NATIONAL RURAL HEALTH MISSION

Meeting people's health needs in rural areas

Programme Implementation Plan 2010-2011

State Health Society
Department of Health
Government of Bihar

Patna

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Preface

The existing Health System of Bihar, both Public and under NRHM, through its more than 3900 Staff Nurse, 10055 ANMs, 6000 (ANM-R), 69124 ASHAs, 70000 Aaganwadi Workers and nearly 5700 regular and contractual doctors reaches out to the people living in more than 80000 villages. The Health infrastructure, particularly PHCs and other Government hospitals ought to be the institutions where people can put their trust for good and affordable quality health services.

NRHM heralded an era where the health of the people has been placed in their own hands and government is playing a role of facilitator providing all round support and ensuring access to health services. Thus National Rural Health Mission has offered unprecedented opportunity in improving the health of the people of Bihar.

SPIP 2010-11 has been prepared through consultation with block and district level functionaries. The plans have been prepared on the needs identified and has addressed lots of critical issues and district specific innovations to implement the programme.

This plan is also aimed at improving the access to comprehensive quality health care by improving the public health infrastructure to desired standards and placing the health of the people in their hands. Technical Human Resource being one of the most important resources for bringing in quality change in the programme in the state is going to be significantly strengthened. Under this Plan, the Programme Management Support Units at the block, district and State level along with HMIS and other support systems shall be strengthened. This year also a number of PPP initiatives are being taken to reach out services to the people through varied channels.

Government's role is visualized as that of a facilitator willing to facilitate new initiatives.

It is expected that for the state of Bihar, this will initiate primary and quality improvement in health.

Executive Summary | Chapter 1

The State Health Society under the aegis of Government of Bihar is committed towards promoting the right of every citizen esp. rural woman and child to enjoy a life of health and equal opportunity and is making all round efforts in this direction. SHSB aims at minimizing regional variations in the areas of Reproductive and Child Health including population stabilization through integrated, focused and participatory interventions. Meeting unmet demands of the target population, and provision of assured, equitable, responsive quality services are central to the programme strategies.

The State Programme Implementation Plan (SPIP) for National Rural Health Mission (2010-11) for Bihar is based on the experience of implementing the NRHM Programmes during 2009-10 and provides the roadmap for the actual implementation of this programme for the next financial year 2010-11.

Vision Statement

The State envisages undertaking proven strategies and activities to bring a paradigm improvement in the Reproductive and Child Health of the people in general and disadvantage sections in particular.

Goal

The goal is to improve quality of life of the rural people by reducing the following-

Table1: RCH Outcomes in the State: Goals

Outcomes Indicators	State		India	
	Current Status	Goal	Current Status	Goal
		2010-11		2010-11
MMR[1]	312	275	407	<100
IMR[2]	56	35	53	<30
NMR[3]	42.1	25	45	20
TFR[4]	4.0	2.25	2.7	2.1

Source: [1] MMR (SRS 2004-06), [2] IMR: (SRS 2009), [3] NMR & [4] TFR (NHFS 05-06)

These goals clearly indicate that the State is planning to drastically upscale availability, accessibility and utilization of RCH services. Given the State's less than encouraging experience henceforth, there might be some skepticism about its ability to achieve these goals. However, the key stakeholders who have been involved in setting these goals have done so based on the realization that in view of the ambitious targets set by GoI, which in turn are guided by the Millennium Development Goals (MDGs), the Tenth Plan Goals and Immediate and Medium Term Goals of the National Population Policy 2000, Bihar has no option but to bring all the resources at its disposal to achieve these goals.

The Department is making all out efforts to reduce the IMR and has initiated an innovative program 'MUSKAAN' for the same cause and aims to also reach the poorest of the poor with effective, quality and equitable health services. Simultaneously taking steps to

effectively implement national health programme while creating synergy and convergence with RCH II.

Status of Important RCH indicators in the state are as follows:

Decrease in….

- MMR from 371 (2001-2003) to 312 (2004-06)
- IMR from 61 (2005) to 56 per 1000 live births (2009)
- Total Fertility Rate (TFR) from 4.3 to 3.9

Increase in….

- Institutional deliveries from **12.1 %** (1992-93) to **22 %** (2005-06) to **27.7** % (2007-08)
- Antenatal Care from **15.9** % (98-99) to **26.4** % (2007-08)
- Full Immunization coverage has increased from **10.7** % (92-93) to **53.8** % (ISB, 2009)
- Contraceptive use has increased from **23.1** percent (92-93) to **28.4** percent (2007-08)
- Sex ratio from 825 to 871 (CRS 2006-07)

Important RCH indicators such as MMR, IMR and TFR are showing declining trends whereas institutional delivery in government facility, complete ANC, contraceptive use in the state has increased. The state has mapped poor performing districts and is now extensively focusing on them.

Strategic Direction

The entire State Health Society Bihar team is working in a *mission* mode to achieve goals set-in for the state and is trying to effectively deal with the challenges. The Department has set the strategic direction that encompasses year wise objectives, technical strategies; interventions include plan for improving maternal health, child health, family planning, adolescent health etc. The complete programme has been bifurcated into institutional and cross cutting programme strategies as well as specific core programmatic strategies for taking effective actions. These institutional and cross cutting strategies have impact on all the components of RCH viz. maternal health, child health, family planning, etc whereas specific core programme strategies have wider impact on the specific programme component. It has been recognized that all these strategies should converge and go hand-in-hand to achieve the programme outcome. The state considers that strengthening institutional mechanisms, infrastructural development, ensuring adequate and trained human resources etc are fundamental requirements for getting better programme outcomes. Accordingly, the document is presented with backward linkages from core programme strategies to institutional framework.

Convergence of strategies and progress is as described below:

i) Core Programme Strategies

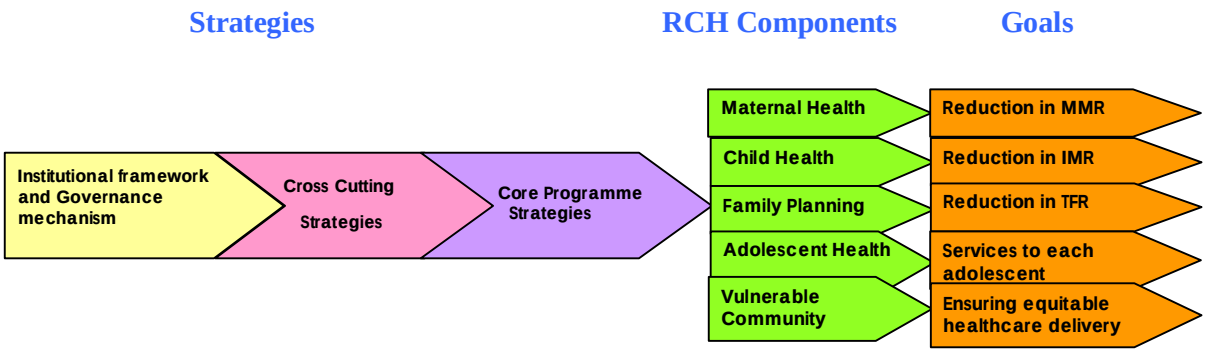
- Special schemes such as *Muskaan, MAMTA* addressing child health, incentives to health staff.

ii) Cross Cutting Programmatic Strategies

- Capacity building, PPP, quality assurance, gender mainstreaming, community participation, serving vulnerable community through mobile units and other innovations (some of which are district specific) etc.

iii) Strengthening Institutional Framework and Governance Mechanisms

- Recruitment and placement of qualified human resource
- Structures: Functional, accountable State/District Health Societies with Governing and Executive Board; Integrated Organizational Structure of Department of Health; Functional SPMU, DPMU, BPMU; Registration of RKS and Constitution of Village Health and Sanitation Committee for bringing in transparency and accountability by involving the community.
- Infrastructure Development and consistent logistics support.



SUMMARY of BUDGET

PART	HEAD	BUDGET 2010-11 (Rs. In lakhs)	%
A	RCH II	78000.46	41.63
B	NRHM Additionalities	94582.25	50.48
C	Immunization	5807.68	3.10
D	NDCP	8991.55	4.80
	TOTAL	**187381.93**	**100.00**
	GRANT TOTAL	**187381.93**	

Process of Plan Preparation | Chapter 2

The State Programme Implementation Plan 2010-11 has been framed on the basis of strategies and activities which worked in the last four years. The major bottlenecks have been identified and an attempt has been made to overcome them through alternative strategies.

The SPIP follows in essence, form and content, “GoI guidelines for SPIP" and the “Suggestive Guidelines for Planning Framework of SPIP in 2010-11”. The standard formats for budgets and work plan have been followed as suggested in the GoI guidelines. Efforts have been made to plan based on evidence, consult all stakeholders, incorporate lessons learnt from previous years under NRHM, set realistic objectives, develop synergies between different vertical programs and strengthen and decentralize programme management.

State Health Society Bihar, under the guidance of Principal Secretary, Health and Executive Director, SHSB has brought in a Systemic Change in the Planning process and has incorporated the Core-Concept of NRHM Mission Document-that of De-Centralisation of Planning. The Planning exercise for FY 2010-11 has been a multi-pronged process.

The State has undertaken Block and District Planning Exercise under which District Action Plans as per the NRHM guidelines have been prepared for 32 out of 38 districts, and for the rest this activity is expected to be completed by end of January 2010. The State Action Plan for 2010-2011 reflects the outcomes of the District Action Plans.

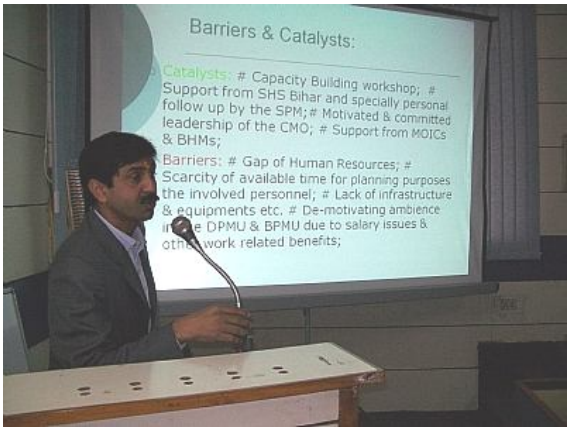
It is noteworthy that for the first time in Bihar NRHM Block Planning exercise has been undertaken alongwith all the 38 districts preparing their DHAPs. The State has constituted Block and District Planning committee for preparing State Programme Implementation Plan under NRHM and designated nodal officers at the district and block level for the task. District Planning team (DPT) at the District level has been constituted with ACMO, DPM, DAM, 1 DPO, 1 MOIC, 1BHM. Two Intensive (7 days) Capacity Building Workshops for the DPT has been held with the support of NHSRC and SPOs, in which the District Planning in all its facets- Why, When, Where, How has been dealt with, and also sensitization done on all NRHM programmes. Block Planning team constitutes the MOIC, Block Health Manager and Block Accounts Manager. At the district level ACMO is the Nodal Officer for Planning, at the block-the MOIC and different DPOs have been designated as Nodal Officers per block in each district for the Block Planning exercise.

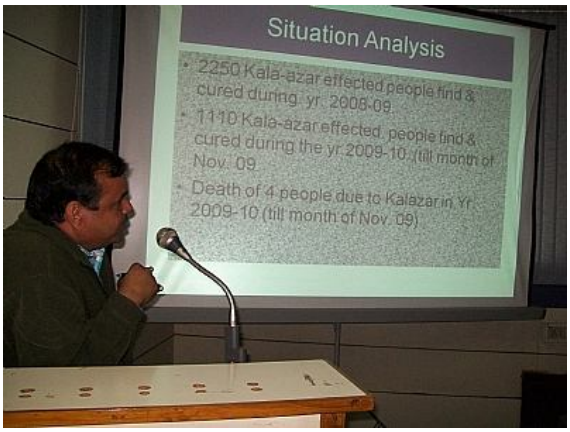
Resource Envelop has been communicated to the districts and the blocks based on the district and block fund allocation in previous year with an anticipated 25% increase from previous year’s budget allocation and Financial Guidelines/Unit Cost for each Budget Head prepared by respective SPOs has been communicated (covering aspects like purpose of the budget head, outcome, unit cost, responsible official, financial protocol etc).

Districts thereafter have conducted Capacity Building workshops for the blocks and various Consultative workshops both at the block and district level and done situational analysis and have drafted their District Plans. At the block level, consultation was done

which was further sent to the District. With the information gathered from the block, district has further held consultations and prepared their priorities and requirements, which is reflected in the District Health Action Plans. The DHAP is a consolidation of BHAPs and incorporation of district level requirements/priorities. The districts presented their Plans before respective SHSB officials/SPOs at a State level workshop held in end December and based on the feedbacks received from SPOs, modified their Plans and gave final shape to the same.

Photographs Showing District Programme Managers of Few Districts presenting different components of their DHAPs





Proposed Specific Initiatives in DHAPs	Name of District
1. Free ambulance for pregnant women	Gaya
2. Blood donation camp	
3. Monthly VHND at Aganwari centre.	Kishanganj, Nalanda and Nawada
4. Maternal death audit	Arwal, Bhagalpur, Buxar, Gaya, Jehanabad, Samastipur, Siwan, Vaishali and West Champaran.
5. Health camps through MMU in Mahadalit Tola (Vulnerable groups)	Banka, Begusarai, Bhagalpur, Kaimur and Kishanganj

6. MTP Training (Safe abortion Nurses/ANM/MO)	Aaria, Arwal, Aurangabad, Darbhanga, East Champran, Gaya, Gopalganj, Jamui, Jehanabad, Katihar, Khagaria, Kishanganj, Madhubani, Munger, Muzaffarpur, Nalanda, Nawada, Purnea, Rohtas, Samastipur, Sheohar, Siwan, Vaishali and West Champaran

Based on the feedback received from the districts state programme officers have discussed and finalized the SPIP requirements. The state has considered the requirement of the district thoroughly and provision has been made in the PIP as per their need. The State Plan is the consolidation of the requirements of the District Plans received and the priorities of the State. The State level Programme Officers have chalked out their plans and requirements for FY 2010-11 which has also been consolidated into the State PIP and synchronized with district level requirements. The progress under various programmes has been analyzed to identify and prioritize the Programme interventions. Moreover, systems development interventions have been incorporated to sustain Programme gains.

In the Planning exercise, two documents which were formulated and disseminated to the districts last year have also been referred to-

1. Annual and Quarterly Fund Allocation for FY 2009-10 on which the districts have undertaken 25% increase as their ceiling for current year
2. Financial Guidelines/Unit costing for each Budget Head

It should also be mentioned that the plan has been prepared keeping in mind that private party can simultaneously complement the role of the Government machinery in delivering the health care services in the state, and till such time the Government machinery becomes self-sufficient and strengthen, the opportunity offered by Private Players can be utilized optimally.

The method of data collection is both primary and secondary in the preparation of the Plan. The secondary data were collected by reviewing records, registers and annual reports. The data were also collected from DLHS, SRS and NFHS surveys to support the background information. For primary data, the procedure involved focus group discussions, interactions and meetings in different districts. This was done to have opinion of all the programme officers, health staff, grass root workers and private partners.

The SPIP and DHAPs consists of five major sections-

1. Reproductive & Child Health Programme-II
2. Additionalities under NRHM
3. Routine Immunization
4. National Disease Control Programmes
5. Inter Sectoral Convergence

The SPMU team was thoroughly involved in the process and their critical inputs were incorporated to make this plan more holistic, realistic and achievable. The Plan was further reviewed by the Executive Director, SHSB and the CEO-cum-Secretary, Health, Deptt.of Health, Govt. of Bihar.

After GOI approval is received on the Bihar SPIP 2010-11, the following steps shall be undertaken-

- District's Annual and Quarterly Fund Allocation for all Major and Minor heads will be communicated to the districts
- Uploading of GOI ROP, State Plan, District Plans, District Allocations and Financial Guidelines on SHSB website
- Flexibility will be given to Districts to re-allocate funds within the sub-heads of the Major sections in qtr. allocations, with the ceiling of annual target. Thus districts can prioritize their needs and meet them at the district level.
- Block's Annual and Quarterly Fund Allocation finalised through District and Block consultation at a District level workshop (SHSB representation in wkp. for clarity of process and guidelines)
- State level officials to undertake Activity Planning exercise which covers the process indicators for each activity and time line for completion of the same.
- State level wkp. shall be held with Development Partners for ensuring their support in proper implementation at the district and block level and to ensure optimum fund utilisation at the district level.

State & District Profile | Chapter 3

STATE PROFILE

Bihar has an area of 94,163 sq. km. The population of the state is 9.50 crores according to Directorate of Statistics, Department of Planning & Development, GOB (2009) making it the second most populous state in India, next only to Uttar Pradesh. Despite efforts in the last few decades to stabilise population growth, the state's population continues to grow at a much faster rate than the national population. The ratio of the rural and urban population is approx. 84:16. The population of Scheduled Caste households as per NFHS 3 is 18.7% and of Other Backward Class is 58.6 percent respectively of the state's total population. BPL population is 56.48% (Source : Deptt. of Rural Development, GOB-2007). 44% of the population in Bihar is under age 15; only 5% is aged 65 or above (NFHS III). The growth rate of population in the state is 1.86% (Directorate of Statistics, GoB). Population density is nearly 880 persons per square kilometer (census 2001). The sex ratio of the state at 921 females per thousand males is less favorable than the national average of 933 per 1000 male (Census 2001 data).

Gender disparity in education is quite evident in the school-age population in Bihar, with 49% of girls aged 6-17 years attend school, compared with 65% of boys in the same age group. 37% of the women and 70% of the men are literate (NFHS III).

Administrative Divisions

Bound by Uttar Pradesh in the west, West Bengal on the east, Nepal on the north and Jharkhand on the south, Bihar covers an area of 94,163 square kilometers. The state has 38 districts divided into 9 administrative divisions. The number of districts in each division is detailed below -

Table 3.2.1: Administrative Divisions

Sl .	Divisions	Districts
1	Patna	Patna, Nalanda, Bhojpur, Rohtas, Kaimur, Buxar
2	Magadh	Gaya, Jehanabad, Arwal, Aurangabad, Nawada
3	Tirhut	Muzaffarpur, Sitamarhi, Vaishali, Champaran East, Champaran West, Sheohar
4	Saran	Saran, Siwan, Gopalganj
5	Darbhanga	Darbhanga, Madhubani, Samastipur
6	Munger	Begusarai, Jamui, Khagaria, Lakhisarai,Munger, Sheikhpura
7	Kosi	Saharsa, Madhepura, Supaul
8	Bhagalpur	Bhagalpur, Banka
9	Purnea	Purnia, Araria, Kishanganj, Katihar

In addition, the state has 101 sub-divisions, 534 community development blocks, 9 urban agglomerations, 130 towns (125 statutory towns and 5 non-statutory census towns) and 37,741 villages.

DISTRICT OVERVIEW

Among the 38 districts of the state, West Champaran is the largest in terms of area (5228.00 sq. km) while the smallest is Sheikhpura (605.96 sq. km). In terms of population, Patna is the largest at 4.72 millions followed by East Champaran that has a population of 3.94 millions. Sheohar and Sheikhpura have the smallest population of 0.52 millions and 0.53 millions respectively. In terms of Sex Ratio, while districts such as Siwan (1031) and Gopalganj (1001) have a favourable ratio, other districts like Munger (872), Patna (873) and Bhagalpur (876) have a less favourable ratio.

Bihar has a total SC population of around 18.7%. However, SC population in certain districts like Gaya (29.6%) and Nawada (24.1%) is much higher than the state average. On the other hand, districts such as Kishanganj (6.6%) and Arwal (8.9%) have a relatively low proportion of SC population. After the bifurcation of the state in 2002, most of the areas with large ST population have been included in the state of Jharkhand. Therefore, the state has less than 1% ST population.

In terms of socio-economic indices too the district level variation is obvious. For literacy rates, districts such as Arwal (26%), Jehanabad (29.3%), Kishanganj (31.1%), Araria (35%) and Katihar (35.1%) are much below the even state average of 46.4%. However, there are districts - Aurangabad (57%), Bhojpur (59%), Munger (59.5%), Patna (62.9%) and Rohtas (61.3%) -that have performed better than the state average with literacy rates close to 60%. Similarly performance of districts on percentage of people living below the poverty line is varied with districts such as Araria faring the worst at 80.3%. Other poor performing districts are Bhagalpur, Madhubani, Purnea, Sitamarhi, Supaul and Sheohar, where close to 70% of the population continues to live below the poverty line. Despite such a large number of districts having a significant proportion of their population living below poverty line, the state average of 56.48% is largely due to the fact that there are some districts such as Kaimur, Saharsa, Samastipur, Arwal, Jehanabad and Gopalganj where close to 80% of the population are living above the poverty line. (See table 2.1.2 for district-wise detailed data).

Sl No	Districts	Area in Sq. Km	Population			BPL (%) DoRD, GOB 2007	Sex Ratio	Literacy Rates
			Rural	Urban	Total			
1	2	3	4	5	6	7	8	9
1	Araria	2830.00	2026257	132351	2158608	61.28	913	35.0
2	Aurangabad	3305.00	1842998	170057	2013055	45.74	934	57.0
3	Arwal	761.12	659270	52458	711728	55.24	929	26.0
4	Banka	3019.56	1552353	56420	1608773	48.56	908	42.7
5	Begusarai	1918.00	2241743	107623	2349366	48.94	912	48.0
6	Bhagalpur	2569.44	1970745	452427	2423172	55.61	876	49.5
7	Bhojpur	2474.17	1930730	312414	2243144	54.74	902	59.0
8	Buxar	1623.83	1273422	128974	1402396	49.26	899	56.8
9	Champaran (E)	3968.00	3688687	251086	3939773	66.74	897	37.5
10	Champaran (W)	5228.00	2733907	309559	3043466	64.70	901	38.9
11	Darbhanga	2279.00	3028441	267348	3295789	53.34	914	44.3
12	Gaya	4976.00	2997479	475949	3473428	55.27	938	50.4
13	Gopalganj	2033.00	2022048	130590	2152638	50.53	1001	47.5
14	Jehanabad	807.88	743433	59154	802587	48.06	929	29.3
15	Jamui	3098.27	1295552	103244	1398796	59.22	918	42.4
16	Kaimur	3361.90	1247299	41775	1289074	53.25	902	55.1
17	Katihar	3057.00	2174361	218277	2392638	52.33	919	35.1
18	Khagaria	1486.00	1204027	76327	1280354	61.10	885	41.3
19	Kishanganj	1884.00	1167340	129008	1296348	78.70	936	31.1
20	Lakhisarai	1299.01	684485	117740	802225	44.43	921	48.0

Sl.No.	Districts	Area in sq.k.m	Population			BPL (%) DoRD, GOB 2007	Sex Ratio	Literacy Rate
			Rural	Urban	Total			
1	2	3	4	5	6	7	8	9
21	Madhepura	1788.00	1458679	67967	1526646	62	915	36.1
22	Madhubani	3501.00	3450736	124545	3575281	67.05	942	42.0
23	Munger	1418.76	819950	317847	1137797	59.81	872	59.5
24	Muzaffarpur	3372.00	3398361	348353	3746714	62.04	920	48.0
25	Nalanda	2367.00	2016899	353629	2370528	57.01	914	53.2
26	Nawada	2494.00	1671253	138443	1809696	49.12	946	46.8
27	Patna	3202.00	2757060	1961532	4718592	51.06	873	62.9
28	Purnia	3229.00	2321544	222398	2543942	59.65	915	35.1
29	Rohtas	3851.10	2123942	326806	2450748	49.73	909	61.3
30	Saharsa	1701.65	1383015	125167	1508182	59.62	910	39.1
31	Samastipur	2904.0	3271338	123455	3394793	50	928	45.1
32	Saran	2641.0	2950064	298637	3248701	48.71	966	51.8
33	Sheikhpura	605.96	444189	81313	525502	50.01	918	48.6
34	Sheohar	442.99	494699	21262	515961	63.55	885	35.3
35	Sitamarhi	2200.01	2529407	153313	2682720	63.67	892	38.5
36	Siwan	2219.0	2564860	149489	2714349	42.66	1031	51.6
37	Supaul	2410.35	1644370	88208	1732578	66.49	920	37.3
38	Vaishali	2036.00	2531766	186655	2718421	63.92	920	50.5

Bihar

S. No.	District	Population 2001 (in thousand)	%SC	%ST	% Low Standard of Living	Female Literacy Rate (7years and above)	% Marriage of girl before age 18	Village that have implemented Janani Suraksha Yojana (JSY)	Number of Sub Centres Covered	Number of PHCs Covered	Number of CHCs Covered	Villages where PRI aware of untied fund by Government	ANM Staying in Sub Centre Village	Sub Centre where Male Health Worker in postion	PHCs having separate Labour Room	Deliveries performed during last one month	PHC having Lady Medical Officer (LMO)	CHC with 24 hour delivery services	Deliveries performed in last one month	CHC having Ambulance on road	CHC with 24 hours New Born Care	CHC recognized as Integrated Counseling and Testing Centre (ICTC)	Institutional Deliveries	Full Vaccination	Children with Diarrhoea in the last two weeks who received ORS (%)	Contraceptive Use	Women who kenw that consistent condom use can reduce the chances of getting HIV/AIDS (%)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
1	Araria	2125	13.7	1.3	93.7	22.1	41.4	44	36	8	3	0	7	4	5	606	0	3	824	1	3	0	13.7	44.5	13	31.5	38.2
2	Arwal																										
3	Aurangabad	2005	23.3	0.03	85.4	42	38.7	33	36	14	3	1	7	6	8	1584	2	3	457	3	3	0	30.6	72.5	23.9	34.5	24.1
4	Banka	1609	12.4	4.7	92	29.1	59.9	37	38	14	3	1	5	4	7	882	5	3	627	3	3	1	24.7	48.9	24.6	25	46.2
5	Begusarai	2343	14.5	0.05	83.7	36.2	46.2	45	40	13	2	0	7	2	7	2121	5	2	585	2	2	0	26.8	51.9	22.3	28	28.7
6	Bhagalpur	2430	10.4	3.5	74	38.8	27.8	38	34	14	2	1	6	1	8	2344	8	2	477	2	1	0	30.4	71.9	42.9	40.3	36.2
7	Bhojpur	2233	14.4	0.3	78.8	42.8	48.1	23	36	17	1	1	7	6	7	2458	7	1	96	0	0	0	40.4	50.7	34.7	35.3	45.8
8	Buxar	1403	14.1	0.6	78	40.4	49.8	21	35	11	0	4	5	5	7	637	4						48	46.8	28.8	31.2	30
9	Darbhanga	3285	14.6	0.01	83.5	30.4	39.1	43	37	17	2	0	8	9	8	1345	6	2	311	2	1	0	15.1	56.8	22.6	31.8	27.5
10	Gaya	3465	29.6	0.05	80.2	37.4	50.4	37	33	23	1	2	6	2	14	1251	12	1	106	1	1	0	20.7	53.1	16.1	30.5	20.9
11	Gopalgunj	2149	12.2	1.1	82	32.8	35.9	46	36	11	2	0	5	4	7	850	5	2	226	1	2	0	36.5	67.6	19.1	22.1	32.1
12	Jamui	1397	17.4	4.8	91.2	26.9	72.9	39	27	10	4	2	3	1	2	677	4	4	895	4	3	1	17.6	33.7	20.7	27.4	23.6
13	Jehanabad	1511	18.4	0.02	83.8	40.1	56.7	39	39	13	2	2	5	7	8	1820	5	2	264	1	2	0	42.5	63.9	13.6	39.8	22.3
14	Kaimur	1285	28.6	19.5	84.4	38.9	56.1	18	28	13	1	3	4	1	4	1047	2	1	177	1	0	1	42.6	29.2	17.9	29.9	28.4
15	Katihar	2390	8.8	5.6	88.1	24	43.7	32	33	14	3	2	2	2	8	424	2	2	185	0	2	0	12.4	44.8	32.6	26	31.5
16	Khagaria	1277	14.5	0.003	84.8	29.6	49.3	43	41	14	1	0	9	4	3	783	2	1	350	1	0	0	25.3	54.8	11.4	31.1	39.8
17	Kishangunj	1294	6.6	3	90.7	18.5	32.1	40	32	8	1	1	5	3	7	901	0	1	50	0	1	1	17.8	36.3	14.8	27.2	27.4
18	Lakhisarai	801	15.8	0.7	79.8	34.3	54.7	38	28	8	1	2	2	4	2	385	2	1	187	0	1	0	32.5	46.1	25.3	31.2	26.1
19	Madhepura	1525	16.3	0.7	90.6	22.3	55.3	45	16	14	0	0	1	3	6	562	0						17.7	50	18.9	35	38.2
20	Madhubani	3571	16.3	0.7	88.4	26.6	39.5	34	27	21	2	2	8	9	11	1272	5	2	131	2	0	2	16	51.2	7.1	34.9	27.8
21	Munger	1136	16.7	2.3	61.7	48	30.5	34	27	9	1	2	5	4	3	657	3	1	184	1	1	0	48.6	60.6	33	41.4	24.5
22	Muzaffarpur	3744	15.7	0.04	81.4	35.2	35.7	40	24	10	2	1	5	3	5	674	4	2	203	2	2	0	23	71.6	19.8	33.1	36.8
23	Nalanda	2368	19.4	0.02	73	39	46.6	33	36	15	3	2	10	5	7	1269	4	2	511	1	2	0	39.3	69.1	45.3	30.9	31.3
24	Nawada	1809	24.4	0.1	87.1	32.6	65.3	42	25	16	2	0	7	10	7	964	1	0	14	0	0	0	31.1	56.7	16.6	24.3	17.7
25	Paschim Champaran	3043	14.4	1.3	89.2	25.9	57.8	40	25	18	2	0	4	5	11	1247	5	1	112	0	1	1	24.9	40.4	13.9	32.3	21.1
26	Patna	4710	15.5	0.2	50.9	52.2	34	20	21	19	2	0	5	5	8	2232	11	2	811	0	2	0	58.8	51.4	45.1	43.7	34.6
27	Purab	3934	13.1	0.04	88	24.7	54.9	27	29	25	3	0	3	3	11	1385	4	3	267	2	2	2	27.1	47.4	14.7	27.7	52.9

	Champaran																										
28	Purnia	2541	12.5	4.4	87	23.7	40.4	41	26	12	2	0	1	2	7	1558	2	2	287	0	2	1	21.6	50	7.6	27.5	29
29	Rohtas	2449	18.8	1.6	74.4	46.6	52.9	38	28	18	1	0	8	3	10	2172	3	1	41	0	1	0	48.5	60.4	13.8	40	41.5
30	Saharsa	1506	15.5	0.3	87.3	25.3	54.4	38	36	9	0	0	5	2	4	394	1						20	61.6	21.7	32.6	29
31	Samastipur	3413	18	0.02	87.6	32.7	51.4	44	35	27	4	0	6	13	7	3171	4	4	1935	3	3	3	27.6	57.5	20.9	34.8	36.6
32	Saran	3251	11.7	0.1	81.9	35.7	31	28	34	14	3	3	4	0	10	2215	8	3	522	1	1	0	22.4	78.1	25.7	29.1	39.3
33	Sheikpura	525	19.7	0.04	79	34.1	53.5	32	28	14	1	1	6	2	6	694	3	1	211	1	1	0	41.6	49.3	24.5	26.7	35
34	Sheohar	514	14.4	0.01	89	27.4	54.8	37	16	7	0	1	3	2	1	5	0						11.9	34	10.4	27.4	48.3
35	Sitamarhi	2669	12.1	0.02	86.8	26.4	44.4	41	39	16	1		12	5	8	1060	4	0	0	1	0	0	16.4	47.3	21.6	25.3	29
36	Siwan	2709	11.1	0.6	78.4	37.3	27.6	46	39	16	2	0	5	4	10	1309	5	2	106	2	2	0	33.5	69.6	23.1	24	34
37	Supaul	1745	14.8	0.3	92	21	44.2	46	27	14	2	1	5	6	7	869	2	2	280	1	2	0	23.2	50	6.6	43.1	33.6
38	Vaishali	2712	19.9	0.07	81.3	38.1	41.2	28	39	12	1	2	4	4	6	2716	8	1	28	0	1	0	28.2	71.9	51.8	43.6	29.5
Source DLHS-III																											

Public Health Infrastructure

District wise Availability of Health Centres of Bihar State

Sl. No.	Name of District	District Hospital		Sub.Div. Hospital		Referal Hospital		APHCs		HSCs		PHCs		Medical College and Hospital		FRU	Blood Bank/Blood Storage Centre in FRUs	
		Existing	Addn. New Target	Existing	Addn. New Target	Existing	Addn. New Target	Existing	Addn. New Target	Sanctioned	Existing	Existing	Addn. New Target	Existing	Addn. New Target		Functional	Remarks
1	Araria		1	1		3		30	41	425	200	9				2		
2	Arwal		1					23	16	92	64	5				1		
3	Aurangabad	1			1	3		58	9	401	207	11				2	1	
4	Banka		1	1		3		24	30	322	227	11				2		
5	Begusarai	1			2	2		31	47	469	288	18				2	1	
6	Bhagalpur	1		1	1	2		46	35	486	280	16		1		2		Blood Bank in JLNMCH, Bhagalpur
7	Bhojpur	1			1	2		20	54	447	284	14				2	1	
8	Buxar		1	1	1			20	27	281	161	11				2	1	
9	Champaran- E	1			1	3		46	85	787	315	27				2		
10	Champaran -W	1		1	1	2		25	76	609	369	18			1	2	1	
11	Darbhanga				1	2		51	59	657	261	18		1		2		Blood Bank in DMCH, Darbhanga
12	Gaya	1			1	2		49	66	693	439	24		1		3		Blood Bank in ANMCH, Gaya
13	Gopalganj	1		1		3		22	50	430	186	14				2	1	
14	Jamui		1	1		3		21	9	279	211	10				2	1	
15	Jehanabad	1		1		2		25	26	256	82	7				2	1	
16	Kaimur		1	1		2		40	3	257	137	11				2	1	
17	Katihar	1				3		32	48	478	257	16				2	1	
18	Khagaria	1				1		18	25	255	193	7				2	1	
19	Kishanganj		1	1		2		8	35	259	136	7				2	1	
20	Lakhisarai		1	1		1		13	14	160	102	7				2	1	
21	Madhepura	1				1		23	28	305	272	13			1	2	1	
22	Madhubani	1		1	1	2		76	43	714	429	19				2	1	
23	Munger	1				1		13	25	227	144	9				2	1	
24	Muzaffarpur	1				1		47	78	749	473	16		1		2	1	Blood Bank in SKMCH, Muzaffarpur
25	Nalanda	1		1		3		36	43	474	301	20			1	2	1	
26	Nawada	1			1	2		27	33	362	139	14				2	1	
27	Patna			3	1	4		70	87	942	418	23		2		2		Blood Bank in PMCH, NMCH, IGIMS & Jai Prabha Hos.
28	Purnia	1			1	2		34	51	508	278	14				2	1	
29	Rohtas	1		1	1	1		17	65	490	186	19				2	1	
30	Saharsa	1			1			33	17	301	152	10				2	1	
31	Samastipur	1		3	2	1		59	55	683	354	20				3	1	
32	Saran	1				3		45	63	650	413	20				2	1	
33	Sheikhpura		1	1		1		18		105	85	7				2	1	
34	Sheohar		1	1		1		7	10	103	34	4				1		
35	Sitamarahi	1			1	1		38	51	534	213	17				2	1	
36	Siwan	1			1	2		34	56	542	370	19				2	1	
37	Supaul		1	1	1	1		28	30	349	178	11				2		
38	Vaishali	1				2		36	54	542	336	17				2	1	
	Total	**25**	**11**	**23**	**21**	**70**		**1243**	**1544**	**16623**	**9174**	**533**		**6**	**3**	**76**	**28**	**8**

Table : Bihar: Public Health Infrastructure – Personnel

Sl. No	Districts	MO		ANM		LHV		MHW		Staff Nurse		AWW	
		Sanct.	Working	Sanct.	Working	Sanct	Working	Sanct.	Working	Sanct.	Working	Sanct.	Working
1	**Araria**	117	98	273	177	41	12	102	40	17	9	1778	1631
2	**Aurangabad**	188	91	342	319	23	17	110	75	12	3	1430	1390
3	**Arwal**	62	24	78	105	4	4	59	34	0	0	631	631
4	**Banka**	97	84	275	213	45	25	124	49	12	6	1352	1044
5	**Begusarai**	117	73	352	351	24	16	33	11	8	8	1314	1296
6	**Bhagalpur**	162	127	387	385	48	27	34	32	8	8	1512	1347
7	**Bhojpur**	132	105	370	368	26	20	106	42	8	1	1658	1646
8	**Buxar**	89	77	212	212	15	11	42	19	2	2	1139	1139
9	**Champaran (E)**	237	135	364	355	35	23	48	28	12	1	2901	2895
10	**Champaran (W)**	145	74	427	308	43	19	60	5	19	15	2263	2252
11	**Darbhanga**	172	152	363	296	29	19	131	96	8	5	2563	2315
12	**Gaya**	231	197	575	563	41	33	245	159	8	1	2427	2385
13	**Gopalganj**	106	95	250	249	20	8	30	3	12	2	1816	1592
14	**Jehanabad**	119	92	59	56	5	5	31	18	13	8	604	599
15	**Jamui**	85	61	222	222	25	12	70	31	12	8	1156	1138
16	**Kaimur**	93	74	146	146	19	11	64	20	19	9	996	993
17	**Katihar**	121	106	238	211	56	31	33	1	12	7	1716	1637
18	**Khagaria**	73	61	190	191	31	18	18	5	4	2	967	965
19	**Kishanganj**	56	37	169	115	31	15	64	27	11	5	1052	963
20	**Lakhisarai**	72	51	131	131	20	14	40	28	10	9	671	608
21	**Madhepura**	81	51	223	93	35	9	22	4	4	0	962	588
22	**Madhubani**	233	124	487	380	37	15	54	43	34	16	3437	2852
23	**Munger**	141	91	157	157	30	28	51	30	23	23	645	644
24	**Muzaffarpur**	241	223	594	592	29	21	140	82	4	4	2822	2610
25	**Nalanda**	178	167	402	402	30	30	36	21	0	0	1785	1761
26	**Nawada**	115	87	207	207	24	11	30	21	25	17	1249	1235
27	**Patna**	289	205	434	434	32	30	49	6	16	13	2481	2465
28	**Purnia**	126	100	356	275	56	29	126	67	8	2	1464	1424
29	**Rohtas**	158	129	286	270	29	12	136	48	20	10	1712	1628
30	**Saharsa**	97	55	192	169	33	15	18	1	26	21	932	825
31	**Samastipur**	192	183	475	470	30	20	29	18	4	4	2692	2512

32	**Saran**	185	133	512	386	33	29	46	17	27	10	2455	2218
33	**Sheikhpura**	53	36	109	109	16	6	18	4	4	1	357	339
34	**Sheohar**	52	34	46	26	4	1	38	13	9	1	265	265
35	**Sitamarhi**	147	127	299	289	27	9	130	82	17	13	2064	1920
36	**Siwan**	151	126	465	298	31	25	102	56	13	9	2099	1934
37	**Supaul**	85	70	206	111	44	8	60	34	2	0	1376	1230
38	**Vaishali**	126	105	421	414	25	24	33	28	8	3	1844	1608
		5124	**3860**	**11294**	**10055**	**1126**	**662**	**2562**	**1298**	**451**	**256**	**60587**	**56524**

Current Status of Outcome | Chapter 4

National Rural Health Mission has offered unprecedented opportunity to improve the health of the people of Bihar.

The current situation of the selected indictors based on NFHS-3, SRS 2009 and DLHS 3 shows that overall the state is moving towards achieving the goals -

Important indicators	NFHS 3 (05-06)	SRS	DLHS III (07-08)	Other Sources
Total Fertility Rate (TFR)	4	3.9 (2007)	-	-
Contraceptive use	34%	-	28.4%	-
ANC		-	26.4%	-
Institutional Delivery	22.8%	-	27.7%	47.9% (CES 2008)
IMR	62 per 1000 live births	56 (2009)	-	-
Percentage of Full Immunisation coverage	33%	-	-	53.8% (ISB-FRDS 2009)

Due to the various health initiatives, the **Maternal Mortality Rate** has reduced from 371 in 2001-2003 to 312 while the **Infant Mortality Rate** has decreased from 61 in year 2005 to 56 in year 2009. Similarly the **Total Fertility Rate** has decreased from 4.3 to 3.9 in the year 2007. The program has made positive impact on the indicators in the state but there is still a long way to go……

Situational Analysis | Chapter 5

Bird's Eye View of Progress in the State

1. SHSB at State level and District Health Societies (in all 38 districts) formed & registered.
2. ASHA: A total of 69124 ASHAs selected against a target of 87,135. ASHA trained in Module I - 63802 and trained in Module II, III,IV -14222 / 87135
3. SPMU, DPMU & BPMU: The State Level consultants in SHSB are in place and more recruitments are underway so as to ensure quality control. DPMU (3 in each district) has been recruited in 33 out of 38 districts. 477 Block Health Managers and 533 Block Accountants under NRHM are already in position. The orientation training for all has been completed.
4. Free drug distribution of essential drugs started from 1st July 2006 and 24 hours presence of doctors ensured in all facilities up to PHC level resulting in unprecedented increase in OPD patients. 10-30 times increase has been reported.

   In the Primary Health Centres of the State, Free Distribution of 33 drugs in OPD and 37 drugs in IPD is being done and in the District/main Hospital of the district 33 drugs are being distributed free in the OPD and 107 drugs in the IPD. The process of expanding the number of drugs being distributed in OPDs and IPDs in the Medical College Hospitals to the District Hospitals till the Additional Primary Health Centres is in process as such-41 essential drugs for the OPD patients and 193 essential drugs for the IPD patients from District Hospitals till Primary Health Centres/Additional Primary Health Centres, 99 essential drugs in the OPD and 172 essential drugs in the IPD for the 6 Government Medical College Hospitals, 48 drugs/materials for the 6 Government Medical College Hospitals.

5. Routine Immunization: Full immunization percentage increased from 10.7 % (NFHS-I 1992-93) to 33% (NFHS 3) to 53.8 % (ISB, 2009).
6. Against a total figure of 11000 posts of ANM (R), appointment of ANM (R) - 6000 posts of ANM(R) have been filled up.5000 new appointments have to be made.
7. Rogi Kalyan Samitis formed in all health facilities till PHC level, registration of RKS completed in 513 of 653 RKS.
8. Training Programmes: Training of EmOC, Life Saving Anesthesia Training, IMNCI, ASHA, DPMUs, BPMUs, SBA training, Immunization and Neonatal resuscitation started. This includes the regular monitoring and corrective actions taken.

9. ANM/GNM training Schools-Out of 22 ANM schools and 6 GNM schools, 22 ANM schools have been restarted and are fully operational. Currently approx. 600 students enrolled. In year 2010, it is being ensured that ANM and GNM schools train students up to their optimum capacity. Besides, efforts have been made to strengthen the overall structure of these schools in the state including hiring contractual staff for filling up vacant faculty position. The posts of Deputy Director - Nursing and Asstt. Deputy Director –Nursing has been created in the Directorate. A centre of excellence for nursing is being established at Indira Gandhi Institute of Medical Sciences, Patna—the premier health institution of the State.
10. Institutional delivery has increased manifold
11. Additionally in the year 2009-10, rate contracting of equipments for Child (SNCU & NSU) and Maternal Health (Labour room) for District, Sub-Divisional, CHC and PHC hospitals has been achieved, and districts have started placing orders for the same, which will pave the way for availability of the same in the Districts.
12. In 34 districts, IDSP unit is functional.
13. Free Radiology and Pathology services have been offered to all Government patients.

Detailed Progress of Activities

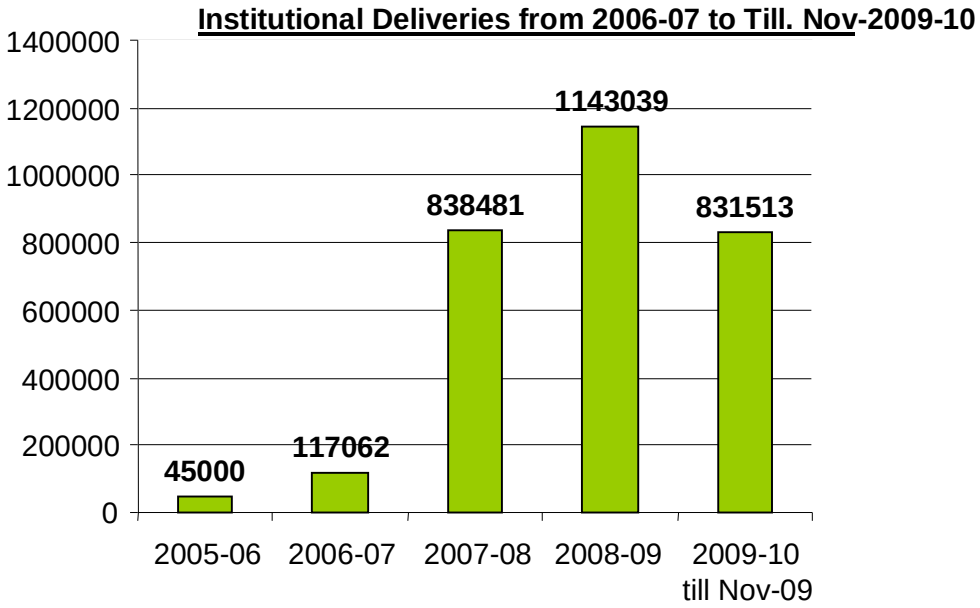
Various programmes have been initiated by the Department of Health, Government of Bihar which has improved the health scenario in the State and has made primary health care accessible and available to the rural masses. The **patient load/turnout** in Government hospitals has increased in the OPDs from 105 lakhs in year 2006-07 to 160 lakhs in 2008-09, similarly the load in IPDs has increased from 7.98 lakhs in 2007-08 to 14.0 lakhs in 2008-09.

The capacity to manage the program in the state has significantly strengthened. There is a significant increase in institutional delivery in Government hospitals. The availability of human resources has increased substantially at different levels of health institutions. Several PPP interventions have been implemented to increase the reach to the people. By and large the improved infrastructure, strengthened facilities and people's confidence in availability and accessibility to public health facilities has improved considerably.

Maternal Health

24 x 7 Health Services is available in 480 Primary Health Centres of the State.

The total no. of **institutional delivery** has increased from 45000 in the year 2005-06 to 1143039 in 2008-09, while the total no. of deliveries from April to November 2009 is 8,31,513. The percentage of increment has been from 22% in 2005-06 to 27.7% in 2007-08.

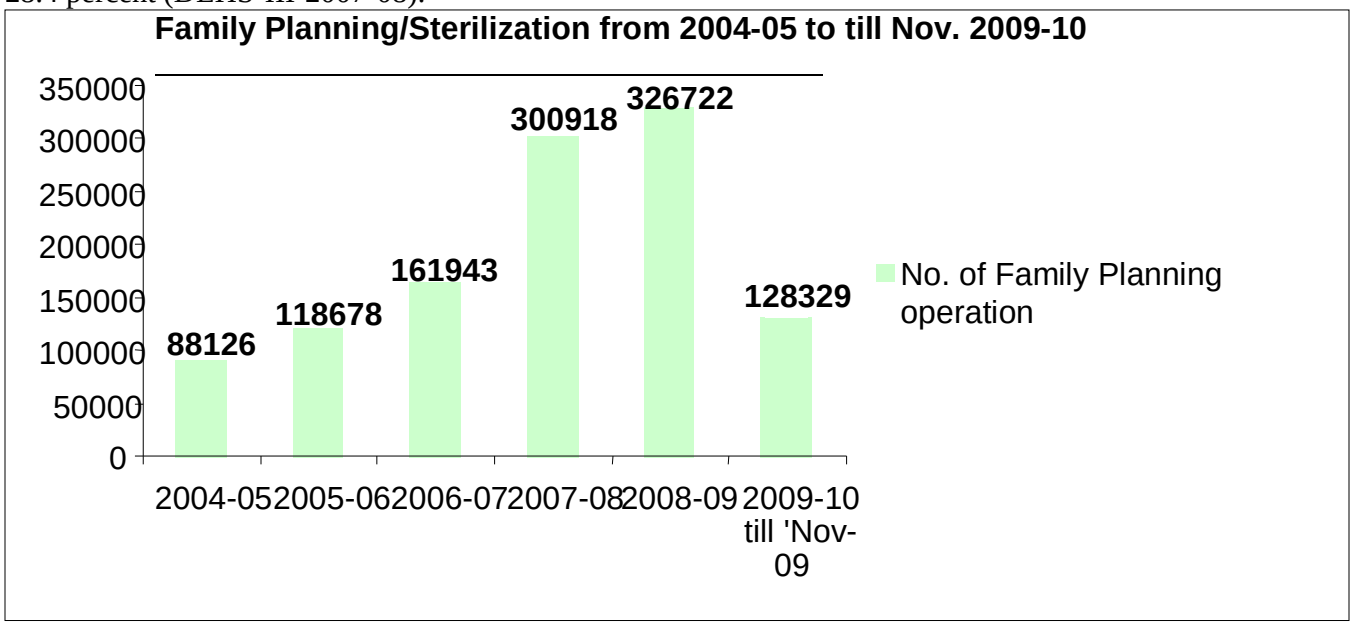


Antenatal Care has increased from 15.9 % in 1998-99 to 26.4 % in 2007-08. Due to the Breastfeeding campaign, the proportion of children breastfed within 1 hour rose from about 5% in 2002-04 to 16.2% in 2007-2008.

Maternal Death Audit was initiated in one district on a pilot basis wherein verbal autopsy of 89 deaths were conducted, data analyzed and shared. State wide system for improving reporting of maternal deaths planned.

Population Stabilisation

Every year about 27,00,000 children are born. The total no. of Family Planning operations has increased from 118678 in 2005-06 to 326722 in 2008-09, and from Apr. to Nov. 2009 a total of 128329 operations have been done. Contraceptive use has increased from 23.1 percent (NFHS-I 1992-93) to 28.4 percent (DLHS-III-2007-08).



Availability of Free Medicine in OPD and IPD

In the Primary Health Centres of the State, Free Distribution of 33 drugs in OPD and 37 drugs in IPD is being done and in the District/main Hospital of the district 33 drugs are being distributed free in the OPD and 107 drugs in the IPD. The process of expanding the number of drugs being distributed in OPDs and IPDs in the Medical College Hospitals to the District Hospitals till the Additional Primary Health Centres is in process as such-41 essential drugs for the OPD patients and 193 essential drugs for the IPD patients from District Hospitals till Primary Health Centres/Additional Primary Health Centres, 99 essential drugs in the OPD and 172 essential drugs in the IPD for the 6 Government Medical College Hospitals, 48 drugs/materials for the 6 Government Medical College Hospitals.

Equipment Procurement

- To strengthen Labour Rooms in the Government Hospitals, State Health Society is ensuring the availability of ten equipments in these units. All the Labour Rooms are being modernized.

- To equip the Government Hospitals with Beds, the State Health Society is providing three types of beds- Fowler Deluxe Bed, Fowler Bed and Semi Fowler Bed.

- State Health Society has already awarded contracts for procurement of equipments for SNCUs and NSUs.

- Establishment of the Bihar Procurement Corporation on the Tamil Nadu Medical Services Corporation model is in the final stage.

Institutional Framework of NRHM

Under NRHM about 3608 Village Health and Sanitation Committees have been formed in the State in the current year, and the constitution of the remaining is being done on a priority basis. 513 Registered Rogi Kalyan Samitis or Hospital Welfare Societies are operational at various facility levels.

69124 ASHAs (Accredited Social Health Activists) have been selected for ensuring village level interventions.

De-centralised Planning

De-centralised Planning under NRHM has been undertaken in FY 2009-10 for the 1st time in Bihar and this year Block Planning has also been undertaken. It is envisaged that once the VHSCs are in place, village planning may also been initiated in the coming year.

Health Infrastructure Status

Health Institutions	Present
Medical Colleges	9
District Hospital	25
Sub-Divisional Hospital	22
Community Health Centre	70
Primary Health Centre	533
Additional PHC	1243
Sub-Centre	8858

Human Resource

Manpower Management in the health sector has been undertaken vide various initiatives like **r**e-organizing & rationalizing the existing manpower, ensuring power to transfer doctors delegated to Civil Surgeons, Web enabled system to capture district level cadre information, appointment of 1763 contractual doctors done, dynamic ACP being rolled out, cadre modified for doctors, cadre rules notified for paramedics and health educator, OT assistant, clerks, pharmacists, lab technicians, X-ray technicians cadre rules to be finalized soon, and draft publication readied for x-ray technicians, OT assistants and clerks.

According to IPHS norms, Bihar should have at least 18 medical colleges as against 9 currently run and the total output of doctors from all the medical colleges is 510 MBBS and 100 specialists for the state.

