# Programme Implementation Plan
# National Health Mission
# 2014-2017

District Health Society

Rohtas ( Sasaram )

# Foreword

National Rural Health Mission (NRHM) was introduced to undertake architectural corrections in the public Health System of India. Programme Implementation Plan is an integral aspect of National Rural Health Mission Programme Implementation Plan are critical for achieving decentralization, interdepartmental convergence, capacity building of health system and most importantly facilitating people's participation in the health system's programmes. NRHM and NUHM both Simultaneously this is National Health Mission (NHM) now from next Financial Year provides opportunity and space to creatively design and utilize various NRHM initiatives such as flexi –financing, Rogi Kalyan Samiti, Village Health and Sanitation Committee in both Rural and Urban area to achieve our goals in the socio-cultural context of Rohtas.

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

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

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

It is our pleasure to present the Rohtas Programme Implementation Plan for the financial year 2014-17. The Programme Implementation Plan seeks to set goals and objective for the District Health system and delineate implementing processes in the present context of gaps and opportunities for the Rohtas district health team in Urban area too.

I am very glad to share that Civil Surgeon/ACMO/Dy. Superintendent /MOICs and all BHMs/BCMs/Block Accountants of the district along with key district level functionaries ***(DPMU –DPM cum DAM- Sunil Kumar Jaiswal, M & E Officer Rituraj , DPC Sanjeev Kumar 'Madhukar' & District Epidemiologist Dr. Priya Mohan Sahay, District Health Society, Rohtas)*** for putting his sheer handwork with dedication to complete the Action Plan on time. participated in the planning process. The plan is a result of collective knowledge and insights of each of the District Health System Functionary. We are sure that the plan will set a definite direction and give us an impetus to embark on our mission.

Sandeep Kr. Pudkalkatti (IAS)
District Magistrate cum Chairman
District Health Society, Rohtas.

# ***ACKNOLEDGEMENT***

The commitment to bridge the gaps in the public health care delivery system, has led to the formulation of Programme Implementation Plan for National health Mission for rural and Urban area. The collaboration of different departments that are directly or indirectly related to determinants of health, hygiene and Water sanitation, will lead to betterment of health care delivery, and to make this collaboration possible actions are to be outlined in the Programme Implementation Plan. Thus this assignment is a shared effort between the departments of Health and Family Welfare, ICDS, PRI, Water and Sanitation, Education to draw up a concerted plan of action.

The development of a Programme Implementation Plan for Rohtas district of Bihar entailed a series of Consultative Meetings with stakeholders at various levels, collection of secondary data from various departments, analysis of the data and presentation of the existing scenario at a District-level workshop. The District level Workshop was organized to identify district specific strategies based on which the Programme Implementation Plan has been prepared by the District & Block Program Management Unit.

We would also like to acknowledge the much needed co-operation extended by the District Magistrate cum Chairman ,and Deputy Development Commissioner cum Vice Chairman ,District Health Society, Rohtas without whose support the conduct of the district level workshop would not have been possible. Our thanks are due to All the Program officers and Medical officers of the district for their assistance and full support from the inception of the project. The involvement of the all the Medical officers played a pivotal role throughout the exercise enabling a smooth conduct of consultations at block and district levels.

The present acknowledgement would be incomplete without mentioning the participation of representatives UNICEF , DFID and officials from department of Integrated Child Development Services (ICDS), Panchayati Raj Institutions(PRIs), Education ,Water and Sanitation, who actively participated in consultations with great enthusiasm. Without their inputs it would not have been possible to formulate the strategic health action plan for the district. The formulation of this plan being a participatory process, with inputs from the bottom up, the participation of community members at village level proved very helpful. These consultations at grassroots level supplemented the deliberations at block and district levels, adding value to the planning process.

Finally, we would like to appreciate the hard and dedicated efforts of DPC Sanjeev Kumar Madhukar And M& E O Rituraj for preparation of National Health Mission Plan

Dr Ramjee Singh
Civil Surgeon -cum- Member Secretary
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# INTRODUCTION

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. But Keeping in gaps of Urban population Government Of India launched National Urban Health Mission (NUHM ) and this is integrated called Nation Health Mission ( NHM) . The specific objectives of the mission are:

- Reduction in child and maternal mortality in Rural and Urban.
- 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.

One of the main approaches of NHM 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 Urban/rural/tribal population. Thus, NHM 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 Programme Implementation Plans (PIPs) formulated through a participatory and bottom up planning process. PIPs 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 NHM, PIP has been envisioned to be the principle instrument for planning, implementation and monitoring, formulated through a participatory and bottom to up planning process. NHM-PiP is anticipated as the cornerstone of all strategies and activities in the district.

For effective programme implementation NHM 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 and District Programme Management Unit Staff |
| Members of NGOs and civil society groups (in case these groups are involved in the PIP ( formulation) |

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

## Objectives of the Process

The aim of the present study is to prepare NHM – PIP based on the framework provided by 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-sect oral convergence by actively engaging a wide range of stakeholders from the community as well as different public and private sectors in the planning process

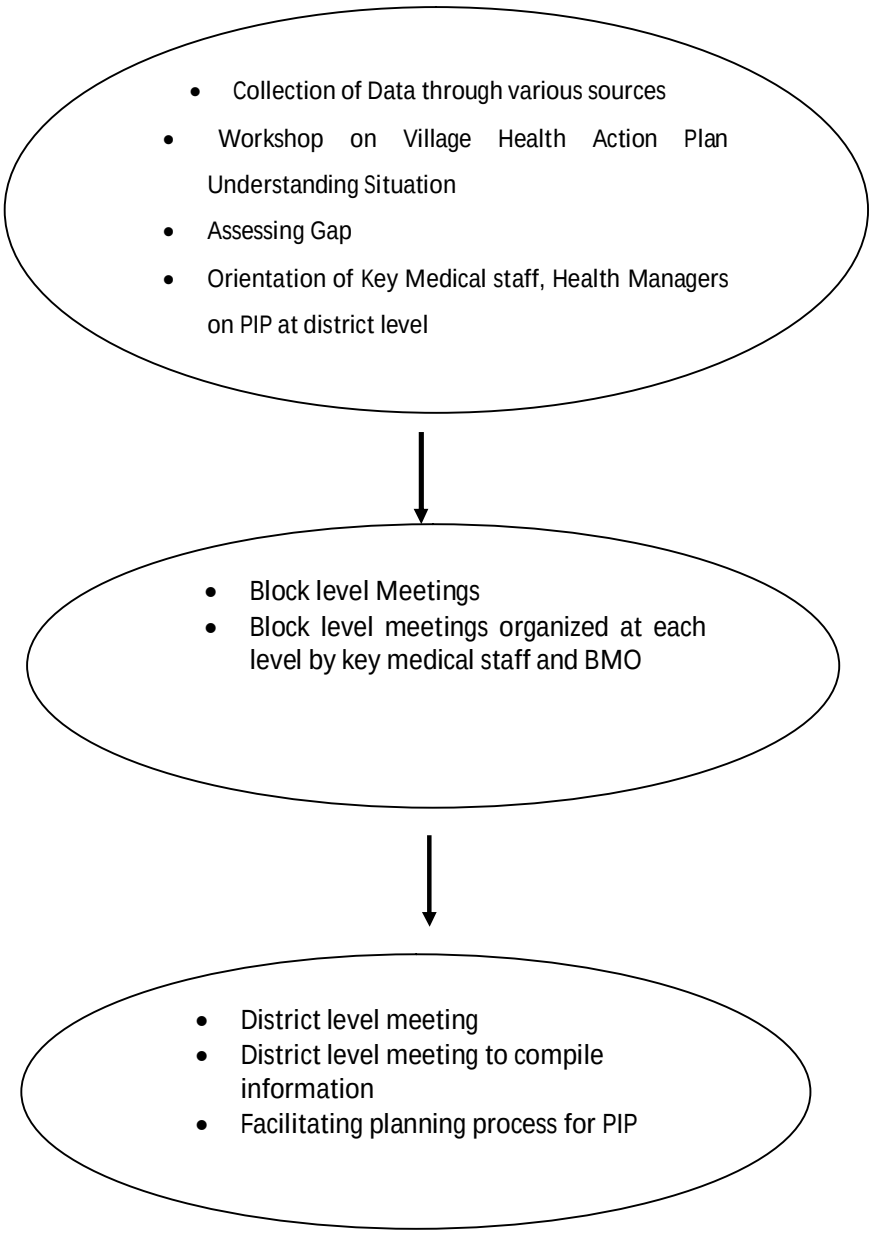
To identify priorities at the grassroots and curve out roles and responsibilities at block level in designing of DHAP for need based implementation of NHM

## District Planning Process

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon, ACMO, all programme officer sas ell as the MOICs, Block Health Managers, ANMs, AWWs and community representatives as a result of a participatory processes as detailed below. After completion the PIP, a meeting is organized by Civil Surgeon with all MOIC of the block and all programme officer. Then discussed and displayed prepared PIP. 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 poor especially women and children, the teams have analyzed the coverage of poor women and children with preventive and primitive 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 PIP 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



# DISTRICT PROFILE

## History

Rohtas has an old & interesting history. In pre-historic days the plateau region of the district has been the abode of aboriginals whose chief representatives now are the Bihar, the Cheers and the Oraons . According to some legends the Kherwars were the original settlers in the hilly tracts near Rohtas. The Oraons also claim that they ruled over the area between Rohtas and Patna. The local legend also connects king Sahasrabahu with Sasaram, the headquarter of Rohtas district. It is believed that Sahasrabahu had terrible fight with Saint Parsuram, the legendary Brahmin Protector, as a result of which Sahasrabahu was killed. The term Sahasram is supposed to have been derived from Sahasrabahu and Parsuram. Another legend connects the ROHTAS hill to Rohitashwa, son of Raja Harishchandra, a famous king who was known for his piety and truthfulness.

The District of ROHTAS formed a part of the Magadh Empire since 6th B.C. to 5TH Century A.D. under the pre Mauryans. The minor rock edict of Emperor Ashok at Chandan Sahid near Sasaram confirmed the Mauryans conquests of this district. In the 7th Century A.D. This district came under the control of Harsha rulers of Kannauj.

Sher Shah's father Hassan Khan Suri was an Afghan adventure, he got the jagir of Sasaram as a reward for his services to Jamal Khan, and the Governor of Province during the latter's attachment with the king of Jaunpur. But the Afghan Jagirdar was not able to exercise full control over this subject since the allegiance of the people was very lose and the landlords were particularly independent. In 1529 Babar invaded Bihar, Sher Shah who lost opposed him. Babar has left in his memories an interesting account of the place. He mentioned about the superstitions of the Hindu with regard to river Karamnasa and also described how he swam across the river Ganga at Buxar in 1528.

When Babar died , Sher Shah become active again .In 1537 Humayun advanced against him and he seized his fortresses at Chunar and Rohtas Garh. Humayun proceeded to Bengal where he spent six months, while on his return journey to Delhi he suffered a crushing defeat at the hands of the Sher Shah at Causa. This victory secured for Sher Shah the imperial throne of Delhi. " The rule of Sur dynasty , which Sher Shah founded, was very short lived. Soon the Mughals regions the imperial

throne of Dehli. After his assassination, Akbar tried to extend his empire and consolidated it. The district of Rohtas was thus included in the empire".

The next event of importance which shook the District, was the reign of Raja Chait Singh of Banaras, his kingdom included large part of Shahabad and his control extended up to Buxar.He raised the banner of revolt against he English who had a difficult time. At Chunar and Ghazipur, the English troops suffered defeat and the very foundations of the English power in India was shaken. But, 'is well known fact that Chait Singh lost eventually.

The district had a very uneventful history till we come to 1857 when Kunwar Singh revolted against the British Empire in line with the Mutineers of 1857. Most of the hiroic details of Kunwar Singh is concerned with the present district of Bhojpur. However he mutiny had its impact and produced similar up-rising and incidents here and there. The hilly tracts of the district offered natural escape to the fugitives of the Mutiny. During Independence movement the district had a substantiates contribution to the freedom movement of India. After Independence Rohtas remained a part of the Shahabad District but in 1972 Rohtas became a separate District.

