Reproductive and Child Health Programme-2

Project Implementation Plan

Revised Proposal

DEPARTMENT OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF CHHATTISGARH

For circulation
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Reproductive And Child Health Programme- 2

PROGRAMME IMPLEMENTATION PLAN FOR CHHATTISGARH STATE

Revised Draft after GoI Review

Department of Health and Family Welfare
Government of Chhattisgarh

Comments

1. Unachievable goals eg. health (indicator) impact in given time frame.
2. Rapid scale-up which may not be possible
3. Xs RCH / FW orientation shifts emphasis from PHC
4. Inadequate focus on buildup of public health capacity
   Public health erroneously equated with
   health administration and social work
   health management.

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1. Summary

1.1 Background and Current Status

Chhattisgarh State is committed to a vision of reducing IMR to less than 30, MMR to below 100 and TFR to 2.1 by the year 2010. These goals will be attained by following processes that empower local communities that are affordable, and provide equitable access to health care services, that are gender sensitive and directly and indirectly contribute to the reduction of poverty in the state. For this the state plans major interventions to strengthen current programmes in maternal health, child health, family planning, adolescent health, urban health and tribal health programmes. The state's current demographic and health profile is given in the table below:

Table 1: Demographic and Health Profile of Chhattisgarh

Indicators	CG		India	
	2000	2003	2000	2003
*IMR Total	79	73	68	64
*IMR Rural	95	85	74	69
*IMR Urban	49	51	44	40
*Birth Rate Total	26.7	25	25.8	25
*Birth Rate Rural	29.2	26.5	27.6	26.6
*Birth Rate Urban	22.8	22.6	20.7	19.9
*Death Rate Total	9.6	8	8.5	8.1
*Death Rate Rural	11.2	9.7	9.3	8.7
*Death Rate Urban	7.1	7.2	6.3	6.1
**Population in million (2001)	20.79			1027
**Population Share (%)	2.02			100
**Decadal Growth Rate during 1991-2001 (%)	18.06			21.34
**Change in decadal growth rate (% points)	-7.67			-2.52
**Female Literacy Rate 2001 (%)	52.4			54.28
**Rise in Female Literacy Rate since 1991 (% points)	24.88			15
**Decadal decline in the number of illiterates (million)	2.07			31.96
**Sex Ratio	990		933	
**Population Density	154		324	
Tribal Population (%)	34			
***Couple Protection Rate (%)		39.9	48.1	
***Couple Protection Rate by Spacing		4.5		
***Couple Protection Rate by Sterilization		35.4		
***Full ANC		12.89		
***Institutional Delivery		21.05		
***Safe Delivery		42.13	41.9	
***Children Fully Immunized (%)		57.58	53.3	
--Based on *SRS-2002, **Census 2001 and ***Key RCH indicators IIPS-				

1.2 Situation Analysis:

The reasons for the relatively poor performance in many of the key RCH indicators have been identified. They include the following:

1. **Gaps in infrastructure**: This is most acute at the Subcentres and the PHC level.
2. **Gaps in Training:** Training is based on funding from national programmes and most are short one or two day meetings. There has been a longer 12 day round for MPW-F that has been very useful but there is no plan in operation of building up the requisite skills in each facility and no training roster by which every employee is regularly trained. A training policy to achieve this has been drawn up.
3. **Inability to provide a dispersed net of quality referral services in the Public Health Sector:** The goal was to have one centre for every lakh population Or about 140 to 180 such centres at the state level, where quality referral services like comprehensive emergency obstetric care, Institutional care for the sick neonate and sick child and Sterilization operations on a regular basis, and diagnosis and treatment centres for infertility, STIs and RTIs are available. Yet despite the attempt to make at least 54 FRUs functional under RCH-I, there are only about 14 such centres in the entire state in the public health system and there are over 7 districts without any such centres. The last year has seen an EAG scheme initiative to create at least 32 more FRUs but this is not completed and the inputs are sub-critical. A referral system complete with ambulance and communication that needs to be linked to referral centres has not been attempted and in its absence the distribution of some grant to each panchayat has not even been utilised.
4. **Inadequate institutions for institutional delivery:** Only one in four Sub-Centres have adequate space for institutional delivery and even in these achieving institutional delivery has been difficult due to inability to make referral arrangements and due to a conflicting job description of the ANM that needs her to be away on most days. These problems are not there with Sector PHCs but due to lack of focus and weakness in design the Sector PHC has yet to become a 24-hour site of institutional delivery and basic emergency care.
5. **Medically Underserved Areas:** There are still many sectors that because of vacancy or absenteeism have not had a doctor in the last year and there are also many sections where because of geographical constraints and workforce issues or programme design issues there have been very poor delivery of paramedical services. Some of these areas are remote hilly tribal areas and others are medium and large urban or semi urban concentrations.
6. **Community Level Care organization:** because of the geographical dispersion of the population (4500 subcentres to cater to 54,000 hamlets and 26,000 villages) and because of inadequate health seeking behaviour first contact curative care for many of the life saving interventions at the village level and for prompt referrals needs an outreach that extends to every hamlet on a Daily basis. This is most critical for preventing infant deaths though it will also have benefits for all other RCH and other disease control components. Current care arrangements include the Mitanin, the traditional Dai, the depot holder and the Jan Swasthya Rakshak. The traditional Dai performs a very limited range of functions even within care at child-birth. The depot holder has a very limited outreach and function both because he is being a male and due to the process of selection and support. The Jan Swasthya Rakshak and RMP provide irrational and wasteful care even though some percentage of lives saved may be attributed to their function. The options therefore are to strengthen the Panchayat role and build on the Mitanin programme. The Mitanin by virtue of being a woman, selected by the community at the hamlet level addresses both these gender and equity imbalances also.

7. **Weak urban health systems:** Urban Health Systems are particularly weak and access to poor is limited. Though there is an abundance of public and private facilities in this area the critical weakness is in access to basic health programmes and secondary level care that is affordable for the urban poor.
8. **Inadequate Health awareness:** Though in many areas of RCH demand factors are not the critical step, they continue to play an important role. More investment in BCC strategies and a greater focus of BCC campaigns are called for.
9. **Programmatic and Financial Management Issues:** Management of RCH programmes – both programmatic and financial need improvement. Part of the problem is qualified manpower for these purposes at the state and district levels and part of the problem is governance related.

1.3 Proposed RCH-II Plan:

Goals: The main goals of the RCH programme are a reduction of the IMR from the current 73 to 35 by the year 2007, of MMR from about 400 to about 150 by the year 2007, an increase of CPR to 65% by the year 2007 and a reduction of total fertility rate to 2.1 and net reproduction rate to 1.0 by the year 2010. The goal also envisages making adolescent health care facilities and safe abortion services easily accessible to all.

unachieved in time for

The goal also includes achieving these targets in a manner that is affordable to the poor and such that it is equitable and so that the services are gender sensitive and are people friendly.

Strategies:

For Maternal Health:

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

For Child Health:

i. 100% immunisation including the booster dose by strengthening subcentre level services and its supervision.
ii. Prompt and appropriate community level care for all sick children and neonates and prompt referral where indicated.
iii. Regular House visits and counselling by community level care givers for preventive and promotive health of children and the reduction of child malnutrition.
iv. Adequate referral arrangement and secondary care facilities for sending a sick child or neonate when it requires hospitalisation.

v. Reducing cost of care especially on inessential and hazardous drugs and therapies so as to favourably impact on poverty levels.

For Family Planning:

i. Every district hospital would provide terminal sterilization services at least twice if not thrice a week.
ii. Hundred CHCs would provide sterilization on a fixed day of the week.
iii. The above block CHCs and 16 district hospitals would also be capable of providing safe MTP services.
iv. The above block and district hospitals would also have adequate diagnostics for referral level STI/RTI services.
v. In three months of the year all the remaining blocks would have at least three sterilization days in their CHCs. In the coming years these would also change to fixed-day weekly-once service availability.
vi. Every village would have one social marketing outlet, which would have supplies of condoms and OCPs without interruption throughout the year. These would be managed by partnership with a private distributor network with subsidy to make it viable to operate in low off take areas.
vii. All 24 hour PHCs would have one fixed-day of the week where IUD insertion would be available and other contraceptive follow up would be encouraged. Emergency contraception would also be available on 24 hour basis.
viii. All 24 hour paramedical and medical staff would be trained to provide basic clinical and counselling services for RTI and STI with basic investigations (side laboratory level).
ix. Every hamlet would have at least two volunteers who would have a limited stock of the supplies available- either collected from the village distribution point or from the health department.
x. A focused IEC campaign would continue to build up demand for these services.

For Adolescent Health

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

For Cross –Cutting Programme/Institutional Themes:

The interventions needed in each of the above technical areas are overlapping. As activities they can be summarised into eight cross-cutting activity groups. These are:

i. Infrastructure Development integrated with its proper utilization.
ii. Training.
iii. Operationalizing FRUs in at least 50 blocks in two years (Definition of FRUs in this context is to be able to deliver Emergency Obstetric Care, Care of sick neonates and sick children, regular FP sterilization services, safe abortion services, adolescent health care and care for RTIs/STIs)all blocks in five years and conversion of all PHCs to 24 hour PHCs which can perform institutional delivery.
iv. Strengthening routine Sub-Centre functioning incl. the coordination of functionaries around the weekly nutrition and health day.
v. Public Private Partnerships to close gaps in medically underserved areas.

vi. NGO participation in service delivery.
vii. Community level care and improved service utilization (to bring about a halving of IMR in three years), including better provisioning of drugs and supplies for this level of care.
viii. Behaviour Change Communication.
ix. Village and Panchayat level capability building to support the entire programme as given above.

For Programme Management Arrangements: This shall occur at five levels. These five levels and their functions are given below. Each of these five bodies requires careful planning at the level of governance, specifically in allocation of powers. They need to be able to function with a higher degree of autonomy, decentralisation of powers and professionalism. The RCH proposal also proposes ways and means and budgetary estimates to strengthen each of these levels.

Level	Measures
Strengthening of the Directorate	Administration and Workforce Issues Infrastructure creation Procurement and Distribution through a separate cell for the same
Strengthening of the State Health Society	Implementation of all technical components of the programme Monitoring and evaluation Financial Management related to programmes: NGO Programmes Public Private Partnership Programmes
Operationalizing the State Health and Family Welfare Society	All Training Programmes and capacity development in all employees
Strengthening of the District Health Societies	Implementation of Programmes of RCH District and Block Level Plan development.
Strengthening of the State Health Resource Centre	Mitanin; Community level capacity building; Operational Research and Policy related Studies: Assistance in Policy development & in Public Private Partnership programmes; NGO run programmes & dist/sub-district local health plan development

Budget Summary:

Sl.	PIP Component	2005-06	2006-07	2007-08	2008-09	2009-010	Total	Section
1	Building adequate infrastructure for ensuring RCH services at appropriate levels.	**607750000**	**1067347500**	**667839375**	**468733050**	**385315481**	**3196985406**	**7.3.1**
2	Training Infrastructure	31200000	3392000	7123200	7479360	7853328	57047888	**7.3.2.1**
	Training of paramedicals	11500000	12075000	12678750	13312688	13978322	63544759	**7.3.2.2**
	Training on adolescent health & STIs	3510000	3685500				7195500	**7.3.2.2**
	Training of medical officers-CME	5000000	5250000	5512500	5788125	6077531	27628156	**7.3.2.2**
	Multiskilling medical officers	4427500	4648875	4881319	5125385	5381654	24458733	**7.3.2.2**
	Training for ISM staff	7500000	7635000	2507925	2548321	2590737	22781984	**7.3.2.2**
	Total Training	**63137500**	**36686375**	**32703694**	**34253879**	**35881572**	**202663020**	
3	Ensuring Quality of care in FRUs and 24 hour PHCs.	28204000	29383200	30852360	32394978	34014727	154849265	**7.3.3**
4..	Strengthening Routine Sub-Centre services.	24000000	25200000	26460000	27783000	29172150	132615150	**7.3.4**
5	Social Marketing for Family Planning Service	324000	340200	357210	375071	393824	1790305	
6	Public Private Partnerships in Obstetric care	85614000	89894700	94389435	99108907	104064352	473071394	**7.3.5**
	PPP in Referral transport /Ambulance Services	50000000	21000000	22050000	23152500	24310125	140512625	**7.3.5**
	PPP in Laboratory Service	4000000	8000000				12000000	**7.3.5**
	TOTAL on Public Private Partnerships	**139614000**	**118894700**	**116439435**	**122261407**	**128374477**	**625584019**	

Sl.	PIP Component	2005-06	2006-07	2007-08	2008-09	2009-010	Total	Section
7	NGO participation in service delivery	20000000	21000000	22050000	23152500	24310125	110512625	7.3.6
8	Community Level Care (Mitanin)	196888300	206732715	217069351	227922818	239318960	1087932144	7.3.7.1
9	CHV/Mitanin drug kit	120000000	113400000	119070000	125023500	131274675	608768175	7.3.7.2
10	Behaviour Change Communication.	20000000	21000000	22050000	23152500	24310125	110512625	7.3.8
11	Panchayat Capability Building & Intersectoral Coordination	44105000	45580250	47129263	48755726	50463512	236033751	7.3.9
12	Adolescent Health	18030000	29431500	30903075	32448229	34070640	144883444	7.2.4
13	Urban Health	72055742	75035984	78787783	82727172	86863531	395470213	7.2.5
14	Tribal Health (mostlyincluded in other sections esp in training section)	19800000	8538000	5329800	5596290	5876105	45140195	7.2.6
15	Strengthening state health society and directorate.	13508000	5258400	5521320	5797386	6087255	36172361	8.1
16	Building Management capacity at the Directorate and in the District	2600000	2635000	2671750	2710338	2750854	13367942	8.2
17	Strengthening district health societies.	10400000	9240000	9702000	10187100	10696455	50225555	8.4
18	Strengthening State Institute of Health and Family Welfare.	14500000	6300000	6615000	6945750	7293038	41653788	8.3
19	Strengthening SHRC.	3998000	4197900	4407795	4628185	4859594	22091474	8.5
20	HMIS	41628200	19349610	20317091	21332945	22399592	125027438	8.6
21	Financial Management Improvement	1004000	378000	396900	416745	437582	2633227	8.7
	Total	**1461546742**	**1845929334**	**1466673202**	**1306598569**	**1264164274**	**7344912121**	

Note on budget:
The budget makes the following assumptions:
Current funds from ministry of family welfare, especially for Sub-Centres (MPW Female wages and their drug and equipment kits) will continue and RCH-II is additionality over the same.
The amount set aside for budgeted BPL reimbursements and for payments for sterilisation under the PPP programmes both in rural and urban areas would expand if demand flows above the 25% estimate and all sterilisations done under PPP can be reimbursed at rates quoted in our state's PPP approach.

2. Process of Plan Preparation

RCH –II design team was formed in January 2003 with the Director Health Services and the Director, State Health Resource Centre. In February 2003 both of them along with the Secretary Health attended the Health Sector Reform workshop hosted by the EU in Goa where the approach to the preparation of the state PIP was explained by the national design team for RCH-II.

Subsequently, a one-day consultation with various stakeholders was held in Raipur. This workshop helped to identify priority areas for the RCH-II programme. Participants included all the Directors and Joint Directors of the Directorate, the Consultants in RCH, Officials from the Government of India, Officials from UNICEF, DANIDA and EU who are the three donor agencies active in Chhattisgarh, and Subject Consultants in specific areas.

In early June the Director Health Services, Dr AK Sen, the Joint Director- RCH, Dr Pramod Singh, the Director SHRC and the secretary health attended the Cluster level Workshop on RCH-II that was held at Kolkata. This workshop explained the log frame aspect of the RCH-II project.

Then based on these inputs a design team was constituted and each member was asked to write and submit their inputs on various components. These included Dr. Subhash Pandey, Deputy Director RCH on RCH-I review, Dr. Jayaprakash on establishment aspects, Dr. Pramod Singh on institutional areas, Dr. Rajni Sao and Dr. Nilanjana Singh on Maternal Health, Dr. Ajay Dani on Child Health, Dr. K. Madangopal on training areas and Dr. Sundararaman on Infrastructure Development. The design team completed their work and submitted their inputs. On July 10th there was a one-day workshop to review these inputs. Many of these inputs had to be revised subsequently during the workshop.

Subsequently in August 2004, the SHRC's four person resource team of Dr. T. Sundararaman, Mr. V. R. Raman, Dr. Premanjali Deepti Singh and Dr. Kamlesh Jain was asked to finalize the draft plan for RCH-II using all the inputs from all the processes that had so far taken place. This draft was then discussed by the key functionaries of the state RCH society (same as state health society) and the Directorate of Health Services on September 8th and then finalized by the government. It was decided in this meeting to take the inputs from the national design team and the union ministry of department of family welfare also before the final submission.

3. Time Frame

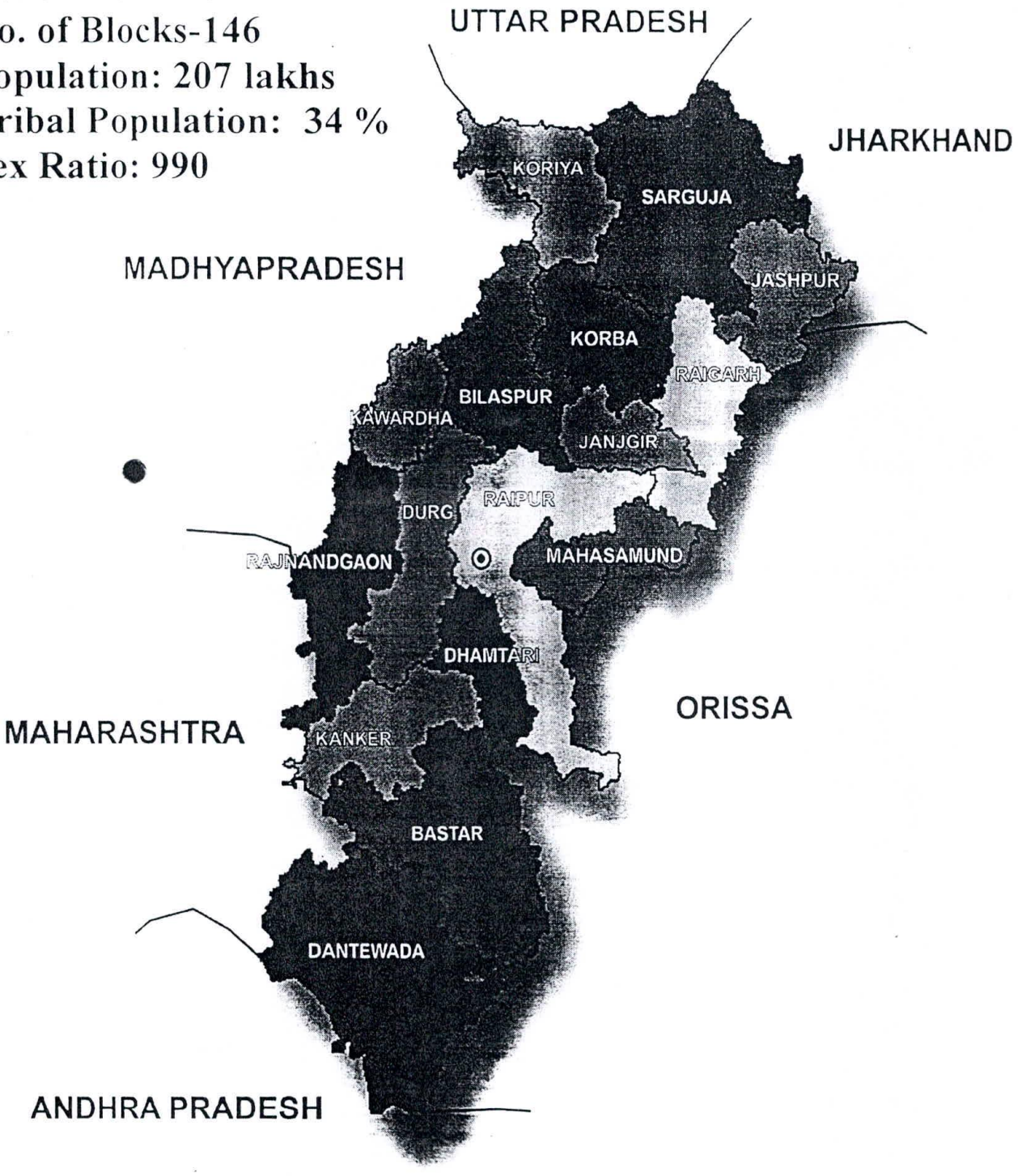
First Phase: Two years – 2005- 2007 presented with budget estimates.

Second Phase: In the next plan period - 2007 to 2010 – Currently a projection made with budgets to be finalized later.

4. Background and Current Status

Chhattisgarh

No. of distts-16
No. of Blocks-146
Population: 207 lakhs
Tribal Population: 34 %
Sex Ratio: 990



4.1 Socio –Economic Profile including Administrative Divisions:

The new state of Chhattisgarh was carved out of erstwhile Madhya Pradesh on the first of November 2000. Its population by census of the year 2001 is 207, 95,956. The state constitutes 2.03% of the total population of the country but occupies 4.11% of its land area. It is the ninth largest state and the 17th most populous state of India. This obviously implies a population density per square kilometre (154) which is about half of the average population density of the nation (324).

Of this land area about 40% is covered with forests and the whole land is criss-crossed with numerous swift flowing rivers all of which can flood during the intense monsoons.

As part of Madhya Pradesh the area that became Chhattisgarh had only 7 districts. With state hood the number of districts multiplied to 16. The state has 98 tehsils, 146 blocks, 20,978 villages. The state has 97 urban centres but the urban population constitutes only 20.08% of the total population.

The state has a comparatively good sex ratio of 990 women per 1000 males in the year 2001 and this is an increase from the sex ratio of 1991, which was 985.

The state has one of the largest concentrations of tribals with 32.46% of the total population constituted of tribals. Scheduled castes account for another 12.2% of the population. The rich ethnic and linguistic diversity of the state is also notable.

In terms of literacy rate the state has attained a total literacy rate of 65% with 78% for males and 49% for females. There has been an almost 20 % increment in the last decade in this figure. Despite this, its rank in the literacy score-card is 23 out of 35 states and union territories of India.

4.2. Performance by Demographic Health Indicators:

The state has a crude birth rate of 25.0, which is the same as the national rate. Thus it is performing better relative to many other EAG states as regards parameters in fertility control. Its total fertility rate is 2.79, which is better than the all India figure of 2.85.

The population growth rate at 18.06% is distinctly better than the national growth rate of 21.34% and has shown an over 7% decadal drop as compared to only a 2.62% drop at the national level. The significance of such a large drop in population growth rate is diminished when we find that the crude death rates and infant and child mortality rates are significantly higher than the national averages.

The crude death rate is 8.7 as compared to a national 8.1. The infant mortality rate is 73 – much higher than the national 64 and if we look at the rural desegregation of IMR it stands at 85 – the third worst index amongst states. The situation in under – 5 mortality is even more alarming with the Chhattisgarh rate being 122.7 as compared to a national average of 94.9. We

note that by international standards and even the standards of states like Kerala and Tamilnadu the national averages are impermissibly high, meaning that the distance this state has to traverse is not to be judged by the national average – but much further than that.

We however note that by SRS data in the last three years for which data is available there has been an improvement in our IMR figures – from 79 to 77 to 73 in the year 2002.

4.3. RCH outcomes and Service utilisation:

4.3.1. Maternal and Neonatal Care:

The determinants of these demographic health indicators are many and include levels of poverty and access to basic commodities like food, water and sanitary facilities as well as to higher educational levels and lesser inequities. However even within prevailing macroeconomic indicators good health services can bring about substantial improvements.

The key indicators regarding maternal and neonatal health provision are percentage who have received full ANC check ups, institutional delivery, and skilled care at birth (safe delivery); access to emergency obstetric services, percentage receiving postnatal care and the outcome indicators: percentage of low birth weight babies and maternal mortality. (Dai training and number of births attended by trained Dai remains important in areas where there is little or no penetration of health services but its impact on maternal mortality is negligible.) Not all these figures are available but one can see from the table below that we have a long way to go.

Table 2:

MMR	400+
ANC Check ups	12.8%
Institutional Delivery	21%
Safe delivery	42.03%
ANC Registration	97%
Postpartum Care	20%

Source: NFHS

4.3.2. Child Health Services:

The key indicators for child health services provision are: Immunization rates, child malnutrition rates, and IMR, and under 5 mortality rates.

Table 3:

IMR Total	73
IMR Rural	85
IMR Urban	51
Under 5 Mortality	122
Immunisation	57.58%

Source:NFHS, SRS 2002

4.3.3 Family Planning Services:

The most important key indicator is the couple protection rate and the outcome indicator is the total fertility rate and birth rate. Other goals are age at marriage and age at first child and average spacing interval and family size. The access to emergency contraception and safe MTP services is also an important component.

Table 4:

*Birth Rate Total	25
*Birth Rate Rural	26.5
*Birth Rate Urban	22.6
Couple Protection Rate (%)	39.9
Couple Protection Rate by Spacing	4.5
Couple Protection Rate by Sterilisation	35.4
Total fertility rate	2.79
Median months of spacing	31.6 months
% of women who had birth in 15- 19 age group	73.8% (?)

Source: NFHS-99, SRS 2002**

4.34. Adolescent Health:

Here development of indicators has been poor. Some of the most important indices would relate to malnutrition measured by BMI, prevalence of anaemia and incidences of violence against women. Pregnancy in adolescence also needs to be addressed as a major issue. We note that some of the problems on which we have data all tend to peak in the late twenties. However the adolescence age is when it sets in and when it starts building up. Available data on this is as follows:

Table 5: Issues related to adolescence health

Indicator	**% of adolescent women in 15 to 19 age**	**Age group where it peaks**	**Over all for women**
Anaemia	**67.5**	**72.6(25 to 29)**	**68.7%**
Mild	42.1	49.2	
Moderate	24.5	22.9	
Severe	1.9	0.5	
Nutritional Status			
- Mean BMI	18.9		
% below 18.5 BMI	44.9%		48%
RTIs			
vaginal discharge + Itching + Lower abd. pain	22.7% + 12.7% +14.2%		37% of married have some RTI of whom 68% have not sought advice
Violence			
% beaten or mistreated	12.6%	21.4 (30 –39 age)	17.4%
NOT Involved in decision making where it affects them	15.8%	15.8 (15 to 19 age group)	7.9%
% of women who had first child in 15 to 19 age group	73.8%		18.1 years – median age of first child.
Source: NFHS			

4.4. Public Health Systems Analysis

4.4.1 State Level Implementation Structure-

See the Organogram in next page.

Chhattisgarh has a fair sized network of health facilities in the public sector as shown below.

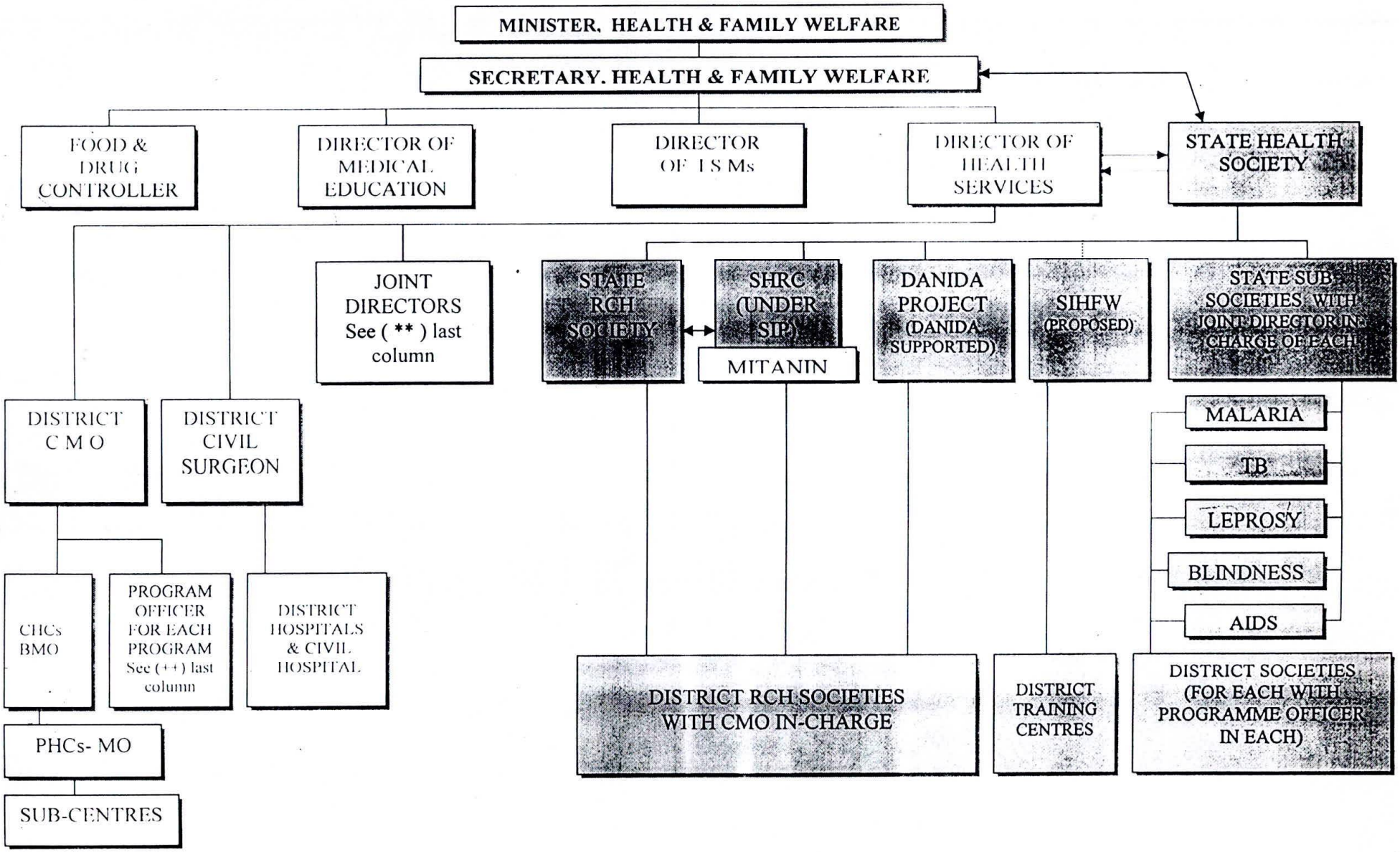
Table 6: Public Sector Health Facilities at a Glance

S .No.	District	Blocks	Distt. Hosp.	Civil Hosp.	CHC	PHC	HSC	C.D.	No. of Beds			
									Distt. Hosp.	Civil Hosp.	CHC	PHC
1	Raipur	15	1		11	47	461	10	100		350	82
2	Surguja	19	1		18	65	488		188		540	18
3	Bastar	15	1	2	12	57	317		269	80	360	18
4	Dantewada	11	1		9	34	204		(100)		296	12
5	Jashpur	8	1		7	27	195		109		210	22
6	Kawardha	4	1		2	12	96		(100)		60	36
7	Raigarh	9	1	2	5	40	249	2	117	76	150	46
8	Janjgir-Champa	9	1	1	6	25	210	1	(100)	38	180	68
9	Dhamtari	4	1	1	3	11	138		100	6	90	16
10	Bilaspur	10	1	1	10	42	282	3	(100)	6	306	23
11	Maha-samund	5	1	1	4	14	143		(100)	32	126	
12	Durg	12	1	2	10	46	353	1	330	45	276	34
13	Raj nandgaon	9	1		6	25	220	1	225		180	55
14	Kanker	6	1	2	5	21	162		100	130	150	36
15	Koria	5	1		5	21	106		(100)		150	12
16	Korba	5	1		3	29	194		100		90	18
	Total	**146**	**16**	**12**	**116**	**516**	**3818**	**18**	**1638 (600)**	**413**	**3514**	**496**

Figures in bracket indicate that facility is under construction.

However a number of facilities do not have the minimum infrastructure needed for optimal functioning. Whereas almost all district hospitals will become 100 bed institutions soon , as we go more peripherally we find the gaps widening. Thus by population norms the state should have 180 CHCs for the rural areas. In practice CHCS are not by population norms but by administrative blocks. Still, excluding 16 district headquarters, we should have 130 CHCs.

ORGANOGRAM SHOWING CURRENT ADMINISTRATIVE STRUCTURE & LINKAGES TO PROGRAMME MANAGEMENT



The gaps in PHCs are more acute. Out of 748 sectors, only 516 got sanctioned PHCs- a gap of 234 PHCs. In subcentres, the gaps have been closed recently by sanction of another 875 Sub-Centres. The situation regarding health infrastructure is given in tables 7 to 9.

Table 7: Health Sub Centres in Chhattisgarh

S.No.	District	Block Head office	Sanctioned HSC	Govt. Building	Run in Panchayat Bhavan/Any Other Building	New Buildings after state formation
1	Raipur	15	461	82	379	0
2	Sarguja	19	488	118	370	0
3	Bastar	15	317	211	106	0
4	Dantewada	11	204	89	115	0
5	Jashpur	8	195	152	43	0
6	Kawardha	4	96	40	56	0
7	Raigarh	9	249	194	55	0
8	Janjgir-Champa	9	210	37	173	0
9	Dhamtari	4	138	44	94	0
10	Bilaspur	10	282	40	242	0
11	Mahasamund	5	143	51	92	0
12	Durg	12	353	105	248	0
13	Rajnandgaon	9	220	110	110	0
14	Kanker	6	162	123	39	0
15	Koria	5	106	42	64	0
16	Korba	5	194	20	174	0
	Total	**146**	**3818**	**1458**	**2360**	**0**

Another 850 HSCs have been sanctioned w.e.f. 2004-2005. All of them have no buildings as yet.

Table 8: Primary Health Centres in Chhattisgarh

S.No.	District	Sanctioned PHC	Govt. Building	Rented and in other building / Without any building
1	Raipur	47	33	14
2	Sarguja	65	46	19
3	Bastar	57	37	22
4	Dantewada	34	25	9
5	Jashpur	27	20	7
6	Kawardha	12	10	2
7	Raigarh	40	18	22
8	Janjgir-Champa	25	12	13
9	Dhamtari	11	6	5
10	Bilaspur	42	23	19
11	Mahasamund	14	3	11
12	Durg	46	34	12
13	Rajnandgaon	25	14	11
14	Kanker	21	17	4
15	Koria	21	11	10
16	Korba	29	18	11
	Total	**516**	**327**	**191**

We note that there are totally 748 sectors in the state. Of these, only 516 have sanctioned PHCs. The need to create 232 more PHCs to reach the required norms of the planning, represent the single largest unaddressed infrastructural challenge of the state.

Table 9: **Community Health Centres in Chhattisgarh**

S.No.	District	Sanctioned CHC	30 bedded CHC according to norms	Run in PHC/any other building
1	Raipur	11(3)	3	8
2	Sarguja	18	3	15
3	Bastar	12(1)	2	10
4	Dantewada	9	3	6
5	Jashpur	7		-
6	Kawardha	2(1)		2
7	Raigarh	5(3)	2	3
8	Janjgir-Champa	6(2)	3	3
9	Dhamtari	3	1	2
10	Bilaspur	10	6	4
11	Mahasamund	4		4
12	Durg	10	6	4
13	Rajnandgaon	6(4)	3	3
14	Kanker	5(1)		5
15	Koria	5	2	3
16	Korba	3(1)		3
	Total	**116(16)**	**34**	**82**

We note that another 16 PHCs needs to be upgraded to CHCs and sanctioned as such. These are indicated in brackets.

Fully Operational and Utilised: It is difficult to estimate How much of these facilities are fully operational and functional, because of varying levels of utilisation. It is more appropriate to look at the constraints of utilisation. Infrastructure constraints are indicated in tables 7 to 9.

But even where infrastructure is in place manpower could be a problem. The tables 10 and 11 present the situation in manpower.

