Khamnor Block Public Health Strategies
An Action Plan

2014-2015

Model Districts Health Project
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Acknowledgements

This document has evolved as a discussion between the Principal Health Secretary – Rajasthan state, Mr. Mukesh Sharma (I.A.S.) and Dr. Nirupam Bajpai (Project Director, MDHP, Earth Institute). Earth Institute at Columbia University would like to thank the Principal Health Secretary and Mission Director, Mr. Naveen Jain (I.A.S) to let the team engage in this opportunity to support the work being done in Rajasthan.

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List of Abbreviation

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Center
AWW	Anganwadi Worker
BAF	Block Asha Facilitator
BAM	Block Accounts Manager
BCMO	Block Chief Medical Officer
BCC	Behaviour Change Communication
BPM	Block Programme Manager
BSU	Blood Storage Unit
CMHO	Chief Medical and Health Officer
CHC	Community Health Center
DC	District Collector
DH	District Hospital
EI	Earth Institute
FRU	First Referral Unit
HD	Home Delivery
IEC	Information Education and Communication
ID	Institutional Delivery
IDR	Infant Death Review
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illness
IYCF	Infant and Young Child Feeding

IUD	Intra Uterine Device
LR	Labour Room
LSAS	Life Saving Anaesthetic Skills
MCH	Maternal and Child Health
MDR	Maternal Death Review
MMR	Maternal Mortality rate
MNH	Maternal New-born Health
MOHFW	Ministry of Health and Family Welfare
MOIC	Medical Officer In Charge
MoU	Memorandum of Understanding
MTC	Malnourishment Treatment Centre
NBCC	New Born Care Corner
NBSU	New Born Stabilization Unit
NSSK	Navjat Sishu Surakasha Karyakaram
PHC	Primary Health Centre
PNC	Post Natal Care
PPIUCD	Post-partum intrauterine contraceptive devices
RMNCH+A	Reproductive Maternal New-born Child and Adolescent Health
SBA	Skilled Birth Attendant
SC	Sub Centre
SDM	Sub Divisional Magistrate
SDR	Service Delivery Register
SN	Staff Nurse

Summary of Recommendations

The following recommendations have the potential to improve service delivery for maternal and child care with block level changes monitored through process indicators. Engagement and support from governance at all levels (State to Block) is crucial. Implementing this plan would provide a gauge of the amount of time required to efficiently implement basic recommendations which in turn can assist in evidence based planning for larger recommendations, taking limitations and constraints and strengths into account.

Please Note: The detailed rationale, advantages and description of recommendation along with primary body responsible for implementation is described in this paper, following the summary of recommendations. Please refer to specified page numbers for details.

1. Increasing uptake of post-partum intrauterine contraceptive devices (PPIUCD) in Peripheral areas of Khamnor (Page 16)

Short term recommendations:

- ASHA should be sensitized and motivated for better counselling on PPIUCD and Spacing
- Regular monitoring of PPIUCD equipment and if in shortage purchase immediately from untied fund
- PPIUCD training to those service providers who are posted at high delivery load facilities
- Review of PPIUCD should be done at block and district level on regular basis.
- Incentivization for ASHAs to motivate women for PPIUCD (already included in PIP)

Long term recommendations:

- A community based survey to understand, which family planning methods eligible couples are interested in, sterilization candidates, barriers to family planning
- Innovative IEC should be developed to influence young generation about importance of family planning and available family planning methods

2. Review of Maternal Deaths and Reporting of Infant Deaths at Sector and Block meetings to Identify Systemic Gaps (Page 20)

Short term recommendation

- Review of maternal deaths and discussion on infant deaths in block and sector level meetings to identify the gaps and subsequent corrective actions planned and taken
- Quality training of MOIC and BCMOs on conduction of social audit and verbal autopsy for maternal death and infant death reporting
- Skill building of ASHA to sensitize community towards maternal and infant deaths
- Relevant IEC in the community towards 3 delays and the crucial role they play, hygiene post-delivery for mother and child.

- Reviews maternal deaths and discuss infant deaths during DHS by DC, as per the GoI guideline. Responsible officers should be instructed to take necessary actions.

Long term recommendations:

- ASHA should be incentivized on reporting of infant deaths which may help resolving the under reporting issue.
- Validation of social audit: it can be done through cross block/district exercise where one block/district validates information from another.
- A block level samelan for Sarpanch and Ward Panch: It is recommended that Sarpanches and Ward Panches should participate in social audits.
- Training of Trainers for Rajasthan on Infant and Child Death Review.

3. Functionalization of FRU - operationalizing Blood Storage Unit and availability of specialized manpower (Page 25)

Short Term Recommendation:

- Deployment of specialist, paediatrician and anaesthetist from different places where one specialist is already available.
- Rational Deployment of nursing staff within the block for 24 x 7 availability of services.
- Training of BSU staff at CHC Khamnor
- Renewal of license for blood storage unit from licencing authority at CHC Khamnor

Long Term Recommendation:

- Life Saving Anaesthetic Skill training of any one of the MBBS doctors at CHC (18 weeks)

4. Strengthening of facility in areas with high home deliveries (Page 28)

Short term recommendation:

- Identification of potential facilities for conducting deliveries close to areas having high number of home deliveries
- Assessment of basic infrastructure at facilities which include building, water supply and electricity
- Scrutinising SN/ANMs about their willingness, skill and confidence to conduct deliveries at sub centers and CHC/PHCs where staff nurse not available.
- Special effort on IEC should be put to generate awareness about functionalization of facilities as delivery points

Long term recommendation:

- Recruitment of staff nurses and their deputation based on need of facilities where high

deliveries are conducted
- Supportive Supervision to strengthen facilities on regular basis

5. Fund Utilisation (Page 32)

Short term recommendations:

- Verifying the expenditure against the activity rather than vouchers only
- Strict monitoring of utilization of untied fund every month in District Health Society and block meetings
- Provision of quarterly internal auditing of facility accounts
- Orientation of financial guidelines and accounting procedure to facility in-charges
- Block officials should start reconciliation of previous unsettled accounts using a camp approach
- State government should issue directions to involve block accountants in a committee where tender processes have to be followed

Long Term Recommendations:

- Un-tied fund allocation should be based on population, need or performance based criteria
- Filling up of vacant post of accountants in the block to streamline the accounting system
- Include fund utilization and settlement in performance appraisal mechanism of different cadres to establish accountability and acknowledge good performers.
- State Pre-Spending for Central Govt, till money is released to avoid delay in utilization

Introduction

The Earth Institute at Columbia University collaborated with the MOHFW to work towards the Model Districts Health Project to provide technical support in implementing the recommendations from the mid-term evaluation of NRHM, conducted by the Earth Institute. More specifically the focus was on the Millennium Development Goals 1, 4 and 5: improving the nutrition status of women and children and reducing maternal and child mortality by 2015. Currently Earth Institute supports three states- Rajasthan, Telangana and Jharkhand. Within these states EI works in two districts. In Rajasthan one was selected for the Model Districts Project (Dausa) and one High Priority District (Rajsamand) where EI is the lead development partner for RMNCH+A.

The Model Districts Project focuses on health systems strengthening through implementation research, strategic technical advice, monitoring and evaluation, and policy advocacy to help ensure the successful scaling up of services. It is ultimately the district governments and district health units that are responsible for implementing the quality improvements, best practices, and innovations based on the situational analysis. State governments and NRHM offices have a key role to play in driving innovations at a district level, and providing additional funding on evidence based need.

An Action Plan for Public Health Strategies – Khamnor Block, Rajsamand

The basic recommendations in the plan aim to serve as a roadmap towards improving the service delivery and strengthening the public health systems to function with better efficiency. It is a micro-level plan which is a building block towards designing a macro-level district based plan and can also have implications for the state. The implementation aspect would be the responsibility of the State, District and Block Health Units along with our technical support.

Rationale

Rajsamand is a hilly district with a large population of tribal groups and migrant labourers that mainly stay in rural areas. The district belongs to the Udaipur division which has seven blocks viz. Amet, Bhim, Kelwara, Khamnor, Rajsamand, Railmagra and Deogarh. Khamnor block has one Sub District Hospital (SDH Nathdwara) and CHC Khamnor, both of which need strengthening to become functional FRUs. Khamnor has been selected for devising the road map, as the health facilities and the recruited public health cadre cater to a large population. Most emergency cases are being currently referred to Udaipur Medical College. Hence, strengthening the service delivery and public health systems of the block can have a direct impact on health outcomes.

Method

The scope of this plan includes addressing some major gaps which include skilled human resource management, infrastructural gaps, and non-functional state of FRUs, to make service

delivery more efficient. These have been drawn out on thematic assessment of indicators, review of block profile, discussion with district and block officials, block monitoring and supportive supervision visits conducted by EI, the perspective of field workers, and challenges and issues faced by them.

Block Profile

Khamnor is located 46 km from Rabindranath Tagore Medical College, Udaipur and 26 KM from district headquarters Rajsamand. The block has a population of 269823 and 186 revenue villages.

Status of health facilities in the block:

Health Facilities	Sanctioned	Functional	Remarks
Sub District Hospital	1	1	
First Referral Unit	1	0	Khamnor not functional
Blood Storage Unit	1	0	Khamnor not functional
Community Health Centers	3	2	Jhalo Ki Madar not Functional
Primary Health Centers	10	8	Bada Bhanuja, Nedach Not Functional
Subcenters	53	38	Chota Bhanuja, Mokhada, Roothjena, Ratanwato Ki Bhagal, Kaag Madarada, Neechli Odan, Pasuniya, Rawacha, Gunjol, Puplwas, Usaan, Kedi, Madka, Dhayala, Parawal
Delivery Points	2	2	
MTCs	1	1	
SNCU	0	0	
NBSU	2	2	
NBCC	NA	10	
Private Hospitals	NA	2	Purohit hospital in Nathdwara, Dr. Rekha Sharma's hospital in Nathdwara.

Strengths of the Khamnor Block

- FRU SDH Nathdwara is located 15 km and the DH Rajsamand is 35 km from Khamnor centre. Therefore currently cases that cannot be handled by the CHC Khamnor can be referred there.
- BCMO, BPM and other officials are able to provide well maintained records; block NHM unit is well versed with programming and has an appreciable hold over the block.
- At facility level record maintenance of OPD, IPD and delivery register is appreciable at majority of the facilities.
- IEC material is displayed in the labour rooms of all the health facilities. Infrastructure of all the labour rooms and the JSY wards is good and they are well equipped maintaining good sanitation and hygiene.

