DISTRICT HEALTH PLAN

NALANDA

(2009-2010)

District Health Society
NALANDA

Foreword

Importance of better human life exists only in better Health Care Management system in a democratic setup for socio economic development of the society.Govt of India recognized this fact and launched National Rural Health Mission in 2005 to rectify anomalies exists in Rural Health Care System and to achieve an optimum health standard for 18 State & Union Territory..

.The District Health Action Plan (DHAP) is one of most key instrument to achieve NRHM goals based on the needs of the district.

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

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

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.

Anupam Kumar (IAS)
DM-CUM-CHAIRMAN
DISTRICT HEALTH SOCIETY
NALANDA

About the Profile

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

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

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

Dr. Ram Vilas Ranjan
Civil Surgeon-Cum-Member Secretary
DHS NALANDA

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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

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

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

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

Stakeholders in Process

- *Members of State and District Health Missions*
- *District and Block level programme managers, Medical Officers.*

- *State Programme Management Unit and District Programme Management Unit Staff*
- *Members of NGOs and civil society groups (in case these groups are involved in the DHAP formulation)*

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

1.2 Objectives of the Process

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

- ⇨ To focus on critical health issues and concerns specifically among the most disadvantaged and under-served groups and attain a consensus on feasible solutions
- ⇨ To identify performance gaps in existing health infrastructure and find out mechanism to fight the challenges
- ⇨ Lay emphasis on concept of inter-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 study comprised of review of available literature and reports. Following this the research strategies, techniques and design of assessment tools were finalized. As a preparatory exercise for the formulation of DHAP secondary Health data were complied to perform a situational analysis.

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

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

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

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

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

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

The study used a number of primary data components which includes collecting data from field through situation analysis format of facilities that was applied on all HSCs and 20 PHCs of Nalanda district. In addition, a number of field visits and focal group discussions, interviews with senior officials 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.

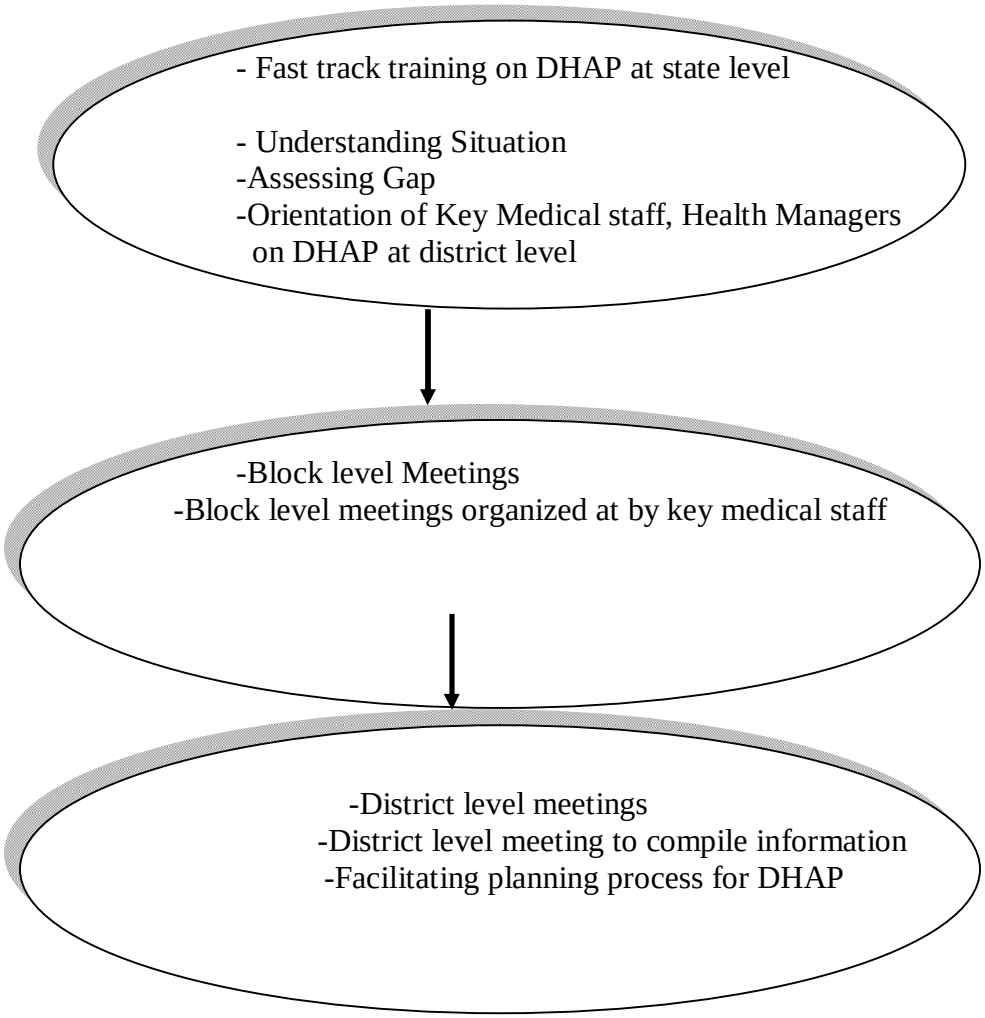
Government of India has launched National Rural Health Mission, which aims to integrate all the rural health services and to develop a sector based approach with effective intersect oral as well as intrasectoral coordination. To translate this into reality, concrete planning in terms of improving the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

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

1.3.3 Preparation of DHAP

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

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



District Health Action Plan Planning Process

Chapter 2

District Profile

History

THE history of Nalanda, the ancient university town of Bihar, goes back to the days of Buddha and Mahavira in the Sixth Century B.C. The town was home to Nalanda Mahavihara, a monastic university of international repute.

There are many versions of what the term *Nalanda* means. One is that *nalam* (lotus) and *da* (to give) combine to mean "giver of the lotus". Since the lotus is supposed to represent knowledge, *Nalanda*means "giver of knowledge". The University of Nalanda, a suburb of Rajgir in ancient times, is just off the main road from Rajgir to Patna.

Both Buddha and Mahavira often stayed at Nalanda during the rainy season. Buddhist scriptures reveal that they once stayed at Nalanda at the same time, but there is no record of them meeting one another.

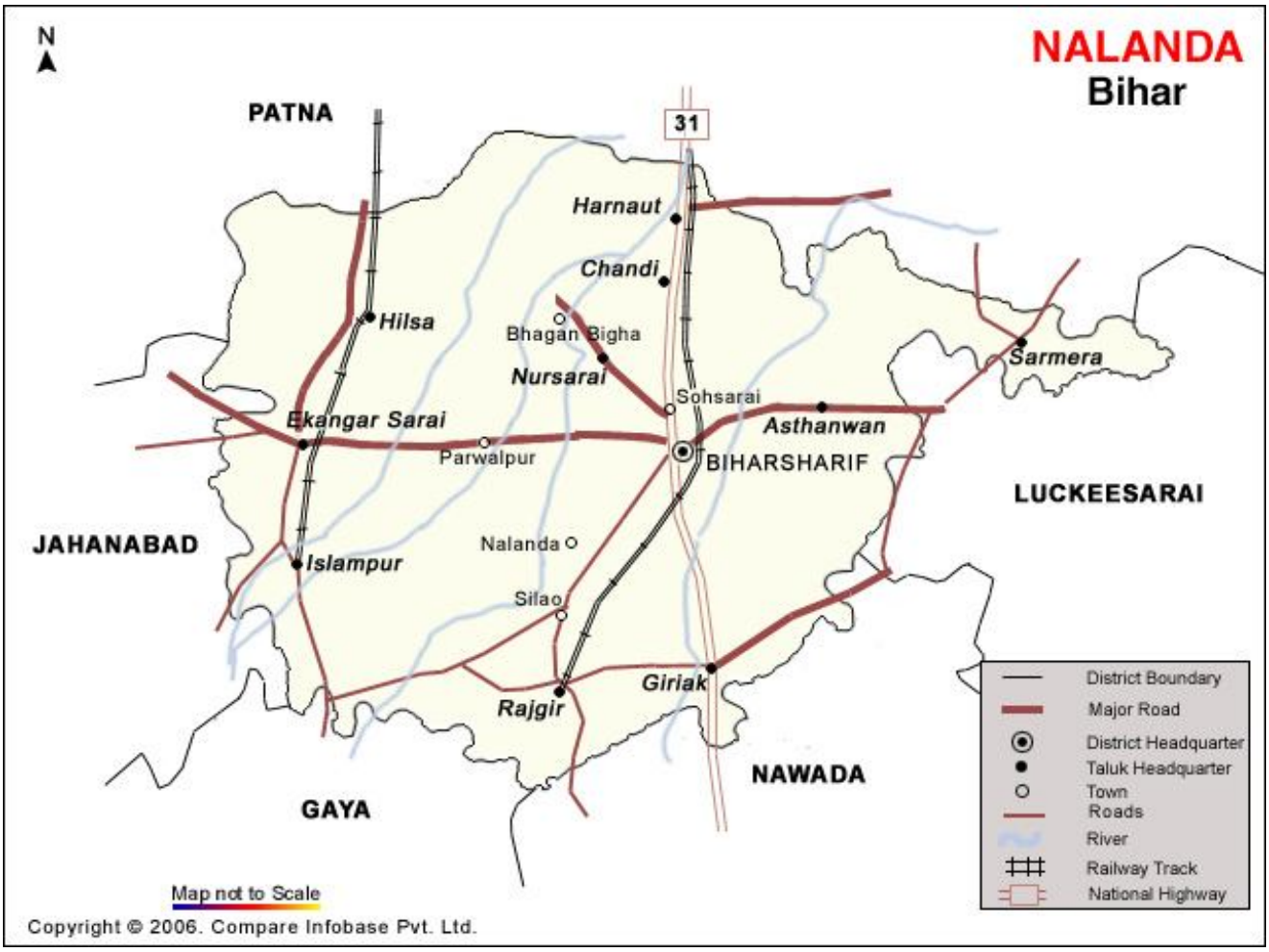
Ancient Buddhist sources say that Asoka, the Mauryan emperor (Third Century B.C) built a temple at Nalanda. It was a flourishing hub where the philosopher and alchemist, Nagarjuna, studied and taught in the Second Century A.D. However, excavations have not revealed anything to suggest that the site was occupied before the Gupta period (Fifth Century A.D.), the earliest finds being a copper plate of Samudragupta and a coin of Kumaragupta (414-455 A.D.). Fa-Hien who visited in the Fifth Century A.D. makes no mention of the massive monastic establishments at Nalanda. But Hiuen Tsang who came in A.D 637 during Harsha's reign (606-647 A.D.) refers to the great monastery that Harsha endowed with liberal grants.

Modern District of Nalanda with HQ Biiharsharif was established on Nov 9, 1972. Earlier it was Biharsharif sub-division of Patna district

Govt's Administrative Set-up

There are three sub divisions and 20 Blocks in the District. The District has 1084 revenue villages and 249 Gram panchayats. Traditionally the District was divided into 12 C.D. Blocks but eight more Blocks were created during last decade. The newly elected Panchayati Raj is enthusiastic to play important role

Communication Map of District



District Health Administrative Setup

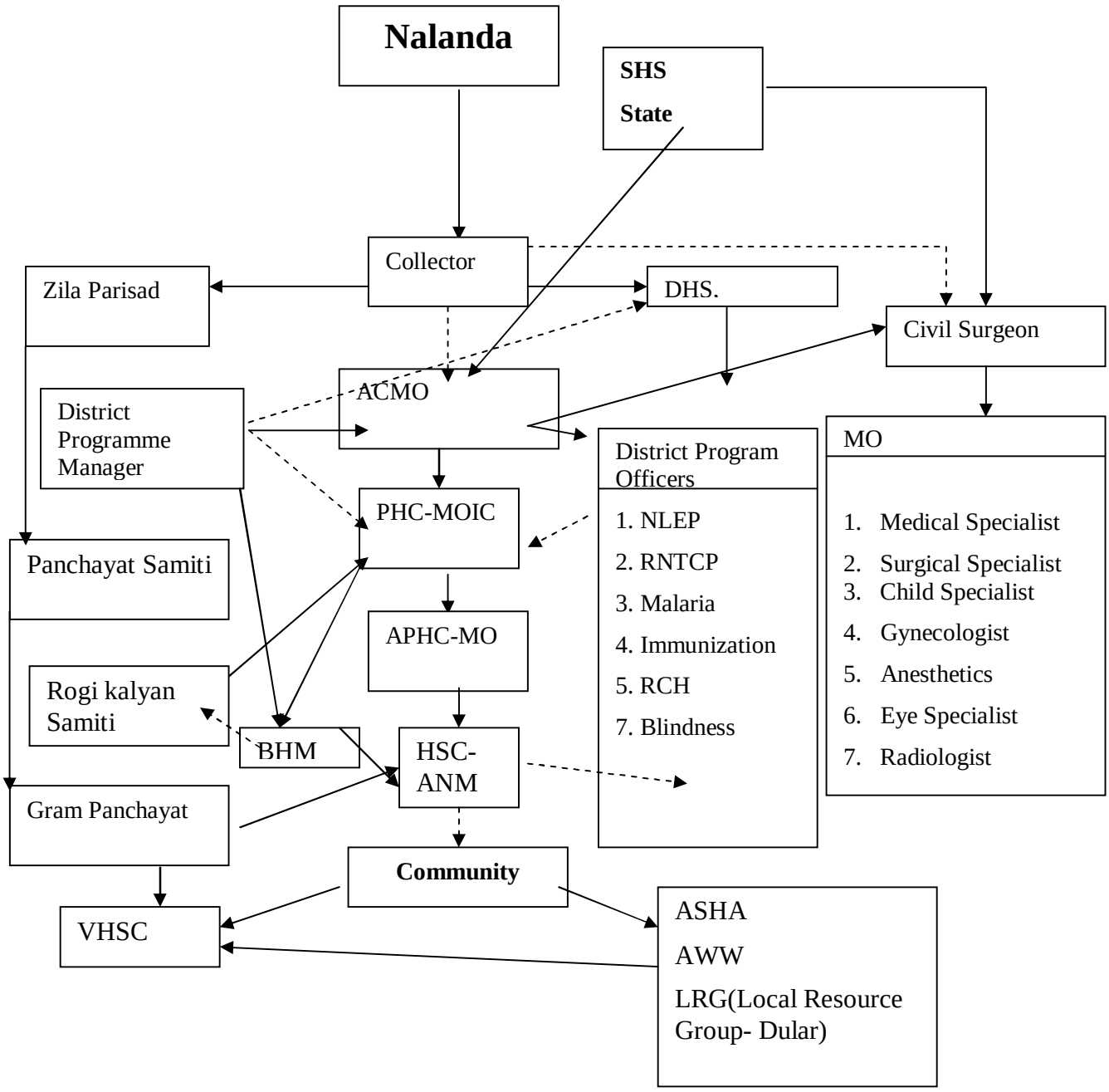


Table 1.1. ADMINISTRATIVE UNITS AND TOWNS IN NALANDA DISTRICT

PHC	Community Development Blocks	Towns
Sadar	Sadar	Biharsharif
Rahui	Rahui	
Giriyak	Giriyak	
Harnaut	Harnaut	
Nagarnausa	Nagarnausa	
Chandi	Chandi	
Noorsarai	Noorsarai	
Karaiparsurai	Karaiparsurai	
Hilsa	Hilsa	Hilsa
Ekangarsarai	Ekangarsarai	
Islampur	Islampur	
Parwalpur	Parwalpur	
Tharthari	Tharthari	
Rajgir	Rajgir	Rajgir
Asthawan	Asthawan	
Silao	Silao	Silao
Ben	Ben	
Sarmera	Sarmera	
Katrisarai	Katrisarai	
Bind	Bind	

Lok Sabha (Parliamentary) **–** 1.

NALANDA – AT A GLANCE

AREA (Sq. Kms)	:-	2367 sq km
POPULATION(CENSUS 2001)		
TOTAL	:-	2370528
MALES	:-	1238599 (52.24%)
FEMALES	:-	1131929 (47.75%)
RURAL POPULATION		
TOTAL	:-	2014948
MALES	:-	1052608 (52.23%)
FEMALES	:-	962340 (47.76%)
URBAN POPULATION		
TOTAL	:-	355580
MALES	:-	184094 (51.77%)
FEMALES	:-	171531 (48.23%)
POPULATION OF SCHEDULED CASTES	:-	473786 (19.98%)
POPULATION OF SCHEDULED TRIBES	:-	970
DENSITY OF POPULATION	:-	1007
SEX RATIO	:-	915

COMPARATIVE POPULATION DATA(2001 Census)

Basic Data	India	Bihar	Nalanda
Population	1027015200	828787	2370528
Density	324	880	1007
Sex- Ratio	933	921	915
Literacy % Total	65.38	47.53	53.64
Male	75.85	60.32	66.44
Female	54.16	33.57	38.58

LITERACY RATE		
TOTAL	:-	53.64%
MALES	:-	66.44%

FEMALES :- 38.58%		
VILLAGES 1084 (RV)		
TOTAL :- 1056		
INHABITED:- 980		
UNINHABITED:- 76		
PANCHAYATS	:-	249
SUB-DIVISION	:-	03
BLOCKS	:-	20
REVENUE CIRCLES	:-	20
HALKAS	:-	119
TOWNS	:-	03
NAGAR PARISHAD(BIHARSHARIF)	:-	01
NAGAR PANCHAYAT(HILSA,RAJGIR).	:-	04
M.P CONSTITUENCY	:-	01
M.L.A. CONSTITUENCY	:-	07
HEALTH		
DISTRICT HOSPITAL	:-	01
REFERRAL HOSPITAL	:-	02
PRIMARY HEALTH CENTRE	:-	20
ADDITIONAL PRIMARY HEALTH CENTRE	:-	25
HEALTH SUB CENTRE	:-	301
BLOOD BANK	:-	01
AIDS CONTROL SOCIETY	:-	01
No of ANM	:-	650
NO.of Doctors	:-	141

2.1 SOCIO-ECONOMIC PROFILE

Social

- Nalanda district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Nalanda have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.
- 19.9% of the population belongs to SC and 0.04% to ST.

2.2 Administration and Demography

Table-1

General Indicators	Nalanda(HQ_Biharsharif)	Bihar
Subdivisions	3	9 divisions, 101 sub-divisions
Blocks	20	534
Towns	3	
No. of Municipalities	01	
Gram Panchayats	249	8471
Revenue Circles	20	
Villages	1084	45,103
Demographic Indicators	**Nalanda**	**Bihar**
Density	**1007**	880
Decadal Growth rate (1991-2000)	18.64%	28.43%
Population	2370528	8,28,78,796
Male	1238599	43243795
Female	1131929	39754714
0-6 years	461240	16806063
0-6 years - male	237527	8652705
0-6 years female	223713	8153358
SC	19.9%	15.72%
ST	0.04%	0.91%
BPL	58.8%	42.60%

Sex Ratio	915	921
Early age of marriage	59.6%	51.50%
Literacy	53.64%	47.53%
Male literacy	66.44%	60.32%
Female literacy	38.58%	33.57%
Crude birth rate	31.2%	29.90%
Infant Mortality rate	62	60
Total Fertility Rate	4.2	4.3
General Information		**Bihar**
Agriculture	Paddy, Wheat, Potato,Onian,Vegetable	**Paddy, wheat, jute, maize, oil seeds, sugarcane, barley etc.**
Industry	Handloom. Weaving Ordinance Factory(Under Construction),Railway Coach Maintenance Factory(Under Construction)	**Oil refinery, Fertilizer factories, Cotton spinning mills, sugar mills**
Prone to flood	Yes	**Yes**

Source: Census 2001

Table 1 shows the demographic scenario of Nalanda district. According to Census of India 2001:

- The size of population of Nalanda district is above 2370528 comprising 2.86% population of Bihar state in 2.51% proportion of state's area.
- Very high density of population (1007) which is still rising
- Decadal population growth rate of 18.6% as against 28.43% of the state as a whole. Thus the decadal growth rate of the district is lowest than that of the state.
- Sex ratio of the population is 915 females per thousand males which is less than the sex ratio of the state. It is difficult to interpret the deficit of 85 females per thousand males in the district despite outward migration, predominantly of males in the working ages. A possible explanation seems to be that over the years male population has benefited more from the epidemiological transition than the female population.
- Only 15% of the population resides in the urban area, and the rest lives in the rural areas.

Based on these statistics one can say that Nalanda district lacks urbanization and industrialization. As far as Industrialisation is concerned situation would improved after the completion of above mentioned two projects.Population Density of this district is 1007 per sq km which is also high in comparison to the state density. Decadal population growth is lowest of this District in Bihar,Which is a positive sign.

2.2 HEALTH PROFILE

General Status of health in Nalanda district

In a study of 593 districts of the country (Jansankhya Sthirata Kosh", www.jsk.gov.in) in terms of overall rank in health it was found that Nalanda district ranks 509 though on the basis of under-five

mortality it ranked 328. Filaria, Malaria, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in Nalanda district. Hepatitis, Diarrhoea, Typhoid, Blindness and Leprosy are other high prevalence diseases.

2.2.1Indicators of Reproductive Health and Reproductive Child Health

Table-6

Variables Description	Nalanda	Bihar
Percentage girls marrying below legal age at marriage	**46.6%**	**51.5**
Percentage of households with low standard of living	73%	**66.3**
Percentage of households using adequate iodized salt (15ppm)	N.A	**29.6**
Birth order 3 and above	47.8%	**54.4**
Percent women know all modern method	27.2%	**52.2**
Percent husbands know NSV (No scalpel vasectomy)	N.A	**35.6**
Percent women/husbands using any family planning method	30.9	**31**
Percent women/husbands using any modern method of family planning	27.2%	**27.3**
Unmet need for family planning	40.7%	**36.7**
Percent women received at least three visits for ANC	25.2%	**19.6**
Percent women received full ANC	N.A	**5.4**
Percentage of Institutional delivery	39.3	**23**
Percentage of delivery attended by skilled personnel	34%	**29.5**
Percentage of children (age12-23 months) received full immunization	54.2	**23**

Percentage of children (age12-23 months) did not received any immunization	30.9	**49.4**
Percent women aware of HIV/AIDS	54.3%	**28.8**
Percent husbands aware of HIV/AIDS	**N.A**	**62.1**

Source: DLHS (2002-2004)

2.3.1HEALTH STATUS AND BURDEN OF DISEASES

Table 1.5. MORBIDITY DUE TO MAJOR DISEASE

S.No.	Disease	2006	2007	2008
1	Kala-azar	01	00	00
2	T.B.	00	00	00
3	Leprosy	00	00	00

Table 1.6. BASIC HEALTH STATUS INDICATORS OF Nalanda DISTRICT

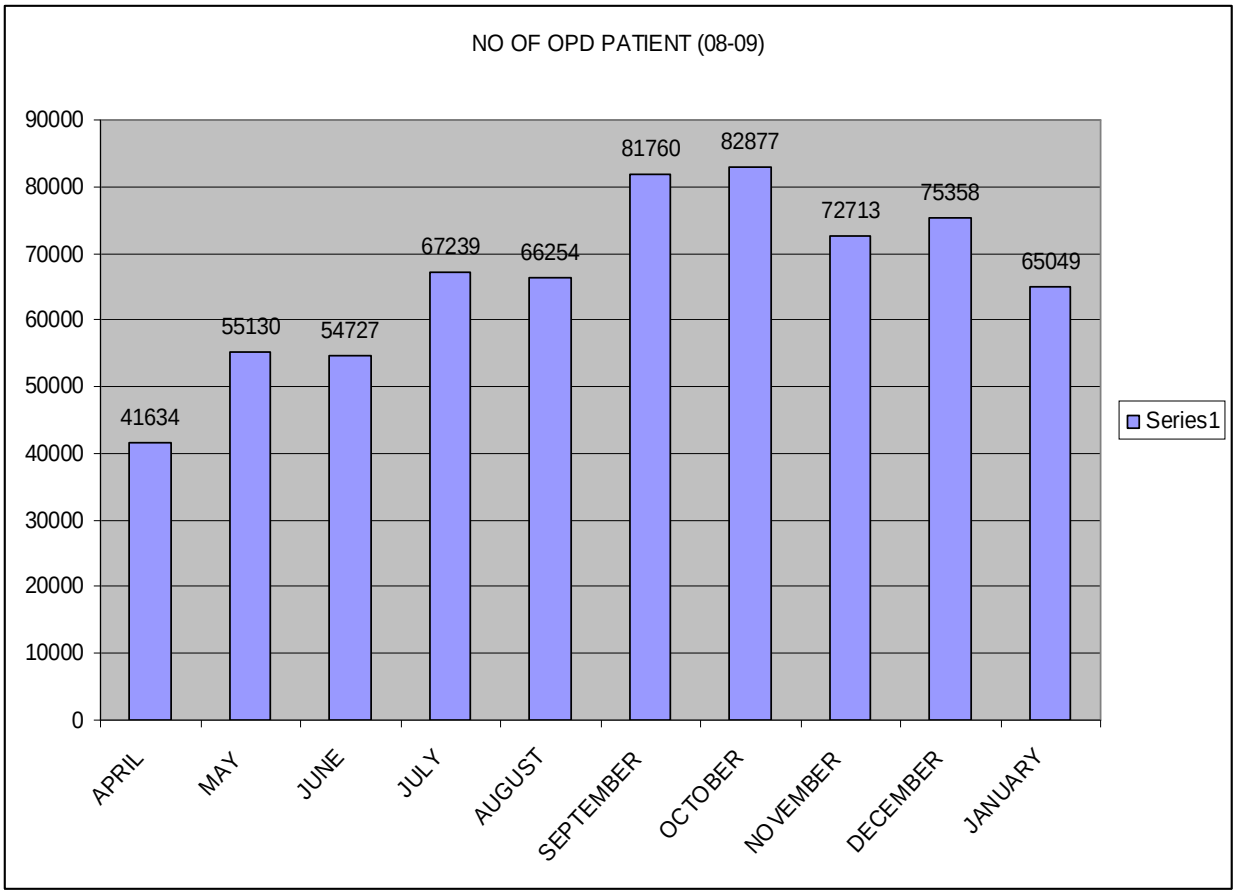
Indicators	Nalanda	Bihar
Couple Protection Rate (CPR)	33%	33%
Crude Death Rate (CDR)	NA	8.1
Crude Birth Rate	31.9	30.4
Infant Mortality Rate	61	61
Maternal Mortality Ra	371	371
Total Fertility Rate (TFR)	4.6	4.2

(Source : CMHO)

SRS fig not available, state fig taken (Source : CMHO)

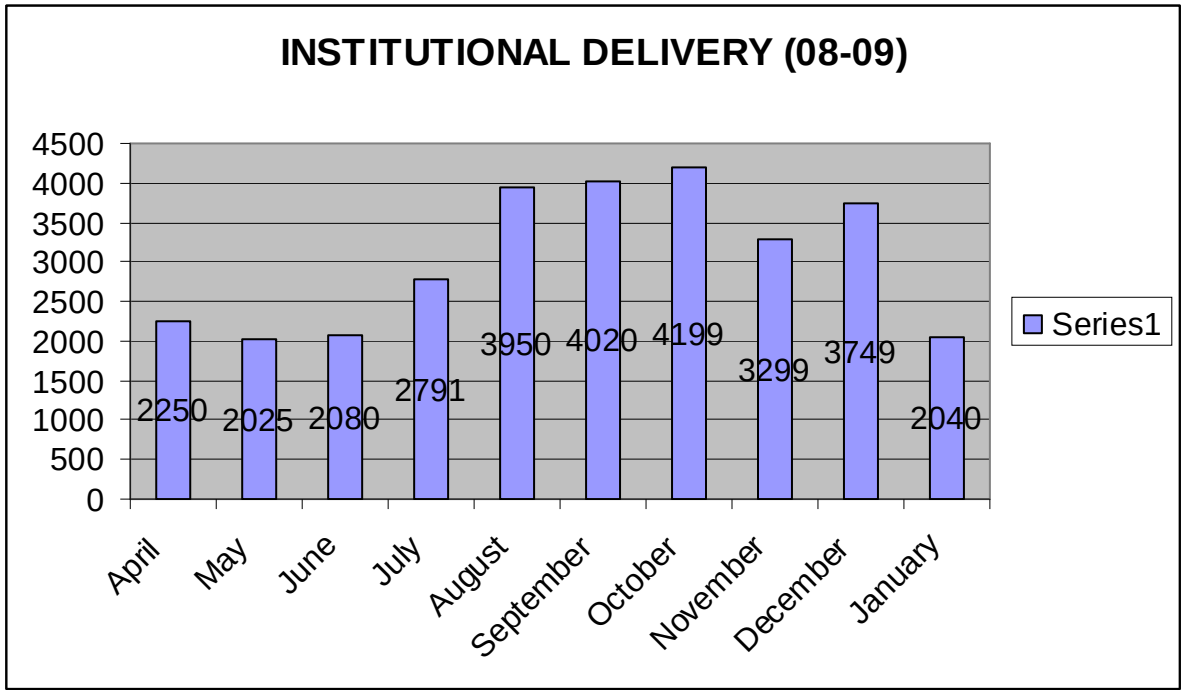
Table 1.7. *DETAILS ABOUT TREATMENT OF COMMON DISEASES*

