District Health Action Plan

2009-2010

Bagmati River Bridge (Dubba Pool), Sheohar

District Health Society, Sheohar

Sub. Divisional Hospital Campus, Sheohar (Bihar)

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Foreword

Districts vary widely in needs and even more widely in possibilities for intervention. Thus, in one district there may be a problem of poor infrastructure whereas in another district shortages of man power other resources. In one district there may be a problem of drug resistance in malaria control programme, where as in another district the need may be to integrate malaria control with filarial control. Thus strategies have to be district specific not only because health needs vary, but because perceptions at people and capacities to conduct programmes also vary.

In a plan which is centrally made and driven, there is little room for such adaptation. District level planning is a necessary component of any effort at decentralization.

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

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

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

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

I hope this District Health Action Plan will help in achieving the goals of National Rural Health Mission (NRHM). It will enable health care personnel to serve people smoothly. DHAP seeks to achieve pooling of financial and human resources allotted through various central and state programmes by bringing in a convergent and comprehensive action plan at the district level. DHAP and its subsequent implementation would inspire and give new momentum to the health services in the District of Sheohar.

Suresh Prasad Singh, IAS
(DM, Sheohar)

About the Profile

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

The information related to data and others used in this action plan is authentic and correct according to my knowledge as this has been provided by the concerned medical officers of every block. I am grateful to the state level consultants, DPM, DAM, DA, MOICs, Block Health Managers, ANMs from their excellent effort.

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

Prasant Kumar
DPM
Sheohar

Dr. Pramanand Dutta
Civil Surgeon
Sheohar

Chapter-1

Introduction

1.1 Background

District Health Action Plans are not a new idea. However they have currently assumed a new centrality and urgency in the context of NRHM.

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

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

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

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

formulated through a participatory and bottom up planning process. NRHM-DHAP is anticipated as the cornerstone of all strategies and activities in the district.

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

Stakeholders in Process

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

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

1.2 Objectives of the Process

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

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

1.3 Process of Plan Development

1.3.1 Preliminary Phase

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

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

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

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

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

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

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

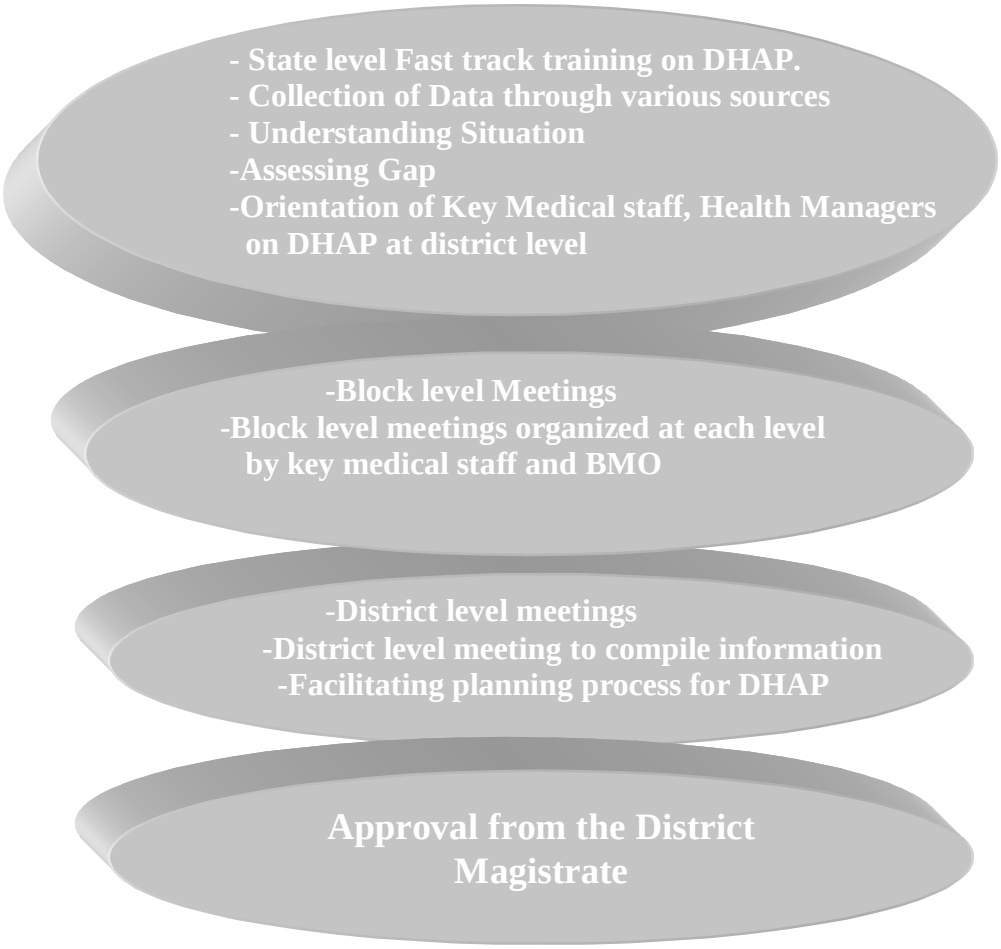
This Integrated Health Action Plan document of Sheohar district has been prepared on the said context.

1.4 Preparation of DHAP

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

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

District Health Action Plan Planning Process



Chapter 2

District Profile

2.1 History

Sheohar is an administrative district in the state of Bihar in India. The district headquarters are located at Sheohar, and the district is a part of Tirhut Division. This district was carved out of Sitamarhi district on October 6, 1994. The district occupies an area of 443 km² and has a population of 515961 (as of 2001). This district has mixed population of Hindus and Muslims. Agriculture is the main stay. It is one of the most flood affected district in Bihar. Dekuli is a holy place popular for ancient temple of lord shiva.

Sheohar is around 150 km in the north and east from Patna, the capital of Bihar. The buses to Sheohar passes through Muzaffarpur. It is 55 km from Muzaffarpur. Sheohar is connected to the adjoining districts(East Champaran headquartered at Motihari, Muzaffarpur, Sitamarhi) by road. Sitamarhi lies to the east of Sheohar. To the west is East Champaran. And to the south-east is Muzaffarpur. There are no railways connecting these districts. The main occupation of the people of this district is agriculture. All types of crops are produced. Varieties of rice, wheat, and a number of *rabbi* crops are produced.

2.2 Geographical Location

Sheohar is located at coor 26.52N, 85.3E. It has an average elevation of 53 metres (173 feet). It is divided into five blocks-Piprahi, Purnahiya, Sheohar, Taryani and Dumri Katsari. It was carved out of the district of Sitamarhi in the year 1994 due to the efforts of Raghunath Jha, a popular leader of this region.

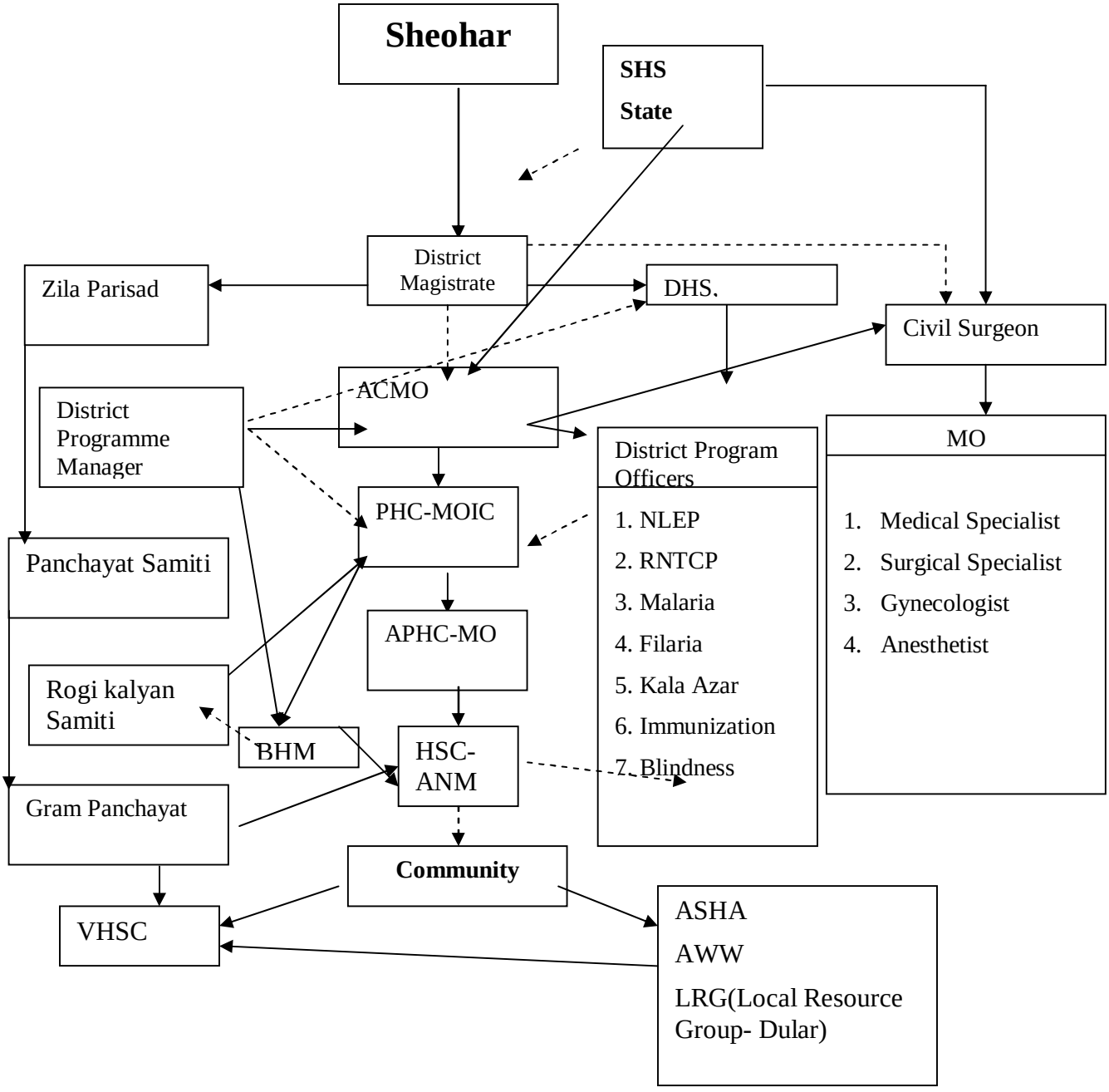
2.3 Demographics

As of 2001 India census, Sheohar has a population of 515961. Males constitute 53% of the population and females 47%. Sheohar has an average literacy rate of 35%, lower than the national average of 59.5%: male literacy is 44%, and female literacy is 25%. In Sheohar, 20% of the population is under 6 years of age.

Govt's Administrative Set-up

There are only one division and 5 Blocks in the District. The District has 207 revenue villages and 53 Gram panchayats, Nagar Nikay 1 and 5 Police Station.

District Health Administrative Setup



2.4. ADMINISTRATIVE UNITS AND TOWNS IN SHEOHAR DISTRICT

PHC	Community Development Blocks	Towns	Assembly Segments
Sheohar	Sheohar	Sheohar	Sheohar
Piprahi	Piprahi		Sheohar
Purnahia	Purnahia		Sheohar
Dumri Katsari	Dumri Katsari		Sheohar
Tariyani	Tariyani		Belsand

Lok Sabha (Parliamentary) – Sheohar

2.5 SHEOHAR – POPULATION AT A GLANCE (2001 Census)

BLOCK NAME	TRU	TOT_P	TOT_M	TOT_F	P_SC	M_SC	F_SC	P_ST	M_ST	F_ST
Sheohar Distt.	**Total**	**515961**	**273680**	**242281**	**74391**	**39405**	**34986**	**64**	**35**	**29**
Sheohar	Rural	494699	262363	232336	71132	37703	33429	55	27	28
Sheohar	Urban	21262	11317	9945	3259	1702	1557	9	8	1
Purnahiya	Total	71722	38209	33513	11361	6048	5313	8	2	6
Purnahiya	Rural	71722	38209	33513	11361	6048	5313	8	2	6
Purnahiya	Urban	0	0	0	0	0	0	0	0	0
Piprarhi	Total	95441	50325	45116	12357	6478	5879	3	1	2
Piprarhi	Rural	95441	50325	45116	12357	6478	5879	3	1	2
Piprarhi	Urban	0	0	0	0	0	0	0	0	0
Sheohar	Total	122340	65039	57301	18992	10106	8886	17	13	4
Sheohar	Rural	101078	53722	47356	15733	8404	7329	8	5	3
Sheohar	Urban	21262	11317	9945	3259	1702	1557	9	8	1
Dumri Katsari	Total	71405	37837	33568	9399	4980	4419	18	10	8
Dumri Katsari	Rural	71405	37837	33568	9399	4980	4419	18	10	8
Dumri Katsari	Urban	0	0	0	0	0	0	0	0	0
Tariani Chowk	Total	155053	82270	72783	22282	11793	10489	18	9	9
Tariani Chowk	Rural	155053	82270	72783	22282	11793	10489	18	9	9
Tariani Chowk	Urban	0	0	0	0	0	0	0	0	0