Situational Analysis

A basic thematic situational overview of Khamnor block has been organised over the RMNCH framework to identify the gaps and select specific areas to be addressed.

Major area	Core Issues	Actual status of the activity	Recommendations to improve	Responsibility
Reproductive Health				
Family Planning	**PPIUCD**	-In 2012 total PPIUCD insertion was 0 which increased to 2 and 404 (Apr'14 - Feb'15) in 2013 and 2014 respectively (PCTS) -Mainly Khamnor CHC and SDH are performing PPIUCD insertion, but no other peripheral facilities	- Sensitize ASHAs about PPIUCD for more rigorous counselling - Train ANMs which are actively performing deliveries for PPIUCD insertion.	- District - State
	Fixed Day Static Service	- Currently no sterilization cases are being conducted at CHCs.	-BCC for improved uptake among community.	-District
Maternal Health				
ANC	**12 week ANC coverage**	- Based on the last three years of PCTS data, ANC registration within 12 weeks is stagnant at around 62%.	-Nischay kit should be available at sector PHCs without stock out. It will help in improving the early detection of ANC	-District
	3 ANC Check-ups	-Figures for 3 ANC check-up have declined in the past 3 years from 80% (2102-13) to 63% (2014-Feb '15) against the total number of ANC registered (PCTS)	-Regular monitoring of ASHA -Motivation of good performing ANM from each block through certificate and monetary incentives.	-MO -District collector -District
	IFA	-Poor skills in prescribing IFA observed during MCHN visits. The difference between therapeutic and prophylactic dose in unclear. -Lack of counselling over when and how to	- ANM supervision during MCHN day by district or block officials - Training to ANM on counselling and prescribing therapeutic and prophylactic	-District -Block

Major area	Core Issues	Actual status of the activity	Recommendations to improve	Responsibility
		consume IFA.	dose of IFA	
HRP	**Inability to identify high risk pregnancy**	- Lack of skills and confidence among ANMs - No special register at facility level - 'Red stickers' on Mamta card is not being prioritized at facility level	- Incentive for identification to ASHA - Strengthening of skills of ANMs through supportive supervision - Developing a HRP register with pre-defined columns - IEC for HRP and BCC through ASHA	-State -District
	Tracking	No tracking mechanism	-Inclusion of new subtitle in PCTS "no. of HRP identified "	-State
	Management	-Iron sucrose camps are being held at CHC level only -Unavailability of blood transfusion facility at FRU's - Unavailability of specialized staff (Anaesthetists) at SDH and CHC Khamnor (Obstetrician, Gynaecologist, Paediatrician and Anaesthetists)	- Iron Sucrose injection can also be administered by MO I/C of PHCs - Reminder calls to severally anaemic pregnant women for attending the Iron Sucrose camps - Blood transfusion facility should be made available at SDH/FRU - FRU should be fully functional (C-section facility, blood storage unit) - Proper referral channel for functional FRUs should be pre decided to avoid delays - LR staff training regarding management of High Risk Pregnancy.	-District
Labour Room	**Quality in LR**	-Disinfection protocols are not being followed (Observed during BMVs)	-Regular monitoring of LR by Block Officials	-Block -District

Major area	Core Issues	Actual status of the activity	Recommendations to improve	Responsibility
		-Partograph not being filled/incorrectly filled (Observed during BMVs) -Unavailability of essential drugs in Labour room of non-delivery points. (Observed during BMVs)	-Training on disinfection to MOIC, LR staff and class IV workers	
Home Delivery	**Mapping of area with high HD**	-Decline has been observed in home deliveries from 604 (2012-13) to 359 (2014-15) (PCTS), however it is high though the block does not have hilly or difficult areas to reach	-Identification of areas with high home deliveries. -Strengthening of facilities of those areas as potential delivery points with the help of untied funds -Counselling on institutional delivery during ANC - Development of IEC material for village with high home delivery	-District - Block
MDR	**MDR**	- Social audit of maternal deaths being done, however the quality of doing the social audit is questionable (findings are based on validations of social audit of maternal death in Rajasthan) - There is under reporting of maternal deaths the reason may be fear among ANM and ASHA	- Co-ordination between health department and birth and death registrar office to extract the information on maternal deaths -Discussion of MDR findings in sector, Block and DHS meeting for corrective action -Training of ASHA and ANM on importance of social audit for maternal death	-District
Institutional	**Quality of**	- Delivery points are well equipped and have	- Skill assessment and regular monitoring	-District

Major area	Core Issues	Actual status of the activity	Recommendations to improve	Responsibility
Delivery	**services rendered**	good infrastructure but due to poor skills of ANM (in conducing deliveries and managing complication) many deliveries are going to higher center like medical college.	of poor performing ANMs at delivery points - SDH Nathdwara and CHC khamnor are the FRUs in the block, they should be functional	
	JSY Payment	-During BMVs it has been seen that JSY payment done from PHCs or CHCs	- Sub centers which are not designated delivery points but conducting deliveries should also be allowed to provide JSY payment at sub center level. Extra untied fund should be provided to SCs that are conducting deliveries.	-Block
Child Health				
NBSU	**Functionalization of NBSU**	- NBSU is functional at SDH and not functional at Delwara CHC due to lack of paediatrician and skilled staff	- Hire separate staff for NBSU - MO and required staff to be trained for NBSU management - Functionalization of NBSU at Delwara	-District
NBCC	**Strengthening NBCC and Inj. Vitamin K**	- Radiant warmer is available at all delivery points. -Low availability of Inj. Vitamin K (Findings based on BMVs)	- Provision of traditional bulb system at facilities which performs delivery and radiant warmer not available. -Ensure availability of Vitamin K at all facility.	-Block
Infant Death Review	**Status of IDR**	- Under reporting of infant deaths - No review of infant deaths reasons in DHS and block level meetings	-Discussion of Infant Deaths and findings should be initiated at sector, Block and DHS meeting for corrective actions - Training on Infant Death Review by GoI	- Block - District -State

Major area	Core Issues	Actual status of the activity	Recommendations to improve	Responsibility
			needs to be done	
Breast Feeding	**Early breast feeding**	- PCTS data reveals that all are children not feeding within 1hr of delivery	- Service provider (labour and JSY ward staff) should be sensitized and ensure feeding within 1 hr	-Block
MTC	**Admissions at MTC**	-MTC is in working condition at SHD (based on available resources) but issue is referral from field	- Incentive to ASHAs may improve referral - Training to ASHA about identifying SAM children	-State
Pneumonia and Diarrhoea	**Pneumonia and Diarrhoea Management**	-Out of total children death between 1 to 5 year, 20 deaths were due to pneumonia and 2 deaths were due to diarrhoea (PCTS – data from Apr'14 to Feb'15) -Availability of ORS and Zinc is poor at block level (findings based on BMVs)	-Incentive to ASHA on identification on severe diarrhoea and pneumonia cases. -Inclusion of district specific action plan in PIP - Availability of ORS and Zinc should be ensured.	-State -District
Immunisation	**Full Coverage**	- Based on AHS (2012-13), 12-24 month children, 65% children found full immunized	-Monthly special catch up round for drop out children (like Indradhanush model) - Appropriate IEC and BCC events should be organised for the awareness in the community - Non-reachable areas, high risk pockets need to added in the micro plan of immunisation like the district does for polio micro plan - At district and block level, review of immunisation should be held on quarterly basis and independent survey should be	- District -Block

Major area	Core Issues	Actual status of the activity	Recommendations to improve	Responsibility
			done through third party to understand the gaps and challenges in the field.	
Miscellaneous				
MCHN Session	**Quality of MCHN sessions**	The below findings are based on selected MCHN day monitored: -Unavailability of logistics -Lack of counselling -poor ANM skills (for example Hemocheck) -Less equipped AWC for MCHN Sessions -Incomplete SDR	-ANM should ensure availability of missing logistics through untied funds -Regular monitoring of MCHN session by the sector MOIC -Strengthening of ANM skills through block meetings -Review MCHN day in DHS particularly quality of MCHN day and no. of MCHN days visited per month by MO IC, block and district level officers	-District -Block
Human Resources	**Deputation of IA in other department and Headquarter stay**	-Information Assistant (IA) posted in Bhamashah Yojana, prevents him/her from regular data entry in PCTS -Head quarter stay of staff – currently assigned staff not utilizing it and staff willing to stay does not have it (ANM/Staff Nurse/Doctors).	-IA should be relieved from other government department -In case deputation of IA is required then collector should make arrangement that they should work for 3 days in original department and 3 days in other department.	-District -Block

Selected Focus Areas - Potential for Impactful Change in a Short Term

1. Increasing uptake of PPIUCD in Peripheral areas of Khamnor

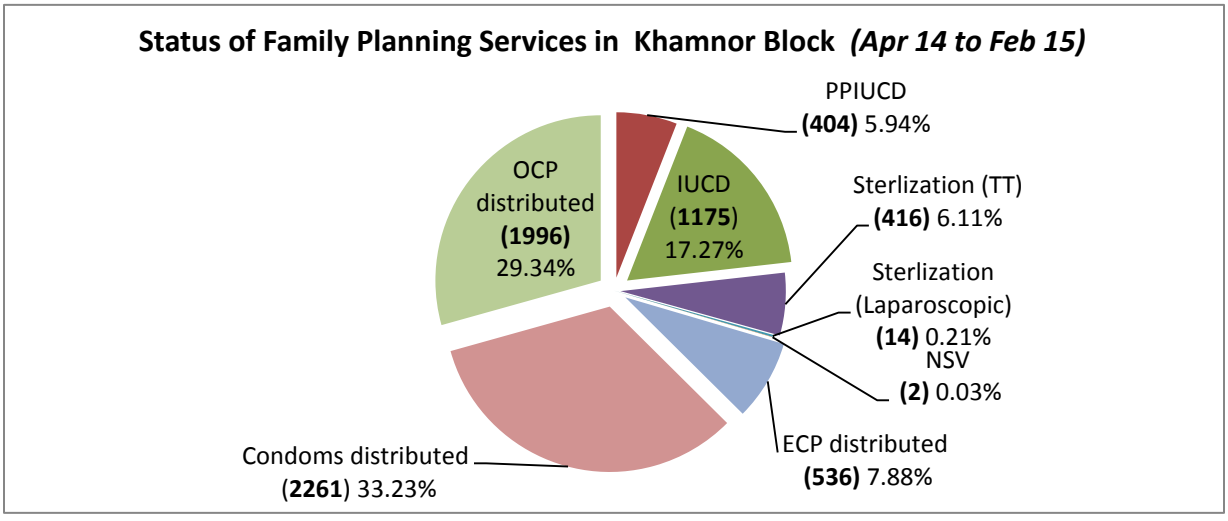
Rationale:

Increase in Institutional Deliveries:

The Rajasthan state's commitment to pursue a robust strategy for improving the maternal and child health outcomes in the state, including the Janani Suraksha Yojana (JSY), and Janani Shishu Suraksha Karyakaram (JSSK), has resulted in more than 75% institutional deliveries in the public health institutions, presenting a unique opportunity for strengthening introducing postpartum IUCD (PPIUCD) services at the public sector health facilities, and repositioning family planning as a maternal neonatal and child health initiative.

