# District Health Plan

# 2009-2010

# District Health Society
# Vaishali

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# Foreword

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system.

This District Health Action Plan (DHAP) is one of the key instruments to achieve NRHM goals. This plan is based on health needs of the district.

After a thorough situational analysis of district health scenario this document has been prepared. In the plan, it is addressing health care needs of rural poor especially women and children, the teams have analyzed the coverage of poor women and children with preventive and promotive interventions, barriers in access to health care and spread of human resources catering health needs in the district. The focus has also been given on current availability of health care infrastructure in pubic/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.

The goals of the Mission are to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

I need to congratulate the department of Health and Family Welfare and State Health Society of Bihar for their dynamic leadership of the health sector reform programme and we look forward to a rigorous and analytic documentation of their experiences so that we can learn from them and replicate successful strategies. I also appreciate their decision to invite consultants (NHSRC/ PHRN) to facilitate our DHS regarding preparation the DHAP. The proposed location of HSCs, PHCs and its service area reorganized with the consent of ANM, AWW, male health worker and participation of community has finalized in the block level meeting.

I am sure that this excellent report will galvanize the leaders and administrators of the primary health care system in the district, enabling them to go into details of implementation based on lessons drawn from this study.

**Atish Chandra, IAS**
**(DM, Vaishali)**

## About the Profile

Under the National Rural Health Mission this District Health Action Plan of Vaishali district has been prepared. From this, the situational analysis the study proceeds to make recommendations towards a policy on workforce management, with emphasis on organizational, motivational and capability building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps identified and addressed. It looks at how the facilities at different levels can be structured and reorganized.

The information related to data and others used in this action plan is authentic and correct according to my knowledge as this has been provided by the concerned medical officers of every block. I am grateful to the state level consultants ( NHSRC/PHRN), ACMO, MOICs, Block Health Managers and ANMs and AWWs from their excellent effort we may be able to make this District Health Action Plan of Vaishali District.

I hope that this District Health Action Plan will fulfill the intended purpose.

**Dr. Ashok Kumar Sinha**
**Civil Surgeon**
**Vaishali**

# Chapter-1

# Introduction

## 1.1 Background

Keeping in view health as major concern in the process of economic and social development revitalization of health mechanism has long been recognized. In order to galvanize the various components of health system, National Rural Health Mission (NRHM) has been launched by Government of India with the objective to provide effective health care to rural population throughout the country with special focus on 18 states which have weak public health indicators and/or weak infrastructure. The mission aims to expedite achievements of policy goals by facilitating enhanced access and utilization of quality health services, with an emphasis on addressing equity and gender dimension. The specific objectives of the mission are:

- Reduction in child and maternal mortality
- Universal access to services for food and nutrition, sanitation and hygiene, safe drinking water
- Emphasis on services addressing women and child health; and universal immunization
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary health care
- Revitalization local health traditions and mainstreaming of AYUSH
- Population stabilization

One of the main approaches of NRHM is to communities, which will entail transfer of funds, functions and functionaries to Panchayati Raj Institutions (PRIs) and also greater engagement of **Rogi Kalyan Samiti** (RKS). Improved management through capacity development is also suggested. Innovations in human resource management are one of the major challenges in making health services effectively available to the rural/tribal population. Thus, NRHM proposes ensured availability of locally resident health workers, multi-skilling of health workers and doctors and integration with private sector so as to optimally use human resources. Besides, the mission aims for making untied funds available at different levels of health care delivery system.

Core strategies of mission include decentralized public health management. This is supposed to be realized by implementation of District Health Action Plans (DHAPs) formulated through a participatory and bottom up planning process. DHAP enable village, block, district and state level to identify the gaps and constraints to improve services in regard to access, demand and quality of health care. In view with attainment of the objectives of NRHM, DHAP has been envisioned to be the principle instrument for planning, implementation and monitoring, formulated through a participatory and bottom to up planning process. NRHM-DHAP is anticipated as the cornerstone of all strategies and activities in the district.

For effective programme implementation NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the need for situation analysis, stakeholder involvement in action planning, community

mobilization, inter-sectoral convergence, partnership with Non Government Organizations (NGOs) and private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving program functionaries and community representatives at district level.

***Stakeholders in Process***

- *Members of State and District Health Missions*
- *District and Block level programme managers, Medical Officers.*
- *State Programme Management Unit, District Programme Management Unit and Block Program Management Unit Staff*
- *Members of NGOs and civil society groups*
- *Support Organisation – PHRN and NHSRC*

Besides above referred groups, this document will also be found useful by health managers, academicians, faculty from training institutes and people engaged in programme implementation and monitoring and evaluation.

### 1.2 Objectives of the Process

The aim of this whole process is to prepare NRHM – DHAP based on the framework provided by NRHM-Ministry of Health and Family Welfare (MoHFW). Specific objectives of the process are:

- ⇨ To focus on critical health issues and concerns specifically among the most disadvantaged and under-served groups and attain a consensus on feasible solutions
- ⇨ To identify performance gaps in existing health infrastructure and find out mechanism to fight the challenges
- ⇨ Lay emphasis on concept of inter-sectoral convergence by actively engaging a wide range of stakeholders from the community as well as different public and private sectors in the planning process
- ⇨ To identify priorities at the grassroots and curve out roles and responsibilities at block level in designing of DHAPs for need based implementation of NRHM

### 1.3 Process of Plan Development

#### 1.3.1 Preliminary Phase

The preliminary stage of the planning comprised of review of available literature and reports. Following this the research strategies, techniques and design of assessment tools were finalized. As a preparatory exercise for the formulation of DHAP secondary Health data were complied to perform a situational analysis.

### 1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

The Government of the State of Bihar is engaged in the process of re – assessing the public healthcare system to arrive at policy options for developing and harnessing the available human resources to make impact on the health status of the people. As parts of this effort present study attempts to address the following three questions:

1. How adequate are the existing human and material resources at various levels of care (namely from sub – center level to district hospital level) in the state; and how optimally have they been deployed?

2. What factors contribute to or hinder the performance of the personnel in position at various levels of care?

3. What structural features of the health care system as it has evolved affect its utilization and the effectiveness?

With this in view the study proceeds to make recommendation towards workforce management with emphasis on organizational, motivational and capacity building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps identified and addressed. It also commends at how the facilities at different levels can be structured and organized.

The study used a number of primary data components which includes collecting data from field through situation analysis format of facilities that was applied on all HSCs and PHCs of Vaishali district. In addition, a number of field visits and focal group discussions, interviews with senior officials, Facility Survey were also conducted. All the draft recommendations on workforce management and rationalization of services were then discussed with employees and their associations, the officers of the state, district and block level, the medical profession and professional bodies and civil society. Based on these discussions the study group clarified and revised its recommendation and final report was finalized.

Government of India has launched National Rural Health Mission, which aims to integrate all the rural health services and to develop a sector based approach with effective intersectoral as well as intrasectoral coordination. To translate this into reality, concrete planning in terms of improving the service situation is envisaged as well as developing adequate capacities to provide those services. This includes health infrastructure, facilities, equipments and adequately skilled and placed manpower. District has been identified as the basic coordination unit for planning and administration, where it has been conceived that an effective coordination is envisaged to be possible.

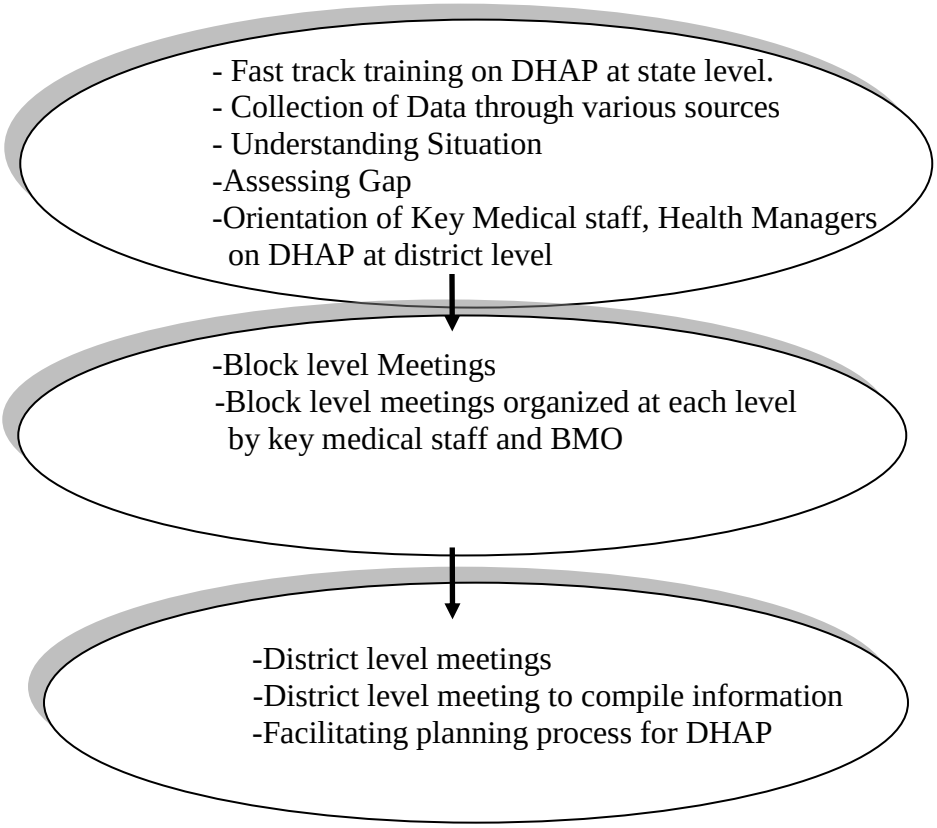
This Integrated Health Plan document of Vaishali district has been prepared on the said context.

### 1.3.3 Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon, ACMO (Nodal officer for DHAP formulation), all programme officers and NHSRC/PHRN as well as the MOICs, Block Health Managers, ANMs, as a result

of a participatory processes as detailed below. After completion the DHAP, a meeting is organized by Civil Surgeon with all MOIC of the block and all programme officer. Then discussed and displayed prepared DHAP. If any comment has came from participants it has added then finalized. The field staffs of the department too have played a significant role. District officials have provided technical assistance in estimation and drafting of various components of this plan.

After a thorough situational analysis of district health scenario this document has been prepared. In the plan, it is addressing health care needs of rural poor especially women and children, the teams have analyzed the coverage of poor women and children with preventive and promotive interventions, barriers in access to health care and spread of human resources catering health needs in the district. The focus has also been given on current availability of health care infrastructure in pubic/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.




**District Health Action Plan Planning Process**

# Chapter 2

## District Profile

# History

Vaishali derives its name from King Vishal of the Mahabharata age. The district of Vaishali came in to existence on 12/10/1972. Earlier it was the part of old Muzzafarpur district. Vaishali has a past that pre-dates recorded history. It is held that the town derives its name from King Vishal, whose heroic deeds are narrated in the Hindu epic Ramayana. However, history records that around the time Pataliputra was the centre of political activity in the Gangetic plains, Vaishali came into existence as centre of the Ganga, it was the seat of the Republic of Vajji. Vaishali is credited with being the World's First Republic to have a duly elected assembly of representatives and efficient administration. The Lord Buddha visited Vaishali more than once during his lifetime and announced his approaching Mahaparinirvana to the great followers he had here. Five years after the Enlightenment in Bodh Gaya, Lord Buddha came to Vaishali, the capital of one the first republican states in the Ganga, Vaishali is bound by the hills of Nepal on the north and the river Gandak on the west. Hundred years after he attained Mahaparinirvana, it was the venue of the second Buddhist Council. According to one belief, the Jain Tirthankar, Lord Mahavir was born at Vaishali. The Chinese travelers Fa-Hien and Hieun Tsang also visited this place in early 5th and 7th centuries respectively and wrote about Vaishali.

The Lichchavi nobility came to receive the Enlightened One with a cavalcade of elephants and chariots bedecked with gold. As the Lord set foot on the soil of Vaishali, **lightning and thunder** followed by a heavy downpour purged the plague-infected city. The Buddha preached the Ratna Sutra to those assembled, and eighty-four thousand people embraced the new faith. It was also at Vaishali that Amrapali, the famous courtesan, earned the respect of the *Sangha* and a place in history, with her generous donations. The neighbouring village of Amvara is said to be the site of Amrapali's mango grove. Once when the Lord was visiting Vaishali, Amrapali invited him to her house and the Lord graciously accepted the offer. An overjoyed Amrapali, returning on her chariot, raised a cloud of dust. The Lichchavi princes going to meet the Buddha got enveloped in the dust and learnt of the Buddha's forthcoming visit to her house. The Lichchavi princes wanted to exchange Amrapali's honour for one hundred thousand gold coins. Amrapali steadfastly refused their offer and after the Buddha's visit to her house she was

purged of all impurities. She gifted her mango grove to the *Sangha*. Amrapali joined the order after realising the transitory nature of all things, including beauty.

A kilometre away is Abhishek Pushkarini, the coronation tank. The sacred waters of the tank anointed the elected representatives of Vaishali. Next to it stands the Japanese temple and the Vshwa Shanti Stupa (World Peace Pagoda) built by the Nipponzan Myohoji sect of Japan. A small part of the Buddha's relics found in Vaishali have been enshrined in the foundation and in the *chhatra* of the Stupa. Near the coronation tank is Stupa 1 or the Relic Stupa. Here the Lichchavis reverentially encased on of the eight portions of the Master's relics, which they received after the Mahaparinirvana. In the north is the Site Museum. It has an excellent collection dating from 3rd century BC to 6th century AD. The terracotta monkey heads in different styles are interesting. The Site Museum is open daily from 9 am to 5 pm. It is closed on Fridays. Entry is free. After his last discourse the Awakened One set out for Kushinagar, but the Lichchavis kept following him. Buddha gave them his alms bowl but they still refused to return. The Master created an illusion of a river in spate which compelled them to go back. This site can be identified with Deora in modern Kesariya village, where Ashoka later built a stupa. Ananda, the favourite disciple of the Buddha, attained *Nirvana* in the midst of the Ganga outside Vaishali.

## Geographical Location

The District is located at 25° to 30° North latitude and 84° to 85° east longitude. The District is surrounded by river Ganga in south, Gandak in west. District Muzaffarpur is in north & Samastipur n East. The District is in semi tropical Gangetic plane. The state capital Patna is linked with famous Mahatma Gandhi Setu. The District is spread over 2036 sq km area.


## Govt's Administrative Set-up

There are three sub divisions and 16 Blocks in the District. The District has 1638 revenue villages and 291 Gram panchayats. Traditionally the District was divided into 11 C.D. Blocks but five more Blocks were created during last decade. A few of the newly created Blocks are still in the formation process. The newly elected Panchayati Raj is enthusiastic to play important role in the District.

## District Health Administrative Setup

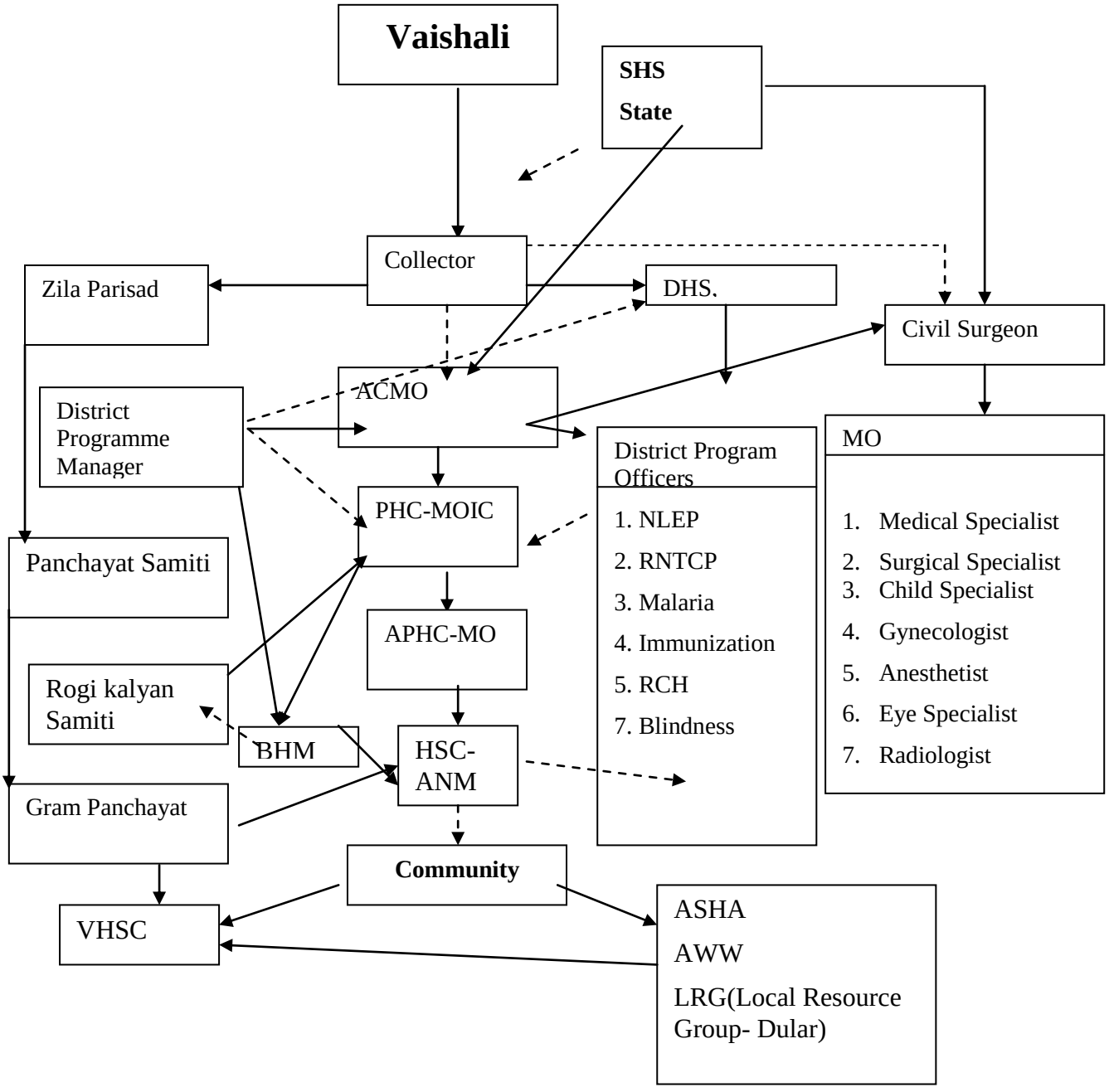


**Table. ADMINISTRATIVE UNITS AND TOWNS IN VAISHALI DISTRICT**

| PHC | Community Development Blocks | Towns | Assembly Segments |
|---|---|---|---|
| Raghopur | Raghopur | | Raghopur |
| Mahnar | Mahnar( Subdivision) | Mahnar | Mahnar |
| Bidupur | Bidupur | | Raghopur |
| Jandaha | Jandaha | | Jandaha |
| Sahdei Bujurg | Sahdei Bujurg | | Mahnar |
| Lalganj ( RH) | Lalganj | Lalganj | Lalganj |
| Mahua | Mahua ( Subdivision) | | Mahua |
| Desri | Desri | | Mahnar |
| Goroul | Goroul | | Vaishali |
| Patepur | Patepur | | Patepur |
| Hazipur | Hazipur ( Subdivision) | Hazipur | Hazipur |
| Rajapakar | Rajapakar | | Jandaha |
| Paterhi Belsar | Paterhi Belsar | | Vaishali |
| Bhagwanpur | Bhagwanpur | | Lalganj |
| Vaishali | Vaishali | | Vaishali |
| Khajechand Chapra ( RH) | | | Vaishali |
| Hazipur sadar hospital | Hazipur ( District HQ) | Hazipur | Hazipur |

*Lok Sabha (Parliamentary)* – 1. Vaishali 2. Hazipur

# VAISHALI – AT A GLANCE

| | | |
|---|---|---|
| AREA ( Sq. Kms):- | 2036 | |
| | | |
| POPULATION(CENSUS 2001) | | |
| TOTAL | :- | 2718421 |
| MALES | :- | 1415603 |
| FEMALES | :- | 1302818 |
| | | |
| RURAL POPULATION | | |
| TOTAL | :- | 2531766 |
| MALES | :- | 1316796 |
| FEMALES | :- | 1214490 |
| | | |
| URBAN POPULATION | | |
| TOTAL | :- | 186655 |
| MALES | :- | 98807 |
| FEMALES | :- | 87848 |
| | | |
| POPULATION OF SCHEDULED CASTES | :- | 562123 |
| | | |
| POPULATION OF SCHEDULED TRIBES | :- | 3068 |
| | | |
| DENSITY OF POPULATION | :- | 1335 |
| | | |
| SEX RATIO | :- | 920 |