Current Status in Manpower

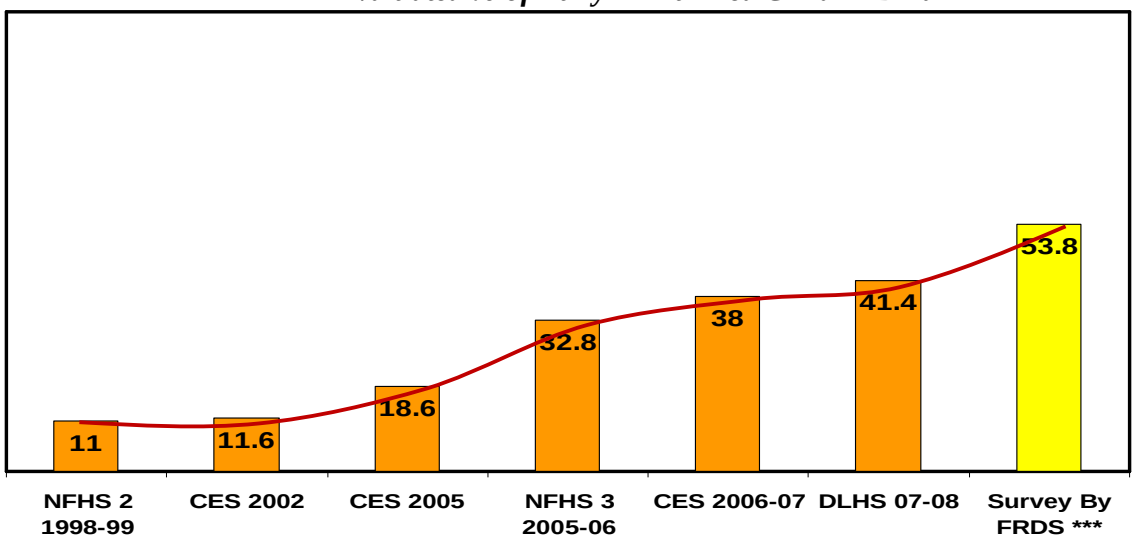
Medical Officers	:	3860
Contractual Doctors	:	1763
Staff Nurses	:	3900
ANM	:	10055
ANM-R (Contratual)	:	6000
Health Managers	:	477
Block Accountant	:	533
ASHA Health worker	:	69124

Private Specialists
From District Hospitals to PHC provision of Private Specialists in Eye, ENT, Orthopedics, Pediatrics, Gynae and Surgery @ Rs.500/day/doctor is being ensured and under this renowned doctors of the regional areas are contributing towards availability of quality services.

Child Health

In **Immunisation**, % of Full Immunization coverage has increased from 10.7 % (1992-93) to 53.8 % (ISB, 2009). Under Immunisation, various initiatives were introduced like alternate vaccine delivery (Couriers) for reaching vaccines, 3-rounds of Mobile Hard-to-reach RI campaigns were conducted in early 2006 to reach communities which hitherto never had access to RI services, the Year 2006 was declared as Immunization year and Wednesdays and Fridays were designated as immunization days. Furthermore in October 2008, ***Muskaan ek Abhiyaan*** was launched which included initial survey and tracking of Pregnant and Newborn till full immunization is achieved and realized partnership between ICDS and Health at all levels. There were twice weekly sessions at HSC and AWC and performance-based incentive schemes for Health Workers and Mobilisers was introduced under the scheme.

Evaluated % of Fully Immunized Child in Bihar



Sick Neonatal Care Units are functional in 6 district hospitals and is further being expanded to 26 more districts while Newborn corners have been established in 45 PHCs. Neonatal Stabilisation Units are being established in 398 Primary Health Centres of the State. Integrated Management of Neonatal Care Initiative (IMNCI) is being implemented in 24 districts and nearly 60% newborns are visited within 24 hrs by the trained worker.

Vitamin A campaign has ensured coverage increase from 8.9% in year 2004 to 95.03% in 2009.

Public Private Partnership Initiatives :

Mobile Medical Units (MMU)

Scheme of 1 MMU per district was launched on 13th July 2009 and at present a total of 12 MMUs are functional in Bihar. In an MMU the following staff is made available -Specialist Doctor, Nurse, X-ray Tec., Lab. Attendant, Para Medic/ Pharmacist-cum Van Supervisor and OT Assistant. Services being provided per MMU are Free OPD, Free Drugs, Gynae/ANC clinic, Eye check up, ENT check up, HIV testing, Pathology, Radiological tests, IEC, Medical camps etc.

Dial 108-Emergency Referral Services

A pilot project was launched in Patna under PPP for Emergency transport. It's operation started from 03 June 2009. 2 kinds of Ambulance services are being provided – 5 Advanced Life Saving and 5 Basic Life Saving ambulance services have been provided. The basic facilities that are being provided are – Drugs, Oxygen, Heart monitor, ventilator and other Supportive Medical System. All this at a very low cost chargeable to the patient @Rs.300/- and additionally free/lower rates are charged from the poor patients. The agency operating the facility is paid a monthly fee for the service. On calling 108, it's service is ensured within 15-20 minutes. This is a scheme which has provided a visible face to NRHM in Bihar and has added to the goodwill of the Health Department.

Diagnostic Services :

Free Diagnostic (Pathology and Radiology) Services to all Government Patients is being provided to the people of Bihar right from PHCs to District Hospitals. Free Diagnostic Services is being provided to all BPL patients in the Medical College Hospitals.

Basic Pathology Services

Private Sector Partner operates, maintains and reports through 24-hours Diagnostic centers. Coverage of this service is 25 District Hospitals, 23 Sub-Divisional Hospitals, 76 Referral Hospitals and 398 PHCs of Bihar. 19 districts each have been divided among two agencies for Pathology and agency pay nominal monthly rent for space in DH & SDH.

Basic Radiology Facilities

38 districts have been given to one agency to operate, maintain and generate X-ray films. 134 units are functional. Space has been provided against nominal rent. It functions under the overall supervision of the Hospital Management Society (RKS) of the respective Hospital. USG facility is also being ensured here and reporting on the same has to be done through a Central Reporting System at State Headquarter level, where Radiologists shall report on USG films.

Ultra-Modern Diagnostic facility

SHSB has set up Ultra-Modern Diagnostic facility through private partners at Government Medical College and Hospitals and Regional Diagnostic Centres (Divisional HQ) levels wherein specialized pathology, bio-medical, ECG, MRI, CT Scan, Mammography etc services are being provided. The services are free for BPL Government patients and under NRHM the Hospital Welfare Societies are reimbursing the cost to the private partner, while for other Government patients the rate chargeable is as per AIIMS, New Delhi rate.

Urban Health Centres

Urban Health Centres have been established to provide support to the Government's Health Programmes under which free OPD facility is provided. 3 Urban Health Centres have been started in three districts- Nalanda, Patna and Samastipur, and 5 more are being operationalised in Nalanda and Muzaffarpur districts. The total number of patients seen in these Urban Health Centres is 20635 (Nov'08-Sept.'09).

Blood Storage Unit (BSU)

27 Blood Banks have been set up in different districts. 21 Blood Banks run through PPP (17 to Red Cross Society & 4 to others). Equipments for Blood Storage Centres have been supplied to all FRUs.

Trauma Centre

The process of establishing Trauma Centre has been initiated in 9 districts of the State (from the perspective of National Highways).

Bedsheets-Cleanliness Initiative

Different Coloured Bed sheets are being ensured per day in each hospital. Promotion of Handloom Industry by procuring only handloom bed sheets for this purpose has also been ensured.

Hospital Maintenance

Maintenance of hospital premises, Generator Facility, Cleanliness of Hospitals, Washing, Diet is being ensured through private partners in each district

Institutional Arrangements and Organizational Development

Along with Health department the ICDS, PHED and Panchayat are helping in implementing the NRHM Programme. The coordination has been placed at State level, District Level and Block Level. At the Grassroot level linkage between ASHA, ANM with AWW has been strengthened especially under the Muskaan programme. PHED department has taken up the training of ASHA.

Trainings are being regularly conducted under different programmes in the state. The state has already started the trainings of IMNCI. The State is trying to operationalise 22 ANM schools. Repair and renovation of these schools are already in progress and are expected to be operationalised in this year.

Most of the districts have their own Drug warehouse, however it is being planned to upgrade the Drug Warehouses so that a comprehensive, consolidated and computerized warehouse system is available.

The state has a unique system of collecting data from each PHC level. The state has established a data centre in the state and has centres in District and at PHC. These data centres collect data from each PHC through mobile phone and feed in the computer. The computerized data is later given to the respective Programme Officers.

Financial Management

Government of India's funds are released to the state through two separate channels, i.e; through the state budget and directly through the State Health Society. Further the Department's outlay for the procurement of vaccines, drugs, equipments etc; is spent centrally and assistance to the state has been in the form of kind.

In 2009-10 the GoI had approved an amount of Rs. 1280.70 crores under RCH II. To decentralise the process, SHSB undertook the task of 'Allocation of Funds for Districts for FY 2009-10' for all the components of NRHM-RCH Flexible Pool (A), Mission Flexipool/Additionalties (B), RI and Pulse Polio (C) & Disease Control Programmes (D). The State Programme Officers were assigned the task of allocating funds for the complete year to the districts based on the unit cost and requirement of the district. The annual fund allocation was done for all the programmes which were grouped under Part A, B, C & D. The DPMU team was then called at the State Headquarter level for a workshop and they undertook the exercise of **allocating the funds for the four quarters**. In

this workshop each State Programme Officer detailed the districts on the unit costs for each district, which assisted the districts in allocating funds for the quarters.

This quarterly allocation was then taken back to the districts and after necessary corrections and vetting by the concerned District Programme Officers, necessary approval of the District Magistrate and Civil Surgeon was taken. This was then communicated to the State. Based on the requirement from the districts and the final approval from Government of India, the fund allocation was finalised for the 4 quarters and the annual targets for the districts were finalized.

To further expedite the Districts in Fund Utilisation and to do away with lack of clear instructions and guidelines on fund utilization, the State Programme Officers prepared **detailed Financial Guidelines for each Budget head**, which covered aspects like purpose of the head, outcome, unit cost, responsible official, financial protocol etc. Prior to approving the guidelines, District Programme Managers from about 10-12 districts were called for a meeting at the State level, wherein these Financial Guidelines were vetted by them and modifications suggested by them were incorporated and then the Financial Guidelines were approved.

In this process a new financial system was introduced. The purpose for introducing this new system was-

- De-centralisation of Resources and Power to the Districts and below
- Transparency in the Fund allocation
- Need based fund allocation
- Better utilization of funds
- Better Fund Accountability of the Districts and PHCs

The salient features of this new system are –

- District allocation for Major and Minor heads for the complete year communicated to the districts
- Districts empowered to re-allocate funds within the sub-heads of the Major sections, keeping in mind the annual target. Thus districts can prioritise their needs and meet them at the district level.
- Funds released to districts and subsequently to other levels for the Major heads for each quarter depending on 80% SOE submission
- Non-performing district's funds to be re-allocated mid-year to the performing districts, thus State would be able to meet the utilization target and performance would be awarded

To sensitise and for handholding of the districts and PHCs, the new financial systems were disseminated among the Civil Surgeons in the monthly meetings, with the DPMUs and with the Development Partners. Furthermore two day workshops were held in the districts where the Districts disseminated the new financial system and guidelines for each programme to the Blocks etc and further got the facilities to allocate funds for each quarter, based on the annual allocation prepared by them in consultation with the District Programme Officers. In these workshops one State level Officer also participated to ensure clarity of the process and guidelines.

To further expedite NRHM activities, the State level officials have undertaken Activity Planning exercise which covers the process indicators for each activity and time line for completion of the same. This is to ensure focused and time-bound manner of implementation of the activities.

State's Concerns and Strategies | Chapter 6

The State has achieved some progress in terms of output indicators, however the maternal mortality, child mortality and population growth continues to be a cause of serious concern to the state's development efforts. In terms of key health indicators, Bihar is among the low performing states. Though the state fares reasonably well in terms of its Infant Mortality Rate (56) as against the national average (53) and NMR (42.1) as against national average of 45, it continues to be among the poorer performing states in terms of TFR and MMR.

Moreover, floods in some parts of the state make the State vulnerable to communicable diseases. Besides, the health infrastructure is inadequate to cater to the needs of the people and the upkeep of the already existing facilities is quite challenging. The delivery of services could only be improved if facilities are within reach and have minimum basic physical infrastructure to provide the basic services. There seems a major challenge in construction of the health care facilities. Lack of clear guidelines sometimes delay the process.

To make the BEmOCs and CEmOCs functional, adequate staff and infrastructure (OT, Labour rooms, new born care area and blood storage units) are to be taken up on a priority.

Human resource is another major issue where the State health system is struggling. The paucity of medical professionals especially the Specialists limits the public health facilities in providing much required higher level of care to the needy. A mismatch exists in the State between the available Medical and Para medical professionals and the demand for their services. More medical graduates and Para medical professionals are required to fill up this gap. Moreover despite number of trainings held, rationalization of manpower is yet to take place. To overcome this, the State has initiated public private partnerships, out sourcing health facilities and programmes to private sector and NGOs, contracting specialists for specialized care, etc. There is also dearth of well-trained public health professionals and managers to effectively steer the public health and family welfare programs.

Another issue which the state is encountering is a declining sex ratio. Several initiatives like advocacy, intensive IEC programs and enforcement of PNDT is aimed at reversing the existing sex ratio is being initiated this year.

Procurement of Equipment- Though essential drugs have been rate contracted so far, the rate contract of various equipments needed for carrying out RCH activities is a time-consuming process and SHSB lacks the technical know-how for the same. A TNMSC model of Corporation has been approved and is in the finalization stages, this would solve the logistic and procurement problem.

BCC strategy formulation- Even after four years of NRHM, Bihar lacks a consolidated BCC strategy in health due to lack of technical know- how. Besides, some other initiatives are planned this year in areas like promotion of Breast feeding, PNDT among others.

Quality Assurance committees in State and Districts- Quality assurance committees formed in the districts as per Quality Assurance Manual of GoI. State Quality Assurance Cell has been formed. Quarterly monitoring visits are being undertaken at the state level and the divisional level to monitor quality of trainings and critical services.

Maternal Health

Improving the maternal health scenario by strengthening availability, accessibility and utilization of maternal health services in the state is one of the major objectives of RCH. However, the current status of maternal health in the state clearly shows that the programme has not been able to significantly improve the health status of women. There are a host of issues that affect maternal health services in Bihar.

The important ones are listed below:

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

Introduction of JBSY acted as a major boost to improving maternal health. Under the Scheme institutional delivery has substantially increased, and there has also been a shift in deliveries from DHs to PHCs, thus easing the load on the DHs. There has been an increased utilization of ANC services which also led to high coverage of PNC, zero dose polio, BCG. However, the minimum two day stay post delivery is not adequately ensured and there are delays in payments to beneficiaries.

Another key challenge for the JBSY programme is that the full potential of JBSY in terms of provision of essential newborn care and oist partum family planning counseling is yet to be realized. Several steps are being undertaken to strengthen JBSY implementation and monitoring like payment prior to discharge through bearer cheque, monitoring of JBSY/verification of beneficiaries by officials at different levels, public disclosure of beneficiaries at the facility and setting up of grievance redressal mechanism for JBSY. The 2-days stay after delivery is being promoted and essential newborn care and post partum counseling is to be focused upon esp. in high volume facilities. Other interventions being conceived are improved monitoring of Quality of deliveries at public health facilities and accredited private sector facilities.

In the State 44 MOs have been trained in EmOC and 57 MOs in Life Saving Anesthetic Skills who are now managing complicated cases at their respective places of posting. Bihar is the first state to

have formally evaluated the LSAS examinees and issued certificates of practice for the obstetric anesthesia.

A quality monitoring cell at the state level housed in State Institute of Health & Family Welfare is monitoring all the trainings. The cell has members drawn from SIHFW faculty, medical colleges, retired faculty members, officials from State Health Society and officials from partner agencies as its members. Their initial focus is to monitor the quality of various trainings being undertaken under NRHM like IMNCI, SBA, Minilap and of quality of critical care health services.

Child Health

The child health indicators of the state reveal that the state's IMR is lower than the national average. Morbidity and mortality due to vaccine-preventable diseases still continues to be significantly high. Similarly, child health care seeking practices in the case of common childhood diseases such as ARI and Diarrhoea are not satisfactory. The child health scenario is worse for specific groups of children, such as those who live in rural areas, whose mothers are illiterate, who belong to Scheduled Castes, and who are from poor households is particularly appalling.

Issues affecting child health are not only confined to mere provision of health services for children, but other important factors such as maternal health and educational status, family planning practices and environmental sanitation and hygiene-all which have enormous bearing on child health. This is more than evident in the case of Bihar where child health continues to suffer not only because of poor health services for children but due to issues such as significantly high maternal malnutrition, low levels of female literacy, early and continuous childbearing, etc. The specific issues affecting child health in the state are listed below-

Maternal Factors

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

Family Planning Services

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

Child Health Services

- The programme has not succeeded fully in effectively promoting colostrum feeding immediately after birth and exclusive breastfeeding despite almost universal breastfeeding practice in the state. In the State majority of mother breast feed children beyond six months. However the State has taken initiative to generate awareness among mothers for exclusive breast feeding.
- High levels of child malnutrition, particularly in rural areas and in children belonging to disadvantaged socio-economic groups leading to a disproportionate increase in under-5 mortality.
- Persistently low levels of child immunisation primarily due to non-availability of timely and quality immunisation services.
- Lack of child health facilities, both infrastructure and human resource, to provide curative services for common childhood ailments such as ARI, Diarrhea, etc.

- Inadequate supply of drugs, ORS packets, weighing scales, etc.
- Lack of knowledge of basic child health care practices among the community.
- Failure to generate community awareness regarding essential sanitation and hygiene practices that impact on the health of children.

Since these factors are inter-linked and synergistic, any effort to improve the health of the children in the state needs to address child health issues in a holistic manner.

IMNCI Training: IMNCI training has successfully started in the State. The Pilot project had been successfully completed in the district of Vaishali. In 2009-10 IMNCI Training has been scaled up to 23 districts.

Nutritional Rehabilitation Centres are in operation in two districts of the State wherein special nutritious food is provided to the severely malnutrition children.

Population Stabilisation

RCH emphasizes on the target-free promotion of contraceptive use among eligible couples, the provision to couples of various contraceptive methods (including condoms, oral pills, IUDs and male and female sterilization), and the assurance of high quality care. It also encourages the spacing of births with at least three years between births. Despite RCH and previous programmes vigorously pursuing family planning objectives, fertility in Bihar continues to decline at much lower rates than the national average. Although the total fertility rate has declined by about half a child in the six-year period between NFHS-1 and NFHS-2, it has increased in NFHS-3 and again decreased as per SRS 2007 but still is far from the replacement level. Furthermore, certain groups such as rural, illiterate, poor, and Muslim women within the population have even higher fertility than the average.

The persistently high fertility levels point to the inherent weakness of the state's family planning programme as well as existing socio-demographic issues. High TFR is reflected by a dismal picture of women in Bihar marrying early, having their first child soon after marriage, and having two or three more children in close succession by the time they reach their late-20s. At that point, about one-third of women get sterilized. Very few women use modern spacing methods that could help them delay their first births and increase intervals between pregnancies.

The major issues affecting the implementation of the Family Planning programme in Bihar are as follows:

- Lack of integration of the Family Planning programmes with other RCH components, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels.
- Failure of the programme to effectively undertake measures to increase median age at marriage and first childbirth.
- Inability of the programme to alter fertility preferences of eligible couples through effective behavior change communication (BCC).
- Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age

groups. (Overall, sterilization accounts for 82 percent of total contraceptive use. User rates for pill, IUD and condoms remains very low, each at about 2 percent or less than 1%-NFHS III).

- Due to high prevalence of RTI/STD, IUDs are not being used by majority of women (user rate at 0.6% only –NFHS III).
- Continued use of mass media to promote family planning practices despite evidently low exposure to mass media in Bihar, leading to less exposure of family planning messages in the community, particularly amongst rural and socio-economically disadvantaged groups.
- Weak public-private partnerships in social marketing to promote and deliver family planning services. (Public Private Partnership has improved since 2008-09. 102 Nursing homes in 20 districts are accredited to conduct Family planning operations. Accredited Private Nursing homes are expected to conduct more than 50-60 thousand family planning operations in the state. 1,28,329 sterilizations conducted till Nov, 2009 of which 22,050 are conducted by the accredited private Nursing Homes**.**

The issues mentioned above are closely interlinked with the existing socio-demographic conditions of the women, especially rural, poor and illiterate. Comprehensive targeted family planning programme as well as inter-sectoral co-ordination on an overall female empowerment drive is needed to address the factors responsible for persistently high fertility levels in Bihar.

The state has quality assurance committee for family planning both at State and District level. The committee sits quarterly and report is sent to state. Also, 135 private hospitals and Clinics are accredited by the District Quality Assurance Committees for conducting sterilization in 20 districts. These private facilities are monitored by the QAC on sterilization conducted in the facilities. Family planning Insurance scheme is also being implemented in the state with ICICI Lombard. Most of the Sterilizations are conducted in the last two quarters due to existing socio-demographic and programmatic reasons.

Efforts are being made to offer fixed day family planning services at District hospitals, Sub divisional hospitals, FRUs and accredited private facilities. Later on this will be extended to the PHCs.

Adolescent Reproductive & Sexual Health

Adolescents, the segment of the population in the age group of 15 -19 years, constitute about 23% of the population of the state. This group is critical to the success of any reproductive and sexual health programme, as it would remain in the reproductive age group for more than two decades and as this age group corresponds to the onset of puberty and the legal age for adulthood.

Commencement of puberty is usually associated with the beginning of adolescence. In some societies, adolescents are expected to shoulder adult responsibilities well before they are adults; in others, such responsibilities come later in life.

Although it is a transitional phase from childhood to adulthood, it is the time that the adolescents experience critical and defining life events – first sexual relations, first marriage, first childbearing and parenthood. It is a critical period which lays the foundation for reproductive health of the individual's lifetime. Therefore, adolescent reproductive and sexual health involves a specific set of needs distinct from adult needs.

The reproductive health needs of adolescents as a group has been largely ignored to date by existing reproductive health services. Many adolescents in India face reproductive and other health risks. Poor nutrition and lack of information about proper diets increase the risk of iron-deficiency anemia for adolescent girls (as high as 68.3% as per NFHS 3). Young women and men commonly have reproductive tract infections (RTIs) and sexually transmitted infections (STIs), but do not regularly seek treatment despite concerns about how these infections may affect their fertility.

Bihar has one of the highest rates of early marriage (69% among women aged 20-24 years) and high rate of childbearing, and a very high rate of iron-deficiency anemia. The prevalence of early marriage in India poses serious health problems for girls, including a significant increase of maternal or infant mortality and morbidity during childbirth. The following facts will help understand the situation objectively.

- The median age of marriage among women (aged 20 to 24) in India is 16 years.
- In rural India, 40% of girls, aged 15 to 19, are married compared to only 8% of boys of the same age.
- Among women in their reproductive years (ages 20 to 49), the median age at which they first gave birth is 18.7.
- Nearly half of married girls, ages 15 to 19, have had a least one child.

- India has the world's highest prevalence of iron-deficiency anemia among women, with 68.3% of adolescent girls being anemic.

Underlying each of these health concerns are gender and social norms that constrain young people – especially young women's access to reproductive health information and services.
Motherhood at a very young age entails a risk of maternal death that is much greater than average, and the children of young mothers have higher levels of morbidity and mortality.

Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting sexually transmitted diseases, including HIV/AIDS; and they are typically poorly informed about how to protect themselves.

Information and education programs should not only be targeted at the youth but also at all those who are in a position to provide guidance and counseling to them, particularly, parents and families, service providers, schools, religious institutions, mass media and peer groups. These programs should also involve the adolescents in their planning, implementation and evaluation.

Thus it can be conclusively stated that adolescents are a diverse group, and their diversity must be considered when planning programs.

In the State there was lack of a cohesive ARSH strategy at the state level and was introduced in 2009-10 Plan, however the strategy requires sensitization and handholding at all levels for proper implementation. The current school health program by and large lacks any adolescent oriented interventions.

The Bihar State AIDS Control Society has several adolescent targeted interventions including special adolescent counselors. The possibility of convergence between the RCH II program priorities and NACP priorities requires to be explored.

Specific capacity building initiatives to orient the health providers at various levels to specific necessities of the ARSH program like adolescent vulnerability to RTI/STI/HIV /AIDS, communication with adolescents, gender related issues, designing adolescent friendly health services, body and fertility awareness, contraceptive needs etc have not been actively taken up.

Health Infrastructure Status

Health Institutions	Required	Present	Shortfall
Medical Colleges	18	9	9
District Hospital	38	25	13
Sub-Divisional Hospital	101	22	79
Community Health Centre	622	70	552
Primary Health Centre	2489	533	1956
Additional PHC	2787	1243	1544
Sub-Centre	16576	8858	7718

Out of 38 Districts 25 have district hospitals. Most of the district hospitals are not functioning up to the level due to shortage of Specialists and Staff Nurses. Construction of 11 District Hospitals are on full swing and expected to be completed in 2010. The identified PHCs require to be upgraded to CHC level for specialised services. The APHCs only provide OPD services and have to be operationalised for meeting in-patient needs and for providing delivery services, so that the load of Block PHCs is reduced. Half of the HSCs are running from the rented place or Panchayat office and are manned by one ANM only.

There is slow progress in Infrastructure as the PWD (BCD) is overloaded To overcome the problem of slow progress in infrastructure, a separate infrastructure cell has been created in State Health Society, Bihar headed by a Consultant. This year, it is proposed that two more personnel may be added to this wing to strengthen it. Moreover all the DMs have been requested to designate an agency for their district that would carry out all infrastructure-related tasks.

Infection Management and Environmental Plan:

Bio medical waste management has emerged as a critical and important function within the ambit of providing quality healthcare in the country. It is now considered an important issue of environment and occupational safety. As per the Bio-Medical Waste (Management & Handling) Rules, 1998, all the waste generated in the hospital has to be managed by the occupier in a proper scientific manner.

GoI has also issued the IMEP guidelines for SCs, PHCs and CHCs, proper dissemination of the same has to be ensured through a technical agency.

The state has identified agencies for undertaking the task of Bio-Waste Management and Treatment but necessary approval and clearance from Bihar State Pollution Control Board and Central Pollution Control Board is still awaited. In the districts under Patna division the task has been handed over to Indira Gandhi Institute of Medical Sciences, Patna which has it’s own Treatment plant. The task has yet to be operationalised and needs streamlining, however all the six Patna division districts have been trained regarding waste management and segregation.

Human Resource Development including Training

Human Resource Development forms one of the key components of the overall architectural corrections envisaged by NRHM. Government of Bihar also has spelt out the same as the number one priority. However the implementation of this vision has been fraught with various obstacles.

Though the state has reasonable number of MBBS doctors, there is an acute shortage of specialized medical manpower. The shortage of specialists like obstetricians and Anesthetists are obstructing the state plans to operationalise all district hospitals as First Referral Units. The available specialists in the state cadre is concentrated at the state Referral Hospital and hence the same handle bulk of the institutional deliveries state wide and is the only center capable of providing comprehensive emergency obstetric care services.

Recruitment of Medical officers and paramedics- The process of recruitment is lengthy and takes about 04-06 months. The number of applicants is quite limited because of dearth of doctors and paramedics in the state. Moreover the consolidate remuneration is not lucrative enough. Hence from the previous year incentive for rural postings and specialist services have been provided in the SPIP. High turnover of Personnel due to low motivation- It is felt that the state needs to restrict the turnover of doctors on contract and also programme managers. It is proposed that a study may be undertaken to assess the situation and recommend remedies, however it is assumed that rural and specialist bonus will help to curb the turnover to same extent and an HR policy needs to be finalized.

Quality of training - Monitoring cell has been constituted at the state level in State Institute of Health & Family Welfare. The trainings are being monitored at regular intervals.

Low motivational level of health staff - The motivational level of health staff at all levels is low. Continuous communication and feedback by state level programme officers is being done.

Sub optimal utilization and rationalisation of trained staff – Regular evaluation and monitoring is being done and corrective steps are being taken. Placement of trained people at such facilities where infrastructure is in place. E.g. The government has taken up on priority the placement of the trained EMoC and LSAS doctors to the FRUs where there is no such facility. Poor monitoring and evaluation framework – Regular monitoring visits by programme officers.

In 2009-10, there has been a continuous focus on the capacity building of the existing manpower in the state. Trainings as per GoI guidelines on Immunization, IMNCI, EmOC, LSAS, SBA and Minilap/MVA etc have been taken up with full vigor, however due to poor quality of training in some centres, training fell behind schedule. It is proposed to continue these trainings in 2010-11. In addition, the state wide training on Immunization for Medical Officers, IPC skills for Breast feeding and basic training of neonatal resuscitation-shall also be taken up for various levels.

Ensuring Gender Equity

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

Gender discrimination continues throughout the life cycle, as well. Women are denied access to education, health care and nutrition. While the state's literacy rate is 47.5%, that for women in rural areas is as low as 30.03%. Abysmally low literacy levels, particularly among3 women in the marginalised sections of society have a major impact on the health and well being of families. Low literacy rate impacts on the age of marriage. The demand pattern for health services is also low in the poor and less literate sections of society.

Women in the reproductive age group, have little control over their fertility, for want of knowledge of family planning methods, lack of access to contraceptive services and male control over decisions to limit family size. According to NFHS data, for 13% of the births, the mothers did not want the pregnancy at all. Even where family planning methods are adopted, these remain primarily the concern of women, and female sterilization accounts for 19% of FP methods used as against male sterilization, which is as low as 1%. In terms of nutritional status too, a large proportion of women in Bihar suffers from moderate to severe malnutrition. Anemia is a serious problem among women in every population group in the state and is more acute for pregnant women at 60.2% (NFHS 3).

In all the programmes efforts will be made to meet the needs of vulnerable groups and ensure equity. Gender sensitization shall be made part of each training. The monitoring system too will be geared for this so that we may get disaggregated data.

The state of Bihar is implementing the PC- PNDT Act at right earnest. The MOs are being trained by the State Health and Family Welfare Institute. The Civil Surgeons are the nodal person in the district in this regard. However monitoring of the activity is still a big problem. The state has procedures for registering the diagnostic centres and hospitals which compel these institutes to follow the PC-PNDT Act.

Urban Slums

Urban health care has been found wanting for quite a number of years in view of the fast of urbanization leading to growth of slums and population as more emphasis is given in rural areas. Most of the Cities and Towns of Bihar have suffered due to lack of adequate primary health care delivery especially in the field of family planning and child health services.

At present, there are 12 Urban Health Centres (UHC) in the state. However, as per the GoI guidelines, there should be one UHC for 50,000 population (outpatient). The Urban Health Centres should provide services of Maternal Health, Child Health and Family Planning and especially cater to the Urban slums. The infrastructure condition of the existing Urban Health Centres is not up to the mark and requires some major renovation work. The staff at each UHC should comprise of 1 Medical Officer (MO), 1 PHN/LHV, 2 ANMs, 1 Lab Assistant and 1 Staff clerk with computer skills.

UHCs are being set up under PPP by SHSB under which 8 have already been made operational and 12 more are in the pipeline.

Current System of drug, equipment, services and supplies

- Procurement in decentralised manner with rate contracts fixed centrally by SHSB
- District officials directly place orders to the concerned entities using a cash and carry system

Positive steps taken by DOH, GOB for improving procurement function:

- Transferring the procurement function to Bihar State Health Society which provides flexibility in functioning
- Guidelines for rate contracts are revised from time to time to make them more prudent and if one analyses the guidelines from initial rounds to current rounds, several points have been included to increase the transparency
- DoH has prioritised strengthening Warehouse Infrastructure in districts and funds have been sanctioned for construction of new warehouses
- Adoption of GOI's GFR to make system transparent and procedures simple for procurement by state level entities
- Rate contracting and cash and carry system introduced by SHSB, resulting in increase in availability of drugs at facility level manifold and has further resulted in increase in patient using state run health facilities.
- All procurement related information starting from advertisement to evaluation to final decision are posted on SHSB website, making the entire system transparent
- DoH keen to establish an independent procurement agency on lines of TNMSC

Issues that the present suffers from –

- Absence of detailed and transparent guidelines for technical evaluation of bids by SHSB results in delayed evaluation process and leads to litigations by disqualified bidders.
- For a number of drugs the rates are not fixed because of limited or even no bidders
- Rates of drugs procured by SHSB are much higher than other states like MP and TN-due to perceived high level of corruption in the state, which results in time taken for finalisation of rate contracts and due to non-surety of the quantities to be supplied to allow the bidders to take economies of scale into account
- No proper systems for drug procurement planning, demand assessment, indenting and supply of drugs at district and lower level health facilities-resulting in supply of drugs on an ad hoc basis without a clear relation to actual demand
- No standard systems for record keeping at district and facility levels which results which results in a lack of re-conciliation of indents and actual supplies; difficulty in compiling actual stock availability at any particular point of time; difficulty in placing orders based on stock availability; and problems ensuring old stock is cleared first, once the new supplies come.
- Infrastructure and staff capacity (both in numbers and qualification) available at district and facility level stores remain weak, as a result of which it becomes difficult to manage the supply chain and inventory management efficiently and effectively.
- Due to absence of central rate contracts for a no. of drugs, the level of local purchase of drugs by district officials remains as high as 20-30% of the district budget value. Since at district level mostly branded drugs are purchased, their cost is higher than drugs bought through centrally fixed rate contracts.
- Systems put in place for quality testing of drugs remain under-utilised due to a lack of capacity for monitoring and supeervision. There is no system for quarantine of supplies and most of the time the onward supply is made before receipt of the quality testing reports. Also, where local purchases are made, quality testing of drugs is minimal.
- For equipments and services, the supply remains top driven and there are no proper mechnaisms for demand assessment. Lack of skills at SHSB level to define detailed specification for equipments and lack of capacity at facility level to inspect the supplies also impact the procurement process.

- As for service contracts, in the absence of properly defined benchmarks and specifications it becomes difficult to monitor the quality of services being delivered. There is also limited capacity within district officials to monitor the activities of different service providers, which results in provision of either sub-standard or no services at all.
- There is huge requirement for physical infrastructure to be put in place at lower levels – construction activities through BCD or is directly outsourced by DHS, depending on the nature of work. However both these organisations lack in capacity to carry out the scale of work that is required.
- PRI structure remains weak-open to fraudulent practices and lack of transparaency in functioning.

Proposed Strategy-

- Establishment of Autonomous Procurement Agency
- Strengthen Demand Assessment and Supply Chain like development of formats and forms for indenting and record keeping, building capacity of concerned officials in use of new formats
- State level Procurement reforms likeimplementation of Bihar State Transparency and Accountability Act (like in AP, TN) with clearly defined roles for PRIs and CSO; setting up of Bihar State Procurement Oversight Body for community monitoring
- Procurement Act

A big leap has been taken in 2009-10 in the field of Procurement concerning Maternal and Child Health equipments and drugs. One of the key achievements has been the finalization of rate contract for the state owned Sick Newborn Care Unit and Neonatal Stabilization Units, Labour room equipments and of quality hospital beds. In addition, rate contracting of some important drugs like Misoprostol has also been ensured.

HMIS and Monitoring & Evaluation

National Rural Health Mission has been launched with the aim to provide effective health care to rural population. The programme seeks to decentralize with adequate devolution of powers and delegation of responsibilities. This requires an appropriate implementation mechanism that is accountable.

In order to facilitate this process a structure right from the village to the national levels with details on key functions and financial powers is already proposed under NRHM. To capacitate the effective delivery of the programme there is a need for a proper HMIS system. In Bihar under NRHM there is Lack of Proper monitoring and evaluation framework.

Regular monitoring and timely review of the NRHM activities should be carried out. The quality of MIES in State HQ and in districts is very poor. Reporting and recording of RCH formats (Plan and monthly reporting) are irregular, incomplete, and inconsistent and few districts are not reporting at all. Formats are not filled up completely at the sub center level. There information is not properly reviewed at the PHC level. No feedback is provided upon that information.

For overall management of the programme, there is a Mission Directorate and a State Programme Management Unit in the state. The Unit is responsible for overall monitoring and evaluation of the programme in the state and the districts. The data gathering is being facilitated by the State, District and PHC Data Centres. Additionally all the districts have been provided training in uploading information in the GOI HMIS and NHSRC HMIS portals. The numerous formats being used have

been reviewed and it is found that data needs to be compiled only as per RCH, NRHM programme and State needs. Hence the new MIES formats have been shared with all the health functionaries and some of the districts have ensured timely reporting in the new formats from the 3rd quarter.

At district level, there is a District Health Society which is responsible for the data dissemination from the sub-district level to the district level. Data Manager/HMIS expert at the State level and Data Assistant at the district level is responsible for management of HMIS.

As such, there is a Monitoring Team constituted at state and district level to monitor the implementation of the NRHM activities and for Quality Assurance of Health Facilities (detailed checklist has been prepared for the same and the health units monitored are ranked accordingly). The State Monitoring Team comprises of representatives from the Mission Directorate and Programme Committee for various health programmes. The Team also comprises of representatives from Govt. of India.

The role of the Hospital Management Committee/Rogi Kalyan Samiti at all PHCs and CHCs needs to be more proactive. The PHC / CHC Health Committee will need to monitor the performance of HSC under their jurisdiction and evaluate the HSC performance, and submit reports to the District, which after compilation will be sent to the State.

Behaviour Change Communication

The state does not have any comprehensive BCC strategy. All the programme officers implement the BCC activity as per their respective programmes.

The IEC logistics is designed, developed and procured at the district level and distributed to the PHC in an ad hoc manner. However some activity is done at the state level.

There is no credible study available to identify the areas / region specific knowledge, attitudes and practices pertaining to various focus areas of interventions like breast feeding, community & family practice regarding handling of infants, etc. At present there is no impact assessment of the IEC and BCC activities. It's very important to assess the impact of IEC/BCC activities, resources and methods to undertake mid way corrective measures and prepare strategic Communication Plan.

Convergence/Coordination

Convergence with ICDS has been taken care of to cover immunization and ANC Service. ASHA, AWW and ANMs together hold monthly meetings with Mahila Mandals under MUSKAAN Programme. Government of Bihar has decided to merge "Village Health and Sanitation Committee" with "*Lok Swasthya Pariwar Kalyan and Gramin Swaschata Samiti*" constituted by Department of Panchayat Raj in Bihar. The PHED has been entrusted to train ASHAs as per GoI norm. Adolescent councilors are placed in each district from State AIDS Control Society. The Health department is looking to cooperate with them by giving training to these councilors for implementing ARSH programme. The State PWD Department has taken care of the construction of Health Department. All the construction activity for Health Institutions under NRHM has already been handed over to the PWD department.

Private and NGO Health Service

The State has a wide network of private health facilities in the urban areas providing Health services. In general, these private health facilities are run either by individuals/ organizations for profit or by Non-profit Charitable organization/NGOs. However, exact data on the number of these health facilities are not available with the State as the registration of private clinics and nursing

homes has not yet started although the Clinical Establishment Act had been proposed. Presently these health facilities are also not regulated by the DoH. However under PNDT Act, the private clinics and nursing homes undertaking ultra sonography have been regulated and these facilities are being monitored. There is an urgent need to create a comprehensive database for private health service providers and develop appropriate regulatory mechanism for them.

NGOs

The state has only 12 Mother NGOs (MNGOs) covering 22 of the 38 districts of Bihar. However the state does not have a structured procedure to assess the working of MNGOs. There is a need to improve coordination between the NGOs and the State Government at all levels i.e. state, districts and sub-district levels in order to make them effective. They can be a big asset in Community Monitoring and Mobilisation.

Further analysis of information related to NGOs in the state revealed that there are many NGOs that are engaged in the health service delivery. Although no attempts have been made to assess the functioning of these NGOs, it is important to take initiative to develop efficient NGO network in the State.

PPP

Acceptance of Private Partners of SHSB at the district level is minimal and there is a general feeling that instead the Government system should be strengthened. Prior to any such project being implemented in the districts, SHSB should undertake orientation and sensitisation of the district officials and ensure handholding of the Private Partners. Also as being ensured by the Secretary, Health regular meetings should be held with the private partners to ensure that their performance is being maintained and that the obstacles being faced by the private partner is removed.

Vulnerable Section/High Focus districts

In 2010-11, the state envisions a system, which provides all the individuals especially the vulnerable population (SC, OBC, BPL) the ability to access health care at an affordable price by tackling the existing problems and building on its strengths and addressing its weaknesses.

Of the 38 districts of Bihar, 35 are high focus or backward (difficult, left wing affected, minority, SC, gender etc) districts of the State which require special attention. These are Sheohar, Purnia, Jamui, Kishanganj, Madhepura, Supaul, Saharsa, Nawada, Araria, Banka, West Champaran, Gaya, Katihar, Sitamarhi, Darbhanga, Kaimur, Lakhisarai, East Champaran, Jehanabad, Rohtas, Buxar, Begusarai, Aurangabad, Khagaria, Bhojpur, Sheikhpura, Madhubani, Muzaffarpur, Nalanda, Samastipur, Vaishali, Bhagalpur, Saran, Siwan and Gopalganj. Of the above, Jamui, Gaya, Jehanabad, Rohtas, Aurangabad and Nawada are Naxal affected/left wing extremism districts. The SPIP has tried to incorporate special programmes or schemes for the high profile districts.

NRHM PART- A

RCH Flexible Pool 2010-2011

RCH II Programme Objectives and Strategies

Vision Statement:
NRHM seeks to provide universal access to equitable, affordable and quality health care which is uncountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilisation, gender and demographic balance in this process. The mission would help achieve goals set under the National Rural Health Policy and the Millennium Development Goals. To achieve these goals NRHM will:

- Facilitate increased access and utilization of quality health services by all.
- Forge a partnership between the Central, state and the local governments.
- Set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.
- Provide an opportunity for promoting equity and social justice.
- Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.
- Develop a framework for promoting inter-sectoral convergence for promotive and preventive health care.

Technical Objectives, Strategies & Activities Chapter 7

1 Maternal Health

Goals: Reduce MMR from present level 312 (SRS 2007-08) to less than 100

Objectives:

1. To increase 3 ANC coverage from 26.4% to 45% by 2009-10 and to 75% by 2010-11. (DLHS3)
2. To increase the consumption of IFA tablets for 90 days from present level of 9.7% to 20% by 2009-10 and to 35% by 2010-11. (DLHS-3)
3. To reduce anemia among pregnant mothers from 60.2% to 52% by 2009-10 and to 40% by 2010-11.
4. To increase institutional delivery from 70% to 76% by 2009-10 and to 85% by 2010-11 (MIS data)
5. To increase birth assisted by trained health personnel from 31.9% to 45%. (DLHS-3).
6. To increase the coverage of Post Natal Care from 26% to 40% by 2009-10 and to 55% by 2010-11. (DLHS-3).
7. To reduce incidence of RTI/STI cases
8. To reduce the no of unsafe abortions

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

Objective No. 1: To increase 3 ANC coverage from 26.4% to 45% by 2009-10 and to 75% by 2010-11.

Strategies and Activities:

1.1. Institutionalization of Village Health and Nutrition Days (VHND)

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

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

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

1.2 Improved Access of ANC Care

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

1.2.2 Setting up of New Sub Centres to cover more areas

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

1.2.4 Organizing Monthly Village Health and Nutrition Days in each Aaganwadi Centres

1.2.5 Organizing RCH camp in Each Block PHC areas.

1.2.6 Tracking of Pregnant mothers by ASHAs

1.3 Ensure quality service and Monitoring of ANC Care

1.3.1 Strengthen the monitoring system by checking of ANMs duty rooster and visits of LHVs and MOs.

1.3.2 Involvement of PRIs in monitoring the ANMs service through convergence

1.3.3 Refresher training of ANMs on ANC care

1.3.4 Proper maintenance of ANC Register and Eligible couple register

1.4 Strengthening of Health Sub Centres
1.4.1 Repair and Renovation of Sub Centres
1.4.2 Provide equipments like BP Apparatus, Weighing machines, Heamoglobinometer etc to the Sub Centers.
1.4.3 Timely supply of Drug Kit A and Kit B
1.5 Generate Awareness for ANC Service
1.5.1 Convergences meeting with AWWs, ASHAs, PRI Members, NGOs at the Gram Panchayat level by ANMs. These meetings will also attended by MOs from Adll PHCs.
1.5.2 Tracking of Pregnant mothers by ASHA, ANM and AWWs though organizing Mahila Mandals meeting. Incentive for ASHAs and ANMs to give for the initiative. This initiative is under MUSKAAN Programme. Incentive for ASHA will be taken care under Intersectoral Convergence.
1.5.3 Counseling by ASHAs and ANMs to the pregnant mothers, mothers and Mother in Laws.

Objective No. 2: To increase the consumption of IFA tablets for 90 days from present level of 9.7% to 20% by 2009-10 and to 35% by 2010-11. (DLHS-3)

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

Objective No.3: To reduce anemia among pregnant mothers from 60.2% to 52% by 2009-10 and to 40% by 2010-11.

3.1 Supplementing IFA tablets consumption with other clinical strategies.
3.1.1 Half yearly de-worming of all adolescent girls.
3.1.2 Training of ANM, AWW and ASHA on module on EDPT (Early Diagnosis and Prompt Treatment) of anemia.
3.1.3 Activities for consumption of IFA tablets as per Objective No. 2
3.2 Other strategies
3.2.1 Refer severely Anemic Pregnant Mothers to referral centers
3.2.2 IPC based IEC campaigns emphasizing on consumption of locally available iron rich foodstuff.
Details given under Special Scheme on Anemia Control in Innovations

Objective No. 4: To increase institutional delivery from 70% to 76% by 2009-10 and to 85% by 2010-11 (MIS data) and to increase facilities for Emergency Obstetric Care (EmOC)

Strategies and Activities:

The strategies will lead to up gradation and operationalization of the facilities to increase institutional deliveries along with providing EmOC and emergency care of sick children. These

facilities will also provide entire range of Family Planning Services, safe MTPs, and RTI/STI Services.

4.1 Upgrading Block PHCs/CHCs in to FRUs

4.1.1 Provision of OT and lab facility by upgrading 76 FRUs

4.1.2 Blood Bank and or Provision of Blood storage, OT and lab facility by upgrading 76 FRUs

1. All district hospitals must have either its own Blood Bank, operational round the clock, or must have access to one that can be accessed in less than 30 minutes
2. All CHC / PHCs have blood storage facility

4.1.3 Training of MOs on Obs & Gynae and Anesthesia

1. 18-week Life Saving Anesthetic Skills (LSAS) training for MBBS Doctors
2. 16 week -Emergency Obstetric Skill training for MBBS doctors
3. 3 days training of doctors and nurses posted at FRUs for the neonatal stabilization unit

4.1.4 Repair and renovations of FRUs

4.1.5 Appointment of Anesthetist, O&G specialist, Staff Nurses at the FRUs

4.1.6 Incentivise the conduct of C section at FRUs @ Rs 1500 per C section for the staff involved at the FRUs.

4.1.7 Accreditation of FRUs

4.2 Operationalization of 24x7 facilities at the PHC level

4.2.1 Training of MOs and Staff Nurses of PHCs in BEmOC

4.2.2 Appointment of at least 3 Staff Nurse in each PHCs

4.2.3 Repair and renovation of PHCs

4.2.5 Availability of and timely supply of medical supplies and DDK & SBA kits

4.2.5 Training of MOs, Staff Nurses on SBA

4.3 Increase beneficiary choice for institutional delivery through IEC campaign complimented by network of link workers working on incentive basis for each institutional delivery achieved

4.3.1 Strengthening JBSY Scheme

1. Improving quality: Infrastructural support to high burden facilities to avoid ‘early discharge’ following institutional deliveries

2. Mapping of high burden facilities and proving them support for matching infrastructural up gradation to increase the hospital stay following delivery

3. Identifying districts and blocks and communities within them, where the awareness and reach of JBSY scheme is poor and to ensure increased service utilization in these areas

4.3.2 Design and implement an IEC campaign focusing on communicating the benefits of institutional delivery and benefits under JBSY scheme.

4.3.3 Equip the ASHA network to reinforce the IEC messages through IPC interventions at village / community level.

4.3.4 Provide incentives to ASHA for every institutional delivery achieved in her village / designated area.

4.3.5 Involvement of PRIs for JBSY scheme to monitor and generate awareness for institutional delivery.

4.4 Provision of Referral Support system

4.4.1 Provision of a dedicated referral transport system for the newborns and pregnant women to refer them from home/HSCs/PHCs to referral centers. (Details of the Scheme proposed under Innovations section)

4.4.2 Monitoring of referral transport system

4.4.3 Development of proper referral system between Health Institutions.

4.4.4.Operationalising of Blood Storage Units in 76 FRUs :

Lack of Blood Storage Units in the state make things complicated during emergency hence in 76 FRUs blood storage units has been proposed. Operationalising of at least one Blood Storage Units in 76 FRUs is proposed as per IPHS guidelines.

Budget Proposed –

S. No.	Activities	Total Amount (in Lakhs)
1	Salary for one Medical Officers in 76 Blood Banks/BSUs - 35000/-pmx76x12 months	319.20
2	Salary for three Laboratory Technician in 76 Blood Banks/BSUs - 3x6500/-pmx76x12 months	177.84
3	Generator and Fuel+Lubricant and incidental charge of generator+Miscellaneous expenditure - 24000/- pmx76x12 months	218.88
4	**Equipments/Instruments for 76 Blood Banks/BSUs** Adult Weighing Scale- 1000/- B.P. Instruments- 1000/- Stethoscope- 600/- Hemoglobin Meter- 1000/- Oxygen cylinder - 15000/- Total - 18600/- For 76 BSUs- 18600/-x76	14.14
5	**Blood Donation Camp** 1 camp- 8000/- 12 Camp in a year by one District For 38 District- 8000/-x12x38	36.48
6	**Contingency Fund-** 6000/-pm per BSU For 76 Blood Banks/BSUs- 6000/-pmx76	4.56
6	**State Monitoring Cell for Blood Banks/BSUs** One Medical Officer-30000/-pm One Computer Operator-8000/-pm Telephone Exp.- 2000/-pm Stationary Exp.- 1000/-pm Mobality Exp.-19000/-pm Total - 60000/- pm For one year - 60000/-pmx12	7.20
Total		**778.30**

Objective No.5: To increase birth assisted by trained health personnel from 31.9% to 45%. (DLHS-3).

Strategies and Activities:

5.1 Ensure safe delivery at Home

5.1.1 Provision of Disposable delivery kits with ANMs and LHVs - Establishing full proof Supply Chain of the DD Kits

5.1.2 Training of ANMs on SBA

1. Providing SBA with approved drug kits, in order to deal with emergencies, like post-partum hemorrhage, eclempsia, and puerperal sepsis
2. Ensuring regular supply of these drugs to the SBA

5.1.3 Supply of adequate DD Kits to ANMs, LHVs.

5.2 Provision of delivery at HSC level

5.2.1 Supply of DDkits to HSCs

5.2.2 Delivery tables to be provided to the HSCs

Objective No.6: To increase the coverage of Post Natal Care from 26% to 40% by 2009-10 and to 55% by 2010-11. (DLHS-3).

Strategies and Activities

6.1 Ensuring proper practice of PNC services and follows ups at the health facility level.
6.1.1 Refresher sessions for all ANMs on uniform guidelines to be followed for PNC care – all delivery cases to remain at facility for minimum 6 hours after normal delivery and to be recalled to facility for check up with 4 days and after 42 days.
6.1.2 Ensuring follow up PNC care through out reach services (ANM) for delivery cases where the patient does not return to facility for follow up check ups.
6.1.3 Referral of all complicated PNC cases to FRU level.
6.1.4 LHV and MO to monitor and report on PNC coverage during their field visits
6.2 Utilizing the ASHA network to strengthen the follow up of PNC services through tracking of cases, mobilization to facilities and providing IPC based education / counseling.
6.2.1 Utilize ASHA to ensure 3 PNC visits by the ANM for home delivery cases (1^{st} within 2 days, 2^{nd} within 4 days and 3^{rd} within 42 days of delivery) and 2 follow up visits for institutional delivery cases.
6.2.2 Counseling of all pregnant women on ANC and PNC during monthly meetings of MSS and during VHND.
6.2.3 Linking of ASHA's incentives on institutional deliveries to completion of the PNC follow-ups.
6.3 Basis Orientation of AWWs on identifying Post-partum and neonatal danger signs during her scheduled visits following delivery
6.3.1 Basic orientation on IMNCI – in order to be able to alert the beneficiary and coordinate with ASHA and ANM (to avoid undue delay)
6.3.2 Basic orientation on identifying post-partum danger signs, specially, for home based deliveries, such that the she can alert ASHA, ANM or the local PHC towards avoiding undue delay

Objective No. 7: Reduce incidence of RTI/STI

Strategies and Activities

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

Objective No. 8 –Reduce incidence of unsafe abortion

Strategies and activities
8.1 Early diagnosis of pregnancy using Nischay pregnancy testing kits
8.2 Counselling and proper referral for termination of pregnancy in 1st trimester if the woman wishes so
8.2.1 Training of MOs and Nurses/LHV in MTP (MVA)
8.2.2 Procurement and availability of MVA at the designated facilities.

