Agra: Rs. 2265000.00
3. Training hall in Thakurganj TB Hospital, Lucknow: For various state level trainings cum workshops under RNTCP, Rs. 3473000.00
4. Additional Instruments for Intermediate Reference Lab (IRL) Lucknow considering additional load for culture & DST for MDR TB suspect, for treatment under DOTS Plus: Rs. 57 Lac

Additional Liquid culture system	35 Lacs	For starting liquid culture at IRL Lucknow (We have cultured >2400 patients' samples in year 2009)
Thermal cycles and other PCR accessories	5 Lacs	For starting assays like line probe assays so that immediate work can be started
Bio safety cabinets	10 Lacs	For culture and DST
Microcentrifuge	3 Lacs	For processing of samples
Inspissator	4 Lacs	For sterilization of solid media (LJ)

Additionality Funds from NRHM-Total =139.38 lacs against which Govt. of India has sanctioned the budget under the following heads, under Mission Flexi-pool (FMR Head B 26.3).

S.N.	Subject	(Rs. in lacs)
1	For continuation phase of MDR cases	25.00
2	Renovation of hostel and training hall in STDC Agra	22.65
3	Construction of Training Hall in TB Hospital, Thakur Ganj, Lucknow	34.73
	Total	**82.38**

D. SITUATIONAL ANALYSIS

I. Infrastructure-

S.No	ITEMS	No.
1	Eye Surgeon in District	All
2	Blocks with inadequate eye care services	Nil
3	Block PHC/CHC equipments(NPCB GOI norms)	735
4	Upgraded block PHC/CHC equipments(i.e refraction Services available) (NPCB GOI norms)	Operative equipments at 187 CHC (IOL Centres) and refractive services at 735 PHC/CHC.
5	Vision Centres	130 established in Govt. sector. at PHCs/CHCs
6	District Hospital- facilities for eye surgery available	71
7	No. of District Hospitals with dedicated Eye O.T.	47
8	Sub District Hospitals	15
9	No of Sub District Hospitals where Cataract Surgeries undertaken	15
10	Medical Colleges	15(10 Govt.+ 5 Pvt.)
11	Central Ophthalmic Mobile Unit	9
12	District Ophthalmic Mobile Unit	60
11	Eye Bank	18
12	Eye Donation Centres	1
13	PMOA(Para medical ophthalmic assistant) Training Schools	3 at Govt. Medical colleges and 86 in Pvt Sector.
14	PMOA Posted	936
15	Eye Surgeon	350 (in Govt. Sector)
16	Blind schools	4 (At Gorakhpur, Saharanpur, Lucknow and Banda)
17	NGO Associated with NPCB	18 recognized at state level and 106 at district level.
18	Number of Eye Surgeons Trained under NPCB (2009-10)	22
19	Number of PMOA's given re-orientation training (2009-10)	70 at Satguru Netra chikitsalaya-chitrakoot

II. Programme-

The component wise status of programme :-

Sl.	Intervention	Targets	Achievement till Dec-09	Expected achievement by Mar-10	Remarks
1	Cataract Operation	714000	300452 (294191-IOL)	7,14,000lacs	• Delayed procedural exercise for purchase of IOL. • The targets will be achieved till March as most of the cases are operated in winters. • Non recurring grant for up gradation for 5 NGO's was not sanctioned, as proposed in PIP of the last year.
2	School eye Screening	33,00,000	14,51,525	33,00,000	• Expecting better results than targeted as the activity has been linked up with School health scheme(Ashirvad)
3	Free Spectacles for Poor Children	70000	21314	70000	• Against separate requirement proposed in PIP 09-10 of Rs. 400 lacs for providing the Spectacles to 2 lacs children, the approved and released budget by GOI was merged with Cat Oprt. which affected the implementation of the programme .???? • Procuring agency at State level notified in Dec-09 which also effected the implementation of the programme
4	Corneal Collection	700	279	700	• Due to lack of public awareness • Separate budget proposed for IEC of this activity last year was not approved by GOI.
5	Vision Centre	50	0	50	• GIA not released by GOI for vision centres till nov-2009
6	Eye donation Centre	5	1	2	• After full functioning of eye banks it will take off gradually. • Lack of response from the field.

