District Health Action Plan

2012-2013

District Health Society

Rohtas (Sasaram)

Foreword

National Rural Health Mission (NRHM) was introduced to undertake architectural corrections in the public Health System of India. District Health Action Plan (DHAP) is an integral aspect of National Rural Health Mission. District Health Action Plan are critical for achieving decentralization, interdepartmental convergence, capacity building of health system and most importantly facilitating people's participation in the health system's programmes. District Health Action Planning provides opportunity and space to creatively design and utilize various NRHM initiatives such as flexi – financing, Rogi Kalyan Samiti, Village Health and Sanitation Committee to achieve our goals in the socio-cultural context of Rohtas.

The **National Rural Health Mission** (NRHM) is a comprehensive health programme launched by Government of India to bring about architectural corrections in the health care delivery systems of India. The NRHM seeks to address existing gaps in the national public health system by introducing innovation, community orientation and decentralization. The mission aims to provide quality health care services to all sections of society, especially for deprived people or those residing in rural areas, women and children, by increasing the resources available for the public health system, optimizing and synergizing human resources, reducing regional imbalances in the health infrastructure, decentralisation and district level management of the health programmes and community participation as well as ownership of the health initiatives. The mission in its approach links various determinants such as nutrition, water and sanitation to improve health outcomes of rural India.

The NRHM regards district level health planning as a significant step towards achieving a decentralised, pro-poor and efficient public health system. District level health planning and management facilitate improvement of health systems by 1) Addressing the local needs and specificities 2) Enabling decentralisation and public participation and 3) Facilitating interdepartmental convergence at the district level. Rather than funds being allocated to the States for implementation of the programmes developed at the central government level, NRHM advises states to prepare their perspective and annual plans based on the district health plans developed by each district.

The concept of DHAP recognises the wide variety and diversity of health needs and interventions across the districts. Thus it internalises structural and social diversities such as degree of urbanisation, endemic diseases, cropping patterns, seasonal migration trends, and the presence of private health sector in the planning and management of public health systems. One area requiring major reforms is the coordinate departments and vertical programmes affecting determinants of health. DHAP seeks to achieve pooling of financial and human resources allotted through various central and state programmes by bringing in a convergent and comprehensive action plan at the district level.

It is our pleasure to present the Rohtas District Health Action Plan for the financial year 2012-13. The District Health Action Plan (including the Block Health Action Plan) seeks to set goals and objective for the District Health system and delineate implementing processes in the present context of gaps and opportunities for the Rohtas district health team.

I am very glad to share that Civil Surgeon/ACMO/Dy. Superintendent /MOICs and all BHMs/BCMs/Block Accountants of the district along with key district level functionaries ***(DPMU –DPM Mr. Amit kumar, DAM- Sunil KumarJaiswal & M & E Officer Rituraj, DPC Sanjeev Kumar 'Madhukar' Dy. Child Health Manager Mr. AQUIL AHMAD & District Epidemiologist Dr. Priya Mohan Sahay, District Health Society, Rohtas)*** for putting his sheer handwork with dedication to complete the Action Plan on time. participated in the planning process. The plan is a result of collective knowledge and insights of each of the District Health System Functionary. We are sure that the plan will set a definite direction and give us an impetus to embark on our mission.

Sd-

Anupam Kumar (IAS)
District Magistrate cum Chairman
District Health Society, Rohtas.

ACKNOLEDGEMENT

The commitment to bridge the gaps in the public health care delivery system, has led to the formulation of District Health Action Plan. The collaboration of different departments that are directly or indirectly related to determinants of health, hygiene and Water sanitation, will lead to betterment of health care delivery, and to make this collaboration possible actions are to be outlined in the District Health Action Plan. Thus this assignment is a shared effort between the departments of Health and Family Welfare, ICDS, PRI, Water and Sanitation, Education to draw up a concerted plan of action.

The development of a District Action Plan for Rohtas district of Bihar entailed a series of Consultative Meetings with stakeholders at various levels, collection of secondary data from various departments, analysis of the data and presentation of the existing scenario at a District-level workshop. The District level Workshop was organized to identify district specific strategies based on which the District Action Plan has been prepared by the District & Block Program Management Unit.

We would also like to acknowledge the much needed cooperation extended by the District Magistrate cum Chairman ,and Deputy Development Commissioner cum Vice Chairman ,District Health Society, Rohtas without whose support the conduct of the district level workshop would not have been possible. Our thanks are due to All the Program officers and Medical officers of the district for their assistance and full support from the inception of the project. The involvement of the all the Medical officers played a pivotal role throughout the exercise enabling a smooth conduct of consultations at block and district levels.

The present acknowledgement would be incomplete without mentioning the participation of representatives UNOPS-NIPI, UNICEF , DFID and officials from department of Integrated Child Development Services (ICDS), Panchayati Raj Institutions(PRIs), Education ,Water and Sanitation, who actively participated in consultations with great enthusiasm. Without their inputs it would not have been possible to formulate the strategic health action plan for the district. The formulation of this plan being a participatory process, with inputs from the bottom up, the participation of community members at village level proved very helpful. These consultations at grassroots level supplemented the deliberations at block and district levels, adding value to the planning process.

Finally, we would like to appreciate the efforts and supports of all those including NHSRC & PHRN Bihar, Team who were associated with the team for complishment of this task and brought the effort to be fruitful.

Sd.

Dr. Shivanand Sinha
Civil Surgeon -cum- Member Secretary
District Health Society, Rohtas.

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1.1 Background

1. INTRODUCTION

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 compiled to perform a situational analysis.

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

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

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

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

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

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

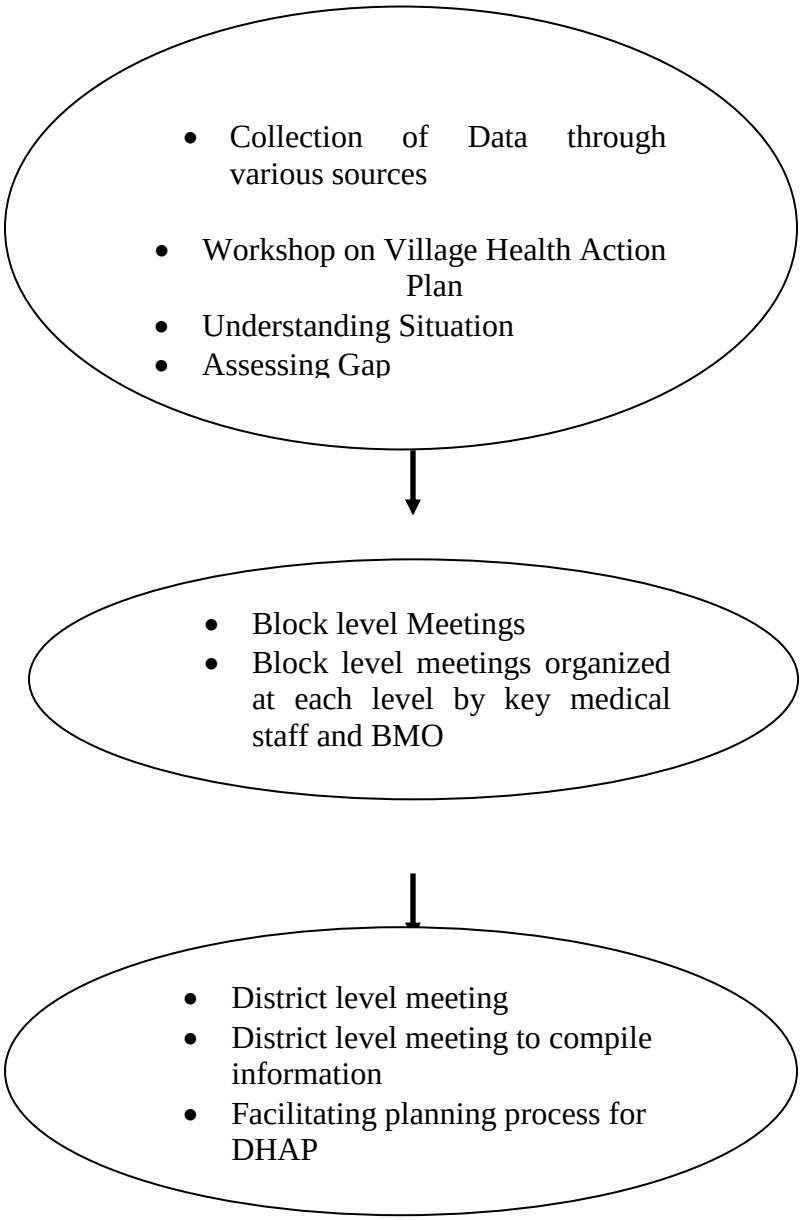
This Integrated Health Plan document of Rohtas district has been prepared on the said context.

2. DISTRICT PLANNING PROCESS

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



3. 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

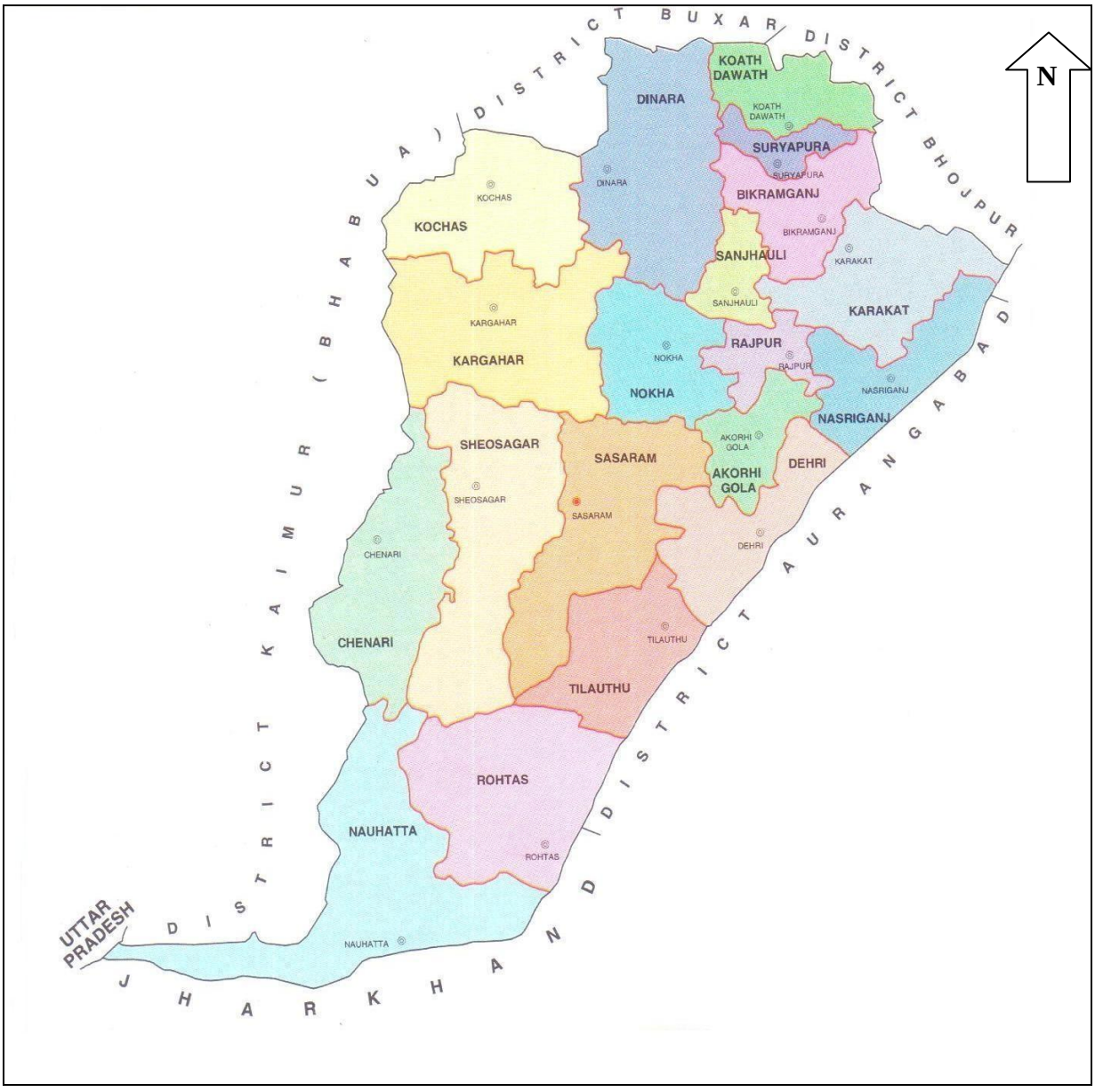
The District is located at **24-30" to 25-20"** North Latitude and **83-14" to 83-20" East L**ongitude with total Area of **3847.82 Sq.Kms.** The District is surrounded by Bhojpur & Buxar Districts in North, Plamu & Garwah District of Jharkhnad in south, Kaimur District in west and Aurangabad & Part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

