

National Rural Health Mission

Revised Programme Implementation Plan With Work Plan for 2006-2007

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**State Rural Health Mission
C/o State Health Society
Department of Health & Family Welfare
Chhattisgarh**

NRHM Revised PIP, Chhattisgarh 2006-07

Sl. No.	Contents Particulars	Page Number
	GOALS	5
	SITUATION ANALYSIS:	6
Section 2	Part A-RCH-II Flexipool	
1.	Training.-	17
1.1.	<i>IMNCI Training</i>	17
1.2.	<i>Training on skilled birth attendance</i>	19
1.3.	<i>Paramedical skill development of male field workers</i>	20
1.4.	<i>Multi-skilling of Doctors</i>	21
1.5.	<i>Induction training of new Medical officers</i>	22
1.6.	<i>Training on Adolescent Health</i>	22
2.	Improving FRU & PHC performance	23
3.	Improving District Hospital Functions	24
4.	Strengthening Routine Sub-Centre functioning: Drugs/supplies	24
5.	Implementation of PNDT Act	26
6.	Strengthening the Mitadin Programme :	26
7.	Behaviour Change Communication:	31
8.	Urban Health Programmes:	33
9.	Tribal Health Programmes:	34
10.	RCH Camps for Non-tribal blocks	35
11.	Adolescent Health	36
12.	Additional Support for Malaria Care for Pregnant Women	37
13.	Incentives for MOs serving in MUAs	38
14.	Special Health Care Initiatives at conflict areas	38
15.	PROGRAMME MANAGEMENT	38
16.	Technical Assistance	42
17.	Mandatory Spending Items under RCH-II	43
	RCH flexipool: Budget At A Glance	44
Section 3	Activities under PART B- NRHM Flexipool	
1.	Jeevan Deep Samitis: Better Management of Facilities	47
2.	Strengthening Nursing Training Facilities	49
3.	Provision of Untied funds for Subcentres	50
4.	Mitadin Programme under 'ASHA' Component	50
5.	Improving BCC	53
6.	Village and Panchayat Level Capacity Building	56
7.	State Level Resource Capacities: SHRC	57
8.	Provision of Drugs for PHCs/CHCs	57
9.	Mainstreaming AYUSH	58
10.	NRHM Programme Management- Block PMUs	58
11.	Advanced Mobile Medical Units in All Districts	58
	Budget At A Glance	59
Section 4	Immunisation Activities	63
Section 5	Budget Summary	77
	Gender Budgeting	81
	District Level Budget Allocations	82
Section 6	Logframe for the NRHM initiatives	85

1. Introduction:

The State of Chhattisgarh was created in the year 2000. It was at the time of its creation one of the weakest states in performance in the health sector. Its rural IMR was a shocking 95 per 1000, which was the second lowest performance amongst all states. Outreach of basic services was very poor and the state inherited a poor manpower, infrastructure. From the year 2002 and the sector investment programme the state put in place a steady programme of health sector reform that is now 4 years old.

The major causes for the poor performance in the health sector were attributed to

- a) Poor situation as regards social determinants of health – poverty, hunger, nutrition, safe water and sanitation – in all of which the state was one of those performing poorly . Indeed the only social determinant in which the state was performing comparably or better than other states was in the sex ratio.
- b) Poor development of the public health system. The number of facilities created were below national norms and the number of facilities with infrastructure was even more alarming. There were large vacancies – over one third posts being vacant in all categories. Financial resource available was limited and even manpower for planning and management was severely constrained.

Over a period of last 5 years, the state has shown tremendous willpower and determination to improve the overall health status of the people. There has been a remarkable improvement not only in the infrastructure scenario, but also in terms of human resources and programme designs, which in turn have yielded very positive results.

2. Goals:

Chhattisgarh State is committed to a vision of reducing IMR to less than 35, MMR to below 200 and TFR to 2.1 by the year 2012- the end of the 11th five year plan period.

These goals will be attained by a set of processes that empower local communities that are affordable, and provide equitable access to health care services, that are gender sensitive and that are directly or indirectly contributing to the reduction of poverty in the state.

For this, the state plans major interventions to strengthen the public health system in whole as well as to improve current health programmes related to maternal health, child health, family planning, adolescent health, urban health and tribal health programmes, disease control and disease surveillance including tertiary level care in other parts of the state.

2. SITUATION ANALYSIS:

The state's current demographic and health profile is given in the table below:

Table 1: Demographic and Health Profile of Chhattisgarh

Indicators	India		CG Situation	
	2000	2004/	2000	2004
<i>*IMR Total</i>	68	58	79	60
<i>*IMR Rural</i>	74	64	95	61
<i>*IMR Urban</i>	44	40	49	52
*Birth Rate Total	25.8	24.1	26.7	27.4
*Birth Rate Rural	27.6	25.9	29.2	29.3
*Birth Rate Urban	20.7	19.0	22.8	19.4
*Death Rate Total	8.5	7.5	9.6	7.7
*Death Rate Rural	9.3	8.2	11.2	8.1
*Death Rate Urban	6.3	5.8	7.1	6.0
**Population in million (2001)		1027	20.79	
*Natural Growth rate- total		16.6		19.7
*Natural growth rate- rural		17.8		21.2
*Natural growth rate- urban		13.3		13.3
**Population Share (%)	100		2.02	
**Population Density	324		154	
**Female Literacy Rate 2001 (%)	54.28		52.4	
**Rise in Female Literacy Rate since 1991 (% points)	15		24.88	
**Sex Ratio	933		990	
**Tribal Populn (%) (SC & ST popln. given in brackets(%))			34(43%)	

* SRS data** Census

Programme Experience:

Apart from the diseases covered under various national programmes, the state has also been facing state specific problems of sickle cell anaemia, enormous levels of malnutrition and anaemia and diseases like Malaria, diarrhoea etc, which are blown out of proportions.

However, the state has been successful to overcome these enormous handicaps to catch up with the national averages –as explained in the figures given below.

A number of external evaluation and data collection processes have yielded considerable data over the last five years. These cover key social determinants of health like malnutrition and the performance on key indicators. A brief meta-analysis of these are presented below.

A “Meta-Analysis” of External Studies of Performance on key health indicators:

Parameter:	NFHS-II (1999)	NFHS-III (2005)	DLHS (2002-04)	UNICEF – Mode(2005-06)
Child Malnutrition- Stunting (<3 yrs)	57.9	45.4		
Child Malnutrition – Underweight	60.8	52.1		
Adult Malnutrition- Women BMI	48.1	41.1		
Anemia Women	68.7	58.6		
Anemia Children	87.7	81.0		
Couple Protection Rate (%)	45.0	53.2	46.6	
Couple Protection Rate by Spacing	3.9	5.1	4.9	
Couple Protection Rate by Sterilization	38.4	44.2	36.4	
Full ANC	33.2	54.7	48.7	30.9% (70%-76% for 2 doses TT)
Institutional Delivery	13.8	15.7	20.2	19.2
Skilled assistance at birth Delivery	32.3	44.3	29.1	33.4
Children Fully Immunized (%)	21.8	57.58	60.9%	48.1
Measles Immunised	40.0	62.5	70.2	72.0
Breastfeeding in first hour 36 mnths/2 hours 36 months(DLHS)/ 2.hrs of birth and 24 hrs – 12months(UNICEF)	13.9	24.5 (1 hr)	30.0 (2 hrs)	71(2hrs) 88(24 hrs)
Breastfeeding Exclusive	NA	82.0 (5mths)	35.1(4mnt hs)	61.4
ORS use in childhood diarrhoea	29.7	42.0	42.2	NA

This meta-analysis shows that there has been a significant decline in malnutrition and anemia- though these are far too high still. A considerable acceleration of the approach would be needed. NFHS and DLHS are done using the same methodology and are hence comparable. Whereas DLHS data collection was partly in 2002 and partly in 2003, NFHS was in 2005. We find therefore find in family planning a steady improvement in couple protection rates – from 45.0% to 46.6% to 53.2% over 5 years. Most of this increase is contributed by increased performance in sterilisation. This is reflected on the ground by unmet needs becoming increasingly unmet demands and conventional tubectomy and vasectomy rising to meet this need – given the constraints on equal expansion of laproscopic tubectomies. Again this is an area where considerable acceleration has become possible and necessary as the decreasing IMR is leading to a sudden spurt in the population growth rate and an increased IMR.

On ante natal care also there is considerable forward movement – at a steady rate from 33.2 to 48.7 to 54.7. This should accelerate further with closing of gaps in the sub-centers and increased provision of ANMs. Quality of care – completion in terms of all the elements of antenatal care remain a challenge. Thus whereas the UNICEF survey shows an impressive 70% for check-ups and completion of two doses of TT- it drops to 30.6% if all elements of care and the third check-up is added in.

In immunisation the figures for total immunisation are completely skewed between the different sources and does not correspond to any pattern pointing to the subjective difficulties of this particular index. On the other hand measles vaccination coverage is a more replicable and definite index. It also correlates better with the advantages in child survival that immunisation provides. Indeed for these reasons it is the preferred index and

has been made the MDG indicator for child survival – along with under 5 and infant mortality. In measles immunisation the state has increased to 70 % by both DLHS and the UNICEF coverage survey. Which is up from 40% in NFHS-II. However NFHS- III puts it at 60% - an increase over NFHS-II but lower than two other figures of this period- probably an underestimate on this parameter.

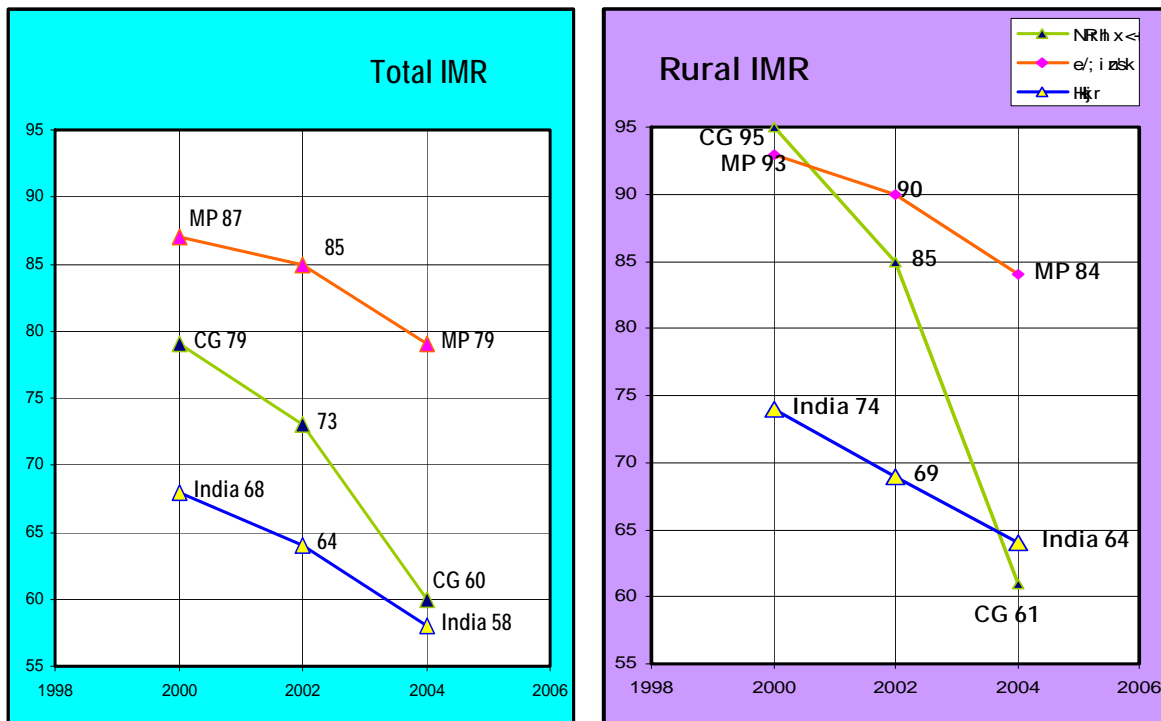
Looking for indicators of community level action we find few indicators that are not dependent on supply side action. Of these breastfeeding in the first hour – which theoretically can by itself lead to a decrease of 16% in infant mortality- is one of the most sensitive and exclusive breast-feeding is another. ORS use in diarrhoea is a third. Breastfeeding initiation is dramatically improved by UNICEF – to 88% in the first day, 71% in the first two hours. This matches very closely with the Mitadin programmes internal evaluation figures which looks at this as a programme outcome and has put the current levels at 76% in the first day. Given the fact that when we started sixth day onset of breastfeeding was the norm this is a great improvement. DLHS sets a base line of 30.0% in 2002-03 and NFHS of 13% in 1999. In contrast to this we need to look at the NFHS figure of 24% for this. Though a doubling of the NFHS –II figure we have the choice of either ignoring it – or believing it very literally. That would mean that most mothers in Chhattisgarh breast feed within the first few hours – but not necessarily in the first hour. This would match with current programme design which puts the focus on the Mitadin visit *after* the child is born. In the first hour would mean that the skilled birth assistant would have to ensure this – and the percentage coverage of skilled birth assistance is still far too low.

In exclusive breast feeding the figure is 82% by NFHS. UNICEF figures put it at 61.4%. However UNICEF report notes that “reported” exclusive breast feeding would be higher- as there is a different meaning made of exclusive breast-feeding at the community level. In ORS usage the figure is a rise to 42% by both NFHS and DLHS. We do not have figures for this from other surveys.

Only one more key issue to be discussed is the dramatic 16 point accelerated fall in IMR over the year 2003 to 2004 by SRS data and an overall decline of 34 points in rural IMR over five years. Even after accounting for statistical variation due to change of sample frame and due to higher range of error the over all change is far too dramatic to be explained by anything other than an over all programme effect. Since it is still too early for it to be due to expansion of curative services, it is much more likely to be related to changes in health seeking behaviour and key child health practices related as much to the social mobilisation and general awareness as the actual service delivery. The only other data of this period is NFHS-III – but as the NFHS takes a five year sample its figure is attributed to the year 2003. Comparing the NFHS- 2003 IMR with SRS data we find that NFHS data is completely comparable with SRS data for 2003.

	NFHS-II	SRS 2000	NFHS-III (2003)	SRS (2003)	SRS 2004
Infant Mortality Total	81	79	71	70	60
SRS Rural	na	95	75	77	61
SRS Urban	na	49	51	55	52

The trends of total IMR and rural IMR in the state as per SRS reports 2002 to 2006 is presented below:



As Per SRS Data

Below we look at the key programme outputs in this period : Many of them have contributed to this situation- but most of them are still being rolled out and their effect would be perceived only later:

1. Addressing Gaps in infrastructure

- There has been a creation of 874 new sub-centers and 200 new PHCs and 16 CHCs in this period. This has brought up the creation of these facilities to what has been stated as required as per norms.
- There has been acceleration in creation of infrastructure buildings. Taking funds from all sources – 34 CHC buildings have been built to IPHS norms and funds are in place for another 96 buildings (5 crores from SIP, state funds, and NRHM). At least we can reach the minimum infrastructure needed for the creation of a functional FRU immediately though it may take longer to meet IPHS norms in all.
- In sub-centers however the gap is enormous. Over 260 sub-center buildings are under construction- but given the enormous gap of over 2800 sub-centers to be built this is less than 10%. If we are to move towards two ANM sub-centers, and institutional delivery at every sub-center then this task becomes a challenge.
- In PHCs also there is a substantial gap of over 300 PHCs that need to be built.
- Other than health facilities we need a district training center in each district and an office for the chief medical officer and district health society.
- We would also need over 10 more ANM training and nurse schools and two medical colleges which also have their infrastructure requirements

2. **Training:**
 - a) The SIHFW building is nearing completion and would be ready for inauguration in October. It is being registered as a society and is given to SHRC to operationalise and then hand over. An administrative set up is in parallel being approved for it.
 - b) The training materials needed for multi-skilling medical and paramedical staff is in place. The material for nationally guided training is also in place. Training of trainers has been completed for skilled birth assistance and for IMNCI.
 - c) Under RCH-II a complete training programme has been chalked out.
 - d) Under NRHM training of Mitanins and some of panchayat members for community based training is planned.
3. **Operationalisation of FRUs & institutional delivery:** Though the state has made considerable headway in this it is doing very poorly. Only one in four Sub-Centres have adequate space for institutional delivery and even in these achieving institutional delivery has been difficult due to inability to make referral arrangements and due to a conflicting job description of the ANM that needs her to be away on most days. These problems are not there with Sector PHCs but it was not focussed on becoming a site of 24-hour institutional delivery and basic emergency care. With such a goal now in place and skilled birth assistance and manpower planning being put in place – about 74 out of a planned 96 PHCs have started providing 24 institutional delivery. Further all 116 CHCs have become functional as 24 hour sites of institutional delivery. The larger goal regarding CHCs is to reach IPHS standards – incorporating both the concept of FRU and CEmONC centers. Of this we began work on 32 centers and of these 32, 9 have now initiated emergency obstetric care services and 25 Basic emergency obstetric care services.
4. **Medically Underserved Areas:** There are still many sectors that because of vacancy or absenteeism have not had a doctor in the last year and there are also many sections where because of geographical constraints and workforce issues or programme design issues there have been very poor delivery of paramedical services. Some of these areas are remote hilly tribal areas and others are medium and large urban or semi urban concentrations. A policy on this is being mooted.
5. **Community Level Care organization: The Mitanin Programme:** because of the geographical dispersion of the population (4500 sub-centres to cater to 54,000 hamlets and 26,000 villages) and because of inadequate health seeking behaviour first contact curative care for many of the life saving interventions at the village level and for prompt referrals needs an outreach that extends to every hamlet on a Daily basis. This is most critical for preventing infant deaths though it will also have benefits for all other RCH and other disease control components. Current community care arrangements are centered around the Mitanin. The traditional Dai performs a very limited range of functions even within care at child-birth. The options therefore are to strengthen the Panchayat role and build on the Mitanin programme. The Mitanin by virtue of being a woman, selected by the community at the hamlet level addresses both these gender and equity imbalances also. The programme is doing well and over 55,000 Mitanins are functional. There is a monitoring system in place and the outcomes are now measurable – both at the level of impact and at the level of immediate outputs and outcomes.

6. **Weak urban health systems:** Urban Health Systems are particularly weak and access to poor is limited. Though there is an abundance of public and private facilities in this area the critical weakness is in access to basic health programmes and secondary level care that is affordable for the urban poor. As a result the urban IMR has been stagnant at around 52/1000 in contrast to the declining rural IMR. A urban health care system has been proposed under RCh-II.
7. **Inadequate Health awareness:** Though in many areas of RCH demand factors are not the critical step, they continue to play an important role. More investment in BCC strategies and a greater focus of BCC campaigns are called for.
8. **Programmatic and Financial Management Issues:** Management of RCH programmes – both programmatic and financial need improvement. Part of the problem is qualified manpower for these purposes at the state and district levels and part of the problem is governance related.
9. **Technical Assistance:** The SHRC is one unique institution created for technical assistance. Now we are also having, UNICEF, the Regional Resource Center, the Micronutrient Foundation and CINI, CARE and possibly another EC technical assistance group. In addition in the area of capacity building and BCC the SIHFW is being built technical assistance. The SHRC is able to provide coordination with all these groups and their coordination with the government.
10. **Financial Position for RCH-II and NRHM** The position of the fund received from GOI is depicted in the table. As per the table no fund is left at the state out of the allocated 27.46 cr received under RCH-II Flexi Pool:

Item	Allocation	Receipt	Actual Exp.	Gap	SOE	UC
A1 (RCH- PIP)	32.5	27.46	31	3.4	29	26
A2 (Mandatory Spending items)	7.89 (JSY, FP & VT)	Nil	4	4	4	4
B1 (ASHA)	14.0(trg) 12.39(drug)	7.85 (trg.) 12.39(drug)	6.3 12	- -	6.3 12	3.9 5.4
B2 : (Special Initiatives)	24.93	12.8 (FRUs) 1.6 (dt plan) 8.83 (untied fund)	13 1.6 8.8	- - -	13 1.6 8.8	6.4 8.8
C: (Immun)	4.23	4.23(accel Imm)	4.1	-	4.1	4.1

This table thus shows that the state has been able to utilise most of the funds available to the state in the year 05-06. In fact under RCH-II, there is a need for another almost Rs. 7.5 crores which has been spent over and above the total receipts. We were assured of mandatory spendings being reimbursed separately, which had not been done and thus this requirement which GoI may like to reimburse.

The detailed write up of the situational analysis has already been presented in the combined 2005 to 2007 PIP presented in January 2005 and is not repeated here.

TECHNICAL STRATEGIES:

These are the broad technical strategies for reduction of IMR, MMR & TFR that the state has decided to focus on. The funding for these activities are addressed along with the cross-cutting themes.

Strategies:

For Maternal Health:

- i. Focus on quality antenatal care in Sub-Centres by better support and training to MPW (F). Institutional delivery only to the extent possible.
- ii. Focus on 24-hour institutional delivery with essential and basic emergency care in all Sector PHCs and in every CHC, with referral linkages from the sub-centre and villages to ensure that all pregnancies are channelized to these centres.
- iii. Focus on select CHCs (100 across the state) becoming venues for comprehensive emergency obstetric care by closing all hardware gaps and a major thrust in multiskilling.
- iv. Bringing in private sector partners to close gaps in basic and comprehensive emergency obstetric care.
 - v. Provision of safe MTP services in all CHCs and district hospitals
 - vi. Provision of RTI/STI services in all CHCs and district hospitals with primary care for the same more peripherally.
- vii. Bringing in NGOs to close gaps in para-medically under-served areas.
- viii. Building up transport and referral systems.
- ix. Building up community care and support systems centred around the Mitandin Programme so as to improve health awareness and demand for institutional services, improve link between ANM and those in need of her services as well as to facilitate the delivery of maternity benefits and referral arrangements.
- x.
- xi. BCC programmes to support the above

For Child Health:

- i. 100% immunisation including the booster dose by strengthening subcentre level services and its supervision.(This would be addressed in a separate supplementary PIP)
- ii. Prompt and appropriate community level care for all sick children and neonates and prompt referral where indicated.
- iii. Regular House visits and counselling by community level care givers for preventive and promotive health of children and the reduction of child malnutrition.
- iv. Adequate referral arrangement and secondary care facilities for sending a sick child or neonate when it requires hospitalisation.
 - v. Special care for the sick malnourished child.
- vi. Reducing cost of care especially on inessential and hazardous drugs and therapies so as to favourably impact on poverty levels.

For Family Planning:

- i. Every district hospital would provide terminal sterilization services at least twice if not thrice a week.
- ii. Hundred CHCs would provide sterilization on a fixed day of the week.
- iii. The above block CHCs and 16 district hospitals would also be capable of providing safe MTP services.
- iv. The above block and district hospitals would also have adequate diagnostics for referral level STI/RTI services.
- v. In three months of the year all the remaining blocks would have at least three sterilization days in their CHCs. In the coming years these would also change to fixed-day weekly-once service availability.