## COMPARATIVE POPULATION DATA( 2001 Census)

| Basic Data | India | Bihar | Vaishali |
|---|---|---|---|
| Population | 1027015 | 828787 | 2718421 |
| Density | 324 | 880 | 1335 |
| Socio- Economic | | | |
| Sex- Ratio | 933 | 921 | 920 |
| Literacy % Total | 65.38 | 47.53 | 50.49 |
| Male | 75.85 | 60.32 | 63.23 |
| Female | 54.16 | 33.57 | 36.58 |

| | | |
|---|---|---|
| **LITERACY RATE** | | |
| TOTAL | :- | 50.49% |
| MALES | :- | 63.23% |
| FEMALES | :- | 36.58% |
| **VILLAGES** | | |
| TOTAL | :- | 1569 |

| | | |
|---|---|---|
| INHABITED:- 1414 | | |
| UNINHABITED:- 155 | | |
| | | |
| PANCHAYATS | :- | 291 |
| | | |
| SUB-DIVISION | :- | 03 |
| | | |
| BLOCKS | :- | 16 |
| | | |
| REVENUE CIRCLES | :- | 15 |
| | | |
| HALKAS | :- | 114 |
| | | |
| POLICE STATIONS | :- | 22 |
| | | |
| POLICE OUTPOSTS | :- | 06 |
| | | |
| TOWNS | :- | 03 |
| NAGAR PARISHAD(HAJIPUR) | :- | 01 |
| NAGAR PANCHAYAT( LALGANJ, MAHNAR). | :- | 02 |
| | | |
| M.P CONSTITUENCY | :- | 2 ( 1 Part) |
| | | |
| M.L.A. CONSTITUENCY | :- | 8 (Part) |
| **HEALTH** | | |
| | | |
| DISTRICT HOSPITAL | :- | 01 |
| | | |
| REFERRAL HOSPITAL | :- | 02 |
| | | |
| PRIMARY HEALTH CENTRE | :- | 14 |
| | | |
| ADDITIONAL PRIMARY HEALTH CENTRE | :- | 30 |
| | | |
| HEALTH SUB CENTRE | :- | 336 |
| | | |
| GRAMIN AUSADHALAY | :- | 09 |
| | | |
| BLOOD BANK | :- | 01 |
| | | |
| AIDS CONTROL SOCIETY | :- | 01 |
| | | |
| TRAINED NURSES | :- | 401 |
| | | |
| TRAINED DOCTORS | :- | 123 |

## 2.1 SOCIO-ECONOMIC PROFILE

### Social

- Vaishali district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Vaishali have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.
- 20.7% of the population belongs to SC and 0.1% to ST. There are at least 13% percent villages where the SC population is more than 40%. Some of the most backward communities are *Mushahar, Turha, Mallah* and *Dome*.

### Economic

- The main occupation of the people in Vaishali is Agriculture, Fisheries and daily wage labour.
- Almost 20% of the youth population migrates in search of jobs to the metropolitan cities like Kolkata, Mumbai, Pune etc.
- The main crops are Wheat, Paddy, Pulses, Oilseeds, Mango.
- Banana and Tobacco are the major cash crop of the community residing at the bank of holy river Ganges.

Demographic scenario of Vaishali district.
According to Census of India 2001:

- The size of population of Vaishali district is above 2718421, comprising 3.27% population of Bihar state in 2.2% proportion of state's area.
- Very high density of population (1335) which is still rising
- Decadal population growth rate of 26.39% as against 28.43% of the state as a whole. Thus the decadal growth rate of the district is slightly less than that of the state.
- Sex ratio of the population is 920 females per thousand males which is almost same as the sex ratio of the state. It is difficult to interpret the deficit of 80 females per thousand males in the district despite outward migration, predominantly of males in the working ages. A plausible explanation seems to be that over the years male population has benefited more from the epidemiological transition than the female population.
- Only 6.9% of the population resides in the urban area, and the rest lives in the rural areas.

Based on these statistics one can say that Vaishali district lacks urbanization and industrialization. As elsewhere in Bihar, Vaishali suffers from lack of infrastructure facilities, lack of connectivity, and lack of social development and most people depend on small size agricultural land. Agricultural productivity is further affected adversely by recurrent floods and droughts (World Bank, 2005).

### Rainfall and Flood Situation

The district receives medium to heavy rainfall (average rainfall 1161 mm), and faces condition of severe flood. In the year 2007 the flood condition was so bad that almost 145 gram panchayats and 583 villages got marooned. Patepur and Jandaha blocks were the worst affected blocks.

According to the estimates of National Disaster Management Department, **in the year 2007, 1,64,237 people were directly affected by the floods.** Crops were damaged, and there was irreparable damage to property and huge loss of lives. **The economic loss due to floods this year amounts to Rs. 65 crore of crop loss, Rs. 25 crore of housing loss and Rs. 27 crore of public property loss.** The district has poor drainage system and nearly 4% of the area is water logged.

The district is spread over 2,036 sq km area, with no forest cover. 67% of the land is agricultural and nearly 67% of the area under cultivation is irrigated. Vaishali district is also affected by droughts. Cycles of floods and droughts severally affect the food production and food distribution system, and lead to distressful situation for most people.

## 2.2HEALTH PROFILE

### General Status of health in Vaishali district

In a study of 513 districts of the country (Jansankhya Sthirata Kosh", www.jsk.gov.in) in terms of overall rank in health it was found that Vaishali district ranks 460 though on the basis of under-five mortality it ranked 274. Filaria, Malaria, Dengue, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in Vaishali district. Hepatitis, Diarrhea, Typhoid, Blindness and Leprosy are other high prevalence diseases. Kala-azar is an endemic problem in Bihar. As per DLHS 2002-2004 the prevalence percentage of kala-azar is 11.4% and TB is 4.3%. The overall prevalence of tuberculosis in India is 544 per 100,000 populations while in Vaishali it is reported to be close to 618 per 100,000 (RCH, Round 2).

**Table-: Infant Mortality Rate (IMR) and Child Mortality Rate (CMR)**

| Indicators | Rural | | | Urban | | | Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | T | M | F | T | M | F | T | |
| Infant Mortality Rate | 41 | 57 | 50 | 34 | 36 | 35 | 40 | 56 | 48 | Vaishali |
| | 56 | 60 | 58 | 41 | 42 | 42 | 55 | 58 | 57 | Bihar |
| | | | | | | | | | | India |
| Child Mortality Rate | 54 | 65 | 59 | 37 | 43 | 40 | 53 | 65 | 59 | Vaishali |
| | **59** | **69** | **64** | **42** | **46** | **44** | **57** | **66** | **62** | **Bihar India** |

*Source: Population Foundation of India May 2008*

The table gives the estimates of infant mortality rates and child mortality rates of Vaishali and compared with the data of Bihar. **IMR in rural areas (50) are higher than the urban areas (35). Also CMR in rural areas (59) is higher than in urban areas (40).** The differential ratio of infant mortality rate of male/female is 0.7 and rural/urban is 1.4. The differential ratio of child mortality rate of male/female is 0.8 and rural/urban is 1.5.

**2.2.1HEALTH STATUS AND BURDEN OF DISEASES**

## *Table. CASE FATALITY RATE*

| S.No. | | 2007 | | 2008( Till Nov) | |
|---|---|---|---|---|---|
| | **Disease** | **Case** | **Death** | **Case** | **Death** |
| 1 | Gastroenteritis | 67 | 6 | 166 | 0 |
| | Diarrhea / Dysentery | 1515 | 5 | 882 | 2 |
| | Cholera | 0 | 0 | 0 | 0 |
| | Meningitis | 0 | 0 | 0 | 0 |
| | Jaundice | 0 | 0 | 0 | 0 |
| | Tetanus | 0 | 0 | 0 | 0 |
| | Kala-azar | 3275 | 6 | 2632 | 3 |
| | Malaria | 0 | 0 | 0 | 0 |
| 9 | Measles | 0 | 0 | 0 | 0 |
| 10 | A.R.I. | NA | NA | NA | NA |

**Table . MORBIDITY DUE TO MAJOR DISEASE**

| S.No. | Disease | 2007 | 2008 |
|---|---|---|---|
| 1 | Kala-azar | 3275 | 2632 |
| 2 | T.B. (NSP) | 997 | 575 |
| 3 | Leprosy (PR/10000) | 1.15 | 1.30 |

**Table . BASIC HEALTH STATUS INDICATORS OF VAISHALI DISTRICT**

| Indicators | Vaishali | Bihar |
|---|---|---|
| Couple Protection Rate (CPR) | 33% | |
| Crude Death Rate (CDR) | NA | 8.1 |
| Crude Birth Rate | 31.9 | 30.4 |
| Infant Mortality Rate | 61 | 61 |
| Maternal Mortality Rate | 371 | 371 |
| Total Fertility Rate (TFR) | 4.6 | 4 |
| Under 5 Mortality Rate | NA | 85 |
| Still Birth Rate | NA | NA |
| Abortion rate | NA | NA |

**Table . DENOTING PRIORITY AREAS IN EACH OF THE BLOCK**

| Block | Hard to Reach area |
|---|---|
| Raghopur | Whole Raghopur block (72 villages) |
| Mahnar | Village Bahlolpur |
| Patepur | Two villages |

**Note:** During raining season i.e. From mid June to September almost 80 percent of the villages become hard to reach area.

**2.2.2**PUBLIC HEALTH CARE DELIVERY SYSTEM: ORGANISATIONAL STRUCTURE AND INFRASTRUCTURETable HEALTH CARE INSTITUTIONS IN THE DISTRICT

| S.No. | Type of Institutions | Number | No. of Beds* |
|---|---|---|---|
| 1 | District Hospital | 1 | 120 |
| 2 | Referal | 2 | 60 |
| 3 | Block PHCs | 15 | 90 |
| 4 | APHCs | 33 | 0 |
| 5 | Sub-centres | 336 | 0 |
| 8 | Ayurvedic Dispensaries | 9 | 0 |
| 9 | Anganwadi Centres | 2476/2672 | - |
| 10 | Others (Pvt. Facility accreditated) | 25 | 250 |

**Table . DISTRIBUTION OF PUBLIC HEALTH FACILITIES IN DISTRICT**

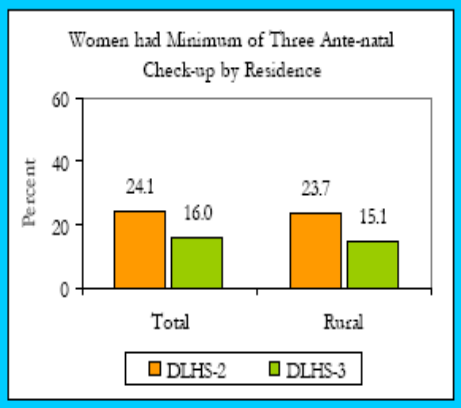
| District Hospital | Civil Hospital | Community Health Centres | Block PHC | FRU/Referal |
|---|---|---|---|---|
| **1** | **0** | **0** | **15** | **2** |

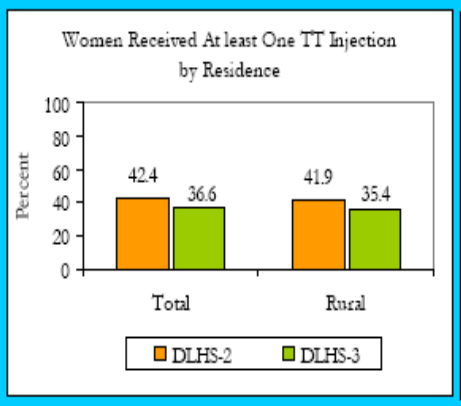
***2.3 Map showing specialist doctors position blockwise***

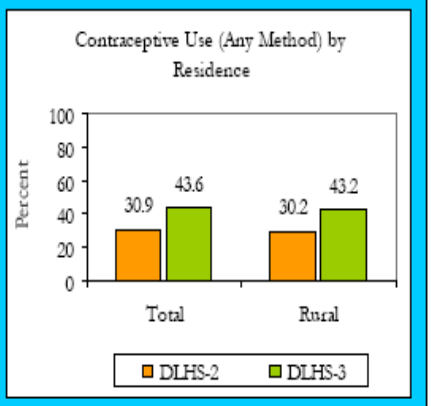
2.4 Map showing PHC and APHC locations

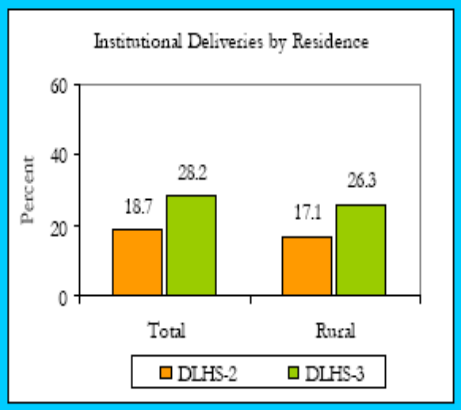
Bihar DLHS-3 District : Vaishali

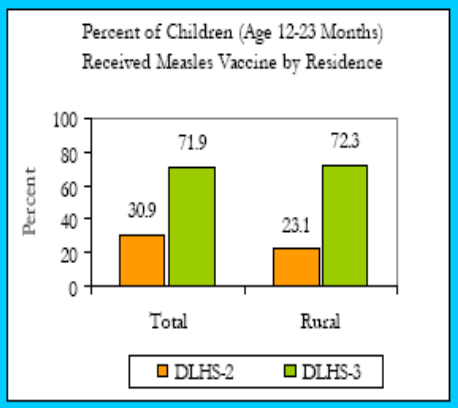
# Performance at a Glance

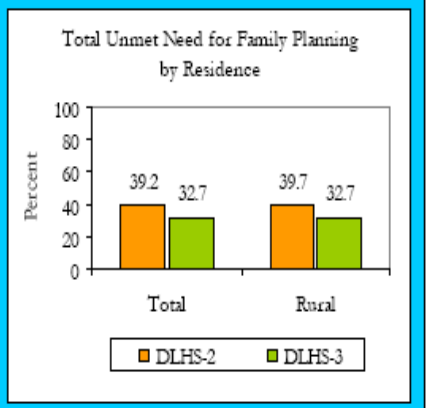


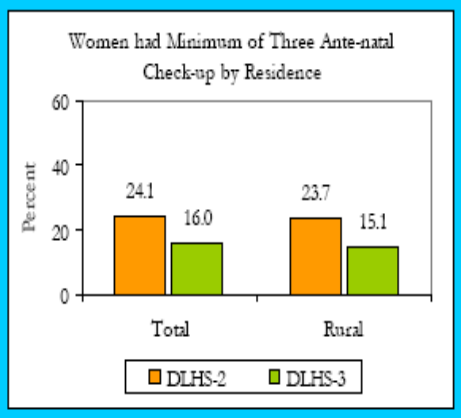



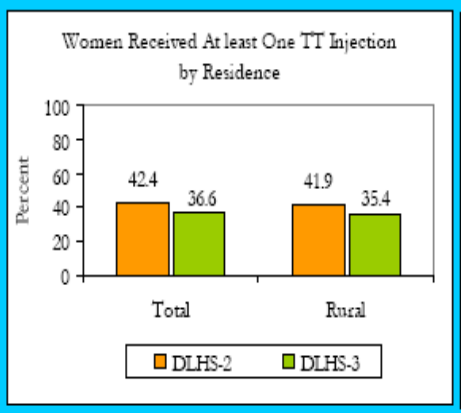



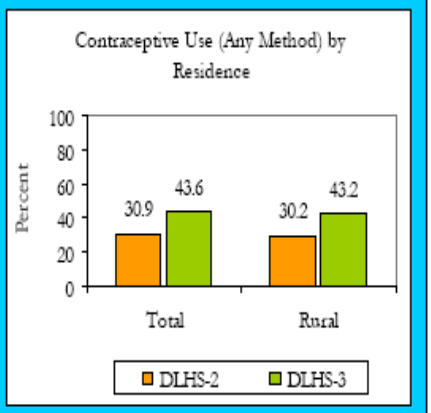



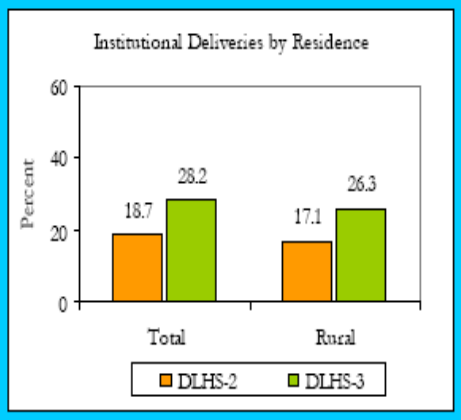
Bihar DLHS-3 District : Vaishali

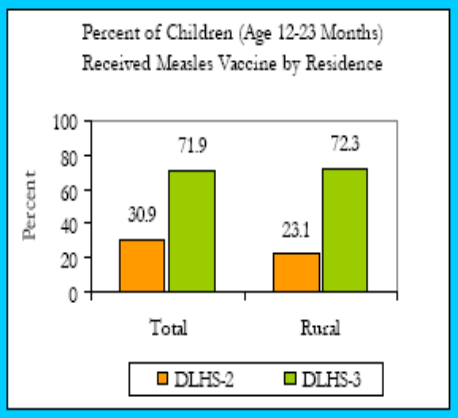
## Performance at a Glance

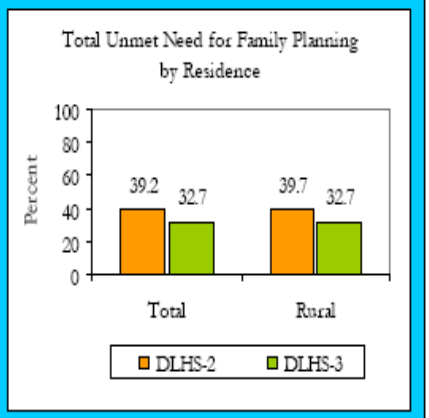


# Chapter 3
# Situation Analysis

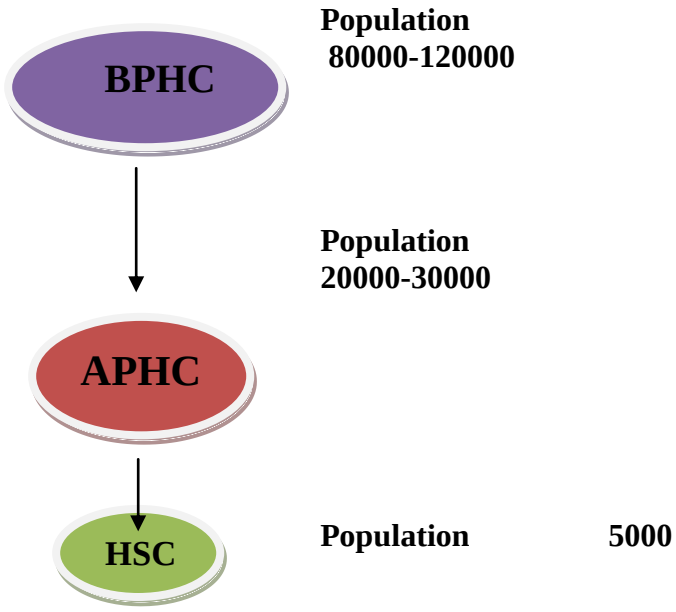
In the present situational analysis of the blocks of district Vaishali the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from census 2001, report of DHS office, Vaishali and various websites as well as other sources. These indicators help in pointing to the health scenario in Vaishali from a quantitative point of view, while they cannot by themselves provide a complete picture of the status of health in the district. However, it is useful to have outcome data to map the effectiveness of public investment in health. Further, when data pertaining to vital rates are analyzed in conjunction with demographic measures, such as sex ratio and mean age of marriage, they throw valuable light on gender dimension. Table below indicates the Health indicators of Vaishali district with respect to Bihar and India as a whole.