Govt's Administrative Set-up

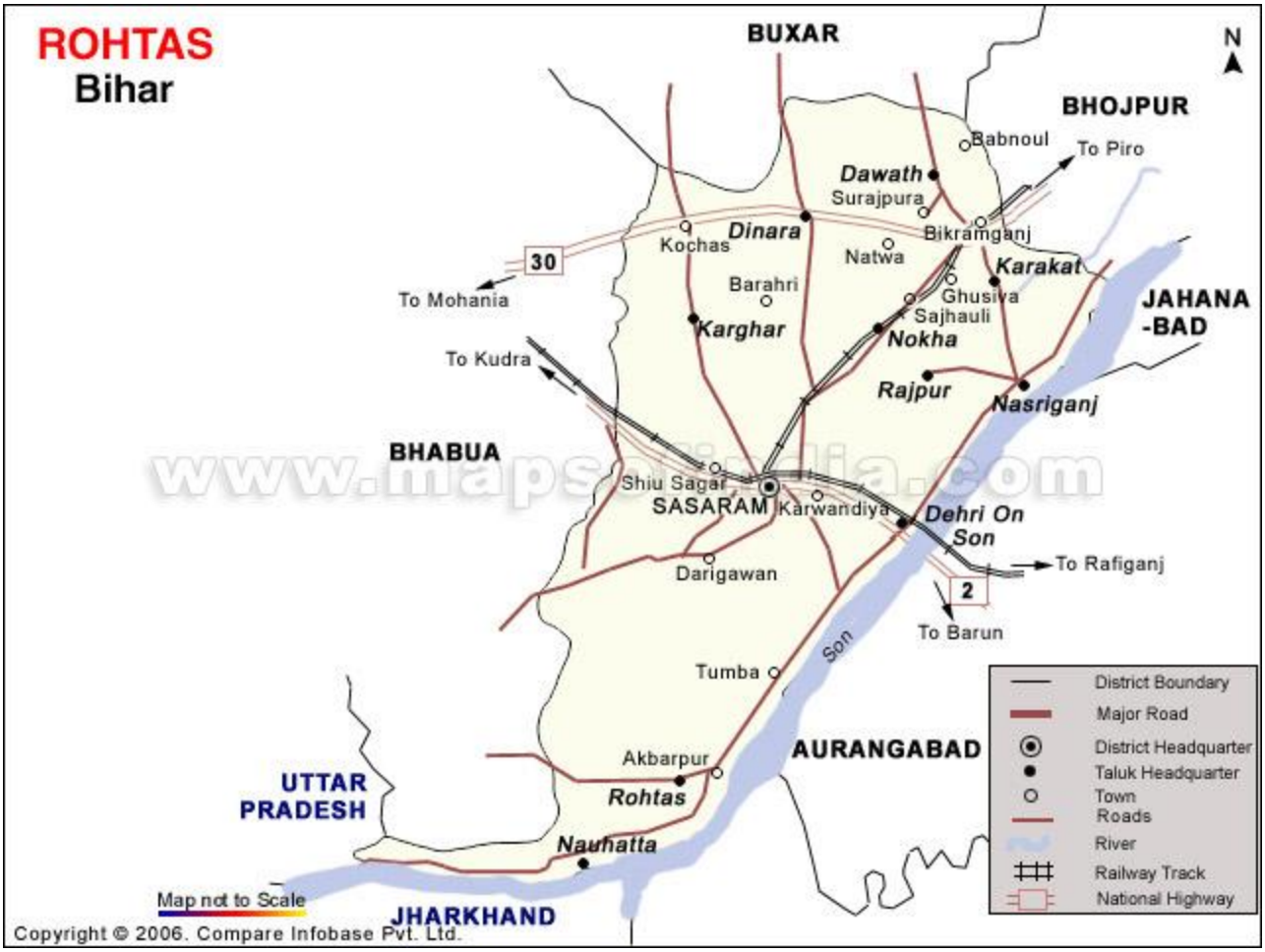
There are three 03 divisions and 19 Blocks in the District. The District has 2103 villages and 246 Gram panchayats. District is divided into 19 C.D. Blocks. The newly elected Panchayati Raj is enthusiastic to play important role in the District.


BIHAR
Pashchim Champaran
Purba Champaran
Sitamarhi
Sheohar
Gopalganj
Madhubani
Supaul
Araria
Kishan ganj
Siwan
Muzaffarpur
Darbhanga
Saran
Vaishali
Samastipur
Saharsa
Madhepura
Purnia
Buxar
Bhojpur
Patna
Begusarai
Khagaria
Katihar
Rohtas
Jehanabad
Nalanda
Lakhisarai
Bhagalpur
Sheikhpura
Munger
Kaimur (Bhabua)
Nawada
Jamui
Gaya
Banka
Aurangab
Rohtas

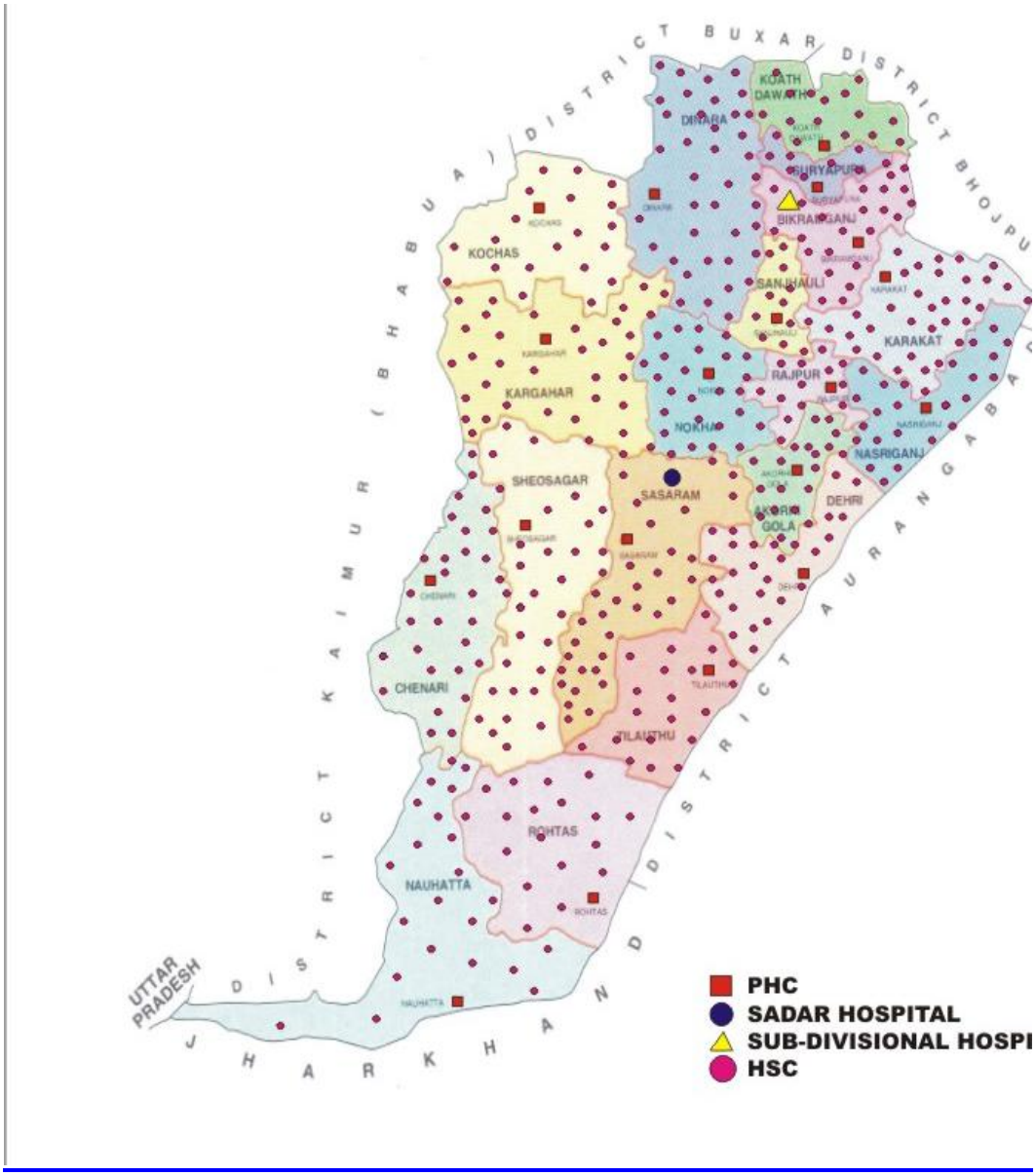
District Map of Rohtas



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	3287240
2	**Population (Census 2011)**	Total	2962593	103804637	1210193472
		Male	1547856	43153964	531277078
		Female	1414737	39724832	495738169
2.1	Rural Population	Total	2535085	64531000	742490639
		Male	1322509	-	-
		Female	1212576	-	-
2.2	Urban population	Total	427508	18347796	286119689
		Male	225347	-	-
		Female	202161	-	-
2.3	Population Of Scheduled Castes			13048608	166635700
2.4	Population Of Scheduled Tribes			758351	84326240
2.4	Population Growth(%)		20.22	25.07	17.64
2.5	Density of Population		763	1102	382
2.6	Sex Ratio		917	916	940
	Literacy %		74.74	63.82	74.04
		Male	85.01	60.32	82.14
		Female	63.50	33.57	65.46

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 & D)	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+61
7	Blood bank	02
8	Aids control society	NA
9	Doctors	122
10	ANM	495(267 Contractual)
11	Grade A Nurse	28(20 Contractual)
12	Block Extension Educator	03
13	Pharmacist	04
14	Lab Technician	14
15	Health Educator	27
16	L.H.V	05

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

SI.No	Name of Block / PHC	Name of APHC	SI.NO	Name of HSC	REMARKS
1	Akorhigola	Bhimkarup	1	Tetrah	
		Tetradh	2	Gowardhanpur	
			3	Bank	
			4	Baligawan	
			5	Karkatpur	
			6	Pakadiya	New
			7	Madhurampur	New
			8	Baradih	New
			9	Kapasiya	New
2	Bikramganj		10	Shivpur	
			11	Kastar	
			12	Baluahi	
			13	Jamhouri	
			14	Nonhar	
			15	Matuli	
			16	Salempur	
			17	Kusumhara	
			18	Mani	
			19	Maidhara	
			20	Ghusi Kala	
3	Chenari	Telari	21	Bharkura	
			22	Bilsi Bilashpur	
			23	Sadokhar	
			24	Diheen	
			25	Telari	
			26	Chandra Kaithi(Narayan)	
			27	Bairiya	
			28	Khurmabad	
			29	Malhipur	
			30	Ugahani	
4	Dawath	Kowath	31	Derdhagaon	
		Khairihi	32	Awardhi	
			33	Chatara	
			34	Semri	
			35	Babhanaul	
			36	Dawath	
			37	Parasiyan Kalan	New

			38	Itawan	New
			39	Chittani	New
			40	Sahpur	New
5	Dehri	Deowaria	41	Chilbila	
		Darihat	42	Pahleja	
		Baraon Kala	43	Jamuhar	
			44	Pitambarpur	
			45	Berkap	
			46	Sujanpur	
6	Dinara	Bhanus	47	East Bhelari	
		Koeria	48	Basdiha	
		Natwar	49	Bakara	
		Arila Raghunathpur	50	Vishambharpur	
			51	Tenuath Mathia	
			52	Ganjbharasara	
			53	Koirea	
			54	Bhanpur	
			55	Mukundpur	New
			56	Manihari	New
			57	Karhansi	New
			58	Ankorha	
			59	Bairipur	
			60	Bisikala	
			61	Lilawachha	
			62	Medinipur	
			63	Ahrawo	
			64	Jamrodh	
7	Karakat	Koupa	65	Kurur	
		Gharwasdih	66	Mohanpur	
		Etarhiya	67	Gamharia	
		Chamardihari	68	Munji	
		Gorari	69	Etarhiya	
		Danwar	70	Chougain	
		Chiksil	71	Osawan	
			72	Belwai	
			73	Sakla	
			74	Ammouna	
			75	Amaritha	
			76	Bensagar	
			77	Padsar	
			78	Dhawani	