III. Financial-

Budget Approved in year 2009-10 PIP(in lacs)	Opening balance for the year 2009-10 (in lacs)	Total amount released till Dec-09 (in lacs)	Total availability of fund during the year was (in lacs)	Total expenditure till Dec 2009 (in lacs)	Unspent amount (in lacs)
3015.00	1479.01	2016.96	3953.92	1422.42	2531.5

E. TARGET FOR 2010-11:

Sl.	Activity	Target for 2010-11	Budget Requirements for the year 2010-11 (Rs. In lacs)
1	Cataract Operations	7.14 lacs with 98% IOL operations	4662.50
2	School Eye Screening	50 lacs Children of aged 8-14 years & free Distribution of 2.00 lacs spectacles to poor children	828.00
3	Corneal Blindness	Target of 2000 eye pair collection and 2000 Corneal transplantation	66 l
4	Diseases other than Cataract Surgeries (Diabetic Retinopathy, Glaucoma, Childhood Blindness, Vitreoretinal Surgery, Laser Technique, Low vision aid etc.)	Treatment of 52,000 patients	1041.83
5	Total		6598.33

F. ACTIVITY WISE SITUATION OF THE PROGRAMME

1. Cataract Surgery

As the survey conducted in 2004 by Govt. of India 62% of blindness is due to cataract .Estimated 3.5 cataract cases are added every year. So to reduce cataract blindness our targets and achievements for last 3 years are mentioned below

TREND

Sl.	Year	Target (In lacs)	Cataract Surgical Rate Achieved per lac population	Achievements	% Achievement of IOL Operations against total Cataract Operations
1	2007-08	5.50	317	5.97 lacs	93.66%
2	2008-09	7.14	371	6.97 lacs	95.02%
3	2009-10	7.14	400	7.83 aimed	97.00%
4	2010-11	7.14	400	7.83 aimed	98.00% (expected)

Strategies to Achieve the Targets of 2010-11

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 NGO's those are good in technical skills
7. Extended I.E.C. Programme by Electronic media, Print media and Local Agencies, AIR & National Channels to approach rural and remote area supported by local IEC.

Budget Requirement-

- Targets for cataract operation in the year 2010-11 is 7.14 lacs, out of which 50% will be operated in hospitals owned by govt. / NGO sector (3.57 lacs) and 50% will be operated in private sector hospitals (3.57 lacs). As GOI provides Rs.750/- for an operation in govt /NGO owned hospital, the total requirement is Rs. 2677.50 lacs.

- This year 130 operating centres (CHCs and other hospitals) will be provided a new microscope. The cost of a microscope is 5.00 lacs each. Therefore for purchase of 130 microscopes we require 650 lacs.
- 10 good performing govt. hospitals will be provided specialized high quality microscope; the cost of such microscopes is 16.00 lacs each. Therefore Rs. 160 lacs is required for procurement of 10 microscopes.
- 20 Good performing District Hospitals will be provided Phecoemulsification Machines . The cost of a Phacomachine is 15.00 lacs each. Therefore for purchase of 20 Phacomachine we will require 300 lacs.
- 350 Flash Autoclaves for autoclaving ophthalmic surgical equipments quickly to avoid boiling of the instruments. Cost of one Flash Autoclaves is 2.50 lacs. Therefore for purchase of 350 Flash Autoclaves Rs 875.00 lacs are required.

Sr.	Activity	Unit cost (in Rs)	Target	Total cost
1	Cataract Surgery by govt. and NGO sector	750	3.57 lacs	3425 lacs(approved under scheme GIA for catops and other approved activities)
2	Microscopes for operating centres (CHCs and other hospitals)	500000	130	650 lacs
3	Specialized high qualities microscope for big govt. hospitals	1600000	10	160 lacs
4	Phacoemulsification Machines	1500000	20	300 lacs
5	Flash Autoclaves	250000	350	875 lacs
6	Total			4662.50

2. School Eye Screening

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. It is proposed that this activity will be under taken by ASHA/ MPW (Male) and primary school teachers trained for the purpose and Optometrists under school health programme under NRHM. These workers will be trained for under taking screening process and making referral for refraction to block PHCs. District Health Society will supply the refractive glass to needy students.

