District Health Action Plan

Darbhanga

2010-11

NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

(2005-2012)

District Health Society
Darbhanga
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Foreword

It has become now crystal clear for policy makers through many empirical studies that health of the common people decides the destiny of that country. If we throw light on our health system we find that they are in shambles. Efforts in other areas would lead us nowhere unless we pay heed towards the fine tuning of our health system. Probably this is the reason government of India launched National Rural Health Mission to fill the gap in our health system and make it be able to meet the Medicare needs of the people who can not effort Medicare at market price.

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

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

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

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

Santosh Kr Mall

(District Magistrate)

About the Profile

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

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

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

Dr. Lakhindra Prasad
Civil Surgeon

Chapter-1

Introduction

1.1 Background

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

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

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

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

For effective programme implementation NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the

need for situation analysis, stakeholder involvement in action planning, community mobilization, inter-sectoral convergence, partnership with Non Government Organizations (NGOs) and private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving program functionaries and community representatives at district level.

Stakeholders in Process

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

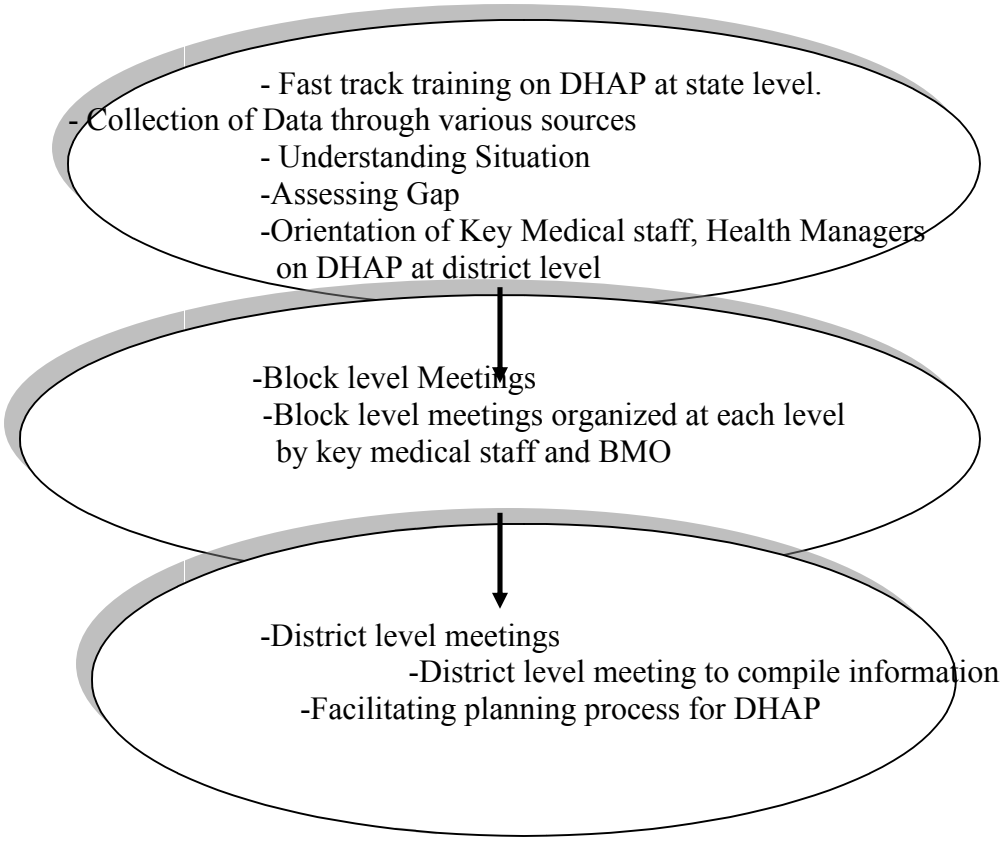
Government of India has launched National Rural Health Mission, which aims to integrate all the rural health services and to develop a sector based approach with effective intersectoral as well as intrasectoral coordination. To translate this into reality, concrete planning in terms of improving the 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 Plan document of district has been prepared on the said context.

1.3.3 Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon, ACMO(Nodal officer for DHAP formulation), all programme officers and NHSRC/PHRN as well as the MOICs, Block Health Managers, ANMs, as a result of a participatory processes as detailed below. After completion the DHAP, a meeting is organized by Civil Surgeon with all MOIC of the block and all programme officer. Then discussed and displayed prepared DHAP. If any comment has 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 Profile

History

Darbhanga fondly remembered as the capital city of ancient Mithila has a glorious past. Mithila, observes Grierson, " is a distinct with its own traditions, its own poet and its own pride ; in a true sense everything belonging to itself." The land of the philosopher king Videh Janak , law saint poet Vidyapati, legendry scholars Yagnavalkya, Mandan of learning and scholarship. All in all, Mithila is universally known as the birth place of Goddess Sita. The splendid site of Balrajgarh, Uchchaith , Jayamanglagarh, Mahishi Bangaon and the like speak volumes of the glorious cultural heritage of Mithila, making the region potentially sound for promoting heritage tourism. Madhubani painting is rightly regarded today as the cultural ambassador of India and not that of the Mithila alone.

The history of Darbhanga dates back to the Ramayana and Mahabharat periods . According to the Vedic Sources , the Videhas of Aryan stock first migrated to the area from the banks of Saraswati in Punjab. They were guided to the east of Sadanira (Gandak river) by Agni, the God of Fire. Settlements were established and, thus, flourished the Kingdom of Vedehas- the Selfless . In course ot time videhas came to be ruled by a line of kings there was a very famous King named Mithi . To commemorate his greatness the territory was named as MITHILA. Another famous king was Janak Sirdhwaja, father of Sita. The legends speak of various learned men patronized by Janak Sirdhwaja , who himself was an erudite scholar. Among them prominent were Yagyavalkya, who codified the Hindu law in his Yagyavalkya Smriti and Gautam , who has various valuable philosophical treatises to his credit. King Janak was himself a great philosopher and his ideas have been eternally enshrined in the Upanishads.

The name of the district has been derived from its head quarter and principal town ,which is said to have been founded by Darbhangi Khan. It is also said that the name **Darbhanga** was derived from **Dwar-Banga** or **Dar-e-Bang** meaning "THE GATEWAY OF BENGAL".Darbhanga is One of the important districts of North Bihar situated in the very heart of Mithilanchal- the fertile , alluvial plains of North India. Under the British rule, Darbhanga was a part of Sarkar Tirhut upto 1875, when it was constituted into a separate district.

The Sub – divisions of the then district Darbhanga were created as earlier as Darbhanga Sadar in 1845, Madhubani in 1846 and Samastipur in 1867. Darbhanga was part of patna Divisions till 1908, when the separate Tirhut Divisions was carved out. Darbhanga become the Divisional headquarters in 1972 When

all its two sub- Divisions got the status of separate district . Thus the present Darbhanga district took shape.

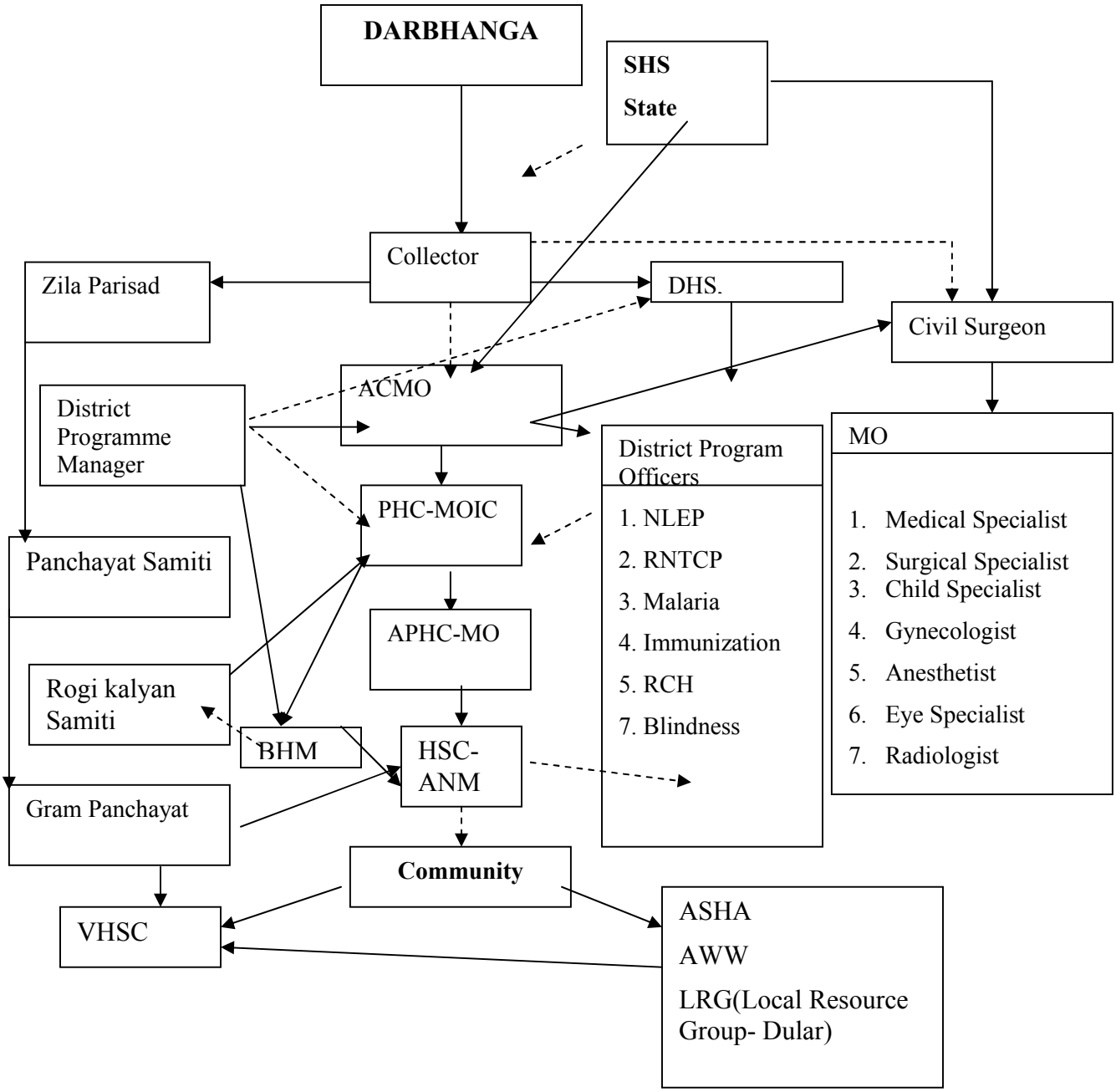
Geographical Location

he District is located at 26.17° North latitude and 85.9° East longitude. The District is situated at the bank of Kamla.The District is surrounded by Madhubani in north,Samastipur in south, Muzzafarpur in west and Saharsa, Supual in East . The District is in Semi tropical Gangetic plane. The state capital Patna is linked with famous Mahatma Gandhi Setu. The District is spread over 2279 sq km area.

Govt's Administrative Set-up

There are three sub divisions and 18 Blocks in the District. The District has 330 Gram panchayats.. The newly elected Panchayati Raj is enthusiastic to play important role in the District.

District Health Administrative Setup



DAR BHANGA– AT A GLANCE

AREA (Sq. Kms):-	2279		
POPULATION(CENSUS 2001)			
TOTAL	:-	3285473	
MALES	:-	1716640	
FEMALES	:-	1568833	
RURAL POPULATION			
TOTAL	:-	3018639	
MALES	:-	1577137	
FEMALES	:-	1441502	
URBAN POPULATION			
TOTAL	:-	266834	
MALES	:-	139412	
FEMALES	:-	127422	
POPULATION OF SCHEDULED CASTES			
TOTAL	:-	511125	
MALES	:-	266236	
FEMALES	:-	240789	
POPULATION OF SCHEDULED TRIBES		:-	
TOTAL	:-	846	
MALES	:-	467	
FEMALES	:-	379	
DENSITY OF POPULATION		:-	1442 per sq.Km
SEX RATIO		:-	914

COMPARATIVE POPULATION DATA(2001 Census)

Basic Data	India	Bihar	Darbhanga
Population	1027015247	82878796	3285473
Density	324	880	1142
Socio- Economic			
Sex- Ratio	933	921	914
Literacy % Total	65.38	47.53	44.32
Male	75.85	60.32	57.18
Female	54.16	33.57	30.35

LITERACY RATE		
TOTAL :- 44.32%		
MALES :- 57.18%		
FEMALES :- 30.35%		
BLOCKS	:-	18
SUB-DIVISION	:-	03
PANCHAYATS	:-	330
VILLAGES:-		1269
POLICE STATIONS	:-	23
TOWNS	:-	01
NAGAR PARISHAD(DARBHANGA)		01
M.P CONSTITUENCY	:-	01
M.L.A. CONSTITUENCY	:-	10
HEALTH		
DARBHANGA MEDICAL COLLEGE & HOSPITAL		01
DISTRICT HOSPITAL	:-	00
REFERRAL HOSPITAL	:-	02
PRIMARY HEALTH CENTRE	:-	18

ADDITIONAL PRIMARY HEALTH CENTRE	:-	36
HEALTH SUB CENTRE	:-	261
BLOOD BANK	:-	01(DMCH)
AIDS CONTROL SOCIETY	:-	01
TRAINED NURSES	:-	516
TRAINED DOCTORS	:-	145

2.1 SOCIO-ECONOMIC PROFILE

Social

- Darbhanga district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Darbhanga have old social hierarchies and caste equations still shape the local development.
- 16.% of the population belongs to SC and 0.025.% to ST. Some Of the most backward communities are *Mushahar, Dusadh,Chamar Mallah* and *Dome*.

Economic

- The main occupation of the people in Darbhanga is Agriculture, Fisheries and daily wage labour.
- Almost 15% of the youth population migrates in search of jobs to the metropolitan cities like Kolkata, Mumbai,Delhi, Amritsar, etc.
- The main crops are Wheat, Paddy, Maize,Makhana and Mango.
- Mango, Makhana and Chilli are the major cash crop of the community residing at the bank of Kamla and Baghmati river

Demographic scenario of Darbhanga district.

According to Census of India 2001:

- The size of population of Darbhanga district is about 3285473, comprising 4% population of Bihar state in 2.30 proportion of state's area.

- Very high density of population 1442 which is still rising
- Decadal population growth rate of 2.25 as against 2.13 of the state as a whole. Thus the decadal growth rate of the district is slightly more than that of the state.
- Sex ratio of the population is 914 females per thousand males which is almost same as the sex ratio of the state. It is difficult to interpret the deficit of 86 females per thousand males in the district despite outward migration, predominantly of males in the working ages. A plausible explanation seems to be that over the years male population has benefited more from the epidemiological transition than the female population.
- Only 8% of the population resides in the urban area, and the rest lives in the rural areas.

Based on these statistics one can say that Darbhanga district lacks urbanization and industrialization. As elsewhere in Bihar, Darbhanga suffers from lack of infrastructure facilities, lack of social development and most people depend on small size agricultural land. Agricultural productivity is further affected adversely by recurrent floods and droughts (World Bank, 2005).

Rainfall and Flood Situation

The district receives medium to heavy rainfall (average rainfall 1142 mm), and faces condition of severe flood. In the year 2007 the flood condition was so bad that almost 198 gram panchayats and 896villages got marooned. According to the estimates of National Disaster Management Department, **in the year 2007, 3,76,249 people were directly affected by the floods.** Crops were damaged, and there was irreparable damage to property and huge loss of lives.