- vi. Every village would have one social marketing outlet, which would have supplies of condoms and OCPs without interruption throughout the year. These would be managed by partnership with a private distributor network with subsidy to make it viable to operate in low off take areas.
- vii. All 24 hour PHCs would have one fixed-day of the week where IUD insertion would be available and other contraceptive follow up would be encouraged. Emergency contraception would also be available on 24 hour basis.
- viii. All 24 hour paramedical and medical staff would be trained to provide basic clinical and counselling services for RTI and STI with basic investigations (side laboratory level).
- ix. Every hamlet would have at least two volunteers who would have a limited stock of the supplies available- either collected from the village distribution point or from the health department.
- x. Social marketing for OCPs and condoms along with other health related commodities
- xi. A focused IEC campaign would continue to build up demand for these services.

For Adolescent Health

- i. BCC programmes.
- ii. Open adolescent counselling services with referral access to essential services at the CHC and district hospital level.
- iii. Major effort to screen for and manage anaemia and malnutrition in adolescence and where relevant for sickle cell anaemia.
- iv. Peer education programmes in schools and some areas in the villages.

Part A- RCH Flexipool

ACTIVITIES UNDER RCH-II PLAN for 2006-07:

1. Training.

Training on the following areas would be undertaken:

1.1. IMNCI training in Three districts: Koriya, Bastar, Rajnandgaon.

WHO/UNICEF have developed a new approach to tackling the major diseases of early childhood called the Integrated Management of Neonatal and Childhood Illness.(IMNCI). Studies show that children presenting with any illness often suffer from more than one disease. For instance, a child presenting with diarrhoea may also be malnourished and may not have received the immunization as per schedule. The integrated approach ensures that all relevant needs of the sick child are looked at and attended to during the contact of the sick child with the health workers. The funding proposed is for two districts this year. The third district Rajnandgaon is already taken up with UNICEF support

Key Operational elements:

- **Training for skills development:**

IMNCI training includes a systematic participatory approach, clinical sessions and feedback, all focused on development of required skills for managing a sick child both during home visits and also in health facilities. While training is an important input for implementation of IMNCI, this is not the only one. Effective implementation of IMNCI in a district also involves the following components.

- **Coordination with other Departments, PRIs, Mitanins, Self Help Groups, etc:**

Implementation of IMNCI in an effective way in any district would be possible only with the total involvement of ANM'S and Anganwadi workers of ICDS, and of Mitanins. Special efforts will thus be required on the part of the district CMHOs to involve the concerned departments. For training of health staff and follow-up and supervision of IMNCI activities in the district, the involvement of paediatrics units/departments of District Hospitals will be necessary. The involvement of the Departments of Paediatrics and Preventive and Social Medicine of the local or regional medical colleges would be sought.

- **Improvement in the health system:**

- Ensure availability of the essential drugs covered under IMNCI. Improving referral to identified referral centre. For this referral centres will need to be identified and their capacity developed
- Ensure availability of health workers / providers at all levels
- Ensure supervision and monitoring through follow up visits by trained supervisors as well as on-the-job supportive supervision

- **Improvement in family and community practices:**

- Counseling of families and creating awareness among communities on their role is an important component of IMNCI. This includes:
 - Counseling of care givers and families as part of management of the sick child when they are brought to the health worker/health facility.
 - During Home Visits- Home Visits provide an opportunity for identification of sickness and focused BCC for improving newborn and child care practices.
 - IEC campaigns for awareness generation.

The IMNCI trainings will be conducted in 3 priority districts of the state as per the guidelines in place issued by Government of India following the technical issues listed out by WHO. A batch of state level trainers has already got trained under this.

Institutional Arrangements:

Training under IMNCI will be held as part of RCH-II trainings but being Chhattisgarh is a state with less training infrastructure, partnership with SHRC or RRC or other suitable agency for state level training would be considered. A nodal officer will be appointed to coordinate entire IMNCI initiatives for RCH society. At district level, the training programme will depend upon the available training infrastructure in the districts. The national guideline does not project budget allocations for accommodation facilities for trainees, as these trainings were supposed to be held in and by training institutions. Looking at the constraints that are being faced by Chhattisgarh in terms of training infrastructure, budget projections have been made for the stay arrangements of trainees.

Budget Estimate:

Sl. NO.	Description of Trainers/Workers	No of courses Per Unit	No of Units	Estimated cost per batch	Total for State
1	8 day Training of 24 STATE LEVEL TRAINERS	1	1	243800	243800
2	10 day Training of 25 District Trainers/Facilitators	1	1	220225	220225
3	8 days Training of 100 Supervisors (LHV, Mukhya Sevika, CDPO, Block PHC MOs).	5	2	101200	1012000
4	8 days Training of about 180 field workers in each district (ANMs, AWWs).	9	2	94588	1702584
	Total				3178609

Every training got expenditure heads as TA for Trainers and participants, DA for Trainers and participants, Food & Accommodation for Trainers and Participants, material cost, expert costs and Contingencies.

Rest of the budget provisions are for meeting Institutional costs at about 15% of total expenditures incurred.

Descriptions of above expenditures for different levels:

Sl. NO.		State Level Trainers	District Trainers/Facilitators	Supervisors	Field workers
1	Strength of the batch (Including 5 Resource Persons)	30	30	25	25
2	No. of camp days	8	10	8	8
3	TA per person per camp	1000	500	400	250
4	DA Per person per camp/travel day	100	100	100	100
5	Food & Stay per person per camp day	500	400	200	200
6	Contingencies per person per camp day	25	25	25	25
7	Material cost per person per camp	300	200	100	100
8	Experts Honorarium per camp	20000	10000	8000	6000
	Total budget for a camp	212000	191500	88000	82250
	Institutional Overheads (15% of total)	31800	28725	13200	12338
	Total budget for a camp incl inst. Overheads	243800	220225	101200	94588

TA and DA for Participants/Trainers should be paid on actuals based on their eligibility keeping the prevailing state rules in mind. The food & stay expenditure should also be on actuals. The amount shown here are ceiling limits.

1.2. Skill Upgradation Training for female paramedicals: for all ANMs, LHVs and staff nurses in 64 blocks: Skilled Birth Attendance Training Plus Neonatal Care Plus RTIs Plus Standard Treatment Guidelines Plus IUD insertion training. A 21 day integrated module.

The single most important determinant of MMR is the access to a skilled birth assistant at child birth. Complications at child birth cannot be predicted: all mothers must be attended to. Midwives and other professionals with midwifery skills can avert, contain or solve many of the life-threatening problems that may arise during childbirth. Thus Skilled attendance at birth saves mothers. Besides Neonatal mortality is lower when mothers are benefited from antenatal and childbirth care with skilled assistance- though for optimal results skilled birth assistance needs the back-up of a hospital.

The proposal is to take up 64 blocks – at an average of four per district and complete the training over an year and then extend it to other blocks. These are the very blocks where all infrastructure gaps and equipment gaps are being closed under NRHM funding or earlier under SIP funding. With this training closing gaps in availability of skills, access to skilled birth attendance would increase. The state level training for this has already been completed under UNICEF support and district facilitators have also been trained. In addition the standard treatment guidelines for paramedicals would be introduced to the ANMs over two days. Basic training in RTIs, adolescent health, IUD insertion would account for at least three days of this training period. Meanwhile on all these days practical training with supervised delivery would continue.

Sl. No	Description of Trainers/Workers	Total for State
1	15 days Training of about 37 field workers in each block,110 in each districts (25 ANMs, 5 staff nurses, 4 supervisors, 3 medical officers per blocks).	13000000
	Total	13000000
	From ANM training head	10000000
	From RCH-II Flexi pool	3000000
Estimates for above expenditure:		
Sl. No	Particulars	Field workers- ANMs, staff nurses and supervisors
1	Strength of the batch (Including Resource Persons)	10
2	No. of camp days	15
3	TA per person per camp	0
4	DA Per person per camp/travel day	100
5	Food & Stay per person per camp day	200
6	Contingencies per person per camp day	50
7	Material cost per person per camp	0
8	Experts Cost per camp	15000
	Total budget for a camp	68500
	Institutional Overheads (15% of total)	6850
	Total budget for a batch of ten persons incl inst. Overheads	75350
	Total budget for 100 persons per district into 16 blocks	13261600

Of this 180 lakhs, Rs 124 lakhs will come from the training of ANMs head of Budget Allocation(M11018/1/2006-FWB dt 20th april,2006 – annexure). The remainder would come from the flexi-pool.

SBA A one month programme for medical officers-

The topics to be covered are given below; again these are to be prioritised in the 64 blocks so that services improvement can be seen soon after.

- Care During Antenatal, labour and post partum period,
- Management of Common Obstetrical Problems and Complications.
- Quality of Services including rights of the clients and gender issues
- Infection Prevention
- RTIs
- Emergency neonatal care
- Sick child care

The central focus of this training package shall however be on skilled birth attendance/ emergency obstetric care as part of our drive to increase institutional delivery.

1.3. Paramedical package course for male paramedicals and supervisors as part of rationalizing workforce (standard treatment guidelines and laboratory based training and RCH programme support and adolescent health and HIV control and other disease control) in 64 blocks. A 14 day integrated module

It has been noted in workforce management studies that whereas there is considerable investment made in training female staff, no corresponding investment is made in training the male staff. This leads to an increased burden of work on the female staff and an underutilisation and subsequent de-motivation of the male staff.

To correct this a multi-skill training was proposed where the MPWs posted in sub-centers are able to provide all services excepting skilled assistance and IUD insertion and the support staff posted at PHC are able to provide support to medical care by numerous supportive roles- dresser, minimal laboratory support, drug dispensation etc.

Both MPW and the support staff in the PHC would undergo training with the standard treatment guidelines as well. In each district four blocks would be taken up for training and in each block 50 trainees would be taken up.

3. Budget for Paramedical Skill Development of Field Workers in 64 blocks

Sl. No	Description of Trainers/Workers	No of batches Per Unit	No of Units	Estimated cost per batch	Total for State
1	14 day Training of 80 STATE LEVEL TRAINERS	4	1	155100	620400
2	8 days Training of 6 Supervisors/block * 2 blocks	1	8	97680	781440
4	8 days Training of about 50 field workers in each block, 200 in districts .	8	16	82280	10531840
	Total				11933680
	From male worker training head				8228000
	From RCH-II flexi -pool				3705680

Every training got expenditure heads as TA for Trainers and participants, DA for Trainers and participants, Food & Accommodation for Trainers and Participants, material cost, expert costs and Contingencies. Rest of the budget provisions are for meeting Institutional costs at about 15% of total expenditures incurred.

Descriptions of above expenditures for different levels

Sl. No		State Level Trainers	District Trainers/Facilitators	Supervisors	Field workers
1	Strength of the batch (Including 5-6 Resource Persons)	25	0	30	25
2	No. of camp days	10	0	8	8
3	TA per person per camp	1000	0	200	200
4	DA Per person per camp/travel day	100	0	100	100
5	Food & Stay per person per camp day	300	0	200	200
6	Contingencies per person per camp day	0	0	0	0
7	Material cost per person per camp	300	0	100	100
8	RPs honorariums per camp	6000	0	4800	4800
	Total budget for a camp	141000	0	88800	74800
	Institutional Overheads (10% of total)	14100	0	8880	7480
	Total budget for a camp incl inst. Overheads	155100	0	97680	82280

TA and DA for Participants/Trainers should be paid on actuals based on their eligibility. The food & stay expenditure should also be on actuals. The amount shown here are ceiling limits.

Of this 119 lakhs, Rs 82.28 lakhs will come from the training of male workers head of Budget Allocation(M11018/1/2006-FWB dt 20th april,2006 – annexure). The remainder would come from the flexi-pool.

1.4. Multi-skilling specialist training for in 32 newly selected FRU blocks

The critical bottle-neck in operationalising FRUs is in the lack of specialists. Both regular recruitment and all India advertisements for contractual appointments have failed to generate names to staff more than 5 FRUs out of 64 that is aimed for. Of the first 32 FRUs in about 25 there are now multiskilled staff and even if CS does not occur basic emergency obstetric care has begun. Now the need is to persist and extend this programme to reach out to the next set of 32 blocks.

Sl	Descriptions	Unit Cost	No. of Units	Duration	Total
A	Day Allowance for Doctors				
1	For Course on Emergency OB Care	150	32	180	864000
2	For Course on Anaesthesia	150	32	180	864000
3	For Course on Sick Neonatal/child care	150	32	60	288000
4	For Course on mini Laproscopy/ conv. tubectomy/safe abortions/RTI	150	32	30	144000
5	Travel and Book Allowance for participant doctors for all courses	2000	128	1	256000
A	Total				2416000
B	Honorarium for Teaching Faculties Rs. 2000 per faculty and 5 faculties per institutions				
1	For Course on Emergency OB Care	10000	3	12	360000
2	For Course on Anaesthesia	10000	3	12	360000
3	For Course on Sick Neonatal/child care	10000	3	4	120000
4	For Course on mini Laproscopy/ conv. tubectomy/ on safe abortion/RTI	10000	3	2	60000
5	Training Facilities esp. dummies	25000	3	1	75000
6	Contingencies & related expenditures @15%	48750	3	1	146250
B	Total				1121250
	Grant Total				3537250

In addition to this training we need to integrate the training on conventional tubectomy or mini-laprotomy and safe abortion and RTI management and emergency neonatal care into this course. Instead of calling the medical officers for training separately – integration with the emergency course , by the addition of one month of training time would help them gain more experience on both tubectomy and MTP as well as in emergency obstetric care. The proposal is to integrate safe abortion and tubectomy with the emergency obstetric course and to integrate. However for those doctors who already have been multi-skilled but for whom safe MTP and conventional tubectomy has not been taught, it is important to have a one month training programme for these skills.

1.5. Induction training for 450 newly appointed medical officers.

There are about 450 doctors joined the state health services through recent PSC processes. To orient them on RCH issues and various other health programmes are important. The state's HRD policy call for a mandatory inservice training We aim for a 14 day training programme- but if all candidates join the space and time available it would be more pragmatic to have 7 days now and then repeat 7 days training later.

Budget Estimate:

Sl. No	Description of Trainers/Workers	No of courses	No of Units	Estimated cost per Unit	Total for State
1	7 day Training of 20 STATE LEVEL TRAINERS	1	1	203550	203550
2	7 day Training of 25 Medical officers per batch	4	4	186300	2980800
	Total				3184350

Every training got expenditure heads as TA for Trainers and participants, DA for Trainers and participants, Food & Accommodation for Trainers and Participants, material cost, expert costs and Contingencies. Rest of the budget provisions are for meeting Institutional costs at about 15% of total expenditures incurred.

Descriptions of above expenditures for different levels:

1	Strength of the batch (Including 5-6 Resource Persons)	25	32
2	No. of camp days	7	7
3	TA per person per camp	1000	500
4	DA Per person per camp/travel day	200	100
5	Food & Stay per person per camp day	500	400
6	Contingencies per person per camp day	100	100
7	Material cost per person per camp	200	200
8	Experts Cost per camp	2000	2000
	Total budget for a camp	177000	162000
	Institutional Overheads (15% of total)	26550	24300
	Total budget for a camp incl inst. Overheads	203550	186300

We note that in practice less than 450 doctors would be joining. This budget head would therefore be used also for other medical officer training. Such training could include any of the following:

- Training for Conventional Tubectomy
- Training for Safe MTPs
- Training for NSV
- Training for provision of skilled birth attendance.

We note that all the four above can be combined into a one month package to be conducted at an identified district hospital.

For achieving this training funds could also be drawn from any of the other training heads where because of operational reasons the total amount cannot be spent.

1.6. Training on adolescent health and for STIs/RTIs.

This has been projected as part of the section on adolescent health.

2. Improving PHC performance- Incentivising Institutional delivery and Operationalising New PHCs:

All Primary Health Centres that attain more than 10 institutional deliveries per month and all Community Health Centres that attain more than 30 institutional deliveries per month would be provided with an incentive of Rs 200 per delivery to be shared amongst those who have conducted the delivery. Another Rs 50 for support staff. If they achieve even one delivery less for that month or averaged over three months then they would not qualify and no incentive would be paid. If they do better then they would get more incentives per delivery at the same rate. It would also be informed that over the next three years – the baseline for the performance based incentives would be shifted upwards to 30 for a PHC and 60 for a CHC. Estimating that 300 PHCs would reach this goal and 50 CHCs would reach this goal we would need to pay incentives for approximately 36,000 deliveries in the PHC and 18,000 deliveries in the CHCs which would be approximately Rs 1.35 crores only. Even if all CHCs and PHCs achieve this goal within a year the total costs would work out only about Rs about Rs 2.7 crore. If the state achieves 50% of all child births deliveries in PHCs and CHCs – excluding what it achieves in private sector, district hospitals etc- even then the cost works out to only Rs 6.25 crores annually- which is modest. Considering that this is the single most effective co-relation with reduction in maternal mortality and maternal mortality rates are directly estimated from this figure- such an investment is well worth it. We note that this is in a situation where both the mother and the Mitamin are incentivised for institutional delivery.

The state government has sanctioned 200 new PHCs in the year 06-07 so as to achieve the national norms. To ensure quick operationalisation of these new centres and to provide them with basic equipments and furnishings as per need, a token provision of Rs. 100000 per centre is being provided. These new PHCs will be providing outreach services, epidemic management and RCH services in the unreached areas.

Budget Estimate:

Sl	Item	Unit Cost	No. of Units	Duration	Total
1	Performance Incentive-CHC on achieving minimum 30 Inst. Deliveries per month	6000	48	9 months	2592000
2	Performance Incentive-PHC on achieving minimum 10 Inst. Deliveries per month	2000	128	9 months	2304000
3	Operationalisation Expenses of 200 New PHCs	100000	200	1	20000000
	Total				24896000

3. Untied Funds for Developing District Hospitals

Under NRHM, upgrading facilities to IPHS standards is a major agenda. Minimum Standards for CHCs, PHCs and Subcentres are already finalised. A provision of support for the participatory hospital management committee also has been earmarked. In Chhattisgarh, we have initiated these processes already but what is felt is that many of our district hospitals also need to achieve some minimum standards which are currently performing not up to the mark. Towards this the basic environment needs to be created, modernised management systems need to be introduced and proper and advanced training needs to be given to the concerned staff on each area. Four of the district hospitals (Durg, Rajnandgaon, Sarguja and Raigarh) are able to deliver the level of services of a district hospitals but there also modernised and improved systems are a must like computerised

hospital management etc. A patient grievances redressal system also needs to be built in and operationalised in all these facilities. Another major intervention that is planned is to have a proper neonatal care unit in all the district hospitals. This would be particularly necessary in light of IMNCI training is being rolled out in the state to begin with 3 districts in the initial year.

An allocation of Rs. 40 lacs per district has been proposed towards this purpose for 12 district hospitals. This shall ensure all the district hospitals to be equipped to provide 24 x 7 services, especially for emergency neonatal care (similar to the Purulia model), secondary level obstetrics and gynaecological services and other basic specialist referral services. Though we are creating first referral services at the CHC level, there are many services like care for the sick severe low birth weight child or rapture uterus or even hysterectomies that cannot be managed at the CHCs even when it is fully functional. Also since most CHCs are manned by multiskilled doctors trained in specialist skills in short term courses, the main effort in institutional care will remain in strengthening the district hospitals.

Budget Estimate:

Item	Unit Cost	No. of Units	Duration	Total Cost
Untied funds for District Hospital	4000000	12	1	48000000

4. Drugs and Equipment for Sub-Centre functioning:

Objectives of the programme:

- a) Drugs and Equipments for optimum functioning of Subcentre
- b) Improve quality of supervision and make it supportive.
- c) Bringing in better systems of internal and external data verification.
- d) Improve cold chain functioning.
- e) Improve the quantity of drugs supplied to subcentres.

Proposed strategies/activities:

- a) Conduct a special programme for supervisors on supportive supervision – so that they play a more active role in helping ANMs and MPWs in overcoming field level problems and addressing gaps. This will also teach supervisions on how to undertake cluster sampling in their area so as to verify data. The cluster sampling database that they need- cumulative population table- would also be prepared for each level of supervision. The supervisors would be required to submit a cluster sample verification report once every six months. The budgetary provision for this is against actually conducting their training and getting two sample surveys done per supervisor every year.
- b) Contract in a firm for providing annual evaluation by sample survey of key RCH indicator for each district.
- c) Expand the ANM drug kit to include 25 drugs and improve its regularity of supply. Let it match the Standard Treatment Guidelines for MPWs that we have already prepared and published in Hindi. (To ensure regularity of supply the funds may be given to the state government for drug procurement- if by then adequate procurement and distribution systems are in place. If this does not meet with the quality benchmarks already established for drug procurement and distribution then the drugs may be supplied as kits as is currently done) This drug list prepared by the state essential drug committee is shown in table below.

- d) Make a provision of additional allocation of Rs 1000 per month per subcentre to meet some expenditure on drugs , laboratory supplies and Equipments etc. This is given provided to any functional sub-center and is over and above the untied fund
- e) Ensure that a certain sum of money is sanctioned under family welfare every year for cold chain upkeep (refrigerator mechanic mobility and repair costs and some replacement costs) and hard ware gaps. Currently two walks in coolers are needed at state level and at block level voltage stabilizers as well as power backup systems (with maintenance support) are needed.

Budget for Strengthening Routine Sub centre Level Services:

Sl. No	Item	Unit cost	No. of Units	Duration	Total budget
	Supervision quality and sample surveys	2000	146	1	292000
	16 dt annual external evaluation	100000	16	1	1600000
	Untied funds for Cold Chain upkeep	100000	16	1	1600000
	Support for drugs and Equipments	7500	4692	1	35190000
	Total costs				38682000

Chhattisgarh Essential Drug List: The Revised ANM drug kit

(To be used by ANM and male MPW)

The state government has adopted an essential drug list for ANMs and MPWs. A specific paramedical training manual based on just these drugs is available in Hindi and has already been widely used in the state. It expands the ANMs role to that of the nurse practitioner, which the Chhattisgarh paramedical act specifically empowers. The manual and this list has been specifically prepared and approved by the government with the understanding that in distant villages and even in many sectors where doctors both in public and private are hard to come by the ANM and the MPW is the only source for rational, ethical modern drugs and treatment. Unfortunately though most aspects of these reforms have been implemented this ANM drug kit has not been revised. The quantities received currently are also grossly inadequate.)