Target for 2010-11

a. Screening of 50 lacs Children of aged 8-14 years
b. Free Distribution of 2.00 lacs spectacles to poor children @ Rs 200 each in year 2010-11.

Strategies to Achieve the Targets of 2010-11:

- Training of ASHA, MPWs and school teachers at primary level.
- Suspected refractive error children referred to PHC/CHC/NGO Hospitals/ trained Optometrist for proper refraction and will provide free spectacles to poor children.
- Involvement of NGO's in Screening of Children having low Vision for non school going children..
- Development of 100 VISION CENTRE at PHC/CHC level each in every 71 district and rest 29 in NGO/PVT sector with the equipment & furniture and fixture in the year 2010-11 so that in next 4 years all block health facility will have a vision centre.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
- The training will be completed by June and screening progamme by Sep. 2010. School wise report will be generated by ASHA depicting name of school, no of children screened, No of children with defective vision referred to PHC.
- Through local IEC all schools will have wall painting/writing in relation to eye screening programme.
- The training of ASHA for eye screening is already included in regular ASHA training programme by NRHM.

Budget Requirement for year 2010-11

- For providing free spectacles to 2.00 lacs students with rate of Rs 200 each, total amount required is Rs 400.00 lacs.

Total amount required is Rs 400.00 lacs for this activity.

Sr.	***Activity***	***Unit cost (in Rs)***	***Targets***	***Total cost***
1	Providing free spectacles	200	200000	400
2	Total			400lacs

9. Corneal Blindness

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 for 2010-11

- Target of 2000 eye collection and 2000 Corneal Transplantation in the year 2010-11 is targeted

- Collection of Donated eye & providing Keratoplasty Services in all Medical Colleges and registered Eye Banks.

Strategies to Achieve the Targets of 2010-11

- Primary eye care medicines will be available at PHC/CHC level.
- 18 Eye Banks are already registered till 2009-2010 and 10 eye banks will be registered in 2010-2011.

Budget Requirements for year 2010-11

- Among all 18 registered eye banks 5 eye banks have received the grant of Rs.10 lacs and rest 13 will require non recurring grant. But in the year 2010-11 we can provide assistance to only 2 eye banks, Rs.15 lacs /per bank (Revised rates). Therefore we require Rs.30 lacs for this purpose.
- 5 eye Donation centres will be provided, Rs.1 lacs each for eye collection and preservation (non recurring grant). Thus Rs.5 lacs will be required for this purpose and Rs.1.00 lacs will be required for recurring GIA to Eye Donation Centre.

Sr.	Activity	Unit cost (in Rs)	Targets	Total cost (in lacs)
1	Assistance to eye banks	1500000	2	30
3	Recurring GIA to Eye Donation Centre.			1
5	Total			31

Total amount sanctioned from GOI for this activity is Rs 31 lacs.

10. Diseases other than Cataract Surgeries

(Diabetic Retinopathy, Glaucoma, Childhood Blindness, Vitreoretinal Surgery, Laser Technique, Low vision aid etc.)

About 16% of total blindness is due to diabetes, glaucoma and other above mentioned disease. Currently there is 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 diabetic retinopathy and other posterior segment disorders.

Strategies to achieve targets:

- All known diabetics to be examined by eye surgeon /ophthalmic asstt.
- Tonometry, fundoscopy and indirect ophthalmoscope will be done at weekly clinic at all district hospitals.
- Medical Management of diabetic retinopathy and surgical management of glaucoma at divisional level hospital.
- For surgical intervention patients referred to Tertiary centres (medical colleges and NGO hospitals) for diabetic retinopathy, Glaucoma and other eye diseases.
- For operation of equipments optometrist should trained at medical colleges by state govt.
- Eye surgeons to be trained in diabetic retinopathy and Glaucoma by central government.

Financial requirement

- A direct ophthalmoscope for each 800 CHC will cost (Rs.15,000 X 800= Rs 120.00 lacs)
- For glaucoma treatment we require 50 applanation tonometers for well working hospitals @Rs 60000 each and will cost (50X 0.60 lac= 30 lacs)
- For glaucoma treatment and screening every CHC and eye hospital will require one schortz tonometer @ Rs 5000 each and will cost (835X 0.05 lac=41.75 lacs)
- For the treatment of diseases other than cataract state require Rs 520 lacs for 52000 patients(50% of the total patients estimated i.e. 1,04,000), Rs 1000 each.