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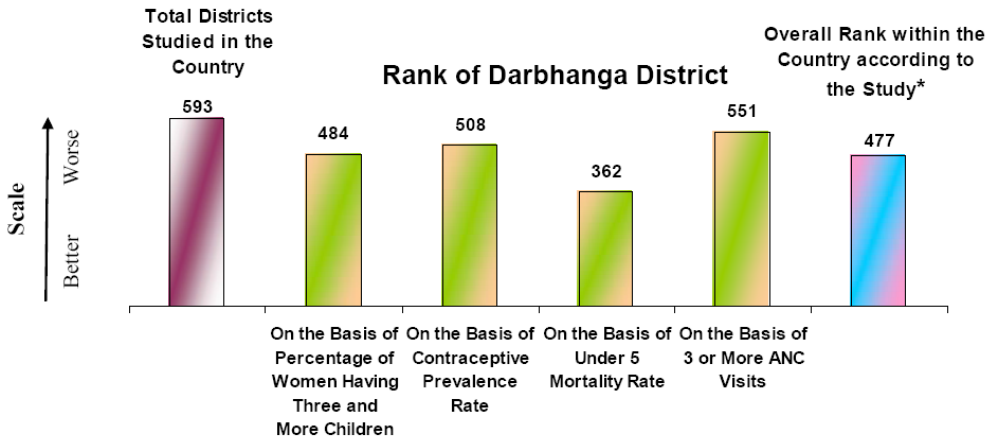
2.3HEALTH PROFILE

General Status of health in Darbhanga district

In a study of 513 districts of the country (Jansankhya Sthirata Kosh", www.jsk.gov.in) in terms of overall rank in health it was found that Darbhanga district ranks 477 though on the basis of under-five mortality it ranked 362. Filaria, Malaria, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in Darbhanga district. Hepatitis, Diarrhea, Typhoid, Blindness and Leprosy are other high prevalence diseases. Kala-azar is an endemic problem in Bihar.



All districts have not been covered due to unavailability of data for some districts

* Source: Ranking and Mapping of Districts, IIPS 2006

IIPS: **International Institute for Population Sciences**, Deonar, Mumbai, is an autonomous institution under the administrative control of the Ministry of Health and Family Welfare, Government of India. It offers academic courses in the area of population studies.

Bihar	DLHS-3	District : Darbhanga

District Indicators, Darbhanga, (2001 Census)

Indicators	Census 2001
Population (in thousands)	3285
Decadal Growth Rate (1991-01)	30.9
Sex Ratio*	914
Percent Urban population	8.1
Percent SC population	14.6
Percent ST population	0.01
Female Literacy Rate (7 years and above)	30.4
Male Literacy Rate (7 years and above)	57.2

Sample outcome, DLHS -3, 2007-08

Category	No. covered	Response Rate
Households	1254	92.9
Ever Married Women (15-49 years)	1119	88.6
Unmarried Women (15-24 years)	199	89.6
Sub Centres (SC)	37	100.0
Primary Health Centres (P H C)	17	100.0
Community Health Centres (C H C)	2	100.0
District Hospital (D H)	1	100.0

Population and Household Characteristics, 2007-08

Background Characteristics	DLHS - 3		DLHS - 2	
	Total	Rural	Total	Rural
Percent total literate Population (Age 7 +)	56.5	54.7	-	-
Percent literate Male Population (Age 7 +)	71.1	70.4	-	-
Percent literate Female Population (Age 7 +)	43.0	40.6	-	-
Percent girls (age 6-11) attending Schools	98.5	98.3	-	-
Percent boys (age 6-11) attending Schools	99.4	99.7	-	-
Have Electricity connection (%)	25.4	21.7	10.5	6.4
Have Access to toilet facility (%)	18.8	14.2	20.1	15.6
Use piped drinking water (%)	0.2	0.1	18.7	18.1
Use LPG for cooking (%)	5.5	1.8	8.2	3.8
Live in a pucca house (%)	12.5	9.6	12.1	8.6
Own a house (%)	98.1	98.3	-	-
Have a BPL card (%)	15.4	15.3	-	-
Own Agriculture Land (%)	29.1	30.7	-	-
Have a television (%)	9.7	6.6	13.8	9.9
Have a mobile phone (%)	18.1	15.5	-	-
Have a Motorized Vehicle (%)	4.9	3.3	7.8	5.8
Standard of Living Index				
Low (%)	83.5	87.2	77.0	81.5
Medium (%)	9.3	8.6	15.1	13.9
High (%)	7.2	4.2	7.9	4.6

* Number of Females per 1000 Males

Bihar	DLHS-3	District : Darbhanga			
Indicators		DLHS - 3		DLHS - 2	
		Total	Rural	Total	Rural
Marriage and Fertility, (Jan 2004 to 2007-08)					
Percentage of girl's marrying before completing 18 years		39.1	41.3	56.6	59.8
Percentage of Births of Order 3 and above		51.4	51.8	57.3	57.8
Sex Ratio at birth		107	105	-	-
Percentage of women age 20-24 reporting birth of order 2 & above		71.8	72.1	-	-
Percentage of births to women during age 15-19 out of total births		96.9	96.9	-	-
Family planning (currently married women, age 15-49)					
Current Use :					
Any Method (%)		31.8	30.4	28.9	27.7
Any Modern method (%)		30.4	29.1	26.7	25.6
Female Sterilization (%)		27.9	27.3	22.0	21.5
Male Sterilization (%)		0.1	0.1	0.3	0.2
IUD (%)		0.3	0.3	0.7	0.7
Pill (%)		1.0	0.9	2.6	2.4
Condom (%)		0.8	0.2	1.0	0.7
Unmet Need for Family Planning:					
Total unmet need (%)		36.3	37.2	42.4	43.3
For spacing (%)		14.7	15.2	17.5	18.2
For limiting (%)		21.6	22.0	24.9	25.1
Maternal Health:					
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)		18.3	17.5	-	-
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)		29.0	28.1	12.6	10.4
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)#		71.9	71.0	24.7	22.1
Institutional births (%)		15.1	14.2	12.5	10.2
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)		2.9	3.0	8.2	7.9
Mothers who received post natal care within 48 hours of delivery of their last child (%)		38.4	38.6	-	-
Child Immunization and Vitamin A supplementation:					
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)		41.8	40.4	28.1	17.5
Children (12-23 months) who have received BCG (%)		91.5	90.9	43.8	35.9
Children (12-23 months) who have received 3 doses of Polio Vaccine (%)		52.5	51.3	40.8	27.2
Children (12-23 months) who have received 3 doses of DPT Vaccine (%)		55.4	53.3	40.8	27.2
Children (12-23 months) who have received Measles Vaccine (%)		56.8	56.9	29.2	19.4
# It is adjusted according to DLHS-3 definition					
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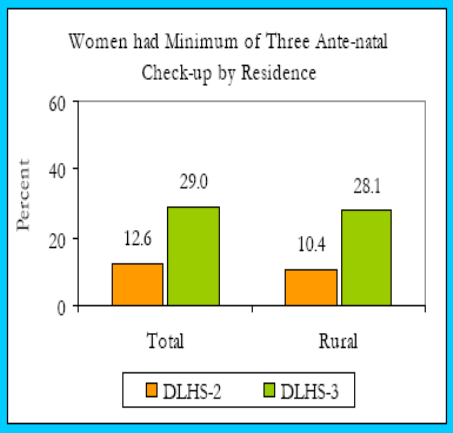
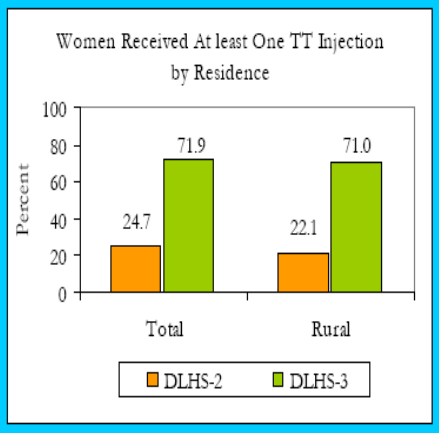
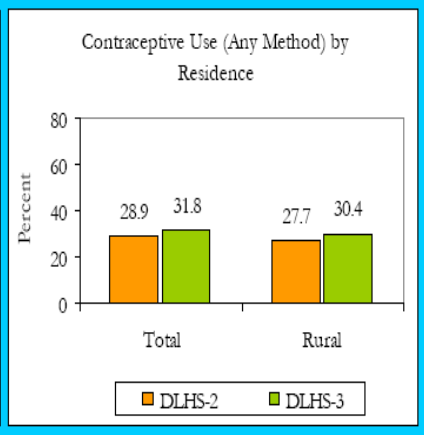
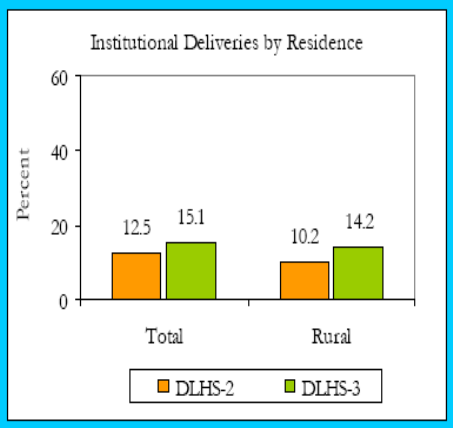
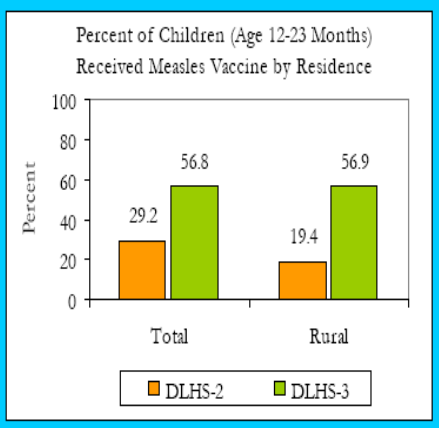
Performance at a Glance

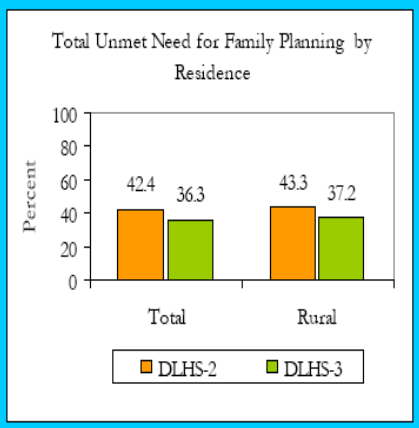












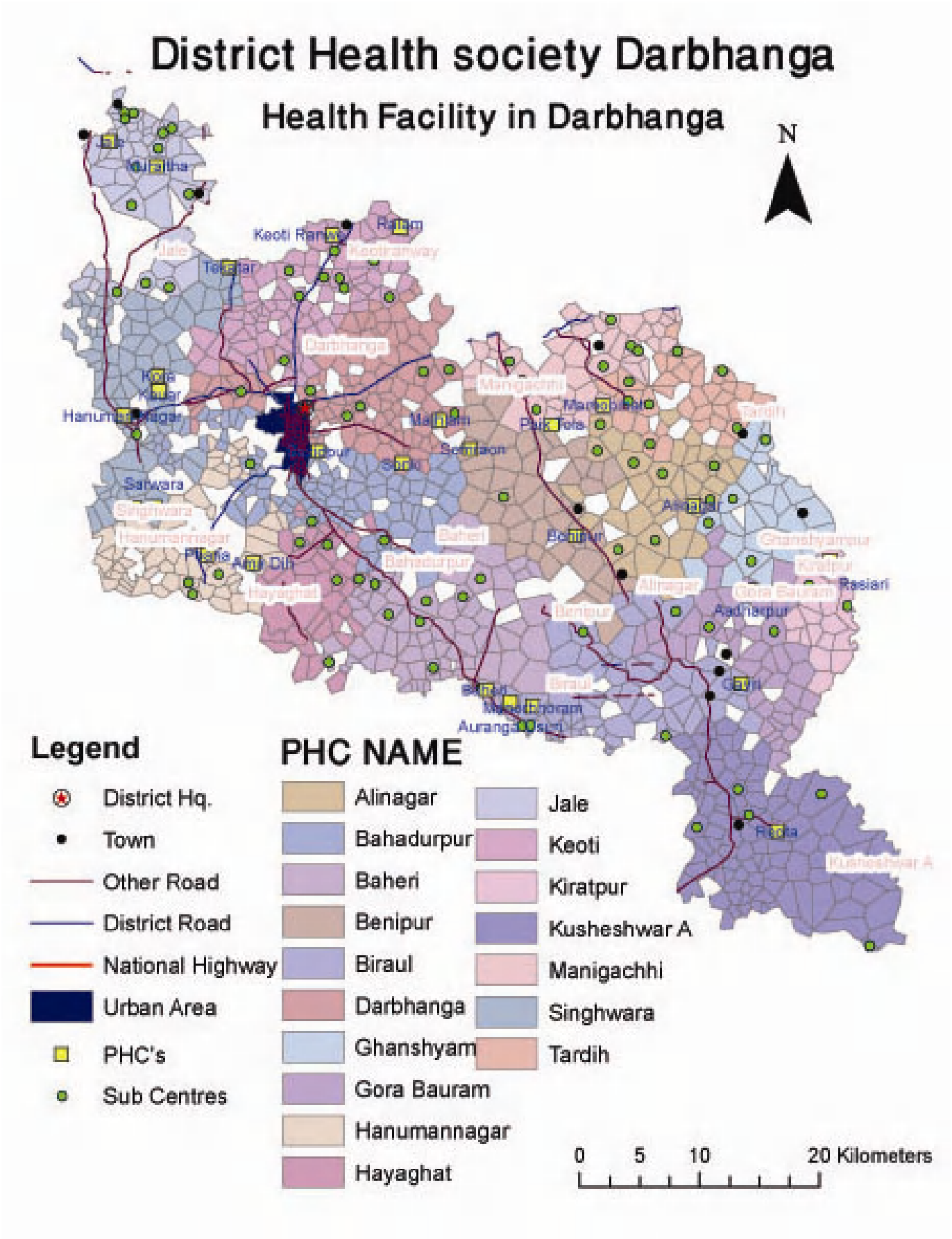
2.3.1HEALTH STATUS AND BURDEN OF DISEASES

Table. CASE FATALITY RATE

S.No.		2008		2009	
	Disease	**Case**	**Death**	**Case**	**Death**
1	Diarrhea / Dysentery	335	0	281	0
2	Cholera	0	0	0	0
3	Meningitis	0	0	0	0
4	Jaundice	0	0	0	0
5	Tetanus	0	0	0	0
6	Kala-azar	1497	4	861	2
7	Malaria	219	0	148	0
8	A.R.I.	NA	NA	NA	NA

2.3.2 PUBLIC HEALTH CARE DELIVERY SYSTEM: ORGANISATIONAL STRUCTURE AND INFRASTRUCTURETable HEALTH CARE INSTITUTIONS IN THE DISTRICT

S.No.	Type of Institutions	Number	No. of Beds*
1	Darbhanga Medical College & Hospital	1	700
2	District Hospital	0	0
3	Referral	2	60
4	Block PHCs	18	72
5	APHCs	36	148
8	Sub-centres	261	0
9	Ayurvedic Dispensaries	0	0
10	Anganwadi Centres	3213	0
11	Others (Pvt. Facility accreditated)	6	150


District Health society Darbhanga
Health Facility in Darbhanga
N
Legend
District Hq.
Town
Other Road
District Road
National Highway
Urban Area
PHC's
Sub Centres
PHC NAME
Alinagar
Bahadurpur
Baheri
Benipur
Biraul
Darbhanga
Ghanshyam
Gora Bauram
Hanumannagar
Hayaghat
Jale
Keoti
Kiratpur
Kusheshwar A
Manigachhi
Singhwara
Tardih
0 5 10 20 Kilometers

Bihar	DLHS-3	District : Darbhang		
Indicators	DLHS - 3		DLHS - 2	
	Total	Rural	Total	Rural
Marriage and Fertility, (Jan 2004 to 2007-08)				
Percentage of girl's marrying before completing 18 years	39.1	41.3	56.6	59.8
Percentage of Births of Order 3 and above	51.4	51.8	57.3	57.8
Sex Ratio at birth	107	105	-	-
Percentage of women age 20-24 reporting birth of order 2 & above	71.8	72.1	-	-
Percentage of births to women during age 15-19 out of total births	96.9	96.9	-	-
Family planning (currently married women, age 15-49)				
Current Use :				
Any Method (%)	31.8	30.4	28.9	27.7
Any Modern method (%)	30.4	29.1	26.7	25.6
Female Sterilization (%)	27.9	27.3	22.0	21.5
Male Sterilization (%)	0.1	0.1	0.3	0.2
IUD (%)	0.3	0.3	0.7	0.7
Pill (%)	1.0	0.9	2.6	2.4
Condom (%)	0.8	0.2	1.0	0.7
Unmet Need for Family Planning:				
Total unmet need (%)	36.3	37.2	42.4	43.3
For spacing (%)	14.7	15.2	17.5	18.2
For limiting (%)	21.6	22.0	24.9	25.1
Maternal Health:				
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	18.3	17.5	-	-
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	29.0	28.1	12.6	10.4
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)#	71.9	71.0	24.7	22.1
Institutional births (%)	15.1	14.2	12.5	10.2
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	2.9	3.0	8.2	7.9
Mothers who received post natal care within 48 hours of delivery of their last child (%)	38.4	38.6	-	-
Child Immunization and Vitamin A supplementation:				
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)	41.8	40.4	28.1	17.5
Children (12-23 months) who have received BCG (%)	91.5	90.9	43.8	35.9
Children (12-23 months) who have received 3 doses of Polio Vaccine (%)	52.5	51.3	40.8	27.2
Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	55.4	53.3	40.8	27.2
Children (12-23 months) who have received Measles Vaccine (%)	56.8	56.9	29.2	19.4