			79	Motha	New
			80	Karup	New
8	Kargahar	Barhari	81	Sonwarsa	
		Lahuara	82	Babhani Pahari	
			83	Samahutta	
			84	Laduai	
			85	Bhokhari	
			86	Mahuli	
			87	Gori	
			88	Torni Baheri	
			89	Mohania	
			90	Saharmedani	
			91	Araruwa	
			92	Panjar	
			93	Barka Deo Khaira	
			94	Thorsan	
			95	Akorhi	
			96	Bilari	
			97	Kusahi	
			98	Tenduni	
			99	Kharahana	
			100	Badahari	
9	Kochas	Parshathuwa	101	Derhaon	
			102	Doiyan	
			103	Indour	
			104	Shekh Bahauara	
			105	Narwar	
			106	Katiyara	
			107	Parasiyan	
			108	Balthari	
			109	Goura	
			110	Kapasiya	
			111	Laheri	
			112	Nauwa	New
10	Nauhatta		113	Daranagar	
			114	Bhadara	
			115	Rehal	
			116	Sholi	
			117	Shahpur	
			118	Matiaon	
			119	Tiyara Kalan	
			120	Nimhat	

			121	Tilokhar	
			122	Uli Banahi	New
			123	Jaintipur	New
11	Nasriganj	Jinamanauli	124	Mednipur	
		Sukahara Dehri	125	Khutahan	
		Paiga	126	Kachhawan	
			127	Piparadih	
			128	Mahadewa	
			129	Etimha	
			130	Paduri	
			131	Parasiyan	
			132	Dhawani Pawani	
			133	Khiriaon	
12	Nokha	Baraon	134	Meyari Bazar	
			135	Gamhariya	
			136	Badyoga	
			137	Bhawarah	
			138	Barawon	
			139	Pach Pokhari	
			140	Penar	
			141	Dharampura	
			142	Jainagara	
			143	Sisrit	
			144	Dharopur	New
			145	Jabra	New
			146	Satwa	New
13	Rohtas	Chaknahawa	147	Karma	
			148	Rashulpur	
			149	Baknaura	
			150	Kouriari	
			151	Majhigaoan	
			152	Nagatoli	
			153	Budhua	
			154	Milki	
14	Rajpur	Barnadehri	155	Tarawn	
			156	Ghordihin	
			157	Rajpur	
			158	Kushadhar	
			159	Siyawak	
			160	Malaon	
15	Sasaram	Darigaon	161	Sikaria	
		Akasi	162	Akasi	

			163	Uchitpur	
			164	Bisrampur	
			165	Gharbair	
			166	Beda	
			167	Kanchanpur	
			168	Samardiha	
			169	Dhaw Darh	
			170	Gotpa	
			171	Aqrer	
			172	Nahouna	
			173	Jaipur	
			174	Muradabad	
			175	Dhanpurwa(Diliyan)	
			176	Karwandia	
			177	Gobina	
			178	Baradih	New
			179	Nekra	New
			180	Amri	New
			181	Amra	New
			182	Mahdiganj	New
			183	Mokar	New
			184	Karpurwa	New
			185	Admapur	New
			186	Dhankadha	New
			187	Lerua	New
			188	Gansadih	New
			189	Chaukhanda Chitauli	New
16	Sheosgaar	Silari	190	Khadihan	
			191	Sikroul	
			192	Silari	
			193	Nad	
			194	Bhagwalia	
			195	Sonhar	
			196	Bishrampur	
			197	Berukahi	
			198	Alampur	
			199	Ulho	
			200	Ankorha	
			201	Raipur Chour	
			202	Torani	
			203	Padari	

			204	Bahuara	
17	Suryapura	Kosandha	205	Gosaldih	
			206	Kosanda Khurd	
			207	Sheobahar	
			208	Imiritha	
			209	Surhuriya	
			210	Agrer Khurd	
18	Sanjauli		211	Sanjhuli	
			212	Udaypur	
19	Tilouthu		213	Saraiyan	
			214	Ramdihara	
			215	Hurka	
			216	Chandanpura	
			217	Pataluka	

4 . SWOT ANALYSI of PART A, B, And C

SWOT Analysis of Part A

Strength

- Decentralized Planning and availability of Resources and Fund for program till HSC level.
- Huge pool of Human Resource working at ground level as ANM, Asha and Anganwadi workers.
- Provision of incentive money for Asha, ANM according to their performance in mobilizing community for institutional delivery ,FP etc.
- Provision of Incentive money for beneficiary under JBSY, Family Planning.
- Extension of emergency facilities in remote rural areas and posting of skilled doctors.
- Regular training program of doctors and other medical staffs for skill up gradation.
- Strong provision of IEC and BCC activity under the programs for effective program implementation and sensitizing people.
- Decentralized implementation process of the entire program.
- Involvement of people in uplifting health facilities through RKS andVHSC.

Weakness

- All PHCs are with only six bedded facility.50-60% of facilities are not adequate as per IPHS norms for providing emergency care.
- Lack of doctors and other human resource in the remote areas medical facilities
- Achievements in most of the program are far less than target.
- Slow pace of most of training like SBA and IMNCI.

- Monthly VHND is not operational as yet.
- Institutional deliveriy is still less than 50% in the district.
- No NRC has been made operational in the district.
- Seat for contractual medical officer and specialist, ANM and Asha are still vacant.
- Achievements in Family Planning and IUD insertation are far less than targets.
- Insensitivity of Doctors and other health staffs for patients.
- Unavailability of doctors and staffs in hospital at the time of duty.

No timely procurement of equipments and drug in the remote health facilities.

Opportunity

- All the time support from state health society for all financial and logistics requirements for program implementation
- Scope for involving Private partner like Surya clinic for timely achievement of targets.
- Scope of getting full support from people through their participation in RKS and VHSC.
- Favourable political and administrative environment for program implementation
- Increasing literacy and awareness among public to support Family planning and institutional deliveries.

Better coordination and support from other line departments like ICDS, Municipality etc

Threat

- Large scale poverty becomes the cause of nutritional deficiency leading to health problems.

- In case of remaining without practice for long time health staff training become useless.
- Extending services in remote rural areas is still a challenge in achieving targets of MCH and FP, RI.

Traditional and religious attitude of public is hindrance for increasing Institutional deliveries, Family planning etc.

SWOT Analysis of Part B

Strength

- Asha support system with DDA and BCM has been made functional in the district.
- Motivational program for Asha like Umbrella distribution is completed in time.
- Formation of VHSC has been completed in most villages of the district.
- Deployment of BHM and Hospital Managers is complete at all the vacant places in the district.
- Services of advanced life saving ambulance (108) is started in the district
- Contractual AYUS H doctors have been placed in APHC.

Decentralized planning at HSC level has been started from this year in the district

Weakness

- Asha Selection is not 100% complete
- RKS is not function in some APHC.
- Utilization of untied fund in most of the health centers is very less.
- Repleshment of Asha kit and drugs is not timely and complete.
- Construction of HSC, APHC, PHC buildings and staff quarters moving with very slow pace.
- ISO certification process of health facilities is still to start in the district.
- Pathology and Radiology services under PPP initiatives are not properly functional at most of the health facilities.

Lack of orientation among members of RKS regarding their scope of works for Health facilities.

Opportunity

- Participation of Mukhiyas and Surpanch in Asha selection process to expedite the process and also proper and complete utilization of Untied fund for health facility development.
- Favourable administrative and political condition for program implementation.
- Availability of fund from both NRHM and State funding for development of health infrastructure.

Threat

- Corruption and ill intention in construction of buildings and selection process of employees.
- Lack of people interest and support for proper maintenance of health infrastructure and quality of services.
- Less knowledge and sensitivity for work among Asha and other contractual employees.
- Not immediately filling vacant positions Specialist Doctors of.

SWOT Analysis of Part C- Routine Immunization

Strength

- Properly and timely formation of block micro-plan of RI.
- Availability and involvement of large human work force in form of ANM and Asha.
- Functioning of one separate dept. in health sector to look after RI.
- Timely availability of vaccines.

Abundance of fund for all kind of review meeting and supervion og the program.

Weakness

- Low achievement against the fixed targets.
- Poor cold chain maintenance.
- Handling of cold chain-deep freezers by untrained persons.
- Poor public mobilization by ANM and Asha.
- Poor or false reporting data from block and sub centers.
- Quarterly review meeting at district and blocks are not happening regularly.

Unavailability or non use of RI logistics like red/black bag, twin bucket etc

Opportunity

- Support from UNOPS-NIPI, UNICEF, WHO and other development agencies in RI.
- Proper coordination and support from Anganwadi –ICDS dept.
- Growing awareness among people regarding immunization.

Threat

- Sudden outbreak of epidemic.
- Corruption in program implementation.

5. MATERNAL HEALTH

Objective

- 100% pregnant women to be given two doses of TT
- 100% pregnant women to consume 100 IFA tablets by 2013
- 75% Institutional deliveries by 2013
- 90% deliveries by trained /Skilled Birth Attendant
- 50% pregnant women receiving postnatal are within 48hrs of delivery

Strategies

- Case management of pregnant women to ensure that they receive all relevant services by ASHAs and ANMs
- Providing ANC along with immunisation services on immunisation days (**VHSND-**Village Health Sanitation and Nutrition Day observation fortnightly at all AWCs will help giving manifold services at one point as well as strengthen our health system).
- Effective monitoring and support to HSCs for ANC by APHC.
- Strengthening ANC services at the Sub centre level and at all AWCs by ensuring availability of appropriate infrastructure, equipment and supplies, particularly carrying Hub cutters, Needle cutter, and Blood Pressure Machines by all ANMs
- Provision of quality Antenatal and Postpartum Care to pregnant Women
- Increase in Institutional deliveries

- Quality services and free medicines to all the deliveries in the health facilities.
- Availability of safe abortion services at all CHCs and PHCs
- Increased coverage under Janani Bal Suraksha Yojna
- Strengthening the Maternal, Child Health and Nutrition (MCHN) days
- Improved behaviour practices in the community
- Referral Transport
- Organizing RCH Camps.

Activities

- Ensuring availability of fully functional and equipped labour rooms, maternal wards, ambulance services and blood storage facilities.
- Training of ASHAs for counselling of eligible couples for early registration and the use of the home based pregnancy kit.
- Regular updating of the ANC register.
- Preparation of the due list with the dates for Ante Natal Checkups for every pregnant woman in the Sub centre area.
- Ensure delivery of ANC services through strengthening of health sub-centres,APHCs and PHCs.
- Form inter-sect oral collaboration to increase awareness, reach and utilization of ANC services
- Promote institutional delivery through reinforced network of APHCs, PHCs/Referral Hospitals, Sub-divisional Hospitals and District Hospitals.
- Promote institutional delivery by involving private sector/NGO providers of EmOC.
- Ensure safe delivery at home.
- Revamp existing referral system for emergency deliveries.

- Form inter-sectoral collaboration to increase awareness regarding safe delivery and referral.
- Identification of all pregnancies through house-to-house visits by ANMs, AWWs and ASHAs.
- Provision of weighting machines to all Sub centres and AWCs.
- Availability of IFA tablets.
- Training of personnel for Safe motherhood and Emergency Obstetric Care.
- Developing the CHCs and PHCs for quality services and IPHS standards.
- Availability of Blood Bank at the District Hospital.
- Certification of the Blood Storage Centres.
- Improving the services at the Sub centres.
- Development of a proper referral system with referral cards and Arrangement of referral facilities to the complicated deliveries at all PHCs.

6. CHILD HEALTH

Objectives

- Ensuring that children of (0-6 months old) are exclusively breastfed.
- Increase in percentage of children (12-23 months) fully immunized (BCG, 3 doses of DPT, Polio and Measles)
- Ensuring initiation of complementary feeding at 6 months of children.
- Increasing the percentage of children with diarrhea who received ORS.
- Increasing the percentage of children with ARI/fever who received treatment from.
- Ensuring monthly health checkups of all children (0-6 months) at AWC.
- Ensuring that all severely malnourished children are admitted, receive medical attention, and are nutritionally rehabilitated.
- Reduction in IMR
- Ensuring in the Treatment of 100% cases of Pneumonia in children
- To strengthen school health services

Strategies

- Promote immediate and exclusive breastfeeding and complementary feeding for children.
- Improving feeding practices for the infants and children including breast feeding.
- Counseling mothers and families to provide exclusive breastfeeding in the first 6 months.

- Convergence with WDC Department for implementation of Rajiv Gandhi Creche Scheme at MNREGA worksites to enable exclusive breastfeeding and child care by women workers.
- Increase timely and quality immunisation service and provision of micronutrients for children in the age group of 0-12 months.
- Eradication of Poliomyelitis.
- Increase early detection and care services for sick neonates in select. Districts through the IMNCI strategy in select districts.