Safe Abortion Services

The causes of maternal death are multiple. Women die because complications during labour and delivery go unrecognized or are inadequate managed. They die because of complications arising early in pregnancy, late pregnancy or even after delivery. Achieving the Millennium Development Goal of improved maternal health and reducing maternal mortality requires actions on all these fronts.

Globally, approximately 13% of all maternal deaths are due to complications of unsafe abortion and in absolute number there are 67,000 women die due to unsafe abortion. An estimated 46 million pregnancies end in induced abortions each year. Nearly 20 million of these are estimated to be unsafe.

In India, unsafe Abortion contributes 8% of total maternal deaths but there is a big regional variance. In EAG states, the total % of maternal deaths due to unsafe abortion is 10 (source: *Causes of maternal deaths from 2001-03. Special Survey of Deaths*).In Bihar, It is estimated that 5, 43,000 induced abortion take place per year (*Source: Ipas; Calculated based on latest population and birth rates (CBR)*. Two third of these Induced Abortion are carried out in unsafe conditions in illegal manner and hence not reported.

Under the MTP Act 1971, MTP up to 20 weeks in an approved facility by a registered service provider is legal. The provisions of the act is an attempt to make the services of Safe abortion available to women but the progress so far has not been satisfactory. Hence the NRHM framework recommends for providing safe abortion services in all health facilities starting from the district hospital to the PHC level.

The Indian Public Health Standard recommends providing safe abortion through MVA in the PHCs (facility catering to a population of 30,000).It may counsel and refer the higher gestation cases to facilities at district or CHC. All the Health facilities at the district, subdivision and CHC must provide safe abortion services. The IPHS also lists MVA kit and suction machine in its list of equipments.

In order to provide safe abortion services in Bihar, the doctors are been trained as per the MTP Act, 1971, with the support and facilitation of Ipas. The training includes skill updating to new technology like Manual Vacuum Aspirations (MVA). Till date, Ipas facilitated training of 457 Medical Officers and Residents on Comprehensive Abortion Care (CAC) in the state. These doctors are placed in 132 APHCs / PHCs, 16 Dist. Hospitals, 13 Sub-Divisional Hospitals/ Referral Hospitals, and 6 Medical College & Hospitals. During December 2008 to November 2009, Ipas facilitated training of 149 doctors in CAC of which 72.5% are providing MTP services after training.

Strategy

- To provide and improve safe abortion services at all the health facilities starting from District hospitals to PHC
- To increase the number of approved MTP sites and service providers in private sector
- To sensitize and make the community as well as the service providers aware about the provisions of MTP act and services of safe abortion

Activities

To provide and improve safe abortion services at all the health facilities starting from District hospitals to PHC

- Provide training to the doctors and other associated staff on safe abortion particularly MVA technique
- Ensure logistics and supply of MVA kits and other related equipments and drugs
- Monitor the number of MTPs being conducted by each district

To increase the number of approved MTP sites and service providers in private sector

- Ensure formation of District Level Committee (DLC) under the chairperson ship of the civil Surgeon as per the MTP act in all the districts
- Encourage the private doctors to get their facilities approved and themselves registered under the Act, if needed through advertisement in the newspaper
- Monitor the number of private facilities registered under the Act in the monthly meetings at the state level

To sensitize and make the community as well as the service providers aware about the provisions of MTP act and services of safe abortion

- Organize region wise orientation programme for Civil surgeon, ACMO, RCH officer, programme managers and service providers to make them aware about the provisions of MTP act (particularly in places where DLC has not been formed yet).
- Sensitize Community on safe and early abortion, practices and the availability of services through banner, posters and Nukkad Natak
- Orient ANMs. ASHA and also Community Based Organizations and NGOs about the safe abortion services
- Ensure a big wall painting (15ft x10 ft) at the public health facilities where doctors have been trained announcing the availability of the safe abortion facility.

Action plan

As performing MTP needs purely technical skill, to enhance the technical skill among the doctors especially those who are posted in the health facilities including doctors posted at the PHCs would be trained on Comprehensive Abortion Care. This year the focus will be the districts like Munger, Gaya, Saran, Siwan, East Champaran, Begusarai and Buxar. Apart from the existing 11 training sites another 4 new training site will be established this year. The exact location of the training sites will be finalized by Ipas after consultations with the state and district officials. Ipas will continue facilitation of CAC training will also continue providing technical support to the Government of Bihar on all issues of MTP. The mid term plan is to train at least 5 doctors in each district hospital, and three each in all the RHs / PHCs.

The Department of H &FW and SHSB will ensure that Each and every District Hospital, Sub divisional hospital, RH and PHC have the steady supply of Manual Vacuum Expiration (MVA) Kits, Xylocaine, other medicines and basic equipments.

2. Child Health

Goal: Reduce IMR from 56 (SRS 2009) to less than 30

Objectives:
1. To reduce low birth weight baby's by supplementing nutritional support to pregnant mothers
2. To increase exclusive breast feeding from 38.4% to 50% by 2009-10 and to 75% by 2010-11.
3. To reduce incidence of underweight children (up to 3 years age) from 58.4% to 50% by 2009-10 and to 40% by 2010-11.
4. To strengthen neonatal care services in all PHCs/CHCs/SDHs by setting newborn care centers & having trained manpower therein.
5. To reduce the prevalence of anaemia among children from 87.6% to 77% by 2008-09 and to 60% by 2009-10.
6. To increase full immunization of Children from 41.4%% to 60% by 2009-10 and then to 70% by 2010-11.
7. To reduce morbidity and mortality among infants due to diarrheoa and ARI

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

Strategies and Activities:
1.1 Convergence with ICDS, supplementary diet which is being given by AWW to pregnant mothers may be improved.
1.1.1 A supplementary diet comprising of rice, dal and ghee will be provided to all pregnant women. This will be given for the last 3 months to all underweight pregnant BPL mothers. The Scheme will be implemented in convergence with ICDS.
1.1.2 Joint Monitoring by Block MO i/cs with CDPO for implementation of the scheme.
1.1.3 Vitamin A supplementation (Annexure)

Objective No. 2: To increase exclusive breast feeding from 27.9% to 35% by 2008-09 and to 50% by 2009-10

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

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

2.1.2 Production and broadcast of TV advertisements and plays on correct breastfeeding practices

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

2.2 Increase community awareness about correct breastfeeding practices through traditional media

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

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

3. To reduce incidence of underweight children (up to 3 years age) from 58.4% to 50% by 2008-09 and to 40% by 2009-10

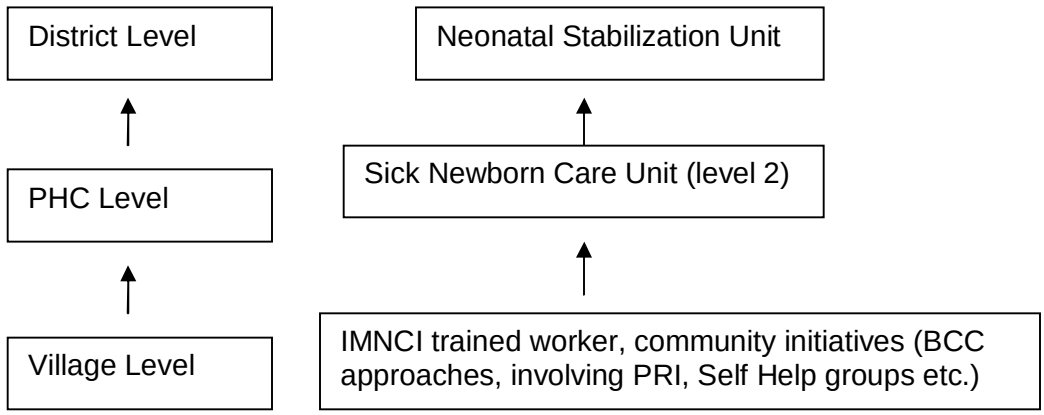
Strategies and Activities:
3.1. Growth monitoring of each child
3.1.1 Supply of spring type weighing machine and growth recording charts to all ASHAs, AWWs. All ASHAs, Aaganwadi centers and sub centers will have a weighing machine and enough supply of growth recording charts for monitoring the weight of all children through Untied fund of S/Cs.
3.1.1 Weighing and filling up monitoring chart for each child (0-6 years) every month during VHNDs
Each child in the village will be monitored by weight and height and records will be maintained

3.2 Referral for supplementary nutrition and medical care
3.2.1 Training for indications of growth faltering and SOPs for referral to AWWC for nutrition supplementation and to PHC for medical care.
3.2.2 Establishment of 10 Nutrition Rehabilitation Centres in Districts having severe problems of malnutrition and continue of 8 existing Centres (A Special Scheme taken up and put under NRHM B)

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

Strategies and Activities:
4.1. Strengthen institutional facilities for provision of new born care
4.1.1. It is planned to develop a model for comprehensive care of the newborn at all levels, from state to the community level.

MODEL FOR COMPREHENSIVE CARE OF NEWBORN



Level	Facility	Services/Activities	Training required	Equipment
1. District Level				
Near Level II Sick Newborn Care Unit ((SNCU) to provide specialized care		Special care of neonates	4 days training	Equipment for SNCU and refurbishment.

services to sick newborns			
2. PHC level			
Neonatal Stabilization Unit with basic care services in health facilities	Delivery services Neonatal Resuscitation Warmth	1 day training in essential newborn care	Neonatal warmer Oxygen supply Ambu bag and Mask
3. Village level			
IMNCI Trained workers in each village to provide essential child care and counseling services to community	Post natal Visits, Counseling for breastfeeding and newborn care practices, immunization Timely identification, classification and treatment and referral, if needed	8 days training in IMNCI	IMNCI training module Drug Kit

Plan of action:

DISTRICT LEVEL: NEAR LEVEL II SICK NEWBORN CARE UNIT

Neonatal mortality accounts for over 60% of Infant mortality. Further reduction in Infant and Child mortality is critically dependant upon significant decline in Newborn deaths. Although on average 41% of deliveries are conducted in the institutions, i.e., at P.H.C and district hospitals, there are no separate facilities to manage sick Neonates in the hospital and health centers, Even at district hospital, the sick Neonates (Home delivered and Institutional delivered) are generally treated along with the older sick children.

It has been observed that near level II Neonatal care is

- Needed for 15-20% of all the neonates
- 5000 neonates need special care per million population per year
- Need for 150 special care beds per million population

Establishment of near leveI SNCU (sick newborn care unit) in 13 districts is proposed.

REQUIREMENTS FOR ACCREDITATION

1. Location of the SNCU:
    - Should be easily accessible from entrance of the hospital
    - Should not be located on top floor
    - For units catering both inborn and out born neonates: next to labor ward & delivery room
    - For units catering out born neonates only: near children ward

2. Space Requirement:

1200 sq ft area for a 12 bed near Level II SNCU @ 100 sq ft per patient of which:

a. 50 sq ft would be patient care area and
b. 50 sq ft would be added up for ancillary areas

3. Equipments for individual patient care in the Sick Newborn Care Unit:

Item	Requirement for the unit
1. Servo controlled radiant warmer	1 for each bed (essential) +2 Total=14
2. Low reading digital thermometer (centigrade scale)	1 for each bed (essential) Total=14
3. Neonatal stethoscope	1 for each bed (essential) Total=14
4. Neonatal resuscitation kit:	1 set for each bed (essential) Total=14
5. Electrically operated pressure controlled slow suction machine	1 for 2 beds (essential) Total=7 (5 electrical, 2 foot operated)
6. Oxygen hood (neonatal or infant size, unbreakable)	1 for each bed (essential) Total=14
7. Non stretchable measuring tape (mm scale)	1 for each bed (essential) Total=14
9. Infusion pump or syringe pump	1 for 2 beds (essential) Total=7
10. Pulse oxymeter	1 for every two beds Total=7
11. Double outlet oxygen concentrator	1 for every two beds Total=7
12. Double sided blue light phototherapy	1 for every three beds Total=2
13. Single side blue light phototherapy	Total=3
13. AC (1.5 ton) split	8
14. Generator (15 KVA)	1

4. Side Laboratory Equipments:

Item	Requirement for the unit
Microscope with gram and Leishman staining facility	1 (essential)
Microhematocrit centrifuge, capillary tubes and reader	1 (essential)
Billirubinometer	1
Multistix strips (in container)	1
Glucometer with Dextrostix	3

5. STAFF

Manpower	12 bed SNCU
1. Pediatricians	2
2. Medical Officer	4
3. Sister-in-charge / PHN	1
4. Staff Nurse	6
5. ANMs	8
6. Class IV	6

6. Life Saving drugs for Emergency:

This list is not exhaustive for an Emergency situation in any Sick Newborn Care Unit

Item	Requirement for the unit
• Injection adrenaline, naloxone,	A stock of 1 set per bed per month

• sodium bicarbonate, aminophylline, phenobarbitone, hydrocortisone, • 10% dextrose, • normal saline, • ampicillin with cloxacillin, ampicillin and cefotaxime and gentamycin etc	should always be maintained in the unit

Support establishment of Neonatal Stabilization Units in select 100 high-mortality blocks with personnel and equipment for neonatal resuscitation, Postnatal Care, Healthy Newborn Care , 35-37 weeks gestation, Stabilize neonates < 35 weeks

FACILITIES FOR PHC LEVEL: NEONATAL STABLIZATION UNIT

NEONATAL STABILIZATION

- Adequate warming through radiant heat source.
- Facilities for Resuscitation with self inflating resuscitation bag and well fitting neonatal face masks (at least two sizes).
- Medicines of essential newborn care

1. Supply of bucket type / spring type weighing machines to all sub centres and Anganwadi centres
Many times new borns and infants are not weighed or incorrectly weighed using adult type weighing machines which are usually available at sub centres and Anganwadi centres. Provision of bucket type or spring type weighing instruments will improve weight monitoring.
2. Pediatrician will be appointed on contract basis @ Rs.26000 pm.
3. Training of MOs on Paediatrics
4. Training of MOs, Staff Nurses on Facility Based New Born care
5. Training and operationalization cost will be borne by the UNICEF.

GRASSROOT LEVEL IMNCI TRAINING

4.2 Generation of awareness on new born and infant care (home-based) in community through MSS
4.2.1 Community Awareness on home-based care of new born (skin-to-skin contact, bathing after a week, not removing vermix, etc.); early recognition of danger signs - ARI, diarrhoea; proper weaning practice
The ASHAs / MPWs / AWWs at every point of contact for ANC and PNC will reinforce tenets of home-based care of new born as per IMNCI guidelines. The training will be part of IMNCI.

5. To reduce the prevalence of Aneamia among children from 87.6% to 77% by 2008-09 and to 60% by 2009-10.

Strategies and Activities
Details in special programme for “Controlling Iron Deficiency Anemia in Bihar” under Part B NRHM Additionalities.

6. To increase full immunization of Children from 32.8% to 40% by 2008-09 and then to 60% by 2009-10.

Strategies and Activities

6.1 Conduct fixed day and fixed-site immunization sessions according to district micro plans.

6.1.1 Fill vacant ANM posts and appoint additional ANMs in a phased manner to achieve GoI norm of one ANM for 5000 population by the year 2009-10.

6.1.2 Update district micro plan for conducting routine immunization sessions

6.1.3 Ensure timely and adequate supply of vaccines and essential consumables such as syringes, equipment for sterilization, Jaccha-Baccha immunization cards, and reporting formats at all levels.

6.1.4 Supply AD Syringes to conduct outreach sessions in select areas.

6.1.5 Enlist help of AWW/ASHA in identification of new-borne and follow-up with children to ensure full immunization during sessions. New born tracking system to be implemented

6.1.6 Replace all Cold Chain equipment, which is condemned, or more than five years old in a phased manner by the year 2007-08 and supply new Cold Chain equipment based on analysis of actual need of the health facilities

6.1.7 Facilitate maintenance of Cold Chain equipment through Comprehensive annual maintenance contract with a private agency with adequate technical capacity. Tender already floated and decided.

6.1.8 Provide POL support to State and Regional WIC/WIF facilities @ Rs. 15000 per month and @ Rs. 5000 per PHC per month to each PHCs for running of Gensets and minor repair

6.1.9 Issue necessary departmental instructions to re-emphasize provision of ANC services in the job description of Aaganwadi Workers and ANMs.

6.2 Build capacity of immunization service providers to ensure quality of immunization services.

6.2.1 Provide comprehensive skill up gradation training to immunization service providers (LHVs/ANMs), particularly in injection safety, safe disposal of wastes and management of adverse effects.

6.2.2 Conduct training to build capacity of Medical Officers, MOICs and DIOs for effective management, supervision and monitoring of immunization services

6.2.3 Train Cold Chain handlers for proper maintenance and upkeep of Cold Chain equipment

6.3 Form inter-sectoral collaboration to increase awareness, reach and utilization of immunization services

6.3.1 Develop working arrangements with ICDS and PRIs to ensure coordination at all levels

6.3.2 Involve Aaganwadi Workers and PRIs to identify children eligible for immunization, motivate caregivers to avail immunization services and follow-up with dropouts.

6.3.3 ASHA, AWW and ANM will hold meeting with Mahila Mandals at each village monthly for increasing the coverage of Immunization. Incentive to be provided to ASHA and ANM under RCH and AWW under intersectoral convergence.

6.3.4 Involve ICDS and PRI networks in behavior change communication for immunization.

6.4 Strengthen Supervision and monitoring of immunization services

6.4.1 Build capacity of Medical Officers, MOICs and DIOs in supervision and monitoring of implementation of immunization services as per the micro-plan.

6.4.2 Provide mobility support to MOICs and DIOs for supervision and monitoring of implementation of immunization services.

6.4.3 Develop effective HMIS to support supervision and monitoring of implementation of immunization services.

6.4.5 Coordinate with representatives of PRI to strengthen supervision and monitoring of immunization services.

6.4.6 Details of Immunization have been incorporated in part- C of PIP.

7. To reduce morbidity and mortality among infants due to Diarrhea and ARI

Strategies and Activities:

7.1 Increase acceptance of ORS
7.1.1 Supply of ORS and ensure availability in all depots and supply of cotrimoxazole tablets.
The ASHA drug kit will have ORS and cotrimoxazole tablets which should be replenished as per need. Aaganwadi centers should also be given ORS. In the absence of ORS, the use of home-based sugar and salt solution will be encouraged.
7.1.2 Orientation of ASHA for diarrhea and ARI symptoms and treatment
ASHAs will be specifically trained to identify symptoms of diarrhea and ARI and to provide home-based care. Danger signs prompting transportation to seek medical care will also be taught to ASHAs.
7.1.3 Organize meetings for ASHAs/AWWs for dissemination of guidelines for Home based care
ASHA and AWW will be trained and provide guidelines for Home based care. The meeting will be held at Block PHC level.

7.2 Strengthening of referral services for infants seeking care for life threatening diarrhoea and ARI
7.2.1 Availability of referral money @ Rs.500 available for transporting of sick infants to the health institute.
7.2.2 Blood slide examination of all febrile children with presumptive treatment
In endemic areas, most children are anemic due to repeated bouts of malaria. Any febrile child needs to be checked for malaria compulsorily.
7.2.1 Strengthening of PHCs/ referral centers

School Health Programmes

Counseling sessions will be organized in Govt. Schools in collaboration with BSACS. Story lines and slogans will be published in text books of schools in collaboration with the Education Deptt. Reference Books on Health Issues and Healthy Life-Style will be published for School libraries. Health Camps will be organized for health check-ups for school children. Innovative strategies will be adopted to orient school children about healthy practices.

S. No.	Activities	Total Amount (in Lakhs)	Remarks
1	Total No. of Children in Govt. School (I to VIII)- 18711178 No. of Children examined per Camp - 100 No. of Medical Camp – 100000 Approx Exp. Per Medical Camp - 3000/- Total expected Exp. In Medical Camp- 100000x3000/-	5613.36	Calculated Budget is as per data provided by, MDM, Directrorate, Govt. of Bihar
2	**Monitoring, Supervision & Evaluation of School Health Programme**		Vehicle+Fuel to be provided by the State Health Society, Bihar
	From State Level Monthy Visit to Different Schools of Dist. by State Level Officers		
	From District Level Weekly Visit to Different Schools of Dist. by District Level Officers		
Total		**3000.00**	

Nutrition Rehabilitation Centres (NRCs) for Treatment of Severe and Acute Malnutrition (SAM)

Child malnutrition extracts a heavy toll on both human and economic development, accounting for more than 50 % of child deaths world wide. The consequences of malnutrition are serious leading to stunting, mental and physical retardation, weak immune defense and impaired development. More than one-third of worlds malnourished children live in India.
In India, as revealed by the recent National Survey (NFHS-3, 2005-06), malnutrition burden in children under three years of age is 46 %. With the current population of India of 1100 million, it is expected that 2.6 million under-five would be suffering from severe and acute malnutrition which is the major killer of children under five years of age. It can be direct or indirect cause of child death by increasing the case fatality rate in children suffering from such common illnesses as diarrhea and pneumonia.

The risk of death in these children is 5-20 times higher compared to well-nourished children. Severe and acute malnutrition is defined by a very low weight for height, below -3 z* scores of the median WHO growth standards, presence of visible severe wasting' or 'bipedal Oedema', or mid-upper arm circumference (MUAC) of <11 or 11.5 cm in children between 6-60 months.

MALNUTRITION IN BIHAR:
In Bihar, malnutrition is a serious concern with a high prevalence of 58.4 % (NFHS-3, 2005-06). Children suffering from severe and acute malnutrition are reported to be 8.33 %. Based on population figures, it is estimated that in Bihar, 2.5 million children under five years of age are threatened to face the consequences of severe malnutrition. With the situation of nutrition among

* A 'z score' is the number of standard deviation below or above the reference mean or median value.

children being far from satisfactory, it will not be surprising to find that these children who have already arrived in a poor state of nutritional status, with further deterioration are at a high risk of morbidity and mortality.

MEASURES TO MANAGE MALNUTRITION:
While mild and moderate forms of malnutrition in the absence of any minor or major illness among children can be addressed through Anganwadi centres, by supporting mothers to ensure service utilization and appropriate feeding and care practices at the household level; the treatment of children with severe and acute malnutrition calls for facility-based treatment by admitting children to a health facility or a therapeutic feeding centre. This is mainly because these children generally are seen to suffer from acute respiratory infections, diarrhea and pneumonia. A decision was thus taken to set up Nutrition Rehabilitation Centers which is a unit for the management of SAM children where they are kept under observation and provided with medical and nutritional care. In additional to curative care, special focus is given on timely, adequate and appropriate feeding to children. Efforts are also made to build the capacity of mothers through counseling to identify the nutrition and health problems in their child.

In 2007 two NRCs were established on a pilot basis in the districts of Muzaffarpur and East Champaran.
By 2009-10, a total of 8 NRCs are already functional. The proposal includes the establishment cost and the running cost for 30 NRCs in the management of child malnutrition.

Budget

S. No.	Activities	Total Amount (in Lakhs)	Remarks
1	**Estimated Cost** For establishment of one NRC (One time cost) - 211270/- For establishment of 30 NRC for 30 District- 30x211270/-	63.381	NRC has already been established in Darbhanga, Khagaria, Muzaffarpur, Motihari, Madhubani, Samastipur, Sitamarhi & Sheohar (8 District) with the help of UNICEF.
2	**Estimated Cost** For Runnng of of one NRC/Month - 224600/- For 38 District per month - 38x224600/- For 38 District in one year - 38x224600/-x12	1024.176	
3	**Monitoring, Supervision & Evaluation of NRC**		Vehicle+Fuel to be provided by State Health Society, Bihar
	From State Level Monthy Visit of NRC of Dist. by State Level Officers		

3 Population Stabilisation

Goal: Reduce TFR by 2.1 from present level of 3.9

Objectives:
1. To reduce total unmet need for contraception from 23.1 % to 15%
2. To increase Contraceptive Prevalence Rate (Any Modern Method) from 28.8% to 35% by 2009-10 and to 45% by 2010-11
3. To increase male participation in family planning
4. To increase proportion of male sterilizations from 0.6% to 1.5%.
5. Monitor the quality of service as per GoI guidelines for Sterilization

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

Strategies and Activities

1.1 Plan to organize RCH camp in each PHC/CHC once in two months.
1.1.1. Creating dedicated cadre of skilled manpower
1. Training of MBBS doctors on Minilap and NSV
2. Training of MBBS doctors on Anesthesia
3. Training on IUCD: MOs, ANMs etc.

1.1.2 One RCH camp will be organize in each PHC/CHC where Laparoscopic Ligation/Mini Lap will be done
1.1.3 Incentive to acceptors Incentive for LL operations
1.1.4 Training on LL operation, MTP and IUD Insertion
1.1.5 ASHA and MPWs will publicize about the RCH in their area and motivate the eligible women to go for spacing & terminal methods of family planning.
1.2 Motivate eligible couples who have had their first child for spacing for condoms, OCPs or IUDs
1.2.1 Update EC register with help of ASHAs and AWW
The eligible couple register is presently being updated once a year (usually in April) in a survey mode. It is done in a hurry and may not have complete information in many cases. With the involvement of ASHAs and AWWs, updates should be done each month preferably during VHNDs. This will result in less wastage of time and resources and better recording of information.

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

1.2.2.1 Each SDH/CHC/PHC should have static FP cell / corner, with earmarked ANM / LHV responsible, for providing these services daily as OPD services to clients
1.2.2.2 Community Based Distribution (CBD) of Condoms and Pills: The OCPs and condoms can be provided to community based motivated volunteers, like members of Self Help Groups (for Pills) and Husbands of motivated ASHA, Satisfied NSV client, active PRI members etc. (for condoms) for community based distribution (CBD) of these. The availability of condoms and OCPs with the volunteers and their geographical responsibilities should be widely known to the potential clients / beneficiaries. Before they are made the community based distributors, they should be properly trained and mechanism developed to regularly monitor them and review their performance
1.2.2.3 Public Private Partnership (Social marketing): This can be taken up on an experimental basis in a couple of districts, or a few blocks in these districts to pilot selling through entrusted community based institutions, volunteers, market mechanisms (like the popular pharmacist of the village, or grocery shop owner or the like) condoms and OCPs at normal or subsidized rates. This

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

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

1.2.3 Ensure follow up after IUD and OCP for side effects and treatment

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

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

The seminar for contraceptive updates will be organized at the district level twice in a year. All the healthcare providers from the district will attend the seminar.

1.3 Motivate eligible couples for permanent methods in post partum period specifically after second and third child

Efforts will be made by the service providers to motivate parents to adopt permanent methods after the birth of the second or third child.

1.3.1 Update EC register with help of ASHAs and AWW

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

1.3.2 Motivate couple after second child in Post Partum period to go in for tubectomy / NSV

After the second child is born, the couple will be motivated to adopt a permanent method of family planning preferably NSV. For this communication materials will be prepared and distributed.

1.3.2 Follow up after tubectomy /NSV for side effects and treatment

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

1.4 Making available MTP Services in all Health Institutions.

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

1.4.1 MTP Services in the state is not fully operational in all the hospitals of the state. Training of MOs have been under taken during RCH-1. To further strengthen the skill of the doctors for MTP training, training shall be taken up during the year. 100 MOs will be trained in 2008-09.

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

Objective No.2: To increase Couple Protection Rate

Strategies and Activities

2.1 Awareness generation in community for small family norm

2.1.1 Preparation of communication material for radio, newspapers, posters

Communication materials highlighting the benefits of a small family will be prepared for radio, TV and newspapers.

2.1.2 Meetings with MSS, CBOs

Communication materials to be used for monthly MSS/CBO meetings will be prepared and distributed for use.
These meetings will be scheduled during or preceding the month family planning camps are scheduled to be held.
2.2 Regularise supply of contraceptives in adequate amounts
2.2.1 Indent and supply contraceptives for all depots and subcentre/ AWCs and social outlets: Each AWC and ASHA will have at least one month's requirement of condoms and OCPs. Sub centres will have adequate supplies of IUDs also.

Objective No.3: To increase male participation in family planning

Strategies and Activities
3.1 Promote the use of condoms
3.1.1 Counseling men in villages to demonstrate ease of use of condoms and for prevention of STDs
Male workers will assist the MPWs in addressing the meetings of men in villages to demonstrate the use of condoms and its benefits in family planning and prevention of STDs. It should be stressed that condoms are easy to use and is a temporary method. Current methods of family planning which target women are not very easy to adopt while condoms can be very easily used.
3.1.2 Regular supply of condoms and setting up depots which are socially accessible to all men
It is very essential to supply condoms through depots which can be easily accessible to men and confidentiality will also be ensured. During the meetings, the sources of condoms in the village will be made known to all. It will be ensured that the client's identity will not be disclosed. The depot holder will be set up only on condition that he shall not reveal the identity of clients.

3.2 Promote adopting NSV: as simple and convenient method of hassle free FP methods (however, it must be told that it doesn't protect from STI/RTI of HIV / AIDS)

Objective No.4: To increase proportion of male sterilizations from 0.6% to 1.5%.

4.1 Increase demand for NSVs (develop a cadre of satisfied NSV Client, who could be the advocates for NSV in their designated geographical areas. Orient and train them and give them specific geographical responsibility to give roster based talks etc to identified groups of probable clients. During these talks the probable clients can be registered and they could be escorted to the nearest static facility or the camp on designated days for NSV. Once completed the procedures, then these new clients can become advocates for the same. This entire process must be fully facilitated by respective PHCs and be provided with all logistics support along with some incentives for the work or activities undertaken by them)
4.1.1 Village level meetings in which men who already underwent NSV share experiences to motivate men to undergo NSV
All the GP/ADC Villages will be chosen in the district to hold meetings in which men who have undergone NSV will tell male members of the community about their experience and the benefits of NSV. These meetings will be repeated each month in the same batch of Gram Panchayat or ADC Villages. NSV will be conducted on the motivated men. The same men will then be requested to share their experiences in the next batch of five villages for the next three months.
4.2 Increase capacity for NSV services
4.2.1 Training of doctors for NSV
While demand is being generated, a team of doctors should be trained at all the FRU level to conduct NSVs.
4.2.2 Organize NSV camps at the Sub District Level

Objective No. 5: Monitor the quality of service as per GoI guidelines for Sterilization

5.1 A quality assurance committee initiated in every district for monitoring the quality of sterilization in the respective district. The Civil Surgeon is the chairman of the committee with at least one Gynecologist.

5.2 Streamline the contraceptive supply chain & Monitoring

1. Identifications &Renovation of Warehouse – State /District/ PHC
2. Budget allocation for transportation at every level
3. Provision for report format printing and their availability at every level

Action Plan for Strengthening Sterilization Services

The activities are segregated into short-term and long-term. They are separately spelled out for the state and the district.

Short Term Activities

State Level Activities:

1. Service Availability

STATIC SERVICES

i. Ensure that district level facilities are fully equipped with manpower and equipments

ii. Availability of Sterilization services everyday at district hospitals, separately for, Males and Females

iii. Availability of Sterilization services at PHC level on at-least 3 fixed-days a week (these days could be fixed for the entire state, like the Immunization Days, which are Wednesday and Saturdays)

iv. Demand generation activities: wide dissemination of information on the regular (daily and on fixed days) availability of the services

1. prominent display
2. workshop of key department functionaries, who in turn would disseminate the same to their line staff, who in turn will directly inform the public about the availability of services

CAMPS

v. The number of camps needs to be planned and based on the ELA of the districts (following SOP)

a. Districts must plan camps in various PHCs and locations based on the need, in the beginning of the year; this should be based on the past years records etc., and these must be shared in the beginning of the year with the state
b. These camps must be planned round the year, they must be evenly distributed through out the year and wide publicity on the venue and dates of the camps, well in advance must be disseminated through out the respective catchment areas
c. Availability of Providers
d. Line listing of available Providers by Geographical Areas (DHQ, PHCs, SDH etc.)
    - Gynecologist,
    - Surgeon
    - Anesthetist
    - Nursing Staff
e. Roster for year long Static Services Providers: Based on the above line listing form Surgical Teams for male and female sterilization separately, the teams then must be provided with earmarked days of the week at static centres, like the rotation duties in Medical Colleges and big private Nursing Homes. For example Team 1 will perform on Mondays and Wednesdays; Team 2 on Tuesdays and Fridays; and Team 3 on Thursdays and Saturdays etc. and on rotation one Team can be on call for emergencies on holidays etc.

f. Roster for year long Camp Services Providers Similarly, by camps the teams should be identified in the beginning of the year and their year-long roster be prepared and informed so to them in advance. The evenness in providers' work load should be ensured such that it is not the situation that a few providers are doing all the surgeries while the remaining are doing none.

g. Identification of Providers for Training: Line Listing of Providers for the same. It must be prepared for every district and every PHC in the district. Before the training begins for the identified future providers, their choice must sought as to the posting to the facility they would be interested in; as far as possible this should be respected. Based on this they should be trained and posted to the pre-identified facility in a time bound fashion. This exercise should be done in advance and proper notification regarding the same should be widely publicised and disseminated. This activity should be very closely monitored by the State Health Society, in order to ensure its full operationalization. Once done, the training in phased manner should happen in a time bound fashion.

h. Equipping the facilities and keeping the sets of equipments ready for the camps
    i. This needs to be ensured as per the guidelines for the facilities: As per the guidelines, minimum numbers of sets must be available at district and sub-divisional hospitals
    ii. The same needs to be ensured for every camp in advance, such that the quality and hygiene are not compromised in the camps

i. Monitoring System: Both for Static Services and Camps: To monitor provider out put and progress in static facilities and camps
    i. A check list needs to be developed at State Health Society to monitor the above
    ii. A mechanism needs to be developed on this and how the information so gathered could be used to improve the services and provider output

j. Monthly Review of sterilization progress and performance by district and sub-district levels, specially focusing on high-burdened areas hard to reach areas
    i. A fixed agenda and points to be reviewed need to developed in order to make there review meetings focused and result oriented

District Level Activities:

1. Undertake block-wise analysis of service utilization and work out detailed service provisions: fixed day roster based static services, camps and their schedules
2. Prepare block wise demand generation activities, separately for static services and camps
3. Prepare a list of providers not providing sterilization services and orient and reorient them and place/post them as per defined roster to the services: static services and camps
4. Finalize work plan with state to get specific need-based inputs
5. Conduct monthly review of sterilization activities at district level

Long Term Actions

State Level Actions

1. increased trained manpower
2. create dedicated pool of providers exclusively for sterilization, develop a mechanism of incentives for the high achievers
3. provide appropriate mix of services – male and female sterilization at static facilities
4. undertake state level NSV campaign
5. gradually increase static facilities and popularize the availability of the same and similarly gradually reduce the number of camps proportionately

6. organize state and regional level experience sharing

District Level Actions

1. saturate training of all available providers
2. ensure presence of providers in all static facilities
3. institutionalize sterilization services
4. public private partnership
    a. line listing of the same
    b. dedicated pool of the same, MBBS doctors (ask them to perform surgeries at government facilities)
5. orient block level MOs in using data for monthly review and stocktaking

4. Adolescent Reproductive and Sexual Health

Objective:
1. To reduce incidence of teenage pregnancies from present 25% to 22% by 2008-09 and to 15% by 2009-10.
2. To ensure the access to information on Adolescent Reproductive & Sexual Health (ARSH) through services at District Hospitals, SDH, CHCs, PHCs & HSC level.
3. To increase awareness levels on adolescent health issues

Objective No.1: To reduce incidences of teenage pregnancies from present 25% to 22% by 2008-09 and to 15% by 2009-10.

Strategies and Activities:
1.1 Improve access to safe abortions
1.1.1 MTP services made available at all the FRUs initially & at all SDHs in subsequent years, through training of select medical officers at DH/MC.
MOs will be trained in MTPs
1.1.2 Manpower (Training) & logistic support to private hospital doctors and will also be trained in conducting safe abortions.

1.2 Ensure availability of condoms/OCPs/Emergency contraceptives
1.2.1 Depot holders among adolescent groups/youth organizations
In addition to the ASHA and the AWW, youth organizations such as football clubs and others will have depot holders who will provide condoms/OCPs and Emergency contraceptive pills and maintain confidentiality.

Objective No.2: To ensure the access to information on Adolescent Reproductive & Sexual Health (ARSH) through services at District Hospitals, SDH, CHCs, PHCs & HSC level.

Strategies and Activities
2.1. Organize regular adolescent clinics/counseling camps at SC/PHC/CHC/SDH/DH
2.1.1 Appointment of 5 nos. Adolescent Counselor for districts setting up Adolescent clinics.
2.1.2 Adolescent health sessions/clinics will be held in each Sub Centre/ PHC / CHC/SDH and DH with service delivery & referral support
2.1.3 Risk reduction counseling for STI/RTI
During the monthly or weekly interactions through health sessions and clinics, counseling for preventing STI/RTI will be also be done. This will include single partner sex and use of condoms for safe sex.

2.2 ASHA/AWW to act as nodal persons at village level for identifying & referring adolescents in need of such services.
2.2.1 Training of AWW/ASHA in adolescent health issues
All ASHAs and AWWs will be oriented on problems faced by adolescents, signs and symptoms of the problems and where to refer these cases.

2.3 Referrals to de-addiction centers for treating alcoholism/drug addiction
2.3.1 Identification of de-addiction centers in the state/district

The state / district will identify NGOs or other de-addiction centres in the state and through the health workers will refer the cases in need to these centres for treatment.
2.3.2 Circulate information on services provided at these centres and setup referral system
The state/district will have an understanding with the de addiction centre on the process for referring patients to the de-addiction centres.

Objective No.3: To increase awareness levels on adolescent health issues

Strategies and Activities

3.1 Organizing Behavioral Change Communication campaigns on specific problems of adolescents
3.1.1 IEC activities along with take-home print material to be organized in coordination with MSS, Youth club
One of the monthly theme meetings with the MSS / CBOs will be related to adolescent health problems, signs and symptoms, treatment and referrals.
3.1.2 4 monthly health checkups under School Health Programme through PHC medical and paramedical staff

School Health Programmes (Health Check up under MDM)

As part of the School Health Programme, adolescents in schools will undergo health check ups thrice in a year. Some counseling related to common adolescent problems will also be given during these check ups.

Children are the asset and future of the Nation. The progress of any country and state depends upon them for which they must remain healthy. In Bihar there are about 1.5 crore children of 6-14 years age reading in government primary & middle schools. The health check-up of these children are must atleast once in a year to detect any serious disease in the early stage, so that preventive and curative measures may be taken at the earliest. For this objective in mind government has decided to do medical health check-up of children reading in government primary and middle schools.

OBJECTIVE :

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

Additionally Counseling sessions will be organized in Govt. Schools in collaboration with BSACS. Story lines and slogans will be published in text books of schools in collaboration with the Education Deptt. Reference Books on Health Issues and Healthy Life-Style will be published for School libraries. Health Camps will be organized for health check-ups for school children. Innovative strategies will be adopted to orient school children about healthy practices.

3.1.3 Orientation of VHSC on adolescent issues

The MPWs will during their routine interactions with the VHSC members apprise them of the problems and issues related to adolescents and what to do for treatment and referrals. (Budgeted in RCH Training along with maternal health, Child health and Family Planning)

3.1.4 Premarital counseling of adolescent girls on reproductive health issues at PHC/RH/SDH/DH

This will be part of the adolescent health session/clinics which will be regularly conducted at sub centres, PHCs and also at youth clubs.

3.2 Dissemination of ARSH Guidelines and Trainings

3.2.1 Organize dissemination of ARSH guidelines at State level.

3.2.2 Training of TOTs on ARSH

3.2.3 Training of MOs, ANMs on ARSH

Proposed Strategies and Activities for Operationalization of ARSH

1. ARSH service delivery through the public health system:
    a. Actions are proposed at the level of sub-centre, PHC, CHC, district hospitals through routine OPDs. Separate arrangements should be done for male and female adolescents.
    b. Fixed day, fixed time approach could be adopted to deliver dedicated services to adolescents and newly married couples. A fixed day across the state, either once a month or twice a month can be declared for ARSH, and the information regarding the same should be properly disseminated in the community and properly displayed at the facilities.
    c. A separate ARSH Cell, comprising of ANM, LHV, Health Educators etc. (perhaps on a rotatory basis) can be established at these Cells.
    d. A separate ARSH Cell can be constituted at every CHCs and Referral Units, with one MO as its nodal officer (on call, sort of) and two counselors.
2. Interventions to operationalise ARSH
    a. Orientation of the service providers: Equipping the service providers with knowledge and skills is important. The core content of the orientation should be vulnerabilities of adolescents, need for services, and how to make existing services adolescent friendly.
    b. Environment building activities: this should include orienting broad range of gatekeepers, like district officials, panchayat members, women's group and civil society. Proper communication messages should be prepared for the same exercise. District, block and sub-block level functionaries should be responsible for this.
    c. The MIS should at least capture information on teenage pregnancy, teenage institutional delivery and teenage prevention of STI.

5 Urban Health

Urban health care has been found wanting for quite a number of years in view of fast urbanization leading to growth of slums and population as more emphasis is given in rural areas. Most of the Cities and Towns of Bihar have suffered due to lack of adequate primary health care delivery especially in the field of family planning and child health services.

Objectives:

1. Ensure delivery of RCH services in urban areas of Bihar specifically the Urban Slums in terms of quality and timely availability

2. Generate awareness about Maternal, Child health and Family Planning services in urban areas esp. Slums of the state

As per the GoI guidelines, there should be one UHC for 50,000 population (outpatient). The Urban Health Centres are required to provide services of Maternal Health, Child Health and Family Planning. The staff at each UHC should comprise of 1 Medical Officer (MO), 1 PHN/LHV, 2 ANMs, 1 Lab Assistant and 1 Staff clerk with computer skills.

At present, in the Department of Health there are 12 Urban Health Centres (UHC) in the state which are non-functional. The infrastructure condition of these Urban Health Centres is not up to the mark and requires some major renovation work.

In this background State Health Society invited Private Partners (Clinics) to set up Urban Health Centres which cater to particular slum areas. Urban Health Centres have been established to provide support to the Government's Health Programmes under which free OPD facility is provided. 3 Urban Health Centres have been started in three districts- Nalanda, Patna and Samastipur, and 5 more are being operationalised in Nalanda and Muzaffarpur districts. This year it is proposed to up-scale it to 20. For the purpose expression of interest has been floated and offers received.

Sno.	Objective	Strategy	Activities
1	**Ensure delivery of RCH services in urban areas of Bihar specifically the Urban Slums in terms of quality and timely availability**	Identify health service providers of both public and private sectors (including NGOs) in urban areas and plan delivery of RCH services through them	1 Mapping of Urban Slums and existing providers of RCH services of both public and private sectors
		Strengthen facilities of both public and private sectors in urban areas	1 Establish partnerships with select private health clinics/NGOs for delivery of facility-based RCH services e.g. institutional delivery, permanent methods of FP, curative MCH service, etc.
			2 Collaborate with health facilities managed by large public sector undertakings such as Railways, ESIS, CGHS and Military to provide RCH services

			to general population from identified urban areas.
			3 Establish 20 Urban Health Centres on a rental basis under PPP in this financial year especially in districts with DHs having heavy patient load
2	**Generate awareness about Maternal, Child health and Family Planning services in urban areas esp. Slums of the state**	Use Multiple channels for delivery of key RCH messages in urban areas	1 Utililise various channels of mass media with extensive reach in urban areas such as TV, local cable networks, radio (particularly Vividh Bharti channels), cinema halls, billboards at strategic locations, etc to propagate messages related to key programme components of RCH.
			2 Extensive use of print media such as newspapers (particularly local newspapers), journals and magazines for dissemination of key RCH messages.
		Broad inter-sectoral coordination to increase awareness and knowledge of key messages under the RCH programme	1 Involve representatives from Urban Local Bodies (municipal corporations and municipalities), commercial associations, sports bodies, voluntary and religious organisations for intensive inter-personal communication and community-based awareness campaigns.
			2 Use various channels of mass media for ensuring utilization of services of Urban Health Centres, private or Government

6. Vulnerable Groups/Interventions in High Focus districts

6.1 Chiranjeevi Yojana in Bihar

The Chiranjeevi Yojana is an exemplary scheme in the area of Public Health which has contributed significantly in improving the access to Institutional deliveries for marginalized section of the society by reducing the maternal deaths.

Our one of the important Goal is to reduce the MMR of the state to 100 by the year 2012.If we consider, the Cost for accessing care in private sector deters the poor from seeking care during delivery. The women particularly belonging to Below Poverty Line (BPL) may not have adequate financial resources to utilize private medical services. Looking to the fact that there is significant presence of private sector providers, Bihar Government is planning to start Chiaranjeevi Yojana as Gujarat did in 2005-06. Bihar is exploring various options to provide skilled care at delivery and EmOC (Emergency Obstetric Care) through private sector in collaboration with Private providers, the government of Bihar health department will work out on a scheme of Public Private Partnership (PPP) to contract private providers to provide delivery care to the poor in rural areas.

This scheme will be called "Chiranjeevi Yojana" (CY) – a local name meaning long life (of mothers and babies). Chiranjeevi Yojana will be initiated with the objective to encourage private practitioners to provide maternity services in remote areas which record the highest infant and maternal mortality rates in the state.

This scheme will be promoted via meetings with the community leaders, local obstetric and gynecological society, and district health Society teams. Auxiliary Nurse Midwives (ANMs) will enroll the eligible mothers under the scheme on one to one contact with eligible pregnant mothers. The scheme will be managed by the district and block health officers. The scheme will use a voucher type of system or BPL cards to target the BPL facilities. The scheme would cover the service charges for normal and complicated deliveries and direct and indirect out-of-pocket costs such as travel and cost of accompanying person on cashless basis. With the BPL cards, the families can visit any of the empanelled private nursing home or private hospital for maternity services (normal or caesarean) and are not required to pay any fee.

Financial Package for Chiranjeevi Yojana			
Procedure	**Cases per 100 deliveries**	**Cost (Rs.) Per procedure**	**Total (Rs.)**
Normal Delivery	85	800	68000
Complicated Cases			
Eclampsia/Forceps/ Vacuum/ Breech	3	1000	3000
Septicemia	2	3000	6000
Blood Transfusion	3	1000	3000
Caesarean	7	5000	35000
Pre delivery visit	100	100	10000
Other Costs			
Investigation	100	50	5000
Sonography	30	150	4500

NICU Support	10	1000	10000
Food	100	100	10000
Dai	100	50	5000
Transport	100	200	20000
Total	100		179500

Selection criteria for private obstetricians for enrolment under the scheme :

Selection criteria for private obstetricians for enrolment in to the PPP scheme

1. Doctor must be having post-graduate qualification in Obstetrics and Gynecology.
2. Must have his/her own hospital - preferably minimum of 15 beds.
3. Must have labor room and operating room.
4. Must be able to access blood in emergency situation.
5. Must be able to arrange for anesthetists and do emergency surgery.
6. Facility should be preferably accredited for sterilization procedures by the government.
7. Norm would be to select 2-3 private obstetricians per sub-district. All the available and willing obstetricians are to be included in the scheme.

Initially, the scheme will be launched on pilot basis in two backward and difficult districts. The evaluation will be done by third party and coordinated by Development Partners. After the evaluation rest of the districts can be considered for implementation in next FY.
This scheme empowers the poor in several ways. It provides them entitlement for free delivery care in private sector (having higher perceived quality than public sector), it provides immediate access to EmOC when needed, it also provides them choice of several providers near by from which they can choose from .
The Scheme has won the Asian innovation award from Singapore for its exemplary service.
Budget – Rs.25,00,000 x 2 districts = Rs.50.00 lakhs

6.2 Establishment of Child Development and Nutrition Center (CDNC)

Background:

As per NFHS III reports Bihar has 48% malnourished children. This has remained stagnant for over a decade. The malnourishment in backward districts may be attributed to poor infant and young child feeding practices. For addressing the Malnutrition, Child Development and Nutrition Support Centers (CDNC) shall be set up in underserved districts. A survey report says, there is a deficit in calorie intake and the proportion of families which are deficit in consumption of proteins and calories is also among the highest in some parts of Bihar which means there is an urgent need for counseling the communities on low cost nutritious diet intake. This shall also be a key activity of CDNC.

The U_5 children found to be severely malnourished (Grade III and IV), growth falters and growth defaulter (GF and GD) while weighing at Immunization day (Muskan day) will be referred along with their mothers to CDNCs and admitted there. These CDNCs shall act as treatment, nutritional care and support units in the blocks PHCs for such severe acute malnourished beneficiaries.
This project shall be initiated on a pilot basis in some blocks/underserved districts.

Objective:

- To provide treatment and nutritional care to the severely malnourished children.
- To ensure adequate nutritional supplementation under the guidance of a nutritionist.
- To arrest the number of Growth Faulters and Growth Defaulters (GF/GD).
- Capacity building of mothers on IYCF (infant and young child feeding practices) and child feeding and training on preparation of low cost nutritious diet.

Under-served Districts under Pilot Project for CDNC : 2

Criteria for selection of blocks:

- Blocks with high malnutrition among 0-5 year old children.
- Community Health Centers with
  - 3 rooms- 1 room where 10 cots can be accommodated, 1 room for play and other activities for children, 1 room for store, 1 kitchen
  - 1 toilet and bathroom

Methodology:

Persons Responsible and Administration-

- These CDNCs will be under administrative control of Block PHCs/MOIC of the block. Nutrition assistant and Cook cum helper will be under administrative control of MOIC/BHM concerned.
- Funds will be provided from the District Health Society – RCH.
- The RCHO/Quality Medical officer will be responsible to open the CDNC in corresponding districts through concerned Block PHC.

Staff at CDNC:

- Suptd.CHC / MOIC- CHC preferably trained in IMNCI- work as an additional duty.
- 1 CHC- staff nurse work as an additional duty.
- 1 Nutrition Assistant in each block where CDNC is running.
- 1 Cook cum Helper

Job roles and Responsibility:

- **Superintendent CHC/ MO- CHC**:
  - The Superintendent, CHC/IC Medical Officer, CHC is required to make round to the CDNC once daily for treatment and care of the referred children.
  - MO-CHC shall do this along with the regular discharge of duties at the CHC.
  - The Superintendent, CHC/Medical Officer, CHC will submit Monthly Progress Reports & Financial Reports to Civil srgeon through Block PHC.

- **CHC Staff nurse**:
  - One staff nurse from CHC will be given additional responsibility to work for CDNC along with her regular duties at the CHC. RDD concern shall issue required orders in this reference.
  - Staff Nurse will assist the Suptd. CHC / MO in maintaining medical history of the child as well as assure that the medication if any, is given timely to the child.
  - She is also required to give medical care and necessary immunization to the child.

- The incentive for staff nurse per CDNC is fixed at Rs.200 per month per CDNC. CHC superintendent/M.O. will give responsibility to work for CDNC to one staff nurse.

- **BHV:**
  - Regular Supervision & Monitoring of CDNC and its Reporting to Chief District Health Officer
  - Monitoring of growth of malnourished children admitted at CDNCs.
  - To keep records of follow up of these children.

- **Nutrition Assistant:**
  - Nutrition Assistant for each CDNC will be recruited on contract basis on the fixed salary of Rs. 5000/- per month by District Health Society of concerned districts**.**
  - Block Headquarter of CDNC will be the headquarter of Nutrition assistant.
  - Shall prepare the diet plan for each child and ensure that the prescribed diet is cooked under her supervision.
  - She is also required to act as a facilitator for capacity building of mothers on low cost nutritious diet preparation and shall them how to monitor growth of their child and take remedial action if need be.
  - She shall ensure that the CDNC facility is running efficiently.
  - The Nutrition Assistant shall be under the administrative control of BHO as well as keep the Suptd. CHC /MO CHC informed.
  - She shall monitor the growth and development of the child on regular basis with the help of Growth Charts and Records.
  - Along with the Staff nurse she shall prepare medical and growth history of each child
  - She shall maintain all records related with CDNC.
  - She shall maintain the equipment records of the CDNC
  - *Qualification of Nutrition Assistant*: Home science graduate/ B.A. or B.Sc. foods and Nutrition.

- **Helping Staff:**
  - **Cook cum Helper/ Attendant:**
    - One Cook cum Helper /Attendant for each CDNC will be recruited on contract basis on the fixed salary of Rs. 2500/- per month by District Health Society of concerned districts
    - Shall assist mothers and children in all daily activities and play. Shall also assist mothers in washing of clothes and feeding weak children as well as cleaning the CDNC unit (making beds, arranging toys and clothes)
    - Shall cook all meals as instructed by the nutritionist under her guidance and maintain kitchen.
    - Shall be responsible for cleaning of rooms & kitchen.

Instruments, Equipments, Furniture, Linen and Utensils per CDNC*:*

For Growth Monitoring

- Weighing Scale:
    - Salter weighing scales for 1-5 year old children (preferably digital)
    - Infant weighing scales (with pan)
    - Adult weighing scale
- Growth chart flex
- Growth Charts for growth monitoring

For children's cognitive development and community capacity building

- **IEC materials:** modules, charts, posters, pamphlets, guide booklets, flip books etc.
- **Toys-** Slide swing + balls (large and small) + building blocks + dolls and soft toys + clay/ "putine" or plaster of paris balls + drawing chart sheets + crayons+ cars (small)

Utensils for Kitchen

- 2 medium sized pressure cookers
- 1 large iron "kadhai"
- 1 milk pan and 1 sieve
- 1 sauce pan
- 1 frying pan
- 1 tava
- 20 dinner 'dal' bowls and 3 serving bowls and 1 chapati keeper
- 1 chakla - belan for chapatis
- Spoons - 10 Teaspoons, 10 Tablespoons, & 3 Serving spoons
- Plates: 10 dinner and 10 quarter plates
- Glasses and cups: 10 steel glass and 10 cup plates for tea/milk.