Table 10: RCH Manpower in Chhattisgarh:

S. No.	District	Staff Nurse			LHV			MPW(M)			MPW(F)		
		Sanctioned	In position	Vacant	Sanctioned	In position	Vacant	Sanctioned	In position	Vacant	Sanctioned	In position	Vacant
1	Raipur	71	68	3	71	68	3	458	316	142	434	429	5
2	Sarguja	81	28	53	90	81	9	406	387	19	557	526	31
3	Bastar	34	16	18	82	77	5	317	287	30	317	296	21
4	Dantewada	36	20	16	61	43	18	205	195	10	205	187	18
5	Jashpur	36	18	18	41	38	3	172	120	52	256	228	28
6	Kawardha	8	9	0	20	17	3	101	73	28	102	75	27
7	Raigarh	73	57	16	50	46	4	211	189	22	307	244	63
8	Janjgir-Champa	36	23	13	57	44	13	213	153	60	215	175	40
9	Dhamtari	28	19	9	25	17	8	139	83	56	154	192	0
10	Bilaspur	113	116	0	84	81	3	282	254	28	301	281	20
11	Mahasamund	25	23	2	24	20	4	149	87	62	149	125	24
12	Durg	106	103	3	67	63	4	298	259	39	438	436	2
13	Rajnandgaon	34	35	0	41	40	1	214	177	37	254	258	0
14	Kanker	49	28	21	35	38	0	155	132	23	162	162	0
15	Koria	21	14	7	26	17	9	124	80	44	124	83	41
16	Korba	13	13	0	40	40	0	113	113	0	119	119	0
	Total	**764**	**590**	**174**	**814**	**730**	**84**	**3557**	**2905**	**652**	**4094**	**3816**	**278**

Table 11: RCH Manpower in Chhattisgarh

S. No.	District	Anaesthetist			Gynae			Paed			Medical officer		
		Sanctioned	In position	Vacant	Sanctioned	In position	Vacant	Sanctioned	In position	Vacant	Sanctioned	In position	Vacant
1	Raipur	0	0	0	3	3	0	1	0	1	124	116	8
2	Sarguja	0	0	0	4	0	4	3	0	3	142	121	21
3	Bastar	1	1	0	6	1	5	5	1	4	131	114	17
4	Dantewada	4	0	4	4	0	4	1	0	1	79	62	17
5	Jashpur	0	0	0	3	2	1	1	0	1	73	52	21
6	Kawardha	0	0	0	0	0	0	0	0	0	31	23	8
7	Raigarh	0	0	0	0	5	0	0	0	0	84	75	9
8	Janjgir-Champa	0	0	0	2	0	2	2	1	1	62	62	0
9	Dhamtari	1	1	0	1	1	0	2	2	0	35	33	2
10	Bilaspur	1	0	1	7	2	5	6	1	5	144	128	16
11	Mahasamund	0	0	0	2	1	1	2	0	2	43	39	4
12	Durg	1	1	0	5	4	1	6		6	151	152	0
13	Rajnandgaon	0	0	0	4	0	4	5	0	5	98	79	19
14	Kanker	0	0	0	3	1	2	2	0	2	70	70	0
15	Koria	3	0	3	2	0	2	2	0	2	37	30	7
16	Korba	0	0	0	0	0	0	0	0	0	32	29	3
	Total	**11**	**3**	**8**	**46**	**20**	**31**	**38**	**5**	**33**	**1336**	**1185**	**152**

Table 12: RCH Manpower in Chhattisgarh

S.No.	District	Lab Tech			BEE		
		Sanctioned	In position	Vacant	Sanctioned	In position	Vacant
1	Raipur	34	30	4	14	13	1
2	Sarguja	54	33	21	20	14	6
3	Bastar	36	32	4	14	13	1
4	Dantewada	28	25	3	12	8	4
5	Jashpur	26	16	10	9	7	2
6	Kawardha	8	5	3	4	1	3
7	Raigarh	37	26	11	8	7	1
8	Janjgir-Champa	18	16	2	9	8	1
9	Dhamtari	9	5	4	4	4	0
10	Bilaspur	46	44	2	11	10	1
11	Mahasamund	13	12	1	5	5	0
12	Durg	47	41	6	14	13	1
13	Rajnandgaon	18	17	1	9	6	3
14	Kanker	27	25	2	7	9	0
15	Koria	21	14	7	5	3	2
16	Korba	14	14	0	4	4	0
	Total	**436**	**355**	**81**	**149**	**125**	**24**

We can see Specialist vacancies are a serious problem. We however note that a number of specialists (Anaesthetist: 42, Gynaecologists: 48, and a number of paediatricians and others) are serving as medical officers currently available within the system.

Transfers of these to fill up specialist vacancies with regular promotions to specialist post will help but only to a point. A rough estimate is that about one third of these specialists would be willing for such transfers where they are needed.

Even where manpower is in place a number of problems especially of workforce management, human resource development and the rational deployment of systems impede the progress of the programme. These are discussed in length in the study report on these same topics brought out by SHRC .The executive summary of this report is annexed and the main report can be had at request.

This report covers the following areas :

- Institutional Arrangements
- Organisational structure
- Accountability of staff
- HRD, rationalisation of services and workforce issues
- Training
- Logistics
- The report does not cover the HMIS, which is discussed in section 8 on Programme Management Arrangements.

4.5. Private and NGO services:

The private sector and not for profit hospitals in the state are many. The latter include public sector hospitals of a number of mines and public sector companies. Their district wise distribution is as follows.

Table 13: Health Facilities run by NGOs.

Sl.	District	Pvt sector nursing homes	Not for profit sector	Public sector
1	Bastar	7	1	0
2	Bilaspur	36	4	2
3	Dhamtari	5	1	0
4	Janjgir	2	2	0
5	Korea	2	0	2
6	Raigarh	1	0	0
7	Raipur	44	1	0
8	Rajnandgaon	7	1	0
9	Mahasamund	8	3	0
10	Korba	5	0	3
11	Kawardha	6	0	0
12	Sarguja	4	1	1
13	Durg	18	3	3
14	Jashpur	1	1	0
15	Kanker	1	0	0
16	Dantewada	0	0	2
	Total	**147**	**17**	**13**

The above figures are indicative. A more recent update of these figures is needed especially for large urban areas.

Between districts and within districts the private sector is very much concentrated in a few centres.

Not for profit hospitals are of two types– Mission run hospitals and other NGO run hospitals. The Ramakrishna Mission runs a major one in Narainpur in Bastar district. The Christian Missions have a major hospital at Dhamtari and smaller ones in Bilaspur, Rajnandgaon, Baitalpur(2), Mungeli, , Tilda and Champa(2) and Jagdishpur. The Catholic Missions have hospitals at Kunkuri, Raigarh, Ambikapur, Charoda and in Dalli Rajhara(Durg). The Public sector undertakings running hospitals are SECL, NMDC, NTPC, BALCO and Railways.

We note that comprehensive emergency obstetric care is available in 25 out of 29 not for profit and public sector hospitals. Of the other NGO hospitals the Jan Swasthya Sahyog hospital at Ganiyari, Bilaspur and the workers union run Shaheed hospital are the two most outstanding examples. One more NGO run hospital is there in Mahasamund.

We note that about 50% of the private sector units are concentrated in just two cities and even the others are concentrated in districts which also have fully functional state run facilities. On the other hand public sector units and NGO units are largely distributed in areas of very poor private sector and public sector penetration, and offer a major space for participation.

4.6. Donor Assisted Programmes In The State:

There are only two such donor-assisted health sector programmes in Chhattisgarh. They are 15 crore Chhattisgarh Basic Health Services Improvement Programme funded by DANIDA and the 16 crore Sector Investment Programme funded by the European Union.

DANIDA: Danida programme has been used for training of Dais, for strengthening training institutions and management capacity building and for improving drug logistics.

European Commission: The Sector Investment Programme funds has been used to set up a State Health Resource centre that has conducted a number of studies and initiated a wide number of health sector reforms – other than coordinating and guiding the largest ongoing community health volunteer programme which is known as the Mitanin programme.

UNICEF: UNICEF contributes strengthening ongoing programmes. Other than it has printed the ANM registers for the current year and provided Rs 10000 per district as a mobility fund to improve supervision and Rs 25000 per district for catch up immunisation. It has also supported closing equipment gaps in subcentres for 32 priority blocks. It is supporting the Mitanin Programme also- by printing of monitoring formats and strengthening focus activities on nutrition by providing weighing machines.

Global Fund: Through the central government the state has programme funding in malaria , tuberculosis and HIV control .The programme designs are identical nation-wide. Some of the funding for these programmes received by the centre are from the World Bank and from the Global fund against the three diseases.

4.7 Programme Expenditures under RCH-I:

The following table gives in brief the physical and financial achievements of RCH-I programme. Though this scheme was initiated in 1997, the scheme allocation for the new Chhattisgarh state was carved out in the year 2000 and the budget and activities shown below are therefore for the period April 2001 to March 2004 a three-year period. In April 2004 it was decided to extend this scheme by one year till the RCH-II was written up.

Table 14: RCH-1 Expenditures

Item	Target (from 2001 cumulative)	Achievement	Financial allocation:	Financial achievement
Contractual appointment of field staff :	For 14 C distts:(except Raigarh /Jashpur): 1012 ANMs plus staff nurses 146 plus lab techs 32(2/dt)	494 + ANMs +76 staff nurse +23 lab. techs	1071 lakhs	844 lakhs+++
Contractual appointment for SCOVA	6 consultants (IEC, finance, monitoring, child health, maternal health asst stats.)	4- (except child health and asst stat off.)	18.72	100%
Major civil works	66 CHC renovations + 5 dt hospitals renovation	Completed	639 lakhs	100%
RCH camps for outreach of all RCH	290 camps were planned till march -04	290 held	196 lakhs	100%

Item	Target (from 2001 cumulative)	Achievement	Financial allocation:	Financial achievement
services esp. FP.				
Cold chain maintenance :	Funds for Vaccine transport.; for frig mech. mobility, for ILR repair/& for inj. safety- kerosene for sterilisation	Used for the purposes stated	27.79	81%
Vaccine handlers trg.	Training for MPWs & ANMs and supervisors	Completed as scheduled		100%
IEC	Hoardings , and kalajathas were main focus	Completed	380	100%
Referral transport	For gram panchayats to transfer emergency cases : funds given to 8054 GPs in 14 distts.	1418 pts used services; 7 distts. Refunded money	42.15	6%
Outreach immunisation	4 distts (durg , Koriya, Raipur and Mahasamund) outreach camp: sessions where there are no functional SCs	Limited response, only partly utilised.	21.12	54%
Em. Obs. Care FRU kits- equipment	This was supplied to FRUs for equipping them for EmObs Care	54 FRUs were supplied		
24 hour delivery in CHC/PHCs	incentive for night shifts for doctors and nurse	any increase in institutional delivery needs evaluation:	80	100%
Community incentive scheme	2 lakhs per distts for 1 GP which has max. Achievements in FP	Fully utilised;	40	80%+++
Dai training	Targets fixed for trg, main funds from Danida	about half the expected done	14.68	50% +++
EC supported SIP	largely used for health sector reform and Mitanin programme	54,000 Mitanins in place and functional and evaluated.	1095	100%
EAG- FRU :Trg/ PPP 2 blocks / Mitanin 2 books	Civil works in 32 blocks for improving PHCs and CHCs; plus Multiskilling some 30 persons in OG and anesth.;also trg and PPP	Civil works and Multiskilling done.	575	478
condoms	For one time condom purchase	This was done. Small amt of money returned	106	100%
Parivar melas	More as IEC, small outreach role	Completed- uncertain impact.	35	100%
Review meeting and mobility support	This is for strengthening supervision	money utilised	5.58	80%+++
NSVT			3.0	100%
PNDT	IEC on sex –selective abortion	Done-	12.0	23.5%++

Item	Target (from 2001 cumulative)	Achievement	Financial allocation:	Financial achievement
Laparoscope's repair	25 to be repaired	All repaired	12.0	75%
Stabilisation of popln.	Workshop to be done and action plan drawn up		20	0%
NGO coordination	To facilitate coordination of NGOs	Utilised	6.0	100%
DD kits	this was for pregnant women as a step in maternal care	procured and distributed.	26.16	100%
NSVT trg.	for training n non scalpel vasectomy technique	Being undertaken.	3.65	100%
Funds for contraception/ sterilisation	For compensation to patients who opt for terminal FP methods as incentive	Been put on hold at request from centre to revise plan.	120	Pending – plan
PPP for RCH service	To set up programme management for state led franchisee	Plan made awaits approval	50(200)	0%
RCH Trg.	ANM, LHV, supervisor, medical officer for 12 days each	Very useful trg- only part covered for logistic reasons	84.35 lakhs	65%++
Trg for ISMs	TOT done, dt officers providing trg for MOs and ANMs	Trg expected to start soon.	1.9	0%

4.8. Details of administration and finance of RCH-I:

Almost all components of RCH-I are organised by the joint director RCH , assisted by the deputy director RCH and one financial consultant, one maternal health consultant and one consultant on IEC and another one on data analysis. This has been very inadequate for the management of such a large programme. There has been no distinction in implementation between the state health society and the directorate as the same officers perform both administrative and programmatic functions. This weakness of staff reflects in every aspect from quality of monitoring to the realisation of utilisation certificates in a timely manner.

The EC supported SIP has however been outsourced to a state health resource centre which has been built up as an additional technical capacity to assist the directorate and this has been useful to design, launch, monitor and support an innovative and complex programme with a high rate of expenditure – almost all of it at the community level.

At the district level the programme is under the district RCH society. Here too the district RCH society has no staff, and the same district chief medical officer assisted by an immunisation officer – who is often holding charge in addition to clinical duties manages the entire programme. Even accounting help is limited.

There is a need to make a major investment in management structures if in future larger programmes need to be better run.

5. Situation Analysis

The reasons for the limited achievements despite the existing health systems has been analysed in detail in the SHRC's study group report on rationalisation of health services, workforce management and human resource development report. This has been summarised in section 4 above and the executive summary of this report is annexed.

We would now re-examine the question from the viewpoint of each health goal. There are five broad health goals we are examining – maternal health, immunisation, neonatal and child health care, adolescent health and family planning services. A large part of the constraints in improving these services are overlapping.

In each of these five technical domains the over coming of these constraints invariably requires action at four levels. These are:

i. Measures for increasing public awareness and promoting appropriate behaviour change.
ii. Need to have community level care arrangements so that basic care which is simple and life saving is received almost immediately on any day of the week.
iii. Building up a system such that a skilled woman paramedical on a regular 24 hour basis so that essential health service inputs of RCH are accessed –like immunization antenatal care, skilled care at delivery. This includes both options- strengthening the ability of the public health system and building up public private partnerships.
iv. Building up a functional referral system with the nodal point being a well equipped and functional secondary care centre so that secondary medical care (largely defined by the ability to manage a Caesarean section and provide in-hospital care for a sick neonate or child) is accessible to all. This too includes both options: strengthening existing public health system, and supplementing with private sector partners where-ever it is required and possible.

We give below the specifics of how the constraints operate in each domain of RCH.

5.1. Maternal Health:

The immediate causes of maternal mortality are well known. They are sepsis, haemorrhage, obstruction, anaemia, toxaemia and unsafe abortions. The larger social determinants of these are also equally well known – they include educational status of women, poverty levels, social inequities and access to quality care.

We would now re-examine these causes from an intermediate operational set of issues. Thus maternal mortality in such an analysis may come from:

1. **Inability to follow optimum health practices-**
   a. Eat the right foods in right quantity,
   b. Take adequate rest while retaining optimum activity,
   c. Protect oneself from infectious disease
   d. Be able to access health care facilities due to a supportive environment.

The above factors may occur due to:

- Lack of education and awareness.
- Burden of work due to poverty
- Inability to afford increased health determining inputs – esp. more food of better quality, more rest, safe water and sanitation etc.
- Lack of money to pay direct and indirect costs of maternity care e.g. visits to a nurse, transport in an emergency, pay for drugs or other treatment prescribed etc. (The loss of wages of woman and her accompanying person should also be costed)
- Poor support from family and community due to discriminatory attitudes that fail to prioritise women's health issues.

2. Inability to access good quality antenatal, natal and post natal services:

This in turn is due to:

a. Lack of nurse (refers to female MPW or ANM) to providing quality ante-natal care at an appropriate time in vicinity of her home.

- **Vacancies:** Some areas are paramedically underserved due to a vacancy situation related to workforce management and governance issues.
- **The Up-down Problem:** The ANM is posted there but does not stay there and visits are occasional. Again workforce management and poor supervision related issue.
- **The Geographical Constraint:** Distances to be covered by ANM are high and the ANM visits only about once a month – and the high degree of coordination needed to ensure that the mothers meet the ANM during this brief visit is not present for at least some of the population. Thus there are only 4800 ANMs but over 54000 hamlets. Each ANM has to cover approximately 10 to 15 hamlets over a 5 to 25 km distance.
- **The Quality of Care Constraint:** The antenatal visit occurs but antenatal care is limited to registration, iron and folic acid tablets and TT injection .All other dimensions- identification and advice on high risk, blood pressure and weight measurements, urine and blood examination are just not done. This is largely a training & supervision issue but may occur as a consequence of equipment and facilities.

b. Lack of skilled birth attendant in vicinity of home (trained midwife, nurse or doctor):

Many lives can be saved if the skills to conduct a safe normal delivery are present, along with the skills needed for management of the first level of complications (uterine massage, injection of oxytocics, intravenous hydration and antibiotics, antihypertensives and anticonvulsants, assisted deliveries etc.) and the ability to identify the need for referrals in a timely manner. This level of skills is not provided by a Dai – even if trained. It needs a trained midwife or nurse at least. Since most often this is available in an institution this goal is usually realised only by encouraging institutional delivery. Constraints operational are all those mentioned in 2a – vacancies, up-down problems, the geography problem and quality of care issues. Up-down problem can be particularly harmful since care at delivery requires physical availability for 24 hours. In addition lack of adequate skills in some ANMs is also a problem. Another problem in access to this care is the high charges that skilled delivery entails as compared to the traditional Dai. On an average the going informal rate for skilled birth attendant even within the public health system is Rs 400 to Rs 700 – in rural Chhattisgarh.

c. **Lack of facility providing institutional delivery on a 24 hour basis:**

- **The Sub-Centre:** The Sub-Centre is not usually a site for institutional delivery. In two thirds of sub centres the lack of buildings rules it out as an option. But even in the one third that has a building the ANM is available at the headquarters only once or twice a week during working hours. The rest of the days she is on tour. In addition she is often not staying there. Equipment gaps may also contribute to poor service. Lack of communication and referral linkages also discourages the staff from taking a risk- as timely referral becomes necessary in 5 to 15 % of cases. It is difficult to predict which case would need such referral and if the referral is made late then the ANM is held responsible. Thus the Sub-Centre would be insisted on as site of institutional delivery only if there are two ANMs posted there (who between them can see that there is someone at the headquarters on at least 5 days of the week) and only if good communication and referral arrangements are built there. Where these two are possible the completion of infrastructure as per norms would result in improved outcomes. For the rest we intend to encourage it but not insist on it.

- **PHCs:** Even most PHCs are not functioning on 24-hour basis and not providing institutional delivery facilities. Here infrastructure is adequate. Total number of staff would be high and out of proportion to the few numbers of patients attended to. On an average only 25 patients may be seen in a day. However the paramedical are categorised into 8 categories – dresser, compounder, laboratory assistant, sector supervisor male, sector supervisor female, staff nurse and MPW (female) and MPW (male) – the last two from the built- in Sub-Centre. The class IV staff also is categorised into 5 categories. Usually one or other of these posts is vacant or not even created and this makes for the perception that manpower availability is the single most important constraint. Except for the MPW (F) given the OPD attendance all the above staff are employed for not more than two hours of work every day- including the sector doctor. Almost no one sees institutional delivery as her responsibility. They see themselves as assisting the medical officer whose availability, skills and leadership at this level is very difficult to attain.

- **CHCs:** CHCs have also similar problems to that of the PHC described above–but less so. In many CHCs some institutional delivery happens. But due to low availability of C-section facilities there is reluctance to take up cases. Paramedical staff is adequate for this purpose as other than LHV and ANM there are staff nurses also available.

- **Private sector facilities:** Private sector facilities are usually not available or too costly for the majority. However there are a number of NGO run hospitals that provides adequate care at affordable costs. Public sector undertakings run facilities are many and provide good quality free care to their workers but are unaffordable and also difficult to access for non-employees.

d. Lack of facility to which one can be referred:

"an institutional delivery location the distance of which is within one hour " For complications when higher (secondary) medical care is needed. (Emergency obstetric care including blood transfusion), such referral facilities are necessary. The current approach to this is to develop all district hospitals and all CHCs as sites of such secondary medical care.

However the large gap between the skilled manpower needed for this and that which is available makes it essential to have a short-term goal. This goal was set for RCH-1 as setting up 54 FRUs. However even this has not been realised and there are only some 15 hospitals including 9 district hospitals, three civil hospitals and three block level CHCs which have this capability as of now.

The constraints have been of infrastructure, equipment, supplies, manpower and skills. These constraints are largely not one of absolute unavailability but emanating from mismatches between the provision of one element and the other. Thus one has gynaecologists posted where there are no operation theatres and operation theatres where neither gynaecologists nor surgeons available. One has shadowless lamps and Boyle's apparatus without functional OTs where many OTs are there whose functionality is constrained only by this gap.

Private sector hospitals and not–for profit hospitals providing these services especially in the further districts are also few. On one hand these private sector hospitals are not enough to service the needs of the poor in the state. But we also note that the not for profit sector has at least 29 hospitals where they would be willing to undertake BPL cases with reimbursement by the government. In none of these centres today referral reimbursement is ongoing. If these were included the number of centres where the state is able to provide health care facilities would be tripled. And this would be easy to initiate because monitoring need not be as stringent in these non-commercial hospitals. With some checks one can allow flexibility in rates charged even as reimbursement rates are kept consistent. The unregulated environment of the private commercial sector will require close monitoring and fixed rates packages.

e. Lack of transport facilities:

From the home or from the site of institutional delivery timely transport to a secondary centre during an obstetric emergency can be life saving. In most places however, even where there is a secondary medical service some transport is either not available or is that a hired vehicle is so costly that this acts as one of the biggest barriers to access of health care. (Public transport is not an option in such situations.) There is a fund kept with the panchayats for such referral. Many panchayats have not received the funds, or where they have received it have little idea of the rules governing it and further in times of emergency the fund is difficult to access. Because of very poor systems designs the fund has gone unutilised and this failure of utilisation is blamed on the panchayats.

f. **Lack of a trained person who can visit the mother on the day of child birth and again within a week**:
The post-partum mother and the neonate requires a visit by a trained volunteer in the first day after birth and at least once more in the first week of the neonate's life. Given geographical constraints it is not possible for the ANM to do so. Only a trained community level caregiver like the Mitanin can do so.

g. **Social issues in access:**
Sometimes the nurse is there and resources are not a problem but there is a poor motivation to provide services or a reluctance to accept services even when the knowledge and attitudes are alright. These gaps are cultural gaps and represent a certain passive discrimination – of caste or creed, or of gender. They are not necessarily perceived as such. Thus the nurse who is available only during the peak working hours may attribute the lack of response from a hamlet to their ignorance or even stupidity. And the hamlet may attribute her failure to come at a convenient time or her rudeness as a form of denial. Even at the level of hospitals rudeness, having to wait for unreasonable periods of time, lack of privacy for examination of women are some examples of discriminatory practices that reduce access. Their actual contribution to reduction of access is difficult to quantify.

Safe MTP:
Here considerable work has been planned and there is a training programme ongoing. But this training needs to be extended in duration and expanded to many more centres as part of our thrust in strengthening a large network of FRUs.

5.2. Child health:

Poor outcomes in child health are related to the following:

a Inability to follow adequate preventive measures and appropriate health seeking behaviour:
Constraints here are same as in discussion on maternal health above.

b. **Immunisation:**
The problems of the ANM as described for maternal health all apply. These are the vacancy situation, the up down problem, the geographical problems and the quality of care issues. The coordination between anganwadi worker, Mitanin and ANM has taken the institutional form of the weekly Nutrition and Health Day (or health mela day) and this concept is being built on.

c. **Care for sick child:**
Here the main problem is the difficulty–indeed impossibility of meeting the sick child and providing care in a prompt manner. In most areas the ANM can visit a habitation only once or twice a month. She herself is available in headquarters only once a week. The family cannot afford not going to work just to seek care until the child becomes too sick and such a delay can be fatal. The only way to bridge this gap is a community level caregiver who provides appropriate first contact care and knows when to refer.

There are currently three types of community level caregivers. The Mitanin is a volunteer selected by the community, based at the hamlet level and trained over 18 days. Her focus is on preventive care. For optimum functioning she requires considerable investment in continued training and support. If this is available she would be the ideal care giver.

The second category is the depot holder. Almost always a male, this is often chosen by the ANM in consultation with more influential sections of the Panchayat. He is often content to have a few drugs adequate for his household and immediate circle's needs. The community does not know or use the drugs deposited there and the lack of pressure for more drugs means less problems for the health functionaries of that level. There is zero training for depot holders. Many districts have moved to making Mitanins the drug holders – but the attraction of having a male dispensing drugs and the local patronage it allows – has been a powerful reason for continuing with this cadre.

The third is the Jan Swasthya Rakshak and RMP. These are almost synonymous except that the first category went through a six month training about eight years ago. These are also almost always males from influential sections and they are liberal with the use of drugs, and injections including steroids and antibiotics. Though undoubtedly they would be saving lives in some sick children their overuse of drugs is on the whole debilitating and a major cause of rural impoverishment.

Though the rational choice between the three categories is clear one has to contend with pressures against women from underprivileged sections who are spokespersons of their community asking for accountability from the system as against the pressures for men dispensing medicines linked by patronage to the local elite. The Mitanin Programme therefore requires special support from above to survive and deliver health outcomes. Potentially, as studies from Jamkhed, Mandwa, Ghhadcharauli, SEWA rural etc shows, it can lead to a fall in current IMR in further 3 years.

d. Care for sick neonate:

Birth weight recording and postnatal care visits are almost not happening except where institutional delivery is in place. Therefore there are no reliable records of percentage of children with low birth weight– which is essential to generate an action plan on neonates. Postnatal care quality is also in question. Again the role of the community level caregiver becomes paramount. Here in addition to the three categories of caregivers discussed for the sick child we also have the trained traditional birth attendant. Unfortunately TBA in Chhattisgarh has a limited role in cutting the cord and burying the placenta. She is seldom invited or involved in any form of antenatal, natal or postnatal care – much less the care of a sick neonate. Some of them have become Mitanins and received more comprehensive training but the majority would have little role to play. The Mitanin's role has been defined as a six point programme- ensure 1.breastfeeding in the first hour, 2.ensure adequate mothers diet, 3.weigh the new born, 4.promote measures to keep the baby warm especially if underweight, 5 facilitate BCG and polio drops and 6. Most important if the child is less than 2 kg or is not feeding well referring at once for institutional care. The depot holder and JSR as men are not resorted to for such care nor do they offer it. They are irrelevant to this goal.

e. **Institutional care for the sick neonate and sick child:**
A good percentage of sick children would require institutional c
include neonatal sepsis, child hood pneumonias and severe dehy
diarrhoea and significant prematurity. In all such cases institutional ca
saving. Institutional care is best done at the 130 CHCs and 16 district hospitals.
even in 54 designated FRUs this level of care has not been possible to organise. C
district hospitals and 3 civil hospitals and 2 CHCs provide C-section level services and
only some of them can provide for the sick neonate and childcare.

The skill gaps are however the most critical and they are due to lack of the appropriate speciality specialist. In the management of the sick child the gap is of getting a paediatrician's service and these can be overcome by ensuring that specialist is utilised in her speciality work and by multi-skilling of medical officers to provide sick neonate and child care.

5.3 Family Planning:

The central issue of family planning services is the enormous unmet need for all categories of services. Demand side management is also a problem but when unmet needs are so high there is little to be gained from further demand side inputs: We identify the constraints as follows:

a **Condom and OCP supply**:
The actual quantities that need to be made available are so huge and the distribution points are so extensive that departmental mechanisms of distribution alone are usually inadequate. They need supplementation by major social marketing networks. Chhattisgarh currently has very few such networks and they cover only a small part of condom and OCP usage. The aim should be to strengthen public distribution systems while simultaneously going in for large-scale social marketing.

b **IUD insertion**:
Here lack of skills and facilities at the subcentre level remain the central problem. The lack of building and/or an examination table at the subcentre would mean that the next available site is the PHC. About one third of the ANMs require retraining and confidence building to undertake this adequately. Most LHVs are very competent in this process and the ANMs who need training can be trained on site.

c **Female sterilisation**:
Here the demand far outstrips supply. Though there are over 50 laproscopes operational only 30 laparoscopic surgeons service the 146 blocks of the state. If the Supreme Court orders are strictly followed and only 20 cases are done per day and the surgeons operate every week then too only 31,200 cases can be done in a year. As against this, potential unmet demand can be said, to be over 7, 65,000 couples. (At least half of all target couples; target couples is calculated as total no of eligible couples minus 25% for those already covered and 60% of the remaining for estimating those with more than two children - are called the target couples). Community needs assessment surveys also arrive at similar estimates of unmet needs. According to this survey, the number of eligible couples who are unprotected is 14, 73, 906 (out of a the total number of

37,73,852 eligible couples) and of these unprotected couples, those requiring sterilisation may be estimated as at least 8.84 lakhs (plus about 2 lakhs new couples every year). Of this unmet need for family planning by terminal methods, at least 35-50% have one member desirous of limiting family size which works out to 3.09-4.42 lakhs. Yet today, we are covering only 1.15 lakhs per year. Most surgeons are doing far less than 52 sterilisation days per year but about 100 cases per day. The only solution is to get much more laparoscopic surgeons and conventional tubectomy surgeons on the job. But for Laparoscopic Tubectomy, multi-skilling is a poor option. Without an emergency situation, operating on a healthy normal situation, and without the ability to convert into an open surgery, the risks of multi-skilling would far outweigh benefits. The aim should be to make sure that in all 16-district hospitals and at least in 100 CHCs spread carefully across the state female sterilisation operation is available on one fixed day every week for all 52 weeks of the year. This would include a major increase in conventional tubectomy where multi-skilling is a viable option. This would increase capacity of the system to provide this procedure for 120640 women. In addition in three months of intensive work one sterilization day per week may be organized in the remaining 46 blocks to cover another 27600 couples (at 50 couples per day). The remaining gap would require major effort at public private partnerships – but even then this gap would be difficult to close. To meet this gap in surgeons would require assistance from private and the not-for-profit sector.

We note that currently the number of sterilizations done in the year 2003-04 is 115,298 that are still far short of requirements even though to meet the need (not merely the targets) the number of cases done per day crossed 100 in many centres. Unless we multiply the centres offering at least once per week services to about 150 we would not be able to close the gap. This we should aim to reach in about 5 years.

d **Male sterilization**:
Here demand side management is a problem. Only 3% of all terminal methods or even less are male targeted– reflecting a deep gender bias in the way the programme gets implemented. However even in this area there is a supply side constraint.

But at the same time well advertised fixed day service for this most simple of surgeries has yet to become available. This can be multi-skilled into medical officers too and the creation of 50 CHCs and 16 district hospitals where this service is made available on a fixed day in every week is easily possible to meet. Once this is in place IEC activity to step up demand may also be organised. The aim should be to increase male sterilisations as a percentage of all sterilisations from the current 3 % to at least 30 %.

e **Emergency contraception**: Though the importance of this is realised in theory its availability and dissemination of information is extremely poor. Every 24 hour PHC needs to be able to provide it.

5.4. Adolescent Health:

There are almost no programmes in this area. What happens in the ICDS programme is more of a token and makes no significant difference. The needs are many. There is a very high degree of under-nutrition and anaemia at this age. If they are not addressed at once the girl is soon married – before she is out of adolescence and then pregnant. This is too late to correct anaemia or malnutrition adequately. Also growth stunting occurs at this stage if the girl is malnourished. Physical and mental development potential and stress due to poor health is also more.

In addition adolescence is a period of higher exposure to violence, to sexually transmitted diseases and to pregnancy associated morbidity and mortality. These need not only counselling at the individual level but also social mechanisms of support and women's empowerment to address.

5.5 Urban Health:

There is a 40-lakh population in urban areas as per the 2001 census. Of these the big cities account for about 20-lakh population. The rest are distributed in smaller municipalities.

We also note that there are a number of towns with a population of less than 10,000 who do not qualify to be treated as towns because they are not municipalities and a few who have over grown the 10,000 number but have not yet been declared as municipalities. These are still being covered by the rural health system and they represent some of the major para-medically under-served areas. Typically they would have a subcentre, but their population per subcentre norm would be adverse. Our strategy for these areas is to place an extra ANM there, which would be adequate for our purposes.

The section on urban health therefore focuses only on the municipalities and corporations. Here the current strength of only 20 urban health posts and 18 dispensaries is merely inadequate to meet the health needs of more than 13 lakh urban poor. Paradoxically there are large number of hospitals and private clinics- but for the poor in this area of health, there is not a single approach. In fact both IMR and crude death rate have gone up, although marginally in the last three years- by SRS data.

5.6 District and Sub-district Variations:

There are large variations in literacy across the districts and even inside districts. These have a direct bearing on health status and the utilisation and spread of health services. Sometimes the low literacy level is not causative, but affected along with health in the overall under-development of the area. Specifically the tribal districts of Dantewada, and Bastar, Koriya and Sarguja and Jashpur show these problems. There are also blocks within the other districts which have such poor performance.

Within blocks forest villages and other geographically remote areas tend to be underserved. Semi-urban concentrations, which are still administratively under rural areas, also have relatively poor coverage.

5.7 Human resources development:

There has been an active round of training under RCH-1. In particular we note that a well-planned, two-week training programme covered all MPW (F). However, neither their supervisors nor male MPW's were exposed to this. There has been however a very favourable response to this training and the need is to persist with such a programme every two years for all categories of paramedics.

On the whole other training programmes are few and are driven exclusively by the vertical health programmes of the day. As a result whatever trainings are there are arbitrary in choice of trainees and fragmented in strategy and are largely driven by expenditure patterns in such vertical programmes. Most of trainings are of one or two days and relate to a single disease or an immediate campaign. It goes on like one day on leprosy or two days on HIV family counselling or one day on blindness control and so on. Some persons have received much such training in many areas while some have received none. The vertical orientation leads to closely associated work of other diseases not being taught- even in much longer capability building trainings. Thus sector supervisors were trained on blood smear examination for malarial parasites but doing a differential count on that same slide would not be emphasised.

Almost no training is based on building competencies to attain a level of clinical service in a given facility. Thus even though there is a perception within the senior cadre of a lot of trainings having been given in the last two years the system cannot guarantee that at a particular level – e.g. SC or PHC or CHC the level of capabilities needed is now available. It may not even be able to state what level of coverage has been achieved and what the gaps are.

The goal of the training plan here shall be to ensure that all the requisite skills to attain a specified quality of care for a given facility becomes available at that level. This is true for para-medicals as well as for medical officers.

5.8 Inequity /gender:

The basic philosophy to addressing equity and gender issues has been the creation of a public health system that provides universal access. Universal access would thereby ensure access for the poorest and for those excluded by reasons of gender or social marginalisation. The reasons to support this approach have been the difficulty in distinguishing those below the poverty line (BPL) from those above it and the limited meaning of such a distinction when poverty levels are set so low by international standards. Any system of making a distinction converts being classified as BPL into a privilege, which the privileged sections of the community are quickly able to appropriate, thus still eliminating the poorest. Also it brings in a lot of conflict between the poorest and the not so poor.

On the other hand there have been recent studies showing that the poorest are still not able to access the free public health services and that patterns of access show persistent gender and socio economic disparities. This has been compounded by user fees and by invisible charges. Also demand patterns seem to be lower in poorer, less illiterate sections. Informal exclusions by health care providers of most marginalized sections because of the 'cultural gap' between them and the communities they serve also limit access. Private care access is on the other hand costly and often irrational and at the village level technically illegal. These can contribute to exacerbating inequities instead of ameliorating them. Chhattisgarh state has attempted to address this problem in four ways:

a) Facilitate access by the poor and make services more accountable to the poorest by community level mobilisation. The Mitanin programme by selecting a woman from every hamlet sees that even marginalized hamlets has a spokesperson and that too a woman who facilitates service delivery to these sections. Since the Mitanin programme follows health rights approach accountability is addressed though perhaps not yet redressed. There has been considerable success in this but weak drug supply to Mitanins and poor referral services still remain a problem to her effectiveness.
b) Equity issues are sought to be addressed by improving quality of services and insisting on 100% coverage in antenatal care, immunisation, institutional delivery, access to emergency care services etc.
c) Affirmative action in the form of special programmes addressed to the needs of the poor and women and marginalized communities. Special programmes for the urban poor, for adolescent women, for tribals, for RTIs etc also seek to address equity issues. Many of these programmes were planned but in practice have yet to take off. Those that have taken off like the referral fund for BPL patients to be shifted during an emergency or the National Maternity Benefit Scheme have poor levels of utilisation because systems that squarely recognise and address grassroots power equations have been slow to develop.
d) Recognising that for a number of reason the majority of people – even the poor still access private health care service, public private partnerships where the poor can get affordable care and even free care have been mooted but are yet to be operationalized.