Patient categotries	2006	2007	2008
Outdoor patients District health facility	NA	NA	597652
Outdoor patients other health facilities	NA	NA	NA
Total out-patients (all facilities)	NA	NA	NA



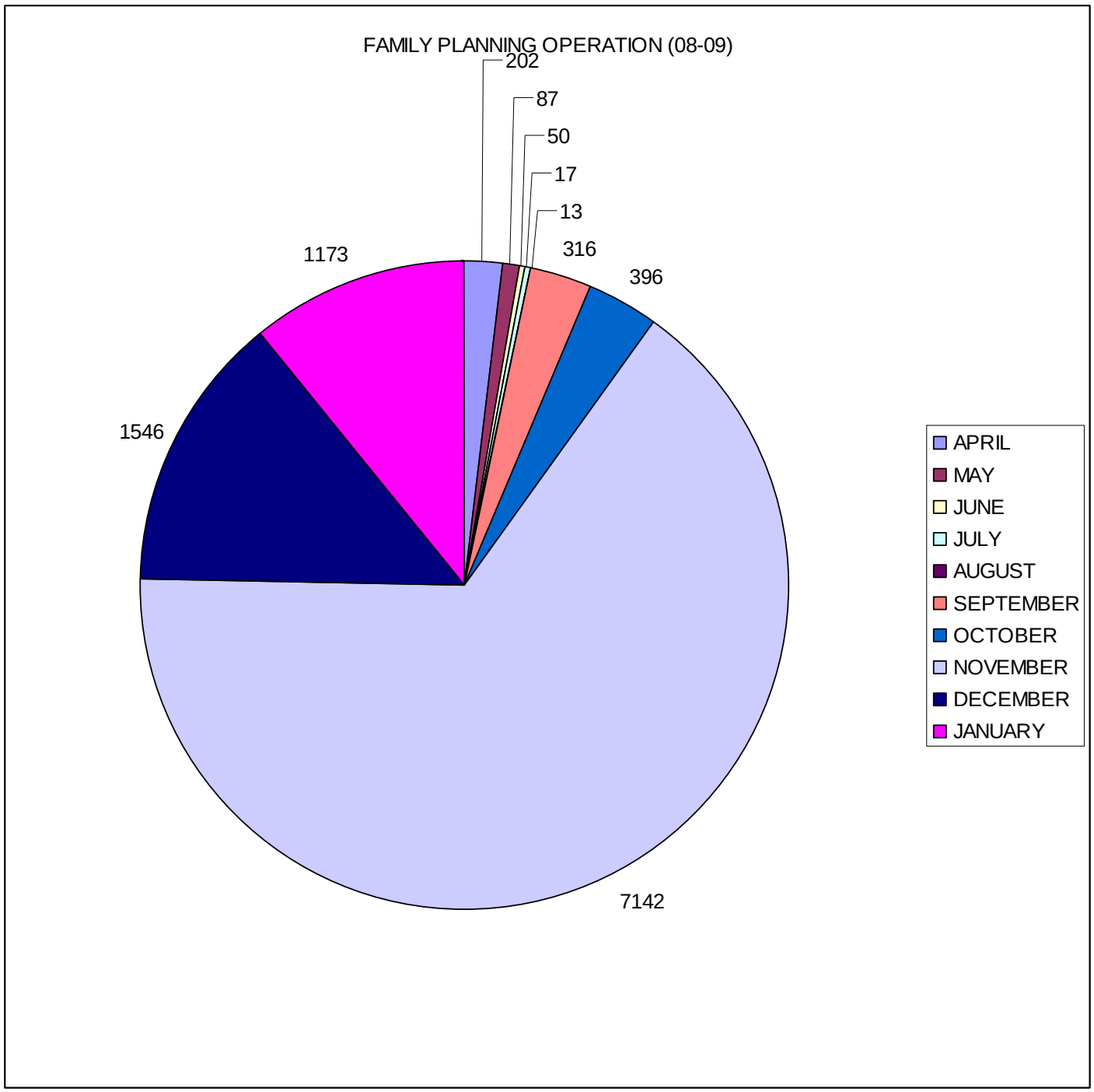
S.N	Name of PHC	OPD-NALANDA (From April 08 to Jan 09)									
		April	May	June	July	August	September	October	November	December	January
1	Asthawan	3224	3839	4195	5317	5585	6368	6517	6207	5335	1169
2	Giriyak	1951	2472	2566	3553	2928	4856	4756	3895	3205	2465
3	Rajgir	3813	5358	5425	7507	6815	9365	9436	8496	5645	4022
4	Harnaut	2574	3173	3011	4203	4169	6747	6851	5895	5795	4179
5	Sarmera	1371	1691	1607	2025	2265	2486	2476	2025	1820	1728
6	Noorsarai	2962	3437	3922	5411	4916	7985	8475	8405	6897	6846
7	Rahui	2936	4266	4843	5564	5008	5494	5726	5225	5208	3756
8	Hilsa_PHC										
9	Hilsa_Sub	2879	6162	5198	5131	5476	6045	7425	5452	5045	1452
10	Chandi	3878	4640	3980	4957	4335	7013	7403	7625	5795	3644
11	Ekangarsarai	2808	3548	3787	4673	4434	5124	4724	3725	3625	3962

12	Islampur	3247	4020	3890	3557	3365	3744	3864	2892	2784	2973
13	Sadar_PHC										
14	Sadar Hospital	9991	12524	12303	15341	16958	16533	15224	12509	13154	13014
15	Urban Health Centre	0	0	0	0	0	0	0	362	502	804
16	Tharthari	0	0	0	0	0	0	0	0	1132	1058
17	Nagarnausa	0	0	0	0	0	0	0	0	1062	3267
18	Karaiparsurai	0	0	0	0	0	0	0	0	1296	1110
19	Parwalpur	0	0	0	0	0	0	0	0	1157	800
20	Silao	0	0	0	0	0	0	0	0	1446	1679
21	Ben	0	0	0	0	0	0	0	0	2006	3368
22	Katrisarai	0	0	0	0	0	0	0	0	1420	1101
23	Bind	0	0	0	0	0	0	0	0	1029	2657
	Total	41634	55130	54727	67239	66254	81760	82877	72713	75358	65049



INSTITUTIONAL-Delivery

S.N	Name of PHC	April	May	June	July	August	September	October	November	December	Janua
1	Asthawan	123	138	92	151	221	207	229	208	185	47
2	Giriyak	92	78	76	123	146	162	159	160	149	92
3	Rajgir	132	231	237	297	300	201	408	325	352	37
4	Harnaut	150	124	122	139	236	274	280	234	240	249
5	Sarmera	44	25	37	37	48	82	126	89	110	61
6	Noorsarai	101	117	124	180	199	253	318	230	214	150
7	Rahui	95	106	106	124	129	199	213	186	147	107
8	Hilsa_PHC										
9	Hilsa_Sub	139	146	126	193	277	275	318	214	236	51
10	Chandi	96	118	115	166	292	356	392	289	249	203
11	Ekangarsarai	95	148	140	201	240	248	257	212	214	235
12	Islampur	48	32	52	39	65	107	101	76	79	83
13	Sadar_PHC										
14	Sadar Hospital	1135	762	853	1141	1797	1656	1398	1058	1534	690
15	Urban Health Centre	0	0	0	0	0	0	0	18	40	35
Total		2250	2025	2080	2791	3950	4020	4199	3299	3749	204


FAMILY PLANNING OPERATION (08-09)
202
87
50
17
13
316
396
1173
1546
7142
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY

S.N	Name of PHC	Family Planning- OPERATION									
		April	May	June	July	August	September	October	November	December	January
1	Asthawan	17	10	6	0	0	0	8	8	82	25
2	Giriyak	0	0	0	0	0	0	0	0	26	12
3	Rajgir	0	0	0	0	0	0	0	0	162	171
4	Harnaut	0	0	0	0	0	0	0	0	243	0
5	Sarmera	0	0	0	0	0	0	0	0	0	24
6	Noorsarai	12	14	15	0	8	18	51	69	81	43
7	Rahui	16	0	0	0	0	0	14	14	120	130
8	Hilsa_PHC	15	0	0	0	0	0	68	68	76	75
9	Hilsa_Sub	0	0	0	0	0	0	0	0	0	0
10	Chandi	0	0	0	0	0	0	0	0	162	190
11	Ekangarsarai	0	4	0	0	0	0	28	28	94	111
12	Islampur	0	8	19	0	0	8	12	20	58	84
13	Sadar_PHC	32	13	0	0	0	274	176	450	212	268
14	Sadar Hospital	110	38	10	17	5	16	39	55	230	40
Total		202	87	50	17	13	316	396	712	1546	1173

Table . DENOTING PRIORITY AREAS IN EACH OF THE BLOCK

Block	**Hard to Reach area**
08	**40 village**

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

2.3.2 **PUBLIC HEALTH CARE DELIVERY SYSTEM: ORGANISATIONAL STRUCTURE AND INFRASTRUCTURE**

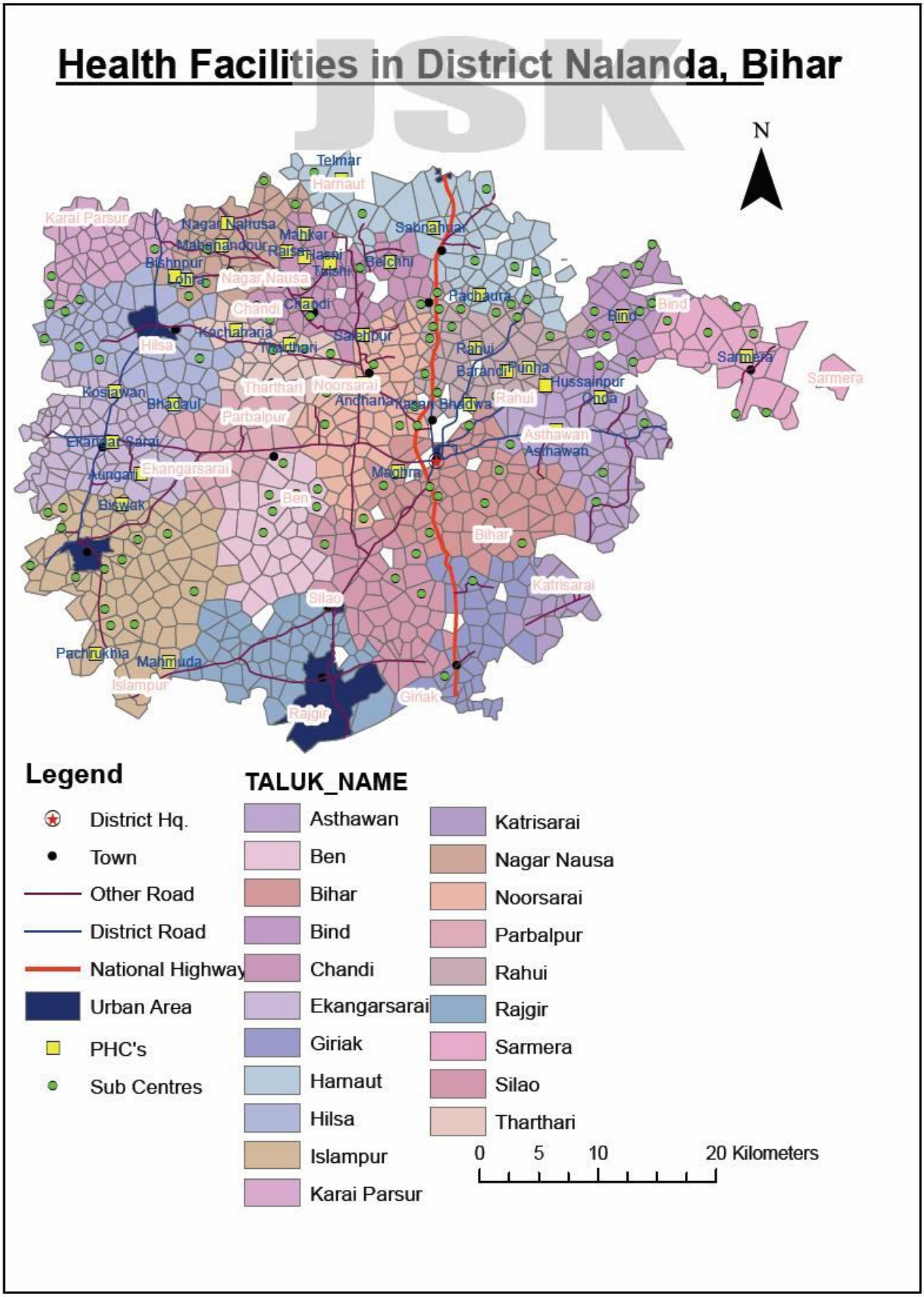


Table HEALTH CARE INSTITUTIONS IN THE DISTRICT

S.No.	Type of Institutions	Number	Total No. of Beds*
1	District Hospital	01	120
2	Referral	02	60
3	Block PHCs	20	72
4	APHCs	25	0
5	Sub-centres	305	0
8	Ayurvedic Dispensaries	00	N.A
9	Anganwadi Centres	2246	N.A
10	Others (Pvt. Facility accreditated)	04	N.A

Table . DISTRIBUTION OF PUBLIC HEALTH FACILITIES IN DISTRICT

District Hospital	Civil Hospital	Community Health Centres	Block PHC	FRU
1	**0**	**0**	**20**	**2**

Table . BLOCK WISE NUMBER OF CHCS, PHCS AND SUB-CENTERS

CHC/ Block PHC	Population	APHC	Number of sub-centers
Sadar	**395588**	**03**	**22**
Rahui	**127975**	**00**	**21**
Giriyak	**75735**	**01**	**21**
Harnaut	**143922**	**04**	**18**
Nagarnausa	**72475**	**01**	**14**
Chandi	**125990**	**00**	**19**
Noorsarai	**127975**	**02**	**24**
Karaiparsurai	**60127**	**01**	
Hilsa	**162546**	**00**	**21**
Ekangarsarai	**145479**	**01**	**27**
Islampur	**192113**	**01**	**24**
Parwalpur	**58501**	**00**	
Tharthari	**52039**	**00**	**06**
Rajgir	**109136**	**01**	**39**
Asthawan	143867	00	34
Silao	**122991**	**02**	
Ben	**72193**	**03**	
Sarmera	**78610**	**02**	**14**
Katrisarai	**37734**		
Bind	**56240**		
Total	**2370528**		

2.3.3 HUMAN RESOURCEs AVAILABLE AT PUBLIC HEALTH CARE SYSTEM IN NALANDA

	Sadar Hospital																		
	Civil Surgeon office										ACMO office							Cholera control Scheme	
Name of the post	**Doctors(working in District hospital**	**Civil Surgeon**	**Head clerk**	**Clerk**	**Stenographer**	**Collector**	**Drug inspector**	**Food Inspector**	**Peon**	**4th grade**	**ACMO**	**Clerk**	**Stenographer**	**Statician**	**PHN**	**4th grade**	**Driver**	**Cholera Supervisor**	**Special Cholera worker**
Sanction	1	1	1	3	2	1	1	1	1	3	1	2	1	1	1	2	1	4	16
Working	23(15-R/8-C)	1	0	2	2	0	1	1	1	3	0	1	1	0	1	1	0	1	9
Vacancy	NA	0	1	1	0	1	0	0	0	0	0	1	0	1	0	1	1	3	7
Gynecologist	1																		
Ortho	1																		
Pediatrician	1																		
Eye	1																		
Radiologist	1																		
Medicine	1																		
Skin	1																		
ENT	1																		
Pathologist	1																		
Anesthetists	1																		
Dental Sugone	1																		

	Sadar Hospital																	
	POX				Media			Matri Shishu			RCH office					T.B	Leprosy	Malar
Name of the post	**Clerk**	**Computer Operator**	**Immunizer**	**Peon**	**Clerk**	**Cinema operator**	**Driver**	**LHV**	**ANM**	**4th Grade**	**DIO**	**Clerk**	**Computer Operator**	**Mechanic**	**Driver**	**Doctors**	**Doctors**	**Doctors**
Sanction	1	12	36	1	1	1	1	2	2	4	1	1	1	1	2	1®+ 1©=2	1®+ ©=2	1®+ ©=2
Working	1	0	8	1	1	0	1	2	2	1	1	1	0	0	1			
Vacancy	0	12	28	0	0	1	0	0	0	3	0	0	1	1	1			

Subdivisional Hospital- Hilsa										
Name of Post	Doctor	"A" Gr Nurse	OT Helper	X-Ray Technician	Pharmacist	Clerk	Lab Astt	Eye Helper	Dresser	4th Gr
Sanction	N.A	6	1	1	2	2	2	1	1	17
Working	8®+11©=12	6	0	1	2	2	2	1	1	12
Vacancy		0	1	0	0	0	0	0	0	5

	Referrals Hospital+PHC Islampur								
Name of Post	Doctor	"A" Gr Nurse	OT Helper	X-Ray Technician	Pharmacist	Clerk	Lab Astt	Eye Helper	Dresser	4th Gr
Sanction	N.A	4	1	1	2	2	1	1	1	14
Working	1®+3(4)=4	2	0	0	0	2	0	0	1	14
Vacancy	N.A	2	1	1	2	0	1	1	0	0

	Refferal Hospital+PHC Asthwan													
Name of Post	Doctor	ANM	LHV	Health Worker	Pharmacist	Clerk	BDO	Sanitary Inspector	Dresser	Basic Health Worker	Lab Asst	Computer Operator	Driver	Health instructor	4th gr
Sanction	N.A	44	3	3	4	3	1	1	4	3	5	1	1	2	11
Working	4®+3©=7	43	1	1	4	2	0	0	1	1	2	1	1	2	11
Vacancy	N.A	1	2	2	0	1	1	1	3	2	3	0	0	0	0

	Referral Hospital- Rajgir									
Name of Post	Doctor	"A" Gr Nurse	OT Helper	X-Ray Technician	Pharmacist	Clerk	Lab Astt	Eye Helper	Dresser	4th Gr
Sanction	N.A	4	1	1	2	2	1	1	1	14
Working	4®+3©=7	4	0	1	2	2	0	1	0	6
Vacancy	N.A	0	1	0	0	0	1	0	1	8

HUMAN RESOURCES AVAILABLE IN 12 PHCs (24x7)

	PHC -Sadar Prakhand														
Name of Post	Doctor	ANM	LHV	Health Worker	Pharmacist	Clerk	BDO	Sanitary Inspector	Dresser	Basic Health Worker	Lab Asst	Computer Operator	Driver	Health instructor	4th gr	Eye Helper

Sanction	N.A	29	2	3	1	3	1	2	3	3	6	1	1	3	8	0
Working	1®+ 1©=2	29	2	3	0	2	1	1	1	0	6	1	0	2	8	0
Vacancy	N.A	0	0	0	1	1	0	1	2	3	0	0	1	1	0	0

PHC -Hilsa

Name of Post	Doctor	ANM	LHV	Health Worker	Pharmacist	Clerk	BDO	Sanitary Inspector	Dresser	Basic Health Worker	Lab Asst	Computer Operator	Driver	Health instructor	4th gr	Eye Helper
Sanction	N.A	38	2	1	3	4	1	1	3	7	1	1	2	1	13	0
Working	1®+ 1©=2	38	2	0	3	4	0	0	0	6	1	1	0	0	11	0
Vacancy	N.A	0	0	1	0	0	1	1	3	1	0	0	2	1	2	0

PHC -Giriyak

Name of Post	Doctor	ANM	LHV	Health Worker	Pharmacist	Clerk	BDO	Sanitary Inspector	Dresser	Basic Health Worker	Lab Asst	Computer Operator	Driver	Health instructor	4th gr	Eye Helper
Sanction	N.A	29	2	3	3	5	1	1	4	9	1	1	2	2	14	0
Working	3®+ 4©=7	29	2	2	3	4	0	0	2	4	1	0	0	2	7	0
Vacancy	N.A	0	0	1	0	1	1	1	2	5	0	1	2	0	7	0

PHC -Sarmera

Name of Post	Doctor	ANM	LHV	Health Worker	Pharmacist	Clerk	BDO	Sanitary Inspector	Dresser	Basic Health Worker	Lab Asst	Computer Operator	Driver	Health instructor	4th gr	Eye Helper
Sanction	N.A	20	2	3	3	4	1	1	3	5	3	1	4	2	7	1
Working	3®+ 2©=5	20	2	3	2	3	0	0	2	1	2	1	1	1	5	1
Vacancy	N.A	0	0	0	1	1	1	1	1	4	1	0	3	1	2	0

PHC -Rahui

Name of Post	Doctor	ANM	LHV	Health Worker	Pharmacist	Clerk	BDO	Sanitary Inspector	Dresser	Basic Health Worker	Lab Asst	Computer Operator	Driver	Health instructor	4th gr	Eye Helper
Sanction	N.A	25	2	3	2	1	1	1	2	2	1	1	1	1	15	
Working	1®+ 4©=5	25	2	3	2	1	0	1	0	2	0	1	0	1	9	
Vacancy	N.A	0	0	0	0	0	1	0	2	0	1	0	1	0	6	

	PHC-Noorsarai															
Name of Post	**Doctor**	**ANM**	**LHV**	**Health Worker**	**Pharmacist**	**Clerk**	**BDO**	**Sanitary Inspector**	**Dresser**	**Basic Health Worker**	**Lab Asst**	**Computer Operator**	**Driver**	**Health instructor**	**4th gr**	**Eye Helper**
Sanction	N.A	26	2	3	3	4	1	1	3	7	3	1	2	1	11	0
Working	2®+4©=6	26	2	1	2	2	1	1	2	4	2	1	2	1	9	0
Vacancy	N.A	0	0	2	1	2	0	0	1	3	1	0	0	0	2	0

	PHC-Harnaut															
Name of Post	**Doctor**	**ANM**	**LHV**	**Health Worker**	**Pharmacist**	**Clerk**	**BDO**	**Sanitary Inspector**	**Dresser**	**Basic Health Worker**	**Lab Asst**	**Computer Operator**	**Driver**	**Health instructor**	**4th gr**	**Eye Helper**
Sanction	N.A	24	2	3	3	3	1	1	3	7	3	1	1	1	10	0
Working	1®+ 4©=5	24	1	2	2	2	0	1	0	2	0	1	1	1	6	0
Vacancy	N.A	0	1	1	1	1	1	0	3	5	3	0	0	0	4	0

	PHC-Chandi															
Name of Post	**Doctor**	**ANM**	**LHV**	**Health Worker**	**Pharmacist**	**Clerk**	**BDO**	**Sanitary Inspector**	**Dresser**	**Basic Health Worker**	**Lab Asst**	**Computer Operator**	**Driver**	**Health instructor**	**4th gr**	**Eye Helper**
Sanction	N.A	47	2	3	1	4	1	2	4	4	6	1	1	3	14	1
Working	2®+ 4©=6	47	2	3	0	3	1	2	1	1	6	1	0	0	9	1
Vacancy	N.A	0	0	0	1	1	0	0	3	3	0	0	1	3	5	0

	PHC-Islampur															
Name of Post	**Doctor**	**ANM**	**LHV**	**Health Worker**	**Pharmacist**	**Clerk**	**BDO**	**Sanitary Inspector**	**Dresser**	**Basic Health Worker**	**Lab Asst**	**Computer Operator**	**Driver**	**Health instructor**	**4th gr**	**Eye Helper**
Sanction	N.A	27	2	3	2	2	1	1	1	2	1	1	2	0	6	1
Working	1®+ 4©=5	27	2	1	2	2	0	0	1	2	0	1	1	0	4	1

Vacancy	N.A	0	0	2	0	0	1	1	0	0	1	0	1	0	2	0

PHC-Asthawan

Name of Post	Doctor	ANM	LHV	Health Worker	Pharmacist	Clerk	BDO	Sanitary Inspector	Dresser	Basic Health Worker	Lab Asst	Computer Operator	Driver	Health instructor	4th gr	Eye Helper
Sanction	N.A	24	2	3	4	6	1	1	4	3	5	1	1	2	11	1
Working	4®+ 3©=7	24	1	1	4	4	0	0	1	1	2	1	1	2	11	1
Vacancy	N.A	0	1	2	0	2	1	1	3	2	3	0	0	0	0	0

PHC-Rajgir

Name of Post	Doctor	ANM	LHV	Health Worker	Pharmacist	Clerk	BDO	Sanitary Inspector	Dresser	Basic Health Worker	Lab Asst	Computer Operator	Driver	Health instructor	4th gr	Eye Helper
Sanction	N.A	55	2	3	9	8	1	1	8	7	7	1	2	5	16	1
Working	4®+ 3©=7	55	2	1	3	7	0	0	2	6	0	1	1	5	8	1
Vacancy	N.A	0	0	2	6	1	1	1	6	1	7	0	1	0	8	0

PHC-Ekangarsarai

Name of Post	Doctor	ANM	LHV	Health Worker	Pharmacist	Clerk	BDO	Sanitary Inspector	Dresser	Basic Health Worker	Lab Asst	Computer Operator	Driver	Health instructor	4th gr	Eye Helper
Sanction	N.A	33	2	3	3	4	1	1	3	3	3	1	2	1	15	0
Working	1®+ 4©=5	33	1	1	1	3	0	0	1	2	2	1	1	1	11	0
Vacancy	N.A	0	0	2	2	1	1	1	2	1	1	0	1	0	4	0

No Of Doctors Posted at Health Institution

Name Of the Institution	Number Of Permanent Doctor	Number Of Contractual Doctor	Total Number Of Doctor	Lady Doctors
Civil Surgeon Office	2	0	2	
ACMO Office	2	0	2	
District Leprosy Office	2	0	2	
District T.B Office	2	0	2	
District Malaria Office	1	0	1	
District Hospital	15	8	23	4
Specialist		Gynecologist	1	
		Ortho	1	
		Pediatrician	1	

		Eye	1	
		Radiologist	1	
		Medicine	1	
		Skin	1	
		ENT	1	
		Pathologist	1	
		Anesthetist	1	
		Dental Surgeon	1	
SDH Hilsa	8	3	11	3
		Surgeon	2	
		Gynecologist	1	
		Anesthetist	1	
Specialist		Pediatrician	1	
Refferal Hospital+PHC Islampur	1	4	5	0
Refferal Hospital+PHC Asthawan	4	3	7	1
		Pediatrician	1	
Specialist		DGO	1	
Refferal Hospital+PHC Rajgir	4	3	7	1
		Anesthetist	1	
		Ortho	1	
PHC Sadar	1	0	1	0
PHC Hilsa	1	1	2	1
PHC-Ekangarsarai	1	4	5	1
PHC-Chandi	2	4	6	1
		Surgeon	1	2
Specialist	2	4	6	
PHC-Harnaut	1	4	5	0
Specialist		Surgeon	2	
PHC-Giriyak	3	4	7	1
PHC-Rahui	1	4	5	1
Specialist		Medicine		
PHC-Sarmera	3	2	5	0
PHC-Silao	1	3	4	1
PHC-Ben	1	3	4	0
PHC-Bind	1	3	4	0
PHC-Nagarnausa	1	4	5	1
PHC-Tharthari	0	4	4	0
Specialist		Pediatrician	1	
PHC-Parwalpur	1	4	5	1
PHC-katrisarai	1	3	4	0
PHC-Karaipursurai	2	4	6	0
APHC-Tetrawa	1	0	1	0
APHC-Sithaura	1	0	1	0
APHC-Murgawn	1	0	1	0
APHC-Debaria	1	0	1	0
APHC-Kalyanbigha	1	1	2	0
APHC-Bajitpur	1	0	1	0
APHC-Koshiyawan	1	0	1	
Total	71	77	172	19
Note; Specialist Are included in Total numbers of Doctors				

