DISTRICT HEALTH ACTION PLAN

F. Y. 2009-2010

DISTRICT ARWAL

NATIONAL RURAL HEALTH MISSION

DISTRICT HEALTH SOCIETY, ARWAL

GOVERNMENT OF BIHAR

Preface

It is our pleasure to present the Arwal District Health Action Plan for the year 2009-10. The District Health Action Plan seeks to set goals and objective for the district health system and delineate implementing processes in the present context of gaps and opportunities for the Arwal district health team.

National Rural Health Mission was introduced to undertake architectural corrections in the public Health System of India. District health action plan is an integral aspect of National Rural Health Mission. District Health Action Plans are critical for achieving decentralisation, interdepartmental convergence, capacity building of health system and most importantly facilitating people's participation in the health system's programmes. District health Action planning provides opportunity and space to creatively design and utilise various NRHM initiatives such as flexi –financing, Rogi Kalyan Samiti, Village Health and Sanitation Committee to achieve our goals in the socio-cultural context of Arwal.

I am very glad to share that all the BHMs and MOIC of the district along with key district level functionaries participated in the planning process. The plan is a result of collective knowledge and insights of each of the district health system functionary. We are sure that the plan will set a definite direction and give us an impetus to embark on our mission.

Acknowledgements

This District Health Action plan prepared Under a Short & Hard Process of about survey of one month and this was a good Opportunity to revisit the situation of health services status and national programs in district as well as to have a positive dialogue with departments like Public Health Engineering, Women and Child Development, Maternal and Child Health care etc.

This document is an outcome of a collective effort by a number of individuals, related to our institutions and programmed:-

- ***Shri Bimlanand Jha,*** Chairman of District Health Society, Arwal was a source of inspiration towards this effort vide his inputs to this process during D.H.S review meetings.

- ***Dr. Manjul Kumar (A.C.M.O)*** Nodal officer for this action plan who always supported this endeavor through her guiding words and language.

- **Mr. Anup Kumar**, District Programme Manager was in charge for this development of the *DISTRICT HEALTH ACTION PLAN*.

- All district level Programme officer for various Health Programmes, B.H.Ms, M.O.I/Cs, PHCs, Field Office Staff have supported with their full participations,cooperation and learning spirit through out this process.

- Special Thanks to **Mr. Lalan Kumar Singh.** BHM Arwal & **Mr. Harendra Kumar** Acoountant, PHC Karpi whose helps to make District Health Action Plan.

I on behalf of the District Health Society, Arwal acknowledge the grateful contribution of all those mentioned above.

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Dr. Serajul Haque

Civil Surgeon-cum-member secretary,

District Health Society, Arwal**.**

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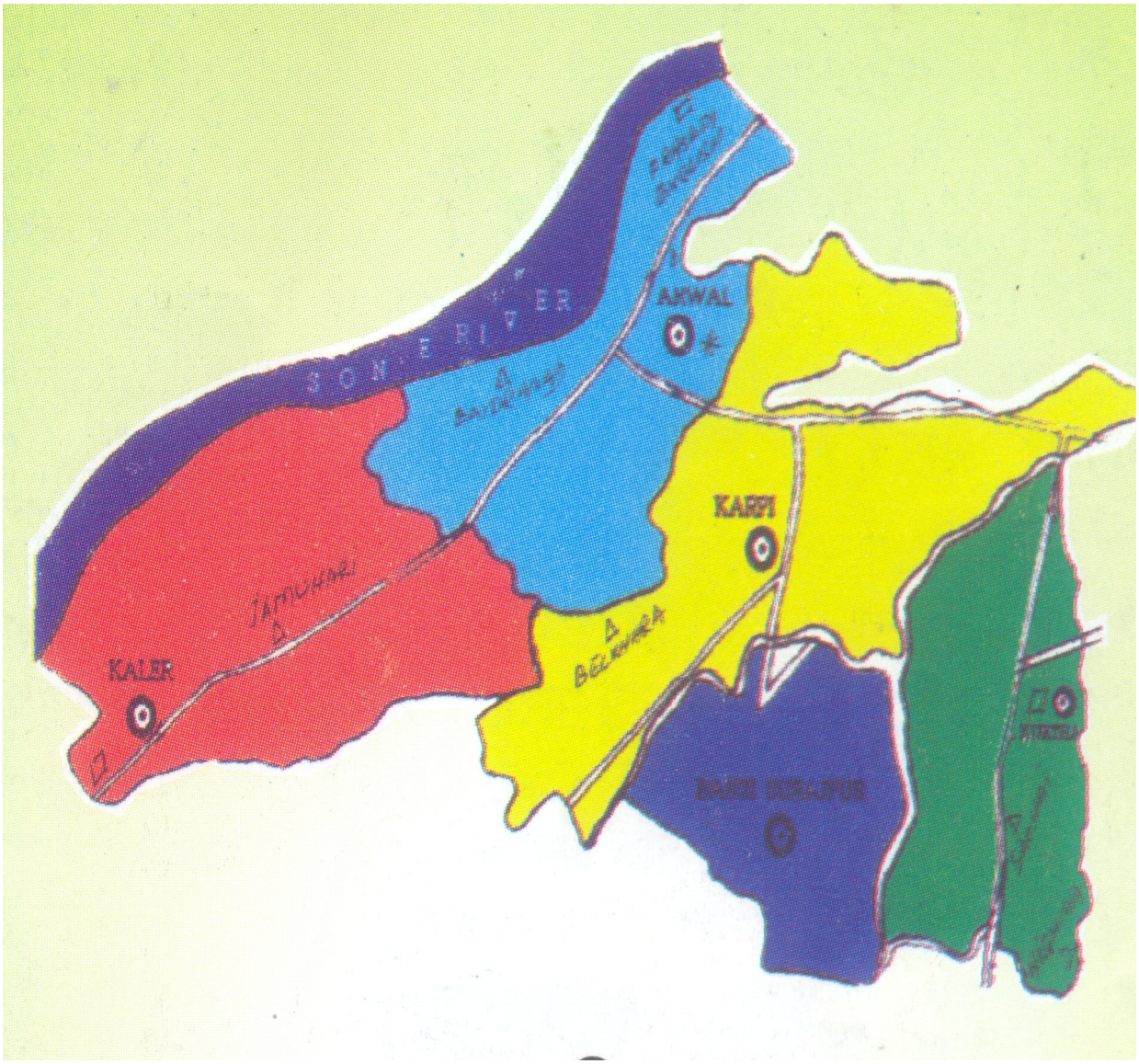
Introduction

The **National Rural Health Mission** (NRHM) is a comprehensive health programme launched by Government of India to bring about architectural corrections in the health care delivery systems of India. The NRHM seeks to address existing gaps in the national public health system by introducing innovation, community orientation and decentralisation. The mission aims to provide quality health care services to all sections of society, especially for those residing in rural areas, women and children, by increasing the resources available for the public health system, optimising and synergising human resources, reducing regional imbalances in the health infrastructure, decentralisation and district level management of the health programmes and community participation as well as ownership of the health initiatives. The mission in its approach links various determinants such as nutrition, water and sanitation to improve health outcomes of rural India.

The NRHM regards district level health planning as a significant step towards achieving a decentralised, pro-poor and efficient public health system. District level health planning and management facilitate improvement of health systems by 1) addressing the local needs and specificities 2) enabling decentralisation and public participation and 3) facilitating interdepartmental convergence at the district level. Rather than funds being allocated to the States for implementation of the programmes developed at the central government level, NRHM advises states to prepare their perspective and annual plans based on the district health plans developed by each district.

The concept of DHAP recognises the wide variety and diversity of health needs and interventions across the districts. Thus it internalises structural and social diversities such as degree of urbanisation, endemic diseases, cropping patterns, seasonal migration trends, and the presence of private health sector in the planning and management of public health systems. One area requiring major reforms is the coordination between various departments and vertical programmes affecting determinants of health. DHAP seeks to achieve pooling of financial and human resources allotted through various central and state programmes by bringing in a convergent and comprehensive action plan at the district level.

Profile of Arwal District



MAP OF ARWAL DISTRICT

DISTRICT AT A GLANCE

History

Arwal district is one of the thirty-eight districts of Bihar state, India, and Arwal town is the administrative headquarters of this district. It was earlier part of Jehanabad district. Arwal has a population of 589476. It's headquarter is situated at Arwal which is approximately 80 km south from the state capital Patna. Arwal town is situated on the right side bank of the Sone river, which is a tributary to the river Sone.

Geography

Latitude. - 25.25°, Longitude. - 84.6833333°

Timezone of Arwal is Asia/Calcutta

Arwal district is one of the thirty-seven districts of Bihar state, India, and Arwal town is the administrative headquarters of this district. It was earlier part of Jehanabad District. Arwal has a population of 589476. The five block divisions are Arwal, Kaler, Karpi, Kurtha and Sonbhadra bansi Suryapur. Paddy, wheat and maize are the main crops.Nearest airport is at Patna and railway station is at Jehanabad. By road, Arwal is linked with Jehanabad, Patna and Aurangabad .It's headquarter is situated at Arwal which is approximately 80 KMs south from the state capital Patna & NH 98. Arwal town is situated on the right side bank of the river Sone which is a tributary to the river of Ganga.

Language

The language spoken here is “MAGADHI”,locally called MAGAHI a dialect of Hindi.

Communication

Arwal is situated 80 km south of Patna. The nearest airport is at Patna from where regular flights are available to all important towns and cities across the country. The nearest railway station is located at Jehanabad. By road, Arwal is efficiently linked with Jehanabad, Patna and Bhojpur

Agriculture

Arwal district is a predominantly agricultural district. The soil is highly fertile. This district is densely populated. Paddy, wheat, maize and pulses are the main agricultural crops raised by farmers in the district. Cane is also grown in some parts of the district.

Socio-Economic :

The relatively small sized district is a cauldron of conflict as far as the socio-economic situation is concerned. There were extreme caste tensions (with an economic bearing) prevailing in the whole Magadh area (old Gaya district - now broken into 5 districts of Gaya, Aurangabad, Nawada, Jehanabad and Arwal) and they were manifested in their worst forms in this district. Thus this place has been badly affected by Naxalism (PWG, MCC, ML(Lib) etc.) and has seen the emergence of rival outfits such as Ranvir Sena.

In the result this district has witnessed horrifying spate of large scale carnages in the past which has resulted in the killing of hundreds of innocents. Laxmanpur-Baathe, Rampur-Chauram, Senari, & Shankarbigha - there is a long list of villages where big massacres have occurred

Industrial Area

There is no any industry in this area .The agriculter is the main source of income in this area.

climate

The climate of Arwal is of extreme nature, i.e. very hot in the summers and biting cold in the winters.

Land Utilization

The total land available in the district is 195966.08 acres. Forest coverage is very small. The net shown area available for cultivation is 129166.39 acres, which is 65.91% of the total available land.

Administration Structure

There is one sub-division and Five blocks in this district.

Table 1: Arwal District at a Glance

Total Area	642.47 K.M
Population in thousands	**589**
Rural Population	**589476**
Urban Population	**0**
Population density	**918 per sq km**
Number of sub-divisions	**1**
Number of blocks	**5**
Total no. of Panchayats	**68**
Number of villages	**335**
Sex Ratio	**935**
Percent of urban population	**0**
Percent of SC population	**18.91**
Percent of ST population	**0.4**
Female literacy	**15%**
Male literacy	**29.5%**
Total literacy	**45%**
NGO Hospitals and centres undertaking RI with government vaccines	**0**
Total Number of Anganwadi centres	**669**

Summary of DHAP process in Arwal

The District Health Action Plan of Arwal has been prepared under the guidance of the Chief Medical Officer and the Additional Chief Medical Officer of Arwal with a joint effort of the District Health Educator, the BMOs and various M.O-PHCs as well as other concerned departments under a participatory process. The field staff of the department have also played a significant role. Public Health Resource Network has provided technical assistance in estimation and drafting of various components of this plan.

Summary Of The Planning Process
Training of district team for preparation of DHAP
Preliminary meeting with CMO and ACMO along with other concerned officials
Data Collection for Situational Analysis - MOIC and BHM meeting chaired by DM and CMO/CS
Block level consultations with MOICs and BHMs
Writing of situation analysis
District Planning workshop to review situation analysis and prepare outline of district health plan- the meeting was chaired by CMO and facilitated by DIO. The workshop was attended by MOICs, BHMs and other key health functionaries at the district level.
District Consultations for preparation of 1st Draft
Preliminary appraisal of Draft
Final Appraisal
Final DHAP: Submission to DHS and State
Adoption by DHS and Zila Parishad
Printing and Dissemination

Health profile of Arwal District

Arwal has shown consistent improvement in some of the key health indicators across the years. Still the overall situation of the district leaves much to be desired. According to a survey by International Institute of Population Sciences conducted in 2006, from a total of 593 districts of India Arwal ranks 386for Under 5 mortality rate. It ranks 328th for women receiving three ANC visits. It ranks 245th on the basis of Contraceptive prevalence rate. The key RCH and other health indicators of the district are as follows:

Table 2 : Arwal Health Profile

Key population indicators	Infant Mortality rate	**62**		
	Maternal mortality rate	**371**		
	Crude birth rate	**28.6**		
	Death rate	**8.1**		
District Level Household & Facility Survey			**DLHS 2 (02-04)**	**Bihar DLHS 3**
Key RCH Indicators (in percentages)	Girls marrying below 18 yrs.		**60.4**	**46.2**
	Birth order 3+			
	Current use of any FP method			**32.4**
	Total unmet need			**37.2**
	Pregnant women who registered in the first trimester		**33.6**	
	Pregnant women with 3 + ANC		**20**	**26.4**
	Pregnant women receive at least 1 TT injections		**89**	**58.4**
	Delivery assisted by a skilled attendant at home		**20**	**5.9**
	Institutional births		**42.6**	**27.7**
	Children with full immunization		**16.8**	**41.4**
	Children with Diarrhoea treated within last two weeks who received treatment		**86**	**73.7**
	Children with Acute Respiratory infections in the last two weeks who were given treatment		**0**	**73.4**
	Children who had check up within 24 hours after delivery		**98**	**75**
	Children who had check up within 10 days of delivery		**78**	**85**
Communicable diseases (percent)	Kala Azar prevalence		**0**	**0**
	TB incidence		**1.2**	**1.1**
	HIV prevalence among STD clinics		**1.2**	**4**
	HIV prevalence among ANC clinics		**0**	**0**

1. Health Facilities in Arwal District

Arwal district has a total of 05 Primary Health Centres (PHCs), 26 Additional Primary Health Centres (APHCs) and 64 Health Subcentres (HSCs). The district has two Referral Hospitals located at Kurtha and Karpi under proposed. One Sadar hospital is under construction at arwal. The planning team for the DHAP undertook a comprehensive mapping and situational analysis of these health facilities in terms of infrastructure, human resources and service delivery.

2. Human Resources for Health in Arwal

Arwal currently has 67 regular doctors sanctioned out of which 18 are present. Similarly 20 contractual positions are sanctioned for doctors against which only 13 are posted. So the total number of doctors present in the district is 31 against the total sanction of 87.

Table 3: Details of Existing Human Resource

Specialisation	Regular	Contract
MD (physician)	1	0
Surgery	2	0
Gynaecologist	0	0
Paediatrician	1	0
Orthopaedics	0	0
Ophthalmologists	0	0
Pathology	0	0
ENT	0	0
Radiologist	0	0
Bio-chemistry	0	0
Physiology	0	0
Anaesthetist		0
Total	**4**	**0**

There are a total of 4 specialist doctors in the district and no any specialist lady doctors. The district also has 2 MBBS lady doctors.

Staff Nurses, Lady Health Visitors (LHVs) and Auxiliary Nurse Midwives (ANMs)

The total number of positions sanctioned under this category is 223. Currently 10 Grade 'A' nurses are posted across APHCS in the district..

06 positions for LHVs are sanctioned out of which 3 are in position and 3 are vacant. For regular ANMs 87 positions are sanctioned and 58 are in position whereas 29 posts of ANMs are vacant in the district. 64 positions for contractual ANM® and 14 contractual ANM are sanctioned where as 33 ANM® and 11 contractual ANM are posted. All the contractual ANMs are posted at the Sub centre level.