**Table: Health Indicators**

| Indicator | Vaishali | Bihar | India |
|---|---|---|---|
| CBR | 31.9 | 29.2 | 23.8 |
| CDR | NA | 8.1 | 6 |
| IMR | 61 | 61 | 58 |
| MMR | 371 | 371 | 301 |
| TFR | 4.6 | 4 | 2.68 |
| CPR | 33 | 34.1 | 56.3 |
| Complete Immunization | 26.1 | 32.8 | 44 |

**Sources: DLHS3, NFHS3, SRS2007**

### 3.1.1. GAPS IN INFRASTRUCTURE:



First contact point with community

**Introduction:**

Health Sub Centre is very important part of entire Health System. It is first available Health facility nearby for the people in rural areas.
We are trying to analyze the situations at present in accordance with Indian Public Health Standards.

1. **Infrastructure for HSCs:**

IPHS Norms:

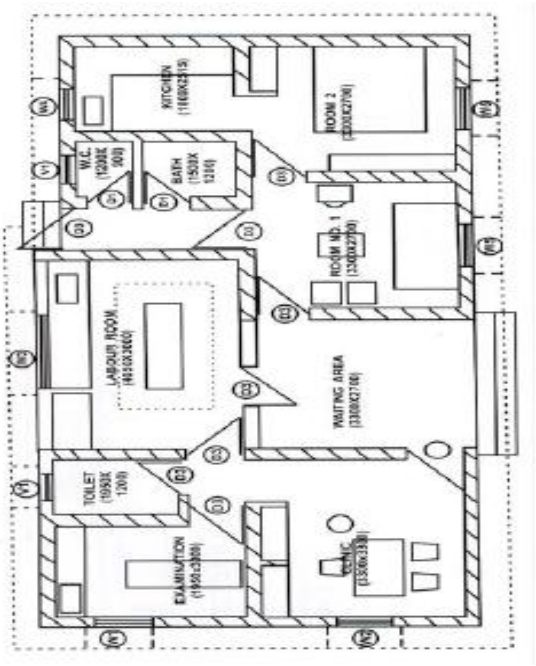
A Sub-centre should have its own building. If that is not possible immediately, the premises with adequate space should be rented in a central location with easy access to population.

i. Location of the centre: The location of the centre should be chosen that:

   a. It is not too close to an existing sub centre/ PHC
   b. As far as possible no person has to be travel more than 3 Km to reach the Sub centre
   c. The Sub Centre Village has some communication network (Road communication/Public Transport/Post Office/Telephone)
   d. Accommodation for the ANM/Male Health Worker will be available on rent in the village if necessary.
      For selection of village under the Sub Centre, approval of Panchayats as may be considered appropriate is to be obtained.

ii. The minimum covered area of a Sub Centre along with residential Quarter for ANM will vary from 73.50 to 100.20 sq mts. depending on climatic conditions(hot and dry climate, hot and humid climate, warm and humid climate), land availability and with or without a labor room. A typical layout plan for Sub-Centre with ANM residence as per the RCH Phase-II National Program me implementation Plan with area/Space Specifications is given below

Typical Layout of Sub- Centre with ANM Residence




| | | |
|---|---|---|
| Waiting Area | : | 3300mm x 2700mm |
| Labour Room | : | 4050mm x 3300mm |
| Clinic room | : | 3300mm x3300mm |
| Examination room | : | 1950mm x 3000mm |
| Toilet | : | 1950mm x 1200mm |

Residential Accomodation : this should be made available to the Health workers with each one having 2 rooms, kitchen, bathroom and WC. Residential facility for one ANM is as follows which is contiguous with the main subcentre area.

Room -1 (3300mm x 2700mm)
Room-2(3300mm x 2700mm)
Kitchen-1(1800mm x 2015mm)
W.C.(1200mm x 900mm)
Bath Room (1500mm x 1200mm)

One ANM must stay in the Sub-Centre quarter and houses may taken on rent for the other/ANM/Male Health worker in the sub centre village. This idea is to ensure that at least one worker is available in the Sub-Centre village after the normal working hours. For specifications the "Guide to health facility design" issued under Reproductive and Child Health Programme(RCH-I and II) of Government of India, Ministry of Health and Family Welfare may be referred.

**Health Sub Centers:** Total population of the district as per 2001 census is 2718421. After considering two percent growth rate of the total population it comes around 3187470 (Decadal Growth Rate2.3). After considering projected population in 2008, the district needs altogether 637 HSCs to cater its whole population. At present Vaishali has 338 established Health Sub Centers and 154 more Health sub centers are proposed to be formed. As per the IPHS norms (5000 population in plain area) the district still requires 135 new HSCs to be formed. Again , out of 338 established HSCs, only 39 have their own buildings and rest 299 run in rented houses. All these 39 HSCs need renovation work. All the above mentioned HSCs need equipments, drugs, furniture and stationeries.

| Health Sub Centers: | | | | |
|---|---|---|---|---|
| **Sub Heads** | **Gaps** | **Issues** | **Strategy** | **Activities** |
| | | | | |
| **Infrastructure** | A. Out of 338 HSCs only 39 are having own building | In adequate facility in constructed building and lack of community ownership | Enhance visibility of HSC through hardware activity by the help of community participation . | A**Strengtheing of HSCs having own buildings** |
| | B. In existing 39 buildings 26 are in running comparatively in good condition, 6 are in under constriction ,one is very poor condition and one is constructed but not hand over to health department. | | | B.1.White washing of HSC buildings.<br><br>B.2.Organize adolescent girls for wall painting and plantation./hire local painter for colure full painting of HSC walls. List out all services which is provided at HSC level. On the wall.<br><br>B.3.Gardening in HSC premises by school children. |
| | C.No one building is having running water and electric supply. | | | C.Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental. |
| | D. Lack of equipments and ANM are reluctant to keep all equipments in HSC .<br><br>E. Lack of appropriate furniture | . Operational problem in availability of equipment in constructed HSC | | D.1.Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/)<br><br>D.2. Purchase of equipments according to services<br>Purchase one almiaria for keep all equipment safely and it could be keep in |

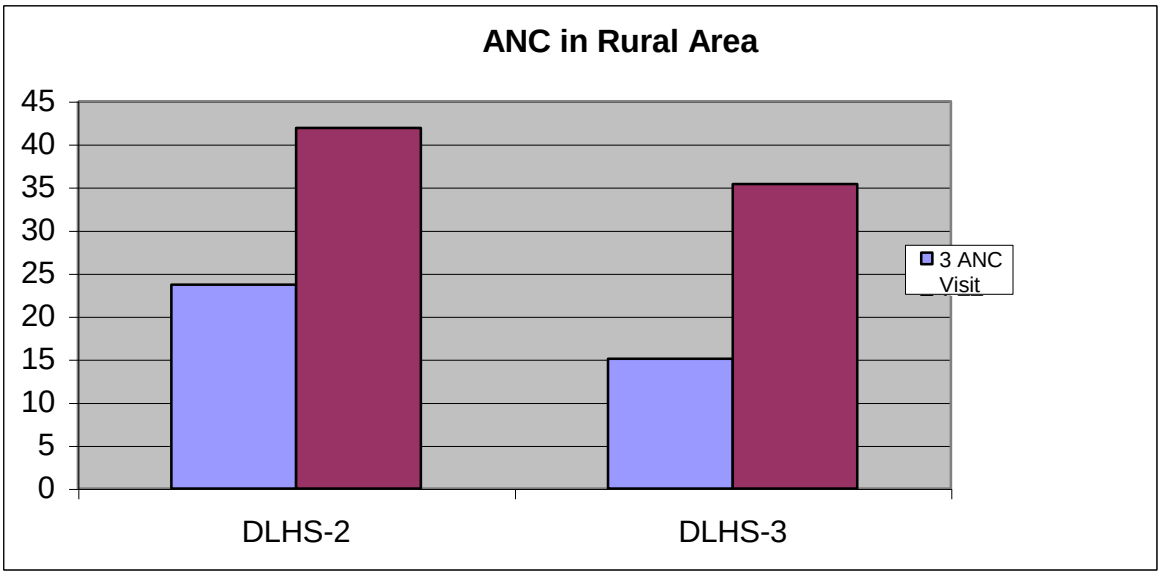
| | | | | |
|---|---|---|---|---|
| | | | | AWW / ASHA house. |
| | 1.Non payment of rent of 299 HSCs for more than three years | 1.Non payment of rent | Regularizing rent payment | **3B. Strengthening of HSCs running in rented buildings.**<br>B1. Estimation of backlog rent and facilitate the backlog payment within two months<br>B2. Streamlining the payment of rent through untied fund from the month of April 09.<br>B3.Purchase of Furniture as per need<br>B4 Prioritizing the equipment list according to service delivery<br>B5 Purchase of equipments as per need<br>B6 Printing of formats and purchase of stationeries |
| | 1.The district still needs 135 more HSCs to be formed. | 1. Land Availability for new construction<br><br>2. Constraint in transfer of constructed building | | **3C. Construction of new HSCs**<br>C1. Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs<br>C2. Community mobilization for promoting land donations at accessible locations.<br>C3. Construction of New HSC buildings<br>C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings. |

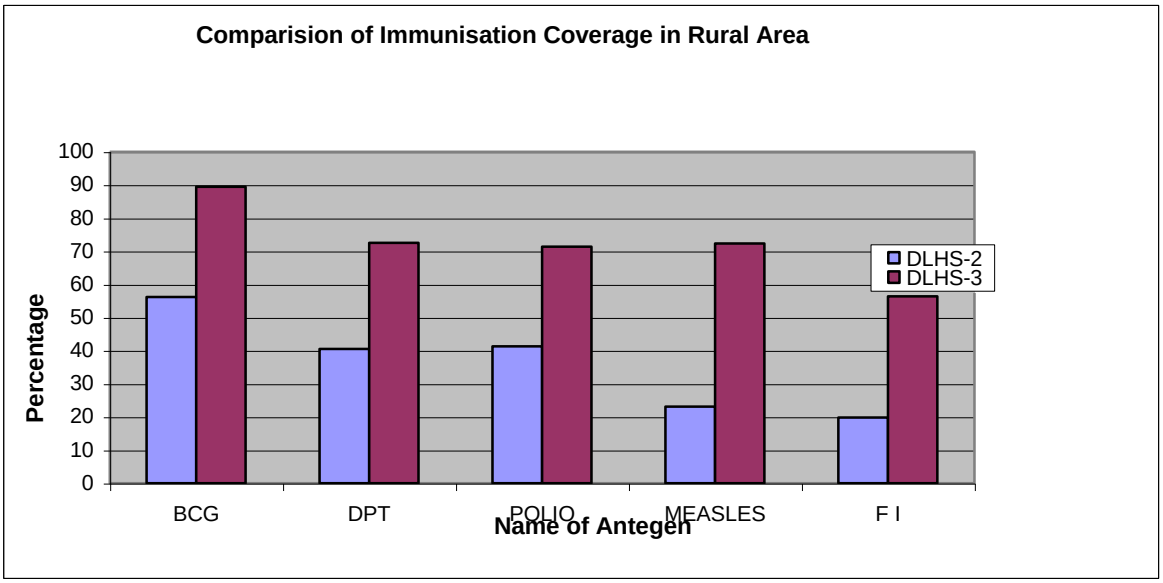
| | | | | |
|---|---|---|---|---|
| | Non participation of Community in monitoring construction work | Monitoring | Ensuring community Monitoring | 1. Biannual facility survey of HSCs through local NGOs as per IPHS format<br>2. Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format.<br>3. Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project.<br>4. Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work.<br>5. Monthly Meeting of one representative of VHSC/Mothers committees on construction work |
| | 1. Lack of community ownership in the | 1.Community ownership | Strengthening of VHSCs, PRI | 1.Formation and strengthening of VHSCs, Mothers committees,<br>2.“Swasthya Kendra chalo abhiyan” to strengthen community ownership<br>3.Nukkad Nataks on Citizen’s charter of HSCs as per IPHS<br>4.Monthly meetings of VHSCs, Mothers committees |

### 3.1.2Services of HSCs:

As per IPHS norms a sub center provides interface with the community at the grass root level providing all the health care services. Of particular importance are the practices packages of services such as immunization, ANC, NC and PNC, prevention of malnutrition and common childhood diseases, family planning services and counseling. They also provide elementary drugs for minor ailments such as ARI, diarrhea, fever, worm infestation etc. And carry out community need assessment. Besides the above the government implements several national health and family welfare programs which again are delivered through these frontline workers.

As per the DLHS3( 2007-08)reports the percentage of full immunization(BCG, 3 doses each of DPT and Polio and measles) coverage(12-23 months) in the district is 56.4%. And BCG coverage of the district is 89.5%. 3 doses of polio vaccine is 72.5%, 3 doses of DPT vaccine is 71.4% and Measles Vaccine is 72.3%. The coverage of Vit A supplementation for the children 9 months to 35 months is 66.6 percent.




| Sub Heads | Gaps | Issues | Strategy | Activities |
|---|---|---|---|---|
| Service performance | Unutilized untied fund at HSC level | Operationalization of Untied fund. | Capacity building of account holder of untied fund | 1.Training of signatories on operating Untied fund account, book keeping etc<br>2. Timely disbursement of untied fund for HSCs<br>3. Hiring a person at PHC level for managing accounts |
| | No ANC at HSC level | Improvement in quality of services | Srengthening one HSC per | 1. Identification of the best HSC on |

| | | | | |
|---|---|---|---|---|
| | | like ANC, NC and PNC, Immunization | PHC for institutional delivery in first quarter | service delivery<br>2.Listing of required equipments and medicines as per IPHS norms<br>3. Purchasing/ indenting according to the list prepared<br>4.Honouring first delivered baby and ANM |
| | Only 14.2% PW registered in first trimester<br>PW with three ANCs is 15.1%, TT1 coverage is 35.4%,<br>Family Planning Status:<br>Any method-43.6%<br>Any modern method-39.8%<br>No sterilization at HSC level<br>IUD insertion -0.5%<br>Pills-1.5%<br>Condom-1.9%<br>Total unmet need is 32.7%, for spacing-14.9, | Improvement in quality of services like ANC, NC and PNC, Immunization and family planning | 1.Phasewise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms.<br>2. Community focused family planning services | 1 Gap identification of 39 HSCs through facility survey<br>2. Eligible Couple Survey<br>3. Ensuring supply of contraceptives with three month's buffer stock at HSCs.<br>4. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS<br>5. Training of ANMs on IUD insertion |
| | Lack of councelling services | Training | Training | 1.Training to ANMs on ANC, NC and PNC, Immunization and other services. |
| | HSC unable to implement disease control | Integration of disease control programs at HSC | Implementation of disease control programs | 1 Review of all disease control programs HSC wise |

| | | | | |
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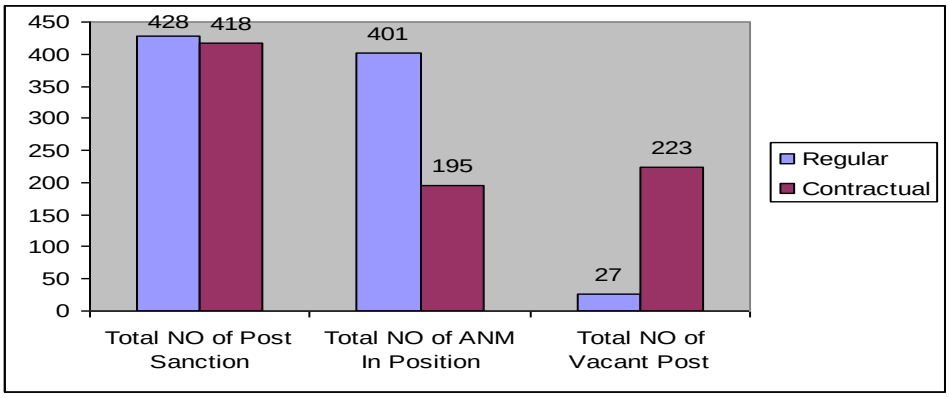
| | programs | level. | through HSC level | in existing Tuesday weekly meetings at PHC with form 6.( four to five HSC per week)<br>2.Strengthening ANMs for community based planning of all national disease control program<br>3. Reporting of disease control activities through ANMs<br>4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. |
| | 80% of the HSC staffs do not reside at place of posting | Absence of staffs | Community monitoring | 1. Submission of absentees through PRI |
| | Problem of mobility during rainy season | Communication and safety | | 1.Purchasing Life saving jackets for all field staffs<br>2. Providing incentives to the ANMs during rainy season so that they can use local boats. |

| | | | | |
|---|---|---|---|---|
| | Lack of convergence at HSC level | Convergence | Convergence | 1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC.<br>2. Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues. |
| | Lack of proper reporting from field<br><br>Lack of appropriate HMIS formats and formate. | Reporting | Strengthening of reporting system | 1.Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc<br>2.Printing of adequate number of reporting formats and registers<br>3.Hiring consultants to develop softwares for reporting. |




Total No of HSC -336
APHC-30
PHC-15
RF-02
DH-01

### 3.1.3 Human Resources

**Source : DHS Vaishali Report**

| **Sub Heads** | Gaps | Issues | Strategy | Activities |
|---|---|---|---|---|
| **Human Resource** | 223 seats of contractual ANM®, 12 seats of contractual ANMs and 27 seats of Regular ANMs are vacant.<br><br>Out of 29 sanctioned post of LHVs only 22 are placed,<br><br>Seat of 28 male workers are vacant | Filling up the staff shortage | Staff recruitment | 1.Selection and recruitment of 262 ANMs<br><br>2.Selection and recruitment of 28 male workers |
| | All 464 contractual ANMs needs training on different services. | Untrained staffs | Capacity building | 1.Training need Assessment of HSC level staffs<br><br>2.Training of staffs on various services |
| | The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities | Training | Strengthening of ANM training school | 1.Analyzing gaps with training school<br><br>2.Deployment of required staffs/trainers<br><br>3.Hiring of trainers as per need |

| | | | | |
|---|---|---|---|---|
| | | | | 4.Preparation of annual training calendar issue wise as per guideline of Govt of India.<br>5.Allocation of fund and operationalization of allocated fund |
| **Drug kit availability** | 1.No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives,<br>2.No Drug kit for AWCs(@one kit per annum,)<br>3.No ASHA kit | Indenting | Strengthening of reporting process and indenting through form 6 | 1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports |
| | Only need based emergency suuply<br>Irregular supply of drugs | Logistics | | 1.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map<br>2.Hiring vehicles for supply of drug kits through untied fund.<br>3.Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) |
| | | Operationalization | Couriers for vaccine and other drugs supply | 1 Hiring of couriers as per need<br>2 Payment of courier through ANMs account |
| | | | Phase wise | 1.Purchasing of cold |

| | | | | |
|---|---|---|---|---|
| | | | strengthening of APHCs for vaccine / drugs storage | chain equipments as per IPHS norms<br>2. training of concerned staffs on cold chain maintenance and drug storage |

