District Health Action Plan

2012-2013

District Health Society Vaishali

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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 part of National Rural Health Mission. District Health Action Plan is critical for achieving decentralization, interdepartmental convergence, capacity building of health system and most importantly facilitating people's participation in health programme. District Health Action Plan 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 Vaishali. The NRHM regards district level health planning as a significant step towards achieving a decentralized, 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 decentralization and public participation and 3) Facilitating interdepartmental convergence at the district level.

DHAP seeks to achieve pooling of financial and human resources allotted through various central and state programme by bringing in a convergent and comprehensive action plan at the district level. Recognizing the importance of Health in the process of economic and social development and improving quality of life of our citizens, Government of India has resolved to launch National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. This District Health Action Plan (DHAP) is one of the key instruments to achieve NRHM goals. This plan is based on health needs of the district. After a thorough situational analysis of district health scenario this document has been prepared. This plan address health care needs of rural poor especially women and children. The focus has also been given on current availability of health care infrastructure in pubic/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level. The goals of the Mission are to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

I need to congratulate the department of Health and Family Welfare and State Health Society of Bihar for their dynamic leadership of the health sector reform programme and we look forward to a rigorous and analytic documentation of their experiences so that we can learn from them and replicate successful strategies.

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

Prem Singh Meena, IAS

(DM, Vaishali)

Acknowledgement

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

The commitment is to bridge the gaps in public health care delivery system, has led to the formulation of District Health Action Plan. The collaboration of different departments which directly or indirectly related to determinants of health 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 Health Action Plan for Vaishali district of Bihar entailed a series of Consultative Meetings with stakeholders at various levels, collection of secondary data from various departments, analysis of data and presentation of the existing scenario at District-level workshop. District level Workshop was organized to identify district specific strategies based on which the District Health Action Plan has been prepared by the District & Block Program Management Unit.

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

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

Dr. Vibhesh Prasad Singh
Civil Surgeon
Vaishali

Chapter - 1

Introduction

1.1 Background

The health status of its population reflects the socio-economic development of a state. Health status is shaped by a variety of factors-level of income and standard of living, housing, sanitation, water supply, education, employment, health consciousness and personal hygiene, and the coverage, availability, accessibility, acceptability and affordability of health services. The poor health status of states is a product of inadequate nutrition, lack of protected water supply, and overcrowded and in sanitary housing conditions. These conditions are conducive to deficiency diseases, airborne diseases, focally related and waterborne diseases, which dominate the morbidity and mortality pattern in less developed regions.

The relationship between health and poverty or health and development is complex and multifaceted. Poverty in its various dimensions could be a manifestation as well as a determinant of an individual's health. In its most basic form- as a state of food deprivation and nutritional inadequacy – poverty has a direct bearing on the morbidity and longevity of people. The other aspects of deprivation such as lack of access to critical amenities including safe water, sanitation, non-polluting domestic fuels, connectivity of life support services and, most importantly to education and general awareness, contribute to reinforcing ill health and morbidity, even leading to higher mortality levels. High child mortality levels on account of supervening infections, particularly diarrhoea and respiratory infections are fairly widespread among people deprived of these basic amenities of life. These commonly seen childhood infections often exacerbate malnourishment. Undernourishment in children in turn reinforces the consequences of such infections.

Health is a state of physical, mental & social well being & not merely an absence of disease or infirmity. Hence recognizing the importance of health in the process of economic & social development & improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission (NRHM) to carry out necessary architectural correction in the health care delivery system to achieve a positive health. The National Rural Health Mission (NRHM) seeks to provide effective health care to the entire rural population in the country with special focus on 18 states, which has weak public health indicators. It aims to undertake some architectural correction of the health system to enable it to be effective in providing "Health for All". The mission envisages strategy for integrating ongoing vertical programs of health and family welfare, addressing issues related to the determinants of health like sanitation, nutrition and safe drinking water. The National Rural Health Mission seeks to adopt sector wide approach and aims at systemic reforms to enable efficiency in health services delivery.

The NRHM is an effort to bring about the architectural change to overall program management to enable rationalization of resources and simultaneously to augment then limited resources so that equity in health is ensured. The commonality of initiatives in the following areas would be complementing the similar efforts under NRHM;

- Infrastructures for facility development,
- Manpower recruitment,
- Capacity building through training, program management, institutional strengthening, organizational development,
- Communitization,
- Promotional efforts for demand generation and
- Improved monitoring & evaluation systems developed under RCH II
- Public Private Partnership
- Convergence & Coordination

The convergence approach which was mooted earlier now finds a clear policy initiative and procedural development by health and all health determinants sectors so that a joint effort is made in tandem from planning to impact evaluation / outcome to ensure investments in health reach the poor /unnerved/underserved/excluded segment of the population. These common efforts would also strengthen gender equity through adolescent and other initiatives of both RCH & NRHM to provide a safety net to young women and girl children.

For effective decentralization in principle as well as practice, health societies have been established at all levels of the healthcare delivery structure. Systematic involvement of various stakeholders at all levels through these societies has helped make healthcare delivery responsive to the needs of the people via participatory planning and removal of bottlenecks at implementation levels. State Health Society provides overall guidance and supervision for effective planning and implementation, and also coordinates activities across the board. The State Health Mission, the Governing Body and the Executive Committee meet at regular intervals and take decisions regarding all matters. District level activities are taken care of through the District Health Society.

Rogi Kalyan Samiti at PHC, CHC, Sub Divisional Hospitals, District Hospitals and Medical Colleges have been set up. The formation of societies under NRHM has given a new direction to management and overall functioning of the health department towards the achievement of its goals.

The National Rural Health Mission envisages the planning process to be participatory and decentralized starting with the Village. It seeks to empower the community by placing the health of the people in their own hands and determine the ways they would like to improve their health. This is the only way to ensure that health plans are need based. The state would play a facilitators role.
NRHM was launched in April 2005. Department of Health, Government of Bihar is implementing the NRHM in right earnest. A number of enabling actions were taken by the State Health Society and this created environment conducive for decentralized planning by the district.

District Health Action Plan is the most important unit of the planning process as the Government of India and the state government would monitor the progress of implementation district wise. The district is also the key administrative unit for most of the development activities. To make

district Plan more meaningful and address local health problems, preparation of Block Health Plans is considered essential.

The decentralized planning process involved village consultations and preparation of Village Health Plans by the Village Health Water and Sanitation committees; followed by development of Block Action Plans through integration of Health Facility Surveys and block specific needs. The Block Action Plans were integrated to form District Action Plans.

A synergistic approach needs to be adopted integrating the segments of nutrition, sanitation, hygiene & safe drinking water, the mechanism to bring about the expected change includes increased public expenditure on health, rending the geographical insolence in health infrastructure, positioning of manpower, decentralization, district management of health programs, community participation & up gradation of present health systems meeting Indian Public Health Standard in each block of the district. Hence the goal of promotion of district health plan is to improve the availability of and access to quality health care by people especially for those residing in far off rural areas, the vulnerable sections of the society especially women & children. Bihar is among the 18 selected states (EAG) that would get benefited under the NRHM. In this state all the districts would be covered under NRHM mission from 2005-2012. Some of the most important aspects of the mission are –

(a) Decentralized Village and District Level Health Planning and Management,

(b) Appointment of Accredited Social Health Activist (ASHA) to facilitate access to health Services,

(c) Strengthening the public health service delivery infrastructure, particularly at village, Primary and secondary levels,

(d) Mainstreaming and improving the Management Capacity to organize health systems and services in public Health.

Therefore the making of District Health Plan has been an exercise of vital importance in response to effective launch and implementation of NRHM. For this the Village Health Plans, plans for Water Supply, provision of proper Sanitation and Nutrition would form the core unit of action proposed. Implementing Departments would integrate into District Health Mission for management and monitoring of the district level plan.

Hon'ble Prime Minister launched the NRHM on 12th April, 2005 throughout the country with special focus on 18 states, including eight empowered action group states, the North- Eastern States, Jammu Kashmir and Himachal Pradesh. The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It also seeks to reduce the Maternal Mortality Ratio (MMR) in the country from 407 to 100 per 1,00,000 live births, Infant Mortality Ratio (IMR) from 60 to 30 per 1000 live births and the Total Fertility Rate (TFR) from 3.0 to 2.1 within the 7 year period of the mission.

Objective of the Mission:-

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

The Key features in order to achieve the goals of the mission include making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, and decentralization, rigorous monitoring and evaluation against standards Convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indicators. Core strategies of mission include decentralized public health management. This is supposed to be realized by implementation of District Health Action Plans (DHAPs) formulated through a participatory and bottom up planning process. DHAP enable village, block, district and state level to identify the gaps and constraints to improve services in regard to access, demand and quality of health care. In view with attainment of the objectives of NRHM, DHAP has been envisioned to be the principle instrument for planning, implementation and monitoring, formulated through a participatory and bottom to up planning process. NRHM-DHAP is anticipated as the cornerstone of all strategies and activities in the district. For effective programme implementation NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the need for situation analysis, stakeholder involvement in action planning, community mobilization, inter-sectoral convergence, partnership with Non Government Organizations (NGOs) and private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving program functionaries and community representatives at district level.

Stakeholders in Process

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

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

1.2 - Objective of the process

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

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

1.3 Process of DHAP Preparation

Information collected from the District HQ, Block level and HSC is the key in preparing the District PIP. With the information gathered from the block, district has further held consultations with MOIC of block PHC and prepared their priorities and requirements, which are being reflected in the Block Health Action Plans. The method of data collection is both primary and secondary in the preparation of the Plan. The secondary data were collected by reviewing records, registers and annual reports. The data were also collected from DLHS, SRS and NFHS surveys to support the background information. For primary data, the procedure involved focus group discussions, interactions and meetings in Block. This was done to have opinion of all the programme officers, health staff, grass root workers and private partners. Based on the feedback received from the Block District programme officers have discussed and finalized the Block PIP requirements. The district has considered the requirement of the Block thoroughly. The BPMU team was thoroughly involved in the process and their critical inputs were incorporated to make this plan more holistic, realistic and achievable.
The Plan was further reviewed by the District Magistrate-Cum- Chairman, DHS Vaishali and the Civil Surgeon-cum-Secretary, DHS Vaishali. It should be mentioned that the plan has been prepared keeping in mind that private party can simultaneously complement the role of the Government machinery in delivering the health care services in the district as well as state.

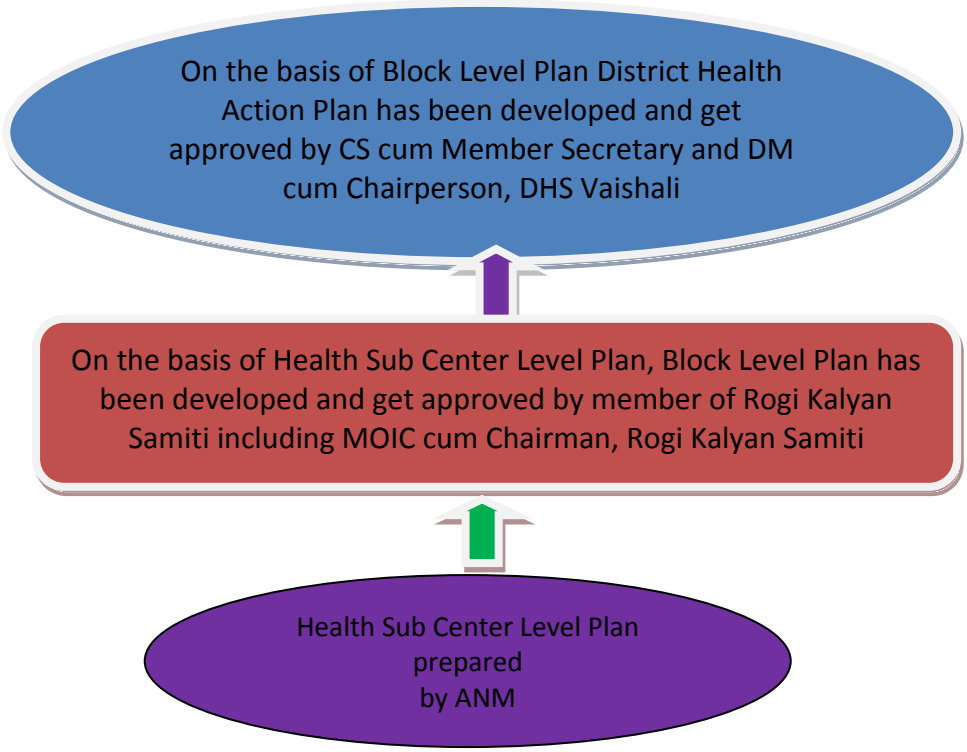
The preliminary stage of the planning comprised of review of available literature and reports. Following this the research strategies, techniques and design of assessment tools were finalized. As a preparatory exercise for the formulation of DHAP secondary Health data were complied to perform a situational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

1.4 Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon, ACMO (Nodal officer for DHAP formulation), as well as the MOICs, Block Health Managers, ANMs, as a result of 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



District Profile

Chapter 2

History

Vaishali derives its name from King Vishal of the Mahabharata age. The district of Vaishali came in to existence on 12/10/1972. Earlier it was the part of old Muzzafarpur district. Vaishali has a past that pre-dates recorded history. It is held that the town derives its name from King Vishal, whose heroic deeds are narrated in the Hindu epic Ramayana. However, history records that around the time Pataliputra was the centre of political activity in the Gangetic plains, Vaishali came into existence as centre of the Ganga, it was the seat of the Republic of Vajji. Vaishali is credited with being the World's First Republic to have a duly elected assembly of representatives and efficient administration. The Lord Buddha visited Vaishali more than once during his lifetime and announced his approaching Mahaparinirvana to the great followers he had here. Five years after the Enlightenment in Bodh Gaya, Lord Buddha came to Vaishali, the capital of one the first republican states in the Ganga, Vaishali is bound by the hills of Nepal on the north and the river Gandak on the west. Hundred years after he attained Mahaparinirvana, it was the venue of the second Buddhist Council. According to one belief, the Jain Tirthankar, Lord Mahavir was born at Vaishali. The Chinese travelers Fa-Hien and Hieun Tsang also visited this place in early 5th and 7th centuries respectively and wrote about Vaishali.

The Lichchavi nobility came to receive the Enlightened One with a cavalcade of elephants and chariots bedecked with gold. As the Lord set foot on the soil of Vaishali, **lightning and thunder** followed by a heavy downpour purged the plague-infected city. The Buddha preached the Ratna Sutra to those assembled, and eighty-four thousand people embraced the new faith. It was also at Vaishali that Amrapali, the famous courtesan, earned the respect of the *Sangha* and a place in history, with her generous donations. The neighbouring village of Amvara is said to be the site of Amrapali's mango grove. Once when the Lord was visiting Vaishali, Amrapali invited him to her house and the Lord graciously accepted the offer. An overjoyed Amrapali, returning on her chariot, raised a cloud of dust. The Lichchavi princes going to meet the Buddha got enveloped in the dust and learnt of the Buddha's forthcoming visit to her house. The Lichchavi princes wanted to exchange Amrapali's honour for one hundred thousand gold coins. Amrapali

steadfastly refused their offer and after the Buddha's visit to her house she was purged of all impurities. She gifted her mango grove to the *Sangha*. Amrapali joined the order after realising the transitory nature of all things, including beauty. A kilometre away is Abhishek Pushkarini, the coronation tank. The sacred waters of the tank anointed the elected representatives of Vaishali. Next to it stands the Japanese temple and the Vshwa Shanti Stupa (World Peace Pagoda) built by the Nipponzan Myohoji sect of Japan. A small part of the Buddha's relics found in Vaishali have been enshrined in the foundation and in the *chhatra* of the Stupa. Near the coronation tank is Stupa 1 or the Relic Stupa. Here the Lichchavis reverentially encased on of the eight portions of the Master's relics, which they received after the Mahaparinirvana. In the north is the Site Museum. It has an excellent collection dating from 3rd century BC to 6th century AD. The terracotta monkey heads in different styles are interesting. The Site Museum is open daily from 9 am to 5 pm. It is closed on Fridays. Entry is free. After his last discourse the Awakened One set out for Kushinagar, but the Lichchavis kept following him. Buddha gave them his alms bowl but they still refused to return. The Master created an illusion of a river in spate which compelled them to go back. This site can be identified with Deora in modern Kesariya village, where Ashoka later built a stupa. Ananda, the favourite disciple of the Buddha, attained *Nirvana* in the midst of the Ganga outside Vaishali.

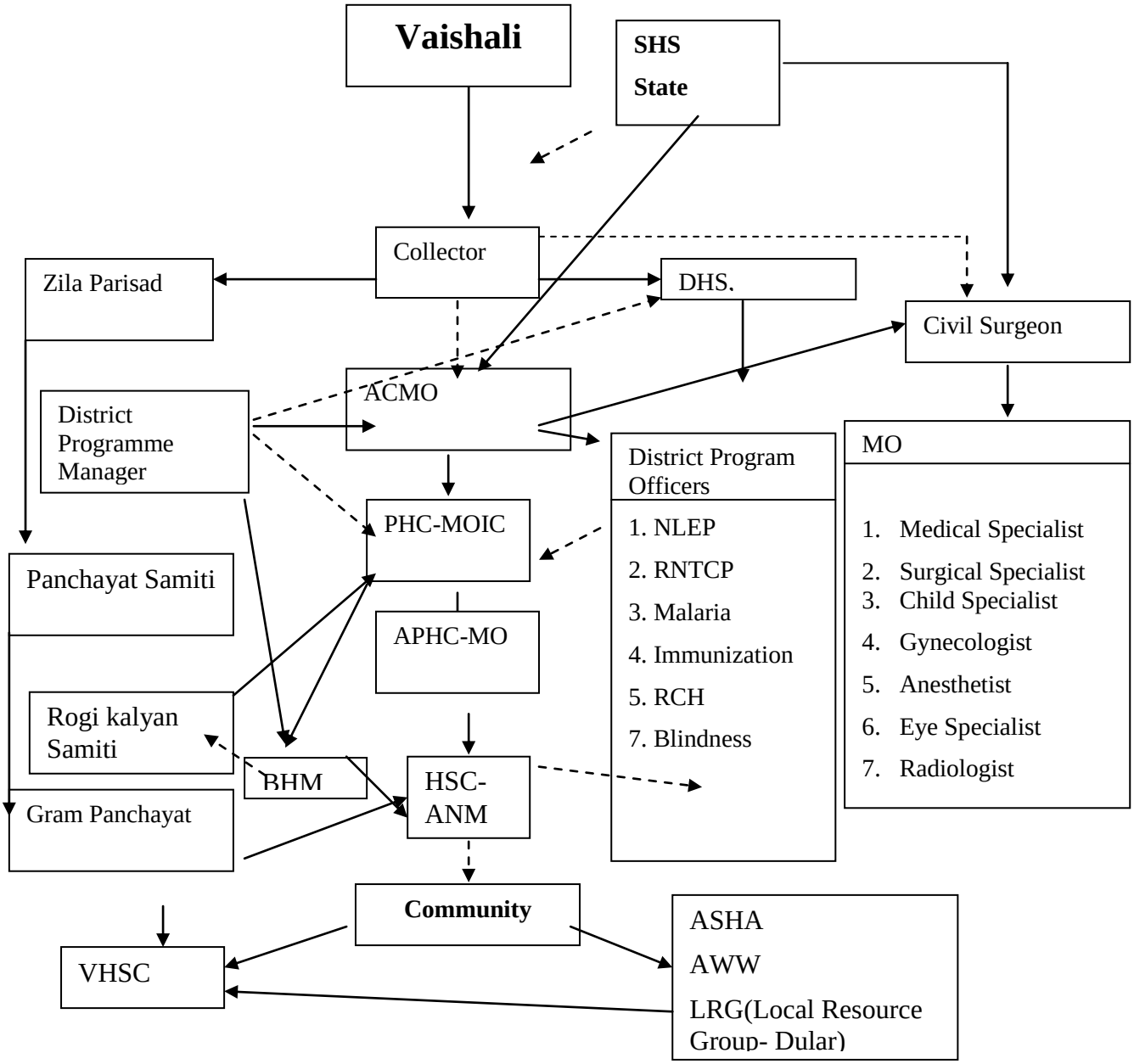
Geographical Location

The District is located at 25° to 30° North latitude and 84° to 85° east longitude. The District is surrounded by river Ganga in south, Gandak in west. District Muzaffarpur is in north & Samastipur n east. The District is in semi tropical Gangetic plane. The state capital Patna is linked with famous Mahatma Gandhi Setu. The District is spread over 2036 sq km area.

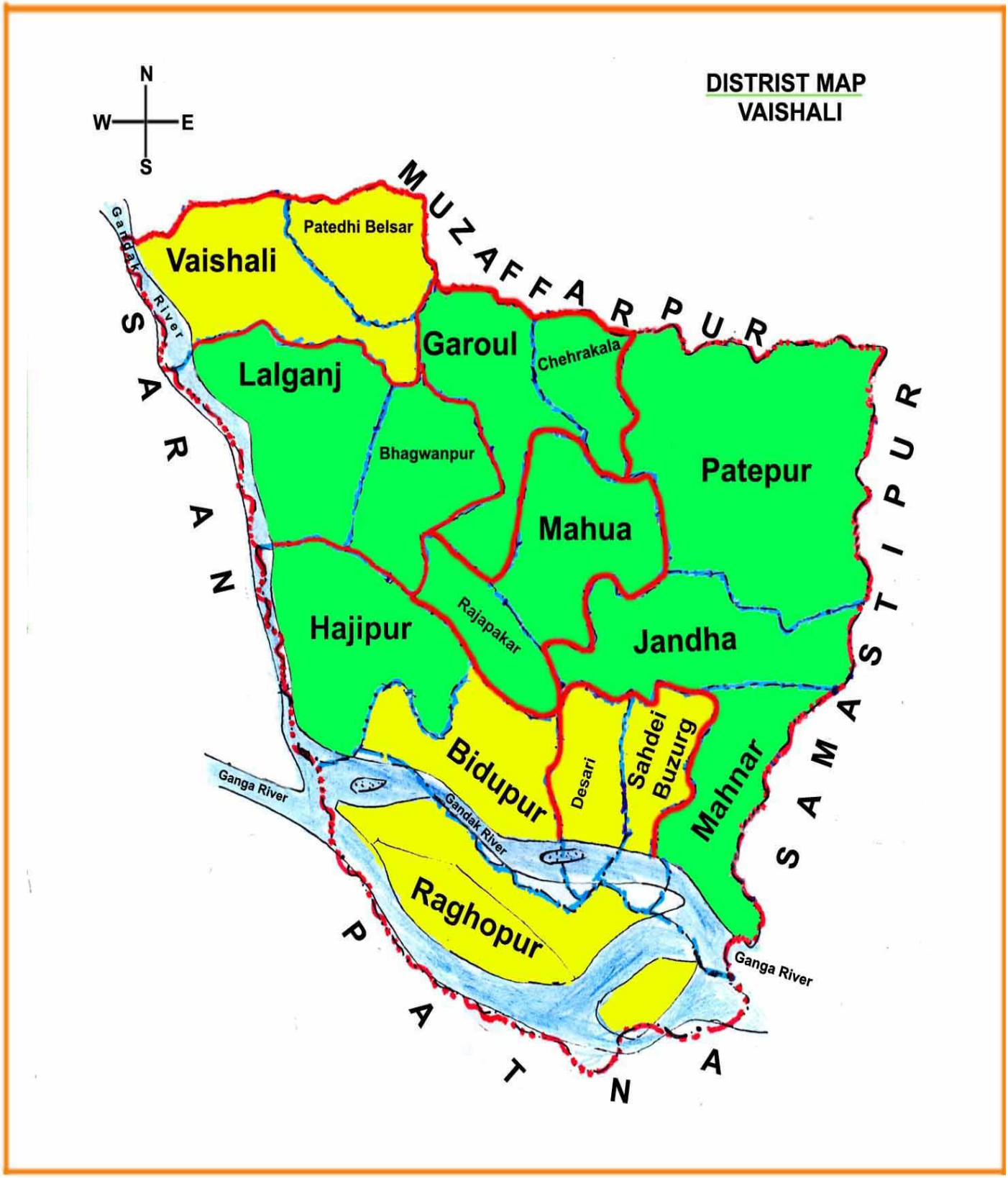
Govt. Administrative Set-up

There are three sub divisions and 16 Blocks in the District. The District has 1638 revenue villages and 290 Gram panchayats. Traditionally the District was divided into 11 C.D. Blocks but five more Blocks were created during last decade. A few of the newly created Blocks are still in the formation process. The newly elected Panchayati Raj is enthusiastic to play important role in the District.

District Health Administrative Setup



Vaishali District Map



VAISHALI – AT A GLANCE

Population:-3495249
Area:-2036 (Sq. Kms)
Density:-1717 Sq.Km
Sex Ratio:-892

Sl. No.	Name of Block	Total Population	No. of HSC	No. of Villages	No. of Panchyats
1	Bidupur	266694	28	115	24
2	Mahua	280739	25	119	24
3	Lalganj	261947	31	162	21
4	Raghopur	241367	21	78	20
5	Patedhi Belsar	95738	10	51	9
6	Bhagwanpur	208562	14	162	21
7	Vaishali	188191	19	117	16
8	Rajapakar	154578	18	71	13
9	Chehrakalan	129644	11	53	12
10	Sahdei Buzurg	127884	12	86	11
11	Desri	99957	11	32	8
12	Jandaha	267230	29	132	23
13	Patepur	363669	32	144	32
14	Goraul	174232	27	91	16
15	Mahnar	185199	18	50	14
16	Hajipur	449618	31	174	26
	Total	3495249	337	1637	290

COMPARATIVE POPULATION DATA (2011 Census)

Basic Data	India	Bihar	Vaishali
Population	1210193422	10,38,04,637	3495249
Density	382	1102	1717
Socio- Economic			
Sex- Ratio	940	916	892
Literacy % Total	74.04	63.82	68.56
Male	82.14	73.39	77.00
Female	65.46	53.33	59.10

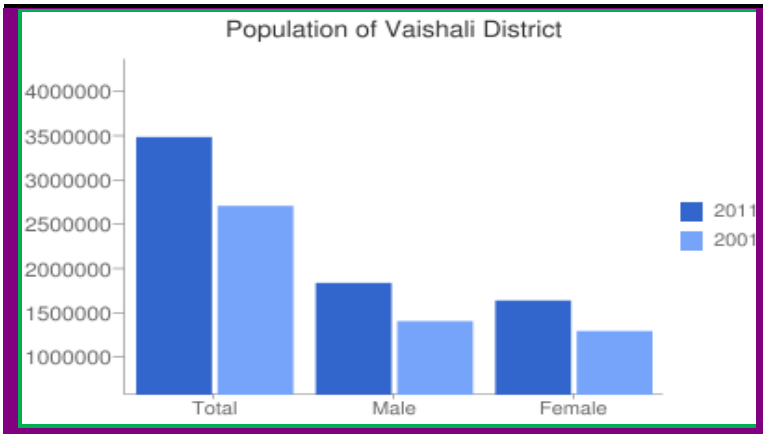
Highlights of 2011 Census

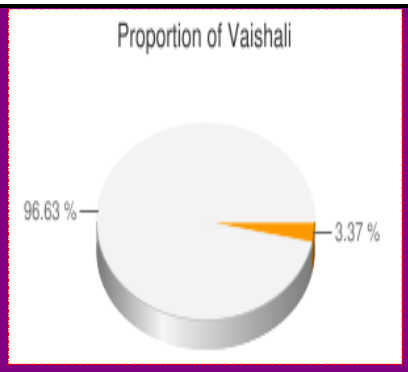
1. Total population is 3,495,249 compared to 2,718,421 of 2001.
2. Male and female were 1,847,058 and 1,648,191 respectively.
3. Population Growth for Vaishali District recorded in 2011 for the decade has remained 28.58 percent. Same figure for 1991-2001 decade was 26.39 percent.
4. Total Area of Vaishali District was 2,036 with average density of 1,717 per sq. km.
5. Vaishali Population constituted 3.37 percent of total Bihar Population.
6. Sex Ratio of Vaishali District is now 892, while child sex ratio (0-6) is 894 per 1000 boys.
7. Children below 0-6 age were 591,634 which forms 16.93 of total Vaishali District population.
8. Average Literacy rate for Vaishali District is 68.56 percent, a change of from past figure of 50.49 percent. In India, literacy rate is counted only for those above 7 years of age. Child between 0-6 ages are exempted from this.
9. Total literates in the Vaishali District increased to 1,990,809.

In 2011, Vaishali had population of 3,495,249 of which male and female were 1,847,058 and 1,648,191 respectively. There was change of 28.58 percent in the population compared to population as per 2001. In the previous census of India 2001, Vaishali District recorded increase of 26.39 percent to its population compared to 1991. The initial provisional data suggest a density of 1,717 in 2011 compared to 1,335 of 2001. Total area under Vaishali district is of about 2,036 sq.km. Average literacy rate of Vaishali in 2011 were 68.56 compared to 50.49 of 2001.

If things are looked out at gender wise, male and female literacy were 77.00 and 59.10 respectively. For 2001 census, same figures stood at 63.23 and 36.58 in Vaishali District. Total literate in Vaishali District were 1,990,809 of which male and female were 1,181,754 and 809,055 respectively. In 2001, Vaishali District had 1,098,151 in its total region. With regards to Sex Ratio in Vaishali, it stood at 892 per 1000 male compared to 2001 census figure of 920. The average national sex ratio in India is 940 as per latest reports of Census 2011 Directorate. In census enumeration, data regarding child under 0-6 age were also collected for all districts including Vaishali. There were total 591,634 children under age of 0-6 against 543,235 of 2001 census. Of total 591,634 male and female were 312,354 and 279,280 respectively.

Child Sex Ratio as per census 2011 was 894 compared to 937 of census 2001. In 2011, Children under 0-6 formed 16.93 percent of Vaishali District compared to 19.98 percent of 2001. There was net change of -3.05 percent in this compared to previous census of India. Vaishali District population constituted 3.37 percent of total Bihar population. In 2001 census, this figure for Vaishali District was at 3.37 percent of Bihar population.





Vaishali comparative figure (2001 to 2011)

Description	2011	2001
Actual Population	**3,495,249**	**2,718,42**
Male	1,847,058	1,415,60
Female	1,648,191	1,302,81
Population Growth	**28.58%**	**26.39%**
Area Sq. Km	2,036	2,036
Density/km2	**1,717**	**1,335**
Proportion to Bihar Population	3.37%	3.28%
Sex Ratio (Per 1000)	**892**	**920**
Child Sex Ratio (0-6 Age)	894	937
Average Literacy	**68.56**	**50.49**
Male Literacy	77.00	63.23
Female Literacy	59.10	36.58
Total Child Population (0-6 Age)	**591,634**	**543,235**
Male Population (0-6 Age)	312,354	280,442
Female Population (0-6 Age)	279,280	262,793
Literates	**1,990,809**	**1,098,15**
Male Literates	1,181,754	717,734
Female Literates	809,055	380,417
Child Proportion (0-6 Age)	**16.93%**	**19.98%**
Boys Proportion (0-6 Age)	16.91%	19.81%
Girls Proportion (0-6 Age)	16.94%	20.17%

2.1 SOCIO-ECONOMIC PROFILE

Social

- Vaishali district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Vaishali have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.
- 20.7% of the population belongs to SC and 0.1% to ST. There are at least 13% percent villages where the SC population is more than 40%. Some of the most backward communities are *Mushahar, Turha, Mallah* and *Dome*.

Economic

- The main occupation of the people in Vaishali is Agriculture, Fisheries and daily wage labour.
- Almost 20% of the youth population migrates in search of jobs to the metropolitan cities like Kolkata, Mumbai, and Pune etc.
- The main crops are Wheat, Paddy, Pulses, Oilseeds, Mango.
- Banana and Tobacco is the major cash crop of the community residing at the bank of holy river Ganges.

