GOVERNMENT OF JAMMU & KASHMIR

DISTRICT HEALTH ACTION PLAN

GANDERBAL

December 2007

District Health Society
District Ganderbal
Jammu & Kashmir

Date: 28.12.2007

Certificate of Approval

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

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

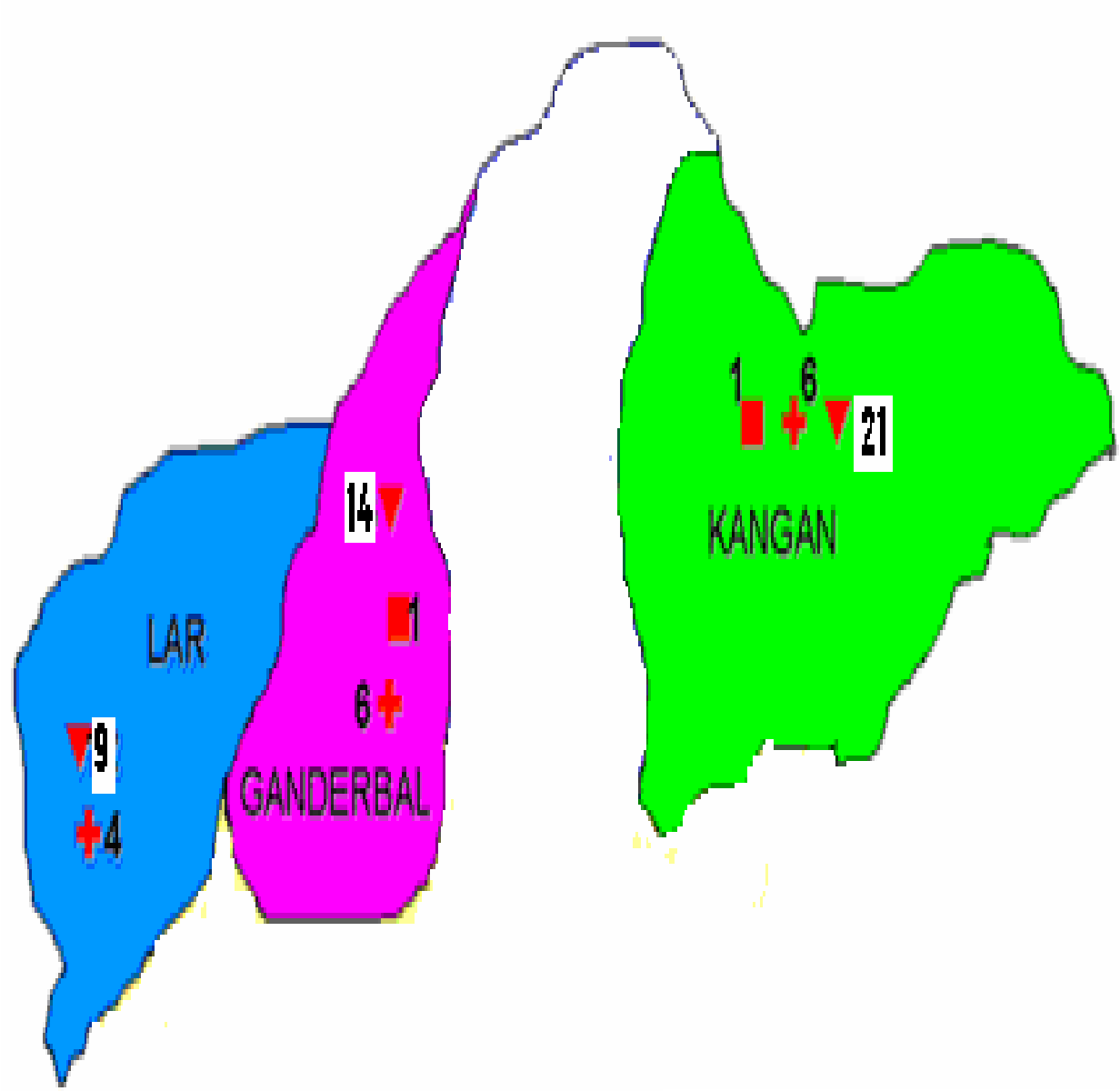
The plan was discussed in the district health society and suggestions were incorporated and approved.

Development Commissioner
& Chairperson
District Health Society
District Ganderbal

DEPUTY COMMISSIONER
Ganderbal

Chief Medical Officer

DISTRICT: GANDARBAL



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PREFACE

The National Rural Health Mission [NRHM] has been envisioned as a planning process that is participatory and decentralized starting with the Village as the basic unit for planning based on community need assessment. It seeks to empower the community by placing the health of the people in their own hands and determine the ways in which they would like to improve their health. This is the only way to ensure that health plans that emerged were truly need based. The state would play a facilitators role.

The NRHM was launched in April 2005. The Department of Health, Government of Jammu & Kashmir, initiated its implementation in right earnest. A number of enabling actions were taken by the J & K State Health Society. This created an environment conducive to decentralized planning by the district.

The district is key administrative unit for most of the development activities. The District Action Plan, therefore, is the most important document, the road map for implementation of NRHM activities, which the Government of India and the state government would use to monitor the progress of implementation district wise. To make District Plan more meaningful and capable of addressing local health problems, Block Health Plans were prepared and integrated in to District Action Plan.

The decentralized planning process involved village consultations [*more of a demand generation exercise but one which made the villagers aware of their health needs and how they could take care of them at the individual, family, community and Panchayat levels as also what they needed to ask for from their government*], preparation of Village Health Plans by the Village Health Water and Sanitation committees; followed by development of Block Action Plans through integration of Village Health Plans, Health Facility Surveys and block specific needs. The Block Action Plans were integrated to form District Action Plans.

We now have the capacity for preparing the need based plans following a participatory process. A District Planning Team was set up for this purpose in the month of June 2007. It has the representation of the various sectors concerned with NRHM. The District Planning Team was responsible for entire planning process in the district leading to preparation of District action Plan and also for providing technical support. The DPT is the standing body and will take charge of the implementation of the plans thus prepared. DPT not only owns the plans but will also be responsible for monitoring the progress of implementation to achieve the objectives of the plan. The members of the DPT are:

No	Name	Designation	Department
1.	Mr. G. N. Boda	DDC	Headquarters
2.	Dr. Shafi Ahmad Wani	CMO	Health
3	Mr. Ather Qadri	CPO	Headquarters
4	Mohammad Mushtaq	DPM	RDD
5	Haji Ghulam Mohd	Dy. CEO	Education
6	Ms. Rubina	DSWO	Social Welfare
7	Mohd Aslam	Nodal Officer	ICDS
8	Mushtaq Ahmad Shah	AEE	PHE
9	Malik Mansoor	Ex. Eng.	PDD
10	Feroz Ahmad Chat	AEE	PWD (R&B)

The orientation session for members of DPT was held on 17th July 2007 which was facilitated by Dr. Abu Altamash Faizi (Head Kashmir Division) and Mr. Shaiq Nazir (District Co-coordinator Ganderbal) from EPOS. This enabled the DPT members to not only understand approach, key components and strategies of NRHM, but also manage the planning process and develop the District Action Plan. The DPT met a number of times and the individual members reviewed the situation of their respective sectors/areas and collectively developed the strategic vision for improving the health status of the district population.

We the members of the DPT on behalf of the entire Planning Group reiterate and certify that this District Action Plan has been prepared through participatory processes. It has been developed by integrating the Block Action Plans prepared by integrating health facility surveys and village health plans in each block of the District. This plan also incorporates the needs and plans from 44 Sub health centers, 23 PHCs and 2 CHCs in the District.

DR. SHAFI AHMAD WANI
(CHIEF MEDICAL OFFICER)

Executive Summary

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

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

International Institute For Population Sciences, in the year 2006, ranked 593 districts in the country. This ranking is on children parity, contraceptive prevalence rate (CPR), under five child mortality and ANC. Because Ganderbal is a new district, its ranking is not available. However, ranking of its parent district Srinagar can give a sense of health status of Ganderbal as well. The overall ranking of the district Srinagar is 246. It is 384 on the basis of percentage of women having three or more children; 394 on the basis of CPR; 317 for under five mortality rate and rank 190 for three or more ANC visits. In this ranking system, the lower is the rank, the better the district.

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

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

the CHCs and PHCs. The district faces a high incidence of water borne, air borne and other NCD diseases. Typically, the illnesses commonly mentioned by VHWSC in most of the villages were gastro, diarrhoea, typhoid, TB, asthama, thyroid, diabetes and hypertension.

In terms of major challenges, the district needs to increase institutional deliveries which are currently at 18.3. The share of male participation in use of family planning methods is almost negligible. Prevalence of anaemia amongst pregnant women is quite high. These issues have to do both with demand and supply of health services. The plan has put emphasis on inter sectoral convergence. The highlight is convergence with education and women and child department for provision of life skills education to both in and out of school adolescent girls and boys. In the absence of existence of Panchayati Raj institutions, there is a component on community action through village health and sanitation committees.

On the supply side, 56 posts of ANM, 51 post of Nurse at PHCs, 25 posts of MO,s, 1 post of paediatrician and 1 post of obstetricians/ gynaecologist are vacant. Over all 56 posts at SCs, 217 posts at PHC,s, and 6 posts at CHC level are vacant. To meet the above mentioned and many others crucial health indicators, the plan provides for filling gaps in the area of human resources by hiring key staff including medical doctors and specialists on contract and converging with AYUSH department.

The basic infrastructure in the district has many gaps. Out of total 44 sub centres, 32 are running in rented building. Sixty four percent SCs do not have water supply connection and electricity is not available at 93% SCs which adversely impacts utilization of services from SCs. There are total 23 PHCs , water supply and electricity is available almost at all PHC,s. Facility survey Report (Anex-1& II) giving clear picture of gaps in infrastructure, equipment, drugs and human resources and considering IPHS standards. Construction of new buildings, expansion and repair of old ones has been proposed. For smooth logistics management and storage, development of logistics management information system and construction of a warehouse has been proposed.

Reproductive and Child Health is one of the priority programmes comprising Maternal health, Child health, Adolescent health including RTI / STI management and Family Planning. In order to increase institutional deliveries, which is a major concern, focus has been fixed on upgrading the PHCs to functioning 24x7 PHCs and also enhancing the EmoC skills of the medical personnel. In order to increase institutional delivery attention has been given to functioning of 24x7 PHCs in phased manner

and construction of rented SC & PHC building with all facilities. A sum of Rs. **5126.721 lac** has been planned for activities under the RCH II.

Under NRHM special focus has been given to Village Health Water and Sanitation Committee, Rogi kalayan committee, Upgradation of health facilities as per IPHS, selection and training of ASHA, functioning of quality assurance committee, infrastructure development etc. A total of Rs. **4789.707 Lac** has been planned for NRHM budget.

"National Disease Control Programme include RNTCP, leprosy control programme, Malaria control programme, Blindness control programme, vector born disease, integrated disease surveillance and iodine deficiency disorder. The Revised National Tuberculosis Control Programme (RNTCP) aims to stop the spread of TB in the region as it is a rising concern among the rural/ Nomadic population and have to be dealt with due to the large influx of tourists and pilgrims who may carry virulent strains into the immunological set up of the host population. A total of Rs **343.8536 lac** has been planned for the National Diseases Control Programme.

A total budget for district Ganderbal for the plan period 2008-2012 has been proposed for Rs. **11445.6 lac**.***(114 crores, 45 Lac and 6 thousand rupees)***

PRIORITIES of the DISTRICT GANDARBAL

S. No	Thematic Area	Critical Issues of the District	Specific Priorities
1.	District Health Management	▪ Societies for different vertical programme function in isolation without coordinated efforts in the district. ▪ Lack of human resource for management and their training ▪ Monitoring and evaluation.	▪ Integrate all district societies into District Health society and function as one unit. ▪ Capacity building of the DHS members for effective management of District Health Society. ▪ Programmatic and financial progress monitoring by health personnel only. ▪ Strengthening the functioning of the District Health System.
2.	District & Block Programme Management	▪ Support to CMO office ▪ Strengthening monitoring and reporting	▪ Clarity amongst officials and Consultants about NRHM goals and activities ▪ Training of district officials and Block SMOs Streamlining financial management system ▪ Strengthening the CMO office ▪ Capacity building of the DPMU personnel for monitoring ▪ Strengthening the Block Management Units
3.	Improving maternal and child health	▪ Increasing Institutional deliveries ▪ Improving postnatal services	▪ Construction of S/Cs and PHC buildings as required and 24 hour service delivery in all PHCs ▪ Operationalisation of 24X7 PHCs and SCs ▪ Ensuring availability of personnel especially specialists and Public Health Nurses for 24 hour PHC, CHC and ANMs at the sub centres ▪ Increased coverage under JSY ▪ To increase IEC/BCC activities • Strengthen FRUs for Emergency Obstetric Care services by providing minimum basic infrastructure, drugs and equipments.

4.	Family Planning	▪ Low level of FP acceptance. ▪ Lack of awareness on FP methods & low level of male participation	▪ Decreasing the Unmet Need for Family Planning ▪ Ensure availability of all FP methods at block level facilities. ▪ Vacant positions to be filled in on a contractual basis. ▪ Increased awareness for Emergency Contraception and 10 yr Copper T ▪ Partnership with private doctors for FP and RCH services ▪ Increasing access to Emergency Contraception and spacing methods through social marketing ▪ Building alliances with other departments, PRIs, Private sector providers and NGOs
5.	Adolescent Health	▪ Adolescent boys are exposed to smoking, drug addictions, and alcoholism. ▪ Teenage pregnancies also emerging as a problem and unsafe abortion & premarital sex trend are on rise.	▪ Implement ASRH programme to increase the knowledge levels of Adolescents on RH and Life skills ▪ Operationalize Adolescent Friendly Health services at the health facilities
6.	Mobile Medical Units (MMUs)	▪ Remote population is not covered ▪ Insufficient staff and logistics.	▪ Provide 1 MMUs equipped with all facilities for services in remote areas. ▪ Contract MOs and staff nurses for MMUs
7.	Upgrading CHCs to IPHS	▪ All the CHC are housed in govt building however the condition of CHC needs to be upgraded as per IPHS standard.	▪ All CHCs needs to be upgraded as per IPHS
8.	Upgrading PHCs for 24 hr Services and IPHS standards	▪ 50% PHCs need to be upgraded to IPHS ▪ Out of 15 only 2 PHCs are working 24 hors ▪ 6 PHCs require new	▪ 6 PHCs require new buildings as per IPHS standards ▪ 17 PHCs require repairs, additions & expansion as per IPHS ▪ Construction of staff quarters in all

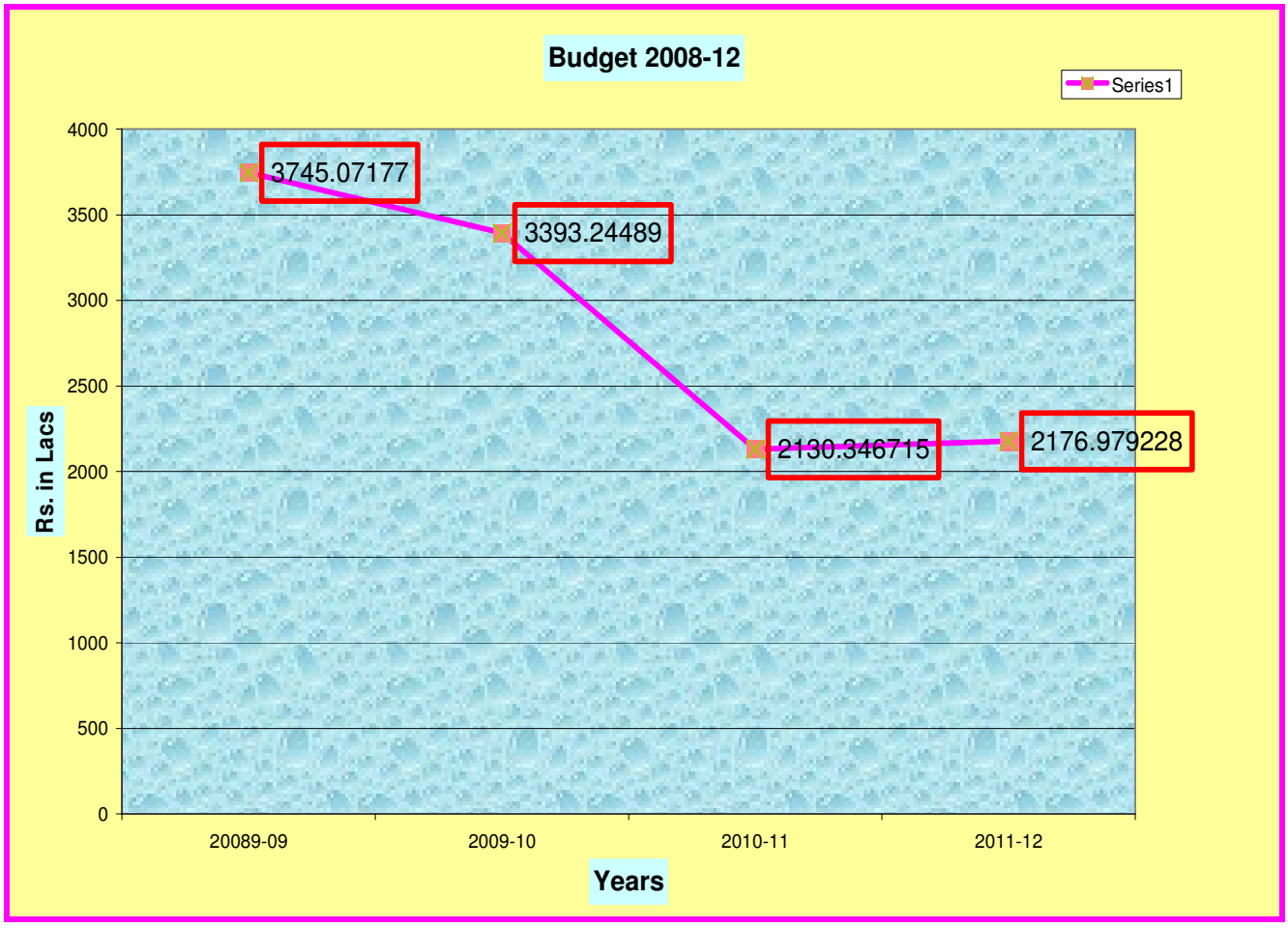
		buildings and 5 PHCs require additions and expansion and 12 PHCs need repairs	21 PHCs ▪ Manpower ▪ Equipments and drugs ▪ To be functional 24x7 ▪ Equipped Labour rooms
9.	Upgrading Sub Centres to IPHS standards	▪ Out of 44 subcentres, 32 subcentres are in rented buildings and 12 subcentres are in government buildings. ▪ There is no staff quarter in any of the subcentres	▪ Need to construct 32+48 Subcentre building ▪ Additional 48 Scs are required ▪ Delivery rooms in SCs for institutional deliveries ▪ Drugs and equipments as per IPHS ▪ Manpower ▪ Construction of staff quarters for all SCs. (44+48 new)
10.	Immunisation	▪ Lack of awareness to mothers ▪ Alternate vaccine delivery ▪ Lack of Cold storage ▪ Efficient monitoring and supervision ▪ Gaps in difficult, flung areas & inaccessible areas ▪ Reporting and documentation	▪ Strengthening the District Family Welfare Office ▪ Enhancing the coverage of Immunization ▪ Alternative Vaccine delivery mechanisms in place ▪ Effective Cold Chain Maintenance upto sub centre level ▪ Zero Polio cases and quality surveillance for Polio cases ▪ Close Monitoring and documentation of the progress
11.	Inter Sectoral Convergence	Lack of coordination b/w ICDS and health department	Linkages to be developed between ICDS workers and health workers for timely diagnosis of malnourished children and their management (detailed activities under thematic heads)

		Lack of coordination b/w RDD and health department	Linkages to be developed between the Health Department and the Rural Development department • Improving the health standard & quality of life • Awareness on sanitation/ Hygiene • Covering of school/ Anganwari • Education & sanitary habits among students. • Promote & encourage cost effective construction of household latrine & their proper use. • Elimination of open defection to minimise the risk of contamination of water source & food.
		Lack of coordination b/w PHE and health department	• Provision of Bleaching powder and chlorine tablets • Joint communication strategy. • Sharing quality monitoring with the Health Department at block, district and state levels • Community based organisations will be engaged by a team of frontline workers – health, ICDS and PHE departments.
12.	Human Resource	Lack of manpower at all levels starting from Sub centres to PHCs to CHCs to DH In the CHC there should be at least 7 specialists, 3 MOs, 10 Staff Nurses, I PHN, 1 Computer clerk, 1 Dresser, 1Pharmacist, 1 Lab technician, 1 BEE, 1 radiographer, 1 UDC, 1 Accountant, 1 LDC, 1	• All staff to be in place as IPHS norms by 2012 • Increased salaries for contractual doctors and Specialists • Special allowances for Regular staff • Increase in the number of training centres for LHV, ANM, Staff Nurses, Lab Technicians • Rational placement of Specialists and trained staff • Recruitment of staff on contract where vacancies

		Epidemiologist, and Ancillary staff on contract.	• Recruitment of staff for new facilities as per the infrastructure requirements • Computers at all PHC and for each MO and Specialist at the CHC • Allowing Specialists and MOs for developing special skills as per their needs by attending special courses anywhere in India.

Budget Summary					
Component	Year wise Budget in Lacs				
	2008-09	2009-10	2010-11	2011-12	Total
A1- Strengthening of District Health Management Unit	14.16	7.48	8.032	4.889	34.561
A2- District Program management unit	85.33	85.743	94.9582	104.8577	370.8889
A3- Maternal Health	91.402	102.2742	107.787	117.5097	418.9729
A-4. Newborn & Child Health	8.8	0	0	0	8.8
A-5. Family Planning	41.244	31.647	34.8117	38.29287	145.9956
A-6. Adolescent Health	9.56	5.516	5.5176	6.06936	26.66296
B-1. ASHA – Accredited Social Health Activist	69.35	69.655	65.4005	71.94055	276.3461
B-2. Provision of Untied Funds at Sub Centers	17.79	27.4	27.41	27.42	100.02
B3- Provision of Untied Funds at CHCs	40.68	18.19	18.2	18.21	95.28
B4- Provision of Untied Funds at PHCs	11.29	4.83	4.83	4.83	25.78
B 5 Mobile Medical Units	39.69	16.538	17.1958	17.91938	91.34318
B6 Upgrading CHCs to IPHS	227.41	177.969	11.0579	11.41969	427.8566
B7 – Upgrading PHCs to 24 Hour Service	803.456	794.682	240.897	223.2501	2062.285
B 8–. Upgrading SCs	572.15	558.311	11.8921	13.08131	1155.434
B 9- VHWSC	3.985	6.5635	7.21985	7.941835	25.71019
C 1. Cold Chain Maintenance	45.6	12.38	7.578	7.7958	73.3538
C 2. IEC and Social Mobilization	29.33	32.263	35.4893	39.03823	136.1205
C3.Alternate Vaccine Delivery Mechanism	17.84	19.624	21.5864	23.74504	82.79544
C 4-Supervisory Support & Vaccine Transportation	0.8775	0.96525	1.061775	1.167953	4.072478
C 5 Data Monitoring & Support	81.088	19.2718	21.52148	23.95363	145.8349
C 6 Supplies & Logistics	221.0942	159.526	125.01	125.01	630.6402
D 1. RNTCP	40.26067	36.24474	39.88631	43.87194	160.2637
D 2. LEPROSY	5.744	6.319	6.95	7.645	26.658
D 3. National Malaria Control Programme	14.5	4.26	4.326	4.3986	27.4846
D 4.Other Vector Borne Diseases	3.86	3.36	3.36	3.36	13.94
D 5. Control Of Blindness	28.42	10.382	6.5802	7.23802	52.62022
D 6. Integrated Disease Surveillance Programme	17.00	10.5	10.5	10.5	48.5
D 7. Iodine Deficiency Disorders	3.1	3.41	3.751	4.1261	14.3871
8. Inter Sectoral Convergence	53.5	54.45	55.495	56.6445	220.0895
9- Community Health Action	1.37	1.747	1.9217	2.11387	7.15257
10- Public Private Partnership	66.15	28	23	23	140.15
11- Gender And Equity	17.8	18.48	20.328	22.3604	78.9684
12- Capacity Building	35.94	25.94	34.48	34.48	130.84
13. Human Resource Plan	745.3364	876.146	876.146	876.146	3373.774
14. Procurement & Logistics	140.83	15.38	13.609	13.979	183.798