Situation Analysis of Health Facilities

The three tiers of the Indian public health system, namely village level **Sub centre, Additional Primary Health Centre and Primary Health Centres** were closely studied for the district of Arwal on the basis of three crucial parameters:

1) Infrastructure
2) Human resources and
3) Services offered at each health facility of the district.

The Indian Public Health System (IPHS) norms define that a Village **Health Sub centre** should be present at the level of 5000 population in the plain regions and at 2500-3000 population in the hilly and tribal regions. As most of the Arwal is situated in the plain terrain, the norm of Sub centre per 5000 population is expected to be followed. A sub centre is supposed to have its own building with a small OPD area and an exam room.. Sub centres are served by an ANM, Lady Health Volunteer and Male Multipurpose Health Worker and supported by the Medical Officer at the APHC. Sub centres primarily provide community based outreach services such as immunisation, antenatal care services (ANC), perinatal and post natal care, management of mal nutrition, common childhood diseases and family planning. It provides drugs for minor ailments such as ARI, diarrhoea, fever, worm infection etc. The Sub centre building is expected to have provisions for a labour room, a clinic room, an examination room, waiting area and toilet. It is expected to be furnished with essential equipment and drugs for conducting normal deliveries and providing immunisation and contraceptive services. In addition equipment for first aid and emergency care, water quality testing and blood smear collection is also expected to be available.

The **Primary Health Centre (PHC)** is required to be present at the level of 30,000 population in the plain terrain and at the level of 20,000 populations in the hilly region. A PHC is a six bedded hospital with an operation room, labour room and an area for outpatient services. The PHC provides a wide range of preventive, promotive and clinical services. The essential services provided by the PHC include attending to outpatients, reproductive and child health services including ANC check-ups, laboratory testing during pregnancy, conducting normal deliveries, nutrition and health counselling, identification and management of high risk pregnancies and providing essential newborn care such as neonatal resuscitation and management of neonatal hypothermia and jaundice. It provides routine immunisation services and tends to other common childhood diseases. It also provides 24 hour emergency services, referral and inpatient services. The PHC is headed by an MOIC and served by two doctors. According to the IPHS norms every 24 *7 PHC is supposed to have three full time nurses accompanied by 1 lady health worker and 1 male multipurpose worker. NRHM stipulates that PHCsshould have a Block Health Manager, Accountant, storekeeper and a pharmacist/dresser to support the core staff.

According to the IPHS norms, a **Community Health Centre** (CHC) is based at one lakh twenty thousand population in the plain areas and at eighty thousand population for the hilly and tribal regions. The Community Health Centre is a 30 bedded health facility providing specialised care in medicine, obstetrics & gynaecology, surgery, anaesthesia and paediatrics. IPHS envisage CHC as an institution providing expert and emergency medical care to the community.

In Bihar, CHCs are absent and PHCs serve at the population of one lakh while APHCs are formed to serve at the population level of 30,000. The absence of CHC and the specialised health care it offers has put a heavy toll on PHCs as well as district and sub district hospitals. Moreover various emergency and expert services provided by CHC cannot be performed by PHC due to non availability of specialised services and human resources. This situation has led to negative outcomes for the overall health situation of the state.

1. Situation Analysis: Health Sub centre level Infrastructure

Table 4: Sub centre Data

Name of Block	Total Population	Total requirement as per District Database	PRESENT (functional)	ALREADY PROPOSED	Further requirement based on District Database
1. Arwal	151916	31	8	7	16
2. Kurtha	118686	25	11	7	7
3. Karpi	190060	42	17	8	17
3. Kaler	151530	30	16	2	12
4. Sonevadra Vansi suryapur	73469	15	12	3	0
Total	685661	143	64	27	52

Table No. 1 presents the additional requirements of Sub centres as per population norms mandated by IPHS as well as according to the database available with District Health Society Arwal. As per IPHS norms, Arwal district requires a total of 143 Sub centres of which 64 are present in the district. 27 are proposed. Thus, what is required is to make functional all of the already proposed Sub centres.

2. Situation Analysis: Health Sub centre level Infrastructure and Human Resource (Detailed)

Table 4 Sub centre Details

	1. Arwal	2. Kurtha	3. Karpi	4. Kaler	5. Sonevadra vansi suryapur	6 Total
Total Number of Sub centres	8	11	17	16	12	64
ANM sanctioned post	16	22	34	32	24	128
ANMs regular	5	6	16	11	5	43
ANMs contract+anm®	8	5	11	12	8	44
ANM residing at HSC	1	3	3	2	0	9
Residential facility for ANM required	7	8	14	14	12	55
HSC in Govt building	1	3	3	2	0	9
HSC in Panchayat building	0	0	0	0	0	0
HSC in rented Building	7	8	14	14	12	55
HSC building under construction	1	3	2	2	1	9
Building required	6	5	12	12	11	46
Running water supply available	0	0	0	0	0	0
Water supply required	8	11	17	16	12	64
Cont. power Supply	0	0	0	0	0	0
Power supply required	8	11	17	16	12	64

Tables 4 present a comprehensive picture of human resources and facilities available at the Sub centre level. At the Sub centre level infrastructure poses major constraints. The analysis reveals that of the existing 64 HSCs, only 9 are situated in GOVT. building premises. Out of these 64, 09 are in a Government building and 55 are in rented buildings. Out of the 55 Sub-centers, 09 buildings are under construction. 46 HSCs still do not have any building. The 09 HSCs operating in Govt buildings are currently being renovated. Of the existing 9 HSC with a building, No any HSCs have availability of a running water supply. Certain blocks score especially low on Sub centre infrastructure.

In five blocks from the total 87 ANMs posted are present at the Sub centres. Arwal 13, kurtha 11, karpi 27, Kaler 23, and sonbhadra bansi suryapur 13 ANMs posted at Sub centres. It is apparent from the data that ANMs are not residing at the Sub centre. Out of 64 existing Sub centres, only 9 Sub centres have ANMs residing in the Sub centres area. District reports show that 55 Sub centres currently do not have a residential facility or ANM in Sub centre area and would require the same.

3. Situation Analysis: APHC level Infrastructure

The gaps in the availability of PHC are calculated as per the IPHS norms of one PHC at the level of 30,000 population. However in Bihar, the current state practice is one PHC at one lakh population level. Since the APHCs function at the level of 30,000 population at present in Bihar, the number of present and proposed APHCs is taken into account for the purpose of calculating the overall requirement of PHCs. The matrix also estimates requirement of CHCs in each block. Like Sub centres, the district has also proposed APHCs. A total 10 APHCs are proposed.

Table 5: APHC Infrastructure

Name of Block	APHC Total required	PRESENT	PROPOSED	Further REQUIRED after including PHC
1. Arwal	8	5	3	0
2. KARPI	9	8	1	0
3.KURTHA	5	3	2	0
4. KALER	7	4	3	0
5. SONBHADRA BANSI SURYAPUR	7	6	1	0
Total	**36**	**26**	**10**	**0**

4. Situation Analysis: APHC level infrastructure and Human Resource (Detailed)

In Bihar Additional PHCs operate at the population of 30,000. The APHC is the cornerstone of the public health system since it serves as a first contact point for preventive, curative and promotive health services. It is the first part of the public health system with a full time doctor and provision for inpatient services. There are 26 functional APHCs in Arwal. 10 new APHCs are newly sanctioned. In general the APHCs in Arwal suffer from

1) lack of facilities including availability of building
2) constant power and water shortages

3) unavailability of doctors
4) doctors not residing at the facility
5) insufficient quantities of drugs and equipment
6) lack of capacity to use untied funds.
7) Lack of avaibility of land.

The level of facilities at the APHCs is expected to be similar to that of a PHC. All the blocks of Arwal do not have APHCs. A summarised version of the state of infrastructure facilities is as follows:

Table 6: APHC Infrastructure

		ARWAL	KARPI	KURTHA	KALER	SONBHADRA BANSI SURYAPUR	Total
Name of facility	Total No. of APHC	5	8	3	4	6	26
Building	APHC with Government Building	1	3	3	2	0	9
	APHC in rented building	4	5	0	2	6	17
	APHC in Panchayat Building	0	0	0	0	0	0
	APHC with No Building	4	5	0	2	6	17
	APHC Under construction	1	2	3	2	1	9
Water supply	APHC with assured water supply	0	0	0	0	0	0
Power supply	Continuous Power Supply	0	0	0	0	0	0
	Interminantly available power supply	0	0	0	0	0	0
	No power supply	0	0	0	0	0	0
Toilets	With Toilets	0	0	0	0	0	0
Labour room	With Labour room in good condition	0	0	0	0	0	0
	No Labour Room	0	0	0	0	0	0
Residential facilities	APHC with residential facilities	0	0	0	0	0	0
	APHC with no residential facilities	0	0	0	0	0	0
	MO residing at APHC	0	0	0	0	0	0

Furniture	**Furniture Available**	**1**	**3**	**3**	**3**	**0**	**10**
Ambulance	**Ambulance**	**0**	**0**	**0**	**0**	**0**	**0**

Out of 26 APHCs, 9 are situated in government buildings, & 9 APHC are under construction, where as 17 Adphc are in rented buildings.

APHC Infrastructure

As per Table 3, APHCs suffer from unavailability of buildings and facilities such as water and power supply, availability of functional labour and operation theatre and toilets. No any APHCs have assured running water supply and no APHC has continuous power supply available. Considering that APHCs are expected to provide laboratory services, maintain the cold chain involving equipment such as deep freezers and ILR, 24 hour emergency services and inpatient services, lack of running water and a continuous power supply is a significant constraint. Perhaps the most challenging constraint for the APHCs is the lack of labour rooms. APHCs as the first port of care for obstetrics are required to have a fully functional labour room. In Arwal no any APHCs in the entire district have functional labour rooms. As residential quarters are not available at the facility level, staff does not reside at the APHC. 26 APHCs need quarters for their staff. The staff across the district also reports absence of furniture and the need of major repair work for the furniture.

5. Situation Analysis: APHC Human Resource

The APHC is expected to be staffed by 2 medical officers; preferably at least one woman, 1 pharmacist, 3 staff nurses, 1 Health worker, 2 health assistants,1 clerk ,2 lab technicians, 1 health educator, 1 driver and other Grade 4 staff. In Arwal all 26 APHCs have posts sanctioned for 52 doctors but only 8 doctors are posted in APHCs, 2 from Arwal block, 1 from kaler, 4 from Karpi and 1 from Sonevadra vansi suryapur. 19 APHCs are functional without a medical officer.

APHC Human Resources

Table 7: APHC Human Resource

		ARWAL	KARPI	KURTHA	KALER	SONBHADRAA BANSI SURYAPUR	Total
Total No. of APHC		**5**	**8**	**3**	**4**	**6**	**26**
Doctors	**2 doctors Sanctioned**	**10**	**16**	**6**	**8**	**12**	**52**
	1 doc Sanctioned	**0**	**0**	**0**	**0**	**0**	**0**
	2 doc in Position	**1**	**1**	**0**	**0**	**0**	**2**
	1 doc in postion	**2**	**2**	**0**	**1**	**1**	**6**
	0 doc in postion	**3**	**5**	**3**	**3**	**5**	**19**
ANM	**2 ANMs Sanction**	**10**	**16**	**6**	**8**	**12**	**52**
	2 ANM in position	**1**	**0**	**8**	**3**	**2**	**32**
	1 in position	**1**	**1**	**0**	**0**	**0**	**5**
	0 in position	**0**	**1**	**0**	**0**	**0**	**2**
Laboratory Technician	**Sanctioned**	**2**	**2**	**8**	**2**	**2**	**32**
	in Position	**0**	**0**	**0**	**2**	**0**	**5**
Pharmacist/ Dresser	**Sanction**	**2**	**2**	**8**	**2**	**2**	**38**
	in Position	**0**	**0**	**0**	**0**	**0**	**2**
Nurses	**2 Sanctioned**	**2**	**2**	**8**	**3**	**2**	**22**
	2 in Position	**2**	**1**	**8**	**3**	**2**	**30**
	1 in position	**0**	**1**	**0**		**0**	**5**

		ARWAL	KARPI	KURTHA	KALER	SONBHADRAA BANSI SURYAPUR	Total
Total No. of APHC		**5**	**8**	**3**	**4**	**6**	**26**
	0 in position	**0**	**0**	**0**		**0**	**0**
Accountant	**In position**	**0**	**0**	**0**	**0**	**0**	**0**
Peon	**In position**	**0**	**2**	**7**	**0**	**0**	**9**
Sweeper	**In position**	**0**		**0**	**0**	**0**	**0**
Specialist		**0**	**0**	**0**	**0**	**0**	**0**

6. Situation Analysis: PHC Infrastructure

PHCs fare well in terms of infrastructure as compared to APHC and Health Sub centres. All the PHCs in the district are based out of government buildings. Out of 5 functional PHCs, 3 have functional OT and 3 have functional labour rooms. Yet the condition of the operation theatres and labour rooms needs to be improved in nearly all the PHCs. PHCs such as Kaler and sonbhadra Bansi Suryapur require New buldingto make their Labour Rooms fully operational. Toilets are available in all the PHCs except Kaler & sonbhadra bansi suryapur. PHCs are in better condition in terms of running water supply and continuous availability of power. Out of 5 PHCs, no any PHC have access to running water and all have continuous power supply by outsourced.

The main problem at the PHC level is not the total lack but inadequacy of facilities. As PHC serves 1 lakh twenty thousand population, the level of infrastructure in terms of size of building, number of rooms, and size of wards is clearly inadequate. The gaps arise as the infrastructure was designed to serve 30,000 populations. As a result several PHCs such as Arwal, Karpi, Kurtha are unable to fulfil the demand for inpatient services.

Infrastructure at PHC

A detailed version of status of infrastructure at all the PHCs is as follows:

Table 8: PHC Infrastructure

	ARWAL	KARPI	KURTHA	KALER	SONBHADRA BANSI SURYAPUR
Building	Govt	Govt	Govt	PRIVATE (RENTED)	Govt (APHC BUILDING)
Building Condition	Good but insufficient	Good but insufficient	GOOD	WORK DOING ON	Blank
Running Water Supply	A	NA	NA	NA	NA
Power Supply	A O	AO	AO	AO	NA
Toilets	A but insufficient	A but insufficient	A but insufficient	A but insufficient	A but insufficient
Functional Labour Room	A	A	A	NA	NA
Condition of Labour Room	Require new building	Require new building	A	Require new building	Require new building
Functional OT	A	A	A	NA	NA
Condition of OT	Inadequate	Inadequate	Inadequate	NA	NA
Condition of ward	Inadequate	Require new building	Inadequate	Require new building	Require new building

A - Available; NA- Not available;AO- Avaibility by outsourced

7. Situation Analysis: PHC Human Resources

Arwal, karpi, kurtha, Kaler and sonbhadra bansi suryapur are served by more than 20 doctors in position. Availability of specialists is still a major constraint for the district as only PHCs, Karpi, Arwal and kurtha have specialists in position. The situation regarding number of ANMs at PHC level is not satisfactory since the gap between sanctioned and in position is either absent or very narrow for most of the PHCs. Pharmacists are sanctioned in all the PHCs but are in position only 2 of them. Similarly Store keepers are in position in 5 PHCs but not posted. The biggest gap is in the availability of Staff Nurses. All other PHCs do not yet have nurses sanctioned or in position. District's human resources availability across all the PHCs can be summarised as follows:

Table 9: Human Resources at PHC

		Number of PHCs
Doctors	**Post Sanctioned (Regular + Contact)**	**35**
	Posted (Regular Doctors)	**9**
	Posted (contractual)	**13**
Specialists	**PHCs with 2 specialist**	**4**
ANM	**PHC with Post sanctioned**	**15**
	PHCs with in position ANMs	**11**
Lab tech	**PHCs with lab tech sanctioned**	**5**
	PHCs with lab tech in position	**0**
Pharmacist	**PHCs with at least 1 pharmacist sanctioned**	**5**
	PHCs with at least 1 pharmacist in position	**3**
Store keepers	**Post Sanctioned**	**5**
	Posted	**0**

Availability of Human resources in each PHC can be studied in detail from the following matrix:

Table 10: Human Resource at PHC

Staff Positions		**ARWAL**	**KARPI**	**KURTHA**	**KALER**	**BANSI SONBHADRA SURYAPUR**	**TOTAL**
Doctors	**Sanctioned**	**7**	**7**	**7**	**7**	**7**	**35**
	In position	**6**	**4**	**4**	**4**	**4**	**22**
ANMs	**Sanctioned**	**3**	**3**	**3**	**3**	**3**	**15**
	in Position	**3**	**2**	**3**	**2**	**1**	**11**
Laboratory Technician	**Sanction**	**1**	**1**	**1**	**1**	**1**	**5**
	in Position	**0**	**0**	**0**	**0**	**0**	**0**
Pharmacist/ Dresser	**Sanctioned**	**1**	**1**	**1**	**1**	**1**	**5**

	in Position	0	1	1	0	0	2
Storekeeper	in position	1	1	1	1	1	5
Health Manager	Sanctioned	1	1	1	1	1	5
	in Position	1	1	1	0	0	3
Accountant	Sanctioned	1	1	1	1	1	5
	in Position	1	1	1	1	0	4

8. Situation Analysis: Support Services at PHCs:

Table 11: Support Services at PHC

PHC Services at a Glance	
Total number of PHCs	5
Availability of Ambulance	4
Generator	4
X – Ray	3
Laboratory Services (Pathology)	0
Laboratory Services (Malaria/Kalazaar)	1
Laboratory Services (T.B)	4
Canteen	1
Housekeeping	0
Rogi Kalyan Samiti set up	4
Untied funds received	4
Untied funds utilised	4

Efficiency of PHC apart from infrastructure facilities and human resources depends on various other factors such as availability of transport facilities, x ray services, generator etc. PHC as an in-patient facility also needs to acquire canteen and housekeeping services. PHC provides basic pathological lab services along with lab services for TB, Malaria and kala azar. A detailed analysis of the services available at each PHC of Arwal is given along side.