## Geographical Location

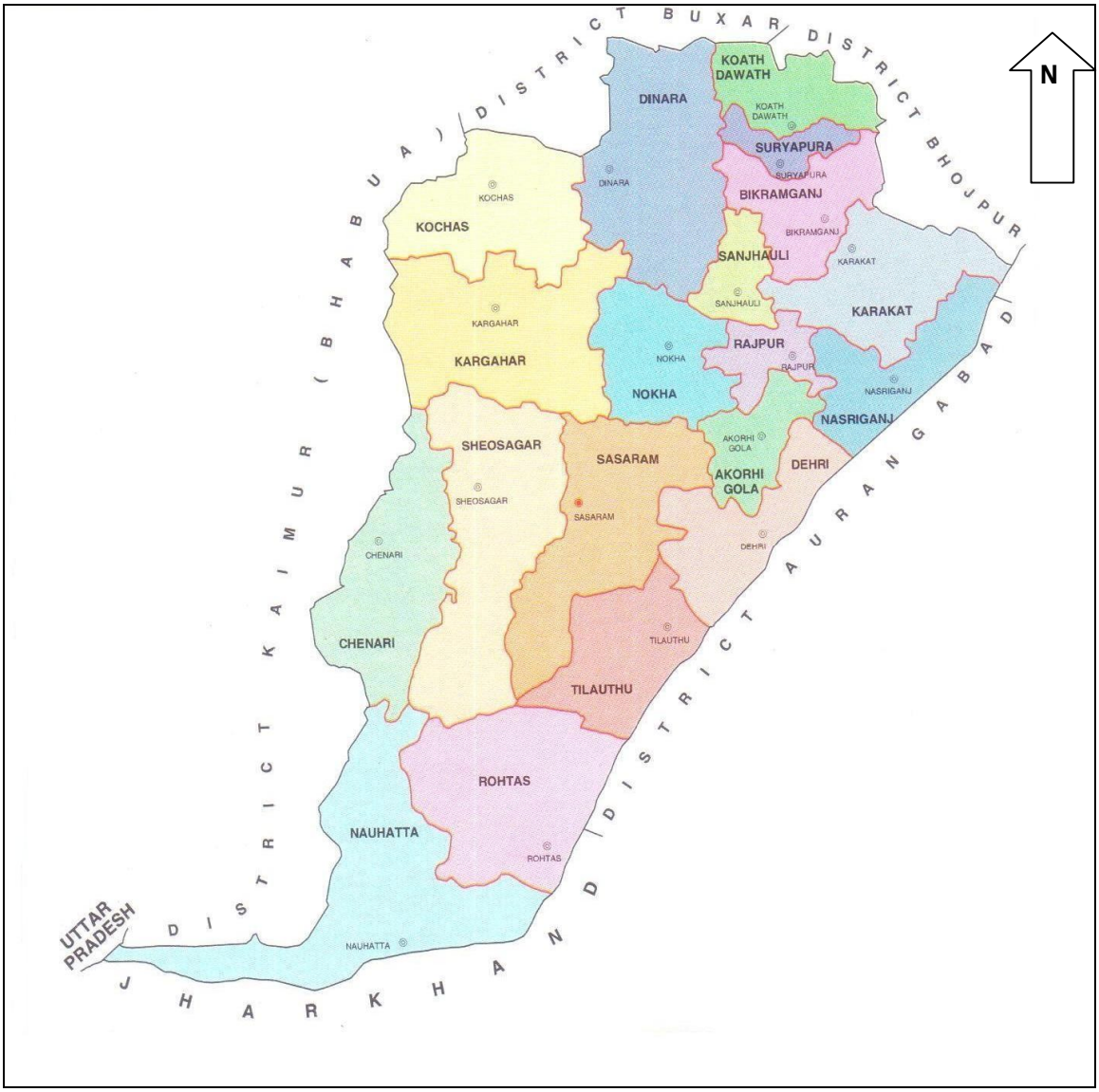
The District is located at **24-30" to 25-20"** North Latitude and **83-14" to 83-20" East L**ongitude with total Area of **3847.82 Sq.Kms.** The District is surrounded by Bhojpur & Buxar Districts in North, Plamu & Garwah District of Jharkhnad in south, Kaimur District in west and Aurangabad & Part of Gaya District in East.

## Govt's Administrative Set-up

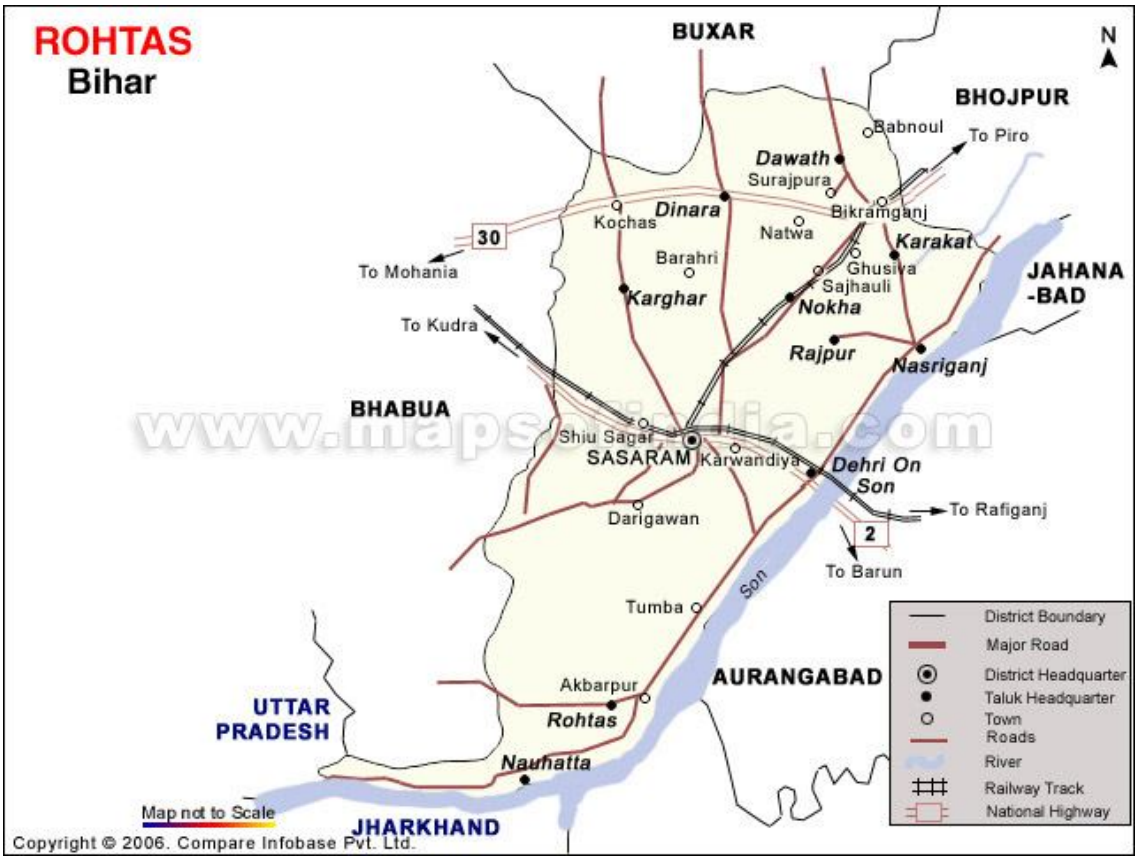
There are three 03 divisions and 19 Blocks in the District. The District has 2103 villages and 246 Gram panchayats. District is divided into 19 C.D. Blocks. The newly elected Panchayati Raj is enthusiastic to play important role in the District.


BIHAR
Pashchim Champaran
Purba Champaran
Sitamarhi
Gopalganj
Sheohar
Madhubani
Supaul
Araria
Kishan ganj
Siwan
Muzaffarpur
Darbhanga
Saran
Vaishali
Samastipur
Saharsa
Madhepura
Purnia
Buxar
Bhojpur
Patna
Begusarai
Khagaria
Katihar
Rohtas
Jehanabad
Nalanda
Lakhisarai
Bhagalpur
Kaimur (Bhabua)
Sheikhpura
Munger
Nawada
Jamui
Banka
Aurangabad
Gaya
Rohtas

# District Map of Rohtas



# Communication map of Rohtas



# ROHTAS – AT A GLANCE

| S.N | Characteristics | | Rohtas | Bihar | India |
|---|---|---|---|---|---|
| 1 | Geographical Area (Sq.Kms) | | 3847.8 | 94163 | 32872 |
| 2 | **Population (Census 2011)** | Total | 296259 | 10380463 | 1210193 |
| | Male | | 154785 | 4315396 | 531277 |
| | Female | | 141473 | 3972483 | 495738 |
| 2.1 | Rural Population | Total | 253508 | 6453100 | 742490 |
| | Male | | 132250 | - | - |
| | Female | | 121257 | - | - |
| 2.2 | Urban population | Total | 427508 | 1834779 | 286119 |
| | Male | | 225347 | - | - |
| | Female | | 202161 | - | - |
| 2.3 | Population Of Scheduled Castes | | | 1304860 | 166635 |
| 2.4 | Population Of Scheduled Tribes | | | 758351 | 843262 |
| 2.4 | Population Growth(%) | | 20.22 | 25.07 | 17.6 |
| 2.5 | Density of Population | | 763 | 1102 | 382 |
| 2.6 | Sex Ratio | | 917 | 916 | 940 |
| | Literacy % | Total | 74.74 | 63.82 | 74.0 |
| | Male | | 85.01 | 60.32 | 82.1 |
| | Female | | 63.50 | 33.57 | 65.4 |

# Administrative Data

| S.No | Basic Data | Rohtas | Bihar |
|---|---|---|---|
| 1 | No. of Sub Division | 03 | 101 |
| 2 | No. Of Blocks | 19 | 534 |
| 3 | Revenue Circles | 19 | - |
| 4 | Panchayat | 246 | 8471 |
| 5 | No. of villages Total | 2103 | 45103 |
| (I) | In habitat | 1672 | - |
| (II) | Uninhabited | 395 | - |
| 6 | No. of Towns<br>(Sasaram , Dehri, Nokha, Bikramganj & Nasriganj) | 5 | 130 |
| 7 | Nagar Parishad | 2 | - |
| 8 | Nagar Panchayat<br>( Nokha, Bikramganj, Nasriganj & Koath) | 4 | - |
| 9 | MP Constituency(Sasaram, Bikramganj) | 2 | 40 |
| 10 | M. L. A. Constituency<br>( Sasaram , Dehri, Nokha, Bikramganj, Karakat, Chenanri & Dinara ) | 7 | 243 |

# HEALTH PROFILE OF THE DISTRICT:

| S. No. | Characteristics | No. in district |
|---|---|---|
| 1 | District hospital | 01 |
| 2 | Sub divisional hospital | 02 |
| 3 | Referral hospital | 02 |

| | | |
|---|---|---|
| 4 | Primary health centre(PHC) | 19 |
| 5 | Additional primary health centre(APHC) | 32 |
| 6 | Health sub centre(HSC) | 230+40 |
| 7 | Blood bank/BSU | 02 |
| 8 | Aids control society | NA |
| 9 | Doctors | 122 |
| 10 | ANM | 479(251 Contractual) |
| 11 | Grade A Nurse | 28(20 Contractual) |
| 12 | Block Extension Educator | 03 |
| 13 | Pharmacist | 04 |
| 14 | Lab Technician | 14 |
| 15 | Health Educator | 27 |
| 16 | L.H.V | 05 |

# Status of Health Indicators

| Sl. No | Indicators | State | District | | | |
|---|---|---|---|---|---|---|
| | | | AHS 2011 | SRS (2011)/(2007-09) | DLHS III | HMIS (2012) |
| 1 | Infant Mortality Rate (SRS- 2012) | 43 | **52** | | | **NA** |
| 2 | Maternal Mortality Ratio (SRS 2007-09) | | **258** | | | **NA** |
| 3 | Total Fertility Rate (SRS 2011) | | **3.5** | | **2.7** | **NA** |
| 4 | Under-five Mortality Rate (SRS 2011) | | **65** | | | **NA** |
| 5 | Institutional Deliveries (In | | 67.9 | | 48.5 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | %) | | | | | |
| 6 | Full Immunisation (In %) | | 59.6% | | 42.3 | |

***NA-** not applicable

# Demographic Profile

| **Indicator** | **State** | **District** |
|---|---|---|
| Total Population (Census 2011) (In Crore) | 10.41 | 29.60 Lakh |
| Crude Birth Rate (SRS 2011) | 26.7 | 27.7 |
| Crude Death Rate (SRS 2011) | 7.2 | 6.6 |
| Natural Growth Rate (SRS 2011) | 19.5 | 21.1 |
| Sex Ratio (Census 2011) | 918 | 918 |
| Child Sex Ratio (Census 2011) | 935 | 931 |
| Total Literacy Rate (%) (Census 2011) | 61.8 | 73.37 |
| Male Literacy Rate (%) (Census 2011) | 71.20 | 82.88 |
| Female Literacy Rate (%) (Census 2011) | 46.40 | 62.97 |

# Information on selected MCH indicators:

| **Indicators** | **State** | **Districts (For all districts)** | | | |
|---|---|---|---|---|---|
| | | AHS 2011 | SRS (2011)/(2007-09) | DLHS III | HMIS (2012) |
| **Child feeding practices (%)** | | | | | |
| Children under the age of 3 years breastfed within one hour of birth | | 17.1% | | 13.7 | |
| Children age 0- 5 months exclusively breastfed for at least 6 months | | | | 19.3% | |

| | | | | | |
|---|---|---|---|---|---|
| Children (6-24 months) who received solid and semi solid food still being breast fed | | 12.8% | | 85% | |
| **Awareness about Diarrhoea and ARI** | | | | | |
| Women aware about danger signs of ARI (%) | | | | | |
| **Treatment of childhood diseases** | | | | | |
| Children with diarrhoea in the last 2 weeks who received ORS (%) | | | | 25.3% | |

# SOCIO-ECONOMIC PROFILE

## Social

- Rohtas district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Rohtas have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.

