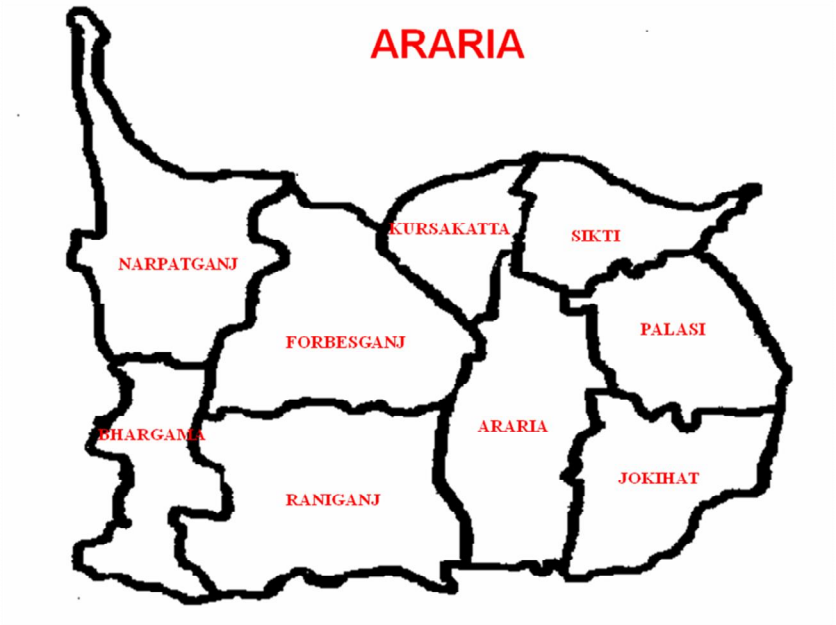
District Health Action Plan

2009-2010



Epid No.035

District Health Society
ARARIA

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Foreword

District Health Action Plan have assumed a new centrality and urgency in the Current Context of the National Rural Health Mission. The rationale for having District Health Action Plans comes from the concept of addressing local needs and local specificities of health and Nutrition in a district. Districts vary widely in their specific population needs and even more in innovations for intervention.

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 situation 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 public/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 programmes and we look forward to a rigorous and analytic documentation of their experiences so that we can learn from them and replicate successful strategies. I also appreciate their decision to invite consultants (NHSRC/ PHRN) to facilitate our District Programme Management Unit(DPMU) regarding preparation the DHAP. The proposed location of HSCs,APHCs, PHCs and its service area reorganized with the consent of ANM, AWW, male health worker and participation of community has finalized in the block level meeting.

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

Dr. A. K. Verma, IAS
(DM, Araria)

About the Profile

Health in now being given due attention by the State with the upgradation of Health infrastracture, manpower, outsource facilities, availibility of free medicines and through a mechanism of web-based monitoring, better health out comes realised in the District. By focusing on the outcomes and the associated key processes for the achievement of these outcomes. Under the National Rural Health Mission this District Health Action Plan of Araria district has been prepared. From this, situational analysis the study proceeds to make recommendations towards a policy on workforce management, with emphasis on organizational, motivational and capability building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps identified and addressed. It looks at how the facilities at different levels can be structured and reorganized.

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

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

Dr. Gavendra Kumar Singh
(Civil Surgeon)
Araria

Chapter-1

Introduction

1.1 Background

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

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

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

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

For effective programme implementation NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the need for situation analysis, stakeholder involvement in action planning, community mobilization, inter-sectoral convergence, partnership with Non Government Organizations (NGOs) and private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving program functionaries and community representatives at district level.

Stakeholders in Process

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

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

1.2 Objectives of the Process

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

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

1.3 Process of Plan Development

1.3.1 Preliminary Phase

The preliminary stage of the planning comprised of review of available literature and reports. Following this the research strategies, techniques and design of assessment tools were

finalized. As a preparatory exercise for the formulation of DHAP secondary Health data were complied to perform a situational analysis.

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

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

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

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

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

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

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

Government of India has launched National Rural Health Mission, which aims to integrate all the rural health services and to develop a sector based approach with effective intersectoral as well as intrasectoral coordination. To translate this into reality, concrete planning in terms of improving the service situation is envisaged as well as developing adequate capacities to provide those services. This includes health infrastructure, facilities, equipments and adequately skilled and placed manpower. District has been identified as the basic coordination unit for planning and administration, where it has been conceived that an effective coordination is envisaged to be possible.

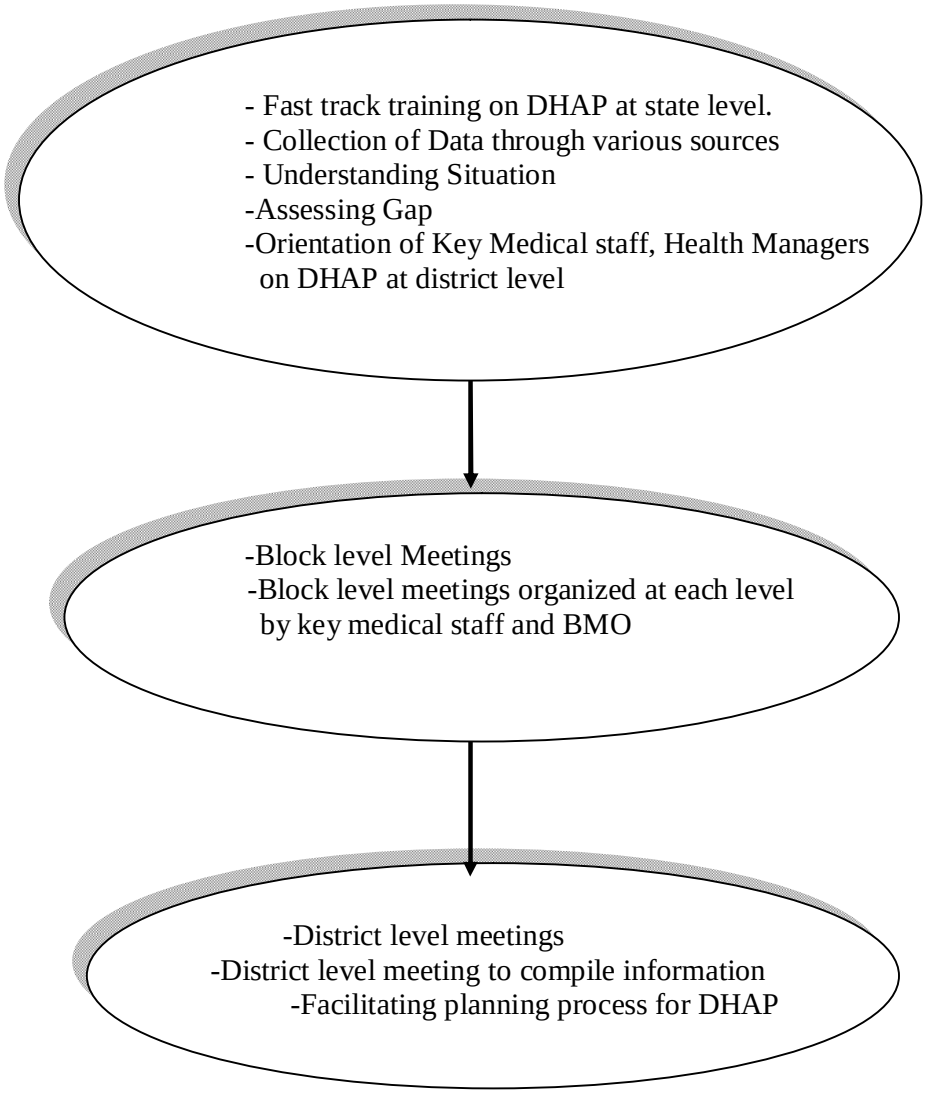
This Integrated Health Action Plan document of Araria district has been prepared on the said context.

1.3.3 Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon,District Health Society Consultants, ACMO (Nodal officer for DHAP formulation), all programme officers and NHSRC/PHRN as well as the MOICs, Block Health Managers, ANMs, as a result of a participatory processes as detailed below. After completion the DHAP, a meeting is organized by Civil Surgeon with all MOIC of the block and all programme officer. Then discussed and displayed prepared DHAP. If any comment has came from participants it has added then finalized. The field staffs of the department too have played a significant role. District Programme Manager, District Accounts Manager, District Data Assitant & Data Entry Operator have provided technical assistance in estimation and drafting of various components of this plan.

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

District Health Action Plan Planning Process



Chapter 2

District Profile

History

Araria District came into existence on the Makar-Sankranti day of 1990 after the bifurcation of the erstwhile Purnea district into three districts, Purnea itself, Araria and Kishanganj.

Araria has a very prestigious past though shrounded in midst of uncertainties. Some passages in the Mahabharata (Sabha Parva and Vana Parva) describing the conquest of Bhima in the eastern India furnish valuable information regarding the antiquity of the district.

In ancient times ruled by three important clans of Indian history Araria may be termed as a place of confluence of three entirely different cultures. The important tribe of Kiratas governed the northern side , while the eastern side was under the Pundras and area west of the river Kosi, at that time flowing some where near the present Araria, by Angas.

Angas are believed to be the earliest inhabitants of the district, mostly in the area west of the river Kosi and these are among the easternmost tribes as described in the Atharva-Samhita known to the Aryans. Pundras are said to be the descendents of Saint Vishwamitra. Whereas the Kiratas were among the few most important ruling clans of that time. It is said that Raja Virata of Mahabharata had married a Kiranti woman who was the sister of Raja Kichaka , King of Kiratas.

Manu regards the Kiratas as Kshatriyas. Mahadeva was associated with Kiratas and Bhima meets the Kiratas in the east of Mithila, i.e. the present Araria district. He is credited with having defeated seven of the Kirata rulers. Kiratas are described in the Kirata-Parva and Vana-Parva of Mahabharata and they were considered so powerful that even the Lord Shiva is said to have taken the form of a Kirata.

During the Mauryan period this area formed the part of the Mauryan Empire and according to Asokavadana the Emperor Asoka put to death many naked heretics of this area who had done despite to the Budhist religion. In later times the district formed the part of the empire of Imperial Guptas.

In the sixth century A.D. the area south of the Himalayan pilgrim center of Varaha Kshetra, namely the Gupta kings Budhgupta and Devagupta gave Koti-varsha for the

maintenance of the said pilgrim centre. Present district of Araria seems to be part of the Koti-varsa.

A brief account of this area and its people has been left by Huen-tsang, the famous Chinese traveler , who visited about 640 A.D. As he saw it had a flourishing population and was studded

with tanks , hospices and flowering groves. The land was low and humid with abundant crops and genial climate.

According to the Ancient History of India by S. Beal the area west of the river Mahananda, i.e., the present Araria district was held by the Vrijis, a confederacy of tribes, who had come in from Nepal many centuries before.

At the beginning of 7th century the tract now included in the district seems to have been under Sasanka , the powerful king of Gauda. He was worshipper of Lord Shiva and hated Buddhism. He destroyed the Budhist convents and scattered the monks carrying his persecutions towards the Nepalese hills.

Harsha, the great Budhist ruler of 7th century defeated Sasanka. But after the death of Harsha it seems likely that Araria became a part of Magadhan Empire under Aditya sena. From the 9th to 12th century it was under the Pala kings and on their decline became subject to the Senas of Bengal.

At the end of 12th century the Muslims under Bakhtiyar Khilji burst down upon Bengal shaking Bihar. Bakhtiar removed the seat of government to Lakhnauti (Gaur) and from this centre Ghiasuddin Iwaz (1211-26) extended the area of Muslim control over the whole country called Gaur as well as Bihar and his rule was acknowledged by the surrounding tracts including Tirhut.

But it seems due to an impenetrable network of rivers interspersed with large patches of jungle, the area of Muslim control could not extend to the northern portion of the erstwhile Purnea district, i.e., the present Araria district. Hence the present Araria district seems still to have been held by the hill tribes of Nepal.

It was not less than the 18th century that it could be gained from the northern tribes. In the year 1738, the military governor of Purnea Nawab Saif Khan, son of an Afgan Amir, recovered the area north of the Jalalgarh fort up to Jogbani (i.e., the present Araria district) from the Rajput kings of Morung. Saif Khan appointed one Raja Nandlal as the administrator of the newly annexed area, who is credited to have built the temple of Lord Shiva at Madanpur.

Saif Khan after forcing the hill tribes back to the terai, cleared the jungles and brought the area under cultivation. He also defeated the Birnagar chief and subjugated his territory. Birnagar included the area west of river Kosi, presently the entire area under Raniganj and Bhargama blocks and some portion of Narpatganj.

In the year 1765 though the area came under the Dewani of East India Company, it was continued to be ruled by the Nawabs of Purnea till 1770. In the same year a British Supervisor, later to be known as District Magistrate and Collector Mr. G.G.Ducarrel was

posted and since then it has the same history as Purnea. But some special events related to the history of this area are worth mentioning.

When in 1738 Saif Khan annexed this area, i.e., the present Araria district, he gave it to the family of Purnea Raja, an old ruling family of this district. This family had its headquarters at Pahsara near Raniganj. They belonged to the Surgan Lauam family of Shrotriya Brahmins of Mithila. Maharaja Samar Singh was the founder of the family during the regime of Shah Jahan, the Mogul king of India. After Samar Singh his son Krishnadev became the ruler, followed by Vishwanath, Veernarayan, Narnarayan, Ramchandranarayan, and Indranarayan all having the title of Maharaja. Indra died in 1784. After his death his wife Maharani Indrawati became the ruler. She ruled till her death in 1803. The contemporary British writers have described her as one of the most able rulers. The area under her administration included the purganas of Sultanpur, Sripur, Nathpur, Gorari, Katihar, Gondwara, Tira Khardah, Asja and others.

Indrawati had built a beautiful palace at Pahsara, which now stands in ruins and a number of temples. One of these temples devoted to Lord Shiva is still present in the Basaiti village of Raniganj block.

In the year 1751 Maharaja Ramchandra of the same family gave the purganas of Tira Khardah (present Kursakata and Sikti blocks) and Asja (present Amour block of Purnea) to one Devanand, who distributed the two purganas between his two sons Parmanand alias Hajari getting Tira Khardah and Maniknanadan getting Asja. The present ex zemindars of Champanagar, Garhbanaili, Sultanganj and Srinagar (all part of the old Banaili Raj) are the descendents of Parmanand .

Maharani Indrawati died without child. After the death the succession of the family became disputed. Indrawati had adopted Bhaiyajee Jha, son of her maternal uncle, as her successor. But the descendents of Maharaja Samar's second son Raja Bhagirath of Sauriya branch put their claim over the large estate of Maharani and a quarrel issued.

In the year 1815 Raja Bhaiyajee Jha died having one son named Vijaygovinda, who became the Raja. Vijaygovinda had two sons Kumar Vijay Gopal Singh and Kumar Bhav Gopal Singh . But both died without a son. The quarrel of the succession ruined the large estate of Indrawati and in 1820 the estate was purchased by Babu Pratap Singh, banker of Murshidabad and Babu Nakchhed Lal grandfather of Raja P.C.Lal of Purnea City. Pratap Singh purchased entire Sultanpur and Sripur parganas. His descendents sold the pargana of Sultanpur to Alexander John Forbes.

A. J. Forbes was a military adventurer and had taken part in the adventures of Northwest India . He was also in the team of Commissioner Yule of Bhagalpur while fighting the rebels of 73rd native infantory.A. J. Forbes founded the Sultanpur estate and a number of indigo factories situated at different places in this district. The sub divisional town of Forbesganj is named after him. Due to its proximity with the international boundary of Nepal the problems from across the borders always have been a special concern for the administrators of this district. In the time of British rule the Nepalese sardars used to the subjects of this area.125

In 1770, Ducarrel the Supervisor or Collector at Purnea reported that Budhkaran who had been the Dewan of the deceased Raja Kamdat Singh of Morung was plundering the Company's frontiers and putting the subjects to flight. Ducarrel's suggestion was to extend the influence by rendering military assistance to Regonault who was opposing Budhkaran.

Depredations of the religious mendicants (Fakirs) was also one of the troubles from the north and above all it were the Dacoits who after committing crimes in this area took refuge in Morung. All these compelled the district administration to have a serious thought in regard of the problems from the north. Again in the year 1788 the collector of Purnea wrote to the board of revenue that the conquest of Morung by the Gorkhas in defiance of Mr. Hasting's order, the assassination of the young Raja and their repeated ravages on our frontier, that nothing but a decisive step will be sufficient to restrain them within their bounds. According to O'Malley the aggression of the Nepalese continued during the next century. In 1808 the Gorkha Governor of Morung seized the whole zamindari of Bheemnagar. This flagrant encroachment could not be over looked and in June 1809 a detachment of troops was sent from Purnea to the frontiers. Climax to all these happening was the Indo Nepalese war of 1811 – 12 and after this war the present boundary between Araria (India) and Nepal was determined.

In the first war of independence of 1857 Araria also witnessed a few skirmishes between the mutineers and the commissioner Yule's forces, which took place near Nathpur. In view of the 1857 episode and other developments regarding the law & order, in the year 1864 Araria was constituted as Sub-Division by merging the small divisions of Araria, Matiari, Dimia, parts of Haveli and Bahadurganj to provide better administration and ultimately it became a district in 1990.

Geographical Location

Araria District is located at 26°9' to 26°15' North latitude and 87°31' to 87°52' east longitude with attitude 47cm from sea level. The District is surrounded by Purnea District in south, Supaul & Madhepura District in west, Kishanganj is in east and International boarder with Nepal in North. The District is in semi tropical Gangetic plane. The District is spread over 2830 sq km area.

Govt's Administrative Set-up

There are two sub division and 09 Blocks in the District. The District has 1638 revenue villages and 291 Gram panchayats. Traditionally the District is divided into 09 C.D. Blocks but Administratively more Blocks creation are required. The newly elected Panchayati Raj is enthusiastic to play important role in the District.

District Health Administrative Setup

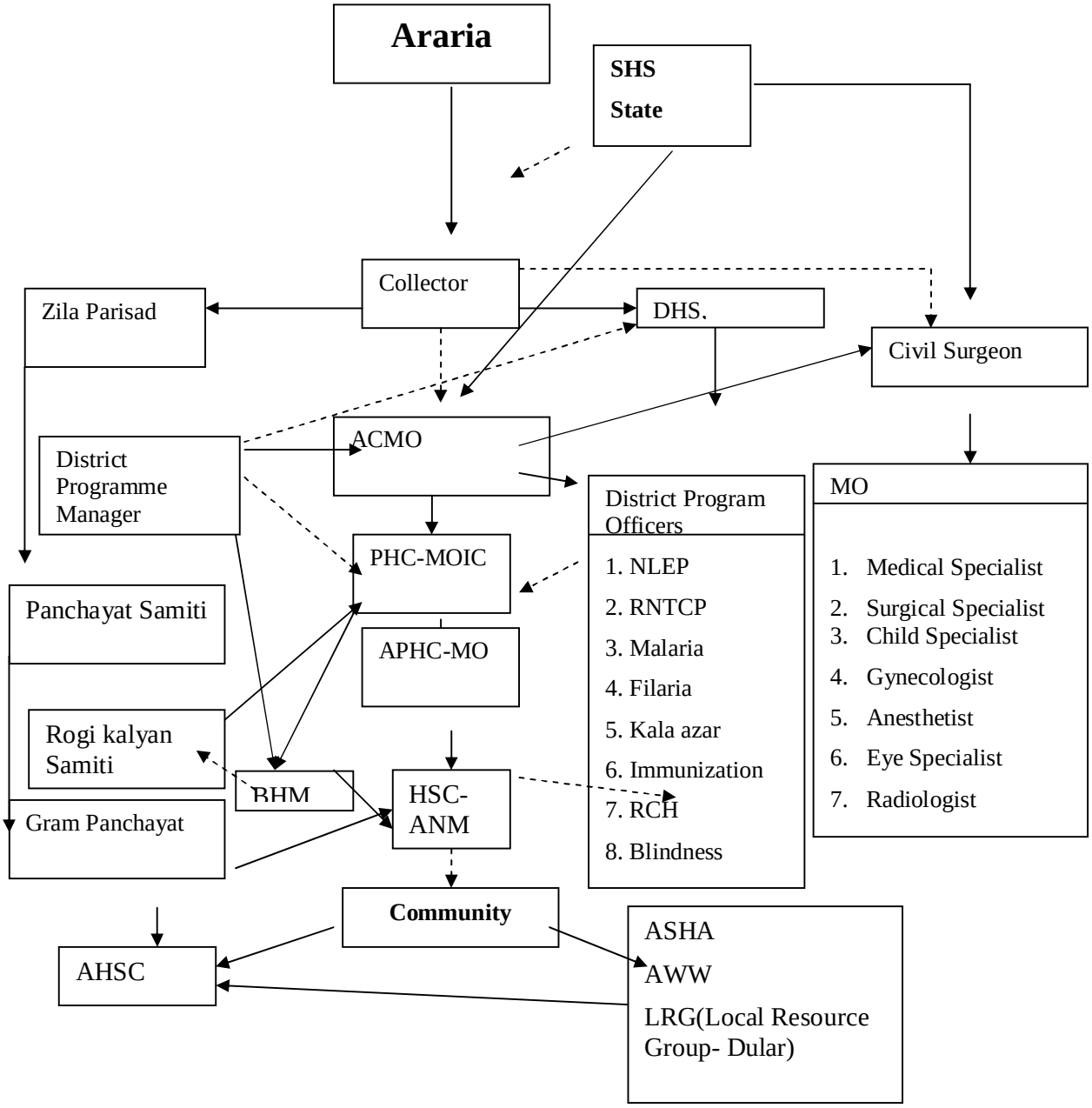


Table. ADMINISTRATIVE UNITS AND TOWNS IN ARARIA DISTRICT

PHC	Community Development Blocks	Towns	Assembly Segments
Araria (Sadar)	Araria (Sadar) (Sub-division)	Araria	Araria
Forbesganj (RH)	Forbesganj (Sub-division)	Forbesganj, Jogbani	Forbesganj
Raniganj (RH)	Raniganj	–	Raniganj
Jokihat (RH)	Jokihat	–	Jokihat
Narpatganj	Narpatganj	–	Narpatganj
Sikti	Sikti	–	Sikti
Palasi	Palasi	–	Sikti
Kursakanta	Kursakanta	–	Sikti
Bhargama	Bhargama	–	Raniganj + Narpatganj