Table . DETAILS OF ICDS PROGRAM IN THE DISTRICT NALANDA

ICDS PROGRAMS

	Name of the Block with ICDS Program	Number of AWCs		CDPOs and ACDPOs	
		S	F	S	IP
	Asthwa	184	184	1	1
	Noorsarai	113	113	1	1
	Harnaut	304	304	1	1
	Sarmera	144	144	1	1
	Sadar	**79**	**79**	**1**	**1**
	Rahui	**137**	**137**	**1**	**1**
	Giriyak	**128**	**128**	**1**	**1**
	Hilsa	**223**	**223**	**1**	**1**
	Rajgir	**271**	**271**	**1**	**1**
	Chandi	**204**	**204**	**1**	**1**
	Ekangarsarai	**191**	**191**	**1**	**1**
	Islampur	**273**	**273**	**1**	**1**

S = Sanctioned; **F** = Functional; **IP** = In Position

(Source : ICDS,NALANDA

2.3.5 BED AVAILABILITY

Table .AVAILABILITY OF NUMBER OF BEDS AT PUBLIC HEALTH INSTITUTION-BLOCK WISE

Name of Block	Institution	Sector PHC	Number of beds*	Population
Sadar		**PHC**	100	395588
Rahui		**PHC**	**06**	127975
Giriyak		**PHC**	**06**	75735
Harnaut		**PHC**	**06**	143922
Nagarnausa		**PHC**	**06**	72475
Chandi		**PHC**	**06**	125990
Noorsarai		**PHC**	**06**	137267

Karaiparsurai		**PHC**	**00**	**60127**
Hilsa		**REF HOS**	**30**	**162546**
Ekangarsarai		**PHC**	**06**	**145479**
Islampur		**REF HOS**	**30**	**192113**
Parwalpur		**PHC**	**00**	**58501**
Tharthari		**PHC**	**00**	**52039**
Rajgir		**REF HOS**	**30**	**109136**
Asthawan		**REF HOS /PHC**	**30**	**143867**
Silao		**PHC**	**06**	**122991**
Ben		**PHC**	**06**	**72193**
Sarmera		**PHC**	**06**	**78610**
Katrisarai		**PHC**	**00**	**37734**
Bind		**PHC**	**00**	**56240**
ISLAMPUR		**PHC**	**06**	**192113**
HILSA		**PHC**	**00**	**162546**
RAJGIR		**PHC**	**00**	**109136**

2.3.6 DISTRICT HOSPITAL

Table AVAILABILITY OF BASIC FACILITIES AT THE DISTRICT HOSPITAL,

Availability of selected facilities	Response
Tap water facility	Y
Over head tank and pump	Y
Electricity line in all parts	Y
Generator	Y(outsourced)
Telephone	Y
Vehicles	N
Sewerage	Y
Incinerator	Y
Clean OPD	Y
Clean OT	Y
Clean toilets	N
Clean premises	Y

(Source : CS)

Chapter 3
Situation Analysis

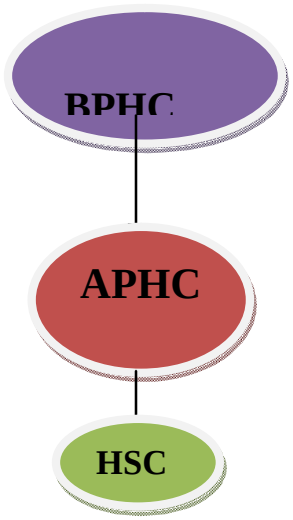
In the present situational analysis of the blocks of district Nalanda the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from census 2001, report of Chief Medical Officer & Health office, Nalanda and various websites as well as other sources. These indicators help in pointing to the health scenario in Nalanda 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 Nalanda district with respect to Bihar and India as a whole

Table 3.1: Health Indicators

Indicator	Nalanda	Bihar	India
CBR	32	31	1.4
CDR	N.A	8.1	6
IMR	60/1000	61	58
MMR	452/100000	371	301
TFR	4.3	4	2.68
CPR	21.5		
Complete Immunization	38%	32.8	

Sources: DLHS3, NFHS3, SRS2007

3.1.1. GAPS IN INFRASTRUCTURE:



Population 80000-120000

Population 20000-30000

Population 5000

First contact point with community

Introduction:

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

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

1. Infrastructure for HSCs:

IPHS Norms:

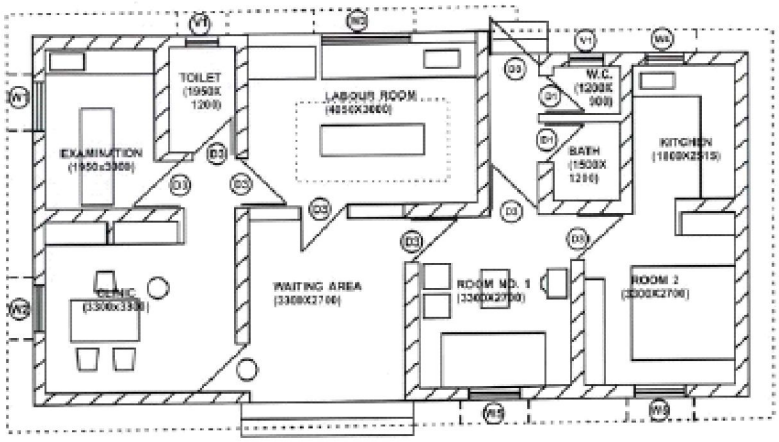
A Sub-centre should have its own building. If that is not possible immediately, the premises with adequate space should be rented in a central location with easy access to population.

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

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

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

Typical Layout of Sub- Centre with ANM Residence



SUBCENTER
COVERED AREA - 73.50 SQ. MTS.

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

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

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

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

Health Sub Centers: 3.1.1.

Total population of the district as per 2001 census is **2370528**. After considering 1.86 percent growth rate of the total population it comes around **2723262** (Decadal Growth Rate- 18.64). After considering projected population in 2008, the district needs altogether **545** HSCs to cater its whole population. At present Nalanda has **305** established Health Sub Centers . As per the IPHS norms (5000 population in plain area) the district still requires **240** new HSCs to be formed. Again, out of **305** established HSCs, only **76** have their own buildings and rest **229** run in rented houses. A large no of these HSCs need renovation work. All the above mentioned HSCs need equipments, drugs, furniture and stationeries.

Table : Status of HSC in the district Nalanda

Name of Block	Population 2001	Population 2009 (1.86% Growth Rate)	No of HSCs required (As per 2009 pop)	Number of HSCs Present	Own Building	Rented Building	Land Availability
Sadar	395588	454451	91	22	04	18	00
Rahui	127975	147017	30	21	04	17	04
Giriyak	75735	87004	17	16	07	09	00
Harnaut	143922	165337	33	19	04	15	01
Nagarnausa	72475	83259	16	14	02	00	00
Chandi	125990	144737	29	19	02	17	00
Noorsarai	137267	157692	31	24	06	18	00
Karaiparsurai	60127	69073	14	07			00
Hilsa	162546	187132	37	14	07	14	01
Ekangarsarai	145479	167126	33	18	07	20	07
Islampur	192113	220699	44	24	06	18	02
Parwalpur	58501	67205	13	09			00
Tharthari	52039	59782	11	06	01	05	01
Rajgir	109136	125375	25	39	09	30	03
Asthawan	143867	165274	33	34	08	26	00
Silao	122991	141292	28				00
Ben	72193	82935	16				00
Sarmera	78610	90307	18	14			00
Katrisarai	37734	43348	9	05			00
Bind	56240	64608	13				00
Total	2370528	2723262	541	305			00

Health Sub Centers:

Indicators	Gaps	Issues	Strategy	Activities

Infrastructure	The district still needs 240 more HSCs to be formed.69 HSC has already been proposed among this number. Out of 305 HSCs only 76 are having own building. Existing buildings are not properly maintained Non payment of rent of 229 HSCs since long time. 229 HSC need new building construction 50 HSC Need Major repair and 26 Need Minor repair work. Running water supply is available in only 30 HSC. None of the Health Centre has Power Supply. 43 HSC has only ANM residential quarter. 545 HSC need new Residential quarter to be constructed for ANM. Lack of equipments & furniture as per IPHS Norms Non availability of HMIS formats/registers and stationeries	• 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	Strengthening of VHSCs & PRI Strengthening of Infrastructure and operationalization of construction works	1. Formation and strengthening of VHSCs, Mothers committees, 2. "Swasthya Kendra chalo abhiyan" to strengthen community ownership 2.1 Launch of awareness programme through various method on Citizen's charter of HSCs as per IPHS 2.2 Monthly meetings of VHSCs, Mothers committees **3A.Strengtheing of HSCs having own buildings** A.1Rennovation of HSCs 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 **3B. Strengthening of HSCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the

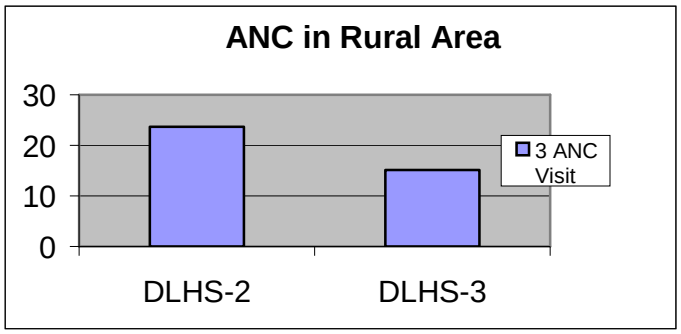
			Monitoring	payment of rent through provide fund from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new HSCs C1. Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings. 4 biannual facility survey of HSCs through BHM as per IPHS format 4.1 Regular monitoring of HSCs facilities through PHC level MOIC and BHM in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work.

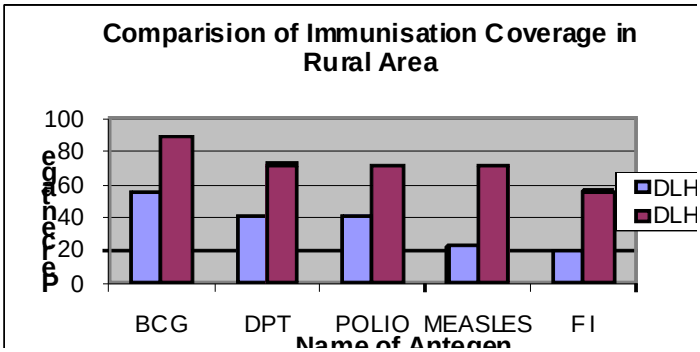
				4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.

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 diarrhea, fever, worm infestation etc. And carry out community need assessment. Besides the above the government implements several national health and family welfare programs which again are delivered through these frontline workers.

As per the DLHS3(2007-08)reports the percentage of full immunization(BCG, 3 doses each of DPT and Polio and measles) coverage(12-23 months) in the district is 54.2%. And BCG coverage of the district is 88%. 3 doses of polio vaccine is 62.8%, 3 doses of DPT vaccine is 65.1% and Measles Vaccine is 69.1%. The coverage of Vit A supplementation for the children 9 months to 35 months is 59.4 percent.





Sub Heads	Gaps	Issues	Strategy	Activities
Service performance	Unutilized untied fund at HSC level No institutional delivery at HSC level Only 25% PW registered in first trimester PW with three ANCs is 25.2%, TT1 coverage is 50%, Family Planning Status: Any method-30.9% Any modern method-27.2% No sterilization at HSC level IUD insertion - 1.5% Pills-1.4% Condom-2.6% Total unmet need is 40.7%, for spacing-14.8%, Approx 90% of HSC staffs not reside at place of posting Lack of counseling services Problem of mobility during rainy season Lack of	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization, Integration of disease control programs at HSC level. Family Planning services Convergence	Capacity building of account holder of untied fund Phasewise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through HSC level Community focused Family Planning services	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 1 Gap identification of 39 HSCs through facility survey 2.strengtheing one HSC per PHC for institutional delivery in first quarter 3.Honouring first delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs.

	convergence at HSC level		Convergence	3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. 2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues

Facility(HR)

Human Resource	For newly created 240 sub centers and for existing vacant position in HSC 440 ANM are required. Almost all the existing sub centre do not have Male Health worker The ANM training school situated at	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	1. Selection and recruitment of 440.ANMs 2. Selection and recruitment of male workers for vacant seats. 1. Training need Assessment of HSC level staffs

	Biharsharif is functional but it is not adequate up to required scale. Non Availability of Male Health Worker at HSC.			2. Training of staffs on various services 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	No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, Irregular supply of drugs	Indenting Logistics	Strengthening of reporting process and indenting through form 2 and 6 and delegating the purchase power from District to PHC level. Couriers for vaccine and other	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 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the HSC to

			drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through ANMs account 4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage

3.1.2

Additional PHCs: There are 25 APHCs functioning in the district and 55 more are proposed to be established.

Additional PHC:				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**

Infrastructure	The district altogether need 80 APHCs but there are only 25 functioning APHC.Govt has already sanctioned 19 APHC but after that the need remains 36 Out of 25 APHCs only 18 are having own building Existing 17 buildings are not properly maintained Nonpayment of rent of 7 APHCs for long period. 62 APHC need new building construction All Existing APHC Need Major repair Running water supply is not available Non availability of Labour room. None of the APHC has Power Supply. All Existing APHC require new construction of toilet Lack of equipments, Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries	Lack of facilities/ basic amenities in the constructed buildings Nonpayment of rent . Land Availability for new construction .Lack of community ownership.	Strengthening of VHSCs, PRI and formation of RKS Strengthening of Infrastructure and operationalization of construction works in Three phase	2."Swasthya Kendra chalo abhiyan" to strengthen community ownership 3.Nukkad Nataks on Citizen's charter of APHCs as per IPHS 4. Registration of RKS 4.Monthly meetings of VHSCs, Mothers committees and RKS **A. Strengthening of APHCs having own buildings** A.1Rennovation 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 providing special 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

			Monitoring	norms. C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New APHC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed APHCs buildings. 4 Biannual facility survey of APHCs through Health Managers as per IPHS format 4.1 Regular monitoring of APHCs facilities through PHC level Health Managers in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.
Human Resource	Out of 25 existing APHCs 50 doctor is required but only 16 doctors are posted still 34 position is vacant, Out of 36	Filling up the staff shortage Untrained staffs	Staff recruitment	1.Selection and recruitment of ….Doctors/Grade A nurse/ANMs/MHW through RKS. 2. Sending back the

	Nurse position only 33 Nurse has been appointed . But still 207 position remains vacant according to IPHS noms. . Non Availability of Male Health Worker at APHC.		Capacity building Strengthening of ANM training school	staffs to their own APHCs. 3. Training need Assessment of APHC level staffs 4. Training of staffs on various services 5. EmoC Training to at least one doctor of each APHC 6. Analyzing gaps with training school 7. Deployment of required staffs/trainers 8. Hiring of trainers as per need 9. Preparation of annual training calendar issue wise as per guideline of Govt of India. 10. Allocation of fund and operationalization of allocated fund
Drug kit availability	No drug kit as such for the APHCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT,	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 2 and 6	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

	MDT, DOTs, DECs)and contraceptives, Only need based emergency supply Irregular supply of drugs		Couriers for vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the APHC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through APHC account 4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage
Service performance	**RKS has not been formed at any of the APHC.** Unutilized untied fund at APHC level No institutional delivery at APHC level OPD for 2days only in most of the APHC No inpatient facility available No ANC, NC and PNC and family planning services. No lab facility No Ayush practitioner posted No rehabilitation services No safe MTP service No OT/ dressing and Cataract operation services. Approx 90% of APHC staffs not reside at place of	Formation of RKS Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps. Integration of disease control programs at APHC level. Family Planning services Convergence Operational issues	Capacity building of account holder of untied fund Phase wise strengthening of 25 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through APHC level where APHC will work as a resource center for HSCc. At present the same	1.Training of signatories on operating Untied fund /RKS account, book keeping etc 2. Assigning PHC RKS accountant for supporting operationalization of APHC level accounts 2. Timely disbursement of untied fund/ seed money for APHCs RKS. 3. 1 Gap identification of 25 APHCs through facility survey 2.strengtheing one APHC per PHC for institutional delivery in first quarter 3.Ownering first delivered baby and ANM 1 Review of all disease control programs APHC wise in existing Tuesday weekly meetings at PHC with form 6 2.Strengthening ANMs for community based

	posting Lack of counseling services Problem of mobility during rainy season Lack of convergence at APHC level Operational gaps: There is no link between HSCs and APHCs and the same way there is no link between APHC and PHC		is being done by PHC only. Community focused Family Planning services PPP Convergence	planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 5.Weekly meeting of the staffs of concerned HSCs (as assigned to the APHC) 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1.Outsourcing services for Generator, fooding, cleanliness, Pathology ambulance 1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. 2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues 3. Arrangement of Hand Pump through PHED 4. Electricity connection through local electricity

				department 5. Telephone connection.

Staff Position in APHCs as per IPHS norms

Staff Designation	Existing Position	Recommended Position
Medical Officer	1	2(one may be from AYUSH or Lady Medical Officer)
Nurse-midwife (Staff nurse)	2	3 (for 24-hour PHCs) (2 may be contractual)
Health Worker Female	0	1
Health educator	0	1
Health Assistant (Male and Female)	0	2
Clerks	1	2
Lab Technicians	1	1
Driver	0	1
Grade IV	1	4

3.1.3 Primary Health Centers:(30 beded)

Indicators	Gaps	Issues	Strategy	Activities

Infrastructure	The district altogether needs 23 PHCs but there are only 20 functioning PHC out of them 8 PHC are new PHC and only OPD services are running there. 3 PHC are required to be formed. All 12 PHCs are having own building All 12 PHCs are running with only six bed facility. **Delivery** : At present only 12 PHC's is conducting delivery. An average of 8 delivery per day. **Family Planning** 12 PHC's are conducting at an average of 7 Family Planning Operation per day in cold season. OPD / Minor operation/ Emergency is 15 - 20 each of 12 PHC in each month. This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms. The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability	Available facilities are not compatible with the services supposed to be delivered at PHCs. Quality of services Community participation.	Up gradation of PHCs into 30 bedded facilities. ISO certification of selected PHCs in the district. Strengthening of BMU Ensuring community participation. Strengthening of Infrastructure and operationalization of construction works	1.Need based (Service delivery)Estimation of cost for up gradation of PHCs 2. Preparation of priority list of interventions to deliver services. 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. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers, Accountants in all institutions. 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community representatives on different issues 2. Nukkad Nataks on Citizen's charter of HSCs as per IPHS 2.3 Monthly meetings of VHSCs, Mothers committees **3A.Strengtheing of HSCs having own buildings** A.1Rennovation of HSCs

	tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also underutilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries 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		Monitoring	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 **3B. Strengthening of HSCs 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 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 HSCs C1. Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings. 4 biannual facility survey

				of HSCs through local NGOs as per IPHS format 4.1 Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.
Human Resource	Doctors : Existing 20 PHC of the district having only 25 regular Doctors.While 54 contractual Doctors are working in these PHC, Thus the total no.of Doctors who are working in PHC is 79. Grade A Nurse : Out of 36 sanctioned post only 33 are working. ANM :- The tolal no.of regular ANM	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	3. Selection and recruitment of ….ANMs 4. Selection and recruitment of …male workers 6. Training need Assessment of HSC level staffs 7. Training of staffs on various services

	is 396 and no. of contractual ANM who are working at PHC is 248. Lab Assistant :- Out of 38 sanctioned post only 23 are working. Pharmacist :- Out of 37 sanctioned post only 23 are working. Block Extension Educator :- Out of 19 sanctioned post only 03 are working. Health Educator :- Out of 29 sanctioned post only 27 are working. L.H.V :- Out of 25 sanctioned post only 22 are working. Sanitary Inspector :- Out of 14 sanctioned post only 06 are workings. Basic Health Worker :No. of sanctioned post is 59 but 31 is working.. Out of 20 BHM & Accountant only\14 BHMs and 19 accountants are placed at present			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	Irregular supply of drugs because of lack of fund disbursement on time. Only … % essential drugs are rate contracted at state level .	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice

	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.		Phase wise strengthening of APHCs for vaccine / drugs storage	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	1.Exessive load on PHC in delivering all services i.e. 10 delivery per day, Family Planning operation/emergency operation and 150 OPD per day in each PHC. Lack of counseling services Problem of mobility during rainy season Lack of convergence	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization, Integration of disease control programs at HSC level. Family Planning services Convergence	Capacity building of account holder of untied fund Phasewise strengthening of HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through HSC level Community focused Family	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts at HSCs untied fund 1 Gap identification of HSCs through facility survey 2.strengtheing one HSC per PHC for institutional delivery in first quarter 3.Owning first delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs

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

Table 3.1. DETAILS OF INFRASTRUCTURE AT PHCs

S.No.	Block	CHC	Details of Building		Needed
			Sanctioned	No. of beds present	
1	Sadar		YES	06	24
2	Rahui		YES	06	24
3	Giriyak		YES	06	24
4	Harnaut		YES	06	24
5	Nagarnausa		YES	02	28
6	Chandi		YES	06	24
7	Noorsarai		YES	06	24
8	Karaiparsurai		YES	00	06
9	Hilsa		YES	06	24

10	Ekangarsarai		YES	06	24
11	Islampur		YES	06	24
12	Parwalpur		YES	00	24
13	Tharthari		YES	00	06
14	Rajgir		YES	06	24
15	Asthawan		YES	06	24
16	Silao		YES	00	06
17	Ben		YES	00	06
18	Sarmera		YES	06	24
19	Katrisarai		YES	00	06
20	Bind		YES	00	06

Table 3.2. DETAILS OF INFRASTRUCTURE AT APHCs

PHC	S.No.	APHC	Condition of building	Needed
1.Sadar	1.	Dumrama	Average	Some Repairs
	2.	Tetrama	Average	Some repair
	3.	Dhanuki	Poor	New Construction
2.Giriyak	1	Pawapuri	Good	
3.Harnaut	1.	Gonawa	Poor	New construction
	2.	Kharthua	Poor	New construction
	3.	Kalyan bigha	Good	
	4.	Sardar Bigha	Good	
4.Nagarnausa	1.	Bishunpur	Good	Some Repair
5.Noorsarai	1.	Dahpar	Good	
	2.	Budhol	Good	
6.Karaipursurai	1.	Bajidpur	Good	
7.Ekangarsarai	1.	Koshiyawa	Poor	New Construction
8.Islampur	1.	Laranpur	Good	
9.Rajgir	1.	Amirganj	Average	Some Repair
10.Silao	1.	Nalanda	Good	
	2.	Sithora	Average	Some Repair
11.Ben	1.	Deoria	Good	
	2.	Saidpur	Poor	Some repair
	3.	Morgawa	Average	Some repair
12.Sarmera	1.	Chheo	Average	Some Repair
	2.	Isua	Poor	New Construction

3.1.4-Referral Hospital/Sub divisional hospital(51-100 Beaded hospital)

Indicators	Gaps	Issues	Strategy	Activities

Infrastructure	The district altogether need 6 Referral Hospital but there are only 4 hospital. Out of them only two are functional. Since Lack of infrastructure these are working as PHC (6 beded). Both Referral Hospital have own building but not adequate space. Require additional building **Delivery** : At present normal delivery is conducted. No cesarean is conducted , or other operation. . Conducting normal delivery. at an average of 5 delivery per day **Family Planning** Family Planning Operation 5 per day. OPD / Minor operation/ Emergency is 112 OPD per day in each Referral. This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms. The	Available facilities are not compatible with the services supposed to be delivered at Referral Quality of services Community participation.	Upgradation of Referral into 30 bedded facilities. ISO certification of selected Referral in the district. Strengthening of BMU Ensuring community participation. Strengthening of Infrastructure and operationalization of construction works	1.Need based (Service delivery)Estimation of cost for upgradation of Referral 2.Preparation of priority list of interventions to deliver services. 1.Selection of any two Referral for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers, Accountants in all institutions.(15 Referral, 2 Referals and Sadar hospital.) 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community9 representatives on erecting boundary, beautification etc, 2. Nukkad Nataks on Citizen's charter of HSCs as per IPHS 2.4 Monthly meetings of VHSCs, Mothers committees **3A.Strengtheing of HSCs having own buildings**

	comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also underutilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries 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 Referral buildings		Monitoring	A.1Rennovation of HSCs 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 **3B. Strengthening of HSCs 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 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 HSCs C1. Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth

				transfer of constructed HSC buildings. 4 biannual facility survey of HSCs through local NGOs as per IPHS format 4.1 Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.

HUMAN RESOUCES

Drug kit availability	Irregular supply of drugs because of improper assessment and improper supply and centralized distribution. Lack of fund for the transportation of drugs from district to blocks.	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system	1.training of store keepers on invoicing of drugs 2.Implementing

	There is no clarity on the guideline for need based drug procurement and transportation.		Phase wise strengthening of A Referral for vaccine / drugs storage	computerized invoice system in all Referral 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	1. Exessive load on Referral Hospital in delivering all services i.e. 8 deliveries per day, Family Planning operation/emergency operation and 112 OPD per day in each Referral. Lack of counseling services Problem of mobility during rainy season Lack of convergence	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization, Integration of disease control programs at HSC level. Family Planning services Convergence	Capacity building of account holder of untied fund Phase wise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through HSC level	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts at HSCs untied fund 1 Gap identification of 39 HSCs through facility survey 2.strengtheing one HSC per PHC for institutional delivery in first quarter 3.Owneringfirst delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national

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

3.1.5-District Hospital				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**

Infrastructure	Infrastructure should made more strong **Delivery** : At present normal delivery is conducted. No cesarean is conducted , or other operation. . Conducting normal delivery. at an average of 25 delivery per day **Family Planning** Family Planning Operation 50 per day. OPD-500 / Minor operation-100/ Emergency is 125 per day in each Deptt. This huge workload is not being addressed with only 100 beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms.(List attached, Annexure..) The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also underutilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries Child Care Unit-absence of Child care unit in district hospital	Available facilities are not compatible with the services supposed to be delivered at District Hospital Quality of services Community participation. **increase the Family Planning Operation**	Upgradation of District Hospital 200 bedded facilities. . Asses the resources and evaluate according to the the coverage population Formulation of Monitoring Body Ensuring community participation. Strengthening of Infrastructure and operationalizati on of construction	1.Need based (Service delivery)Estimation of cost for upgradation of District Hospital 2.Preparation of priority list of interventions to deliver services. Recruit adequate no of Doctors and Paramedical Staff Introduce new & easy method of operation Prepare special team for this purpose Addvertise about this services through different mass media sources Constitute a separate body from the existing member of DHS Nalanda to look after the services delivered through Distt Hospital 1.Meeting with community representatives on erecting boundary, beautification etc, 2. Nukkad Nataks on Citizen's charter of pe IPHS **3A.Strengtheing of District Hospital having own buildings** A.2 Purchase of Furniture A.3 Prioritizing the

	ICU facility is not available Lack of specialist doctors in different department,(Ortho,Eye, ENT,Cardiologist)		works	equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries **A.6 Computer made available for better execution of work it should be made compulsory for every accounting &,reporting work**
Human Resource	Doctors : Lack of Obstetrician & Gynecologist, Anesthetist Lack of Grade A Nurse, O.T Assistant, Ward Boys, Sweeper, Chowkidar, Ophthalmic Assistant	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building	1.Selection and recruitment of ….ANMs 2.Selection and recruitment of …male workers 3.Training need Assessment of HSC level staffs 4.Training of

			Strengthening of ANM training school	staffs on various services 5.Analyzing gaps with training school 7.Deployment of required staffs/trainers 8.Hiring of trainers as per need 9.Preparation of annual training calendar issue wise as per guideline of Govt of India. 10.Allocation of fund and operationalizatio n of allocated fund
Drug kit availability	Irregular supply of drugs because of improper assessment and improper supply and centralized distribution. 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.	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system Phase wise strengthening of Referral for	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in District Hospital 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

			vaccine / drugs storage	list of drugs with store keeper.
Service performance	1. Exessive load on Referral Hospital in delivering all services i.e. 8 delivery per day, Family Planning operation/emergency operation and 112 OPD per day in each Referral. Lack of counseling services Problem of mobility during rainy season Lack of convergence	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization, Integration of disease control programs at HSC level. Family Planning services Convergence	. Community focused Family Planning services Convergence	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 District for managing accounts at HSCs untied fund 3. Reporting of disease control activities through ANMs . 2. Ensuring supply of contraceptives with three month's buffer stock at District Hospital. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues

3.2 GAPS IN EQUIPMENT :

All the sub-centres, PHCs and CHCs that are running in government building have been fully equipped according to IPHS norms. Soft gap in equipments such as hemoglobin meter, weighing machine, BP instrument,

stethoscope etc. are supplied as per the demands from health worker through sector doctor and BMO. The district hospital Nalanda does not have an incinerator and it is being demanded from state govt. The supply of water testing kit for drinking water and iodine testing kit for salt testing is not available despite regular demands. These tests if done at local level can check the spread of morbidity and timely referral will be helpful in saving lives.