## Economic

- The main occupation of the people in Rohtas is Agriculture and daily wage labour.
- A large number of the youth population migrates in search of jobs to the other states like Delhi, Kolkata, Punjab, Maharastra, Gujrat,
- The main crops are Wheat, Paddy, Pulses, Oilseeds .

# SWOT ANALYSIS of PART I (A,B and C)and SWOT Analysis of Part A

## Strength

- Decentralized Planning and availability of Resources and Fund for program till HSC level.
- Huge pool of Human Resource working at ground level as ANM, ASHA and Anganwadi workers.
- Provision of incentive money for ASHA, ANM according to their performance in mobilizing community for institutional delivery ,FP etc.
- Provision of Incentive money for beneficiary under JBSY, Family Planning.
- Extension of emergency facilities in remote rural areas and posting of skilled doctors.
- Regular training program of doctors and other medical staffs for skill up gradation.
- Strong provision of IEC and BCC activity under the programs for effective program implementation and sensitizing people.
- Decentralized implementation process of the entire program.
- Involvement of people in uplifting health facilities through RKS and VHSC.

## Weakness

- All PHCs are with only six bedded facility. Facilities are not adequate as per IPHS norms for providing emergency care.
- Lack of doctors and other human resource in the remote areas medical facilities
- Achievements in most of the program are far less than target.
- Slow pace of most of training like SBA and IMNCI.
- Institutional delivery is still less than 50% in the district.
- More NRC is needed.
- Seat for contractual medical officer and specialist, ANM and ASHA are still vacant.

- Achievements in Family Planning and IUD insertion are far less than targets.
- Insensitivity of Doctors and other health staffs for patients.
- Unavailability of doctors and staffs in hospital at the time of duty.
- No timely procurement of equipments and drug in the remote health facilities.

Opportunity

- All the time support from state health society for all financial and logistics requirements for program implementation
- Scope for involving Private partner like Surya clinic for timely achievement of targets.
- Scope of getting full support from people through their participation in RKS and VHSC.
- Favourable political and administrative environment for program implementation
- Increasing literacy and awareness among public to support Family planning and institutional deliveries.
- Better coordination and support from other line departments like ICDS, Municipality etc

Threat

- Large scale poverty becomes the cause of nutritional deficiency leading to health problems.
- In case of remaining without practice for long time health staff training become useless.
- Extending services in remote rural areas is still a challenge in achieving targets of MCH and FP, RI.
- Traditional and religious attitude of public is hindrance for increasing Institutional deliveries, Family planning etc.

# SWOT Analysis of Part B

## Strength

- ASHA support system with DCM and BCM has been made functional in the district.
- Formation of VHSC has been completed in most villages of the district.
- Deployment of BHM and Hospital Managers is complete at all the vacant places in the district.

- Services of advanced life saving ambulance (108) is started in the district
- Contractual AYUSH doctors have been placed in APHC.
- Decentralized planning at HSC level has been started from this year in the district

## Weakness

- ASHA Selection is not 100% complete
- ASHA training is Not Completed On time .
- Utilization of untied fund in most of the health centres is very less.
- Replenishment of ASHA kit and drugs is not timely and complete.
- Construction of HSC, APHC, PHC buildings and staff quarters moving with very slow pace.
- ISO certification process of health facilities is not completed till yet.
- Pathology and Radiology services under PPP initiatives are not properly functional at most of the health facilities.
- Lack of orientation among members of RKS regarding their scope of works for Health facilities.

## Opportunity

- Participation of Mukhiyas and Surpanch in ASHA selection process to expedite the process and also proper and complete utilization of Untied fund for health facility development.
- Favourable administrative and political condition for program implementation.
- Availability of fund from both NRHM and State funding for development of health infrastructure.

## Threat

- Corruption and ill intention in construction of buildings and selection process of employees.
- Lack of people interest and support for proper maintenance of health infrastructure and quality of services.
- Less knowledge and sensitivity for work among ASHA and other contractual employees.
- Not immediately filling vacant positions Specialist Doctors .

# SWOT Analysis of Part C- Routine Immunization

## Strength

- Properly and timely formation of block micro-plan of RI.
- Availability and involvement of large human work force in form of ANM and Asha.
- Functioning of one separate dept. in health sector to look after RI.
- Timely availability of vaccines.
- Abundance of fund for all kind of review meeting and supervision of the program.

## Weakness

- Low achievement against the fixed targets.
- Poor cold chain maintenance.
- Handling of cold chain-deep freezers by untrained persons.
- Poor public mobilization by ANM and Asha.
- Poor or false reporting data from block and sub centers.
- Quarterly review meeting at district and blocks are not happening regularly.
- Unavailability or non use of RI logistics like red/black bag, twin bucket etc

## Opportunity

- Support from UNOPS-NIPI, UNICEF, WHO and other development agencies in RI.
- Proper coordination and support from Anganwadi –ICDS dept.
- Growing awareness among people regarding immunization.

## Threat

- Sudden outbreak of epidemic.
- Corruption in program implementation.

# MATERNAL HEALTH

**Name of Program: Maternal Health**

**FMR Code: A.1 to A.1.6.6.3**

## Current Status & Situation Analysis:

As per DLHS 3 figures, percentage of pregnant women registered for ANC is only 30.7% ,Mothers who received at least 3 ANC visits during the last pregnancy is 26.6 %. percentage of mothers who got at least one TT injection in their last pregnancy is 49.6%. Percentage of Institutional deliveries 48.5 %. Where according to HMIS (2012-13) figures, percentage of pregnant women registered for ANC is 62.56 % Mothers who received at least 3 ANC is 64% and TT 2 achievement is only 52.57 %. As well as Institutional delivery is only 53.18 %.

According to DLHS III Percentage of institutional deliveries in Rohtas district is average at 48.5 %. Deliveries at home assisted by doctors or another skilled attendant such as a nurse/LHV/ANM is even lower at 20.8% whereas only 28.3 % of mothers received postnatal care within 48 hours of delivery. Factors leading to the low rates of assisted and institutional deliveries include a shortage of functional Sub centres as L1, poor infrastructure and lack of skills at the Sub centre level and an almost exclusive focus of the Sub centre on immunization activities. Similarly, APHCs suffer from severe shortages in labour rooms and medical officers, though some ANM and staff nurses have recently been appointed. There is only two APHCs which is functioning as Delivery points but no APHC providing 24*7 services and no ambulance services available at the APHC level. Also, because of lack of appropriate infrastructure most mothers are not able to stay for the required 48 hrs at the facility. At the PHC level the District faces a shortage of Gynaecologists and Paediatricians. There is also not a single lady doctors at District Hospital and APHC.

**Goals:** To decrease the maternal mortality rate and provide better facilities to the beneficiary.

## Objective:

- Ensuring 100% registration of pregnant women for ANC

- Increase in the percentage of pregnant women registered in the first trimester from 52.6 % to 80%
- Increase in the percentage of pregnant women with full ANC from 26.6% to 80%
- Ensuring that 100% of pregnant women receive 2 TT injections.
- Ensuring that 100% of pregnant women consume 100 IFA tablets
- Increase in skilled attendance during delivery to 90%
- Increase in institutional delivery from 53.18 % to 75%
- Increase in the percentage of mothers receiving postnatal care within 48hrs of delivery from 28.3% to 75%
- Ensure percentage of neonates breastfed within 1 hour of birth to 100%
- Ensuring colostrums feeding of 100% of neonatal.
- Ensuring that all newborns are weighed within 48 hrs of birth
- Facility and community based management of sick newborns and low birth weight babies

## Targets:

| Si. No. | FMR Code | Name of Programme | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|
| **1.** | A.1.2.2. | Monthly Village Health and Nutrition Days | **7749** | **7749** | **7749** | **7749** |
| **2.** | A.1.3.1. | Home Delivery | 125 | 125 | 125 | 125 |
| **2.** | A.1.3.2.a | Rural | 8040 | 10050 | 12060 | 10050 |
| **3** | A.1.3.2.b | Urban | 300 | 300 | 300 | 300 |
| **4** | A.1.3.2.c | C-sections | *17* | 21 | 25 | 21 |
| **5** | A.1.3.4 | Incentives to ASHA | **8357** | **10371** | **12385** | **10371** |
| **6** | A.1.4 | Maternal Death Review (both in institutions and community) | **10** | **15** | **25** | **28** |

## Strategies proposed:

- Increasing early registration through counselling of eligible couples by ASHAs and ANMs and distribution of home based pregnancy kits
- Case management of pregnant women to ensure that they receive all relevant services by ASHAs and ANMs
- Creating awareness about maternal health through VHSND day.
- Providing ANC along with immunisation services on immunisation days
- Strengthening ANC services at the Sub centre level by ensuring availability of appropriate infrastructure, equipment and supplies
- Ensuring quality ANC through appropriate training of the ANM
- Effective monitoring and support to HSCs for ANC by APHC.
- Setting up of referral transport system at every APHC level.

## Activity Proposed:

- Training of ASHAs for counseling of eligible couples for early registration and the use of the home based pregnancy kit
- Regular updating of the ANC register.
- Preparation of the due list with the dates for Ante Natal Checkups for every pregnant woman in the Sub centre area.
- Preparing format for the due list in Hindi.
- Orientation of ASHAs and AWWs to fill out and update due list and ANC schedule list for every pregnant woman in their work area.
- Organizing Antenatal checkups on immunisation days.
- ASHAs and AWWs to coordinate with ANM to provide Antenatal care according to the ANC schedule maintained in the register for every expectant mother. ASHAs and AWWs to track left outs and drop outs before every ANC & immunisation day and ensure their participation for the coming day.
- Organizing VHSND day to share information and create awareness about maternal and child health on every Immunization day of the month at each AWC.
- Orientation to ANMs to provide complete Ante natal care and identify high risk pregnancies.
- Strengthening of Sub centre in terms of equipment to conduct ANC services. (refer to health facilities section)
- Ensuring regular supply of IFA tablets at each Sub centre level. (refer to health facilities section)
- Setting up Helpline with Ambulance at every PHC (APHC).

**Whether new or continued**: The activity is continued**.**

**Achievements (if the activity has been continued from previous year):**

**Justification:** To decrease the rate of Maternal Mortality in district Lakhisarai there is need of work on ensuring ANC, PNC, use of IFA, provision of better infrastructure, instruments, referral facility, immunization, skill based work and a better environment for the benificiaries.

**Deliverables:** **To provide a better environment with all facilities for the Maternal health.**

## Funding proposed:

| Unit of Measure | No of units | Cost per Unit (In Rs.) | Total Cost (Rs.in Lakh) | FMR Code |
|---|---|---|---|---|
| No.of VHSND Session | 30996 | 100 | 46.49 | A.1.2.2. |
| No.of Rural inst. Delivery | 40200 | 1400 | 562.80 | A.1.3.2.a |
| No.of Urban inst. Delivery | 1200 | 1000 | 12.00 | A.1.3.2.b |
| No.of C-Section | 84 | 1500 | 1.26 | A.1.3.2.c |
| No.of Rural inst. Delivery | 41484 | | 248.90 | A.1.3.4 |
| No.of Maternal Death | 78 | 750 | 0.59 | A.1.4 |

# Name of Program: Child Health

**FMR Code: A2.1 to A2.10.5**

**Current Status & Situation Analysis:** As per HMIS data 2012 -13 Complete Immunization of children in Rohtas District is 65%

**Goals:** Ensuring exclusive breastfeeding and timely initiation of complementary feeding is critical for appropriate child development.

