District Health Action Plan

2010-2011

District Health Society
Rohtas (Sasaram)

Chapter-1

Introduction

1.1 Background

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

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

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

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

For effective programme implementation NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the need for situation analysis, stakeholder involvement in action planning, community mobilization, inter-sectoral convergence, partnership with Non Government Organizations (NGOs) and private sector,

and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving program functionaries and community representatives at district level.

Stakeholders in Process

- *Members of State and District Health Missions*
- *District and Block level programme managers, Medical Officers.*
- *State Programme Management Unit and District Programme Management Unit Staff*
- *Members of NGOs and civil society groups (in case these groups are involved in the DHAP formulation)*

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

1.2 Objectives of the Process

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

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

1.3 Process of Plan Development

1.3.1 Preliminary Phase

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

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

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

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

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

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

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

The study used a number of primary data components which includes collecting data from field through situation analysis format of facilities that was applied on all HSCs and 19 PHCs of Rohtas district. In addition, a number of field visits and focal group discussions, interviews with senior officials were also conducted. All the draft recommendations on workforce management and rationalization of services were then discussed with employees and their associations, the officers of the state, district and block level, the medical profession and professional bodies and civil society. Based on these discussions the study group clarified and revised its recommendation and final report was finalized.

Government of India has launched National Rural Health Mission, which aims to integrate all the rural health services and to develop a sector based approach with effective 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 Rohtas district has been prepared on the said context.

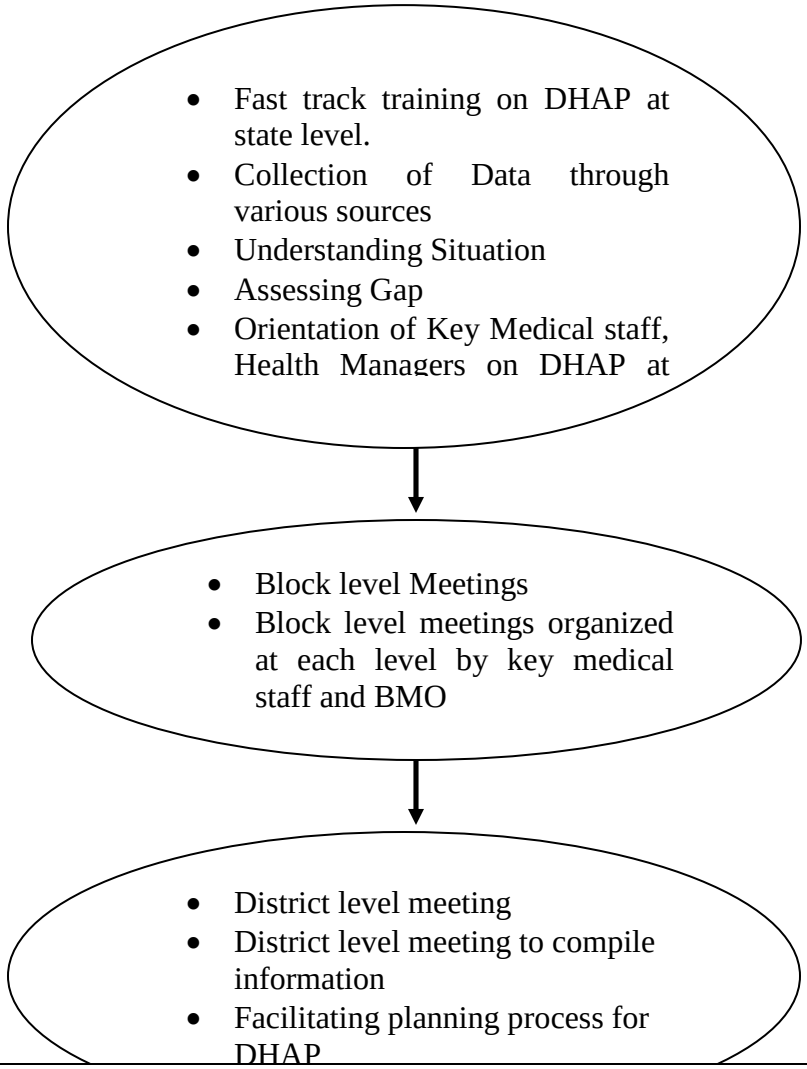
1.3.3 Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon, ACMO, all programme officers and NHSRC/PHRN as well as the MOICs,

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

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

District Health Action Plan Planning Process



Chapter 2

District Profile

History

Rohtas has an old & interesting history. In pre-historic days the plateau region of the district has been the abode of aboriginals whose chief representatives now are the Bhars, the Cheers and the Oraons . According to some legends the Kherwars were the original settlers in the hilly tracts near Rohtas. The Oraons also claim that they ruled over the area between Rohtas and Patna. The local legend also connects king Sahasrabahu with Sasaram, the headquarter of Rohtas district. It is believed that Sahasrabahu had terrible fight with Saint Parsuram, the legendary Brahmin Protector, as a result of which Sahasrabahu was killed. The term Sahasram is supposed to have been derived from Sahasrabahu and Parsuram. Another legend connects the ROHTAS hill to Rohitashwa, son of Raja Harishchandra, a famous king who was known for his piety and truthfulness.

The District of ROHTAS formed a part of the Magadh Empire since 6th B.C. to 5TH Century A.D. under the pre Mauryans. The minor rock edict of Emperor Ashok at Chandan Sahid near Sasaram confirmed the Mauryans conquests of this district. In the 7th Century A.D. This district came under the control of Harsha rulers of Kannauj.

Sher Shah's father Hassan Khan Suri was an Afghan adventure, he got the jagir of Sasaram as a reward for his services to Jamal Khan, and the Governor of Province during the latter's attachment with the king of Jaunpur. But the Afghan Jagirdar was not able to exercise full control over this subject since the allegiance of the people was very lose and the landlords were particularly independent. In 1529 Babar invaded Bihar, Sher Shah who lost opposed him. Babar has left in his memories an interesting account of the place. He mentioned about the superstitions of the Hindu with regard to river Karamnasa and also described how he swam across the river Ganga at Buxar in 1528.

When Babar died , Sher Shah become active again .In 1537 Humayun advanced against him and he seized his fortresses at Chunar and Rohtas Garh. Humayun proceeded to Bengal where he spent six months, while on his return journey to Delhi he suffered a crushing defeat at the hands of the Sher Shah at Causa. This victory secured for Sher Shah the imperial throne of Delhi. " The rule of Sur dynasty , which Sher Shah founded, was very short lived. Soon the Mughals regions the imperial throne of Dehli. After his assassination, Akbar tried to extend his empire and consolidated it. The district of Rohtas was thus included in the empire".

The next event of importance which shook the District, was the reign of Raja Chait Singh of Banaras, his kingdom included large part of Shahabad and his control extended up to Buxar.He raised the banner of revolt against he English who had a difficult time. At Chunar and Ghazipur, the English troops suffered defeat and the very foundations of the English power in India was shaken. But, 'is well known fact that Chait Singh lost eventually.

The district had a very uneventful history till we come to 1857 when Kunwar Singh revolted against the British Empire in line with the Mutineers of 1857. Most of the hiroic details of Kunwar Singh is concerned with the present district of Bhojpur. However he mutiny had its impact and produced similar up-rising and incidents here and there. The hilly tracts of the district offered natural escape to the fugitives of the Mutiny. During Independence movement the district had a substantiates contribution to the freedom movement of India. After Independence Rohtas remained a part of the Shahabad District but in 1972 Rohtas became a separate District.

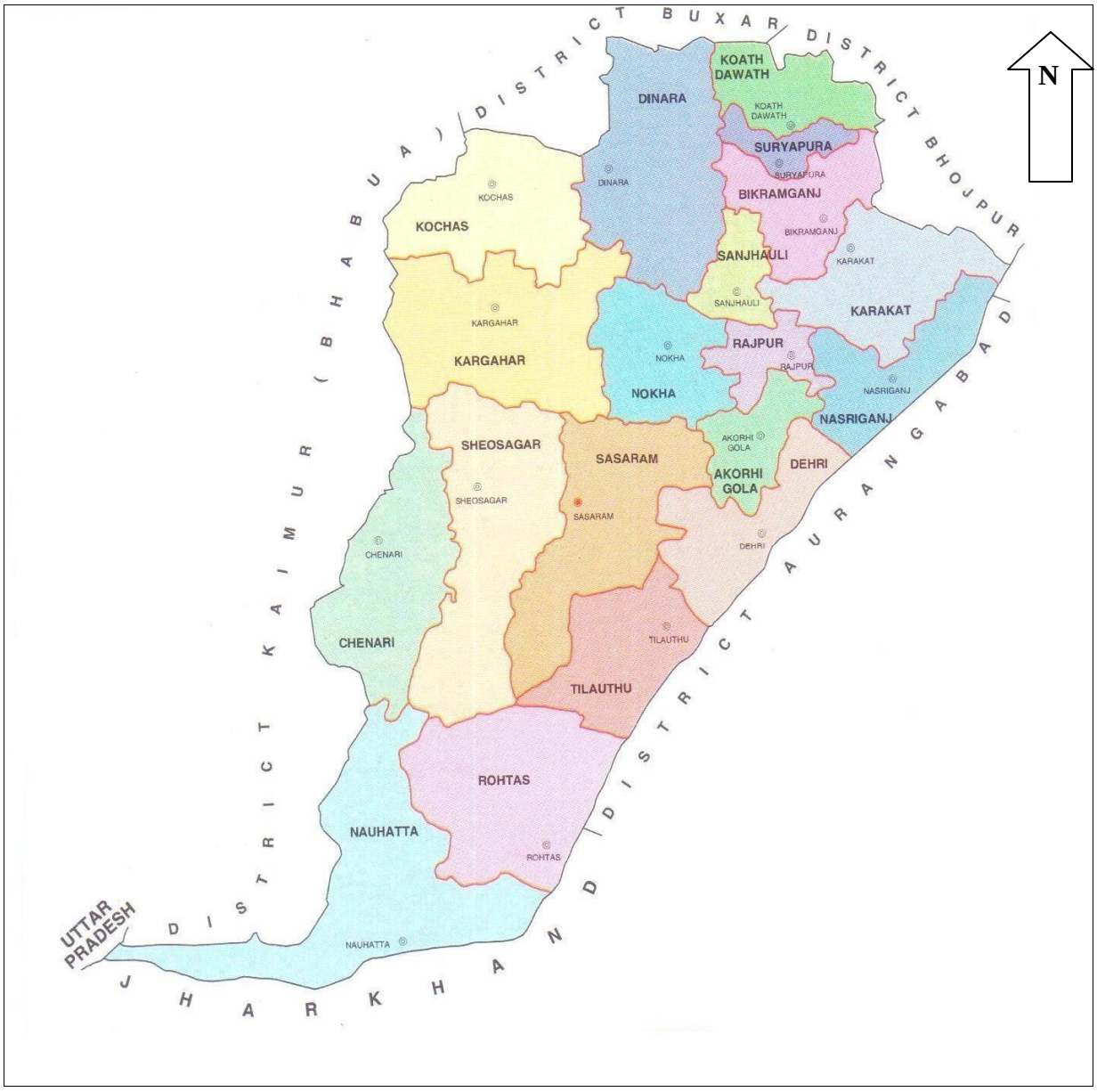
Geographical Location

The District is located at **24-30" to 25-20"** North Latitude and **83-14" to 83-20" East L**ongitude with total Area of **3847.82 Sq.Kms.** The District is surrounded by Bhojpur & Buxar Districts in North, Plamu & Garwah District of Jharkhnad in south, Kaimur District in west and Aurangabad & Part of Gaya District in East.

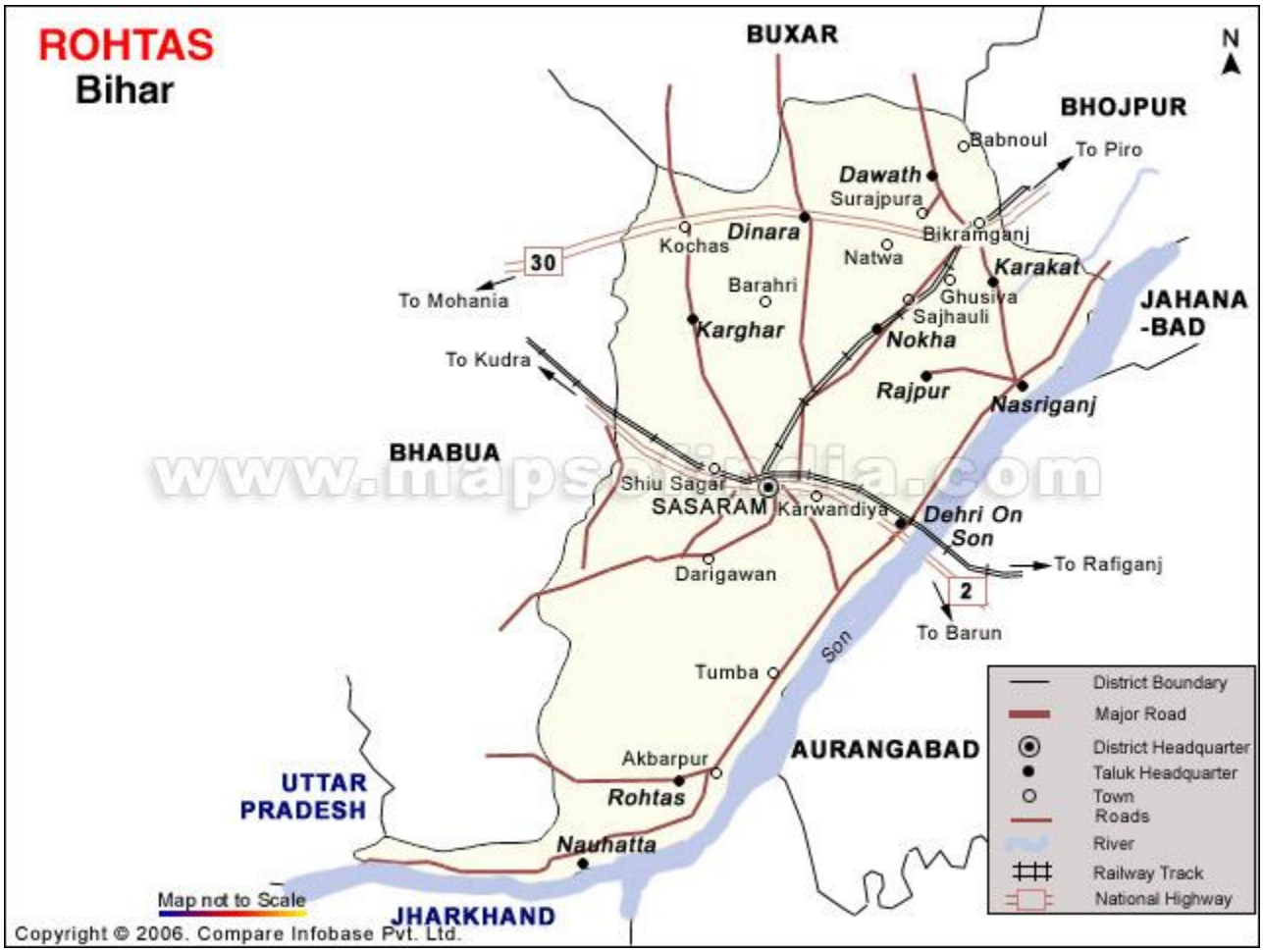
Govt's Administrative Set-up

There are three 03 divisions and 19 Blocks in the District. The District has 2103 villages and 246 Gram panchayats. District is divided into 19 C.D. Blocks. The newly elected Panchayati Raj is enthusiastic to play important role in the District.