**3.2Additional PHCs:** -- There are 33 APHCs functioning in the district and 56 more are proposed to be established.

| **Additional PHC:** | | | | |
|---|---|---|---|---|
| **Sub Heads** | **Gaps** | **Issues** | **Strategy** | **Activities** |
| **Infrastructure** | 1.The district altogether need 90 APHCs but there are 33 APHCs functioning in the district and 56 more are proposed to be established.<br>2. Four more are required to be formed.<br>3.Out of 33 APHCs only 16 are having own building<br>4.Existing 16 buildings are not properly maintained<br>5.Non payment of rent of 14 APHCs for more than three years<br>Lack of equipments,<br>Lack of appropriate furniture<br>Non availability of HMIS formats/registers | Lack of facilities/ basic amenities in the constructed buildings<br><br>Non payment of rent<br>Land Availability for new construction<br><br>Constraint in transfer of constructed building .<br><br>Lack of community ownership | Strengthening of VHSCs, PRI and formation of RKS<br><br>Strengthening of Infrastructure and operationalization of construction works in Three phase | 1."Swasthya Kendra chalo abhiyan" to strengthen community ownership<br>2.Nukkad Nataks on Citizen's charter of APHCs as per IPHS<br>3. Registration of RKS<br>4.Monthly meetings of VHSCs, Mothers committees and RKS<br>**A.Strengtheing of APHCs having own buildings**<br>A.1Rennovation of APHCs buildings<br>A.2 Purchase of Furniture<br>A.3 Prioritizing the equipment list according to service delivery<br>A.4 Purchase of equipments<br>A.5 Printing of formats and purchase of stationeries<br>**B. Strengthening of APHCs running in rented buildings.**<br>B1. Estimation of backlog rent and facilitate the backlog payment within two |

| | | | | |
|---|---|---|---|---|
| | and stationeries | | Monitoring | months<br>B2. Streamlining the payment of rent through untied fund/ RKS from t he month of April 09.<br>B3.Purchase of Furniture as per need<br>B4 Prioritizing the equipment list according to service delivery<br>B5 Purchase of equipments as per need<br>B6 Printing of formats and purchase of stationeries<br>3C. Construction of new APHC buildings as standard layout of IPHS norms.<br>C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs<br>C2. Community mobilization for promoting land donations at accessible locations.<br>C3. Construction of New APHC buildings<br>C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed APHCs buildings.<br>4 Biannual facility survey of APHCs through local NGOs as per IPHS format<br>4.1 Regular monitoring of APHCs facilities through PHC level supervisors in IPHS format.<br>4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others |

| | | | | |
|---|---|---|---|---|
| | | | | as implemented in Bihar Education Project.<br>4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work.<br>4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work. |
| **Human Resource** | Lack of doctors,<br><br>Lack of ANMs,<br><br>Lack of A Grade nurses,<br><br>Lack of Pharmacists.<br><br>Untrained ANMs and male workers<br><br>The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs | Filling up the staff shortage<br>Untrained staffs | Staff recruitment<br><br>Capacity building<br><br>Strengthening of ANM training school | 1.Selection and recruitment of 51 Grade A nurse/ANMs<br>2.Selection and recruitment of 28 male workers<br>3. Sending back the staffs to their own APHCs.<br>1. Training need Assessment of APHC level staffs<br>2. Training of staffs on various services<br>3. EmoC Training to at least one |

| | | | | |
|---|---|---|---|---|
| | and facilities<br>Out of 22 sanctioned post of LHVs only 17 are placed<br>Most of the APHC staffs are deputed to respective PHCS hence APHCS are defunct | | | doctor of each APHC<br><br>1. Analyzing gaps with training school<br>2. Deployment of required staffs/trainers<br>3. Hiring of trainers as per need<br>4. Preparation of annual training calendar issue wise as per guideline of Govt of India.<br>5. Allocation of fund and operationalization of allocated fund |
| **Drug kit availability** | No drug kit as such for the APHCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives,<br>Only need based emergency suuply<br>Irregular supply of drugs | Indenting<br><br>Logistics<br><br>Operationalization | Strengthening of reporting process and indenting through form 2 and 6<br><br>Couriers for vaccine and other drugs supply<br><br>Phase wise strengthening of APHCs for vaccine / drugs storage | 1.Weekly meeting of APHC staffs at PHC for promoting APHC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports<br>2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map<br>2.1 Hiring vehicles for supply of drug kits through untied fund.<br>2.3 Developing three coloured indenting format for the APHC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) |

| | | | | |
|---|---|---|---|---|
| | | | | 3.1 Hiring of couriers as per need<br>3.2 Payment of courier through APHC account<br>4.1 Purchasing of cold chain equipments as per IPHS norms<br>4.2 training of concerned staffs on cold chain maintenance and drug storage |
| **Service performance** | RKS has not been formed at any of the APHC.<br>Unutilized untied fund at APHC level<br>No institutional delivery at APHC level<br>No OPD At any of the APHC<br>No inpatient facility available<br>No ANC, NC and PNC and family planning services.<br>No lab facility<br>No Ayush practitioner posted<br>No rehabilitation services<br>No safe MTP service<br>No OT/ dressing and Cataract operation services.<br>Approx 80% of APHC staffs not reside at place of posting<br>Lack of counseling services<br>Problem of mobility during | Formation of RKS Operationalization of Untied fund.<br><br>Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps.<br><br>Integration of disease control programs at APHC level.<br><br>Family Planning services<br><br>Convergence Operational issues | Capacity building of account holder of untied fund<br><br>Phasewise strengthening of 16 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms.<br><br>Implementation of disease control programs through APHC level where APHC will work as a resource center for HSCc. At present the same is being done by PHC only.<br><br>Community | 1.Training of signatories on operating Untied fund /RKS account, book keeping etc<br>2. Assigning PHC RKS accountant for supporting operationalization of APHC level accounts<br>2. Timely disbursement of untied fund/ seed money for APHCs RKS.<br>3. 1 Gap identification of 16 APHCs through facility survey<br>2.strengtheing one APHC per PHC for institutional delivery in first quarter<br>3.Owner ing first delivered baby and ANM<br>1 Review of all disease control programs APHC wise in existing Tuesday weekly meetings at PHC with form 6<br>2.Strengthening ANMs for community based planning of all national disease control program<br>3. Reporting of disease control activities through ANMs<br>4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.<br>5.Weekly meeting of the staffs of concerned HSCs |

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| | rainy season<br>Lack of convergence at APHC level<br>Operational gaps: There is no link between HSCs and APHCs and the same way there is no link between APHC and PHC | | focused Family Planning services<br><br>PPP<br><br>Convergence | ( as assigned to the APHC)<br>1.Eligible Couple Survey<br>2. Ensuring supply of contraceptives with three month's buffer stock at HSCs.<br>3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS<br>4. Training of ANMs on IUD insertion<br><br>1.Outsourcing services for Generator, fooding, cleanliness and ambulance i<br><br>1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. |

**3.3Primary Health centers:** The district has 16 PHCs, two referral hospitals and a District hospital. The PHC of Lalganj and referral hospital of lalganj is running in the same building.

| **Primary Health Centers:(30 bedded)** | | | | |
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| **Indicators** | **Gaps** | **Issues** | **Strategy** | **Activities** |
| **Infrastructure** | All PHCs are running with only six bed facility.<br>At present 15 PHC are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.<br>Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms.(List attached, Annexure..)<br>The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement.<br>Lack of equipments as per IPHS norms and also under utilized equipments.<br>Lack of appropriate furniture<br>Non availability of HMIS formats/registers and stationeries<br>Operation of RKS:<br>Lack in uniform process of RKS operation.<br>Lack of community participation in the functioning of RKS.<br>Lack of facilities/ basic amenities in the PHC buildings | Available facilities are not compatible with the services supposed to be delivered at PHCs.<br><br>Quality of services<br><br>Community participation. | Upgradation of PHCs into 30 bedded facilities.<br><br>ISO certification of selected PHCs in the district.<br><br>Strengthening of BMU<br><br>Ensuring community participation.<br><br>Strengthening of Infrastructure and operationalization of construction works | 1.Need based ( Service delivery)Estimation of cost for upgradation of PHCs<br>2.Preparation of priority list of interventions to deliver services.<br><br>1.Selection of any two PHCs for ISO certification in first phase.<br>2. Sending the recommendation for the certification with existing services and facility detail.<br><br>1. Ensuring regular monthly meeting of RKS.<br>2. Appointment of Block Health Managers, Accountants in all institutions.(15 PHCs, 2 Referals and Sadar hospital.)<br>3. Training to the RKS signatories for account operation.<br>4. Trainings of BHM and accountants on their responsibilities.<br><br>1.Meeting with community |

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| | | | Monitoring | representatives on erecting boundary, beautification etc,<br>2. Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS.<br>**3.Strengtheing of PHCs**<br>1Rennovation of PHCs<br>2 Purchase of Furniture<br>3 Prioritizing the equipment list according to service delivery and IPHS norms.<br>4 Purchase of equipments<br>5 Printing of formats and purchase of stationeries<br>1. Biannual facility survey of PHCs through local NGOs as per IPHS format<br>2. Regular monitoring of PHC facilities through PHC level supervisors in IPHS format. |
| **Human Resource** | As per IPHS norms each PHC requires the following clinical staffs:(List attached)<br>But the actual position is<br>General Surgeon 8/15<br>Physician 2/15<br>Gynecologist 2/15<br>Pediatrics 5/15<br>Anesthetist…./15<br>Eye surgeon 4./15(Proposed)<br>As per IPHS norms each PHC requires the following para | staff shortage<br>Untrained staffs | Staff recruitment | 1.Selection and recruitment of Doctors<br>2.Selection and recruitment of ANMs/ male workers<br>3.Selection and recruitment of paramedical/ support staffs<br>4.Appointment of |

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| | medical support:(List attached)<br>But the actual position is<br>Nurse midwife…../135<br>Dresser…../15<br>Pharmacist/compounders…/15<br>Lab technician…./15<br>Radiographer…./15<br>Ophthalmic assistant…/15<br>Ward boys/nursing orderly…/30<br>Sweepers…./45<br>Chowkidars…./15<br>OPD attendants…../15<br>Statistical assistants…./15<br>OT attendants…/15<br>Registration clerck…/15<br>Untrained doctors/ANMs in emergency obstetrics care.<br><br>Only Ten BHMs and 14 accountants are placed at present.<br>Demotivated BPMU staffs | | Capacity building | Block Health Managers, Accountants in all institutions.(15 PHCs, 2 Referals and Sadar hospital.)<br>1.Training need Assessment of PHC level staffs<br>2.Training of staffs on various services<br>3.Trainings of BHM and accountants on their responsibilities.<br>4. Trainings of BHM on implementation of services/ various National program programs. |
| **Drug kit availability** | Irregular supply of drugs because of lack of fund disbursement on time.<br>Only … % essential drugs are rate contracted at state level .<br><br>Lack of fund for the transportation of drugs from district to blocks.<br>There is no clarity on the guideline for need based drug procurement and transportation. | Indenting<br><br>Logistics<br><br>Operationalization | Strengthening of reporting process and indenting through form 7<br><br>Strengthening of drug logistic system | 1.training of store keepers on invoicing of drugs<br>2.Implementing computerized invoice system in all PHCs<br>3.Fixing the responsibility on proper and timely indenting of medicines( keeping three months buffer stock)<br>4. Enlisting of equipments for safe storage of drugs.<br>5. Purchase of enlisted equipments.<br>6. Ensuring the availability of FIFO list of drugs with store keeper.<br>7. Orientation meetings on |

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| | | | | guidelines of RKS for operation. |
| **Service performance** | 1.Exessive load on PHC in delivering all services i.e. 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC.<br>2. Total 59 seats of Regular and 25 seats of contractual doctors in the district is vacant.<br>3. All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less( only average16 patients per Doctor per OPD days during April08-Nov 08, however the IPHS norms says that the OPD should be 40 per Doctor.)<br>4. 5 PHCs out of 15 are lacking 24 hrs new born care services.<br>5. 2 PHCs are still not providing Tubectomy services.<br>6.Only one PHC (Mahnar) provides safe abortion service.<br>7. Only five PHCs provides 24 hrs BEmoC services.<br>8. None of the PHC provides 24 hour blood transfusion services, however PHC Mahnar has been provided the equipments for blood storage unit.<br>9.8 PHC does not have laboratory facilities.<br>11. … Lab services provided by PPP services have fled away.<br>12. Only one PHC provides adolescent sexual and reproductive health services.<br>13.Health facility with AYUSH services is not being provided<br>14. Referal<br>a. No pick up facility for PW or patients.<br>b.BPL patients are not exempted | Optimun Utilization of Human Resources<br><br>Epidemic outbreaks and Need based intervention in epidemic areas.<br><br>Service Load centered at PHC<br><br>Availability of AYUSH pathy.<br><br>Insecurity ( Staff and Properties) | Quality improvement in residential facility of doctors/ staffs.<br><br>Recruitment<br><br>Proper and timely information of outbreaks<br><br>Strengthening of equipments and services and increase in the number of ambulances.<br><br>Strengthening of AYUSH services at PHC level in the first level. | 1. Hiring of rented houses from RKS fund for the residence of doctors and key staffs.<br>2. Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.<br>3. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day<br><br>1.Selection and appointment of contractual doctors and staffs<br><br>1. Mapping of the areas having history of outbreaks disease wise.<br>2.Developing micro plans to address epidemic outbreaks<br>2.Assigning areas to the MOs and staffs<br>3.Motivating ASHA on immediate information of outbreaks<br>4. Purchasing folding tents, beds and equipments |

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| | in paying fee of ambulance.<br>c. Lack of maintenance of ambulances<br>d. Shortage of ambulances<br>15. Quality of food, cleanliness (toilets,Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC.<br>16. All PHCs have their own generator sets but are not in use.<br>17. In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases.<br><br>18. Several cases of theft of instruments, computers, and submersible pumps etc at PHCs.<br>19. No guidance to the patients on the services available at PHCs.<br>20.Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.<br>21. Lack of inpatient facility for kala-azar patients.<br>22.Lack of councelling services<br>23.Problem of mobility during rainy season<br>24.Lack of convergence<br>25. Lack of timely reporting and delay in data collection | Govts existing services like lab, x-ray, generator, fooding and cleanliness services. | Confidence building measures<br><br>Strengthening of the Govts existing services like lab, x-ray, generator, fooding and cleanliness services.<br><br>Creating friendly environment<br><br>HMIS and strengthening of reporting process | and medicines to organize camps in epidemic areas.<br>1. Repairing of all defunct Ambulances<br>2. Repairing of PHcs gensets and initiating their use.<br>3. Hiring of ambulances as per need.<br>1. Appointment of one AYUSH practitioner and Yoga teacher in every PHC<br><br>1.Insurance of all properties and staffs of PHC<br>2.Placing one TOP in every PHC<br><br>1. Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate.<br>2.Recruitment of lab technicians as required<br>3. Purchase of equipments/ instruments for strengthening lab.<br>4. Hiring of menial workers for cleanliness works.<br>1. Assigning LHV for counseling work<br>2. Wall writing on every section of the building denoting the facilities<br>3. Name plates of doctor |

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| | | | | 4. Displaying Roster of doctors with their details.<br>5. Gardening<br>6. Sitting arrangement for patients<br>7. Installation of LCD TV with cable connection<br>8.Installation of safe drinking water equipments/water cooler,<br>9.Installation of solar heater system and light with the help of BDO/Panchayat<br>9. Apron with name plates with every doctors<br>10. Presence of staffs with uniform and name plates.<br><br>1.Orientation of the staffs on indicators of reporting formats<br>2.Puchase of Laptops for DPMs and BHMs |

### 3.4District Hospital:

| **District Hospital Hajipur:** | | | | |
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| **Indicators** | **Gaps** | **Issues** | **Strategy** | **Activities** |
| **Infrastructure** | 1.There are 120 beds in the Sadar hospital which is not adequate as per the requirement.<br>**Ward No of beds**<br>Male medical ward: 20<br>Male surgical ward: 20<br>Female ward : 20<br>Child ward : 20<br>Delivery ward : 10<br>TB ward : 10<br>Infectious disease : 10<br>Prisoners ward : 10<br>**Total : 120**<br>2. At present District hospital is working with average 25 delivery per day, 30 inpatient Kala-azar, 20 FP operation/emergency operation and 800 OPD per day. This huge workload is not being addressed with only 120 beds inadequate facility.<br>3.Lack of equipments as per IPHS norms and also under utilized equipments.<br>4.Lack of appropriate furniture<br>5.Operation of RKS: Delayed process of operation.<br>Delay in disbursement of fund<br>6.Lack of facilities/ basic amenities in the PHC buildings<br>7.Huge workload in central registration unit<br>8. No sitting arrangement for patients. | Lacks in infrastructure | Strengthening of infrastructure | 1. Purchase of 500 beds.<br>2. Repairing of beds.<br>3. Listing of required equipments as per IPHS norms and their purchase.<br>4. Listing of required furniture and their purchase.<br>5. Simplifying process of RKS operation.<br><br>6.Computerization of registration system for the OPD/IPD patients.<br><br>7.Construction of shed for waiting patients<br>8. Installation of 3 Water cooler freezes as per requirement.<br>9.Installation of seven vapor lights as per requirements.<br>10. Rennovation of boundary wall and gate.<br>11.Construction of new Post mortem room with all facilities.<br>12. Renovation of drainage system and internal road level upgradation.<br>13. Construction of enquiry counter at |

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| | 10. No safe drinking water facility.<br>11. Half of the hospital area remains dark at night.<br>12. Delivery room lacks beds, labor table, stretchers, equipments.<br>13. No proper gate and boundary wall.<br>14.No proper post mortem room and equipments.<br>15. Heavy water logging during rainy season.<br>16.Buildings for ICU, Causality ward are ready but due to lack of equipments, facilities are not functional.<br>17. No use of paying wards.<br>18.No enquiry counter as such for the patients.<br>20.No residential facilities for doctors and staffs.<br>21. No canteen facility | | | the gate.<br>14. Hiring of ambulances.<br>15. Construction of new residential buildings.<br>16.Hiring of rented houses from RKS fund for the residence of doctors, BMU and key staffs.<br><br>16.Tender for canteen facility.<br>17. Sitting arrangement for patients<br>18. Installation of LCD TV with cable connection |
| **Human Resource** | 1.Post of gynecologist and pathologist are vacant.<br>2.Post of one dresser, one OT assistant and one ophthalmic assistant are vacant. | Lack in Staff position | Recruitment<br><br>Deputing staffs | 1. Appointment of gynecologist and pathologist on contract basis.<br>2. Appointment of one dresser, one OT assistant and one ophthalmic assistant on contract basis.<br><br>1. Deputation of required staffs from field. |
| **Drug kit availability** | 1. Irregular supply of drugs because of lack of fund disbursement on time.<br>2. Only … % essential drugs are rate contracted at state level.<br>3. There is no clarity on the guideline for need based drug procurement and transportation.<br>4. Lack of proper space, | Improper Supply and logistics<br><br>Lack in storage facility | | 1.training of store keepers on invoicing of drugs<br>2.Implementing computerized invoice system<br>4. Enlisting of equipments for safe storage of drugs.<br>5. Purchase of enlisted equipments.<br>6. Ensuring the availability of FIFO |

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| | furniture and equipments for drug storage | | | list of drugs with store keeper. |
| Service performance | 1.Exessive load in delivering all services<br>2. Blood storage unit is present but not utilized<br>3.No 24hrs Lab facility<br>4.Health facility with AYUSH services is not being provided<br>5. Referal<br>a. No pick up facility for PW or patients.<br>b.BPL patients are not exempted in paying fee of ambulance.<br>c. Lack of maintenance of ambulances<br>d. Shortage of ambulances<br>6. No guidance to the patients on the services available at DH.<br>7.Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular. | | | 1. Incentivizing doctors/ staffs on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.<br>2. Purchase of equipments for Blood storage unit,<br>3. IEC on blood storage unit.<br>4. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day<br><br>5. Repairing of all defunct Ambulances<br>6. Hiring of ambulances as per need.<br>7. Appointment of one AYUSH practitioner and Yoga teacher<br>8. Purchase of equipments/ instruments for strengthening lab.<br>9. Wall writing on every section of the building denoting the facilities<br>10. Name plates of doctor<br>11. Displaying Roster of doctors with their details.<br>12. Gardening<br><br>13. Apron with name plates with every doctors<br>14. Presence of staffs with uniform and name plates. |

# CHAPTER 4

## Setting Objectives and Suggested Plan Of Action

### 4.1 Introduction

District health action plan has been entrusted as a principal instrument for planning, implementation and monitoring of fully accountable and accessible health care mechanism. It has been envisioned through effective integration of health concerns via decentralized management incorporating determinants of health like sanitation and hygiene, safe drinking water, women and child health and other social concerns. DHAP envisages accomplishing requisite amendments in the health systems by crafting time bound goals. In the course of discussions with various stakeholder groups it has been anticipated that unmet demand for liable service provision can be achieved by adopting Intersectoral convergent approach through partnership among public as well as private sectors.

