

District Health Action Plan

2009-2010



DISTRICT HEALTH SOCIETY
AURANGABAD, BIHAR

Foreword

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

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

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

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

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

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

About the Profile

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

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

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

Dr. Parshuram Prasad
Civil Surgeon, Aurangabad

Table of contents

Foreword

About the Profile

CHAPTER 1- INTRODUCTION

CHAPTER 2- DISTRICT PROFILE

History

Geographic Location

Govt administrative setup

Communication Map of the district

District Health Administrative setup

Aurangabad at a Glance

Comparative Population Data

2.1 Socio economic Profile

2.2 Administration and Demography

2.3 Health Profile

Indicators of Reproductive health and Child health

2.3.1 Health Status and Role of District

2.3.2 Public Health Care system

2.3.4 Man Power

2.3.5 Bed Availability

2.3.6 Basic Facilities at rural Institutions

2.3.7 District Hospital

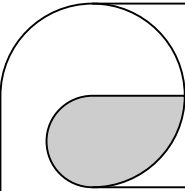
CHAPTER 3- SITUATION ANALYSIS Gaps

3.1 Program Performance and Achievements during the year 2007-2008

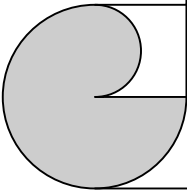
3.2 Problems and issues emerged from the block level meetings

3.3 Programme wise issues

3.4 Issues in IEC Activities

- 
-
- 3.5 Issues in Community Participation**
 - 3.6 Issues in Training of Health Functionaries**
 - 3.7 ASHA Program**
 - 3.8 Issues Block wise**
 - 3.9 Indicator wise issues**
 - 3.10 Issues at coordinating with sub center level**
 - 3.11 Issues at coordinating with district level administration**
 - 3.12 Administration and managerial issues**

CHAPTER 4-Setting Objectives and suggested Plan of Action

- 4.1 Introduction**
 - 4.2 Targeted objectives and suggested Strategies**
 - 4.3 Health Programmes**
 - 4.4 Performance Indicators for RCH**
 - 4.5 Child Health and Immunization**
 - 4.6 Health Infrastructure Indicators**
 - 4.7 Kala-azar program**
 - 4.8 Blindness Control Program**
 - 4.9 Leprosy Eradication Program**
 - 4.10 Tuberculosis control Program**
 - 4.11 Filaria Control Program**
 - 4.12 Disease Surveillance Program**
 - 4.13 ASHA program**
 - 4.14 Urban Health**
 - 4.15 Logistics Management**
 - 4.16 Intersectoral Convergence**
-
- 

Chapter-1

Introduction

Health is a state of physical, mental & social well being & not merely an absence of disease or infirmity. Hence recognizing the importance of health in the process of economic & social development & improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission (NRHM) to carry out necessary architectural correction in the health care delivery system to achieve a positive health.

The National Rural Health Mission (NRHM) seeks to provide effective health care to the entire rural population in the country with special focus on 18 states, which has weak public health indicators. It aims to undertake some architectural correction of the health system to enable it to be effective in providing "Health for All". The mission envisages strategy for integrating ongoing vertical programs of health and family welfare, addressing issues related to the determinants of health like sanitation, nutrition and safe drinking water. The National Rural Health Mission seeks to adopt sector wide approach and aims at systemic reforms to enable efficiency in health services delivery.

A synergistic approach needs to be adopted integrating the segments of nutrition, sanitation, hygiene & safe drinking water, the mechanism to bring about the expected change includes increased public expenditure on health, ridding the geographical insolvency in health infrastructure, positioning of manpower, decentralization, district management of health programs, community participation & up gradation of present health systems meeting Indian Public Health Standard in each block of the district. Hence the goal of promotion of district health plan is to improve the availability of and access to quality health care by people especially for those residing in far off rural areas, the vulnerable sections of the society especially women & children.

Bihar is among the 18 selected states (EAG) that would get benefited under the NRHM. In this state all the districts would be covered under NRHM mission from 2005-2012. Some of the most important aspects of the mission are –

- (a) Decentralized Village and District Level Health Planning and Management,
- (b) Appointment of Accredited Social Health Activist (ASHA) to facilitate access to health services,
- (c) Strengthening the public health service delivery infrastructure, particularly at village, primary and secondary levels,
- (d) Mainstreaming and improving the Management Capacity to organize health systems and services in public Health.

Therefore the making of District Health Plan has been an exercise of vital importance in response to effective launch and implementation of NRHM. For this the Village Health Plans, plans for Water Supply, provision of proper Sanitation and Nutrition would form the core unit of action proposed. Implementing Departments would integrate into District Health Mission for management and monitoring of the district level plan.

Chapter 2

District Profile

Aurangabad is one of the 38 districts in Bihar, with a city of the same name. The beautiful city boasts of a unique culture and identity. The Magahi-speaking people that are settled here have largely taken up agriculture and related activities as their occupation. Aurangabad city offers a host of tourist attractions to its visitors, ranging from historical places to temples. It boasts of a vibrant history and holds the distinction of being a part of one of the largest and strongest empires in ancient India - **Magadha**. The region of Magadha comprised of a vast empire in the ancient period, dating from 600 to 250 BC. Apart from India, the boundaries of this region were spread across parts of Burma, Pakistan, Indonesia, Sri Lanka & Bangladesh. Aurangabad was also ruled by Bimbisar and Ajatshatru. Later on, Chandragupta Maurya and Ashoka ruled the region. After a period, Rajputana came here to settle down. All these rulers have left their mark on the city.

The ancient name of Aurangabad is Naurangabad on the name of the king Naurang Sah Deo. In the reign of Aurangjeb, its name was modified to Aurangabad. Previously a part of the Gaya district, Aurangabad is now an independent district of Bihar. Aurangabad came into existence as a district on 23 January, 1972.

The city of played a significant role in the freedom struggle of India as well. Its valuable contribution was in the form of the great Gandhian - Dr. Anugrah Narayan Sinha - who had a close association with Mahatma Gandhi and worked with Dr. Rajendra Prasad (the first President of India) as well. He encouraged the cause of freedom in Bihar and also led the Satyagraha movement in the state.

Apart from contributing towards the freedom struggle of India, Aurangabad holds a traditional significance as well. The renowned Ayurvedic product, Chyawanprash, derives its name from 'Chyawan Aashram' near Devkund village of Haspura block, in Aurangabad district, where Saint Chyawan spent his life. Another significant place in the district is Obra, a small town located 16 km away from Aurangabad city.

Obra is well known for the production of Kaleen (carpets). The tradition of weaving beautiful and unique carpets in the town dates back to 15th century. Set up near Koriepur village, the Kaleen Udyog is currently managed by the state government. Then, there is Burha, 3 kms to the east of Aurangabad, a location known for a number of historical sites in which "Chaityas" and large "Viharas" (Buddhist monasteries) once stood.

Aurangabad features in traditional records. The Saint Chyawan spent his life in this district, and gives his name to a product of the area, called Chyawanprash. According to Hindu mythology, a deity named a small town in the area Surya Devta. In modern times, the town's name is Deo, and is the location of a popular religious festival called Chhath puja .

* Headquarters:	Aurangabad
* Sub Divisions:	Aurangabad, Daudnagar
*Blocks:	Madanpur, Kutumba, Daudnagar, Barun, Aurangabad, Obra, Deo, Nabinagar, Haspura, Goh, Rafiganj
*Agriculture:	Paddy, Wheat, Lentils
*Industry:	Carpet and Blanket Weaving
*Rivers:	Sone, Punpun, Auranga, Bataane, Morhar, Aadri

Geographical Location

The District is located at 24.19° to 25.70° North latitude and 84° to 84.55° east longitude.

Height from sea level -364 ft.

Area: 3,305 SQ km.

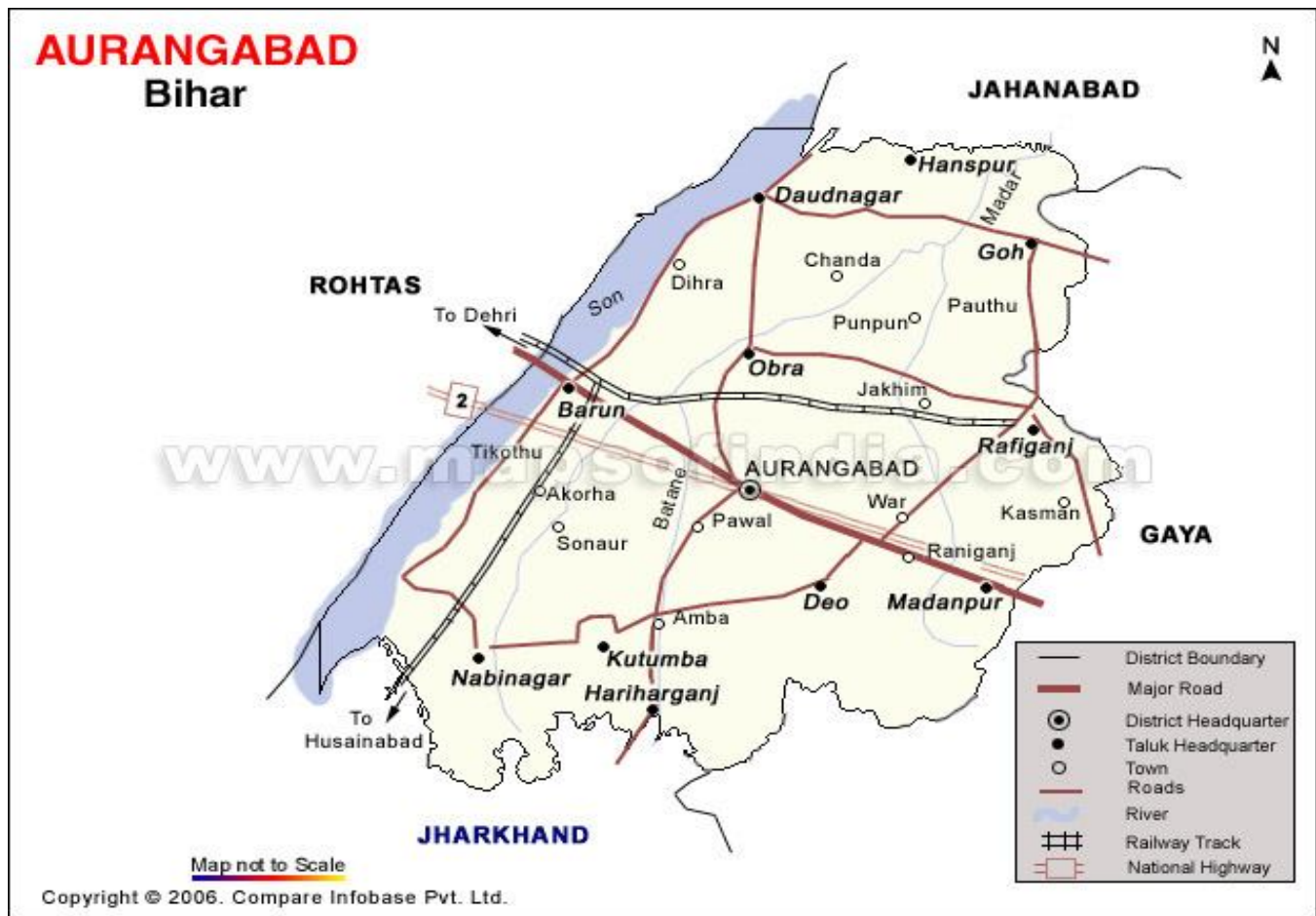
Population: Total: 2392899 Rural:

Urban: 118,052



The District has 1638 revenue villages and 291 Gram panchayats. A few of the newly created Blocks are still in the formation process. The newly elected Panchayati Raj is enthusiastic to play important role in the District.

Communication Map of District



Health Facilities in District Aurangabad, Bihar

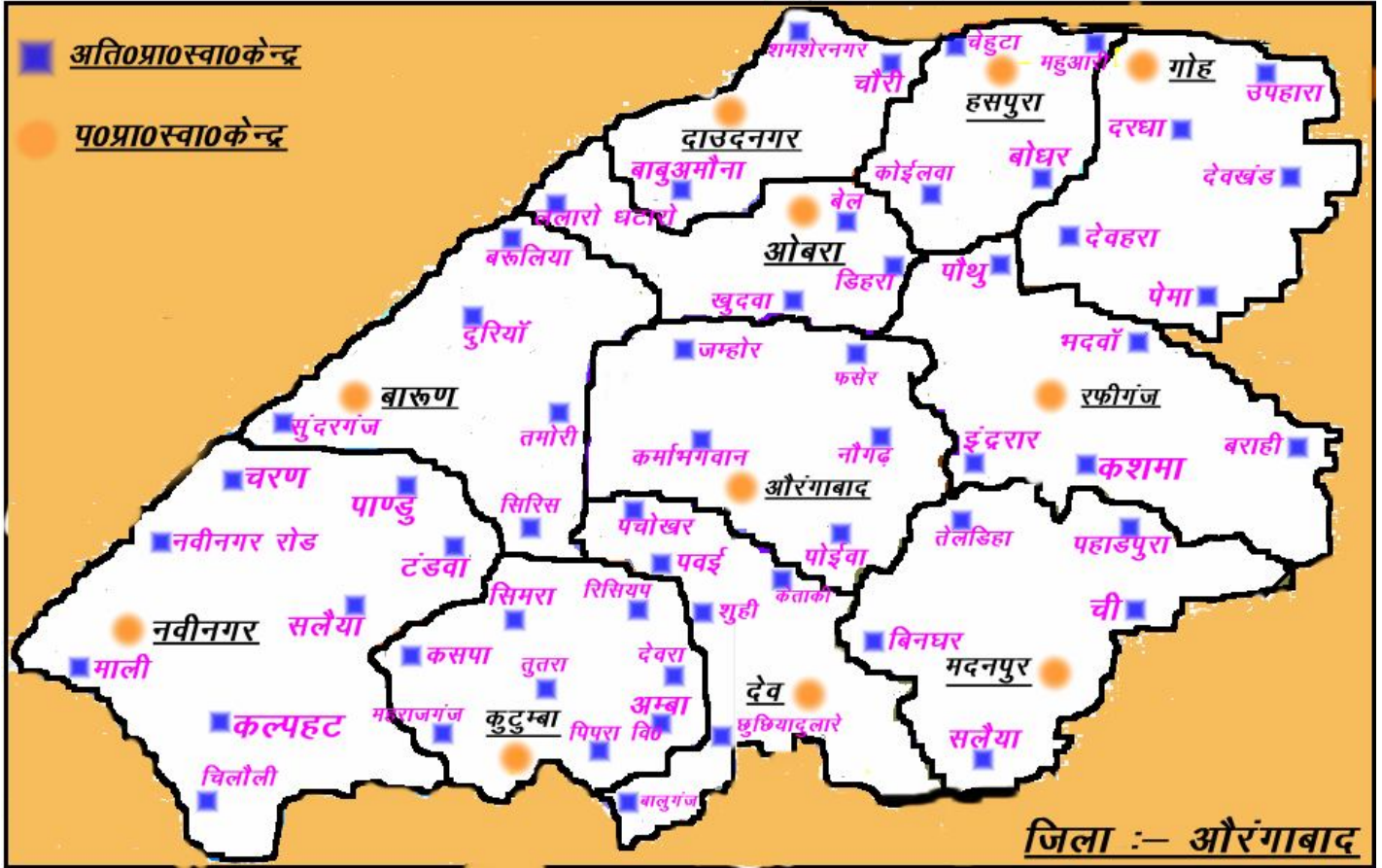


Table. ADMINISTRATIVE UNITS AND TOWNS IN AURANGABAD DISTRICT

PHC	Community Development Blocks
Obra	Obra
Daudnagar	Daudnagar (Subdivision)
Haspura	Haspura
Goh	Goh
Rafiganj	Rafiganj
Madanpur	Madanpur
Deo	Deo
Kutumba	Kutumba
Nabinagar	Nabinagar
Barun	Barun
Aurangabad	Aurangabad

Lok Sabha (Parliamentary) – 1. Aurangabad

AURANGABAD – AT A GLANCE

AREA : - 2036 (Sq. Kms)
DENSITY OF POPULATION : - 465
SEX RATIO : - 930

SI No.	Name of Block	POPULATION 08-09		
		Total	Male	Female
1	Aurangabad Rural	159799	82897	76902
2	Aurangabad Urban	94374	50282	44092
3	Jamhor Urban	10233	5331	4902
4	Total Aurangabad	264406	138510	125896
5	Barun	191991	100071	91920
6	Deo	163797	84288	79509
7	Kutumba	217885	112443	105442
8	Nabinagar Rural	267133	137565	129568
9	Nabinagar Urban	22645	11627	11018
10	Total Nabinagar	289778	149192	140586
11	Madanpur	197527	101601	95926
12	Rafiganj Rural	256180	132115	124065
13	Rafiganj Urban	29708	15559	14149
14	Total Rafiganj	285888	147674	138214
15	Daudnagar Rural	153824	79477	74347
16	Daudnagar Urban	45187	23646	21541
17	Total Daudnagar	199011	103123	95888
18	Obra	212988	110446	102542
19	Haspura	149711	76452	73259
20	Goh	219917	113565	106352
TOTAL DISTRICT		2392899	1237365	1155534

ASHA status

***** Against the target of 1842 , 1761 ASHA have been selected and 1561 ASHA have been trained in the District. Selection of rest is under process.*

PHC	Selected	Trained
Sadar Block	153	126
Obra	166	140
Daudnagar	142	142
Haspura	118	118
Goh	173	168
Rafiganj	192	120
Barun	187	187
Nabinagar	145	135
Kutumba	170	118
Deo	138	136
Madanapur	177	177
Total	1761	1567

Primary Health Centres/ Referral Hospital/Sub-Divisional Hospital/District Hospital : Infrastructure

Sl. No.	Block Name	PHC/Referral Hospital/S DH/DH Name	Building Ownership (Govt./pan/Rent)	Building condition (+++/+++/#)	Assured running water supply (A/NA/I)	Continuous Power supply (A/NA/I)	Toilets (A/NA/I)	Functional Labour room (A/NA)	Condition of Labour room (+++/+++/#)	No. of rooms	No. of beds	Functional OT (A/NA)	Condition of Ward (+++/+++/#)	Condition of OT (+++/+++/#)
1	Obra	PHC	Govt	+++	A	A	A	A	#	11	6	A	++	#
2	Goh	PHC	Govt	++	A	A	A	A	#	6	6	NA	++	#
3	Deo	PHC	Govt	++	A	A	A	A	#	14	6	A	++	++
4	Rafiganj	PHC	Govt	+++	A	A	A	A	+++	5	6	A	+++	+++
5	Madanpur	PHC	Govt	++	A	A	A	A	#	10	6	A	++	++
6	Barun	PHC	Govt	++	A	I	A	A	++	10	6	A	++	++
7	Daudnagar	PHC	Govt	++	NA	A	A	A	++	15	10	A	+	+++
8	Aurangabad	PHC	PHC not functional											
		DH	Govt.	++	+++	++	A	A	+	89	105	A	+	+
9	Haspura	PHC	Govt	++	A	I	A	A	#	4	6	A	#	#
		Referral	Govt	#	I	I	A	A	#	25	30	A	#	#
10	Kutumba	PHC	Govt	#	NA	NA	NA	NA	NA	3	0	NA	#	#
		Referral	Govt	+++	NA	A	A	A	+	24	30	A	++	++
11	Nabinagar	PHC	Govt	+++	NA	I	NA	A	+++	8	6	A	+++	+++
		Referral	Govt	+++	A	NA	A	A	+++	28	30	A	+++	+++