Table 12: Support Services for PHCs (Detail)

	ARWAL	KARPI	KURTHA	KALER	SONBHADRA BANSI SURYAPUR	TOTAL
Ambulance	**2**	**1**	**1**	**1**	**0**	**5**
Generator	**1**	**1**	**1**	**1**	**0**	**4**
X – Ray	**1**	**1**	**1**	**O**	**0**	**3**
Laboratory Services (Pathology)	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Laboratory Services (Malaria/Kalazaar)	**1**	**NA**	**NA**	**NA**	**NA**	**NA**
Laboratory Services (T.B)	**1**	**1**	**1**	**1**	**0**	**4**
Canteen	**1**	**NA**	**NA**	**NA**	**NA**	**1**
Housekeeping	**0**	**0**	**0**	**0**	**0**	**0**

As per the analysis in Table 12, the Arwal health system requires to focus its attention on support services for PHCs in the district. Transportation facilities are available in all the PHCs All of the places Ambulance services are outsourced. Generator is also outsourced in all the PHCs except Sonbhadra Bansi suryapur. Laboratory services for Pathology, Malaria and Kala Azar are not available in any PHC in the district. Laboratory services for TB are available in 4 PHCs. The analysis highlights the need to invest in laboratory services. Canteen and Housekeeping are also not available in most of the PHC. Canteen is available only at Arwal.

9. Situation Analysis: Sub Divisional Hospital (SDH) and Referral Hospitals (RH)

SDH are under construction and Two Referal Hospital are proposed.

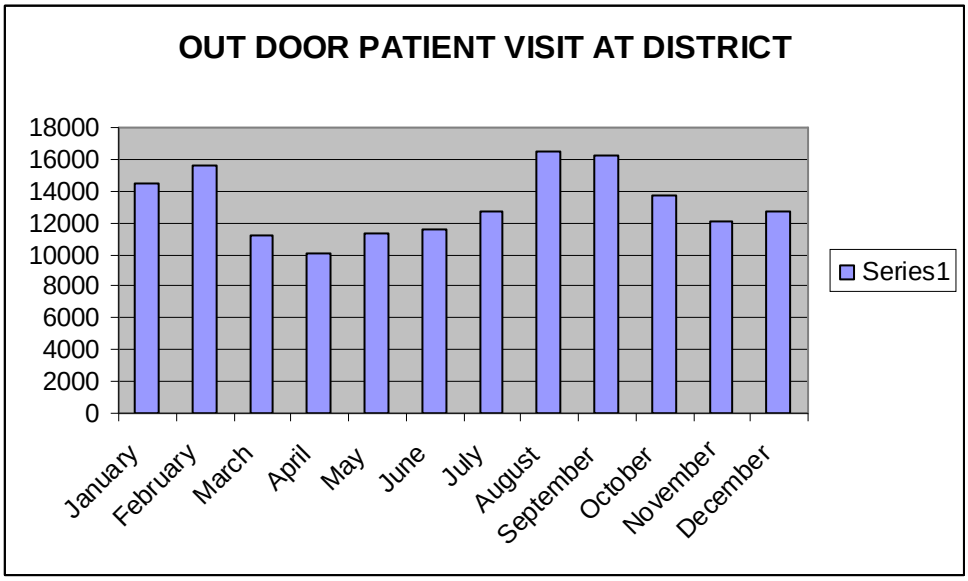
10. Situation Analysis: Service Delivery

The infrastructure, human resources and support services available for the PHCs need to be compared with the work burden of each PHCs. Primary data for outpatient services given in the table below indicates significant work pressure on all the PHCs in the district.

Table 13: Treatment of OPD Patients in PHCs

Name of PHCs/	ARWAL	KARPI	KURTHA	KALER	SONBHADRA BANSI SURYAPUR
JANUARY	2952	3882	3449	2456	695
FEBRUARY	4222	3317	3560	3336	1200
MARCH	4112	1821	2911	2403	0
APRIL	2847	2349	2992	1862	0
MAY	3669	2339	3548	1741	0
JUNE	3848	2264	3581	1866	0
JULY	4124	2098	3656	2647	236
AUGUST	3937	3144	5019	3934	485
SEPTEMBER	3998	3474	4126	4145	497
OCTOBER	3993	2947	3080	2997	654
NOVEMBER	2750	2849	3332	2565	567
DECEMBER	3880	2717	3469	2922	516
TOTAL	44532	33201	42723	32874	4850
AVERAGE	3711	2768	3560	2740	404

According to the available data, on an average, PHC Arwal 3711, Karpi 2768, Kurtha 3560, Kaler 2740 & Sonbhadra bansi suryapur only 404 patients attends in OPD a month. This is certainly huge number in terms of work burden. Total patients attended by all the PHCs in year 2008 are one lakh fifty eight thousand one hundred and eighty.



Graphical representation of number of OPD services offered by all the PHCs in the district over the period of January 2008 to Dec 2008 highlights the seasonal variations in patient's numbers.

Figure 4: OutPatients Treated

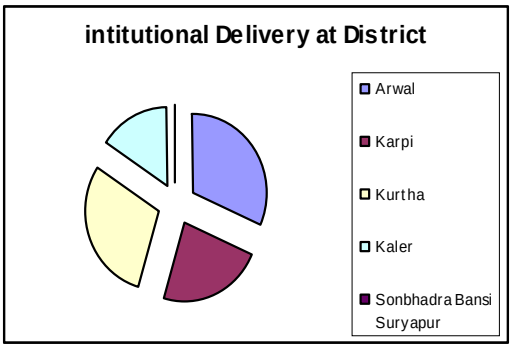
Increase in the work burden in the monsoon months of July to October in both the years is quite evident from the graph. Yet one can also gauge the gravity of the flood situation in 2008 as compared to 2007. The graph also tells us the tragic tale of 2008 floods and the pain and suffering it brought to Arwal. The number of outpatients rocketed to 1,41,242 in September 2008. In July, August and September 2008 the number of outpatients were more than a lakh. This fact highlights the need to integrate flood preparations and emergency planning in the district health plans in terms of increased availability of drugs, equipments, services and human resources.

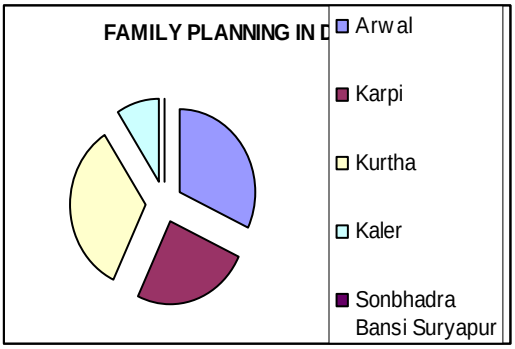
11. Situation Analysis: Reproductive and child health

Salient RCH statistics for the district are given in the district profile section of this document. Mentioned below are the performance figures of PHCs across the district.

Table 14: Reproductive and Child Health

Sl.No.	Name of PHC	Institutional Delivery	Family Planning
1	ARWAL	3251	702
2	KARPI	2279	557
3	KURTHA	3018	746
4	kALER	1611	201
5	SONBHADRA BANSI SURYAPUR	0	0
Total		**10159**	**2206**





12. Situation Analysis: Revised National Tuberculosis Control Programme

District has total 1 T.B units in the district- DTC Arwal,

Table 15: Revised National Tuberculosis Control Programme

Name of TU	Total no. of patients put on treatment	Annualised total case of detection rate	Number of new smear positive case put on treatment	Annualised NSP case detection rate	Cure rate for cases detected in last 4 corresponding quarter	Annulaised NSP case detection rate	Current rate
ARWAL	661	64%	292	44%	59%	44%	86%

13. Situation Analysis: Leprosy Control Programme

Table 16: Leprosy in Arwal District

Current prevalence rate (per 10,000)	**1.87**
Current detection rate	1.17
Current number of patients	134
New cases detected in last year	216
Percentage of children in new cases	22.61
Percentage of disabled in new cases	3.57
% of SC in new cases	21.42
Percentage of ST in new cases	0
Total number of cured patients	57

14. Situation Analysis: Kala Azar Control Programme

Kala Azar continues to pose a challenge for the state of Bihar. In 2008, there are 4 Cases of Kala Azar patients in blocks of Arwal. A total number of 4 cases were detected in the district in 2008, out of which 4 were fully treated. No deaths were reported in 2008 in the district secondary to Kala Azar.

Table 17: Kalazar Cases

Name of the PHCs	Population of effected PHCs	Cases	Death	Treated
ARWAL	151916	4	0	4

15. Situation Analysis: Filaria Control Programme

Status of Filaria in the district is as follows:

Table 18: District level data on Filaria Cases

Indicators	Total No. of Cases in 2008
No. of Cases Reported	**0**
No. of Night Blood Sample Collected	**22779**
No. of Hydrocele Operation done	**12**

16. Situation Analysis: Malaria Control Programme

Even though the number of malaria cases reported in Arwal is not significant, Arwal is a malaria endemic district. In 2007 a no any cases were reported and treated in the district. In 2008 also no any cases reported to Maleria Division in a District. Under the National malaria programme, blood smears are routinely collected and examined to outside of hospital premises becouse Pathological cheque system not available in the District.

17. Situation Analysis: National Blindness Control Programme

This programme is carried out at the facilities available at DHS Arwal and also through various school health camps. Salient information from the National Blindness Control Programme is given in the matrix below:

Table 19: National Blindness Control Programme Data

CATARACT PERFORMANCE	QUARTER – I			QUARTER – II			QUARTER - III			QUARTER - IV			TOTAL
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	
NGOS								193	296				489
PVT. SECTOR	214	123	112	106	170	197	196	181	265				1564
OTHERS	0	0	0	0	0	17	156	13	11				197

TOTAL	231	136	121	116	180	221	363	409	**584**	0	0	0	**2361**
SCHOOL EYE SCREENING							15	12					27
No. of school going children screened	209	247	195	179	236	330	224	340	183				2143
No. of school going children detected with referective errors	12	14	15	9	12	23	12	33	14				144

18. Situation Analysis: ASHA Training

Accredited Social Activist (ASHA) is a key strategy of the NRHM to link the community with the health systems. ASHA works with the community to raise awareness about various health programmes, provide basic health knowledge, and provide information on health practices thus generating demand for health services. She also helps and supports the community to access health services. Proper selection and training of ASHAs is a crucial step for the success of NRHM. In Arwal ASHAs have been selected in all the blocks. In most of the blocks ASHAs have completed two rounds of training, while in some of the blocks they have completed one round of training. Salient information related to ASHAs in the district can be found in the matrix below:

Table 20: Selection and Training of ASHA

Target (Total no. of ASHA to be selected)= 669						
Total No. of ASHA selected(till date)= 645						
Sl.No.	**Name of PHC**	**Total Target**	**Total No. of ASHA selected**	**Total No. of ASHA not selected**	**Total No. of ASHA Trained**	**Total No. of ASHA Untrained (amoung selected)**
1	Arwal	145	140	5	140	7
2	Kurtha	97	97	0	97	0
3	Karpi	191	188	3	188	0
4	Kaler	151	136	15	136	0
5	Sonevadra vansi suryapur	85	84	1	84	0

Table 21: Aanganwadi workers in PHCs

Name of PHC	**No. of AWW**	
	Sanction	Present
Arwal	131	124
Kurtha	108	103
Karpi	158	158
Kaler	127	121

Sonevadra vansi suryapur	85	83

For Arwal and Bihar NRHM is a challenging task. However it also provides the opportunity to identify gaps, innovate and invest in the public health system. The above situation analysis presents a detailed review of the status of infrastructure, human resources and services in the district. This analysis can be used as a baseline from which to design new strategies and approaches to achieve the goals of the National Rural Health Mission by ASHA & AWW workers in Arwal.

Strengthening Health Facilities in Arwal District

Goal: To ensure that all health facilities have required infrastructure, human resources, supplies and equipment for effective functioning

1. Sub centres

Objectives:

1. To ensure that Arwal has 100% functioning Sub centres as required by population norm
2. To ensure that all Subcentres have the facilities to provide a comprehensive range of services
3. To strengthen the Subcentre as the provider of primary outreach services

Infrastructure
Situation analysis: As per the norm, 143 HSCs are required. Out of the total 143 subcentres, 64 HSCs already exist. 27 additional HSCs have recently become functional. 52 HSCs are further required and these have been proposed. Of the existing 64 HSCs, only 09 are situated in any building premises. Out of these 64, 9 are in Government building, 55 are in rented building. Out of the 55 remaining sub-centers, buildings are under construction for 9 HSCs. 55 HSCs still do not have any building. The 9 HSCs operating in Govt building are currently being renovated. Of the existing 64 HSC do not have reported the availability of running water supply and availability of continuous power supply

Strategies	Activities	Budget
• requisition for sanctioning of 46 HSCs • Certain blocks like Arwal, Karpi,Kurtha,Kaler, Sonbhadra Bansi suryapur the number of required HSC is more than 50-100% more than the existing Sub centres. Prioritizing setting up of 64 new HSCs in these blocks. • Construction of buildings for the 27 newly sanctioned HSCs as per IPHS norms. • Ensuring that the 9 Sub centres currently located in Government buildings are renovated according to IPHS norms • Ensuring that the 9 Sub centres currently being constructed are constructed according to IPHS norms • Revising rent rates for the sub centres operating from rented houses and for any further rentals in order to get adequate space and facilities for HSC functioning.	**For new construction** • Meeting with CO to identify availability of land for setting up the priority HSCs in the selected villages. • Follow up the responses to the advertisement given by Bihar Govt for donation of land for setting up of HSCs. • Village meetings to identify accessible locations for setting up of HSCs • Finding locations for new HSCs on the basis of hard to reach areas and population. Distance between two facilities should also be considered. • Requesting allotment for construction of new HSCs to State Health Society • Requesting state government to revise the rent rates for HC building and make the grant for payment of the rent. • Ensuring construction of HSC	**New construction** 55 currently operating from rented building= 55* Rs.950,000.0= Rs 5225,0000.0 Rent for 27newly sanctioned + 55 new HSCs in priority blocks= 82* Rs.500.0*12 months=Rs.492,000.0 Furniture for sub-centers 64+27+52 * 10,000=Rs.1430000.0 (One time payment for 2 chairs, one table, one almirah, one bench**)**

	building as per IPHS norm along with residence for ANM and other health staff. **For review of on going renovation/construction** • Meeting of DHS in presence of SE, Building Division, for review of ongoing constructions for IPHS norms **INTERIM ARRANGEMENT** • Meeting local bodies to identify temporary building for newly aprroved 27 HSCs + 55 HSCs working from rented building	
Human Resources		
Situation analysis: All 143HSCs have one regular and one contractual ANM posted at the Sub centre. The contracts of the contractual ANMs need to be renewed on a yearly basis. Contractual ANMs have been posted for 27 newly sanctioned HSCs The posts of regular ANMs need to be sanctioned and appointed for the 27 newly sanctioned HSCs		
Strategies	Activities	Budget
• Renewing the contracts of the ANMs on contract • Appointment of regular and contractual ANMs for the newly sanctioned HSCs	**Appointment of ANMs for new HSCs** • Submission of proposal for the appointment of regular and contractual ANMs for the newly sanctioned HSCs • Holding interviews and issuing appointment letters	**Salaries for contractual ANMs** 64+ 27 + 52= 143*Rs.6000.0*12= Rs.10296,000.0 **Salaries for regular ANMs (from treasury route)** 64+ 27 + 52= 143*Rs.6000.0*12= Rs.10296,000.0