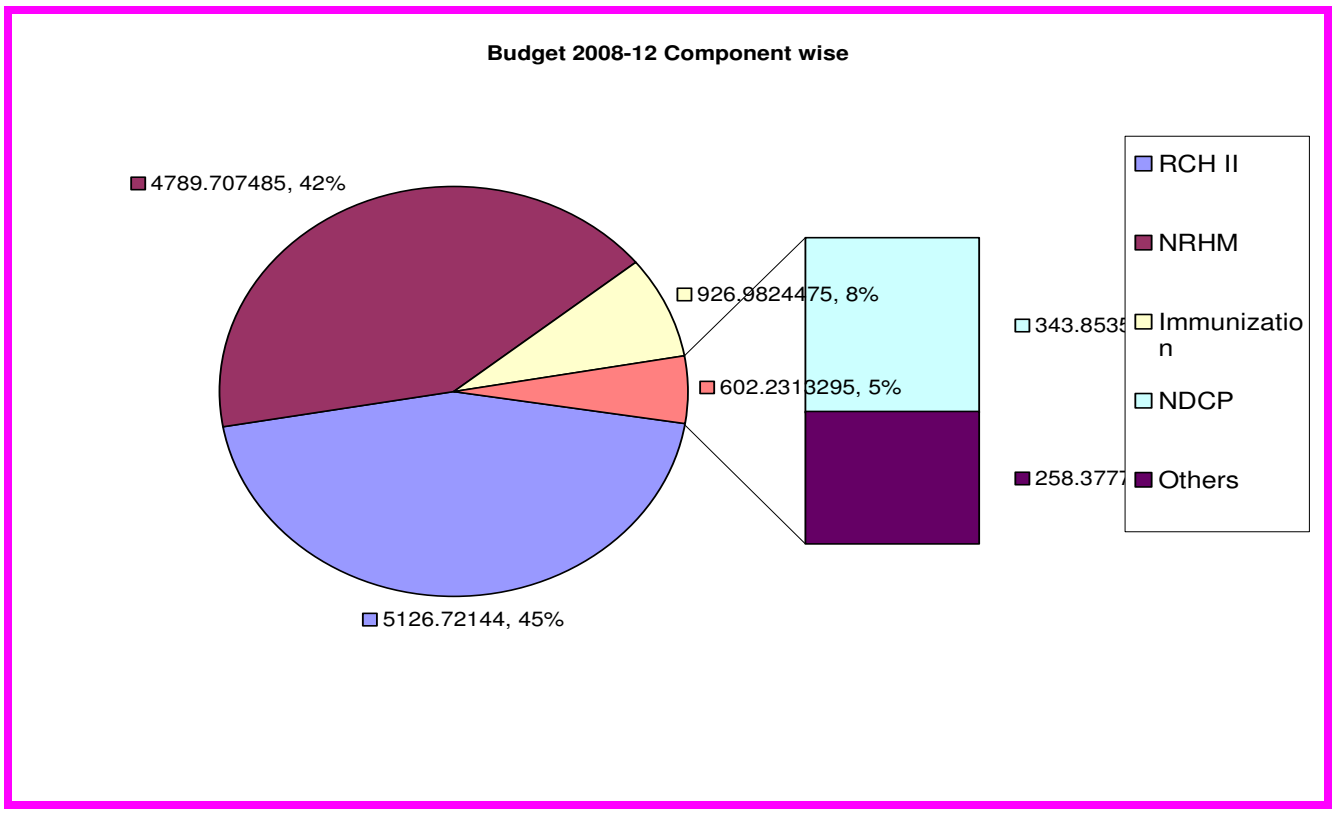
15 Demand Generation - IEC	***84.34***	***92.774***	***102.0514***	***112.2569***	***391.4223***
16. School Health	***8.25***	***9.075***	***9.9825***	***10.98075***	***38.28825***
17. Financing Health Care	***32.1***	***30.06***	***33.041***	***36.308***	***131.509***
18. Bio medical waste management	***14.444***	***15.8884***	***17.482***	***19.228***	***67.0424***
TOTAL	***3745.072***	***3393.245***	***2130.347***	***2176.979***	***11445.64***



District Ganderbal
BUDGET - AT- A GLANCE (In Lakhs)

S. No.	Components	2008-09	2009-10	2010-11	2011-12	Total
A	RCH-II					
1	DHS	*14.16*	*7.48*	*8.032*	*4.889*	*34.561*
2	DPMU	*85.33*	*85.743*	*94.9582*	*104.8577*	*370.8889*
3	Maternal health	*91.402*	*102.2742*	*107.787*	*117.5097*	*418.9729*
4	Child Health	*8.8*	*0*	*0*	*0*	*8.8*
5	Family Welfare	*41.244*	*31.647*	*34.8117*	*38.29287*	*145.9956*
6	Adolescent Health	*9.56*	*5.516*	*5.5176*	*6.06936*	*26.66296*
7	Gender & Equity	*17.8*	*18.48*	*20.328*	*22.3604*	*78.9684*
8	Capacity Building	*35.94*	*25.94*	*34.48*	*34.48*	*130.84*
9	Human Resource	*745.3364*	*876.146*	*876.146*	*876.146*	*3373.774*
10	IEC	*84.34*	*92.774*	*102.0514*	*112.2569*	*391.4223*
11	HMIS & Monitoring	*81.088*	*19.2718*	*21.52148*	*23.95363*	*145.8349*
	Total	1215	1265.272	1305.633	1340.816	5126.721
B	NRHM					
1	ASHA	*69.35*	*69.655*	*65.4005*	*71.94055*	*276.3461*
2	SC Untied Fund & Maintenance	*17.79*	*27.4*	*27.41*	*27.42*	*100.02*
3	PHC Untied Fund & Maintenance	*40.68*	*18.19*	*18.2*	*18.21*	*95.28*
4	CHC Untied Fund & Maintenance	*11.29*	*4.83*	*4.83*	*4.83*	*25.78*
5	MMU	*39.69*	*16.538*	*17.1958*	*17.91938*	*91.34318*
6	Upgradation of CHC	*227.41*	*177.969*	*11.0579*	*11.41969*	*427.8566*
7	Upgradation of PHC	*803.456*	*794.682*	*240.897*	*223.2501*	*2062.285*
8	Upgradation of SC	*572.15*	*558.311*	*11.8921*	*13.08131*	*1155.434*
9	VHWSC	*3.985*	*6.5635*	*7.21985*	*7.941835*	*25.71019*
10	Community Action Plan	*1.37*	*1.747*	*1.9217*	*2.11387*	*7.15257*
11	PPP	*66.15*	*28*	*23*	*23*	*140.15*
12	Health Care Financing	*32.1*	*30.06*	*33.041*	*36.308*	*131.509*
13	Procument & logistics	*140.83*	*15.38*	*13.609*	*13.979*	*183.798*
14	Biomedical Waste	*14.444*	*15.8884*	*17.482*	*19.228*	*67.0424*
	Total	2040.695	1765.214	493.1569	490.6417	4789.707
C	Immunization					
1	Cold Chain Maintenance	*45.6*	*12.38*	*7.578*	*7.7958*	*73.3538*
2	IEC & Social Mobilisation	*29.33*	*32.263*	*35.4893*	*39.03823*	*136.1205*
3	Alternate Vaccine Delivery	*17.84*	*19.624*	*21.5864*	*23.74504*	*82.79544*
4	Supervisory Support & Vaccine	*0.8775*	*0.96525*	*1.061775*	*1.167953*	*4.072478*
5	Supplies and Logistics	*221.0942*	*159.526*	*125.01*	*125.01*	*630.6402*
	Total	*314.7417*	*224.7583*	*190.7255*	*196.757*	*926.9824*
D	NDCP					
1	RNTCP	*40.26067*	*36.24474*	*39.88631*	*43.87194*	*160.2637*
2	Leprosy	*5.744*	*6.319*	*6.95*	*7.645*	*26.658*
3	National Malaria Control Program	*14.5*	*4.26*	*4.326*	*4.3986*	*27.4846*
4	Other Vector Born Diseases	*3.86*	*3.36*	*3.36*	*3.36*	*13.94*

5	**Blind Control Programme**	***28.42***	***10.382***	***6.5802***	***7.23802***	***52.62022***
6	**Integrated Disease Surveillance**	***17***	***10.5***	***10.5***	***10.5***	***48.5***
7	**Iodine Deficiency Disorders**	***3.1***	***3.41***	***3.751***	***4.1261***	***14.3871***
	Total	112.8847	74.47574	75.35351	81.13966	343.8536
E	**Others**					
1	**InterSectoral**	***53.5***	***54.45***	***55.495***	***56.6445***	***220.0895***
2	**School Health**	***8.25***	***9.075***	***9.9825***	***10.98075***	***38.28825***
	Total	***61.75***	***63.525***	***65.4775***	***67.62525***	***258.3778***
	Grand total	3745.07	3393.24	2130.35	2176.98	11445.6



1. SITUATION ANALYSIS

District Profile

Ganderbal District is one of the newly carved out four districts from among 12 Districts of the J&K State. District Ganderbal is flanked by District Baramulla in the west, District Srinagar and Ganderbal in the south, newly created District Ganderbal in the north-west, Arahome Forests in the north and District Ganderbal in the east. Ganderbal District enjoys a unique geographical position as it represents the last station depicting all the scenic features of the Kashmir valley and the gateway to the sky-touching, denuded, magnificent and multicolored mountain ranges of the famous “moon land” i.e. Ladakh. Added to this; the presence of famous health resort Sonamarg and Mansbal lake on its fringes, Qamar Sahib and Tulmulla shrines in its lap and Sindh Nallah traversing through; contribute to the emergence of this area both as a recreation and pilgrim tourist spot, triggering a chain of development activities that would catapult this region into economic prominence. District headquarter is situated at Duderhama Ganderbal. District is divided in to three administrative Tehsils namely Ganderbal, Kangan and Lar. The newly created Tehsil Lar is carved out of existing Tehsil Ganderbal, with Tulmullah Nallah forming boundary between the two Tehsils. Projected Population of District Ganderbal for year 2007 is 2,54,833 living in 217 villages, (63 Gram Panchayats) and 2 towns.

District Profile

Name of District		Ganderbal	Villages without motor able roads	NA
Name of District Headquarters		Duderhama	Villages without electricity	NA
No. of Blocks in the District		3	No. of Towns	2
No. of Gram Panchayats		63	Urban Local Bodies (ULB)	
No. of Villages		217	Municipal Corporation	
Size of Villages	1-500	119	Municipality	
	501-2000	92	Notified Area Committee	
	2001-5000	9	Others	
	5000+	Nil		

Development Indicators of the Block

SN	Indicators	State		District
1	Crude Birth Rate	18.9 (SRS 2005)		27
2	Crude Death Rate	5.5 (SRS 2005)		8
3	Infant Mortality Rate	50 (SRS 2005)		63
5	TFR	2.4 (SRS 2004)		2.7
6	Couple Protection Rate	54 (NFHS-III)		32
7	Sex Ratio (General)	948 (892-Census 2001)		953
8	Sex Ratio (0 – 6 years)	937		951
9	Sex Ratio at birth	NA		NA
10	Literacy rate (overall)	54% (Census 2001)		
11	Literacy rate (male)	68.8		
12	Literacy rate (female)	44.7(41.9)(Census 200)		
13	Enrolment of students for elementary education	T		
		M		
		F		

Source: CMO office

Demographic, Socio Economic and Health Indicators of the District

Name of Block	Ganderbal	Kangan	Lar	District
Demographic indicators				
Total Population	89342	115000	50491	254833
Population of males	46457	58667	26220	131344
Population of females	42885	56333	24271	123489
Population of children less than a year old	2589	1227	1463	5279
Population of children in age group between 1 and 6 years	14294	17000	706	38360
% Scheduled Castes	NA	NA	NA	Not Available
% Scheduled Tribes	NA	37%(42550)	6%(3029)	21.5%
Number of Inhabited Villages	55	74	42	171
Socio-economic indicators				
No. of children aged <2 year benefiting from the ICDS scheme	959	6383	707	8049
No. of children aged 2 years and above benefiting from the ICDS scheme	6296	5676	3517	15489
No. of BPL households	5199	9640	1326	16165
No. of girls enrolled in primary schools last year	4198	8223	NA	12421
No. of girls dropping out of primary schools last yr	169	139	NA	308
Number of over head tanks or hand pumps	5 OH Tanks 277 HP	5	NA	10 OH Tanks 277HP
Number of functional hand pumps	NA	NIL	NA	Not Available
Number of wells currently being used for drinking water purposes	3	20	NA	23
Number of households with access to toilets	NA	NA	NA	Not Available
No. of private health facilities/clinicians	2	NIL	NA	2
No. of women who have benefited through the JSY Scheme till now[1]	298	278	248	824
No. of girls who got married last year	NA	NA	NA	Not Available
No. of girls who got married last year and were <18 years at the time of marriage	NA	NA	NA	Not Available
Health Indicators				
No. of Tubectomies done in last year	NIL	69	10	79
No. of IUD insertions done in last year	77	300	37	414
No. of vasectomies done in the last reporting year	01	08	NIL	9
No. of pregnant women	2628	4302	1713	8643

No. of pregnant women registered for ANC during the last reporting year		443	3527	1713	5683
No. of pregnant women who received two doses of TT during pregnancy in the last reporting year		1778	3474	400	5652
No. of institutional deliveries in the last reporting year		248	926	600	1774
No. of MTPs in the last reporting year		NIL	NA	Nil	NIL
No. of RTI/STI cases reported in the last reporting year		NA	NA	Nil	Not Available
No. of children given measles vaccine in the last reporting year		2173	2776	1547	6496
No. of outpatients- (monthly average)		8182	15000	1200	24382
No. of inpatients- (monthly average)		150	250	Nil	400
Prevalent Diseases	1.Water Borne	16673	NA	NA	16679
	2. Air Borne	18112	NA	NA	18112
	3.Cardio Vascular Disorder	4146	NA	NA	4146
	4. Mental and Behavioral Disorder	203	NA	NA	203
Tuberculosis and Leprosy					
No. of patients currently undergoing DOTS therapy in the block		87	NA	06	93
Number of new leprosy cases reported in last reporting year		NIL	01	NA	1
NVBDCP					
No. of slides examined for malaria in last reporting year		Nil	Nil	Nil	Nil
No. of notified malaria cases (last reporting year)		Nil	Nil	Nil	Nil
No. of new kala-azar cases in the block in the last reporting year		Nil	Nil	Nil	Nil
No. of microfilaria cases reported in the last reporting year		Nil	Nil	Nil	Nil
No. of JE cases reported in the last reporting year		Nil	Nil	Nil	Nil
Blindness Control					
No. of cataract operations conducted in the block last year		NIL	57	Nil	57
School Health Programme					
No. of schools covered in the last reporting year		NA	10	NA	10

Health Institutions, Population Coverage and Health Functionaries in District

Name of District		Ganderbal	Kangan	Lar	Total
No. of Specialty Hospitals		01	00	00	1
No. Referral Hospitals		00	01	00	1
No. of Blood Banks		00	00	00	NIL
No. of Blood Storage Units		00	00	00	NIL
No. of CHC/Block PHCs		01	01	00	2
No. of CHCs (IPHS Standards)		00	00	00	NIL
No. of PHCs in the District		06	06	03	15
No. of PHCs (IPHS Standards)		00	02	00	2
No. of MOs in Positions		09	NA	06	15
No. of MTP Centres		00	01	00	1
No. of Sub Health Centres		14	21	09	44
No. of ANMs in Position		13	23	05	32
No. of AYUSH Dispensaries		07	NIL	02	9
No. of Private Hospitals		02	NIL	00	2
No. of Beds in Govt. Institutions		10	66	22	98
No. of Beds in Pvt. Institutions		NA	NA	NA	Not Available
No. of Anganwari Centres		174	145	116	435
No. of Ultrasound Clinics	Govt.	01	02	00	3
	Pvt.	01	00	00	1
	Unregistered	NA	00	00	Not Available
Population covered		89342	115000	50491	254833
No. of Subcentres covering more than norm (5000/3000)		NIL	NIL	02	2
No. of Obstetricians	Govt.	00	01	00	1
	Pvt.	NA	NA	NA	Not Available
No. of Gynecologists	Govt.	00	01	00	1
	Pvt.	NA	NA	NA	Not Available
No. of Pediatricians	Govt.	01	00	00	1
	Pvt.	NA	NA	NA	Not Available
No. of Surgeons	Govt.	03	01	00	4
	Pvt.	NA	NA	NA	Not Available
No. of Anesthetists	Govt.	01	01	00	2
	Pvt.	NA	NA	NA	Not Available
No. of Orthopedics	Govt.	00	01	00	1
	Pvt.	NA	Nil	Nil	Not Available
No. of Dentists	Govt.	01	03	Nil	4
	Pvt.	NA	NA	NA	Not Available
No. of Eye Surgeons	Govt.	01	01	NA	2
	Pvt.	NA	NA	NA	Not Available
No. of General Physicians	Govt.	01	01	NA	2
	Pvt.	NA	NA	NA	Not Available
No. of Radiographers	Govt.	01	NA	NA	1

	Pvt.	NA	NA	NA	Not Available
No. of Public Health Nurses		NA	NA	NA	Nil
No. of Staff Nurses		10	06	03	19
No. of LHVs		01	NA	NA	1
No. of Pharmacists		09	17	04	30
No. of Lab. Technicians		01	07	02	10
No. X Ray Technicians		NA	05	02	7
No of Ophthalmic Assts.		01	01	1	3
No. Dental Mech. / Hygienists		NA	04	03	7
No. of Male Health Supervisors		05	NA	01	6
No. of ANMs		13	23	05	41
No. of Male Health Workers		03	04	03	10
No. of AW Workers		174	145	116	435
No. of UDCs		01	04	01	6
No. of LDCs		02	NA	01	3
No. of Computer/ Stati. Assts.		NA	NA	NA	NA
No. of Drivers		03	12	03	18
No. of ASHAs selected		3	106	32	141
No. of Trained Dais		80	100	40	220

Table: 2	Identified Gaps of Manpower						
	District- : Ganderbal						
Name of Blocks		Lar	Ganderbal	Kangan	No. 0f Req.Staff	No. of Exis. Staff	Total Gaps
No. of Sub- Centres (44)	IPHS Norm	9	14	21			
ANM	2	14	19	23	88	32	56
N0. Of PHC's (20)		5	6	12			
MO	2	2	5	18	40	15	25
Pharmacist	1	-2	1	2	20	19	1
Nurse	3	3	16	32	60	9	51
Female Health Worker	1	2	4	1	20	13	7
Health Educator	1	3	3	9	20	5	15
Health Assistant	2	6	12	19	40	3	37
Clerks	2	4	12	18	40	6	34
Lab. Technician	1	0	3	7	20	10	10
Driver		1	5	4		0	0
Class IV	4	7	7	23	80	43	37
Total		26	68	133	340	123	217
No. of CHC's (2)			1	1			
A. CLINICAL MANPOWER							
General Surgeon	1		0	0	2	2	0
Physician	1		0	1	2	1	1
Obstetrician / Gynecologist	1		1	0	2	1	1
Pediatrics	1		0	1	2	1	1
Anesthetist	1		0	0	2	2	0
Public Health Programme Manager	1		1	1	2	0	2
Eye Surgeon	1		1	0	2	1	1
Other specialists (if any)							
General duty officers (Medical Off.)							
B. SUPPORT MANPOWER							
Nursing Staff	7+2						
Public Health Nurse	1		1	1	2	0	2
ANM	1		1	0	2	1	1
Staff Nurse Nurse/Midwife	7		2	-2	14	14	0
Dresser	1		0	0	2	2	0
Pharmacist / compounder	1		1	-1	2	2	0
Lab. Technician	1		0	-3	2	5	-3
Radiographer	1		1	1	2	0	2
Ophthalmic Assistant	1		1	0	2	1	1
Ward boys / nursing orderly	2		0	-6	4	10	-6
Sweepers	3		0	-5	6	11	-5
Chowkedar	1		1	1	2	0	2
OPD Attendant	1		1	-1	2	2	0
Statistical Assistant / Data entry	1		1	1	2	0	2
OT Attendant	1		1	1	2	0	2
Registration Clerk	1		1	1	2	0	2
Any other staff (specify)							
Total			15	-9	62	56	6
Note: (-) Surplus staff							

Table- 2A	Manpower At District Hospital

A.	Doctors			
S.No.	**Personnel**	**IPHS Norm**	**Current Availability**	**Identified Gaps**
1	Hospital Superintendent	1	0	1
2	Medical Specialist	3	0	3
3	Surgery Specialists	2	0	2
4	O&G specialist	4	0	4
5	Psychiatrist	1	0	1
6	Dermatologist / Venereologist	1	0	1
7	Paediatrician	2	0	2
8	Anesthetist (Regular / trained)	2	0	2
9	ENT Surgeon	1	0	1
10	Opthalmologist	1	0	1
11	Orthopedician	1	0	1
12	Radiologist	1	0	1
13	Microbiologist	1	0	1
14	Casualty Doctors / General Duty Doctors	6	0	6
15	Dental Surgeon	1	0	1
16	Forensic Expert	1	0	1
17	Public Health Manager[1]	1	0	1
18	AYUSH Physician[2]	2	0	2
19	Pathologists	2	0	2
	Total	**34**	0	**34**

[1] ***May be a Public Health Specialist or management specialist trained in public health***

[2] ***Provided there is no AYUSH hospital / dispensary in the district headquarter***

B.	Para-Medicals			
S.No.	**Personnel**	**IPHS Norm**	**Current Availability**	**Identified Gaps**
1	Staff Nurse*	75 to 100	0	**75**
2	Hospital worker (OP/ward +OT+ blood bank)	20	0	20
3	Sanitary Worker	15	0	15
4	Ophthalmic Assistant / Refractionist	1	0	1
5	Social Worker / Counsellor	1	0	1
6	Cytotechnician	1	0	1
7	ECG Technician	1	0	1
8	ECHO Technician	1	0	1
9	Audiometrician		0	
10	Laboratory Technician (Lab + Blood Bank)	12	0	12
11	Laboratory Attendant (Hospital Worker)	4	0	4
12	Dietician	1	0	1
13	PFT Technician	-	0	-
14	Maternity assistant (ANM)	6	0	6
15	Radiographer	2	0	2
16	Dark Room Assistant	1	0	1
17	Pharmacist[1]	5	0	5
18	Matron	1	0	1
19	Assistant Matron	2	0	2
20	Physiotherapist	1	0	1
21	Statistical Assistant	1	0	1
22	Medical Records Officer / Technician	1	0	1
23	Electrician	1	0	1
24	Plumber	1	0	1
	Total	**154**	0.0	**154**

* ***1 Staff Nurse for every eight beds with 25% reserve***

[1] ***One may be from AYUSH***

C.	Administrative Staff				
S.No.	**Personnel**	**IPHS Norm**	**Current Availability**		**Identified Gaps**
	Manager (Administration)	-			
	Junior Administrative Officer	1	0		1
	Office Superintendent	1	0		1
	Assistant	2	0		2
	Junior Assistant / Typist	2	0		2
	Accountant	2	0		2
	Record Clerk	1	0		1
	Office Assistant	1	0		1
	Computer Operator	1	0		1
	Driver	2	0		2
	Peon	2	0		2
	Security Staff*	2	0		2
	Total	**17**	**0**		**17**

Note: *Drivers post will be in the ratio of 1 Driver per 1 vehicle. Driver will not be required if outsourced*

** The number would vary as per requirement and to be outsourced.*

D.	Operation Theatre				
S.No.	**Staff**	**IPHS Norm**	**Current Availability**		**Identified Gaps**
		Emergency / FW OT	**General OT**		
1	Staff Nurse	8	1	0	9
2	OT Assistant	4	2	0	6
3	Sweeper	3	1	0	4
	Total	**15**	**4**	**0**	19

E.	Blood Bank / Blood Storage				
S.No.	**Staff**	**IPHS Norm**	**Current Availability**		**Identified Gaps**
		Blood Bank	**Blood Storage**		
1	Staff Nurse	3	1	0	4
2	MNA / FNA	1	1	0	2
3	Lab Technician	1	-	0	1
4	Safai Karamchari	1	1	0	2
	Total	**6**	**3**	**0**	9

Status of Health Facility Buildings in the District

Sub-Centre (SC) Status:-

Sub Centers	No.	Percentage
Sub-Centers in own building	**12**	27 %
Sub-Centre in Panchayats / rented Buildings	**32**	73 %
SC without Electricity	**41**	93%
SC without Water Supply	**30**	68%
SC without Toilets	**42**	95%

Primary Health Centers (PHC) Status:-

PHC status	Number
24 hour PHC	**1**
Total beds	**128**
No. of OPD cases	**Not Available**
No. of indoor cases	**Not Available**
Rogi Kalyan Samiti functioning	**In Process for Nunar & Gutli Bagh PHCs**

Block Primary Health Centres (BPHC)/CHC Status:

CHC Status	Numbers
Total no. of beds	**40**
Total no of OPD cases	**84000**
Total no. of indoor admissions	**1888**
Bed occupancy rate	**44.87 %**
Total no. of deliveries	**832**
Vehicle / Ambulance	**5**
Ambulance with NGO partner	**NIL**
Rogi Kalyan Samiti functioning	**Yes**

Number of Institutions Requiring New Buildings

#	Institution	New Building	Addition/Expansion	Repairs
1	SCs	**32**	**8**	**6**
2	PHCs	**6**	**14**	**9**
3	CHCs	**0**	**2**	**2**

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

Category	Staff Quarters	Condition* (G: Good, NMR: Needs Minor Repairs, MR: Needs Major Repairs, NAD: Needs Additions
CHC Ganderbal	**3**	MR
CHC Kangan	**6**	MR
CHC		
PHC		

Status of Staff Quarters Attached to Sub Centers in the District

Sub Centres	No. of SCs	Size in sq. mts.
SHCs having 2 staff Qtrs. in addition to clinic, examination and delivery room area	NIL	NIL
SHCs having 1 staff Qtr. in addition to clinic, examination and delivery room area	NIL	NIL
SHCs having no staff Qtrs	44	Not Available

PLANNING PROCESS

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

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

The District Planning Core Group (DCG) provided technical oversight and strategic vision for the process of development of District Action Plan. The members of the District Planning Core Group also contributed in selected thematic areas such as RCH, newer initiatives under NRHM, immunization etc. Assessment of overall situation of the district and development of broad framework for planning was done through a series of meetings of the DCG.

This District Action Plan has been prepared through integration of Block Action Plans including Health Facility Surveys. Status of the District Action Plan was presented in meeting and suggestions / feedback were received. The roles and responsibilities of DCG were finalized in the same meeting and contents of each chapter were discussed. Based on the inputs received from the Blocks, a chapter wise draft was developed after discussions. These were further improved upon through individual consultations with groups and nodal officers. Specific time line was fixed for this purpose.