3.2.1 GAPS IN MANPOWER AND SKILLS:

A detailed table of the sanctioned post and the vacancies has been given . More staff will be needed when the newly sanctioned sub-centre and PHCs will start functioning, as without the presence of trained staff, the working of sub-centre can not start. It is suggested by community representatives that district CMHO should be given the responsibility of recruiting all the sanctioned and vacant posts of field health workers and Lab assistants including class – III and class – IV employees For urban areas, 1 ANM / MPW per 10000 population is proposed esp. for Immunization, Post natal care, Primary care and for IEC and other community based activities.

3.2.2 GAPS IN SERVICES:

The district has inadequate number of sub-centers according to norms. 27 new sub-centres have been sanctioned in the year 2007-08. There are 2 referrals i.e. one in each block of ASTHWA & ISLAMPUR FRU services but they are not functional as Referral Hospital. The frequently faced problem remains that patient & family are not able to organise timely transportation and referral services. There are some villages especially of Sarmera and Katrisarai where communication is not possible. Hence, maternal and infant mortality in such cases during emergency cannot be ruled out.

3.2.3 GAPS IN INSTITUTIONAL DELIVERY:

The percentage of Institutional Delivery is more than 34% in Nalanda. The reason could be attributed to lack of adequate space at Sub-Centre levels. In the hired sub-centre buildings, there is no space to keep a single bed where the mother and neonate could be advised to rest for few hours after delivery. In certain sub-centre, the ANM is not residential and hence, cannot perform delivery at night or at any time other than office hours. All PHCs are not working 24x7 . This also attributes to lower percentage of institutional delivery. Also, it has been found out from discussions with stakeholders that the consent of immediate family members is important in deciding the place of conduction of delivery. Most often, it is not the pregnant woman but her husband, in-laws and parents who decide on her place of delivery. Hence, the whole family needs to be convinced that the PHC building is the safest place both for the mother & the newborn. For the past generations, home delivery was the most common method of delivery, especially in rural areas. In a randomly taken population ,a higher percentage of mothers & children survive than die (out of 100 deliveries conducted, roughly 15 turn to high risk & 5-6 need caesarean section delivery) , hence convincing the family members is a difficult task .A big increase in institutional delivery percentage(for eg. from 15% to 34% in Nalanda) would mean a social change in terms of community perception.

3.2.4 GAPS IN URBAN HEALTH CARE:

As there are no sub-centre especially in slums and other backward areas, access to poor is limited in terms of basic health programs. Also poor sanitary habits and unhealthy living and working conditions give rise to poor health status. The proposition of appointing an ANM / MPW on a fixed number of inhabitants (for e.g. 10000) will be helpful in addressing the above stated problems through community education and inter personnel communication.

3.2.5 GAPS IN IEC:

A large portion of the population is not aware of various health programmes such as JBSY, Family Planning Compensation Packages, Kala-Azar Compensation packages etc., they are not able to benefit from the health services, when needed and spend money & time on getting treatment from quacks. This could be change by focusing on IEC & BCC strategies.

3.2.6 GAPS IN LOGISTICS:

Nearly 60% of the drugs supplied come from central pool & 40 % are procured at the district level. Occasionally flow of logistics from source to end-user i.e. Central – State – District – Block - Sector is disrupted.

There are certain areas such as Sarmera which become unreachable during rainy season. This geographical constraint withholds the delivery of timely & essential medical services and emergency care is almost impossible.

3.2.7 GAPS IN HMIS:

Late submission or reporting of stocks can also be considered a gap in health management, which presently is mostly on manual operation. Although the district has been equipped with computers at the block level, their use as management tool is not optimal. A computerized inventory system needs to be developed & implemented so that Demand / Supply / Stock MIS reports can be collected / generated for bridging the gaps in logistics, reports & database maintenance. The need is to provide trained personnel & Customized software for health management.

3.3 PROGRAMME PERFORMANCE AND ACHIEVEMENTS DURING THE YEAR 2007-08 OF DISTRICT

An attempt was made to analyze the programme achievement against the planned for year 2007-08 to understand the status of health service delivery. It is also important to use this information for planning the services for current year 2009-10. The table given below presents the service component-wise achievement against the planned along with variation of achievement. The information on variation between planned activity and its achievement will be used to set the objective for year 2009-2010.

PROGRAMME PERFORMANCE AND ACHIEVEMENTS DURING THE YEAR 2007-08

	Target	Achievement	Percentages	Pert. Var.
	2007-08	**2007-08**		
Family welfare program	N.A	NA		
Family planning				
Sterilization	10710	5552	51.84	
IUD Insertions	9690	2957	30.54	
Oral pills cycles	28052	10576	37.70	
CC Pieces	101760	259895	255.30	
Leprosy eradication program				
New cases detected	632			
New cases discharged	682			
Total cases	1314			
TB control program				
New cases detected				
Sputum slide examined	6034			
Positive	1140			
Blindness control program				
Cataract Operations	9059			
School Health program				
Total registered (School)				
Children examined	493			

Number of children found ill	**00**			
Expenditure				
Beneficiaries of JBSY				
Applications	26377			
Rejected	0000			
Pending	0000			
No affected by epidemic				
Number of died	0000			
Malaria eradication program				
Blood slide collected	5888			
Blood slide examined	5888			
Positive	0002			
Pv positive	0003			
RT given	0000			
RCH program (CNA)				
Antenatal care				
Registered ANC cases	81846	42273		
No of high risk cases				
TT 1				
TT 2				
Booster				
No of Anemic cases treated				
No of pregnant women given IFA tablet				
Natal Care				
Total No. of Deliveries				

3.3. PROBLEMS AND ISSUES EMERGED FROM THE BLOCK LEVEL MEETINGS

Problem	Effect on work / performance	Possible solutions	Person responsible
Building not present as per	Intuitional delivery	Building of sub-centre	MOIC

norms.	could not be conducted.	hiring of bigger building for sub-centre & residence of ANM.	MO ANM
.	More then 16 patients can not be accommodated.	Bigger building for CHC to include 14 beds.	CMHO BMO
Immunization, RCH & other programmes acceptance is not high in urban areas.	Performance of all programmes suffers due to low acceptance and presence of pvt. Medical services(skilled & unskilled)	Starting an urban health centre and appt. of 1 ANM+ 1 MPW at 10000 populations.	State Govt. CMHO

3.4. PROGRAM WISE ISSUES

3.4.1. NATIONAL TB CONTROL PROGRAM

- **Tuberculosis program needs more awareness regarding detection and sustained treatment.**
- **Low priority is given to TB program**
- **National guidelines are not being followed for the diagnosis of patients. Doctors at the PHC/CHC suggest the treatment on the basis of x ray results .Sometimes this leads to false diagnosis of the cases.**
- **Improper training and non availability of drugs**
- **Workers do not collect sputum slides from their respective areas on a regular basis.**
- **The complete range of medicines required for tuberculosis treatment is not adequately available.**

- Problems in administering BCG vaccination to all newborn are mainly due to
    - Majority of children are borne at home
    - Refusal case
    - Due to difficulty in covering inaccessible /remote villages,
- There is inadequate reporting of TB cases at the district office. Even at the DTC
- Office information is available only about the new registered cases.
- No co-ordination exists with other sources of health care, like private practitioners, private clinics etc.
- Actual number of patients suffering from TB in the district is not available in absence of any epidemiological study or disease surveillance system.
- There is no active involvement of peripheral worker, resulting in poor follow up of Patients.
- The activities are more or less concentrated at the district level & stronger monitoring is required at periphery.
- The program is looked by MO having additional responsibilities for other National Programs i.e. NLEP

3.4.2 Kalazar eradication program

- Inadequate staff
- Lack of awareness
- Insufficient testing kits(RK-39)
- Delayed payment of Loss of wages
- High cases of drop outs
- No follow up for PKDL

3.4.3 . NATIONAL LEPROSY ERADICATION PROGRAM

- **Inadequate staff**
- **Lack of awareness is still a problem with the Leprosy Program as most of the cases are detected accidentally.**
- There is no active involvement of the Medical officers at sector and Block levels.
- The community, generally not involved about the camps.
- Lack of integration of leprosy programs with other programs.
- Lack of PHC staff involvement. No manpower support,
- No participation for preparing plan of action.

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3.4.4. NATIONAL PROGRAM FOR CONTROL OF BLINDNESS

- Lack of adequate eye surgeon in the district.
- **Lack of awareness in the community regarding cataract blindness and its treat ability.**
- Blindness control program needs greater screening and filtering skills of the workers so that only those beneficiaries are identified who need surgery during the camps.
- Poor coordination between the health functionaries and the voluntary organizations resulting in less cataract surgeries.
- Inadequate staff.
- Poor monitoring of the program.

3.4.5. NATIONAL FAMILY WELFARE PROGRAM

- The recurring problem related to family welfare services in the district is non-availability of health workers at head quarters. Though in principle the workers should be located at HQs, due to personal and other reasons most of them do not stay there. As a result the services delivery gets affected to a large extent.
- There is excessive pressure on the worker with multiple responsibilities to perform.
- At several instances some communities are resistant to FP measures.
- Due to improper data management no proper planning could be made at the field level.

3.4.6. ISSUES IN MCH / REPRODUCTIVE HEALTH:

- **Due to long distance from CHC to point of service delivery, it is difficult to maintain the cold chain.**
- **Inadequate supply of immunization cards**
- **Inadequate number of trained dais.**
- **Lack of public awareness**
- **No cooperation from local government.**

3.4.7. ANTENATAL CARE

- The Antenatal care is restricted to TT immunization and distribution of IFA tablets
- No Anganwadi centres to support the services in some blocks
- Majority of the workers also expressed inability to carry the weighing machine during their visit to the remote villages in their beat area.
- There existed some villages that had poor service delivery. Some of these were inaccessible villages which did not have public transport facilities and some others which had a major proportion of resistant communities
- Referred cases do not go to referral points
- There was lack of diagnostic facilities at PHC level due to non-availability of lab technicians
- Lack of early referral of pregnant women

- Referral patients did not get proper attention at FRUs
- lack of adequate transportation facilities to take women in risk to health facility
- The benefits under different government schemes intended for mother and child health care viz. Maternity benefit, could not be made available to the beneficiaries due to lack of awareness.
- The early registration during pregnancy was low (before 12 weeks).
- The pregnant women not always examined for identification of moderate and severe anemia
- Low consumption of IFA tablets owing to perceived side effects
- No proper maintenance of high risk records

3.4.8. NATAL CARE

- Pregnant women have less knowledge on complications and no check up is done for their identification
- Weak referral system
- Home deliveries attended by ANM / LHV are very low
- Deliveries were not encouraged at SC level because of non-availability of basic facilities
- Lack of basic lab facility & blood storage/ transfusion facility at some CHC/PHC

3.4.9. POST NATAL CARE

- No follow up visits of health workers.
- No weight record for the new-born.
- No immunization coverage for neonates and very low status of completely immunized infants especially with regards to Vitamin A solution and measles.
- Supply of AD Syringes to all HSC not done
- ANM mentioned that carrying of vaccine carrier, sterilizer and baby weighing machine to inaccessible areas was very difficult.
- Under essential new born care only nutritional and breast feeding advice were being given to the women by ANMs.
- Gaps in immunization services, provision of Vit A, IFA ,deworming & proper method of feeding including exclusive breast feeding, weaning, time of weaning, content & quantity of feeding
- No authentic data or records
- Very poor Institutional delivery & domiciliary delivery system does not support adequate neonate care
- Lack of proper system in place for sick neonate care
- Improper growth monitoring & gaps in identification of malnourished children, provide proper facilities to care for severely malnourished & sick children & their follow-up

3.4.10. REPRODUCTIVE TRACT INFECTIONS / SEXUAL TRACT INFECTIONS

- Lack of information regarding hygienic practices, sexuality & safe sexual practices
- The awareness regarding RTI /STI among health workers was less. This lead to severe difficulty in case detection
- Women are hesitant to express their problem related to RTI or STI because of social cultural reasons.
- Majorities of the women do not perceive RTI as a health problem and do not come forward for treatment.
- Partner treatment management for RTI is very weak due to non co-operation of husbands.
- Non availability of all medicines for RTI at SC level.
- Males do not come for treatment.
- Much gap between survey and camp data.
- Attendance was thin during camps of RTI.

3.4.11. SAFE MTP AND FAMILY PLANNING SERVICES

- Pregnant women and community members do not understand the importance of Birth plan.
- Low usage of contraceptives due to inadequate information.

- Females sterilized in camps reported postoperative problems like abdominal pain, headache and irregularity in menstrual cycle etc.
- Proper follow-up & counseling not carried out
- Screening for RTI before IUD insertion was not being carried out (women suffering from RTI were also inserted IUD for sake of achieving the IUD insertion targets).
- .
- Most of the clients preferred static centre rather than camps for sterilization purpose.
- Transportation facilities for taking patient to service centre and back were not available.
- The awareness and knowledge of non-scalpel vasectomy was very low in the community.
- Workers face a lot of problems in getting the MTP services to LS failure cases.
- MTP facilities should be provided at PHC level.
- More IEC activities needed for MTP.
- Shortage of gloves for IUD

3.5. ISSUES IN IEC ACTIVITIES

- **IEC activities related to different national level programs are grossly neglected at the block level.**
- All communication activities are mainly based on family welfare
- Health education is not base on needs of the community; rather it is based on the program.
- IEC activities are not given on a regular basis on any topic, according to the disease pattern, depending on seasonal variation; health education is given on ad hoc basis.
- **It basically consists of putting up of slogans, posters and banners on walls; mouth to mouth publicity is inconsequential.**
- Adequate training aids are not available and IEC materials are not provided regularly.
- Non availability of vehicles to carry out the IEC activities.

3.6 ISSUES IN COMMUNITY PARTICIPATION

- The PRI leaders have not yet realized or are aware about their rights and responsibilities related to the improvement of health status of the community.
- Lack of interest on part of PRI for their village health problem.
- Lack of awareness about Govt programs among the people representatives
- There are few NGOs who are actively working in the rural areas.
- Mahila Swasthya Sangh is not functional in many villages.
- The PRI does not monitor the functioning of health workers as per the workers monthly travel /field plan
- The Depot holders do not report of having adequate/inadequate stock of medicines
- Poor knowledge about the government schemes

3.7. ISSUES IN TRAINING OF HEALTH FUNCTIONARIES:

- There is no proper planning of training activities at the district.
- Poorly managed monitoring and evaluation of training activities
- Training courses are more focused towards theoretical aspects rather than hands on practical and field based training.
- There is no impact assessment of any training program .This has mostly been due to lack of vehicle, manpower etc.In addition the block heads do not have interest in the assessment of training impacts.
- Faculty trainer profile is not adequate and appropriate ,no capacity building efforts have been made to strengthen the competitiveness of the existing trainers
- Poor networking with other training institutions
- Absence of certain skills on different level of health functionaries
- Lack of source to provide advanced clinical/scientific information to doctors
- Poor management of stocks & supplies & improper inventory system

3.8. ASHA PROGRAMME

The concept of "ASHA" is to select & train a health volunteer at community level- to act as link between government health provider & community. Role of ASHA is

- Providing elementary health Education
- Assuming leadership in community action for health
- Imparting First aid & OTC drugs
- Treatment of minor ailments
- Ensuring timely referrals

ASHA program at present has seen considerable grass root success,**.** At present**,** there are 2532 ASHA that have been identified & are at various levels of training. Out of these 2521 have completed training till 1st round . Blockwise detail of ASHA is as follows

District Health Society, Nalanda

Status Of ASHA Selection

Sl. No.	Name Of Block	Population of Block	No. of Panchayat	No. of ASHA for which Fund is allotted for training			
					Sanctioned	Selection	Trained*
1	Asthwa	143867		169	189	169	169
2	Noorsarai	137267		129	129	129	129
3	Harnaut	143922		131	136	131	131
4	Sarmera	78610		69	74	69	69
5	Sadar	395588		150	154	150	150
6	Rahui	127975		121	121	121	121
7	Giriyak	75735		101	107	101	101
8	Hilsa	162546		211	211	211	211
9	Rajgir	101936		286	286	286	286
10	Chandi	12599		100	100	100	100

.* First phase training till Dec 2008(Seven days).

Constraints:

- Training & keeping high Quality Facilitators is a challenge
- There are no health sector NGOs of standing in this district, having adequate experience& are responsible in dealings.
- Drug kits for trained ASHA are yet to be distributed

- Day 1 interventions by ASHA have proved useful & good results are achieved in safe delivery, early onset of breast feeding &weight at birth
- Non payment of ASHA for ASHA Days since last six months.

3.9. ISSUES BLOCK WISE

3.10.1. NATIONAL TB CONTROL PROGRAM

Problem	Effect on Work/Performance	Possible Solution	Person Responsible
Number of defaulter cases increasing.	Proper implementation of program cannot be done.	Health education.	BETO BEE
Under 14 DOT medicines are not available in proper dosages.	The tablet given to patients under 14 has to be broken down manually; hence quantity of medicine is not accurate.	Regular drugs supply in appropriate dosages.	DTO BETO
No guideline for chronic case treatment.	Proper implementation of program cannot be done.	Technical training to medical officers.	STO CMHO DTO
Distance between some village & PHC high. Hence patients cannot give the required number of sputum samples.	Patients do not come to give successive sputum samples.	These patients can go to another block MC centre and get sputum tests done	BMOs of two blocks

3.10.2. NATIONAL LEPROSY ERADICATION PROGRAM

Problem	Effect on Work/Performance	Possible Solution	Person Responsible
Traditional stigma associated with the disease.	Defaulter case increasing	Community awareness to remove stigma.	ANM MPW Supervisor BEE
Low levels of Awareness.	High level of MB cases.	Community awareness and health education.	ANM MPW Supervisor BEE ASHA
Stigmatic approach of society towards leprosy patient.	Patients hide their disease till terminal stage.	Health education and community awareness.	MPW Supervisor BEE MO

3.10.3. NATIONAL PROGRAM FOR CONTROL FOR BLINDNESS

Problem	Effect on Work/Performance	Possible Solution	Person Responsible
Absence of operation facility at all PHCs.	Target achievement is difficult.	Operation facility can be provided at PHCs level, as OT is fully functional.	Sanctioned of conduction of IOL operation has to be given

			by state.
Attendant of cataract patient are busy and are unable to assist patient.	Timely removal of cataract is not possible.	IEC of timely removal of cataract.	ANM MPW Ophthalmic Assistant

3.10.4. NATIONAL FAMILY WELFARE PROGRAM

I. ANTENATAL CARE

Problem	Effect on Work/Performance	Possible Solution	Person Responsible
Lack of awareness of necessity of ANC checkups, TT doses and consumption of IFA in adequate quantity to prevent anemia.	Increase in complicated pregnancies.	IEC + Regular checkups of ANC case by ANM at sub centre level., Training to the ASHA on ANC	ANM MPW Supervisor Sector Doctors
Most sub-centres are without buildings where Hb gm% and Urine test kit are not available.	Complete check-up is difficult.	Proper place of check-up & necessary equipments should be supplied.	CMHO BMO RCH Nodal Officer
Maximum sub-centres do not have own building.	100% achievement is not possible.	Provide necessary Equipments and proper facility of medical checkups.	CMHO BMO RCH Nodal Officer
For high risk ANC, large distances between some villages and Institutional delivery centre.	Timely intervention is not possible.	Information of high risk to the family.	ANM MPW
Problem of transportation.	Timely intervention is not possible.	Ensure transportation facility before hand with the help of panchayat.	ANM MPW ASHA Along with Sarpanch of Gram Panchayat.
Early registration of ANC not done.	IFA and TT doses cannot be provided in required doses. Possibility of maternal deaths increases.	Timely registration of all ANC in the 1st trimester.	ANM MPW ASHA Family members

NATAL CARE

Problem	Effect on Work/Performance	Possible Solution	Person Responsible
Absence of pediatric services	Patients have to either spend money on pvt practioner or travel to district hospital	Availability of regular paediatric services at PHC.	CMHO
Building, Electricity and running water not available at most of the sub centres. Hence, institutional delivery difficult.	Institutional delivery decreases risk factor.	Construction of building and appointment of necessary staff., arrangement of equipments	State CMHO EE, PWD

Provision of services of unskilled private doctors or quacks.	Safe delivery services by untrained hands increases risk factors.	Encouraging delivery by trained hands through IEC.	ANM MPW Supervisor ASHA Family members Anganbadi Worker
For EMOC proper transportation facilities are unavailable to PHC from far off villages/hamlets.	Timely intervention in emergency delivery cases at PHC not possible due to lacks of transport.	Arrangement of vehicle through local sources.	MPW (M) Sarpanch

iii. POST NATAL CARE

Problem	Effect on Work/Performance	Possible Solution	Person Responsible
Post partum care for mother & neonate necessary.	Increase risk in MMR and IMR.	Promotion of Post Natal Check-up of mother and neonate.	ANM MPW ASHA
Low community awareness about the benefits of institutional delivery.	Mother & child suffer from malnutrition. Increase risk in MMR and IMR	IEC about benefits of nutritional food, immunisation and institutional delivery.	ANM MPW Supervisor ASHA
Lower cases of colustrum feeding	Increase risk of IMR	IEC of parents/family to dangers on colostrums feeding and early breast feeding.	ANM MPW Supervisor MO
Not referring low birth weight babies to hospital.	Life Threatening condition.	Counseling of family on low birth weight and malnutrition.	ANM MPW Supervisor MO

3.10.6. RTI/STI

Problem	Effect on Work/Performance	Possible Solution	Person Responsible
Hesitation regarding disclosure of disease.	Increasing Risk of RTI and STI cases and Habitual abortion, Pre mature baby	IEC, Mahila Mandal meetings	BEE BMO Sector doctor ANM MPW Supervisor ASHA
Poverty and lack of	Increasing risk of HIV case.	Awareness	BEE

awareness		generation Counseling.	BMO Sector doctor ANM MPW Supervisor ASHA
Treatment from quacks.	This leads to increase in STI cases.	Health camps at village levels to increase community awareness.	BEE BMO Sector doctor ANM MPW Supervisor ASHA
Careless about personal sanitation & hygiene. Hesitations to talk about STI, till infection turns secondary.	Increase chances of transmission of infection to other partners.	Counselling & health education should necessarily be given to secondary school students. Detection at early stages can stop transmission to other partners.	ANM MPW LHV MO ASHA

3.10.7. SAFE MTP & FAMILY PLANNING SERVICES

Problem	Effect on Work/Performance	Possible Solution	Person Responsible
Lack of awareness of MTP services.	Increase in birth of unplanned children.	Health education, conducting Nav dampatti, Sas Bahu meetings at village level in every trimester	BEE BMO Sector doctor ANM MPW Supervisor ASHA
Absence of gynecological service at CHC/ PHC	Increasing risk of RTI, STI cases and sterility.	Provision of specialist Gynaey. Services.	State Govt. District administration .
Early ANC registration not done. Temporary methods of FP not utilized.	Increase in Birth rate. Repeated pregnancy. Results in malnutrition and anaemia. Spacing between two children not done.	Community awareness about the benefits of spacing between two children.	BEE BMO Sector doctor ANM MPW Supervisor ASHA
To opt for unsafe abortion services through quacks.	Could lead to infection and loss of life.	Information of benefits of safe MTP services available at PHC & maintenance	ANM LHV MO ASHA

		of secrecy should be followed	
Lower coverage of male VT.	This is much safer and less time consuming.	Regular information of benefits of these methods. Increasing incentives	MPW Supervisor State
Very few women opt for CupT as temporary method.	A safe & useful method of spacing between two children.	Regular information of benefits of these methods.	ANM LHV MO

3.10.8. ISSUES IN IEC ACTIVITIES

Problem	Effect on Work/Performance	Possible Solution	Person Responsible
Un approachable area, illiteracy, no vehicles for commuting PHC does not have a meeting hall.	Awareness regarding Programme is not 100%.	Literacy rate should be increase.	BETO
Publicity material and IEC budget not available in time.	Results of IEC programmes are not achieved as expected.	Publicity material and budget from state level should be provided in time.	Program Officer BEE

There are routinely provided budgets for IEC activities which are conducted regularly & include all components of public health. Most programs are planned at state level & implemented at district levels, where local specific issues do not appear in presentations. Presently, the district's ability to plan, chart out contents, make appropriate strategies & select the right media for communication is very limited. Involving local NGO participation in formulation & implementation of district IEC plan along with IEC officer at district level & BEE at block level can be a possible strategy to introduce area specific BCC activities.

3.11.1. IMMUNISATION

Problem	Effect on work / performance	Possible solutions /Suggestions	Person responsible
Immunisation time is	**Timely immunisation as due**	**To develop PR**	**Health dept.**

not matching with working hrs/habits of public. **Public are unaware about the scientific changes in immunisation procedure.**	**not done**	**between HW & public.** **HW should reside at his working area.** **Creating awareness that changes in immunisation procedure is for their betterment e.g. Giving BCG vaccine in thigh instead of hip prevent the cases of paralysis.**	**PRI** **AWW** **ASHA** **ANM**

3.11.2. MMR

Problem	Effect on work /performance	Possible solutions /Suggestions	Person responsible
Late Registration **Malnutrition** **Not utilising benefits given** **Delivery is not considered a risk, unless it turns risky**	**If desirous of MTP services ,cannot be given** **Deficit in Blood & other complications due to it e.g. Anaemia** **Referral arrangements are not planned beforehand** **Family doesn't have capacity/knowledge to arrange funds.**	**Creating awareness regarding early registration** **Informing benefits offered under different schemes** **Educating that if maternal health is taken care of, all members will be healthy.** **Head of the family/Mukhiya should be informed about High Risk so that they can plan beforehand**	**ASHA** **ANM** **MPW** **Sarpanch**

3.11.3. CBR

Problem	Effect on work /performance	Possible solutions /Suggestions	Person responsible
Public is unaware about different contraceptive techniques **Lack in supply/service of contraceptives**	**Low demand generation** **Unmet needs not met**	**Educating the public about the latest methods of contraceptives** **Proper & easy**	**ASHA** **MPWM** **MPWF** **ANM**

		availability of contraceptive	**Depot Holder**

3.11.4. DEATH RATE

Problem	**Effect on work /performance**	**Possible solutions /Suggestions**	Person responsible
Road accidents **Suicide**	**Death rate increases**	**Licence should be issued strictly** **Roads should be wide** **Psychiatric services should be available when needed** **Proper warning should be given when selling the pesticides**	**District Administration** **NGO**

3.11.5. MALNUTRITION

Problem	**Effect on work /performance**	**Possible solutions /Suggestions**	Person responsible
Take home ration package is used/consumed by all family members & not only by mother &child **Public is unaware about the long-term drawback of Malnutrition** **Public is unaware of weight/age/height chart**	**Malnutrition** **Anaemia increases** **Leads to various other complications**	**Creating awareness about the long term benefits of who is the actual needy** **Educating that there is no special food for Malnutrition but general household items (groundnuts, jaggery etc) are adequately nutritious if taken in proper quantity.**	**MPW (M)** **MPW (F)** **ASHA**

3.11.6. OPD ATTENDANCE

Problem	**Effect on work /performance**	**Possible solutions /Suggestions**	Person responsible
Very low OPD attendance **Impression of Govt. Hospitals not so good**	**Services/Bed are under-utilised**	**Staff should be polite & helpful to gain goodwill & confidence of public** **Creating awareness about the Quality**	**Doctors** **Paramedical staff** **HW**

		of equipts,drugs& Doctors are better in Govt. Hospitals	

3.11.7. INFRASTRUCTURE

Problem	**Effect on work /performance**	**Possible solutions /Suggestions**	Person responsible
Safe drinking water: **All the daily activity (taking bath, washing cloths etc) are done at the source of drinking water (tube well, well, common tap)** **No proper outlets for waste water**	**Spread of communicable diseases.** **Spread of Epidemic cannot be ruled out**	**Bigger platform area should be constructed** **Outlet for waste water should be up to 100-200 feet from the source**	**Village panchyat** **Nagar Nigam**
Sanitation: **Public is unaware about the sanitation habits** **No proper place/ building for sanitation**		**General awareness should be created among the public about the sanitation habits.** **Construction of at least one public lavatory per village**	**Construction of …… new sanitary latrines is targeted by Nagar Nigam this year**

ISSUES AT COORDINATING WITH SUB CENTRE LEV

3.12 More help from Anganbadi worker & ASHA is needed for ANM to function smoothly. Also the ANM should regularly inform & educate AW & ASHA about all programmes, epidemics, identification and treatment of minor diseases

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3.13. ISSUES AT COORDINATING WITH DISTRICT LEVEL ADMINISTRATION.