5.8 Logistics:

The essential drug list is in place and is largely implemented. Sporadic procurement and a sub-optimal quota based distribution system was the rule. However as part of the DANIDA supported programme, every district has had a warehouse, and storekeepers and officers have been trained in drug and supplies logistics. A computerised inventory system has been developed by a consultancy with DSPRUD but is not yet fully operational. The problem with consumables is equally of concern and laboratory chemicals seem the worst affected but even gauze and bandages, needles and needle holders could be in short supply repeatedly. These would correct with the distribution system becoming fully operational.
In equipment there are two types. We have relatively low investment equipment like Haemoglobinometer or BP apparatus and infant weighing machines- which, if used, will need replacement frequently. These minor equipments need to be absorbed into the same distribution system.

As for costly equipment like ECG and ultrasound and X-rays, which require replacement less-up to once in ten years- but which require trained manpower to operate and considerable consumables as well- the problem is matching for infrastructure, skills and services provided so that these are adequately utilised.

5.10. Other Issues:

The Mitanin programme is one major crosscutting innovation that has seen considerable grass roots success. A detailed operational manual and its a rigorous sample study based interim evaluation of the programme is available. This is also an initiative that would take a longer time to succeed and it needs sustained support at all levels for at least another three to five years.

Integration with ISMs is another goal. There is a large workforce and institutional and infrastructure base within the health department that is willing to contribute to RCH goals but has been used only minimally for this purpose. Under RCH-I a small sum in the order of 1.9 lakhs has been allotted, and even this is in the process of utilisation.

6. Lessons Learnt from RCH-I

One of the first lessons of RCH-I is the need to invest in adequate staff and capabilities for programme management. In the absence of any formal evaluation of RCH-I we list below some of the impressions about the utility and implementability of various schemes that were tried.

Contractual appointments:
This was very useful but there was difficulty in getting ANMs. As the ANM Training Centres have re-opened, we expect no further problem. Also trained nurses are being given this appointment. Two ANMs per subcentre in remote areas has been welcomed and the impression is that they are doing much better. As of now regular posts also remain vacant. If regular posts, now currently increased by 850 are filled, then all contractual ANMs could be absorbed. However for making institutional delivery happen in every sector PHC where we already have a LHV a contractual ANM would be useful. The contractual appointments for SHS/SCOVA were also found useful.

Strengthening FRUs:
In the first round of civil works and equipment purchase to strengthen FRUs the inputs have been sub-critical. Except at district hospital level almost no other FRU came into functioning. In the second round with better planning and matching of equipments, with manpower and skills and infrastructure work there is a greater likelihood of at least 15 more FRUs coming into being – up from the current 14 for the state.

RCH Camps & Melas:
RCH camps and parivar melas as visible activities have had their positive side. However as almost all services require follow up at regular intervals they are not viable ways of extending the outreach of the basic health care facilities. However for a population deprived of any access or whose access is limited this may be welcome. It is not clear that all RCH camps took place for such areas. In the 4 districts where immunisation sessions were similarly targeted only for under-served areas the outcome has been limited and there is little interest in pursuing it. Whatever their value they would not be a substitute to the policy on medically underserved areas that we are proposing for establishing regular services in such areas.

Cold chain maintenance:
This component was found useful and some regular component on this should perhaps be part of the family welfare budget as it would be recurrent every year.

There are still unmet needs in the state as regards the cold chain. We need one major cold storage equipment- a walk in freezer – costed at about Rs. 50 lakhs- from the GOI. Since this is supplied always by the government of India exact costs would also be available with GOI. Two walk in coolers are also desirable. Also we need to purchase 146 stabilisers; there is also a need to insist on disposable syringe supply along with the vaccine. Supplying money for kerosene is not as effective and its savings are also limited. The training for vaccine handlers was useful and need not be repeated immediately.

IEC Initiatives:
The IEC programmes were considered successful too and mainly took the form of kalajathas and radio programmes and hoardings. The community incentive scheme requires redesign if it is to be a motivation for weaker panchayats to do better and needs to be integrated with Panchayat level health initiatives and capability building. Other items like DD kits.

Referral transport:
This in particular has had very poor utilisation with most districts returning the funds. The need of the hour is to develop systems by which a woman in need or a panchayat chief who wants to help can call an ambulance at once and transport to a reliable FRU. In the absence of vehicle or secondary centres and insufficient investment in informing people about the scheme, the programme has done very poorly. The incentives for 24 hour delivery in PHC/CHCs also suffer from design issues.

Family Planning Incentives:
The material incentives for contraception //sterilisation funds remain unused because they have been put on hold pending instructions. They are possibly best integrated into private sector reimbursement.

Public-private partnerships have been designed but this has not been launched.

Strengthening Management:

Serious bottle necks in management capacity and even absolute numbers of management personnel available crippled the programme. Capacities were low not only in public health management but also in financial management. The construction of buildings in routine channels also was to slow down programme implementation in many crucial areas. The creation of a state health resource center helped planning and technical expertise availability and community oriented programmes immensely- but this was built up under the SIP only in the last two years of the programme.

7. RCH II Programme- Objectives and Strategies:

7.1. Vision Statement:

Chhattisgarh state has adopted a document called Vision 2010. Its section on health care reads:

"Health relates to the well being of society. The State would ensure that its citizens are healthy and have access to adequate health infrastructure. Emphasis would be laid on disease prevention and provision of sanitation and hygiene services. Provision would be made to provide free health care to the poor and disadvantaged sections and outbreaks of malaria and tuberculosis would be brought down to minimum levels. Improvement in the health status of the population would be one of the major thrust areas for social development in the State."

In line with this vision the state has set itself the following goals – a ratio of 1: 800 for hospital beds; and IMR of 35 per 1000, a fertility rate of 2.2 a life expectancy of 65 years for males and 68 years for females.

7.2 Technical Objectives, Strategies and Activities

7.2.1 Maternal Health

Objectives:
Reduce MMR from current 400 plus to about 100 in five years.

Strategies:

i. Focus on quality antenatal care in subcentres- Institutional delivery only to the extent possible.
ii. Focus on 24-hour institutional delivery with essential and basic emergency care in all sector PHCs and in every CHC.
iii. Focus on select CHCs (100 across the state) becoming venues for comprehensive emergency obstetric care
iv. Bring in private sector partners to close gaps in basic and comprehensive emergency obstetric care.
v. Bringing in NGOs to close gaps in para-medically under-served areas.
vi. Building up transport and referral systems.
vii. Building up community care and support systems so as to improve health awareness and demand for institutional services, improve link between ANM and those in need of her services as well as to facilitate the delivery of maternity benefits and referral arrangements.
viii. Focus on provide safe abortion services.
ix. Focus on treating RTI/STI.

Activities:

i. Block level planning to identify bottlenecks in achieving the above goals and then accordingly:
   - Closing infrastructure gaps in the above facilities
   - Closing training/skills gaps in the paramedical and medical workforce with use of multi-skilling where needed.
   - Closing equipment gaps in the above-mentioned facilities.

ii. Streamlining procurement and distribution mechanisms for supplies.

iii. Community level awareness and basic care arrangements – through trained Dais, Mitanins, and increased role for PRIs and village level capacity building and an incentivised referral arrangement for the Mitanin that would drive every pregnant woman into the sites of institutional delivery.

iv. Building Increased awareness for service utilisation.

v. Putting in place a 24 hour ambulance service linked to venues of institutional delivery.

vi. Declaring areas as medically underserved and paramedically underserved and seeking NGO/ private sector cooperation in these areas.

vii. Multi-skill training for the staff in institutions to be able to provide services of safe MTP Services and to provide treatment in cases of RTI/STI.

viii. All the CHCs and district hospitals would also have adequate diagnostics for referral level STI/RTI services.

ix. All 24 hour paramedical and medical staff would be trained to provide basic clinical and counselling services for RTI and STI with basic investigations (side laboratory level).

Elaboration of strategie

MATERNAL HEALTH

- **Antenatal Care:**

Here the central strategy is to improve quality of care. This requires improved training and a monitoring and supervision system where quality is factored in. (See action plan on training)

The second issue is to improve coverage. Here the Mitanin programme and the coordination with the anganwadi worker is the key. Strengthening these elements are more useful than any other. Building panchayat and village level capacities would also help. (See action plan on Mitanin programme, and on building village and panchayat level capabilities)

The third issue is to improve coverage in paramedically underserved areas. Here the policy approach for medically underserved areas should be applied. In most cases this requires either contracting in an NGO that would undertake this or identifying and training a Mitanin with adequate basic qualification from that area for a longer course and then appointing her as a block level cadre in that same area.

- **Institutional Delivery**:
  The goal of institutional delivery has two reasons. Firstly that skilled care adequate to give oxytocics and manage a first level of complications is available. Secondly that referral is easier. In the subcentre the second is not readily available and even the first would require more skill building to achieve. However the ANM providing care is better than that of the traditional birth attendant's and she providing care at the home and her providing care at the subcentre the differences and advantages are minor. Where there is no place at the house then the subcentre has advantages. The subcentre may also have an advantage if it is better situated for referral linkage. However as discussed earlier, the non-availability of ANMs on most days makes it an unreliable site for the care seeker once labour pain starts.

  Therefore the strategy proposed keeps the Sub-Centre as an optional site of institutional delivery – where facilities are available for a sudden need but where delivery is not insisted on. Instead the focus of our strategy is on maintaining sector PHCs and CHCs as the main venue of institutional delivery. The advantages of this approach are that-

  a) The PHC and CHC can be staffed and made functional as 24 hour functional centres.
  b) Institutional delivery of adequate quality can be assured.
  c) All elements of emergency obstetric care can be assured except for blood transfusion and caesarean section.
  d) Quick referral and transport arrangements to an FRU are guaranteed.

  In a block of one lakh population we can estimate the number of deliveries to be about 2500 per year or about 208 per month. Of this if we achieve 50 per month at the CHC and 30 per month at the 3 PHCs we would have achieved a total coverage of 67% as compared to the present 22% coverage. Further to close the remaining gaps – we can equip upwards the Ayurvedic hospitals esp. in sectors without PHCs and we can make use of a few designated subcentres that have buildings by making it two -ANM subcentres. (Please note that most blocks are meant to have four sector PHCs but in practice they would have anything from one to three PHCs only – seldom would they have four).

  Also we propose to encourage nurse professionals and community midwifes in the private sector to set up a facility as part of a franchisee arrangement.

- **Making a sector PHC function on a 24 hour basis with quality care**:
  In the primary health care centre however it is possible to over come all the limitations that make the subcentre an unsuitable venue for the PHC. There are usually three women paramedical available there – the sector supervisor (female) or LHV and the ANM of that subcentre and often the staff nurse. In practice many sector PHCs have only two of the three women needed. If one ensures that another ANM is posted in the subcentre that is usually located in the sector PHC– then it is relatively easier to insist on the centre being open 24 hours with the three women on a shift arrangement– so that the PHC is never locked and never in the dark.

  Obviously their needs to be a functional labour room, toilets and two to six beds along with all the equipment and supplies needed. In most PHCs this is available and where it is not it can easily be so equipped within the next three years – taking on 50 blocks every year.

  Of the many male para-medicals of different categories – dresser, compounder, laboratory technician, MPW, supervisor – male, leprosy worker (NMA or NMS)- who are available there

three of them should be multiskilled to provide assistance to all the PHC functions on a 24 hour basis and also placed on an 8 hour shift.

The plan also includes both male and female worker are trained on the standard treatment guidelines for para-medicals and the list of 27 drugs drawn up for the subcentre are made available there. In such a situation The 24 hour's centre would be cost effective and able to handle all basic curative care and first aid level emergency needs in a competent manner. Our understanding is that if the PHC is not seen as a reliable site of providing basic curative care and if it does not have referral arrangements for all common illness and especially emergencies, it would lose credibility as a reliable site to take one's wife to when she is in labour.

Thus the goal is that with existing paramedical staff, sometimes needing supplementation by the appointment of one more woman paramedical the sector PHC becomes a 24 hour paramedical run facility with a doctor on call /or in remote areas visiting the facility from the CHC. The paramedical act of the state of Chhattisgarh empowers the 18 month trained male and female para-medicals to provide such care and the very effective and innovative Hindi Standard Treatment Guidelines for para-medicals makes it possible to assure quality care at that level.

It is also possible to link all the PHCs with the CHCs and the ambulance service by phone so that an ambulance can be called and reach within the hour and reach the patient to the secondary referral centre within the next hour. For all these reasons the achievable goal must be to make the sector PHCs the main sites of institutional delivery with subcentres being the preferred sites of antenatal care and provision of skilled care at birth – only occasionally doing institutional delivery.

Finally to kick-start the system we may offer Rs.100 per delivery as night duty allowance to all those who have achieved at least 10 deliveries in a month in the institution. There is already a provision for this – but by linking it to a 24-hour duty and set of performance indicators we would get more returns of this current budgetary allocation. The financial implication of this would be Rs.1.5 lakhs per block per year, which is affordable. To the ANM beginning to work night shifts it is Rs.1000 per month to up to Rs. 3000 per month, which would be attractive. Those ANMs who do not take as much interest or where caseloads are sub-critical would not get rewarded.

- **CHC as site of institutional delivery:**
  In addition and for the same reasons stated above all CHCs can be venues of institutional delivery. They already have the staff and infrastructure to do so. Indeed they should have a quota of 50 deliveries per month to reach and be provided with supportive monitoring till they achieve this goal.

- **Private Sector partnerships**:
  In addition to what sector PHCs and CHCs can cover we need to cover 60 to 100 births per block per month. Where the public sector is not able to cover this we need to encourage and support nurse professionals and community midwifes to set up such practice.

  Single doctor private clinics and private nursing homes in the vicinity can also be roped in to close this gap. Notifying medically underserved areas would considerably assist in the process.

There are two approaches proposed. One is just providing reimbursement for existing providers when they see BPL patients. The other the promotion of new centres with not only credits arrangements but also by funnelling patients to them so that they have adequate volumes at the pre-fixed rates to make the enterprise viable. This requires a franchisee chain arrangement.

The recurrent cost to the government for about 50 births per month per block for those who are BPL would be about Rs 30,000 per month or Rs 7.2 lakhs per year (@ Rs 1200 a normal delivery). More details on these issues are given in section on public-private partnerships.

- **Referral Incentivisation:**

  For the public-private partnership to succeed, also to maximise health seeking behaviour changes that brings women for institutional delivery, we need an incentivised linkage with the Mitanin programme.

  If we assume that of the 2500 births almost 2000 would be through referrals. We can budget for Rs 1 lakhs per block for incentives to Mitanins for having made the referral. This would strengthen both the Mitanin programme and the cause of institutional delivery. Where she has been unable to secure institutional delivery, if maintains record and reports of birth weight alone she would get Rs 25 as incentive. As each Mitanin would have about 6 deliveries in their area – this Rs 300 they get *per year* is not a big amount. But in panchayats where 100% institutional delivery is reached they could get another small group monetary incentive. (An expansion of the capital base of a SHG savings group would be such an example.)

  Mitanins would be given coupons that they would pass on to the pregnant women. This coupon would be given to the private sector or public sector unit they choose to go to. The "Managed competition" that results in a setting of quality regulation and incentives for both sectors, would make choice to the patient and for a better quality of care and outcomes.
  We note that this scheme of incentives and reimbursement – at the public, and private and community level requires a good monitoring system in place. About 10% of the total costs of reimbursement plus incentives and another 10% for administration and financial management of reimbursements would be advisable. The incentives and reimbursements would need a parallel system that is more accountable and efficient. The Monitoring system for the private sector partners would also monitor the incentives in public sector. This is not duplication but a built in check and balance needed to guard against false claims. The details have been worked out in the PPP module developed.

- **Ambulance Services:**

  Current ambulance services are not available 24 hours and would require three drivers per vehicle to make it so available. The vehicle at the CHC is used for ferrying stores from the district more often and for shifting patients less often. The use to shift patients from CHC to district hospital is more common then shifting a patient from village to CHC or back or from PHC/Subcentre to CHC.

  While retaining the larger ambulance currently available for CHC- to district transport, the suggestion is that for every tehsil one vehicle- smaller, rugged one which can traverse the narrow village roads- be made available to an NGO or charitable organisation or ex – servicemen's group. The ambulance is provided with a cell phone/wireless and it also builds up a system by which anyone who can access a telephone can call it at once from anywhere. They

can charge per km basis for APL patients and for BPL patients. Fo
would pay as they have referral funds already in place and under

To maintain viability of the service they can also provide non-
patients from village to CHC for other activities like blindness
transport of patients coming for sterilization etc and they can char
sharing it between the passengers and deducting what money they get fr
that particular scheme's implementation. We would initially start these se
blocks where emergency care is being initiated with linkages to the neighbouring
there are no emergency obstetric services available.

- **Services in Treatment of RTI/STI**
    - All the CHCs and district hospitals would also have adequate diagnostics for referral level STI/RTI services.
    - All 24 hour paramedical and medical staff would be trained to provide basic clinical and counselling services for RTI and STI with basic investigations (side laboratory level).

- **Safe Abortion Services**
    - All the block CHCs and district hospitals would also be capable of providing safe MTP services.
    - Train General Medical Officers (MBBS) to perform MTPs and to examine and treat for STI/RTIs. Since we are anyway investing in Multiskilling for emergency obstetric care this is a small extra effort and can be provided after the earlier training has fructified.

- **Incentivisation of Community level caregivers for MTP referrals**:

This is on the lines of the referral arrangement for Emergency obstetric care.

7.2.2 Child Health

Objectives:

a. To reduce IMR from 73 to 35 by the year 2008
b. To reduce rural IMR from 85 to 40 by the year 2008
c. To reduce child malnutrition levels

Strategies:

a. 100% immunisation including the booster dose
b. Prompt and appropriate community level care for all sick children and neonates
c. Regular House visits and counselling by community level care givers for preventive and promotive health of children and the reduction of child malnutrition.
d. Strengthening and supervising the subcentres for its routine services esp. immunisation.
e. Adequate referral arrangement and secondary care facilities for sending a sick child or neonate when it requires hospitalisation.
f. Reducing cost of care especially on inessential and hazardous drugs and therapies so as to favourably impact on poverty levels:

Activities:

Immunisation:

- **Maintenance of the cold chain:** This remains central to the concerns of child health. The cold chain is in place but yearly there would be a set of equipment that would require repairs and even replacement.

- **Logistics of vaccine and disposables supply:** This too is in place – but is rather weaker for disposable syringes. The aim is to supply vaccines with equivalent amounts of disposables.

- **Monitoring systems:** Insistence on regular first level supervision (i.e. of ANM by LHV) and by a cluster sample check by every second level supervisor (by BEE/BMO/ district immunisation officer) and sample survey review by an external professional marketing research agency should all be institutionalised .It is also important to identify and notify the 10% least accessible hamlets and villages in each block so that special verification of this is possible.

- **Medically underserved areas:** There are still many areas where there is an ANM vacancy or high absenteeism or geographical constraints. These areas are proposed to be notified and the option best suited for these areas are to be put in place in consultation with the janpad (block) panchayats. The choices for immunisation service delivery are between-
  a) Mobile clinics visiting the haats (community market places) linked to Mitanins bringing the patients in.
  b) NGOs as service delivery agency. Special incentives package for government staff to go there and remove it from the notified list would also be in place.
- **Coordination with Mitanin and Anganwadi worker and ANM:** Immunisation is the main and along with antenatal care often the only point of contact between the ANM and the persons she serves. To maximise these opportunities she is provisioned and encouraged to provide first contact curative care, and seek cases for referral for tuberculosis and leprosy case detection and for correctable blindness. Close coordination with the Mitanin

and the anganwadi system provides her the community support she needs to complete both immunisation and when she visits for immunisation – all these other activities as well. Without such help even meeting all her immunisation and antenatal clients would become impossible. Strengthening the Mitanin programme is therefore also critical to successful outcomes.

Community Level Care For Halving Rural IMR: The estimated number of children below 5 in a population of 5000 who -on any given day- are: newborn; or have diarrhoea; or have ARI or even pneumonia; or have fever is in the range of 25 to 50 children. (This is calculated assuming 10% of the population is of children below 5 – it is actually a bit higher and that 5 to 10% of them would have one or other of these four situations).

Good community level care means that in all four of the situations given below the child must be seen on the same day as when the event occurs.

For neonates a trained volunteer must visit on the day of birth for there are six actions to be achieved. These are breastfeeding in the first hour, adequate food for mother, keeping the baby warm, weighing the child, referral for the low birth weight and sick neonate, and immunization with BCG and polio drops. A second and third visit in the same week for referral if the neonate is sick is also a must.

For a child with diarrhoea ORT has to be instituted immediately and monitored to see whether dehydration corrects or needs timely referral.

For most ARI the goal is really home remedies and protection from unnecessary and costly care. Yet if there are any danger signs, which should be recognised on the very day of its occurrence prompt referral, with some stopgap antibiotics could be life saving.

And in Chhattisgarh where malaria is one of the major causes of child deaths a blood smear examination on the first day of fever and an appropriate presumptive treatment of malaria is also mandatory.

Without such care in these four situations reduction of rural infant mortality to the goal of 30 would take decades to realise. But with such intervention – even with limitations in referral back up halving of the current levels of rural infant mortality placed at 85 is possible within a three to five year period.

If we assume that these 25 to 50 cases are spread over 10 to 15 hamlets we can realise that it is impossible for the ANM to attend to these cases on the first day or even the first week of illness. But then we must also remember that often these cases are highly clustered in time. For example, in the rainy season there could be one out of four children affected on a given day. In a more developed state the population is less dispersed and the families could access health care providers – at least on payment. In situation like Chhattisgarh this gap is filled in by a huge army of RMPs who are poorly trained or more often completely untrained, totally unregulated, and are fairly high cost health care providers (high costs relative to real needs though they may be cheaper that qualified doctors charges). They tend to intensively treat trivial self-limiting illness and refer – later than is advisable - all cases that need definitive treatment. Trying to train them into adopting rational and ethical practice when there are no systems of regulation, and where their role models are MBBS doctors whose practice is similar in costs (though less hazardous) and where they have already got habituated to the high returns of unethical practice is not a feasible option. The Mitanin (community health volunteer) is the only hope.

Since the Mitanin is in place in almost every hamlet of the state what is needed is to persist with it with a strong support system with continued training, some degree of incentivisation of her work and a good referral arrangement and secondary care support. With these three steps and an extension of the programme to urban areas it would be possible to reduce the under-5 child mortality by half in less than three years. That is from a current rural IMR of 85 to about 40 to 50. The rigorously documented data from 100 village NGO led experiences of Jamkhed, Mandwa, Ghadchiroli, SEWA, RUHSA and many other programmes all show that such a reduction from high levels (varying from 80 to 150) to about 30 to 40 in three to five years is possible to guarantee in a well administered community health worker programme provided some cardinal conditions are met. These seven conditions of success have been set out in the note on the Mitanin programme.

In addition to these four day-1 interventions the community level caregiver would visit and counsel the family of every child with malnutrition at least once every month and ensure that the child has access to food supplements where this is relevant. Since malnutrition is the single most important underlying cause of death, this is essential for the reduction of IMR. Also by visiting and counselling of families with normal children in the age group of 6 months to one year malnutrition can be dramatically reduced from the community by its primary prevention (see UNICEF's best practices report for 2001).

Counselling would be also a form of interpersonal communication based BCC. It would aim for reaching out to all families with a set of 75 health education messages that would cover all the basic health awareness elements. Over three years every household should be able to recall all these messages and the potential for behaviour change is the maximum in such an approach.

Referral Arrangement and Secondary Level Care: When a sick neonate is identified or a sick child is identified a nurse, MPW or doctor can provide a good level of primary level curative care. However a few children – about 50 neonates per 1000 children born and another 30 in the first year and yet another 25 to 30 in the next four years would require a secondary level care to save lives. This would require hospitalisation and injecteable fluids and drugs. In neonates esp. where caesarean section is being done it may require baby warmers and incubators. Therefore it is important to develop such a facility within two-hour access of any village.

The facilities that were developed as sites for comprehensive emergency obstetric care should as well be developed as sites for institutional treatment of the sick neonate and child. This requires appointing, contracting in or multiskilling medical officer through a two-month crash course to be able to undertake intensive paediatric work. In addition it needs development of laboratory services –either completely in house or with public private partnerships. The proposal is to develop 100 CHCs and 16 dist hospitals as such sites and supplement there with private sector partners.

The referral and ambulance arrangements: These are the same as for maternal care. By using the same arrangement for sick neonates and children we make the service more viable and cost effective.

Public Private Partnerships: These are also opened up as in the provision of emergency obstetric care- and some work would be required to cost the wider range of services and costing packages that treatment of sick neonates and children would apply.

7.2.3 Family Planning

Objectives:
At least cover 50% of unmet needs for terminal methods in the first two years and 100 % of unmet needs by 5 years.

Strategies:

- Every district hospital would provide terminal sterilization services at least twice if not thrice a week.
- 100 CHCs would provide sterilization on a fixed day of the week.
- In three months of the year all the remaining blocks would have at least three sterilization days in their CHCs. In the coming years these would also change to fixed day weekly once service availability.
- Every village would have one social marketing outlet, which would have supplies of condoms and OCPs without interruption throughout the year. These would be managed by partnership with a private distributor network with subsidy to make it viable to operate in low off take areas.
- All 24 hour PHCs would have one fixed day of the week where IUD insertion would be available and other contraceptive follow up would be encouraged.
- Every hamlet would have at least two volunteers who would have a limited stock of the supplies available- either collected from the village distribution point or from the health department.
- A focused IEC campaign would continue to build up demand for these services.

Activities:

- **Building up referral secondary institutions:** The closure of gaps in infrastructure, equipment and supplies is as described for maternal care.
- **Multi-skill training for the staff in institutions to be able to do these surgeries:** For tubectomy, for vasectomy. Since we are anyway investing in Multiskilling for emergency obstetric care this is a small extra effort and can be provided after the earlier training has fructified. Also once one is experienced in C-section, conventional tubectomy if not laparoscopic should be possible. For laparoscopic tubectomies, we would be looking at hiring more surgeons rather than Multiskilling qualified surgeons who require only tubectomy training would be provided this training. For general medical officers (MBBS) a one month course covering safe MTP, conventional tubectomy, vasectomy, STI/RTI would be designed and at least 250 doctors provided such trainings over next 3 years.
- **Incentivisation of Community level caregivers for FP referrals and collective achievements in spacing:** This is on the lines of the referral arrangement for Emergency obstetric care. It should be able to provide another Rs 300 to Rs 500 per Mitanin per year if even Rs 50 is paid for every tubectomy or vasectomy case referred. An incentive may also be considered to be shared amongst panchayat members and Mitanins where all births have had at least a three-year gap and no birth before the age of 19 or within one year of marriage if the marriage is before 20. Since very few would qualify the budgetary outlay needs be very limited at the cash award could be high.

- **Preparation and Signature of MOU on Social Marketing with three to five distributors:** Two stockists would cover 8 districts each. This includes NGOs who are interested. They are selected from those responding to an advertisement. They are provided the contraceptive supplies and a seed money(about six months costs as shown in the budget below) for start up. A government sponsored or appointed body would do the evaluation. If they have achieved volumes and stated goals then they would qualify for further adminstratve subsidies as indicated in the budget given below. The exact terms of such a social marketing arrangement has to be worked out an MOU signed with the selected distributors /market chains. The aim would be a 100% coverage of all villages. A well-organized IEC campaign by the state would help them in achieving viability for the marketing chain.

Social marketing to initiate would need a budget support which is estimated as follows:

Social Marketing Budget

Particulars	Unit	Unit cost per month	2005-06	2006-07	2007-08	2008-09	2009-10	Total
Stockist Overhead	2	3000	72000	75600	79380	83349	87516	397845
Sales Force Cost	8	2000	192000	201600	211680	222264	233377	1060921
Warehousing/godown	1	0	0	0	0	0	0	0
Administrative cost	1	5000	60000	63000	66150	69458	72930	331538
Total			**324000**	**340200**	**357210**	**375071**	**393824**	**1790305**

1. Two Stockist will cover total 16 districts one will be located at Raipur and other one at Bilaspur
2. Overheads to the stockists mainly relate to cover-up rent for godown and administrative cost
3. One Sales person will cover two districts and therefore for 16 District their will be eight persons.
4. Rent for godown is not taken into account as State Government will provide for that.
5. The administrative cost will include report compilation, follow up etc
6. Since the product is offered free of cost -other costs can be recovered from the sales windows/ agenices recrutied after selling the products- on a commission on sales basis.

- **IEC campaign:** The IEC campaign is being discussed here in the family planning section but it is needed for all aspects of the RCH programme. The key messages in each area need to be identified by a process of qualitative and quantitative surveys. Then these messages should be integrated with the ongoing programmes. Then using a variety of media of which folk media would be the most powerful these important messages should be carried forward again prioritizing those areas where there is a programme linkage.

  Thus an IEC campaign on the use of condoms or OCPs will be based on addressing why people are not using it today and it will also inform where these are available and how they can be accessed. In other words IEC would not be stand-alone but would be integrated with ongoing programmes.

7.2.4 Adolescent Health:

Objectives:

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

Strategies:

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

Activities:

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

Budget: Adolescent Health

Head	Unit Cost	Nos.	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
Training Counsellors 5nos*15days*Rs 200 By (NGOs & Govt Staff)	15000	146	2190000					
Training peer educators 20nos*5days*Rs 100By (NGOs & Govt Staff)	10000	146	1460000					
IEC activity:	10000	146	1460000					
Honararium for counsellors 5*200* 12	12000	146	1752000					
Overheads contingencies	8000	146	1168000					
Total for block	**55,000**	**146**	8030000	8431500	8853075	9295729	9760515	10248541
Mass screening/counselling programme in a block for all children and adolescnet for iron def.& sickle cell trait and disease (Ten blocks in first year then twenty blocks in each subsequent year for four years)	1000000	10	10000000	21000000	22050000	23152500	24310125	100512625
Total			**18030000**	**29431500**	**30903075**	**32448229**	**34070640**	**144883444**

Note : The aim is to limit the mass screeding to a few blocks every year- since it is very effor intensive .At the end of five years we would complete only 90 blocks which are considered having the highest prevalence of anemia- both sickle and iron deficiency. We would estimate which are the most prevalent blocks during the first year based on instrituional data and camp based data as sickle detection centers have been set up in all the districts.

Mass screening/counselling programme in a block for all .Children and adolescnets for iron deficiency .& sickle cell trait and disease

Details of Budget for a normative block of one lakh population

Break-up for Rs. 10,00,000 for a normative block is given below.

Approx population in age group 0-25	40% of the population	
Approx population to be tested	40,000	
Cost per test (Hemoglobin + solubility including confirmation if positive	@ Rs. 15 per test	6.00,000
IEC and mobilization to get people to participate in		
Meeting and Kalajtha 100 villages	(Rs1000) per village*	1,00,000
Logistics at block level – vehicle, camp arrangement	400camps*Rs400	1,60,000
Documentation		20,000
Total		9,00,000
Overheads 10	10%	90,000
Grant total		9,90,000
	Approximated to 10,00,000	

7.2.5 Urban RCH

Objectives:

To improve the health status of the urban poor community by provision of quality primary health care services with focus on RCH services and to achieve population stabilisation.

Situational Analysis

There is a 40-lakh population in urban areas as per the 2001 census. Of these the big cities account for about 20-lakh population. The rest are distributed in smaller municipalities.

	Population range	Numbers	Total population
A	>2 lakhs	4	20,98,879
B	> 1 to 2 lakhs	6	7,79,708
C.	70,000 to 1 lakh	5	4,17,388
D.	40,000 to 70,000	4	2,02,476
E.	15,000 to 40,000	22	4,91,154
F	< 15,000	14	1,54,902
	TOTAL	**55**	**41,44,507**

(Note that Korba with population of 191245 is included in A and Khatgora of 175,718 is included in B. Also note that Janjgir of 72,318 and Champa of 37,951 are included as one urban area under category B.)

We also note that there are a number of towns with a population of less than 10,000 who have not yet been declared as towns because they are not municipalities and a few who have over grown the 10,000 number but have not yet been declared as municipalities. These are still being covered by the rural health system and they represent some of the major para-medically under-served areas. Typically they would have a sub centre, but their population per sub centre norm would be adverse. Our strategy for these areas is to place an extra ANM there, which would be adequate for our purposes.

The section on urban health therefore discusses the situation in three contexts- the large corporations, the municipalities and the nagar panchayats.

The large corporations and municipalities present a situation of high inequity in health care. At one end there are numerous tertiary care institutions and private nursing homes providing specialist services that a section of the population is able to access. At the other end are large slums, sometimes geographically proximate to the most advanced medical facilities, which are unable to access even basic immunisation and institutional delivery services.

Even within the poor in the slums there are categories like the migrant rickshaw pullers, the homeless, the street children etc who face special problems of marginalization and consequent invisibility within the system.

The health status of the poor here is also determined by the extremely unsanitary and unhealthy living conditions that obtain in the slums- far more than in any comparable rural area. Poor working conditions and issues of pollution also affect health. Along with this there are issues of alcoholism and substance abuse that affect small sections of the population.

Behind the deprivation of basic entitlements of the poor also lies the fact of their illegalisation. Often they are staying in illegal settlements, but paying high rents and has no protection against eviction. Since the settlements are illegal their ability to secure their civic rights is even more difficult.

The small urban areas are still more of the nature of overgrown villages that have not recognised that the administration of a town calls for a different set of approaches. In many areas sewers and drainage systems are not in place and health outreach services are organised in the same lines as the rural areas- though the problems may be different.

Reflecting these facts the data reveals that both IMR and crude death rate have gone up, although marginally in the last three years- by SRS data.

The Urban Health Infrastructure:

This exists in five categories:

Here the current strength of only 20 urban health posts and 18 dispensaries under the chief medical officer's jurisdiction.

Other than these under the civil surgeon's jurisdiction are another set of dispensaries and clinics and hospitals.

A third aspect is the number of municipality or corporation run dispensaries and a few hospitals. Some of these are ISM institutions

In addition there are few ISM clinics run directly by the state directorate of ISMs.

Also most urban centres are district or block headquarters and by virtue of these host a district hospital or a block PHC (CHC) which is being upgraded to 30 bedded hospitals.

The distribution of these centres is shown in the table in annexure 1.

Objectives:

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

Strategies:

1. Careful identification of beneficiary families and vulnerable families through a participatory mapping exercise followed by a door to door survey
2. Community Level care givers covering 100 beneficiary households intensively and touching on all households in their area.
3. Paramedical and basic medical services, through a network of urban health centres- without fresh infrastructure creation -each catering to 5000 population. Utilize both NGO and Private sector partners for this. This may mean an urban health centre for about 10 to 15,000 households.
4. Urban secondary referral services through a linkage with the CHC/district hospital or PPP arrangements with a network of private clinics for emergency obstetric care, institutional care of sick child, safe MTP services, FP sterilization services, adolescent health care and counselling and diagnosis and management of RTIs /STIs/ infertility. These services are subsidized for the poor and at reasonable cost for the rest with a provision for exemption of the poorest in special emergency situations.
5. Linkages will also be made available to district hospitals and teaching hospitals.
6. Peer caregivers for special highly marginalized groups – the homeless, the street child and the commercial sex workers etc– reached out through NGO programmes.
7. Peer education programmes in urban schools for adolescents and in adolescent frequency zones for out of school adolescents.
8. Designing a programme for social health insurance cover for the urban poor to cover all institutional health needs.

Elaboration of Strategies:

1. **Identification of Beneficiary (poor) and vulnerable beneficiary (marginalized poor) families.**

- The entire area under a municipality or corporation should be distributed between urban health centres so that no part of the population is left out. Thus each UHC will have a geographically demarcated "section" to cater to.

- Within the UHC-coverage population the UHC may in a participatory process with all stakeholders participating, identify those who are in need of intensive coverage. The ULB may be assisted by an NGO. Those under intensive coverage would be known as the beneficiaries. This may be undertaken annually. The criteria for identifying a beneficiary population- may include an income criteria supplemented by an asset measure so as to arrive at a measure of those who are below the poverty line.

- In addition within the category of the beneficiary the programme would identify a sub-category called the vulnerable beneficiary. These would have an additional criteria of marginalization in addition to poverty- suggested criteria are nature of occupations- e.g. rag pickers, rickshaw pullers, conservancy staff etc, handicapped, beggars, as also destitute and homeless, migrants and women headed households where only the woman is the earning member . This may be further discussed at the community level. Involving a sensitized organisation to facilitate in identification of the "vulnerable" beneficiary would also be useful. The purpose of having additional criteria to only income as a criterion is the recognition that there would be some categories that are so powerless that they would slip through the safety net– unless an easily visible criterion brings them in.

- The sanctioning and deciding authority would be the ULB- but the ULB would have much better data and better criteria at its disposal.

- This mapping of communities and beneficiaries is the first step and separate funds are earmarked for this .Both ULBs and NGOs are involved in this.