- | | |
|--------------------------------|---|
| 1. Albendazole | 15. Gamma BHC lotion |
| 2. Aluminium Hydroxide | 16. Gentian Violet 1% solution or other her skin antimicrobial. |
| 3. Amoxycillin/co-trimoxazole | 17. Methylergometrine tablets. |
| 4. Bisacodyl | 18. Methylergometrine—Injection |
| 5. Calamine Lotion | 19. Metronidazole |
| 6. Calcium Carbonate | 20. Miconazole 1% cream. |
| 7. Chlorhexidine | 21. Oral Rehydration Salts |
| 8. Chloroquine | 22. Paracetamol |
| 9. Chlorpheniramine | 23. Primaquine |
| 10. Chloramphenicol applicaps | 24. Sodium Bicarbonate |
| 11. Dicyclomine | 25. Vitamin A liquid. |
| 12. Domperidone | 26. Vitamin B complex |
| 13. Ferrous Sulfate+Folic Acid | |
| 14. Furazolidone | |

Doctor Initiated Drugs (DID)

1. Anti Leprosy Drugs
2. Anti tubercular Drugs
3. Folic Acid for Sickle Cell Disease
4. Oral Contraceptives
5. Salbutamol for bronchial Asthma
6. Tetracycline eye ointment for trachoma

DIDs would be dispensed under prescription by the PHC medical officer. The ANM only stocks these so that the patient need not go to the PHC every week but can get a supply for the duration of the prescribed treatment. They can be reflected as PHC stocks and need not come as part of the ANM drug kit.

5. Implementation of PNDT Act

Constraints Being Addressed:

- Appropriate bodies at district and block levels formed, meetings needs to be regularized and their capacities need to be enhanced
- Mass awareness Programmes through various electronic/print/visual media as well as through electricity and telephone bills/percolated messages but still the issue continues to be burning.
- Orientation for various professional organizations yet to be done.
- NGO support and participation needs to be expanded.

Activities:

- NGO support in 4 regions for rapid identification of cases or allocation of this sum to 4 regions to CHMOs to undertake the above tasks themselves
- Support for coordinating functions at Directorate of Health Services

Budget Estimates:

Sl. No	Item	Unit cost	Units.	Duration	Total
1	Assistance for Supporting NGOs/ 4 regional centers for PNDT follow up(can be also shown as Rs 50,000 per district)	200000	4	1	800000
2	Assistance to SIHFW/ SHRC/RRC for training of appropriate authority members	400000	1	1	400000
3	Assistance for coordinating activities, especially awareness roles at Directorate Level, brochures etc.	800000	1	1	800000
	Total				2000000

6. Strengthening Mitadin Programme

Community level health care and improved service utilization (to bring about a halving of IMR in three years) which includes better provisioning of drugs and supplies for this level of care. Rs 22 crores for the Mitadin Programme and Rs 12 crores for drugs. We estimate that Rs 15 crores would come from the ASHA scheme and the remaining 7 crores would be costed to the RCH-II.

Operational Objectives of Programme:

1. Sustain and support a trained woman volunteer in every hamlet supported by a women's health group i.e. approximately 54,000 Mitadins.
2. Ensure that 100 key messages on RCH reach every single household in the state in the appropriate language and idiom.
3. Ensure that every single sick child of fever, diarrhoea, and ARI gets visited on the very first day of illness with appropriate first contact care and referral where indicated.
4. Ensure that every newborn is visited and weighed in the first day after birth and visited once more in the first week and appropriate messages and referral are done.
5. Ensure that all pregnant women are counselled on general measures and access to antenatal care, and referred to an institutional delivery facility for childbirth.
6. Ensure that tackling child malnutrition becomes a priority on the local Panchayats agenda and families and local bodies are empowered to tackle it.

7. Ensure that outreach of all key RCH services are facilitated by better people's knowledge, by assistance to health department staff in service delivery and by community participation and advocacy.
8. Sensitisation and capability building in women and Panchayats and link with other health related sectors locally.
9. By all the above measures linked to improvements in the facility to reduce the infant mortality rate by the year 2007 -08 to below 35 (currently 73)(the technical possibility of doing so has been demonstrated adequately by smaller community health worker programmes)

The programme will largely involve six dimensions:

- a) Continued training and support to the Mitanins so that ongoing facilitation of service delivery by Mitanins and community basing of all health programmes is sustained. This year the training would be for 12 days camp based and 30 days field based and would cover the following new topics- in addition to revising the old topics:
 - a. Food security and Nutrition.
 - b. AYUSH (Home and Herbal remedies for Mitanins)
 - c. IMCNI for Mitanins- a video based training module
 - d. Health Communication kits
 - e. The Mitanin Diary and Mitanin Register.
- b) Strengthening and deepening the health education and counselling work at the household level by equipping the Mitanins with charts, posters and other tools of monitoring.
- c) Strengthening the access of the poor to essential curative care through adequately provisioned Mitanins linked to improved peripheral primary and secondary medical care facilities, by a functional referral system. Ability of the public health system to respond promptly and adequately to needs of institutional care of sick children, referred in by Mitanins.
- d) Incentivisation of the Mitanin's work so that there is enough encouragement and recognition of their work at both the family and at the community level.
- e) Inter-sectoral integration at the habitation and panchayats level with related sectors and strengthening local planning at panchayats level.
- f) Better outcome monitoring and closing all gaps to achieve an effective health outcome.

Indicators:

1. Every Mitanin already trained for initial 18 days package and receives a further 12 days of camp –based training and 24 days of on-the-job village level training every year.
2. Day 1 visits during delivery is held by Mitanins to assure family level counselling and possible assistance on ensuring six major initiatives related neonatal and mother care issues.
3. Micro planning of delivery is done assisted by Mitanins at family level based on EDD so as to promote institutional delivery in all possible cases or at least in those cases with risk factors. In rest of the cases, efforts are made to have skilled delivery or at least safety measures are assured during home based delivery. (An important factor

needs to be streamlined is the prompt disbursements of JSY payments to pregnant women as well as Mitanins towards this.)

4. Mitanins are approached by a certain minimum number of families for common ailments and first level care has been given and prompt referrals initiated based on symptoms on all necessary cases. (The key factor for this to happen is that effective access to basic drugs in every hamlet should be ensured through the Mitanin drug kit and that she is backed by a referral chain from ANMs and PHCs to CHCs and district hospitals so that sick neonates, children, adolescents and women esp. in pregnancy get timely referral when needed.)
5. Mitanins are attending Immunisation sessions at AWCs regularly as a token of she is helping mobilising the community for health services. (The important background factor here is the prompt disbursement of immunisation camp incentives to Mitanins.)
6. Mitanins should know all malnourished children within under 5 or under 3 age groups in their respective hamlets; feeding related counselling given to families of those grade-1 and grade-2 children in regular intervals so as to improve the situation and severe and acute malnutrition (grade 3 &4) has been referred to health care facilities. (Necessary health system supportive action here is to ensure all food security programmes are run properly and the needy people are benefited out of them as well as to take care of giving adequate treatment to those severely/acutely malnourished children who are referred to public health facilities by Mitanins.)
7. Women Committees formed in the hamlets are regularly met and key health education messages are discussed there. This should lead to behaviour changes in certain areas at family level.
8. Ensure that a set of intersectoral interventions planned and coordinated locally and with the Panchayats shall lead to a local plan that shall include food security, safe drinking water and sanitation, early childhood care services and school health services and access to health care services and health education.

The effectiveness of all the above should be visible by a measured decline in child malnutrition rates, decreased low birth weight rates, decreased anaemia in women and decreased micro-epidemics and decreased epidemic deaths in gastroenteritis, childhood acute respiratory infections and malaria. Sample surveys should show decrease in IMR by at least 50% at the end of three years and all the indices like Child malnutrition prevalence, Anaemia in women, Birth weight of babies, IMR and MMR, Tuberculosis/ Leprosy prevalence, Malaria incidences, should have declined.

Institutional Mechanism: The programme will continue to be led by the directorate, coordinated on its behalf by the State Health Resource Centre and will be organized at the district level by the District RCH (health) societies.

Budget Estimate: Out of the 2210 lacs projected below for Mitanin Training & support activities, the state would be getting at least 800 lacs from ASHA budget under NRHM and about 100 lacs from state budget. Rs. 200 lacs from RCH-II flexipool and the for the rest some other sources would be explored.

Sl	Head	Unit cost	No. of Units	Du ration	Exp. Per block per year
A. Training and regular support for Mitanins					
1.	Training of Mitanins	75	60092	12	54082800
2.	Training Compensation for Mitanins	75	60092	12	54082800
3.	Training of Mitanin Trainers (BRPs)	350	3650	15	19162500
4.	Compensation for Mitanin Trainers (BRPs)	1000	2920	12	35040000
5.	Training of Block Coordinators (DRPs)	650	730	15	7117500
6.	Compensation for Block Coordinators (DRPs)	2500	292	12	8760000
7.	Training Material	40	66000	5	13200000
A	Total				191445600
B. Social Mobilisation					
1.	Block Level Interventions*	75000	146	1	10950000
2	District level Interventions*	25000	146	1	3650000
3	State Level Interventions **	30000	146	1	4380000
B	Total				18980000
C Programme Management and Coordination					
1	Block Level Programme Coordination and Monitoring ***	5000	146	12	8760000
2	District Level Programme Coordination and Monitoring ***	2000	146	12	3504000
3	State level Programme Coordination and Monitoring ****	4000	146	12	7008000
C	Total				10512000
Grant Total					220937600
Requirement from RCH-2					20000000

*B-1, B-2 District & Bloc Level interventions include wall-writing, folk-media, certification, public meetings/events and other social mobilisation initiatives.

**B-3 State level interventions include electronic media, certification, print media, special events, media briefings, etc.

***C-1, C-2 Block and District Level Coordination includes travel, coordination meetings, monitoring, events, correspondence, overheads and contingencies etc.

****C-3 State Level Programme Coordination includes travel, coordination meetings, monitoring, Compensation for field coordinators and support for programme management unit, events, correspondence, overheads and contingencies etc.

The District & State Level expenditures, though derived on the basis of no. of blocks, these amounts are notional at block levels.

The CHV or Mitanin Drug Kit:

Constraints being addressed:

The mid-term evaluation of the Mitanin programme analysed the work performance of a randomly chosen sample of 1250 Mitanins, which showed that the single greatest weakness in the programme is the supply of basic drugs to her. Even a drug like chloroquine which is in abundant supply and which has no controversy regarding its provisioning at the village level was found not too has reached in the majority of Mitanins at that time. This issues was discussed in length at state level and a unique scheme called Mukhyamantri Mitanin Dawapeti Yojana was lunched by state so as to solve this. This scheme has an annual provision of 5 crore rupees to provide drugs and accessories to Mitanin. Currently Allocations has been given to provide initial drug kits and certain monthly refills to all Mitanins under the first year allocation though the distribution in some areas is still delayed. The existing constraints are the gap of about 6 crore rupees in budget as well as the problems in managing the logistics of such a massive supply spread across 60000 hamlets. The shortage of budget under Mukhyamantri Mitanin Dawapeti Yojna is proposed to be filled by RCH.

Objectives:

Ensure effectiveness of community level care givers by dedicating regular refills of supplies (as well as replacement of drug kit accessories wherever it is necessary) under Mitanin Drug kit, for her dispensation in the hamlet.

Activities:

Each CHV (Mitanin) would be supplied with a drug kit with two months supply of drugs. Each month one-month supply of drug or whatever has been consumed- whichever is less would be supplied to her as refill of the kit. In epidemics and special need situations the state government would increase the supply through the CMHO. Labelling the drugs pictorially on the picture code we have written up along with pictorial instructions that are already in place would maximise utility of these kits.

Budget estimate:

The cost of drugs that the programme consumes is estimated at Rs 150 per month per Mitanin- who handles a normative 50 households of about 250 populations. Another Rs 200 per Mitanin is the cost of the kit bag and pictorially labelled bottles. This a normative block of 100,000 populations has about 400 Mitanins. The state as whole is now have 60092 Mitanins and another 2400 urban Mitanins are proposed. Thus a total of 62500 Mitanins who cater to approximately 150-lakh beneficiaries -which is the lower 75% of the population. The rest would not need coverage by this programme. We note that though the cost of drugs proposed may seem high, it works out to only Rs 2000 per Mitanin or Rs 8 per beneficiary household per year. Of the total requirement of Rs. 1250 lacs, Rs. 500 lacs are allocated under Mukhyamantri Mitanin Dawapeti Yojana and we hope a provision of ASHA drug kit for all 60092 Mitanins from Government of India. In case this is not available from GOI- a sum of not more than Rs 7 crores would be taken from the 22.03 crores shown on the drug budget under NRHM shall be used for this—after exhausting the state budgetary provision for Mitanin drug kits.

The monthly kit would have the following contents:

(For 50 households or a population of 250 or in a rural area):

S.No.	Contents	Quantity per kit
1	Paracetamol Tab 500mg	70 Tabs
2	Paracetamol Syrup (60 ml bottle)	2 Bottles
3	Albendazole 400 mg	5 Tabs
4	Cotrimoxzole Tab 400+80 mg	60 Tabs
5	Cotrimoxzole Syrup 200+40 mg(60 ml)	2 Bottles
6	Metronidazole Tab 400mg	110 Tabs
7	Antacid Tab	60 Tab
8	Gentian Violet Lotion	1 Bottle
9	Gamma BHC (100 ml)	1 Bottles
10	Gauze	5 Piece
11	Bandage	1 Packet(12 piece)
12	Slides	25 Nos.(1/2 packet)
13	Cotton	1 Roll
14	Spirit	1 Bottle
15	Lancets	25 Piece
16	Chloroquine	100
17	Iron and Folic Acid tablets	100
18	Condoms	

Other than this, Doctor Initiated Drugs like female contraceptive pills, MDT drugs for Leprosy and TB can also be given. The above amount estimated for the kit is with an assumption that chloroquine, slides, lancets, condoms and IFA tablets are filled in, but from different programme budgets. The DIDs are not part of Mitanin Drug kit but they need to be supplied from appropriate programme stocks as and when necessary.

7. Behaviour Change Communication:

BCC is one of the key components of any health sector strategy. BCC is essential to modify risk prone life styles and practices and to promote healthy lifestyles and practices. In the last 3 years the state has had many major rounds of Kalajathas which have helped to take key health messages to even the most interior of the rural areas. This has led to sensitisation of community leaders and increased awareness in the community. However, change of practices takes time and we need to persist and intensify the BCC efforts so that the national health programmes can be better implemented and the burden of disease in the community decreases. The results of last 3 years had been encouraging. The prevalence of malaria has come down, and healthy practices like exclusive breastfeeding have gone up. we hope that in the coming 5 years we can show further improvements in all key health parameters by synergising service deliveries with good quality and extensive BCC.

Situation Analysis:

The overall receptivity of the IEC campaign on health has improved in the state after some of the conscious interventions in the area:

1. A study on the communication needs was done under the DANIDA assisted Basic Health Services Project.
2. State level BCC strategy document has been developed and notified as result of a major stakeholder consultation process.
3. Implementation Framework for the strategy has been formulated. The state is committed to using this framework to guide planning and action on BCC.
4. District Level IEC plans have been prepared as part of the District Health Plans, with interventions on every components and sub-components.
5. 50 media officers have been trained in advanced health communication at MICA Ahmedabad.
6. Folk-art based mass communication campaigns held in almost all the villages of the state.

Apart from above, all the national health programmes as well as the state programme on control of Sickle Cell Anaemia had their own specific IEC interventions.

Activities for the year:

Special emphasis on the use of folk art to transmit locale specific messages is proposed under this. All three regional insititutes of health and family welfare (one existing and two proposed) will develop locale specific material and act as the resource centers for BCC. They would ensure that BCC activities are mainstreamed into all training programmes and activities. Till the capacities of these centres are built up, experts of the arena will be sought assistance for finalising the scripts and materials, based on the state IEC/BCC strategy finalised by the government.

Objectives of Programme:

- Developing IEC material and campaigns specific for different client groups- by social, linguistic and ethnic characteristic and conducting effective multimedia IEC campaign based on this.
- Creating folk art based plays, songs and skits so that key messages are conveyed in culturally appropriate way and in relation to existing practices.
- To create mass awareness about various health related issues and social marketing of health fundas.

Key Operational Elements:

- Identify suitable partners for conducting the programmes in the village level and for creating BCC strategies.
- Defining the focus of IEC based on study of local health needs and health beliefs.
- Development of appropriate material based on defining client groups and their cultural specificities.
- Organising scriptwriters, and choreography workshops for developing folk art based material.
- Organizing kalajatha and other locale specific IEC programmes, including programmes in melas and village markets; posters and wall writings in the blocks. Organising radio programmes, TV programmes and hoarding centrally.

Strategies:

- One strategy Development Workshop will be conducted with participation of all IEC experts/stake holders from the major four regions of the state. This shall identify the behaviours to be addressed, the audience segments to be focussed on and the key messages and media mix as described in the BCC implementation framework.
- Production workshops for folk-art based radio programmes- separate workshops for each region. This work shall be done by SHRC/SIHFW who got a specialist team on radio production.
- Contracting –in an advertising agency for designing the print-media interventions as well as the display. A conceptual session would be done with all programme units towards orienting the agency on various communication needs. After the content development and the copywrite/design are done, a review workshop will be done to finalise the panels/hoardings design as well as the other print media advertisements.
- A district Level Workshop to list out the interventions under district specific IEC interventions. The state shall hire 4 consultants in a way that one consultant shall help design of the IEC interventions for the year in 4 districts each. The priority programmes under the district IEC plan will be listed out.
- To organise kalajatha programmes atleast with one show in each village/ Panchayat, to deliver key health messages and to initiate mass mobilisation including sensitisation of PR representatives in health issues.

Budget Estimate:

The total budget for BCC has been estimated to Rs 800 lacs and Rs. 300 lacs out of the same has been budgeted to RCH-II flexipool. Rs. 500 lacs shall be allocated from NRHM flexipool. Breakup of for the amount to be used from RCH –II flexipool is presented below. The overall budget has been presented in Part B NRHM flexipool.

Sl.No	Item	Unit cost	No. of Units	Duration	Total Cost
1	One strategy development and three material development workshops per year	100,000	2	4	800000
2	Block level campaigns which are folk art based	100,000	146	2	29200000
3	Total				30000000

8. Urban Health Programmes:

Urban areas are categorized into six (A through F) based on population. The smallest two groups E & F would just have their sub-centers upgraded by an additional ANM as required by norms. In C & D towns the focus would be on opening urban health centers with a part time doctor under an urban health administration unit – linked for secondary care to the CHC. This is particularly suited for mining towns which have large uncovered unorganized worker population. In category A & B towns careful participatory mapping would identify beneficiaries (the 33% poorest) and then an unit of one lakh beneficiaries would be provided with 10 urban health centers and one secondary health center. In all 120 UHCs are proposed. A urban health center is roughly in design a fusion of the current rural sub-center and some aspects of the PHC and covers 10,000 beneficiaries each and would cost about Rs 2.6 lakhs per year. The secondary center is situated for every 1 lakh beneficiaries. In a step by step approach a limited social insurance package is also proposed to cover the poorest at government cost and to cover all others with premiums paid/deducted for a limited range of services in PPP or government facilities. Peer education programmes for marginalised groups are also built in.

Objectives:

- To improve the health status of the urban poor community by provision of quality primary health care services with focus on RCH services and to achieve population stabilization.
- To ensure that investments in health contribute to poverty reduction by reducing out of pocket expenditure on health care amongst the poor.

Strategies:

1. Careful identification of beneficiary families and vulnerable families through a participatory mapping exercise followed by a door to door survey
2. Community Level care givers(similar to Mitanin) but covering 200 beneficiary households or 1000 population intensively and touching on all households in their area.
3. Paramedical and basic medical services, through a network of urban health centres-without fresh infrastructure creation -. Utilize both NGO and Private sector partners for this. This may mean an urban health centre for about 10 to 15,000 households. Each such urban health center would have a rented premise and two ANMs or nurses or qualified female paramedicals who can conduct delivery if needed and provide immunisation services and ante-natal care and other services similar to the rural sub-center. Each such urban health center will be attached to 10 to 15 community level care givers and she would be their trainers and support. They in turn would support the urban health center and ensure minimum attendance and services delivery. Thus the urban slum area would be demarcated into sections each of about 10,000 to 15,000 population and each section or a number of sections taken together could be contracted out.
4. The urban municipality would be coordinated with for these services.
5. Urban secondary referral services through a linkage with the CHC/district hospital or PPP arrangements with a network of private clinics for emergency obstetric care, institutional care of sick child, safe MTP services, FP sterilization services, adolescent health care and counselling and diagnosis and management of RTIs /STIs/ infertility. These services are subsidized for the poor and at reasonable cost for the rest with a provision for exemption of the poorest in special emergency situations.

6. Linkages will also be made available to district hospitals and teaching hospitals.
7. Peer caregivers for special highly marginalized groups – the homeless, the street child and the commercial sex workers etc– reached out through NGO programmes.
8. Peer education programmes in urban schools for adolescents and in adolescent frequency zones for out of school adolescents.
9. Designing a programme for social health insurance cover for the urban poor to cover all institutional health needs would be undertaken.

Budget:

A urban health centre cost would about Rs 2.6 lakhs per year. This excludes infrastructure costs though it includes rental costs. Approx two ANM @ Rs 5,000 per ANM per month, Rs 24,000 package for minor equipments and training, a Rs 36,000 per year for infrastructure repairs or rent and incidents. The part time medical office if utilized then would be Rs 5000:per month or Rs 60,000 per year will be paid. Consumables and some of the infrastructure costs would have to come from the state budget and the over all drugs procurement. This is the first years costs only and would be reworked upwards if required.

Sl No.	Head	Unit Cost	Nos.	Duration	Total Cost
1	Participatory Mapping for A category	20000	4	1	80000
2.	Technical Staff 1(including training and travel costs)	10000	110 sections	12 months	13200000
3	Health Administrators – including 5000 TA and office expenses	15,000	10	12	1800000
4	Training of Community care givers	2000	1100	1	2200000
5	Training of Peer educators	2000	100	1	200000
6	Rent , infrastructure, supplies	5000	110	12	6600000
11	State level contingencies for management, training and monitoring	5%			90000
	Total Programme Cost				24170000
	From RCH-II				20000000

9. Tribal Health :

There is an ongoing programme of 74 mobile clinics already ongoing in tribal areas under the state budget and the special attention being given to close infrastructure gaps in these blocks.

Objectives:

- Improve outreach by strengthening programme linked to the mobile medical unit

Activities:

- a) Provide support to mobile medical units to become effective in BCC as well as in reaching the remote and more difficult areas as well as in providing ambulance services- through enhanced communication links. The NRHM we note makes provision for a district level mobile medical unit. Districts in Chhattisgarh are very large and one mobile unit would not be able to cover each haat even once in six months.(Sarguja for example would have about 200 haats). Also the state government has already invested in starting up 64 mobile medical units- on an arrangement that it provides for the vehicle and drugs and POL and doctor in a govt run MMU and for the vehicle and drugs alone in a NGO run MMU. This can be improved upon by making an untied pool of Rs 3 lakhs available for each MMU- to be used for local meetings, camp arrangements, hiring in support staff etc. ten more units are to be added this year and hence the provision is for all 74 mobile medical units.

- b) Since in tribal areas health outreach is still very poor there is a proposal for organising health melas in every village haat. Estimating 7 haats per blocks and 81 tribal blocks in all we need to conduct 567 health melas thrice a year. Or 1701 health melas at 6,000 rupees per health mela the cost would work out Rs 1,53,09,000. This expenditure would go into publicity, logistics, supplies for melas. In health melas immunisation and antenatal cases which have been left out would be mobilized, chronic diseases would be given speciality care iron and folic acid tablets would be distributed. These melas are supplementary to the mobile van visits and thus cost less than the melas proposed for non tribal areas.