## Objective:

- Ensuring that children of (0-6 months old) are exclusively breastfed.
- Increase in percentage of children (12-23 months) fully immunized (BCG, 3 doses of DPT, Polio and Measles)
- Ensuring initiation of complementary feeding at 6 months of children.
- Increasing the percentage of children with diarrhea who received ORS.
- Increasing the percentage of children with ARI/fever who received treatment from.
- Ensuring monthly health checkups of all children (0-6 months) at AWC.
- Ensuring that all severely malnourished children are admitted, receive medical attention, and are nutritionally rehabilitated.
- Reduction in IMR
- Ensuring in the Treatment of 100% cases of Pneumonia in children

- To strengthen school health services

## Targets:

| Si. No. | FMR Code | Name of Programme | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|
| **1.** | A.2.2.1 | SNCU | 1 | 1 | 1 | 1 |
| **2.** | A.2.2.2 | NBSU | 2. | 2 | 2 | 2 |
| **3** | A.2.2.3 | NBCC | 5 | 10 | 9 | 0 |
| **4** | A.2.3 | Home Based Newborn Care/HBNC | | | | |
| **5** | A.2.5 | Care of Sick Children and Severe Malnutrition (e.g. NRCs, CDNCs, Community Based Programme etc.) | 2 | 2 | 2 | 2 |
| **6** | A.2.6 | Management of Diarrhoea & ARI & micronutrient malnutrition | 1 | 1 | 1 | 1 |
| **7** | A.2.9.1 | Drugs & Consumables (other than reflected in Procurement) | 120000 | 12000 | 12000 | 4800 |
| **8** | A.2.10.1 | BCM meetings for childhood diarrhoea program at district level every month @ Rs 50/BCM | | | | |
| **9** | A.2.10.2 | Asha Facilitator meeting for childhood diarrhoea program at block level every | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | month @ Rs 30/AF | | | | |

## Strategies proposed:

- Promote immediate and exclusive breastfeeding and complementary feeding for children.
- Improving feeding practices for the infants and children including breast feeding.
- Counseling mothers and families to provide exclusive breastfeeding in the first 6 months.
- Convergence with WDC Department for implementation of Rajiv Gandhi Creche Scheme at MNREGA worksites to enable exclusive breastfeeding and child care by women workers.
- Increase timely and quality immunisation service and provision of micronutrients for children in the age group of 0-12 months.
- Eradication of Poliomyelitis.
- Increase early detection and care services for sick neonates in select.
- Districts through the IMNCI strategy in select districts.

## Activity Proposed:

- Orientation and Training of ANM, ASHA, and AWW on exclusive breast feeding.
- Training by Health Department of crèche workers on nutrition and child care.
- Organising health checkups at AWC for children in the 0-6 year age group on Immunisation day of every month
- Referral of severely undernourished sick children to Nutrition Rehabilitation Centre (NRCs)
- Setting up 20 bedded more NRCs at referral hospital Barhiya.
- Providing food and wage loss support for one parent of every child admitted to enable the child to stay at the NRC for the required period of time
- Promotion of health seeking behaviour for sick children through BCC campaigns.
- BCC for pregnant women and mothers to regarding feeding practices, immunisation, and other aspects of child care.
- Capacity building of ASHA, AWW and ANM for the management of common childhood diseases and identification of serious cases for referral.
- Training of ANM for IMNCI.
- Training ASHAs to refer sick child to facility in case of serious illness.
- ASHAs equipped to provide ORS to children with diarrhea and suggest referral in case of emergency.
- Regular stock up of ASHA drug kits.
- Providing weighing machines to every AWC to ensure monthly weighing
- ASHAs to support AWWs in monthly weighing

## Whether new or continued: The activity is continued

## Achievements (if the activity has been continued from previous year):

Awareness on care of neo natal child is increasing continuously. Breast feeding and exclusive breast feeding is taking place. Even in village level mother promoting exclusive breast feeding to their child.

**Justification:** For better health of child and decrease in Neo Natal mortality rate, promotion of exclusive breast feeding and weighed of Neo natal just after the birth is necessary.

**Deliverables:** Quality of care for the Neo Natal

## Funding proposed:

| Unit of Measure | No of units | Cost per Unit (Rs in Lakhs) | Total Cost (Rs in Lakhs) | FMR Code |
|---|---|---|---|---|
| No.of SNCU operationalisation quarterly exp. | 1 | 7.50 | 7.50 | A.2.2.1 |
| For 1 NBSU New Establishment exp. | 1 | 5.00 | 5.00 | |
| For 1 NBSU operationalsation quarterly exp. | 1 | 5.00 | 5.00 | A.2.2.2 |
| For 24 NBCC operationisation cost monthly exp. | 24 | 0.20 | 4.80 | A.2.2.3 |
| No.of child birth visit | | | | A.2.3 |
| No.of NRC | 2 | 4.10 | 98.40 | A.2.5 |
| No.of NRC ( NEW) | 1 | 3.00 | 3.00 | B8.3.1 |
| No. of Mgt Diarrohea | 1 | 1.46 | 1.46 | A.2.6 |

| | | | | |
|---|---|---|---|---|
| No.of Newborn received drugs @ 100/case | 40800 | 0.010 | 40.80 | A.2.9.1 |

# Name of Program: Family Planning.

# FMR Code: A3 to A.3.5.4.

**Current Status & Situation Analysis:** The utilization of any method of contraception is increasing day by day. According to AHS 2011 the fertility rate of Rohtas is 3.5 Male sterilization is low at 0.6%. Cu- T utilization is also at 0.6 &.Other spacing methods is 18.1

**Goals:** **To control the population and decrease the fertility rate from 3.5 to .**

## Objective:

- Fulfilling unmet need for family planning services at the community level
- Increasing the use of any modern method of family planning from 35% to 50%
- Increasing male sterilization rates from 0.5% to 2%
- Increasing the utilization of condoms as the preferred choice of contraception from 2.7% to 8%.
- Reduction in Total fertility Rate from 2.5 to 2.4 Increase in Contraceptive Prevalence Rate to 70 %
- Decrease in the Unmet need for modern Family Planning methods to 0%
- Increase in the awareness levels of Emergency Contraception from 60% to 80%

## Targets:

| Si. No. | FMR Code | Name of Programme | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|
| **1.** | A.3.1.1 | Female sterilization camps | 103 | 129 | 155 | 129 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **2.** | A.3.1.2 | NSV camps | 1 | 1 | 2 | 1 |
| **3** | A.3.1.3 | Compensation for female sterilization (Provide breakup: APL (@Rs 650)/BPL (@Rs 1000) ; Public Sector (@Rs 1000)/Private Sector (@Rs 1500)) | 4000 | 5000 | 6000 | 5000 |
| **4** | A.3.1.4 | Compensation for male sterilization @ Rs 1500 / Case | 120 | 260 | 300 | 320 |
| **5** | A.3.2.1 | IUD Camp | 8 | 10 | 10 | 10 |
| **6** | A.3.2.2 | Compensation for IUCD insertion at health facilities (including fixed day services at SHC and PHC) [Provide breakup: Public Sector (@Rs. 20/insertion)/Private Sector (@Rs. 75/insertion for EAG states)] | 6000 | 75000 | 9000 | 7500 |
| **7** | A.3.2.2.1 | PPIUCD Services | 50 | 50 | 50 | 50 |
| **8** | A.3.2.4 | Orientation of ASHA & ANM, Block & District Official | 16 | 19 | 16 | 13 |
| **9** | A.3.3 | POL for Family Planning/ Others (including additional mobility support to surgeon's team if req) | 17 | 21 | 25 | 21 |
| **10** | A.3.5.3 | Performance Award for MOIC, Surgeon, ANM, ASHA & ASHA Facilliator | 0 | 0 | 0 | 1 |
| **11** | A.3.5.4 | World Population Day' celebration (such as mobility, IEC activities etc.): funds earmarked for district and block level activities | 0 | 2 | 1 | 0 |
| **11** | A.3.5.5 | Family Planning Indemnity Scheme | 4 | 5 | 6 | 5 |
| **12** | A.3.5.6.1 | Family Planning Corner at SDH | 0 | 0 | 1 | 0 |

## Strategies proposed:

- Promotion of health seeking behaviour for sick children through BCC campaigns.
- BCC for pregnant women and mothers to regarding feeding practices, immunisation, and other aspects of child care.
- Capacity building of ASHA, AWW and ANM.

## Activity Proposed:

- Training by Health Department on different method of Family Planning.
- Organising Family Planning camp fortnightly.
- Use of Updated facilities like PPIUCD.
- Creating awareness to decrease the growth rate of Population.

## Whether new or continued:

Continued.

## Achievements (if the activity has been continued from previous year):

The fertility rate of Rohtas district has decreased by 4 from 3.3. and it is continuous decreasing.

## Justification:

Since the population growth is increasing day by day. To decrease the population growth rate there is need of regular family planning camp, campaign , rally, organizing world health population day, meeting with govt. officials.

## Deliverables:

Dicrease of population is key points of the programme. So that people can live with dignity.

## Funding proposed:

| Unit of Measure | No of units | Cost per Unit | Total Cost | FMR Code |
|---|---|---|---|---|
| No.of Female Sterillization camps | 516 | 0.0500 | 25.80 | A.3.1.1 |
| No.of NSV Camps | 5 | 0.0500 | 0.25 | A.3.1.2 |
| No.of Female Sterillization | 20000 | 0.0115 | 230.00 | A.3.1.3 |
| Compensation for male sterilization @ Rs 1500 / Case | 1000 | 0.015 | 15.00 | A.3.1.4 |
| No.of IUD Camps | **38** | 0.020 | 0.76 | A.3.2.1 |
| Compensation for IUCD insertion at health facilities (including fixed day services at SHC and PHC) [Provide breakup: Public Sector (@Rs. 20/insertion)/Private Sector (@Rs. 75/insertion for EAG states)] | **30000** | 0.0020 | 6.00 | A.3.2.2 |

| | | | | |
|---|---|---|---|---|
| PPIUCD services | **200** | 0.020 | 0.40 | A.3.2.2.1 |
| Orientation of ASHA & ANM, Block & District Official | **64** | .10 | 6.40 | A.3.2.4 |
| POL for Family Planning/ Others (including additional mobility support to surgeon's team if req) | **84** | 0.015 | 1.26 | A.3.3 |
| Performance Award for MOIC, Surgeon, ANM, ASHA & ASHA Facilliator | **1** | 1.0 | 1.00 | A.3.5.3 |
| World Population Day' celebration (such as mobility, IEC activities etc.): funds earmarked for district and block level activities | **3** | **4.163** | 12.49 | A.3.5.4 |
| Family Planning Indemnity Scheme | **20** | **2.00** | 40.00 | A.3.5.5 |
| Family Planning Corner at SDH | **1** | **2.00** | **2.00** | A.3.5.6.1 |

# Name of Program: Human Resources
# FMR Code: A.8 to A.8.1.11.f

**Current Status & Situation Analysis: In Rohtas district there is always huge crisis of Specialist Docotrs & Para Medical Staff. In present scenario the staff strength is as follows :**

| Name of Post | Sanctioned | In Position |
|---|---|---|
| Doctors ( MBBS) ( Regular ) | 228 | 45 |
| Doctors ( MBBS) ( Contractual ) | 89 | 44 |
| Dental Doctors | 5 | 5 |
| Female Medical Officer | | 3 |
| AYUSH Doctors | 32 | 32 (R-3, C-29) |
| District Programme Manager | 1 | 0 |
| District Accounts Manager | 1 | 1 |
| DCM | 1 | 0 |
| DDA (ASHA) | 1 | 1 |
| District M & E Officer | 1 | 1 |
| District Planning Coordinator | 1 | 1 |
| Hospital Manager | 4 | 4 |
| Block Health Manager | 19 | 18 |
| Block Accountant | 19 | 18 |
| BCM | 19 | 16 |
| Nurse Grade 'A' ( Contractual ) | 88 | 25 |
| Nurse Grade 'A' ( Regular ) | 22 | 8 |
| A.N.M.(R) ( Contractual) | 308 | 251 |
| A.N.M.(R) ( Regular) | 286 | 222 |
| ASHA | 2490 | 2412 |
| Mamta | 115 | 111 |
| Epidemologist ( IDSP Unit ) | 1 | 1 |

## Goals:

Through the better Human resources provide a better facilities at all level to the beneficiary.