***Lok Sabha (Parliamentary) – .* ARARIA**

ARARIA – AT A GLANCE

AREA (Sq. Kms):- 2830
POPULATION(CENSUS 2001)
TOTAL:- 21,58,608
MALES :- 11,28,105
FEMALES :- 10,30,503
RURAL POPULATION
TOTAL:- 20,26,257
MALES :- 10,57,202
FEMALES :- 9,69,055
URBAN POPULATION
TOTAL:- 1,32,351
MALES :- 70,903
FEMALES :- 61,448
POPULATION OF SCHEDULED CASTES :- 2,93,488
POPULATION OF SCHEDULED TRIBES :- 29,423
DENSITY OF POPULATION :- 751 per km.^{2}
SEX RATIO :- 916

COMPARATIVE POPULATION DATA(2001 Census)

Basic Data	India	Bihar	Araria

Population	1027015	82878796	2158608
Density	324	880	751
Socio- Economic			
Sex- Ratio	933	921	916
Literacy % Total	65.38	47.53	34.94
Male	75.85	60.32	46.50
Female	54.16	33.57	22.14

LITERACY RATE
TOTAL:- 34.94%
MALES :- 46.50%
FEMALES :- 22.14%
VILLAGES
TOTAL:- 742
INHABITED:- N.A
UNINHABITED:- N.A
PANCHAYATS :- 218
SUB-DIVISION :- 02
BLOCKS :- 09
REVENUE CIRCLES :- 09
HALKAS :- 82
POLICE STATIONS :- 18
POLICE OUTPOSTS :- 06
TOWNS :- 03
NAGAR PARISHAD(Araria, Forbesganj) :- 02
NAGAR PANCHAYAT(Jogbani). :- 01
M.P CONSTITUENCY :- 01 (1 Part)
M.L.A. CONSTITUENCY :- 06 (Part)
HEALTH
DISTRICT/SUB-DIVISIONAL HOSPITAL :- 01

REFERRAL HOSPITAL :- 03
PRIMARY HEALTH CENTRE :- 09
ADDITIONAL PRIMARY HEALTH CENTRE :- 32
HEALTH SUB CENTRE :- 199
GRAMIN AUSADHALAY :- 06
BLOOD BANK :- NIL (Blood storage centre functioning)
AIDS CONTROL SOCIETY :- 01
TRAINED NURSES :- 401
TRAINED DOCTORS :- 62 + 23 (Contractual)

2.1 SOCIO-ECONOMIC PROFILE

Social

- Araria district has a strong hold of tradition with a high value placed on joint family, kinship,religion, caste and community.
- The villages of Araria have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.
- 13.59 % of the population belongs to SC and 1.36 % 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 Araria is Agriculture, Fisheries and Daily wage labour.
- Most of the youth population migrates in search of jobs to the metropolitan cities like Delhi, Punjab, Hariyana etc.
- The main crops are Wheat, Paddy, Pulses, Oilseeds, Mango.
- Jute and Wheat are the major cash crops of the community residing in rural areas.

Demographic scenario of Araria district.

According to Census of India 2001:

- The size of population of Araria district is above 21,58,608, comprising 2.60 % population of Bihar state in 2.629 % proportion of state's area.
- Very high density of population (751) which is still rising
- Decadal population growth rate of 31.8 % as against 28.43 % of the state as a whole. Thus the decadal growth rate of the district is more than that of the state.
- Sex ratio of the population is 916 females per thousand males which is lower than that of the state. It is difficult to interpret the deficit of 84 females per thousand males in the district despite outward migration, predominantly of males in the working ages. A

plausible explanation seems to be that over the years male population has benefited more from the epidemiological transition than the female population.

- Only 6.1 % of the population resides in the urban area, and the rest lives in the rural areas.

Based on these statistics one can say that Araria district lacks urbanization and industrialization. As elsewhere in Bihar, Araria 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 2008 the flood condition was so bad that almost 71 gram panchayats and 124 villages got marooned. Narpatganj and Bhargama blocks were the worst affected blocks. According to the estimates of National Disaster Management Department, **in the year 2008, 6,26,062 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 some of the area is water logged.

The district is spread over 2830 sq km area, with minor percentage forest cover. 65.43 % of the land is agricultural and nearly 67 % of the area under cultivation is irrigated. Araria 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.

2.2HEALTH PROFILE

General Status of health in Araria district

In a study of 513 districts of the country (Jansankhya Sthirata Kosh", www.jsk.gov.in) in terms of overall rank in health it was found that Araria district ranks 549 though on the basis of under-five mortality it ranked 507 Filaria, Malaria, Dengue, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in Araria district. Hepatitis, Diarrhea, Typhoid, Blindness and Leprosy are other high prevalence diseases. Kala-azar is an endemic problem in Bihar. As per DLHS 2002-2004 the prevalence percentage of kala-azar is 11.4 % and TB is 4.3 %. The overall prevalence of tuberculosis in India is ..... per 100,000 populations while in Araria it is reported to be close to 618 per 100,000 (RCH, Round 2).

Table-: Infant Mortality Rate (IMR) and Child Mortality Rate (CMR)

Indicators	Rural			Urban			Total			
	M	F	T	M	F	T	M	F	T	
Infant Mortality Rate	-	-	-	-	-	-	-		71	Araria
	56	60	58	41	42	42	55	58	57	Bihar
										India

Child Mortality Rate	-	-	-	-	-	-	-	-	-	**Araria**
	59	**69**	**64**	**42**	**46**	**44**	**57**	**66**	**62**	**Bihar India**

Source: Population Foundation of India May 2008

The table gives the estimates of infant mortality rates and child mortality rates of Araria and compared with the data of Bihar. **IMR in rural areas are higher than the urban areas**. **Also CMR in rural areas is higher than in urban areas .** The differential ratio of infant mortality rate of male/female is 0.7 and rural/urban is 1.4. The differential ratio of child mortality rate of male/female is 0.8 and rural/urban is 1.5.

2.2.1 HEALTH STATUS AND BURDEN OF DISEASES

Table. CASE FATALITY RATE

S.No.		**2007**	**2008(Till Nov)**		
	Disease	**Case**	**Death**	**Case**	**Death**
1	Gastroenteritis	67	6	166	0
	Diarrhea / Dysentery	1515	5	882	2
	Cholera	0	0	0	0
	Meningitis	0	0	0	0
	Jaundice	0	0	0	0
	Tetanus	0	0	0	0
	Kala-azar	3275	6	2632	3
	Malaria	0	0	0	0
9	Measles	0	0	0	0
10	A.R.I.	NA	NA	NA	NA

Table . MORBIDITY DUE TO MAJOR DISEASE

Sl.No.	**Disease**	**2007**	**2008**
1	Kala-azar	3275	2632
2	T.B. (NSP)	724	643
3	Leprosy (PR/10000)	1.15	1.30

Table . BASIC HEALTH STATUS INDICATORS OF ARARIA DISTRICT

Indicators	**Araria**	**Bihar**
Couple Protection Rate (CPR)	33%	
Crude Death Rate (CDR)	8.1	8.1
Crude Birth Rate	31.9	30.4

Infant Mortality Rate	61	61
Maternal Mortality Rate	371	371
Total Fertility Rate (TFR)	4.6	4
Under 5 Mortality Rate	85	85
Still Birth Rate	2%	NA
Abortion rate	NA	NA

Table . DENOTING PRIORITY AREAS IN EACH OF THE BLOCK

Block	**Hard to Reach area**
Narpatganj	Whole Narpatganj block (72 villages)
Bhargama	Village Bahlolpur
Sikti	Two vilages

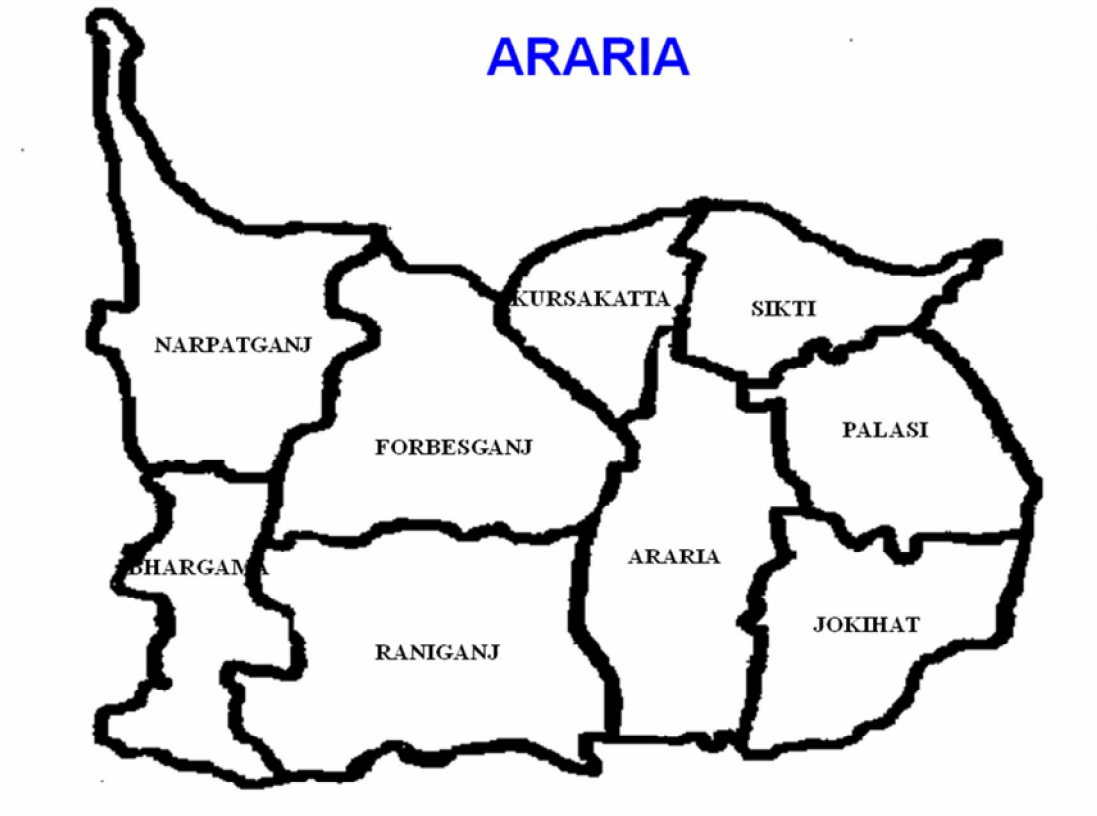
Note: During raining season i.e. From mid June to September almost 80 percent of the villages become hard to reach area.

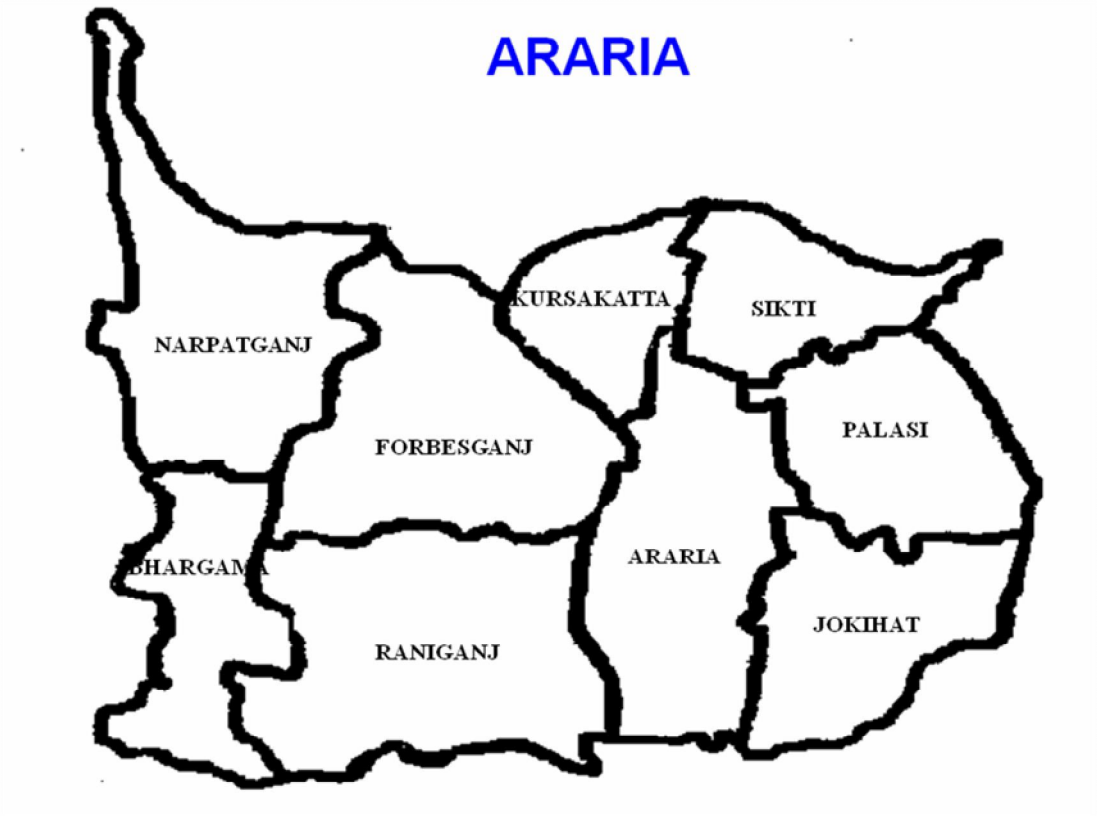
2.2.2PUBLIC HEALTH CARE DELIVERY SYSTEM: ORGANISATIONAL STRUCTURE AND INFRASTRUCTURETable HEALTH CARE INSTITUTIONS IN THE DISTRICT

S.No.	**Type of Institutions**	**Number**	**No. of Beds***
1	District Hospital	1	100 (under construction)
2	Sub.Divisional Hospital	1	32
3	Referal	3	90
4	Block PHCs	06	36
5	APHCs	32	0
6	Sub-centres	199	0
7	Ayurvedic Dispensaries	02	0
8	Anganwadi Centres	2125	-
9	Others (Pvt. Facility accredited)	NIL	NIL

Table . DISTRIBUTION OF PUBLIC HEALTH FACILITIES IN DISTRICT

District Hospital	Sub-Div. Hospital	Community Health Centres	Block PHC	Referral Hospital
1	01	0	06	03


ARARIA
NARPATGANJ
KURSAKATTA
SIKTI
PALASI
FORBESGANJ
ARARIA
JOKIHAT
RANIGANJ



2.4 Map showing PHC and APHC locations

Chapter-3
Situational Analysis

In the present situational analysis of the blocks of district Araria 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 District Health Society & Health Office, Araria and various websites as well as other sources. These indicators help in pointing to the health scenario in Araria 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 Araria district with respect to Bihar and India as a whole.

Table 3.1: Health Indicators

Indicator	Araria	**Bihar**	**India**
CBR#	36.2	30.4	23.8 (SRS 2005)
CDR#	8.80	8.1	7.6
IMR#	71	61	58 (SRS 2005)
MMR#	-	400	301

Internal MIS data

3.1 Availability of facilities and location of facilities

As per existing norms one HSC is planned for every 5000 population and for tribal areas the 3000 population, one APHC for every 30,000 population and for tribal area 20,000 population one PHC for every 1, 20,000 population.

The number of gap is in the number of sectors without HSCs, without APHC, we have major gap in PHC where in practice the norm followed is one PHC per administrative block. There is noPHC in the Bihar. Amongst existing facilities there is considerable loss of utilization due to improper location and improper distribution. And this is compounded by improper choice of village within the section or sector and the choice of venue within the village. Sub centers were most affected by such poor location. The existing process of choice of venue is flawed and a specific alternative policy on this is required.

Gaps in Health Infrastructure

It is required to prepare block level maps showing all villages with location of existing HSCs and APHC and its service area in all blocks as well as demarcating various sections and sectors according to population norms fixed for areas with tribal, primitive population and non tribal populations. Based on this to search out ideal locations for HSCs and APHC as and compare this to where they are currently.

The location of proposed HSCs and APHC are effectively done by based on GIS. So apart from constructing the requisite number of new sub - centers we also need to either construct buildings for these 186 old HSCs and 249 new HSCs or we can take over the existing building from where they are functioning from and upgrade and equip them sub-centre requirements. The district and block level team has discussed and finalized the location of the new sub centers with the help of community, local administration and health service providers with the help of GIS map.

To ensure one progress of any district, it is important to ensure that its people are healthy and have round the clock easy access to adequate health infrastructure. 23 APHC and 186 HSCs are functioning in the district. The block wise details are as follows:

Table 3.2: Block wise health infrastructure details of Araria district

Blocks	Population covered	PHC Existing (In No.)	APHC Existing (In No.)	HSCs Existing (In No.)
Araria	355675	01	05	22
Kursakanta	115667	01	03	15
Sikti	124203	01	03	16
Palasi	190241	01	03	16
Jokihat	246043	01	02	29
Narpatganj	270128	01	04	22
Forbesgaj	373933	01	02	19
Bhargama	180457	01	05	24
Raniganj	302281	01	05	36
	2158608	09	32	199

Table 3.3: Proposed Infrastructure as per IPHS norms

Blocks	Population covered	PHC		APHC		HSCs	
		Existing (In No.)	Proposed (In No.)	Existing (In No.)	Proposed (In No.)	Existing (In No.)	Proposed (In No.)
Araria	355675	01	0	05	05	22	25

Kursakanta	115667	01	0	03	04	15	20
Sikti	124203	01	0	03	04	16	25
Palasi	190241	01	0	03	04	16	30
Jokihat	246043	01	0	02	05	29	30
Narpatganj	270128	01	0	04	05	22	20
Forbesgaj	373933	01	0	02	05	19	30
Bhargama	180457	01	0	05	04	24	20
Raniganj	302281	01	0	05	05	36	25
Total	2158608	09	0	32	41	199	225

Table3.4 : PHC level Infrastructure details

PHC/ Block PHC	Building		Building Condition	Power Supply (in hrs)	Gen set	Water Supply	Telephone	Sanitation (Toilet / Bath)		No. of Beds	Waste Management
	Govt.	Rented						Patient	Staff		
Araria SDH	01	0	good	24	01	01	01	01	01	32	01
Kursakanta	01	0	good	24	01	01	01	01	01	06	01
Sikti	01	0	good	24	01	01	01	01	01	06	01
Palasi	01	0	good	24	01	01	01	01	01	06	01
Jokihat	01	0	good	24	01	01	01	01	01	30	01
Narpatganj	01	0	good	24	01	01	01	01	01	06	01
Forbesgaj	01	0	good	24	01	01	01	01	01	30	01
Bhargama	01	0	good	24	01	01	01	01	01	06	01
Raniganj	01	0	good	24	01	01	01	01	01	30	01
Total	09	0			09	09	09	09	09	152	09

1◎ implies availability
0◎ implies unavailability

Further, the current health infrastructure is supported by Sub Divisional Hospital and Referal Hospital, and PHCs. All PHCs, Referal Hospital and Sub Divisional Hospital except Araria PHC are having vehicle services with ambulance.

Table 3.5: PHC level Vehicle details

Sl.No.	PHC/ Block	Type of Vehicle	No.	Condition
1	Araria	Ambulance	01	Good
2	Kursakanta	Ambulance	01	Good

3	Sikti	Ambulance	01	Good
4	Palasi	Ambulance	01	Good
5	Jokihat	Ambulance	02	Good
6	Narpatganj	Ambulance	01	Good
7	Forbesgaj	Ambulance	02	Good
8	Bhargama	Ambulance	01	Good
9	Raniganj	Ambulance	01	Good
Total			11	

The gaps in accommodation are huge. APHC do not have the required number of quarters for Doctors as well as nurses (Table annexed). Whatever the existing quarters are there, they are in a very sorry state. There is acute shortage of quarters for Paramedics and other staff at all the APHC. In the campus residential accommodation for all staff is required not just for few is very necessary if we really want to have our PHC working for 24 hours a day and 7 days a week.