Budget Details:

Item	Units cost	No. of Units	Duration	Amount (rs.)
Health Camp in Tribal Blocks in Haats	6000	567	3	10206000
Total				10206000

10.RCH Camps in Non-Tribal Areas

The non tribal blocks which includes urban and semi-urban blocks have also in some areas very low health indicators. This is very evident in the recent Sample Registration survey bulletin where upward movement of Infant Mortality Rate of the Urban areas has compensated in a negative direction the big improvement in the rural areas. In the remaining 65 blocks the relatively medically underserved areas would be identified and a special health camp twice a year for a population of over 20,000 will be organised. In such camp emphasis will be in identification of high risk pregnancy through ANC check up, immunisation of children and pregnant mother, identification of persons with communicable disease like Tuberculosis, leprosy. Health education on sanitation, drinking water etc will also be taken up. These camps will be organised in common gathering places like Haat, weekly bazaar etc. Estimating 5 haats per block for 65 blocks we need to conduct 325 camps twice a year i.e. 650 camps At the rate of Rs. 20,000 per health camp the cost work out to Rs 130,00,000. This expenditure would go into publicity, logistics, and supplies for melas. In health melas immunisation and antenatal cases which have been left out would be mobilized, chronic diseases would be given speciality care iron and folic acid tablets would be distributed.

Budget Requirements:

Item	Units cost	No. of Units	Duration	Amount (Rs.)
Haat bazaar level: RCH Camps in Non-Tribal Blocks	20000	650	1	13000000
Total				13000000

11. Adolescent Health

The focus is on NGO participation in adolescent clinics and counselling, in training peer educators in high schools and in a pilot 10 block mass screening and counselling programme that aims “ to eliminate iron deficiency anemia in this generation and sickle cell anemia(which has a very high prevalence in this state) in the next generation. These mass screening programmes are also major adolescent health camps.

Objectives:

1. Reduce malnutrition and anaemia amongst adolescent's especially adolescent girls.
2. To reduce percentage of marrying in this group from 35% to 5%.
3. To increase the awareness regarding pitfalls of early marriage and child bearing, regarding family planning and nutritional requirements of adolescents.
4. Increase awareness of ones own body and control over it – including fertility control and safe sexual practices.
5. Provide easily accessible and friendly health care services and counselling for adolescents.

Strategies:

2. BCC programmes.
3. Open adolescent counselling services with referral access to essential services at the CHC and district hospital level.
4. Major effort to screen for and manage anaemia and malnutrition in adolescence and where relevant for sickle cell anaemia.
5. Peer education programmes in schools and some areas in the villages

Activities:

1. An NGO will be identified and asked to hold an adolescent clinic providing counselling services once a month in the Govt PHC/CHC/Urban Health Centre.
2. They will also be asked to provide training to create peer educators in high schools of that Block. Sponsored activities by sanitary napkin and brassiere manufacturers, including guest lectures could be organized in feasible locations.
3. NGOs will be involved in community outreach programs to disseminate information to adolescents in groups through various methods including sports events and film shows in villages. Vocational training institutes and other adolescent hangouts will also be targeted for activities by NGOs to maximize the chances of having an interface with the out of school adolescent.
4. In all CHCs esp. where NGOs do not have a presence, a staff member will be given training, preferably LHV level to counsel and have a designated day of the month, which is disseminated by ANMs and Mitans to the public.
5. Camps will be organized to do screening of adolescents for anaemia. All girls in 15-19 age group will be targeted for this activity. Mitans will be sensitised to ensure complete coverage. This will address iron deficiency in this generation and prevent sickle cell anaemia in the next.
6. IEC campaign through print and mass media to reinstate messages to postpone childbearing and marriage age and to focus on nutritional needs of the adolescent girl.

Budget:

The aim is to limit the mass screening to a few blocks every year- since it is very effort intensive. At the end of five years we would complete only 90 blocks which are considered

having the highest prevalence of anaemia- both sickle and iron deficiency. We would estimate which are the most prevalent blocks during the first year based on institutional data and camp based data as sickle detection centres have been set up in all the districts. Mass screening/counselling programme will be done in a block for all Children and adolescents for iron deficiency & sickle cell trait and disease.

Sl	Head	Unit Cost	No of Units	Duration	Total
1	Training of 5 Counsellors per block (NGOs & Govt Staff)	400	730	15	4380000
2	Training of 20 peer educators per block (NGOs & Govt Staff)	300	2920	5	4380000
3	IEC activity:	10000	146	1	1460000
4	Honararium for counsellors	200	730	12	1752000
5	Overheads and contingencies	1000	146	12	1752000
	Total				13724000
6	Mass screening/counselling programme in a block for all children and adolescent for iron def.& sickle cell trait and disease (Ten blocks in first year then twenty blocks in each subsequent year for four years)**	1000000	10	1	10000000
	Grant Total				23724000

*Break-up for Rs. 10,00,000 (for mass screening)for a normative block is given below.

Approx population in age group 0-25	40% of the population	
Approx population to be tested	40,000	
Cost per test (Hemoglobin + solubility including confirmation if positive)	@ Rs. 15 per test	6,00,000
IEC and mobilization to get people to participate in		
Meeting and Kalajtha 100 villages	(Rs1000) per village*	1,00,000
Logistics at block level – vehicle, camp arrangement	400camps*Rs400	1,60,000
Documentation		20,000
Total		9,00,000
Overheads 10	10%	90,000
Grant total		9,90,000
	Approximated to 10,00,000	

12. Additional Support For Malaria Care for Pregnant Women

Malaria is the greatest public health problem in Chhattisgarh as large number pregnant women and children succumb of deaths due to malaria this call for special RCH initiative. Though proven malaria deaths are low – fever cases suspected to be malaria are high. We know that there is a 3 to 5% case mortality for falciparum malaria. The control of malaria require considerable consumption of supplies chloroquine, medicated bed nets, insecticide-DDT and synthetic pyrethriods etc. Current supply are grossly inadequate. The department also proposes to cover the entire state where the API is above two with adequate provision of chloroquine and mass fever survey campaign to reduce the incidence of malaria. Given the emerging threats of drug resistant falciparum there is special urgency for such a campaign. Total cost of Rs 20000000 has been allocated for the purpose. This amount will be primarily used to provide malaria care to pregnant women and children o these areas.

Budget Estimate:

Rs. 20000000

13. Incentives for Medical Officers Serving in Medically Underserved Areas

The Medical Officers who are putting their special effort to reach out to the needy in disturbed area like naxalite effected area, unreachable area, forest zone etc will be provided with special mobility support pack based on their performance and health indicators in work area. Total provision of 50,00,000 has been made for this purpose. A Policy and an action plan for this has been prepared which is under approval processes by the state government. Identification and listing of such areas are underway.

Budget Estimate:

Rs. 50,00,000.

14. Special Health Initiatives at Rehabilitation Camps in Conflict Areas

In the context of Salva Judum Campaign and the problems of naxalism, more than one lakh people are now housed in regular camps in district Dantewada. The current flood situation has added to this. There are 9 more districts which are facing the conflict situation though not to the level of Dantewada. There is need to launch a special health effort for preventing and providing health relief. An allocation of Rs. 80 lakhs is proposed as an imprest amount to enable the district health authorities to make necessary extra provision of drugs and supplies needed in this context.

Budget Estimate:

Rs. 80,00,000.

15. Programme Management

This shall occur by five institutional arrangements which are delineated below. Each of these five bodies requires careful planning at the level of governance, specifically in allocation of powers. They need to be able to function with a higher degree of autonomy, decentralisation of powers and professionalism. The RCH proposal proposes ways and means and budgetary estimates to strengthen each of these levels. We have adopted the norms suggested for district health societies staffing. For the state health society, we would be needing additional technical expertise and hence the proposed staff would be incorporated within the budgetary outlay we have already suggested.

INSTITUTION	Function
PROGRAMME MANAGEMENT INSTITUTION	
Strengthening of the NRHM Initiatives through strengthening Directorate of health Services and PMU under RCH-II	<ul style="list-style-type: none"> ○ Administration and Human Resource Issues ○ Infrastructure Management Cell ○ Procurement and Distribution through a separate cell for the same – to be made into an autonomous body. ○ Implementation of all technical components of the RCH and disease control programmes
Strengthening of the State Health Society	<ul style="list-style-type: none"> ○ Monitoring and evaluation of all programmes ○ Support and monitoring of Jeevandeep samitis ○ Financial Management related to programmes: ○ NGO Programmes ○ Public Private Partnership Programmes
Strengthening of the District Health Societies	<ul style="list-style-type: none"> ○ Implementation of Programmes of RCH ○ District and Block Level Plan development.
Strengthening the Block level programmes	<ul style="list-style-type: none"> ○ Setting up a block PMU ○ Strengthening HMIS at block level through computerised data flow ○ Mobility support

The proposal envisages strengthening each of the above three management institutional mechanisms and two technical assistance agencies along with the establishment of an innovative Health Management Information System. There is also a special focus on improving financial management.

At the state directorate and NRHM PMU level the proposal is for 8 consultants as against six who are functional today. Further there is a proposal for continuing the district PMUs as already are in place. To this is added a provision for a block PMU. The budgetary projection for SIHFW is meant to start the SIHFW functioning on an outsourcing basis- as a turn key arrangement – so that after three years it can function autonomously. The budgetary provision for this by then would be absorbed by the state government with the approval of the set up for the SIHFW. The SIHFW shall coordinate all training activities and institutions in the state and ensure the implementation of the HRD policy as regards in service training. The SHRC support has been assured a three year term under an MOU between the government of Chhattisgarh and the SHRC. Two more years of this MOU exist. This support is as envisaged in the MOU and is as approved in the RCH-II PIP. This is essential for continuing the SHRC’s support function- both for community programmes and for capacity building. And for providing technical assistance to programme and policy design and for support to implementation of innovative, effort and process intensive new programmes. .

Specific Issues of Programme Management:

Background and tenure (at least 3 years) of person(s) having overall responsibility for RCH II at state and district levels; delegation of powers	One Joint Director RCH and one deputy director RCH- the latter with over 15 years in RCH and assured tenure in this post as of now
	Mission Director NRHM , Joint Secretary, given this post on the understanding that he would continue for three years in this assignment
	State Programme Manager has assured three year tenure.
Steps to ensure that RCH II is high priority for the District Collector	<ul style="list-style-type: none"> ○ The Programme is reviewed in district collectors conference by the chief minister. One or other component is taken up in each meeting. Components taken up include Mitani programme, Jeevan deep scheme, operationalisation of FRU etc. ○ Also the district collector is head of the district health mission as also on the hospital development committees. He is required to review the mission and the health societies at least once every month. ○ Secretary health writes to district collectors on each programme and talks to them on tour so that they are informed and take interest in the health sector.
Programme management support structure at state and district / sub-district levels & its expertise required for programme strategies;	<ul style="list-style-type: none"> ○ State PMU: Has State Programme Manager and three more officers for data, finance and accounts management. At district level there is a three person team and one person is proposed at the block level. These have to be management or social science postgraduates with experience in health sector or with experience in data, finance or accounts management as the case may be ○ SHRC: This is a support structure especially designed to support the directorate. Has three programme coordinators and three associates other than the director. It can contract in consultants as an when required. Assists in state and district level. ○ At district level there are four programme officers who assist the CHMO in carrying out the management functions other than the three contractual staff described above.

Steps to establish financial management systems	<ul style="list-style-type: none"> ○ Finance Manager is in place. The RCH-II National PIP document and its financial rules and regulations have been circulated and were part of the training programme for district programme managers. During this year a separate training programme for financial managers is visualised under the EU's state partnership plan.
Capacity building of programme management staff at state and district levels	<ul style="list-style-type: none"> ○ One round of training programme has been organised for PMU staff at state and district level with help of UNICEF and SHRC. This will be followed up this year with two three day training programmes in July and January. ○ Other than this the SHRC would be launching a distance education programme on Public Health Management that would benefit
All district plans are in place by April 1, 2007.	<p>The district Plans have all been prepared. However for want of a clear picture of the financial envelope their budgets have not been revised to match fund allocation. This would be done by each district PMU with assistance from the SHRC</p> <p>To be completed by September 30th 2006.</p>
Review of HRD practices	A detailed review of HRD policies has been done under SIP programme. This has been used for several measures – like drawing up a training policy and BCC implementation framework, making BMO into a designated post , changing staffing pattern in the administrative set – up etc. There are however a number of changes still to be achieved or on which a final decision is to be taken and these would be taken up for consideration this year.
Strengthening of HMIS	Under EU- SPP a detailed plan is being launched to strengthen the HMIS. Funds of Rs 5 crores are earmarked for this.. The emphasis is on using HMIS for improved decision making at block, district and state levels and using it as a system for monitoring of utilisation of health facilities in terms of volume and quality.
Improved logistics/ management of drugs & medical supplies	Under EU-SPP in the coming year we are proposing to build drug stores in all CHCs along with improved software based inventory management systems and training to store keepers and supervisors for the same. The funds for this have been earmarked.
Provision for MoU with districts	No MOU with district is being envisaged though against their district budget a milestone based system of release of funds would be worked out.
Strategy for piloting public-private partnerships	A plan for PPP has been put up but due to reservations on ability to regulate Private partners it was decided to limit it to only public sector undertakings. This would be reviewed this year
Functional review of State Health and Family Welfare Department including respective roles of state, district, block and community level (including PRI) institutional structures; delegation of powers; organisational emphasis to key functions like quality, HRD and training	<p>The Rationalisation of health services study and the situational analysis done for the main RCH-II PIP has reviewed these aspects extensively and adequately.</p> <p>The reorganisation of the district health societies and the district health missions and the Jeevandeep samitis into Jeevandeep samitis have adequately delineated organisational roles and powers and key functions and notified these.</p>

Optimising the utilization of existing health facilities/ scope of relocation based on load/ utilisation, distance/ travel time and cost especially for the poor/women and taking into account availability of private/ NGO run facilities, referral transport arrangements	All the health facilities of the state have been plotted on a GIS platform. Optimisation of sub-center location was done last year and of PHCs is ongoing this year – based on the plotting of their present locations and fitting in newly sanctioned facilities into gaps. However existing locations are not possible to change due to objections from the village they are currently located in. Intra village choice of location however remains a priority and where buildings have not been built emphasis is being given that choice of location be chosen at the best possible site.
Training Strategy	The state has adopted a detailed training policy and strategy and had it notified. As part of implementing this it is strengthening existing pre-service training schools, creating District Training Centres with EU-SPP support. Training would be done by these under the guidance and supervision of SIHFW. The training management structure and administrative setup has to be approved. The training calendar for the current year has been drawn up. (copy annexed)
BCC strategy	The state has adopted a detailed BCC strategy and published it and it has evolved a framework for implementation. The framework lays down the hierarchy of institutions and functions and the mechanisms for determining appropriate combination of messages and media and a mechanism for assessing impact at appropriate stages. (copy annexed)
Coordination arrangements	Coordination between development partners has been excellent. Both European Union and UNICEF have been active in the health sector in this state.
Convergence	State and District health missions and district health societies are the main institutional mechanisms of convergence between departments that is envisaged.
Pro poor strategy	The SPIP should demonstrate how pro poor and gender strategies are mainstreamed into the State PIP. The recommendations of the equity and gender studies and contained as supporting documents in the National PIP are of relevance. Some steps that could be taken are e. g. a arrangements for collection and reporting of disaggregated data; gender needs of female health service providers e. g. addressing the needs of ANMs, LHVs, and doctors; policy for encouraging staff to work in less developed districts; strategy developed for creating gender and equity consciousness amongst various stakeholders especially programme staff and community.
Low/ no cost interventions	Promotions on time would be a priority and time-bound promotions as a policy would be a direction. Though there many such policy decisions possible – this would be the priority for the coming year.
Sustainability	The state does have extensive use of user fees but this is for local accountability and flexibility. It sees little role for user fees in cost recovery and even less role in sustainability. It could however be very useful in maintenance. The state is committed to moving towards an allocation of 6% of the budgetary outlay to the health sector. Continued optimal budgetary support along with allocative efficiency and full utilisation and public participation in public health are the cornerstones of a sustainability policy in Chhattisgarh's current context.
TECHNICAL STRATEGIES	These are provided in the main text of the proposal.
WORK PLAN & LOGFRAME	This is provided below.

Identification of those milestones that may be related to performance based benchmarking	We suggest rural IMR (index of child survival strategies)and skilled and institutional delivery rates(co-relate of maternal health services) and number of Mitanins who received at least 10 days training in the year as the indices(index of community participation) of choice for performance based benchmarking.
COSTS/ BUDGET (Mandatory)	Given below and in budget section
Gender Budgetting	Given after budget section

Budget Estimate for Programme Management:

Sl.	Particulars	Unit Cost	Units	Duration	Total Cost
A	Strengthening State PMU & NRHM Secretariate				
1	State Programme Manager	25000	1	12	300000
2	State Consultant- Maternal/Child Health issues	23000	1	12	276000
3	State Consultant-IEC	23000	1	12	276000
4	State Consultant-Infrastructure Cell	23000	1	12	276000
5	State Consultant-Monitoring/Evaluation	20000	1	12	240000
6	State Finance Manager	22000	1	12	264000
7	State Accounts Manager	20000	1	12	240000
8	State Data Officer	16000	1	12	192000
9	Office hands	8000	6	12	576000
10	State level Travel of PMU officials	50000	1	12	600000
11	Inter state travel & Exchange Programmes	500000	1	1	500000
12	Office Coordination/ Contingencies	60000	1	12	720000
A	Total				4460000
B	Strengthening District PMU				
1	District Programme Managers	23000	16	12	4416000
2	District Accounts managers	18000	16	12	3456000
3	Data Assistants	15000	16	12	2880000
4	District Level Mobility of PMU officials	10000	16	12	1920000
5	District level PMU Coordination & Contingencies	15000	16	12	2880000
B	Total				15552000
C	Total				20012000

16. Technical Assistance For RCH Programme - SIHFW

One of the priorities is to provide technical assistance to the entire training programme and to provide leadership to it. The SIHFW is being set up in Chhattisgarh to play this role. Though the SHRC has been asked to undertake the operationalisation of the SIHFW, this would be on a turn-key basis. The new building has been taken over and its furnishing is likely to be completed within a month. A new administrative/faculty set up has been proposed. A annual work plan has been evolved. And a registered society is being formed. Main role is to provide leadership to all aspects of BCC and training.

TECHNICAL ASSISTANCE INSTITUTION	
Operationalizing the State Institute of Health and Family Welfare	○ All Training Programmes and capacity development in all employees

In the first year it would take time to approve a setup. Also the first team of key persons could be taken on contract and we would choose very good resource persons who can set up a suitable institution. A grant for this purpose would enable this. The budgetary provision for this by then would be absorbed by the state government with the approval of the set up for the SIHFW.

Budget for Technical Assistance: SIHFW

A	Strengthening SIHFW				
	Director	40000	1	12	480000
	Registrar	30000	1	12	360000
	3 Expert Faculties	28000	3	12	1008000
	1 Research & Publication officer	20000	1	12	240000
	1 Illustrator cum Grphic Artist	15000	1	12	180000
	1 Librarian cum Documentation Officer	10000	1	12	120000
	1 resident officer cum premise manager	8000	1	12	96000
	1 Accountant	12000	1	12	144000
	4 DEOs cum statistical Assistants	5500	3	12	198000
	5 helpers	3500	4	12	168000
	Tour & Travel	60000	1	12	720000
	Office Coordination/ Contingencies	75000	1	12	900000
	Preparatory Workshops & material Production	200000	5	1	1000000
	Furnishing, remodelling part of building for accommodation and the lift	30.00.000			30,00,000
A	Total				8614000

17. Mandatory Spending Items Under RCH-II:

In addition to the above there are three schemes which are envisaged under the RCH-II. These are Janani Suraksha Yojana, the wages compensation for sterilisation and the NSV camps. An approximate budget for this is indicated below:

SI	Item	Total Amnt. In lakhs
1	Janani Suraksha Yojana	400
2	Wages Compensation for sterilization beneficiaries	520
3	NSV camps	265
4	Total	1185

This is proposed as outside the flexi –pools and can be counted against the principle of performance based funding – if we achieve our annual objectives.

Budget Summary : Part A- RCH Flexipool

Sl. No.	Item	Budget
1	Training	16605889
2	Improving CHC/ PHC performance and Operationalising 200 New PHCs	24896000
3	Improving District Hospital Performance	48000000
4	Improving Subcentre functioning: Evaluation, Drugs and Equipments	38682000
5	Implementation of PNDT Act	2000000
6	Strengthening the Mitadin Programme	20000000
7	Behaviour Change Communication	30000000
8	Urban Health Programmes	20000000
9	Tribal Health: <i>(MMUs)</i>	10206000
10	RCH Camps at Hatt Bazaar	13000000
11	Adolescent Health	23724000
12	Additional Support for Malaria Care for Pregnant women	20000000
13	Incentive to MO for serving in under served area	5000000
14	Special Health Initiative at Relief camps	8000000
15	Technical Assistance- SIHFW	8614000
16	PROGRAMME MANAGEMENT	20012000
17	Mandatory Spending Items	118500000
	Grant Total	427239889

Part B: NRHM Flexipool

The National Rural Health Mission Special Initiatives: Part B of NRHM

The NRHM part B or flexi-pool components is guided by the National Rural Health Missions Framework for Implementation. Every single component of this is most welcome and the state of Chhattisgarh is in a position to implement all of them . However as shown in table , if even a short list of these 42 components were to be implemented the annual outlay on these items alone would be more than Rs 200 crores. But the sanctioned amount under the flexi-pool is only Rs 37 crores.

Given this ceiling we have been constrained to limit our planned interventions to a much smaller sum of Rs 55 crores – a sum that was agreed to during the presentation of the state NRHM PIP held in the Ministry of Health family welfare on the 22nd of September, 2006. We have therefore proposed for only the following items:

1. Jeevan Deep Samitis: Making PHCs and CHCs fully functional
2. Strengthening Routine Sub-Centre functioning
3. Strengthening the Mitatin Programme
4. Behaviour Change Communication
5. Village and Panchayat Level Capability Building
6. State Level Resource Center
7. Provision of Drugs
8. AYUSH
9. Programme Management
10. Mobile Medical Unit

1. Jeevan Deep Samitis: Making PHCs and CHCs fully functional:

Situation Analysis:

Provision of infrastructure, plus manpower plus training plus equipment does not add up to increased quantity or quality of services. Between central and state government, over the RCH-I and RCH-II programmes there has been an investment of about Rs 10 crores into infrastructure of these 100 CHCs. For this investment to be converted into actual improvements in services, we need to invest in some management and motivational processes and resolve along the way a number of systems issues that arise. The Rogi Kalyan Samiti which was functional in District and Community Health centres before Jeevan Deep Samiti was fulfilling the task of Hospital Management Committee. As on today, 580 out of 679 facilities concerned have completed the registration procedure of Jeevandeep Samiti and completing their meetings. Annexure 2 shows the financial status of these Rogi Kalyan Samiti (Now Jeevan Deep Samiti) in the financial year 2005-06.