It is adjusted according to DLHS-3 definition

4

Chapter 3

Situation Analysis

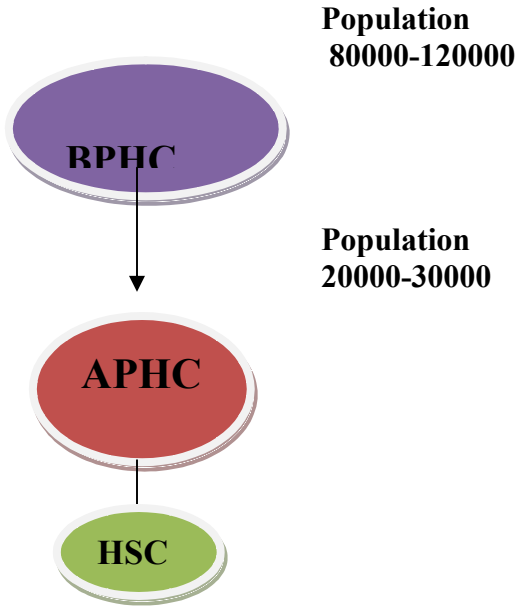
In the present situational analysis of the blocks of district Darbhanga the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from census 2001, report of DHS office, Darbhanga and various websites as well as other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

Table 3.1: Health Indicators

Indicator	Darbhanga	Bihar	India
CBR	33.1	29.2	23.8
CDR	8.1	8.1	6
IMR	67	61	58
MMR	400	371	301
TFR	4.5	4	2.68
CPR	31	34.1	56.3
Complete Immunization	59.2	32.8	44

Sources: DLHS3, NFHS3, SRS2007

3.1.1. GAPS IN INFRASTRUCTURE:



Population 5000
First contact point with community

Introduction:

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

1. **Infrastructure for HSCs:**

IPHS Norms:

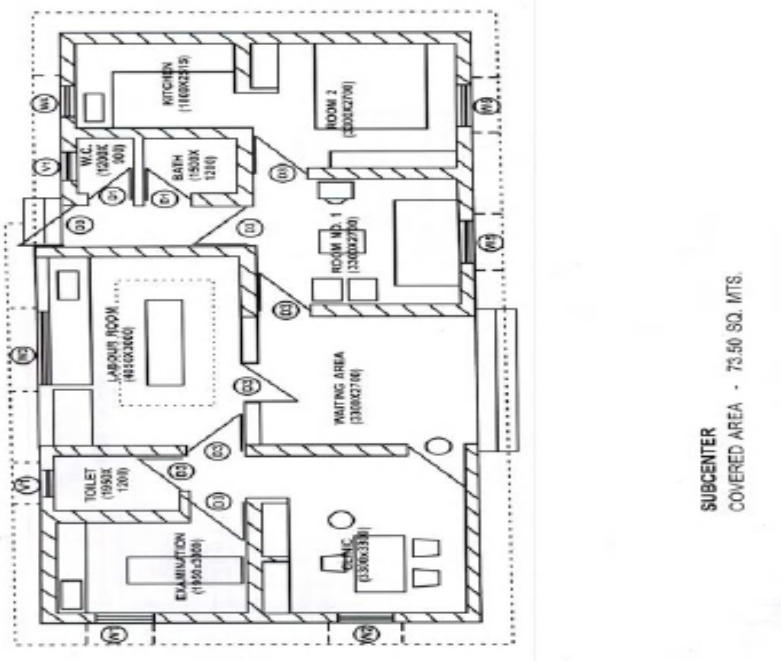
A Sub-centre should have its own building. If that is not possible immediately, the premises with adequate space should be rented in a central location with easy access to population.

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

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

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

Typical Layout of Sub- Centre with ANM Residence



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

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

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

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

HSCs Gaps, Issues and Strategy

Health Sub Centers: Total population of the district as per 2001 census is 3285473. After considering two percent growth rate of the total population it comes around 3187470 (Decadal Growth Rate2.3). After considering projected population in 2008, the district needs altogether 637 HSCs to cater its whole population. At present Darbhanga has 261 established Health Sub Centers and 154 more Health sub centers are proposed to be formed. As per the IPHS norms (5000 population in plain area) the district still requires 135 new HSCs to be formed. Again , out of 338 established HSCs, only 39 have their own buildings and rest 299 run in rented houses. All these 39 HSCs need renovation work. All the above mentioned HSCs need equipments, drugs, furniture and stationeries.

Health Sub Centers:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	A. Out of 261 HSCs only 39 are having own building	In adequate facility in constructed building and lack of community ownership	Enhance visibility of HSC through hardware activity by the help of community participation .	A**Strengtheing of HSCs having own buildings**
	B. In existing 39 buildings 16 are in running comparatively in good condition,			B.1.White washing of HSC buildings. B.2.Organize adolescent girls for wall painting and plantation./hire local painter for colure full painting of HSC walls. List out all services which is provided at HSC level. On the wall. B.3.Gardening in HSC premises by school children.
	C.No one building is having running water and electric supply.			C. Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental.
	D. Lack of equipments and ANM are reluctant	. Operational problem in availability of		D.1.Purchase of Furniture Prioritizing the equipment list according to service delivery(for

	to keep all equipments in HSC . E. Lack of appropriate furniture	equipment in constructed HSC		ANC /Family planning /Immunization/) D.2. Purchase of equipments according to services Purchase one almirah for keep all equipment safely and it could be keep in AWW / ASHA house.
	1.Non payment of rent of HSCs	1.Non payment of rent	Regularizing rent payment	**3B. Strengthening of HSCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries
	1.The district still needs 158 more HSCs to be formed.	1. Land Availability for new construction 2. Constraint in transfer of constructed building		**3C. Construction of new HSCs** C1. Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local

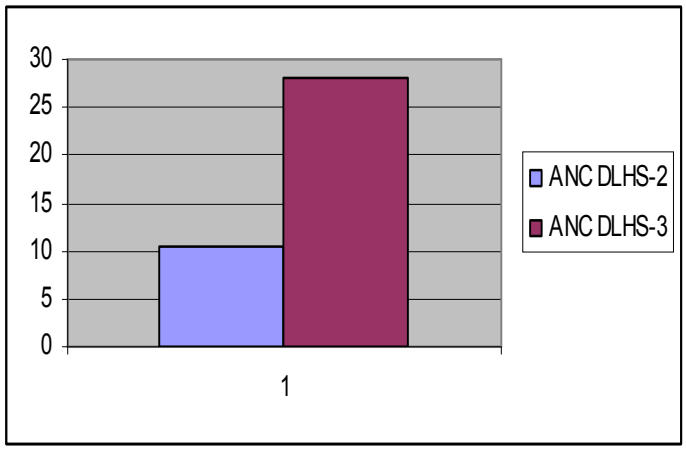
				PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings.
	Non participation of Community in monitoring construction work	Monitoring	Ensuring community Monitoring	1. Biannual facility survey of HSCs through local NGOs as per IPHS format 2. Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 3. Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4. Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 5. Monthly Meeting of one representative of VHSC/Mothers committees on construction work

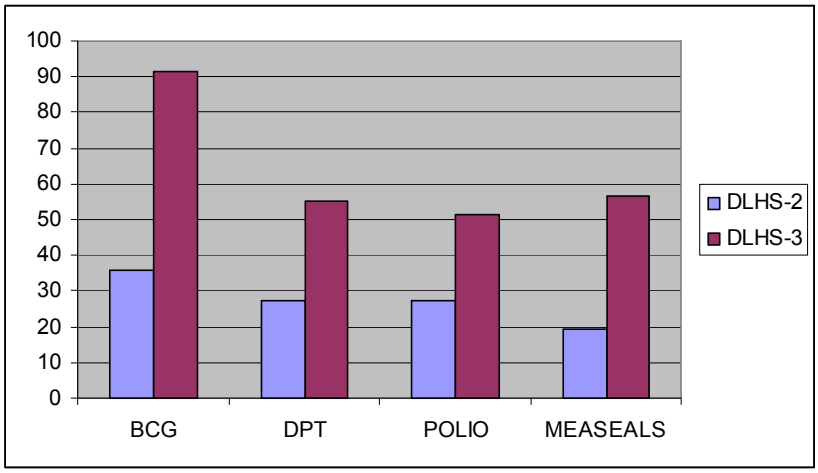
	1. Lack of community ownership in the	1.Community ownership	Strengthening of VHSCs, PRI	1.Formation and strengthening of VHSCs, Mothers committees, 2."Swasthya Kendra chalo abhiyan" to strengthen community ownership 3.Nukkad Nataks on Citizen's charter of HSCs as per IPHS 4.Monthly meetings of VHSCs, Mothers committees

Services of HSCs:

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

As per the DLHS3(2007-08)reports the percentage of full immunization(BCG, 3 doses each of DPT and Polio and measles) coverage(12-23 months) in the district is 41.8%. And BCG coverage of the district is 91.5%. 3 doses of polio vaccine is 52.5%, 3 doses of DPT vaccine is 55.4% and Measles Vaccine is 72.3%. The coverage of Vit A supplementation for the children 9 months to 35 months is 63.2 percent.





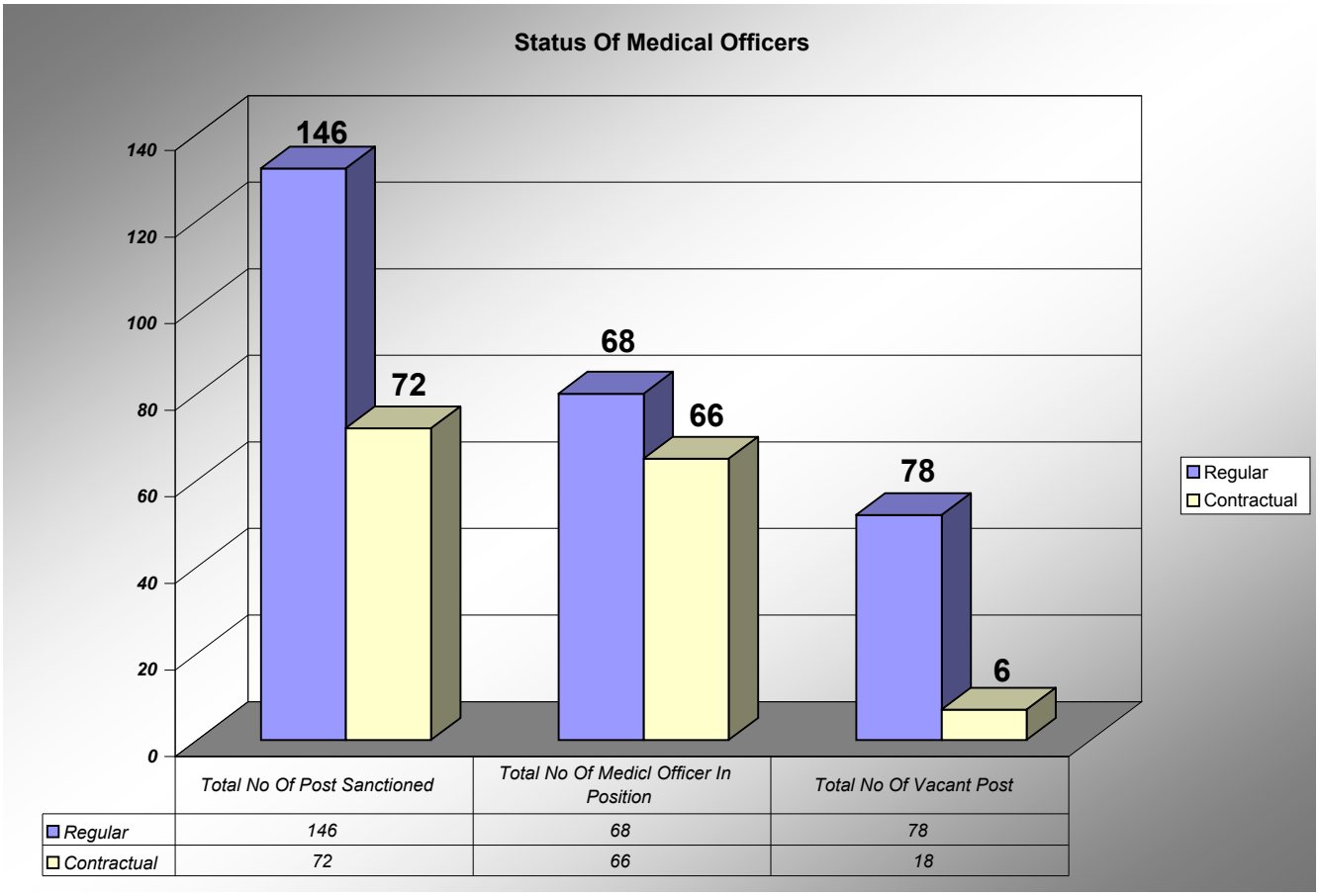
Sub Heads	Gaps	Issues	Strategy	Activities
Service performance	Unutilized untied fund at HSC level	Operationalization of Untied fund.	Capacity building of account holder of untied fund	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts
	No ANC at HSC level	Improvement in quality of services like ANC, NC and PNC, Immunization	Strengthening one HSC per PHC for institutional delivery in first quarter	1. Identification of the best HSC on service delivery 2.Listing of required equipments and medicines as per IPHS norms 3. Purchasing/ indenting according to

				the list prepared 4.Honouring first delivered baby and ANM
	Only 18.2% PW registered in first trimester PW with three ANCs is 29%, TT1 coverage is 71.94%, Family Planning Status: Any method-31.8% Any modern method-30.4% No sterilization at HSC level IUD insertion - 0.3% Pills-1% Condom-0.8% Total unmet need is 36.3%, for spacing-14.7,	Improvement in quality of services like ANC, NC and PNC, Immunization and family planning	1.Phase wise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. 2. Community focused family planning services	1 Gap identification of 39 HSCs through facility survey 2. Eligible Couple Survey 3. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 4. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 5. Training of ANMs on IUD insertion
	Lack of counseling services	Training	Training	1.Training to ANMs on ANC, NC and PNC, Immunization and other services.