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

Rainfall and Flood Situation

The district receives medium to heavy rainfall (average rainfall 1161 mm), and faces condition of severe flood. In the year 2007 the flood condition was so bad that almost 145 gram panchayats and 583 villages got marooned. Patepur and Jandaha blocks were the worst affected blocks. According to the estimates of National Disaster Management Department, **in the year 2007, 1,64,237 people were directly affected by the floods.** Crops were damaged, and there was irreparable damage to property and huge loss of lives. **The economic loss due to floods this year amounts to Rs. 65 crore of crop loss, Rs. 25 crore of housing loss and Rs. 27 crore of public property loss.** The district has poor drainage system and nearly 4% of the area is water logged.

The district is spread over 2,036 sq km area, with no forest cover. 67% of the land is agricultural and nearly 67% of the area under cultivation is irrigated. Vaishali district is also affected by droughts. Cycles of floods and droughts severally affect the food production and food distribution system, and lead to distressful situation for most people.

2.2 HEALTH PROFILE

Situational Analysis of Key RCH Indicators

2.2.1 Maternal Health

Improving the maternal health scenario by strengthening availability, accessibility and utilization of maternal health services in the district is one of the major objectives of RCH. However, the current status of maternal health in the district clearly shows that the programme has not been able to significantly improve the

health status of women. There are a host of issues that affect maternal health services in district. The important ones are listed below:

• Shortage of skilled frontline health personnel (ANM, LHV) to provide timely and quality ANC and PNC services.
• The public health facilities providing obstetric and gynecological care at district and sub-district levels are inadequate.
• Mismatch in supply of essential items such as BP machines, weighing scales, safe delivery kits, Kit A and Kit B, etc and their demand.
• Shortage of gynecologists and obstetricians to provide maternal health services in peripheral areas.
• Inadequate skilled birth attendants to assist in home-based deliveries.
• Weak referral network for emergency medical and obstetric care services.
• Lack of knowledge about antenatal, prenatal and post natal care among the community especially in rural areas
• Low mean age of marriage resulted in pregnancy and difficult deliveries.
• Low levels of female literacy resulted unawareness on maternal health services.
• High levels of prevalence of malnutrition (anemia) among women in the reproductive age group

Important MCH indicators

Current Status vs. Goals:

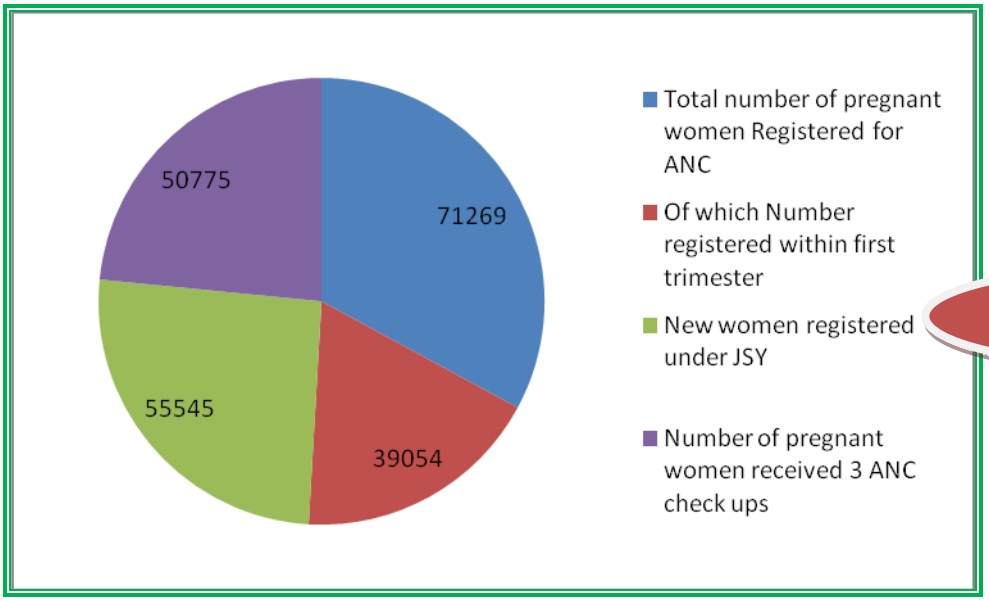
	Current Tenth Five Year Plan	NPP2010	MDGs2015
IMR	53 (SRS 2009)	45	30
NMR	36 (SRS 2007)	26	20
MMR	254 (SRS 2004-2006)	200	100

IMR,NMR-per 1000 live births; MMR per 1,00,000 live births

Note: IMR – Infant Mortality Rate; NMR – Neonatal Mortality Rate; MMR – Maternal Mortality Ratio, SRS – Sample Registration Survey; NPP – National Population Policy; MDG – Millennium Development Goals.

Maternal Factors

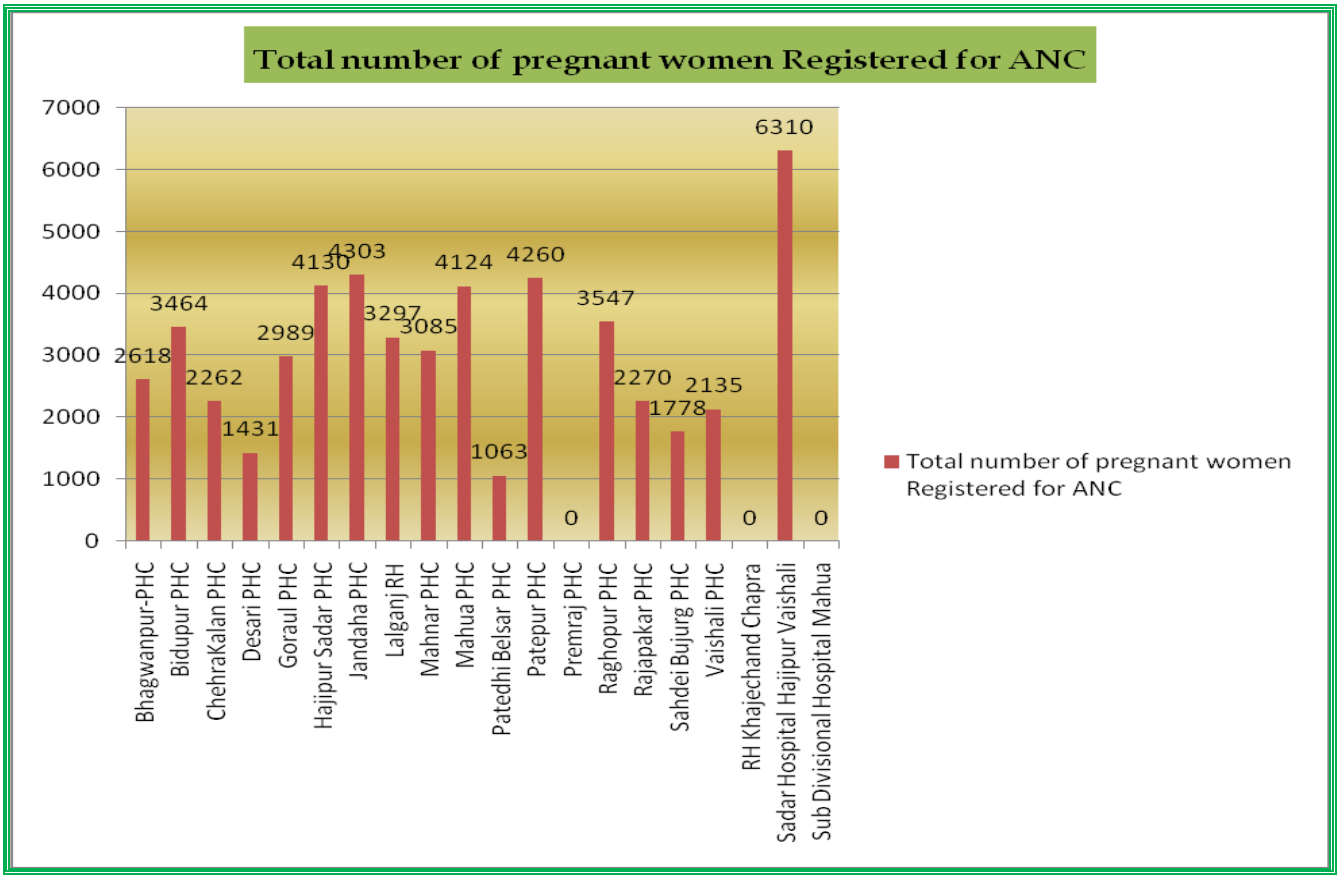
• High levels of maternal malnutrition leading to increased risk pre-term and low - birth weight babies' that in turn increase risk of child mortality.
• Low levels of female literacy, particularly in rural areas.



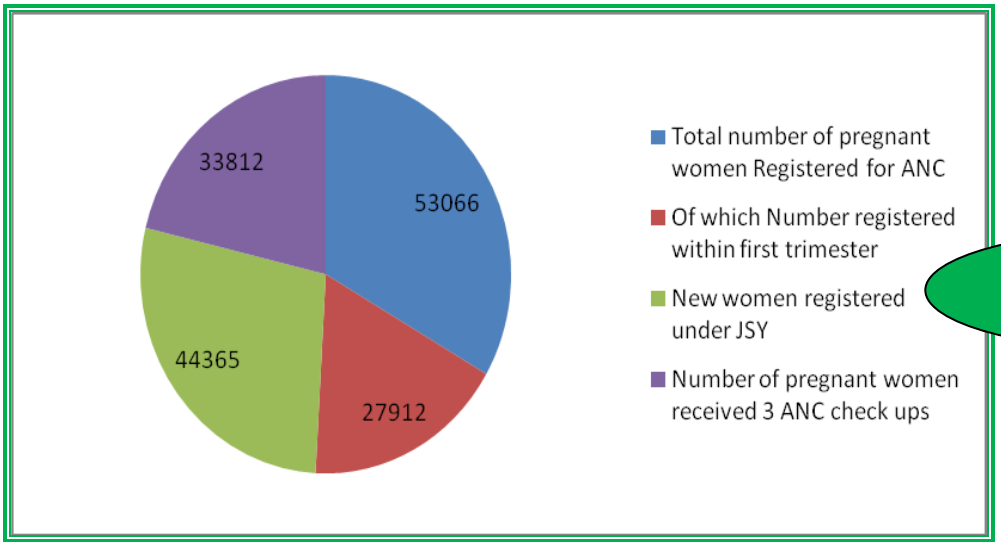
ANC status 2010-11

Sources-HMIS

Above diagram shows the improvement in the ANC status in 2010-11.



Total No. of PW registered for ANC
Block Wise
Figure - 2011-12 till Nov.
Source-HMIS



ANC status 2011-12 till Nov.

Sources-HMIS

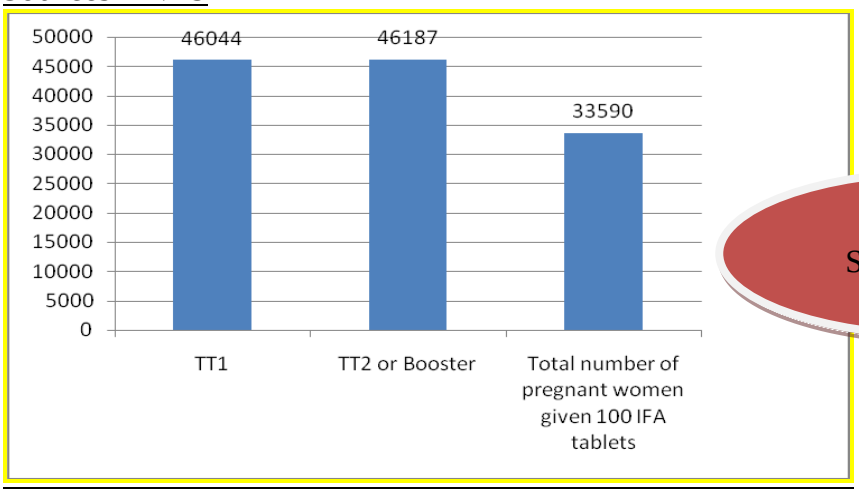
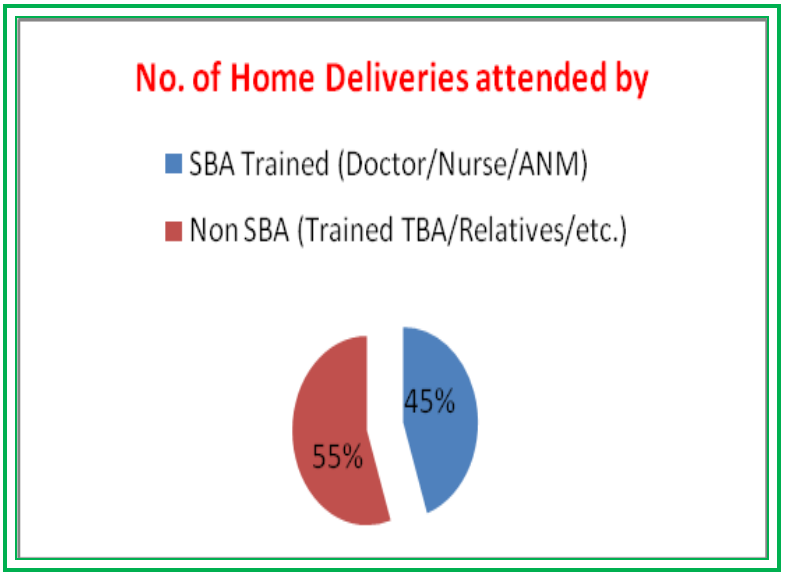
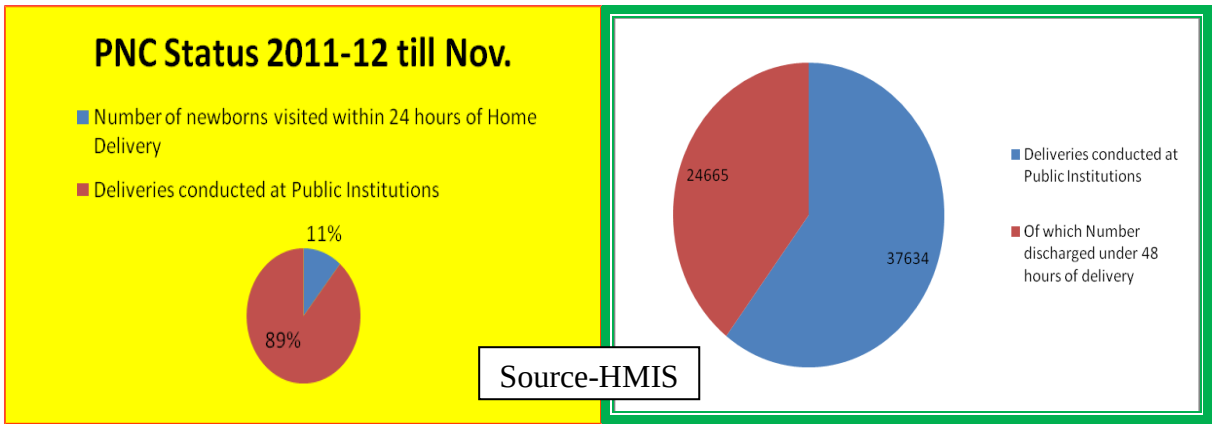


Fig.2011-12
Sources -HMIS

Compare with the Expected Level of achievement 33,590 PW have taken 100 IFA tab. Till Nov. where as the total ELA for the 2011-12 is 109576, like wise46044 & 46187 PW have taken TT-1,TT-2 where as ELA for this is 109576.



Home delivery status 2011-12 till Nov. (Source-HMIS)



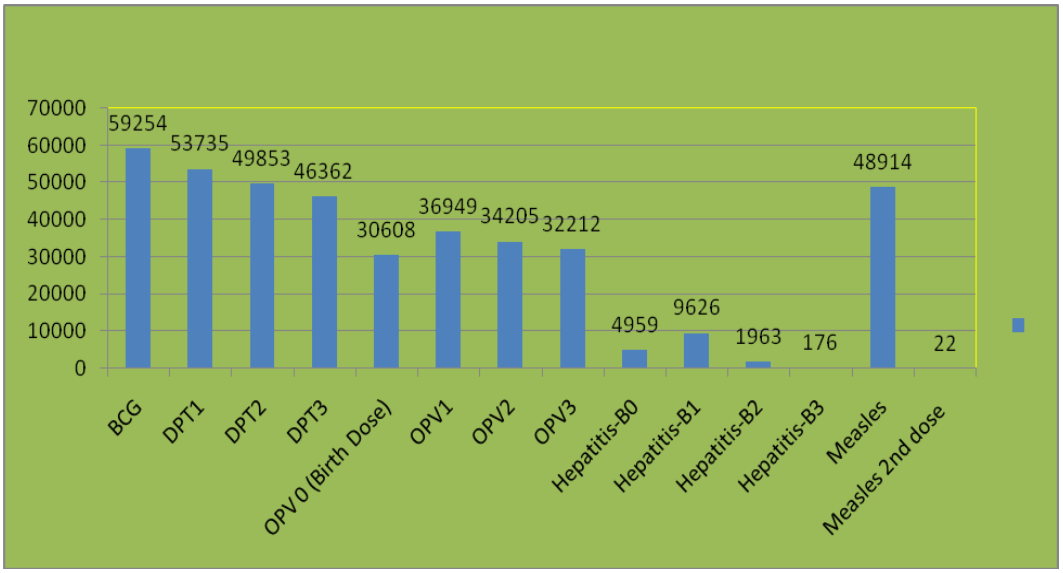
The above diagram shows the PNC status of the Vaishali district, the figure seems that there should be given a special attention on Post Natal Checkups for the preventing of PPH and other risks, where as the fig.-2 shows the no. of staying of PW(24665) where as the total deliveries conducted at Public Institutions in 37634 till Nov.

2.2.2 Child Health

The child health indicators of the state reveal that the state's IMR is lower than the national average but the NMR is disproportionately high. Morbidity and mortality due to vaccine-preventable diseases still continues to be significantly high. Similarly, child health care seeking practices in the case of common childhood diseases such as ARI and Diarrhoea are not satisfactory. The child health scenario is worse for specific groups of children, such as those who live in rural areas, whose mothers are illiterate, who belong to Scheduled Castes, and who are from poor households is particularly appalling. Issues affecting child health are not only confined to mere provision of health services for children, but other important factors such as maternal health and educational status, family planning practices and environmental sanitation and hygiene have enormous bearing on child health. This is more than evident in the case of Bihar where child health continues to suffer not only because of poor health services for children but due to issues such as significantly high maternal malnutrition, low levels of female literacy, early and continuous childbearing, etc. The specific issues affecting child health in the state are listed below.

High levels of child malnutrition, particularly in rural areas and in children belonging to disadvantaged socio-economic groups leading to a dis-proportionate increase mortality.

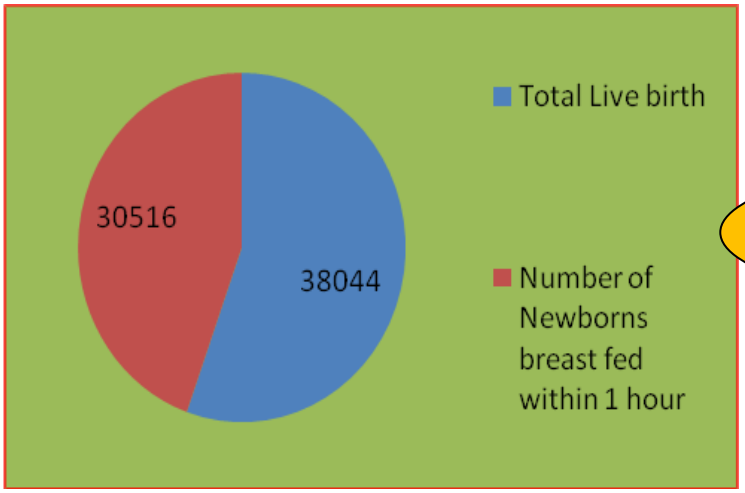
• Persistently low levels of child immunization primarily due to non-availability of timely and quality immunization services.



• Lack of child health facilities, both infrastructure and human resource, to provide curative services for common childhood ailments such as ARI, Diarrhea, etc.
• Inadequate supply of drugs, ORS packets, weighing scales, etc.
• Lack of knowledge of basic child health care practices among the community.
• Failure to generate community awareness regarding essential sanitation and hygiene practices that impact on the health of children.

Child Health Services

The programme has not succeeded fully in effectively promoting colostrums feeding immediately afterbirth and exclusive breastfeeding despite almost universal breastfeeding practice in the state. In the State majority of mother breast feed children beyond six months. However both State and UNICEF have taken initiative to generate awareness among mothers for exclusive breast feeding. In this context Vaishali have given more emphasis on the exclusive breastfeeding. The given diagram shows the figure. The no. of newborns breast fed within 1 hour is 30516 where as the total live birth is 38044.



Status- 2011-12 till Nov.
Source-HMIS

2.2.3 Family Planning

Family Planning Services

The Family Planning programme has partially succeeded in delaying first birth and spacing births leading to significantly high mortality among children born to mothers under 20 years of age and to children born less than 24 months after a previous birth.

We really need to reposition our family planning strategy to reach our population stabilization goals. The fact is there's a huge unmet need for contraception in India. There's a huge demand and 18 per cent fertility is due to this unmet need. There's no reason why a woman should have a child just because she does not have access to contraceptives. Access must be improved. Another major contributor to population is the population momentum caused by couple in reproductive age having children. This can't be fully controlled. So we need to help such couples delay the first child birth and space children better. For that to happen, temporary methods have to be made available to advance fertility. To address the third issue of wanted fertility, we need better healthcare facilities so that newborns survive. In 2011, let us also remember that literacy is the best contraception and work towards the goal of literacy.

RCH emphasizes on the target-free promotion of contraceptive use among eligible couples, the provision to couples a choice of various contraceptive methods (including condoms, oral pills, IUDs and male and female sterilization), and the assurance of high quality care. It also encourages the spacing of births with at least three years between births. Despite RCH and previous programmes vigorously pursuing family planning objectives, fertility in Bihar continues to decline at much lower rates than the national average. Although the total fertility rate has declined by about half a child in the six-year period between NFHS-1 and
NFHS-2, it has increased in NFHS-3 and is far from the replacement level.
Furthermore, certain groups such as rural, illiterate, poor, and Muslim women within the population have even higher fertility than the average, The persistently high fertility levels point to the inherent weakness of the state's family planning programme as well as existing socio demographic issues. High TFR is reflected by a dismal picture of women in Bihar marrying early, having their first child soon after marriage, and having two or three more children in close succession by the time they reach their late-20s. At that point, about one-third of women get sterilized. Very few women use modern spacing methods that could help them delay their first births and increase intervals between pregnancies.
The major issues affecting the implementation of the Family Planning programme in Bihar are as follows.

- Lack of integration of the Family Planning programmes with other RCH components, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels.

• Failure of the programme to effectively undertake measures to increase median age at marriage and first childbirth.
• Inability of the programme to alter fertility preferences of eligible couples through effective behavior change communication (BCC).
• Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age groups. (Overall, sterilization accounts very less in the total contraceptive use. Use rates for the pill, IUD, and condoms remain very low).

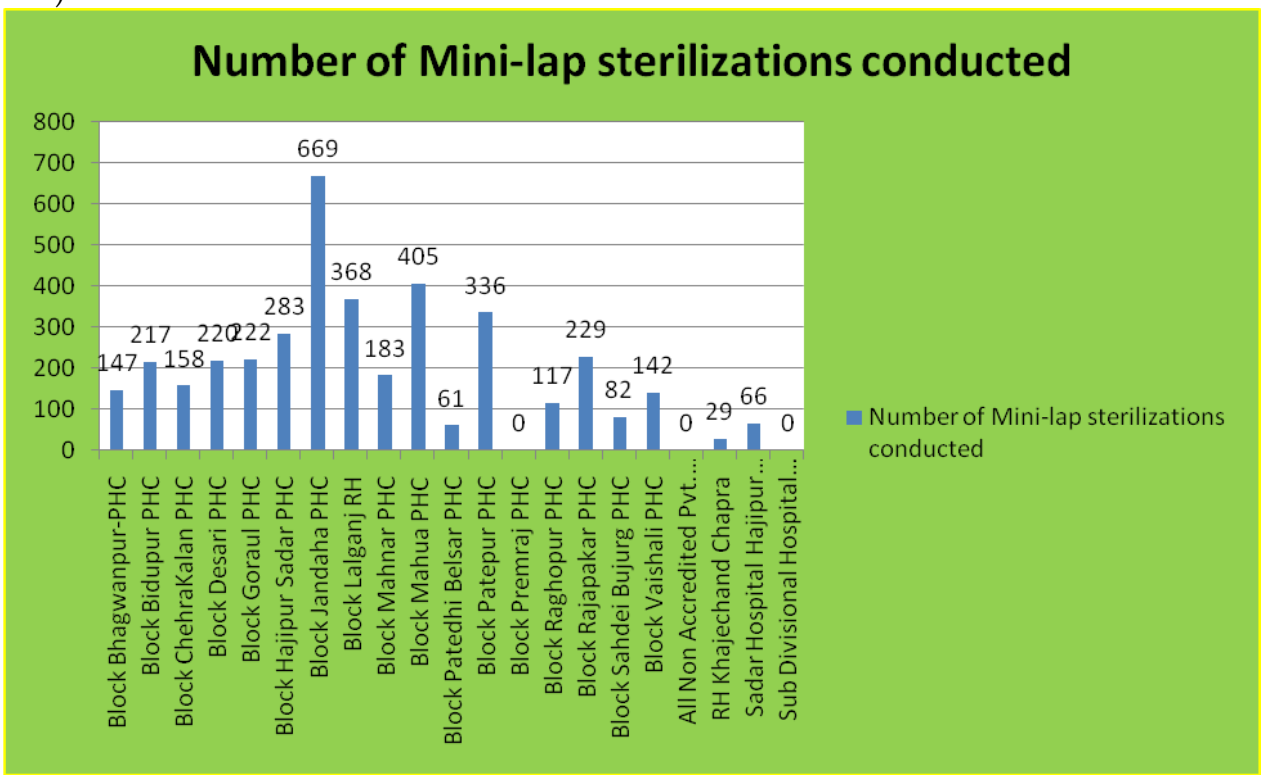
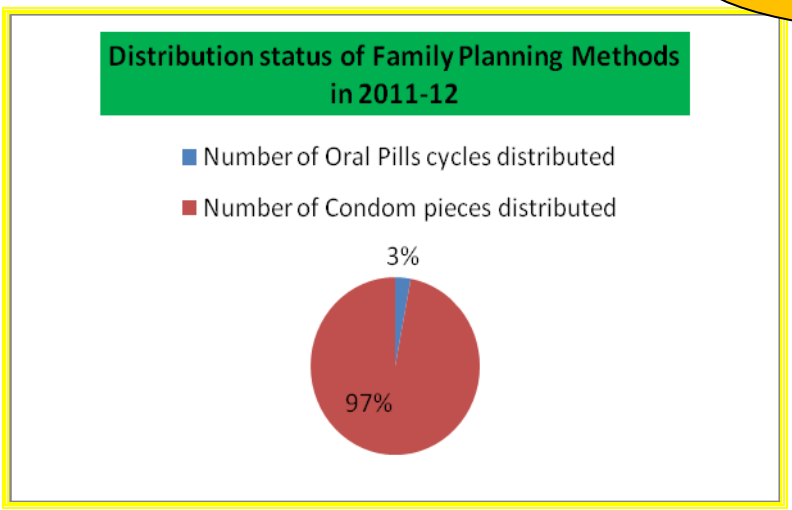


Fig. 2011-12 till Nov.
Source-HMIS



• Due to high prevalence of RTI/STD, IUDs are not being used by majority of women.

• Continued use of mass media to promote family planning practices despite evidently low exposure to mass media in Bihar, leading to lower exposure of family planning messages in the community, particularly among rural and socio-economically disadvantaged groups.
• Weak public-private partnerships, social marketing to promote and deliver family planning services. Nursing homes in districts are accredited to conduct Family planning operation.
The issues mentioned above are closely interlinked with the existing socio demographic conditions of the women, specially rural, poor and illiterate. Comprehensive targeted family planning programme as well as inter sectoral coordination on an overall female empowerment drive is needed to address the factors responsible for persistently high fertility levels in Bihar.

2.2.4 Adolescent Reproductive & Sexual Health

The World Health Organization (WHO) defines adolescence as the period between 10 and 19 years of age, which broadly corresponds to the onset of puberty and the legal age for adulthood. Commencement of puberty is usually associated with the beginning of adolescence. In some societies, adolescents are expected to shoulder adult responsibilities well before they are adults; in others, such responsibilities come later in life.

Being better educated and with better health profiles than earlier generations, they are both a huge asset to the country and also a potential challenge, if not nurtured well. While access to education, exposure to the electronic media, and wider academic and employment choices have provided them with an environment rich in potential and possibilities, these developments have also exposed them to great vulnerabilities. Specific to health, poor information and limited power to make informed sexual and reproductive health choices places them at great risk.

It is critical to reach out to this vulnerable age group. In the short term, they are exposed to health risks. From a long-term perspective, the sexual and reproductive choices and behaviors they adopt would determine the future population and health map of the country.

Although it is a transitional phase from childhood to adulthood, it is the time that the adolescents experience critical and defining life events – first sexual relations, first marriage, first childbearing and parenthood. It is a critical period which lays the foundation for reproductive health of the individual's lifetime. Therefore, adolescent reproductive and sexual health involves a specific set of needs distinct from adult needs. The reproductive health needs of adolescents as a group has been largely ignored to date by existing reproductive health services.
Many adolescents in India face reproductive and other health risks. Poor nutrition and lack of information about proper diets increase the risk of iron-deficiency anemia for adolescent girls. Young women and men commonly have reproductive

tract infections (RTIs) and sexually transmitted infections (STIs), but do not regularly seek treatment despite concerns about how these infections may affect their fertility. India also has one of the highest rates of early marriage and childbearing, and a very high rate of iron deficiency anemia. The prevalence of early marriage in India poses serious health problems for girls, including a significant increase of maternal or infant mortality and morbidities during childbirth. The following facts will help understand the situation objectively.

- The median age of marriage among women (aged 20 to 24) in India is 16 years.
- In rural India, 40 percent of girls, ages 15 to 19, are married, compared to only 8 percent of boys the same age.
- Among women in their reproductive years (ages 20 to 49), the median age at which they first gave birth is 19.
- Nearly half of married girls, ages 15 to 19, have had a least one child.
- India has the world's highest prevalence of iron-deficiency anemia among women, with 60 percent to 70 percent of adolescent girls being anemic.

Underlying each of these health concerns are gender and social norms that constrain young people –especially young women's – access to reproductive health information and services. Motherhood at a very young age entails a risk of maternal death that is much greater than average, and the children of young mothers have higher levels of morbidity and mortality. Early child bearing continues to bean impediment to improvements in the educational, economic and social status of women in India. Overall for young women, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children's quality of life.

In many societies, adolescents face pressures to engage in sexual activity. Young women, particularly low income adolescents are especially vulnerable. Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting sexually transmitted diseases, including HIV/AIDS; and they are typically poorly informed about how to protect themselves. To meet the reproductive and sexual health needs of adolescents, information and education should be provided to them to help them attain a certain level of maturity required to make responsible decisions. In particular, information and education should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction.