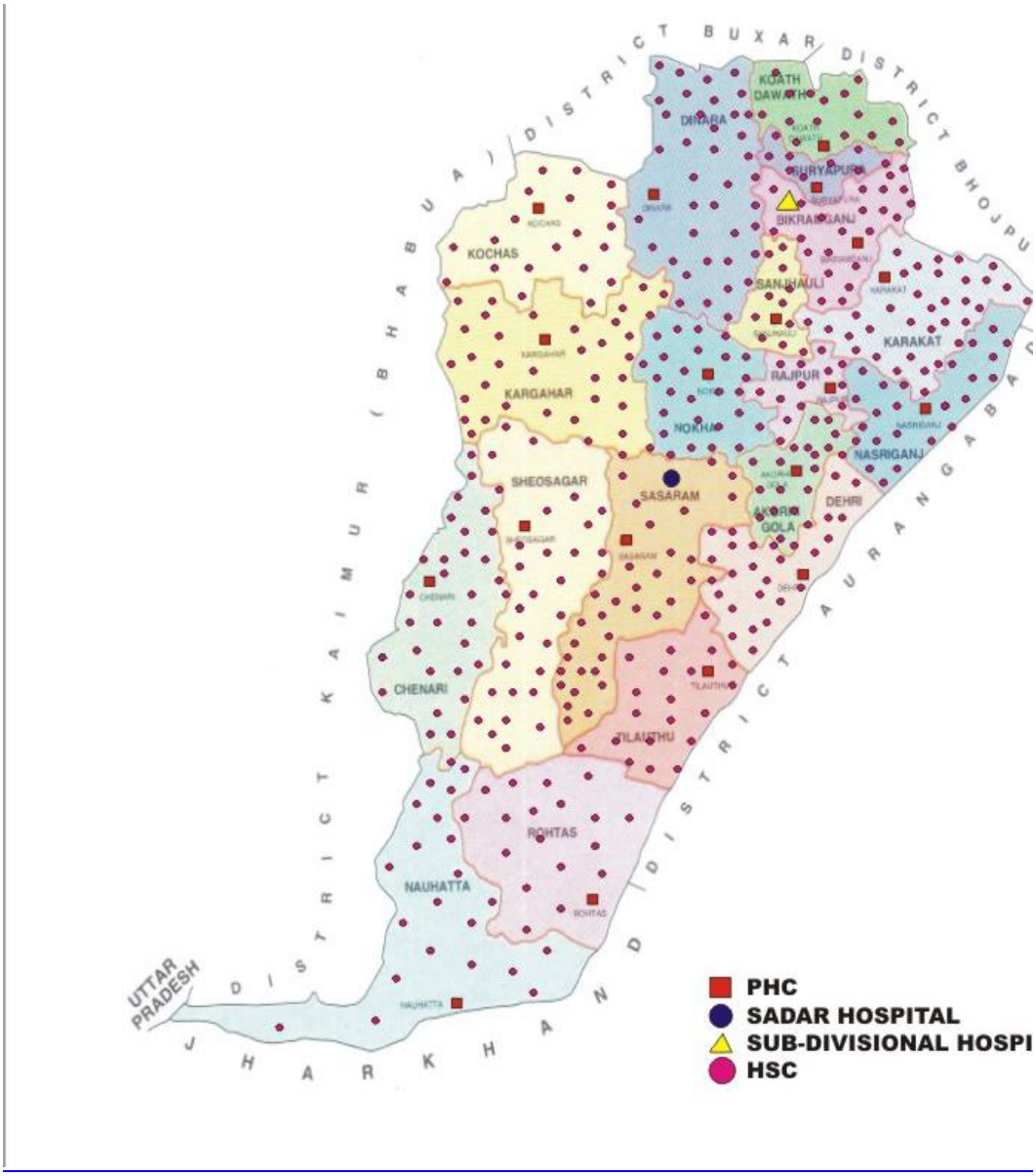
District Map of Rohtas



Communication map of Rohtas



Health Facilities in District-Rohtas



ROHTAS – AT A GLANCE

S.No.	Characteristics		Rohtas	Bihar	India
1	Geographical Area (Sq.Kms)		3847.82	94163.00	3287240
2	**Population (Census 2001**	Total	2448762	82878796	1027015247
		Male	1282655	43153964	531277078
		Female	1166107	39724832	495738169
2.1	Rural Population	Total	2122175	64531000	742490639
		Male	1109288	-	-
		Female	1012887	-	-
2.2	Urban population	Total	326587	18347796	286119689
		Male	173367	-	-
		Female	153220	-	-
2.3	Population Of Scheduled Castes		444333	13048608	166635700
2.4	Population Of Scheduled Tribes		25663	758351	84326240
2.4	Decadal Population Growth(%) (1991-2001)		27.71	28.43	21.34
2.5	Density of Population		636	880	324
2.6	Sex Ratio		909	921	933
	Literacy %	Total	62.36	47.53	65.38
		Male	76.54	60.32	75.85
		Female	46.62	33.57	54.16

Administrative Data :

S.No	Basic Data		Rohtas	Bihar
1	No. of Sub Division		03	101
2	No. Of Blocks		19	534
3	Revenue Circles		19	-
4	Panchayat		246	8471
4	No. of villages	Total	2103	45103
		In habitat	1672	-
		Uninhabited	395	-
5	No. of Towns (Sasaram , Dehri, Nokha, Bikramganj & Nasriganj)		5	130
6	Nagar Parishad		2	-
7	Nagar Panchayat (Nokha, Bikramganj, Nasriganj & Koath)		4	-
8	MP Constituency(Sasaram, Bikramganj)		2	40
9	M. L. A. Constituency (Sasaram , Dehri, Nokha, Bikramganj, Karakat, Chenanri & Dinara)		7	243

HEALTH PROFILE OF THE DISTRICT:

S. No.	Characteristics	No. in district
1	District hospital	01
2	Sub divisional hospital	01
3	Referral hospital	02
4	Primary health centre(PHC)	19
5	Additional primary health centre(APHC)	32
6	Health sub centre(HSC)	186
7	Blood bank	01(Non Functional)
8	Aids control society	NA
9	Doctors	122
10	ANM	476(190 Contractual)
11	Grade A Nurse	28(14 Contractual)
12	Block Extension Educator	03
13	Pharmacist	04
14	Lab Technician	04
15	Health Educator	27
16	L.H.V	08

SOCIO-ECONOMIC PROFILE

Social

- Rohtas district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Rohtas have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.

Economic

- The main occupation of the people in Rohtas is Agriculture and daily wage labour.
- A large number of the youth population migrates in search of jobs to the other states like Delhi, Kolkata, Punjab, Maharastra, Gujrat,
- The main crops are Wheat, Paddy, Pulses, Oilseeds .

Block Wise APHC / HSC Report

SI.No	Name of Block / PHC	Name of APHC	Name of APHC Approved in the Year 2007	Name of Existing HSC			Name of Approved HSC in the Year 2007		
1	Akorhigola	Bhimkarup		Tetrah	Bank	Karkatpur			
		Tetradh		Gowardhanpur	Baligawan				
2	Bikramganj		Morauna	Shivpur	Nonhar	Mani			
			Pawara	Kastar	Matuli	Maidhara			
				Baluahi	Salampur	Ghusi Kala			
				Jamhouri	Kusumhara				
3	Chenari	Telari	Khurmabad	Diheen	Bharkura	Khurmabad	Banauli	Kenar kala	Ubhawan
			Pewandi	Telari	Bilsi Bilashpur	Malhipur	Hata	Doian	Ramgarh
			Karma	Chandra Kaithi(Narayan)	Sadokhar	Ugahani	Langar Kakai	Reriya Kala	Naraina
				Bairiya			Sabrabad		
4	Dawath	Kowath	Dedhgawan	Chatara	Derdhagaon	Babhanaul	Gidha	Itwa	Jamsona
		Khairihi	Awardhi	Semri	Awardhi	Dawath	Parasiya Kala	Usari	Chaunri Kedar
							Hathdihan	Sahpur	Chhitani

5	Dehri	Deowaria		Jamuhar	Chilbila	Berkap			
		Darihat		Pitambarpur	Pahleja	Sujanpur			
		Baraon Kala		Sidhauli					
6	Dinara	Bhanus	Belwai	Ganjbharasara	East Bhelari	Karhansi			
		Koeria		Koirea	Basdiha	Ankorha			
		Natwar		Bhanpur	Bakara	Bairipur			
		Arila Raghunathpur		Mukundpur	Bishamharpur	Bisikala			
				Manihari	Tenuath Mathia	Lilawachha			
7	Karakat	Koupa		Chougain	Kurur	Amaritha	Motha	Bad	Sohda
		Gharwasdih		Osawan	Mohanpur	Bensagar	Baradih	Samahuta	Bharkudia
		Etarhiya		Belwai	Gamharia	Padsar	Deo	Sahri	Kusi
		Chamardihari		Sakala	Munji	Dhawani	Budhawal	Karma	Gadura
		Gorari		Ammouna	Etarhiya		Karup	Kirhi	Basdiha
		Danwar					Jaisari	Ibrahimpur	Itwa
		Chiksil							
8	Kargahar	Barhari	Kharai	Torni Baheri	Sonwarsa	Thorsan			
		Lahuara	Pipra	Ulho Bazar	Babhani Pahari	Ankorhi			
			Sidi	Mohania	Samahutta	Bilari			
				Saharmedani	Laduai	Kusahi			
				Araruwa	Bhokhari	Tenduni			

				Panjar	Mahuli	Badahari			
				Barka Deo Khaira	Gori				
9	Kochas	Parshathuwa		Indour	Derhaon	Narwar	Laheri	Parasiya	Dighata
					Doiyan	Kapasia	Balathari	Chatra Pachhimwa	Katharain
							Agarsidihra	Salas	
							Gara	Sareya	
							Naua	Karjar	
				Shekh Bahauara			Baradih	Katiyara	
10	Nauhatta		Daranagar	Sholi	Daranagar	Tiyara Kalan	Uli Banahi	Bishunpura	Matiwan
			Parchha	Shahpur	Bhadara	Nimhat	Jaintipur	Lohara	
				Matiaon	Rehal	Tilokhar	Pipardih		
11	Nasriganj	Jinamanauli	Pawni	Piparadih	Mednipur	Parasiyan	Amiawar	Shankar pur	Sahgi
		Sukahara Dehri		Mahadewa	Khutahan	Dhawani Pawani	Kaithi	Pokharahan	Agini
		Paiga		Etimha	Kachhawan	Khiriaon	Dhanwan English	Balia	Paiga
				Paduri			Mouna	Maraujhia	
12	Nokha	Baraon	Kadwa	Bhawarah	Meyari Bazar	Dharampura			
			Ghsiyan	Barawon	Gamhariya	Jainagara			
			Biharidih	Pach Pokhari	Badyoga	Sisrit			
				Penar					

13	Rohtas	Chaknahawa	Wajitpur	Kouriari	Karma	Budhua			
			Tumba	Majhigaoan	Rashulpur	Milki			
				Nagatoli	Baknaura				
14	Rajpur	Barnadehri		Rajpur	Tarawn	Malaon			
				Kushadhar	Ghordihin	Siyawak			
15	Sasaram	Darigaon	Sikariyan	Samardiha	Sikaria	Jaipure	Amri	Amra	Rampur
		Akasi	Karseruan	Dhaw Darh	Akasi	Muradabad	Kanchanpur	Dhankarha	Baradih
			Muradabad Kalan	Gotapa	Uchitpur	Dhanpurwa(Diliyan)	Mokar	Mohadiganj	Murhi
				Aqarer	Bisrampur	Karwandia	Belarhi	Malawan	Gotpa
				Nahouna	Gharbair	Gobina	Bararhi	Gansadih	Nekra
					Beda		Gobina	Choukhanda Chitauli	Admapur
							Bhainsahi	Garura	Karpurwa
				Kanchanpur			Lerua		
16	Sheosgaar	Silari	Alampur	Sonhar	Khadihan	Ankorha			
			Malwar	Bishrampur	Sikroul	Raipur Chour			
				Berukahi	Silari	Torani			
				Alampur	Nad	Padari			
				Ulho	Bhagwalia	Bahuara			
17	Suryapura	Kosandha	Agrer Khurd	Sheobahar	Gosaldih	Surhuriya			

				Imiritha	Kosanda Khurd	Agrer Khurd			
18	Sanjauli		Tilian	Udaypur	Sanjhuli				
19	Tilouthu		Sewahi	Saraiyan	Hurka	Pataluka			
			Chandanpura	Ramdihara	Chandanpura				
			Sariyan						

Population and Household characteristics:

Background Characteristics	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
Percent total literate Population(Age 7+)	69.7	67.8	-	-
Percent literate Male Population(Age 7+)	81.6	80.6	-	-
Percent literate Female Population(Age 7+)	57.3	54.7	-	-
Percent girls (age 6-11) attending Schools	99.3	99.4	-	-
Percent boys (age 6-11) attending Schools	99.7	99.7	-	-`
Have electricity connection (%)	38.5	32.5	21.6	15.9
Have Access to toilet facility(%)	22.8	14.5	21.1	13.6
Use piped drinking water (%)	3.1	0.6	5.2	2.8
Use LPG for cooking (%)	8.2	2.1	6.7	2.6
Live in a pucca house (%)	25.2	17.8	21.6	16.8
Own a house (%)	97.2	97.3	-	-
Have a BPL card (%)	21.8	22.8	-	-
Own Agriculture Land (%)	54.9	57.1	-	-
Have a Television (%)	17.2	10.6	19.2	14.3
Have a mobile phone (%)	26.0	21.6	-	-
Have a Motorized Vehicle (%)	9.6	7.2	14.8	13.6
Standard of Living Index (%)				
Low (%)	74.4	82.2	65.7	71.9
Medium (%)	13.2	11.1	25.0	21.7
High (%)	12.4	6.7	9.3	6.4

Health Scenario of the District:

(Comparison of DLHS-3,DLHS-2 and NFHS-3 figures)

1. Marrriage and Fertility:

Indicators	DLHS-3(Rohtas)		DLHS-2(Rohtas)		NFHS-3(Bihar)	
	Total	Rural	Total	Rural	Total	Rural
Percent of girl's marrying before completing Percent 18 years	**52.9**	**59.6**	**51.2**	**54.8**	60.3	65.2
Percent of Births of Order 3 and above	47.7	49.3	47.1	47.8	-	-
Sex Ratio of Birth	108	105	-	-	-	-
Percentage of women age 20-24 reporting birth of order 2 & above	67.8	69.1	-	-	-	-
Percentage of births to women during age 15-19 out of total births	15.0	15.1	-	-	25.0	27.6

2. Family planning (currently married women, age 15-49):

Indicators	DLHS-3		DLHS-2		NFHS-3(Bihar)	
	Total	Rural	Total	Rural	Total	Rural
Current use:						
Any Method(%)	40.0	37.5	34.2	33.3	34.1	31.4
Any modern method (%)	33.4	31.7	27.2	26.2	28.8	41.2
Female Sterlization (%)	29.7	28.4	22.2	21.8	23.8	22.6
Male Sterlization (%)	0.8	0.7	0.8	0.9	0.6	0.5
IUD (%)	0.6	0.6	0.8	0.8	0.6	0.5
Pill (%)	0.6	0.4	2.1	1.7	1.3	1.0
Condom (%)	1.8	1.6	1.2	1.0	2.3	1.9
Unmet Need for Family Planning						
Total unmet need (%)	29.8	31.4	29.6	29.8	23.1	24.0
For Spacing (%)	12.6	13.0	10.9	10.7	10.7	11.5
For limiting (%)	17.2	18.4	18.7	19.1	12.4	12.5

3. Maternal Health:

Indicators	DLHS-3		DLHS-2		NFHS-3(Bihar)	
	Total	Rural	Total	Rural	Total	Rural
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	30.7	26.2	-	-	-	-
Mothers who had at least 3 Ante –Natal care visits During the last pregrancy (%)	26.6	21.5	24.2	22.3	16.9	14.5
Mothers who got at least one TT injection When they were pregnant with their last live birth/ still birth (%)	49.6	45.6	48.1	46.2	-	-
Institutional births (%)	48.5	45.3	38.2	36.3	22.0	18.6
Delivery at home assisted by a doctor/ Nurse/LHV/ANM (%)	20.8	21.0	12.1	8.4	30.9	27.6
Mothers who received post natal care within 48 hours of their last child (%)	28.3	25.0	-	-	15.3	13.1

4. Child Health:

4.1 Child Immunization and Vitamin a supplemenatation:

Indicators	DLHS-3		DLHS-2		NFHS-3(Bihar)	
	Total	Rural	Total	Rural	Total	Rural
Children 12-23 months fully immunized (BCG, Measles, and, 3 doses each of polio/DPT) (%)	42.3	45.3	26.8	25.0	32.8	31.1
Children 12-23 months who have recived BCG (%)	82.6	82.2	48.1	48.1	64.7	63.9

Children 12-23 months who have received 3 doses Of Polio vaccine (%)	53.4	55.8	33.3	32.4	82.4	81.3
Children 12-23 months who have received 3 doses DPT vaccine (%)	49.5	53.7	34.0	33.3	46.1	45.2
Children 12-23 months who received measles Vaccine (%)	60.4	57.7	30.8	28.0	40.4	39.3
Children 12-35 months who received a vitamin A Dose in last 6 months (%)	46.7	45.2	-	-	29.4	30.7

4.2 Treatment of childhood diseases(children under 3 years)

Indicators	DLHS-3		DLHS-2		NFHS-3(Bihar)	
	Total	Rural	Total	Rural	Total	Rural
Children with diarrhea in the last 2 weeks who Received ORS (%)	13.8	9.6	95.9	100.0	22.2	20.8
Children with diarrhea in the last 2 weeks taken to A health facility (%)	77.7	76.5	0.0	0.0	48.7	46.7
Children with acute respiratory infection or fever in The last 2 weeks taken to a health facility (%)	78.7	75.8	-	-	54.6	53.8

4.3 Child feeding practices(Children under 3 years)

Indicators	DLHS-3		DLHS-2		NFHS-3(Bihar)	
	Total	Rural	Total	Rural	Total	Rural
Children breastfed within one hour of birth	14.4	14.6	-	-	4.0	3.8
Children (age 6 months above) exclusively breastfed	17.6	17.0	-	-	27.9	27.3
Children (6-24 months) who received solid Or semisolid food and still being breastfed	87.5	86.8	-	-	57.3	58.3