Activities

- Meeting with WDC officials to review the status of implementation of the Rajiv Gandhi Creche scheme.
- Training by Health Department of crèche workers on nutrition and child care.
- Organizing health checkups at AWC for children in the 0-6 year age group on the 2nd Monday of every month.
- Referral of severely malnourished sick children to Nutrition Rehabilitation Centre (NRCs)
- Use mass media (particularly radio) to promote breastfeeding immediately after delivery.
- Birth (colostrums feeding) and exclusively till 6 months of age.
- Increase community awareness about correct breastfeeding practices through
- Build capacity of immunization service providers to ensure quality of immunization services.
- Form inter-sect oral collaboration to increase awareness, reach and utilization of immunization services.
- Strengthen Supervision and monitoring of immunization services.

7. Family Planning Population Stabilization

Objectives

- Fulfilling unmet need for family planning services at the community level
- Increasing the use of any modern method of family planning from 35% to 50%
- Increasing male sterilization rates from 0.5% to 2%
- Increasing the utilization of condoms as the preferred choice of contraception from 2.7% to 8%.
- Reduction in Total fertility Rate from 2.5 to 2.4 Increase in Contraceptive Prevalence Rate to 70 %
- Decrease in the Unmet need for modern Family Planning methods to 0%

Increase in the awareness levels of Emergency Contraception from 60% to 80%

Strategies

- IEC/BCC at community level with the help of ASHAs, AWW.
- Addressing complications and failures of family planning operations.
- Training male peer educators to increase awareness amongst men about the importance of contraception and the ease of spacing methods.
- ASHAs to have a stock of contraceptives for distribution.
- Training of MOs in NSV & Female Sterilization.
- Raise awareness and demand for Family Planning services among women, men and adolescents.
- Availability of all methods and equipments at all places.

- Increase access to and utilization of Family Planning services (spacing and terminal methods)
- Increasing access to terminal methods of Family Planning.
- Increased awareness for Emergency Contraception and 10 yr Copper T
- Decreasing the Unmet Need for Family Planning.
- Expanding the range of Providers.

Activities

- Selecting and training male peer educators (1 for every 500 persons) in 5 blocks to counsel men for the adoption of spacing methods.
- Interpersonal counseling of eligible couples on family planning choices by ASHAs and male peer educators.
- Family planning day at all health facilities every month.
- ANM and ASHA to report complications and failure cases at community to facility.
- Quick facility level action to address complications and failures.
- Extensive campaign using multiple channels to raise awareness and demand for Family Planning.
- Broad inter-sect oral collaboration to promote small family norm, late marriage and childbearing.
- Promotion of Family Planning Services at community level through peer educators.
- Each APHC and PHC will have one MO trained in any sterilization method 6. Increase availability of contraceptives through Social Marketing and community-based distribution of contraceptives.
- Increase utilization of Family Planning services through provision of incentives to acceptors and private providers FP services

8. Adolescent Reproductive and Sexual Health

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Objectives

- Improve sex ratio 917 -> 922
- Increase the knowledge levels of Adolescents on RH and HIV/AIDS
- Enhance the access of RH services to all the Adolescents.
- Improvement in the levels of Anemia.

Strategies

- Raise awareness and knowledge among adolescents about Reproductive Health and Family Planning services with emphasis on late marriage and childbearing.
- Improve micronutrient service for adolescents primarily to reduce anemia.
- Awareness amongst all the adolescents regarding Reproductive health and HIV/AIDS.
- Provision of Adolescent Friendly Health & counseling services

Activities

- Create conducive environment to promote adolescent health needs among health service providers and community at large.
- Targeted BCC campaign using multiple channels to raise awareness about safe reproductive health practices and Family Planning among adolescents.
- Partnerships with key stakeholders and major networks to promote safe reproductive health practices and Family Planning among adolescents.
- Provide RTI/STI curative services for adolescents through expanded network of health facilities and frontline health workers.

- Targeted BCC campaign using multiple channels to promote good nutritional practices and micronutrients such as Iron Folic Acid and Iodine among adolescents.
- Increase availability and distribution of micronutrient Workshop to develop an understanding regarding the Adolescent health and to finalize the operational Plan.
- Supplements to adolescents at grassroots level primarily through health and education networks.
- Provision of Adolescent friendly health services at PHCs, CHCs, FRUs and district hospitals in a phased manner. Training of the MOs, ANMs on the needs of this group, vulnerabilities and how to make the services Adolescent friendly.
- Adolescent Health Clinics will be conducted at least twice in a month by the MO to provide Clinical services**,** Nutrition advice, Detection and treatment of anemia, Easy and confidential access to medical termination of pregnancy, Antenatal care and advice regarding child birth, RTIs/STIs detection and treatment, HIV detection and counseling.
- Treatment of psychosomatic problems, De-addiction and other health concerns.
- Awareness building amongst the PRIs, Women's groups, ASHA, AWWs.
- Provision of IFA tablets to all Adolescents, deworming every 6 months,
- Vitamin A administration and Inj. TT.
- Carrying out the services at the fixed MCHN days.
- Involvement of NGOs for Environment building. One NGO per Block will be selected. NGO will select the counselor in the villages.
- Involvement of ASHAs as counselor and one Male & Female person of all the villages, and training of all the health personnel in the Sub centers, PHCs and CHC in the block

- There will be equal number of Male and Female counselors and will alternate between two PHCs – one week the male counselor is in one PHC and the female counselor in the other and they switch PHCs in the next week so that both the boys and girls benefit.
- Facilitating group meetings.
- Organizing Counseling session once per week at the PHCs with Wide publicity regarding the days of the sessions.
- Collecting data and information regarding the problems of Adolescents Close monitoring of the under 18 marriages, pregnancies, prevalence of RTI/STDs.

9. Health Sub Centre

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 old + 61 New = 247**	
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	The district still needs 394 more HSCs to be formed. Out of 186 old + 33 New HSCs only 121 are having own building Existing buildings are not properly maintained 98 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 Supply. 43 HSC has only ANM	• 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

	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		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 position in HSC 742 ANM are required. Almost all the existing sub centre do not have Male Health worker	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	1. Selection and recruitment of 742.ANMs 2. Selection and recruitment of 542 male workers 1. Training need Assessment of

	The ANM training school situated at Sasaram is non functional. Out of 151 sanctioned post of Male Health Worker only 38 are placed			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 delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, Irregular supply of drugs	Indenting Logistics	Strengthening of reporting process and indenting through form 2 and 6 and delegating the purchase power from District to PHC level. Couriers for	1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits

			vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	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 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 %	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, Integration of disease control programs at HSC level. Family Planning services Convergence	Capacity building of account holder of untied fund Renovation of HSC, through construction of delivery room & supply of equipments. 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	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts at HSCs untied fund 1. Gap identification of 186 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)

	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		Community focused Family Planning services Convergence	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

10. Additional Primary Health Sub Cenre

Additional PHC:				**32**
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	The district altogether need 98 APHCs but there are only 32 functioning APHC 66 APHC are required to be formed. Out of 32 APHCs only 11 are having own building Existing 11 buildings are not properly maintained 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 furniture Non availability of HMIS formats/registers	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 B5 Purchase of

	and stationeries		Monitoring	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 required 64 doctors but only 31 doctors are posted. Out of 88 grade A Nurse only 20 grade A Nurse has been appointed , but they are deputed at PHC or district Hospital Out of 32 Health Assistant Male only 8 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	RKS has been	Formation of RKS	Capacity building	1.Training of signatories

performance	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 rehabilitation services No safe MTP service No OT/ dressing and Cataract operation services. Approx 90% of APHC staffs not reside at place of posting. Lack of counseling services Problem of mobility during rainy season Lack of convergence at APHC level Operational gaps: There is no link between HSCs and APHCs and the same way there	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	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 Planning services PPP	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 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)

	is no link between APHC and PHC		Convergence	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	Sanctioned 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

11. Primary Health Sub Cenre

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 29 PHCs but there are only 19 functioning PHC. 10 PHC are required to be formed. All 19 PHCs are having own building All 15 PHCs are running with only six bed facility. **Delivery:** At present only 15 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:** 15 PHC's are conducting Family Planning Operation OPD / Minor operation/ Emergency is 120-250 OPD per day in each PHC. This huge workload is not being	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. Certification of selected PHC in First Phase. 1. Ensuring regular monthly meeting of RKS. 2. Training to the RKS signatories for account operation. 3. 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 2.3 Monthly meetings of VHSCs, Mothers

	addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms.(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 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 Monitoring	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 : Existing 19 PHC district have 57 sanctioned post of regular doctor only 24 are working and in respect of 76 contractual doctor appointment only 41 are working. Grade A Nurse : Out of 88 sanctioned post only 21 are working.	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM training school	Selection and recruitment of ANM& Grade A Nurse 3. Selection and recruitment of 46 male workers 6. Training need Assessment of

	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 24 are working. L.H.V :- Out of 30 sanctioned post only 04 are working. Sanitary Inspector :- Out of 14 sanctioned post only 02 are working. Basic Health Inspector :All sanctioned 13 post are vacant. Out of 19 BHM & Accountant , 19 BHMs and 18 accountants are placed at present			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 of allocated fund
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time. Only … % essential drugs are rate contracted at state level .	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all PHCs 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock)

	Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.		Phase wise strengthening of APHCs for vaccine / drugs storage	4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	1.Exessive load on PHC in delivering all services i.e. 10 delivery per day, Family Planning operation/emergency operation and 120 - 250 OPD per day in each PHC. Lack of counseling services Problem of mobility during rainy season Lack of convergence	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization, Integration of disease control programs at HSC level. Family Planning services Convergence	Capacity building of account holder of untied fund Phasewise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through HSC level	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts at HSCs untied fund 1 Gap identification of 39 HSCs through facility survey 2.strengtheing one HSC per PHC for institutional delivery in first quarter 3.Owneringfirst delivered baby and ANM 1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program

			Community focused Family Planning services Convergence	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.

12 Referral Hospital/Sub divisional hospital

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 & 2 Sub Divisional Hospital. Referral Hospitals are non functional referral hospitals (30 bedded). Since Lack of infrastructure these are working as PHC. Both Referral Hospital have own building but not adequate space. Require additional building Delivery: At present normal delivery is being conducted. Cesarean Operation is conducted only at SDH Bikramganj ,. Nnormal delivery at an average of 7-10 delivery per day **Family Planning:** Family Planning Operation not conducted everyday only on fixed day in a week OPD / Minor operation/ Emergency is 150-300 OPD per day in	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	1.Need based (Service delivery)Estimation of cost for up gradation of Referral 2.Preparation of priority list of interventions to deliver services. 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. Meeting with community representatives on erecting boundary, beautification etc,

	each Referral. This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms.(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 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		Infrastructure and operationalization of construction works Monitoring	

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	**4.** Selection and recruitment of **Grade A Nurse** 5. 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 distribution. Lack of fund for the	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7	

	transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.		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.

13. District Hospital

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 300-500 OPD per day This huge workload is not being addressed with only 100 beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms.(List attached, Annexure..)	Available facilities are not compatible with the services supposed to be delivered at District Level Quality of services Community participation.	Completion of ISO certification process of the District. Hospital Ensuring community participation. Strengthening of Infrastructure and operationalization of construction works	1.Preparation of priority list of interventions to deliver services. 2. Ensuring regular monthly meeting of RKS. 4. Appointment of 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 4.1 Regular monitoring of District Hospital s facilities through District official in IPHS format. 4.2 Monitoring of

	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 formats/registers and stationeries Operation of RKS: Lack in uniform process of RKS operation. Lack of community participation in the functioning of RKS.		Monitoring	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	6. Selection and recruitment of 93 Grade A Nurse. 7. 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 procurement and transportation.	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 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

			Phase wise strengthening of AReferral for vaccine / drugs storage	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 Community focused Family Planning services	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 in the covering area of he hospital. all schools on health , nutrition and sanitation issues

			Convergence	

14. ASHA

Accredited Social Activist (ASHA) is a key strategy of the NRHM to link the community with the health systems. ASHA works with the community to raise awareness about various health programmes, provide basic health knowledge, and provide information on health practices thus generating demand for health services. She also helps and supports the community to access health services. Proper selection and training of ASHAs is a crucial step for the success of NRHM. In Rohtas ASHAs have been selected in all the blocks. In most of the blocks ASHAs have completed two rounds of training, while in some of the blocks they have completed one round of training. Salient information related to ASHAs in the district can be found in the matrix below:

Situation analysis:

Out of a total target 2490 ASHAs for the District, 2410 have already been selected.

Activities

- Submission of proposal for the sanction and selection of additional ASHAs
- Development of an IEC campaign on the role of the ASHA using print and folk media by Block Health Educators.
- Building partnerships with NGOs for conducting an IEC campaign on the ASHA programme.
- Monitoring of the IEC Campaign by Block Community mobilizer.
- Determining the community based selection and review process for ASHAs by DHS.
- Partnership with NGOs for implementing the community based selection and review process
- Monitoring of NGO partnership for community based selection and review of ASHAs by Block Health Educators.