Objectives:

In this situation, we are providing funds for:

- a) Improved quality of care in 64 CHCs plus 16 district hospitals, all PHCs and subcentres in these blocks.
- b) Ensure that all CHCs and PHCs in these blocks are functioning as 24 hour PHCs of IPHS standards

- c) Ensure that the services provide for equitable access and are woman friendly and adolescent friendly.

An investment of about Rs 12 crores in the form of untied funds placed at the disposal of the facilities, and this is used to not only gaps but also stimulate public participation and accountability is well worth it and could accelerate attainment of quality in each of the facilities.

Key Operational Elements:

- a) There would be a participatory hospital management committee built up for all CHCs, PHCs and district hospitals. This is already achieved.
- b) Design quality of care standards and quality of care indicators as applicable to PHC and CHC and subcentres, including indicators for gender sensitivity and equity in access.
- c) Participatory micro planning to ensure that all employees in these blocks understand the quality standards and identify constraints in closing the gaps: including gaps in minor equipment. This is facilitated by technical assistance agencies for each district.
- d) Initiate and support hospital committee level group processes that will address motivational and attitudinal issues.
- e) Close gaps in infrastructure, manpower and skills and equipment along with measured improvements in quality.
- f) Address all local level “systems” problems- like linkages to a functional ambulance service, designing a viable referral system, getting access to blood organized, ensuring that the referral fund through Mitans is fully utilised. It also requires motivational and management inputs.
- a) At the end of the two years these FRU facilities should provide adequate quality of the following: Access to Basic and comprehensive Emergency Obstetric Care Services and to Comprehensive Emergency Obstetric Care services: Better quality ANC and post partum and neonatal care, institutional neonatal and sick child care, Reduce unsafe abortions; Improved RTI/STI services with utilisation of referral system and ambulance and laboratory services needed to support this set of interventions.
- b) The performance of the hospitals would be rated by an independent agency and they would be accredited using a star rating system and the best performers would be rewarded.

Each district hospital would get a grant of Rs 5 lakhs, each CHC would get a grant of Rs two lakhs and PHC would get a fund of Rs 50,000 from NRHM flexi-pool. To ensure however that these funds made available under NRHM are used in the manner outlined above we need to deploy technical assistance agencies whose funds need to come from the RCH-II flexi-pool. This could be used for following purposes:

- a. Renovation or even new construction to ensure that there is conformity to IPHS standards. Similar standards would be built up for PHCs as well.
- b. Improving residences of staff.
- c. Buying equipment to close gaps.
- d. Local purchase of drugs for the poor.
- e. Payment towards fees for the poor to the Jeevan Deep samiti account.
- f. Motivational meetings and training for the Jeevan Deep samiti members.

Each Jeevan deep samiti would draw up an annual plan and work to implement it and achieve necessary standards. For one year each Jeevan Deep samiti would be supported by a technical assistance agency (TAA) and for each district one TAA would be assigned. Approximately each TAA would be sanctioned additional staff at one coordinator per district for this role and for districts with more than 10 blocks two persons would be sanctioned. The potential TAAs in the state today are UNICEF, SHRC, CARE, RRC and Jan Swasthya Sahayog. The state government of Chhattisgarh is providing start up fund of Rs 50000 (fifty thousand each) for each Jeevan Deep Samiti registered in Primary Health Centre. As per NRHM the JDSamiti should receive seed fund of lakh each. For CHCs since there is a larger issue of maintenance and improvements we are providing for Rs 2 lakhs each taking funds from both item 15 head and item 40 head of the NRHM framework for implementation.

Budget Estimate:

Sl. No	Item	Unit cost	No of Units.	Duration	Total
1	Assistance for District Hospitals(item 40, NRHM framework)	500000	16	1	8000000
2	Assistance for CHCs(item 15 + item 40, NRHM framework)	200000	117	1	23400000
3	Assistance for PHCs(item 40, of NRHM framework)	50000	517	1	25850000
4	Technical Assistance (21 district coordinators [16+5 for >10 block districts]@Rs.20000 pm plus Rs.10000 per month for contingencies	30000	21	12	7560000
	Total				64810000
	From NRHM Mission Flexi Pool				6,48,10,000

2. Strengthening Nurse Training Facilities

One of the major problem that the state face is the non-availability of qualified personnel to fill up the gaps in ANM, MPW and staff nurse vacancies. Another issue is the poor status of available facilities for training of these functionaries. In order to overcome this, the NRHM plan envisages to provide all minimum facilities to the existing 15 such facilities run by the state government as detailed below:

Sl	Facility Level	Existing Centres
1	ANMTC	7
2	MPWTC	3
3	Nursing Schools (Diploma)	4
4	Nursing College (BSc Degree)	1
	Total	15

The above centres should be equipped with all necessary amenities needed for better quality teaching training as well as their physical infrastructure needs some refurbishing. Towards this, an amount of 15 lacs per centre would be allocated.

In order to increase the available number of trained staff nurses, it has been decided that 4 Nursing colleges shall be opened with those district hospitals which fulfil the nursing

council norms for accreditation. Currently there are four such district hospitals in Durg, Rajanandgaon, Raigarh and Sarguja where these colleges are going to be started. In the existing nursing college, a proposal is under consideration to start MSc nursing. However for the new training centres would need some initial expenditure and the state allocations for the same would take some time to get allocated. To bridge this gap, an untied allocation of Rs. 20 lacs per centre is allocated as part of NRHM Flexipool.

Sl. No	Item	Unit cost	No. of Units	Duration	Total budget
1	Allocation for refurbishing and equipping Nurse training Centres	1500000	15	1	22500000
2	Untied Allocation for the initial expenditures for setting up 4 new nursing colleges	2000000	4	1	8000000
	Total				30500000

3. Strengthening Routine Sub-Centre functioning:

Every sub centres will be have Rs 10,000 in joint account of Sarpanch and ANM to reduce the out of pocket expenditure for routine work. This fund will be utilized for proving transport facility for pregnant mother, incentive to Mitandin purchase of consumables, disinfect the facility after delivery etc. It could also be used to observe the health and nutrition day in a fitting manner.

Budget for Strengthening Routine Sub centre Level Services:

Sl. No	Item	Unit cost	No. of Units	Duration	Total budget
1	Untied funds for subcentre functions	10000	4692	1	46920000

4. Strengthening the Mitandin Programme :

Community level health care and improved service utilization (to bring about a halving of IMR in three years) which includes better provisioning of drugs and supplies for this level of care. Rs 22 crores for the Mitandin Programme and Rs 12 crores for drugs. We estimate that Rs 15 crores would come from the ASHA scheme and the remaining 7 crores would be costed to the RCH-II.

Operational Objectives of Programme:

- a. Sustain and support a trained woman volunteer in every hamlet supported by a women's health group i.e. approximately 54,000 Mitandins.
- b. Ensure that 100 key messages on RCH reach every single household in the state in the appropriate language and idiom.
- c. Ensure that every single sick child of fever, diarrhoea, and ARI gets visited on the very first day of illness with appropriate first contact care and referral.
- d. Ensure that every newborn is visited and weighed in the first day after birth and visited once more in the first week and appropriate messages and referral.
- e. Ensure that all pregnant women are counselled on general measures and access to antenatal care, and referred to an institutional delivery facility for childbirth.

- f. Ensure that tackling child malnutrition becomes a priority on the local Panchayats agenda and families and local bodies are empowered to tackle it.
- g. Ensure that outreach of all key RCH services are facilitated by better people's knowledge, by assistance to health department staff in service delivery and by community participation and advocacy.
- h. Sensitisation and capability building in women and Panchayats and link with other health related sectors locally.
- i. By all the above measures linked to improvements in the facility to reduce the infant mortality rate by the year 2007 -08 to below 35 (currently 73)(the technical possibility of doing so has been demonstrated adequately by smaller community health worker programmes)

The programme this year will involve the following dimensions:

- Continued training and support to the Mitanins so that ongoing facilitation of service delivery by Mitanins and community basing of all health programmes is sustained. This year the training would be for 12 days camp based and 30 days field based and would cover the following new topics- in addition to revising the old topics:
 - Food security and Nutrition.
 - AYUSH (Home and Herbal remedies for Mitanins)
 - IMCNI for Mitanins- a video based training module
 - Health Communication kits
 - The Mitanin Diary and Mitanin Register.
- Strengthening and deepening the health education and counselling work at the household level by equipping the Mitanins with charts, posters and other tools of monitoring.
- Strengthening the access of the poor to essential curative care through adequately provisioned Mitanins linked to improved peripheral primary and secondary medical care facilities, by a functional referral system. Ability of the public health system to respond promptly and adequately to needs of institutional care of sick children, referred in by Mitanins.
- Incentivisation of the Mitanin's work so that there is enough encouragement and recognition of their work at both the family and at the community level.
- Inter-sectoral integration at the habitation and panchayats level with related sectors and strengthening local planning at panchayats level.
- Better outcome monitoring and closing all gaps to achieve an effective health outcome.

Indicators:

- Every Mitanin receives a further 12 days of camp –based training and 24 days of on-the-job village level training every year.
- Day 1 visits during delivery is held by Mitanins to assure family level counselling and possible assistance on ensuring six major initiatives related neonatal and mother care issues.
- Micro planning of delivery is done assisted by Mitanins at family level based on EDD so as to promote institutional delivery in all possible cases or at least in those cases with risk factors. In rest of the cases, efforts are made to have skilled delivery

- or at least safety measures are assured during home based delivery. (An important factor needs to be streamlined is the prompt disbursements of JSY payments to pregnant women as well as Mitanins towards this.)
- Mitanins are approached by a certain minimum number of families for common ailments and first level care has been given and prompt referrals initiated based on symptoms on all necessary cases. (The key factor for this to happen is that effective access to basic drugs in every hamlet should be ensured through the Mitanin drug kit and that she is backed by a referral chain from ANMs and PHCs to CHCs and district hospitals so that sick neonates, children, adolescents and women esp. in pregnancy get timely referral when needed.)
 - Mitanins are attending Immunisation sessions at AWCs regularly as a token of she is helping mobilising the community for health services. (The important background factor here is the prompt disbursement of immunisation camp incentives to Mitanins.)
 - Mitanins should know all malnourished children within under 5 or under 3 age groups in their respective hamlets; feeding related counselling given to families of those grade-1 and grade-2 children in regular intervals so as to improve the situation and severe and acute malnutrition (grade 3 &4) has been referred to health care facilities. (Necessary health system supportive action here is to ensure all food security programmes are run properly and the needy people are benefited out of them as well as to take care of giving adequate treatment to those severely/acutely malnourished children who are referred to public health facilities by Mitanins.)
 - Women Committees formed in the hamlets are regularly met and key health education messages are discussed there. This should lead to behaviour changes in certain areas at family level.
 - Ensure that a set of intersectoral interventions planned and coordinated locally and with the Panchayats shall lead to a local plan that shall include food security, safe drinking water and sanitation, early childhood care services and school health services and access to health care services and health education.

The effectiveness of all the above should be visible by a measured decline in decreased IMR and decrease in child malnutrition rates, decreased low birth weight rates. We had committed in the year 2002 that our goal should be that sample surveys should show decrease in IMR by at least 50% at the end of three years and we seem to be on schedule. Other indices like Child malnutrition prevalence, Anaemia in women, Birth weight of babies, tuberculosis/ Leprosy prevalence, Malaria incidences, would also be observed..

Institutional Mechanism: The programme will continue to be coordinated and managed by the State Health Resource Centre on behalf of the directorate and will be organized at the district level by the District RCH (health) societies.

Budget Estimate: Out of the 2210 lacs projected below for Mitanin Training & support activities, the state would be getting at least 1500 lacs from ASHA budget under NRHM and other sources. In this case, the actual requirement would be Rs. 700 lacs from RCH-II regular budget.

Sl	Head	Unit cost	No. of Units	Duration	Exp. Per block per year
A. Training and regular support for Mitanins					
1.	Training of Mitanins	75	60092	12	54082800
2.	Training Compensation for Mitanins	75	60092	12	54082800
3.	Training of Mitanin Trainers (BRPs)	350	3650	15	19162500
4.	Compensation for Mitanin Trainers (BRPs)	1000	2920	12	35040000
5.	Training of Block Coordinators (DRPs)	650	730	15	7117500
6.	Compensation for Block Coordinators (DRPs)	2500	292	12	8760000
7.	Training Material	40	66000	5	13200000
A	Total				191445600
B. Social Mobilisation					
1.	Block Level Interventions*	75000	146	1	10950000
2	District level Interventions*	25000	146	1	3650000
3	State Level Interventions **	30000	146	1	4380000
B	Total				18980000
C Programme Management and Coordination					
1	Block Level Programme Coordination and Monitoring ***	5000	146	12	8760000
2	District Level Programme Coordination and Monitoring ***	2000	146	12	3504000
3	State level Programme Coordination and Monitoring ****	4000	146	12	7008000
C	Total				10512000
Grant Total					220937600
From NRHM Sources-					10000000

*B-1, B-2 District & Bloc Level interventions include wall-writing, folk-media, certification, public meetings/events and other social mobilisation initiatives.

**B-3 State level interventions include electronic media, certification, print media, special events, media briefings, mobilisation trainings etc.

***C-1, C-2 Block and District Level Coordination includes travel, coordination meetings, monitoring, events, correspondence, overheads and contingencies etc.

****C-3 State Level Programme Coordination includes travel, coordination meetings, monitoring, Compensation for field coordinators and support for programme management unit, events, correspondence, overheads and contingencies etc.

The District & State Level expenditures, though derived on the basis of no. of blocks, these amounts are notional at block levels.

5. Behaviour Change Communication:

BCC is one of the key components of any health sector strategy. BCC is essential to modify risk prone life styles and practices and to promote healthy lifestyles and practices. In the last 3 years the state has had many major rounds of Kalajathas which have helped to take key health messages to even the most interior of the rural areas. This has led to sensitisation of community leaders and increased awareness in the community. However, change of practices takes time and we need to persist and intensify the BCC efforts so that the national health programmes can be better implemented and the burden of disease in the community decreases. The results of last 3 years had been encouraging. The prevalence of malaria has come down, and healthy practices like exclusive breastfeeding have gone up. we hope that in the coming 5 years we can show further improvements in all key health parameters by synergising service deliveries with good quality and extensive BCC.

Situation Analysis:

The overall receptivity of the IEC campaign on health has improved in the state after some of the conscious interventions in the area:

1. A study on the communication needs was done under the DANIDA assisted Basic Health Services Project.
2. State level BCC strategy document has been developed and notified as result of a major stakeholder consultation process.
3. Implementation Framework for the strategy has been formulated. The state is committed to using this framework to guide planning and action on BCC.
4. District Level IEC plans have been prepared as part of the District Health Plans, with interventions on every components and sub-components.
5. 50 media officers have been trained in advanced health communication at MICA Ahmedabad.
6. Folk-art based mass communication campaigns held in almost all the villages of the state.

Apart from above, all the national health programmes as well as the state programme on control of Sickle Cell Anaemia had their own specific IEC interventions.

Activities for the year:

Special emphasis on the use of folk art to transmit locale specific messages is proposed under this. They would ensure that BCC activities are mainstreamed into all training programmes and activities. Till the capacities of these centres are built up, experts of the arena will be sought assistance for finalising the scripts and materials, based on the state IEC/BCC strategy finalised by the government.

Objectives of Programme:

- Developing IEC material and campaigns specific for different client groups- by social, linguistic and ethnic characteristic and conducting effective multimedia IEC campaign based on this.
- Creating folk art based plays, songs and skits so that key messages are conveyed in culturally appropriate way and in relation to existing practices.

Key Operational Elements:

- Identify suitable partners for conducting the programmes in the village level and for creating BCC strategies.
- Defining the focus of IEC based on study of local health needs and health beliefs.
- Development of appropriate material based on defining client groups and their cultural specificities.
- Organising scriptwriters, and choreography workshops for developing folk art based material.
- Organizing kalajatha and other locale specific IEC programmes, including programmes in melas and village markets; posters and wall writings in the blocks. Organising radio programmes, TV programmes and hoarding centrally.
- Building up the regional family welfare training centres- existing and proposed as centres of BCC strategy and of integration of ethnic specific messages into all health programmes.

Strategies:

- One strategy Development Workshop will be conducted with participation of all IEC experts/stake holders from the major four regions of the state. This shall identify the behaviours to be addressed, the audience segments to be focussed on and the key messages and media mix as described in the BCC implementation framework.
- Production workshops for folk-art based radio programmes- separate workshops for each region. This work shall be done by SHRC/SIHFV who got a specialist team on radio production.
- Contracting –in an advertising agency for designing the print-media interventions as well as the display. A conceptual session would be done with all programme units towards orienting the agency on various communication needs. After the content development and the copywrite/design are done, a review workshop will be done to finalise the panels/hoardings design as well as the other print media advertisements.
- A district Level Workshop to list out the interventions under district specific IEC interventions. The state shall hire 4 consultants in a way that one consultant shall help design of the IEC interventions for the year in 4 districts each. The priority programmes under the district IEC plan will be listed out.
- To display hoardings, billboards, wallwritings, pamphlets, banners, TV Spot programmes, radio jingles and all other possible means of spreading health messages as per local needs.

Budget Estimate:

Sl.No	Item	Unit cost	No. of Units	Duration	Total Cost
1	One strategy development and three material development workshops per year	100,000	2	4	800000 (RCH)
2	Block level campaigns which are folk art based	100,000	146	2	29200000 (RCH)
	Total				30000000
	From NRHM				
1	Radio programmes – three regional specific 15 part radio programmes broad cast six times a year	500,000	6	3	90,00,000
2	Electronic Media	10,00,000	3	3	90,00,000
3	Print media & Hoardings	100,000	64	1	64,00,000
4	District Plan based focussed programme for each district – untied fund of Rs 10 lakhs per district	10,00,000	16		1,60,00,000
5	State & District Level Events	1,00,000	17	1	17,00,000
6	Overheads & Contingencies for districts	50,000	16	1	8,00,000
7	State level coordination	200,000	1	1	200000
8	Untied BCC funds- to be used for material production to support different programmes and for cost of consultants, films, presentations of work done, state level promotional events etc.				10000000
	Total – under budget allocation specific head				5,31,00,000

7. Village and Panchayat Level Capability Building:

To support the entire programme as given above. This is to be based on a Health & Human Development Index measurable and applicable to panchayats on which the panchayats would be trained.

Objectives of Programme:

- Incentive for high Build the capability of panchayats and village level institutions in health and in assisting/governing health care services.
- Build up local inter-sectoral coordination through panchayat/ village level planning.
- Popularise a simple tool by which panchayats can understand their own performance so as to improve it and by which people can judge them.
- Identify weak and vulnerable villages for special attention from the district government. and Promote performing panchayats by according them with recognition.

Key Operational Elements:

- Develop a health and human development index applicable for hamlets and panchayats: This should include all health services and health related services. It would largely reflect health and health related inputs but some outcome measures are also proposed. The index also incorporates equity and gender concerns.
- The index is capable of being modified at the district level by the district collector/ district panchayat to reflect the district's priorities and availability of funds without sacrificing over all development goals. The index must have its developmental "goal-posts" set at the district level. Note: that as the programme becomes repeated it would tend to become mechanical. However by increasing the role of district and even gram panchayats in the design of the HDI we hope to be able to rescue it from slipping into a mechanical top- down exercise. Then train villages and panchayats elected persons and employees in understanding the indices and how it works. Ensure that 50% of persons so trained are women.
- Provide the panchayats with a fund for working on improving these indices as part of a comprehensive village level plan. This would come from the panchayat department.
- Train also Mitans and NGOs in this health and human development index. One NGO is commissioned for each block to train the panchayats and to train the Mitans and to train the preraks. Unless there is a specific reason the same NGO, which is undertaking, the Mitanin programme in that area would be given this task. Where there is no NGO in this role – as in about 80 blocks an NGO can be recruited. The NGO is provided funds according to the number of GPs each block has so that it can appoint a full time facilitator cum trainer for every three to five panchayats.
- Compile the index according to the manual- first hamlet wise with aggregation at village and panchayat level.
- Rank each panchayat according to each subject and then on the whole- to get subject ranks and total rank on the panchayat report card and reward the successful top rankers and provide support to the weakest panchayats and vulnerable villages where all the above services are weak..
- Monitor implementation of the plan for one full year and then repeat the above process.

Budget Estimate:

Sl.	Item	Unit Cost	Units	Duration	Total
1	Printing of Manual, formats and dissemination	50	100000	1	5000000
	Grand total				5000000

8. The State Level Resource Support: The SHRC

The SHRC support has been assured a three year term under an MOU between the government of Chhattisgarh and the SHRC. Two more years of this MOU exist. This support is as envisaged in the MOU and is as approved in the RCH-II PIP. This is essential for continuing the SHRC's support function- both for community programmes and for capacity building. And for providing technical assistance to programme and policy design and for support to implementation of innovative, effort and process intensive new programmes. The budgetary projection for SIHFW under Part A RCH-II flexipool is meant to start the SIHFW functioning on an outsourcing basis- as a turn key arrangement – so that after three years it can function autonomously. The SIHFW shall coordinate all training activities and institutions in the state and ensure the implementation of the HRD policy as regards in service training.

Technical Assistance Institution	Fucntions
The State Health Resource Centre	<ul style="list-style-type: none"> • Mitanin • Community level capacity building • Oerational Research and Policy related Studies: • Assistance in Policy and programme development • Support to implementation of effort and process intensive innovation

Budget for Technical Assistance: SHRC

Strengthening SHRC (Under Existing MoU)					
Item	Unit cost	Unit	duration	total	
Personnel	206800	1	12	2481600	
Workshops and core publications of annual reports and studies	550000	1	1	550000	
Tour & Travel	35200	1	12	422400	
Office Expenditures & contingencies	52800	1	12	633600	
Total Budget – under current MOU				40,87,600	
Further strengthening for rest of year- staff, core projects, meetings of GB/ECs	10,00,00			10,00,000	
Total				5087600	

9. Procurement of Drugs for Sub Centre, PHC, CHC

In the financial year 2005-06 state has received financial assistance of Rs 12.3 crores towards purchase of drugs for subcentres, PHCs, CHCs, Mitanin(ASHA)s. As per the norms and to fulfil the needs of existing facilities in Chhattisgarh, the funds needed should be about 25 crores. Currently, there is no clear information about whether government of India is going to fulfil this need either by cash or by kind. However, to avoid the complications of having lack of drugs in these facilities, we are keeping a stopgap provision of Rs. 18 crores for meeting the emergencies on this.