1	IMMUNIZATION COVERAGE OF CHILDREN < 3 YEAR OF AGE			
	No. <3 years	Number completely immunized	% of fully immunized children	Maximum 100% Minimum 0%
	16761	10694	61.3%	**61**
2	ESSENTIAL ANTENATAL CARE			
	Total no. of pregnant women	No of women who got full antenatal care as defined	% of women getting antenatal care as defined	Maximum 100% Minimum 0%
	9904	Not Available	Not Available	
3	INSTITUTIONAL DELIVERY			
	Total no. of pregnant women	Total no of women delivered in Institution	% of pregnant women delivered in Institution	Maximum 100% Minimum 0%
	9904	1825	18.3 %	18
4	WEIGHING OF NEWBORN WITH IN THREE DAYS			
	Total no. of births in the year	No. of newborn weighed within three days	Percentage of newborn weighed within three days	Maximum 100% Minimum 5%
	6677	1325 (Gbl & Kan)	14.11 %	14
5	BREASTFEEDING IN FIRST HOUR			
	Total no of births in the last year	No of newborns who were breastfed in the first hour	Percentage of newborns who were breastfed within an hr.	Maximum 100% Minimum 0%
	6677	5867	86%	86
6	REPORTING OF BLOOD SLIDE			
		Approx no of blood slides sent in last 3 months	Average time taken for reporting of blood slide	Maximum over 30 days Minimum 1 day
		Nil	Nil	
7	ACCESS TO STERILISATION SERVICES			
	No of target couples for sterilization services (> 2 children)	Total no. of couples with at least one of them wanting FP operation:	No. who wanted to get FP operation done last year but could not	% of unmet demand for FP operation	Maximum 100% Minimum 0%
	NA	NA	NA	NA	
8	USE OF DOMESTIC/ COMMUNITY TOILET			
	Total no. of families	Total no. of families where all members are using domestic/ community toilet	Percentage of families where where all members are using domestic/ community toilet	Maximum : 50 % Minimum 0%
	NA	NA	NA	
9	MIDDAY MEAL			

	Total no. of primary and middle schools	Total no. of schools giving cooked midday meals	Percentage of schools giving midday meals	Maximum : 50 % Minimum 0%
	NA	NA	NA	
10	PDS FUNCTIONING			
	Total no. of BPL families eligible for lower cost grains	No. of families getting grains from PDS shop	Percentage of beneficiaries	Maximum : 50 % Minimum 0%
	NA		NA	
11	ANTYODAYA YOJNA			
	Total no. of BPL families eligible for free grains	No. of families getting free grains from PDS shop	Percentage of beneficiaries	Maximum : 50 % Minimum 0%
	NA	NA	NA	
12	SCHOOL ENROLLMENT			
	Total no. of children in 6-14 age group	No. of children in age group not going to school	Percentage of school going children	Maximum : 50 % Minimum 0%
	NA	NA	NA	
13	CHILD MALNUTRITION			
	Total no. of children below 3 with wt record.	no. of children with gr I or above malnutrition**	% of children malnourished	Maximum : 50 % Minimum 0%
	NA	NA	NA	
14	LOW BIRTH WEIGHT			
	Total no. of newborn weighed last year	Total no. of babies with LBW	Percentage of babies *with* LBW	Maximum : 50 % Minimum 0%
	NA	NA	NA	
15	AGE OF MARRIAGE			
	Total no. of girls married last year	No. of girls married below 19 year of age	100% - % of married women below 19 year of age	Maximum : 50 % Minimum 0%
	NA	NA	NA	
16	SPACING			
	Total number of births last year which were second or > child	Total number of births last year with spacing of < 3 years	Total % age of births last year with spacing of < 3 years	Maximum : 50 % Minimum 0%
	NA	**NA**	NA	
17	INFANT DEATHS			
	Total number of births last year	Any deaths of any child below one year	% age of Infant deaths	Maximum : 50 % Minimum 0%
	NA	NA	NA	
18	OUTBREAK OF WATER BORNE DISEASE			

	Diarrheal outbreaks (More than three cases of a disease in same week	jaundice outbreaks (as defined)	Sum of water borne disease outbreaks	Maximum : 50 % Minimum 0%
	NA	NA	NA	

Health Facilities as per population norms				
Health Facility	**Recommended**	**Required**	**Existing**	**Gap/ to be constructed**
Block:- Ganderbal			**Population :-89342 (Projected population for 2012 - 98276)**	
SC's	1/3000	32	14	18
PHC's	1/20000	04	06	02 (Surplus)
CHC's	1/80000	01	01	
Block:-Lar			**Population :-50491 (Projected population for 2012 - 55540)**	
SC's	1/3000	18	09	09
PHC's	1/20000	04	05	01 (Surplus)
CHC's	1/80000	00	00	……
Block:- Kangan			**Population :-115000 (Projected population for 2012 -126500)**	
SC's	1/3000	42	21	21
PHC's	1/20000	06	12	06 (surplus)
CHC's	1/80000	1	1	

PRIORITIES AS PER BACKGROUND AND PLANNING PROCESS

National Rural Health Mission encompasses a wide range of health concerns including the determinants of the good health. There is a significant increase in resource allocation under NRHM. However, there can never be adequate resources for all the health needs and all that needs to be done for ensuring good health of all the people. It is therefore necessary to prioritize the areas of interventions. Following overall priorities are identified on the basis of decentralized planning process and situational analysis.

1. **Increasing number of Institutional Delivery**

2. **Demand Generation for health services, IEC/BCC on** Nutrition, Health & RCH Education to Adolescents and behavior change in the resistant Populations.
3. **Human Resources:** There is a need for more staff in district. Vacant positions need to be filled up through fresh recruitment. To facilitate a higher retention of medical staff, residential accommodation require to be constructed and incentives given to attract medical practitioners.
4. **Capacity Building:** Besides induction training to new staff, existing staff needs regular periodic training to maintain and upgrade their skills. The existing and newly recruited staff needs adequate training to ensure good maternal and child health services in rural areas. Training need assessment is to be carried out for all categories of staff against their job descriptions. Appropriate training programmes have to be developed and implemented in the near future. This must also include health education to adolescents and children to help shape healthier life styles (i.e. about alcohol, drugs, sexual practices, nutrition etc).Staff requires developing newer skills to face the new challenges that are coming up in the district.
5. **Monitoring & Evaluation:** System require to be strengthened for regular flow of computerized data and its validation for monitoring of health programme.
6. **Procurement and Logistics:** Construction of a scientific Warehouse for Drugs
7. **Adolescent Health:** The focus is on provision of Adolescent Reproductive and Sexual health education through schools and also awareness generation on good health practices, responsible family life, harmful effects of Alcoholism etc.
8. **Anemia.**

9. **Family Planning:** Improving the coverage for Spacing methods and NSV.

PRIORITIES BASED ON VILLAGE HEALTH ACTION PLANS:

1. **RCH/Maternal Health**: Complete awareness on need and availability of reproductive and child health services, provisions of Iron folic tablets, Calcium and Vitamin A at the sub-centres have been recommended in the village plans. Facilities of institutional delivery at sub-centres and transport facilities for the pregnant women for referral have also been suggested.

2. **Child Health & Immunizations**: Improvement of child health interventions through adequate supply of vaccines at sub-centers and maintenance of cold chain, creating awareness on need for immunizations among the public have also been strongly recommended.

3. **Family welfare:** The village plans emphasizes on easy availability of contraceptives at the sub centres and need to encourage use of contraceptives by community..

4. **Adolescent health:** Vigorous awareness campaign has been suggested in the village plans and has been urged to be taken seriously under NRHM. Guidance, counseling facility at sub centre, proper scrutiny of RTI/STI cases and awareness regarding AIDS and STD has also been recommended.

5. **National Disease Control Programme:** T.B is prevalent throughout Gandarbal district and intensive efforts are needed for complete eradication of the disease through proper measures such as anti-smoking campaign, anti-pollution drives, highly organized DOTS programme, random checking of sputum and blood samples among the vulnerable group.

6. **Leprosy control:** Proper guidance and awareness in the community on symptoms and treatment of leprosy cases has been suggested.

7. **Blindness Control:** Increasing the frequency of eye check up and cataract operation camps which normally happen once or twice in a year has been strongly recommended in the village plans. Availability of Vitamin A at sub centres, availability of eye specialist once a week at sub centre for vision check up of children has also been recommended.

8. **NRHM Additionalities** :(ASHA) Clear role clarity of ASHAs, adequate training, provision of medicine kit and timely honorarium for their services has also been suggested.

9. J**SY:** Timely remuneration of financial assistance to mothers at the time of delivery, proper monitoring of JSY funds has also been recommended. Other additional ties like gender equity, IEC, capacity building, inter-sectoral convergence, untied funds to VWHSC have been suggested to be improved and properly applied

4. GOALS

INDICATOR	Current	Goals				
		07-08	08-09	09-10	10-11	11-12
Reduction in Infant Mortality Rate (IMR)	63/1000	60	57	51	44	39
Reduce Neo-natal Mortality Rate (NMR)	NA					
Reduction Maternal Mortality Ratio (MMR)	300/1000000	290	250	200	150	100
Reduction in Birth Rate	27	26	23	20	17	15
Reduction in Total Fertility Rate	2.7 %	2.6	2.5	2.3	2.1	1.9
Reduction in Death Rate	8	8	7	6	5	4
Increase Ante-Natal Care as defined	94%	95	96	97	98	99
Increase Proportion of Women getting IFA tablets	94%	95	96	97	98	99
Increase Proportion of Women getting 2 TT Injections	94 %	95	96	97	98	99
Increase Institutional Deliveries	18.3%	25	45	70	75	80
Increase Delivery by Skilled Birth Attendants	53	55	61	69	77	83
Increase Contraceptive Prevalence Rate	32	35	41	48	53	61
Increase Complete Immunizations of Children (12-23 month of age)	61%	70%	80%	90%	100%	100%
Increase Proportion of Children Exclusively Breastfed	NA					
Reduce Prevalence of STI/RTI	NA					

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

PART A: Reproductive and Child Health (RCH) II

A-1. Strengthening of District Health Management						
Situation Analysis/ Current Status	Constitution of District Health Society is under process. The members of DHS are from health, AYUSH, Education, SDM, PHE, ICDS, Rural Development etc. The Societies under the vertical Health Programmes like Blindness Control Society, TB Control Society, District Malaria Society, and society for IDSP have been integrated into single society at the district level.					
Objectives	1. To improve the functioning of the societies at the District Level. 2. To provide contractual human resource & logistic support for conduction of meetings					
Strategies & Activities	1. There should be an Effective Planning, Implementation, monitoring and inter-sectoral co-ordination in the field of Health under the close guidance and supervision of Deputy Commissioner. 2. Strengthening the management functions of the District Health and Family Welfare Societies by hiring consultants. 3. Hire a management consultant at state and identify nodal officers at all levels. 4. Coordinate the implementation of programme. 5. Seek financial/ technical support for preparation of district PIP.					
Support required	1. Operational Guidelines for District Health Society. 2. Technical Assistant for organizing and execution of such meetings.					
Timeline	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Developing systems	x				
	Orientation Workshop of the members	x	x	x	x	
	Issue based orientation	x	x	x	x	
	Ensuring provision of Technical Assistance at the district, block level.	x	x	x	x	
	Exposure visits of DHS members		x	x		
	Formation of a monitoring Committee from all departments.	x				
	Development of a Checklist for the Monitoring Committee. Two vehicles for DHMU & CMO	x				
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Orientation Workshop	0.5	0.55	0.605	0.666	**2.321**
	Exposure visit	0.0	3.1	3.41	0.000	**6.51**
	Issues based Workshops	0.5	0.55	0.605	0.666	**2.321**
	Mobility for Monitoring	1.2	1.32	1.452	1.597	**5.569**
	Vehicle @ 5.lac * 2	10.00	0.00	0.00	0.00	**10.00**
	POL for 2 vehicles @ 50000/ per vehicle/ year	1.00	1.00	1.00	1.00	**4.00**
	Salary for 2 drivers @ 4000/M	0.96	0.96	0.96	0.96	**3.84**
Total		**14.16**	**7.48**	**8.032**	**4.889**	**34.561**

Detailed Calculations

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

A- 2 District Programme Management Unit	
Status	In NRHM a large number of activities have been introduced with very definite outcomes. The cornerstone for smooth and successful implementation of NRHM depends on the management capacity of District Programme officials. The officials in the districts looking after various Programmes are overworked and there is immense pressure on the personnel. There is also lack of capacities for planning, implementing and monitoring. The decisions are too centralized and there is little delegation of powers. In order to strengthen the district PMU, three skilled personnel i.e. Programme Manager, Accounts Manager and Data Assistant have being provided in each district. These personnel are there for providing the basic support for programme implementation and monitoring at district level. At present there is no office for DPMU staff at District/Block Head Quarters. There is no computers and peripherals available with the DPMU, Ganderbal, which is one of the utmost need for HMIS in the district. There is a need for providing more support to the CMO office for better implementation especially in light of the increased volume of work in NRHM, monitoring and reporting especially in the areas of Maternal and Child Health, Civil works, Behaviour change and accounting right from the level of the Sub centre.
Objectives	To make District Programme Management Unit functional and strengthened.
Strategies	1. Support to the CMO for proper implementation of NRHM. 2. Capacity building of the personnel 3. Development of total clarity at the district and the block levels amongst all the district officials and Consultants about all activities 4. Provision of infrastructure for the personnel 5. Training of district officials and MOs for management 6. Use of management principles for implementation of District NRHM 7. Streamlining Financial management 8. Strengthening the CMO office 9. Strengthening the Block Management Units 10. Convergence of various sectors
Activities	**1. Support to the CMO** for proper implementation of NRHM through involvement of more consultants for support in data analysis, trends, timely reports and preparation of documents for the day-to-day implementation of the district plans so that the CMO and the other district officers:

- Finalizing the TOR and the selection process
- Advertisements for Management unit team members and consultants, one each for Maternal Health, Civil Works, Child health, and Behaviour change. If properly qualified and experienced persons are not available then District Facilitators to be hired which may be retired persons.
- Selection of the DPMU/BPMU staff and consultants.
- Provision of dealing assistant NRHM in DHS chairman office for better coordination between Chairman, Management Units and other allied departments of DHS.

2. Capacity building of the personnel

- Joint Orientation of the District officers and the consultants
- Induction training of the DPM and consultants
- Training on Management of NRHM for all the officials
- Review meetings of the District Management Unit to be used for orientation of the consultants.

3. Development of total clarity in the Orientation

Workshops and review meetings at the district and the block levels amongst all the district officials and Consultants about the set of activities:

4. Provision of infrastructure for officers, DPM, DAM, DDM and the consultants of the District Project Management Unit and Provision of office space with furniture and computer facilities, photocopy machine, printer, Mobile phones, digital camera, fax etc.

5. Use of Management principles for implementation of District NRHM

- Development of a detailed Operational manual for implementation of the NRHM activities in the first month of approval of the District Action Plan including the responsibilities, review mechanisms, monitoring, reporting and the time frame. This will be developed in participatory consultative workshops at the district level and block levels.
- Financial management training of the officials and the Accounts persons
- Provision of Rs. 500,000 as untied funds at the district level under the jurisdiction of the CMO.
- Compendium of Government orders for the DC, CMO, district officers, hospital, CHCs, PHCs and the Sub centres need to be taken out every 6 months. Initially all the relevant documents and guidelines will be compiled for the last two years.

6. Strengthening the Block Management Unit: The Block Management units need to be established and strengthened through the provision of :

- Block Programme Managers (BPM), Block Accounts Managers (BAM) and Block Data Assistants (BDA) for each block. These will be hired on contract. For the post of BPM and the BAM retired persons may also be considered.
- Office setup will be given to these persons
- Accountants on contract for each PHC since under NRHM Sub centres have received Rs 10,000 also the village committees will get Rs 10,000 each, besides the funds for the PHC.
- Provision of Computer system, printer, Digital Camera with date and time, furniture.

7. Convergence of various sectors at district level

- Provision of Convergence fund for workshops, meetings, joint outreach and monitoring with each CMO.

8. **Monitoring the Physical and Financial progress** by the officials as well as independent agencies.
9. **Yearly Auditing** of accounts

Support required

1. State should ensure delegation of powers and effective decentralization.
2. State to provide support in training for the officials and consultants.
3. State level review of the DPMU on a regular basis.
4. Development of clear-cut guidelines for the roles of the DPMs, DAM and District Data Manager.
5. Developing the capacities of the CMOs and other district officials to utilize the capacities of the DPM, DAM and DDA fully.
6. Each of the state officers Incharge of each of the programmes should develop total clarity by attending the Orientation workshops and review meetings at the district and the block levels for all activities.
7. If qualified persons for the posts of DPM, DAM are not available then State should allow the appointment of facilitators or Coordinators or retired qualified persons by the District Health Society.

Time Frame

Activity / Item	**2008-09**	**2009-10**	**2010-11**	**2011-12**
Establishment of DPMU and Consultants	x	x	x	x
Infrastructure, furniture, computer systems, fax, UPS, Printer, Digital Camera	x			
Workshops for development of the operational Manual at district and Block levels	x	x	x	x
Compendium of Govt orders	x	x	x	x
Joint Orientation of Officials and DPM, DAM, DDM	x	x	x	x
Management training workshop of Officials				
Establishment of BPMU	x			
Training of DPM and Consultants	x	x	x	x
Review meetings	x	x	x	x
Computer systems with printer and Digital Camera & furniture for DPMU, BPMUs, District, block personnel	x			
Monitoring of the progress	x	x	x	x

Budget (In Lakhs)

Activity / Item	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
Honorarium DPM,DAM,DDA and Consultants	29.4	32.34	35.57	39.13	**136.44**
Travel Costs for DPMU @ Rs 10,000/ per month x 12 mths	1.20	1.32	1.452	1.597	**5.569**
Infrastructure costs, furniture, computer systems, fax, UPS, Printer, Digital Camera,	5.00	0	0	0	**5.00**
Workshops for development of the operational Manual at district and Block levels	1.00	1.1	1.21	1.33	**4.64**
Untied Fund	5.00	6.00	7.00	8.00	**26.00**
Compendium of Govt orders	0.5	0.55	0.605	0.666	**2.321**

	Joint Orientation of Officials and DPM, DAM, DDM	0.25	0.275	0.303	0.333	**1.161**
	Management training workshop of Officials	0.50	0.55	0.605	0.666	**2.321**
	Personnel for BPMU	27.12	29.832	32.8152	36.09672	**125.8639**
	Training of DPM and Consultants	0.5	0.75	1	1.25	**3.500**
	Review meetings @ Rs 1000/ per month x 12 months	0.12	0.132	0.145	0.16	**0.557**
	Office Expenses @ Rs 10,000/month x 12 months for DPMU	1.2	1.3	1.5	1.6	**5.600**
	Computer systems (5) with printer and Digital Camera and furniture for DPMU, BPMUs and District and block personnel	3.00	0	0	0	**3.000**
	Annual Maintenance Contract for the equipment	0.54	0.594	0.653	0.719	**2.506**
	Travel costs for BPMU	7.2	7.92	8.712	9.5832	**33.4152**
	Monitoring of the progress by independent agencies	1.00	1.1	1.21	1.331	**4.641**
	Office expenses for Blocks @ Rs 5000 x 3 blocks	1.80	1.98	2.178	2.3958	**8.3538**
	Total	**85.33**	**85.743**	**94.9582**	**104.8577**	**370.8889**

Detailed calculation for Personnel at DPMU for one year

S. No	Details	Units	Unit Cost	Amt for 12 months
	Personnel at District level			
	District Programme manager	1	18000	216000
	District Accounts Manager	1	15000	180000
	District Data Assistant	1	12000	144000
	Consultant for Maternal Health	1	40000	480000
	Consultant for Child Health	1	40000	480000
	Consultant for Civil Works	1	40000	480000
	Consultant for HMIS	1	40000	480000
	Consultant for Behaviour Change	1	40000	480000
	Sub Total			**2940000**
	Personnel at Block level			
	Block Programme manager	3	15000	540000
	Block Accounts Manager	3	12000	432000
	Block Data Assistant	3	10000	360000
	Part Time Accountant at PHC	23	5000	1380000
	Sub Total			**2712000**
	Hiring of vehicles at block level @ Rs 2000 x 10days /mth x 3 blocksx12 mths	3	20000	**720000**
	Office Automation with Furniture, Computer system, Camera, Printer, etc	3 for BPMU 1 for DPM 1 for DAM	60,000	300000

A-3. MATERNAL HEALTH

Situation Analysis	**Maternal Mortality:** Authentic data on maternal death are not available as district is recently carved out. There is a lot of under reporting due to lack of personnel and improper supervision. **Deliveries:** Institutional deliveries are 18.3 % as per CMO office record. **Referrals:** There is no adequate data for referrals during complications.
Objectives	▪ Improve Coverage of Anti Natal care. ▪ Develop Linkage with private practitioners for improving early registration and ANC services. ▪ Increasing Awareness in the community for improving ANC seeking during pregnancy, and community role in reaching adolescent mothers / ST/Nomadic population of Kangan Block. ▪ Promotion of institutional Deliveries ▪ Increase access to EmOC for complicated Deliveries. ▪ Operationalize CEmOC services at FRU's. ▪ Develop partnership with private/ trust / grant in aid hospitals for CEmOC / BEmOC. ▪ Increase coverage of Post Partum care. ▪ Increase access to early and safe abortion services. ▪ Improve access to early RTI / STI. ▪ Bring down the prevalence of Anemia
Strategies & Activities	Improve ANC coverage by: Organizing weekly ANC sessions o improve early ANC registration and ANC services. Organizing ANC sessions by ANM's on fixed days in the outreach areas assisted by LHV's. Organizing ANC clinic sessions in remote / tribal areas through MHUs. Organizing ANC clinics in Ayurvedic dispensaries. Engage private clinics, hospitals and practitioners especially in tribal areas for holding ANC clinics. Incentive of Rs 150 per case to private practitioners on the completion of full ANC visits and care as per guidelines. Provide support in terms of guidelines, supplies etc to private practitioners for holding ANC sessions. Motivation for early ANC registration by ASHA followed by effective services of Antenatal and Postnatal care. Motivation by ASHA for at least 3 antenatal and postnatal checkups. Awareness for AWW to emphasize importance of institutional deliveries. Providing mobility support to ANM's for home deliveries in outreach areas other than sub center / HQ @ Rs 50 for home delivery other than SC. Increasing availability of SBA by hiring staff nurses & training of SBA. Provision of free transport for referral of cases. Operationalize BEmOC services in 100 % FRUs, 50 % of CHCs and 10 % of PHCs by training on BEmOC and providing BEmOC service guidelines. Introduce mechanisms for referral transport through private agencies / NGOs. Increasing post partum care by: Ensuring home visits by ANM, AWW LHV within three days of delivery, in case of home delivery. Sensitize the HSPs on the need for providing care to women and new born during post natal period, Undertake IEC activities particularly in tribal areas. Awareness programs for the importance of Exclusive Breastfeeding. Introduce mechanism for timely distribution of incentives of JSY so that incentives are used effectively by mothers.Improve access to safe abortions services by: Ensuring one service center in each Block. Increase awareness in the community regarding availability of MTP and safe delivery services. Strengthen all PHCs, CHCs and FRUs for diagnosis and treatment of RTI/STI.
Support Required	Adequate availability of labor room building for 24 hr delivery system. Availability of skilled and unskilled manpower to run the institution round the clock.

Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**
	Construction of Delivery Hut	**x**	**-**	**-**	**-**
	Printing of Referral Cards	**x**	**x**	**x**	**x**

	Organize Mothers' Meetings in Villages		**x**	**x**	**x**	**x**
	Providing mobile phone to ANM's		**x -**	**-**	**-**	**-**
	Identify and register beneficiaries for JSY		**x**	**x**	**x**	**x**
Budget For IEC will reflect in part C2	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Delivery Huts @ Rs 1 lakhs /hut x 3/blocks	3.00	6.00	0	0	**9.00**
	JSY- 2% of Total Population X1400 5096X1400)	71.34	78.474	86.3214	94.95354	**331.0889**
	Ref. Transport 10 % of 2.5 % of pop. x 300 (637x300)	1.91	2.101	2.3111	2.54221	**8.86431**
	Referral Cards @ Rs 2 per card x 637	0.012	0.0132	0.01452	0.015972	**0.055692**
	Mother's meeting- No. of villages @ 500 / meeting / month (220x500x12)	13.2	14.52	15.972	17.5692	**61.2612**
	Mobile phone instrument @ Rs 2000/SC (1 ANM) (2000 X 44) (48 new SCs)	0.88	0	0.96	0	**1.84**
	Mobile Phones recurring cost to ANMs @ Rs 2400 per annum x 44 SC	1.06	1.166	2.208	2.4288	**6.8628**
Total		**91.402**	**102.2742**	**107.787**	**117.5097**	**418.9729**

A-4. NEWBORN & CHILD HEALTH

Situation Analysis/ Current Status	**IMR= 63 and Complete immunization = 61%** **Anemia in children**: There is no data available `with the CMO or the ICDS regarding the prevalence of anemia in children. Children are given IFA tablets for iron supplements under the national programme... **Breast feeding:** There is no data regarding early initiation and exclusive breast feeding. **Training:** IMCI / **IMNCI** training is needed for the MOs, Staff Nurses, ANMs. Training on the home based care package is required for the ANMs / AWWs / ASHAs / TBAs. **Data:** No data available for childhood diseases, prenatal mortality, % age of low birth weight babies at birth and deaths due to various causes.
Objectives	To Reduce Infant Mortality. To give special attention of Nomadic/ Tribal population of Kangan block. To increase access of essential care to all neonates. To Promote exclusive breastfeeding up to 6 months and complementary feeding at 6 months of age. To Enhance immunization coverage of children and antenatal women. Management of Diarrhea and ARIs in children. To provide 5 doses of Vitamin A to all children under 3 years.
Strategies & Activities	**Provide essential new born care by:** ▪ Adapting home based newborn care package of services ▪ Scheduling of visits of all neonates by ASHA/AWW/ ANM. ▪ Supply of need based equipment, drugs, medicines and supplies. ▪ Training of MOs in CEmOC, TBAs / ANMs / LHVs. ▪ IMNCI training for the health workers. ▪ Provision of staff (nurses and MOs.) trained in newborn care, at all SDH / DHs and few selected CHCs (with provision to hire nurses and pediatrician on contract). ▪ Renovation/ Refurbishment of newborn care corner/room in above mentioned institutions ▪ Provision of facilities for resuscitation, warming, weighing, temperature recording, ▪ Supply of equipment, consumable medicines and supplies in sufficient quantity. **Promote exclusive breastfeeding by:** ▪ Orientation of ASHAs / AWW / ANM / MOs about advantages and techniques of EBF and counseling for complementary feeding ▪ Organize IEC/BCC, communication campaign, advocacy programs, and special advocacy efforts to promote breast-feeding practices -integrate with BCC. **Strengthening Immunization by:** ▪ Organize Mother Child Protection Sessions twice a week, so as to cover all villages/ hamlets at least once a month. ▪ Tracking of drop outs by the ASHAs/AWW. ▪ Support DIOs for monitoring immunization programs **Controlling ARI and Diarrheal diseases in children.** ▪ Social marketing of ORS to promote use of ORS for diarrhea management. ▪ Orient health personnel on prevention and management of diarrhea and ARI and referral of sick child to higher level of care. ▪ Promote home available oral dehydration fluids. Health Education regarding diet and exercise during pregnancy. Provision of Referral Transport as mentioned in Maternal Care. Provision of Blood Storage facilities.
Support required	The availability of services of anesthetists, obstetricians and gynecologists, pediatricians and supporting staff with a blood storage facility is critical for providing emergency obstetrics and newborn care. Training modules for specialists training. Availability of vitamin A, ORS and anti bacterial drugs for ARI and Diarrhea.

Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Furnishing of Newborn Corner	**x**	**-**	**-**	**-**	

	Setting up Malnutrition Corner	**x**	**-**	**-**	**-**	
	Supply of weighing machine, Foetoscope	**x**	**-**	**-**	**-**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Newborn Corner furnished with equipment @ Rs 1.40 lakh / CHC x 3	4.20	0.0	0.0	0.0	**4.20**
	Foetoscope @ Rs.50 x 435 AWCs	0.22	0.0	0.0	0.0	**0.22**
	Infant Weighing Machines @ Rs. 800 x 435 AWCs	3.48	0.0	0.0	0.0	**3.48**
	Malnutrition Corners @ Rs 30,000 per CHC (30000 X 3)	0.90	0.0	0.0	0.0	**0.90**
	Total	**8.80**	0.00	0.00	0.0	**8.80**

A-5. FAMILY PLANNING

Situation Analysis/ Current Status

Indicators	No. or Rate
Eligible Couple	15186
Couple Protection Rate	32
Female Sterilization operations during last year	79
Vasectomies during the last year	9
Couples using temporary method	1393

Objectives

To reduce the TFR to 2.1% by 2010
To reduce the unmet need in family planning to 10 % by 2010
Increase in Contraceptive Prevalence Rate to 80 % by 2012
Increase in the awareness levels of Emergency Contraception to 100% by 2010
To promote the NSV as a method of terminal family planning
Increase the availability of FP services through Public- Private Partnerships
To increase the number of doctors performing family planning operations.

Strategies & Activities

- Widening the choice of clients for availability of sterilization service
- Provision of sterilization services on all working days in all SDH & DH
- Organizing sterilization camp in CHCs on fixed days of every month
- Availability of condoms and oral pills through social marketing especially in tribal / urban slum areas.
- IEC through satisfied clients and mass media
- Holding of NSV camps every quarter in every DH
- Training of MOs in NSV at NSV camps
- Orientation of ASHAs/ AWW by ANM's about spacing methods
- Supply and monitoring of contraceptives to ASHAs/AWW by ANM's
- Display of information on emergency contraception in all health institutions.
- Training of staff for insertion of IUDs.
- Awareness and motivation to community for adopting family planning methods.
- Counseling of newly married couples on importance of birth spacing.
- IEC campaign on importance of birth spacing.
- Enhance availability and access to birth spacing contraceptive methods through social marketing

Support required

Supply of emergency contraceptive to all health institutions.
Provide IEC material.
Introduction of the concept of quality care in family planning Programmes.
Training Modules on NSVs for MOs

Timeline

Activity Plan	2008-09	2009-10	2010-11	2011-12	
Training of MOs/Specialists in NSV	x	-	-	-	
Organizing Sterilization camps	x	x	x	x	
Procurement of EC Pills /Copper-T	x	x	x	x	
Development of static center	x	-	-	-	
Procurement of NSV kit / laparoscope	x	-	-	-	

Budget Budget for IEC will reflect in part C2

Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
Training of MOs & Specialists in NSV @ Rs 7500 x 2 persons x 3 Blocks	0.45	0	0	0	**0.45**
NSV camps @ Rs. 359750 x 2camps x 3	21.6	23.76	26.136	28.7496	**100.246**

	Sterilization Camps @ 436 X 600 cases	2.62	2.882	3.1702	3.48722	**12.1594**
	Copper T-380 @ Rs 45 / piece x 3000 users	1.35	1.485	1.6335	1.79685	**6.26535**
	Emergency Contraception @ Rs 10 per 2 tabs x 2000	0.2	0.22	0.242	0.2662	**0.9282**
	Development of Static Center @ Rs1 lakhx3	3	0	0	0	**3**
	NSV Equipment @ Rs 800 x 3 CHC	0.024	0	0	0	**0.024**
	Laparoscopes for 3 CHC@ Rs3.00 lakhs x 3	9	0	0	0	**9**
	NSV Incentives @ Rs. 1000 per case x100 cases x3 block	3	3.3	3.63	3.993	**13.923**
Total		**41.244**	**31.647**	**34.8117**	**38.2929**	**145.996**

Requirements for organizing one camp (600 cases)

S. No	Head	Unit	Unit Cost	Amount
1.	District Workshop	1	4000	
2.	Block workshops	4	7500	30000
3.	TA/DA for NSV surgeons	5	2000	10000
4.	IEC activities			93250
5.	TA to Acceptor for Semen Analysis	600	50	30000
6.	Payment to NSV Advocate/motivator and Drugs / dressings	600	327.5	196500
	Total			**359750**

Budget for sterilization per case

S. No	Head	Unit Cost
1.	Payment to acceptor	198
2.	Mobilization/Transport cost	50
3.	Payment to Service Provider	50
4.	Payment to IEC advocate/Motivator	35
5.	Payment to Assistant/OT Nurse etc;	10
6.	Drugs and Dressing	93.5
	Total	**436.5**

A-6. ADOLESCENT HEALTH					
Situation Analysis	1. Majority of the adolescence are going to school or college. Very few (less then1%) get married during adolescence. 2. Adolescence have unmet needs regarding nutrition, reproductive health, mental health and require appropriate guidance 3. Adolescence pregnancy 4. Unsafe abortion 5. Increasing trend of premarital sex				
Objectives	1. Improve adolescent health. 2. Enhance access of RH services to adolescents. 3. Increase awareness among the adolescents about available services 4. Avoid high risk taking behavior including unsafe sex, alcohol, substance abuse and teenage pregnancy. 5. To curb drug addiction and other addictions. 6. To improve the awareness of the sexually transmitted diseases especially HIV / AIDS				
Strategies & Activities	Improve adolescent health through provision of AFHS at PHCs, CHCs by: a. Identifying facilities and provide service guideline. b. Providing training of the health officials on AFHS. c. Improve service environment. d. Provide additional drugs and supplies Peer educator approach, capacity building for counseling in AH clinics and involvement of NGOs in phased manner. a. Selection of NGOs by NGO coordinator. b. Selection of peer educators (male & female) one each from every village by ANM, PRI and NGOs. c. Organize 3-day workshops for capacity building of peer educators at PHC. d. Recruit and train counselors (males & females) for conducting peer educator workshops and for conducting counseling at AH clinics e. Organize counseling clinics in CHCs, SDH and DH. Increase awareness among the adolescents by: a. Disseminate IEC/BCC material. b. Organize advocacy programs for key stake holders to create conducive environment for providing services- print and electronics media, seminars, workshops, experience sharing meets, etc. c. Increase awareness among adolescents on RH issues. d. Providing information to adolescents on importance of proper nutrition for proper growth and better reproductive health for Adolescents e. Controlling anemia in adolescent girls (even boys if possible) and pregnant women-attention to compliance to IFA. f. Providing information to adolescents on importance of proper nutrition for proper growth and better reproductive health for Adolescents. g. Audio visual aids for awareness of sex related diseases. Supply of condoms. Separate teams for school health. Services of specialists for school adolescence health.				
Support required	Manpower: Team of psychologist, counselor, psychiatrist, pediatrician (one day per week)				
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**
	Organizing Mental Health Camp	**x**	**x**	**x**	**x**
	Joint evaluation	**-**	**x**	**-**	**-**
	Health Care Check up	**x**	**x**	**x**	**x**
	Recruitment of contractual staff	**-**	**-**	**-**	**-**

Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Research	5.00	0	0	0	**5.00**
	Mental health camps for Adolescents once in a year/PHC @ 5000 per camp	1.15	1.265	1.3915	1.53065	**5.33715**
	Joint Evaluation after one year by independent agency and Government	0.00	0.5	0	0	**0.500**
	Heath care checkups/ @Rs. 15000 / camp x 2 camps in a year x 3 blocks	0.99	1.089	1.1979	1.31769	**4.59459**
	Psychologist 1 visit per week @Rs. 1000 / visit x 52 Wks	0.54	0.594	0.6534	0.71874	**2.50614**
	Psychiatrist 1 visit per week @Rs. 1000 / visit x 52 wks	0.54	0.594	0.6534	0.71874	**2.50614**
	Counselor 1 visit per week @Rs.1000/ visit x 52 Wks	0.54	0.594	0.6534	0.71874	**2.50614**
	Traveling allowance- No. of visits of Psy / Sic. Coun @ Rs. 500 per visit x 53 x 3	0.8	0.88	0.968	1.0648	**3.7128**
Total		**9.56**	**5.516**	**5.5176**	**6.06936**	**26.66296**

PART B: New NRHM initiatives

B-1. ASHA – Accredited Social Health Activist						
Situation Analysis/	The Sub centre caters to population of approximately 3000 spread over an average of 3-5 villages. Keeping in view the difficulties faced by the ANM to provide health and family welfare services in all the villages and also carry out effective community contact, a village level community based functionary (ASHAS) has been suggested in NRHM in all villages. ASHA will be trained for meeting health-related demands of people create awareness on health and its social determinants, mobilize the community towards local health planning and increased utilization and accountability of the existing health services indicators in the villages. ASHA is an honorary worker and will be reimbursed incentives based on performance. ASHA will be given preference for involvement in different health programmes wherever incentives are being provided (like institutional delivery being promoted under Janani Suraksha Yojana, motivation for sterilization, DOTS provider, etc.). It is conceived that she will be able to earn about Rs. 1,000.00 per month**.** 242 ASHA are needed in district Ganderbal as per norms. 215 ASHAs have been selected and all have received training in module 1. All the villages should have an ASHA by 2008.					
Objectives	▪ To increase the participation of ASHA with the community. ▪ To train ASHA about all NRHM activities. ▪ To make ASHA motivate people. ▪ To increasing ANC registration.					
Strategies & Activities	Increase number of ASHAs: 68 ASHA's more to be selected. Additional number of ASHA's to be selected as per yearly increase in population. Newly selected ASHAs to be trained. **Training Programme for ASHA's:** Out of the 242 selected ASHA's 215 have been trained in module I. Remaining 25 ASHA needs to be trained in Module I. 26 ASHAs to be selected for town area in the coming years. ASHA will act as a social mobilizer, facilitator and a link between ANM at sub-centre, anganwadi worker (under the Integrated Child Development Services Programme) and the community, and will play a major role in forging ownership of the community for the health programme. ASHA will track drop outs. The incentives of the ASHA's are required to be increased and make performance based so that they actively indulge in activities and contribute for improving health care system. Increase the awareness in community regarding role of ASHA through village health and sanitation committee. ASHA's will create awareness and motivate community for institutional deliveries and ANC. The PHC staff will involve and encourage ASHA and other community based volunteers/workers to work with the community and create awareness on danger signs in pregnant women, newborns and children who require referral to an appropriate health facility. Community should be made aware of the names and location of various health facilities where such cases can be referred.					
Support required	Training Modules about the Role of ASHA's. Procurement of Kits to ASHA's					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	

	Training of 255 ASHAs	**x**	**-**	**-**	**-**	
	Provision of drug kit to ASHAs	**x**	**x**	**x**	**x**	
	Enumeration of JSY beneficiaries	**x**	**x**	**x**	**x**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	ASHAs incentives JSY- beneficiaries @ Rs. 600 per beneficiary x 5096	30.58	33.638	37.0018	40.70198	**141.9218**
	ASHAs as DOTS provider- No. of ASHAs @ Rs. 500 x 255 ASHAs	1.28	1.408	1.5488	1.70368	**5.94048**
	Training of ASHAs- No. of ASHAs @ Rs. 10000 per /ASHAS x 255 (60% in 1st and 40 % in 2nd Year)	15.3	10.2	-	-	**25.5**
	Drug Kit@ Rs.8700/kit per year x 255 ASHAs	22.19	24.409	26.8499	29.53489	**102.9838**
Total		**69.35**	**69.655**	**65.4005**	**71.94055**	**276.3461**

B-2. Provision of Untied Funds at Sub Centers						
Situation Analysis/	1. Village Health and Sanitation Committee has been formed and functioning properly. 2. Untied Funds of Rs 10000 (Rs 10,000 for 14 Sub centers = 140000) have been paid to ANM's for opening accounts in their respective sub centre village and carrying out various health activities. 3. Almost 80 % of the funds have been already utilized for the betterment of each sub center as per NRHM guidelines.					
Objectives	Strengthening of the Sub centre through financial support for immediate needs and maintenance					
Strategies & Activities	1. Provision of Untied funds of Rs 10000 per year to all subcentres at the disposal of the ANM for local needs 2. Rs 10000 to be used for construction and annual maintenance 3. In addition to usual recurring cost to sub-centers, each sub centre would be given an untied support of Rs. 10,000 per annum. The fund would be kept in a joint account to be operated by the ANM and the local Sarpanch. 4. Rs 10000 will be given as annual maintenance grant to each Sub centre. This will be under the mandate of the VHWSC for undertaking construction and maintenance. This will bring in greater community control and the sub-centers would be brought fully under the Panchayati Raj framework. 5. Activities suggested for the untied funds include minor modifications, cleanliness of premises, transport of emergencies, transport of samples, purchase of consumables, etc; 6. This fund will not be used for salaries, vehicle purchase and recurring expenses of Gram Panchayat 7. Monthly and quarterly expenditure statement will be submitted along with UC					
Support required	Additional fund from State & Central Government					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Minor repairs of sub center buildings	**x -**	**-**	**-**	**-**	
	Supply of Account Books	**x**	**x**	**x**	**x**	
	Annual Maintenance grants	**x**	**x**	**x**	**x**	
	Holding meetings of VHWS committees	**x**	**x**	**x**	**x**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Untied funds @ Rs. 10000 a year x 44	4.10	4.10	4.10	4.10	**16.4**
	Account Books @ Rs. 200 per year x44	0.09	0.10	0.11	0.12	**0.42**
Non recurring	Repair works @ 10% of building cost x SCs in bad condition - 12X10% of 400000	4.80	0.0	0.0	0.0	**4.8**
	Untied Fund @ Rs. 10000 a year x 48	0.00	4.80	4.80	4.80	**14.4**
	Annual Maintenance grants @ 20000 per year per SCs	8.80	8.80	8.80	8.80	**35.2**
	Annual Maintenance grants 20000 per year per SC **48 new SCs**	0.0	9.60	9.60	9.60	**28.8**
Total		**17.79**	**27.4**	**27.41**	**27.42**	**100.02**

B-3. Provision of Untied Funds at PHCs						
Situation Analysis/	1. Untied Funds of Rs 25,000 have been paid to Zonal Medical Officers for opening accounts in their respective PHC's for carrying out various activities. 2. Almost 80% of funds have been utilized for which it was received. 3. Since the records at PHC level is not properly maintained due to the lack of staff & equipments, which creates the discrepancy in the records at block level and in turn at district level.					
Objectives	▪ Strengthening of the PHC through financial support ▪ Training of MO's for proper usage of the untied funds. ▪ Computerization of records. ▪ Training of staff for record maintenance electronically.					
Strategies & Activities	▪ Provision of Untied funds of Rs 25000 each year to the PHC at the disposal of the Rogi Kalyan Samities ▪ Provision of an Annual Maintenance grant of Rs 50,000 to the PHC ▪ These funds will be routed through the Rogi Kalyan Samities who will approve the yearly activities and the related budgets and also undertake and supervise improvement and maintenance of physical infrastructure. ▪ An untied fund of Rs 25000 will be provided each year for activities as per the local needs including minor modifications, cleanliness of premises, transport of emergencies, transport of samples, purchase of consumables, etc; ▪ This fund will not be used for salaries, vehicle purchase and recurring expenses of Gram Panchayat or any other facility. ▪ An Annual Maintenance grant of Rs 50,000 will be given to the PHC for water, toilets,, maintenance of building. ▪ Monthly and quarterly expenditure statement will be submitted along with UC ▪ Contractual engagement of computer operator is must which will maintain the records electronically so that all the discrepancies are avoided at PHC level which is the primary station of utilization of funds. Perfect record maintenance system and efficiently trained staff is needed. ▪ There should be a quarterly visit of Block Programme Management person to all PHCs and Sub Centers so as to check the proper maintenance of records. Furthermore during the visit Block Programme Management person should audit the RED ACCOUNT of all the expenditures utilized during the quarter at all PHCs and Sub Centers which will help in efficient maintenance of records at Block level and in turn at District Level.					
Support required	Equipment: 1. Computer System. 2. Provision of funds for Transport Allowances for Block Programme Management person to visit PHCs and Sub Centers quarterly. Manpower: 1. Computer operator.					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Supply of Account Books	**x**	**x**	**x**	**x**	
	Minor repairs of PHC buildings	**-**	**-**	**-**	**-**	
	Training of staff in accounting	**x**	**x**	**x**	**x**	
	Holding RKS Meeting PHC	**x**	**x**	**x**	**x**	
	Annual Maintenance grants	**x**	**x**	**x**	**x**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Untied Funds @ Rs.25000 a year / PHC (23)	5.75	5.75	5.75	5.75	**23.00**

	Account Book @ Rs. 2000 x 23 PHC	0.47	0.48	0.49	0.5	**1.940**
	Training on use of Acc. Books @ Rs.2000 x 23 PHCs	0.46	0.46	0.46	0.46	**1.840**
	Repair works of PHC building @10%of Building cost (15x150000)	22.5	0.0	0.00	0.00	**22.50**
	Annual Maintenance grants 50000 per year per PHC	11.5	11.5	11.5	11.5	**46.00**
Total		**40.68**	**18.19**	**18.2**	**18.21**	**95.28**

B-4. Provision of Untied Funds at CHCs						
Situation Analysis	Funds for CHCs were not allocated prior to launching of NRHM. CHCs are in bad shape due to unavailability of fund. . CHCs are unable to provide services as per the needs of the patients. Repair of a number of equipment needed					
Objectives	Strengthening of the CHC through financial support					
Strategies & Activities	Provision of Untied funds of Rs 50000 each year to the CHC at the disposal of the Rogi Kalyan Samities. Provision of an Annual Maintenance grant of Rs 100,000 to the CHC These funds will be routed through the Rogi Kalyan Samities who will approve the yearly activities and the related budgets and also undertake and supervise improvement and maintenance of physical infrastructure. 1. An untied fund of Rs 50000 will be provided each year for activities as per the local needs including minor modifications, cleanliness of premises, transport of emergencies, transport of samples, purchase of consumables, etc; 2. This fund will not be used for salaries, vehicle purchase and recurring expenses of Panchayat or any other facility. 3. An Annual Maintenance grant of Rs 100,000 will be given to the CHC for water, toilets,, maintenance of building. 4. Monthly and quarterly expenditure statement will be submitted along with UC					
Support required	Timely release of funds Meetings of the Rogi Kalyan Samitis to be regularly held					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Supply of Account Books	**x**	**x**	**x**	**x**	
	Minor repairs of CHC buildings	**x**	**-**	**-**	**-**	
	Training of staff in accounting	**x**	**x**	**x**	**x**	
	Holding RKS Meeting CHC	**x**	**x**	**x**	**x**	
	Annual Maintenance grant	**x**	**x**	**x**	**x**	
	Preparation of reference material	**x**	**-**	**-**	**-**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Untied funds @ Rs. 50000 a year + 1 new CHC to be constructed in 2008-09	1.00	1.5	1.5	1.5	**5.5**
	Account Books @ Rs. 5000 x 2 + one new CHC from 2009	0.10	0.165	0.165	0.165	**0.595**
	Training on use of acc. Books @ Rs. 2000 (2x2000) + 1 new CHC from 2009	0.04	0.165	0.165	0.165	**0.535**
	Preparation of reference manual @ Rs. 15000/ District	0.15	0	0	0	**0.15**
	Repair work @ Rs. 10% of building cost (2x400000)	8.00	0	0	0	**8.00**
	Annual Maintenance grant of Rs 100,000	2.00	3.00	3.00	3.00	11.00
Total		**11.29**	**4.83**	**4.83**	**4.83**	**25.78**

B- 5. Mobile Medical Units						
Situation Analysis/	There are many underserved areas in the district. Health services could not be provided in these areas due to shortage of staff.					
Objectives	Provision of Mobile Medical Unit for health care service to far flung areas.					
Strategies & Activities	Most of the hilly areas in the District can be provided health care services by provision of Mobile Medical Units. Since the District covers some areas where there is no regular transport facility mobile medical units will help in bringing down the mortality rate by providing urgent medical care.					
Support required	Each CHC requires medical mobile unit with provision of staff, mobile vehicle. POL and maintenance for mobile medical van.					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Procurement of MMU	x	-	-	-	
	Recruitment of MO, Pharmacist, LHV etc	x	-	-	-	
	Holding mobile medical camps	x	x	x	x	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	MMU@ Rs. 23.75 lac	23.75	0	0	0	**23.75**
	MO @ Rs.25000 per month x 12x 2	6.00	6.00	6.00	6.00	**24.00**
	Pharmacist @ Rs. 6000x12 months	0.72	0.72	0.72	0.72	**2.88**
	LHV @ Rs. 8000 / month x 12	0.96	0.96	0.96	0.96	**3.84**
	Counselor @ Rs. 10000 / month x 12	1.2	1.2	1.2	1.2	**4.8**
	Driver @ Rs. 4000/ month x 12	0.48	0.48	0.48	0.48	**1.92**
	Lab technician @ Rs. 5000/month x 12	0.6	0.6	0.6	0.6	**2.4**
	Mobile Medical Camps- @ Rs. 6000/camp x 25 camp/block x 3 blocks	4.5	4.95	5.445	5.9895	**20.8845**
	POL @ Rs. 500 / visit x 250 visits in year	1.28	1.408	1.5488	1.70368	**5.94048**
	Maintenance @ Rs. 20000/year from 2008	0.2	0.22	0.242	0.2662	**0.9282**
Total		**39.69**	**16.538**	**17.1958**	**17.91938**	**91.34318**

B – 6. Upgrading CHCs to IPHS	
Situation Analysis/	CHC Ganderbal and CHC Kangan are not to the level of Indian Public Health Standard (IPHS) at present. CHC Ganderbal is 10 bedded CHC at present.
Objective	Up gradation of CHC Ganderbal and CHC Kangan to IPHS Standards. Up gradation of CHC Ganderbal to 30 bedded CHC. Provision of seven specialists (against four at present) and nine staff nurses (against seven at present) One more CHC to be created in the Block Lar
Strategies & Activities	Aim is to ensure functional 30-bedded rural hospital at all Community Health Centre in the District. The availability of services of anesthetists, obstetricians and gynecologists and pediatricians and supporting staff with blood storage facility is critical for providing emergency obstetrics and newborn care. (mentioned in New Born Care also) Block pooling/transfer of doctors/specialists from the PHC level within district with facilities of transport, mobile phones and residential facilities at the CHCs so that the OPDs are run in the PHCs and the 24-hours emergency services are ensured at CHCs. The CHCs must have delivery huts and FRUs services Two refrigerators for Cold chain maintenance one for Ward & one for OT Standard treatment protocol for all National Programme & locally common disease should be made available at all CHCs Outsourcing of diet & laundry service. 2 specialists for each specialty. 5 MOs separate for casualty. All MOs trained for basic needs like OBG. Conveyance allowance to MOs. Mobile phones and vehicles for doctors needed in emergency and living outside hospital. One general OPD is a must. C.T. Scan, Modern lab etc. Class IV as per number of beds. All CHC`s should be completely computerized for accurate record maintenance. Computerization is essential for record maintenance and surveillance This can be achieved by outsourcing to the professional body. Provision for a system of hospital waste management of all potentially infectious and hazards waste in accordance with biomedical waste management guidelines. Essential drug list at the CHC level has to be updated to ensure proper treatment. Must have Doctor, Pharmacist, LT, and Radiographer, x-Ray, Driver, Class IV, medicines Biomedical Waste Disposal System is required Mobile phones to ANM so that they can remain connected to the doctors any time in need. Xerox Machine should be provided one for each CHC Telephone: minimum two direct lines with intercom facility should be available. Water Supply - Arrangements shall be made to supply 10,000 liters of potable water per day to meet all the requirements (including laundry) except fire fighting. Storage capacity for 2 days requirements should be on the basis of the above consumption. Round the clock water supply shall be made available to all wards and departments of the hospital. Separate reserve emergency overhead tank shall be provided for operation theatre. Necessary water storage overhead tanks with pumping/boosting arrangement shall be made. Cold and hot water supply piping should be run in concealed form embedded into wall with full precautions to avoid any seepage. Geyser in O.T. / L.R. and one in ward also should be provided. Wherever feasible solar installations should be promoted. Emergency lighting: Use of solar energy wherever feasible may be used. Administrative zone: Separate rooms should be available for Office. Since there are no personnel for the Block Programme Management and as such there is enormous load of work on single shoulders which will not give efficient outputs from the Block Programme Management unit. Therefore one computer clerk and one peon is in need at the CHCs.