2.6 COMPARATIVE POPULATION DATA(2001 Census)

Basic Data	India	Bihar	Sheohar
Population	1027015247	82878796	515961
Socio- Economic			
Sex- Ratio	933	921	885
Literacy % Total	65.38	47.53	35.27
Male	75.85	60.32	45.28
Female	54.16	33.57	23.86

LITERACY RATE		
TOTAL	:-	35.27%
MALES	:-	45.28%
FEMALES	:-	23.86%

2.7 DISTRICT PROFILE

Sl. No.	Variable	Data
1	Total Areas	443 sq. km.
2	Total No. of blocks	5
3	Total no. of Gram Panchayats	53
4	No. of Villages	207
5	No. of PHCs	5
6	No. of APHCs	7
7	No. of HSCs	34
8	No. of Sub divisional hospitals	1
9	No. of referral hospitals	1
10	No. of Doctors	31 (including contractual)
11	No. of ANMs	35 (including contractual)
12	No. of Grade A Nurse	4 (including contractual)
13	Total Population	515961
14	No. of Male Population	273680
15	Female Population	242281
16	Sex Ratio	896
17	SC Population	74391
18	ST Population	0
19	BPL %	31.2%
20	No. of primary schools	228
21	No. of Anganwadi centers	513
22	No. of Anaganwadi workers	493
23	No. of ASHA	495
24	No. of electrified villages	43
25	No. of villages having access to safe drinking water	189
26	No. of villages having motorable roads	68

Population : (census 2001)

2.8 Health Facilities in the District

Health Sub Centers

Sl. No.	Block Name	Population	Sub Centre required	Sub Centre present	Sub Centre proposed *	Further sub centre required	Status of building		Availability of Land (Y/N)
							Own	Rented	
1	Sheohar	122340	24	10	14	-	6	4	N
2	Piprahi	95441	19	6	13	-	4	2	N
3	Dumri Katsari	71405	14	4	10	-	4	0	Y
4	Purnahia	71722	14	5	9	-	1	4	N
5	Tariyani	155053	32	9	23	-	7	2	N
	Total		103	34	69	-	22	12	

* Newly Sanctioned. Landless

Additional Primary Health Centers (APHCs)

Sl. No.	Block Name	APHC required (after including PHCs)	APHCs present	APHCs proposed *	APHCs required	Status of building		Availability of Land
						Own	Rented	
1	Sheohar	4	1	3	3	1	0	N
2	Piprahi	3	1	2	2	1	0	N
3	Dumri Katsari	3	2	1	1	1	1	N
4	Purnahia	2	1	1	1	1	0	N
5	Tariyani	5	2	3	3	2	0	N

* Newly Sanctioned. Landless

Primary Health Centers / Referral Hospital / Sub-divisional Hospital / District Hospital

Sl. No.	Block Name	Population (Census 2001)	PHCs / Referral / SDH/ DH Present	PHCs required (After including referral / DH/ SDH)	PHCs proposed
1	Sheohar	122340	1	0	0
2	Piprahi	95441	1	0	0
3	Dumri Katsari	71405	0	1	0
4	Purnahia	71722	1	0	0
5	Tariyani	155053	1	0	0

Note : 1 Sheohar PHC is situated in the same campus of sub divisional hospital, PHC Piprahi running in its own building. PHC Building for Tariyani, Purnahia and Dumri Katsari is to be constructed. 30 bedded sub divisional hospital is running. District hospital is under construction. Referral Hospitals are not in working condition.

2.9 Human Resources and Infrastructure

Sub-centre database

Block : Piprahi

Sl. No.	Name of Sub Centre	ANMs (R)/(C) posted formally	ANMs (R)/(C) posted required	Building ownership (Govt/ Pri/ Rent)	Building condition (+++/ ++/ +/ #)	Assured running water supply (A/ NA/ I)	Cont. power supply (A/ NA/ I)	ANM residing at HSC area (Y/ N)	Condition of residential facility (+++/++/+/ #)	Status of furnitures	Status of Untied fund
1	Kamrauli	1	1		#	NA	NA	N	#	NA	Yes
2	Singahi	1	1	Govt.	+	NA	NA	N	#	NA	Yes
3	Mahuawa	1	1	Govt.	+	NA	NA	N	#	NA	Yes
4	Amba	1	1		#	NA	NA	N	#	NA	Yes
5	Bairya	0	2		#	NA	NA	N	#	NA	Yes
6	Kuama	1	1	Govt.	+	NA	NA	N	#	NA	Yes

Block : Purnahia

Sl. No.	Name of Sub Centre	ANMs (R)/(C) posted formally	ANMs (R)/(C) posted required	Building ownership (Govt/ Pri/ Rent)	Building condition (+++/ ++/ +/ #)	Assured running water supply (A/ NA/ I)	Cont. power supply (A/ NA/ I)	ANM residing at HSC area (Y/ N)	Condition of residential facility (+++/++/+/ #)	Status of furnitures	Status of Untied fund
1	Barahi Jagdish	0	2		#	NA	NA	N	#	NA	Yes
2	Bedaul Ajam	0	2		#	NA	NA	N	#	NA	Yes
3	Chandiha	0	2		#	NA	NA	N	#	NA	Yes
4	Basant Jagjivan	0	2		#	NA	NA	N	#	NA	Yes
5	Parsauni Gope	1	1	Govt.	+	NA	NA	N	#	NA	Yes

Block : Sheohar

Sl. No.	Name of Sub Centre	ANMs (R)/(C) posted formally	ANMs (R)/(C) posted in position	Building ownership (Govt/ Pri/ Rent)	Building condition (+++/ ++/ +/ #)	Assured running water supply (A/ NA/ I)	Cont. power supply (A/ NA/ I)	ANM residing at HSC area (Y/ N)	Condition of residential facility (+++/++/+/ #)	Status of furnitures	Status of Untied fund
1	Chamanpur	1	R	Rent	#	NA	NA	N	#	#	NA
2	Bisahia	1	R	Govt.	++	NA	NA	NA	N	#	NA
3	Sugia	1	R	Govt.	++	NA	NA	NA	N	#	NA
4	Tajpur	1	R	Govt.	++	NA	NA	NA	N	#	NA
5	Fatehpur	1	R	Govt.	++	NA	NA	NA	N	#	NA
6	Harnahi	1	R	RENT	#	NA	NA	NA	N	#	NA
7	Pavitra Nagar		0	Govt	++	NA	NA	NA	N	#	NA
8	Fatmachak	1	R	RENT	#	NA	NA	NA	N	#	NA
9	Madhopur Anant	1	R	Govt.	++	NA	NA	NA	N	#	NA
10	Sahpur	1	R	Govt.	++	NA	NA	NA	N	#	NA

Block : Dumri Katsari

Sl. No.	Name of Sub Centre	ANMs (R)/(C) posted formally	ANMs (R)/(C) posted required	Building ownership (Govt/ Pri/ Rent)	Building condition (+++/ ++/ +/ #)	Assured running water supply (A/ NA/ I)	Cont. power supply (A/ NA/ I)	ANM residing at HSC area (Y/ N)	Condition of residential facility (+++/++/+/ #)	Status of furnitures	Status of Untied fund
1	Dhanhara	1	1	Govt.	+	NA	NA	N	#	NA	Yes
2	Bhenteha	1	1	Govt.	+	NA	NA	N	#	NA	Yes
3	Jahangirpur	1	1	Govt.	+	NA	NA	N	#	NA	Yes
4	Gajipur		2		#	NA	NA	N	#	NA	Yes

Block : Tariyani

Sl. No.	Name of Sub Centre	ANMs (R)/(C) posted formally	ANMs (R)/(C) posted required	Building ownership (Govt/ Pri/ Rent)	Building condition (+++/ ++/ +/ #)	Assured running water supply (A/ NA/ I)	Cont. power supply (A/ NA/ I)	ANM residing at HSC area (Y/ N)	Condition of residential facility (+++/++/+/ #)	Status of furnitures	Status of Untied fund
1	Sumhauti	1	1	Govt.	+	NA	NA	N	#	NA	Yes
2	Vrindavan	1	1	Govt.	+	NA	NA	N	#	NA	Yes
3	Aura	1	1	Govt.	+	NA	NA	N	#	NA	Yes
4	Belahia Sultanpur		2		#	NA	NA	N	#	NA	Yes
5	Dumma Hirauta	1	1	Govt.	+	NA	NA	N	#	NA	Yes
6	Fetehpur	1	1	Govt.	+	NA	NA	N	#	NA	Yes
7	Chatauni	1	1	Govt.	+	NA	NA	N	#	NA	Yes
8	Tariyani Chapra	1	1	Govt.	+	NA	NA	N	#	NA	Yes
9	Athkoni	1	1	Govt.	+	NA	NA	N	#	NA	Yes

ANM(R)- Regular/ ANM(C)- Contractual; Govt- Gov/ Rented-Rent/ Pan –Panchayat or other Dept owned;
Good condition +++/ Needs major repairs++/Needs minor repairs-less that Rs10,000-+/ needs new building-#;
Water Supply: Available –A/Not available –NA, Intermittently available-I

Additional Primary Health Centre (APHC) Database: Infrastructure

No	APHC Name	Building ownership (Govt/ Pri/ Rent)	Building condition (+++/++/+/#)	Assured running water supply (A/ NA/ I)	Continuous power supply (A/ NA/ I)	Toilets (+++/++/#)	Condition of Labour room (+++/++/#)	No. of rooms	No. of beds	Condition of residential facility (+++/++/+/#)	MO residing at APHC area (Y/N)	Status of furniture	Ambulance/ vehicle (Y/N)
1	Adauri	Gov.	+	NA	NA	+	#	2	6	++	Y	NA	NA
2	Dhankaul	Gov.	#	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
3	Kushar	Gov.	++	NA	NA	++	#	2	NA	#	N	NA	NA
4	Ganga Dharampur	Gov.	#	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
5	Narwara	Gov.	+	NA	NA	++	#	2	NA	#	N	NA	Y
6	Ramvan	Rent	++	NA	NA	++	#	2	NA	#	N	NA	NA
7	Lalgarh	Gov.	#	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Note : APHC Dhankaul, Ganga Dharampur and Lalgarh working in Health Sub Centre Building.

ANM(R)- Regular/ ANM(C)- Contractual; Govt- Gov/ Rented-Rent/ Pan –Panchayat or other Dept owned; Good condition +++/ Needs major repairs++/Needs minor repairs-less that Rs10,000-+/ needs new building-#; Water Supply: Available –A/Not available –NA, Intermittently available-I

3. Situation Analysis: APHC level Infrastructure

The gaps in the availability of PHC are calculated as per the IPHS norms of one PHC at the level of 30,000 population. However in Bihar, the current state practice is of one PHC at one lakh population level. Since APHC function at the level of 30,000 population at present in Bihar, number of present and proposed APHCs is taken into account for the purpose of calculating the overall requirement of PHCs.

The matrix also estimates requirement of CHC in each block. Like sub centres, district has also proposed APHCs.

Additional Primary Health Centre (APHC) Database: Human Resources

No	APHC Name	Doctors		ANM		Laboratory technician		Pharmacists / dresser		Nurses A Grade		Accnt/ Peons /Sweeper/Night Guards	Availability of specialist
		Sanction	In Position	Sanction	In position	Sanction	In position	Sanction	In position	Sanction	In Position		
1	Adauri	2	1	2	1	1	0	1	0	2	0	0	0
2	Dhankaul	2	1	2	1	1	0	1	0	2	1	0	0
3	Kushar	2	1	2	1	1	0	1	0	2	1	0	0
4	Ganga Dharampur	2	0	2	1	1	0	1	0	2	0	0	0
5	Narwara	2	2	2	1	1	0	1	0	2	0	0	0
6	Ramvan	2	1	2	1	1	0	1	0	2	0	0	0
7	Lalgarh	2	1	2	1	1	0	1	0	2	0	0	0

Sub Div. Hospital & Primary Health Centres : Infrastructure

No	Name of PHC / Sub divi. Hospital	Building ownership (Govt/ Pan/ Rent)	Building condition (+++/ ++/ #)	Assured running water supply (A/ NA/ I)	Continuous power supply (A/ NA/ I)	Toilets (A/ NA/ I)	Functional Labour room (A/ NA)	Condition of labour room (+++/ ++/ #)	No. of rooms	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/ ++/#)
1	Sub. Div. hospital, Sheohar	Govt.	+++	A	A	A	A	+++	8	30	A	++	+++
2	PHC Sheohar	Govt.	+	A	A	A	NA	#	2	0	NA	#	#
3	PHC, Piprahi	Govt.	++	A	A	A	A	++	4	6	A	++	+++
4	PHC Purnahia	-	-	-	-	-	-	-	-	-	-	-	-
5	PHC Tariyani	-	-	-	-	-	-	-	-	-	-	-	-
6	PHC Dumri	-	-	-	-	-	-	-	-	-	-	-	-

Note : PHC Purnahia, Tariyan and Dumri Katsari dos not have own building.