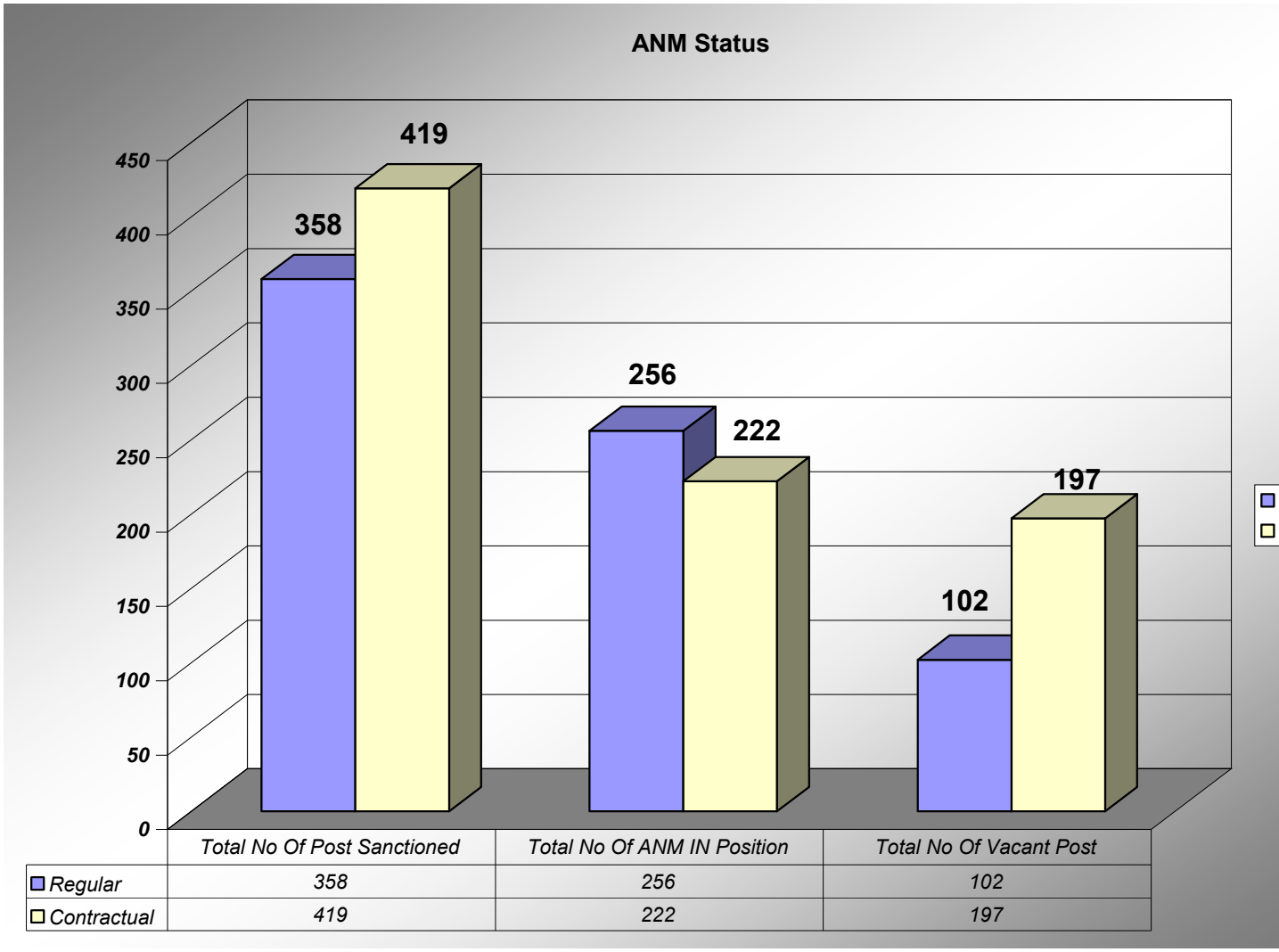
	HSC unable to implement disease control programs	Integration of disease control programs at HSC level.	Implementation of disease control programs through HSC level	1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.
			Lack of Cleaner	Recruitment of Cleaner through RKS on Contract
	80% of the HSC staffs do not reside at place of posting	Absence of staffs	Community monitoring	1. Submission of absentees through PRI
	Problem of mobility during rainy season	Communication and safety		1.Purchasing Life saving jackets for all field staffs 2. Providing incentives to the ANMs during rainy season so that they can use local boats.

Lack of convergence at HSC level	Convergence	Convergence	1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. 2. Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues.
Lack of proper reporting from field Lack of appropriate HMIS formats .	Reporting	Strengthening of reporting system	1.Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc 2.Printing of adequate number of reporting formats and registers 3.Hiring consultants to develop softwares for reporting. 4.Establish data centre at APHC which will monitor all HSC

Human Resource



	Total No Of Post Sanctioned	Total No Of Medicl Officer In Position	Total No Of Vacant Post
Regular	146	68	78
Contractual	72	66	18



Total No of
HSC -261
APHC-36
PHC-18
RF-02

Source: DHS Darbhanga Report.

Sub Heads	Gaps	Issues	Strategy	Activities
Human Resource	1.Out of 261 HSCs 85. don't have either ANMs or Male worker, 2.Out of 25 sanctioned post of LHVs only 16 are placed	Filling up the staff shortage	Staff recruitment	1.Selection and recruitment of ANMs 2.Selection and recruitment of male workers
	1.Out of 478 ANMs 148 Are trained on different services.	Untrained staffs	Capacity building	1.Training need Assessment of HSC level staffs 2.Training of staffs on various services
	Lacks adequate number of trainers, staffs and facilities	Training	Strengthening of ANM training school	1.Analyzing gaps with training school 2.Deployment of required staffs/trainers 3.Hiring of trainers as per need 4.Preparation of annual training calendar issue wise as per guideline of Govt of India. 5.Allocation of fund and operationalization

				of allocated fund
Drug kit availability	1.No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, 2.No Drug kit for AWCs(@one kit per annum,) t	Indenting	Strengthening of reporting process and indenting through form 6	1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports

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

Additional PHCs Status

Additional PHC:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	1.The district altogether need 109 APHCs but there are 36 APHCs functioning in the district . 2. 73 more are proposed to be established. 3.Out of 36 APHCs only 19 are having own building 4.Non payment of rent of APHCs for more than three years Lack of equipments, Non availability of HMIS formats/registers and stationeries 5. PHCs doesn't have boundary walls resulting PHC Premises Safe heaven for Astray animals and trespasser	Lack of facilities/ basic amenities in the constructed buildings Non payment of rent Land Availability for new construction Constraint in transfer of constructed building . Lack of community ownership	Strengthening of VHSCs, PRI and formation of RKS Strengthening of Infrastructure and operationalization of construction works in Three phase	1."Swasthya Kendra chalo abhiyan" to strengthen community ownership 2.Nukkad Nataks on Citizen's charter of APHCs as per IPHS 3. Registration of RKS 4.Monthly meetings of VHSCs, Mothers committees and RKS **A.Strengtheing of APHCs having own buildings** A.1 Prioritizing the equipment list according to service delivery A.2 Purchase of equipments A.3 Printing of formats and purchase of stationeries **B. Strengthening of APHCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund/ RKS from t he month of April 09. B3 Prioritizing the equipment list according to service delivery B4 Purchase of equipments as per need B5 Printing of formats and purchase of stationeries 3C. Construction of new APHC buildings as standard layout of IPHS

			Monitoring	norms. C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New APHC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed APHCs buildings. 4 Biannual facility survey of APHCs through local NGOs as per IPHS format 4.1 Regular monitoring of APHCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.
Human Resource	Out of 36 APHCs 11. don't have doctors, 10 don't	Filling up the staff shortage Untrained staffs	Staff recruitment	1.Selection and recruitment of .Doctors/Grade A

	have A grade nurse, 4.don,t have ANMs,.		Capacity building	nurse/ANMs 2.Selection and recruitment of male workers 3. Sending back the staffs to their own APHCs.
	Hospital campus, lacks adequate number of trainers, staffs and facilities Most of the APHC staffs are deputed to respective PHCS hence APHCS are defunct		Strengthening of ANM training school	1. Training need Assessment of APHC level staffs 2. Training of staffs on various services 3. EmoC Training to at least one doctor of each APHC 1. Analyzing gaps with training school 2. Deployment of required staffs/trainers 3. Hiring of trainers as per need 4. Preparation of annual training calendar issue wise as per guideline of Govt of India. 5. Allocation of fund and operationalization

				of allocated fund
Drug kit availability	No drug kit as such for the APHCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, Only need based emergency suuply Irregular supply of drugs	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 2 and 6 Couriers for vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	1.Weekly meeting of APHC staffs at PHC for promoting APHC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the APHC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through APHC account 4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage
Service performance	RKS has not been formed at any of the APHC. No institutional delivery at APHC level No inpatient facility available No ANC, NC and PNC and family planning services. No lab facility No Ayush practitioner posted	Formation of RKS Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps. Integration of disease control programs at	Capacity building of account holder of untied fund Phase wise strengthening of 36 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms.	1.Training of signatories on operating Untied fund /RKS account, book keeping etc 2. Assigning PHC RKS accountant for supporting operationalization of APHC level accounts 2. Timely disbursement of untied fund/ seed money for APHCs RKS. 3. 1 Gap identification of 36 APHCs through

	No rehabilitation services No safe MTP service No OT/ dressing and Cataract operation services. Approx 80% of APHC staffs not reside at place of posting Lack of counseling services Problem of mobility during rainy season Lack of convergence at APHC level Operational gaps: There is no link between HSCs and APHCs and the same way there is no link between APHC and PHC	APHC level. Family Planning services Convergence Operational issues	Implementation of disease control programs through APHC level where APHC will work as a resource center for HSCc. At present the same is being done by PHC only. Community focused Family Planning services PPP Convergence	facility survey 2.strengtheing one APHC per PHC for institutional delivery in first quarter 3.Ownering first delivered baby and ANM 1 Review of all disease control programs APHC wise in existing Tuesday weekly meetings at PHC with form 6 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 5.Weekly meeting of the staffs of concerned HSCs (as assigned to the APHC) 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1.Outsourcing services for Generator, fooding, cleanliness and ambulance

				1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC.

Primary Health Centre Status

Primary Health Centers:(30 bedded)				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	All PHCs are running with only six bed facility. At present 12 PHC are working with average 30 delivery per day, 2 inpatient Kala-azar, and 140 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms. • The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also under utilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries	Available facilities are not compatible with the services supposed to be delivered at PHCs. Quality of services Community participation.	Upgradation of PHCs into 30 bedded facilities. ISO certification of selected PHCs in the district. Strengthening of BMU Ensuring community participation. Strengthening of Infrastructure and operationalization of construction works	1.Need based (Service delivery)Estimation of cost for upgradation of PHCs 2.Preparation of priority list of interventions to deliver services. 1.Selection of any two PHCs for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers, Accountants in all institutions 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community

	Operation of RKS: Lack in uniform process of RKS operation. Lack of community participation in the functioning of RKS. Lack of facilities/ basic amenities in the PHC buildings		Monitoring	representatives on erecting boundary, beautification etc, 2. Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS. **3.Strengtheing of PHCs** 1Rennovation of PHCs 2 Purchase of Furniture 3 Prioritizing the equipment list according to service delivery and IPHS norms. 4 Purchase of equipments 5 Printing of formats and purchase of stationeries 1. Biannual facility survey of PHCs through local NGOs as per IPHS format 2. Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.
Human Resource	As per IPHS norms each PHC requires the following clinical staffs General Surgeon Physician Gynecologist Pediatrics Anesthetist	staff shortage Untrained staffs	Staff recruitment	1.Selection and recruitment of Doctors 2.Selection and recruitment of ANMs/ male workers 3.Selection and

	Eye surgeon As per IPHS norms each PHC requires the following para medical support:(List attached) But the actual position is Nurse midwife 256/358 Dresser 48./45 Pharmacist/compounders 11/51 Lab technician2./43 Ophthalmic assistant 3/18 Demotivated BPMU staffs		Capacity building	recruitment of paramedical/ support staffs 1.Training need Assessment of PHC level staffs 2.Training of staffs on various services 3.Trainings of BHM and accountants on their responsibilities. 4. Trainings of BHM on implementation of services/ various National program programs.
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time. . Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.	Indenting Logistics Operationalizatio n	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all PHCs 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of

				FIFO list of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	1.Exessive load on PHC in delivering all services i.e. 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC. 2. Total 52seats of Regular and 15 seats of contractual doctors in the district is vacant. 3. All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less(only average16 patients per Doctor per OPD days during April08-Nov 08, however the IPHS norms says that the OPD should be 40 per Doctor.) 4. 5 PHCs out of 18 are lacking 24 hrs new born care services. 5. Only five PHCs provides 24 hrs BEmoC services. 6. None of the PHC provides 24 hour blood transfusion services. 7. PHC does not have laboratory facilities. 8. No any PHC provides adolescent sexual and reproductive health services. 9.Health facility with AYUSH services is not being provided 10. Referal	Optimum Utilization of Human Resources Epidemic outbreaks and Need based intervention in epidemic areas. Service Load centered at PHC Availability of AYUSH pathy.	Quality improvement in residential facility of doctors/ staffs. Recruitment Proper and timely information of outbreaks Strengthening of equipments and services and increase in the number of ambulances.	1. Hiring of rented houses from RKS fund for the residence of doctors and key staffs. 2. Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment. 3. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day 1.Selection and appointment of contractual doctors and staffs 1. Mapping of the areas having history of outbreaks disease wise. 2.Developing micro plans to address epidemic outbreaks 2.Assigning areas to the MOs and staffs 3.Motivating ASHA on

	a. No pick up facility for PW or patients. b.BPL patients are not exempted in paying fee of ambulance. c. Lack of maintenance of ambulances d. Shortage of ambulances 11. Quality of food, cleanliness (toilets,Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC. 12. In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases. 13. Several cases of theft of instruments, computers, and submersible pumps etc at PHCs. 14. No guidance to the patients on the services available at PHCs. 15.Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular. 16. Lack of inpatient facility for kala-azar patients. 17.Lack of counseling services 18.Problem of mobility during rainy season 19.Lack of convergence 20. Lack of timely reporting and delay in data collection	Insecurity (Staff and Properties) Govts existing services like lab, x-ray, generator, fooding and cleanliness services.	Strengthening of AYUSH services at PHC level in the first level. Confidence building measures Strengthening of the Govts existing services like lab, x-ray, generator, fooding and cleanliness services. Creating friendly environment HMIS and strengthening of reporting process	immediate information of outbreaks 4. Purchasing folding tents, beds and equipments and medicines to organize camps in epidemic areas. 1. Repairing of all defunct Ambulances 2. Repairing of PHcs gensets and initiating their use. 3. Hiring of ambulances as per need. 1. Appointment of one AYUSH practitioner and Yoga teacher in every PHC 1.Insurance of all properties and staffs of PHC 2.Placing one TOP in every PHC 1. Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate. 2.Recruitment of lab technicians as required 3. Purchase of equipments/ instruments for strengthening

				lab. 4. Hiring of menial workers for cleanliness works. 1. Assigning LHV for counseling work 2. Wall writing on every section of the building denoting the facilities 3. Name plates of doctor 4. Displaying Roster of doctors with their details. 5. Gardening 6. Sitting arrangement for patients 7. Installation of LCD TV with cable connection 8.Installation of safe drinking water equipments/water cooler, 9.Installation of solar heater system and light with the help of BDO/Panchayat 9. Apron with name plates with every doctors 10. Presence of staffs with uniform and name plates. 1.Orientation of the staffs on indicators of reporting formats 2.Puchase of Laptops for

				DPMs and BHMs

CHAPTER - 4

4.1 Introduction

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

4.2 Targeted Objectives and Suggested Strategies

During consultation at district level involving a range of stakeholders from different levels, an attempt has been made to carve out certain strategies to achieve the specific objectives that are represented by different indicators. The following segment of the chapter corresponds to the identified district plan objectives demonstrating current status of the indicators along with the expected target sets that are projected for period of next five years (2007-12).

District Health Society,Darbhanga

Malaria

S. No.	Gaps	Issue	Strategy	Activities
1	Poor quality of Management of Malaria Cases	Persistence of Malaria in the region	1.Early Case Detection & treatment	1. Provide facility at the APHC level for Thick & thin smear test for Malaria Parasite, Rapid diagnostic test
				2. Ensure functionality of FTDs & DDCs at 1000 population with support of ASHA
				3.Regular supply of malaria drugs in the district
				4. Use of prophylactic measures in suspected cases

			2.Strengthening of Referral system	1. Ambulance facility at the APHC level for referring the Falciparum cases
				2.Training & sensitization of Professionals at sub centre, APHC, PHC , DH
				3. Strengthening of case detection & ensuring fortnightly visits to all villages
			3. Epidemic Preparedness & Rapid response	1. Early response to the incidence of malaria cases in the district
				3. Earliest response to the area having increase in malaria by double in last two years
2	Poor vector control mechanism	1.Integrated Vector Control	1.Indoor residual insecticide spray in rural areas	1. Ensuring availability of sprayers , fogging machines and buckets in adequate number.
			2. Training of the spraying squad	2. Ensuring regular supply of DDT and insecticides
				1. Regular training of the spraying team for dissolving DDT, filling , carrying and spraying process
				2. Supervision by the supervisors to get the feedback of training
				3. Follow up survey: First survey after 21 days of control and second survey after 22 days of first survey
			2. Use of Insecticide treated bed nets	1. Space spray for 7-10 days , residual insecticidal spraying to be started simultaneously as per district micro plans
				2.Supply of Insecticide treated bed nets to suspected patients free

				of cost
			3. Anti larval measures	1. Promotion of use of larvivorous fishes like gambusia in the natural water tank

District Health Society,Darbhanga

T.B.