Communication gap i.e. means of communication from Sub centre – Sector to Block and District is not easily possible. Some Sub-centres are situated at large distances from block headquarter; hence commuting from these hamlets is difficult during rainy season. Timely supply of material is not received at blocks. It is suggested that supervising officer at district level can attend staff monthly meeting at least 6 times a year to provide guidance about improvising quality of services & achievement of targets.

3.14. ADMINISTRATIVE AND MANAGERIAL ISSUES:

- Lack of interpersonal communications between MOs and BEEs, BEEs and Supervisors, Supervisors and workers,
- Poor coordination between health and other departments

- Lack of adequate supervision of manpower
- Inadequate supply of required stationary.
- Excessive written work load.
- Inadequate training of workers on MIS
- Inadequate and improper redressal of workers requirements and problems.
- No availability of MOs during working hours.
- Inadequate monitoring to review the quality and coverage of services.
- Non availability of worker at the sub centre.
- Poor supervision by the supervisors. Supervision is in fact non existent or not functional at most of the places
- No building at sub centres
- Demand for money at the health institutions for the services.
- No interaction between PRI, ICDS, and health workers for preparation of Plan.
- Health workers do not spend much time in villages as per their schedule.

Chapter 4
Setting Objectives and Suggested Plan of Action

4.1 Introduction

District health action plan has been entrusted as a principle 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 stakeholders 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 five years (2007-12).

4.3.1 Reproductive and Child Health Programme components

4.3.1.1 Maternal Health Care

In the district young girls Enter the reproductive phase of their life as victims of under nourishment and anemia. Their health risks increase with early marriages, frequent pregnancies and unsafe abortions choices regarding marriage, child bearing and contraception are denied to women. There is also lack of access to functional reproductive health services and most deliveries are still carried out by untrained birth attendants especially in the rural areas where there is no effective system of referral or management in case complications arise through there has been widespread increase of infrastructure service in the district during the past years, access to these facilities is still varied.

The immediate causes of maternal mortality are well known. They are sepsis, hemorrhage, obstruction, anemia, toxemia and unsafe abortions. The larger social determinants of these are also equally well known – they include educational status of women, poverty levels, social inequities and access to quality care. It is evident that all the health / health service indicators of Nalanda district are not better as compared to that of Bihar CDR, MMR IMR but in Immunization, Institutional Delivery and Safe delivery is not better than Bihar State. However efforts in terms of quality and service need to be taken for the betterment of the present indicators.

Constraints:

- Health workers are not able to do 100% pregnancy registration due to different reasons such as unreachable areas, personal reasons, illiteracy etc
- No proper follow-up by workers of ANC cases and monitoring by supervisors, sector doctors etc
- No proper referral service
- Lack of awareness among rural masses/ low IEC activities
- Improper access quality antenatal, natal and post natal services may be due to
- Lack of nurse (refers to female MPW or ANM) for providing quality ante-natal care at an appropriate time in vicinity of her home.
- Lack of skilled birth attendant in vicinity of home (trained midwife, nurse or doctor).
- Lack of facility providing institutional delivery on a 24 hour basis:

- The Sub-Centre is not usually a site for institutional delivery 75% percentage of sub centres the lack of buildings rules it out as an option. But even in the 25% that has a building the ANM is available at the headquarters only twice or thrice a month during working hours.

- Out of 25 existing APHC only 18 have their own building, these could be converted a site of delivery after some repair work
- Equipment gaps also contribute to poor service.
- The post-partum mother and the neonate require a visit by a trained volunteer in the first day after birth and at least once more in the first week of the neonate's life.

- Sometimes the nurse is there and resources are not a problem but there is a poor motivation to provide services or a reluctance to accept services even when the knowledge and attitudes are alright. These gaps are cultural gaps and represent a certain passive discrimination – of caste or creed, or of gender.

Introduction: Women's health, as we know, is determined largely by the basic and severe socio economic inequalities beset most women in our country. However the strategic thrust for improving women's health has been focused on the provisions of services related to reproductive health. Maternal mortality in India is high and has remained high over the decades.

Present Status: Out of 30403 deliveries in the year 2008-09(till January) no of maternal deaths have been reported in the district Nalanda is 112. However the MMR of the district is 371 and the state is also 371.

Causes: Medical causes of maternal mortality are as followings:

1. Bleeding- The most common cause of maternal mortality is bleeding before, during or after child birth which may amount for almost 25% of all deaths.
2. Sepsis- This is infection during the process of child birth which accounts for some 15% of deaths.
3. Hypertensive disorders of pregnancy accounts for 12%of maternal deaths.
4. Prolonged and obstructed labour accounts for about 8% of deaths and is due to unsafe abortion.
5. Anemia- About 20% of deaths is due to exacerbation of medical ailments occurring during pregnancy when the body's resistance is diminished. Other causes are heart diseases, hepatitis and others.

The other social determinants of maternal mortality are poverty, marginalization, early age marriages, early first pregnancy, Decreased spacing intervals, large family size, poor educational levels, poor access to transport at time of need, poor access to health facilities and health services etc.

Goal: Improved women's health and nutritional status.

Objectives:

1. Decreased maternal deaths
2. Increase in Institutional delivery
3. Increase in skill birth attendance at birth
4. Decrease in anemia in women
5. Decrease in malnourished women

Outcome Indicators:

- Decrease in MMR
- Increase in percentage of institutional/skilled assistance childbirths.
- Decrease in percentage of women with Hemoglobin less than 11mg/100ml
- Decrease in percentage of women with BMI less than 18

Strategies:

1. Community support to a pregnant woman
2. Access to quality Ante-Natal care
3. Access to skilled birth attendant
4. Working 24 hour institutional delivery facility
5. An emergency Obstetric care unit for 1 lakh population
6. Referral transport system
7. Affirmative action to reach vulnerable families
8. Women's organization and Women's right

Process Indicators :

- Percentage of Pregnant Women attended by ASHA, VHC members
- Percentage of PW getting three ANC Check ups, TT1, TT2/Booster,
- Percentage of anemic PW underwent treatment, supplemented with 100 IFA tabs
- Percentage of Home deliveries attended by SBAs
- Percentage of Institutional deliveries
- No. of critical delivery cases referred to FRU
- Percentage decrease in Maternal Mortality, Still birth and infant mortality

- Percentage of Pregnant mothers getting registered under JBSY and getting financial support for PNC
- Percentage of villages having Mother Committees functioning

Sl No	Activities	Activity Detail	Unit Cost	Total Budget
1	SBA Training for 4 days (ANM,A-Gr Nurse/Nurse) Total no of ANM and A Grade Nurse is 716. Entire Trainning process is divided in to session wise. One Session =4 days One Batch=30 Trainee One Batch=2 Trainer Total no. of Session=24	**1. Arrange Training of Still Birth Attendant training for all ANM and A grade nurse.** **2. Training detail-one session =4 days**	**1.Fee of Trainer =700/day*2=1400** **TA/DA for 2.Trainee =100/day*30 Trainee=3000** **3.Cost of hiring the Hall 500/day** **4.Cost of stationary 50/trainee** **5. Fooding Rs 50 for 35 persons=1750** **6.TA/DA for support staff 100*2=200** **TOTAL COST FOR ONE DAY TRAINNING=8350** **TOTAL COST FOR ONE SESSION 8350*4=33400**	**24 Session *33400=801600**
2	Recruitment of Contractual ANMs	**1.Arrange recruitment process with help of internet -complete within one week.** **2.Made merit list and call the next candidate immediately after resignation of any candidate.**	**1.Cost of hiring one ANM Rs 72000/anum Requirement of ANM-421**	**1. 79*72000=5688000 (For HSC requirement)**
3	Hiring of Ambulance through PPP	**1. Hiring of Ambulance for 8 new PHCs & 25 APHC** **2 .Through tender process**	**1.Assuming that one ambulance would cover at least 150 km/day** **2.Cost of one Km charge=4.50/km** **3.Cost of one day movement of Ambulance=150*4.5=Rs 675** **4.Cost of One month=675*30=rs 20250** **5.Cost of one year=243000**	**Total Cost=243000*33=2916000**
4	Training to the Doctors on EmoC			

5	Purchase of Instruments to ensure Safe delivery and ANC	**Purchase of labor table for every new PHC(8 in no) & APHC (25 in no)**	**Rate identified by the SHS**	
6	Formation and strengthening of Mother committees			
7	Formation and strengthening of VECs			
8	Training to ASHA on ANC, Natal Care and Post Natal Care	**1. Training session should organize for every PHC for ASHAs-3 days**	**Total No of ASHA=2017 No of trainee for one batch=35 No of day for training for one ASHA=3 Total No of batch=58 No of days for training=174 1.Trainers fee-Rs 500/day No of trainer required for one day=2 2.Cost of breakfast Rs 15/person Cost of breakfast for one day=40*15=600 3.stationary & Misllaneous cost =Rs 20/participant (One time in Training session) 4.Total cost for training for one day=Rs 2300**	**Total Cost=(Total No of training days=174) 174*2300=Rs 400200.00**
9	Arrangement of 24 hrs water facilities, attached toilets with Delivery rooms,	**Appropriate rate would be decided by DHS Nalanda**		
10	Financial support to pregnant mother through JBSY	**1.Increase Institutional Delivery from 34% to 50% 34% Delivery=30403(Approx) 50% Delivery=44710**	**1.Unit Cost=Rs 2000/case**	**Total Cost=44710*2000=Rs 89420000.00**
11	Streamlining procurement and distribution mechanism for			

	supplies at CHCs and PHCs.			
12	Purchase of essential drugs required for ANCs, Delivery and PNCs.			
13	Wall writing/painting on JBSY, exclusive Breast Feeding, Colustrum feeding and other related issues			
14	RCH Camps and Honoring PW who have taken two doses of TT, 100 tabs IFA and three check ups			
15	Accreditation to the Private nursing homes for Institutional deliveries and Family Planning Operations			

4.3.1.2 Family Planning

In all the blocks of district Nalanda the achievement with respect to target in case of Family Welfare is quite satisfactory.

Table 4.1: Knowledge of Family Planning

Indicator	Percentage
Knowledge of any modern method	
Any modern spacing method	
All modern methods	
Knowledge of any traditional method	

(Source: RCH-DLHS survey 2003)

Table 4.2: Current users of Family Planning

Any Method (CPR)	30.9
Any Modern Method	27.2
Female sterilization	21.2
Male Sterilization	0.5
IUD/Loop	1.5
Pills	1.4
Condom	2.6
Any Traditional method	14.7

(Source: RCH-DLHS survey 2003 & Internal MIS data)

Table 4.3: Unmet Need

Percentage of women having unmet need for	40.7
Limiting	25.9
Spacing	14.8
Total	40.7

(Source: RCH-DLHS survey 2003)

4.3.1.3 RTI / STI and HIV / AIDS Control

In Vaishali district till date there are no cases of HIV/AIDs have been detected. In the district hospital Vaishali there is blood testing facility available. Simultaneously VCTC and STD clinic is also provided in the district hospital. Efforts are needed for health check-ups and partner treatment camps.

Table 4.4: Awareness of RTI/STI and HIV/AIDS

(i) Percentage of eligible women aware of RTI/STI	40.8
(ii) Percentage of eligible women aware of HIV/AIDS	54.3
(iii) Women who had any symptoms of RTI / STI	
(iv) Women who utilized government health facility for treatment of RTI/ STI	

(Source: RCH-DLHS survey 2003)

Table 4.5: RTI / STI cases - detected and treated in the year 2008-09

RTI/STI Cases	Year 2008-09(December)
Cases Attended	
Cases Treated	

Various NGOs are proving condoms as well as they hold various clinics for truckers, travellers etc for prevention and counselling for RTI/STIs as well as HIV cases. The major constraints are:

- People do not come out in the open about their infections with a fear of being ostracized by the community.
- Lack of knowledge about RTI/STI
- Lack of practice of condoms by males
- In-migrating population

Following are the suggestions to counter these issues:

- We need to educate the people regarding RTI/STI a well as HIV/AIDs.
- People need to be made aware of the presence of VCTC/STD clinics.
- Major focus should be on High risk groups and areas by regularly organizing exhibitions, camps, melas etc.
- Regular quiz competitions, debates, skits/dramas etc. regarding knowledge of RTI/STI as well as HIV/AIDs among truckers, college students, in-migrant laborers.
- NGOs should be made responsible for all these activities and supporting and coordinating the field health functionaries

4.3.1.4 Adolescent Health

There are almost no programmes in the area of Adolescent health. The following are the constraints:

- There is a very high degree of under-nutrition and anemia at this age.

- Also growth stunting occurs at this stage if the girl is malnourished.
- Physical and mental development potential and stress due to poor health is also more.
- Adolescence is a period of higher exposure to violence, to sexually transmitted diseases and to pregnancy associated morbidity and mortality.

Suggestions:

- These need not only counseling at the individual level.
- But also social mechanisms of support and women's empowerment to address.

The following matrix highlights the indicators that are taken into consideration to achieve the objectives of reproductive and child health. For each indicator current status has been assessed and targets have been set that are to be achieved in the period of next five year plan period. In order to attain the set goals certain strategies are laid out against each indicator.

Table 4.4: Performance Indicators for Reproductive child health

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
1.	Universal coverage of all pregnant women with package of quality ANC services as per national guidelines		75%	▪ Strengthening information base of pregnant women ▪ Improvement in monitoring and supportive supervision of ANM tour programme ▪ Provision of equipment to subcentres, PHCs, CHCs ▪ Streamlining logistics ▪ Specific interventions for inaccessible areas ▪ Effective coordination with ICDS workers/NGOs and faith based institutions ▪ Involving ISMPs ▪ Area specific IEC and Behavioral change communication strategy.
2.	Increase in deliveries with skilled			▪ Training of ANMs

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
	attendance at birth including institutional deliveries		90%	▪ Training of dais/ SBAs ▪ Training of community based midwives (long duration training) ▪ Transport facilities to pregnant women ▪ Improving delivery facilities at subcentres and PHCs ▪ 24 hour delivery services at PHCs, Referal hospitals ▪ Involving public sector/ private and nursing homes in deliveries ▪ Awareness generation about JBSY scheme among women/ community ▪ IEC / Behavioral change communication to improve awareness about pregnancy complications and need for utilizing institutional services for deliveries ▪ Involvement of ANMs, dais, AWWs, women self help groups, VHC and elected representatives of community /faith based institutions in identification of pregnant women at high risk.
3.	FRUs (including DHs, CHCs/PHCs) made functional as defined in the National RCH-2 PIP	Nil		▪ Identification of health institutions and equipping them to provide basic and/ or comprehensive emergency obstetric health care. ▪ Appointing required health professionals such as gynecologists, anesthetists and staff nurses to provide EMOC services ▪ Ensuring adequate and safe blood supplies by strengthening existing blood banks or opening new blood banks in the district. ▪ Establishing linkages with private nursing homes having adequate facilities to provide emergency obstetric care services
4.	Universal coverage of all eligible pregnant women under JBSY scheme		All eligible women i.e.50-55% of all expected delivery	
5.	Increase in percentage of new born babies given colostrums			▪ Introduction of a package of home based new born care ▪ Strengthen referral network ▪ Strengthen new born care infrastructure and facilities in all PHCs and Referals, District hospitals. ▪ Upgrade education infrastructure for neonatal services training
6.	Increase in prevalence of exclusive breast-			▪ Educating mothers on benefits of

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
	feeding			immediate breast feeding ▪ Educating mothers on need to exclusive breast feeding ▪ Educating mothers on type of supplements and also the need to start supplements from sixth month onwards ▪ Reorientation training to service providers
7.	Percentage of severely malnourished children below 6 years referred to medical institutions			▪ Training to AWWs/ ASHA for identification of malnourished children
8.	Unmet demand for contraception (Total) - Spacing - Limiting			▪ Increasing the base of service providers for both male and female sterilization services ▪ Increasing the number of service delivery points to provide quality male and female sterilization services ▪ Organizing camps in systematic and effective manner ▪ Building linkages and involving NGOs to promote both male and female sterilization methods and modern spacing methods ▪ Social marketing projects to promote access to and demand for spacing methods ▪ Communication campaign to improve demand for terminal and modern spacing methods ▪ Conducting Workshops to service providers on linkages between spacing of children and infant mortality rate ▪ Every tolas would have at least one volunteers who would have a limited stock of the supplies available- either collected from the village distribution point or from the health department.
5.	A. Number of government health institutions providing i) Female sterilization services ii) Male sterilization services iii) IUD insertion services			▪ Ensure posting of trained LMOs, surgeon and staff at PHCs/Referals ▪ Skill upgradation of ANMs for IUD insertion services ▪ Collaboration with private practitioners/ institutions on contractual basis
10.	Number of health institutions in PHCs offering ARSH services	-		▪ Orientation training of staff for enhancing ARSH services ▪ Sensitize adolescent and reproductive groups through local health workers ▪ Involvement of NGOs

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
11.	Number of health institutions providing services for management of STIs and RTIs	_	To equip & trained to all CHC & all PHCs.	▪ Select health institutions in the district and equip them with lab facilities and lab technicians ▪ Train medical officers in RTI/STI management ▪ Supply medicines in adequate quantity for RTI/STI services ▪ Provide RTI/STI services during RCH camps ▪ Conduct special camps for health check ups and RTI/STI services ▪ Promote partner treatment ▪ Establish linkages with private practitioners providing RTI/STI services

***Source: RCH II**

4.5 Child Health and Immunization

. Poor outcomes in the child health due to the following reasons:

- Workers not following the 8/8 quality ante-natal care norms
- Poor nutritional habits
- Early marriages
- Illiteracy among rural masses
- Poverty
- Less no. of institutional deliveries

Table 4.7: Child health indicators

A. Percentage of women who started breastfeeding immediately/within 2 hours of the birth to their children	
B. Percentage of women who gave exclusive breast milk for at least 4 months to their children	
(i) BCG	88.0
(ii) DPT (Three injections)	65.1
(iii) Polio (Three doses)	62.8
(iv) Measles	69.1
(v) Complete immunizations (BCG + 3 DPT + 3 Polio + measles)	54.2

(Source: RCH-DLHS survey 2003 & Internal MIS data)

The block wise immunization performance within the district seems to be satisfactory. But when this data is compared with the external data like that of SRS there seems to be large variance. Possible reason for this can be that the internal data is taken out of vaccine utilization whereas the external data represents the actual service delivery.

Constraints for poor quality of immunization:

- Unavailability of vaccines on time
- Inadequate supply of vaccine
- Lack of equipment of cold chain like Icepack, Vaccine Carrer,Cold Box
- Lack of staff

- Non payment of Couriers
- Far-away sub-centre's and improper transportation
- Illiteracy
- Absence of software for monitoring purpose
- Absence of vehicle for monitoring purpose

Suggestions for improving the quality of immunization:

- Vacant staff positions should be filled-in
- At least two months stock of all the vaccines at CHC level
- Timely payment of Couriers
- Proper transportation facilities
- Maximum IEC coverage so that people should know about the date and venue of immunization
- Vehicle should be made available for monitoring purpose
- A special software should be made for monitoring & evaluation for immunization drive

Table 4.5: Performance Indicators for Child Immunization

Sl.	District Plan Objectives	Current levels*	Target for 2008-9	Suggested Strategies
1.	Increase in percentage of fully protected children in 12-23 months as per national immunization schedule			▪ To Increase number of sub centers and health workers ▪ Increase Outreach sessions ▪ Ensure adequate posting of ANMs ▪ Increase IEC at grass root level with the help of NGOs.
2.	Universal coverage with Vitamin A prophylaxis in 5-36 months children	25582	367435	

***Source: RCH II, 2002-04**

4.6 Health Infrastructural Indicators

The performance with respect to certain key activities under NRHM shows that infrastructure related issues needs to be sorted out to ensure a successful implementation of plan. Next section details out probable strategies and activities:

Suggested Strategies and Activities:

Two female MPWs in each sub centre: Sub centers may plan for two MPWs, preferably both women. The job description and workload of the MPW (F) needs to be lessened and made realistic. Along with this, workload rationalization would be achieved by equal sharing of the work between the two persons posted at the sub centre. In the first stage this achieved by redefining of the male MPWs work to be identical with the female MPWs. Except or institutionalization delivery and IUCD insertion, every task currently done by women can be done by men also. And in the second stage by ensuring that the second person in the HSC is also a female MPW i.e. converting the male MPW post to a female MPW post.

Multi skilling all PHC paramedical: The PHC staffing pattern needs restricting to ensure utilization of manpower and better functioning of the facility. PHCs may plan for having two or three male multi-skilled

employees with a male multi-skilled supervisor and three female multi-skilled workers (including the section incorporated in the sector) and a female multi-skilled supervisor. There would also be one medical officer in every PHC (preferably two). These multi-skilled workers must be skilled in dressing, drug dispensation (the compounder's) and first contact curative care and in basic laboratory package as well as in RCH. Between them they should be able to keep the PHC functional for 24 hours, provide institutional delivery and the other services as proposed in the service delivery norms. Though the immediate step is only multi-skilling and revising job descriptions, cadre restricting may follow this. In this process of transition no one has to be dropped unless they are unwilling for multi-skilling. New recruitments would be into the multi-skilled category and many existing cadre would die away. Some like staff nurses would function as multi-skilled staffs when posted in a PHC and can play the role of staff nurse when posted in CHC and district hospitals. We estimate that such retraining and redeployment would solve a substantial part of the manpower vacancy problem. Each PHC may also have two staff at class IV qualifications.

Rationalization of Deployment Medical Doctors in the APHC Level

Differentiated Strategy According to Difficulty Levels: The ideal would have been two regular medical officers at every PHC.

24 hour Multi-Skilled Paramedical Based Service in al PHCs: We recommend that in all PHCs irrespective of category, 24 hour service with emphasis on institutional delivery be insisted on by multi-skilling and deploying paramedical. The multi-skilled paramedical worker should also be trained in emergency care management at primary level.

Strengthening of PHCs

Appointment of Six Medical Officers at Least, four of whom at least are specialist or within them have the required four – skill (physician, pediatrician, surgeon, gynecologist) mix. If there are a number of APHCs not having doctors to be looked after with visits, the number posted here may increase further.
Adequate Multi – Skilled Male and Female Paramedical Staff, who can manage the necessary support work and multi skilled imaging technicians who can also mange X – rays, ultrasound and ECG too. In addition there would be a unskilled worker category of undifferentiated, interchangeable class IV functional – chowkidar, peon, sweeper, waterman – all rolled into one. Four qualified staff nurses, two qualified laboratory technicians and an optometrist are also a must at this level. Introduce the Out Source services specially in the field of X-Ray,Ultrasound,Blood Unit at the PHC level.

Re-designating the BEE, The block level extension educator may be renamed the block senior paramedical supervisor and be responsible for capability building, IEC and supervision of the sector supervisors**. Health-Educator** could be used for the above mentioned purpose also.

Role of Health Manager-Better health care facility and delivery system depends upon planning execution monitoring & evaluation of work. There should be made an arrangement where every Health Manager is required to develop an annual plan for their PHC.Once the plan come in to existence then RKS would discuss on it and give their suggestion. Health Manager Role should not confine only as an spectator but he should given certain power to control execution of NRHM activities in their jurisdiction. Present system does not give desired results. Administrative setup of deptt of health doesn't give them authority to control the affairs of NRHM activities. A separate body should be formed at the district level for the redressal of grievances (ROG) for Managers & Accountants. if they feel or observe any problem and he thinks that solution could be obtained only from the higher authorities he should register his case in to that ROG.

Adequate Clerical and Accounting Staff, at least two, be provided to every PHC along with two computer and printers One computer should be provided separately for the accountant and manager where they could

process the report and keep it, about every work related with NRHM work execution .There should be made compulsory provision to do every financial transaction with help of computers like banking operation for the smooth and crystal clear record keeping, It will also abolish the financial mismanagement. Every District Data Manager should given task to write a specific programme(computer language) for every work either financial or record keeping for better HMIS.Once it would introduce in HMIS then a rule should be framed by the DHS authorities to monitor progress of every programme on daily bassis,because current system does not give the desired results. Right now only one computer is available in every PHC which is used only for patients registration, attendance system, and reporting to the DHS & SHS,Office.If we introduce another computer in PHC we could keep every record without any mismanagement and execute the official work smoothly.

RATIONALISATION OF WORK ALLOCATION AND APPROACHES TO IMPROVE OUTREACH

Every PHC is having a certain no of different category of staff which include doctors, paramedical & Support staff. Try to formulate a strategy at the PHC level where authorities could assign the work to those staff which are not supposed to perform these work according to their service condition. For this purpose authorities could make a special plan according to the need and assign the job to a person according to his/her category of their designation and made provision that the person would be accountable if he gets the assignment but assignment must suit their categorical status defend by the Govt of Bihar and SHS Bihar.Find out the outreach area of every PHC and made special plans to monitor these area regularly

Reorganisation of MPW Work Schedule

MPWs may be required to tour for three days a week, instead of the present one or two days a week. One day a week should be devoted to review and drawing supplies from PHCs. The remaining two days a week should be devoted to clinical work and other services provided at the sub centre. These two days are fixed and her clientele should know that she is available there in headquarters on these two days.

Integration with ASHA Programme

It is extremely important to develop a mechanism to sustain interactions between MPWs and ASHA. Such a mechanism is also required for the long – term success of the ASHA programme. The ASHA programme offers the scope to rationalize and the MPWs job responsibilities more achievable. The ASHA's focus is on health education, family level counseling and prompt and adequate management of diarrhoea and acute respiratory infections. The ASHA also maintains a register for her village which tracks each family to identify any specific health service gap and motivates the family to receive this service as the coordinates with the MPW to ensure that the service is delivered. The MPWs focus is on actual service delivery on RCH and in all national programmes – like immunization, provision of contraception, care in pregnancy and assistance at delivery and soon and on support to ASHA, anganwadis and panchayats.

Revised MPW Job Description

A MPWs job description for both male and female worker can be reorganized as:

- Immunization – Children and pregnant women largely at the village visit and camps but supplemented by immunization at the sub centre.
- Ante natal care and post partum care at sub centre, with visits to those pregnant women unable/ unwilling to come.
- Motivation and facilitation for all methods of contraception.
- Training and support to ASHA and local women's health committees.
- Regular house visits, such that every household is visited once every month (or two months in difficult areas) for a set of "case detection, follow up and counseling activities" along with first contact curative care where required. (this includes all national programme related activities)
- Focal group discussion / health education sessions/health camps during village visits.