Strategies

- Sanction of additional ASHAs
- Facilitate selection through a community process focused on creating awareness about the role of the ASHA as a community mobiliser and activist and her positioning as a representative of the community.
- Community based review of existing ASHAs for performance and replacement of non-functional ASHAs.
- Partnership with local, active voluntary organizations with a background in community health work in the community based selection and review process.

ASHA Training

Situation Analysis: Out of 2490, 2050 ASHAs have received only the first round of training.

Strategies

- Conducting 12 days of camp based training for all ASHAs
- Conducting 30 days of field based training for 30% of ASHAs in the district.

Supportive Supervision Activities

- Monthly cluster level meetings of ASHAs, ANMs, AWWs, VHSC members and ASHA trainers.
- Monthly block level trainer's meeting
- Monthly district level trainer's meeting
- Development of simple monitoring formats to be filled out by ASHA trainers, and District Resource Persons to review the functionality of the programme
- Organising an ASHA mela every year at the District level to create a sense of solidarity and support amongst ASHAs
- ASHA Helpline to be managed by the ASHA helpdesks

Selecting active ASHAs with leadership qualities to be ASHA trainers

Strategies

- Timely release of monetary incentives to ASHAs

Instituting social incentives for ASHAs

Activities

- Advertising for an ASHA coordinator at the district level

Recruitment of ASHA coordinator Health educators at the block level to support in ASHA training

15.Rogi Kalyan Samitis & Untied Funds

Rogi Kalyan Samitis & Untied Funds for Health Sub-Centre, APHC & PHCs

"Health Sub Centre"

Strategies

- Ensuring that HSCs receive untied funds

Activities

- Opening Bank Accounts
- Ensuring timely release of funds to HSCs

"Additional Primary Health Centre"

Strategies

- Ensuring that all APHCs receive untied funds as per the NRHM guidelines

Activities

- Ensuring that all APHCs receive untied funds as per the NRHM guidelines

"Primary Health Centre"

Strategies

- Ensuring timely release of funds to HSCs
- Ensure that RKS is registered in all PHCs.
- Ensure UCs are sent regularly.
- Utilisation of RKS funds to pay for outsourced services
- Ensuring that HSCs receive untied funds
- Opening Bank Accounts

Activities

- Training of RKS office bearers on documentation of meetings as well as of the potential of the RKS
- Training of block level accountants in preparation of the utilization certificates
- Monthly review meeting of block level accountants by District Accounts Manager to strengthen the documentation process
- Developing a check list for review

16. Immunization

Objectives

- 100 % Complete Immunization of children.
- 100 % BCG vaccination of children.
- 100% DPT 3 vaccination of children.
- 100% Polio 3 vaccination of children.
- 90% Measles vaccination of children.
- 100% Vitamin A vaccination of children

Activities

- Organizing regular routine immunization training for ANM and AWW and IPC/IEC/BCC trainings for ASHA and AWWs.
- Organizing immunization camps at every Sub centre level on every Wednesday and at the AWCs on every Saturday.
- Regular house to house visits for registration of pregnant women for ANC and children for immunization.
- Developing tour plan schedule of ANM with the help of BHM and MOIC.
- Timely payment to MOICs to arrange transportation of vaccines from district hospital to PHCs.
- Regular disbursement of funds from the DIO to MOs for providing incentives to ANMs.
- Regular disbursement of funds for ANMs to provide incentives to AWWs and ASHA workers.
- Providing per diem for health workers, mobilisers, supervisors and vaccinators and alternative vaccinators.

- Maintaining the disbursement records.
- Visits by MOIC, CDPO, BHM, LHV and health educator to monitor the progress of immunization schedule and prepare report.
- Ensuring the unrestricted movement of the monitoring team with fuel for vehicle and funds for hiring of the vehicle.
- Maintaining continuous power supply at PHC level for maintaining the cold chain.
- Applying for acquisition of ILR and deep freezer for the 1 PHCs which do not have ILR at present.
- Applying to State Heath society for the funding for Vaccine van to get timely stock of vaccines for the districts.
- Timely and regular requests from district to state as well as blocks to district to replenish the supply of DPT and syringe.
- Rationalisation of courier rates and making request to the SHS for increased funding for courier in order to ensure timely supply of vaccines to sub centres.
- Reviewing the contract of Voltas Cooling Company, currently responsible for repair and maintenance.
- Submitting a proposal to the state health society to acquire power of issuing maintenance and repair contract for cold chain equipment from district.
- Procure stock of hub cutters for all the PHCs for safe disposal of needles and syringe.

ACHIEVEMENT DURING (April 2011 – December 2011)

No of Pregnant Women Completely Immunized	
No of Children Immunized Completely	

17. Vitamin A Supplementation Programme

Situation Analysis:

The programme faces lack of skilled manpower for implementation of program. There is also shortage of drugs and RCH kits. The shortages put constraints on ensuring first dose of Vitamin-A along with the measles vaccination at 9 months.There are also problems for procurement of Vitamin-A bottles by the district for biannual rounds. The reporting mechanism of the district need to be improved. There is lack of coordination among health & ICDS workers for report returns & MIS. The district also needs a joint monitoring & supervision plans with ICDS department.

Strategies

- Updation of Urban and Rural site micro –plan before each round.
- Improving inter-sectional coordination to improve coverage.
- Capacity building of service provider and supervisors.
- Bridging gaps in drug supplies.
- Urban Planning for Identification of Urban sites and urban stakeholders.
- Human resource planning for Universal coverage.
- Intensifying IEC activities for Community mobilization.
- Strengthening existing MIS system and incorporating 9 doses of Vitamin-A in existing reporting structure.
- Strong monitoring and supervision in Urban areas.

Activities

- Orientation , stationary, data compilation, validation and updating.
- Constituting district level task force and holding regular meetings.
- Organising meeting of block coordinators.
- Training and capacity building of service providers.

- Strategy planning meetings, orientation of stakeholders, resource planning and site management for urban centre and orientation of urban supervisors.
- Ensuring availability of immunization cards
- Procurement of Vit A Syrup

18 .National Disease Control Programme "R NTCP"

Strategies

- Detection of New cases.
- House to House visit for detection of any cases.
- IEC for awareness regarding the symptoms and effects of TB.
- Prompt treatment to all cases.
- Rehabilitation of the disabled persons.
- Distribution of Medicine kit and rubber shoes.
- Honorarium to ASHA for giving DOTs.

Activities

- Participation of ASHAs and AWWs for providing DOTS so as to reach services close to the patients for decrease default rate.
- Ensure proper counselling of the patient by the health workers.
- Organizing awareness campaign and community meetings to aware people about the TB and DOTS.
- Sensitization of MOTCs/MOs at the Peripheral health facilities to ensure every TB suspect
- undergo Sputum Smear examination (at least 3% of Total New OPD patient)
- Sensitization of all Lab Technician for Correct Sputum Smear Microscopy(5%-15% positivity is expected among patients examined for diagnosis)
- Ensuring 3 sputum smear examinations for TB patients.
- Participation of ASHA and Community Volunteers to provide effective DOTS.

- Incentive to ASHA and Volunteers for timely Sputum smear microscopy Collection and follow-up.
- Initiation of treatment of New Smear Positive (NSP) patients within a weak of diagnosis.
- To control spared of infection in Group.
- Proper Monitoring/Supervision to ensure regular and interrupted DOTS as per guidelines.

"Proper counselling of patients by the DOTS provider and supervisory staffs".

- Maintenance/ Replacement of defective Binocular microscopes.
- Establishment of new DMC as per need and repairing/renovation of closed DMCs with proper electricity connection and water supply.
- Refreshment training of Lab Staffs specially Lab Technician for maintenance of microscopes.
- Ensure regular and adequate supply of laboratory consumables to DMCs from |District TB Centre(DTC)
- Recruitment of Counsellor at PHC level.
- Active participation of community specially ASHA and AWW.
- Capacity building of ASHA.
- Remuneration to ASHA/Community volunteer for providing DOTS will be paid timely.
- New recruitment for lacks in staffs i.e., Lab Technician, STS, STLS, TBHV and other.

ACHIEVEMENT DURING (April 2011 – December 2011)

No of Sputum cases Examined	
No of Positive Cases	

"National Leprosy Elimination programme"

Objective

- To reduce the leprosy disease prevalence rate to.

Strategies

- Currently disease prevalence rate per 10,000 population is.
- New patients registered .
- Awareness in urban areas.

Activities (Improving case detection)

- House to house visits for tracing cases of Leprosy, by health workers (BHWs, ASHA, ANM)
- Detected cases are to be taken to hospital for proper counselling, by professional counsellors.
- The cases detected are to be monitored and followed up by health workers, mainly by BHWs/ASHA to detect deformity.

IEC/BCC to create awareness

- Awareness creation among community by having hoardings, pamphlet, advertisements in the news papers.
- Sensitization of AWW.
- School quiz contest.
- Awareness in the community through Gram- Goshti.
- Organizing 2 Health camps in each block.
- Rally to create awareness.

Strengthening Facilities

Increasing availability of fuel, vehicle, stationary and medicine at facility level.

Human Resources

- Walk-in interview for filling of all required staff at the district level.
- Continued training for all health workers.
- Training of all health workers specifically in counselling patients and the family about the disease.
- Contracting of services that are essential for management of cases.
- Contracting of a consoler at least at the PHC level.

ACHIEVEMENT DURING (April 2011 – December 2011)

No of Cases Detected	
No of leprosy Cases Deleted	

"Malaria Control Programme"

Situation Analysis:

District faces lack of laboratory technicians and facilities at the APHC/PHC level. This has proved to be a hurdle in prompt diagnosis of the cases. All BHW, BHI, ANM are responsible for collecting the BS of the suspected cases. The exact burden of disease in Rohtas is not known as reports from private sector is not collected or not reported. The BCC activities in the district are also limited. There is also shortage of mosquito bed nets but anti-malarial drugs are in abundant.

Strategy

- Ensuring registration of all private laboratories.
- Filling-up of all vacant posts.

- Enhancing BCC activities.
- Ensuring adequate supply of mosquito bed nets.

Activities

- Meeting with DM for issuing an order for all old and new laboratories to register with DHS.
- Following their registration, they would be expected to report all the disease specific cases to the DHS.
- All HWs would also be then requested to collect the reports.
- Training of all health workers in BCC.

ACHIEVEMENT DURING (April 2011 – December 2011)

No of Cases Detected	**2815**
No of leprosy Cases Deleted	**218**

"Filaria Control Programme"

Situation Analysis

Similar to Malaria lack of laboratory technicians and facilities at the APHC/PHC level continues to pose a challenge for an effective filarial control programme in the district. In case of Filaria specifically the exact burden of disease is not known because reports from the private sector are not collected or not reported. BCC activities in the district are limited. There is a shortage of chemically treated bed nets. Mass Drug Administration has been carried out in the population where cases have been detected.

Strategy

- Early diagnosis and prompt treatment.
- Ensuring registration of all private laboratories.
- Filling all vacant posts.
- Enhancing BCC activities.
- Ensuring adequate supply of mosquito bed nets.
- Ensuring adequate supply of drugs.

Activities

- House to house visits for tracing cases of Filariasis, by health workers (BHWs, ASHA, ANM)
- Collection of reports from local private practitioners and laboratories in the village.
- Following their registration, they would be expected to report all the disease specific cases to the DHS.
- All HWs would also be then requested to collect the reports.
- Training of all health workers in BCC.
- District level procurement of drugs for MDA, with funds from respective department.

ACHIEVEMENT DURING (April 2011 – December 2011)

No of cases Reported	**1251**
No of Night Blood Sample Collected	**1083**

"National Blindness Control Programme"

Strategy

- Prompt case detection.
- Ensuring proper treatment.

Activities

- Screening of all children in the schools Including Optometrists in Mobile medical unit's visits to camps in villages.
- Fortnightly visit by optometrist opthometrician to health sub-centres and weekly visit to APHCs.
- Contracting of ophthalmologist services.
- Distribution of spectacles from the health facilities.
- Conducting in-hospital minor surgeries for cataract.
- Conducting surgeries in the NGO run hospitals and follow-up.
- Distribution of spectacles for BPL population undergoing surgery in private sector.