Sl	Item	Unit Cost	Units	Total Budget
1	ANM Drug kit-A & B	5650	4692	26509800
2	NRHM extended ANM Kit	1100	4692	5161200
3	State EDL drugs for ANM other than above	3400	4692	15952800
4	Sector level kits: PHCs and for Supplementing state Mitanin drug kits	300000	517	155100000
5	Mitanin drug kit	2000	60,000	1200,00,000
6	CHC kits	1000000	133	133000000
Total				455723800
Allocation under NRHM pool				18,00,00,000

Priority would be given to the ANM drug kit and then the Mitanin kits and then PHC and CHC kits – since the state drug budget is prioritised in the reverse order.

10. Mainstreaming AYUSH:

The Ayurvedic medical officers are already engaged in giving mainstream health services in the periphery of ayurvedic dispensaries- all ISM MOs are supporting preventive health care activities under various national health programmes in atleast 5 villages of the dispensary locality. For providing AYUSH services in mainstream health facilities, we are already availing budget support from MoHFW under department of AYUSH grants, hence the same is not duplicated. In addition to this, the department is proposing to build in public function roles with minimum facilities needed for the same into all dispensaries. This requires that all the 692 AYUSH Dispensaries and clinics will also be given equipments for estimating anemia, for weighing children, for managing malnutrition and for managing normal labour etc. The approximate cost per centre would be Rs 20,000 and for 692 centres it works out to Rs 13840000.

Building and Strengthening Block PMU					
1	Improving Ayush DISPENSARIES	20000	692	1	1,38,40,000

11. Programme Management

Setting up a block PMU as per GOI guideline which will strengthen HMIS at block level through computerised data flow. The unit will ensure proper utilization of fund received from the district. The block programme management unit will consist of a block programme manager and Account Assistant under contractual basis. The education qualification of the block programme manager is Post Graduate in any subject with two years of experience and the account assistant should be B.Com with one year experience. The unit will be station at the CHC and report to the BMO and DPMU.

Building and Strengthening Block PMU					
1	Block Programme managers	8000	146	12	14016000
2	Account Assistant	5000	146	12	8760000
Total					22776000

12. Mobile Medical Unit :

The objective to take health care to the door step of the public in the rural areas, especially in under served area; Mobile Medical Units are proposed to be provided one per district under NRHM.

The staff and modality for operationalisation of the MMU will be on the Jeevan Deep Samiti (The Hospital Management committee). The Unit cost of the mobile unit will be around 23.75 lakhs and recurring cost will be around 19.87 lakhs per annum per district which is as per norms. The Mobile Unit will be used for mobilizing local communities for health action and for creating demand. In initial phase eight districts will have these mobile medical units to provide services. The experience learned form these districts will help to launch Mobile Medical Unit in remaining eight districts.

Sr. No	Mobile Medical Unit	Amount	No. of Units	
1	Capital Cost per unit	2375000	8	1,90,00,000
2	Recurring Cost per District per annum	1987000	8	1,58,96,000
Total				3,48,96,000

Budget at a Glance- Part B NRHM Flexipool:

Sl.No	Items	Amount
1	Jeevan Deep Samitis: Making PHCs and CHCs fully functional	64810000
2	Strengthening ANM/ MPW/ Staff Nurse Training Facilities and setting up of 4 new nursing colleges	30500000
3	Strengthening Routine Sub-Centre functioning	46920000
4	Strengthening the Mitani Programme	100000000
5	Behaviour Change Communication	53100000
6	Village and Panchayat Level Capability Building	5000000
7	State Level Resource Center	5087600
8	Provision of Drugs	180000000
9	AYUSH	13840000
10	Programme Management	22776000
11	Mobile Medical Unit	34896000
	Total	556929600

Part C: Immunisation Activities

State Immunization Plan - Chhattisgarh (2006 – 07)

(State Specific Action Plan as Part of Reproductive and Child Health
Implementation Plans)
Draft as on 1/06/06

Background

State Profile

Total Population (2001)	20795956	Census 2001
Rural (%)	79.92	do
Urban (%)	20.08	do
Infant Mortality Rate (IMR)	60	SRS 2004
Below Poverty Line (BPL) (%)	26	Planning Comm.
Crude Birth Rate (CBR)	27.4	SRS 2004
Infants / year	569809	CBR x Population
Pregnancies / year	626790	Infants x 1.1
Divisions	3	
Districts	16	
Blocks	146	
Gran Panchayat	9129	
Villages	19720	
Towns / Urban Areas	97	

Recent performance

Reported and evaluation coverage

Comparison of Reported and Evaluated Coverage 1998/9-2004/5 (%)

Antigen	NFHS 1999	Reported Coverage 2001-2	Reported Coverage 2004-05	Reported Coverage 2005 – 06*
Fully vaccinated	21.8	69.3	91.42	96.93
BCG	74.3	86.1	100.41	101.57
DPT-3	40.9	81.4	95.12	98.65
Measles	40	77.5	91.42	96.93
Drop-out BCG – Measles rate	46.16	9.98%	8.95%	4.57%
TT 2 + booster	58.2	72.2	93.52	95.78

Vaccine preventable diseases

Vaccine Preventable Diseases (No.)

Disease	2003-04		2004-05		2005-06	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Measles	nil	nil	nil	nil	nil	nil
Diphtheria	nil	nil	nil	nil	nil	nil
Pertussis	nil	nil	nil	nil	nil	nil
Neonatal Tetanus	nil	nil	nil	nil	nil	nil
Polio	nil	nil	nil	nil	nil	nil

Source:

Outbreaks reported and outbreaks investigated in the last year

Outbreaks were not reported during last year.

Infrastructure & Staffing Levels

In addition to dedicated immunization staff and cold storage points, please indicate all areas of planned expansion under RCH II as this will effect budget calculations for immunization trainings and supply inputs.

Health Staff

Position	Sanctioned Posts	In position	Proposed Addition	Trained in last 3 years
Medical Officers	1685	1009	576	Regular training is conducted every year since 3 year
LHV (Female Multi-purpose Health Supervisor)	775	705	70	Regular training is conducted every year since 3 year
Male Multi-purpose Health Supervisor	459	310	149	Regular training is conducted every year since 3 year
ANM (Female Multi-purpose Health Worker)	4954	3962	992	Regular training is conducted every year since 3 year
Male Multi-purpose Health Worker	3320	2811	515	Regular training is conducted every year since 3 year
Contractual ANM		nil	874	
Other relevant health staff (designation_____)				

Dedicated Immunization Staff

Position	Sanctioned	In position	Proposed Addition	Trained in last 3 years
State Immunization Officer	1	1	-	-
State Statistical Officer	1	1		
State Cold Chain Officer	-	-	-	
D.I.O.	9	16	7	Trained
Cold chain mechanic	18	8	10	Trained
Driver (dedicated to UIP vehicles)	16	16	0	Trained

Public Health Infrastructure

Building	Sanctioned	No. Functioning	With Functional Cold Chain	Proposed Expansion (No. Of Facilities)
Sub-centre	4692	3818	3818	
Dispensary		12+ 17		
PHC	517	517	517	232
CHC	116	116	116	
Any other				

Cold Chain Storage Points

Cold Storage Point	Total Number	Proposed Expansion
State Store	1	One storage Point
District Store	16	
ILR Storage Point	16	25

Summary of recent initiatives

Service delivery improvements As per Immunisation PIP 2005-06 every PHC(last vaccine stocking point) were provided with a person (on contractual basis) to deliver vaccines to the session points/sub centres on every Immunisation day.

Partnerships with other agencies / organisations (e.g. ICDS, IAP, etc.) Three month extensive immunisation session for urban slums and urban unreachable area was conducted in collaboration with State unit of UNICEF. Defaulter tracking chart was supplied for every sub centre by UNICEF. On every Health Day organised by Agganwadi Centre (ICDS) the ANM of sub centre inoculate pregnant women and children of the village.

UIP related trainings conducted in the last 3 years

Position	No.
DIO (Mid Level Manager)	once
MOs	Regular every year
LHVs	Regular every year
ANMs	Regular every year
Other i.e. HA (M), HW (M), SN	Regular every year

Assessment of critical bottlenecks for full coverage

Availability Due to geographical terrain of the state of Chhattisgarh there are many under served and unreachable areas. This situation is compounded with Naxalite problem in tribal district. The power situation in most of the Primary Health Centre is erratic and the ILR and Deep Freezer are powered by generators.

The shortage of human resource (Para medical staff) in also impeding the supply of vaccine

Accessibility The main problem in ensuring regular immunisation for villages/urban slums are nomadic nature of the inhabitants and less infrastructural support of the urban slums. Many unorganised overgrown colonies are still served by single Female Multipurpose worker. Since Pulse Polio is organised in campaign mode the inhabitants of urban slums consider Pulse Polio as only vaccination which is enough to protect them for all the six vaccine preventable diseases

Utilization / Adequate Coverage Low awareness of vaccination schedule is one of the major causes of low attendance in immunisation session. Parents lose interest in inoculating their children when they are turned down from health centre due to non availability of required antigens in any immunisation day.

Effective Coverage / Quality The norms of injections safety get violated due to lack of training and supervisory support.

Objective

The overall goal is to increase immunization coverage rates. Based on review of past performance, assessment of critical bottlenecks, and planned activities indicate below the current (2005/6) and expected performance (2006/7).

Immunization Coverage Targets

Indicator	Current 2005/6	Planned 2006/7
BCG coverage (%)	106.42	>=100%
DPT-1 coverage (%)	106.42	100%
DPT-3 coverage (%)	104.36	100%
Districts with over 80% DPT-3 coverage – No. (%)	100	All 16 districts
Measles coverage (%)	102.71	100%
Vit A coverage (% 2+ doses)	79.37%	100%
Districts with over 70% vit A coverage – No. (%)	13 Dist with 81%	All Dist
Drop-out rate BCG – Measles (%)	3.48	<2%
Districts with under 15% BCG Measles Drop Out – No. (%)	100	All 16 districts
Children fully vaccinated by 12 months of age (%)	101.77	100%

Source of data:

Improve Vaccine / Supply Logistics

Key Performance Indicators

Indicator	Current 2005/6	Planned 2006/7
Districts with any antigen stock-out more than 1 month in the last 12 months – No. (%)	None	None
Districts with AD syringe stock-out more than 1 month in the last 12 months – No. (%)		50%

Expand Cold Chain Reach and Improve Performance

Key Performance Indicators

Indicator	Current 2005/6	Planned 2006/7
Cold chain assessment done within last 3 years (exact year done or planned)	every 3 months	every month
Proportion of ILR registered (not condemned) non-functional (%)	None	None

Ensure all children in all villages/towns covered with regular (monthly / quarterly) immunization session according to village size

Key Performance Indicators

Indicator	Current 2005/6	Planned 2006/7
% Districts with routine immunization micro-plans available	all	all
% Villages (over 1,000 population) covered 1 or more times a month	100%	100%
% Villages (under 1,000 population) covered 1 or more times a quarter	100%	100%
% Slums / high risk areas covered monthly	100%	100%
% Urban areas covered monthly	100%	100%
% Sessions planned versus sessions held	289968	289968

Source of data:

Improve injection safety by introducing AD-syringes

Key Performance Indicators

Indicator	Current 2005/6	Planned 2006/7
PHCs using ADS for all immunizations (%)	all	all
PHCs with appropriate waste disposal in place (%)	40%	100%

Proposal for construction pits at annexure - IV

Ensure accurate record-keeping/monitoring with improved supervision

Key Performance Indicators

Indicator	Current 2005/6	Planned 2006/7
Gap between reported and evaluated full immunization coverage (%)	No external evaluation done in 2005/06	

Train Immunization Staff

Key Performance Indicators

Indicator	Current 2005/6	Planned 2006/7
ANMs having received refresher training in immunization within that last 3 years (%)	80%	100%
DIOs having participated in mid-level managers (MLM) training within the last three years (%)	90% at SIHFW Bombay	100%

Action Plan

Alternative Vaccine Delivery

ANMs spend much of her time in receiving and carrying logistics to immunization site. This precious time of ANM can be saved so that she gets more time to visit villages to provide services. For each Primary Health Centre area, route map will be prepared and vaccines will be supplied to all ANMs on the morning of immunization day. At every sector a person will be contracted in to deliver the vaccines to the session site or the sub centre and he will be responsible to carry back used, unused or partially used vials and Bio medical waste on the same day in the evening as per GOI guidelines. The Medical officer will verify the report of vaccinated children by the number of used vials received for disposal.

Mobilization of Children by ASHA, NRHM States, etc.

Immunisation is the main and along with antenatal care often the only point of contact between the ANM and the persons she serves. To maximize these opportunities she is provisioned and encouraged to provide first contact curative care, and seek cases for referral for tuberculosis and leprosy case detection and for correctable blindness. Close coordination with the Mitandin and the Aganwadi System provides her the community support she needs to complete both immunisation and

¹ Detailed GOI guidelines are available as an annex to this template.

when she visits for immunisation – all these other activities as well. Without such help even meeting all her immunisation and antenatal clients would become impossible. Strengthening the Mitadin programme is therefore also critical to successful outcomes. Performance based incentive in line of Janani Suraksha Yojna can be used as catalyst to increase immunization coverage in hamlets where Mitadin are active.

Slums & Underserved areas

There are still many areas where there is no ANM posted or have high absenteeism or geographical constraints. These areas are proposed to be notified and the option best suited for these areas are to be put in place in consultation with the janpad (block) Panchayats. The choices for immunisation service delivery are between-

1. Mobile clinics visiting the haats (community market places) linked to Mitadins bringing the patients in.
2. NGOs as service delivery agency. Special incentives package for government staff to go there and remove it from the notified list would also be in place.
3. Service of retired AMN or ANM posted in private sector will be asked to render their service to conduct vaccination session at these areas
4. Special immunisation campaign of slums in coordination with development partners

The special immunisation session thus held will be certified by the public representative or higher authority of active NGO of the slum area and the District Health Society.

Strengthening monitoring and supervision and surveillance

Insistence on regular first level supervision (i.e. of ANM by LHV) and by a cluster sample check by every second level supervisor (by BEE/BMO/ district immunisation officer) and sample survey review by an external professional marketing research agency should all be institutionalised .It is also important to identify and notify the 10% least accessible hamlets and villages in each block so that special verification of this is possible. The DIO and field supervisor will sign the ANM register in every visit. DIO and second in line will provide supportive supervision to the Female and Male Health workers

Computer assistant to DIO

Computer Assistant

A provision of up to Rs. 7,000 / month is available to employ a computer assistant for the DIO. The computer assistant should be minimum graduate and two years of experience in related field. The person is already in place and recruited on contractual basis by district health society.

The computer assistance is gathering data form the sectors by visiting sector meeting and compiling the data of the immunisation session. The person is providing with analytical information to the DIO for taking decision to improve the services. The Computer Assistance is updating the RIMS and responsible of sending data to GOI.

Introduction of RIMS software for monitoring UIP

GoI has contracted an external agency to prepare and introduce “RIMS” computer software into all districts. A provision has been made to train up to 5 persons / district. Indicate plans for this initiative.

Review Meetings

Regular review meetings will be held at State level with CMHO and DIO to assess immunization coverage

Provision for additional support

Vaccine supplies

As per annexes (1a & 1b).

Cold chain strengthening

Complete the cold chain equipment annex (2) to summarize the overall requirement for the coming year. The state was supplied with 295 ILR small and this year we require 295 Deep Freezer capacity 140 litres and 25 deep freezer capacity 300 liters to strengthen the cold chain

- **Replace CFC equipment with non-CFC equipment** All CFC equipment is replaced by non CFC equipment. Only WIC of RAIPUR which is CFC equipment is to be replaced in 2006-07
- **Replacement of non-functional (beyond repair) equipment**
Only Deep Freezer needs to be replaced (number mentioned above)

Expansion of cold chain storage points²

200 new PHC are coming up which need all cold chain equipment as per norms ie set of Deep Freezer and ILR is required for new PHCs

Cold chain maintenance

Cold chain technicians

13 cold chain technicians are available for cold chain maintenance for 16 districts. Those districts not having cold chain mechanics are managing by getting the work done by out sourced technicians or private mechanics on payment basis

Maintenance fund

A total of Rs. 500 per ILR should be budgeted for spares and other maintenance requirements. The fund will be disbursed to the district health society and the maintenance of the cold chain will be approved by the governing body of the society.

² National norms for vaccine storage provide 1 ILR/Sml + 1 DF/Sml per PHC (last storage point). Large ILR / DF are intended for district and state HQ only.

AD syringes

The total AD syringe requirement is outlined in vaccine supply format provided. As AD syringe is to used in all vaccination schedule the supply of the same from GOI should be regular

Printing and dissemination of tally sheets

Supply mother-child card / vaccination card

Total requirement is indicated in vaccine supply requirement – as these will be printed and supplied by the central government.

Re-orientation of ANMs

A provision is made for 3-day refresher training to all ANMs, LHVs, and male health workers. A total of Rs. 350 per participant has been allocated. The training will be provided by SIHFW on planning immunisation out reach session and handling Bio- Medical waste.

Additional trainings

Refresher training to DIO / Regional Store on supply formats This training will be done by NIHFW for the DIO on RMIS and delegation of financial/ administrative power under NRHM.

Training of cold chain technicians

Refresher training to cold chain technicians (2 days) could be planned every two years. Benchmark estimate is 1,700 per participant (1,000 travel + 2 x 250 per diem + 2 x 100/day material cost). Costing in budget sheet

Summary of all UIP-related training activities, 2006-7

Training	Target Group	Number of participants	Duration	Remarks
Immunization Safety	ANM, LHV, Male MPW, Male Supervisor	9508	1 day	To be organised by SIHFW
Immunization Safety	DIO, BMO,MO	1685	1 day	To be organised by SIHFW
Infection Control Para Medical Staff	DIO, BMO, LHV	2460	1 day	To be organised by SIHFW

State-specific strategies

Schemes where central funding support is requested mentioned

- Cold Chain - Replacement of two WIC in the state of Chhattisgarh
- Vaccine Logistics The central
- Evaluation The central should organise and fund external evaluation of immunisation services

- should supply seven vaccine van for the state
- Social Mobilization The central government should provide fund for IEC and Behaviour Communication Change in tribal areas
 - Injection Safety Plastic bags to carry waste generated during immunisation session should be supplied by the central
- biannually.
- Only WIF which is functioning at Secretariat building is near replacement and to manage with single storage point is difficult. Need installation of another WIF

Budget A. Existing Support for State and additional requirements:

Sl.No.	Item	Existing	Additional Requirement				
			2005-06	2006-07	2007-08	2008-09	2009-10
1	Cold Chain:						
	WIC	2	1	1	1	1	1
	WIF	1	1	1	1	1	1
	ILR	590	295	50	50	50	50
	DF	527	295	50	50	50	50
	Vaccine carrier	17000	5000	3000	3000	2000	2000
	Cold Box(22 litter)	680	100	100	100	100	100
	ICE pack	68000	20000	10000	10000	5000	5000
	Funds for cold chain maintenance	418500	418500	439425	461396	484466	508689
	Vaccine Van(for 6 new districts)	16	3(Not Received)	6	3	3	4
	Vaccination Cards required for the state (will be supplied by GOI)		700000	750000	800000	875000	950000
2	Vaccine This will be provided by GOI						
3.	Support For Computer Assistant at State Headquarter	(Salary96,000)	(Salary96,000)	(Salary96,000)	(Salary96,000)	(Salary96,000)	(Salary96,000)
4.	Support for Computer Assistant at District Level (16 Districts)	Salary 1344000	Salary 1344000	Salary 1344000	Salary 1344000	Salary 1344000	Salary 1344000
5.	Support of Review Meeting	120000	120000	120000	120000	120000	120000

⇒ **ILRs, DF, Voltage stabilizers**

- i. A1 CFC equipments supplied till 1992 has been replaced with Non CFC equipments. The expansion plan includes replacement of remaining CFC equipments supplied during the period 93 – 98.

- ii. Replacement of all condemned or non-serviceable equipments, which is beyond repair.
 - iii. Expansion:- Need based depending on the setting up of New- 200 PHC.
- ⇒ **Cold Boxes, Vaccine Carriers** – Replacement plan for expansion or replacement of condemn equipment.
- ⇒ **Insulated Vaccine Van:** Supply of insulated vaccine vans against condemned vehicles and expansions plan for supply of Vaccine Vans for newly created District.
- ⇒ **Existing norms for maintenance of Cold Chain equipments:** Rs.500 per PHC/CHC per year and district Rs.10,000 per year.