High Total Fertility Rate:

Rajasthan is a state with high fertility rates, low socio demographic indicators and is one of 8 EAG states (Source-AHS 2012-13). Total Fertility Rate (TFR) for Rajasthan is 2.9 (AHS 2012-13) is higher than the national average 2.3 (SRS 2013). Most mothers in Rajasthan, especially in the rural areas, loose one or more children. The mortality in children belonging to scheduled castes, scheduled tribes and OBCs is higher than in other social groups, as a result of which the TFR in these groups is also higher (Rajasthan Development Report 2004). The TFR of Rajsamand is almost 3.78 which is higher than 2.9 the Rajasthan average (Source-AHS 2012-13).



Spacing: The district health team revealed lack of openness in the community towards reception of family planning measures. The pie chart above indicates the diminutive uptake of sterilisation methods (only 2 male sterilization cases were performed); whereas temporary

methods have a large uptake (70.45% assuming all distributed items have been consumed). However the data for EC pills, OC pills and condoms cannot be validated at ground level due to their consumable nature. The distribution of emergency contraceptive (EC) pills is about 8% which is even higher than PPIUCD. It suggests that community doesn't have access to family planning services which compromise their unmet need and more depend on EC pills. Apart from social norms, quality of services provided and skills and attitude of the service providers also impact family planning acceptance in the community and the unmet needs**.** In such a scenario PPIUCD method should be encouraged as it can be more **receptive, monitored and also encourages spacing.**

Sterilization According to number of Children	
1 Child	1
2 Children	175
3 Children	143
4 or More Children	113
Total	**432**

Gaps and strengths:

- Training data on PPIUCD of CHC Khamnor is not available while at SDH Nathdwara there are only 3 GNMs and 1 Medical Officer who are trained.
- According to PCTS, 4 PHCs out of 7 in Khamnor Block show maximum deliveries. PPIUCD training can be given to available staff, ANMs and MOs to strengthen this service.
- Last three year PCTS data reveals increase in use of PPIUCD in the block at CHC Khamnor and at SDH (0 in 2012-13, 155 in 2013-14, and 404 in 2014-15). However it is zero in peripheral area.

Comparison between Institutional Deliveries and PPIUCD services (April '14 to Feb '15)

Facility Name	No. of deliveries	No. of PPIUCD	%
Nathdwara SDH	1298	183	14.1%
Delwara CHC	791	1	0.1%
Jhalo Ki Madar CHC	12	0	0.0%
Khamnor CHC	606	212	35.0%
Aakodadra PHC	9	1	11.1%
Bada Bhanuja PHC	0	1	
Fathepura PHC	0	0	
Kotharia PHC	4	0	0.0%
Machind PHC	27	0	0.0%

Facility Name	No. of deliveries	No. of PPIUCD	%
Needch PHC	0	0	
Saloda PHC	4	2	50.0%
Salor PHC	12	3	25.0%
Sayo Ka Kheda PHC	4	1	25.0%
Sishoda PHC	5	0	0.0%
Total	2772	404	14.6%

At CHC Delwara a high number of deliveries (791) were performed but PPIUCD insertion was very less due to non-availability of trained staff. CHC Khamnor performed well comparatively due to availability of trained staff. PHC Machind where maximum deliveries were performed, there was no insertion of PPIUCD. However PHCs Salor and Saloda showed good numbers.

Short term Recommendations:

- **Sensitization of ASHAs on Counselling for PPIUCD and Spacing**
    - MOI/C should organize regular meetings at PHC level and motivate all ASHAs on BCC and counselling.
    - PPIUCD counselling should be coupled with couples counselling for spacing of birth. All the advantages should be described and the risks and disadvantages for mother and child when the pregnancies are not well planned should be highlighted.
    - ASHA should be rewarded not only financially, but also certificates should be distributed at different level (block, district and state level)

- **Monitor the availability of PPIUCD equipment**
    - At block level BCMO should monitor availability of required equipment for the PPIUCD on regular basis
    - There should be provision to purchase PPICUD equipment in case of shortage from untied or RMRS fund.

- **Training of service providers:** -
    - Training of service providers should be done based on priority. Personnel working in facilities with high deliveries should be trained first.

- **Review of PPIUCD** should be done at block and district level on regular basis

Long term recommendations:

- **A Survey:** a community based survey should be conducted by third party to understand
    - family planning methods eligible couples are interested to use
    - Barriers to family planning methods
    - Candidates for sterilization.
- This will provide a clear picture about the unmet need of community and their choices. Based on the survey, block health team can decide their strategy in a more holistic way.

- **IEC:** Innovative IEC should be used based on the survey. Different mechanism like Whatsapp messages, animated pictures should be developed to influence young generation about importance of family planning and their different methods.

- **Incentivization for ASHAs for motivating women for PPIUCD:** This has been included in the state PIP and should be strongly advocated.

Recommendations	**Responsibilities**
Sensitization of ASHAs on Counselling Activities for PPIUCD and spacing	MOIC
Monitor the availability of PPIUCD equipment	Block
Training of service providers on PPIUCD	District/state
Review of PPIUCD at block and district level	Block and district
A survey to understand community need for family planning	Block and district
Innovating IEC for awareness generation on family planning	District and state
Incentivization for ASHAs for PPIUCD	State

2. Review of Maternal Deaths and Reporting of Infant Deaths at Sector and Block meetings to Identify Systemic Gaps

Maternal Deaths:

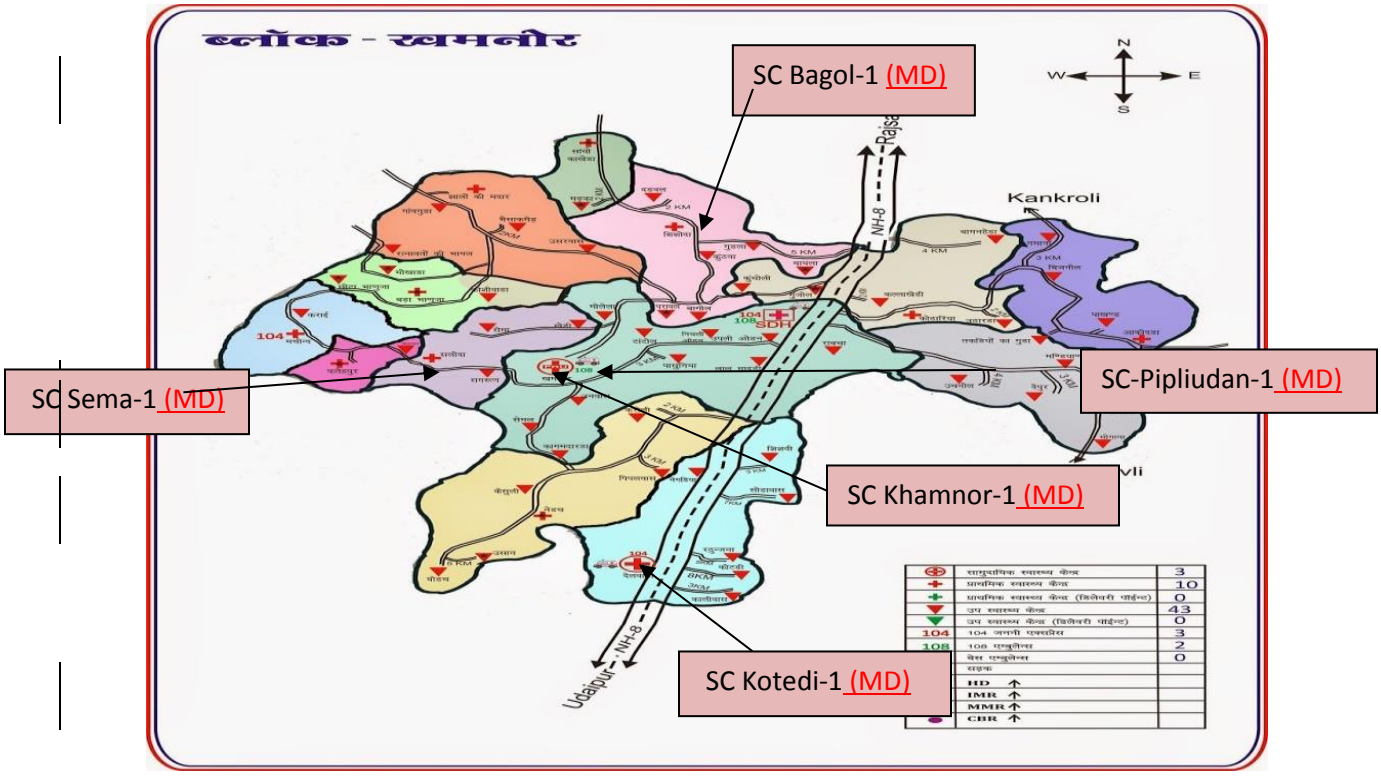
Rajsamand is situated in Udaipur zone. The zonal MMR as per AHS 2010-2011 was 364 which have reduced to 265 as per AHS 2012-13. Although this is a positive decline, it still constitutes a large figure and needs to be addressed. 38 maternal deaths have been reported in Rajsamand last year of which Khamnor contributed 13% (PCTS April 2014- Feb'15). As compared to the AHS data this number is marginal. One of the potential reasons could be under reporting of maternal deaths, due to fear in field level workers about judging the quality of their services. This compromises data quality and designing evidence-based solutions. Social Audits have been conducted; however no awareness and discussions on how to address system gaps have been observed.