Equipment		
Situation analysis: Most HSCs do not have equipment as per the IPHS norms		
Strategies	Activities	Budget
• Assessing the equipment needs of all currently sanctioned HSCs and identifying equipment requiring repair and equipment that needs to be requisitioned • Acquiring permission from the state government to appoint district level agency for repair and maintenance. • Ensuring timely supply of the equipment • Ensuring timely repair of the equipment by the local agency • Ensuring quick replacement of nonfunctional equipment	• Identifying a local repairing agency • Training for the ANM and other health staff at the HSC in handling the equipment and conducting minor repairs. • Setting up of a district level equipment replacement unit	**For currently functional HSCs** 64* Rs.2000.0*2 (half yearly) = Rs.256000.0 **For new HSCs** 27+52 = 79*Rs10,000.0= Rs.7,90,000.0
Drugs		
Situation analysis: Most HSCs do not have the drugs required as per IPHS norms		
Strategies	Activities	Budget
• Ensuring timely replenishment of essential drugs prescribed under IPHS standards • Ensuring management of adverse drug reactions • Ensuring proper storage of the drugs.	• Weekly reporting of the drugs status: availability, requirement, expiry status • Setting up a block level drug replacement unit • Utilization of untied funds for purchase of essential drugs locally • Providing basic training for management of drug reactions.	**General purchase** 64+ 27 + 52= 143*Rs.1000.0*4 (quarterly)=Rs5,72,000.0 **Local purchase** (if stock is limited at district level) 64+ 27 + 52= 143*Rs.500.0*4 (quarterly)= Rs.286000.0
Untied Funds		
Situation analysis: Some HSCs do not have received any untied funds because of problems in the opening of bank accounts		
Strategies	Activities	Budget
• Ensuring that HSCs receive untied funds.	• Opening Bank Accounts • Ensuring timely release of funds to HSCs	64+ 27 + 52= 143*Rs.10,000.0 = Rs.1430000.0

2. Additional Primary Health Centres

Objectives:

1. To ensure that Arwal has 100% of functional APHCs as required by population norms
2. To upgrade all APHCs as per PHC level IPHS norms and to name all APHCs as PHCs
3. To operate 25% of APHCs on a 24*7 basis

Infrastructure		
Situation analysis: As per the norm of 1 APHC (now termed as PHC) for every 30,000 population, Arwal requires a total of 36 APHCs (PHCs), of these 26 APHCs already exist and are functional. A total of 26 new APHCs (PHCs) are required which have been proposed. Of the existing 26 APHCs, 9 work in Government buildings, 17 in rented buildings, Buildings for 9 APHCs are currently under construction.		
Strategies	Activities	Budget
• 26 APHCs to be newly established should be set up to meet the PHC level IPHS norms. Of these 9 are proposed to be constructed in this year and 10 operationalised. The overlap is to enable initiation of services while ensuring the requisite construction of infrastructure. • Prioritising the setting up of APHCs Construction of buildings for the existing 17 APHCs working in rented buildings or without any building as per PHC level IPHS norms ensuring the availability of labour room facilities, maternity wards and toilets. • Ensuring running water supply and drinking water supply in all existing APHCs • Ensuring power supply and power back up for all existing APHCs • Building residential facilities for doctors and other staff at 36 APHCs	**Construction of buildings for existing & proposed APHCs** • Meeting with CO to identify available land for setting up the priority APHCs (PHCs) in the selected villages • Follow up the responses to the advertisement given by Bihar Govt for donation of land for setting up of APHCs HSCs. • Village meetings to identify accessible locations for setting up of APHCs • Finding locations for new APHCs on the basis of hard to reach areas and population. Distance between two facilities should also be considered. • Requesting state government to revise the rent rates for APHC (PHC) building and make the grant for payment of the rent. • Ensuring construction of APHC (PHC) building as per IPHS norm along with residence for MOs, ANM and other health staff. • Ensuring power supply to all APHCs • Ensuring running water supply for 9 APHCs, since constructions for 9 are this year.	**For construction (including MO and staff quarters)** Current APHCs without Govt Building: 17 + New APHCs to be constructed = 26 17+ 26*Rs.1,500,000.0= Rs.64500,000.0 **For rent (including MO and staff quarters)** 26 existing APHCs + 10 new APHCs*Rs.2000.0*12 = Rs.864,000.0 **For Electrification** Rs.100,000.0 **For power backup** 36 APHCs* Rs65.0/hr* 8hrs/day*20 days/month*12 months=Rs.44,92,800.0 **For running water supply** 9 APHCs*Rs.200,000.0/unit = Rs.18,000,000.0

Human Resources		
Situation Analysis: While posts of 2 MOs have been sanctioned for 26 APHCs, only 3 APHCs function with 1 doctors in position while 3 APHCs have only 1 MO in position and an overwhelming 3 do not have any doctors in position. Blocks such as Arwal, Karpi, Kurtha ,Kaler &Bansi do not have doctors in position in either all or more than 35% of APHCs. All 36 APHCs have 2 Grade A Staff Nurse positions sanctioned and but only 5-7 APHC have Grade A Staff Nurses in position. Laboratory technicians are sanctioned in all APHCs but in position 0 . Pharmacists are sanctioned in all APHCs but in position in 0 all posted pharmashist deputed at PHC level. Accountants are in position in 36 APHCs.		
Strategies	Activities	Budget
Doctors • Rationalization of doctors across block facilities to ensure filling of basic minimum positions • If any APHC (PHCs) after rationalization is in need of more doctors then additional doctors can be deputed from PHC to run at least one day OPD. This should be considered as an interim arrangement. • Filling vacancies by hiring doctors on contract or appointing regular doctors **Grade A Nurses** • Renewal of contract of Nurses for 3 years based on performance • Filling 9 vacancies • Recruitment of Nurses for newly established 35 APHCs **ANMs** • Filling13 ANM vacancies • Recruitment of two ANMs for each of the newly established 35 APHCs **MPWs** • Appointment of 2 MPWs (M/F) for all 74 APHCs **Laboratory technicians** • Filling up of vacancies of Laboratory technicians in all APHCs (PHCs) **Pharmacists** • Filling up of vacancies of Pharmacists in all APHCs (PHCs) **Accountant** • Filling up of vacancies of Accountants	**For Rationalization of Doctors across facilities** • Reviewing current postings • Preparing a rationalization plan • Introducing rationalization plan in DHS meeting agenda to consider and approve the rationalization plan **Additional charge as interim arrangement** • Preparation of the roster for deputation of Doctors at the APHC (PHC) where no doctor is available. • Informing community about the 1 day per week OPD services at APHCs (PHCs) • Hiring of vehicles for the movement of doctors for fixed OPD days. **Filling vacancies** • Requisition to state health department for recruitment of permanent doctor and requisition to State Health Society for hiring of contractual doctors. • Requisition to state health department for recruitment of permanent nurses and requisition to State Health Society for hiring of contractual nurses. • Appointment of 2 MPWs (M/F) at each APHC • Hiring Laboratory technicians and pharmacists (permanent positions) • Hiring of clerks/accountants	**Medical Officers** 26+10*2=72 MOs 72 MOs*Rs.20,000.0*12 months= Rs.1728,0000.0 **Nurse** 26+10*2=72 Nurses 72 Nurses*Rs.7,500.0*12 months=648,0000.0 **MPWs (M/F)** 26+10*2=72 MPWs 72 MPWs* Rs.7,000.0*12 months=60,48,000.0 **ANMs** 26+10*2=72 72 ANMs*Rs.6000.0*12 months = Rs.5184000.0 **Lab tech** 26+10= 36*2 72 LabTech*Rs.7,000.0* 12 months=Rs60,48,000.0 **Pharmacist** 26+10= 36 36 Pharmas*Rs.7,000.0* 12 months=Rs3024,000.0 **Accountant** 26+10 = 36 = Rs.3456,000.00

	Contract Renewal • Renewal of contract of Grade A staff nurses for the next three years based on performance.	
Equipment		
Situation Analysis: Most APHCs do not have all equipment as per IPHS norms		
Strategies	Activities	Budget
• A detailed assessment of the status of functional equipment in all APHCs as per IPHS norms • Rational fulfilling of the equipment required • Repair/replacement of the damaged equipment	• Monthly reporting of the equipment status, functional/non-functional • Purchase of essential equipment locally by utilizing the funds or through RKS funds • Identification of a local repair shop for minor repairs • Training of health worker for handling of the equipment.	**Existing APHCs** 26 APHCs*Rs.5,000.0*4 quarters=Rs5,20,000.0 **Operationalizing 10 APHCs** 10 APHCs*Rs20,000.0= Rs200,000.0
Drugs		
Situation Analysis: Most APHCs do not have a regular supply of drugs and do not have all drugs as per IPHS norms		
Strategies	Activities	Budget
• Ensuring timely replenishment of essential drugs prescribed under IPHS standards • Ensuring management of adverse drug reactions • Ensuring proper storage of the drugs	• Block level drug replacement unit by providing fortnightly status of the drug availability/expiry in the store • Utilization of RKS funds for purchase of essential drugs locally • Providing basic training for management of drug reactions for health workers mainly Staff Nurse and refresher course for Doctors • Separate provision of drugs mainly for camps. • Rationalizing the collection of user fees on drugs and utilization of these funds for purchase of essential/emergency drugs • Utilization of PMGY funds allotted for drugs purchase at the local level.	**Existing APHCs** 26 APHCs* Rs.5000.0*4 quarters= Rs.520000 **Operationalisation of 10 APHCs** 10 APHCs* Rs.30,000.0= 300000.
Untied funds		
Situation Analysis: Currently since APHCs have not been upgraded to PHC level they do not receive any untied funds		
Strategies	Activities	Budget
• Ensuring that all APHCs receive untied funds as per the NRHM guidelines	• Ensuring that all APHCs receive untied funds as per the NRHM guidelines	36 APHCs*Rs.25,000.0* = Rs.900000.0

Operating 25% of APHCs on a 24*7 basis		
Strategies	Activities	Budget
• Operationlising 9APHCs which have their own building on a 24*7 basis and upgrading them to the PHC level. • Upgradation of infrastructure as per PHC level IPHS norms • Ensuring continuous power supply and power back up in these 9 APHCs. • Hiring Ambulance services for these 9 APHCs. • Outsourcing housekeeping and canteen services for these 9 APHCs (PHCs). • Sanctioning the post of an additional Staff Nurse at these 9APHCs taking the total number of Staff Nurses posted at each APHC to 3. • Filling vacancies of Staff Nurses and ANMs in APHCs (PHCs) on a priority basis. Relieving ANMs posted at these APHCs of outreach duties including Routine Immunisation and weekly meeting at PHC level. • Rationalisation of doctors to APHCs of these blocks on a priority basis. • Filling vacancies of doctors of these APHCs on a priority basis • Appointment of Laboratory Technicians, Pharmacists, Accountant and MPWS (M/F) in these 17 APHCs on a priority basis	**For Upgradation of Infrastructure** • Meeting of DHS to plan upgradation of existing 9 APHCs which have their own building. • Request to Building division to review, prepare layout, plan and make overall budget for upgradation of 9 APHCs (PHCs as per IPHS norms) with their own building **For power supply** • Ensuring power supply (PHCs) • Ensuring power back up by hiring a generator **For Ambulance services** • Hiring ambulance services provided by an appropriate NGO **For outsourcing housekeeping & canteen services** • Issuing a call for tenders for housekeeping services • Selection and awarding contract • Canteen services to be provided by local SHGs • Selection of SHGs through a call for proposals and selection of lowest bidder **Filling Vacancies** • Requisition to state health department for recruitment of permanent doctor and requisition to State Health Society for hiring of contractual doctors. • Requisition to state health department for recruitment of permanent Grade A and requisition to State Health Society for hiring of contractual Grade A nurses. • Submission of proposal for appointment of 2 MPWs (M/F) at each APHC • Appointing Laboratory technicians and pharmacists (permanent positions) • Submission of proposal for appointment of clerks/accountants • Holding interviews and issuing appointment letters	**Upgradation of infrastructure** 9 APHCs * Rs.700,000.0= Rs.63,00,000.0 **Setting up Pathological labs** 9 APHCs *Rs150,000.0= Rs.1350000.0 **Power back up** 9 APHCs* Rs.65.0/hr*24hr*30days* 12 months=Rs.5054400.0 **Ambulance** 9 APHCs* Rs.15,000.0/month*12 month=Rs.1620000.0 **Electrification** 9APHCs*Rs.100,000.0= Rs.900,000.0 **Water supply** 9 APHCs*Rs200,000.0 =Rs.1800,000.0 **Canteen funds**- 9APHCs*Rs.60per person*15 people*30days*12months = Rs.5,508,000.00 **Housekeeping Funds**- 17*Rs.7000=Rs.119,000.00 **Human Resources** 9 Staff Nurses for 24*7 APHCs *Rs.7,500.0*12 months=Rs.810000.0

3. Primary Health Centres

Objectives

1. To ensure that 100 % of the PHCs are functional with full staff strength, functional Operation Theatres, Labour Rooms, Wards and Laboratory services, adequate equipment and drugs
2. To establish CHCs, providing services of First Referral Unit (FRU) and SDH accessible within 20-25 kms for all blocks of Arwal as per IPHS norms.
3. Fully operationalise newly set up SDH at Arwal as FRU.