2.1 SOCIO-ECONOMIC PROFILE

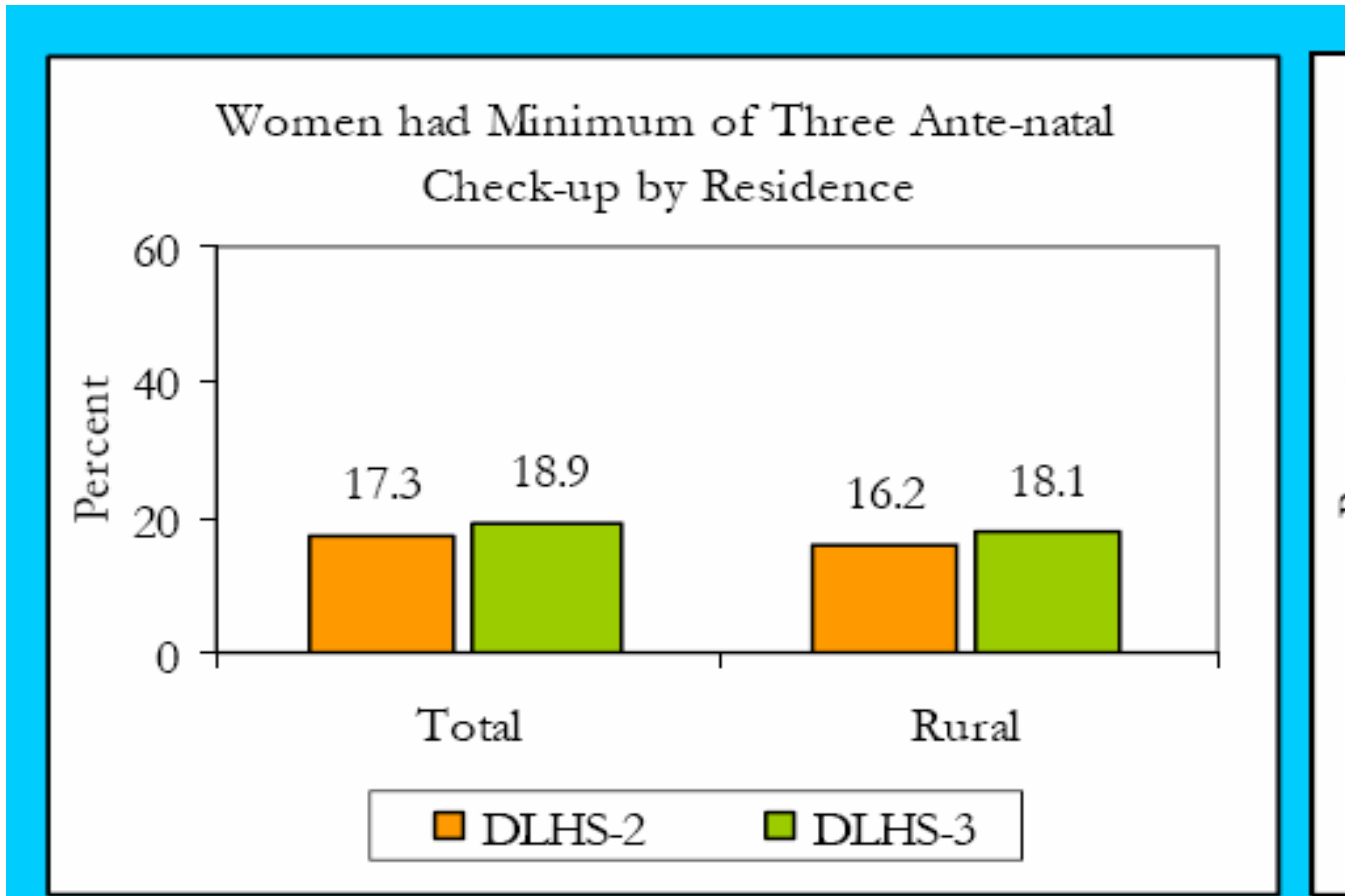
Social

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

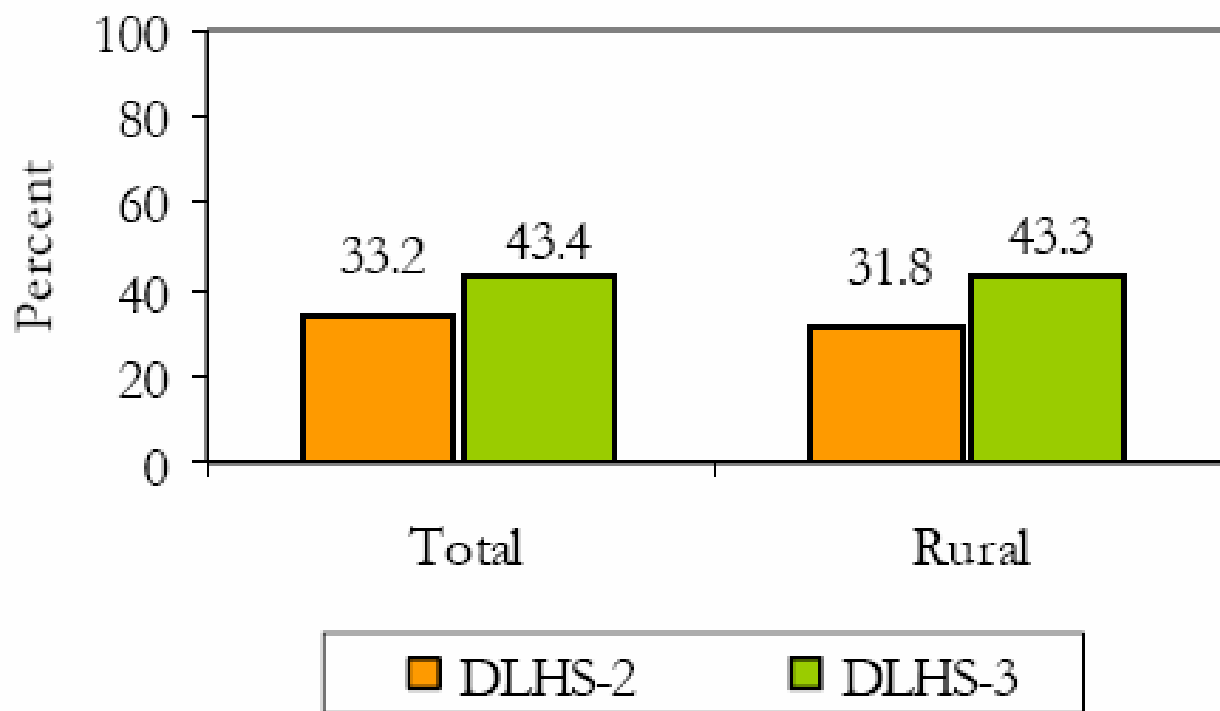
Economic

- The main occupation of the people in Aurangabad is Agriculture, Fisheries and daily wage labour.
- Almost 15% of the youth population migrates in search of jobs to the metropolitan cities like Ludhiyana, Kolkata, Mumbai, Delhi etc.
- The main crops are Wheat, Paddy, Pulses, Oilseeds, Mango.

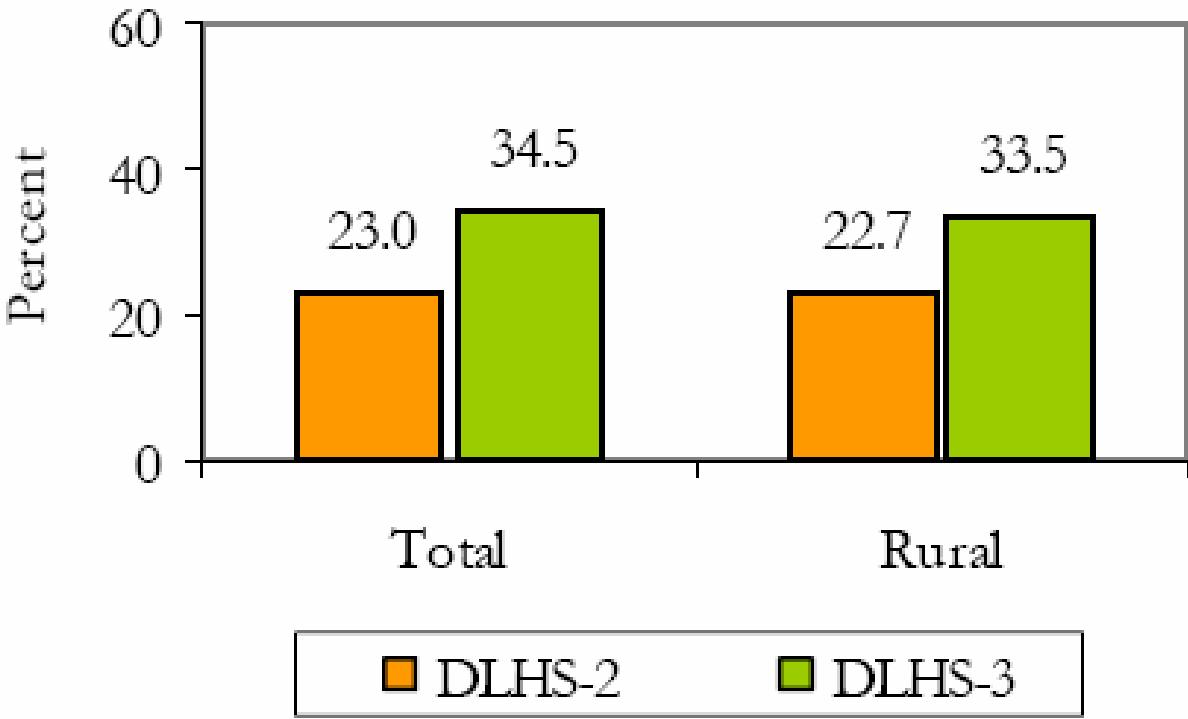
PERFORMANCE AT A GLANCE



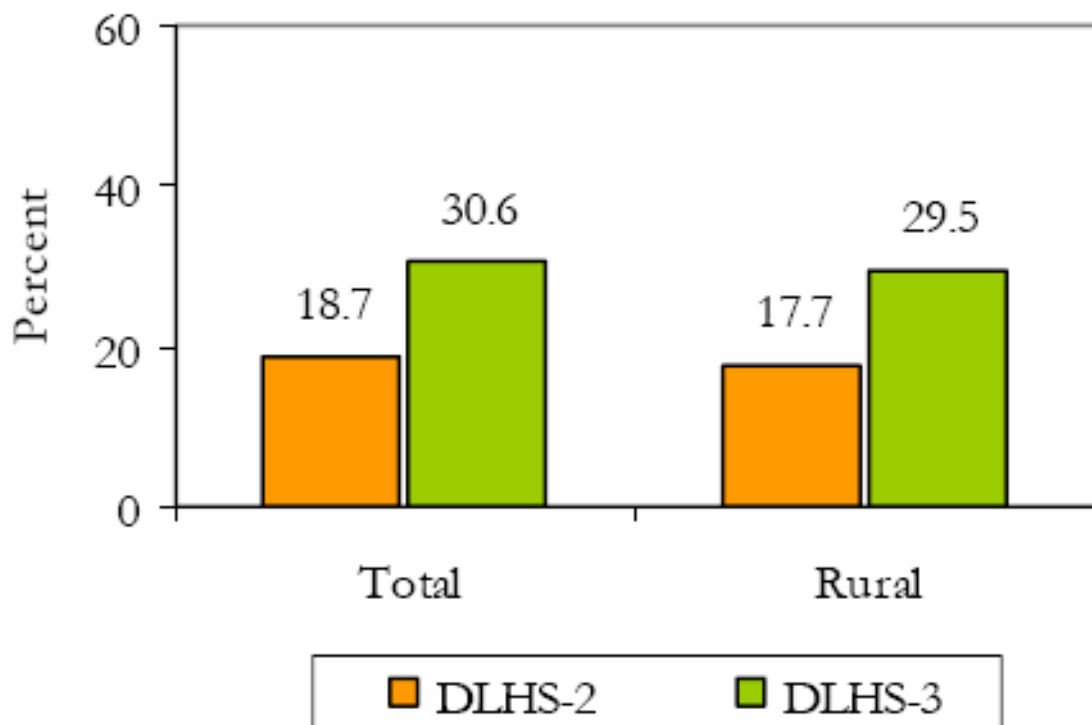
Women Received At least One TT Injection by Residence



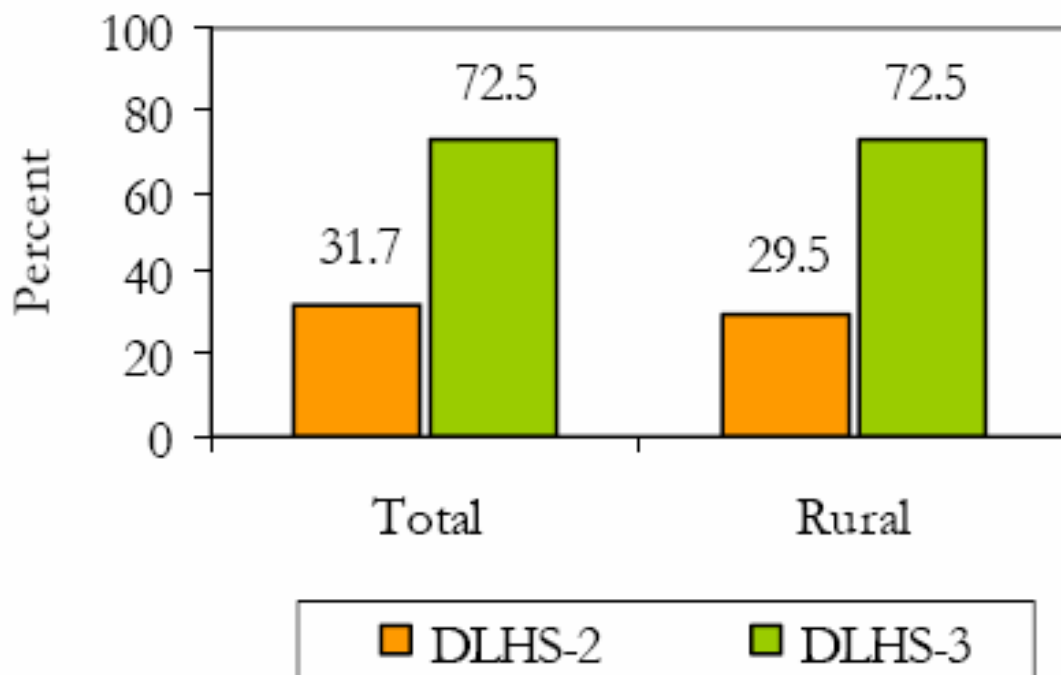
Contraceptive Use (Any Method) by Residence



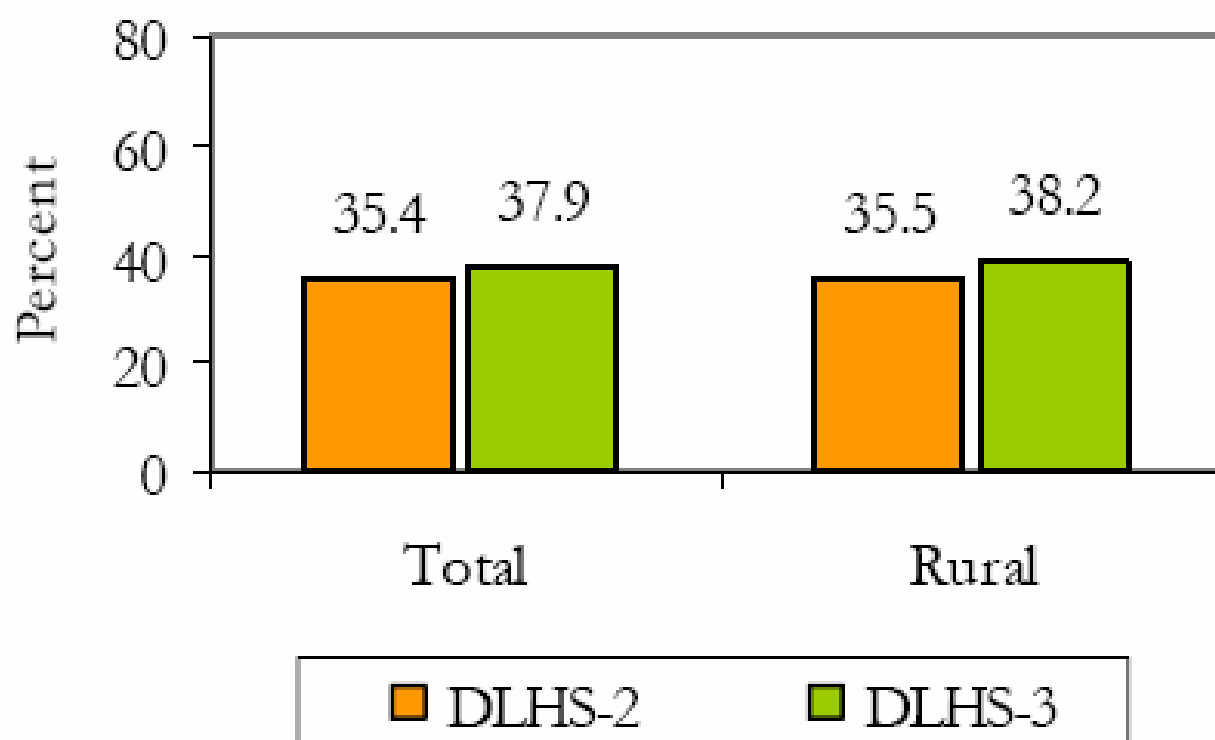
Institutional Deliveries by Residence



Percent of Children (Age 12-23 Months)
Received Measles Vaccine by Residence



Total Unmet Need for Family Planning by Residence



2.3.1 HEALTH STATUS AND ROLE OF DISTRICT

LokLF; foHkkx] vkjckn

dk; Øe		2006&07	2007&08	2008&09(uoEcj 08 rd½	dy ; ks
ifjokj dY; k.k dk; Øe	ul cUnh	21	152	7	180
	cd; kdj.k	6172	9801	2117	18090
	yi kkdki d	0	5	0	5
	dkij Vh	2164	2115	1134	5413
	fujkk	244259	243906	89737	577902
	vkjy fiYl ¼ qt l ½	18670	4842	4814	28326
	l h0 l h0 ; qt l l	7654	11756	5904	25314
fu; fer ifrj{k.k	ikfy; ks	57528	56818	33705	148051
	Mh0 i h0 Vh0	57467	57356	28289	143112
	Vh0 Vh0 xHkbrh efgyk	26501	29179	21505	77185
	Vh0 Vh0 10 o"kz cPps	6743	2143	1231	10117
	Vh0 Vh0 16 o"kz cPps	5000	2033	644	7677
	Mh0 Vh0 5 o"kz cPps	10101	3272	1060	14433
	feftYl	8452	51683	37277	97412
	ch0 l h0 th0	57552	59101	33388	150041
	foVkfue ,	43134	43589	32082	118805
iyI ikfy; ks jkmM	56372	58510	37578	152460	
vr xz uotkr f'k'kq/ka dh l q; k ftUgs nok fiyk; h x; h					

tuuh dly I j {kk ; kst uk	I hFKkr id o	17372	26757	20556	64685
; {ek %/10 ch0½	ckg; jkfx; ks dh [kkst	3124	2737	2764	8625
	cyxe tkp	2096	1818	1623	5537
	u; s; {ek jkfx; ka dh [kkst	1279	1291	1332	3902
	jks eä	225	239	495	959
	dly jkfx; ka dh I ä; k %/10 % fpdfRI k i kjkk djus okys I fgr½	1009	1291	1332	3632
eyfj; k	jä I xg	743	6452	6733	13928
	jä tkp	743	6452	6733	13928
	?kukRed jkfx; ka dh I ä; k	60	312	219	591
	mi pkj	60	312	219	591
	LoLF; jksch	60	312	219	591
dñB	[kkst s x; s dñB jkfx; ka dh I ä; k	506	497	332	1335
	fpdfRI k ea yk; s x; s dñB jkfx; ka dh I ä; k	506	497	332	1335
	fpdfRI k lk' pkr jks eä fd; s x; s jkfx; ka dh I ä; k	495	490	301	1286
vñki u	Cataract Operation Done	1972	3033	383	5388
	No. of teachers trained in screening for refractive errors	150	708	163	1021
	No. of School going children screened	7833	11951	16241	36025
	No. of schools going children detected with refractive errors	369	433	361	1163

	No. of Schools going children provided free glasses	0	62	121	183
M4	Counseling	*****	*****	1826	1826
	Testing	*****	*****	1494	1494
	Reactive	*****	*****	30	30
v'kk	y{;	*****	*****	1969	1969
	p; fur	*****	*****	1761	1761
	if'kf{kr	*****	*****	1567	1567
v'kkjHkr I j'puk	<p>36 LokLF; mi dlnka dk mRdæ.k dk dk; Z py jgk gA</p> <p>11 i kFked LokLF; dlnka ds mRdæ.k , oa fuekZk dk; Z I a UUK gks ppk gA</p> <p>I nj vLirky] vkj'akckn ifl j ea Mk; XukfLVd I wj] vki krdkyhu d{k , oa vkbD I hO ; D Hkou ds fuekZk dk; Z py jgk gA</p>				
I keW;	<p>ejhtka ds cgrj pfdRI k grq vko'; drkuq kj eksr; kfcln vkwj'sku] ifjokj dY; k.k vkwj'sku , oa vU; 'kY; dk; ka grq vk/kfud mi dj.kka dh I fo/kk mi yC/k gA CYKM cfd] jDr tkp dlnj , DI js , oa i fksyksth dh I fo/kk Hkh vLirky ifl j ea gh I Lrs nj ij mi yC/k gA I kFk gh] I jdkj }kjk mi yC/k dj; s x; s nokvka dk eQr forj.k fd; k tk jgk gA</p>				

Table . DENOTING PRIORITY AREAS IN EACH OF THE BLOCK

Block	Hard to Reach area
Daudnagar	Chauri, Belwan
Obra	Pauthu
Goh	Several Villages

2.3.2 PUBLIC HEALTH CARE DELIVERY SYSTEM: ORGANISATIONAL STRUCTURE AND INFRASTRUCTURE

HEALTH CARE INSTITUTIONS IN THE DISTRICT

S.No.	Type of Institutions	Number
1	District Hospital	1
2	Sub-divisional Hospital	1 (Under Process)
2	Referral	3
3	Block PHCs	11
4	APHCs	22
5	Sub-centres	207
6	Anganwadi Centres	2004

2.3.3 HUMAN RESOURCE

CATEGORY	POSTS SANCTIONED	IN POSITION	VACANT
Chief medical officer	1	1	0
Total medical officers	174	68	106
Doctors on Contract	49	35	14
Dental Doctor	12	5	7
Clerk	96	81	15
Computer	11	8	3
Nurse Grade A	22+128 (C)	8+30	14+98
LHV	23	16	7
ANM	340+23 +285 (C)	306+20+83	34+3 +202
Stat. Clerk	3	2	1
Steno	2	1	1
Block Ext. Educator	11	1	10
Health Educator	55	37	18
Health Supervisor	11	0	11
BHW	34	26	8
Family Planning Worker	33	22	11
Pharmacist	72	22	50
Dresser	71	16	55
Lab Tech.	76	2	74
Health Worker	33	7	26
Driver	25	18	7
4 th Grade	301	221	80

CATEGORY	POSTS SANCTIONED	IN POSITION	VACANT
Specialist Cholera	8	4	4
Cholera Supervisor	2	0	2
Vaccinator	17	4	13
Trained Dai	1	1	0
BC Tech.	6	2	4
X-Ray Tech	1	1	0
Dispenser	1	1	0
Malaria Supervisor	4	2	2
BHW (Malaria)	36	3	33
Regional Worker	2	0	2
Motor Mechanic	2	0	2
OT Asstt.	3	0	3
Eye Asstt.	5	5	0
BHS (Malaria)	11	1	10
Medical Social Worker	10	4	6
Non-Medical Asstt.	61	14	47
Health Manager	11	7	4
Accountant	11	9	2
District Programme Manager	1	0	1
District Account Manager	1	1	0
District Nodal M& E Officer	1	1	0

(Source : DHS)

2.3.4 BED AVAILABILITY

Name of Block	Population	Institution	Number of beds*
Aurangabad	264,406	DH	105
Kutumba	212,777	Ref	30
Nabinagar	289,778	Ref+ PHC	30+6
Haspura	149,711	Ref+PHC	30+6
Daudnagar	199,011	PHC	10
Deo	167,752	PHC	6
Rafiganj	285,888	PHC	6
Madanpur	197,527	PHC	6
Barun	191,991	PHC	6
Obra	212,988	PHC	6
Goh	219,917	PHC	6
Total	2391746	-	253

(Source : DHS)

2.3.5 BASIC FACILITIES AT RURAL INSTITUTIONS

Facility Appraisal Of The Health Institutions

Amenities	BPHCs	APHCs	Sub-centres
	Number	Number	Number
Total no of institutions	11	58	207
<i>Building</i>			
Rented		45	139
Government-owned	11	13	70
Residential Accommodation	11	10	38
<i>Electric Connection</i>	11	8	42
<i>Water Connection</i>	11	0	0
<i>Sanitary Latrine</i>	11	2	38

<i>Amenities</i>	<i>CHCs/Referral</i>	<i>PHCs</i>	<i>Sub-centres</i>
	<i>Number</i>	<i>Number</i>	<i>Number</i>
<i>Waste Disposal</i>	3	11	0
<i>Telephone Facility</i>	3	11	0
<i>X ray facility</i>	0	3	0
<i>Blood storage facility</i>	0	1	0
<i>Laboratory testing facility</i>	2	5	0
<i>Ambulance for referral</i>	3	10	0
<i>OT Facility</i>	2	10	0

(Source : DHS-Facility Survey)

2.3.7 DISTRICT HOSPITAL

Availability of basic facilities at the district hospital,

Availability of selected facilities

Tap water facility

Over head tank and pump

Electricity line in all parts

Generator

Telephone

Vehicles

Sewerage

Incinerator

Clean OPD

Clean OT

Clean toilets

Clean premises

Response

Yes

Yes

Yes

Yes

Yes

Yes

No

No

No

Yes

Yes

No

(Source : Sadar Hospital)

Chapter 3

Situation Analysis

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

3.1.1. GAPS IN INFRASTRUCTURE:



Introduction:

Health Sub Centre is very important part of entire Health System. It is first available Health facility nearby for the people in rural areas.