Information and education programs should not only be targeted at the youth but also at all those who are in a position to provide guidance and counseling to them, particularly, parents and families, service providers, schools, religious institutions, mass media and peer groups. These programs should also involve the adolescents in their planning, implementation and evaluation. Being a sensitive and often, controversial area, adolescent reproductive and sexual health issues and information are very often difficult to handle and disseminate. Furthermore, the

contents do not only deal with factual and knowledge-based information but more importantly, need to deal with attitudinal and behavioral components of the educational process.

Thus it can be conclusively stated that adolescents are a diverse group, and their diversity must be considered when planning programs. Adolescents, the segment of the population in the age group of 15 -19 years, constitute about 23% of the population of the state. This group is critical to the success of any reproductive and sexual health programme, as it would remain in the reproductive age group for more than two decades. Early marriages seem to be still a key problem. Percentage of boys who are married before attaining 21 years in consistently high in most districts. The mean age of marriage for girls is 16.9. 25% pregnant mothers in the state are in the age group of15-19 years. This is due to the reason that most of the girl's married before18years.

The various anecdotal evidences emerging from the community level participatory planning exercises and opinions voiced by the various levels of health officials during consultation exercise indicate that there is lack of a cohesive ARSH strategy at the state level. Possibility of bifurcating the total target into school going and out of school going adolescents have not been examined as a strategy option. Hence the current school health program by and large lacks any adolescent oriented interventions.

The possibility of convergence between the RCH II program priorities and NACP priorities require to be integrated. Specific capacity building initiatives to orient the health providers at various levels to specific necessities of the ARSH program like adolescent vulnerability to RTI/STI/HIV /AIDS, communication with adolescents, gender related issues, designing adolescent friendly health services, body and fertility awareness, contraceptive needs etc have not been actively taken up the state health department to prepare itself to tackle the problems / issues of this important segment.

At the district and Block levels, we can–Support and implement a number of young people's reproductive and sexual health programme to create education and awareness among adolescents in partnership with local NGOs. These include life skills education, group counseling sessions, peer education, and empowerment of married and unmarried adolescents. Support service delivery initiatives aimed at reducing iron deficiency anemia and addressing other health concerns of adolescents.

Child Sex Ratio

The declining female sex ratio has been a matter of concern for several years now. The 2001 and 2011 Census had set the alarm bells ringing when data showed that in Vaishali especially in the age group 0-6 years, the ratio of girls per 1000 boys

had fallen from 894 in 2001 to 937. This was attributed to the practice of sex-selective abortion.

There are various socio-economic and health implications of a declining sex ratio. A fall in the number of females in society is likely to increase sex-related crimes against women, polyandry, bride selling, prostitution, sexual exploitation and increase in cases of STD and HIV/ AIDS. The health of the woman is affected as she is forced to go for repeated pregnancies and abortions.

It has been found that the imposition of a two-child norm, where disincentives are associated with the number of children, also has a negative impact on the sex ratio and needs to be strongly discouraged.

Focus on the girl child

While a lots of effort to empowering women to exercise their reproductive rights, there is a need of special focus on the prevention of Sex determination of girl child. There is a necessity of campaign highlighted the positive value of the girl child and interlinked the issue of sex-selective abortion with human rights.

At the district and Block levels, we Can

Promote the value of a girl child by generating awareness on the issue and on the problems the society would face due to the 'missing girls'. Increase awareness about the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act and government schemes for the girl child. Engage with district and block level officials, Panchayats members, AWWs, ANMs, mahila mandals and midwives. Work with the community through the formation of community support groups, identify leaders and build their capacities.

<u>Support required from the state level,</u>

Sensitize key stakeholders, including Members of the Legislative Assembly (MLAs), state departments of health, education, women and child development and Panchayati Raj; the corporate sector, media, NGOs, medical professionals and school/college teachers and students on the issue declining female sex ratio. Advocate collective action and monitor implementation of supportive laws and policies. Facilitate inter-state consultation meetings, promoting an exchange of learning as well as the development of joint strategies to address issues such as cross-border and inter-district practice of sex-selective abortions.

2.2.5 Health Infrastructure and Facilities of Vaishali

District Hospitals:

Introduction:

Sadar hospital- Hajipur is designated as District hospital for the Vaishali District with the bed strength of 120 beds. The scope of hospital service delivery has been expanded since its up gradation from sub divisional hospital to district hospital and presently hospital is providing in area of Maternal and Child Health, General Surgery, Physician, Orthopedics, Dentistry, ophthalmology, RTI / STI etc. Hospital also has Blood bank and Special Care Newborn Unit, kala azar ward, ICTC, ARI Centre. With the expansion in service delivery, utilization rate of hospital is also increased many folds. On an average, Hospital serves about 900-1000 OPD patients and conduct around 25-30 Deliveries per day. The major achievements of in service delivery are summarized at last.

Infrastructure:

Infrastructure of hospital is not in good position. The hospital cannot be identified easily as its main entrance is almost does not exist. . The hospital premises can be broadly the hospital can be divided into four wings i.e. (i) Emergency / Causality (ii) Indoor building (iii) OPD building (iv) MCH unit comprising Labor ward and SCNU. There are many offices like Civil Surgeon office, , District Health Society, NPSP- WHO unit, Red Cross office, Office of TB and leprosy, Rogi Kalyan Samiti office are also situated in the hospital premises. The road has many potholes and broken at many places. In such condition patient suffers a lot while being transferred from one place to another. The drains are fully logged which also becomes an ideal breeding site for mosquitoes and thus spreading the infectious diseases. The condition gets worsen during monsoon season due to water logging at many places on road and people are left with no alternative but to wade through the water logged areas to reach different departments. PHED department was contacted for water logging problem, according to them the only solution for the problem is raising or elevating the ground level. Hospital also do not have separate pediatric ward despite availability of specialist pediatricians at the hospital. Presently, the cases of sick children are being treated in the general ward by Medical officer. Probable site has been identified for the pediatric ward – Either 1st floor of SCNU or building in-front of the CS office. For proper care of sick children, the setting up of the ward is critically important. Hospital also lacks any Enquiry centre, without proper enquiry centre many patients' attendants are found to be ramble around the different departments and hence suffered a lot. Therefore it is proposed to have separate pediatric ward and enquiry centre at the hospital. Overall infrastructure of hospital buildings can be marked with ripping plaster, broken window and pipes, abrupt supply of water, missing and broken basins and taps, loose electrical fittings etc. Indoor wards are running in old building, OT is also present in the same building. Emergency ward is currently under repairing with the support of UNICEF. OPD runs both in morning and

evening and in new OPD building. MCH OT comprises of SCNU and labor ward. A separate MCH OT is recently started on the first floor of labor ward. This building also requires minor repairing work. To cope up with the frequent Electric faults and plumbing problems which affect routine activities of hospital an agency could be identified for regular maintenance and repairing of these items on basis of Annual Maintenance contract. Ground water is being supplied at the hospital with no any filtering or cooling equipment. Therefore it is proposed to have at least two water filtering machine and two water cooling machine.

Sl.No	Designation	Sanctioned	Regular	On deputation	Contractual	Daily wage worker	Hospital Total	Remarks
1	Deputy Superintendent	1					0	DS in charge
2	Medical Officers	11	9	9	9		27	
3	Clerk	1	1	1			2	One clerk for RKS
4	Store keeper	1	1				1	
5	Sister "A"	1	0				0	
6	Grade "A" Nurse	14	6		4		10	One on deputation to other place
7	Pharmacist	3	3	1			4	
8	OT assistant	1	0		1		1	
9	X-ray Technician	1	1				1	
10	Laboratory Technician	2	1				1	
11	Assisstant Lab Technician	1	1				1	
12	Driver	1	1			1	2	One Working in CS office
13	Dresser	3	3				3	
14	Physiotherapist	1	1				1	
15	Peon	2	2				2	
16	Mali	1	1				1	
17	Cook	1	1				1	
18	Cook assistant	1	1				1	
19	Ward attendant	11	11				11	
20	Sweeper	11	10				10	
21	Trained Dai	1	0				0	
22	Ophthalmic assistant			3			3	
23	Lady Health visitor			2			2	One for Immunization
24	ANM			20			20	
25	Child Health Supervisior				1		1	
26	Health Educator			4			4	
27	Grade IV staff			9			9	
28	Emergency duties					3	3	
29	Drug Dispensing					4	4	
30	ECG technician					1	1	
31	Pump operator					1	1	
32	Regional worker			2			2	
33	Leader			1			1	
34	Hospital manager				1		1	
35	Data Operator				1		1	
36	Dental surgeon				2		2	
Total		70	54	52	19	10	135	

Human Resources:

The hospital has been selected to upgrade as Model FRU. Presently hospital has all the necessary facilities required for functional FRU as per guidelines. But all these health services and all other health services of hospital are being offered and managed with acute shortage of manpower. The shortage is even worse in case of nursing staff. There is only two dedicated nursing staff for the labor ward managing about 25-30 deliveries per day. The scenario of manpower not only increases the work load among staff but many a times it also leads to comprise in quality of services.

In spite of being upgraded as District hospital, hospital is still working as per the staff sanctioned for sub divisional hospital. Although the facility has been approved to be upgraded as 500 bedded hospital with required staff, but no progress has been observed in the matter.

The human resource of hospital is shown in below table:

Recently separate OT has started for exclusive MCH services on first floor of labor ward without any substantial addition to the labor ward staff. To make hospital fully functional and model FRU it is required that hospital must be allotted the fund sanctioned for up gradation as 500 bedded hospital. Meanwhile hospital urgently requires paramedical staff especially for nursing and for MCH OT which is reflected in budget. The nursing staff so available is also not placed as per their trainings. The thrust will be placing the ANMs and Grade A Nurse as per their trainings. Efforts will be put on providing SBA, new born training to the nursing staff placed at labor ward and SCNU respectively. The training status of nursing staff is summarized in below table:

MCH training status	
Total Trained in SBA	**8**
Total trained in New born care	**16**
Trained in Both SBA & Newborn care	**4**
Trained in SBA only	**3**
Trained in New born care only	**12**
Trained in new born care and posted in SCNU	**12**
Trained in SBA and posted / duty in Labour ward	**3**

Equipments, Drugs and supplies:

To plan, implement and monitor all the activities related to FRU operationalization and hospital day to day function a Hospital coordination committee is formed under the chairmanship of Deputy Superintendent. The hospital committee has identified and approved following MCH equipment to procure.

Equipment requirement for Sadar Hospital - Hajipur **(Maternal Health)**	
Instruments/ Equipments	**Requirement**
ANC Clinic	
Sphygmomanometer - stethescope	2
Weighing machine	2
Labour Room	
Baby weighing scale	2
Sphygmomanometer - stethescope	2
Stethoscope	2
Oxygen cylinder	4
EmOC Equipments	
Labor table	3
Outlet forceps	4
Ventouse vaccum extractor	2
Kelley's	1
Kocher's	12
Allis	24
Sponge sticks (also used on the uterus)	12
Needle drivers	24
Bandage scissors (to cut cord)	12
Straight mayos (suture scissors)	6
Curved Mayos (anatomy scissors)	12
Adsons (skin) forcep	12
Smooth pick ups (bladder flap)	12
Pick ups with teeth	6
Abdominal retractors	6
OT Lights	6
Spinal anaesthesia tray	4
Boyles apparatus	2
Newborn Care Corner in Labour Room	
Baby cot/trolley with radiant warmer (1)	2
Bag & mask of two sizes: size '1' for normal weight baby and '0' for small baby (Physical verification)	2
Oxygen	6
Foot operated suction pump	2
Weighing machine	2
Safe Abortions	
Dilators (Hegar: sizes 4–14mm)	2 set
Vacuum aspirator (manual vacuum aspiration syringe or electric pump + tube)	6 set
Flexible cannulas (sizes 6–12 or 14) plus adaptors, if needed	6 set
Speculums of various sizes (Sims, Cusco, Graves or valve(s))	6 set
Volsellum	6 set
Set of three curettes of different diameters	6 set
Family Planning	
Minilaparotomy kit (FS)	*6 Kit*
Others	
OT lights (mobile)	4
OT lights (Ceiling)	4
Pulse oxymeter	2
Monitor (Anesthesia)	2

Sub District Hospitals: At present there is Two Sub Divisional Hospital in Vaishali district namely Mahua and the Mahnar**.**

Referral Hospitals: There are 3 referral Hospitals in Vaishali District namely as Lalganj, Mohanpur and Khajechand Chapra. These referral hospitals get patient from PHCs, APHCs and are covered by specialised services.

Block PHCs: At present there are 16 in the district.These PHCs require to be upgraded at CHC level for specialised Services. These upgraded new PHC require proper building infrastructure as per IPHS norms. It is proposed in PIP 2012-13.

Additional PHCs: The total no. of Additional PHC is 32. These Additional PHCs only provide OPD services. All these APHCs require functionalizing the inpatient for providing deliver services and reduce the load of Block PHCs.

- APHC list with their blocks name:-

Sl. No.	Name of APHC	Name of Block
1	MalangHatt	Lalganj
2	Ghattaro	Lalganj
3	Prataptand	Bhagwanpur
4	Sarai Patedha	Bhagwanpur
5	Patedha Sarai	Bhagwanpur
6	Hasimalahi	Bhagwanpur
7	Pohiyar	Sahdei Buzurg
8	Sondho	Goraul
9	Kathara	Chehrakalan
10	Pakauli	Bidupur
11	Dhabauli	Bidupur
12	Madarna	Vaishali
13	Bhagwanpur Ratti	Vaishali
14	Haujpur Hatt	Vaishali
15	Anirudh	Patedhi Belsar
16	Saien	Patedhi Belsar
17	Jarang	Patedhi Belsar
18	Chmarhara	Mahnar
19	Basudevpur Chandel	Mahnar
20	Chandsarai	Mahnar
21	Chaksikandar	Rajapakar
22	Garahi	Jandaha
23	Mahisaur	Jandaha
24	Nasratpur	Jandaha
25	Veerpur	Raghopur
26	Zurawanpur	Raghopur
27	Mallikpur	Raghopur
28	Ghoshwar	Hajipur
29	Baligaon	Patepur
30	Tisiotta	Patepur
31	Subhai	Hajipur
32	Karnpura	Hajipur

HSCs:

At present there are 337 HSCs in the district. Most of the HSCs are running from the rented place or Panchayat office. Mostly these HSCs are managed by one ANM only.

Infection Management and Environmental Plan:

Bio medical waste management has emerged as a critical and important function within the ambit of providing quality healthcare in the country. It is now considered an important issue of environment and occupational safety. As per the Bio-Medical Waste (Management & Handling) Rules, 1998, all the waste generated in the hospital has to be managed by the occupier in a proper scientific manner. The GoI has also issued the IMEP guidelines for SCs, PHCs and CHCs. The DHS Vaishali is in the process of establishing the Biomedical Waste Management system for all the hospitals of Vaishali district.

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

S.No.	Type of Institutions	Number	No. of San.Beds*	No. of available bed
1	District Hospital	1	120	100
2	Sub Divisional Hospital	1	60	30
3	Referral	2	60	50
4	Block PHCs	15	90	90
5	APHCs	30	0	
6	Sub-centres	337	0	
7	Ayurvedic Dispensaries	9	0	
8	Anganwadi Centres	2476/2672	-	
9	Others (Pvt. Facility accreditated)	25	250	

Table . DENOTING PRIORITY AREAS IN EACH OF THE BLOCK

Block	Hard to Reach area
Raghopur	Whole Raghopur block (72 villages)
Mahnar	Village Bahlolpur
Patepur	Two villages

Note: During raining season i.e. From mid June to September almost 80 percent of the villages become hard to reach area.

Table . DISTRIBUTION OF PUBLIC HEALTH FACILITIES IN DISTRICT

District Hospital	Civil Hospital	Community Health Centres	Block PHC	FRU/Referral
1	0	0	16	2

2.2.6 Human Resource Development including Training

Human Resource Development forms one of the key components of the overall architectural corrections envisaged by both the RCH II and NRHM programs. Though the district has reasonable number of MBBS doctors, there is an acute shortage of specialized medical manpower. The shortage of specialists like obstetricians and Anesthetists are obstructing the district plans to operationalise all hospitals at full swing. Trainings as per GoI guidelines on Immunization, IMNCI, EmOC, LSAS, SBA and Minilap/MVA etc have been taken up with full vigor. It is proposed to continue these trainings in 2012-13.

2.2.7 Inequity and Gender

Ensuring Gender Equity

One of the broad indicators for measuring gender disparity is the sex ratio. The sex ratio in Bihar is unfavorable to women. Analysis of other indicators on the basis of gender reveals widening gaps between the sexes. While NMR for females is marginally higher than that of males, it widens further for the IMR, and even further for the under-five Mortality Rate. In conditions of absolute poverty, where resources to food and health care are severely limited, preference is given to the male child, resulting in higher female malnutrition, morbidity and mortality.

Gender discrimination continues throughout the life cycle, as well. Women are denied access to education, health care and nutrition. While the state's literacy rate is 47.5%, that for women in rural areas is as low as 30.03%. Abysmally low literacy levels, particularly among women in the marginalized sections of society have a major impact on the health and well being of families.

Low literacy rate impacts on the age of marriage. The demand pattern for health services is also low in the poor and less literate sections of society. Women in the reproductive age group, have little control over their fertility, for want of knowledge of family planning methods, lack of access to contraceptive services and male control over decisions to limit family size. According to NFHS data, for 13% of the births, the mothers did not want the pregnancy at all. Even where family planning methods are adopted, these remain primarily the concern of women, and female sterilization accounts for 19% of FP methods used as against male sterilization, which is as low as 1%.

In terms of nutritional status too, a large proportion of women in Bihar suffers from moderate to severe malnutrition. Anemia is a serious problem among women in every population group in the state, with prevalence ranging from 50% to 87% and is more acute for pregnant women.

In all the programme efforts will be made to meet the needs of vulnerable groups and ensure equity. Gender sensitization shall be made part of each training. The monitoring system too will be geared for this so that we may get disaggregated data. The state of Bihar is implementing the PC- PNDT Act at right earnest. The MOs are being trained by the State Health and Family Welfare Institute. The Civil Surgeon is the nodal person in the district in this regard. However monitoring of the activity is still a big problem and requires to improve.

BASIC FACILITIES AT RURAL INSTITUTIONS

Facility Appraisal of the Health Institutions

Amenities	**Block PHCs**
Total no of institutions	16
Building	
Rented	
Government-owned	16
Residential Accommodation	
Electric Connection	16
Water Connection	16
Sanitary Latrine	16
Waste Disposal	Process
Telephone Facility	16
X ray facility	16
Blood storage facility	
Laboratory testing facility	16
Ambulance for referral	16
OT Facility	16

Situation Analysis

Chapter 3

In the present situational analysis of the blocks of district Vaishali the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from census 2001, report of DHS office, Vaishali and various websites as well as other sources. These indicators help in pointing to the health scenario in Vaishali from a quantitative point of view, while they cannot by themselves provide a

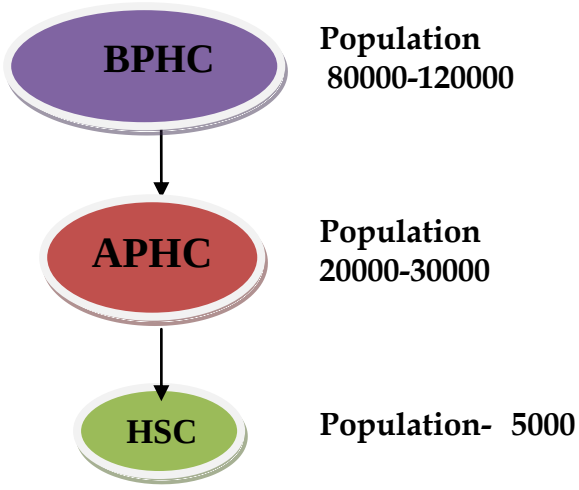
complete picture of the status of health in the district. However, it is useful to have outcome data to map the effectiveness of public investment in health. Further, when data pertaining to vital rates are analyzed in conjunction with demographic measures, such as sex ratio and mean age of marriage, they throw valuable light on gender dimension. Table below indicates the Health indicators of Vaishali district with respect to Bihar and India as a whole.

Table - BASIC HEALTH STATUS INDICATORS OF VAISHALI DISTRICT

Indicators	Vaishali
Crude Death Rate (CDR)	7.6
Crude Birth Rate	27.3
Infant Mortality Rate	50
Maternal Mortality Rate	319 (Tirhut)
Under 5 Mortality Rate	70

In a study of 513 districts of the country (Jansankhya Sthirata Kosh", www.jsk.gov.in) in terms of overall rank in health it was found that Vaishali district ranks 460 though on the basis of under-five mortality it ranked 274. Filaria, Malaria, Dengue, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in Vaishali district. Hepatitis, Diarrhea, Typhoid, Blindness and Leprosy are other high prevalence diseases. Kala-azar is an endemic problem in Bihar.

3.1.1. GAPS IN INFRASTRUCTURE:



First contact point with community

Introduction:

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

1. Infrastructure for HSC s:

IPHS Norms:

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

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

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

Typical Layout of Sub- Centre with ANM Residence

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

Toilet : 1950mm x 1200mm

Residential Accommodation:

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

Room -1 (3300mm x 2700mm)

Room-2(3300mm x 2700mm)

Kitchen-1(1800mm x 2015mm)

W.C.(1200mm x 900mm)

Bath Room (1500mm x 1200mm)

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

Health Sub Centers:

Total population of the district as per 2001 census is 2718421. After considering two percent growth rate of the total population it comes around 3187470 (Decadal Growth Rate2.3). After considering projected population in 2008, the district needs altogether 637 HSCs to cater its whole population. At present Vaishali has 338 established Health Sub Centers and 154 more Health sub centers are proposed to be formed. As per the IPHS norms (5000 population in plain area) the district still requires 135 new HSCs to be formed. Again , out of 338 established HSCs, only 39 have their own buildings and rest 298 run in rented houses. All these 39 HSCs need renovation work. All the above mentioned HSCs need equipments, drugs, furniture and stationeries.

Health Sub Centers:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	A. Out of 337 HSCs only 39 are having own building	In adequate facility in constructed building and lack of community ownership	Enhance visibility of HSC through hardware activity by the help of community participation	**Strengthening of HSCs having own buildings**
	B. In existing 39 buildings 26 are in running comparatively in good condition, 6 are in under constriction, one is very poor condition and one is			B.1.White washing of HSC buildings. B.2.Organize a training of adolescent girls for wall painting and plantation./hire local painter for colure full painting of HSC walls.

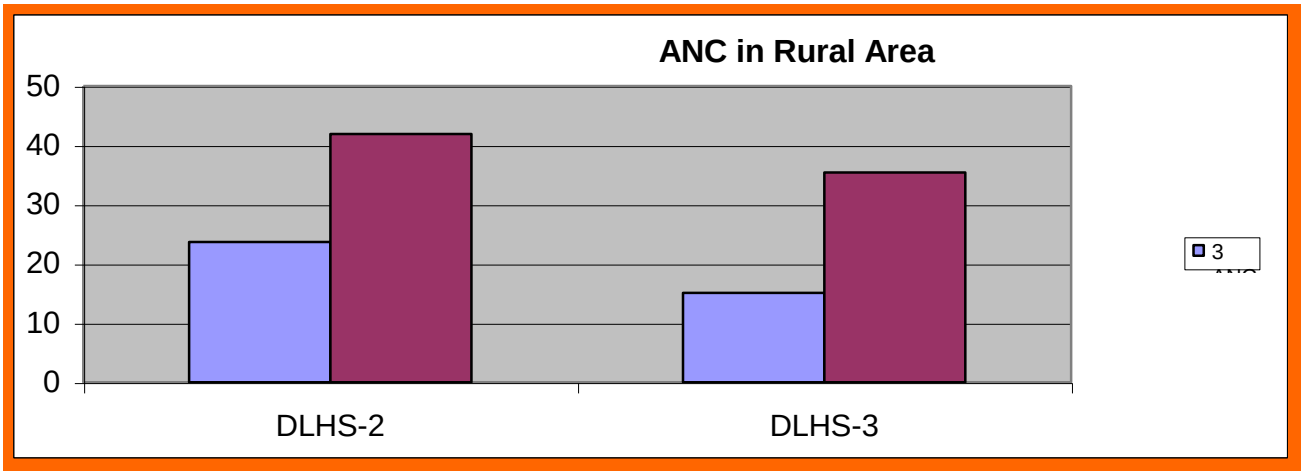
	constructed but not hand over to health department.		.	List out all services which are provided at HSC level. On the wall. B.3.Gardening in HSC premises by school children.
	C. No one building is having running water and electric supply.			C. Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental.
	D. Lack of equipments and ANM are reluctant to keep all equipments in HSC. E. Lack of appropriate furniture	. Operational problem in availability of equipment in constructed HSC		D.1.Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/) D.2. Purchase of equipments according to services Purchase one almira for keep all equipment safely and it could be kept in AWW / ASHA house.
	1.Non payment of rent of 298 HSCs on regular basis	1.Non payment of rent	Regularizing rent payment	3B. Strengthening of HSCs running in rented buildings. B1. Estimation of backlog rent and facilitate the backlog payment within three months B2. Streamlining the payment of rent through untied fund. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries

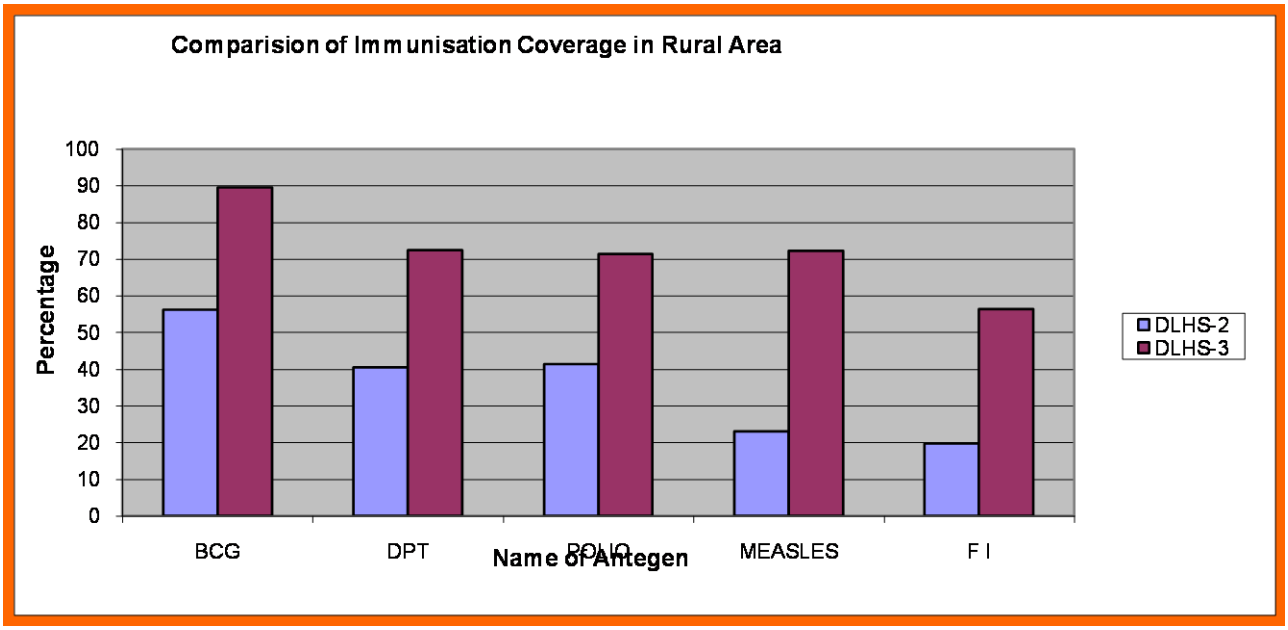
	1. The district still needs 154 more HSCs to be formed.	1. Land Availability for new constructio n 2. Constraint in transfer of constructed building		**3C. Construction of new HSCs** C1. Preparation of PHC wise priority list of HSCs according to IPHS population and location norms of HSCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings.
	Non participation of Community in monitoring construction work	Monitoring	Ensuring communit y Monitoring	1. Biannual facility survey of HSCs through local NGOs as per IPHS format 2. Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format. 3. Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4. Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 5. Monthly Meeting of one representative of VHSC/Mothers committees on construction work
	1. Lack of community ownership in the	1.Communi ty ownership	Strengthen ing of VHSCs, PRI	1.Formation and strengthening of VHSCs,

				Mothers committees, 2."Swasthya Kendra chalo abhiyan" to strengthen community ownership 3.Nukkad Nataks on Citizen's charter of HSCs as per IPHS 4.Monthly meetings of VHSCs, Mothers committees

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

As per the DLHS3 (2007-08)reports the percentage of full immunization(BCG, 3 doses each of DPT and Polio and measles) coverage(12-23 months) in the district is 56.4%. And BCG coverage of the district is 89.5%. 3 doses of polio vaccine is 72.5%, 3 doses of DPT vaccine is 71.4% and Measles Vaccine is 72.3%. The coverage of Vit. A supplementation for the children 9 months to 35 months is 66.6 percent.



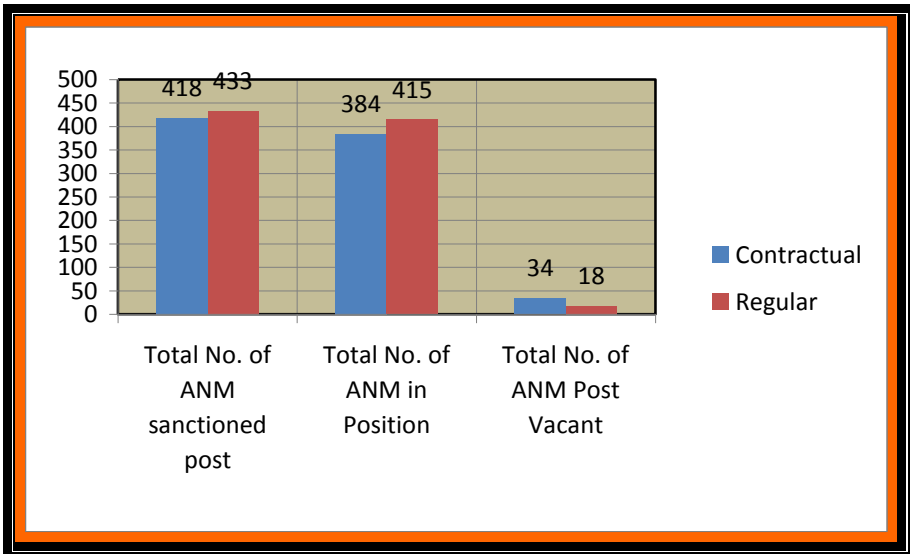


Sub Heads	Gaps	Issues	Strategy	Activities
Service performance	Unutilized untied fund at HSC level	Operationalization of Untied fund.	Capacity building of account holder of untied fund	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts
	No ANC at HSC level	Improvement in quality of services like ANC, and PNC, Immunization	Strengthening one HSC per PHC for institutional delivery in first quarter	1. Identification of the best HSC on service delivery 2.Listing of required equipments and medicines as per IPHS norms 3. Purchasing/ indenting according to the list prepared 4.Honouring first delivered baby and ANM
	Only 14.2% PW registered in first trimester PW with three ANCs is 15.1%, TT1	Improvement in quality of services like ANC, NC and PNC, Immunization and family planning	1. Phase wise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS	1 Gap identification of 39 HSCs through facility survey 2. Eligible Couple Survey 3. Ensuring supply of contraceptives with three month's buffer stock at

	coverage is 35.4%, Family Planning Status: Any method-43.6% Any modern method-39.8% No sterilization at HSC level IUD insertion -0.5% Pills-1.5% Condom-1.9% Total unmet need is 32.7%, for spacing-14.9,		norms. 2. Community focused family planning services	HSCs. 4. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 5. Training of ANMs on IUD insertion
	Lack of councelling services	Training	Training	1.Training to ANMs on ANC, NC and PNC, Immunization and other services.
	HSC unable to implement disease control programs	Integration of disease control programs at HSC level.	Implementation of disease control programs through HSC level	1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.
	80% of the	Absence of staffs	Community	1. Submission of absentees

	HSC staffs do not reside at place of posting		monitoring	through PRI
	Problem of mobility during rainy season	Communication and safety		1.Purchasing Life saving jackets for all field staffs 2. Providing incentives to the ANMs during rainy season so that they can use local boats.