Maternal deaths in Khamnor April '14- Feb'15 (PCTS)

Sr. No.	Maternal Death	Village from where she was	Facility for the village	Details About Delivery and Death	Death Reason (RCHO, Rajsamand)	Death Reason (PCTS)	Review Done	Audit Done
1	Kamli devi	Bilota	Delwara	Kotedi SC, 03/2/15	Nausea and Vomiting	Cause Unknown	Y	N
2	Kalashi	Dingala	Khamnor	Pipliudaan 26/8/14	DOTS TB	Cause Unknown	Y	Y
3	Navli	Sema	Saloda	Sema SC 14/7/14	Anaemic	Cause Unknown	Y	Y
4	Puspa	Josiyo ki madri	Sisoda	Bagol SC 25/12/14	Bleeding	Bleeding	Y	Y
5	Kanni Gadri	Tatol	Khamnor	Khamnor SC 14/1/15	N/A	N/A	Y	Y

The clinical cause does not point to the specific health system gaps related to cause of death. Stating 'Cause Unknown' brings out no critical finding to proceed with evidence based planning.

Mapping of Maternal and Infant deaths Khamnor Block
ID- Infant Death and MD- Maternal Death



Infant Deaths:

Neo-natal mortality rate of Rajsamand is 38 whereas state average is 37 (source). The infant mortality rate is 59 as per AHS 2012-13 which is higher than the state average (55/1000 live births). Child mortality for under 5 deaths is 80 whereas state average is 74 (AHS 2012-13). This underscores the importance of understanding information relevant to these deaths to engage in data driven planning.

Block and district neo-natal, infant and under 5 child deaths

(Source PCTS, Apr '14 to Feb '15)

Indicator	Khamnor block	Rajsamand district	Contribution of Khamnor block to Rajsamand district
No. of Neo-natal deaths	56	214	26%
No. of Infant deaths	88	402	22%
No. of Under 5 years deaths	97	542	18%

Note: Line-listing of neo-natal, infant and child death is attached in annexure

Details of Neo-natal, Infant and Under Five Child deaths which have occurred in the Khamnor block during April 2014-Feb2015 (PCTS)

Children deaths within 24 hours of their birth			9
Infant death up to 4 weeks by cause	Up to 1 Weeks of Birth	Between 1 Week & 4 Weeks of birth	Total
Sepsis	7	4	11
Asphyxia	0	1	1
LBW	18	2	20
Tetanus	0	0	0
Others	13	2	15
Total	**38**	**9**	**47**
Infant/Child death up to 5 years by cause	Between 1 months and 11 months	Between 1 year and 5 year	Total
Pneumonia	18	2	20
Diarrhea	2	0	2
Fever related	1	1	2
Measles	0	0	0
Diptheria	0	0	0
Others	11	6	17
Total	**32**	**9**	**41**

Only reporting clinical cause limits policy makers at state level to discuss and draw out the system gaps.

Rationale:

Facility based and social audits of reported maternal deaths is being currently done, however further focus is required to take evidence based actions. A review of maternal deaths and discussion on infant deaths at block and sector meetings could draw out **health systems related information and gaps leading to the cause**, apart from clinical cause of death. Preventive and corrective actions can be planned accordingly.

Advantages:

- Discussion between health personnel at all levels for steps that could have been potentially taken to prevent deaths and plan for future steps - short and long term.
- Complete Information reaching field workers which also serves as a feedback mechanism so that there is a broader awareness of cause and greater engagement overall.

Short term recommendation:

- **Review of maternal deaths and discussion on infant deaths in block and sector level meetings:** To identify the gaps and subsequent corrective actions planned and taken

- **Quality training of MOIC and BCMOs on conduction of social audit and verbal autopsy for maternal and infant death reporting**
    - Train health workers in the use of the maternal death audit form, as formal tools for the audit process and how to use the audit findings
    - Address the concerns and fears of health workers regarding maternal and infant reporting and auditing
    - Sensitize Maternal Death Review (MIDR) Committees- Local community representatives, including family member of deceased should participate during social audits. Meeting minutes should be shared with district officials.
    - Train concerned personnel on which aspects of infant death should be discussed

- **Skill building of ASHA** to sensitize community towards maternal and infant deaths
    - Sensitize the ASHA with establishing how deaths can be identified.

- **Relevant IEC in the community** towards 3 delays and the crucial role they play, hygiene post-delivery for mother and child.

- **Reviews** maternal deaths and discuss infant deaths **during DHS** by DC, as per the GoI guideline. Responsible officers should be instructed to take necessary actions.

Long term recommendations:

- **ASHA should be incentivized** on reporting of infant deaths which may help resolving the under reporting issue.

- **Validation of social audit:** it can be done through cross block/district exercise where one block/district validates information from another. The validation should be discussed at DHS where quality of social audit can be discussed in length. In HPDs, it should be also discussed in RMNHC+A meetings.

- **A block level samelan for Sarpanch and Ward Panch:** It is recommended that Sarpanches and Ward Panches should participate in social audits.

- **Training of Trainers for Rajasthan on Infant and Child Death review.**

Recommendations	Responsibilities
Training of MOIC and BCMO on conduction of social audits	State
IDR as per CDR guidelines	District
Review in Block and Sector meeting	MOI/C/Block official
Skill building of ASHA to sensitize community towards maternal and infant deaths	MOI/C /Block official
Relevant IEC for community	State
Discussion in DHS for corrective action	District
Incentive to ASHAs for infant death	State
Validation of social audit	State/District
A block level Samelan for Sarpanch and Ward Panch	Block official District
Training of Trainers on Infant and Child Death review	GoI State

3. Functionalization of FRU - operationalizing Blood Storage Unit and availability of specialized manpower

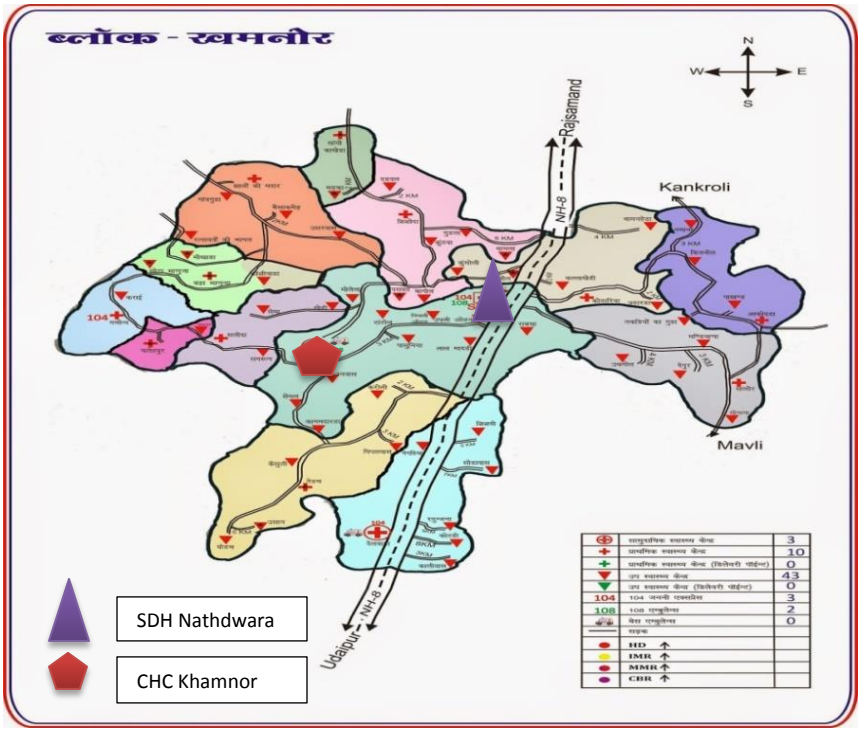
Rationale:

AHS 2012-13 data reveals maternal mortality ratio of Udaipur zone is 265 per 100000 live births. This is highest in Rajasthan as compared to other zones. The major causes of these deaths have been identified as Anaemia, Haemorrhage, Hypertension, Obstructed Labor, Sepsis and unsafe Abortions. To overcome these complications first referral units are established**. Lack of specialists/trained providers like Anaesthetists and Gynaecologists, is the main reason for inadequacy in providing emergency care.** The nearest functional higher center to cater emergency services is the Udaipur Medical College and the District Hospital. From the 38 maternal deaths in Rajsamand 7 deaths occurred before reaching a higher center (PCTS - Apr '14 to Feb '15).

FRUs are facilities which provide round the clock service for maternal and new-born care with all emergencies. According to Govt. of India minimum services in FRUs include the following based on Guidelines published

- 24-hour delivery services including normal and assisted deliveries
- Caesarean Sections.
- Emergency Care of sick children

FRU Profile: SDH Nathdwara and CHC Khamnor are sanctioned as first referral units.



Status of the FRUs highlighting the gaps and strengths to draw out its potential to become functional units

SN.		SDH Nathdwara	CHC Khamnor
1	**Availability of Services**		
2	Functional OT	Yes	Yes
3	Functional LR	Yes	Yes
4	NBCC	Yes	Yes
5	Blood Storage Unit	Yes	**No(pending license renewal)**
6	Referral Services (Public/ Private)	Yes	Yes
7	**Availability of Human Resource**		
8	Gynaecologist	Yes	**No**
9	Paediatrician	**No**	**No**
10	Anaesthetic	**No**	**No**
11	Medical officer	Yes	Yes
12	**Why Functionalization is Crucial**		
13	Distance from District Hospital	20 km	35km
14	Distance from RNT Medical college – Udaipur	40km	55km
15	Distance from first referral unit	20km	35 km
16	Catchment population it has the potential serve (District health office)	37007	4402
17	Estimated Pregnancies in block (District health office)	1406	1088
18	Estimated deliveries in block (District health office)	1277	988
19	Number of maternal Deaths (APR'14-FEB'15)	5	
20	Number of C- sections	0	0
21	Number of abortions	0	0

- SDH is partially functional due to unavailability of anaesthetist. Due to this C-section are not being done since last year. As per RCH program anaesthetist can be called from private hospital. But the unavailability of an anaesthetist in the private sector is a barrier.

- Khamnor CHC is not functional due to unavailability of specialists and pending licences for renewal of blood storage unit.