Comparison of present scenario with IPHS

IPHS Norms:

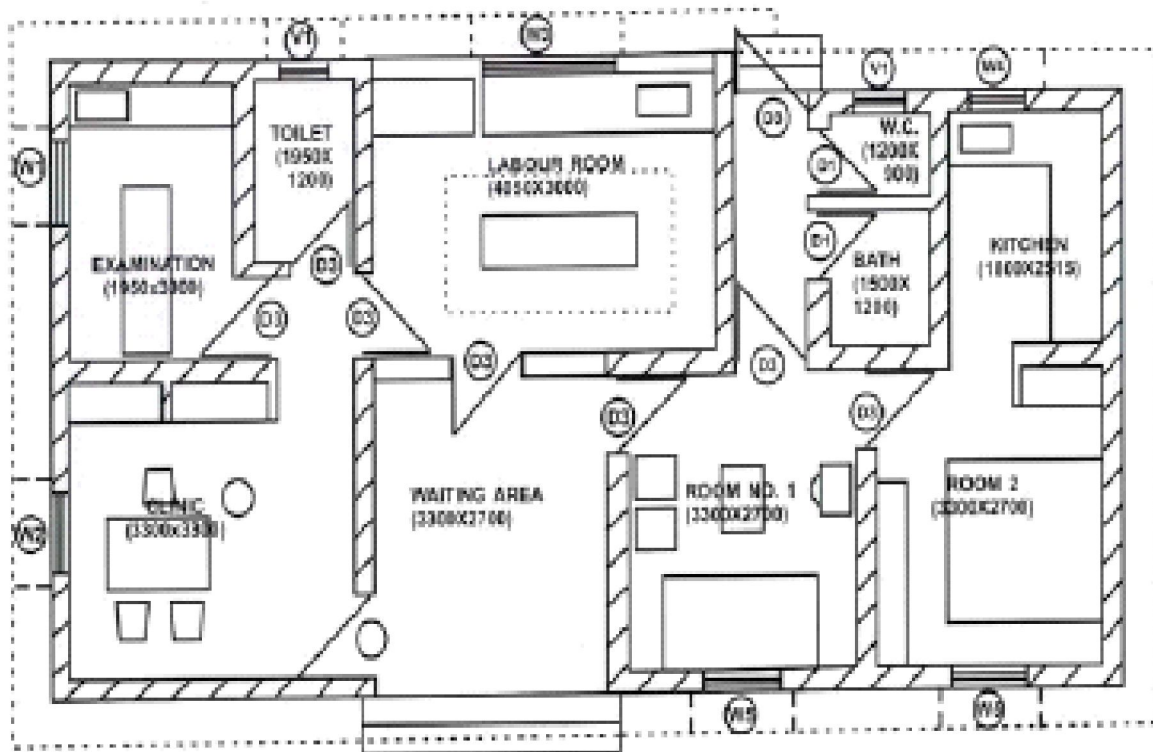
A sub centre should have its own building . If that is not possible immediately, the premises with adequate space should be rented in a central location with with easy access to population.

- i. Location of the centre: The location of the centre should be chosen that:
 - a. It is not too close to an existing sub centre/ PHC
 - b. As far as possible no person has to be travel more than 3 Km to reach the Sub centre
 - c. The Sub Centre Village has some communication network (Road communication/Public Transport/Post Office/Telephone)
 - d. Accommodation for the ANM/Male Health Worker will be available on rent in the village if necessary.

For selection of village under the Sub Centre, approval of Panchayats as may be considered appropriate is to be obtained.

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

Typical Layout of Sub- Centre with ANM Residence



Total Area of Sub Centre : 73.50 Sq. Metre

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

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

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

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

Health Sub Centers: Total population of the district after considering 2.5% growth rate of the total population it comes around 2389438. After considering projected population in 2008, the district needs altogether 479 HSCs to cater its whole population. At present Aurangabad has 207 established Health Sub Centers, 77 more Health sub centers are proposed to be formed in coming two years. As per the IPHS norms (5000 population in plain

area) the district still requires 195 new HSCs to be formed. Again , out of 207 established HSCs, only 70 have their own buildings and rest 139 run in rented houses. Among these 41 HSCs need renovation work. Almost HSCs need resources like Human resource, equipments, drugs, furniture etc..

Health Facilities in the District

Health Sub Centres

S.No.	Block Name	Population	Sub-centres required	Sub-centers Present	Sub-centers proposed	Further sub-centers required	Status of building		Availability of Land (Y/N)	
							Own	Rented	Y	N
1	Aurangabad	264,406	53	19	13	21	7	12	12	7
2	Kutumba	212,777	43	26	6	11	1	25	5	21
3	Nabinagar	289,778	58	23	8	27	5	18	5	18
4	Obra	212,988	43	17	6	20	6	11	7	10
5	Goh	219,917	44	21	7	16	2	19	2	19
6	Deo	167,752	34	18	6	10	5	13	5	13
7	Rafiganj	285,888	57	20	6	31	6	14	7	13
8	Madanpur	197,527	39	14	7	18	9	5	9	5
9	Barun	191,991	38	19	6	13	12	7	12	7
10	Haspura	149,711	30	16	4	10	7	11	13	3
11	Daudnagar	199,011	40	14	8	18	10	4	10	4
	Total	2,391,746	479	207	77	195	70	139	87	120

(Source : DHS)

Health Sub Centers:

Sub Heads	Gaps	Issues	Strategy	Activities
Infrastructure	The district still needs 195 more HSCs to be formed.	<ul style="list-style-type: none"> • Land availability for new construction • Lack of community ownership 	Construction of HSC and to make it functional.	<ul style="list-style-type: none"> • Preparation of PHC wise priority list of HSCs according to IPHS population and location norms of HSCs. • Community mobilization for promoting land donations at accessible locations. • Construction of New HSC buildings
	Out of 207 HSCs only 70 have their own building, but existing 41 buildings are not properly maintained	Lack of facilities/ basic amenities in the constructed buildings	Strengthening of Infrastructure and operationalisation of construction works	<ul style="list-style-type: none"> • Renovation of HSCs • Purchase of Furniture • Prioritizing the equipment list according to service delivery • Purchase of equipments • Printing of formats and purchase of stationeries
	Out of 207 HSCs only 139 run into rented building, but they aren't in proper condition.	Non payment of rent	Timely Payment	<ul style="list-style-type: none"> • Estimation of backlog rent and facilitate the backlog payment within short period. • Streamlining the payment of rent through untied fund.

Services of HSCs: need assessment. Besides the above the government implements several national health and family welfare programs which again are delivered through these frontline workers.

Sub Heads	Gaps	Issues	Strategy	Activities
Service performance	Unutilised untied fund at HSC level	Operationalization of Untied fund.	Capacity building of account holder of untied fund	<ul style="list-style-type: none"> • Training of signatories on operating Untied fund account, book keeping etc • Timely disbursement of untied fund for HSCs • Depute a person at PHC level for managing accounts

	No institutional delivery at HSC level	Improvement in quality of services like ANC, NC and PNC, Immunization,	Phase wise strengthening of HSCs for Institutional delivery and fix a day for ANC as per IPHS norms.	<ul style="list-style-type: none"> • Strengthening one HSC per PHC for institutional delivery in first quarter. • Depute an ANM at least once in a week
	HSC staffs not reside at place of posting.	<ul style="list-style-type: none"> • Improvement in the quality of HSC. • Problem of mobility during rainy season. 	To Make HSCs residable for everyone	<ul style="list-style-type: none"> • With the help of PWD & administration, the place of HSCs should be made safe and be convenient to move there
	Lack of disease control Program	Awareness to people residing in that HSC.	Implementation of disease control programs through HSC level	<ul style="list-style-type: none"> • Monthly Video shows at public places and in all schools of the concerned HSC area on health, nutrition and sanitation issues. • Strengthening ANMs for community based planning of all national disease control program • Reporting of disease control activities through ANMs. • Submission of reports of national programs by the supervisors duly signed by the respective ANMs

Facility(HR)

Sub Heads	Gaps	Issues	Strategy	Activities
Human Resource	Lack of adequate number of staffs	Posting of required staff	Staff recruitment	<ul style="list-style-type: none"> • Recruiting Staff • Volunteers may be used for this after providing them proper training
	Lack of trained Staff	Training of Staff required	Capacity building	<ul style="list-style-type: none"> • Deployment of required trainers • Hiring trainers as per need • Preparation of annual training calendar issue wise as per guideline of Govt of India. • Allocation of fund and operationalization of allocated fund.

Drug Kit Availability

Sub Heads	Gaps	Issues	Strategy	Activities
Drug kit availability	No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DEC)s)and contraceptives,	Indenting	Strengthening of reporting process and indenting through form 2 and 6 and delegating the purchase power from District to PHC level.	Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports
	2) Irregular supply of drugs	Logistics	<ul style="list-style-type: none"> • Couriers for vaccine and other drugs supply • Phase wise strengthening of APHCs for vaccine / drugs storage 	<ul style="list-style-type: none"> • Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map • Hiring vehicles for supply of drug kits through untied fund. • Hiring of couriers as per

				<p>need</p> <ul style="list-style-type: none">• Payment of courier through ANMs account• Purchasing of cold chain equipments as per IPHS norms• Training of concerned staffs on cold chain maintenance and drug storage
--	--	--	--	---

APHC

Introduction:

Addition Primary Health Centre is second important part of Health System. The objectives for Add PHC are:

- i. To provide comprehensive primary health care to the community through the Add PHC.
- ii. To achieve and maintain an acceptable standard of quality of care.
- iii. To make the services more responsive and sensitive to the needs of the community.

Current Scenario of Aurangabad District

There are 58 APHCs functioning in the district and 06 more are proposed to be established.

Additional Primary Health Centers (APHCs)										
S.No.	Block Name	Population	APHCs required (After including PHCs)	APHCs Present	APHCs Proposed	APHCs required	Status of building		Availability of Land (Y/N)	
							Own	Rented	Y	N
1	Aurangabad	264,406	9	5	1	3	1	4	1	4
2	Kutumba	212,777	8	8	0	0	3	5	3	5
3	Nabinagar	289,778	10	8	1	1	2	6	2	6
4	Obra	212,988	7	5	0	2	2	3	2	3
5	Goh	219,917	7	5	0	2	0	5	0	5
6	Deo	167,752	6	6	0	0	1	5	1	5
7	Rafiganj	285,888	9	5	1	3	1	4	1	4
8	Madanpur	197,527	6	5	0	1	1	4	1	4
9	Barun	191,991	6	5	0	1	1	4	1	4
10	Haspura	149,711	5	3	1	1	1	2	2	1
11	Daudnagar	199,011	7	3	2	2	0	3	0	3
	Total	2,391,746	80	58	6	16	13	45	14	44

Additional Primary Health Centre:

Sub Heads	Gaps	Issues	Strategy	Activities
Infrastructure	The district still needs 16 more APHCs to be formed.	<ul style="list-style-type: none"> • Land availability for new construction • Lack of community ownership 	Construction of APHCs and to make it functional.	<ul style="list-style-type: none"> • Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs. • Community mobilization for promoting land donations at accessible locations. • Construction of New APHC's buildings
	Out of 58 APHCs only 13 have their own building, but existing 8 buildings are not properly maintained	Lack of facilities/ basic amenities in the constructed buildings	Strengthening of Infrastructure and operationalisation of construction works	<ul style="list-style-type: none"> • Renovation of APHCs • Purchase of Furniture • Prioritizing the equipment list according to service delivery • Purchase of equipments • Printing of formats and purchase of stationeries
	Out of 58 APHCs only 45 run into rented building, but they aren't in proper condition.	Non payment of rent	Timely Payment	<ul style="list-style-type: none"> • Estimation of backlog rent and facilitate the backlog payment within short period. • Streamlining the payment of rent through untied fund.

Human Resources

Sub Heads	Gaps	Issues	Strategy	Activities
Human Resources	Lack of adequate number of staffs	Posting of required staff	Staff recruitment	<ul style="list-style-type: none"> • Recruiting Staff • Volunteers may be used for this after providing them proper training

	Lack of trained Staff	Training of Staff required	Capacity building	<ul style="list-style-type: none"> • Deployment of required trainers • Hiring trainers as per need • Preparation of annual training calendar issue wise as per guideline of Govt of India. • Allocation of fund and operationalization of allocated fund.
--	-----------------------	----------------------------	-------------------	---

Sub Heads	Gaps	Issues	Strategy	Activities
Service performance	Unutilised untied fund at APHC level	Operationalization of Untied fund.	Capacity building of account holder of untied fund	<ul style="list-style-type: none"> • Training of signatories on operating Untied fund account, book keeping etc • Timely disbursement of untied fund for APHCs • Depute a person at PHC level for managing accounts
	No institutional delivery at APHC level	Improvement in quality of services like ANC, NC and PNC, Immunization,	Phase wise strengthening of APHCs for Institutional delivery and fix a day for ANC like RI as per IPHS norms.	<ul style="list-style-type: none"> • Strengthening one APHC per PHC for institutional delivery in first quarter. • Depute an ANM at least once in a week
	Almost APHC staffs not reside at place of posting.	<ul style="list-style-type: none"> • Improvement in the quality of APHC. • Problem of mobility during rainy season. 	To Make APHCs residable for everyone	<ul style="list-style-type: none"> • With the help of PWD & administration, the place of APHCs should be made safe and be convenient to move there
	Lack of disease control Program	Awareness to people residing in that APHC.	Implementation of disease control programs upto APHC level	<ul style="list-style-type: none"> • Monthly Video shows at public places and in all schools of the concerned APHC area on health, nutrition and sanitation issues. • Strengthening ANMs for community based

				planning of all national disease control program <ul style="list-style-type: none"> • Reporting of disease control activities through ANMs. • Submission of reports of national programs by the supervisors duly signed by the respective ANMs
--	--	--	--	--

Drug Kit availability

Sub Heads	Gaps	Issues	Strategy	Activities
Drug kit availability	No drug kit as such for the APHCs as per IPHS norms.(Kit A, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DEC)s)and contraceptives,	Indenting	Strengthening of reporting process and indenting through form 2 and 6 and delegating the purchase power from District to PHC level.	Weekly meeting of APHC staffs at PHC for promoting APHC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports

<p>Service performance</p>	<p>2) Irregular supply of drugs</p>	<p>Logistics</p>	<ul style="list-style-type: none"> • Couriers for vaccine and other drugs supply • Phase wise strengthening of APHCs for vaccine / drugs storage 	<ul style="list-style-type: none"> • Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map • Hiring vehicles for supply of drug kits through untied fund. • Hiring of couriers as per need • Payment of courier through ANMs account • Purchasing of cold chain equipments as per IPHS norms • Training of concerned staffs on cold chain maintenance and drug storage
-----------------------------------	-------------------------------------	------------------	--	--

BPHC

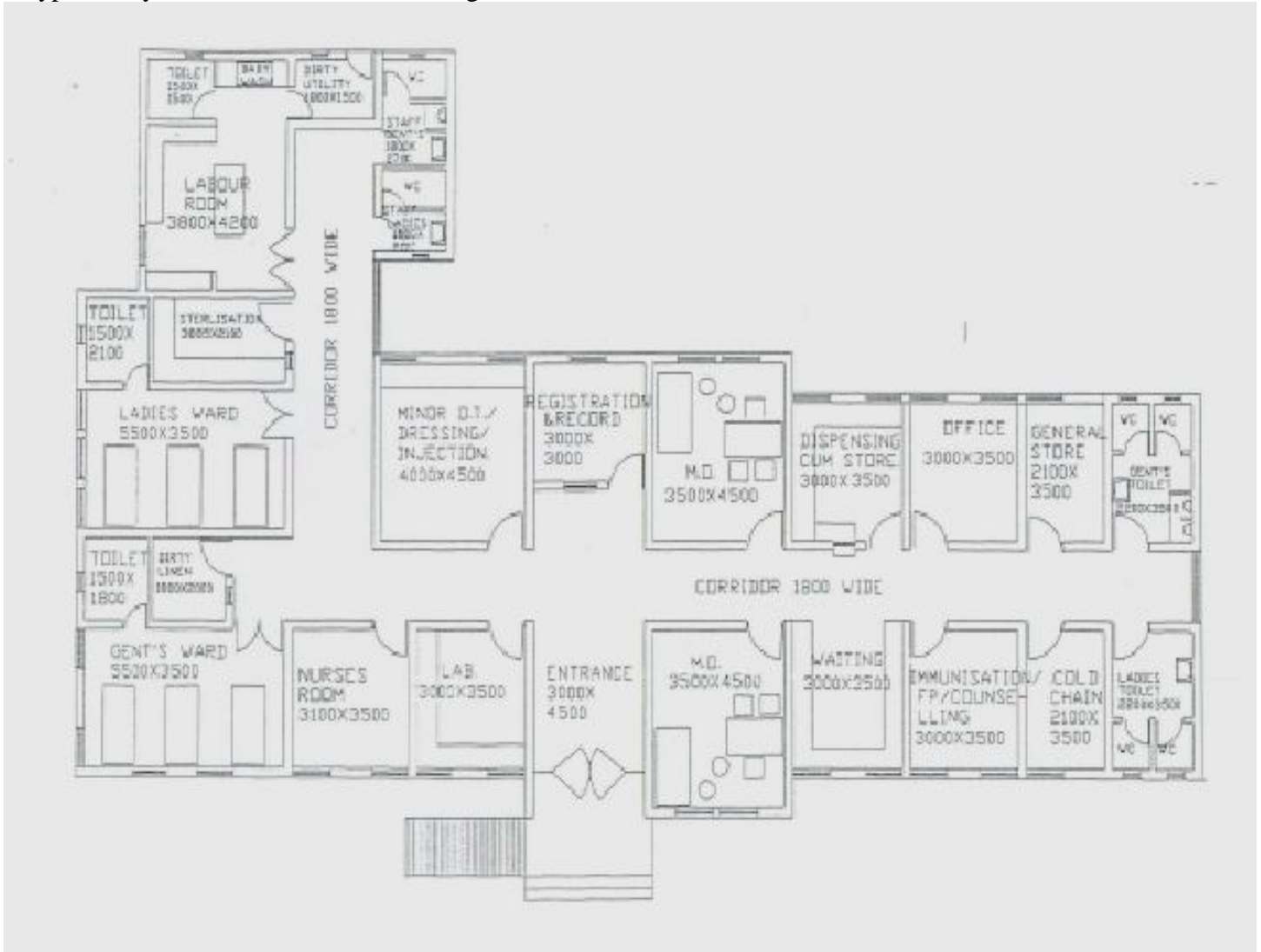
Introduction:

Block Primary Health Centre is an important part of Health System in the present scenario of health system in Bihar.

Primary Health Centres/ Referral Hospital/Sub-Divisional Hospital/District Hospital : Infrastructure

Sl. No.	Block Name	PHC/Referral Hospital/S DH/DH Name	Building Ownership (Govt./pan/Rent)	Building condition (+++/+++/#)	Assured running water supply (A/NA/I)	Continuous Power supply (A/NA/I)	Toilets (A/NA/I)	Functional Labour room (A/NA)	Condition of Labour room (+++/+++/+/#)	No. of rooms	No. of beds	Functional OT (A/NA)	Condition of Ward (+++/+++/+/#)	Condition of OT (+++/+++/+/#)
1	Obra	PHC	Govt	+++	A	A	A	A	#	11	6	A	++	#
2	Goh	PHC	Govt	++	A	A	A	A	#	6	6	NA	++	#
3	Deo	PHC	Govt	++	A	A	A	A	#	14	6	A	++	++
4	Rafiganj	PHC	Govt	+++	A	A	A	A	+++	5	6	A	+++	+++
5	Madanpur	PHC	Govt	++	A	A	A	A	#	10	6	A	++	++
6	Barun	PHC	Govt	++	A	I	A	A	++	10	6	A	++	++
7	Daudnagar	PHC	Govt	++	NA	A	A	A	++	15	10	A	+	+++
8	Aurangabad	PHC	PHC not functional											
		DH	Govt.	++	+++	++	A	A	+	89	105	A	+	+
9	Haspura	PHC	Govt	++	A	I	A	A	#	4	6	A	#	#
		Referral	Govt	#	I	I	A	A	#	25	30	A	#	#
10	Kulumba	PHC	Govt	#	NA	NA	NA	NA	NA	3	0	NA	#	#
		Referral	Govt	+++	NA	A	A	A	+	24	30	A	++	++
11	Nabinagar	PHC	Govt	+++	NA	I	NA	A	+++	8	6	A	+++	+++
		Referral	Govt	+++	A	NA	A	A	+++	28	30	A	+++	+++

A typical Layout of PHC/BPHC according to IPHS norms:



Current Scenario Of Aurangabad District

At present, there are 11 BPHCs/PHCs in the District. One PHC namely Sadar Block, Aurangabad is situated nearby the District Hospital, and therefore there is no Outdoor-facility in that. However, it is to be shifted in an APHC in near future as per instruction of the SHSB, Patna.

Note : In context of Bihar, CHC is treated as BPHC/PHC.