Furniture and Linen:

- 10 cots- one for mother and children
- 10 Mattresses
- 10 pillows
- 20 bed sheets
- 10 blankets
- 20 pillow covers
- 1 study table with 2 chairs

There is separate budget for each CDNC, 1 LPG gas stove & 1 LPG connection with 2 Cylinders, 1 refrigerator, and 1 Aquaguard.

Action Points:

- Block are already Identified as per recommendation from CDHOs concerned.

CHC Superintendent:

- CHC Superintendent: has to vacate 3 rooms for CDNCs & inform MOIC of concerned Block .

District Health Society:

- Set up of infrastructure and procurement of cots, mattresses, bed sheets, pillows, blankets, pillow covers and one study table with two chairs.
- Procure and install one LPG gas connection with two cylinders, one gas stove, one refrigerator, and one aquagaurd for water purification
- Procure toys to play, IEC material and growth chart, handouts and modules, weighing machines
- Required Human Resource to be made available eg. Nutrition Assistant and helper or Ayah

State:

- State has to ensure that at these CDNCs- MO CHC should preferably be trained in IMNCI or else should be trained later.

Training:

- Expenditure on Training for MO and Nutritionist on IMNCI to be booked under District Health Society- RCH
- Nutrition Training for Nutrition Assistants may be done by Foods and Nutrition departments & may be organized by State.
- UNICEF shall give support in organizing training of CDNC team.

Expected Outcome:

- Short term outcomes
  - Identification and referral of undernourished children
  - Treatment of severely undernourished children and arrest of further worsening of condition
- Long term outcomes
  - Improvement in child feeding practices at community level through capacity building of mothers in nutrition and low cost meal preparation
  - Gradual decrease in number of severely malnourished cases
  - Decrease in no. of malnutrition related deaths.

Estimated Budget: 5 lakh x 5 blocks x 2 districts = Rs. 50,00,000/-

6.3 **Free Referral Transport for Pregnant Women for Delivery Services**

Reducing MMR from 312 to 109 by 2015 is envisaged by Millennium Development Goals

Justification

1. In Bihar one women dies every hour due to pregnancy and childbirth
2. 40 per cent of Bihar's population live below the poverty line, and this state has one of the lowest levels of per capita social sector expenditure
3. With JBSY being implemented in the state for the last 4 years, the institutional delivery in the state has increased from 18.8% to 27.7% (DLHS III)
4. Referral transport is available (Dial 102), however the costs are a concern.
5. Referral transport money in JBSY is provided to the ASHA @Rs. 200/- per mother brought to the institution for delivery.

6. MAPEDIR data from Vaishali shows that nearly 15% of the maternal deaths occurred during transit and out of the 120 maternal deaths interviewed ambulance services were used in only 2 cases.

Aim-

1. To increase institutional delivery in the state by provision of free referral transport.
2. Improve the utilization of referral transport services (Dial 102) by pregnant women for delivery services.
3. To ensure safe delivery by cutting down on the second delay i.e. delay in transportation.
4. Reduction in Maternal Mortality

Implementation Modalities-

With a view to provide free referral transport for pregnant women, the following modality is envisaged.

1. The beneficiary to call the call centre for Referral transport
2. The call centre informs the concerned PHC as well as the beneficiary about the ambulance.
3. The money for referral transport in JBSY gets pooled in the RKS, which will be used later to make payments to the ambulance
4. Ambulances may be empanelled by the PHC considering the load of delivery services (Average PHC with a population of 3 lac will have nearly 25 deliveries per day and considering 50% will be institutional, nearly 12 deliveries per day will need ambulance services. Therefore a need for empanelling private ambulance services). These ambulances may be paid directly from the RKS immediately after arrival of the patient.
5. ASHA worker is paid Rs. 400 for accompanying the women to the facility. Remaining Rs. 200/- is retained by the RKS to pay the ambulance provider at the end of the month.
6. Provision of extra money (more than Rs. 200/-) for supporting the referral transport from hard to reach areas.

Project Area – Across the State in all the high focus districts

Budget –

No additional budget will be required for this initiative. However provision of money for supporting the extra expenses from the hard to reach areas will be required in RKS.

- Provision of Rs. 200/- in JBSY for supporting the referral transport
- Outsourced Ambulances/Government ambulances are available in most PHCs under DIAL 102

Remarks /Outcome-

- Increased utilization of JBSY and 102 services
- Reduction in Maternal mortality

7. Tribal Health **- Deleted**

8. Innovations

8.1 PNDT (Implementation of Medical Termination of Pregnancy Act, 1971 and Pre-natal Diagnostic Techniques (prohibition) Act, 1994)-

In order to arrest the abhorrent & growing menace of illegal termination of pregnancies as well that of pre-natal diagnostic test ascertaining sex-selection, the Medical Termination of Pregnancy Act, 1971 read with Regulations & Rules 2003 and the pre-natal Diagnostic Techniques (Prohibition of sex selection)Act were formulated.

The misuse of modern science & technology by preventing the birth of girl child by sex determination before birth & thereafter abortion is evident also from the fact that, there has been a decline in sex ratio despite the existing laws.

The Apex court has observed that:-
"We may state that there is total slackness by the Administration in implementing the Act. Some learned counsel pointed out that even though the Genetic Counseling Centre, Genetic Laboratories or Genetic Clinics are not registered, no action is taken as provided under Section 23 of the Act, but only a warning issued. In our view, those Centres which are not registered are required to be prosecuted by the Authorities under the provision of the Act and there is no question of issue of warning and to permit them to continue their illegal activities" .The apex court accordingly directed the central as well as state Governments to implement the PNDT Act. In Bihar too the concerned authorities have been directed to implement the provisions of the both the Acts forcefully.

Following actions have been taken and planned in this regard -

A. State, District and block level workshops on PNDT has been planned.

B. Create public awareness against the practice of prenatal determination of sex and female feticide through advertisement in the print and electronic media by hoarding and other appropriate means

C. A district wise task force to carry out surveys of clinics and take appropriate action in case of non registration or non compliance of the statutory provisions. Appropriate authorities are not only empowered to take criminal action but to search and seize documents, records, objects etc.

D. Beti Bachao Abhiyaan – As female feticide is a concern both in rural and urban areas, this year, Beti Bachao Abhiyaan will be launched to sensitize people against this heinous practice. Massive awareness drive with the support of College students, women's organizations and other voluntary associations is planned this year. Human Chain, rallies, seminars, workshops and press conferences will be organized for the same.

Budget for Pre-conception & Pre-natal Diagnostic Techniques in 38 Districts of Bihar, 2010-11

SL No	Name of District	No. of PHC	Orientation programme of PNDT activities, Workshop at State, District & Block Level @ Rs. 15000	Monitoring at District level and Meeting of District level Committee @ Rs. 10000
1	Araria	9	135000	90000
2	Arwal	5	75000	50000
3	Aurangabad	11	165000	110000
4	Banka	11	165000	110000
5	Begusarai	18	270000	180000
6	Bhagalpur	16	240000	160000

7	Bhojpur	14	210000	140000
8	Buxar	11	165000	110000
9	Champaran East	27	405000	270000
10	Champaran West	18	270000	180000
11	Darbhanga	18	270000	180000
12	Gaya	24	360000	240000
13	Gopalganj	14	210000	140000
14	Jamui	10	150000	100000
15	Jahanabad	7	105000	70000
16	Kaimur	11	165000	110000
17	Katihar	16	240000	160000
18	Khagaria	7	105000	70000
19	Kishanganj	7	105000	70000
20	Lakhisarai	7	105000	70000
21	Madhepura	13	195000	130000
22	Madhubani	19	285000	190000
23	Munger	9	135000	90000
24	Muzaffarpur	16	240000	160000
25	Nalanda	20	300000	200000
26	Nawada	14	210000	140000
27	Patna	23	345000	230000
28	Purnea	14	210000	140000
29	Rohtas	19	285000	190000
30	Saharsa	10	150000	100000
31	Samastipur	20	300000	200000
32	Saran	20	300000	200000
33	Sheikhpura	7	105000	70000
34	Sheohar	4	60000	40000
35	Sitamarhi	17	255000	170000
36	Siwan	19	285000	190000
37	Supaul	11	165000	110000
38	Vaishali	17	255000	170000
	State Level		900000	300000
	Total	**533**	**8895000**	**5630000**

Grand Total - 1,45,25,000/-
(One Crore Fourtyfive Lacs Twentyfive Thousand Only)

8.2 MUSKAAN Programme

The state has started a New Programme called MUSKAAN Programme to track pregnant women and New Born Child. Under this programme ASHA, AWW and ANMs jointly track the pregnant mothers and New Born Child.

This programme was launched in October 2007. Under this programme ASHA, AWW and ANM will hold meeting with Mahila Mandals in AWWCs. The main objective is to cover ANC coverage and Immunization. A Data Centre also placed in all the 533 PHCs to monitor this programme.
After the introduction of this programme it has been seen that the coverage of ANC and Immunization increased. The State wants to continue this programme and requested the GoI to fund the programme.

8.3 Family friendly Hospital certification

Background

Access to public health services in Bihar has witnessed tremendous improvement since the inception of National Rural Health Mission. Many facilities like KAKO (Jehanabad), Barachatti & Gurua (Gaya), Vaishali (Vaishali) is already providing quality family friendly services. The certification proposed will provide a formal acknowledgement to the service standards already available at those facilities. Since the procedure for certification of family friendly hospitals do not take longer period , many health facilities can get certified within shorter period. This is an advantage which the institutes would be able to gain from certification.
The Family friendly hospital certification is one of the ways to ensure improvement in quality services. The certification process will not only create quality institutions but also ensure sustenance of the services offered, once certified.
The number of certified institutes in a district could also be a criterion for computing district ranking.

Introduction

The Maternal Mortality Ratio (371 per 100,000 live births) in Bihar is fourth highest in the country and above the national average of 301. The goal for Bihar is to reduce it to 123 by the end of Eleventh Plan. Though this is a formidable task, the State should make all out efforts to reach that goal. With the operationalisation of Janani Evam Bal Suraksha Yojana(JBSY), the institutional deliveries are picking up, but this needs to be further accelerated. Nearly 60% of postnatal deaths occur during first 24 hour after delivery. There should be facilities available so that pregnant women come to health facilities for delivery and stay there for 48 hours. For this to happen, the institutions need to be Family friendly.
The Infant Mortality Rate in Bihar (61 per 1000 live births) is above the national average (58 per 1000 live births) and sixth highest in the country. The goal for the State is to reduce it to 29 by the end of Eleventh Plan. The neonatal deaths during the first 24 hours is very high which could be prevented by ensuring the stay of mother and baby for 24 hours in the health facilities.
The health facilities should also have basic facilities like running water, functioning toilets, warm water , food which would encourage the women to stay in the health facilities for 24 hours if not 48 hours. It is very important to observe the delivered mother and baby for 24 hours as 60% of the complications occur in mother and baby duo during that period.
The health facilities should have the essential drugs and equipments to provide basic care and to provide first aid in case of complications. It is also to be ensured that standard treatment and infection control protocols are available and the staff are trained to use the protocols.
The mother and child friendly hospital initiative primarily focused to improve the quality of maternal and newborn care in the health facilities. The certification systems proposed will help

the facilities to achieve some quality standards which will enable them to reach the ISO certification at a later date.

Definitions:

- A Family friendly Hospital is a health care facility where the practitioners who provide care for women and babies adopt quality practices that aim to protect, promote and support activities conducive for the health of mother and baby viz; antenatal care, safe delivery, exclusive breastfeeding of neonate, and postnatal care in an enabling environment.

Procedure for certification

- Once the concept note and the certification format is approved by the Executive Director and Health Secretary, Sensitization of the key stakeholders in the SHS and directorate of Health services will be ensured.
- This is followed by Creation of a **support group** consisting of public health experts, NHSRC, development partners, representatives from SHS, CMO/ACMO of the concerned district. A single member from a team will be identified who will provide constant support and guidance to the institutions aspiring to get certified.
- A set of training modules which are to be used in the process will be developed concurrently. Before the support group starts functioning, the training modules have to be in place. The MOICs and health managers will be trained to prepare the "as is list" of the institute which will work as a guide map for the certification process. (the list will cover areas like services offered (IP, OP, Delivery etc.), support services available (lab, pharmacy, diet etc.), utility services (e.g. laundry), services (patient load, bed occupancy rate, surgeries/ deliveries/caesareans conducted, average length of stay), process records (e.g. blood transfusion), Human resources management, and SWOT analysis.
- The support group plays an active role in the process of the facility being accredited family friendly. The facilitating role provided by the support group includes identification of potential facilities for certification, discussions with the MOIC/HM of the concerned facility regarding the accreditation process, handholding the facility through the process, getting the facility accredited, follow up on procedures (to maintain the accreditation process status and second, to facilitate the hospital towards higher standards like ISO at a later date). The member will be performing the role of a facilitator, and a resource person, to the health facility. He /she can fix up continuous follow up meetings with the institute team so as to support them constantly through the process.
- The certification procedure also proposes the formation of a **certification body**. The body will consist of public health experts, medical college teachers, NHSRC, development partners, representatives from SHS, and NGO hospital members. A team consisting of 3 members will form the **inspection team**.
- The institutes aspiring to get certified will be identified and constantly supported by the support team. Once the support team is satisfied that the institute is fit for inspection, the certification team will be informed. The support group member will then facilitate inspection. If the certification team is satisfied of the facilities provided, certification is granted. The expenses needed for improving the patient amenities and training in the use of protocols will be from the RKS/annual maintenance grants. The travel cost of the support team and inspection ream could come from innovation funds or could also be supported by any development partner.
- Once the facility qualify the standard norms for certification a certificate would be issued to the institution in public function.

- The certificate would be displayed in front of the CHC/ hospital and a board will be displayed with the declaration by all the staff to ensure the fulfillment of mother and baby friendly certification norms in the institution. All the staff would sign the declaration with the assurance to provide quality services.
- The facilities would be revisited after one year for recertification.

Categories

The categories are a constant source to improve the checklist, so that progress can be continuously monitored, as and when the facilities starts to fulfill the existing criteria and then attempt to progress further.

A. Service Environment - adequate physical space, running water supply, clean toilets, cleanliness, bulbs in toilets, telephone, working labour room/ OT/ ward
B. Client – provider interaction – providers friendly and courteous, informed consent is taken before procedures are done
C. Integration of services – adequate referral systems across PHC, SDH, RH, and DH. What is the experience of clients with more than one needs (RTI & contraception)
D. Access – location, distance, timing of services (if not 24*7), whether service providers are available on routine basis, whether services and timings are mentioned on a well marked board (signage), whether emergency services are available, ambulance services
E. Equipments and supplies – availability, are they in working condition, what is the procurement and inventory system, storage space
F. Professional Standards and Technical Competence – are infection control protocols followed, service standards, whether trained staff is available
G. Continuity of care – antenatal, natal and postnatal care, maintenance of records, follow up care, management of side effects/complications/relapse/recurrence
H. Service delivery – FP, antenatal care, management of normal (incl. active management of 3rd stage)/complicated deliveries, essential newborn care, basic emergency obstetric care, prompt referral, management of RTI/STI
I. Availability of all essential drugs.

Based on the above mentioned broad categories a checklist is made which is in turn used a criterion for ascertaining whether the health facility is Family friendly or not (the checklist will be updated from the above mentioned criteria as and when the facilities progress in the state).

Assessment format

Serial number	Criteria	Yes / No	Max score	Means of verification	Facility score
1.	Running water in Labour room/OT/OP/Toilets @ 24hrs		40	(i)Presence of Overhead tank, (ii)water coming in tap at the time of visit	
2.	Uninterrupted electric supply		20	Electric connection/generator present	
3.	Protected drinking water		10	Purification system present and working	
4.	Functional autoclave		10	Pressure indicator works	
5.	Basic laboratory services available, Ambulance service Drugs available		30	(i)Lab- blood – TC/DC/ESR/Blood sugar/Urine routine conducted (ii)Ambulance service available (iii)Drug availability displayed (iv) drug store is separated from chemical store	
6.	Bio-medical waste Management		20	(i)Deep burial pit available where anatomical waste is disposed (ii)Needle cutter in working condition (iii) no mix of infectious or non-infectious waste done (iv) waste bins not overfilled (v) needles and syringes mutilated and disinfected before putting in waste bin (vi) metal sharps disposed in puncture proof containers (vii) disposable gloves and masks not reused	
7.	Services available 24*7 PHC		20	(i)24 hour doctor availability (ii)24 hour nurse availability (iii)24 hour delivery services (iv)24 hour newborn care services	
8.	FRU: provides caesarean section/ blood transfusion services		20	(i)Gyanecologist and Anaesthetist present, (ii)Equipments for blood	

				storage present	
9.	Is privacy assured during examination		10	Screens and curtains present	
10.	% of Babies breast fed within 1 hour of birth (in the previous month)		10	Inspect delivery register and observation	
11.	Condition of labour room i. Essential equipments are present in the labour room ii. Surgical scrub practiced iii. Emergency drugs are available iv. Disinfectant cleaning done		40	(i)Spot light, vacuum extractor, foetal heart monitor, baby resuscitation mask and bag, infant warmer, mucus sucker, crash cart / emergency trolley (list) (ii)Staff demonstrates surgical scrub (iii)Oxytocin, Misoprostol Magnesium Sulphate, IV antibiotics (List) (iv)Labour room clean at the time of inspection, cotton swabs not put on floor (v) Labour board is kept clean without any rusting.	
12.	Condition of OT i. Aseptic precautions followed (infection control protocols) ii. Ante room present iii. Disinfectant cleaning and fumigation done iv. Windows not open v. Equipments in working condition (List)		40	(i)Observe one procedure to check adherence to aseptic practices (e.g. surgical scrub), use of sterile gloves (ii)Ante room present and not used for any other purpose (iii)OT clean at the time of visit (iv)Fumigation machine present and working (v)Windows not broken, not kept open at the time of visit	
13.	Ward – clean linen, windows not broken		20	Rainbow linen, windows intact	
14.	Names of staff on duty displayed		10	Check for display list	

Districts Proposed – 2 facility in 5 high focus districts

Budget – 2.00 Lacs x 5 districts x 2 facilities = Rs. 20.00 Lacs
Additional Cost can be met from RKS of the concerned facility.

8.4 **Maternal Death Reviews (Institutional and Community Based)**

Background

Pregnancy-related mortality and morbidity continues to take a huge toll on the lives of Indian women and their newborns. Maternal Mortality Ratio (MMR) needs to be reduced drastically in order to achieve the NRHM and MDG Goal of 100 per 100,000 live births, Similarly, Infants death rate is also high in our country. IMR which is currently 53 for India and 56 for Bihar is aimed to be reduced to 30 deaths per 1000 live births.

Maternal and Infant Death Review (MIDR) as a strategy has been spelt out clearly in the RCH –II National Programme Implementation Plan document. It is an important strategy to improve the quality of obstetric care and reduce maternal mortality and morbidity. The importance of MIDR lies in the fact that it provides detailed information on various factors at facility, district, community, regional and national level that are needed to be addressed to reduce maternal deaths. Analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service delivery.

Strategy

a. To establish operational mechanisms/modalities for undertaking MIDR at selected institutions and in community level
b. To disseminate information on data collection tools, data/information flow, analysis /review and follow up actions

8.4.1. <u>Institutional based Maternal and Infant Death Review</u>

A. Consultant Maternal and Child Health –will be the nodal officer for MIDR. The Nodal officer will identify and notify names of institutions which will take up MIDRs. In the first phase, this exercise will be limited to 10 District Hospitals only.
B. Orientation of Nodal Officers from these selected institutions in the data collection tools and processes. A one day orientation meeting to be held after the institute has identified their nodal officer.
C. Each facility level Nodal Officer will constitute a MIDR committee at facility level. The members of this committee would be staff members from Obstetrics, Pediatrics, Anesthesia, Nursing, Medicine and Surgery Department. The Nodal officer will be the member secretary of this committee.
D. For all maternal and infant deaths occurring in the institution, separate relevant forms should be completed after clinical review by the treating team using a structured format and signed by the duty doctor and the doctor in charge of the unit.

E. It is proposed that any maternal death occurring in the institution (in any ward) should be reviewed within 72 hours. For each maternal death, the MO on duty /Medical Officer I/c of ward (where death took place) will complete and sign the maternal death review form. Case sheet available with respect to the deceased should invariably be referred to while filling this

form. It is desirable to attach this case sheet with the review form. Any post facto recording/entry in the case sheets should be discouraged.

F. The facility level MIDR committee shall meet Quarterly
G. The terms of reference for the facility based review committee are as follows:
    1. Committee will meet and review the following:
        i. Circumstances under which the death took place
        ii. Cause of maternal death: Direct obstetric, Indirect obstetric and non obstetric cause.
        iii. Causes of Infant death: Asphyxia, Infections, Low Birth Weight, others
        iv. Whether death was preventable?
        v. What steps are required to prevent such deaths in future:
            - Action related to infrastructural strengthening
            - Action required to augment human resource availability
            - Supplies and Equipment
            - Demand Side Interventions to address first and second delays
            - Management interventions
H. Committee will nominate a member to the quarterly review meetings to be convened by the District Health Society, in case they are called for.
I. Committee will map any particular pattern in occurrence of deaths in the facility such as
    1. Deaths occurring on particular week days
    2. Any pattern in timing of deaths
    3. Any pattern in relation with staff deployment

SHSB to organize once a year review meetings at State Level to review all institutional level maternal Deaths and status on follow up actions

Project Area – 10 high focus districts

Budget – 30 lakhs x 10 districts = Rs.3,00,00,000/-

8.4.2. <u>Community based Maternal and Infant Death Review (Verbal Autopsy)</u>

- The verbal autopsy is a technique whereby family members, relatives, neighbours or other informants and care providers are interviewed to elicit information on the events leading to the death of the mother during pregnancy in their own words to identify the medical and non medical (including socio-economic) factors for the cause of death of the mother.

- The main purpose of the CBMIDR is to identify the various delays and causes leading to maternal deaths, to enable the health system to take corrective measures at various levels. Identifying maternal deaths would be the first step in the process, the second step would be the investigation of the factors/causes which led to the maternal death – whether medical, social, systemic, and the third step would be to take appropriate and corrective measures on these, depending on their amenability to various demand side and communication interventions.
- UNICEF has already taken this exercise in nine blocks of Vaishali. It is proposed to scale it up to the whole of Vaishali and in two more high focus districts. While all the PHCs will be included for maternal death verbal autopsy. it will be one PHC each for the infant death autopsy.
- The District will be the unit for undertaking Community based MIDR. The District nodal officer for MIDR will organize a one- day orientation programme for all MOs of the primary health care institutions, focused on the processes to be adopted and formats to be used for data collection.

- The district nodal officer will be responsible for convening a district level review committee meeting, organizing necessary documentation for review by the committee and keeping a record of follow up actions initiated. District nodal person could be the RCH officer, Deputy CMO, or some other district level programme manager.
- As a first step in implementation, all MOs will orient ASHAs in scheduled monthly meetings about line listing of all deaths of women in the age group of 15-49 yrs irrespective of cause or pregnancy status and a line listing of all infant deaths in the chosen PHC area. Line listing format as given in the annexure would need to be explained and adequate copies should be made available in the local language for ASHAs to report to the nearest PHC she is attached to. If possible this can be incentivized and required resources can be reflected in the PIP.
- Once the report reaches the concerned PHC, Medical officer I/C will designate a LHV/BPHN or ANM to further investigate and conduct a verbal autopsy. The designated person may be required to make 2-3 visits to the deceased women's house in order to collect complete information. It is proposed that such investigations should be completed within a fortnight of receiving information from ASHA. These visits should be made to the house as per the convenience of respondent/s.
- Medical Officers should undertake orientation of nursing staff designated to undertake verbal autopsy in data collection.
- The standard guidelines, modules and the questionnaires would be used to undertake the verbal autopsy.
- At district level, the maternal death review committee should be constituted under the chairpersonship of Chairperson District Health Society. Specific terms of reference for this committee could include the following:
    - To review VA records for maternal deaths in the district
    - To draw inferences on causes / circumstances leading to each maternal death in the district
    - To get additional information w.r.t. institutions where maternal death took place
    - To review progress on addressing specific programmatic elements to prevent deaths in future.

- Annual state level review meeting can be organized to get a sense of any clustering of maternal and/or infant deaths in a particular district or in pockets within districts in the state and common causes and actions required to be undertaken at the district/ state level.

Project Area : All PHCs in Vaishali (where already the project is on-going) and in two more high focus districts for Maternal Deaths and One PHC each in all these districts for Infant Deaths

Project Cost – Rs.30.00 lakhs x 3 districts = Rs.90.00 lakhs (State has budgeted for Rs.20.00 lakhs under this head in Annex 3 e, the remaining amount of Rs.70.00 lakhs to be sourced from JSY (Other Activities – Budget head).

9. **Strengthening of SIHFW**

9.1 Fast-Track Training Cell in SIHFW

It is also proposed in this budget to have a full time training experts/coordinator to spearhead various trainings under NRHM. Unless a dedicated Fast-Track Training cell is constituted at state level (at SIHFW), it will be very difficult to improve the quality of trainings and linkage training with performance. As training constitutes one of the largest single components of NRHM Budget allocation, this investment in creating the Fast-Track Training cell at the State level will be very cost effective intervention. Looking at the magnitude of the work under trainings, it is being proposed that under the training co-coordinator, there should be two training sub-coordinators, looking after 50% districts each. Additionally, one clerical staff is suggested. This training cell should be at the SIHFW and will eventually further strengthening SIHFW.

Budget:

(1.) One Training expert/coordinator
= Monthly salary Rs. 30,000/- x 12 months = Rs. 3,60,000/- per annum
(2.) Two Training sub-coordinators
= Monthly salary Rs. 25,000/- x 2 individuals x 12 months = Rs. 6,00,000/- per annum
(3.) One Clerk = Monthly salary Rs. 10,000/- x 12 months =Rs. 1,20,000/- per annum
(4.) Office expenses = Monthly Rs. 5000/- x 12 months =Rs. 60,000/- per annum
Total Annual Budget = Rs. 3,60,000/- + Rs. 6,00,000/- + Rs. 1,20,000/- + 60,000/- = Rs. 11,40,000/-

9.2 Filling Vacant Position at SIHFW/Hiring Consultant at SIHFW

AT the same time, the remaining vacancies of SIHFW can be filled. In order to fast-track the appointments of these faculties and support staff, the appointments can happen on a contractual basis such that trainings can be better organized and their quality improved. As part of strengthening SIHFW, a monitoring section needs to be created at SIHFW to use data on various aspects of training and to improve the quality of training, to make them need based, to assess if skill enhancement is happening, if program efficiency and effectiveness are increasing or if the trained staff are being rationally posted etc.

Budget

(1.) 10 consultant/faculties = Monthly Salary @ Rs. 30,000/- x 10 individuals x 12 months = Rs. 36,00,000/- per annum
(2.) 4 Clerical Staff = Monthly salary Rs. 10,000/- x 4 individuals x 12 months = Rs.4,80,000/- per annum
(3.) Office expenses = Monthly expenses Rs. 15,000/- x 12 months = Rs. 1,80,000/- per annum
(4.) Monitoring Cell (additional expenses for regular reporting within the system = Rs. 5,000,00/- per annum
Total annual budget= Rs. 47,60,000/- per annum

10. Infrastructure and Human Resource

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

1. As per RCH Programme operationalisation of 76 First Referral Unit to provide emergency obstetric and newborn care 24 hrs. a day / 7 days a week. The aim is to ensure atleast two operational FRUs per district. There are 76 hospitals in the State which have been identified to be upgraded as FRUs. The main focus initially to provide remedial measures absolutely required to ensure proper functioning of the facility. Another important aims to provide appropriate specialist in each of these 76 Hospitals. It is proposed to upgrade 76 Health facilities to FRUs in 2007 – 2008. Unit cost of construction at the rate of average of 2 crores as per RCH norm. The above hospital will be well equipped with OT, electric supply, water supply, toilet, telephone services, sewerage system and disposal system for hospital infectious waste.

2. Anesthetist will be hire @ Rs.1000 per case for EmOC. A provision for 50000 cases included in the PIP. Similarly Gynecologists and Pediatrician will also be hired as per requirement.

3. For follow up and monitoring RCH Coordinators will be hired at Commissionaire level and at SIHFW.

4. Newborn Care Unit will be set up in all the 533 PHCs and DH. This includes minor civil work and purchase of Equipments.

5. Setting up of Intensive Care Unit in all the District Hospitals

An Intensive Care Unit (ICU) is a specialized department in a hospital that provides intensive care medicine. Many hospitals also have designated intensive care areas for certain specialties of medicine, as dictated by the needs and available resources of each hospital. The naming is not rigidly standardized.

In most of the districts do not have Intensive Care Unit in any set up whether it is Private or Public. The patients have to shift either to the nearest medical colleges or to Patna for Intensive Care. In the process of transfer most of time it has been seen that patient die on transportation. The distance to the nearest ICU set up is long and most precious time waste for treatment of the patient.

Setting up of Intensive Care Unit will help to avail patient the facility in all districts so that accessibility for intensive care can be addressed. The state has proposed to establish 4 bedded ICU in all the 36 District Hospitals.

11. Institutional Strengthening

For HRD, training of 10 regular Government doctors is being proposed in Public Health for improving their administrative skills.

Further more it is proposed that for Multi skilling of Doctors they can be sent to hospitals like Safdarjung etc in New Delhi for continuing medical education.

Sub-centre rent shall be provided for 20% of the HSCs operational.

Quality Assurance

The state has Quality Assurance Committee for Sterilisation, Birth Control, Maternity Services, Child Survival Services, Immunization, and Case Management of Diseases in the district

Quality of health care and reproductive health services consists of the proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question and have the ability to produce an impact on client attraction & satisfaction, belief, population stabilization, inclination towards the continuation of method(s) etc.

As per the guidelines laid down by the Honorable Supreme Court of India, the State Government has set up Quality Assurance Committees (QACs) at the State and District levels to ensure that the standards for female and male sterilization and other health services are being followed in respect of pre-operative measures, operational facilities and post-operative follow-ups and other ethical diagnostic and treatment protocols.

The terms of reference for the State / District QAC are as follows:

- The District QAC shall conduct medical audit of all deaths related to sterilization, maternity deaths and deaths arising out of suspected medical negligence and send reports to the State QAC office. The State QAC shall deliberate on the report.
- Shall collect information on all hospitalization cases related to complications following sterilization as well as sterilization failure and maternity deaths and deaths arising out of suspected medical negligence.
- Shall process all cases of failure, complications requiring hospitalization, and deaths following sterilization for payment of compensation and will pursue these cases with the insurance company or otherwise.
- Shall review all static institutions i.e. Government and accredited private/NGOs and selected camps providing sterilization services and providing maternity, Child survival and other medical care for quality of care as per the standards laid down, and recommend remedial action for institutions not adhering to the standards.
- A minimum of three members shall constitute the quorum.

Presently the QAC are also looking after the quality of all the trainings done under RCH.

Monitoring of delivery of critical services & NRHM trainings (IMNCI, SBA, Immunization, EmOC, LSAS, NSU, BCC for promoting Breastfeeding, Minilap, MVA, ASHA).

In Bihar state, there is a quality assurance cell housed in the State Institute of Health & Family Welfare. The key responsibility of this cell has been to coordinate with multiple stakeholders and keep a track on the trainings happening in the state. There are members from the SHSB, SIHFW, Faculty of various medical colleges, retired medical college faculty members, and health officials, members from the professional organizations, and officials from the development partners are on its panel. The monitoring visits are proposed to be undertaken by the members to different districts and sub districts for initial handholding and to ensure quality training. As a part of this, standard monitoring formats available with the state are to be used. The experience till now has been that many of the doctor members are reluctant to undertake field visits. This is more so when the trainings happen in such districts from where same day return is not feasible. The key underlining reason for this has been found out to be the implementation of RCH I TA and DA norms. As it is well known, these norms were defined more than ten years ago. The different monitors undertaking field visits tend to spend from their pockets for the monitoring visits. In the last ten years, the cost

of living has gone up substantially and thus it is proposed to review the financial norms for the disbursement of TA and DA while on official duty.

After discussions with the stakeholders, it is suggested that the following norms may be adopted by the SHSB/GoB pending more clear guidelines from the GoI.

S No	Category	Description	Honorarium	Travel	Cost per monitoring day
1.	State/Division Government officials and doctors	With same day return	800 per day	AC Scorpio/Travera (@Rs 2000 per day)	2800
2.	State/Division Government officials and doctors	With night stay involved	1500 per night	AC Scorpio/Travera (@Rs 2000 per day)	2750
3.	Medical college faculty/retired professionals	With same day return	800 per day	AC Scorpio/Travera (@Rs 2000 per day)	2800
4.	Medical college faculty/retired professionals	With night stay involved	1500 per night	AC Scorpio/Travera (@Rs 2000 per day)	2750
5.	Free lance professionals (by invitation)	With same day return	1000 per day	AC Scorpio/Travera (@Rs 2000 per day)	3000
6.	Free lance professionals (by invitation)	With night stay involved	2000 per night	AC Scorpio/Travera (@Rs 2000 per day)	3000

In a month, on an average, 150 monitoring days would be involved for the training monitoring.

Supportive Supervision

Inspection formats have been developed for supervision of health facilities. SHSB has constituted State Monitoring team with Directorate officials, SIHFW officials and SHSB officials which randomly visit the facilities, suggest improvements and rank the facilities. The Supervision format is provided for in the Annexure.

12 Training

Successful Implementation of any programme depends on the capacity building of the personnel engaged. In RCH – II also ,human resource base will be created by enhancing the capacities through training .The sensitization of health personnel towards various RCH interventions is one of the major focus of the capacity building initiatives under RCH - II . Various trainings will be provided to State and district level managers, medical officers, nursing staff, ANMs, AWWs, ASHA and others.

The training will be provided at the State Institute of H & FW , Regional training Institutes , ANM training schools , District hospital ,PHCs and also in Railways , ESI ,private sector hospitals where there is enough case load for a proper training. Some of the trainings will be contracted out to the NGOs and private players also, so that any limitation of State infrastructure is overcome easily. [Available in detail in NGO chapter]. As BCC will be a major training aspect, it has been dealt in a separate chapter.

All the technical training programmes will ensure that.along with the theoretical inputs, proper practical exposure is also provided. Apart from this each training programme will stress on the managerial aspect and on the communication with the clients.

The TOTs will ensure that the trainers not only master the contents of the training topic but also aquire skills as teachers/trainers or facilitators and motivators.The state official, trainers, professionals and functionaries who excel in implementing training programmes will be recognized through awards and citations. A rational selection criterion will be used to select the trainees for the trainings where the no. of trainees are limited.

Moreover promotion and posting policy will be linked to training and the functionary will have to undergo training to avail the promotion. There will be provision for proper rational posting so that the personnel trained, utilize their training in their day to day work.

A feedback system will be developed to assess the quality of the training. From time to time, presence of state/regional observers will be ensured to assess the quality of district level trainings and workshops. Detailed Records and data about personnel undergone training should be available with all concerned at all levels. SIHFW will coordinate and monitor this with the help of district Data Officers

Training Institutes

SIHFW

The State Institute of Health and Family Welfare (SIHFW) is the premier training institute in the state of Bihar. SIHFW needs to be further strengthened as the apex institute in the state of Bihar for co-ordination and implementation of all capacity building initiatives under RCH II program. SIHFW has the required infrastructure and facilities, which need to be reinforced further so that it can conduct the various training programs on continuous basis.

As the nodal agency for training activities in the State, SIHFW will have following major tasks:

- To develop annual training calendars based on the district action plans in close co-ordination with RHFWTCs and ANMTCs.
- To conduct clinical and non-clinical training programs for medical officers.
- To support RHFWTCs and ANMTCs to conduct timely induction and refresher training programs for ANMs and LHVs.
- To facilitate ongoing assessment of training needs of functionaries at all levels
- Co-ordinate and implement integrated skill development and specialized skill development training programs.
- Conducting TOTs with RHFWTCs and ANMTCs
- To co-ordinate with SHSB for need based hiring of resource persons for the training programs

In addition, adequate provisions will be made for the institute to hire need based services of electricians, plumbers, carpenters, etc. on contract basis.

RHFWTCs

There are Eight Regional Health and Family Welfare Training Centers (RHFWTCs) in the state – Three for male and five for female health staff. All the sanctioned posts of trainers at these institutes are filled. However, functioning of all RHFWTCs is severely affected due to lack of proper infrastructure. The State proposes to use the facility Survey to do a detailed assessment of the needs of these training centers. Based on the report of the facility survey, adequate resources will be provided to all RHFWTCs to upgrade their respective infrastructure and maintenance support.

Location of the RHFWTCs in the State:

RFWTC Male	RFWTC Female
Patna (non residential) Muzaffarpur Bhagalpur	Patna Gaya Muzaffarpur Saran Purnea

The Facility Survey will also assess the need for new Regional Health and Family Welfare Training Centers (RHFWTCs) in the state.

Strengthening Nursing Education in Bihar

Since India attained Independence, there have been vast improvements in the health scenario in rural India. This has been further complimented in the last five years after the launch of the National Rural Health Mission (NRHM). However, in states like Uttar Pradesh and Bihar, major challenges still exist. In Bihar, after the launch of NRHM, there has been a 400% jump in full Immunization Coverage, 300% increase in OPD attendance in district and sub district health care facilities, and a dramatic rise in the institutional deliveries. With the increase in demand, there is one factor which threatens to jeopardize this progress i.e. the acute human resource shortage. In fact, in some districts, the human resources availability of all levels is about 30% of the sanctioned positions only.

Current Status in nursing (hospital/field based) services

In Bihar, the availability of nursing staff is also very poor. The state has a deficiency of 5448 ANMs, 1157 LHVs, 70 PHNs, 76 DPHNOs, 13818 staff nurses, 383 head nurses, 114 assistant matrons and 147 teachers in ANM schools. Under NRHM, the state had advertised for the 11,000 contractual positions, however, there was a 40 % shortfall in the number of applicants itself.

One of the key reasons for this shortage had been the sub optimal functioning of Nursing/ANM schools in the state. In public sector, there are 21 schools spread over the state for the ANM training and six schools for the GNM training linked to all six state run medical colleges. In addition, there is a one GNM school in the Indiara Gandhi Institute of Medical Sciences (IGIMS). Nineteen ANM and six GNM schools have been operationalized and the IGIMS schools strengthened with technical and financial assistance from UNICEF.

Beginning October 2008, a consistent effort has been put up by the department of health and the SHSB to ensure that the strengthening of nursing education gets its due attention. The existing faculty has been promoted as per rules; funds for renovation of the existing buildings have been released through NRHM, four existing faculty members have been nominated under Government of India scheme to other states for M Sc course.
The state has revised the honorarium for the contractual positions and vacant faculty positions are being advertised to ensure adherence to the Nursing Council of India standards.

Constraints

The Academy of Nursing studies, Hyderabad has shared a study of the state's nursing scenario. In Bihar, the availability of nursing education programmes vis a vis their availability in India is described in the table below:

	India	Bihar	%
ANM training or MPHW(F) training institutes-18 months after 10^{th} class	487	27	5.5
General nursing and midwifery (GNM) training institute for three years after 12^{th} class or intermediate	1805	11	0.6
B Sc nursing colleges for four years after 12^{th} class with science	1069	Nil	Nil
Post basic B Sc nursing college for two years for staff nurses with GNM diploma	129	Nil	Nil
M Sc (N) college for 2 years after completion of B Sc nursing	153	Nil	Nil

Sufficient number of nurses equipped with appropriate skills and knowledge are essential for achieving goals set by NRHM. In Bihar, there are acute shortages in all categories of nursing personnel making it difficult to meet the NRHM goals. As can be seen in the above table, the nursing schools and colleges required to produce the desired number of local nurses and ANMs is woefully inadequate as of today. As other states offer comparatively better remuneration and living conditions, there are not many qualified nurses and ANMs willing to serve in Bihar from outside the state.

Opportunities for strengthening nursing education in Bihar

The state government has initiated a multi pronged strategy to strengthen the nursing education. There are short term, medium term and long term plans to revamp nursing education as

The Immediate Plan 2009

- Promotion of existing faculty & contractual recruitment of vacant faculty positions **In process**
- Urgent repair of all nursing institutions being taken by districts on priority **In process**
- Renewal of accreditation of all nursing institutions from NCI **Completed**

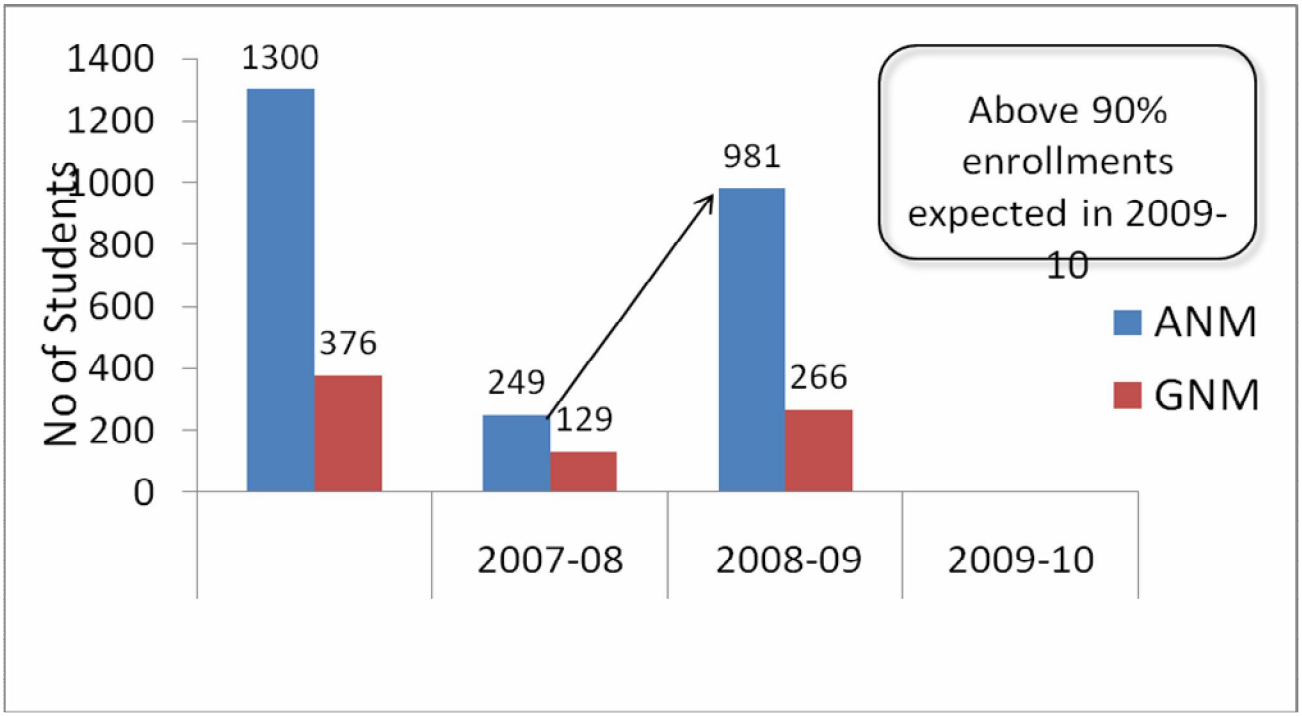
Short Term Plan 2010-2012

- Future faculty development initiatives---nominating and sponsoring diploma and degree holder nurses for the higher education courses in other states in consultation with MoHFW/NCI
- Strengthening state nursing directorate and nursing council. Two posts of Deputy Dir (Nursing) and Assist Deputy Dir (Nursing) have been created.
- Upgrading the GNM School at IGIMS to the Center of Excellence for Nursing. The state cabinet has sanctioned requisite staff positions which are being filled through the independent recruitment process.
- Commissioning of two new Nursing colleges including one in PPP model
- Promoting the private players to open Nursing schools/colleges
- Strengthening the existing infrastructure including increase in the hostel space
- Providing opportunities for continuing nursing education to all employed nurses

Long Term Plan beyond 2012

- Commissioning four more nursing colleges and ten ANM schools
- Providing opportunities for continuing nursing education
- Regulating the private nursing education and ensuring quality services in private sector

The training capacity of these institutes varies from 60 to 90 participants per batch. Most of these training centers were functioning sub-optiminaly in absence of proper infrastructure and other essential support but after the facility survey was completed with the help of UNICEF, GoB has been able to restart all 22 ANM schools. Based on the report of the facility survey, adequate resources will be provided for all ANMTCs to upgrade their respective infrastructure and maintenance support. Further status of faculty positions/trainers and their requirements at ANMTCs would be assessed in course of facility survey and then adequate provisions will be made to address their needs.



Key Training Activities

The wide range of training activities to be conducted under RCH II program by various agencies and training institutes is outlined below. The trainings not mentioned in training plan would be taken up with the help of development partners .Adequate changes will be made to make all the trainings as per GOI guidelines.

Maternal Health

- Provide comprehensive skill up gradation training to frontline ANC service providers (ANMs and LHVs) to ensure delivery of quality ANC services
- Conduct training to build capacity of LHVs for effective supervision and monitoring.

- Train Aaganwadi Workers and PRI members would help in identification and motivation of pregnant women for healthy antenatal care practices and for utilization of ANC services.
- Impart refresher training to Gynecologists and Obstetricians on safe delivery practices and referral procedures
- Train all ANMs, LHVs, and Nurses in identification of danger signs during delivery, referral procedures and PNC services.
- Train NGOs, Aaganwadi Workers and PRI members in raising community awareness and knowledge about importance of institutional delivery, safe delivery practices at home, referral and PNC services.

Child Health

- Train frontline Health workers, Aaganwadi Workers, PRIs, local NGOs and CBOs in correct breastfeeding and complementary feeding practices
- Provide comprehensive skill up gradation training to immunization service providers (LHVs/ANMs), particularly in injection safety, safe disposal of wastes and management of adverse effects.
- Conduct training to build capacity of Medical Officers, MOICs and DIOs for effective management, supervision and monitoring of immunization services
- Train Cold Chain handlers for proper maintenance and upkeep of Cold Chain equipment
- Train Aaganwadi Workers and PRI members in identification of children eligible for immunisation, in motivation of caregivers to avail immunisation services and in follow-up of dropouts
- Identify key persons to join IMNCI master training pool
- Train members of master trainer pool in national level course
- Recruit and train district trainers (using state master trainer pool)
- Train all health and ICDS staff in a phased manner
- Train frontline health workers and Aaganwadi workers in health education techniques to build community capacity for early recognition of childhood illnesses, home-based care and care-seeking

Family Planning

- Train partners such as NGO and civil society networks, religious organisations and leaders, PRIs, ICDS, Education, General Administration, Corporate Associations and Professional bodies (IAP, IMA) in promotion of Family Planning, at state, district and block levels
- (Re) train frontline health workers, Aaganwadi Workers and PRIs as motivators and counselors for family planning services through IPC and counseling
- Impart technical skill-enhancement training to existing and newly appointed frontline health workers on provision of various spacing (Oral contraceptive, condom, IUD insertion, emergency contraception) and terminal (female and male sterilization) methods of Family Planning.

- Train doctors in various reversible and terminal FP procedures (MTP, Minilap, NSV and IUD).

Adolescent Health

- Conduct annual orientation and training of all health service providers on adolescent health needs at state, district and block levels
- Train/sensitize community leaders, school teachers, PRIs, NGO networks, Anganwadi Workers, towards the health needs of the adolescents
- Train NGO and civil society networks, religious organisations and leaders, PRI members and teachers in promotion of safe reproductive health practices and family planning among adolescents.
- (Re) train frontline health workers and schoolteachers as motivators and counsellors for safe reproductive health practices and family planning among adolescents through IPC and counseling
- (Re) train frontline health workers to provide RTI/STI curative services for adolescents

Anaesthesia Training –

Action Points:

1. Third party review of Anesthesia trainings: It is requested to get a review, of the LSAS training process in Bihar, conducted by Anesthesiologists of National repute already associated with GoI. Based on the assessment, the State Health Society, Bihar can be requested to fill in the gaps.
2. Reorientation of Anesthesia trainers: There are two to three Anesthesiologists in each medical college who were trained in LSAS training about two years ago. A reorientation of all these trainers, for two days in Patna by GoI identified trainers, can be helpful in adhering to the standard training protocols and thus improving the quality of the trainings. A tentative amount of Rs Five lakhs is being proposed for this.
3. Identification of five district hospitals having good anesthesia facilities where the trainees may be deputed for 10 weeks during the total training period of 18 weeks.
4. Continuous field monitoring: The State has an established Quality Assurance Cell. Quality check of LSAS trainings also form a part of this cell activity. A regular (once a month for each medical college) monitoring visit should be conducted.
5. Immediate posting plans for the LSAS trained doctors in the designated FRUs should also follow.
6. Infrastructure strengthening process at the FRU level to give requisite working environment to the LSAS trained doctor should also be completed.
7. Voluntary application/nomination system for the future batches of LSAS trainings should be proactively encouraged by the state.

Medical Officers' Training on SBA (BEMoC Training) ---Ten days training

The Maternal Health Division of MoHFW has finalized the training guidelines and the duration of the training. In the year 2010-11, it is planned to train/reorient Medical officers of the state-regular and contractual (in order of priority) for ten days in a medical college.

a) The Medical College should adhere to the minimum training standards as per the protocol and checklist attached in the trainers' handbook sent by MoHFW.
The batch size should be of 4-6 candidates. The monthly delivery load should be at least 150-160. In Bihar, all the medical colleges have a monthly delivery load of >400.
The training package and other logistics should be planned and kept ready at the training site before the start of the training. The books and other logistics for 1500 trainees may be printed. The print ready versions of the materials to be printed is available in soft copies.

TRAINING PACKAGE

- Duration of training – 10 days.
- Package consists of :

Sl. No		Trainee	Trainer
1	**Guidelines for Pregnancy Care and Management of Common Obstetric Complications by Medical Officers**	• Reading • Reference	• Reading • Knowledge imparted to trainees should conform to the content of the guidelines.
2	**Trainers' Guide for Training of MOs in Pregnancy Care & Management of Common Obstetric Complications**	————————	• Instructions on how to conduct the training. • Issues dealing with the training-Assessment, Record keeping, etc. • Sample answers to the case studies.
3	**Trainees' Handbook for Training of MOs in Pregnancy Care & Management of Common Obstetric Complications**	• Introduces the training component, Session plans, Case Study, etc. • Key points and notes for quick reference.	• Reading and practice material. like case study, etc.
4	**Trainees' Workbook for Training of MOs in Pregnancy Care & Management of Common Obstetric Complications**	• Contains case sheets which have to be filled. during *hands on practice.* • Maintain record of the activities performed by him/her. • Ensure that the activities performed by them are supervised by the trainer and have been duly certified.	• Assessment of day to day activities of the trainee. • Ensure that the tasks which have not been performed satisfactorily are repeated.

Illustrated Budget per batch for Training of Medical officers in BEmOC

Heads of Expenditure with a batch size of 6	Cost
DA (Rate x No. of Days x No. of Participants) (Rs. 200 x 10 x no. of participants)	200 x 10 x 6 = Rs. 12,000
Honorarium for faculty (Rate x Days of training x no. of trainers) Doctors (Rs. 1000 x 10 x 3) Nurses (Rs. 500 x 10 x 2)	 Rs. 30,000 Rs. 10,000 Total Rs 40,000
Incidental Exp. like, Photo copying, job aids, flip charts, LCD hiring etc. (Rate x Days of training x no. of trainees) (Rs. 250 x 10 x 6)	250 x 10 x 6 = Rs. 15,000
Lunch, Tea & Snacks, (Rate x Days of training x no. of trainees) (Rs. 150 x 10 x 6)	150 x 10 x 6 = Rs. 9,000
TA @Rs 2000 x 6 (to be disbursed as per state norms)	Rs 12,000
Sub Total	Rs. 88,000
IOH @5% of Subtotal (State has revised it to 5%)	Rs. 4,400
Total	Rs. 92,400

Total budget per batch would be Rs Ninety Two Thousand and Four Hundred only. The state intends to undertake on an average one batch per month in every medical college. Thus, the total batches estimated would be six batches per month (in six medical colleges) for ten months which amounts to a total of 60 batches and a expected training of 360 medical officers in Bihar.

Thus the budget proposed in SBA training for Medical Officers' is Rs Fifty Five Lakhs and Forty Four Thousand (55,44,000).