Short Term Recommendation:

- **Deployment of specialist:** Shortage of staff is a problem across the state. However the state government can depute a paediatrician and anaesthetist from different places where one specialist is already available. This will lead to functionalization of SDH Nathdwara as an FRU.

- **Rational Deployment:** Re-deployment of nursing staff within the block for 24x7 availability of services. This could be from a low delivery load area to high delivery load.

- **Training of BSU staff:** One medical doctor and one lab technician from the CHC Khamnor can be identified for blood storage unit and should be trained at state training center.

- **Renewal of license for blood storage unit:** BMCHO should ensure the renewal of licence in CHC Khamnor from licencing authority.

Long Term Recommendation:

- **LSAS training of Medical officer:** Considering the general lack of anaesthetists at both the CHCs, it is feasible to train any one of the MBBS doctor from CHC in life saving anaesthetic skill for 18 weeks.

Recommendation	Responsibility
Deployment of specialist	State
Rational Deployment	State
Three day training for BSU staff	District/state
License renewal of blood storage unit	District
LSAS training of MO within block	SIHFW

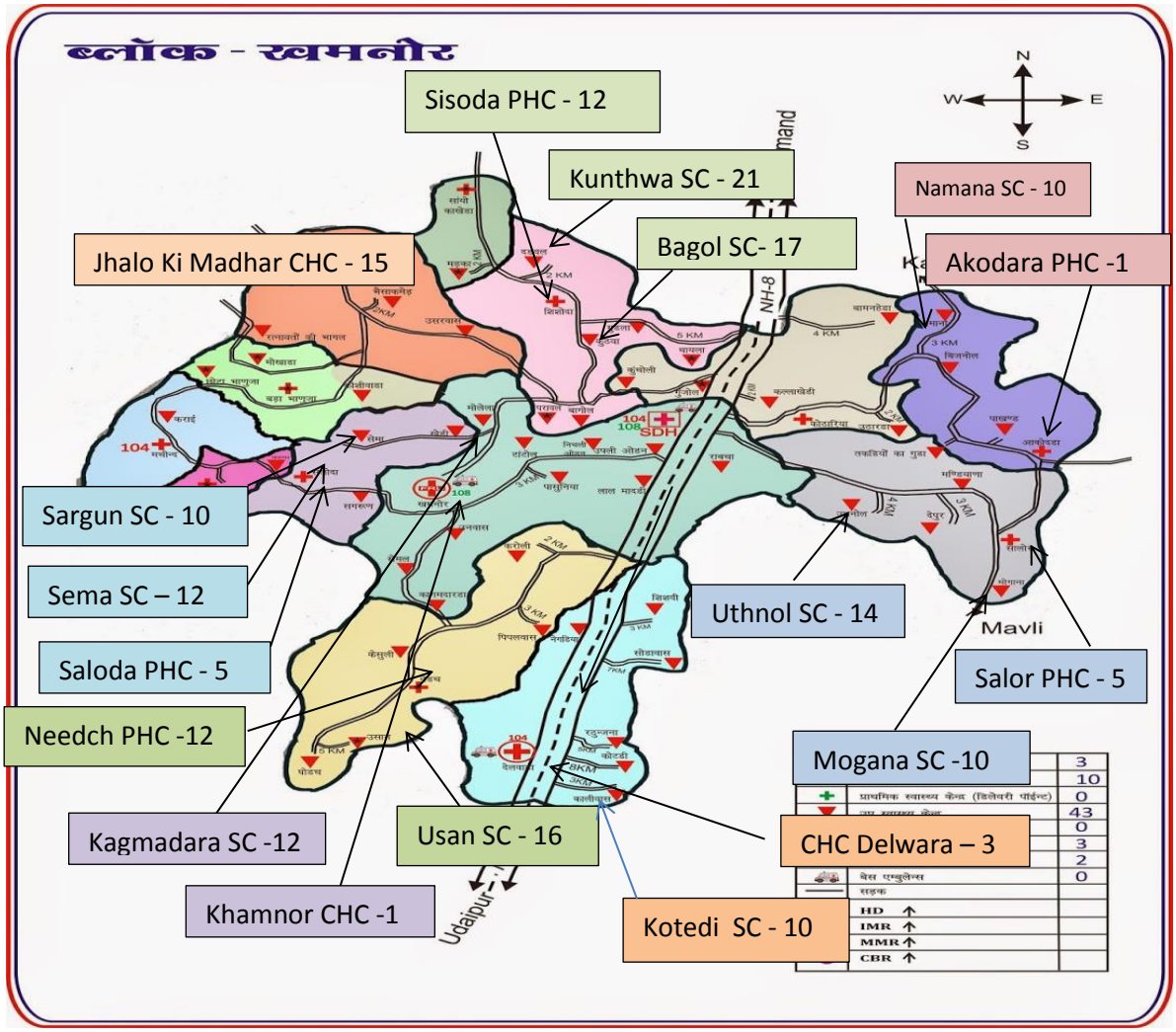
4. Strengthening of facilities in areas with high home deliveries

Rationale:

There are certain areas with a high number of home deliveries. Based on the PCTS data (Apr 2014-Feb 2015) 359 home deliveries have been reported in Khamnor block. Therefore it is imperative to provide delivery care services at facilities near to these areas. Thus strengthening of the services at these centers may lead to a decline in home deliveries and also promote institutional deliveries.

Reported Home Deliveries

(Same coloured boxes shows home delivery cases from same sector)



Strengths and Gaps:

- Out of 359 (April 2014-Feb 2015 – PCTS) home deliveries, 173 (48%) were conducted by Skilled Birth Attendants (SBA). This highlights the existence of skilled personnel in the field which are available and willing to conduct deliveries.

- During BMVs it has been observed that facilities like PHC Sisoda, SC Bagol are having good infrastructure and are well-equipped but not providing the delivery services. The main reasons are poor skill of ANM in conducting the deliveries and managing complications. Most of the deliveries in the block are going directly to the CHCs or higher centres.

Short Term Recommendation:

- **Identification of potential facilities** for conducting deliveries, close to areas having high number of home deliveries
- **Assessment of basic infrastructure** at facilities which include building, water supply and electricity
- **Scrutinising Staff Nurse/ANMs** about their willingness, skill and confidence to conduct deliveries at sub centers and at CHC/PHCs where staff nurses not available.
- **Special effort on IEC** should be put in for the nearby areas where home deliveries are high to generate awareness about functionalization of facilities as delivery points

Long term recommendation:

- Recruitment of staff nurses and their deputation based on need of facilities where high deliveries are conducted.
- Supportive Supervision to strengthen facilities on regular basis

Identified facilities for Strengthening

Facilities	PHC Sisoda	CHC Jhalo Ki Madar	SC Pakhand (PHC Akodara)	PHC Salor	SC Godach (PHC Nedach)	PHC Saloda
Building available	Yes	Yes	Yes	Yes	Yes	Yes
Labour room available	Yes	Yes	Yes	Yes	No	Yes
Electricity	Yes	Yes	Yes	Yes	Yes	Yes

Facilities	PHC Sisoda	CHC Jhalo Ki Madar	SC Pakhand (PHC Akodara)	PHC Salor	SC Godach (PHC Nedach)	PHC Saloda
Water	Yes	Yes	Yes	Yes	Yes	Yes
MO	Yes (1)	Yes (1)	NA	One MO, on 3 days deputation (weekly)	NA	Yes (1)
Staff Nurse	Yes (1)	Yes (1)	NA	Yes (2)	NA	Yes (2)
ANM	No	Yes (1)	Yes (1)	No	Yes (1)	No
Nearest high home delivery area	Sisoda, Bagol, Kunthwa	Jhalo Ki Madar	Namana	Mandiyana, Mogana, Uthnol	Nedach, Usan, Pipawas	Saloda, Sargun, Sema
Distance from nearest Delivery point	14 km, khamnor	30 km, khamnor	31 km, Nathdwara	22 km, Nathdwara	31 km, Nathdwara	20 km, Nathdwara

Recommendation for identified facilities:

In the above listed facilities, where MO is available, s/he should be engaged in conducting deliveries on regular basis. BCMHO and district team should encourage MOs who are conducting deliveries and appraise them in different forums.

- **PHC Sisoda:** Only 1 SN is available and no ANM; to make the facility 24 X 7 operational (particularly for conducting deliveries) it is essential to depute one SN or SBA trained ANM for a short term.
- **CHC Jhalo Ki Madar:** Deputation of one staff nurse or SBA trained ANM
- **SC Pakhand:** Pakhand sub centre has one ANM who is conducting delivery continuously. So the facility should be strengthened with basic logistics for a delivery room and new-born care corner.
- **PHC Salor:** Already has 2 Staff Nurses and requires one more SN; deputation of one staff nurse, if not then SBA trained ANM. 8 hourly basis SNs can be assigned duty to conduct deliveries on rotation basis.
- **SC Godach:** ANM is not conducting delivery as there is no specified labour room available and labour table is also not available. Hence labour table and other required accessories should be provided including new-born care corner related items.

- **PHC Saloda-**
  - Already have 2 Staff Nurses and require one more SN; deputation of one staff nurse OR then SBA trained ANM. 8 hourly basis SNs can be assigned duty to conduct deliveries on rotation basis.