2. Community level care givers (Urban Mitanins)

The Mitanin Programme currently is not covering urban areas. This initiative would be introduced to select and deploy one Urban Mitanin for a group of 100 "beneficiary" households. Her major functions after training would be:

a) To provide health education.

b) To ensure delivery of paramedical services esp. immunization and antenatal and postnatal care.

c) To promote referral for institutional delivery, for FP sterilization and for institutional care for sick children and neonates.

a. The Mitanin may visit non-beneficiary households in that section also but that would be only twice a year along with the female paramedical workers at the time of pulse polio preparations for collecting information and ensuring that all basic services are being availed of.

b. The Mitanin would be selected by the community that she would serve. She would be trained by a training team under the guidance of the state level Mitanin programme.

c. The Mitanin would not be paid an honorarium but would be compensated on days of training as well as paid incentives for select tasks.

d. The Mitanin shall be fluently literate with at least an 8th class education.

e. The exact numbers of Mitanins needed would emerge only after the participatory mapping and the surveys are completed.

f. The Mitanin programme is supplemented by and supported by a number of community level processes.

Improving community participation

Community participation in planning, and implementation needs to be enhanced considerably. There are three ways in which this would be done:

a. Form a women's health committee – especially or only in those habitations where performance is low by criteria like how many are unable to utilize the secondary care centre because of costs, nor visit sub-centre for ante natal care etc or any group that constitutes a vulnerable beneficiary. This could be a health and development committee. This could be any pre- existing non- party forum that is acceptable. It could be a self help group. The women's health committee should have a secretary or coordinator in whom we need to invest some capability building through training and support processes. This would help her keep the group together, reinforce messages to the group and organize self help groups etc. The women's health committee would help the Mitanin in needs assessment and disease surveillance and vital events registration.

b. Ward level committees that identify the most - poor based on objective criteria and help to plan interventions that are intersectoral – especially improving living conditions, working together with the municipality, also need to be reinforced and where necessary initiated.

c. Organisation of occasional community level mobilization event is desirable– a public show, a drama programme, a meeting where the key messages are reiterated, the participatory structures are strengthened and the services offered by the ULB are informed of. Such an event is almost mandatory if the community has to get actively engaged with the participatory institution being created and the Mitanin plays the role of organisation and empowerment. The major part of the funding for this is with community contribution.

3. Paramedical and basic medical services through the Urban Health Centres:

a) There shall be one urban health sub centre for every block of 10,000 populations. This can go up to 15,000 populations in smaller municipalities of up to 40,000 sizes.

b) Shall have one female paramedical (ANM) per urban health centre that shall provide first contact care at the centre and shall also make home visits. If there are more than 3000 beneficiary families in that area then the urban sub-centre would have one additional female paramedical. If there are more than 6000 beneficiary families in that area there would be two additional female paramedical. Thus if the 10,000 families covered are all beneficiaries (poor) then the sub centre has 3 ANMs and if less than 3000 are beneficiaries the sub-centre has one ANM. This same norm applies even if the urban health centre has population coverage of 15,000. If out of the 15,000, more than 9000 are beneficiaries than the sub-centre would have 4 ANMs. The rationale is that the beneficiary would require greater follow-up and often household level care.

c) There would be one male para-medical in all urban health centres. This would not vary with population coverage as his role would be largely of a multi-skilled assistant in the urban health centre .

d) Shall have part time medical officer for attending to PHC level care.

e) Shall have same list of drugs as recommended for sector PHC.

f) Shall have a part time basic laboratory assistant.

Services Organized at and from the Urban Health Centres

- Quality antenatal care reaches 100% (with all 9 components- counselling, physical esp. abdominal examination, weight record, anaemia estimation, urine examination, BP measurements, iron and folic acid administration, TT immunization and referral linkages for medical referral sought at least once in the third trimester)
- 100% immunizations against six killer diseases within 12months of birth
- Prophylaxis against vitamin A deficiency, intestinal worms, and prevention and treatment of anaemia in children.
- Better vector control and reduced vector borne disease.
- Help in implementation of all the national diseases control programmes.
- Better quality of water supply, ensuring safe water use at community level and domestic level and promotion of hygienic measures all to lead to reduced diarrhoea disease with low cost interventions and prompt and appropriate care, reducing household expenditure on recurrent diarrhoea.
- Easy access at cost to contraceptives in every habitation and sub-group.
- Promotion of spacing, age of first child would continue to have urgency.
- Growth monitoring at least once in six months (and once in three months for very sick child), and anaemia assessment with adequate family counselling and supplementation to ensure that *below three years* child malnutrition levels show a consistent decline. Nutrition measurement and counselling to extend to adolescents and adult women and pregnant women also.
- Good quality primary health care based on graded standard treatment protocols available at the household level based on 10 drugs through Mitanins , at the sub centre level based on a 25 drug package through the ANM – supplemented by the part time medical officer. Such care is to be linked by a two way referral system to the secondary care centres and some special clinics of the state hospitals. This would therefore include STI/RTI/HIV dimensions of care. It would also include many non reproductive dimensions of women's health. This would also include primary care for mental health. The cost of the package would be the same as the current Mitanin- ANM- sub centre system – with the addition of training costs and some increase in drugs costs.
- A special clinic for adolescents organized in the sub centres that would link educational and vocational opportunities and counselling to better adolescent health and their access to services.
- Adequate disease surveillance by a system that centres on the data generated by the Mitanin but incorporates inputs from private practice, from the state health department hospitals and also the secondary care centres.
- Good quality referral linkage to the secondary care services (first referral unit) and ambulance services with efforts to see that at least 50% of the poor (beneficiaries as redefined) would resort to these or to other nor for profit hospitals who offer comparable costs as the better cost and better quality option.

- Promotion of Crèche facilities for babies of the working mothers linked to better pre school child education programme and a universalized ICDS programme that covers the entire beneficiary population.
- Promotion of Community level collective action supplemented by inputs from the municipality to ensure basic living and working conditions in all the habitations .Provision of women's basic education and vocational training to help them in self employment, to enhance their self efficacy and to enable them to take decisions with regards to sexual and reproductive health.
- Peer education programmes to reach out to specially vulnerable sections;
- Extensive awareness generation and community mobilization through IEC to supplement and make the above interventions effective.
- Monitor health status and provide first level response to mini and major epidemics.
- Optional – consider including disability identification and support in the Mitanin package of services.

Clinical Services at the Urban Health Centre :

The Urban Health Centre should provide an adequate quality of curative care by ensuring that

a) The part time medical officer be trained on a standard treatment guidelines that covers a number of specialties at the level that an MBBS doctor with basic laboratory support can handle

b) The ANM and MPW should be trained on a paramedical level standard treatment guideline with a slightly larger set of drugs than the Mitanin would provide services on all days at all times.

c) Good quality counselling and diagnostic facilities for RTIs/ STIs (where the ANM plays a key role) would be available

d) Basic infrastructure as needed for adequate privacy to examine patients and provide counselling to them is either leased in or built up, and for one room for laboratory work(if this is opted for).

e) That a laboratory that can estimate level of anaemia, do a routine urine examination (albumin, sugar, microscopy), and examine sputum for AFB and blood smear for malaria is built up. The ANM can be trained in a one month course to do these tests. In which case the additionally, is only the training cost and the microscope and a very small co on consumables. We note that this level of laboratory work forms part of the MBBS course and medical officer may need a one week training refresher so that he/she can adequately supervise the male paramedical worker to do these tests himself when need arises. A good basic laboratory manual with pictures would also facilitate this.

f) The timing of the urban health should be considered and in tune with the convenience of the population.

4. Urban Secondary Care Centres (or first referral units)

The Urban secondary care service centre shall provide for

a) Institutional delivery
b) Emergency obstetric care
c) Institutional care of sick child
d) Safe MTP services
e) FP sterilization services
f) Adolescent health care and counselling
g) Diagnosis and management of RTIs /STIs/ infertility

The urban secondary care centre would be one of the following:

a. A CHC or district hospital able to provide all these services
b. A private sector (commercial or not for profit centre) facility which is able to provide all these services – with which an MOU guarantees a minimum quality and fixed rate of services.

5. Referral Linkages with district hospitals and tertiary care centres:

All large corporations have district hospitals and or tertiary care centres like medical college hospitals. These hospitals are meant to cater to higher level of care for the entire district or state. However they are often flooded with patients requiring primary care from the adjoining urban areas. This overcrowding not only leads to less attention to patients requiring specialist care and tertiary services, it also means a poorer quality of primary care for those seeking it at such a location. Also a lot of waiting time, delay in providing services and patient dissatisfaction.

The main reasons for this are that the urban health centres have very low functionality. Even when functional such a high proportion of patients get referred up that it makes more sense for patients to seek care only at the higher centre.

To present this we need

a) A higher quality of curative service at the urban health centre - discussed above.
b) A good referral linkage that is two way – so that some categories of patients can be followed up at the urban health centre and so that patients referred up have a special clinic or green line to go through at the district hospital.
c) The linkage may also be to accredit private sector partners if the rates have been fixed as proposed under the draft PPP policy framework.

6. Peer Educator Programmes for special highly marginalized groups –:

Though health needs are most in marginalized groups, they are often the most difficult to reach out to. Such groups include a. homeless, b. the street child c. the commercial sex workers and d, seasonal migrants.

The proposal is to reach out through NGO programme to these groups. Each identified such marginalised community would be interacted with and a number of peer educators would be chosen from this group. There are criteria that apply in making such a choice- they should be on the group, having a good communication skills and commanding peer respect, and yet capable of critical thinking etc(there are techniques of peer educator identification that apply here). Then the peer educator is trained. Then deployment and acceptance within the peer group is another distinct technique-laden step and finally feedback and support of their function.

Peer educator programmes would have a RCH focus as well as focus on all the national health programmes including HIV.

7. Peer education programmes in urban schools for adolescents and in adolescent frequency zones for out of school adolescents.

Adolescents are another group where peer educators convey messages more effectively. Adults tend to be judgmental and are not able to relate adequately to the adolescent context. This is most so in areas related to sexual health but is also true of many other areas of health care. This is also a vulnerable period for addictions and violence.

Peer education programmes in schools require.

a. correct identification of peer educator
b. training
c. introduction as peer educator into the group
d. Follow up and support.

Peer educators for out of school adolescents are even more of a priority. It follows the same steps as delineated above – though each step is even more complex to achieve in practice. One example of deployment of peer educator is to set up a café in locality frequented by adolescents, and provide a space or corner, for information and basic supplies along with the advertised presence of peer educators there. The café managers themselves could double for this role.
Many such innovations are possible. At the planning level the key elements are
A. Identifying an NGO with good innovation skills
B Careful study of the group that has to be addressed and working out details within the budgetary allocation available for the same.

8. Designing a programme for supplementary social health insurance scheme

The issue of concern is making the quality health services available to the vulnerable population of the society which is estimated to be around 10% of the total population. However taking the resource constraints into consideration, a feasible alternative is to design and implement a model in which the health care cost for the poor is met through cross subsidy without any substantial loss to the healthy and affordable masses. This scheme is an endeavour to meet the purpose of making the health facilities available to the poor, by optimal resource utilization and cross subsidization.

The scheme proposes to cover around 17 lakhs population in Phase I i.e. first year. It could be then extended to the remaining population in the subsequent years depending on the claim experience of the first year. The premium amount of Rs. 600 per family (for a family of 5) will be paid by the beneficiary (propose) from Class I, (non-poor) while those belonging to Class II will pay only 50% of the premium(poor) i.e. Rs. 300 per year , the remaining amount will be borne by the government. However the premium for the vulnerable class i.e. from Class III will be paid by the government with a prerequisite that the beneficiary enrolls as a member of a Self Help Group with a nominal payment of Rs. 10 per month, which will be utilized to provide loans to meet the indirect costs of health care at the time of need.

The proposed scheme offers cover up to a limit of Rs. 20,000 per family for only secondary level care. This payment will be made directly to the health care provider as a third party payment and the beneficiary is not entitled to any cash benefits or reimbursements. This will also ensure continual monitoring of the process.

Not all hospitalisation needs are addressed. Only a package of services is provided such cover. These would however include a. institutional delivery, caesarean sections, hysterectomies or equivalent gynaecological surgery, acute abdomen, hydrocoele, hernia, circumcision, haemorrhoids, RTI/STI identification and family planning services- broadly secondary care needs or first referral unit services.

The third party payment would be made to the Rogi Kalyan Samiti if it is a CHC or district hospital that the patient chooses to go to. Or it would be made to a private sector provider who is functional under the proposed Mitan Kendra or Mitra Chikitsalay scheme. This scheme therefore requires the new state PPP policy and Mitan Kendra scheme to be in place.

The Mitanins would help and urban health centres would help in administering the scheme. The scheme itself should be worked out with a health insurance agency.

The budgetary requirement is to pay the costs of social insurance for the poor in the first year and half the costs in the second year. From the third year the system should be able to meet its own costs. (See annexure 2). Though budgetary calculations have been shown for the entire state, we could even launch this in small units a few category D, C, B and A towns as a pilot and then go ahead to expand this to the whole state.

A key variable is how much of those who are not beneficiaries would enroll. The option is that if this is run by the ULB to make the deduction part of ULB revenue or to leave it optional. Both variants would be piloted.

Service entitlements of the population:

The entire population in the geographic area would receive a minimum package of services. These include:

a. Pulse polio

b. Annually two visits to record vital events and child immunization status and check out on notifiable diseases.

c. A system in place of notifying any of a short list of notifiable diseases brought under a community- based component of the disease surveillance programme. This needs to be very simple system- like ten post cards left with a volunteer for every group of houses or sub-group or distinct community grouping.

d. One can add sampling drinking water quality testing with a low cost kit.

e. Similarly one can add – weighing all children below three once in six months- but this would require community support. Not insisted upon- except where they are poor but for some reason have not made it to the beneficiary group.

f. Enrolment in a social insurance package which would provide for a limited range of secondary health care – but which would cover all RCH secondary care needs. The premium could be deducted with property tax or enrolment could be made optional. The estimated sum is Rs 600 per family per year.

For the beneficiaries: the package could be (in addition to the general list above):

a. ensuring quality antenatal care at the sub-centre and post-natal care at the house

b. ensuring immunization at the sub-centre

c. ensuring access to temporary methods of contraception at the sub-centre

d. Ensuring access to sterilization on a fixed day of the week in one or two places in each municipality.

e. Ensuring access through a subsidized social insurance package to emergency obstetric care at nominal or free rates at a designated centre for emergency obstetric care, sick neonatal care and institutional delivery and a larger package of inpatient care for common childhood emergencies of the sick child – diarrhoea with dehydration ; acute respiratory infections: acute fevers,

f. Ensuring access to specialist services at the secondary centres at subsidized rates through the subsidized social insurance package.

g. Peer counselling programme for adolescents with adolescent clinics combined with activities to attract adolescents once a month at the sub-centre level.

h. Treatment equivalent to the "normative" rural sector primary health centre level based on a 50 to 75 drug list – and backed by basic (what is known as side-lab) diagnostics at the sub-centre – so that the PTMO is fully utilized. The package of services and level of services that would be available here should be notified and accompanied by a standard treatment guidelines built for this level.

i. Six monthly weighing of all children with nutrition counselling for the family for families with children in the 6 to 12 month age group or with children on any grade of malnutrition. For grade III and IV children medical visit and monthly or quarterly weighing may be added on.

j. Extension of ICDS services to these areas.

For the vulnerable beneficiary (in addition to all the above)

a. Door step delivery of primary health care may be retained as a goal – but now it must be seriously operationalized. This would mean that for this group we should ensure
   i. Regular visit from a Mitanin
   ii. Providing immunization at the home – if they are not coming to the sub-centre even after two months behind scheduled time
   iii. Providing antenatal and post natal care at the home.
   iv. Providing for a better quality of first contact curative care at the doorstep with 10 drugs and a standard treatment protocol for Mitanins and at the urban health centre with 25 drugs and the paramedical standard treatment guideline.
   v. Total exemption of all payments (or to be precise third party payments) at the maternity homes and other secondary care services along with a state paid social insurance mechanism linked to self help groups.

b. Creation of community level structures and credit mechanisms to meet health needs. (This is needed for all beneficiaries – but is critical for this group.)

c. Ensuring flexibly and innovatively run day care centres along with child weighing as suggested for the earlier group.

d. Collective community initiated and municipality supported initiatives to improve local living conditions.

e. Peer educator programmes through trained volunteers from within the groups- esp. for most difficult even within the vulnerable.

Provision of Urban Health Care Services:

In category F townships the proposal is to have the existing sub-centre renamed an urban health centre and provided ANMs as per the norms stated. The Mitanin programme would also be introduced in these areas. The CHC would act as the secondary care site.

In category E towns one would need to convert the existing sub-centres to urban health centres and add in more urban health centres as per the norms stated above- one per 10,000 with number of ANMs as per the beneficiary population. No part time doctors need be placed in these health centres and no separate administrative arrangement is required in E and F category.

In category D and C towns one would need to open a number of urban health Centres, have ANMs and other staff as per newly stated norms, including a part time doctor and have an urban health administration unit, headed by a public health officer. The CHC would play the role of the secondary care centre but where the potential to provide better care is available in the private sector the secondary care could be entrusted to them as per the Mitan Kendra PPP policy. (In special situations even the entire urban health package could be contracted out – if an NGO is willing to play this role.) This is particularly applicable to mining towns where there public sector undertaking or company run health facilities. In company towns, mining towns and collieries we may negotiate similar packages with their hospitals where they can contribute part of the co. The company town's main organised working population is already under medical coverage in almost all cases. The scheme is only for unorganised labour and casual labour and services that spring up around these areas and which cannot afford or access the services provided for organised labour.

In all these towns, especially where we have not for profit facility playing the secondary care role a " Supplementary Social Insurance Approach" linked to self help groups shall be included into the programme to cover the health needs of the poor and the vulnerable.

In category B and A towns we have four options to the provision of these services:

a) Recruit a secondary care service provider who is able to provide the entire package for a population of about one lakh, work out a unit cost for services and reimbursement package and sign an MOU for the same.

b) Make separate package for paramedical and community level care and a separate package for secondary level care. Though the first is the preferred route the second may be required where we have no takers for the first.

c) The urban local bodies that want to take up and run such a programme may also do so. The budget overheads are adequate for this. They would contract in a secondary referral centre and the other services would be directly under them or they could contract the entire package out.

d) We can also consider a similar package being run by the government with cost recovery as for the PPP where there are no private or NGO takers for such services. The secondary care in such a situation would be by the district hospital and the CHMO office would run the urban health centres under an urban health officer post created specifically for this task and equivalent to a BMO in designation.

In all these towns too the beneficiaries would be brought under a "supplementary social insurance programme approach" linked to self help groups and Mitan Kendra.

SETTING THE PROGRAMME INDICATORS:

The quantifiable objectives proposed are therefore the following 10 indices- **all of them to be presented with segregate for three socio-economic classes** – two of them within the beneficiary group(the poorest about 10% being seen separately from the rest of the beneficiaries and called vulnerable beneficiary) *and with segregate where relevant for gender :*

- Infant mortality rate
- Under three or under 5 child malnutrition rates
- Anaemia in women, especially in adolescents
- Birth weight of babies
- Age of first child and spacing intervals
- Percentage of births which are third order or higher
- Percentage using institutional delivery
- Case detection of tuberculosis and case holding to match up to the RNTCP norms.
- More innovative indices to include cost of care and resulting household indebtedness and disease burden should also be developed, if investment in health care as poverty alleviation is taken up as a serious goal.
- Number of days of work lost due to illness per earning member
- Out of pocket co of institutional deliveries for the poor.
- Out of pocket cost for management of three recurrent childhood trivial illness- fever, diarrhoea, and respiratory infection- of the poor.
- Number of poor who had to borrow at usurious rates for meeting either of above co.

ESTIMATING NEEDS AND COST

An estimate of the urban poor based on poverty data is about one thirds- or about 12 lakhs. (of the urban population of the category A to D towns).
The estimated need for urban community level caregivers would be 2,400. In addition we would seek about 10% of that number of peer educators- roughly 240.
Urban health centres needed – again category A to D towns would be 120 with at least 260 ANMs and one male worker in them. In category E& F about 60 urban health centres would have to be created or as is more likely the sub-centres would need to be upgraded to urban health centres.
And there would be about 10 secondary referral centres needed.
The package for training and deploying a community caregiver is roughly about Rs 4000 per year per caregiver excluding drugs. Incentives would be from referrals and form part of the costs of the urban health centres and the secondary referral centres. Though the total amount would work out to Rs 1.04 crores this is only an investment of about Rs 30 a household – which is a small but essential investment to set up the household and community level processes that are crucial to the success of the programme. There is already a major demand for extending the Mitanin programme to urban areas and since the systems for training and supporting the Mitanin programme has been developed its extension to urban areas would pose few problems.

The package for training and deploying a peer educator is also approximately the same cost of Rs 4000 per year. It includes approx 20 days training per year, and for each day of training Rs 75 is cost for fooding, Rs 25 is cost of material and Rs 100 is cost of compensation/incentive.

The urban health centre cost would about Rs 2.6 lakhs per year. This excludes infrastructure costs though it includes rental costs. Approx two ANM @ Rs 5,000 per ANM per month, Rs 30,000 package for minor equipments and training, a Rs 50,000 per year for infrastructure repairs or rent and incidents. Redeployment of existing staff would be able to cover the cost of the third ANM and male attendant and where needed state will fill the gap. The part time medical office if utilized then Rs 5000per month or Rs 60,000 per year will be paid.

The understanding is that all civil dispensaries CMO run centres, and ULB run centres and ISM run centres come under a common ULB management that has a health officer deputed from the directorate of health services to manage it. This would minimise the needs for infrastructure. However in some areas where new clinics are needed they would be taken on rent. Existing infrastructure up gradation needs would also be attended to.

For the secondary referral centres the costs are being projected as Rs 1.2 lakhs per year for overheads and general subsidy. We are proposing using existing public hospital for private sector where the note the rate have been fixed in accordance with state PPP Mitan kendra policy.
The cost of reimbursement for institutional delivery for the BPL population would range between one crore (at 25% efficiency) to four crores (at 100% efficiency). This cost would not be charged in per cases basis, but included as part of an insurance charge so that after two years it is sustainable. The government therefore only pays the premium for the poorest 10% of the BPL section and 50% of the premium cost for another 30%.The other 60% of the population in the locality- is given the option of joining in. The proposal is that we initiate this innovative social insurance approach in only about one fifth of the total urban areas for the category A to D towns. The social insurance premium payments shown are estimates for the pilot programme in the first year. In the first year it is

proposed to cover 33,333 houses in category A Urban areas, 13,333 households in category B urban areas, 6667 households in cateory C towns and , 3333 househols in category D towns. Of these houses appox 10% would have 100% premium paid by the govt (category III) while another 30% would have 50% premium paid by the govt and the remaining 60% are voluntarily recruited in. This budget is needed only on the assumption that 60% do not voluntarily or mandatory join the scheme with full payment- which in the first two years is the likely secnario. If on the other hand they join, which we hope to achieve from the second year onwards no further subsidy is needed as it would be self sustaining. However since the first year we are taking up about one sixth of the estimated urban poor population- it would be useful to have a similar sum available to expand the programme to more and more urban areas each year. (For mote details see annexures of the Urban RCH proposal).

This can be contracted out to an NGO but preferable decentralised to an ULB with a 10% of overheads, for their management. The state management costs would have in turn another 10%, for monitoring and support. This does not include cost of drugs and Supplies for Community Care Givers and Urban Health Centres which would be from district funds. The state level mangement cost is high as this is a very experimental approach and it is going to require considerable management inputs- both consultants and regular to make it viable.

For implementation and day to day monitoring the programme one Health Administrator (post graduate in management with experience in health sector) per one lakh urban population in category A and B. Monthly emoluments per Health Administrator will be Rs 20.000.

Budget: Urban RCH

Head	Unit Cost	Nos.	2005-06	2006-07	2007-08	2008-09	2009-10	Total
Participatory Mapping for A category	Rs 10,000	4	210000	0				
Participatory Mapping for B, C, D categories	Rs 20,000	15	280000	0				
Health Administrator for A, B categories (for one year)	Rs 20,000	29	7000000	7350000				
Community care givers	Rs 4000	2,400	9600000	10080000				
Peer educators	Rs 4000	240	960000	1008000				
Urban health centers	Rs 2.6 lakhs	120	31200000	32760000				
Secondary centers	Rs 1.2 lakhs	10	1200000	1260000				
Social insurance for pilot ULBs (govt. paid premium in first two years for category III beneficiaries)	600	5667	3400200	3570210				
Social insurance for pilot ULBs (govt. paid premium in first two years for cateogry II beneficiaries)	300	19000	5700000	5985000				
Total			59550200	62013210	65113871	68369564	71788042	71788042
Overheads and management cost for ULBs/state management	10%		5955020	6201321	6511387	6836956	7178804	32683489
Net			65505220	68214531	71625258	75206520	78966846	359518375
State level co for management, training and monitoring	10%		6550522	6821453	7162526	7520652	7896685	35951838
Total Programme Cost			**72055742**	**75035984**	**78787783**	**82727172**	**86863531**	**395470213**

The urban health centre cost would about Rs 2.6 lakhs per year. This excludes infrastructure costs though it includes rental costs. Approx two ANM @ Rs 5,000 per ANM per month, Rs 30,000 package for minor equipments and training, a Rs 50,000 per year for infrastructure repairs or rent and incidents. Redeployment of existing staff would be able to cover the cost of the third ANM and male attendant and where needed state will fill the gap. The part time medical office if utilized then Rs 5000per month or Rs 60,000 per year will be paid.

The social insurance premium payments are estimates for a pilot programme. To understand which this has to been along with the Mitan kendra PPP proposal. And the urban RCH proposal annexed. In the pilot phase it is proposed to cover 33,333 houses in category A Urban areas, 13,333 households in category B urban areas, 6667 households in cateory C towns and , 3333 housholds in category D towns. Of these houses appox 10% would have 100% premium paid by the govt (category III) while another 30% would have 50% premium paid by the govt and the remaining 60% are voluntarily recruited in. This budget is needed only on the assumption that 60% do not voluntarily or mandatory join the schemewith full payment. If on the other hand they join then from the next year onwards no further subsidy is needed as it would be self sustaining. However since the first year we are taking up about one sixth of the estimated urban poor population- it would be useful to have a similar sum available to expand the programme to more and more urban areas each year. The state level mangement cost is high as this is a very experimental approach and it is going to require considerable management inputs- both consultants and regular to make it viable. For mote details see text.

7.2.6 Tribal RCH

Constraints/Situation:
Chhattisgarh large tribal population of about 32% has considerable cultural, ethnic and linguistic diversity. Inadequate recognition of this has been a major constraint in the success of most health programmes in this area. Very high levels of malaria, tuberculosis and malnutrition and alcoholism present unique challenges. Many of the problems relate to livelihood issues. Health systems cannot address these issues but investing in health gives a better chance for tribal development programmes to succeed. Geographical constraints to access are also a major issue. There is also a lack of epidemiological profiling of disease patterns in these communities.

Objectives:

- Integrate the cultural, ethnic and linguistic diversities and specifications into health planning esp into BCC strategies.
- Build up incentives for employees to work here and alternate systems of health care delivery for underserved areas.
- Build up an epidemiologic profile of diseases in these communities.

Activities:

a) Build up two regional **Tribal Health & Family welfare training centres**- one at Ambikapur to cater to the tribal sections of Jashpur, Raigarh, Koriya, Korba and Sarguja and the other at Jagdalpur to cater to the tribal section of Bastar, Dantewada, Kanker and parts of Dhamtari.
In the northern districts the tribes that are present are the primitive tribe of the Hill Korbas and Sahriyas and Baigas and the Oraons and Gonds.The dialects spoken are Sagdi and Oraon.
In the Southern districts there are six major tribal groups- the Gonds, the Murias, the abhujmurias, the halbis, the battaris and the Kamars (more central) and many smaller tribal groups. Halbi is understood by most- but Chhattisgarhi and Hindi are not. Health communication in these areas has been very poor due to the lack of understanding of language and even more important of their cultural practices and value systems. There is a very large cultural gap between health care providers and the people they serve. We also have very few members of these tribes themselves involved as health employees. Community participation is low. It is to correct these distortions that the two regional H& FW training centers are proposed. The differenes between then northern group of tribals and the southern groups are so marked that the same center will not do. The third Regional HFWTC is at Bilaspur(already in existence) would also have these same areas of work but with focus on non tribal areas and the Chhattisgarhi language.

These centers will become the major training centers for all BCC activities and for developing suitable health communication materia for these tribal areas.

Other than BCC and communit training the three cneters would also undertake training for LHVs and HAs (male and female sector supervisors- six months training programmes). This is essential pre-promotion training. The major gap this proposal addresses is the lack of any training facility in the state for LHVs and HAs. By current norms, a six-months training is required.

Proposed size :

Training space plus accommodation for 60.

Staff Sanctioned :

One head, three subject specialists, six trainers and supporting staff.

The other activites proposed under the tribal health plan are:

b) Notify medically and paramedically under-served and unserved areas in these districts and follow the process outlined to choose between mobile clinics or fixed services run by NGOs, janpad panchayat run services and PPPs to cover these areas. The budget for the same is expressed along with the section on NGOs and on PPPs.

c) Build up an epidemiologic profile of disease pattern in the primitive tribal groups-AbhujMurias, Kamars, Hill Korbas etc as well as in other sections and use this to write up more specific proposals in the coming years. To link specfic sector PHCs to research institutions for this work so that there is an element of operational research and capability building embedded in this.

d) Incorporate cultural aspects of Health Communication into BCC programmes along with epidemiologic insights into both in-service training programmes and BCC programme design. The incoporation would be done at the tribal training centers and the budget for the field level programmes would come from the BCC budget.

Budget For Secction 7.2.6 Tribal RCH

Head	Unit Cost	Nos.	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
Training,PPP,NGO Programmes, BCC			in respective sections					
Epidemiologic studies	1,500,000	8	60,00,000	60,00,000				12000000
Regional Training Centre at Jagdalpur and Ambikapur	See below in 7.2.6.1.		13800000	25,38,000	53,29,800	5596290	5876105	33140195
Total			**198,00,000**	**85,38,000**	**53,29,800**	55,96,290	**58,76,105**	**45140195**

Sub table 7.2.6.1. Regional Training Centres for Tribal Areas :

Sl	Head	Descriptions	2005-06					
A	Non Recurring Exp.							
1	Building, Furniture & Fixtures	Refurbish existing centre at Bilaspur- Rs. 5 lakhs	500000					
		For establishing 2 more centres in Jagdalpur and Sarguja: Rs. 50 lakhs each	10000000					
2	Equipments	Computers-2;Printers-1 Photocopier-1 Projectors,Sound Systems & Accessories Rs. 6.00,000/ centre*3	1800000					
3	Vehicles	1 vehicle each for a centre. 3*5,00,000	1500000					
A	Total		13800000					
B	Recurring Exp.		2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
1	Salaries							
	1 Principal	1*Rs15000*12months *1*3 RTCs		270000	567000	595350	625118	2057468
	3 Expert Faculties	3*Rs 10000*12 months*3 RTCs		540000	1134000	1190700	1250235	4114935
	6 Trainers	6*Rs 8000*12 months*3 RTCs		864000	1814400	1905120	2000376	6583896
	1 Data Entry Operator/ assistant	1*Rs 4000*12 months* 3 RTCs		72000	151200	158760	166698	548658
	1 Driver	1*Rs 4000*12 months *3 RTCs		72000	151200	158760	166698	548658
2	POL	1 vehicle*Rs5000*12 months*3 RTCs		90000	189000	198450	208373	685823
3	Workshops& material Prodn.	Lumpsum 3 lakhs * 3 RTCs		450000	945000	992250	1041863	3429113
3	Office Expenditures and Comtingencies	10,000*12 months*3 RTCs		180000	378000	396900	416745	1371645
	Total		13800000	2538000	5329800	5596290	5876105	33140195

Note: In 2005 –06 and first 6 mnths of 2006-07 since building is under construction no running costs are shown. From second half of 2006-07, running costs- salaries, actvities, travel are budgetted for).

7.3 Institutional Strengthening:

Introduction:

The central problem of infrastructure in the public health system of Chhattisgarh is the peculiar combination of a highly inadequate infrastructure with a gross under utilization of the same. This is the central problematic- the matching of investment with utilisation- that the infrastructure development plan of RCH-II addresses.

The discussion of technical strategies shows that the same set of issues recur in each technical domain and strategies needed are so closely overlapping that they cannot be discussed independent of each other. We have therefore chosen to look at the activities within eight activity groups. These are:

7.3.1. Infrastructure Development and Utilisation
7.3.2. Training of all different types for both paramedical and medicals
7.3.3. Strengthening 100 CHCs to become FRUs for set of secondary services- this includes basic & emergency obstetric care, institutional care for sick neonates and sick children, STI/RTI, adolescence counselling and health care services, safe MTP services and fixed day for tubectomy and vasectomy services.
7.3.4. Strengthening routine subcentre services.
7.3.5. Public-private partnerships.
7.3.6. Service delivery & NGOs.
7.3.7. Community level care- Mitanin Programme
7.3.8. Increasing drug kits
7.3.9. Panchayat and village level capability building

7.3.1 Infrastructure Development for the Public Health System in Chhattisgarh:

Infrastructure – Current Situation and Gaps: There has been a major effort to bring all district hospitals to 100 bed levels. Since 9 new districts were created after the formation of Chhattisgarh in almost all a CHC or a civil hospital was built up to district standards or an altogether new 100 bed hospital was built. Ancillary buildings are required in many of these hospitals- for incinerators, for garages, for residences and for supplementary services. However since the new buildings that have been built are yet to become fully utilized, and many constructions are to be completed- further new immediate infrastructure needs at the district level would be small and can be managed within state funds.

The Community Health Centres: By population norms of one CHC per lakh population we need 180 CHCs even if we leave out the 40 lakhs population of large urban towns. The system is however currently aiming for only one functional CHC per block. This gap between number required by two different ways of estimation gets reflected in a number of blocks where the population is close to two lakhs and the CHC is physically too far away from over half the population (e.g. Podi-Uproda). The recommendation is that as an interim measure to upgrade some of the PHCs in these blocks at a suitable location and these upgraded PHCs are be made capable to perform 24 hour medical officer attended emergency services sans operation facilities and link it up with the main CHC of the block.

If we assume a block per every CHC as our immediate goal then the state requires 130 CHCs- assuming that the district hospital would play the CHC role in urban areas. However noting that urban areas are medically underserved there is a need to retain the CHC- for serving the local population with a range of public health and specialist outpatient services and decreasing the load on the district hospital. In which case the number of CHCs to plan is 146. The sanctioned strength as now is 121.The distribution of this is shown in table 2.

Table 15: Distribution of CHCs.

District	No of Blocks	CHCs sanctioned plus blocks with civil hospitals	CHCs with new 30 bedded structure
Bastar	15	12(+ 2)	-
Bilaspur	10	10	6
Dantewada	11	9	3
Dhamtari	4	3	1
Durg	12	10	6
Janjgir	09	6	3
Jashpur	8	7	-
Kanker	7	5	0
Kawardha	4	2	-
Korba	5	3	-
Koriya	5	5	2
Mahasamund	5	4	-
Raigarh	9	5	2
Raipur	15	11	3
Rajnandgaon	9	6	3
Sarguja	19	18	3
Total	**146**	**116**	**34**

Of those CHCs, which are sanctioned, many do not have the requisite infrastructure. The situation regarding this is also seen in the table above. This table has taken number of beds as the single criteria of adequacy. Thirty bedded CHCs are almost all newly built and accompanied by all infrastructure requirements. There are also a fair number of older CHCs with beds varying from 11 to 30. Most of these were earlier PHCs, now re-designated as PHCs. Though they have beds they are not fully functional yet.

CHC infrastructure requires a number of facilities other than the beds – the operation theatre, the labour room, the X-ray rooms, the laboratory, the stores, the toilets and bathrooms, waste disposal systems etc – and so on. Many of these facilities require extensive renovation and repairs. In many such facilities the building is very old and cracks have appeared in walls and the ceiling often drips. The ceilings have to be renovated and made waterproof. Cracks would have to be attended to and walls strengthened along with fresh painting to give it a presentable appearance. The floors especially in the delivery room and in the toilets and in the operation room would have to be non–porous. Years of lack of investment in maintenance have given them a dilapidated look even where the building itself is not damaged.

Basic cleanliness is also a problem and facilities for waste disposal remain very weak. At least some areas must be marked off for deep burying or landfill and fenced off. If this is not done disposal of placenta, MTP products and other body fluids etc becomes difficult and unethical and dangerous. Incinerators would be required in larger facilities.

Toilets are either not there or in a state of utter disrepair and poor maintenance. Moreover a minimal bathing facility is needed for patients wherever in patients are considered. For example any woman giving birth to a child would like to have at least a wash and a convenient room-- for that is not a luxury, it is basic right. Similarly when we are talking of a 24-hour service it is equally important to provide a staff toilet separate from patient toilets.