Most of the quarters for the Doctors, Nurses, paramedics and other staff needs to be immediately renovated and quarters need to be constructed according to the minimum manpower norms for PHC.

As far as 32 APHC are concerned, all APHCs are functioning without any facilities with damaged building. Either functioning in the sub-centre building. Almost 08 APHCs are functioning in government buildings, but building condition is very poor. All APHC are devoid of electricity, lacking of water supply because Hand pumps are not functioning properly. There are no residential facilities for staff in APHCs except Jogbani APHC in Forbesganj.

Out of 199 existing Health Sub-Centre, 49 HSCs are running in Government building, 150 HSCs are running without building. 25 HSCs building is under construction, rest are in poor condition and immediately renovation / new constructions are required. As per population norms and geographical conditions 225 new more sub-centers are required to provide better health facility to the community. The total number of new buildings is required 364 others are renovated i.e. 35 HSCs.

Manpower Availability and Gaps in Manpower

Sl. No.	Cadre	Sanctioned	In position	Vaccant
	Medical Officer	**121**	**56**	**65**

	Contractual Doctors	**36**	**13**	**23**
	'A' Grade nurse	**17**	**08**	**09**
	Contractual 'A' Grade nurse	**96**	**25**	**71**
	LHV	**45**	**12**	**33**
	A.N.M.	**274**	**203**	**71**
	Contractual A.N.M.	**290**	**61**	**229**
	Sanatary Inspector	**09**	**0**	**09**
	Pharmacists	**43**	**04**	**39**
	Health Educator	**18**	**12**	**06**
	Dresser	**42**	**05**	**37**
	Lab Tech	**36**	**04**	**32**
	B.H.W.	**48**	**23**	**25**
	F.P. Worker	**27**	**18**	**19**
	Health Worker	**27**	**03**	**24**
	Block Extension Educator	**09**	**0**	**09**
	O.T. Assistant	**03**	**0**	**03**
	Opth. Assistant	**09**	**03**	**06**
	Statistician	**04**	**01**	**03**
	Medical Officer (Lep)	**01**	**0**	**01**
	Medical Social Worker (Lep)	**02**	**0**	**02**
	Health Visitor	**04**	**0**	**04**
	B.C.G. Technician	**06**	**0**	**06**
	Computer	**09**	**03**	**06**
	Clerk	**63**	**50**	**13**
	4th Grade	**205**	**151**	**54**
	ASHA	**2376**	**2026**	**350**

3.3 Infrastructure: Current Status and Gap

3.3.1 Infrastructure facilities at PHC

Araria District has 09 PHC. All the PHC function from their own building. The source of water for all PHC is overhead tank and hand pump.

All the facilities have electricity in all parts of the hospital. all PHCs, Referal Hospital and SDH Araria have operations theatres and Ambulance. Generator and Telephone is available in all PHCs.

None of the facility has OPD facilities for RTI /STI. OPD facility for gynecology/obstetric is not available.

There are facilities for privacy in all PHC, for sterilizing instruments is available in 09 PHC while facility for counseling is available in none of the facilities. There is blood storage cnter available in the district H.Q.

Quarters for MOs & Paramedical staff in all PHC are inadequate and required immediate new construction renovation. Accommodation facilities for relatives or attendants of patients are not available in any PHC. Personal Computers are available in all PHC Out Sources.

Specific staff training of medical officer in PHC

The post of obstetrician/ gynecologist is not filled in any PHC. The post of RTI/STI specialist is not filled in any of the facilities. The posts of laboratory technician, pharmacist and staff nurse are not full- filled and available in all PHC. The post of Health Assistant (Female) is filled and available in all PHC. There is no training on sterilization, MTP, RTI / STI since last 6 years in any PHC.

3.3.2 Availability of specific facilities in Additional Primary Health Centres

There are no facilities of toilet, water supply electricity, laboratory, vehicle, labour room in any APHC. Because, Bihar has Primary Health Centre, Additional Primary Health Centre and Health Sub Centre. But other state has CHC, PHC and HSC. In NRHM period Bihar Government has notified all the PHC has to be converted into CHC, and all the APHC converted into PHC. That's why; PHC is not according to IPHS norms.

3.3.3 Availability of specific facilities in Sub-centre

Of the Sub-centres surveyed in Araria district, only 60 HSCs function from government buildings, 139 are running without building. The total buildings are required 199 and 35 existing HSCs are required to renovate. All of them have not the source of water, There is no facilities of electricity, toilet facility and quarters for the health worker. The ANMs is present in all SCs, but there is no any means of transportation. 11% of the SCs have health worker (male). There is no training on IUD insertion, CDD / ORT, UIP, CSSM, RCH and ARI.

3.3.4 Availability of specific facilities in District H Q level.

There is a sub divisional Hospital in Araria district. The Sadar Hospitalis under construction. The source of water is over headtank , The Sub Divisional hospital has electricity supply, generator and a telephone. The hospital has toilet facility and a vehicle in working condition. There are facilities like laboratory and X-ray machine. There are separate indoor or outdoor departments in the Hospital. Beds, pillows, bed sheets, delivery table and examination table are available as per norms. There is an independent 01 Sub-Divisional Hospital, 09 Primary Health Centre (PHC) and 32 APHC in the district. The all facilities cover the entire ablout 25 lakhs population of the district.

Physical Infrastructure

a. Hospital Building

The SDH has a compound wall fencing all around. The SDH has its own building. The other facilities also operate from their own buildings.

b. Source of Water Supply

The source of water supply for the SDH is OverHead Tank/Hand Pump/ Tube Well. This is also the case with the other facilities surveyed, which have piped water, Overhead tank and pump are available at the SDH. Water supply and associated facilities are not adequate in all these facilities.

c. Electricity

Electricity is available in all parts in the facilities. The electricity supply to the DH is continuous. All the facilities have regular electricity supply. The generators available at both the SDH and 09 PHC are in working condition. It was reported that the capacity of the generators is sufficient as per the requirement at all these facilities.

d. Disposal of waste

SDH is disconnected to the municipal sewage. The other facilities surveyed do not have any sewage facility. The waste is not segregated as infectious/ non-infectious at any of the facilities. There is not any waste treatment plant in Sub. Div. Hospital compound, The biological wastes are buried in a pit need of incinerator in all the Health facilities of District.

e. Staff Quarters

It is found that quarters for both Doctors/MO and other staff are available but not sufficient. PHC of SDH and Referal Hospitals have quarters for the doctors / in-charge. None of the PHCs have staff quarters for gynecologists, /obstetricians, pediatrician, RMOs and anesthesiologists.

f. OPD Services

OPD facilities are available in the SDH, Other Referal Hospitals and PHCs. OPD facilities are found to be good in the SDH. It is observed that OPD services for gynecology /obstetric and RTI / STI are available in the SDH. OPD services are available in all Units very well.

g. Availability of Beds

The information about total number of in-patient wards is available in the SDH while the total numbers of beds are 60 but it will upgrade into 300 bedded District Hospital. All PHC have the number of beds being 6 respectively.

h. Man power and In-service Training

In the SDH, all the sanctioned posts of doctor in charge, gynecologist and obstetrician, pediatrician, pathologist, and anesthesiologist are not filled and available. There is no gynecologist and obstetrician in any PHC.

3.4 Rationalisation Equipment – Gap, Procurement & Utilisation

It is also quitessential that equipments assessment is done to ascertain gaps. Smaller low cost equipment that is frequently replaceable must be dealt with as for consumables. Larger equipment, which is costlier and requires training to make operational needs to be purchased and deployed only as part of block and district level plans linked to service quality deliverables. This would ensure that there is no mismatch between equipment purchase and infrastructure, between equipment and skilled manpower available, between equipment and related consumables supply and that the purchase of equipment is linked to quality improvements in the package of services offered at this level.

Purchase can have the same policy of pre-qualification and price negotiation at the state level with districts then placing orders. The same empowered body which implements drug and supplies procurement and distribution may undertake all equipment purchase. Further such a body would ensure that adequate arrangements are made for maintenance and such arrangements are renewed.

Attention may be given to closing the gaps regarding water supply and power supply and to ensuring that separate toilets for staff as well as bating facilities for men and women are also in place in each of the PHC and other facilities. Inadequately recognized priority areas are waste disposal systems, drainage and sewerage all of which needs to be put into place in all APHC and PHC.

Major equipments like X-ray machines, ECG, Hemoglobinometers, surgical equipments, Boyle's apparatus are not available in any PHC. Auto clave, instrument sterilizers, microscopes, stethoscopes, BP apparatus, weighing machine, infant weighing machine, oxygen cylinders, ambu bags, emergency lamps, Deep freezers, ILR etc. are available but condition of most of the instruments are not up to the mark (Table annexed). All of them have the minimum necessary hospital furniture for the running of PHC. But the main problem is that they do not have any proper maintenance by the staff. There are many instruments like the Ambu bags which are not very costly and can be replaced in a short notice. They were out because of irregular maintenance. X-Ray machines are also installed at Sub-Divisional Hospital and Referal Hospital Forbesganj and Raniganj.

At the PHC level 100% are having BP apparatus, weighing machines, sterilizers, IV stands, scissors, and delivery tables. None of the PHC are having the X-ray machines, binocular, blood cell calculator.

All the PHC should be provided with Blood Transfusion and other Hematological investigation and ECG facilities for complete, improved as well as ideal PHC. Regular servicing of the instruments needs to be done to make the PHC function at its optimum level. Training needs to be provided to the staffs regarding how to use equipments that are being provided to the PHC. Most of the staff does not know how to use them nor do they want to know. So these instruments provided never come out of the boxes and get destroyed with out even being used once.

At PHC level, there should be a provision for X-ray, laboratory and also transportation facilities like ambulance, jeeps, etc. PHC staff also needs to be trained how to use the instruments and what are they for. Even if they have the instruments, as they do not know what are they called or for what purpose they are used when generally asked they say they do not have the equipments

Contractual appointment of technicians for maintenance of major/minor equipments is proposed.

3.5 Training Need Assessment /Human resource development/ Capacity Building

Though regular trainings are provided under various national programmes to doctors, paramedical staff specially lab techs and MPWs, the quality of trainings are not Upto the level expected. So far the block level trainings are concerned, these are largely done like meetings and the lower level trainings go to even poorer results. Skilled team for training is another issue. This leads largely to logistics gaps and also affects the training quality and transmission sustenance. Thus the major focus should be training logistics and personnel. No any ANM training center locatedin District whichimparts is months trainings to ANMs sothat they retain what they have beentaught.

There is an ANM Training Centre located in the Hathuwa which imparts 18 months of trainings to ANMs. Though most of the ANMs & LHVs have been covered under these trainings but some feedback trainings also needs to done so that they retain what they have been taught.

The following additional trainings for various levels need to be imparted in 2009–10.

- Skilled birth attendant training for ANM, LHV and Grade "A" Nurse etc.

The capacity of participants needs to be further built up by exposure visits to model health institutions of other states as well. Apart from all the above mentioned trainings the staff at all levels should be constantly updated about the latest technology and developments. All the staff should be given regular training on how to use computers and instruments that are being regularly provided to them by the centre so that the dream of having completely functioning PHC, APHC, HSCs for 24 hours a day and 7 days a week comes true.

The goal of the training policy shall be attainment of a specified quality of care for a given facility. The same is applied for para-medicals as well as for medical officers. To achieve this goal we recommend an in-service training package with following features:

Multi-skilling for Paramedical

Training Roster: A roster of all MPWs and health supervisors should be maintained at the block and district level just for this purpose denoting last training attended topics and number of days of training in each.

Syllabus: The syllabus for it should be built up to include:

- Changes in health programme guidelines of national health programmes- best address through two day sensitization programmes, whenever such a change is made.
- Renewal of core area of their work – RCH programme for MPWs and national programmes for male workers.
- Multi skilling training in which female workers learn more about national programmes and about basic laboratory skills and male workers learn about RCH and adequate levels of basic laboratory skills.
- Adequate training for first contact curative care.
- A modified IEC training programme capability with focus on interpersonal and community mobilization skills along with better understanding of a multicultural and ethnically diverse society.

On-the job Training : The supervisors should be held responsible for on the job training of the health workers and periodic evaluation of knowledge and skill of health workers be used to ensure that they perform this task adequately, as they should be accountable for this in their juniors. The medical officers must be equipped to evaluate the supervisors on training in most areas and in some areas like basic laboratory services they should be capable of providing in-service training.

Integrate Training Funds: All training funds from various programmes are deployed in such a way that even as the objective of that grant is realized, the training goals the state has set itself is also advanced within that same space.

Training Cell: A training cell for in-service MOs, MPWs and supervisors training have constituted in the Institute of Public Health (IPH) that is constantly doing training needs assessment, training material development, master trainer training of district training centers, supervision of training roasters and training evaluation.

Trainings for Medical Officers

Continuing Medical Education: We recommend a continuing medical education scheme for medical doctors to upgrade their knowledge and skills. A continuing

medical education scheme should be pursued as a very useful intervention strategy in health care delivery system.

Minimum Skill-Mix for PHC: Having defined a minimum package of services at the PHC as essential to meet public health goals one needs to a put in place a road map by which the desirable skill mix needed for delivering such a package of service would become a reality. We make the following suggestions in this regard.

- Decide on what skill mix is needed in each PHC and what the gaps are. The focus is on emergency obstetric care but the skill mix approach need not be confined to this alone.

- Draw up a schedule for providing short term trainings so that existing medical officers and specialists fill up the gaps with acquired basic skill sets other than in areas which their primary specialization. Thus a surgeon may also learn to do caesarean section or ENT and ophthalmic work, or a physician may learn paediatric functions and so on.

- Where gaps still remain one may use public private partnership to fill up the gaps.

Though regular trainings are provided under various national programmes to doctors, paramedical staff especially lab techs and MPWs, the quality of trainings are not Up to the level expected. So far the block level trainings are concerned, these are largely done like meetings and the lower level trainings go to even poorer results. Skilled team for training is another issue. This leads largely to logistics gaps and also affects the training quality and transmission sustenance. Thus the major focus should be training logistics and personnel.

3.6 Health Services:

There are 199 subcentres, 32 APHC and 09 PHC/ Referal Hospitals spread in the 09 blocks of Araria District. The OPD situation, bed occupancy and hospital management related issues are not in a very good condition if compared to the potential and capacity of institutions. The quality of public health services has been described in concerned sections and here the analysis of the clinical services.

- APHC have yet to start function on a 24 hour basis though roasters in this view have been prepared in all facilities.
- ANMs availability in the headquarters still is an issue.
- Though contractual appointments are given, the no. of doctors is not adequate.

- Neonatal care is also a problem area needs improvement. Equipments and nursery facility provided to improve this also needs to be properly installed and used in concerned facilities.
- The management of severe and acute malnutrition is not at all taking place.
- Supervisors are neither in sufficient number nor trained enough for supervising the work of the ANMs.
- In many places post of sector supervisors are vacant and needs to be fulfilled
- ANMs are not provided with stationery by the concern units
- Supervisors also complaint that they are not provided any stationery from the block headquarters and they are purchasing stationery on their own expenses.
- There is no system of checklist to get the actual data from ANMs for reporting.
- The complete system of monitoring the current status of the health needs to be redefined.
- The geographical constraint is the main constraint in reaching 100% immunization.
- The distance between most of the tolas is greater compared to those villages in the plain areas.
- ANM/MPWs are overburdened with work due to the shortage of staff which needs attention from the district / State authorities.
- Most of the ANMs either travel by cycle or they merely walk due to lack of proper communicationdue to flood prone area..
- There is less coordination among ANM / MPWs, and AWWs.
- There is a greater gap of man power, infrastructure and equipment's at subcentre level due to which Subcentres are not functioning with quality services.
- Continuing out of pocket expenditure by ANM on stationary and travel with lack of adequate arrangements for facilitating mobility also effects the proper functioning of the subcentres.
- Continuing gaps in the cold chain maintenance and supply of disposables needed to improve quality in immunization.

Creating Conducive environment: Service condition

(Transfer, promotion; financial burdens; Personal Security Accommodation for staff)- The lack of a transparent fair system of transfer is easily one of the greatest causes of workforce dissatisfaction and demoralization. Some staff spends their lifetimes working in remote areas seeking and never getting a transfer whereas others perceived to be able to personally and unfairly influence decision making get plum postings throughout their careers. This makes less staff willing to serve in rural areas and when they are so posted do their task with such a deep-rooted sense of frustration and anger that the quality of the work suffers. The problems of doctors not willing to serve in rural areas should be seen only in this context and should not even be raised against the medical profession unless a basic transfer policy has been put in place.

Promotions need to be regular and timely and fair. There have been almost no promotions for the last three years in this state. This has led to situation of deep dissatisfaction that runs through the entire department. It has also meant that all positions of authority starting from the top most and preceding through the CMO up to the BMOs are held in an adhoc and arbitrary manner. Further the opportunities for an active career plan for a talented doctor or one who is able to work is able to work hard and perform more are absent. Considerable possibilities for non-medical and even non-service incentives that can be given to a doctor have bee left unexplored. For paramedical staff too the lack of any possibility of a promotion let alone a career acts as a great demotivation from taking any initiative. These are all remediable aspects that need to be urgently attended to.

One nagging problem is the significant amount of expenditure that is being required to be spent out of pocket for staff, especially junior most staff, for what are clearly official functions. The main problems relate to travel allowance and stationary. This needs to be remedied at once, starting with stationary expenses of MPW females.

Another major problem is personal security, again a problem maximam with MPW females. Violence and sexual harassment, covert and overt affects about 10% but creates a sense of insecurity in all.

Another basic service issue is accommodation. At no level is there adequate housing for all staff. The focus has been on developing government housing for doctors first. At the PHC level there is no accommodation available for doctors and other categories of staff. In many of these locations, availability of basic quality rental accommodation is also a problem.

Laboratory Services

Laboratory services at the sub-centre are absent. By norms four basic tests- Blood pressure, weighing of pregnant women and children, blood haemoglobin estimation and urine testing for sugar and albumen (also ESR) are expected to take place here. These above tests however should do take place infrequently in APHC but even here they are not regular. That the PHC, as per norms, has a basic laboratory which can do about 20 basic diagnostic tests has almost been forgotten within the system. Even microscope availability is low. In the last three years there has been considerable movement forward in this area through Out Sourcing.

In PHC the laboratory is active but performs almost exclusively two tests, the blood smear examination for malarial parasites and sputum examination for AFB. The list of desirable diagnostics at the PHC level is over 40 tests. Where PHC are active the workload of these two tests are heavy (as no tests are being don at sector level) and this crowds out the possibility of doing any other laboratory investigations except the four that are to be done at the HSC level. Also as a

consequence, the 'smear taking to report reaching back' time gets lengthened considerably (on an average 15 days to a month). With such delay this entire workload on the laboratory brings no additionality to health service outcomes. The blood smear examination has increasingly taken the form of a "modern" ritual denoting medical care devoid of content.

There is no major perception of the lack of laboratory services as serious lacunae – again reflecting on the weaknesses in understanding and lack of emphasis of quality issues in medical care.

Referral Services

The current referral services have two forms. Firstly there is a fund placed at the disposal for use hire / pay for transport to shift needy patients to hospital. There is an understanding that this must be used for high risk and complication of child birth. Fund flow and even awareness of this provision in panchayats is low and because of other structural constraints lack of vehicle, inability to call vehicle in time etc) its utilization is very low even as the need for referral goes unanswered.

The other referral is the patient asked orally or with a slip to go seek treatment at a higher centre. This brings no advantage to patient or to the system and is perceived by patient as the referring facility having deliberately or otherwise failed to deliver its services. There no clear norms for what is to be referred and when and there are no mechanisms to monitor referral to reduce unnecessary referral and insist on necessary ones. There is no feedback of any sort. In sort there is no "referral system" in place.

Preventive services:

This being the most important aspect of disease control, a lot of stress has to be laid on it. All the staff of the MMU should be trained on the preventive strategies for the control of various diseases. MMU staff has to be identified, trained and assigned the duty of propagating this preventive aspect. Preventive strategy should be in tandem with the IEC/Advocacy being undertaken and it should be a flow of information, starting from basic information of the disease and its treatment modalities in IEC and ending with the preventive aspect of the disease.

- Diagnostic services:
- Laboratory based
- Complete Blood Count
- Routine Urine examinations
- Urine examinations for sugar and Albumin
- Stool examinations.
- Peripheral smear for Malaria / Kala Azar.
- Laboratory based diagnostic and surveillance procedures for Leprosy and other endemic diseases should also be made available.

