

District Health Action Plan

2009 - 2010



District Health Society
Vaishali

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Foreword

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

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

After a thorough situation 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.

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

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

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

About the Profile

Under the National Rural Health Mission this District Health Action Plan of Vaishali district has been prepared. From this, 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 our knowledge as this has been provided by the concerned medical officers of every block. We are grateful to the state level consultants (NHSRC/PHRN), DPMU, MOICs, Block Health Managers and ANMs and AWWs from their excellent effort we may be able to make this District Health Action Plan of Vaishali District.

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

Dr. R. K Choudhary
ACMO
Vaishali

Dr. Ashok Kumar Sinha
Civil Surgeon
Vaishali

Chapter-1

Introduction

1.1 Background

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

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

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

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

For effective programme implementation NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the need for situation analysis, stakeholder involvement in action planning, community mobilization, inter-sectoral convergence, partnership with Non Government Organizations (NGOs) and private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving program functionaries and community representatives at district level.

Stakeholders in Process

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

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

1.2 Objectives of the Process

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

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

1.3 Process of Plan Development

1.3.1 Preliminary Phase

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

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

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

1. How adequate are the existing human and material resources at various levels of care (namely from sub – center level to district hospital level) in the state; and how optimally have they been deployed?
2. What factors contribute to or hinder the performance of the personnel in position at various levels of care?
3. What structural features of the health care system as it has evolved affect its utilization and the effectiveness?

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

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

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

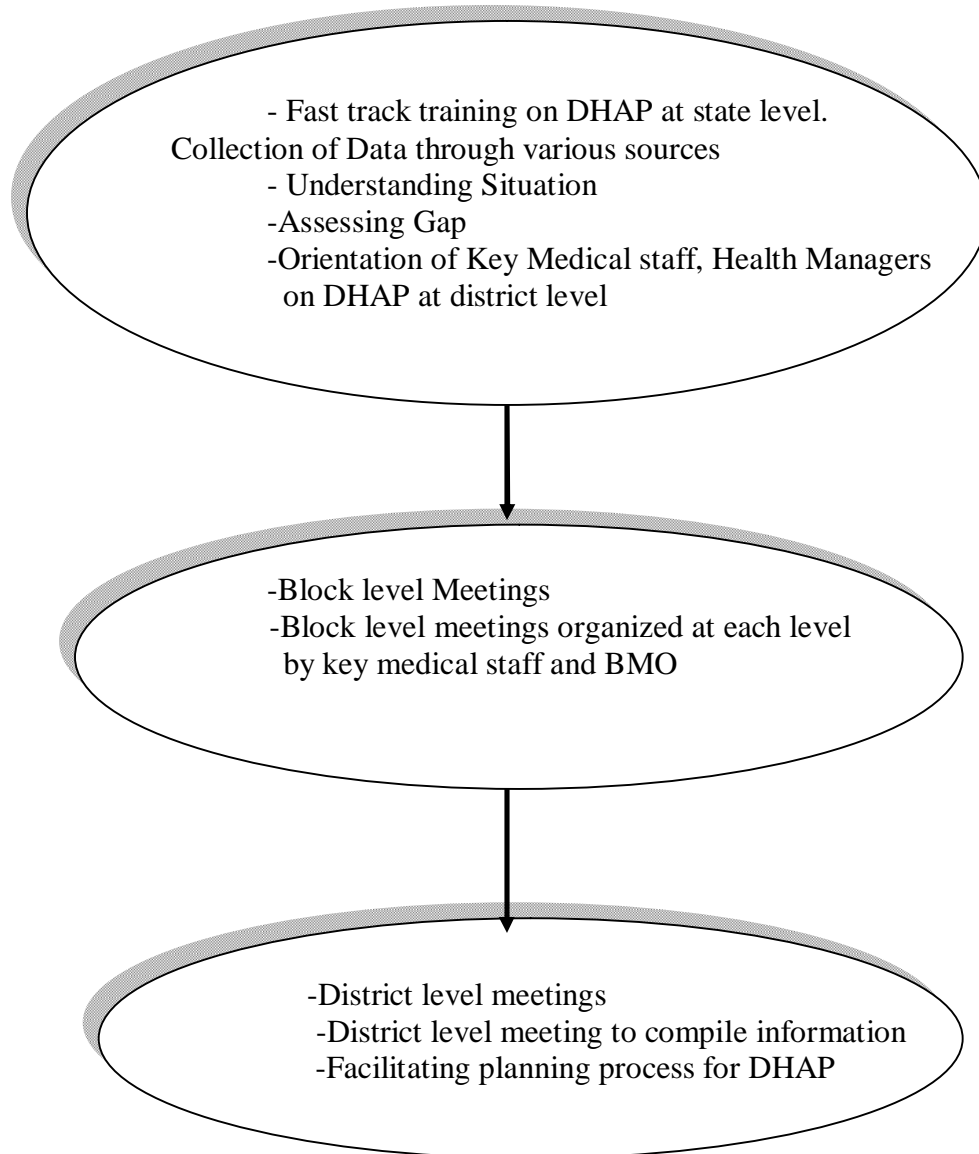
This Integrated Health Action Plan document of Vaishali district has been prepared on the said context.

1.3.3 Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon, ACO (Nodal officer for DHAP formulation), all programme officers and NHSRC/PHRN as well as the MOICs, Block Health Managers, ANMs, as a result of a participatory processes as detailed below. After completion the DHAP, a meeting is organized by Civil Surgeon with all MOIC of the block and all programme officer. Then discussed and displayed prepared DHAP. If any comment has come from participants it has added then finalized. The field staffs of the department too have played a significant role. District officials have provided technical assistance in estimation and drafting of various components of this plan.

After a thorough situational analysis of district health scenario this document has been prepared. In the plan, it is addressing health care needs of rural poor especially women and children, the teams have analyzed the coverage of poor women and children with preventive and promotive interventions, barriers in access to health care and spread of human resources catering health needs in the district. The focus has also been given on current availability of health care infrastructure in 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.

District Health Action Plan Planning Process



Chapter 2

District Profile

History

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

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

Sangha. Amrapali joined the order after realising the transitory nature of all things, including beauty.

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

Geographical Location

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

Govt's Administrative Set-up

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



District Health Administrative Setup

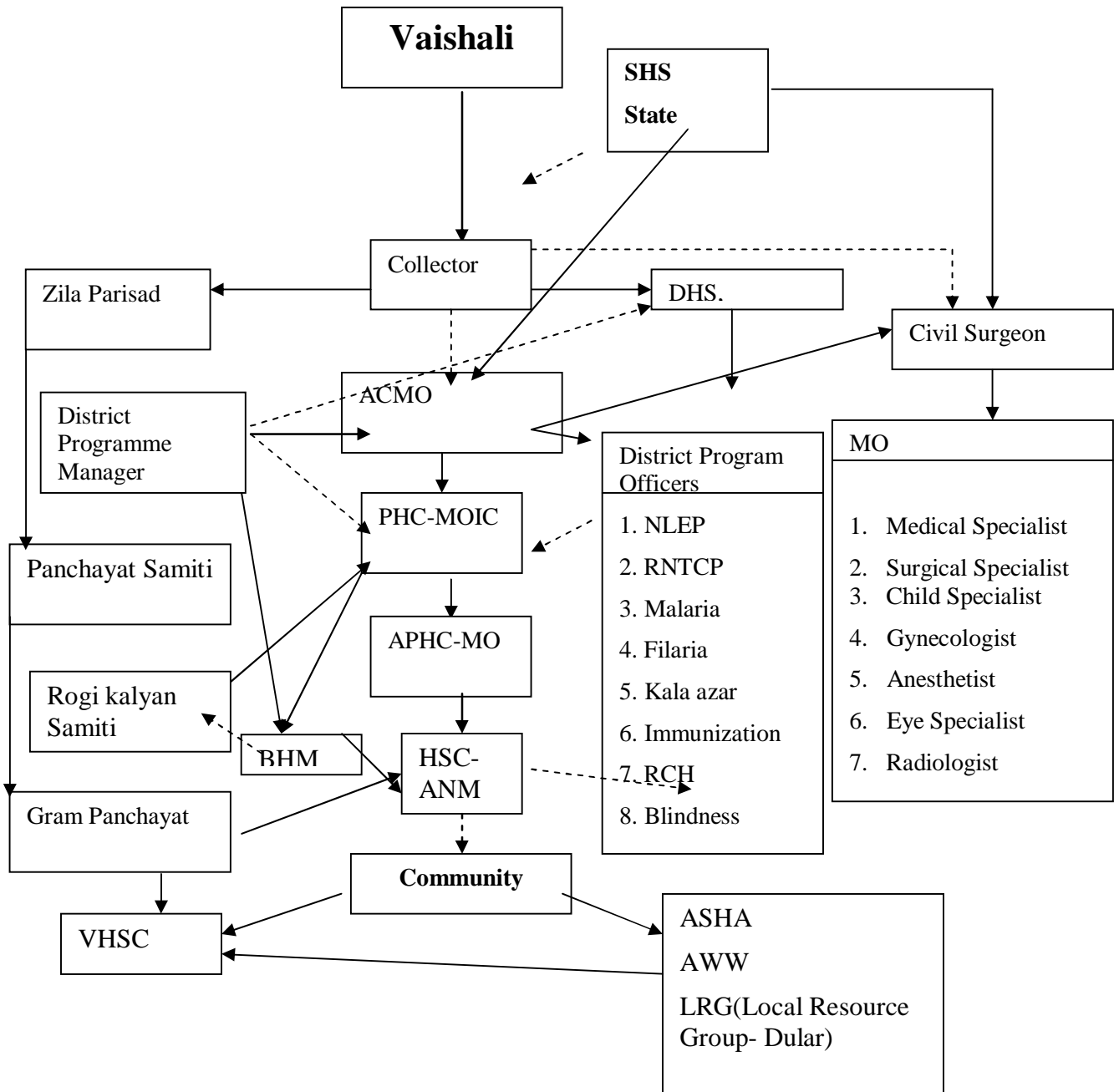


Table. ADMINISTRATIVE UNITS AND TOWNS IN VAISHALI DISTRICT

PHC	Community Development Blocks	Towns	Assembly Segments
Raghopur	Raghopur		Raghopur
Mahnar	Mahnar (Sub-Division)	Mahnar	Mahnar
Bidupur	Bidupur		Raghopur
Jandaha	Jandaha		Jandaha
Sahdei Bujurg	Sahdei Bujurg		Mahnar
Lalganj (RH)	Lalganj	Lalganj	Lalganj
Mahua	Mahua (Sub-Division)		Mahua
Desri	Desri		Mahnar
Goroul	Goroul		Vaishali
Patepur	Patepur		Patepur
Hajipur	Hajipur (Sub-Division)	Hajipur	Hajipur
Rajapakar	Rajapakar		Jandaha
Paterhi Belsar	Paterhi Belsar		Vaishali
Bhagwanpur	Bhagwanpur		Lalganj
Vaishali	Vaishali		Vaishali
Khajechand Chapra (RH)	Chehra Kalan		Vaishali
Hajipur Sadar Hospital	Hajipur (District HQ)	Hajipur	Hajipur
Chehra Kalan	Chehra Kalan		
Mohanpur (RH)	Raghopur		

Lok Sabha (Parliamentary) – 1. Vaishali 2. Hajipur

VAISHALI – AT A GLANCE

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

COMPARATIVE POPULATION DATA(2001 Census)

Basic Data	India	Bihar	Vaishali
Population	1027015	828787	2718421

Density	324	880	1335
<u>Socio- Economic</u>			
Sex- Ratio	933	921	920
Literacy % Total	65.38	47.53	50.49
Male	75.85	60.32	63.23
Female	54.16	33.57	36.58

LITERACY RATE		
TOTAL :-	50.49%	
MALES :-	63.23%	
FEMALES :-	36.58%	
VILLAGES		
TOTAL :-	1569	
INHABITED:-	1414	
UNINHABITED:-	155	
PANCHAYATS	:-	291
SUB-DIVISION	:-	03
BLOCKS	:-	16
REVENUE CIRCLES	:-	15
HALKAS	:-	114
POLICE STATIONS	:-	22
POLICE OUTPOSTS	:-	06
TOWNS	:-	03
NAGAR PARISHAD(HAJIPUR)	:-	01
NAGAR PANCHAYAT(LALGANJ, MAHNAR).	:-	02
M.P CONSTITUENCY	:-	2 (1 Part)
M.L.A. CONSTITUENCY	:-	8 (Part)
<u>HEALTH</u>		
DISTRICT HOSPITAL	:-	01
REFERRAL HOSPITAL	:-	03

PRIMARY HEALTH CENTRE	:-	16
ADDITIONAL PRIMARY HEALTH CENTRE	:-	30
HEALTH SUB CENTRE	:-	339
GRAMIN AUSADHALAY	:-	09
BLOOD BANK	:-	01
AIDS CONTROL SOCIETY	:-	01
TRAINED NURSES	:-	401
TRAINED DOCTORS	:-	120

2.1 SOCIO-ECONOMIC PROFILE

Social

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

Economic

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

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

- The size of population of Vaishali district is above 2718421, comprising 3.27% population of Bihar state in 2.2% proportion of state's area.
- Very high density of population (1335) which is still rising
- Decadal population growth rate of 26.39% as against 28.43% of the state as a whole. Thus the decadal growth rate of the district is slightly less than that of the state.