Good condition +++/ Needs major repairs++/Needs minor repairs-less that Rs10,000-+/ needs new building-#; Water Supply: Available –A/Not available –NA, Intermittently available-I

Sub Div. Hospital & Primary Health Centres : Human Resources

Sl	Name of PHC & Sub. Divi. Hospital	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses		Specialists*		Storekeeper
		Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	Sub. Divi. Hosp., Sheohar	4	4	0	0	1	1	2/1	0/1	4	2	0	0	0
2	PHC Sheohar	1	1	3	2	1	0	1	0	0	0	4	3	0
3	PHC Piprahi	1	1	4	2	1	0	1	0	0	0	4	4	0
4	PHC Purnahia	1	1	4	0	1	0	1	0	0	0	4	1	0
5	PHC Tariyani	2	2	4	2	1	0	1	0	0	0	4	2	0
6	PHC Dumri	1	0	4	0	1	0	1	0	0	0	4	0	0

Note : Sanction of specialist post for PHC on contract basis. * For doctors 4 specialist posts are sanctioned in each PHC on contract basis but due to unavailability of specialist doctors general MBBS doctors are appointed in those places.

Referral Hospital/CHC : Infrastructure

No	Name of Referral Hospital	Building ownership (Govt/ Pan/ Rent)	Building condition (+++/ ++/ #)	Assured running water supply (A/ NA/ I)	Continuous power supply (A/ NA/ I)	Toilets (A/ NA/ I)	Functional Labour room (A/ NA)	Condition of labour room (+++/ ++/ #)	No. of rooms	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/ ++/#)
1	Refferal Hospital Tariyani Chapra	Govt.	#	NA	NA	NA	NA	#	-	-	NA	#	#

Note : Referral hospital Tariyani chapra building condition is not good.

A ANM(R)- Regular/ ANM(C)- Contractual; Govt- Gov/ Rented-Rent/ Pan –Panchayat or other Dept owned; Good con dition +++/ Needs major repairs++/Needs minor repairs-less that Rs10,000-+/ needs new building-#; Water Supply: Available –A/Not available –NA, Intermittently available-I

Referral Hospital : Human Resources

	No. of /Referral/ CHC	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses		Specialists		Storekeeper
		Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	**1**	**4**	**4**	**0**	**0**	**1**	**0**	**1**	**0**	**4**	**0**	**0**	**0**	**0**

Note : Out of 4 doctors of Referral hospital 2 working in PHC Tariyani and 1 deputed in High Court, Patna.

District Hospital: Infrastructure

No	No. of Sadar Hospital present	No. of Sadar Hospital required	Gaps in Sadar	Building ownership (Govt)	Building Required (Govt)	Gaps in Building	No. of Toilets available	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/++/#)
Under construction													

ANM(R)- Regular/ ANM(C)- Contractual; Govt- Gov/ Rented-Rent/ Pan –Panchayat or other Dept owned; Good condition +++/ Needs major repairs++/Needs minor repairs-less that Rs10,000-+/ needs new building-#; Water Supply: Available –A/Not available –NA, Intermittently available-I

2.10. Equipment

No.	Name of facility	Equipment required
3	Immunization	Deep Freezer, ILR , Vaccine Van
4	Puls Polio	Vaccision Career ect.
5	Filareia	Vehicles etc.

2.11. ROGI KALYAN SAMITI

No.	Name of the Facility	Funds Received	Funds Balance
1	Sub. Divi. Hospital, Sheohar	200000	111547
2	PHC Piprahi	200000	136740

2.12 SUPPORT SYSTEM

No	Facility name	Services available							
		Ambulance	Generator	X-ray	Laboratory services O/I/ NA			Canteen	Housekeeping
		O/I/ NA	O/I/ NA	O/I/ NA	Pathology	Malaria/ kala-azar	T B	O/I/ NA	
1	PHC LEVEL	O	O	NA	NA	NA	I	NA	O
2	Sub. Divi. Hospital	I	O	O	I	NA	I	**NA**	O

O : Outsource, I – In source, NA : Not Available

2.13 HEALTH SERVICES

Name of the District:			
No.	Service	Indicator	District Data
1	***Child Immunization***	% of children 9-11 months fully immunized (BCG+DPT123+OPV123+Measles)	28.3%
		% of immunization sessions held against planned	100%
2	***Child Health***	Total number of live births	3068
		Total number of still births	98
		% of newborns weighed within one week	100%
		% of newborns weighing less than 2500 gm	56.55%
		Total number of neonatal deaths (within 1 month of birth)	-
		Total number of infant deaths (within 1-12 months)	-
		Total number of child deaths (within 1-5 yrs)	-
		Number of diarrhea cases reported within the year	474
		% of diarrhea cases treated	99.5%
		Number of ARI cases reported within the year	-
		% of ARI cases treated	66.5%
		Number of children with Grade 3 and Grade 4 under nutrition who received a medical checkup	-
		Number of children with Grade 3 and Grade 4 under nutrition who were admitted	-
		Number of undernourished children	-
		% of children below 5 yrs who received 5 doses of Vit A solution	12%
3	***Maternal Care***	Number of pregnant women registered for ANC	2948
		% of pregnant women registered for ANC in the 1st trimester	12.9%
		% of pregnant women with 3 ANC check ups	18.9%
		% of pregnant women with any ANC checkup	64.8%
		pregnant women with anaemia	3113
		% of pregnant women who received 2 TT injections	32.01%
		Pregnant women who received 100 IFA tablets	715

		Number of pregnant women registered for JSY	3122
		Number of Institutional deliveries conducted	3080
		Number of home deliveries conducted by SBA	22
		% of institutional deliveries in which JBSY funds were given	100%
		% of home deliveries in which JBSY funds were given	NA
		Number of deliveries referred due to complications	-
		% of mothers visited by health worker during the first week after delivery	-
4	***Reproductive Health***	Number of MTPs conducted	-
		Number of RTI/STI cases treated	-
		% of couples provided with barrier contraceptive methods	-
		% of couples provided with permanent methods	-
		% of female sterlisations	66.14%
5	***RNTCP***	% of TB cases suspected out of total OP	2.25%
		Proportion of New Sputum Positive out of Total New Pulmonary Cases	159
		Annual Case Detection Rate (Total TB cases registered for treatment per 100,000 population per year)	477
		Treatment Success Rate (% of new smear positive patients who are documented to be cured or have successfully completed treatment)	87
		% of patients put on treatment, who drop out of treatment	12.99%
6	***Vector Borne Disease Control Programme***	Annual Parasite Incidence	0
		Annual Blood Examination Rate	0
		Plasmodium Falciparum percentage	0
		Slide Positivity Rate	0
		Number of patients receiving treatment for Malaria	0
		Number of patients with Malaria referred	0
		Number of FTDs and DDCs	0
7	***National Programme for Control of Blindness***	Number of cases detected	402
		Number of cases registered	402
		Number of cases operated	402
		Number of patients enlisted with eye problem	402
		Number of camps organized	10
8	***National Leprosy Eradication Programme***	Number of cases detected	75
		Number of Cases treated	52
		Number of default cases	75

		Number of case complete treatment	75
		Number of complicated cases	-
		Number of cases referred	-
9	***Outpatient services***	Outpatient attendance (Jan 08 to Dec. 08)	150943

2.14 Community Participation

S. No	Name of Block	No. of GPs	No. VHSC formed	No. of VHSC meetings held in the block	Total amount released to VHSC from untied funds	No. of ASHAs	Number of ASHAs trained		Number of meetings held between ASHA and Block offices	Total amount paid as incentive to ASHA
							Round 1	Round 2		
1	Sheohar	-	-	-	-	99	380	0		
2	Piprahi	-	-	-	-	95				
3	Dumri Katsari	-	-	-	-	71				
4	Purnahia	-	-	-	-	73				
5	Tariyani	-	-	-	-	135				
	TOTAL	-	-	-	-	473				

2.15 Training Activities

S.No	Name of Block	Rounds of SBA Trainings held	No. of personnel given SBA Training	Rounds of IMNCI Trainings held	No. of personnel given IMNCI Training	Any specific issue on which need for a training or skill building was felt but has not being given yet
1.	District level	5	20 per batch	NA	NA	Required more training for TOT and block level training to improve the quality of health worker.

2.16 BCC campaigns

No.	Name of Block	BCC campaigns/ activities conducted
1	Sheohar	Community meetting, Mahila Mandal Meetting, I.E.C., etc.
2	Piprahi	Do
3	Dumri Katsari	Do
4	Purnahia	Do
5	Tariyani	Do

2.17. District and Block level Management

S.No	Name of Block	Health Manager Appointed (Y/N)	Accountant appointed (Y/N)	Store keeper appointed (Y/N)
	DISTRICT	DPM-Y	DAM-Y DA-Y	N
1	Sheohar	Y	N	N
2	Piprahi	Y	N	N
3	Dumri Katsari	N	N	N
4	Purnahia	N	N	N
5	Tariyani	N	N	N

2.18. ACHIEVEMENTS : STATUS OF PROGRESS IN DIFFERENT HEALTH PROGRAMS

Sl. No.	Program	Status in 2008-09
01.	OPD facilities	150943
02.	JBSY	3144
03.	FP Operation	1761
04.	Full immunized child	9529
05.	Leprosy	75
06.	Kala-azar	178
07.	TB	477
08.	Blindness Operation	402
09.	AIDS	31
10.	Epidemic (Diarrhea / Dysentery)	474
11.	Filaria	206

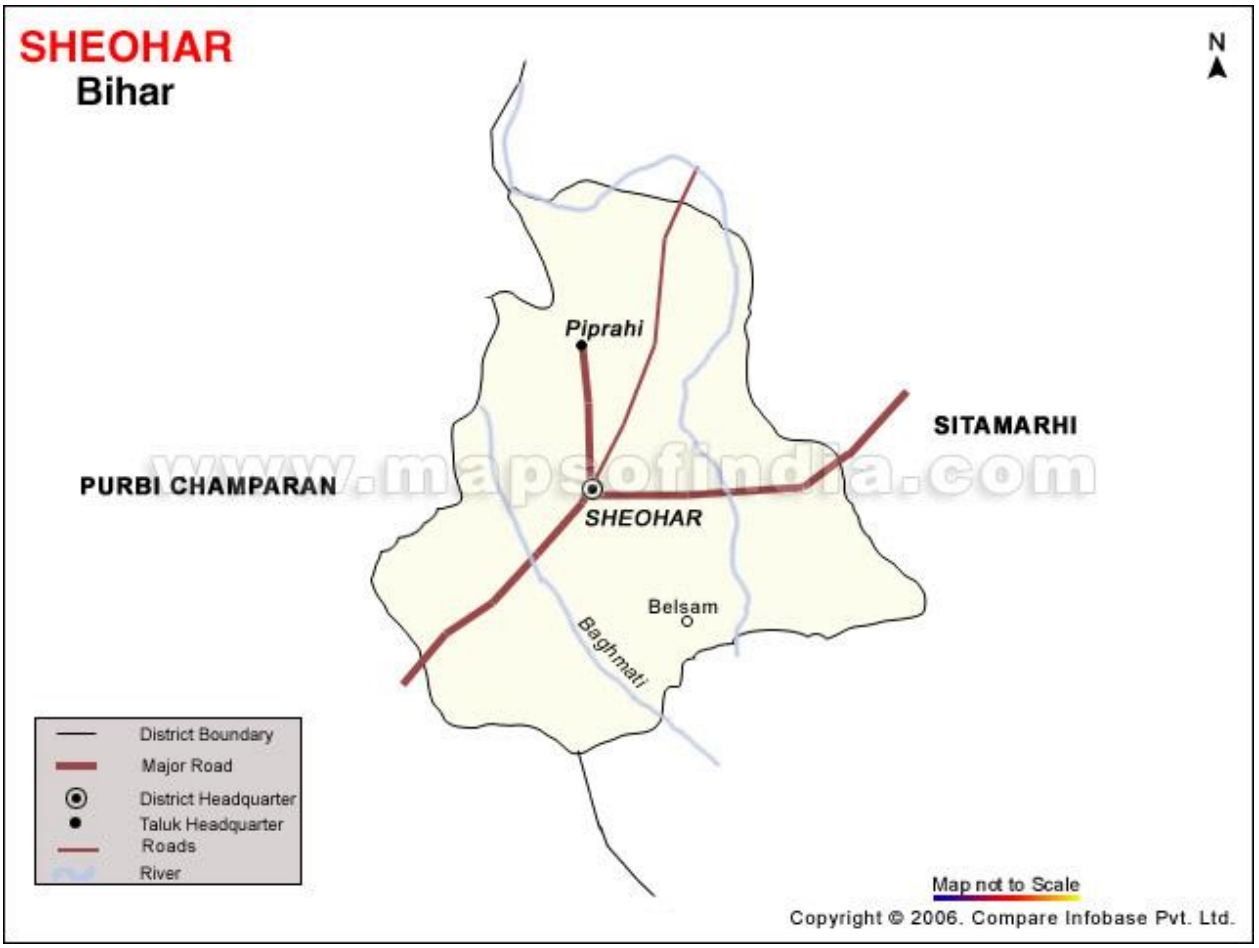
2.19 HEALTH CARE INSTITUTIONS IN THE DISTRICT

S.No.	Type of Institutions	Number
1	District Hospital	0
2	Referal	1
3	Block PHCs	5
4	APHCs	7
5	Sub-centres	34
6	Anganwadi Centres	513
7	Others (Pvt. Facility accredited)	0