## Objective:

- To ensure that Rohtas has 100% functioning Sub centres as required by population norm.
- To ensure that all health facilities provide a comprehensive range of services.
- To strengthen the Sub centre as the provider of primary outreach services .

### 1. Targets:

| Si. No. | FMR Code | Name of Programme | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|
| 1. | A.8.1.1.1.f | Salary for 368 ANM | 3 | 3 | 3 | 3 |
| 2. | A.8.1.1.2.e | Salary for 88 SN | 3 | 3 | 3 | 3 |
| 3 | A.8.1.2.1.b | Salary for 5 LT at FRU | 3 | 3 | 3 | 3 |
| 4 | A.8.1.3.1a | Salary for 4 Specialist for DH | 3 | 3 | 3 | 3 |
| 5 | A.8.1.3.1b | Salary for 6 Specialist for FRU | 3 | 3 | 3 | 3 |
| 6 | A.8.1.3.2a | Salary for 4 Specialist for DH | 3 | 3 | 3 | 3 |
| 7 | A.8.1.3.2b | Salary for 4 Specialist for FRU | 3 | 3 | 3 | 3 |
| 8 | A.8.1.3.3a | Salary for 2 Specialist for DH | 3 | 3 | 3 | 3 |
| 9 | A.8.1.3..3b | Salary for 3 Specialist for FRU | 3 | 3 | 3 | 3 |
| 10 | A.8.1.3.4a | Salary for 4 Specialist for DH | 3 | 3 | 3 | 3 |
| 11 | A.8.1.3.4b | Salary for 3 Specialist for FRU | 3 | 3 | 3 | 3 |
| 12 | A.8.1.3.7a | Salary for 2 Dental Surgeon for DH | 3 | 3 | 3 | 3 |
| 13 | A.8.1.3.7b | Salary for 4 Dental Surgeon or FRU | 3 | 3 | 3 | 3 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 14 | A.8.1.3.7d | Salary for 14 Dental Surgeon @ Rs 30,000 for PHC | 3 | 3 | 3 | 3 |
| 15 | A.8.1.5.4 | Salary of 75 MO at PHC @ Rs 50,000 per month | 3 | 3 | 3 | 3 |
| 16 | A.8.1.5.7 | Salary of MO at 38 APHC @ Rs 50,000 Per Month New activity | 3 | 3 | 3 | 3 |
| 17 | A.8.1.5.8 | Salary for MO ( For Blood Bank) on Monthly | 3 | 3 | 3 | 3 |
| 18 | A.8.1.7.1.a | Salary of 2 Pharmacists @15000/Month at DH | 3 | 3 | 3 | 3 |
| 19 | A.8.1.7.1.b | Salary of 1 Pharmacists @15000/Month at FRU | 3 | 3 | 3 | 3 |
| 20 | A.8.1.7.1.d | Salary of 1 Pharmacists @15000/Month at PHC | 3 | 3 | 3 | 3 |
| 21 | A.8.1.7.3.a | Salary of 2 OT Technician @10000/Month at DH | 3 | 3 | 3 | 3 |
| 22 | A.8.1.7.3.b | Salary of 4 OT Technician @10000/Month at FRU | 3 | 3 | 3 | 3 |
| 23 | A.8.1.7.3.d | Salary of 14 OT Technician @10000/Month at PHC | 3 | 3 | 3 | 3 |
| 24 | A.8.1.7.4.a | Salary of 76 AYUSH MO @27000/Month | 3 | 3 | 3 | 3 |
| 25 | A.8.1.7.4.b | Salary of 76 Staff Nurse/ ANM@20000/Month | 3 | 3 | 3 | 3 |
| 26 | A.8.1.7.4.c | Salary of 76 Pharmacists @15000/Month | 3 | 3 | 3 | 3 |
| 27 | A.8.1.7.5.1 | Salary of 5 FP Counselors @ 18000/Month | 3 | 3 | 3 | 3 |
| 28 | A.8.1.11.a | Support Staff for DH @ Rs 8000 | 3 | 3 | 3 | 3 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 29 | A.8.1.11.c | Support Staff for FRU @ Rs 8000 | 3 | 3 | 3 | 3 |
| 30 | A.8.1.11.d | Support Staff for PHC @ Rs 8000 | 3 | 3 | 3 | 3 |
| 31 | A.10.2.1 | Salary of DPM | 3 | 3 | 3 | 3 |
| 32 | A.10.2.2 | Salary of DAM | 3 | 3 | 3 | 3 |
| 33 | A.10.2.3 | Salary of DDM | 3 | 3 | 3 | 3 |
| 34 | A.10.2.4 | Salary of DPC | 3 | 3 | 3 | 3 |
| 35 | A.10.2.6 | Salary of 2 DEO | 3 | 3 | 3 | 3 |
| 36 | A.10.2.7 | Salary of Office Assistant + assist accountant. @10000/month | 3 | 3 | 3 | 3 |
| 37 | A.10.2.8.1 | 1Store Keeper for DHS @ Rs 15000 | 3 | 3 | 3 | 3 |
| 38 | A.10.2.8.2 | 2 Peon for DHS @ Rs 8000 / Per Month | 3 | 3 | 3 | 3 |
| 39 | A.10.4.2 | Salary for 2 Hos. Manager @ Rs 33275, 2 @ Rs 27500 & 1 @ Rs 25000 | 3 | 3 | 3 | 3 |
| 40 | A.10.4.3 | Salary for 5 FRU Accountant @ Rs 15000 | 3 | 3 | 3 | 3 |
| 41 | A.10.3.1 | Salary of 19 BPM | 3 | 3 | 3 | 3 |
| 42 | A.10.3.2 | Salary of 619BAM | 3 | 3 | 3 | 3 |
| 43 | A.10.3.3 | Salary of 19 BDM | 3 | 3 | 3 | 3 |
| 44 | A.10.3.5 | Salary of 19DEO | 3 | 3 | 3 | 3 |
| 45 | A.10.7.2 | Mobility Contingency support @ 55000/month for DPMU | 3 | 3 | 3 | 3 |
| 46 | A.10.7.3 | Mobility & Contingency support for 19 BPMU @40000/Month | 3 | 3 | 3 | 3 |
| 47 | A.10.7.4.1 | Contingency for DH & SDH @ Rs 10,000 | 3 | 3 | 3 | 3 |
| 48 | B1.1.5.2 | No.of DCM & DDA | 3 | 3 | 3 | 3 |
| 49 | B1.1.5.3 | No.of BCM and Asha facilitator | 3 | 3 | 3 | 3 |

## Strategies proposed:

- Renewing the contracts of the ANMs on contract
- Appointment of regular and contractual ANMs for the newly sanctioned HSCs
- Training and capacity building of staff .

## Activity Proposed:

- Submission of proposal for the appointment of regular and contractual Medical Officer as per sanctioned.
- Holding interviews and issuing appointment of contractual staff.
- Skilled development training for all level of staff.
-

## Whether new or continued: **Continued**

## Achievements (if the activity has been continued from previous year):

Because of these human resource now we are on the right track. Progress of work shows at every level. Decrease in IMR and MMR, Fertility rate is the main points which shows our achievements.

**Justification:** Due to lack of Medical Officer all the program effect. This is the key problem of the activity. After doing so much work the result found negligible where the demand of Gyn. And other specialist is not present.

**Deliverables:** **Continuous availability** of all level of staff is key points of the health program.

## Funding proposed:

| Unit of Measure | No of units | Cost per Unit (In rs.) | Total Cost (Rs. In Lakh) | FMR Code |
|---|---|---|---|---|
| Salary for 368 ANM @18000/ Per Month | 368 | 18000 | 794.88 | A.8.1.1.1.f |
| Salary for 88 SN @ Rs 30,000 / Per Month | 50 | 20000 | 316.80 | A.8.1.1.2.e |
| Salary for 5 LT at FRU @Rs15000/monthly | 5 | 15000 | 9.00 | A.8.1.2.1.b |

| | | | | |
|---|---|---|---|---|
| Salary for 4 Specialist @ Rs 60,000 for DH | 4 | 60,000 | 28.00 | A.8.1.3.1a |
| Salary for 6 Specialist @ Rs 60,000 for FRU | 6 | 60,000 | 43.20 | A.8.1.3.1b |
| Salary for 4 Specialist @ Rs 60,000 for DH | 4 | 60,000 | 28.00 | A.8.1.3.2a |
| Salary for 4 Specialist @ Rs 60,000 for FRU | 6 | 60,000 | 43.20 | A.8.1.3.2b |
| Salary for 2 Specialist @ Rs 60,000 for DH | 2 | 60,000 | 14.40 | A.8.1.3.3a |
| Salary for 3 Specialist @ Rs 60,000 for FRU | 3 | 60,000 | 21.60 | A.8.1.3..3b |
| Salary for 4 Specialist @ Rs 60,000 for DH | 2 | 60,000 | 14.40 | A.8.1.3.4a |
| Salary for 3 Specialist @ Rs 60,000 for FRU | 3 | 60,000 | 21.60 | A.8.1.3.4b |
| Salary for 2 Dental Surgeon @ Rs 30,000 for DH | 2 | 30,000 | 7.20 | A.8.1.3.7a |
| Salary for 4 Dental Surgeon @ Rs 30,000 for FRU | 4 | 30,000 | 14.40 | A.8.1.3.7b |
| Salary for 14 Dental Surgeon @ Rs 30,000 for PHC | 14 | 30,000 | 50.40 | A.8.1.3.7d |
| Salary of 75 MO at PHC @ Rs 50,000 per month | 75 | 50,000 | 450.00 | A.8.1.5.4 |
| Salary of MO at 38 APHC @ Rs 50,000 Per Month New activity | 38 | 50,000 | 228.00 | A.8.1.5.7 |

| | | | | |
|---|---|---|---|---|
| Salary for MO ( For Blood Bank) on Monthly | 1 | 50,000 | 6.00 | A.8.1.5.8 |
| Salary of 2 Pharmacists @15000/Month at DH | 2 | 15000 | 3.60 | A.8.1.7.1.a |
| Salary of 1 Pharmacists @15000/Month at FRU | 4 | 15000 | 7.20 | A.8.1.7.1.b |
| Salary of 1 Pharmacists @15000/Month at PHC | 14 | 15000 | 25.20 | A.8.1.7.1.d |
| Salary of 2 OT Technician @10000/Month at DH | 2 | 10,000 | 4.80 | A.8.1.7.3.a |
| Salary of 4 OT Technician @10000/Month at FRU | 4 | 10,000 | 9.60 | A.8.1.7.3.b |
| Salary of 14 OT Technician @10000/Month at PHC | 14 | 10,000 | 16.80 | A.8.1.7.3.d |
| Salary of 76 AYUSH MO @27000/Month | 76 | 27,000 | 246.24 | A.8.1.7.4.a |
| Salary of 76 Staff Nurse/ ANM@20000/Month | 76 | 20,000 | 182.40 | A.8.1.7.4.b |
| Salary of 76 Pharmacists @15000/Month | 76 | 15000 | 136.80 | A.8.1.7.4.c |
| Salary of 5 FP Counselors @ 18000/Month | 5 | 18000 | 10.80 | A.8.1.7.5.1 |
| Support Staff for DH @ Rs 8000 | 4 | 8000 | 3.84 | A.8.1.11.a |
| Support Staff for FRU @ Rs 8000 | 8 | 8000 | 7.68 | A.8.1.11.c |
| Support Staff for PHC @ Rs 8000 | 14 | 8000 | 13.44 | A.8.1.11.d |
| Salary of DPM | 1 | 32000 | 3.84 | A.10.2.1 |
| Salary of DAM | 1 | 37000 | 4.44 | A.10.2.2 |
| Salary of DDM | 1 | 32000 | 3.84 | A.10.2. |

| | | | | |
|---|---|---|---|---|
| | | | | 3 |
| Salary of DPC | 1 | 28000 | 3.36 | A.10.2.4 |
| Salary of 2 DEO | 2 | 12000 | 2.88 | A.10.2.6 |
| Salary of Office Assistant + assist accountant. @10000/month | 2 | 12000 | 2.88 | A.10.2.7 |
| 1Store Keeper for DHS @ Rs 15000 | 1 | 15000 | 1.80 | A.10.2.8.1 |
| 2 Peon for DHS @ Rs 8000 / Per Month | 2 | 8,000 | 1.92 | A.10.2.8.2 |
| Salary for 2 Hos. Manager @ Rs 33275, 2 @ Rs 27500 & 1 @ Rs 25000 | 5 | 85775 | 10.29 | A.10.4.2 |
| Salary for 5 FRU Accountant @ Rs 15000 | 5 | 15000 | 9.00 | A.10.4.3 |
| Salary of 19 BPM | 19 | 26354 | 60.09 | A.10.3.1 |
| Salary of 619BAM | 19 | 17570 | 40.06 | A.10.3.2 |
| Salary of 19 BDM | 19 | 12000 | 27.36 | A.10.3.3 |
| Salary of 19DEO | 19 | 10,000 | 22.80 | A.10.3.5 |
| Mobility Contingency support @ 55000/month for DPMU | 1 | 55000 | 6.60 | A.10.7.2 |
| Mobility & Contingency support for 19 BPMU @40000/Month | 19 | 40,000 | 91.20 | A.10.7.3 |
| Contingency for DH & SDH @ Rs 10,000 | 5 | 50000 | 6.60 | A.10.7.4.1 |
| Salary.of DCM @ Rs 20,000 & Salary of DDA @ Rs 19965 | 2 | 39965 | 4.80 | B1.1.5.2 |
| Salary .of 19 BCM @ Rs 15972 and Asha facilitator (115x20x150) | 134 | 648468 | 77.82 | B1.1.5.3 |