	Indicators	Gaps	Activities	Unit Cost	Total Cost
1	**Infrastructure**	As per RNTCP standard one more TU is needed	Development of TUand Renovation of DMCs with proper water supply and Electricity connection	35000	35000
		As per RNTCP standard four more DMCs are needed	Establishment of four DMCs	22500	90000
		Six Tus need up gradation	Up gradation	1300	78000
2	**HR**	four more LT is needed	Recruitment Process should be followed.	NA	0
		one more STS and STLs are needed	Recruitment Process should be followed.	7500	18000
			Honorarium for 17 TB technicians	Rs6500 per month for 13 with five percent increment and four technicians @6500/- for 12 months	1376700
		three more TBHVs are needed	Recruitment Process should be followed.	Rs 6500/-	234000
		Constraint in selection Process of new Staffs by the District Health Society	Obstacle in recruitment Process will be rectified.	NA	0
		Remuneration of Pvt DOT Providers has not been paid	Problems in payment of remuneration will be solved	Rs 250 per DOTS provider for 2939 units	734750
3	**Drugs and Chemicals**	Irregular supply of Drugs specially of Pediatric Drug Boxes (PC-13, PC-14)	To ensure regular and adequate supply of drugs and other Laboratory materials	From state budget	0
		Supply of short expiry drugs which causes difficulties in drug management	Proper care should be taken regarding short expiry drugs. Short expiry drugs may be used where there is large number of patients having DOTS.	NA	0
		Poor Retrieval of Drug Boxes of Defaulted patient	Retrieval of Drugs may be ensured by STS.	NA	0
		Irregular supply of slides and other Chemicals and other logistics	Proper supply of Slides and other Chemicals should be ensured	Rs 2000 per DMCs per month	696000

		Delay in purchasing of chemicals and other logistics at District level	Constraints in purchasing of Chemicals and other logistics will be removed. Official Process will be simplified.	NA	0
4	**Service Performance**	Poor quality of DOTS	Proper and Regular supervision and monitoring of programmes will be ensured.	NA	0
		ANMs providing DOTS at the HSCs do not visit the Center on DOTS day resulting irregular intake of drugs by the patient causing poor Cure-rate.	Motivation and Sensitization of Staffs by Refreshment training for friendly behavior with patient	NA	0
		Due to irregularities in DOTS cases of MDR TB may be increased	Proper counseling of patient should be done regarding importance of DOTS and importance of Follow-up Sputum examination	NA	0
		Not friendly behavior of Lab Technician and other staffs with patient who comes for sputum examination or for DOTS	Appointment of a Counselor at all PHC	Discussed in maternal health	0
		Case Detection i.e., <83.99%		NA	0
		Cure Rate i.e., <92%	Organizing Community meetings	NA	0
		low Default Rate	In order to keep vigil on default rate, it is necessary to sensitize MOs at PHCs to monitor treatment card regularly. Training of MO, LT , Paramedical of PHCs are needed	NA	150000
			Medical Officers should take care of referring all chest symptomatic patients for sputum examination	NA	0
			Proper Follow-up Schedule should be maintained	NA	0
			Proper care for side effects of drugs.	NA	0
			Total Budget		**3412450**

Kala -Azar

	Gaps	issues	Strategy	Activities	unit Cost	Total Budget
1	Poor coverage of DDT spray	Vector control through insecticide spray in the attack area	To increase the coverage of DDT spray in the endemic zone , there should be proper monitoring by the supervisors, capacity building of the sprayer, supervisors and other healthcare professionals	1. Ensure planning for timely spray of DDT in Feb-March and May-June for 45 days in each block	NA	0
			Monitoring of the spraying squad by MOIC	2. Identification of Houses with Kala-Azar patients by ANM & ASHA @ 50/ per village.	Rs 50 for 1522 villages twice in a year	152200

				3. Two round of spraying scheduled in Feb-March and May-June should be strictly observed	NA	0
				4. DDT spray should be at the rate of 1gm/sq. meter up to the height of 6 feet.	NA	0
		Less time spent on spraying DDT	Training and capacity building for proper spraying	Regular capacity building training on prescribed module for the sprayer to ensure that very corner of the house is properly spray up to height of six feet from ground level.	Rs 5000 per PHC	90000

		Poor condition of Sprayer, pump and nozzles etc No of Pumps available-294, No of bucket savailable-279, No of buckets required-225, No of gallon available-127, No of gallon required-45, No of pond measure available-127.	Regular checking of the spraying pumps for better functioning and timely replacement of the faulty pieces.	Fund allocation and timely release for : maintenance of old sprayer pumps, Purchase of new pumps and other articles needed- buckets, mugs etc.	Rs 150000 for the district	150000
		Inadequate stock of DDT, DDT available-45mt, DDT required-127mt	Making available DDT during spraying round	Ensure adequate Stock of DDT through proper & timely indenting to improve the quality of spray	DDT Carriage	45000

		Faulty payment plan	Appropriate fund allocation for the payment of the spraying of DDT	Fund would be allocated for regular payment of wages (126 SFW to be used and 630 FW to be used for monitoring and spraying work)	126SFW x Rs113 x 45 days	640710
					630FW x Rs 92 x 45 Days	2608200
2	Poor rate of case detection of Kalazar	Early diagnosis and treatment through PHC system	Case detection rate should be increased with appropriate diagnostic test	Increase efficiency of case detection through training of Community workers on signs and symptoms of Kala-azar: **1)** three weeks persistent fever not responding to antibiotics, malaria being excluded, with palpable spleen.**2)** Ensure availability of Alde Hyde test at PHC level **3**) Purchase of RK 39 kit for detection of Kalazar	Purchase of 50000 units of RK39 @ Rs 25 per unit	1250000

		Reduction of kala-azar mortality and morbidity	Early diagnosis and treatment through PHC system	1. Ensuring availability of Amphotoricin at all level	Purchase of 2400 vials of Amphotoricin B @ Rs 65 per unit	156000
				Loss of wages for KZ patients(case detection in year 2007-3275)	Rs 50 for 22 days for 3200 patients	3520000
				2. Replacing of medicines on priority based	NA	0
				3. Training of ANMs and ASHA for IM injection	Rs 5000 per PHC	90000

3	Lack of monitoring and supervision mechanism,		Monitoring and supervision mechanism	Preparation of Monthly visit plan for supervision :- Checking spraying schedule- For supervision & treatment follow up	Mobility support for CS, ACMO and DMO	45000
					Mobility for MOIC 15x 40days x Rs 100	60000
					Mobility for supervisor 33x 40 daysx Rs100	132000
				Office expenses	25000 for the district	25000

4	Lack of appropriate BCC & Community Mobilization.	Increasing awareness for prevention of Kala-azar	Community participation in reducing mortality and morbidity due to Kala-azar	1. Fund allocation for training activities	NA	0
				2. Identification of NGO/Private partner as trainer	NA	0
				3. Knowledge sharing with the community on signs and symptoms of Kala-azar through VHSC	NA	0
				4. Training of VHSC/PRI and community health worker on sign & symptom of Kala-azar	NA	0
				5. Regular monitoring of IEC activities	NA	0
				6. IEC activities through nukkad natak, kalajatha mass media like radio	Rs 10000 per PHC	180000
				7.Activity for surveillance like polio surveillance	NA	0

				8.Wall painting of Treatment protocol and provisions for patients in PHC in Hindi.	Above mentioned	0
				IEC van for each PHC	15x 40x 750	450000
				Total Budget		**9594110**

District Health Society,Darbhanga

Chid Health

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, attendance and dropout				
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
1	To increase ORS distribution from 20%(DLHS3) to 60%	1.1	% increase of ORS distribution .	1.1.1	*IMNCI,Home Based Newborn Care/HBNC*		% of PHC initiated IMNCI and HBNC training.
2	To increase treatment of diarrohoea from 78% to 90% within two weeks		% increase of treatment of diarrohoea within two weeks				
3	To increase treatment of ARI/Fever in the last two weeks from 56.2%(DLHS3) to 80%		% increase of treatment of ARI/Fever in the last two weeks				
4	To increase of infant care with in 24hr of delivery from 38.2%(DLHS3) to 60%		% 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..
	To increase % of breastfeeding from 15.5% to 30% 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 organized in PHC on IYCF
	To increase initiation of complimentary feeding among 6 month of children from77.7% to 90%		% increase of complimentary feeding among 6month of children.				
	To increase exclusive breastfeeding among 0-6 month of children from 3.4% to 20%		% increase of exclusive breastfeeding among 0-6 month of children .				

	To increase immunization coverage from 40.7% to 70%		% increase of full immunization coverage .				
	To increase vit A coverage of received atleast one dose (9month to 35 months) from 67.3% to 80% and include up to 5 yers.		To increase Vit A reported adequte coverage among (9m to 5ys)	1.1.3	Management of diarrhea, ARI and Micronutrient Malnutrition through Child srvival months		Two round of Child servival Month orgnised in one finicial year.
	To decrease Malnutrition form 58%(NFHS III state) to 30% of the age group of (0 to 5 yrs)		% of decrease Malnutrition age group of (0 to 5 yrs)	1.1.4	Care of Sick Children and Severe Malnutrition and strenthen VHND at all AWCs		No of VHND orgnised vs Planed.
2		2.1		2.1.1	School Health Programme		No Of school health programme organized in the PHC
Sl.	Strategy		Gaps		Activities	Unit Cost	Budget
	IMNCI,Home Based Newborn Care/HBNC		*Training Gaps(AWW-2328/2476,ASHA-0,ANM-377/401,MPW-11/83,MO-47/146,CDPO-05/16,ICDS Super-05,Health supervisors-27,NGOs-06)* *No ASHA is trained on IMNCI*		*Assessment of Training load and prepare calendar of training*	NA	0
					Incorporate ASHA in IMNCI training team	NA	0
					ASHA kit regular supply and incorporate use of ASHA Kit in training curriculum.		
			Inadequate monitoring of this activity at field level		*Division of area among all trained supervisor for revision of IMNCI activity in their area.*	NA	0

					BHM will be responsible for review of health supervisor and LS(ICDS)on given format .Unicef staff will support in developing review mechanism in PHC.	NA	
					Incorpate IMNCI reports in HIMS format	NA	
					Encouraging mother regarding child care. in VHND	NA	
					Frequent checkups of babies by Pediatrician. *Distribute telephone number to AWW and ANM of respective doctors those who are supervising them in the field.*	NA	
					Wednesday could be fixed a day for IMNCI related work at HSC level	NA	
					Community based Monitoring support system devlop with SHG in one PHC *Training of Group members* *seed money to SHG for referral services and other need based services.*	Rs 100000 for one PHC	100000

	Facility Based Newborn Care/FBNC		No institutions have baby warmer machines . maintenance of machine is not up to the markand district having referal six bedded SNCU		All PHCs should be equipped with baby warmer machines.	Mobilizing 19 units from UNICEF	0
			ANMs and Doctors are not trained to operate these machines		Training of Doctors and ANM to operate baby warmer machine.	Rs 5000/- for demonstration at District level	5000
			There is no provision of stay of mothers of neonates at PHC.		Organize training programme for newborn care for the nurses in the district hospitals	One Nurse from each PHC Cost will be 5000/-	5000
			Neonatal Care Unit not up to mark.		District level Supporting supervisory team should be developed with the responsibility of nonfunctioning of neonatal care unit. Training of team on monitoring of NCU	Rs.5000/- for one time training	5000
			Non availability of "MAMTA" at PHC level.		*Training of Mamta and staff nurse on logistics of New born Care units.by district level supervisory Team.*	Rs 1500 for team members for each PHC per month	324000
	Infant and Young Child Feeding/IYCF		Non awareness of breast feeding and proper diet of young children.		Colostrums feeding and breast feeding inclusively for six months. Through IMNCI Training.	NA	0
					Baby friendly hospital Training of one doctor form each Nursing hospital at District Level	Rs.20000 for training programme	20000

					Two days training of one staff nurse from each private hospital on counseling skill.	Rs 20000/- for training programm e	20000
					Accreditation of nursing home and facility according to norms of baby friendly hospital	NA	0
			Poor knowledge regarding new born care and child feeding practices		Development and Printing of BCC materials	Rs 5 per unit for 10000 units	50000
					Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA	NA	0
					Linking JBSY with colostrums feeding	NA	0
			Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding		Counseling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries in mothers meetings and VHSCs meetings	NA	0
					Folk performance to promote exclusive breast feeding	Included in maternal health	0
					Uniform message on radio from state head quarter	State budget	0

					Organize social events through VHSCs	NA	0
					Strengthening of *Mahila Mandal* meetings- fortnightly with involvement of adolescent girl	NA	0
					Organize healthy baby shows, healthy mother / pregnant woman.	Rs 2000 per month per PHC	432000
			Lack of awareness on importance of appropriate and timely IYCF		Appreciation and reorganization of positive practices in community. For this purpose hiring a documentation specialist.	Rs 100000 for the whole district on community wise sample basis	100000
					Celebration of "*Annaprashan(Muhjutthi) Day*" at AWC	NA	0
					Demonstration of recipes.	Rs 250 per month per AWC(Under MUSKAN program)	0
					Exposure visits to existing NRCs to observe different models in the country	Rs 50000 for the district	50000
	Care of Sick Children and Severe Malnutrition		There is not a single unit in the district where severally malnourished children could be treated.		Establish rehabilitation center in FRU and one PHC and promote local available food formula for nutritional Tharapy as Hadrabad Mix	Rs 1000000 per unit	3000000

					Procurement of ,ORS , Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup.	100000 ORS packets at the rate of Rs 5 per packet.(If ORS is not provided in Kit A) IFA syrup for 600000 children at rate of Rs 4 per children	2900000
	Management of diarrhea, ARI and Micronutrient Malnutrition		There is high prevalence of PEM and anemia among children because of Child nutrition is least priority among service providers.		Include covrage of Vitamin A and IFA,children in New HIMS format.	NA	0
					Insure two round of Vitamin A and deworming for the age group of (9m to 5 yrs) & (2 yrs to 5 yers) respectively in the month of April And Oct as per GOI guide line.	Rs 1200000 per round into two rounds(If Vit A is not provided in Kit A)	2400000
					Involvement of ICDS, school teachers and PRI for monitoring and evolution	NA	0
	School Health Programme		No Pre School Health checkup & complete Immunization card.		Half yearly health checkup camp for children in schools should be organized.	Rs 2000 per PHC	36000
			No training of school teacher for basic health care and personnel hygiene.		Training of school teacher by the medical personnel with support administrative person.	Budget incorporated in adolescent health	0
			No regular health checkup camp at school.		Quarterly meetings of VEC representatives by attending existing meetings of VECs representatives at block level by the concerned MOICs and BHMs.	NA	NA

			No Training & Screening of school's teacher for eye sight test.		Linking existing 7 opthalmic paramedics with this program and developing school wise calendar.	Mobility support of Rs 10000 per PHC for moving other blocks and hard to reach areas.	180000
					School health anemia control programme should be strengthen with bi annually de worming .	Budget incorporate d in adolescent health	0
					Organizing competitions/Debates /Painting competitions/Essay/de monstration and model preparation of nutritional food and health.	Rs 20000 per PHC	360000
			No other specific program has been formulated in the district.		Half yearly Health checkups and health card of all school going children.	Printing of Health Card at the rate of Re 1 per card for the children of class 6 to 10	100000
					Films shows on health, sanitation and nutrition issues	Use LCD projector in this activity.	0
					Social Since Lab activities.	Included in adolescent health	0
					Rally and Prabhat Phery in epidemic areas. (Kala-azar & Malaria)	Local contributio n/ Untied Fund/VHS C	0
					Referral system for the school children for higher medical care.	From RKS fund	0
					Total		**10087000**