5. Women heard of HIV/ AIDS among Un-married Women (age 15-24)

Indicators	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
Women heard of HIV/AIDS (%)	57.9	50.9	-	-
Women(15-24) who Knew that consistant condom Use can reduce the chances of getting HIV/AIDS(%)	41.5	38.2		
Women having correct knowledge of HIV/ AIDS (%)	92.8	91.4	-	-
Women underwent test for detecting HIV/ AIDS (%)	0.0	0.0	-	-
Women heard of RTI/STI (%)	44.5	43.3	-	-

Facility Survey of the Public Health System within the District:

1. Community Health Centre(CHC):

Indicators	Number	Indicators	Number
Community Health Centre (CHC) N = 1			
Infrastructure :		**Performance :**	
CHC having Personal Computer	0	In-patients admission in last one month	42
CHC having Operation Theatre	1	Referred cases for serious ailments from CHC to higher centre during last one month	24
CHC having Labour Room	1	Deliveries performed in last one month	41
CHC having Blood Storage Facility	0	Blood transfusion done in last one month	0
CHC having large deep freezer	0	Sterilization conducted in last one month	0
CHC prepared a CHC plan for the current year	0		
CHC having water supply for 24 hours	1		
CHC having Ambulance on road	0		
Human Resource :		**Supply :**	
CHC having General Surgeon	1	CHC with 24 hours normal delivery services	1
CHC having Obstetrician/ Gynecologist	0	CHC with 24 hours New born care	1
M.O. received training of Non-Scalpel Vasectomy (NSV) during last five years	1	CHC recognized as Integrated Counseling and Testing Centre (ICTC)	0
M.O. received training for Prevention, Care and Support for HIV/AIDS during last five years	0		
M.O. received training of basic Emergency Obstetric Care during last five years	0		
M.O. received training of Integrated Management of Neonatal and Childhood illness during last five years	0		

2. Primary Health Centre:

Indicators	Numbers	Indicators	Numbers

Primary Health Centre (PHC) N= 18			
Infrastructure :		**Performance :**	
PHC having Residential Quarter for Medical Officer	9	Haemoglobin tests (TLC/DLC) conducted during last one month	231
PHC having separate Labour Room	10	Blood smear examinations for malaria parasite conducted during last one month	102
PHC having Personal Computer	9	In-patient admissions during last one month	1,731
PHC having Normal Delivery Kit	8	Referral cases for serious ailments from PHC to higher centres during last one month	282
PHC having Large Deep Freezer	5	Deliveries performed during last one month	2,172
PHC having regular water supply	17	Beneficiaries of JSY during last one month	1,337
PHC having Neonatal Warmer (Incubator)	1	Women provided with post-natal care services during last one month	2,087
PHC having Operation Theater with Boyles Apparatus	6	New born care provided during last one month	2,348
PHC having Operation Theater with anaesthetic medicine	2	Infants and children immunized during last one month	11,831
		Condoms distributed during last one month	617
		PHC prepared the PHC plan for current year	8

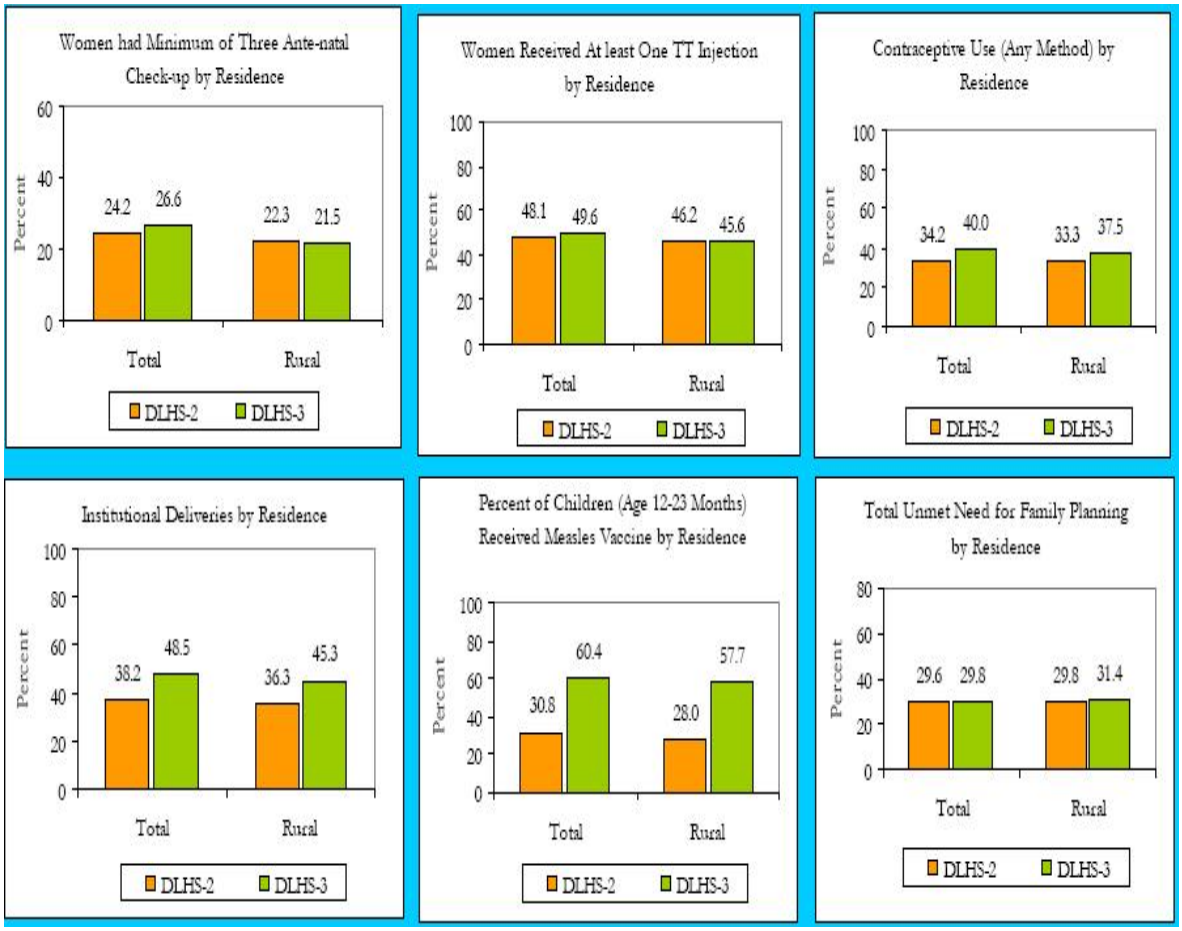
Human Resource :		**Supply :**	
PHC having Lady Medical Officer (LMO)	3	PHC that received the untied fund in previous financial year	9
PHC having Laboratory Technician	2		
PHC organized any training programme in their PHC during last year	16		
PHC having at least one MO, who received Integrated Skill Development Training for 12 days during last five years	5		
PHC having at least one MO, who received IMNCI training during last five years	1		

3. Health Sub Centre(SC):

Indicators	Numbers	Indicators	Numbers

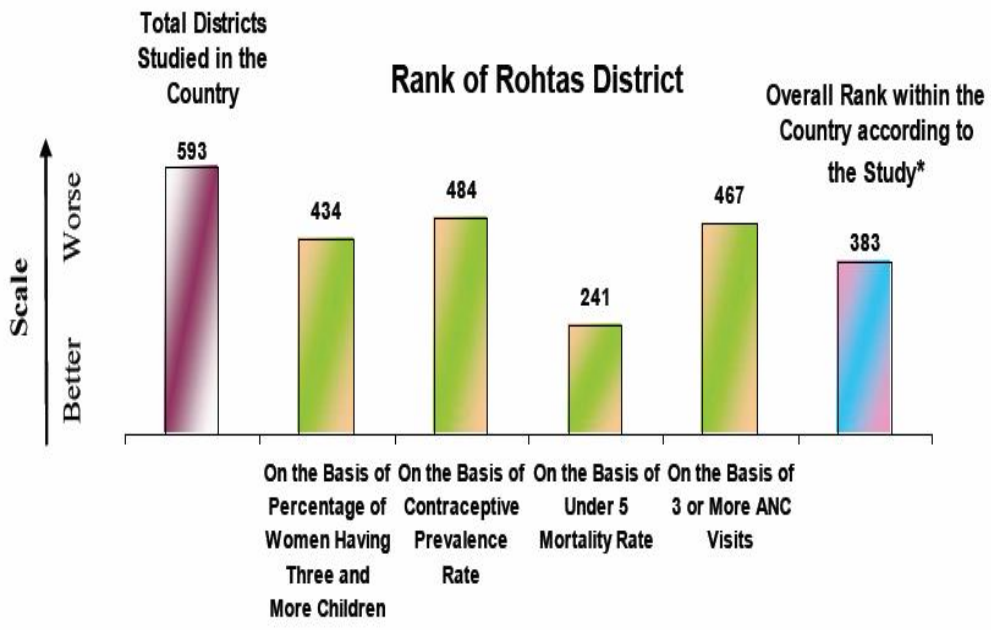
Infrastructure :		**Performance :**	
Sub Centre located in government building	10	Number of Infants and children immunized	3,104
Sub Centre having communication facility	0		
Sub Centre having separate labour room	5		
ANM staying in Sub Centre village	8		
Sub Centre having staff quarter for ANM	5		
Sub Centre having regular water supply	23		
Human Resource :		**Supply :**	
Sub Centre where Male Health Worker in position	3	Sub-Centre having auto-disposable syringes	25
ANM had Integrated Skill Development Training in last 5 years	8	Sub-Centre reporting IFA tablets out of stock for more than 10 days during last one month	27
ANM ever been trained in Integrated Skill Development Training	15	Sub-Centre reporting Vitamin A out of stock for more than 10 days during last one month	5
ANM trained in integrated management of neonatal and childhood Illnesses (IMNCI) in last 5 years	8	Sub-Centre reporting ORS packets out of stock for more than 10 days during last one month	28
ANM ever been trained in integrated management of neonatal and childhood Illnesses (IMNCI)	8	Sub-Centre that received untied fund in previous financial year	8
ANM who attended Skilled birth attendant (SBA) training	15		

Performance Graph as per DLHS-3 and DLHS-2:



Rank of Rohtas in India:

On the basis of Total 593 districts studied in the country, overall rank of the district found 383(Source Jansankhya Sthirta Kosh www.jsk.org.in). On the basis of percentage of women having three and more children, rank of the district found 434. Some more facts are shown in the graph.



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.

Chapter 3
Situation Analysis

Health and demographic indicator for the district Rohtas is based on the facility survey and situational analysis formats for each block including PHC, APHC and HSC used for the assessing the health system. Situation analysis is also based on the community perception observed in the process of interview and group discussion with ASHA/ANM/MOs and staffs of Health service delivery system used for the purpose of DHAP. In the process of analysis reference has been taken from DLHS-3 &DLHS-2 data, NFHS-3, SRS 2007 and Census 2001 data and other reliable sources. In this process focused has been finding Gaps in the public Health Service delivery system and finding solution for them. These indicators help in pointing to the health scenario in the district from a quantitative point of view, while they cannot by themselves provide a complete picture of the status of health in the district.

Table 3.1: Health Indicators

Indicator	Rohtas	Bihar	India
CBR	31.2	29.2	23.8
CDR	8.9	8.1	6
IMR		61	58
MMR		371	301
TFR		4	2.68
CPR		34.1	56.3
Complete Immunization		32.8	44

Sources: DLHS3, NFHS3, SRS2007

1. Health Sub Centre (HSC):

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

Health Sub Centers:				**186**
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	The district still needs 394 more HSCs to be formed. Out of 186 HSCs only 96 are having own building Existing buildings are not properly maintained Non payment of rent of 90 HSCs since long time. 57 HSC need new building construction 34 HSC Need Major repairs and 32 Need Minor repair work. Running water supply is available in only 26 HSC. None of the Health Centre has Power	• Lack of facilities/ basic amenities in the constructed buildings • Nonpayment of rent • Land Availability for new construction • Constraint in transfer of constructed building • Lack of community ownership	Strengthening of VHSCs, PRI Strengthening of Infrastructure and operationalization of construction works	1. Formation and strengthening of VHSCs, Mothers committees, 2. "Swasthya Kendra chalo abhiyan" to strengthen community ownership 2.1 Nukkad Nataks on Citizen's charter of HSCs as per IPHS 2.2 Monthly meetings of VHSCs, Mothers committees **3A.Strengtheing of HSCs having own buildings** A.1. Rennovation of HSCs A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments

	Supply. 43 HSC has only ANM residential quarter. 21 ANM Residential quarter Require major repair, 10 require minor repair, 457 need new quarter to be constructed. Lack of equipments & furniture as per IPHS Norms Non availability of HMIS formats/registers and stationeries		Monitoring	A.5 Printing of formats and purchase of stationeries **3B. Strengthening of HSCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new HSCs C1. Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs C2. Community mobilization for promoting land donations at accessible

				locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings. 4 biannual facility survey of HSCs through local NGOs as per IPHS format 4.1 Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.
Human Resource	For newly created 394 sub centers and for existing vacant	Filling up the staff shortage Untrained staffs	Staff recruitment	1. Selection and recruitment of 742.ANMs

	position in HSC 742 ANM are required. Almost all the existing sub centre do not have Male Health worker The ANM training school situated at Sasaram is non functional. Out of 151 sanctioned post of Male Health Worker only 38 are placed		Capacity building Strengthening of ANM training school	2. Selection and recruitment of 542 male workers 1. Training need Assessment of HSC level staffs 2. Training of staffs on various services 1. Analyzing gaps with training school 2. Deployment of required staffs/trainers 3. Hiring of trainers as per need 4. Preparation of annual training calendar issue wise as per guideline of Govt of India. 5. Allocation of fund and operationalization of allocated fund
Drug kit availability	No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for	Indenting Logistics	Strengthening of reporting process and indenting through form 2 and 6 and delegating the	1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines

	delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, Irregular supply of drugs		purchase power from District to PHC level. Couriers for vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	according to services and reports 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through ANMs account 4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage
Service performance	Unutilized untied fund at HSC level No institutional delivery at HSC level Only 50-60 % Pregnant Women registered in	Operationalization of Untied fund. Lack of delivery room and other facilities at sub centre level. Improvement in quality of services like ANC, NC and PNC, Immunization,	Capacity building of account holder of untied fund Renovation of HSC, through construction of delivery room & supply of equipments.	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts at HSCs untied fund

	first trimester PW with three ANCs is 56%, TT1 coverage is 73%,TT2 68%, Family Planning : Any method-40 % Any Modern Method – 33.4 % I.U.D – 0.6% Oral Pill – 0.6 % Condom – 1.8 % No sterilization at HSC level Total unmet need is 29.8%, for spacing-12.6 % Approx 80% of HSC staffs not reside at place of posting Lack of counseling services Problem of mobility during rainy season Lack of convergence at HSC level	Integration of disease control programs at HSC level. Family Planning services Convergence	Phase wise strengthening of 186 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through HSC level Community focused Family Planning services Convergence	1. Gap identification of 186 HSCs through facility survey 2.strengtheing one HSC per PHC for institutional delivery in first quarter 3.Owneringfirst delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. 2 Monthly Video shows in all schools of the

				concerned HSC area schools on health , nutrition and sanitation issues

Additional PHC:				32
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	The district altogether need 97 APHCs but there are only 32 functioning APHC 65 APHC are required to be formed. Out of 32 APHCs only 11 are having own building Existing 11 buildings are not properly maintained Non payment of rent of 21 APHCs for long period. 86 APHC need new building construction All Existing APHC Need Major repair Running water supply is not available Non availability of Labour room. None of the APHC has Power Supply. All Existing APHC require new construction of toilet Lack of equipments, Lack of appropriate	Lack of facilities/ basic amenities in the constructed buildings Nonpayment of rent Land Availability for new construction Constraint in transfer of constructed building. Lack of community ownership.	Strengthening of VHSCs, PRI and formation of RKS Strengthening of Infrastructure and operationalization of construction works in Three phase	2."Swasthya Kendra chalo abhiyan" to strengthen community ownership 3.Nukkad Nataks on Citizen's charter of APHCs as per IPHS 4. Registration of RKS 4.Monthly meetings of VHSCs, Mothers committees and RKS **A. Strengthening of APHCs having own buildings** A.1Rennovation of APHCs buildings A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries **B. Strengthening of APHCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund/ RKS from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery

	furniture Non availability of HMIS formats/registers and stationeries		Monitoring	B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new APHC buildings as standard layout of IPHS norms. C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs 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 32 APHCs require 64 doctors but only 6 doctors are posted. Out of 88 grade A Nurse only 14 grade A Nurse has been appointed , but they are deputed at PHC or district Hospital Out of 32 Health Assistant Male only have been posted.	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	1.Selection and recruitment of 58 Doctors. 2.Selection of 74 Grade A nurse. 2.Selection and recruitment of 121 male workers 3. Sending back the staffs to their own APHCs. 3. Training need Assessment of APHC level staffs 4. Training of staffs on various services 5. EmoC Training to at least one doctor of each APHC 6. Analyzing gaps with training school 7. Deployment of required staffs/trainers 8. Hiring of trainers as per need

				9. Preparation of annual training calendar issue wise as per guideline of Govt of India. 10. Allocation of fund and operationalization of allocated fund
Drug kit availability	No drug kit as such for the APHCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, Only need based emergency supply 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 colored indenting format for the APHC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through APHC account 4.1 Purchasing of cold chain equipments as per

				IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage
Service performance	RKS has not been formed at any of the APHC. Unutilized untied fund at APHC level No institutional delivery at APHC level OPD for 2days only in most of the APHC No inpatient facility available No ANC, NC and PNC and family planning services. No lab facility No Ayush practitioner posted No rehabilitation services No safe MTP service No OT/ dressing and Cataract operation services. Approx 80% of APHC staffs not reside at place of posting.	Formation of RKS Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps. Integration of disease control programs at APHC level. Family Planning services Convergence Operational issues	Capacity building of account holder of untied fund Phase wise strengthening of 16 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through APHC level where APHC will work as a resource center for HSCc. At present the same is being done by PHC only. Community focused Family	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 16 APHCs through facility survey 2.strengtheing one APHC per PHC for institutional delivery in first quarter 3.Owneringfirst 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

	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		Planning services PPP Convergence	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 i 1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. 2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues

				3. Arrangement of Hand Pump through PHED 4. Electricity connection through local electricity department 5. Telephone connection.