# ASHA

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

## Situation analysis:

- Out of a total target 2490 ASHAs for the District, 2410 have already been selected.
- Training of ASHA Couldn't be Completed only 1st phase Training of 1210 ASHA could complete while only 576 ASHA got 2nd phase training and No one could get 3rd and 4th phase training.
- No one ASHA have Drug Kit in Proper manner.
- **HBNC** couldn't be started in each Block . This year due to lack of ASHA training it could't be started in each Block.
- Replenishment of Drug Can't be happened due to not rate contract of Medicine which are approved for ASHA drug Kit.

## Activities

- Timely release of Fund to Training agency.
- Timely payment of Agency.
- Orientation of BCM and ASHA Facilitator
- Selection of ASHAs in Urban area.
- Monitoring of the IEC Campaign by Block Community mobilizer.
- Determining the community based selection and review process for ASHAs by DHS.
- Partnership with NGOs for implementing the community based selection and review process
- Monitoring of NGO partnership for community based selection and review of ASHAs by Block Health Educators.

## Strategies

- Sanction of additional ASHAs
- Facilitate selection through a community process focused on creating awareness about the role of the ASHA as a community mobiliser and activist and her positioning as a representative of the community.

- Community based review of existing ASHAs for performance and replacement of non-functional ASHAs.
- Partnership with local, active voluntary organizations with a background in community health work in the community based selection and review process.

# ASHA Training

Situation Analysis: Out of 2490, 1200 ASHAs have received only the first round of training.

## Strategies

- Conducting 6 days of residential training of ASHAs
- Proposal for Conducting 30 days of field based training of ASHAs in the district.

## Supportive Supervision Activities

- Monthly cluster level meetings of ASHAs, ANMs, AWWs, VHSC members and ASHA .
- Monthly block level ASHA meeting
- Monthly district level trainer's meeting
- Development of simple monitoring formats to be filled out by ASHA trainers, and District Resource Persons to review the functionality of the programme
- Organising an ASHA mela every year at the District level to create a sense of solidarity and support amongst ASHAs
- ASHA Helpline to be managed by the ASHA helpdesks
- Selecting active ASHAs with leadership qualities to be ASHA trainers

## Strategies

- Timely release of monetary incentives to ASHAs
- Instituting social incentives for ASHAs.

# Name of Program: Rogi Kalyan Samitis & Untied Funds

# FMR Code: B2 to B2.6

**Rogi Kalyan Samitis & Untied Funds for Health Sub-Centre, APHC & PHCs**

## Health Sub Centre

### Strategies

- Ensuring that HSCs receive untied funds timely.

### Activities

- Opening Bank Accounts of New RKS.
- Ensuring timely release of funds to HSCs

## "Additional Primary Health Centre"

### Strategies

- Ensuring that all APHCs receive untied funds as per the NRHM guidelines

### Activities

- Ensuring that all APHCs receive untied funds as per the NRHM guidelines

## "Primary Health Centre"

### Strategies

- Ensuring timely release of funds to HSCs
- Ensure that RKS is registered in all PHCs.
- Ensure UCs are sent regularly.
- Utilisation of RKS funds to pay for outsourced services
- Ensuring that HSCs receive untied funds
- Opening Bank Accounts

### Activities

- Training of RKS office bearers on documentation of meetings as well as of the potential of the RKS

- Training of block level accountants in preparation of the utilization certificates
- Monthly review meeting of block level accountants by District Accounts Manager to strengthen the documentation process .
- Developing a check list for review

- **Current Status & Situation Analysis:** All HSC received untied fund but their expance level is not up to mark. Due to political problem use of fund is very slow. After So many talking, meeting, Orientation and training the use of fund is taking place.
-

**Goals:** To provide ground level health and others related facilities as per requirement.

**Objective:** To insure the use of untied fund through PRI and ANM at HSC Level.

## Targets:

| Si. No. | FMR Code | Name of Programme | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|
| 1. | B2.1 | Untied Fund for DH | 0 | 1 | 0 | 0 |
| 2. | B2.2 | Untied Fund for CHCs/SDH | 0 | 4 | 0 | 0 |
| 3 | B2.3 | Untied Fund for PHCs | 10 | 9 | 0 | 0 |
| 4 | B2.4 | Untied Fund for Sub Centres | 40 | 190 | 0 | 0 |
| 5 | B2.5 | Untied fund for VHSC | 0 | 1710 | 0 | 0 |
| 6 | B2.6 | Others (APHC) | 20 | 12 | 0 | 0 |

## Strategies proposed:

- Ensuring that HSCs receive untied funds timely.
- Regular orientation and Training to ANM for use of fund.
- Acceleration of use of fund through motivation.

## Activity Proposed:

- Ensuring timely release of funds to HSCs
- Ensuring use of fund through regular meeting, Training etc.

## Whether new or continued: Continued

## Achievements (if the activity has been continued from previous year):

The use of untied fund is more than previous year. The current year we received fund from SHSB is lakhs on which the expenditure is lakh in all type of untied fund. i.e. percent of total untied fund.

**Justification:** This year we hope that our expenditure on untied fund should be 100%. As the fund requested as per current year approved. But here I would like to receive fund as per 2011-12 guildline .

## Fund Allocation

| Unit of Measure | No of units | Cost per Unit | Total Cost (In lakh) | FMR Code |
|---|---|---|---|---|
| Untied fund for DH | **1** | 100000 | **1.00** | B2.1 |
| Untied fund for SDH and CHC | 4 | 50000 | 2.00 | B2.2 |
| Untied fund for PHC | 19 | 25000 | 4.75 | B2.3 |
| Untied fund for Sub Centres | 230 | 10000 | 23.00 | B2.4 |
| Untied fund for VHSC | 1710 | 10000 | 171.00 | B2.5 |
| Untied fund for APHC | 32 | 25000 | 8.00 | B2.6 |

# Name of Program: Annual Maintenance Grants & Hospital Strengthening

# FMR Code: B3 to B5.12.

## Current Status & Situation Analysis:

As per the IPHS norm, 600 HSCs are required for Rohtas District where as only 230 HSCs functioning in which 112 have own building while 118 are in rented building . For APCH: As per the IPHS norms of 1 APHC for every 30,000 population, Rohtas requires a total of 100 APHCs, in which 32 APHCs already exist and are functional. So that 68 more APHCs required in which 25 have been Sanctioned and 33 reuired to be sanctioned. Of the existing 32 APHCs, 12 work in Government buildings. Till now Only 2 APHC have labour room and toilet. While 2 APHC have residential facilities for MOs. Rohtas has 19 PHCs in its 19 blocks . In which Three PHC running as MCH centre while rest 16 are working as 24*7 . In Rohtas District 1 District Hospital are functioning ,2 SDH is functioning, 2 CHC are sanctioned but not fully functioning now ,but building has been constructed . Each PHC currently has 6 beds which is going to be upgraded to 30 beds. All 13 existing PHCs operating in their own building. While three PHC running in APHC building.

## Goals:

To ensure that the DH, RH, PHCs, APHC & HSC are 100% functional with full staff strength, functional. And where required Operation Theatres, Labour Rooms, Wards and Laboratory services, adequate equipment and drugs availability as per IPHS norms.

## Objective:

- To ensure that Rohtas has 100% of functional DH, RH, PHCs, APHC & HSC as required by population norms
- To operate 32 APHCs and 230 HSC as Delivery point and 24*7 basis in three Phase.
- To provide quality secondary care with a special focus on BPL patients

## Targets:

| Si. No. | FMR Code | Name of Programme | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|
| **1.** | B3.1 | Annual Maintenance Grant for CHC | 0 | 1 | 1 | 0 |
| **2.** | B3.2 | Annual Maintenance Grant for PHCs | 9 | 10 | 0 | 0 |
| **3** | B3.3 | Annual Maintenance Grant for Sub Centers | 30 | 92 | 0 | 0 |
| **4** | B3.4 | Annual Maintenance Grant for DH | 0 | 1 | 0 | 0 |
| **5** | B3.5 | Annual Maintenance Grant for SDH | 0 | 02 | 0 | 0 |
| **6** | B3.6 | Annual Maintenance Grant for Other (APHC) | 05 | 10 | 0 | 0 |
| **7** | B4.1.1.1 | Additional ward for Labour room in District Hospital | 0 | 0 | 1 | 0 |
| **8** | B4.1.2.1 | Major maintainence of existing Structure of Referal Building | 0 | 1 | 1 | 0 |
| **9** | B4.1.3.1 | Additional Building/ Major Upgradation of existing Structure for Three PHC | 0 | 3 | 0 | 0 |
| **10** | B4.1.4.2 | Repair/ Renovation of HSC Building | 2 | 3 | 0 | 0 |
| **11** | B4.1.5.4.1 | Repair/ Renovation for APHC | 0 | 2 | 0 | 0 |
| **12** | B4.1.5.4.2 | Construction of APHC Building | 0 | 10 | 0 | 0 |
| **13** | B4.1.5.4.3 | Boundrywall for PHC | 0 | 2 | 0 | 0 |
| **14** | B4.1.5.4.4 | Boundrywall for APHC | 0 | 4 | 0 | 0 |
| **15** | B4.1.5.4.5 | Boundrywall for HSC | 0 | 5 | 0 | 0 |
| **16** | B4.1.6.1 | Additional Building/ Major Upgradation of existing Structure of SDH | 0 | 1 | 0 | 0 |
| **17** | B.4.3 | Sub Centre Rent and Contingencies | 130 | 130 | 130 | 130 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **18** | B5.3 | Construction of new SHCs/Sub Centres buildings | 0 | 30 | 0 | 0 |
| **19** | B.5.6.1 | Absolutely new one NBSU and 5 NBCC | 0 | 1 | 0 | 0 |
| **20** | B.5.9 | Civil Works for Operationalising Infection Management & Environment Plan at health facilities | 0 | 12 | 0 | 0 |

## Strategies proposed:

- New Construction of 30 HSC, Repairing and major maintainence of 1 Referral Building, 2 APHC and 5 Sub centre.
- Infrastructure as Furniture and Equipment Required for all HSC
- Ensuring the availability of labour room facilities, maternity wards and toilets, ensuring running water supply and drinking water supply in all existing APHCs.
- Ensuring power supply and power back up for all existing APHCs.
- Rationalization of doctors across APHCs, and PHCs
- Filling vacancies of doctors by hiring doctors on contract/appointment of regular.
- Sanction and appointment of an OT Assistant in all PHCs

## Activity Proposed:

- Meeting with BD0/CO to identify availability of land for setting up the priority HSCs in the selected villages.
- Follow up the responses to the advertisement given by Bihar Govt for donation of land for setting up of HSCs.
- Village meetings to identify accessible locations for setting up of HSCs
- Finding locations for new HSCs on the basis of hard to reach areas and population. Distance between two facilities should also be considered.
- Requesting allotment for construction of new HSCs to State Health Society
- Requesting state government to revise the rent rates for HSC building and make the grant for payment of the rent.
- Ensuring construction of HSC building as per IPHS norm along with residence for ANM and other health staff.
- Meeting with officials for operationalise all APHC and HSC as delivery pts.