Infant Mortality Rate	41	57	50	34	36	35	40	56	48	Vaishali
	56	60	58	41	42	42	55	58	57	Bihar
										India
Child Mortality Rate	54	65	59	37	43	40	53	65	59	Vaishali
	59	69	64	42	46	44	57	66	62	Bihar
										India

Source: Population Foundation of India May 2008

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

2.2.1 HEALTH STATUS AND BURDEN OF DISEASES

Table. CASE FATALITY RATE

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

Table . MORBIDITY DUE TO MAJOR DISEASE

S.No.	Disease	2007	2008
-------	---------	------	------

1	Kala - azar	3275	2632
2	T.B. (NSP)	997	575
3	Leprosy (PR/10000)	1.15	1.30

Table . BASIC HEALTH STATUS INDICATORS OF VAISHALI DISTRICT

Indicators	Vaishali	Bihar
Couple Protection Rate (CPR)	33%	
Crude Death Rate (CDR)	8.1	8.1
Crude Birth Rate	31.9	30.4
Infant Mortality Rate	61	61
Maternal Mortality Rate	371	371
Total Fertility Rate (TFR)	4.6	4
Under 5 Mortality Rate	85	85
Still Birth Rate	2%	NA
Abortion rate	NA	NA

Table . DENOTING PRIORITY AREAS IN EACH OF THE BLOCK

Block	Hard to Reach area
Raghopur	Whole Raghopur block (72 villages)
Mahnar	Village Bahloipur
Patepur	Two vilages

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

2.2.2 PUBLIC HEALTH CARE DELIVERY SYSTEM: ORGANISATIONAL STRUCTURE AND INFRASTRUCTURE
Table HEALTH CARE INSTITUTIONS IN THE DISTRICT

Sl. No.	Type of Institutions	Number	No. of Beds*
1	District Hospital	1	120
2	Referral	3	60
3	Block PHCs	16	90
4	APHCs	30	0
5	Sub - centres	339	0
8	Ayurvedic Dispensaries	9	0

9	Anganwadi Centres	2476 / 2672	-
10	Others (Pvt. Facility accredited)	25	250

Table . DISTRIBUTION OF PUBLIC HEALTH FACILITIES IN DISTRICT

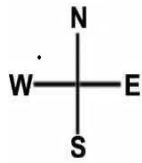
District Hospital	Civil Hospital	Community Health Centres	Block PHC	FRU / Referral
1	0	0	16	3

2.3 Map showing specialist doctors position blockwise



2.4 Map showing PHC and APHC locations

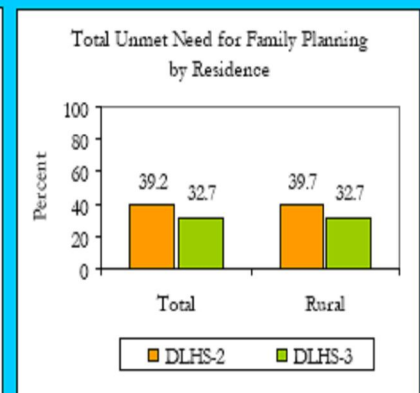
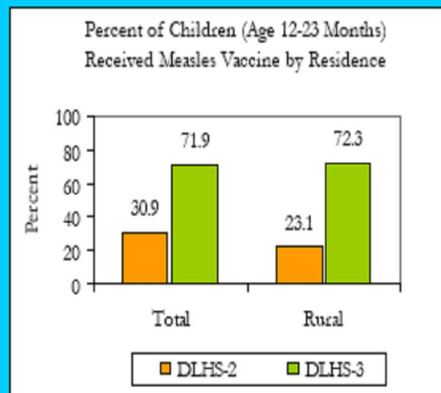
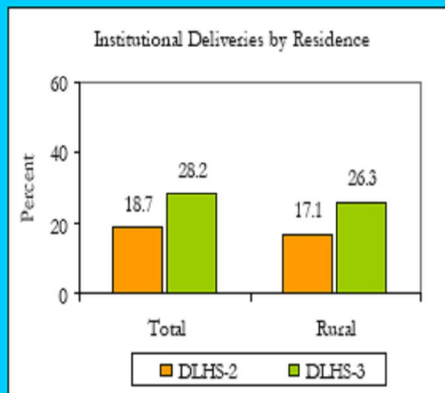
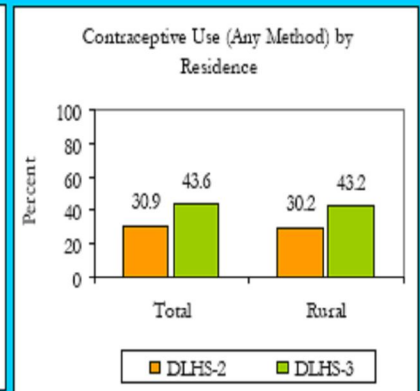
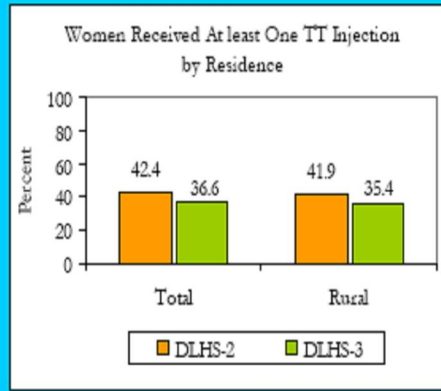
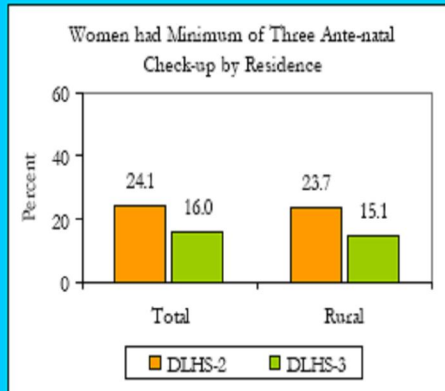
**DISTRICT MAP
VAISHALI**



INDICATORS
 E - EYE
 P- PAED.
 S-SURGEON
 O-ORTHO



Performance at a Glance



Chapter - 3

Situation Analysis

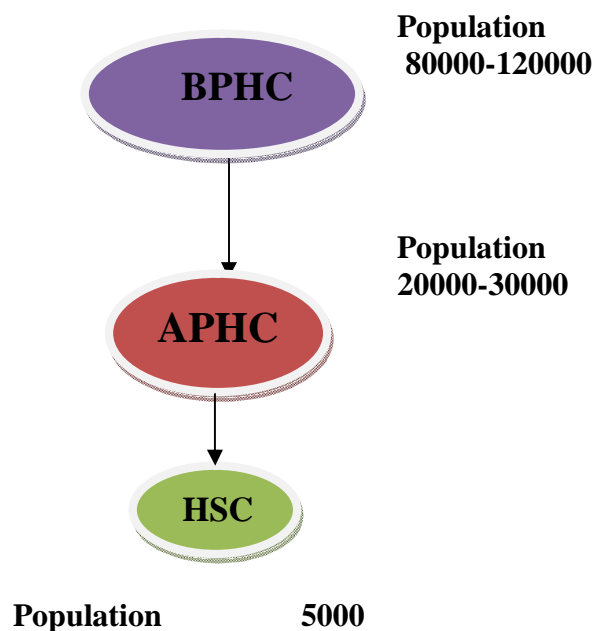
In the present situational analysis of the blocks of district Vaishali the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from census 2001, report of DHS office, Vaishali and various websites as well as other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

Table: Health Indicators

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

Sources: DLHS3, NFHS3, SRS2007

3.1.1. GAPS IN INFRASTRUCTURE:



First contact point with community

Introduction:

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

We are trying to analyze the situations at present in accordance with Indian Public Health Standards.

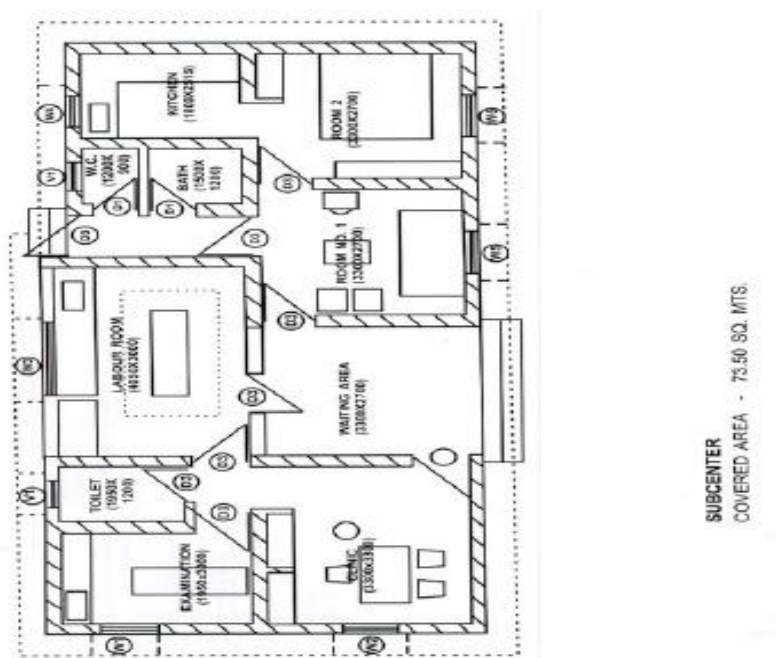
1. Infrastructure for HSCs:

IPHS Norms:

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

- i. Location of the centre: The location of the centre should be chosen that:
 - a. It is not too close to an existing sub centre/ PHC
 - b. As far as possible no person has to 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 Programme implementation Plan with area/Space Specifications is given below

Typical Layout of Sub- Centre with ANM Residence



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

Residential accommodation: 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 sub centre 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 be 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 Program (RCH-I and II) of Government of India, Ministry of Health and Family Welfare may be referred.

Health Sub Centers: Total population of the district as per 2001 census is 2718421. After considering two percent growth rate of the total population it comes around 3187470 (Decadal Growth Rate 2.3). After considering projected population in 2008, the district needs altogether 637 HSCs to cater its whole population. At present Vaishali have 339 established Health Sub Centers and 154 more Health sub centers are proposed to be formed. As per the IPHS norms (5000 population in plain area) the district still requires 135 new HSCs to be formed. Again, out

of 339 established HSCs, only 39 have their own buildings and rest 300 run in rented houses. All these 39 HSCs need renovation work. All the above mentioned HSCs need equipments, drugs, furniture and stationeries.