Infrastructure		
Situation analysis: Arwal has 5 PHCs in its 5 blocks whereas 2 PHCs are under construction in the 2 newly created blocks of Kaler & Sonbhadra Bansi Suryapur. Each PHC currently has 6 beds.. Sonbhadra Bansi Suryapur currently have facilities only for OPD services. All 5 existing PHCs operated out of their 3 PHC have own building PHC Kaler functioning in Rented building and Sonbhadra Bansi Suryapur Presentally functioning in APHC Building to be Upgraded PHCs have functional OTs and 3 have functional labour rooms. The condition of the OT and labour rooms needs to be improved in nearly all of the PHCs. The PHCs in Toilets need to be made available in all PHC .		
Strategies	Activities	Budget
• Fully operationalise newly constructed PHCs –2 To phase out PHCs from blocks which already have a 3 PHCs to ensure basic facilities especially functional labour rooms and OTs – Arwal, Karpi & Kurtha • Ensuring running water supply and drinking water supply in all PHCs • Ensuring power supply and power back up for all PHCs • To Provide Mobile Phone To BHM & Accountant.	**Fully operationalising 2 new PHCs** • To commission the Kaler & Sonbhadra Bansi Suryapur PHCs fully equipped and staffed by November 2009. **Phasing out PHCs from blocks with Referral facilities** • Placing a proposal for phasing out of PHCs to District Health Society • Sending proposal approved by DHS to State Health Society for approval. **Strengthening existing PHCs to ensure that 75% of PHCs are fully functional** • Setting up of fully functional Labour rooms and OTs in All PHC in the District. **Ensuring running water supply** • Requesting PHED to prepare a budget for provision of running water supply in the All PHC's. **Ensuring power supply and power back up** • Hiring of generators for all PHCs	**Labour room** 5 PHCs* Rs.700,000.0= Rs.3,500,000.0 **OT with complete infrastructure** 5 PHCs* Rs.1,000,000.0= Rs.5,000,000.0 **Setting up Pathological Laboratories** 5 PHCs* Rs150,000.0= Rs.7500,000.0 **Separate M/F Toilets** 5 PHCs* Rs.200,000.0= Rs.10,00000.0 **Power back up** 5 PHCs*Rs.125/hr*24 hrs*30 days*12 months= Rs.54,00000.0 **Water supply** 5 PHCs * Rs.200,000.0= Rs.1000,000.0

		Building Maintenance fund 5PHCs*Rs100,000.0= Rs.500,000.0 **Mobile Phone for BHM & Accountant** 5PHC *10000*5BHM+5Accountant= 100000=00 **Mobile Bill** 2000/permonth*5 BHM+5Accountant *12month=240000.00
Human Resources		
Situation Analysis: All PHCs are expected to have a team of 6-7 doctors. Currently all PHCs Grade A nurses have not been sanctioned of the PHCs All 5 PHC have sanctioned the post. ANM, Staff Nurse, LHV, Compounder, BHM, Accountant & Clerk.		
Strategies	Activities	Budget
• Rationalization of doctors across APHCs, and PHCs • Operationalized All Account by the joint Signature of BHM & Accountant. • Filling vacancies of doctors by hiring doctors on contract/appointment of regular doctors – 5 PHCs would need 5 Doctors each – Medicine, Surgery, Paediatrician, Gyanecologist and Anaesthetist • Sanction and appointment /hiring of 5 Staff Nurses for all PHCs • Sanction and appointment/hiring of 2 ANMs for all PHCs • Filling vacancies of Pharmacists, Dressers, Laboratory Technicians and Storekeeper • Sanction and appointment of an OT Assistant in all PHCs • Appointed 2 BHM and 1 Accountant for PHC.	**For Rationalization of Doctors across facilities** • Reviewing current postings • Preparing a rationalization plan • Meeting to DHS to consider and approve the rationalization plan • Presently All PHC Accounts operated by the M.O.I/c. In this financial year we assuared to Joint account operated by the BHM & Accountant. **Filling Vacancies** • Requisition to state health department for recruitment of permanent doctor and requisition to state health society for hiring of contractual doctors. • Appointed to BHM and Accountant in the PHC against Vacanat Post of those. • Requisition to state health department for recruitment of permanent Grade A nurse and requisition to state health society for hiring of contractual Grade A nurses. • Appointment of Laboratory technicians, pharmacists, dressers and Store keepers (permanent positions) • Submission of proposal for sanction and appointment of an OT Assistant in all 16 PHCs • Holding interviews and issuing	**Doctors** 5 Doctors*5 PHCs* Rs.25,000.0*12 months= Rs.75,00000.0 **Block Health Manager** 5 BHM*18000*12=180000 **Accountants**- 5 Accountants*Rs.16000*12= Rs,960000.00 **Grade A Staff nurse** 5 Staff Nurses * 5 PHCs* Rs.7,500*12 months= Rs.31,50,000.0 **ANMs** 2 ANMs* 5 PHCs*Rs.6000.0*12 months=Rs7,20,000.0 **Pharmacist** 5 Pharmacists* Rs.7,000.0*12 months= Rs.420000.0 **Lab tech** 12 Lab tech*Rs7,000.0*12 months= Rs.1,008,000.0 **OT assistants** 5 OT Assistants* Rs.7,000.0* 12 months=

	appointment letters	Rs.1,008,000.0
Equipment		
Situation Analysis: Most PHCs do not have equipment as per IPHS norms		
Strategies	Activities	Budget
• A detailed assessment of the status of functional equipment in all PHCs as per IPHS norms • Rational fulfilling of the equipment required • Repair/replacement of the damaged equipment	• Monthly reporting of the equipment status, functional/non-functional • Purchase of essential equipment locally by utilizing the funds or through RKS funds • Identification ofa local repair shop for minor repairs • Training of health worker for handling the equipment and minor repair.	**Existing PHCs** 5 PHCs* Rs.5000.0*4 quarters= Rs.100000.0 **Operationalizing 2 PHCs**= PHCs*20,000= Rs.40,000.0
Drugs		
Situation Analysis: Most PHCs do not have a regular supply of drugs and do not have all the drugs as per IPHS norms		
Strategies	Activities	Budget
1. Ensuring timely replenishment of essential drugs prescribed under IPHS standards 2. Ensuring management of adverse drug reactions 3. Ensuring proper storage of the drugs	1. Block level drug replacement unit by providing fortnightly status of the drug availability/expiry in the store 2. Utilization of RKS funds for purchase of essential drugs locally 3. Providing basic training for management of drug reactions for health workers mainly Staff Nurse and refresher course for Doctors 4. Separate provision of drugs mainly for camps. 5. Rationalizing the collection of user fees on drugs and utilization of these funds for purchase of essential/emergency drugs 6. Utilization of PMGY funds allotted for drugs purchase at the local level.	**Existing PHCs** 5 PHCs*Rs.10,000.0*4 quarterly= Rs.200000.0
Rogi Kalyan Samiti and Untied Funds		
Situation Analysis: Rogi Kalyan Samitis have been established in 5 PHCs and while RKS funds are being utilized in nearly 70% of the PHCs, fund flows and submission of utilization certificates is not regular. Untied funds have been received only by 4 PHCs of which 4 PHCs have utilized the funds.Only Sonbhadra Bansi Suryapur PHC have not Registered becouse fund not released under RKS.		
Strategies	Activities	Budget
• Ensure that RKS is registered to Sonbhadrra Bansi Suryapur in this	• Training of RKS office bearers on documentation of meetings as well as of the potential of the	5 PHCs*Rs.100,000.0= Rs.5,00,000.0

month. • Ensure UCs are sent regularly. • Utilisation of RKS funds to pay for outsourced services • Rks Account signaturey must to be BHM & Accountant to improve the NRHM goals.	RKS • Training of block level accountants in preparation of the utilization certificates • Monthly review meeting of block level accountants by District Accounts Manager to strengthen the documentation process • Developing a check list for review	
Facility level services (Ambulance, Diagnostic services, Canteen and Housekeeping)		
Situation Analysis: **Ambulance services** are known to be available at 4 out of 5 PHCs. The PHCs which do not have these services include Sonbhadra BAnsi Suryapur which are under construction . Of these 4 PHCs, ambulance services have been outsourced . X-Ray services are not available at most PHCs where they have been outsourced. Canteen services are available in only 1 PHCs of which are outsourced. Housekeeping services are available by outsourced in 3 PHC		

Ambulance • To ensure that ambulance services are made available at Arwal, Karpi, Kurtha & Kaler PHC functioning by outsourced • Ensuring that 70% of ambulance service utilization is by BPL families **X-Ray Services** • To ensure that X-ray services are available at all PHCs • To increase the utilization of X-ray services by BPL patients. **Canteen** • To ensure that canteen services are available at all PHCs • To ensure that the food provided is nutritious **Housekeeping** • To ensure that housekeeping services are available at all PHCs	**Ambulance** • To review the existing ambulance services by the following indicators: o % of BPL mothers who availed of ambulance services of the BPL mothers who came for institutional deliveries o % of BPL patients (including mothers) who availed of ambulance services from total patients who availed of ambulance services o % of emergency cases who availed of ambulance services o Average time taken for emergency patient to be brought to hospital by ambulance • To renew contracts of ambulance service providers based on review • To strengthen district run ambulance services • To create awareness about the ambulance services at the community level through local radio, newspapers, wall paintings and for remote areas through the ASHA, AWWs and ANMs • ASHA helpdesk to take feedback from each patient on the timeliness of the ambulance service and the user fees collected • To use RKS funds for the running costs of government run ambulance services **X-Ray Services** • To identify X-Ray service providers for all PHCs with appropriate qualifications and equipment • To review the services being provided every quarter on the basis of % of exemptions for BPL patients **Canteen services** • To identify canteen service providers for each PHC based on nutritional quality and cost **Housekeeping services**	**Ambulance** 5 PHCs* 2 Ambulances*Rs.15,000/month* 12 months= Rs.1800000.0 **Canteen –** 5 PHCs*Rs60 per person*15 people*30days*12 months=Rs.16,20,000.00 **Housekeeping-** 5 PHCs*10,000*12 month =600000

	being provided every quarter on the basis of % of exemptions for BPL patients **Canteen services** • To identify canteen service providers for each PHC based on nutritional quality and cost **Housekeeping services** • To identify providers for housekeeping services for all PHCs	

Establishing CHCs providing services of First Referral Unit (FRU)

Situation Analysis: Arwal currently has a 6 bedded PHC at Arwal, Karpi, Kurtha, Kaler & Sonbhadra Bansi Suryapur. There are 2 coming up at Karpi & Kurtha block to being a CHC . Each block is expected to have its own First Referral Unit in the form of a CHC, in the short term it is important for a referral facility to be accessible within 20-25 kms for every block in Arwal. It is therefore proposed to set up 2 CHCs in the plan year. The break up is as follows- 2 to be upgraded From PHC to CHCs- Karpi and Kurtha.

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Strategies	Activities	Budget
• Upgrading referral hospitals at Arwal as a fully functional CHC following IPHS norms. • To phase out PHCs from blocks which do not have a Referral Hospital and/or Sub-divisional Hospital so that there is no overlap of facilities providing the same level and nature of services – at Arwal, Karpi, Kurtha. • Ensuring the construction of CHC as per IPHS norms with 30 bedded ward, OT, Labour Room, X-ray and Laboratory facility • Ensuring staffing as per CHC IPHS norms (MD/MS – General Medicine, General Surgery, Paediatrician, Obstetrician/Gynaecologist, Anaesthetist, Eye Surgeon; 7 Staff Nurses + 1 PHN and 1	**Upgrading referral hospitals to CHCs as per IPHS norms** • Assessing the infrastructure of All PHC for CHC level IPHS norms and identifying gaps • Requisition to address gaps **For upgrading Kurtha & Karpi PHCs as per CHC level IPHS norms** **For Construction** • Requisitioning land where needed for construction. Meeting with CO to scope the availability of land. • Requesting allotment for construction of CHCs to State Health Society • Ensuring construction of CHC building as per IPHS norms along with quarters for doctors and other staff. **Filling Vacancies** • Ensuring the posting of 4	**Upgrading referral hospital to CHC (infra + equipment)** 2 Referral*Rs.5,000,000.0 = Rs.10,000,000.0 **Upgrading PHCs to CHC (infra + equipment)** 2 PHCs*Rs.15,000,000.0 =Rs.30,000,000.0 **Doctors** 6 Doctors*5 CHCs* Rs.25,000.0*12 months= Rs.9,000,000.0 **Staff nurse** 7 Staff Nurses*5 CHCs* Rs.7,500.0 *12 months= Rs.3,150,000.0 **ANM** 2 ANMs* 5 CHCs* Rs.6,000.0*12 months=

ANM; 1 Pharmacist; 1 Dresser; 1 Lab Technician; 1 Radiographer; 2 ward boys; 10 support staff including 1 OT attendant + 1 OPD attendant + 1 Data Entry Operator) • Obtaining the services of Anaesthetists on contractual and on-call basis for all Referral Hospitals and Sub-Divisional Hospitals • Setting up a Blood Storage Facility at all Referral Hospitals and Sub-Divisional Hospitals • Preparing effective outsourcing plan for the 7 referral facilities for X-ray and other diagnostic and pathological services • A detailed assessment of equipment as per CHC level IPHS norms of All PHC • Ensuring that all 5 CHCs are equipped as per CHC level IPHS norms • Ensuring timely replenishment of essential drugs prescribed under IPHS standards • Ensuring management of adverse drug reactions • Ensuring proper storage of the drugs	specialists – Medicine, Surgery, Paediatrician and Gynaecologist at each of the 5 CHCs • Contract with private anaesthetists to provide services on call basis to the 5 CHCs • Submission of proposal for hiring of 7 Staff Nurses and 2 ANMs each for the All CHCs. • Submission of proposal for sanction of posts filling 3 vacancies in Pharmacist and Dresser positions in both CHCs • Submission of proposal for sanction of 3 additional posts for Grade A Staff Nurses for 2CHC and 7 posts for Arwal hospital • Submission of proposal for sanctioning the post of 1 more ANM at the all PHCs • Filling vacancies of 1 Laboratory Technician for all PHC • Sanctioning 1 position for Pharmacist/ Dresser at all PHC • Hiring of a storekeeper for All PHC **Drugs** • Setting up drug replacement units at each of the 5 PHCs for the block and for the PHC • Reporting on a fortnightly status of the drug availability/expiry in the store • Utilization of RKS funds for purchase of essential drugs locally • Providing basic training for management of drug reactions for health workers mainly Staff Nurse and refresher course for Doctors • Rationalizing the collection of user fees on drugs and utilization of these funds for purchase of essential/emergency drugs • Utilization of PMGY funds allotted for drugs purchase at the local level. Equipment • Monthly reporting of the equipment status,	**Lab tech** 5 Lab techs* Rs.7,000.0*12 months= Rs.420,000.0 **Pharmacist** 5 Pharmacists* Rs.7000.0*12 months= Rs.420,000.0 **Dresser** 5 Dresser*Rs.7,000.0*12 months= Rs.420,000.0 **Radiographer** 5 Radiographers* Rs.7,000.0*12months= Rs.420,000.0 Social worker/counsellers- 10 counsellers*Rs.7000*12 months=Rs.16,80,000.00 **Accountant**- 5 accontants*Rs.8,000*12months=Rs.480,000.00 **Support Staff** 10 Staff* 5 CHCs* Rs4000.0*12months= Rs.2,400,000.0 **Drugs** 5 CHCs *Rs.100,000.0= Rs.500,000.0 **Blood storage** 5 CHCs* Rs.100,000.0= Rs.500,000.0 **Pathological services** 5 CHCs* Rs.300,000.0= Rs.1,500,000.0 **Ambulance** 2 Ambulances* 5 CHCs Rs15,000/month*12months= Rs.1,800,000.0 Maintenance fund-

	functional/non-functional • Purchase of essential equipment locally by utilizing the funds or through RKS funds • Identification of a local repair shop for minor repairs • Training of health workers for handling the equipment and minor repair. **Services** • Setting up a blood storage facility at each of the 5 CHCs • Setting up a fully functional pathology lab at each of the 5 CHCs • Developing an outsourcing plan for X-ray services, housekeeping, canteen and ambulance services • Setting up of maternity ward in all CHCs • Setting up an ASHA helpdesk to provide support to patients referred by ASHAs and for BPL patients • Setting up an ASHA room with a toilet to enable ASHAs to stay with mothers whom they have escorted for 48 hours **Rogi Kalyan Samiti** • Registering a Rogi Kalyan Samiti for each of the 5 CHCs • Ensuring that seed money is received • Training of office bearers on documentation (minutes and accounts)	Rs.200,000.0*5=Rs.1,000,000.0 **Canteen Services=** 5 CHC*Rs.60 Per person*60 persons*30*12=Rs.6,480,000.00, **Housekeeping-** 5 CHC*12,000Rs.*12months= Rs.720,000.00 **Rogi Kalyan Samitis** 5 CHCs* Rs.100,000.0= Rs.500,000.0

Reproductive and Child Health

A. Maternal and Neonatal health

Objectives

- Ensuring 100% registration of pregnant women for ANC
- Increase in the percentage of pregnant women registered in the first trimester from 47% to 90%
- Increase in the percentage of pregnant women with full ANC from 30% to 60%
- Ensuring that 80% of pregnant women receive 2 TT injections.
- Ensuring that 80% of pregnant women consume 100 IFA tablets
- Increase in skilled attendance during delivery from 55% to 80%
- Increase in institutional delivery from 40% to 90%
- Increase in the percentage of mothers receiving postnatal care within 48hrs of delivery from 24% to 90%
- Increase in percentage of neonates breastfed within 1 hour of birth from 53% to 90%
- Ensuring colostrum feeding of 80% of neonates
- Ensuring that all newborns are weighed within 48 hrs of birth
- Facility and community based management of sick newborns and low birth weight babies

Ante-natal Care			
Situation Analysis: For Arwal as2007, percentage of pregnant women registered for ANC is only 37%. Mothers who receive at least 3 ANC visits during the last pregnancy is 35%, percentage of mothers who got at least one TT injection in their last pregnancy is 42%. Percentage of mothers who were motivated by ASHA for ante natal care is 5.8%.			
Strategies	Activities	Budget	Remarks
• Increasing early registration through counseling of eligible couples by ASHAs and ANMs and distribution of home based pregnancy kits • Case management of pregnant women to ensure that they receive all relevant services by	• Training of ASHAs for counseling of eligible couples for early registration and the use of the home based pregnancy kit • Regular updating of the ANC register. • Preparation of the due list with the dates for Ante Natal Checkups for every pregnant woman in the Sub centre area. • Preparing format for the due list in Hindi. • Training ASHAs and AWWs to fill out and update due list and ANC schedule list for every pregnant woman in their	**Handbills** Printing 5000 Hand-bills @ Rs 500 for 143 HSCs =71500.0 **Pregnancy kits** 669ASHAs*Rs30/pregnancy kit*10 kits*4 quarters= Rs.802800.0	• Campaigning for registration for ANC along with immunisation budget • Monthly Mahila Mandal days budgeted in immunisation section • ANC (SBA) trainings for ANM. For details refer to training section. • The handbill would include information on ANC days, immunisation days, breast feeding practices, RTI/STI counseling days, Family Planning, RCH camps days at APHC level.