## Whether new or continued: Continued

## Achievements (if the activity has been continued from previous year):

Two APHC is functioning as Delivery point but still there is lack of Some basic infrastructure.

**Justification:** Most of the HSC building in Rohtas district are about to worst. Need major repairing more than 118 HSC required own building in this regard thirty have sufficient

**Deliverables: To run the program in village level infrastructure is the main issue.**

## Funding proposed:

| Unit of Measure | No of units | Cost per Unit | Total Cost | FMR Code |
|---|---|---|---|---|
| Annual Maintenance Grant for CHC | 2 | 50000 | 1.00 | B3.1 |
| Annual Maintenance Grant for PHCs | 19 | 50000 | 9.50 | B3.2 |
| Annual Maintenance Grant for Sub Centers | 112 | 50000 | 56.00 | B3.3 |
| Annual Maintenance Grant for DH | 1 | 100000 | 1.00 | B3.4 |
| Annual Maintenance Grant for SDH | 2 | 50000 | 1.00 | B3.5 |
| Annual Maintenance Grant for Other (APHC) | 15 | 50000 | 7.50 | B3.6 |
| Additional ward for Labour room in District Hospital | 1 | 5000000 | 50.00 | B4.1.1.1 |
| Major maintainence of existing Structure of Referal Building | 2 | 3500000 | 70.00 | B4.1.2.1 |
| Additional Building/ Major Upgradation of existing Structure for Three PHC | 3 | 5000000 | 150.00 | B4.1.3.1 |
| Repair/ Renovation of HSC Building | 5 | 1000000 | 50.00 | B4.1.4.2 |

| | | | | |
|---|---|---|---|---|
| Repair/ Renovation for APHC | 2 | 1500000 | 30.00 | B4.1.5.4.1 |
| Construction of APHC Building | 10 | 7500000 | 750.00 | B4.1.5.4.2 |
| Boundrywall for PHC | 2 | 1000000 | 20.00 | B4.1.5.4.3 |
| Boundrywall for APHC | 4 | 1000000 | 40.00 | B4.1.5.4.4 |
| Boundrywall for HSC | 5 | 500000 | 25.00 | B4.1.5.4.5 |
| Additional Building/ Major Upgradation of existing Structure of SDH | 1 | 1500000 | 15.00 | B4.1.6.1 |
| Sub Centre Rent and Contingencies | 130 | 500*12 | 2.60 | B.4.3 |
| Construction of new SHCs/Sub Centres buildings | 130 | 1500000 | 450.00 | B5.3 |
| Absolutely new one NBSU @ Rs Five Lakh and 5 NBCC @ Rs. 50Thousand at APHC | 6 | 7500000 | 7.5 | B.5.6.1 |
| Civil Works for Operationalising Infection Management & Environment Plan at health facilities | 12 | 500000 | 60.00 | B.5.9 |

# Name of Program: PROCUREMENT

# FMR Code: B10.2.1.1 to B.17.6.2

**Current Status & Situation Analysis: If** we compare from IPHS no HSC , APHC Referal ,SDH or DH is upto mark **.** neither building nor equipment are upto level .old equipments for either delivery or Operation Theafter. As the equipments purchase time to time as per need. All the facilities required double set of all types of equipments fully functional. The current situation of medicine availability at all health centre is far better than before. The process is taking place for chain maintenance.

**Goals:** To insure availability of medicine, equipments, kits, at the facilities.

## Objective:

- To make Availability of Medicine, Equipments. Kits etc/
- Maintain the supply chain from DHS to HSC.
- To provide a computerized channel for medicine.
- Proper planning of purchasing items.

## Targets:

| Si. No. | FMR Code | Name of Programme | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|
| 1 | B.10.2.1.1 | Mass media for MCH | 0 | 0 | 1 | 1 |
| 2 | B.10.2.2.1 | Mass media for CH | 0 | 0 | 1 | 1 |
| 3 | B.10.2.3.1 | Mass media for Family Planning | 0 | 0 | 1 | 1 |
| 4 | B.10.5.1 | Printing of MCP cards, safe motherhood booklets etc | 0 | 0 | 100000 | 0 |
| 5 | B12.2.2 | Operating Cost /Opex for ASL ambulance ( For 1099 ) | 3 | 3 | 3 | 3 |
| 6 | B12.2.3 | Opex EMRI-BLS( Mortituary Van) | 3 | 3 | 3 | 3 |
| 7 | B12.2.4 | Opex EMRI-ALS (For 108 ) | 3 | 3 | 3 | 3 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **8** | B13.2.2 | Segregation , Collection, Treatment and Disposal in all Health acilities upto PHC Level | 3 | 3 | 3 | 3 |
| **9** | B16.1.1.3.1 | New Born Kit for Mamta | 0 | 0 | 42036 | 0 |
| **10** | B16.1.1.3.2 | Procurement of equipment for MCH Centres at L1 , L2 and L3 | 5 | 5 | 10 | 10 |
| **11** | B16.1.1.3.6 | Equipments for ICU for DH | 1 | 0 | 0 | 0 |
| **12** | B16.1.3.1 | NSV kits | 0 | 0 | 5 | 0 |
| **13** | B16.1.5.1 | Dental Chair | 0 | 0 | 10 | 0 |
| **12** | B16.1.5.3 | Bed for Hospitals | 0 | 200 | 0 | 0 |
| **14** | B.16.2.2.1 | ORS Packet for Rural population 0-5 yrs | 0 | 1200000 | 0 | 0 |
| **15** | B.16.2.3.1 | Ketamine and other essential Drug for FP | 10000 | 10000 | 10000 | 10000 |
| **16** | B.16.2.5.1 | OPD | 0 | 0 | 1 | 1 |
| **17** | B.16.2.5.2 | IPD | 0 | 0 | 1 | 1 |
| **18** | B.16.2.6.1 | IFA | 0 | 5000000 | 0 | 0 |

## Strategies proposed:

- Set up computerized OPD, IPD, Medicine distribution system.
- Daily reporting system
- Timely Use of fund on Equipment and Drug
- Safety of equipments.
- AMC Of Equipments.
- Regular touch with SHSB for timely procurement of Drug and Equipment

## Activity Proposed:

- Monthly reporting of the equipment status, functional/non-functional
- Purchase of essential equipment locally by utilizing the funds or through RKS funds
- Identification local repair shop for minor repairs
- Training of health worker for handling the equipment and minor repair.

## Whether new or continued: Continued

## Achievements (if the activity has been continued from previous year):

Every year things are purchase through different- different FMR Code. But till date very less purchasing amount reported.

**Justification:** To improve the level of facilities its need new and additional set of equipments, more different type medicine, working instruments so that public can believe on our work.

## Funding proposed:

| Unit of Measure | No of units | Cost per Unit | Total Cost | FMR Code |
|---|---|---|---|---|
| Mass media for MCH | 2 | 100000 | 2.00 | B.10.2.1.1 |
| Mass media for CH | 2 | 100000 | 2.00 | B.10.2.2.1 |
| Mass media for Family Planning | 2 | 100000 | 2.00 | B.10.2.3.1 |
| Printing of MCP cards, safe motherhood booklets etc | 100000 | 5 Rs | 5.00 | B.10.5.1 |
| Operating Cost /Opex for ASL ambulance ( For 1099 ) | 12 | 98900 | 11.87 | B12.2.2 |
| Opex EMRI-BLS( Mortituary Van) | 12 | 60000 | 7.20 | B12.2.3 |
| Opex EMRI-ALS (For 108 ) | 12 | 174000 | 20.88 | B12.2.4 |
| New Born kit for Mamta | 42036 | 300 | 126.11 | B16.1.1.3.1 |
| Segregation , Collection, Treatment and Disposal in all Health acilities upto PHC Level | 12 | 100700 | 12.06 | B13.2.2 |
| Procurement of equipment for MCH Centres at L1 , L2 and L3 | 30 | 150000 | 45.00 | B16.1.1.3.2 |
| NSV kits | 5 | 1100 | 0.06 | B16.1.3.1 |
| Dental Chair | 10 | 400000 | 40.00 | B16.1.5.1 |
| Bed for Hospitals | 200 | 12000 | 24.00 | B16.1.5.3 |
| ORS Packet for Rural population 0-5 yrs | 120000 | 3 Rs | 36.00 | B.16.2.2.1 |
| Ketamine and other essential Drug for FP | 40000 | 70 | 28.00 | B.16.2.3.1 |
| OPD drugs | 2 | 5000000 | 100.00 | B.16.2.5.1 |

| | | | | |
|---|---|---|---|---|
| IPD drugs | 2 | 5000000 | 100.00 | B.16.2.5.2 |
| IFA | 5000000 | 10 Paise | 5.00 | B.16.2.6.1 |

# Name of Program: IMMUNISATION

# FMR Code: C1 to C1v

## Current Status & Situation Analysis:

According to HMIS 2012-13, 68.79% children coverage under BCG scheduled, 66.84% children covered under DPT3, For OPV1 56.78% children immunized, in OPV3 49.33% children immunized , Full immunization children coverage is 66.31%. Measlels coverage is 66.49% where as measeles 2 coverage is only 9.60%. After having seen the above data the overall status of immunization is not satisfactory. As the efficient has been given to improve the immunization coverage. With the support of staff focus on all 2307 AWW centre are on main focus. All 2307 AWCs are to be covered under this programme at least once in a month. 230+47 HSCs are to be covered under this programme on all Wednesdays and Friday observed as immunisation day. APHCs will also provide immunisation services on Wednesday and all days in PHCs/CHC and DH. Incentives are provided under this programme forn ANM and ASHA as per immunisation. To cover immunisation 100% the special campaign run on demand.

## Goals:

To achieve 100% Immunization of Mother and Children**.**

## Objective:

- All the targeted children to be immunized on time.
- To cover all the escaped children.
- Proper maintenance of cold chain equipments.
- Regular maintain of cold chain.
- Maintain Immunization supply chain.

## Targets:

| Si. No. | FMR Code | Name of Programme | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|
| **1.** | C.1.a | Mobility Support for supervision for distict level officers. | 3 | 3 | 3 | 3 |
| **2.** | C.1.c | Printing and dissemination of Immunization cards, tally sheets, monitoring forms etc. | 0 | 25000 | 25000 | 55000 |
| **3** | C.1.e | Quarterly review meetings exclusive for RI at district level with Block Mos, CDPO, and other stake holders | 1 | 1 | 1 | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **4** | C.1.f | Quarterly review meetings exclusive for RI at block level | 57 | 57 | 57 | 57 |
| **5** | C.1.g | Focus on slum & underserved areas in urban areas/alternative vaccinator for slums | 16 | 16 | 30 | 16 |
| **6** | C.1.h | Mobilization of children through ASHA or other mobilizers | 1000 | 1000 | 1000 | 1000 |
| **7** | C.1.i | Alternative vaccine delivery in hard to reach areas | 215 | 215 | 215 | 215 |
| **8** | C.1.j | Alternative Vaccine Deliery in other areas | 10000 | 10000 | 10000 | 10000 |
| **9** | C.1.k | To develop microplan at sub-centre level | 0 | 0 | 230 | 0 |
| **10** | C.1.l | For consolidation of micro plans at block level | 0 | 0 | 19 | 0 |
| **11** | C.1.m | POL for vaccine delivery from State to district and from district to PHC/CHCs | 0 | 1 | 1 | 1 |
| **12** | C.1.n | Consumables for computer including provision for internet access | 3 | 3 | 3 | 3 |
| **13** | C.1.o | Red/Black plastic bags etc. | 5000 | 16000 | 14000 | 19000 |
| **14** | C.1.p | Hub Cutter/Bleach/Hypochlorite solution/ Twin bucket | 6 | 6 | 6 | 6 |
| **15** | C.1.v | Others (Vaccine Carrier and Ice Pack) | 0 | 1000 | 1000 | 1000 |

## Strategies proposed:

- First of all Updating of Due list of ASHA AWW and ANM
- Improve skill of Vaccinators.
- Increasing utilisation of immunisation services through awareness generation by ASHAs and AWWs by Special Campaign
- Ensuring continued tracking of pregnant women and children for full immunisation
- Establishing sound monitoring mechanism to review and guide the progress
- Improving availability and maintaining quality of cold chain equipment
- Improving timely supply of the vaccines

- Timely supply of all Vaccines and syringes. .
- Adopting safe disposal policies for needles and syringes

## Activity Proposed:

- First of all Updation of Quality due list by ASHA , AWW and ANM.
- Regorus Monitoring of Session site by District and block Officials.
- Organising regular routine immunisation training for ANM and AWW and IPC/IEC/BCC trainings for ASHA and AWWs.
- Organising immunisation camps at every Sub centre level on everyday and at the AWCs on every Wednesday/ Friday.
- Regular house to house visits for registration of pregnant women for ANC and children for immunisation
- Developing tour plan schedule of District and block Officials , they will submit plan for there monitoring to concerned officials .
- ANM with the help of BHM and MOIC.
- Timely payment to MOICs to arrange transportation of vaccines from district hospital to PHCs.
- Visits by MOIC, CDPO, BHM, LHV and health educator to monitor the progress of immunisation schedule and prepare report.
- Ensuring the unrestricted movement of the monitoring team with fuel for vehicle and funds for hiring of the vehicle.
- Maintaining continuous power supply at PHC level for maintaining the cold chain.