Health Sub Centers:				
Sub Heads	Gaps	Issues	Strategy	Activities
Infrastructure	A. Out of 339 HSCs only 39 are having own building	Inadequate facility in constructed building and lack of community ownership	Enhance visibility of HSC through hardware activity by the help of community participation.	A. Strengthening of HSCs having own buildings
	B. In existing 39 buildings 26 are running in comparatively in good condition, 6 are in under construction , one is in very poor condition and one is constructed but not handed over to health department.			B.1. White washing of HSC buildings. B.2. Organize adolescent girls for wall painting and plantation./hire local painter for colorful painting of HSC walls. List out all services which are provided at HSC level on the wall. B.3. Gardening in HSC premises by school children.
	C. Not even one building is having running water and electric supply.			C. Mobilize running water facility from nearby house if they have bore well and water storage facility and it could be on monthly rental.
	D. Lack of equipments and ANMs are reluctant to keep all equipments in HSC . E. Lack of appropriate furniture	Operational problem in availability of equipment in constructed HSC		D.1. Purchase of Furniture Prioritizing the equipment list according to service delivery (for ANC / Family planning / Immunization) D.2 Purchase of equipments according to services D.3 Purchase one almirah to keep all equipments safely and it could be keep in AWW / ASHA house.
	1. Non payment of rent of 300 HSCs for more than three years	1.Non payment of rent		Regularizing rent payment

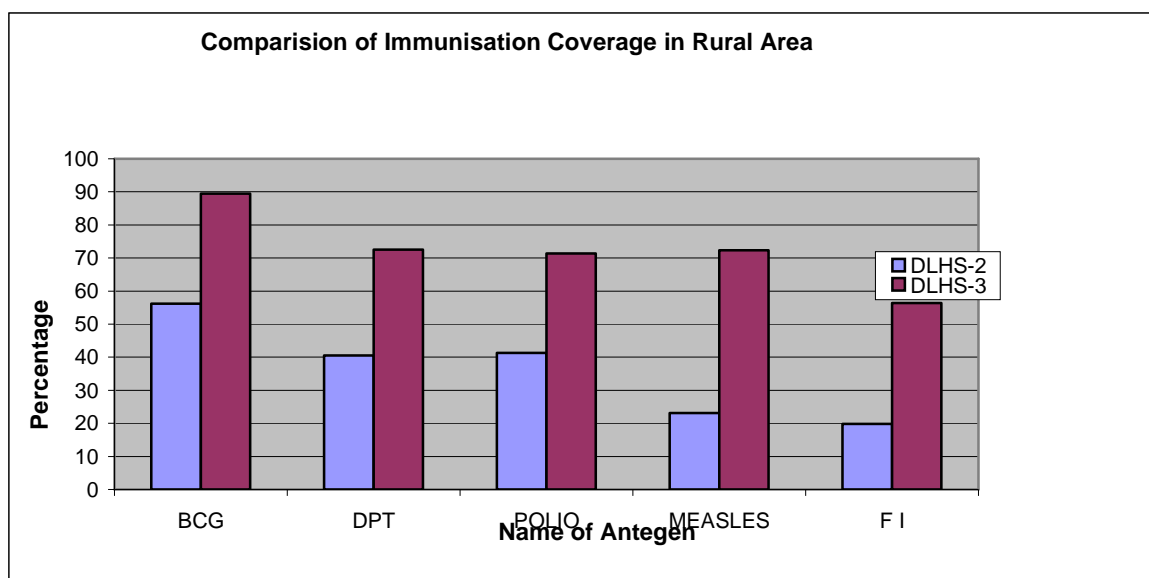
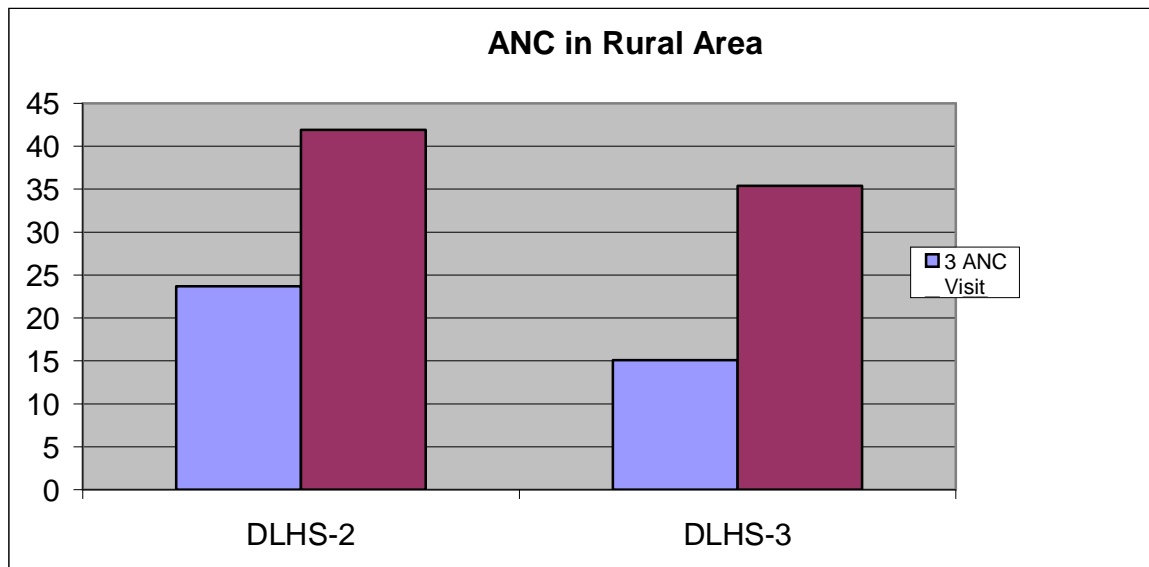
				<p>facilitate the backlog payment within two months</p> <p>B2. Streamlining the payment of rent through untied fund from the month of April 09.</p> <p>B3.Purchase of Furniture as per need</p> <p>B4 Prioritizing the equipment list according to service delivery</p> <p>B5 Purchase of equipments as per need</p> <p>B6 Printing of formats and purchase of stationeries</p>
	<p>1. The district still needs 135 more HSCs to be formed.</p>	<p>1. Land Availability for new construction</p> <p>2. Constraint in transfer of constructed building</p>		<p>3C. Construction of new HSCs</p> <p>C1. Preparation of PHC wise priority list of HSCs according to IPHS population and location norms of HSCs</p> <p>C2. Community mobilization for promoting land donations at accessible locations.</p> <p>C3. Construction of New HSC buildings</p> <p>C4. Meeting with local PRI /CO/BDO/Police Inspector for smooth transfer of constructed HSC buildings.</p>
	<p>Non participation of Community in monitoring construction work</p>	<p>Monitoring</p>	<p>Ensuring community Monitoring</p>	<p>1. Biannual facility survey of HSCs through local NGOs as per IPHS format</p> <p>2. Regular monitoring of HSC facilities through PHC level supervisors in IPHS format.</p> <p>3. Monitoring of renovation / construction works through VHSC members / Mothers committees / VECs /</p>

				<p>others as implemented in Bihar Education Project.</p> <p>4. Training of VHSC / Mothers committees / VECs / Others on technical monitoring aspects of construction work.</p> <p>5. Monthly Meeting of one representative of VHSC / Mothers committees on construction work.</p>
	<p>1. Lack of community ownership in the construction of Health infrastructures.</p>	<p>1. Community ownership</p>	<p>Strengthening of VHSCs, PRIs</p>	<p>1. Formation and strengthening of VHSCs, Mothers committees.</p> <p>2. “Swasthya Kendra Chalo Abhiyan” to strengthen community ownership.</p> <p>3. Nukkad Nataks on Citizen’s charter of HSCs as per IPHS.</p> <p>4. Monthly meetings of VHSCs, Mothers committees.</p>

3.1.2 Services of HSCs:

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

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



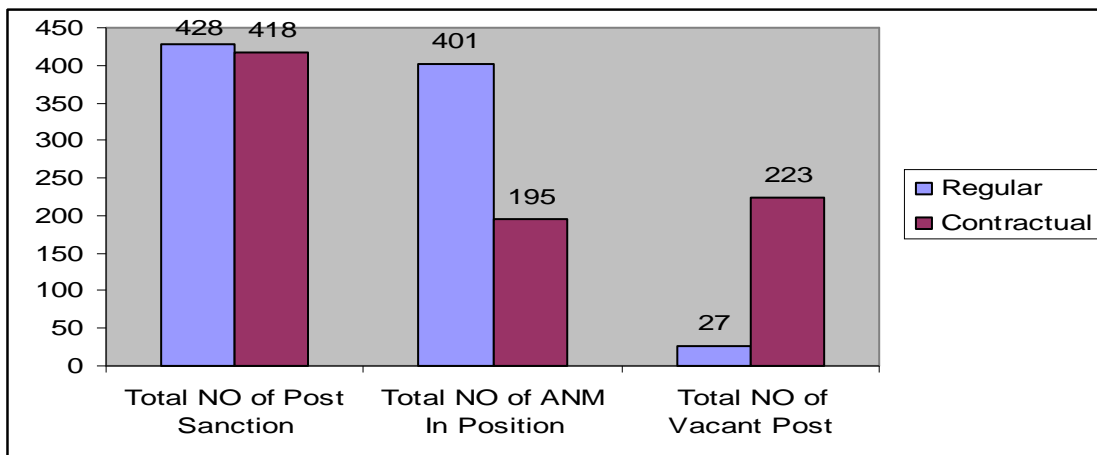
Sub Heads	Gaps	Issues	Strategy	Activities
Service performance	Unutilized untied fund at HSC level	Operationalization of Untied fund.	Capacity building of account holder of untied fund	<ol style="list-style-type: none"> 1. Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts.
	No ANC at HSC level	Improvement in quality of services like ANC, NC and PNC, Immunization	Strengthening one HSC per PHC for institutional delivery in	<ol style="list-style-type: none"> 1. Identification of the best HSC on service delivery 2. Listing of required equipments and medicines as per IPHS norms 3. Purchasing / indenting

			first quarter	according to the list prepared 4.Honouring first delivered baby and ANM
	<p>Only 14.2% PW registered in first trimester PW with three ANC's is 15.1%, TT1 coverage is 35.4%, 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,</p>	<p>Improvement in quality of services like ANC, NC and PNC, Immunization and family planning</p>	<p>1. Phasewise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. 2. Community focused family planning services</p>	<p>1 Gap identification of 39 HSCs through facility survey 2. Eligible Couple Survey 3. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 4. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 5. Training of ANMs on IUD insertion</p>
	Lack of counseling services	Training	Training	1. Training to ANMs on ANC, NC and PNC, Immunization and other services.
	HSC unable to implement disease	Integration of disease control programs at HSC level.	Implementation of disease control	1. Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.

	control programs		programs through HSC level	<p>(four to five HSC per week)</p> <p>2.Strengthening ANMs for community based planning of all national disease control program</p> <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>
	80% of the HSC staffs do not reside at place of posting	Absence of staffs	Community monitoring	1. Submission of absentees through PRI
	Problem of mobility during rainy season	Communication and safety		<p>1.Purchasing Life saving jackets for all field staffs</p> <p>2. Providing incentives to the ANMs during rainy season so that they can use local boats.</p>

	Lack of convergence at HSC level	Convergence	Convergence	<p>1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG 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>
	<p>Lack of proper reporting from field</p> <p>Lack of appropriate HMIS formats.</p>	Reporting	Strengthening of reporting system	<p>1.Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc</p> <p>2.Printing of adequate number of reporting formats and registers</p> <p>3. Hiring consultants to develop software's for reporting.</p>

3.1.3 Human Resource



Total No of
HSC -339
APHC-30
PHC-16
RF-03
DH-01

Source: DHS Vaishali Report.