Recommendation	**Responsibility**
Identification of potential facilities for conducting deliveries close to areas having high number of home deliveries	Block
Assessment of basic infrastructure at facilities to conduct deliveries	Block
Scrutinising SN/ANMs about their willingness, skill and confidence to conduct deliveries	Block/District
Awareness generation about importance of institutional deliveries and nearby facility conducting deliveries through IEC	District/Block
Recruitment of staff nurses and their deputation based on need	State/District
Supportive Supervision to strengthen facilities on regular basis	Block/District

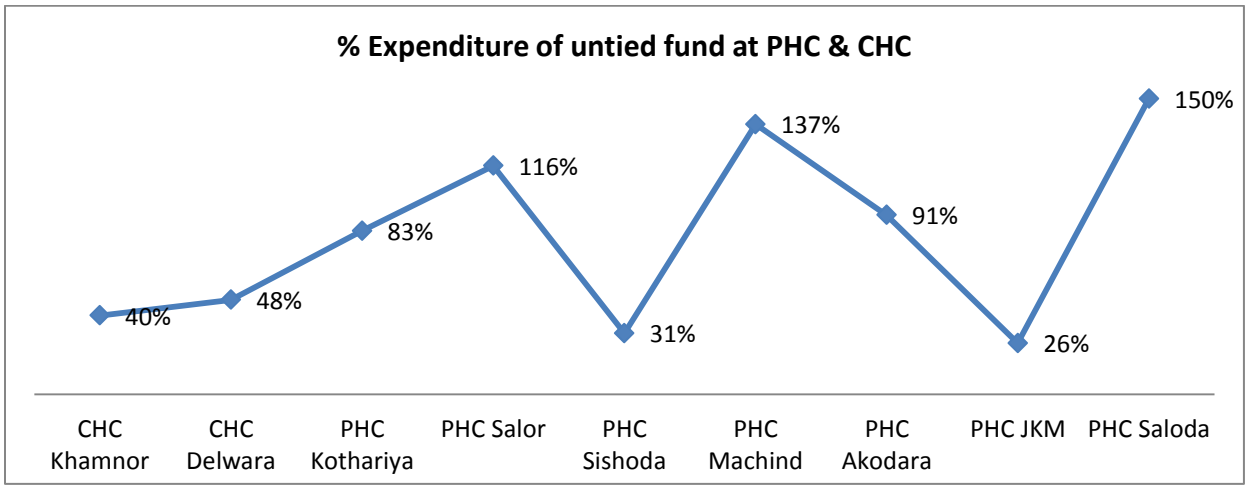
5. Fund Utilization

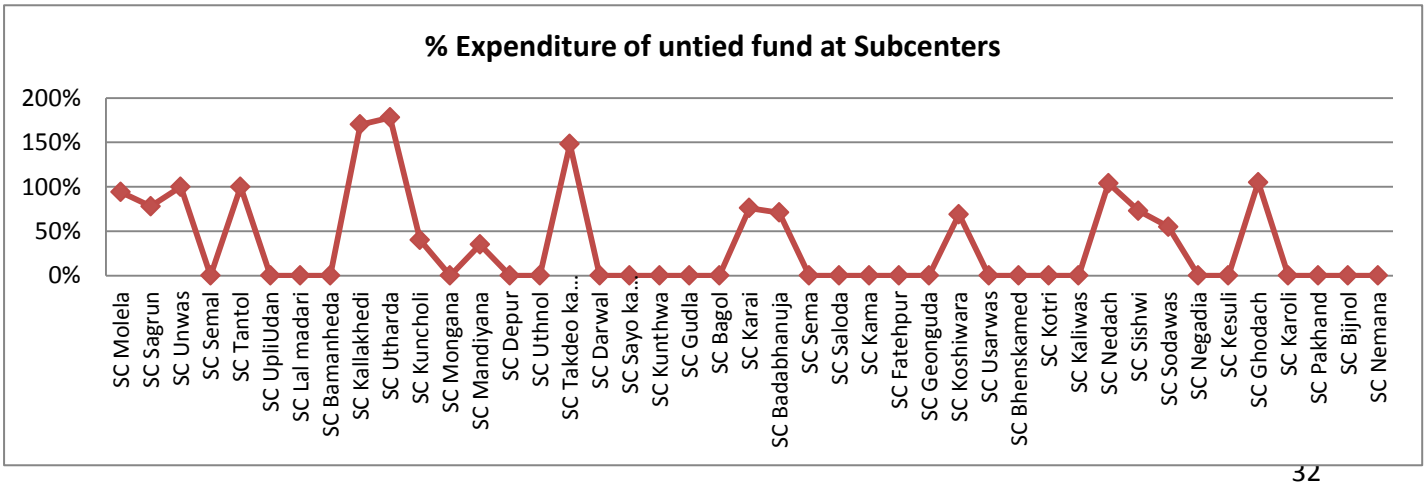
NRHM provides flexi-fund to states and districts for paying urgent need based expenses for maintenance of health infrastructure and services at district, block and village level. Use of such funds is to be made locally through various committees such as District Health Societies (DHS), Rajasthan Relief Medical Society (RMRS), Panchayat Raj Institutions (PRIs), Village Health and Sanitation Committees (VHSC) and village level health and Integrated Child Development Services (ICDS).

Rationale:

The utilization of available funds for providing quality services if not 100%. Regular monitoring of fund utilization and reconciliation can enable procurement and spending to provide the basic and emergent logistics at all facilities to improve and uphold the quality of ANC services being provided.

Un-tied fund utilization 2014-15 in Khamnor





Gaps identified:

- **100% Utilization not done:** Data on fund utilization till February 2014 shows 24 subcenters haven't utilised its funds.
- **Incorrect Expenditure:** On assessing (randomly selected) 5 subcenters (Semal, Upliodan, Lal madri Bamanheda, Mongana) we found that they were not using the funds as per need of facility. Some of them had spent money but not made bookings for the expenditure at office.
- Due to **vacant post of accountants** at facilities, it affects the settlement of accounts.
- During block monitoring visits to Kucholi SC, Bagol SC and PHC Sisoda, it was found that these facilities were lacking basic logistics (baby weighing machine, thermometer, heamoglobinometer etc.). **But staff felt handling of financial matters is a burden so they are not purchasing them.**
- **Lack of documentary evidence:** Many Facilities have received the funds and also spent it correctly. But in the absence of original documentary evidence it is very difficult to settle the accounts. In the future it leads to show large amount of fund lying un-utilized at the facility level and as a result less amount will be sanctioned from the state/central government.

Short term recommendations:

- Practice of verifying the expenditure against the activity rather than simply verifying it against vouchers.
- Strict monitoring of utilization of untied fund should be done every month in District Health Society meeting and also similar monitoring system in block meeting with the help of SDM.
- There should be provision of quarterly internal auditing of facility accounts. Such type of audits can be done by higher institutions e.g. PHC can do the audit of their sector SC.
- Financial year orientation of guidelines and accounting procedure should be given to facility in-charges every year.
- Block officials should call facility in-charges at block office and start reconciliation of previous unsettled account as a Camp approach.
- State government should issue directions to involve block accountant in a committee where tender processes are required to be followed.

Long Term recommendations:

- Un-tied fund allocation should be based on either population criteria, need based criteria or performance based criteria.
- Filling up of vacant post of accountants in the block to streamline the accounting system.
- Appropriate Fund Utilisation should be included in the performance appraisal mechanism of different cadres from ANMs to BCMHOs, hence accountability can be established and good performer can be acknowledged.
- Utilization of State Funds for Central Govt. allocated health spending to avoid delays of fund utilization and give sufficient time for spending over the whole financial year. The state may explore the possibility of pre-spending on the Center's behalf till those funds come in. In this way funds can be made available from first quarter to ensure timely utilization.

Recommendation	Responsibility
Monitoring of utilization in DHS and block	District & block
Provision of internal auditing of accounts	Block
Filling up of accountants post	State
Include fund utilisation in the performance appraisal mechanism	State
State Pre-Spending for Central Govt, till money is released	State

Conclusion

Each of the key focus areas and the recommendations discussed in this plan have the potential to improve service delivery for maternal and child care. Addressing labor and delivery, human resources responsible for maternal child services, ability of block to handle basic complications and nutrition for health and survival- encompasses some major components. Implementing these strategies would provide a gauge of the amount of time required to efficiently operationalize them. Based on an evaluation of these plans specific activities can be scaled up to the district and outside.

Annexures:

All the information provided in the annexures are belong to Apr 2014 to Feb 2015

Overview of Human Resource: (BCMHO office – Khamnor block)

SN.	Name of the Post	Sanctioned	In Position	Vacant
1	BCMO	1	1	0
2	Senior Specialist	6	1	5
3	SMO	1	1	0
4	MO	19	13	6
5	Accountant	2	0	2
6	Staff Nurse I	2	1	1
7	GNM	32	14	18
8	LHV	16	6	10
9	ANM	57	37	20
10	IA	16	9	7
Managerial Post				
11	BPM	1	0	1
12	BNO	1	1	0
13	Block ASHA Facilitator	1	0	1
14	PHC ASHA Supervision	7	3	4
16	CPDO	1	1	0
17	ASHAs	173	163	10

Facility Wise Human Resource: (S- # Sanctioned P -# present)(BCMHO office – Khamnor block)

PHC	MO		MN-1/2		G.N.M		ANM/Add		LHV	
	S	P	S	P	S	P	S	P	S	P
Kothariya	1	1	3	2	2	2	1	2	1	1
Salor	1	1	1	0	2	2	1	0	1	0
Akodara	1	1	2	1	2	2	1	1	1	1
Sisoda	1	1	1	1	2	2	1	0	1	1
Machind	1	1	1	1	2	1	1	1	1	1
Sayo ka kheda	1	0	2	0	0	1	1	1	1	0
Saloda	1	1	2	0	0	2	1	0	1	1
Fathepur	1	0	2	0	0	1	1	1	1	0
Badabhanuja	1	1	2	0	0	1	1	1	1	0
Nedach	1	0	2	0	0	1	1	1	1	0
Total	10	7	18	5	10	15	10	8	10	5

CHC	SS		JS		MO		MN-1/2		G.N.M.		ANM/Add.		LHV	
	S	P	S	P	S	P	S	P	S	P	S	P	S	P
Delwara		0		0		2		3		4		1		0
Khamnor		0		0		2		5		6		2		0
JKM		0		0		2		1		2		1		1

Details of Ambulances: (BCMHO office – Khamnor block)

Name of the facility	Base ambulance	108	104	MMU/MMV	Remarks
Khamnor	1	1	0	1	
Delwara	1	0	1	0	
Nathdwara	3	1	1	0	
Total	5	2	2	1	

Referral Center: (BCMHO office – Khamnor block)

S.No	Name of the referral Center in Block	Distance
1	General hospital, Nathdwara	15km
2	RK hospital, Rajsamand	35km
3	MB hospital,Udaipur	46km

Khamnor Block PHC wise HR (CMHO Office – Rajsamand district)

PHC	**MO**		**MN-1/2**		**G.N.M**		**ANM/Add**		**LHV**	
	S	P	S	P	S	P	S	P	S	P
Kothariya	1	1	3	2	2	2	1	2	1	1
Salor	1	1	1	0	2	2	1	0	1	0
Akodara	1	1	2	1	2	2	1	1	1	1
Sisoda	1	1	1	1	2	2	1	0	1	1
Machind	1	1	1	1	2	1	1	1	1	1
Sayo ka kheda	1	0	2	0	0	1	1	1	1	0
Saloda	1	1	2	0	0	2	1	0	1	1
Fathepur	1	0	2	0	0	1	1	1	1	0
Badabhanuja	1	1	2	0	0	1	1	1	1	0