2.20 DISTRIBUTION OF PUBLIC HEALTH FACILITIES IN DISTRICT

District Hospital	Sub. Div. Hospital	Community Health Centres	Block PHC	FRU/Referral
0	**1**	**0**	**5**	**1**

2.21 MAP OF SHEOHAR DISTRICT

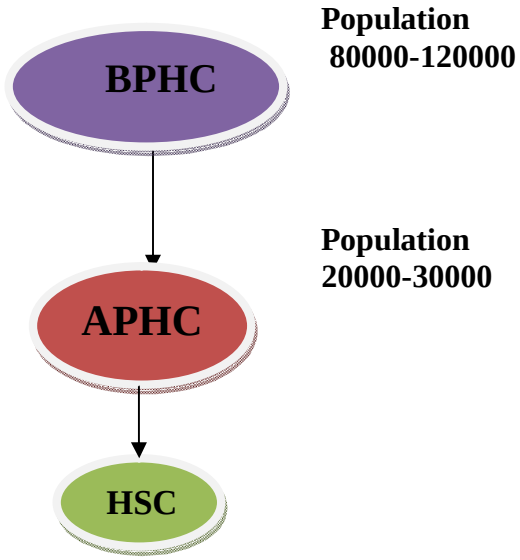


Chapter 3

Situation Analysis

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

3.1 GAPS IN INFRASTRUCTURE:



Introduction:

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

Infrastructure for HSCs:

IPHS Norms:

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

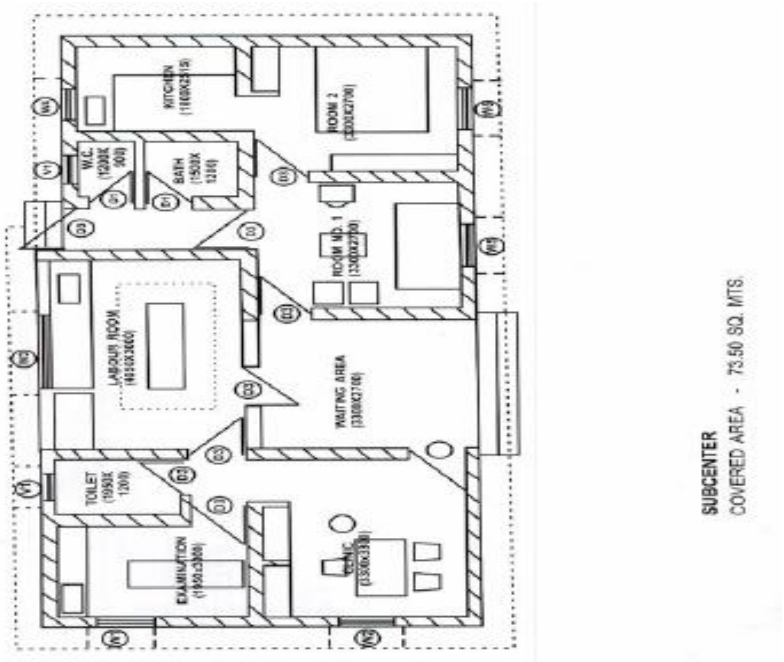
i. Location of the centre: The location of the centre should be chosen that:

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

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

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

Typical Layout of Sub- Centre with ANM Residence



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

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

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

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

3.2 Health Sub Centers: Total population of the district as per 2001 census is 515961. After considering two percent growth rate of the total population it comes around 604985 (Decadal Growth Rate 2.3). After considering projected population in 2008, the district needs altogether 103 HSCs to cater its whole population. At present Sheohar have 34 established Health Sub Centers and 69 more Health sub centers are proposed to be formed. Again, out of 34 established HSCs, only 24 have their own buildings and rest 10 run in rented houses. All these 24 HSCs need renovation work. All the above mentioned HSCs need equipments, drugs, furniture and stationaries.

Health Sub Centers : -- There are 34 HSCs functioning in the district and 69 more are proposed to be established.

Health Sub Centers:				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	1. 34 sub centres are sanctioned in the district 69 others newly sanctioned out of 34 sub centre 10 sub centres have not its own building due to unavailability of land. 2. Lack of appropriate furniture 3. Un utilization of untied fund.	Lack of proper infrastructure, unavailability of land for construction work.	Strengthening of infrastructure. Motivation	1. Construction and renovation of building as per need. 2. Purchase of furnitures and other required materials 3. Proper utilization of untied fund. 4. Proper monitoring of HSC work and construction work. 5. For sub centre Pojhya land is available hence fund is required for same. Besides that in this financial year according to availability of land construction work will be done hence for those places fund also will require.
Human Resources	Lack of ANM & Other staff.	Provision to full fill the vacant position	Staff recruitment, capacity building.	Selection & recruitment of staff as per vacant position. Training assessment and proper training.
Drugs availability	Some times lack of drugs due to supply problems from the agencies.			
Service performance	1. Due to lack of building & man power all HSC have not become yet functional 2. Un-utilized untied fund.	Optimum utilization of available resources	Quality improved and services must be available to all sub centres.	Proper utilization of fund. Insure availability of man power, drugs and other consumables.

3.3 Additional PHCs: -- There are 7 APHCs functioning in the district and 10 more are proposed to be established.

Additional PHC:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	1. 7 APHC are sanctioned and 10 other APHC are newly sanctioned out of 7 APHC only 3 are having own building. 3 APHC are running in sub centre building & one APHC is running in rented building. 2. Lack of equipments 3. Lack of appropriate furniture. 4. No beds available in any place 5. Lack of residential facilities of staff 6. Lack of safe drinking water.	Lack of proper infrastructure. Basic amenities in the buildings lack of land.	1.Strengthening of infrastructure & operationalization of all APHC as 24 hour services 2.Monitoring.	1. Construction of 2 APHC Kamrauli & Jahangirpur where land is available construction work is under process. Fund will be required for the same. 2. Revnovation of APHCs building as per need. 3. Purchase of beds, equipments, furnitures. 4. Provision of residential building for staff. 5. Provision of safe drinking water. 6. Community mobilization for promoting land donation so that construction work can be completed. 7. Monitoring aspects of construction work.
Human Resource	1. Lack of Doctor 2. Lack of ANMs 3. Lack of A Grade Nurses 4. Lack of pharmacists 5. Lack of other paramedical.	Filling of the staff strategy	Staff recruitment Capacity Building	Selection & recruitment of staff per vacancies. Training of untrained ANMs & other staff.
Availability of Drugs	Irregular supply of drugs by the selected agencies of SHSB.	Identity Logistics Operationalization	Strengthening of reporting process & identity system	Training of store keeper implementing computerize system & provision of software for availability of drugs.
Service Performance	No Institutional delivery, No in patients facility, No ANC, No family Planning, No lab	Optimum utilization of available resources	Quality improvement and services must be available to all APHCs	Proper utilization of untied fund. Purchase of un available materials. Insurance availability of

	facility, No OT facility, Un utilized untied fund.			Dais, Nurses, etc. Insure availability of drugs and other consumables.

3.4 Primary Health centers: 5 PHCs are sanctioned in the district namely PHC Sheohar, PHC Piprahi, PHC Tariyani and PHC Dumri Katsari.

PHC Sheohar : PHC Sheohar is situated in the same campus of sub divisional hospital Sheohar, hence OPD and IPD is not required National Programmes, Routine Immunization, Muskan Programme, ASHA workers are being conducted.

PHC Piprahi : PHC Piprahi is six bedded and running in its own building.

PHC Tariyani : It has no own building. At present it is running in APHC Narwara.

PHC Purnahia : It has no own building. At present it is running in Jila Parisad Hospital, Purnahia.

PHC Dumri Katsari : It has no its own building. It is running in PHC Sheohar.

Primary Health Centers:(30 bedded)				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	Out of 5 sanctioned PHC, PHC's (Tariyani, Purnahia, Dumri Katsari) have no building infrastructure. Sheohar PHC : is situated in the same campus of the Sub Divisional Hospital Sheohar, RI, Muskan Programme are conducted but IPD and OPD facilities are not available here. At PHC Piprahi facilities are not adequate as per IPHS norms lack of equipments, lack of appropriate furnitures and lack of appropriate infrastructure in the	Available facilities are not comfortable the services support to be delivered at PHCs.	Upgradation of one PHC into 30 bedded facilities, strengthening of infrastructure and operationalization of construction works. Strengthening of block management unit Monitoring	Renovation of PHCs purchase of furnitures priorities the equipments. Appointment of block health manager & accountants for all running PHCs. For the proper work it is necessary to monitor the PHCs facilities. Formation of RKS where it is not form.

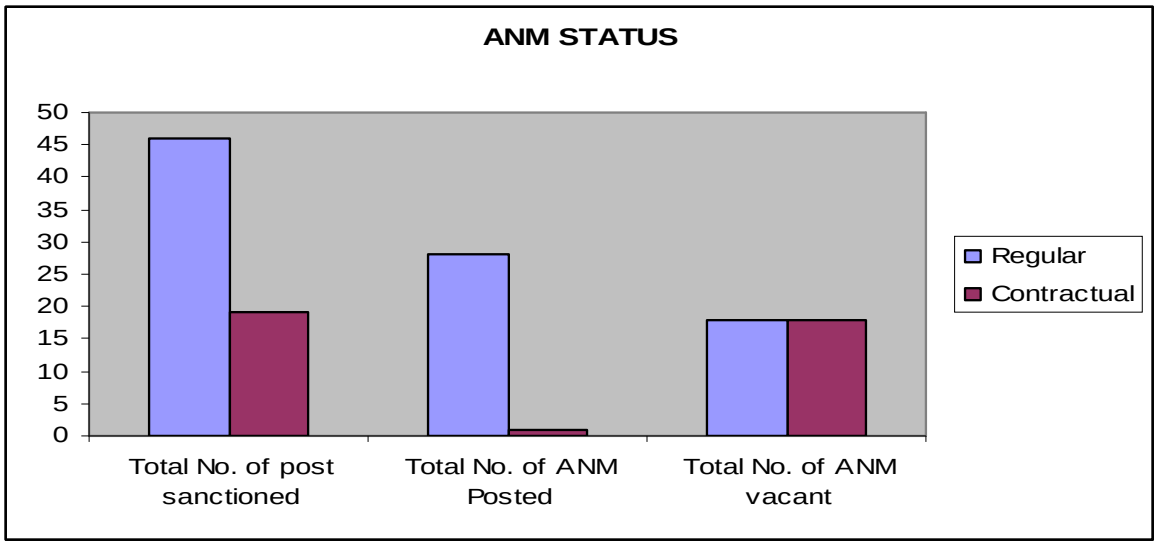
	PHC Building. Lack of RKS			
Human Resource	Lack of A Grade Nurse, Lack of Specialist doctors, Lack of ANM, Lack of pharmacist, Lack of Trained Male workers, Must of the PHCs staff are deputed to SDH, Sheohar.	Filling up the shortage staff untrained staff.	Staff recruitment capacity building. Capacity building	Selection and recruitment of staff. Appointment of block health manager and accountant. Training need assessment PHC's level staff. Training of other staff as per need.
Availability of Drugs	Irregular supply of drugs by the selected agencies of SHSB	Indenting Logistics Operationalization	Strengthening of reporting process and indenting system.	Training of store keeper, implementing computerise system & provision of software for availability of drugs.
Service Performance	At present only one PHC is running in its own building (except headquarter PHC), it needs strengthening of services been provided that is lack of delivery facility, lack of specialist doctors, lack of proper lab services.	Optimum utilization of Human Resource	Quality Improvement.	