Sub Heads	Gaps	Issues	Strategy	Activities
Human Resource	223 seats of contractual ANM®, 12 seats of contractual ANMs and 27 seats of Regular ANMs are vacant. Out of 29 sanctioned post of LHVs only 22 are placed, Seat of 28 male workers are vacant	Filling up the staff shortage	Staff recruitment	1.Selection and recruitment of 262 ANMs 2.Selection and recruitment of 28 male workers
	All 464 contractual ANMs needs training on different services.	Untrained staffs	Capacity building	1.Training need Assessment of HSC level staffs. 2.Training of staffs on various services
	The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities	Training	Strengthening of ANM training school	1. Analyzing gaps with training school 2.Deployment of required staffs / trainers 3. Hiring of trainers as per need. 4. Preparation of annual training calendar issue wise as per guideline of Govt of India. 5. Allocation of fund and operationalization of allocated fund.
Drug kit availability	1.No drug kit as such for the HSCs as per IPHS norms.(Kit A, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DEC)s)and contraceptives, 2.No Drug kit for AWCs(@one kit per annum,) 3.No ASHA kit	Indenting	Strengthening of reporting process and indenting through form 6	1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs / vaccines according to services and reports

	Only need based emergency supply Irregular supply of drugs	Logistics		1.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.Hiring vehicles for supply of drug kits through untied fund. 3.Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)
		Operationalization	Couriers for vaccine and other drugs supply	1 Hiring of couriers as per need 2 Payment of courier through ANMs account
			Phase wise strengthening of APHCs for vaccine / drugs storage	1.Purchasing of cold chain equipments as per IPHS norms 2. training of concerned staffs on cold chain maintenance and drug storage

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

Additional PHC:				
Sub Heads	Gaps	Issues	Strategy	Activities

<p>Infrastructure</p>	<p>1.The district altogether need 94 APHCs but there are 30 APHCs functioning in the district and 60 more are proposed to be established. 2. Four more are required to be formed. 3.Out of 30 APHCs only 16 are having own building 4.Existing 16 buildings are not properly maintained 5.Non payment of rent of 14 APHCs for more than three years Lack of equipments, Lack of appropriate furniture Non availability of HMIS formats/registers and stationaries</p>	<p>Lack of facilities / basic amenities in the constructed buildings Nonpayment of rent land Availability for new construction Constraint in transfer of constructed building. Lack of community ownership</p>	<p>Strengthening of VHSCs, PRI and formation of RKS Strengthening of Infrastructure and operationalization of construction works in Three phase</p>	<p>1.“Swasthya Kendra Chalo Abhiyan” to strengthen community ownership 2.Nukkad Nataks on Citizen’s charter of APHCs as per IPHS 3. Registration of RKS 4.Monthly meetings of VHSCs, Mothers committees and RKS A. Strengthening of APHCs having own buildings A.1Renovation of APHCs buildings A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries B. Strengthening of APHCs running in rented buildings. B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund/ RKS from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new APHC buildings as standard layout of IPHS norms. C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs</p>
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	lacks adequate number of trainers, staffs and facilities Out of 22 sanctioned post of LHVs only 17 are placed Most of the APHC staffs are deputed to respective PHC hence APHC are defunct.		Strengthening of ANM training school	<p>2. Deployment of required staffs / trainers</p> <p>3. Hiring of trainers as per need.</p> <p>4. Preparation of annual training calendar issue wise as per guideline of Govt of India.</p> <p>5. Allocation of fund and operationalization of allocated fund.</p>
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, Only need based emergency supply Irregular supply of drugs	<p>Indenting</p> <p>Logistics</p> <p>Operationalization</p>	<p>Strengthening of reporting process and indenting through form 2 and 6</p> <p>Couriers for vaccine and other drugs supply</p> <p>Phase wise strengthening of APHCs for vaccine / drugs storage</p>	<p>1. Weekly meeting of APHC staffs at PHC for promoting APHC staffs for regular and timely submission of indents of drugs / vaccines according to services and reports</p> <p>2. Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map</p> <p>2.1 Hiring vehicles for supply of drug kits through untied fund.</p> <p>2.3 Developing three coloured indenting format for the APHC to PHC (First reminder - Green, Second reminder - Yellow, Third reminder - Red)</p> <p>3.1 Hiring of couriers as per need</p> <p>3.2 Payment of courier through APHC account</p> <p>4.1 Purchasing of cold chain equipments as per IPHS norms</p> <p>4.2 training of concerned staffs on cold chain maintenance and drug storage</p>
Service performance	RKS has not been formed at	Formation of RKS Operationalization	Capacity building of	1. Training of signatories on operating Untied fund /RKS

	<p>any of the APHC.</p> <p>Unutilized untied fund at APHC level</p> <p>No institutional delivery at APHC level</p> <p>No OPD At any of the APHC</p> <p>No inpatient facility available</p> <p>No ANC, NC and PNC and family planning services.</p> <p>No lab facility</p> <p>No Ayush practitioner posted</p> <p>No rehabilitation services</p> <p>No safe MTP service</p> <p>No OT/ dressing and Cataract operation services.</p> <p>Approx 80% of APHC staffs not reside at place of posting</p> <p>Lack of counseling services</p> <p>Problem of mobility during rainy season</p> <p>Lack of convergence at APHC level</p> <p>Operational gaps: There is no link between HSCs and APHCs and the same way there is no link between APHC</p>	<p>of Untied fund.</p> <p>Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps.</p> <p>Integration of disease control programs at APHC level.</p> <p>Family Planning services</p> <p>Convergence Operational issues</p>	<p>account holder of untied fund</p> <p>Phase wise strengthening of 16 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms.</p> <p>Implementati on of disease control programs through APHC level where APHC will work as a resource center for HSCs. At present the same is being done by PHC only.</p> <p>Community</p>	<p>account, book keeping etc</p> <p>2. Assigning PHC RKS accountant for supporting operationalization of APHC level accounts</p> <p>2. Timely disbursement of untied fund / seed money for APHCs RKS.</p> <p>3. 1 Gap identification of 16 APHCs through facility survey</p> <p>2.strengtheing one APHC per PHC for institutional delivery in first quarter</p> <p>3.Honouring first delivered baby and ANM</p> <p>1 Review of all disease control programs APHC wise in existing Tuesday weekly meetings at PHC with form 6</p> <p>2.Strengthening ANMs for community based planning of all national disease control program</p> <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>5.Weekly meeting of the staffs of concerned HSCs (as assigned to the APHC)</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.Outsourcing services for Generator, fooding, cleanliness and ambulance.</p> <p>1. Fixed Saturday for meeting</p>
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	and PHC		focused Family Planning services PPP Convergence	day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC.
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3.3 Primary Health centers: The district has 17 PHCs, three referral hospitals and a District hospital. The PHC of Lalganj and referral hospital of Lalganj is running in the same building. Also the PHC of Raghapur and Referral hospital of Mohanpur is running in the same building.

Primary Health Centers:(30 bedded)				
Indicators	Gaps	Issues	Strategy	Activities

<p>Infrastructure</p>	<p>All PHCs are running with only six bed facility. At present 15 PHCs are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.</p> <p>Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms.(List attached)</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 the area of improvement.</p> <p>Lack of equipments as per IPHS norms and also under utilized 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. Lack of community participation in the functioning of RKS. Lack of facilities/ basic amenities in the PHC buildings</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>Upgradation of PHCs into 30 bedded facilities.</p> <p>ISO certification of selected PHCs in the district.</p> <p>Strengthening of BMU</p> <p>Ensuring community participation.</p>	<p>1.Need based (Service Delivery)Estimation of cost for upgradation of PHCs 2.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, Accountants in all institutions.(16 PHCs, 3 Referrals and Sadar hospital.) 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities.</p> <p>1.Meeting with community representatives on erecting boundary, beautification etc, 2. Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS.</p>
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			<p>Strengthening of Infrastructure and operationalization of construction works</p> <p>Monitoring</p>	<p>Strengthening of PHCs</p> <ol style="list-style-type: none"> 1. Renovation of PHCs 2. Purchase of Furniture 3. Prioritizing the equipment list according to service delivery and IPHS norms. 4. Purchase of equipments 5. Printing of formats and purchase of stationeries <ol style="list-style-type: none"> 1. Biannual facility survey of PHCs through local NGOs as per IPHS format 2. Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.
Human Resource	<p>As per IPHS norms each PHC requires the following clinical staffs:(List attached) But the actual position is General Surgeon 8/16 Physician 2/16 Gynecologist 2/16 Pediatrics 5/16 Eye surgeon 4./16(Proposed) As per IPHS norms each PHC requires the following para medical support:(List attached) But the actual position is Nurse midwife 381/419 Dresser: 20/16 Pharmacist/compounders: 14/16 Lab technician: 17/16 Radiographer0/16 Ophthalmic assistant:</p>	<p>Staff shortage Untrained staffs</p>	<p>Staff recruitment</p> <p>Capacity building</p>	<ol style="list-style-type: none"> 1. Selection and recruitment of Doctors 2. Selection and recruitment of ANMs/ male workers 3. Selection and recruitment of paramedical/ support staffs 4. Appointment of Block Health Managers, Accountants in all institutions.(16 PHCs, 3 Referrals and Sadar hospital.) <ol style="list-style-type: none"> 1. Training need Assessment of PHC level staffs 2. Training of staffs on various services 3. Trainings of BHM and accountants on

	<p>7/16 Ward boys / nursing orderly: 78/32 Sweepers: 59/48 Chowkidars:3/16 OPD attendants 12/16 Statistical assistants 6/16 OT attendants 2/16 Registration clerck 0/15 Untrained doctors / ANMs in emergency obstetrics care. Only Ten BHM and 14 accountants are placed at present. Demotivated BPMU staffs</p>			<p>their responsibilities. 4. Trainings of BHM on implementation of services / various National programs.</p>
Drug kit availability	<p>Irregular supply of drugs because of lack of fund disbursement on time. Only 70 % 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>Indenting Logistics Operationalization</p>	<p>Strengthening of reporting process and indenting through form 7</p> <p>Strengthening of drug logistic system</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.
Service performance	<ol style="list-style-type: none"> 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. 2. Total 59 seats of 	<p>Optimum Utilization of Human Resources</p>	<p>Quality improvement in residential facility of doctors/ staffs.</p>	<ol style="list-style-type: none"> 1. Hiring of rented houses from RKS fund for the residence of doctors and key staffs. 2. Incentivizing doctors on their performances especially on OPD,

	<p>Regular and 25 seats of contractual doctors in the district is vacant.</p> <p>3. 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.)</p> <p>4. 5 PHCs out of 15 are lacking 24 hrs new born care services.</p> <p>5. 2 PHCs are still not providing Tubectomy services.</p> <p>6. Only one PHC (Mahnar) provides safe abortion service.</p> <p>7. Only five PHCs provides 24 hrs BEmoC services.</p> <p>8. None of the PHC provides 24 hour blood transfusion services, however PHC Mahnar has been provided the equipments for blood storage unit.</p> <p>9. 8 PHC does not have laboratory facilities.</p> <p>11. 2 Lab services provided by PPP services have fled away.</p> <p>12. Only one PHC provides adolescent sexual and reproductive health services.</p> <p>13. Health facility with AYUSH services is not being provided</p> <p>14. Referral</p> <p>a. No pick up facility for PW or patients.</p> <p>b. BPL patients are not</p>	<p>Epidemic outbreaks and Need based intervention in epidemic areas.</p> <p>Service Load centered at PHC</p> <p>Availability of AYUSH pathy.</p>	<p>Recruitment</p> <p>Proper and timely information of outbreaks</p> <p>Strengthening of equipments and services and increase in the number of ambulances.</p> <p>Strengthening of AYUSH</p>	<p>IPD, FP operations, Kala - azar patients treatment.</p> <p>3. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day</p> <p>1. Selection and appointment of contractual doctors and staffs</p> <p>1. Mapping of the areas having history of outbreaks disease wise. 2. Developing micro plans to address epidemic outbreaks 2. Assigning areas to the MOs and staffs 3. Motivating ASHA on immediate information of outbreaks 4. Purchasing folding tents, beds and equipments and medicines to organize camps in epidemic areas.</p> <p>1. Repairing of all defunct Ambulances 2. Repairing of PHCs gensets and initiating their use. 3. Hiring of ambulances as per need.</p> <p>1. Appointment of one AYUSH practitioner and Yoga teacher in every PHC</p> <p>1. Insurance of all properties and staffs of PHC</p>
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	<p>exempted in paying fee of ambulance.</p> <p>c. Lack of maintenance of ambulances</p> <p>d. Shortage of ambulances</p> <p>15. Quality of food, cleanliness (toilets, Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC.</p> <p>16. All PHCs have their own generator sets but are not in use.</p> <p>17. In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs are reluctant to handle emergency cases.</p> <p>18. Several cases of theft of instruments, computers, and submersible pumps etc at PHCs.</p> <p>19. No guidance to the patients on the services available at PHCs.</p> <p>20. Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.</p> <p>21. Lack of inpatient facility for kala-azar patients.</p> <p>22. Lack of counseling services</p> <p>23. Problem of mobility during rainy season</p> <p>24. Lack of convergence</p> <p>25. Lack of timely reporting and delay in data collection</p>	<p>Insecurity (Staff and Properties)</p> <p>Govts existing services like lab, x-ray, generator, fooding and cleanliness services.</p>	<p>services at PHC level in the first level.</p> <p>Confidence building measures</p> <p>Strengthening of the Govts existing services like lab, x-ray, generator, fooding and cleanliness services.</p> <p>Creating friendly environment</p> <p>HMIS and</p>	<p>2.Placing one TOP in every PHC</p> <p>1. Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate.</p> <p>2. Recruitment of lab technicians as required</p> <p>3. Purchase of equipments/ instruments for strengthening lab.</p> <p>4. Hiring of menial workers for cleanliness works.</p> <p>1. Assigning LHV for counseling work</p> <p>2. Wall writing on every section of the building denoting the facilities</p> <p>3. Name plates of doctor</p> <p>4. Displaying Roster of doctors with their details.</p> <p>5. Gardening</p> <p>6. Sitting arrangement for patients</p> <p>7. Installation of LCD TV with cable connection</p> <p>8. Installation of safe drinking water equipments/water cooler,</p> <p>9. Installation of solar heater system and light with the help of BDO/Panchayat</p> <p>9. Apron with name plates with every doctors</p> <p>10. Presence of staffs with uniform and name plates.</p> <p>1. Orientation of the</p>
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			strengthening of reporting process	staffs on indicators of reporting formats 2.Purchase of Laptops for DPMs and BHM
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3.4 District Hospital:

District Hospital Hajipur:																								
Indicators	Gaps	Issues	Strategy	Activities																				
Infrastructure	<p>1. There are 120 beds in the Sadar hospital which is not adequate as per the requirement.</p> <table border="0"> <tr> <td>Ward</td> <td>No of beds</td> </tr> <tr> <td>Male medical ward:</td> <td>20</td> </tr> <tr> <td>Male surgical ward:</td> <td>20</td> </tr> <tr> <td>Female ward</td> <td>: 20</td> </tr> <tr> <td>Child ward</td> <td>: 20</td> </tr> <tr> <td>Delivery ward</td> <td>: 10</td> </tr> <tr> <td>TB ward</td> <td>: 10</td> </tr> <tr> <td>Infectious disease</td> <td>: 10</td> </tr> <tr> <td>Prisoners ward</td> <td>: 10</td> </tr> <tr> <td>Total</td> <td>: 120</td> </tr> </table> <p>2. At present District hospital is working with average 25 deliveries per day, 30 inpatient Kala-azar, 20 FP operation/emergency operations and 800 OPD per day. This huge workload is not being addressed with only 120 beds inadequate facility.</p> <p>3. Lack of equipments as per IPHS norms and also under utilized equipments.</p> <p>4. Lack of appropriate furniture</p> <p>5. Operation of RKS: Delayed process of operation. Delay in disbursement of fund</p> <p>6. Lack of facilities/ basic amenities in the PHC buildings</p> <p>7. Huge workload in central registration unit</p>	Ward	No of beds	Male medical ward:	20	Male surgical ward:	20	Female ward	: 20	Child ward	: 20	Delivery ward	: 10	TB ward	: 10	Infectious disease	: 10	Prisoners ward	: 10	Total	: 120	Lacks in infrastructure	Strengthening of infrastructure	<p>1. Purchase of 500 beds.</p> <p>2. Repairing of beds.</p> <p>3. Listing of required equipments as per IPHS norms and their purchase.</p> <p>4. Listing of required furniture and their purchase.</p> <p>5. Simplifying process of RKS operation.</p> <p>6. Computerization of registration system for the OPD/IPD patients.</p> <p>7. Construction of shed for waiting patients</p> <p>8. Installation of 3 Water cooler freezes as per requirement.</p> <p>9. Installation of seven vapor lights as per requirements.</p> <p>10. Renovation of boundary wall and gate.</p> <p>11. Construction of new Post mortem room with all facilities.</p> <p>12. Renovation of drainage system and leveling of internal area up to the level of outer area.</p>
Ward	No of beds																							
Male medical ward:	20																							
Male surgical ward:	20																							
Female ward	: 20																							
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Delivery ward	: 10																							
TB ward	: 10																							
Infectious disease	: 10																							
Prisoners ward	: 10																							
Total	: 120																							

	<p>8. No sitting arrangement for patients.</p> <p>10. No safe drinking water facility.</p> <p>11. Half of the hospital area remains dark at night.</p> <p>12. Delivery room lacks beds, labor table, stretchers, equipments.</p> <p>13. No proper gate and boundary wall.</p> <p>14.No proper post mortem room and equipments.</p> <p>15. Heavy water logging during rainy season.</p> <p>16.Buildings for ICU, Causality ward are ready but due to lack of equipments, facilities are not functional.</p> <p>17. No use of paying wards.</p> <p>18.No enquiry counter as such for the patients.</p> <p>20.No residential facilities for doctors and staffs.</p> <p>21. No canteen facility</p>			<p>13. Construction of enquiry counters at the gate.</p> <p>14. Hiring of ambulances.</p> <p>15. Construction of new residential buildings.</p> <p>16.Hiring of rented houses from RKS fund for the residence of doctors, BMU and key staffs.</p> <p>16.Tender for canteen facility.</p> <p>17. Sitting arrangement for patients</p> <p>18. Installation of LCD TV with cable connection</p>
Human Resource	<p>1.Post of gynecologist and pathologist are vacant.</p> <p>2.Post of one dresser, one OT assistant and one ophthalmic assistant are vacant.</p>	Lack in Staff position	<p>Recruitment</p> <p>Deputing staffs</p>	<p>1. Appointment of gynecologist and pathologist on contract basis.</p> <p>2. Appointment of one dresser, one OT assistant and one ophthalmic assistant on contract basis.</p> <p>1. Deputation of required staffs from field.</p>
Drug kit availability	<p>1. Irregular supply of drugs because of lack of fund disbursement on time.</p> <p>2. Only 70% essential drugs are rate contracted at state level.</p> <p>3. There is no clarity on the guideline for need based</p>	Improper Supply and logistics	Capacity building and strengthening of reporting process and indenting through form 7	<p>1.Training of store keepers on invoicing of drugs</p> <p>2.Implementing computerized invoice system</p> <p>4. Enlisting of equipments for safe storage of drugs.</p> <p>5. Purchase of</p>

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

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

4.2 Targeted Objectives and Suggested Strategies

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

4.3 MATERNAL HEALTH

Logical Framework

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

						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 received JBSY payments immediately after delivery
2	To increase safe delivery by trained SBA 9.6%(DLHS3) to 100% by year 2010	2.1	Proportion of birth 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 accelrate APHC for OPD and Fixed AN clinics	3.1.4.1	% of OPD clinics orgnised at APHC level.

4	To provide safe abortion services at all facilities	4.1	% MTP cases reported through HMIS formats / Form -7	4.1.1	To provide MTP services at health facilities	4.1.1.1	No of facilities having MTP services (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. No.	Strategy	SI	Gaps	SI	Activities	Unit Cost	Total Budget
A1	To make functional PHC (24 hr x 7 days) for institutional deliveries		Infrastructure				
		1.1	All PHCs are with only six bedded facility. 50 - 60% of facilities are not adequate as per IPHS norms. (List attached, Annexure.)	1.1.1	Need based (Service delivery) Estimation of cost for upgradation of PHCs. Selection of any two PHCs for ISO certification in first phase	@ 200000/- Per PHC	3800000
		1.2	At present 16 PHC are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation / emergency operation and 120 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	1.2.1	Preparation of priority list of interventions to deliver services.	NA	0
		1.4	The comparative analysis of facility survey (08-09) and DLHS3 facility survey (06-07), the service availability tremendously increased but	1.4.1	Sending the recommendation for the certification with existing services and facility detail.	NA	0

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

	1.12.10		Selection and recruitment of grade A nurses for conducting delivery	3 Grade A nurse for each PHC	5130000
			Selection and recruitment of dresser	19 Dresser, one for each PHC	1026000
			Selection and recruitment of Pharmasist.	19 x 2 Pharmasist for each PHC	2280000
			Three month induction training of Grade A nurse under supervision of District level resource team.	100/- per day x 90 days for 51 grade A nurse	459000
	1.13	1.13.1	Training need Assessment of PHC level staffs	NA	0
			Honorarium of Block Accountants	13 Accountant @ 12000/	1872000
			Rent of Data Center	17 Data Center @ 7500/	1530000

				Honorarium of BHM	10 BHM @ 18000/-	2160000
				Mobility support to BHM	Rs 2000 per month per BHM	408000
	1.14		1.14.1	Appointment of Block Health Managers, Accountants in all institutions.(15 PHCs, 2 Referrals and Sadar hospital.)	7 BHM and 4 Accountants Budget in RKS head	0
				Process of all recruitments	6 types of recruitment @ 10000	60000
				Trainings of BHM	19 BHM	38000
				Training on Program, Finance management and HMIS	19 BHM, 19 Block Accountants and 19 Data Center operators	114000
Drug Supply						

1.16	Irregular supply of drugs because of lack of fund disbursement on time.	1.16.1	Ensuring the availability of FIFO list of drugs with store keeper.	NA	0
1.17	Only 38 essential drugs are rate contracted at state level .	1.17.1	2.Implementing computerized invoice system in all PHCs	NA	0
			Purchase of Drug invoice software	Rs 10000 per PHC	190000
	Lack of fund for the transportation of drugs from district to blocks.	1.17.2	3.Fixing the responsibility on proper and timely indenting of medicines (keeping three months buffer stock)	NA	0
1.18		1.18	4.Payment from Rogi Kalyan samiti account.	Rs 2000 per month per PHC	456000
1.19	There is no clarity on the guideline for need based drug procurement and transportation.	1.19.1	5. Orientation meetings/ training on guidelines of RKS for operation.	Rs 2000 per PHC	38000
1.2	Drugs are not properly stored	1.20.1	6. Enlisting of equipments for safe storage of drugs.	NA	0
		1.20.2	7. Purchase of enlisted equipments.	Rs 15000 per PHC	285000
		1.20.3	8.training of store keepers on invoicing of drugs	Rs 2000 per PHC	38000
	Performance				0

	1.21.1	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
	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 5000 per PHC per month	1140000
1.22.2			Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.	Rs 5000 per PHC per month	1140000	
1.22.3			Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day	NA	0	
	1.24	5 PHCs are lacking 24 hrs new born care services.	1.24.1	Ensure 24 hrs new born care services in 10 PHC.	Budget in Child health care activity	0
To make functional PHC (24hr x7days) for	1.27	Only five PHCs provides 24 hrs BEMoC services.	1.27.1	Ensure 24 hrs BEMoC services at 10 PHC		0

institutional deliveries			Training of one Doctor from each PHC on BEMoC.	2000/-Per Docter	20000	
			Equipments for BEMoC	50000 per facility	500000	
	1.29	13 PHC does not have laboratory facilities on PPP based srvides.But except Mahnar all Phc have T.B lab Technician. In addition to this the regular lab technician has been deputed for this purpose.	1.29.1	Deputation of 17 regular Lab tech at PHC level for providing free of cost lab services to all pregnant women and BPL families.	NA	0
	1.3		1.30.1	Recruitment of 5 lab technicians as required for regular support of lab activity	6000/- per head	360000
				Training of TB lab technician on other pathological tests.	1000/- per training	17000
				Purchase reagent (recurring) for strengthening lab.	5000 per unit per month	1020000
				Purchase of equipments / instruments if needed . Fund could be rooted through RKS and if it is not utilised it could be diverted to other women and child friendly activites.	50000/- per PHC	850000
	1.32	Health facility with AYUSH services is not being provided		Establishing one Panchkarm center in Chehrakala PHC	10000/- Per PHC	120000

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

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

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

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

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

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

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

2	To make FRU functional and upgradation of PHC to CHC for institutional deliveries		2.1.2	Training of MOs of three PHCs in multiskilling.	3 Doctors from each PHC @ 2000/-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	900000
			2.1.8	Need based Equipments and drugs in O.T and Labour room.	List of Equipment attached (100000/- per PHC)	1900000
		None of the PHC provides 24 hour blood transfusion services, however PHC Mahnar has been provided the equipments for blood storage unit.		Establishing blood storage units at Lalganj, Mahua & Rahopur,	60000/- Per PHC	180000