Block Primary Health Centers:(30 beded)		[CHC as per IPHC]		
Indicators	Gaps	Issues	Strategy	Activities
Infrastructure	<p>As per IPHS norms, on the population of 120000, there should be one 30 beded BPHC / CHC. Aurangabad has a population of 24 lacs, therefore it is needed 20 BPHCs. But there are 11 functioning PHC. Rests are required to be formed.</p> <p>All 11 PHCs are having own building 10 PHCs are running with only six bed facility.</p> <p>Delivery : At present only 10 PHCs are conducting delivery at an average of 08-10 delivery per day.</p> <p>Family Planning All 11 PHC's are conducting at an average of 3 Family Planning Operation per day.</p>	<p>Available facilities are not compatible with the services supposed to be delivered at PHCs.</p> <p>Quality of services</p> <p>Community participation.</p>	<p>Up gradation of PHCs into 30 bedded facilities.</p> <p>ISO certification of selected PHCs in the district.</p> <p>Strengthening of BPMU</p> <p>Ensuring community participation.</p>	<p>1.Need based (Service delivery) 2. Estimation of cost for up gradation of PHCs 3. Preparation of priority list of interventions to deliver services.</p> <p>1. Selection of any two PHCs for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail.</p> <p>1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers in rest of the vacant place & Accountants in all institutions. 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities.</p> <p>1.Meeting with community</p>

	<p>OPD per day an average is 200 in each PHC.</p> <p>This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms</p> <p>The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement.</p> <p>Lack of equipments as per IPHS norms and also underutilized equipments.</p> <p>Lack of appropriate furniture</p> <p>Non availability of HMIS formats/registers and stationeries</p> <p>Operation of RKS: Lack in uniform process of RKS operation.</p> <p>Lack of community</p>		<p>Strengthening of Infrastructure and operationalization of construction works</p>	<p>representatives on erecting boundary, beautification etc,</p> <p>2. Nukkad Nataks on Citizen's charter of HSCs as per IPHS</p> <p>1.1 Monthly meetings of VHSCs, Mothers committees</p> <p>3A.Strengtheing of HSCs having own buildings</p> <p>A.1 Renovation of HSCs</p> <p>A.2 Purchase of Furniture</p> <p>A.3 Prioritizing the equipment list according to service delivery</p> <p>A.4 Purchase of equipments</p> <p>A.5 Printing of formats and purchase of stationeries</p> <p>3B. Strengthening of HSCs running in rented buildings.</p> <p>B1. Estimation of backlog rent and facilitate the backlog payment within two months</p> <p>B2. Streamlining the payment of rent through untied fund from the month of April 09.</p> <p>B3.Purchase of Furniture as per need</p> <p>B4 Prioritizing the equipment list according to service delivery</p> <p>B5 Purchase of equipments as per need</p> <p>B6 Printing of formats and purchase of stationeries</p> <p>3C. Construction of new HSCs</p> <p>C1. Preparation of PHC wise priority list of HSCs according to IPHS</p>
--	---	--	---	--

	<p>participation in the functioning of RKS. Lack of facilities/basic amenities in the PHC buildings</p>		<p>Monitoring</p>	<p>population and location norms of HSCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings. 4 biannual facility survey of HSCs through local NGOs as per IPHS format 4.1 Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.</p>
<p>Human Resource</p>	<p>Doctors : Existing 11 PHC district have 44 sanctioned post of specialist Doctors & 11 General Doctors. Out of which only 6 Specialist and 95 General Doctors are working. And</p>	<p>Filling up the staff shortage. Untrained staffs</p>	<p>Staff recruitment Capacity building Strengthening of</p>	<p>Selection and recruitment of ANMs Selection and recruitment of male workers Training need Assessment of HSC level staffs Training of staffs on various services</p>

	<p>in respect of 49 contractual doctors appointment only 35 are working.</p> <p>Grade A Nurse : Out of 128 sanctioned post only 20 are working.</p> <p>ANM :- Out of 126 sanctioned post only 97 are working.</p> <p>Lab Technician :- Out of 18 sanctioned post only 1 are working.</p> <p>Pharmacist :- Out of 36 sanctioned post only 9 are working.</p> <p>Block Extension Educator :- Out of 18 sanctioned post only 5 are working.</p> <p>Health Educator :- Out of 16 sanctioned post only 5 are working.</p> <p>L.H.V :- Out of 30 sanctioned post only 23 are working.</p> <p>Out of 18 BHM & Accountant only 11 BHMs are placed at present.</p>		ANM training school	<p>Analyzing gaps with training school</p> <p>Deployment of required staffs/trainers</p> <p>Hiring of trainers as per need</p> <p>Preparation of annual training calendar issue wise as per guideline of Govt of India.</p> <p>Allocation of fund and operationalization of allocated fund</p>
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time.	<p>Indenting</p> <p>Logistics</p>	Strengthening of reporting process and indenting through form 7	

	<p>A few essential drugs are rate contracted at state level .</p> <p>Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.</p>	<p>Operationalization</p>	<p>Strengthening of drug logistic system</p> <p>Phase wise strengthening of APHCs for vaccine / drugs storage</p>	<ol style="list-style-type: none"> 1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all PHCs 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
<p>Service performance</p>	<ol style="list-style-type: none"> 1.Excessive load on PHC in delivering all services i.e. 10 delivery per day, Family Planning operation/emergency operation and 125 OPD per day in each PHC. Lack of counseling services Problem of mobility during rainy season Lack of convergence 	<p>Operationalization of Untied fund.</p> <p>Improvement in quality of services like ANC, NC and PNC, Immunization,</p> <p>Family Planning services</p> <p>Convergence</p>	<p>Capacity building of account holder of untied fund</p> <p>Phase wise strengthening of 30 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms.</p> <p>Implementation of disease control programs through HSC level</p>	<ol style="list-style-type: none"> 1. Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts at HSCs untied fund 1 Gap identification of 30 HSCs through facility survey 2.strengthening one HSC per PHC for institutional delivery in first quarter 3.Owning first delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program

			Community focused Family Planning services	<p>3. Reporting of disease control activities through ANMs</p> <p>4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.</p> <p>1. Eligible Couple Survey</p> <p>2. Ensuring supply of contraceptives with three month's buffer stock at HSCs.</p> <p>3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS</p> <p>4. Training of ANMs on IUD insertion</p> <p>1. Fixed Saturday for meeting day of ANM, AWW, ASHA, with VHSCs rotation wise at all villages of the respective HSC.</p> <p>2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues</p>
Operational				

S.No	Indicators	Present Status (08-09)	% Availability	Availability as per DLHS 3	%age Availability
1	PHC having Residential Quarter for Medical Officer	11 (Repairable)	90.00	9	50.00
2	PHC having separate Labour Room	15	83.33	11	61.00
3	PHC having Personal Computer	18	100	1	05.60
4	PHC having Normal Delivery Kit	16	88.9	10	55.50
5	PHC having Large Deep Freezer	6	33.33	4	22.22
6	PHC having regular water supply	14	80.00	12	66.70
7	PHC having Neonatal Warmer (Incubator)	0	0	0	0.00
8	PHC having Operation Theater with Boyles Apparatus	4	22.22	2	11.00

9	PHC having Operation Theater with anaesthetic medicine	6	33.33	4	22.20
---	--	---	-------	---	-------

Sub divisional / Referral Hospital
This is Under Construction in Daudnagar.

District Hospital
The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of the people of the district. The specific objectives of IPHS for DHs are:

To provide comprehensive secondary health care (specialist and referral services) to the community through the District Hospital.

To achieve and maintain an acceptable standard of quality of care.

To make the services more responsive and sensitive to the needs of the people of the district and the hospitals/centers from which the cases are referred to the district hospitals

Indicators	Gaps	Issues	Strategy	Activities
Infrastructure	<p>1) Size of Hospital: Number of beds is 89 which are far less than the requirement. Standard is 500 beds.</p> <p>2) Building and Space Requirement: Poor building conditions need minor repairing Number and conditions of toilets are poor.</p> <p>3) Ambulatory Care Area (OPD): No general or subsidiary waiting space/ room for patients</p>	<p>To increase number of beds up to 500</p> <p>Repairing and Maintenance of Old Building</p> <p>New buildings for RCH, wards, diagnostic services, waiting space etc</p> <p>Need of new toilets</p> <p>Expantion of delivery wards to make it 60 bedded ward</p> <p>One ward of 30 beds for Family Planning Operation</p>	<p>Repairing of existing buildings and infrastructures</p> <p>Repairing of boundary wall</p> <p>Hand-over of buildings already completed</p> <p>Timely completion of work in progress</p> <p>Construction of new buildings needed</p> <p>One water tank</p> <p>One separate transformer for power supply</p> <p>Upgradation into 500 bedded facilities.</p>	<p>1.Need based (Service delivery)Estimation of cost for upgradation of Referral</p> <p>2.Preparation of priority list of interventions to deliver services.</p> <p>1.Selection of any two Referral for ISO certification in first phase.</p> <p>2. Sending the recommendation for the certification with existing services and facility detail.</p> <p>1. Ensuring regular monthly meeting of RKS.</p>

	<p>Diagnostic Services: No ultrasound, radio-diagnosis facility</p> <p>Clinical Laboratory: Outsourced</p> <p>Blood Bank: 4) Intermediate Care Area (Inpatient Nursing Units):</p> <p>5) Critical Care Area (Emergency Services):</p> <p>6) Therapeutic Services:</p> <p>Toilet condition poor Sanitation, waste disposal poor Physiotherapy: Need separate building</p> <p>7) Hospital Services: Hospital Kitchen: Central sterile and supply department: Hospital Laundry: Mortuary: Medicine and General Store</p> <p>8) Engineering and Services: Electric engineering: Generator and lighting Call Bells: Mechanical Engineering: AC, Room</p>	<p>New building for laundry, kitchen, mortuary etc</p> <p>Repairing of water tank. Installation of new tube wells (5 at least)</p> <p>New buildings for residential quarters and community hall.</p> <p>Not Functioning</p> <p>General Wards need Minor repair</p> <p>.</p> <p>Not independent of OPD</p> <p>OT: Not according to IPHS Delivery Suit Unit: No distinct antenatal and postnatal wards</p>	<p>Strengthening of BMU</p> <p>Community participation</p> <p>Strengthening of Infrastructure and operationalization of construction works</p> <p>Monitoring</p>	<p>2. Appointment of Block Health Managers, Accountants in institutions</p> <p>3. Training to the RKS signatories for account operation.</p> <p>4. Trainings of BHM and accountants on their responsibilities.</p> <p>1.Meeting with community representatives on erecting boundary, beautification etc, 2.Monthly meetings of DHS, RKS</p> <p>A.1 Renovation of buildings</p> <p>A.2 Purchase of Furniture</p> <p>A.3 Prioritizing the equipment list according to service delivery</p> <p>A.4 Purchase of equipments</p> <p>A.5 Printing of formats and purchase of stationeries</p> <p>3C. Construction of new buildings according to IPHS norms</p> <p>3.1 Monitoring of renovation/construction works through DHS/RKS members.</p>
--	---	--	--	---

	<p>Heating Public Health Engineering: Water Supply:</p> <p>Drinking Water: Drainage and Sanitation: Poor Waste disposal System: 9) Fire Protection: 10) Telephone and Intercom: Parking:</p> <p>Committee room:</p> <p>Residential Quarters:</p>	<p>Need new building</p> <p>Storage Condition is poor</p> <p>Continuous Water Supply – not continuous for 24 hours Not available. Dependent on tube well.</p> <p>No separate parking area</p>		<p>Need minor repairs Insufficient, more quarters are needed (7 for doctors, 6 for paramedical staffs)</p>
--	--	---	--	--

		No separate committee room		
Human Resource	<p>Doctors: Only 18 doctors. Sanctioned 23 Standard 77</p> <p>Paramedical: Only 28 Nurses. Sanctioned 37 Standard is 200-250</p> <p>No lab technician Sanctioned 1</p> <p>Pharmacist: Only 3 Sanctioned 6 Standard 10</p> <p>Dresser: Only 2 Sanctioned 4</p> <p>Other Staffs are also insufficient and not according to the norms of IPHS</p>	<p>Appointment of new Doctors and Paramedical Staffs</p> <p>Use of Contractual Staffs and Outsourcing for different services</p>	<p>Staff recruitment</p> <p>Capacity building</p> <p>Strengthening of ANM training school</p>	<p>Selection and recruitment of Doctors and Paramedical Staffs</p> <p>Selection and recruitment of ...male workers</p> <p>Training need</p> <p>Assessment of Dist. level staffs</p> <p>Training of staffs on various services</p> <p>Analyzing gaps with training school</p> <p>Deployment of required staffs/trainers</p> <p>Hiring of trainers as per need</p> <p>Preparation of annual training calendar issue wise as per guideline of Govt of India.</p> <p>Allocation of fund and operationalization of allocated fund</p>
Drug kit availability	<p>(A) Drugs</p> <p>1) OPD Drugs: Only 14 OPD Standard is 33</p> <p>2) IPD Drugs: Only 57 IPD Drugs Standard is 107</p> <p>(B) Equipments</p> <p>1) Imaging Equipments: No Dental X-ray Machine, No Ultra sonogram, No C.T. Scan</p> <p>2) X-Ray room accessories: Not according to IPHS</p>	<p>Indenting</p> <p>Logistics</p> <p>Operationalization</p>	<p>Strengthening of reporting process and indenting through form 8</p> <p>Strengthening of drug logistic system</p>	<p>1.training of store keepers on invoicing of drugs</p> <p>2.Implementing computerized invoice system in all Referral</p> <p>3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer</p>

	<p>3) Cardiac Equipment: ECG 1 Not according to IPHS</p> <p>4) Labour Ward & Neo Natal Equipments: Lacking weighing machines, baby incubators, phototherapy unit, etc as according to IPHS</p>			<p>stock)</p> <p>4. Enlisting of equipments for safe storage of drugs.</p> <p>5. Purchase of enlisted equipments.</p> <p>6. Ensuring the availability of drugs with store keeper.</p> <p>7. Orientation meetings on guidelines of RKS for operation.</p>
Service performance	<p>Blood Bank ECG Nonfunctioning of RKS</p> <p>6. Essential Services (Minimum Assured Services)</p> <p>Services include OPD, indoor, emergency services.</p> <p>Secondary level health care services regarding following specialties will be assured at hospital:</p> <p>Consultation services with following specialists:</p> <p>General Medicine General Surgery O&G services</p>	<p>Operationalization of Untied fund.</p> <p>Improvement in quality of services like ANC, NC and PNC, Immunization,</p> <p>Integration of disease control programs at Dist. level.</p> <p>Family Planning services</p>	<p>Capacity building of account holder of untied fund</p> <p>Community focused Family Planning services</p>	<p>It provides effective, affordable healthcare services (curative including specialist services, preventive and promotive) for a defined population, with their full participation and in co-operation with agencies in the district that have similar concern. It covers both urban population (district headquarter town) and the rural population in the district.</p> <p>2. Function as a secondary level referral centre for the public health institutions below the district level such as Sub-divisional Hospitals, Community Health Centres, Primary Health Centres and Sub-centres.</p> <p>3. Technical and administrative support and education and training for primary health care</p>

	<p>Paediatrics including Neonatology Emergency (Accident & other emergency) Critical care Anaesthesia Ophthalmology ENT Dermatology and Venerology (Skin & VD) RTI/STI Orthopaedics Radiology including ultrasonologist Radiotherapy Dental care Public Health Management Psychiatry Plastic Surgery Allergy Super Specialties Cardiology Cardio-thoracic Vascular Surgery Gastro-enterology Surgical Gastro- enterology Nephrology Urology Neurology Neurosurgery Oncology Endocrinology/Me tabolism Diagnostic and other Para clinical services regarding: Laboratory services Imaging services CT Scan services Sonography ECG EEG</p>			
--	---	--	--	--

	<p>Echocardiogram Endoscopy Angiography Echocardiography Pathology Physiotherapy Dental Technology (Dental Hygiene) Drugs and Pharmacy</p> <p>Ancillary and support services: Following ancillary services shall be ensured: Medico-legal /postmortem Ambulance services Dietary services Laundry services Security services Waste management Counseling services for domestic violence, gender violence, adolescents, etc. Gender and socially sensitive service delivery be assured. Ware housing/ central store Maintenance and repair Electric Supply (power generation and stabilization) Water supply (plumbing) Heating, ventilation and air- conditioning Transport</p>			<p>Outsourcing of services like laundry, ambulance, dietary, housekeeping and sanitation, waste disposal etc. to be arranged by hospital itself. Manpower and outsourcing work could be done through local tender mechanism</p>
--	--	--	--	--

	<p>Communication Medical Social Work Nursing Services Sterilization and Disinfection Horticulture (Landscaping) Lift and vertical transport Refrigeration Administrative services (i) Finance* (ii) Medical records (Provision should be made for computerized medical records with anti-virus facilities whereas alternate records should also be maintained) (iii) Procurement (iv) Personnel (v) Housekeeping and Sanitation (vi) Education and training (vii) Inventory Management Services under various National Health and Family Welfare Programmes Epidemic Control and Disaster Preparedness</p>			<p>Medical Superintendent to be authorized to incur and expenditure up to Rs.25.00 lakhs for repair/upgrading of impaired equipments/instruments with the approval of executive committee of RKS. Financial powers of Head of the Institution Financial accounting and auditing be carried out as per the rules along with timely submission of SOEs/UCs.</p> <p>No equipment/instruments should remain non- functional for more than 30 days. It will amount to suspension of status of IPHS of the concerned institutions for absence period.</p>
Operational				

5. TECHNICAL COMPONENTS

PART A: Maternal Health (RCH) II

1 Maternal Health

Improving the maternal health scenario by strengthening availability, accessibility and utilization of maternal health services in the state is one of the major goals of RCH. However, the current status of maternal health in the state clearly shows that the programme has not been able to significantly improve the health status of women. There are a host of issues that affect maternal health services in Bihar. The important ones are listed below.

- Paucity of skilled frontline health personnel (ANM, LHV) to provide timely and quality ANC and PNC services.
- The public health facilities providing obstetric and gynecological care at district and sub district levels are inadequate.
- Mis match in supply of essential items such as BP machines, weighing scales, safe delivery kits, Kit A and Kit B, etc and their demand.
- Shortage of gynaecologists and obstetricians to provide maternal health services in peripheral areas.
- Inadequate skilled birth attendants to assist in home-based deliveries
- Weak referral network for emergency medical and obstetric care services
- Lack of knowledge about antenatal, perinatal and post natal care among the community especially in rural areas.
- Low levels of female literacy
- High levels of prevalence of malnutrition (anaemia) among women in the reproductive age group.
- Poor communication because of bad roads and a law and order situation.

These issues have continued to impede maternal health services in the state. It has been envisaged that RCH I would improve the status of maternal health services, however, due to inadequate infrastructure, manpower and weak managerial systems maternal health care continues to be poor. Presently the maternal health services that are mainly available in the urban area of the State are being provided by the private sector.

2 Child Health

The child health indicators of the state reveals that the state's IMR is lower than the national average but the NMR is disproportionately high. Furthermore, the state is at the bottom in terms of immunisation coverage, both antigen-wise as well as full immunisation. Given this low level of immunisation, morbidity and mortality due to vaccine-preventable diseases continues to be significantly high. Similarly, child health care seeking practices in the case of common childhood diseases such as ARI and Diarrhoea are not satisfactory. Although at the state level, the child health scenario (except for immunisation) is comparatively better, the same for specific groups of children, such as those who live in rural areas, whose mothers are illiterate, who belong to Scheduled Castes, and who are from poor households is particularly appalling.

Issues affecting child health are not only confined to mere provision of health services for children, but other important factors such as maternal health and educational status, family planning practices and environmental sanitation and hygiene have enormous bearing on child health. This is more than evident in the case of Bihar where child health continues to suffer not only because of poor health services for children but due to issues such as significantly high maternal malnutrition, low levels of female literacy, early and continuous childbearing, etc. The specific issues affecting child health in the state are listed below.

Maternal Factors

- High levels of maternal malnutrition leading to increased risk pre-term and low -birth weight babies that in turn increase risk of child mortality.
- Low levels of female literacy, particularly in rural areas.

Family Planning Services

- The Family Planning programme has partially succeeded in delaying first birth and spacing births leading to significantly high mortality among children born to mothers under 20 years of age and to children born less than 24 months after a previous birth.

Child Health Services

- The programme has not succeeded fully in effectively promote chostrum feeding immediately after birth and exclusive breastfeeding despite almost universal breastfeeding practice in the state. In the State majority of mother brest feed children beyond six months.
- High levels of child malnutrition, particularly in rural areas and in children belonging to disadvantaged socioeconomic groups leading to a disproportionate increase in under five mortality.
- Persistently low levels of child immunisation primarily due to non-availability of time and quality immunisation services.
- Lack of child health facilities, both infrastructure and human resource, to provide curative services for common childhood ailments such as ARI, Diarrhea, etc.
- Inadequate supply of drugs, ORS packets, weighing scales, etc.
- Lack of knowledge of basic child health care practices among the community.
- Failure to generate community awareness regarding essential sanitation and hygiene practices that impact on the health of children. Since these factors are inter-linked and synergistic, any effort to improve the health of the children in the state needs to address child health issues in a holistic manner.

3 Family Planning

RCH emphasizes the target-free promotion of contraceptive use among eligible couples, the provision to couples of a choice of various contraceptive methods (including condoms, oral pills, IUDs and male and female sterilization), and the assurance of high quality care. It also encourages the spacing of births with at least three years between births. Despite RCH and previous programs vigorously pursuing family planning objectives, fertility in Bihar continues to decline at much lower rates than the national average. Although the total fertility rate has declined by about half a child in the six-year period between NFHS-1 and NFHS-2, it remains quite high and far from the replacement level. At current fertility levels, women in the state will have an average of 3.5 children each throughout their childbearing years. Furthermore, certain groups such as rural, illiterate, poor, and Muslim women within the population have even higher fertility than the average. The persistently high fertility levels point to the inherent weakness of the state's family planning programme. This failure is reflected in a dismal picture of women in Bihar marrying early, having their first child soon after marriage, and having two or three more children in close succession by the time they reach their late-20s. At that point, about one-third of women get sterilized. Very few women use modern spacing methods that could help them delay their first births and increase intervals between pregnancies. The major issues affecting the implementation of the Family Planning programme in Bihar are as follows.

- Lack of integration of the Family Planning programs with RCH, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels.
- Failure of the programme to effectively undertake measures to increase median age at marriage and first childbirth.
- Inability of the program to alter fertility preferences of eligible couples through effective behavior change communication (BCC).
- Lack of health facilities, both in terms of physical infrastructure and skilled human resources to deliver quality family planning services.
- Inability of the program to up-scale family planning services to cater the enhanced demand for family planning leading to significantly high level of unmet need.
- Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age groups. (Overall, sterilization

accounts for 82 percent of total contraceptive use. Use rates for the pill, IUD, and condoms remain very low, each at 1 percent or less).

- Continued use of mass media to promote family planning practices despite evidently low exposure to mass media in Bihar, leading to lower exposure of family planning messages in the community, particularly among rural and socio-economically disadvantaged groups.
- Weak public-private partnerships to promote and deliver family planning services.

These issues clearly indicate an urgent need to design and implement an effective family planning programme in the state. Such a programme would not only deliver benefits leading to limitation of population size, but also favorably impact the status of maternal and child health.

Adolescent Health

Adolescents, the segment of the population in the age group of 15 -19 years, constitute about 23% of the population of the state. This group is critical to the success of any reproductive and sexual health program, as it would remain in the reproductive age group for more than two decades. The health needs of this age group are different from that of the general population so there is a need for a tailor made public health programs to address the key issues related to adolescent health. However, in Bihar, this realization has not yet been translated into practice. This is evident from the fact that the existing RCH programme does not have separate planning of health services to address the specific needs of adolescents of the state. Ideally, a program for adolescent should promote reproductive care and hygiene practices, encourage delayed marriage and child bearing, educate young people about safe sex practices. In addition, the program should also sensitise young people about gender discrimination and sexual violence. Particular emphasis should be paid to strategies such as counselling and interpersonal and behaviour change communication. Moreover, such a program should also be designed in a manner that would sensitise health care providers about the unique health care needs of this group.