Sr.	Activity	Unit cost (in Rs)	Targets	Total cost (in lacs)
1	Direct ophthalmoscope	15,000	800	120.00
4	Applanation Tonometers	60000	50	30
5	Schortz Tonometer	5000	835	41.75
7	Other than Cataract, corneal blindness and refractive errors(including 20 lacs for corneal blindness)	1000	52,000	520
	Repair and maintainance of ophthalmic equipments at district hospitals-71, sub district hospital 16		71 district and 16 sub district hospitals	87.00

8	**Total**			**798.75**

Total amount sanctioned is Rs 798.75 lacs for this activity.

G. HUMAN RESOURCE:

I. TRAININGS

Target for year 2010-11

- Training of PMOA (Paramedical Ophthalmic assisstant/Optometrist) to be conducted by State in Refraction & instrumentation on 4 training centers namely – Satguru eye Hospital Chitrakoot, U.P., KGMU Lucknow, MD eye hospital Allahabad & LLR Medical College Meerut.
- Training of Staff Nurses in Ophthalmic O.T. and Ward Management at – Satguru eye Hospital Chitrakoot, U.P., KGMU Lucknow, MD eye hospital Allahabad & LLR Medical College Meerut.

- **Budget Requirement**

S.No.	No. of Trainees	Name of Training	Duration	Cost (in lacs)
1	200 PMOA's	Refraction & Instrument Management	5 Days	8
2	150 Staff Nurses (2 from each district)	O.T. & Ward Management	4 Weeks	15
3	**Total**			**23**

II. MANPOWER

Contractual Manpower for Govt. hospitals and eye banks-
Budget Requirement

Vacancies	No. of post	Annual expenditure
Ophthalmic Surgeon (Salary of Rs.25000/- p. m.)	**30**	**90.00**
Ophthalmic Assistant (Salary of Rs.8000/- p.m.)	**35**	**33.60**
Eye Donation Counsellor (Salary of Rs.10000/- p.m.)	**10**	**12.00**
Total	**75**	**135.6**

The budget sanctioned from GOI under this head is Rs. 135.60 which has previously been released from GOI and no expenditure has been reported.

H. INFRASTRUCTURE

I. Strengthening of State Cell of Blindness Control Programme

GoI has recommended staff and financial norms for strengthening State Cell of NPCB at Directorate. Fund for this activity is available. With the integration of the State Health Society NRHM, the strengthening component will be integrated with the State Programme Cell. The fund requirement for 20010-11 is as under:

S No		Staff on Contract Basis	Monthly Rate	Annual Requirement (In Rs.)
A.	1	Budget & Finance Officer	15000	180000.00
	2	Administrative Assistant/ Statistical Assistant	7000	84000.00
	3	Data Entry Operator	7000	84000.00
	4	Peon	5000	60000.00
	Sub-Total			4,08,000.00
B.	1	TA/DA to Staff	8000	96000.00
	2	POL and Vehicle maintenance	15000	180000.00
	3	Stationery & Consumables	8000	96000.00
	4	Hiring Of Vehicles	8000	96000.00
	5	Contingency and Other expences	10000	344000.00
	6	Monthly Review Meeting	15000	180000.00
	Sub-Total			9,92,000.00
C.	Support for District Nodal Office for 71 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 –POL and other Misc Exp Rs.7000/- per month)		One time Expense – Rs. 0.50 lacs/ District for 71 districts Recurring - Rs.0.105 lacs pm/ per District for 71 districts	35,50,000.00 89,46,000.00
Total				1,38,96,000.00

II. Up gradation of hospitals

In the year 2010-11 following new Centers will be added for eye care services.

Sl.	Level	Infrastructure to developed	Funds required

		in 2008-09	
1	Up gradation of 2 NGO Hospitals	2 NGO hospitals will be provided non-recurring grant of Rs. 30.00 lacs for the strengthening /up-gradation of their Hospital.	60.00 lacs.