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



Total No of HSC -337
APHC-32
PHC-16
RF-03
SDH - 01
DH-01

3.1.3 Human Resources

Source: DHS Vaishali Report

Sub Heads	Gaps	Issues	Strategy	Activities
Human Resource	34 seats of contractual ANM® and 18 seats of Regular ANMs are vacant. Out of 29 sanctioned post of LHVs only 22 are placed, Seat of 28 male workers are vacant	Filling up the staff shortage	Staff recruitment	1.Selection and recruitment of 52 ANMs 2.Selection and recruitment of 28 male workers
	All 799 ANMs needs training on different services.	Untrained staffs	Capacity building	1.Training need Assessment of HSC level staffs 2.Training of staffs on various services
	The ANM training	Training	Strengthening	1.Analyzing gaps

	school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities		of ANM training school	with training school 2.Deployment of required staffs/trainers 3.Hiring of trainers as per need 4. Preparation of annual training calendar issue wise as per guideline of Govt of India. 5.Allocation of fund and operationalization of allocated fund
Drug kit availability	1.Irregular supply of drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, 2.No Drug kit for AWCs(@one kit per annum,) 3. Need of Orientation on how to use ASHA kit.	Indenting	Strengthening of reporting process and indenting through form 6	1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports
	Only need based emergency supply Irregular supply of drugs	Logistics		1.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2. Hiring vehicles

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

3.2 Additional PHCs: --There are 32 APHCs functioning in the district and 58 more are proposed to be established.

Additional PHC:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	The district altogether need 90 APHCs but there are 32 APHCs functioning in the district and 58 more are proposed to be established. Out of 32 APHCs only 18 are having own building.	Lack of facilities/ basic amenities in the constructed buildings. Non payment of rent on regular basis. Land Availability for new construction	Strengthening of VHSCs, PRI Members Strengthening of Infrastructure	"Swasthya Kendra chalo abhiyan" to strengthen community ownership Nukkad Nataks on Citizen's charter of APHCs as per IPHS Out of 32, 28 APHC have got registered. Regular Monthly meetings of VHSCs, Mothers committees and RKS.

	Existing 18 buildings are not properly maintained. There is a need of regular payment of the rent of 14 APHCs. There is need of equipments & appropriate furniture & beds for providing the better health services to the community people. There is a need of HMIS Training of the APHC Staffs & Make conceptual Clarity on the formats/registers.	Lack of community ownership	Monitoring	Strengthening of APHCs having own buildings Renovation of APHCs buildings, Purchase of Furniture, Prioritizing the equipment list according to service delivery. Purchase of equipments Printing of formats and purchase of stationeries **Strengthening of APHCs running in rented buildings.** Estimation of backlog rent and facilitate the backlog payment within one months Streamlining the payment of rent through untied fund/ RKS. Purchase of Furniture & Beds as per need Prioritizing the equipment list according to service delivery Purchase of equipments as per need Printing of formats and purchase of stationeries Construction of new APHC buildings as standard layout of IPHS norms. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs Community mobilization for promoting land donations at accessible locations. Meeting with local

				PRI/CO/BDO/Police Inspector in smooth transfer of constructed APHCs buildings. Biannual facility survey of APHCs through local NGOs as per IPHS format Regular monitoring of APHCs facilities through PHC level supervisors in IPHS format. Monitoring of renovation/construction works through VHSC members/ Mother committees/VECs/others as implemented in Bihar Education Project. Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. Monthly Meeting of one representative of VHSC/Mothers committees on construction work.
Human Resource	Lack of doctors, ANMs, A Grade nurses, Pharmacists. There is a need of Proper training to the APHC staffs for smooth running of the APHC. The ANM training school situated at Sadar Hospital campus, lacks	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building Strengthening of ANM	Selection and recruitment of Grade A nurse/ANMs Selection and recruitment of male workers Sending back the staffs to their own APHCs. Training & need Assessment of APHC level staffs. Training of staffs on various services. EmoC Training to at least one doctor of each APHC Analyzing gaps with

	adequate number of trainers, staffs and facilities Out of 22 sanctioned post of LHVs only 17 are placed Most of the APHC staffs are deputed to respective PHCS hence APHCS services are affected.		training school	training school Deployment of required staffs/trainers. Hiring of trainers as per need. Preparation of annual training calendar issue wise as per guideline of Govt of India. Allocation of fund and operationalization of allocated fund.
Drug kit availability	Irregular supply of drug kit as such for the APHCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptives, Only need based emergency suuply Irregular supply of drugs	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 2 and 6 Couriers for vaccine and other drugs supply Phase wise strengthening of APHCs for vaccine / drugs storage	1.Weekly meeting of APHC staffs at PHC for promoting APHC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the APHC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through APHC account 4.1 Purchasing of cold chain equipments as per IPHS norms

				4.2 training of concerned staffs on cold chain maintenance and drug storage
Service performance	Out of 32, 30 RKS has been formed. There is a need of Proper Utilization of untied fund at APHC level. No institutional delivery at APHC level. No inpatient facility available No lab facility, No rehabilitation services, No safe MTP service, No OT/ dressing and Cataract operation services. Approx 80% of APHC staffs not reside at place of posting. Lack of counseling services Problem of mobility during rainy season. Lack of convergence at APHC level Operational gaps: There is no link between HSCs and APHCs and the	Formation of rest RKS. Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps. Integration of disease control programs at APHC level. Family Planning services Convergence Operational issues	Capacity building of account holder of untied fund Phase wise strengthening of 16 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through APHC level where APHC will work as a resource center for HSCc. At present the same is being done by PHC only. Community focused Family Planning services	Training of signatories on operating Untied fund /RKS account, book keeping etc Assigning PHC RKS accountant for supporting operationalization of APHC level accounts. Timely disbursement of untied fund/ seed money for APHCs RKS. Gap identification of 16 APHCs through facility survey. Strengthening one APHC per PHC for institutional delivery in first quarter. Review of all disease control programs APHC wise in existing Tuesday weekly meetings at PHC with form 6 Strengthening ANMs for community based planning of all national disease control program. Reporting of disease control activities through ANMs. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.

	same way there is no link between APHC and PHC		PPP Convergence	Weekly meeting of the staffs of concerned HSCs (as assigned to the APHC) 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3. Training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS. 4. Training of ANMs on IUD insertion. Outsourcing services for Generator, fooding, cleanliness and ambulance. Fixed Saturday for meeting day of ANM, AWW, ASHA, and LRG with VHSCs rotation wise at all villages of the respective HSC.

3.3 Primary Health centers:

The district has 16 PHCs, three referral hospitals and a District hospital. The PHC of Lalganj and referral hospital of lalganj is running in the same building.

Primary Health Centers:(30 bedded)				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**

Infrastructure	All PHCs are running with only six bed facility. At present 16 PHC are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms. The comparative analysis of facility survey (08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still area of improvement. Lack of equipments as per IPHS norms and also under utilized equipments. Lack of appropriate furniture Need of Proper filling & update the HMIS &	Available facilities are not compatible with the services supposed to be delivered at PHCs. Quality of services Community participation.	Upgradation of PHCs into 30 bedded facilities. ISO certification of selected PHCs in the district. Strengthening of BMU Ensuring community participation. Strengthening of Infrastructure and operationalization of construction works Monitoring	1.Need based (Service delivery)Estimation of cost for upgradation of PHCs 2. Preparation of priority list of interventions to deliver services. 1. Selection of two more PHCs for ISO certification. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of 2 Block Health Managers & 5 Block Community Mobilizer. 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 1. Meeting with community representatives, PRI & other stakeholders on Family Friendly Hospital Initiatives. 2. Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS. **3.Strengtheing of PHCs** Renovation of PHCs & Purchase of Furniture Prioritizing the

	MCTS data & regular analysis. 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.			equipment list according to service delivery and IPHS norms. Purchase of equipments Printing of formats and purchase of stationeries Biannual facility survey of PHCs through local NGOs as per IPHS format Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.
Human Resource	As per IPHS norms each PHC requires the following clinical staffs But the actual position is Less. As per IPHS norms each PHC requires the following Para medical support But the actual position is inadequate. There is a need trained doctors/ANMs in emergency obstetrics care. There are two BHMs Post are Vacant at present. Lack of motivation, zeal and dedication in the BPMU staffs towards their work.	staff shortage Untrained staffs	Staff recruitment Capacity building	1.Selection and recruitment of Doctors 2.Selection and recruitment of ANMs/ male workers 3.Selection and recruitment of paramedical/ support staffs 4.Appointment of Block Health Managers. 1.Training need Assessment of PHC level staffs 2.Training of staffs on various services 3. Trainings of BHM and accountants on their responsibilities. 4. Trainings of BHM on implementation of services/ various National program programs.
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time. Essential drugs are rate	Indenting Logistics Operationa	Strengthening of reporting process and indenting through form 7	1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all PHCs 3.Fixing the

	contracted at state level Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.	lization	Strengthening of drug logistic system	responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	Excessive load on PHC in delivering all services. All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less however the IPHS norm says that the OPD should be 40 per Doctor.) There is a need of proper training & orientation to operate new born care services. Lack of proper outbreak information on time.	Optimum Utilization of Human Resources Epidemic outbreaks and Need based intervention in epidemic areas.	Quality improvement in residential facility of doctors/ staffs. Training & orientation Proper and timely information of outbreaks	Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patient's treatment. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day. There is a need of training & orientation on NBCC to the There is a need of training & orientation on NBCC to the PHC Staffs. 1. Mapping of the areas having history of outbreaks disease wise. 2.Developing micro plans to address epidemic outbreaks, Assigning areas to the MOs and staffs 3.Motivating ASHA on immediate information

	There is a need of adolescent sexual and reproductive health services by all the PHCs. There is a need of mainstreaming AYUSH doctors that they can support to Health facility. Referral Quality of food, cleanliness (toilets, Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC. In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases. Need of display the services available at PHCs for the patients on the front of PHC. Lack of guidance about service facility. Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular. Lack of inpatient facility for kala-azar patients. Lack of counseling	Service Load centered at PHC Insecurity (Staff and Properties) Govts existing services like lab, x-ray, generator, fooding and cleanliness services.	Strengthening of AYUSH services at PHC level in the first level. Strengthening of equipments and services Confidence building measures Strengthening of the Govts existing services like lab, x-ray, generator, fooding and cleanliness services. Creating friendly environment	of outbreaks Take regular support of AYUSH doctors at APHC & VHSND and other programme. Insurance of all properties and staffs of PHC Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate. Recruitment of lab technicians as required Purchase of equipments/ instruments for strengthening lab. Hiring of menial workers for cleanliness works. Assigning LHV for counseling work Wall writing on every section of the building denoting the facilities Name plates of doctor Displaying Roster of doctors with their details. Plantation & Gardening for maintain the environmental balance. Sitting arrangement for patients

	services Problem of mobility during rainy season Lack of convergence. There is a need of making entry in MCTS & HMIS for strengthening data base and for the analysis purpose. Lack of clarity among staff nurses about how to fill the MCTS register in a correct way.		HMIS and strengthening of reporting process	Installation of LCD TV with cable connection Installation of safe drinking water equipments/water cooler, Installation of solar heater system and light with the help of BDO/Panchayat. Apron with name plates with every doctor. Presence of staffs with uniform and name plates. Orientation of the staffs on MCTS & HMIS along with indicators of reporting formats Puchase of Laptops for DPMU and BPMU

3.4 District Hospital:

District Hospital Hajipur:				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	1. There are 120 beds in the Sadar hospital which is not adequate as per the requirement. 2. At present District hospital is working with average 25 deliveries per day, 30 inpatient Kala-azar, 20 FP operation/emergency operations and 800 OPD per day. This huge workload is not	Lacks in infrastructure	Strengthening of infrastructure	1. Purchase of 500 beds. 2. Repairing of beds. 3. Listing of required equipments as per IPHS norms and their purchase. 4. Listing of required furniture and their purchase. 5. Simplifying process of RKS operation.

	being addressed with only 120 beds inadequate facility. 3. Lack of equipments as per IPHS norms and also under utilized equipments. 4.Lack of appropriate furniture 5.Operation of RKS: Delayed process of operation. Delay in disbursement of fund 6.Lack of facilities/ basic amenities in the PHC buildings 7.Huge workload in central registration unit 8. No sitting arrangement for patients. 10. No safe drinking water facility. 11. Half of the hospital area remains dark at night. 12. Delivery room lacks beds, labor table, stretchers, and equipments. 13. No proper gate and boundary wall. 14. No proper post mortem room and equipments. 15. Heavy water logging during rainy season. 16. Buildings for ICU, Causality ward are ready but due to lack of equipments, facilities are not functional. 17. No use of paying			6. Computerization of registration system for the OPD/IPD patients. 7.Construction of shed for waiting patients 8. Installation of 3 Water cooler freezes as per requirement. 9. Installation of seven vapor lights as per requirements. 10. Rennovation of boundary wall and gate. 11. Construction of new Post mortem room with all facilities. 12. Renovation of drainage system and internal road level upgradation. 13. Construction of enquiry counters at the gate. 14. Hiring of ambulances. 15. Construction of new residential buildings. 16. Hiring of rented houses from RKS fund for the residence of doctors, BMU and key staffs. 16. Tender for canteen facility. 17. Sitting arrangement for

	wards. 18. No enquiry counters as such for the patients. 20. No residential facilities for doctors and staffs. 21. No canteen facility			patients 18. Installation of LCD TV with cable connection
Human Resource	1. Post of gynecologist and pathologist are vacant. 2. Post of one dresser, one OT assistant and one ophthalmic assistant are vacant.	Lack in Staff position	Recruitment Deputing staffs	1. Appointment of gynecologist and pathologist on contract basis. 2. Appointment of one dresser, one OT assistant and one ophthalmic assistant on contract basis. 1. Deputation of required staffs from field.
Drug kit availability	1. Irregular supply of drugs because of lack of fund disbursement on time. 2. There is no clarity on the guideline for need based drug procurement. 4. Lack of proper space, furniture and equipments for drug storage	Improper Supply and logistics Lack in storage facility		1.training of store keepers on invoicing of drugs 2.Implementing computerized invoice system 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.
Service performance	1.Exessive load in delivering all services 2. Blood storage unit is present but not utilized 3.No 24hrs Lab facility 4.Health facility with AYUSH services is not being provided			1. Incentivizing doctors/ staffs on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment. 2. Purchase of

	5. Referral a. No pick up facility for PW or patients. b.BPL patients are not exempted in paying fee of ambulance. c. Lack of maintenance of ambulances d. Shortage of ambulances 6. No guidance to the patients on the services available at DH. 7. Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.			equipments for Blood storage unit, 3. IEC on blood storage unit. 4. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day 5. Repairing of all defunct Ambulances 6. Hiring of ambulances as per need. 7. Appointment of one AYUSH practitioner and Yoga teacher 8. Purchase of equipments/ instruments for strengthening lab. 9. Wall writing on every section of the building denoting the facilities 10. Name plates of doctor 11. Displaying Roster of doctors with their details. 12. Gardening 13. Apron with name plates with every doctors 14. Presence of staffs with uniform and name plates.

CHAPTER 4

Setting Objectives and Suggested Plan of Action

4.1 Introduction

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

4.2 Targeted Objectives and Suggested Strategies

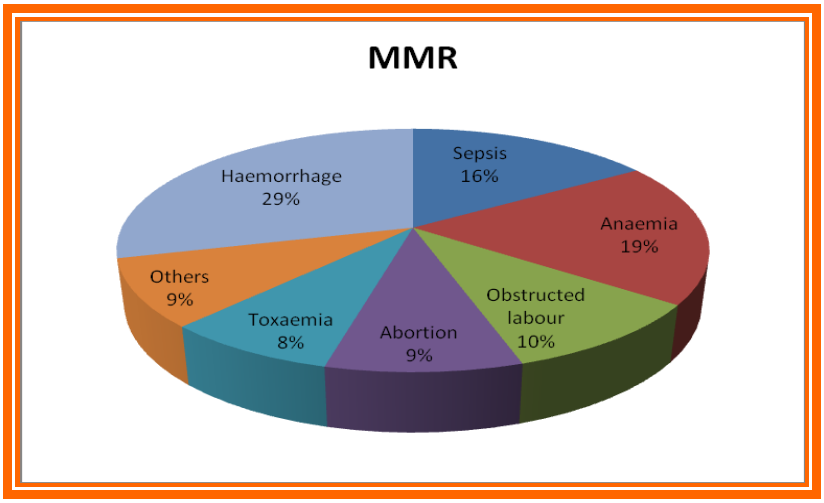
During consultation at district level involving a range of stakeholders from different levels, an attempt has been made to carve out certain strategies to achieve the specific objectives that are represented by different indicators. The following segment of the chapter corresponds to the identified district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

Technical Objectives, Strategies and Activities

4.2.1 Maternal Health

Maternal Mortality Ratio (MMR)

MMR, a sensitive indicator of overall socio-economic development, social status of women, and adequacy or inadequacy of healthcare system. The maternal mortality ratio is the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births.



Causes of Maternal Death

Each year in India, roughly 28 million women experience pregnancy and 26 million have a live birth. Of these, an estimated 67,000 maternal deaths and one million newborn deaths occur each year. In addition, millions more women and newborns suffer pregnancy and birth related ill-health. Thus, pregnancy-related mortality and morbidity continues to have a huge impact on the lives of Indian women and their newborns. Maternal Mortality Ratio (MMR) in India has shown an appreciable decline from 398/100,000 live births in the year 1997-98 to 301/100,000 live births in the year 2001- 03 to 254/100,000 live births in the year 2004-06 as per the latest RGI-SRS survey report, released in April 2009. However, to accelerate the pace of decline of MMR in order to achieve the NRHM and MDG Goal of less than 100 per 100,000 live births, there is a need to give impetus to implementation of the technical strategies and interventions for maternal health. Levels of maternal mortality vary greatly across the regions, due to variation in underlying access to emergency obstetric care, antenatal care, anemia rates among women, education levels of women, and other factors. About two thirds of maternal deaths occur in a handful of states – Bihar and Jharkhand, Orissa, Madhya Pradesh and Chattisgarh, Rajasthan, Uttar Pradesh and Uttarakhand and in Assam, all these states being among the 18 high focus states under NRHM. AS per Annual Health Survey 2010 the region of Tirhut Commissionary (Vaishali lies in Tirhut Division) the MMR is 319/100000 live births.

Maternal Death Review:-

(MDR) as a strategy has been spelt out clearly in the RCH –II National Programme Implementation Plan document. It is an important strategy to improve the quality of obstetric care and reduce maternal mortality and morbidity. The importance of MDR lies in the fact that it provides detailed information on various factors at facility, district, community, regional and national level that are needed to be addressed to reduce maternal deaths. Analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service. MDR has been conducted as an established intervention for the last few years by some states like Tamil Nadu, Kerala and West Bengal which have also shared their experiences while these guidelines and tools were being framed. However, in most of the other states the efforts in this area have been at best fragmented. Recognizing the need for sharing of and learning from experiences of different stakeholders, MOHFW organized a two day workshop to finalize the MDR strategy at PGIMER, Chandigarh, in May 2009, with the objective of developing a road map and also guidelines and tools, which the states could

use and implement easily. During the workshop, participants from various states shared their experiences in initiating maternal death reviews in facilities and also in community settings. The various tools for MDR have been developed with the objectives of identifying gaps and the reasons for maternal deaths, for taking corrective actions to fill such gaps and improve service delivery. The process of MDR should not be utilized for taking punitive action against service providers.

Goals: Reduce Maternal Mortality Rate.

Objectives:

- To increase Antenatal Care coverage from 71% to 85% by 2012-13.
- To increase Early ANC Registration coverage from 55% to 65% by 2012-13.
- To increase 3 ANC coverage from 72% to 80% by 2012-13.
- To increase the consumption of IFA tablets for 90 days from present level of 40% to 60% by 2012-13.
- To reduce anemia among pregnant mothers from 60.2% to 40% by 2012-13.
- To increase institutional delivery from 51% to 65% by 2012-13.
- To increase birth assisted by trained health personnel from 31.9% to 45%.
- To increase the coverage of Post Natal Care from 26% to 55% by 2012-13
- To reduce incidence of RTI/STI cases.
- To reduce the no. of unsafe abortions.

Source of data: DLHS 3, NFHS 3 and MIS Data

Objective No. 1: To increase 3 ANC coverage from 40% to 70% by 2012-13

Strategies and Activities:

1.1. Institutionalization of Village Health Sanitation and Nutrition Days (VHSND)

1.1.1 In collaboration with ICDS, such that the Take Home Ration (THR) distribution and ANC Happens on the same day.

1.1.2 This will require minor changes in the microplans of Health and ICDS.

1.1.3 Policy decision and appropriate guideline under convergence between Health and ICDS need to happen as a priority.

1.2 Improved Access of ANC Care.

1.2.1 Provision for Additional ANMs in each Sub Centers (Refresher Training to ANMs on Full ANC to improve the quality of ANC).

1.2.2 Setting up of New Sub Centers to cover more areas.

1.2.3 Micro planning: Identifying vulnerable groups, left out areas and communities having high percentages of BPL under each block and incorporating the same into the block micro plans to focus attention on them for providing Community and Home based ANC to them.

1.2.4 Organizing Monthly Village Health and Nutrition Days in each Aganwadi Centers.

1.2.5 Organizing RCH camp in Each Block PHC areas.

1.2.6 Tracking of Pregnant mothers by ASHAs.

1.3 Ensure quality service and Monitoring of ANC Care.

1.3.1 Strengthen the monitoring system by checking of ANMs duty rooster and visits of LHVs and MOs.
1.3.2 Involvement of PRIs in monitoring the ANMs service through convergence.
1.3.3 Refresher training of ANMs on ANC care.
1.3.4 Proper maintenance of ANC Register and Eligible couple register.

1.4 Strengthening of Health Sub Centre
1.4.1 Repair and Renovation of Sub Centers
1.4.2 Provide equipments like BP Apparatus, Weighing machines, Heamoglobinometer etc to the Sub Centers.
1.4.3 Timely supply of Drug Kit A and Kit B

1.5 Generate Awareness for ANC Service
1.5.1 Convergences meeting with AWWs, ASHAs, PRI Members, NGOs at the Gram Panchayat level byANMs. These meetings will also attended by MOs from Additional PHC`s.
1.5.2 Tracking of Pregnant mothers by ASHA, ANM and AWWs though organizing Mahila Mandals meeting. Incentive for ASHAs and ANMs to give for the initiative. This initiative is under MUSKAAN Programme. Incentive for ASHA will be taken care under Intersectoral Convergence.
1.5.3 Counseling by ASHAs and ANMs to the pregnant mothers, mothers and Mother in Laws.

Objective No. 2: To increase the consumption of IFA tablets for 90 days from present level of 40% to 75% by 2012-13.

Strategies and Activities:
2.1 Purchase and Supply of IFA Tablets
2.1.1To include IFA under essential drug list
2.1.2 Timely supply of IFA Tablets to the Health Institutions (Ensuring no stock out of IFA at every level down to Sub-Centre Level)
2.1.3 District to purchase IFA tablets in the case of stock out.
2.1.4 Convergence with ICDS and Education for regular supply of IFA tablets through AWWCs And Schools for the pregnant and lactating women, children 1-3 years and adolescent girls.
2.2 Awareness generation for consumption of IFA Tablets.
2.2.1 Pregnant mothers will be made aware for consumption of IFA tablets for 90 days.
2.2.2 ASHA and AWWs will generate awareness along with ANMs at the Village level.
2.2.3 Ensure utilizing the platform of Mahila Mandal meetings being held every third Wednesday.

Objective No.3: To reduce anemia among pregnant mothers from 60.2% to 40% by 2012-13.
3.1 Supplementing IFA tablets consumption with other clinical strategies.
3.1.1 Half yearly de-worming of all adolescent girls.
3.1.2 Training of ANM, AWW and ASHA on module on EDPT (Early Diagnosis and Prompt Treatment) of anemia.

3.1.3 Activities for consumption of IFA tablets as per Objective No. 2

3.2 Other strategies.
3.2.1 Refer severely Anemic Pregnant Mothers to referral centers.
3.2.2 IPC based IEC campaigns emphasizing on consumption of locally available iron rich foodstuff. Details given under Special Scheme on Anemia Control in Part B.

Objective No. 4: To increase institutional delivery from 70% to 85% by 2012-13

(MIS data) and to increase facilities for Emergency Obstetric Care (EmOC)
Strategies and Activities:
The strategies will lead to up gradation and operationalization of the facilities to increase institutional deliveries along with providing EmOC and emergency care of sick children. These facilities will also provide entire range of Family Planning Services, safe MTPs, and RTI/STI Services.
4.1 Upgrading Block PHCs/CHCs in to FRUs
4.1.1 Provision of OT and lab facility by upgrading FRUs
4.1.2 Blood Bank and or Provision of Blood storage, OT and lab facility by upgrading FRUs
1. district hospitals must have either its own Blood Bank, operational round the clock, or must have access to one that can be accessed in less than 30 minutes
2. All CHC / PHCs have blood storage facility
4.1.3 Training of MOs on Obs.& Gynae and Anesthesia
1. 18-week Life Saving Anesthetic Skills (LSAS) training for MBBS Doctors
2. 16 week -Emergency Obstetric Skill training for MBBS doctors
3. 3 days training of doctors and nurses posted at FRUs for the neonatal stabilization unit
4.1.4 Repair and renovations of FRUs, construction of APHC & HSCs.
4.1.5 Appointment of Anesthetist, O&G specialist, Staff Nurses at the FRUs.
4.1.6 Incentives the conduct of C section at FRUs @ Rs 1500 per C section for the staff involved at the FRUs.
4.1.7 Accreditation of FRUs
4.2 Operationalization of 24x7 facilities at the PHC level
4.2.1 Training of MOs and Staff Nurses of PHCs in BEmOC
4.2.2 Appointment of at least 3 Staff Nurse in each PHCs
4.2.3 Repair and renovation of PHCs
4.2.4 Availability of and timely supply of medical supplies and DDK & SBA kits
4.2.5 Training of MOs, Staff Nurses on SBA
4.3 Increase beneficiary choice for institutional delivery through IEC campaign complimented by network of link workers working on incentive basis for each institutional delivery achieved
4.3.1 Strengthening JBSY Scheme
1. Improving quality: Infrastructural support to high burden facilities to avoid early discharge' following institutional deliveries
2. Mapping of high burden facilities and proving them support for matching infrastructural up gradation to increase the hospital stay following delivery.
3. Identifying districts and blocks and communities within them, where the awareness and

reach of JBSY scheme is poor and to ensure increased service utilization in these areas.
4.3.2 Design and implement an IEC campaign focusing on communicating the benefits of institutional delivery and benefits under JBSY scheme.
4.3.3 Equip the ASHA network to reinforce the IEC messages through IPC interventions at village /community level.
4.3.4 Provide incentives to ASHA for every institutional delivery achieved in her village / designated area.
4.3.5 Involvement of PRIs for JBSY scheme to monitor and generate awareness for institutional delivery.
4.4 Provision of Referral Support system
4.4.1 Provision of a dedicated referral transport system for the newborns and pregnant women to refer them from Home/HSCs/PHCs to referral centers.
4.4.2 Monitoring of referral transport system
4.4.3 Development of proper referral system between Health Institutions.
4.4.4. Operationalising of Blood Storage Units in all FRUs Lack of Blood Storage Units in the state make things complicated during emergency hence in all FRUs blood storage units has been proposed. Operationalising of at least one Blood Storage Units in all FRUs is proposed as per IPHS guidelines.

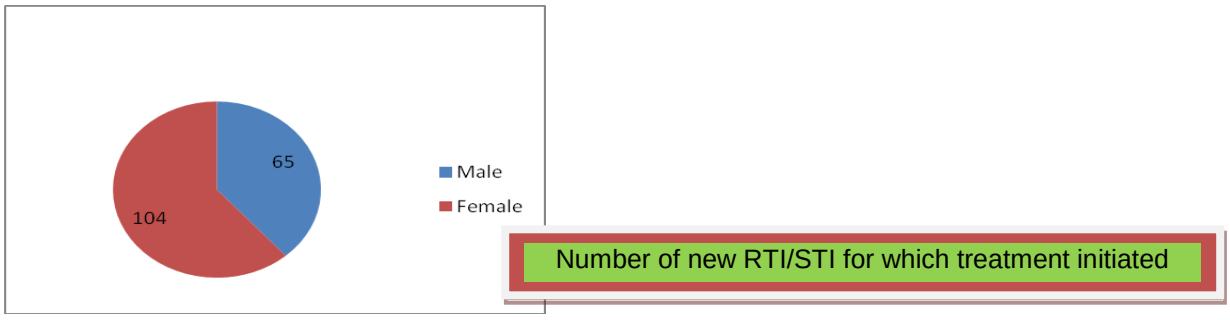
Objective No.5: To increase birth assisted by trained health personnel.
Strategies and Activities:
5.1 Ensure safe delivery at Home
5.1.1 Provision of Disposable delivery kits with ANMs and LHVs – Establishing full proof Supply Chain of the DD Kits.
5.1.2 Training of ANMs on SBA
1. Providing SBA with approved drug kits, in order to deal with emergencies, like post-partum hemorrhage, eclempsia, and puerperal sepsis
2. Ensuring regular supply of these drugs to the SBA
5.1.3 Supply of adequate DD Kits to ANMs, LHVs.
5.2 Provision of delivery at HSC level
5.2.1 Supply of DDkits to HSCs
5.2.2 Delivery tables to be provided to the HSCs

Objective No.6: To increase the coverage of Post Natal Care.
Strategies and Activities
6.1 Ensuring proper practice of PNC services and follows ups at the health facility level.
6.1.1 Refresher sessions for all ANMs on uniform guidelines to be followed for PNC care – all delivery cases to remain at facility for minimum 6 hours after normal delivery and to be recalled to facility for check up with 4 days and after 42 days.
6.1.2 Ensuring follow up PNC care through out reach services (ANM) for delivery cases where the patient does not return to facility for follow up check ups.
6.1.3 Referral of all complicated PNC cases to FRU level.
6.1.4 LHV and MO to monitor and report on PNC coverage during their field visits
6.2 Utilizing the ASHA network to strengthen the follow up of PNC services through tracking of cases, mobilization to facilities and providing IPC based education / counseling.
6.2.1 Utilize ASHA to ensure 3 PNC visits by the ANM for home delivery cases (1st within

2 days, 2nd within 4 days and 3rd within 42 days of delivery) and 2 follow up visits for institutional delivery cases.
6.2.2 Counseling of all pregnant women on ANC and PNC during monthly meetings of MSS and during VHND.
6.2.3 Linking of ASHA's incentives on institutional deliveries to completion of the PNC follow-ups.
6.3 Basis Orientation of AWWs on identifying Post-partum and neonatal danger signs during her scheduled visits following delivery
6.3.1 Basic orientation on IMNCI – in order to be able to alert the beneficiary and coordinate with ASHA and ANM (to avoid undue delay)
6.3.2 Basic orientation on identifying post-partum danger signs, specially, for home based deliveries, such that the she can alert ASHA, ANM or the local PHC towards avoiding undue delay

Objective No. 7: Reduce incidence of RTI/STI

Strategies and Activities
7.1 Ensuring early detection through regular screenings and contact surveillance strategies.
7.1.1 Early diagnosis of RTI / STI through early detection of potential cases through syndromic approach and referral by ANM and ASHA.
7.1.2 Conducting VDRL test for all pregnant women as a part of ANC services.
7.1.3 Implementing contact surveillance of at risk groups in convergence with Bihar AIDS Control Society.
7.2 Strengthening the infrastructure, service delivery mechanism and capacity of field level staff for handling of RTI / STI cases.
7.2.1 Conducting community level RTI / STI clinics at PHCs
7.2.2 Training to all MOs at PHC / DH level in Management of RTI / STI cases in coordination with Bihar AIDS control Society.
7.2.3 Training of frontline staff, LHV, ANM and ASHA in identifying suspected cases of RTI / STI in coordination with Bihar AIDS Control Society.
7.2.4 Strengthening RTI / STI clinic of the District Hospitals



Status-2011-12 (Sources-HMIS)

Estimated Cases of RTI/STI

Total Pop.of Vaishali	Adult Pop.(50% of the total Pop.)	STI/RTI episodes (6%)	NACO target (28% of the total annual STI/ RTI targets for govt. health facilities	NRHM target 52% of the total annual STI/RTI targets	Private sector targets 19% of the total Annual STI/RTI targets
3495249	1747624	104857	29360	54525	19922

Assumptions for drug kits- About 60% of the STI/RTI episodes will be treated with syndromic drugs. And 20% of the syndromic drug is kept as buffer

Estimated STI/RTI syndromic Drugs (60% of the STI/ RTI Episodes)	20% syndromic drug is kept as buffer	Total drug kit required
62914	12582	75497

Name of the kit	Required to be procured	Amount
Kit-1	@ 25*12835	320864
Kit-2	@8*33974	271791
Kit-3	@32*7550	241592
Kit-4	@40*1510	60398
Kit-5	@30*3775	113246
Kit-6	@49*15099	739874
Kit-7	@49*755	36994
RPR Test Kits	@60*1510	90596
	Total	1875355

Objective No. 8 –Reduce incidence of unsafe abortion.