- Sputum examinations should be carried out for diagnosis and monitoring of treatment under RNTCP.
- Facilities for diagnosis/ collection centre for the investigations of HIV/AIDS infection shall be made available.
- Radiological investigations (optional, to be need based and decided locally)
- A portable X-ray machine.
- Portable Ultrasonography equipment.
- Portable ECG machine (optional, to be need based and decided locally)
- Screening for breast cancer, cervical cancer (optional, to be need based and decided locally).
- Basic facilities for diagnosis ophthalmic anomalies/deficiencies (optional, to be need based and decided locally).
- Clinical services:
- Maternal health- Outreach Gynecological health care services
- ANC services
- Minimum 3 ANC check-ups.
- Prophylaxis of iron and folic acid.
- Tetanus Toxoid immunization.
- Early detection of complicated pregnancy.
- Counseling and referrals for institutional delivery.
- Child health
- Outreach pediatric health care services.
- Management of Diarrhoea and dehydration.
- Management of malnutrition.
- Monitoring of growth of under five year olds.
- Routine immunization.
- Family planning and Reproductive health services
- Clinical FP services- Cu-T, Injectables, Sterilizations (optional).
- RTI/STI management.
- Counseling on Various family planning initiatives/ methods (Natural- LAM, Safe period etc. and Modern- Condoms, Oral pills etc)
- Adolescent health issues
- Breast feeding
- First Aid and Minor Surgical procedures.
- Drug Distribution centre for various treatment modalities available under NRHM and State health initiatives.
- Specialized health care services (optional, to be need based and decided locally)
- Pediatrics / Orthopedic / Skin and STD /Ophthalmic /Psychiatric/Cardio-thoracic
- Ear Nose Throat disorders

Pharmacy services:

Referral and Transportation services

Linkages to be developed with Institutional health care providers from the public as well as private sector. MMU should also act as a means of transportation for cases requiring Institutional care.

Emergency Care Services

MMU shall be in the forefront of the support and care required during disasters/epidemics/public health emergencies/accidents etc. MMU will have a preformed action plan with duties delegated to each of the staff to cope up with such emergencies.

Telemedicine

(optional, every district should aim at establishing this facility as a part of scaling up of the outreach activities) This initiative shall help reduce the time lapse between diagnosis and treatment. To be linked with the local Medical College, where a technical hub shall be created.

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 stakeholders groups it has been anticipated that unmet demand for liable service provision can be achieved by adopting Intersectoral convergent approach through partnership among public as well as private sectors.

4.2 Targeted Objectives and Suggested Strategies

During consultation at district level involving a range of stakeholders from different levels, an attempt has been made to carve out certain strategies to achieve the specific objectives that are represented by different indicators. The following segment of the chapter corresponds to the identified district plan objectives demonstrating current status of the indicators along with the expected target sets that are projected for period of present year (2009-10).

4.3 Health Programmes

4.3.1 Reproductive and Child Health Programme components

4.3.1.1 Maternal Health Care

Women are the foundation of the Country's families and communities. Over the years, Complications of pregnancy and childbirth are the leading cause of death and disability for childbearing women in many parts of the country. Comprehensive, high-quality maternity care can help prevent infant and maternal death and disability. No matter where they live, women should have access to the information and care that keeps them healthy and safe. Engender Health has learned that when women have access to family planning, fewer women die from risky pregnancies or unsafe abortions. Our work safeguards women's health.

Engender Health works with partners to develop practical strategies to strengthen and integrate maternal health care services into national health systems.

In the district young girls inter the reproductive phase of their like as victims of under nourishment and anemia. Their health risks increase with early marriages, frequent pregnancies and unsafe abortions choices regarding marriage, child bearing

and contraception are denied to women. There is also lack of access to functional reproductive health services and most deliveries are still carried out by untrained birth attendants especially in the rural areas where there is no effective system of referral or management in case complications arise through there has been widespread increase of infrastructure service in the district during the past years, access to these facilities is still varied.

The immediate causes of maternal mortality are well known. They are sepsis, hemorrhage, obstruction, anemia, toxemia and unsafe abortions. The larger social determinants of these are also equally well known – they include educational status of women, poverty levels, social inequities and access to quality care.

It is evident that all the health / health service indicators of Araria district are as lower as compared to that of Bihar CDR, MMR IMR , Immunization, Institutional Delivery and Safe delivery is not better than Bihar State. However efforts in terms of quality and service need to be taken for the betterment of the present indicators. Service utilization is not good in Araria district. In urban areas, there is no any Urban Health Centre in the Araria district. In this reason, the slum population is neglected for proper immunization, Institutional Delivery and Safe delivery.
Field observations show that the blocks Narpatganj, Bhargama andSikti are lagging with respect to no. of institutional deliveries due to lack of staff, proper health facilities as well as they are unreachable areas. Further the no. of maternal deaths in that block are much more as compared to other blocks as these are non tribal belts, far-away sub-centers, unapproachable areas etc.

Constraints:

- Health workers are not able to do 100% pregnancy registration due to different reasons such as unreachable areas, personal reasons, illiteracy etc.
- No proper follow-up by workers of ANC cases and monitoring by supervisors, sector doctors etc
- No proper referral service
- Lack of awareness among rural masses / low IEC activities
- Improper access quality antenatal, natal and post natal services may be due to
- Lack of nurse (refers to female MPW or ANM) for providing quality ante-natal care at an appropriate time in vicinity of her home.
- Lack of skilled birth attendant in vicinity of home (trained midwife, nurse or doctor).
- Lack of facility providing institutional delivery on a 24 hour basis:
- The Sub-Centre is not usually a site for institutional delivery. 75% approxof sub centres the lack of buildings rules it out as an option. Equipment gaps may also contribute to poor service.
- Lack of transport facilities
- The post-partum mother and the neonate require a visit by a ASHA in the first day after birth and at least once more in the first week of the neonate's

life. Given geographical constraints it is not possible for the ANM to do so. Only a trained community level care give like the ASHA can do so.

- Sometimes the nurse is there and resources are not a problem but there is a poor motivation to provide services or a reluctance to accept services even when the knowledge and attitudes are alright. These gaps are cultural gaps and represent a certain passive discrimination – of caste or creed, or of gender.

The following matrix highlights the indicators that are taken into consideration to achieve the objectives of reproductive and child health. For each indicator current status has been assessed and targets have been set that are to be achieved in the period present year plan . In order to attain the set goals certain strategies are laid out against each indicator.

Table 4.1: Performance Indicators for Reproductive child health

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
1.	Universal coverage of all pregnant women with package of quality ANC services as per national guidelines			▪ Strengthening information base of pregnant women ▪ Improvement in monitoring and supportive supervision of ANM tour programme ▪ Provision of equipment to sub centres, APHC, PHC ▪ Streamlining logistics ▪ Specific interventions for inaccessible areas ▪ Effective coordination with ICDS workers/NGOs and faith based institutions ▪ Area specific IEC and Behavioral change communication strategy.
2.	Increase in deliveries with skilled attendance at birth including institutional deliveries			▪ Training of ANMs ▪ Training of dais/ SBAs ▪ Training of community based midwives (long duration training) ▪ Transport facilities to pregnant women ▪ Delivery homes in villages run by

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
				VHC ▪ Improving delivery facilities at sub centres and APHC ▪ 24 hour delivery services at APHC and PHC ▪ Involving public sector/ private and nursing homes in deliveries ▪ Awareness generation about Janani ayam Bal Suraksha Yojana. ▪ IEC / Behavioral change communication to improve awareness about pregnancy complications and need for utilizing institutional services for deliveries ▪ Involvement of ANMs, dais, AWWs, women self help groups, VHC and elected representatives of community /faith based institutions in identification of pregnant women at high risk.
3.	FRUs (including SDH/,Referal/ PHC/APHC) made functional as defined in the National RCH- 2 PIP			▪ Identification of health institutions and equipping them to provide basic and/ or comprehensive emergency obstetric health care. ▪ Appointing required health professionals such as gynecologists, anesthetists and staff nurses to provide EOC services ▪ Ensuring adequate and safe blood supplies by strengthening existing blood blood storage center and opening new blood banks in the district. ▪ Establishing linkages with private nursing homes having adequate facilities to provide emergency obstetric care services
4.	Universal coverage of all eligible pregnant women under JBSY scheme			▪ IEC & Behavioral change communication to improve awarness ▪ Improving referral Network ▪ ASHA Training and Motivation.
5.	Increase in percentage of new born			▪ Introduction of a package of home

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
	babies given colostrums			based new born care ▪ Strengthen referral network ▪ Strengthen new born care infrastructure and facilities in all APHC and PHC ▪ Upgrade education infrastructure for neonatal services training
6.	Increase in prevalence of exclusive breast-feeding			▪ Educating mothers on benefits of immediate breast feeding ▪ Educating mothers on need to exclusive breast feeding ▪ Educating mothers on type of supplements and also the need to start supplements from sixth month onwards ▪ Reorientation training to service providers
7.	Percentage of severely malnourished children below 6 years referred to medical institutions			▪ Training to AWWs for identification of malnourished children ▪ Training of MOs.
8.	Unmet demand for contraception (Total) - Spacing - Limiting			▪ Increasing the base of serviceproviders for both male and female sterilization services ▪ Increasing the number of service delivery points to provide quality male and female sterilization services ▪ Organizing camps in systematic and effective manner ▪ Building linkages and involving NGOs / FBOs to promote both male and female sterilization methods and modern spacing methods ▪ Social marketing projects to promote access to and demand for spacing methods ▪ Communication campaign to improve demand for terminal and modern spacing methods ▪ Conducting Workshops to service providers on linkages between spacing of children and infant mortality rate ▪ Every tolas would have at least one

	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies and Activities
				volunteers who would have a limited stock of the supplies available- either collected from the village distribution point or from the health department.
9.	A. Number of government health institutions providing i) Female sterilization services ii) Male sterilization services iii) IUD insertion services			▪ Ensure posting of trained LMOs, surgeon and staff at PHC ▪ Skill upgradation of ANMs for IUD insertion services ▪ Collaboration with private practitioners/ institutions on contractual basis
10.	Number of health institutions in APHC/PHC offering ARSH services			▪ Orientation training of staff for enhancing ARSH services ▪ Sensitize adolescent and reproductive groups through local health workers ▪ Involvement of NGOs
11.	Number of health institutions providing services for management of STIs and RTIs			▪ Select health institutions in the district and equip them with lab facilities and lab technicians ▪ Train medical officers in RTI/STI management ▪ Supply medicines in adequate quantity for RTI/STI services ▪ Provide RTI/STI services during RCH camps ▪ Conduct special camps for health check ups and RTI/STI services ▪ Promote partner treatment ▪ Establish linkages with private practitioners providing RTI/STI services

***Source: RCH II and DPMU**

4.3.1.2 Child Health and Immunization

Data is not available of infants delivered weighed below 2.5 kg. Poor outcomes in the child health due to the following reasons:

- Workers not following the 8/8 quality ante-natal care norms
- Poor nutritional habits
- Early marriages
- Illiteracy among rural masses especially SC/ST.
- Poverty
- Less no. of institutional deliveries

Table 4.2: Child health indicators (2008-2009)

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

(Source: RCH-DLHS survey 2003, PFI 2007 & Internal MIS data)

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

Constraints for poor quality of immunization:

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

Suggestions for improving the quality of immunization:

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

Table 4.3: Performance Indicators for Child Immunization

Sl.	District Plan Objectives	Current levels*	Target for 2009-10	Suggested Strategies
1.	Increase in percentage of fully protected children in 12-23 months as per national immunization schedule			▪ To Increase number of sub centers and health workers ▪ Increase Outreach sessions ▪ Ens. adequate posting of ANMs
2.	Universal coverage with Vitamin A prophylaxis in 5-36 months children			▪ Increase IEC at grass root level with the help of NGOs.

***Source: RCH II, 2002-04**

4.3.1.3 Family Planning

The availability of family planning does more than enable women and men to limit family size. It safeguards individual health and rights, preserves our planet's resources, and improves the quality of life for individual women, their partners, and their children. This section provides basic information on a range of contraceptive methods, including factors to consider when choosing a method. In all the blocks of district Araria the achievement with respect to target in case of Family Welfare is quite satisfactory.

Table 4.4: Knowledge of Family Planning

Indicator	Percentage
Knowledge of any modern method	
Any modern spacing method	
All modern methods	
Knowledge of any traditional method	

(Source: RCH-DLHS survey 2003)

Table 4.5: Current users of Family Planning

Any Method (CPR)	
Any Modern Method	
Female sterilization	
Male Sterilization	
IUD/Loop	
Pills	
Condom	
Any Traditional method	

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

Table 4.6: Unmet Need

Percentage of women having unmet need for	

Limiting	
Spacing	
Total	

(Source: RCH-DLHS survey 2003)

4.3.1.4 RTI / STI and HIV / AIDS Control

Reproductive tract infections (RTIs) include three types of infection that affect the reproductive tract of women and men (Population Council 2001). These are:

1. Sexually transmitted infections (STIs)—also known as sexually transmitted diseases (STDs)—caused by viruses, bacteria, or parasitic organisms that are passed through sexual activity with an infected partner.

2. Infections that result from an overgrowth of organisms normally present in the vagina (endogenous infections). These infections are not usually sexually transmitted, and include bacterial vaginosis and candidiasis.

3. Infections introduced into the reproductive tract by a medical procedure (Atrogenic infections) such as menstrual regulation, induced abortion, IUD insertion, or childbirth. This can happen if surgical instruments used in the procedure are not properly sterilized, or if an infection already present in the lower reproductive tract is pushed through the cervix into the upper reproductive tract.

These three types of RTIs overlap and should be considered together. For example, some STIs, like gonorrhea or chlamydia, can be spread in the reproductive tract if not treated prior to a procedure. In addition, some non-sexual infections, such as candidiasis, can be passed on through sexual activity.

Challenges to controlling RTIs/STIs

While not all RTIs are curable, they are all preventable. Prevention efforts aim to stop people from becoming infected, as well as to stop those infected from transmitting their infection to others (PATH 2001). Primary prevention focuses on educating people about personal risk and how to protect themselves from disease. Abstinence; consistent, correct condom use; mutually exclusive sexual relationships with an STI-negative partner; and early treatment of STIs are the most effective STI prevention options. Secondary prevention aims to shorten the duration of disease by promoting early detection and treatment, and providing acceptable, accessible, and effective care.

The key public health interventions needed to control STIs include:

- Promotion of safer sexual behaviors and primary prevention.
- Condom promotion, supply, and distribution.
- Promotion of appropriate health care-seeking behaviors.

- Integration of STI prevention and care into many existing health care services, including primary care, reproductive health care, HIV/AIDS prevention and treatment, and private-sector services.
- Comprehensive syndromic case management.
- Specific targeted services for high-risk groups.
- Prevention and care of congenital syphilis and neonatal conjunctivitis.
- Early detection and effective treatment of symptomatic and asymptomatic infections

Women have a greater risk of RTIs than men due to physiological, social, cultural, and economic factors. Women are:

- biologically more susceptible than men;
- usually infected at a younger age than men;
- more likely to suffer from complications;
- limited in their ability to protect themselves from high-risk sex or to negotiate condom use;
- more apt to suffer from asymptomatic infections and remain untreated; and
- Less likely to seek treatment, even for symptomatic infections.

The consequences of RTIs, including stigmatization, reproductive impairment, domestic abuse, and abandonment, can be severe for women. Women have limited ways to protect themselves. Female condoms offer some protection and may be cost-effective, but their use will depend on how they are promoted and how well they are accepted. In Araria district till date there are 66 cases of HIV/AIDs have been detected. In the district hospital Araria there is blood testing facility available. Simultaneously VCTC and STD clinic is also provided in the SDH hospital. Efforts are needed for health check-ups and partner treatment camps.

Table 4.7: Awareness of RTI/STI and HIV/AIDS

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

(Source: RCH-DLHS survey 2003)

As tabulated below, 46 cases were detected and all of them were treated in the year 2008-09

Table 4.8: RTI / STI cases - detected and treated in the year _2008-09.

RTI/STI Cases	Year _2008-09_
Cases Attended	
Cases Treated	

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

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

Following are the suggestions to counter these issues:

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

4.3.1.5 Adolescent Sexual and Reproductive Health (ASRH)

Sexual development is a normal part of adolescence. Fortunately, most adolescents go through these changes without significant problems. Nonetheless, all adolescents need support and care during this transition to adulthood, and some need special help.

The lives of millions of adolescents worldwide are at risk because they do not have the information, skills, health services and support they need to go through sexual development during adolescence and postpone sex until they are physically and socially mature, and able to make well-informed, responsible decisions.

The main issues in adolescent sexual and reproductive health are:

- Sexual development and sexuality (including puberty)
- Sexually transmitted diseases/ HIV/AIDS
- Unwanted and unsafe pregnancies

The reasons that adolescents are at risk include:

- Social and economic environment – For millions of adolescents, sex is linked with coercion, violence and abuse – sometimes even by family members or adults with privileged relations. In many societies, women are conditioned to be submissive to men, and they find it difficult or impossible to refuse early marriage, to space births, or to refuse to have unprotected sex with an unfaithful spouse or partner. Additionally, the social environment is critical to healthy adolescent development. There are key aspects of this environment, which can prevent adolescents from engaging in unsafe/unwanted sexual behaviour, for example, a strong relationship with

parents, a connection to school and open communication with sexual partners.

- Information and skills (life and livelihood) – In most countries, the great majority of adolescents are poorly informed about sexuality and reproduction. Often policy makers, public opinion leaders and parents believe that withholding information about sexuality and reproduction from young people will dissuade them from becoming sexually active. In fact, good quality sex education does not lead to earlier or increased sexual activity among adolescents. Adolescents need life skills in order to face the challenges of adulthood. During personal development, an adolescent's competence develops whenever there are opportunities to practice certain skills by understanding and using social conventions. Adolescents also prioritise livelihood skills and opportunities as very important to them. Many adolescents are victims of exploitative sex because of lack of livelihood skills and opportunities.
- Access to health services – Most adolescents (boys and girls, married and unmarried) become sexually active before the age of 20, but generally lack access to family planning services (including appropriate contraceptives), prevention and care of sexually transmitted diseases, or pregnancy care. For many young people, the opening times or location of services make them inaccessible, or the care is too expensive. Many health care facilities require the consent of parents or spouses, or may be forbidden by law to provide services to adolescents. In addition, the judgmental attitudes of many health care professionals often discourage adolescents from seeking advice and treatment related to sexual and reproductive health.
- Intervention Areas
- The Common Agenda advocates the following specific measures to prevent unsafe sex and early childbearing among adolescents:
- Create a safe and supportive environment through promoting delayed marriage and childbearing, expanding access to education and training, and providing income-earning
- opportunities.
- Provide information and skills (life and livelihood) so that adolescents are better equipped to make good decisions.
- Expand access to health services that are affordable, accessible, confidential, and non-judgmental.
- Provide counselling for adolescents.

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

- There is a very high degree of under-nutrition and anemia at this age.
- Also growth stunting occurs at this stage if the girl is malnourished.
- Physical and mental development potential and stress due to poor health is also more.

- Adolescence is a period of higher exposure to violence, to sexually transmitted diseases and to pregnancy associated morbidity and mortality.

Suggestions:

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

4.3.2 Health Infrastructural Indicators

The performance with respect to certain key activities under NRHM shows that infrastructure related issues needs to be sorted out to ensure a successful implementation of plan. Next section details out probable strategies and activities:

Suggested Strategies and Activities:

Two female MPWs in each sub centre: Sub centers may plan for two MPWs, preferably both women. The job description and workload of the MPW (F) needs to be lessened and made realistic. Along with this, workload reatinalisation would be achieved by equal sharing of the work between the two persons posted at the sub centre. In the first stage this achieved by redefining of the male MPWs work to be identical with the female MPWs. Except or institutionalization delivery and IUCD insertion, every task currently done by women can be done by men also. And in the second stage by ensuring that the second person in the HSC is also a female MPW i.e. converting the male MPW post to a female MPW post. Without increasing costs or number of sub centers we would be doubling the density of the most active, effective and critical workforce of the entire system.

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

Rationalization of Deployment Medical Doctors in the PHC Level

Differentiated Strategy According to Difficulty Levels: The ideal would have been two medical officers at every PHC. However this may not immediately be realized due to shortage of potential recruits and the difficulty in finding even one medical officer per remote area. Therefore we suggest that APHC be categorized into most difficult, difficult and easy and a different strategy be adopted for each.

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

Daily Visits by PHC Based Doctors for Most Difficult APHC: Where no medical doctors are available currently, where access is a problem and accommodation facilities are low (category C), even as efforts are made to fill these posts, the backing up is done by daily visits and in a few distant APHC two to three visits per week of a medical doctor from the respective PHC. The doctor would be required to be available during working hours and his stay at the PHC would be insisted on only adequate accommodation arrangements, governmental or rental are available. Even in this exemption may be given for special reasons as long as stay is in nearby block town as part of the PHC team and daily attendance is regular. Family accommodation at the PHC would be easier to organize. In other word, HMS we should not insist on medical doctors staying in APHC designated category C- most difficult.

Strengthening AYUSH Doctor's role while keeping Medical Officers Option open: The use of medical officers with AYUSH (Ayurvedic scheme) to fill up vacancies where no medical officers are currently available is welcome. However all the service issues discussed equally affect their functionality. Moreover currently they would be unable to deliver the notified services of the PHC level and special training would be needed to close the gaps.

Strengthening of PHC

Appointment of Six Medical Officers at Least, four of whom at least are specialist or within them have the required four – skill (Anaesthetist, paediatrician, surgeon, gynecologist) mix. If there are a number of APHC not having doctors to be looked after with visits, the number posted here may increase further. Currently the recommended norm is only four doctors per PHC, which is sub – critical.