- Curative care during field visits on three days at sub centres on two days.
- Response to epidemic using a graded epidemic response protocol.

In addition to the above male workers would have the following tasks:

- Addressing male youth on adolescent problems and STDs control.
- Interaction with panchayats and with local leaders for facilitation of health programmes.

In addition to the above female MPWs shall have the following tasks:

- Assistance at child birth
- IUCD insertion
- Addressing adolescent girls on health problems

Having the right number of manpower at the required positions / places is one of the most important factors for the success any health programme. Also in the rural health centres, especially in the primary health centres, there are two major problems concerning the doctors and the supporting medical staff posted there. Firstly, the number of doctors and supporting medical staff is less than what the norms suggest, problem that is further compounded is by delays in filling up vacancies in health centres, cases of high absenteeism are also seen sometimes.

Outreach Strategies to Enhance Access

Lack of roads and transport facilities and natural obstacles and high degree of scatter of hamlets within a section or sector add to the problems of access. These problems are not remediable by increasing facilities beyond the norms. Instead they need a high degree of community support and a high degree of planning and rationalization of the work of the various categories of staff already available. Camps are the major outreach strategies aimed to close outreach gaps but their effectiveness and even their occurrence in most areas is far from certain.

A variety of other camps for different vertical programmes take effort and expense to organize but with uncertain benefits. The ASHA programme has attempted to build on this dimension and provide a well – supported cadre of trained volunteers in every hamlet. The integration of this force with the sub centre's function offers the best scope of advance in improving outreach.

Staff Situation and their Utilization with Relation to Functionality of Centers

Female paramedical staff is near adequate in numbers. There are serious shortfalls in all other staff. A converse dimension of this situation is that of all the paramedical staff. Only the female multipurpose worker and to a lesser extent the sector supervisor female shares the greater part of the workload. All other categories of staff at HSC and PHC level are characterized by poorly designed work schedule and are poorly utilized with a high degree of redundant work time. Rationalization of paramedical work time offers therefore the most effective route to addressing staff adequacy.

The current work description of the MPW female is unrealistic and is being coped with by developing a focus on just one or two tasks and informal local arrangements. As a result a number of essential services are completely left out (e.g. early recognition of child-hood pneumonia or proper treatment of diarrhea or adolescent health care etc) and the quality of a number of other services, like antenatal care are seriously compromised. (Almost no pregnant women has her BP taken and blood and urine examined)

Rationalization of Drugs and Consumables Supply

The essential drug list is being implemented to an extent. The main deficits are a failure to procure the entire items of the list, a failure to send samples for quality control, and a failure to exclude drugs not on the list. Other elements of the drug policy are also not in place. Thus procurement is sporadic, occurring once or twice a year with quotas to peripheral facilities to distribute the drugs. There are numerous breaks in supply and the distribution system is unresponsive to changing needs. Restriction of drugs to a narrow spectrum and breaks in supply are not even perceived as serious within the system reflecting poor perception of quality of care issues. The problem with consumables is even more serious that with drugs. Laboratory chemicals seem the worst affected but even gauze and bandages, needles and needle holders could be in short supply repeatedly.

Rationalization of Equipment

In equipment we have two types. We have relatively low investment "minor equipment" like Sahil's Haemoglobinometer or BP apparatus and infant weighing machines, which, if used, will need replacement frequently.

And we have more costly "major equipment" like ECG ultrasound and X-rays, which require replacement less, (up to once in five to ten years), but which require trained manpower to operate and often-considerable consumables as well.

In minor equipment we find considerable under utilization, and simultaneously reports of non-availability. Due to quality of care issues many of this equipment are not utilized. But equally there is a problem that if they are used many of these last only one to three years and then would need replacement, for which no ready system of purchases and restocking is available.

In major equipment the main problem is mismatches, between equipment supply and manpower to use (e.g. ECG machines without anyone who can operate it), between equipment supply and level of services currently provided at that level(e.g. six neonatal care units supplied to a facility where there is no caesarean sections or even as many normal delivery neonates per month, color Doppler equipments supplied where there is no cardiology or cardiothoracic capability etc.), between equipment supply and consumables available to use it (e.g. X-ray machines running out of film) and between equipment purchase and maintenance. At one level all such mismatches are attributable to failures of concerned officers. But at another level it points to governance/ administrative failure, with one committee maximizing purchases, and another set of persons looking at distribution, and no one looking at training and maintenance or eventual utilization of equipment.

Infrastructure Adequacy

The shortfalls in basic availability of buildings are well known. It is in the range of 75% for HSCs ,72.% of APHC,60% PHCs. Referrals are all in government owned buildings but as yet only an estimated 100% are upgraded to the 30-bed Referral norm. Toilet construction and maintenance too are major infrastructure inadequate. Maintenance of buildings is also poor and most buildings are old and need extensive renovation or replacement.
Problems with electricity supply are minimal and generator back up is usually available where there are problems. Problems with water supply are however considerable. Most of these facilities have a bore-well and hand-pump so that they are functional. However any hospital with inpatient facilities, even if it were for only conducting normal delivery would require running tap water, bathing facilities and toilets separately for staff and for patients. Waste management based on segregation of wastes with proper disposal of each category of biological waste is a relatively untouched area of intervention.

Table 4.6: Performance indicators of Health Infrastructure

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
1.	Number of ASHA functional in			▪ Trainings for ASHA

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
	the district (received induction training)			o Finish training of ASHA o Monitoring of working capacity of ASHA
2.	Number of RKS registered/ established	18	02	▪ Establishment of RKS o Selection of members ▪ Functioning of RKS o Guidelines for expenditure of maintenance grant o Orientation and training of elected RKS members o Decentralizing the procedure by appointing other representatives
3.	Number of health care delivery institutions upgraded - SHCs - PHCs - Referrals to FRUs	 Nil Nil Nil		▪ Up gradation of health institutions in conformity with IPHS o Sub centers in government building o Availability of facilities like water supply, electricity, labour table o Identification and ensuring involvement of trained Dai o Posting of LMOs at PHCs and Referals o Training of LMOs regarding EmOC o Posting of gynecologists, anesthetist, and pediatrician at FRUs o Blood storage center at PHCs o Adequate equipments and supply of other material
4.	VHSC constituted - Grants given	Nil		▪ Constitution of VHSC o Guidelines for VHSC o Orientation of VHSC members o Organization of training for sensitizing members on working mechanism o Roles and responsibilities fixed for each member of the committee o Coordination between health and sanitation initiatives
5.	Number of SCs strengthened - Additional ANMs hired - Annual maintenance grants given			▪ Strengthening infrastructure of health centers o Carry out civil work for SCs with respect to building, running water supply and electricity o Involvement of gram *Panchayat* for taking land for construction of SC/ PHC o Ensure equipment and drug supply ▪ Refresher training course for ANM ▪ Posting of LMO and staff nurse at PHCs ▪ Directions for use of maintenance grant(UNTIED FUND) o Regular monitoring and reporting system for used grant
6.	Number of PHCs strengthened to provide 24x7 - 3 staff nurses hired - Annual maintenance grants given			▪ Strengthening infrastructure of health centers o Carry out civil work for PHCs with respect to building, running water supply and electricity o Involvement of gram *Panchayat* for taking land for construction of

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
				PHC o Ensure equipment and drug supply ▪ Refresher training course for ANM ▪ Posting of LMO and staff nurse at PHCs ▪ Directions for use of maintenance grant(UNTIED FUND) o Regular monitoring and reporting system for used grant
7.	Staff for mobile medical units in place	Nil		▪ Strengthening of Medical Mobile Units for both preventive and curative care o Availability of conveyance and staff workers (radiologist, LMO, X-ray technician, ECG technician, LT, pharmacist, driver) o Availability of equipments and medicine
8.	Number of facilities to be covered for facility survey - SHCs - PHCs - Referals			o Implementation of activities to fill in the identified gaps
9.	Number of villages to be covered for HH survey	Nil		
10.	Number of community hearings planned			▪ Organization of regular community meetings at SC and PHC level ▪ Integration with ASHA and PRI
11.	District training plan developed and implemented	-	**District training plan in place & implemented**	▪ **Formulation of district training plan** o Recognition of need of trainings o Organization of trainings as per state guidelines o Refresher training of paramedics on minor ailments o Training of MOs for managerial skills, EmOC o Training of ANMs for ANC, DOTS
12.	District BCC plan developed and implemented	Nil	**District BCC plan developed & implemented**	▪ **Formulation of district BCC plan** o Assessment of communication needs in the context of NRHM ▪ Development of communication plan and its implementation o Use of print media, folk, T.V. and radio
13.	District procurement and logistics plan developed	Nil	**District logistic plan developed & implemented**	▪ **Formulation of need based plan** for streamlined procurement and logistics o Provide required equipments o Financial planning for reaching of supplies at various levels including ASHAs o Well established supply chain
14.	Number of PHCs/Referals where AYUSH physicians posted	Nil		▪ **Posting of AYUSH practitioners** o Relocation and appointment of physicians o Coordination with other private health facilities

***Source: District Project Management Unit**

4.7 Kala Azar Programme

The disease Kala-azar is caused by one celled animal called protozoa. The name of Protozoa is Leishmania Donovani.This disease is transmitted by sandfly vector called Phlebotomus argentipes. Kala-azar is responsible for high morbidity and mortality in Vaishali district.

Table: Kalaazar Indicators

Indicator	Year		
	2006	2007	2008
No. of Kalazar Suspected Cases			
Found Positive			
RK-39 Test done			
Deaths			

Source: District Malaria Office, Nalanda

Constraints:

- Lack of awareness among people regarding Kala Azar.
- Lack of health education among masses regarding KZ.
- Late reporting of +ve cases,
- Lack of laboratory facilities at PHC level.
- Delayed reporting of fever cases.
- Staff not available every where.
- Lack of integration into Development Efforts
- Lack of Sound Administrative Support
- Lack of Effective Leadership and Team Work
- Lack of Logistic Support

Suggestions:

- Reduction in time and timely Tests.
- Lab facilities at PHC level should be improved
- +ve cases should be treated immediately
- Involvement of AWWs and ASHA in identification of fever cases
- Medicated Mosquito nets need to be distributed to those communities where KZ prevalence rate is higher compared to others.
- Mobile RK39 test centers.
- Massive one day surveys
- Strengthen Regional and Local Epidemiological Services
- Specialized Competence, both Technical and Administrative
- Adapt to Local Situations
- Coordinate with School Education

Table: Performance indicators for Kalaazar control programme

	District Plan Objectives	Current levels*	Target for 2009-10	Strategies
1.	KZ prevalence rate			▪ Encouraging the use of Gambuzia ▪ Encouraging the use of mosquito net ▪ Early diagnosis and prompt treatment ▪ Prediction, early detection and effective response to outbreaks ▪ Laboratory Services to be provided at PHC level also for examination of smears ▪ To involve ISM practioners for usage of herbal medicine to control Kalaazar programme.
2.	Annual blood examination rate			
3.	Slide Positivity Rate			
4.	Number of deaths due to malaria			
5.	Percentage of PHCs/ CHCs having functional laboratory for malaria microscopy			
6.	Percentage of DDCs reporting stock out of antimalarial drugs			

***Source: District Malaria Department**

4.8 Blindness Control Programme

National Programme for Control of Blindness was launched in the year 1976 as a 100% centrally sponsored programme. Various activities of the programmes include establishment of Regional Institute of Ophthalmology, up gradation of medical colleges and district hospitals and block level Primary Health Centres, development of mobile units, and recruitment of required ophthalmic manpower in eye care units for provision of various ophthalmic services. The programme also extends assistance to voluntary organizations for providing eye care services including cataract operations and eye banking.

The achievements of NBCP are tabulated below:

Table: Achievements of the National Blindness Control Programme (2008-09)

Particulars	Achievement
No. of Urban Eye Camps	N.A
No. of Cataract operations (Total)	N.A
No. of refractive error	N.A

Constraints:

- Lack of Education among the masses about the existing facilities: Need of wide publicity.
- Shortage of quality Equipment and medicine.
- Apathy and indifference on the part of health personnel.
- Lack of adequate referral services to take care of complications.
- People have tendency to neglect the aged family members.
- Post operative follow up of people is not being done properly.
- Fear of eye operation.
- Old myths are still prevailing.

Suggestions:

- Integrate Eye care as part of Primary Health Care

- Involve NGO's
- Train Ophthalmic Medical Assistants
- Provide Low Cost Spectacles
- Correct Chronic Vitamin-A Deficiency
- Proper survey should be done by health workers
- Proper investigation before operation
- Camp should be done at well equipped hospitals and by surgeon
- Need of strict control to maintain quality.
- Need of change of attitudes.
- Need of designing referral services

Table : Performance Indicator for NBCP

	District Plan Objectives	Current levels*	Targets for 2009-10	Strategies
1.	Cataract surgery rate (per lakh)		100%	Conductance of no. of eye camps in coordination with lions club, rotary club etc. strengthening service delivery developing human resources for eye care promoting outreach activities and public awareness and developing institutional capacity
2.	Percent surgery with IOL		100%	
3.	School Eye Screening: children in the age group of 10-14 years should be screened for refractive errors		100%	

*** Source: District Blindness Control Programme**

4.9. Leprosy Eradication Programme

Leprosy continues to remain a serious public health problem in the developing countries, particularly if one considers that the populations at risk of contracting the disease are very large, and that more than one-third of all leprosy patients face the threat of permanent and progressive physical and social disability. It should be emphasized here that the problem of leprosy is for more serious than what is represented by the numbers alone, particularly in terms of the intense human suffering involved resulting from the physical deformities and the related social problems.

Leprosy is a chronic bacterial disease caused by Mycobacterium leprae. It affects the peripheral nerves, skin and the upper airway. The main clinical presentations are the tuberculoid and lepromatous forms.

The exact mode of transmission has been established naso pharyngeal root but household and prolonged contact appears to be important. Environmental factors such as overgrowing and poor hygiene facilitate the spread of the disease. The incubation period ranges between 2 months and 40 years. Leprosy is rarely seen in children below three years of age. At present, there is vaccine under trial as HKML (Heat Killed Mico bacterium laprae obtain from Arma dilo nine bandade), ICRC vaccine (Indian Cancer research Centre) by Dr. Dave, MW (Mico bacterium Welchi and BCG)

Unlike some other diseases, such as tuberculosis, there does not appear to be a connection between leprosy and HIV infection. With the implementation of MDT (Multi Drug Therapy) services under the programme since 1983, a large number of leprosy cases have been discharged as disease cured.

In the year 2006-07 the prevalence rate of leprosy was …… per 10,000 populations which have been reduced to …… during the year 2007-08. To detect the hidden cases of leprosy in the community six search campaigns were organized in the district. Several sensitization Workshops and awareness programmes were also conducted to achieve the targets. The goal of leprosy elimination is that prevalence rate should be less than one case per

10,000 populations in the coming years. The focus is now being made on voluntary reporting of cases by promoting intensive IEC / BCC.

Table: Indicators showing achievements of NLEP 2008-09

Indicators	Status
New case detection	667

Suggestions

- Strengthen Health Care Services
- Rehabilitation
- Updation of master register
- Case validation, to have check on wrong diagnosis and re registration
- Prompt and early detection of the cases to avoid deformity and disability,
- Ulcer care foot ware reorientation training of medical & Para medical staff.
- Involvement of Lokdoot (old & rehabilitated to have the best IEC.
- Community Education
- Removal False beliefs from the Community
- Financial and personal support and psychological assurances

Table : Performance indicators for Leprosy Programme

	Indicators	Current level*	Target for 2009-10	Strategies
1	Prevalence rate (PR) - leprosy cases per 10,000 population	1.5	1	Conductance of timely surveillance Orientation trainings to new staff Organization of POD camps Conductance of sensitization workshop at gram panchayat involving new panchayat representative Organization of skin diseases diagnosis and education camps Conductance of urban leprosy awareness camps Procurement of TV, VCD, Camera, Mike for IEC Implementation of PFMS (Project Financial Management System)
2	ANCDR – New leprosy cases per 11,00,000 population		0	
3	Proportion of patients completed treatment		100%	

4.10 Tuberculosis Control programme

Tuberculosis (TB) is an infectious disease caused by a bacterium, Mycobacterium tuberculosis. It is spread through the air by a person suffering from TB. A single patient can infect 10 or more people in a year. DOTS, known as the Revised National Tuberculosis Control Programme (RNTCP) in India, are a comprehensive strategy for TB control. DOTS are the only strategy which has proven effective in controlling TB on a mass basis.

India has adapted and tested DOTS in various parts of the country since 1953, with excellent results, and the RNTCP now covers more than 120 million populations. The Revised National Tuberculosis Programme (RNTCP) was launched in the country on 26 March 1957.

Table: Indicators showing achievements of RNTCP 2008-09

S.No.	Particulars	Status (2008
1	Total Number of OPD	

2	No. of patients whose sputum were examined for diagnosis	6034
3	No. of Smear Positive patients diagnosed	1140
4	Total Patients Registered & put on DOTS	1906
	a) New Smear Positive	
	b) New Smear Negative	
	c) New Extra-Pulmonary	
	d) Re-treatment cases	
5	No. of Patients put on Non-DOTS	
6	Total Patients under treatment	
7	Annualized case detection rate	

- TB prevalence estimate for the district per lakh is ……..
- Drugs, supplies and equipments as well as required staff are provided to districts
- Regular training, orientation programmes and awareness campaigns are being done
- Full treatment currently to ……..patients through DOTS providers

Suggestions

To increase the case detection rate following majors should be taken:

- Increasing referral from the field and from OPD, mobilizing community participation, ensuring involvement of Private practioners, NGOs and other sector, intensifying supervisory activities and intensifying IEC activities
- TB has a cure, and treatment is inexpensive
- TB control is a very cost-effective health intervention equivalent to that of the well known childhood immunization programmes.
- Successful treatment demands education and timely follow-up examination to achieve sputum conversion & cure rate up to the desired level.
- Successful treatment requires 6-8 months of consistent, uninterrupted medication
- New drop resistant strains of TB are developing because patients are not completing their treatment. These drug-resistant strains are significantly more dangerous to the individual and the community because they are more difficult and more expensive to treat.
- The best was to prevent TB is to cure infectious cases in their early stages in order to prevent transmission to others.
- TB, control programmes that treat infectious patients by don't ensure that they are cured risk doing more harm than good. Patients who have incomplete treatment can develop and spread drug-resistant TB.

Table : Performance Indicator for RNTCP

	District Plan Objectives	Current levels*	Targets for 2009-10	Suggested strategies
1.	Proportion of TB suspects examined out of the total outpatients		2 - 3%	Increasing the awareness/ visibility of DOTS among rural masses by distributing pamphlets and conducting group discussions with villagers Provide facilities for diagnosis of TB Patients through integrated general health services. Provide optimum treatment nearer to
2.	Annualized New Smear Positive (ANSP) case detection rate per 100,000 population		53%	
3.	Annualized Total case detection rate per 100,000 populations		0.203%	

4.	Treatment success rate		99%	the residence of the patients. To prevent infection, immunization is done by doing BCG Vaccination. Health Education to encourage patients through Health Workers, their relatives and village leaders to take full course of treatment. Detection of New TB cases (Sputum positive, X-ray suspects and extra pulmonary cases)

***Source: District TB Control Programme**

4.11 Filaria control Programme

The National Filaria Control Programme was launched in 1955 for the control of filariasis. Activities taken under the programme include: (i) delimitation of the problem in hitherto unsurveyed areas, and (ii) control in urban areas through recurrent anti-larval measures and anti parasite measures. Man, with micro Filaria in the blood is the main reservoir of infection. The disease is not directly transmitted from person to person, but by the bite of many species of mosquitoes which harbor infective larvae. Important vectors are species of Culex, Anopheles, Mansonia and Aedes. The incubation period varies, and micro-Filaria appears in the blood after 2-3 months in B. malayi after 6-12 months in W. bancrofti infections.

Constraints

- It affects mainly the economically weaker sections of communities
- Result in low priority being accorded by governments for the control of lymphatic filariasis.
- Low effectiveness of the tools used by the control programme
- The chronic nature of the disease and that

Suggestions

1. Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.
2. Continuous use of vector control measures.
3. Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.
4. IEC for ensuring community awareness and participation in vector control as well as personal protection measures.

4.12 Disease surveillance programme

Disease surveillance programme is a key intervention which provides feedback to the disease prevalence and measures to be taken.

Constraints:

- People not following proper hygiene/ sanitation practices even after knowing the ill effects of unhygienic conditions
- Bad food habits (such as eating uncovered outside snacks etc)
- Timely immunization as well as supervision not done because of lack of manpower

Suggestions

- Frequent camps in rural areas for solubility tests
- Special medical supervision for +ve cases
- Couples before marriage should go through solubility test
- To improvise the current surveillance situation and supervision under district administration is needed.

4.13ASHA programme:

The concept of ASHA is one of the best health worker programme in our state where the Community selects a Health Volunteer – called the "ASHA" . **The concept of "ASHA"** is about Empowerment, Participation, Sharing, Caring, Gender Equity and Self Reliance. Role of ASHA is:

- Providing elementary Health Education
- Assuming Leadership in Community Action for Health
- Imparting First Aid & OTC Drugs
- Treatment of Minor Ailments
- Ensuring timely referral
- To provide the health service in unreachable villages.

The ASHA programme is one major crosscutting innovation that has seen considerable grass roots success. A detailed operational manual and it's a rigorous sample study based interim evaluation of the programme is available. This is also an initiative that would take a longer time to succeed and it needs sustained support at all levels for at least another three to five years.

4.14 Urban Health

In Nalanda district 14.02 % percent of the total population lives in urban areas as per the 2001 census.

On the basis of the study work it is quiet obvious that people should be prepared for tackling any kind of disaster and at the same time government should make necessary arrangement for making people aware. Different media of mass communication, awareness and others should be used for creating consciousness. Not only government agencies, but NGOs are also expected to create mass awareness. Inclusion of disaster preparedness into school curriculum should be mandatory as in other disaster prone countries. Targeting children will create an aware generation and minimize life risks.

The section on urban health therefore focuses only on the municipalities and corporations. Paradoxically there are large number of hospitals and private clinics- but for the poor in this area of health, there is not a single approach.

4.15 Logistics management

The essential drug list is in place and is largely implemented. As Nalanda district has storekeepers and officers have been trained in drug and supplies logistics. A computerized inventory system is yet to be developed in HMIS software. The problem with consumables is equally of concern and laboratory chemicals seem the worst affected but even gauze and bandages, needles and needle holders could be in short supply repeatedly. These would correct with the distribution system becoming fully operational. Supply side of logistic management is very poor as far as medicine supply is concerned. It would be better to introduce a special vehicle for this purpose which will supply the medicine directly to PHCs.As far as HSCs supply concerned there could be made provision to hire a separate vehicle for this purpose and this vehicle could also be used for monitoring purpose.

In equipment there are two types. We have relatively low investment equipments like Hemoglobin meters or BP apparatus and infant weighing machines- which, if used, will need replacement frequently. These minor equipments need to be absorbed into the same distribution system.

As for costly equipment like ECG and ultrasound and X-rays, which require replacement less-up to once in ten years- but which require trained manpower to operate and considerable consumables as well- the problem is matching for infrastructure, skills and services provided so that these are adequately utilized.

4.16 Intersect oral Convergence

4.16.1 Coordination with ICDS and PHED

Most of the activities like Routine Immunization, Vit A supplementation, DOTS, Health Check ups etc are implemented through ICDS program. The construction of bathrooms and toilets and provision of regular water supply have been done at PHCs through PHED. The detail is given below.

4.16.2 Coordination with Panchayats

Panchayats are not totally involved in participating in the health activities with the health department. Most of the Panchayats are not aware of the fact that by participating in health activities. There is no such government policy to link Panchayat directly for increasing the participation of the Panchayats to the health services.

4.16.3 Infrastructure and Service Delivery Issues

Training and Capacity Building

Training programmes are few and are driven exclusively by the vertical health programmes of the day, largely funded from external donors or the central government. As a result whatever trainings are taking place are arbitrary in choice of trainees and fragmented as strategy. Most training programmes are of one or two days and relate to a single disease and an immediate campaign for example one day leprosy training or two days on HIV family counseling or one day on blindness control and so on. Some persons have received many such training programmes in diverse areas while some have received many such training programmes in diverse areas while some have received none. Then again all MPW (F) had a special round of training in RCH but neither their supervisors nor male MPWs were exposed to this. The vertical orientation of training leads to closely associated work of other diseases not being taught – even in much longer capability buildings. Thus sector supervisors were training on blood smear examination for malarial parasites but doing a differential counts on that same slide would not be emphasized.

Almost no training is based on building competencies to attain a level of clinical services in a given facility. We therefore have a situation where there is a perception within senior officials that the system is being flooded

with training programmes. Yet the system cannot guarantee that in the sub-centres or PHCs or CHCs of a given district, the level of knowledge and skills needed is now available. It may not even be able to state; facility-wise what level of skill building has been achieved and what are the gaps.

Building awareness on Environment Health

Environmentally-related childhood diseases represent an enormous public health problem, particularly in developing countries and impoverished communities, where there is often lack of awareness and knowledge about the effects of chemicals and other environmental hazards on children's health.

- Handbook on Children's Environmental Health - a collection of information that focuses mainly on the needs of developing countries.
- Children's Environmental Health (EH) for the Primary Health Care Sector – preparation of a simple training guide and incorporation of EH concepts into existing first level health care services (e.g. into the Integrated Management of Childhood Illnesses (IMCI).
- Training Package for Health Providers
- Leaflets for health care providers - concise information on what health care professionals should know about selected environmental risks (e.g. water pollution, lead, chemicals……)
- Pilot Training Activities – for the peer review and field testing of existing materials, using a "train the trainers" approach
- Presentations given by experts, visitors.

The study recognizes that the financing or health care is an important issue and that budgetary allocations on each facility workforce relate to outcomes. Also that what is adequate utilization or wasteful relates to amount of investment that has gone into it. These financial aspects are the subject matter of the subsequent study.

Mapping the private sector and exploring its possibility of synergy with the public health system and developing a policy framework for its growth and regulation are yet another issue that we have not addressed.