I. INNOVATIONS

- Mobile Ophthalmic units with tele network- we want to establish at least 2 unit in our state@ Rs. 60 lacs /unit = 120 lac

J. BUDGET SUMMARY (Figure in Lacs)

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS GRANT – IN – AID TO STATES / UTs FOR VARIOUS COMPONENT DURING 2010-11		**Physical Target**	**Funds Approved from GOI(in lacs)**
Recurring Grant-in aid(*)	For free Cataract operations @ Rs 750/- per case and other Approved schemes as per financial norms(*)	357000	2677.50000
	GIA for 130 Ophthalmic Microscopes Operating centres and CHC.(5.00 lacs X 130=650 lacs)	130	650.00000
	10 specilized ophthalmic microscope for 10 big hospitals @ Rs 16.00 lacs (16.00 lacs X 10=160 lacs)	10	160.00000
	20 Pheco Machines 20 District Hospitals and other big hospitals @ 15.00 lacs each. (15lacs X 20=300lacs)	20	300.00000
	Flash Autoclaves for 350 operating centers in State @ -2.5lacs.(2.5 X 350= 875 lacs)	350	875.00000
	100 Refraction unit chair with slit lamp @ of Rs 2.50 lace. each	100	250.00000
	100 Streak retenocope for district and subdistrict hospitals(100 X.@20000/each= 20.00 lacs)	100	20.00000
	52 Auto refractometers for district and sub district hospitals (52 X @4.00 lacs /each=208.00 lacs)	52	208.00000
	800 Direct Ophthalmoscope for PHCs/CHCs @ 0.15 lacs (0.15 X 800=120.00 lacs)	800	120.00000

	50 applination tonometer for selected district hospitals (50 X 60000/each=30.00 lacs)	50	30.00000
	835 sheortz tonometer for treatement of glaoucoma in Phc/Chc and DH(835 X @5000/each=41.75 lacs)	875	41.75000
	Repair and maintenance of Ophthalmic Equipments at District Hospitals-71, Sub-district hospitals-16. (@ 1.00 lacs/district X 71)	71 DH and 16 sub district ospitals	87.00000
	GIA for Diseases other than cataract (Diabetic Retinopathy, Glaucoma, etc.) @ Rs 1000.00	52000	520.00000
	Training- PMOA & Staff Nurse.		23.00000
	IEC(World Sight Day (2 lacs X 71= 142 lacs and Eye donation Fort night (0.35 lacs X 71= 24.85 lacs) and comprehensice IEC Rs 1.00 lacs each distrctr=71 lacs	-	237.85000
	Office Expences of State NPCB under NRHM, Other activities & contingency.	-	14.00000
	Recurring GIA to Eye Banks(2000 eye DonationX Rs 1500.00 per pair eye collection)	2000	30.00000
	Recurring GIA to EDC (@1000 X 1 EDC)	100	1.00000
	Grant-in-aid for School Eye Screening(2 lacs spec. @ 200/- each=400.00lacs	2000000	400.00000
	For Vision Centres @ Rs.50000/-	50	25.00000
	For Eye Bank @ Rs.15 Lakhs	1	15.00000
	For Eye Donation Centre @ Rs.1 Lakhs	5	5.00000
	For NGOs @ Rs.30 Lakhs	1	30.00000
			6720.10
	Fund sanctioned from GOI for Cataract operations and other activities under recurring GIA is -		3425.00
	Fund sanctioned from GOI under non recurring GIA is -		75.00
Total fund sanctioned from GOI is 3500 lacs. In case funds in a specific allocation are exhausted, the State may demand further funds.			

*** Recurring Grant-in-Aid for Free Cataract Operations and various other schemes which include**: Other Eye Diseases @ Rs 1000/-, School Eye Screening Programme @ Rs 200/- per pair of spectacles, Private Practitioners @ as per NGO norms , Management of

State Health Society and District Health Society @ Rs 14 lakhs/ 7 lakhs, Recurring GIA to Eye Donation Centres @ Rs 1000/- pair of Eye Ball collection and Eye Banks @ Rs 1500/- per pair of Eye Ball collection Rs 1500, Training, IEC, Procurement of Ophthalmic Equipment, Maintenance of Ophthalmic Equipments, Remuneration, Other Activities & Contingency.