Adequate Multi – Skilled Male and Female Paramedical Staff, who can manage the necessary support work and multi skilled imaging technicians who can also mange X – rays, ultrasound and ECG too. In addition there would be a unskilled

worker category of undifferentiated, interchangeable class IV functional – chowkidar, peon, sweeper, waterman – all rolled into one. Four qualified staff nurses, two qualified laboratory technicians and an optometrist are also a must at this level.

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

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

RATIONALISATION OF WORK ALLOCATION AND APPROACHES TO IMPROVE OUTREACH

In addition to the above measures improving outreach would require:

Reorganisation of MPW Work Schedule

MPWs may be required to tour for three days a week, instead of the present one or two days a week. One day a week should be devoted to review and drawing supplies from APHC. The remaining two days a week should be devoted to clinical work and other services provided at the sub centre. These two days are fixed and her clientele should know that she is available there in headquarters on these two days. In each field visit day, he/she would visit a specified number of houses and hold meetings with one of the four identified focal groups. Once a month he/she should attend to Block level review and training. If there are two MPWs posted their two days at the headquarters may be fixed such that the sub centre is open on four previously specified days every week, which is better than the current one day a week.

Integration with ASHA Programme

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

Revised MPW Job Description

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

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

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

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

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

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

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

Outreach Strategies to Enhance Access

Lack of roads and transport facilities and natural obstacles and high degree of scatter of hamlets within a section or sector add to the problems of access. These problems are not remediable by increasing facilities beyond the norms. Instead they need a high degree of community support and a high degree of planning and rationalization of the work of the various categories of staff already available. Camps

are the major outreach strategies aimed to close outreach gaps but their effectiveness and even their occurrence in most areas is far from certain.

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

Staff Situation and their Utilization with Relation to Functionality of Centers

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

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

Rationalisation of Drugs and Consumables Supply

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

Rationalization of Equipment

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

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

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

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

Infrastructure Adequacy

The shortfalls in basic availability of buildings are well known. It is in the range of approx 25% for HSCs. PHC are all in government owned buildings but as yet only an estimated 100% are upgraded to the 30-bed PHC norm. Toilet construction and maintenance too are major infrastructure inadequate. Maintenance of buildings is also poor and most buildings are old and need extensive renovation or replacement.

Problems with electricity supply are minimal and generator back up is usually available where there are problems. Problems with water supply are however considerable. Most of these facilities have a bore-well and hand-pump so that they are functional. However any hospital with inpatient facilities, even if it were for only conducting normal delivery would require running tap water, bathing facilities and toilets separately for staff and for patients. Yet only one third of PHC and Referal Hospital and none of APHC have such a water supply arrangement. Waste management based on segregation of wastes with proper disposal of each category of biological waste is a relatively untouched area of intervention.

Table 4.5: Performance indicators of Health Infrastructure

	District Plan Objectives	Current levels*	Target for 2007-12	Suggested Strategies and Activities
1.	Number of ASHA functional in the district (received induction training)	2026	2376	▪ Trainings for ASHA ▪ Selection of more 350 ASHA. o Finish training of ASHA o Monitoring of working capacity of ASHA

	District Plan Objectives	Current levels*	Target for 2007-12	Suggested Strategies and Activities
				o Increase incentives for ASHA working in difficult areas
2.	Number of HMS registered/ established		HMS formed in all PHC & APHC	▪ Establishment of HMS o Selection of members ▪ Functioning of HMS o Clear guidelines for working of HMS o Guidelines for expenditure of maintenance grant o Orientation and training of elected HMS members o Decentralizing the procedure by appointing other representatives
3.	Number of health care delivery institutions upgraded - HSCs - APHCs - PHC to FRUs			▪ Upgradation of health institutions in conformity with IPHS o Subcenters in government building o Availability of facilities like water supply, electricity, labour table o Part-time *dai* at subcenter o Incentives for ANMs working in difficult areas o Posting of LMOs at APHC and PHC o Training of LMOs regarding EmOC o Posting of gynecologists, anesthetist, and pediatrician at PHC o Blood storage center at PHC o Adequate equipments and supply of other material
4.	VHSC constituted - Grants given			▪ Constitution of VHSC o Guidelines for VHSC o Orientation of VHSC members o Organization of training for sensitizing members on working mechanism o Roles and responsibilities fixed for each member of the committee o Coordination between health and sanitation initiatives
5.	Number of HSCs, APHCs strengthened - Additional ANMs hired - Annual maintenance grants given			▪ Strengthening infrastructure of health centers o Carry out civil work for SCs with respect to building, running water supply and electricity o Involvement of gram *Panchayat* for taking land for construction

	District Plan Objectives	Current levels*	Target for 2007-12	Suggested Strategies and Activities
				of SC/ PHC/PHC o Ensure equipment and drug supply ▪ Refresher training course for ANM ▪ Posting of LMO and staff nurse at APHC ▪ Directions for use of maintenance grant o Regular monitoring and reporting system for used grant
6.	Number of APHC strengthened to provide 24x7 - 3 staff nurses hired - Annual maintenance grants given			o
7.	Staff for mobile medical units in place			▪ Strengthening of Medical Mobile Units for both preventive and curative care o Availability of conveyance and staff workers (radiologist, LMO, X-ray technician, ECG technician, LT, pharmacist, driver) o Availability of equipments and medicine
8.	Number of facilities to be covered for facility survey - HSCs - APHC - PHC			o Implementation of activities to fill in the identified gaps
5.	Number of villages to be covered for HH survey			
10.	Number of community hearings planned			▪ Organization of regular community meetings at SC and PHC level ▪ Integration with ASHA and PRI
11.	District training plan developed and implemented		**District training plan in place & implemented**	▪ **Formulation of district training plan** o Recognition of need of trainings o Organization of trainings as per state guidelines o Refresher training of paramedics on minor ailments o Training of MOs for managerial skills, EmOC o Training of ANMs for ANC, DOTS
12.	District BCC plan developed and implemented		**District BCC plan**	▪ **Formulation of district BCC plan** o Assessment of communication

	District Plan Objectives	Current levels*	Target for 2007-12	Suggested Strategies and Activities
			developed & implemented	needs in the context of NRHM ▪ Development of communication plan and its implementation o Use of print media, folk, T.V. and radio
13.	District procurement and logistics plan developed		**District logistic plan developed & implemented**	▪ **Formulation of need based plan** for streamlined procurement and logistics o Provide required equipments o Financial planning for reaching of supplies at various levels including ASHA o Well established supply chain
14.	Number of APHC/PHC where AYUSH physicians posted			▪ **Posting of AYUSH practitioners** o Relocation and appointment of physicians o Coordination with other private health facilities

***Source: District Project Management Unit**

4.3.3 Blindness Control Programme

National Programme for Control of Blindness was launched in the year 1976 as a 100% centrally sponsored programme. Various activities of the programmes include establishment of Regional Institute of Ophthalmology, up gradation of medical colleges and district hospitals and block level Primary Health Centres, development of mobile units, and recruitment of required ophthalmic manpower in eye care units for provision of various ophthalmic services. The programme also extends assistance to voluntary organizations for providing eye care services including cataract operations school screening.

The achievements of NBCP are tabulated below:

Table 4.12: Achievements of the National Blindness Control Programme (2008-09)

Particulars	Achievement
No. of Urban Eye Camps	
No. of Cataract operations (Total)	
No. of School Screening	
No. of refractive error	

Constraints:

- Lack of Education among the masses about the existing facilities: Need of wide publicity.
- Shortage of quality Equipment and medicine.
- Apathy and indifference on the part of health personnel.
- Lack of adequate referral services to take care of complications.

- People have tendency to neglect the aged family members.
- Post operative follow up of people is not being done properly.
- Fear of eye operation.
- Old myths are still prevailing.

Suggestions:

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

Table 4.13: Performance Indicator for NBCP

	District Plan Objectives	Current levels*	Targets for 2007-12	Strategies
1.	Cataract surgery rate (per lakh)			Conductance of no. of eye camps in coordination with (NGO)Jai Ambe Welfare , Society strengthening service delivery developing human resources for eye care promoting outreach activities and public awareness and developing institutional capacity
2.	Percent surgery with IOL			
3.	School Eye Screening: children in the age group of 10-14 years should be screened for refractive errors			
4.	Oral Health Screening for - Community - School children			

*** Source: District Blindness Control Programme**

4.3.5 Leprosy Eradication Programme

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

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

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

Unlike some other diseases, such as tuberculosis, there does not appear to be a connection between leprosy and HIV infection. With the implementation of MDT (Multi Drug Therapy) services under the programme since 1583, a large number of leprosy cases have been discharged as disease cured.

The goal of leprosy elimination is that prevalence rate should be less than one case per 10,000 populations in the coming years. The focus is now being made on voluntary reporting of cases by promoting intensive IEC / BCC.

Table 4.14: Indicators showing achievements of NLEP 2008-09

Indicators	Status
New case detection	
M.B.	
P.B.	
S.S.L.	
Patients put on treatment	
M.B.	
P.B.	
S.S.L.	
Patients treated & discharged	
Disability cases	
Grade I	
Grade II	

Suggestions

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

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

Table 4.15: Performance indicators for Leprosy Programme

	Indicators	Current level*	Target for 2007-12	Strategies
1	Prevalence rate (PR) - leprosy cases per 10,000 population			Conductance of timely surveillance Orientation trainings to new staff Organization of POD camps Conductance of sensitization workshop at gram panchayat involving new panchayat representative Organization of skin diseases diagnosis and education camps Conductance of urban leprosy awareness camps Procurement of TV, VCD, Camera, Mike for IEC Implementation of PFMS (Project Financial Management System)
2	ANCDR – New leprosy cases per 11,00,000 population			
3	Proportion of patients completed treatment			
4	POD Camps			
5	Gram Goshthi			
6	Hat – Bazar			
7	School Awareness			
8	Health Mela			

4.3.6 Tuberculosis Control programme

Tuberculosis (TB) is an infectious disease caused by a bacterium, Mycobacterium tuberculosis. It is spread through the air by a person suffering from TB. A single patient can infect 10 or more people in a year. DOTS, known as the Revised National Tuberculosis Control Programme (RNTCP) in India, are a comprehensive strategy for TB control. DOTS are the only strategy which has proven effective in controlling TB on a mass basis.

India has adapted and tested DOTS in various parts of the country since 1953, with excellent results, and the RNTCP now covers more than 120 million populations. The Revised National Tuberculosis Programme (RNTCP) was launched in the country on 26 March 1957.

Table 4.16: Indicators showing achievements of RNTCP 2008-09.

S.No.	Particulars	Status
1	Total Number of OPD	
2	No. of patients whose sputum were examined for diagnosis	
3	No. of Smear Positive patients diagnosed	
4	Total Patients Registered & put on DOTS	

	a) New Smear Positive	
	b) New Smear Negative	
	c) New Extra-Pulmonary	
	d) Re-treatment cases	
5	No. of Patients put on Non-DOTS	
6	Total Patients under treatment	
7	Annualised case detection rate	

- TB prevalence estimate for the district per lakh is 257
- Drugs, supplies and equipments as well as required staff are provided to districts
- Regular training, orientation programmes and awareness campaigns are being done
- Full treatment currently to 196 patients through DOTS providers

Suggestions

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

- Increasing referral from the field and from OPD, mobilizing community participation, ensuring involvement of Private practioners, NGOs and other sector, intensifying supervisory activities and intensifying IEC activities
- TB has a cure, and treatment is inexpensive
- TB control is a very cost-effective health intervention equivalent to that of the well known childhood immunization programmes.
- Successful treatment demands education and timely follow-up examination to achieve sputum conversion & cure rate up to the desired level.
- Successful treatment requires 6-8 months of consistent, uninterrupted medication
- New drop resistant strains of TB are developing because patients are not completing their treatment. These drug-resistant strains are significantly more dangerous to the individual and the community because they are more difficult and more expensive to treat.
- The best was to prevent TB is to cure infectious cases in their early stages in order to prevent transmission to others.
- TB, control programmes that treat infectious patients by don't ensure that they are cured risk doing more harm than good. Patients who have incomplete treatment can develop and spread drug-resistant TB.

Table 4.17: Performance Indicator for RNTCP

	District Plan Objectives	Current levels*	Targets for 2007-12	Suggested strategies

1.	Proportion of TB suspects examined out of the total outpatients			Increasing the awareness/ visibility of DOTS among rural masses by distributing pamphlets and conducting group discussions with villagers Provide facilities for diagnosis of TB Patients through integrated general health services. Provide optimum treatment nearer to the residence of the patients. To prevent infection, immunization is done by doing BCG Vaccination. Health Education to encourage patients through Health Workers, their relatives and village leaders to take full course of treatment. Detection of New TB cases (Sputum positive, X-ray suspects and extra pulmonary cases)
2.	Annualized New Smear Positive (ANSP) case detection rate per 100,000 population			
3.	Annualized Total case detection rate per 100,000 populations			
4.	Treatment success rate			

***Source: District TB Control Programme**

4.3.7 Filaria control Programme

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

Constraints

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

Suggestions

1. Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.
2. Continuous use of vector control measures.
3. Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.

4. IEC for ensuring community awareness and participation in vector control as well as personal protection measures.

4.3.8 Disease surveillance programme

Constraints:

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

Suggestions

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

4.3.9 ASHA programme:

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

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

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

4.3.10 Urban Health

On the basis of the study work it is quiet obvious that people should be prepared for tackling any kind of disaster and at the same time government should make necessary arrangement for making people aware. Different media of mass communication, awareness and others should be used for creating consciousness. Not only government agencies, but NGOs are also expected to create mass

awareness. Inclusion of disaster preparedness into school curriculum should be mandatory as in other disaster prone countries. Targeting children will create an aware generation and minimize life risks.

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

4.3.11 Logistics Management

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

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

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

4.3.12 Intersectoral Convergence

4.3.12.1 Coordination with ISMs

There is a large workforce and institutional and infrastructure base within the health department that is willing to contribute to RCH goals but has been used only minimally for this purpose.

4.3.12.2 Coordination with ICDS and PHED

Meeting is held at District level for the coordination of Health Department. Health officials have little faith in coordinating with ICDS and PHED. The vision of intersectoral approach is lacking. More details about ICDS and PHED are provided in the annexures.

4.3.12.3 Coordination with Panchayats

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

4.3.13 Infrastructure and Service Delivery Issues

Training and Capacity Building

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

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

Capacity building

Environmentally-related childhood diseases represent an enormous public health problem, particularly in developing countries and impoverished communities, where there is often lack of awareness and knowledge about the effects of chemicals and other environmental hazards on children's health.

- Handbook on Children's Environmental Health - a collection of information that focuses mainly on the needs of developing countries.
- Children's Environmental Health (EH) for the Primary Health Care Sector – preparation of a simple training guide and incorporation of EH concepts into existing first level health care services (e.g. into the Integrated Management of Childhood Illnesses (IMCI).
- Training Package for Health Providers
- Leaflets for health care providers - concise information on what health care professionals should know about selected environmental risks (e.g. water pollution, lead, chemicals……)
- Pilot Training Activities – for the peer review and field testing of existing materials, using a "train the trainers" approach
- Presentations given by experts, visitors.

The study recognizes that the financing or health care is an important issue and that budgetary allocations on each facility workforce relate to outcomes. Also that what is adequate utilization or wasteful relates to amount of investment that has gone into it. These financial aspects are the subject matter of the subsequent study.

Mapping the private sector and exploring its possibility of synergy with the public health system and developing a policy framework for its growth and regulation are yet another issue that we have not addressed.

Chapter 5

Work Plan

5.1 Proposed Activities with Reference to Time Frame

To make suggested strategies and activities more accountable a model work plan has been developed. In the matrices below, proposed activities for the performance indicators have been planned year-wise to give a broad picture as to when the activity could happen. Besides, persons/departments that share the responsibility for primary activities have also been broadly demarcated.

5.1.1 Work Plan for RCH

NRHM envisage to have an substantial impact on: (*i*) reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR); (*ii*) universal access to integrated comprehensive public health services; (*iii*) child health, water, sanitation and hygiene; (*iv*) prevention and control of communicable and non-communicable diseases, including locally endemic diseases; (*v*) population stabilization, gender and demographic balance; (*vi*) revitalize local health traditions and main-stream Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health (AYUSH); (vii) promotion of healthy life styles.

Table 5.1: Work plan for RCH

	Activity	Time Frame (from 2009-20012) In percentage		
		09-10	10-11	11-12
	Objective			
	Universal coverage of all pregnant women with package of quality ANC services as per national guidelines	70.0	80.0	95.0
	Increase in deliveries with skilled attendance at birth including institutional deliveries	65.0	75.0	90.0
	FRUs (including DHs, PHC/APHC) made functional as defined in the National RCH- 2 PIP	45	65	76
	Activities			
	Block level microplanning to find gaps in infrastructure, manpower, skills & equipments	-	-	-
	Filling of equipment gaps	-	-	-
	Streamlining procurement and distribution mechanism for supplies at PHC and APHC.			
	Performance incentives for staff			
	RCH Camps (Minimum of 2 camps per block)	To complete	To complete	To complete
	Appointment of contractual staff (ANM, LHV and staff nurse)	To complete	To complete	To complete

	Posting of specialists at PHC	09 PHC	-	-
	Referral transport	09 PHC	-	-
	PPP for ambulance services	09 PHC	-	-
	PPP for EmOC centres		-	-
	24 hour delivery services at PHC and APHC	09 PHC	-	-
	Training to dais/SBAs (7 day programme)	SBA training 6 batches	-	-
	Motivational workshops (1 day)	09 Blocks	09 Blocks	09 Blocks
	Involvement of private sector/nursing homes to improve institutional deliveries	To complete		
	IEC and BCC activities			
	Objective			
	Universal coverage of all eligible pregnant women under JSY scheme	65%	80%	90%
	Ensuring all eligible women covered under Janani Suraksha Yojana	65%	80%	90%
	Objective			
	Increase in percentage of new born babies given colostrums	50%	75%	95%
	Increase in prevalence of exclusive breast-feeding	90%	95%	98%
	Percentage of severely malnourished children below 6 years referred to medical institutions	15%	15%	20%
	Strengthen referral network			
	Orientation of AWWs, SHG women and ASHA on importance of breast feeding (1 day)			
	Workshop on provision of low cost nutritious food to AWWs, SHG women and ASHA (1 day)			
	Workshop on gender related sensitization to MOs (2 day)			
	Reorientation training to service providers			
	IEC for behaviour change of community	20%	20%	20%
	Unmet demand for contraception - Total - Spacing - Limiting	 1.2% 15%	 0.5% 10%	 0.1% 5%
	Increasing Number of government health institutions providing i) Female sterilization services ii) Male sterilization services iii) IUD insertion services	 50% 11% 3.5%	 60% 12% 5.5%	 65% 15% 7%
	Compensation on sterilization	To complete	To complete	To complete
	Organization of Cu-T insertion camp	To complete	To complete	To complete
	Organization of sterilization camps	To complete	To complete	To complete
	Multi-skill training to staff/ MOs for sterilization techniques	To complete	To complete	To complete
	Procurement of laparoscopes	To complete	To complete	To complete
	Social marketing of family planning devices	To complete	To complete	To complete
	Provision of Medical Termination of Pregnancy	To complete	To complete	To complete
	IEC for promotion of male and female sterilization	To complete	To complete	To complete

	Training to MOs on management of RTI/STI (3 day)	To complete	To complete	To complete
	Health check up and partner treatment camps	To complete	To complete	To complete
	Adequate medicine supply for RTI/STI management	To complete	To complete	To complete
	Training on adolescent counseling (to NGOs, paramedical staff, SHG women, AWWs, ASHA (3 day)	To complete	To complete	To complete
	Educational programmes in schools			
	Counseling day at block PHC/CHC	Once a month	Once a month	Once a month
	Honorarium to counselors			
	Establish link with private practitioners			
	Special interventions			
	PNDT campaign	1/year	1/year	1/year
	Capacity Building of Staff			
	Strengthening working capacity of ASHA	Once in a month at AWC	Once in a month at AWC	Once in a month at AWC
	Family health camps at district level (3 day)	1/year	1/year	1/year
	Institutional strengthening			
	Repair/renovation of HSCs	35		
	Construction of new HSCs	100	100	25
	Construction of new APHC	25	15	11
	Construction of new PHC	NIL	NIL	NIL
	Operationalization of mobile clinics	01	-	-
	Adequacy of equipments at health centers			
	Formation of Urban Health Center	4	-	-
	Establishment of Trauma center		-	-
	Regular monitoring and evaluation at blocks and district	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks

5.1.2 Work Plan for Health Infrastructure

Functional and accountable infrastructure being an essential prerequisite for an effective health delivery system a set of strategies has been neatly designed taking into consideration already existing infrastructure and the possible constraints.