Blindness

issues	Strategy	Activities	Unit Cost	Total Budget
Staff shortage	Recruitment	Recruitment of Eye Specialists and surgeons on contractual basis.	Already discussed in maternal health	0
		Recruitment of Opthalmic Assistants on contractual basis.	Only 4 in the current year @ Rs 8000 per month	384000
Untrained staffs	Capacity building	Training of Doctors on IOL technique	Rs 10000 per person for 5 person	50000
		Training of Opthalmic Assistant		
Low achievement	Increasing noof camps	Organising Operations at District level	Rs1000 per operation for 3000 operations	3000000
	PPP	Accreditation of Nursing Homes capable of doing Cataract surgeries	NA	0
		Establishing Nagarnausa Cataract Operation Center at PHC	Rs 500000	500000
		Purchase of equipments and medicines		
Lackof awareness	Awareness building	Assigning LHV/Supervisor counseling work	NA	0

		Organising eye screening camps in villages/ schools	NA	0
		IEC on cataract and its facilities	Rs 100000 at district level	100000
	InvolvingNGOs	Meeting with Local NGOs onthis issue	NA	0
Lackof adequate referal services	Strengthening referal system	Arrangement of carrying patients to the Operation Centers and then taking them back homes	Rs 10000 per PHC	200000
Monitoring and follow up	Monitoring and follow up	Mobility support for Visiting homes of the patients tomanage any post treatment complication.	Rs 10000 per PHC	200000
		Developing records of cataract cases fromOPD registers at PHC level	NA	0
		Total		4434000

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

	To increase vit A coverage of received atleast one dose (9month to 35 months) from 67.3% to 80% and include up to 5 yers.		To increase Vit A reported adequte coverage among (9m to 5ys)	1.1.3	Management of diarrhea, ARI and Micronutrient Malnutrition through Child srvival months		Two round of Child servival Month orgnised in one finicial year.
	To decrese Malnutrition form 58%(NFHS III state) to 30% of the age group of (0 to 5 yrs)		% of decrese Malnutrition age group of (0 to 5 yrs)	1.1.4	Care of Sick Children and Severe Malnutrition and strenthen VHND at all AWCs		No of VHND orgnised vs Planed.
2		2.1		2.1.1	School Health Programme		No Of school health programme orgnised in the PHC
Sl.	Strategy		Gaps		Activities	Unit Cost	Budget
	IMNCI,Home Based Newborn Care/HBNC		*Training Gaps(AWW-2328/2476,ASHA-0,ANM-377/401,MPW-11/83,MO-47/146,CDPO-05/16,ICDS Super-05,Health supervisors-27,NGOs-06)* *No ASHA is trained on IMNCI*		*Assessment of Training load and prepare calendar of training*	NA	0
					Incorporate ASHA in IMNCI training team	NA	0
					ASHA kit regular supply and incorporate use of ASHA Kit in training curriculum.		
			Inadequate monitoring of this activity at field level		*Division of area among all trained supervisiore for revision of IMNCI activity in their area.*	NA	0

					BHM will be responsiable for review of health superviser and LS(ICDS)on given formate.Unicef staff will support in devloping review mechnisum in PHC.	NA	
					Incorpate IMNCI reports in HIMS formate	NA	
					Encouraging mother regarding child care.in VHND	NA	
					Frequent checkups of babies by Paediatrician. *Distribute teliphone number to AWW and ANM of respective docters those who are supervising them in the field.*	NA	
					Wednusday could be fixed a day for IMNCI related work at HSC level	NA	
					Community based Monitoring support system devlop with SHG in one PHC *Traing of Group members* *seed 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 markand district having referal 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 ANM to operate baby warmer machine.	Rs 5000/- for demonstration at District level	5000
			There is no provision of stay of mothers of neonates at PHC.		Organize training programme for newborn care for the nurses in the district hospitals	One Nurse from each PHC Cost will be 5000/-	5000
			Neonatal Care Unit not up to mark.		District level Supporting supervisory team should be devlop with the responsibility of nunfuctioning of neonatal care unit. Training of team on monitoring of NCU	Rs.5000/-for one time training	5000
			Non availability of "MAMTA" at PHC level.		*Training of Mamta and staff nurse on logistics of New born Care units.by district level supervisory Team.*	Rs 1500 for team members for each PHC per month	360000
	Infant and Young Child Feeding/IYCF		Non awareness of breast feeding and proper diet of young children.		Colostrum feeding and breast feeding inclusively for six months. Through IMNCI Training.	NA	0
					Baby friendly hospital Training of one docter form each Nursing hospital at District Level	Rs.20000 for training programme	20000
					Two days training of one staff nurse from each private hospital on counslling skill.	Rs 20000/- for training programme	20000
					Accreditation of nursing home and facility according to norms of baby friendly hospital	NA	0
			Poor knowledge regarding new born care and		Development and Printing of BCC materials	Rs 5 per unit for 10000 units	50000

			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
			Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding		Counselling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries in mothers meetings and VHSCs meetings	NA	0
					Folk performance to promote exclusive breast feeding	Included in maternal health	0
					Uniform message on radio from state head quarter	State budget	0
			Lack of awareness on importance of appropriate and timely IYCF		Organize social events through VHSCs	NA	0
					Strengthening of *Mahila Mandal* meetings- fortnightly with involvement of adolescent girl	NA	0
					Organize healthy baby shows, healthy mother / pregnant woman.	Rs 2000 per month per PHC	480000
					Appreciation and reorganization of positive practices in community. For this purpose hiring a documentation specialist.	Rs 100000 for the whole district on communitywise sample basis	100000
					Celebration of "*Annaprashan(Muhjutthi) Day*" at AWC	NA	0

					Demonstration of recipes.	Rs 250 per month per AWC(Under MUSKAN program)	0
					Exposure visits to existing NRCs to observe different models in the country	Rs 50000 for the district	50000
	Care of Sick Children and Severe Malnutrition		There is not a singal unit in the district where seviarly malnurished children could be treated.		Establish rehabilitation center in district hospital, FRU and one PHC and promote local aviliable food farmula for nutritional Tharapy as Hadrabad Mix	Rs 1000000 per unit	4000000
	Management of diarrhea, ARI and Micronutrient Malnutrition		There is high privlance of PEM and anemia among childrn because of Child nutrition is least priporty among service providers.		Procurement of ,ORS , Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup.	100000 ORS packets at the rate of Rs 5 per packet.(If ORS is not provided in Kit A) IFA syrup for 800000 children at rate of Rs 4 per children	3700000
					Include covrage of Vitamin A and IFA,children in New HIMS format.	NA	0
					Insure two round of Vitamin A and deworming for the age group of (9m to 5 yrs) & (2 yrs to 5 years) respectivly in the month of April And Oct as per GOI guide line.	Rs 1500000 per round into two rounds(If Vit A is not provided in Kit A)	3000000
					Involvement of ICDS, school teachers and PRI for monitoring and evolution	NA	0
	School Health Programme		No Pre School Health checkup & complete Immunization card.		Half yearly health checkup camp for children in schools should be organized.	Rs 2000 per PHC	40000
			No training of school teacher for basic health care and personnel hygiene.		Training of school teacher by the medical personnel with support administrative person.	Budget incorporated in adolescent health	0

			No regular health checkup camp at school.		Quarterly meetings of VEC representatives by attending existing meetings of VECs representatives at block level by the concerned MOICs and BHMs.	NA	NA
			No Training & Screening of school's teacher for eye sight test.		Linking existing 7 opthalmic paramedics with this program and developing school wise calender.	Mobility support of Rs 20000 per PHC for moving other blocks and hard to reach areas.	400000
			No other specific program has been formulated in the district.		School health anemia control programme should be strengthen with bi annually de worming .	Budget incorporated in adolescent health	0
					Organizing competitions/Debates/Painting competitions/Essay/demonstration and model preparation of nutritional food and health.	Rs 20000 per PHC	340000
					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 Since 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

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	104600
				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 very corner of the house is properly spraye upto heigth of six feet from ground level.	Rs 10000 per PHC	200000

		Poor condition of Sprayer, pump and nozzles etc No of Pumps available-266, No of pumps required-20, No of bucket savailable-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 : maintencae of old sprayer pumps, Puchase of new pumps and other articles needed- buckets, mugs etc.	Rs 150000 for the district	150000
		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

2	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 persisten fever not responding to antibitics, malaria being excluded, with palpable spleen.**2)** Ensure availability of aldehyde test at PHC level **3**) Purchase of RK 39 kit for detection of Kalazar	Purchase of 50000 units of RK39 @ Rs 25 per unit	1250000
		Reduction of kala-azar mortality and morbidity	Early diagnosis and treatment through PHC system	1. Ensuring availability of Amphotoricin at all level	Purchase of 10000 vails of Amphotoricin 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	3300000
				2. Replacing of medicines on priority based	NA	0
				3. Training of ANMs and ASHA for IM injection	Rs 5000 per PHC	100000
3	Lack of monitoring and supervision mechanism,		Monitoring and supervision mechanism	Preparation of Monthly visit plan for supervision : - Checking spraying schedule - For supervision & treatment follow up	Mobility support for CS, ACMO and DMO	`
					Mobilty for MOIC 15x 40days x Rs 100	60000
					Mobility for supervisor 33x 40 daysx Rs100	132000
				Office expenses	25000 for the district	25000
4	Lack of appropriate BCC & Community	Increasing awareness for prevention	Community participation in reducing mortality and	1. Fund allocation for training activities	NA	0
				2. Identification of NGO/Private partner as trainer	NA	0

	Mobilization.	of Kala-azar	morbidity due to Kala-azar	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	Rs 10000 per PHC	200000
				7.Activity for survilence like polio survilence	NA	0
				8.Wall painting of Tretment protocole and provisions for pateints in PHC in Hindi.	Above mentioned	0
				IEC van for each PHC	20x 40x 750	450000
				Total Budget		10020840

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

4.13 RI/Muskan			
Sl No	**Activities**	**Unit Cost**	**Total Budget**
1	Training of Health workers on Immunization	Rs 100 for 600 workers	60000
2	Printing of RI Formats	Rs 5 for approx 1100000 PW	5500000
3	Printing of Muskan Registers	Rs 125 for 2246 AWCs	280750
4	Suuplementary immunization during flood	Rs 50000 per PHC	1000000
5	Catch up immunization	Rs 50000 per PHC	1000000
6	Incentive money	Rs 550 per AWC	1235300
7	Mahila Mandal	Rs 250 per AWC	668750
9	POL for cold chain	Rs 1500 per day	547500
10	Vaccines and logistics mobility	Rs 40000 per month	480000
11	Mobility for supervisor	Rs 10000 per month	120000
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	2400000
16	RI Catch up round	Rs 100000 per PHC	2000000

17	Training of Medical Officers	Rs 1000 per person	20000
18	Meeting of epidemic Response Teams	Rs 5000 per PHC	100000
19	Travel expenses for case investigation per outbreak	Rs 25000 per month	300000
20	Shipment cost of lab specimen	Rs Rs 10000 per PHC per month	2400000
21	Outbreak Response	Rs 25000 per PHC	500000
		Total	**18872300**

Family Planning

Logical Framework

Sl.	Goal	Sl.	Impact indicators
1	Population stablisation	1.1	To decrease TFR upto replacement level To increase sex ratio

Sl.	Objectives	Sl.	Outcome indicators		Strategy	Sl.	Output indicato
2	To increase female sterilisation from present 35%(DLHS3) to 50%	2.1	% increase in female sterilsation	1	Terminal/Limiting Methods	1	% of terminal/limi use
				2	Dissemination of manuals on sterilization standards & quality assurance of sterilization services	2	No of facilities pr quality manuals c sterilization stand sterilization servi
				3	Female Sterilization camps	3	No of camps orgr female sterlizatio
				4	Compensation for female sterilization	4	% of Female reci compensation
				5	IUD camps	5	No of IUD used ir
				6	Accreditation of private providers for IUD insertion services	6	No of Private pro accrediate for IU services.
3	To increase male sterilisationfrom 0.6%(DLHS 3) to 2%	3.1	% increase in male sterilisation	1	NSV camps	1	No of NSV Camp
				2	Compensation for male sterilization	2	% of Male recive compensation
				3	Accreditation of private providers for sterilization services	3	No of Private pro accrediate for Ste services.
4	To increaseuse of condoms from 1.9% (DLHS3) to 5%	4.1	% increase in the use of condoms	1	Promotion to Social Marketing of condoms	1	No of Condoms d through Social M
				2	Contraceptive Update seminars	2	No of Seminars C Contraceptive Up
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	1	Promotion to Social Marketing of pills	1	No of Pills distrib 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 every PHC	Rs 20000	20000*25=50000
				Training of nurses and ANMs on IUD and other spacing methods at PHC level.	Rs 10000	10000*25=25000

				Ensure availability of contra septives (indenting , logistic	Rs 500000 per PHC	500000*20=1000
	Female Sterilization camps		Laparoscopy surgery not done.	Trained doctors on laparoscopy.	Above mentioned	
				Procure Laparoscopy equipments for trained docters	Rs 100000 per PHC	TRU
				Training of doctors needed.	Mentioned above	
	NSV camps		Trained doctors are not available.	Procurement of equipment.	Mentioned above	
	Compensation for female sterilization		Fund for Compensation for sterlization is not aviliable on time at facility.	Immediate disbursement of incentive after sterilization camps.	Rs1000 each for 5000 female and 5000 male operations	
	Compensation for male sterilization			Logistic planning is needed before organizing camps.	NA	
				Block Health manager could be hire one support staff for disbursement for logistic support.	NA	
				Immediate disbursement of incentive after sterilization camps.	Discussed earlier	
				Logistic planning is needed before organizing camps.	NA	
				Block Health manager could be hire one support staff for disbursement for logistic support.	NA	
				Accreditation of private nursing home. As per GOB	NA	
	IUD camps		Camps not held	Training of ANM & staff nurse for IUD insertion.	Discussed earlier	

				Procurement of IUD.	Rs 30 into 55000 units	
	Accreditation of private providers for IUD insertion services		No accreditation of private providers for IUD insertion services	Equipments for IUD insertion	Discussed earlier	
				Accreditation of private providers for IUD insertion services. As per GOI guide lines.	NA	
	Social Marketing of contraceptives		Monitoring of Social Markiting is not monitored by PHC.	Social marketing of need based OC & IUD.	NA	
				Increasing access to contraceptive through communities based distribution system free of cost.	NA	
	Contraceptive Update seminars		Not being held.	seminars for MO and other through Professional bodies (FOGSI. BMA, Nursing association etc..on	NA	
				Copper-t 380-A should be popularized.	NA	
				Awareness for emergency contraceptive.	NA	
				Total		

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	1000
• Inadequate staff, requirement of Supervisor is 20 and that of NMA is 25(One NMAeach in each APHC)	Lack of Human Resource	Staff Recruitment on contract basis	Recruitment of 20 supervisors	Rs 7000per superisor per month	16800
• There is no active involvement of the Medical officers at Block levels.		Strengthen Health Care Services	Orientation of MOs and staffs on Leprosy	NA	
• Lack of PHC staff involvement. No manpower support,			Case validation, to have check on wrong diagnosis and re registration	NA	
			Prompt and early detection of the cases to avoid deformity and disability,	NA	
			Ulcer care foot ware reorientation training of medical & para medical staff.	Rs2000 per PHC	400
No lab testing facility in the district	Infrastructure Gap	Establishing Lab	Establishing Lab at district level	Rs 200000	2000

			Recurring expenditure like reagents	Rs 1000 per month	120
Lack of monitoring at all level	Monitoring Gap	Increasing mobility	Updation of master register	NA	
			Mobility support for DLO	RS 5000 per month	600
			Office expenses	Rs 3000 per month	360
			Total		**21280**

MATERNAL HEALTH							
Logical Framework							
Sl.	**Goal**	**Sl.**	**Impact indicators**				
1	To improve maternal health		Reduction in MMR				
Sl.	**Objectives**	**Sl.**	**Outcome indicators**	**Sl.**	**Strategy**	**Sl.**	**O in**
1	To increase institutional safe delivery by 39.3% (DLHS3) to 65% by year 2010		39.3% of institutional delivery reported	1.1.1	To make functional PHC (24hr x7days) for institutional deliveries	1.1.1.1	% o hav func OT Lab with equ
						1.1.1.2	% o hav Obe Firs med 24h
						1.1.1.3	% o nurs avai 24h
						1.1.1.4	% o hav func Neo care
				1.1.2	To make functional FRUfor institutional deliveries	1.1.2.1	No hav func bloc unit with ban 24h refe tran
						1.1.2.2	No hav and faci

						1.1.2.3	No hav spe doc mul Me Off
						1.1.2.4	No hav fun Ne car
				1.1.3	To provide Referral transport services at FRU /PHC	1.1.3.1	No preg wor ava refe faci (pic dro
				1.1.4	To strengthen Janani Suraksha Yojana / JSY	1.1.4.1	% o preg wor ree JSY pay imn afte
2	To increase safe delivery by trained SBA 9.6%(DLHS3) to 100% by year 2010	2.1	Proportion of birth attendent by skilled health personnel	2.1.1	To ensure support of SBA at home deliveries	2.1.1.1	% o deli atte SB
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	% o hav AN
						3.1.1.2	% o con fixe and pla hel
				3.1.2	To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas	3.1.2.1	% o cam pla hel

				3.1.3	To improve adolescent reproductive and sexual health	3.1.3.1	No preg ado cou AN AW
				3.1.4	To accelrate APHC for OPD and Fixed AN clinics	3.1.4.1	% o clin orgr APH
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 faci hav serv (pul priv
5	To increase community participation in maternal care	5.1	% of Mahila mandal meetings conducted.	5.1.1	To strenghten Monthly Village Health and Nutrition Days	5.1.1.1	% o Vill Hea Nut Day and
MATERNAL HEALTH							
Sl.	**Strategy**	**Sl**	**Gaps**	**Sl**	**Activities**	Unit Cost	Tota
	To make functional PHC (24hr x7days) for institutional deliveries		**Infrastructure**				
A1		1.1	All PHCs are running with only six beded 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	
		1.2	At present 15 PHC are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	1.2.1	2.Preparation of priority list of interventions to deliver services.	NA	0

		1.4	The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement.	1.4.1	2. Sending the recommendation for the certification with existing services and facility detail.	NA	
		1.5	Lack of equipments as per IPHS norms and also under utilized equipments.	1.5.1	3 Prioritizing the equipment list according to service delivery and IPHS norms.	Cost of equipment is attachet Anx..	
				1.5.2	4 Purchase of equipments		
		1.6	Lack of appropriate furniture	1.6.1	2 Purchase of Furniture	Cost of Furniture is attachet Anx..	
		1.11	Lack of facilities/ basic amenities in the PHC buildings	1.11.1	1Rennovation of PHCs	cost of rennovation is attachet Anx..	
	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 Contarctual Docters	8 Specialist@ 25000/ 25 MBBS @20000/	
		1.12.1	But the actual position is not sufficient as per IPHS norms List of Human resource is attached in Annaxer .		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	
				1.12.10.1	Salary of Contarctual Grade A	6 Grade A Nurse	
		1.12.10			Selection and recruitment of grade A for conducting delivery	3 Grade A nurse for each PHC	
					Selection and recruitment of dresser	20 Dresser for each PHC	
					Selection and recruitment of Pharmasist.	20 x2 Pharmasist for each PHC	
					Three month indication training of Grade A nurse under supervision of District level resource team.	100/-per day x 90 days for 51 grade A nurse	
		1.13		1.13.1	Training need Assessment of PHC level staffs	NA	
					Honorarium of Block Accountants	20 Accountant @ 18000/	

			Rent of Data Center	20 Data Center @ 7500/	
			Honorarium of BHM	20 BHM @ 25000/-	
			Mobility support to BHMs	Rs 5000 per month per BHM	
1.14		1.14.1	Appointment of Block Health Managers, Accountants in all institutions.(6 PHCs, 4 Referrals and Sadar hospital.)	6 BHM Budget in RKS head	
			Process of all recruitments	6 types of recruitment @ 20000	
			Trainings of BHMs on Health statistics	20 BHMs	
			Training on Program, Finance management and HMIS	20 BHMs, 20 Block Accountants and 20 Data Center operators	
	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	
1.17	Only 38 essential drugs are rate contracted at state level .	1.17.1	2.Implementing computerized invoice system in all PHCs	NA	
			Purchase of Drug invoice software	Rs 25000 per PHC	
	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	
1.18		1.18	4.Payment from Rogi Kalyan samiti account.	Rs 5000 per month per PHC	
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	
1.2	Drugs are not properly stored	1.20.1	6. Enlisting of equipments for safe storage of drugs.	NA	
		1.20.2	7. Purchase of enlisted equipments.	Rs 25000 per PHC	
		1.20.3	8.training of store keepers on invoicing of drugs	Rs 2000 per PHC	
	Performence				

		1.21.1	Exessive load on PHC in delivering all services i.e. 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC.	1.21.1	Recruitment of Doctors on contractual basis	NA	
		1.21.2	Total 59 seats of Regular and 25 seats of contractual doctors in the district is vacant.			NA	
		1.22	All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less(only average16 patients per Doctor per OPD days during April08-Nov 08, however the IPHS norms says that the OPD should be 40 per Doctor.)	1.22.1	Hiring of rented houses from RKS fund for the residence of doctors and key staffs.	Rs 20000 per PHC per month	
				1.22.2	Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.	Rs 20000 per PHC per month	
				1.22.3	Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day	NA	
	To make functional PHC (24hr x7days) for institutional deliveries	1.24	8 PHCs out of 20 are lacking 24 hrs new born care services.	1.24.1	Ensure 24 hrs new born care services in 20 PHC.	Budget in Child health care activity	
		1.27	Only five PHCs provides 24 hrs BEmoC services.	1.27.1	Ensure 24 hrs BEmoC services at 10 PHC		
					Training of one Docter from each PHC on BEmoC.	5000/-Per Doctor	
					Equipments for BEmoC	50000 per facility	
		1.29	8 PHC does not have laboratory facilities on PPP based srvices. In addition to this the regular lab technician has been deputed for this purpose.	1.29.1	Duputation of 17 regular Lab tech at PHC level for providing free of cost lab services to all pregnant women and BPL families.	NA	
		1.3		1.30.1	Recruitment of 20 lab technicians as required for regular support of lab activity	6000/-per head	
					Training of TB lab technician on other pathological tests.	1000/-per training	

			Purchase reagent(recurring) for strengthening lab.	5000 per unit per month	
			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	
1.32	Health facility with AYUSH services is not being provided		Establising one Panchkarm center in Nagarnausa PHC	10000 Per PHC	
			Establising homeopathy centers in all PHC	5000/- each PHC for medicine , equipments and Furniture.	
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 out for pregnant mothers and BPL families free of cost using existing Ambulence services at PHC level.	60000/-each PHC per month	
			Provide EDD list of pregnant women to Ambulence driver and Number of ambulence diriver and 102 /PHC tel No to all Pregnant woment	NA	
1.33.4	Shortage of ambulances	1.33.4.1	Hiring of ambulances as per need.	one in each PHC @ Rs 15000 Per month	
			Prepaer list of Vechecal those are utilised in Monitoring work in PHC that can be use in pick up and drouping facility for PW.	NA	
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	
			Rewiev of Cleanliness activity in all PHC by Qulity assurence committee and payment of agency should be link with it.		

		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	
			Perchage equipments and uniform for clinliness in all PHC	50000/each PHC	
			Training of Workers on using machine/equipments and importence of clinliness .	2500/-per PHC twice in a year.	
			Devlop mechnisume for monitoring of clinliness work	NA	
1.7	Non availability of HMIS formats/registers and stationeries	1.7	Printing of formats and purchase of stationeries	Rs 50000 per PHC	
		1.7.2	Biannual facility survey of PHCs through BHM as per IPHS format	NA	
		1.7.3	Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.	NA	
1.8	Operation of RKS:	1.8.1	Ensuring regular monthly meeting of RKS.	Confectionary costs @ Rs 1000 per month per PHC	
		1.8.2	Appointment of Block Health Managers, Accountants in all institutions.(20 PHCs, 2 Referals and Sadar hospital.)	6 more BHMs a(Rs 25000 per month for BHMs)	
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	
		1.9.2	Trainings of BHM and accountants on their responsibilities.	Rs 1000 per participant, Two participants from each PHC	
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	
		1.10.2	Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS.	NA	

		1.36	In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases.	1.36.1	Meeting in RKS with Local Police Station incharge to handdale emargency situation .	NA	
					Training local NCC/NYK/Scout & Guide/NSS etc.volentiers on identification of emargency situation. And deployment of volentears at PHC.	5000/-per PHC	
	To make functional PHC (24hr x7days) for institutional deliveries	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	
		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	
		1.39	Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.	1.39.1	Name plates of Doctors	Rs 2000 per PHC	
					Displaying Name Photograph and DOB of all staff of PHC and put clinliness staff name on top of the list.		
		1.41	Lack of councelling services	1.41.1	There re 24 LHV in the district we can utilise their experience in counseling work of women and adolecent girls after training.	1000 per person	
		1.42	there is no hot water facility for PW and there is no adequte liting facility at adjoining area of PHC	1.42.1	Installation of solar heater system and light with the help of BDO/Panchayat at PHC or purchage equipments from market.	50000/-per PHC	
		1.43	Lack of convergence	1.43.1	Convergence meeting by RKS & DHS	NA	
		1.44	Lack of timely reporting and delay in data collection	1.44.1	Orientation of the staffs on indicators of reporting formats	NA	
				1.44.2	Puchase of Laptops for DPMs and BHMs with internet facility.	Rs 35000 per unit+ 2000 per month	
		1.45	Lack of space for waiting, environmental cleanliness around PHC,	1.45.1	Gardening	Rs 12000 per PHC	
				1.45.2	Sitting arrangement for patients	Rs 5000 per PHC	

			provision for hospitality etc		Construction of patients waiting shade	75000/-Per PHC	
				1.45.3	Installation of LCD projecter for manage waite over time of OPD patients.	Rs 100000/- per PHC	
				1.45.4	Installation of safe drinking water equipments/water cooler,	Rs 10000 per PHC	
				1.45.5	Apron with name plates with every doctors	Rs 300 per Doctor for total 172 doctors	
				1.45.6	Presence of staffs with uniform and name plates.	NA	
				1.45.7	"MAMTA" should be appointed at PHC level as well.	Rs 75 per delivery for approx 60000 institutional delivery	
	To make FRU functional and upgradation of PHC to CHC for institutional deliveries						
2		2.1	C-Section deliveries are not conducted in institution.	2.1.1	Devlop Lalganj, Mahua and Mahnar PHC for C-section facility	NA	
				2.1.2	Training of MOs of 12 PHCs in mulltiskilling.	3 Docters from each PHC @ 2000/-per person	
				2.1.5	Specialist should be posted at Sadar Hospital/and above mention three PHC	NA	
				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	
				2.1.8	Need based Equipments and drugs in O.T and Labour room.	List of Equpment attached(100000 per PHC)	
			None of the PHC provides 24 hour blood transfusion services, however PHC Mahnar has been provided the equipments for blood storage unit.		Establising blood storage unit at Lalganj, Mahua & Rahopur,	60000/- Per PHC	
					Training of lab technision on management of blood storage	3 lab technision	

			Infection control protocols is not at all maintain at all facilities	2.2.2	Licensing blood storage / blood bank	NA	
				2.2.3	Meeting infrastructure requirements as per norms for Blood storage	10000 Per PHC	
				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	
				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	
				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	
		2.3	Welcome PW at Institution and PHC and FRU	2.3.1	Provision of food for the delivered mothers and mothers under gone in tubectomy in all the health facilities.	NA	
				2.3.2	Mobilize community Resources for providing Free food for PW at Institution.	NA	
				2.3.3	Quality indicators (clean environment, wards with clean linen, clean toilets , clean labour rooms, running waters supply, hot water and protected water for inpatients, new born corners, treatment protocols, aseptic precautions, immediate disbursement of	NA	
		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	
				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	

				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	
				2.4.4	Institution and urban center also to report Maternal death to the district CS/CMO.	NA	
				2.4.5	Maternal Death should be reported by ASHA AWW, ANM Staff Nurse & Doctors to the district data center .	NA	
				2.4.6	Investigation of maternal death by district team. and third party review(District magistrate)	NA	
				2.4.7	Training of ASHA and investigation team objective and process of investigation and review of maternal death	Rs 3000 per PHC	
		2.5	Biomedical waste management is not properly taken care off at all institution	2.5.1	Procurement of equipment	Rs 50000 per PHC	
				2.5.2	As per example Introduce color coded buckets for facilities as per IMEP	NA	
4	**To strengthen Janani Suraksha Yojana / JSY**	4.1	Tracking of pregnant women from first Trimester is not done form the register.	4.1.1	Review of early registration with 3 AN checkup ,two TT.100/200 IFA Tab. in ASHA Diwas.	NA	
		4.2	Too much documentation process. Photo required for mother and baby. It cost Rs.30/- to Rs.60/- .	4.2.1	Ensure 100 %Pregnancy Test Kit is to ASHA and regular supply.	Rs 50 for 99000 pregnancies	
				4.2.2	Direct transfer of funds from district to PHC through core banking / directly from DHS	NA	
				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	
				4.2.4	The photo system should be replaced by some other alternatives like- bank account opnin of pregnant women in first trimister and directaly transfer the money to their account after delivery.	Incentive to ASHA for rs 50 per PW for opening of bank account of PW for 99000 pregnancies	
					Incentive for institutional	Rs 2000 per	1

					delivery.	delivery	
5	**To ensure support of SBA at home deliveries**	5.1	Home Delivery is still prevailing through untrained traditional Dai's	5.1.1	Home Delivery should be conducted by SBA trained Staff Nurse or ANM.	NA	
				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	
				5.1.3	Delivery kit (equipment, medicine)for ANM should be supplied	Rs 10000 per PHC	
				5.1.4	Supply of delivery Kits as per number of deliveries conducted in home.	NA	
		5.2	Reporting of home delivery is not done so the PNC is not provided	5.2.1	Incentive based system for reporting of home delivery by ASHA and it should linked with ANM	NA	
		5.3	Non paiment of Home delivery through JSY	5.3.1	The JSY money to the mother who has delivered baby at Home paid by ANM.	Rs 500 per home delivery for approx 33000 home deliveries	
6	**To strengthen HSC for providing outreach maternal care**	**Infrastructure**					
		6.1	Out of 305 HSCs only76 are having own building	6.1.1	Strengtheing of HSCs having own buildings		
		6.2		6.2.1	White washing of HSC buildings.	Rs 2000 per PHC	
				6.2.2	Organize adolescent girls for wall painting and plantation./hire local painter for colourful painting of HSC walls.	NA	
				6.2.3	List out all services which is provided at HSC level. On the wall.	NA	
				6.2.4	Gardening in HSC premises by school children.	NA	
		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.	
					Arrangement of water supply upto HSC (Wiring) from water source	Rs 5000 per HSC	