Staff Position in APHCs as per IPHS norms

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

Primary Health Center:

The primary Health Center is the primary unit of our public health delivery system.

Functions:

1. To supervise and provide guidance to the Sub-Center and their staff in implementing RCH programmes and other national programmes.
2. To provide primary level curative care services including referral services to the Sub-Center along with basic laboratory services.

Primary Health Centers:(30 bedded)				**19**
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	The district altogether needs 26 PHCs but there are only 19 functioning PHC. 7 PHC are required to be formed. All 19 PHCs are having own building All 17 PHCs are running with only six bed facility. **Delivery:** At present only 16 PHC's is conducting delivery. At an average of 5 delivery per day Out of which only 03 PHC having an average of 10 delivery per day. **Family Planning:** 10 PHC's are conducting at an average of 7 Family Planning Operation per day. OPD / Minor operation/ Emergency is 120 OPD per day in each PHC. This huge workload is not being addressed with only	Available facilities are not compatible with the services supposed to be delivered at PHCs. Quality of services Community participation.	Up gradation of PHCs into 30 bedded facilities. ISO certification of selected PHCs in the district. Strengthening of BMU Ensuring community participation.	1.Need based (Service delivery)Estimation of cost for up gradation of PHCs 2. Preparation of priority list of interventions to deliver services. 1. Selection of any two PHCs for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers, Accountants in all institutions. 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community representatives on

	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.(List attached, Annexure..) The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also underutilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries 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		Strengthening of Infrastructure and operationalization of construction works	erecting boundary, beautification etc, 2. Nukkad Nataks on Citizen's charter of HSCs as per IPHS 2.3 Monthly meetings of VHSCs, Mothers committees **3A.Strengtheing of HSCs having own buildings** A.1Rennovation of HSCs A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries **3B. Strengthening of HSCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats

			Monitoring	and purchase of stationeries 3C. Construction of new HSCs C1. Preparation of PHC wise priority list of HScs according to IPHS population and location norms of HScs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings. 4 Biannual facility survey of HSCs through local NGOs as per IPHS format 4.1 Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers

				committees on construction work.
Human Resource	Doctors : Existing 19 PHC district have 57 sanctioned post of regular doctor only 48 are working and in respect of 76 contractual doctor appointment only 41 are working. Grade A Nurse : Out of 19 sanctioned post only 14 are working. ANM :- Out of 100 sanctioned post only 89 are working. Lab Technician :- Out of 51 sanctioned post only 4 are working. Pharmacist :- Out of 51 sanctioned post only 4 are working. Block Extension Educator :- Out of 19 sanctioned post only 03 are working. Health Educator :- Out of 29 sanctioned post only 27 are working. L.H.V :- Out of 30 sanctioned post only 08 are working. Sanitary Inspector :- Out of 14 sanctioned post only 02 are working. Basic Health Inspector :All sanctioned 13 post are vacant.	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	3. Selection and recruitment of 14.ANMs & 168 Grade A Nurse. 4. Selection and recruitment of 46 male workers 6. Training need Assessment of HSC level staffs 7. Training of staffs on various services 1. Analyzing gaps with training school 2. Deployment of required staffs/trainers 3. Hiring of trainers as per need 4. Preparation of annual training calendar issue wise as per guideline of Govt of India. 5. Allocation of fund and operationalization

	Out of 19 BHM & Accountant only 8 BHMs and 19 accountants are placed at present			of allocated fund
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time. Only … % essential drugs are rate contracted at state level . Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system Phase wise strengthening of APHCs for vaccine / drugs storage	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,	Operationalization of Untied fund. Improvement in	Capacity building of account holder of untied fund	1.Training of signatories on operating Untied fund account, book keeping etc

	Family Planning operation/emergency operation and 120 OPD per day in each PHC. Lack of counseling services Problem of mobility during rainy season Lack of convergence	quality of services like ANC, NC and PNC, Immunization, Integration of disease control programs at HSC level. Family Planning services Convergence	Phasewise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through HSC level Community focused Family Planning services Convergence	2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts at HSCs untied fund 1 Gap identification of 39 HSCs through facility survey 2.strengtheing one HSC per PHC for institutional delivery in first quarter 3.Owning first delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with

				VHSCs rotation wise at all villages of the respective HSC. 2 Monthly Video shows in all schools of the concerned HSC area schools on health , nutrition and sanitation issues

Table 1. Basic Infrastructure Available

S.No.	Indicators	Present Status (08-09)	% Availability	Availability as per DLHS 3	%age Availability
1	PHC having Residential Quarter for Medical Officer	6(Repairable)	35.29	6	35.29
2	PHC having separate Labour Room	17	100	6	35.29
3	PHC having Personal Computer	1	82.34	2	11.76
4	PHC having Normal Delivery Kit	16	94.11	6	35.29
5	PHC having Large Deep Freezer	2	11.76	3	17.65
6	PHC having regular water supply	17	100	8	47.06
7	PHC having Neonatal Warmer (Incubator)	0	64.70	0	0
8	PHC having Operation Theater with Boyles Apparatus	NA		4	23.53
9	PHC having Operation Theater with anaesthetic medicine	14	82.34	2	11.76

The data presented by DLHS 3 shows that none of the PHCs is having incubator. Only half of the PHCs (47.06%) are having regular water supply, which needs immediate attention. Most of the operation theatres are inadequate to meet the emergency demands of surgery as 87.24 % of OTs lacks anaesthetic medicine.

Referral Hospital/Sub divisional hospital(51-100 Beaded hospital) 03				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	The district altogether need 6 Referral Hospital but there are only 2 Referral Hospital & 1 Sub Divisional Hospital. Referral Hospitals are non functional referral hospitals (bedded). Since Lack of infrastructure these are working as PHC (bedded). Both Referral Hospital have own building but not adequate space. Require additional building Delivery: At present normal delivery is conducted. No cesarean is conducted , or other operation. . Conducting normal delivery. at an average of 5 delivery per day **Family Planning:** Family Planning Operation 5 per day. OPD / Minor operation/ Emergency is 112 OPD per day in each Referral. This huge workload is not being addressed with only six beds inadequate	Available facilities are not compatible with the services supposed to be delivered at Referral Quality of services Community participation.	Up gradation of Referral into 100 bedded facilities. ISO certification of selected Referral in the district. Strengthening of BMU Ensuring community participation. Strengthening of Infrastructure and operationalization of construction	1.Need based (Service delivery)Estimation of cost for upgradation of Referral 2.Preparation of priority list of interventions to deliver services. 1.Selection of any two Referral for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers, Accountants in all institutions.(15 Referral, 2 Referals and Sadar hospital.) 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 1.Meeting with community representatives on erecting boundary, beautification etc, 2. Nukkad Nataks on Citizen's charter of HSCs as per IPHS

	facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms.(List attached, Annexure..) The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also underutilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries Operation of RKS: Lack in uniform process of RKS operation. Lack of community participation in the functioning of RKS. Lack of facilities/ basic amenities in the Referral buildings		works Monitoring	2.4 Monthly meetings of VHSCs, Mothers committees **3A.Strengtheing of HSCs having own buildings** A.1Rennovation of HSCs A.2 Purchase of Furniture A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries **3B. Strengthening of HSCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new HSCs C1. Preparation of PHC

				wise priority list of HScs according to IPHS population and location norms of HScs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings. 4 biannual facility survey of HSCs through local NGOs as per IPHS format 4.1 Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.
Human Resource	Doctors : Lack of Obstetrician	Filling up the staff shortage	Staff recruitment	**5.** Selection and recruitment of

	& Gynecologist, Anesthetist Lack of Grade A Nurse, O.T Assistant, Ward Boys, Sweeper, Chowkidar, Ophthalmic Assistant	Untrained staffs	Capacity building Strengthening of ANM training school	447 **Grade A Nurse** 6. Selection and recruitment of Attendant as per need. 8. Training need Assessment of HSC level staffs 9. Training of staffs on various services 6. Analyzing gaps with training school 7. Deployment of required staffs/trainers 8. Hiring of trainers as per need 9. Preparation of annual training calendar issue wise as per guideline of Govt of India. 10. Allocation of fund and operationalization of allocated fund
Drug kit availability	Irregular supply of drugs because of improper assessment and improper supply and centralized	Indenting Logistics	Strengthening of reporting process and indenting through form 7	

	distribution. Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.	Operationalization	Strengthening of drug logistic system Phase wise strengthening of A Referral for vaccine / drugs storage	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all Referral 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.

District Hospital, Sasaram				01
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	Lack of spaces for bed as per need. Need Construction of wards. **Delivery:** At present normal delivery is being conducted. No cesarean is conducted , or other operation. . Conducting normal delivery. at an average of 20 delivery per day **Family Planning:** Family Planning Operation 5 per day. OPD/Minor operation / Emergency is 325 OPD per day in each PHC. This huge workload is not being addressed with only 25 beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms.(List attached, Annexure..) The comparative	Available facilities are not compatible with the services supposed to be delivered at Referral Quality of services Community participation.	ISO certification of the District. Hospital Need of BMU Ensuring community participation. Strengthening of Infrastructure and operationalization of construction works	1.Preparation of priority list of interventions to deliver services. 2. Sending the recommendation for the certification with existing services and facility detail. 3. Ensuring regular monthly meeting of RKS. 4. Sanctioning post of Health Managers & Accountants in the Hospital. 3. Training to the RKS signatories for account operation. 1.Meeting with community representatives on erecting boundary, beautification etc, **3A.Strengtheing of District Hospital.** A.1 Purchase of Furniture A.2 Prioritizing the equipment list according to service delivery A.3 Purchase of equipments A.4 Printing of formats and purchase of stationeries

	analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also underutilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries Operation of RKS: Lack in uniform process of RKS operation. Lack of community participation in the functioning of RKS. Lack of facilities/ basic amenities in the PHC buildings		Monitoring	4.1 Regular monitoring of District Hospital s facilities through District official in IPHS format. 4.2 Monitoring of construction works
Human Resource	Doctors : Lack of Obstetrician & Gynecologist, Anesthetist Lack of Grade A Nurse, O.T Assistant, Ward Boys, Sweeper, Chowkidar, Ophthalmic Assistant	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	7. Selection and recruitment of 93 Grade A Nurse. 8. Selection and recruitment of male workers as per need. 10. Training need Assessment of

				District Hospital staffs 11. Training of staffs on various services 11. Analyzing gaps with training school 12. Deployment of required staffs/trainers 13. Hiring of trainers as per need 14. Preparation of annual training calendar issue wise as per guideline of Govt of India. 15. Allocation of fund and operationalization of allocated fund
Drug kit availability	Irregular supply of drugs because of improper assessment and improper supply and centralized distribution. Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all Referral

	procurement and transportation.		Phase wise strengthening of AReferral for vaccine / drugs storage	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 Sadar Hospital in delivering all services i.e.20 delivery per day, Family Planning operation/emergency operation and 325 OPD per day in each Referral. Lack of counseling services Problem of mobility during rainy season Lack of convergence	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization, Integration of disease control programs. Family Planning services Convergence	Capacity building of account holder of untied fund Strengthening of District Hospital for Caesarian Institutional delivery.. Implementation of disease control programs at district level	1.Training of signatories on operating account, 2. Submission of reports of national programs by the supervisors duly signed by the respective staffs. 3. Ensuring supply of contraceptives with three month's buffer stock at the hospital. 4. Training of concerning staffs on family planning methods and RTI/STI/HIV/AIDS. 5. Training of staff nurse on IUD insertion 1. Fixed Saturday for meeting day of staffs 2 Monthly Video shows

			Community focused Family Planning services Convergence	in the covering area of he hospital. all schools on health , nutrition and sanitation issues

6. Health Programmes

A. Reproductive and Child Health Programme components

(a) Maternal Health Care

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

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

Constraints:

- Health workers are not able to do 100% pregnancy registration due to different reasons such as unreachable areas, personal reasons, illiteracy etc
- No proper follow-up by workers of ANC cases and monitoring by supervisors, sector doctors etc
- No proper referral service
- Lack of awareness among rural masses/ low IEC activities
- Improper access quality antenatal, natal and post natal services may be due to
- Lack of nurse (refers to female MPW or ANM) for providing quality ante-natal care at an appropriate time in vicinity of her home.
- Lack of skilled birth attendant in vicinity of home (trained midwife, nurse or doctor).
- Lack of facility providing institutional delivery on a 24 hour basis:
- The Sub-Centre is not usually a site for institutional delivery. 48.% of sub centres the lack of buildings rules it out as an option. But even in the 52% that has a building the ANM is available at the headquarters only twice or thrice a month during working hours.
- Equipment gaps also contribute to poor service.
- The post-partum mother and the neonate require a visit by a trained volunteer in the first day after birth and at least once more in the first week of the neonate's life.
- Sometimes the nurse is there and resources are not a problem but there is a poor motivation to provide services or a reluctance to accept services even when the knowledge

and attitudes are alright. These gaps are cultural gaps and represent a certain passive discrimination – of caste or creed, or of gender.

Maternal Health:	Percentage
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	30.7
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	26.6
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)#	49.6
Institutional births (%)	48.5
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	20.8
Mothers who received post natal care within 48 hours of delivery of their last child (%)	28.3
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	30.7

(b) Family Planning

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

Table: 6.1. Current users of Family Planning

Family planning (currently married women, age 15-49)	Percentage
Any Method (%)	40.0
Any Modern method (%)	33.4
Female Sterilization (%)	29.7
Male Sterilization (%)	0.8
IUD (%)	0.6
Pill (%)	0.6
Condom (%)	1.8

(Source: RCH-DLHS survey 2003)

Table: 6.2 Unmet Need

Total unmet need (%)	29.8
For spacing (%)	12.6
For limiting (%)	17.2

(Source: RCH-DLHS survey 2003)

Table: 6.3 Marriage and Fertility

Marriage and Fertility, (Jan 2004 to 2007-08)	Percentage
Percentage of girl's marrying before completing 18 years	**52.9**

Percentage of Births of Order 3 and above	**47.7**
Sex Ratio at birth	**108**
Percentage of women age 20-24 reporting birth of order 2 & above	**67.8**
Percentage of births to women during age 15-19 out of total births	**15.0**

Table 6.4 Child Immunization and Vitamin A Supplementation

Child Immunization and Vitamin A supplementation:	**DLHS - 3**	
	Total	Rural
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)	42.3	45.3
Children (12-23 months) who have received BCG (%)	82.6	82.2
Children (12-23 months) who have received 3 doses of Polio Vaccine (%)	53.4	55.8
Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	49.5	53.7
Children (12-23 months) who have received Measles Vaccine (%)	60.4	57.7
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)	42.3	45.3
Children (12-23 months) who have received BCG (%)	82.6	82.2

(c) RTI / STI and HIV / AIDS Control

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

Table 6.5: Awareness of RTI/STI and HIV/AIDS

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

(Source: RCH-DLHS survey 2003)

Table 6.6: RTI / STI cases - detected and treated in the year 2008-09

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

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

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

Following are the suggestions to counter these issues:

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

(d) Adolescent Health

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

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

Suggestions:

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

Child Health and Immunization

Data shows that out of 33378 deliveries 2510 infants weighed below 2.5 kg. Poor outcomes in the child health due to the following reasons:

- Workers not following the 8/8 quality ante-natal care norms
- Poor nutritional habits
- Early marriages
- Illiteracy among rural masses

- Poverty
- Less no. of institutional deliveries

Table 6.7: Child health indicators

A. Percentage of women who started breastfeeding immediately/within 2 hours of the birth to their children	14.4%
B. Percentage of women who gave exclusive breast milk for at least 4 months to their children	17.6%
(i) BCG	82.6%
(ii) DPT (Three injections)	49.5%
(iii) Polio (Three doses)	53.4%
(iv) Measles	60.4%
(v) Complete immunizations (BCG + 3 DPT + 3 Polio + measles)	42.3%

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

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

Constraints for poor quality of immunization:

- Unavailability of vaccines on time
- Lack of staff
- Far-away sub-centres and improper transportation
- Illiteracy

Suggestions for improving the quality of immunization:

- Vacant staff positions should be filled-in
- At least two months stock of all the vaccines at CHC level
- Proper transportation facilities
- Maximum IEC coverage so that people should know about the date and venue of immunization

Suggested Strategies and Activities:

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

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

Rationalization of Deployment Medical Doctors in the APHC Level

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

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

Strengthening of PHCs

Appointment of Six Medical Officers at Least, four of whom at least are specialist or within them have the required four – skill (physician, paediatrician, surgeon, gynecologist) mix. If there are a number of APHCs not having doctors to be looked after with visits, the number posted here may increase further.