Table 5.2: Work Plan for Health Infrastructure

	Activity	Time Frame (from 2009-2012)			Responsibilities
		09-10	10-11	11-12	
1	Finish training of ASHA	350	2376	2376	Civil Surgeon, MOIC
2	Monitoring of working capacity of ASHA	To complete	To complete	To complete	Civil Surgeon, MOIC
3	Increase incentives for ASHA working in difficult areas	Ensuring in 6 blocks	Ensuring in 6 blocks	Ensuring in 6 blocks	Civil Surgeon, MOiC
4	Selection of members	HMS formed in all PHC	HMS formed in all PHC	To complete	Civil Surgeon, MOIC

	Activity	Time Frame (from 2009-2012)			Responsibilities
		09-10	10-11	11-12	
5	Orientation of selected members	-	-	To complete	Civil Surgeon, MOIC
6	Guidelines for functioning of committees	-	To complete	-	Civil Surgeon, MOIC
7	Provide government building to existing sub centres	50	50	39	Civil Surgeon
8	Construction of new sub centres	100	100	25	Civil Surgeon
5	Filling up vacant posts for ANM and MPW at sub-centres	To complete	To complete	To complete	Civil Surgeon
10	Additional ANM at sub-centre	To complete	To complete	To complete	MOiC
11	Grant for maintenance and contingency at sub-centre level	To complete	To complete	To complete	MOiC
12	Infrastructural set-up for PHC			-	Civil Surgeon
13	Recruitment of specialists (gynecologist, surgeon, pediatrician and anesthetist)	-	-	-	Deputy Commissioner, Civil Surgeon
14	Contractual appointment of staff nurse and LTs				DHS
15	Provision of electricity, water supply and staff quarters at APHC	-	-	-	DHS
10	Deployment of medical doctors at PHC level	-	-	-	Civil Surgeon
17	Repair and maintenance of equipments	-	-	-	MOIC
18	Specialized management training (for BMOs, DPOs and DPM)	-	-	-	State Training Co-ordinator
15	Specialized communication training (for BEEs, NGOs & media officers)	-	-	-	State Training Co-ordinator
20	Awareness generation training for health workers, link workers, ICDS workers, SHG leaders and PRI members	-	-	-	State Training Co-ordinator
21	Multiskilling training for paramedical staff	-		-	State Training Co-ordinator
22	Refresher training course for ANMs	-		-	State Training Co-ordinator
23	Selection of members for VHSC	-	-	-	Civil Surgeon, MOIC

	Activity	Time Frame (from 2009-2012)			Responsibilities
		09-10	10-11	11-12	
24	Establishment of guidelines for functioning of committee	-	-	-	Civil Surgeon, MOIC
25	Interaction between MPWs/ANMs, AWWs and ASHA	-	-	-	Civil Surgeon, MOIC
26	Development of guidelines	-	-	-	Civil Surgeon MOIC
27	Regular monitoring and reporting system for used grant	-	-	-	Civil Surgeon MOIC
28	Appointment of staff	-	-	-	Deputy Commissioner, Civil Surgeon
	Availability of conveyance	-	-	-	Civil Surgeon
	Adequate equipments and medicines	-	-	-	Civil Surgeon, MOiC
28	Monthly meeting conducted at sub-centre level	Once a month	Once a month	Once a month	MOiC
25	Meeting at PHC level to review problems related to health delivery mechanism	Once a month	Once a month	Once a month	MOiC
30	Organization of training as per state guidelines	-	-	-	Civil Surgeon
31	District level training of MOs for managerial skills and EmOC	-	-	-	Civil Surgeon
32	Assessment of communication needs in the context of NRHM	To complete	To complete	To complete	Civil Surgeon
33	Use of print media, folk media, T.V. and radio	To complete	To complete	To complete	Civil Surgeon
34	Financial planning for reaching of supplies at various levels	Ensuring Supply in 09 Blocks	Ensuring Supply in 09 Blocks	Ensuring Supply in 09 Blocks	Civil Surgeon
35	Well established supply chain	Ensuring Supply in 09 Blocks	Ensuring Supply in 09 Blocks	Ensuring Supply in 09 Blocks	Civil Surgeon
36	Appointment of AYUSH practitioners at PHC/PHC	-	-	-	Deputy Commissioner, Civil Surgeon
37	Integration with private doctors at village level	To complete	-	-	Civil Surgeon

5.1.3 Work Plan for Child Immunization

Table 5.3 Work plan for child immunization

	Activity	Time Frame (from 2009-2012)			Responsibilities
		09-10	10-11	11-12	
1	Cold chain maintenance for quality assurance of vaccine	Ensuring Supply in 9 Blocks	Ensuring Supply in 9 Blocks	Ensuring Supply in 9 Blocks	Civil Surgeon, MOiC
2	Improving transport system	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Civil Surgeon, MOiC
3	Monitoring mechanism for adequate supply	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Civil Surgeon, MOiC
5	Organization of weekly immunization day at sub-center	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Civil Surgeon, MOiC
6	Fill-up vacant post of ANMs	-	-	-	Deputy Commissioner, Civil Surgeon
7	Pulse polio immunization camps	-	-	-	Civil Surgeon, MOiC
8	Catchup round	-	-	-	Civil Surgeon
5	Close coordination between ANM, AWW and ASHA	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Ensuring in 9 Blocks	MOiC
10	Safe injection practices (provision of disposable syringes)	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Ensuring in 9 Blocks	MOIC
11	Identification of areas with low immunization coverage	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Ensuring in 9 Blocks	MOIC
12	Involving AWWs, NGOs, ASHA and Panchayat on immunization day	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Ensuring in 9 Blocks	MOIC
13	Orientation and awareness generation training for health workers	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Ensuring in 9 Blocks	MOIC

5.1.4 Work Plan for Kala- azar under NVBDCP

Table 5.4: work plan for Kala - Azar Control

	Activity	Time Frame (from 2009-20012)			Responsibilities
		09-10	10-11	11-12	
1	Use of video display, posters, pamphlets, booklets, wall painting and street plays	To complete in each block	To complete in each block	To complete in each block	District Malaria Officer
2	Coordination with school education	To complete in each block	To complete in each block	To complete in each block	District Malaria Officer
3	Fortnightly door to door surveillance by health worker	-	-	-	District Malaria Officer
4	Increase blood smear collection	-	-	-	Civil Surgeon, District Malaria Officer
5	Transportation of slides from collection point to laboratory on daily basis	-	-	-	District Malaria Officer
6	Functional laboratory at PHC/PHC level	-	-	-	Civil Surgeon
7	Blood examination center at each block	-	-	-	Civil Surgeon
8	Appointment of lab technicians	-	-	-	Civil Surgeon
5	Insecticidal sprays at high risk areas	To complete in each block	To complete in each block	To complete in each block	District Malaria Officer
10	Promotion of Gambuzia culture	-	-	-	District Malaria Officer
11	Distribution of medicated mosquito nets	-	-	-	District Malaria Officer
12	Acceptance/ treatment of usage of herbal medicine	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Civil Surgeon

5.1.5 Work Plan for RNTCP

Table 5.5: Work plan for TB control

	Activity	Time Frame (from 2009-20012)			Responsibilities
		09-10	10-11	11-12	
1	Interpersonal communication by local health workers, NGOs and Panchayat	Ensuring in 9 Blocks	Ensuring in 9 Blocks	Ensuring in 9 Blocks	DTO, MOiC
2	Use of posters, pamphlets, wall paintings and street plays	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DTO, MOiC
3	Increase awareness of DOTS	Dissemination on VHN day	Dissemination on VHN day	Dissemination on VHN day	Health Worker, ICDS, NGO, PRI, Education Department
4	Community participation	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Health Worker, ICDS, NGO, PRI, Education Department
5	Involvement of private practitioners	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DTO , MOIC, BHM
6	Promote case detection through sputum microscopy	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DTO , MOIC, BHM
7	Complete treatment	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DTO , MOIC, BHM
8	Increase accessibility to treatment	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DTO , MOIC, BHM
5	Follow-up examination to achieve sputum conversion	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DTO , MOIC, BHM
10	Establishment of TB cells at block level	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DTO , MOIC, BHM
11	Quality assurance of sputum smear	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DTO , MOIC, BHM
12	Regular and uninterrupted supply of drugs	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DTO , MOIC, BHM
13	Systematic monitoring and evaluation	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DTO , MOIC, BHM

	Activity	Time Frame (from 2009-20012)			Responsibilities
		09-10	10-11	11-12	
14	Appointment of field staff	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Civil Surgeon, DTO, MOIC
15	Training to DOTS providers	Refresher Training	-	-	Civil Surgeon, DTO
10	Sensitization training to MOs providing treatment at block level	-	Refresher Training	-	Civil Surgeon, DTO

5.1.6 Work Plan for NBCP

Table 5.6: Work plan for Blindness control

	Activity	Time Frame (from 2009-20012)			Responsibilities
		09-10	10-11	11-12	
1	Organization of eye camps in collaboration with private agencies/ institutions	Thrice at block level	Thrice at block level	Thrice at block level	DTO , MOIC, BHM
2	Integrate eye care as a part of primary health care	-	-	-	
3	Availability and repair of necessary equipments	Ensuring in 09 Blocks	Ensuring in 09 Blocks	Ensuring in 09 Blocks	DBO, MOiC, DPM
4	Posting of eye-surgeon at block level	-	-	-	Civil Surgeon
5	Follow-up of treated cases	Regular Monitoring at each block	Regular Monitoring at each block	Regular Monitoring at each block	DTO , MOIC, BHM
6	Quality control mechanism	-	-	-	MOIC, DBO
7	Streamlined vitamin-A supply	Ensuring in 09 Blocks	Ensuring in09 Blocks	Ensuring in 09 Blocks	DBO, MOIC, DPM
8	Availability of medicines during eye camps	Strenghthen procurement & Supplies	Strenghthen procurement & Supplies	Strenghthen procurement & Supplies	CIVIL SURGEON, DBO, BHM
9	Sensitization work Shop at block level for MOs and health workers	09 (once at each block)	09 (once at each block)	09 (once at each block)	DBO, MOIC, BHM
10	Technical training of ophthalmic medical assistants at district for	-	-	-	CS, DBO,

	Activity	Time Frame (from 2009-20012)			Responsibilities
		09-10	10-11	11-12	
	skill up-gradation and new techniques				
11	Behaviour change of community to increase treatment acceptance	-	-	-	CS, DBO, DPM
12	Interpersonal communication by health workers and ICDS workers	-	-	-	DBO, DPM, MO I/C, BHM
13	Use of print media, mass media and folk media	-	-	-	DBO, MO I/C, BHM

5.1.7 Work Plan for NLEP

Table 5.7: Work plan for Leprosy eradication

	Activity	Time Frame (from 2009-20012)			Responsibilities
		09-10	10-11	11-12	
1	Recruitment of field staff	-	-	-	
2	Orientation training of new staff	One training programme	One training programme	One training programme	
3	Updating records				DLO, DA
4	Increase case detection and referral for treatment	-	-	-	CS, DLO
5	Case validation and re-registration	-	-	-	MO I/C, DLO
6	Organization of POD camps	-	-	-	
7	Organization of Skin Disease Diagnosis, Treatment & Education Camps in remote and inaccessible areas	-	-	-	MO I/C, DLO
8	Urban leprosy awareness camps	-	-	-	CS, DLO
5	Procurement of IEC equipments	-	-	-	CS, DLO
10	Sensitization workshop for panchayat members to motivate them for community education	09 (once at each block)	-	-	CS, DLO
11	Proper counseling by health worker and MOs to prevent deformities	09 (once at each block)	09 (once at each block)	09 (once at each block)	CS, DLO
12	Sensitize community for self reporting	-	-	-	DLO, MEO

	Activity	Time Frame (from 2009-20012)			Responsibilities
		09-10	10-11	11-12	
13	Sensitization workshop at gram Panchayat	-	-	-	CS, DLO DPM, BHM
	Community mobilization through interpersonal communication, print media and folk media (in local dialect)	-	-	-	CS, DLO DPM, BHM
14	Provide personal support and psychological assurance	-	-	-	DLO

Chapter 6

Monitoring and Evaluation

6.1 Introduction

Monitoring and Evaluation is a key and integral part of NRHM and systems are in place at each level to ensure the monitoring for smooth progress. The Mission Steering Group (MSG) has been set up at the Center and further the Empowered Programme Committee has also been set up to monitor the progress. The various societies at the state and the district level have been merged into an Integrated Society at the state level where it is the executive arm of the State Health Mission.

Monitoring and Evaluation plan would help in providing an overview of progress that has to be addressed during monthly review meetings held at different levels of the health system. It is strongly recommended that all activities are monitored and integrated at different levels of the health system to address the specific NRHM requirements and collated into a single format. As the aim is to ultimately institutionalize quality assessment in routine monitoring, the performance evaluation mechanism will mostly rely on ongoing monthly reports, progress report concurrent and mid-term and end-line surveys.

In line with the objective set and work plan finalized, subsequent section details out the monitoring and evaluation indicators in matrix form for each programmatic area.

6.1.1 Monitoring and Evaluation Matrix for Health Infrastructure

Activity	Indicator	Means of verification
Strategy 1: Training of ASHA		

Activity	Indicator	Means of verification
Finish training of ASHA	Number of ASHA trained	DPMU Report
Monitoring of ASHA	Monitoring mechanism in place	DPMU Report
Strategy 2: Establishment of HMS		
Selection of members	opening of bank accounts for HMS members Development and acceptance of model MOU Meetings of CPS/ HMS/ HMS	DPMU Report
Strategy 3: Functioning of HMS		
Clear guidelines for working of HMS	Guideline formulated and Number of HMS members oriented Number of orientation/ training session held	DPMU Report
Guidelines for expenditure of maintenance grant		
Orientation and training of elected HMS members		
Strategy 4: Upgradation of health institutions		
Provide government building to existing sub centres	Number of sub centres to be provisioned in government building	DPMU Report/CMO Report /Health MIS
Construction of new sub centres	Number of sub centre constructed	DPMU Report/CMO Report /Health MIS
Filling up vacant posts for ANM and MPW at sub-centres	Number of ANM and MPW recruited	Health MIS/DPMU Report
Additional ANM at sub-centre	Number of additional ANM recruited at sub centre	Health MIS/DPMU Report
Grant for maintenance and contingency at sub-centre level	Grants for maintenance and contingency level provided at sub-centre level	Health MIS/DPMU Report
Infrastructural set-up for PHC	Number of PHC Strengthened	
Recruitment of specialists (gynecologist, surgeon, pediatrician and anesthetist)	Number of specialists recruited (gynecologist, surgeon, pediatrician and anesthetist)	
Contractual appointment of staff nurse and LTs	Number of LTs appointed on contractual basis	
Provision of electricity, water supply and staff quarters at APHC	Number of APHC wherein provision of electricity, water supply and staff quarters are made	
Strategy 3: Human resource development		
Specialized management training (for BMOs, DPOs and DPM)	Number of management training programme organized for BMOs, DPOs and DPM	Health MIS/Training Plan
Specialized communication training (for BEEs, NGOs & media officers)	Number of training programme organized for BEEs, NGOs & media officers	
Awareness generation training for health workers, link workers, ICDS workers, SHG leaders and PRI members	Number of awareness generation training organized for health workers, link workers, ICDS workers, SHG leaders and PRI members	
Multiskilling training for paramedical staff	Number of paramedical staff trained	
Refresher training course for ANMs	Number of refresher training course for ANMs	
Strategy 5: Constitution of Village Health and Sanitation Committees		

Activity	Indicator	Means of verification
Guidelines for VHSC	Number of HMS members oriented	DPMU Report
Strategy 5: Integration with ASHA programme		
Interaction between MPWs/ANMs, AWWs and ASHA	Number of meetings held between MPWs/ANMs, AWWs and ASHA	Health MIS/MOs Report
Strategy 6: Directions for use of maintenance grant at each level		
Development of guidelines	Guidelines developed and formed	CMO office Report
Regular monitoring and reporting system for used grant	Regular monitoring and reporting system in place	
Strategy 7: Organization of community meeting		
Monthly meeting conducted at sub-centre level	Number of monthly meeting organized a sub centre level	DPMU/Block MOs Report
Meeting at PHC level to review problems related to health delivery mechanism	Meetings organized at the PHC level	
Strategy 8: Formulation of district training plan		
Recognition of need of trainings	Training need identified	DPMU Report/CMO Report /Health MIS
Organization of trainings as per state guidelines	Number of training organized	
Refresher training of paramedics on minor ailments	Number of paramedics trained	
Training of MOs for managerial skills, EmOC	Number of MO's, ANM identified	
Training of ANMs for ANC, DOTS		
Strategy 5: Formulation of district BCC plan		
Assessment of communication needs in the context of NRHM	Assessment of communication needs	DPMU Report/CMO Report /Health MIS
Strategy10: Streamlined procurement and logistic supply plan		
Financial planning for reaching of supplies at various levels	Financial Plan at each level in place	DPMU Report
Well established supply chain	Establishment of supply chain	
Strategy 11: Coordination with private practitioners/ institutions		
Appointment of AYUSH practitioners at PHC/PHC	Number of AYUSH physicians relocated and appointed	DPMU Report
Integration with private doctors/ISMP at village level	Number of private practitioners involved	DPMU Report

6.1.2 Monitoring and Evaluation Matrix for Immunisation

Activity	Indicator	Means of verification
Strategy1: Streamlining cold chain system		
Cold chain maintenance for quality assurance of vaccine	Institution wherein cold chain is established and streamlined	Logistic Plan/MIS
Strategy 2: Logistics of vaccine and disposable supply		
Improving transport system	Transportation system improved	CMO office Report/ Nodal officers Report
Monitoring mechanism for adequate supply	Monitoring mechanism in place	CMO office Report/ Nodal officers Report
Strategy 3: Strengthening service delivery		
Organization of weekly immunization day at sub-center	Number of weekly immunization day at sub-center	Monthly Progress Report/Health MIS

Activity	Indicator	Means of verification
Fill-up vacant post of ANMs	Number of ANMs recruited on contractual basis	Monthly Progress Report/Health MIS
Pulse polio immunization camps	Number of pulse polio immunization camp organised	Monthly Progress Report/Health MIS
Catchup round	Number of catch up round organised	Monthly Progress Report/Health MIS
Close coordination between ANM, AWW and ASHA	Cordination meeting organized and grievance addressed between ANM, AWW and ASHA	Block MO's Report
Strategy 4: IEC for behaviour change of community		
Identification of areas with low immunization coverage	Number of low immunization coverage area	DPMU Report/Health MIS
Involving AWWs, NGOs, ASHA and panchayat on immunization day	Number of AWWs, NGOs, ASHA and panchayat involved on immunization day	
Orientation and awareness generation training for health workers	Number of orientation and awareness generation training for health workers	

6.1.3 Monitoring and Evaluation Matrix for Vector Borne Disease Programme

Activity	Indicator	Means of verification
Strategy1: IEC activities		
Use of video display, posters, pamphlets, booklets, wall painting and street plays	Number of video display, posters ,pamphlets and street plays organised	Health MIS/Communicatio n Plan
Coordination with school education	Number of school involved as part of school education	
Strategy 2: Increased surveillance		
Fortnightly door to door surveillance by health worker	Number of door to door surveillance programme organized by health worker	
Strategy 3: Early diagnosis and prompt treatment		
Increase blood smear collection	Percentage increase in blood smear collection	Health MIS/Nodal officers Report
Transportation of slides from collection point to laboratory on daily basis	Percentage increase in slides transported from collection point to laboratory on daily basis	
Strategy 4: Strengthening laboratory facilities		
Functional laboratory at PHC/PHC level	Number of functional laboratory at PHC/PHC level	Health MIS/Nodal officers Report
Blood examination center at each block	Blood examination centre established	
Appointment of lab technicians	Number of lab technicians appointed	
Strategy 5: Preventive measures to reduce chances of outbreak		
Insecticidal sprays at high risk areas	Proportion of high risk areas having insecticidal sprays	Malaria Programme Plan Report

Activity	Indicator	Means of verification
Distribution of medicated mosquito nets	Number of medicated mosquito nets distributed	
Strategy 6: Integration with ISM practitioners		
Acceptance/ treatment of usage of herbal medicine	Proportion of members accepting herbal medicine	Health Survey

6.1.4 Monitoring and Evaluation Matrix for NTCP

Activity	Indicator	Means of verification
Strategy 1: Sensitization of community through IEC activities		
Use of posters, pamphlets, wall paintings and street plays	Number of posters, pamphlets, wall paintings and street plays conducted/displayed	Health MIS
Increase awareness of DOTS	Proportion of community members aware of DOTS	Survey Report
Strategy 2: Increasing referral from grass root to health institutions		
Community participation	Proportion of community members involved	Health Survey
Involvement of private practitioners	Number of private practioners involved	Health MIS
Strategy 3: Treatment strengthening		
Complete treatment	Number of cases completed treatment	RNTCP Report/MIS
Follow-up examination to achieve sputum conversion	Number of cases followed up	
Strategy 4: Infrastructural strengthening		
Establishment of TB cells at block level	TB cells established at block level	RNTCP Report/ Health MIS/Logistic Plan
Regular and uninterrupted supply of drugs	Number of days drug was stocked out	
Systematic monitoring and evaluation	Monitoring and evaluation plan finalized	
Appointment of field staff	Number of field staff appointed	
Training to DOTS providers	Number of DOTS provider trained	
Sensitization training to MOs providing treatment at block level	Number of training session organised at the block level	