Strategies and activities

8.1 Early diagnosis of pregnancy using Nischay pregnancy testing kits

8.2 Counselling and proper referral for termination of pregnancy in 1st trimester if the woman wishes so

8.2.1 Training of MOs and Nurses/LHV in MTP (MVA)

8.2.2 Procurement and availability of MVA at the designated facilities.

4.2.2 (A) CHILD HEALTH

Objective:-

To increase full immunization of Children from 53% to 70% by 2012-13.

Strategies and Activities:-

- Conduct fixed day and fixed-site immunization sessions according to district/Block micro plans.
- Fill vacant ANM posts and appoint additional ANMs in a phased manner to achieve GoI norm of one ANM for 5000 population by the year 2009-10.

- Update Block micro plan for conducting routine immunization sessions
- Ensure timely and adequate supply of vaccines and essential consumables such as syringes, equipment for sterilization, Jaccha-Baccha immunization cards, and reporting formats at all levels.
- Supply AD Syringes to conduct outreach sessions in select areas.
- Enlist help of AWW/ASHA in identification of new-borne and follow-up with children to ensure full immunization during sessions. New born tracking system to be implemented.
- Replace all Cold Chain equipment, which is condemned, or more than five years old in a phased manner by the year 2007-08 and supply new Cold Chain equipment based on analysis of actual need of the health facilities
- Facilitate maintenance of Cold Chain equipment through Comprehensive annual maintenance contract with a private agency with adequate technical capacity.
- Provide POL support to district @ Rs. 9000 per PHC per month to each PHCs for running of Gensets and minor repair
- Issue necessary departmental instructions to re-emphasize provision of ANC services in the job description of Aaganwadi Workers and ANMs.
- Build capacity of immunization service providers to ensure quality of immunization services.
- Provide comprehensive skill up gradation training to immunization service providers (LHVs/ANMs), particularly in injection safety, safe disposal of wastes and management of adverse effects.
- Conduct training to build capacity of Medical Officers, MOICs and DIOs for effective management, supervision and monitoring of immunization services
- Train Cold Chain handlers for proper maintenance and upkeep of Cold Chain equipment
- Form inter-sectoral collaboration to increase awareness, reach and utilization of immunization services
- Develop working arrangements with ICDS and PRIs to ensure coordination at all levels
- Involve Aaganwadi Workers and PRIs to identify children eligible for immunization, motivate caregivers to avail immunization services and follow-up with dropouts.
- ASHA, AWW and ANM will hold meeting with Mahila Mandals at each village monthly for increasing the coverage of Immunization. Incentive to be provided to ASHA and ANM under RCH and AWW under intersectoral convergence.
- Involve ICDS and PRI networks in behavior change communication for immunization.
- Strengthen Supervision and monitoring of immunization services
- Build capacity of Medical Officers, MOICs and DIOs in supervision and monitoring of implementation of immunization services as per the micro-plan.
- Provide mobility support to MOICs and DIOs for supervision and monitoring of implementation of immunization services.
- Develop effective HMIS to support supervision and monitoring of implementation of immunization services.
- Coordinate with representatives of PRI to strengthen supervision and monitoring of

immunization services.

For the improvement of Child Health, thrust will be given on Vitamin –A Supplementation Programme in 2012-13. The budget for the meeting/orientation and monitoring support are as given below-

Budget Head	Amount
Meeting of district coordination committee @ Rs.2500*2round/dist.	5000
Meeting of Block Coordination Committee @ Rs.1000*2 round/PHC.	32000
Orientation of ANM, AWW & ASHA as additional site worker in rural area @ Rs.25/person*2 round	183500
Monitoring support for ASHA as additional site worker/Volunteer @ Rs.300 per worker *2 round for 4 days	154200
Monitoring support for ASHA Facilitator /supervisor for add. Site @ Rs.400 per supervisor*2 round for 4 days	20560
Monitoring by district official(DIO/DCM)@ Rs.3000*2rounds per district	6000
Monitoring by block official (MOIC/BCM)@ Rs.500*2 rounds per PHC	17000
Total Vit. A bottle requirement for 1 year -17476	
GOI supply through Kit-A (1Kit = 12 Bottles*2)8040	
Gap supply to be procured-9436	
Fund required @ Rs.44.32 per Vit. A Bottle	418204
Total no. of sites-3316	
Marker for round 1 & 2-6632 @ 18.50	122692
Grand Total	959156

4.2.2 (B) Child Health

Goal: Reduce IMR from 50 (AHS-2010) to less than 40

Objectives:

1. To reduce low birth weight baby's by supplementing nutritional support to pregnant mothers
2. To increase exclusive breast feeding from 42% to 75% by 2012-13.
3. To reduce incidence of underweight children (up to 3 years age).
4. To strengthen neonatal care services in all PHCs/CHCs/SDHs by setting newborn care centers & having trained manpower therein.
5. To reduce the prevalence of anaemia among children from 87.6% to 50% by 2012-13.
6. To increase full immunization of Children.
7. To reduce morbidity and mortality among infants due to diarrhea and ARI

Objective No.1: To reduce low birth weight baby's by supplementing nutritional support to pregnant mothers

Strategies and Activities:

1.1 Enroll malnourished child into Nutritional Rehabilitation Center for the Nutritional and Medical care & support.

1.2 Convergence with ICDS, supplementary diet which is being given by AWW to

pregnant mothers may be improved.

1.3 A supplementary diet comprising of rice, dal and ghee will be provided to all pregnant women. This will be given for the last 3 months to all underweight pregnant BPL mothers. The Scheme will be implemented in convergence with ICDS.

1.4 Joint Monitoring by Block MO i/cs with CDPO for implementation of the scheme

Objective No. 2: To increase exclusive breast feeding from 42% to 75% by 2012-13

Strategies and Activities:

2.1 Use mass media (particularly radio) to promote breastfeeding immediately after birth (colostrums feeding) and exclusively till 6 months of age.

2.1.1 Production and broadcast of radio spots, jingles, folk songs and plays promoting importance of correct breastfeeding practices

2.1.2 Production and broadcast of TV advertisements and plays on correct breastfeeding practice.

2.1.3 Publication of newspaper advertisements, booklets and stories on correct breastfeeding practices.

2.2 Increase community awareness about correct breastfeeding practices through traditional media

2.2.2 Involve frontline Health workers, Aaganwadi Workers, PRIs, TBAs, local NGOs and CBOs in promoting correct breastfeeding and complementary feeding through IPC, group meetings, folk media and wall writing.

2.2.3 Educate adolescent girls about correct breastfeeding and complementary feeding practices through school -based awareness campaign.

3. To reduce incidence of underweight children (up to 3 years age)

Strategies and Activities:

3.1. Growth monitoring of each child

3.1.1 Supply of spring type weighing machine and growth recording charts to all ASHAs, AWWs. All ASHAs, Aaganwadi centers and sub centers will have a weighing machine and enough supply of growth recording charts for monitoring the weight of all children through Untied fund of S/Cs.

3.1.1 Weighing and filling up monitoring chart for each child (0-6 years) every month during VHSNDs Each child in the village will be monitored by weight and height and records will be maintained.

3.2 Referral for supplementary nutrition and medical care

3.2.1 Training for indications of growth faltering and SOPs for referral to AWWC for nutrition supplementation and to PHC for medical care.

3.2.2 Establishment of 4 Nutrition Rehabilitation Centers in Districts having severe problems of malnutrition and continue of 1 existing Centers (A Special Scheme taken up and put under NRHM B)

Objective No.4: To strengthen neonatal care services in all PHCs/CHCs/SDHs by setting newborn care centers & having trained manpower therein.

Strategies and Activities:

4.1. Strengthen institutional facilities for provision of new born care

4.1.1. It is planned to develop a model for comprehensive care of the newborn at all levels,

from district to the community level.
5. To reduce the prevalence of Anemia among children Strategies and Activities Details in special programme for "Controlling Iron Deficiency Anemia in Bihar" under Part B NRHM Additionalities.
6. To increase full immunization of Children from 53% to 70% by 2012-13.
Strategies and Activities
Details in special programme for "**Strenthening of Routine Immunisation** "
under NRHM Part C
7. To reduce morbidity and mortality among infants due to Diarrhea and ARI
Strategies and Activities:
7.1 Increase acceptance of ORS
7.1.1 Supply of ORS and ensure availability in all depots and supply of cotrimoxazole tablets. The ASHA drug kit will have ORS and cotrimoxazole tablets which should be replenished as per need.Aaganwadi centers should also be given ORS. In the absence of ORS, the use of home-based sugar and salt solution will be encouraged.
7.1.2 Orientation of ASHA for diarrhea and ARI symptoms and treatment ASHAs will be specifically trained to identify symptoms of diarrhea and ARI and to provide home-basedcare. Danger signs prompting transportation to seek medical care will also be taught to ASHAs.
7.1.3 Organize meetings for ASHAs/AWWs for dissemination of guidelines for Home based careASHA and AWW will be trained and provide guidelines for Home based care. The meeting will be held at Block PHC level.
7.2 Strengthening of referral services for infants seeking care for life threatening diarrhoea and ARI
7.2.1 Availability of referral money @ Rs.500 available for transporting of sick infants to the health institute.
7.2.2 Blood slide examination of all febrile children with presumptive treatment In endemic areas; most children are anemic due to repeated bouts of malaria. Any febrile child needs to be checked for malaria compulsorily.
7.2.1 Strengthening of PHCs/ referral centers

Nayee Pidhi Swasthya Guarantee Karyakram

This program was launched on 22nd March with the view to make the Health Card to all the children of the age group 0 to 18. Bihar is set to become the first state in the country to issue health cards to 3.4 crore children in the age group of 0-14 years. Besides offering OPD facilities and free medicines, the health card, this will be valid for five years.

The Main emphasis given through this program is on the Malnutrition, Anemia & the Marriage in Early Age. As part of the School Health Programme, adolescents in schools will undergo health check ups in a year. Some counseling related to common adolescent problems will also be given during these check ups. Children are the asset and future of the Nation. The progress of any country and state depends upon them for which they must remain healthy.

The health check-up of children are must at least once in a year to detect any serious

disease in the early stage, so that preventive and curative measures may be taken at the earliest. For this objective in mind government has decided to do medical health check-up of children reading in government schools.

Minister Health and Family Welfare, on the occasion, announced that after the successful launch of 'Nayi Pidhi Swasthya Guarantee Yojana' providing health cards to 3.4 crore children under 14 years, the government was in the process of making a road map to provide health cards to students, widows, senior citizens and physically challenged persons. "We are evaluating how they can be integrated into health insurance schemes," He said, adding the state government aimed to provide heath insurance to its 10 crores people. "We aim to provide health cards to every family of the state".

OBJECTIVE:

• Regular annual health check-up of Children registered in government primary and middle school.
• To detect any defect in progress of health and nutritional deficiencies.
• Early detection of serious illnesses and to refer them in the nearest specialized government
health facilities.
• To develop good habit for better health and hygiene to remain healthy.
• To inculcate through the children habit to remain healthy among Family members and community.
• To improve quality of food supplied to children by adding micronutrients.

Additionally Counseling sessions will be organized in Govt. Schools in collaboration with BSACS. Storylines and slogans will be published in text books of schools in collaboration with the Education Dept. Reference Books on Health Issues and Healthy Life-Style will be published for School libraries. Health Camps will be organized for health check-ups for school children. Innovative strategies will be adopted to orient school children about healthy practices.
The budget of this FY are as given below-

DHQ	SDH	Ref.	PHCs	Total Unit
1	2	3	16	22

Budget Head	**Amount**
Cost for training/orientation Rs.30000/unit @ Rs.50/ASHA/ANM/AWW/HW	690000
Cost for traveling/transportation @ Rs.650/120days	1794000
Cost for staff hiring cont. ophthal.asst., 1 lab tech.,@ Rs.250/person for 120 days	1380000
Cost for IEC activities @ Rs. 40000 for poster, banner, flex and handbill @ Rs.10000/unit for each item	1100000
Cost for miking @ Rs. 250 per day/PA system for 40 days(2 days per week) for each unit	230000
Cost for purchase of medicine & Lab testing equipments @ Rs. 60000/unit	1320000

Cost for specialized treatment @ Rs.30000/unit	660000
Cost for contingency @ Rs.60000/unit	1320000
Grand Total	**8494000**

4.2.3 Family Planning

Goal: Reduce TFR by 2.1 from present level.

Objectives:

1. To reduce total unmet need for contraception from 23.1 % to 15%
2. To increase Contraceptive Prevalence Rate (Any Modern Method)
3. To increase male participation in family planning
4. To increase proportion of male sterilizations from 0.6% to 1.5%.
5. Monitor the quality of service as per GoI guidelines for Sterilization

Objective No.1: To reduce total unmet need for contraception from 23.1 % to 15%

Strategies and Activities

1.1 Plan to organize RCH camp in each PHC/CHC once in two months.

1.1.1. Creating dedicated cadre of skilled manpower

1. Training of MBBS doctors on Minilap and NSV
2. Training of MBBS doctors on Anesthesia
3. Training on IUCD: MOs, ANMs etc.

1.1.2 One RCH camp will be organize in each PHC/CHC where Laparoscopic Ligation/Mini Lap will be done

1.1.3 Incentive to acceptors Incentive for LL operations

1.1.4 Training on LL operation, MTP and IUD Insertion

1.1.5 ASHA and MPWs will publicize about the RCH in their area and motivate the eligible women to go for spacing & terminal methods of family planning.

1.2 Motivate eligible couples who have had their first child for spacing for condoms, OCPs or IUDs

1.2.1 Update EC register with help of ASHAs and AWW The eligible couple register is presently being updated once a year (usually in April) in a survey mode. It is done in a hurry and may not have complete information in many cases. With the involvement of ASHAs and AWWs, updates should be done each month preferably during VHNDs.This will result in less wastage of time and resources and better recording of information.

1.2.2 Availability of FP services: IUCDs, OCPs, Emergency Pills, Condoms

1.2.2.1 Each SDH/CHC/PHC should have static FP cell / corner, with earmarked ANM / LHV responsible, for providing these services daily as OPD services to clients

1.2.2.2 Community Based Distribution (CBD) of Condoms and Pills: The OCPs and condoms can be provided to community based motivated volunteers, like members of Self Help Groups (for Pills) and Husbands of motivated ASHA, Satisfied NSV client, active PRI members etc. (for condoms) for community based distribution (CBD) of these. The availability of condoms and OCPs with the volunteers and their geographical responsibilities should be widely known to the potential clients / beneficiaries. Before they are made the community based distributors, they should be properly trained and mechanism developed to regularly monitor them and review their performance

1.2.2.3 Public Private Partnership (Social marketing): This can be taken up on an experimental basis in couple of districts, or a few blocks in these districts to pilot selling through entrusted community based institutions, volunteers, market mechanisms (like the popular pharmacist

of the village, or grocery shop owner or the like) condoms and OCPs at normal or subsidized rates. This should be properly preceded by adequate awareness generation of the availability of these for price in the community itself and that the clients or the community members could buy these from specified vendors (volunteers etc.). The research has shown that the services, drugs, supplies etc. bought for fee are valued more by the user and they use them more.

1.2.2.4 Organize monthly IUD Camps in PHCs/CHCs/SDHs IUD camps will be organize in each/CHC/SDH every month. ANM and ASHA will be informed the dates on which the camp will be held in the concern HIs.

1.2.3 Ensure follow up after IUD and OCP for side effects and treatment .Many of the drop outs for IUD and OCP occur due to side effects and lack of proper attention to take care of these. Follow-ups after IUD insertion and starting of OCPs and provision of medical care to mitigate side effects will help in continuing with the service and also create further demand.

1.2.4 Organize Contraceptive update seminars at the Block level twice in a year.

1.3 Motivate eligible couples for permanent methods in post partum period specifically after second and third child Efforts will be made by the service providers to motivate parents to adopt permanent methods after the birth of the second or third child.

1.3.1 Update EC register with help of ASHAs and AWW Every event will be recorded in the EC register and thus the register will be updated. This can be done after every event has occurred or reported to have occurred or during the VHNDs visit each month to a village.

1.3.2 Motivate couple after second child in Post Partum period to go in for tubectomy / NSV After the second child is born, the couple will be motivated to adopt a permanent method of family planning preferably NSV. For this communication materials will be prepared and distributed.

1.3.2 Follow up after tubectomy /NSV for side effects and treatment Each tubectomy / NSV will be followed up for side effects and their treatment. This will provide positive reinforcement and motivate others to adopt family planning.

1.4 Making available MTP Services in all Health Institutions. Since 8% of maternal mortality continues to be attributed to unsafe abortion, therefore, availability of and accessibility to quality abortion services / MTP services acquire greater importance. There is a need to identify, map and train the providers, both in public and private sectors on abortions / MTP services. There is also a need to ensure availability of medical abortion drugs; this can be done by including these drugs in to the state procurement list. The latest guidelines on this can be had from GoI. Revisions in MTP Act are underway; once done, systematic orientation of entire cadre of health personnel on this is required.

1.4.1 MTP Services in the state is not fully operational in all the hospitals of the state. Training of MOs has been under taken during RCH-1. To further strengthen the skill of the doctors for MTP training, training shall be taken up during the year.

1.4.2 Plastic MVAs will utilize and state will made purchase for availability in health institutions.

Objective No.2: To increase Couple Protection Rate

Strategies and Activities

2.1 Awareness generation in community for small family norm

2.1.1 Preparation of communication material for radio, newspapers, posters Communication materials highlighting the benefits of a small family will be prepared for radio, TV and newspapers.

2.1.2 Meetings with MSS, CBOs Communication materials to be used for monthly MSS/CBO meetings will be prepared and distributed for use.
These meetings will be scheduled during or preceding the month family planning camps are scheduled to beheld.
2.2 Regularize supply of contraceptives in adequate amounts
2.2.1 Indent and supply contraceptives for all depots and sub centre/ AWCs and social outlets: Each AWC and ASHA will have at least one month's requirement of condoms and OCPs. Sub centers will have adequate supplies of IUDs also.
Objective No.3: To increase male participation in family planning
Strategies and Activities
3.1 Promote the use of condoms
3.1.1 Counseling men in villages to demonstrate ease of use of condoms and for prevention of STDs Male workers will assist the MPWs in addressing the meetings of men in villages to demonstrate the use of condoms and its benefits in family planning and prevention of STDs.
3.1.2 Regular supply of condoms and setting up depots which are socially accessible to all men.
3.2 Promote adopting NSV: as simple and convenient method of hassle free FP methods (however, it must be told that it doesn't protect from STI/RTI of HIV / AIDS)
Objective No.4: To increase proportion of male sterilizations from 0.6% to 1.5%.
4.1 Increase demand for NSVs (develop a cadre of satisfied NSV Client, who could be the advocates for NSV in their designated geographical areas. Orient and train them and give them specific geographical responsibility to give roster based talks etc to identified groups of probable clients.)
4.1.1 Village level meetings in which men who already underwent NSV share experiences to motivate men to undergo NSV
4.2 Increase capacity for NSV services
4.2.1 Training of doctors for NSV While demand is being generated, a team of doctors should be trained at all the FRU level to conduct NSVs.
4.2.2 Organize NSV camps at the Sub District Level.
Objective No. 5: Monitor the quality of service as per GoI guidelines for
Sterilization
5.1 A quality assurance committee initiated in every district for monitoring the quality of sterilization in the respective district. The Civil Surgeon is the chairman of the committee with at least one Gynecologist.
5.2 Streamline the contraceptive supply chain & Monitoring
1. Identifications &Renovation of Warehouse – District/ PHC
2. Budget allocation for transportation at every level
3. Provision for report format printing and their availability at every level

YUKTI YOJNA

Although abortion has been legal in India since 1971, safe and legal abortion services are still not readily available, especially to poor, rural women, and morbidity and mortality from unsafe abortions are still serious problems for women in Bihar. The maternal mortality ratio (MMR) of 312 in Bihar far exceeds the national ratio of 254. Approximately 5.8 lakh induced abortions occur in Bihar annually with a majority of them happening outside of government-recognized

health centers, often in unhygienic conditions or by untrained abortion providers. Reducing the number of unsafe abortions will have a direct bearing on reducing the MMR of the state. Addressing the following two critical barriers can contribute to decreasing unsafe abortions:

- unavailability of reasonably priced quality safe abortion care services; and
- Low awareness among women/community regarding legality of abortion and need for early abortion seeking behavior.

The for-profit private sector provides a substantial proportion of all medical termination of pregnancies (MTP) performed in the state. However, this sector has remained largely fragmented and unregulated. Problems include, but are not limited to:

- Inadequate number of (legal/safe/qualified) providers in rural areas
- Over-pricing of services
- Non-compliance with the law1,
- Inadequate and/or inappropriate treatments

To augment service provision by the public sector and increase availability of quality comprehensive abortion care (CAC) services, the Government of Bihar (GoB) intends to accredit eligible and interested private sector sites to provide free first trimester CAC services; treat abortion complications, spontaneous and missed abortion; and stabilize and refer cases of abortion complications and second trimester abortions and be reimbursed by the government at a fair price. The accreditation system is the mechanism for GoB to buy services from the private sector in a transparent way to ensure wider availability of CAC services beyond the public sector. MTP certified private and not-for-profit NGO healthcare facilities are eligible to enlist as accredited CAC service sites and include accredited family planning sites with MTP site certification. These sites will offer free of cost first trimester CAC services and treat post abortion complications, incomplete and missed abortion cases and stabilize and refer cases of abortion complications and second trimester induced abortions (as needed) to district hospitals or other appropriate private sites (in cases where the site is not certified to offer second trimester abortion services).

To encourage early abortion seeking behavior the accreditation is limited to cover first trimester abortion cases only. GoB will reimburse the accredited facilities on a per case basis on submission of the required documentation and case details. The reimbursement rate covers the cost of drugs, consumables, overheads, other recurring costs and a margin as provider fee. Where applicable, the private site will also provide transport subsidy to the community health intermediary (ASHA/ANM/AWW/Health Worker) who accompanies the woman to the accredited private site for abortion services.

1 The MTP Act 1971, Rules and Regulations 2003

Guidelines for accreditation of private sites for provision of comprehensive abortion care services |

All public sector sites with a CAC trained provider shall continue to offer CAC services as appropriate. All such public sector sites will prominently display a signage and other IEC materials to increase awareness about availability of CAC services at their site. While the transportation subsidy as applicable under the Yukti Yojana will be payable to the accompanying intermediary (ASHA/ANM/AWW/Health Worker), the public sector sites are not be eligible for receiving reimbursements for provision of services.

II. Accreditation Scheme for CAC services: *Yukti Yojana*

In the current context, accreditation refers to a process wherein the requirement for provision of CAC services in participating private health sites is assessed against set standards, the qualifying facilities are recognized, empanelled and accredited for provision of below-

mentioned services and reimbursed for these in accordance with the provisions contained in these guidelines. The accreditation scheme is known as the **Yukti Yojana** and includes provision of the following services:

- First trimester abortion services
- Treatment of cases of incomplete abortion
- Treatment of abortion complications and referrals (after stabilization) when needed
- Referral of second trimester induced abortion cases

For women seeking the above services, the participating private sites will also ensure counseling on and provision of post abortion contraception services. The *Yukti Yojana* is a private site accreditation scheme of GoB with the specific objective of increasing access to safe abortion services and treatment of abortion complications. Private sites accredited under this scheme are also eligible to participate in other GoB schemes involving provision of reproductive health services by the private sector.

4.3 Mainstreaming AYUSH under NRHM

The Indian systems of medicine have age old acceptance in the communities in India and in most places they form the first line of treatment in case of common ailments. Of these, Ayurveda is the most ancient medicalsystem with an impressive record of safety and efficacy.Other components such as Yoga, Naturopathy are being practised by the young and old alike, to promote goodhealth. Now days, practice of Yoga has become a part of every day life. It has aroused a world wide awakeningamong the people, which plays an important role in prevention and mitigation of diseases. Practice of Yogaprevents psychosomatic disorders and improves an individual's resistance and ability to endure stressful situation.

Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) are rationally recognised systems of medicineand have been integrated into the national health delivery system. India enjoys the distinction of having the largest network of traditional health care, which are fully functional with a network of registered practitioners, research institutions and licensed pharmacies. The NRHM seeks to revitalize local health traditions and mainstream AYUSH (including manpower and drugs), to strengthen the Public Health System at all levels. It is decided that AYUSH medications shall be included in the drug kit of ASHA, The additional supply of genericdrugs for common ailments at SC/PHC/CHC levels under the Mission shall also include AYUSH formulations. At the CHC level two rooms shall be provided for AYUSH practitioner and pharmacist under the Indian PublicHealth Standards (IPHS) model. At the same time, it has been decided to place or provision one Ayush doctor on contract at the APHCs for the purpose and to ensure complete coverage of the population. Activities improve the availability of AYUSH treatment faculties and integrating it with the existing Health Care Service.

Strategies

- Integrate and mainstream ISM &H in health care delivery system including National Programmes.

- Encourage and facilitate in setting up of Ayush wings-cum-specialty centres and ISM clinics.
- Facilitate and Strengthen Quality Control Laboratory.
- Strengthening the Drug Standardization and Research Activities on AYUSH.
- Develop Advocacy for AYUSH.
- Establish Sectoral linkages for AYUSH activities Delivery System.

1. Integration of AYUSH services in 33 APHC with appointment of contractual AYUSH Doctors.
2. Appointment of paramedics where AYUSH Doctors shall be posted.
3. Strengthening of AYUSH Dispensaries with provision of storage equipments.
4. Making provision for AYUSH Drugs at all levels.
5. Establishment of specialized therapy centers/yush wings in District Head Quarter Hospitals & Medical Colleges.
6. AYUSH doctors to be involved in all National Health Care programmes, especially in the priority areas like IMR, MMR, JSY, Control of Malaria, Filaria, and other communicable diseases etc.
7. Training of AYUSH doctors in Primary Health Care and NDCP.
8. All AYUSH institutions will be strengthened with necessary infrastructure like building, equipment, manpower etc.
9. Yoga trainings were held in various District hospitals to provide Yogic therapy for specific diseases and also as a synergistic therapy to all other systems of treatment.

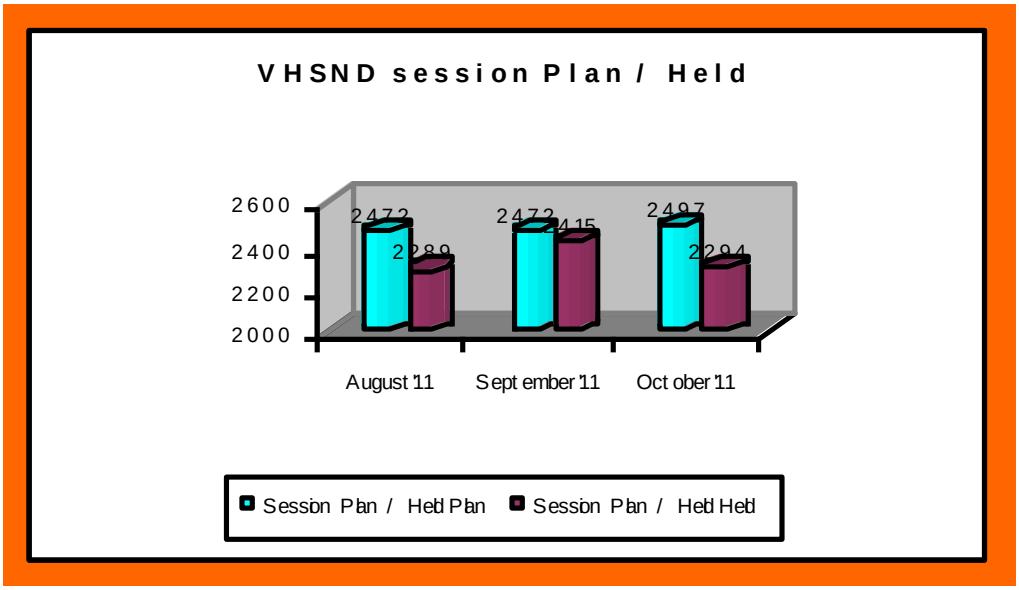
VHSND

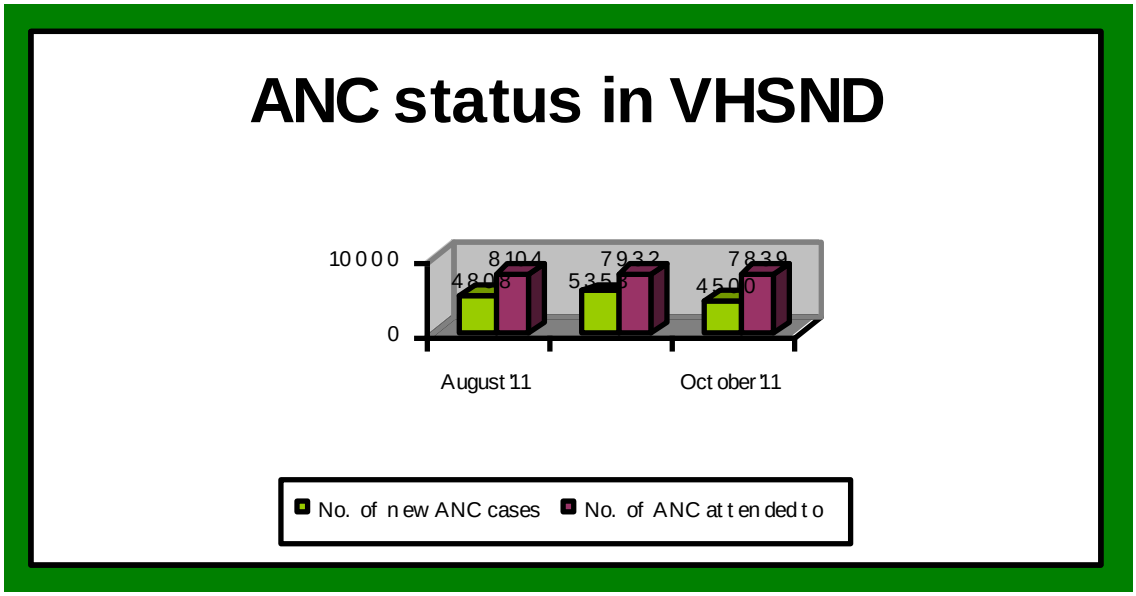
The NRHM guarantees better health outcomes for millions of people in rural areas, especially those belonging to marginalized and vulnerable communities. The VHND promises to be an effective platform for providing first-contact primary health care.
The VHND is to be organized once every month (preferably on Wednesday and for those villages that have been left out, on any other day of the same month) at the AWC in the village. This will ensure uniformity in organizing the VHND. The AWC is identified as the hub for service provision in the RCH-II, NRHM, and also as a platform for inter-sect oral convergence.