Adequate Multi – Skilled Male and Female Paramedical Staff, who can manage the necessary support work and multi skilled imaging technicians who can also mange X – rays, ultrasound and ECG too. In addition there would be a unskilled worker category of undifferentiated, interchangeable class IV functional – chowkidar, peon, sweeper, waterman – all rolled into one. Four qualified staff nurses, two qualified laboratory technicians and an optometrist are also a must at this level.

Re-designating the BEE, The block level extension educator may be renamed the block senior paramedical supervisor and be responsible for capability building, IEC and supervision of the sector supervisors.

Adequate Clerical and Accounting Staff, at least two, be provided to every PHC along with a computer and printers.

RATIONALISATION OF WORK ALLOCATION AND APPROACHES TO IMPROVE OUTREACH

In addition to the above measures improving outreach would require:

Reorganisation of MPW Work Schedule

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

Integration with ASHA Programme

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

Revised MPW Job Description

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

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

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

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

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

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

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

Outreach Strategies to Enhance Access

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

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

Staff Situation and their Utilization with Relation to Functionality of Centers

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

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

Rationalisation of Drugs and Consumables Supply

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

Rationalization of Equipment

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

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

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

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

Infrastructure Adequacy

The shortfalls in basic availability of buildings are well known. It is in the range of 83% for HSCs,88% of APHC,34% PHCs. Referrals are all in government owned buildings but as yet only an estimated 100% are upgraded to the 30-bed Referral norm. Toilet construction and maintenance too are major infrastructure inadequate. Maintenance of buildings is also poor and most buildings are old and need extensive renovation or replacement.
Problems with electricity supply are minimal and generator back up is usually available where there are problems. Problems with water supply are however considerable. Most of these facilities have a bore-well and hand-pump so that they are functional. However any hospital with inpatient

facilities, even if it were for only conducting normal delivery would require running tap water, bathing facilities and toilets separately for staff and for patients. Waste management based on segregation of wastes with proper disposal of each category of biological waste is a relatively untouched area of intervention.

B. Blindness Control Programme

National Programme for Control of Blindness was launched in the year 1576 as a 100% centrally sponsored programme. Various activities of the programmes include establishment of Regional Institute of Ophthalmology, up gradation of medical colleges and district hospitals and block level Primary Health Centres, development of mobile units, and recruitment of required ophthalmic manpower in eye care units for provision of various ophthalmic services. The programme also extends assistance to voluntary organizations for providing eye care services including cataract operations and eye banking.

The achievements of NBCP are tabulated below:

Table 6.8: Achievements of the National Blindness Control Programme (2009-10)

Particulars	Achievement
No. of Urban Eye Camps	03
No. of Cataract operations (Total)	2041
No. of refractive error	273

Constraints:

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

Suggestions:

- Integrate Eye care as part of Primary Health Care
- Involve NGO's
- Train Ophthalmic Medical Assistants
- Provide Low Cost Spectacles
- Correct Chronic Vitamin-A Deficiency
- Proper survey should be done by health workers
- Proper investigation before operation
- Camp should be done at well equipped hospitals and by surgeon
- Need of strict control to maintain quality.

- Need of change of attitudes.
- Need of designing referral services

C. Leprosy Eradication Programme

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

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

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

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

In the year 2008-09 total no of new case detected is 1003. To detect the hidden cases of leprosy in the community six search campaigns were organized in the district. Several sensitization Workshops and awareness programmes were also conducted to achieve the targets. The goal of leprosy elimination is that prevalence rate should be less than one case per 10,000 populations in the coming years. The focus is now being made on voluntary reporting of cases by promoting intensive IEC / BCC.

Table 6.9: Indicators showing achievements of NLEP 2009-10

Indicators	Status
New case detection	953

Suggestions

- Strengthen Health Care Services
- Rehabilitation
- Updation of master register
- Case validation, to have check on wrong diagnosis and re registration
- Prompt and early detection of the cases to avoid deformity and disability,
- Ulcer care foot ware reorientation training of medical & para medical staff.

- Involvement of Lokdoot (old & rehabilitated to have the best IEC.
- Community Education
- Removal False beliefs from the Community
- Financial and personal support and psychological assurances

D. Tuberculosis Control programme

Tuberculosis (TB) is an infectious disease caused by a bacterium, Mycobacterium tuberculosis. It is spread through the air by a person suffering from TB. A single patient can infect 10 or more people in a year. DOTS, known as the Revised National Tuberculosis Control Programme (RNTCP) in India, are a comprehensive strategy for TB control. DOTS are the only strategy which has proven effective in controlling TB on a mass basis.
India has adapted and tested DOTS in various parts of the country since 1993, with excellent results, and the RNTCP now covers more than 120 million populations. The Revised National Tuberculosis Programme (RNTCP) was launched in the country on 26 March 1997.

Table 6.10: Indicators showing achievements of RNTCP 2009-10

S.No.	Particulars	Status
1	Total Number of OPD	357852
2	No. of patients whose sputum were examined for diagnosis	13209
3	No. of Smear Positive patients diagnosed	
4	Total Patients Registered & put on DOTS	-
	a) New Smear Positive	917
	b) New Smear Negative	488
	c) New Extra-Pulmonary	67
	d) Re-treatment cases	473
5	No. of Patients put on Non-DOTS	00
6	Total Patients under treatment	1945
7	Annualised case detection rate	70.16

- TB Prevalence estimated for the district per Lakh- 203.
- Drugs, supplies and equipments as well as required staff are provided to districts
- Regular training, orientation programmes and awareness campaigns are being done
- Full treatment currently to 1945patients through DOTS providers

Suggestions

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

- Increasing referral from the field and from OPD, mobilizing community participation, ensuring involvement of Private practioners, NGOs and other sector, intensifying supervisory activities and intensifying IEC activities
- TB has a cure, and treatment is inexpensive
- TB control is a very cost-effective health intervention equivalent to that of the well known childhood immunization programmes.
- Successful treatment demands education and timely follow-up examination to achieve sputum conversion & cure rate up to the desired level.

- Successful treatment requires 6-8 months of consistent, uninterrupted medication
- New drop resistant strains of TB are developing because patients are not completing their treatment. These drug-resistant strains are significantly more dangerous to the individual and the community because they are more difficult and more expensive to treat.
- The best was to prevent TB is to cure infectious cases in their early stages in order to prevent transmission to others.
- TB, control programmes that treat infectious patients by don't ensure that they are cured risk doing more harm than good. Patients who have incomplete treatment can develop and spread drug-resistant TB.

Revised Naional Tuberculosis Control Programme(RNTCP)

Goal of the programme:

The main goals of the RNTCP are to eliminate/minimize source of infection i.e., to reduce

- Transmission of TB
- Mortality due to TB
- Drug resistance of TB

Objective	Gaps	Priority Areas	Activity planned under each priority area
• To achieve and maintain a cure rate of at least 85% among detected infectious(New Smear Positive Cases, and • To achieve and maintain detection of at least 70% of such cases in the population	• Low Cure rate i.e., 78.21% • Irregular intake of drugs not per guidelines • Proper Follow-up schedule is not followed • Proper supervision and Monitoring by Supervisory and Monitoring Team i.e., STS, STLS, MOTCs • Proper Counseling of the patient has not been done at the time of initiation of treatment • Participation of ASHA as DOTS	**Increase Cure-rate***	(a) Effective monitoring and supervision to ensure the follow-up sputum smear examinations done according to guidelines (b) Ensuring that every dose of medication is observed during the intensive phase of treatment and at least one dose per week in the continuation phase. (c) Return of empty blister packs during weekly collection of drugs ensured (d) Participation of ASHAs and AWWs for providing DOTS so as to reach services close to the patients for decrease default rate. (e) Proper counseling of the patient by the health workers ensured.

	provider is low.		
	• Lack of awareness among people about DOTS • Referral of Chest symptomatic patient is low. • Collection of Sputum Sample is not as per guidelines • Lack of Attention of MOs at the Health Centre regarding referral of chest symptomatic patients.	**Increase Case-detection**	(a) Organizing awareness campaign and community meetings to aware people about the TB and DOTS. (b) Sensitization of MOTCs/MOs at the Peripheral health facilities to ensure every TB suspect undergo Sputum Smear examination (at least 2% of Total New OPD patient) (c) Sensitization of all Lab Technician for Correct Sputum Smear Microscopy(5%-15% positivity is expected among patients examined for diagnosis) (d) Ensuring 3 sputum smear examinations for TB patients
	• Lack of dispensing medication properly as per technical guidelines in district. ANMs providing DOTS at HSCs do not visit Center on DOTS day. • Regular intake of Drugs is not being conducted by DOTS providers • Delay in initiation of Treatment of NSP Patient within a weak • Follow-up sputum smear microscopy examination at	Ensure Quality of DOTS	(a) Participation of ASHA and Community Volunteers to provide effective DOTS. (b) Initiation of treatment of New Smear Positive (NSP) patients within a weak of diagnosis. To control spared of infection in Group. (c) Proper Monitoring/Supervision to ensure regular and interrupted DOTS as per guidelines. (d) Proper counseling of patients by the DOTS provider and supervisory staffs.

	the end of Intensive Phase and at the end of the treatment is not done in many cases		
	• Microscopes of many DMCs are defective or dysfunctional • Proper space with electricity connection for keeping microscopes and proper water supply in the DMCs is not available • Poor maintenance of microscopes • Irregular supply of Lab consumables i.e., Slides, sputum containers and chemicals	Provide Quality DMC services	(a) Maintenance/Replacement of defective Binocular microscopes. (b) Establishment of new DMC as per need and repairing/renovation of closed DMCs with proper electricity connection and water supply. (c) Refreshment training of Lab Staffs specially Lab Technician for maintenance of microscopes. (d) Regular and adequate supply of laboratory consumables to DMCs from |District TB Center(DTC) will be ensured.
	• Lack of staffs i.e., Lab Technician(LT), STS, STLS, TBHV and other Staffs • Untimely payment of contractual Staffs. • Untimely payment of fuel	HR Issues	(a) Active participation of community specially ASHA and AWW. (b) Capacity building of ASHA (c) Remuneration to ASHA/Community volunteer for providing DOTS will be paid timely. (d) New recruitment for lacks in staffs i.e., Lab Technician, STS, STLS, TBHV and other staffs. (e) Timely payment of contractual

	Allowances of Supervisory Staffs • Operational Issues: Lack of coordination between ASHA, AWW and ANMs.		Staffs will be ensured. (f) Timely payment of fuel allowances will be ensured.

**Cure-rate*: No. of cured NSP cases/Total No. of NSP cases X 100
***Cured Cases*: Initially sputum smear-positive patient who has completed treated and had negative sputum smears, on two occasions, one of which was at the end of treatment**

E. Filaria control Programme

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

Constraints

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

Suggestions

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

F. Disease surveillance programme

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

Constraints:

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

Suggestions

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

G.ASHA programme:

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

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

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

F. Urban Health

In Rohtas district 13.33% percent of the total population lives in urban areas as per the 2001 census.

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

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

Logistics management

The essential drug list is in place and is largely implemented. As Rohtas district has storekeepers and officers have been trained in drug and supplies logistics. A computerized inventory system is yet to be developed in HMIS software. The problem with consumables is equally of concern and laboratory chemicals seem the worst affected but even gauze and bandages, needles and needle holders could be in short supply repeatedly. These would correct with the distribution system becoming fully operational.

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

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

Coordination with ICDS and PHED

Most of the activities like Routine Immunization, Vit A supplementation, DOTS, Health Check ups etc are implemented through ICDS program. The construction of bathrooms and toilets and

provision of regular water supply have been done at PHCs through PHED. The detail is given below.

Coordination with Panchayats

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

Infrastructure and Service Delivery Issues

Training and Capacity Building

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

Almost no training is based on building competencies to attain a level of clinical services in a given facility. We therefore have a situation where there is a perception within senior officials that the system is being flooded with training programmes. Yet the system cannot guarantee that in the sub-centres or PHCs or CHCs of a given district, the level of knowledge and skills needed is now available. It may not even be able to state; facility-wise what level of skill building has been achieved and what are the gaps.

Chapter 4

Setting Objectives and Suggested Plan of Action

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.

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).

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

			2. Training of the spraying squad	2. Ensuring regular supply of DDT and insecticides
				1. Regular training of the spraying team for dissolving DDT, filling , carrying and spraying process
				2. Supervision by the supervisors to get the feedback of training
				3. Follow up survey: First surveyafter 21 days of control and second survey after 22 days of first survey
			2. Use of Insecticide treated bednets	1. Space spray for 7-10 days , residual insecticidal spraying to be started simultaneously as per district micro plans
				2.Supply of Insecticide treated bednets to suspected patients free of cost
			3. Anti larval measures	1. Promotion of use of larvivorous fishes like gambusia in the natural water tank

T.B.					
	Indicators	**Gaps**	**Activities**	**Unit Cost**	**Total Cost**
1	**Infrastructure**	Lack of well equipped/Designed Microscopy Centre	Development and Renovation of DMCs with proper water supply and Electricity connection	Rs 5000 per PHC	85000
		Microscopes of many Designated Microscopy Centers(DMC) are not functioning	Supply of New binocular Microscopes	Rs 50000 per PHC	850000

		Poor Maintenance of Microscopes	Special Training to Lab Technician/Microscopist for maintenance of Microscopes	NA	0
2	**HR**	Many DMCs are closed due to lack of Microscopist/Lab Technician	Recruitment Process should be followed.	NA	0
			Honurarium for 17 TB technicians	Rs8000 per month for 17 technicians for 12 months	1632000
		Constraint in selection Process of new Staffs by the District Health Society	Obstacle in recruitment Process will be rectified.	NA	0
		Remuneration of Pvt DOT Providers has not been paid	Problems in payment of remuneration will be solved	Rs 50 per DOTS provider for 500 units	25000
3	**Drugs and Chemicals**	Irregular supply of Drugs specially of Pediatric Drug Boxes (PC-13, PC-14)	To ensure regular and adequate supply of drugs and other Laboratory materials	From state budget	0
		Supply of short expiry drugs which causes difficulties in drug management	Proper care should be taken regarding short expiry drugs. Short expiry drugs may be used where there is large number of patients having DOTS.	NA	0
		Poor Retrieval of Drug Boxes of Defaulted patient	Retrieval of Drugs may be ensured by STS.	NA	0
		Irregular supply of slides and other Chemicals and other logistics	Proper supply of Slides and other Chemicals should be ensured	Rs 2000 per PHC per month	408000
		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

		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
4	**Service Performance**	Not friendly behavior of Lab Technician and other staffs with patient who comes for sputum examination or for DOTS	Appointment of a Counselor at all PHC	Discussed in maternal health	0
		Poor Case Detection i.e., <70%		NA	0
		Poor Cure Rate i.e., <85%	Organizing Community meetings	NA	0
		High Default Rate		NA	0
			Medical Officers should take care of referring all chest symptomatic patients for sputum examination	NA	0
			Proper Follow-up Schedule should be maintained	NA	0
			Proper care for side effects of drugs.	NA	0
			Total Budget		3000000

Kala a Zar					
	Gaps	**issues**	**Strategy**	**Activities**	**unit C**
1	Poor coverage of DDT spray	Vector control through insecticide spray in the attack area	To increase the coverage of DDT spray in the endemic zone , there should be proper monitoring by the supervisors, capacity building of the sprayer, supervisors and other healthcare professionals	1. Ensure planning for timely spray of DDT in Feb-March and May-June for 40 days in each block	NA
			Monitoring of the spraying squad by MOIC	2. Identification of Houses with Kala-azar patients by ANM & ASHA @ 50/ per village.	Rs 50 f villages a year
				3. Two round of spraying scheduled in Feb-March and May-June should be strictly observed	NA

				4. DDT spray should be at the rate of 1gm/sq. meter upto the height of 6 feet.	NA
		Less time spent on spraying DDT	Training and capacity building for proper spraying	Regular capacity building training on prescribed module for the sprayer to ensure that very corner of the house is properly spraye upto heigth of six feet from ground level.	Rs 500 PHC
		Poor condition of Sprayer, pump and nozzles etc No of Pumps available-266, No of pumps required-20, No of bucket savailable-421, No of buckets required-167, No of gallon available-102, No of gallon required-	Regular checking of the spraying pumps for better functioning and timely replacement of the faulty pieces.	Fund allocation and timely release for : maintencae of old sprayer pumps, Puchase of new pumps and other articles needed- buckets, mugs etc.	Rs 150 the dist