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

			2.3.1	Provision of food for the delivered mothers and mothers under gone in tubectomy in all the health facilities.	NA	0
			2.3.2	Mobilize community Resources for providing Free food for PW at Institution.	NA	0
	2.3	Welcome PW at Institution and PHC and FRU	2.3.3	Quality indicators (clean environment, wards with clean linen, clean toilets , clean labour rooms, running waters supply, hot water and safe water for inpatients, new born corners, treatment protocols, aseptic precautions, immediate disbursement of JBSY funds	NA	0
	2.4	Reporting of maternal death Maternal death reporting is usually not reported by worker	2.4.1	Training of ASHA & ANM on reporting of Maternal deaths and conduct Verbal Autopsy	Rs 5000/- per PHC	95000
			2.4.2	Incentives for maternal death reporting by ASHA @ Rs 50/- per maternal death	Rs 50/- per maternal death for approx 300 maternal deaths	15000

		2.4.3	Reporting line should be in five columns – name of mother, place of death, date of death, cause of death and no. of birth.	NA	0	
		2.4.4	Institution and urban center also to report Maternal death to the District CS / ACOMO.	NA	0	
		2.4.5	Maternal Death should be reported by ASHA, AWW, ANM Staff Nurse & Doctors to the district data center.	NA	0	
		2.4.6	Investigation of maternal death by district team. and third party review (District magistrate)	NA	0	
		2.4.7	Training of ASHA and investigation team objective and process of investigation and review of maternal death	Rs 3000 per PHC	57000	
	2.5	Biomedical waste management is not properly taken care off at all institution	2.5.1	Procurement of equipment	Rs 50000 per PHC	950000
			2.5.2	As per example Introduce color coded buckets for facilities as per IMEP	NA	0
	4.1	Tracking of pregnant women from first Trimester is not done form the register.	4.1.1	Review of early registration with 3 AN checkup, two TT. 100 / 200 IFA Tab. in ASHA Diwas.	NA	0
	4.2	Too much documentation process. Photo required for mother and baby. It cost	4.2.1	Ensure 100 % Pregnancy Test Kit is to ASHA and regular supply.	Rs 50/- for 99000 pregnancies	4950000

4	To strengthen Janani Suraksha Yojana / JSY	Rs.30/- to Rs. 60/- .	4.2.2	Direct transfer of funds from district to PHC through core banking / directly from DHS	NA	0
			4.2.3	Finger print technology for JSY beneficiaries at facility level where computer with internet facility is available. This will help in financial monitoring.	NA	0
			4.2.4	The photo system should be replaced by some other alternatives like- bank account opening of pregnant women in first trimester and directly transfer the money to their account after delivery.	Incentive to ASHA for rs 50 per PW for opening of bank account of PW for 99000 pregnancies	4950000
				Incentive for institutional delivery.	Rs 2000/- per delivery	132000000
	5.1	Home Delivery is still prevailing through untrained traditional Dai's	5.1.1	Home Delivery should be conducted by SBA trained Staff Nurse or ANM.	NA	0

				5.1.2	Provision of Dai Delivery kit (DDK) to TBA where institution access is poor. And it should be supervised by ANM for home deliveries.	NA	0	
5	To ensure support of SBA at home deliveries			5.1.3	Delivery kit (equipment, medicine) for ANM should be supplied	Rs 10000/- per PHC	190000	
				5.1.4	Supply of delivery Kits as per number of deliveries conducted in home.	NA	0	
		5.2	Reporting of home delivery is not done so the PNC is not provided	5.2.1	Incentive based system for reporting of home delivery by ASHA and it should be linked with ANM	NA	0	
		5.3	Non payment of Home delivery through JSY	5.3.1	The JSY money to the mother who has delivered baby at Home paid by ANM.	Rs 500/- per home delivery for approx 33000 home deliveries	16500000	
		Infrastructure						0
		6.1	Out of 338 HSCs only 39 are having own building	6.1.1	Strengthening of HSCs having own buildings		0	
6	To strengthen HSC for providing outreach	6.2	In existing 39 buildings 26 are in running comparatively in good	6.2.1	White washing of HSC buildings.	Rs 2000 per PHC	38000	

maternal care		condition, 6 are in under construction, one is very poor condition and one is constructed but not handed over to health department.	6.2.2	Organize adolescent girls for wall painting and plantation./hire local painter for colourful painting of HSC walls.	NA	0
			6.2.3	List out all services which is provided at HSC level. On the wall.	NA	0
			6.2.4	Gardening in HSC premises by school children.	NA	0
	6.3	No one building is having running water and electric supply.	6.3.1	Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental. (Untied fund)	Water rent for 39 HSC, Rs 100/- per month from untied fund.	0
				Arrangement of water supply upto HSC (Wiring) from water source	Rs 5000/- per HSC	195000
	6.4	Lack of appropriate equipments and ANM are reluctant to keep all equipments in HSC .	6.4.1	Purchase of Furniture Prioritizing the equipment list according to service delivery (for ANC / Family planning / Immunization)	Rs 20000/- per HSC having own buildings	780000
	6.4.2		Purchase of equipments according to services	NA	0	
	6.4.3		Purchase one almira for keep all equipment safely and it could be keep in AWW / ASHA house.	Rs 10000/- per HSC	3390000	
	To strengthen HSC for providing outreach maternal					

care	6.5	Non payment of rent of 300 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 12 months (from State fund)	0
			6.5.4	Purchase of Furniture as per need where building is on rent	From untied fund	0
			6.5.5	Prioritizing the equipment list according to service delivery	NA	0
			6.5.6	Purchase of equipments as per need	From untied fund	0
			6.6	The district still needs 135 more HSCs to be formed.	6.6.1	Construction of new HSCs. 39 are having own building, 54 new is proposed and rest 480 are supposed to be constructed.

To strengthen HSC for providing outreach maternal care			6.6.2	Preparation of PHC wise priority list of HSCs according to IPHS population and location norms of HSCs	NA	0
			6.6.3	Community mobilization for promoting land donations at accessible locations.	NA	0
			6.6.5	Meeting with local PRI / CO / BDO / Police Inspector in smooth transfer of constructed HSC buildings.	NA	0
	6.7	Non participation of Community in monitoring construction work	6.7.1	Biannual facility survey of HSCs through local NGOs as per IPHS format	Rs 200/- per HSC biannually	135600
	6.7.2		Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format.	NA	0	
	6.7.3		Monitoring of renovation / construction works through VHSC members / Mothers committees / VECs / others as implemented in Bihar Education Project.	NA	0	
	6.7.4		Training of VHSC / Mothers committees / VECs / Others on technical monitoring aspects of construction work.	Rs 20000/- per PHC	340000	

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

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

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

		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
8	To strengthen HSC for providing outreach maternal care		No Drug kit for AWCs (@ one kit per annum). No ASHA kit, only need based emergency but that too being irregular in supply	8.1.2	Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map	From state fund	0
				8.1.3	Hiring vehicles for supply of drug kits through untied fund.	Rs 200/- per HSC per month	813600
				8.1.4	Developing three coloured indenting format for the HSC to PHC (First reminder - Green, Second reminder - Yellow, Third reminder - Red)	Rs 2000/- per PHC	38000
				8.1.5	Hiring of couriers as per need	Rs 50/- per courier for 200 couriers for 8 days per month	960000

				8.1.6	Payment of courier through ANMs account	Fund for the payment of Couriers should be transferred to ANMs account.	0
Performance							
				9.1.1	Training of signatories on operating Untied fund account, book keeping etc	Rs 100/- per person for two persons for 339 HSCs	67800
9	To strengthen HSC for providing outreach maternal care	9.1	Unutilized untied fund at HSC level	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	9.2.1	Identification of the best HSC on service delivery

		registered in first trimester PW with three ANCs is 15.1%, TT1 coverage is 35.4%,	9.2.2	Listing of required equipments and medicines as per IPHS norms in facility survey	NA	0
			9.2.4	Honouring those ANMs who develop women friendly HSC in given criteria (list is attached)	5 ANM in a year per PHC social honouring with one shawl.	47500
	9.3	Family Planning Status:-Any method-43.6%,Any modern method-39.8%,No sterilization at HSC level,IUD insertion - 0.5%,Pills-1.5%,Condom-1.9%,Total unmet need is 32.7%, for spacing-14.9,Lack of counselling Skill.	9.3.1	Gap identification of 39 HSCs through facility survey	NA	0
			9.3.2	Eligible Couple Survey	NA	0
			9.3.3	Ensuring supply of contraceptives with three month's buffer stock at HSCs.	State Fund	0
			9.3.4	One day training of AWW / ASHA on family planning methods and RTI / STI / HIV / AIDS.	Rs. 5000/- per PHC	95000
			9.3.5	Training of ANMs on IUD insertion	Rs 10000/- per PHC	190000
	9.4	HSC unable to implement disease control programs	9.4.1	Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6. (four to five HSC per week)	NA	0

			9.4.2	Strengthening ANMs for community based planning of all national disease control program	NA	0
			9.4.3	Reporting of disease control activities through ANMs	NA	0
			9.4.4	Submission of reports of national programs by the supervisors duly signed by the respective ANMs.	NA	0
To strengthen HSC for providing outreach maternal care	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 of Rs 3000 per unit	171000
			9.6.2	Providing incentives to the ANMs during rainy season so that they can use local boats.	From untied fund	0
	9.7	Lack of convergence at HSC level	9.7.1	Fixed Saturday for meeting day of ANM, AWW, ASHA, LRG with VHSCs rotation wise at all villages of the respective HSC.	from untied fund	0
			9.7.1	Monthly Video shows in all schools of the concerned HSC area schools on health, nutrition and sanitation issues.	From untied fund	0

		9.8	Lack of knowledge and skill of field level staffs in data compilation in HMIS formats	9.8.1	Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc	NA	0
				9.8.2	Printing of adequate number of reporting formats and registers	Discussed earlier	0
				10.1.1	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	2280000
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 organised in plan manner. It is totally based on demand of organisation and eventually it is not reported to respective HSCs and PHCs.	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 organise Camps.	NA	0
				10.1.5	Community based reporting system through SMS. involve PRI members and training on reporting and Camp approach.	NA	0
		11.1	No training programme for adolescent particularly health and sex.	11.1.1	Multipurpose counsellor can be used for adolescent care. For this services of LHV can be used.and callender of activity could be developed.	NA	0

		11.2	Preventions of anemia in adolescent girls	11.2.1	Linkage with adolescent anemia control programme in Schools with Unicef and training to one teacher from the school	Rs 5000/- per PHC	95000
11	To improve adolescent reproductive and sexual health	11.3	Marriage before legal age.	11.3.1	Sensitization of PRI members particularly women	Rs 5000/- Per PHC	95000
		11.4	Preventions of teen age pregnancy and abortion.	11.4.1	Adolescent pregnancy should be addressed with priority care (eclampsia, 3 ANC, anemia, 100 IFA, 100% institution delivery, low birth weight baby, Breast feeding. PNC within 48 hours.	NA	0
		11.6	Limited interventions for empowering adolescent girls	11.6.1	Family counseling for adolescent pregnancy tracking on above mentioned through ASHA and AWW.	NA	0
				11.6.2	State to develop and issue guidelines for implementation of Kishori Mandals Formation of Kishori Mandals by registration of all girls (11-18 yrs)	NA	0
				11.6.3	Prepare a monthly plan of activities for one day per week	NA	0
				11.6.4	Counseling nutrition, health and social issues every week at AWCs by AWW	NA	0
				11.6.5	Weekly distribution of IFA Tablets to out-of-school girls at AWCs	From State	0
	To improve adolescent reproductive and sexual						

	health			11.6.6	Deworming adolescent every 6 months	Purchase of 12 lac tablets	900000
				11.6.8	Initiate family schools for learning child care, safe motherhood life skills and Family life education	Rs 10000/- per Schools each in each PHC	190000
		12.1	MTP services are not available in Public sectors	12.1.1	Selection of facilities for provision of safe abortion services	NA	0
				12.1.2	Location of facility availability of trained service provider, space, equipments.	NA	0
12	To provide MTP services at health facilities			12.1.3	To Provide appropriate equipments at all facilities and MVA syringes.	50000/- per PHC	850000
				12.1.4	Putting the trained doctors at appropriate facilities to commence the services	NA	0
				12.1.5	Training of Medical officers and Para medical staffs on Safe abortion services training including awareness about legal aspects of MVA / EVA and Medical abortion by IPAS .	One doctor and one ANM from each PHC @ Rs 2000	38000
				12.1.6	Formation of district level committee (DLC) to accredit private sites as per GOI guide line .	NA	0
				12.1.7	Develop reporting system of MTP services in private and public sector.	NA	0