A facility- extension of a veranda like space where patients and their attendants can wait is also needed if it does not already exist. Power supply is not a problem in most CHCs studied. Those that do have a problem all have generators as back up. However electrical fittings are usually needed and sometimes-fresh wiring is urgently needed. At present more than 50% do not have telephone access and none of them have a functional Internet access.

Staff quarters are also major lacunae. In the infrastructure study staff quarters were there in many CHCs (92.5%) had some doctors accommodation but never adequate for all doctors. About 70% had nurses' quarters and 52% had some paramedical quarters, 70% had some quarter occupied by clerical staff and 37% had some quarters occupied by class 4 staff. Again never was the accommodation enough for all.

Under RCH-1, EAG civil works for renovation has been done in almost 70 CHCs. We need to upgrade these CHCs into 30 bedded secondary care centres with functional OTs. The state government is funding another 30 such new buildings. The immediate gap to reach our goal of 100 CHCs as secondary care centres is 30.

Adequacy of Primary Health Centres: Of the primary health centres the infrastructure position is more complex. First there is a large gap in sanctions. This leads to a tremendous overload of coverage area on existing PHCs and CHCs. This is shown in the table 3 below.

Sectors and PHCs

District	Sector	Sector PHCs final	Av. Popn/ PHC	Av Popn /Sector	Sectors without PHCs	Sanctioned PHCs without own bldg
Bastar	65	54/57	24115	20034	11	20
Bilaspur*	66	49/42	40674	30197	17	19
Dantewada	47	34/34	71909	15299	13	9
Dhamtari	24	14/11	50255	29315	10	4
Durg*	65	48/46	58370	49104	17	12
Janjgir*	46	22/25	59825	28612	24	13
Jashpur	33	25/27	30124	22822	8	7
Kanker	34	24/21	27138	19156	10	4
Kawardha	19	10/12	58467	38978	9	2
Korba*	44	29/29	35601	23464	15	11
Koriya	23	18/21	32525	25455	5	10
Mahasamund	37	15/14	62901	25500	22	11
Raigarh	35	38/40	33291	36145	-3	22
Raipur*	89	44/47	68387	33809	45	14
Rajnandgaon*	36	22/25	58264	35606	14	11
Sarguja	85	64/65	30792	23184	21	19
Total	**748**	**510/516**	**40776**	**27952**	**238**	**189**

Where PHCs are sanctioned there is large gap in adequacy of infrastructure.

Adequacy of PHC infrastructure: If we define a sector PHC as having the capacity to conduct institutional delivery on a 24 hour basis for high risk cases – all the above – labour room, a small 2 to 6 bed ward, toilets and bathing facilities for patients, staff toilets, communication facilities for accessing referral etc are all essential features. Clearly this has not been achieved in most sector PHCs. Of 516 PHCs, as many as 189 (36.62%) have no PHC government building. The infrastructure study that had a sample size of 59 PHCs showed that most were in some type of government buildings-- but this was largely Sub-Centre building having been recently upgraded to PHCs.

This is barely adequate for PHC function and an extension of one or two rooms is desirable. PHCs, which are in government buildings built for that purpose, have good infrastructure with about 6 beds, which can be even pushed upto ten beds. PHCs in panchayat and rented buildings or using space built for an ISM facility have usually got inadequate space for basic functions. Most PHCs have power supply and of these many (61.37%) reported that it was regular. But almost all needed better electrical fittings and wiring to be adequately usable. Water situation was less than satisfactory. Though most had a water source only one fourth had running tap water connected to an over head tank. A well or bore well was the commonest situation and was present in roughly half the PHCs. About one fourths report that their source is absent or inadequate. Telephones were present in one thirds of the PHCs studied.

Only one third had staff toilets and of these one third 11% were considered of adequate maintenance. Most other PHCs had one toilet without separate provision of staff. The condition of one thirds of these was rated as poor and the rest as fair. None were considered as of adequate maintenance. One thirds of PHCs had in addition some bathing facilities. Accommodation in PHCs is also a major issue. In remote areas the lack of accommodation makes it impossible for doctors to be resident there – as there is often no suitable rented accommodation either.

This proposal therefore seeks renovation of existing sector PHCs and new PHCs in all those sectors which do not have a sector PHC as of now.

Adequacy of Sub-Centre Infrastructure: This is difficult to assess. The government annual report for 2002-2003, records that overall for the state, 1458 out of 3818 sanctioned SCs or 38.19% of Sub-Centres have a government building. Government buildings usually had five rooms- a outpatient room of about 8ft square, a hall of about 22 ft* 8ft used for conducting deliveries and labour, two rooms of about 8ft square for residential purposes, a store- often used as kitchen and two small toilets and two verandas (of about 700 esq.) one of which functions as a waiting room for patients. Whereas in rented buildings, there is usually a single room, of about 100 to 150 sq ft, with little other facilities. In other cases, the stores were kept in the ANM's own accommodation, for which also the government paid no rent. 57% of govt buildings were rated as being in good condition, about 26% fair and the rest poor. In contrast in rental buildings only about 30% rated good condition and an equal amount rated fair – the rest being perceived as poor condition. Subcentres with government building most have adequate water supply- usually bore-wells with hand pumps. But one fifth report some problems, which are large enough to compromise quality of service. These gaps need local solutions. As such the system in place is neither able to take note of such gaps periodically nor is it able to respond to the needs adequately. At present any gap notified via the BMO to the chief medical officer and he funds earmarked for this to each district are not known at the year's beginning. There is no set procedure, which takes care of such gaps.

Table 17: Sub-Centres with buildings:

District	No of SCs sanctioned	Number with own buildg	Number which need bldg.
Bastar	317	211	106
Bilaspur	282	40	242
Dantewada	204	89	115
Dhamtari	138	44	94
Durg	353	105	248
Janjgir	210	37	173
Jashpur	195	152	43
Kanker	162	123	39
Kawardha	96	40	56
Korba	194	20	174
Koriya	106	42	64
Mahasamund	143	51	92
Raigarh	249	194	55
Raipur	461	82	379
Rajnandgaon	220	110	110
Sarguja	488	118	370
Total	**3818**	**1458**	**2360**

Training Infrastructure: This is dealt with in the section on training.

Understanding Infrastructure Under-utilization: Utilisation at the district hospitals is good in most district hospitals. In contrast, utilisation at the other three levels- CHC, PHC and subcentre is a problem. Many of the 30-bedded CHCs are not functional and almost none of them has full bed occupancy. Most operation theatres built have not become functional. Very few PHCs are doing any institutional delivery and almost none are doing so on a 24 hour basis. This is true also for subcentres. The causes for such underutilisation are listed below :(Not in order of importance).

1. Poor location of facilities --geographically and in relationship to social sectors and markets reduces access.
2. Inadequate manpower and therefore non-availability or very poor quality of services.
3. Inadequate skills – especially in some critical areas- e.g. emergency obstetrics or anaesthesia or laboratory work- makes it impossible to provide many services for which the infrastructure is built.
4. Inadequate health care provider motivation and poor quality of client – provider interaction reduces attendance.
5. Costs of care – both legal and illegal - have an adverse impact on attendance.
6. lack of prompt referrals and poor referral arrangements also leading to poor utilization
7. Poor health awareness also contributes.

Whatever are the reasons, such underutilisation is a waste of scarce resources and a major de-motivation for both the state finance and for donors to invest in more infrastructure.. The obvious lesson is that any planning for increased investment in infrastructure must simultaneously address the above issues. (Note: infrastructure underutilisation has been studied in detail in the SHRC study on rationalisation of health services).

Addressing infrastructure utilisation in parallel to infrastructure creation:

The Proposal:
The main objective must be to close the gaps in infrastructure in parallel to closing the gaps in skilled manpower and equipment through careful block level planning. This in itself has to be done as part of a participatory process to be closely followed by management and motivational inputs so as to improve quality of care.

The strategy that we propose to follow is to take about 50 blocks per year so that at the end of the two years 100 well distributed blocks other than the district hospitals have been addressed and all gaps in infrastructure, skilled manpower and equipment are closed.

In each block closing infrastructure gaps would require the following order of intervention:

1. Repair and renovation and completion of work of existing CHCs so as to make it capable of functioning like an FRU i.e. with a functional major OT and with 30 beds. This has been done in 70 CHCs.
2. Repair and renovation of existing PHCs so as to make them capable of giving a level of care defined by its ability to conduct 24 hour institutional delivery. This has been done in 30 CHCs.
3. Construct 30-bedded CHCs where there are not already such a CHC in place.
4. Construct a PHC in those sectors which have no PHC currently and where no ISM building can play this role. This may be done only after the PHC for that sector is sanctioned along with its implications for manpower.
5. Construct subcentre buildings for all subcentres where such a building is not in place.

In parallel to each of the above steps, a number of steps would be done.

Sl. No.	Infrastructure action	Parallel actions
1	Repair and renovation(if needed new)buildings for CHCs	Purchase of equipment needed, Basic Emergency obstetric care skills and sick neonate care skills are in place in all 100 blocks and in addition anaesthetist and CS and blood transfusion capability in place for 50 blocks . Motivational inputs and block planning
2	Repair and renovation of PHCs.	Purchase of equipment. to close gaps. Ensuring that 3 female and 3 male para-medicals are available and multiskilled. Ensuring basic laboratory is functional.
3	Constructing new 30-bedded CHCs	Sanction for CHC and staff . The rest is the same as in the first row
4	Constructing new PHCs.in sectors without PHCs	Sanction of new PHCs with staff for same. The rest is the same as row 2.
5	Construct Sub-Centre buildings	Two ANMs or one ANM and one MPW is in place and is providing quality care
6.	Construction of residences	Whenever all the above s are completed and service delivery has improved – both in quantity and quality.

Between the two years, we also need to address few key "systems" problems. These are:

a) Ambulance services-at least in 50 blocks – but each serving three blocks for getting sick neonates and children and for those needing emergency obstetric care to the hospital in time.
b) Designing a viable referral system.
c) Getting access to blood organized.
d) Adequate laboratory services for that level to provide STI services, safe MTP.

All these are budgeted for independently.

Making the above services happen goes far beyond merely closing the above gaps. It is really a function of leadership and support and team building. It requires organizational, motivational and technical inputs. The specific steps needed would include workshops, evolution of quality indicators, incentives and disincentives packages, and addressing systems issues.

At the end of the two years 100 blocks chosen would have facilities that provide adequate quality of the following:

a) 24 hour access to Basic Emergency Obstetric Care Services at the sector level.
b) Comprehensive Emergency Obstetric Care services(in at least 50 CHCs and 16 district hospitals which are designated FRUs– in the other 50 blocks only basic emergency obstetric care is promised, though even here comprehensive care would be aimed for.
c) Institutional neonatal and sick child care in the 100 CHCs.
d) fixed day every week for tubectomy and vasectomy surgery at the CHC level in the FRUs
e) Utilisation of referral facilities, so as to get adequate points to these.
f) Safe MTP services available in all 100 centres.
g) Improved RTI/STI services in all 24-hour sector level PHCs and adequate secondary level RTI/STI services with diagnostics in the 66 FRUs.
h) Better quality ANC and post partum and neonatal care in all blocks.

It is only after the performance is assessed annually and found to be favourable that more investment would be made in the next year. In the second year further infrastructure inputs for second level priority infrastructure- i.e. residential accommodation for staff at PHCs and CHCs can be organized matched to already achieved above quality and quantity indicators and to revised goals.

Budgetary Estimates:

A. PHCs and Subcentres:

For one normative block: Unit cost of one new PHC is taken Rs 18 lakhs and of one Sub-Centre is taken as Rs 5 lakhs.

Averaging state figures to a notional normative district and block we may state the following: An average block would have four sectors of which two would not have PHCs sanctioned OR would be sanctioned but still need fresh buildings and only two would have adequate buildings needing repair and renovation only. The average block would also have about 20 Sub-Centre level facilities—of which only about 7 would have buildings.

We may cost a new PHC building at Rs 18 lakhs and a new Subcentre Rs 5 lakhs. Thus the cost of closing PHC and subcentre gaps worked out block wise would be Rs 36 lakhs for PHCs and Rs 65 lakhs for subcentres – or about Rs 95 lakhs per normative block.

The normative block would have 7 subcentres with buildings. At Rs. 10000 per subcentre, we cost Rs. 0.7 lakh per block for renovation of these subcentres. The normative blocks would have 2 sector PHCs for which we cost repairs @Rs. 1,82,500 per PHC (50,000 for labour room, 1,00,000 for water, 10,000 for wiring, and 22,500 for toilets) or Rs. 3,65,000 per block.

Table : Budget for Subcentres and PHCs in a normative block.

ITEM	Unit Cost	Estimated No in One Block	Total Cost
Old Sub centres Renovation/Repair	10,000	7	70,000
Old PHCs Renovation/Repair	182,500	2	365,000
New Sub centres Building Construction	500,000	13	6,500,000
New PHCs Building Construction	1,800,000	2	3,600,000
Total			**10,535,000**

We would be sanctioning this 105 lakhs only to those blocks which have drawn up in parallel a plan to not only close infrastructure- equipment- manpower-skills gaps but actually understood the need to record increased quality services.

Considering development of 50 blocks every year, 350 subcentres will be renovated, 650 new subcentres will be constructed., 100 PHs will be renovated and 100 PHCs will be constructed.

For 146 blocks:

Before construction of new facilities the following planning steps would be undertaken:

1. All sectors, which have no PHCs, would be identified. Sanction for new PHCs would be sought. However since as a sector it already has its complement of paramedical staff the PHC building can be proceeded with and the sector PHC may be managed by the male and female health supervisors. Residential accommodation however will wait formal sanction of the medical officers post and achievement of quality of care..
2. In the above we would identify those sectors, which have an ISM facility, which can be upgraded or renovated to give a functional PHC that can undertake at least 24-hour institutional delivery. The existing ISM facility manpower would be integrated with the sector PHC so as to give minimum staff strength needed at the earliest.
3. Then we would map out the ideal location of the sector PHC in the remaining sectors and plan to build a new structure there. This would relate to ease of access to population it serves- geographical distances, public transport availability and market and social access factors.
4. To do all the above in 50 blocks each year so that in three years the entire state is covered. One may have to do more or less than 30 as the funds requested are or 50 PHCs every year.
5. The same process would be repeated for the Sub-Centres.

B. CHCs:

The cost of renovation of a CHC is Rs.4.00 lakhs as per estimate. This would include Rs300000 for civil works (Renovation of building, painting, improving of appearance, patient waiting, accommodation, compound wall etc) and Rs. 1,00,000 for electrical, plumbing work and other repairs. Already 70 CHCs are renovated. Only 30 more are needed to reach 100 CHCs aimed for. But in Parallel to renovation, we need to build new CHCs as per norms we have laid down. For this, we propose 15 CHCs per year The Budget is shown in table below.

Budget Estimate for CHC

ITEM	Unit Cost(Rs.)
Old CHC Renovation/Repair	400,000
New CHC Construction	5,000,000
Total	5400000

C. Closing residential accommodation gaps:

For one block: A sector PHC requires three quarters (1F, 1 H, and one I) with a unit cost of 10 lakhs. In a block we assume 4 sectors – other than the CHC a block would cost Rs 40.00 lakhs.

Staff quarters required at the CHC is 4F, 2G, 2H and 2 I type quarters – a total of 15 quarters that may be costed at Rs 50 lakhs. Thus together staff quarters in a block reach 90.00 lakhs. We are planning to close the staff quarters gap only in the second year where first year targets not only in construction but also in levels of care provided have improved. This would act as an incentive for completing the first year work and for building up the systems and motivation for achievements in the future also.

Infrastructure Gaps at a glance: -

Sub centes		Community Health Centres		
Total No.	4692(3818)	Total No.	130	
Govt Building needing renovation-1050	1458	Govt Building needing renovation	40	
Need of New Subcetre construction	2360(3234)	Need of New CHC construction	60	
Adequate sub-center building:	408	Adequate building already	30	
Primary Health Centres				
Total No.				720(516)
Govt Building needing renovation				327
Need of New PHC construction				189+204

Figures in brackets was the number of sub-centers in existence in 2003-04. This year a further 874 has been sanctioned. For PHC figures in brackets denote sanctioned PHCs-whereas estimation is for total number of PHCs as per norms.

Section 7.3.1 Infrastructure Development For The Public Health System

Budget For 50 Blocks in a year-

ITEM	Unit Cost	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
Old Sub centres Renovation/Repair 350/year	10000	3500000	3675000	3858750			11033750
No of SCs(only those needing renovation)		350	350	350			1050
Old PHCs Renovation/Repair 100/year	182500	18250000	19162500	20120625	5683050		63216175
No of PHCs (needing renovation)		100	100	100	27		327
New Sub centres Building Construction 650/year	500000	325000000	341250000	358312500	376228125	385315481	1786106106
No of SCs		650	650	650	650	634	3234
New PHCs Building Construction 100/year	1800000	180000000	189000000	198450000			567450000
No of PHCs		100	100	100			300
CHCs Renovation/Repair 15/ Year	400000	6000000	6300000	4410000			16993333
No of CHCs		15	15	10			40
For new CHCs 15/year	5000000	75000000	78750000	82687500	86821875		420499875
No of CHCs		15	15	15	15		60
For Residential Accommodation in 50 blocks	9000000	---	4500,00,000	472500000	496125000		
TOTAL		**607750000**	**1067347500**	**667839375**	**468733050**	**385315481**	**3196985406**

Appox 30 CHCs and 93 PHCs and 408 sub-centers are estimated as not needing renovation

Budget for Subcentres and PHCs in a normative block

ITEM	Unit Cost	Estimated No in One Block	Total Cost
Old Sub centres Renovation/Repair	10000	7	70000
Old PHCs Renovation/Repair	182500	2	365000
New Sub centres Building Construction	500000	13	6500000
New PHCs Building Construction	1800000	2	3600000
Residences for one block		4 F; 2 G; 2 H, 2 I type @ a CHC(Rs 50 lkhs plus for 4 PHCs (@ Rs 40 lakh)	9000000
Total			195,35,000

7.3.2. Training:

A. Introduction and Goals:

The government of Chhattisgarh is in the process of adopting a training policy so as to ensure that the public health system has the necessary knowledge and skills for its effective functioning. The goal of the training policy is to ensure that all the health care facilities that deliver RCH services – Sub-Centre, PHC, CHC, district hospital, and ISM dispensary and hospital- have the requisite skills needed for full capacity utilization and effectiveness.

In this section, we are presenting training needs in medical technical domains needed for different category of staff.

We are not discussing management and administration training – which is being dealt with under component 4. We are also not discussing pre-service trainings, training of community health workers, advocacy with stakeholders, and capability building of new players like Panchayati Raj institutions.

B. Objectives Of The Training Action Plan:

1. Build up the minimum training infrastructure that shall be needed to have adequate skills built up to achieve the training goals laid down in the training policy.
2. Chart out a paramedical training programme to provide multiskilled staff for PHCs, CHCs and effectiveness of RCH services.
3. Draw up a training plan for medical officers as part of a CME programme.
4. Design a multiskilling programme for 100 CHCs to achieve the necessary skill sets needed for running functional FRUs.

7.3.2.1 Plan on Training Infrastructure:

A. State Institute Of Health and Family Welfare

Present Status: Building under construction – to be completed by November 2005.

Proposed Functions : (Accommodation for 100 trainees at a time).

1. Training of Trainers for all paramedical; Training of trainers for multiskilling as well. (Esp. laboratory)
2. Coordinating Continuing Medical Education Programme for medical officers.
3. Material development for Training
4. Operational Research
5. Assistance in Policy development,
6. Administrative training/ training follow-up for medical officers and Senior paramedical
7. Training Evaluation of all training programmes
8. Guiding and monitoring implementation of the training policy.
9. Supervision of the functioning of the regional training centres and DTCs

Staff Sanctioned: As delineated in Component 8.3, under programme management issues.

Budget: One crore already received for civil works. Further budget estimated for furniture and fixtures and institutional development has been elaborated under component 8.3.

B. Regional Training Centres-3:(Jagadalpur, Bilaspur,Ambikapur)

Present Status:

Currently one at Bilaspur. Two others at Jagdalpur and Sarguja proposed. The major gap this addresses is the lack of any training facility in the state for LHVs and HAs. By current norms, a six-months training is required. Also we need region-specific IEC material for the 3 main cultural zones and these centres would be suited for this purpose.

Proposed functions: Accommodation for 60.

1. Training and planning and material development on IEC and cultural /communication aspects and locale specific IEC training and programme design – specific to tribal culture, tribal languages and tribal socio-economic context. Also training workers to be able to take forward their programmes in such a milieu.
2. Training of trainers for community level workers.
3. Six month pre-promotion training for female *and* male supervisors

Staff Sanctioned : One head, three subject specialists, six trainers and supporting staff.

The detailed budget and proposals are given as part of the tribal health section:

C. District Training Centre (accommodation for 30)

Present Status: Currently 5 available, 11 more needed.

Proposed Functions:

1. Training of male and female MPWs and all other class III paramedical support staff .
2. Tele-training reception venue for CME/training for medical officers.
3. Training of ISMs staff for public health goals.

Staff Sanctioned : One district officer in charge, three trainers and supporting staff.

Budget: Accomodation for 30

7.3.2.1. Budget For Infrastructure : District Training Centres

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
A	Non Recurring Exp.							
1	Building, Furniture & Fixtures	Refurbish existing 5 centres Rs. 1 lakhs	500000					
		For establishing 11 more centres: Rs. 25 lakhs each. (5*1,00,000)+(11* 25,00,000)	27500000					
2	Equipments	Computers-1 Printers-1 Projectors Sound Systems & Accessories Rs. 2,00,000 per centre*16 centres Maintainence of Equipments	3200000					
A	Total		31200000					
B	Recurring Exp.		2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
	Salaries							
	1 Training Officer	On secondment		0				
1	3 Trainers (MSw qualified proffessionals)	3*Rs 5000*12 months*16 DTCs		1440000	3024000	3175200	3333960	10973160
2	1 Data Entry Operator/Statistical assistant cum accounting clerk	1*Rs 4000*12 months* 16 DTCs		384000	806400	846720	889056	2926176
	1 Residential staff	1*Rs 3000*12 months* 16 DTCs		288000	604800	635040	666792	2194632
3	Untied funds for Preparatory Workshops and material	Lumpsum 1 lakhs * 16 RTCs		800000	1680000	1764000	1852200	6096200
4	Office Expenditures and Contingencies	5,000*12 months*16 DTCs		480000	1008000	1058400	1111320	3657720
	Total (A+B)		31200000	3392000	7123200	7479360	7853328	57047888

(Note: In 2005 –06 and first 6 mnths of 2006-07 since building is under construction no running costs are shown. From second half of 2006-07, running costs- salaries, actvities, travel are budgetted for).

7.3.2.2 Plan on Training Staff:

For full utilisation of this infrastructure investment requires a number of staff to be sanctioned. All full time trainers shown above are for the paramedical and would be from nurse-tutors or from other senior paramedical who have been trained to play the role of trainers.

Subject experts would be from social sciences, social work or any health science of any communication background with experience in conducting and organizing training for health programmes

For the SIHFW to start functioning it is suggested that a health management or HR development consultancy be given so that the staff recruited for it are trained and the systems that are needed are developed for the efficient functioning of the SIHFW as well as putting in place the entire systems advocated by the training policy.

Proposed Staff Training Activities Under Rch-2

A. Training of Paramedics

Training Needs:

- There are about 8,000 multipurpose workers –at the block, sector and Sub-Centre level. They require regular training of at least 18 days once every two years. This is for refreshing their knowledge and upgrading their skills and for multi-skilling them to be able to perform their roles as both a supporting paramedical in the 24 hour PHC and as a MPW in a subcentre.
- There are about 1500 supervisors who need to be trained and multi-skilled to act as effective supervisors and as multi-skilled assistants in the PHC.
- Training and multi-skilling of pharamacists, compounders, uni-purpose leprosy workers, dressers etc so that all of them can play an equal role as paramedical support staff in the PHC is an important direction.

Content of training:

The syllabus for training paramedical (MPWs included) shall consist of:

i. Knowledge of RCH areas shall include all essential obstetric skills for women Para-medicals (This is already done, needs only some strengthening).
ii. Knowledge of National Programmes.
iii. Ability to do basic laboratory work where relevant (especially male workers and underutilised staff categories at PHC).
iv. Ability to assist doctor to dispense medicines.
v. First contact care and first aid/dressing skills based on the standard treatment guidelines and drug formulary for paramedical
vi. Interpersonal and community mobilisation skills along with better understanding of cultural gaps in a multicultural and ethnically diverse society. This is particularly needed for persons working in tribal areas. Also on mainstreaming gender and equity issues.

Approach:
Each district training centre shall make and maintain a record of each paramedical and support employee and what trainings they have attended. It shall also have a list of the skills available in each facility. Every district training centre will aim to ensure that over a five year period every facility in its charge as the necessary skills needed at that level and that every employee in the district has the minimum specified skill sets needed as part of that facility- so that the facility is fully functional.

Centrally sponsored training programmes which fit into the above skill set requirement can be reduced from these 18 days. Or else they have to be treated as additionality over and above these 18 days.

Trainers:
The trainers will be of three types. One are the full time trainers working in the facility-largely drawn from senior public health nurses or nurse tutors or LHVs so are effective as trainers. The second are from the same group who are trained as trainers but called in only for specific sessions – otherwise attending to their main work. A third category may be NGO trainers – who must be persons active in NGO work of their own – who are invited for specific sessions where they are effective as trainers.
Training of trainers shall be largely done at the SIHFW.
Budget:

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
1	Training of Trainers	80 Trainers @Rs.1000 per day*15 days	1,200,000	1,260,000	1,323,000	1,389,150	1,458,608	6,630,758
2	Day allowance/ Food and logistics for participants	5000 trainees @125Rs a day*14 days	8,750,000	9,187,500	9,646,875	10,129,219	10,635,680	48,349,273
3	Training Fees and Travel for trainers	80 trainers*10 days *200	160,000	168,000	176,400	185,220	194,481	884,101
4	Travel for participants(by mother departments)		-	-	-	-	-	-
5	Stationary and Training Material	5000*200 Rs per trainee	1,000,000	1,050,000	1,102,500	1,157,625	1,215,506	5,525,631
6	Preparatory activities, correspondence, Documentation, Report Preparation, Monitoring, contingencies and other training related expenditures	125 batches@3120 Rs per batch	390,000	409,500	429,975	451,474	474,047	2,154,996
A	**Grand Total**		**115,00,000**	**12,075,000**	**12,678,750**	**13,312,688**	**13,978,322**	**63,544,759**

B. Training Needs and Approach for Medical Officers and Specialists:

1. **Continuing Medical Education scheme for medical officers:** This shall be initiated to upgrade the knowledge and skills of medical doctors. The CME shall be credit based and annual. Every year a medical officer must gain at least 1000 points. Credit points can be gained in one of five ways:

(a) Completing reading of a web-based topic/CME publication and then sending a feed back form. This could cover core topics like the management of immunisation, cold chain etc.
(b) Attending CME programmes, organised by professional bodies.
(c) Completing a professional periodical based feed back form that is filled in after studying the concerned section or sections - a sort of questionnaire- but there is no pass and fail- only a proof of having read it.
(d) Attending training workshops
(e) Training postings in special clinics (private or public sector) for acquiring skills like specific surgery or doing ultrasound etc.

Of the above 300 points are from core areas and are compulsory and 700 are optional. The core area topics and publications are specified by the department and must be covered by all. The optional areas are what the individual medical officer chooses to benefit by.

The SIHFW will lay down the credit points for various programmes (example 50 points for a CME attended, 200 points for study of a department CME publication etc) and this can be publicised by both the department body and the professional body conducting the CME. The state unit of any nationally recognised professional body like IMA, API, FOGSI, ASI, and IAP are all automatically recognised bodies for this purpose. Others would need to be accredited.

The SIHFW in collaboration with the training cell in the medical colleges would bring out the CME publications for the core credit points and also a CME periodical. The SIHFW would administer the CME programme. Acquiring necessary 1000 CME points per year would be essential for promotion.

Budget

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
	Expenditure For CME For Medical Officers							
1	Preparation and production of CME material	Rs 500 per doctor * 1000 doctors	500,000	525,000	551,250	578,813	607,753	2,762,816
2	Postage per doctor per year	6 times/year* Rs 20 * 1000 doctors*2 years	240,000	252,000	264,600	277,830	291,722	1,326,152
3	Course coordinators/evaluators honorarium /salary	lump sum, negotiated based on task	1,200,000	1,260,000	1,323,000	1,389,150	1,458,608	6,630,758
4	Full time support staff	Rs 20,000 * 12 months* 2 years	480,000	504,000	529,200	555,660	583,443	2,652,303
	CME contact programmes over two years	Rs 250 per person * 5 programmes /year * 2years* 1000 persons	2,500,000	2,625,000	2,756,250	2,894,063	3,038,766	13,814,078
5	Preparatory activities, correspondence, Documentation, Report Preparation, Monitoring, contingencies and other expenditures	Lump sum	80,000	84,000	88,200	92,610	97,241	442,051
A	**Grand Total**		**50,00,000**	**5,250,000**	**5512500**	**5788125**	**6077531.25**	**27,628,156**

2. Skill Sets for CHCs and Multi-Skill Training For Specialists:

Functional CHCs require much higher degrees of skills than are currently available, especially as specialists are not available in most CHCs and even in many district hospitals.

Multiskilling general medical officers for specialist skills in specific priority areas become essential. Multiskilling has begun with short-term courses in anaesthesia and emergency obstetric care- but this would be extended to many more skills till every CHC and district hospital has the minimum skill sets required as per the declared norms.

A related issue is that with some further inputs specialists like general physicians and general surgeons can handle more complex but essential procedures. A general surgeon being trained in laproscopy is one such example. This training would be a function of the training centres proposed in the two medical colleges. Other tertiary care centres could be accredited for this purpose.

At present, 32 CHCs are covered under this where a 6 months course on Obstetrics/Gynaecology and a 6 months course on anaesthesia completed. This proposal intends to cover further 70 under the same. An extra 30 would be desirable to cover dropouts, transfers etc. Other than this, two new courses are introduced in all these 100 blocks under this proposal- a 2 months course on sick neonatal/paediatric care. Also planned to train another 200 doctors for a 1 month course on conventional tubectomy, safe abortions and RTIs is also proposed.

Doctors are to be given travel costs and a Daily allowance, and allowance. In a year we can do a maximum of three batches of 5 persons each for all these courses in an institution. These courses would be run in 4 such institutions- Medical Colleges in Raipur and Bilaspur, BSP Hospital in Bhilai and Dhamtari Christian Hospital in Dhamtari. 5 faculties of concerned Medical College/ the designated centre will be given an honorarium. The cost of strengthening the seminar room and guest arrangements and contingency expenditures also would be given.

Another round of training for adolescent counselling and for nurses and paramedicals on laboratory works. In the first year, training on adolescents would be taken up and training on laboratory skills in the next year.

Budget for training for Skill sets for CHCs (and Multiskill Training for Specialists)

Skill Sets for CHCs and Multi-Skill Training For Specialists:

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
1	Day Allowance for Doctors							
	For Course on Emergency OB Care	180 Days@150 Rs *15 doctors * 2	810000	850500	893025	937676	984560	4475761
	For Course on Anaesthsia	180 Days@150 Rs *15 doctors*2	810000	850500	893025	937676	984560	4475761
	For Course on Sick Neonatal/child care	60 Days@150 Rs *15 doctors*2	270000	283500	297675	312559	328187	1491920
	For Course on mini Laproscopy/ conv. tubectomy/safe abortions/RTI	30 Days@150 Rs *15 doctors*4	135000	141750	148838	156279	164093	745960
2	Travel and Book Allowance for participant doctors for all courses	Total 150 doctors@ 2000 Rs	300000	315000	330750	347288	364652	1657689
Honorarium for Teaching Faculties								
1	For Course on Emergency OB Care	6 months@2000 Rs *5 faculties/institution* 3 inst* 2	360000	126000	132300	138915	145861	663076
2	For Course on Anaesthsia	6 months@2000 Rs *5 faculties*3 inst*2	360000	126000	132300	138915	145861	663076
3	For Course on Sick Neonatal/child care	2 months@2000 Rs *5 faculties*3* 2	120000	42000	44100	46305	48620	221025
4	For Course on mini Laproscopy/ conv. tubectomy/ on safe abortion/RTI	1 months@1000 Rs *5 faculties*3 inst* 4	60000	21000	22050	23153	24310	110513
5	Training Facilities esp. dummies	Lump sum	800000	840000	882000	926100	972405	4420505
		Net	**4025000**	**3596250**	**3776063**	**3964866**	**4163109**	**18925287**
1	Contingencies & related expenditures @10%	Lump Sum	402500	359625	377606	396487	416311	1892529
		Total	**4427500**	**4648875**	**4881319**	**5125385**	**5381654**	**24458733**

B. For Training of Nurses and paramedics on adolescence health/STIs.

Sl	Head	Descriptions	2005-06	2006-07	Total cost
1	Training of Trainers	80 Trainers @Rs.1000 per day* 8 days	640000	672000	1312000
2	Day allowance/ Food and logistics for participants	3000 trainees @125 Rs a day*6 days	2250000	2362500	4612500
3	Training Fees and Travel for trainers	80 trainers*20 days *200	320000	336000	656000
4	Stationary and Training Material	3000*50 Rs per trainee	150000	157500	307500
5	Contingencies & related expenditures (10%)	75 batches@ 2000 Rs per batch	150000	157500	307500
		Grand Total	**3510000**	**3685500**	**7195500**

After two years future programmes will conducted with budgets provided for regular retraining of paramedicals. This is only for the initial training to introduce this component into the system.

D. Training for ISM Staff:

As part of the effort for mainstreaming ISM facilities and staff to help in reaching public health goals in RCH area a 21 day training programme would be prepared and all the staff would be trained in it.

The training would be for Ayurvedic officers and for paramedical staff and appropriate syllabus would be developed for the same.
The training content would include immunisation, antenatal care, basic obstetrics care, integrated management of childhood illness and combining systems for child malnutrition and micronutrient deficiency management.

Preparation would be done at the directorate of ISMs in coordination with the SIHFW and implementation would be by the DTC in cooperation with the district ISM officer.

Budget

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
1	Material Production	1100persons @ Rs. 300	330000	346500				676500
2	Training of Trainers	80 Trainers* Rs. 1000 (food / acc) per day* 25 days	20,00,000	2100000				4100000
2a	Training of Trainers	80 Trainers*1000 Rs. per day* 5 days			400000	420000	441000	1261000
3	Honorarium for state training faculties	20 faculties @5000 Rs.	100000	105000	110250	115763	121551	552563
4	Expenses for training all categories of staff	30 Days@ Rs300 *500 trainees	4500000	4500000				9000000
4a	.Expenses for training all categories of staff	10 Days@ Rs 300 *500 doctors/staff			1500000	1500000	1500000	4500000
5	Day allowance Honorarium For Trainers	80 trainers *250 Rs * 15 days/trainer	300000	300000				600000
5a	Day allowance Honorarium For Trainers	80 trainers *250 Rs * 10 days/trainer			200000	200000	200000	600000
6	Other Training & related exp.	Lump Sum	270000	283500	297675	312559	328187	1491920
	Total		**7500000**	**7635000**	**2507925**	**2548321**	**2590737**	**22781984**

E. Training for Administration, Management and Leadership:

The Plan on this has been elaborated with budget in component 7.

All programme officers, district officers and block medical officers need a formal induction in public health management, some aspects of hospital administration and in epidemiology.

The SIHFW/Directorate of Health Services shall enter into an MOU with a health management training institution for a **three month** course of distance education with some contact classes that shall be made available to all medical officers with administrative responsibility. All block medical officers and programme officers must take this course within the next three years. After three years appointment to all administrative posts for medical officers are open only to those who have served three years as block medical officers and they must take this course before being eligible for promotion.

A more rigorous and through course on public health management of two year duration would also be encouraged and for this purpose the state would sponsor candidates to heath management institutes with which it would have an understanding.

7. 3. 3. Ensuring Quality of Care in FRUs and 24 hour PHCs

Constraint being addressed:
Provision of infrastructure, plus manpower plus training plus equipment does not add up to increased quantity or quality of services. Between central and state government, over the RCH-I and RCH-II programmes there has been an investment of about Rs 10 crores into infrastructure of these 100 CHCs. For this investment to be converted into actual improvements in services, we need to invest in some management and motivational processes and resolve along the way a number of systems issues that arise.
Experience in RCH-I, especially in the 32 blocks under EAG programme shows that most of the employees in these blocks were not even aware that their blocks were part of such a programme. Developing ownership and quality standards was an even more distant reality. Elsewhere in this proposal we have proposed for closing infrastructure and training gaps in these 100 CHCs. In this section we are putting forth the proposal for closing minor equipment gaps, and for building up the necessary management and motivational inputs needed to achieve desired quality of care levels.