### 4.2 Targeted Objectives and Suggested Strategies

During consultation at district level involving a range of stakeholders from different levels, an attempt has been made to carve out certain strategies to achieve the specific objectives that are represented by different indicators. The following segment of the chapter corresponds to the identified district plan objectives demonstrating current status of the indicators along with the expected target sets that are projected for period of next three years (2009-12).

| Malaria | | | | |
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| **S. No.** | **Gaps** | **Issue** | **Strategy** | **Activities** |
| 1 | Poor quality of Management of Malaria Cases | Persistence of Malaria in the region | 1.Early Case Detection & treatment | 1. Provide facility at the APHC level for Thick & thin smear test for Malaria Parasite, Rapid diagnostic test |
| | | | | 2. Ensure functionality of FTDs & DDCs at 1000 population with support of ASHA |
| | | | | 3.Regular supply of malaria drugs in the district |
| | | | | 4. Use of prophylactic measures in suspected cases |
| | | | 2.Strengthening of Referral system | 1. Ambulance facility at the APHC level for referring the Falciparum cases |
| | | | | 2.Training & sensitisation of Professionals at subcentre, APHC, PHC , DH |
| | | | | 3. Strengthening of case detection & ensuring fortnightly visits to all villages |
| | | | | |
| | | | 3. Epidemic Preparedness & Rapid response | 1. Early response to the incidence of malaria cases in the district |
| | | | | 3. Earliest reponse to the area having increase in malaria by double in last two years |
| 2 | Poor vector control mechanism | 1.Integrated Vector Control | 1.Indoor residual insecticide spray in rural areas | 1. Ensuring availability of sprayers , fogging machines and buckets in adequate number. |
| | | | 2. Training of the spraying squad | 2. Ensuring regular supply of DDT and insecticides |
| | | | | 1. Regular training of the spraying team for dissolving DDT, filling , carrying and spraying process |
| | | | | 2. Supervision by the supervisors to get the feedback of training |
| | | | | 3. Follow up survey: First surveyafter 21 days of control and second survey after 22 days of first survey |
| | | | 2. Use of Insecticide treated bednets | 1. Space spray for 7-10 days , residual insecticidal spraying to be started simultaneously as per district micro plans |
| | | | | 2.Supply of Insecticide treated bednets to suspected patients free of cost |
| | | | 3. Anti larval measures | 1. Promotion of use of larvivorous fishes like gambusia in the natural water tank |

| 4.3 MATERNAL HEALTH | | | | | | | |
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| **Logical Framework** | | | | | | | |
| **Sl.** | **Goal** | **Sl.** | **Impact indicators** | | | | |
| 1 | To improve maternal health | 1.1 | Reduction in MMR | | | | |
| **Sl.** | **Objectives** | **Sl.** | **Outcome indicators** | **Sl.** | **Strategy** | **Sl.** | **Output indicators** |
| 1 | To increase institutional safe delivery by 28.2 % (DLHS3) to 100 % by year 2010 | 1.1 | % of institutional delivery reported | 1.1.1 | To make functional PHC (24 hr x 7 days) for institutional deliveries | 1.1.1.1 | % of PHC having functional OT and Labour room with equipment |
| | | | | | | 1.1.1.2 | % of PHC having Obestetric First Aid medicine 24 hr x 7 days |
| | | | | | | 1.1.1.3 | % of Grade A nurse available 24 hr x 7days |
| | | | | | | 1.1.1.4 | % of PHC having functional Neo-natal care units |
| | | | | 1.1.2 | To make functional FRUfor institutional deliveries | 1.1.2.1 | No of FRUs having functional blood storage units linkage with blood banks and 24 hr ready referral transport |
| | | | | | | 1.1.2.2 | No of FRUs having EmOc and CEmOc facilities |
| | | | | | | 1.1.2.3 | No of FRUs having specialist doctors / multiskilled Medical Officers |

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| | | | | | | 1.1.2.4 | No of FRU having functional Neo-natal care units |
| | | | | 1.1.3 | To provide Referral transport services at FRU /PHC | 1.1.3.1 | No of pregnant women availed the referral facilities (pick up and drop) |
| | | | | 1.1.4 | To strengthen Janani Suraksha Yojana / JSY | 1.1.4.1 | % of pregnant women reecieved JBSY payments immediately after delivery |
| 2 | To increase safe delivery by trained SBA 9.6%( DLHS3) to 100% by year 2010 | 2.1 | Proportion of birth attendent by skilled health personnel | 2.1.1 | To ensure support of SBA at home deliveries | 2.1.1.1 | % of home deliveries attended by SBA |
| 3 | To increase ANC coverage with quality 16% (DLHS3) to 50% by year 2010 | 3.1 | % ANC reported through HMIS formats / Form -7 | 3.1.1 | To strengthen HSC for providing outreach maternal care | 3.1.1.1 | % of HSCs having ANMs |
| | | | | | | 3.1.1.2 | % of HSCs conducted fixed ANC and clinics (planned & held) |
| | | | | 3.1.2 | To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas | 3.1.2.1 | % of RCH camps planned and held |
| | | | | 3.1.3 | To improve adolescent reproductive and sexual health | 3.1.3.1 | No of pregnant adolescent counselled by ANM / AWW / ASHA |
| | | | | 3.1.4 | To accelrate APHC for OPD and Fixed AN clinics | 3.1.4.1 | % of OPD clinics orgnised at APHC level. |
| 4 | To provide safe abortion services at all facilities | 4.1 | % MTP cases reported through HMIS formats / Form -7 | 4.1.1 | To provide MTP services at health facilities | 4.1.1.1 | No of facilities having MTP services |

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| | | | | | | | (public and private ) |
| 5 | To increase community participation in maternal care | 5.1 | % of Mahila mandal meetings conducted. | 5.1.1 | To strenghten Monthly Village Health and Nutrition Days | 5.1.1.1 | % of mothly Village Health & Nutrition Days planned and held |
| **MATERNAL HEALTH** | | | | | | | |
| **Sl. No.** | **Strategy** | **Sl** | **Gaps** | **Sl** | **Activities** | **Unit Cost** | **Total Budget** |
| A1 | **To make functional PHC (24 hr x 7 days) for institutional deliveries** | | **Infrastructure** | | | | |
| | | 1.1 | All PHCs are with only six bedded facility. 50 - 60% of facilities are not adequate as per IPHS norms. (List attached, Annexure.) | 1.1.1 | Need based (Service delivery) Estimation of cost for upgradation of PHCs. Selection of any two PHCs for ISO certification in first phase | @ 200000/- Per PHC | 3800000 |
| | | 1.2 | At present 16 PHC are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation / emergency operation and 120 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility. | 1.2.1 | Preparation of priority list of interventions to deliver services. | NA | 0 |
| | | 1.4 | The comparative analysis of facility survey (08-09) and DLHS3 facility survey (06-07), the service availability tremendously increased but the quality of services is still the area of improvement. | 1.4.1 | Sending the recommendation for the certification with existing services and facility detail. | NA | 0 |

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| | | 1.5 | Lack of equipments as per IPHS norms and also under utilized equipments. | 1.5.1 | Prioritizing the equipment list according to service delivery and IPHS norms. | NA | 0 |
| | | | | 1.5.2 | Purchase of equipments | NA | 0 |
| | | 1.6 | Lack of appropriate furniture | 1.6.1 | Purchase of Furniture | NA | 0 |
| | | 1.11 | Lack of facilities / basic amenities in the PHC buildings | 1.11.1 | Rennovation of PHCs | NA | 0 |
| | **To make functional PHC (24hr x7days) for institutional deliveries** | 1.12 | **As per IPHS norms each PHC requires the following clinical staffs: (List attached)** | | | | |
| | | | | | Salary of Contrctual Doctors | 8 Specialist @ 25000 / 25 MBBS @ 20000 / | 8400000 |
| | | 1.12.1 | The actual position is not sufficient as per IPHS norms List of Human resource is attached in Annexure. | | Selection and recruitment of Doctors on contractual basis and give priority in selection those who are living in same PHC. | 36 Doctors to be appointed | 10800000 |
| | | | | 1.12.10.1 | Salary of Contarctual Grade A nurses | 6 Grade A Nurse | 540000 |
| | | 1.12.10 | | | Selection and recruitment of grade A nurses for conducting delivery | 3 Grade A nurse for each PHC | 5130000 |

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| | | | | | Selection and recruitment of dresser | 19 Dresser, one for each PHC | 1026000 |
| | | | | | Selection and recruitment of Pharmasist. | 19 x 2 Pharmasist for each PHC | 2280000 |
| | | | | | Three month induction training of Grade A nurse under supervision of District level resource team. | 100/- per day x 90 days for 51 grade A nurse | 459000 |
| | | 1.13 | | 1.13.1 | Training need Assessment of PHC level staffs | NA | 0 |
| | | | | | Honorarium of Block Accountants | 13 Accountant @ 12000/ | 1872000 |
| | | | | | Rent of Data Center | 17 Data Center @ 7500/ | 1530000 |
| | | | | | Honorarium of BHM | 10 BHM @ 18000/- | 2160000 |

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| | | | | | Mobility support to BHMs | Rs 2000 per month per BHM | 408000 |
| | | 1.14 | | 1.14.1 | Appointment of Block Health Managers, Accountants in all institutions.(15 PHCs, 2 Referrals and Sadar hospital.) | 7 BHM and 4 Accountants Budget in RKS head | 0 |
| | | | | | Process of all recruitments | 6 types of recruitment @ 10000 | 60000 |
| | | | | | Trainings of BHMs on Health statistics | 19 BHMs | 38000 |
| | | | | | Training on Program, Finance management and HMIS | 19 BHMs, 19 Block Accountants and 19 Data Center operators | 114000 |
| | | **Drug Supply** | | | | | |
| | | 1.16 | Irregular supply of drugs because of lack of fund disbursement on time. | 1.16.1 | Ensuring the availability of FIFO list of drugs with store keeper. | NA | 0 |
| | | 1.17 | Only 38 essential drugs are rate contracted at | 1.17.1 | 2.Implementing computerized invoice system in all PHCs | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | state level . | | Purchase of Drug invoice software | Rs 10000 per PHC | 190000 |
| | | | Lack of fund for the transportation of drugs from district to blocks. | 1.17.2 | 3.Fixing the responsibility on proper and timely indenting of medicines ( keeping three months buffer stock) | NA | 0 |
| | | 1.18 | | 1.18 | 4.Payment from Rogi Kalyan samiti account. | Rs 2000 per month per PHC | 456000 |
| | | 1.19 | There is no clarity on the guideline for need based drug procurement and transportation. | 1.19.1 | 5. Orientation meetings/ training on guidelines of RKS for operation. | Rs 2000 per PHC | 38000 |
| | | 1.2 | Drugs are not properly stored | 1.20.1 | 6. Enlisting of equipments for safe storage of drugs. | NA | 0 |
| | | | | 1.20.2 | 7. Purchase of enlisted equipments. | Rs 15000 per PHC | 285000 |
| | | | | 1.20.3 | 8.training of store keepers on invoicing of drugs | Rs 2000 per PHC | 38000 |
| | | | **Performance** | | | | 0 |
| | | 1.21.1 | Exessive load on PHC in delivering all services i.e. 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation / emergency operation and 120 OPD per day in each PHC. | 1.21.1 | Recruitment of Doctors on contractual basis | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1.21.2 | Total 59 seats of Regular and 25 seats of contractual doctors in the district is vacant. | | | NA | 0 |
| | | 1.22 | All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less (only average16 patients per Doctor per OPD days during April08-Nov 08, however the IPHS norms says that the OPD should be 40 per Doctor.) | 1.22.1 | Hiring of rented houses from RKS fund for the residence of doctors and key staffs. | Rs 5000 per PHC per month | 1140000 |
| | | | | 1.22.2 | Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment. | Rs 5000 per PHC per month | 1140000 |
| | | | | 1.22.3 | Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day | NA | 0 |
| | | 1.24 | 5 PHCs are lacking 24 hrs new born care services. | 1.24.1 | Ensure 24 hrs new born care services in 10 PHC. | Budget in Child health care activity | 0 |
| | **To make functional PHC (24hr x7days) for institutional deliveries** | 1.27 | Only five PHCs provides 24 hrs BEmoC services. | 1.27.1 | Ensure 24 hrs BEmoC services at 10 PHC | | 0 |
| | | | | | Training of one Doctor from each PHC on BEmoC. | 2000/-Per Docter | 20000 |
| | | | | | Equipments for BEmoC | 50000 per facility | 500000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1.29 | 13 PHC does not have laboratory facilities on PPP based srvices.But except Mahnar all Phc have T.B lab Technician. In addition to this the regular lab technician has been deputed for this purpose. | 1.29.1 | Deputation of 17 regular Lab tech at PHC level for providing free of cost lab services to all pregnant women and BPL families. | NA | 0 |
| | | 1.3 | | 1.30.1 | Recruitment of 5 lab technicians as required for regular support of lab activity | 6000/- per head | 360000 |
| | | | | | Training of TB lab technician on other pathological tests. | 1000/- per training | 17000 |
| | | | | | Purchase reagent (recurring) for strengthening lab. | 5000 per unit per month | 1020000 |
| | | | | | Purchase of equipments / instruments if needed . Fund could be rooted through RKS and if it is not utilised it could be diverted to other women and child friendly activites. | 50000/- per PHC | 850000 |
| | | 1.32 | Health facility with AYUSH services is not being provided | | Establising one Panchkarm center in Chehrakala PHC | 10000/- Per PHC | 120000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Establishing two homeopathy centers in Jandaha and Vaishali | 5000/- each PHC for medicine , equipments and Furniture. | 120000 |
| | | **1.33** | **Referral Services** | | | | |
| | | 1.33.1 | No pick up facility for PW or BPL patients. | 1.33.1.1 | Provision for pick up & drop pregnant mothers and BPL families free of cost using existing Ambulence services at PHC level. | 60000/-each PHC per month | 13680000 |
| | | | | | Provide EDD list of pregnant women to Ambulance driver and Number of ambulance diriver and 102 /PHC tel No to all Pregnant woment | NA | 0 |
| | | 1.33.3 | Lack of maintenance of ambulances | 1.33.3.1 | Repairing of all defunct Ambulances | Three Ambulances @ Rs 50000 per Ambulance | 150000 |
| | | 1.33.4 | Shortage of ambulances | 1.33.4.1 | Hiring of ambulances as per need. | One in each PHC @ Rs 10000/- Per month | 2280000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Prepare list of Vehicle those are utilised in Monitoring work in PHC that can be use in pick up and dropping facility for PW. | NA | 0 |
| | | 1.34 | Quality of food, cleanliness (Toilets, Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC. | 1.34.1 | Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate. | Rs 50 per patients into 25 patients per day per PHC | 8550000 |
| | | | | | Rewiev of Cleanliness activity in all PHC by Qulity assurance committee and payment of agency should be link with it. | | 0 |
| | | | | 1.34.2 | Hiring of workers for cleanliness of OT and Labour room in PHC | Two workers per PHC for maximum 30 days @ Rs 100 per day by concerned RKS | 1368000 |
| | | | | | Purchage equipments and uniform for cleanliness in all PHC | 50000/- each PHC | 950000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Training of Workers on using machine/equipments and importance of cleanliness . | 2500/- per PHC twice in a year. | 95000 |
| | | | | | Develop mechanism for monitoring of cleanliness work | NA | 0 |
| | | 1.35 | All PHCs have their own generator sets but are not in use. | 1.35.1 | Repairing of PHCs gensets and initiating their use. | Rs 5000 per PHC | 95000 |
| | | 1.7 | Non availability of HMIS formats/registers and stationeries | 1.7 | Printing of formats and purchase of stationaries | Rs 50000 per PHC | 950000 |
| | | | | 1.7.2 | Biannual facility survey of PHCs through BHM as per IPHS format | NA | 0 |
| | | | | 1.7.3 | Regular monitoring of PHC facilities through PHC level supervisors in IPHS format. | NA | 0 |
| | | 1.8 | Operation of RKS: | 1.8.1 | Ensuring regular monthly meeting of RKS. | Confectionary costs @ Rs 500/- per month per PHC | 114000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 1.8.2 | Appointment of Block Health Managers, Accountants in all institutions. (16 PHCs, 3 Referals and Sadar hospital.) | Nine more BHMs and 6 more Accountants (Rs. 18000/- per month for BHMs and Rs 12000/- per month for Accountants) | 2808000 |
| | | 1.9 | Lack in uniform process of RKS operation. | 1.9.1 | Training to the RKS signatories for account operation. | Rs. 1000/- per participant, Two participants from each PHC | 38000 |
| | | | | 1.9.2 | Trainings of BHM and accountants on their responsibilities. | Rs 1000/- per participant, Two participants from each PHC | 34000 |