			12.1.8	Through training program make the govt doctors skilled to perform MTP in the approved sites.	NA	0
			12.1.9	To Involve community to aware about location of services , process and legal aspects of MTP services through - AWW, ASHA & ANM, LRG and mass media.(IEC)	Rs 5000/-Per PHC	95000
			12.1.10	The services of Pregnancy testing should be strengthened and it should be linked with MTP services.	NA	0
			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.	Incorporated in ASHA training	0
		13.1	13.1.1	Nutrition and Counselling Component is not visible in AWC should be developed as a Hub of activities (VHND)	NA	0
	To provide MTP services at health facilities					

		VHND 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	To strenghten Monthly Village Health and Nutrition Days		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	95000
			13.1.6	Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourished children , New born, DOTs and other services	From untied fund	0
			13.1.7	SMS reporting system of conducting VHND and ANM collect Data from field level and compile it in weekly / Monthly formats.	NA	0

			Infrastructure				0
		1.3	Out of 30 APHCs only 16 are having own building	1.3.1	Registration of RKS	NA	0
B	APHC	1.4	Existing 16 buildings are not properly maintained	1.4.1	Renovation of APHCs buildings from RKS Fund	Rs 150000/- per APHC	2850000
	To form / strenghten APHC in Phase manner	1.5	Non payment of rent of 14 APHCs for more than three years	1.5.1	Payment Of Rent of APHC building	From state fund	0
		1.6	Lack of equipments,	1.6.1	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				0
		2.1	in the district no any APHC functioning as per IPHS norms	2.1.1	Operationalising one APHC in each PHC by conducting daily OPD by Doctor and support staff.	NA	0
		2.2		2.2.1	Notification from district for oprationaliing APHC	NA	0
			Drug Supply				0
2		3.1	No drug kit as such for the APHCs as per IPHS norms.,	3.1.1	Purchasing 23 listed OPD Drugs of PHC for APHC	Rs 200000/- Per PHC for OPD drugs for one year.	3800000

3		5.1	No regular clinic at all PHCs & APHCs.	5.1.1	Trained service provider on syndrome management of RTI / STI (As per GOI guide line) up to APHC level.	Rs 1000/- for Two person from each PHC	34000
				5.1.2	Logistics of setting of clinics and free drugs availability	NA	0
5	RTI / STI services at health facilities			5.1.3	Integrated Counselling services in four public sector facilities by trained personnel .	NA	0
				5.1.4	IEC / BCC for awareness available RTI / STI services at all health facilities.	Rs20000 for Per PHC	380000
						Total	310736750

4.4 Child Health

Logical Framework

Sl.	Goal	Sl.	Impact indicators						
1	To improve Child health & achieve child survival	1.1	Reduction in IMR						
		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 .					Strengthening of Facility Based Newborn Care/FBNC and trained workers on using equipments.	No of PHC initiated FBNC with trained MAMTA on facility based new born care..
5	To increase % of breastfeeding from 33.8% to 70% within 1 hr of birth		% increase of breastfeeding within 1 hr of birth .	1.1.2				Infant and Young Child Feeding/IYCF	No of training organised in PHC on IYCF
6	To increase initiation of complimentary feeding among 6 month of children from 88.3% to 90%		% increase of complimentary feeding among 6month of children.						
7	To increase exclusive breastfeeding among 0-6 month of children from 36.4% to 80%		% increase of exclusive breastfeeding among 0-6 month of children .						
8	To increase immunization coverage from 53.3% to 70%		% increase of full immunization coverage .						

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

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

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

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

					Exposure visits to existing NRCs to observe different models in the country	Rs 50000 for the district	50000
	Care of Sick Children and Severe Malnutrition		There is not a single unit in the district where severely malnourished children could be treated.		Establish rehabilitation center in district hospital, FRU and one PHC and promote locally available food formula for nutritional therapy as Hadrabad Mix	Rs 1000000 per unit	4000000
	Management of diarrhea, 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 800000 children at rate of Rs 4 per children	3700000
					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		No Pre School Health checkup & complete Immunization card.		Half yearly health checkup camp for children in schools should be organized.	Rs 2000 per PHC	38000

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

				Rally and Prabhat Phery in epidemic areas. (Kala-azar & Malaria)	Local contribution/ Untied Fund/VHSC	0
				Referral system for the school children for higher medical care.	From RKS fund	0
Total						12561000

4.5 Family Planning

Logical Framework

Sl.	Goal	Sl.	Impact indicators				
1	Population stabilisation	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 sterilization 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	Dissemination of manuals on sterilization standards & quality assurance of sterilization services	2.1.2.2	No of facilities providing quality manuals on sterilization standards of sterilization services.
				2.1.3	Female Sterilization camps	2.1.3.3	No of camps orgnised for female sterilization .
				2.1.4	Compensation for female sterilization	2.1.4.4	% of Female received compensation
				2.1.5	IUD camps	2.1.5.5	No of IUD used in Camps
				2.1.6	Accreditation of private providers for IUD insertion services	2.1.6.6	No of Private providers accrediate for IUD Insertion services.
3	To increase male sterilization from 0.6%(DLHS 3) to 2%	3.1	% increase in male sterilization	3.1.1	NSV camps	3.1.1.1	No of NSV Camps orgnised.
				3.1.2	Compensation for male sterilization	3.1.2.2	% of Male received compensation
				3.1.3	Accreditation of private providers for sterilization services	3.1.3.3	No of Private providers accredited for Sterilization services.
4	To increase use of condoms from 1.9% (DLHS3) to 5%	4.1	% increase in the use of condoms	4.1.1	Promotion to Social Marketing of condoms	4.1.1.1	No of Condoms distributed through Social Marketing.
				4.1.2	Contraceptive Update seminars	4.1.1.2	No of Seminars Orgnised on Contraceptive Update.
5	To increase use of pills from present 1.5%(DLHS3) among current married women age 15-49 yrs to 5%	5.1	% increase in the use of pills	5.1.1	Promotion to Social Marketing of pills	5.1.1.1	No of Pills distributed through Social Marketing.

Sl.	Strategy	Gaps	Activities	Unit Cost	Total Budget
	Terminal/Limiting Methods	Lack of knowledge of small family norms.	Ensure one MO trained on minilep and NSV up to PHC	Rs 20000	380000

				Training of nurses and ANMs on IUD and other spacing methods at PHC level.	Rs 10000	190000
				Ensure availability of contra ceptives (indenting , logistic	Rs 500000 per PHC	9500000
	Female Sterilization camps		Laparoscopy surgery not done.	Trained doctors on laparoscopy.	Above mentioned	0
				Procure Laparoscopy equipments for trained doctors	Rs 100000 per PHC	1900000
				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 sterilization is not available on time at facility.	Immediate disbursement of incentive after sterilization camps.	Rs1000 each for 25000 male and 5000 female operations	32500000
	Compensation for male sterilization			Logistic planning is needed before organizing camps.	NA	0
				Block Health manager can hire one support staff for logistic support.	NA	0
				Immediate disbursement of incentive after sterilization camps.	Discussed earlier	0
				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
				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 52800 units	1584000
				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						46054000

4.6 Kala a Zar

Gaps	Issues	Strategy	Activities	Unit Cost	Total Budget
1 Poor coverage of DDT spray	Vector control through insecticide spray in the attack area	To increase the coverage of DDT spray in the endemic zone, there should be proper monitoring by the supervisors, capacity building of the sprayer, supervisors and other healthcare professionals	1. Ensure planning for timely spray of DDT in Feb-March and May-June for 40 days in each block	NA	0
		Monitoring of the spraying squad by MOIC	2. Identification of Houses with Kala-azar patients by ANM & ASHA @ 50/ per village.	Rs 50 for 751 villages twice in a year	75100
			3. Two round of spraying scheduled in Feb-March and May-June should be strictly observed	NA	0
			4. DDT spray should be at the rate of 1gm/sq. meter upto the height of 6 feet.	NA	0

Less time spent on spraying DDT	Training and capacity building for proper spraying	Regular capacity building training on prescribed module for the sprayer to ensure that every corner of the house is properly sprayed upto height of six feet from ground level.	Rs 5000 per PHC	95000
Poor condition of Sprayer, pump and nozzles etc No of Pumps available-266, No of pumps required-20, No of bucket available-421, No of buckets required-167, No of gallon available-102, No of gallon required-45, No of pond measure available-119, No of pond measure required-28, .	Regular checking of the spraying pumps for better functioning and timely replacement of the faulty pieces.	Fund allocation and timely release for : maintenance of old sprayer pumps, Purchase of new pumps and other articles needed- buckets, mugs etc.	Rs 150000 for the district	150000

2

	Inadequate stock of DDT, DDT available-41mt, DDT required-33mt	Making available DDT during spraying round	Ensure adequate Stock of DDT through proper & timely indenting to improve the quality of spray	DDT Carriage	30000
	Faulty payment plan	Appropriate fund allocation for the payment of the spraying of DDT	Fund would be allocated for regular payment of wages (147 SFW to be used and 735 FW to be used for monitoring and spraying work)	147SFW x Rs113 x 40 days	664440
				735FW x Rs 92 x 40 Days	2704800
Poor rate of case detection of Kalazar	Early diagnosis and treatment through PHC system	Case detection rate should be increased with appropriate diagnostic test	Increase efficiency of case detection through training of Community workers on signs and symptoms of Kala-azar: 1) three weeks persistent fever not responding to antibiotics, malaria being excluded, with palpable spleen. 2) Ensure availability of aldehyde test at PHC level 3) Purchase of RK 39 kit	Purchase of 50000 units of RK39 @ Rs 25 per unit	1250000

1250000

			for detection of Kalazar		
	Reduction of kala-azar mortality and morbidity	Early diagnosis and treatment through PHC system	1. Ensuring availability of Amphotericin at all level	Purchase of 10000 vails of Amphotericin B @ Rs 65 per unit	650000
			Loss of wages for KZ patients(case detection in year 2007-3275)	Rs 50 for 22 days for 3200 patients	3520000
			2. Replacing of medicines on priority based	NA	0
			3. Training of ANMs and ASHA for IM injection	Rs 5000 per PHC	95000
3	Lack of monitoring and supervision mechanism,	Monitoring and supervision mechanisim	Preparation of Monthly visit plan for supervision :- Checking spraying schedule- For supervision & treatment follow up	Mobility support for CS, ACMO and DMO	45000
				Mobilty for MOIC 16x 40days x Rs 100	64000
				Mobility for supervisor 33x 40 daysx Rs100	132000

				Office expenses	25000 for the district	25000
4	Lack of appropriate BCC & Community Mobilization.	Increasing awareness for prevention of Kala-azar	Community participation in reducing mortality and morbidity due to Kala-azar	1. Fund allocation for training activities	NA	0
				2. Identification of NGO/Private partner as trainer	NA	0
				3. Knowledge sharing with the community on signs and symptoms of Kala-azar through VHSC	NA	0
				4. Training of VHSC/PRI and community health worker on sign & symptom of Kala-azar	NA	0
				5. Regular monitoring of IEC activities	NA	0
				6. IEC activities through nukkad natak, kalajatha mass media like radio etc	Rs 10000 per PHC	190000
				7. Activity for surveillance like polio surveillance	NA	0
					Above mentioned	

8. Wall painting of Treatment protocols and

0

			provisions for pateints in PHC in Hindi.		
			IEC van for each PHC	16x 40x 750	480000
Total Budget					10170340