District / Sub-district Variations

Key indicators related to Maternal and Child Health (MCH) and Family Planning clearly show the poor status of RCH in Bihar. However, close examination of data reveals that there exist wide inter-district variations for almost all the key indicators. Listed below is the top five and lowest five performing districts for select key indicators. Data related to institutional delivery suggests that Aurangabad has the highest rate of institutional delivery of 43.7%, in year 2007-08 46 %

Health Facilities

Strengthening of Health Sub-Centers (HSCs)

Existing No. of HSCs 369

Construction of new HSCs 257

Primary Health Centers (PHCs)

There are 18 PHCs in the District, which is significantly less than the requirement as per the GoI norms.

Against the GoI norm of one PHC for population of about 30000, the State has one PHC for about 2 lakhs population. Add to this, the existing PHCs are also in bad shape and need elaborate refurbishment, repair and maintenance. To fill the big gap in number of PHCs the district has a network of 30 Additional PHCs. Now, to develop the PHC network as per the GoI guidelines and deliver the interventions planned under RCH II, the state will expand the existing PHC network with two pronged strategy i.e. upgrade all 30 APHCs to PHCs, construct new PHCs and refurbish repair and maintain the existing 18 PHCs based on facility survey recommendation.

Strengthening of Primary Health Centers (PHCs)

Existing PHCs 18

Upgrade all APHCs to PHCs

7.3.1.3. Health Personnel

For successful implementation of the planned interventions under RCH II, it is essential that the health facilities be adequately staffed. The data suggest that there are many vacant posts at different levels and with new planned facilities at Health Sub-centre, PHCs and FRUs levels, there will be requirement for more health staff. To address this increased need of health staff, the State plan to aggressively recruit health staff at all levels primarily on contract basis.

A-1. Strengthening of District Health Management	
Situation Analysis/ Current Status	The District Health Mission and Society have formed been registered in Aurangabad. There are 10 members with the District Collector as the Governing board President. The members are all the programme officers, Education, SDM, IMA president, ICDS, PWD. The Governing body meetings are held monthly under the chairmanship of the District Magistrate. Although the DHS formed and meetings conducted regularly but still they are not focused on health issues and need proper training on planning and management.
Objectives / Milestones/ Benchmarks	District Health Society to make functional and empower to plan, implement and monitor the progress of the health status and services in the district.
Strategies	Capacity building of the members of the District Health Mission and District Health Society regarding the programme, their role, various schemes and mechanisms for monitoring and regular reviews Establishing Monitoring mechanisms Provide ASHA as link workers to mobilize the community to strengthen health seeking behaviour and to promote proper utilization of health services.
Activities	Orientation Workshop of the members of the District health Mission and society on strategic management, financial management & GoI/GoH Guidelines. Issue based orientation in the monthly Review and planning meetings as per needs. Improving the Review and planning meetings through a holistic review of all the programmes under NRHM and proper planning. Formation of a monitoring Committee from all departments. Development of a Checklist for the Monitoring Committee. Arrangements for travel of the Monitoring Committee Sharing of the findings of the committee during the Field visits in each Review Meeting with follow-up of the recommendations.
Support required	Technical and financial assistance needs to be imparted for orientation and integration of societies. A GO should be taken out that at the district level each department should monitor the meetings closely and ensure follow-up of the recommendations. Instructions & directions from GoH for proper functioning of the societies and monitoring committee. Funds to maintain society office & staff.
Timeline	2009-10 1.Orientation Workshops of the members of the District Health Mission and District Health society

	<ol style="list-style-type: none"> 1. Issues based workshops will be organized. 2. Formation of the monitoring Committee and will start the monitoring visits. 3.Reorientation Workshops 4.Workshops as per need 5.Strengthening of the Monitoring Committee 	
Budget In Lakhs	Activity / Item	2009-10
	Orientation Workshop	0.5
	Issues based Workshops	3.1
	Mobility for Monitoring	0.5
	Salary	0.4
	Total	4.5

A- 2 District Programme Management	
Status	<p>In NRHM a large number of activities have been introduced with very definite outcomes. The cornerstone for smooth and successful implementation of NRHM depends on the management capacity of District Programme officials. The officials in the districts looking after various programmes are overworked and there is immense pressure on the personnel. There is also lack of capacities for planning, implementing and monitoring. The decisions are too centralized and there is little delegation of powers.</p> <p>In order to strengthen the district PMU, three skilled personnel i.e. Programme Manager, Accounts Manager and Data Assistant have being provided in each district. These personnel are there for providing the basic support for programme implementation and monitoring at district level.</p> <p>The District Programme Manager is responsible for all programmes and projects in district and the District Accounts Manager (DAM) is responsible for the finance and accounting function of District RCH Society including grants received from the state society and donors, disbursement of funds to the implementing agencies, preparation of submission of monthly/quarterly/annual SoE, ensuring adherence to laid down accounting standards, ensure timely submission of Ucs, periodic internal audit and conduct of external audit and implementation of computerised FMS.</p> <p>The District Data Assistant (DDA) has to work in close consultation with district officials, facilitate working of District RCH Society, maintain records, create and maintain district resource database for the health sector, inventory management, procurement and logistics, planning and monitoring & evaluation, HMIS, data collection and reporting at district level. There is a need for providing more support to the CMHO office for better implementation especially in light of the increased volume of work in NRHM, monitoring and reporting especially in the areas of Maternal and Child Health, Civil works, Behaviour change and accounting right from the level of the Subcentre.</p> <p>The Civil surgeon's office is located in the premises of the only General hospital in the district due to which the hospital cannot expand and take on additional patients. The office of the District Family Welfare officer and other district health officials is also in hospital premises.</p>

Objectives	Strengthened District Programme Management Unit
Strategies	<p>Support to the Civil surgeon proper implementation of NRHM.</p> <p>Capacity building of the personnel</p> <p>Development of total clarity at the district and the block levels amongst all the district officials and Consultants about all activities</p> <p>Provision of infrastructure for the personnel</p> <p>Training of district officials and MOs for management</p> <p>Use of management principles for implementation of District NRHM</p> <p>Streamlining Financial management</p> <p>Strengthening the Civil Surgeon's office</p> <p>Strengthening the Block Management Units</p> <p>Convergence of various sectors</p>

Activities	<p>Support to the Civil surgeon for proper implementation of NRHM through proper involvement of DPMU and more consultants for support to civil surgeon for data analysis, trends, timely reports and preparation of documents for the day-to-day implementation of the district plans so that the Civil Surgeon and the other district officers:</p> <p>Finalizing the TOR and the selection process</p> <p>Selection of consultants, one each for Maternal Health, Civil Works, Child health, Behaviour change. If properly qualified and experienced persons are not available then District Facilitators to be hired which may be retired persons.</p> <p>Capacity building of the personnel</p> <p>Joint Orientation of the District officers and the consultants</p> <p>Induction training of the DPM and consultants</p> <p>Training on Management of NRHM for all the officials</p> <p>Review meetings of the District Management Unit to be used for orientation of the consultants</p> <p>Development of total clarity in the Orientation workshops and review meetings at the district and the block levels amongst all the district officials and Consultants about the following set of activities:</p> <p>Disease Control</p> <p>Disease Surveillance</p> <p>Maternal & Child Health</p> <p>Accounts and Finance Management</p> <p>Human Resources & Training</p> <p>Procurement, Stores & Logistics</p> <p>Administration & Planning</p> <p>Access to Technical Support</p> <p>Monitoring & MIS</p> <p>Referral, Transport and Communication Systems</p> <p>Infrastructure Development and Maintenance Division</p> <p>Gender, IEC & Community Mobilization including the cultural background of the Meos</p> <p>Block Resource Group</p> <p>Block Level Health Mission</p> <p>Coordination with Community Organizations, PRIs</p> <p>Quality of Care systems</p> <p>Provision of infrastructure for officers, DPM, DAM, DDM and the consultants of the District Project Management Unit.</p> <p>Provision of office space with furniture and computer facilities, photocopy machine, printer, Mobile phones, digital camera, fax, etc;</p> <p>Use of Management principles for implementation of District NRHM</p> <p>Development of a detailed Operational manual for implementation of the NRHM activities in the first month of approval of the District Action Plan including the responsibilities, review mechanisms, monitoring, reporting and the time frame. This will be developed in</p>
------------	---

	<p>participatory consultative workshops at the district level and block levels.</p> <p>Financial management training of the officials and the Accounts persons</p> <p>Provision of Rs. 500000 as Untied funds at the district level under the jurisdiction of the Civil Surgeon</p> <p>Compendium of Government orders for the DC, Civil surgeon, district officers, hospitals, CHCs, PHCs and the Subcentres need to be taken out every 6 months. Initially all the relevant documents and guidelines will be compiled for the last two years.</p> <p>Strengthening the Block Management Unit: The Block Management units need to be established and strengthened through the provision of :</p> <p>Block Programme Managers (BPM), Block Accounts Managers (BAM) and Block Data Assistants (BDA) for each block. These will be hired on contract. For the post of BPM and the BAM retired persons may also be considered.</p> <p>Office setup will be given to these persons</p> <p>Accountants on contract for each PHC since under NRHM Subcentres have received Rs 10,000, also the village committees will get Rs 10,000 each, besides the funds for the PHCs.</p> <p>Provision of Computer system, printer, Digital Camera with date and time, furniture</p> <p>Convergence of various sectors at district level</p> <p>Provision of Convergence fund for workshops, meetings, joint outreach and monitoring with each Civil Surgeon</p> <p>Monitoring the Physical and Financial progress by the officials as well as independent agencies</p> <p>Yearly Auditing of accounts</p>
<p>Support from state</p>	<p>State should ensure delegation of powers and effective decentralization.</p> <p>State to provide support in training for the officials and consultants.</p> <p>State level review of the DPMU on a regular basis.</p> <p>Development of clear-cut guidelines for the roles of the DPMs, DAM and District Data Manager.</p> <p>Developing the capacities of the Civil Surgeons and other district officials to utilize the capacities of the DPM, DAM and DDA fully.</p> <p>Each of the state officers Incharge of each of the programmes should develop total clarity by attending the Orientation workshops and review meetings at the district and the block levels for all activities.</p> <p>If qualified persons for the posts of DPM, DAM are not available then State should allow the appointment of facilitators or Coordinators or retired qualified persons by the District Health Society.</p>
<p>Time Frame</p>	<p>2009-10</p> <p>Selection of District level consultants, their capacity building and infrastructure</p> <p>Development of an operational Manual 2009-10</p> <p>Selection of Block management units and provision of adequate infrastructure and office automation</p> <p>Capacity building up of District and Block level Management Units</p> <p>Training of personnel</p> <p>Reorientation of personnel</p>

Budget in Lakhs	<p>ActivityYear : 2009-10</p> <p>Honorarium DPM, DAM, DDA and Consultants 41.52</p> <p>Travel Costs for DPMU -2 Vehicles @ Rs 10,000/ per month x 12 mths 02.40</p> <p>Infrastructure costs, furniture, computer systems, fax, UPS, Printer, Digital Camera 10.20</p> <p>Workshops for development of the operational Manual at district and Block levels 1.000</p> <p>Untied Fund 50.00</p> <p>Compendium of Govt orders 0.50</p> <p>Joint Orientation of Officials and DPM, DAM, DDA 01.00</p> <p>Management training workshop of Officials 1.00</p> <p>Personnel for BPMU 147.60</p> <p>Training of DPM and Consultants 0.50</p> <p>Review meetings @ Rs 1000/ per month x 12 months 1.20</p> <p>Office Expenses @ Rs 10,000/month x 12 months for district 1.20</p> <p>Computer systems (5) with printer and Digital Camera & furniture for DPMU, BPMUs, District, block personnel 5.00</p> <p>Annual Maintenance Contract for the equipment 0.50</p> <p>Travel costs for BPMU @ Rs 5000 per month per block 9.00</p> <p>Monitoring of the progress by independent agencies 1.00</p> <p>Hiring of vehicles at block level @ Rs 10000 /mth x 11 PHCsx12 mths</p>
-----------------	---

Detailed calculation of Budget for Personnel at DPMU for one year

S.No	Details	Units	Unit Cost	Amount for 12 months
	Personnel at District level			
	District Programme manager	1	40000	480000
	District Accounts Manager	1	40000	480000
	District Data Assistant	1	40000	480000
	Accountant in DHS	1	16000	192000
	District Data Operator	7	10000	840000
	Consultant for Maternal Health	1	20000	240000
	Consultant for Child Health	1	20000	240000
	Consultant for Civil Works	1	20000	240000
	Consultant for Behaviour Change	1	20000	240000
	Health Manager for District Hospital	1	24000	288000
	Accountant in District Hospital	1	16000	192000
	Data Operator in District Hospital	2	10000	240000
	SubTotal			4152000
	Personnel at Block level including SDH/RH			
	Block Health Manager	11+4	24000	4320000
	Block ASHA Coordinator	11+4	20000	3600000
	Block Accounts Manager	11+4	16000	2880000
	Block Data Assistant	11+4	12000	2160000
	Block Data Operator	11+4	10000	1800000
	Subtotal			14760000
	Hiring of vehicles at block level @ Rs 15000 x (DH-1+SDH – 1 + RH-3 + PHC – 11) x 12 months	16	180000	2880000
	Office Automation with Furniture, Computer system, Camera, Printer, etc	17	60,000	1020000

A-2. MATERNAL HEALTH		
Situation Analysis/ Current Status	Indicator	No.
	No of Pregnant women	22565
	Maternal Deaths	6
	ANC registration No.	19762
	%	88%
	Full ANC coverage	DNA 7.10% (DLHS02)
	Full ANC coverage (3 ANC)	DNA
	Institutional Deliveries (In the last reporting year)	10645
		60.2%
	Deliveries by skilled birth attendants	14722
		83.5%
	Home deliveries (Total No.):	6986
	Skilled	
	Unskilled	
	No.	
	%	
	No.	
	%	
	4049	
	58	
	2937	
	42	
	No. of pregnancy related complications referred to FRU level	
	DNA	
	Source: Data from C.S.Office Dec 07 Report	
	ANC: 88% pregnant women in the last reporting year were registered for ANC checkups. The data regarding Full ANC is not available. As per DLHS 2002, only 7.1 % of the pregnant women had received full ANC care that is three doses of TT, required number of IFA tablet and at least 3 ANC checkups during their pregnancy. The reasons for low ANC coverage are the shortage of staff, sociocultural beliefs, large areas and populations unreached and the unmotivated staff.	
	IFA: 82% of pregnant women receive IFA Tablets. As per DLHS 2002 only 11% of the pregnant women were receive adequate iron and folic acid tablets.	

	<p>TT: As per DLHS 2002, 85 % women had received two or more than two doses of TT. This hence carries a grave risk for the pregnant women.</p> <p>Deliveries: Institutional deliveries are 60.2% rest of all the deliveries being done by Skilled Birth Attendants.</p> <p>Referrals: There is no adequate data for referrals during complications.</p> <p>MTP: There are 927 cases of MTP held in the institutions in the district and out of these 820 held in the private institutions and 107 are at Govt. Institutions and the Govt Institutions is the only General Hospital and there is a problem of non availability of trained MOs in MTP. The General Hospital and some of the private clinics are performing MTP in the district. Most of the MTPs carried out are in the first trimester and mainly in the age group 20 to 30 years. There is a need to have MTP facilities at all the Primary Health Centres for carrying out MTPs upto the first trimester so that safe abortions can be done.</p> <p>Janani Surakha Yojana: The JSY scheme has been launched in Haryana and 3459 women have benefited till date. This low uptake has been due to poor awareness in the people and non availability of regular funds from the government at the health facilities.</p> <p>Services: The Community does not have enough confidence in the government facilities since the personnel are not always available especially Lady MOs and also adequate infrastructure, equipment and drugs. There is a dearth of facilities as per the population norms for facilities. A large number of the women use private facilities. The government has started intensive efforts to improve the facilities through delivery huts, 24 hour PHCs, development of CHCs as per IPHS standards. Also the Vikalp scheme is in place and also the Delivery huts. At present there are 31 delivery huts are functional with special facilities for institutional deliveries. The Delivery huts are very popular amongst the community and hence there is a need to operationalize delivery huts at all the Subcentres and also after 2009 one hut for each 5000 population.</p> <p>Fixed Maternal, Child Health and Nutrition Days (MCHN days) are being organized but there is little awareness amongst the community about the days when these are held and also regarding the services being provided.</p> <p>RCH Camps: RCH camps are organized through NGOs each year to reach the community and provide services at the doorsteps. These camps provide specialist services with simple diagnostic tests. They also serve for screening of RTI and STDs.</p>
Objectives	<p>100% pregnant women to be given two doses of TT</p> <p>90% pregnant women to consume 100 IFA tablets by 2010</p> <p>70% Institutional deliveries by 2010</p> <p>90% deliveries by trained /Skilled Birth Attendant by 2010</p> <p>95% women to get improved Postnatal care by 2010</p> <p>Increase safe abortion services from current level to 80 % by 2010</p>
Strategies	<p>Provision of quality Antenatal and Postpartum Care to pregnant women</p> <p>Increase in Institutional deliveries</p> <p>Quality services in the health facilities</p> <p>Availability of safe abortion services at all CHCs and PHCs</p> <p>Increased coverage under JSY</p> <p>Strengthening the Maternal, Child Health and Nutrition (MCHN) days</p> <p>Improved behaviour practices in the community</p>
Activities	<p>Identification of all pregnancies through house-to-house visits by ANMs, AWWs and ASHAs</p> <p>Fixed Maternal, Child Health and Nutrition days</p> <p>Once a week ANC clinic by contract LMO at all PHCs and CHCs</p> <p>Development of a microplan for ANMs in a participatory manner</p>

Wide publicity regarding the MCHN day by AWWs and ASHAs and their services
A day before the MCHN day the AWW and the ASHA should visit the homes of the pregnant women needing services and motivate them to attend the MCHN day
Registration of all pregnancies
Each pregnant woman to have at least 3 ANCs, 2 TT injections and 100 IFA tablets
Nutrition and Health Education session with the mothers
Postnatal Care
The AWW along with ANM will use IMNCI protocols and visit neonates and mothers at least thrice in first week after delivery and in total 5 times within one month of delivery. They will use modified IMNCI charts to identify problems, counsel and refer if necessary
Tracking bags
Provision of tracking bags for the left outs and the dropout Pregnant mothers
Training of ANMs and AWWs for the use of Tracking bags
Provision of Weighing machines to all Subcentres and AWCs
Establishing Delivery Huts for all the Subcentres alongwith provision of additional ANMs in all these Delivery huts for 24 hour deliveries.
Availability of IFA tablets
ASHAs to be developed as depot holders for IFA tablets
ASHA to ensure that all pregnant women take 100 IFA tablets

Training of personnel for Safe motherhood and Emergency Obstetric Care (Details in Component on Capacity building)
Developing the CHCs and PHCs for quality services and IPHS standards (Details in Component Upgradation of CHCs & PHCs and IPHS Standards)
Availability of Blood at the General Hospital and CHCs
Establishing Blood storage units at GH and CHCs
Certification of the Blood Storage centres
Improving the services at the Subcentres (Details in Component on Upgradation of Subcentres and IPHS)
Behaviour Change Communication (BCC) efforts for awareness and good practices in the community (Details in Component on IEC)
Increasing the Janani Suraksha coverage
Wide publicity of the scheme (Details in Component on BCC ...)
Availability of advance funds with the ANMs
Timely payments to the beneficiary
Starting of Janani Suraksha Yojana Helpline in each block through Swasthya Kalyan Samitis
Training of TBAs focussing on their involvement in MCHN days, motivating clients for registration, ANC, institutional deliveries, safe deliveries, post natal care, care of the newborn & infant, prevention and cure of anaemia and family planning
Safe Abortion:
Provision of MTP kits and necessary equipment and consumables at all PHCs
Training of the MOs in MTP
Wide publicity regarding the MTP services and the dangers of unsafe abortions
Encourage private and NGO sectors to establish quality MTP services.
Promote use of medical abortion in public and private institutions: disseminate guidelines for use of RU-486 with Mesoprestol
Development of a proper referral system with referral cards
Improvement of monitoring of ANM tour programme and Fixed MCHN days

	<p>Fixed MCHN days and Tour plan of ANM to be available at the PHCs with the MOs Checklist for monitoring to be developed Visits by MOs and report prepared on basis of checklist filled Findings of the visits by MOs to be shared by MO in meetings RCH Camps: These will be organized once each quarter through NGOs/Rotary/Lions clubs to provide specialist services especially for RTI/STD cases.</p>	
State support	<p>Issue of joint letters from Health & WCD department for joint working Ensuring availability of personnel especially specialists and Public Health Nurses for the 24 hour PHCs, CHCs and two ANMs at the subcentres Ensuring availability of formats and funds with the ANM for JSY and timely payments Certification of PHCs as MTP centres The State should closely monitor the progress of all the activities</p>	
Timeline	<p>Activity 2009-2010</p> <p>Strengthening of the Fixed MCHN days x</p> <p>Developing the CHC for EmOC All CHCs</p> <p>Developing Delivery huts 40</p> <p>Developing MTP centres All CHCs</p> <p>Tracking Bags Operational All AWCs</p> <p>JSY beneficiaries 5000</p> <p>Promoting Medical Abortion All CHCs</p> <p>RCH Camps At all CHC and PHCs</p>	
Budget	Activity / Item	2009-10
	Consultancy for support for developing Microplan for MCHN days	1.00
	Tracking Bags @ Rs 300/ bag x AWCs 2004 and refilling	6.01
	Adult Weighing machines @ Rs 1200 per machine x 2004 AWCs & Maintenance	24.05
	58 Delivery Huts (on APHCs) @ Rs 50000 /hut	29.00
	Recurring cost of 58 Delivery Huts @ Rs 109000 per year	63.22

	Blood Storage @ Rs 3 lakhs per unit (2 Existing+3 Proposed)	15.00
	Referral Cards @ Rs 2 per card x 20,000	0.4
	MTP kits @ Rs 15000 Per kit	3
	One day training workshop on Tracking bags at the district level and each sector	1.5
	JSY beneficiaries @ Rs 2000	14.00
	RCH Camps @ Rs 25000 per camp x 7	1.75
	Total	158.93

Recurring Costs per delivery hut for one year

S.No	Head	Unit	Unit Cost	Amount
	O.C	1 year	35000	35000
	Material and supply	1 year	50000	50000
	Motor Vehicles	12 mths	1500	18000
	Honorarium for TBA	12 mths	500	6000
	Total			109000