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| | | 1.1 | Lack of community participation in the functioning of RKS. | 1.10.1 | Meeting with community (School children or other) representatives on erecting boundary, beautification etc, | 5000/- per PHC | 95000 |
| | | | | 1.10.2 | Meeting with local public representatives / Social workers and mobilizing them for donations to RKS. | NA | 0 |
| | | 1.36 | In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases. | 1.36.1 | Meeting in RKS with Local Police Station incharge to handle emargency situation . | NA | 0 |
| | | | | | Training local NCC/NYK/Scout & Guide/NSS etc.volunteers on identification of emargency situation. And deployment of volentears at PHC. | 5000/- per PHC | 95000 |
| | | 1.37 | Several cases of theft of instruments, computers, and submersible pumps etc at PHCs. | 1.37.1 | Insurance of all properties and staffs of PHC | Rs 10000/- per PHC | 190000 |
| | **To make functional PHC (24 hr x 7days) for institutional deliveries** | 1.38 | No guidance to the patients on the services available at PHCs. | 1.38.1 | Pictorial wall painting on every section of the building denoting the facilities and attached trained volenters to guide paitents. | Rs 2000/- per PHC | 38000 |
| | | 1.39 | Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in | 1.39.1 | Name plates of Doctors<br>Displaying Name Photograph and DOB of all staff of PHC and put cleanliness staff name on top of the | Rs 2000/- per PHC | 38000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | particular. | | list. | | |
| | | 1.41 | Lack of counselling services | 1.41.1 | There are 22 LHV in the district we can utilise their experience in counseling work of women and adolecent girls after training. | 1000/- per person | 22000 |
| | | 1.42 | There is no hot water facility for PW and there is no adequate lighting facility at adjoining area of PHC | 1.42.1 | Installation of solar heater system and light with the help of BDO/Panchayat at PHC or purchage equipments from market. | 50000/- per PHC | 950000 |
| | | 1.43 | Lack of convergence | 1.43.1 | Convergence meeting by RKS & DHS | NA | 0 |
| | | 1.44 | Lack of timely reporting and delay in data collection | 1.44.1 | Orientation of the staffs on indicators of reporting formats | NA | 0 |
| | | | | 1.44.2 | Puchase of Laptops for DPM and BHMs with internet facility. | Rs 35000/- per unit + 2000/- per month | 1062000 |
| | | 1.45 | Lack of space for waiting, environmental cleanliness around PHC, provision for hospitality etc | 1.45.1 | Gardening | Rs 5000/- per PHC | 95000 |
| | | | | 1.45.2 | Sitting arrangement for patients | Rs 5000/- per PHC | 95000 |
| | | | | | Construction of patients waiting shade | 75000/- Per PHC | 1425000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 1.45.3 | Installation of LCD projector for manage wait over time of OPD patients. | Rs 100000/- per PHC | 1900000 |
| | | | | 1.45.4 | Installation of safe drinking water equipments / water cooler | Rs 10000/- per PHC | 190000 |
| | | | | 1.45.5 | Apron with name plates with every doctors | Rs 250/- per Doctor for total 205 doctors | 51250 |
| | | | | 1.45.6 | Presence of staffs with uniform and name plates. | NA | 0 |
| | | | | 1.45.7 | "MAMTA" should be appointed at PHC level as well. | Rs 75/- per delivery for approx 60000 institutional delivery | 4500000 |
| | | 2.1 | C-Section deliveries are not conducted in institution. | 2.1.1 | Devlop Lalganj, Mahua and Mahnar PHC for C-section facility | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 2.1.2 | Training of MOs of three PHCs in mulltiskilling. | 3 Doctors from each PHC @ 2000/-per person | 18000 |
| 2 | **To make FRU functional and upgradation of PHC to CHC for institutional deliveries** | | | 2.1.5 | Specialist should be posted at Sadar Hospital/and above mention three PHC | NA | 0 |
| | | | | 2.1.6 | Incentive for C-section to PHC those who conducted 10 -15 = 10000, 15-20 =20000, 25-30 = 50000 / C-section in a month the incentive money should be distributed among all staff of the PHC after the decision of RKS. | Rs 25000 per PHC per month | 900000 |
| | | | | 2.1.8 | Need based Equipments and drugs in O.T and Labour room. | List of Equpment attached (100000/- per PHC) | 1900000 |
| | | | None of the PHC provides 24 hour blood transfusion services, however PHC Mahnar has been provided the equipments for blood storage unit. | | Establishing blood storage units at Lalganj, Mahua & Rahopur, | 60000/- Per PHC | 180000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Training of lab technicions on management of blood storage | 3 lab technicions | 3000 |
| | | | Infection control protocols is not at all maintained at all facilities | 2.2.2 | Licensing blood storage / blood bank | NA | 0 |
| | | | | 2.2.3 | Meeting infrastructure requirements as per norms for Blood storage | 10000/- Per PHC | 30000 |
| | | | | 2.2.4 | Training of MO and lab tech. / staff nurse blood storage on grouping / cross matching and management of transfusion reactions stabilized linkages with mother blood bank. | Rs 1000/- per participant, Two participants from each PHC | 38000 |
| | | | | 2.2.5 | Provide free of cost Blood for pregnant women who need blood transfusion for severe anemia / PPH on prescribed through RKS Fund | 20000/- for each PHC per month | 720000 |
| | | | | 2.2.11 | Organize Blood donation camps at all institution and mobilize community for voluntary blood donation | Rs 10000/- per camp per PHC for organizing two camp annually | 380000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 2.3.1 | Provision of food for the delivered mothers and mothers under gone in tubectomy in all the health facilities. | NA | 0 |
| | | | | 2.3.2 | Mobilize community Resources for providing Free food for PW at Institution. | NA | 0 |
| | | 2.3 | Welcome PW at Institution and PHC and FRU | 2.3.3 | Quality indicators (clean environment, wards with clean linen, clean toilets , clean labour rooms, running waters supply, hot water and safe water for inpatients, new born corners, treatment protocols, aseptic precautions, immediate disbursement of JBSY funds | NA | 0 |
| | | 2.4 | Reporting of maternal death Maternal death reporting is usually not reported by worker | 2.4.1 | Training of ASHA & ANM on reporting of Maternal deaths and conduct Verbal Autopsy | Rs 5000/- per PHC | 95000 |
| | | | | 2.4.2 | Incentives for maternal death reporting by ASHA @ Rs 50/- per maternal death | Rs 50/- per maternal death for approx 300 maternal deaths | 15000 |
| | | | | 2.4.3 | Reporting line should be in five columns – name of mother, place of death, date of death, cause of death and no. of birth. | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 2.4.4 | Institution and urban center also to report Maternal death to the District CS / ACMO. | NA | 0 |
| | | | | 2.4.5 | Maternal Death should be reported by ASHA, AWW, ANM Staff Nurse & Doctors to the district data center. | NA | 0 |
| | | | | 2.4.6 | Investigation of maternal death by district team. and third party review (District magistrate) | NA | 0 |
| | | | | 2.4.7 | Training of ASHA and investigation team objective and process of investigation and review of maternal death | Rs 3000 per PHC | 57000 |
| | | 2.5 | Biomedical waste management is not properly taken care off at all institution | 2.5.1 | Procurement of equipment | Rs 50000 per PHC | 950000 |
| | | | | 2.5.2 | As per example Introduce color coded buckets for facilities as per IMEP | NA | 0 |
| | | 4.1 | Tracking of pregnant women from first Trimester is not done form the register. | 4.1.1 | Review of early registration with 3 AN checkup, two TT. 100 / 200 IFA Tab. in ASHA Diwas. | NA | 0 |
| | | 4.2 | Too much documentation process. Photo required for mother and baby. It cost Rs.30/- to Rs. 60/- . | 4.2.1 | Ensure 100 % Pregnancy Test Kit is to ASHA and regular supply. | Rs 50/- for 99000 pregnancies | 4950000 |
| 4 | **To strengthen Janani Suraksha Yojana / JSY** | | | 4.2.2 | Direct transfer of funds from district to PHC through core banking / directly from DHS | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 4.2.3 | Finger print technology for JSY beneficiaries at facility level where computer with internet facility is available. This will help in financial monitoring. | NA | 0 |
| | | | | 4.2.4 | The photo system should be replaced by some other alternatives like- bank account opening of pregnant women in first trimister and directaly transfer the money to their account after delivery. | Incentive to ASHA for rs 50 per PW for opening of bank account of PW for 99000 pregnancies | 4950000 |
| | | | | | Incentive for institutional delivery. | Rs 2000/- per delivery | 132000000 |
| | | 5.1 | Home Delivery is still prevailing through untrained traditional Dai's | 5.1.1 | Home Delivery should be conducted by SBA trained Staff Nurse or ANM. | NA | 0 |
| | | | | 5.1.2 | Provision of Dai Delivery kit (DDK) to TBA where institution access is poor. And it should be supervised by ANM for home deliveries. | NA | 0 |
| 5 | **To ensure support of SBA at home deliveries** | | | 5.1.3 | Delivery kit (equipment, medicine) for ANM should be supplied | Rs 10000/- per PHC | 190000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 5.1.4 | Supply of delivery Kits as per number of deliveries conducted in home. | NA | 0 |
| | | 5.2 | Reporting of home delivery is not done so the PNC is not provided | 5.2.1 | Incentive based system for reporting of home delivery by ASHA and it should be linked with ANM | NA | 0 |
| | | 5.3 | Non paiment of Home delivery through JSY | 5.3.1 | The JSY money to the mother who has delivered baby at Home paid by ANM. | Rs 500/- per home delivery for approx 33000 home deliveries | 16500000 |
| | | **Infrastructure** | | | | | 0 |
| | | 6.1 | Out of 338 HSCs only 39 are having own building | 6.1.1 | Strengtheing of HSCs having own buildings | | 0 |
| 6 | **To strengthen HSC for providing outreach maternal care** | 6.2 | In existing 39 buildings 26 are in running comparatively in good condition, 6 are in under construction, one is very poor condition and one is constructed but not handed over to health department. | 6.2.1 | White washing of HSC buildings. | Rs 2000 per PHC | 38000 |
| | | | | 6.2.2 | Organize adolescent girls for wall painting and plantation./hire local painter for colourful painting of HSC walls. | NA | 0 |
| | | | | 6.2.3 | List out all services which is provided at HSC level. On the wall. | NA | 0 |
| | | | | 6.2.4 | Gardening in HSC premises by school children. | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 6.3 | No one building is having running water and electric supply. | 6.3.1 | Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental. (Untied fund) | Water rent for 39 HSC, Rs 100/- per month from untied fund. | 0 |
| | | | | | Arrangement of water supply upto HSC ( Wiring ) from water source | Rs 5000/- per HSC | 195000 |
| | | 6.4 | Lack of appropriate equipments and ANM are reluctant to keep all equipments in HSC . | 6.4.1 | Purchase of Furniture Prioritizing the equipment list according to service delivery (for ANC / Family planning / Immunization) | Rs 20000/- per HSC having own buildings | 780000 |
| | | | | 6.4.2 | Purchase of equipments according to services | NA | 0 |
| | **To strengthen HSC for providing outreach maternal care** | | | 6.4.3 | Purchase one almirah for keep all equipment safely and it could be keep in AWW / ASHA house. | Rs 10000/- per HSC | 3390000 |
| | | 6.5 | Non payment of rent of 300 HSCs for more | 6.5.1 | Strengthening of HSCs running in rented buildings. | | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | than three years | 6.5.2 | Estimation of backlog rent and facilitate the backlog payment within two months | Rs 300/- per HSC per month for 36 months (State fund) | 0 |
| | | | | 6.5.3 | Streamlining the payment of rent from the month of April 09. | Rs 300/- per HSC per month for 12 months (from State fund) | 0 |
| | | | | 6.5.4 | Purchase of Furniture as per need where building is on rent | From untied fund | 0 |
| | | | | 6.5.5 | Prioritizing the equipment list according to service delivery | NA | 0 |
| | | | | 6.5.6 | Purchase of equipments as per need | From untied fund | 0 |
| | | 6.6 | The district still needs 135 more HSCs to be formed. | 6.6.1 | Construction of new HSCs. 39 are having own building, 54 new is proposed and rest 480 are supposed to be constructed. | From State Govt fund | 0 |
| | | | | 6.6.2 | Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 6.6.3 | Community mobilization for promoting land donations at accessible locations. | NA | 0 |
| | | | | 6.6.5 | Meeting with local PRI / CO / BDO / Police Inspector in smooth transfer of constructed HSC buildings. | NA | 0 |
| | | 6.7 | Non participation of Community in monitoring construction work | 6.7.1 | Biannual facility survey of HSCs through local NGOs as per IPHS format | Rs 200/- per HSC biannually | 135600 |
| | | | | 6.7.2 | Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. | NA | 0 |
| | **To strengthen HSC for providing outreach maternal care** | | | 6.7.3 | Monitoring of renovation / construction works through VHSC members / Mothers committees / VECs / others as implemented in Bihar Education Project. | NA | 0 |
| | | | | 6.7.4 | Training of VHSC / Mothers committees / VECs / Others on technical monitoring aspects of construction work. | Rs 20000/- per PHC | 340000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 6.7.5 | Quartely Meeting of one representative of VHSC / Mothers committees on construction work and other issues | Rs 50/- for TA to VHSC members for attending monthly meeting at PHC | 204000 |
| | | 6.8 | Lack of community ownership in the monitoring of construction work. | 6.8.1 | Formation and strengthening of VHSCs, Mothers committees, | NA | 0 |
| | | | | 6.8.2 | "Swasthya Kendra chalo abhiyan" to strengthen community ownership | NA | 0 |
| | | | | | One week Training of Nukkad Natak team on IPHS | Rs 300/- per participant per day for 85 persons for 7 days | 178500 |
| | | | | 6.8.3 | Nukkad Nataks on Citizen's charter of HSCs as per IPHS | Three days performance at 339 HSCs | 1525500 |
| | | | | 6.8.4 | Monthly meetings of VHSCs, Mothers committees | NA | 0 |
| | | **Human Resource** | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 7.1.1 | Selection and recruitment of 262 ANMs | Honorarium of 262 ANMs @ Rs 6000/- per month for 12 months | 18864000 |
| 7 | | 7.1 | 1.Out of 29 sanctioned post of LHVs only 22 are placed, 2.All 195 posted ANM ® are not trained enough to deliver services. 3. 223 seats of contractual ANM®, 12 seats of contractual ANMs and 27 seats of Regular ANMs are vacant. | | Honorarium of existing 202 ANMs | Honorarium of existing 202 ANMs @ Rs. 6000/- per month for 12 months | 14544000 |
| | | | | 7.1.2 | Selection and recruitment of 28 male workers | Honorarium of 28 male workers @ Rs 5000/- per month for 12 months | 1680000 |
| | | | | 7.1.3 | Training need Assessment of HSC level staffs by BHM in weekly meeting | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 7.1.4 | Training of staffs on various services in the PHC, | Rs 1000/- per participant (Total no of participants 262 new ANMs, 202 existing ANMs and 28 new male workers) | 492000 |
| | | 7.2 | The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities | 7.2.1 | Analyzing gaps with training school | | 0 |
| | | | | 7.2.2 | Deployment of required staffs/trainers | | 0 |
| | **To strengthen ANM Training School for providing regular training of ANMs.** | | | 7.2.3 | Hiring of trainers as per need | | 0 |
| | | | | 7.2.4 | Preparation of annual training calendar issue wise as per guideline of Govt of India. | | 0 |
| | | | | 7.2.5 | Allocation of fund and operationalization of allocated fund | Rs 200000 in a year | 200000 |
| | | **Drug Kit Availability** | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs) and contraceptives | 8.1.1 | Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports | NA | 0 |
| 8 | **To strengthen HSC for providing outreach maternal care** | 8.1 | No Drug kit for AWCs (@ one kit per annum). No ASHA kit, only need based emergency but that too being irregular in supply | 8.1.2 | Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map | From state fund | 0 |
| | | | | 8.1.3 | Hiring vehicles for supply of drug kits through untied fund. | Rs 200/- per HSC per month | 813600 |
| | | | | 8.1.4 | Developing three coloured indenting format for the HSC to PHC (First reminder - Green, Second reminder - Yellow, Third reminder - Red) | Rs 2000/- per PHC | 38000 |
| | | | | 8.1.5 | Hiring of couriers as per need | Rs 50/- per courier for 200 couriers for 8 days per month | 960000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 8.1.6 | Payment of courier through ANMs account | Fund for the payment of Couriers should be transferred to ANMs account. | 0 |
| | | **Performance** | | | | | |
| 9 | **To strengthen HSC for providing outreach maternal care** | 9.1 | Unutilized untied fund at HSC level | 9.1.1 | Training of signatories on operating Untied fund account, book keeping etc | Rs 100/- per person for two persons for 339 HSCs | 67800 |
| | | | | 9.1.2 | Timely disbursement of untied fund for HSCs | Rs 10000/- per HSC per year for 339 HSCs | 3390000 |
| | | | | 9.1.3 | Assigning a person at PHC level for managing accounts | NA | 0 |
| | | 9.2 | No ANC at HSC level Only 14.2% PW registered in first trimester PW with three ANCs is 15.1%, TT1 coverage is 35.4%, | 9.2.1 | Identification of the best HSC on service delivery | NA | 0 |
| | | | | 9.2.2 | Listing of required equipments and medicines as per IPHS norms in facility survey | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 9.2.4 | Honouring those ANMs who devlope women friendly HSC in given criteria (list is attached) | 5 ANM in a year per PHC social honouring with one shawl. | 47500 |
| | | 9.3 | Family Planning Status:-Any method-43.6%,Any modern method-39.8%,No sterilization at HSC level,IUD insertion - 0.5%,Pills-1.5%,Condom-1.9%,Total unmet need is 32.7%, for spacing-14.9,Lack of counselling Skill. | 9.3.1 | Gap identification of 39 HSCs through facility survey | NA | 0 |
| | | | | 9.3.2 | Eligible Couple Survey | NA | 0 |
| | | | | 9.3.3 | Ensuring supply of contraceptives with three month's buffer stock at HSCs. | State Fund | 0 |
| | | | | 9.3.4 | One day training of AWW / ASHA on family planning methods and RTI / STI / HIV / AIDS. | Rs. 5000/- per PHC | 95000 |
| | | | | 9.3.5 | Training of ANMs on IUD insertion | Rs 10000/- per PHC | 190000 |
| | | 9.4 | HSC unable to implement disease control programs | 9.4.1 | Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6. (four to five HSC per week) | NA | 0 |
| | | | | 9.4.2 | Strengthening ANMs for community based planning of all national disease control program | NA | 0 |
| | | | | 9.4.3 | Reporting of disease control activities through ANMs | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 9.4.4 | Submission of reports of national programs by the supervisors duly signed by the respective ANMs. | NA | 0 |
| | | 9.5 | 80% of the HSC staffs do not reside at place of posting | 9.5.1 | Submission of absentees through PRI | NA | 0 |
| | | 9.6 | Problem of mobility during rainy season | 9.6.1 | Purchasing Life saving jackets for all field staffs | 3 units per PHC at the rate ofRs 3000 per unit | 171000 |
| | | | | 9.6.2 | Providing incentives to the ANMs during rainy season so that they can use local boats. | From untied fund | 0 |
| | **To strengthen HSC for providing outreach maternal care** | 9.7 | Lack of convergence at HSC level | 9.7.1 | Fixed Saturday for meeting day of ANM, AWW, ASHA, LRG with VHSCs rotation wise at all villages of the respective HSC. | from untied fund | 0 |
| | | | | 9.7.1 | Monthly Video shows in all schools of the concerned HSC area schools on health, nutrition and sanitation issues. | From untied fund | 0 |
| | | 9.8 | Lack of knowledge and skill of field level staffs in data compilation in HMIS formats | 9.8.1 | Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc | NA | 0 |
| | | | | 9.8.2 | Printing of adequate number of reporting formats and registers | Discussed earlier | 0 |
| | | 10.1 | Out reach camps are not orgnised in plan manner. | 10.1.1 | Identifying Socially Backward, Slums & Maha Dalit Tolas. | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | It is totally based on demand of orgnisation and eventually it is not reported to respective HSCs and PHCs. | 10.1.2 | Hiring trained alternate vaccinator / retired ANMs and Medical officer .hiring vehicle for fixed day out reach camps with drugs. | Rs 10000/- per PHC per month | 2280000 |
| 10 | **To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas** | | | 10.1.3 | Fixed day OPD clinics at APHC level and adjoining HSC of respective APHCs. with dedicated MO and support staff. | NA | 0 |
| | | | | 10.1.4 | To make calendar for camps with date and identified areas.and link NGOs those who are willing to orgnise Camps. | NA | 0 |
| | | | | 10.1.5 | Community based reporting system through SMS. involve PRI members and training on reporting and Camp approach. | NA | 0 |
| | | 11.1 | No training programme for adolescent particularly health and sex. | 11.1.1 | Multipurpose counsellor can be used for adolescent care. For this services of LHV can be used.and callender of activity could be devloped. | NA | 0 |
| | | 11.2 | Preventions of anemia in adolacencent girls | 11.2.1 | Linkage with adolescent anemia control programme in Schools with Unicef and training to one teacher from the school | Rs 5000/- per PHC | 95000 |
| 11 | **To improve adolescent reproductive and sexual health** | 11.3 | Marriage before legal age. | 11.3.1 | Sensitization of PRI members pertculerly women | Rs 5000/- Per PHC | 95000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 11.4 | Preventions of teen age pregnancy and abortion. | 11.4.1 | Adolescent pregnancy should be addressed with priority care (eclampsia, 3 ANC, anemia, 100 IFA, 100% institution delivery, low birth Wight baby, Brest feeding. PNC with in 48 hours. | NA | 0 |
| | | 11.6 | Limited interventions for empowering adolescent girls | 11.6.1 | Family counseling for adolescent pregnancy tracking on above mentioned through ASHA and AWW. | NA | 0 |
| | | | | 11.6.2 | State to develop and issue guidelines for implementation of Kishori Mandals Formation of Kishori Mandals by registration of all girls (11-18 yrs) | NA | 0 |
| | | | | 11.6.3 | Prepare a monthly plan of activities for one day per week | NA | 0 |
| | | | | 11.6.4 | Counseling nutrition, health and social issues every week at AWCs by AWW | NA | 0 |
| | **To improve adolescent reproductive and sexual health** | | | 11.6.5 | Weekly distribution of IFA Tablets to out-of-school girls at AWCs | From State | 0 |
| | | | | 11.6.6 | Deworming adolecent every 6 months | Purchase of 12 lac tablets | 900000 |
| | | | | 11.6.8 | Initiate family schools for learning child care, safe motherhood life skills and Family life education | Rs 10000/- per Schools each in each PHC | 190000 |
| | | 12.1 | MTP services are not available in Public sectors | 12.1.1 | Selection of facilities for provision of safe abortion services | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 12.1.2 | Location of facility availability of trained service provider, space, equipments. | NA | 0 |
| 12 | **To provide MTP services at health facilities** | | | 12.1.3 | To Provide appropriate equipments at all facilities and MVA syringes. | 50000/- per PHC | 850000 |
| | | | | 12.1.4 | Putting the trained doctors at appropriate facilities to commence the services | NA | 0 |
| | | | | 12.1.5 | Training of Medical officers and Para medical staffs on Safe abortion services training including awareness about legal aspects of MVA / EVA and Medical abortion by IPAS . | One doctor and one ANM from each PHC @ Rs 2000 | 38000 |
| | | | | 12.1.6 | Formation of district level committee (DLC) to accredit private sites as per GOI guide line . | NA | 0 |
| | | | | 12.1.7 | Develop reporting system of MTP services in private and public secter. | NA | 0 |
| | | | | 12.1.8 | Through training program make the govt doctors skilled to perform MTP in the approved sites. | NA | 0 |
| | | | | 12.1.9 | To Involve community to aware about location of services , process and legal aspects of MTP services through - AWW, ASHA & ANM, LRG and mass media.(IEC) | Rs 5000/-Per PHC | 95000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | 12.1.10 | The services of Pregnancy testing should be strengthened and it should be linked with MTP services. | NA | 0 |
| | **To provide MTP services at health facilities** | | | 12.1.11 | NGO's and local Practitioner should be involved for counseling and information of facility | NA | 0 |
| | | | | 12.1.12 | Assurance of privacy and link with family welfare services counseling at all facility. | NA | 0 |
| | | | | 12.1.13 | Linkage with MTP services with NGOs (PPP) those who are working in Safe abortion services. and create one modal center at district and PHC level. | NA | 0 |
| | | | | 12.1.14 | Training of ASHA on medical abortion. | Incorparoted in ASHA training | 0 |
| | | 13.1 | Nutrition and Counselling Component is not visible in VHND and there is no monitoring of VHND activity by Community. | 13.1.1 | AWC should be developed as a Hub of activities (VHND) | NA | 0 |
| | | | | 13.1.2 | Develop an activity plan calendar for VHND as seasonality. | NA | 0 |
| 13 | **To strenghten Monthly Village Health and Nutrition** | | | 13.1.3 | Counseling of mothers on ANC, preparation for Child care ,STI / RTI, and AYUSH, adolescent Health | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Days** | | | 13.1.4 | Organize VHND in Four Table concept regularly where One place is for registration, one is for weighing, one is for immunization and fourth is for counseling | Booklet on four table concept @ Rs 5 for 10000 booklets | 50000 |
| | | | | 13.1.4 | Meeting of VHSC and preparation for area specific epidemiological planning and community based monitoring. | NA | 0 |
| | | | | 13.1.5 | Skill development training is required to ANM , ASHA & AWW and Dular (LRG) | Rs 5000/- per PHC | 95000 |
| | | | | 13.1.6 | Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourished children , New born, DOTs and other services | From untied fund | 0 |
| | | | | 13.1.7 | SMS reporting system of conducting VHND and ANM collect Data from field level and compile it in weekly / Monthly formats. | NA | 0 |
| | | | **Infrastructure** | | | | 0 |
| | | 1.3 | Out of 30 APHCs only 16 are having own building | 1.3.1 | Registration of RKS | NA | 0 |
| B | **APHC** | 1.4 | Existing 16 buildings are not properly maintained | 1.4.1 | Rennovation of APHCs buildings from RKS Fund | Rs 150000/- per APHC | 2850000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **To form / strenghten APHC in Phase manner** | 1.5 | Non payment of rent of 14 APHCs for more than three years | 1.5.1 | Payment Of Rent of APHC building | From state fund | 0 |
| | | 1.6 | Lack of equipments, | 1.6.1 | Purchse of equipment as per service need from RKS fund | From state fund | 0 |
| | | 1.7 | Lack of appropriate furniture | 1.7.1 | Purchase of Furniture from RKS fund | From state fund | 0 |
| | | | **Human Resource** | | | | 0 |
| | | 2.1 | in the district no any APHC functioning as per IPHS norms | 2.1.1 | Operationalising one APHC in each PHC by conducting daily OPD by Doctor and support staff. | NA | 0 |
| | | 2.2 | | 2.2.1 | Notification from district for oprationaliing APHC | NA | 0 |
| | | | **Drug Supply** | | | | 0 |
| **2** | | 3.1 | No drug kit as such for the APHCs as per IPHS norms., | 3.1.1 | Purchasing 23 listed OPD Drugs of PHC for APHC | Rs 200000/- Per PHC for OPD drugs for one year. | 3800000 |
| **3** | | 5.1 | No regular clinic at all PHCs & APHCs. | 5.1.1 | Trained service provider on syndrome management of RTI / STI (As per GOI guide line) up to APHC level. | Rs 1000/- for Two person from each PHC | 34000 |
| | | | | 5.1.2 | Logistics of setting of clinics and free drugs availability | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **5** | **RTI / STI services at health facilities** | | | 5.1.3 | Integrated Counselling services in four public sector facilities by trained personnel . | NA | 0 |
| | | | | 5.1.4 | IEC / BCC for awareness available RTI / STI services at all health facilities. | Rs20000 for Per PHC | 380000 |
| | | | | | | **Total** | **310736750** |