Objectives:
In this situation, we are providing fund for:

a) Improved quality of care in 100 CHCs and all 24 hour PHCs and subcentres in these blocks...
b) Ensure that all 100 CHCs and PHCs in these blocks are functioning as 24 hour PHCs.
c) Ensure that the linkages needed to ambulance services, referral funds in the panchayats, Mitanin programme and private sector partners that are needed to reach the RCH-II goals are built up.
d) Ensure that all employees in the block are part of the process of building up quality and not only the top few- for it cannot be done thus.
e) Ensure that the services provide for equitable access and are woman friendly and adolescent friendly.

Understanding is that when we have sunk Rs 10 crore in closing 'hard' gaps in 70 blocks, a further Rs 50 lakhs in management & motivational process is well worth it.
Moreover the entire thrust of the RCH-II proposal is about ensuring quality referral services in these 100 blocks. The total investment that relates to it under different heads is over a 100 crores. We are also committed to performance based funding and outcome based programming. Without investing in such a management and support process we would neither get the outcomes nor even be able to know whether we are moving towards it – making it impossible to actually have performance based funding. Earlier when funds for strengthening FRUs were sanctioned this amount was cut out resulting in weak support. We are learning from this now.

Key Operational Elements:

a) Design quality of care standards and quality of care indicators as applicable to PHC and CHC and subcentre. This includes indicators for gender sensitivity and for equity in access.
b) Participatory micro planning to ensure that all employees in these blocks understand the quality standards and identify constraints in closing the gaps: including gaps in minor equipment.
c) Initiate and support block level group processes that will address motivational and attitudinal issues.

d) Close gaps in infrastructure, manpower and skills and equipment along with measured improvements in quality.
e) Address all local level "systems" problems- like linkages to a functional ambulance service, designing a viable referral system, getting access to blood organized, ensuring that the referral fund with the panchayat is fully utilised. It also requires motivational and management inputs.
f) Along with this we would have to closely monitor and support the blocks to achieve volumes and quality standards- during and after the infrastructure is built and equipment is bought and manpower is trained
g) Provide support and trouble shooting to the team.
a) At the end of the two years these 100 facilities should provide adequate quality of the following: Access to Basic and comprehensive Emergency Obstetric Care Services and to Comprehensive Emergency Obstetric Care services: Better quality ANC and post partum and neonatal care, institutional neonatal and sick child care, Reduce unsafe abortions; Improved RTI/STI services with utilisation of referral system and ambulance and laboratory services needed to support this set of interventions.

The key to achieving all this is would be:

a) Hiring in a management group/ resource team to conduct the block level workshops and monitor the programme. This group must be in place before the funds for the blocks is in flow:
b) The management group would hire ten field coordinators and train them so that they can each monitor and support 10 blocks.
c) This group would not replace the district's authority on the blocks- but it would supplement it and give its feedback to the district and state RCH societies so that they would act on it. For this to be useful – it is essential that this team and this group not be internally selected and paid but have an element of externality so that they could be objective and where necessary even critical of what is being done. We have found such an arrangement extremely useful to monitor and support the Mitanin programme which is also executed by the RCH societies but with SHRC providing the support.

Budget Estimate:

A.Block Level Micro planning- Requires one meeting with field visits in each block at the outset of the programme.

(Before any expenditure on infrastructure or training is made.)
Budget for planning initiatives

Item	Unit Cost	Nos.of Block	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Microplan	2000	100	200000					200000

B. Dissemination of quality/standard & motivational meeting to help employee attain desired level and block level review.

Budget

Item	Yearly	No. of Employee/	Training Days	Unit Cost	Total cost for 100 blocks	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Motivational meeting	2	100	1	100	2,000,000	2000000	2100000	2205000	2315250	2431013	11051263

C. Management team to conduct workshops and help set & monitor quality indicator.

10 Field coordinators would be appointed for 100 blocks. One Programme coordinator, a person with experience or aptitude in public health management would be appointed for coordinating this.

Yearly Budget for management for state.

Item	Nos.	Unit cost/Month	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Programme coordinator	1	20,000	240,000	252,000	264,600	277,830	291,722	1,086,152
Field coordinator	10	5,000	600,000	630,000	661,500	694,575	729,304	2,715,379
Travel & support		50,000	600,000	630,000	661,500	694,575	729,304	2,715,379
Total			**1,440,000**	**1,512,000**	**1,587,600**	**1,666,980**	**1,750,329**	**7956909**

D. Equipment Gaps in 70 blocks.

We note that this money would not go for infrastructure or for training. However it may be used beside equipment on minor supplies gaps and block level needs e.g. referral forms that are found essential after a micro planning exercise or review meeting. Since these are matched against constantly improving quality and quantity of services the wastage elements should be minimal.

Estimated Budget for equipment/ critical supplies.

Item	Nos.of blocks.	Unit Cost	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Equipment	35	70,00.00	70,00,000	73,50,000	7717500	8103375	8508544	386,79,419

E. Performance Incentive (modified Night Duty Allowance)

Item	Nos.of blocks.	Unit Cost	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Performance incentive (Night Duty Allownce)	100	1,50,000	1,50,00,000	15,750,000	16,537,500	17,364,375	18,232,594	8,28,84,469

Total Budget in Operationalizing & quality care of FRUs. /Year

Ensuring Quality of Care in FRUs and 24 hour PHCs

Item	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Block Level Microplanning	200000	----	----	-----	------	200000
Motivational Meeting	2000000	2100000	2205000	2315250	2431013	11051263
Field level Programme Management	1440000	1512000	1587600	1666980	1750329	7956909
Filling of Equipment Gap (35 block /year)	7000000	7350000	7717500	8103375	8508544	38679419
Performance Incentive	15000000	15750000	16537500	17364375	18232594	82884469
Total	**25640000**	**26712000**	**28047600**	**29449980**	**30922479**	**1405,72,059**
Contingencies, fees to firm etc(10%)	2564000	2671200	2804760	2944998	3092248	14057206
Grand Total	**28204000**	**29383200**	**30852360**	**32394978**	**34014727**	**1548,49,265**

7.3.4. Strengthening Routine Subcentre Level Services:

Constraints being addressed:
Much of public health moves around the ANMs and her functioning. Yet there are many issues that need to be addressed for her to be effective. Issues related to infrastructure, training and quality of care processes have been discussed in previous sections. Issues related to community level processes and private sector inputs will be discussed in the next few sections. In this section we only flag four constraints the overcoming of which are critical to better functioning – just at the subcentre level.

These constraints are:

a) Continuing out- of- pocket expenditure on stationary & travel with lack of adequate arrangements for facilitating mobility.
b) Continuing gaps in cold chain maintenance and supply of disposables needed to improve quality in immunisation.
c) Lack of supportive supervision.
d) Lack of adequate basic drugs & supplies needed to respond better to the peoples felt health needs.
e) Lack of objective data to identify gaps and reward achievements. (All data that the system uses is generated at this level by these very functionaries. So identifying their failures through the same data is obviously impossible)

Objectives of the programme:

a) Reduce out of pocket expenditure and facilitate mobility.
b) Improve quality of supervision and make it supportive.
c) Bringing in better systems of internal and external data verification.
d) Improve cold chain functioning.
e) Improve the quantity of drugs supplied to her.

Proposed strategies/activities:

a) Print all the stationary needed for her and provide. A number of registers is not printed/supplied as date, but these supply needs are maintained by her. This also improves quality of records, which are weak now.
b) Give an option of availing for a bank loan for buying a motorised two- wheeler with a down payment of Rs 2000 from the government but subsequent payments made by her or getting a cycle at about same costs.
c) Conduct a special programme for medical officers and supervisors on supportive supervision – so that they play a more active role in helping ANMs and MPWs in overcoming field level problems and addressing gaps. This will also teach supervisions on how to undertake cluster sampling in their area so as to verify data. The cluster sampling database that they need- cumulative population table- would also be prepared for each level of supervision. The supervisors would be required to submit a cluster sample verification report once every six months. The budgetary provision for this is against actually conducting their training and getting two sample surveys done per supervisor every year.
d) Contract in a firm for providing annual evaluation by sample survey of key RCH indicator for each district.
e) Expand the ANM drug kit to include 25 drugs and improve its regularity of supply. Let it match the Hindi Standard Treatment Guidelines that we have already prepared. (To ensure regularity of supply the funds may be given to the state government for drug procurement-

if by then adequate procurement and distribution systems are in place. If this does not meet with the quality benchmarks already established for drug procurement and distribution then the drugs may be supplied as kits as is currently done) This drug list prepared by the state essential drug committee is shown in table below.

f) Ensure that a certain sum of money is sanctioned under family welfare every year for cold chain upkeep (refrigerator mechanic mobility and repair costs and some replacement costs) and hard ware gaps. Currently two walks in coolers are needed at state level and at block level voltage stabilisers are needed.

Budgetary estimates:

Budget for Strengthening Routine Subcentre Level Services:

Item	Unit cost	Quantities	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Stationary	300	8000	2,400,000	2,520,000	2,646,000	2,778,300	2,917,215	13,261,515
Mobility	2000	5000	10,000,000	10,500,000	11,025,000	11,576,250	12,155,063	55,256,313
Supervision quality and sample surveys	2000	5000	10,000,000	10,500,000	11,025,000	11,576,250	12,155,063	55,256,313
16 dt annual external evaluation	100000	16 dists.	1,600,000	1,680,000	1,764,000	1,852,200	1,944,810	8,841,010
Expanded ANM drug kit	Rs 12000	5000	6crores (To be supplied by central govt under FW)					
Cold Chain upkeep	1.0lakhs	16 dists.	16lakhs (Plus major equipment costs to be borne by central govt.)					
Total costs	(Excluding 6 crores that could be direct central govt costs)		**240,00,000**	25,200,000	26,460,000	27,783,000	29,172,150	132,615,150

Note: Cost of equipment supplied by GoI is not included in the budget.(a walk in freezer at Rs 50 lk is the main requirement- and two walk in coolers are also deisrable).

Chhattisgarh Essential Drug List: The Revised ANM drug kit
(To be used by ANM and male MPW)

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

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

Doctor Initiated Drugs (DID)

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

DID- these drugs are under prescription by the PHC medical officer and the ANM only stocks these so that the patient need not go to the PHC every week but can get a supply for the duration of the prescribed treatment. (they can be reflected as PHC stocks and need not come as part of the ANM drug kit).

7.3.5. Public Private Partnerships:

7.3.5.1. Public Private Partnerships for Essential & Emergency Obstetric Care:

Constraint being addressed:

Chhattisgarh does not have a very good infrastructure of secondary level hospitals even at the block level. Most blocks have do not have facilities for emergency obstetric care. There are no operations rooms, and very few trained surgeons and even less anaesthetists, and no facility for blood transfusion in most blocks. Many newly created district hospitals also lack these facilities. Of the 16 district hospitals only 9 undertake regular caesarean sections and of the 146 block hospitals only some 54 including the 7 district hospitals where section is not regularly undertaken have been designated as FRUs (first referral units). Of the 54 FRUs less than 10 have developed adequate emergency obstetric care capability. The RCH-II proposal plans to increase the number of FRUs to 116 within the government sector of which at least 66 will be functional at the C-section level. Even then there would be a large supply side gap that needs to be closed.

Similarly we have seen in the section on family planning that about 50% of the current demand for FP sterilization services can only be met by a much-expanded public sector provisioning of such services.

This is true of institutional delivery also. Of 2500 deliveries in a normative block of one lakh population a meaningful estimate will still be able to provide for only 1500 institutional deliveries. The current level of institutional delivery attained in Chhattisgarh remains a very low 13.8%.

The only way the state can reach its stated goals is if the private sector can be won over to sub serve these goals too in a manner that the poor are able to afford and access these services. However even is we do manage to recruit the private sector fully there are many areas where private sector penetration is too low to help reach these goals. Any policy approach to public private partnerships must therefore have three objectives:

a) it should supplement, not replace the existing and maximally increased public sector provisioning of RCH services.
b) Existing private sector providers must be brought in to provide these services with adequate quality and affordability.
c) there must be an effort to extend outreach of the private sector to those areas where currently it is not operational ensuring that it complements – not substitutes private sector expansion.

The debate between which should be prioritised – public sector or private sector provisioning is to be reviewed in the context where even with maximal expansion of both we may still fall short of our targets. As demand for services expands with the Mitanin programme urgent measures are needed for supply of services to catch up with it. . Supply will not rise to meet demand if left to the mediation of the market place alone. Health care for the poor especially in geographically dispersed population is a recognized area of market failures and the state would need to intervene to facilitate the growth of the supply of these essential services.

When we address private sector expansion we also need to flag three important corollaries:

a) Such expansion esp. if it is done with state support must carry with it the means of regulation.
b) Considerable flexibility and innovation in programme management and financing would be needed to fix costs and prices and adjust them periodically so that the needs of equity and access are addressed and they system as a whole is sustained.
c) There must be a net increase in service delivery – not merely a shift from one sector to the other.

The PPP proposals stated below builds in all these elements. Not all of these are detailed here – but the SHRC has prepared a detailed set of papers and MOU drafts on the basis of which this is done. We wish to acknowledge here that we have drawn considerably on the Janini experience in doing so, without being bound by it.

Objectives of Programme:

- To enter into partnership arrangements with the private sector such that the private sector can contribute to emergency obstetric care.
- To encourage health care providers in the rural areas to contribute to the provision of maternal care services and postnatal care- especially in remote medically underserved areas. The focus is on institutional delivery with referral back up

Key Operational Elements:

1. Identify private and not for profit hospitals who are willing to participate.
2. Develop quality standards and register/accredit private sector partners who have achieved this level. Help those who have not to attain it with training and consultancy inputs
3. Develop a system of reimbursement of the below poverty line patients attended to in these centres. For FP services all patients can be reimbursed. For other services only BPL patients would be reimbursed.
4. Assist doctors/NGOs to set up services in medically underserved areas by assuring them bank credit, and more patient volumes, by franchising and brand image build up, and by developing a system of referrals by which cases can be channelled to them. They would be part of a franchisee chain – state led called the Mitan Kendras. They would pay a franchisee fee in some contexts. They would charge pre fixed rates for all patients – even though they would be reimbursed only for BPL patients.
5. Build partnership arrangements with existing secondary care centers to provide RCH care to BPL patients- who are referred there.These Mitr Chikitsalays can charge what they want for other patients but for BPL rates would be fixed.
6. Enter into MOUs with individual doctors willing to lend their services to public health facilities(Mitr Chikitsaks)
7. Link with Referral fund placed at the Panchayat's disposal and with ambulance and laboratory services placed in their area.
8. Arrange for monitoring by a two tiered system – contracting this out and insisting that 25% of all patients be met and interviewed to verify that no excess payments were made.
9. Develop a link with local accounting/audit firms and banks through which payments can be made with minimum delay.

Budget Requirements for One year :

Approximate Case Load and Reimbursement Costs in a district where one EmOC center has been recruited as a partner:

Item	Nos. Per Month	Per Unit Cost	Total Cost per mnth
C-section	5	6000	30,000
Institutional deliveries	30	1500	45,000
Sterilisations	50	800	40,000
Others	50	200	1.000
A. Total Monthly	**Reimbursement**		1,16,000
B.Total Annual			13.92 lakhs

Reimbursement cost for 50 PPP centers: **Rs 696 lakhs(81. 31%)**

Please note referral refunds costs may be included .This fund also lies underutilised.

Programme Management Costs:

A. Variable Programme Costs: shown below for 50 franchisees:/partners

1. Monitoring and Accounting Support

Monitoring 1st level	Appox 25% cases:	Rs100 per case or 10% of A	11,600
Monitoring 2nd level	Appox 5% of cases	2% of A	2320
Accounting costs		2% of A	2320
Total for one month			16,240
Total for 12 months			1,94,880

1. Monitoring & Accoounting Support for 50 partners per year: 97,44,000

2. Upgradation of Skills & Improvements in clinics & 0.6/partner: **Rs 30,00,000**

B> Fixed Programme Costs

1.. Programme Administration Costs:

One CEO, 3 prog. officers and one CA firm /per mnth	:	Rs. 85,000
Travel Costs for state office	:	Rs. 15,000
Office costs for state office	:	Rs. 30,000
5 field officers @ Rs 6000pm:	:	Rs. 30,000
5 filed officers travel and support costs	:	Rs 10,000
Total programme management costs per month	:	1,60,000
Per year	:	***19,20,000***

2. Promotion Costs:

Brochure /ads/visits:	:	Rs 1,50,000
Accredittation visits: 200 partners* 1500	:	Rs 3,00,000
Training expenses 100* Rs400/day * 10 days	:	Rs 4,00,000
Melas – other promotional activity:	:	Rs 5,00,000
Initial restructuring, brand image promotion,		
Total Promotion Costs per year:	:	***Rs 53,50,000***

Total Annual PPP Programme support Costs : Rs 160.14 lakhs (18.69%)

Total Annual PPP in emergency obstetric care : budget in brief

ITEM	Unit cost (Rs.)	Nos.	2005-06	2006-07	2007-08	2008-09	2009-10	Total
Reimbursements		50	696,00,000					
Programme Management		1	160,14,000					
Total	**856.14**		**856,14,000**	**89894700**	**94389435**	**991,08,907**	**1040,64,352**	**4730,71,394**

This projection makes the assumption that we would have only 50 partners and that their total reimbursement needs would be only in the range of Rs 13 92 lakhs per year per partner – adjusted for inflation. In practice we expect to increase by about 25% every year. More important we expect to introduce insurance as a complement to this programme. The exact budget estimats for this would be known later – but we are planning to do it within current programme management costs.

Institutional Mechanisms:

An appropriate management consultancy or special mechanism under State Health Society or the SHRC to be given the nodal role.

7.3.5.2. Public Private Partnerships for Ambulance Services

Constraint being addressed:

Currently transport of patients to the CHC is a big constraint. The CHC ambulance takes patients to districts hospital. It also helps in movement of stores. Its 24-hour availability to bring patients from the village is not happening. But a 24-hour service needs to be created to bring high-risk cases from the village to the CHC. There is a fund at the village provided to the panchayats to be used for transport of patients in an obstetric emergency. But this fund is not used due to lack of systems or information needed for its use.

Log frame Reference& Technical Domains:

Maternal health	shifting of emergency obstetric case to secondary referral centre
Child health	shifting of sick neonates and children to referral centre
Family planning	Shifting of FP cases needing sterilization operation to the venue of the surgery.

Objectives of the Programme:

- Increase cases for institutional delivery; especially bring in all high-risk cases.
- Ensure existing referral funds with panchayats are used and build up system for its full utilization.
- Improve ambulance services for all purposes intra-block

Key Operational Elements:

- The proposal is to identify an NGO and give them an ambulance.
- They can get service fee for high risk BPL cases reimburses from referral funds. They can charge APL patients. They must have phone connectivity and must be evaluated for promptness, fairness and courtesy of services.
- Philanthropic organizations may provide the services for free.
- The services would be available for 24 hours.

Budget estimate for ambulance services:-

Cost of per ambulance 10 lakhs fixed/block. Recurrent cost 5 lakhs per year. A referral fund also should be given to the panchayat so that people who deserve it or who are below poverty line can utilize that benefit. Information should be reached up to panchayat level systematically. This we estimate eventual requirement – as for about 200 women at Rs 1000 a woman or about Rs 2 lakhs. For hundred blocks it would work out to Rs 200 lakhs.

Year wise Budget estimate: 2005-2006: 500 lakhs and for 2006-2007: 200 lakhs

ITEM	Unit cost (Rs.)	Nos.	Year 2005-2006	Year 2006-2007	2007-08	2008-09	2009-10	Total
Ambulance	1000000	30	30000000					
Referral fund	200000	100	20000000	21000000	22050000	23152500	24310125	110512625
Total			**50000000**	**21000000**	**22050000**	**23152500**	**24310125**	**140512625**

Institutional Mechanisms: State level nodal agency to operationalize the PPPs.

7.3.5.3. Public Private Partnerships for Laboratory Services.

Constraint being addressed:
Currently there are very few laboratory technicians' posts and even in this there are many vacancies. These over all the CHCs but there is no laboratory service in most PHCs. This is the situation even for basic tests like urine albumin or blood haemoglobin which does not need much skill but is currently not being done. Even if all sectors had working PHCs this would not be enough to meet the needs of anaemia testing, and testing of blood smears and sputum examination – if all those who needed such tests came forward for it. As of today even with poor utilization it takes over 15 days for a blood smear examination to reach back to the patient. We need to create an even more decentralized laboratory system. **Log frame Reference & Technical Domains addressed:**

Maternal health	Laboratory support for comprehensive emergency obstetric care
Child health	Management of sick children
	STI/RTI management
	Additional benefits in tuberculosis and malaria control programmes may outweigh the benefits to RCH programme.

Objectives of Programme:

- The goal of this component is to provide the equipment, the human power and most important the systems so that basic laboratory facilities are accessible within 24 hours for the entire population in the block.
- Promoting a widely dispersed network on laboratory services in the private sector through an innovative partnership programme.
- In addition to this, to train local NGOs and Mitanin preraks in laboratory work which they can do later on a payment by fee basis.

Key Operational Elements:

- All basic blood urine stools sputum examination including microscopy made available at roughly one centre per 10,000 population i.e. about one centre per 2 to 3 subcentres.
- Many of the trainers in the Mitanin programme are youth in search of livelihoods. Some of them who may be interested may be provided the training and start up equipment for the start of basic package of laboratory services.
- Appropriate manuals would be made available
- Eventually, organise a network providing more advanced tests at a CHC level franchisee arrangement.

Budget Estimates:
For the first year we can give some counter guarantee – like fee payment once they have done the blood haemoglobin levels of all women or sputum of all persons with chronic cough in the hamlets in their area etc. This work will in turn help them establish themselves. For this we are putting aside Rs 5000.

This training work would be outsourced to technical institutions in partnership with specific NGOs who can play this role. This would be on a trial basis and confined to some 150 persons in the first year).

They would be paid 100 Rs per person per day during training days. We will give them 30 days training for laboratory work. In the first year we would be giving training to 500 persons, then next year 1000 trainees will be trained so that 1500 trainee will be built up with in two years for lab tech support in PPP system.

Budget for Technical support under PPP:

ITEM	Unit Cost/day	Unit cost	Training days	Nos.	2004-2005	2005-2006	Total
Lab tech (Training of Master Trainers)	100/-		30	500	1500000		4000000
Establishment		5000/-		500	2500000		
Lab tech (Training of Master Trainers)	100/-		30	100		3000000	8000000
Establishment		5000/-		1000		5000000	
Total					**4000000**	**8000000**	**12000000**

Institutional Mechanisms: State level nodal agency to operationalize the PPPs.

7.3.6. Grant – in- aid scheme for NGOs

Constraint being addressed:
Health requires inputs from all sections of society. The government cannot work on this in isolation. While there is considerable scope to involve civil society in facilitating and monitoring public health systems there is also a need to support independent identity and action of NGOs. Their role in advocacy for better health care has been a critical input to ensure that health care reaches the poor. Such advocacy work is best done independent of state funding. However, organisations and individuals who devote themselves to advocacy may need support and the state should also draw upon their commitment to improve services– especially outreach to special vulnerable groups like remotely located tribal communities or urban homeless and in special problems like adolescent health care.

Log frame reference:
Improving service delivery & reach medically underserved areas for maternal health, child health, family planning, adolescent health, urban health and tribal health.

Objectives of Programme:

1. Involve NGOs in service delivery so as to increase access to care in remote medically and paramedic ally underserved areas and to especially vulnerable sections of society.
2. Involve NGOs in provision of specific services or to special groups that are unable to get due priority within public provisioning of health care.
3. Involve NGOs in health education work.

Key Operational Elements:

a. Develop a data base of NGOs and their work and objectives.
b. Identify and notify remote and underserved areas. - Both medically underserved sector and paramedically underserved sections.
c. Identify key areas of RCH that currently not addressed adequately by the public health system even in areas of adequate staff strength and functionality.
d. Identify marginalised and vulnerable sections and issues that cannot be reached to by the subcentre- PHC – CHC system – like the homeless, like migrant workers, like remote forest areas and develop special strategies for them.
e. Negotiate and enter into MoU with NGOs specifying work outputs and process indicators by which they would be monitored and building in the monitoring mechanisms for the same.

Budget Estimate:
Rs 200 lakhs per year.

A medically underserved sector would be roughly contracted out at Rs 10 lakhs per year excluding drugs and vaccines. All paramedical services would be expected including the paramedical level curative care package. Part time medical services would be expected. Out of this 10 lakhs, Rs 3.6 lakhs (30 thousand pm) would go to 30 community level workers for 1:1000 population paid at Rs 1000 per each CLVs or six ANM equivalents at Rs 5000 each with voluntary Mitanins for help. Another 0.96 lakhs would go for a supervisor @8000 pm.

Remaining money would be used for organising weekly medical camps attended by doctors, other programme costs, administrative costs and contingencies. The programme costs would vary as supervision costs and training cost would also vary.

The cost of drugs and supplies would be borne by the state in kind who would give them 30 CHV kits and five ANM kits. In each year only 15 relatively under – served areas would be taken up and this would be evaluated before recasting the programme for the next three years. About 10% of the above costs would go into state level monitoring of the programme. The remaining 35 lakhs is for special groups or areas – like primitive tribals or migrants- where detailed programmes would be worked out.
Budget for NGO grant-in aid per year: 200 lakhs.

ITEM	Unit cost (Rs.)	Nos	2005-06	2006-07	2007-08	2008-09	2008-10	Total
30 CLVs /ANM equivalents	3.60 lakhs	15	5,400,000	5,670,000	5,953,500	6,251,175	6,563,734	29,838,409
1 Supervisor	0.96 lakhs	15	1,440,000	1,512,000	1,587,600	1,666,980	1,750,329	7,956,909
Medical Assistance and camp expenditure for 100 one day camps	2.00 lakhs	15	3,000,000	3,150,000	3,307,500	3,472,875	3,646,519	16,576,894
Staff Training	1.20 lakhs	15	1,800,000	1,890,000	1,984,500	2,083,725	2,187,911	9,946,136
Referral transports, equipments, programme support and contingencies	1.74 lakhs	15	2,610,000	2,740,500	2,877,525	3,021,401	3,172,471	14,421,898
NGO level management costs	0.50 lakhs	15	750,000	787,500	826,875	868,219	911,630	4,144,223
Total	10 lakhs	15	15,000,000	15,750,000	16,537,500	17,364,375	18,232,594	82,884,469
State level Coordination, Monitoring and Evaluation	10%	--	1,500,000	1,575,000	1,653,750	1,736,438	1,823,259	8,288,447
Allocation for special areas	--	--	3,500,000	3,675,000	3,858,750	4,051,688	4,254,272	19,339,709
Total			**20,000,000**	**21,000,000**	**22,050,000**	**23,152,500**	**24,310,125**	**110,512,625**

Institutional Mechanisms:
State NGO management Cell .

7.3.7. Community Level Care: Mitanin –II Programme

Constraint being addressed:
The Mitanin programme is a key strategy of reducing infant mortality of improving service delivery, of community participation, of health education as also of making all current child survival and safe motherhood programmes more effective. It addresses lack of awareness about causes of infant and maternal mortality and morbidity, about right to RCH services as a basic right, about how to access services. It also addresses problems in outreach of services to a dispersed population and to ensure adequate community participation. The Mitanin programme has over the last two years attained its goals of creating a trained volunteer in every single hamlet of the state. This community selected hamlet level volunteer has been able to intervene and bring about significant changes in health seeking behaviour and health practices. For her work to translate into major declines in child mortality and morbidity there is a need to sustain the programme for at least three more years. Since her work also involved building up accountability, the health system at local levels would require continual persuasion and partner ship with civil society at all levels to sustain this programme.

Log frame Reference & Technical Domains addressed:

Maternal health:	Better access to ANM for antenatal care and referral to institution for delivery and postnatal care in the community itself
Child health:	First contact care for sick neonates, infants and children: and the reduction of child morbidity and mortality. Counselling on child malnutrition. Potential to halve current infant mortality rate based on extrapolation of data from similar programmes
Family planning:	Better access and encouragement for spacing and delaying the first child, motivation for terminal methods
Adolescent health:	Campaign against anaemia and malnutrition, against violence and women related issues; first contact care and counselling for minor women health issues, education about the body and its normal functions,
RTI/STIs	Education, first contact care.
Urban health:	All the issues touched upon above
Tribal Health:	All the issues touched upon plus the fact that she is the only health caregiver who can speak the language of many tribal sections.
Most important	**Key strategy of promoting equitable access, of addressing gender imbalances:** The hamlet level approach ensures outreach to every section. The woman as care giver, with emphasis on selection by women makes her access to women much more (other community care givers like depot holders, RMPs, JSRs are almost completely men. **Ensuring accountability**: addresses health services from a health rights viewpoint.. Indeed because of her role in accountability and addressing gender imbalances and equity issues the programme requires definite assistance against vested interests at all levels. **Cross- cutting strategy**: touching on all technical issues and many of the institutional goals as well.

Background:

The Mitanin Programme was announced in November 2001 and inaugurated in the state in May 2002. After a long process of planning, and development of training material and some experimentation in pilot blocks *the first phase of the programme- when it was expanded to 80 blocks-- was launched in January 2003.* Since it takes six months to select Mitanins- it was *in June 2003 that training for Mitanins began* in these first phase blocks. In January 2004 the programme was further expanded to all blocks in the state and by June 2004 Mitanins have been selected in the entire state. By march 2005 Mitanins would have trained and deployed in all hamlets of the state.

The Mitanin programme has been able to largely attain the operational objectives it set itself. This is evidenced from the monitoring data, from the impression on numerous field visits. Further the programme has undertaken a rigorously organized internal evaluation (external to the programme implementation agencies at the block and district level) programme to validate the claim on achievement of operational goals. The results for a sample of 1250 Mitanins from 25 blocks are available and these confirm that the programme has met its operational (process indicators) goals.

Results from other pioneer community health volunteer programmes like Jamkhed and SEARCH programme show that for these process indicators to translate into programme outcomes defined by improvements in health outcomes especially a reduction in infant mortality the whole process has to be sustained for three to five years. Jamkhed for example achieved a dramatic reduction of the IMR from 140 to about 50 in five years and after that another 20 points over the next 15 years. The current rural infant mortality being 85- it should be possible for similar reason to reduce it dramatically to 50 in the coming three years provided all the processes set up are not only sustained, but also strengthened. The hard scientific rationale of such a claim is explained in the text. This proposal also looks at the modifications and improvements that are needed in the current programme design of the Mitanin programme so as to make it more effective.

The total budgetary implication is about Rs 3500 per Mitanin per year, which is about Rs 14 lakhs per year per block or about 20 crores per year for the state. In the continuation phase also no payment is envisaged for the Mitanin but for each day of training she attends she would get Rs 50 as livelihood compensation- i.e about Rs 600 per year for 12 days of training.

Operational Objectives of Programme:

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

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

The programme will largely involve six dimensions:

a) Continued training and support to the Mitanins so that ongoing facilitation of service delivery by Mitanins and community basing of all health programmes is sustained.
b) Strengthening and deepening the health education and counselling work at the household level by equipping the Mitanins with charts, posters and other tools of monitoring.
c) Strengthening the access of the poor to essential curative care through adequately provisioned Mitanins linked to improved peripheral primary and secondary medical care facilities, by a functional referral system.
d) Incentivisation of the Mitanin's work so that there is enough encouragement and recognition of their work at both the family and at the community level.
e) Inter-sectoral integration at the habitation and panchayats level with related sectors and strengthening local planning at panchayats level.
f) Better outcome monitoring and closing all gaps to achieve an effective health outcome.

Indicators:

1. Every Mitanin already trained for 18 days receives every year a further 12 days of camp –based and 24 days of on-the-job village level training.
2. Every household has attained adequate knowledge in a set of 100 key health messages as verifiable by a random survey and that in certain key messages there is a major change in practices at the family level.
3. Establish effective access to basic drugs in every hamlet through the Mitanin and that she is backed by a referral chain from Mitanins to ANMs and primary health care centres to CHCs so that sick neonates, children, adolescents and women esp. in pregnancy get timely referral when needed.
4. Ensure that a set of inter-sectoral interventions planned and coordinated locally and with the panchayats shall lead to a local plan that shall include food security, safe drinking water and sanitation, early childhood care services and school health services and access to health care services and health education.
5. The effectiveness of all the above should be visible by a measured decline in child malnutrition rates, decreased low birth weight rates, decreased anaemia in women and decreased micro-epidemics and decreased epidemic deaths in gastroenteritis, childhood acute respiratory infections and malaria. Baselines for this are being generated and should be ready by December 2004.

Sample surveys should show decrease in IMR by at least 50% at the end of three years and all the indices like Child malnutrition prevalence, Anaemia in women, Birth weight of

babies, IMR and MMR, Tuberculosis/ Leprosy prevalence, Malaria incidences, should have declined.

Budget per year:

Sl	Head	Exp. per block per year		2005-06	2006-07	2007-08	2008-09	2009-10	Total
1	**Training**								
1	12 Day Training for 400 Mitanins	672000							
1.2.	Field Training and Support for Mitanins	268800							
1.3.	Dt. Trg. of Trainers*	48000							
1.4	State Training of DRPs*	29500							
1.5.	Training Material *	30000							
1.6.	Skills/and Capacity Building *	10000							
1	**Total**	1058300		154511800	162237390	170349259	178866722	187810059	853775230
2	**Social Mobilisation**								
2.1	Folk Media	122250							
2.2	Trg for above campaign*	16000							
2.3	Electronic Media*	10000							
2.4	Print Media*	5000							
2.5	Training CDs *	5000							
2	**Total**	158250		23104500	24259725	25472711	26746347	28083664	127666947
3	**Administrative and Others**								
3.1	Admin: block level	60000							
3.2	Admin/support Dt level.	24000							
	Total	84000		12264000	12877200	13521060	14197113	14906969	67766342
4	Admin/support State Level	48000		7008000	7358400	7726320	8112636	8518268	38723624
	Grand Total	**1348550**		**19,68,88,300**	**206732715**	**217069351**	**227922818**	**239318960**	**1087932144**

Administrative and Other Expenditures at block ,District and state level include travel, coordination meetings, monitoring, events, correspondence, overheads and contingencies)
Note: The star marked (*) expenditures are been incurred at state level, thus the cost shown per block is notional.

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

13.48 L
+13.5 L per block
X146
1010
540
135
1991.0 Crore

7.3.7.2 The CHV or Mitanin Drug Kit:

(The Cost of Supplies for Community Level Care)

Constraints being addressed:

The mid-term evaluation of the Mitanin programme, which analysed the work performance of a randomly chosen sample of 2500 Mitanins, shows that the single greatest weakness in the programme is the supply of basic drugs to her. Even a drug like chloroquine which is in abundant supply and which has no controversy regarding its provisioning at the village level was found not too have reached in the majority of Mitanins. The Mitanin programme anticipated this bottleneck and was so designed that it would survive it. However there is a dramatic drop in effectiveness of the Mitanin if she is not supplied with the requisite tools. When as a course correction we released the list of drugs shown below packed in drug kit back along with pictorially labelled bottles and drugs- the dramatic improvement was there for all to see. However refill of these kits after two months has again become a problem.

Objectives:

Ensure effectiveness of community level care givers by dedicating a CHV drug kit and regular refills of supplies for the same, for her dispensation in the hamlet.

Activities:

Each CHV (Mitanin) would be supplied with a drug kit with two months supply of drugs. Each month one-month supply of drug or whatever has been consumed- whichever is less would be supplied to her as refill of the kit.

In epidemics and special need situations the state government would increase the supply through the CHMO.

The kits can be supplied as kits by the central government, or if the state meets acceptable benchmarks in procurement and distribution processes – it may be supplied as funds. Labelling the drugs pictorially on the picture code we have written up along with pictorial instructions that are already in place would maximise utility of these kits.

Budget estimate:

The cost of drugs that the programme consumes is estimated at Rs 150 per month per Mitanin- who handles a normative 50 households of about 250 populations. Another Rs 200 per Mitanin is the cost of the kit bag and pictorially labelled bottles. This a normative block of 100,000 populations has about 400 Mitanins. The state as whole is now have around 59000 Mitanins and another 1300 urban Mitanins are proposed. Thus a total of 60,000 Mitanins who cater to approximately 150-lakh beneficiaries -which is the lower 75% of the population. The rest would not need coverage by this programme. We note that though the cost of drugs proposed may seem high, it works out to only Rs 2000 per Mitanin or Rs 8 per beneficiary household per year.