Follow up training on SBA---two days

The SBA training in the state is going on since February, 2008. The state has thus far trained above 1200 ANMs, LHVs and A grade nurses as SBAs in different districts. It is important that a follow up training is planned to reorient the trained SBAs. In addition, this will be an opportunity to find the gaps present which are limiting the trainees to practice their skills. A two days follow up training is proposed in Bihar across all districts. It will be in a batch size of 12-15 participants at the district hospital/medical college. The proposed budget based on revised RCH norms is as follows:
Illustrated Budget per batch for follow up training of trained SBAs

Total budget per batch would be Rs Twenty Eight Thousand and Sixty only. The state intends to undertake 80 batches in 2010-11 in selected District hospitals and medical colleges. Thus the budget proposed in Follow up SBA training for trained SBA would be Rs Twenty two lakhs Forty four thousand and Eight hundred only (2244800).

Medical Termination of Pregnancy (MTP) Training

Projected Budget For the Period of April 2010 to March 2011

Sl. No	Training Details	No. of Trainees	No. of trainings	DA to be paid for no. of days	DA @ Rs. Per day	Total DA	Honorarium for Trainers	Contingency limit to Rs.100 per participants per day	Institutional over head limited to 15%	TA expenditure	GoB Cost	Ipas Cost
1 (a)	**12 Days training for MBBS Doctors**											
	# of Doctors to be Trained	160		12	250	480,000.00		192,000.00	100,800.00	64,000.00	836,800.00	
	# of Support Staff to be Trained	80		6	150	72,000.00		48,000.00	18,000.00	32,000.00	170,000.00	
	# of Trainings to be Conducted (to arrive at Honorarium)		78				234,000.00					234,000.00
1 (b)	**6 Days training for ObGyns and lady doctors**											
	# of Doctors to be Trained	80		6	250	120,000.00		48,000.00	25,200.00	32,000.00	225,200.00	
	# of Support Staff to be Trained	41		6	150	36,900.00		24,600.00	9,225.00	16,400.00	87,125.00	
	# of Trainings to be Conducted (to arrive at Honorarium)		35				105,000.00					105,000.00
	Sub Total										**1,319,125.00**	**339,000.00**

2	MTP services at health facilities				
	Availability of MVA syringes at health facilities				
2 (a)	**Name of health facilities**	**No of health facilities**	**Yearly requirment of MVA syringes**	**Cost of MVA per unit**	**Total cost**
	Sadar Hospitals (10 syringes in each facility)	25	250	1500	375000
	Sub Divisional Hospitals (8 syringes in each facility)	23	184	1500	276000
	Referral Hospitals (6 syringes in each facility)	55	330	1500	495000
	Primary Health Centers (4 syringes in each facility)	398	1592	1500	2388000
	GOB Cost				**3,534,000.00**

IEC (one hoarding board) at health facilities

2 (b)

Name of health facilities	**No of health facilities**	**Cost of hoarding board per unit at each health facilities [size of the hoarding board will be 6'x3' (Rs. 100/- per sq ft)]**	**Total cost**
Sadar Hospitals (1hoarding board at each facility)	25	1800	45000
Sub Divisional Hospitals	23	1800	41400
Referral Hospitals	55	1800	99000
Primary Health Centers	398	1800	716400
GOB Cost			**901800**

Heads of Expenditure with a batch size of 15	Cost
DA (Rate x No. of Days x No. of Participants) (Rs. 100 x 10 x no. of participants)	100 x 2 x 15 = Rs. 3,000
Honorarium for faculty (Rate x Days of training x no. of trainers) District faculty (Rs. 600 x 2 x 2) Regional/State faculty (Rs. 1000 x 2 x 2)	 Rs. 2,400 Rs. 4,000 Total Rs 6,400
Incidental Exp. like, Photo copying, job aids, flip charts, LCD hiring etc. (Rate x Days of training x no. of trainees) (Rs. 250 x 2 x 15)	250 x 2 x 15 = Rs. 7,500
Lunch, Tea & Snacks, (Rate x Days of training x no. of trainees) (Rs. 150 x 10 x 6)	150 x 2 x 15 = Rs. 4,500
TA @ Rs 200 x 15 (to be disbursed as per state norms)	Rs 3,000
Sub Total	Rs. 24,400
IOH @15% of Sub	Rs. 3,660
Total	Rs. 28,060

13 IEC/BCC

Bihar is a state with high cultural heterogeneity. It has been a challenging area to address for the issues of behaviour change in a heterogeneous population. Even if the language of communication in Bihar is Hindi/maithili/maghahi/angika/bhojpuri etc the use of words and styles differs from area to area. It indicates that no common strategy is going to work for the entire state as different areas have different dialects of communication. Use of SBCC has been one of the key components in any health sector strategy. It is essential to modify risk prone life styles and practices to promote healthier lifestyles and practices. In past the state have had many major rounds of social mobilizations and awareness generation which have helped to take key health messages to even the most interior of the rural areas. But still there is a lot of space for the improvement. High prevalence rate of malaria, kalazar, TB, filaria and sickle cell anaemia indicates the magnitude of the problem in the state which can be reduced through behavior change approach. All these need area specific strategies for the positive change like to motivate the people through behavior change communication for the use of bed nets avoid water logging in and around habitation area and collection of garbage in a common place away from the habitation. The approach would be adopted to impart attention precise to the existing problems district wise focused manner.

The Annual Action Plan 2010-11 for IEC/SBCC has been prepared in the light of the number of initiatives taken by Dept. of Health, Government of Bihar and State Health Society Bihar in the implementation of NRHM. It follows in essence, form and content, the National Communication Strategy. The National PIP for RCH and instructions and guidelines received from Government of India and Government of Bihar from time to time has also been kept in mind.

The selection and implementation of set of behavior change have been adopted with a view to improve a wide range of family care-giving and care-seeking practices, and enhance supportive environments for improved household health practices at community, institutional and policy level. The IEC/SBCC Programme will focus on building an environment favoring health seeking practices, preferably through low cost and no cost interventions, especially for the disadvantaged and the marginalized sections of society. This outlook will set the tone and tenor of the mobilization process for effectuating a positive change in the existing socio-cultural mores, systems and processes.

Key activities for the year of 2010-11

A. Human Resource

Appointment of Consultant-IEC at SHSB level

B. Trainings & Workshops

1. **Capacity building training program of DPMs & State level officials in strategic communication**

Communication understanding and sensitivity is essential before any attempt to initiate activities to achieve goals of SBCC under NRHM. Since this discipline is becoming more and more research and evidenced based, it is necessary for those to understand the concept, tools and advance techniques, who are supposed to undertake and supervise these activities in the state. It is a well recognized fact that accomplishment of NRHM goals largely depends upon quality of SBCC inputs and its impact on behaviour and social change.

To build the capacities of DPMs & State level officials of the health department and that of the State Health Society, a training workshop will be organized. Inputs from tools employed during capacity assessment of State Health Society and specific need assessment for this

training will be incorporated into the design of the training workshop. The capacity assessment exercise will aim to find:

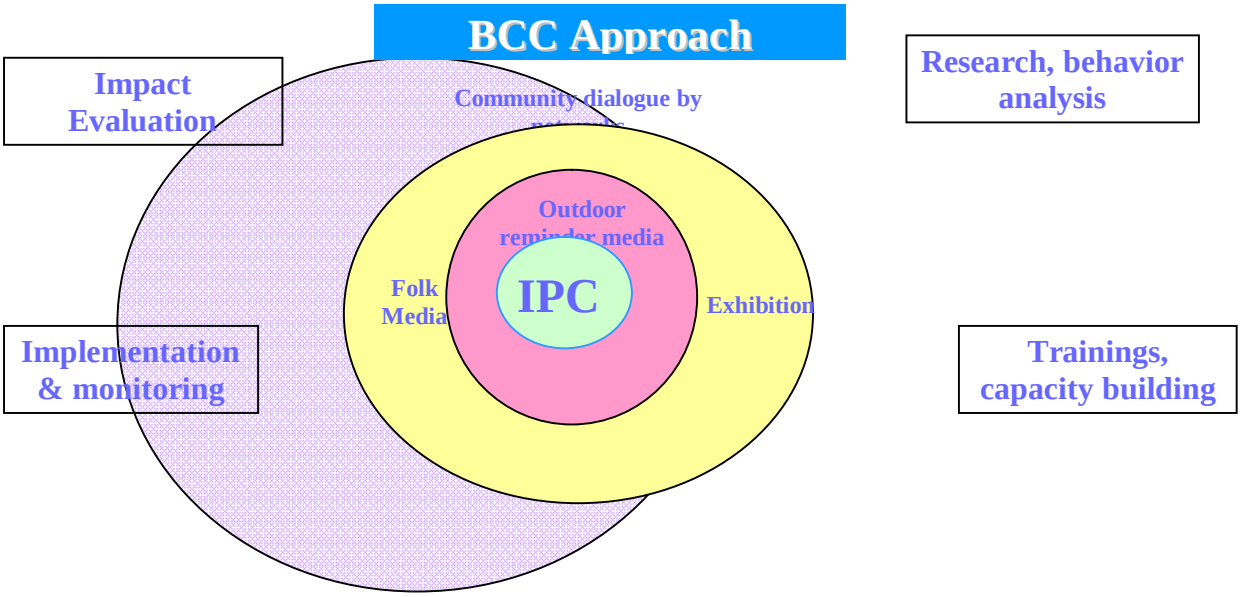
- Individual capacity of officials of SHS to carry out / implement state wide IEC / SBCC activities- experience & skill
- Capacity in designing and developing appropriate material & program
- Training skill for the use of IEC / SBCC material
- Capacity in communication monitoring- dissemination and tracking of progress
- Capacity for storage and appropriate distribution IEC / SBCC material

All these topics will be dealt in the light of new research and thinking in the area of development communication.

2. **Workshop for development of District communication plan for 2010-11**

While the institutional strengthening and communication strategy development process will be carried out, communication plans for different programmes under NRHM will be prepared and implemented under the 2010-11 PIP with technical support from different internal / national agencies and partners.

Broadly, the multimedia communication around the above issues will follow the following approach:



The state and district health communication plans for different programmes / issues will be prepared by the State Health Society. The communication plan will have following components:

- Identification of issues to be communicated - NRHM's objectives
- Identification and planning regarding communication channels – guided by the state communication strategy
- Capacity building of service providers- IPC, skills to use material and issues
- Distribution and dissemination plan of communication material
- Monitoring and evaluation mechanisms

SHSB will work in the development of communication plans and materials for the following issues also:

Maternal health

- IFA/anemia
- Institutional delivery
- Birth preparedness and referral transport promotion

Child Health

- Breast feeding
- Routine Immunization
- Diarrhea management (ORS/Zinc) and hygiene
- Measles
- Management of severely acutely malnourished (SAM) children

Adolescent health

- IFA/Anemia
- HIV prevention

Inter Personal Communication, counseling by trained functionaries supported with various social mobilization and mass media activities will be built into communication plan for each program under NRHM.

3. Training of ANM & ASHA on IPC skill building on Fact for life frame work

Inter Personal Communication being the core element of the communication package and the lead medium; it is imperative to build the skills of frontline functionaries who are in direct interface with the communities at household and / or facility level. SHSB will create a pool of trainers at State, District and Block levels on:

- Use of Interpersonal Communication and counseling techniques to promote health seeking behaviors in the context of issues identified under RCH II.
- Appropriate and effective use of communication tools and materials

In order to build the skills of service providers around a number of issues, State Health Society will develop and use a training module based on Facts for Life (FFL) framework. A detailed training and monitoring plan using cascade approach and also SATCOM training technology (on pilot basis) will be developed and implemented.

4. Workshop for review of SBCC (Social & Behaviour Change Communication) activities

It meeting will be called twice in the year for the progress review of communication activities. In this meeting we review SBCC / IEC financial budget and activities done by districts in that period. Monitor the impact of SBCC / IEC activities and finding the gaps in that, which done by the district. DPM will come and present the status of SBCC / IEC in their district. It's a totally review workshop of the district SBCC / IEC activities, where DPM share their achievement and problem to conduct the activities.

C. Events

1. **Mass Media** Radio spot, TV spot & others, Press release, Media & News Paper advertisement on various health related days, Information, Recruitment notice & tender notice advertisement for message dissemination through mass media
2. **Local Media** Tin plates, Bus panel, Glow Signs board & others Hoardings, Wall Painting, Bill boards, Cinema slides, Local Cable and other Wall writing/ Miking & others**,** Laminated Board etc., on issues related to RCH and NRHM will be place at vantage points, displayed at important locations like at District Offices, Block Offices, PHCs, Halt points, Bus Stands, Railway stations, etc. Monthly magazine brought out by the I & P.R. Dept. is being again

sponsored by SHSB. Space has been allocated in the magazine for publicizing about health related programmes

3. **Community Media**

Workshop, Fair (Mela), Stall organization, Tableau exhibit Other media Folk drama, Nukkad natak, Magic show, Puppet show, Video show, AV film show, Community meeting (with SHG, influencers, opinion leaders, PRI, youth), Health Camps and other health related activities / functions will be organized in state and each district from time to time to expand reach of different programmes. Folk Media will also be used as a tool for publicity. Health related Posters/Banners will be displayed at entire state.

D. Campaigns

1. **Safe motherhood**

Motherhood has a very humanizing impact on family, community and the nation. Yet mothers are probably the most neglected persons in the society. Quite a few women die a few days or hours before giving birth to a child or just after the childbirth. The promotion will focus on:

- ANC promotion,
- Promotion of IFA supplementation for anemia prevention
- Promotion of institutional delivery
- Birth preparedness & referral transport promotion
- Post natal care

2. **Child Survival & development**

The Indian infant mortality rate is 55 per 1,000 live births. The under-five mortality rate is estimated at 75 per 1,000 live births. Major investments in child health in India have not yet yielded substantial decline in maternal, infant and young child mortality in the recent decade. Importantly, the current neonatal mortality rate accounts for nearly two-thirds of all infant mortality and half of under-five child mortality, these facts point to two inescapable conclusions:

One is India must accelerate efforts to reduce infant and child mortality and

Secondly of them these efforts must give particular attention to reducing neonatal morality. The promotion will focus on:

- New born care
- Diarrhea management
- Promotion of use of ORS
- Zinc supplementation
- Management of severely acutely malnourished (SAM) children

3. **Breastfeeding**

Too Address the knowledge gaps, myths & misconceptions and change the behaviors from traditional to recommended practices, the following messages were identified to be delivered to the providers, change agents and the primary audiences. The promotion will focus on:

- Early initiation of breastfeeding and importance of Colostrums
- Exclusive breast feeding
- Position and attachment during breast feeding
- Benefits of breastfeeding to mother & child
- Overcoming traditional practices, myths and misconception related to breast feeding

4. **Health emergencies**

Many people are concerned about the influenza A H1 N1 (swine flu) outbreak. This is a new strain of flu virus that has not infected humans in the past. When a new flu virus begins infecting people, public health officials often take special measures to help slow the spread of the virus. H1 N1 flu (swine flu) is a type of flu virus that causes respiratory disease that can spread from person to person. Most people infected with this virus in the U.S. have had mild cases of the disease, but some have had more severe illness. The promotion will focus on:

- Wash your hands
- Personal Hygiene

5. Family Planning

In a growing economy like India the need to accelerate efforts for the improvement of Reproductive and Child Health statistics has been the foremost agenda of Millennium Development Goals (MDG) 4 & 5. In an effort to strengthen work that impacts the national RCH indicators. The promotion will focus on:

- Promotion of spacing methods for contraception
- Promotion of permanent methods of contraception

6. Routine Immunization

The aim is to immunize all the children and pregnant mothers under Universal immunization Program, in order to reduce IMR, MMR and NMR through routine immunization of all children and mothers from six vaccine preventable disease in the state.

The promotion will focus on:

- 6 vaccines (Vitamin A, TT, BCG, DPT, OPV, Measles)
- Pregnant women and children as per EPI schedule
- Catch–up Vitamin A doses
- Effective against intestinal parasites 2 years to 5 years

7. PPP

The aim is to ensure provision of services through private partnership to generate public faith in availability of facilities in Government institutions.

The promotion will focus on all PPP initiatives undertaken by SHSB

E. Printing Material

Poster, Flex banner , Pannel, Banner, Striker, Leaflet, Brochures, Badhai Cards, Booklet, IPC flip card, Letter with massage, T shirts, Desk Calendar, Pocket calendar, wall calendar, health calendar, dairy, quarterly magazines Banner, Letter with massage, Rally Flag, T shirts, Flex banner and other materials will be developed and publicized on different issues eg. Dial 102 (Ambulance Service), Dial 1911 (Doctor's Consultancy), Dial 102/1911 (Samadhan: Rogi Shikayat Niwaran Wyawastha), ICU Service, JBSY, Promotion of Breast Feeding, Family Planning including Non Scalpel Vasectomy, Immunization, Adolescent and Sexual Reproductive Health, PNDT Act, Role of ASHA under NRHM, Role of Mamta, Importance of Super Specialty Hospitals etc., various PPP facilities through various print.

F. Material production & prototypes

TV / radio are best medium to reach rural and urban community. Develop the TV spot / AV spot and other for the different type of campaign. TV and radio spot will be develop for the better impact of campaign.

Additionally the various prototypes already developed and available with Government and Development partners will be synchronized and utilized.

G. Monitoring & Documentation

Research, Monitoring and evaluation, documentation of reports of SBCC / IEC activities which is done by state & districts will be undertaken as before.

S.N.	Unit Description	State Level	District Level	Block/ PHC Level	Total
1	**Human Resource**				
	Consultant-IEC	Yes			360000
	Mobility (Travel) Support	Yes			100000
2	**Trainings & Workshops**				
	Capacity building training program of DPMs & State level officials in strategic communication	Yes			500000
	Workshop for development of District communication plan for 2010-11	Yes			500000
	Training of ANM & ASHA on IPC skill building on Fact for life frame work	Yes			15000000
	Workshop for review of SBCC (Social & Behaviour Change Communication) activities	Yes			600000
3	**Events**				
	Mass Media				
	Radio spot/ TV spot & others (telecast & broadcast cost)	Yes			15000000
	Press Ads/ Media Ads / News Paper ads on various health related days / Information/ Recruitment notice & tender notice advertisement	Yes	Yes		29000000
	Local Media				
	Tin plates/ Bus panel/ Glow Signs board & others	Yes			5000000
	Hoardings/ Wall Painting/ Bill boards/ Cinema slides/ Local Cable and other		Yes		38000000
	Wall writing/ Miking & others			Yes	13325000
	Community Media				
	Workshop / Fair (Mela) /Stall organization/ Tableau exhibit Other media	Yes	Yes	Yes	20930000
	Folk drama / Nukkad natak / Magic show/ Puppet show/ Video show/		Yes		38000000
	AV film show/ Community meeting (with SHG, influencers/ opinion leaders, PRI, youth)/ others			Yes	5330000
	Health Camps and other health related activities	Yes	Yes	Yes	6865000

4	**Campaigns**				
	Safe motherhood (ANC promotion/ Promotion of IFA supplementation for anemia prevention / Promotion of institutional delivery/ Birth preparedness & referral transport promotion / Post natal care	**Yes**			**2000000**
	Child Survival & development (New born care/ Diarrhea management / promotion of use of ORS / Zinc supplementation / Measles / Management of severely acutely malnourished (SAM) children	**Yes**			**2000000**
	Breastfeeding	**Yes**			**5000000**
	Health emergencies (A1 / H1 & others)	**Yes**			**1000000**
	Family Planning Promotion of spacing methods for contraception / Promotion of permanent methods of contraception	**Yes**			**5000000**
	Routine Immunization				**5000000**
5	**Printing Material**				
	Poster / Flex bannar , Pannel/ Banner/ Striker/ Leaflet / Brochure/ Badhai Cards/ Booklet / IPC flip card / Letter with massage/ T shirts / Desk Calendar / Pocket calendar / wall calendar/ health calendar/ dairy/ quarterly magazines and other.	**Yes**			**5000000**
	Banner / Letter with massage/ Rally Flag / T shirts/ Flex banner and other		**Yes**		**34200000**
6	**Material production & prototypes**				
	Development of TV spot / AV spot and other	**Yes**			**5000000**
8	**Monitoring & Documentation**				
	Research / Monitoring and evalaution / documentation of reports / other	**Yes**			**1500000**
	Grand Total				**267162000**

14. Procurement of Equipments/Instruments and Drugs/Supplies

Procurement is done in a decentralised manner with rate contracts fixed centrally by SHSB while District officials directly place orders to the concerned entities using a cash and carry system

Positive steps taken by DOH, GOB for improving procurement function:

- Transferring the procurement function to Bihar State Health Society which provides flexibility in functioning
- Guidelines for rate contracts are revised from time to time to make them more prudent and if one analyses the guidelines from initial rounds to current rounds, several points have been included to increase the transparency
- DoH has prioritised strengthening Warehouse Infrastructure in districts and funds have been sanctioned for construction of new warehouses
- Adoption of GOI's GFR to make system transparent and procedures simple for procurement by state level entities
- Rate contracting and cash and carry system introduced by SHSB, resulting in increase in availability of drugs at facility level manifold and has further resulted in increase in patient using state run health facilities.
- All procurement related information starting from advertisement to evaluation to final decision are posted on SHSB website, making the entire system transparent
- DoH keen to establish an independent procurement agency on lines of TNMSC

A big leap has been taken in 2009-10 in the field of Procurement concerning Maternal and Child Health equipments and drugs. One of the key achievements has been the finalization of rate contract for the state owned Sick Newborn Care Unit and Neonatal Stabilization Units, Labour room equipments and of quality hospital beds. In addition, rate contracting of some important drugs like Misoprostol has also been ensured.

Strategy and Activities
14.1 Delivery Kits at HSC/ANM/ASHA

Medical equipment & accessories: Disposable Delivery Kits consisting of the following items:
(1) Four pieces Gauze (F11) 14x16 cm, folded 4 times each;
(2) Stainless steel blade;
(3) Cotton pad 20x6 cm;
(4) Two pieces of strong thread each 25 cm (9 tari);
(5) Small bar of soap;
(6) 4 pieces cotton (IP) 2.5 sq. inch each;
(7) Plastic sheet 60x60 cm;
Total Cost- Rs 25 Only

DULY STERILIZED BY GAMMA RAYS. THE CONTENTS SHOULD BE PACKED IN POLYTHENE OF 200 GAUGE, WITH LITERATURE ON USE OF THE CONTENTS IN HINDI/ENGLISH WITHIN THE KIT. POLYTHENE COVER TO CARRY MESSAGES IN HINDI/ENGLISH ON ONE SIDE AND ON THE OTHER SIDE OF THE COVER 'STERILIZED BY GAMMA RAYS' SHOULD BE WRITTEN.

Budget-2,00,000 no. x Rs.25 = Rs.47,82,018

14.2 SBA Drug Kits with SBA-ANM/Nurses

S.no	Drug/Item	Preparation/Packing	Cost per unit (In Rs)

1.✓	Misoprostol	Tablet 200 µg / tablet.* 3 tablets per patient	45
2.✓	Oxytocin	Injection 5 IU / ampoule* 3 amp per case	51
3✓	Magnesium Sulphate	Injection 50% solution 10 mg (20 ml) / ampoule	30
4.✓	Gentamycin	Injection 80 mg / ampoule* 4 amp	22
5.✓	Ampicillin	Capsule 500 mg / capsule*6 cap	30
6.✓	Metronidazole	Tablet 400 mg / tablet*6 tab	12
7.✓	Veinflow	20 G	13
8	IV set		10
9 (a)	Disposable Needles	23 G	1
9 (b)	Disposable Needles	22 G	1
10(a).	Syringes	5 ml	2
10(b).	Syringes	10 ml	3
11	Disposable Delivery Kit		25
			245

Budget – Rs.61,25,000/-

14.3 Sanitary Napkins at Govt. Hospitals – To be piloted in 1 district

Budget – Rs.9,50,000/-

14.4 Quality improvement of Health facilities

14.1.1. Procuring equipments for Labour room
14.1.2.Procuring equipments for SNCU & NSU
14.1.3. Procuring various supplies like Beds

14.5 Strengthening Life Saving Skills for Anesthesia (LSAS)

Procuring equipment for the Anesthesia departments in six medical colleges

In Bihar state, LSAS training is being undertaken in all six Government Medical Colleges for the last two years. A total of 55 doctors have been trained in LSAS till now. All the six medical colleges in the state are imparting this training. Monitoring visits to all Medical Colleges has been undertaken by UNICEF Health Officer Dr O P Kansal, Dr Himanshu Bhushan from GoI and Dr A K Tiwari, Programme officer for Anesthesia trainings, in the last one year. An exposure visit was also organized to Gujarat comprising State Programme Officer, all Heads of the departments of Anesthesiology and Health officer, UNICEF in April, 2008.

In the last one year, there have been many formal and informal discussions with the heads of the Anesthesia departments of all the medical colleges. With the technology update taking place all around, the anesthesia departments in the state need strengthening of the basic infrastructure. The departmental heads had submitted a proposal to this effect about a year ago. It is proposed to spend Rs. Nine crore (@Rs One and half crore for each of these colleges) to help them procure the equipment. This in terms will help the trainees of LSAS training grasp the skills as per the current technology. A simple indicative list of the equipment required is given in the table below.

S No	*Equipment*	*Requirement*
1	Anesthesia workstation	For all colleges
2	Boyle's apparatus latest model	3 sets for each college
3	Fibreoptic nasopharyngolarryngoscope	One for each college
4	Anesthesia emergency resuscitation kit	One for each college
5	Ethylene Oxide sterlizer	One for each college

It is worth mentioning that the funds to the state medical colleges would be released as per the need and therefore fresh proposals would be invited from them after the GoI approval.

14.6 Instrument for ANM In 38 districts

S. No.	*Name of Equipment*	*Price*
1	Stethoscope	Rs.140/-
2	B.P. Instrument (Air blood instrument Non-mercurial sphygmomanometer)	Rs. 280/-
3	Weighing Machine weighing capacity of 10 Kgs)	Rs. 540/-
4	Weighing Machine Square Model (120 Kgs)	Rs. 449/-

14.7 ICU Equipment

Procurement of ICU Equipment

1	Bed Side Monitor	Approx. Rs. 13.50 lakh per ICU Unit for Total 48 Units (25 District Hospital + 23 Sub Divisional Hospital) = Rs. 1350000.00 X 48 = **Rs. 64800000.00**
2	Defibrillator	
3	Syringe Pump	
4	ECG Machine	
5	ICU Ventilator	
6	Air Fumigator	
7	Suction Machine	
8	Laryngoscope	
9	Nebuliser	
10	Glucometer	
11	Air Viva (Ambu Bag)	
12	ICU Bed	
13	Bed Side Lockers	
14	Medicine Trolley	
15	Transfer Trolley	
16	Three Fold Stand	
17	X-Ray View Box	

S No	Equipment	Requirement
1	Anesthesia workstation	For all colleges
2	Boyle's apparatus latest model	3 sets for each college
3	Fibreoptic nasopharyngolarryngoscope	One for each college
4	Anesthesia emergency resuscitation kit	One for each college
5	Ethylene Oxide sterlizer	One for each college

It is worth mentioning that the funds to the state medical colleges would be released as per the need and therefore fresh proposals would be invited from them after the GoI approval.

15. Programme Management

Programme management arrangements have been made at state, district and block level. The entire NRHM including RCH is governed by the highest body i.e. State Health Mission chaired by the Hon'ble CM. The SHSB functions under the overall guidance of the State Health Mission.

The objective of State Health Society is to provide additional managerial and technical support to the Department of H &FW, Government of Bihar for implementation of National Rural Health Mission which includes RCH –II, General Curative Care, National Disease Control Programme and AYUSH. SHSB has a Governing Body whose Chairperson is the Development Commissioner, Govt. of Bihar and an Executive Committee whose Chairman is the Secretary, Dept. of Health & Family Welfare, Govt. of Bihar. There is a Project Appraisal Committee (PAC) whose Chairman is the Executive Director, SHSB and which has representations from Directorate, Development partners, RHO-GOI and other line departments of Bihar Government. The Committee (PAC) considers the expenditure proposals.

Financial powers of the bodies/office bearers have been clearly defined in the Society's Financial Rules and Bye-Laws.

Programme Management Units

State Level (State Programme Management Unit):

SL	Designation	No.	Salary Pm	Salary Pa
1	State Programme Manager	1	39930	479160
2	Consultant NRHM	1	36300	435600
3	Data Asstt. Cum System Analysis	1	30250	363000
4	Consultant Cold Chain	1	30250	363000
5	Consultant Accounts Manager(Salary Rs.23540/- Pension Rs.Rs.11770.00)	1	14242	170900
6	Accountant	1	18150	217800

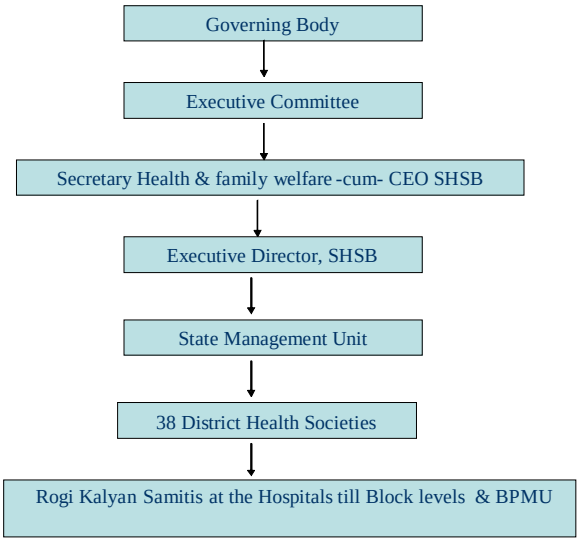
7	Store Keeper	2	9680	116160
8	Clerk cum Steno	1	13310	159720
9	Data Assistant	6	10890	130680
10	Computer Operator	1	9680	116160
11	Accountant	1	18150	217800
12	Executive Assistant	8	108900	1306800
13	Computer Operator-cum-Steno	10	9680	116160
Total				**4192940**

A 10% hike in salaries per year has been recommended in the PIP and is part of RCH II budget.

Sno.	Budget Head	@	Total
	Mobility and office expenses	150000 pm	18,00,000
	Meeting Expenses	25000/- pm	3,00,000
	Upgradation of SHSB office	800000/- pa	8,00,000
	Purchase of furniture	50000/- pa	50000
	Total -		**29,50,000**

Grand Total – Rs. 71,42,940/-

The Overall picture of programme management functioning is as follows



District Health Societies

The society directs its resources towards performance of the following key tasks:-

- To act as a nodal forum for all stake holders-line departments, PRI, NGO, to participate in planning, implementation and monitoring of the various Health & Family Welfare Programmes and projects in the district.
- To receive, manage and account for the funds State level Societies in the Health Sector) and Govt. of India for Implementation of Centrally Sponsored Schemes in the Districts.
- Strengthen the technical/management capacity of the District Health Administration through recruitment of individual/ institutional experts from the open market.
- To facilitate preparation of integrated district health development plans.
- To mobilize financial/non-financial resources for complementing /supplement the NRHM activity in the district.
- To assist Hospital Management Society in the district.
- To undertake such other activity for strengthening Health and Family Welfare Activities in the district as may be identified from time to time including mechanism for intra and inter sectoral convergence of inputs and structures.

The DHS has it's own Governing body with the District Magistrate as the Chairman and Executive Body with the Civil Surgeon as Chairman.

District level (DPMU)

District Programme Management Support unit consists of following personnel:-

1. District Programme Manager
2. District Accounts Manager
3. District M & E Officer

Sl. No.	Name of the post	No. of Post	Salary (PM)	Salary (PA)	Budget (Amount in Rs)
1.	District Programme Manager	38	23000 + 10% increment = 25300 (2009-10) 25300+ 10% increment = 27830 (2010-11)	27830 x12x38 = 12690480	12690480
2.	District Accounts Manager	38	18000 + 10% increment = 19800 (2009-10) 19800 + 10% increment = 21780 (2010-11)	21780 x12x38 = 9931680	9931680
3.	M & E Officer	38	15000 + 10% increment = 16500 (2009-10) 16500 + 10% increment = 18150 (2010-11)	18150 x 12 x 38 = 8276400	8276400
Recurring expenses of 38 DPMU (salary head) per year					**30898560**
4.	Mobility and office expenses	38	55000	50000x 12x38	25080000
	Assistant or Data Operator	38 x 2	Rs. 8000/- Pm	8000x 2x12x38	7296000
	Rent of DHS Office	38	4500/-pm	4500 x 12 x 38	2052000
	Meeting Expenses	38	5000/- pm	5000 x 12 x 38	2280000
	Purchase of furniture	38	20000/- pa		20000
Total Expenses of 38 DPMU per year					**36718000**

Block Unit (BPMU)

Block Programme Management Unit consists of following personnel-

1. Block Health Manager
2. Block Accountant

Budgeted in Part B

16. Financial Management

FUND FLOW MECHANISM AT STATE

Presently the State Health Society is getting Grants-in-Aid from GoI through electronic transfer by crediting the A/c of SHS. These funds are transferred to District Health Society A/c as Untied funds

as per their respective District Action Plans, which then gets routed to the CHCs, PHCs, district hospitals and RKS for smooth conduct of the activities of RCH- II.

On the lines of the GOI regarding transfer of funds, SHS and DHS has implemented the system of e-transfer of funds to the districts and blocks.

OPERATION OF BANK ACCOUNTS

- The Account of State Health Society is being operated as per the delegated powers.
- The persons authorized as per the powers delegated to them are also operating the bank accounts of DHS.

ACCOUNTING PROCEDURES FOLLOWED

The State is following the Double Entry System of accounting on Cash Basis.
For the sake of convenience in consolidation of accounts districts are also instructed to follow the same system.
In addition to this for proper accounting and maintenance of books, a manual cum guidelines had been issued to the districts. Also the monthly auditor appointed at each district is reporting on the accounting procedures followed by the districts on a monthly basis, along with the deviations, if any.

FINANCIAL MANAGEMENT AT STATE

The Financial Management group at state consists of the State Finance Consultant and state accounts officer. Similarly at districts also the DAM is looking after the financial matters and at the block level, there is the Block Accountant.

New Financial System was introduced in 2009.

The purpose for introducing this new system was-

- De-centralisation of Resources and Power to the Districts and below
- Transparency in the Fund allocation
- Need based fund allocation
- Better utilization of funds
- Better Fund Accountability of the Districts and PHCs

The salient features of this new system are –

- District allocation for Major and Minor heads for the complete year communicated to the districts
- Districts empowered to re-allocate funds within the sub-heads of the Major sections, keeping in mind the annual target. Thus districts can prioritise their needs and meet them at the district level.
- Funds released to districts and subsequently to other levels for the Major heads for each quarter depending on 80% SOE submission
- Non-performing district's funds to be re-allocated mid-year to the performing districts, thus State would be able to meet the utilization target and performance would be awarded

FINANCIAL MONITORING

The financial monitoring is being done through the understated mechanisms-

1. Analysis of SOEs submitted by the districts and its comparison with audited expenditures on monthly basis and reconciliation of the same by the financial consultant.
2. Training cum discussion meets with all the districts officials at regular intervals.
3. AUDITS:
    a) Comprehensive audit (Annual) as per the Directions of GoI. The auditor for the F.Y 2009-10 has been appointed and they have initiated the audit of DHS's accounts.
    b) Monthly Audit is being conducted and reports are submitted to state regularly which are then reviewed.
    c) Audit by CGA officials is also going on as on date.
    d) Concurrent audit has been initiated in ½ of the districts of the State with Concurrent Auditors in place.

Appointment of CA at SHSB & C.A. Level

Due to increase in funds flow & for maintenance of Accounts as per NRHM guidelines, all the DHS were directed to appoint C.A. Similarly; CA. at SHSB level is to be appointed soon.

Constitution of Internal Audit wing at SHSB:
Internal Audit wing is proposed to be constituted in 2010-11 in which services of 6 retired officers form Recognised Audit & Accounts Services will be engaged, who will be well versed in Audit work.

Budget for strengthening of Financial Management Systems

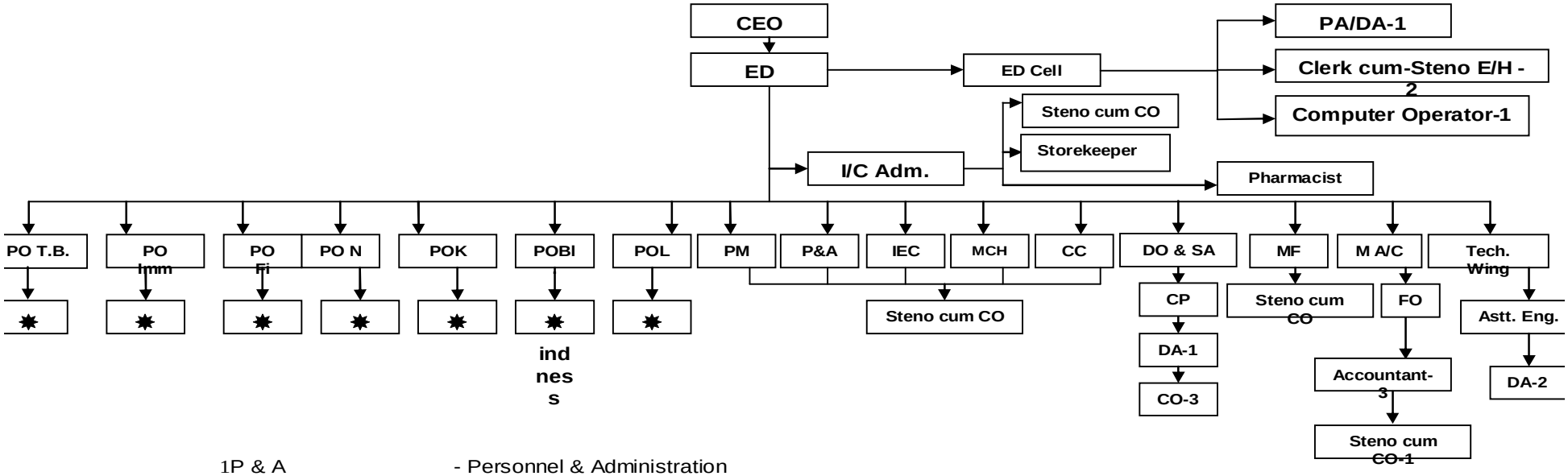
Sl.No.	Activity	Budget 2009-10	Expenditure may be incurred upto March, 2010	Prosposed budget for 2010-11	Remark
1	**Chartered Accountant at DHS** 20,000.00 X 38 X 12 = 91,20,000/- (Approx)	1,36,52,000/-	1,30,00,000/- (Approx)	**1,82,04,800/-**	
2	**Statutory Audit Fee** 10,00,000/- (Approx)				
3	**Chartered Accountant At State** 20,000/- X 12 = 2,40,000/- (Approx)				
4	**Constituation of Internal Audit Wing at State** (Annexure attached)				
5	**Meeting at State Level of DAM & Block Accountant** (Annexure attached)				

6	**Special Audit from financial year 2005-06 to 2008-09** 50,00,000/- (Approx)				
7	**Tally at DHS & State**				
8	**Installation of Tally at PHC level (Single User)** 533 X 13,500/-	-	-	**71,95,500/-**	As per NRHM Guideline (D.O. No. G27034/1/2009/ NRHM (F) dt. 12.08.09
9	**Purchase Computer for Block Accountant at PHC** 533 X 50,000/-(Approx)	-	-	**2,66,50,000/-**	For Accounts works & Others
10	**TA/DA for SHSB Account Wing**	-	-	**5,00,000/-**	For inspection of DHS & Block
Total				**5,25,50,300/-**	

Budget for Two days Quarterly Meeting at State Level of DAM & Block Accountant

TA/DA of Guest Faculty Trainer	2 X 1000 X 4 X 2days	16000.00
TA/DA of State level Trainer	2 X 700 X 4 X 2days	11200.00
TA/DA of Block Accountant	533 X 200 X 4 X 2days	852800.00
TA/DA of District Account Manager	38 X 200 X 4 X 2days	60800.00
Refreshment cost	670 X 100 X 4 X 2days	536000.00
Total budget		**1476800.00**

	Budget for Constituation of Internal Audit Wing at State		
1)	Salary of Three Retired Persons	20,000/- X 3 X 12	720000.00
2)	TA/DA for District Visit	600 X 30 X 3 X 12	648000.00
	Total budget		**1368000.00**



1P & A - Personnel & Administration
2POBl - Programme Officer Blindness
3PON - Programme Officer Nutrition
4POK - Programme Officer Kala-Azar
5PO Fi - Programme Officer Filaria
6PO Imm - Programme Officer Immunization
7MF - Manager Finance
8MA/C - Manager Accounts
9PM - Programme Manager
1FO - Finance Officer
1CO - Computer Operator
1DO & SA - Data Officer & System Analyst
1POL - Program Officer Leprosy
1MCH - Maternal & Child Health
1CC - Cold Chain
1Asst. Eng - Assistant Engineer
1CP - Computer Programmer
1DA - Data Assistant
1PA - Private Assistant

17. Convergence and Coordination

Coordination with other departments such as ICDS, PHED, Education and Panchayat Raj is important for tackling health issues. The involvement of representative of these departments help the health service providers in reducing the maternal mortality, Infant Mortality and increase the coverage of Family Planning Service and Adolescent Health Service. The state would take certain initiatives to ensure a synergistic effort from the community level to the state level which is defined in part E along with a detailed budget

Convergence with BSACS

State level campaign to increase the voluntary non-remunerative blood donation.

Background:
Collection of blood from non-remunerative blood donors has been globally recognized as the ideal method in support of assuring safety of blood and blood components. To meet the burgeoning demand for safe blood, it is imperative to promote donation by voluntary non-remunerative blood donors from low risk population. For a safe blood service in Bihar, where comprehensive laboratory tests are neither possible nor pragmatic, it is best to switch over to 100% voluntary donations. Still as per BSACS records, the voluntary blood donation constitutes less than 25% of the total blood collection in Blood Banks in Bihar.
Bihar is witnessing a huge upsurge in the utilization of the government health services over last few years. Keeping this in mind various activities have been initiated regarding Blood Safety in Bihar. An assessment of all the Public Sector Blood Banks in Bihar has been conducted. License has been obtained by state for new Blood Banks. Licensing process has been initiated in the districts where there are no Blood Banks. Government has entered into agreements with third parties for the operationalization of already running Blood Banks. In spite of all these steps being taken, the blood units stored in these Blood Banks is very less (roughly 12% of the available storage capacity- at the time of initial assessment). Thus to enhance blood safety, motivating non-remunerated blood donors and phasing out even replacement donors should be one of our key strategies.

Objectives:
General objective: Conduct a state wide campaign to improve awareness regarding Blood Safety and to increase the Voluntary Non-Remunerative Blood Donation.

Specific objectives:
1. To increase the percentage of voluntary blood collection from present level of below 25% to at least 50% by the year end.
2. To establish a long term self sustainable system for regular Voluntary Non-Remunerative Blood Donation.
3. To retain the regular donors in the system.
4. To encourage new donors to be empaneled.

Activities and duration:

ACTIVITIES	TIMELINE
BSACS to finalize and get approval for the financial guideline for conducting Voluntary Blood Donation (VBD) Camps	to be finalized before 20th October
SHSB to make necessary changes and get approval for the	to be finalized before

financial guideline for conducting VBD Camps (on similar lines to BSACS guidelines)	20th October
Hiring of a Communication Agency (by UNICEF) to carry out various IEC activities Finalization of the specifications and TOR for the agency.	to be finalized by 25th October
Identification of Partner agency / Network NGOs for each of these districts for mobilization and conduction of VBD camps	to be finalized before 25th October
Letter from State to all the Districts having Medical Colleges (Patna, Muzaffarpur, Bhagalpur, Gaya, Darbhanga, Kishanganj and Katihar) to synchronize activities between Medical College and Blood Bank, with Civil Surgeon being the overall in-charge for this programme. Following this letter, a district level team 'District VBD Task Force' to be formed to look into the programme under Civil Surgeon's leadership, consisting of – an IMA member of the district, district Blood Bank's Medical Officer In-Charge, one faculty member from the PSM department of medical college, one member of the Partner NGO identified for the district and one representative of the students of the respective medical college. One person from BSACS/SHSB will be an attached member of this district level team.	Letter to be sent to districts by 25th October. District level team to be functionalized by 31st October.
All the Public Sector Blood Banks in these 7 districts to be adequately • staffed with trained workforce • stocked with consumables – kits and blood bags • equipped with instruments in working conditions	to be ensured before 31st October
IEC activities to be conducted by the Communication Agency: • Messages from Chief Minister, other ministers etc. in paper. • Preparing IEC materials – Developing new or using existing materials: o Radio Spots – Radio Mirchi, AIR FM, o Newspaper advertisement, posters and pamphlets for VBD camps o Newspaper articles, posters and pamphlets on Blood Safety Awareness o Newspaper interviews / articles to 'GLORIFY the DONORS' (individual donors – regular/new; corporate with excellent participation) • Planning and implementation of the IEC drive throughout the months of November and December 2009. • To prepare for the BSACS a newsletter, which can be continued to be published on a quarterly basis, highlighting all the activities of BSACS (including various activities conducted for Voluntary Blood Donation) • Include VBD as atopic in on going media person's training: "Voice of Bihar" – Round table meet.	Preparation of IEC by 31st October. IEC activities throughout November and December 2009 in all the 7 districts. The first edition of the newsletter can be released on the World AIDS Day – 1st Dec 2009, highlighting the various activities being undertaken to promote VBD in Bihar.

• Planning and conducting a group discussion on television on the eve of World AIDS Day, involving various stakeholders. • Helping in improving the website of BSACS- updating all the current and forthcoming events.	
Activities to be conducted by the NGO selected at the district level for - 'Mobilizing Young People', 'Mobilizing General Public' etc. • Poster making competition for VBD • Slogan making competition for VBD • Candle light march for awareness generation • Liaison building and involvement of local celebrity, regular donors (e.g. like centurion donors), media icon, religious leaders, corporate sector, student body etc. for promoting the campaign. • Planning with the district team and implementation of a function to recognize the contribution of various groups on the day of World AIDS Day o Awards for best poster, best slogan. o Facilitation of - regular individual donors, corporate and local bodies with maximum involvement. • Highlighting all these activities in the local media.	These activities are to be spanned throughout the months of November and December.
Similar activities can also be done in the districts of Vaishali and Nalanda because of the upcoming Melas – Sonpur Mela and Rajgir Mela respectively. Partner NGO in these two districts will also have the added responsibility of facilitating • with the hired Communication Agency for IEC in these Melas and • with the Mela organizers to plan and run a VBD corner in these Melas. Ready to use kits need to be developed for these activities.	General activities are to be spanned throughout the months of November and December and the Mela activities to be conducted specifically during the Rajgir and Sonpur Melas resp.
Honoring the District Magistrate of the district which has maximum collection of blood units in this two month campaign.	
From the month of January onwards (after this campaign is over), this drive can be extended further to involve various colleges, starting with their active participation during Saraswati Puja.	
This system once in place, can be utilized to organize mini-campaigns on their own at the district level every year at least 4 times: • World Health Day – 7th April • World Blood Donor's Day – 14th June • National Blood Donation Day – 1st October • World AIDS Day – 1st December	

Outputs:

This campaign will produce the following outputs:

- In all the 9 districts - organization of two month long IEC campaign on Blood Safety, along with VBD camp organization on regular basis and function on the occasion of the World AIDS Day on 1st December, 2009.
- Increased availability of blood stock of various blood groups in the Public Sector Blood Banks.
- A Network of NGOs to sustain VBD in the state on regular basis.
- A Network of local bodies in each district to sustain VBD on regular basis.
- Blood Banks having a complete database of regular donors as well as record of new donors.

Beneficiaries:
This campaign will benefit the public of Bihar leading to a regular supply of safe blood when ever required – thus causing reduction in HIV infection (by reducing availability and use of unsafe blood), reduction in maternal mortality (as with the availability of safe blood at the FRUs-First Referral Units, there would be improvement in the Emergency Obstetric Care services) and availability of safe blood for various other surgical procedures.

Impacts:

- Availability of safe blood as desired by NACO under NACP-III.
- Availability of blood at FRUs in Blood Banks and Blood Storage Centers, as desired under NRHM for strengthening of EmOC services.

Project management:
BSACS will have the overall responsibility of supervision, monitoring and financial management of the campaign. It will have support from SHSB in the project management.
Budget: To be finalized by BSACS

18. Role of State, District and Blocks

The role of State, District and Block are well defined. The role of each one has been clearly indicated in the workplan (Annex 3 d) as per activity wise. The financial decentralization process has given more roles to Districts and Blocks to perform in executing the various programs. The State mainly looks after Monitoring, Policy decisions, Rate Contracts, Technical support etc and helps the district in executing the actions planned.

19. Monitoring and Evaluation

One of the major weaknesses of the RCH program in Bihar is the absence of an effective Monitoring and Evaluation system that would provide accurate and reliable information to program managers and stakeholders and enable them to determine whether or not results are being achieved and thereby assist them in improving program performance. A triangulated process of Monitoring and Evaluation would enable cross checking and easy collection, entry, retrieval and analysis of data.
Main Activities

A. Health Management Information System
B. Data Centre at State Level, District Level & Block Level and SMS based Mobile Data Centre for HSC & APHC

A. Health Management Information System (HMIS)

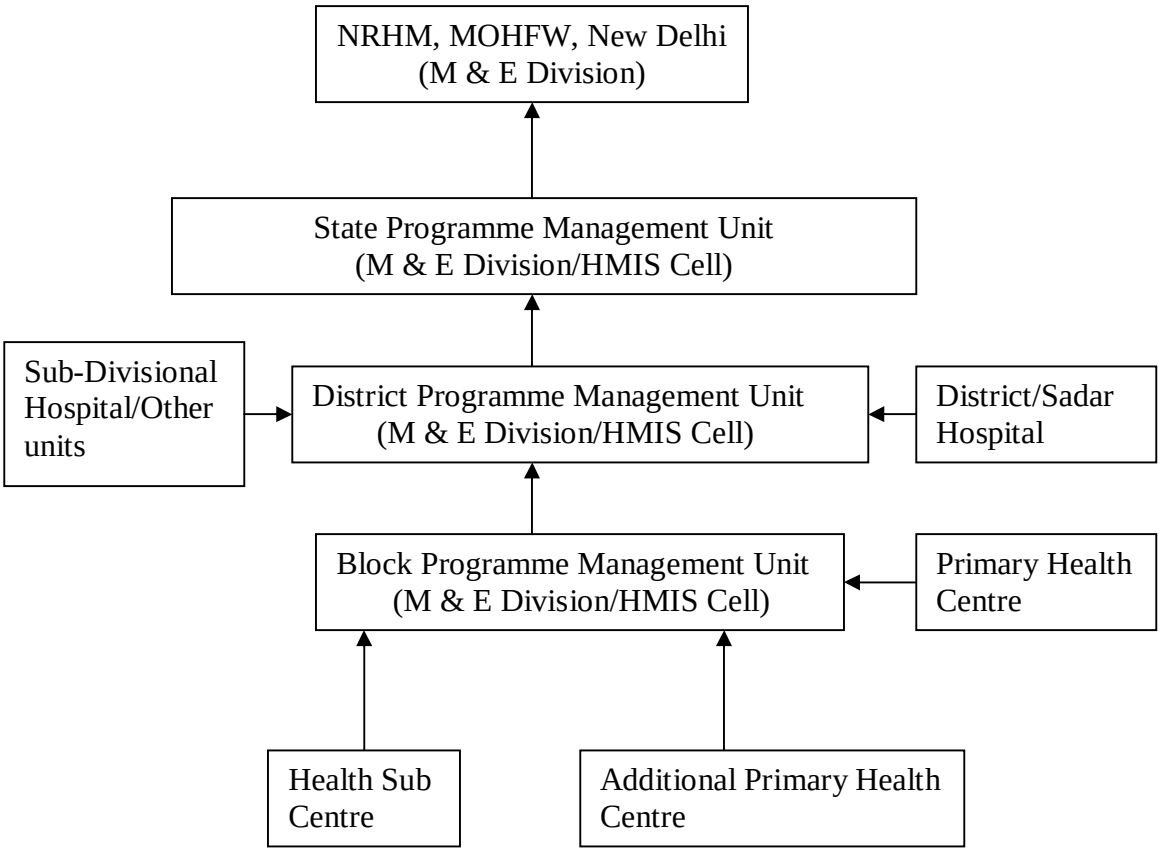
1. Background

As we know that NRHM aims to continuously improve and refine its strategies based on the input and feedback received from the state and from various review missions. One of our priorities has to build and to strengthen the Health Management Information System (HIMS) in the State and to use it for improving the quality of data for planning and programme implementation at each level. NRHM has introduced revised HMIS formats for each and every level and they are as follows:-

SN	Form No.	Form Name	Used at	Frequency
1	**NRHM/HSC/3/M**	Monthly format for SCs and equivalent facilities	HSC	Monthly (5th of following month)
2	**NRHM/PHC/3/M**	Monthly format for PHC's and equivalent facilities	PHC	Monthly (5th of following month)
3	**NRHM/CSC/3/M**	Monthly format for CHC's and equivalent facilities	CSC	Monthly (5th of following month)
4	**NRHM/SDH/3/M**	Monthly format for SDH and equivalent hospitals	SDH	Monthly (5th of following month)
5	**NRHM/DH/3/M**	Monthly format for DH and equivalent hospitals	DH	Monthly (5th of following month)
6	**NRHM/DHQ/3/M**	Monthly format for District	DHQ	Monthly (10th of following month)
7	**NRHM/DHQ/2/Q**	Quarterly format for District	DHQ	Quarterly (10th)
8	**NRHM/DHQ/1/A**	Annual format for District	DHQ	Annual (5th)
9	**NRHM/SG/2/Q**	Quarterly format for State HQ	State HQ	Quarterly (20th)
10	**NRHM/SG/1/A**	Annual format for State HQ	State HQ	Annual (15th April)
11	**NRHM/GOI/3/M**	Monthly Consolidated	State HQ/DHQ	Monthly (20th of following month)
12	**NRHM/GOI/2/M**	Quarterly Consolidated	State HQ/DHQ	Quarterly (20th of following month)
13	**NRHM/GOI/1/A**	Annual Consolidated	State HQ/DHQ	Annual (30th April)

Ministry of Health & Family Welfare, Govt. of India have launched the Health MIS (HMIS) Portal (http://nrhm-mis.nic.in.) on 21st October 2008 with a view to place NRHM related information in the public domain. NHSRC, New Delhi has also introduced HMIS Portal (http://bihar.nhsrc-hmis.org) which is specific for bihar state. Govt. of India has been focusing on importance of HMIS and emphasized on quality of data so that the reports generated from the HMIS Portal can facilitate evidence-based decision making process.