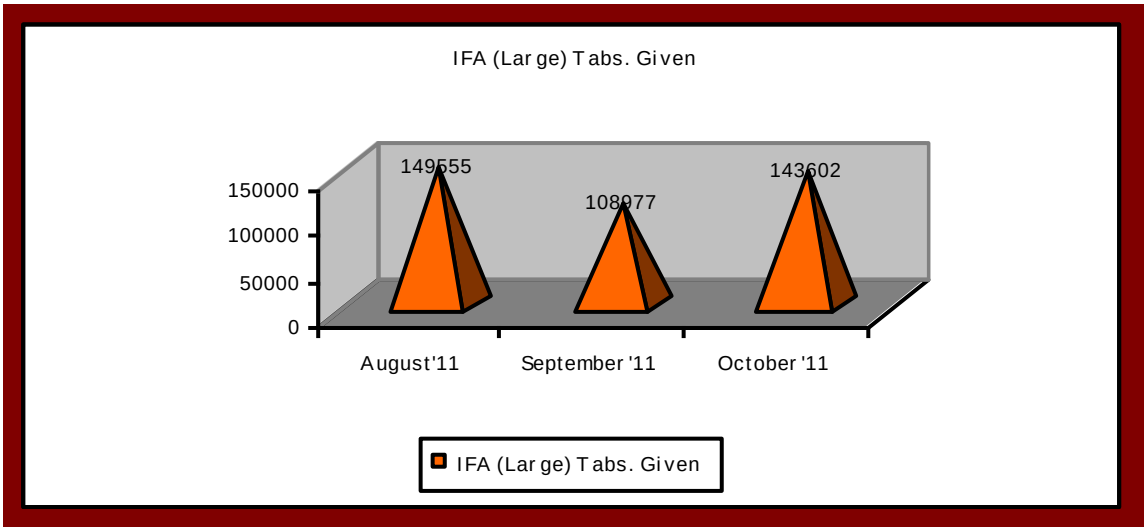
VHND is also to be seen as a platform for interfacing between the community and the health system. Keeping in view the significance of holding the VHND, the important steps that need to be taken while organizing the event have been put together in this manual. The roles of the ANM, ASHA and AWW should be well defined. The quality of the VHND needs to be improved, and hence the outcomes should be measured and monitored.

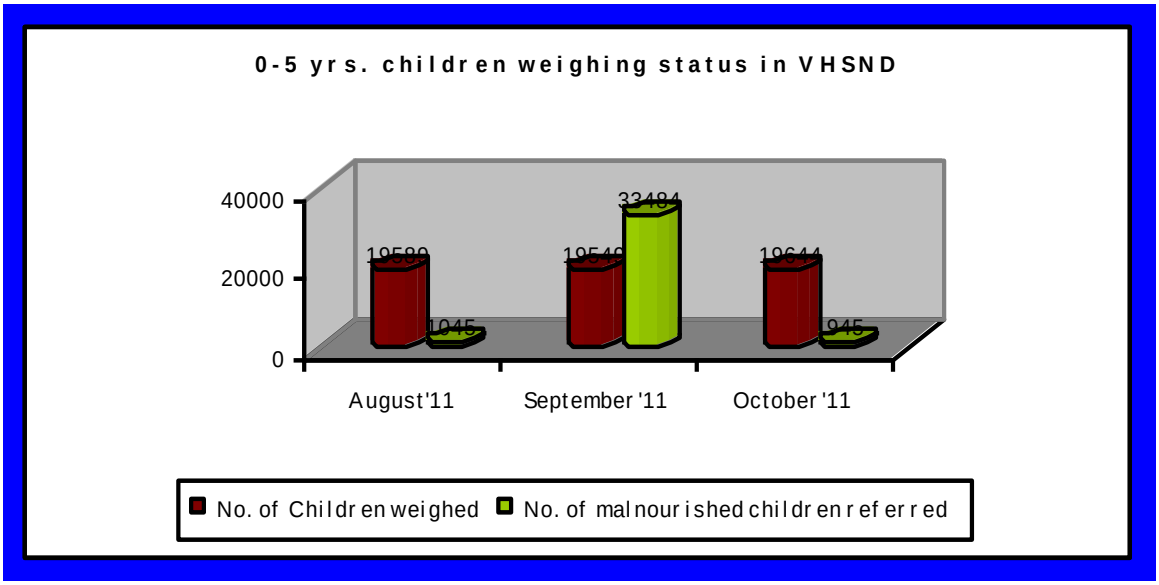
The Village Health and Nutrition Day (VHND) is organized at every Anganwadi kendras once in every month through which the services like registration of expectant mothers are provided with Ante Natal Care. Further important services like vaccination against six vaccine preventable diseases to children below one year, weighing of children,

distribution of condoms and oral contraceptive pills among the eligible couples, and supplementary nutrition to the under weight children are provided at the respective areas. The VHND also discusses various health related preventive measures identify the cases that need special attention and collection of data with the involvement of the local populace. The District Health Society of VAISHALI aiming to strengthen the VHND in the district.









Community Women taking health services during VHSND

4.4 Muskan…Ek Abhiyan

It has been decided by the Government of Bihar to attain 100% immunization of infants and pregnant women, for which tracking of pregnant women and infants are being undertaken through Muskan…Ek Abhiyaan .

Objective:
To achieve 100% immunization of Infants and Pregnant Women

Operational Strategy

Convergence with ICDS and Health for our-reach-service delivery
For Routine Immunization Aaganwadi Centers are acting as the "service delivery unit" as well as Headquarters for AWWs and ASHAs For 8 – 10 AWWs , ANM are designated as 'Team Leader'

Components:

- Tracking of all Pregnant Women and Newborns
- House-to-house survey
- Registration of all Pregnant Women and Children from 0 – 2 yrs age group
- Immunization sessions at Anganwadi Centers on each Friday
- Field Verification in the form of Supportive Supervision by both MO`s & CDPO`s are also planned under Muskan to Improve Immunization coverage in the Blocks
- Due List register to Track and Identify Due Beneficiaries for every RI Session
- 'Mahila Mandal' Meetings in the AWC to improve Health & Nutrition, in the Village.

Status of ASHA cell Block wise

Block's name	ASHA Selection Tar/Achievement	ASHA Facilitator selection Tar/Achiev	ASHA Diwas Tar/Achiev
Bhagwanpur	189/178	9/9	12/9
Bidupur	243/243	12/10	12/9
Chehrakalan	117/107	5/5	12/9
Desri	90/67	4/3	12/9
Goraul	160/121	8/6	12/9
Jandaha	244/223	12/10	12/9
Lalganj	204/203	10/10	12/9
Mahnar	126/126	6/6	12/9
Mahua	257/240	12/0	12/9
P. Belsar	87/78	4/4	12/9
Patepur	332/314	16/10	12/9
Raghopur	220/183	10/10	12/9
Rajapakar	140/113	7/5	12/9
Hajipur	270/230	13/0	12/9
S. Buzurg	118/106	6/5	12/9

Vaishali	**172/150**	**7/7**	**12/9**
Total	**2969/2682**	**141/100**	**192/144**

4.5 HMIS and Monitoring & Evaluation

The National Rural Health Mission has been launched with the aim to provide effective health care to rural population. The programme seeks to decentralize with adequate devolution of powers and delegation of responsibilities has to have an appropriate implementation mechanism that is accountable. In order
to facilitate this process the NRHM has proposed a structure right from the village to the national levels with details on key functions and financial powers. To capacitate the effective delivery of the programme there is a need of proper HMIS system so that regular monitoring, timely review of the NRHM activities should be carried out. The quality of MIES in districts is very poor. Reporting and recording of RCH formats (Plan and monthly reporting) are irregular, incomplete, and inconsistent. Formats are not filled up completely at the sub center level. There information is not properly reviewed at the PHC level. No feedback is provided upon that information.
For overall management of the programme, there is a Mission Directorate and a State Programme Management Unit in the state. .At district level, there is a District Health Society who will be responsible for the data dissemination from the sub-district level to the district level. District M & E Officer at the district level and Accountant cum M& E Officer at block level will be responsible for management of HMIS.As such, there is a Monitoring Team constituted district level as well as block level to monitor the implementation of the NRHM activities.
There is a Hospital Management Committee/Rogi Kalyan Samiti at all PHCs and CHCs. The PHC / CHC Health Committee will monitor the performance of HSC under their jurisdiction and will submit the report and evaluate the HSC performance, and will be submitted to the District, which will compile and sent it to the State.

4.6 Behaviour Change Communication

The district does not have any comprehensive BCC strategy. All the programme officers implement the BCC activity as per their respective programmes. The IEC logistic is designed, developed and procured at the district level and distributed to the PHC in an adhoc manner. However some activity is done at the state level. There is no credible study available to identify the areas / region specific knowledge, attitudes and practices pertaining to various focus areas of interventions like breast feeding, community & family practice regarding handling of infants, ARSH issues etc. At present there is no impact assessment of the IEC and BCC activities. It's very important to assess the impact of IEC/BCC activities, resources and methods to undertake mid way corrective measures.

4.7 Infrastructure and Human Resource

Infrastructure is one of the important components for up gradation of facility to deliver the quality service. In the PIP it has been proposed a number of infrastructural corrections for upgrading the facilities.

- *The Human Resource of the Permanent and contractual employees are mention below:-*

नियमित पद

कम0 सं0	पद का नाम	स्वीकृत	कार्यरत	रिक्त
1.	चिकित्सक	144	119	25
2.	लिपिक	75	70	5
3	बु0 स्वा0 कार्य0	74	47	27
4	फार्मासिस्ट	53	14	39
5	प्रयोगशाला प्रावैधिकी	52	35	17
6	परिधापक	45	10	35
7	ए0 एन0 एम0	428	373	55
8	ए0 ग्रेड नर्स	26	9	17
9	संगणक	11	7	4
10	स्वा0 कार्य0	48	9	39
11	स्वा0 प्रशिक्षक	25	24	1
12	चालक	30	7	23
13	प्रखंड प्रसार प्रशिक्षक	11	0	11
14	आंशुलिपिक	3	1	2

अनुबंध आधारित पद

कम0 सं0	अनुबंध पर नियुक्ति	स्वीकृत	कार्यरत	रिक्त
1.	जिला कार्यक्रम प्रबंधक	1	1	0
2.	जिला लेखा प्रबंधक	1	1	0
3	जिला पर्यवेक्षण एवं मुल्यांकन पदाधिकारी	1	1	0
4	विशेषज्ञ चिकित्सक	69	60	9
5	ए0 एन0 एम0 (आर0)	418	384	34

6	नर्स ग्रेड ए0	118	79	39
7	स्वास्थ्य प्रबंधक	16	14	2
8	लेखापाल	16	16	0
9	ममता	161	161	0
10	उप शिशु स्वास्थ्य प्रबंधक	1	0	1
11	जिला समुदायिक प्रेरक आशा	1	1	0
12	प्रखंड सुमुदायिक प्रेरक आशा	16	11	5
13	जिला डाटा सहायक	1	1	0
14	कालाजार तकनीकि पर्यवेक्षक	6	5	1
15	वित्त एवं लॉजस्टिक सहायक	1	0	1
16	डाटा इंट्री ऑपरेटर	3	3	0
17	आयुष चिकित्सक आर्यूवेद	42	21	21
18	आयुष चिकित्सक होम्योपैथ	25	15	10
19	आयुष चिकित्सक यूनानी	17	5	12
20	अस्पताल प्रबंधक	2	2	0
21	जिला योजना समन्वयक	1	1	0
22	चिन्हित दन्त चिकित्सक	16	16	0

4.8 Institutional Strengthening

Sub-centre rent shall be provided for the HSCs operational in rented building. In this FY 2012-13, we have planned for the renovation of the ANM training School & construction of APHCs & HSCs. The Consultant from State has already made the feasibility report for the repairing and maintenance. In this FY we have make provision for making computer lab, library, skill lab and other essential requirements. There is a need of boundary wall in almost all the PHCs & other health units to make safe from the bad elements of the society and use the hospital campus for gardening. Apart from this there is also need for the residential quarters of all the PHCs staffs (including doctors and other paramedical staffs). District Health Society also needs a separate building, at present it is functioning in a very damage building.

4.9 Training

Successful Implementation of any programme depends on the capacity building of the personnel engaged. In RCH – II also, human resource base will be created by enhancing the capacities through training .The sensitization of health personnel towards various RCH interventions is one of the major focus of the capacity building initiatives under RCH - II . Various trainings will be provided to district level managers, medical officers, nursing staff, ANMs, AWWs, ASHA and others. The training will be provided at the State Institute of H & FW, Regional training Institutes, ANM training schools, District hospital, PHCs. Some of the trainings will be contracted out to the NGOs and private players also, so that any limitation of State infrastructure is overcome easily. .As BCC will be a major training aspect; it has been dealt in a separate chapter. The entire technical

training programme will ensure that along with the theoretical inputs, proper practical exposure is also provided. Apart from this each training programme will stress on the managerial aspect and on the communication with the clients. The TOTs will ensure that the trainers not only master the contents of the training topic but also acquire skills as teachers/trainers or facilitators and motivators.

4.10 IEC/BCC

The Annual Action Plan 2012-13 for IEC/BCC has been prepared in the light of the number of initiatives taken by Dept. of Health, GoB, and State Health Society, Bihar, in the implementation of NRHM .It follows in essence, form and content, the National Communication Strategy. The National PIP for RCH and instructions and guidelines received from GoI and GoB from time to time has also been kept in mind.

The selection and implementation of set of behavior change have been adopted with a view to improve a wide range of family care-giving and care-seeking practices, and enhance supportive environments for improved household health practices at community, institutional and policy level.

The IEC/BCC Programme will focus on building an environment favoring health seeking practices, preferably through low cost interventions, especially for the disadvantaged and the marginalized sections of society especially in 33 model Panchyats one is identified for the holistic development. This outlook will set the tone and tenor of the mobilization process for effectuating a positive change in the existing socio-cultural mores, systems and processes. In these 32 Panchyats our effort will be creating awareness to the community people for the availability of the health care facilities and the safety measures of different communicable diseases. In this process we will organize Nukkad Natak, Role Play, Sign board, hoarding, Wall Writing etc.

FOR THE ISO CERTIFICATION OF THREE PHCs-VAISHALI, GORAUL & JANDAHA

In this FY District Vaishali have three PHCs nominated for the ISO Certification. Already, feasibility study have completed for this certification. ISO 9001certification is utilized in a variety of ways as a vehicle for healthcare organizations to:

- Identify systemic break-downs and close gaps or loopholes
- Define key interfaces between processes, departments and staff
- Streamline work flow and maximize resource utilization
- Proactively prevent problems from occurring
- Provide ways to detect and correct errors and problems
- Ensure conformance to and effectiveness of documented processes
- Focus on patient and provider needs and expectations
- Maximize customer satisfaction
- Facilitate compliance to healthcare quality certifications, accreditation standards and regulatory requirements

The Budget of these three PHCs has given below:-

Expenditure Heads	PHC Vaisali	PHC Goraul	PHC Jandaha
Curtanis for Labor room/ IPD/OT	Available	Available	5000
delivery Table	Available	Available	Available
Emegency Drug Tray/ cabinets at Nursing Station, Labor Room, OT and Emergency	Available	3000	3000
Minor Equipments and instruments in Labor room Mucus sucker, Suction Machine, Boiler, Instrument trolley, foetalscope etc.	10000	10000	10000
Hand washing facilities -washbasins, Elbow taps, soap, hand rub.	5000	5000	5000
X-Ray view box in clinics	2000	2000	2000
Partition of OPD Clinics	10000	10000	10000
Screens at OPD, Labor Room , OT, Emergency	5000	5000	5000
Electronic Patient Calling system with voice	7500	7500	7500
Disinfectant- carbolic Acid// Cidex/ sodium Hypochlorite	2000	2000	2000
Citizen Charter	3000	3000	3000
IEC Material	1000	1000	1000
Complaint Box	1000	1000	1000
Signage System including Glow sign Board for front	1000	1000	1000
Installation of May I Help You Desk	1000	1000	1000
Land Scaping/ Facility Management	15000	15000	15000
Deep Burial pit	Available	Available	5000
Display of work Instructions	Available	Available	Available
Immunization of Staff	5000	5000	5000
Medical Check Up food Handlers and Housekeeping Staff	2000	2000	2000
Doctor Duty Room (Fan, Bed, TV, small pantry and Refrigerator)	15000	15000	15000
Display Board for QI Activities	1000	1000	1000
Validation of Lab Reports	3000	3000	3000
Calibration of Measuring Equipments	8000	8000	8000
Culture surveillance of Infection Prone areas	5000	5000	5000
Improving illumination Level of Facility	5000	5000	5000
Disable Friendly Toilets	5000	5000	5000
Construction of Ramps	10000	10000	10000
Physical Indicator Strips for Autoclaving	1000	1000	1000
Fire Fighting Equipments	5000	5000	5000
Whitewashing/ Minor Civil Work	50000	50000	50000
Demarcated breastfeeding area	2000	2000	2000
Fumigator	2000	2000	2000

Lab Thermometers for all refrigerators	Available	Available	1000
Printing of form/ Formats- Bed Head Tickets, Requisition form, Patient Satisfaction form, MLR etc.	10000	10000	10000
TLD Badges for Radiographers	3000	3000	3000
Lead Aprons	Available	Available	Available
Colour Coded Bins	2500	2500	2500
Needle Cutters	5000	5000	5000
Puncture Proof Box	2000	2000	2000
Covered Trolley for distribution of food	1000	1000	1000
Authorization for BMW Handling and Disposal	5000	5000	5000
AERB Site approval	1000	Available	Available
Mislenious (waiting shade, Chairs, Wheel Chairs, Trolleys etc as per need.	3500	3500	3500
Sleepers and Shoe Rack for OT and Labor Room	30000	30000	30000
Medicine Dispensing Box at drug Distribution counter	1000	1000	1000
Envelop for dispensing medicines	1000	1000	1000
Baby Identification tags for labour room	1000	1000	1000
Tokens for OPD appointment	1000	1000	1000
Additional Delivery Kits to Adhere one Kit per delivery policy	2000	2000	2000
A geyser for warm water in Labor room/ Maternity ward	5000	5000	5000
Rain water Harvesting	5000	5000	5000
AC in OT	10000	10000	10000
Others	25000	25000	25000
Grand Total-904500	296500	298500	309500

SABLA-RAJIV GANDHI SCHEME FOR EMPOWERMENT OF ADOLESCENT GIRL

The term "Adolescence" literally means "to emerge" or "achieve identity". Its origin is from a Latin word "Adolescere" meaning, "to grow, to mature". It is a significant phase of transition from childhood to adulthood. A universally accepted definition of the concept of adolescence has not been established, but WHO has defined it in terms of age spanning between 10 to19 years. In India, the legal age of marriage is 18 years for girls and 21 years for boys. There is a high correlation between the age at marriage, fertility management and family health with education. Having regarded to this and other considerations, for the purpose of this scheme, the girls in the age group between 11 to 18 years will be considered in the category of adolescent girls.

In India, adolescent's girls (11-18 years) constitute nearly 16.75 % (Registrar General and Census Commissioner, India, 2001) of the total female population of 49.6514 crores which is approx. 8.3 crores. The female literacy rates are only 53.87% and nearly 2.74 crore girls are undernourished (33% of 8.3 crores). About 56.2% women (age 15-49), are anaemic as

reflected in NFHS-3 survey. Thus, they have considerable unmet needs in terms of education, health (mainly reproductive health) and nutrition. This is largely due to the lack of targeted health services for adolescents and widespread gender discrimination that prevail and limit their access to health services as well as the practice of early marriage and child-bearing that persists and puts adolescent girls and their children at increased risk of adverse outcomes. The Constitution of India enshrines the principle of gender equality to enable the State to adopt positive measures to prevent discrimination against girl children, adolescent girls and women.

Adolescence is a significant period for mental, emotional and psychological development. Adolescence represents a window of opportunity to prepare for healthy adult life. During this period, nutritional problems originating earlier in life can be partially corrected, in addition to addressing the current ones. It is also the period to shape and consolidate healthy eating and life style behaviors, thereby preventing the onset of nutrition related chronic diseases in womanhood and prevalence of malnutrition in future generation. Iron deficiency anemia is the most widespread micronutrient deficiency affecting the vulnerable groups including an adolescent girl which reduces the capacity to learn and work, resulting in lower productivity and limiting economic and social development. Anemia during pregnancy leads to high maternal and neonatal mortality and low birth weight etc. Addressing the health needs of Adolescent Girls will not only lead to a healthier and more productive women force but will also help to break the intergenerational cycle of malnutrition.

Within the Human Rights framework established and accepted by the global community, the rights particularly relevant to adolescents include gender equality, right to education and health (including reproductive and sexual health) and information and services appropriate to their age, capacities and circumstances. Definite measures should to be taken to ensure these rights and also make the girls aware of their duties and responsibilities. The Adolescent Girls (AGs) need to be 2 looked at not just in terms of their own needs as AGs but also as individuals who can be productive members of the society.

The Ministry of Women and Child Development, Government of India, in the year 2000 came up with scheme called "Kishori Shakti Yojna"(KSY) using the infrastructure of Integrated Child Development Services(ICDS). The objectives of the Scheme were to improve the nutritional and health status of girls in the age group of 11-18 years as well as to equip them to improve and upgrade their home-based and vocational skills; and to promote their overall development including awareness about their health, personal hygiene, nutrition, family welfare and management. The scheme provided for Rs.1.1 lakh per project per annum. 2-3 AGs per AWC are targeted under this scheme who are also provided supplementary nutrition by the state governments. Thereafter, Nutrition Programme for Adolescent Girls (NPAG) was initiated as a pilot project in the year 2002-03 in 51 identified districts across the country to address the problem of under-nutrition among adolescent girls. Under the programme, 6 kg of free food grains per beneficiary per month are given to underweight adolescent girls. The above two schemes have influenced the lives of AGs to some extent, but have not shown the desired impact. Rajiv Gandhi Scheme for Empowerment of Adolescent Girls - SABLA -would be implemented using the platform of ICDS Scheme through Anganwadi Centers (AWCs).

OBJECTIVES

The objectives of the Scheme are to-

i. Enable the AGs for self-development and empowerment
ii. Improve their nutrition and health status.
iii. Promote awareness about health, hygiene, nutrition, Adolescent Reproductive and Sexual Health (ARSH) and family and child care.
iv. Upgrade their home-based skills, life skills and tie up with National Skill Development Program (NSDP) for vocational skills
v. Mainstream out of school AGs into formal/non formal education
vi. Provide information/guidance about existing public services such as PHC, CHC, Post Office, Bank, Police Station, etc.3

TARGET GROUP

The Scheme would cover adolescent girls in the age group of 11-18 years under all ICDS projects in selected 200 districts in all the States/UTs in the country. In order to give appropriate attention, the target group would be subdivided into two categories, viz. 11-15 & 15-18 years and interventions planned accordingly. The Scheme focuses on all out-of-school adolescent girls who would assemble at the Aganwadi Centre as per the time table and frequency decided by the States/UTs. The others, i.e., the school going girls would meet at the AWC at least twice a month and more frequently during vacations/holidays, where they will receive life skill education, nutrition & health education, awareness about other socio-legal issues etc. This will give an opportunity for mixed group interaction between in-school and out-of-school girls, motivating the latter to join school.

SERVICES -An integrated package of services is to be provided to AGs that would be as follows-

i. Nutrition provision
ii. Iron and Folic Acid (IFA) supplementation
iii. Health check-up and Referral services
iv. Nutrition & Health Education (NHE)
v. Counseling/Guidance on family welfare, ARSH, child care practices and home management
vi. Life Skill Education and accessing public services
vii. Vocational training for girls aged 16 and above under National Skill Development Program (NSDP).

Budget breakup for SABLA training program of District & block level

Total District Level participant (16 MOIC+16 CDPO)=32+3 trainer @50 Rs. Refreshment	1750
Total Block level participant (6085- AWW,ASHA,ANM)+3 Trainer @ 40 Rs. Refreshment	243520
Stationary at district level	1700
Stationary at block level	152125
Contingency for district level training	1000
Contingency for block level training	8500
TA for district level participants	6800
TA for Block level participants	304250
Total	719645
IEC(Poster) @ 3.50/poster for the 3007 sites	10525

Grand total	730170

Requirement of IFA tablets for Adolescent girls(11-18 Years)

District	Total Women Population	Adolescent girls(School going girl in secondary school +SABLA+non school going+no.of girls in KGBV)16.75% of the total women pop.	No. of IFA tabs for adolescent girls (52 tabs./year)	Total cost@ Rs.0.105 per IFA Tab.
Vaishali	1648191	276072	14355744	1507353

Budget for the training of AWW, ASHA,ANM	Amount
Total field workers to be trained (6085-AWW,ASHA & ANM)	
No. of batches @ 50 Persons per batch=122	
Refreshment@ Rs.25 for 1 day per participants	152125
Stationary @ Rs.20 per participant	121700
TA for trainees @ Rs.25 per participants	152125
Total	425950
Cost of social mobilization @ Rs.50/AWC+HSC	150350
Grand Total=(1507353+425950+150350)	2083653

District Quality Assurance Committee

- To Ensure Quality healthcare services to every individual.

Specific Objectives:

- To ensure quality services including monitoring of the trainings.
- To follow Standard Treatment Protocol (STP/SOP) in service delivery for all programs.
- Ensure protocols are being practiced at all relevant service delivery points.
- To provide and to maintain quality accreditations to facilities.
- To ensure ethical staff work practices

Under District Quality Assurance Committee the members are

- Civil Surgeon - Chairperson
- DPM – Convenor
- ACMO - Member secretary (Hospital manager will assist)
- Members:
  - District Gynaecologist and/or district surgeon and /or district Anaesthetist/or district Paediatrician
  - NGO representative
  - District Nursing head
  - District RCH officer/FW officer
  - District Program officer, TB, Vector Borne, Blindness and leprosy
  - DPC

- Technical assistance
  - Two health educator (competency on computer) can be deputed to the cell by CS
- Secretarial assistance – District M&E Officer
- Special Invitee: Representative from Development Partners in the district

Steps to Operationalise QA Cell:-

Creation of Planning Team- State, Regional & District with specific Tor for Technical and Managerial staff – Orientation meetings (Visioning Exercise and develop vision statement of Hospital)

- Prepare Operational Guidelines (SOPs)
- Planning for Facility Development to provide Family Friendly Environment
- Conducting visioning exercise and Gap analysis.
- Making a long-term plan for achieving IPHS
- Medium term plan for achieving hospital accreditation standards
- Develop Annual Facility Development Matrix
  Annual Work Plan for Facility Development with support from RKS
- Facilitating the Implementation of the Plan (Collective action by RKS and hospital staff)
- Training in Quality [establishment of Skill labs, competency certification in protocols etc.]
- Ensure regular RKS meetings, motivation building, responsibility fixations, appreciative inquiry and review processes
- Monitoring team to focus on outreach activities as well
- Annual External Evaluation and Accreditation Processes
- Setting the timelines.
- Establishment of QA cells at various levels and their Orientation.
- Finalization (adaptation/ adopting) of protocols.
- Preparing monitoring tool for Quality Assurance.
- Training schedules.
- Certification / Accreditation

For the smooth running of the programme and to ensure quality health care the DQAC will visit all the health units. Ayush Drs. will monitor the quality of HSCs. The budgets for monitoring visits are given below.

Budget Head		
Mobility support for the members of the DQAC	Hiring of Vehicle for monitoring visit with fuel	@600 Vehicle+300 Fuel*10 Visit/month*12*4 Team (Each team consists 3 members)
	Fooding of Monitoring person	@200
	Total	528000
TA/DA for the AYUSH Dr. of the monitoring visit (HSC-337) Total-45	200/visit*337HSCs*2 times in a year	134800

AYUSH		
District level training on quality improvement of health facilities & services + FFHI/ISO(MOIC,MO1,Hos.managers+BHM+DCM+BCM+Staff Nurse)	40 Participants, Venue-2000,Fooding@200*40-8000,Travel-4000,LCD projector-1200, Stationary-150*40-6000,Res.per.fee-2000*1day-2000 Rs.Banner@200,Chair+sound system-1500	20900
Refresher Training on QA	40 Participants	20900
Block level /Facility based training on FFHI for all staff of facility including 4th Grade staff	30 Participants* 5 PHCs=150participants @200	30000
Facility level gap analysis exercise	5000*5 PHCs	25000
Gap Fulfillment for FFHI Certification	500000*5 PHCs	2500000
	Grand Total	3237100

SWOT ANALYSIS OF THE DISTRICT AND INDIVIDUAL SECTORS

Chapter-5

To identify the strength, weakness, opportunities and threats of districts a workshop was organized during the plan preparation process and suggestions were taken from different stakeholders from different sectors. The strategic planning workshops highlight the followings as SWOT in different sectors / sub-sectors.