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 14.2% (DLHS3) to 60% by year 2011	1.1	% of institutional delivery reported	1.1.1	To make functional PHC (24hr x7days) for institutional deliveries	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 FRU for institutional deliveries	1.1.2.1	No of FRUs having functional blood storage units linkage with blood banks and 24hr ready referral transport
						1.1.2.2	No of FRUs having EmOc and CEmOc facilities
						1.1.2.3	No of FRUs having specialist doctors/ multiskilled Medical Officers
						1.1.2.4	No of FRU having functional Neo-natal care units
				1.1.3	To provide Referral transport services at FRU /PHC	1.1.3.1	No of pregnant women availed the referral facilities (pick up and

							drop)
				1.1.4	To strengthen Janani Suraksha Yojana / JSY	1.1.4.1	% of pregnant women reecieved JSY payments immediately after delivery
2	To increase safe delivery by trained SBA 11.5%(DLHS3) to 100% by year 2010	2.1	Proportion of birth attendant by skilled health personnel	2.1.1	To ensure support of SBA at home deliveries	2.1.1.1	% of home deliveries attended by SBA
3	To increase ANC coverage with quality 28.1% (DLHS3) to 70% 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 organize integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas	3.1.2.1	% of RCH camps planned and held
				3.1.3	To improve adolescent reproductive and sexual health	3.1.3.1	No of pregnant adolescent counselled by ANM/ AWW/ASHA
				3.1.4	To accelerate APHC for OPD and Fixed AN clinics	3.1.4.1	% of OPD clincs 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		5.1	% of Mahila Mandal meetings conducted.	5.1.1	To strengthen 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**	Unit Cost	Total Budget
	To make functional PHC (24hr x7days) for institutional deliveries		**Infrastructure**				
A1		1.1	All PHCs are running with only six beded facility.50-60% of facilities are not adequate as per IPHS norms.	1.1.1	Need based (Service delivery)Estimation of cost for up gradation of PHCs Selection of any two PHCs for ISO certification in first phase	@400000/-Per PHC	800000
		1.2	At present 12 PHC are working with average 15 delivery per day, 2 inpatient Kala-azar, 5 FP operation/emergency operation and 140 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	1.2.1	2.Preparation of priority list of interventions to deliver services.	NA	0
	To make functional PHC (24hr x7days) for institutional deliveries	1.3	**As per IPHS norms each PHC requires the following clinical staffs:(List attached)**				0

					Salary of Contractual Doctors	6 Specialist@ 25000/ 66 MBBS @20000/	15990000
		1.3.1	But the actual position is not sufficient as per IPHS norms List of Human resource is attached in Annexure .		Selection and recruitment of Doctors on contractual basis and give priority in selection those who are living in same PHC.	72 Doctors to be appointed	17280000
				1.3.1.1	Salary of Contractual Grade A	56 Grade A Nurse	5040000
		1.3.2			Selection and recruitment of grade A for conducting delivery	3 Grade A nurse for each PHC	4860000
					Selection and recruitment of dresser	18 Dresser for each PHC	1728000
					Selection and recruitment of Pharmacist.	14 x2 Pharmacist for each PHC	1680000
					Three month indication training of Grade A nurse under supervision of District level resource team.	100/-per day x 90 days for 51 grade A nurse	459000
		1.13		1.13.1	Training need Assessment of PHC level staffs	NA	0
					Honorarium of Block Accountants	13 Accountant @ 12000/	1872000
					Rent of Data Center	17 Data Center @ 7500/	1530000
					Honorarium of BHM	10 BHM @ 18000/-	2160000
					Mobility support to BHMs	Rs 2000 per month	408000

				per BHM	
			Process of all recruitments	6 types of recruitment @ 10000	60000
			Trainings of BHMs on Health statistics	18BHMs	36000
			Training on Program, Finance management and HMIS	18 BHMs, 18Block Accountants and 18 Data Center operators	108000
	Drug Supply				
1.16	Irregular supply of drugs because of lack of fund disbursement on time.	1.16.1	Ensuring the availability of FIFO list of drugs with store keeper.	NA	0
1.17	Only 38 essential drugs are rate contracted at state level .	1.17.1	2.Implementing computerized invoice system in all PHCs	NA	0
			Purchase of Drug invoice software	Rs 10000 per PHC	180000
	Lack of fund for the transportation of drugs from district to blocks.	1.17.2	3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock)	NA	0
					0
1.18		1.18	4.Payment from Rogi Kalyan samiti account.	Rs 2000 per month per PHC	432000
1.19	There is no clarity on the guideline for need based drug procurement and transportation.	1.19.1	5. Orientation meetings/ training on guidelines of RKS for operation.	Rs 2000 per PHC	36000
1.2	Drugs are not properly stored	1.20.1	6. Enlisting of equipments for safe storage of drugs.	NA	0
		1.20.2	7. Purchase of enlisted equipments.	Rs 25000	450000

					per PHC	
			1.20.3	8.training of store keepers on invoicing of drugs	Rs 2000 per PHC	36000
		Performance				0
		1.21.1 Excessive load on PHC in delivering all services i.e. 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC.	1.21.1	Recruitment of Doctors on contractual basis	NA	0
		1.21.2 Total 52 seats of Regular and 15 seats of contractual doctors in the district is vacant.			NA	0
						0
		1.22 All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less(only average20 patients per Doctor per OPD days during April08-March 09, however the IPHS norms says that the OPD should be 40 per Doctor.)	1.22.1	Hiring of rented houses from RKS fund for the residence of doctors and key staffs.	Rs 5000 per PHC per month	1080000
			1.22.2	Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.	Rs 5000 per PHC per month	1080000
			1.22.3	Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day	NA	0
To make functional PHC (24hr x7days) for institutional deliveries		1.24 6 PHCs out of 18 are lacking 24 hrs new born care services.	1.24.1	Ensure 24 hrs new born care services in 12 PHC.	Budget in Child health care activity	0
		1.27 No any PHCs provides 24 hrs BEmoC services.	1.27.1	Ensure 24 hrs BEmoC services at 12 PHC		0
				Training of one Docter from each PHC on BEmoC.	4000/- Per Docter	48000
				Equipments for BEmoC	50000 per facility	500000
						0

1.29	18 PHC does not have laboratory facilities on PPP based services.	1.29.1	Recruitment of 18 regular Lab tech at PHC level for providing free of cost lab services to all pregnant women and BPL families.	NA	0
1.3		1.30.1	Recruitment of 18 lab technicians as required for regular support of lab activity	6000/- per head	1296000
			Training of TB lab technician on other pathological tests.	1000/- per training	18000
			Purchase reagent(recurring) for strengthening lab.	5000 per unit per month	1080000
			Purchase of equipments/ instruments if needed . Fund could be routed through RKS and if it is not utilised it could be diverted to other women and child friendly activites.	50000/- per PHC	90000
1.32	Health facility with AYUSH services is not being provided		Establishing one Panchkarm center	10000 Per PHC	180000
			Establising two homeopathy centers in Biraul and Baheri	6000/- each PHC for medicine , equipments and Furniture.	216000
1.33	**Referral Services**				0
1.33.1	No pick up facility for PW or BPL patients.	1.33.1.1	Provision for pick up & drop out for pregnant mothers and BPL families free of cost using existing Ambulance services at PHC level.	60000/- each PHC per month	1296000
			Provide EDD list of pregnant women to Ambulance driver and Number of ambulance deriver and 102 /PHC tel No to all Pregnant women	NA	0

	1.33.3	Lack of maintenance of ambulances	1.33.3.1	Repairing of all defunct Ambulances	Five Ambulances @ rs 50000 per Ambulance	250000
	1.33.4	Shortage of ambulances	1.33.4.1	Hiring of ambulances as per need.	one in each PHC @ Rs 10000 Per month	2160000
				Prepare list of Vehicle those are utilized in Monitoring work in PHC that can be use in pick up and drooping facility for PW.	NA	0
	1.34	Quality of food, cleanliness (toilets,Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC.	1.34.1	Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate.	Rs 50 per patients into 25 patients per day per PHC	2700000
				Review of Cleanliness activity in all PHC by Quality assurance committee and payment of agency should be link with it.		0
			1.34.2	Hiring of workers for cleanliness of OT and Labour room in PHC	Two workers per PHC for maximum 30 days @ Rs 100 per day by concerned RKS	1296000
				Perchage equipments and uniform for cleanliness in all PHC	50000/each PHC	90000

				Training of Workers on using machine/equipments and importance of cleanliness .	2500/- per PHC twice in a year.	90000
				Develop mechanism for monitoring of cleanliness work	NA	0
	1.35	All PHCs have their own generator sets but are not in use.	1.35.1	Repairing of PHCs gensets and initiating their use.	Rs 5000 per PHC	90000
	1.7	Non availability of HMIS formats/registers and stationeries	1.7	Printing of formats and purchase of stationeries	Rs 50000 per PHC	90000
			1.7.2	Biannual facility survey of PHCs through BHM as per IPHS format	NA	0
			1.7.3	Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.	NA	0
	1.8	Operation of RKS:	1.8.1	Ensuring regular monthly meeting of RKS.	Confectionary costs @ Rs 500 per month per PHC	108000
			1.8.2	Appointment of Block Health Managers, Accountants in all institutions.(18 PHCs, 2 Referals hospital.)	Two more BHMs and 2 more Accountants(Rs 18000 per month for BHMs and Rs 12000 per month for Accountants)	720000

		1.9	Lack in uniform process of RKS operation.	1.9.1	Training to the RKS signatories for account operation.	Rs 1000 per participant, Two participants from each PHC	36000
				1.9.2	Trainings of BHM and accountants on their responsibilities.	Rs 1000 per participant, Two participants from each PHC	36000
		1.1	Lack of community participation in the functioning of RKS.	1.10.1	Meeting with community (School children or other)representatives on erecting boundary, beautification etc,	5000/- per PHC	90000
				1.10.2	Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS.	NA	0
		1.36	In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases.	1.36.1	Meeting in RKS with Local Police Station in-charge to handle emergency situation .	NA	90000
					Training local NCC/NYK/Scout & Guide/NSS etc.volunteers on identification of emergency situation. And deployment of volunteers at PHC.	5000/- per PHC	85000
	To make functional PHC (24hr x7days) for institutional deliveries	1.37	Several cases of theft of instruments, computers, and submersible pumps etc at PHCs.	1.37.1	Insurance of all properties and staffs of PHC	Rs 10000 per PHC	180000
		1.38	No guidance to the patients on the services available at PHCs.	1.38.1	Pictorial wall painting on every section of the building denoting the facilities and attached trained volunteers to	Rs 2000 per PHC	36000

					guide patients.		
		1.39	Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.	1.39.1	Name plates of Doctors	Rs 2000 per PHC	36000
					Displaying Name Photograph and DOB of all staff of PHC and put cleanliness staff name on top of the list.		
		1.41	Lack of counseling services	1.41.1	There re 25 LHV in the district we can utilize their experience in counseling work of women and adolescent girls after training.	1000 per person	25000
		1.42	there is no hot water facility for PW and there is no adequate lifting facility at adjoining area of PHC	1.42.1	Installation of solar heater system and light with the help of BDO/Panchayat at PHC or purchase equipments from market.	50000/- per PHC	90000
		1.43	Lack of convergence	1.43.1	Convergence meeting by RKS & DHS	NA	0
		1.44	Lack of timely reporting and delay in data collection	1.44.1	Orientation of the staffs on indicators of reporting formats	NA	0
				1.44.2	Purchase of Laptops for DPMs and BHMs with internet facility.	Rs 40000 per unit+ 2000 per month	798000
		1.45	Lack of space for waiting, environmental cleanliness around PHC, provision for hospitality etc	1.45.1	Gardening	Rs 5000 per PHC	90000
				1.45.2	Sitting arrangement for patients	Rs 5000 per PHC	90000
					Construction of patients waiting shade	75000/- Per PHC	1350000
				1.45.3	Installation of LCD projector for manage wait over time of OPD patients.	Rs 100000/- per PHC	1800000
				1.45.4	Installation of safe drinking water equipments/water cooler,	Rs 10000 per PHC	180000
				1.45.5	Apron with name plates with every doctors	Rs 250 per Doctor for total	51250

						205 doctors	
				1.45.6	Presence of staffs with uniform and name plates.	NA	0
				1.45.7	"MAMTA" should be appointed at PHC level as well.	Rs 75 per delivery for approx 72000 institutional delivery	5400000
	To make FRU functional and upgradation of PHC to CHC for institutional deliveries						
2		2.1	C-Section deliveries are not conducted in institution.	2.1.1	Develop Baheri,Benipur , Jalley and Keoti PHC for C-section facility	NA	0
				2.1.2	Training of MOs of three PHCs in mulltiskilling.	2 Docters from each PHC @ 2000/- per person	24000
				2.1.5	Specialist should be posted at above mention three PHC	NA	0
				2.1.6	Incentive for C-section to PHC those who conducted 10 -15 = 10000,15-20=20000, 25-30= 50000/,C-section in a month the incentive money should be distributed among all staff of the PHC after the decision of RKS.	Rs 25000 per PHC per month	1200000
				2.1.8	Need based Equipments and drugs in O.T and Labour room.	100000 per PHC	1800000
			None of the PHC provides 24 hour blood transfusion services, however Jalley and Manigachi Referal has been provided the equipments for blood storage unit.		Establishing blood storage unit at Jalley and Manigachi Referal	60000/- Per PHC	120000

					Training of lab technician on management of blood storage	5 lab technician	5000
			Infection control protocols is not at all maintain at all facilities	2.2.2	Licensing blood storage / blood bank	NA	0
				2.2.3	Meeting infrastructure requirements as per norms for Blood storage	10000 Per PHC	20000
				2.2.4	Training of MO and lab tech/ staff nurse blood storage on grouping /cross matching and management of transfusion reactions stabilized linkages with mother blood bank.	Rs 1000 per participant, Two participants from each PHC	36000
				2.2.5	Provide free of cost Blood for pregnant women who need blood transfusion for severe anemia/ PPH on prescribed through RKS Fund	20000/- for each PHC per month	4320000
				2.2.11	Organize Blood donation camps at all institution and mobilize community for voluntary blood donation	Rs 10000 per camp per PHC for organizing two camp annually	36000
		2.3	Welcome PW at Institution and PHC and FRU	2.3.1	Provision of food for the delivered mothers and mothers under gone in tubectomy in all the health facilities.	NA	0
				2.3.2	Mobilize community Resources for providing Free food for PW at Institution.	NA	0

				2.3.3	Quality indicators (clean environment, wards with clean linen, clean toilets , clean labour rooms, running waters supply, hot water and protected water for inpatients, new born corners, treatment protocols, aseptic precautions, immediate disbursement of	NA	0
		2.4	Reporting of maternal death Maternal death reporting is usually not reported by worker	2.4.1	Training of ASHA & ANM on reporting of Maternal deaths and conduct Verbal Autopsy	Rs 5000 per PHC	90000
				2.4.2	Incentives for maternal death reporting by ASHA @ Rs 50/-per maternal death	Rs 50/- per maternal death for approx 300 maternal deaths	15000
				2.4.3	Reporting line should be in five columns – name of mother, place of death, date of death, cause of death and no. of birth.	NA	0
				2.4.4	Institution and urban center also to report Maternal death to the district CS/CMO.	NA	0
				2.4.5	Maternal Death should be reported by ASHA AWW, ANM Staff Nurse & Doctors to the district data center .	NA	0
				2.4.6	Investigation of maternal death by district team. and third party review(District magistrate)	NA	0
				2.4.7	Training of ASHA and investigation team objective and process of investigation and review of maternal death	Rs 3000 per PHC	54000
		2.5	Biomedical waste management is not properly taken care	2.5.1	Procurement of equipment	Rs 50000 per PHC	90000

			off at all institution	2.5.2	As per example Introduce color coded buckets for facilities as per IMEP	NA	0
4	**To strengthen Janani Suraksha Yojana / JSY**	4.1	Tracking of pregnant women from first Trimester is not done form the register.	4.1.1	Review of early registration with 3 AN checkup ,two TT.100/200 IFA Tab. in ASHA Diwas.	NA	0
		4.2	Too much documentation process. Photo required for mother and baby. It cost Rs.30/- to Rs.60/- .	4.2.1	Ensure 100 %Pregnancy Test Kit is to ASHA and regular supply.	Rs 50 for 99000 pregnancies	5000000
				4.2.2	Direct transfer of funds from district to PHC through core banking / directly from DHS	NA	0
				4.2.3	Finger print technology for JSY beneficiaries at facility level where computer with internet facility is available. This will help in financial monitoring.	NA	0
				4.2.4	The photo system should be replaced by some other alternatives like- bank account opnin of pregnant women in first trimister and directaly transfer the money to their account after delivery.	Incentive to ASHA for rs 50 per PW for opening of bank account of PW for 100000 pregnancies	5000000
					Incentive for institutional delivery.	Rs 2000 per delivery	140000000
5	**To ensure support of SBA at home deliveries**	5.1	Home Delivery is still prevailing through untrained traditional Dai's	5.1.1	Home Delivery should be conducted by SBA trained Staff Nurse or ANM.	NA	0
				5.1.2	Provision of Dai Delivery kit(DDK) to TBA where institution access is poor. And it should be supervised by ANM for home deliveries.	NA	0