Flow of Data in HMIS in Bihar



Present Status of HMIS in Bihar

Data Centre at Block Level as well as District/Sub-Divisional level hospital has been functioning well in all 38 districts. Data Centre means computer system with operator and internet connectivity. Almost all 38 Districts of the State are uploading monthly MIS report and FMR on the web portal of NRHM, GoI by generating reports (In Excel Format) from web portal of NHSRC which is being used for online entry of monthly MIS and FMR from Block Level as well as District/sub-divisional level hospitals.

HMIS Training on different data elements/indicators of MIS reporting formats has been given to block level, district level as well as state level officers/managers/consultants and they have been also trained that how reports can be entered, uploaded and analyzed by using web portals of NRHM and NHSRC but training on HMIS is the continuous process for quality movement.

Strengthening HMIS

The HIMS system has been running well in the State but there are several gaps in training and analysis of reports for improving the quality of data. Therefore the following activities must be performed in the next financial year 2010-11.

Sub Activities

Up gradation and Maintenance of web server of State Health Society, Bihar

State Health Society, Bihar has it's own web server with 512 KBPS leased line connection from BSNL. It has been decided to move Bihar Specific web application (http://bihar.nhsrc-hmis.org) and data based from NHSRC server to server of State Health Society, Bihar but configuration of this server is very low so up gradation of server with leased line and their different network systems are required. Currently this server is being used to run website of the society and online reporting system.

The details of up gradation are as follows:-

SN	Items	Amount (Rs.)
1.	Leased line (2MBPS)	1100000
2.	Up gradation of Server with hardware/software as per requirement. As like RAM, Hardisk, Stable Storage, Devices, Switch, Firewall etc.	500000
3.	Software Development as per local needs.	500000
4.	Anti- Virus (Quantity 3)	20000
5.	Designing, Creation, Maintenance, Registration, Hosting of Website of all 38 Districts and State.	500000
Total		**2620000/-**

2. Printing of revised MIS formats prescribed under NRHM

The revised MIS formats have to be printed and supplied to all health facilities starting from Sub. Centre and upwards. The expenditure to be incurred towards printing would be incorporated in the state PIP 2010-11.

Details of requirement of formats and cost of printing-

SN	NRHM format No.	Institution	No. of Institution	Requirement of formats per annum	Approx cost per format (In Rs.)	Total Cost (In Rs.)
1.	NRHM/HSC/3/M	HSC	9174	121096	4.00	484384
2.	NRHM/PSC/3/M	APHC, PHC	1243+533=1776	23443	5.00	117215
3.	NRHM/SDH/3/M	SDH	23	303	5.00	1515
4.	NRHM/DH/3/M	DH/SH	25	330	5.00	1650
5.	NRHM/DHQ/3/M	DHS	38	501	1.00	501
6.	NRHM/DHQ/2/Q	DHS	38	167	2.00	334
7.	NRHM/DHQ/1/A	DHS	38	42	2.00	84
8.	NRHM/SG/2/Q	SHS	1	4	1.00	4
9.	NRHM/SG/1/A	SHS	1	1	3.00	3

10.	NRHM/GOI/3/M	DHS	38	501	5.00	2505
11.	NRHM/GOI/2/Q	DHS	38	167	2.00	334
12	NRHM/GOI/1/A	DHS	38	42	5.00	210
	Total (Rs.)					**608739**

3. HMIS Training

District as well as Block level Capacity Building Workshop (HMIS Training) for the year 2009-10 on Revised HMIS Reporting Formats and Web Portals of NRHM and NHSRC has been completed with the help of resource persons from National Health System Resource Centre (NHSRC), New Delhi for District M & E Officer, District Programme Manager, DS of District/Sub Div. Hospital, MOIC, BHM and BAM but training on HMIS is the continuous process for quality movement.

Therefore in FY 2010-11, Training on HMIS for the whole state is required for State Level Officers/ Consultants, CS, ACMO, DPM, DAM, District M & E Officer, District Level other Programme Officers/Consultants, MOIC, BHM, BAM, Health Educator, Grade "A" Nurses, ANM and LHV etc.

The details are as follows:-

SN	Designation	Number
1	State Level Officers/Consultants	30
2	CS	38
3	ACMO	38
4	DPM	38
5	DAM	38
6	District M & E Officer (DA)	38
7	District Level other Programme Officers/Consultants	4 X 38 = 152
4	DS/MOIC	581 (PHC-533,DH-25,SDH-23)
5	MO (APHC)	1243
9	BHM	581
10	BAM	581
11	Health Educator	539
12	ANM (Regular & contractual)	15476
13	Grad- 'A' Nurse	3511
14	LHV	499
15	Operators	685
	Total	**24068**

Budget

(i) TA/DA Cost for Trainees (for 2 days) = Rs. 200/- per day per trainee x 2 days x 24068
= Rs. **9627200/-** per annum

(ii) Miscellaneous for Trainees (for 2 daya) = Rs. 100/- Per day Per trainee x 2 days x 24068
= Rs. **4813600/-**

Total annual Budget = **Rs. 1,44,40,800/- per annum**.

4. Strengthening HR for HMIS

Additional skilled persons are required at State level as well as Divisional level for effective implementation and maintenance of HMIS in the state. The details of skilled persons with their job responsibilities and salary are as follows-

SN	Designation of Staff	No. of Staff	Positioned at	Salary (Rs.) per month	Total Salary per year (Rs.)
1	Deputy Director-Monitoring & Evaluation	1	State	26000	312000
2	Conultant – M&E	1	State	30000	270000
3	Consultant-Data Manager	1	State	30000	270000
4	Software Programmer	2	SHSB, Patna	15000	360000
5	Computer Operator	2	SHSB, Patna	8000	192000
6	HMIS Supervisor	9	Divisional Headquarter	12000	1296000

Total – Rs.27,00,000/-

5. Mobility for M & E Officers

Fund may be made available in SPIP 2010-11 for giving mobility facilities to M & E officers = Rs.**500000/-**

Summary Sheet (HMIS)

SN	Activities	Cost
1.	Up gradation & Maintenance of Web-server	2620000
2.	Printing of revised HMIS formats prescribed under NRHM	608739
3.	HMIS Training	14440800
4.	HMIS HR	2700000
5	Mobility for M & E officers	500000
	Total	2,08,69,539/-

Hence Total Budget for HMIS is Rs. 2,08,69,539/-

20. Synergie with NRHM Additionalities

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

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

.

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

21. Sustainability

The usage of government services in Bihar has certainly picked up with number of patients increasing manifolds due to free drugs and availability of doctors at PHC level. Similarly there has been an unprecedented increase in number of deliveries being conducted at government health facilities under Janani Baal Suraksha Yojana This can be largely attributed to huge influx of funds under NRHM. To hedge the growth from lack of funds and for its sustainability Government of Bihar has already applied user charges for referral transport services. The ambulance user charges are being determined by Rogi Kalyan Samitis. The state already has paying wards in our medical colleges and GoB is contemplating having such wards in all district hospitals too.

For sustainability of manpower, incentives have been proposed for specialist services and for postings in rural areas in this Programme Implementation Plan. Government has finalized Dynamic ACP and Cadre division of doctors for providing them better benefits.

Private parties are also being encouraged to make investments in Health sector so that the sector doesn't become dependent on NRHM funds. However they would be urged to take up mapping of available facilities and also analysis of demand before investing and providing services so that any duplication may be avoided. Moreover GoB is also increasing its allocation to health sector. This year the state government proposes to expand Emergency Medical Service, establish Dialysis Unit under PPP initiative. The state is also increasing the number of Urban Health Centres.

22. Extra Inclusions in RCH

IFA (Details Annexed)

Proposal for reduction of maternal mortality and morbidity and neonatal mortality by management of severe anaemia among pregnant women

Anemia is prevalent in pregnant women is more than 60% in Bihar and UP (NFHS-3).Studies have proved that iron deficiency is responsible for > 95% of the anemias during pregnancy. The factors responsible for iron deficiency precede pregnancy and include diet poor in iron content, menstrual loss, poor oral intake of iron supplements and increasing demand of the fetus during pregnancy. Anemia directly contributes to 8% mortality and indirectly to 22% mortality of the total maternal mortality rates. It also contributes to high fetal losses and increased incidence of LBW babies and consequent infant mortality.

Oral iron is given in the form of Iron Folic Acid tablets to combat anemia both as a therapeutic and preventive measure.To correct severe anemia with Hb% less than 8 gms within 6 months the women need parentral iron . Though studies proved that parentral iron and oral iron have the same benefits , the various factors like poor compliance, poor absorption etc resulted in poor outcomes among severely anemic women.

In the high focus states often women are seen in the hospitals with complications of anemia and the haemoglobin levels are around 3-4 gms. When the haemoglobin levels of these women are to be improved within shorter time either blood transfusion or intravenous iron therapy is to be given. As the availability of blood transfusion facility is limited , intravenous iron sucrose is the next best alternative.

Iron sucrose is administered as IV/ IM drug for the management of anemia. The advantage with this drug is the near absence of side effects of oral iron therapy and the allergic reactions noted with other parenteral iron preparations. The second important advantage is the rapidity in the correction of anemia which occurs within 5 weeks (Bangladesh study) and hence can be administered even in advanced stages of pregnancy say 30- 32 weeks.

It is also important to develop uniform guidelines which can be implemented across the state in all the institutions so that the benefit of iron therapy reaches the targeted population of the pregnant women .

Accordingly guidelines have been developed for the administration of iron sucrose in all the medical institutions . All the pregnant women who attend antenatal clinics in all CHCs/BPHCs, FRUs and district hospitals with Hb% levels less than 8 gms may be administered with Intravenous Iron Sucrose as per the protocol.The ANMs would screen the women for severe anemia and refer the women to CHCs, FRUs and for the treatment with Intravenous iron Sucrose.

A technical group will be formed with the senior specialist in Obstetrics , officer incharge of maternal health in State Health Society and state programme officer will prepare the state specific guidelines including method of administration of Iron Sucrose injection.

Guide lines for management of anemia at tertiary and district, sub district administration of iron sucrose injections to the AN mothers

a. Compulsory Hemoglobin estimation at 14 weeks, 20th weeks and 32 weeks of pregnancy for all pregnant mothers.

b. De worming at 20th week of gestation (Second Trimester).

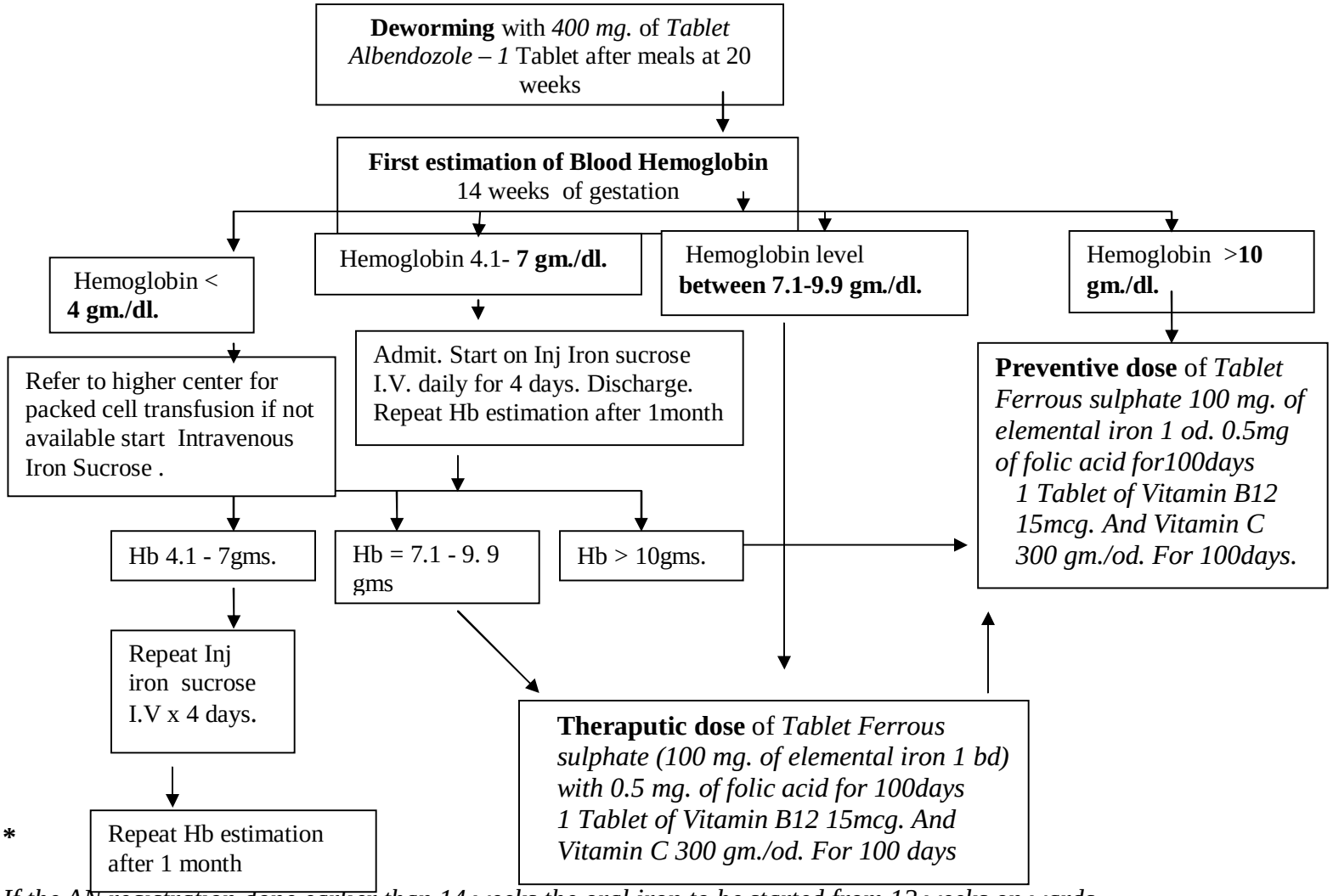
   (Tablet Albendazole 400mg – single dose.)

c. Iron in the form of Ferrous Sulphate is the best choice. Preventive and therapeutic form of Iron to be started after deworming.

   (Preventive dosage of Iron – 100 mg. of elemental iron- FST 0.5mg. Folic acid once daily for 100 days. Therapeutic dosage of Iron – 100 mg. of elemental iron – FST 0.5 mg. folic acid twice daily for 100 days).

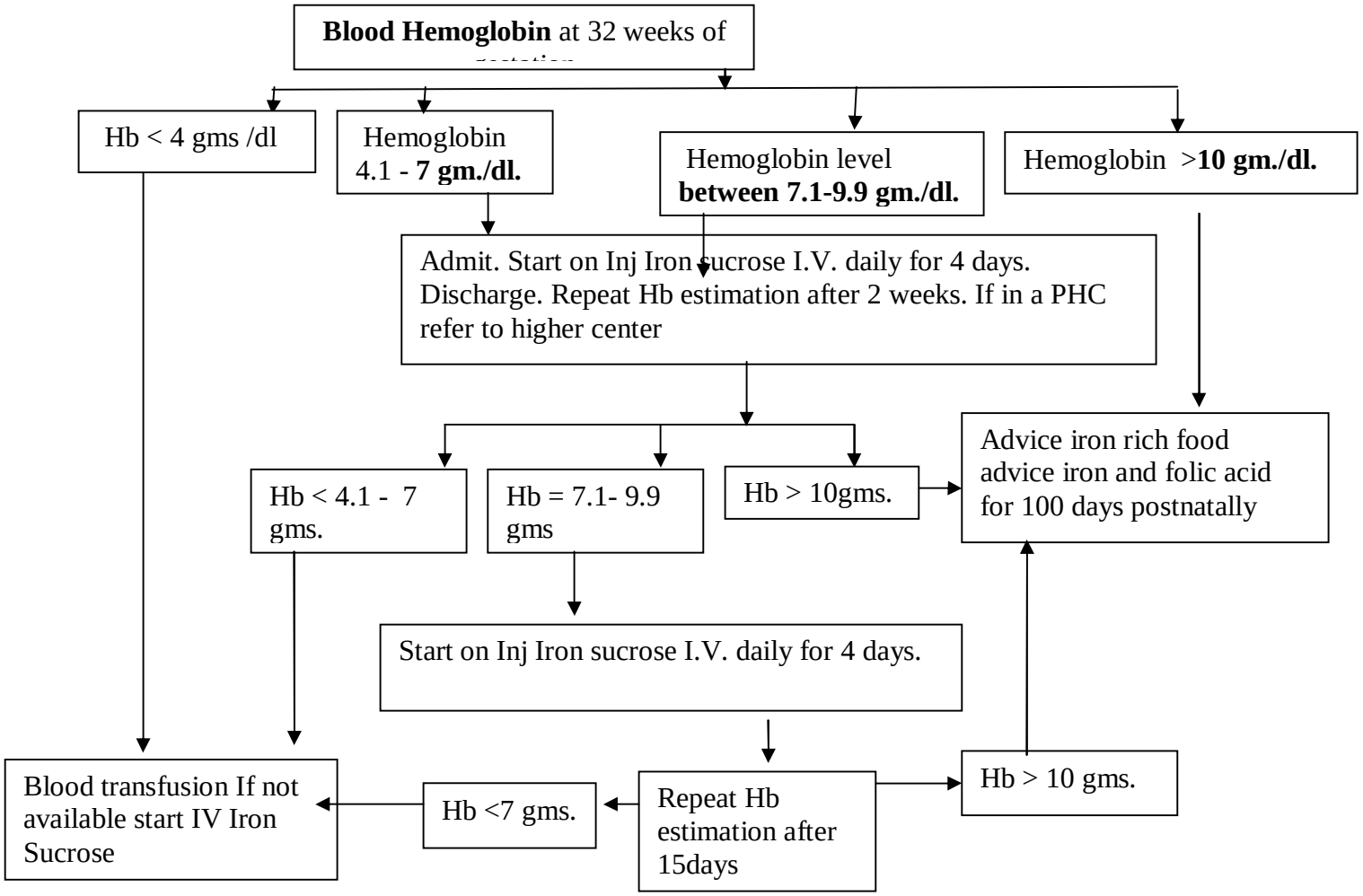
GUIDELINES FOR MANAGEMENT OF MATERNAL ANAEMIA
FLOW CHART

I. AT 20 WEEKS * OF GESTATION:-



If the AN registration done earlier than 14 weeks the oral iron to be started from 12 weeks on wards.

II. AT 32 WEEKS * OF GESTATION:-



It is suggested that after dilution of Intavenous Iron Sucrose complex 100 mg in 100 ml of saline , 5 ml of the dissolved solution to be administerd slowly for 5 minutes to observe any adverse reaction. If there is no adverse reaction, the remaining solution may be administered in 20 minutes

Budget

Out of 12 lakh deliveries conducted in the institutions around 3 lakh women may seek care during the antenatal period. The 3 dose Iron sucrose may cost around Rs.600 and the total budget for the year 2010-11 will be around Rs.18 crores

23. Work plan

Annexure 3 d

24. Budget

Annex 3e and 3c

NRHM PART- B

NRHM Flexible Pool/ Mission Additionalities 2010-2011

1. Decentralization

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

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

1.1 ASHA-10-11

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – 'ASHA' or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA is trained to work as an interface between the community and the public health system.

Under NRHM, 87135 ASHAs (revised as per the decadal growth in 2008) are to be selected and trained in Bihar. The previous target was 74313 (as per 2001 census). The first orientation training of seven days has been completed for about 63802 ASHAs. The 2nd, 3rd and 4th round /2, 3 & 4th module training is being done by PHED and its NGOs. The 5th round/module 5 of training is to start simultaneously for the ASHAs completing the first 4 modules of training.

A total number of 69124 ASHAs have been selected so far. The ASHAs are given the copies of each module (Hindi version) and reading material in the form of flip charts for their better understanding and also dissemination of key health messages among villagers.

Table 1: ASHA Status (Target, Selection and Training)

Sl. No.	District	Revised Target of ASHA Selection	ASHA Selection till Now	No. of ASHA Trained With Module 1
I	II	III	IV	V
1	Araria	2376	2026	2026
2	Arwal	773	645	645
3	Aurangabad	2160	1850	1620
4	Banka	1820	1532	1471
5	Begusarai	2629	2091	2091
6	Bhagalpur	2311	1971	1971
7	Bhojpur	2264	1728	1704
8	Buxar	1493	1102	974
9	Champaran(E)	4326	3392	2686
10	Champaran(W)	3206	2653	2445
11	Darbhanga	3550	2368	2250
12	Gaya	3514	2839	2244
13	Gopalganj	2371	2015	1988
14	Jamui	1520	1263	1263
15	Jehanabad	871	769	769

16	Kaimur	1462	1247	1247
17	Katihar	2549	1824	1626
18	Khagaria	1412	1049	857
19	Kishanganj	1368	1132	1094
20	Lakhisarai	802	581	557
21	Madhepura	1711	1409	1291
22	Madhubani	4046	3034	2751
23	Munger	961	839	810
24	Muzaffarpur	3984	3219	2980
25	Nalanda	2365	1990	1850
26	Nawada	1959	1536	1271
27	Patna	3233	2636	2193
28	Purnia	2723	2113	2000
29	Rohtas	2490	1950	1935
30	Saharsa	1622	667	646
31	Samastipur	3835	3143	3004
32	Saran	3459	2749	2555
33	Sheikhpura	521	453	453
34	Sheohar	580	473	380
35	Sitamarhi	2965	2203	1778
36	Siwan	3008	2538	2327
37	Supaul	1928	1563	1529
38	Vaishali	2969	2532	2521
Total		87135	69124	63802

ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services and she will provide her service mainly under the following heads-

Table 1: The compensation package of ASHA

Sl. No.	Programme & Relevant Task	Amount of Compensation
1.	Janani & Bal Suraksha Yojana For Institutional Delivery and Full Immunization of the New Born	RURAL AREA- @Rs. 600/- (100(Registration)+ 200(Transport)+ 300(B.C.G)) Per Pregnant Woman URBAN AREA- @ Rs. 200 (100- Registration+ 100 B.C.G)
2.	Mobilizing all the children of the village for Immunization(Under Muskaan Ek Abhiyaan) to be given to ASHA	5 to 10 Children = 50/- 11 to 15 Children = 100/- 16 to 20 Children = 150/- 20 to …. Children = 200/-

3.	Providing DOTS under Tuberculosis Control Program		Rs 250 per patient.
4.	For identifying Patient of Leprosy and accompanying him/her to PHC		@ Rs. 300/- P.B cases (Only Rs. Three hundred) Per Patient- Rs. 100 on confirmation of Disease and Rs. 200 on completion of treatment @ Rs. 500 M.B. cases per patient- Rs. 100 on confirmation of Disease and Rs. 400 on completion of treatment
5.	Training	D.A. Per Day	@ Rs. 100/- (Only Rs. One hundred) Per Day(During the Training)
		T.A. Per Training (To & Fro)	@ Rs. 100/- (Only Rs. Hundred) Per Training
6.	To participate in ASHA Divas organized at PHC		@ Rs. 115/- (Only Rs. Hundred Twenty) Per Meeting (100/- - to ASHAs and 15 for refreshment)
7.	For motivating for Sterilization		@ Rs. 150/- (Only Rs. One hundred Fifty) on Completion of Surgery
8.	For motivating client for vasectomy/ NSV		@ Rs. 200/- (Only Rs. Two hundred) on Completion of Surgery
9.	For 6 no. home visits under HBNC and IMNCI		@ Rs. 200/- (Only Rs. Two hundred) on Completion of the 6th visit
10	**National Blindness Control Programme**		Rs. 175/- per Cataract Patient for operation and staying till operation
11	**Kalazar**		Rs. 100/- For Bringing Kalazar Patient to the Hospital and after completion of treatment

Programme Description

Communitisation process involves empowerment of community based institutions, health activities and community managed interventions as outlined in the National Implementation Framework of NRHM. To contribute to effective facilitation of supportive structures and mechanisms at all levels of Programme implementation which essentially needs appropriate monitoring, mentoring, handholding and leadership support to the ongoing initiative in addressing health, health care and health services for the rural poor. In this context, a **State Owned Resource Centre** of its unique nature is conceptualized and proposed to facilitate health system, strengthening within the existing governance mechanism under NRHM. This would help in integrating various efforts of communitisation processes for achieving effective outcome.

This is mandated and specially designed to implement, support and facilitate community process while mobilizing appropriate technical assistance from NHSRC and partnership support involving key stakeholders from the government, NGOs , research institutions etc. ARC will operate under strategic direction and leadership of Mission Director, NRHM in the State.

Rationale:-The State of Bihar, has the population of approximately 9 crores, with prevalence of

malnutrition in under 3 years Children is 58(NFHS- 3), IMR 56, (per 1000 Live birth MMR- 312 per lakh population). One of the main goals of NRHM is to reduce IMR- to 30 and MMR to 100 upto 2012. Under NRHM, ASHAs are the key functionaries with the target of selection of 87135 ASHAs and approximately 70,000 selected ASHAs. In lieu of this there is an urgent need to create a support structure for ASHAs at the grassroots level to handhold the ASHAs so as to better the efficiency of the ASHAs which is very much required for effective programme implementation. For providing regular support strong support structures needs to be built up at the State, District and Block. ASHA programme is the backbone of NRHM and reflects creation of community processes that help strengthen and empower the community towards better health care. For creating these processes establishment of ASHA Resource Centre is an urgent requirement for the State of Bihar, so that the communitisation processes are created effectively. Since the programme is of such huge magnitude, it is very much required and essential to speed up the programmatic interventions systematically specifically the trainings.

ASHA Resource Center is expected to contribute to State Facilitation Support for Community Processes under NRHM;

- In assisting State Team to train the district & block coordinators who would train & support the Facilitators for community processes.
- State specific facilitations would ensure on-the-job training as well as improved service delivery as an outcome of training effort.
- Build up the review system with indicators for monitoring and initiation of mid-course corrections at Sub-center, Block and District level of operations.
- Ensure involvement of NGOs including effective engagement of Civil Society at all levels of operations.
- Build up a campaign of Social Mobilization to support the ASHAs, VHSC and involvement of PRIs for effective coordination and programme facilitation at grassroots level.
- Establish facilitation of management of Incentives involving tracking of support systems while addressing district specific issues and concerns especially identifying and addressing bottlenecks in the supports systems.
- Documentation and dissemination of best practice innovations specific to Districts highlighting different themes of Community Processes from time to time.

Objectives;

- Ensure the availability of state specific institutional support to Community Processes under NRHM.
- Strengthening of ARC Team capacity in undertaking appraisals, assessments, facilitation and documentation of above outlined contributions strategically with active involvement of NHSRC State facilitation support.
- Development, Training, Review and Mentoring support to District and Block level support team responsible for facilitation of Community Processes.
- Undertaking periodic review, assessment and orientation of State and District Health Officials for ensuring effective cooperation in the ongoing programmatic implementation.

- Identifying districts of innovations and less adequate functioning in undertaking corrective measures through coordination of technical assistance and mobilization of facilitation support strategically.
- Secretariat of State ASHA Mentoring Group and Secretarial Support for the visit of members of State ASHA Mentoring Group to different districts. Also, organization of AMG meeting and dissemination of recommendations of State AMG on a quarterly basis with the support of NHSRC State Facilitation support.
- Strategic coordination with NHSRC for facilitation of technical assistance to contribute to program effectiveness and capacity strengthening on community process on a regular basis.

Strategic Functions

- Provision of technical assistance to the state and district team for planning and coordination of outlined activities related to the community processes under NRHM.
- Capacity building of the district team for conducting training, supportive supervision and implementation of ASHA, Rogi Kalyan Samiti (RKS), effective involvement of PRI, VHSC and Monitoring Committee.(Nigrani Samiti) and activities relevant to community participation components of NRHM.
- Assessment of ongoing community processes for incorporating realistic input in review, assessment and planning with respect to PIP preparation on components of community processes.
- Assist Mission Director for effective coordination among various stakeholders form the government departments and non-government sector to strengthen community processes.
- Ensure effectiveness in programme monitoring and updating programmatic progress to the Mission Director periodically.
- To act as secretariat of ASHA Mentoring Group.
- Commissioning, contracting and outsourcing of IEC/BCC/Advocacy related activities contributing to the community processes at the state level and provide coordination support to similar activities at the district level.
- Assessment of training needs, designing of state specific training module and facilitation of training programmes.
- Reviews all evaluations carried out on state specific CP programmes and appropriately documentation of best practice innovations for sharing and advocacy on NRHM strategies for scaling up of Community Participation processes.
- Documentation of the successful innovation and model community processes, sharing with the authorities and stakeholders and prepare strategies for replication.

Programmatic and Structural Framework of ARC.

A. At the State Level

1.1 Personnel

1.11 Team Leaders:- A Project Manager, ASHA and Deputy Project Manager, ASHA will be the Nodal Officers who would report directly to the Mission Director, NRHM and will be closely coordinated with the State Facilitator, NHSRC.

1.12 Training Wing:- the Training wing would constitute of one Community Training Officer, 1 Water and Sanitation Officer, 1 Nutrition and Food security and 1 Consultant Doctor. This is specially envisioned in view of the convergence of different streams will help create a strong training strategy and mechanism for the state. The training Wing will overall supervise, design, monitor and develop strategic plans with close coordination with the ASHA Mentoring Group.

1.13 Community based planning and monitoring wing:- This wing will have a **Community** planning and monitoring Officers who will be assisted by a Community planning and monitoring Associate to have an overall designing, planning supervising and monitoring**.** The NRHM Framework for Implementation outlines the composition and broad roles of monitoring and planning committees at various levels. These outlines were to be subsequently elaborated for developing the process of community planning and monitoring and it is also one of the key strategies of National Rural Health Mission (NRHM) to ensure that the services reach those for whom they are meant, especially for those residing in rural areas, the poor, women and children. Community planning and Monitoring is also seen as an important aspect of promoting community led action in the field of health.

In order to ensure that the outcomes of NRHM are achieved and quality and accountable health services which are responsive and are taking care of the needs of the poor and vulnerable sections of the society, community ownership and participation in management has been seen as an important pre-requisite within NRHM. Community monitoring and planning is an important component for achieving these results.

Community monitoring and planning is a key step towards communitisation; this is the crucial direction required to bring in fresh energies and momentum for Health system changes; those with a stake are given the space to influence decisions. It is to review the progress to ensure that the work is moving towards the decided purpose, and the purpose has not shifted, nor has the work got derailed in any way. Such a review can help to identify obstacles in the work, so that appropriate changes can be made to cross the obstacles.

It has been realized that there should be convergence between people and government health employees for reforms to take place in health services. Ownership and management of health services should be enlarged; ownership will move beyond public health functionaries and would involve the common people. The concept of communitisation of health services is based on the strong belief that the entire health machinery is owned by the people. The problems identified in any area, such as spreading of communicable diseases, maternal mortality, child mortality or malnutrition should not be matter of concern only for the Health Department, rather these should become matters of the peoples concern. For this people should have a proper orientation about these problems and also the health system working to address these problems

The community monitoring process involves a three way partnership between health care providers and managers (health system); the community, community based organizations and CSOs and the Panchayati Raj Institutions. The success of the community monitoring process will depend upon the ownership of the process by all three parties and a developmental spirit of fact-finding and learning lessons for improvement rather than fault finding.

Keeping this in view, the Government of India formed an Advisory Group for Community Action (AGCA), a standing committee constituted to support and advise the MoHFW on community action under NRHM for implementation across the country. As part of this support, the AGCA provided guidance and mentoring for the first phase of Community Monitoring across selected districts in nine states. Population Foundation of India (PFI) was made the National Secretariat for implementing the project on Community Based Monitoring. The AGCA also established a Task Group for the technical

support and oversight in implementing the project, Chaired by Mr. A R Nanda, Executive Director, PFI. PFI with the support from GoI implemented the Community Based Monitoring (CBM) in nine states through partnerships with State, District and Block Level Civil Society Organizations.
The State Health Society Bihar has planned to initiate the CBM in the state of Bihar and for this a provision has also been made for carrying out the CBM in the current state PIP of NRHM. This initiative would take into consideration the experiences from 1st phase of the CBM implemented in nine states by PFI supported by GOI.
A Consultative Meeting of all the Stakeholders was organized to assess the various dimensions of Community based planning and monitoring Programme**..**

Objectives of Community Planning and Monitoring
Following are the objectives of Community Planning and Monitoring

- Providing regular and systematic information about community needs, which will be used to guide the planning process appropriately.
- Providing feedback according to the locally developed yardsticks, as well as on some key indicators.
- Providing feedback on the status of fulfillment of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability through community planning and monitoring..
- Enabling the community and community-based organizations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system.
- The community should emerge as active subjects rather than passive objects in the context of the public health system.
- It can also be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

Process of Community Planning and Monitoring

The exercise of Community planning and monitoring involves drawing in, activating, motivating, capacity building and allowing the community and its representatives e.g. community based organizations (CSOs), peoples movements, voluntary organizations and Panchayat representatives, to directly give feedback about the functioning of public health services, including giving inputs for improved planning of the same. The community and community-based organizations will monitor demand / need, coverage, access, quality, effectiveness, behavior and presence of health care personnel at service points, possible denial of care and negligence. The monitoring process will include outreach services, public health facilities and the referral system and plan as per the local needs of and by the Community regarding health services.

Some of the frameworks on which Community Planning and Monitoring may be done, and which are included within the NRHM are as follows

- Village Health Plan
- Block Health Plan
- District Health and Action Plan
- Entitlements under the Janani Evam Bal Suraksha Yojna (JBSY)
- Roles and responsibilities of the ASHA
- Indian Public Health Standards for different facilities like Sub Centre, PHC, CHC

- Concrete Service Guarantees
- Citizens Charter and so on

Levels of Planning and Monitoring Committees

The key institutions for community monitoring and planning at different levels will be as follows

- Village Level Planning and Monitoring Committee
- Block Health planning and monitoring committee
- District Health planning and monitoring committee
- State Health planning and monitoring committee
- State Advisory Group for Community Action (SAGCA)

In other states, as envisioned under NRHM, a Village Health and Sanitation Committee (VHSC) has been formed as the institutional mechanism at the village level. A Policy decision has been taken by the State to begin with the formation of a Lok Swasthaya, Pariwar Kalyan Evam Swakshata Samiti of Panchayati Raj Institution (PRI), to be co-opted at the Gram Panchayat Level, where ANM acts as the Secretariat, and there are Ward Members. The untied funds for all the revenue villages under each Gram Panchayat will be provided to this Samiti to perform the functions expected of a VSHC under the NRHM Implementation Framework. Additionally, provision has also been made to form a separate committee at Village (Revenue) level which would be known as Village Level Monitoring Committee which stands at the revenue village consisting of ASHA , AWW, Ward Commissioner, SHG leaders and other members. This village level Monitoring Committee(Nigrani Samiti) will monitor the functioning of Lok Swasthaya, Pariwar Kalyan Evam Swakshata Samiti.

Keeping this in mind, it is proposed to extend the monitoring committee to Village Level Planning and Monitoring Committee which can then be incorporated as per the implementation framework of NRHM. In order to avoid duplication of another committee of the same members at the village level for community monitoring the proposed Village Level Monitoring committee will need to be strengthened. However, the committees at the block, district and state level will be formed independently. It is hence proposed to take Village Level Planning and Monitoring Committee as the basis for implementation of the community monitoring process at the community level.

In the first phase it will be piloted in three districts for which the necessary criteria will be developed.

State Health Monitoring and Planning Committee

The committee will be constituted at the state level would contribute to the development of State Health Plan. This committee would be the members drawn from service providers, representatives of Village, Block and District level Planning and Monitoring Committee and the representative of Panchayat. The chairperson would be one of the elected members. The executive chairperson would be the Executive Director, State Health Society, Bihar. The Secretary would be one of the CSO coalition representatives.

Composition

- 30% of total members should be elected representatives, belonging to the State legislative body (public representative) or Conveners of Health committees of Zilla Parishads of selected districts (from different regions of the state) by rotation.
- 15% would be non-official members of district committees, by rotation from various districts belonging to different regions of the state.
- 20% members would be representatives from State health CSO coalitions working on Health rights, involved in facilitating community based planning and monitoring, Nodal CSOs of district level and Advisory Group CSO.

- 25% members would belong to state Health Department.
- Secretary Health and Family Welfare, Commissioner Health, relevant officials from Directorate of Health Services (incl. NRHM Mission Director) along with technical experts from the State.
- 10% members would be officials belonging to other related departments and programmes such as Women and Child Development, Water and Sanitation, Rural development.

Roles and Responsibilities

- Discuss the programmatic and policy issues related to access to health care and to suggest necessary changes.
- Review and contribute to the development of the State Health Plan, including the plan for implementation of NRHM at the state level; the committee will suggest and review priorities and overall programmatic design of the State Health Plan.
- Discuss Key issues arising from various district health committees, which cannot be resolved at that level (especially relating to budgetary allocations, recruitment policy, programmatic design etc) and initiate appropriate action initiated by the committee.
- Also discuss administrative and financial level queries, which need urgent attention.
- Institute a health rights redressal mechanism at all levels of the health system, which will take action within a time bound manner. Review summary report of the actions taken in response to the enquiry reports.
- Operationalise and assess the progress made in implementing the recommendations of the national health committees, to actualize the right to health care at the state level.
- Take proactive role to share any related information received from GOI and will also share achievements at different levels. The copies of relevant documents will be shared.
- Meeting on quarterly basis to share the findings, innovations and constraints.
- Recommended strategically the areas of concerns that need immediate attention of Mission Director to intervene timely.
- Preparation of assessment reports and presentations of findings from the field especially with respect to effectiveness of support system, procedures and mechanism in the districts, block and village level. Additionally, they can recommend strategic actions to be undertaken by the Mission Director in the state in the light of their successive visits and assessments.

Power(s) of the committee

Ensure that the different levels committees are properly constituted and they meet regularly and transact their mandates in letter and spirit.

Yardsticks for Monitoring at State Level

- National level recommendations related to health and National Action Plan on Right to Health Care; responses of state Health Departments and actions to which the State Government has committed itself.
- NRHM state level plan and the State Health Mission guidelines.
- Formulating of strategic guidelines for ASHA programme.

Tools for Monitoring at State Level

- Reports of the district health committees
- Periodic assessment reports by various taskforces/ state level committees about the progress made in formulating policies according to IPH Standards, national recommendations and its implementation status etc.

State Level Advisory Group on Community Action

At the State level, the Task Group of the Advisory Group on Community Action (AGCA) will be formed to guide the entire process of community action in consultation with the Department of Health and Family Welfare at State level and Ministry of Health Family Welfare at the National level.

Composition

The Committee will comprise of

- Principal Secretary, Dept. of Health Family Welfare, GoB
- Executive Director, State Health Society Bihar
- Director SIHFW
- Principal Secretary / Director Panchayati Raj
- Principal Secretary / Director PHED
- Managing Director WDC
- National Advisor- Public Health, NHSRC
- PFI Representatives (one each from national and state level) State Technical Agency
- State Program Manager, SHS Bihar
- ASHA Cell, SHSB
- Civil Society / CSO Representatives Two

Roles and Responsibilities

- Conceiving and planning the entire intervention.
- Periodic review.
- Support the relationship building with the state government.
- Support the formation of State Community Planning and Monitoring Group.
- Identify State Level Organization for providing technical support
- Coordinate with the State Government.
- Prepare state level plan/design and budgets.
- Identify districts and blocks.
- Identify CSOs for district and block level.
- Review progress at the state level.
- Distil lessons learnt from the state level experiences.

State Level Agency for providing Technical Support

PFI will provide technical support (as per GOI Guidelines) for implementation of Community Based Planning and Monitoring at District / Block level. The agency has the experience of providing technical support for CBM in different states.

Roles and Responsibilities of the technical Agency

- Coordinating activities of the State preparatory phase, which includes developing tools, model curriculum, workshops, awareness materials and documentation formats for the programme.
- Assist the AGCA members and the state NRHM Directorates and CSO networks for the state preparatory stage.
- Facilitate process documentation and review of the pilot implementation phase in consultation with AGCA members.
- Facilitate in conducting quarterly review of AGCA for review of the pilot programme.
- Assist in implementing the decisions taken at the CM Monitoring Team.

- Facilitate in arranging for technical support to district/block level CSOs.
- Support the process of adaptation, translation and publication state level materials/manuals.
- Facilitate for documentation of state level processes.
- Facilitate and supervise progress and support processes/activities at the district, block and community levels.

1.14 ASHA Mentoring Group- A Mentoring Group comprising of leading NGOs and well known experts on community health, research institutions, academia etc is under the process of formation, to provide guidance, advocacy, strategic planning and advice on matter relating to selection, training and support and other programmatic interventions for ASHA. This will especially help in giving technical expertise to all concerned wings of ARC.

1.15 BCC/IEC wing:- a BCC wing will comprise of 2 communication Officers and one Consultant related to Public Health who would be an expert in content framing. This is an urgent requirement as a compete integrated plan needs to be built up to provide the much needed support , awareness to the programme.

1.16 Programme and Admin support:- This will constitute of an Human Resource Officer who will supervise the recruitments as well as also address the grievances of ASHAs. This wing will also have an accounts Officer and an HMIS officer, 1 Documentation Officer and a computer operator to manage the accounts and the vast database of the programme.

B. At the District Level

1.11 Personnel :- Community Mobilizer/ District Project Manager ASHA She/He will be appointed in the capacity of Community Mobilizer and will act as a Nodal Officer at the district level for effective programme management, implementation and execution.

Training:-

1.12 ASHA Training

Training of Module 2, 3 and 4:- It has been analyzed that the training for ASHA is lagging much behind the scheduled time in lack of an integrated structure and supervision and monitory mechanisms. Thus, the strategies for better and effective training plan which will also strengthen the institutional mechanism and create and build accountability and ownership is planned which will have the following strategic interventions:-

Status of the present training:-

No of District	No of Districts where training of ASHAs completed	No. of Districts where Districts TOTs completed	No of Districts where ASHA training at Block level was going on	No of districts where no training has been conducted
38	10	20	8	8

Strategic Interventions:-

A. Step 1:- District level Trainers Team

No of Master Trainers required for the training for 28 Districts	No of Master trainers already trained By PRANJAL	No of Active Master Trainers at present	No of Master Trainers required(MOs, HE(BEE)/Grade A Nurse, DLC) for 28 Districts
28 Districts *3 MTs= 84	71	35(will be encouraged to apply for DLC)	3 MTx 28 Districts = 84

- The Master trainers will act as trainers to Block Level Resource Persons (BLRP) and as monitors to the Block level trainings.

Strategy: - A team of three (3) trainers will be formed who will be MOs, Health Educators/ Grade "A" Nurse and DLC.
MOs and Health Educators or Grade a Nurse will be identified and selected by the District by the Civil Surgeon and letter for the same regards will be issued by the State.

The purpose of DLC's will be to act as MT for the District trainers and also as coordinators of all training programme , quality assurance and coordination with NGO and health department officials , he will be placed at DHS and his immediate supervisor can be DPM.DPM will send his absently on which Pranjal will disbursed TA/ DA of DLC.

- Role of NGO: - a. It was felt that the NGOs playing the overburdening role of Organizers as well as rollers of training affected the Quality of the training. Thus the role of the NGOs was re- defined as organizers and reports For 20 Districts; The organization & Logistic management (venue, food etc) will be done by the NGOs already existing for 20 Districts.

1.13 Community based planning and monitoring

District Health Monitoring and Planning Committee

The committee constituted at the district level would contribute to the development of District Health Plan. This committee would have members drawn from service providers, representatives of Panchayat and Block level planning and monitoring committees and representative of panchayts.

Constitution

- Two representatives of the Zila Parishad
- Two representatives from CSOs / CSOs (Nodal CSO/CSO)
- Two member (officials) preferably Civil Surgeon and ACMO
- One representative from Rogi Kalyan Samiti in district level
- One representative(From CSO/ CSO) from each Block Level Committee and one ASHA Block Facilitator from each Block
- One District Community Mobiliser ASHA(When appointed) / District Program Manager
- The Chairperson would be one of the ZP representatives, preferably convener of the Zilla Parishad Health committee.
- The Executive Chairperson would be the CS / ACMO
- The Secretary would be one of the CSO / CSO representatives.

Roles and Responsibilities

- Discuss on the reports of the PHC health committees.
- Financial and solving blockages in flow of resources, if any.

- Assess infrastructure, medicine and health personnel related information and necessary steps required to correct the discrepancies.
- Review progress report of the PHCs/blocks emphasizing the information on referrals utilization of the services, quality of care etc.
- Contribute to development of the District Health Plan, based on an assessment of the situation and priorities for the district. This would be based on inputs from representatives of Block health committees, community based organizations and CSOs.
- Ensure proper functioning of the Hospital Management Committees.
- Discuss on circulars, decisions or policy level changes done at the state level; deciding about their relevance for the district situation.
- Take into cognizance of the reported cases of the denial of health care and ensure proper redressal.

Yardsticks for Monitoring at District Level

- Charters of Citizens Health Rights
- District Action Plan
- NRHM guidelines
- Indian Public Health Standards

Tools for Monitoring at the District Level

- Report from the Block Health Planning and Monitoring committee
- Report of the District Mission committee
- Public Dialogue (Jan Samvad)

C. at Block Level:-

1.11 Personnels:- A block Level Organizer ASHA is to be appointed to overall facilitate the activities related to ASHA.

1.12 ASHA Training Module 2, 3 & 4:-

Step 2:- Block Level Resource persons:-

No of District Trainers required for the training	No of Blocks in 20 Districts	No of BLRP Required	No of BLRP in place	No of Additional BLRP required- 1st MOs
4 per Blocks	313	313x4= 1252	939	313

Strategy: - 1st MOs/ BHM will be identified and selected by the MOIC's and letter in the same regards will be issued by the State asking the CS & ACMO for getting it done through MOIC's these nominated persons would be responsible for ensuring quality of the trainings at the PHC level by being one of the BLRP & transacting technical sessions as well as daily monitoring & supportive supervision. They would be similarly, trained to perform these responsibilities

Strategy for the 8 Districts where no training has yet been conducted;-

Status:-

No of BLRP required for the training	No of Blocks in 8 Districts	No of BLRP Required	No of BLRP Trainers in place – 1st MOs/BHM	No of Additional BLRP required/ to be selected
4 per Blocks	88	88*4= 352	88	264

Strategy: - 1st MOs/ BHM (for 88) will be identified and selected by the District Civil Surgeon and letter in the same regards will be issued by the State.

For these 8 District 8 NGOs will be selected

- Selection will be done through the following Block Level Task Force consisting of MO+ HE+ DLC+2 representatives from the selected NGOs (It can be done through RKS)
- *The selection of the BLRPs will be facilitated by the Block Level Task Force consisting of MOIC, MO/BHM& Representative of NGO. During the selection process, participation of DLCs and the District level Master trainers should be ensured as far as possible.*

A letter for the same will be issued by the State to the concerned civil surgeon/ ACMO for getting it done through the defined process in collaboration with the NGOs.

1.13 Community Based Planning and Monitoring at the Block Level

Block Health Planning and Monitoring Committee -

Constitution

- Two representatives of the Block Panchayat Samiti
- Two representatives from CSOs / CSOs(Nodal CSO/CSO)
- Two members (officials) preferably MOIC and Block Health Manager
- One representative from Rogi Kalyan Samiti
- One representatives from Lok Swasthaya, Pariwar Kalyan Evam Swakshata Samiti preferable ANM.
- One representative from Village level Planning and Monitoring Committee
- One Block Level Organizer (when appointed)/ and one Block ASHA Facilitator

The Chairperson would be one of the Block Panchayat Samiti representatives.
The Convener would be the MOIC.
The Member Secretary would be one of the CSO/CSO representatives.
The Block Level Organizer and Block ASHA Facilitator are one of the very important pillars for communitisation

Roles and Responsibilities

- Consolidation of the village health plans and charting out the annual health action plan in order of priority. The plan should clearly lay down the goals for improvement in health services and key determinants.
- Presentation of the progress made at the village level, achievements, actions taken and difficulties faced followed by discussion on the progress of the achievements of the PHC, concerns and difficulties faced and support received to improve the access to health facilities in the area of that particular PHC. The discussion could include
- Sharing of reports of Village Health Committees.
- Reports from ANM, MPW about the coverage of health facilities.
- Any efforts done at the village level to improve the access to health care services.
- Record and analysis of neonatal and maternal deaths and the status of other indicators such as JBSY, coverage for immunization and other national programmes.
- Any epidemic occurring in the area and preventive actions taken.
- Ensure that the Charter of citizens health rights is disseminated widely and displayed out side

the PHC informing the people about the medicine facilities available at the PHC, timings of PHC and the facilities available free of cost. A suggestion box can be kept for the health care facility users to express their views about the facilities. These comments will be read at the coordination committee meeting to take necessary action.

- Monitor physical resources like, infrastructure, equipments, medicines, water connection etc at the PHC and inform the concerned government officials to improve it. Similar exercise for manpower issues of the health facilities that come under the jurisdiction of the block.
- Discuss and develop a Block Health Plan based on an assessment of the situation and priorities identified by representatives of village health committees and community based organizations.
- Share information about any health awareness programme organized in the PHCs jurisdiction, its achievements, follow up actions, difficulties faced etc.
- Coordinate with local CSOs and CSOs to improve the health scenario of the PHC area.
- Review functioning of sub-centers, APHCs, PHCs operating under jurisdiction of the block (CHC) and taking appropriate decisions to improve their functioning.
- Brief minutes of the meeting at the end of the meeting along with the action plan emphasizing the actions to be taken by different committee members, which will be shared at the District Level Committee. The minutes will also serve as a reference point, while sharing the progress done between two committee meetings.
- Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The report may become a part of the performance appraisal of the concerned staff member. The committee may recommend corrective measures to the district level. The decisions taken in the committee need to be forwarded to higher concerned officials and a copy to the corresponding health committee of that level who will be responsible to take necessary decision for action to be taken on the inquiry within a period of three months.

Powers of the committee

- Contribute to annual performance appraisal of Medical officer/other functionaries at the PHC and CHC.
- Take collective decision about the utilization of the special funds given to PHC for the repairs, maintenance of equipments, health education etc and any other aspects, which will facilitate the improvement of access to health care services. The MO/ACMO can utilize this fund after the discussion and approval from the committee.

Yardsticks for Monitoring at Block level

- IPHS or similar standards for PHC (this would include continuous availability of basic outpatient services, indoor facility, community outreach services, referral services, delivery and antenatal care, drugs, laboratory investigations and ambulance facilities).
- Charter of Citizens Health Rights for PHC CHC
- Block Health Plan.

Tools for Monitoring at Block level

- Village health registers/calendars
- PHC records
- Discussions with and interviews of the PHCRKS members
- Report of Public dialogue (Jan Samvad)
- Quarterly feedback from village and PHC Health Committees
- Periodic assessment of the existing structural and functional deficiencies

D. At Village Level:-

1.11 Block Facilitator- ASHA/Cluster facilitator:- 1 on every 2ASHAs who will be the ASHA herself. The Facilitator will be the 21st ASHA worker. This will help in building up and developing the necessary skill required for a community health worker in a sustainable way
Village Health Planning and Monitoring Committee Revenue Village

1.12 Community based planning and monitoring at Village Level:-

Constitution:-
As per the State Guidelines that has been sent earlier to the districts, the Constitution of the Village Level Monitoring Committee has the following members:-

- ASHA
- AWW
- PRI Ward Member
- SHG leaders

The Chairperson would be one of the PRI ward members especially the female.
The Convener would be the ASHA.
The Member Secretary would be one of the SHG leaders / CBO representative.