| 4.4Chid Health | | | | | | | |
|---|---|---|---|---|---|---|---|
| Logical Framework | | | | | | | |
| Sl. | Goal | Sl. | Impact indicators | | | | |
| 1 | | 1.1 | Reduction in IMR | | | | |
| | To improve Child health & achieve child survival | 1.2 | Child performance in the school - enrolment, attendence and dropout | | | | |
| Sl. | Objectives | Sl. | Outcome indicators | Sl. | Strategy | Sl. | Output indicators |
| 1 | To increase ORS distribution from 51%(DLHS3) to 80% | 1.1 | % increase of ORS distribution . | 1.1.1 | | | % of PHC initiated IMNCI and HBNC training. |
| 2 | To increase treatment of diarrohoea from 77.1% to 90% within two weeks | | % increase of treatment of diarrohoea within two weeks | | | | |
| 3 | To increase treatment of ARI/Fever in the last two weeks from 82.2%(DLHS3) to 95% | | % increase of treatment of ARI/Fever in the last two weeks | | *IMNCI,Home Based Newborn Care/HBNC* | | |
| 4 | To increase of infant care with in 24hr of delivery from 29.7%(DLHS3) to 50% | | % increase of infant care with in 24hr of delivery . | | Strengthening of Facility Based Newborn Care/FBNC and trained workers on using equipments. | | No of PHC initiated FBNC with trained MAMTA on facility based new born care.. |
| 5 | To increase % of breastfeeding from 33.8% to 70% within 1 hr of birth | | % increase of breastfeeding within 1 hr of birth . | 1.1.2 | | | No of training orgnised in PHC on IYCF |
| 6 | To increase intiation of complimentry feeding among 6 month of children from 88.3% to 90% | | % increase of complimentry feeding among 6month of children. | | | | |
| 7 | To increase exclusive breastfeeding among 0-6 month of children from 36.4% to 80% | | % increase of exclusive breastfeeding among 0-6 month of children . | | | | |
| 8 | To increase immunization coverage from 53.3% to 70% | | % increase of full immunization coverage . | | Infant and Young Child Feeding/IYCF | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 9 | To increase vit A coverage of received atleast one dose (9month to 35 months ) from 67.3% to 80% and include up to 5 years. | | To increase Vit A reported adequte coverage among (9m to 5ys ) | 1.1.3 | Management of diarrhea, ARI and Micronutrient Malnutrition through Child srvival months | | Two round of Child survival Month organised in one financial year. |
| 10 | To decrese Malnutrition form 58%(NFHS III state ) to 30% of the age group of (0 to 5 yrs) | | % of decrese Malnutrition age group of (0 to 5 yrs) | 1.1.4 | Care of Sick Children and Severe Malnutrition and strenthen VHND at all AWCs | | No of VHND orgnised vs Planned. |
| | | 2.1 | | 2.1.1 | School Health Programme | | No Of school health programme orgnised in the PHC |
| Sl. | Strategy | | Gaps | | Activities | Unit Cost | Budget |
| | *IMNCI,Home Based Newborn Care/HBNC* | | *Training Gaps(AWW-2328/2476,ASHA-0,ANM-377/401,MPW-11/83,MO-47/146,CDPO-05/16,ICDS Super-05,Health supervisors-27,NGOs-06)*<br><br>*No ASHA is trained on IMNCI* | | *Assessment of Training load and prepare calendar of training* | NA | 0 |
| | | | | | *Incorporate ASHA in IMNCI training team* | NA | 0 |
| | | | | | *ASHA kit regular supply and incorporate use of ASHA Kit in training curriculum.* | | |
| | | | | | *Division of area among all trained supervisors for revision of IMNCI activity in their area.* | NA | 0 |
| | | | Inadequate monitoring of this activity at field level | | *BHM will be responsible for review of health supervisor sand LS(ICDS)on given format.Unicef staff will support in devloping review mechanism in PHC.* | NA | 0 |
| | | | | | *Incorpate IMNCI reports in HIMS formate* | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | *Encouraging mother regarding child care.in VHND* | NA | 0 |
| | | | | | *Frequent checkups of babies by Paediatrician.*<br><br>*Distribute teliphone number to AWW and ANM of respective doctors those who are supervising them in the field.* | NA | 0 |
| | | | | | *Wednusday could be fixed a day for IMNCI related work at HSC level* | NA | |
| | | | | | *Community based Monitoring support system devlop with SHG in one PHCTraining of Group membersseed money to SHG for reffral services and other need based services.* | Rs 100000 for one PHC | 100000 |
| | Facility Based Newborn Care/FBNC | | only eight institutions have baby warmer machines but maintenance of machine is not up to the mark and district having referral six bedded SNCU | | All PHCs should be equipped with baby warmer machines. | Mobilizing nine units from UNICEF | 0 |
| | | | ANMs and Doctors are not trained to operate these machines | | Training of Doctors and ANMs to operate baby warmer machine. | Rs 5000/- for demonstration at District level | 5000 |
| | | | There is no provision of stay of mothers of neonates at PHC. | | Organize training programme for newborn care for the nurses in the district hospitals | One Nurse from each PHC Cost will be 5000/- | 5000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | *Neonatal Care Unit not up to mark.* | | District level Supporting supervisory team should be devlope with the responsibility of nunfuctioning of neonatal care unit. Training of team on monitoring of NCU | Rs.5000/-for one time training | 5000 |
| | | | *Non availability of "MAMTA" at PHC level.* | | *Training of Mamta and staff nurse on logistics of New born Care units.by district level supervisory Team.* | Rs 1500 for team members for each PHC per month | 342000 |
| | Infant and Young Child Feeding/IYCF | | Non awareness of breast feeding and proper diet of young children. | | Colostrum feeding and breast feeding inclusively for six months. Through IMNCI Training. | NA | 0 |
| | | | | | Baby friendly hospital<br>Training of one doctor from each Nursing hospital at District Level | Rs.20000 for training programme | 20000 |
| | | | | | Two days training of one staff nurse from each private hospital on counselling skill. | Rs 20000/- for training programme | 20000 |
| | | | | | Accreditation of nursing home and facility according to norms of baby friendly hospital initiatives | NA | 0 |
| | | | Poor knowledge regarding new born care and child feeding practices | | Development and Printing of BCC materials | Rs 5 per unit for 10000 units | 50000 |
| | | | | | Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA | NA | 0 |
| | | | | | Linking JBSY with colostrums feeding | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding | | Counselling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries in mothers meetings and VHSCs meetings | NA | 0 |
| | | | | | Folk performance to promote exclusive breast feeding | Included in maternal health | 0 |
| | | | | | Uniform message on radio from state head quarter | State budget | 0 |
| | | | Lack of awareness on importance of appropriate and timely IYCF | | Organize social events through VHSCs | NA | 0 |
| | | | | | Strengthening of *Mahila Mandal* meetings- fortnightly with involvement of adolescent girl | NA | 0 |
| | | | | | Organize healthy baby shows, healthy mother / pregnant woman. | Rs 2000 per month per PHC | 456000 |
| | | | | | Appreciation and reorganization of positive practices in community. For this purpose hiring a documentation specialist. | Rs 100000 for the whole district on communitywise sample basis | 100000 |
| | | | | | Celebration of "*Annaprashan( Muhjutthi) Day*" at AWC | NA | 0 |
| | | | | | Demonstration of recipes. | Rs 250 per month per AWC( Under MUSKAN program) | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Exposure visits to existing NRCs to observe different models in the country | Rs 50000 for the district | 50000 |
| | Care of Sick Children and Severe Malnutrition | | There is not a single unit in the district where severly malnurished children could be treated. | | Establish rehabilitation center in district hospital, FRU and one PHC and promote locally aviliable food farmula for nutritional Tharapy as Hadrabad Mix | Rs 1000000 per unit | 4000000 |
| | Management of diarrhea, ARI and Micronutrient Malnutrition | | There is high privlance of PEM and anemia among childrn because of Child nutrition is least priporty among service providers. | | Procurement of ,ORS , Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup. | 100000 ORS packets at the rate of Rs 5 per packet.(If ORS is not provided in Kit A) IFA syrup for 800000 children at rate of Rs 4 per children | 3700000 |
| | | | | | Include covrage of Vitamin A and IFA,children in New HIMS format. | NA | 0 |
| | | | | | Insure two round of Vitamin A and deworming for the age group of (9m to 5 yrs) & (2 yrs to 5 years) respectivly in the month of April And Oct as per GOI guide line. | Rs 1500000 per round into two rounds( If Vit A is not provided in Kit A) | 3000000 |
| | | | | | Involvement of ICDS, school teachers and PRI for monitoring and evolution | NA | 0 |
| | School Health Programme | | No Pre School Health checkup & complete Immunization card. | | Half yearly health checkup camp for children in schools should be organized. | Rs 2000 per PHC | 38000 |
| | | | No training of school teacher for basic health care and personnel hygiene. | | Training of school teacher by the medical personnel with support of administrative person. | Budget incorporated in adolescent health | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | No regular health checkup camp at school. | | Quarterly meetings of VEC representatives by attending existing meetings of VECs representatives at block level by the concerned MOICs and BHMs. | NA | NA |
| | | | No Training & Screening of school's teacher for eye sight test. | | Linking existing 7 opthalmic paramedics with this program and developing school wise calender. | Mobility support of Rs 10000 per PHC for moving other blocks and hard to reach areas. | 190000 |
| | | | No other specific program has been formulated in the district. | | School health anemia control programme should be strengthened with biannually de worming . | Budget incorporated in adolescent health | 0 |
| | | | | | Organizing competitions/Debates/Painting competitions/Essay/demonstration and model preparation of nutritional food and health. | Rs 20000 per PHC | 380000 |
| | | | | | Half yearly Health checkups and health card of all school going children. | Printing of Health Card at the rate of Re 1 per card for the children of class 6 to 10 | 100000 |
| | | | | | Films shows on health, sanitation and nutrition issues | Use LCD projector in this activity. | 0 |
| | | | | | Social science Lab activities. | Included in adolescent health | 0 |
| | | | | | Rally and Prabhat Phery in epidemic areas. (Kala-azar & Malaria) | Local contribution/ Untied Fund/VHSC | 0 |
| | | | | | Referral system for the school children for higher medical care. | From RKS fund | 0 |
| | | | | | | | |
| | | | | | **Total** | | **12561000** |

# 4.5 Family Planning

## Logical Framework

| Sl. | Goal | Sl. | Impact indicators |
|---|---|---|---|
| 1 | Population stablisation | 1.1 | To decrease TFR upto replacement level<br>To increase sex ratio |

| Sl. | Objectives | Sl. | Outcome indicators | Sl. | Strategy | Sl. | Output indicators |
|---|---|---|---|---|---|---|---|
| 2 | To increase female sterlization from present 35%(DLHS3) to 50% | 2.1 | % increase in female sterilsation | 2.1.1 | Terminal/Limiting Methods | 2.1.1.1 | % of terminal/limiting methods use |
| | | | | 2.1.2 | Dissemination of manuals on sterilization standards & quality assurance of sterilization services | 2.1.2.2 | No of facilities providing quality manuals on sterilization standards of sterilization services |
| | | | | 2.1.3 | Female Sterilization camps | 2.1.3.3 | No of camps orgnised for female sterlization |
| | | | | 2.1.4 | Compensation for female sterilization | 2.1.4.4 | % of Female received compensation |
| | | | | 2.1.5 | IUD camps | 2.1.5.5 | No of IUD used in Camps |
| | | | | 2.1.6 | Accreditation of private providers for IUD insertion services | 2.1.6.6 | No of Private provider accrediate for IUD Insertion services. |
| 3 | To increase male sterlizationfrom 0.6%( DLHS 3) to 2% | 3.1 | % increase in male sterlization | 3.1.1 | NSV camps | 3.1.1.1 | No of NSV Camps orgnised. |
| | | | | 3.1.2 | Compensation for male sterilization | 3.1.2.2 | % of Male received compensation |
| | | | | 3.1.3 | Accreditation of private providers for sterilization services | 3.1.3.3 | No of Private provider accrediated for Sterilization services. |
| 4 | To increase use of condoms from 1.9% (DLHS3) to 5% | 4.1 | % increase in the use of condoms | 4.1.1 | Promotion to Social Marketing of condoms | 4.1.1.1 | No of Condoms distributed through Social Marketing. |
| | | | | 4.1.2 | Contraceptive Update seminars | 4.1.1.2 | No of Seminars Orgnised on Contraceptive Update |
| 5 | To increase use of pills from present 1.5%(DLHS3 ) among current married women age 15-49 yrs to 5% | 5.1 | % increase in the use of pills | 5.1.1 | Promotion to Social Marketing of pills | 5.1.1.1 | No of Pills distributed through Social Marketing. |

| Sl. | Strategy | | Gaps | | Activities | Unit Cost | Total Budget |
|---|---|---|---|---|---|---|---|
| | Terminal/Limiting Methods | | Lack of knowledge of small family norms. | | Ensure one MO trained on minilep and NSV up to PHC | Rs 20000 | 38000 |
| | | | | | Training of nurses and ANMs on IUD and other spacing methods at PHC level. | Rs 10000 | 19000 |
| | | | | | Ensure availability of contra ceptives (indenting , logistic | Rs 500000 per PHC | 950000 |
| | Female Sterilization camps | | Laparoscopy surgery not done. | | Trained doctors on laparoscopy. | Above mentioned | |

| 4.6 Kala a Zar | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| **Gaps** | **Issues** | **Strategy** | **Activities** | **Unit Cost** | **Total Budget** |
| Poor coverage of DDT spray | Vector control through insecticide spray in the attack area | To increase the coverage of DDT spray in the endemic zone , there should be proper monitoring by the supervisors, capacity building of the sprayer, supervisors and other healthcare professionals | 1. Ensure planning for timely spray of DDT in Feb-March and May-June for 40 days in each block | NA | 0 |
| | | Monitoring of the spraying squad by MOIC | 2. Identification of Houses with Kala-azar patients by ANM & ASHA @ 50/ per village. | Rs 50 for 751 villages twice in a year | 75100 |
| | | | 3. Two round of spraying scheduled in Feb-March and May-June should be strictly observed | NA | 0 |
| | | | 4. DDT spray should be at the rate of 1gm/sq. meter upto the height of 6 feet. | NA | 0 |
| | Less time spent on spraying DDT | Training and capacity building for proper spraying | Regular capacity building training on prescribed module for the sprayer to ensure that every corner of the house is properly spraye upto heigth of six feet from ground level. | Rs 5000 per PHC | 95000 |
| **1** | Poor condition of Sprayer, pump and nozzles etc<br>No of Pumps available- | Regular checking of the spraying pumps for better functioning and timely replacement of the faulty pieces. | Fund allocation and timely release for : maintencae of old sprayer pumps, Puchase of new pumps and other articles | Rs 150000 for the district | 150000 |

**4.7Blindness**

| Gaps | issues | Strategy | Activities | Unit Cost | Total Budget |
|---|---|---|---|---|---|
| Lack of adequate eye surgeon and staffs in the district.Only 4 eye surgeons are posted in the district out ofwhich one is on deputation to the other district. | Staff shortage | Recruitment | Recruitment of Eye Specialists and surgeons on contractual basis. | Already discussed in maternal health | 0 |
| Only 7 Opthalmic Assistants are posted in the district,however the requirement is 19. | | | Recruitment of Opthalmic Assistants on contractual basis. | Only 4 in the current year @ Rs 8000 per month | 384000 |
| Most of the doctors and staffs are not trained enough on new IOL tehniques | Untrained staffs | Capacity building | Training of Doctors on IOL technique | Rs 10000 per person for 5 person | 50000 |
| | | | Training of Opthalmic Assistant | Rs 5000 for 4 Opthalmic assistants | 20000 |
| In the Year2008-09 only 66 Cataract operationshave been done by the Govt facilities and 1763 bythe private facilities(till Nov 08).In the year 2007-07,altogether 1945 surgeries were performedout of 3000 and in the year 2007-08 2966 surgeries have been performed. | Low achievement | Increasing no of camps | Organising Operations at District level | Rs750 per operation for 3000 operations | 2250000 |
| | | PPP | Accreditation of Nursing Homes capable of doing Cataract surgeries | NA | 0 |
| | | | Establishing another Cataract Operation Center at PHC Lalganj | Rs 500000 | 500000 |
| | | | Purchase of equipments and medicines | | |
| Lackof awareness among community regarding cataract blindness and its treatability. | Lackof awareness | Awareness building | Assigning LHV/Supervisor counselling work | NA | 0 |
| Fear of eye operation. | | | Organising eye screening camps in villages/ schools | NA | 0 |
| Lack of Education among the masses about the existing facilities: Need of wide publicity. | | | IEC on cataract and its facilities | Rs 100000 at district level | 100000 |
| Poor coordination between the health functionaries and the voluntary organisations resulting in less cataract surgeries. | | | Meeting with Local NGOs onthis issue | | |