				5.1.3	Delivery kit (equipment, medicine)for ANM should be supplied	Rs 10000 per PHC	180000
				5.1.4	Supply of delivery Kits as per number of deliveries conducted in home.	NA	0
		5.2	Reporting of home delivery is not done so the PNC is not provided	5.2.1	Incentive based system for reporting of home delivery by ASHA and it should linked with ANM	NA	0
		5.3	Non paiment of Home delivery through JSY	5.3.1	The JSY money to the mother who has delivered baby at Home paid by ANM.	Rs 500 per home delivery for approx 40000 home deliveries	20000000
6	**To strengthen HSC for providing outreach maternal care**	**Infrastructure**					0
		6.1	Out of 261 HSCs only 48 are having own building	6.1.1	Strengthening of HSCs having own buildings		0
		6.2	In existing 39 buildings 26 are in running comparatively in good condition, 6 are in under constriction ,one is very poor condition and one is constructed but not hand over to health department.	6.2.1	White washing of HSC buildings.	Rs 2000 per PHC	36000
				6.2.2	Organize adolescent girls for wall painting and plantation./hire local painter for colourful painting of HSC walls.	NA	0
				6.2.3	List out all services which is provided at HSC level. On the wall.	NA	0
				6.2.4	Gardening in HSC premises by school children.	NA	0
		6.3	No one building is having running water and electric supply.	6.3.1	Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental.(Untied fund)	Water rent for 48 HSC, Rs 100 per month from untied fund.	0
					Arrangement of water supply upto HSC (Wiring) from water source	Rs 5000 per HSC	240000

	To strengthen HSC for providing outreach maternal care	6.4	Lack of appropriate equipments and ANM are reluctant to keep all equipments in HSC .	6.4.1	Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/)	Rs 20000 per HSC having own buildings	960000
				6.4.2	Purchase of equipments according to services	NA	0
				6.4.3	Purchase one almarah for keep all equipment safely and it could be keep in AWW / ASHA house.	Rs 10000 per HSC	2610000
		6.5	Non payment of rent of HSCs for more than three years	6.5.1	Strengthening of HSCs running in rented buildings.		0
				6.5.2	Estimation of backlog rent and facilitate the backlog payment within two months	Rs 300 per HSC per month for 36 months(State fund)	0
				6.5.3	Streamlining the payment of rent from the month of April 09.	Rs 300 per HSC per month for 12months(from State fund)	0
				6.5.4	Purchase of Furniture as per need where building is on rent	From untied fund	0
				6.5.5	Prioritizing the equipment list according to service delivery	NA	0
				6.5.6	Purchase of equipments as per need	From untied fund	0
		6.6	The district still needs 158 more HSCs to be formed.	6.6.1	Construction of new HSCs. 85 are having own building, and rest are supposed to be constructed.	From State Govt fund	0

				6.6.2	Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs	NA	0
				6.6.3	Community mobilization for promoting land donations at accessible locations.	NA	0
				6.6.5	Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings.	NA	0
	To strengthen HSC for providing outreach maternal care	6.7	Non participation of Community in monitoring construction work	6.7.1	Biannual facility survey of HSCs through local NGOs as per IPHS format	Rs 200 per HSC per biannually	81200
				6.7.2	Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format.	NA	0
				6.7.3	Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project.	NA	0
				6.7.4	Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work.	Rs 20000 per PHC	360000
				6.7.5	Quarterly Meeting of one representative of VHSC/Mothers committees on construction work and other issues	Rs 50 for TA to VHSC members for attending monthly meeting at PHC	722400
		6.8	Lack of community ownership in the	6.8.1	Formation and strengthening of VHSCs, Mothers committees,	NA	0
				6.8.2	"Swasthya Kendra chalo abhiyan" to strengthen	NA	0

					community ownership		
					One week Training of Nukkad Natak team on IPHS	Rs 300 per participant per day for 85 persons for 7 days	178500
				6.8.3	Nukkad Nataks on Citizen's charter of HSCs as per IPHS	Three days performance at 301 HSCs	1354500
				6.8.4	Monthly meetings of VHSCs, Mothers committees	NA	0
7		**Human Resource**					
		7.1	1.Out of 25 sanctioned post of LHVs only16 are placed, 2.All 478 posted ANM ® are not trained enough to deliver services. 3. 197 seats of contractual ANM®, and 102seats of Regular ANMs are vacant.	7.1.1	Selection and recruitment of 197 ANMs	honorarium of 197ANMs @ Rs 6000 per month for 12 months	14184000
					Honorarium of existing 222 ANMs	Honorarium of existing 222 ANMs @ rs 6000 per month for 12 months	15984000
				7.1.2	Selection and recruitment of 32 male workers	Honorarium of32 male workers @ Rs 5000 per month for 12 months	1920000

				7.1.3	Training need Assessment of HSC level staffs by BHM in weekly meeting	NA	0
				7.1.4	Training of staffs on various services in the PHC,	Rs 1000 per participant (Total no of participants 197 new ANMs, 222 existing ANMs and 32 new male workers)	451000
8	**To strengthen HSC for providing outreach maternal care**	**Drug Kit Availability**					0
		8.1	No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives,	8.1.1	Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports	NA	0
			No Drug kit for AWCs(@one kit per annum,) . No ASHA kit, only need based emergency but that too being irregular in supply	8.1.2	Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map	From state fund	0
				8.1.3	Hiring vehicles for supply of drug kits through untied fund.	Rs 200 per HSC per month	722400
				8.1.4	Developing three colored indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)	Rs 2000 per PHC	36000
				8.1.5	Hiring of couriers as per need	Rs 50 per courier	960000

						for 200 couriers for 8 days per month	
				8.1.6	Payment of courier through ANMs account	Fund for the payment of Couriers should be transferred to ANMs account.	0
9	**To strengthen HSC for providing outreach maternal care**	**Performance**					0
		9.1	Unutilized untied fund at HSC level	9.1.1	Training of signatories on operating Untied fund account, book keeping etc	Rs 100 per person for two persons for 301HSCs	60200
				9.1.2	Timely disbursement of untied fund for HSCs	Rs 10000 per HSC per year for 301 HScs	3010000
				9.1.3	Assigning a person at PHC level for managing accounts	NA	0
		9.2	No ANC at HSC level Only 18.2% PW registered in first trimesterPW with three ANCs is 29%, TT1 coverage is 71.94%,	9.2.1	Identification of the best HSC on service delivery	NA	0
				9.2.2	Listing of required equipments and medicines as per IPHS norms in facility survey	NA	0
				9.2.4	Honoring the ANM those who develop women friendly HSC in given criteria	5 ANM in a year per PHC social honouring with one shawl.	45000

	To strengthen HSC for providing outreach maternal care	9.3	Family Planning Status:-Any method-31.8%,Any modern method-30.4%,No sterilization at HSC level,IUD insertion -0.3%,Pills-1%,Condom-0.8%,Total unmet need is 36.3%, for spacing-14.7%,Lack of counseling Skill.	9.3.1	Gap identification of 39 HSCs through facility survey	NA	0
				9.3.2	Eligible Couple Survey	NA	0
				9.3.3	Ensuring supply of contraceptives with three month's buffer stock at HSCs.	State Fund	0
				9.3.4	One day training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS	Rs5000 per PHC	90000
				9.3.5	Training of ANMs on IUD insertion	Rs 10000 per PHC	180000
		9.4	HSC unable to implement disease control programs	9.4.1	Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week)	NA	0
				9.4.2	Strengthening ANMs for community based planning of all national disease control program	NA	0
				9.4.3	Reporting of disease control activities through ANMs	NA	0
				9.4.4	Submission of reports of national programs by the supervisors duly signed by the respective ANMs.	NA	0
		9.5	80% of the HSC staffs do not reside at place of posting	9.5.1	Submission of absentees through PRI	NA	0
		9.6	Problem of mobility during rainy season	9.6.1	Purchasing Life saving jackets for all field staffs	3 units per PHC at the rate of Rs 3000 per unit	162000
				9.6.2	Providing incentives to the ANMs during rainy season so that they can use local boats.	From untied fund	0
		9.7	Lack of convergence at HSC level	9.7.1	Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC.	from untied fund	0

				9.7.1	Monthly Video shows in all schools of the concerned HSC area schools on health, nutrition and sanitation issues.	From untied fund	0
		9.8	Lack of Knowledge and skill of field level staff of data compilation in HMIS formats and formats.	9.8.1	Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc	NA	0
				9.8.2	Printing of adequate number of reporting formats and registers	Discuse d earlier	0
10	**To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas**	10.1	Out reach camps are not organized in plan manner. It is totally base on demand of organization and it eventually it is not reported to respective HSCs and PHC.	10.1.1	Identifying Socially Backward, Slums & Maha Dalit Tolas.	NA	0
				10.1.2	Hiring trained alternate vaccinator/ retired ANMs and Medical officer .hiring vehicle for fixed day out reach camps with drugs.	Rs 10000 per PHC per month	2160000
				10.1.3	Fixed day OPD clinics at APHC level and adjoining HSC of respective APHCs. with dedicated MO and support staff.	NA	0
				10.1.4	To make calendar for camps with date and identified areas.and link NGOs those who are willing to organized Camps .	NA	0
				10.1.5	Community based reporting system through SMS. involve PRI members and training on reporting and Camp approach	NA	0
11	**To improve adolescent reproductive and sexual health**	11.1	No training programme for adolescent particularly health and sex.	11.1.1	Multipurpose counselor can be used for adolescent care. For this services of LHV can be used.and callender of activity could be devlop.	NA	0
		11.2	Preventions of anemia in adolescence girls	11.2.1	linkage with adolescent anemia controle programme in Schools with Unicef. And traing to the one teacher from the school	Rs 5000 per PHC	90000

		11.3	Marriage before legal age.	11.3.1	Sensitization of PRI members particularly women	Rs 5000/- Per PHC	90000
		11.4	Preventions of teen age pregnancy and abortion.	11.4.1	Adolescent pregnancy should be addressed with priority care(eclampsia, 3 ANC, anemia, 100 IFA, 100% institution delivery, low birth Wight baby, Brest feeding.PNC with in 48 hours.	NA	0
	To improve adolescent reproductive and sexual health	11.6	Limited interventions for empowering adolescent girls	11.6.1	Family counseling for adolescent pregnancy tracking on above mention through ASHA and AWW.	NA	0
				11.6.2	State to develop and issue guidelines for implementation of Kishori MandalsFormation of Kishori Mandals by registration of all girls(11-18 yrs)	NA	0
				11.6.3	Prepare a monthly plan of activities for one day per week	NA	0
				11.6.4	Counseling nutrition, health and social issues every week at AWCs by AWW	NA	0
				11.6.5	Weekly distribution of IFA Tablets to out-of-school girls at AWCs	From State	0
				11.6.6	Deworming adolecent every 6 months	Purchase of 12 lack tablets	900000
				11.6.8	Initiate family schools for learning child care , safe mother hood life skills and Family life education	Rs 10000 per Schools each in each PHC	180000
12	**To provide MTP services at health facilities**	12.1	MTP services are not available in Public sectors	12.1.1	Selection of facilities for provision of safe abortion services	NA	0
				12.1.2	Location of facility availability of trained service provider, space, equipments.	NA	0

				12.1.3	To Provide appropriate equipments at all facilities and MVA syringes.	50000/- per PHC	900000
				12.1.4	Putting the trained doctors at appropriate facilities to commence the services	NA	0
				12.1.5	Training of Medical officers and Para medical staffs on Safe abortion services training including awareness about legal aspects of MVA/ EVA and Medical abortion by IPAS .	One doctor and one ANM from each PHC @ Rs 2000	36000
				12.1.6	Formation of district level committee (DLC) to accredit private sites as per GOI guide line .	NA	0
				12.1.7	Develop reporting system of MTP services in private and public sector.	NA	0
				12.1.8	Through training program make the govt doctors skilled to perform MTP in the approved sites.	NA	0
	To provide MTP services at health facilities			12.1.9	To Involve community to aware about location of services , process and legal aspects of MTP services through - AWW, ASHA & ANM, LRG and mass media.(IEC)	Rs 5000/- Per PHC	90000
				12.1.10	The services of Pregnancy testing should be strengthen and it should be linked with MTP services.	NA	0
				12.1.11	NGO's and local Practitioner should be involved for counseling and information of facility	NA	0
				12.1.12	Assurance of privacy and link with family welfare services counseling at all facility.	NA	0
				12.1.13	Linkage with MTP services with NGOs (PPP) those who are working in Safe abortion services. and create one modal center at district and PHC level.	NA	0

				12.1.14	Training of ASHA on medical abortion.	Incorporated in ASHA training	0
13	**To strengthen Monthly Village Health and Nutrition Days**	13.1	Nutrition and Counseling Component is not visible in VHND and there is no monitoring of VHND activity by Community.	13.1.1	AWC should be develop Hub of activities (VHND)	NA	0
				13.1.2	Develop an activity plan calendar for VHND as seasonality.	NA	0
				13.1.3	Counseling of mothers on ANC, preparation for Child care ,STI/RTI, and AYUSH, adolescent Health	NA	0
				13.1.4	Organize VHND in Four Table concept regularly where One place is for registration, one is for weighing, one is for immunization and fourth is for counseling	Booklet on four table concept @Rs 5 for 10000 booklets	50000
				13.1.4	Meeting of VHSC and preparation for area specific epidemiological planning and community based monitoring.	NA	0
				13.1.5	Skill development training is required to ANM , ASHA & AWW and Dular (LRG)	Rs 5000 per PHC	90000
				13.1.6	Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourish children , New born, DOTs and other services	From untied fund	0
				13.1.7	SMS reporting system of conducting VHND and ANM collect Data from field level and compile it in weekly/Monthly	NA	0
B	**APHC**		**Infrastructure**				0
	To form /strengthen APHC in Phase manner	1.3	Out of 36 APHCs only 19 are having own building	1.3.1	Registration of RKS	NA	0
		1.4	Existing 19 buildings are not properly maintained	1.4.1	Renovation of APHCs buildings from RKS Fund	Rs 150000 per	2850000

						APHC	
		1.5	Non payment of rent of 17 APHCs for more than three years	1.5.1	Payment Of Rent of APHC building	From state fund	0
		1.6	Lack of equipments,	1.6.1	Purchase of equipment as per service need from RKS fund	From state fund	0
		1.7	Lack of appropriate furniture	1.7.1	Purchase of Furniture from RKS fund	From state fund	0
2			**Human Resource**				0
		2.1	in the district no any APHC functioning as per IPHS norms	2.1.1	Operationalising one APHC in each PHC by conducting daily OPD by Doctor. And support staff.	NA	0
		2.2		2.2.1	Notification from district for operationalising APHC	NA	0
3			**Drug Supply**				0
		3.1	No drug kit as such for the APHCs as per IPHS norms.,	3.1.1	Purchasing 23 listed OPD Drugs of PHC for APHC	Rs 200000/- Per PHC for OPD drugs for one year.	3600000
5	**RTI/STI services at health facilities**	5.1	No regular clinic at all PHCs & APHCs.	5.1.1	Trained service provider on syndrome management of RTI/STI (As per GOI guide line) up to APHC level.	Rs 1000/- for Two person from each PHC	36000
				5.1.2	Logistics of setting of clinics and free drugs availability	NA	0
				5.1.3	Integrated Counseling services in four public sector facilities by trained personnel .	NA	0
				5.1.4	IEC/BCC for awareness available RTI/STI services at all health facilities.	Rs20000 for Per PHC	360000
						Total	**3138554 50**

District Health Society,Darbhanga

Family Planning

Sl.	Goal	Sl.	Impact indicators				
1	Population stabilization	1.1	To decrease TFR upto replacement level To increase sex ratio				
Sl.	**Objectives**	**Sl.**	**Outcome indicators**	**Sl.**	**Strategy**	**Sl.**	**Output indicators**
2	To increase female sterilization from present 27%(DLHS3) to 40%	2.1	% increase in female sterilsation	2.1.1	Terminal/Limiting Methods	2.1.1.1	% of terminal/limiting methods use
				2.1.2	Dissemination of manuals on sterilization standards & quality assurance of sterilization services	2.1.2.2	No of facilities providing quality manuals on sterilization standars of sterilization services.
				2.1.3	Female Sterilization camps	2.1.3.3	No of camps orgnise for female sterlization .
				2.1.4	Compensation for female sterilization	2.1.4.4	% of Female recived compensation
				2.1.5	IUD camps	2.1.5.5	No of IUD used in Camps
				2.1.6	Accreditation of private providers for IUD insertion services	2.1.6.6	No of Private providers accrediate for IUD Insertion services.
3	To increase male sterilization from 0.1%(DLHS 3) to1%	3.1	% increase in male sterilisation	3.1.1	NSV camps	3.1.1.1	No of NSV Camps orgnised.
				3.1.2	Compensation for male sterilization	3.1.2.2	% of Male received compensation
				3.1.3	Accreditation of private providers for sterilization services	3.1.3.3	No of Private providers accredited for Sterilization services.
4	To increaseuse of condoms from 0.8% (DLHS3) to 3%	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 Organized on Contraceptive Update.
5	To increase use of pills from present 1%(DLHS3) among current married women age 15-49 yrs to 3%	5.1	% increase in the use of pills	5.1.1	Promotion to Social Marketing of pills	5.1.1.1	No of Pills distributed through Social Marketing.