Roles and Responsibilities of Village Health and Monitoring Committee

- Create public awareness about the essentials of health programmes, with focus on peoples knowledge of entitlements to enable their involvement in the monitoring.
- Create awareness and BCC especially on Pre, during and Post Natal Care.
- Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community through filling up and analysis of Facility Score Card, Village Report Card
- Analyze key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present an annual health report of the village in the Gram Sabha.
- Participatory Rapid Assessment to ascertain the major health problems and health related issues in the village. The mapping will also take into account the health resources and the unhealthy influences within village boundaries.
- Mapping will be done through participatory methods with involvement of all strata of people (Village Health Profile, Facility Assessment, Village Report Card).
- The health mapping exercise shall provide quantitative and qualitative data to understand the health profile of the village. These would be village information (number of households caste, religion and income ranking, geographical distribution, access to drinking water sources, status of household and village sanitation, physical approach to village, nearest health facility for primary care, emergency obstetric care, and transport system) and the morbidity pattern.
- Maintain village health register and health information board/calendar The health register and board, put up at the most frequented section of the village will have information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc.
- Similarly, dates of visit and activities expected to be performed during each visits by health

functionaries may be displayed and monitored by means of a Village health calendar. These will be the most important document maintained by the village community about the exhibition of health status and health care services availability.

- This will also serve as the instrument for cross verification and validation of data.
- Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW.
- Obtain a bi-monthly health delivery report from health service providers during their visit to the village. Discuss the report submitted by ANM and MPW and take appropriate action.
- Consider the problems of the community and the health and nutrition care providers and suggest mechanisms to solve it.
- Discuss every maternal death or neonatal death that occurs in their village, analyze it and suggest necessary action to prevent such deaths. Get these deaths registered in the Panchayat
- Acts as a Monitoring committee for overlooking that Rs.10,000/- is spent on the Development works as per the Guideline.

Powers of the Committee

- The Committee would monitor that Rs. 10000.00 is used for development works by the PRI committee.
- Planning and Monitoring

Yardsticks for Monitoring at Village Level

- Village Health Plan
- NRHM indicators translated into Village health indicators.

Tools for Monitoring at Village Level

- Village Health Card, Facility Score Card, Report Card etc.
- Village Health Register.
- Records of the ANM
- Village Health calendar
- Infant and maternal death audit
- Public dialogue (Jan Samvad)

Detailed terms of Reference for ASHA Resource Center are:

SN	Activity	Sub-activities
1	**Recruitment of Staff**	1. Recruiting staff like Program Officer, Research Officers for ARC 2. Recruitment of District ASHA Facilitators and Zonal Facilitators.
2	**Technical backstopping in Training**	3. Develop user friendly training methodology and the training modules. 4. Print the modules in prescribed time, 5. Disseminate the modules in the District. 6. The modules are being developed by MOHFW; GOI .These will be modified in the state context on the basis of functions of ASHA. 7. Work on the training modalities 8. Provide the supportive supervision to maintain quality

		checks and control at District and Block level.
3	**Development of IEC Material**	1. Developing or collecting the IEC material from different agencies for dissemination during the training. 2. Develop and disseminate the facilitation kit including flip books, chart, posters etc on different related issues. 3. Develop need based IEC material from time to time.
4	**Planning of Monthly Meetings**	1. Develop tentative monthly agenda for the monthly meetings including the Mentoring group;; 2. Provide required resource material and IEC material. 3. Develop the monitoring mechanism for the meetings.
5	**Development of Reporting formats and registers**	1. Develop the formats and orient ASHA for its utility and use. 2. Defining indicator.
6	**Processing of Statistical Data and records**	1. On the basis of reports and registers of ASHA and other sources of data's. ARC will compile the statistical data, analyze the data and provide the feedback of the program to the Mission.
7	**Intersectoral Coordination pertaining to ASHA**	1. Coordinate with different departments and facilitate empanelment of ASHAs in various other programs like Sarva Shiksha Abhiyan, Total Sanitation Campaign etc.
8	**Planning, implementation and strengthening f community planning and monitoring process**	1. Will be done through the CBMP Wing for effective coordination and implementation.
9	**Involving NGOs to strengthen the program**	1. There could be many roles of NGOs and these roles could be identified by the ARC. In consultation of NRHM the NGOs should be involved in the program.
10	**Provision of Drug Kits**	1. Facilitate the procurement process and supply it to ASHA. 2. Develop the mechanism to maintain at least two months stock of medicines with ASHA.
11	**ASHA role in Village Health Plan**	1. Capacity building of ASHA so that she could help in planning and implementation of Health Programs in the Village.
12	**Organize Quarterly meeting of Mentoring Group**	1. Conduct the quarterly meetings of the mentoring group. 2. Incorporate the valuable inputs provided by the group in the program.
13	**Provision of services of Helpline**	Form and strengthen the helpline for the ASHA and associated functionaries. strengthen the ASHA Help Desk at the block level and District Level 1. Respond to the queries or clarifications needed in the field.

		2. Ensure the prompt help is provided to ASHA.
14	**Capacity Building and academic support programme to approx 1000 ASHAs**	- facilitation of the districts in identification and - Enabling ASHA 10th pass For up gradation of academic strength of ASHA, SHSB will provide examination fees for the 10th examination of open schooling mode/Board/IGNOU to 100ASHAs. Fee for the same to be provided by SHSB.
15	**Motivations for ASHA (if the process still continues for the next year) and Identity for ASHAs**	Provision of two sarees and 1 umbrella to ASHAs Best performance award to ASHAs at district level. @ Rs.200per block= 3 ASHAs from each block @ Rs.100for 1st, Rs.50for 2nd and Rs. 30for 3rd prize, Rs. 20for Certificate printing and distribution = Rs. 200x 533) = 10,66,000/- Identity Card (Rs. 2x 87135) = 17,42,700/-
16	**Organizing ASHA Sammelan, Exposure visits**	1. Organize such events with the help of State Health Society and District Health Society. 2. Also organize the exposure visits with in the state and outside the state.
17	**Linkages of ASHA Resource Center-**	1. Provide support to the districts through NRHM and all the administrative guidelines will be issued through NRHM.

Sl. No.	Community based planning and monitoring – Plan of Action
1	Setting up the State Level AGCA Task Group
2	State Level AGCA meeting
3	Setting up State Level Community Planning and Monitoring Group
4	State Level Training of Trainers (including orientation of State Level Planning and Monitoring Committee members) by AGCA/Technical Agency/ASHA Cell of SHS Bihar
5	State level workshop to finalize the modalities of village level intervention with AGCA members, State Planning and Monitoring Committee members and developmental partners
6	2 days' State Level Consultative workshop for preparation of Module for training of Kalajatthas, Village Planning and Monitoring Committee and CSOs for facilitation and Orientation of Village Planning and Monitoring Committee.
7	Preparation of necessary Materials, Curricula and Modules (for CSO,Kalajatthas,Village Planning and Monitoring Committee by the State Technical Agency / ASHA Cell of SHS Bihar/Development Partners)
8	Consultative meeting with DM/CS by State representative at district level for selection of blocks and Panchayat
9	Advertisement for CSOs selection (six CSO for six blocks) at Block Level to facilitate the process at village level
10	Selection of Nodal NGOs at Block level
11	Consultative meeting with MOIC/BHM by State representative at district level for orientation of the CBM process
12	Training of trainers of CSO Representatives(of Block Level) by the State Level Master Trainers(AGCA/ State Planning and Monitoring Committee) at District Level to prepare the block level trainers pool
13	Preparation of IEC/BCC Plan through Consultative Meeting at State Level
14	Development and Printing of IEC/BCC materials, report cards, facility cards, cumulative report cards etc.
15	State level ToT for Kalajatta team Dept of Information and Public Relation, Govt. of Bihar
16	Conduction of Kalajatha at village level
17	Identification of Community Level Artists for Kalajattha performances by CSO
18	Facilitation for formation of Village level Planning and Monitoring Committee by CSO
19	Conduction of any other IEC/BCC activities (as per the final IEC/BCC plan emerged from State Level Consultative meeting on IEC/BCC plan)
20	Two rounds of orientation cum Training of Village Level Planning and Monitoring committee at Panchayat level
21	Filling up of Village Health Card
22	Filling up of Village Facility Card
23	Data gathering and preparation of Report Card
24	Preparation of Village Health Plan
25	Conduction of Report Sharing Meeting at Panchayat level
26	Conduction of Jan Samvad at Block level
27	District Level Dissemination and planning Workshop on Community Monitoring Planning and Monitoring
28	Monitoring Visits by State Level Planning and Monitoring Group members / State Advisory Group for Community Action Members
29	Documentation including process documentation
30	**Preparation of Documentary**

Work and Time Frame:-

Sl. No.	Issues in Planning in ASHA	Current Status as per evidence from data triangulation	Activities to be undertaken to achieve targets	Outputs to be achieved	Time Frame for 2010-11
1	Lack of Human Resource	- One Officer- In – Charge ASHA and one Deputy Project Manager, ASHA monitoring 10 programmes from state level. - At District and Block level one DCM /DATA assistant, Block organizer had sanctioned in last PIP but they are not yet appointed, appointment process has been initiated. - At the Cluster level ASHA facilitator (1 ASHA for 20 ASHA) had sanctioned in last PIP in some district they have selected one ASHA as facilitator total number is not available.	-Concept note on ARC -TOR for ARC personals -Letter to NHSRC for the same will be issued -Recruitment of the Personnel at all the levels - Induction Training/ Orientation of the same.	Human Resource in place With proper orientation training for effective implementation of the programme	1st and 2nd Quarter
2	ASHA Selection	69124 ASHAs of 87135(already revised)	Selection of 18011 ASHAs	Target selection to be completed	Till 2nd Quarter
3	1. ASHA Trainings- Lagging and Qualitative Issues **2.** Technical backstopping in Training	63802- Module 1 14222- Module 2, 3 and 4	• Creation of training Pool at the State, District and Block Levels • Develop user friendly training methodology and the training modules. • Print the modules in prescribed time, • Disseminate the modules	Completion of Module 1, 2, 3 and 4 trainings and rolling out of Module 5 training	1st, 2nd and 3rd Quarter- completion of Module 1, 2, 3, and 4 Training Module 5 – 3rd and 4th Quarter

			in the District. • The modules are being developed by MOHFW; GOI .These will be modified in the state context on the basis of functions of ASHA. • Work on the training modalities • 6. Provide the supportive supervision to maintain quality checks and control at District and Block level.		
4	ASHA Drug Kit-Incompetent Kit bags/ Non availability of Kit bags and Drugs	- Kit bag available to ASHAs not adequate	- Provision of Drug Kit Bag to ASHAs (Kits provided earlier are not designed to keep medicines) through tender after designing. - Strengthening of processes with the Facilitate the procurement process and supply it to ASHA. Develop the mechanism to maintain at least two months stock of medicines with ASHA. - Training of ASHAs	- Better health Care of the community - Self- Help Mechanism will be developed	1st quarter
5	Community Based Planning and	- Workshop with the development Partner and different States held to assess the Community based	- Develop Plan as per the existing structure - The CBMP wing established under	- Building up of communitisation process	1st, 2nd, 3rd and 4th Quarter

	Monitoring	planning and monitoring process - Process could not be initiated thereafter because of lack of synchronization of the CBMP plan with a different structure of VHSC in the State of Bihar and non-formation of VHSCs.	ARC will help effectively designing and rolling out of the programme.	which is the base of ASHA programme - Forming of Planning and monitoring committees at State, District and Block level - Development of Village Health Plans	
6	Capacity Building and Academic support Programme	This was inbuilt in last years PIP but data not available	- develop a guideline - follow- up	- Academic knowledge enhancement of ASHAs	2nd Quarter
7	HMIS- no data management	In Lack of an integrated Data System, The data was asked through individual telephonic calls which was practically not feasible	- Recruitment of HMIS Officer under ARC - Data formats to be developed and channelised at all the levels - An integrated management of data systems and database	- the data received will help develop a feedback mechanism at the lowest level for mid-term corrections and take corrective measures	All 4 quarters

Budget:

Sr. No.	Particulars	Tentative Budget
	ASHA Resource Centre	
	(A) AT THE STATE LEVEL	
1	**Personnel on contract** 1. Deputy Director – Rs.40,000/- per month x12 months = Rs.4,80,000/- 2. Consultant – Rs.35,000/- per month x 12 months = Rs.4,20,000/-	**9,00,000/-**
2	**Training Wing** 1. One Community Training Officer – Rs. 30,000/- per month x 12	

	months = 3,60,000/- 2. One Water & Sanitation Officer – Rs. 25,000/- per month x 12 months = 3,00,000/- 3. One Nutrition & Food Security Officer – Rs. 25,000/- per month x 12 months = 3,00,000/- 4. One Consultant Doctor – Rs. 25,000/- per month x 12 months = 3,00,000/-	**12,60,000/-**
3	**<u>Community Based Planning and Monitoring Wing</u>** 1. Community Planning and Monitoring Officer – Rs. 30,000/- per month x 12 months = 3,60,000/- 2. VHSC Coordinator – Rs. 25,000/- per month x 12 months = 3,00,000/-	**6,60,000/-**
4	**<u>ASHA Mentoring Group</u>**	**3,00,000/-**
5	**<u>BCC and IEC Wing</u>** 1. Personnel on Contract (i) Two Communication Officer – Rs. 25,000/- per month x 12 months = Rs. 3,00,000/- (ii) One Public Health Consultant - Rs. 30,000/- per month x 12 months = 3,60,000/- 2. Development of IEC and monitoring materials (ASHA flip chart, ASHA Activity Diary, ASHA Register, IEC material, reporting format, monitoring formats and resource materials for meetings) = 500 x 87135 = 4,35,67,500/-	**4,42,27,500/-**
6	**<u>Programme and Admin Support</u>** 1. One Human Resource Officer – Rs.30,000/- per month x 12 months = Rs.3,60,000/-. 2. One Documentation Officer – Rs.25,000/- per month x 12 months = Rs.3,00,000/-. 3. One Account Officer – Rs.20,000/- per month x 12 months = Rs.2,40,000/-. 4. One HMIS Officer – Rs.20,000/- per month x 12 months = Rs.2,40,000/-. 5. One Computer Operator – Rs.12,000/- per month x 12 months = Rs.1,44,000/-. 6. One Office Attendant – Rs.9,000/- per month x 12 months = Rs.1,08,000/-. 7. Office Expenses Computer Set = 15 (Rs. 11,00/-(On Rent) x 15 x 12 month = 1,98,000/-) Printer = 2 (Rs.300/- (On Rent) x 2 x 12 month = 7,200/-) Fax Machine = 1 (Rs.15,000/- (To be contracted) Scanner = 1 (Rs.300/-(On Rent) x 12 month) = 3,600/-) Xerox Machine = 1 (Rs.1,50,000/-)(To be contracted) Internet = [{1800(Initial Cost) + 850 (Recurring Cost Including Service Tax)} x 12 month =31,800/-]	**17,97,600/-**
7	**<u>Community Based Planning and Monitoring</u>** A. One Day State Level Advisory Group Meeting (4 times). B. State level ToT (2 Days') at SIHFW (includes State Level planning	

	and monitoring committee members, AGCA members) C. State Level Workshop to finalise the modalities of village level interventions State Health Society, Bihar (includes AGCA Members, Stae Level planning DPM, MOIC, ACMO) {4 representatives from each district) D. 2 days' State Level Consultative workshop for preparation of Module for training of Kalajatthas, Village Planning and Monitoring Committee and CSOs E. Selection of CSO F. District level ToT for Block Level Trainers Resource Pool (3 Days')(includes Stae Level resource person, 10 persons from each block etc.) G. State Level Consultative Meeting for IEC/BCC Plan (for finalsistion of state and region specific IEC/BCC materials for CBM) at SIHFW / SHS Bihar (includes AGCA Members, Stae Level planning and monitoring committee members, 2 representatives from each district, CSO Representatives etc.) H. Development and printing of BCC / IEC Materials I. State level ToT for Kalajatta team (2 Days') at SIHFW J. Other area/issue specific IEC/BCC Activities (if any as per the IEC/BCC Plan) K. District Level Dissemination and planning Workshop on Community Planning and Monitoring L. Concurrent Monitoring Visits by State Planning and Monitoring Members / State Advisory Group for Community Action Members (Rs. 10000/- per month per block for 12 months) M. Documentation including process documentation (including reports, case studies, success stories, designing, composing and editing) N. Documentary (Of 30 minutes as per Govt. approved rate of Dept of Public Relation) O. Contingency State Level	**1,13,22,600/-**
7	**Monitoring and supervision**	**2,00,000/-**
8	**Operation research and documentation**	**2,00,000/-**
9	**Induction Training of Newly Recruited Personnel (Total No. of People 15)** {Hall Charge= Rs.2000/-, Fooding=Rs.200/- x (533 Block +38 District +20 State) person, Resource Person= Rs.2000/- x 4 Person, LCD=Rs.1000/-, IEC Material= Rs.100/- x 20 Person }= 7,53,200/- [4 days Activity]	**7,53,200/-**
10	**Workshops, Seminars and Meetings**	**2,00,000/-**
11	**Contingency**	**1,00,000/-**
	Total (A)	**6,19,20,900/-**
	(B) ASHA Support System at the District Level	
1	**Personnel On Contract** (i) **District Community Mobilizer/District Project Manager-ASHA** (Master in Social Work) Rs.20,000/- per month x 12 months x 38 District = Rs.91,20,000/- who will report to District Nodal Officer. (ii) **District Data Assistant (Graduate with Basic Computer knowledge)**	**1,79,43,600/-**

	- Rs.15,000/- per month x12 months x 38 District = Rs. 68,40,000/- **(iii)Office Expenses** Computer Set = Rs. 11,00/-(On Rent) x 38 District x 12 month = 5,01,600/-) Printer = Rs.300/- (On Rent) x 38 District x 12 month = 1,36,800/-) Scanner = Rs.300/-(On Rent) x 38 District x 12 month) = 1,36,800/-) (iv) Internet = [{1800(Initial Cost) + 850 (Recurring Cost)} x 38 District x 12 month =12,08,400/-]	
2	**ASHA Help Desk at the district level** (As In-charge Block ASHA Facilitator) = Rs.150/- x 4 ASHA x 38 District x 7 day x 12 months =Rs.19,15,200/-	**19,15,200/-**
3	**ASHA Sammelan** (Traveling cost for ASHA @ 80/- per ASHA from collection point to district HQ and back, Snacks for ASHA @ 40/- per ASHA Facilitation cost for local NGO @ 10000/- per NGO per District, Organizational Cost @ Rs. 50,000/- per District, Miscellaneous @ Rs.8787/-)	**1,30,70,226/-**
4	**Community Based Planning and Monitoring** A. District level ToT for Block Level Trainers Resource Pool (3 Days')(includes Stae Level resource person, 10 persons from each block etc.). B. Conduction of Kalajatha at Village level @ Rs 5600/- per show (Three District) C. Activity Cost for formation of Village Planning and Monitoring Committee (including travel cost for facilitators and meeting cost at village level) {approximately 6 villages will be there in each panchayat for 5 Panchayats in a block} D. Four rounds of Orientation cum Training of Village Planning and Monitoring Committee at Panchayat level (6 members from each village level monitoring committee x 180 committees i.e. approx total 1080 members will be there and will have batch size of 30 persons i.e. total no. of batches will be approximately 36) E. Data Collection and analysis of Village level report cards, health facility card, preparation of village health plans F. Conduction of Quarterly Block Level Jan Samvad in each of the pilot blocks (in units total units will be 4 Block Jan Samvad per block x 6 blocks = 24 units) G. District Level Dissemination and planning Workshop on Community Planning and Monitoring H. Coordination Expenses (per block) for CSOs (including HR and other admin and programme supporting expenses (Rs. 30000/- per month per block for 12 months) I. District level Contingency(Rs.5000/- Per month per District x 12 months)	**76,91,250/-**
	Total (B)	**4,06,20,276/-**
	(C) ASHA Support System at the Block Level	
1.	**Personnel on Contract** (i) **Block ASHA Manager** in all the blocks. (Rs.12000/- x 533 x 12 months = Rs. 7,67,52,000/-).	**10,36,15,200/-**

	(ii) **ASHA Help Desk at the Block level** (As In-charge Block ASHA Facilitator) = Rs.150/- x 4 ASHA x 533 Block x 7 day x 12 months =Rs. 2,68,63,200/-	
(D) ASHA Trainings		
1	For Module 2, 3 and 4 Training (Of the Total approved budget of 32.13 crore)	**22,13,00,000/-**
2	For Module 1 Training – TA (Including Fooding and DA = per ASHA x 7 days x Rs.200/-), Honorarium @ Rs.100/- per trainer (Total of 4 training per batch and 4 session I a day), Training Material @ Rs. 300/- per participant = Rs. 4,13,22,600/-.	**4,13,22,600/-**
3	**For Module 5 Training –** **For ASHA** "TA (Including Fooding and DA = per ASHA x 4 days x Rs.200/-), Honorarium @ Rs.100/- per trainer (Total of 4 training per batch and 4 session I a day), Training Material @ Rs. 300/- per participant = 2,73,22,200/-" **State ToT of Master Trainer** Hall Charge= Rs.2000/-, Fooding=Rs.200/- x 38 person, Resource Person= Rs.2000/- x 4 Person, LCD=Rs.1000/-, IEC Material= Rs.100/- x 38 Person = 22,400/- **District ToT of Block Level Resource Person** Hall Charge= Rs.2000/- x 38 District, Fooding=Rs.200/- x 600 person, Resource Person= Rs.2000/- x 2 Person x 38 District, LCD=Rs.1000/- x 38 District , IEC Material= Rs.100/- x 600 Person =4,46,000 /-	**2,77,90,600/-**
	Total (E)	**29,04,13,200/-**
(E) ASHA Drug Kit & Replenishment		
1	Drug Kit for 87135 ASHA Rs.897.65/- x **2 Time** x No. of ASHA= **15,64,33,465.50/-**	**15,64,33,465.50/-**
2	Kit Bag for 87135 ASHA Rs.100/-x 87135 ASHA= Rs.87,13,500/-	**87,13,500/-**
	Total (F)	**1,65,146,965.50/-**
(F) Motivation of ASHA		
1	Provision of two Sarees to ASHAs (87135 ASHAxRs.600(two Sarees) =5,22,81,000/-	**6,31,72,875/-**
2	Provision of one umbrella to ASHAs (87135 ASHAs x Rs.125/-) =1,08,91,875/-	
3	Best performance award to ASHAs at district level. @ Rs.2000 per block= 3 ASHAs from each block @ Rs.1000 for 1st, Rs.500 for 2nd and Rs. 300 for 3rd prize, Rs. 200 for Certificate printing and distribution = Rs. 2000 x 533) = 10,66,000/- (For this activity the administrative system/procedure shall be chalked out with support of Development Partners)	**10,66,000/-**
4	Identity Card (Rs. 20 x 87135) = 17,42,700/-	**17,42,700/-**
	Total (G)	**6,59,81,575/-**
(G) Capacity Building/Academic Support Programme		

1	Approx. 1000 ASHAs in the State to be enrolled into 10th grade or Bachelor's Preparatory Programme through Open Schools or IGNOU. Fee for the same to be provided by SHSB. The amount being requested is less, more shall be requested in case of god response to the proposal. @ Rs.1000 x 1000 students =10,00,000/-	**10,00,000/-**
	(H) ASHA Divas	
1	TA/DA for ASHA Divas @ Rs.115 per ASHAs per month (Rs. 87135 x 115x12) = 12,02,43,300/-	**12,02,46,300/-**
	Grand Total(A+B+C+D+E+F+G+H)	**84,89,44,416.50/- OR 84,89,44,500.00/-**

1.2 Untied Fund for Health Sub Centre, APHC and PHC

The objective of the activity is to facilitate meeting urgent yet discrete activities that need relatively small sums of money at Health Sub Centers.

The suggested areas where Untied Funds can be used mentioned below:

- Cover minor modifications to sub center-curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level;
- Ad hoc payments for cleaning up sub center, especially after childbirth; transport of emergencies to appropriate referral centers;
- Purchase of consumables such as bandages in sub center;
- Purchase of bleaching powder and disinfectants for use in common areas of the village;
- Labour supplies for environmental sanitation, such as clearing/larvicidal measures for stagnant water
- Payment/reward to ASHA for certain identified activities.
- In PHC and APHC purchase of patient examination table, delivery table, DP apparatus, Hemoglobin meter, Cu-T insertion kit, Instruments tray, baby tray etc.
- Provision of running water.
- Transportation of emergencies to appropriate referral centre.

Budget

Budget Head	Untied Fund	
Sub-Heads	@	Proposed Budget (in Crores)
Untied Fund for sub-centre	Rs. 10,000 x 9174 no.	9,17,40,000
Untied fund for APHCs	1243 APHC x 25,000	3,10,75,000
Untied fund for PHCs	533 PHC x 25,000	1,33,25,000
Meeting at District for untied fund	Rs. 2000 x 38 district	76,000
PHC level ANMs Orientation on Untied Funds for HSC	533 PHCs x Rs. 3000	15,99,000
Quarterly review meeting at district level to review and facilitation for utilization of untied fund.	Rs. 1000 per meeting x 4 Quarter x 38 districts	1,52,000
	Total	13,79,67,000

1.3 Village Health and Sanitation Committee

Government of Bihar has decided to merge "Village Health and Sanitation Committee" with "Lok Swathya Pariwar Kalyan and Gramin Swaschata Samiti" constituted by Department of Panchayati Raj in Bihar.
Budget

Budget Head	**Untied Fund for VHSC**	
Sub-Heads	**@**	**Proposed Budget (in Crores)**
Untied Fund for VHSCs	40,000 villages x 10,000	40,00,00,000
Training/Capacity Building of members of VHSC regarding functioning mechanism at the PHC level	533 PHCs x Rs. 10000	53,30,000
	Total	**40,53,30,000**

1.4 Rogi Kalyan Samitis

RKS is operational district hospital, SDH, RH & PHC. Govt. of Bihar is operationalising the APHCs this year. In light of this RKS have to be setup in all the APHCs and registered simultaneously.

Aims and Objectives

The objectives of the RKS is :

- » Upgrade and modernize the health services provided by the hospital and any associated outreach services
- » Supervise the implementation of National Health Programme at the hospital and other health institutions that may be placed under its administrative jurisdiction
- » Organize outreach services / health camps at facilities under the jurisdiction of the hospital
- » Monitor quality of hospital services; obtain regular feedback from the community and users of the hospital services
- » Generate resources locally through donations, user fees and other means

Functions of the RKS

To achieve the above objective, the Society utilizes it's resources for undertaking the following activities/ initiatives:

- » Acquire equipment, furniture, ambulance (through, donation, rent or any other means) for the hospital

- » Expand the hospital building, in consultation with and subject to any guidelines that may be laid down by the GoBMake arrangements for the maintenance of hospital building (including residential buildings), vehicles and equipments available with the hospital
- » Improve boarding/lodging arrangements for the patients and their attendants
- » Enter into partnership arrangement with the private sector (including individuals) for the improvement of support services such as cleaning services, laundry services, diagnostic facilities and ambulatory services etc
- » Develop/lease out vacant land in the premises of the hospital for commercial purposes with a view to improve financial position of the Society
- » Encourage community participation in the maintenance and upkeep of the hospital
- » Promote measures for resource conservation through adoption of wards by institutions or individuals
- » Adopt sustainable and environmental friendly measures for the day-to-day management of the hospital, e.g. scientific hospital waste disposal system, solar lighting systems, solar refrigeration systems, water harvesting and water re-charging systems etc.
- » Rogi Kalyan Samiti has to also provide for Refrral Transport for pregnant women high focus districts and for family friendly hospital certification in five focus district of the state.

Budget

S.No.	Initiative	Number Proposed	@ Rate Proposed	Total Amount (In lakhs)
1.	RKS-DH	37	500000	185
2.	RKS-SDH	44	500000	220
3.	RKS-Referal	70	200000	140
4.	RKS-PHC	533	100000	533
			Total	**1078**

2. INFRASTRUCTURE PLAN

2.1. CONSTRUCTION /ESTABLISHMENT OF HEALTH SUB- CENTRE

The NRHM aims to ensure Health sub-centers facility on the Govt. of India Population norms of 1 per 5000 populations in general areas and 1 per 3000 populations in tribal areas. As per 2001 Census, population of the Bihar State is approximately 8,29,98,509. Existing facility of HSCs are 8858. Out of this 4875 are without building. State government has taken up construction of 2291 from own fund and loan from R.I.D.F. To facilitate the above population the state required additional 7765 HSCs. To achieve the total target it was proposed to create 1553 HSCs every year. But this could not be achieved.

However construction of 1600 PHC is proposed during 2010-11.

In 2007- 2008 the State proposed to take up 1000 Health Sub- Centres @ Rs.6.45 lakh per Health Sub Centre. This year the state has revised the rate @ 9.50 lakhs as per GoI norms. Again state has revised the rate @ 11.00 lakhs but this unit cost does not include cost of land in case of non-availability of government land. It is anticipated that 20% of 1600 i.e. 320 sites will need land acquisition. A sum of Rs. 320 lakh will be required @ Rs. 1.00 lakh per site (assumed) for land acquition. Cost of construction of 1600 units @ Rs. 11.00 per units will be Rs. 17600lakh. Total cost with land acquisition will be Rs.17932 lakh. Per unit cost will then be Rs. 11.20 lakhs. The State proposes to share 25% expenses in the construction of these HSCs. The balance 75% the state put under this PIP for financial support from NRHM. Till the time of construction the state shall take building for these facilities on rental basis.

NRHM Action - Plan 20010-11					
Proposed Activity	**Expected Physical Out Come**	**Proposed Budget 2010-2011**	**Details of Budget Basis of Costing (No. of Units X Unit Cost)**		
Creation of 16**00 HSCs**	Construction of 1600 HSC	**Rs. 11587.50 lakhs**	**Total cost** at the @ Rs 11.20 lakh per unit	**Contribution of GoI** @75% will be Rs. 8.40 lakhs per unit. For 1600 units cost will be 14080lakh	**Contribution of GOB** @ 25% will be Rs. 2.80 lakhs per unit. For 1600 units, cost will be Rs. 4480 lakhs
			Rs.17920 Lakhs	**Rs. 14080 Lakhs**	**Rs.4480 Lakhs**

1600 Health Sub- Centres shall be taken up for construction during 2010-11. Contribution of GoI will be Rs. 14080 lakhs. Rs. 2992.50 lakh was approved by GoI in the year 2009-10. Expected expenditure during this year is Rs 500.00 lakh. The balance Rs 2492.50 lakhs will be deducted from Rs.14080 lakh, The budget amount then will be Rs.11587.50 lakhs.

2.2. CONSTRUCTION OF PHC (APHC in Bihar)

(A) The NRHM aims to ensure PHCs on the Govt. of India population norm of 1 per 30000 populations in general areas and 1 per 20000 population in tribal/ remote areas. As per 2001 census Population of Bihar state is approximately 82958509. The Existing facility of PHCs(APHCs) is 1243. Further requirement is of 2787 PHCs(APHCs). Therefore 1665 PHCs (APHCs) are required to be set up, by 2012. Government of Bihar decided to construction 331 per year but this could not waterialise. There are 121 PHCs which does not have its own building.

It is proposed to take up new construction 350 PHCs in 2010-2011. Unit cost of construction of Rs. 53.15 lakh was approved by GoI on 17.03.08. There has been sharp rise in prices of all commodities during recent two years. To accommodate the increase, 20% escalation is being

assumed. The unit cost will then be around Rs. 63.80 lakh. Cost of construction 350 units will be Rs. 22,330 lakh. This cost does not include cost of land acquision. Assuming 15% sites where land may not be available, the number of sites will be around 52 nos. Rate of land acquision per unit may be around Rs. 2.50 lakh(assumed). Then cost involved in L.A. for 350 PHCs will be Rs. 875 lakh.

Thus total cost of construction & land acquisition will be to Rs. 23205 lakh. Unit cost works out to be Rs. 66.30 lakh only.

Proposed Budget for financial year 2010-11 will be Rs. 23205 lakh for 350 untis @ Rs. 66.30 lakh. Till the time, the construction is completed the state shall take buildings for these facilities on rental basis.

NRHM Action - Plan 2008-09			
Proposed Activity	**Expected Physical Out Come**	**Proposed Budget**	**Details of Budget Basis of Costing (No. of Units X Unit Cost)**
Construction of **350PHCs(APHCs) Buildings.**	A corporation under Health Department is being established. It is hoped that construction work will be stepped up. Around 350 units may be completed.	**Rs.18205.00 Lakhs**	**Unit Cost Rs.66.30 lakhs** Contribution of GoI 100% (Rs.66.30 lakhs x 350)= Rs.23205.00 Lakhs.

Note: 350 shall be taken up for construction. at a total estimated cost of Rs. 23205.00 lakhs. Rs. 2710.65 lakh has been approved by GoI in year 2009-10. A sum of Rs. 500 lakh may not be utilized Thus the balance fund required in 2010-11 will be Rs18205.00 lakh(23205-500).

2.2 (B)

Most of the quarters of existing PHCs(APHCs) are damaged. Good number of existing PHCs(APHCs) are without quarter. The total build up area of new PHCs(APHCs) under construction is 6300 sft. which include 1500 sft for PHC and 4800 sft. for its residential quarters. 3000 sft. Is needed for 3 nos. staff quarters. It is proposed to construct residential quarters for staff in 30 old APHCs @ Rs. 30.00 lakh each as sanctioned during 2009-2010.

NRHM Action - Plan 2008-09			
Proposed Activity	**Expected Physical Out Come**	**Proposed Budget**	**Details of Budget and Basis of Costing (No. of Units X Unit Cost)**
Construction of residential quarters of 30 old for APHCs for Staff nurses.	Construction to be done in an area of 3000 sq. ft.(1000 sq.ft. x 3 quarters) @ 30 lakhs per APHCs.	**Rs. 900.00 lakh**	Sanctioned during 2009-10 @ Rs. 30.00 lakh per quarters. (30 x 30)

2.3 <u>UPGRADATION OF PHCs to COMMUNITY HEALTH CENTRE (PHC to CHC)</u>

The NRHM aims to ensure CHCs on the Govt. of India population norm of 1 per 1.20 Lakhs populations. The Govt. of Bihar plans to upgrade all its PHCs and Referral Hospitals to CHC as per IPHS standard. In the state of Bihar the total no of existing PHCs are 534 and the no of balance Referral Hospital is 55. Hence a total of 589 units needs to be upgraded to CHC and converted into 30-bedded hospitals. It is proposed to upgrade facilities in 200 CHCs every year. As per NRHM guideline the entire cost of construction would be borne by GOI.

It is proposed to take up upgradation of 200 PHCs to CHCs in the year 2010-11 and the rest PHCs/Referral hospitals will be upgraded to CHCs in next year. The unit cost of upgradation will be around Rs. 40 lakhs. The upgradation of hospital buildings shall be taken up from funds provided by the State Govt. The doctors and staff quarters shall be provided under the NRHM. In case government land is not available the fund can also be used for land acquisition. The doctors quarters would also be taken up on rental basis till the construction. The costs also include provision of equipments at these hospitals either as per IPHS standard or as required.

Up gradation of PHCs to Community Health Centre As Per IPHS NRHM Action - Plan 2008-09			
Proposed Activity	**Expected Physical Out Come**	**Proposed Budget**	**Details of Budget, Basis of Costing (No. Of Units X Unit Cost)**
Creation and Up gradation of PHC to CHCs as per IPHS Standard 200 PHCs to are proposed to be upgraded in 2010-11.	Construction of Quarters for Doctors and Staffs and for the Purchase of New Surgical Instruments, Equipments, Furniture, etc.	Rs.4000.00 lakh	Unit cost @ Rs. 40 lakh (Contribution of GOI 100%) @ Rs. 40 lakhs x 200 = Rs. 8000.00 Lakhs

Note- Rs. 8040.00 lakh has been made available during 2009-10 for this work but Rs. 4080.00 is expected to be spent during 2009-10. Rest amount of Rs. 4000 lakh will be available which can be adjusted from required amount of Rs. 8000 lakh. Thus balance amount of Rs. 4000 lakh only will be the final budget for 2010-2011.

2.4 Upgrading District Hospitals and Sub-Divisional Hospital as per IPHS

The state of Bihar has 25 District Hospitals & 23 Sub Division Hospital at present. Construction for 12 District Hospitals are under process and will be completed by 2009-10. Most of these District hospitals are 100 to 200 beded. The state has already appointed one hospital consultancy firm to carryout the situation analysis of these District Hospitals and prepare a master plan in terms of Infrastructure, Equipment and Manpower for strengthening these hospitals as per IPHS. State has also requested Bridge construction corporation to prepare D.P.R for 100 bedded hospitals. State intends to strengthen and upgrade the 25 district hospitals and 23 sub-divisional hospitals as per IPHS in phased manner.

The state also intends to develop the hospitals at Rajvanshi Nagar, Rajendra Nagar, Gardanibagh and Guru Govind Singh Hospital, Patnacity at Patna into specific speciality

hospitals. The preparation of Master Plan is in process. The strengthing and upgradation would include upgradation of Civil Infrastructure as well as provision of equipments.

In the upgradation process effort would also be made towards making the hospitals 'Junk Free'.

B**udget**

Sl. No.	Particulars	Amount (Rs.)
1	Strengthening and upgrading of 25 nos. District Hospitals and 23 nos. Sub Divisional Hospitals and 4 Super Specialty Hospitals as per IPHS Standard	1500.00 Lakh

2.6 Annual Maintenance Grant

During the course of up-gradation in setting up of different units in the different health facilities of the state. maintenance will also be essentially required. It is proposed that all district hospitals and sub divisional hospitals are provided @ Rs. 5.00 lakh and Referral/PHC @ Rs. 1.00 lakh. PHCs buildings are very very old. Some of them do not have compound wall. There is no proper approach road. Roads within campus is also damaged and water logged. Hence provision of Rs. 2.00 lakh per PHC is being made.

Sl.No.	Activities	Total Proposed budget (in lakh)
1.	25 old District Hospitals and 23 old sub-divisional Hospitals @ Rs. 5.00 lakh each. = Rs. 240.00 lakh	240.00
2.	Referral and PHCs 589 (55+534) @ Rs. 1.00 lakh each =Rs. 589.00 lakh	589.00
3.	Special repair of labour room and O.T. and old building of PHC, Sangrampur, Munger =Rs. 20.00 lakh	20.00
4.	Construction of Drains in Madhubani Sadar Hospital as per estimate submitted. =Rs. 10.00 lakh	10.00
	Total-	**859.00 lakh**

2.7 Accreditation / ISO : 9000 certification of Health Facilities

The state with the help of NHSRC has got ISO accreditation/certification for its District Hospital at Bhojpur and is in the process of getting 3 more DHs certified. This year Bihar would like to outsource this task through NHSRC or some competent agencies to take up 10 PHCs and 5 SDH and 5 DH under ISO certification across the state for addressing quality issues, this would cater to the high profile districts.

Budget:

Activity	Amount (In Rs)
Accreditation/ISO certification for 10 PHCs x Rs.10.00 lakhs	1,00,00,000/-
Accreditation/ISO certification for 5 SDH + 5 DH x Rs.20.00 lakhs	2,00,00,000/-
Total	**3,00,00,000/-**

2.8 Upgradation of Infrastructure of ANM Training Schools

In year 2008-09, a State coordination committee for the strengthening ANM and GNM schools has been activated under the chairmanship of the Additional Commissioner, Health. The Executive Director, SHSB, officers from the Directorate and SHSB and UNICEF are its members. The committee has chalked a comprehensive strategy for the rejuvenation of the ANM and GNM schools.

Key decisions made till now include

- Streamlining the student intake in all ANM and GNM schools up to their full capacity
- Ensuring that the vacant faculty and staff positions in all the schools are filled through contractual appointments to undertake teaching assignment sas per INC norms
- Finalizing five ANM schools in PPP mode
- Formulation of the managing committee at respective ANM and GNM schools to look after the local management affairs
- Strengthening the hands of the principals of these institutes
- Reviewing the progress on a regular basis

Initiatives have been taken in Operationalisation of 22 ANM schools in terms of -

- site assessment,
- basic renovation,
- provision of kitchen items, audiovisual equipments, lab equipments
- provision of study material,
- capacity building of faculty,
- standard curriculum development for the ANMs and GNMs
- Facilitation in accreditation from Nursing Council of India.

It is proposed to upgrade the Infrastructure of 22 ANM and 6 GNM Training Schools. In addition, the state is willing to open up more ANM and GNM schools as per the GoI's letter in this regard. The approximate cost of up gradation of each ANM/GNM Training Schools is expected to be Rs 50 lakhs per Unit. It was proposed to upgrade the Infrastructure of 12 ANM Training Schools in 2008-09 PIP and a fund for the same to the tune of Rs.3.00 crores is available.

Additional funds are requested for the remaining 9 ANM schools and 6 GNM schools. The state is preparing a separate proposal to upscale the standards of nursing education. Additionally under PPP 5 ANM schools are proposed to be operationalised.

M.Sc/B.Sc. nursing faculty for nursing school to be taken from hindi speaking states like MP, Pondicherry, for which Govt of India shall be approached for coordinating the same.

Budget

Annexure 2: PROJECT:-AUXILLARY NURSING & MIDWIFERY SCHOOL & GNM SCHOOL						
SUMMARY OF COST						
Sl.No.	**ITEM**	**School**	**Hostel**	**Residential Accommodation**		**Grand Total**
				Teaching Staff Quarters	**Non-Teaching Staff Quarters**	
Upgradation of infrastructure of 1 ANM/GNM school sper Feedback ventures study						
1	CIVIL WORK	2717875	4757054	2592467	2592467	12659863
2	ELECTRICALS	193839	269126	245830	245830	954625
3	P.H.E.	138477	239779	211416	211416	801088
4	TOTAL	3050191	5265959	3049713	3049713	14415576
5	ADD 10% FOR ADMINISTRATIVE AND SUPERVISION CHARGES (	305019	526596	304971	304971	1441557
6	ADD 0.5% FOR CONTINGENCY	15251	26330	15249	15249	72079
	TOTAL for 1 ANM school	3370461	5818885	3369933	3369933	15929212
	GRAND TOTAL (for 21 ANM and 6 GNM Schools)					430088724
	Amount proposed for release initially for Infrastructure and subject to utilization further release may be done *					60022000
Strengthening of Nursing cell in the GoB						5000000

Hiring of additional faculty for all ANM and GNM schools						5000000
	GRAND TOTAL					**70022000**

** UNICEF to provide for equipments, teaching aids and furnitures*

3. Contractual Manpower

3.1. Incentives to Rural Area Doctors, Contractual Salaries of Staff Nurse and ANM (R) and Mobile Phone Facility for health personnel

As human resources are the most important resource steps shall be taken to motivate them through various benefits and incentives. This would ensure timely information generation like cellphone facility for all MOICs, Programme Officers, CDPOs etc. and rural and specialist incentives.

All the doctors posted in the rural area would get an additional incentive of Rs.3000. All the doctors performing specialist duties including the MBBS doctors trained for specialized tasks e.g. Life saving Anesthesia skills etc. will get an incentive of Rs.4000.

Mobile Phone Facility

BSNL CUG mobile facility has been provided to various officials upto PHC level. Presently 831 connections are in service and this facility is also to be provided to DPM.

Budget:

Sub-Heads	**@**	**Proposed Budget (Rs. In lakhs)**
Mobile facility for health functionaries	@38 handsets with SIM for DPM: (Rs 1350*38) = Rs 51300/- + Approx monthly charges for Rs 525 plan for 869 connections: (Rs 500000*12 months) = Rs 600000/-	6051300
Total		**6051300**

3.2. Block Programme Management Unit

The state has already established Block Programme Management Unit in all the Block PHCs. Each BPMU consists of One Block Health Manager and One Accountant. It has been observed that after the establishment of BPMUs the implementation of National Programmes has been managed efficiently and getting improved results.

Budget

Sl. No.	Name of the post	No. of Post	Salary (PM)	Salary (PA)	Budget (Amount in Rs)
1.	Block Health Manager	533	12000 + 10% increment = 13200 (2009-10) 13200+ 10% increment = 14520 (2010-11)	14520 x12x533 = 92869920	92869920
2.	Block Accountant	533	8000 + 10% increment = 8800 (2009-10) 8800 + 10% increment = 9680 (2010-11)	9680x12x 533= 61913280	61913280
Recurring expenses of 533 BPMU (Salary head) per year					**154783200**
3.	Mobility and office expenses	533	25000	25000x 12x533 = 159900000	**159900000**
Total Recurring expenses of 533 BPMU per year					**314683200**

3.3. Additional Manpower for State Health Society, Bihar

NRHM being a large programme covering various components, SHSB requires more manpower to run the programmes. The State Health Society requires additional manpower other than State Programme Management Support to manage all the Programmes under NRHM umbrella.

It is further being clarified that the present Programme Officers as given hereunder shall be adjusted in the new manpower proposed further below.

A. Details of Programme Officers

For Government officials on deputation new salary slab as such is proposed-

Sl.	Name	Salary Pm	Salary (pa)
1	Administrative Officer- SHSB	34143	409716
2	Programme Office – TB	32983	395796
3	Programme Officer-Kalazar/IDSP	38643	463716
4	Programme Officer –Blindness	29882	358584
5	Programme Officer- IDD/Filaria	35664	427968
6	State Immunization Officer	42108	505296
7	Programme Officer-Malaria	30751	369012
8	Programme Officer – Leprosy	30000	360000
Total Salary of ProgrammeOfficers		**274174**	**32,90,088**

B. Details of Staff

Sl	Post	Salary (pm)	Salary (pa)
1	Accountant (RNTCP)	15000	180000
2	Pharmacist (RNTCP)	11500	138000
3	Data Assistant (RNTCP)	9000	108000
4	Computer Operator (RNTCP)	8000	96000
5	Accountant (NBCP)	15000	180000
6	Computer Operator/Data Assistant (NBCP)	8000	96000
7	Steno-cum-LDC (NBCP)	8000	96000
8	Computer Programmer (NLEP)	15000	180000
9	Data Officer (Malaria/Kalazar)	15000	180000
10	Computer Operator (Malaria/Kalazar)	8000	96000
11	Store Keeper (Malaria /Kalazar)	8000	96000
12	Accountant (Filaria)	15000	180000
13	Computer Operator (Filaria)	8000	96000
	Total Per Annum		**1722000/-**
10% annual increment as approved by the Governing Body of SHSB, therefore the total required =			**Rs.18,94,200/-**

C. The details of Manpower as follows with Budget:

Sl. No.	Name of the post	No. of Post	Salary (PM)	Salary (PA)	Remarks
1	State Programme officer-Routine Immunization & Polio	1	33000	396000	Selection process is going on.
2	Consultant – Routine Immunization	1	30000 (Tentative)	270000	
3	Consultant – Polio	1	30000 (Tentative)	270000	
4	Consultant – M & E of PPP	1	30000 (Tentative)	270000	
5	Additional Director – PPP	1	50000 (Tentative)	450000	
6	Consultant – PPP	1	30000 (Tentative)	270000	
7	Consultant – Drugs	1	30000 (Tentative)	270000	
8	Consultant – Prog. Management	1	30000 (Tentative)	270000	
9	Additional Director – Disease Control & Convergence	1	50000 (Tentative)	450000	

10	Deputy Director – Intra & Inter Convergence	1	40000 (Tentative)	360000	
11	Consultant – Leprosy	1	30000 (Tentative)	270000	
12	Consultant – Blindness Control	1	30000 (Tentative)	270000	
13	Consultant – VBD	1	30000 (Tentative)	270000	
14	Consultant – TB	1	30000 (Tentative)	270000	
15	Consultant – IDSP	1	30000 (Tentative)	270000	
16	Additional Director – Infrastructure & Accreditation	1	50000 (Tentative)	450000	
17	Consultant – IPHS	1	30000 (Tentative)	270000	
18	Consultant – Health Facilities	1	30000 (Tentative)	270000	
19	Additional Director – Additionalities	1	50000 (Tentative)	450000	
20	Consultant – RKS	1	30000 (Tentative)	270000	
21	Consultant – Untied Funds	1	30000 (Tentative)	270000	
22	Consultant – IEC	1	30000 (Tentative)	270000	
23	Deputy Director – ANM & GNM Nursing Schools	1	40000 (Tentative)	360000	
	Total Rs.			**7236000**	

SHSB has / is in the process of advertising for the same.

Total proposed budget **=7236000/-**

D. Details of Engineers

Sl.	Name		Salary Pm	Salary (pa)
1	Executive Engineer - SHSB	2 no.	30000 x 2	
2	Bio-Medical Engineer –SHSB	1 no.	25000 x 1	10,20,000
Total Salary for Engineers			**85000**	**-**

Total Budget for Additional Manpower at SHSB (A+B+C+D) = Rs. 86,65,716/-

3.4. Additional Manpower under NRHM

Being a big state, Bihar requires more manpower to provide services at various facility levels and for better management of NRHM programme.

i. Hospital Managers

Addl. Manpower in the form of Hospital managers is being proposed for each of the 76 FRUs.
Hospital managers would facilitate process of quality control and also ensure that FRUs in the real sense get functional with all critical determinants. Further presentably Institutional delivery is one of the main activity of operational FRU and 24 hours management of facility is a challenge, for the solution of this problem GOB has appointed Hospital managers in medical colleges that needs to be replicated in operational FRU also.

Budget Proposed - @ Rs.25000 x 9 months x 76 FRUs =Rs. 1,71,00,000/-

i. Regional Programme Management Unit

In order to oversee properly and qualitatively implement NRHM in the districts, including the planning and utilisation, it is felt that that a Regional Programme Management Unit be established at the 9 Divisional Headquarter level which would include Regional Programme Manager, Regional Accounts Manager and Regional M & E Officer. It is also seen as a platform where performing DPM, DAM and District M & E officer can be promoted and thus this would act as a motivation for the DPMUs.

Budget

Sl.	Name	Salary Pm	Salary (pa)
1	Salary of RPM (9)	40000 x 9 mths. x 9 nos.	3240000
2	Salary of RAM (9)	35000 x 9 mths. x 9 nos.	2835000
3	Salary of RM&E (9)	25000 x 9 mths. x 9 nos.	2025000
Total Salary			**81,00,000**
Office expenditure + Mobility		75000 x 9 x 9	60,75,000
Meeting		25000 x 9 x 9	20,25,000
Total=-			**1,62,00,000/-**

PPP Initiatives in State

4. Referral & Emergency Transport

4.1 Emergency Medical Service /102 – Ambulance Service

The Toll free number 102 was launched during 2006-07 and is running in all the six regional headquarters successfully. Under this scheme Ambulance for emergency transport is being provided in all the districts of Bihar. The empanelled ambulance & ambulance available in Govt. institutions are made available on receipt of calls from the beneficiaries.

This service has been outsourced to a private agency for Operationalisation. The Telephone Charges for the free toll free number is paid to BSNL by SHSB. The amount required would be for payment of incoming calls received from the beneficiaries.

In the year 2009-10 (figures till 20 December 2009) 6072 requisitions have been successfully met by this service.

Budget summary of 102 :

Budget Head	**102 Emergency Service**	
Sub-Heads	**@**	**Proposed Budget**
Control Room (including office rent, salary of staff (24x7), stationary, 2 outgoing telephones for compliance of 102 & for reporting to Headquarter)	Rs. 41,000.00 x 6 units = Rs, 246000.00 x 12 months =Rs. 29,52,000.00 + Per Control Room Rs. 15,000.00 pm x 6 = 90,000.00 x 12 months	**40,32,000.00**
Total		**40,32,000.00**

4.2. Doctor on Call & *Samadhan*: Dial 1911

A scheme is operational in the state wherein patients can dial a number and call for doctors. For this a special toll free number of 1911 has been provided for w.e.f. 01.3.2008. The objective of the scheme is to give medical assistance to the patients at their home at any time as well as act as a Samadhan of Rogi Shikayat.

Doctors and Specialists have been empanelled for this scheme. Pathology labs have also been attached to collect samples for tests from patient's home.

Budget summary of 1911:

Budget Head	**1911 Doctor on Call service**	
Sub-Heads	**@**	**Proposed Budget**
Control room	3,500 per person (Four persons) = 14,000.00 per control room is being paid to the outsourced agency. Rs. 14,000.00 x 6 = Rs. 84,000 x 12 months	1008000.00
Telephone bill	Each control room is being paid telephone bill (i) Doctors conferencing Rs. 1,500.00 x 12 months = 18,000 x 6 control rooms = 1,08,000.00 & (ii) Rogi Jan Shikayat Rs. 2,000.00 x 12 months = 24,000 x 6 control rooms = Rs. 1,44,000.00.	252000.00
Provision of Annual Maintenance of EPBAX	Rs. 10,000.00 per annum x 6 control rooms.	60000.00
Total		**1320000.00**

4.3 Advanced Life Saving Ambulances

SHSB is providing prompt quality pre hospital care to patients, trauma victims, pregnant women, for the purpose of which Emergency Network service is being piloted under PPP in Patna District. The objective is to save lives of Road Traffic Accidents, cardiac emergencies, fire victims and other emergency cases.