		45, No of pond measure available-119, No of pond measure required-28, .			
		Inadequate stock of DDT, DDT available-41mt, DDT required-33mt	Making available DDT during spraying round	Ensure adequate Stock of DDT through proper & timely indenting to improve the quality of spray	DDT C
		Faulty payment plan	Appropriate fund allocation for the payment of the spraying of DDT	Fund would be allocated for regular payment of wages (147 SFW to be used and 735 FW to be used for monitoring and spraying work)	147SF Rs113
					735FW x 40 D

2	Poor rate of case detection of Kalazar	Early diagnosis and treatment through PHC system	Case detection rate should be increased with appropriate diagnostic test	Increase efficiency of case detection through training of Community workers on signs and symptoms of Kala-azar: **1)** three weeks persisten fever not responding to antibitics, malaria being excluded, with palpable spleen.**2)** Ensure availability of aldehyde test at PHC level **3**) Purchase of RK 39 kit for detection of Kalazar	Purcha 50000 RK39 per uni
		Reduction of kala-azar mortality and morbidity	Early diagnosis and treatment through PHC system	1. Ensuring availability of Amphotoricin at all level	Purcha 10000 Ampho @ Rs 6 unit
				Loss of wages for KZ patients(case detection in year 2007-3275)	Rs 50 f days fo patient
				2. Replacing of medicines on priority based	NA
				3. Training of ANMs and ASHA for IM injection	Rs 500 PHC
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 for CS, and DM

					Mobilt MOIC 40days
					Mobili supervi 40 days
				Office expenses	25000 district
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
				2. Identification of NGO/Private partner as trainer	NA
				3. Knowledge sharing with the community on signs and symptoms of Kala-azar through VHSC	NA
				4. Training of VHSC/PRI and community health worker on sign & symptom of Kala-azar	NA
				5. Regular monitoring of IEC activities	NA
				6. IEC activities through nukkad natak, kalajatha mass media like radio	Rs 100 PHC
				7.Activity for survilence like polio survilence	NA
				8.Wall painting of Tretment protocole and provisions for pateints in PHC in Hindi.	Above mentio
				IEC van for each PHC	15x 40
				Total Budget	

Chid Health							
Logical Framework							
Sl.	Goal	Sl.	Impact indicators				
1		1.1	Reduction in IMR				
	To improve Child health & achieve child survival	1.2	Child performance in the school - enrolment, attendance and dropout				
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indi
1	To increase ORS distribution from 13.8%(DLHS3) to 80%	1.1	% increase of ORS distribution .	1.1.1	*IMNCI,Home Based Newborn Care/HBNC*		% of PH IMNCI a trai
2	To increase treatment of diarrohoea from 77.7% to 90% within two weeks		% increase of treatment of diarrhea within two weeks				
3	To increase treatment of ARI/Fever in the last two weeks from 78.7%(DLHS3) to 95%		% increase of treatment of ARI/Fever in the last two weeks				
4	To increase of infant care with in 24hr of delivery from 27.4%(DLHS3) to 50%		% increase of infant care with in 24hr of delivery .		Srengthening of Facility Based Newborn Care/FBNC and trained workers on using equipments.		No of PHC FBNC with MAMTA on based new
	To increase % of breastfeeding from 14.4% to 70% within 1 hr of birth		% increase of breastfeeding within 1 hr of birth .	1.1.2	Infant and Young Child Feeding/IYCF		No of t organized IY
	To increase initiation of complimentary feeding among 6 month of children from 87.5% to 90%		% increase of complimentary feeding among 6month of children.				
	To increase exclusive breastfeeding among 0-6 month of children from 36.4% to 80%		% increase of exclusive breastfeeding among 0-6 month of children .				
	To increase immunization coverage from 17.6% to 70%		% increase of full immunization coverage .				

	To increase vit A coverage of received at least one dose (9month to 35 months) from 46.7% to 80% and include up to 5 years.		To increase Vit A reported adequate coverage among (9m to 5ys)	1.1.3	Management of diarrhea, ARI and Micronutrient Malnutrition through Child survival months		Two round survival Mo organized i financial ye
	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 strengthen VHND at all AWCs		No of VHN organized v
2		2.1		2.1.1	School Health Programme		No Of scho programme in the PHC
Sl.	Strategy		Gaps		Activities	Unit Cost	Budget
	IMNCI,Home Based Newborn Care/HBNC		*Training Gaps(AWW-0/2307,ASHA-0/1935,ANM-0/418,MPW-0,MO-0/122,CDPO-0/19,ICDS Super-05,Health supervisors-0,NGOs-0)* *No ASHA is trained on IMNCI*		*Assessment of Training load and prepare calendar of training*	NA	
					Incorporate ASHA in IMNCI training team	NA	
					ASHA kit regular supply and incorporate use of ASHA Kit in training curriculum.		

			Inadequate monitoring of this activity at field level		*Division of area among all trained supervisor for revision of IMNCI activity in their area.*	NA	
					BHM will be responsible for review of health supervisor and LS(ICDS)on given formate.Unicef staff will support in developing review mechanism in PHC.	NA	
					Incorporate 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 develop 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	
	Facility Based Newborn Care/FBNC		only eight institutions have baby warmer machines but maintenance of machine is not up to the mark and district having referral six bedded SNCU		All PHCs should be equipped with baby warmer machines.	Mobilizing nine units from UNICEF	
			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	
			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/-	
			Neonatal Care Unit not up to mark.		District level Supporting supervisory team should be develop with the responsibility of nonfunctioning of neonatal care unit. Training of team on monitoring of NCU	Rs.5000/-for one time training	

			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	
	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	
					Baby friendly hospital Training of one doctor form each Nursing hospital at District Level	Rs.20000 for training programme	
					Two days training of one staff nurse from each private hospital on counseling skill.	Rs 20000/- for training programme	
					Accreditation of nursing home and facility according to norms of baby friendly hospital	NA	
			Poor knowledge regarding new born care and child feeding practices		Development and Printing of BCC materials	Rs 5 per unit for 10000 units	
					Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA	NA	
					Linking JBSY with colostrums feeding	NA	

			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	
					Folk performance to promote exclusive breast feeding	Included in maternal health	
					Uniform message on radio from state head quarter	State budget	
			Lack of awareness on importance of appropriate and timely IYCF		Organize social events through VHSCs	NA	
					Strengthening of *Mahila Mandal* meetings- fortnightly with involvement of adolescent girl	NA	
					Organize healthy baby shows, healthy mother / pregnant woman.	Rs 2000 per month per PHC	
					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	

					Celebration of "*Annaprashan(Muhjutthi) Day*" at AWC	NA	
					Demonstration of recipes.	Rs 250 per month per AWC(Under MUSKAN program)	
					Exposure visits to existing NRCs to observe different models in the country	Rs 50000 for the district	
	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 district hospital, FRU and one PHC and promote local available food formula for nutritional Therapy as Hyderabad Mix	Rs 1000000 per unit	
	Management of diarrhea, ARI and Micronutrient Malnutrition		There is high prevalence of PEM and anemia among children because of Child nutrition is least priority among service providers.		Procurement of ,ORS , Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup.	150000 ORS packets at the rate of Rs 5 per packet.(If ORS is not provided in Kit A) IFA syrup for 1200000 children at rate of Rs 4 per children	

					Include coverage of Vitamin A and IFA,children in New HIMS format.	NA	
					Insure two round of Vitamin A and deworming for the age group of (9m to 5 yrs) & (2 yrs to 5 years) respectively in the month of April And Oct as per GOI guide line.	Rs 1500000 per round into two rounds(If Vit A is not provided in Kit A)	
					Involvement of ICDS, school teachers and PRI for monitoring and evolution	NA	
	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	
			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	
			No regular health checkup camp at school.		Quarterly meetings of VEC representatives by attending existing meetings of VECs representatives at block level by the concerned MOICs and BHMs.	NA	NA

			No Training & Screening of school's teacher for eye sight test.		Linking existing 7 ophthalmic paramedics with this program and developing school wise calendar.	Mobility support of Rs 10000 per PHC for moving other blocks and hard to reach areas.	
			No other specific program has been formulated in the district.		School health anemia control programme should be strengthen with bi annually de worming .	Budget incorporated in adolescent health	
					Organizing competitions/Debates/Painting competitions/Essay/demonstration and model preparation of nutritional food and health.	Rs 20000 per PHC	
					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	
					Films shows on health, sanitation and nutrition issues	Use LCD projector in this activity.	
					Social Since Lab activities.	Included in adolescent health	

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

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 48.5% (DLHS3) to 100% by year 2010	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 FRUfor institutional deliveries	1.1.2.1	No of FRUs having functional blood storage units linkage with blood banks and 24hr ready referral transport
						1.1.2.2	No of FRUs having EmOc and CEmOc

							facilities
						1.1.2.3	No of FRUs having specialist doctors/ multiskilled Medical Officers
						1.1.2.4	No of FRU having functional Neo-natal care units
				1.1.3	To provide Referral transport services at FRU /PHC	1.1.3.1	No of pregnant women availed the referral facilities (pick up and drop)
				1.1.4	To strengthen Janani Suraksha Yojana / JSY	1.1.4.1	% of pregnant women reecieved JSY payments immediately

							after delivery
2	To increase safe delivery by trained SBA 20.8%(DLHS3) to 100% by year 2010	2.1	Proportion of birth attendent by skilled health personnel	2.1.1	To ensure support of SBA at home deliveries	2.1.1.1	% of home deliveries attended by SBA
3	To increase ANC coverage with quality 26.6% (DLHS3) to 50% by year 2010	3.1	% ANC reported through HMIS formats / Form -7	3.1.1	To strengthen HSC for providing outreach maternal care	3.1.1.1	% of HSCs having ANMs
						3.1.1.2	% of HSCs conducted fixed ANC and clinics (planned & held)
				3.1.2	To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas	3.1.2.1	% of RCH camps planned and held
				3.1.3	To improve adolescent reproductive and sexual health	3.1.3.1	No of pregnant adolescent counselled by ANM/ AWW/ASHA

				3.1.4	To accelrate APHC for OPD and Fixed AN clinics	3.1.4.1	% of OPD 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	To increase community participation in maternal care	5.1	% of Mahila mandal meetings conducted.	5.1.1	To strenghten Monthly Village Health and Nutrition Days	5.1.1.1	% of mothly Village Health & Nutrition Days planned and held
MATERNAL HEALTH							
Sl.	**Strategy**	**Sl**	**Gaps**	**Sl**	**Activities**	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.(List attached, Annexure..)	1.1.1	Need based (Service delivery)Estimation of cost for upgradation of PHCs Selection of any two PHCs for ISO certification in first phase	@200000/-Per PHC	3800000

		1.2	At present 19 PHC are working with average 15delivery per day, 15 inpatient , 10 FP operation/emergency operation and 130 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	1.2.1	2.Preparation of priority list of interventions to deliver services.	NA	0
		1.4	The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement.	1.4.1	2. Sending the recommendation for the certification with existing services and facility detail.	NA	0
		1.5	Lack of equipments as per IPHS norms and also under utilized equipments.	1.5.1	3 Prioritizing the equipment list according to service delivery and IPHS norms.	Cost of equipment is attachet Anx..	0
				1.5.2	4 Purchase of equipments		0
		1.6	Lack of appropriate furniture	1.6.1	2 Purchase of Furniture	Cost of Furniture is attachet Anx..	0

	To make functional PHC (24hr x7days) for institutional deliveries	1.11	Lack of facilities/ basic amenities in the PHC buildings	1.11.1	1Rennovation of PHCs	cost of rennovation is attachet Anx..	0
		1.12	**As per IPHS norms each PHC requires the following clinical staffs:(List attached)**				0
					Salary of Contarctual Docters	2 Specialist@ 25000/ 40 MBBS @20000/	10200000
		1.12.1	But the actual position is not sufficient as per IPHS norms List of Human resource is attached in Annaxer .		Selection and recruitment of Doctors on contractual basis and give priority in selection those who are living in same PHC.	48 Doctors to be appointed	14400000
				1.12.10.1	Salary of Contarctual Grade A	14 Grade A Nurse	1260000
		1.12.10			Selection and recruitment of grade A for conducting delivery	3 Grade A nurse for each PHC	73530000
					Selection and recruitment of dresser	15 Dresser for each PHC	1282500
					Selection and recruitment of Pharmasist.	14 x2 Pharmasist for each PHC	2280000
					Three month induction training of Grade A nurse under supervision of District level resource team.	100/-per day x 90 days for 57 grade A nurse	513000
		1.13		1.13.1	Training need Assessment of PHC level staffs	NA	0
					Honorarium of Block Accountants	16 Accountant @ 12000/	2304000

					Rent of Data Center	19 Data Center @ 5200/	1185600
					Honorarium of BHM	9 BHM @ 18000/-	1944000
					Mobility support to BHMs	Rs 2000 per month per BHM	456000
		1.14		1.14.1	Appointment of Block Health Managers, Accountants in all institutions.(17 PHCs, 2 Referrals and Sadar hospital.)	10 BHM and 3 Accountants Budget in RKS head	0
					Process of all recruitments	6 types of recruitment @ 10000	60000
					Trainings of BHMs on Health statistics	19 BHMs	38000
					Training on Program, Finance management and HMIS	19 BHMs, 19 Block Accountants and 19 Data Center operators	114000
			Drug Supply				
		1.16	Irregular supply of drugs because of lack of fund disbursement on time.	1.16.1	Ensuring the availability of FIFO list of drugs with store keeper.	NA	0
		1.17	Only 38 essential drugs are rate contracted at state level .	1.17.1	2.Implementing computerized invoice system in all PHCs	NA	0
					Purchase of Drug invoice software	Rs 10000 per PHC	190000

			Lack of fund for the transportation of drugs from district to blocks.	1.17.2	3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock)	NA	0
							0
		1.18		1.18	4.Payment from Rogi Kalyan samiti account.	Rs 2000 per month per PHC	456000
		1.19	There is no clarity on the guideline for need based drug procurement and transportation.	1.19.1	5. Orientation meetings/ training on guidelines of RKS for operation.	Rs 2000 per PHC	38000
		1.2	Drugs are not properly stored	1.20.1	6. Enlisting of equipments for safe storage of drugs.	NA	0
				1.20.2	7. Purchase of enlisted equipments.	Rs 15000 per PHC	285000
				1.20.3	8.training of store keepers on invoicing of drugs	Rs 2000 per PHC	38000
			Performence				0
		1.21.1	Exessive load on PHC in delivering all services i.e. 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC.	1.21.1	Recruitment of Doctors on contractual basis	NA	0
		1.21.2	Total 59 seats of Regular and 25 seats of contractual doctors in the district is vacant.			NA	0

							0
		1.22	All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less(only average16 patients per Doctor per OPD days during April08-Nov 08, however the IPHS norms says that the OPD should be 40 per Doctor.)	1.22.1	Hiring of rented houses from RKS fund for the residence of doctors and key staffs.	Rs 5000 per PHC per month	1140000
				1.22.2	Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.	Rs 5000 per PHC per month	1140000
				1.22.3	Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day	NA	0
	To make functional PHC (24hr x7days) for institutional deliveries	1.24	5 PHCs out of 15 are lacking 24 hrs new born care services.	1.24.1	Ensure 24 hrs new born care services in 10 PHC.	Budget in Child health care activity	0
		1.27	Only five 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.	2000/-Per Docter	24000
					Equipments for BEmoC	50000 per facility	600000
							0

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

		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 Ambulence services at PHC level.	60000/-each PHC per month	12240000
					Provide EDD list of pregnant women to Ambulence driver and Number of ambulence diriver and 102 /PHC tel No to all Pregnant woment	NA	0
		1.33.3	Lack of maintenance of ambulances	1.33.3.1	Repairing of all defunct Ambulances	three Ambulances @ rs 50000 per Ambulance	150000
		1.33.4	Shortage of ambulances	1.33.4.1	Hiring of ambulances as per need.	one in each PHC @ Rs 10000 Per month	2040000
					Prepaer list of Vechecal those are utilised in Monitoring work in PHC that can be use in pick up and drouping facility for PW.	NA	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	7650000

					Rewiev of Cleanliness activity in all PHC by Qulity assurence committee and payment of agency should be link with it.		0
				1.34.2	Hiring of workers for cleanliness of OT and Labour room in PHC	Two workers per PHC for maximum 30 days @ Rs 100 per day by concerned RKS	1224000
					Perchage equipments and uniform for clinliness in all PHC	50000/each PHC	850000
					Training of Workers on using machine/equipments and importence of clinliness .	2500/-per PHC twice in a year.	85000
					Devlop mechnisume for monitoring of clinliness work	NA	0
		1.35	All PHCs have their own generator sets but are not in use.	1.35.1	Repairing of PHCs gensets and initiating their use.	Rs 5000 per PHC	85000
		1.7	Non availability of HMIS formats/registers and stationeries	1.7	Printing of formats and purchase of stationeries	Rs 50000 per PHC	850000
				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	102000
				1.8.2	Appointment of Block Health Managers, Accountants in all institutions.(15 PHCs, 2 Referals and Sadar hospital.)	Seven more BHMs and 4 more Accountants(Rs 18000 per month for BHMs and Rs 12000 per month for Accountants)	2088000
		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	34000
				1.9.2	Trainings of BHM and accountants on their responsibilities.	Rs 1000 per participant, Two participants from each PHC	34000
		1.1	Lack of community participation in the functioning of RKS.	1.10.1	Meeting with community (School children or other)representatives on erecting boundary, beautification etc,	5000/-per PHC	85000
				1.10.2	Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS.	NA	0