Part-II

Budget

Malaria

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

			2. Use of Insecticide treated bednets	1. Space spray for 7-10 days , residual insecticidal spraying to be started simultaneously as per district micro plans
				2. Supply of Insecticide treated bednets to suspected patients free of cost
			3. Anti larval measures	1. Promotion of use of larvivorous fishes like gambusia in the natural water tank

Tuberculosis (T.B)

Tuberculosis					
	Indicators	Gaps	Activities	Unit Cost	Total Cost
1	Infrastructure	Lack of well equipped/Designed Microscopy Centre	Development and Renovation of DMCs with proper water supply and Electricity connection	Rs 15000 per PHC/CHC/DH	225000
		Microscopes of many Designated Microscopy Centers(DMC) are not functioning	Supply of New binocular Microscopes	Rs 35000 per PHC/CHC/DH	525000
		Poor Maintenance of Microscopes	Special Training to Lab Technician/Microscopist for maintenance of Microscopes	Rs. 500 per LT/Microscopist (350)	175000
2	HR	Many DMCs are closed due to lack of Microscopist/Lab Technician	Recruitment Process should be followed.	NA	0
		Honararium are not given timely	Honararium for 8 TB technicians	Rs 8000 per month for 8 technicians for 12 months	768000
		Constraint in selection Process of new Staffs by the District Health Society	Obstacle in recruitment Process will be rectified.	NA	0
		Remuneration of Pvt DOT Providers has not been paid	Problems in payment of remuneration will be solved	Rs 250 per DOTS provider for 300 units	75000
			Dues of Previous Years	Rs 250 per DOTS provider for 300 units for 36 Months	225000
3	Drugs and Chemicals	Poor Retrieval of Drug Boxes of Defaulted patient	Retrieval of Drugs may be ensured by STS.	NA	0
		Irregular supply of slides and other Chemicals and other logistics	Proper supply of Slides and other Chemicals should be ensured	Rs 2000 per PHC per month	264000
		Delay in purchasing of chemicals and	Constraints in purchasing of Chemicals and other logistics will be removed. Official Process will	NA	0

		other logistics at District level	be simplified.		
4	Service Performance	Poor quality of DOTS	Proper and Regular supervision and monitoring of programmes will be ensured.	NA	0
		ANMs providing DOTS at the HSCs do not visit the Center on DOTS day resulting irregular intake of drugs by the patient causing poor Cure- rate.	Motivation and Sensitization of Staffs by Refreshment training for friendly behavior with patient	NA	0
		Due to irregularities in DOTS cases of MDR TB may be increased	Proper counseling of patient should be done regarding importance of DOTS and importance of Follow-up Sputum examination	NA	0
		Not friendly behavior of Lab Technician and other staffs with patient who comes for sputum examination or for DOTS	Appointment of a Counselor at all PHC	Discussed in Maternal health	0
		Poor Case Detection i.e., <70%		NA	0
		Poor Cure Rate i.e., <85%	Organizing Community meetings	NA	0
		High Default Rate		NA	0
			Medical Officers should take care of referring all chest symptomatic patients for sputum examination	NA	0
			Proper Follow-up Schedule should be maintained	NA	0
			Proper care for side effects of drugs.	NA	0
Total Budget					2257000

Child Health

Chid Health

Logical Framework

SI.	Goal	SI.	Impact indicators
1		1.1	Reduction in IMR
	To improve Child health & achieve child survival	1.2	Child performance in the school - enrolment, attendance and dropout

Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
1	To increase ORS distribution from 51%(DLHS3) to 80%	1.1	% increase of ORS distribution .	1.1.1	<i>IMNCI, Home Based Newborn Care/HBNC</i>		% of PHC initiated IMNCI and HBNC training.
2	To increase treatment of diarrhoea from 77.1% to 90% within two weeks		% increase of treatment of diarrhoea within two weeks				
3	To increase treatment of ARI/Fever in the last two weeks from 82.2%(DLHS3) to 95%		% increase of treatment of ARI/Fever in the last two weeks				
4	To increase of infant care with in 24hr of delivery from 29.7%(DLHS3) to 50%		% increase of infant care with in 24hr of delivery .				
	To increase % of breastfeeding from 33.8% to 70% within 1 hr of birth	1.1.2	% increase of breastfeeding within 1 hr of birth .	1.1.2	Stanthening of Facility Based Newborn Care/FBNC and trained workers on using equipments.		No of PHC initiated FBNC with trained MAMTA on facility based new born care..
	To increase intiation of complimentary feeding among 6 month of children from 88.3% to 90%		% increase of complimentary feeding among 6month of children.				
	To increase exclusive breastfeeding among 0-6 month of children from 36.4% to 80%		% increase of exclusive breastfeeding among 0-6 month of children .				
	To increase immunization coverage from 53.3% to 70%		% increase of full immunization coverage .				
	To increase vit A coverage of received atleast one dose (9month to 35 months) from 67.3% to 80% and include up to 5 yrs.	1.1.3	To increase Vit A reported adequte coverage among (9m to 5ys)	1.1.3			Two round of Child servival Month orgnised in one finicial year.

Management of diarrhea, ARI and Micronutrient Malnutrition through Child

	To decrease Malnutrition form 58%(NFHS III state) to 30% of the age group of (0 to 5 yrs)		% of decrease Malnutrition age group of (0 to 5 yrs)	1.1.4	Care of Sick Children and Severe Malnutrition and strenthen VHND at all AWCs	No of VHND orgnised vs Planned.	
2	(0 to 5 yrs)	2.1		2.1.1	School Health Programme	No Of school health programme orgnised in the PHC	
Sl.	Strategy		Gaps		Activities	Unit Cost	Budget
	<i>IMNCI,Home Based Newborn Care/HBNC</i>		<i>Adequate no. of ASHA/ANM/MO/C DPO/HW are not trained in Child Health Programme.</i>		<i>Assessment of Training load and prepare calendar of training</i>	NA	0
					<i>Incorporate ASHA in IMNCI training team</i>	NA	0
					<i>ASHA kit regular supply and incorporate use of ASHA Kit in training curriculum.</i>	120.75 per ASHA	222422
			<i>Division of area among all trained supervisiore for revision of IMNCI activity in their area.</i>		NA	0	
			<i>Inadequate monitoring of this activity at field level</i>		<i>BHM will be responsiable for review of health supervisor and LS(ICDS)on given formate.Unicef staff will support in devloping review mechnisum in PHC.</i>	NA	

				Incorporate IMNCI reports in HIMS formate	NA	
				Encouraging mother regarding child care.in VHND	NA	
				Frequent checkups of babies by Paediatrician. Distribute telephone number to AWW and ANM of respective docters those who are supervising them in the field.	NA	
				Wednesday could be fixed a day for IMNCI related work at HSC level	NA	
				Community based Monitoring support system devlop with SHG in two PHCTraining of Group membersseed money to SHG for reffral services and other need based services.	Rs 100000 per PHC	200000
	Facility Based Newborn Care/FBNC		A few institution has baby warmer machines	All PHCs should be equipped with baby warmer machines.	Mobilizing nine units from UNICEF	0

			ANMs and Doctors are not trained to operate these machines		Training of Doctors and ANM to operate baby warmer machine.	Rs 5000/- for demonstration at District level	5000
			There is no provision of stay of mothers of neonates at PHC.		Organize training programme for newborn care for the nurses in the district hospitals	One Nurse from each PHC Cost will be 5000/-	5000
			Neonatal Care Unit not up to mark.		District level Supporting supervisory team should be develop with the responsibility of nunfunctioning of neonatal care unit. Training of team on monitoring of NCU	Rs.5000/-for one time training	5000
			Non availability of "MAMTA" at PHC level.		Training of Mamta and staff nurse on logistics of New born Care units.by district level supervisory Team.	Rs 1500 for team members for each PHC per month	198000
	Infant and Young Child Feeding/IYCF		Non awareness of breast feeding and proper diet of young children.		Colostrum feeding and breast feeding inclusively for six months through IMNCI Training.	NA	0
					Baby friendly hospital Training of one docter form each Nursing hospital at District Level	Rs.20000 for training programme	20000
							Rs 20000/- for training programme

Two days training of one staff nurse from each private

				hospital on counselling skill.		
				Accreditation of nursing home and facility according to norms of baby friendly hospital	NA	0
			Poor knowledge regarding new born care and child feeding practices	Development and Printing of BCC materials	Rs 5 per unit for 10000 units	50000
				Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA	NA	0
				Linking JBSY with colostrums feeding	NA	0
			Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding	Counseling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries in mothers meetings and VHSCs meetings	NA	0
				Folk performance to promote exclusive breast feeding	Included in maternal health	0

				Uniform message on radio from state head quarter	State budget	0
			Lack of awareness on importance of appropriate and timely IYCF	Organize social events through VHSCs	NA	0
				Strengthening of <i>Mahila Mandal</i> meetings- fortnightly with involvement of adolescent girl	NA	0
				Organize healthy baby shows, healthy mother / pregnant woman.	Rs 2000 per month per PHC	264000
				Appreciation and reorganization of positive practices in community. For this purpose hiring a documentation specialist.	Rs 100000 for the whole district on communitywise sample basis	100000
				Celebration of "Annaprashan (Muhjutthi) Day" at AWC	NA	0
				Demonstration of recipes.	Rs 250 per month per AWC (Under MUSKAN program)	6012000
					Rs 50000 for the district	50000

Exposure visits to existing NRCs to observe

				different models in the country		
	Care of Sick Children and Severe Malnutrition		There is not a single unit in the district where severely malnourished children could be treated.	Establish rehabilitation center in district hospital, FRU and one PHC and promote local available food formula for nutritional Therapy as Hyderabad Mix	Rs 1000000 per unit	4000000
	Management of diarrhoea, ARI and Micronutrient Malnutrition		There is high prevalence of PEM and anemia among children because of Child nutrition is least priority among service providers.	Procurement of ,ORS , Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup.	100000 ORS packets at the rate of Rs 5 per packet.(If ORS is not provided in Kit A) IFA syrup for 336000 children at rate of Rs 4 per children	1844000
				Include coverage of Vitamin A and IFA,children in New HIMS format.	NA	0
				Insure two round of Vitamin A and deworming for the age group of (9m to 5 yrs) & (2 yrs to 5 yrs) respectively in the month of April And Oct as per GOI guide line.	Rs 1500000 per round into two rounds(If Vit A is not provided in Kit A)	3000000
				Involvement of ICDS, school teachers and PRI for monitoring and evolution	NA	0
	School Health Programme			Half yearly health checkup camp for children in	Rs 2000 per PHC	22000

No Pre School Health checkup & complete Immunization

		card.		schools should be organized.		
		No training of school teacher for basic health care and personnel hygiene.		Training of school teacher by the medical personnel with support administrative person.	Budget incorporated in adolescent health	0
		No regular health checkup camp at school.		Quarterly meetings of VEC representatives by attending existing meetings of VECs representatives at block level by the concerned MOICs and BHMs.	NA	NA
		No Training & Screening of school's teacher for eye sight test.		Linking existing 7 ophthalmic paramedics with this program and developing school wise calender.	Mobility support of Rs 10000 per PHC for moving other blocks and hard to reach areas.	110000
		No other specific program has been formulated in the district.		School health anemia control programme should be strengthen with bi annually de worming .	Budget incorporated in adolescent health	0
				Organizing competitions/D ebates/Painting competitions/Es say/demonstrati on and model preparation of nutritional food and health.	Rs 20000 per PHC	220000

			1.1.1.2	% of PHC having Obestetric First Aid medicine 24hrx 7 days
			1.1.1.3	% of Grade A nurse available 24hrx7days
			1.1.1.4	% of PHC having functional Neo-natal care units
	1.1.2	To make functional FRU for institutional deliveries	1.1.2.1	No of FRUs having functional blood storage units linkage with blood banks and 24hr ready referral transport
			1.1.2.2	No of FRUs having EmOc and CEmOc facilities
			1.1.2.3	No of FRUs having specialist doctors/ multiskilled Medical Officers
			1.1.2.4	No of FRU having functional Neo-natal care units
	1.1.3	To provide Referral transport services at FRU /PHC	1.1.3.1	No of pregnant women availed the referral facilities (pick up and drop)
	1.1.4	To strengthen Janani Suraksha Yojana / JSY	1.1.4.1	% of pregnant women reecieved JSY payments immediatly after

							delivery
2	To increase safe delivery by trained SBA 9.6% (DLHS3) to 100% by year 2010	2.1	Proportion of birth attendant by skilled health personnel	2.1.1	To ensure support of SBA at home deliveries	2.1.1.1	% of home deliveries attended by SBA
3	To increase ANC coverage with quality 16% (DLHS3) to 50% by year 2010	3.1	% ANC reported through HMIS formats / Form -7	3.1.1	To strengthen HSC for providing outreach maternal care	3.1.1.1	% of HSCs having ANMs
						3.1.1.2	% of HSCs conducted fixed ANC and clinics (planned & held)
				3.1.2	To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas	3.1.2.1	% of RCH camps planned and held
				3.1.3	To improve adolescent reproductive and sexual health	3.1.3.1	No of pregnant adolescent counselled by ANM/AWW/ASHA
				3.1.4	To accelerate APHC for OPD and Fixed AN clinics	3.1.4.1	% of OPD clinics organised at APHC level.
4	To provide safe abortion services at all facilities	4.1	% MTP cases reported through HMIS formats / Form -7	4.1.1	To provide MTP services at health facilities	4.1.1.1	No of facilities having MTP services (public and private)
5	To increase community participation in maternal care	5.1	% of Mahila mandal meetings conducted.	5.1.1	To strengthen Monthly Village Health and Nutrition Days	5.1.1.1	% of monthly Village Health & Nutrition Days planned and held
MATERNAL HEALTH							

Sl.	Strategy	SI	Gaps	SI	Activities	Unit Cost	Total Budget
	To make functional PHC (24hr x7days) for institutional deliveries		Infrastructure				
A1		1.1	All PHCs are running with only six bedded facility.50-60% of facilities are not adequate as per IPHS norms.(List attached)	1.1.1	Need based (Service delivery)Estimation of cost for upgradation of PHCs Selection of any two PHCs for ISO certification in first phase	@200000/- Per PHC	2200000
		1.2	At present 10 PHC are working with average 08-10 delivery per day, 3 FP operation and 200 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	1.2.1	2.Preparation of priority list of interventions to deliver services.	NA	0
		1.4	The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement.	1.4.1	2. Sending the recommendation for the certification with existing services and facility detail.	NA	0
		1.5	Lack of equipments as per IPHS norms and also under utilized equipments.	1.5.1	3. Prioritizing the equipment list according to service delivery and IPHS norms.	Rate of Equipments to be finalised at higher level	0
				1.5.2	4. Purchase of equipments		0
		1.6	Lack of appropriate furniture	1.6.1	1. Purchase of Furniture	Rate of furnitures to be finalised at higher level	0
	To make functional PHC (24hr x7days) for institutional deliveries	1.7	As per IPHS norms each PHC requires the following clinical staffs:(List				

	attached)				
			Salary of Contractual Doctors	34 Specialist@ 25000/	10200000
1.7. 1	Actual position is not sufficient as per IPHS norms List of Human resource is attached in Annexer .		Selection and recruitment of Doctors on contractual basis and give priority in selection those who are living in same PHC.	15 Doctors to be appointed	4500000
			Salary of Contractual Grade A	6 Grade A Nurse	540000
1.7. 2			Selection and recruitment of grade A for conducting delivery	3 Grade A nurse for each PHC	2970000
			Selection and recruitment of dresser	15 Dresser for each PHC	742500
			Selection and recruitment of Pharmasist.	11 x2 Pharmasist for each PHC	1320000
			Three month induction training of Grade A nurse under supervision of District level resource team.	100/-per day x 90 days for 103 grade A nurse	927000
1.8		1.13. 1	Training need Assessment of PHC level staffs	NA	0
			Honorarium of Block Accountants	9 Accountant @ 16000/-	1728000
			Rent of Data Center	15 Data Center @ 10,000/-	1800000
			Honorarium of BHM	7 BHM @ 24,000/-	2016000

			Mobility support to BHMs	Rs 2000 per month per BHM	360000
1.14		1.14.1	Appointment of Block Health Managers, Accountants in all institutions.(11 PHCs, 3 Referrals, 1 Sub-divisional Hospital and 1 Sadar hospital.)	7 BHM and 9 Accountants Budget in RKS head	0
			Process of all recruitments	6 types of recruitment @ 10000	60000
			Trainings of BHMs on Health statistics	15 BHMs	30000
			Training on Program, Finance management and HMIS	15 BHMs, 15 Block Accountants and 15 Data Center operators	90000
	Drug Supply				
1.16	Irregular supply of drugs because of lack of fund disbursement on time.	1.16.1	Ensuring the availability of FIFO list of drugs with store keeper.	NA	0
1.17	Only 38 essential drugs are rate contracted at state level .	1.17.1	2.Implementing computerized invoice system in all PHCs	NA	0
			Purchase of Drug invoice software	Rs 10000 per PHC	150000
	Lack of fund for the transportation of drugs from district to blocks.	1.17.2	3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock)	NA	0
					0
1.18		1.18	4.Payment from Rogi Kalyan samiti account.	Rs 2000 per month per PHC	360000

1.19	There is no clarity on the guideline for need based drug procurement and transportation.	1.19.1	5. Orientation meetings/ training on guidelines of RKS for operation.	Rs 2000 per PHC	30000
1.2	Drugs are not properly stored	1.20.1	6. Enlisting of equipments for safe storage of drugs.	NA	0
		1.20.2	7. Purchase of enlisted equipments.	Rs 15000 per PHC	225000
		1.20.3	8. training of store keepers on invoicing of drugs	Rs 2000 per PHC	30000
	Performance				0
1.21.1	Excessive load on PHC in delivering all services i.e. 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC.	1.21.1	Recruitment of Doctors on contractual basis	NA	0
1.21.2	Total 59 seats of Regular and 25 seats of contractual doctors in the district is vacant.			NA	0
					0
1.22	All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less(only average 16 patients per Doctor per OPD days during April 08- Nov 08, however the IPHS norms says that the OPD should be 40 per Doctor.)	1.22.1	Hiring of rented houses from RKS fund for the residence of doctors and key staffs.	Rs 25000 per PHC per month	4500000
		1.22.2	Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.	Rs 50000 per PHC per month	9000000
		1.22.3	Revising Duty rosters in such a way that all posted doctors	NA	

**To make functional
PHC (24hr x7days)
for institutional
deliveries**

			are having at least 8 hrs assignments per day		
1.24	No any PHC has new born care services.	1.24.1	Ensure 24 hrs new born care services in 11 PHC.	Budget in Child health care activity	0
1.27	No any PHC provides 24 hrs BEmoC services.	1.27.1	Ensure 24 hrs BEmoC services at all PHC		0
			Training of one Docter from each PHC on BEmoC.	2000/-Per Docter	22000
			Equipments for BEmoC	50000 per facility	550000
1.29	4 PHC does not have laboratory facilities on PPP based srvcies.	1.29.1	Duputation of regular Lab tech at PHC level for providing free of cost lab services to all pregnant women and BPL families.	NA	0
1.3		1.30.1	Recruitment of 4 lab technicians as required for regular support of lab activity	6000/-per head	288000
			Training of TB lab technician on other pathological tests.	1000/-per training	11000
			Purchase reagent(recurring) for strengthening lab.	5000 per unit per month	660000
			Purchase of equipments/ instruments if needed . Fund could be rooted through RKS and if it is not utilised it could be diverted to other women and child friendly	50000/-per PHC	550000

			activites.		
1.32	Health facility with AYUSH services is not being provided		Establising one Panchkarm center in All PHC	10000 Per PHC	110000
			Establising two homeopathy centers	5000/- each PHC for medicine , equipments and Furniture.	110000
1.33	Referral Services				0
1.33 .1	No pick up facility for Pregnant Woman or BPL patients.	1.33. 1.1	Provision for pick up & drop out for pregnant mothers and BPL families free of cost using existing Ambulence services at PHC level.	60000/-each PHC per month for 10 PHCs.	7200000
			Provide EDD list of pregnant women to Ambulence driver and Number of ambulence diriver and 102 /PHC tel No to all Pregnant woment	NA	0
1.33 .3	Lack of maintenance of ambulances	1.33. 3.1	Repairing of all defunct Ambulances	three Ambulances @ rs 50000 per Ambulance	150000
1.33 .4	Shor tage of ambulances	1.33. 4.1	Hiring of ambulances as per need.	one in each PHC @ Rs 10000 Per month	1200000

			Prepaer list of Vecheecal those are utilised in Monitoring work in PHC that can be use in pick up and drouping facility for PW.	NA	0
1.34	Quality of food, cleanliness (toilets,Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC.	1.34.1	Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate.	Rs 50 per patients into 25 patients per day per PHC	5018750
			Rewiev of Cleanliness activity in all PHC by Quality Assurence Committee and payment of agency should be link with it.		0
		1.34.2	Hiring of workers for cleanliness of OT and Labour room in PHC	Two workers per PHC for maximum 30 days @ Rs 100 per day by concerned RKS	803000
			Perchage equipments and uniform for clinliness in all PHC	50000/each PHC	550000
			Training of Workers on using machine/equipments and impotence of clinliness .	2500/-per PHC twice in a year.	55000
			Devlop mechnisume for monitoring of clinliness work	NA	0

1.35	All PHCs have their own generator sets but are not in use.	1.35.1	Repairing of PHCs gensets and initiating their use.	Rs 5000 per PHC	55000
1.7	Non availability of HMIS formats/registers and stationeries	1.7	Printing of formats and purchase of stationeries	Rs 50000 per PHC	550000
		1.7.2	Biannual facility survey of PHCs through BHM as per IPHS format	NA	0
		1.7.3	Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.	NA	0
1.8	Operation of RKS:	1.8.1	Ensuring regular monthly meeting of RKS.	Confectionary costs @ Rs 500 per month per PHC	66000
		1.8.2	Appointment of Block Health Managers, Accountants in all institutions.(15 PHCs, 2 Referrals and Sadar hospital.)	Six more BHM's and Five more Accountants (Rs 24000 per month for BHM's and Rs 16000 per month for Accountants)	2688000
1.9	Lack in uniform process of RKS operation.	1.9.1	Training to the RKS signatories for account operation.	Rs 1000 per participant, Two participants from each PHC	22000
		1.9.2	Trainings of BHM and accountants on their responsibilities.	Rs 1000 per participant, Two participants from each PHC	22000