ASHAs and ANMs • Creating awareness about maternal health through Mahila Mandal day • Providing ANC along with immunisation services on immunisation days • Strengthening ANC services at the Sub centre level by ensuring availability of appropriate infrastructure, equipment and supplies • Ensuring quality ANC through appropriate training of the ANM • Effective monitoring and support to HSCs for ANC by APHC. • Setting up of referral transport system at every APHC level.	work area. • Organizing Antenatal checkups on immunisation days. • ASHAs and AWWs to coordinate with ANM to provide Antenatal care according to the ANC schedule maintained in the register for every expectant mother. ASHAs and AWWs to track left outs and drop outs before every ANC & immunisation day and ensure their participation for the coming day. • Organizing Mahila Mandal day to share information and create awareness about maternal and child health on every third Friday of the month at each AWC. • Wide publicity of Mahila Mandal day. • Training to ANMs to provide complete Ante natal care and identify high risk pregnancies. • Strengthening of Sub centre in terms of equipment to conduct ANC services. (refer to health facilities section) • Ensuring regular supply of IFA tablets at each Sub centre level. (refer to health facilities section) • Setting up Helpline with Ambulance at every PHC (APHC). (refer to health facilities section)		
Natal, neo-natal and postnatal care			
Situation Analysis: Percentage of institutional deliveries in Arwal district is medium at 58%. Deliveries at PHC assisted by doctors or another skilled attendant such as a nurse/LHV/ANM is even lower at 42% whereas only 52% of mothers received postnatal care within 48 hours of delivery for their last child. Factors leading to the low rates of assisted and institutional deliveries include a shortage of Sub centres, poor infrastructure and skills at the Sub centre level and an almost exclusive focus of the			

Sub centre on immunization activities. Similarly, APHCs suffer from severe shortages in labour rooms and medical officers, though staff nurses have recently been appointed. There are currently no APHCs providing 24*7 services and no ambulance services available at the APHC level. Also, because of lack of appropriate infrastructure most mothers are not able to stay for the required 48 hrs at the facility. At the PHC level the District faces a shortage of Gynecologists and Paediatricians. 2 PHCs in the district – Kaler & sonbhadra Bansi suryapur do not have fully functional labour rooms and almost no PHC has blood storage facilities. There is also a need of appointing lady doctors at APHC, PHC,CHC and above. In addition, breastfeeding practices need to be improved. According to DLHS 3, only 52% infants were fed within one hour of birth which is institunal Delivery. While 36% children were exclusively breastfed for 6 months and only 30% of neonates received a check up within 24 hours after delivery. There are almost no facilities for the management of sick newborns. Infant mortality rate for Arwal is reported to be 52% as per 2001 census data which, although down from 20% in 1991 is still quite high.

Furthermore, there are have been problems in the implementation of the Janani and Bal Suraksha Yojana (JBSY) launched to increase the utilization of ANC, assisted deliveries and postnatal care and immunisation services with delays in payments.

Strategies	Activities	Budget
• Strengthening 25% of APHCs to provide 24*7 services • Strengthening 87% of APHCs to provide institutional delivery care. • Strengthening 12 of 16 PHCs to provide institutional delivery care • Setting up 5 CHCs to provide Emergency and Comprehensive Obstetric Care • Ensuring that ambulance services are available for transportation to APHCs and referral to PHCs and CHCs • Developing a pool of skilled births attendants for each block. • IMNCI Training for ASHAs and ANMs • Improving accessibility of skilled birth attendants to communities • Creating community level awareness on the importance of assisted and institutional deliveries through ASHAs • Counseling of mothers and families for early initiation of breastfeeding, colostrum feeding and	**Strengthening facilities for institutional deliveries (please see facilities section)** • Ensuring availability of fully functional and equipped labour rooms, maternal wards, ambulance services and blood storage facilities • Equipping 24*7 APHCs and PHCs to provide minimum 24 hours post delivery stay to mothers and newborns by setting up maternity and neonatal wards • Equipping CHCs, SDH and DH to enable 48 hrs of post delivery stay for mothers and newborns by setting up maternity and neonatal wards • Ensuring availability of required medical officers, nurses and ANMs at all facilities • Appointment of Paediatricians and Gynaecologists at every PHC and CHC • Regular stocks of PPH controlling drugs. **Ambulance services** • Identifying ambulance service providers for 26 APHCs, 5 PHCs, signing contracts for services • Focus on increasing exemption to BPL patients in the utilisation of ambulance services **Developing a pool of Skilled Birth Attendants for each block** • Regular rounds of SBA training for ANMs, LHVs and Nurses.(see training	**Mobile phones** 124 ANMs*Rs2000/mobile phone instrument=Rs248,000.0 **Monthly mobile bills** 124 ANMs*Rs600/month* 12months=Rs.892800.0 **Facility level phones** 5 M.O.I/C ofice +5 RKS office=10 Facilities*Rs1000/phone =Rs.10,000.0 **Landline bills** 10 Facilities *Rs500/month*12 months= Rs.60,000.0 **Telephone directory of SBAs for ASHAs** Rs.20,000.0 **Printing JBSY cards** Rs.100,000.0 **JBSY payments** **Rural:** Rs2,000/beneficiary *20, 000 deliveries estimated= Rs.40000,000.0

exclusive breastfeeding for 6 months by ASHAs • Weighing of all newborns by ASHAs and AWWs at the community level within 48 hours • Ensuring timely payment of JBSY funds to mothers and ASHAs • Setting up a Sick Newborn Care Unit at the District Hospital • Ensuring telephone connectivity between all facilities providing institutional delivery care	section) • ASHAs to have the names and numbers of skilled birth attendants for every block • Extending the Helpline 102 to enable calling for skilled birth attendants during deliveries **Accessibility of skilled birth attendants** • Providing mobile phones to ANMs at Sub centre to enable them to be available for assistance during delivery at the community level **IMNCI Training for all ASHAs and ANMs** • IMNCI training for all ASHAs and ANMs **EmOC Training** • EmOC training for all MOs and Grade A Nurses at PHCs and CHCs **Improving communication between facilities providing institutional delivery services** • Ensuring that 26 APHCs, 5 PHCs are connected through functional phone lines **JBSY** • Creating a JBSY card which combines the services in the MCH card along with info on JBSY payments • Streamlining JBSY money from district to PHC to provide timely payment to beneficiaries and ASHAs. • Support ASHAs to open accounts in the bank. • Explore the options of direct money transfer to ASHAs' accounts. **Counseling and support to new mothers for initiation of the breast feeding after one hour of delivery, colostrum feeding and post natal care within 48 hrs**. • ASHAs to visit newborn baby in first 48 hours to ensure exclusive breast feeding and counsel the families about newborn care and postnatal care. • ANM and staff at facility to provide counseling and support for exclusive breast feeding. • Each mother to receive a post natal check up before discharge • Postnatal follow up by ASHAs and	

	ANMs at the village level **Sick Newborn Care Unit** • Setting up a Sick Newborn Care Unit at the District Hospital	
Other services	• Weekly RTI/STI clinics to be held at all PHCs with OBG visits during these days • Monthly RCH camps at distant villages, Doctors and OBG specialists • Deputing health workers MOs, SNs/ANMs from PHC, three other staff. • Procurement of drugs from the district drug house following the requisition of separate drugs for 12 camps.	One OBG contracting in daily basis @ Rs.500.0 * 4 days*12 months *12 PHCs = Rs.288,000.0 Two OBG/pediatrician contracting in per camp @ Rs.1000.0 * 12 camps * 64 APHCs= Rs.1,536,000.0 Cost of each camp @ Rs 5000*12 months*64 APHCs = Rs.3,840,000.0 Drugs for each camp @ Rs 2000*12 months*64 APHCs = Rs.1,536,000.0

B. Infant Health

Objectives

- Ensuring that 50% of children (0-6 months old) are exclusively breastfed
- Increase in percentage of children (12-23 months) fully immunised (BCG, 3 doses of DPT, Polio and Measles) from 50% to 70%
- Ensuring initiation of complementary feeding at 6 months for 50% of children
- Increasing the percentage of children with diarrhoea who received ORS from 43% to 70%
- Increasing the percentage of children with ARI/fever who received treatment from 77% to 100%
- Ensuring monthly health checkups of all children (0-6 months) at AWC
- Ensuring that all severely malnourished children are admitted, receive medical attention, and are nutritionally rehabilitated.

Nutrition		
Situation Analysis: Ensuring exclusive breastfeeding and timely initiation of complementary feeding is critical for appropriate child development		
Strategies	Activities	Budget
• Counseling mothers and families to provide exclusive breastfeeding in the first 6 months • Convergence with WCD Department for implementation of Rajiv Gandhi Creche Scheme at NREGA worksites and	• Meeting with WCD officials to review the status of implementation of the Rajiv Gandhi Creche scheme • Training by Health Department of crèche workers on nutrition and child care • Organising health checkups at AWC for children in the 0-6 year	**Creche worker training** 70 batches*Rs10,000/batch= Rs.700,000.0 **NRC setting up** 3 PHC*Rs.30,000.0= Rs.90,000.0 **NRC Staff** 3 Staff Nurses*Rs.7500/month*12

other places where land lable worker work doing in this District to enable exclusive breastfeeding and child care by women workers • Identification of severely undernourished children (Grade III & Grade IV) through monthly health checkups at AWC. • Setting up a Nutrition Rehabilitation Centre at PHC lavel.	age group on the 2nd Monday of every month • Referral of severely undernourished sick children to Nutrition Rehabilitation Centre (NRCs) • Setting up 10 bedded NRCs at PHc Arwal • Providing food and wage loss support for one parent of every child admitted to enable the child to stay at the NRC for the required period of time	months*3 PHC= Rs.810,000.0 **Kitchen equipment** 3 PHC*5,000.0= Rs.15,000.0 **Kitchen expenses(including salary of cook)** 3 PHC12,000.0/month* 12months= Rs.432,000.0 **Wage loss compensation** 3 PHC*900per day*30days* 12 months=Rs.97,200.0
Health Services		
Situation Analysis: Only 43% children with diarrhoea received ORS whereas 23% of children with acute respiratory infection/ fever did not receive any medical attention		
Strategies	Activities	Budget
• Promotion of health seeking behaviour for sick children through BCC campaigns. • BCC for pregnant women and mothers to regarding feeding practices, immunisation, and other aspects of child care. • Capacity building of ASHA, AWW and ANM for the management of common childhood diseases and identification of serious cases for referral.	• Training of ANM and AWW for IMNCI • Training ASHAs to refer sick child to facility in case of serious illness. • ASHAs equipped to provide ORS to children with diarrhea and suggest referral in case of emergency. • Regular stock up of ASHA drug kits. • Providing weighing machines to every AWC to ensure monthly weighing • ASHAs to support AWWs in monthly weighing	IMNCI training (pls refer to training section for details) **ASHA Drug Kit** 669 ASHAs*Rs600/kit= Rs.401400.00 **Weighing machine** 589 AWWs*Rs.1000/machine= Rs.589000.00
Health Services – Immunisation		
Situation Analysis: According to DLHS 3, percentage of children (12-23 months) fully immunised (BCG, 3 doses each of DPT, Polio and Measles) is only 50.0%. The immunisation coverage has increased from 43.4 which was DLHS 2 figure, however much improvement is still required. As per DLHS 3, percentage of children who received BCG vaccine is 88.5%, percentage of children who received 3 doses of polio vaccination is 62.4%, children who receive 3 doses of DPT is 62.8%, and children who receive measles vaccine is 71.9%. Children who received at least one dose of vitamin A is 63.9% while those who received three doses of Vitamin A is 22.8. The District currently faces a shortage of skilled vaccinators. **Muskhan EK Abhiyan: Immunization of all pregnant women for T.T. and children up to one year (full immunization)** All 589 AWCs are to be covered under this programme at least once a month. 64+27 HSCs are to be covered under this programme on all Wednesdays observed as immunisation day. APHCs will also provide immunisation services on Wednesday and all days in PHCs. Incentives are provided under		

this programme for AWW, ANM and ASHA when 90 per cent immunisation is achieved. The programme involves organizing Mahila Mandal camps at the AWCs.

95%ANMs in the district are proficient in administering the vaccines. Skills level of ANMs is high. Routine immunisation training has not been taking place on a regular basis. 453 participants need to be trained in Routine Immunisation in batches of 30. There is a shortage of cold chain equipment such as ILR and deep freezer at PHC level. Most of the PHCs are operating with either ILR or deep freezer. The District has also not received vaccine funds from April 2008. Arwal gets vaccines from WIC, Aurangabad. The District have a vaccine van which needs to be repaired. DPT and needle supply is not timely in last month of 2008. The maintenance and repair of cold chain equipment is not being done properly by the company currently appointed. The District also needs to adopt better waste management practices for the disposal of syringe and needles.

Funds for Printing of RI formats are under utilised.

Strategies	Activities	Budget
• Improving availability of skilled vaccinators. • Increasing utilisation of immunisation services through awareness generation by ASHAs and AWWs. • Ensuring continued tracking of pregnant women and children for full immunisation • Establishing sound monitoring mechanism to review and guide the progress • Improving availability and maintaining quality of cold chain equipment • Improving timely supply of the vaccines • Timely supply of DPT and syringes. • Discussion with the state to acquire power of issuing maintenance and repair contract for cold chain equipment from district. • Adopting safe disposal policies for needles and syringes	• Organising regular routine immunisation training for ANM and AWW and IPC/IEC/BCC trainings for ASHA and AWWs. • Organising immunisation camps at every Sub centre level on every Wednesday and at the AWCs on every Saturday. • Regular house to house visits for registration of pregnant women for ANC and children for immunisation • Developing tour plan schedule of ANM with the help of BHM and MOIC. • Timely payment to MOICs to arrange transportation of vaccines from district hospital to PHCs. • Regular disbursement of funds from the DIO to MOs for providing incentives to ANMs • Regular disbursement of funds for ANMs to provide incentives to AWWs and ASHA workers • Providing per diem for health workers, mobilisers, supervisors and vaccinators and alternative vaccinators • Maintaining the disbursement records • Visits by MOIC, CDPO, BHM, LHV and health educator to monitor the progress of immunisation schedule and prepare report. • Ensuring the unrestricted	**Incentives for AWWs** 589 AWWs @ Rs.200.0*12 months = Rs.1413600.0 **Incentives for ANMs** 589 (AWC visit by ANM) @ Rs 150.0*12 months = Rs.1060200.0 **Incentives for ASHAs** 669 Asha@ Rs 200.0*12 months = Rs.1605600.0 **Mahila Mandal Meetings** 589 (Mahila mandals) @ Rs.250.0*12 months = Rs.1767000.0 **Health workers** (couriers) 127*50*105 days= 666750.00 One supervisior/3 team for seven days @ 100/person/day = Rs 77,700.0 Alternative vaccinators Rs 100/person/day = Rs 4900 **Supervision** 1 vehicle 2 teams 4 days * Rs 650/day = Rs 4,34,200.0 Contingencies Rs 1750/block and Rs 3000/district = Rs 31,000.0 **Training** Honorarium and TA for participants @ Rs 250 for two days = Rs.113,250.0 Honorarium for trainers @ Rs.

	movement of the monitoring team with fuel for vehicle and funds for hiring of the vehicle. • Maintaining continuous power supply at PHC level for maintaining the cold chain. • Applying for acquisition of ILR and deep freezer for the 3 PHCs which do not have Deep Freezer at present • Applying to State Heath society for the funding for new Vaccine van to get timely stock of vaccines for the districts. • Timely and regular requests from district to state as well as blocks to district to replenish the supply of DPT and syringe. • Rationalisation of courier rates and making request to the SHS for increased funding for courier in order to ensure timely supply of vaccines to sub centres. • Reviewing the contract of currently responsible for repair and maintenance. • Submitting a proposal to the state health society to acquire power of issuing maintenance and repair contract for cold chain equipment from district. • Procure stock of hub cutters for all the PHCs for safe disposal of needles and syringe.	600 for two days training = Rs. 27,000.0 Contingency Rs.100/day = Rs.90,600.0 Budget for print material included with the hand bill in the section of maternal health.