4.7Blindness

Gaps	issues	Strategy	Activities	Unit Cost	Total Budget
Lack of adequate eye surgeon and staffs in the district.Only 4 eye surgeons are posted in the district out ofwhich one is on deputation to the other district.	Staff shortage	Recruitment	Recruitment of Eye Specialists and surgeons on contractual basis.	Already discussed in maternal health	0
Only 7 Ophthalmic Assistants are posted in the district,however the requirement is 19.			Recruitment of Ophthalmic Assistants on contractual basis.	Only 4 in the current year @ Rs 8000 per month	384000
Most of the doctors and staffs are not trained enough on new IOL tehniques	Untrained staffs	Capacity building	Training of Doctors on IOL technique	Rs 10000 per person for 5 person	50000
			Training of Ophthalmic Assistant	Rs 5000 for 4 Ophthalmic assistants	20000
In the Year2008-09 only 66 Cataract operationshave been done by the Govt facilities and 1763 bythe private facilities(till Nov 08).In the year 2007-07,altogether 1945 surgeries were performedout of 3000 and in the year 2007-08 2966 surgeries have been performed.	Low achievement	Increasing no of camps	Organising Operations at District level	Rs750 per operation for 3000 operations	2250000
		PPP	Accreditation of Nursing Homes capable of doing Cataract surgeries	NA	0
			Establishing another Cataract Operation Center at PHC Lalganj	Rs 500000	500000
			Purchase of equipments and medicines		

Lackof awareness among community regarding cataract blindness and its treatability.	Lackof awareness	Awareness building	Assigning LHV/Supervisor counselling work	NA	0
Fear of eye operation.			Organising eye screening camps in villages/ schools	NA	0
Lack of Education among the masses about the existing facilities: Need of wide publicity.			IEC on cataract and its facilities	Rs 100000 at district level	100000
Poor coordination between the health functionaries and the voluntary organisations resulting in less cataract surgeries.		InvolvingNGOs	Meeting with Local NGOs onthis issue	NA	0
Lack of adequate referral services to take care of complications.	Lack of adequate referral services	Strengthening referral system	Arrangement of carrying patients to the Operation Centers and then taking them back homes	Rs 10000 per PHC	190000
Lack of monitoring and follow up	Monitoring and follow up	Monitoring and follow up	Mobility support for Visiting homes of the patients to manage any post treatment complication.	Rs 10000 per PHC	190000
			Developing records of cataract cases fromOPD registers at PHC level	NA	0
Total					3684000

4.8 Leprosy

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

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

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

4.10 Filaria

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

4.11 INSTITUTIONAL STRENGTHENING

Logical Framework

Sl.	Goal	SI.	Impact indicators				
1	To improve institutional setup as per IPHS norms	1.1	Improved service delivery for women and children friendly with quality				
2	To bring required architectural correction in the Institutional System						
Sl.	Objectives	SI.	Outcome indicators	SI.	Strategy	SI.	Output indicators
1	To strengthen NGOs Partnership/ PPP for communitization of Health services .	1.1	No and Type of MOU signed between NGO and DHS/RKS for strengthening of communitization of health servies and NGO partnership/ PPP in place	1.1.1	To enforce PNDDT Act and to increase sex ratio of female child	1.1.1.1	% decrease in sex selective abortions. % increase in birth of female babies (delivery registers)
				1.1.2	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routin facility where it is not functional.	1.1.2.1	No of cases supported by referral transport system under PPP.
						1.1.2.2	No of canteen facility functional at 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	Strengthen Logistics management system for regular supply of Drugs and equipments
1.1.2.3	Develop a strong Monitoring & Evaluation / HMIS System in all PHC	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 persin per 20 ASHA)	4.1.1.1	Establishment of ASHA support system at DHS and RKS level
		4.2	No of activities carried out by RKS	4.1.2	Strengthening RKS	4.1.1.2	No of RKS having monthly meetings.
						4.1.1.3	% of untied fund, JSY fund, referral transport etc utilised

Sl.	Strategy		Gaps		Activities	Unit Cost	Budget	
	To enforce PNDT Act and to increase sex ratio of female child		No registration of ultra sound clinic.		Registration and monitoring of ultra sound clinic.	NA	0	
					MTP clinic should be watched for termination of pregnancy following USG.	NA	0	
					IEC on PNDT act	Rs 5000 per PHC	95000	
	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routeen facility where it is not functional.		Out sourcing of services is not as per the need of local Need and BPL families are not exemted 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	

Develop partnership with NGO Programmes in the districts			listing of NGOs those who are working in F.P ,MTP,programme, Institutional delivery, Blindness control programme.	NA	0
		Non involvement of NGO in F.P programme, Institutional delivery, Blindness control programme.	Accreditation of these facility from state Health Society.	NA	0
		There is no MOU with NGO/VO/individuals for Donation and voluntary support in PHC	Process of MOU should be dicentralization and it should oprationlise through RKS.	NA	0
		Strengthening of DMU NGOs Management aspects is one of the area of improvement	ASHA Programme manager facilitate the NGO management process in the district and ASHA Facilitators will be managed at the PHC level	NA	0
			Honourarium to DPM, DPM(ASHA), DAM and DA	Rs 30000 pm for DPM, Rs 28000 pm for DPM(ASHA), Rs 26000 pm for DAM and Rs 22000pm for DA	1272000
			Capacity building training programme for NGOs office bearer with the help of professionals on linkage with health system strengthening component.	Rs 5000 per PHC	95000
			Mentoring Group at district level.	NA	0

				Reporting mechanism should be developed of NGOs work in the district.	NA	0
			There is no any VHSC in the district.	Co-ordination with community based organisation at SHG, LRG, VEC, ,PRI for VHSC formation.	NA	0
	Capacity building of Managers and Doctors.			Expoure visit of DPM/BHM /ASHA DPM/ selected ASHA to other state where facility is comparatively working better.	Rs 100000 for the district	100000
				To start DNB (Family Physician) 3 year course in the district hospitals.	Rs 100000 for the district	100000
				ASHA/ AWW career advancement programme may be planned to retain them in the system. Seats in the ANM course, staff nurses and other paramedical courses may be reserved for the qualified ASHAs	Rs 10000 per PHC	190000
	Preparation of dicentralised 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, 17 Doctors(One from each PHC) , 17 BHM's and district planning team	80000

				Start preparation of plan from the month of October with situational analysis, Facility survey, line reporting system and qualitative 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.	Distribution of role and responsibility among MO and Managers of programme implementation.	NA	0
			Lack of Supervisors in all PHC	Use Process indicators as monitoring of respective programme.	NA	0
			Lack of skill of use of data	Develop Programme review calendar for review of HSC/PHC performance as per form 6 & 7	NA	0
			Community is not aware about monitoring aspects of Health Programme.	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
				Develop four potential VHSCs in all PHC on Community based Monitoring of Health and Nutrition programme.	Rs 2000 in each PHC	38000
				Organise "JAN ADALAT" in with PRI & VHSC and invite nearby VHSC to observe	NA	0

				thr process of "JAN ADALAT"		
				Devlop Health and Nutrition Report Card by using growth monitoring chartsof Village and present in "JAN ADALAT" By VHSC	Rs 2000 in each PHC	38000
	Strengthen Logistics management system for regular supply of Drugs and equipments		There is no system of logistic management of Drugs and other supply at any level. Only vaccine supply management is comparatively stronger than other logistic work.	Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports	NA	0
				Hiring vehicles for supply of drug kits	Rs 20000 per PHC per month	4080000
				Hiring of courriers as per need	Discussed in maternal health	0
				Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)	Discussed in maternal health	0
				Training of all ANM and Stock keepers on Indenting and Logistic Management.	Rs 5000 per PHC	85000
				Devlop TMC model for Logistic Management in the state.	NA	0

				Impact analysis of Performance by Organisation	NA	0
	Strengthening RKS		RKS are not uniformly functioning in the district	Ensure registration of RKS of all functional APHC	NA	0
				Training of RKS signatory and BHM on financial Management of RKS	Discussed in maternal health	0
				Presentation of case study of functional RKS in district level Meeting.	NA	0
	Strengthening community process through supportive supervision of ASHA program		Poor monitoring mechanism of ASHA program	Appointment of PHC level ASHA facilitator	Rs 12000 per Facilitator per month for 19 facilitator	2736000
				Provide training cum supervisory support @ one supervisor for 20 ASHA	Rs 250 per supervisor for 133 supervisors for maximum 15 days in a month	5985000
				Training of DPM (ASHA) , Facilitator and supervisors at block level.	Rs 250 per participant for three days for 180 participants.	45000
	Media Sensitization		Wrong and provocative Reporting Having baseless News.	Media Sensitization work shop	Rs 5000 per Quarter at district level.	20000

Total 15009000

4.12
HIV/AIDS

Issues	Strategy	Activities	Unit Cost	Total Budget
1. Program Management System, District HIV/AIDS action Plan, District AIDS prevention and control unit, Strengthening the evidence base for program tracking progress	Recruitment	Deployment of personnel	District Coordinator	264000
			M&E officer	162000
			Office Assistant	96000
		Refurbishing of Office	Lmsm 20000	20000
		Recurring Expenditure		84200
		Travel		170000
2. Strengthening systems for service delivery	Meetings	DACC Meeting	Rs 1000 per month	12000
- PPTCT				
- Pediatric AIDS		Dist level HIV program Review meeting	Rs 2400 per month	28800
- Prevention (ICTCs, Condom promotion)		BHMs meeting	Rs 6400	6400
- Protection, care and support for children affected by HIV/AIDS		Consultation meeting		9600
		Meeting with PLHA		27600
Partnerships at all levels (community, district, networks, different Govt departments, civil society, positive networks)		Meeting with Principals of Govt.,High Schools for AEP		25600
	Trainings	Two days refresher Training of Nodal Teachers/ Master Trainers of AEP		74000
		One day Meeting of district level medical professionals		10000

Behaviour change communication		One day Link Worker Conference at district level (Youth Camp)		100000
LAKSHYA (Link Workers – rural HRGs), Young people (Peer education with young people RRCs)	Day celebration	World AIDS day celebration		25000
Scale Up Intervention up to Young Vulnerable Population Easy access to ART center		Travel support to HIV positive women with children		15000
Capacity Building Of Local Administration/NGO/CBO for reach out to Maximum Young Population		Two day residential Capacity Building Training of executive members of Farmers Club, ATMA		189000
		Two days Refresher Training of Facilitators of RRC.		36000
		Two days training of Youth facilitators of VICs of IVPP		360000
		Two days refresher training of Peer Educators/ Volunteers		72000
Owning this project by Village Community		Two days residential Capacity Building Training of ANM		288000
Capacity Building of Different service Providers		Two days residential Capacity Building Training of AWW		360000

		Two days residential Capacity Building Training of AWW		360000
		Total		2795200

4.13 RI/Muskan

SI No	Activities	Unit Cost	Total Budget
1	Training of Health workers on Immunization	Rs 100 for 500 workers	50000
2	Printing of RI Formats	Rs 4 for approx 1089000 PW	4356000
3	Printing of Muskan Registers	Rs 100 for 2672 AWCs	267200
4	Suuplementary immunization during flood	Rs 50000 per PHC	950000
5	Catch up immunization	Rs 50000 per PHC	950000
6	Incentive money	Rs 550 per AWC	1469600
7	Mahila Mandal	Rs 250 per AWC	668750
9	POL for cold chain	Rs 1300 per day	474500
10	Vaccines and logistics mobility	Rs 38500 per month	462000
11	Mobility for supervisor	Rs 9000 per month	108000
12	Usage of courier	As discussed in child health	0
13	Hiring of computer operator for RIMS	Rs 5000 per month	60000
14	Measles Campaign	Rs 200000 for the district	200000
15	Hard to Reach area strategy	Rs 10000 per month per PHC	2280000
16	RI Catch up round	Rs 100000 per PHC	1900000
17	Training of Medical Officers	Rs 1000 per person	19000
18	Meeting of epidemic Response Teams	Rs 5000 per PHC	95000
19	Travel expenses for case investigation per outbreak	Rs 20000 per month	240000
20	Shipment cost of lab specimen	Rs Rs 10000 per PHC per month	2280000
21	Outbreak Response	Rs 20000 per PHC	380000
Total			17210050

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21	Outbreak Response	Rs 20000 per PHC	380000
		Total	17210050

4.14 Programme wise Budget

Srl No	Budget Head	%	TotalBudget
1	TB	0.79%	3350000
2	Kala azar	2.40%	10170340
3	Leprosy	0.31%	1329000
4	Filaria	0.21%	889700
5	Blindness	0.87%	3684000
6	Child Health	2.96%	12561000
7	MaternalHealth	73.32%	310736750
8	Family Planning	10.87%	46054000
9	Institution Strengthening	3.54%	15009000
10	HIV AIDS	0.66%	2795200
11	RI/Muskan	4.06%	17210050
	Total		423789040