Sl.	Strategy		Gaps		Activities	Unit Cost	Total Budget
	Terminal/Limiting Methods		Lack of knowledge of small family norms.		Ensure one MO trained on on minilap and NSV up to PHC	Rs 20000	360000
					Training of nurses and ANMs on IUD and other spacing methods at PHC level.	Rs 10000	180000
					Ensure availability of contra septives (indenting , logistic	Rs 500000 per PHC	9000000
	Female Sterilization camps		Laparoscopy surgery not done.		Trained doctors on laparoscopy.	Above mentioned	0
					Procure Laparoscopy equipments for trained docters	Rs 100000 per PHC	1800000
					Training of doctors needed.	Mentioned above	0
	NSV camps		Trained doctors are not available.		Procurement of equipment.	Mentioned above	100000
	Compensation for female sterilization				Immediate disbursement of incentive after sterilization camps.	Rs1000 each for 25000 male and 5000 female operations	32500000
	Compensation for male sterilization		Anesthetists are not available		Logistic planning is needed before organizing camps.	NA	0
					Block Health manager could be hire one support staff for disbursement for logistic support.	NA	0
					Immediate disbursement of incentive after sterilization camps.	Discussed earlier	0

					Logistic planning is needed before organizing camps.	NA	0
					Block Health manager could be hire one support staff for disbursement for logistic support.	NA	0
					Accreditation of private nursing home. As per GOB	NA	0
	IUD camps		Camps not held		Training of ANM & staff nurse for IUD insertion.	Discussed earlier	0
	Accreditation of private providers for IUD insertion services		No accreditation of private providers for IUD insertion services		Procurement of IUD.	Rs 30 into 52800 units	1584000
					Equipments for IUD insertion	Discussed earlier	0
					Accreditation of private providers for IUD insertion services. As per GOI guide lines.	NA	0
	Social Marketing of contraceptives		Monitoring of Social Markiting is not monitored by PHC.		Social marketing of need based OC & IUD.	NA	0
					Increasing access to contraceptive through communities based distribution system free of cost.	NA	0
	Contraceptive Update seminars		Not being held.		seminars for MO and other through Professional bodies (FOGSI. BMA, Nursing association etc..on	NA	0
					Copper-t 380-A should be popularized.	NA	0
					Awareness for emergency contraceptive.	NA	0
					Total		**45524000**

INSTITUTIONAL STRENGTHENING			
Logical Framework			
Sl.	**Goal**	**Sl.**	**Impact indicators**
1	To improve institutional setup as per IPHS	1.1	Improved service delivery For women and child friendly with quality
2	To bring required architectural correction in the Institutional System		

Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
1	To strengthen NGOs Partneship/ PPP for communitisation 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 birt of female babie (delivery registers)
				1.1.2	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routine facility where it is not functional.	1.1.2.1	No of cases supported by referral transport system under PPP.
						1.1.2.2	No of canteen facility functional at institutional facility level.
						1.1.2.3	No of STD booth and other routine facility carried out under PPP.
						1.1.2.4	No of cases supported and payments made by RKS/ DHS to BPL families in availing these services
				1.1.2	To develop partnership with NGO Programmes in the districts	1.1.2.1	No of partnership with NGO for programme implementatio n for MCHN, Micronutrient supplimentati on, national programme implementatio n 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 develop IEC and BCC and Training support system .	3.1	No of IEC materials developed and BCC event carried out	3.1.1	Establishing 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 organized
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	**Unit Cost**	**Budget**

	To enforce PNDT Act and to increase sex ratio of female child		No registration of ultra sound clinic.		Registration and monitoring of ultra sound clinic.	NA	0
					MTP clinic should be watched for termination of pregnancy following USG.	NA	0
					IEC on PNDT act	Rs 5000 per PHC	90000
	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routine facility where it is not functional.		Out sourcing of services is not as per the need of local Need and BPL families are not exempted from Fee of out source services		District /PHC level managers should be aware about the TOR of PPP which is finalized at State level.	NA	0
					Build the capacity of manager to manage contracts of PPP	NA	0
			There is an acute shortage of para medics like radiographer, lab technician, ECG technician etc. in the state.		Accreditation of institutions and to set standards, an institute of paramedical sciences may be started in the state. This would create more employment opportunities in addition availability of para medical personnel for absorption into the government health system.	NA	0

	Devlop partnership with NGO Programmesin the districts				listing of NGOs those who are working in F.P ,MTP,programme, Institutional delivery, Blindness control programme.	NA	0
			Non involvement of NGO in Institutional delivery and Blindness control programme.		Accreditation of these facility from state Health Socity.	NA	0
			There is no any MOU with NGO/VO/individuals for Donation and voluntary support in PHC		Process of MOU should be decentralization and it should be oprationlise through RKS.	NA	0
			Strengthening of DMU NGOs Management aspects is one of the area of improvement		ASHA Programme manager facilitate the NGO management process in the district and ASHA Facilitator will be manage at the PHC level	NA	0

					Honorarium to DPM, DPM(ASHA), DAM and DA	Rs 30000 pm for DPM, Rs 28000 pm for DPM(ASHA), Rs 26000 pm for DAM and Rs 22000pm for DA	1272000
					Capacity building training programme for NGOs office bearer with the help of professionals on linkage with health system strengthening component.	Rs 5000 per PHC	90000
					Mentoring Group at district level.	NA	0
					Reporting mechanism should be develop of NGOs work in the district.	NA	0
			There is no any VHSC in the district.		Co-ordination with community based orgnisation as SHG, LRG, VEC, ,PRI for VHSC formation.	NA	0

	Capacity building of Managers and Doctors.				Exposure visit of DPM/BHM /ASHA DPM/ selected ASHA to other state where facility is comparatively working better.	Rs 100000 for the district	100000
					To start DNB (Family Physician) 3 year course in the district hospitals.	Rs 100000 for the district	100000
					ASHA/ AWW career advancement programme may planned to retain them in the system. Seats in the ANM course, staff nurses and other paramedical courses may be reserved for the qualified ASHAs	Rs 10000 per PHC	180000
	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	1 DPM, 18Doctors(One from each PHC) , 18 BHMs and district planning team	100000

					Start preparation of plan from the month of October with situation anlysis,Facility survey, line reporting system and qualitative finding from Community and users of facility.	Rs 50000 for the district	50000
	Devlop a strong Monitoring & Evaluation / HMIS System in all PHC.Appointment of Data Centre for APHC with the responsibility of collecting Information from HSCs		Monitoring of all programme is one of the weakest link of all programme.Lack of Supervisers in all PHCLack of skill of use of dataCommunity is not aware about monitoring aspects of Health Programme.		Distribution of role and responsbility among MO ,Managers Grade A Nurses and ANMs of Programme Implementation.	NA	0
					Use Process indicatore as monitoring of respective programme.	NA	0
					Devlop Programme review calendar for review of HSC/PHC performance as per form 6 & 7	NA	0

					Gradation of Health Sub centers in three categories.	NA	0
					Information exchange visits among ANM according to Grade.	NA	0
					Social recognition of Grade one ANM.	NA	0
					Devlop four potentioal VHSCs in all PHC on Community based Monitoring of Health and Nutrition programme.	Rs 2000 in each PHC	36000
					Establishment of Data Center for each ADPHC	RS 5200 for each ADPHC	2246400
					Organise"JAN ADALAT" in with PRI & VHSC and invite nearby VHSC to observe thr process of "JAN ADALAT"	NA	0
					Devlop Health and Nutrition Report Card by using growth monitoring chartsof Village and present in "JAN ADALAT" By VHSC	Rs 2000 in each PHC	36000

	Strenthen Logistics management system for regular supply of Drugs and equipments		There is no system of logistic management of Drugs and other supply at any level. Only vaccine supply management is comarativaly stroger then other logistic work.		Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports	NA	0
					Hiring vehicles for supply of drug kits	Rs 20000 per PHC per month	4320000
					Hiring of couriers as per need	Discussed in maternal health	0
					Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)	Discussed in maternal health	0
					Training of all ANM and Stock keepers on Indenting and Logistic Management.	Rs 5000 per PHC	90000
					Devlop TMC model for Logistic Management in the state.	NA	0

	Establishing BCC and training cell at District & BPHC level		There is not as such designated post for BCC and Training at the district and PHC level		ASHA Programme manager facilitate the process of training and BCC in the district and ASHA Faclitatore will be manage at the PHC level	NA	0
					Devlop resource team at District Level.	NA	0
					MOU with Local NGOs for logistic management of training and Devlop issues wise Master traners in district	Na	0
					Devlop ASHA support system on one person/20 ASHA for on the job training of AHSA and AWW	NA	0
	Net working with folk media team		There is no BCC management unit at District Level		Identify Health Communication orgnisation for identification of BCC issues as per need of District.	Discussed in child health	0
					MOU with orgnisation for formative research .	NA	0
					Devlop IEC/BCC material based on Findings of formative search	Discussed in child health	0

					Printing of IEC and BCC material	Discussed in child health	0
					Training of Folk Media group on IEC/BCC material	Discussed in maternal health	0
					Planning of performance route chart of Folk media Group	NA	0
					Monitoring of performance through SMS of PRI members	NA	0
					Impact analysis of Performance by Orgnisation	NA	0
	Strengthening RKS		RKS are not uniformly functioning in the district		Ensure registration of RKS of all functional APHC	NA	0
					Training of RKS signatory and BHM on financial Management of RKS	Discussed in maternal health	0
					presentation of case study of functional RKS in district level Meeting.	NA	0
	Strengthening community process through supportive supervision of ASHA program		Poor monitoring mechanism of ASHA program		Appointment of PHC level ASHA facilitator	Rs 12000 per Facilitator per month for 18 facilitator	2592000

					Provide training cum supervisory support @ one supervisor for 20 ASHA	Rs 250 per supervisor for 152 supervisors for maximum 15 days in a month	6840000
					Training of DPM (ASHA) , Facilitator and supervisors at block level.	Rs 250 per participant for three days for 180 participants.	45000
						Total	**18187400**

District Health Society,Darbhanga

Blindness

Gaps	issues	Strategy	Activities	Unit Cost	Total Budget
Lack of adequate eye surgeon and staffs in the district. Only 4 eye surgeons are posted in the district out of which one is on deputation to the other district.	Staff shortage	Recruitment	Recruitment of Eye Specialists and surgeons on contractual basis.	Already discussed in maternal health	0
Most of the doctors and staffs are not trained enough on new IOL tehniques	Untrained staffs	Capacity building	Training of Doctors on IOL technique	Rs 10000 per person for 5 person	50000
			Training of Opthalmic Assistant	Rs 2000 per person for 7 persons	14000
In the Year 2009-10 only 672 Cataract operations have been done by the Govt facilities and 1338 by the private facilities(till Nov 9.In the year 2007-08, 2966 surgeries have been performed.	Low achievement	Increasing roof camps	Organizing Operations at District level	Rs750 per operation for 6000 operations	4500000
		PPP	Accreditation of Nursing Homes capable of doing Cataract surgeries	NA	0
			Establishing another Cataract Operation Center at PHC Benipur and Jalley	Rs 1200000	2400000

			Purchase of equipments and medicines		
Lack of awareness among community regarding cataract blindness and its treatability.	Lack of awareness	Awareness building	Assigning LHV/Supervisor counseling work	NA	0
Fear of eye operation.			Organizing eye screening camps in villages/ schools	NA	0
Lack of Education among the masses about the existing facilities: Need of wide publicity.			IEC on cataract and its facilities	Rs 100000 at district level	100000
Poor coordination between the health functionaries and the voluntary organisations resulting in less cataract surgeries.		Involving NGOs	Meeting with Local NGOs on this issue	NA	0
Lack of adequate referral services to take care of complications.	Lack of adequate referal services	Strengthening referal system	Arrangement of carrying patients to the Operation Centers and then taking them back homes	Rs 10000 per PHC	180000
Lack of monitoring and follow up	Monitoring and follow up	Monitoring and follow up	Mobility support for Visiting homes of the patients to manage any post treatment complication.	Rs 10000 per PHC	180000
			Developing records of cataract cases from OPD registers at PHC level	NA	0
			Total	**7424000**	

District Health Society,Darbhanga
Leprosy

Gaps	issues	Strategy	Activities	Unit Cost	Total Budget
· Existing PR of the district is 1.1 and the target is only 1, so the existing program performance is good.					
• Lack of awareness is still a problem with the Leprosy Program as most of the cases are detected accidentally.	Lack of Awareness	Awareness generation	IEC on Leprosy	Rs 5000 per PHC in a year	90000
• Inadequate staff, Only 4 supervisors and 13 Non Medical Assistants are working while the requirement of Supervisor is 8 and that of NMA is 36(One NMAeach in each APHC)	Lack of Human Resource	Staff Recruitment in contract basis	Recruitment of 4 supervisors	Rs 7000per superisor per month	336000
• There is no active involvement of the Medical officers at sector and Block levels.		Strengthen Health Care Services	Orientation of Mos and staffs on Leprosy	NA	0
• Lack of PHC staff involvement. No manpower support,			Case validation, to have check on wrong diagnosis and re registration	NA	0
			Prompt and early detection of the cases to avoid deformity and disability,	NA	0
			Ulcer care foot ware reorientation training of medical & para medical staff.	Rs2000 per PHC	36000

No lab testing facility in the district	Infrastructure Gap	Establishing Lab	Establishing Lab at district level	Rs 200000	200000
			Recurring expenditure like reagents	Rs 1000 per month	12000
Lack of monitoring at all level	Monitoring Gap	Increasing mobility	Updation of master register	NA	0
			Mobility support for DLO	RS 10000 per month	120000
			Office expenses	Rs 2000 per month	24000
			Total		**818000**

District Health Society,Darbhanga

Filaria

Gaps	issues	Strategy	Activities	unit Cost	Total Budget
It affects mainly the economically weaker sections of communities	Five days are required for MDA	1. Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.	Line listing of the cases	NA	0
			Purchase of equipments for the management of Filaria cases like towel, Bucket, soap, mug etc	Rs 500 per HSC for 261 old and 50new HSCs	150500
			DEC distribution through AWCs and paying hon to AWWs for this.	Rs 100 for all 3213AWC	1606500
			Transportation of DEC from State		12000
			Transportation of DEC District to PHC		18000
			Monitoring to PHC		124200
			Monitoring to Head Quarter		19320
			Training Of Medical Officers		54950
			Training to AWWs/ASHA on DEC distribution and filaria case management	Rs 2000 per PHC	36000

Result in low priority being accorded by governments for the control of lymphatic filariasis.		2. Continuous use of vector control measures.	Meeting with VHSC members	NA	0
Low effectiveness of the tools used by the control programme			Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.	NA	0
The chronic nature of the disease		4. IEC for ensuring community awareness and participation in vector control as well as personal protection measures.	Wall paintings and Miking	Rs 7000 per PHC	133000
			Total		**2154470**