3.5. Sub-Divisional Hospital, Sheohar

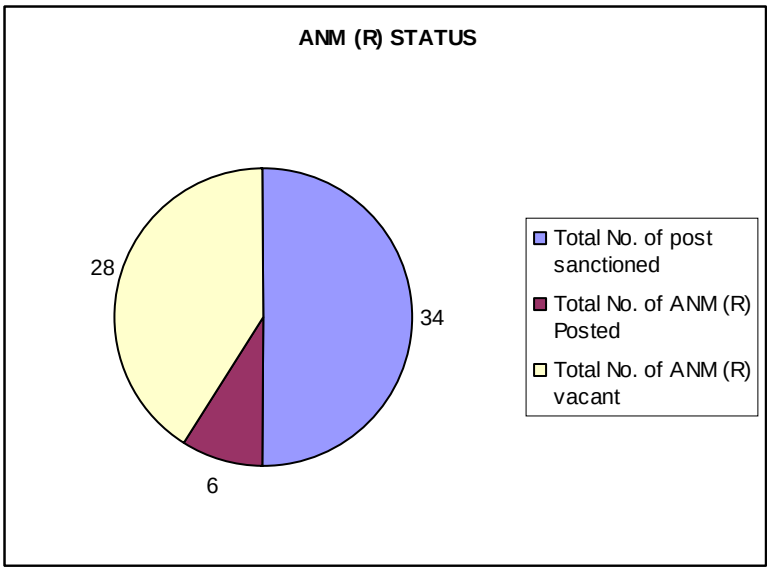
Indicators	Gaps	Issues	Strategy	Activities
Infrastructure	1. There are 30 beds in the Sub divisional hospital which is not adequate as per the need. 2. Huge work load is being at this hospital. This huge work load is not being addressed only 30 beds in adequate facilities. 3. Lack of equipments, beds as	Lack of Infrastructure	Strengthening of infrastructure.	1. Purchase of beds as per need. 2. Provision of arrangement of more beds to fulfill the need. 3. Purchase of require equipments as per IPHS norms. 4. Purchase of required furniture. 5. Construction of shade for OPD patients and provision for sitting IPD patients.

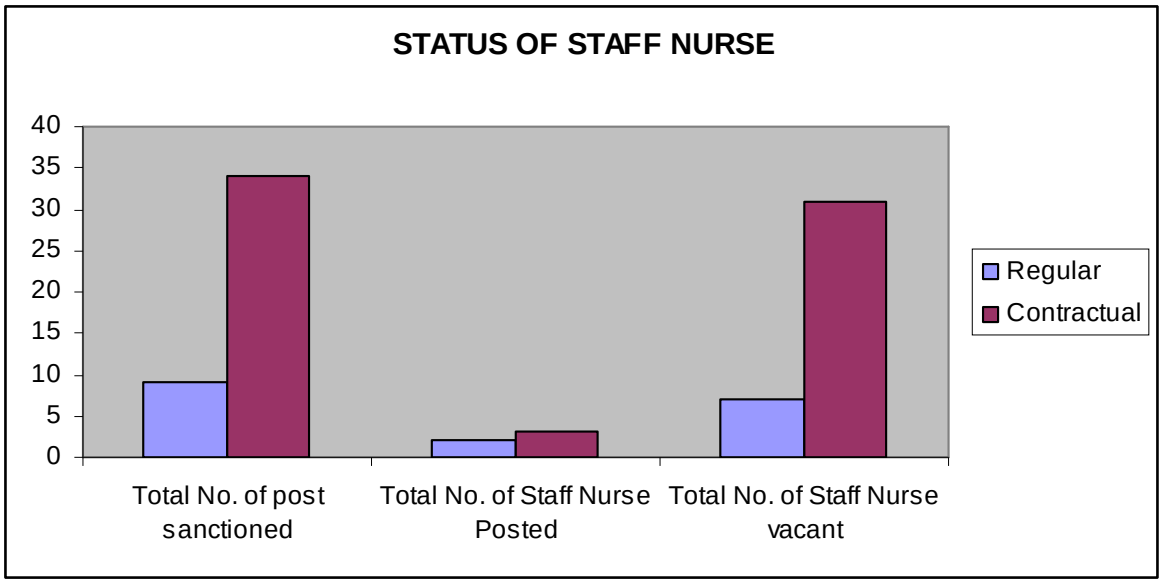
	per IPDS norms. 4. Lack of appropriate furniture. 5. No sitting arrangement for patients. 6. Lack of Delivery room, Lack of proper infrastructure and other equipments. 7. No postmortem facilities. 8. Heavy work load during raining seasons. 9. Not proper registration system. 10. Not proper registration system. 11. No enquiry counter for the patients. 12. No residential facilities of Doctors and other staffs. 13. No canteen facilities. 14. Lack of paying wards.			6. Installation of water cooler as per requirements. 7. Provision for adequate construction for delivery room and purchase of equipments. 8. Sanctioning for the appropriate authority for the postmortem facilities. 9. Provision for adequate drainage system. 10. Computerization of registration system for the OPD and IPD patients. 11. Construction of enquiry counters at the enterance gate. 12. Construction of residence facilities for doctors and other staffs. 13. Invite tender for canteen facilities. 14. Sanctioning the construction for paying wards.
Human Resource	Acute crisis of sufficient staff, No surgeon, No Pathology Test, Eye, ENT, Dental, Chest specialist.	Lack in staff position	Recruitment	Appointment as per vacant seat.
Availability of Drugs	1. Irregular supply of drugs by the selected agencies of SHSB 2. Lack of proper storage place of medicine and equipments.	Indenting Logistics Operationalization	Strengthening of reporting process and indenting system.	Training of store keeper, implementing computerise system & provision of software for availability of drugs.

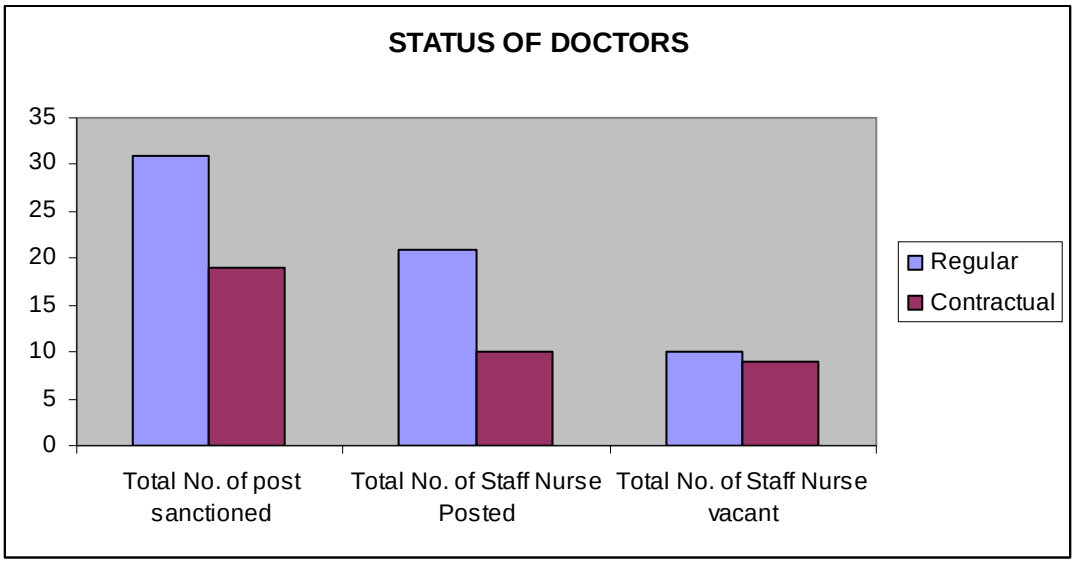
Service Performance	1. Excessive load in delivery in all services. 2. No 24 hours lab facilities. 3. Blood storage unit not available 4. BPL patient are not exempted in paying fee of ambulance.			1. Construction of wards, sitting and waiting places of patients. 2. Recruitment of Lab technician. 3. Purchase of blood storage equipments. 4. Sanctioning of free facilities for BPL patients.



3.6 Chart of Man Power Status




STATUS OF STAFF NURSE
40
35
30
25
20
15
10
5
0
Total No. of post sanctioned
Total No. of Staff Nurse Posted
Total No. of Staff Nurse vacant
Regular
Contractual


STATUS OF DOCTORS
35
30
25
20
15
10
5
0
Total No. of post sanctioned
Total No. of Staff Nurse Posted
Total No. of Staff Nurse vacant
Regular
Contractual

Chapter 4

Setting Objectives and Suggested Plan of Action

4.1 Introduction

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

4.2 Targeted Objectives and Suggested Strategies

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

4.3 MATERNAL HEALTH

Logical Framework

Sl.	Goal	Sl.	Impact indicators
1	To improve maternal health	1.1	Reduction in MMR

Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
1	To increase institutional safe delivery by 11.9% to 50% by year 2010	1.1	% of institutional delivery reported	1.1.1	To make functional PHC (24hr x7days) for institutional deliveries in phased manner. Piprahi PHC & Tariyani PHC then Purnahia PHC	1.1.1.1	% of PHC having functional OT and Labour room with equipment
						1.1.1.2	% of PHC having Obestetric First Aid medicine 24hrx 7 days
						1.1.1.3	% of Grade A nurse available 24hrx7days
						1.1.1.4	% of PHC having functional Neo-natal care units
				1.1.2	To make functional FRUfor institutional deliveries	1.1.2.1	No of FRUs having functional blood storage units linkage with blood banks and 24hr ready referral transport

						1.1.2.2	No of FRUs having EmOc and CEmOc facilities
						1.1.2.3	No of FRUs having specialist doctors/ multiskilled Medical Officers
						1.1.2.4	No of FRU having functional Neo-natal care units
				1.1.3	To provide Referral transport services at FRU /PHC	1.1.3.1	No of pregnant women availed the referral facilities (pick up and drop)
				1.1.4	To strengthen Janani Suraksha Yojana / JSY	1.1.4.1	% of pregnant women reecieved JBSY payments immediately after delivery and how many PHCs having JBSY facilities
2	To increase safe delivery by trained ANM 100%	2.1	Proportion of birth attendent by skilled health personnel	2.1.1	To ensure support of SBA at home deliveries	2.1.1.1	% of home deliveries attended by SBA
3	To increase ANC coverage with quality 18.9% to 50% by year 2010	3.1	% ANC reported through HMIS formats / Form -7	3.1.1	To strengthen HSC for providing outreach maternal care	3.1.1.1	% of HSCs having ANMs

						3.1.1.2	% of HSCs conducted fixed ANC and clinics (planned & held)
				3.1.2	To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas	3.1.2.1	% of RCH camps planned and held
				3.1.3	To improve adolescent reproductive and sexual health	3.1.3.1	No of pregnant adolescent counselled by ANM/ AWW/ASHA
				3.1.4	To accelrate APHC for OPD and Fixed AN clinics	3.1.4.1	% of OPD clinics orgnised at APHC level.
4	To provide safe abortion services at all facilities	4.1	% MTP cases reported through HMIS formats / Form -7	4.1.1	To provide MTP services at health facilities	4.1.1.1	No of facilities having MTP services (public and private)
5	To increase community participation in maternal care	5.1	% of Mahila mandal meetings conducted.	5.1.1	To strenghten Monthly Village Health and Nutrition Days	5.1.1.1	% of mothly Village Health & Nutrition Days planned and held

MATERNAL HEALTH							
Sl.	**Strategy**	**Sl**	**Gaps**	**Sl**	**Activities**		
	To make functional PHC (24hr x7days) for institutional deliveries		**Infrastructure**				
A1		1.1	(Besides head quarter PHC) only one PHCs is running in its own building other are running in APHC building.	1.1.1	Need based (Service delivery)Estimation of cost for upgradation of PHCs.		
		1.2	At present no PHCs are working with delivery planning and 50-60 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	1.2.1	Preparation of priority list of interventions to deliver services.		
		1.3	The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still the area of improvement.	1.3.1	Sending the recommendation for the certification with existing services and facility detail.		

		1.4	Lack of equipments as per IPHS norms and also under utilized equipments.	1.4.1	Prioritizing the equipment list according to service delivery and IPHS norms.		
				1.4.2	Purchase of equipments		
		1.5	Lack of appropriate furniture	1.5.1	Purchase of Furniture		
		1.5.2	Lack of facilities/ basic amenities in the PHC buildings	1.5.2.1	Construction of PHCs		
	To make functional PHC (24hr x7days) for institutional deliveries	1.6	**As per IPHS norms each PHC requires the following clinical staffs:(List attached)**				
		1.6.1	The actual position is not sufficient as per IPHS norms List of Human resource is attached		Selection and recruitment of ANMs, Nurse Grade A, Doctors on contractual basis and give priority in selection those who are living in same PHC.		
					Salary of Contarctual Grade A nurses		
					Selection and recruitment of grade A nurses for conducting delivery		
					Selection and recruitment of dresser		
					Selection and recruitment of Pharmasist.		