Budget B. Additional Support Required for 2006-07

	Item	Amount Required
1	Mobility support for supervision @ Rs. 50,000 rupees per District for District Immunization Officer (this includes POL and maintenance) per year(16 districts)	800000
2	Alternative Vaccine Delivery: Alternate vaccine delivery support for 4 sessions p.m. @ Rs. 50 per session= Rs. 200 per Sub Centre per month which is Rs. 2,400/- per sub centre p.a.	11980800
3	Focus on slum & underserved area in urban areas: Hiring an ANM @ Rs. 300/session for four sessions/month/slum and Rs 200 per month as contingency per slum i.e. total expense of Rs. 1400/- per month per slum.	18480000
4	Mobilization of children through MITANIN @ Rs. 50/p.month for one session. per worker	37800000
5	Trainings Districts level orientation training for three days ANM, Multi Purpose Health Worker (male), LHV, Health Assistant (Male/Female), Nurse Mid Wife, BEEs & other specialist (per diem Rs. 100 per day & Rs. 50 institution costs.)	4500000
6	Districts level trainings for Refrigerator Mechanics Frequency: once in two years; Days: 2 days ; No. of participants; 5 Travel allowance: 1000 per participants; Per Diem; 250 rupees, Training materials and contingency: 100 rupees per participant per day	0
7	Cold Chain Maintenance requirement especially for spare parts @ Rs 500 per ILR The Storage for AD syringe space will be utilized for keeping inventory of Spare Parts	392700
8	Computer Assistant to all 16 DIO and one for State immunization Officer. Payment per computer up to Rs 7000 per month and at state level Rs 8000 per month	1440000
9	Support for Review Meetings	120000
Total		75513500

**Summary Budget
For All Components**

PROPOSED BUDGET FOR NRHM; CHHATTISGARH 2006-07

NRHM BUDGET SUMMARY:

Part A:	RCH Flexipool:	Rs.42.83 crores
Part B:	NRHM Flexipool:	Rs.37.50 crores
Part C:	Immunisation:	Rs.7.37(sanctioned 5.97)crores.
Part D:	Disease Control Programmes:	
Part E:	Convergence: Integrated in Part B	

Budget Summary : Part A- RCH Flexipool

Sl. No.	Item	Budget
1	Training	16605889
2	Improving CHC/ PHC performance and Operationalising 200 New PHCs	24896000
3	Improving District Hospital Performance	48000000
4	Improving Subcentre functioning: Evaluation, Drugs and Equipments	38682000
5	Implementation of PNDT Act	2000000
6	Strengthening the Mitatin Programme	20000000
7	Behaviour Change Communication	30000000
8	Urban Health Programmes	20000000
9	Tribal Health: (MMUs)	10206000
10	RCH Camps at Hatt Bazaar	13000000
11	Adolescent Health	23724000
12	Additional Support for Malaria Care for Pregnant women	20000000
13	Incentive to MO for serving in under served area	5000000
14	Special Health Initiative at Relief camps	8000000
15	Technical Assistance- SIHFW	8614000
16	PROGRAMME MANAGEMENT	20012000
17	Mandatory Spending Items	118500000
	Grant Total	427239889

Budget Summary- Part B NRHM Flexipool:

Sl.No	Items	Amount
1	Jeevan Deep Samitis: Making PHCs and CHCs fully functional	64810000
2	Strengthening ANM/ MPW/ Staff Nurse Training Facilities and setting up of 4 new nursing colleges	30500000
3	Strengthening Routine Sub-Centre functioning	46920000
4	Strengthening the Mitanin Programme	100000000
5	Behaviour Change Communication	53100000
6	Village and Panchayat Level Capability Building	5000000
7	State Level Resource Center	5087600
8	Provision of Drugs	180000000
9	AYUSH	13840000
10	Programme Management	22776000
11	Mobile Medical Unit	34896000
	Total	556929600

Budget Summary : Part C; Immunisation:

Sl.No	Item	Budget Requirements
1	Mobility support for supervision	800000
2	Alternative Vaccine Delivery	11980800
3	Focus on slum & underserved area in urban areas	18480000
4	Mobilization of children through MITANIN	36000000
5	<i>Trainings</i>	4500000
6	Districts level trainings for Refrigerator Mechanics	29700
7	Cold Chain Maintenance requirement especially for spare parts	374000
8	Computer Assistant to all 16 DIO and one for State	1440000
9	Support for Review Meetings	120000
	Total	73724500

Part D: Other National Programme

SrNo	Items	Amount Communicated by GoI	Amount Sanctioned
1	National TB Control Programme	3.65 cr	2.15cr
2	National Leprosy Eradication Programme	2.09 cr	1.29cr
3	Integrated Disease Surveillance Programme	2.45cr	0
4	National Iodine Deficiency Disorder Control Programme	0.06 Cr	0.03 Cr
5	National Programme for control of Blindness	1.45cr	1.26cr
6	National Vector Borne Disease Control Programme	21.81cr	6.40 cr

Budget Requirements if all the NRHM framework Components are Implemented

Activity	Unit Cost	No. Of Units	
Visioning workshops for State, District and Block level Mission Teams	10 lakhs for State, 5 lakhs for District and one lakhs for Block	one at state one at 16 district and one at 146 blocks	23600000
Constitution and orientation of all community leaders on village, SHC, PHC, CHC Committees	Rs 5000	AT 4692 Sub center	23460000
Untied grants to Village Health and Sanitation Committees	Rs 10000	Vilages 20193	201930000
Selection and training of Community Health Workers (ASHAs, AWWs) etc.	Rs 10000	Mitanin 60,000	600000000
Performance related incentives for ASHAs, AWWs.	Rs 5000	Gram Panchayat 9820	49100000
Selection, remuneration and training of ANMs.	Rs 13000 per ANM & Rs 18000 per LHV	2000 ANMs & 250 LHV	30000000
Selection, training and remuneration of Staff Nurses at PHC/CHC level.	Rs one lakh per Staff Nurse	400 Staff Nurse	40000000
Selection, training and remuneration of Medical Officers at PHCs	Rs 18000 pmonth	717 Doctors	154872000
Selection, training and remuneration of Specialists at CHC level.	Rs 25000 per month	64 Equiped CHC	21900000
Construction and maintenance of physical infrastructure of SHCs	Rs 10000	4692 Sub Centers	46920000
Construction and maintenance of physical infrastructure of PHCs	Rs 50000	517 Existing PHCs	25850000
Construction and maintenance of physical infrastructure of CHCs.	Rs 100000	117 Existing CHCs	11700000
Support to BPL families for institutional deliveries under the JSY	Government Allocation		40000000
Untied grants to SHCs, PHCs and CHCs	ten thousand for SNC/ 25,000 for PHC / 50,000 for CHC	4692 Sub Centers/ 517 PHC/117 CHC	65695000
Support to Mobile Medical Units/ Health Camps	Rs 2375000 capital cost and 1987000 Recurring cost	16 district	96000000

Support for School Health Programmes	Rs ten lakhs	Remaining 136 blocks	136000000
Support for IEC activities	two third of Rs 10 per capita	Population Two cr	133400000
Resources for surveys, camps, public hearings.	Ten lakhs per district	16 districts	16000000
Grants in aid to NGOs at district, state and national levels.	Rs 45 lakhs per MNGOs	Eight MNGOs	36000000
Monitoring and Evaluation Costs.	Three fourth of Rs 5 per capita	Population Two cr	75000000
State level Resource Centre	As per Norms		5000000
Support to district and Block level Resource Groups.	Rs 5000 per month	146 blocks	9000000
Research Studies	75% of Rs 5 per capita	Population Two cr	75000000
Support for Planning activities.	Approximate figure		10000000
Rogi Kalyan Samitis / Hospital Management Committees	Rs 5 lakhs for District Hospital/Rs one lakhs per PHC&CHC	15 DH/ 117CHC/517 PHC	70900000
Preparation of District Health Action Plans	Rs Twenty lakhs per district	16 district	32000000
Total			2029327000

GENDER BUDGETTING & GENDER PRIORITY:

Sl. No.	Item	Total Budget	Priority Areas in terms of Gender	Approx. Budget Proportion on Gender	Approx. Gender Budget Amount
3.1.1	IMNCI Training	3178609	Focus on counselling on mother and child health	80%	2542887.2
3.1.2	ANM Training including on skilled birth attendance	13000000	Focus on reducing maternal mortality	100%	13000000
3.1.3	Paramedical skill development of male field workers	11933680	Reduced burden for female workers, Lab tests particularly on anaemia routinised, better access to care	50%	5966840
3.1.4	Multiskilling of Doctors	3537250	Eobc & EMoC as well as Anaesthesia training- also focus on male sterilisation & reduction of MMR	100%	3537250
3.1.7	Induction training of new Medical officers	3184350	Focus on maternal health and population stabilisation	60%	1910610
3.2.	Improving FRU & PHC performance: Incentivising Institutional delivery:	4896000	EObc and EmoC & safe motherhood, better health care access for women	100%	4896000
3.3.	Jeevan Deep Samitis: Making PHCs and CHCs fully functional:	22690000	Women participation	50%	11345000
3.4	Implementation of PNDT Act	2000000	Maintaining the Sex Ratio	100%	2000000
3.5	Strengthening routine Sub-Centre functioning:	107352000	ANCs and women health issues as main outcomes	75%	80514000
3.6.	Strengthening the Mitatin Programme :	220937600	Women organisation and empowerment, health awareness among women, access to health care	80%	176750080
3.7	Behaviour Change Communication:	48780000	Gender Sensitivity on health	50%	24390000
3.8	Village and Panchayat Level Capability Building:	7150000	Women Participation in Panchayat processes	50%	3575000
3.9	Urban Health Programmes:	20539000	Female Community Health Workers & attention to complex womens health issues	50%	10269500
3.1	Tribal Health: (MMUs)	44909000	Access of women to health services	50%	22454500
3.11	Adolescent Health :	23724000	Health Awareness of girls & women as well Behavioural Change	75%	17793000
4.1	PROGRAMME MANAGEMENT	62498600	Gender Sensitivity	50%	31249300
4.2.	Technical assistance institutions(SIHF& SHRC)	9701000	Gender consciousness in policy development & capacity building	50%	4850500
5	Mandatory Spending Items	118500000	MMR reduction & maternal care, focus on male sterilisation	100%	118500000
6	Strengthening of Malaria Programme	30000000	Focus on care at pregnancy	60%	18000000
7	Incentive to MO for serving in under served area	5000000	Focus on RCH services in tribal and marginalised	60%	3000000
8	RCH Camps at Hatt Bazaar in 65 non tribal Blocks	13000000	dedicated to ensure outreach of RCH services	100%	13000000
9	Special Health Initiative at Relief camps	20000000	Major target group will be women & children	60%	12000000
	Grant Total	803431089	Average	70%	566069600

District Wise Allocations Proposed:

Sl. No.	Item	Total Budget	From Other Sources	From RCH-II	Sarguja	Koriya	Jashpur	Raigarh	Korba	Janjgir	Bilaspur	Raipur	mahasamund	Durg	Rajnandgaon	Kawardha	Dhantari	Kanker	Bastar	Dantewada	State Component	
3.1.	Training.																				243800	
3.1.1	IMNCI Training	12958775	0	12958775	0	63574875														63574875		
3.1.2	Training on skilled birth attendance	18084000	0	18084000	1130250	1130250	1130250	1130250	1130250	1130250	1130250	1130250	1130250	1130250	1130250	1130250	1130250	1130250	1130250	1130250	1130250	0
3.1.3	Paramedical skill development of male field workers	11933680	0	11933680	707080	707080	707080	707080	707080	707080	707080	707080	707080	707080	707080	707080	707080	707080	707080	707080	707080	620400
3.1.4	Multiskilling of Doctors	3537250	0	3537250	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3537250
3.1.7	Induction training of new Medical officers	3184350	0	3184350	186300	186300	186300	186300	186300	186300	186300	186300	186300	186300	186300	186300	186300	186300	186300	186300	186300	203550
	Total Training	49698055	0	49698055	2023630	65598505	2023630	2023630	2023630	2023630	2023630	2023630	2023630	2023630	2023630	2023630	2023630	2023630	2023630	65598505	2023630	4361200
3.2.	Improving FRU & PHC performance: Incentivising Institutional delivery:	6976000	0	6976000	436000	436000	436000	436000	436000	436000	436000	436000	436000	436000	436000	436000	436000	436000	436000	436000	436000	0
3.3.	Jeevan Deep Samitis: Making PHCs and CHCs fully functional:	27630000	21000000	6630000	390000	390000	390000	390000	390000	390000	390000	390000	390000	390000	390000	390000	390000	390000	390000	390000	390000	390000
3	Implementation of PNDD Act	2000000	0	2000000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	200000
4	Strengthening routine Sub-Centre functioning:	87948000	46920000	41028000																		41028000
3.6.	Strengthening the Mitani Programme :	220937600	150937600	70000000	8550000	2250000	3600000	4050000	2250000	4050000	4500000	6750000	2250000	5400000	4050000	1800000	1800000	3150000	6300000	4950000	4300000	
4	Behaviour Change Communication:	20000000	0	20000000	1985000	585000	885000	985000	585000	985000	1085000	1585000	585000	1285000	985000	485000	485000	785000	1585000	1285000	2440000	
4	Village and Panchayat Level Capability Building:	47150000	37150000	10000000	1235000	325000	520000	585000	325000	585000	650000	975000	325000	780000	585000	260000	260000	455000	910000	715000	510000	
4	Urban Health Programmes:	71825842	41825842	30000000																		
3	Tribal Health: (see notes)			0*																	30000000	
3	Adolescent Health :	23724000	0	23724000	1786000	470000	752000	846000	470000	846000	940000	1410000	470000	1128000	846000	376000	376000	658000	1316000	1034000	10000000	
4	PROGRAMME MANAGEMENT	73247600	0	73247600	6717932	2439877	3356603	3662178	2439877	3662178	3967753	5495630	2439877	4578904	3662178	2134301	2134301	3051027	5190055	4273329	14041600	
	Total	557889497	224585842	333303655	23123562	72494382	11963233	12977808	8919507	12977808	13992383	19065260	8919507	16021534	12977808	7904931	7904931	10948657	81725560	15106959	107270800	
5	Mobility Support for blocks	75920000	0	75920000	9880000	2600000	4160000	4680000	2600000	4680000	5200000	7800000	2600000	6240000	4680000	2080000	2080000	3640000	7280000	5720000	0	

LOG Frame

Chhattisgarh RCH-II Plan : Logframe :

Domain: Institutional Strengthening :

Overall Purpose: Paradigm of flexible and responsive RCH programme. Service providers are empowered and accountable with a focus on core outcomes of RCH

Purpose	Object/Output	Output indicators(MOVs underlined)	Inputs/Activities	Activity OVI/MOVs (MOVs underlined)
1. Strengthen the decentralised planning process	1.1 Prioritise interventions based on state level and district level needs. 1.2.Strengthen capacity for decentralised planning including communication programmes	District Health Plans District Health Planning Committee is created and is functional. Plan outcomes and their achievement at the end of one year. <u>The Plan document:</u> <u>The planning committee minutes and order creating it.</u>	1. Strengthening of state and district health societies and recruitment of staff so as to create adequate planning capabilities. 2. Manual on district level planning prepared and district teams trained in it. 3. Capability building for epidemiology, operational research and public health management built up at district and state levels. 4. Technical Support in Planning from SIHFW built up and SHRC strengthened. 5. Defining roles and Capability building of panchayats and Jeevandeep samitis and ULBs in health planning 6. Evolving annual district plans and review of outcomes at end of year and next planning cycle based on this. 7. Announce Swasthya Panchayat scheme and design Panchayat level HDIs 8. Train panchayat functionaries	1.Functional status of district planning cell. <u>Notification of district planning cell.</u> <u>Minutes of meetings and draft plans.</u> 2.Number of district teams trained <u>Training Report:</u> <u>District Planning Guidelines Manual</u> 3. For capability building see section on management. 4. Ability and role played by SIHFW and SHRC.as planning supports <i>Institutional Evaluation report</i> 5. Guidelines issued on role of local bodies and Jeevandeep samitis. Minutes of Jeevandeep samithis; local body health committees. 6. District plans and reports of implementation: <u>District plan documents and achivement review documents</u> <u>Data sheet showing current achievements and projected achievements with relation to plan.</u>

	Strengthen Panchayat capability in health planning and programme implementation	HDI's available for every panchayat. HDI- Equity score is also available for all panchayats.	and village activists and NGOs on HDI's and how to use them for planning and programme improvement. 9. Special assistance to most mulnerable panchayats and rewards to high performance ones.	<u>HDI's for every panchayat first in 50 blocks by August 2006 and all 146 by april 2007. Media publicity of scheme and high performers and poor performers.</u>
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Purpose	Object/Output	Output indicators(MOVs underlined)	Inputs/Activities	Activity OVI's/MOVs (MOVs underlined)
2. Improve quality of service delivery and increase the services available	2.1. Achieve minimum infrastructure needed for each facility and where needed the creation of new facilties to meet the existing norms. (to be read along with section 6 on filling of vacancies of staff.)	All infrastructure in place in 80 blocks.(32 under SIP and 32 under NRHM) plus in 16 blocks with district hospitals Reports of work completed <u>Survey & field visits by evaluation team.</u>	1.Standardize minimum infrastructure needed norms for each facility. 2. Identify 64 blocks other than 16 district headquartres block where infrastructure gaps need to be filled. Blocks identified on maximising access and on possibility of success(vacancy sitation etc>) 3.Preparing a block by block plan to close current gaps in infrastructure in 64 blocks as well as the district headquarters 16 blocks. 4. Sanction constructions on receeiving money.	Complete block level plan identifying all current infrastructure gaps in 80 blocks. <u>Documents stating norms for infrastructure and for adequacy/gaps of facilities and block plans for 80 blocks.</u> No. of facilities where Constructions /renovations/watersupply and electrical work completed to make facility functionally ready. Reports on progress of civil works, renovations and new contructions <u>Block wise achievement statement of how many blocks have reached zero infrastructure gaps.</u> <u>Sample survey by evaluation team for further verification.</u>

	<p>2.2. Achieve minimum set of skills needed for each facility for all services to be in place through implementing human resource development policy for paramedicals and medical officers</p>	<p>All necessary skills for performing <i>all identified RCH activities</i> in place in 80 blocks. (this includes emergency OT care and anaesthesia care, safe MTPs, sick neonatal care) <u>Report of manpower with Skill sets now available for all aspects of RCH referral care available in a series of well chosen 64 CHCs/FRUs and 16 district hospitals .</u></p> <p>External Evaluation study showing what % of designated CHCs have achieved skill sets needed</p>	<ol style="list-style-type: none"> 1. Identify medical officers in the chosen 64+ 16 facilities who need to take training in 5 months emergency obs. Course, through 3 months anaesthesia course , 2 months sick neonate and child course and in adolescent health ; and one month safe MTP and conventional TT course and STI/RTI. 2. Identify suitable tertiary care training institutions who would play this role and sign MOU with them. 3. Conduct training. 4. Multiskill sector level paramedics in laboratory work and other support functions to enable good quality 24 hr sector PHC . 5. Ensure that all MPWs and supervisors are receiving 14 days training once in two years 	<p>Skill sets available and those that are needed in each of the prioritised blocks.</p> <p>Database of training needs in each of prioritised blocks and training plan</p> <p>Number of medical and paramedical employees trained.</p> <p>Chart. matrix showing no of medical officers and paramedicals trained per facility and in what skills as against gaps that were identified.</p>
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	<p>2.2. Achieve delivery of a good quality of pre-defined set of RCH services in each district hospital, in each CHC, in each PHC and in each Health Sub-center.(with reference to RCH)</p> <p>2.3. Quality of care assesment in place for all RCH programmes.</p>	<p>No of PHCs / CHCs that have achived service delivery levels as envisaged may be prepared. The service delivery package is defined .</p> <p>Reports from PHC/CHCs</p> <p>Improvement in number of patients seen , variety of services provided and quality of care – all record improvement in at least 100 blocks.</p> <p>Regular facility wise reporting backed by a sample study by external evaluation agency.</p>	<p>1.Recommended Norms for services in each PHC and CHC adopted.</p> <p>2. Standardised technical guidelines for each element of programme delivery prepared. Develop quality standards and quality of care. measurement indicators.</p> <p>3.Train and motivate ALL staff in the 100 blocks to use quality indicators to achieve these standards. This is done over four one day meetings per year.</p> <p>4.Upgrade a list of equipment needed for every facility and close all gaps</p> <p>5.Create a cell/hire an agency to provide the training and motivation and closely monitor and faciltiate the linkage of training and infrastructure dev with quality improvements with</p> <p>3.</p> <p>4.</p>	<p>Publication and dissemination of facility wise statement of how much has been achieved against published recommended norms.</p> <p>Reports from the district planning cell.</p> <p>Facility wise list of equipment needed to close gaps and statement indicating completion of purchase.</p> <p>Sample survey of facilities by evaluation team to judge the equipment position.</p> <p>Number of facilities/persons trained in quality standards.</p> <p>Quality standards booklets and training modules.</p> <p>Facility wise list of number of patients seen and quality of care indicators – to be repeated annually to record changes .</p>
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	<p>2.4. Policies for partnership with private sector and for special strategies to reach out to currently medically underserved areas evolved.</p> <p>2.5. Improved access through a systems approach involving ambulance services, improved communications and referral systems with laboratory linkages</p>	<p>Increase in RCH outreach in notified remote medically underserved areas.</p> <p><i>Sample study</i></p> <p>Improved access to FRU services consequent to the ambulance – communications linked two way referral system. <u>Number of referred cases in FRUs that used the above system as seen from FRU records.</u></p>	<ol style="list-style-type: none"> 1. Notification for medically underserved areas: 2. Special incentive package for staff in difficult areas 3. Recruitment of NGOs to close such gaps – either paramedical services alone or if possible with some medical services also. 4. 	<p>Notification of remote medically underserved areas.</p> <p>Choice of strategy to reach each such areas are announced. <u>List of areas notified as remote and medically underserved and later strategies to close these gaps.</u></p> <p>NGOs recruited for some under-served areas.</p> <p><u>Number of NGOs MOUs signed for remote areas .Number of areas covered by special strategies.</u></p>
Purpose	Object/Output	Output indicators(MOVs underlined)	Inputs/Activities	Activity OVI/MOVs (MOVs underlined)
3. Improve management structures at all levels	3.1.Achieving a trained management at all levels of the public health management system- block, district and state;.	<p>At least 50% of the leadership functionaries – trained within two years -- in the three month course. And 5 persons per year trained in the one year course</p> <p>All administrative posts</p>	<ol style="list-style-type: none"> 1. Identification of all those who constitute the administrative functionaries. 2. Short term distance education based public health management training of three months for all those who join 	<p>Identification of 240 employees performing administrative leadership functions</p> <p>MOU with Health Management Instituted reached and officers trained with them. MOU with health management institutions .List of officers who have undergone training for three months. List of officers who have undergone</p>

	<p>3.2 Systems for recognising performance in place.</p> <p>3.3 Programme management structures in place at state and district levels.</p>	<p>held by persons regularly promoted to the post.</p> <p>Management support teams available at district and state levels by June 2005.</p> <p><u>List of persons holding key posts on regular and on adhoc basis.</u></p>	<p>adminstrative cadre.</p> <p>3. Higher one year course of public health management for CHMO level officers and above.</p> <p>4. Management support teams created at state levels in State Health Society and State Health Society functioning as envisaged with appropriate rules and collective decision making.</p> <p>5. Also continued support to SHRC.</p> <p>6. Management support teams created at district level in functional district health societies.</p> <p>7. Introduction of performance assessment system.</p> <p>8. All management promotions made timely and based on regular procedures related to seniority and objectively assessed merit .</p>	<p>training of one year.</p> <p><u>Rules of State health society and minutes of meetings.</u></p> <p>Recruitment of management support cadre at SHS, district health/RCH societies completed.</p> <p><u>Also evaluation report on SHRC.</u></p> <p>District health/RCH socety rules and and minutes.</p> <p>Performance assessment system in place and promotions based on it. <u>GO notifying performance assesement system .</u></p> <p>All management posts held on regular basis by fair promotion process. Number of management posts held ad hoc for more than 6 months. Confirmation by external evaluation.</p>
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Purpose	Object/Output	Output indicators(MOVs underlined)	Inputs/Activities	Activity OVI/MOVs (MOVs underlined)
4. Effectively monitor outcomes	4.1.Functional Computerised Health Management Information System extending from state upto block level. (Will be achieved under EU-SPP)	<p>Computerisation achieved in all CHCs which are 30 bedded as of then.</p> <p><u>Monthly programme reports</u> generated at all levels for all programmes with feedbacks from state to districts and districts to blocks documented..</p> <p>Annual internal evaluation reports available</p> <p>Sample based external evaluation of RCH programmes done on a bi annual basis</p>	<p>Creation of five person monitoring cell in each dt- made of CHMO and four deputy CHMOs- equivalent of programme officers.</p> <p>A health management system to be put it place with computerised web- based linkages to the CHC level. Train staff facility- wise in use of HMIS. Data used at state and district level for monitoring progress.</p> <p>Review mechanisms of data gathering at peripheri and explore greater efficiencies by use of electronic devices and compatibility with HMIS.</p> <p>Establish external monitoring mechanisms for assessing services and comparison with data generated by HMIS.</p> <p>Interlinkages with Jeevandeep samitis /PRIs/ULBs and with civil society / NGOs in the monitoring process. Specific roles assigned and linkages built it.</p>	<p>Monitoring cells functional at state and district Health management system in place levels.</p> <p><u>Reports from CHMOs.</u></p> <p>Quarterly/Monthly programme achievement data update available and published.</p> <p>Accuracy of data and concordance between external and internal data improves.</p> <p>District wise external evaluation done annually . MOU with evaluation agency and evaluation reports Manuals for instruction on monitoring by RKS/PRI/ NGOs. Reports of appropriate committee stuctures which includes their inputs.</p>