- Timely and regular requests from district to state as well as blocks to district to replenish the supply of all Vaccine and syringes.
- Rationalisation of courier rates and making request to the SHS for increased funding for courier in order to ensure timely supply of vaccines to sub centres.
- Reviewing the contract of Kalka Cooling company, currently responsible for repair and maintenance.
- Submitting a proposal to the state health society to acquire power of issuing maintenance and repair contract for cold chain equipment from district.
- Procure stock of hub cutters for all the PHCs for safe disposal of needles and syringe.

## Whether new or continued: Continued.

## Achievements (if the activity has been continued from previous year):

The current situation of the immunization is far better than before. The achievement level in percentage of the year of 2012-13 is 71.11. and the current situation is above 86%.

**Justification:** To give a better and health full live of the child. It is necessary the immunization system should better.

## Funding proposed:

| Unit of Measure | No of units | Cost per Unit | Total Cost (In Lakh) | FMR Code |
|---|---|---|---|---|
| No.of Supervision of RI Session by DIO/district & Block level officials | **12** | **25000** | **3.0** | C.1.a |
| No.of cards. | 70000 | **10** | 7.00 | C.1.c |
| Qtrly review meeting at dist. Level | 4 | 9500 | 1.14 | C.1.e |
| Qtrly review meeting at Block. Level | 12 | 186875 | 22.43 | C.1.f |
| no.of urban slum to be cover | 78 | 2500 | 1.95 | C.1.g |
| no.of Session with ASHA per year based on Beneficiaries | 40000 | 150 | 60.00 | C.1.h |
| No.of Hard to reach area | 860 | 150 | 1.29 | C.1.i |
| No.of Session Per year | 40000 | 75 | 30.00 | C.1.j |
| No.of HSC | 230 | 100 | 0.23 | C.1.k |
| No.of PHC and District Head quarter | 19 +1 | 1000+2000 | 0.21 | C.1.l |
| POL for vaccine delivery | 3 | 150000 | 4.5 | C.1.m |
| Consumables for computer including provision for internet access | 12 | 400 | 0.048 | C.1.n |
| Red/Black plastic bags etc. | 54000 | 3 | 1.62 | C.1.o |
| Hub Cutter/Bleach/ Hypochlorite solution/ Twin bucket at 24 Health Facilities | 24 | 1200 | 0.29 | C.1.p |
| Others (Vaccine Carrier and Ice Pack) | 3000 | 3000 | 90.00 | C.1.v |

# National Disease Control Programme

# "RNTCP"

## Strategies

- Detection of New cases.
- House to House visit for detection of any cases.
- IEC for awareness regarding the symptoms and effects of TB.
- Prompt treatment to all cases.
- Rehabilitation of the disabled persons.
- Distribution of Medicine kit and rubber shoes.
- Honorarium to ASHA for giving DOTs.

## Activities

- Participation of ASHAs and AWWs for providing DOTS so as to reach services close to the patients for decrease default rate.
- Ensure proper counselling of the patient by the health workers.
- Organizing awareness campaign and community meetings to aware people about the TB and DOTS.
- Sensitization of MOTCs/MOs at the Peripheral health facilities to ensure every TB suspect
- undergo Sputum Smear examination (at least 3% of Total New OPD patient)
- Sensitization of all Lab Technician for Correct Sputum Smear Microscopy(5%-15% positivity is expected among patients examined for diagnosis)
- Ensuring 3 sputum smear examinations for TB patients.
- Participation of ASHA and Community Volunteers to provide effective DOTS.
- Incentive to ASHA and Volunteers for timely Sputum smear microscopy Collection and follow-up.
- Initiation of treatment of New Smear Positive (NSP) patients within a weak of diagnosis.
- To control spared of infection in Group.
- Proper Monitoring/Supervision to ensure regular and interrupted DOTS as per guidelines.

## "Proper counselling of patients by the DOTS provider and supervisory staffs".

- Maintenance/ Replacement of defective Binocular microscopes.
- Establishment of new DMC as per need and repairing/renovation of closed DMCs with proper electricity connection and water supply.
- Refreshment training of Lab Staffs specially Lab Technician for maintenance of microscopes.

- Ensure regular and adequate supply of laboratory consumables to DMCs from |District TB Centre(DTC)
- Recruitment of Counsellor at PHC level.
- Active participation of community specially ASHA and AWW.
- Capacity building of ASHA.
- Remuneration to ASHA/Community volunteer for providing DOTS will be paid timely.
- New recruitment for lacks in staffs i.e., Lab Technician, STS, STLS, TBHV and other.

## ACHIEVEMENT DURING ( April 2013 – November 2013 )

| | |
|---|---|
| **No of Sputum cases Examined** | **9972** |
| **No of Positive Cases** | **831** |

# "National Leprosy Elimination programme"

## Objective

- To reduce the leprosy disease prevalence rate to.

## Strategies

- Currently disease prevalence rate per 10,000 population is.
- New patients registered .
- Awareness in urban areas.

## Activities **(Improving case detection)**

- House to house visits for tracing cases of Leprosy, by health workers (BHWs, ASHA, ANM)
- Detected cases are to be taken to hospital for proper counselling, by professional counsellors.
- The cases detected are to be monitored and followed up by health workers, mainly by BHWs/ASHA to detect deformity.

## IEC/BCC to create awareness

- Awareness creation among community by having hoardings, pamphlet, advertisements in the news papers.
- Sensitization of AWW.
- School quiz contest.
- Awareness in the community through Gram- Goshti.
- Organizing 2 Health camps in each block.

- Rally to create awareness.

## Strengthening Facilities

Increasing availability of fuel, vehicle, stationary and medicine at facility level.

## Human Resources

- Walk-in interview for filling of all required staff at the district level.
- Continued training for all health workers.
- Training of all health workers specifically in counselling patients and the family about the disease.
- Contracting of services that are essential for management of cases.
- Contracting of a consoler at least at the PHC level.

## ACHIEVEMENT DURING ( April 2013 – November 2011\3 )

| | |
|---|---|
| **No of Cases Detected** | **690** |
| **No of leprosy Cases Deleted** | **715** |

# "Malaria Control Program"

## Situation Analysis:

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

## Strategy

- Ensuring registration of all private laboratories.
- Filling-up of all vacant posts.

- Enhancing BCC activities.
- Ensuring adequate supply of mosquito bed nets.

## Activities

- Meeting with DM for issuing an order for all old and new laboratories to register with DHS.
- Following their registration, they would be expected to report all the disease specific cases to the DHS.
- All HWs would also be then requested to collect the reports.
- Training of all health workers in BCC.

## ACHIEVEMENT DURING ( April 2013 – November 2013 )

| | |
|---|---|
| **No. of Blood Slide Collection** | **7519** |
| **No. of + Ve Case** | **99** |

# "Filaria Control Programme"

## Situation Analysis

Similar to Malaria lack of laboratory technicians and facilities at the APHC/PHC level continues to pose a challenge for an effective filarial control programme in the district. In case of Filaria specifically the exact burden of disease is not known because reports from the private sector are not collected or not reported. BCC activities in the district are limited. There is a shortage of chemically treated bed nets. Mass Drug Administration has been carried out in the population where cases have been detected.

## Strategy

- Early diagnosis and prompt treatment.
- Ensuring registration of all private laboratories.
- Filling all vacant posts.
- Enhancing BCC activities.
- Ensuring adequate supply of mosquito bed nets.

- Ensuring adequate supply of drugs.

## Activities

- House to house visits for tracing cases of Filariasis, by health workers (BHWs, ASHA, ANM)
- Collection of reports from local private practitioners and laboratories in the village.
- Following their registration, they would be expected to report all the disease specific cases to the DHS.
- All HWs would also be then requested to collect the reports.
- Training of all health workers in BCC.
- District level procurement of drugs for MDA, with funds from respective department.

## ACHIEVEMENT DURING ( April 2011 – November 2013 )

| | |
|---|---|
| **No of cases Reported** | **0** |
| **No of Night Blood Sample Collected** | **1581** |

# "National Blindness Control Programme"

## Strategy

- Prompt case detection.
- Ensuring proper treatment.

## Activities

- Screening of all children in the schools Including Optometrists in Mobile medical unit's visits to camps in villages.
- Fortnightly visit by optometrist opthometrician to health sub-centres and weekly visit to APHCs.
- Contracting of ophthalmologist services.
- Distribution of spectacles from the health facilities.
- Conducting in-hospital minor surgeries for cataract.
- Conducting surgeries in the NGO run hospitals and follow-up.
- Distribution of spectacles for BPL population undergoing surgery in private sector.

## ACHIEVEMENT DURING ( April 2013 –November 2013 )

| | |
|---|---|
| No. of Cataract Operated | 878 |
| No. of School Children Screened | 6639 |
| No. of School Children Detected for Refractive Error | 208 |
| No.Of Teachers Trained | 75 |
| Provided Free Glass | 0 |

# "Integrated Disease Surveillance Programme (IDSP)"

## Situation Analysis

## (The programs with major surveillance components include):

- The National Anti-Malaria Control Program.
- National Leprosy Elimination Program
- Revised National Tuberculosis Control Program
- Nutritional Surveillance
- National AIDS Control Program.
- National Polio Surveillance Program as part of the Polio eradication initiative
- National Programme for Control of Blindness (Sentinel Surveillance)

Surveillance activities of all these vertical programs of Malaria, Tuberculosis, Polio, and HIV are functioning independently leading to duplication of Surveillance efforts. Surveillance has been ineffective due to

- There are a number of parallel systems existing under various programs which are not integrated
- The existing programs do not cover non-communicable diseases
- Medical colleges and large tertiary hospitals in the private sector are not under the reporting system as well as for utilization of laboratory facilities.
- The laboratory infrastructure and maintenance is very poor
- Presently, surveillance is sometimes reduced to routine data gathering with sporadic response systems thereby leading to slow response to Epidemics,
- Information technology has not been used fully for information and to analyze and sort data so as to predict epidemics based on trends of the reported data.

- In response to these issues the Integrated Disease Surveillance Programme was launched in Bihar in 2005 to provide essential data to monitor progress of on going disease control programs and help in optimizing the allocation of resources.

IDSP includes 22 diseases/ conditions (Malaria, Acute diarrhoeal disease-Cholera, Typhoid, Jaundice, Tuberculosis, Acute Respiratory Infection, Measles, Polio, Road Traffic Accidents, Plague, Yellow Fever, Meningoencephalitis /respiratory distress, etc.,(HIV, HCB, HCV) and 5 state specific diseases (Thyroid diseases, Cutaneous Leishmaniosis, Acid Peptic Diseases, Rheumatic Heart Diseases).

- Establishing of District Surveillance unit.
- Up gradation of 2 PSU Labs.
- Water testing labs are in place.
- V-Sat has been installed but training is required.
- Rapid response teams have been established at District levels.
- DSUs (District Surveillance Units) have been established in all districts.
- Regional Lab has been proposed fro specialized test.

## Objectives

- Improving the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors.
- Establishing a decentralized state based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the country at the state and national level.
- Improving the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.

## Activities

- Strengthening of the District Surveillance Unit (DSU), established under the project,
- Training of the Unit Incharge for epidemiology – {DMO)
- Hiring of Administrative Assistant.
- Training of contract staff on disease surveillance and data analysis and use of IT.
- Providing support for collection and transport of specimens to laboratory networks.
- Provision of computers and accessories
- Provision of software of GOI
- Notifying the nearest health facility of a disease or health condition selected for community-based surveillance
- Supporting health workers during case or outbreak investigation

# THANKS