Support required	Equipment: 1. Three Computer systems for CHC Ganderbal, CHC Kangan and New CHC to be created at Lar Block Manpower: 1. Three Computer Operators for CHC Ganderbal, CHC Kangan and New CHC to be created at Lar Block 2. Three Peons for CHC Ganderbal, CHC Kangan and New CHC to be created at Lar Block 3. Xerox machines for every CHC in the district.					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Repair OF District Hospital building	x	-	-	-	
	Construction of staff quarters	x	-	-	-	
	Supply of furniture, computer etc	x	-	-	-	
	Providing Internet connectivity	x	-	-	-	
	Recruitment of staff	x	-	-	-	
Budget **Non Recurring**	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Up gradation of CHC as District hospital@ Rs 50 lacs	50.00	0.0	0.0	0.0	50.0
	Staff quarters for District Hospital	27.20	27.20	0.0	0.0	54.40
	Staff Quarter for 04 MOs per CHC @ Rs. 48.0 lac * 3 ***(Rs. 1000 / sft.)***	72.00	72.00	0.0	0.0	144.000
	Staff Quarter for 04 staff nurses per CHC @ Rs. 40.0 la* 3 ***(Rs. 1000 / sft.)***	60.00	60.00	0.0	0.0	120.00
	Staff Quarter for 01 chowkedar per CHC @ 4.0 lac x 3 ***(Rs. 1000 / sft.)***	6.00	6.00	0.0	0.0	12.00
	Furniture 5% CHC building Cost-% available 5% of 40lac -70% (2.00-70%) x 2	1.20	2.00	0.0	0.0	3.20
	Computer, printer, fax @ Rs. 50000 x 3 CHCs	1.50	0	0.0	0.0	1.50
	Mechanical laundry @ 50000 / CHC, DH (50000X3)	1.00	1.00	0.0	0.0	2.00
Recurring	TA @ Rs. 75 / visit X 24 visits per month x 3 x12	0.65	0.715	0.7865	0.86515	3.01665
	Telephone @ Rs. 2000 per month Per CHC x 12 x 3 CHCs	0.72	0.792	0.8712	0.95832	3.34152
	Internet @ Rs. 500 per month x3 CHC x 12 months	0.18	0.198	0.2178	0.23958	0.83538
	Other expenses @ 4000 per month per CHC x 12 months	1.44	1.584	1.7424	1.91664	6.68304
	Maintenance grant -water, electricity @ Rs. 10000 / month x 3 CHC x12 m	3.6	3.6	3.6	3.6	14.4
	Staff for Mech. Laundry 2 persons / CHC @ Rs. 4000/month/person12 x 4	1.92	2.88	3.84	3.84	12.48
Total		**227.41**	**177.969**	**11.0579**	**11.41969**	**427.856 6**

B – 7. Upgrading PHCs for 24 hr Services						
Situation Analysis/	▪ One PHC is working as 24x7 PHC out of 23PHCs ▪ Only one MO available for each PHC. ▪ Only one ANM available for each PHC ▪ Presently no means of communication is available at almost every PHC. ▪					
Objectives	Up gradation of PHC for 24 hr services by providing: 24-hour delivery services, both normal and assisted. Referral for emergencies. Ante-natal care and routine immunization services for children and pregnant women (besides fixed day services). Post-natal care. Early and safe abortion services (including MVA). Family planning services. Prevention and management of RTIs / STIs. Essential laboratory services Computerization of PHC.					
Strategies & Activities	Provision of essential newborn care to every baby can help prevent the development of various complications causing neonatal mortality. The community should be made aware of conditions (danger signs) in which a woman and a child require immediate referral, the transport facilities available, and the place where they should go in case of various emergencies. PHC should try and ensure that the complete package of ante-natal care services, including the essential investigations, is provided to all pregnant women visiting the PHC on all working days. PHC medical officer should ensure that adequate and timely numbers of PNC visits are provided for all deliveries, whether institutional or domiciliary. All 24-hour PHCs should provide round-the-clock counseling services for all the clients desirous of availing contraceptive services. Two MO's and two Lady MOs to provide round the clock delivery services and essential newborn health care are required for each PHC. Outpatient services would be strengthened through postings/appointments of AYUSH doctors, over and above the medical officers posted at the PHCs. Provision of five staff nurses to ensure round-the-clock services. Additional paramedical workers will also be necessary for managing the services like the laboratory, pharmacy and referral transport. Multi skilling of staff is a viable option in these cases including Clerical staff. Residential quarters for Doctors, Nursing Staff, and other paramedical staff. Regular and uninterrupted power supply or provision of generator. Supply of 24-hour running water is needed. Ambulance and drivers needed at PHC's. Computerizing the PHC. Telephones to be provided at each PHC. Dispensary. Arrangements for waste disposals.					
Support required	State & Central government					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Repair OF PHC building	**x**	**-**	**-**	**-**	
	Construction of PHC buildings	**x**	**x**	**-**	**-**	
	Construction of staff quarters	**x**	**x**	**-**	**-**	
	Supply of furniture, computer etc	**x**	**-**	**-**	**-**	
	Providing Internet connectivity	**x**	**-**	**-**	**-**	

	Recruitment of staff	**x**	**-**	**-**	**-**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	All PHCs to be upgraded to 24X7 as per IPHS @ 25% of building cost (3.75 lacs) 08 PHCs in 2008-09, 08 PHCs in 2009-10 & 07 PHCs in 20010-11	30.0	30.00	26.25	0.0	**86.25**
	Construction of 06 PHC buildings @ 15 lac / PHC existing in other than govtt. Buildings ***(Rs. 1000 / sft.)***	45.00	45.00	0.0	0.0	**90.00**
	Staff Quarters for 1 Mo & 3 Staff Nurse / PHCs @ 48.00 lac / PHC* 23 (***Rs. 1000 / sft.)***	552.00	552.00	0.0	0.0	**1104.00**
	Furniture @ 5% of building cost X no. of PHC- % available 75000 X 23-38% available	6.67	0.0	0.0	0.0	**6.67**
	Invertors for staff quarters @15000/PHC x 23 PHCs	3.45	0.0	0.0	0.0	**3.45**
	Computer@40000/PHC x 23	9.20	0.0	0.0	0.0	**9.20**
	Vehicle @ Rs. 3 lacs /per vehicle 13 PHC	39.0	0.0	0.0	0.0	**39.00**
	Washing machines- @ Rs.10000x23 PHC	2.30	0.0	0.0	0.0	**2.30**
	Additional Manpower for 24X7 PHC in 1 PHC / CD Block as per IPHS- (1 MO / block @21000/M)- (2 Nurses/Block @12800 /M)	44.736	89.472	128.616	128.616	**391.44**
	Telephone expenses @ Rs. 2000 / month/PHC x 12 x 23	5.52	6.072	6.6792	7.34712	**25.61832**
	Internet expenses @Rs.500/month/PHCx12x23	1.38	1.518	1.6698	1.83678	**6.40458**
	Electricity charges @ Rs. 5000 per monthX12X23	13.8	15.18	16.698	18.3678	**64.0458**
	POL @ Rs. 300 /case x 80 cases / year/ PHC x 23	5.52	6.072	6.6792	7.34712	**25.61832**
	Driver @ Rs. 4000 / month 12 x 13 PHCs	6.24	6.864	7.5504	8.30544	**28.95984**
	Laundry staff @ Rs.4000 /month/PHC x 12 x 23 PHCs	11.04	12.144	13.3584	14.69424	**51.23664**
	Maintenance & other expenses @ Rs.10000 / month /PHC	27.6	30.36	33.396	36.7356	**128.0916**
Total		**803.456**	**794.682**	**240.897**	**223.2501**	**2062.285**

B – 8. Upgrading Sub Centers						
Situation Analysis/	1. 41 sub centers are currently functional in the District 2. 3 Sub centers are defunct in block Ganderbal. (Total 44 SCs) 3. No water source & electricity or pump in all sub-centers 4. Most of the S/C`s are in the rented buildings 5. All sanctioned posts are not filled up					
Objective	To Upgrade the Sub Centers. The provision of an additional ANM at each sub-centre					
Strategies & Activities	Since every village needs one sub center therefore 47 more Sub centers are to be constructed with efficient toilet facilities. The location of the sub-center should not be too close to PHC or sub-center, so that services are accessible to all within 3 km distance Uninterrupted power supply has to be ensured by provision of inverter facility / solar facility Potable water for patients and staff and water for other uses should be in adequate quantity. The adequate water supply should be ensured and safe water may be provided by use of technologies like filtration, chlorination etc. as per the suitability of the center. Wherever feasible Telephone facility/cell phone facility is to be provided wherever feasible. Residential facility for staff needed. Two ANM's, two MPHW- female, one MPHW-male needed for each Sub center. Sturdy and easy to maintain furniture in adequate quantity should be provided to the sub-center. Provision for waste disposal system. Voluntary worker one funded and one optional to keep sub-center clean. The staff of sub-center will have the support of ASHAs where ever the ASHAs scheme is implemented.					
Support required	Support for funds for electricity, water and telephone should be provided.					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Construction of sub centers	**x**	**x**	**-**	**-**	
	Construction of staff quarters	**x**	**x**	**-**	**-**	
	Procurement of furniture	**x**	**-**	**-**	**-**	
	Recruitment of voluntary workers	**x**	**-**	**-**	**-**	
	Water supply and electricity	**x**	**-**	**-**	**-**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
Non recurring	Construction of SCs @ Rs.5.00 lac / SC * 33 (***Rs. 5.00 lac includes provision of Water supply, electricity, sanitary toilets***)	82.50	82.50	0.0	0.0	**165.00**
	Construction of staff quarter @ Rs.7.50 lac/ SC x 44 SCs (***Rs. 1000 / sft.)***	165.00	165.00	0.0	0.0	**330.00**
	Furniture @ Rs.20000 (5% of Building cost) X 44 SCs	8.80	0.0	0.0	0.0	**8.800**
	Traveling allowance @ Rs. 100/visitX10 visits/SC x 44	0.44	0.484	0.5324	0.58564	**2.04204**
	Electricity charges & other Expenses @ Rs. 1000 / month / SC	5.28	5.808	6.3888	7.02768	**24.50448**
	Voluntary worker @ Rs. 1200 / SC x 44 SC	0.53	0.583	0.6413	0.70543	**2.45973**
Construction of additional new SCs to be sanctioned as per population norms of IPHS 3000/SC (NR)						
	Construction cost of 41SC @ Rs. 3.0 Lac x 48 new SCs(***Rs. 5.00 lac***	120.00	120.00	0.0	0.0	**240.00**

	includes provision of Water supply, electricity, sanitary toilets)					
	Staff quarters @ 7.50 lac / SC X 48 SCs (***Rs. 1000 / sft.)***	180.00	180.00	0.0	0.0	**360.00**
	Furniture @ Rs. 20000/SC x 48 SCs	9.60	00.0	0.0	0.0	**9.60**
Recurring	Voluntary worker @1200 /SC x 48 SCs	0.0	0.576	0.6336	0.69696	**1.90656**
	Traveling & other expense @ 7000/Scx 48 SCs	0.0	3.36	3.696	4.0656	**11.1216**
Total		**572.15**	**558.311**	**11.8921**	**13.08131**	**1155.434**

B-9 Untied Funds and Incentive Fund for the Village Health and Water Sanitation Committees						
Situation Analysis/ Current Status	NRHM has placed a lot of stress on Community involvement and formation of Village Health & Water Sanitation Committees (VHWSC) in each village. These committees are responsible for the health of the village. In District Ganderbal these committees have been formed but need strengthening to improve their functioning. The selection of ASHA, her working, progress of the village is part of the responsibilities of the Gram Panchayat. In Ganderbal there are 119villages with population less than 1500. There are 92 villages with population between 1500 and 3000. There are 9 villages with population more than 3000. Hence these amount to 119units of 1500 population.					
Objectives	Strengthening the Village Health & Water Sanitation Committees through financial support					
Strategies	1. Provision of annual Untied funds of Rs 10000 each year to the villages upto a population of 1500 2. Provision of Rs 5000 as permanent advance fund for Incentives for ASHA					
Activities	1. Provision of Annual Untied funds of Rs 10000 each year to the villages' upto a population of 1500. Villages with more than 1500 population upto 3000 will get twice the funds. Villages with population more than 3000 will get three times the funds. Hence there will be 119 units of population 1500 or less to get the funds annually of Rs 10,000.00.This untied fund is to be used for household surveys, health camps, sanitation drives, revolving fund etc; 2. Orientation of the MPHWF for the utilization of the untied funds and she in turn will orient the Village, Health & Water Sanitation committee. **3.** Provision of Rs 5000 as permanent advance fund for Incentives for ASHA based on performance norms. **4.** Monthly meetings of the VHWSC for reviewing the funds and activities. This is to be facilitated by the MPHWF **5.** Monthly review at the PHC level regarding the VHWSC functioning and utilization of funds.					
Support required	1. State should ensure the orientation procedure for the VHWSC 2. Funds to be transferred on time to the MPHWF 3. PRIs to ensure proper usage and accounts					
Timeline	**Activity/ Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Untied Fund of Rs 10000/unit for Pop 1500/unit x 119 units	x	x	x	x	
	Orientation and reorientation of the VHWSC	x	x	x	x	
	Provision of Rs 5000 as permanent advance for incentives to ASHA	x	x	x	x	
	Monthly meetings of the VHWSC	x	x	x	x	
	Review of the VHWSC functioning at PHC level	x	x	x	x	
Budget	**Activity / Item**	**2008- 09**	**2009- 10**	**2010-11**	**2011-12**	**Total**
	Untied Fund of Rs 10000/unit 1500Population/unit x 119units	1.785	1.9635	2.15985	2.375835	**8.284185**
	Permanent Advance to VHWSC for ASHA incentive @ Rs5000/SC	2.2	4.6	5.06	5.566	**17.426**
Total		**3.985**	**6.5635**	**7.21985**	**7.941835**	**25.7101**

PART C: Immunization

C-1. Cold Chain Maintenance						
Situation Analysis/	1. Presently each CHC possesses ILR/DF 2. Presently each PHC have one ILR and DF. 3. Regular maintenance and minor repair required					
Objectives	Provision of Uninterrupted Power supply. Efficient Running of cold chain equipments. Provision of ILR and Deep Freezer to PHC's which don not have the facility. Provision of waste disposal pits.					
Strategies & Activities	Maintain uninterrupted power supply either by providing solar battery facilities or generator facility. Budget for POL and maintenance of Generator. Waste Disposable pits should be provided in each village. Functional gadgets can be provided. Ensure availability and regular supply of vaccines.					
Support required	Budget for repair and maintenance of ILR and Deep Freezers. Five more vaccine carriers required					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Supply of DG set/ILR/DF/	**x**	**-**	**-**	**-**	
	Construction of Clod Room	**x**	**-**	**-**	**-**	
	Recruitment of Cold Chain engineer	**x**	**-**	**-**	**-**	
	Repair of cold chain equipment	**x**	**x**	**x**	**x**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	District Hospital:DG set @ 1Lac	1	0	0	0	**1**
	DH-ILR @ Rs.20000	0.2	0	0	0	**0.2**
	Deep freezer @ Rs.15000	0.15	0	0	0	**0.15**
	CHC; DG set @ Rs.1 Lac / CHC x 3	3	0	0	0	**3**
	CHC-One I LR@ Rs.20000	0.6	0	0	0	**0.6**
	Stabilizer @ 10000x3	0.3	0	0	0	**0.3**
	Deep freezer@15000x2	0.9	0	0	0	**0.9**
	PHC:DG set @ Rs. 45000/ PHC x 23	10.35	0	0	0	**10.35**
	Stablizer@10000x23PHC's	2.3	0	0	0	**2.3**
	SCs-I ILR at one SC/Block @ Rs.20000x3 blocks	0.6	0	0	0	**0.6**
	Ice pack boxes 1/SC @ 9 lac / district	9	0	0	0	**9**
	Construction of cold chain maintenance room with air condition at CHC @ Rs.5 lac / CHC x 3	10	5	0	0	**15**
	Staff for C.C.M-CCM engineer at CHC @ 15000 / month x 12 x 3	5.4	5.4	5.4	5.4	**21.6**
	Annual maintenance\ @ Rs. 5000 x12 x 3 CHCs	1.8	1.98	2.178	2.3958	**8.3538**
Total		**45.6**	**12.38**	**7.578**	**7.7958**	**73.3538**

C-2. IEC & Social Mobilization						
Situation Analysis/	Awareness generation programs not held regularly					
Objectives	Awareness generation program on need for immunization. Immunization campaigns to be held for increased coverage Social Mobilization campaigns for acceptance of immunization					
Strategies & Activities	IEC activities through mass media like news paper, television, radio etc shall be increased to create awareness on importance of timely immunization. Organize immunization sessions in the remote/tribal areas through MHUs. ASHA considered as social mobilizer. She will mobilize the community for immunization. Incentives will be paid to community mobilizer. Preparation of micro-plans by ANM & holding of MCP sessions as per plan. ANM to give prepare list of drop outs and left outs to ASHA /AWW for motivating the parents for completing the immunization schedule. Provide immunization card and other requirements.					
Support required	Provide IEC/BCC material.					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Conduct IEC programme in village	**x**	**x**	**x**	**x**	
	Mass media activities	**x**	**x**	**x**	**x**	
	Procurement of Audio-visual aids	**x**	**-**	**-**	**-**	
	Establishment of IEC unit at District HQ	**x**	**-**	**-**	**-**	
	Recruitment of IEC staff	**x**	**-**	**-**	**-**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
Recurring	IEC programme on MH, CH,FW for 15-49 age-group women One programme / village / month @ Rs. 100 x 220 x 12	2.64	2.904	3.1944	3.51384	**12.25224**
	One prog. /SC/month @500-Adolescent health-1X44X12X500	2.64	2.904	3.1944	3.51384	**12.25224**
	Drama/film shows @Rs10000/block x 3	0.3	0.33	0.363	0.3993	**1.3923**
	Local T.V Ads. @ Rs.60000/district	0.6	0.66	0.726	0.7986	**2.7846**
Non recurring	LCD player @ 1 lac at district	1	1.1	1.21	1.331	**4.641**
	VCD player @ Rs.5000 /PHC x 23 PHC	1.15	1.265	1.3915	1.53065	**5.33715**
Recurring	News paper messages 12 messages per year @ Rs10000x 12	1.2	1.32	1.452	1.5972	**5.5692**
	Establishment of IEC unit at district-IEC Prog. Manager @ Rs.20000/monthx 12	2.4	2.64	2.904	3.1944	**11.1384**
	Two Artists @ Rs. 5000 /month x 2x 12	3.6	3.96	4.356	4.7916	**16.7076**
	Four Health Educators @Rs.10000/monthx4x12	4.8	5.28	5.808	6.3888	**22.2768**

	IEC activity RNTCP & VBDC@Rs.3 lac/ block x 3 blocks	9	9.9	10.89	11.979	**41.769**
Total		**29.33**	**32.263**	**35.4893**	**39.03823**	**136.1205**

C-3. Alternate Vaccine Delivery Mechanism						
Situation Analysis/	Vaccine not reaching to immunization session sites in time regularly					
Objectives/	Preparation of Micro –Plan for transport of vaccines to every Health Centre on the fixed Immunization days. To deliver the vaccine to the immunization site. Increase coverage of routine immunization to 100%. Immunization support to slums / remote areas of Ganderbal district.					
Strategies & Activities	Ensure vaccine delivery at outreach session. Distribution of vaccine by PHC to session sites in remote locations (Rs 50/- per immunization session for four sessions every month for each sub centre). Special scheme for routine immunization of children Mobile vaccination team to visit each slum / remote areas at least four times in a month. There are many underserved / non motor-able areas in Ganderbal district. t ANM's may be provided tracking bags to immunize these areas.					
Support required	POL for vehicle for mobile vaccine team. Engagement of ANM's in urban slums / remote underserved areas. Material for IEC activities.					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Supply of vaccine at session site	**x**	**x**	**x**	**x**	
	Enumeration of beneficiaries by ASHA	**x**	**x**	**x**	**x**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	POL for vehicles@ Rs 200/session /SC - 200X52X44	4.58	5.038	5.5418	6.09598	**21.25578**
	Incentives to ASHAs- @100/session/ ASHA- (100X52X255)	13.26	14.586	16.0446	17.64906	**61.53966**
Total		**17.84**	**19.624**	**21.5864**	**23.74504**	**82.79544**

C-4. Supervisory Support and Vaccine Transportation						
Situation Analysis/	Ineffective supervision of immunization activities by supervisory staff					
Objectives	To provide safe and effective immunization services Arrangement for vaccine transportation at district level.					
Strategies & Activities	Support for monitoring immunization program to DIOs under NRHM. All the supervisory staff shall be mobilized to monitor and ensure qualitative services. Vaccine transportation van should be provided at district level which will ensure vaccine delivery for 100 % immunization in the district.					
Support required	POL for vehicles used by Supervisors. POL and maintenance for vaccine transportation van. Disposal of syringes and needs at SC level. Identification and reporting of adverse reactions following vaccine.					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Vaccine potency testing	x	x	x	x	
	Training of Health workers	x	x	x	x	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Strengthening vaccine potency testing at site after transportation POL to MO i/c immunization or someone specially trained @ 60000/ district	0.6	0.66	0.726	0.7986	**2.7846**
	Training of Health worker & ANM @ Rs. 250/HW & ANM x 111HWs	0.2775	0.30525	0.335775	0.369353	**1.287878**
Total		**0.8775**	**0.96525**	**1.061775**	**1.167953**	**4.072478**

C-5. HMIS

Situation Analysis/

HMIS is a monitoring tool for the performance that provides information to support planning, decision-making and executive control for managers in the Health & FW department.
Data collected on more then 90 parameters in health sector and it is ongoing activity. Data collected by the ANM is the basis of monitoring. ANM is over burdened with a substantial amount of her time being spent on surveillance related activities. Each year a Community Need Assessment exercise is carried out but the set procedures under the CNAA are generally not followed in development of annual action plans and in their utilization in planning the activities of health workers. The action plans are prepared more as a normative exercise rather than as a management tool for estimation of service needs and monitoring the programme outputs.

There is no horizontal integration of surveillance activities of existing disease control programmes. Absence of clear case definitions, poor supervision and absence of cross checking of the data collected hampers the quality of reporting. Non-communicable diseases are not included in surveillance even though the it's burden is high. Absence of uniform formats for reporting diseases also affects quality of the data collect.

The data from the ANM is sent up to the district level with no analysis done at any of the higher levels. There is no system of feedback to the lower levels in the health system. The transmission of data is affected by poor communication facilities available.

Data is not collected from private practitioners, private laboratories and private hospitals both in rural and urban setting. Data collected during emergencies and an epidemic is of better quality. The response system at the district level is activated only in times of outbreaks.
There is lack of coordination between various departments. Data discrepancy between the data of the Health and ICDS department is observed.. There is large gap between reported and evaluated coverage. The District administrative system not able to make use of the health data.
In District Ganderbal There is a dearth of authentic baseline data especially on IMR, MMR, NMR and TFR in Gandarbal District. There is no clear understanding on classification of diseases. HMIS software capable of handling all the data collected right from the subcenters with online transmission facilities is not available. Computers need to be supplied at each PHC.

Objectives

1. Maintaining of records and reports of health services provided
2. Monitoring the process of collection, compilation and analysis of data..
3. To check the validity of the data

Strategies & Activities

Training of staff for proper record keeping and reporting
To utilize the collected information for future planning.

Time Line	**Activities**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Survey for practices, coverage, behaviour etc through independent agency	x				
	Software development	x				
	Data Entry of each household	x	x			
	Internet connectivity	x	x			**Total**
	Provision of computers for each CHC and PHC	x				4.00
	AMC for computers	x	x	x	x	9.20
	GIS for the district, training and updation	x	x	x	x	82.80

	Printing monitoring Charts	x	x	x	x	6.90
	POL @ 2000/ month	0.24	0.24	0.24	0.24	1.20
Budget	**Activities**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Survey for practices, coverage, behaviour etc through independent agency	15	0	0	0	**15**
	Software development	20	0	0	0	**20**
	Data Entry of each household's health card @ Rs 2 per card x 90000 cards (aprox.)	1.8	0.4	0.8	1.2	**4.2**
	Internet connectivity @ Rs 900 /mth x No of facilities x12 mths	2.808	3.0888	3.39768	3.737448	**13.03193**
	provision of computers for each CHC and PHC @ Rs 60,000/computer system with UPS and printer	15.6	0	0	0	**15.6**
	AMC for computers @ Rs 5000 /computer /year x 26computers	1.3	1.43	1.573	1.7303	**6.0333**
	Consumables for computers @ Rs 4000/mth/facility x 12 mths	12.48	13.728	15.1008	16.61088	**57.91968**
	GIS for the district, training and updation	12	0.5	0.5	0.5	**13.5**
	Printing monitoring Charts @ Rs. 5 per monitoring chart	0.1	0.125	0.15	0.175	**0.55**
Total		**81.088**	**19.2718**	**21.52148**	**23.95363**	**145.8349**

C-6. Supplies and Logistics						
Situation Analysis/	All vaccines are being supplied by GOI. Requirement: about 22,000 to 25,000 doses Additional supplies like AD syringes required					
Objectives/	Immunization of 100 % children by 2011					
Strategies & Activities	Use of AD Syringes and their safe disposal					
Support required	Supply of AD syringe (0.5ml), and (0.1ml)					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Supply of equipment at District Hospital	**x**	**-**	**-**	**-**	
	Supply of equip. at CHC/PHC/SC	**x**	**-**	**-**	**-**	
	Supply of drugs in District Hospital	**x**	**x**	**x**	**x**	
	Supply of drugs in CHC/PHC/SC	**x**	**x**	**x**	**x**	
	Maintenance of equipment	**x**	**x**	**x**	**x**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Equipments at district hospital @22.19lac	22.19	0.00	0.00	0.00	**22.19**
	Equipment at CHC's @ 22.19lac / CHC	44.38	22.19	0.00	0.00	**66.57**
	Equipments at PHs @ 111500X 23	25.645	0.00	0.00	0.00	**25.645**
	Equipments at SCs @ 25680 X44 (48 new SCs)	11.2992	12.326	0.00	0.00	**23.6252**
Recurring	Maintenance of equipments @ 20000/ block x 3 blocks	0.6	0.60	0.60	0.60	**2.40**
	Drugs at district hospital @ 10.00 lac	10.0	10.00	10.00	10.00	**40.00**
	Drugs at CHC @ 10.00 lac X 3	30.0	30.00	30.00	30.00	**120.00**
	Drugs at PHC @ 3.0 lac X23	69.0	69.00	69.00	69.00	**276.00**
	Drugs at SC @ 18135 X44 +(new SCs 41 X 18135 from 2009	7.98	15.41	15.41	15.41	**54.21**
Total		**221.0942**	**159.526**	**125.01**	**125.01**	**630.6402**

PART D: National Disease Control Programme

D-1. RNTCP

Situation Analysis/ Current Status	Indicators New Sputum Positive cases (ACDR) Annual total cases Total new pulmonary TB cases Proportion of new sputum positive out of Total new pulmonary cases Cure rate Smear Conversion Rate Treatment success rate Defaulter cases Failure cases	No. / Rate **New District, Information not presently available in full**				
Objectives	1. More then 70 % Detection Rate to be achieved 2. More then 85% Cure Rate to be achieved					
Strategies & Activities	1. All SCs, PHCs, CHCs and District Hospitals work as DOTS Centers. In addition, the community DOTS providers are also trained to deliver DOT. A room of the CHC is used to function as DOTS centre. Drinking water and seating to be made available to the patients for consumption of drugs. 2. All Medical Officers are trained in RNTCP to suspect symptomatic pulmonary TB,, refer them for sputum microscopy and be able to categories the patients and handle side effects of anti TB drugs. 3. Multi Purpose Workers (MPWs), Pharmacists and Staff Nurses are trained to monitor consumption of anti TB drugs by the patients. 4. Drugs in patient wise packets and loose drugs should be provided at DOT Centers through District TB Centre (DTC). 5. ASHA to be DOTS provider (Rs 500/- per year each). PRI's also can help. (This is included in ASHA budget). 6. Initial defaulters up to 4% by 2007/08. 7. Address verification issues. 8. Electronic information sharing. 9. Lab Technicians to be trained to reduce defaulters in treatment. 10. Risk allowance for people working with TB. 11. Strengthen prevention – wearing of masks by patient. 12. Paid sputum's – must write distance from DMC (carriage). 13. IEC activities for improved treatment seeking behavior for symptoms suggestive of suspected TB					
Support required	1. Persons carrying the sputum to DMC 2. Every health centre should be a collecting centre 3. Private DOT provider may be paid as a Govt rates. 4. Telephones and computers					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Improving the DTC building, MC Centres and TC centres	x				
	Increasing the DOT providers through ASHAs	x	x	x	x	
	Training to RNTCP staff and ASHA	x	x	x	x	
	Awareness drives	x	x	x	x	
	Mask Provision					