					Three month induction training of Grade A nurse under supervision of District level resource team.		
		1.7		1.7.1	Training need Assessment of PHC level staffs		
					Mobility support to BHMs		
		1.8		1.8.1	Appointment of 3 Block Health Managers, 5 Accountants		
					Trainings of BHMs on Health statistics		
					Training on Program, Finance management and HMIS		
			Drug Supply				
		1.9	Irregular supply of drugs because of unavailability supply of drugs agency.	1.9.1	Ensuring the availability of FIFO list of drugs with store keeper.		
		1.10	Only 38 essential drugs are rate contracted at state level .	1.10.1	2.Implementing computerized invoice system in all PHCs		
					Purchase of Drug invoice software		
			Lack of fund for the transportation of drugs from district to blocks.	1.10.2	3.Fixing the responsibility on proper and timely indenting of medicines (keeping three months buffer stock)		

		1.11	There is no clarity on the guideline for need based drug procurement and transportation.	1.11.1	4. Orientation meetings/ training on guidelines of RKS for operation.		
		1.12	Drugs are not properly stored	1.12.1	5. Enlisting of equipments for safe storage of drugs.		
				1.12.2	6. Purchase of enlisted equipments.		
				1.12.3	7.training of store keepers on invoicing of drugs		
	To make functional PHC (24hr x7days) for institutional deliveries	1.13	5 PHCs are lacking 24 hrs new born care services.	1.13.1	Ensure 24 hrs new born care services in PHC.		
		1.14	Afew PHCs provides 24 hrs BEmoC services.	1.14.1	Ensure 24 hrs BEmoC services at PHC		
					Training of one Doctor from each PHC on BEmoC.		
					Equipments for BEmoC		
		1.15	PHC does not have laboratory facilities on PPP based srvices. Phc have T.B lab Technician.	1.15.1	Deputation of regular Lab tech at PHC level for providing free of cost lab services to all pregnant women and BPL families.		
		1.16		1.16.1	Recruitment of lab technicians as required for regular support of lab activity		

					Training of TB lab technician on other pathological tests.		
					Purchase reagent(recurring) for strengthening lab.		
					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.		
		1.14	**Referral Services**				
		1.14.1	No pick up facility for BPL patients.	1.14.1.1	Provision for pick up & drop pregnant mothers and BPL families free of cost using existing Ambulence services at PHC level.		
					Provide EDD list of pregnant women to Ambulance driver and Number of ambulance diriver and 102 /PHC tel No to all Pregnant woment		
					Prepare list of Vehicle those are utilised in Monitoring work in PHC that can be use in pick up and dropping facility.		
		1.15	Quality of food, cleanliness (toilets,Labour room, OT, wards etc) electricity facilities	1.15.1	Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate.		

			are not satisfactory in any of the PHC.		Rewiev of Cleanliness activity in all PHC by Qulity assurance committee and payment of agency should be link with it.		
				1.15.2	Hiring of workers for cleanliness of OT and Labour room in PHC		
					Purchage equipments and uniform for cleanliness in all PHC		
					Training of Workers on using machine/equipments and importance of cleanliness .		
					Develop mechanism for monitoring of cleanliness work		
		1.16	Non availability of HMIS formats/registers and stationeries	1.16.1	Printing of formats and purchase of stationaries		
				1.16.2	Biannual facility survey of PHCs through BHM as per IPHS format		
				1.16.3	Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.		
		1.17	Operation of RKS:	1.17.1	Ensuring regular monthly meeting of RKS.		

				1.17.2	Appointment of Block Health Managers, Accountants in all institutions.		
		1.18	Lack in uniform process of RKS operation.	1.18.1	Training to the RKS signatories for account operation.		
				1.18.2	Trainings of BHM and accountants on their responsibilities.		
		1.19	Lack of community participation in the functioning of RKS.	1.19.1	Meeting with community (School children or other)representatives on erecting boundary, beautification etc,		
				1.19.2	Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS.		

		1.20	In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases.	1.20.1	Meeting in RKS with Local Police Station incharge to handle emargency situation .		
	To make functional PHC (24hr x7days) for institutional deliveries	1.37	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.		
		1.38	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		
		1.41	Lack of counselling services	1.41.1	Displaying Name Photograph and DOB of all staff of PHC and put cleanliness staff name on top of the list. There are 2 LHV in the district we can utilise their experience in counseling work of women and adolecent girls after training.		
		1.42	There is no hot water facility for PW and there is no adequate lighting facility at adjoining area of	1.42.1	Installation of solar heater system and light with the help of BDO/Panchayat at PHC or purchage equipments from market.		

			PHC				
		1.43	Lack of convergence	1.43.1	Convergence meeting by RKS & DHS		
		1.44	Lack of timely reporting and delay in data collection	1.44.1	Orientation of the staffs on indicators of reporting formats		
		1.45	Lack of space for waiting, environmental cleanliness around PHC, provision for hospitality etc	1.44.2	Puchase of Laptops for DPM and BHMs and DA with internet facility.		
				1.45.1	Gardening		
		2.3	Welcome PW at Institution and PHC and FRU	1.45.2	Sitting arrangement for patients		
					Construction of patients waiting shade		
				1.45.3	Installation of LCD projector for manage wait over time of OPD patients.		
				1.45.4	Installation of safe drinking water equipments/water cooler,		
				1.45.5	Apron with name plates with every doctors		

				1.45.6	Presence of staffs with uniform and name plates.		
				1.45.7	"MAMTA" should also be appointed at PHC level as well.		
				2.3.1	Provision of food for the delivered mothers and mothers under gone in tubectomy in all the health facilities.		
		2.4	Reporting of maternal death Maternal death reporting is usually not reported by worker	2.3.2	Mobilize community Resources for providing Free food for PW at Institution.		
				2.3.3	Quality indicators (clean environment, wards with clean linen, clean toilets , clean labour rooms, running waters supply, hot water and safe water for inpatients, new born corners, treatment protocols, aseptic precautions, immediate disbursement of JBSY funds		

				2.4.1	Training of ASHA & ANM on reporting of Maternal deaths and conduct Verbal Autopsy		
		2.5	Biomedical waste management is not properly taken care off at all institution	2.4.2	Incentives for maternal death reporting by ASHA @ Rs 50/-per maternal death		
				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.		
				2.4.4	Institution and urban center also to report Maternal death to the district CS/ACMO.		
				2.4.5	Maternal Death should be reported by ASHA, AWW, ANM Staff Nurse & Doctors to the district data center .		
				2.4.6	Investigation of maternal death by district team. and third party review(District magistrate)		

				2.4.7	Training of ASHA and investigation team objective and process of investigation and review of maternal death		
				2.5.1	Procurement of equipment		
			Tracking of pregnant women from first Trimester is not done form the register.	2.5.2	As per example Introduce color coded buckets for facilities as per rule.		
		4.1		4.1.1	Review of early registration with 3 AN checkup ,two TT.100/200 IFA Tab. in ASHA Diwas.		
4	**To strengthen Janani Suraksha Yojana / JSY**	4.2	Too much documentation process. Photo required for mother and baby.	4.2.1	Ensure 100 %Pregnancy Test Kit is to ASHA and regular supply.		
				4.2.2	Direct transfer of funds from district to PHC through core banking / directly from DHS		
				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.		
				4.2.4	The photo system should be replaced by some other alternatives like- bank account opening of pregnant women in first trimister and directaly transfer the money to their account after delivery.		

					Incentive for institutional delivery. If postoffice saving account is opened for all the ASHAs then payment process will be easier for them.		
		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.		
5	**To ensure support of SBA at home deliveries**	5.2	Reporting of home delivery is not done so the PNC is not provided	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.		
				5.1.3	Delivery kit (equipment, medicine)for ANM should be supplied		
				5.1.4	Supply of delivery Kits as per number of deliveries conducted in home.		
				5.2.1	Incentive based system for reporting of home delivery by ASHA and it should be linked with ANM		
		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.		

		10.1	Out reach camps are not orgnised in plan manner. It is totally based on demand of orgnisation and eventually it is not reported to respective HSCs and PHCs.	10.1.1	Identifying Socially Backward, Slums & Maha Dalit Tolas.		
10	**To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas**			10.1.2	Hiring trained alternate vaccinator/ retired ANMs and Medical officer .hiring vehicle for fixed day out reach camps with drugs.		
				10.1.3	Fixed day OPD clinics at APHC level and adjoining HSC of respective APHCs. with dedicated MO and support staff.		
				10.1.4	To make calendar for camps with date and identified areas.and link NGOs those who are willing to orgnise Camps .		
		11.1	No training programme for adolescent particularly health and sex.	10.1.5	Community based reporting system through SMS. involve PRI members and training on reporting and Camp approach		
				11.1.1	Multipurpose counsellor can be used for adolescent care. For this services of LHV can be used.and callender of activity could be devloped.		

11	**To improve adolescent reproductive and sexual health**	11.2	Preventions of anemia in adolacencent girls	11.2.1	Linkage with adolescent anemia control programme in Schools with Unicef. And training to one teacher from the school		
		11.3	Marriage before legal age.	11.3.1	Public Sensitization particularly women		
		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, Breast feeding.PNC with in 48 hours.		
		11.6	Limited interventions for empowering adolescent girls	11.6.1	Family counseling for adolescent pregnancy tracking on above mentioned through ASHA and AWW.		
		12.1	MTP services are not available in Public sectors	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)		
				11.6.3	Prepare a monthly plan of activities for one day per week		
	To improve adolescent reproductive and			11.6.4	Counseling nutrition, health and social issues every week at AWCs by AWW		

	sexual health			11.6.5	Weekly distribution of IFA Tablets to out-of-school girls at AWCs		
				11.6.6	Deworming adolecent every 6 months		
				11.6.8	Initiate family schools for learning child care , safe motherhood life skills and Family life education		
				12.1.1	Selection of facilities for provision of safe abortion services		
12	**To provide MTP services at health facilities**	13.1	Nutrition and Counselling Component is not visible in VHND and there is no monitoring of VHND activity by Community.	12.1.2	Location of facility availability of trained service provider, space, equipments.		
				12.1.3	To Provide appropriate equipments at all facilities and MVA syringes.		
				12.1.4	Putting the trained doctors at appropriate facilities to commence the services		
				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 .		
				12.1.6	Formation of district level committee (DLC) to accredit private sites as per GOI guide line .		

				12.1.7	Develop reporting system of MTP services in private and public secter.		
				12.1.8	Through training program make the govt doctors skilled to perform MTP in the approved sites.		
				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)		
	To provide MTP services at health facilities			12.1.10	The services of Pregnancy testing should be strengthened and it should be linked with MTP services.		
				12.1.11	NGO's and local Practitioner should be involved for counseling and information of facility		
				12.1.12	Assurance of privacy and link with family welfare services counseling at all facility.		
				12.1.13	Linkage with MTP services with NGOs (PPP) those who are working in Safe abortion services. and create one nodal center at district and PHC level.		
				12.1.14	Training of ASHA on medical abortion.		

				13.1.1	AWC should be developed as a Hub of activities (VHND)		
13	**To strenghten Monthly Village Health and Nutrition Days**		**Infrastructure**	13.1.2	Develop an activity plan calendar for VHND as seasonality.		
				13.1.3	Counseling of mothers on ANC, preparation for Child care ,STI/RTI, and AYUSH, adolescent Health		
				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		
				13.1.4	Meeting of VHSC and preparation for area specific epidemiological planning and community based monitoring.		
				13.1.5	Skill development training is required to ANM , ASHA & AWW and Dular (LRG)		
				13.1.6	Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourished children , New born, DOTs and other services		

				13.1.7	SMS reporting system of conducting VHND and ANM collect Data from field level and compile it in weekly/Monthly formats.		
B	**APHC**	1.3	Out of 7 APHCs only 5 are having own building	1.3.1	Registration of RKS		
	To form /strenghten APHC in Phase manner	1.4	Existing 5 buildings are not properly maintained	1.4.1	Rennovation of APHCs buildings from RKS Fund		
			Human Resource				
2		2.1	in the district no any APHC functioning as per IPHS norms	2.1.1	Operationalising one APHC in each PHC by conducting daily OPD by Doctor and support staff.		
		2.2		2.2.1	Notification from district for oprationaliing APHC		
			Drug Supply				
3		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		
		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.		
5	**RTI/STI services at health facilities**			5.1.2	Logistics of setting of clinics and free drugs availability		

				5.1.3	Integrated Counselling services in four public sector facilities by trained personnel .		
				5.1.4	IEC/BCC for awareness available RTI/STI services at all health facilities.		

4.4. 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 10.4% to 100%	1.1	% increase of ORS distribution .	1.1.1	*Home Based Newborn Care/HBNC*		Case increasement
2	To increase treatment of diarrohoea 60.4% to 100%		% increase of treatment of diarrohoea within two weeks				
3	To increase treatment of ARI/Fever in the last two weeks 66.5% to 100%		% increase of treatment of ARI/Fever in the last two weeks				
4	To increase of infant care with in 24hr of delivery from 9.6% to 50%		% increase of infant care with in 24hr of delivery .		Strengthening of Facility Based Newborn Care/FBNC and trained workers on using equipments.		No of PHC initiated FBNC with trained MAMTA on facility based new born care..
5	To increase % of breastfeeding from 8.3% to 100% within 1 hr of birth		% increase of breastfeeding within 1 hr of birth .	1.1.2	Infant and Young Child Feeding/IYCF		No of training orgnised in PHC on IYCF
6	To increase intiation of complimentry feeding among 6 month of children from 86.1% to 100%		% increase of complimentry feeding among 6month of children.				