		1.36	In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases.	1.36.1	Meeting in RKS with Local Police Station incharge to handdale emargency situation .	NA	0
					Training local NCC/NYK/Scout & Guide/NSS etc.volentiers on identification of emargency situation. And deployment of volentears 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	170000
		1.38	No guidance to the patients on the services available at PHCs.	1.38.1	Pictorial wall painting on every section of the building denoting the facilities and attached trained volenters to guide paitents.	Rs 2000 per PHC	34000
		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 Displaying Name Photograph and DOB of all staff of PHC and put clinliness staff name on top of the list.	Rs 2000 per PHC	34000

		1.41	Lack of councelling services	1.41.1	There re 22 LHV in the district we can utilise their experience in counseling work of women and adolecent girls after training.	1000 per person	22000
		1.42	there is no hot water facility for PW and there is no adequte liting facility at adjoining area of PHC	1.42.1	Installation of solar heater system and light with the help of BDO/Panchayat at PHC or purchage equipments from market.	50000/-per PHC	850000
		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	Puchase of Laptops for DPMs and BHMs with internet facility.	Rs 35000 per unit+ 2000 per month	1062000
		1.45	Lack of space for waiting, environmental cleanliness around PHC, provision for hospitality etc	1.45.1	Gardening	Rs 5000 per PHC	85000
				1.45.2	Sitting arrangement for patients	Rs 5000 per PHC	85000
					Construction of patients waiting shade	75000/-Per PHC	1275000
				1.45.3	Installation of LCD projecter for manage waite over time of OPD patients.	Rs 100000/- per PHC	1700000
				1.45.4	Installation of safe drinking water equipments/water cooler,	Rs 10000 per PHC	170000
				1.45.5	Apron with name plates with every doctors	Rs 250 per Doctor for total 205 doctors	51250
				1.45.6	Presence of staffs with uniform and name plates.	NA	0

				1.45.7	"MAMTA" should be appointed at PHC level as well.	Rs 75 per delivery for approx 60000 institutional delivery	4500000
	To make FRU functional and upgradation of PHC to CHC for institutional deliveries						
2		2.1	C-Section deliveries are not conducted in institution.	2.1.1	Devlop Lalganj, Mahua and Mahnar PHC for C-section facility	NA	0
				2.1.2	Training of MOs of three PHCs in mulltiskilling.	3 Docters from each PHC @ 2000/-per person	18000
				2.1.5	Specialist should be posted at Sadar Hospital/and above mention three PHC	NA	0
				2.1.6	Incentive for C-section to PHC those who conducted 10 -15 = 10000,15-20=20000, 25-30= 50000/,C-section in a month the incentive money should be distributed among all staff of the PHC after the decision of RKS.	Rs 25000 per PHC per month	900000
				2.1.8	Need based Equipments and drugs in O.T and Labour room.	List of Equpment attached(100000 per PHC)	1700000

			None of the PHC provides 24 hour blood transfusion services, however PHC Mahnar has been provided the equipments for blood storage unit.		Establising blood storage unit at Lalganj, Mahua & Rahopur,	60000/- Per PHC	180000
					Training of lab technision on management of blood storage	3 lab technision	3000
			Infection control protocols is not at all maintain at all facilities	2.2.2	Licensing blood storage / blood bank	NA	0
				2.2.3	Meeting infrastructure requirements as per norms for Blood storage	10000 Per PHC	30000
				2.2.4	Training of MO and lab tech/ staff nurse blood storage on grouping /cross matching and management of transfusion reactions stabilized linkages with mother blood bank.	Rs 1000 per participant, Two participants from each PHC	34000
				2.2.5	Provide free of cost Blood for pregnant women who need blood transfusion for severe anemia/ PPH on prescribed through RKS Fund	20000/-for each PHC per month	720000
				2.2.11	Organize Blood donation camps at all institution and mobilize community for voluntary blood donation	Rs 10000 per camp per PHC for organizing two camp annually	340000

		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	85000
				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	51000
		2.5	Biomedical waste management is not properly taken care off at all institution	2.5.1	Procurement of equipment	Rs 50000 per PHC	850000
				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	4950000
				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 99000 pregnancies	4950000
					Incentive for institutional delivery.	Rs 2000 per delivery	132000000
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	170000
				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	5.2.1	Incentive based system for reporting of home delivery by ASHA and it should linked with	NA	0

			provided		ANM		
		5.3	Non paiment of Home delivery through JSY	5.3.1	The JSY money to the mother who has delivered baby at Home paid by ANM.	Rs 500 per home delivery for approx 33000 home deliveries	16500000
6	**To strengthen HSC for providing outreach maternal care**	**Infrastructure**					0
		6.1	Out of 338 HSCs only 39 are having own building	6.1.1	Strengtheing 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	34000
				6.2.2	Organize adolescent girls for wall painting and plantation./hire local painter for colourful painting of HSC walls.	NA	0
				6.2.3	List out all services which is provided at HSC level. On the wall.	NA	0
				6.2.4	Gardening in HSC premises by school children.	NA	0
		6.3	No one building is having running water and electric supply.	6.3.1	Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental.(Untied fund)	Water rent for 39 HSC, Rs 100 per month from untied fund.	0
					Arrangement of water supply upto HSC (Wiring) from water source	Rs 5000 per HSC	195000

	To strengthen HSC for providing outreach maternal care	6.4	Lack of apropriet equipments and ANM are reluctant to keep all equipments in HSC .	6.4.1	Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/)	Rs 20000 per HSC having own buildings	780000
				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	3380000
		6.5	Non payment of rent of 299 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 135 more HSCs to be formed.	6.6.1	Construction of new HSCs. 39 are having own building, 54 new is proposed and rest 480 are supposed to be constructed.	From State Govt fund	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	135600
				6.7.2	Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format.	NA	0
				6.7.3	Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project.	NA	0
				6.7.4	Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work.	Rs 20000 per PHC	340000

				6.7.5	Quartely Meeting of one representative of VHSC/Mothers committees on construction work and other issues	Rs 50 for TA to VHSC members for attending monthly meeting at PHC	204000
		6.8	Lack of community ownership in the	6.8.1	Formation and strengthening of VHSCs, Mothers committees,	NA	0
				6.8.2	"Swasthya Kendra chalo abhiyan" to strengthen community ownership	NA	0
					One week Training of Nukkad Natak team on IPHS	Rs 300 per participant per day for 85 persons for 7 days	178500
				6.8.3	Nukkad Nataks on Citizen's charter of HSCs as per IPHS	Three days performance at 339 HSCs	1525500
				6.8.4	Monthly meetings of VHSCs, Mothers committees	NA	0
7		**Human Resource**					
		7.1	1.Out of 29 sanctioned post of LHVs only 22 are placed, 2.All 195 posted ANM ® are not trained enough to deliver services. 3. 223 seats of contractual ANM®, 12 seats of contractual ANMs and	7.1.1	Selection and recruitment of 262 ANMs	honorarium of 262 ANMs @ Rs 6000 per month for 12 months	18864000
					Honorarium of existing 202 ANMs	Honorarium of existing 202 ANMs @ rs 6000 per month for 12 months	14544000

			27 seats of Regular ANMs are vacant.	7.1.2	Selection and recruitment of 28 male workers	Honorarium of 28 male workers @ Rs 5000 per month for 12 months	1680000
				7.1.3	Training need Assessment of HSC level staffs by BHM in weekly meeting	NA	0
				7.1.4	Training of staffs on various services in the PHC,	Rs 1000 per participant (Total no of participants 262 new ANMs, 202 existing ANMs and 28 new male workers)	492000
	To strengthen ANM Training School for providing regular training of ANMs.	7.2	The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities	7.2.1	Analyzing gaps with training school		0
				7.2.2	Deployment of required staffs/trainers		0
				7.2.3	Hiring of trainers as per need		0
				7.2.4	Preparation of annual training calendar issue wise as per guideline of Govt of India.		0
				7.2.5	Allocation of fund and operationalization of allocated fund	Lmsm Rs 200000 in a year	200000
8	**To strengthen HSC**	**Drug Kit Availability**					0

	for providing outreach maternal care	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	811200
				8.1.4	Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)	Rs 2000 per PHC	34000
				8.1.5	Hiring of couriers as per need	Rs 50 per courier for 200 couriers for 8 days per month	960000
				8.1.6	Payment of courier through ANMs account	Fund for the payment of Couriers should be transferred to ANMs account.	0

9	**To strengthen HSC for providing outreach maternal care**	**Performance**					0
		9.1	Unutilized untied fund at HSC level	9.1.1	Training of signatories on operating Untied fund account, book keeping etc	Rs 100 per person for two persons for 339 HSCs	67800
				9.1.2	Timely disbursement of untied fund for HSCs	Rs 10000 per HSC per year for 339 HScs	3390000
				9.1.3	Assigning a person at PHC level for managing accounts	NA	0
		9.2	No ANC at HSC levelOnly 14.2% PW registered in first trimesterPW with three ANCs is 15.1%, TT1 coverage is 35.4%,	9.2.1	Identification of the best HSC on service delivery	NA	0
				9.2.2	Listing of required equipments and medicines as per IPHS norms in facility survey	NA	0
				9.2.4	Honouring the ANM those who devlop women friendly HSC in given criteria (list is attachet)	5 ANM in a year per PHC social honouring with one shawl.	42500
		9.3	Family Planning Status:-Any method-43.6%,Any modern method-39.8%,No sterilization at HSC level,IUD insertion -0.5%,Pills-1.5%,Condom-1.9%,Total unmet need is 32.7%, for spacing-14.9,Lack of councelling 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	85000
				9.3.5	Training of ANMs on IUD	Rs 10000 per PHC	170000

					insertion		
		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
	To strengthen HSC for providing outreach maternal care			9.4.2	Strengthening ANMs for community based planning of all national disease control program	NA	0
				9.4.3	Reporting of disease control activities through ANMs	NA	0
				9.4.4	Submission of reports of national programs by the supervisors duly signed by the respective ANMs.	NA	0
		9.5	80% of the HSC staffs do not reside at place of posting	9.5.1	Submission of absentees through PRI	NA	0
		9.6	Problem of mobility during rainy season	9.6.1	Purchasing Life saving jackets for all field staffs	3 units per PHC at the rate ofRs 3000 per unit	153000
				9.6.2	Providing incentives to the ANMs during rainy season so that they can use 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 Knowladgae and skill of fileld level staff of data compilation in HMIS formats and formate.	9.8.1	Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc	NA	0
				9.8.2	Printing of adequate number of reporting formats and registers	Discused earlier	0
10	**To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas**	10.1	Out reach camps are not orgnised in plan mannaer. It is totally baes on demand of orgnisation and it eventually it is not reported to respective HSCs and PHC.	10.1.1	Identifying Socially Backward, Slums & Maha Dalit Tolas.	NA	0
				10.1.2	Hiring trained alternate vaccinator/ retired ANMs and Medical officer .hiring vehicle for fixed day out reach camps with drugs.	Rs 10000 per PHC per month	2040000
				10.1.3	Fixed day OPD clinics at APHC level and adjoining HSC of respective APHCs. with dedicated MO and support staff.	NA	0
				10.1.4	To make calendar for camps with date and identified areas.and link NGOs those who are willing to orgnised Camps .	NA	0
				10.1.5	Community based reporting system through SMS. involve PRI members and training on reporting and Camp approach	NA	0

11	**To improve adolescent reproductive and sexual health**	11.1	No training programme for adolescent particularly health and sex.	11.1.1	Multipurpose counselor can be used for adolescent care. For this services of LHV can be used.and callender of activity could be devlop.	NA	0
		11.2	Preventions of anemia in adolacencent girls	11.2.1	linkage with adolacent anemia controle programme in Schools with Unicef. And traing to the one teacher from the school	Rs 5000 per PHC	85000
		11.3	Marriage before legal age.	11.3.1	Senstigation of PRI members pertculerly women	Rs 5000/-Per PHC	85000
		11.4	Preventions of teen age pregnancy and abortion.	11.4.1	Adolescent pregnancy should be addressed with priority care(eclampsia, 3 ANC, anemia, 100 IFA, 100% institution delivery, low birth Wight baby, Brest feeding.PNC with in 48 hours.	NA	0
		11.6	Limited interventions for empowering adolescent girls	11.6.1	Family counseling for adolescent pregnancy tracking on above mention through ASHA and AWW.	NA	0
				11.6.2	State to develop and issue guidelines for implementation of Kishori MandalsFormation of Kishori Mandals by registration of all girls(11-18 yrs)	NA	0
	To improve adolescent			11.6.3	Prepare a monthly plan of activities for one day per week	NA	0

	reproductive and sexual health			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	170000
12	**To provide MTP services at health facilities**	12.1	MTP services are not available in Public sectors	12.1.1	Selection of facilities for provision of safe abortion services	NA	0
				12.1.2	Location of facility availability of trained service provider, space, equipments.	NA	0
				12.1.3	To Provide appropriate equipments at all facilities and MVA syringes.	50000/-per PHC	850000
				12.1.4	Putting the trained doctors at appropriate facilities to commence the services	NA	0
				12.1.5	Training of Medical officers and Para medical staffs on Safe abortion services training including awareness about legal aspects of MVA/ EVA and Medical abortion by IPAS .	One docter and one ANM from each PHC @ Rs 2000	34000

				12.1.6	Formation of district level committee (DLC) to accredit private sites as per GOI guide line .	NA	0
				12.1.7	Develop reporting system of MTP services in private and public secter.	NA	0
	To provide MTP services at health facilities			12.1.8	Through training program make the govt doctors skilled to perform MTP in the approved sites.	NA	0
				12.1.9	To Involve community to aware about location of services , process and legal aspects of MTP services through - AWW, ASHA & ANM, LRG and mass media.(IEC)	Rs 5000/-Per PHC	85000
				12.1.10	The services of Pregnancy testing should be strengthen and it should be linked with MTP services.	NA	0
				12.1.11	NGO's and local Practitioner should be involved for counseling and information of facility	NA	0
				12.1.12	Assurance of privacy and link with family welfare services counseling at all facility.	NA	0
				12.1.13	Linkage with MTP services with NGOs (PPP) those who are working in Safe abortion services. and create one modal center at district and PHC level.	NA	0

				12.1.14	Training of ASHA on medical abortion.	Incorparoted in ASHA training	0
13	**To strenghten Monthly Village Health and Nutrition Days**	13.1	Nutrition and Counseling Component is not visible in VHND and there is no monitoring of VHND activity by Community.	13.1.1	AWC should be develop Hub of activities (VHND)	NA	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	85000
				13.1.6	Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourish children , New 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 /strenghten APHC in Phase manner	1.3	Out of 30 APHCs only 16 are having own building	1.3.1	Registration of RKS	NA	0
		1.4	Existing 16 buildings are not properly maintained	1.4.1	Rennovation of APHCs buildings from RKS Fund	Rs 150000 per APHC	2400000
		1.5	Non payment of rent of 14 APHCs for more than three years	1.5.1	Payment Of Rent of APHC building	From state fund	0
		1.6	Lack of equipments,	1.6.1	Purchse 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 Docter. And support staff.	NA	0
		2.2		2.2.1	Notification from district for oprationaliing APHC	NA	0
3			**Drug Supply**				0
		3.1	No drug kit as such for the APHCs as per IPHS norms.,	3.1.1	Purchasing 23 listed OPD Drugs of PHC for APHC	Rs 200000/- Per PHC for OPD drugs for one year.	3400000

5	**RTI/STI services at health facilities**	5.1	No regular clinic at all PHCs & APHCs.	5.1.1	Trained service provider on syndrome management of RTI/STI (As per GOI guide line) up to APHC level.	Rs 1000/- for Two person from each PHC	34000
				5.1.2	Logistics of setting of clinics and free drugs availability	NA	0
				5.1.3	Integrated Counseling services in four public sector facilities by trained personnel .	NA	0
				5.1.4	IEC/BCC for awareness available RTI/STI services at all health facilities.	Rs20000 for Per PHC	340000
						Total	379725450

Family Planning

Logical Framework

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

Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
2	To increase female sterilisation from present 29.7%(DLHS3) to 50%	2.1	% increase in female sterilsation	2.1.1	Terminal/Limiting Methods	2.1.1.1	% of terminal/limiting methods
				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 standa 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 compens
				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 accred for IUD Insertion services.
3	To increase male sterilisationfrom 0.8%(DLHS 3) to 2%	3.1	% increase in male sterilisation	3.1.1	NSV camps	3.1.1.1	No of NSV Camps orgnised.
				3.1.2	Compensation for male sterilization	3.1.2.2	% of Male recived compensati
				3.1.3	Accreditation of private providers for sterilization services	3.1.3.3	No of Private providers accred for Sterilization services.
4	To increase use of condoms from 1.8% (DLHS3) to 5%	4.1	% increase in the use of condoms	4.1.1	Promotion to Social Marketing of condoms	4.1.1.1	No of Condoms distributed thro Social Marketing.
				4.1.2	Contraceptive Update seminars	4.1.1.2	No of Seminars Orgnised on Contraceptive Update.
5	To increase use of pills from present 0.6%(DLHS3) among current married women age 15-49 yrs to 5%	5.1	% increase in the use of pills	5.1.1	Promotion to Social Marketing of pills	5.1.1.1	No of Pills distributed through Social Marketing.