Budget	Activity / Item	2008-09	2009-10	2010-11	2011-12	Total
	Civil Works					
	DTC building 1.5 lakhs	1.5	0	0	0	**1.5**
	MC 0.28/MC	4.76	0	0	0	**4.76**
	TU 0.35/Tu except DTC	1.05	0	0	0	**1.05**
	Material and supplies	1.32	1.45	1.6	1.76	**6.13**
	Laboratory material	1.1	1.21	1.33	1.46	**5.1**
	Training	15.7907	17.36974	19.10671	21.01738	**73.2845**
	Awareness drive on World TB day	1.00	1.1	1.21	1.33	**4.64**
	IEC activities	1.00	1.1	1.21	1.33	**4.64**
	Vehicle hiring for STS/STLS in winter @ 1 lakh	1.00	1.1	1.21	1.33	**4.64**
	Salaries of contractual staff	8.76	9.636	10.5996	11.65956	**40.65516**
	Vehicle maintenance inc POL	1.00	1.1	1.21	1.33	**4.64**
	4 wheeler					
	Hiring of vehicle	1.7	1.87	2.06	2.27	**7.9**
	DTO					
	MO TC @ Rs 0.42lakh/yr					
	Equipment and maintenance	0.085	0.094	0.103	0.113	**0.395**
	Microscope @ Rs1000/yr/microscope					
	Computer@ Rs 5000/yr					
	Photocopier/Fax Rs2500/ machine					
	Miscellaneous – TA/DA, Telephone, Meetings, Electricity repair etc	0.195	0.215	0.247	0.272	**0.929**
Total		**40.26067**	**36.24474**	**39.88631**	**43.87194**	**160.2637**

Detailed Calculations

Training in RNTCP

Personnel	Unit Cost	Units	2007-08
DTO	State		
MOTC	23320	3	69960
MO	15580	46	716680
STS	6726	2	13452
STLS	16720	2	33440
LT	5972	30	179160
ANM	2875	197	566375
			1579067

Personnel RNTCP

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

D-2. LEPROSY						
Situation Analysis	1. Balance Cases at beginning of year NA 2. New cases detected in year NA 3. Cases Discharged in year NA 4. Balance Cases at end of year NA 5. Per 10,000 Population NA 6. Proportion of Deformity Ratio among cases NA					
Objectives	1. Awareness Program among the people.					
Strategies & Activities	1. To hold awareness programs among the people so that people will be aware of the Leprosy disease 2. Public awareness (IEC activities) by group meetings, pamphlets/ handbills/ public announcements etc					
Timeline	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	House to house detection	x	x	x	x	
	Wide publicity	x	x	x	x	
	Rigorous follow-up	x	x	x	x	
	Treatment	x	x	x	x	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Treatment -1 (240x 393.01)	0.943	1.038	1.141	1.255	**4.377**
	Treatment -2 (240x 1167.53)	2.801	3.081	3.389	3.728	**12.999**
	IEC for information on the disease to be spread all over the rural outposts through posters and instructional booklets.	2.00	2.200	2.420	2.662	**9.282**
	Total	**5.744**	**6.318**	**6.950**	**7.645**	**26.657**

D-3. NATIONAL MALARIA CONTROL PROGRAMME						
Situation Analysis	**Issues**				**No.**	**%**
	1. Total Blood Slides Examined (BSE)				NA	
	2. Total Positive Cases:				NA	
	3. Slide Positivity Rate (SPR)				NA	
	4. Slide Positive Plasmodium Falciparum Rate (PFR)				NA	
	5. Annual Blood Examination Rate (ABER)				to NA	
	6. Deaths				NA	
Objectives	Awareness program be held.					
Strategies & Activities	1. Health educator should be given remuneration for promoting awareness programs regarding malarial disease. 2. Public awareness on vector borne diseases (IEC activities) by group meetings, pamphlets/ handbills/ public announcements etc					
Support required						
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Procurement of fogging machine, spray machine	**x**	**-**	**-**	**-**	
	Recruitment of staff	**x**	**-**	**-**	**-**	
	Procurement of Phenyl	**x**	**x**	**x**	**x**	

Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**TOTAL**
Non recurring	Fogging machine for each block & D.H @ Rs.10.00 lacs	10.00	0	0	0	**10.00**
Recurring	Two spraying machines for each block @ Rs. 5000/ blockx2x3 Blocks	0.30	0	0	0	**0.30**
	Staff 2 persons / block @ Rs.5000/ month x12 x2x3	3.60	3.6	3.6	3.6	**14.40**
	Phenyl Rs. 20000 /block x 3	0.60	0.66	0.726	0.7986	**2.7846**
Total		**14.50**	**4.26**	**4.326**	**4.3986**	**27.4846**

D-4. OTHER VECTOR BORNE DISEASES						
Situation Analysis	Other VBDs Kala-azar Dengue Lymphatic Filariasis Japanese Encephalitis	No. NA NA NA NA				
Objectives	1. Awareness Program be held for other vector borne diseases					
Strategies & Activities	1. Public awareness (IEC activities) by group meetings, pamphlets/ handbills/ public announcements etc					
Support required	Activity Plan	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Recruitment of Programme Officer/DEO	**-**	**-**	**-**	**-**	
	Supply of Computer etc	**-**	**-**	**-**	**-**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
Recurring **Non recurring**	Programme Officer for Preventive measures @ Rs. 20000 / month x12	2.4	2.4	2.4	2.4	**9.6**
	Data entry operator @ Rs. 8000 /M	0.96	0.96	0.96	0.96	**3.84**
	Computer etc @ Rs. 50000/ district	0.5	0	0	0	**0.5**
Total		**3.86**	**3.36**	**3.36**	**3.36**	**13.94**

D-5. BLINDNESS CONTROL PROGRAMME						
Situation Analysis	**Indicators**			**No.**		
	Total Cataract surgery performed			57		
	Cataract surgery with IOL			NIL		
	School going children screened			NIL		
	Children detected with refractive error			NIL		
	Children provided with free corrective spectacles			NIL		
	Villages having no register					
Objectives	1. Diagnosis and Treatment of Common Eye Diseases 2. Provision for primary Eye Care & Vision Testing.					
Strategies & Activities	1. Prepare a team for conduction of ophthalmic checks in the in the schools at district level. 2. Provision for Surgical Services including Cataract Surgery (by IOL implantation) at CHC level. 3. To detect almost all cataract cases in the district.					
Support required	Manpower: - Eye Surgeon (trained in IOL Surgery), Ophthalmic Assistant for each CHC.					
Timeline	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	H-H Survey for Vision defects	**x**				
	IEC activities	x	x	x	x	
	School Eye Screening					
	Blind Register	x	x	x	x	
	Cataract Camps	12 PHC	11 PHC	0 PHC	0 PHC	
	Development of PHC and CHC as Vision Centre	3 CHC	12 PHC	11 P HC		
	Development of CHC for Eye Unit	3	0			
	Training of School teachers	100	100	100	100	
	Training of Numbardar / Chowkedar	100	100	100	100	
	Repair and purchase of equipment and maintenance	x	x	x	x	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	IEC @2lakh	2.00	2.20	2.42	2.662	**9.282**
	School Eye Screening @1000 X100 school	1.00	1.10	1.21	1.331	**4.641**
	Blind Register	0.22	0.242	0.2662	0.29282	**1.02102**
	Cataract Camps @ Rs 40000 per camp x 12 PHC	4.8	4.40	0	0	**9.200**
	POL fro Eye Camps @ Rs 2000/camp x10	0.2	0.22	0.242	0.2662	**0.9282**
	Training of School teachers @ Rs 100/head x 100	0.1	0.11	0.121	0.133	**0.464**
	Training of Numberdar / Chowkedar @ Rs 100/head x 100	0.1	0.11	0.121	0.133	**0.464**
	Repair and purchase of equipment and maintenance	20.00	2.00	2.20	2.42	**26.62**
Total		**28.42**	**10.382**	**6.5802**	**7.23802**	**52.62022**

D-6. Integrated Disease Surveillance Programme						
Situation Analysis/	The vertical diseases control; **programs with surveillance components** include: • The National Anti-Malaria Program • National Leprosy Elimination Program • Revised National Tuberculosis Control Program • Nutritional Surveillance • National AIDS Control Program • National Polio Surveillance Program as part of the Polio eradication initiative • National Programme for Control of Blindness (Sentinel Surveillance) Surveillance activities of all these vertical programs of Malaria, Tuberculosis, Polio, HIV are functioning independently leading to duplication of surveillance efforts. Surveillance has been ineffective due to ▪ Multiple systems existing under various programs which are not integrated. ▪ The existing programs do not cover non-communicable diseases. ▪ Medical colleges and large tertiary hospitals in the private sector and laboratories are not under the reporting system The laboratory infrastructure and maintenance is very poor ▪ Presently, surveillance is sometimes reduced to routine data gathering with sporadic response systems thereby leading to slow response to outbreaks. ▪ Information technology has not been used fully for collection of information and to analysis of data so as to predict epidemics based on trends of the reported data. In response to these issues the Integrated Disease Surveillance Programme was launched in J & K to provide essential data to monitor progress of on going disease control programs and help in optimizing the allocation of resources. IDSP includes 15 diseases/ conditions (Malaria, Acute diarrheal disease-Cholera, Typhoid, Jaundice, Tuberculosis, Acute Respiratory Infection, Measles, Polio, Road Traffic Accidents, Plague, Yellow Fever, Meningoencephalitis /respiratory distress, etc., HIV, HCB, HCV)) and 5 state specific diseases (Thyroid diseases, Coetaneous Leishmaniosis, Acid Peptic Diseases, Rheumatic Heart Diseases).					
Objectives/ Milestones/ **Benchmarks**	1. To forecast outbreak / epidemic and take containment measures 2. To know disease pattern in district. 3. Manage surveillance by using existing resources and involving other Departments, NGOS and Panchayats. 4. Assessment of labs and identification of needs for strengthening surveillance activities.					
Strategies & Activities	1. The IEC activities 2. Training of staff in surveillance activities. 3. Up gradation of laboratories					
Support required	1. Separate vehicle, staff and office buildings. 2. Additional budget is required 3. Additional staff required: administrative assistant, accountant, class IV and sweeper					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Procurement of furniture, computer etc	**X**	**-**	**-**	**-**	
	Recruitment of Epidemiologist, Microbiologist, DEO, Lab. technician	**X**	**-**	**-**		
	Training of Staff in IDSP	**x**	**x**	**x**	**x**	
	Printing of registers/reporting formats	**x**	**x**	**x**	**x**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**

Recurring	Furniture @ Rs. 1.00 lac / district	1.00	0.0	0.0	0.0	**1.00**
	Computer etc @ Rs. 50000/district	0.5	0.0	0.0	0.0	**0.50**
	Vehicle @ Rs. 5.00lac	5.00	0.0	0.0	0.0	**5.0**
	Epidemiologist-1@Rs.23000/M x 12	2.76	2.76	2.76	2.76	**11.04**
	Micro biologist-1 @ 23000/ month	2.76	2.76	2.76	2.76	**11.04**
	Data operator @ 8000/monthx12	0.96	0.96	0.96	0.96	**3.84**
	Lab. Technician-2@ 9900/month	2.38	2.38	2.38	2.38	**9.52**
	Register & formats etc @Rs. 30000/ block	0.30	0.3	0.3	0.3	**1.20**
	Training of staff @ 50000/district	0.5	0.5	0.5	0.5	**2.00**
	POL for vehicle @ 3000/month	0.36	0.36	0.36	0.36	**1.44**
	Driver @ 4000/ month x 12	0.48	0.48	0.48	0.48	**1.92**
Total		**17**	**10.5**	**10.5**	**10.5**	**48.5**

D-7. Iodine Deficiency Disorders						
Situation Analysis/ Current Status	Iodine is one of the essential micronutrients. Iodine is taken from food grown in iodine rich soil. At present there is a depletion of Iodine in the soil due to which there is a deficiency of Iodine. Deficiency result in a variety of disorders ranging from Abortion, stillbirths, Goiter, impaired mental function, retarded growth. In J & K the National Iodine Deficiency Programme is being implemented. People in J & K consume rock Salt and crystal salt					
Objectives/	1. Prevention of Iodine Deficiency diseases 2. Consumption of Iodized salt by 100% families					
Strategies & Activities	1. Assessment of the magnitude of the problem 2. Supply/monitor quality of Iodized salt 3. Laboratory Monitoring of Iodized salt and urine samples 4. Health Education					
Support required	1. Regular Supply of Testing Kits 2. Regular Supply of Iodized salt 3. Regular supply of IEC material					
Timeline	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-2012**	
	Testing kit Supply	x	x	x	x	
	Programme in schools – 100 Primary, Upper Primary, Secondary- Govt and Private by School health team	x	x	x	x	
	Awareness programme with the SHGs and shopkeepers	220 villages	220 villages	220 villages	220 villages	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Programme in schools – 100 Primary, Upper Primary, Secondary- Govt and Private school by School health team	2.00	2.20	2.42	2.662	**9.282**
	Awareness programme with the SHGs and shopkeepers @ Rs 500 per village x 220 villages	1.10	1.21	1.331	1.4641	**5.1051**
Total		**3.1**	**3.41**	**3.751**	**4.1261**	**14.3871**

6: Areas of Inter-Sectoral Convergence

Partnership with AYUSH department

Issues / Areas	Areas of cooperation	Areas of convergent action
Curative ; Patient care, Surveillance referral	In order to provide Medicare facilities to the masses there is a vast potential for cooperation with health department so as to implement all the national programs like National Malaria Control Programme, T.B. control programme (DOTS), HIV / Aids awareness programme, implementation of RCH services The cooperation is also needed from the department of social welfare, (ICDS) Anganwari centers located in the areas where the ISM dispensaries are functioning. Anganwari workers can bring the unvaccinated children to the nearest ISM institutions so that their complete vaccination is ensured. As per earlier practice, medical officer of the concerned ISM institution was visiting Anganwari centre once in a month. This should be started for general health check up of the children of Anganwari centres.	The ISM doctors are providing the health & Medicare services using Ayurvedic / Unani medicine. AYUSH dispensaries are located in the isolated and far flung areas where health facilities like primary health centres / community health centres or even allopathic dispensaries are not available. In case of emergencies, people are likely to be attended by Ayurvedic / Unani doctors or staff. Therefore there is dire need of emergency drugs, life saving drugs, bandaging material, antiseptic lotions, antibiotics which are not supplied in ISM dispensaries. Due to non availability of these drugs in some cases precious lives are lost and wrath of people falls on the staff of ISM institutions. Therefore life saving drugs, antiseptic lotions & dressing materials need to be supplied to avoid suffering of the ailing masses.
Preventive; Immunization, Prophylaxis services Promotive, IEC	Health department's can provide ILR and Deep freezers to the ISM dispensaries. ISM Dispensaries are without immunization facility and also lacking cold chain facility, twelve ISM dispensaries which are working in Pacca buildings having electric supply should be immediately provided cold chain facility in the form of ILR's & deep freezers.	Routine vaccination as well as out reach vaccination camps can be easily organized in remotest & far flung areas once facility of cold chain in the form of ILR's & deep freezers is provided to ISM institutions. IEC funds should be kept at the disposal of the Asstt. District. Medical officer for awareness programmes.
Specific issues in Implementation of national programme for maternal care	Health Department to assist ISM institutions & to provide kits of Iron Folic Acid tablets directly to the ISM dispensaries through the Asstt. District. Medical officer. All ASHAs working in the areas of ISM institutions should be given training on providing emergency health care services.	Only Ayurvedic / Unani medicines which contain iron are given to pregnant women for deficiencies of Iron at present.ISM Doctors can treat pregnant women as well as cases of iron deficiency anaemia afterIron folic acid tablets provided to ISM institutions In
Child care	Health department may provide kits containing Iron & folic acid (small) , Antihelminthics and Septran (paediatric) to Assistant District Medical officer for supply to all the ISM institutions. Functionaries of Social Welfare Department can cooperate in bringing	ISM dispensaries can provide better care of children suffering from iron deficiency anemia, worm infestation & other diseases. If kits containing Iron, Septran (Paed) & Antihelminthics tabs are provided to them. Anganwari workers / helpers bring the children to the ISM Dispensaries on a fixed day of immunization. Goal of 100 % immunization can be

	unvaccinated children to the dispensaries.	achieved by cooperation from AYUSH and Social Welfare Department.
Adolescent health	Health department & Education department organis camps for the awareness of adolescent age group. Ayurvedic / Unani doctors should be involved in such camps to give talks on Adolescent Health issues. Such camps can be organized at ISM institution. Education department can cooperate with ISM institutions in areas through Chief or Zonal Education Officers. Medical Officer of area should visit schools & give awareness lectures to the adolescent children on different issues.	Some funds should be kept at the disposal of the concerned ADMO for procuring IEC materials like banners / posters etc. for organizing awareness camps. People living in remotest & far flung areas particularly adolescent can be benefited from this awareness campaign as most of the ISM institutions are in remotest & far flung areas.
School Health	Education department's help is needed for the health check up of children as was done as a routine few years back.	ISM Doctors are willing to provide these services for general health check up of children of different schools if approached by the concerned chief education officer/ Zonal education officers, the
Leprosy	Cooperation from health department is needed to train ISM doctors/ Paramedical staff. All ISM doctors, paramedical staffs should be given training to address sensitive health issues like Leprosy.	Once diagnosis of a case of leprosy is done, anti-Leprotic drugs should be made available directly to ISM institution so that patients can avail the medicines from the nearest dispensary
IDD	Support in salt testing and IEC activities	AYUSH doctors can be involved in IEC activities such as creating awareness about iodine deficiency diseases and use of iodised salt
Tuberculosis	Health department should cooperate with ISM department & all ISM doctors /paramedical staff should be trained through regular training / workshop from time to time.	DOTS Drugs should be provided directly to ISM dispensaries so that patient of Tuberculosis can avail the facility from the nearest dispensary as in some far flung areas. There is no existence of allopathic institutions & only ISM institutions are catering the health needs of the areas
HIV/AIDS	Cooperation from health department is needed for training of ISM Doctors / Paramedical staff for AIDS. Regular workshops training Programmes should be organized so that knowledge of the staff is updated about the disease.	Funds for AIDS awareness camps should be kept at the disposal of Asstt. District. Medical officer at District. Level so that IEC material like Banners , pamphlets etc should be disturbed to the masses so that exact cases of the disease its sign & symptoms are known to the people or IEC material from health (allopathic) department should be supplied to the ADMO's
Water borne diseases	Cooperation of Public Health Engineering Department & Health Department is needed for control and prevention of water born diseases. Chlorine tablets should be supplied.	In order to check the cases of the water borne disease in particular area, chlorine tablets & other drugs should be supplied to the ISM institutions so that Medical officers / officials can use it and also treat the cases. IEC materials related to prevention of water born diseases should be kept at the disposal of ADMOso that according to need it should be distributed to the masses & awareness camps about the safe drinking water can be organized.Major source of drinking water is well, springs, & the water is often polluted in rainy season.

RTI/ STI	Health department to provide medicines, antibiotics as to check RTI / STI. One laboratory technician with laboratories should be given to dispensaries	As antibiotics are provided to ISM institutions, Medical officers of these institutions can treat the patients of RTI /STI. by providing laboratory facilities in these institutions which are situated in remotest areas , the diagnosis of diseases Is made in initial stage that helps in early treatment of the patient.

6.2 Department of Women & Child Development

Issues / Areas	Areas of cooperation	Areas of convergent action
Basic Health Services	• AWW will record births and deaths and will report these to ANM. • Weighing the babies and referring the babies with low weight for consultation to ANMs during her visits to anganwadi. • Visiting and counseling mother and the newborn at least 3 times in the first week of the postnatal period. • Assist ANM in vitamin-A supplementation to children in the age group of 9 months-3 years. • Motivation of pregnant mothers for ANCs, to take IFA tablets and TT vaccinations. • Motivating the mothers for institutional deliveries for which AWWs will get activity-based incentives. • Tracking children who have not completed vaccination and reducing the drop outs.	AWW share information/records of pregnant mothers and newborns with ANMs AWW help in tracking beneficiaries and bring them for immunization They keep community informed of next session's date of health checkup camp and immunization. AWW should reports disease outbreaks in the village to ANM. IEC to be developed and disseminated to the community regarding food and nutrition. For proper management of malnourished cases, medicines will be supplied along with the PHC and CHC drug kits annually.

6.3 Rural Development Department

Issues / Areas	Areas of cooperation	Areas of convergent action
Health services in remote villages and to BPL, SC and ST population is inaccessible	Villages without motor able roads. Details of BPL families. Details of Scheduled Caste (SC) and Tribal (ST) population.	Information available with Rural Development Department which helps in planning

6.4 Public Health Department

Issues / Areas	Areas of cooperation	Areas of convergent action
Population not using domestic / community toilets have greater chances of epidemics	Total no. of families where all members are using domestic/ community toilet	Information helps in planning of control and prevention of diseases

6.5 PRIs

Issues / Areas	Areas of cooperation	Areas of convergent action
Community participation in health programme is neglible	Constitution of Village Health and Sanitation Committee	Need assessment for health services, involvement of PRI members in planning and monitoring of health services, owning of health related activities

6.5 Education Department

Issues / Areas	Areas of cooperation	Areas of convergent action
Poor nutritional status of school going children	• Total no. of schools giving cooked midday meals. • No. of families getting grains from PDS shop. • No. of families getting free grains from PDS shop.	• Medical check up of school going children • Health sanitation education • DT and TT Immunization • Adolescent Health

Inter Sectoral Convergence						
Situation Analysis	**Indicator** **No. (%)** Households having access to potable drinking water Households having access to sanitary toilets					
Objective	Bring convergence in activities of different government department with a view to better resource mobilization, unity of purpose and better output through cooperation and coordination					
Benchmarks	No. of coordination meetings at district, block and village level					
Strategies & Activities	Organise coordination meetings at district, block and village level					
Support required	Financial support for conduction of meetings					
Timeline	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Meetings of the Block Committees	x	x	x	x	
	Joint monitoring at the sector level	x	x	x	x	
	Hiring of vehicle	x	x	x	x	
	Joint monitoring at the block level	x	x	x	x	
	Yearly joint Planning Workshops at the Block level for development of the Action Plans	x	x	x	x	
	Yearly joint Planning Workshops at the District level for development of the Action Plans	x	x	x	x	

	Yearly joint Workshops to consolidate the plans from the village to the Sectors and then Blocks at the Block level for Annual Action Plans	x	x	x	x	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Meetings of the Block Committees @ Rs 1000 /meeting x 3 blocks x 12 months	0.36	0.396	0.4356	0.47916	**1.67076**
	Meetings of the Village groups @ Rs 100 per village x 220 villages x 12	2.64	2.904	3.1944	3.51384	**12.25224**
	Yearly joint Planning Workshops at the Block level for development of the Action Plans @ Rs 0.5 lakhs per block x 3 blocks	1.5	1.65	1.815	1.9965	**6.9615**
	Yearly joint Planning Workshops at the District level for development of the Action Plans @ Rs 1.00 lakh	1.00	1.10	1.210	1.331	**4.641**
	Yearly joint Workshops to consolidate the plans from the village to the Sectors and then Blocks at the Block level for Annual Action Plans @ Rs 1.00 lakhs per block x 3blocks	3.00	3.30	3.630	3.993	**13.923**
	Yearly joint Workshops to consolidate the findings at the block levels at the District level for development of the Action Plans @ Rs 1.00 lakh	1.00	1.10	1.210	1.331	**4.641**
	Training of PRIs/,VHWS committee members under Chiranjeevi Scheme @22 lakhs	22.00	22.00	22.00	22.00	**88.00**
	Regular monthly meetings under Chiranjeevi Scheme @12 lakhs	12.00	12.00	12.00	12.00	**48.00**
	Development of Education material and hands on training under Chiranjeevi Scheme @ 10 lakhs	10.00	10.00	10.00	10.00	**40.00**
	Total	**53.5**	**54.45**	**55.495**	**56.6445**	**220.0895**

7. COMMUNITY ACTION PLAN

Community Health Action						
Situation Analysis/	**Village level** : Constitution of Village Health Water and Sanitation Committees have been constituted ıge Health Water and Sanitation Committees should be actively involved and reviewed by the Local ge heads based on village health plans. **Block level** : Rogi Kalyan Samiti is formed and is functioning at Block Level CHC. **District level** District Health Society has already been constituted and functioning.					
Objectives	Preparation of training module for the training of members of VHSC Formation of Block Committee for monitoring Coordinate the implementation of programme Seek financial/ technical support for preparation of district PIP.					
Strategies & Activities	Members of Village Health, Water and Sanitation Committee shall be trained. Regular meetings of the committee, twice a month, shall be held twice a month. District Development Committee shall review the implementation of village and Block Health Plans. Good District Action Plan will ensure good quality of health services in the District. Organization of Health Camps in every Sub Health Centre catchments area. Organization of a public hearing in every cluster (PHC area) within a block. Organizing Block level team with a mandate for holding health camps and public hearings. Prioritize the community activities as per the need of the community.					
Support required	Preparation of "Operational Guidelines for District Health Societies".					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Planning meetings at village level	x	x	x	x	
	Preparation of Block action Plan	x	x	x	x	
	Preparation of District action Plan	x	x	x	x	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Village level @ Rs. 500/VHWSCx44	0.22	0.242	0.2662	0.29282	**1.02102**
	PHC level RKS@ Rs.5000/RKSx 23	1.15	1.265	1.3915	1.53065	**5.33715**
	New VHWSC - 48X500 from 2009	0	0.24	0.264	0.2904	**0.7944**
Total		**1.37**	**1.747**	**1.9217**	**2.11387**	**7.15257**