Budget at a Glance:

Item	Unit cost	Nos.	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Drug Kit For Mitanins	200	60,000	12,000,000	0	0	0	0	12,000,000
Drug Supplies for 12 months@ Rs. 150	1,800	60,000	108,000,000	113,400,000	119,070,000	125,023,500	131,274,675	596,768,175
Total			**120,000,000**	**113,400,000**	**119,070,000**	**125,023,500**	**131,274,675**	**608,768,175**

The monthly kit would have the following contents (for 50 households or a population of 250 or in a rural area):

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

The above amount estimated for the kit as elaborated below is with an assumption that chloroquine and IFA tablets are filled in, but from different programme budgets.

7.3.8.Behaviour Change Communication:

Constraints being addressed:
Lack of awareness about causes of infant and maternal mortality and morbidity, about right to RCH services as a basic right, about how to access services are all continuing problems – though unlike popular perception they are not what is limiting health care services. However if the supply of health services expands as envisaged in this RCH-II proposal the hitherto unmet demand for services could shift to an excess supply situation. Per se this is welcome except that there is a lot of unmet needs that have not yet become unmet demands. ***In short, expanding demand for services and encouraging better health practices at the family and the community level remains central to achieving our goals.***

Due to considerable linguistic and ethnic diversity and different social and economic settings, it messages inappropriate when applied across the state. Need to build up capability for developing district and even block level community specific IEC material and integrating this with different forms of IEC needs to be.

Log frame reference:
BCC in following areas :Immunisation; Resort to safe delivery, utilization of all existing services, promotion of breastfeeding, promotion of FP methods, adolescent health.

Objectives of Programme:

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

Key Operational Elements:

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

Budget Estimate:

Item	Cost per unit	Qty	2005-06	2006-07	2007-08	2008-09	2009-010	TOTAL
One strategy development and three material development workshops done twice a year 20 persons * 10 days* 300 plus 40,000 for related expenses	100,000	8	800,000	840,000	882,000	926,100	972,405	4,420,505
Block level campaigns which are folk art based	100,000	146	14,600,000	15,330,000	16,096,500	16.901,325	17,746,391	80,674,216
Radio programmes – three regional specific 15 part radio programmes broad cast thrice a year	500,000	3	1,500,000	1,575,000	1,653,750	1,736,438	1,823,259	8,288,447
State level event – inaugurations/ announcements etc	100,000	3	300,000	315,000	330,750	347,288	364,652	1,657,689
Total			**20,000,000**	**21,000,000**	**22050000**	**23152500**	**24310125**	**110512625**

Institutional Mechanisms:

- IEC bureau of the directorate
- Identifying appropriate agency (3 regional HFWTCs one existing and two proposed) for support to districts in material development.
- Identifying NGOs for village level campaigns
- District Health (RCH) Societies are implementing agencies
- Block level cultural teams formed for Mitanin Programme.
- Mitanin Programme would also use this input extensively

7.3.9. Panchayat Capability Building & Intersectoral Coordination:

Constraint being addressed:
Inter-sectoral areas need to be coordinated with – water and sanitation, food supply , ICDS programmes, poverty alleviation programmes- as all of them directly impact on health outcomes. Panchayats cooperation is needed for the success of many health sector programmes. Eventually as part of constitutional mandate they have to play the role of local governance for the health sector. There is currently no programme to build capabilities for this. The programme design needs to incorporate capability building of panchayats, a system of locally measurable indicators, and a system of rewards and disincentives.

Log frame reference:
Institutional: Improving Management Structures at all levels: Reference to PRIs and their enhanced role in health and even their taking charge of ANMs. Effective capability building is needed.
Intersectoral: Effective coordination mechanisms at all levels to achieve multisectoral goals.
Objectives of Programme:

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

Key Operational Elements:

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

- Compile the index according to the manual- first hamlet wise with aggregation at village and panchayat level.
- Rank each panchayat according to each subject and then on the whole- to get subject ranks and total rank on the panchayat report card.
- Reward the successful top rankers and provide support to the weakest panchayats and vulnerable vulnerable villages where all the above services are weak..

Note: the index is adapted from an index developed under an UNDP sponsored programme in three blocks of Uttar pradesh being organised by the Bharat Gyan Vigyan Samiti. It is as yet not adequately field-tested and there may be more modifications as we go along. The principle however is the same as the role of HDI in the international context.

One must however note that certain indices that are the cornerstone of the international HDI like IMR and MMR and death rates are not included in the calculation of the Panchayat level HDI as they are "tips of icebergs" which when we come close to do not allow meaningful planning or estimates. Also they are "loaded" with administrative implications and tend to get falsified. There is much more thrust on input indicators and these can convert to more outcome indicators once both performance and means of verification improve. The model of the HDI calculation score card along with instructions is annexed.

Budget Estimate :

Section 7.3.9. Panchayat Capability Building & Intersectoral Coordination

Item	Qty	2005-06	2006-07	2007-08	2008-09	2009-10	Total
Development of index/manual and dissemination	70000	3500000					
Training of 3 functionaries per GP-2 one day camps Rs 70 per day for 2 days	30000	4200000					
Training of village and hamlet reps- 2 one day camps per year Rs 70 per day for 2 days	60000	8400000					
One NGO per block as overheads for conducting the training providing support and assisting govt officers in compiling the index. Rs 1000 pm/per cluster * 12 months	1000 GP clusters of 10 GPs each	12000000					
Total		28100000	29505000	30980250	32529263	34155726	1552,70,239
5% overheads at state level for training of trainers, development of materials etc.		1405000	1475250	1549013	1626463	1707786	
Incentive of one 0.5 lakh rupees to two best panchayats of each block 0.5 lalkhs * 2	146	14600000	14600000	14600000	14600000	14600000	
Grand total		**44105000**	**45580250**	**47129263**	**48755726**	**50463512**	**236033751**

Programme management needs a designated lead agency at the state level who would manage all the funds, train all the NGOs who are the trainers, help distts to adapt the HDI for their needs, monitor the training and ensure that the basic rules are being followed. This would require about 30 field coordinators and two programme coordinators to drive the process.

We see this programme as synergising with the Mitanin programme to ensure that the demand for services is fully created and that the panchayats are fully involved in the programme. In the course of two years they should be ready for considerable decentralisation of programmes and powers.

THE SWASTHYA PANCHAYAT SCHEME (DRAFT)
THE HEALTH & HUMAN DEVELOPMENT INDEX

Name of hamlet/Village/Panchayat----------

HEALTH SERVICE INDICATORS					
BASIC HEALTH SERVICES					
Sl	**Indicator**	**Criteria**			**GoalPosts &SCORE**
1	IMMUNIZATION COVERAGE < 3 YEAR OF AGE	no. <3 years	% completely immunised	% of fully immunized hildren	Maximum 100% Minimum 0%
2	ESSENTIAL ANTENATAL CARE	Total no.of pregnant women	No of women who got full antenatal care as defined	% of women getting ntenatal care as defined	Maximum 100% Minimum 0%
3	INSTITUTIONAL DELIVERY	Total no.of pregnant women	Total no of women who had instituitional delivery	% of pregnant women who had institutional delivery.	Maximum 100% Minimum 0%
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%
5	BREASTFEEDING IN FIRST HOUR	Total no of births in the last year	No of newborns who were breastfed in the first hour	Percentage of newborns who were breastfed within an hour	Maximum 100% Minimum 0%
6	REPORTING OF BLOOD SLIDE	Approx no of blood slides sent in last 3 monts	Average time taken for reporting of blood slide		Maximum over 30 days Minumum 1 day

7	AVAILABILITY OF CHLOROQUINE	Total number of hamlets	No. of hamlets with shop/person having unbroken supply of chloroquine last year	% of hamlets		Maximum 100% Minimum 0%
8	AVAILABILITY OF SPACING METHODS	Total number of hamlets	No. of hamlets with shop/person having unbroken supply of OCP+condoms last year	% of hamlets		Maximum 100% Minimum 0%
9	ACCESS TO STERILISATION SERVICES	No of target couples for sterilisation services (> 2 children)	Total no. of couples with at least one of them wanting FP operation:	No. who wanted to get FP operation done last year but could not	% of unmet demand for FP operation	Maximum 100% Minimum 0%
10	FIRST DAY VISIT/ CONSULTATION OF MITANIN IN 4 CONTEXTS	Total no of hamlets with Mitanin	Number of hamlets where Mitanins make first day visits/or are consulted at least 50% of the time	% of functional Mitanin hamlets		Maximum 100% Minimum 0%
11	PANCHAYAT LEVEL HEALTH COMMITTEE	No. of panchayat level health committee meetings held in the last year				Max 12 Minimum 0
12	WOMEN HEALTH COMMITTEE	Total no. of hamlets	No. of hamlets with active women's committee that discusses health issues	% of hamlets with active womens committee that discusses health and or developmental issues		Max 100% Min 0%

HEALTH RELATED SERVICES					
WATER & SANITATION					
13	STAGNANT WATER	No. of hand pumps	No.of hand pumps without stagnant water	%	Maximum 100% Minimum 0%
14	SAFE DRINKING WATER	Total no. of families	Total no. of families using safe drinking water as defined	Percentage of families using safe drinking water	Maximum 100% Minimum 25%
15	USE OF DOMESTIC/ COMMUNITY TOILET	Total no. of families	Total no. of families where all members are using domestic/ community toilet	Percentage of families where where all members are using domestic/ community toilet	Max imum : 50 % Minimum 0%
FOOD SECURITY RELATED					
16	ANGANWADI	Total no. of children eligible for anganwadi	Actual No.getting diet regularly	Percentage of Anganwadi beneficiaries	
17	MIDDAY MEAL	Total no. of primary schools	Total no. of schools giving cooked midday meals	Percentage of schools giving midday meals	
18	PDS FUNCTIONING	Total no. of BPL families eligible for lower cost grains	No. of families getting grains from PDS shop	Percentage of beneficiaries	
19	ANTYODAYA YOJNA	Total no. of BPL families eligible for free grains	No. of families getting free grains from PDS shop	Percentage of beneficiaries	
20	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	

HEALTH STATUS					
21	CHILD MALNUTRITION	Total no. of children below 3 with wt record.	no. of children with gr I or above malnutrition**	% of children malnourished	Max 200% Minimum 0%
(Note: count each child with grade 2 , 3 or 4malnutrition as 2 child with malnutrition)					
22	LOW BIRTH WEIGHT	Total no. of newborn who were weighed last year	Total no. of babies with LBW	Percentage of babies *with* LBW	Max 100% Min 10%
23	AGE OF MARRIAGE	Total no. of girls married last year	No. of girls married below 19 year of age	100% - % of married women below 19 year of age	Max 100% Mim 0%
24	SPACING	Total number of births last year which were second or > child	No. of children born with more than 36 months difference	% of unspaced second or third children born	Max 100% Minimum 0%
25	INFANT DEATHS	Total number of births last year	Any deaths of any child below one year	% of infant deaths	Maximum 20% Minimum 0%
26	OUTBREAK OF WATER BORNE DISEASE	Diarrhoeal outbreaks(More than three cases of a disease in same week)	jaundice outbreaks (as defined)	Sum of water brone disease outbreaks	Maximum 4 Minimum 0

Other suggested indices for inclusion if means of verification at least by sample survey can be organised for each hamlet:

- Anaemia levels in pregnant women
- Anaemia levels in adolescents
- Malnutrition levels in adolescents
- API
- Infant spleen index
- Number of births which were the fourth child or more: and how many of them was due to the rest having been only girls:
- Number of births in those waiting for FP services.

The score of each item is made by the formula: $\frac{\text{(Actual value - Minimum value)}}{\text{(Maximum value – Minimum value).}}$

The maximum and minimum values for each item are given in the score card above but can be re-set at the district level to express their priorities and possibilites. Means of verification are given in accompanying note:

Hamlet score card :

Health services/practices Score	Max score 12 Min score 0	
Water and Sanitation Score	Max score 3 Min score 0	
Food Security Score	Max score 4 Min, score 0	
Schooling score	Max score 1 Min score 0	
Total Health And Related Services Score	Max score 20 Min score 0	
Child Malnutrition Score	Max score 1 Min score 0	
Health Outcome Score	Maximum 0 Minimum 6	

The above is aggregated item by item to measure the village health development index and again aggregated item by item to get panchayat health development index. Then an equity scorecard is also built in to reflect the intra panchayat variation between hamlets.

7.4 Equity/ Gender:

See also discussion on the Mitanin programme and 5.7 in situation analysis.

We have already discussed the over all current situation regarding gender and equity concerns and the approach the state has to addressing these issues(see section 5.7) In this we posit that the main ways of addressing these issues are:

a) a strengthened comprehensive primary care public health system with affirmative action to ensure that the weaker sections have access to it. The Mitanin programme, the process of panchayat level HDIs with identification of vulnerable panchayats, and the ethnic specific BCC programme design would be all examples of such affirmative action. These are discussed in detail in the respective sections. Even amongst this the critical input is the Mitanin programme.
b) In the quality of care component (7.3.3) by including gender and equity concerns into the quality standards and indicators and by investing in adequate central (i.e. from state and district headquarters) processes to monitor and support this taking place we hope to make the 100 FRUs and all the 24 hour PHCs we are investing on as more equitable in access and woman friendly.
c) In the public private partnerships (7.3.5.) the complete reimbursement provided to below poverty line families is a major contribution towards equity concerns.
d) In the urban health project the focus of community level care and primary care at the one third below the poverty line is also a major focus on equity.
e) In the adolescent health component (7.2.4) the special emphasis on issues of violence against women, on anaemia and malnutrition, on awareness of the body and control over it are specifically designed to address major gender concerns.
f) Not reflected in the proposal but needing to be flagged here is the special initiative by the state to have a grievance redressal forum for women employees of the department – recognising that such a forum is needed for their morale and more effective functioning.

7.5. Convergence/Coordination:

State Level: At the state level the State health society, which has the chief secretary as vice chairperson and other department secretaries provided co-ordination. Based on assessment of its functioning its inter-sectoral nature should be strengthened.

District Level: At the district level the district health society is providing Intersectoral coordination and coordination with NGOs as well. The Intersectoral nature of this needs to be strengthened .

Village and Panchayat level: At the panchayat level we have outlined in section 7.3.9 the investment being made for better inter-sectoral coordination. More than any other single measure such a comprehensive approach where health outcomes are matched to all intersectoral service inputs would be the major innovation of this programme.

Indeed the district level co-ordination forums would derive a purpose driven by the insights and work that emerges from the HDI process.

7.6.Financial management:

The State Health Society would be in charge of programme funds at the state level and the district health society at the district level.

Components relevant to their domain would be managed by arrangements within this umbrella- the SIHFW for training, The SHRC for Mitanin programme the directorate for infrastructure and so on.

At the district level it would be the district health societies.

In the section on programme management the proposal for improving financial management is included.

7.7 HMIS:

Section on HMIS given with programme management:

7.8. Work Plan:

This is indicated in the discussion on each item. As every item needs its own work plan and as there are five implementing agencies and the mechanisms of each have to be firmed up – the work plan is best made at that stage.

8. Programme Management Arrangements:

This shall occur at five levels.these five levels and their functions are given below.

Level	Functions
Strengthening of the directorate	Administration and Workforce Issues Infrastructure creation Procurement and Distribution through a separate cell for the same .
Strengthening of the State Health Society	Implementation of all technical components of the programme Monitoring and evaluation Financial Management related to programmes: NGO Programmes Public Private Partnership Programmes
Operationalizing the State Health and Family Welfare Society	All Training Programmes and capacity development in the directorate staff
Strengthening of the District Health Societies	Implementation of Programmes of RCH District and Block Level Plan development
Strengthening of the State Health Resource Centre:	Mitanin and other community level capacity building and Community basing of Programmes Operational Research and Policy related Studies: Assistance in Policy development Assistance in Public Private Partnerhsip programmes. Assistance in NGO run programmes. Assitance to districts in plan development and at block and panchayat levels.

+ SIHFW

clarity upd abt different roles & responsibilities & methods of linkages

8.1. Building up skills and manpower in State Health Society and Directorate:

Lack of skills and manpower at the directorate are a continuing problem at a time when there is a sharp increase in programmes. RCH-II would represents a major increase in programme outlay and this would require a corresponding increase in skills and manpower. Coordination between State Health Society and Directorate is also essential.

Objectives of Programme:

Increase manpower and skills available at the directorate for programme implementation of RCH-II , and other donor funded special programmes operationalised through the state health society.

Strategy:

Create a programme Planning and monitoring cell , which acts as the office secretariat for the state health society and for the RCH-II programme. This should have four consultants recruited from the open market and four officers of deputy director rank allotted from within the directorate. The four consultants would be qualified in public health management with or without medical background.

The eight member monitoring team would be backed by two finance professionals and two data analysts with software expertise for building up and sustaining a computerized MIS.

Budget Estimate:

Non Recurring Exp.								
1	Office set up and furnishing	Lump sum	1000000					
2	Computers, Photocopier & Accessories	Computers-11 Printers-3 Networking Photocopier-1& Accessories	1100000					
3	Vehicles	8 Vehicles (4 for Advisors and 4 for Deputy Directors on secondment)	6400000					
A	**Total**		**8500000**					
B	**Recurring Exp.**							
4	Salaries		**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-010**	**Total**
	4 Advisors	4*Rs 30000*12months	1440000	1512000	1587600	1666980	1750329	7956909
	2 Fin. consultants	2*25000*12 months	600000	630000	661500	694575	729304	3315379
	8 Drivers	8*4000*12 months	384000	403200	423360	444528	466754	2121842
	3 Staff for Data Entry, analysis, and assistance	3*4000*12months	144000	151200	158760	166698	175033	795691
5	POL	8 vehicles*10000*12 months	960000	1008000	1058400	1111320	1166886	5304606
6	Printing& Stationary	Lumpsum	400000	420000	441000	463050	486203	2210253
6	Office Exp and conting.	90000*12 months	1080000	1134000	1190700	1250235	1312747	5967682
B		**Total**	**13508000**	**5258400**	**5521320**	**5797386**	**6087255**	**36172361**

8.2.Building management capability at the directorate and in the districts:

Public Health management and administration capability needs to be enhanced at all levels- the state, the district and the block. Currently most persons at this level are clinicians who are assigned public health and management functions and learn their skills on the job. The whole emergence of health administration as a separate professional domain goes unrecognised This leads to costly administrative lapses and inefficiencies and most programmes fail to expend their budgets and /or deliver expected outcomes.

At the state level the state health society and the directorate need to have capability building. We also need to strengthen the two support institutions – the state institute of health and family welfare and the state health resource centre.

At the district level we need to strengthen the district health societies and in the blocks the block medical officer. The strengthening at the district and state society level can be done by the creation of an administrative cadre and specific public health management training and by the direct recruitment of health management and social work professionals;

Strategies:

Create administrative cadre

Build adequate health management capabilities in district and state level in department professionals.

Recruit as consultants and outsourcing/in sourcing arrangements for performing key health management tasks.

Activities:

1. All block medical officers, programme officers, district CMHOs and deputy directors and above would be considered as health administrators.
2. All health administrators above would complete three months of a mandatory training on health management. MOU would be reached with management institutions for this purpose.
3. All those who are equivalent or above to chief medical officer will have an opportunity to attend a one year course on health management. About 5 persons per year would attend the course. Costs would be shared between trainees and the government.

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-010	Total
1	Fees for 3 months Management course for health administrators 250 HAs	50/year @Rs. 10000	500,000	525,000	551,250	578,813	607,753	2,762,816
	Logistics for Training 250HAs	50/year @400*90 days	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	9,000,000
2	Higher level health management course for state level officials 25 SHAs	5/year @40000	200,000	210,000	220,500	231,525	243,101	1,105,126
3	State Level Monitoring and Coordination	Lumpsum 500000	100,000	100,000	100,000	100,000	100,000	500,000
A	**Grant Total**		**2,600,000**	**2,635,000**	**2,671,750**	**2,710,338**	**2,750,854**	**13,367,942**

8.3.Operationalizing the State Institute of Health and Family Welfare.

The state level training institution is needed to coordinate and lead all the training that is proposed. It also will have some capacity in planning.

A state institute of health and family welfare is already under construction.

Objective:

To build up a management team for the SIHFW so that capability building can begin as envisaged in the training policy document;

Strategy:

Establish a "Change Management Unit" headed by an HRD expert or recruit a director from the open market for a three year consultancy. The CMU may also be outsourced to a health management agency or reputed health NGO who has worked on health policy and health administration issues. This unit shall recruit the expert staff, train it and build the systems needed for a functional SIHFW. At the end of three years the management unit would transfer the institute to the direct charge of the directorate and withdraw leaving behind the staff and systems and having by then built the capability and linkages by which the directorate shall be able to guide and be guided by the SIHFW. The SHRC could also be entrusted with this role if found the best option amongst those who are considered for this.

The operationalisation of a policy and planning unit within this is also part of the functions of a CMU.

Budget

A	**Non Recurring Exp.**							
	Building, Furniture & Fixtures		14,00,000					
	Equipments	Computers-15, Printers-3 Networking Photocopier-1 Projectors Sound Systems Accessories	45,00,000					
	Vehicles	3 Vehicles(2 four wheeler and 1 mini 6 wheeler- 1 for Director and 1 for rest of senior staff, 6 wheeler for field trips)	26,00,000					
A	**Total**		**85,00,000**					
B	**Recurring Exp**		**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-010**	**Total**
1	Salaries							
	1 Director	1*50000*12months	600,000	630,000	661,500	694,575	729,304	3,315,379
	5 Expert Faculties	5*30000*12 months	1,800,000	1,890,000	1,984,500	2,083,725	2,187,911	9,946,136
	1 Research & Publication Officer	1*20000*12 months	240,000	252,000	264,600	277,830	291,722	1,326,152
	1 Illustrator cum Graphic Artist	1*15000*12 months	180,000	189,000	198,450	208,373	218,791	994,614
	1 Librarian cum Documentation officer	1*10000*12 months	120,000	126,000	132,300	138,915	145,861	663,076
	1 Lab Assistant	1*5000*12 months	60,000	63,000	66,150	69,458	72,930	331,538
	3 DEOs /Statistical assistants	3*4000*12 months	144,000	151,200	158,760	166,698	175,033	795,691
	1 Registrar	1*15000*12 months	180,000	189,000	198,450	208,373	218,791	994,614
	1 Accountant	1*10000*12 months	120,000	126,000	132,300	138,915	145,861	663,076
	1 Residential officer and Premises manager	1*8000*12 months	72,000	75,600	79,380	83,349	87,516	397,845
	3 Drivers	3*4000*12 months	144,000	151,200	158,760	166,698	175,033	795,691
	5 supporting staff	5*3000*12 months	180,000	189,000	198,450	208,373	218,791	994,614

2	POL	3vehicles*10000*12 months	360,000	378,000	396,900	416,745	437,582	1,989,227
3	Preparatory Workshops and material Production	Lumpsum	900,000	945,000	992,250	1,041,863	1,093,956	4,973,068
4	Office Expenditures and Comtingencies	@75000*12	900,000	945,000	992,250	1,041,863	1,093,956	4,973,068
	Total		**6000000**	**6,300,000**	**6615000**	**6945750**	**7293037.5**	**33,153,788**
	Grand Total		**14500000**	**6300000**	**6615000**	**6945750**	**7293038**	**41653788**

8.4. District Level Planning and Management Capacity:

Districts are expected to generate plans but currently there are no systems or capability building programmes to make this happen.

Build a district level planning team and district level capabilities in district level planning.

Build a planning team composed of four programme officers, the block medical officers and the chief medical officer. Also two or three from related sectors and two or three from the private sector/ NGOs working in health area.

Train the planning team through a three month programme- designed in consultation with a health management institute. The course will largely be through correspondence but there would be 15 days of contact programmes

Budget Estimate :

A	**Non Recurring Exp.**		**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-010**	**Total cost**
1	Untied grants for setting up office, buying equipments etc @ 1,00,000 per district	@ 1,00,000 per district	100,000	0	0	0	0	100,000
A	**Total**							
B	**Recurring Exp**		**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-010**	**Total cost**
1	Programme Associates	1*8000*12months	96,000	100,800	105,840	111,132	116,689	530,461
2	Fin./Accounting Assistants	1*8000*12months	96,000	100,800	105,840	111,132	116,689	530,461
3	Logistics for Contact Training	25HAs@400*15days	150000	157,500	165,375	173,644	182,326	828,845
4	Untied Grants for Mobility for supporting block teams	15000*12 months	180000	189,000	198,450	208,373	218,791	994,614
5	Monitoring and coordination expenses	Lump Sum	28,000	29,400	30,870	32,414	34,034	154,718
Total per district			**550,000**	**577,500**	606375	636693	668528	3,039,097
Total for 16 District			**10,400,000**	**9,240,000**	9,702,000	10,187,100	10,696,455	50,225,555

8.5 Strengthening the SHRC:

Operational research, studies to guide policy planning and programmes to secure community participation and sustaining the Mitanin programme requires the continued role of the SHRC. The SHRC unlike the SIHFW is not a governmental institution but an institution representing state civil society partnership. This requires that the department and government recognize and welcome the key innovative and watchdog and advocacy role that civil society organizations have played in securing health rights for the poor. This energy is harnessed to provide an additional technical and managerial capacity for the department without compromising the autonomy that is needed for the institution to remain a civil society organization. Thus the internal organization of the SHRC is left to the governing body formed by a consortium of NGOs and government relationship is designed by periodical task assignments and reviews of work done under MOUs and projects. The SHRC plays a key role in block level and panchayat level capability building also largely by building up trainers and developing replicable models of such planning. In this proposal itself, the SHRC has the following areas of programme management: Mitanin Programme, quality management programme for 100 blocks, assisting in PPPs and designing operational guidelines for urban health, tribal health and panchayat HDI.

Budget:

The entire amount of SHRC budget would be handed over to SHRC as a financial year allocation, which would be given autonomy on running the institution as per the MoU. In addition, programme funds would be transferred separately to SHRC, as comes necessary. The total budget proposed per quarter is 10 lakhs rupees and Rs 40 lakhs per year.

Budget

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-10	Total
A	**Recurring Exp.**							
1	Salaries							
	1 Director	1*50000*12months	600,000	630,000	661,500	694,575	729,304	3,315,379
	3 Programme Corrdinators	3*30000*12 months	1,080,000	1,134,000	1,190,700	1,250,235	1,312,747	5,967,682
	3 Programme Associates	3*15000*12 months	540,000	567,000	595,350	625,118	656,373	2,983,841
	1 Research Assistant	@6000*12 months	72,000	75,600	79,380	83,349	87,516	397,845
	1 Accounts Manager	@10000*12 months	120,000	126,000	132,300	138,915	145,861	663,076
	1 Accountant	@8000*12 months	96,000	100,800	105,840	111,132	116,689	530,461
	1 Office Assistant	@5000*12months	60,000	63,000	66,150	69,458	72,930	331,538
2	Review and Planning Workshops and core publications of annual reports and studies	Lumpsum	500,000	525,000	551,250	578,813	607,753	2,762,816
3	Tour & Travel	30000*12 months	360,000	378,000	396,900	416,745	437,582	1,989,227
4	Office Expenditures and Contingencies	47500*12	570,000	598,500	628,425	659,846	692,839	3,149,610
B	**Total for an year**		**3,998,000**	**4,197,900**	**4,407,795**	**4,628,185**	**4,859,594**	**22,091,474**

8.6 Computerised Health Management Information Systems with outreach upto block level.

Health management now is largely manual operation. Districts however have been equipped with computers but their use as a management tool is still sub-optimal. Effective health management requires that not only district s but that even blocks are equipped with computers, customised software for health management and web-links and trained personnel to handle these.

Objectives of Programme:

To ensure that a computerised health management system is in place that links all district headquarters and at least 50 other CHCs within two years and in all CHCs within 5 years.

Strategy:

1. Ensure that every district has three functional computers and at least 50 CHCs have one functional computer along with all necessary accessories including web-linkages – where needed through wireless protocols by first year and all other CHCs to reach this stage by next year.
2. Develop a customised health management and information system, complete training and capacity building and operationalise the system within next two years.
3. Improved data collection and feed in at the peripheri – using "smart cards" is it cn be made technically feasible. Improved use of the data and feedbacks at the centres- state by fifth year. The Implementation of smart card based information/reporting system would depend upon engaging a techno-institution for the development of the technology and device for the same.

Activity:

Outsource to a health management firm. Their MOU will not only cover development of the necessary processes but also developing capability to manage this at the state level in the state level society and in the district health societies.

Budget

Sl	Head	Description	2005-06					
A	Computers and Peripherals @50000							
1	For All District Head Quarters	16*3*50000	2400000					
	For 50 Blocks in first year	50*1*50000	2500000					
	For remaining 96 blocks in next year	96*1*50000	4800000					
	Smart cards for all MPWs (depending upon the availability of reliable technology)	@1500						
2	For 50 blocks in first year	4000*1500	6000000					
	For remaining 96 blocks in second year	5000*1500	7500000					
			23200000					
B	**Recurring Exp.**		**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**Total**
	162 Data entry operators	162*3000*12 months	5832000	6123600	6429780	6751269	7088832	**32225481**
	Training of Officials and DEOs	1*200000*16 dists	3200000	3360000	3528000	3704400	3889620	**17682020**
	Repair & Maintenance	1*100000*16	1600000	1680000	1764000	1852200	1944810	**8841010**
	Insurance Coverage for electronic equipments	@.5 % of total price per annum	116000	121800	127890	134285	140999	**640973**
	Maintenance of equipments	162*Rs2500 per centre	405000	425250	446513	468838	492280	**2237881**
	Transportation	162*5000 per centre	810000	850500	893025	937676	984560	**4475761**
	State level monitoring and coordination	Lump Sum @100000*12 months	1200000	1260000	1323000	1389150	1458608	**6630758**
	Total Recurring Costs for whole state per annum		13163000	13821150	14512208	15237818	15999709	**72733884**
	Recurring cost For First Year 40% of estimate		5265200	5528460	5804883	6095127	6399884	**29093554**
	Total per year		18428200	19349610	20317091	21332945	22399592	**101827438**
	Grand Total		**41628200**	**19349610**	**20317091**	**21332945**	**22399592**	**125027438**

8.7. Improving Financial Management:

Health administration requires high degrees of financial management and skills. The possibility of using fund flow for optimising programme management has also never been utilized. At the current stage even getting utilization certificates in time and getting the next instalment of funds released without breaks in the programme is difficult to manage. We therefore intend to build in a component to strengthen the financial management of the programme.

Objectives:

1. To train one person at every block level in financial maangement.
2. To recruit where needed and further train one accounting professional at the district health society level so as to efficiently lead finance management.
3. To have an efficient financial management arrangment for the health societies as well as for the public private partnerships at the state level .
4. To build up a computerised web-interfaced accounting system so that all districts and at the state level- quarterly and eventually monthly financial statements are submitted and there are no delays due to weaknesses in the accounting system

Budget:

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2008-10	Total
	Recurring Exp.							
1	Honarariums/ Fees							
	Annual Contract to a Senior Chartered Accountant firm as financial management unit	@30000*12 months including compiling accounts and preparing statements assistance in financial planning and management contingencies etc.	360000	378000	396900	416745	437582	1989227
	4 Consultant Trainers (MBA/CA) for district level training	4* 60 days * 1000 per day	240000					
	Tour & Travel for trainers	4 persons*20000 Rs lumpsum	80000					
	Training cost for 162 Dist/Block level Finance persons	162*250 per head per day * 8 days. (incl. travel food stationary and material costs)	324000					
	Total per year		**1004000**	**378000**	**396900**	**416745**	**437582**	**2633227**

Budget Section

Section 7.3 Institutional Strengthening

Section 7.3.1 Infrastructure Development For The Public Health System

Budget For 50 Blocks in a year-

ITEM	Unit Cost	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
Old Sub centres Renovation/Repair 350/year	10000	3500000	3675000	3858750			11033750
No of SCs(only those needing renovation)		350	350	350			1050
Old PHCs Renovation/Repair 100/year	182500	18250000	19162500	20120625	5683050		63216175
No of PHCs (needing renovation)		100	100	100	27		327
New Sub centres Building Construction 650/year	500000	325000000	341250000	358312500	376228125	385315481	1786106106
No of SCs		650	650	650	650	634	3234
New PHCs Building Construction 100/year	1800000	180000000	189000000	198450000			567450000
No of PHCs		100	100	100			300
CHCs Renovation/Repair 15/ Year	400000	6000000	6300000	4410000			16993333
No of CHCs		15	15	10			40
For new CHCs 15/year	5000000	75000000	78750000	82687500	86821875		420499875
No of CHCs		15	15	15	15		60
For Residential Accommodation in 50 blocks	9000000	---	4500,00,000	472500000	496125000		
TOTAL		607750000	1067347500	667839375	468733050	385315481	3196985406

Appox 30 CHCs and 93 PHCs and 408 sub-centers are estimated as not needing renovation

Budget for Subcentres and PHCs in a normative block

ITEM	Unit Cost	Estimated No in One Block	Total Cost
Old Sub centres Renovation/Repair	10000	7	70000
Old PHCs Renovation/Repair	182500	2	365000
New Sub centres Building Construction	500000	13	6500000
New PHCs Building Construction	1800000	2	3600000
Residences for one block		4 F; 2 G; 2 H, 2 I type @ a CHC(Rs 50 lkhs) plus for 4 PHCs (@ Rs 40 lakh)	9000000
Total			**195,35,000**

According to data available for -Total No. -

Sub centes		Community Health Centres		
Total No.	4692	Total No.	130	
Govt Building needing renovation	1458	Govt Building needing renovation	40	
Need of New Subcetre construction	2360(3234)	Need of New CHC construction	60	

Primary Health Centres	
Total No.	720(516)
Govt Building needing renovation	327
Need of New PHC construction	189+204

7.3.2.Training

7.3.2.1. Infrastructure : District Training Centres

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
A	Non Recurring Exp.							
1	Building, Furniture & Fixtures	Refurbish existing 5 centres Rs. 1 lakhs	500000					
		For establishing 11 more centres: Rs. 25 lakhs each. (5*1,00,000)+(11* 25,00,000)	27500000					
2	Equipments	Computers-1 Printers-1 Projectors Sound Systems & Accessories Rs. 2,00,000 per centre*16 centres Maintainence of Equipments	3200000					
A	Total		31200000					
B	Recurring Exp.		2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
	Salaries							
	1 Training Officer	On secondment		0				
1	3 Trainers (MSw qualified proffessionals)	3*Rs 5000*12 months*16 DTCs		1440000	3024000	3175200	3333960	10973160
2	1 Data Entry Operator/Statistical assistant cum accounting clerk	1*Rs 4000*12 months* 16 DTCs		384000	806400	846720	889056	2926176
	1 Residential staff	1*Rs 3000*12 months* 16 DTCs		288000	604800	635040	666792	2194632
3	Untied funds for Preparatory Workshops and material	Lumpsum 1 lakhs * 16 RTCs		800000	1680000	1764000	1852200	6096200
4	Office Expenditures and Contingencies	5,000*12 months*16 DTCs		480000	1008000	1058400	1111320	3657720
	Total (A+B)		31200000	3392000	7123200	7479360	7853328	57047888

(Note: In 2005 –06 and first 6 mnths of 2006-07 since building is under construction no running costs are shown. From second half of 2006-07, running costs- salaries, actvities, travel are budgeted for).

Section 7.3.2.2 Training of Paramedicals

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
1	Training of Trainers	80 Trainers @Rs.1000 per day*15 days	1200000	1260000	1323000	1389150	1458608	6,630,758
2	Day allowance/ Food and logistics for participants	5000 trainees @125Rs a day*14 days	8750000	9187500	9646875	10129219	10635680	48349273
3	Training Fees and Travel for trainers	80 trainers*10 days *200	160000	168000	176400	185220	194481	884101
4	Stationary and Training Material	5000*200 Rs per trainee	1000000	1050000	1102500	1157625	1215506	5525631
5	Preparatory activities correspondence Documentation Report Preparation Monitoring contingencies and other training related expenditures	125 batches@3120 Rs per batch	390000	409500	429975	451474	474047	2154996
	Grand Total		**11500000**	**12075000**	**12678750**	**13312688**	**13978322**	**63544759**

The training details – who is trained and what is the content-- is given in the corresponding section. The number of days each trainer is needed is only ten days though the total number of training days are 14. Training of Trainers has a 15 day training.

B. For Training of Nurses and Paramedics on adolescence health/STIs.

Sl	Head	Descriptions	2005-06	2006-07	Total cost
1	Training of Trainers	80 Trainers @Rs.1000 per day* 8 days	640000	672000	1312000
2	Day allowance/ Food and logistics for participants	3000 trainees @125 Rs a day*6 days	2250000	2362500	4612500
3	Training Fees and Travel for trainers	80 trainers*20 days *200	320000	336000	656000
4	Stationary and Training Material	3000*50 Rs per trainee	150000	157500	307500
5	Contingencies & related expenditures (10%)	75 batches@ 2000 Rs per batch	150000	157500	307500
		Grand Total	**3510000**	**3685500**	**7195500**

After two years future programmes will conducted with budgets provided for regular retraining of paramedicals. This is only for the initial training to introduce this component into the system.