Strength	Weakness	Opportunity	Threat

Rogi Kalyan Samiti is constituted at Primary health centers which regulates and controls over functioning of health Centers and gives suggestion/feedback for smooth and effective delivery of services further **Availability of skilled staffs and position filled-up of all most all positions in the blocks of the district.**	**As per IPHS norms there is shortage of doctors/Paramedics** **Need of regular motivation among medical and paramedical staffs** **Hospital is not attracting vast population who chooses private Doctor's clinic.** **Lack of physical infrastructure does not support medical and paramedics in Order to get optimum patient load.** **There is no suggestion/complain in cell so sometimes it Shows that lack of transparency.**	**Hospital administration can do study related to satisfaction level of patients** **Availability of the space construction of new building** **As per IPHS norms hospital can get ISO 9001 certification.** **By the vertical and horizontal transfer of hospital staffs it is possible that this transfer can accelerate health services.** **Public-Private partnership can be strengthen**	**Despite giving health services still hospital is not stands at par of private health services** **To get faith of people in Government hospital is very big challenges in spite of giving all facilities as compare to private**

NRHM Part-A Budget

	Part-A		
A.1	Maternal Health		
A.1.1.1.2	Monitor Progress and quality of service delivery	3 (No. of Meeting per qtr.@15000/meeting)	45000
A.1.1.2	Operationalise 24*7 PHCs (MCH Center-APHC)	16(1 APHC/Block @30000/APHC)	480000
A.1.1.5	Operationalise Sub Centers (MCH Center-HSC)	2(sub center@50000/sub center)	100000

A.1.3.1	RCH Outreach camps/others	48(no. of camps@10000/camp)	480000
A.1.3.2	Monthly village health and nutrition days	2595(Monthly VHSND at AWC)@1000	2595000
A.1.4.1	Home Deliveries	250(no. of home deliveries@500/delivery	125000
A1.4.2.a	Institutional Deliveries-Rural	81278(no. of institutional deliveries @2000/delivery)	162556000
A1.4.2.b	Institutional Deliveries-Urban	2000(no. of institutional deliveries @1200/delivery)	2400000
A.1.4.2.c	Institutional Deliveries C-Section	800(no. of C-section delivery @1500/C-section)	1200000
A.1.4.3	Administrative Expenses	@336714 per quarter*4 qtr	1346856
A.1.5	Maternal Death Review	200(no. of maternal death reviewed @1000/case	650000
	Total Maternal Health		171977856
A.2	Child Health		
A.2.1.1	Implementation of IMNCI activities in districts	@20000 per quarter*4qtr	80000
A.2.1.3	Incentives for HBNC to ASHA/AWWs(state initiative)3 PNC for normal baby	15000(no. of 3 PNC for normal baby)@100/PNC	1500000
A.2.1.4	Incentives for HBNC to ASHA/AWWs(state initiative)6 PNC for low birth baby	4000(no. of 6 PNC for low birth baby) @200/PNC	800000
A.2.2	Maintenance of Facility based New Born Care(SDH Mahua)	1 (no. of NBSU functional@500000/NBSU	500000
	Annual Maintenance of SCNU (procurement of consumables, CMC of equipments)	1*1000000	1000000
	Training of MAMTA (DH+SDH+PHC)	161 no. of MAMTA @ 719 including TA DA of trainer +Partcipants+lunch of Trainer & Trainee	115800
	Annual maintenance cost of NBCC	15*50000	750000
A.2.6	NRC	142658.75/quarter	570635
	Total Child Health		5316435
A.3	Family Planning		
A.3.1.1	Dissemination of manuals on sterilization standards & QA of sterilization services	1(Refresher sterilization standards & QA Meeting/Seminar at district & Block levels)@20000/district & 2000/block*16 block	52000
A.3.1.2	Female sterilization camps	432(No. of camps @30000 (PHC+FRU)*2 camps/month	12960000

A.3.1.3	NSV camps	5(No. of NSV Camps)@5000	25000
A.3.1.4	Compensation for female sterilization	26214(compensation of Female sterilization)@1000	26214000
A.3.1.5	Compensation for male sterilization	200(No. of NSV Cases/Vasectomy Cases)@1500	300000
A.3.1.6	Accreditation of private providers for sterilization services	3500(@1500 per sterilization Services)*3500	5250000
A.3.3	POL for family Planning (For state level + District level monitoring)	16 Blocks (no. of blocks @ 15000 +20000 district for FP monitoring)	260000
A.3.5.4	Provide IUD services at health facility (IUD Camps)	49 Camps (16 PHC*3qtr.)+1 dist.@2000	98000
	Total Family Planning		45159000
A.4	ARSH		
A.4.3	Other Strategies/ Activities (Menstrual Hygiene)	1368911(No. of adolescent girls 10-19 years) @28 (sanitary Napkin)	38548034
	Total ARSH		38548034
A.7	PNDT & Sex Ratio		
A.7.2	Other PNDT Activities (Monitoring & review meeting with other dept. & District Level workshop-MOIC+NGOs+IMA rep.+ Ultrasound owner)	5000 for district level workshop, 50000 for monitoring and review meeting	100000
	Total PNDT & Sex Ratio		100000
A.8	Infrastructure (Minor Civil Works) & Human Resources (Except AYUSH)		
A.8.1.1	ANMs, staff nurses, supervisory nurses (salary of contractual ANM/Contractual SN)	118 A grade Nurse*20000*12+418 contractual ANM*11500*12	86004000
A.8.1.2	Laboratory Technicians (Laboratory Technicians in Blood Banks)	3(lab tec.)@10000/month*12 month	360000
A.8.1.5	Salary of MOs in Blood Banks	1(35000per month*12 month)	420000
A.8.1.7	FP Counselors	2(@15000 PM*12 Month)	360000
A.8.1.8	Muskan program -incentive to ASHA & ANM	46584(No. of session per year based on beneficiaries)@60 Rs	2795040
	Provision of Boundary Wall of all PHCs	16*@200000	3200000
	Renovation of indoor wards	1 DH	500000
	Renovation of emergency ward	1 DH	500000

	Establishment of pediatric ward	1 DH	500000
	Minor repairing of labor ward	1 DH	100000
	Construction of hospital entrance gate	1 DH	100000
	AMC for electrical and bath fittings	1 DH	100000
	Water filtring with RO system	6 units in 1 DH	200000
	Total infrastructure (minor civil works & human resource (Except AYUSH)		91624000
A.9	Training		
A.9.1	Strengthening of training institutions(repair/renovation of ANM training institution)	(@ 5041015)for 1 institution	5041015
A.9.3.1	Skilled Attendance at Birth		592350
A.9.3.2	Comprehensive EmOC Training (including C-section)		1000000
	Life saving anethesic skill training		
A.9.3.4	MTP training		112800
	Skill Lab Trg. Of MO. & ANM	15batch*80000	1200000
	NBCC Trg. Of MO & ANM	7 Batch*40000	280000
A.9.3.7	Other MH training (any integrated training etc.)Training of MOs and Paramedics staffs at Sub District Level (Convergence with BSACS)	2 batch@115000	230000
A.9.5.1	IMNCI		1867580
A.9.5.5.3	NSSK Training (SN/ANM)	6(@67370/batch)	317400
A.9.6.2	Minilap Training	1 at district level	70237
A.9.6.4.1	Training of Medical officers in IUD insertion	1 at district level	55289
A.9.6.4.2	Training of ANMs/LHVs /SN in IUD insertion	3 batches to be conducted at district level@29420	88260
A.9.8.2	DPMU Training	1@50000	50000
A.9.11.3.2	Community Visit for Students and teachers		
	Total Training		8188652
A.10	Programme/NRHM Management Costs		
A.10.1.5	Mobility support (District Malaria Office)	@15000*12 months	180000

A.10.2.1	Contractual staff for DPMU recruited and in position	4(1 DPM@42858,1 DAM @35937, 1 M&E O @29947 & 1 DPC @24200)*12 months	1595304
A.10.2.2	Provision of equipment/furniture and mobility support for DPMU staff (Laptop for DPC Rs.35000)	1	1235000
A.10.3	Strengthening of Block PMU	16	14080000
A.10.4.2	Renewal(Upgradation)Tally Software	1	8100
	Renewal(Upgradation)Tally Software	16 PHCs*2700	43200
	Tally Purchase	1 SDH	13500
A.10.4.3	AMC (DPMU)	1	22500
A.10.4.9	Management Unit at FRU (Hospital Manager & FRU Accountant)	2	990000
A.10.5.1	Annual Audit of the Prog. (Statutory Audit)	7(@9000*7)	63000
A.10.6	Concurrent Audit (State & District)	1(@20000*12)	240000
	Total Programme/NRHM Management Costs		18470604
	Grand Total (Part-A)-473655803	Committed Expenditure-94271222	379384581
	Part-B		
B1.1.1	Training of ASHA Facilitator	141(no. of ASHA facilitator)Round 1,2,3,4	1523082
	Office Expenses for ASHA Cell	2700 *12	32400
B1.1.2	Procurement of ASHA drug kit & replenishment	2969(no. of ASHA)@250/ASHA*2	1484500
B1.1.3	TA/DA for ASHA Diwas	2969*125*12	4453500
B1.1.4.a	Best performance award to ASHAs at dist.level	2969	34000
B1.1.4.c	Diary to ASHA	2969*100	296900

B1.1.5	ASHA Mentoring group	159(1DCM+1 DDA+16 BCM+141 AF)	5072640
	Total ASHA		12897022
B2.1	Untied fund for SDH	1	75000
B2.2.a	Untied fund for PHCs	16*50000	800000
B2.2.b	Untied fund for APHCs	32*30000	960000
B2.3	Untied fund for Sub Centers	337*20000	740000
B2.4	Untied fund for VHSC	1637*10000	16370000
	Total Untied Fund		16370000
B3.1	Annual Maintenance Grant for SDH+Ref	5*300000	1500000
	Annual Maintenance Grant for 1 DH	1*500000	500000
B.3.2	Annual Maintenance Grant for PHCs	16*200000	3200000
B.3.2.a	Annual Maintenance Grant for APHCs	18*100000	1800000
B.3.3	Annual Maintenance Grant for HSCs	164*25000	4100000
	Total Annual Maintenance Grants		11100000
B4.2.a	Installation of Solar Water System	7@67785	474500
B4.3	Sub Center Rent and Contingencies	164(@500/month*12month)	984000
	Provision of curtain(Polyacrylic with stand) between labour table in the FRU(SDH Mahua, Lalganj, K.Chapra, DH)	4*@6000/curtain	24000
	Labour table & Revolving stool	16*2 @15000+16*2@2000	544000
	Electronic baby weighing machine	16*1 @ 7000	112000
	Purchase of fetoscope	16 PHCs*2per*@1500	48000
	Provision of OT Light System in FRU	4*@150000	6000000
	Comprehensive Maintenance Contract of OT Light System in FRU	4*@15000	60000
	Total Hospital Strengthening		6788000
B.5.2.a	Construction of APHC	12*8000000	96000000
B.5.2.b	Construction of residential quarters for doctors & staff	16*5000000	80000000

	nurses		
B.5.2.c	Strengthening of Cold chain & renovation of the office of the DIO	(for 16 PHC@50000)+200000	1000000
	For the spare parts +gas	district level-100000	100000
B.5.3	Construction of HSC	1 HSC/PHC=16 HSCs*2000000	32000000
			209100000
B.6.1	Corpus Grant to HMS/RKS-Dist. Hospital	1*1000000	1000000
B.6.2	Corpus Grant to HMS/RKS-SDH	3*150000	450000
B.6.3	Corpus Grant to HMS/RKS-PHC	16*120000	1920000
B.6.4	Corpus Grant to HMS/RKS-APHC	32*100000	3200000
	Total Corpus Grants to HMS/RKS		6570000
B.7	District Action Plans, (BHAP)+ HSC Plan	353 (HSC @1500& BHAP@5000+DHAP@5000)	590500
	Planning Cell at District Level(Salary of Computer Assistant)	1 (@ 6000/month *12 Month)	72000
	District Level workshoop for the preparation of Health Action Plan	25000*2 workshop	50000
	Printer,scanner for DPC	1@4000+1@3000	7000
	Mobile +Internet for DPC	500/month+98 /month*12	7176
	Total DHAP+BHAP+HSC & Comp. Asst. Salary		726676
B.8.1	Constit. and Orient. of Com.Leader & Of VHSC,SHC, PHC,CHC	290Village @1500/village	435000
B.8.2	Orient.workshop,trg.and CB of PRI at State/DHS/CHC/PHC	16+290 @623 per participants	190900
	Total Panchyati Raj Initiative		625900
B.9.1	Mainstreaming of AYUSH-MO at DH/CHCs/PHCs(only AYUSH)	No. of AYUSH Dr. 45 @ 20000* 12 months	10800000
	Total Mainstreaming of AYUSH		10800000
B.10.1	Development of State BCC/IEC Strategy	1 hoarding,2 wall painting,1sign board,/FRU-1 health camp,9wall painting, 1 sign board/PHCs, other IEC /BCC activities	745000

B.10.3	Health Mela (Leprosy)	1	5000
			750000
B.11	Mobile Medical Units(including reccuring expenditure)	1	4212000
			4212000
B.12.2.c	Advanced Life Saving Ambulance(Call 108)	1	1560000
B.12.2.d	Referral Transport in districts(BLSA)	18*@200000*12	43200000
	Total Refferal Transport		44760000
B.13.3.b	Outsourcing of Patho. And Radio. Services from PHCs to DH	23(no. of functional X-ray/ultrasound & pathology centers)	11147460
B.13.3.d	Bio Waste Management	16 PHC@8000*12+5 Ref+SDH@12000*12+1DH@30000*12	1536000
	Total PPP/NGO		12683460
B.14.a	SABLA	1 Dist.level trg.+1 block level trg. +IEC(Rs. 730170+IFA tab.procurement+ AWW,ASHA training- Rs.2083653	2813823
B.14.b	Yukti Yojna	914(no. of safe abortion cases)	310133
	Total Innovations		3123956
B.15.2	Family Friendly Hosp.Initiative (Certification of 5 PHCs)	Facility level gap analysis exercise@5000*5 PHCs	25000
	Gap fulfillment for FFHI certification	500000*5 PHCs	2500000
B.15.3.1.a	District, Block Data Center	19	1824000
B.15.3.2.a	MCTS & HRIS	16+1(Block & dist. Level trg.)	455931
	Out sourcing security (DH) 24/7	1@100000/month	1200000
B.15.3.2.b	RI Monitoring	16	130000
B.15.3.3	Other M & E Activities(District Quality Assurance Committee)	Monitoring Visit@1100*10 visit*12 months*4 Teams (District level team)	528000
		AYUSH Dr. Visit to the HSC @200 per visit*337*2 times	134800
	District & Block level Training	2 training @20900 , Block trg.-30000	71800
B.15.3.3.a	Strengthening of HMIS	1	5000
B.15.3.3.b	Plans for HMIS Suppportive Supervision and data	48 Visits by M & E off. & 1 Bulletin	290000

	Validation		
	HR support for the Model FRU at DH	5 OT asst.@ 12000*12 + 6 OT attend.@ 10000*12+6 Ward Boy@8000*12	2159000
	Nayee Pidhi Swasthya Gurantee Karyakarm	Training & Orientation of ASHA, ANM,AWW,HW . Hiring of opthalmic assistant & Lab Tech., Cost of IEC Activities, Miking, Purchase of Medicine & Lab testing, Cost for contingency, specialized treatment	8494000
	Total Planning, Implementation and monitoring		15112600
B.16.1.1	Procurement of equipment:(MH)	32 APHC*6 beds*15000	2880000
	Procurement of equipment MH (Dist. Hosp.)	1@500000	500000
B.16.1.3.a	Procurement of Minilap Set: FP	4 kit /PHC*16 PHC@3000	192000
B.16.1.3.b	Procurement of NSV Kit (FP)	5 kit@1100	5500
B.16.1.3.c	Procurement of IUD Kit (FP) PHC Level	2@15000	30000
	Procurement of DDK	@500*110000	55000000
B.16.1.5.a	Dental Chair Procurement	4@226315	905260
B.16.1.5.c	AC .1.5 ton window	1(SDH Mahua)	25000
B.16.2.1.a	Parental Iron sucrose (IV/IM) as therp.measure to PW with S.A	1	600000
B.16.2.1.b	IFA tab.for PW & LW	155069@14	2170966
B.16.2.2.a	IFA Small tab. & syrup for child.6-59 months	591634 (6-59 months)*6 Rs	3549804
B.16.2.2.b	IMNCI Drug Kit	2000@250/ KIT	500000
B.16.2.5	General Drugs & Supplies for Health Facilities	3495249	1600000
	Drugs for dist. hospital	1@300000/month*12	3600000
	procurement of Vitamin-A Bottle & Training	44.32*9436 +Training Cost	959156
	Drug kit procurement for RTI /STI & Training		1875355
	Emergency drugs for FRU(Labour Room ,SCNU,NSU,NBCC)		500000
	Total Procurement		65814511
B.22.4	Support strengthening RNTCP	11+(Lab.Asst.+MO)	198000

B.23.a	Payment of Monthly bill to be BSNL	17	290000
			488000
	Grand Total (Part-B)-433422359	Committed Expenditure-11500234	421922125

NRHM Part –C

Routine Immunization (Budget-2012-13)

Sl. N0.	Activity Narration	Budget
1	Mobility Support-	70000
2	Printing & dissemination of Imm formats, tally sheets, monitoring forms etc.	750000
3	Quarterly Review meeting for RI at dist. Level with MOIC, CDPO, and other stake holders	50000
4	Quarterly Review meeting for RI at Block Level with MOIC, CDPO, and other stake holders	800000
5	Focus on slum & underserved areas in urban areas/Alternative vaccinator for slums	500000
6	Mobilization of children through ASHA under Muskan Ek Abhiyan	800000
7	Alternative Vaccine delivery in hard area to reach areas	40000
8	Alternative Vaccine delivery in other areas	2500000
9	Computer Assistant	132000
10	Alternative vaccinator hiring for Access compromised area, POL of Generators for cold chain and for serious AEFI cases	450000
11	One day cold chain handlers training for block level cold chain handlers	25000
12	District Level Orientation	1400000
13	Microplans at Block Level	20000
14	Data Handlers training	22000
15	Microplans at sub center level	75000
16	Cold chain Maintenance	90000
17	POL for Vaccine delivery	150000

18	Consumables for computer	6000
19	For injection safety and plastic bags	110000
20	Safety Pits	70000
	Total	**8060000**

Pulse Polio

Part-C

Quarter wise	Budget
1st Quarter	7362171
2nd Quarter	2707088
3rd Quarter	5242166
4th Quarter	7300107
Total	22611532

Part-D

IODINE DEFICIENCY DISORDER PROGRAM			
Sl. No.	Activity Proposed	Rate	Amount
	Running cost of IDD Cell		
1	Technical officer	25000/month*12	300000
2	Statistical Assistant	15000/month*12	180000
3	LDC/Typist	8000/month*12	96000
4	Laboratory Technician (For IDD Lab)	12000/month*12	144000
5	Laboratory Assistant (For IDD Lab)	8000/month*12	96000
	Total		816000
	Intersectoral Coordination		
1	Intersectoral Coordination Meeting at district level for ensuring multisectoral activities	Rs.10000	10000
	Total		10000
	Training/Orientation		
1	Orientation of food safety officer for institutionalizing salt testing	Rs.500/participants*4	2000

2	Orientation of field functionaries (ASHA, AWW & ANM) for salt sample collection and counseling for awareness generation	Rs. 2000/PHC*16	32000
	Total		34000
	Health Education & Publicity		
1	Printing of awareness generation material poster, pamphlets	Rs.500*16 PHC	8000
2	Awareness generation activity and competitions in schools	Rs.1000*16 PHC	16000
	Total		24000
1	IDD prevalance survey	50000	50000
	Total		50000
	Grand Total		934000

IDSP BUDGET VAISHALI (2012-2013)

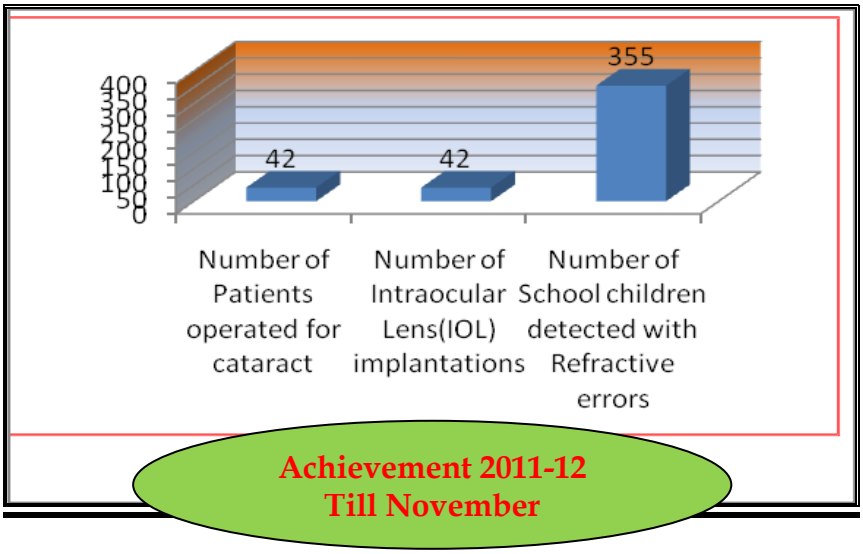
Sub-activity	Sl.no.		Unit Cost	No. of Units	2012-13	Remarks
1. Staff Salary	1	Epidemiologists	40000	1	40000*12=480000	Revised Salary as per Govt. of India(33% Increment)
	2	Microbiologists	N/A	N/A	N/A	N/A
	3	Entomologist	N/A	N/A	N/A	N/A
	4	Consultant (Finance)	N/A	N/A	N/A	N/A
	5	Consultant (Training)	N/A	N/A	N/A	N/A
	6	State Data Manger	N/A	N/A	N/A	N/A
	7	District Data Manager	18000	1	18000*12=216000	Salary revision required as there is no increments for this post only under NRHM(33% Required)
	8	Data Entry Operator	11500	1	11500*12=138000	Salary revision required
		Sub Total			834000	
2. Training	1	Training of Hospital Doctors	As per NRHM guiedline			
	2	Training of Hospital Pharmasist / Nurses (Reporting	As per NRHM guiedline			

		Person)				
	3	Training of Data Managers	As per NRHM guiedline			
	4	Training Health Manager & Data Operator	As per NRHM guiedline			
		Sub Total				
3. Operational Cost	1	Mobility Support for IDSP and RR Team	10000	1	10000*12=120000	Vehical for IDSP office & RRT
	2	Office Expenses	4000	1	4000*12=48000	Stationary 2000*12=24000, News Paper for News Allarts 300*12=3600, Contengency 1000*12=12000 & Others Expences 700*12=8400
	3	ICT Equipment Maintenance	10000	1	10000	All Training centre and Data centre equipments requires maintenance for their proper functioning.
	4	Collection & transportation of samples	10000	1	10000	Collection & transportation of samples from field to lab
	5	Printing of Reporting Forms	10000	1	10000*1=10000	Printing of Reporting Forms at HQ
	6	Phone & Broadband Expenses	1500	1	1500*12=18000	Phone & Broadband Expenses @ Rs 1500 par month
	7	Monthly Meeting	3000	1	3000*12=36000	Monthly Meeting of DSU
		Sub Total			252000	
		Grand Total			1086000	

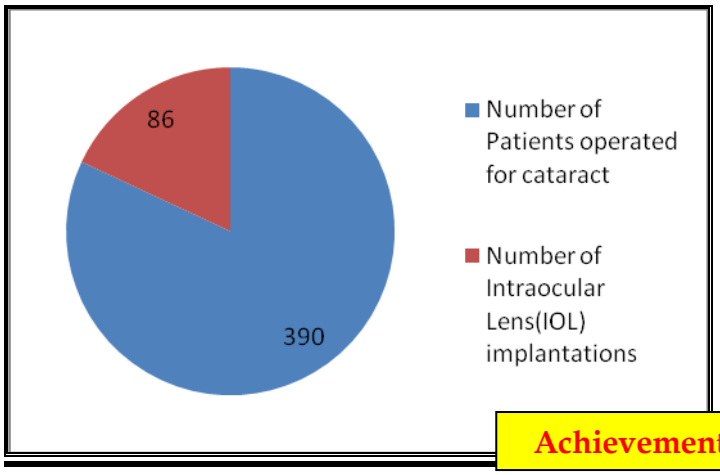
Blindness

FMR	Budget Head	Physical	Budget

Code		Target	
H.1.1	Recurring GIA for free cataract operation and other approved schemes as per financial norms	3000	1632762
H.1.3	Recurring GIA for school Eye Screening Programme	1000(Unit cost for 200/-per case	200000
H.1.12	Recurring GIA for maintenance of ophthalmic equipments	1	70000
			2000000
H.2.3	Non recurring GIA for Vision	6	300000
	Total		4202762



Achievement 2011-12 Till November



Achievement during 2010-11

Leprosy

Sl.no.	Functional Head Wise Budget	Budget
1	ASHA	142100/-
	Total	142100
2	Improved Case Management I. DPMR II. Urban III. Office Expenses	 74000/- 71000/- 20000/-
	Total	165000
3	Stigma Reduction (IEC)	278300/-
	Total	278300
4	Training	153800/-
	Total	153800
5	Monitoring & Supervision	88400/-
	Total	88400
	Grand Total=Eight Lakhs Twenty Seven Thousand Six Hundred only.	827600/-

Tuberculosis

Tuberculosis (TB) is an infectious disease caused by a Bacterium, *Mycobacterium tuberculosis*. It is spread through the air by a person suffering from TB. A single patient can infect 10 or more people in a year.

India has a long and distinguished tradition of research in TB. Studies from the Tuberculosis Research Centre in Chennai and the National Tuberculosis Institute in Bangalore provided key knowledge to improve treatment of TB patients all around the world.

Modern anti-TB treatment can cure virtually all patients. It is, however, very important that treatment be taken for the prescribed duration, which in every case is a minimum of 6 months. Because treatment is of such a long duration and patients feel better after just 1-2 months, and because many TB patients face other problems such as poverty and unemployment, treatment is often interrupted.

Therefore, just providing anti-TB medication is not sufficient to ensure that patients are cured. Today, for the first time since the discovery of the first anti-TB medicines in 1944, there is

hope of stopping TB. This breakthrough is a strategy known as DOTS, an acronym for Directly Observed Treatment, Short-course.

The Director-General of the World Health Organization has declared that, "The DOTS strategy represents the most important public health breakthrough of the decade, in terms of lives which will be saved."

Directly Observed Treatment, Short-course (DOTS)

In 1992, the Government of India, together with the World Health Organization (WHO) and Swedish International Development Agency (SIDA), reviewed the national programme and concluded that it suffered from managerial weakness, inadequate funding, over-reliance on x-ray, non-standard treatment regimens, low rates of treatment completion, and lack of systematic information on treatment outcomes. As a result, a **Revised National Tuberculosis Control Programme (RNTCP)** was designed. **DOTS** is known as the **Revised National Tuberculosis Control Programme (RNTCP)** in India and is a comprehensive strategy for TB control.

The goal of **RNTCP** is to cure at least 85% of new smear-positive cases of tuberculosis and to detect at least 70% of such patients, after the desired cure rate has been achieved. Clearly, both good outcomes and high case detection rates are essential. But it is essential that the system is geared up to reliably cure patients, before any attempts are made at expanding case detection. In fact, experience clearly shows that reliably curing patients results in a "recruitment effect" – wherever effective services are offered, case detection rates steadily increase. Cured patients act as one of the best motivators promoting case detection and patient adherence to treatment.

DOTS is the only strategy which has proven effective in controlling TB on a mass basis. To date, 148 countries are implementing the DOTS strategy. India has adapted and tested DOTS in various parts of the country since 1993, with excellent results, and the RNTCP now covers more than 1 billion populations in over 564 districts in 29 states and union territories. The entire Country now covered by Revised National Tuberculosis Control Programme, making it the second largest such programme in the World. The programme has developed a 'strategic Vision for TB Control for the Country up to 2015; under which it aims to achieve and maintain a Cure Rate of at least 85% in New Sputum Positive Pulmonary TB Patients, and detection of at least 70% of such cases.

DOTS is a systematic strategy which has five components

Political and administrative commitment:- TB is the leading infectious cause of death among adults. It kills more women than all causes associated with childbirth combined and leaves more orphans than any other infectious disease. And, since TB can be cured and the epidemic reversed, it warrants the topmost priority, which it has been accorded by the Government of India and the state governments. This priority must be continued and expanded at the state, district and local levels.

Good quality diagnosis:-Top quality microscopy allows health workers to see the tubercle bacilli and is essential to identify the patients who need treatment the most.

Good quality drugs:-An uninterrupted supply of good quality anti-TB drugs must be available.

In the RNTCP, a box of medications for the entire treatment is earmarked for every patient registered, ensuring the availability of the full course of treatment to the patient the moment he is registered for treatment. Hence in DOTS, the treatment will never fail for lack of medicine.

The right treatment, given in the right way:-The RNTCP uses the best anti-TB medications available. But unless treatment is made convenient for patients, it will fail. This is why the heart of the DOTS programme is "directly observed treatment" in which a health worker, or another trained person who is not a family member, watches as the patient swallows the anti-TB medicines in their presence.

Systematic monitoring and accountability: - The programme is accountable for the outcome of every patient treated. The cure rate and other key indicators are monitored at every level of the health system, and if any area is not meeting expectations, supervision is intensified. The RNTCP shifts the responsibility for cure from the patient to the health system.