7	To increase exclusive breastfeeding among 0-6 month of children from 24.4% to 100%		% increase of exclusive breastfeeding among 0-6 month of children .				
8	To increase immunization coverage from 28.3% to 100%		% increase of full immunization coverage .				
9	To increase vit A coverage of received atleast one dose (9month to 35 months) from 30% to 100%		To increase Vit A reported adequte coverage among (9m to 5ys)	1.1.3	Management of diarrhea, ARI and Micronutrient Malnutrition through Child srvival months		Two round of Child survival Month organised in one financial year.
10	To decrese Malnutrition		% of decrese Malnutrition age group of (0 to 5 yrs)	1.1.4	Care of Sick Children and Severe Malnutrition and strenthen VHND at all AWCs		No of VHND orgnised vs Planned.
		2.1		2.1.1	School Health Programme		No Of school health programme orgnised in the PHC
Sl.	Strategy		Gaps		Activities	Unit Cost	
	Home Based Newborn Care/HBNC		*Training Gaps(AWW-,ASHA,ANM1,MPW-No ASHA is trained on IMNCI*		*Assessment of Training load and prepare calendar of training*	NA	
					Incorporate ASHA in IMNCI training team	NA	
					ASHA kit regular supply and incorporate use of ASHA Kit in training curriculum.		

					Division of area among all trained supervisors for revision of IMNCI activity in their area.	NA	
					BHM will be responsible for review of health supervisor sand LS(ICDS)on given format.Unicef staff will support in devloping review mechanism in PHC.	NA	
					Incorpate IMNCI reports in HIMS formate	NA	
					Encouraging mother regarding child care.in VHND	NA	
			Inadequate monitoring of this activity at field level		*Frequent checkups of babies by Paediatrician.* *Distribute telephone number to AWW and ANM of respective doctors those who are supervising them in the field.*	NA	
					Wednusday could be fixed a day for IMNCI related work at HSC level	NA	
					Community based Monitoring support system devlop with SHG in one PHCTraining of Group membersseed money to SHG for reffral services and other need based services.		
	Facility Based Newborn Care/FBNC		Lack of Baby warmer machines		All PHCs should be equipped with baby warmer machines.		

			ANMs and Doctors are not trained to operate these machines		Training of Doctors and ANMs to operate baby warmer machine.		
			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		
			Neonatal Care Unit not up to mark.		District level Supporting supervisory team should be devlope with the responsibility of nunfuctioning of neonatal care unit. Training of team on monitoring of NCU		
			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.*		
	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.		
					Baby friendly hospital Training of one doctor from each Nursing hospital at District Level		
					Two days training of one staff nurse from each private hospital on counselling skill.		

					Accreditation of nursing home and facility according to norms of baby friendly hospital initiatives		
			Poor knowledge regarding new born care and child feeding practices		Development and Printing of BCC materials		
					Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA		
					Linking JBSY with colostrums feeding		
			Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding		Counselling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries in mothers meetings and VHSCs meetings		
					Folk performance to promote exclusive breast feeding		
					Uniform message on radio from state head quarter		
			Lack of awareness on importance of appropriate and timely IYCF		Organize social events through VHSCs		

					Strengthening of *Mahila Mandal* meetings- fortnightly with involvement of adolescent girl		
					Organize healthy baby shows, healthy mother / pregnant woman.		
					Appreciation and reorganization of positive practices in community. For this purpose hiring a documentation specialist.		
					Celebration of "*Annaprashan(Muhjutthi) Day*" at AWC		
					Demonstration of recipes.		
					Exposure visits to existing NRCs to observe different models in the country		
	Care of Sick Children and Severe Malnutrition		There is not a single unit in the district where severly malnourished children could be treated.		Establish rehabilitation center in district hospital, FRU and one PHC and promote locally available food formula		

	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.		
					Include covrage of Vitamin A and IFA,children in New HIMS format.		
					Insure two round of Vitamin A and deworming for the age group of (9m to 5 yrs) & (2 yrs to 5 yers) respectivly in the month of April And Oct as per GOI guide line.		
					Involvement of ICDS, school teachers and PRI for monitoring and evolution		
	School Health Programme		No Pre School Health checkup & complete Immunization card.		Half yearly health checkup camp for children in schools should be organized. Implementation through selection NGO.		
			No training of school teacher for basic health care and personnel hygiene.		Training of school teacher by the medical personnel with support of administrative person.		
			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.		
			No Training & Screening of school's teacher for eye sight test.		Linking existing 7 opthalmic paramedics with this program and developing school wise calender.		

					School health anemia control programme should be strengthened with biannually de worming .		
					Organizing competitions/Debates/Painting competitions/Essay/demonstration and model preparation of nutritional food and health.		
			No other specific program has been formulated in the district.		Half yearly Health checkups and health card of all school going children.		
					Films shows on health, sanitation and nutrition issues		
					Social science Lab activities.		
					Rally and Prabhat Phery in epidemic areas. (Kala-azar & Malaria)		
					Referral system for the school children for higher medical care.		

Promotion of child health through screening & proper care to the school through involvement of NGOs and budget will be as follows:

1. Implementation of FBNC activities in District : 7939.00
2. School Health Programme – 2917275.00 : Total – 2932542.00

4.5 Family Planning

Logical Framework							
Sl.	**Goal**	**Sl.**	**Impact indicators**				
1	Population stablisation	1.1	To decrease TFR upto replacement level To increase sex ratio				
Sl.	**Objectives**	**Sl.**	**Outcome indicators**	**Sl.**	**Strategy**	**Sl.**	**Output indicators**
2	To increase female sterlization As previous target was 2661 and achievement is 1760.	2.1	% increase in female sterilsation	2.1.1	Terminal/Limiting Methods	2.1.1.1	% of terminal/limiting methods use
				2.1.2	All PHCs must be equipped with all logistics. Dissemination of manuals on sterilization standards & quality assurance of sterilization services	2.1.2.2	No of facilities providing quality manuals on sterilization standards of sterilization services.
				2.1.3	Female Sterilization camps	2.1.3.3	No of camps orgnised for female sterlization .
				2.1.4	Compensation for female sterilization	2.1.4.4	% of Female received compensation
				2.1.5	IUD camps	2.1.5.5	No of IUD used in Camps
				2.1.6	Accreditation of private providers for IUD insertion services	2.1.6.6	No of Private providers accrediate for IUD Insertion services.
3	To increase male sterilization from which is almost nil only one sterilization done.	3.1	% increase in male sterlization	3.1.1	NSV camps	3.1.1.1	No of NSV Camps orgnised.

				3.1.2	Compensation for male sterilization	3.1.2.2	% of Male received compensation
				3.1.3	Accreditation of private providers for sterilization services	3.1.3.3	No of Private providers accrediated for Sterilization services.
4	To increase use of condoms from 0.4% to 5%	4.1	% increase in the use of condoms	4.1.1	Promotion to Social Marketing of condoms	4.1.1.1	No of Condoms distributed through Social Marketing.
				4.1.2	Contraceptive Update seminars	4.1.1.2	No of Seminars Orgnised on Contraceptive Update.
5	To increase use of pills from 1.2% to 5%	5.1	% increase in the use of pills	5.1.1	Promotion to Social Marketing of pills	5.1.1.1	No of Pills distributed through Social Marketing.

Sl.	Strategy		Gaps		Activities		
	Terminal/Limiting Methods		Lack of knowledge of small family norms.		Ensure one MO trained on minilep and NSV up to PHC		
					Training of nurses and ANMs on IUD and other spacing methods at PHC level.		
					Ensure availability of contra ceptives (indenting , logistic		
	Female Sterilization camps		Laparoscopy surgery not done.		Trained doctors on laparoscopy.		
					Procure Laparoscopy equipments for trained doctors		
					Training of doctors needed.		
	NSV camps		Trained doctors are not available.		Procurement of equipment.		
	Compensation for female sterilization				Immediate disbursement of incentive after sterilization camps.		
	Compensation for male sterilization						
					Logistic planning is needed before		

					organizing camps.		
					Block Health manager can hire one support staff for logistic support.		
					Immediate disbursement of incentive after sterilization camps.		
					Logistic planning is needed before organizing camps.		
					Block Health manager could be hire one support staff for disbursement for logistic support.		
					Accreditation of private nursing home. As per GOB		
	IUD camps		Camps not held		Training of ANM & staff nurse for IUD insertion.		
	Accreditation of private providers for IUD insertion services		No accreditation of private providers for IUD insertion services		Procurement of IUD.		
					Equipments for IUD insertion		
					Accreditation of private providers for IUD insertion services. As per GOI guide lines.		
	Social Marketing of contraceptives		Monitoring of Social Markiting is not monitored		Social marketing of need based OC & IUD.		

			by PHC.		Increasing access to contraceptive through communities based distribution system free of cost.		
	Contraceptive Update seminars		Not being held.		seminars for MO and other through Professional bodies (FOGSI. BMA, Nursing association etc..on		
					Copper-T 380-A should be popularized.		
					Awareness for emergency contraceptive.		

Financial Budget for Family Planning

3. Family Planning	3.1. Terminal / Limiting Methods	3.1.1. Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services	3.1.2. Implementation of sterilisation services by districts	3.1.2.1. Provide female sterilisation services on fixed days at health facilities in districts (Mini Lap)	3.1.2.2. Organise NSV camps in districts @Rs.10,000 x 500 camps	3.1.2.3. Compensation for female sterilisation at PHC level in camp mode	3.1.2.4.Compensation for NSV Acceptance @50000 cases x1500	3.1.3. Accreditation of private providers to provide sterilisation services	3.1.3.1 Compensation for sterilization done in Pvt. Accredited Hospitals (1.50 lakh cases)
		9.50		**1000.00**	**50.00**	**3100.00**	**750.00**		**2250.00**
		25000 each district							
		#REF!		#REF!	#REF!	2034000	492000		2010000
Quarter									
1st		0		0	0	500000	0	0	100000
2nd		2000		150000	10000	200000	0	0	400000
3rd		2000		300000	10000	400000	0	0	700000
4th		2232		200000	10000	934000	50000	0	800000
Total		**6232**		**650000**	**30000**	**2034000**	**50000**	**0**	**2000000**

3.1.4. Monitor progress, quality and utilisation of services	3.2. Spacing Methods	3.2.1. IUD Camps	3.2.2. Organise Contraceptive Update seminars for health providers (one at state level & 38 at district level) (Anticipated Participants-50-70)	3.3 POL for Family Planning for 500 below sub-district facilities	3.4 Repair of Laproscopes	3.5. Establishing Community Based Condom and OCP Distribution Centres (pilot in one district/1 PHC)	Sub-total Family Planning
4.68		**155.84**	**9.75**	**100.00**	**2.00**	**0.25**	**7432.02**
		155.84 (Fund available in 2008-09)PHC wise camps/ 48 per PHC /1000	**926250**			**Munger 25000**	
#REF!		#REF!	#REF!	#REF!	#REF!		#REF!
0		0	0	0	NA	0	600000
1000		60000	6077	22570	NA	0	851647
1000		55000	0	40000	NA	0	1508000
1000		60000	0	50000	NA	0	2107232
3000		**175000**	**6077**	**112570**	**NA**	**0**	**5066879**

4.6 Kala Azar

	Gaps	Issues	Strategy	Activities		
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 affected blocks.		
			Monitoring of the spraying squad by MOIC	2. Identification of Houses with Kala-azar patients.		
				3. Two round of spraying scheduled.		
				4. DDT spray should be at the rate of 1gm/sq. meter upto the height of 6 feet.		
		Less time spent on spraying DDT	Training and capacity building for proper spraying	Regular capacity building training on prescribed module for the sprayer to ensure that every corner of the house is properly spraye upto heigth of six feet from ground level.		

			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.		
			Making available DDT during spraying round	Ensure adequate Stock of DDT through proper & timely indenting to improve the quality of spray		
		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)		
2	Poor rate of case detection of Kalazar	Reduction of kala-azar mortality and morbidity	Early diagnosis and treatment through PHC system	1. Ensuring availability of Amphotericin at all level		
			Monitoring and supervision mechanism	Loss of wages for KZ patients		
				2. Replacing of medicines on priority based		
				3. Training of ANMs and ASHA for IM injection		
				Preparation of Monthly visit plan for supervision :- Checking spraying schedule- For supervision & treatment follow up		
3	Lack of monitoring and supervision mechanism,			Office expenses		
		Increasing awareness for prevention of	Community participation in	1. Fund allocation for training activities		

		Kala-azar	reducing mortality and morbidity due to Kala-azar			
4	Lack of appropriate BCC & Community Mobilization.			2. Identification of NGO/Private partner as trainer		
				3. Knowledge sharing with the community on signs and symptoms of Kala-azar through VHSC		
				4. Training of VHSC/PRI and community health worker on sign & symptom of Kala-azar		
				5. Regular monitoring of IEC activities		
				6. IEC activities through nukkad natak, kalajatha mass media like radio etc		
				7.Activity for survillance like polio survillance		
				8.Wall painting of Tretment protocole and provisions for pateints in PHC in Hindi.		