6.1.5 Monitoring and Evaluation Matrix for Blindness Control Programme

Activity	Indicator	Means of verification
Strategy 1: Outreach activities		
Organization of eye camps in collaboration with private agencies/ institutions	Number of eye camp organized in collaboration with private agencies/ institutions	BCP Report/Health MIS
Strategy 2: Strengthening service delivery		
Posting of eye-surgeon at block level	Number of eye surgeon recruited	CMO Office Report/DPMU/Healt
Follow-up of treated cases	Number of cases followed up	

Activity	Indicator	Means of verification
Integrate eye care as a part of primary health care	Institutions who integrated eye care as a part of primary health care	h MIS
Availability and repair of necessary equipments	Number of equipments repaired	
Strategy 3: Adequate drug/vaccine supply		
Streamlined vitamin-A supply	No of days Vitamin A has been out of stock	Health MIS/Logistic plan Report
Availability of medicines during eye camps	Number/Type of Medicine being supplied at eye camp	
Strategy 4: Capacity building of human resources		
Sensitization Workshop at block level for MOs and health workers	Number of sensitization work organized at block level for MOs and health workers	Health MIS/DPMU Report
Technical training of ophthalmic medical assistants at district for skill up-gradation and new techniques	Number of ophthalmic medical assistants at district trained for skill up-gradation and new techniques	
Strategy 5: IEC for public awareness on eye care		
Behaviour change of community to increase treatment acceptance	Number of community members who showed positive behavioral change	DPMU/Communicati on deptt. report
Interpersonal communication by health workers and ICDS workers	Proportion of community members contacted health workers and ICDS workers	

6.1.6 Monitoring and Evaluation Matrix for NLEP

Activity	Indicator	Means of verification
Strategy1: Surveillance for case detection		
Recruitment of field staff	Number of field staff recruited	LCP Nodal officers Report/Health MIS
Orientation training of new staff	Number of new staff oriented	
Updating records	Proportion of records updated	
Strategy 2: Strengthen service delivery		
Increase case detection and referral for treatment	Number of cases detected and referred	LCP Nodal officers Report/Health MIS
Case validation and re-registration	Number of cases validated and re-registered	
Organization of POD camps	Number of POD camps organized	
Organization of Skin Disease Diagnosis, Treatment & Education Camps in remote and inaccessible areas	Number of Skin Disease Diagnosis, Treatment & Education Camps in remote and inaccessible areas	
Urban leprosy awareness camps	Number of Urban leprosy awareness camps organised	
Strategy 3: Collaboration with PRI		
Sensitization Workshop for panchayat members to motivate them for community education	Number of Workshop organized for panchayat members to motivate them for community education	Health MIS
Strategy 4: Prevention of disability and rehabilitation		

Activity	Indicator	Means of verification
Proper counseling by health worker and MOs to prevent deformities	Proportion of cases counseled by health worker and MOs	Block MOs Report
Sensitize community for self reporting	Proportion of community members sensitized	Health MIS
Strategy 5: IEC to mitigate stigma		
Sensitization Workshop at gram panchayat	Number of Workshop organized at gram panchayat level	Health MIS/ ICP Report/Communication division
Community mobilization through interpersonal communication, print media and folk media (in local dialect)	Reach of IEC activity i.e. interpersonal communication, print media and folk media (in local dialect)	
Orgination of Trainings as state guideline	No. of Training Organised	DPMU Report/
Organization of training as per State guidelines	No. of training organized	DPMU Report/CMO Report /Health MIS
Refresher training of paramedics on minor ailments	No. of paramedics trained	
Training of MOs for managerial skills, EmOC	No. of MO's, ANM identified	
Training of ANMs for ANC, DOTS		

Strategy 5 : Formulation of district BCC plan		
Assessment of communication needs in the context of NRHM	Assessment of communication needs	DPMU Report/CMO Report /Health MIS
Strategy 10 : Streamlined procurement and logistic supply plan		
Financial planning for reaching of supplies at various levels	Financial Plan at each level in place	DPMU Report
Well established supply chain	Establishment of supply chain	
Strategy 11 : Coordination with private practitioners/institutions		
Appointment of AYUSH practitioners at PHC/PHC	Number of AYUSH physicians relocated and appointed	DPMU Report
Integration with private doctors/ISMP at village level	No. of private practitioners involved	DPMU Report
6.1.2 Monitoring and Evaluation Matrix for Immunization		
Strategy 1 : Streamlining cold chain system		
Cold chain maintenance for quality assurance of vaccine	Institution wherein cold chain is established and streamlined	Logistic Plan/MIS
Strategy 2 : Logistics of vaccine and disposable supply		
Improving transport system	Transportation system improved	CMO office Report/ Nodal officers Report

Monitoring mechanism for adequate supply	Monitoring mechanism in place	CMO office Report/ Nodal officers Report
Strategy 3 : Strengthening service delivery		
Organization of weekly immunization day at sub-center	No. of weekly immunization day at sub-center	Monthly Progress Report/ Health MIS
Fill-up vacant post of ANMs	No. of ANMs recruited on contractual basis	Monthly Progress Report/ Health MIS
Pulse Polio Immunization Camps	No. of Pulse Polio immunization camp organized	Monthly Progress Report/ Health MIS
Catch-up Round	No. of Catch-up Round organized	Monthly Progress Report/ Health MIS
Close co-ordination between ANM, AWW and ASHA	Co-ordination meeting organized and grievance addressed between ANM, AWW and ASHA	

Activity	Indicator	Means of verification
Strategy 4 : IEC for behavior change of community		
Identification of areas with low immunization coverage	No. of low immunization coverage area	DPMU Report/ Health MIS
Involving AWWs, NGOs, ASHA and panchayat on immunization day	No. of AWWs, NGOs, ASHA and panchayat involved on immunization day	
Orientation and awareness generation training for health workers	No. of orientation and awareness generation training for health workers	
6.1.3 Monitoring and Evaluation Matrix for Vector Borne Disease Programme		
Strategy 1 : IEC Activity		
Use of video display, poster, pamphlets, booklets, wall painting and street plays	No. of video display, posters, pamphlets and street plays organized	Health MIS/Communication Plan
Co-ordination with school education	No. of school involved as part of school education	
Strategy 2 : Increased surveillance		
Fortnightly door to door surveillance by health worker	No. of door to door surveillance programme organized by health worker	
Strategy 3 : Early diagnosis and prompt treatment		
Increase blood smear collection	Percentage increase in blood smear collection	Health MIS/ Nodal Officers Report
Transportation of slides from collection point to laboratory on daily basis	Percentage increase in slides transported from collection point to laboratory on daily basis	
Strategy 4 : Strengthening laboratory facilities		
Functional laboratory at PHC/ PHC level	No. of functional laboratory at PHC/ PHC level	Health MIS/ Nodal Officers Report
Blood examination center at each block	Blood examination center established	
Appointment of lab technicians	No. of lab technicians appointed	

Strategy 5 : Preventive measures to reduce chances of outbreak		
Insecticidal sprays at high risk areas	Proportion of high risk areas having insecticidal sprays	Malaria Programme Plan Report
Distribution of medical mosquito nets	No. of medicated mosquito nets distributed	
Strategy 6 : Integration with ISM practitioners		
Acceptance / treatment of usage of herbal medicine	Proportion of members accepting herbal medicine	Health Survey

6.1.4 Monitoring and Evaluation Matrix for NTCP

Strategy 1 : Sensitization of community through IEC activities		
Use of posters, pamphlets, wall painting and street plays	No. of posters, pamphlets, wall paintings and street plays conducted / displayed	Health MIS

Activity	Indicator	Means of verification
Increase awareness of DOTS	Proportion of community members awareness of DOTS	Survey Report
Strategy 2 : Increasing referral from grass root to health institutions		
Community participation	Proportion of community members involved	Health Survey
Involvement of private practitioners	No. of private practitioners involved	Health MIS
Strategy 3 : Treatment strengthening		
Complete treatment	No. of cases completed treatment	RNTCP Report
Follow-up examination to achieve sputum conversion	No. of cases followed up	
Strategy 4 : Infrastructural strengthening		
Establishment of TB cells at block level	TB cells established at block level	RNTCP Report/ Health MIS/ Logistic Plan
Regular and uninterrupted supply of drugs	No. of days drug was stocked out	
Systematic monitoring and evaluation	Monitoring and evaluation plan finalized	
Appointment of field staff	No. of field staff appointed	
Training to DOTS providers	No. of DOTS provider trained	
Sensitization training to MOs providing treatment at block level	No. of training session organized at the block level	

6.1.5 Monitoring and Evaluation Matrix for Blindness Control Programme

Strategy 1 : Outreach activities		
Organization of eye camps in collaboration with private agencies/institutions	No. of eye camp organized in collaboration with private agencies/institutions	BCP Report/Health MIS
Strategy 2 : Strengthening service delivery		
Posting of eye-surgeon at block level	No. of eye-surgeon recruited	CMO Office Report/DPMU/ Health MIS
Follow-up of treated cases	No. of cases followed up	
Integrate eye care as a part of primary health care	Institutions who integrated eye care as a part of primary health care	
Availability and repair of	No. of equipments repaired	

necessary equipments		
Strategy 3 : Adequate drug/vaccine supply		
Streamlined vitamin-A supply	No. of days Vitamin A has been out of stock	Health MIS/Logistic plan Report
Availability of medicines during eye camps	No./Type of medicine being supplied at eye camp	
Strategy 4 : Capacity building of human resources		
Sensitization Workshop at block level for MOs and health workers	No. of sensitization work organized at block level for MOs and health workers	Health MIS/DPMU Report

Activity	Indicator	Means of verification
Technical training of ophthalmic medical assistants at district for skill up-gradation and new techniques	No. of ophthalmic medical assistants at district trained for skill up-gradation and new techniques	
Strategy 5 : IEC for public awareness on eye care		
Behaviour change of community to increase treatment acceptance	No. of community members who showed positive behavioral change	DPMU/Communication deptt. Report
Interpersonal communication by health workers and ICDS workers	Proportion of community members contracted health workers and ICDS workers	
6.1.6 Monitoring and Evaluation Matrix for NLEP		
Strategy 1 : Surveillance for case detection		
Recruitment of field staff	No. of field staff recruited	LCP Nodal officers Report/ Health MIS
Orientation training of new staff	No. of new staff oriented	
Updating records	Proportion of records updated	
Strategy 2 : Strengthen service delivery		
Increase case detection and referral for treatment	No. of case detected and referred	LCP Nodal officers Report/ Health MIS
Case validation and re-registration	No. of case validated and re-registered	
Organization of POD camps	No. of POD camps organized	
Organization of Skin Disease Diagnosis, Treatment & Education Camps in remote and inaccessible areas	No. of Skin Disease Diagnosis, Treatment & Education Camps in remote and inaccessible areas	
Urban leprosy awareness camps	No. of Urban leprosy awareness camps organized	
Strategy 3 : Collaboration with PRI		
Sensitization Workshop for Panchayat members to motivate them for community education	No. of Workshop organized for panchayat members to motivate them for community education	Health MIS
Strategy 4 : Prevention of disability and rehabilitation		
Proper counseling by health worker and MOs to prevent deformities	Proportion of case counseled by health worker and MOs	Block MOs Report
Sensitize community for self reporting	Proportion of community members sensitized	Health MIS
Strategy 5 : IEC to mitigate stigma		

Sensitization Workshop at gram panchayat	No. of Workshop organized at gram panchayat level	Health MIS/ICP Report/ Communication division
Community mobilization through interpersonal communication, print media and folk media (in local dialect)	Reach of IEC activity i.e. interpersonal communication, print media and folk media (in local dialect)	

Budget Finaly Alocated by State Health Society for the financial Year – 09-10 for Araria District.

	PART - A (RCH-II)						
METARNAL HEALTH							
S.No.	**Head**	**State Approved Budget**	**Total (Q1 To Q4)**	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
1	1.1.1 Operationalise FRU esel, Service Mentenance e, Misc. & Other Cost) Blood Storage units in FRU	288000.00	288000.00	72000.00	72000.00	72000.00	72000.00

2	1.1.2 Operationalise 24x7 Service (Organise workshops on various aspects of operationalisation of 24x7 services at the facilities @ Rs. 25,000 / year / district)	25000.00	25000.00	—	25000.00	—	—
3	1.3.1. RCH Outreach Camps in un-served/ under-served areas	85000.00	85000.00	—	42500.00	42500.00	—
4	1.4.1 Home deliveries	148000.00	148000.00	37000.00	37000.00	37000.00	37000.00
5	1.4.2.1. (A) Institutional deliveries (Rural) @ Rs.2000/- per delivery for 10.00 lakh deliveries	51806918	51806918	10000000.00	10000000.00	15903459.00	15903459.00
6	1.4.2.2 (B) Institutional deliveries (Urban) @ Rs.1200/- per delivery for 2.00 lakh deliveries	6218339.00	1000000.00	1739446.00	1739446.00	1739446.00	1739447.00
7	1.4.2.3 Caesarean Delivery (Facility Gynec,Anesth & Paramediac) 10.3.1 Incentive for C-section @ 1500/-(Facility Gynec,Anesth & Paramediac)	241941.00	241941.00	51685.00	60485.00	60485.00	69286.00
8	Other Activities (JSY) 1.4.3 Monitor Quality and Utilisation of Service and Mobile Data Center at HSC and APHC level and State supervisory Committee for Blood Storage Unit	586227.79	586227.79	—	195409.26	195409.26	195409.26

CHILD HEALTH

9	2.2. Facility Based Newborn Care/FBNC IN District 2.1.1.(Monitor progress against plan; follow up with training, procurement, review meetings etc.) (details of training, drugs and supplies, under sections 9 ,11,13)	115594.00	115594.00	28899.00	28899.00	28899.00	28898.56

	2.2.1. Implementation of FBNC activities in districts. (Monitor progress against plan; follow up with training, procurement, etc.)						
10	2.4 School Health Programme (Details annexed)	5644840.00	5644840.00	1411201.00	1411201.00	1411201.00	1411237.00
FAMILY PLANNING							
11	3.1.1. Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services	25000.00	25000.00	—	25000.00	—	—
12	3.1.3. 3.1.2.2. Organise NSV camps in districts @Rs.10,000 x 500 camps	70000.00	70000.00	—	10000.00	30000.00	30000.00
13	3.1.4 Compensation for female sterilisation 3.1.2.3. Compensation for female sterilisation at PHC level in camp mode 3.1.2.1. Provide female sterilisation services on fixed days at health facilities in districts (Mini Lap)	11022000.00	11022000.00	1837000	1837000	1837000	5511000
14	3.1.5 Compensation for Male sterilisation 3.1.2.4.Compensation for NSV Acceptance @50000 cases x1500	940884.00	940884.00	-	-	470442.00	470442.00
15	3.1.6 Accreditation of private providers for sterilisation services 3.1.3.1 Compensation for sterilization done in Pvt. Accredited Hospitals (1.50 lakh cases)	3065250.00	3065250.00	—	—	1532625.00	1532625.00
16	3.2.1. IUD Camps	108000.00	81000.00	—	27000.00	27000.00	27000.00

17	3.3 POL for Family Planning for 500 sub-district facilities	168855.53	168853.53	-	_	84427.00	84428.53
18	3.5 Other stratigies/activities 3.1.4. Monitor progress, quality and utilisation of services 3.5. Establishing Community Based Condom and OCP Distribution Centres (pilot in one district/1 PHC)	12581.00	12581.00	—	_	6290	6290

ARSH Urban RCH

19	4.1. Adolescent services at health facilities. 4.1.1. Disseminate ARSH guidelines. 4.1.2. Establishing ARSH Cells in Facilities 4.1.2.1. Developing a Model ARSH Cell for the facilities 4.1.2.3. Establishing ARSH Cell is 50% PHCs of Patna District 4.2 Conducting ARSH Camps at all PHCs for a week (as ARSH Week) 4.2.2 Establishing Youth friendly health clinics in Urban Area/ Universities Campus / Market Place	25000.00	25000.00	—	25000.00	—	—

PNDT & Sex Ratio

20	8.1.PNDT and Sex Ratio 8.1.1. Orientation programme of PNDT activities, Workshop at State, District and Block Level (1+38+533) 8.1.2 Monitoring at District level and Meetings of District level Committee (100 Lakhs)	253283.00	188696.06	—	62898.69	62898.69	62898.69
	Total	534709.00	531144.00	—	177048.16	177048.16	177048.16
21	9.1.1 ANMs 10.1.1.2. Hiring of 1000 Retired ANMs or ANMs from other states for out reach services @ Rs. 5000 / month / ANM	2400000.00	2400000.00	_	800000.00	800000.00	800000.00

22	9.1.2 Laboratory Technician	468000.00	468000.00	117000.00	117000.00	117000.00	117000.00
23	9.1.4 Doctors and Specialists (Anaesthetists , Ob/Gyn , Surgeons , Physician 1.1.1.1 Operationalise FRU (Diesel, Service Mentenance Charge, Misc. & Other Cost) Blood Storage units in FRU - Salary of Medical Officer 10.1.2.1. Empanelling Gynaecologists in under or un served areas @ Rs.1000/- week x 52 weeks, on CALL BASIS for conducting institutional deliveries, providing Essential and Emergency Obs Care at government facilities @ Rs. 1,00,000 per annum per district for 38 districts 10.1.2.3. Empanelling Gynaecologists for PHCs to provide OPD services @ Rs. 300 / week x 52 weeks 10.1.2.4. Hiring Anesthetists for facilities that have vacant Anesthetist positions @ Rs. 1000 per case x 120000 10.1.2.5. Hiring Paediatrician for facilities where there are vacant Paediatricians positions @ Rs. 35,000 / month (2 per district) 10.1.2.6 Hiring Gynaecologists for facilities that have vacant positions @ Rs. 650 per case x 75000 cases.	5511982.00	5511982.00	1377995.00	1377995.00	1377995.00	1377995.00
24	Other Contractual Staff 9.1 Fast-Track Training Cell in SIHFW 9.2 Filling Vacant Position at SIHFW/Hiring Consultant at SIHFW 10.1.1 Honorarium of Voluntary @ of 1200/- PA x 3106 No.	125029.99	125029.99	31257.50	31257.50	31257.50	31257.50

25	Incentive/Awards etc. 8.2.1 Incentive for ASHA per AWW center (80000x200 per month) and incentive to ANMs per Anganwari Center under Muskan Programme (@80000 x Rs. 150 Per Month)	9032482.50	9032482.50	2258120.62	2258120.62	2258120.62	2258120.64
26	9.3.1 Monitor Civil Work for Operationalisation of FRU 10.4.1 Facility improvement for establishing New Born Centres at 76 FRUs across the state - @ Rs. 50,000 / per FRU	100000.00	100000.00	100000.00	—	—	—
27	Minor civil works for operationalisation of 24 hour services at PHC's 10.4.2. Facility improvement for establishing New Born Centtres at PHC's across the state - @ Rs. 25,000 / PHC	225000.00	225000.00	56250.00	56250.00	56250.00	56250.00
	Total Infra + HR	17862494.26	17862494.27	3940623.56	4640623.56	4640623.56	4640623.58
28	10.4 Sub-centre rent and contigencies @ 1770 no. x Rs. 500 /- x 60 months	3187500.00	3187500.00	_	1062500.00	1062500.00	1062500.00
29	Skilled Birth Attendance / SBA 12.1.2 Skilled Attendance at Birth / SBA - Two days Reorientation of the existing trainers in Batches 12.1.3 Strengthening of existing SBA training centres 12.1.4 Setting up of additional SBA training centre - one per district 12.1.5 Training of staff Nurses in SBA (batches of four) 12.1.6 Training of ANM's /LHVs in SBA (batch size of four) 20 batches x 38 districts x Rs. 59,000 /-	1257600.00	1257600.00	374400.00	294400.00	294400.00	294400.00

30	11.3.4 MTP training 12.1.6.1 Training of Nurses / ANM's in safe abortion 12.1.8 Training of Medical Officers in safe abortion	25000.00	25000.00	_	25000.00	_	_
31	11.5.1 MNCI 12.2.1.1 TOT on IMNCI for Health and ICDS worker 12.2.1.2 IMNCI Training for Medical Officers (Physician) IMNCI Training for all Health Workers 12.2.1.4 (Physician) IMNCI Training forANM's / LHV's / AWW's 12.2.1.6 followup training (HEs. LHVs)	5628015.00	5628015.00	1407003.75	1407003.75	1407003.75	1407003.75
32	11.8.2 DPMU Training 12.5.1 Trainaing of DPMU staff @ 38 x Rs. 10.000 12.5.2 Training of SHSB/DAM/BHM on accounts at Head Quarter level @ 6 x 1500 x 12 = 1,08,000/-+ DAM=38x1500x4 +BHM=538x1500x4 12.5.3 Training for ASHA Help Desk to DPM's (38), Block Level organisers (533) and MOICs (533), @ 1104 x1000/-	78000.00	78000.00	15000.00	15000.00	15000.00	15000.00
33	12.2 Development of State BCC/IEC strategy 13.3 Concept and material deveopment workshops by State BCC/IEC Cell 13.8 Stablishment cost of State BCC cell/IEC 13.10 Technical support at District level	25000.00	25000.00	12500.00	0.00	12500.00	0.00
34	12.4 Other activities 13.4 State Level events 13.5 District level events (Radio, TV, AV, Human Media as per IEC strategy dissemination) 13.6 Printed Material (Poster, bulletin, success story reports, health calendar, Quartarly magazines & diaries etc.) 13.7 Block level BCC interventations (Radio, Kalajatth and for IEC strategy dissemination) 13.11 Media Advertesements on various health related days 13.12 Various advertisements/tender advertisements /EOIs in print media at state level 13.13 Developing mobile hoarding Vans and A V Van for state and district 13.14 Hiring and IEC consultancy at state level for operationation of BCC strategy. (@ Rs. 50000 x 1x12) 13.16 Implementation of specific interventions including innovations of BCC Strategy plans block level	1033000.00	1033000.00	258250.00	258250.00	258250.00	258250.00