To make functional PHC (24hr x7days) for institutional deliveries	1.1	Lack of community participation in the functioning of RKS.	1.10.1	Meeting with community (School children or other)representatives on erecting boundary, beautification etc,	5000/-per PHC	55000
			1.10.2	Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS.	NA	0
	1.36	In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases.	1.36.1	Meeting in RKS with Local Police Station incharge to handdale emergency situation .	NA	0
				Training local NCC/NYK/Scout & Guide/NSS etc.volentiers on identification of emergency situation. And deployment of volentears at PHC.	5000/-per PHC	55000
	1.37	Several cases of theft of instruments, computers, and submersible pumps etc at PHCs.	1.37.1	Insurance of all properties and staffs of PHC	Rs 10000 per PHC	110000
	1.38	No guidance to the patients on the services available at PHCs.	1.38.1	Pictorial wall painting on every section of the building denoting the facilities and attached trained volenters to guide paitents.	Rs 10000 per PHC	110000
	1.39	Non friendly attitude of staffs towards the	1.39.1	Name plates of Doctors	Rs 5000 per	55000

	poor patients in general and women are disadvantaged group in particular.		Displaying Name Photograph and DOB of all staff of PHC and put cleanliness staff name on top of the list.	PHC	
1.41	Lack of counseling services	1.41.1	There are 16 LHVs in the district we can utilise their experience in counseling work of women and adolescent girls after training.	1000 per person	16000
1.42	there is no hot water facility for PW and there is no adequate lighting facility at adjoining area of PHC	1.42.1	Installation of solar heater system and light with the help of BDO/Panchayat at PHC or purchase equipments from market.	50000/-per PHC	550000
1.43	Lack of convergence	1.43.1	Convergence meeting by RKS & DHS	NA	0
1.44	Lack of timely reporting and delay in data collection	1.44.1	Orientation of the staffs on indicators of reporting formats	NA	0
		1.44.2	Purchase of Laptops for DPMs and BHM with internet facility.	Rs 35000 per unit+ 2000 per month	708000
1.45	Lack of space for waiting, environmental cleanliness around PHC, provision for hospitality etc	1.45.1	Gardening	Rs 5000 per PHC	55000
		1.45.2	Sitting arrangement for patients	Rs 5000 per PHC	55000
			Construction of patients waiting shade	75000/-Per PHC	825000
		1.45.3	Installation of LCD projector for manage wait over time of OPD patients.	Rs 100000/- per PHC	1100000
		1.45.4	Installation of safe drinking	Rs 10000 per PHC	110000

					water equipments/water cooler,		
				1.45.5	Apron with name plates with every doctors	Rs 250 per Doctor for total 109 existing doctors	27250
				1.45.6	Presence of staffs with uniform and name plates.	NA	0
				1.45.7	“MAMTA” should be appointed at PHC level as well.	Rs 75 per delivery for approx 40000 institutional delivery	3000000
2	To make FRU functional and upgradation of PHC to CHC for institutional deliveries	2.1	C-Section deliveries are not conducted in institution.	2.1.1	Devlop Two PHCs Out of 11 PHCs for C-section facility	NA	0
				2.1.2	Training of MOs of three PHCs in multiskilling.	3 Docters from each PHC @ 3000/-per person	18000
				2.1.5	Specialist should be posted at Sadar Hospital/and above mention three PHC	NA	0
				2.1.6	Incentive for C-section to PHC those who conducted 10 -15 = 10000,15-20=20000, 25-30= 50000/,C-section in a month the incentive money should be distributed among all staff of the PHC after the decision of RKS.	Rs 25000 per PHC per month	600000

		2.1.8	Need based Equipments and drugs in O.T and Labour room.	List of Equipment attached(10 0000 per PHC)	1100000
	None of the PHC provides 24 hour blood transfusion services, however PHC, Daudnagar has been provided the equipments for blood storage unit.		Establishing blood storage unit at Haspura, Nabinagar and Kutumba	60000/- Per PHC	180000
			Training of lab technician on management of blood storage	3 lab technician	3000
	Infection control protocols is not at all maintain at all facilities	2.2.2	Licensing blood storage / blood bank	NA	0
		2.2.3	Meeting infrastructure requirements as per norms for Blood storage	10000 Per PHC	30000
		2.2.4	Training of MO and lab tech/ staff nurse blood storage on grouping /cross matching and management of transfusion reactions stabilized linkages with mother blood bank.	Rs 1000 per participant, Two participants from each PHC	22000
		2.2.5	Provide free of cost Blood for pregnant women who need blood transfusion for severe anemia/ PPH on prescribed through RKS Fund	20000/-for each PHC per month	240000

		2.2.1 1	Organize Blood donation camps at all institution and mobilize community for voluntary blood donation	Rs 10000 per camp per PHC for organizing two camp annually	220000
2.3	Welcome PW at Institution and PHC and FRU	2.3.1	Provision of food for the delivered mothers and mothers under gone in tubectomy in all the health facilities.	Rs. 50 per day per patient at all PHCs	270000
		2.3.2	Mobilize community Resources for providing Free food for PW at Institution.	NA	0
		2.3.3	Quality indicators (clean environment, wards with clean linen, clean toilets , clean labour rooms, running waters supply, hot water and protected water for inpatients, new born corners, treatment protocols, aseptic precautions, immediate disbursement of	NA	0
2.4	Reporting of maternal death Maternal death reporting is usually not reported by worker	2.4.1	Training of ASHA & ANM on reporting of Maternal deaths and conduct Verbal Autopsy	Rs 5000 per PHC	55000
		2.4.2	Incentives for maternal death reporting by ASHA @ Rs 50/-per maternal death	Rs 50/-per maternal death for approx 300 maternal deaths	15000

			2.4.3	Reporting line should be in five columns – name of mother, place of death, date of death, cause of death and no. of birth.	NA	0	
			2.4.4	Institution and urban center also to report Maternal death to the district CS/CMO.	NA	0	
			2.4.5	Maternal Death should be reported by ASHA AWW, ANM Staff Nurse & Doctors to the district data center .	NA	0	
			2.4.6	Investigation of maternal death by district team. and third party review(District magistrate)	NA	0	
			2.4.7	Training of ASHA and investigation team objective and process of investigation and review of maternal death	Rs 3000 per PHC	33000	
		2.5	Biomedical waste management is not properly taken care off at all institution	2.5.1	Procurement of equipment	Rs 50000 per PHC	550000
				2.5.2	As per example Introduce color coded buckets for facilities as per IMEP	NA	0
4	To strengthen Janani Suraksha Yojana / JSY	4.1	Tracking of pregnant women from first Trimester is not done form the register.	4.1.1	Review of early registration with 3 AN checkup ,two TT.100/200 IFA Tab. in ASHA Diwas.	NA	0
		4.2	Too much documentation process. Photo	4.2.1	Ensure 100 %Pregnancy Test Kit is to ASHA	Rs 50 for 80000 pregnancies	4000000

			required for mother and baby. It cost Rs.30/- to Rs.60/- .		and regular supply.		
				4.2.3	Finger print technology for JSY beneficiaries at facility level where computer with internet facility is available. This will help in financial monitoring.	NA	0
				4.2.4	The photo system should be replaced by some other alternatives like- bank account opnin of pregnant women in first trimister and directaly transfer the money to their account after delivery.	Incentive to ASHA for rs 50 per PW for opening of bank account of PW for 80000 pregnancies	4000000
					Incentive for institutional delivery.	Rs 2000 per delivery	80000000
5	To ensure support of SBA at home deliveries	5.1	Home Delivery is still prevailing through untrained traditional Dai's	5.1.1	Home Delivery should be conducted by SBA trained Staff Nurse or ANM.	NA	0
				5.1.2	Provision of Dai Delivery kit(DDK) to TBA where institution access is poor. And it should be supervised by ANM for home deliveries.	NA	0
				5.1.3	Delivery kit (equipment, medicine)for ANM should be supplied	Rs 10000 per PHC	110000

			5.1.4	Supply of delivery Kits as per number of deliveries conducted in home.	NA	0	
		5.2	Reporting of home delivery is not done so the PNC is not provided	5.2.1	Incentive based system for reporting of home delivery by ASHA and it should linked with ANM	0	
		5.3	Non payment of Home delivery through JSY	5.3.1	The JSY money to the mother who has delivered baby at Home paid by ANM.	10000000	
6	To strengthen HSC for providing outreach maternal care	Infrastructure					0
		6.1	Out of 207 HSCs only 70 are having own building	6.1.1	Strengthening of HSCs having own buildings		0
		6.2	In existing 70 buildings 29 are in running comparatively in good condition.	6.2.1	White washing of HSC buildings.	Rs 2000 per HSC in well condition	58000
				6.2.2	Organize adolescent girls for wall painting and plantation./hire local painter for colourful painting of HSC walls.	Rs 2000 per HSC in well condition	58000
				6.2.3	List out all services which is provided at HSC level. On the wall.	NA	0
				6.2.4	Gardening in HSC premises by school children.	NA	0
		6.3	No one building is having running water and electric supply.	6.3.1	Mobilize running water facility from near by house if they have bore well and water storage facility and it could be	Water rent for All HSCs, Rs 100 per month from untied fund.	248400

To strengthen HSC for providing outreach maternal care

			on monthly rental.(Untied fund)		
			Arrangement of water supply upto HSC (Wiring) from water source	Rs 5000 per HSC	350000
6.4	Lack of appropriate equipments and ANM are reluctant to keep all equipments in HSC .	6.4.1	Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/)	Rs 20000 per HSC having own buildings	1400000
		6.4.2	Purchase of equipments according to services	NA	0
		6.4.3	Purchase one almarah for keep all equipment safely and it could be keep in AWW / ASHA house.	Rs 10000 per HSC	2070000
6.5	Non payment of rent of 139 HSCs for more than three years	6.5.1	Strengthening of HSCs running in rented buildings.		0
		6.5.2	Estimation of backlog rent and facilitate the backlog payment within two months	Rs 300 per HSC per month for 36 months(State fund)	0
		6.5.3	Streamlining the payment of rent from the month of April 09.	Rs 300 per HSC per month for 12months(from State fund)	500400
		6.5.4	Purchase of Furniture as per need where building is on	From untied fund	0

			rent			
		6.5.5	Prioritizing the equipment list according to service delivery	NA	0	
		6.5.6	Purchase of equipments as per need	From untied fund	0	
	6.6	The district still needs 195 more HSCs to be formed.	6.6.1	Construction of new HSCs. 70 are having own building, 77 new is proposed and rest 409 are supposed to be constructed.	From State Govt fund	0
			6.6.2	Preparation of PHC wise priority list of HSCs according to IPHS population and location norms of HSCs	NA	0
			6.6.3	Community mobilization for promoting land donations at accessible locations.	NA	0
			6.6.5	Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings.	NA	0
To strengthen HSC for providing outreach maternal care	6.7	Non participation of Community in monitoring construction work	6.7.1	Biannual facility survey of HSCs through local NGOs as per IPHS format	Rs 200 per HSC per biannually	82800
			6.7.2	Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format.	NA	0

		6.7.3	Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project.	NA	0
		6.7.4	Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work.	Rs 20000 per PHC	220000
		6.7.5	Quartely Meeting of one representative of VHSC/Mothers committees on construction work and other issues	Rs 50 for TA to VHSC members for attending monthly meeting at PHC	132000
6.8	Lack of community ownership in the	6.8.1	Formation and strengthening of VHSCs, Mothers committees,	NA	0
		6.8.2	“Swasthya Kendra chalo abhiyan” to strengthen community ownership	NA	0
			One week Training of Nukkad Natak team on IPHS	Rs 300 per participant per day for 55 persons for 7 days	115500
		6.8.3	Nukkad Nataks on Citizen’s charter of HSCs as per IPHS	Three days performance at 207 HSCs	931500
		6.8.4	Monthly meetings of VHSCs, Mothers committees	NA	0

Human Resource						
To strengthen ANM Training School for providing regular training of ANMs.	7.1	1.Out of 23 sanctioned post of LHVs only 16 are placed, 2.All 306 posted ANM ® are not trained enough to deliver services. 3.202 seats of contractual ANM-R, 3 seats of contractual ANMs and 34 seats of Regular ANMs are vacant.	7.1.1	Selection and recruitment of 205 ANM.	honorarium of 205 ANM @ Rs 6000 per month for 12 months	14760000
				Honorarium of existing 103 ANM - R.	Honorarium of existing 103 ANM - R @ rs 6000 per month for 12 months	7416000
			7.1.2	Selection and recruitment of 26 male workers	Honorarium of 26 male workers @ Rs 5000 per month for 12 months	1560000
			7.1.3	Training need Assessment of HSC level staffs by BHM in weekly meeting	Contingencies for Meeting @ Rs. 150/- per candidate per meeting	4843800
			7.1.4	Training of staffs on various services in the PHC,	Rs 1000 per participant (Total no.of participants 103 new ANMs, 306 existing ANMs and 26 new male workers)	435000
	7.2	The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities	7.2.1	Analyzing gaps with training school		0
			7.2.2	Deployment of required staffs/trainers		0
			7.2.3	Hiring of trainers as per need		0

			7.2.4	Preparation of annual training calendar issue wise as per guideline of Govt of India.		0	
			7.2.5	Allocation of fund and operationalization of allocated fund	Lmsm Rs 200000 in a year	200000	
8	To strengthen HSC for providing outreach maternal care	Drug Kit Availability					0
	8.1	No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DEC)s)and contraceptives,	8.1.1	Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports	NA	0	
		No Drug kit for AWCs(@one kit per annum,) . No ASHA kit, only need based emergency but that too being irregular in supply	8.1.2	Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map	From state fund	0	
			8.1.3	Hiring vehicles for supply of drug kits through untied fund.	Rs 200 per HSC per month	811200	
			8.1.4	Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder- Yellow, Third reminder-Red)	Rs 2000 per PHC	34000	
			8.1.5	Hiring of couriers as per need	Rs 50 per courier for 200 couriers for 8 days per month	960000	

			8.1.6	Payment of courier through ANMs account	Fund for the payment of Couriers should be transferred to ANMs account.	0	
9	To strengthen HSC for providing outreach maternal care	Performance					0
	9.1	Unutilized untied fund at HSC level	9.1.1	Training of signatories on operating Untied fund account, book keeping etc	Rs 100 per person for two persons for 339 HSCs	67800	
	9.1.2		Timely disbursement of untied fund for HSCs	Rs 10000 per HSC per year for 339 HSCs	3390000		
	9.1.3		Assigning a person at PHC level for managing accounts	NA	0		
	9.2	No ANC at HSC level Only 14.2% PW registered in first trimester PW with three ANCs is 15.1%, TT1 coverage is 35.4%,	9.2.1	Identification of the best HSC on service delivery	NA	0	
	9.2.2		Listing of required equipments and medicines as per IPHS norms in facility survey	NA	0		
	9.2.4		Honouring the ANM those who develop women friendly HSC in given criteria (list is attached)	5 ANM in a year per PHC social honouring with one shawl.	42500		
	9.3	Family Planning Status:-Any method-43.6%,Any modern method-39.8%,No sterilization at HSC level,IUD insertion - 0.5%,Pills- 1.5%,Condom- 1.9%,Total unmet need is 32.7%, for spacing-14.9,Lack of counselling Skill.	9.3.1	Gap identification of 39 HSCs through facility survey	NA	0	
	9.3.2		Eligible Couple Survey	NA	0		
	9.3.3		Ensuring supply of contraceptives with three month's buffer stock at HSCs.	State Fund	0		

**To strengthen HSC
for providing
outreach maternal
care**

		9.3.4	One day training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS	Rs5000 per PHC	85000
		9.3.5	Training of ANMs on IUD insertion	Rs 10000 per PHC	170000
9.4	HSC unable to implement disease control programs	9.4.1	Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week)	NA	0
		9.4.2	Strengthening ANMs for community based planning of all national disease control program	NA	0
		9.4.3	Reporting of disease control activities through ANMs	NA	0
		9.4.4	Submission of reports of national programs by the supervisors duly signed by the respective ANMs.	NA	0
9.5	80% of the HSC staffs do not reside at place of posting	9.5.1	Submission of absentees through PRI	NA	0
9.6	Problem of mobility during rainy season	9.6.1	Purchasing Life saving jackets for all field staffs	3 units per PHC at the rate ofRs 3000 per unit	153000
		9.6.2	Providing incentives to the ANMs during rainy season so that they can use	From untied fund	0

					local boats.		
		9.7	Lack of convergence at HSC level	9.7.1	Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC.	from untied fund	0
				9.7.1	Monthly Video shows in all schools of the concerned HSC area schools on health, nutrition and sanitation issues.	From untied fund	0
		9.8	Lack of Knowladgae and skill of fileld level staff of data compilation in HMIS formats and formate.	9.8.1	Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc	NA	0
				9.8.2	Printing of adequate number of reporting formats and registers	Discused earlier	0
10	To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas	10.1	Out reach camps are not orgnised in plan mannaer. It is totally baes on demand of orgnisation and it eventually it is not reported to respective HSCs and PHC.	10.1.1	Identifying Socially Backward, Slums & Maha Dalit Tolas.	NA	0
				10.1.2	Hiring trained alternate vaccinator/ retired ANMs and Medical officer .hiring vehicle for fixed day out reach camps with drugs.	Rs 10000 per PHC per month	2040000

				10.1.3	Fixed day OPD clinics at APHC level and adjoining HSC of respective APHCs. with dedicated MO and support staff.	NA		0
				10.1.4	To make calendar for camps with date and identified areas.and link NGOs those who are willing to orgnised Camps .	NA		0
				10.1.5	Community based reporting system through SMS. involve PRI members and training on reporting and Camp approach	NA		0
11	To improve adolescent reproductive and sexual health	11.1	No training programme for adolescent particularly health and sex.	11.1.1	Multipurpose counselor can be used for adolescent care. For this services of LHV can be used.and callender of activity could be develop.	NA		0
		11.2	Preventions of anemia in adolacentent girls	11.2.1	linkage with adolacent anemia controle programme in Schools with Unicef. And traing to the one teacher from the school	Rs 5000 per PHC		85000
		11.3	Marriage before legal age.	11.3.1	Senstigation of PRI members pertculerly women	Rs 5000/- Per PHC		85000

To improve adolescent reproductive and sexual health	11.4	Preventions of teen age pregnancy and abortion.	11.4.1	Adolescent pregnancy should be addressed with priority care(eclampsia, 3 ANC, anemia, 100 IFA, 100% institution delivery, low birth Wight baby, Brest feeding.PNC with in 48 hours.	NA	0
	11.6	Limited interventions for empowering adolescent girls	11.6.1	Family counseling for adolescent pregnancy tracking on above mention through ASHA and AWW.	NA	0
			11.6.2	State to develop and issue guidelines for implementation of Kishori MandalsFormati on of Kishori Mandals by registration of all girls(11-18 yrs)	NA	0
			11.6.3	Prepare a monthly plan of activities for one day per week	NA	0
			11.6.4	Counseling nutrition, health and social issues every week at AWCs by AWW	NA	0
			11.6.5	Weekly distribution of IFA Tablets to out-of-school girls at AWCs	From State	0
			11.6.6	Deworming adolecent every 6 months	Purchase of 12 lack tablets	900000
			11.6.8	Initiate family schools for learning child	Rs 10000 per Schools each in each	170000

					care , safe mother hood life skills and Family life education	PHC	
12	To provide MTP services at health facilities	12.1	MTP services are not available in Public sectors	12.1.1	Selection of facilities for provision of safe abortion services	NA	0
				12.1.2	Location of facility availability of trained service provider, space, equipments.	NA	0
				12.1.3	To Provide appropriate equipments at all facilities and MVA syringes.	50000/-per PHC	850000
				12.1.4	Putting the trained doctors at appropriate facilities to commence the services	NA	0
				12.1.5	Training of Medical officers and Para medical staffs on Safe abortion services training including awareness about legal aspects of MVA/ EVA and Medical abortion by IPAS .	One docter and one ANM from each PHC @ Rs 2000	34000
				12.1.6	Formation of district level committee (DLC) to accredit private sites as per GOI guide line .	NA	0
				12.1.7	Develop reporting system of MTP services in private and public sector.	NA	0
				12.1.8	Through training program make the govt doctors skilled to	NA	0

					perform MTP in the approved sites.		
	To provide MTP services at health facilities			12.1.9	To Involve community to aware about location of services , process and legal aspects of MTP services through - AWW, ASHA & ANM, LRG and mass media.(IEC)	Rs 5000/- Per PHC	85000
				12.1.10	The services of Pregnancy testing should be strengthen and it should be linked with MTP services.	NA	0
				12.1.11	NGO's and local Practitioner should be involved for counseling and information of facility	NA	0
				12.1.12	Assurance of privacy and link with family welfare services counseling at all facility.	NA	0
				12.1.13	Linkage with MTP services with NGOs (PPP) those who are working in Safe abortion services. and create one modal center at district and PHC level.	NA	0
				12.1.14	Training of ASHA on medical abortion.	Incorporate d in ASHA training	0
13	To strenghten Monthly Village Health and Nutrition Days	13.1	Nutrition and Counseling Component is not visible in VHND	13.1.1	AWC should be develop Hub of activities (VHND)	NA	0

and there is no monitoring of VHND activity by Community.

13.1.2	Develop an activity plan calendar for VHND as seasonality.	NA	0
13.1.3	Counseling of mothers on ANC, preparation for Child care ,STI/RTI, and AYUSH, adolescent Health	NA	0
13.1.4	Organize VHND in Four Table concept regularly where One place is for registration, one is for weighing, one is for immunization and fourth is for counseling	Booklet on four table concept @Rs 5 for 10000 booklets	50000
13.1.4	Meeting of VHSC and preparation for area specific epidemiological planning and community based monitoring.	NA	0
13.1.5	Skill development training is required to ANM , ASHA & AWW and Dular (LRG)	Rs 5000 per PHC	85000
13.1.6	Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourish children , New	From untied fund	0

					born, DOTs and other services		
				13.1.7	SMS reporting system of conducting VHND and ANM collect Data from field level and compile it in weekly/Monthly	NA	0
B	APHC		Infrastructure				0
	To form /strengthen APHC in Phase manner	1.3	Out of 30 APHCs only 16 are having own building	1.3.1	Registration of RKS	NA	0
		1.4	Existing 16 buildings are not properly maintained	1.4.1	Renovation of APHCs buildings from RKS Fund	Rs 150000 per APHC	2400000
		1.5	Non payment of rent of 14 APHCs for more than three years	1.5.1	Payment Of Rent of APHC building	From state fund	0
		1.6	Lack of equipments,	1.6.1	Purchase of equipment as per service need from RKS fund	From state fund	0
		1.7	Lack of appropriate furniture	1.7.1	Purchase of Furniture from RKS fund	From state fund	0
				Human Resource			
2		2.1	in the district no any APHC functioning as per IPHS norms	2.1.1	Operationalising one APHC in each PHC by conducting daily OPD by Docter. And support staff.	NA	0
		2.2		2.2.1	Notification from district for oprationaliing APHC	NA	0
3			Drug Supply				0

		3.1	No drug kit as such for the APHCs as per IPHS norms.,	3.1.1	Purchasing 23 listed OPD Drugs of PHC for APHC	Rs 200000/- Per PHC for OPD drugs for one year.	3400000
5	RTI/STI services at health facilities	5.1	No regular clinic at all PHCs & APHCs.	5.1.1	Trained service provider on syndrome management of RTI/STI (As per GOI guide line) up to APHC level.	Rs 1000/- for Two person from each PHC	34000
				5.1.2	Logistics of setting of clinics and free drugs availability	NA	0
				5.1.3	Integrated Counseling services in four public sector facilities by trained personnel .	NA	0
				5.1.4	IEC/BCC for awareness available RTI/STI services at all health facilities.	Rs20000 for Per PHC	340000

Total

224389400

Family Planning

Logical Framework							
Sl.	Goal	Sl.	Impact indicators				
1	Population stablisation	1.1	To decrease TFR upto replacement level To increase sex ratio				
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
2	To increase female sterilisation from present 35%(DLHS3) to 50%	2.1	% increase in female sterilisation	2.1.1	Terminal/Limiting Methods	2.1.1.1	% of terminal/limiting methods use
				2.1.2		2.1.2.2	No of facilities providing quality manuals on sterilization standars of sterilization services.