Sl.	Strategy		Gaps		Activities	Unit Cost	Total Budget
	Terminal/Limiting Methods		Lack of knowledge of small family norms.		Ensure one MO trained on on minilep and NSV up to PHC	Rs 20000	3
					Training of nurses and ANMs on IUD and other spacing methods at PHC level.	Rs 10000	1

					Ensure availability of contra septives (indenting , logistic	Rs 500000 per PHC	95
	Female Sterilization camps		Laparoscopy surgery not done.		Trained doctors on laparoscopy.	Above mentioned	
					Procure Laparoscopy equipments for trained docters	Rs 100000 per PHC	19
					Training of doctors needed.	Mentioned above	
	NSV camps		Trained doctors are not available.		Procurement of equipment.	Mentioned above	
	Compensation for female sterilization		Fund for Compensation for sterlization is not aviliable on time at facility.		Immediate disbursement of incentive after sterilization camps.	Rs1000 each for 25000 male and 5000 female operations	325
	Compensation for male sterilization				Logistic planning is needed before organizing camps.	NA	
					Block Health manager could be hire one support staff for disbursement for logistic support.	NA	

					Immediate disbursement of incentive after sterilization camps.	Discussed earlier	
					Logistic planning is needed before organizing camps.	NA	
					Block Health manager could be hire one support staff for disbursement for logistic support.	NA	
					Accreditation of private nursing home. As per GOB	NA	
	IUD camps		Camps not held		Training of ANM & staff nurse for IUD insertion.	Discussed earlier	
	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	15
					Equipments for IUD insertion	Discussed earlier	
					Accreditation of private providers for IUD insertion services. As per GOI guide lines.	NA	
	Social Marketing of contraceptives		Monitoring of Social Markiting is not monitored		Social marketing of need based OC & IUD.	NA	

			by PHC.		Increasing access to contraceptive through communities based distribution system free of cost.	NA	
	Contraceptive Update seminars		Not being held.		seminars for MO and other through Professional bodies (FOGSI. BMA, Nursing association etc..on	NA	
					Copper-t 380-A should be popularized.	NA	
					Awareness for emergency contraceptive.	NA	
					Total		460

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 birth of female babies (delivery registers)
				1.1.2	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routeen facilty where it is not functional.	1.1.2.1	No of cases supported by referral transport system under PPP.
						1.1.2.2	No of canteen facility functional at insttutional facility level.
						1.1.2.3	No of STD booth and other routine facility carried out under PPP.
						1.1.2.4	No of cases supported and payments made by RKS/ DHS to BPL families in availing these services
				1.1.3	To develop partnership with NGO Programmes in the districts	1.1.2.1	No of partnership with NGO for programme implementation for MCHN, Micronutrient supplimentation, national programme implementation specially Kalazar elimination

					Strengthen Logistics management system for regular supply of Drugs and equipments	1.1.2.2	No and % of drug & equipments available and supplied (stock ledger)
					Devlop a strong Monitoring & Evaluation / HMIS System in all PHC	1.1.2.3	Regular monitoring and evaluation reports
3	To devlop IEC and BCC and Training support system .	3.1	No of IEC materials developed and BCC event carried out	3.1.1	Establising BCC and training cell at District & BPHC level	3.1.1.1	Functional BCC cell at DHS/ RKS level
			No of training support system developed		Net working with folk media team	3.1.1.2	No of folk media team engaged in BCC activity. Type and No. of BCC event oragnised
4	To strengthen ASHA support System	4.1	No of ASHA capacities	4.1.1	Develop ASHA support System in all PHC(One persion per 20 ASHA)	4.1.1.1	Establishment of ASHA support system at DHS and RKS level
		4.2	No of actvities carried out by RKS	4.1.2	Strengthening RKS	4.1.1.2	No of RKS having monthly meetings.
						4.1.1.3	% of untied fund, JSY fund, referral transport etc utilised

Sl.	Strategy		Gaps		Activities	Unit Cost	Budget
1	To enforce PNDT Act and to increase sex ratio of female child	1.1	No registration of ultra sound clinic.	1.1.1	Registration and monitoring of ultrasound clinic.	NA	0

				1.1.2	MTP clinic should be watched for termination of pregnancy following USG.	NA	0
				1.1.3	IEC on PNDT act	Rs 5000 per PHC	95000
2	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routeen facilty where it is not functional.	2.1	Out sourcing of services is not as per the need of local Need and BPL families are not exampted from Fee of out source services	.2.1.1	District /PHC level managers should be aware about the TOR of PPP which is finalized at State level.	NA	0
				2.1.2	Build the capacity of manager to manage contracts of PPP	NA	0
		2.2	There is an acute shortage of para medics like radiographer, lab technician, ECG technician etc. in the state.	2.2.1	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

3	Devlop partnership with NGO Programmesin the districts	3.1	**Non involvement of NGO in F.P programme, Institutional delivery, Blindness control programme.**	3.1.1	listing of NGOs those who are working in F.P ,MTP,programme, Institutional delivery, Blindness control programme.	NA	0
				3.1.2	Accreditation of these facility from state Health Socity.	NA	0
		3.2	There is no any MOU with NGO/VO/individuals for Donation and volantory support in PHC	3.2.1	Process of MOU should be dicentrlization and it should oprationlise through RKS.	NA	0
		3.3	Strainthening of DMU NGOs Management aspects is one of the area of improvement	3.3.1	ASHA Programme manager facilitate the NGO management process in the district and ASHA Faclitatore will be manage at the PHC level	NA	0

				3.3.2	Honourarium to DPM, DPM(ASHA), DAM and DA	Rs 32000 pm for DPM, Rs 28000 pm for DPM(ASHA), Rs 26000 pm for DAM and Rs 22000pm for DA	1296000
				3.3.3	Capacity building training programme for NGOs office bearer with the help of professionals on linkage with health system strengthening component.	Rs 5000 per PHC	95000
				3.3.4	Mentoring Group at district level.	NA	0
				3.3.5	Reporting mechanism should be develop of NGOs work in the district.	NA	0
		3.4	There is no any VHSC in the district.	3.4.1	Co-ordination with community based orgnisation as SHG, LRG, VEC, ,PRI for VHSC formation.	NA	0

4	Capicity buiding of Managers and Doctors.			4.1.1	Expoure visit of DPM/BHM /ASHA DPM/ selected ASHA to other state where facility is comparatively working better.	Rs 100000 for the district	100000
				4.1.2	To start DNB (Family Physician) 3 year course in the district hospitals.	Rs 100000 for the district	100000
				4.1.3	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	190000
5	Prepration of decentrlised District Health Action Plan	5.1	First time five members of the districts were trained on DHAP prepration	5.1.1	Trainings of DPMU,BPMU members on implementation of services/ various National program and district Health action Plan through distance education	1 DPM, 19 Doctors(One from each PHC) , 12 BHMs and district planning team	80000

				5.1.2	Start prepration of plan from the month of October with sitution anlysis,Facility survey,line reporting system and qulitative finding from Community and users of facility.	Rs 50000 for the district	50000
6	Devlop a strong Monitoring & Evaluation / HMIS System in all PHC	6.1	Monitoring of all programme is one of the weakest link of all programme. Lack of Supervisers in all PHC Lack of skill of use of data Community is not aware about monitoring aspects of Health Programme.	6.1.2	Distribution of role and responsbility among MO and Managers of programme implementation.	NA	0
				6.1.2	Use Process indicator as monitoring of respective programme.	NA	0
				6.1.3	Devlop Programme review calander for review of HSC/PHC performance as per form 6 & 7	NA	0
				6.1.4	Gradation of Health Sub centers in three categories.	NA	0

				6.1.5	Information exchange visits among ANM acording to Grade.	NA	0
				6.1.6	Social recognition of Grade one ANM.	NA	0
				6.1.7	Devlop four potentioal VHSCs in all PHC on Community based Monitoring of Health and Nutrition programme.	Rs 2000 in each PHC	38000
				6.1.8	Organise"JAN ADALAT" in with PRI & VHSC and invite nearby VHSC to observe thr process of "JAN ADALAT"	NA	0
				6.1.9	Devlop Health and Nutrition Report Card by using growth monitoring charts of Village and prasent in "JAN ADALAT" By VHSC	Rs 2000 in each PHC	38000
7	Strenthen Logistics management system for regular supply of Drugs and equipments	7.1	There is no system of logistic management of Drugs and other supply at any level. Only vaccine supply management is	7.1.1	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	NA	0

			comarativaly stroger then other logistic work.		reports		
				7.1.2	Hiring vehicles for supply of drug kits	Rs 20000 per PHC per month	4560000
				7.1.3	Hiring of couriers as per need	Discussed in maternal health	0
				7.1.4	Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)	Discussed in maternal health	0
				7.1.5	Training of all ANM and Stock keepers on Indenting and Logistic Management.	Rs 5000 per PHC	95000
				7.1.6	Devlop TMC modal for Logistic Management in the state.	NA	0

8	Establising BCC and training cell at District & BPHC level	8.1	There is not as such disignated post for BCC and Traning at the district and PHC level	8.1.1	ASHA Programme manager facilitate the process of traning and BCC in the district and ASHA Faclitatore will be manage at the PHC level	NA	0
				8.1.2	Devlop resoure team at District Level.	NA	0
				8.1.3	MOU with Local NGOs for logistic management of training and Devlop issues wise Master traners in district	Na	0
				8.1.4	Devlop ASHA support system on one person/20 ASHA for on the job training of AHSA and AWW	NA	0
9	Net working with folk media team	9.1	There is no BCC management unit at Distrct Level	9.1.1	Identify Health Communication orgnisation for identification of BCC issues as per need of District.	Discussed in child health	0
				9.1.2	MOU with orgnisation for formative reaserch .	NA	0

				9.1.3	Devlop IEC/BCC material based on Findings of formative reasrch	Discussed in child health	0
				9.1.4	Printing of IEC and BCC material	Discussed in child health	0
				9.1.5	Training of Folk Media group on IEC/BCC material	Discussed in maternal health	0
				9.1.6	Planning of performance route chart of Folk media Group	NA	0
				9.1.7	Monitoring of performance through SMS of PRI members	NA	0
				9.1.8	Impact analysis of Performance by Orgnisation	NA	0
10	Straenthening RKS	10.1	RKS are not uniformally fungtioning in the district	10.1.1	Ensure ragistration of RKS of all fungctional APHC	NA	0
				10.1.2	Training of RKS signatory and BHM on finincial Management of RKS	Discussed in maternal health	0
				10.1.3	presentation of case study of fungctional RKS in district level Meeting.	NA	0

11	Strengthening community process through supportive supervision of ASHA program	11.1	Poor monitorinng mechanism of ASHA program	11.1.1	Appointment of PHC level ASHA facilitator	Rs 12000 per Facilitator per month for 17 facilitator	2736000
				11.1.2	Provide training cum supervisory support @ one supervisor for 20 ASHA	Rs 250 per supervisor for 140 supervisors for maximum 15 days in a month	6300000
				11.1.3	Training of DPM (ASHA) , Facilitator and supervisors at block level.	Rs 250 per participant for three days for 180 participants.	135000
						Total	15908000

Blindness

Gaps	**issues**	**Strategy**

Lack of adequate eye surgeon and staffs in the district.Only 4 eye surgeons are posted in the district out ofwhich oneisodeputation to the other district.	Staff shortage	Recruitment
Only ….Opthalmic Assistants are posted in the district,however the requirement is ….		
Most of the doctors and staffs are not trained enough on new IOL tehniques	Untrained staffs	Capacity building

In the Year2008-09 only 66 Cataract operationshave been done by the Govt facilities and 1763 bythe private facilities(till Nov 08).In the year 2007-07,altogether 1945 surgeries were performedout of 3000 and in the year 2007-08 2966 surgeries have been performed.	Low achievement	Increasing noof cam
		PPP
Lackof awareness among community regarding cataract blindness and its treatability.	Lackof awareness	Awareness building
Fear of eye operation.		

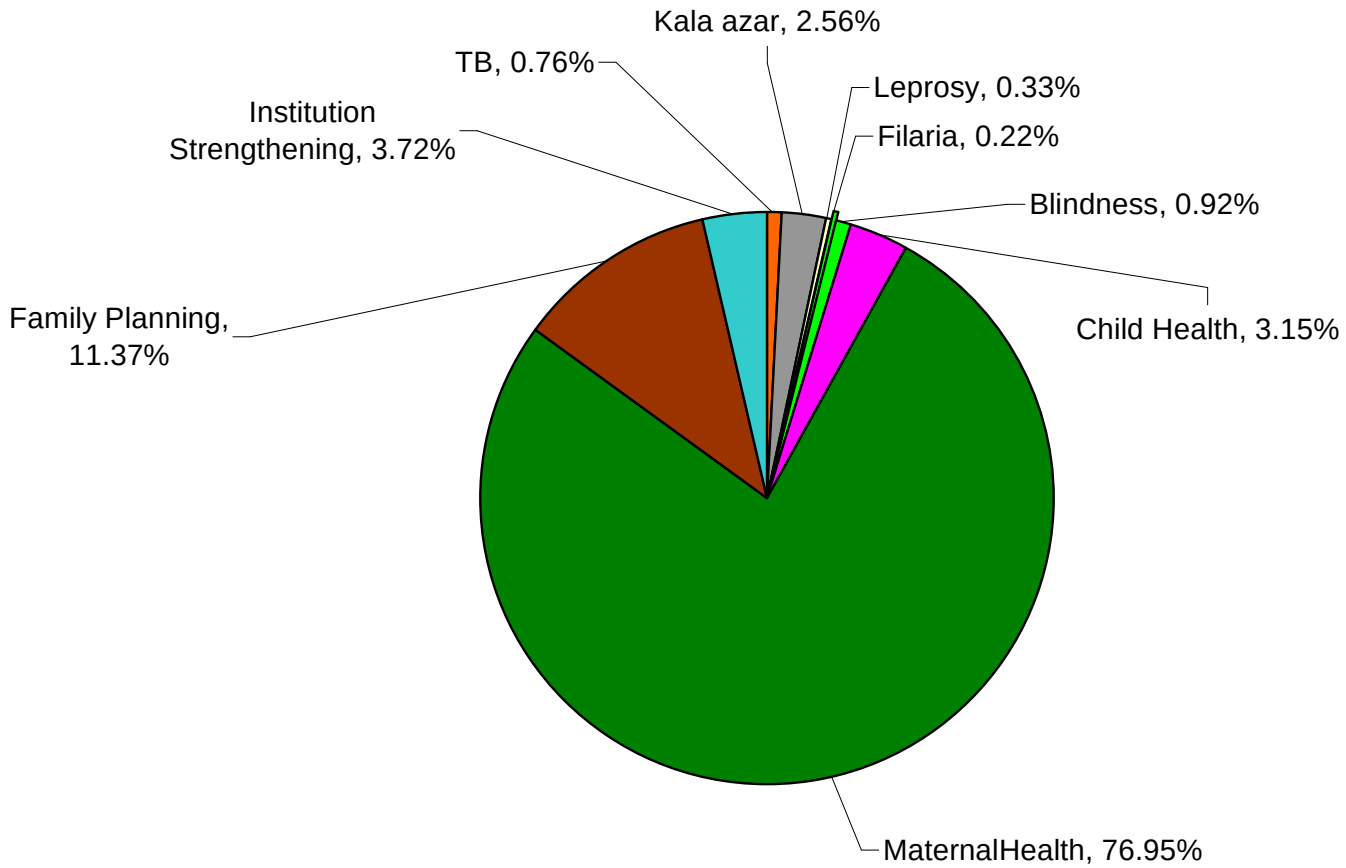
Lack of Education among the masses about the existing facilities: Need of wide publicity.		
Poor coordination between the health functionaries and the voluntary organisations resulting in less cataract surgeries.		InvolvingNGOs
Lack of adequate referral services to take care of complications.	Lackof adequate referal services	Strengthening r system
Lackof monitoring and follow up	Monitoring and follow up	Monitoring and follow u

Leprosy

Gaps	issues	Strategy	Acti
· 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 o
• Inadequate staff, Only 6 supervisors and 11 Non Medical Assistants are working while the requirement of Supervisor is 17 and that of NMA is 33(One NMAeach in each APHC)	Lack of Human Resource	Staff Recruitment in contract basis	Recru

• There is no active involvement of the Medical officers at sector and Block levels.		Strengthen Health Care Services	Orien
• Lack of PHC staff involvement. No manpower support,			Case
			Prom disab
			Ulcer staff.
No lab testing facility in the district	Infrastructure Gap	Establishing Lab	Estab

			Recu
Lack of monitoring at all level	Monitoring Gap	Increasing mobility	Upda
			Mobi
			Offic
			Tota



BudgetShare in the DHAP ofVhaisali 2009-10