Budget : Kala Azar

1. Wages for FW & SFW = 412560
2. Office expenses = 1800
3. Contingency = 1800
4. Transportation of DDT = 3000
5. Repair of spray equipment including Nozal tips = 6000
6. Distt. Mobility for ACMO Vehicles = 4800
7. Mobility for PHCs MO = 2400
8. DA for supervision = 2000
9. IEC = 2000
10. Incentive to ASHA = 15000
11. Loss of wages = 225000
12. Bed strengthens = 20000
13. Mobility for Officers & MI, POL & Maintenance = 148000
14. Storage of drugs = 6000
15. Treatment card = 750
16. Register for line listing = 100
17. Ware houses hiring = 55000
18. Fortnight programme = 8000
19. KTS Emoluments = 600000

Total = 15,14,210=00

4.7 Blindness

Gaps	issues	Strategy	Activities	
No eye surgeon is available in the district.	Staff shortage	Recruitment	Recruitment of Eye Specialists and surgeons on contractual basis.	
			Recruitment of Opthalmic Assistants on contractual basis.	
Staffs are not trained enough on new IOL techniques	Untrained staffs	Capacity building	Training of Doctors on IOL technique	
			Training of Opthalmic Assistant	
		Promotion through PPP	More NGO is required for the same.	
			Purchase of equipments and medicines	
Lackof awareness among community regarding cataract blindness and its treatability.	Lackof awareness	Awareness building	Assigning LHV/Supervisor counselling work	
Fear of eye operation.			Organising eye screening camps in villages/ schools	

Lack of Education among the masses about the existing facilities: Need of wide publicity.			IEC on cataract and its facilities	
Poor coordination between the health functionaries and the voluntary organisations resulting in less cataract surgeries.		Involving NGOs	Meeting with Local NGOs onthis issue	
Lack of adequate referral services to take care of complications.	Lack of adequate referral services	Strengthening referral system	Arrangement of carrying patients to the Operation Centers and then taking them back homes	
Lack of monitoring and follow up	Monitoring and follow up	Monitoring and follow up	Mobility support for Visiting homes of the patients to manage any post treatment complication.	
			Developing records of cataract cases fromOPD registers at PHC level	

Financial Budget for Blindless

Free cataract operation

Target = 500

For cataract operations = 375,000

School eye screening = 100000

Total = 4,75,000=00

Leprosy

Gaps	Issues	Strategy	Activities	
• 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	
	Lack of Human Resource	Staff Recruitment in contract basis	Recruitment of supervisors	
• There is no active involvement of the Medical officers at sector and Block levels.		Strengthen Health Care Services	Orientation of MOs and staffs on Leprosy	
• Lack of PHC staff involvement. No manpower support,			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.	
No lab testing facility in the district	Infrastructure Gap	Establishing Lab	Establishing Lab at district level	
			Recurring expenditure like reagents	

Lack of monitoring at all level	Monitoring Gap	Increasing mobility	Updation of master register	
			Mobility support for DLO	
			Office expenses	

Financial Budget Leprosy (in Rs.)

a> School quiz = 15000

1. Training :
    - b> Sensitizations meeting = 12000
    - c> Health Melas = 5000
    - d> MO Training = 13650
    - e> ASHA Training = 48000

2. Audit Fee = 6000
3. Honorarium for Accts. Work = 4400
4. Miscellaneous = 15000
5. Consumable expense = 14000
6. Vehicle = 75000
7. Drugs Materials supplies = 43000
8. AIDS & Application = 12500
9. Incentive to ASHA = 21000

Total = 2,84,550=00

4.9 T.B.

	Indicators	Gaps	Activities	
1	**Infrastructure**	Lack of well equipped/Designed Microscopy Centre	Development and Renovation of DMCs with proper water supply and Electricity connection	
		Microscopes of many Designated Microscopy Centers(DMC) are not functioning	Supply of New binocular Microscopes	
		Poor Maintenance of Microscopes	Special Training to Lab Technician/Microscopist for maintenance of Microscopes	
2	**HR**	Many DMCs are closed due to lack of Microscopist/Lab Technician/DEO & Accountant	Recruitment Process should be followed.	
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	
		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.	
		Poor Retrieval of Drug Boxes of Defaulted patient	Retrieval of Drugs may be ensured by STS.	
		Irregular supply of slides and other Chemicals and other logistics	Proper supply of Slides and other Chemicals should be ensured	
		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.	
4	**Service Performance**	Poor quality of DOTS	Proper and Regular supervision and monitoring of programmes will be ensured.	

		ANMs providing DOTS at the HSCs do not visit the Center on DOTS day resulting irregular intake of drugs by the patient causing poor Cure- rate.	Motivation and Sensitization of Staffs by Refreshment training on friendly behavior with patient	
		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	
		Lack of proper guidance to patients.	Appointment of a Counselor at all PHC	
			Organizing Community meetings	
			Medical Officers should take care of referring all chest symptomatic patients for sputum examination	
			Proper Follow-up Schedule should be maintained	
			Proper care for side effects of drugs.	

Financial Budget of T.B (in Rs.)

1. Civil works = 41000
2. Lab consumables = 100000
3. Contractual services = 919500
4. Vehicle maintenance = 15000
5. Equipment = 60000
6. IEC = 100000
7. Training = 100000
8. Vehicle hiring = 100000
9. Printing = 100000
10. Honorarium = 300000
11. NGO/Pvt. Practitioner = 78000
12. Miscellaneous = 100000

Total Rs. = 20,13,500=00

4.10 Filaria

Gaps	Issues	Strategy	Activities	
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	
			Purchse of equipments for the management of Filaria cases like towel, Bucket, soap, mug etc	
			DEC distribution through AWCs and paying hon to AWWs for this.	
			Purchse of DEC	
			Training to AWWs/ASHA on DEC distribution and filaria case management	
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	
Low effectiveness of the tools used by the control programme			Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.	
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	

Financial Budget for Filaria (in Rs.)

1. Distt. Coordination meeting = 15000
2. IEC = 25000
3. Training for MOIC = 25000
4. Training for Paramedicals = 25000
5. Line listing = 45000
6. Night blood survey = 16698
7. POL = 13000
8. Training of drug distributor = 158240
9. Honorarium of drug district = 158240
10. Supervisor Training = 19436
11. Honorarium of supervision in distt. = 19436

Total = 5,20,050=00

4.11 INSTITUTIONAL STRENGTHENING IN TERMS OF SERVICE

Logical Framework

Sl.	Goal	Sl.	Impact indicators
1	To improve institutional setup as per IPHS norms	1.1	Improved service delivery for women and children friendly with quality
2	To bring required architectural correction in the Institutional System		

Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
1	To strengthen NGOs Partnership/ PPP for communitization of Health services .	1.1	No and Type of MOU signed between NGO and DHS/RKS for strengthening of communitization of health servies and NGO partnership/ PPP in place	1.1.1	To enforce PNDT Act and to increase sex ratio of female child	1.1.1.1	% decrease in sex selective abortions. % increase in birth of female babies (delivery registers)
				1.1.2	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routin facility where it is not functional.	1.1.2.1	No of cases supported by referral transport system under PPP.
						1.1.2.2	No of canteen facility functional at insttutional facility level.
						1.1.2.3	No of STD booth and other routine facility carried out under PPP.

						1.1.2.4	No of cases supported and payments made by RKS/ DHS to BPL families in availing these services
				1.1.2	To develop partnership with NGO Programmes in the districts	1.1.2.1	No of partnership with NGO for programme implementation for MCHN, Micronutrient supplimentation, national programme implementation specially Kalazar elimination
					Strengthen Logistics management system for regular supply of Drugs and equipments	1.1.2.2	No and % of drug & equipments available and supplied (stock ledger)
					Devlop a strong Monitoring & Evaluation / HMIS System in all PHC	1.1.2.3	Regular monitoring and evaluation reports
3	To devlop IEC and BCC and Training support system .	3.1	No of IEC materials developed and BCC event carried out	3.1.1	Establising BCC and training cell at District & BPHC level	3.1.1.1	Functional BCC cell at DHS/ RKS level
			No of training support system developed		Net working with folk media team	3.1.1.2	No of folk media team engaged in BCC activity. Type and No. of BCC event oragnised

4	To strengthen ASHA support System	4.1	No of ASHA capacities	4.1.1	Develop ASHA support System in all PHC(One person per 20 ASHA)	4.1.1.1	Establishment of ASHA support system at DHS and RKS level
		4.2	No of activities carried out by RKS	4.1.2	Strengthening RKS	4.1.1.2	No of RKS having monthly meetings.
						4.1.1.3	% of untied fund, JSY fund, referral transport etc utilised

Sl.	**Strategy**		**Gaps**		Activities		
	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routeen facilty where it is not functional.		Out sourcing of services is not as per the need of local Need and BPL families are not exampted from Fee of out source services		District /PHC level managers should be aware about the TOR of PPP which is finalized at State level.		
					Build the capacity of manager to manage contracts of PPP		

			There is an acute shortage of para medics like radiographer, lab technician, ECG technician etc. in the District.		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	
	Devlop partnership with NGO Programmes in the districts		A few 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	
					Accreditation of these facility from state Health Socity.	NA	
			There is no MOU with NGO/VO/individuals for Donation and voluntary support in PHC		Process of MOU should be dicentralization and it should oprationlise through RKS.	NA	

			Strengthening of DMU NGOs Management aspects is one of the area of improvement		NGO management process in the district and ASHA Faclitators will be managed at the PHC level	NA	
					Honourarium to DPM, DAM and DA		
					Capacity building training programme for NGOs office bearer with the help of professionals on linkage with health system strengthening component.		
					Mentoring Group at district level.	NA	
					Reporting mechanism should be developed of NGOs work in the district.	NA	
			There is no any VHSC in the district.		Co-ordination with community based orgnisation at SHG, LRG, VEC, ,PRI for VHSC formation.	NA	
	Capacity building of Managers and Doctors.				Expoure visit of DPM/BHM selected ASHA to other state where facility is comparatively working better.		

					ASHA/ AWW career advancement programme may be planned to retain them in the system. Seats in the ANM course, staff nurses and other paramedical courses may be reserved for the qualified ASHAs	If ASHA worker is trained then she would be able to inject medicines and immunization.	
	Preparation of decentralized District Health Action Plan		First time five members of the districts were trained on DHAP preparation		Trainings of DPMU,BPMU members on implementation of services/ various National program and district Health action Plan through distance education		
					Start prepration of plan from the month of October with situtional anlysis,Facility survey, line reporting system and qulitative finding from Community and users of facility.		
	Devlop a strong Monitoring & Evaluation / HMIS System in all PHC		Monitoring of all programme is one of the weakest link of all programme.		Distribution of role and responsbility among MO and Managers of programme implementation.	NA	

			Lack of Supervisers in all PHC Lack of skill of use of data Community is not aware about monitoring aspects of Health Programme.		Use Process indicatore as monitoring of respective programme.	NA	
					Devlop Programme review calander for review of HSC/PHC performance as per form 6 & 7	NA	
					Gradation of Health Sub centers in three categories.	NA	
					Information exchange visits among ANM acording to Grade.	NA	
					Social recognition of Grade one ANM.	NA	
					Devlop four potentioal VHSCs in all PHC on Community based Monitoring of Health and Nutrition programme.		
					Organise"JAN ADALAT" in with PRI & VHSC and invite nearby VHSC to observe thr process of "JAN ADALAT"		

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

					Develop TMC model for Logistic Management in the state.		
	Strengthening RKS		RKS are not uniformally functioning in the district		Ensure registration of RKS of all functional PHC & APHC		
					Training of RKS signatory and BHM on financial Management of RKS		
					Presentation of case study of functional RKS in district level Meeting.		
	Strengthening community process through supportive supervision of ASHA program		Poor monitoring mechanism of ASHA program		Appointment of PHC level ASHA facilitator		
					Provide training cum supervisory support @ one supervisor for 20 ASHA		
	Media Sensitization		Wrong and provocative Reporting Having baseless News.		Media Sensitization work shop		

4.12 RI/Muskan

Sl No	Activities
1	Training of Health workers on Immunization
2	Ensure availability of vaccines. Good provision to keep the vaccines in the cold chain room
3	Repair of vaccine vans. Ensure availability of Deep freezer, ILR, Vaccine carrier, etcc.
2	Printing of RI Formats
3	Printing of Muskan Registers
4	Suuplementary immunization during flood
5	Catch up immunization
6	Incentive money
7	Mahila Mandal
9	POL for cold chain
10	Vaccines and logistics mobility
11	Mobility for supervisor
12	Usage of courier
13	Ensure work of computer operator for RIMS
14	Measles Campaign
15	Hard to Reach area strategy
16	RI Catch up round
17	Training of Medical Officers
18	Meeting of epidemic Response Teams
19	Travel expenses for case investigation per outbreak
20	Shipment cost of lab specimen
21	Outbreak Response