Nedach	1	0	2	0	0	1	1	1	1	0
Total	10	7	18	5	10	15	10	8	10	5

Khamnor Block CHC wise HR (CMHO Office – Rajsamand district)

CHC	SS	**JS**	MO	MN-1/2	G.N.M.	ANM/Add.	**LHV**
Delwara	0	0	2	3	4	1	0
Khamnor	0	0	2	5	6	2	0
JKM	0	0	2	1	2	1	1

ASHA Details: (CMHO Office – Rajsamand district)

S.No.	Name of CHC/PHC	No. of AWC	No. of Sanctioned ASHA	No. of Working ASHA	No. Trained in Induction Training	No. Trained in Module 5	No. Trained in Module 6 &7 Round 1	No. Trained in Module 6 &7 Round 2
1	Khamnor	27	27	24	24	22	22	22
2	Delwara	36	36	32	32	27	31	31
3	Sishoda	24	24	24	24	21	22	22
4	Machind	13	13	13	13	12	13	13
5	Jkm	15	15	15	15	11	15	15
6	Kotharia	19	18	18	18	17	17	17
7	Salor	15	15	14	14	11	12	12
8	Saloda	13	13	12	12	10	12	12
9	Akodara	11	11	11	11	6	10	10
Total		**173**	**173**	**163**	**163**	**137**	**154**	**154**

VHSNC Account Details: (CMHO Office – Rajsamand district)

S.No.	Name of CHC/PHC	Total No of Revenue Villages	Total No of Functional VHSC	No. of VHSC where Separate Bank Account Opened	No. of VHSC where Separate Bank Account not Opened
1	Khamnor	16	16	14	2
2	Delwara	57	57	57	0
3	Sishoda	21	21	20	1
4	Machind	9	9	9	0
5	Jkm	10	10	10	0

6	Kotharia	33	33	33	0
7	Salor	17	17	17	0
8	Saloda	10	10	9	1
9	Akodara	13	13	13	0
Total		186	186	182	4

NHM Expenditure Details: (For Whole Block) (BCMHO Office – Khamnor block)

Sr. No	Component	Up to March 2014			Up to FEB 2015		
		Total Sanction Received	Expenditure	% Expenditure	Total Sanction Received	Expenditure	% Expenditure
1	RCH Flexi Pool	1,25,00,000	10,000,906	**80**	11,402,730	9,165,460	**80.37**
2	NRHM Additional ties	7,500,000	6,414,164	**85.52**	6,364,348	4,601,948	**72.30**
3	Immunization	1,200,000	9,95,954	**82.97**	9,38,380	7,86,395	**83.80**
Total		**21,200,000**	**17,411,024**	**82.18**	**18,705,458**	**14,553,803**	**77.80**

Untied Funds Details: For CHC, PHCs and SCs (BCMHO Office – Khamnor block)

Sr. No	Name of the Facility	Total untied fund received in 14-15	Total untied fund expenditure in 14-15 (till Feb)	% Expenditure
1.	CHC Khamnor	595984	232984	40%
2.	CHC Delwara	598984	289582	48%
3.	PHC Kothariya	140301	117062	83%
4.	PHC Salor	113178	131237	116%
5.	PHC Sishoda	185375	57487	31%
6.	PHC Machind	115952	158712	137%
7.	PHC Akodara	77387	70286	91%
8.	PHC JKM	132284	33852	26%
9.	PHC Saloda	52952	79624	150%
10.	SC Molela	10000	9458	94%
11.	SC Sagrun	10000	7869	78%
12.	SC Unwas	10000	10000	100%
13.	SC Semal	10000	0	0%

Sr. No	Name of the Facility	Total untied fund received in 14-15	Total untied fund expenditure in 14-15 (till Feb)	% Expenditure
14.	SC Tantol	10000	10000	100%
15.	SC UpliUdan	10000	0	0%
16.	SC Lal madari	10000	0	0%
17.	SC Bamanheda	10000	0	0%
18.	SC Kallakhedi	10000	17000	170%
19.	SC Utharda	10000	17889	178%
20.	SC Kuncholi	10000	4068	40%
21.	SC Mongana	10000	0	0%
22.	SC Mandiyana	10000	3549	35%
23.	SC Depur	10000	0	0%
24.	SC Uthnol	10000	0	0%
25.	SC Takdeo ka Guda	10000	14890	148%
26.	SC Darwal	10000	0	0%
27.	SC Sayo ka Kheda	10000	0	0%
28.	SC Kunthwa	10000	0	0%
29.	SC Gudla	10000	0	0%
30.	SC Bagol	10000	0	0%
31.	SC Karai	10000	7668	76%
32.	SC Badabhanuja	10000	7193	71%
33.	SC Sema	10000	0	0%
34.	SC Saloda	10000	0	0%
35.	SC Kama	10000	0	0%
36.	SC Fatehpur	10000	0	0%
37.	SC Geonguda	10000	0	0%
38.	SC Koshiwara	10000	6965	69%
39.	SC Usarwas	10000	0	0%
40.	SC Bhenskamed	10000	0	0%
41.	SC Kotri	10000	0	0%
42.	SC Kaliwas	10000	0	0%
43.	SC Nedach	10000	10415	104%
44.	SC Sishwi	10000	7398	73%
45.	SC Sodawas	10000	5522	55%
46.	SC Negadia	10000	0	0%
47.	SC Kesuli	10000	0	0%

Sr. No	Name of the Facility	Total untied fund received in 14-15	Total untied fund expenditure in 14-15 (till Feb)	% Expenditure
48.	SC Ghodach	10000	10555	105%
49.	SC Karoli	10000	0	0%
50.	SC Pakhand	10000	7248	0%
51.	SC Bijnol	10000	10000	0%
52.	SC Nemana	10000	0	0%
	Total	2442397	1338513	55%

OPD, IPD, Deliveries for CHCs, PHCs (PCTS April 2014- Feb 2015)

Facility	Village	OPD 2014-15(Till Feb)	IPD 2014-2015 (Till Feb)	Number of deliveries 2014-2015(Till Feb)
1.	CHC Khamnor	66927	7123	606
2.	CHC Delwara	62503	5952	791
3.	CHC Jhalo ki Madhar	12376	25	12
4.	PHC Kothariya	12460	61	4
5.	PHC Salor	6933	138	12
6.	PHC Sishoda	15704	938	5
7.	PHC Machind	5737	539	27
8.	PHC Akodara	9226	200	9
9.	PHC bada Bhanuja	2408	0	0
10.	PHC Saloda	4111	65	4
11.	PHC Sayo ka kheda	1481	11	4
12.	PHC Needach	1155	0	0
13.	PHC Fatehpura	1016	0	0

Village Level Information under each facility (PCTS April 2014 – Feb 2015)

Facility	Village	Population	Number of ANCs 2014-15	Number of deliveries 2014-15
1.	CHC Khamnor	35123	83	606
2.	CHC Delwara	38544	110	791
3.	CHC Jhalo ki Madhar	16229	134	12
4	PHC Kothariya	15351	160	4

Facility	Village	Population	Number of ANCs 2014-15	Number of deliveries 2014-15
5.	PHC Sishoda	28224	81	5
6.	PHC Machind	16493	166	27
7.	PHC Akodara	11510	57	9
8.	PHC bada Bhanuja	6607	96	0
9.	PHC Saloda	15031	85	4
10	PHC Sayo ka kheda	5072	65	4
11	PHC Salor	14640	90	12
12	PHC Needach	5140	150	0
13	PHC Fatehpura		107	0
14	SC Kaliwas	4967	134	0
15	SC Kotedi	5714	153	0
16	SC Negdiya	5679	87	0
17	SC Rooth Jana		54	0
18	SC Sishvi	3435	99	0
19	SC Sodawas	2137	58	0
20	SC Besa Kamed	1952	48	0
21	SC Gaoguda	5148	85	0
22	SC Ratnawato Ki Bhagal		67	0
23	SC Usar Was	3282	79	0
24	SC Kagmadara		51	0
25	SC Lal Madri	6061	76	0
26	SC Molela	4629	123	0
27	SC Nichala Odan		68	0
28	SCPasuniya		61	0
29	SC Rabcha		46	0
30	SC Semal	4278	63	0
31	SC Tantol	6266	80	0
32	SC Unwas	3394	91	0
33	SC Upali Oddan	6806	121	0
34	SC Bijnol	3693	113	0
35	SC Namana	4814	130	0
36	SC Pakhand	3003	76	26
37	SC Chota Bhanuja		82	N/A
38	SC Koshiwara	5847	71	N/A
39	SC Mokhada		44	N/A
40	SC Kama	1431	40	N/A
41	SC Baman Heda	4237	104	0

Facility	Village	Population	Number of ANCs 2014-15	Number of deliveries 2014-15
42	SC Gunjol		69	0
43	SC Kalla Khedi	5416	64	0
44	SC Kuncholi	1898	57	0
45	SC Utharada	3800	105	0
46	SC Karai	2083	74	0
47	SC Goodch	5973	79	N/A
48	SC Karoli	4092	113	N/A
49	SC Kesuli	4554	82	N/A
50	SC Pipawas		50	N/A
51	SC Ushan		87	N/A
52	SC Khedi		64	0
53	SC Sagrun	4683	129	0
54	SC Sema	6372	70	0
55	SC Depur	1731	68	0
56	SC Mandiyana	2892	72	0
57	SC Mogana	3725	60	0
58	SC Takdiyo ka Ghudda	1384	39	0
59	SC Uthnol	4908	106	0
60	SC Mudmaka		59	0
61	SC Bagol	7280	97	5
62	SC Dadwal	2357	38	0
63	SC Dhayala		56	0
64	SC Gudla	7815	58	6
65	SC Kunthwa	5700	52	0
66	SC Parawal		55	0

The facilities which have not provided population are newly sanctioned.