Vitamin A Supplementation Programme-

The programme faces lack of skilled manpower for implementation of program. There is also shortage of drugs and RCH kits. The shortages put constraints on ensuring first dose of Vitamin-A along with the measles vaccination at 9 months.There are also problems for procurement of Vitamin-A bottles by the district for biannual rounds. The reporting mechanism of the district need to be improved. There is lack of coordination among health & ICDS workers for report returns & MIS. The district also needs a joint monitoring & supervision plans with ICDS department.

Strategies	Activities	Budget
• Updation of Urban and Rural site micro –plan before each round. • Improving inter-sectional coordination to improve coverage. • Capacity building of	• Orientation , stationary, data compilation, validation and updating • Constituting district level task force and holding regular meetings • Organising meeting of block	Orientation of 5 PHCs *1000=Rs.5,000.00 Constituting district level task force- 1*5000=Rs.5000.00 Training of 5 PHCs*Rs1500=

service provider and supervisors. • Bridging gaps in drug supplies. • Urban Planning for Identification of Urban sites and urban stakeholders. • Human resource planning for Universal coverage. • Intensifying IEC activities for Community mobilization. • Strengthening existing MIS system and incorporating 9 doses of Vitamin-A in existing reporting structure. • Strong monitoring and supervision in Urban areas.	coordinators • Training and capacity building of service providers. • Strategy planning meetings, orientation of stakeholders, resource planning and site management for urban centre and orientation of urban supervisors. • Ensuring availability of immunisation cards • Procurement of Vit A Syrup	Rs.7500.00 5 centres*Rs.5000=Rs.25,000.00 Strategy planning workshops- Rs. 7500.00 Honorarium to ASHAs and AWWs- 750 health workers*100= Rs.75000.00 Honorarium to supervisors- Rs.7000.00 Immunisation cards- Rs.120,000.00 Procurement of Vit A Syrup- Rs.463,424.00 Hiring vehicle for campaigns – Rs.36,000.00 IEC/ BCC activities- Rs.60,000.00 Vehicle support for monitoring- Rs.72,000.00

C. Family planning

Objective

- Fulfilling unmet need of 35% for family planning services at the community level
- Increasing the use of any modern method of family planning from 35% to 50%
- Increasing male sterilisation rates from 0.5% to 2%
- Increasing the utilization of condoms as the preferred choice of contraception from 2.7% to 8%.

Situation Analysis: The utilisation of any method of contraception has increased a bare 2 percentage points in the district over the past five years whereas the utilisation of modern methods has increased from 28% to 35%. Of this, nearly 30% is contributed by female sterilization. Male sterilization is low at 0.5%. Other spacing methods are equally low with the use of IUD at a mere 0.6%, oral contraceptive pills at 1.8% and condoms at 2.7%.

A significant unmet need for family planning services has been recorded at 37% which importantly comprises of 13% need for spacing and 24% for limiting methods.

Strategies	Activities	Budget
• IEC/BCC at community level with the help of ASHAs, AWW • Addressing complications and failures of family planning operations • Training male peer educators to increase awareness amongst men about the importance of contraception and the ease of spacing methods • ASHAs to have a stock of contraceptives for distribution	**Spacing methods** • Selecting and training male peer educators (1 for every 500 persons) in 5 blocks to counsel men for the adoption of spacing methods • Interpersonal counseling of eligible couples on family planning choices by ASHAs and male peer educators **Limiting methods** • Family planning day at all health facilities every month. • ANM and ASHA to report complications and failure cases at community to facility. • Quick facility level action to address complications and failures. • Streamlining compensation channels • Streamlining incentives for MOs **Abortion services** • MTP services to be provided at all PHCs. **Training** • Training of MOs for conducting tubectomy and vasectomies procedures using Laproscopy • Training of MOs for providing MTP services • Training of ANMs on encouraging reproductive choices and the features of different methods • Training of ASHAs on family planning choices, contraceptives and behavior change communication	**Training of Male Peer Educators** 40 batches (25 educators in each batch trained for 3 days)*Rs3000.0/batch=Rs.120,000.0 **Incentives** For 400 NSVs @ Rs 1500 = Rs.600000.0 For 5000 tubectomies @ Rs 1000= Rs.5,000,000.0 For 10,000 IUD insertions @ Rs 20 per case= Rs.200,000.0

D. Adolescent Reproductive & Sexual Health

Objectives

- Reducing the percentage of births to women during age 15-19 years from 96% to 85%
- Reducing anaemia levels in adolescent girls and boys

Situation analysis: Nearly 96% of births are to women in the age group of 15-19 years. This is a very vulnerable age group deserving of special attention and support.		
Strategies	**Activities**	**Budget**
• Providing life skills education to married and unmarried adolescent girls by ASHAs and AWWs • Treating anemia among adolescent girls and boys	• Training of ASHAs and AWWs on providing life skills education to adolescent girls • Screening of all adolescents especially girls for anemia during the monthly health checkups of children at AWC on the 2nd Monday of every month • Screening of all adolescents for RTIs and STIs • Providing IFA supplementation to adolescents	RTI/STI Screening budget included in the RCH camp **Anaemia Screening** 589 AWCs*Rs500.0*12month = Rs.3534000.0 **IFA supplements** Rs.100,000.0
School Health Programme		
Situation Analysis: There are about 800 government middle schools where the camps are conducted. Till date 175 camps have been completed, covering 175 schools. The services provided include refraction, general check up, and distribution of medicines.		
Strategy	**Activity**	**Budget**
• Continuing the school health programme • Initiation of School Health Programmes in Primary/high school • Ensuring proper referral and follow-up of students	• Requisition to be sent to the state health society for expanding the school health programme to priamy and high school of government schools. • School Health programmes to be conducted through partnership with NGOs • Requisition to state for providing spectacles for refractive corrections • Providing referral cards for the needy children to the nearest PHC Providing an award for the 'Healthiest' school in the block	1. For 800 schools @ Rs 2500 per camp =Rs.2,000,000.0 2. Rs 10,000 per block for healthy school award *5 blocks =50,000.0

National Vector Borne Disease Control Programmes

A. National Leprosy Elimination programme

Objective

- To reduce the leprosy disease prevalence rate to <1

Situation analysis:
Currently disease prevalence rate per 10,000 population is 1.29
Disease detection rate per 10,000 population is 1.63
Number of cases under treatment is 375
New patients registered – 473
Percentage of children in new cases – 15.64
Percentage of deformity – 3.59
Percentage of SCs in new cases – 16.27
Percentage of ST in new cases – 2.74
Total treated patients treated from April'08 to Dec'08 – 365

Infrastructure: The district has an upgraded district leprosy office, leprosy control units Arwal to be modified leprosy control unit at Arwal, leprosy training centre.

Human Resources: No MOs are in position in Leprocy Division bcouse leprocy division not functioning in District due to unavaibility of Sadar Hospital in the District. only 4 or 5 non-medical assistants are in position and one incharge DLO are present in the District.

Strategy	Activity	Budget
• To Enhancing the leprocy Division team work by appointing Mo. and other staff in the District. • Enhancing the case detection rate • Strengthening of all health facilities for case detection • Creating awareness among the community about the disease • Strengthening health facilities for management of deformity cases • Separate pediatric ward for treating of children at the Arwal leprosy unit • Fillingvacant posts • Ensuring continued training	**Improving case detection** • House to house visits for tracing cases of Leprosy, by health workers (BHWs, ASHA, ANM) • Detected cases are to be taken to hospital for proper counseling, by professional counselors • The cases detected are to be monitored and followed up by health workers, mainly by BHWs/ASHA to detect deformity. **IEC/BCC to create awareness** • Awareness creation among community by having hoardings, phamphlet, advertisements in the news papers. • Sensitization of AWW • School quiz contest • Awareness in the community through Gram- Goshti. • Organizing 2 Health camps in each block. • Rally to create awareness • Awareness in urban areas	**Hoardings** Rs.420,000.0 **Handbills** Rs.35,000.0 **AWW Sensitisation** 25 batches*Rs.4500/batch= Rs.112500.0 **School Quiz** Rs.1250,000.0 **Gram Goshtis** Rs.140,000.0 **Health Camps** Rs.140,000.0 **Rally** Rs.84,000.0 **Awareness in Urban areas** Rs.100,000.0 **Strengthening facilities** Fuel + vehicle=Rs.90,000.0 Stationary=Rs.40,000.0 Medicine=Rs.20,000.0 Patient welfare=Rs. 15,000.0

	Strengthening Facilities • Increasing availability of fuel, vehicle, stationary and medicine at facility level **Human Resources** • Walk-in interview for filling of all required staff at the district level as well as PHC level. • Continued training for all health workers • Training of all health workers specifically in counseling patients and the family about the disease • Contracting of services that are essential for management of cases • Contracting of a consoler at least at the PHC level.	

B. Revised National Tuberculosis Control Programme (RNTCP)

Situation analysis: The RNTCP is mainly to control the spread and treatment of Tuberculosis. Under this programme, sputum is collected from suspected cases and cases are referred to nearest the center by health workers. Annualised total case detection rate is 64% with 661 patents put on treatment.

Infrastructure:
8 MCs are present and 20 are required . 2 MCs are already built but need manpower to function.. Construction of DMCs is required in newly function PHC is most urgent.

Human resources
589Aww and 669 Asha workers added as Community Volunteers. Which is sufficient no. for DOT Providers. Budget is available from last years plan for hiring contractual services of STS, STLS, TBHV, DEO, Part time accountant and contractual LTs.

Equipment
An inverter is needed as well as procurement of laboratory materials as per guidelines

Strategy	Activity	Budget
• Ensuring timely construction of DMCs and DTCs. • Create awareness among the community • Ensuring early case detection and prompt treatment • Bridging the gap between NGOs and government health facilities and officials thereby creating a synergestic effect on overall process of	• Upgradation of one TU • Upgradation of 5 MCs • Strengthening TB labs • The newly constructed facility to be made functional. • Identifying laboratories for early detection of suspected cases at the block level • Educating community through ASHA/ANM and NGOs about identifying the cases with chronic	**Upgradation of TUs** Rs.35,000.0 **Upgradation of 5 MCs** Rs.150,000.0 **Purchase of Lab materials** Rs.250,000.0 **NGO networking** Rs.150,000.0 **Building network with private practitioners** Rs.125,000.0 **Publicity Campaign**

awareness. • Building network with private practitioners to widen the reach of TB services. IEC/ BCC activities to create awareness • Ensuring adequate supply of equipment and materials • Ensuring filling of vacant posts • Ensuring timely training of all newly recruited staff	cough with sputum. • Identifying the press for printing of information materials and displaying them in the community. • Requisition for revising the honorarium amount to be proposed to DHS • Networking with the old and new NGOs by having regular meetings at the district level • Establishing a network of private practitioners for reporting/referring of suspected cases. • Undertaking a publicity campaign to create awareness with the use of publicity materials such as banners, hoardings and handbills and printing of publicity poster • Outreach activities such as patient interaction meeting and community meetings • Organising awareness activities in schools • Organising community level sensitisation meetings to create opinion leaders • Organising world TB day • Maintenance of equipments • Other miscellaneous expenses • Requisition for state level procurement agency to establish a district level units • Vehicle maintenance • Vehicle hiring • Advertising for filling vacant posts • Filling vacancies for STS, STLS, TBHV, DEO, part time accountant and contractual LTs. • Honorarium to health workers at per 250 per patients.	Rs.119,500.0 **Outreach activities** Rs.30,000.0 **School awareness activities** Rs.40,000.0 **Community meeting** Rs.9,600.0 **World TB day** Rs.10,000.0 **Maintenance of equipment** Rs.30,000.0 **Misc expenses** Rs.418,500.0 **Vehicle Maintenance** Rs.250,000.0 **Vehicle Hiring** Rs.336,000.0 **Human resources** Rs.700,000.0

C. Malaria, Kala Azar and Filaria-

Kala Azar
Situation Analysis - Cases are reported only from Arwal PHC, making these as endemic areas. There are around 4 villages affected in 1 blocks and 1 PHC areas fall under the zone. Surveillance has been less effective in detecting the exact burden of the epidemic. Cases that needed hospitalisation were provided service and remuneration as per GoB Kala Azar programme (i.e., Rs 50 per pt., food for 30 days qid). The challenge for the district has been poor follow up. Control measures for Kala-Azar like spraying of DDT in hot spots has been minimal due to inadequate manpower. Population to be covered: 151916 – therefore spraying has to be done fortnightly during the month of May-June. DDT & Spraying Equipment to be needed: DDT (50%) – 16.8 MT DDT (50%) – 9.2 MT (available) Bucket required 48 Gallan measure – 24 Pond Measure – 24 Nozzle Tips – 192 pics Cup leather washer – 384 pics Strirrup Pumps – 48 Mosquito Bed Net Human resources required- At present only 20 BHW are present in the district aganst the total requirement of 70. District also needs 12 Malaria inspectors. DMO has responsibility of one more district than Arwal. There is need to increase human resources available for DDT spraying. District needs 25 teams each comprising of 7 persons in order to successfully complete spraying task.

Strategy	Activity	Budget
• Ensuring early diagnosis and prompt treatment • Ensuring active surveillance in the villages • Creating awareness about prevention of Kala Azar and GoB schemes. • Ensuring prompt prevention and control of the spread of Vector • Ensuring adequate quantity of DDT at all PHCs/APHCs • Ensuring adequate supply of Mosquito bed nets • Ensure filling of vacant BHW and MI posts in the A priority PHCs • Revising the wages for DDT spraying team	• House to house visits for tracing cases of Kala Azar, by health workers (BHWs, ASHA, ANM) • Collection of reports from local private practitioners and laboratories in the village • Adequate stock of essential drugs, like Amphotericin B at PHCs. • follow-up of all the cases discharged from the Hospitals for 3months and test with RK 39 for PKDL cases. The follow-up to be done by BHWs/BHI • Identifying the pockets in the village and the spraying DDT in these places. • Announcement in the villages about the days of active spraying of DDT inside the houses and village along with advice about preparing the house for spraying of DDT.	**Office expenditure-** Rs. 3600.00 **Contingency Fund**-Rs. 3600.00 **Transportation of DDT**- Rs. 12,000.00 **IEC Van -** IEC van @ 750 per PHC per day for 60 days= Rs.360,000.00 **Training to BHW-** Rs. 3000.00 **Wages**- SFW @ Rs.86 per day of spray worker= Rs.123,840.00 + FW@70 Rs per day Rs. 50400= Rs. **627,840.00**

	• Local announcement about the prevention of Kala Azar in the village and the benefits offered by GoB at the nearest health facility • Following the DDT spraying schedule as mentioned in action plan. • Autonomy and funds for local purchase of DDT and other • Procurement of requisite materials • Basic training of health workers (BHWs) in spraying and mixing of DDT. • Autonomy and funds for purchase of mosquito bed nets locally • Training to BHWs for treating the bed nets with chemical solution • Contractual appointment of BHWs and MIs • Discussing with DHS for revising the wages for the team for spraying DDT. • Training of local people for spraying DDT in case of non-availability of manpower.	

Malaria Control Programme

Situation Analysis: District faces lack of laboratory technicians and facilities at the APHC/PHC level. This has proved to be a hurdle in prompt diagnosis of the cases. All BHW, BHI, ANM are responsible for collecting the BS of the suspected cases. The exact burden of disease in Arwal is not known as reports from private sector is not collected or not reported. The BCC activities in the district are also limited. There is also shortage of mosquito bed nets but anti-malarial drugs are in abundant.