Purpose	Object/Output	Output indicators(MOVs underlined)	Inputs/Activities	Activity OVI/MOVs (MOVs underlined)
5.Improved Financial Management systems at center, state and district levels to help efficient use of resources to achieve RCH outcomes	5.1.Strengthen financial management systems and structures for all health programmes. 5.2 Improve efficiency and timely use of financial resources and use of financial indicators for programme monitoring and improvement.	Strengthen financialRegular Prompt submission of UCs Able to maintain planned rate of expenditure. Improved efficiency in use of financial resources. No break in programmes due to fund flow problems. Evaluation report on the above	a.Provide qualified accounting and financial management staff at district and state levels b.Multiskill one staff member at Block level for fund management there. c.Develop a computerised financial management package and train all those handling financial matters in tis use. d.Mechansims for tracking fund flow to PRIs and their utilisation in place. e.Mechanisms for reimbursements /payments /accountability o private sector partners and NGOs to be evolved	All vacancies in financial management filled up and financial support staff hired under contrctual provsions where posts are needed but not sanctioned. <u>List of financial staff – by every facility that should have one.</u> Training report of financial staff. <u>Monthly/Quartrely financial statements to generated.</u> Monthly/Quarterly reports of financial statements pertaining to PRIs, NGOs and to private sector partners Internal Audit and process Monitoring mechanisms of private sector partners and NGOs as well as district health societies and other district funds <u>Inspection and Audit Reports.</u>

Purpose	Object/Output	Output indicators(MOVs underlined)	Inputs/Activities	Activity OVIs/MOVs (MOVs underlined)
6. Suitably trained, motivated and responsive staff are in place in appropriate facilities according to need	<p>6.1.All vacancies especially in remote areas are filled up.</p> <p>6.2. Adequate training infrastructure and capabilities built up to be able to implement human resource development policy (Is shifted to EU-SPP) .</p> <p>6.3. Number of para-medicals trained- both retraining in core areas and multi-skilling as envisaged</p>	<p>Human resource requirements and development policy in place.</p> <p>Policy documents. <u>Report on staff position and vacancies.</u></p> <p>Reports of training infrastructure built up along with training staff posts created and persons in place.</p> <p>Reports of training programmes- achieved in the programme period with reference to training programmes that are part of state human resource development</p>	<p>1.Adequate posts created as per norms (as modified by multiskilling possibilities).</p> <p>2. Incentive package for doctors in areas categorised as most difficult..</p> <p>3.Incentive package for paramedical staff in areas categorised as most difficult.</p> <p>4.Building up of training infrastructure- one training institution per district(currently five in place) , three regional and one state level training center.</p> <p>5.Roster based periodic in-service multi-skill training for all paramedical staff</p>	<p>1.Statement on posts needed as per norms and posts created and posts available as additionally through contractual appointments.</p> <p>2.GO on incentive packages for medical officers for most difficult areas.<u>Report of implementation status of GO</u></p> <p>3. Incentive schemes for paramedicals.</p> <p><u>Report on training institutions built and filling up of staff vacancies.</u></p> <p><u>Number of paramedicals trained .</u></p>

	<p>in human resource development policy.</p> <p>6.4. Number of medical officers trained as part of the HRD policy of the state.</p> <p>6.5. Motivation/quality of care and accountability mechanism also developed.</p>	<p>policy.</p> <p>Number of facilities that have got full complement of skills required (with recently retrained staff.)</p> <p>.</p>	<p>6..Continuing medical education programme for doctors</p> <p>7.multiskilling of medical officers for ensuring that all designated referral centers have the specialist skills needed.</p> <p>8.Interlinkages with PRIs/ULBs for support/accountability and with civil society / NGOs for training/motivation. .</p>	<p>Continuing medical education programme for all doctors. <u>Report on CME programme.</u> <u>CME booklets.</u></p> <p>Number of medical officers multiskilled.</p> <p>MOUs with NGOs for training</p> <p>.</p>
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Purpose	Object/Output	Output indicators(MOVs underlined)	Inputs/Activities	Activity OVI/MOVs (MOVs underlined)
7.Supplies Procurement & logistics systems facilitate positive RCH outcomes	<p>7.1. Procurement processes and capabilities at state and district level built up.</p> <p>7.2.Efficient, transparent, accountable procurment and logistics systems in place for all major procurement items.</p> <p>7.3Inventory management and distribution systems able</p>	<p>Cost of drugs purchased comparable to TNMSC or other accepted benchmarks</p> <p>Management evaluation of system done. Details of quotations/successful bidders accessible in website.</p> <p>Sample survey of peripheral</p>	<p>Central Rate contract established with procurement procedures put in place.</p> <p>All procedures for purchase and inventory maangement laid down in written form.</p> <p>Website on consumables purchase regularly updated.</p> <p>Computerised inventory</p>	<p>Report on drug availability in peripheri's as compared to EDL.</p> <p>Cost of drugs purchased measured against benchmarks.</p> <p><u>Published procedures.</u></p> <p>Functional websites with requisite data.</p>

	to ensure that supplies at periphairs are maintained even through major fluctuations in demand.nd transparent.	centres show all essential drugs and supplies were available at all times with no breaks in supply.	management and Logistics system developed and put in place. All staff entrusted with such responsibilities trained on the above systems.	Adequate logistics management established, <u>External avaluation report by management consultant.</u> Number of persons trained and number of stores with and without trained persons. <u>Training Reports</u>
Purpose	Object/Output	Output indicators(MOVs underlined)	Inputs/Activities	Activity OVIs/MOVs (MOVs underlined)
8.To improve health status of urban slums by provision of quality primary health care services.	8.1.Network of urban health workers and urban health centers and referral centers established . 8.2.Coverage of Urban areas disaggregated for slums and marginalised groups shows improved coverage for all social sector facilities. 8.3 Enhance ULB capabilities to plan and implement urban health programmes.	IMR and access to health care disaggregated for urban poor, for urban slums and for marginalised groups are comparable with rest of the urban population. Increase in urban facilities that poor can access as compared to base line.	Participatry mapping exercise with ULBs to mark about priority areas and identify beneficiaries needing intensive coverage. Demarcate zones of one lakhs for a referral center, with urban health centers covering 10,000 beneficiaries and community level care givers covering 1000 each. Minimum norms and service package for each level of care for urban health facilites and urban health plan to be drawn up. Identify programme implementors in coordination with ULBs- NGOs, private	Urban health plan and demarcation on beneficiary areas into zones as envisaged. <u>MOUs with NGOs, private sector or with ULBs.</u> . Training of programme implementors and where needed of programme staff. <i>Training reports</i>

			<p>sector providers and ULBs themselves and sign MOUs with them</p> <p>Arrange for training of programme implementors and where needed of peripheral staff.</p> <p>Training and deploying health volunteers and peer educators to reach most vulnerable sections like homeless and migrants.</p> <p>Public private partnerships for effective urban care to the marginalised and poorest sections.</p> <p>Set up urban health monitoring cell in the directorate.</p>	<p><i>Monitoring reports</i></p>
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TECHNICAL:

Maternal Health:

Purpose	Output	OVI/MOVs	Inputs/Activities	OVI/MOVs
1.Improved use of skilled care for delivery and early neonatal care.	1.1.Increased skilled care for delivery.in public sector 1.3. Increase information and desire to use skilled birth care services and seek emergency care where appropriate	Over 75% institutional deliveries in high literacy blocks , 50% in moderate literacy blocks and over 30% of deliveries in low literacy districts closing the rest of the gap with skilled care at delivery. <u>Sample survey of child births by evaluation agency.</u> More referrals from village level volunteers(Mitanins) , AWWs for skilled care and incentivisation of referrals put in place. Change in knowledge and attitudes leads to greater use of skilled care at birth.	All PHCs and CHCs capable of 24 hour institutional delivery : by a block by block approach to closing infrastructure, equipment, manpower and motivation gaps. 100 blocks to be covered by this approach in two years. Link up with Mitanin programme to ensure that all pregnant women are counselled to seek skilled birth care and to go for institutional emergency care where indicated. Intensive promotion of use of skilled birth care/institutional deliveries by BCC interventions.	50 blocks in first year and fifty blocks in next year and 46 in the third year achieve institutional delivery capacities in every sector so as to complete all 146 blocks in three years(already). <u>Report from CMHOs</u> <u>Sample survey</u> Number of pregnant women referred for and having used skilled care and institutional delivery. ANM reports and sample survey verification by supervisors and external evaluation at the district level Sample Survey
2.Increase access to basic and comprehensive emergency obstetric care with focus on the poorest.	2.1.Ensure that all district hospitals and another 50 CHCs geographically chosen so as to provide within 2 hour access from any habitation -achieve Comp. Em.Obs care	All dt hospitals and 64 CHCs (designated FRUs) provide 24 hour Comp. Em.Ob.Care – at least Basic Em.Ob.Care – At least 30% of those availing these services are from BPL category.	Identify ideal location of the 64 FRUs which in addition to dt hospitals would provide Comp.Em.Ob.Care. Identify and close gaps in infrastructure, equipment, skilled	Report on 64 FRUs for closing gaps. Report on service delivery in 64 FRUs --On an

	2.2. Build up a network of ambulance services that enable emergency access to all the FRUs	<p>Ambulance services cover 50 blocks at least.</p> <p><u>Sample surveys</u> <u>Reports from CHMOs</u></p>	<p>manpower and motivation needed for getting the above 100 FRUs plus 16 district hospitals operational on 24-hour basis.</p> <p>Link up with Mitanin and trained dais to improve timely referrals for Em Obs Care</p>	<p>average 2 CSs and 24 emergency care cases admitted per month per CHC.</p> <p>Ambulances handling at least 30 cases per month.</p> <p><u>Report from CHMOs</u> <u>Sample surveys</u></p> <p>Referral feedbacks and referral payments made documentation</p>
Improved access to quality antenatal services especially among the poorest	Quality antenatal care.	<p>Quality of antenatal care achieved</p> <p>All tribal habitations and SC habitations have same rate as antenatal coverage as the rest of panchayat.</p> <p><u>Evaluation of Samples by external agency.</u></p>	<p>Developing quality index for antenatal care and training staff on it.</p> <p>Training and monitoring to strengthen quality of antenatal care</p> <p>Improving ANM mobility and quality of supervision:</p> <p>Adequate awareness for such services through folk based health education</p>	<p>Ensuring 100% antenatal care of at least 50% quality in all blocks and 100% quality in 50 blocks.</p> <p><u>KAP study on health awareness.</u></p>
Improved access to post-partum care	Universal postpartum care Prompt and adequate referral for sick neonates	<p>Ensure two visits in the first week for every newborn by a trained volunteer with 100% weighing of all newborns.</p> <p>Prompt referrals of post-partum women with fever or signs of infection.</p>	<p>a. Incentivise Mitanin programme for ensuring 100% neonatal visits with birth weighing.</p> <p>b. In 50 blocks aim for 100% referrals in cases of birth weight below 2 kg and in sick</p>	<p>Training reports of Mitanins</p> <p>Referral cards with feedbacks document functional referral system.</p>

		<i>Sample survey</i>	neonates and of all women with postpartal complications..	
Reduced unsafe abortions	Reduced unsafe abortions	Number of facilities offering safe abortion services. Better knowledge in community about dangers of abortions, esp illegal abortion and where to access safe abortions Reports from CHMOs	Operationalize CHCs as FRUs as suggested for emergency care. Train AWWs; ANMs and Mitanins in counseling abortion services and to avoid the need for recurrent abortions through contraception., Promote MVA method, Em Contraception	<u>List of centres offering MTP services.</u> <u>Number of safe abortions done in referral centers and reimbursed in private sector clinics</u>
Improved access to quality and women friendly & responsive RTI and STI services.	Every PHC and subcenter and CHC able to provide basic help including basic diagnosis 50 designated CHCs and all district hospitals able to provide comprehensive assistance including range of diagnostics Peer educators programme in all sensitive populations and in schools. Increased public awareness on RTIs/STIs	List of facilities offering basic services and list of facilities – both public and private offering comprehensive services. Women from weaker sections also use the facility in same proportion as they are in the local population. <u>Evaluation study and exit interview from these facilities.</u>	Basic training package on RTIs evolved and all staff. Criteria of woman friendly and responsive services laid down as part of quality of care measures All subcenter staff and PHC and CHC staff oriented on this. 64 designated CHCs equipped for this with NGO linkages for counselling. PPP linkages with laboratories where needed for ensuring adequate laboratory support. Involvement of NGOs in reaching out to sensitive populations and to schools. and IEC programmes for better public awareness. Linkages to Mitanin programme for better first contact curative care and counselling.	List of facilities equipped to offer basic and comprehensive services. List of people trained. Evaluation and exit study of the facilities offering these services. Peer educators trained in schools. Grant –in- aid scheme notification.- may modify existing GO- NGO scheme to build in state priorities. <i>MOUs with NGOs</i> <u>Concurrent Evaluation reports on Mitanin programme</u>

IMMUNISATION:

<p>1. Improve quality and coverage of routine immunization services.</p>	<p>100% immunisation obtained.</p> <p>Vulnerable sections with special problems of access also reached out to.</p>	<p>100% of immunisation schedule to be achieved.</p> <p>Tribal, distant hamlets list available and checked separately.</p> <p>Sample survey</p>	<p>Strengthening monthly immunisation day at the angawadis and improving AWW/ANM and Mitanin coordination for this.</p> <p>Careful mapping of most difficult to cover hamlets and planning outreach camps to reach them.</p> <p>Drawing up block level assessment of persisting bottlenecks esp as regards associated supplies and cold chain.</p> <p>Improve ANM mobility, and assist on critical constraints. Improve quality of supervision.</p> <p>District level external evaluation on an annual basis.</p> <p>Medically underserved areas to be covered by package of schemes as outlined .</p>	<p>Immunisation coverage with diasaggregation for difficult areas and vulnerable sections.</p> <p>Tribal, distant hamlets list available and checked separately</p> <p>Mobility arrangements for ANMs.</p> <p>Training on supervision.</p> <p><u>Evaluation study</u> of sample villages selected for geographical and social difficulty.</p> <p><u>Report</u> on fixed day immunisations.</p> <p>Cluster sampling periodically done.</p> <p><u>Reports from districts.</u></p> <p><u>Surveys.</u></p>
<p>Achieve polio eradication certification</p>	<p>No fresh polio cases</p> <p>Surveillance 100% effectiveness</p>	<p>Polio cases if any..</p> <p>Effective AFP surveillance to ≥ 1 non-polio AFP cases per 1 lakh population under 15 years.</p>	<p>Strengthen routine immunisation as above.</p> <p>Improve AFP surveillance.</p> <p>Identify problems areas in pulse polio coverage and special efforts to cover these also.</p>	<p>AFP surveillance report.</p> <p>Proportion of AFP cases sampled with adequate stool sample.</p>

NEWBORN AND CHILD HEALTH:

<p>1.Reduce neonatal and child mortality and morbidity</p>	<p>Prompt referral of sick neonates and children to higher level care.</p> <p>Adequate first contact treatment on “day one” to any child with diarrhea, ARI, or fever.</p> <p>Visit by trained volunteer on day 1 and by day 7 to every woman with a newborn.</p> <p>Complete Measles immunisation</p>	<p>IMR, Child malnutrition rate IMR disaggregated for difficult areas(remote tribal areas)</p> <p>Number of children below five who received prompt and effective and appropriate management of childhood illness.. Disggregated for tribal and weaker sections – the inner panchyat diffences would be minimal. Number of newborns who received two visits of which one was on the very first day.</p> <p><i>Sample survey</i></p>	<p>Prompt referral of sick neonates and children to the district hospitals and 64 referral centers (32 in first year)that are strengthened for this purpose.</p> <p>Ensuring that every child with diarrhea or ARI is seen by a Mitanin or AWW or ANM on day 1 in their house and given the proper advice and drug as part of a IMCNI approach.</p> <p>Ensuring a focussed campaign by Mitanin,ANM.AWW on child malnutrition with counselling and food supplememnts as the main strategies and built into an IMCNI approach.</p> <p>Expanded drug kit for ANMs, Introduction of Drug kit for CHVs</p>	<p>Number of children receiving visit and adopting correct practices on day 1 of ARI, Diarrhoea, fever and at birth.</p> <p>Proportion of children with diarrhoea who had received ORS.</p> <p>Proportion of neonates weighed within 24 hours of birth and proportion of low birth weight children who received appropriate care.</p> <p>Proportion of the CHCs which have skills and equipment for providing a declared level of intensive pediatric care.</p> <p><i>Sample survey</i> <u>Referral centers records.</u></p>
<p>Promote breastfeeding & complementary feeding .</p>	<p>Universal exclusive breastfeeding for the first four months and 100% start of complementary feeding by the six months</p>	<p>Number of newborns who received exclusive breast feeding.</p> <p>Number of six month old children who are onto complementary</p>	<ol style="list-style-type: none"> 1. Family level counselling and follow up by Mitanin Programme. 2. Strong promotion by ANMs and AWWs during camps and immunisation days. 3. Multimedia IEC. 4. Involvement of panchayats in 	<p>Number of newborn households visited by Mitanins and counselled succesfully.</p> <p>Number of famlies chidren in 6 to 12 months or with malnourished children who have been counselled for correct feeding an</p>

		<p>feeds:</p> <p>Number of children in the age group below three years who are malnourished.</p> <p>Sample survey:</p>	reaching this targets.	<p>illness prevention and management practices. And child malnutrition levels in the hamlet.</p> <p>KAP study baseline and follow up to measure impact.</p>
Improved care of sick neonates, infants and children	<p>All district hospitals and one in three CHCs(FRUs) to provide referral level care for sick neonates and children</p> <p>Improved health awareness on childhood illness.</p> <p>Prompt and effective community level care.</p>	<p>Number of sick newborns and sick children treated in CHCs and the district hospitals through appropriate referrals.</p> <p>Infant and under five mortality rates Declines also present when diassgregated for vulnerable sections</p> <p>Access to care differences between communities minimised.</p>	<ol style="list-style-type: none"> 1. Prompt identification on referral of sick neonatal children(follows same set of measures as for emergency obstetric care). 2. All ANM; AWWs and Mitanins adequate trained in community level management of childhood illness – esp diarrhoea, fevers and ARI and measles 3. Improve care seeking through good communication programmes backed by interpersonal contacts through health volunteers 	<p>Trained volunteer available in every hamlet.</p> <p>Number of hamlets without a trained volunteer.</p> <p>Drugs for first contact care available with a health volunteer(Mitanin) in every hamlet and in every anganwadi and with ANM without a break.</p> <p>Sample surveys. Drug consumption records. And referral center records.</p> <p>.</p>
Improved facility level care for sick neonates and children.	Adequate quality of intensive care of secondary hospital level available within two hours of every habitation.	<p>Proportion of deaths of children in govt/pvt facilities and hospitals as overall proportion of deaths in community.(should increase!!)</p> <p>Proportion of children</p>	<ol style="list-style-type: none"> 1. All district hospitals and one in three block level CHCs to be able to provide intensive pediatric care to treat sick neonates and children. 2. Multiskilling medical officers and nurses through a one month programme for provding intensive pediatric 	<p>All district hospitals and 64 (32 in first year) CHCs have intensive pediatric facility based care capabilities.- equipment and trained manpower.</p> <p>Referral system in place- includes feedback mechanisms, communications and ambulance</p>

		and sick neonates of BPL and SC/ST families who use hospital facilities for sick children should correspond to their proportion in the population. <u>Hospital records.</u> <u>Sample surveys.</u>	care for sick neonates and children. 3. Linkages to good communication and ambulance services and referral system with feedbacks so that neonates and children reach on time.	systems
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ADOLESCENT HEALTH

Improve reproductive health and nutrition of adolescents especially those who are married or are out-of-school	Adequate knowledge and access to services for all in this age group esp those married and out of school Better health practices and lesser high risk practices in this age group	Adolescents report increased access to friendly reproductive health and nutrition services in selected districts. Anemia level in premarrriage adolescents improves and awareness of sickle cell risks increases. Awareness on safe sexual practices and sexual health improves.	Training one staff member in each CHC and some NGO volunteers to provide appropriate facility based consulting and counselling services for adolescent health. Focus on RTIs/STIs School based adolescent health programmes in all high and higher secondary classes. Peer educator based adolescent health counselling services available in select CHCs and urban centres. Mass screening for anemia – both iron deficiency and sickle cell anemia in high prevalence communities and appropriate Counselling /treatment programmes aimed at adolescents. Strengthening adolescent health programme in linkage with Mitadin programme to reach out to adolescents out of school	CHC Facilities with trained consultant and linked to voluntary counsellors. Teachers sensitised through camps. Adolescent health camps and “12 – period” health course conducted in schools. MOUs with NGOs for counselling and peer educator services to reach out to highly vulnearable groups.
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FAMILY PLANNING PROGRAMMES

<p>Reduce the 'unmet need' for spacing</p>	<p>Increased Use of spacing methods</p>	<p>Household survey for unmet need.</p> <p>Average age of mother at first child and average spacing interval.</p>	<p>1.Increase availability of spacing through: (a)Social marketing (b)Better Distribution through health system</p> <p>2.Targetted timed counselling through Mitanins/AWWs/ANMs and other volunteers for spacing.</p> <p>3.General IEC through folk medium</p> <p>4.Recruitment of NGOs and private sector partners for improving outreach to medically underserved areas.</p> <p>5.Involving and capability building of panchayats through the swasthya panchayat programme.</p>	<p>Increase in total number of outlets . No hamlet without a regular well known source of getting OCPs and condoms.</p> <p>Every sector PHC reaching its IUD insertion needs.</p> <p>MOUs with social marketing agencies.</p> <p>Increase in number of temporary devices consumed.</p>
<p>Reduce the "unmet need" for terminal methods of FP</p>	<p>Eliminate unmet need for terminal methods</p>	<p>Household survey for unmet needs show a marked decrease in unmet needs.</p> <p>Sample survey.</p>	<p>1.Thrice weekly availability of all terminal sterilisation methods including NSVs in any of the district hospitals and once weekly- on a prefixed day -of the week in the 64 CHCs which are strengthened.(in many CHCs LTT & CTT would be available and in others only CTT).</p> <p>2.Training of one medical officer per CHC and three medical officers per district hospital in NSV/conventional vasectomy..</p> <p>3. Training of one medical officer per CHC and three medical officers per district hospital in conventional TT.</p> <p>4.Increased number of doctors trained in laproscopic tubectomy.</p> <p>5.Considerable expansion and extension of terminal method provision through training and MOUs with private partners.</p> <p>6. Good referral systems with feedback to draw in every unmet need..</p>	<p>Plan document listing doctors available and needed in the district hospitals and the 64 facilities.</p> <p>Number of doctors trained in NSV and in conventional vasectomy and tubectomy in all the 64 designated CHCs and at least three doctors in each district hospital.</p> <p>Training report and report from CMHOs.</p>