ACHIEVEMENT DURING (April 2011 – December 2011)

No. of Cataract Operated	2754
No. of School Children Screened	13345
No. of School Children Detected for Refractive Error	256
No.Of Teachers Trained	178
Provided Free Glass	0

"Kala Azar"

- Rohtas District is free from Kala Azar

"Integrated Disease Surveillance Programme (IDSP)"

Situation Analysis

(The programs with major surveillance components include):

- The National Anti-Malaria Control Program.
- National Leprosy Elimination Program
- Revised National Tuberculosis Control Program
- Nutritional Surveillance
- National AIDS Control Program.
- National Polio Surveillance Program as part of the Polio eradication initiative
- National Programme for Control of Blindness (Sentinel Surveillance)

Surveillance activities of all these vertical programs of Malaria, Tuberculosis, Polio, and HIV are functioning independently leading to duplication of Surveillance efforts. Surveillance has been ineffective due to

- There are a number of parallel systems existing under various programs which are not integrated
- The existing programs do not cover non-communicable diseases
- Medical colleges and large tertiary hospitals in the private sector are not under the reporting system as well as for utilization of laboratory facilities.
- The laboratory infrastructure and maintenance is very poor
- Presently, surveillance is sometimes reduced to routine data gathering with sporadic response systems thereby leading to slow response to Epidemics,

- Information technology has not been used fully for information and to analyze and sort data so as to predict epidemics based on trends of the reported data.
- In response to these issues the Integrated Disease Surveillance Programme was launched in Bihar in 2005 to provide essential data to monitor progress of on going disease control programs and help in optimizing the allocation of resources.

IDSP includes 22 diseases/ conditions (Malaria, Acute diarrhoeal disease-Cholera, Typhoid, Jaundice, Tuberculosis, Acute Respiratory Infection, Measles, Polio, Road Traffic Accidents, Plague, Yellow Fever, Meningoencephalitis /respiratory distress, etc.,(HIV, HCB, HCV) and 5 state specific diseases (Thyroid diseases, Cutaneous Leishmaniosis, Acid Peptic Diseases, Rheumatic Heart Diseases).

- Establishing of District Surveillance unit.
- Up gradation of 2 PSU Labs.
- Water testing labs are in place.
- V-Sat has been installed but training is required.
- Rapid response teams have been established at District levels.
- DSUs (District Surveillance Units) have been established in all districts.
- Regional Lab has been proposed fro specialized test.

Objectives

- Improving the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors.

- Establishing a decentralized state based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the country at the state and national level.
- Improving the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.

Activities

- Strengthening of the District Surveillance Unit (DSU), established under the project,
- Training of the Unit Incharge for epidemiology – {DMO)
- Hiring of Administrative Assistant.
- Training of contract staff on disease surveillance and data analysis and use of IT.
- Providing support for collection and transport of specimens to laboratory networks.
- Provision of computers and accessories
- Provision of software of GOI
- Notifying the nearest health facility of a disease or health condition selected for community-based surveillance
- Supporting health workers during case or outbreak investigation
- Using feedback from health workers to take action, including health education and coordination of community participation.

19. DEMAND GENERATIO, IEC/BCC

Situation Analysis

- There is lack of awareness and good practices amongst the community due to which they neither avail the services nor take any positive action. There is lack of awareness regarding the services, schemes including the Fixed Health days.

The following issues need special focus:

- Importance of 3 visits for ANC, advantages of institutional delivery, Post natal care.
- Availability of skilled birth attendants, balanced diet during pregnancy, anaemia, misgivings about IFA, kitchen garden.
- Importance of complete immunization, disadvantages of drop outs, nutritional requirements of infants and children, malnutrition, exclusive breastfeeding.
- Problems of adolescents, drugs addiction, malnutrition, problems of sexuality, age at marriage, tendency to take risks in sexual matters.
- DOTS programme for TB, location of microscopy centres, cardinal symptoms of TB,
- High risk behaviour in the community in relation to water born diseases, heart diseases and lung diseases, and HIV/AIDS, STDs
- Evil of drugs addiction affecting adolescents,
- High prevalence of RTIs, including STDs,
- Issues of malaria spread and prevention and also other diseases
- JSY, Fixed Health days, availability of services.
- The personnel have had no training on Interpersonal communication

Objectiv

- Widespread awareness regarding the good health practices
- Knowledge on the schemes, Availability of services

Strategy

- Information Dissemination through various media,
- Interpersonal Communication.
- Promoting Behaviour change.

Activity

- Awareness on Fixed MCHN days
- Designing of BCC messages on exclusive breast feeding and complimentary feeding, ANC, Delivery by SBA, timely referral, PNC, FP, Care of the Newborn,
- Gender, hygiene, sanitation, use of toilets, male involvement in the local language.
- Consistent and appropriate messages on electronic media – TV, radio.
- Use of the Folk media, Advertisements, hoardings on highways and at prominent sites.
- Training of ASHA/AWW/ANM on Interpersonal communication and Counselling on various issues related to maternal and Child health.
- Display of the referral centres and relevant telephone numbers in a prominent place in the village.
- Promoting inter-personal communication by health and nutrition functionaries during the Fixed health & Nutrition days.
- Orientation and training of all frontline government functionaries and elected representatives.
- Integration of these messages within the school curriculum.

- Mothers meeting to be held in each village every month to address the above mentioned issues and for community action.
- Kishore Kishori groups to be formed in each village and issues relevant to be addressed in the meetings every month
- Meetings of adult males to be held in each village to discuss issues related to males in each village every month and for community action.
- Village Contact Drives with the whole staff remaining at the village and providing services, drugs , one to one counselling and talks with the Village Health & Water Sanitation Committee and the Mother's groups
- Developing Nirdeshika for holding Fixed Health & Nutrition days to be distributed to all MOs, ANMs, AWWS, LS, PRIs,
- Monthly Swasthya Darpan describing all the forthcoming activities and also what happened in the month along with achievements
- Bal Nutrition Melas 4 times at each Sub centre
- Wall writings.
- Pamphlets for various issues packed in an envelope.

20.PROGRAM MANAGMENT

Objective

- District Health Society to make functional and empower to plan, implement and monitor the progress of the health status and services in the district.

Strategies

- Capacity building of the members of the District Health Society regarding the programme, their role, various schemes and mechanisms for monitoring and regular reviews.
- Establishing Monitoring mechanisms.
- Regular meetings of Society.
- Bimonthly meetings of Health, ICDS and PHED (as role of water and sanitation will play an important role in providing better health)

District Programme Management Unit

Status

- In NRHM a large number of activities have been introduced with very definite outcomes. The cornerstone for smooth and successful implementation of NRHM depends on the management capacity of District Programme officials. The officials in the districts looking after various programmes are overworked and there is immense pressure on the personnel. There is also lack of capacities for planning, implementing and monitoring. The decisions are too centralized and there is little delegation of powers.
- In order to strengthen the district DPMU, Four skilled personnel i.e. District Programme Manager, District Account Manager, District Nodal M&E

Officer, District planning coordinator, District Data Assistant ASHA have being provided in the district.

- These personnel are there for providing the basic support for programme implementation and monitoring at district level under DHS.
- The District Programme Manager (DPM) is responsible for all programmes and projects in district under the umbrella of NRHM and the District Accounts Manager (DAM) is responsible for the finance and accounting function of District Health Society including grants received from the State Health Society and donors, disbursement of funds to the implementing agencies, preparation of submission of monthly/ quarterly/ annual SOE, ensuring adherence to laid down accounting standards, ensure timely submission of UCs, periodic internal audit and conduct of external audit and implementation of computerised FMR.
- The District Nodal Monitoring and Evaluation Officer (M&E Officer) has to work in close consultation with district officials, facilitate working of District Health Society, Maintain records, Create and maintain district resource database for the health sector, Inventory management, procurement and logistics, Planning, monitoring & evaluation, HMIS, data collection and reporting at district level.
- There is a need for providing more support to the Civil Surgeon office for better implementation especially in light of the increased volume of work in NRHM, monitoring and reporting especially in the areas of Maternal and Child Health, Civil works, Behaviour change and accounting right from the level of the Sub centre.

- The Civil surgeon's office is located in the premises of the Sadar Hospital in the district. The office of all the Deputy Civil Surgeons is also in Sadar Hospital premises.

Activities

- Support to the Civil Surgeon for proper implementation of NRHM through proper involvement of DPMU and more consultants for support to civil surgeon for data analysis, trends, timely reports and preparation of documents for the day-to-day implementation of the district plans so that the Civil Surgeon and the other district officers.

- Finalizing the TOR and the selection process

- Selection of consultants, one each for Maternal Health, Civil Works, Child health, Behaviour change. If properly qualified and experienced persons are not available then District Facilitators to be hired which may be retired persons.

- **Capacity building of the personnel**

- Joint Orientation of the District Officers and the consultants

- Induction training of the DPM and consultants

- Training on Management of NRHM for all the officials

- Review meetings of the District Management Unit to be used for orientation of the consultants

Development of total clarity in the Orientation workshops and review meetings at the district and the block levels amongst all the district officials and Consultants about the following set of activities:

- Disease Control

- Disease Surveillance
- Maternal & Child Health
- Accounts and Finance Management
- Human Resources & Training
- Procurement, Stores & Logistics
- Administration & Planning
- Access to Technical Support
- Monitoring & MIS
- Referral, Transport and Communication Systems
- Infrastructure Development and Maintenance Division
- Gender, IEC & Community Mobilization including the cultural background of the Meows
- Block Resource Group
- Block Level Health Mission
- Coordination with Community Organizations, PRIs
- Quality of Care systems

Provision of infrastructure for officers, DPM, DAM, M&E Officer and the consultant of the District Project Management Unit. Provision of office space with furniture and computer facilities, photocopy machine, printer, Mobile phones, digital camera, fax, etc;

Use of Management principles for implementation of District NRHM

Development of a detailed Operational manual for implementation of the NRHM activities in the first month of approval of the District Action Plan including the responsibilities, review mechanisms, monitoring, reporting and the time frame. This will be developed in participatory consultative workshops at the district level and block levels.

- Financial management training of the officials and the Accounts persons. jurisdiction of the Civil Surgeon
- **Strengthening the Block Management Unit**: The Block Management units need to be established and strengthened through the provision of :
- Block Health Managers (BHM), Block Accounts Managers (BAM), Block Community Mobilizer ASHA and Data Operators (DO) for each block. These are hired on contract.
- Office setup will be given to these persons
- Accountants on contract for each PHC since under NRHM Sub centres have received Rs 10,000 also the village committees will get Rs 10,000 each, besides the funds for the PHCs.
- Provision of Computer system, printer, Digital Camera will be provided for BHM
- **Convergence of various sectors at district level**
- Provision of Convergence fund for workshops, meetings, joint outreach and monitoring with each Civil Surgeon
- **Monitoring the Physical and Financial progress** by the officials as well as independent agencies
- **Yearly Auditing** of accounts

Strategies

- Support to the Civil Surgeon for proper implementation of NRHM.
- Capacity building of the personnel
- Development of total clarity at the district and the block levels amongst all the district officials and Consultants about all activities
- Provision of infrastructure for the personnel
- Training of District Officials and MOs for management
- Use of management principles for implementation of District NRHM
- Streamlining Financial management
- Strengthening the Civil Surgeon's office
- Strengthening the Block Management Units
- Convergence of various sectors

21. CAPACITY BUILDING AND TRAINING

Situation Analysis

SBA Trainings- SBA trainings are being organized in DHS Rohtas. Grade 'A' Nurse & ANM have got SBA training. Out of 28 Grade 'A' Nurse, 495 ANMs posted in the district, 40 have got the SBA training. The remaining is yet to receive the training. 8 present LHV also require SBA training.

- **Family Planning –** Only 4 doctors have received Non scalpel Vasectomy training. Minilap training has been organized in the district at DH & SDH.

Activities

- SBA trainings have to be given ANMs posted at Sub centre and APHC.
- Staff nurses from each of 19 PHCs, 2 RH, 1 DH & 1 SDH.
- LHV from each PHC and RH to be trained

EMOC-

- 2 medical officers from District hospital, SDH and 2 RH.
- 1 MO from each PHC
- 1 MO from 32 priority APHCs.

Safe abortion services training

- 2 medical officer s from District hospital, SDH and 2 RH.
- 1 MO from each PHC
- 1 MO from 32 APHCs.

Anaesthetics skill training-

- 1 MO from each functional PHC and 1 each from 3 RH, 2 SDH and 1 DH.

NSV training

- 1 MO from each blocks PHC
-

- **STI/RTI training-**
- 1 MO from each functional PHC and 1 DH, 1 SDH and 2 RH.

MINLAP training

- 1 MO from each functional PHC and 1 DH, 1 SDH and 2 RH.

Training on Family Planning choices and IUD insertion

- 1 ANM from each of 32 APHC
- 1 ANM from 19 functional PHC
- 1 ANMs from 2 RH, 1 SDH and DH.

Programme management training-

Basic computer skills for clerical staff at DPMU, DHS, District hospital, SDH, Referral and PHCs and DPMU.

District health planning and management for DPMU and BPMU.