Dissemination of manuals on sterilization standards &

					services		
				2.1.3	Female Sterilization camps	2.1.3.3	No of camps orgnise for female sterlization .
				2.1.4	Compensation for female sterilization	2.1.4.4	% of Female recived compensation
				2.1.5	IUD camps	2.1.5.5	No of IUD used in Camps
				2.1.6	Accreditation of private providers for IUD insertion services	2.1.6.6	No of Private providers accrediate for IUD Insertion services.
3	To increase male sterilisation from 0.6% (DLHS 3) to 2%	3.1	% increase in male sterilisation	3.1.1	NSV camps	3.1.1.1	No of NSV Camps orgnised.
				3.1.2	Compensation for male sterilization	3.1.2.2	% of Male recived compensation
				3.1.3	Accreditation of private providers for sterilization services	3.1.3.3	No of Private providers accrediate for Sterilization services.
4	To increase use of condoms from 1.9% (DLHS3) to 5%	4.1	% increase in the use of condoms	4.1.1	Promotion to Social Marketing of condoms	4.1.1.1	No of Condoms distributed through Social Marketing.
				4.1.2	Contraceptive Update seminars	4.1.1.2	No of Seminars Orgnised on Contraceptive Update.
5	To increase use of pills from present 1.5% (DLHS3) among current married women age 15-49 yrs to 5%	5.1	% increase in the use of pills	5.1.1	Promotion to Social Marketing of pills	5.1.1.1	No of Pills distributed through Social Marketing.

Sl.	Strategy	Gaps	Activities	Unit Cost	Total Budget
	Terminal/Limiting Methods	Lack of knowledge of small family norms.	Ensure one MO trained on on minilep and NSV up to PHC	Rs 20000	220000
			Training of nurses and ANMs on IUD and other spacing methods at PHC level.	Rs 10000	110000
			Ensure availability of contra	Rs 500000 per PHC	5500000

				septives (indenting , logistic				
	Female Sterilization camps		Laparoscopy surgery not done.		Trained doctors on laparoscopy.	Above mentioned	0	
				Procure Laparoscopy equipments for trained doctors	Rs 100000 per PHC	1100000		
				Training of doctors needed.	Mentioned above	0		
	NSV camps		Trained doctors are not available.		Procurement of equipment.	Mentioned above	0	
	Compensation for female sterilization		Fund for Compensation for sterlization is not aviliable on time at facility.		Immediate disbursement of incentive after sterilization camps.	Rs1000 each for 15000 female and 1000 male operations	16000000	
	Compensation for male sterilization				Logistic planning is needed before organizing camps.	NA	0	
					Block Health manager could be hire one support staff for disbursement for logistic support.	NA	0	
						Immediate disbursement of incentive after sterilization camps.	Discussed earlier	0
							NA	0

Logistic
planning is

				needed before organizing camps.		
				Block Health manager could be hire one support staff for disbursement for logistic support.	NA	0
				Accreditation of private nursing home. As per GOB	NA	0
	IUD camps		Camps not held	Training of ANM & staff nurse for IUD insertion.	Discussed earlier	0
	Accreditation of private providers for IUD insertion services		No accreditation of private providers for IUD insertion services	Procurement of IUD.	Rs 30 into 20000 units	600000
Equipments for IUD insertion				Discussed earlier	0	
Accreditation of private providers for IUD insertion services. As per GOI guide lines.				NA	0	
Social Marketing of contraceptives			Monitoring of Social Marketing is not monitored by PHC.	Social marketing of need based OC & IUD.	NA	0
				Increasing access to contraceptive through communities based distribution system free of cost.	NA	0

	Contraceptive Update seminars	Not being held.	seminars for MO and other through Professional bodies (FOGSI, BMA, Nursing association etc..on	NA	0
			Copper-t 380-A should be popularized.	NA	0
			Awareness for emergency contraceptive	NA	0
Total				23530000	

INSTITUTIONAL STRENGTHENING

Logical Framework

Sl.	Goal	Sl.	Impact indicators				
1	To improve institutional setup as per IPHS	1.1	Improved service delivery For women and child friendly with quality				
2	To bring required architectural correction in the Institutional System						
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
1	To strengthen NGOs Partnership/ PPP for communitisation of Health services	1.1	No and Type of MOU signed between NGO and DHS/RKS for strengthening of communitization	1.1.1	To enforce PNDT Act and to increase sex ratio of female child	1.1.1.1	% decrease in sex selective abortions. % increase in birth of female babies (delivery registers)

		of health services and NGO partnership/ PPP in place	1.1.2	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routine facility where it is not functional.	1.1.2.1	No of cases supported by referral transport system under PPP.
					1.1.2.2	No of canteen facility functional at institutional facility level.
					1.1.2.3	No of STD booth and other routine facility carried out under PPP.
					1.1.2.4	No of cases supported and payments made by RKS/ DHS to BPL families in availing these services
			1.1.2	To develop partnership with NGO Programmes in the districts	1.1.2.1	No of partnership with NGO for programme implementation for MCHN, Micronutrient supplementation, national programme implementation specially Kalazar elimination
					1.1.2.2	No and % of drug & equipments available and supplied (stock ledger)
					1.1.2.3	Regular monitoring and evaluation reports

3	To develop IEC and BCC and Training support system .	3.1	No of IEC materials developed and BCC event carried out No of training support system developed	3.1.1	Establishing BCC and training cell at District & BPHC level	3.1.1.1	Functional BCC cell at DHS/ RKS level
					Net working with folk media team	3.1.1.2	No of folk media team engaged in BCC activity. Type and No. of BCC event organised
4	To strengthen ASHA support System	4.1	No of ASHA capacities	4.1.1	Develop ASHA support System in all PHC(One person per 20 ASHA)	4.1.1.1	Establishment of ASHA support system at DHS and RKS level
				4.1.2	Strengthening RKS	4.1.1.2	No of RKS having monthly meetings.
						4.1.1.3	% of untied fund, JSY fund, referral transport etc utilised

Sl.	Strategy		Gaps		Activities	Unit Cost	Budget
	To enforce PNMT Act and to increase sex ratio of female child		No registration of ultra sound clinic.		Registration and monitoring of ultra sound clinic.	NA	0
					MTP clinic should be watched for termination of pregnancy following USG.	NA	0
					IEC on PNMT act	Rs 5000 per PHC	55000
	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routeen facility where it is not functional.		Out sourcing of services is not as per the need of local Need and BPL families are not exempted from Fee of out source services		District /PHC level managers should be aware about the TOR of PPP which is finalized at State level.	NA	0
				Build the capacity of manager to manage contracts of PPP	NA	0	

			There is an acute shortage of para medics like radiographer, lab technician, ECG technician etc. in the state.	Accreditation of institutions and to set standards, an institute of paramedical sciences may be started in the state. This would create more employment opportunities in addition availability of para medical personnel for absorption into the government health system.	NA	0
Devlop partnership with NGO Programmes in the districts		Non involvement of NGO in F.P programme, Institutional delivery, Blindness control programme.		listing of NGOs those who are working in F.P ,MTP,programme, Institutional delivery, Blindness control programme.	NA	0
				Accreditation of these facility from state Health Society.	NA	0
			There is no any MOU with NGO/VO/individuals for Donation and voluntary support in PHC	Process of MOU should be dicentrization and it should oprationlise through RKS.	NA	0
			Strainthening of DMU NGOs Management aspects is one of the area of	ASHA Programme manager facilitate the NGO management process in the district and ASHA Faclitatore will be manage at the PHC level	NA	0

			improvement		Honourarium to DPM, DPM(ASHA), DAM and DA	Rs 40,000 pm for DPM, , Rs 40,000 pm for DAM and Rs 40,000pm for DA	1440000
					Capacity building training programme for NGOs office bearer with the help of professionals on linkage with health system strengthening component.	Rs 5000 per PHC	55000
					Mentoring Group at district level.	NA	0
					Reporting mechanism should be develop of NGOs work in the district.	NA	0
			There is no any VHSC in the district.		Co-ordination with community based organisation as SHG, LRG, VEC, ,PRI for VHSC formation.	NA	0
	Capacity buiding of Managers and Doctors.				Expoure visit of DPM/BHM /ASHA DPM/ selected ASHA to other state where facility is comparatively working better.	Rs 100000 for the district	100000
					To start DNB (Family Physician) 3 year course in the district hospitals.	Rs 100000 for the district	100000

				ASHA/ AWW career advancement programme may planned to retain them in the system. Seats in the ANM course, staff nurses and other paramedical courses may be reserved for the qualified ASHAs	Rs 10000 per PHC	110000
	Preparation of dicentrised District Health Action Plan		First time five members of the districts were trained on DHAP preparation	Trainings of DPMU,BPMU members on implementation of services/ various National program and district Health action Plan through distance education	1 DPM, 11 Doctors (One from each PHC) , 11 BHMs and district planning team	46000
				Start preparation of plan from the month of October with situation anlysis, Facility survey, line reporting system and qulitative finding from Community and users of facility.	Rs 50000 for the district	50000
	Develop a strong Monitoring & Evaluation / HMIS System in all PHC		Monitoring of all programme is one of the weakest link of all programme. Lack of Supervisers in all PHC	Distribution of role and responsibility among MO and Managers of programme implementation.	NA	0
			Lack of skill of use of data	Use Process indicatore as monitoring of respective programme.	NA	0
			Community is not aware about monitoring aspects of Health Programme.	Develop Programme review calander for review of HSC/ PHC performance as per form 6 & 7	NA	0

				Gradation of Health Sub centers in three categories.	NA	0
				Information exchange visits among ANM according to Grade.	NA	0
				Social recognition of Grade one ANM.	NA	0
				Devlop four potential VHSCs in all PHC on Community based Monitoring of Health and Nutrition programme.	Rs 2000 in each PHC	22000
				Organise "JAN ADALAT" in with PRI & VHSC and invite nearby VHSC to observe thr process of "JAN ADALAT"	NA	0
				Devlop Health and Nutrition Report Card by using growth monitoring chartsof Village and prasant in "JAN ADALAT" By VHSC	Rs 2000 in each PHC	22000
	Strenthen Logistics management system for regular supply of Drugs and equipments		There is no system of logistic management of Drugs and other supply at any level. Only vaccine supply management is comarativly stroger then other logistic work.	Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports	NA	0
				Hiring vehicles for supply of drug kits	Rs 20000 per PHC per month	2640000
				Hiring of couriers as per need	Discussed in maternal health	0
				Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second	Discussed in maternal health	0

				reminder-Yellow, Third reminder-Red)		
				Training of all ANM and Stock keepers on Indenting and Logistic Management.	Rs 5000 per PHC	55000
				Devlop TMC modal for Logistic Management in the state.	NA	0
	Establising BCC and training cell at District & BPHC level		There is not as such disignated post for BCC and Traning at the district and PHC level	ASHA Programme manager facilitate the process of traning and BCC in the district and ASHA Faclitatore will be manage at the PHC level	NA	0
				Devlop resoure team at District Level.	NA	0
				MOU with Local NGOs for logistic management of training and Devlop issues wise Master traners in district	Na	0
				Devlop ASHA support system on one person/20 ASHA for on the job training of AHSa and AWW	NA	0
	Net working with folk media team		There is no BCC management unit at Distrcet Level	Identify Health Communication orgnisation for identification of BCC issues as per need of District.	Discussed in child health	0
				MOU with orgnisation for formative reaserch .	NA	0
				Devlop IEC/BCC material based on Findings of formative rearsch	Discussed in child health	0

				Printing of IEC and BCC material	Discussed in child health	0
				Training of Folk Media group on IEC/BCC material	Discussed in maternal health	0
				Planning of performance route chart of Folk media Group	NA	0
				Monitoring of performance through SMS of PRI members	NA	0
				Impact analysis of Performance by Orgnisation	NA	0
	Straenthening RKS		RKS are not uniformly functioning in the district	Ensure ragistration of RKS of all fungctional APHC	NA	0
				Training of RKS signatory and BHM on finincial Management of RKS	Discussed in maternal health	0
				presentation of case study of fungctional RKS in district level Meeting.	NA	0
	Strengthening community process through supportive supervision of ASHA program		Poor monitorinnng mechanism of ASHA program	Appointment of PHC level ASHA facilitator	Rs 12000 per Facilitator per month for 11 facilitator	1584000
				Provide training cum supervisory support @ one supervisor for 20 ASHA	Rs 250 per supervisor per day for 100 supervisors for maximum 15 days in a month	4500000
				Training of DPM (ASHA) , Facilitator and supervisors at block level.	Rs 250 per participant per day for three days for 112 participants.	84000

Total

10863000

Blindness

Blindness

Gaps	issues	Strategy	Activities	Unit Cost	Total Budget
Lack of adequate eye surgeon and staffs in the district.Only 2 eye surgeons are posted in the district out of which one is on deputation to the other district.	Staff shortage	Recruitment	Recruitment of Eye Specialists and surgeons on contractual basis.	Already discussed in maternal health	0
Most of the doctors and staffs are not trained enough on new IOL techniques	Untrained staffs	Capacity building	Training of Doctors on IOL technique	Rs 10000 per person for 2 person	20000
			Training of Ophthalmic Assistant	Rs 2000 per person for 5 persons	10000
In the Year 2008 - 09 only 383 Cataract operations have been done by the Govt facilities and private facilities(till Nov 08).In the year 2006-07,altogether 1972 surgeries were performed out of 3500 and in the year 2007-08 3033 surgeries have been performed.	Low achievement	Increasing no of camps	Organising Operations at District level	Rs750 per operation for 3000 operations	2250000
		PPP	Accreditation of Nursing Homes capable of doing Cataract surgeries	NA	0

			Establishing another Cataract Operation Center at PHC Lalganj	Rs 500000	500000
			Purchase of equipments and medicines		
Lackof awareness among community regarding cataract blindness and its treatability.	Lack of awareness	Awareness building	Assigning LHV/Supervisor counseling work	NA	0
Fear of eye operation.			Organising eye screening camps in villages/ schools	NA	0
Lack of Education among the masses about the existing facilities: Need of wide publicity.			IEC on cataract and its facilities	Rs 100000 at district level	100000
Poor coordination between the health functionaries and the voluntary organisations resulting in less cataract surgeries.		Involving NGOs	Meeting with Local NGOs onthis issue Qtrly in a Year.	Rs. 5000/- per meeting.	20000
Lack of adequate referral services to take care of complications.	Lackof adequate referal services	Strengthening referral system	Arrangement of carrying patients to the Operation Centers and then taking them back homes	Rs 10000 per PHC	110000
Lackof monitoring and follow up	Monitoring and follow up	Monitoring and follow up	Mobility support for Visiting homes of the patients tomanage any post treatment complication.	Rs 10000 per PHC	110000
			Developing records of cataract cases fromOPD registers at PHC level	Rs. 1000/- per PHC	11000
			Total		3131000

Leprosy

Gaps	issues	Strategy	Activities	Unit Cost	Total Budget
· Existing PR of the district is 1.1 and the target is only 1, so the existing program performance is good.					

<ul style="list-style-type: none"> Lack of awareness is still a problem with the Leprosy Program as most of the cases are detected accidentally. 	Lack of Awareness	Awareness generation	IEC on Leprosy	Rs 5000 per PHC in a year	55000
<ul style="list-style-type: none"> Inadequate staff, Only 6 supervisors and 11 Non Medical Assistants are working while the requirement of Supervisor is 17 and that of NMA is 33(One NMAeach in each APHC) 	Lack of Human Resource	Staff Recruitment in contract basis	Recruitment of 11 supervisors and 58 None medico Staff (One NMA each in every APHC)	Rs 15,000 per superisor per month and Rs. 10,000 per NMA.	8940000
<ul style="list-style-type: none"> There is no active involvement of the Medical officers at sector and Block levels. 		Strengthen Health Care Services	Orientation of Mos and staffs on Leprosy	NA	0
<ul style="list-style-type: none"> Lack of PHC staff involvement. No manpower support, 			Case validation, to have check on wrong diagnosis and re registration	NA	0
			Prompt and early detection of the cases to avoid deformity and disability,	NA	0
			Ulcer care foot ware reorientation training of medical & para medical staff.	Rs.2000 per PHC	22000
No lab testing facility in the district	Infrastructure Gap	Establishing Lab	Establishing Lab at district level	Rs 200000	200000
			Recurring expenditure like reagents	Rs 1000 per month	11000

Lack of monitoring at all level	Monitoring Gap	Increasing mobility	Updation of master register	NA	0
			Mobility support for DLO	Rs. 3000 per month	33000
			Office expenses	Rs 2000 per month	22000
Total					9283000

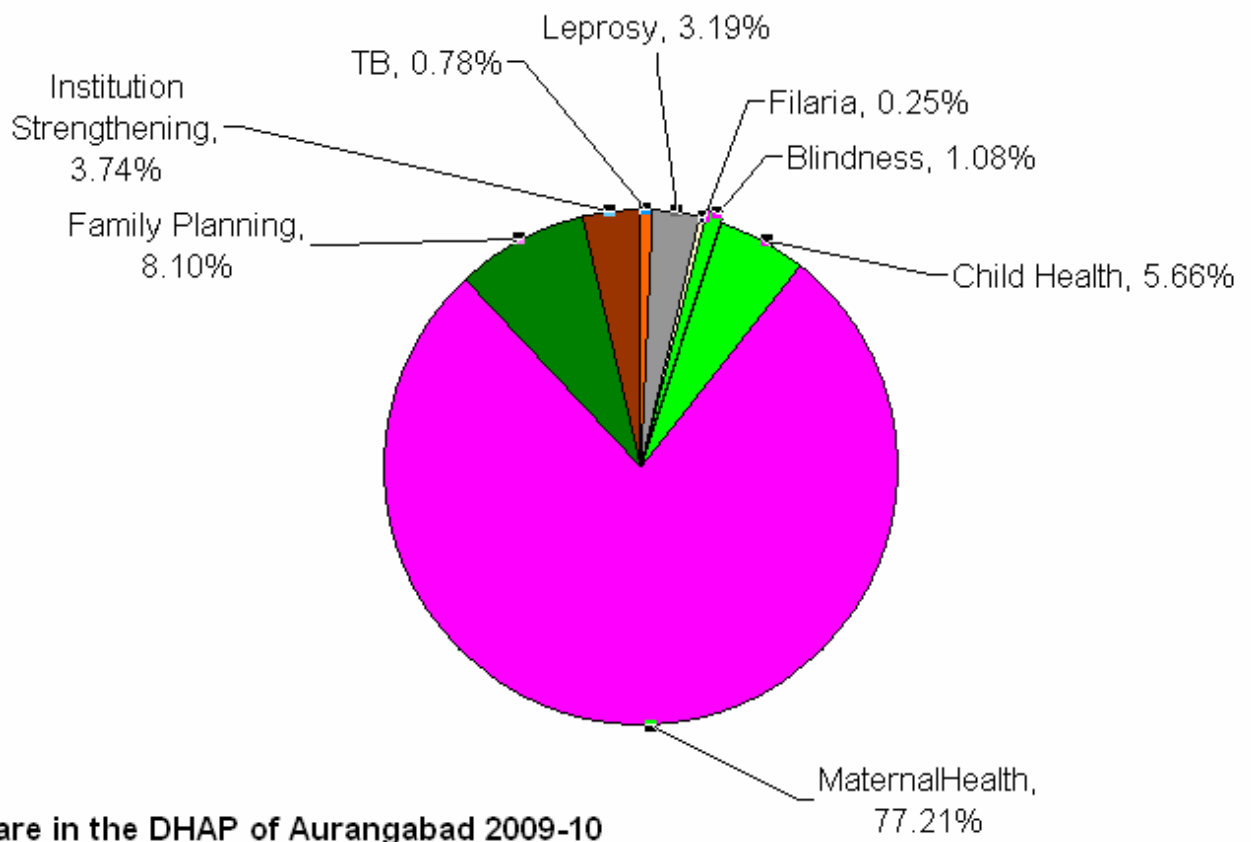
Fileria

Gaps	issues	Strategy	Activities	unit Cost	Total Budget
It affects mainly the economically weaker sections of communities		1. Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.	Line listing of the cases	NA	0
			Purchase of equipments for the management of Filaria cases like towel, Bucket, soap, mug etc	Rs 500 per HSC for 207 old and 76new HSCs (Proposed)	141500
			DEC distribution through AWCs and paying hon to AWWs for this.	Rs 100 for all 2004 AWC	200400
			Purchase of DEC	Rs 300000	300000
			Training to AWWs/ASHA on DEC distribution and filaria case management	Rs 5000 per PHC	55000
Result in low priority being accorded by governments for the control of lymphatic filariasis.		2. Continuous use of vector control measures.	Meeting with VHSC members	NA	0
Low effectiveness of the tools used by the control programme			Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.	NA	0

The chronic nature of the disease	4. IEC for ensuring community awareness and participation in vector control as well as personal protection measures.	Wall paintings	Rs 2000 per PHC	22000
		Total budget		718900

Budget Summary

Sl. No	Budget Head	%	Total Budget
1	TB	0.78%	2,257,000.00
2	Leprosy	3.19%	9,283,000.00
3	Filaria	0.25%	718,900.00
4	Blindness	1.08%	3,131,000.00
5	Child Health	5.66%	16,447,422.00
6	Maternal Health Family	77.21%	224,389,400.00
7	Planning Institution	8.10%	23,530,000.00
8	Strengthening Grand Total	3.74%	10,863,000.00 290,619,722.00



Budget Share in the DHAP of Aurangabad 2009-10

Thank you.