Major gaps in RNTCP
Lack of well equipped / Designed Microscopy Centre
Microscopes of many Designated Microscopy Centers (DMC) are not functioning
Poor Maintenance of Microscopes
Many DMCs are closed due to lack of Microscopist / Lab Technician
Constraint in selection Process of new Staffs by the District Health Society
Remuneration of Pvt DOT Providers has not been paid
Irregular supply of Drugs specially of Pediatric Drug Boxes (PC-13, PC-14)
Supply of short expiry drugs which causes difficulties in drug management
Poor Retrieval of Drug Boxes of Defaulted patient
Irregular supply of slides and other Chemicals and other logistics
Delay in purchasing of chemicals and other logistics at District level
Poor quality of DOTS
ANMs providing DOTS at the HSCs do not visit the Center on DOTS day resulting irregular intake of drugs by the patient causing poor Cure- rate.
Due to irregularities in DOTS cases of MDR TB may be increased
Not friendly behavior of Lab Technician and other staffs with patient who comes for sputum examination or for DOTS
Poor Case Detection i.e., <70%
Poor Cure Rate i.e., <85%
High Default Rate

ANNUAL PLAN FOR PROGRAMME PERFORMANCE & BUDGET FOR THE YEAR 1ST APRIL 2012 TO 31ST MARCH 2013

Section-A – General Information about the District

1	Population (in lakh) please give projected population 2012	34,95,249
2	Urban population	1,59,469
3	Tribal population	0
4	Hilly population	0
5	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums)	Raghopur Diyara 241367

(These population statistics may be obtained from Census data /District Statistical Office)

Does the District have a DTC – Yes

ORGANIZATION OF SERVICES IN THE DISTRICT:

S. No.	Name of the TU	Population (in Lakhs)	Please indicate if the TU is-		No. of MCs		
			Govt	NGO	Govt	NGO	Private
1	SADAR (DTC, HAJIPUR)	449618	Govt.	0	03		
2	BIDUPUR	266694	Govt.	0	04		
3	GORAUL	174232	Govt.	0	03		
4	JANDAHA	267230	Govt.	0	03		
5	MAHUA	280739	Govt.	0	03		
	DISTRICT	**3495249**			**16**		

RNTCP performance indicators:

Important: Please give the performance for the last 4 quarters i.e. July 2010 to June 2011

TB Unit	Total number of patients put on treatment	Annualized total case detection rate (per lakh pop)	No of new smear positive cases put on treatment	Annualized New smear positive case detection rate (per lakh p op)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year		Proportion of TB patients tested for HIV
						Annualized NSP CDR	Cure rate (85%)	
SADAR (DTC, HAJIPUR)	756	86.90	249	27.06	80	50	90	
BIDUPUR	591	84.40	179	25.50	61	50	85	
GORAUL	494	113.80	138	27.60	85	50	90	
JANDAHA	603	131.00	151	30.20	82	50	90	
MAHUA	889	104.00	206	25.70	80	50	85	
DISTRICT	3333	104.00	923	28.80	77.6	50	88	

Section B – List Priority areas for achieving the objectives planned:

S.No.	Priority areas	Activity planned under each priority area
1	NGOs	1. (a) Involvement of NGO's in ACSM Scheme (MAMTA)
		1. (b) Training of DOTS Providers
2	Community Workers	2. (a) Social Interaction / Mobilization
		2. (b) Community Volunteers & Patient provider meetings.
3	Private Practitioners	3. (a) Training & Involvement of Private Practitioner under various schemes.
		3. (b) Sensitization, Workshop.
4	IEC	4. (a) Wall painting, Hoardings, Publicity through Mass Media (Radio & TV)

Section C – Plan for Performance and Expenditure under each head:

Civil Works

Activity	*No. required as per the norms in the district*	*No. actually present in the district*	*No. planned for this year*	*Pl provide justification if an increase is planned (use separate sheet if required)*	*Estimated Expenditure on the activity*	*Quarter in which the planned activity expected to be completed*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
DTC	*1*	*1*	*1*	*Maintenance*	*4500.00*	
TU	*6*	*5*	*1*	*Up-gradation of 1 new TU as per population norms and maintenance of existing TUs*	41,500.00	
DMC	*32*	*16*	*8*	*Up-gradation of 8 new DMCs and maintenance of 16 existing DMCs*	*2,56,000.00*	
	1	*0*	*1*	*Up-gradation of DTC Drug Store for 2nd Line drugs*	*30,000.00*	
				Total	***3,32,000.00***	

Laboratory Materials

Activity	*Amount permissible as per the norms in the district*	*Amount actually spent in the last 4 quarters*	*Procurement planned during the current financial year (in Rupees)*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Purchase of Lab Materials	4.50	*1,08,306.00*	*1,60,000.00*	***3,60,000.00***	***According to the guidelines***

Honorarium

Activity	*Amount permissible as per the norms in the district*	*Amount actually spent in the last 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Honorarium for DOT providers (both tribal and non tribal districts)		*0*	*1,80,000.00*	37,00,000.00	
Honorarium for DOT					

providers of Cat IV patients				25,000.00	
				37,25,000.00	

Budget for next financial year for the district as per action plan detailed below-

Program Challenges to be tackled by ACSM during the Year 2010-11	**WHY** **ACSM Objective**	**For WHOM** **Target Audience**	**WHAT** **ACSM Activities**		**When** **Time Frame**				**By WHOM**	**Monitoring and Evaluation**		**Budget**
Based on existing TB indicators and analysis of communication challenges ***(Maximum 3 Challenges)***	Desired behavior or action (make **SMART:** specific, measurable, achievable, realistic & time bound objectives)		Activities	Media / Material Required	Q 1	Q 2	Q 3	Q 4	Key implementer and RNTCP officer responsible for supervision	Outputs; Evidence that the activities have been done	Outcomes: Evidence that it has been effective	Total expenditure for the activity during the financial year
Challenge 1. – Low Referral and Low Case detection												
Advocacy Activities												
Poor suspect referral and low case detection	To obtain support so as to increase referrals	Private Practitioners	Sensitisation Meeting	Dairy	X				DTO, STS	Purchase Vouchers	Increase in referrals from private sector	5000
				Table-top Material			X			Purchase Vouchers		1,500
Communication Activities												
Poor Suspect referral and Low case detection	To inform communities about DOTs and RNTCP services so as to increase self reported	Community	Community Meeting	Banner	X	X	X	X	STS / STLS	Signature in Meeting Register	Increase awareness about TB and RNTCP among public; increas	19,500
			Poster							Purchase Vouchers		10,000.00

	referrals		Pamphlet							Purchase Vouchers	e in self reported referral	25,000.00

Social Mobilization activities												
Poor Suspect referral and Low case detection	To inform communities about DOTs and RNTCP services so as to increase self reported referrals	Members of Dairy	Meeting		X	X	X	X	STS / STLS	Signature in Meeting Register	Increase awareness about TB and RNTCP	75,000.00
		MOTC & MOIC, STS, STLS etc.	World TB Day Celebration		X				DTC	Photographs		25,000.00
Challenge 2: Irregular Treatment												
Advocacy Activities												
Communication Activities												
Poor Compliance with DOT and follow-ups	To Motivate patients for regular treatment and timely follow-ups	Patients	Patient Provider Meetings	Nil	X	X	X	X	STS, STLS Cured Patients	Records of meeting Evidence of material	Reduction in default rate by 2 %, Decrease in 'Not Available' for end IP follow-ups, increase in proportion of Smear Positive cured.	9000.00
	To motivate Community DOT Providers so as to ensure	Community DOT Providers	Get Togethers Facilitation Certification	Nil Mementos Certificates					MOIC	Photographs Signature of felicitated CV Prototype of Certific		48,000.00 2,400.00 16,000.00

	regular treatment and follow-ups									ates		
Social Mobilization												
Challenge 3:-												
Advocacy activities												

Communication activities												
Social Mobilization Activities												
										TOTAL BUDGET		**2,36,400.00**

Equipment Maintenance:

Item	*No. actually present in the district*	*Amount actually spent in the last 4 quarters*	*Amount Proposed for Maintenance during current financial yr.*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Office Equipment *(Maintenance includes computer software and hardware upgrades, repairs of photocopier, fax, OHP etc)*	*01*	*3510.00*	*20,000.00*	*30,000.00*	
Binocular Microscopes (RNTCP)	*32*	*-*	*-*	*48,000.00*	*1500 x 32*
			Total	***78,000.00***	

Training:

Activity	*No. in the district*	*No. already trained in RNTCP*	*No. planned to be trained in RNTCP during each quarter of next FY (c)*				*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
			Q1	*Q2*	*Q3*	*Q4*			
	(a)	*(b)*					*(d)*	*(e)*	*(f)*

Training of MOs	*125*	*66*	*20*	*20*	*19*	*0*	*0*	*90000.00*	
Training of LTs of DMCs- *Govt + Non Govt*	41	*16*	*25*	*0*	*0*	*0*	*0*	*21000.00*	
Other trainings #									
DOTs Plus Training (STS / STLS / Para Medicals)	*100*	*0*	*0*	*0*	*0*	*100*	*0*	*65,000.00*	
								1,76,000.00	

 # Please specify

Vehicle Maintenance:

Type of Vehicle	*Number permissible as per the norms in the district*	*Number actually present*	*Amount spent on POL and Maintenance in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
Four Wheelers	*1*	*1*	*4156.00*	*25,000.00*	*1.25 lakhs*	
Two Wheelers	*6*	*5*	*0*	*20,000.00*	*1.50 lakhs*	*25,000 x 6*
				Total	***2,75,000.00***	

Vehicle Hiring:

Hiring of Four Wheeler	*Number permissible as per the norms in the district*	*Number actually present*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
For DTO	*1*	*0*	*0*	*0*	*0*	
For MO-TC	*0*	*0*	*0*	*0*	*0*	
				Total		

Miscellaneous:

*Activity**	*Amount permissible as per the norms in the district*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*

T.A.	*3.00 lakhs*			*50,000.00*	
D.A.				*50,000.00*	
Stationary				*50,000.00*	
Drug Placement			*21,245.00*		
Telephone bills				*15,000.00*	
MO-TC (TA/DA)				*20,000.00*	
DTO (TA/DA)				*40,000.00*	
Contractual				*50,000.00*	
			Total	***2,75,000.00***	

NGO/ PP Support: (New schemes w.e.f. 01-10-2008)

Activity	*No. of currently involved in RNTCP in the district*	*Additional enrolment planned for this year*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification / remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
ACSM Scheme: TB advocacy, communication, and social mobilization	*0*	*1*	*0*	*0*	*1,50,000.00*	
SC Scheme: Sputum Collection Centre/s	-					
Transport Scheme: Sputum Pick-Up and Transport Service	*0*	*2*	*0*	*0*	*48,000.00*	
DMC Scheme: Designated Microscopy Cum Treatment Centre (A & B)	*0*	*0*	*0*	*0*		
LT Scheme: Strengthening RNTCP diagnostic services	-					
Culture and DST Scheme: Providing Quality Assured Culture and Drug Susceptibility Testing Services	-					
Adherence scheme: Promoting treatment adherence	-					
Slum Scheme: Improving TB control in Urban Slums	-					
Tuberculosis Unit Model	-					

TB-HIV Scheme: Delivering TB-HIV interventions to high HIV Risk groups (HRGs)	-					
					Total	***1,98,000.00***	

** Please mention the main activities proposed to be met out through this head*

Contractual Services:

Activity	*No. required as per the norms in the district*	*No. actually present in the district*	*No. planned to be additionally hired during this year*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification / remarks*
	(a)	*(b)*	*(c)*		*(d)*	*(e)*	
Medical Officer-DTC	*Not to be filled*	*-*	*-*		*-*	*-*	
STS	*6*	*0*	*5*	*0*		*7,20,000.00*	
STLS	*6*	*0*	*5*	*0*		*7,20,000.00*	
TBHV/ Sr. DOTs Plus Supervisor	*1*	*0*	*1*	*0*		*1,80,000.00*	
DEO	*1*	*1*	*0*	*1,01,546.00*	*1,12,200.00*	*1,07,000.00*	
Accountant – part time	*1*	*0*	*1*	*0*		*36,000.00*	
Driver	*1*	*1*	*0*	*98,550.00*	*92,400.00*	*1,03,000.00*	
Contractual LT		*5*	*6*	*7,08,945.00*	*5,61,000.00*	*11,28,000.00*	
					Total -	***29,94,000.00***	

Printing:

Activity	*Amount permissible as per the norms in the district*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
*Printing**	*4,50,000.00*	*0*	*20,000.00*	***3,00,000.00***	

** Please specify items to be printed*

Procurement of Vehicles:

Equipment	*No. actually present in the district*	*No. planned for this year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
*4-wheeler ** *	*0*	*0*	*0*	
2-wheeler	*5*	*1*	***50,000.00***	

** Only if authorized in writing by the Central TB Division

Procurement of Equipment:

Equipment	*No. actually present in the district*	*No. planned for this year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
Office Equipment (computer, modem, scanner, printer, UPS etc)	*1 Computer, 1 Modem, 1 Printer, 1 UPS, 1 Photo Copier Machine*	*1 Scanner*	*4000.00*	
Any Other				

Budget for FY 2012-13

Sl. No.	Category of Expenditure	Budget estimate for the coming Fy 2012-13
1	Civil works	332000
2	Laboratory Materials	360000
3	Honararium	3725000
4	IEC/publicity	236400
5	Equipment maintenance	78000
6	Training	176000
7	Vehicle Maintenance	275000
8	Vehicle Hiring	0
9	NGO/PP Support	198000
10	Miscellaneous	275000
11	Contractual Services	2994000
12	Printing	300000
13	Research and studies	0
14	Medical Colleges	0
15	Procurement- Vehicles	50000
16	Procurement-Equipment	4000
	Total	**90,03,400.00**

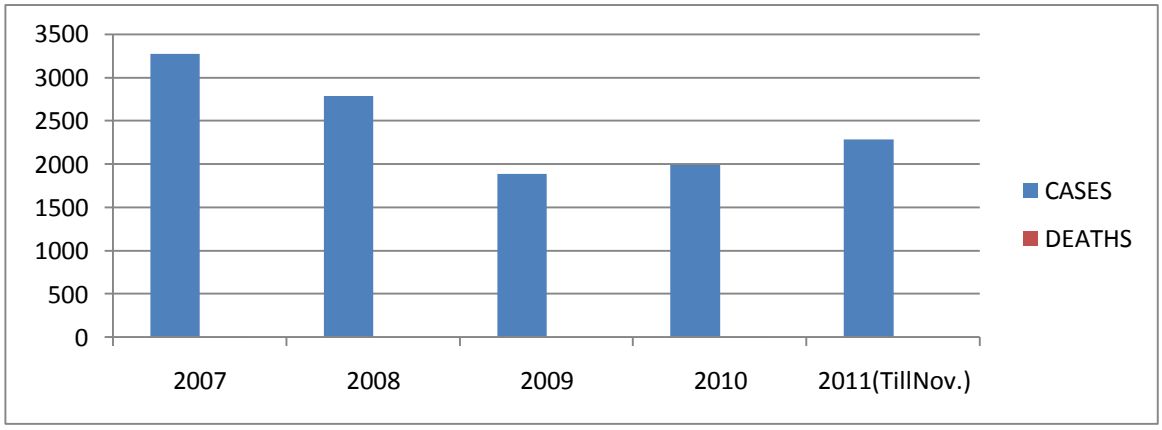
Kalazar

Visceral leishmaniasis or Kala-azar is a intracellular protozoal infection caused by*Leishmania donovan*i and transmitted by phlebotomine sandflies.Kala-azar is a major public health problem in the areas of its prevalence, principally India and its neighbors Bangladesh and Nepal, and Brazil and Sudan.In India the disease is found in Bihar, Jharkhand, West Bengal and pockets of eastern Uttar Pradesh. A national health programme to eliminate the disease by2015 is in operation in India. The programme relies on case management, vector control, community involvement in control activities and capacity building as the principal components of the elimination strategy.

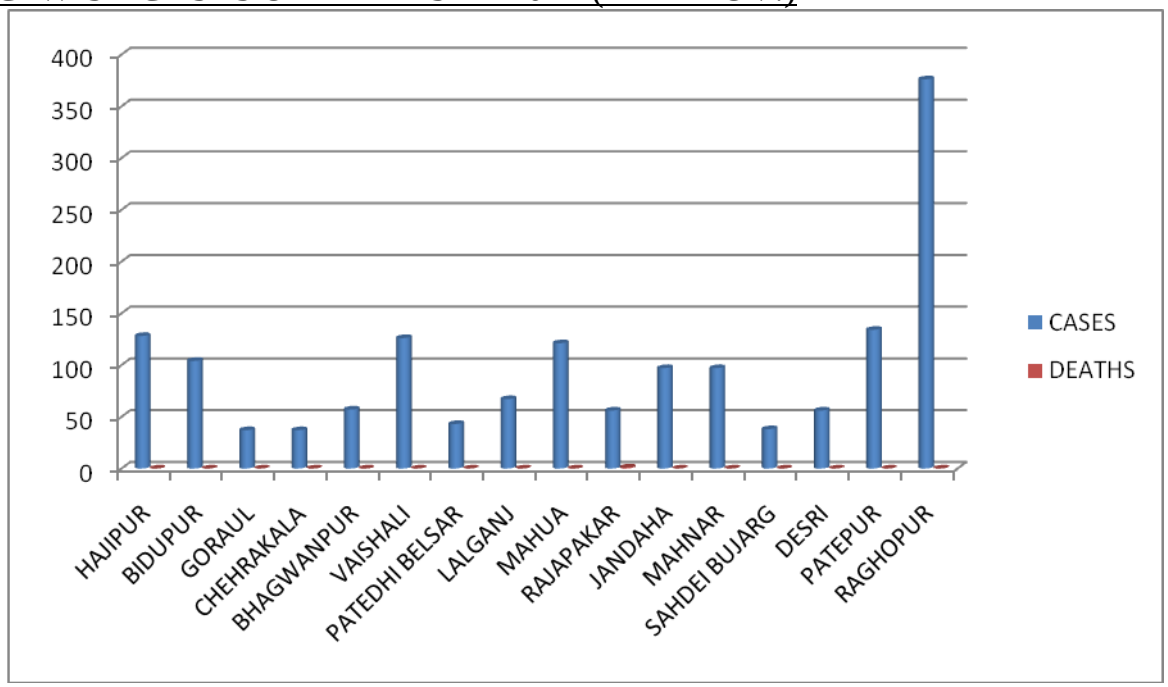
Kala-Azar is a serious public health problem mainly in North Bihar in few districts along Ganga river in the South Bihar. Bihar contributes to over 80-85% of National Kala-Azar burden. 31 Dist. Out of 38 dist. are endemic for Kala-Azar cases. 9 Districts out of 31 KA affected Dist. of Bihar contributes to 65-70% cases of Kala-Azar (These are Araria, Madhepura, Muzaffarpur, Purnia, E.Champaran, Saharsa, Vaishali, Darbhanga & Samastipur) 11 distrcts out of 31 KA affected districts of Bihar are medium endemic distrcts which reported 200 to 1600 KA cases.

NAME OF THE PHC	CASES 2007	DEATH 2007	CASES 2008	DEATH 2008	CASES 2009	DEATH 2009	CASES 2010	DEATH 2010	CASES 2011 (Till Nov)
Hajipur	139		206		129		133		128
Bidupur	129		126		85		82		104
Goraul	158	01	166	01	63		51		37
Cheharakala					17		44	1	37
Bhagwanpur			56		54		44		57
Vaishali	226		251		167	1	151	1	126
Patedhi belsar			48		28		34		43
Lalganj	250	03	184		96		62		67
Mahua	408		348		147		118		121
Rajapakar			51		51		73	01	56
Jandaha	246	1	204		99		105		97
Mahnar	173	0	120		98		91	1	97
Sahdei Bujurg	121		72		40		43		38
Desri			27		35		52		56
Patepur	237	1	385	01	151		97		139
Raghopur	386		385	01	302	1	368		384
Sadar hospital	707								
TOTAL	3275	06	2787	03	1883	04	1989	07	2283

YEAR WISE CASES WITH DEATHS FROM 2007



PHC WISE CASES & DEATHS IN 2011 (TILL NOV.)



SITUATION ANALYSIS

PREVENTIVE MEASURE

Sl. no	Gaps	Issues	Strategies	Activities
1	Poor coverage of DDT spray	Vector control through insecticides spray in the affected area	Proper monitoring & Supervision Capacity building of spray squad, Supervisor, & other staff involved in IRS Regular monitoring by officials of PHC & Districts levels	2 round of DDT spray 1st round in feb –mar 2nd round in may-June

2	Poor Quality of Spray i.e . patchy and non homogeneous	Defective stirrup pump Untrained spray team Lack of proper Maintenance	Timely repair of stirrup pump and replacement If pump is beyond repair. Proper Training to the spray Squad	Proper instruction to the spray squad regarding it maintenance i.e. daily washing of pump after spray Timely replacement of Nozzle if it not working properly Proper preparation of DDT Suspension
3	Lack of IEC/BCC before IRS	Very Less fund is provided by the state for pre IRS IEC/BCC	Meeting With PRI members ,VHSC MIKING , WALL PAINTING, COMMUNITY MOBILISATION , HOARDINGS & BANNERS' PUPPET SHOW,STREET PLAY, USE OF LOCAL CHANNEL	KTS and other PHC Staff along with MOI/C Should conduct meeting with respective PRI members and ASHA before Spray Active Participation Of VHSC in IRS MIKING must be done before IRS Respective ASHA should must inform her villagers two days earlier about spray Information can also be given by local channel on TV
4	Lack of supervision and monitoring by PHC staff	There is lack of supervision by PHC staff due to over burden of other programme at same time Supervision by ASHA &ANM is very less	Provision for Incentive base supervision if allowed and fund is given by state	Some incentive can be given to ASHA & ANM for daily supervision during spray after submission of daily report if permission and fund is provided by state

CURATIVE MEASURE

Sl. no	Gaps	Issues	Strategies	Activities
1	Poor case detection	Lack of infrastructure at PHCs level and DMO office Lack of sufficient fund & vehicles for organising screening camps Lack of manpower at PHCs & DMO office	Strengthening of PHCs and DMO office Screening camp. Recruitment of contractual staff Creation of new contractual post of lab technicians by concerned authorities.	Providing basic infra structure to DMO office & PHCs Organising more screening camp Recruitment against vacant post of KTS and FLA
2	Poor services to the community	Loss of wages Lack of Free to diet the patient and one of its attendant	Timely payment There should be provision for free diet to the patient and one of its attendant	Ensure the presence of fund in loss of wages head so that patient can be given there money quickly after treatment Free diet to the patient and one attendant if patient is given second line of treatment
3	Treatment compliance	Non or delay in payment of ASHA incentive	Timely payment	Timely payment of incentive encourages ASHA to work with full enthusiasm
4	IEC/BCC for services provided	Villagers are still not aware about the services being provided by the govt agency	Meeting With PRI members ,VHSC MIKING , WALL PAINTING, COMMUNITY MOBILISATION , HOARDINGS &	KTS and other PHC Staff along with MOI/C Should conduct meeting with respective PRI members and ASHA about facilities being provided by govt agency Active Participation Of VHSC MIKING must be done before camp mode ,screening camp Respective ASHA should

5	Capacity building	Lack of training/ Workshop for ASHA PRI Members MI Spray Workers BHI SI MO	BANNERS' PUPPET SHOW,STREET PLAY, USE OF LOCAL CHANNEL Ensure regular training/ Workshop for ASHA PRI Members MI Spray Workers BHI SI MO	must inform her villagers about treatment& other facilities Information can also be given by local channel on TV Conduct regular training/ Workshop for ASHA PRI Members MI Spray Workers BHI SI MO

Budget for preventive measures

A. IRS ACTIVITIES

2Round INTENSIVE SPRAY (60 days in each round)

Target population	3495249
Requirement of DDT	131.07*2=262MT
No. of PHC	16
No. of panchyat	292
No. of Squad	192
No. of supervisor	294
No. of MO	103
No. of Camp	48
DDT consumption	262MT

.Wages of SFW&FW

	Number	Wages	day	Total
1. SFW	192	145	120	3340800
2. FW	960	118	120	13593600

3. Office Expense for District@250/squad for 2round 192*250*2=96000
4. Transportation of DDT

District to PHC @2000/MT

262*2000=524000

PHC to Affected Village @1500/MT

262*1500=393000

5. Contingency @250/squad

250*192*2=96000

6. Repair of Equipments@ 150/squad 150*192*2=57600
7. Purchase of nosal tips@800/squad/round 800*2*192=307200

District mobility (2 round)

8. For C.S.@10000/month

10000*4=40000

9. For ACMO@10000/month

10000*4=40000

10. For DMO@20000/month
20000*4=80000

11. For MOI/C@650/day(120days)
650*16*120=1248000

12. For VBD consultants @20000/month 20000*4= 80000

13. D A for supervision @2000/PHC
2000*16*2=64000

14. IEC@2000/PHC
2000*16*2=64000

TOTAL Rs 20024200

B. Curative measures budget

1. Mobility for DMO & VBD consultant 20000*8=160000

2. Treatment card @Rs5/card(2card/case)

(Avg case=2000/year) card required 2000*2=4000
(Buffer 20% =400) ,, 400*2=800
total card 4000+800=4800
Fund required= 4800*5=240000

3. Register for PHC

Line listing, loss of wages. ASHA record, Drug record (4)
Fund required = 16*4*50
=3200

4. Hiring of warehouse at district level storage of DDT@5000/month 5000*12 =60000

5. KALAAZAR SEARCH PROGRAMME(CAMP MODE)/PHC for 8months

One day in a month in every PHC
Rs750 forcamp/PHC=
750*16*8=96000
Rs750/for banner/PHC 750*16=
12000
Rs500 for miking/PHC/camp
500*16*8=64000
Rs 250for refreshment/camp/PHC 250*16*8=32000
Rs1000 for camp box 1000*16
=16000

TOTAL Rs683200

C. CAPACITY BUILDING

1. Training of MO, PRI, ASHA, SPRAY WORKER , BHI, SI, BHW

Total MO =126 Batch =5(25 MO in each batch)
Fund required=
120000*5=600000

2. PRI members 8000(approx) Batch 160 (50members in each batch) Cost/batch@2000

2000*160=320000

3. Total ASHA 2669 Batch 54 (50ASHA in each batch) cost/batch@2000

2000*54=108000

4. Total spray squad 1152 Batch23 (50 in persons each batch) cost/batch@2000

2000*23=46 000

5. Total health supervisor 1 batch cost/batch Rs 30000
=30000

6. Total health worker (47) 2 batch cost/batch 30000 *2
=60000

Total Rs1164000

D. Others activities

1.ASHA INCENTIVE (Due since inception)

Avg case 2000

Buffer20%=400 Total case=2400

Fund required =

2400*200=480000

LOSS OF WAGES

Avg case 2000

Buffer20%=400 Total case=2400

Fund required=

2400*50*30=3600000

FOOD SUPPLEMENT FOR KA PATIENT AND ONE ATTENDENT @35/person

Avg case 2000

Buffer20%=400 Total case=2400

Fund required=

2400*30*2*30=5040000

TOTAL

Rs9120000

E. STORAGE OF DRUGS

AMPHOTERACIN-B at district level @500/month

500*12=6000

TOTAL Rs 6000

Grand Total -24397400

Malaria control programme

Vaishali district is not malaria endemic zone. But still under national malaria programme blood smears are routinely collected and examined.

MALARIA DATA- 2011(TILL NOV.)

Name of PHC	B.S.COLL.	B.S.EXAMINED	POSITIVE CASE PV& PF	MASS THERAPY	R.T.GIVEN	DEATH
BHAGWANPUR					0	0
BIDUPUR	52	52	0	156	00	0
CHEHRAKALA						0
DESRI	18	18	0		0	00
GORAUL					00	0
HAJIPUR	12	12	0	48	0	0
JANDAHA	72	72	0	297		
LALGANJ					0	0
MAHNAR					0	00
MAHUA					00	
PATEDHI BELSAR					0	0
PATEPUR	4	4	0	28		0
RAGHOPUR	5	5	0	20	0	0
RAJAPAKAR					00	00
SAHDEI BUJURG	179	179	0			0
VAISHALI					0	0
TOTAL	342	342	0	549	0	0

However Vaishali district is not a malaria endemic zone, but the re occurrence may be happen and to prevent any outbreak of the disease we must be always ready. So to ensure the prevention measure herewith the action plan.

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S. No.	Gaps	Issue	Strategy	Activities
1	Poor quality of Management of Malaria Cases	Persistence of Malaria in the region	1.Early Case Detection & treatment	1. Provide facility at the APHC level for Thick & thin smear test for Malaria Parasite, Rapid diagnostic test
				2. Ensure functionality of FTDs & DDCs at 1000 population with support of ASHA
				3.Regular supply of malaria drugs in the district
				4. Use of prophylactic measures in suspected cases
			2.Strengthening of Referral system	1. Ambulance facility at the APHC level for referring the Falciparum cases
				2.Training & sensitisation of Professionals at subcentre, APHC, PHC , DH
				3. Strengthening of case detection & ensuring fortnightly visits to all villages
			3. Epidemic Preparedness & Rapid response	1. Early response to the incidence of malaria cases in the district
				3. Earliest reponse to the area having increase in malaria by double in last two years
2			1.Indoor residual insecticide spray in rural areas	1. Ensuring availability of sprayers, fogging machines and buckets in adequate number.
				2. Ensuring regular supply of DDT and insecticides
			2. Training of the spraying squad	1. Regular training of the spraying team for dissolving DDT, filling , carrying and spraying process
				2. Supervision by the supervisors to get the feedback of training
				3. Follow up survey: First surveyafter 21 days of control and

S. No.	**Gaps**	**Issue**	**Strategy**	**Activities**
1	Poor quality of Management of Malaria Cases	Persistence of Malaria in the region	1.Early Case Detection & treatment	1. Provide facility at the APHC level for Thick & thin smear test for Malaria Parasite, Rapid diagnostic test
				2. Ensure functionality of FTDs & DDCs at 1000 population with support of ASHA
				3.Regular supply of malaria drugs in the district
				4. Use of prophylactic measures in suspected cases
			2.Strengthening of Referral system	1. Ambulance facility at the APHC level for referring the Falciparum cases
				2.Training & sensitisation of Professionals at subcentre, APHC, PHC , DH
				3. Strengthening of case detection & ensuring fortnightly visits to all villages
			3. Epidemic Preparedness & Rapid response	1. Early response to the incidence of malaria cases in the district
				3. Earliest reponse to the area having increase in malaria by double in last two years
2	Poor vector control mechanism	1.Integrated Vector Control	1.Indoor residual insecticide spray in rural areas	1. Ensuring availability of sprayers, fogging machines and buckets in adequate number.
			2. Training of the spraying squad	2. Ensuring regular supply of DDT and insecticides
				1. Regular training of the spraying team for dissolving DDT, filling , carrying and spraying process
				2. Supervision by the supervisors to get the feedback of training
				3. Follow up survey: First surveyafter 21 days of control and second survey after 22 days of first survey
			2. Use of Insecticide treated bednets	1. Space spray for 7-10 days , residual insecticidal spraying to be started simultaneously as per district micro plans
				2.Supply of Insecticide treated bednets to suspected patients free of cost
			3. Anti larval measures	1. Promotion of use of larvivorous fishes like gambusia in the natural water tank

The budget needed for malaria
For malaria month/PHC

Moblity	10,000
IEC/BCC materials	2000
Cotton ,slides etc	1000
TOTAL	13000

FUND REQUIRED 13000*16= Rs208000

Office expense	50000

GRAND TOTAL= Rs 258000

Filaria

Gaps	Issues	Strategy	Activities		
It affects mainly the economically weaker sections of communities		1. Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.	Line listing of the cases		
			Purchase of equipments for the management of Filaria cases like towel, Bucket, soap, mug etc		
			DEC distribution through AWCs and paying hon to AWWs for this.		
			Purchse of DEC		
			Training to AWWs/ASHA on DEC distribution and filaria case management		
Result in low priority being accorded by governments for the control of lymphatic filariasis.		2. Continuous use of vector control measures.	Meeting with VHSC members		
Low effectiveness of the tools used by the control programme			Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.		
The chronic nature of the disease		4. IEC for ensuring community awareness and participation in vector control as well as personal protection measures.	Wall paintings		

Due to lack of laboratory technician and other basics facilities at APHC/PHC continue to pose a challenge for an effective filarial control programme in the district. The exact burden of the disease is not known as many cases are treated outside and not reported.
The budget for mass drug administration (MDA) is hereunder.

BUDGET FOR MDA

NAME OF DISTRICT	VAISHALI
POPULATION	3495249
NO. OF PHC	16
DISTRICT HQ	1
NO.OF DRUG DISTRIBUTOR	3410*3

NO. OF SUPERVISOR	341*3
TRAINING OF DRUG DISTRIBUTOR	313720
TRAINING OF SUPERVISOR	31372
HONORARIUM OF DRUG DISTRUBUTOR	941160
HONORARIUM OF DRUG SUPERVISOR	115599
MEETING OF DISTRCT COORDINATION COMMITTEE	20000
IEC/BCC	145000
TRAINING OF MO	80000
TRAINING OF PARAMEDICAL STAFF	95000
LINELISTING	75000
NIGHT BLOOD SURVEY	95000
POL	90000
MISCELLINIOUS	110000
TOTAL	**Rs2111851**

HUMAN RESOURCES

Permanent staff

DISTRICT-VAISHALI				
STAFF POSITION				
SL.NO	NAME OF THE POST	SANCTIONED POST	POSTED	VACANT
1	District malaria officer	1	1	0
2	Assistant DMO	-	-	-
3	Entomologist	-	-	-
4	Assistant Entomologist	-	-	-
5	Office superintendent cum accountant	-	-	-
6	Clerk	2	2	0
7	Steno typist	-	-	-
8	Malaria inspector	5	5 one of MI is deputed at CMO office patna	0
9	Lab technician	11	1	10

10	Basic health inspector	11	4	7
11	Basic health worker	45	4	41
12	Surveillance inspector	-	-	-
13	Surveillance worker	-	-	-
14	Motor mechanic	1	0	1
15	Motor driver	2	1 retirement in jan2012	1
16	Insect collector	-	-	-
17	Superior field worker	2	1	1
18	Field worker	4	4 One of FW is deputed at CMO office patna	0
19	Office attendant	2	2	0
20	Motor cleaner	2	2	0
21	sweeper	1	1	0

Contractual staff

Sl.no	Name of the post	sanctioned	posted	Vacant
1	VBD consultant	1	1	0
2	KTS	6	4	2
3	Data entry operator	1	1deputed in DHS	0
4	Financial and logistics assistant	1	0	0

Salary for contractual staffs

Sl.no	Post name	unit	Unit cost	Month	Amount
1	VBD consultant	1	33000	12	396000
2	KTS	6	11000	12	792000
3	Finance & logistics assitant	1	8000	12	96000
4	Data entry operetor	1	7150	12	85800
	Total				1369800

District Health Society, Vaishali			
Summary of the Budget			Committed Expenses
1	Part-A	379384581	94271222
2	Part-B	421922125	11500234
3	Part-C		
	Routine Immunization	8060000	
	Pulse Polio	22611532	
4	Part-D	934000	
5	Part-E	1086000	
6	Part-F (NVBDCP)		
	Blindness	4202762	
	Leprosy	826700	
	TB	9003400	
	Kalazar	27397400	
	Malaria	258000	
	Filaria	3481651	
	Grand Total	879168151	105771456

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