Public Private Partnerships						
Situation Analysis/	The private sector like NGOs, Private Practitioners, Trade and Industry Organizations, Corporate Social Responsibility Initiatives are major provider of curative health services in the country. These organizations also contribute in national health programmes. For example 43% of the total IUD clients get services from the private sector. Forging public private partnership for provision of family planning and other RCH services has the potential to significantly expand the coverage of quality FP and RCH services. Public-private partnerships can generate and meet demand for RCH services as these organizations provide good quality services and acceptance by community. To ensure efficient services of good quality from the private and public sectors, monitoring and regulatory mechanisms need to be developed. Private sector can participate in all the National Health Programmes and also share scare resources. At present, Public Private Partnership for health services does not exist in the district. No initiatives have been taken to forge Public Private Partnership.					
Objectives	Partnership with NGO's, Private Practitioner's, Industry organization for various health services, ambulance services and outsourcing of laundry, canteen, security, scavenging services					
Strategies & Activities	1. Committee shall be formed for consultation with NGO's and industry organizations for the resource mobilization. 2. Entering into public-private partnerships and hiring specialists from private sector. 3. Formation of partnership with NGO's for providing Services like ambulances, mobile clinics health camps. 4. Outsourcing laundry, food, security services to private organizations for quality. 5. Incentives to be given to NGO's for their works.					
Support required	Equipments, Ambulances, diagnostic equipments Manpower: Health Volunteers.					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Feasibility study	**x**	**-**	**-**	**-**	
	Oerationalising PPP	**x**	**x**	**x**	**x**	
	Establishment of TSA	**x**	**x**	**x**	**x**	
	Innovative activities based on the study	**x**	**x**	**x**	**x**	
	Preparation of Directories	**x**	**-**	**-**	**-**	
	Training Need Assessment	**x**	**-**	**-**	**-**	
Budget-Non Recurring	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Feasibility study @ Rs. 9.0 lacs	9.00	0.00	0.00	0.00	**9.00**
	Operational frame work @ Rs.2.0 l	9.00	0.00	0.00	0.00	**9.00**
	Innovative activities based on the study	20.00	20.00	20.00	20.00	**80.00**
	Operationalisation of PPP@10.00 l	10.00	0.00	0.00	0.00	**10.00**
	Advertisement expenses for TSA @ Rs. 15000	0.15	0.00	0.00	0.00	**0.15**
	establishment cost of TSA @ 9.0 lac	9.00	0.00	0.00	0.00	**9.00**
	Preparation of directories of Pvt-. Partners and resource agencies @ 10.0 lac	5.00	0.00	0.00	0.00	**10.00**
	TNA for Pvt. Partners 1.00 lac	1.00	0.00	0.00	0.00	**1.00**
	Innovative interventions @ 1.0 lac / block x 3 blocks	3.00	3.00	3.00	3.00	**12.00**
Total		**66.15**	**28.00**	**23.00**	**23.00**	**140.15**

Gender and Equity						
Situation Analysis/ Current Status	Gender discrimination has a direct bearing on the health status of women and children. Some of the parameters indicative of gender discrimination are the adverse sex ratio, lower age at marriage, lesser enrolment of girls in schools, less no. of males accepting sterilization. The main reasons are culture, social costumes like dowry and lower status of women in the society. No specific data on **Gender Based Violence** are available Women take it as part of marriage and hence undermine the facts. **Male involvement in Family Welfare** is minimal and there are very few acceptors of vasectomies as compared to Tubectomies. The **morbidity and mortality** rates also show differential values for boys and girls. The health service providers are also not **gender sensitive**.					
Objectives/ Milestones/ Benchmarks	1. Improve service environment (facilities) for gender sensitive services. 2. Reduce the adverse sex ratio 3. Awareness programme to be held for increasing age at marriage, higher status of women. 4. Avod gender discrimination in provision of health services					
Strategies & Activities	1. Awareness Programs to be held by ASHA's and ANM's about the rights of women in the society, importance of marriage at the permissible age. 2. ASHA and ANMs to be trained for the awareness programs 3. Reduction in sex selective MTP (this is under family planning table) 4. Workshops of the village heads, imam's of the village and other dignified people of the village to disseminate information about the medical disadvantages of early marriage, differentials in enrolment of school children on sex basis and other domestic violence					
Support required						
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	IEC campaign through print audio visual and folk media	x	x	x	x	
	Capacity building	x	x	x	x	
	Orientation of public and Pvt health care providers including NGOs on various laws related to health specially PC-PNDT & MTP act	x	x	x	x	
	Reorientation	x	x	x	x	
	Development/procurement training modules					
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011- 12**	**Total**
	IEC Campaign @2000 X220 villages	4.4	4.84	5.324	5.8564	**20.4204**
	Periodic Advisory committee meetings @ 10000	0.4	0.44	0.484	0.532	**1.856**
	Development of Trg. Modules	1.00	0	0	0	**1.000**
	Training of MO's &,ANM's	2.00	2.2	2.42	2.662	**9.282**
	Workshops with private providers, IMA members, Religious leaders, Caste leaders, Community leaders and women groups	10.00	11.00	12.10	13.31	**46.41**
Total		**17.8**	**18.48**	**20.328**	**22.3604**	**78.9684**

Capacity Building					
Situation Analysis	1. Medical, paramedical staff and PRI members require clear understanding of goals, strategies activities and output of NRHM activities causing difficulty in execution of these activities.				
Objectives	1. Training of members of VH&SC in NRHM. 2. Training for implementation IMNCI in the district to manage sick neonates and children in phased manner. 3. Training of Skilled Birth Attendants.				
Strategies & Activities	1. ANMs will be trained to improve their skills as skilled birth attendants (SBAs). 2. Providing short-term training to medical officers in anesthesia and emergency obstetrics care. 3. Training of MOs, BHOs, HVs, and FHWs in IMNCI. 4. Train 40 MOs in CEmOC / BEmOC, Emergency neo natal care, NSV in next 5. three years (at least the city doctors) 6. Training of MOs in MTP in each block level. 7. Training of MOs, ANMs / Staff Nurses to provide quality RTI / STI services and counseling. 8. Training of MOs, ANMs / Staff Nurses, ANMs, SBAs especially on danger signs in new born care facility. 8. One TBA per village is the norm but require extra TBAs for larger villages. 9. Importance of Immunization, Institutional deliveries, Family Planning etc. will be showed on television and VCD Player in the waiting room of the hospitals where patients are waiting for check ups. 10. Provision of one LCD Projector and one Laptop in each block for organizing training programme.				
Support required	Manpower: Clerk-1, Class IV-1, Computer Operator-1, Peon-1 Resources: One training hall (at least 100 seat capacity Training modules, service guidelines for MOs. Logistics: One computer. One TV VCD/DVD Player. One projector, one laptop.				
Timeline	Activity Plan	**2008-09**	**2009-10**	**2010-11**	**2011-12**
	Construction of Training Hall	**-**	**-**	**-**	**-**
	TBA training				
	MVA / MTP training to all PHC MOs				
	Training on Blood transfusion for MOs and Lab Technicians of CEmOC centres - 3 days				
	Training in Obstetric management & skills for 24x7 PHC for 16 weeks				
	Training in Skilled Birth attendants for 15 days				
	IMNCI training to ANM/LHV, SN, ASHA for 8 day				
	IMNCI training to MOs				
	Training in Life saving/Anaesthesia for EmOC at CHC for MOs (State Budget)				
	Integrated skill training of Staff Nurses				
	Integrated skill training for ANMs				
	Integrated skill training for MOs				
	Training of MOs/ SN in Mgt of Newborns & sick children at Medical College				
	Training in BCC for MOs, LHV, ANM				
	Training of Ayush personnel on issues of RCH and reporting				
	Training on NSV for MOs at NSV camps				

	Training on Minilap				
	Training for Laparoscopic Sterilization-Surgeons, Gynaecologists, SN, OT attendants-12 days				
	Orientation on contraceptive devices for MOs - Govt as well as private facilities				
	Training on Medico-legal aspects to MOs				
	CME sessions for doctors each month during the monthly meetings on current topics				
	Orientation on PCPNDT Act for Dy. CMO, CMOs, doctors both Govt and private, members of District Appropriate authority NGOs in a workshop				
	General & Financial rules (G & FR) for Officials, MOs, clerical staff for 3 days				
	Financial management training for Accounts Officers, Accountants for 2 days				
	Computer training to all the MOs, Clerical staff, accounts personnel				
	CNAA for MOs, LHV, ANM & MPW, AWW				
	Total sanitation orientation and reorientation of VHWSC x 1 day				
	Training of NGOs in BCC				
	Professional Development course for District Prog. Managers, Senior Officers, MOs- 10 weeks				
	Training of ASHAs				

Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
Non recurring	Construction of training hall @ 10.00lac	10.00	0.0	0.0	0.0	**10.00**
	Trainings: VHWSC@Rs. 2000/commitee	0.88	0.88	1.84	1.84	**5.44**
	ANMS @ 2000/ x 90 ANMs	1.80	1.80	3.94	3.94	**11.48**
	Nurses @ Rs. 2000/nursex83	1.66	1.66	3.30	3.30	**9.92**
	MO @ Rs. 20000 / MOx46	9.20	9.20	9.20	9.20	**36.8**
	Specialists @ Rs. 20000 x 36 specialists	7.20	7.20	11.00	11.00	**36.4**
	Lab.Technician @ Rs. 10000 / L.t.x 30	3.00	3.00	3.00	3.00	**12.00**
	TBA @ Rs. 1000 /TBAx220	2.20	2.20	2.20	2.20	**8.800**
Total		**35.94**	**25.94**	**34.48**	**34.48**	**130.84**

Human Resource Plan

Situation Analysis	**1.** One MO, Extension Educator, Nursing orderly, one BHW, One ANM, one Chowkedar and one sweeper are present at each PHC
Objectives	1. Posting of suitably qualified human resource at specified positions (match qualifications with position) 2. Posting of human resource at SCs as per IPHS to provide 24 hr services. 3. Posting of human resource at PHCs as per IPHS to provide 24 hr services. 4. Posting of human resource at CHCs as per IPHS to provide 24 hr services. 5. Computerization of PHCs to maintain all the records efficiently. 6. Computerization of CHCs to maintain all the records efficiently.
Strategies & Activities	1. A committee is constituted at state headquarters to review cadre and transfers. 2. Preparation of HR policy by HR consultant based on review committee recommendations 3. Identify vacant positions and fill these on contract basis immediately 4. ACRs to be made more objective reflecting performance linked service benefits. 5. District cadres for ANMs and MOs to be notified and implemented. 6. Requirement of ASHA in the block [norm of one for 1000 population]. 7. Requirement of ANMs in those sub-centers having population of more than 5000. 8. Requirement of Staff Nurses for PHCs [2 per PHC]. 9. Two specialists for each specialty in CHC. 10. The availability of services of anesthetists, pediatricians, obstetricians and gynecologists and supporting staff with blood storage facility is critical to providing emergency obstetrics and newborn care. 11. Motivating factors such as positive work environment, adequate remuneration / compensation, career development opportunities, supportive health system, working conditions to ensure retention of skilled workers in the health system. 12. Gaps identified in facility survey to be filled up

Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Framing of Recruitment Rules	-	-	-	-	
	Selection of Suitable Manpower	-	-	-	-	
	Appointment of staff	x	x	x	x	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	CHC Staff:-------					
	Obstetrician /Gynecologist -1@ Rs. 26270 per monthx12	3.15	3.15	3.15	3.15	**12.6**
	Physician-1 @ Rs. 26270 / month x12	3.15	3.15	3.15	3.15	**12.6**
	Pediatrician-2 @ Rs. 26270 / month x 12	3.15	3.15	3.15	3.15	**12.6**
	Public health Prog. Manager -2 @ Rs.26270/ Monthx12	6.3	6.3	6.3	6.3	**25.2**
	Eye surgeon-1 @ Rs. 26270/Mônthx12	3.15	3.15	3.15	3.15	**12.6**
	Public health nurse-2@ 14265/ Mônx12	3.43	3.43	3.43	3.43	**13.72**
	Staff nurse-4 @ Rs.12800/ Mônthx12	6.15	6.15	6.15	6.15	**24.6**
	Sweeper, OPD & OT attendant,chowkedar4 @ Rs.5777/ Mônthx4x12	2.77	2.77	2.77	2.77	**11.08**
	Statistical assistant- 2 @ 7610/ Mônx12	1.83	1.83	1.83	1.83	**7.32**
	Registration clerk-2@8000/ Mônx12	1.93	1.93	1.93	1.93	**7.72**

	New CHCs Staff for block Lar					
	7 Specialists @ 26270/Monthx12	22.07	22.07	22.07	22.07	**88.28**
	Public Health Nurse-1@14265 /Monthx12	1.71	1.71	1.71	1.71	**6.84**
	ANM 1 @ 11355 / monthx12	1.36	1.36	1.36	1.36	**5.44**
	Staff Nurse 1 @ 12800/M	1.54	1.54	1.54	1.54	**6.16**
	Dresser 1 @ 5777/Monthx12	0.69	0.69	0.69	0.69	**2.76**
	Pharmacist 1@ 12800 /Monthx12	1.54	1.54	1.54	1.54	**6.16**
	Lab. Tech 1@ 9900/monthx12	1.19	1.19	1.19	1.19	**4.76**
	Opthamalic ass. 1@ 7610 /M	0.9132	0.9132	0.9132	0.9132	**3.6528**
	Ward boy 2@ 5777	1.39	1.39	1.39	1.39	**5.56**
	Sweeper, OPD & OT attendant Chowkedar,- 6 @ 5777 / Month x12	4.16	4.16	4.16	4.16	**16.64**
	Statistical assist. 1@ 7610/Monthx12	0.9132	0.9132	0.9132	0.9132	**3.6528**
	Registration clerk 1@ 8000/Monthx12	0.96	0.96	0.96	0.96	**3.84**
	PHC Staff : ----					
	MOs 28 @ 21000/ monthx12x28	43.01	43.01	43.01	43.01	**172.04**
	Pharmacist-1@ 12800/ monthx12	1.54	1.54	1.54	1.54	**6.16**
	AYUSH-Pharmacist 23@12800 / month x 12	35.33	35.33	35.33	35.33	**141.32**
	Clerk 37@ 8000 / monthx12	35.52	35.52	35.52	35.52	**142.08**
	Lab technician-12 @ 9900/monthx12	14.26	14.26	14.26	14.26	**57.04**
	Class IV-41@ 4000/monthx12	19.68	19.68	19.68	19.68	**78.72**
	Staff nurse-60 @ 12800/monthx12	92.16	92.16	92.16	92.16	**368.64**
	Sub Centre :-					
	ANMS-56 @ 11355/monthx12	76.31	76.31	76.31	76.31	**305.24**
	Sub Centre staff 48 new SCs:--					
	ANM's for new 48Sc's from 2010 @ 11355/ month	0	130.8096	130.8096	130.8096	**392.4288**
	DISTRICT HOSPITAL :-					
	Hospital Superintendent-1 @ 28000/M	3.36	3.36	3.36	3.36	**13.44**
	Medical Specialist 3 @ 26270/ month	9.46	9.46	9.46	9.46	**37.84**
	Surgery specialist 2 @ 26270/ month	6.3	6.3	6.3	6.3	**25.2**
	OG Specialist 4@ 26270/ M	12.61	12.61	12.61	12.61	**50.44**
	Psychiatrist 1 @ 26270/ M	3.15	3.15	3.15	3.15	**12.6**
	Dermatologist 1 @ 26270/ M	3.15	3.15	3.15	3.15	**12.6**
	Pediatrician 2 @ 26270/ M	6.31	6.31	6.31	6.31	**25.24**
	Anesthetist 2 @ 26270 / M	6.31	6.31	6.31	6.31	**25.24**
	ENT surgeon 1 @ 26270/ M	3.15	3.15	3.15	3.15	**12.6**
	Orthopadician 1 @ 26270/ M	3.15	3.15	3.15	3.15	**12.6**
	Radiologist 1 @ 26270 / M	3.15	3.15	3.15	3.15	**12.6**
	Microbiologist 1 @ 26270/ M	3.15	3.15	3.15	3.15	**12.6**
	Causality doctor-6 @ 21000/m	15.12	15.12	15.12	15.12	**60.48**
	Dental surgeon 1@ 26270/m	3.15	3.15	3.15	3.15	**12.6**
	Forensic expert 1 @ 26270/ M	3.15	3.15	3.15	3.15	**12.6**

	Public health manager 1 @ 26270/ M	3.15	3.15	3.15	3.15	**12.6**
	AYUSH physician 2 @ 26270/ M	6.31	6.31	6.31	6.31	**25.24**
	Pathologist 2 @ 26270/ M	6.31	6.31	6.31	6.31	**25.24**
	Staff nurse 75 @ 12800/ month	115.2	115.2	115.2	115.2	**460.8**
	H. workers OT blood bank 20 @ 9900 / M	23.76	23.76	23.76	23.76	**95.04**
	Sanitary worker 15 @ 5777/ M	10.4	10.4	10.4	10.4	**41.6**
	Social worker Counselor 1 @ 15000/ M	1.8	1.8	1.8	1.8	**7.2**
	Ophthalmic assistant 1@ 9900/M	1.19	1.19	1.19	1.19	**4.76**
	Cytotechnician 1 @ 9900/ M	1.19	1.19	1.19	1.19	**4.76**
	ECG technician 1 @ 9900/ M	1.19	1.19	1.19	1.19	**4.76**
	ECHO technician 1 @ 9900/ M	1.19	1.19	1.19	1.19	**4.76**
	Lab. Technician 12 @ 9900/ M	14.26	14.26	14.26	14.26	**57.04**
	Lab. Attendant 4 @ 5777/ M	2.77	2.77	2.77	2.77	**11.08**
	Dietician 1 @ 10000/ M	1.2	1.2	1.2	1.2	**4.8**
	ANM 6 @ 11355/ M	8.18	8.18	8.18	8.18	**32.72**
	Radiographer 2 @ 9900/ M	2.38	2.38	2.38	2.38	**9.52**
	Dark room assistant 1 @ 7610/M	0.91	0.91	0.91	0.91	**3.64**
	Pharmacists 3 @ 12800/ M	4.61	4.61	4.61	4.61	**18.44**
	Pharmacist ISM 5 @ 12800/ M	7.68	7.68	7.68	7.68	**30.72**
	Matron 1 @ 8000/ M	0.96	0.96	0.96	0.96	**3.84**
	Assistant Matron 2 @ 5000/ M	1.2	1.2	1.2	1.2	**4.8**
	Physiotherapist 1 @ 15000/ M	1.8	1.8	1.8	1.8	**7.2**
	Statistical Assistant 1 @ 7610/ M	0.91	0.91	0.91	0.91	**3.64**
	Medical record officer 1 @ 15000/ M	1.8	1.8	1.8	1.8	**7.2**
	Electrician Plumber 2 @9900/M	2.38	2.38	2.38	2.38	**9.52**
	Junior Administrative officer 1@ 8000	0.96	0.96	0.96	0.96	**3.84**
	Office superintendent 1@ 12000	1.44	1.44	1.44	1.44	**5.76**
	Assistant 2@ 7000	1.68	1.68	1.68	1.68	**6.72**
	Junior Ass. Typist 2 @9900/month	2.38	2.38	2.38	2.38	**9.52**
	Accountant 2@ 10000/M	2.4	2.4	2.4	2.4	**9.6**
	Record Clerk 1@9900/M	1.19	1.19	1.19	1.19	**4.76**
	Office Assistant 1@ 7610/M	0.91	0.91	0.91	0.91	**3.64**
	Computer Operator 1@6000/ M	0.72	0.72	0.72	0.72	**2.88**
	Peon Staff, Security, Driver 6 @4000 / M	2.88	2.88	2.88	2.88	**11.52**
	O.T,Staff Nurse 9@ 12800/M	13.82	13.82	13.82	13.82	**55.28**
	O.T. assistant 6@ 9900	7.13	7.13	7.13	7.13	**28.52**
	Sweeper 4 @ 3000/M	1.44	1.44	1.44	1.44	**5.76**
	Staff nurse 4@ 12800/M	6.14	6.14	6.14	6.14	**24.56**
	MNA/FNA 2@7000/M	1.68	1.68	1.68	1.68	**6.72**
	Lab. Tech 1@ 9900/M	1.19	1.19	1.19	1.19	**4.76**
	Sweeper 2@3000/M	0.72	0.72	0.72	0.72	**2.88**
Total		**745.3364**	**876.146**	**876.146**	**876.146**	**3373.774**

Procurement and Logistics						
Situation Analysis/	Warehouse facility for storage of drugs, medicine and equipment is not available in district Ganderbal. Rooms built for other purpose are used as store rooms. But there is no systematic storage system. Most rugs are supplied by the State and some drugs are procured locally. Inventory Management is also not satisfactory. Receipt and issue records are not computerized. There is no system of wastage control, replacements, transfer of stocks from one centre to the other. Record Keeping is done manually.					
Objectives	To streamline the procurement, storage& distribution of drugs, medicine and other supplies.					
Strategies & Activities	Strengthening inventory control through computerization. 1. Preparation of logistic plans by contracting inventory manager. 2. Tracking of supplies through computerization. 3. Need based hiring of transport services for distribution of supplies. 4. Construction of warehouse at state and district level. 5. Training of staff in use of computers for record keeping. 6. Guidelines for purchasing supplies in case of emergency.					
Support required	**Financial support**					
Timeline	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Construction of Warehouse	x				
	Software	x				
	Computer system with UPS, Printer, Scanner,	x				
	Equipment & Hardware	x				
	Pharmacist @ Rs 9000/mth	x				
	Assistant Pharmacist @ Rs 5000/mth	x				
	Security Staff @ Rs 6000/mth	x				
	Training of personnel	x				
	Consultancy to agency for Operationalization of the Warehouse	x				
	Procurement of Washing machine	X				
	Activity / Item	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Construction of Warehouse and maintenance	100.00	10..00	10.00	10.00	**130.00**
	Software	0.25	0.00	0.00	0.00	**0.250**
	Computer system with UPS, Printer, Scanner,	0.60	0.00	0.00	0.00	**0.600**
	Equipment & Hardware	34.5	0.00	0.00	0.00	**34.50**
	Pharmacist @ Rs 9000/mth	1.08	1.19	1.31	1.44	**5.020**
	Assistant Pharmacist @ Rs 5000/mth	0.6	0.66	0.726	0.799	**2.785**
	Packers -1 @ Rs 4000/mthx1	0.48	0.528	0.581	0.639	**2.228**

	Security Staff @ Rs 6000/mth	0.72	0.792	0.871	0.968	**3.351**
	Training of personnel	0.1	0.11	0.121	0.133	**0.464**
	One washing machine 20 Kg @ Rs 50000	0.5	0.00	0.00	0.00	**0.50**
	Consultancy to agency for Operationalisation of the Warehouse	2.00	2.10	0.00	0.00	**4.10**
	Total	**140.83**	**15.38**	**13.609**	**13.979**	**183.798**

Demand Generation - IEC						
Situation Analysis/ Current Status	Communities do not use available health services due to lack of awareness and information on need and availability of health services. The following health related issues need special focus for creating awareness and generating demand for services. Importance of 3 visits for ANC, advantages of institutional delivery, post natal care, availability of skilled birth attendants, balanced diet during pregnancy, anemia, misgivings about IFA, kitchen garden Importance of complete immunization, disadvantages of drop outs, nutritional requirements of infants and children, malnutrition, exclusive breastfeeding Problems of adolescents, drugs addiction, malnutrition, problems of sexuality, age at marriage, tendency to take risks in sexual matters Spacing methods, ideal interval between births, no scalpel vasectomy, information about FP facilities and MTP facilities available at different levels DOTS programme for TB, location of microscopy centers, cardinal symptoms of TB, High risk behavior in the community in relation to water born diseases, heart diseases, lung diseases, HIV/AIDS and STDs Ill effects of drugs addiction affecting adolescents, High prevalence of RTIs, including STDs, Issues of malaria spread and prevention and also other diseases JSY, Fixed Health days , availability of services					
Objectives/ Milestones/ Benchmarks	Awreness and demand generation for Antenatal care, institutional delivery, postnatal care, availability of skilled birth attendant in vicinity, need for balanced diet during pregnancy, anemia in pregnancy and prevention, Importance of complete immunization, Nutritional requirements of children and infants, benefits of exclusive breast feeding Hazards of drug addiction, HIV/AIDS risk and STDs					
Support required	Support for need based audio visual IEC equipments. Support for need based material for all programs.					
Timeline	**Activities**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Finalizing the messages	x	x	x	x	
	Advertisements	x	x	x	x	
	TV spots	x	x	x	x	
	Radio Jingles	x	x	x	x	
	Folk Media shows	x	x	x	x	
	Hoardings on prominent places	x	x	x	x	
	Display boards	x	x	x	x	
	Pamphlets	x	x	x	x	
	Developing Nirdeshika for holding VHD days		x			
	Monthly Swasthya Darpan	x	x	x	x	
	Orientation & training of all frontline govt functionaries and elected representatives					
	Bal Nutrition Melas	x	x	x	x	
	Adolescent meetings	x	x	x	x	

	Opinion leaders workshops	x	x	x	x	
	Wall writings	x	x	x	x	
	Activities	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Hiring of an agency for carrying out the intensive IEC and behaviour change activities	40.00	44.00	48.4	53.24	**185.64**
	Finalizing the messages in the local language	1.00	1.10	1.21	1.331	**4.641**
	Advertisements	5.00	5.50	6.05	6.655	**23.205**
	TV spots	1.00	1.10	1.21	1.331	**4.641**
	Radio Jingles in local language	1.00	1.10	1.21	1.331	**4.641**
	Folk Media shows @ Rs 1000/vill	2.2	2.42	2.662	2.9282	**10.2102**
	Hoardings @ Rs 10000/hoarding	10.00	11.00	12.10	13.31	**46.41**
	Display boards @ Rs 2000/board	2	2.2	2.42	2.662	**9.282**
	Pamphlets @ Rs 10/pamphlets x 100000	10	11	12.1	13.31	**46.41**
	Nirdeshika for Fixed Health Nutrition days @ Rs 20/ Nirdeshika x 8000	1.6	1.76	1.936	2.13	**7.426**
	SwasthyaDarpan @Rs.10 /copy/mth x 8000	0.8	0.88	0.968	1.065	**3.713**
	Orientation of elected rep and community leaders@ Rs 200 x 1000persons x1 day	2	2.2	2.42	2.662	**9.282**
	Bal Nutrition Melas @ Rs 300 x 4 times x AWCs	5.22	5.742	6.3162	6.94782	**24.22602**
	Kishori Shakti meetings @ Rs 100 per group x 220llages	0.22	0.242	0.2662	0.29282	**1.02102**
	Community and religious leaders workshops @ Rs 300 /person x 100 x 4 times	1.2	1.32	1.452	1.597	**5.569**
	Wall writings @ Rs 500 x 220 villages	1.1	1.21	1.331	1.4641	**5.1051**
	Total	**84.34**	**92.774**	**102.0514**	**112.2569**	**391.4223**