22. MONITORING AND EVALUATION

Situation Analysis

Monitoring is an important aspect of the programme but it is not happening effectively and regularly. Each officer and the MOIC, MO, BHM at PHCs are supposed to make regular visits and monitor the progress and check on the activities and also the data provided by the ANMs. The reports have to be submitted and discussed in the monthly review meetings at the entire forum.. No proper Check-lists exist for monitoring. Also analysis is not done of the visits and any data collected No Verbal Autopsies (Maternal, Neo-natal, Infant & Child Death audits) are carried out any levels. The Role & Functioning of the Sub centre level Committee, PHC level Committee, RKS at PHC and VLC need to be clearly defined. There is no system of concurrent Evaluation by independent agencies so that the district officials are aware regarding the progress and the lacunae.

Strategies

- Developing the system for visits, reporting and review
- Developing a system of Concurrent Evaluation

Activities

- Fixing the dates for visits, review meetings and reports.
- Development of Checklist for Monitoring.
- Software for the checklist and entry of the findings in the checklist.
- MOIC, MOs & BHM to make at least 5% facility visits and also of the villages.
- Quality assessment of all health institutions.

- Maternal Mortality Audit by MO and by involving ANM AWW for reporting of maternal deaths,
- Mobility for monitoring at all levels and with the use of district monitors.

23. PUBLIC PRIVATE PARTNERSHIP

The private sector includes NGOs, Private Practitioners, Trade and Industry Organisations, Corporate Social Responsibility Initiatives.

The private sector is the major provider of curative health services in the country. 43% of the total IUD clients obtain their services from the private sector. Engaging with it to provide family planning services has the potential to significantly expand the coverage of quality services. Public-private partnerships can stimulate and meet demand and have a synergistic impact of the RCH. To ensure efficient services of good quality from the private and public sectors, robust monitoring and regulatory mechanisms need to be developed so that the private sector can come forward and cooperate in all the National programmes and also in sharing its resources. There is no policy on Public Private Partnership in Haryana Unless there are incentives for the private sector to venture into this area, its involvement is unlikely.

Objectives

Increasing the coverage of the health services and also increasing the accessibility for health services widening the scope of the services to be provided to the clients.

24 BIO-MEDICAL WASTE MANAGEMENT

Situation Analysis

- As per the Bio-Medical Waste Rules, 1998, indiscriminate disposal of hospital waste was to be stopped with handling of Waste without any adverse effects on the health and environment. In response to this the Government has taken steps to ensure the proper disposal of biomedical waste from all Nursing homes, hospitals, Pathological labs and Blood Banks.

- The District Health Officer is the Nodal Person in each district for ensuring the proper disposal of Biomedical Waste.

- Trainings to the personnel for sensitizing them have been imparted, Pits have been dug, Separate Colour Bins/containers and Segregation of Waste is taking place though has to be done more systematically. Proper Supervision is lacking.

- GOI has sanctioned a Plasma Pyrolysis Plant. Plasma Pyrolysis is a state-of-the-art technology for safe disposal of medical waste. It is an environment friendly technology, which converts organic waste into commercially useful by-products in a safe and reliable manner.

- The plant will soon be installed and training will be imparted to two persons from the district.

Objectives

- Stopping the indiscriminate disposal of hospital Waste from all the facilities by 2011-12

Strategies

- Capacity Building of personnel
- Proper equipment for the disposal and disposal as per guidelines
- Strict monitoring and Supervision

Activities

- Review of the efforts made for the Biomedical Waste Interventions
- Development of Micro plan for each facility in District & Block workshops

Capacity Building of personnel

- One day reorientation workshops for District & Block levels
- Training to two persons for Plasma Paralysis Plant. The company persons will impart this training.
- Biomedical Waste management to be part of each training in RCH and IDSP
- Proper equipment for the disposal
- Plasma Paralysis Plant to be installed
- Installation of the Separate Colour Bins/containers and Plastic Bags for the bins
- Segregation of Waste as per guidelines
- Partnering with Private providers for waste disposal
- Proper Supervision and Monitoring
- Formation of a Supervisory Committee in each facility by the MOs and the Supervisors

BUDGET
2012-13

Part - A

Budgetary Proposal:																													
FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)		Unit of measure (in words)	Physical Target (where applicable)										Unit Cost (in Rs.)	Financial Requirement (in Rs.)										Committed Fund requirement (if any in Rs.)		Responsible Agency (State/SHSB/Name of Development Partner)		Remarks
					Q1		Q2		Q3		Q4		Total no of Units			Q1		Q2		Q3		Q4		Total Annual proposed budget (in Rs.)					
		HFD *	State Total		HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total		HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total				
A	RCH Flexipool																												
A.1	MATERNAL HEALTH																												
A.1.1.1.2	Monitor Progress and Quality of Service Delivery			4	1		1		1		1		4		12500	12500		12500		12500		12500		50000					
A.1.1.2	Operationalise 24x7 PHCs (Mch Center- Aphc)			15	2		4		6		3		15		25000	50000		100000		150000		75000		375000					
A.1.1.5	Operationalise Sub-Centres (MCH Center-Hsc)			19	3		6		4		6		19		50000	150000		300000		200000		300000		950000					
A.1.3	Integrated Outreach RCH Services																												
A.1.3.1	RCH Outreach Camps/ Others			38	8		10		10		10		38		7000	56000		70000		70000		70000		266000					
A.1.3.2	Monthly Village Health and Nutrition Days			2307												306850		306850		306850		306850		1227400					
A.1.4	Janani Suraksha Yojana / JSY																												
A..1.4.1	Home Deliveries			1000	150		150		300		400		1000		500	75000		75000		150000		200000		500000					
A_1.4.2	Institutional Deliveries																												
A.1.4.2.A	Institutional Deliverie-Rural	251		40000	8000		8000		12000		12000		40000		2000	16000000		16000000		24000000		24000000		80000000					
A.1.4.2.B	Institutional Deliveries-Urban	25000		5000	1000		1000		1500		1500		5000		1200	1200000		1200000		1800000		1800000		6000000					
A.1.4.2.C	Institutional Deliveries-C-Sections	69		500	80		120		150		150		500		1500	120000		180000		225000		225000		750000					
A.1.4.3	Administrative Expenses			80	20		20		20		20		80		2000	40000		40000		40000		40000		160000					
A.1.5	Maternal Death Review			187	18		55		56		58		187		750	13500		41250		43500		43500		141750					

A.2	**CHILD HEALTH**																														
A.2.1	**IMNCI**																														
A.2.1.1	Implementation of IMNCI Activities in Districts			4	1		1		1		1		1			12600	12600		12600		12600		12200		50000						
A.2.1.3	Incentive for FBNC to ASHA/AWWs(State Iniative) 3 PNC for Normal Baby			20000	5000		5000		5000		5000		20000			100	500000		500000		500000		500000		2000000						
A.2.1.4	Incentive for HBNC to ASHA(State Iniative) 6PNC for Low Birth Baby			5000	600		800		2000		1600		5000			200	120000		160000		400000		320000		1000000						
A.2.2	Facility Based Newborn Care/FBNC (Operationalise 40 NBSUs)			1			1									775000			775000						775000						
A.2.6	Management of Diarrhoea, ARI and Micronutrient Malnutrition (Nutritional Rehabilitation Centres)	1		1										Maintenance of NRC@RS.	103535.Running of	1294835			1191300		1261800		1191300		4939235						
A.3	**FAMILY PLANNING**																														
A.3.1	**Terminal/ Limiting Methods**																														
A.3.1.1	Dissemination of Manuals on Sterilisation Standards & QA of Sterilisation Services			1					1				1			20000					20000				20000						
A.3.1.2	Female Sterilisation Camps			504	50		100		150		204		504			5000	250000		500000		750000		1020000		2520000						
A.3.1.3	NSV Camps			19	3		3		6		7		19			5000	15000		15000		30000		35000		95000						
A.3.1.4	Compensation for Female Sterilisation	4315		12000	1000		2000		4500		4500		12000			1000	1000000		2000000		4500000		4500000		12000000						
A.3.1.5	Compensation for Male Sterilisation (Compensation for NSV Acceptance)	434		600	25		50		250		275		600			1500	37500		75000		375000		412500		900000						
A.3.1.6	Accreditation of Private Providers for Sterilisation Services	1705		4000	300		700		1500		1500		4000			1500	450000		1050000		2250000		2250000		6000000						
A.3.3	POL for Family Planning (for District Level + State Level Monitoring)			15	5		10		0		0		15			17000	85000		170000		0		0		255000						
A.3.5.4	Provide IUD Services at Health Facilities (IUD Camps)			58	2		10		20		26		58			1500 / PHC & 1 District level @ 2000	3000		15000		30000		41000		89000						
A.4.2	ARSH (School Health Program)Nai Pidhi																1000000		1500000		2000000		2500000		7000000						

A.9.6.2	A.9.6	A.9.5.5.3	A.9.5.1	A.9.5	A.9.3.7	A.9.3.1	A.9.3	A.9	A.8.1.8	A.8.1.7	A.8.1.5	A.8.1.2	A.8.1.1	A.8.1	A.8	A.7.2
Minilab Training	**Family Planning Training**	NSSK (SN/ANM)	IMNCI	**Child Health Training**	Other MH Training (Training of TBAs as a community resource, any integrated training, etc.)	Skilled Birth Attendance / SBA	**Maternal Health Training**	**TRAINING**	Incentive/ Awards etc. to SN, ANMs etc. (Muskan Program)	FP Counsellors	Medical Officers at Blood Bank	Laboratory Technicians, MPWs (Blood Bank)	ANMs.Supervisory Nurses, LHVs,	Contractual Staff & Services(Excluding AYUSH)	INFRASTRUCTURE (MINOR CIVIL WORKS) & HUMAN RESOURCES	PNDT Activities
						1							ANM -243 G Nurse -21			
1		6	30		2 Batch for MO 2 Batch for Para medicals	4			66000	2	1	3	ANM 308 Grade A Nurse -50			4 Meeting & 10 Monitoring
			0						14000	2	1	3	358			
		2	4			1			18000	2	1	3	358			
1		2	13		2	1			24000	2	1	3	358			
		2	13		2	2			10000	2	1	3	358			
1		6	30		4	4			66000	8	4	12	1432			
70237		52900	134760		MO Batch @ Rs 65000 Para Medical @Rs 50000	88110			RS. 50 - 200	18000	42000	12500	ANM -15000 Grade A Nurse - 25000			Meeting @ 5000 and Monitoring @ Rs. 3000
0		0	0			0			2000000	36000	42000	37500	5870000			10000
0		105800	539040			88110			3000000	36000	42000	37500	5870000			10000
70237		105800	1751880		115000	88110			4000000	36000	42000	37500	5870000			15000
0		105800	1751880		115000	176220			1000000	36000	42000	37500	5870000			15000
70237		317400	4042800		230000	352440			10000000	144000	168000	150000	23480000			50000

A.9.6.3	NSV Training	2		4					2		2		4			33900	0		0		67800		67800		135600						
A.9.6.4.1	Training of IUD Insertion (Medical Officer)			1					1				1			55300	0		0		55300		0		55300						
A.9.6.4.2	Training of IUD Insertion (SN/ANM/LHV)			1					1				1			29425	0		0		29425		0		29425						
A.9.8	**Programme Management Training**																														
A.9.8.2	DPMU Training			1			1		0				1			50000	0		50000		0		0		50000						
A.10.2.1	DPMUs Recruited & in Position			4												148570	445710		445710		445710		445710		1782840					DPM's Salary 48702 /PM DAM's Salary 40837 /PM M&E's Salary 34031/PM DPC's Salary 25000 /PM	
A.10.2.2	Provision of equipments/furnitures & Mobility Support for DPMU Staffs																373200		373200		543200		373200		1662800					2 DEO's Salary 12000 /PM Office Assistant's Salary 10000/PM Office Assistant's (Account) 10000/PM Medical allowamce @Rs 200/Pm for 8 Person PF @ Rs 780/PM for 10 Person Vehicle Hiring for 2 Vehicle @ Rs 18000 /PM Meeting Expenses @ Rs 8000/ PM DHS Rent	
A.10.3	Strengthening of Block PMU (Including HR, Management Cost, Mobility Support, Field Visits)	19		19												1143373	3430119		3430119		3430119		3430119		13720476						
A.10.4.1	Purchase of TALLY			3	3											17100	51300								51300						
A.10.4.2	Renewal (Upgradation)			19			19									Rs 2700 for 18 Rs 8100 for 1			56700						56700						
A.10.4.3	AMC (State, Regional & DHS)			19												Rs 10000 for 18 Rs 22500 for 1	202500								202500						