Physical Status: (PCTS)

S.No	Indicators	2012-13	2013-14	2014-15(till Feb)
A	**Antenatal Care**			
1	ANC Registration	6221	6023	5600
2	Registration Within 12 Weeks	3666	3923	3587
3	4 ANC Checkups	4983	4358	3763
4	Women consumed 100 IFA	5476	3577	3124
5	TT1 injection	4973	4613	3981
B	**Delivery Care**			

S.No	Indicators	2012-13	2013-14	2014-15(till Feb)
1	Institutional Delivery	1783	2005	1511
2	Delivery at Home	604	512	359
3	Delivery at home by SBA trained	164	223	173
4	C- SECTION	0	0	0
C	**New Born Care**			
1	Children received early initiation of breast feeding	1428	2436	1675
2	Children whose birth weight was taken	1627	2420	1737
3	Children with birth weight less than 2.5 Kg.	12	37	29
D	**Post Natal Care**			
1	Less than 24 hrs. stay in institution after delivery	53	14	9
2	Mothers who received Post-natal Check-up within 48 hrs. of delivery	2608	3317	2808
3	Children with full immunization	2585+2051	2769 + 2375	2233 + 2070
E	**Family Planning**			
1	IUD insertion	1408	1108	1036
2	Total Male sterilization (VT/NSV)	16	3	2
3	Total female sterilization (Minilap/LT)	394	360	225
4	Number of PPIUCD insertion	0	3	221
F	**General Data**			
1	Total OPD	210333	223543	239407
2	Total IPD	2929 + 7136	2766 + 7667	2901 + 9484

Neonatal, Infant and Child Deaths – Khamnor block (PCTS – Apr 14 to Feb 15)

S.no	CHC/PHC	Sub center	Village	Name	Sex	Age	Death place
Death within 24 hours (as per PCTS)							
1	Delwara	Negdiya	Goyala	Baby	Girl	NDA	Govt/pvt inst.
2	Machind	Machind	Machind	Baby	Boy	1 hour	Govt/pvt inst.
3	Machind	Karai	Karai	Baby	Girl	6 hour	Govt/pvt inst.
4	Needch	Needch	Barwa	Baby	Girl	1 hour	Home
5	Saloda	Saloda	Saloda	Laxmi	Boy	1 hour	Home

S.no	CHC/PHC	Sub center	Village	Name	Sex	Age	Death place
				saloda			
6	Saloda	Sagrun	Sagrun	Sagrun	Boy	7 hour	Home
7	Saloda	Sagrun	Sagrun	Baby sagrun	Boy	23 hour	Govt/pvt inst.
8	Sishoda	Gudla	Gudla	Baby of kali	Girl	2 hour	Govt/pvt inst.
9	Sishoda	Bagol	Joshiyo ki madri	Baby	Boy	1 hour	Govt/pvt inst.
Infant death up to 4 weeks by cause (PCTS)							
1	Kotharia	Kalla khedi	Kalla khedi pariya	Baby of rekha kanwar	Girl	10 month	Home
2	Saloda	Sagrun	Sagrun	Baby sagrun	Girl	3 day	Govt/pvt inst.
3		Sema	Sema	Kailashi	Boy	3 week	Home
4	Salor	Salor	Salor	Fch	Girl	2 week	Other place
5	Sishoda	Dadwal	Dadwal	Baby	Boy	2 day	Govt/pvt inst.
6		Kunthwa	Kheliya	Baby	Girl	4 day	Govt/pvt inst.
7			Kunthwa	Jamku	Girl	1 day	Home
8			Shisoda khurd	Champpa	Boy	1 day	Home
9		Bagol	Bagol	Valra	Boy	1 day	Govt/pvt inst.
10		Dhayala	Dhayala	Baby	Boy	3 week	Govt/pvt inst.
11				Baby	Boy	3 week	Govt/pvt inst.
1	Machind	Machind	Machind	Jamku	Boy	2 week	Home
1	Delwara	Kotedi	Neeta ka guda	Baby	Boy	4 day	Govt/pvt inst.
2		Kaliwas	Barwaliya	Baby	Girl	6 day	Home
3		Sodawas	Lolero ka guda	Lali	Girl	1 day	Home
4		Negdiya	Goyala	Baby	Girl	1 day	Govt/pvt inst.
5	Khamnor	Pasuniya	Pasuniya	Guddi	Boy	6 day	Govt/pvt inst.
6	Bada bhanuja	Chota bhanuja	Kando ka guda	Gagli gamety	Boy	4 day	Other place
7				Baby	Boy	2 day	Govt/pvt inst.
8				Baby	Boy	6 day	Other place
9				Baby	Boy	1 day	Govt/pvt inst.
10	Needch	Needch	Dadmi	Baby	Girl	1 day	Home
11		Karoli	Karoliyo ki dhani	Baby	Girl	2 day	Govt/pvt inst.
12	Saloda	Saloda	Saloda	Saloda	Girl	3 week	Home
13		Sagrun	Sagrun	Baby	Boy	1 day	Govt/pvt inst.

S.no	CHC/PHC	Sub center	Village	Name	Sex	Age	Death place
				sagrun			
14	Sayo ka kheda	Sayo ka kheda	Sayo ka kheda	Baba	Boy	1 day	Govt/pvt inst.
15	Sishoda	Kunthwa	Kunthwa	Baby of kasni	Girl	3 day	Home
16			Shisoda khurd	Baby	Girl	2 day	Home
17		Bagol	Joshiyo ki madri	Manju	Boy	3 day	Govt/pvt inst.
18			Paneriyo ki madri	Baba	Boy	2 week	Home
19		Dhayala	Dhayala	Baby	Boy	2 day	Govt/pvt inst.
20		Parawal	Parawal	Baby of jassu	Boy	1 day	Govt/pvt inst.
1		Goverdhan govt hospital nathdwara	Ward 11	Baby swati yadav	Boy	1 day	Govt/pvt inst.
2	Delwara	Kotedi	Bilota	Baby	Boy	3 week	Home
3		Sishvi	Jar sadari	Pappu	Boy	1 day	Govt/pvt inst.
4	Bada bhanuja	Bada bhanuja	Bada bhanuja	Kiki mamta yogesh paliwal	Girl	1 day	Home
5			Rochoti	Baby tulsi gamety	Boy	4 day	Home
6	Needch	Pipawas	Pipawas	Pappu	Boy	2 week	Govt/pvt inst.
7		Ushan	Kunda	Baby	Girl	6 day	Home
8	Saloda	Saloda	Saloda	Manju saloda	Boy	1 day	Govt/pvt inst.
9		Sagrun	Sagrun	Bbay	Girl	4 day	Govt/pvt inst.
10		Khedi	Khedi	Priti khedi	Boy	3 day	Govt/pvt inst.
11	Salor	Mandiyana	Mandiyana	Mch	Boy	4 day	Govt/pvt inst.
12		Uthnol	Sardarpura	Baby of samita	Girl	1 day	Govt/pvt inst.
13			Saruppura	Baby of bhawar	Boy	1 day	Govt/pvt inst.
14			Uthnol	Baby of girja	Boy	1 day	Govt/pvt inst.
15	Sishoda	Bagol	Bagol	Baby	Boy	1 day	Govt/pvt inst.
Infant/child death up to 5 years by cause (PCTS)							
1	Delwara	Kotedi	Bilota	Pappu	Boy	3 month	Home

S.no	CHC/PHC	Sub center	Village	Name	Sex	Age	Death place
2				Baby	Girl	2 year	Govt/pvt inst.
3			Majeera	Pappu	Boy	4 month	Govt/pvt inst.
4		Kaliwas	Barawa	Baby	Boy	1 month	Home
5	Needch	Karoli	Karoliyo ki dhani	Baby	Girl	2 month	Home
6	Saloda	Saloda	Saloda	Baby	Girl	5 month	Home
7				Baby saloda	Boy	3 month	Home
8				Baby saloda 2	Boy	2 month	Home
9		Khedi	Balida	Baby	Girl	5 month	Home
10			Khedi	Baby	Girl	1 year	Home
11	Sayo ka kheda	Mudmaka	Chikal was	Jamuna	Boy	3 month	Home
12			Mudmaka	Baby of shanta	Girl	1 month	Home
13	Sishoda	Kunthwa	Kheliya	Mukesh	Boy	10 month	Govt/pvt inst.
14		Gudla	Gudla	Hameri	Girl	2 month	Govt/pvt inst.
15		Bagol	Bagol	Baba	Boy	2 month	Govt/pvt inst.
16			Paneriyo ki madri	Tara	Boy	2 month	Home
17				Meena	Boy	2 month	Govt/pvt inst.
18		Parawal	Parawal	Nirma	Boy	2 month	Other place
19				Parwati	Girl	3 month	Other place
20				Garima	Boy	7 month	Govt/pvt inst.
1	Needch	Kesuli	Kesuli	Guatam	Boy	11 month	Govt/pvt inst.
2	Sishoda	Dadwal	Atatiya	Devendra	Boy	7 month	Govt/pvt inst.
1	Salor	Mandiyana	Mandiyana	Fch	Girl	9 month	Home
2	Sishoda	Bagol	Bagol	Garima	Girl	1 year	Govt/pvt inst.
1	Delwara	Kotedi	Bilota	Ishwar	Boy	1 year	Home
2				Valu	Boy	11 month	Home
3		Kaliwas	Kamali ka guda	Baby	Boy	2 month	Home
4		Sishvi	Jar sadari	Kajal	Girl	2 year	Home
5	Bada bhanuja	Bada bhanuja	Bada bhanuja	Amoli meena kanheyalal paliwal	Girl	4 month	Home
6	Kotharia	Kalla khedi	Kalla khedi pariya	Baby of rekha kanwar	Girl	10 month	Home
7	Machind	Karai	Karai	Baby	Boy	1 month	Home

S.no	CHC/PHC	Sub center	Village	Name	Sex	Age	Death place
8	Needch	Goodch	Goodch	Pappu	Boy	2 month	Govt/pvt inst.
9		Karoli	Karoli	Vardi	Girl	3 month	Home
10		Kesuli	Kesuli	Ganag	Girl	3 year	Home
11				Gotam singh	Boy	10 month	Home
12		Pipawas	Pipawas	Pappu	Boy	1 year	Home
13	Saloda	Saloda	Saloda	Sayri	Boy	9 month	Govt/pvt inst.
14		Sema	Sema	Baby	Girl	1 month	Home
15		Khedi	Khedi	Yasoda khedi	Girl	1 year	Home
16	Salor	Mogana	Rupawali	Fch	Girl	1 year	Home
17	Sishoda	Bagol	Bagol	Garima	Boy	9 month	Govt/pvt inst.