	13.17 Implementation of specific interventions including innovations of BCC strategy /plans District level (rs. 5000 x38x12) 13.18 Implementing need based IEC Activities in urban Areas (Support for Organization of need based IEC Activities in Urban Areas) (Rs. 50000 x9x2) 13.19 Capacity building of frontline functionaries (ANM, ASHA) in IPC skills building 12.30 Research, M&E, IEC prototypes etc.						
35	13.1.1 Procurement of equipment 14.2. Equipments for EmOC services for identified facilities (PHC,s CHCs) @ Rs 1 Lac/facility/year (in two districts - kishanganj and Jehanabad) 14.4 Equipments / instruments for Blood Storage Facility / Bank at facilities 14.6. Equipments / instruments, reagents for STI/ RTI services @ Rs. 1 Lac per district per year	132894.74	132894.74	–	44298.25	44298.25	44298.25
	Total Procurement with in District	132895.00	132895.00	_	44298.00	44298.00	44298.00
36	14.2 Strengthening of District Society/DPMU 16.2.1 Contractual Staff for DPMSU recruited and in position	739184.00	739184.00	_	369592.00	_	369592.00
37	14.3 Strengthening of Financial Management Systems 16.3.1. Training in accounting procedures 16.3.2. Audits 16.3.2.1. Audit of SHSB/DHS by CA for 2009-10 16.4 Appointment of CA 16.4.1 At State level 16.4.2 At District level 16.5 Constitution of Internal Audit wing at SHSB	24000.00	24000.00	6000.00	6000.00	6000.00	6000.00

38	14.4 Other activities (Programme management expenses, mobility support to state, district, block) 16.1.2 Provision of mobility support for SPMU staff @ 12 month x Rs. 10.00 lacks and Updgration of SHSB Office 16.2.2 Provision of mobility support for DPMU staff @ 12 month x 38 districts x Rs. 69945,17/-	839342.10	839342.00	209836.00	209836.00	209836.00	209836.00
TOTAL		117973572	117973572	21363321	25214837	33211662	38183752

PART-B

NRHM ADDITIONALITIES/MISSION FLEXIPOOL

1	District Allocation (Part B)	1326221080.00		31790272.00	35283246.00	34189613.00	31357949.00
1	1.12 ASHA Support System at District Level	36000.00	36000.00	0.00	12000.00	12000.00	12000.00
2	1.13 ASHA support System at Block Level	1350000	1350000	_	450000	450000	450000
3	1.14 ASHA support System at Village Level	122194.00	122194.2857	30549.00	30549.00	30549.00	30549.00
4	1.15 ASHA Trainings	0.00	0.00	0.00	0.00	0.00	0.00
5	1.16 ASHA Drug Kit & Replenishment	615600.00	615600.00	0.00	0.00	615600.00	0.00
6	1.17 Emergency Service of ASHA	0.00	0.00	0.00	0.00	0.00	0.00
7	1.18 Motivation of ASHA	1722725.00	1722725.00	430775.00	430650.00	430650.00	430650.00
8	1.19 Capacity Building Academy Support Programme	0.00	0.00	0.00	0.00	0.00	0.00
9	1.20 ASHA Divas	2203920.00	2203920.00	550980.00	550980.00	550980.00	550980.00
10	1.21 Untied Fund for Health Sub- Centre . Additional Primary Health Centre and Primary Health Centre	3008000.00	3008000.00	752001.00	752000.00	752001.00	751998.00

11	1.22 Village Health and Sanitation Committee	7152500.00	7152500.00	1788125.00	1788125.00	1788125.00	1788125
12	1.23 Rogi Kalyan samiti	1700000.00	1400000.00	_	300000	_	1700000
13	2.1 Construction of HSCs	7600000.00	7600000.00	1900000.00	1900000.00	1900000.00	1900000.00
14	2.2 Construction of residential quarters of 150 old APHCs for staff nurses (3000000)	6000000.00	6000000.00	1500000	1500000	1500000	1500000
15	2.2 Construction of buildings of where land is available (37967000/51 APHCs)	10630000	10630000	2657500	2657500	2657500.00	2567500.00
16	2.3 Upgradation of CHCs as per IPHS standards	20000000.00	20000000.00	5000000.00	5000000.00	5000000.00	5000000.00
17	Infrastructure and Service improvement as per IPHS in 48 (DH & SDH) Hospitals for accreditation or ISO : 9000 Certification	0.00	0.00	0.00	0.00	0.00	0.00
18	2.6 Annual maintainance Grant	1700000.00	1700000.00	425000.00	425000.00	425000.00	425000.00
19	3.1A Incentive for PHCs Doctors and Staff's	429543.00	429543.00	107386.00	107386.00	107385.918	107385.5
20	3.1B Salaries for Contractual Staff Nurses	5806942.00	5806941.84	1451735.00	1451735.00	1451737.00	1451734.84
21	3.1 C Contracat Salaries for ANM's	1440000.00	1440000.00	360000.00	360000.00	360000.00	360000.00
20	3.1 D Mobile Facility for All Health functionaries	1013133.208	1013133.21	253284.00	253248.00	253274.21	253291.00
24	3.2 Block Programme Management Unit (528000/- per PHC's) 533-398=135 @ 600000	4888772.983	4888772.98	1222194.00	1222194.00	1222189.98	1222195.00
25	3.4 Additional Main Power for NRHM	468000.00	468000.00	_	156000.00	156000.00	156000.00
26	4.1 102- Ambulance Service (State - 806400) @ 537600 x 6 District	0.00	0.00	0.00	0.00	0.00	0.00

27	4.2 1911- Doctor on Call and Samadhan	0.00	0.00	0.00	0.00	0.00	0.00
28	4.3 Additional PHC Management by NGO's	2718000.00	2718000.00	679500.00	679500.00	679500.00	679500.00
29	4.6 Services of Hospital waste treatment and Disposal in all Government Health facility up to PHC's in Bihar (IMEP)	998300.00	998300.00	0.00	332766.667	332766.667	332766.6667
30	Dialysis unit in various Government Hospitals in Bihar	0.00	0.00	0.00	0.00	0.00	0.00
31	4.8 Setting of Ultra - Modern Diagnostic Centres in Regional Diagnostic Centres (RDCs) and all Government Medical Collage Hospitals of Bihar	0.00	0.00	0.00	0.00	0.00	0.00
32	4.11 Operationalising MMU	4212000.00	4212000.00	1053000.00	1053000.00	1053000.00	1053000.00
33	4.14Monitoring and evaluation (State,District and Block Data Centre)	1080000.00	1080000.00	270000.00	270000.00	270000.00	270000.00
34	5.1 Delivery Kits at the HSC/ ANM/ASHA (no. 200000 xRs. 25/-)	221631.2057	221631.00	0.00	110815.00	110816.00	0.00
35	5.2 SBA Drug kits with SBA-ANMs/Nurses etc (no. 50000 /38x Rs. 245/-)	164655.00	164654.63	82327.00	82327.00	0.00	0.00
36	5.3 Availability of Sanitary Napkins at Govt. Health Facilities @ 25000/district/Year	25000.00	25000.00	0.00	25000.00	0.00	0.00
37	5.4 Procurement of beds for PHCs to DHs	529920.00	529920.00	529920.00	0.00	0.00	0.00
38	6.1 Cost of IFA for Pregnant & Lactating mothers (Details annexed)	643672.00	643672.00	160918.00	160918.00	160918.00	160918.00
39	6.2 Cost of IFA for (1-5) years children (Details annexed)	1100107.98	1100107.98	275027.00	275027.00	275026.98	275027.00
40	6.3 Cost of IFA for adolescent girls (Details annexed)	1009192.00	1009192.00	252298.00	252298.00	252298.00	252297.74

41	9 Refurbishment of existing cold chain room for direct storage in all direct with proper electrification, earthing for electrical cold chain equipment and sheives and dry space for noon electrical cold chain equipment and logistics @ Rs. 300000 lacks per district x38 districts	700000.00	700000.00	100000.00	200000.00	200000.00	200000.00
42	Earthing and wiring of existing cold chain rooms in all PHC's @ Rs. 10000 /-per PHC x533 PHC's	90000.00	22500.00	22500.00	22500.00	22500.00	22500.00
43	10.1 Preparation of District Health Action Plan (2 Lacks per district x 38)	100000.00	100000.00	0.00	0.00	100000.00	0.00
44	11. Mainstreaming Ayush under NRHM	8208000.00	8208000.00	0.00	2736000.00	2736000.00	2736000.00
45	13.2 Equipment for ICU	1705263.00	1705263.00	0.00	0.00	1705263.00	0.00
46	13.4 Equipment for the labour room	2206721.1	2206721.1	2206721.1	0.0	0.0	0.0
47	13.5 Equipments for SNCU & NSU	3632686.00	3632686.00	0.00	3632686.00	0.00	0.00
48	13.6 NSV Kits	20000.00	20000.00	_	20000.00	_	_
49	13.7 IUD insertion Kit	15000.00	15000.00	_	15000.00	_	_
50	13.8 Minilap sets	39474.00	39474.00	_	39474.00	_	_
	TOTAL	132621080	132621080	31790272	35283246	34189613	31357949

PART – C (Immunization)							
1	Mobility Support to District Officials Rs. 50000/- per District	50000.00	50000.00	12500.00	12500.00	12500.00	12500.00
2	Cold Chain Maintainance for AMC @ Rs. 2000/- per machine per yaar for 2200 machines (DF+ILR) and 10 WIC and 3 WIF @ Rs. 10000/- per year and maintenance of vaccine vans @ Rs. 25000/- per van for 47 vans. 2200000/- for AMC given at state level to one agencies for repair of existing ILR & DF has been deducted from Rs. 5000000/- alloted and the remaining Rs. 2800000/- lacks is divided for WIC/WIF maintenance of vaccine vans as per approved rates. The final remaining amount of 1430000/- could be utilized for minor repair for districts and regional cold chain stores among the districts @ Rs. 2585 aprox per year per cold chain stores for minor repairs.	0.00	0.00	0.00	0.00	0.00	0.00
3	Cold Chain Maintainance for AMC @ Rs. 2000/- per machine per yaar for 2200 machines (DF+ILR) and 10 WIC and 3 WIF @ Rs. 10000/- per year and maintenance of vaccine vans @ Rs. 25000/- per van for 47 vans. 2200000/- for AMC given at state level to one agencies for repair of existing ILR & DF has been deducted from Rs. 5000000/- alloted and the remaining Rs. 2800000/- lacks is divided for WIC/WIF maintenance of vaccine vans as per approved rates. The final remaining amount of 1430000/- could be utilized for minor repair for districts and regional cold chain stores among the districts @ Rs. 2585 aprox per year per cold chain stores for minor repairs.	25000.00	25000.00	0.00	12500.00	0.00	12500.00

4	Minor Repair	25859.00	25859.00	4000.00	8000.00	6930.00	6929.00
5	For 3565 Slums and 14385 undeserved areas @ Rs. 350/- per month per slum for one session. *slum @ 10000 population (each AWTC in slum has 1500 population , therefore 7 slums = 10000 population	651000.00	651000.00	162750.00	162750.00	162750.00	162750.00
6	Alternate vaccinators honrarium (Detail in separate sheet)	4478600.00	4478600.00	719650.00	1075950.00	1683000.00	1000000.00
7	Alternate vaccine delivery in hard to reach areas in 4500 session per month @ Rs. 100 per session.	114000.00	114000.00	24000.00	30000.00	30000.00	30000.00
8	Alternate vaccine delivery in other area @ Rs. 50/- per session for sessions 17000 ANM's for 104 days.	2470400	2470400.00	617600.00	617600.00	617600.00	617600.00
9	Computer Assistant support for district level @ Rs. 8000/- per person per month for one Computer Assistant in 38 Districts.	96000.00	96000.00	20000.00	36000.00	20000.00	20000.00
10	Quaterly review meeting exclusive for RI at District level with one block MO's, CDPO's and other stake holders @ Rs. 100/- per participants for 5 participants per PHC's 515	18000.00	18000.00	4500.00	4500.00	4500.00	4500.00
11	Quaterly review meeting exclusive for RI at block level @ Rs. 50/- per participants as honorarium for ASHA and Rs. 25/- per persons for meeting expenses for 80000 ASHA's	607800.00	607800.00	151950.00	151950.00	151950.00	151950.00

12	District level Orientation for two days for ANM's MPHW, LHV, Health Assistants, Nurse, Mid Wife Bees and other specialist as per training norms of RCH for 9000 persons in 600 batches.	68400.00	68400.00	28400.00	28400.00	0.00	0.00
13	One day cold chain handler training for block level cold chain handlers by State and District Cold Chain Officers in 28 batches for 542 cold chain handlers.	12800.00	12800.00	12800.00	—	—	—
14	One day training of block level Data handlers by DIO's and District Cold Chain Officers for 542 persons.	10150.00	10150.00	10150.00	—	—	—
15	To develop microplan at subcentre level @ Rs. 100/- per subcentre.	28500.00	28500.00	14250.00	14250.00	—	—
16	For Consolidation of microplans at block levels @ Rs. 1000/- per block/PHC's (515) and at District level @ Rs. 2000/- per district for 38 districts.	11000.00	0.00	—	11000.00	—	—
17	POL for vaccine delivery from state to district to PHC's / CHC's @ Rs. 100000/- per district for 38 districts.	100000.00	100000.00	15000.00	25000.00	30000.00	30000.00
18	Consumables for Computer including provision for Internet Access for RIMS Rs. 400/- per month per district for 38 districts.	4800.00	4800.00	1200.00	1200.00	1200.00	1200.00
19	Twin bucket @ Rs. 400/- per PHC's /CHC per year for 515 PHC's.	3600.00	3600.00	3600.00	0.00	0.00	0.00
20	Red / Black plastics bags etc. @ Rs. 2 per session for 17000	13680.00	13680.00	6840.00	6840.00	—	—

21	Bleach / Hyphochlrorite solution @ Rs. 500/- per PHC's /CHC per year for 515 PHC's	4500.00	4500.00	—	4500.00	—	—
22	Honorarium + TA to Participants @ Rs. 400/- per participants.	8000.00	8000.00	2000.00	2000.00	2000.00	2000.00
23	No. of Cold Chain Handler (2 per PHC's & 2 per districts)	4400.00	4400.00	1100.00	1100.00	1100.00	1100.00
24	Honorarium for trainers / faculty @ Rs. 600/- per day (subject to atleast 2 lecture per guest faculties for one days) for one days.	600.00	600.00	150.00	150.00	150.00	150.00
25	Working lunch and refreshment Rs. 200/- per participants + faculty per day for one day	4200.00	4200.00	1050.00	1050.00	1050.00	1050.00
26	Honorarium + TA to participants (Data Handler) @ Rs. 400/- per participants.	4400.00	4400.00	1100.00	1100.00	1100.00	1100.00
27	Honorarium for trainers / Faculty @ Rs. 600/- per day (subject to atleast 2 lecture per guest per day) for one day.	600.00	600.00	150.00	150.00	150.00	150.00
28	Working lunch and refreshment Rs. 200/- per participants + faculty per day for one day	2400.00	2400.00	600.00	600.00	600.00	600.00
29	Incidental Exp. For Phtocopy, Job aids , flip Charts, TV LCD hiring etc. @ Rs. 250/- per participants per day for one day .	2750.00	2750.00	687.5	687.5	687.5	687.5
30	Honorarium for ulternate vaccinators @ Rs. 1400/- per month	4317600.00	4317600.00	1E+06	1E+06	1E+06	1E+06

31	One month Honorarium for Break Period for Contractual ANM's @ Rs. 1400/- per ANM	161000.00	161000.00	40250.00	40250.00	40250.00	40250.00
TOTAL		10992611	10992611	2358820	2764170	3270060	2599559

PULSE POLIO							
	District	H-t-Teams	Transit Teams	Mobile Teams	Mela Teams	OneMan Teams	Total Teams
1	ARARIA	10890	2110	345	94	100	13539
2	Per Diem to Vaccinators @ Rs. 75 per day per Vaccinators for actual working day	10116750.00	10116750.00	2379187.5	2579187.5	2579187.5	10116750.0
3	Per Diem to Supervisors @ Rs. 75 per day per Supervisor for actual working day	1399500.00	1399500.00	349875.00	349875.00	349875.00	349875.00
4	Per Diem to Cold Chain Handler per sub-depot 1, @ Rs. 75 per day for actual working day	329625.00	329625.00	82406.00	82406.00	82406.00	82406.00
5	3 Vehicles per district HQ and 1 vehicle per sub-depot for 5 days @ Rs. 650 per vehicle per day (hiring with POL)	2112500.00	2112500.00	528125.00	528125.00	528125.00	528125.00
6	4 Ice Packs per Vaccination team / Supervisor & 20 Ice Packs per Sub-Depot / Depot per day @ Rs. 3 per Ice Pack for 5 days & Rs. 3000/ for HQ	1332960.00	1332960.00	333240.00	333240.00	333240.00	333240.00
7	Mobility support to Supervisors @ Rs. 100 per day per supervisor for actual working day	1845000.00	1845000.00	461250.00	461250.00	461250.00	461250.00

8	Supplies & Logistics @ Rs. 25 per team & per Supervisor for the whole activity period	431775.00	431775.00	107944.00	107944.00	107944.00	107944.00
9	IEC & Social Mobilization @ 350/ per 40 H-t-H Teams for 1 Days	95290.00	95290.00	23822.00	23822.00	23822.00	23823.00
10	Contingency fopr Xerox, Stationery etc. for Dist HQ Rs. 3000/- & for each PHC @ Rs. 1750/-per area for the whole activity period	240000.00	240000.00	60000.00	60000.00	60000.00	60000.00
11	Per Diem to Vaccine Cold Chain Handler at Dist. HQ 5 person & at PHC 3 person(including 1 depotholder) @ Rs. 50 per person per day for 5 days	153750.00	153750.00	38437.00	38437.00	38438.00	38438.00
12	Support to WIC for maintenance, vaccine transport from PHI Patna & payment of per diem to 2 vaccine handler @ Rs. 50 per day for 7 days	–	–	–	–	–	–
13	Support to districts @ Rs. 2000 per dist & @ Rs. 1000 per PHC for lifiting vaccine from WIC/District	140000.00	140000.00	35000.00	35000.00	35000.00	35000.00
	B - Team Activity						
15	B - Team Activity	2444210.00	2444210.00	611052.00	611053.00	611052.00	611053.00
TOTAL (A + B) TEAM		20641360	20641360	5160340	5160340	5160340	5160340

PART-D (BLINDNESS)								
S.No.	Head	State Approved dget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total (Q1 To Q4)	
1	Consolidated Fund allocation	420817	105204	105204.00	210408.00	-	420817	

2	Cataract Operation & School Eye Screening Programme	336654.00	84164.00	84164.00	168327.00	_	336654.00	
3	Vision Centre	25000	0.00	0.00	0.00	0.00	25000	Balance in DHS.
4	Recurring GIA For Eye Donation Centre	0.00	0.00	0.00	0.00	0.00	0.00	0.00

(IDD, National Iodine Deficeency Disorder Control Programme)

S.No.	Head	State Approved Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total (Q1 To Q4)	State Approved Budget Raised By 25 %
1	National Iodine Deficeency Disorder Control Programme	42939.00	0.00	14313.00	14313.00	14313.00	42939.00	

(IDSP)

S.No.	Head	State Approved Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total (Q1 To Q4)	State Approved Budget Raised By 25 %
1	IDSP	876538.00	219135.00	219135.00	219135.00	219135.00	876540.00	

(Leprosy)

S.No.	Head	State Approved Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total (Q1 To Q4)	State Approved Budget Raised By 25 %
1	Fund allocation	489500.00	122375.00	122375.00	122375.00	122375.00	489500.00	

(Kala-azar)								
S.No.	Head	State Approved Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total (Q1 To Q4)	State Approved Budget Raised By 25 %
1	Kala-azar	13608217.00	4267190.00	2536918.00	2536918.00	4267190.00	13608217.0	

Falaria(MDA)								
S.No.	Head	State Approved Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total (Q1 To Q4)	State Approved Budget Raised By

T.B								
S.No.	Head	State Approved Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total (Q1 To Q4)	State Approved Budget Raised By 25 %
1	T.B	4934375.00	1825719.00	1430969.00	1036219.00	641469.00	4934375.00	