A.10.4.5	Training of Customisation of Tally			1 for DHS & 21 for DH,SDH, PHC	0		0		22						7000 For DHS & 4500 for Blocks	0		0		101500		0		101500							
A.10.4.9	Management unit in FRU (Hospital Mgr. and FRU A/c)			2											HM @ 31250 PM Accountant @ Rs 20000 /PM	307500		307500		307500		307500		1230000							
A.10.5.1	Audit Fees Statutory Audit)			9	2		2		2		3		9		9000	18000		18000		18000		27000		81000							
A.10.6	Concurrent Audit system			1											20000	60000		60000		60000		60000		240000							

Note Salary Hike shown 25% due to hard to reach area

Part - B

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)		Unit of measure (in words)	Physical Target (where applicable)										Unit Cost (in Rs.)	Financial Requirement (in Rs.)										Committed Fund requirement (if any in Rs.)		Responsible Agency (State/SHSB/Name of Development Partner)	
					Q1		Q2		Q3		Q4		Total no of Units			Q1		Q2		Q3		Q4		Total Annual proposed budget (in Rs.)					
		HFD *	State Total		HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total		HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total				
B	**Mission Flexible Pool**																											
B.1	**ASHA**																											
B.1.1	**ASHA COST**																											
B.1.1.1	Selection & Training of ASHA	2410		2490 ASHA i.e166 Batch (No.ofASHA per batch @30)	25		25		50		66		166		69350 per batch	2E+06		1733750		3467500		4577100		11512100					
B.1.1.2	Procurement of ASHA Drug Kit & Replenishment			2490											250					622500								
B.1.1.3	Other Incentive to ASHAs (TA/DA for ASHA Divas)			2490	7470		7470		7470		7470		37350		86	642420		642420		642420		642420		2569680					
B.1_1.4	**Awards to ASHA's/Link Workers**																											
B.1.1.4.A	Best Performance Award to ASHAs at District Level			57 for ASHA and Distt. Exp.							57				1000 for 1st prize 500 for 2nd prize ,3rd prizeRs 200							38000		38000					
B.1.1.4.C	Identity Card to ASHA			500			500								20			10000						10000					
B.1.1.5	ASHA Resource Centre/ASHA Mentoring Group			DCM 1, DDA 1, BCM 19, AF - 118 , Office Expenses											DCM -25000 DDA -20625 BCM-16500 AF- 1313	2E+06		1555500		1555500		1555500		6222000					
B.2	**Untied Funds**																											
B.2.1	Untied Fund for SDH/CHC			2					2				2		50000			100000						100000					
B.2.2.A	Untied Fund for PHCs			19					19				19		25000			475000						475000					
B.2.2.B	Untied Fund for APHC			32					32				32		25000			800000						800000					
B.2.3	Untied Fund for Sub Centres			220					220				220		10000			2200000						2000000					
B.2.4	Untied Fund for VHSC			1710					1710				1710		10000			17100000						17100000					
B.3	**Annual Maintenance Grants**																											
B.3.1	CHCs																											
B.3.1.A	SDH			2					2				2		100000					200000				200000					
B.3.2	PHCs			19					19				19		50000					950000				950000					
B.3.2.A	APHC			32					32				32		50000					1600000				1600000					
B.3.3	Sub Centres			100					100				100		10000					1000000				1000000					
B.3.3.A	DH			1					1				1		200000					200000				200000					A
B.4	**Hospital Strengthening**																											
B.4.1.3	PHCs (Construction of 2Doctors & 4 Staff Nurse Quarters in 5 PHCs)\			5 Doctor + 5 Nurse					15		15		30		7720000 & 8118500					47515500		31677000		79192500					
B.4.1.4	Sub Centres(Hospital Strengthening)			19					19				19		2000000					38000000				38000000					
B4.2.A	Installation of Solar Water Systemin 9 PHC			9			9						9		38500			346500						731500					
B.4.3	Sub Centre Rent and Contingencies			100											500	150000		150000		150000		150000		600000					
B5.2.C	Strengthening of Cold Chain (Refurbishment of Existing Cold Chain Room for District Stores and Earthing and Wiring of Existing Cold Chain Rooms in All PHCs			1 Dist.& and 19 PHC					20						For Dist. RS.100000& and Rs10000for PHC					2900000				2900000					

B.6	**Corpus Grants to HMS/RKS**																														
B6.1	District Hospital			1									1			500000	100000		100000		150000		150000		500000						
B6.2	CHCs (SDH)			2									2			100000	50000		50000		50000		50000		200000						
B6.3	PHCs - RKS			19									19			100000	475000		475000		475000		475000		1900000						
B6.4	Other (APHC)			32									32			100000	800000		800000		800000		800000		3200000						
B.7	**District Action Plans (Including Block, Village)**																														
B.7	District Action Plans (Including Block, Village)			1 District + 19 Block + 220 HSC+ 50 Villages			290						290			District - 50000 Block -5000 HSC -1500 Village - 1000			525000						525000						
B.7.A	Computer Assistant for Planning Cell			1												6000	18000		18000		18000		18000		72000						Propo
B.7.B	Laptop for DPC			1												35000			35000						35000						Propo
B.8	**Panchayati Raj Initiative**																														
B8.1	Constitution and Orientation of Community Leader & of VHSC,SHC,PHC,CHC Etc			246			123		123				246			1500			184500		184500				369000						
B.8.2	Orientation Workshops, Trainings and Capacity Building of PRI at State/Dist. Health Societies, CHC,PHC			1 District Level + 19 Block Level			1		19				20						2850		159900				162750						
B.9	**Mainstreaming of AYUSH**																														
B.9.1	**Medical Officers at DH/CHCs/ PHCs (Only AYUSH)**																														
B.9.1	Medical Officers at DH/CHCs/ PHCs (Only AYUSH)			30									30			20000	2E+06		1800000		1800000		1800000		7200000						
B_10	**IEC-BCC NRHM**																														
B.10	**Strengthening of BCC/IEC Bureaus (State and District Levels)**																50000		50000		100000		150000		350000						
B.10.2.1	Development of State BCC/IEC strategy																		750000						750000						
B.10.3	Health Mela																						4000		4000						
B_12	**Referral Transport**																														
B.12.2	**Operating Cost (POL)**																														
B.12.2.A	Emergency Medical Service/102-Ambulance Service			19									19			130000 PM	7E+06		7410000		7410000		7410000		29640000						
B.12.2.C	Advanced Life Saving Ambulance (Call 108)			3									3			130000 PM	1E+06		1170000		1170000		1170000		4680000						
B_13	**PPP/ NGOs**																														
B_13.3	**NGO Programme/ Grant in Aid to NGO**																														
B.13.3.B	Outsourcing of Pathology and Radiology Services From PHCs to DH			21									21			400000	2E+06		1500000		2700000		2700000		8400000						
B.13.3.D	IMEP(Bio-Waste Management)			21									21			100000	500000		500000		500000		600000		2100000						
B_14	**Innovations**																														
B.14.B	YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services																200000		200000		300000		300000		1000000						
B_15	**Planning, Implementation and Monitoring**																														
B.15.3	**Monitoring and Evaluation**																														
B.15.3.1	**Monitoring & Evaluation/HMIS/MCTS (State, District , Block & Divisional Data Centre)**																														
B15.3.1.A	State, District, Divisional, Block Data Centre			21									21			12000	756000		756000		756000		756000		3024000						Propose 12000 f Cen
B.15.3.2	**Computerization HMIS and E-Governance, E-Health (MCTS, RI Monitoring, CPSMS)**																														
B.15.3.2.A	MCTS and HRIS (Training)			1 District +13 PHC Level																	394589				394589						
B.15.3.2.B	RI Monitoring																		40000		45000		45000		130000						

B.15.3.3	**Other Activities (HMIS)**																													
B.15.3.3.A	Strengthening of HMIS (Up-Gradation and Maintenance of Web Server of SHSB)			21					21				21			4000					84000									Pr Ext Disk D
B15.3.3.B	Plans for HMIS Supportive Supervision and Data Validation			48 Visit by M& E and 76 Visit by RP+ 1 Quarterly Bulletin	31		31		31		31		124			M& E @ 1500 RP @ 5000	125500		125500		125500		125500		502000						
B15.3.3.C	Additional Data Centre for DHS & PHC			21									21			12000	252000		252000		252000		252000		1008000					P A
B15.3.3.D	Website Development & Innovations			1									1			100000			100000						100000					P A
B_16	**PROCUREMENT**																													
B.16.1	**Procurement of Equipment**																													
B.16.1.3	**Procurement of Equipment: FP**																													
B16.1.3.A	Procurement of Minilap Set (FP)			1																			285000		285000					
B16.1.3.B	Procurement of NSV Kit (FP)																						5500		5500					
B16.1.3.C	Procurement of IUD Kit (FP) (PHC Level)																						15000		15000					
B16.1.5	**Procurement of Others**																													
B16.1.5.A	Dental Chair Procurement			5					5				5			283500					1417500				1417500					
B16.1.5.E	POL for Vaccine Delivery From State to District and to PHC/CHC																50000		50000		50000		50000		200000					
B.16.1.1	Procurement of Equipment: MH (Labour Room)																				1000000				1000000					
B 16.2	**Procurement of Drugs and Supplies**																													
B16.2.1	**Drugs & Supplies for MH**																													
B16.2.1.A	Parental Iron Sucrose (IV/IM) As Therapeutic Measure to Pregnant Women with Severe Anaemia																				500000				1000000					
B.16.2.1.B	IFA Tablets for Pregnant & Lactating Mothers																				1700000				1000000					
B16.2.2	**Drugs & Supplies for CH**																													
B.16.2.2.A	Budget for IFA Small Tablets and Syrup for Children (6 -59 Months)																				2200000				1000000					
B16.2.2.B	IMNCI Drug Kit																				1500000				1500000					
B16.2.5	General Drugs & Supplies for Health Facilities																				6000000		6000000		12000000					
B.22.3	Support Strengthening NVBDCP																													
B.22.4	Support Strengthening RNTCP																60000		60000		60000		60000		240000					
B.22.5	Contingency Support to Govt. Dispensaries																													
B.22.6	Other NDCP Support Programmes																													
B_23	**Other Expenditures (Power Backup, Convergence Etc)-**																													
B.23.A	Payment of Monthly Bill to BSNL																													

Note Salary Hike shown 25% due to hard to reach area

Part - C

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)		Unit of measure (in words)	Physical Target (where applicable)										Unit Cost (in Rs.)	Financial Requirement (in Rs.)										Committed Fund requirement (if any in Rs.)		Responsible Agency (State/SHSB/Name of Development Partner)	
					Q1		Q2		Q3		Q4		Total no of Units			Q1		Q2		Q3		Q4		Total Annual proposed budget (in Rs.)					
		HFD *	State Total		HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total		HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total	HFD	State Total				
C	Routine Immunisation & PP																											
C.1	Routine Immunisation																											
C	Routine Immunisation																											
C.1. A	Mobility Support for Supervision for DIO														50000	12500		12500		12500		12500		50000				
C.1.C	Printing & dissemination of Imm Format , Tally Sheet & Monitoring Formats															127706		127706		127706		127706		510824				
C.1.E	Quarterly Review Meeting at District Level			4	1		1		1		1		4		9500	9500		9500		9500		9500		38000				
C.1.F	Quarterly Review Meeting at Block Level			4	1		1		1		1		4		170700	9500		9500		9500		9500		38000				
C.1.G	Focus On Slum and Underserved areas in Urban Area															134400		134400		134400		134400		537600				
C.1.H	Mobilistaion of Children Through ASHA Under Muskan Ek Abhiyan															160013		160013		160013		160013		640052				
C.1.I	Alternate Vaccine Delivery in Hard To Reach Area															49500		49500		49500		49500		198000				
C.1.J	Alternate Vaccine Delivery in Other Area															543900		543900		543900		543900		2E+06				
C.1.K	To Develop Microplan at Sub Centre Level																	55300						55300				
C.1.L	Consolidation of Micro Plan at Block Level																	21000						21000				
C.1.M	POL for Vaccine and Logistic Delivery From District To PHC															30450		30450		30450		30450		121800				
C.1.N	Consumable for Computer including Provison for Internet Access Rs 400 /Month														400	1200		1200		1200		1200		4800				
C.I.O&P	Red / Black Plastic Bags															23391		23391		23391		23391		93564				
C.1.Q	Saftey Pits																			50000				50000				
C.1.R	Alternate Vaccinator															3750		3750		3750		3750		15000				
C.2.B	Computer Assistant Support at District Level														10000	30000		30000		30000		30000		120000				
C.3.A	Distrct Level Orientation Training															240000		240000		240000		240000		960000				
C.3.D	Cold Chain Handler training																			22000								
C.3.E	Data Handler training																			22000								
C.4	Cold Chain Maintenance															19750		19750		19750		19750		79000				
	TOTAL															1E+06		1E+06		1489560		1E+06		6E+06				

Part - D