Financing Health Care						
Situation Analysis/	Financial support is necessary for need based healthcare and long term sustainability. Rogi Kalyan Samitis (RKS) have been formed in each of the hospitals, CHCs and PHCs of District Ganderbal. These are autonomous local bodies of the hospital constituted for smooth and fast decision making on administrative and fin ancial issues. Rogi Kalyan Samitis have dictionary powers to decide on user fee for services provided by the hospitals. Level of satisfaction among patients and staff has increased after formation of RKS. Samiti has flexibility for fund utilization for better facilities.					
Objectives/ Benchmarks	Efficient use of NRHM funds through decentralization of powers to local authorities leading to better healthcare services.					
Strategies & Activities	1. Strengthening financial management structure at all levels and streamlining of financial management practices 2. Updating of a manual on financial rules, guiding principals, formats for budget planning and expenditure reports with technical assistance of a consultant. 3. Establishment of Financial Management Cells at District level and separate accounts for all societies ▪ Preparation of budgets with activity. ▪ Quarterly review of expenditure reports and providing feed back.					
Support required	Financial support under NRHM Guidelines form Government					
Timeline	**Activity**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Provision of Speed money @ Rs 1 lakh per CHC and PHC	x	x	x	x	
	Training of the Incharges and second in command	x	x	x	x	
	Development of Software for RKS with training of personnel on the use	x	x	x	x	
Budget	**Activity**	**08-09**	**09-10**	**10-11**	**11-12**	**Total**
	Provision of Seed money @ Rs 1 lakh per CHC and PHC @ Rs 1.00 lakhs	26	28.6	31.46	34.606	**120.666**
	Training of the In charges and second in command @ Rs 1000 per person x 1 day	1.1	1.21	1.331	1.452	**5.093**
	Development of Software for RKS with training of personnel on the use	5	0.25	0.25	0.25	**5.75**
	Total	**32.1**	**30.06**	**33.041**	**36.308**	**131.509**

School Health

Situation Analysis/	▪ School health checkups are being carried out by existing medical staff including health education activities at present. ▪ Treatment of minor ailments, referrals, dental checkups and refractions are also being carried out. ▪ Monthly performance reports are submitted to Block Headquarters and then to District Headquarters.					
Objectives/	Keeping children healthy through regular health check ups, early identification of abnormalities and treatment to achieve goal of reduction child mortality and morbidity.					
Strategies & Activities	▪ Existing staff cannot carry out the school health check up activities in all educational institutions on regular basis. Therefore dedicated contractual staff requires to be engaged to conduct the health check ups of all the school children on monthly basis under supervision of DPM ▪ Provision of drugs, supplies and transport facilities. ▪ Provision of IEC material, pamphlets, hand bills and audio visual aids for carrying out health education activities on Nutrition, Hygiene, Sanitation, Adolescent health, Drug Addiction, Immunization and National Health Programme ▪ Provision of supplementary nutrition ▪ Training of doctors / paramedics regarding school health. ▪ Provision of spectacles for children having refractive errors. ▪ Training of teachers in batches for carrying out health education regarding preventive measures for both communicable and non communicable diseases. ▪ Extensive school health camps. ▪ Provision of Vehicles for logistic support. ▪ Usage of Mobile Medical Unit and appointment of staff thereto for exclusive school health team. ▪ On spot diagnosis and follow up of Identified abnormal children through ASHAs/ANMs ▪ Making one Health Checkup compulsory before joining a new class.					
Support required	▪ Govt. Support ▪ School Education Deptt. ▪ School Managing committees, Village Health Committees.					
Timeline	**Activity Plan**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	
	Health Checkup camps	**x**	**x**	**x**	**x**	
	Supply of Sanitary Pads	**x**	**x**	**x**	**x**	
	IEC Activities	**x**	**x**	**x**	**x**	
	Training of Teachers	**x**	**x**	**x**	**x**	
Budget	**Activity / Item**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Health checkups @ Rs. 25000 / block x 3	0.750	0.825	0.908	0.998	**3.481**
	Supply of sanitary pads for girls above age 12 @ Rs.1.00 lac / block	3.000	3.300	3.630	3.993	**13.923**
	IEC programme @ Rs.1.00 / block	3.000	3.300	3.630	3.993	**13.923**
	Trg of teachers @ Rs. 25000/ block x 3	0.750	0.825	0.908	0.998	**3.481**
	School health camps @ Rs. 25000 / block x 3	0.750	0.825	0.908	0.998	**3.481**
Total		**8.250**	**9.075**	**9.983**	**10.981**	**38.288**

Bio-Medical Waste Management						
Situation Analysis / Current Status	As per the Bio-Medical Waste Rules, 1998, indiscriminate disposal of hospital waste was to be stopped with handling of Waste without any adverse effects on the health and environment. In response to this the Government has taken steps to ensure the proper disposal of Biomedical waste from all Nursing homes, hospitals, Pathological labs and Blood Banks. The District Health Officer is the Nodal Person in each district for ensuring the proper disposal of Biomedical Waste. For effective disposal of Biomedical waste in the district; Trainings to the personnel for sensitizing them, Pits. Segregation of Waste is taking place though Separate Colour Bins/containers it has to be done more systematically. Proper Supervision is lacking. The treatment (incineration) of waste is suppose to handled by a company selected at the State level but till date the company has not been selected. There is a monopoly of these companies so their charges are very high.					
Objectives	1. Stopping the indiscriminate disposal of hospital Waste from all the facilities by 2008 2. Ensuring proper handling and disposal of Biomedical Waste in each Facility					
Strategies	1. Capacity Building of personnel 2. Proper equipment for the disposal and disposal as per guidelines 3. Strict monitoring and Supervision					
Activities	1. Review of the efforts made for the Biomedical Waste Interventions 2. Development of Microplan Plan for each facility in District & Block workshops 3. Capacity Building of personnel. Biomedical Waste management to be part of each training in RCH and IDSP 4. Proper equipment for the disposal Installation of the Separate Colour Bins/containers and Plastic Bags for the bins 5. Segregation of Waste as per guidelines 6. Partnering with Private providers for waste disposal 7. Proper Supervision and Monitoring Formation of a Supervisory Committee in each facility by the MOs and the Supervisors					
Support Required						
Timeline	**Activity**	**2008- 09**	**2009-10**	**2010-11**	**2011-12**	
	Orientation and reorientation for Biomedical Waste Management at District and Block levels	X	X	X	X	
	Consumables	X	X	X	X	
	Payment for incinerators@ Rs. 8 per bed 12 mths	X	X	X	X	
Budget	**Activity**	**2008- 09**	**2009-10**	**2010-11**	**2011-12**	**Total**
	Orientation and reorientation for Biomedical Waste Management at District and Block levels	1.5	1.65	1.82	2.00	**6.97**
	Consumables	2.00	2.2	2.42	2.662	**9.282**
	Payment for incinerators@ Rs. 8 per bed 12 mths	10.944	12.0384	13.242	14.566	**50.7904**
Total		**14.444**	**15.8884**	**17.482**	**19.228**	**67.0424**

ANNEXURE– I
FACILITY SURVEY

Table:1	Percentage Availability of Infrastructure				
District: Ganderbal					
	Indicators	SC (44)	PHC (23)	CHC (2)	DH(0)
1	Building (Govnt. + Donated)	27	77	100	
2	Building (Rented)	73	23	0	
3	Condition of Building (Good + Fair)	38	Na	Na	
4	Water Supply (Tap, bore well/ hand pump /tube well, well)	32	79	100	
4.1	Tap water supply	Na	73	100	
5	Electricity	7	100	100	
5.1	In all parts of hospital	Na	84	100	
5.2	Electric supply (power generation stabilization)	Na	Na	Na	
6	Separate Toilet	5	14	50	
6.1	Sep. Toilet with running water	Na	Na	0	
7	Furniture	28	42	70	
8	Labor Room	5	26	100	
8.1	Aseptic labor room	Na	Na	50	
9	Avail. of Quarter for staff	11	6	100	
10	Number of beds available (Average)		6	40	
11	Laboratory		59	100	
12	Operation Theater		31	100	
13	Waste Disposal (Burnt Dump)		75	50	
14	Availability of incrator		Na	0	
15	Telephone		0	50	
16	Computer		0	0	
17	Generator/Invertors		26	50	
18	Vehicle		40	54	
19	Emergency Room / Casualty			100	
20	Separate wards for males and females			0	
21	No. of beds : Male			35	
22	No. of beds : Female			5	
23	Availability of ECG facilities			100	
24	X-Ray facility			100	
25	Ultrasound facility			100	
26	Cardiac Monitor for OT			50	
27	Blood Storage Unit available			0	
28	Blood Bank Facility				
29	Other Investigative Facility				
30	Heating ventilation & air conditioning				
31	Lift & vertical transport				
32	Refrigeration				
Na = Not applicable					

Table: 2	Identified Gaps of Manpower						
District- : Ganderbal							
Name of Blocks		Lar	Ganderbal	Kangan	No. 0f Req.Staff	No. of Exis. Staff	Total Gaps
No. of Sub- Centres (44)	IPHS Norm	9	14	21			
ANM	2	14	19	23	88	32	56
N0. Of PHC's (23)		5	6	12			
MO	2	2	5	18	40	15	25
Pharmacist	1	-2	1	2	20	19	1
Nurse	3	3	16	32	60	9	51
Female Health Worker	1	2	4	1	20	13	7
Health Educator	1	3	3	9	20	5	15
Health Assistant	2	6	12	19	40	3	37
Clerks	2	4	12	18	40	6	34
LT	1	0	3	7	20	10	10
Driver		1	5	4		0	0
Class IV	4	7	7	23	80	43	37
Total		26	68	133	340	123	217
No. of CHC's (2)			1	1			
A. CLINICAL MANPOWER							
General Surgeon	1		0	0	2	2	0
Physician	1		0	1	2	1	1
Obstetrician / Gynaecologist	1		1	0	2	1	1
Paediatrics	1		0	1	2	1	1
Anaesthetist	1		0	0	2	2	0
Public Health Programme Manager	1		1	1	2	0	2
Eye Surgeon	1		1	0	2	1	1
Other specialists (if any)							
General duty officers (Medical Officer)							
B. SUPPORT MANPOWER							
Nursing Staff	7+2						
Public Health Nurse	1		1	1	2	0	2
ANM	1		1	0	2	1	1
Staff Nurse Nurse/Midwife	7		2	-2	14	14	0
Dresser	1		0	0	2	2	0
Pharmacist / compounder	1		1	-1	2	2	0
Lab. Technician	1		0	-3	2	5	-3
Radiographer	1		1	1	2	0	2
Ophthalmic Assistant	1		1	0	2	1	1
Ward boys / nursing orderly	2		0	-6	4	10	-6
Sweepers	3		0	-5	6	11	-5
Chowkidar	1		1	1	2	0	2
OPD Attendant	1		1	-1	2	2	0
Statistical Assistant / DEO	1		1	1	2	0	2
OT Attendant	1		1	1	2	0	2
Registration Clerk	1		1	1	2	0	2
Any other staff (specify)							
Total			15	-9	62	56	6
Note: (-) Surplus staff							

Table 3- Percentage Availability of Equipments

Name of the Blocks		Lar	Ganderbal	Kangan	Average % of the District
No. of Sub- Centres (44)	IPHS Norm	9	14	21	
kit- C	55	22	11	28	20
N0. Of PHC's (23)		5	6	12	
Suggested equipments	36	9	26	25	20
Operational labour room	10	0	0	30	10
Pap Smear	11	7	61	18	29
Laboratory Reagents	10	0	0	10	3
Glassware and other equipment	7	0	0	14	5
Furniture	25	6	23	16	15
TOTAL	99	31	32	19	27
No. of CHC's (2)		NA	1	1	
Standard Surgical Set-1 FRU	32		97	81	89
Standard Surgical Set - II	33		97	97	97
IUD Insertion Kit	19		16	74	45
CHC Standard Surgical Set - III	17		100	100	100
Normal Delivery	12		100	92	96
Standard Surgical Set - IV	16		100	100	100
Standard Surgical Set - V	21		0	0	0
Standard Surgical Set - VI	11		0	0	0
Equipment for Anaesthesia	17		6	12	9
Equipment for Neo-natal Resuscitation	10		0	0	0
Materials Kit for Blood tranfusion	15		0	0	0
Equipment for Operation theatre	11		73	82	77
Equipment for Labour room	13		92	92	92
Equipment for Radiology	9		89	89	89
TOTAL NO.	236		12	62	37

TABLE 4	Percentage Availability of Medicines				
	DISTRICT - GANDERBAL				
Name of the Blocks		Lar	Ganderbal	Kangan	Average % of the District
No. of Sub- Centres (44)	IPHS Norm	9	14	21	
Kit- A	5	0	0	3	1
Kit- B	9	32	29	50	37
Drugs req. byANMs and LHVs	6	20	23	17	20
Other Drugs and Vacc.	8	35	30	48	38
Medicines req.for NDCP	7	14	3	21	13
Contracep. Req. for F.Plang.	4	42	39	33	38
Proposed Drug List for AWC	12	11	29	26	22
Total	51	22	31	31	28
N0. Of PHC's (23)		5	6	12	
Essential & emergecy obstetrics care drugs	38	10	18	27	18
Antidots	4	0	0	0	0
Anticonvulsant / Antiepileptics	4	0	0	0	0
Antiinfective Medicines	5	0	0	30	10
Antifilarials	1	0	0	0	0
Antibacterials	16	0	6	13	6
Dermatological medicine	14	0	0	7	2
Antileprosy &Antitubercullar	2	0	0	0	0
Antifungal medicine	4	0	0	0	0
Antiprotozoal medicine	5	0	0	10	3
Blood Products and Plasma Substitutes	13	0	0	4	1
Antiseptics	6	0	0	15	5
Disinfectants	3	0	0	0	0
Diuretics	2	0	0	0	0
Gastrointestinal	22	2	5	16	7
Hormones, Endocrine & Contraceptives	10	0	0	6	2
Ophthalmological preparation	12	0	0	6	2
Psychotic Disorders	15	0	0	7	2
Solutions correcting water Electrolyte and Acid-	9	0	33	27	20
Vitamins & Minerals	3	0	0	40	13
Drugs under RCH	1	0	0	0	0
Product Strength formulation Units	31	0	0	18	6
RTI / STI Drugs	10	0	10	26	12
Drugs and Consumablefor MVA	6	0	17	8	8
TOTAL	236	22	6	15	14
No. of CHC's (2)			1	1	
Essential drugs	70		40	36	38

ANNEXURE- II
DETAILED INFRASTUCTURE

Table: 1 A		Block : Ganderbal		District :Ganderbal				
	Name of SC	Ownership of the Building	Condition of the Building	Water supply	Electricity	Separate toilet	Labor room	Staff Quarter
1	Gundrehman	Govt.	Good	Y	N	N	N	N
2	Shallabug	Govt.	Good	Y	N	N	N	N
3	Badurkund	Govt.	Poor	N	N	N	N	N
4	Khalmulla	Govt.	Poor	Y	N	N	N	N
5	Saloora	Rented	Good	Y	N	N	N	N
6	Gulabbagh	Rented	Poor	Y	N	N	N	N
7	Bandaybagh	Rented	Good	Y	N	N	N	N
8	Gadoora	Rented	Good	N	N	N	N	N
9	Bakura	Rented	Good	N	N	N	N	N
10	Pandach	Rented	Good	Y	N	N	N	N
11	Nuner	Rented	Good	Y	N	N	N	N
12	Hakimgund	Rented	Good	Y	N	N	N	N
13	Thuru	Rented	Poor	N	N	N	N	N
14	Harran	Rented	Good	N	N	N	N	Y

Table: 1 B		Block: Ganderbal																
	Name of PHC/CHC	Ownership of the Building	Water supply	Electricity / In all Parts	Separate toilet /with running water	Labor room / Aseptic labor room	Staff Quarter	Laboratory	Operation Theater	Waste disposal/ inclinator	Telephone	Generator	Vehicle	Emerg./Casuality Room	ECG / USG	X-RAY	Cardiac Monitor	Blood storage unit
1	Kachan	Govt.	Y	Y/Y	N	N	N	N	N	Burned	N	N	N					
2	Shuhama	Govt.	Y	Y/Y	N	N	N	Y	N	Burned	N	N	N					
3	AD Nuner	Govt.	Y	Y/N	N	N	N	Y	N	Burned	N	N	N					
4	Chandura	Govt.	Y	Y/Y	N	Y	N	Y	Y	Burned	N	Y	Y					
5	Tulmulla	Govt.	Y	Y/Y	N	N	N	Y	N	Burned	N	N	N					
6	Gutlibagh	Govt.	N	Y/Y	N	N	N	N	N	Burned	N	N	N					
1	CHC Ganderbal	Govt.	Y	Y/Y	N	Y	Y	Y	Y	NA	Y	NA	Y	Y	NA	Y/N	Y	Y

Table: 1 A		Block :Kangan			District :Ganderbal			
	Name of SC	Ownership of the Building	Condition of the Building	Water supply	Electricity	Separate toilet	Labor room	Staff Quarter
1	Gowbal	Govt.	Good	Y	N	N	N	N
2	Nilgrath	Govt.	Good	N	Y	N	N	Y
3	Anderwani	Govt.	Poor	N	N	N	N	N
4	Chattergul	Govt.	Good	N	N	N	N	N
5	Sufraw	Govt.	Good	N	N	N	N	N
6	Sumbal	Rented	Poor	N	N	N	N	N
7	Rezen	Rented	Poor	Y	N	N	N	N
8	Kachpatri	Rented	Poor	N	N	N	N	N
9	Thune	Rented	Good	N	N	N	N	N
10	Bonibagh	Rented	Good	N	N	N	N	N
11	Tangchatter	Rented	Good	N	N	N	N	N
12	Pshker	Rented	Poor	N	N	N	Y	N
13	Naranag	Rented	Poor	N	Y	N	N	N
14	Botakullan	Rented	Poor	N	N	N	N	N
15	Pathpora	Rented	Good	N	N	N	N	N
16	Najwan	Rented	Poor	N	N	N	N	N
17	Chinner	Rented	Poor	N	N	N	N	N
18	Belawussan	Rented	Good	N	N	N	N	Y
19	Bonizal	Rented	Good	N	N	N	N	N
20	Monogram	Rented	Good	N	N	N	N	Y
21	Gagangeer	Rented	Poor	N	N	N	N	N

Table: 1 B		Block: Kangan																
	Name of PHC/CHC	Ownership of the Building	Water supply	Electricity/ In all Parts	Separate toilet /with running water	Labor room / Aseptic labor room	Staff Quarter	Laboratory	Operation Theater	Waste disposal/ inclinator	Telephone	Generator	Vehicle	Emerg./Causuality Room	ECG / USG	X-RAY	Cardiac Monitor	Blood storage unit
1	Safapora	Rent	Y	Y/N	N	N	N	N	N	Burned	N	N	N					
2	Preng	Rented	Y	Y/Y	N	N	N	Y	N	Dumped	N	N	N					
3	Wussan	Rented	N	Y/Y	N	N	N	Y	N	Dumped	N	N	N					
4	Cherwan	Rented	Y	Y/Y	N	N	N	N	N	Dumped	N	N	N					
5	Babanagri	Rented	Y	Y/Y	N	N	N	N	N	Burned	N	N	Y					
6	Ganiwan	Donated	Y	Y/Y	N	Y	N	N	N	Burned	N	N	Y					
7	Wangeth	Donated	N	Y/N	N	N	N	Y	N	Burned	N	N	Y					
8	Chattergul	Donated	N	Y/N	N	N	Y	N	N	Burned	N	N	Y					
9	Gund	Govt.	Y	Y/Y	Y	Y	Y	Y	Y	River	N	Y	Y					
10	Wayil	Govt.	N	Y/Y	N	N	N	N	N	Dumped	N	N	N					
11	Sonamarg	Govt.	Y	Y/Y	N	N	N	N	N	Burned	N	Y	Y					
12	Kullan	Govt.	N	Y/Y	N	Y	N	Y	N	Thrown in river	N	Y	Y					
1	CHC Kangan	Govt.	Y	Y/Y	Y	Y	Y	Y	Y	NA	N	Y	Y	Y	Y	Y	Y	N

Table: 1 A		Block: Lar				District:Ganderbal		
	Name of SC	Ownership of the Building	Condition of the Building	Water supply	Electricity	Separate toilet	Labor room	Staff Quarter
1	Zazna	Govt.	Poor	N	N	Y	Y	N
2	Haripora	Govt.	Good	N	N	N	N	N
3	Kurhama	Donated	Poor	N	N	N	N	N
4	Waliwar	Rented	Good	Y	N	N	N	Y
5	Lar	Rented	Poor	Y	N	N	N	N
6	Barsoo	Rented	Good	N	N	Y	N	N
7	Narainbagh	Rented	Good	N	N	N	N	N
8	Yangora	Rented	Good	N	N	N	N	N
9	Korg	Rented	Good	Y	Y	N	N	N

Table: 1 B		Block: Lar																
	Name of PHC/CHC	Ownership of the Building	Water supply	Electricity/ In all Parts	Separate toilet /with running water	Labor room / Aseptic labor room	Staff Quarter	Laboratory	Operation Theater	Waste disposal/ incinator	Telephone	Generator	Vehicle	Emerg./Causuality Room	ECG / USG	X-RAY	Cardiac Monitor	Blood storage unit
1	Lar	Govt.	Y	Y/Y	N	Y	N	Y	Y	Dumping	N	N	Y					
2	Batwina	Govt.	Y	Y/Y	Y	N	N	Y	N	NA	N	Y	N					
3	Wakura	Govt.	Y	Y/Y	Y	N	NA	Y	Y	NA	N	N	Y					
4	Watlar	Govt.	Y	Y/Y	N	N	N	N	N	Dump	N	N	N					
5	Kundbal	Rent	Y	Y/N	N	N	N	N	N	Burn	N	N	N					

ANNEXURE – III
APPRAISAL CRITERIA

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

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

Sl. No.	Criteria	Remarks Yes/ No
	1. Absorptive capacity: If very ambitious utilization of funds is envisaged compared to performance of 05-06/06-07, then what are the key steps proposed to achieve plan expenditure?	**Yes**
B RCH-II PROGRAM		
	PROGRAM MANAGEMENT ARRAGEMENTS	
1	Steps to establish financial management system including fund flow mechanisms to blocks and downward upto village level and accounting system including timely reporting expenditure.	**Yes**
2	Steps to establish quality assurance committees in the district.	**Yes**
3	Step to ensure systems for holistic monitoring (Outputs, activities, costs) against DHAP including variance analysis.(Dist level review meeting and DHS meetings)	**Yes**
4	Strengthening of HMIS with emphasis on timely availability of reliable and relevant information at appropriate level e.g. community, SC, PHC, Block and district, analysis and feedback system, steps to ensure implementation of revised HMIS system.	**Yes**
5	Provision of logistics management of drugs and medical supplies in order to ensure continuous availability of essential supplies at S/C, PHC and CHC level.	**Yes**
TECHNICAL STRATEGIES		
1	**Maternal Health**	
	A. Interventions for 100% ANC coverage, B. 24x7 for EmOC services at selected institutions C. Skill birth attendance during labour (ANM) D. Provision of Blood storage units in FRUs/CEmOCs, E. Intervention for anesthesia training for MOs, F. Provision of Safe abortion services and, G. Management of RTI/STI Cases H. Provision for Janani Suraksha Yojana	**Yes**
2	**Child Health**	
	A. Organizing MCHN days for complete immunization coverage, B. Interventions for IMNCI services (Optional) C. Provision for new born care at institutions and, D. Promotion of breast feeding E. School Health Programme	**Yes**
3	**Family Planning**	
	A. Interventions to increase static centre, B. Increase number of service providers for NSV, Tubectomy, and Laproligation , C. Intervention to improve quality of camps, D. Quality IUD insertion services, E. Increased availability of OP, Condoms through community workers, ASHA, AWW, NGOs	**Yes**
4	**ARSH**	
	A. Intervention for training of MOs, paramedic for ARSH services B. Provision of AFHS services at selected institutions	**Yes**

Sl. No.	Criteria	Remarks Yes/ No
5	**Gender Mainstreaming**	
	Activities planned for awareness generation of gender, PCPNDT Act and strengthening implementation of PCPNDT Act.	**Yes**
7	**Urban RCH**	
	Interventions for provision of MH/CH/FP services in urban slums and urban areas.	**Yes**
8	**Tribal Health**	
	Interventions to cover tribal population for FP/MH/CH.	**Yes**
C	**NRHM ADDITIONALITIES** Whether provision made for-	
1	ASHA Training in the district	**Yes**
2	PRI Trainings (Block/Village health & Sanitation Committees)	**Yes**
3	Untied Funds at SC & Untied funds to RKS at PHC/CHC/District Hospitals	**Yes**
4	Civil Works as per IPHS (CHC/PHC/SC) Hospital Building- Staff Quarters	**Yes**
5	Strengthening Field Monitoring and Supervision (Enhance the provision of POL, Maintenance and of vehicle)	**Yes**
6	Need assessment done for-Procurements as per IPHS CHC/PHC/SC)	**Yes**
7	Appropriate provision made for-Programme Management Units at Divisional, District and Block levels-Adequate salary and OE provisions	**Yes**
8	Adequate provision made for-Additional Manpower Specialists at CHCs ANMs at SCs Divisional/Block Programme Managers	**Yes**
9	Provision made for-Drug Kits at different institutions	**Yes**
10	Plan for management of Mobile Medical Units at districts	**Yes**
11	No of Ambulances available and required	**Yes**
	District specific innovative activities to address local needs have been incorporated	**Yes**
12	Provision of hiring of vehicle for BMOs (as per requirements)	**Yes**
D	**IMMUNIZATION PROGRAM** Whether provision made for-	
1	Social mobilization	**Yes**
2	Alternative vaccine delivery	**Yes**
3	Cold Chain Maintenance	**Yes**
4	PoL & Maintenance requirement for vehicles	**Yes**
E	**National Disease Control Programme**	
1	**Water Borne Diseases** Clear strategy prepared for combating Water Borne Diseases like Malaria, dengue etc	**Yes**
2	**TB**	
	Whether Separate section on TB with operational details and budget prepared	**Yes**

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

Mwani 30.11.07

Dr. Gh. Mohi-Din- Wani

(Chief Medical Officer)