**4.8 Leprosy**

| Gaps | Issues | Strategy | Activities | Unit Cost | Total Budget |
|---|---|---|---|---|---|
| · Existing PR of the district is 1.1 and the target is only 1, so the existing program performance is good. | | | | | |
| · Lack of awareness is still a problem with the Leprosy Program as most of the cases are detected accidentally. | Lack of Awareness | Awareness generation | IEC on Leprosy | Rs 5000 per PHC in a year | 95000 |
| · Inadequate staff, Only 6 supervisors and 11 Non Medical Assistants are working while the requirement of Supervisor is 17 and that of NMA is 33( One NMAeach in each APHC) | Lack of Human Resource | Staff Recruitment in contract basis | Recruitment of 11 supervisors | Rs 7000per superisor per month | 924000 |
| · There is no active involvement of the Medical officers at sector and Block levels. | | Strengthen Health Care Services | Orientation of MOs and staffs on Leprosy | NA | 0 |
| · Lack of PHC staff involvement. No manpower support, | | | Case validation, to have check on wrong diagnosis and re registration | NA | 0 |
| | | | Prompt and early detection of the cases to avoid deformity and disability, | NA | 0 |
| | | | Ulcer care foot ware reorientation training of medical & para medical staff. | Rs2000 per PHC | 38000 |
| No lab testing facility in the district | Infrastructure Gap | Establishing Lab | Establishing Lab at district level | Rs 200000 | 200000 |
| | | | Recurring expenditure like reagents | Rs 1000 per month | 12000 |
| Lack of monitoring at all level | Monitoring Gap | Increasing mobility | Updation of master register | NA | 0 |
| | | | Mobility support for DLO | RS 3000 per month | 36000 |
| | | | Office expenses | Rs 2000 per month | 24000 |
| | | | **Total** | | **1329000** |

| 4.9 T.B. | | | | | |
|---|---|---|---|---|---|
| | **Indicators** | **Gaps** | **Activities** | **Unit Cost** | **Total Cost** |
| 1 | **Infrastructure** | Lack of well equipped / Designed Microscopy Centre | Development and Renovation of DMCs with proper water supply and Electricity connection | Rs 5000 per PHC | 95000 |
| | | Microscopes of many Designated Microscopy Centers (DMC) are not functioning | Supply of New binocular Microscopes | Rs 50000 per PHC | 950000 |
| | | Poor Maintenance of Microscopes | Special Training to Lab Technician / Microscopist for maintenance of Microscopes | NA | 0 |
| 2 | **HR** | Many DMCs are closed due to lack of Microscopist / Lab Technician | Recruitment Process should be followed. | NA | 0 |
| | | | Honorarium for 17 TB technicians | Rs 8000 per month for 17 technicians for 12 months | 1824000 |
| | | Constraint in selection Process of new Staffs by the District Health Society | Obstacle in recruitment Process will be rectified. | NA | 0 |
| | | Remuneration of Pvt DOT Providers has not been paid | Problems in payment of remuneration will be solved | Rs 50 per DOTS provider for 500 units | 25000 |
| 3 | **Drugs and Chemicals** | Irregular supply of Drugs specially of Pediatric Drug Boxes (PC-13, PC-14) | To ensure regular and adequate supply of drugs and other Laboratory materials | From state budget | 0 |
| | | Supply of short expiry drugs which causes difficulties in drug management | Proper care should be taken regarding short expiry drugs. Short expiry drugs may be used where there is large number of patients having DOTS. | NA | 0 |
| | | Poor Retrieval of Drug Boxes of Defaulted patient | Retrieval of Drugs may be ensured by STS. | NA | 0 |
| | | Irregular supply of slides and other Chemicals and other logistics | Proper supply of Slides and other Chemicals should be ensured | Rs 2000 per PHC per month | 456000 |
| | | Delay in purchasing of chemicals and other logistics at District level | Constraints in purchasing of Chemicals and other logistics will be removed. Official Process will be simplified. | NA | 0 |
| 4 | **Service Performance** | Poor quality of DOTS | Proper and Regular supervision and monitoring of programmes will be ensured. | NA | 0 |

| | | | | | |
|---|---|---|---|---|---|
| | | ANMs providing DOTS at the HSCs do not visit the Center on DOTS day resulting irregular intake of drugs by the patient causing poor Cure- rate. | Motivation and Sensitization of Staffs by Refreshment training on friendly behavior with patient | NA | 0 |
| | | Due to irregularities in DOTS cases of MDR TB may be increased | Proper counseling of patient should be done regarding importance of DOTS and importance of Follow-up Sputum examination | NA | 0 |
| | | Not friendly behavior of Lab Technician and other staffs with patient who comes for sputum examination or for DOTS | Appointment of a Counselor at all PHC | Discussed in maternal health | 0 |
| | | Poor Case Detection i.e., <70% | | NA | 0 |
| | | Poor Cure Rate i.e., <85% | Organizing Community meetings | NA | 0 |
| | | High Default Rate | | NA | 0 |
| | | | Medical Officers should take care of referring all chest symptomatic patients for sputum examination | NA | 0 |
| | | | Proper Follow-up Schedule should be maintained | NA | 0 |
| | | | Proper care for side effects of drugs. | NA | 0 |
| | | | **Total Budget** | | **3350000** |

4.10 Filaria

| Gaps | Issues | Strategy | Activities | Unit Cost | Total Budget |
|---|---|---|---|---|---|
| It affects mainly the economically weaker sections of communities | | 1. Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas. | Line listing of the cases | NA | 0 |
| | | | Purchse of equipments for the management of Filaria cases like towel, Bucket, soap, mug etc | Rs 500 per HSC for 339 old and 154 new HSCs | 246500 |
| | | | DEC distribution through AWCs and paying hon to AWWs for this. | Rs 100 for all 2672 AWC | 267200 |
| | | | Purchse of DEC | Rs 300000 | 300000 |
| | | | Training to AWWs/ASHA on DEC distribution and filaria case management | Rs 2000 per PHC | 38000 |
| Result in low priority being accorded by governments for the control of lymphatic filariasis. | | 2. Continuous use of vector control measures. | Meeting with VHSC members | NA | 0 |
| Low effectiveness of the tools used by the control programme | | | Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis. | NA | 0 |
| The chronic nature of the disease | | 4. IEC for ensuring community awareness and participation in vector control as well as personal protection measures. | Wall paintings | Rs 2000 per PHC | 38000 |
| | | | **Total budget** | | **889700** |

| 4.11 INSTITUTIONAL STRENGTHENING | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Logical Framework** | | | | | | | |
| **Sl.** | **Goal** | **Sl.** | **Impact indicators** | | | | |
| 1 | To improve institutional setup as per IPHS norms | 1.1 | Improved service delivery for women and children friendly with quality | | | | |
| 2 | To bring required architectural correction in the Institutional System | | | | | | |
| **Sl.** | **Objectives** | **Sl.** | **Outcome indicators** | **Sl.** | **Strategy** | **Sl.** | **Output indicators** |
| 1 | To strengthen NGOs Partnership/ PPP for communitization of Health services . | 1.1 | No and Type of MOU signed between NGO and DHS/RKS for strengthening of communitization of health servies and NGO partnership/ PPP in place | 1.1.1 | To enforce PNDT Act and to increase sex ratio of female child | 1.1.1.1 | % decrease in sex selective abortions. % increase in birth of female babies ( delivery registers) |
| | | | | 1.1.2 | To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routin facility where it is not functional. | 1.1.2.1 | No of cases supported by referral transport system under PPP. |
| | | | | | | 1.1.2.2 | No of canteen facility functional at insttutional facility level. |
| | | | | | | 1.1.2.3 | No of STD booth and other routine facility carried out under PPP. |
| | | | | | | 1.1.2.4 | No of cases supported and payments made by RKS/ DHS to BPL families in availing these services |
| | | | | 1.1.2 | To develop partnership with NGO Programmes in the districts | 1.1.2.1 | No of partnership with NGO for programme implementation for MCHN, Micronutrient supplimentation, national programme implementation specially Kalazar elimination |
| | | | | | Strengthen Logistics management system for regular supply of Drugs and equipments | 1.1.2.2 | No and % of drug & equipments available and supplied ( stock ledger) |
| | | | | | Devlop a strong Monitoring & Evaluation / HMIS System in all PHC | 1.1.2.3 | Regular monitoring and evaluation reports |
| 3 | To devlop IEC and BCC and Training support system . | 3.1 | No of IEC materials developed and BCC event carried out<br><br>No of training support system developed | 3.1.1 | Establising BCC and training cell at District & BPHC level | 3.1.1.1 | Functional BCC cell at DHS/ RKS level |
| | | | | | Net working with folk media team | 3.1.1.2 | No of folk media team engaged in BCC activity. Type and No. of BCC event oragnised |
| 4 | To strengthen ASHA support System | 4.1 | No of ASHA capacities | 4.1.1 | Develop ASHA support System in all PHC(One persin per 20 ASHA) | 4.1.1.1 | Establishment of ASHA support system at DHS and RKS level |
| | | 4.2 | No of actvities carried out by RKS | 4.1.2 | Strengthening RKS | 4.1.1.2 | No of RKS having monthly meetings. |
| | | | | | | 4.1.1.3 | % of untied fund, JSY fund, referral transport etc utilised |

| Sl. | Strategy | | Gaps | | Activities | Unit Cost | Budget |
|---|---|---|---|---|---|---|---|
| | To enforce PNDT Act and to increase sex ratio of female child | | No registration of ultra sound clinic. | | Registration and monitoring of ultra sound clinic. | NA | 0 |
| | | | | | | | |
| | | | | | MTP clinic should be watched for termination of pregnancy following USG. | NA | 0 |
| | | | | | IEC on PNDT act | Rs 5000 per PHC | 95000 |
| | To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routeen facilty where it is not functional. | | Out sourcing of services is not as per the need of local Need and BPL families are not exampted from Fee of out source services | | District /PHC level managers should be aware about the TOR of PPP which is finalized at State level. | NA | 0 |
| | | | | | Build the capacity of manager to manage contracts of PPP | NA | 0 |
| | | | There is an acute shortage of para medics like radiographer, lab technician, ECG technician etc. in the state. | | Accreditation of institutions and to set standards, an institute of paramedical sciences may be started in the state. This would create more employment opportunities in addition availability of para medical personnel for absorption into the government health system. | NA | 0 |
| | Devlop partnership with NGO Programmes in the districts | | Non involvement of NGO in F.P programme, Institutional delivery, Blindness control programme. | | listing of NGOs those who are working in F.P ,MTP,programme, Institutional delivery, Blindness control programme. | NA | 0 |
| | | | | | Accreditation of these facility from state Health Socity. | NA | 0 |
| | | | There is no MOU with NGO/VO/individuals for Donation and voluntary support in PHC | | Process of MOU should be dicentralization and it should oprationlise through RKS. | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Strengthening of DMU<br><br>NGOs Management aspects is one of the area of improvement | | ASHA Programme manager facilitate the NGO management process in the district and ASHA Faclitators will be managed at the PHC level | NA | 0 |
| | | | | | Honourarium to DPM, DPM(ASHA), DAM and DA | Rs 30000 pm for DPM, Rs 28000 pm for DPM(ASHA), Rs 26000 pm for DAM and Rs 22000pm for DA | 1272000 |
| | | | | | Capacity building training programme for NGOs office bearer with the help of professionals on linkage with health system strengthening component. | Rs 5000 per PHC | 95000 |
| | | | | | Mentoring Group at district level. | NA | 0 |
| | | | | | Reporting mechanism should be developed of NGOs work in the district. | NA | 0 |
| | | | There is no any VHSC in the district. | | Co-ordination with community based orgnisation at SHG, LRG, VEC, ,PRI for VHSC formation. | NA | 0 |
| | Capacity buiding of Managers and Doctors. | | | | Expoure visit of DPM/BHM /ASHA DPM/ selected ASHA to other state where facility is comparatively working better. | Rs 100000 for the district | 100000 |
| | | | | | To start DNB (Family Physician) 3 year course in the district hospitals. | Rs 100000 for the district | 100000 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | ASHA/ AWW career advancement programme may be planned to retain them in the system. Seats in the ANM course, staff nurses and other paramedical courses may be reserved for the qualified ASHAs | Rs 10000 per PHC | 190000 |
| | Prepration of dicentralised District Health Action Plan | | First time five members of the districts were trained on DHAP prepration | | Trainings of DPMU,BPMU members on implementation of services/ various National program and district Health action Plan through distance education | 1 DPM, 17 Doctors( One from each PHC) , 17 BHMs and district planning team | 80000 |
| | | | | | Start prepration of plan from the month of October with situtional anlysis,Facility survey, line reporting system and qulitative finding from Community and users of facility. | Rs 50000 for the district | 50000 |
| | Devlop a strong Monitoring & Evaluation / HMIS System in all PHC | | Monitoring of all programme is one of the weakest link of all programme.<br><br>Lack of Supervisers in all PHC<br><br>Lack of skill of use of data<br><br>Community is not aware about monitoring aspects of Health Programme. | | Distribution of role and responsbility among MO and Managers of programme implementation. | NA | 0 |
| | | | | | Use Process indicatore as monitoring of respective programme. | NA | 0 |
| | | | | | Devlop Programme review calander for review of HSC/PHC performance as per form 6 & 7 | NA | 0 |
| | | | | | Gradation of Health Sub centers in three categories. | NA | 0 |
| | | | | | Information exchange visits among ANM acording to Grade. | NA | 0 |
| | | | | | Social recognition of Grade one ANM. | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Devlop four potentioal VHSCs in all PHC on Community based Monitoring of Health and Nutrition programme. | Rs 2000 in each PHC | 38000 |
| | | | | | Organise"JAN ADALAT" in with PRI & VHSC and invite nearby VHSC to observe thr process of "JAN ADALAT" | NA | 0 |
| | | | | | Devlop Health and Nutrition Report Card by using growth monitoring chartsof Village and present in "JAN ADALAT" By VHSC | Rs 2000 in each PHC | 38000 |
| | Strengthen Logistics management system for regular supply of Drugs and equipments | | There is no system of logistic management of Drugs and other supply at any level.<br><br>Only vaccine supply management is comparatively stronger than other logistic work. | | Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports | NA | 0 |
| | | | | | Hiring vehicles for supply of drug kits | Rs 20000 per PHC per month | 4080000 |
| | | | | | Hiring of courriers as per need | Discussed in maternal health | 0 |
| | | | | | Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) | Discussed in maternal health | 0 |
| | | | | | Training of all ANM and Stock keepers on Indenting and Logistic Management. | Rs 5000 per PHC | 85000 |
| | | | | | Devlop TMC model for Logistic Management in the state. | NA | 0 |
| | Establising BCC and training cell at District & BPHC level | | There is not as such disignated post for BCC and Traning at the district and PHC level | | ASHA Programme manager facilitate the process of traning and BCC in the district and ASHA Faclitatore will be managed at the PHC level | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Devlop resoure team at District Level. | NA | 0 |
| | | | | | MOU with Local NGOs for logistic management of training and Devlop issue wise Master trainers in district | Na | 0 |
| | | | | | Devlop ASHA support system on one person/20 ASHA for on the job training of AHSA and AWW | NA | 0 |
| | Net working with folk media team | | There is no BCC management unit at Distrct Level | | Identify Health Communication orgnisation for identification of BCC issues as per need of District. | Discussed in child health | 0 |
| | | | | | MOU with orgnisation for formative reaserch . | NA | 0 |
| | | | | | Devlop IEC/BCC material based on Findings of formative reasrch | Discussed in child health | 0 |
| | | | | | Printing of IEC and BCC material | Discussed in child health | 0 |
| | | | | | Training of Folk Media group on IEC/BCC material | Discussed in maternal health | 0 |
| | | | | | Planning of performance route chart of Folk media Group | NA | 0 |
| | | | | | Monitoring of performance through SMS of PRI members | NA | 0 |
| | | | | | Impact analysis of Performance by Orgnisation | NA | 0 |
| | Strengthening RKS | | RKS are not uniformally functioning in the district | | Ensure ragistration of RKS of all functional APHC | NA | 0 |
| | | | | | Training of RKS signatory and BHM on financial Management of RKS | Discussed in maternal health | 0 |
| | | | | | Presentation of case study of functional RKS in district level Meeting. | NA | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Strengthening community process through supportive supervision of ASHA program | | Poor monitorinng mechanism of ASHA program | | Appointment of PHC level ASHA facilitator | Rs 12000 per Facilitator per month for 19 facilitator | 2736000 |
| | | | | | Provide training cum supervisory support @ one supervisor for 20 ASHA | Rs 250 per supervisor for 133 supervisors for maximum 15 days in a month | 5985000 |
| | | | | | Training of DPM (ASHA) , Facilitator and supervisors at block level. | Rs 250 per participant for three days for 180 participants. | 45000 |
| | Media Sensitization | | Wrong and provocative Reporting Having baseless News. | | Media Sensitization work shop | Rs 5000 per Quarter at district level. | 20000 |
| | | | | | | **Total** | 15009000 |

## Annual Action Plan (District HIV Programme)

**Name of the District: VAISHALI**
**Supporting Agency: UNICEF**
**Year – 2010-2011**

**National Goal:**

The goal of NACP III is to reverse the epidemic in India over the next 5 years through integration of prevention and treatment programmes. This will be achieved through:

1. Prevention of new infections in high risk groups and vulnerable populations through:
a) Saturation of coverage of high risk groups with Targeted Interventions (TIs)
b) Scaled up interventions among other vulnerable populations

2. Increasing the proportion of persons living with HIV/AIDS receiving care and treatment
3. Strengthening the infrastructure, systems and human resources in prevention and treatment programmes at the district, state and national levels
4. Establishing nation wide strategic planning, programme management, monitoring and evaluation system.

The vision of NACP III for vulnerable populations is to scale up interventions among these groups, with the presumption that increased awareness, skills building, changes in attitude and behaviour, and predominantly social change through communication, community mobilisation and advocacy, will result in the adoption and maintenance of sustaining safe behaviours and reduction of risk.

**National Outcomes:**

A cadre of trained local people the Link Workers and Volunteers
Increase in knowledge about HIV transmission, risk behaviours, HIV prevention and available health services among HRGs and vulnerable young people and women
Increase in knowledge about HIV transmission, risk behaviours, HIV prevention and available health services among community members/significant others (SHGs, PRI, VHC, etc.)
Increased use of condoms by HRGs, their partners and clients
Increased utilisation of STI management, ICTC, PPTCT and ART services by HRIs/HRGs, their partners and clients
Increased access for young men and women to health services (e.g. STI management, VCTC, ICTC, PPTCT)
Reduced stigma and discrimination against PLHA and their families

**State level outcome:**

UNICEF to provide support for effective implementation of the NACP III – Link Worker concept through technical, monitoring and advocacy and BCC support with the view to reduce vulnerabilities slowing down the rate of new infections and mitigating impact of HIV/ AIDS among children and young people.

1. Reduction in HIV prevalence rate in vulnerable groups through scale up of the '4Ps' – Prevention of parent to child transmission, Paediatric AIDS, Primary Prevention and Protection and care for children affected by AIDS.
2. Model and process to decentralize planning and management of NACP III in palace in 3 districts including 1 integrated districts.
3. HIV info Quaterly Updated
4. Prog Mgmt and support systems: DAPCU moves as per NACP/NRHM structure and strong monitoring system
5. BCC activities – young people
6. link workers and peer educators for measurable change in HIV awareness / behaviour change
7. young people reached – close to 70-80 % coverage
8. TIs plan: 100% HRG coverage in urban areas
9. Advocacy campaigns: High visibility campaigns (at least two in each district) addressing stigma and discrimination

**Implementing Partners:**
Bihar State AIDS Control Society, District Administration, District Health Dept. (NRHM) and NGOs/CBOs/PLHA Network

# DISTRICT HEALTH SOCIETY VAISHALI
# BUDGET SUMMARY

| SL.NO | BUDGET HEAD | TOTAL BUDGET AMOUNT |
|---|---|---|
| 1 | NRHM-A | 423,207,723.00 |
| 2 | NRHM-B | 154,144,313.00 |
| 3 | NRHM-C,D,E | 36,766,140.00 |
| 4 | OTHERS | 81,600,000.00 |
| | TOTAL | 695,718,176.00 |