3.2.2. B1 Continuing Medical Education Scheme for Medical Officers

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
1	Preparation and production of CME material	Rs 500 per doctor * 1000 doctors	500000	525000	551250	578813	607753	2762816
2	Postage per doctor per year	6 times/year* Rs 20 * 1000 doctors*2 years	240000	252000	264600	277830	291722	1326152
3	Course coordinators/evaluators honararium /salary	lump sum, negotiated based on task	1200000	1260000	1323000	1389150	1458608	6630758
4	Full time support staff	Rs 20,000 * 12 months* 2 years	480000	504000	529200	555660	583443	2652303
5	CME contact programmes over two years	Rs 250 per person * 5 programmes /year * 2years* 1000 persons	2500000	2625000	2756250	2894063	3038766	13814078
6	Preparatory activities, correspondence, Documentation, Report Preparation, Monitoring, contingencies and other expenditures	Lumpsum	80000	84000	88200	92610	97241	442051
		Grand Total	**5000000**	**5250000**	5512500	**5788125**	**6077531**	**27628156**

7.3.2.2 –B2 Skill sets for CHCs and Multiskill Training for Specialists

Skill Sets for CHCs and Multi-Skill Training For Specialists:								
Sl	**Head**	**Descriptions**	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-010**	**Total cost**
1	Day Allowance for Doctors							
	For Course on Emergency OB Care	180 Days@150 Rs *15 doctors * 2	810000	850500	893025	937676	984560	4475761
	For Course on Anaesthsia	180 Days@150 Rs *15 doctors*2	810000	850500	893025	937676	984560	4475761
	For Course on Sick Neonatal/child care	60 Days@150 Rs *15 doctors*2	270000	283500	297675	312559	328187	1491920
	For Course on mini Laproscopy/ conv. tubectomy/safe abortions/RTI	30 Days@150 Rs *15 doctors*4	135000	141750	148838	156279	164093	745960
2	Travel and Book Allowance for participant doctors for all courses	Total 150 doctors@ 2000 Rs	300000	315000	330750	347288	364652	1657689
Honorarium for Teaching Faculties								
1	For Course on Emergency OB Care	6 months@2000 Rs *5 faculties/institution* 3 inst* 2	360000	126000	132300	138915	145861	663076
2	For Course on Anaesthsia	6 months@2000 Rs *5 faculties*3 inst*2	360000	126000	132300	138915	145861	663076
3	For Course on Sick Neonatal/child care	2 months@2000 Rs *5 faculties*3* 2	120000	42000	44100	46305	48620	221025
4	For Course on mini Laproscopy/ conv. tubectomy/ on safe abortion/RTI	1 months@1000 Rs *5 faculties*3 inst* 4	60000	21000	22050	23153	24310	110513
5	Training Facilities esp. dummies	Lump sum	800000	840000	882000	926100	972405	4420505
		Net	**4025000**	**3596250**	**3776063**	**3964866**	**4163109**	**18925287**
1	Contingencies & related expenditures @10%	Lump Sum	402500	359625	377606	396487	416311	1892529
		Total	**4427500**	**4648875**	**4881319**	**5125385**	**5381654**	**24458733**

D. Training For ISM Staff

Training For ISM Staff:								
Recurring Costs								
Sl	**Head**	**Descriptions**	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-010**	**Total cost**
1	Material Production	1100persons @ Rs. 300	330000	346500				676500
2	Training of Trainers	80 Trainers* Rs. 1000 (food / acc) per day* 25 days	20,00,000	2100000				4100000
2a	Training of Trainers	80 Trainers*1000 Rs. per day* 5 days			400000	420000	441000	1261000
3	Honorarium for state training faculties	20 faculties @5000 Rs.	100000	105000	110250	115763	121551	552563
4	Expenses for training all categories of staff	30 Days@ Rs300 *500 trainees	4500000	4500000				9000000
4a	.Expenses for training all categories of staff	10 Days@ Rs 300 *500 doctors/staff			1500000	1500000	1500000	4500000
5	Day allowance Honorarium For Trainers	80 trainers *250 Rs * 15 days/trainer	300000	300000				600000
5a	Day allowance Honorarium For Trainers	80 trainers *250 Rs * 10 days/trainer			200000	200000	200000	600000
6	Other Training & related exp.	Lump Sum	270000	283500	297675	312559	328187	1491920
		Total	**7500000**	**7635000**	**2507925**	**2548321**	**2590737**	**22781984**

Section 7.3.3 Ensuring Quality of Care in FRUs and 24 hour PHCs

Item	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Block Level Microplanning	200000	----	----	-----	------	200000
Motivational Meeting	2000000	2100000	2205000	2315250	2431013	11051263
Field level Programme Management	1440000	1512000	1587600	1666980	1750329	7956909
Filling of Equipment Gap (35 block /year)	7000000	7350000	7717500	8103375	8508544	38679419
Performance Incentive	15000000	15750000	16537500	17364375	18232594	82884469
Total	25640000	26712000	28047600	29449980	30922479	1405,72,059
Contingencies, fees to firm etc(10%)	2564000	2671200	2804760	2944998	3092248	14057206
Grand Total	28204000	29383200	30852360	32394978	34014727	154849265

Details of each item- and how the budget for it has been estimated is given in the corresponding section:

Section 7.3.4. Strengthening Routine Subcentre Level Services:

Item	Unit cost	Quantities	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Stationary	300	8000	2400000	2520000	2646000	2778300	2917215	13261515
Mobility	2000	5000	10000000	10500000	11025000	11576250	12155063	55256313
Supervision quality and sample surveys	2000	5000	10000000	10500000	11025000	11576250	12155063	55256313
16 dt annual external evaluation	1 lk	16 dists.	1600000	1680000	1764000	1852200	1944810	8841010
Expanded ANM drug kit	Rs 12000	5000	6crores (To be supplied by central govt under FW)					
Cold Chain upkeep	1.0lakhs	16 dists.	16lakhs (Plus major equipment costs to be borne by central govt.)					
Total costs	(Excluding 6 crores that could be direct central govt costs)		**24000000**	**25200000**	26460000	27783000	29172150	13,26.15,150

Note Cost of equipment supplied by GoT is not included in the budget.(a walk in freezer at Rs 50 lakhs is the main requirement and two walk in coolers are also desirable)
The Central government also supplies the ANM drug kit as of now and thisdi needs to be maintained and strengthened as indicated in the text.

Section 7.2.3 Family Planning

Social Marketing Budget

Particulars	Unit	Unit cost per month	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Stockist Overhead	2	3000	72000	75600	79380	83349	87516	397845
Sales Force Cost	8	2000	192000	201600	211680	222264	233377	1060921
Warehousing/godown	1	0	0	0	0	0	0	0
Administrative cost	1	5000	60000	63000	66150	69458	72930	331538
	Total		324000	340200	357210	375071	393824	1790305

7. Two Stockists will cover total 16 districts one will be located at Raipur and other one at Bilaspur
8. Overheads to the stockists mainly relate to cover-up rent for godown and administrative cost
9. One Sales person will cover two districts and therefore for 16 District their will be eight persons.
10. Rent for godown is not taken into account as State Government will provide for that.

11. The administrative cost will include report compilation, follow up etc
12. Since the product is offered free of cost -other costs can be recovered from the sales windows/ agenices recrutied after selling the products- on a commission on sales basis.

Section 7.3.5 Public Private Partnerships

Section 7.3.5.1 Public Private Partnerships for Essential & Emergency Obstetric Care:

Budget Requirements for One year :

Approximate Case Load and Reimbursement Costs in a district where one EmOC center has been recruited as a partner:

Item	Nos. Per Month	Per Unit Cost	Total Cost per mnth
C-section	5	6000	30,000
Institutional deliveries	30	1500	45,000
Sterilisations	50	800	40,000
Others	50	200	1,000
A. Total Monthly	**Reimbursement**		1,16,000
B.Total Annual			13.92 lakhs

Reimbursement cost for 50 PPP centers: **Rs 696 lakhs(81. 31%)**

Please note referral refunds costs may be included .This fund also lies underutilised.

Programme Management Costs:

A> Variable Programme Costs: **shown below for 50 franchisees:/partners**

1. Monitoring and Accounting Support

Monitoring 1st level	Appox 25% cases:	Rs100 per case or 10% of A	11,600
Monitoring 2nd level	Appox 5% of cases	2% of A	2320
Accounting costs		2% of A	2320
Total for one month			16,240
Total for 12 months			1,94,880

1. Monitoring & Accoounting Support for 50 partners per year: 97,44,000

2. Upgradation of Skills & Improvements in clinics & 0.6/partner: Rs 30,00,000

B> Fixed Programme Costs

1.. Programme Administration Costs:

One CEO, 3 prog. officers and one CA firm /per mnth	:	Rs. 85,000
Travel Costs for state office	:	Rs. 15,000
Office costs for state office	:	Rs. 30,000
5 field officers @ Rs 6000pm:	:	Rs. 30,000
5 filed officers travel and support costs	:	Rs 10,000
Total programme management costs per month	:	1.60,000
Per year	:	*19,20,000*

2. Promotion Costs:

Brochure /ads/visits:	:	Rs 1,50,000
Accredittation visits: 200 partners* 1500	:	Rs 3,00,000
Training expenses 100* Rs400/day * 10 days	:	Rs 4,00,000
Melas – other promotional activity:	:	Rs 5,00,000
Initial restructuring, brand image promotion,		
Total Promotion Costs per year:	:	*Rs 53,50,000*

Total Annual PPP Programme support Costs : Rs 160.14 lakhs (18.69%)

Total Annual PPP in emergency obstetric care : budget in brief

ITEM	Unit cost (Rs.)	Nos.	2005-06	2006-07	2007-08	2008-09	2009-10	Total
Reimbursements		50	696,00,000					
Programme Management		1	160,14,000					
Total	**856.14**		**856,14,000**	**89894700**	94389435	991,08,907	**1040,64,352**	**4730,71,394**

This projection makes the assumption that we would have only 50 partners and that their total reimbursement needs would be only in the range of Rs 13 92 lakhs per year per partner – adjusted for inflation. In practice we expect to increase by about 25% every year. More important we expect to introduce insurance as a complement to this programme. The exact budget estimats for this would be known later – but we are planning to do it within current programme management costs.

Section 7.3.5.2. Public Private Partnerships for Ambulance Services

ITEM	Unit cost (Rs.)	Nos.	Year 2005-2006	Year 2006-2007	2007-08	2008-09	2009-10	Total
Ambulance	1000000	30	30000000					
Referral fund	200000	100	20000000	21000000	22050000	23152500	24310125	110512625
Total			**50000000**	**21000000**	**22050000**	**23152500**	**24310125**	**140512625**

Section 7.3.5.3. Public Private Partnerships for Laboratory Services

ITEM	Unit Cost/day	Unit cost	Training days	Nos.	2004-2005	2005-2006	Total
Lab tech (Training of Master Trainers)	100/-		30	500	**1500000**		**4000000**
Establishment		5000/-		500	**2500000**		
Lab tech (Training of Master Trainers)	100/-		30	100		**3000000**	**8000000**
Establishment		5000/-		1000		**5000000**	
Total					**4000000**	**8000000**	**12000000**

Section 7.3.6. Grant – in- aid Scheme for NGOs

ITEM	Unit cost (Rs.)	Nos	2005-06	2006-07	2007-08	2008-09	2008-10	Total
30 CLVs /ANM equivalents	3.60 lakhs	15	5400000	5670000	5953500	6251175	6563734	29838409
1 Supervisor	0.96 lakhs	15	1440000	1512000	1587600	1666980	1750329	7956909
Medical Assistance and camp expenditure for 100 one day camps	2.00 lakhs	15	3000000	3150000	3307500	3472875	3646519	16576894
Staff Training	1.20 lakhs	15	1800000	1890000	1984500	2083725	2187911	9946136
Referral transports equipments programme support and contingencies	1.74 lakhs	15	2610000	2740500	2877525	3021401	3172471	14421898
NGO level management costs	0.50 lakhs	15	750000	787500	826875	868219	911630	4144223
Total	10 lakhs	15	15000000	15750000	16537500	17364375	18232594	828,84,469
State level Co-ordination Monitoring and Evaluation	10%	--	1500000	1575000	1653750	1736438	1823259	8288447
Allocation for special areas	--	--	3500000	3675000	3858750	4051688	4254272	19339,709
		Total	20000,000	21000000	22050000	23152500	24310125	1105,12,625

A medically underserved sector would be roughly contracted out at Rs 10 lakhs per year excluding drugs and vaccines. Thus the budget is for 15 such areas. All paramedical services would be expected including the paramedical level curative care package. Part time medical services would be expected. Out of this 10 lakhs, Rs 3.6 lakhs (30 thousand pm) would go to 30 community level workers for 1:1000 population paid at Rs 1000 per each CLVs or six ANM equivalents at Rs 5000 each with voluntary Mitanins for help. Another 0.96 lakhs would go for a supervisor @8000 pm. Other expenses are medical camps attended by doctors, administrative costs and contingencies. The cost of drugs and supplies would be borne by the state in kind who would give them 30 CHV kits and five ANM kits. State level monitoring is 10% as considerable skill building/moniotring of the NGOs would be required. The remaining 35 lakhs is for special groups or areas – like primitive tribals or migrants- where detailed programmes would be worked out.
Budget for NGO grant-in aid per year: 200 lakhs.

7.3.7. Community Level Care: Mitanin –II Programme

Sl	Head	Exp. per block per year		2005-06	2006-07	2007-08	2008-09	2009-10	Total
1	**Training**								
1	12 Day Training for 400 Mitanins	672000							
1.2.	Field Training and Support for Mitanins	268800							
1.3.	Dt. Trg. of Trainers*	48000							
1.4	State Training of DRPs*	29500							
1.5.	Training Material *	30000							
1.6.	Skills/and Capacity Building *	10000							
1	**Total**	1058300		154511800	162237390	170349259	178866722	187810059	853775230
2	Social **Mobilisation**								
2.1	Folk Media	122250							
2.2	Trg for above campaign*	16000							
2.3	Electronic Media*	10000							
2.4	Print Media*	5000							
2.5	Training CDs *	5000							
2	**Total**	158250		23104500	24259725	25472711	26746347	28083664	127666947
3	**Administrative and Others**								
3.1	Admin: block level	60000							
3.2	Admin/support Dt level.	24000							
	Total	84000		12264000	12877200	13521060	14197113	14906969	67766342
4	Admin/support State Level	48000		7008000	7358400	7726320	8112636	8518268	38723624
	Grand Total	**1348550**		**19,68,88,300**	**206732715**	**217069351**	**227922818**	**239318960**	**1087932144**

Administrative and Other Expenditures at block ,District and state level include travel, coordination meetings, monitoring, events, correspondence, overheads and contingencies)

Section 7.3.7.2 The CHV or Mitanin Drug Kit:

Item	Unit cost	Nos.	2005-06	2006-07	2007-08	2008-09	2009-010	Total
Drug Kit For Mitanins	200	60000	12000000	0	0	0	0	12000000
Drug Supplies for 12 months@ Rs. 150	1800	60000	108000000	113400000	119070000	125023500	131274675	596768175
Total			**120000000**	**113400000**	**119070000**	**125023500**	**131274675**	**608768175**

Section 7.3.8.Behaviour Change Communication:

Item	Cost per unit	Qty.	2005-06	2006-07	2007-08	2008-09	2009-010	TOTAL
One strategy development and three material development workshops done twice a year 20 persons * 10 days* 300 plus 40000 for related expenses	100000	8	800000	840000	882000	926100	972405	4420505
Block level campaigns which are folk art based	100000	146	14600000	15330000	16096500	16901325	17746391	80674216
Radio programmes – three regional specific 15 part radio programmes broad cast thrice a year	500000	3	1500000	1575000	1653750	1736438	1823259	8288447
State level event – inaugurations/ announcements etc	100000	3	300000	315000	330750	347288	364652	1657689
		Total	**200,00,000**	**210,00,000**	**220,50,000**	**231,52,500**	**243,10,125**	**1105,12,625**

Section 7.3.9. Panchayat Capability Building & Intersectoral Coordination

Item	Qty	2005-06	2006-07	2007-08	2008-09	2009-10	Total
Development of index/manual and dissemination	70000	3500000					
Training of 3 functionaries per GP- 2 one day camps Rs 70 per day for 2 days	30000	4200000					
Training of village and hamlet reps- 2 one day camps per year Rs 70 per day for 2 days	60000	8400000					
One NGO per block as overheads for conducting the training providing support and assisting govt officers in compiling the index. Rs 1000 pm/per cluster * 12 months	1000 GP clusters of 10 GPs each	12000000					
Total		28100000	29505000	30980250	32529263	34155726	1552,70,239
5% overheads at state level for training of trainers, development of materials etc.		1405000	1475250	1549013	1626463	1707786	
Incentive of one 0.5 lakh rupees to two best panchayats of each block 0.5 lalkhs * 2	146	14600000	14600000	14600000	14600000	14600000	
Grand total		**44105000**	**45580250**	**47129263**	**48755726**	**50463512**	**236033751**

See section 7.3.9. for details and explanations:

Section 7.2.4 Adolescent Health

Head	Unit Cost	Nos.	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
Training Counsellors 5nos*15days*Rs 200 By (NGOs & Govt Staff)	15000	146	2190000					
Training peer educators 20nos*5days*Rs 100By (NGOs & Govt Staff)	10000	146	1460000					
IEC activity:	10000	146	1460000					
Honararium for counsellors 5*200* 12	12000	146	1752000					
Overheads contingencies	8000	146	1168000					
Total for block	55,000	146	8030000	8431500	8853075	9295729	9760515	10248541
Mass screening/counselling programme in a block for all children and adolescnet for iron def.& sickle cell trait and disease (Ten blocks in first year then twenty blocks in each subsequent year for four years)	1000000	10	10000000	21000000	22050000	23152500	24310125	100512625
Total			**18030000**	**29431500**	**30903075**	**32448229**	**34070640**	**144883444**

Note : The aim is to limit the mass screeding to a few blocks every year- since it is very effor intensive .At the end of five years we would complete only 90 blocks which are considered having the highest prevalence of anemia- both sickle and iron deficiency. We would estimate which are the most prevalent blocks during the first year based on instrituional data and camp based data as sickle detection centers have been set up in all the districts.

Mass screening/counselling programme in a block for all. Children and adolescnets for iron def.& sickle cell trait and disease

Details of Budget for a normative block of one lakh population

Break-up for Rs. 10,00,000 for a normative block is given below.

Approx population in age group 0-25	40% of the population	
Approx population to be tested	40,000	
Cost per test (Hemoglobin + solubility including confirmation if positive	@ Rs. 15 per test	6.00,000
IEC and mobilization to get people to participate in		
Meeting and Kalajtha 100 villages	(Rs1000) per village*	1,00,000
Logistics at block level – vehicle, camp arrangement	400camps*Rs400	1,60,000
Documentation		20,000
Total		9,00,000
Overheads 10	10%	90,000
Grant total		9,90,000
	Approximated to 10,00,000	

Section 7.2.5 Urban RCH

Head	Unit Cost	Nos.	2005-06	2006-07	2007-08	2008-09	2009-10	Total
Participatory Mapping for A category	Rs 10,000	4	210000	0				
Participatory Mapping for B, C, D categories	Rs 20,000	15	280000	0				
Health Administrator for A, B categories (for one year)	Rs 20,000	29	7000000	7350000				
Community care givers	Rs 4000	2,400	9600000	10080000				
Peer educators	Rs 4000	240	960000	1008000				
Urban health centers	Rs 2.6 lakhs	120	31200000	32760000				
Secondary centers	Rs 1.2 lakhs	10	1200000	1260000				
Social insurance for pilot ULBs (govt. paid premium in first two years for category III beneficiaries)	600	5667	3400200	3570210				
Social insurance for pilot ULBs (govt. paid premium in first two years for cateogry II beneficiaries)	300	19000	5700000	5985000				
Total			59550200	62013210	65113871	68369564	71788042	71788042
Overheads and management cost for ULBs/state management	10%		5955020	6201321	6511387	6836956	7178804	32683489
Net			65505220	68214531	71625258	75206520	78966846	359518375
State level co for management, training and monitoring	10%		6550522	6821453	7162526	7520652	7896685	35951838
Total Programme Cost			**72055742**	**75035984**	**78787783**	**82727172**	**86863531**	**395470213**

The urban health centre cost would about Rs 2.6 lakhs per year. This excludes infrastructure costs though it includes rental costs. Approx two ANM @ Rs 5,000 per ANM per month, Rs 30,000 package for minor equipments and training, a Rs 50,000 per year for infrastructure repairs or rent and incidents. Redeployment of existing staff would be able to cover the cost of the third ANM and male attendant and where needed state will fill the gap. The part time medical office if utilized then Rs 5000per month or Rs 60,000 per year will be paid.

The social insurance premium payments are estimates for a pilot programme. To understand which this has to been along with the Mitan kendra PPP proposal. And the urban RCH proposal annexed. In the pilot phase it is proposed to cover 33,333 houses in category A Urban areas, 13,333 households in category B urban areas, 6667 households in cateory C towns and , 3333 housenols in category D towns. Of these houses appox 10% would have 100% premium paid by the govt (category III) while another 30% would have 50% premium paid by the govt and the remaining 60% are voluntarily recruited in. This budget is needed only on the assumption that 60% do not voluntarily or mandatory join the schemewith full payment. If on the other hand they join then from the next year onwards no further subsidy is needed as it would be self sustaining. However since the first year we are taking up about one sixth of the estimated urban poor population- it would be useful to have a similar sum available to expand the programme to more and more urban areas each year. The state level mangement cost is high as this is a very experimental approach and it is going to require considerable management inputs- both consultants and regular to make it viable. For mote details see correspondng section and the Urban RCH proposal.

Section 7.2.6 Tribal RCH

Head	Unit Cost	Nos.	2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
Training,PPP,NGO Programmes, BCC			in respective sections					
Epidemiologic studies	1,500,000	8	60,00,000	60,00,000				12000000
Regional Training Centre at Jagdalpur and Ambikapur	See below in 7.2.6.1.		13800000	25,38,000	53,29,800	5596290	5876105	33140195
Total			198,00,000	85,38,000	53,29,800	55,96,290	58,76,105	45140195

Sub table 7.2.6.1. Regional Training Centres for Tribal Areas :

Sl	Head	Descriptions	2005-06					
A	Non Recurring Exp.							
1	Building, Furniture & Fixtures	Refurbish existing centre at Bilaspur- Rs. 5 lakhs	500000					
		For establishing 2 more centres in Jagdalpur and Sarguja: Rs. 50 lakhs each	10000000					
2	Equipments	Computers-2;Printers-1 Photocopier-1 Projectors,Sound Systems & Accessories Rs. 6,00,000/ centre*3	1800000					
3	Vehicles	1 vehicle each for a centre. 3*5,00,000	1500000					
A	Total		13800000					
B	Recurring Exp.		2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
1	Salaries							
	1 Principal	1*Rs15000*12months*1 *3 RTCs		270000	567000	595350	625118	2057468
	3 Expert Faculties	3*Rs 10000*12 months*3 RTCs		540000	1134000	1190700	1250235	4114935
	6 Trainers	6*Rs 8000*12 months*3 RTCs		864000	1814400	1905120	2000376	6583896
	1 Data Entry Operator/ assistant	1*Rs 4000*12 months* 3 RTCs		72000	151200	158760	166698	548658
	1 Driver	1*Rs 4000*12 months *3 RTCs		72000	151200	158760	166698	548658
2	POL	1 vehicle*Rs5000*12 months*3 RTCs		90000	189000	198450	208373	685823
3	Workshops& material Prodn.	Lumpsum 3 lakhs * 3 RTCs		450000	945000	992250	1041863	3429113
3	Office Expenditures and Comtingencies	10,000*12 months*3 RTCs		180000	378000	396900	416745	1371645
	Total		13800000	2538000	5329800	5596290	5876105	33140195

(Note: In 2005 –06 and first 6 mnths of 2006-07 since building is under construction no running costs are shown. From second half of 2006-07, running costs- salaries, actvities, travel are budgetted for).

Section 8. Programme Management Arrangements

8.1. Building up skills and manpower in State Health Society and Directorate

Non Recurring Exp.								
1	Office set up and furnishing	Lump sum	1000000					
2	Computers, Photocopier & Accessories	Computers-11 Printers-3 Networking Photocopier-1& Accessories	1100000					
3	Vehicles	8 Vehicles (4 for Advisors and 4 for Deputy Directors on secondment)	6400000					
A	Total		8500000					
B	Recurring Exp.							
4	Salaries		2005-06	2006-07	2007-08	2008-09	2009-010	Total
	4 Advisors	4*Rs 30000*12months	1440000	1512000	1587600	1666980	1750329	7956909
	2 Fin. consultants	2*25000*12 months	600000	630000	661500	694575	729304	3315379
	8 Drivers	8*4000*12 months	384000	403200	423360	444528	466754	2121842
	3 Staff for Data Entry & analysis, and assistance	3*4000*12months	144000	151200	158760	166698	175033	795691
5	POL	8 vehicles*10000*12 months	960000	1008000	1058400	1111320	1166886	5304606
6	Printing& Stationary	Lumpsum	400000	420000	441000	463050	486203	2210253
6	Office Expenditures and contingencies	90000*12 months	1080000	1134000	1190700	1250235	1312747	5967682
B		Total	13508000	5258400	5521320	5797386	6087255	36172361

Section 8.2 Building Management Capability at the Directorate and in the Districts

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-010	Total
1	Fees for 3 months Management course for health administrators 250 HAs	**50/year** @Rs. 10000	500000	525000	551250	578813	607753	2762816
	Logistics for Training 250HAs	**50/year** @400*90 days	1800000	1800000	1800000	1800000	1800000	9000000
2	Higher level health management course for state level officials 25 SHAs	**5/year** @40000	200000	210000	220500	231525	243101	1105126
3	State Level Monitoring and Coordination	Lumpsum 500000	100000	100000	100000	100000	100000	500000
		Grand Total	**2600000**	**2635000**	**2671750**	**2710338**	**2750854**	**13367942**

Section 8.4. District Level Planning and Management Capacity

A	Non Recurring Exp.							
1	Untied grants for setting up office buying equipments etc @ 100000 per district	@ 100000 per district	100000	0	0	0	0	100000
A	Total							
B	Recurring Exp		2005-06	2006-07	2007-08	2008-09	2009-010	Total cost
1	Programme Associates	1*8000*12months	96000	100800	105840	111132	116689	530461
2	Fin./Accounting Assistants	1*8000*12months	96000	100800	105840	111132	116689	530461
3	Logistics for Contact Training	25HAs@400*15days	150000	157500	165375	173644	182326	828845
4	Untied Grants for Mobility for supporting block teams	15000*12 months	180000	189000	198450	208373	218791	994614
5	Monitoring and coordination expenses	Lump Sum	28000	29400	30870	32414	34034	154718
Total per district			550000	577500	606375	636693	668528	3039097
Total for 16 District			10400000	9240000	9702000	10187100	10696455	50225555

Section 8.3 Operationalizing the State Institute of Health and Family Welfare

Sl	Head	Descriptions	2005-06
A	Non Recurring Exp.		
1	Furniture & Fixtures		1400000
2	Equipments	Computers-15 Printers-3 Networking Photocopier-1 Projectors Sound Systems & Accessories	4500000
3	Vehicles	3 Vehicles(2 four wheeler and 1 mini 6 wheeler- 1 for Director and 1 for rest of senior staff, 6 wheeler for field trips)	2600000
	Total		8500000

Recurring Exp.								
B	Perticulars		2005-06	2006-07	2007-08	2008-09	2009-010	Total
	1 Director	1*50000*12months	600000	630000	661500	694575	729304	3315379
	5 Expert Faculties	5*30000*12 months	1800000	1890000	1984500	2083725	2187911	9946136
	1 Research & Publication Officer	1*20000*12 months	240000	252000	264600	277830	291722	1326152
	1 Illustrator cum Graphic Artist	1*15000*12 months	180000	189000	198450	208373	218791	994614
	1 Librarian cum Documentation officer	1*10000*12 months	120000	126000	132300	138915	145861	663076
	1 Lab Assistant	1*5000*12 months	60000	63000	66150	69458	72930	331538
	3 Data Entry Operators/Statistical assistants	3*4000*12 months	144000	151200	158760	166698	175033	795691
	1 Registrar	1*15000*12 months	180000	189000	198450	208373	218791	994614
	1 Accountant	1*10000*12 months	120000	126000	132300	138915	145861	663076
	1 Residential officer and Premises manager	1*8000*12 months	72000	75600	79380	83349	87516	397845
	3 Drivers	3*4000*12 months	144000	151200	158760	166698	175033	795691
	5 supporting staff	5*3000*12 months	180000	189000	198450	208373	218791	994614
2	POL	3 vehicles*10000*12 months	360000	378000	396900	416745	437582	1989227
3	Preparatory Workshopsand material Production	Lumpsum	900000	945000	992250	1041863	1093956	4973068
3	Office Expenditures and Comtingencies	@75000*12	900000	945000	992250	1041863	1093956	4973068
	Total		14500000	6300000	6615000	6945750	7293038	41653788

Section 8.5 Strengthening SHRC

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2009-10	Total
A	**Recurring Exp.**							
1	Salaries							
	1 Director	1*50000*12months	600000	630000	661500	694575	729304	3315379
	3 Programme Corrdinators	3*30000*12 months	1080000	1134000	1190700	1250235	1312747	5967682
	3 Programme Associates	3*15000*12 months	540000	567000	595350	625118	656373	2983841
	1 Research Assistant	@6000*12 months	72000	75600	79380	83349	87516	397845
	1 Accounts Manager	@10000*12 months	120000	126000	132300	138915	145861	663076
	1 Accountant	@8000*12 months	96000	100800	105840	111132	116689	530461
	1 Office Assistant	@5000*12months	60000	63000	66150	69458	72930	331538
2	Review and Planning Workshops and core publications of annual reports and studies	Lumpsum	500000	525000	551250	578813	607753	2762816
3	Tour & Travel	30000*12 months	360000	378000	396900	416745	437582	1989227
4	Office Expenditures and Contingencies	47500*12	570000	598500	628425	659846	692839	3149610
B		**Total**	**3998000**	**4197900**	**4407795**	**4628185**	**4859594**	**22091474**

Section 8.6 Computerised Health Management Information Systems with outreach upto block level.

Sl	Head	Description	2005-06					
A	Computers and Peripherals @50000							
1	For All District Head Quarters	16*3*50000	2400000					
	For 50 Blocks in first year	50*1*50000	2500000					
	For remaining 96 blocks in next year	96*1*50000	4800000					
	Smart cards for all MPWs (depending upon the availability of reliable technology)	@1500						
2	For 50 blocks in first year	4000*1500	6000000					
	For remaining 96 blocks in second year	5000*1500	7500000					
			23200000					
B	Recurring Exp.		2005-06	2006-07	2007-08	2008-09	2009-10	Total
	162 Data entry operators	162*3000*12 months	5832000	6123600	6429780	6751269	7088832	32225481
	Training of Officials and DEOs	1*200000*16 dists	3200000	3360000	3528000	3704400	3889620	17682020
	Repair & Maintenance	1*100000*16	1600000	1680000	1764000	1852200	1944810	8841010
	Insurance Coverage for electronic equipments	@.5 % of total price per annum	116000	121800	127890	134285	140999	640973
	Maintenance of equipments	162*Rs2500 per centre	405000	425250	446513	468838	492280	2237881
	Transportation	162*5000 per centre	810000	850500	893025	937676	984560	4475761
	State level monitoring and coordination	Lump Sum @100000*12 months	1200000	1260000	1323000	1389150	1458608	6630758
	Total Recurring Costs for whole state per annum		13163000	13821150	14512208	15237818	15999709	72733884
	Recurring cost For First Year 40% of estimate		5265200	5528460	5804883	6095127	6399884	29093554
	Total per year		18428200	19349610	20317091	21332945	22399592	101827438
	Grand Total		**41628200**	**19349610**	**20317091**	**21332945**	**22399592**	**125027438**

Section 8.7 Improving Financial Management

Sl	Head	Descriptions	2005-06	2006-07	2007-08	2008-09	2008-10	Total
	Recurring Exp.							
1	Honarariums/ Fees							
	Annual Contract to a Senior Chartered Accountant firm as financial management unit	@30000*12 months including compiling accounts and preparing statements assistance in financial planning and management contingencies etc.	360000	378000	396900	416745	437582	1989227
	4 Consultant Trainers (MBA/CA) for district level training	4* 60 days * 1000 per day	240000					
	Tour & Travel for trainers	4 persons*20000 Rs lumpsum	80000					
	Training cost for 162 Dist/Block level Finance persons	162*250 per head per day * 8 days. (incl. travel food stationary and material costs)	324000					
	Total per year		**1004000**	**378000**	**396900**	**416745**	**437582**	**2633227**

Budget Summary:

Sl.	Programme Implementation Plan Component	2005-06	2006-07	2007-08	2008-09	2009-010	Total	Section
1	Building adequate infrastructure for ensuring RCH services at appropriate levels.	**607750000**	**1067347500**	**667839375**	**468733050**	**385315481**	**3196985406**	7.3.1
2	Training Infrastructure	31200000	3392000	7123200	7479360	7853328	57047888	7.3.2.1
	Training of paramedicals	11500000	12075000	12678750	13312688	13978322	63544759	7.3.2.2
	Training on adolescent health & STIs	3510000	3685500				7195500	7.3.2.2
	Training of medical officers-CME	5000000	5250000	5512500	5788125	6077531	27628156	7.3.2.2
	Multiskilling medical officers	4427500	4648875	4881319	5125385	5381654	24458733	7.3.2.2
	Training for ISM staff	7500000	7635000	2507925	2548321	2590737	22781984	7.3.2.2
	Total Training	**63137500**	**36686375**	**32703694**	**34253879**	**35881572**	**202663020**	
3	Ensuring Quality of care in FRUs and 24 hour PHCs.	28204000	29383200	30852360	32394978	34014727	154849265	7.3.3
4..	Strengthening Routine Sub-Centre services.	24000000	25200000	26460000	27783000	29172150	132615150	7.3.4
5	Social Marketing for Family Planning Service	324000	340200	357210	375071	393824	1790305	
6	Public Private Partnerships in Obstetric care	85614000	89894700	94389435	99108907	104064352	473071394	7.3.5
	PPP in Referral transport /Ambulance Services	50000000	21000000	22050000	23152500	24310125	140512625	7.3.5
	PPP in Laboratory Service	4000000	8000000				12000000	7.3.5
	TOTAL on Public Private Partnerships	**139614000**	**118894700**	**116439435**	**122261407**	**128374477**	**625584019**	

	PIP Component	2005-06	2006-07	2007-08	2008-09	2009-010	Total	Section
	NGO participation in service delivery	20000000	21000000	22050000	23152500	24310125	110512625	7.3.6
	Community Level Care (Mitanin)	196888300	206732715	217069351	227922818	239318960	1087932144	7.3.7.1
	CHV/Mitanin drug kit	120000000	113400000	119070000	125023500	131274675	608768175	7.3.7.2
10	Behaviour Change Communication.	20000000	21000000	22050000	23152500	24310125	110512625	7.3.8
11	Panchayat Capability Building & Intersectoral Coordination	44105000	45580250	47129263	48755726	50463512	236033751	7.3.9
	Adolescent Health	18030000	29431500	30903075	32448229	34070640	144883444	7.2.4
	Urban Health	72055742	75035984	78787783	82727172	86863531	395470213	7.2.5
14	Tribal Health (mostlyincluded in other sections esp in training section)	19800000	8538000	5329800	5596290	5876105	45140195	7.2.6
15	Strengthening state health society and directorate.	13508000	5258400	5521320	5797386	6087255	36172361	8.1
	Building Management capacity at the Directorate and in the District	2600000	2635000	2671750	2710338	2750854	13367942	8.2
17	Strengthening district health societies.	10400000	9240000	9702000	10187100	10696455	50225555	8.4
18	Strengthening State Institute of Health and Family Welfare.	14500000	6300000	6615000	6945750	7293038	41653788	8.3
	Strengthening SHRC.	3998000	4197900	4407795	4628185	4859594	22091474	8.5
	HMIS	41628200	19349610	20317091	21332945	22399592	125027438	8.6
	Financial Management Improvement	1004000	378000	396900	416745	437582	2633227	8.7
	Total	**1461546742**	**1845929334**	**1466673202**	**1306598569**	**1264164274**	**7344912121**	