To strengthen HSC for providing outreach maternal care	6.4	Lack of apropriet 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	
			6.4.2	Purchase of equipments according to services	NA	
			6.4.3	Purchase one almarah for keep all equipment safely and it could be keep in AWW / ASHA house.	Rs 10000 per HSC	
	6.5	Non payment of rent of 299 HSCs for more than three years	6.5.1	Strengthening of HSCs running in rented buildings.		
			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)	
			6.5.3	Streamlining the payment of rent from the month of April 09.	Rs 300 per HSC per month for 12months(from State fund)	
			6.5.4	Purchase of Furniture as per need where building is on rent	From untied fund	
			6.5.5	Prioritizing the equipment list according to service delivery	NA	
			6.5.6	Purchase of equipments as per need	From untied fund	
	6.6	The district still needs 135 more HSCs to be formed.	6.6.1	Construction of new HSCs. 39 are having own building, 54 new is proposed and rest 480 are supposed to be constructed.	From State Govt fund	
			6.6.2	Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs	NA	
			6.6.3	Community mobilization for promoting land donations at accessible locations.	NA	
			6.6.5	Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings.	NA	
To strengthen HSC for	6.7	Non participation of Community in monitoring construction	6.7.1	Biannual facility survey of HSCs through local NGOs as per IPHS format	Rs 200 per HSC per biannually	

	providing outreach maternal care		work	6.7.2	Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format.	NA	
				6.7.3	Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project.	NA	
				6.7.4	Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work.	Rs 20000 per PHC	
				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	
		6.8	Lack of community ownership in the	6.8.1	Formation and strengthening of VHSCs, Mothers committees,	NA	
				6.8.2	"Swasthya Kendra chalo abhiyan" to strengthen community ownership	NA	
					One week Training of Nukkad Natak team on IPHS	Rs 300 per participant per day for 85 persons for 7 days	
				6.8.3	Nukkad Nataks on Citizen's charter of HSCs as per IPHS	Three days performance at 339 HSCs	
				6.8.4	Monthly meetings of VHSCs, Mothers committees	NA	
7		**Human Resource**					
		7.1	1.Out of 29 sanctioned post of LHVs only 24 are placed, 2.All 397 posted ANM ® are not trained enough to deliver services. 3. 248 seats of contractual ANM	7.1.1	Selection and recruitment of 440 ANMs	honorarium of 440 ANMs @ Rs 6000 per month for 12 months	
					Honorarium of existing 202 ANMs	Honorarium of existing 248 ANMs @ rs 6000 per month for 12 months	
				7.1.3	Training need Assessment of HSC level staffs by BHM in weekly meeting	NA	

				7.1.4	Training of staffs on various services in the PHC,	Rs 1000 per participant (Total no of participants 650 existing ANMs and 28 new male workers)	
	To strengthen ANM Training School for providing regular training of ANMs.	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		
				7.2.2	Deployment of required staffs/trainers		
				7.2.3	Hiring of trainers as per need		
				7.2.4	Preparation of annual training calendar issue wise as per guideline of Govt of India.		
				7.2.5	Allocation of fund and operationalization of allocated fund	Lmsm Rs 200000 in a year	
8	**To strengthen HSC for providing outreach maternal care**	**Drug Kit Availability**					
		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, DECs)and contraceptives,	8.1.1	Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports	NA	
			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	
				8.1.3	Hiring vehicles for supply of drug kits through untied fund.	Rs 600 per HSC per month	
				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	
				8.1.5	Hiring of couriers as per need	Rs 50 per courier for 200 couriers for 8 days per month	
				8.1.6	Payment of courier through ANMs account	Fund for the payment of Couriers should be transferred to ANMs account.	

9	**To strengthen HSC for providing outreach maternal care**	**Performance**					
		9.1	Unutilized untied fund at HSC level	9.1.1	Training of signatories on operating Untied fund account, book keeping etc	Rs 100 per person for two persons for 339 HSCs	
				9.1.2	Timely disbursement of untied fund for HSCs	Rs 10000 per HSC per year for 339 HScs	
				9.1.3	Assigning a person at PHC level for managing accounts	NA	
		9.2	No ANC at HSC levelOnly 25% PW registered in first trimesterPW with three ANCs is 25.2%, TT1 coverage is 50%,	9.2.1	Identification of the best HSC on service delivery	NA	
				9.2.2	Listing of required equipments and medicines as per IPHS norms in facility survey	NA	
				9.2.4	Honouring the ANM those who devlop women friendly HSC in given criteria (list is attachet)	5 ANM in a year per PHC social honouring with one shawl.	
		9.3	Family Planning Status:-Any method-30.9%,Any modern method-27.2%,No sterilization at HSC level,IUD insertion -1.5%,Pills-1.4%,Condom-2.6%,Total unmet need is 40.7%, for spacing-14.8%,Lack of councelling Skill.	9.3.1	Gap identification of 39 HSCs through facility survey	NA	
				9.3.2	Eligible Couple Survey	NA	
				9.3.3	Ensuring supply of contraceptives with three month's buffer stock at HSCs.	State Fund	
				9.3.4	One day training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS	Rs5000 per PHC	
				9.3.5	Training of ANMs on IUD insertion	Rs 10000 per PHC	
		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	
	To strengthen HSC for providing outreach maternal care			9.4.2	Strengthening ANMs for community based planning of all national disease control program	NA	
				9.4.3	Reporting of disease control activities through ANMs	NA	
				9.4.4	Submission of reports of national programs by the supervisors duly signed by the respective ANMs.	NA	

		9.5	90% of the HSC staffs do not reside at place of posting	9.5.1	Submission of absentees through PRI	NA	
		9.6	Problem of mobility during rainy season	9.6.1	Purchasing Life saving jackets for all field staffs	3 units per PHC at the rate ofRs 3000 per unit	
				9.6.2	Providing incentives to the ANMs during rainy season so that they can use local boats.	From untied fund	
		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	
				9.7.1	Monthly Video shows in all schools of the concerned HSC area schools on health, nutrition and sanitation issues.	From untied fund	
		9.8	Lack of Knowladgae and skill of fileld level staff of data compilation in HMIS formats and formate.	9.8.1	Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc	NA	
				9.8.2	Printing of adequate number of reporting formats and registers	Discused earlier	
10	**To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas**	10.1	Out reach camps are not orgnised in plan mannaer. It is totally baes on demand of orgnisation and it eventually it is not reported to respective HSCs and PHC.	10.1.1	Identifying Socially Backward, Slums & Maha Dalit Tolas.	NA	
				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	
				10.1.3	Fixed day OPD clinics at APHC level and adjoining HSC of respective APHCs. with dedicated MO and support staff.	NA	
				10.1.4	To make calendar for camps with date and identified areas.and link NGOs those who are willing to orgnised Camps .	NA	
				10.1.5	Community based reporting system through SMS. involve PRI members and training on reporting and Camp	NA	

					approach		
11	**To improve adolescent reproductive and sexual health**	11.1	No training programme for adolescent particularly health and sex.	11.1.1	Multipurpose counselor can be used for adolescent care. For this services of LHV can be used.and callender of activity could be devlop.	NA	
		11.2	Preventions of anemia in adolacencent girls	11.2.1	linkage with adolacent anemia controle programme in Schools with Unicef. And traing to the one teacher from the school	Rs 5000 per PHC	
		11.3	Marriage before legal age.	11.3.1	Senstigation of PRI members pertculerly women	Rs 5000/-Per PHC	
		11.4	Preventions of teen age pregnancy and abortion.	11.4.1	Adolescent pregnancy should be addressed with priority care(eclampsia, 3 ANC, anemia, 100 IFA, 100% institution delivery, low birth Wight baby, Brest feeding.PNC with in 48 hours.	NA	
		11.6	Limited interventions for empowering adolescent girls	11.6.1	Family counseling for adolescent pregnancy tracking on above mention through ASHA and AWW.	NA	
				11.6.2	State to develop and issue guidelines for implementation of Kishori MandalsFormation of Kishori Mandals by registration of all girls(11-18 yrs)	NA	
	To improve adolescent reproductive and sexual health			11.6.3	Prepare a monthly plan of activities for one day per week	NA	
				11.6.4	Counseling nutrition, health and social issues every week at AWCs by AWW	NA	
				11.6.5	Weekly distribution of IFA Tablets to out-of-school girls at AWCs	From State	
				11.6.6	Deworming adolecent every 6 months	Purchase of 12 lakh tablets	
				11.6.8	Initiate family schools for learning child care , safe mother hood life skills and Family life education	Rs 10000 per Schools each in each PHC	

12	**To provide MTP services at health facilities**	12.1	MTP services are not available in Public sectors	12.1.1	Selection of facilities for provision of safe abortion services	NA	
				12.1.2	Location of facility availability of trained service provider, space, equipments.	NA	
				12.1.3	To Provide appropriate equipments at all facilities and MVA syringes.	50000/-per PHC	
				12.1.4	Putting the trained doctors at appropriate facilities to commence the services	NA	
				12.1.5	Training of Medical officers and Para medical staffs on Safe abortion services training including awareness about legal aspects of MVA/ EVA and Medical abortion by IPAS .	One docter and one ANM from each PHC @ Rs 2000	
				12.1.6	Formation of district level committee (DLC) to accredit private sites as per GOI guide line .	NA	
				12.1.7	Develop reporting system of MTP services in private and public secter.	NA	
				12.1.8	Through training program make the govt doctors skilled to perform MTP in the approved sites.	NA	
	To provide MTP services at health facilities			12.1.9	To Involve community to aware about location of services , process and legal aspects of MTP services through - AWW, ASHA & ANM, LRG and mass media.(IEC)	Rs 5000/-Per PHC	
				12.1.10	The services of Pregnancy testing should be strengthen and it should be linked with MTP services.	NA	
				12.1.11	NGO's and local Practitioner should be involved for counseling and information of facility	NA	
				12.1.12	Assurance of privacy and link with family welfare services counseling at all facility.	NA	

				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	
				12.1.14	Training of ASHA on medical abortion.	Incorparoted in ASHA training	
13	**To strenghten Monthly Village Health and Nutrition Days**	13.1	Nutrition and Counseling Component is not visible in VHND and there is no monitoring of VHND activity by Community.	13.1.1	AWC should be develop Hub of activities (VHND)	NA	
				13.1.2	Develop an activity plan calendar for VHND as seasonality.	NA	
				13.1.3	Counseling of mothers on ANC, preparation for Child care ,STI/RTI, and AYUSH, adolescent Health	NA	
				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	
				13.1.4	Meeting of VHSC and preparation for area specific epidemiological planning and community based monitoring.	NA	
				13.1.5	Skill development training is required to ANM , ASHA & AWW and Dular (LRG)	Rs 5000 per PHC	
				13.1.6	Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourish children , New born, DOTs and other services	From untied fund	
				13.1.7	SMS reporting system of conducting VHND and ANM collect Data from field level and compile it in weekly/Monthly	NA	
B	**APHC**		**Infrastructure**				
	To form /strenghten APHC in Phase manner	1.3	Out of 25 APHCs only 8 are having own building	1.3.1	Registration of RKS	NA	

		1.4	Existing 8 buildings are not properly maintained	1.4.1	Rennovation of APHCs buildings from RKS Fund	Rs 150000 per APHC	
		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	
		1.6	Lack of equipments,	1.6.1	Purchse of equipment as per service need from RKS fund	From state fund	
		1.7	Lack of appropriate furniture	1.7.1	Purchase of Furniture from RKS fund	From state fund	
2			**Human Resource**				
		2.1	in the district no any APHC functioning as per IPHS norms	2.1.1	Operationalising one APHC in each PHC by conducting daily OPD by Docter. And support staff.	NA	
		2.2		2.2.1	Notification from district for oprationaliing APHC	NA	
3			**Drug Supply**				
		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.	
5	**RTI/STI services at health facilities**	5.1	No regular clinic at all PHCs & APHCs.	5.1.1	Trained service provider on syndrome management of RTI/STI (As per GOI guide line) up to APHC level.	Rs 1000/- for Two person from each PHC	
				5.1.2	Logistics of setting of clinics and free drugs availability	NA	
				5.1.3	Integrated Counseling services in four public sector facilities by trained personnel .	NA	
				5.1.4	IEC/BCC for awareness available RTI/STI services at all health facilities.	Rs20000 for Per PHC	
						Total	3

T.B.					
	Indicators	**Gaps**	**Activities**	**Unit Cost**	**Tota**
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	
		Microscopes of many Designated Microscopy Centers(DMC) are not functioning	Supply of New binocular Microscopes	Rs 50000 per PHC	
		Poor Maintenance of Microscopes	Special Training to Lab Technician/Microscopist for maintenance of Microscopes	NA	
2	**HR**	Many DMCs are closed due to lack of Microscopist/Lab Technician	Recruitment Process should be followed.	NA	
			Honurarium for 17 TB technicians	Rs8000 per month for 17 technicians for 12 months	

		Constraint in selection Process of new Staffs by the District Health Society	Obstacle in recruitment Process will be rectified.	NA	
		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	
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	
		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	
		Poor Retrieval of Drug Boxes of Defaulted patient	Retrieval of Drugs may be ensured by STS.	NA	
		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	
		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	
4	**Service Performance**	Poor quality of DOTS	Proper and Regular supervision and monitoring of programmes will be ensured.	NA	
		ANMs providing DOTS at the HSCs do not visit the Center on DOTS day resulting irregular intake of drugs by the patient causing poor Cure- rate.	Motivation and Sensitization of Staffs by Refreshment training for friendly behavior with patient	NA	
		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	
		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	
		Poor Case Detection i.e., <70%		NA	
		Poor Cure Rate i.e., <85%	Organizing Community meetings	NA	
		High Default Rate		NA	

			Medical Officers should take care of referring all chest symptomatic patients for sputum examination	NA	
			Proper Follow-up Schedule should be maintained	NA	
			Proper care for side effects of drugs.	NA	
			Total Budget		

	Filaria				
Gaps	issues	Strategy	Activities	unit Cost	Total Budget
It affects mainly the economically weaker sections of communities		1. Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.	Line listing of the cases	NA	0
			Purchse of equipments for the management of Filaria cases like towel, Bucket, soap, mug etc	Rs 500 per HSC for 305	152500
			DEC distribution through AWCs and paying hon to AWWs for this.	Rs 100 for all 2672 AWC	224600
			Purchse of DEC	Rs 300000	300000
			Training to AWWs/ASHA on DEC distribution and filaria case management	Rs 2000 per PHC	40000

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	40000
			Total budget		757100

Logical Framework						
oal	**Sl.**	**Impact indicators**				
o improve stitutional tup as per PHS	1.1	Improved service delivery For women and child friendly with quality				
o bring quired chitectural orrection in e stitutional ystem						
bjectives	**Sl.**	**Outcome indicators**	**Sl.**	**Strategy**	**Sl.**	**Output indicators**
o strengthen GOs artneship/ PP for ommunitisat n of Health rvices .	1.1	No and Type of MOU signed between NGO and DHS/RKS for strengthening of communitization of health servies and NGO partnership/ PPP in place	1.1.1	To enforce PNDT Act and to increase sex ratio of female child	1.1.1.1	% decrease in sex selective abortions. % increase in birth of female babies (delivery registers)
			1.1.2	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routeen facilty where it is not functional.	1.1.2.1	No of cases supported by referral transport system under PPP.
					1.1.2.2	No of canteen facility functional at insttutional facility level.
					1.1.2.3	No of STD booth and other routine facility carried out under PPP.

					1.1.2.4	No of cases supported and payments made by RKS/ DHS to BPL families in availing these services
			1.1.2	To develop partnership with NGO Programmes in the districts	1.1.2.1	No of partnership with NGO for programme implementation for MCHN, Micronutrient supplimentation, national programme implementation specially Kalazar elimination
				Strengthen Logistics management system for regular supply of Drugs and equipments	1.1.2.2	No and % of drug & equipments available and supplied (stock ledger)
				Devlop a strong Monitoring & Evaluation / HMIS System in all PHC	1.1.2.3	Regular monitoring and evaluation reports
o devlop EC and BCC nd Training upport ystem .	3.1	No of IEC materials developed and BCC event carried out No of training support system developed	3.1.1	Establising BCC and training cell at District & BPHC level	3.1.1.1	Functional BCC cell at DHS/ RKS level
				Net working with folk media team	3.1.1.2	No of folk media team engaged in BCC activity. Type and No. of BCC event oragnised
o strengthen SHA upport ystem	4.1	No of ASHA capacities	4.1.1	Develop ASHA support System in all PHC(One persion per 20 ASHA)	4.1.1.1	Establishment of ASHA support system at DHS and RKS level
	4.2	No of actvities carried out by RKS	4.1.2	Strengthening RKS	4.1.1.2	No of RKS having monthly meetings.
					4.1.1.3	% of untied fund, JSY fund, referral transport etc utilised

rategy		**Gaps**		Activities	**Unit Cost**	**Budget**
To enforce PNDT Act and to ncrease sex		No registration of ultra sound clinic.		Registration and monitoring of ultra sound clinic.	NA	0

ratio of emale child				MTP clinic should be watched for termination of pregnancy following USG.	NA	0
				IEC on PNDT act	Rs 10000 per PHC	200000
To make Public Private artnerships for referral transport, IPD care canteen acility, STD booth and ther routeen acilty where it is not functional.		Out sourcing of services is not as per the need of local Need and BPL families are not exampted from Fee of out source services		District /PHC level managers should be aware about the TOR of PPP which is finalized at State level.	NA	0
				Build the capacity of manager to manage contracts of PPP	NA	0
		There is an acute shortage of para medics like radiographer, lab technician, ECG technician etc. in the state.		Accreditation of institutions and to set standards, an institute of paramedical sciences may be started in the state. This would create more employment opportunities in addition availability of para medical personnel for absorption into the government health system.	NA	0
Devlop artnership with NGO rogrammesi the districts		**Non involvement of NGO in F.P programme, Institutional delivery, Blindness control programme.**		listing of NGOs those who are working in F.P ,MTP,programme, Institutional delivery, Blindness control programme.	NA	0
				Accreditation of these facility from state Health Socity.	NA	0

		There is no any MOU with NGO/VO/individuals for Donation and volantory support in PHC		Process of MOU should be dicentrlization and it should oprationlise through RKS.	NA	0
		Strainthening 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 Faclitatore will be manage at the PHC level	NA	0
				Honourarium to DPM, DPM(ASHA), DAM and DA	Rs 35000 pm for DPM, Rs 30000 pm for DPM(ASHA), Rs 30000 pm for DAM and Rs 25000pm for DA	1320000
				Capacity building training programme for NGOs office bearer with the help of professionals on linkage with health system strengthening component.	Rs 5000 per PHC	85000
				Mentoring Group at district level.	NA	0
				Reporting mechanism should be develop of NGOs work in the district.	NA	0
		There is no any VHSC in the district.		Co-ordination with community based orgnisation as SHG, LRG, VEC, ,PRI for VHSC formation.	NA	0
Capicity buiding of Managers nd Doctors.				Exposure visit for DPM/BHM /ASHA DPM/ selected ASHA to other state where facility is comparatively working better.	Rs 1000000 for the district	1000000

				To start DNB (Family Physician) 3 year course in the district hospitals.	Rs 100000 for the district	100000
				ASHA/ AWW career advancement programme may planned to retain them in the system. Seats in the ANM course, staff nurses and other paramedical courses may be reserved for the qualified ASHAs	Rs 10000 per PHC	200000
repration of centrlised istrict ealth ction Plan		First time five members of the districts were trained on DHAP prepration		Trainings of DPMU,BPMU members on implementation of services/ various National program and district Health action Plan through distance education	1 DPM, 20 Doctors(One from each PHC) , 20 BHMs and district planning team	80000
				Start prepration of plan from the month of October with sitution anlysis,Facility survey,line reporting system and qulitative finding from Community and users of facility.	Rs 50000 for the district	50000
Devlop a strong Monitoring & Evaluation / HMIS ystem in all PHC		Monitoring of all programme is one of the weakest link of all programme. Lack of Supervisers in all PHC Lack of skill of use of data Community is not aware about monitoring aspects of Health Programme.		Distribution of role and responsbility among MO and Managers of programme implementation.	NA	0
				Use Process indicatore as monitoring of respective programme.	NA	0
				Devlop Programme review calander for review of HSC/PHC performance as per	NA	0

				form 6 & 7		
				Gradation of Health Sub centers in three categories.	NA	0
				Information exchange visits among ANM acording to Grade.	NA	0
				Social recognition of Grade one ANM.	NA	0
				Develop four potential VHSCs in all PHC on Community based Monitoring of Health and Nutrition programme.	Rs 2000 in each PHC	40000
				Organise"JAN ADALAT" in with PRI & VHSC and invite nearby VHSC to observe thr process of "JAN ADALAT"	NA	0
				Devlop Health and Nutrition Report Card by using growth monitoring chartsof Village and prasent in "JAN ADALAT" By VHSC	Rs 2000 in each PHC	40000
Strenthen Logistics anagement 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 comarativaly stroger then other logistic work.		Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports	NA	0
				Hiring vehicles for supply of drug kits	Rs 20000 per PHC per month	4080000
				Hiring of couriers as per need	Discussed in maternal health	0
				Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow,	Discussed in maternal health	0

				Third reminder-Red)		
				Training of all ANM and Stock keepers on Indenting and Logistic Management.	Rs 5000 per PHC	85000
				Devlop TMC modal for Logistic Management in the state.	NA	0
Establising BCC and raining cell t District & PHC level		There is not as such disignated post for BCC and Traning at the district and PHC level		ASHA Programme manager facilitate the process of traning and BCC in the district and ASHA Faclitatore will be manage at the PHC level	NA	0
				Devlop resoure team at District Level.	NA	0
				MOU with Local NGOs for logistic management of training and Devlop issues wise Master traners in district	Na	0
				Devlop ASHA support system on one person/20 ASHA for on the job training of AHSA and AWW	NA	0
Net working with folk media team		There is no BCC management unit at Distrct Level		Identify Health Communication orgnisation for identification of BCC issues as per need of District.	Discussed in child health	0
				MOU with orgnisation for formative reaserch .	NA	0
				Devlop IEC/BCC material based on Findings of formative reasrch	Discussed in child health	0
				Printing of IEC and BCC material	Discussed in child health	0

				Training of Folk Media group on IEC/BCC material	Discussed in maternal health	0
				Planning of performance route chart of Folk media Group	NA	0
				Monitoring of performance through SMS of PRI members	NA	0
				Impact analysis of Performance by Orgnisation	NA	0
traenthening KS		RKS are not uniformally fungtioning in the district		Ensure ragistration of RKS of all fungctional APHC	NA	0
				Training of RKS signatory and BHM on finincial Management of RKS	Discussed in maternal health	0
				presentation of case study of fungctional RKS in district level Meeting.	NA	0
trengthening ommunity rocess rough pportive pervision f ASHA rogram		Poor monitorinng mechanism of ASHA program		Appointment of PHC level ASHA facilitator	Rs 18000 per Facilitator per month for 20 facilitator	4320000
				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
					Total	17630000

Programme wise Budget

Srl No	Budget Head	%	Total Budget
1	Kala azar	2.18%	10020840
2	Filaria	0.17%	757100
3	Blindness	0.97%	4434000
4	Child Health	2.79%	12775000
5	Maternal Health	79.28%	363593400
6	Family Planning	5.43%	24900000
7	Institutional Strengthening	3.84%	17630000
8	TB	0.77%	3525000
9	R.I/Mushkan	4.11%	18872300
10	Leprosy	0.46%	2128000
11	Total		**458635640**

Chapter 4

Setting Objectives and Suggested Plan of Action

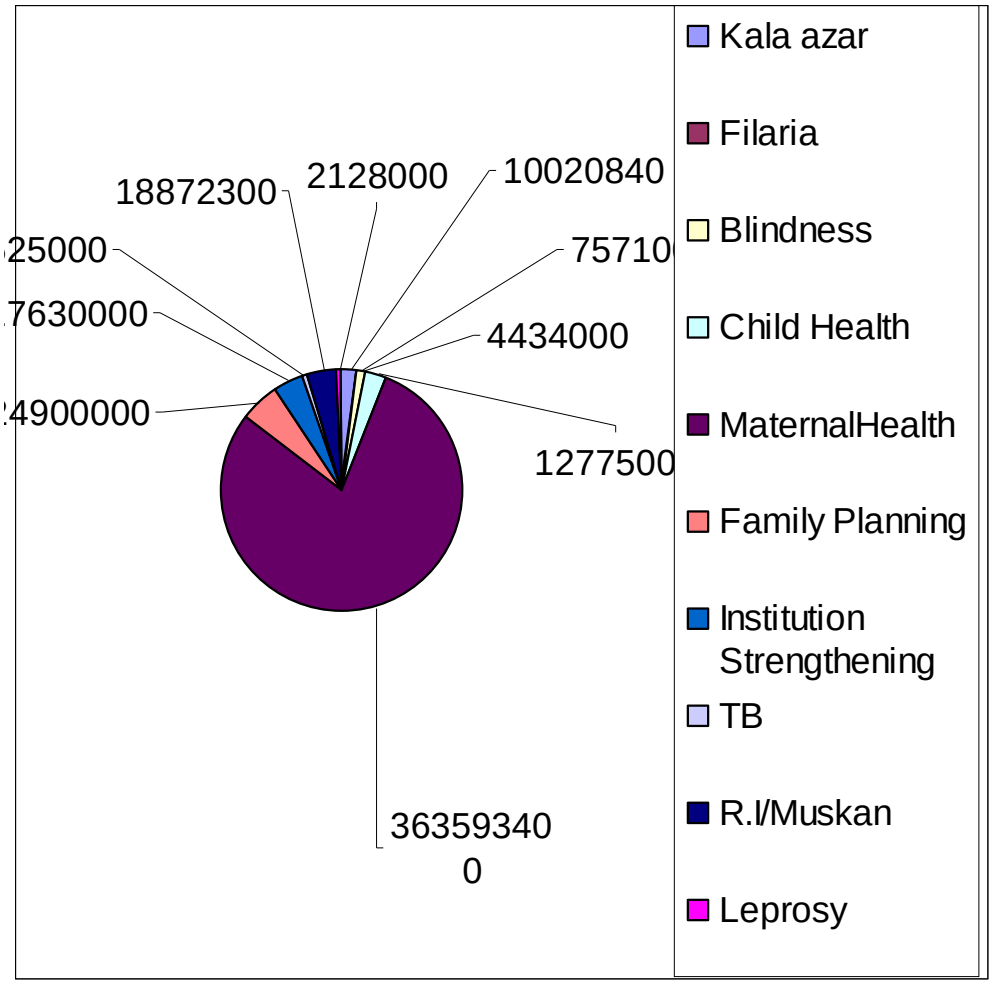
4.1 Introduction

District health action plan has been entrusted as a principle 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 stakeholders 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 five years (2007-12).

Srl No	**Budget Head**	**Total Budget**
1	Kala azar	10020840
2	Filaria	757100
3	Blindness	4434000
4	Child Health	12775000
5	MaternalHealth	363593400
6	Family Planning	24900000
7	Institution Strengthening	17630000
8	TB	**3525000**
9	R.I/Muskan	18872300
10	Leprosy	2128000
11	**Total**	**458635640**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2128000
10020840
25000
75710
7630000
4434000
4900000
1277500
36359340
0
Kala azar
Filaria
Blindness
Child Health
MaternalHealth
Family Planning
Institution Strengthening
TB
R.I/Muskan
Leprosy