Strategy	Activities	Budget
• Ensuring registration of all private laboratories • Filling-up of all vacant posts • Enhancing BCC activities • Ensuring adequate supply of mosquito bed nets	• Meeting with DM for issuing an order for all old and new laboratories to register with DHS. • Following their registration, they would be expected to report all the disease specific cases to the DHS. • All HWs would also be then requested to collect the reports. • Training of all health workers in BCC. • Supply of bed nets as per Maleria	Health workers- 50 additional health workers for spraying DDT on daily basis @Rs 200 * 30 days= Rs.300,000.00

Filaria Control Programme-		
Situation Analysis- Similar to Malaria and Kala Azar, lack of laboratory technicians and facilities at the APHC/PHC level continues to pose a challenge for an effective filarial control programme in the district. In case of Filaria specifically the exact burden of disease is not known because reports from the private sector are not collected or not reported. BCC activities in the district are limited. There is a shortage of chemically treated bed nets. Mass Drug Administration has been carried out in the population where cases have been detected.		
Strategy	**Activities**	**Budget**
1. Early diagnosis and prompt treatment 2. Ensuring registration of all private laboratories 3. Filling all vacant posts 4. Enhancing BCC activities 5. Ensuring adequate supply of mosquito bed nets 6. Ensuring adequate supply of drugs	1. House to house visits for tracing cases of Filariasis, by health workers (BHWs, ASHA, ANM) 2. Collection of reports from local private practitioners and laboratories in the village 3. Meeting with DM for issuing an order for all old and new laboratories to register with DHS. 4. Following their registration, they would be expected to report all the disease specific cases to the DHS. 5. All HWs would also be then requested to collect the reports. 6. Training of all health workers in BCC. 7. Supply of bed nets as per Kala-Azar 8. District level procurement of drugs for MDA, with funds from respective department.	**Health workers**-20 Additional workers on daily basis @ Rs 200 * 30 days= Rs.120,000.00 **Publicity campaign**- Rs.30,000.00 **Handbills and hoardings for BCC and IEC campaign** – Rs. 50,000.00

D. National Blindness Control Programme

Strategy	Activities	Budget
1. Prompt case detection 2. Ensuring proper treatment	• Screening of all children in the schools • Including Optometristsin Mobile medical units visits to camps in villages. • Fortnightly visit by optometrist optometrician to health sub-centers and weekly visit to APHCs • Contracting of ophthalmologist services • Distribution of spectacles from the health facilities	**Optometric**- 10 Optometrics *Rs.4000= Rs.480,000.00. Contracting in ophthalmologist- 25 ophthalmologist @Rs. 300 per hour* 8 Hours*2 weeks per month*12= Rs.1,440,000.00 Distribution of spectacles- 5,000spectacles* Rs.200 per spectacle=Rs.10,00,000.00

	• Conducting in-hospital minor surgeries for cataract. • Conducting surgeries in the NGO run hospitals and follow-up • Distribution of spectacles for BPL population undergoing surgery in private sector.	

Community Participation

Goal: to ensure that communities lead and determine health change

Objectives

- To ensure that the ASHA programme is fully operationalised with ASHAs representing community requirements in the implementation of health programmes and being an active link for the community to the health system
- To ensure that Village Health and Sanitiation Committees (VHSCs) are established across the district
- To establish a vibrant support structure for ASHAs and VHSCs across the district through selection and training of District Resource Persons and ASHA trainers.
- To strengthen the capacity of the DPMU to coordinate the ASHA programme by recruiting an ASHA Coordinators

ASHA		
1. Selection		
Situation analysis: Out of a total target 669 ASHAs for the District, All have already been selected. The number of ASHAs to be selected has been determined on the basis of older population estimates. Given that the current estimate of district rural population is 685661, the total number of ASHAs required at the norm of 1 for every 1000 population is 669. 14 ASHAs need to be further selected		
Strategies	Activities	Budget
• Sanction of 14to 20 additional ASHAs according to growth rate of Population. • Facilitate selection through a community process focused on creating awareness about the role of the ASHA as a community mobiliser and activist and her positioning as a representative of the community.	• Submission of proposal for the sanction and selection of 14 to 20 additional ASHAs • Development of an IEC campaign on the role of of the ASHA using print and folk media by Block Health Educators • Building partnerships with NGOs for conducting an IEC campaign on the ASHA programme • Monitoring of the IEC	**Selection** Rs100/visit for ASHA selection* 3 visits/ASHA * 20 ASHAs=Rs.6000.0 **Selection meetings** Rs. 250/meeting/ ASHA* 20 ASHAs=Rs.5000.0 **Review** Rs 100/visit for review meetings* 2 visits/ASHA*669 ASHAs=Rs.133,800.0 **Review meetings** Rs 250/meeting/

• Community based review of existing ASHAs for performance and replacement of non-functional ASHAs. • Partnership with local, active voluntary organizations with a background in community health work in the community based selection and review process	Campaign by Block Health Educators • Determining the community based selection and review process for ASHAs by DHS. • Partnership with NGOs for implementing the community based selection and review process • Monitoring of NGO partnership for community based selection and review of ASHAs by Block Health Educators.	ASHA* 669 ASHAs= Rs.167250.0 **Campaign for ASHA** 335 Villages* Rs200/Kalajatha event= Rs. 67000.0 **Monitoring of selection and review process** 12 visits/block*5 blocks*Rs200/visit= Rs.12000.0
2. Training		
Situation Analysis: Out of 669, 645 ASHAs have received only the first round of training.		
Strategies	Activities	Budget
• Conducting 12 days of camp based training for all ASHAs • Conducting 30 days of field based training for 30% of ASHAs in the district.	• Selection of trainers (8 trainers per block,1 per 20 ASHAs. A total of 40 trainers) • Development of training modules for training of trainers (TOT) and ASHAs. • Identification of 26 member team (2 /block) as District Resource Persons from the trainers who have received training at the state level as well as others. • Developing a training calendar for training 669 ASHAs in training phases of125 ASHAs each • Training of Trainers: (2 batches of apprx 20 trainers each to be trained for 7 days. Trainings can be organized parallely for two batches.) • Conducting camp based training at the APHC level. (for each block, training of 5 batches of ASHAs, each consisting 30 ASHAs will be conducted. This training will be conducted in total 4 rounds, each of the duration of 3 days. The entire training will spread across 5 months. There will be a one month	**Camp Based trainings** **Training of trainers expenses** 40 Trainers*7 days*Rs.100/day for food and travel= Rs28000.0 **Prep of TOT modules** 40 Trainers* Rs.300/module= Rs.12000.0 **ASHA training expenses** **Travel expense** 669 ASHAs*Rs 100/training* 4 trainings= Rs.267600.0 **Wage loss** 669 ASHAs*Rs100/day*12 days= Rs 802800.0 **Food +Stay**= 669 ASHAs*Rs.70/day*12 days= Rs.561960.0 **ASHA training modules** 669 ASHAs *Rs 300=Rs.200700.0 **District Resource Person's honorarium=** 5 DRPs* Rs150/day*300 days=

	gap between two rounds for every batch). Four trainers will be training for one batch. Block can conduct trainings of two batches simultaneously. • Phase 2 to be started by the 3rd month of Phase 1 and Phase 3 to be started by the 3rd month of Phase 2. • ASHAs trained in the 1st phase are expected to receive 30 days of field based training through the ASHA trainers. • Training review by Master trainers and hands on support to ASHA trainers during ASHA training • Review of and support to field based training provided by ASHA trainers • Continuous capacity building of ASHA trainers through cluster, block and district level monthly meetings	Rs.225000.0 **ASHA trainers honorarium** 40 ATs*Rs.100/day* 300days= Rs.1200000
3. Supportive Supervision		
Strategies	Activities	Budget
• ASHA trainers as supportive supervisors of the ASHA • Regular meetings of ASHAs and their trainers to review activities and provide support	• Monthly cluster level meetings of ASHAs, ANMs, AWWs, VHSC members and ASHA trainers • Monthly block level trainer's meeting • Monthly district level trainer's meeting • Development of simple monitoring formats to be filled out by ASHA trainers, and District Resource Persons to review the functionality of the programme • Organising an ASHA mela every year at the District level to create a sense of solidarity and support amongst ASHAs • ASHA Helpline to be managed by the ASHA helpdesks • Selecting active ASHAs with leadership qualities to be ASHA trainers	**Block level trainer meeting** Rs 500/meeting*12 meetings* 5 blocks=Rs.30,000.0 **District level trainer's meeting** Rs.500*12 meetings= Rs.6,000.0 **Printing of monitoring formats** =Rs.5000.0 **ASHA Mela** Rs.100,000.0

4. Incentive		
Strategies	Activities	Budget
• Timely release of monetary incentives to ASHAs • Instituting social incentives for ASHAs	• Review of hurdles in receiving incentives during training sessions • Smoothening process glitches • Sensitising MOs to honour ASHA referral • Ensuring that ASHAs have all updated contact information of health system functionaries at the relevant block and district level • Instituting an award for 10% of ASHAs at the district level	ASHA awards Rs. 50,000.0 Asha monthly meeting vehicle Allowances 669 Asha @100per asha *12 month = 802800.00 Refreshment of monthaly meeting 669 asha @ Rs 50 each *12 months = 401400.00
5. ASHA Programme Management		
Strategies	Activities	Budget
• Strengthening the DPMU for effective coordination of the ASHA programme by hiring an ASHA coordinator • Joint working of DPMU and Health Educators on operationalisation of the ASHA programme	• Advertising for an ASHA coordinator at the district level • Recruitment of ASHA coordinator • Health educators at the block level to support in ASHA training	ASHA Coordinator Rs.15,000.0/month* 12months= Rs.180,000.0 Cost of recruitment Rs.15,000.0
Village Health & Sanitation Committees		
Situation analysis: VHSCs have not yet been set up		
Strategies	Activities	Budget
1. Campaign on the importance and roles of VHSCs 2. Setting up of all VHSCs 3. Ensuring that VHSC funds are received by all VHSCs	1. Kala jathas on the role and importance of VHSCs 2. Partnerships with NGOs for setting up of VHSCs through 2 rounds of Gram Sabha meetings 3. Opening of bank accounts for all VHSCs 4. Ensuring transfer of funds	335 Villages* Rs200/Kalajatha event= Rs. 67000.0 VHSC untied funds 335 Villages*Rs10,000= Rs.3350,000.0

Capacity Building and Training

Maternal health		
Situation Analysis- All types of training organised by the DHS Arwal in the campus of PHC Arwal or DHS meeting hall becouse presentaly not functioning Sadar hospital. **Training of M.O. -** Mos training need for all purposes like a TB, leprocy, or Finnacial matters time to time to improve of all programme. **Training of BHM & Accountant-** There to posts of The DHS is the Key post. There need to training against time to time changing of Govt. Policy. Accountant training to be must in every monthor Quartly. **SBA Trainings**- SBA trainings are being organized in PHC Arwal. 12 regular Anm has got SBA training. The remaining regular and contractual ANMs are yet to receive the training. 25 present LHV also require SBA training. **EMOC Training-** 4 medical officer from the district has received EmOC training. **Family Planning -** 4 doctors have received Non scalpel Vasectomy training. No Minilap training has been organized in the district.		
Strategy	Activities	Budget
• Accountant and BHM Training must to be organised. • To ensure Mos Training for all type training must to be attend • SBA training to Sub centre ANMs. • SBA training to all three staff nurses from 9 priority APHCs • Building capacity of 2 staff nurses from each of 5PHC • Establishing district level training centers for regular trainings of the district staff.	• Accountant and BHM Training organised in the District With M.O. and CS, DPM, DAM. • SBA trainings to ANMs posted at Sub centre. Total ANMs present at Sub centre level is SBA trainings to ANM at 7*3 24*7 PHC.21 ANMs.Total number of ANMs=156. Therefore 39 batches each comprising of 4 ANMs have to be trained. • 2 Staff nurses from each of 5 PHCs, Total number of SNs to be trained=15. So total 3 batches need to be trained. • 1 LHV from each PHC. total number of LHV=5. So 1batches for training. **EMOC-** • 1 MO from each PHC • 1 MO from 9 priority APHCs. • Total number of MOs to be trained=13. Total 3 batches to be	**BHM and Accountant Training-** 5 BHM + 5Accountant total 10 @ 500 each participant = 5000 **Training refereshment -** 100 per participaints. **SBA trainings** SBA trainings for ANM-39 batches*Rs.8275per batch=Rs.322725.00 Staff Nurses- 3 batches*Rs.8275per batch=Rs.24825.00 LHV- 1 batches*Rs.8275=8275. **EMOC** 3 batches*Rs.106625per batch=Rs.319825.00

	trained. **Safe abortion services training** • 1 MO from each PHC • 1 MO from 9 priority APHCs. Total number of MOs to be trained=13. Total 3 batches to be. **IMNCI**- Basic training for- 1. 148 ANMs. 2. 6 LHVs, 3. 589 AWWs Physician's training 48 Mos **Anaesthetics skill training-** • 1 MO from each functional PHC. Total number of MOs to be trained=5. Total number of batches=1. **NSV training** • 1 MO from each block PHC. So 1 batches of 5 participants each. **STI/RTI training**- • 1 MO from each functional PHC So 1 batches of 5 participants each. **MINLAP training** • 1 MO from each functional PHC So 1 batches of 5 participants each. • . • **Training on Family Planning choices and IUD insertion** • 1 ANM from each of 26 APHC • 1 ANM from 5 functional PHC • 1 ANMs from 5 PHCs, So total number of ANM=5. So total 1 batches to be trained. • **ARSH training** • 1 MO each from 5 PHCs, Total number of MOs to be trained=5. So 1 batches of 5 participants each.	**Safe abortion services training** 3 batches*Rs.8,000=Rs.24,000.00 **IMNCI-** **Basic health worker training.** 750*100=Rs.75000 **Health worker ToT-** 2 batches*Rs.116,235= 232470 **Basic physician's training** 3 batches*Rs.126,630=Rs. 379890.00 **Follow up trainings-** 2 batches*40,131=Rs.80262.00 **Anaesthetics skill training=** 1 batches*Rs**.** 140,800=Rs.140800.00 **NSV training** 1batches*Rs.10,000=Rs.10,000.00 **STI/RTI training**- 1 batches*Rs.10,000=Rs20,000.00 **MINLAP training** 2 batches*Rs.10,000=Rs20,000.00 **Training on Family Planning choices and IUD insertion** 6 batches*Rs.10,000=Rs.60,000.00 **ARSH Training** 2 batches*Rs.8000=Rs.16,000.00

	• **SNCU training-** 2 MOs from 5 PHCs, Total number of MOs to be trained=10 so toatal 2 batches. Programme management training- Basic computer skills for clerical staff at DPMU, DHS, and PHCs and DPMSU. District health planning and management for DPMSU and DPM. Demanding and follow-up of the demand for training budget.	**SNCU training-** 2 batches*Rs.50,000=Rs100,000.00
Revised National Tuberculosis Control Programme		
Situation analysis- only 12 MOs in the district have received RNTCP Training. 6 LTs, 25 nursing staff and 224 community health workers in the district have been trained in RNTCP. Refresher training of MOs has not been organized though it was budgeted in the last year's action plan.		
strategy	Activities	Budget
Organizing trainings for all levels of TB workers	Refresher training for private practitioners. TB/HIV training for STLS,LTs, MPWs, MPHS, Nursing staff, community volunteers etc. TB/HIV training for STS Any other training activity Training for ASHA workers	**Refresher training to private practitioners-** **Health worker-** Rs.10,000.00 **Training for STS-** Rs.20,000.00 **Any other training-** Rs.21,000.00 **ASHA trainings**- Rs.66900.00 **Refereshment -** 33450.00
National Leprosy Control Programme.		
Strategy	Activity	Budget
Capacity building of district staff to create awareness towards leprosy.	Training of paramedics Refresher trainings for paramedics NGO trainings POD training	**Paramedics training-** 2 batches *Rs.12,000= Rs. 24000.00 **Refresher trainings for paramedics-** 2 batches *Rs.10,000=Rs.20,000.0 **NGO trainings**- 28 batches*Rs.4500=Rs.126,000.00 **POD Training-** 14 batches*Rs.5000=Rs.70000.00