Description

There are 5 Advance Life saving Ambulances (Trauma, Critical & Cardiac Care) & 5 Basic Life saving Ambulances which run within Patna Municipal Corporation area and its sub urban areas. Every Ambulance is manned by a Driver, an Emergency Medical Technician and trained Helper to provide basic care during transportation of patients.). For each trip made by the Ambulance to anywhere within the limits of Patna Municipal Corporation and its sub-urban areas, a charge of Rs. 300/- shall be collected by the outsourced agency from the patients. The agency has set up a Control Room in Patna which would operate for 24 hours in a minimum of 3000 sq. ft. area through dedicated toll free three digit telephone numbers (108). The agency has to provide 10 parallel lines with hunting facilities. The Control Room receives emergency calls related to Medical Services and from Police and Fire Fighting Services to cater to Medical Emergencies. The agency provides GIS (Geographic Information System) maps, GPS (Global positioning systems) / AVLT (Automatic Vehicle Location Track) and all the other necessary hardware/software for Computer Telephonic Integration. The agency keeps a record of the contact numbers and location of each of the 10 Ambulances, all Hospitals of city which can provide medical emergency, all the Police Stations, Police Control Room, Police Head-quarters and Fire Services in the city. The agency bears all expenses relating to hire of space, water, electricity charges, furniture, furnishing etc in running the Control Room. The Control Room shall also keep battery / generator backup facility so that services could be provided un-interrupted round the clock.

Support activities- The agency has undertaken the following-listing of Govt and private hospitals which can provide emergency services round the clock. It has undertaken necessary training of hospital personnel to take up Emergency cases. Dissemination of the scheme is being done by the agency itself and the toll free numbers for police, fire, health, education and general public so that this service can be utilized.

The project has been successfully piloted in Patna town which provides timely emergency services and additionally is adding to the goodwill of the Government. It is proposed to upscale the activity to 2 more Divisional HQ towns-namely Purnea and Bhagalpur.

Budget-

Items	*Amount (Cost/month)*
Cost of Emergency service network (annual cost for running 10 ambulances x 3)	989000.00 x 12 x 3= 3,56,04,000.00
Total	**3,56,04,000.00**
IEC of the project, dissemination, monitoring and training	To be met from IEC-Part A

4.4. Referral Transport in Districts

In the districts at health facilities in various levels, Ambulance services are operational through PPP or Government. It is proposed to bring this expenditure under NRHM as this would fall under the ambit of Referral Transport and would also streamline timely payment to private parties, resulting in smooth operation of the project.

The anticipated average Ambulance expenditure per month (be it payment to Private Party or POL on Government operated ambulances) is Rs.15000/- per month per ambulance. The total no. of ambulances under operation at various facilities in the districts is 586.

Budget – Rs.15000 x 12 months x 586 no. = Rs.1054.80 lakhs

5. American Association of Physicians of Indian Origin (AAPIO)

AAPIO survey on Specific Disease :

The Ministry of Overseas Affairs, Govt of India and American Association of Physicians of Indian Origin (AAPIO) signed an MoU at the Pravasi Bharatiya Divas in Jan 2006 to conduct a study on 5 specific diseases. Thereafter a meeting of Core Committee was held in New Delhi in this regard.

As a follow-up to the above activities this project was included in the Annual Plan of NRHM in 2007-08 and a provision of Rs.50 lakhs has been made in the PIP. A sum of Rs.1.56 crore for the project has already been approved. In 2007-08 as per annual plan a sum of Rs.50 lakhs released for the operation of the Project.

This year the State again proposes another installment of Rs.56 lakhs in the 2010-11 State PIP.

6. Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP)

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

Strategy/Project Description

State Health Society Bihar is implementing National Rural Health Mission (NRHM) to carry out necessary architectural correction in the basic health care delivery system. In order to provide quality services to the public, SHSB has sought Public Private Partnership in providing proper Hospital Waste Treatment and Disposal Services, in all Health facilities right from Medical Colleges to the PHCs.

Services to be provided

1. Provide Service of Hospital Waste Treatment and Disposal in all Medical Colleges, District Hospitals, Sub-Divisional Hospitals, Referral Hospitals and PHCs of the State.
2. Install, Operate and maintain appropriate Common Biomedical Waste Treatment facility, as per the Biomedical Waste (Management & Handling) Rules, 1998 and subsequent amendments in it.
3. Provide one day orientation training to all the health service providers.
4. Maintain the above-mentioned arrangement for a period of minimum 10 years. The Common Biomedical Waste Treatment facilities are proposed to be established at various locations across the State

Setting up a Bio-Medical Waste Management System:

1. The state has started a CWTF facility at Indira Gandhi Institute of Medical Sciences, Patna (autonomous institute). The facility has been approached for undertaking waste treatment for all PHCs to DHs in all the eight districts of Patna division.
   Status – Registration of the health facilities with IGIMS and with Bihar State Pollution Control Board being ensured. Anticipated to be fully functional in all the eight districts by March 2009.
2. As per the rules each CWTF should cater to all facilities in 100 Km radius, keeping this in mind, more CWTF are to be operationalised in each of the division except Patna (which already has such a facility).

   To implement the IMEP in a comprehensive systematic manner, Private Parties have been invited through National Open Tender. SHSB has already finalized two agencies for undertaking the BWM project that would set up CBWM Treatment facilities at various locations in the State and cater to all the PHCs to DHs to MCHs in all the Divisions except Patna.

   The agency shall ensure segregation and collection of waste, disinfection, treatment, transportation, handling and disposal of waste both within and outside the healthcare setting; also ensure use of protective devices and safety precautions. The objective being to ensure waste management, waste minimization and infection control.

   Trainings to be provided to health care workers and officers in Infection Management and Environment Plan implementation by the respective agencies. Payment is to be made on a per bed Per day monthly basis to both IGIMS and the Private Agencies.

Status- The project is in the finalization stage, agencies have been finalised and Contract has been approved to be signed with both the agencies. However approval of the Bihar State Pollution Control Board is awaited.

Budget

Activities	Total proposed budget (in Rs.)
Dissemination and Sensitization workshops on IMEP Guidelines at divisional levels	1,00,000/-
Training of in-house staff (ANM, Safai Karmacharis, clinical support staff) on recognizing, segregating and disposing of bio-medical wastes	10,00,000/-
Operationalization of Biomedical Waste Management @ Rs. 0.08 lacs pm per PHC (533), Rs. 0.12 lacs per Referral Hospital and SDH (113) and Rs. 0.30 lacs per DH (36) and Rs 0.45 lacs pm per Medical College (6)	9,36,16,000/-
Total (Budgeted in Part-A)	

Work plan

Activities	2010-11			
	Q1	Q2	Q3	Q4
Dissemination and Sensitization workshops on IMEP Guidelines at divisional level				
Training of in-house staff (ANM, Safai Karmacharis, clinical support staff) on recognizing, segregating and disposing of bio-medical wastes				

Sno.	Deliverables	Time Period
1	Setting up the required infrastructure along with acquisition of land and acquiring necessary clearances from the respective Governmental and/or Municipal Departments and PCB/ boards	Within 8 months of signing the contract
2	Conducting sessions to orient and train health professionals across the public and private hospitals in the district	Within 270 days of contract signing
3	Initiation and commissioning of Biomedical waste management, disposal and treatment services, as per agreed protocols	Within 270 days of signing the contract

7. Dialysis Units in various Government Hospitals of Bihar

It is proposed to set up & Operationalise Dialysis Units through Public Private Partnership (PPP) in District Hospitals of Bihar. This would require operation, maintenance and reporting 24-hours 7 days a week Dialysis units in Hospitals.

The State Government shall provide vacant space in the premises of the Hospital itself with additional space for washing and RO plant installation (incase it is not in-built). The space provided shall be approx. 750-1000 sq.ft. including RO plant. The agency has to provide everything from equipments & machine, logistics, consumables etc to suitable medical personnel to man these units. The agency has to also ensure the installation, maintenance, functioning with provision of technical manpower round the clock. No rates shall be charged from the patients.

Tender bids have already been floated for the same and M/s Apollo Hospitals, Chennai have been finalized for undertaking the task. Government/SHSB shall pay a monthly rental to the agency, based on the monthly cost as projected by them in the financial bid.
Status – Negotiations are on with M/s Apollo on the costing for the Dialysis unit and contract terms are being finalised

It is proposed to undertake the project on a pilot basis for 3 DHs initially and based on performance further upscaling can be done in the next FY.

Budget

Activities	Total proposed budget
Project cost for one Dialysis unit with 8 Dialysis machines (covering suitable manpower, power, diesel, water, general medical indent & consumables, CMC, RO membrane changing, resin changing, pre-filter changing, activated carbon filter changing, sedimentation filter changing, insurance of equipments, building maintenance, administrative expense, contingency, depreciation on equipments etc)	Rs.50.00 lacs x 1 year x 3 units= Rs.1.50 Crores (The previously approved Rs.3.00 is available with the State which may be ratified for expenditure in 2009-10)

8. Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar

Ultra-Modern Diagnostic Centres through Public Private Partnership (PPP)' in 9 Regional Diagnostic Centres (RDCs) and 6 Medical College Hospitals (MCHs) of Bihar have been or are in the process of being set up.

M/s Softline, New Delhi and M/s Doyen Diagnostics, Kolkata are the private partners in these initiative which caters to high profile districts of the State.

Project Area –Regional Diagnostic Centers in Ara, Gaya, Bhagalpur, Munger, Muzaffarpur, Motihari, Purnea, Saharsa and Chapra. Government Medical College Hospitals – PMCH, NMCH, SKMCH, DMCH, ANMMCH, JLMNCH

Project Scope– To operate, maintain and report 24-hours 'Ultra-Modern Diagnostic Centers' in RDCs & MCHs and report the progress to the RDDs (who would be in-charge of monitoring the RDCs project) and the Superintendents (who would be in-charge of monitoring the MCH project) and the SHSB.

Project Condition -

- The State Government has created the buildings for Regional Diagnostic Centers at all the towns mentioned in Project Area. In the case of MCHs, space is provided in the premises of the MCH itself.
- The agency provides everything from equipments & machine, logistics, consumables etc to personnel; the said RDC/MCH provides space for the Diagnostic Centre along with space for storage at a nominal monthly rent payable to the DHS of the concerned district (in the case of RDC) and the Rogi Kalyan Samiti of the concerned MCH (in the case of MCH) by the agency.
- Rates (charged from the users) is as per AIIMS, New Delhi for the basic, standard and other specialized tests under each Diagnostic head.
- The project is on a revenue sharing model

The project is for ten (10) years depending upon performance further extension will be considered.
Facilities that are being provided in RDCs and MCHs are→ Pathology- Bio-Chemistry, Radiology – Digital x-ray, CT scan, MRI, ECG, Mammography.
GOI had approved an allocation of Rs.3.60 cr in the SPIP 2009-10 for reimbursement through RKS to BPL patients.

The state again requires budget in this regard only for reimbursement to the Private Parties by the RKS of the concerned hospital for providing free services to BPL patients. All the remaining cost for setting up centers will be borne by the private providers.

Budget

Activities	Total proposed budget
Reimbursement cost to the Private Parties by the RKS of the concerned hospital for providing free services to BPL patients	Rs.200 x 1000 BPL patients x 12 months x 15 units= Rs.3.60 Crores

9. Outsourcing of Pathology and Radiology Services from PHCs to DHs

Under this scheme Pathology and Radiology services have been outsourced to different Private agencies. The agencies have and/or are in the process of setting up centers/diagnostic labs/collection centers at the hospitals/facilities.

The state has taken a policy decision to provide free service under this to all Government patients and the reimbursement to the agency as per the fixed rates of SHSB and is reimbursed to RKS. The state has provided space at the hospitals to the agency for running the Pathology and Diagnostic Centre.

However under the project service expansion has been done and Ultrasound facility is also being provided at various locations at DHs and SDHs. For this purpose of establishment of Central Reporting System (CRS) for X-ray and Ultrasound Units is being done at IGIMS, Patna. The purpose being CR system will connect all the Ultrasound and X-ray centers of IGEMS set up in Government Hospitals under this contract, with Tele-radiology in a phased manner.

The Agency has provided all necessary hardware, software and manpower for establishing the network between IGIMS and each of its Radiology unit having X-Ray and Ultrasound facilities for running the Tele-Radiology service.

SHSB has to provide radiologist (preferably retired persons) to report on the ultrasound and x-ray images, telephone line with broad band connection and necessary power connections. All the remaining cost for setting up centers and providing services is being borne by the private providers.

GOI had approved an amount of Rs.26.00 cr in previous PIP for reimbursement to Government patients availing this facility.

Budget

Activities	Total proposed budget
Reimbursement fee to private partners for providing free diagnostic services to patients (through RKS)	50,00,00,000
Telephone line with broad band connection and necessary power connections	Rs.1,00,000 x 12 months =12,00,000
Sourcing of private radiologists to report on the ultrasound and x-ray images through the CRS at IGIMS incase of non-availability of Government radiologists @Rs.25000 per month for 6 radiologists	25000 x 6 x 12= 18,00,000
Total	**50,30,00,000/-**

10. Operationalising Mobile Medical Unit

SHS, Bihar on behalf of the Department of Health, Government of Bihar invited Private Service Providers for providing Mobile Medical Units (each unit fitted with GPS- Global Positioning System) to provide primary health care facilities in the hard to reach rural areas of various districts of Bihar.

Three agencies have been awarded the contract for operationalising mobile medical units in all the districts.

Scope of Work

Private Service Providers for providing mobile health care services in rural Bihar of curative, preventive and rehabilitative nature, to be provided by the service provider along with all deliverables like Mobile Clinic (each unit fitted with GPS- Global Positioning System), professional manpower, and other such services, to provide and supplement primary health care services for the far flung areas in the various districts of Bihar and to provide a visible face for the Mission.

Project Objective

To provide and supplement regular, accessible and quality primary health care services for the farthest areas in the districts of Bihar and to provide visible face for the mission and the Government, also establishing the concept of Healthy Living among the rural mass

Project Scope

The detailed roles and responsibilities of the private partners to meet the aforesaid objectives are as follows:

- Providing the requisite vehicle and equipments and software for Operationalization of the MMU.
- Install, Operate and maintain appropriate GPS facility.
- Technical manpower support to run the MMU and provide the services
- Continued technical back up for maintenance of the system.
- Ensuring Quality Standards
- Providing detailed reports and maintain database of information of MMU services as per the Proformas provided at the time of signing of the contract, or as issued by the SHS from time to time.

Vehicle Type for MMU

- Brand new GPS fitted, fully Air Conditioned TATA 709 chasis or equivalent vehicle of similar dimension from reputed manufacturers for MMU
- An accompanying vehicle of TATA Sumo or Mahindra Bolero or equivalent specification make vehicle for Carriage of Medical persons and also to be used as ambulance for transporting patients in case of emergency. The body of vehicle should be suitably modified to serve this dual purpose.
- Mobile Van should be designed keeping in mind the following criteria -ease of deployment, female privacy, community acceptance and cost.
- Web enabled MIS has to be ensured along with a Control room at Patna or Commissioner HQ.
- Temporary shed facility shall have to be ensured at the site for the patients in waiting.

Manpower

The manpower to be employed for the program is to be appointed by the Private agency as such-1 Doctor, 1 Nurse, 1 Pharmacist (van supervisor),1 OT assistant , 1 X-ray technician, 1 ANM , 1 Driver (Qualification requirements annexed)

Equipments being provided in the MMU

Medical Equipments -Semi Auto-Analyzer, Portable X ray unit, Portable ECG, Microscope, Screen, Stretcher, O.T Table with standard accessories, Stools, Dressing Trolley/Instrument trolley, Dressing drums, Oxygen Cylinder, Suction Machine., Ophthalmoscope, Refraction set, Horoscope, Mobile light or Ceiling light (OT Light),Centrifugal Machine, Hemoglobin meter, Glucometer, Autoclave, Incubator, Urine Analyzer, Vaccine carrier, Weighing machines-adult and infant, Stethoscope, BP Instrument, Kits like Suture removal kit, Pregnancy test kit, IUD insertion kit, Starter, Regent kit, HIV testing kit, General Instrument kit, First Aid kit, various, tests and surgery kits, Normal Ambulance appliances or accessories like foldable furniture, waste basket, linen, mattress, mackintosh sheets, fire extinguisher etc

Silent DG set, Audio-Visual Equipment with projection system for IEC especially with, 40" LCD, P&A System, Cell phone

Service Areas

The Medical areas which would be handled include:

1. Free General OPD/ Doctor Consult
2. Free Drugs - Free dispensation and procurement of medicines as per the Essential Drug List prescribed by GoB for PHCs (Annexed) has to be ensured by the private agency
3. Emergency Services during epidemics and Disasters
4. Network and referral between PHC/CHC/Private clinics
5. Generating health indicators and monitoring behavioral changes
6. Gynec clinic
7. Antenatal Clinics
8. Post Natal Care
9. Infants and Child Care including immunization with Vitamin A supplementation (support for the same to be provided by the Government)
10. Diagnosis, Referral and Rehabilitation for Non-communicable diseases eg. Cardiac Diseases, Hypertension, Diabetes, etc

11. Adolescent and Reproductive Health
12. Other Services like Treatment of Minor Injuries and Burns, Aseptic Dressing, TT immunization, Treatment of Minor burns, Minor Suturing and removal – referral etc
13. Minor lab investigations
14. Eye examination
15. ENT examination
16. HIV testing
17. Promotion of contraceptive services including IUD insertion.
18. Prophylaxis and treatment of Anemia with IFA Tablets.
19. IEC and counseling along with preventive health screening and health awareness programs
20. Service related to different public health programmes.
21. Pathological services.
22. Radiology Services – X-ray and Ultra-sound
23. Preventive Health Screening and Health awareness programs
24. Medical camps will have to be conducted whenever emergency need be

Commissioning Period- 2 months from the date of contract signing.

Budget

Activities	Total proposed budget (in Rs.)
Projected cost for 1 MMU project at district level	Rs.4.68 lakhs x38 units x 12 months =21,34,08,000/-
Projected cost for 1 MMU for MahaDalit Tolas of the State (on a pilot basis)	Rs.4.68 lakhs x 10 units x 12 =5,61,60,000
Total	**26,95,68,000/-**

11. Monitoring and Evaluation

Data Centre at State Level, Divisional Level, District Level and Block Level

Item No. 1: State Data Centre

The State has One Data Centre which collects data from all PHCs, Sadar Hospitals ,Sub. Div. Hospitals and Medical Colleges and Hospitals of all 38 districts on monthly basis through Fax / E-mail. The collected data are stored and maintained in a computerised format and they are sent to respective programme officers according to their requirements. The collected data includes all the parameters required under RCH/NRHM for monitoring. The State Data Centre will also be involved in Monitoring and Evaluation through HMIS .The main activities of Data Centre in HMIS are-1 collecting, the MIS reports and FMR from those district/Block which are unable to upload reports The Data Centres has the following facilities:-

(1) Supervisor- 1 (One)
(2) Computer Operators- 4 (Four)
(3 Computers with UPS - 5 (Five)
(4) Laser Printers with Fax & Photo Copy Facility - 1 (One)
(5) Fax Machine with Auto Sending & Receiving Facility - 1 (One)

(6) Telephone connection (with Broadband connection) - 4 (Four)
(7) EPABX-Telephone Network System
(8) All necesary furnitures - As Required

Estimated Budget

50,000 X 12= Rs. 600000/- (Rupees Six Lakh) only

Item No. 2: District Data Centre

The Data Centres at each and every hospitals (PHC, Sadar Hospital, Sub-Divisional Hospital etc.) are being establised through outsourcing. The main purpose of these Data Centres of Hospitals is to gather and maintain health related data under RCH/NRHM programme in their computer system and they upload the gathered health related data on the web-server of SHSB on daily basis. The Data Centres also enter and upload the monthly MIS reports and FMR in revised HMIS formats on Web-Portals of NRHM and NHSRC. The Data Centres contains one computer with UPS, Laser printer, Phone connection, Internet connection, Computer operator, Misc. etc.
The GPRS enabled mobile set has been given to each and every data centres. The total no. of Data Centres is to be established is 685 and the estimated cost is Rs. 7500/- per Data Centre per month. So, fund requires for the District Data Centre as a recurring cost and put under State PIP- 2009-10 as follows:

- ✓ Primary Health Centre (PHC): 533
- ✓ Sub-Divisional Hospital (SCH): 44 (23+21 (proposed))
- ✓ District Hospital: 37 (25+12 (proposed))
- ✓ RDD: 09
- ✓ District Health Society: 38
- ✓ Medical Colleges & Hospitals: 24 (6 x 4)

Total Data Centre: **685**

Hence the Total Fund needed for 2009-10 **= Rs. 7500/- x 12 x 685 = Rs. 61650000/-**
(Rupees Six Crore Sixteen Lac Fifty Thousand only)

Item No. 3: Divisional Data Centre

Data Centre may be established at all 9 Divisional District Headquarter for entry ,confirmation , uploading of data from districts of the particular division and also giving feedback reports to all their concerned districts which helps in effective Monitoring & Evaluation of Health related activities under NRHM. Therefore fund may be made available for establishing Data Centre at all 9 Divisional district Headquarters in SPIP 2010-2011. The Data Centres has the following facilities:-

(1) Supervisor- 1 (One)
(2) Computer Operators- 4 (Four)
(3 Computers with UPS - 5 (Five)
(4) Laser Printers with Fax & Photo Copy Facility - 1 (One)
(5) Fax Machine with Auto Sending & Receiving Facility - 1 (One)
(6) Telephone connection (with Broadband connection) - 4 (Four)
(7) EPABX-Telephone Network System
(8) All necesary furnitures - As Required

Estimated Budget=
Rs. 50,000 X 12 X 9= Rs. 54,00, 000/= (Rupees Fifty four lacs) Only

Summary Sheet (Monitoring and Evaluation)

SN	Activities	Cost
1.	State Data Centre	6,00,000/-
2.	District Data Centre	61650000/-
3.	Divisional Data Centre	54,00,000/-
4	Other expenses (Traveling & Monitoring purpose etc.)	5,00,000/-
	Total	**6,81,50,000/-**

12. Generic Drug Shop

Under the PPP initiative Generic Drug Stores shall be set up at all MCHs, DHs and PHCs. The Private agency has to keep 188 types of drugs at the store. The state has provided only space for this purpose to the agency and the agency shares a % revenue share with the Government. The state has also fixed rates for the Generic Drug as per MRP.
No additional cost is involved.

13. Hospital Maintenance

The state has outsourced the cleanliness and maintenance of Hospitals to private agencies.
The activities include -

- Maintenance of Hospital Premises @Rs.15000 per facility per month
- Generator Facility @Rs.10,000 per facility per month
- Washing- Rs.5000 per month per facility

The amount required for this purpose was earlier borne by the state government. In FY 2010-11 it is proposed to be done from NRHM as timely payment to the Private partner is becoming a regular issue with the district. Furthermore better monitoring of the programme can be ensured through SHSB/DHS.

Budget –

	@ Rs.	**Total No. of facility**	**Months**	**Amounts**	
Maintenance of Hospital	15000	651	12	117180000	
Generator Facility	10000	651	12	78120000	
Washing	5000	651	12	39060000	
			Total Amount Rs.	**234360000**	**23.436 Cr.**

14. Provision for HR Consultancy services

SHSB has invited offers from Human Resource Consultancy Services for assisting State Health Society in selection and recruitment of doctors, nurses, paramedical staffs and other managerial and clerical staff under guidance and direction of State Health Society, Bihar.

Responsibilities of the Human Resources Consultant: The Consultant will be required to prepare panel of names for selection for the post as per reservation roster. Applications would be invited through open advertisements. Selection process may include open written test or interview or marks obtained or combination of these processes in the qualifying examination depending upon the no. of applicants and urgency. The mode of selection to be adopted will be the sole discretion of the State Health Society.

To achieve this objective, Human Resources Consultant shall be responsible for the following services:-

- Will have to set up an office for this purpose.
- Will be providing all office equipments and professional manpower for this purpose. SHSB shall provide only space.
- All works like processing, data entry, scrutiny, selection, panel formation as per reservation roaster and recruitment etc.
- Any other task related to Human Resources Consultancy Services prescribed by the authority.

Budget – Rs.22,50,000/- per year

15. Strengthening of Cold Chain

Effective cold chain maintenance is the key to ensuring proper availability and potency of vaccines at all levels. However the recently concluded Vaccine Management assessment (VMAT) in Bihar in 2008 and the National Cold chain assessment (July 2008) observed several deficiencies in cold chain storage and management in Bihar.

With a steadily increasing immunization coverage for Routine Immunization, rise in demand for Immunization services throughout the state, the consumption of large quantities of vaccines in frequent Supplementary Immunization activities and the possibility of introduction of newer vaccines in the near future, it is necessary that the capacity of existing cold chain stores as well as the proper management of immunization related logistics be strengthened on a urgent basis.

For this there is need for refurbishment of existing cold chain stores at all levels, particularly at the level of the larger state, 9 regional and 38 district stores. Often there is lack of storage space in the existing health stores leading to dumping of critical immunization related logistics like AD syringes, vaccine carriers and cold boxes in the open, exposing them to the vagaries of nature and sometimes leading to their damage. Renovation of existing stores would help in creating more organized dry space for both proper storage of material as well as proper loading, packing and unloading of Immunization related logistics. The state store in particular receives large quantities of materials and a separate ware house is needed to store immunization related logistics. Provision to hire storage space on arrival of large quantities of material should also exist. In all stores across the state there is also a need for proper electrification and wiring to ensure longevity of electrical cold chain equipment and for reducing their frequent breakdown.

The lack of dedicated support manpower for immunization logistics management and for cold chain equipment repair at all levels was observed during the aforesaid cold chain assessments and it was recommended that “At each of these facilities there should be a full time dedicated store manager. Where the load of operations is high (SVS and RVS) the store manager should have adequate support

staff to help him." (VMAT Bihar 2008) The National cold chain assessment also recommended that a there should be a cold chain technician along with a cold chain handler at all district stores and a cold chain handler at all PHCs. Since provision of regular staff in these positions is not possible it is envisaged that contractual persons be hired for these activities.

Budget

9.1 Infrastructure Strengthening for Cold Chain		
Items	**Units**	**Amount**
Refurbishment and integration of existing Warehouse facilities for R.I. as well as provision for hiring external storage space for (during Immunization Campaigns) Logistics at State HQ @Rs 15,00,000/-	1	1500000
Cold Chain handlers@Rs.12000	38	54,72,000
Refurbishment of existing Cold chain room for district stores in all districts with proper electrification,Earthing for electrical cold chain equipment and shelves and dry space for non elecrtical cold chain equipment and logistics @Rs 7 Lakhs per district	38	26600000
Earthing and wiring of existing Cold chain rooms in all PHCs @Rs 10000/- per PHC	533	5330000
Total	**572**	**3,89,02,000**

16. Mainstreaming of AYUSH under NRHM

Introduction

Recognizing the importance of Health in the process of economic and social development and for improving the quality of life of the citizens, the government of India launched the "National Rural Health Mission" for improving the availability of and access to quality heath care by people, especially for those residing in rural areas, the poor women and children and to adopt a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. One of the important aims of ***NRHM is to revitalize local health tradition and mainstream AYUSH (including manpower and drugs).***

Mainstreaming of AYUSH under NRHM:

Integration of AYUSH system including infrastructure, manpower and AYUSH medicines to strengthen the Public Health care delivery system at all levels and promote AYUSH medicines at grass-root level or village level with different national health programs. The AYUSH personnel work under the same roof of the Public Health Infrastructure. (Guidelines in Annexure 2)

AYUSH Scheme for Hospital & Dispensaries:

- The main objective is to facilitate expansion of health care facilities of AYUSH and building up confidence of the practitioners of these systems while propagating them and establishing their strengths and potentials.
- Another objective of the scheme is to provide facilities of specialized therapies of AYUSH like "Panchkarma", "Kshar-Sutra" of Ayurvda, "Regimental Therapy" of Unani, with Homoeopathy, Naturopathy and Yoga at the modern hospital where the specialized facilities are available so that the citizen have a choice of different systems of treatment under the same roof.

1. Profile of AYUSH in Bihar.

AYUSH is being administered under Directorate - Indian System of Medicine (ISM), of Health Department, Bihar Government. Since the systems of AYUSH are widely practiced in Bihar, an emphasis on them in this state will go a long way in improving the health system.

Current Scenario of AYUSH in Bihar is:

1. State Level:
   - Separate Directorate for Indian System of Medicine with Director (ISM).
   - 3 Deputy Directors: one each for Ayurveda, Unani and Homeopathy.
   - Guidelines are currently being prepared for the Mainstreaming of AYUSH in the state using the ISM infrastructure which will be headed at state level by Director (ISM) and assisted by Program In-charge Officer (AYUSH).
2. District Level:
   - Out of 38 districts in Bihar, in 26 districts there is Joint Hospitals(ISM) with OPD services of Ayurveda, Unani and Homeopath systems.
   - Bihar has 26 District Medical Officers (ISM) at these Joint Hospitals to control the functioning of all government ISM dispensaries in the concerned districts.
   - Guidelines are currently being prepared for the Mainstreaming of AYUSH in all the districts using the ISM infrastructure which will be headed at district level by District Medical Officer (ISM).
3. Total 127 Rural Dispensaries are functional under ISM
   - Ayurvedic: 69
   - Unani: 30
   - Homeopathic: 28
4. 20 AYUSH dispensaries are functional in different sectors (i.e., Welfare Department, Labor Department and Rural Development Department under Government of Bihar)
5. A 10 bedded government Homeopathy hospital is functional in Patna.
6. AYUSH Teaching and Research Facilities:
   - 4 Government Ayurvedic colleges (one out of these has also got PG facility and is in process of being converted to Model College with financial support of Department of AYUSH, GoI)
   - 1 Government Unani College (is in process of being converted to Model College with financial support of AYUSH Department, GoI)
   - 1 Government Homoeopathic College (is in process of being converted to Model College with financial support of AYUSH Department, GoI)
   - 1 Regional Research Institute of Ayurveda is being run by Central Government of India
   - 1 Regional Research Institute of Unani is being run by Central Government of India.
   - 1 State Ayurvedic Unani Pharmacy for manufacturing and supply of Ayurvedic and Unani medicine to Government Ayurvedic and Unani Medical College Hospitals in Patna respectively. In this premise a State level Drug Testing Laboratory is proposed for testing of Ayurvedic and Unani medicine with the financial support of Department of AYUSH, GoI.
7. ISM staff profile:
   - Doctors: 195 Ayurvedic doctors, 90 Unani Doctors and 85 Homeopathic doctors are currently working in the state's Joint Hospitals, Rural dispensaries and co-located additional PHCs under ISM.

- Paramedics and Pharmacists: Approximately 85 Ayurvedic paramedics and pharmacists each, 56 Unani paramedics and pharmacists each and 55 Homeopathic paramedics and pharmacists each are currently working in the state's Joint Hospitals and rural dispensaries under ISM.

2. AYUSH Facilities Co-location

429 Additional Primary Health Centre (APHCs) under health system have been co-located for AYUSH, **before the launch of NRHM**.
The numbers of APHCs co-located under different systems of ISM are:

- Ayurvedic: 215
- Unani: 88
- Homeopathic: 126

No Co-location of the AYUSH facilities has occurred till date in District Hospitals, Sub divisional Hospitals and PHCs.

3. Progress of Implementation of Mainstreaming of AYUSH

Till 2008-09, no PIP was prepared for Mainstreaming of AYUSH in Bihar.

In 2009-10 for the first time AYUSH State PIP is being prepared which includes the AYUSH component added for the first time in the State PIP for NRHM.

4. Utilization Status

As no PIP has been submitted till 2008-09, no fund available under Mainstreaming of AYUSH till 2008-09. Approximately Rs 82 lakh has been received for medicine procurement from Department of AYUSH for 272 Additional PHCs and 127 Rural Dispensaries. This fund has been kept for expenditure in 2009-10.

2009.10 From RHM Rs 39.15 Crores sanctioned, for salaries, IEC& TRAINING. APOINTMENT ISIN PROCESS.

2009-10 FROM AYUSH DEPARTMENT; RS. 25 crorores for 250 APCH infrastrucres @10.00 lacks each. And RS. 11.17 crorors for 471 aphc's medicine supply @ Rs. O.25 lack. Each for Procurement of AYUSH DRUGS, process in progress.

5. Proposal for the year 2010-11

Part A: Proposal for the requirement of funds from NRHM

Part B: Proposal for the requirement of funds from Department of AYUSH

- **Part B (I): for AYUSH Dispensaries and Hospitals**

Part A	Part B (I)	Total
120.876 Crores	**195.35 Crores**	**316.226 Crores**

5. A <u>Co-location</u>: Number of AYUSH facilities to be under taken for co-location (system-wise) separately at District Sadar hospital (DHs), Sub-Divisional Hospital (SDHs), PHCs. (24x7) primary health centers & APHCs. One of the targets for mainstreaming AYUSH in the state is to co-locate each DH, SDH, PHC with one Ayurveda, one Unani, and one Homoeopathy wing in each, and one Naturopathy & Yoga unit in 10 DHs only.

Sr. No	**System**	**DH(2 doctors)**		**SDH (2 doctors)**		**PHC (1 doctor)**		**APHC (1 doctor)**		**Total**		
		Upto-2009-1`0	New for 2010-11	Upto-2009-1`0	New for 2010-11	Upto-2009-1`0	New for 2010-11	Upto-2009-1`0	New for 2010-11	Upto-2009-1`0	New for 2010-11	Cumulated
1	Ayurveda		17		22		266	621	**155**	**621**	**460**	**1081**
2	Unani		8		10		107	249	**63**	**249**	**188**	**437**
3	Homoeopathic		8		10		160	373	**93**	**373**	**271**	**644**
4	Naturopath, yoga		5	-	5	-		-			**10**	**10**
Total			**38**		**47**		**533**	**1243**	**311**	**1243**	**929**	**2172**

5. B <u>Appointments:</u> Number of AYUSH doctors, Pharmacists, Nursing Staff/ MPW, proposed for contractual hiring during 2009-10.

Sr. No.	**Category of staff**	**Recruitment up to-2009-10**	**Recruitment proposed 2010-11**
1	Medical officers	1243	1014
2	Pharmacists	1243	1014
3	Paramedics	1243	1014
5	AYUSH Consultant (training)	01	
6	Program manager PMU ((MBA)		01
7	PMU (Fin.)		01
8	PMU (COMPT)		01
9	(Data OPRATOT)/ASST	01	02
10	Program/ OFFICER Doctor I/C	01	
11	PMU (Attendant)		03

5. C <u>Training</u>: Number of trainings proposed to be imparted to AYUSH Doctors & paramedical staffs on Mainstreaming of AYUSH and National Health Programs at National/ State/ District/Block levels.

5. D <u>Centrally Sponsored Schemes (AYUSH)</u>: Following Centrally Sponsored Schemes proposed for 2009-10.

1. Geriatric Care unit at Govt. Ayurvedic college hospital & Govt. Unani college hospital at Patna.
2. Panch Karma unit at Govt. Ayurvedic hospital and Regimental therapy unit at Govt. Unani college hospital at Patna.
3. Special Care units on mother and child care at 10 bedded Homoeopathy hospitals at Patna.
4. Organize 04 ROTP Program of each Unani, Ayurveda, Homoeopathy at respective Govt. colleges and one ROTP (mixed path, Unani, Ayurveda, Homoeopath And Naturopath & Yoga) for Allopathic and AYUSH Doctors at Directorate level
5. 2 CME and 2 State level seminars at Directorate level at Patna.
6. Established AYUSH library at State Medicinal Plants Board office at Patna.

5. E IEC/BCC: Awareness programs and IEC campaign on strengths of AYUSH and Mainstreaming, Awareness of Allopath Doctors with AYUSH systems, Organization of Health Fair & Health camps, School boys Health checkup, Awareness of Medicinal plants to the school and college level students.

5. F Proposal for reviving LHT: Reviving of Local Health Traditions (LHT) in West Champaran and Bhagalpur planned in 2009-10.

5. G Others:

- Proposal to conduct special project for
  - Prevention of Malaria & Kalaazar in Muzaffarpur and Tirhut Region
  - Eradication of iron deficiency and worm infestation by Unani Medicines in Champaran Region
- Strengthening of AYUSH cell with AYUSH consultant, I/c Doctors & PMU - Contractual recruitment of MBA, Financial Manager, Accountant & Computer Personnel along with one attendant.

Medicinal plants board: A separate action plan is to be prepared and sent in due course.

National campaigns: Department of AYUSH, Ministry of Health and Family Welfare, Government of India has launched National campaigns on various strengths of AYUSH Systems to sensitize all stake holders, i.e. Policy Makers, Program Evaluators, Opinion Makers, AYUSH doctors, Allopathic doctors and other physicians and NGOs regarding the strengths of AYUSH systems. State may also organize these campaigns with financial assistance from Dept. of AYUSH, (MOHFW), and New Delhi.

Budget Proposal for 20010-11

Part –A: Proposal for the requirement of funds from NRHM:

A-1; SALARY OF AYUSH CO-LOCATION HOSPITALS.
No. of ayush doctors and other to be appointed

Sr. No	**System**	**DH(2 doctors)**		**SDH (2 doctors)**		**PHC (1 doctor0**		**APHC (1 doctor)**		**Total**		
		Upto-2009-1`0	New for 2010-11	Upto-2009-1`0	New for 2010-11	Upto-2009-1`0	New for 2010-11	Upto-2009-1`0	New for 2010-11	Upto-2009-1`0	New for 2010-11	**Cumulated**
1	Ayurveda		17		22		266	621	**155**	**621**	**460**	**1081**
2	Unani		8		10		107	249	**63**	**249**	**188**	**437**
3	Homoeopathic		8		10		160	373	**93**	**373**	**271**	**644**
4	Naturopath, yoga		5	-	5	-		-			**10**	**10**
5	AYUSH Specialist doctors		38		47						**85**	**85**
Total			**76**		**94**		**533**	**1243**	**311**	**1243**	**1014**	**2257**

Amount required for ayush personals.

Sr No.	Components	Upto 2009-10	For new 2010-11	Amounts cumulated.
1	**Manpower for Ayurvedic, Unani and Homeopathic dispensaries**	No.	No.	(Rs.in Lacks.)
1.I	Provision of 1 AYUSH doctor on contract @ Rs.30,000/- x 2172 x 12 months	1243	929	7819.20
	Provision of 1 AYUSH specialist doctor on contract @ Rs.40,000/- x 85 SDH,DH x 12months	-	85	408.00
1.II	Salary of Paramedics @ Rs.4000 x 2260 x 12months	1243	1017	1084.80
1.III	Salary of Pharmacists @ Rs.6500 x 2257 x 12 months	1243	1014	1760.60
2	**Training** of AYUSH Doctors & Paramedical staffs w.r.t AYUSH wing		1000	415.00
3	**IEC**			100.00
Grand Total (A)				**11587.60**

A-2; REVITALISATION OF LOCAL HEALTH AND TRADITIO (LHT);

In this program 250 APHC which is co-located and uplifted by AYUSH department are expected to cover at least one VILLAGE of their prep hare to" ***AYUSH GRAM***"
In THIS PROGRAM

a); one village is covered for "***health for all***". Which cover up? Sensation, vaccination, prophylaxis measure for vector bond desieses and all programs of desieses control is adopted with regular heath checkup, child and mother care. Villagers are trained to identify field near by Medicinal plants and their benefits, and cultivation.

b); survey of total Traditional Practioners, and they are trained for NRHM schems AND latter on they will be involed in all health programs as promoter and supporting sttaf on bassis of referral incentives.

Cost of each APHCs; @ 2.00 lacks total cost will be= **2x 250 = 500 lacks**.

Total Part A = 115.876 + 5.00 = 120.876 Crores

This proposed budget for Part – A (120.876 Crore) is required from the AYUSH head in NRHM PIP 20010-11 (in Flexi pool - Part B-Chapter 11)

Part –B: Proposal for the requirement of funds from AYUSH Department:

Part B (I): Requirement of the funds from the AYUSH Department - for AYUSH Dispensaries and Hospitals

1- Procurement of Medicines:

1. a. Procurement of Medicines for Dispensaries;

Sr. No.	Type of Dispensary	Total number 2090-10of units	No. of Units new for 2010-11	No. of Units for which fund is required	Amount (Rs. in Lacks)
1	New Add PHCs. Sanctioned for AYUSH@ 50,000/-	743	1014	1757	875.50
2	Rural Dispensaries@ 50,000/-	127		127	63.50
3	District Joint Hospitals@ 50,000/-	26 x 3	0	78	39.00
4	Upgraded APHCs @ 3.0 lacks	250		250	750.00
Sub Total (1.a)					**1728.00**

2- Infrastructures strengthening of co-located Institutions

Sr. No.	**Components** (one time)	Cost per Unit	Units	Amounts (Rs. In Lacks)
1.1	Building Repair, addition, alteration, partitioning etc Equipments, furniture	APHCs.@ Rs.15.00 L	500	7500.00
1.2		PHC.@ Rs.15 L	300	4500.00
1.3		SDH.@ Rs.25.0L	30	750.00
1.4		DH.@ Rs.30.0 L	35	1050.00
3.1	Medicine & diets	APHCs.@ Rs.3 L	500	1500.00
3.2		PHC.@ Rs.5 L	300	1500.00
3.3		SDH.@ Rs.5 L	30	150.00
3.4		DH.@ Rs.5.0 L	35	175.00
4.1	Lump sum contingency fund for plan period	APHCs.@ Rs.0.3 L	500	150.00
4.2		PHC.@ Rs.0.5 L	300	150.00
4.3		SDH.@ Rs.0.7 L	30	21.00
4.4		DH.@ Rs.0.7 L	35	24.50
Sub. Total (2)				**17470.50**

Total for Infrastructure strengthening of co-located Institutions = **174.705 Crores**

3- Special Schemes for AYUSH.

Sr. No.	Scheme	Number of Units	Rate per Unit (Rs. in Lacks)	Amount (Rs. in Lacks)
1	Specialized AYUSH facility in govt territories medical college hospitals ppp mode (02 ayr.01 unani)	3	95	285.00
2	State level Seminar	4	4	16
Sub. Total (3)				**301.00**

Total for Special Schemes for AYUSH = **3.01 Crores**
(Annexure 6)

4- Other AYUSH Schemes.

Sr. No.	Schemes	Financial (Rs. in Lacks)
1- Proposal to conduct special project: Identified area: Muzaffarpur and Vaishali for Kalazar, Chapra and Siwan for Malaria.		
2.1	Incentive & TA for MOs	4.00
2.3	Medicines Rs.2.0 L x 2 systems	8.00
2.4	Hiring of 4 vehicles for four districts for 6 months @ Rs.0.2 L / month	4.80
2.5	Contingency for period	1.00
2.6	IEC activities	2.20
Sub. Total (4.2)		**20**
2- Strengthen of AYUSH Cell: With AYUSH consultant, I/c Doctors & PMU(Contractual recruitment of MBA, Financial Manager, Accountant & Computer Personnel along with one attendant)		
3.1	One MBA qualified personnel @ 0.25 L / month x12	3.00
3.2	Finance manager @ Rs.0.25 L / month x 12	3.00
3.3	Accountant @ RS. 0.15 L / month x12	1.80
3.4	4-Computer personnel @ 0.065 L / month x12	3.12
3.5	Office Assistant cum PA for I/C doctor @ 0.065 L / month x 12	0.78
3.5	4 Office Attendant cum helper @ 0.045 L / month x 2 x 12	2.16
3.6	Office setup: Furniture for office – Rs. 4 L, 6 desk top with accessories @ 0.5 L, 1 laptop @ 0.5 L, 1 projector @ 1 L & Internet, fax, Xerox, Printer and telephones facility @ Rs. 1.5 L	10.00
3.7	Hiring of two vehicle for monitoring of AYUSH OPDs & other works @ Rs.0.30 x2 x12	7.20
Sub. Total (4.3)		**31.06**

Total for Other Schemes= **0.20 + 0.31 = Rs. 0.3106 Crores**

Total Part B (I): from the Department of AYUSH – for AYUSH Dispensaries and Hospitals includes:

1- **Total** for Procurement of Medicines = **17.28 Crores**
2- Total for Infrastructure strengthening - co-located Institutions =**174.75 Crores**
3- Total for Special Schemes for AYUSH = **3.01 Crores**
4- Total for Other Schemes **= 0.31 Crores**

Total Part B (I) = (1) 17.28 + (2) 174.75 + (3) 3.01 + (4) 0.31 = 195.35Crores

Part A	Part B (I)	Total
120.876 Crores	**195.35 Crores**	**316.226 Crores**

6. <u>Proposed Time frames</u>

a. **Time frame for implementation** of activities is one year - FY 2010-11.
b. The **expected out comes** of the initiatives are:
- Development & effective utilization of AYUSH medicines by the population.
- Availability of accessible, quality and affordable AYUSH services at public health institutions.
- Promotion of preventive & curative treatment facility.
- Availability of qualified AYUSH practitioners, in the public health facilities.
- Availability of AYUSH medicines which are accessible to the rural poor.

17. Procurement and Logistics

17.1 Drug Procurement

The State Government has taken a policy decision to provide Free Essential Drugs right from PHC to MCH. State has it's own EDL for each level of health facility is as such -

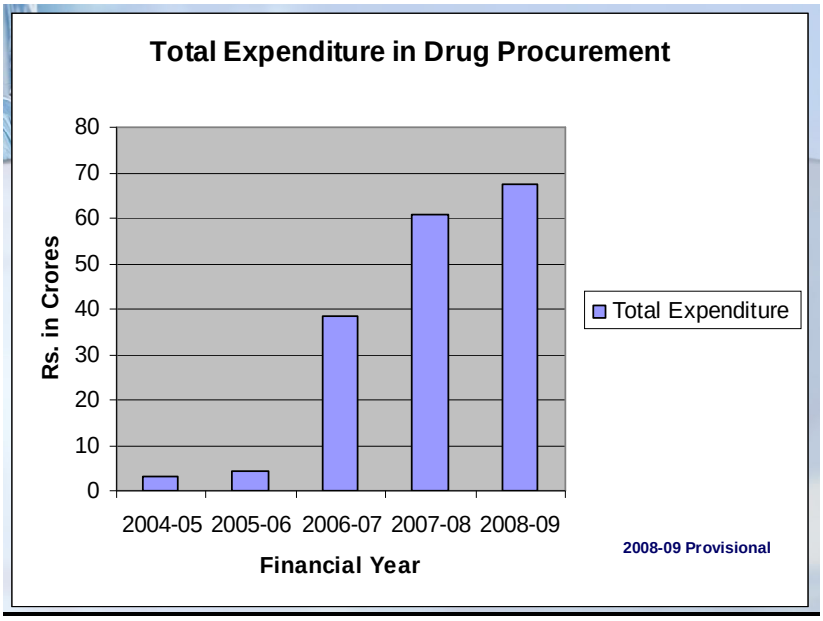
Sl no.	Health Facility	OPD	IPD
1	PHC	41	193
2	District Hospital	41	193
3	Medical College Hospitals	99	172

SHSB undertakes rate contracting of the Drugs-

Year	Drug Tender round	No of drugs
2006	1	38

2006	2	89
2007	3	225
2008	4	46
2009	5	282
2009	6	152 out of 253finalised

The expenditure pattern in State has been as such -



The per capita expenditure on drugs of Bihar is Rs.7/- as compared to Rs. 29/- in Tamil Nadu.

It is proposed to meet the expenditure under Drugs from NRHM as the requirement of drugs has increased due to increase in institutional delivery and OPD patients, it is essential that smooth and timely drug supply is ensured.

Budget Proposed – Rs.100.00 crores (Drug Procurement + District level support manpower at DHS level)

17.2. Controlling Iron Deficiency Anemia in Vulnerable Population in Bihar

Iron-deficiency anemia is the most common form of malnutrition in the world and is the ninth leading cause of disease in children, girls and women in developing countries. According to WHO 2002, estimates, India is one of the countries in the world that has highest prevalence of anemia affecting an estimated 50 per cent of the population, affecting children, women and adolescent girls, and resulting in reduced work productivity, impaired physical capabilities and increased susceptibility to illness.

The Government of India is committed to the cause of controlling anemia and has identified a 25 per cent reduction in this deficiency disease as a National Nutrition Goal (Tenth Five Year Plan). The situation has taken a serious turn as can be seen from the data of NFHS-2 (1998-99) and NFHS-3 (2005-06) as per table below these efforts continue more rigorously in the Eleventh Five Year Plan. (NFHS-3, 2005-06).

Group	NFHS-2	NFHS-3
6-35 months	81%	87%
Ever married women	60.4%	68.3%

Although the National Anemia Control Programme has been in operation for more than two decades, it has not made a marked impact of the prevalence of anemia and the problem continues to prevail. The recent National Health and Family Survey data suggests that the most vulnerable population groups are the women in pregnant and lactating stages, preschool children and adolescent girls.

Anemia in Women:
In women, anemia is an important direct as well as indirect cause of maternal mortality and prenatal mortality. Anemia also results in an increased risk of premature delivery and low birth weights. Latent iron deficiency is known to alter brain iron content and neurotransmitters irreversibly in fetal life and postnatal babies. In Bihar, data from NFHS-3 (2005-06) reveals that 60.2 % of women in pregnancy period are anemic.

Anemia in Adolescents:
Apart from pregnancy and lactating stages, adolescent period (11-18 years) in girls has been recognized as a specific period in the life cycle that requires special attention. Adolescent girls' health plays an important role in determining the health of future population, as it has an intergenerational effect.

As per NFHS-3, the data shows that 66.4 % of adolescent girls in the age of 15-19 years are anemic in Bihar. This is mainly due to menstruation, social factors such as gender discrimination in intra-household food allocation and early marriage leading to early pregnancy. Considering the fact that 25 % of the adolescents in the age group 15-19 years begin early child bearing during this period. Early marriage and pregnancy further aggravates their pre-existing anemia. (NFHS-3, 2005-06).

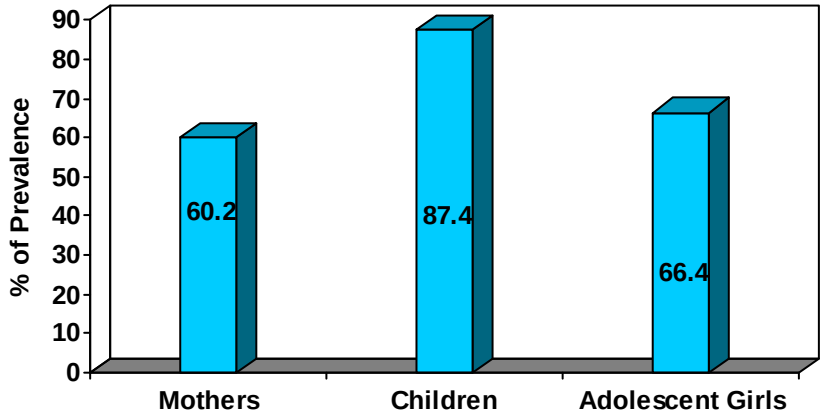
In adolescents, the anemia leads to a fall in academic performance with a drop in memory power and concentration level. It also leads to physical exhaustion and susceptibility to infection, thus increasing the risk of morbidity.

Anemia in Children:
There is adequate evidence to suggest that anemic preschool and school aged children reveal poor cognitive functions which can lead to cumulative deficits in school performance due to impaired attention, lack of concentration and memory. Also, it is found that there is reduced ability to engage in physical activities resulting in lack of stimulus for optimum development of motor skills in this crucial period.

The data on anemia prevalence in children are inadequate; however, they confirm that it is an issue of concern as the NFHS-3 reports that 87.4 % of children 6m-35 m are anemic. While, 66.2 % of children in the older age group of 3-5 years are anemic in Bihar.

In Bihar, which is at the lowest rung of the development and with nutrition-health indicators far from satisfactory, it is not surprising to find that the prevalence considerably high as shown below in Figure 1.

Figure 1: Prevalence of Anemia



Anemia, in its severe form, is known to be an underlying cause of 20.3 per cent of maternal deaths. It is now increasingly recognized that if the problem of anemia in women is to be overcome, it must be addressed across the inter-generational cycle, i.e., beginning from the period of adolescence (UNICEF 1997).

The dietary practices and food habits as influenced by traditions, availability and family income also prevent the use of foods rich in iron to be included in the diet on daily basis.

Therefore, it is extremely important that oral supplementation of iron tablets or syrup be administered to these vulnerable groups. As per the revised policy vide letter dated 23rd April 2007 from MOHFW,GOI, the supplementation under the national prophylaxis program for prevention and control of anemia, it is recommended that adolescent girls will be given due priority. Recommended dosage is defined as under:

Beneficiaries	Dose	Duration
Women: Pregnant/Lactating	1 tablet of 100 mg/day	100 tablets in the 2nd and last trimester and 100 tablets postpartum
Children 6-24 months	1 tsf of IFA syrup (20 mg)/day	100 doses in a year
Children 2-5 years of age	1 tsf of IFA syrup (1ml=20 mg)/day Or 1 tablet of 20 mg/day	100 doses/tablets in a year
Adolescent Girls	1 tablet of 100 mg/week	52 Tablets in a year

In the present PIP cycle (2010-11) State Health Society, Bihar under National Anemia Control program apart from continuing efforts of IFA supplementation to pregnant women and Lactating mothers proposes to implement the recommendations in the revised policy for preschool children (Infant and Young children) and adolescent girls.

Modus operandi:

Pregnant and Lactating women: Essential Antenatal and post natal care services under maternal health and 'Janani Suraksha Yojna' will be the major center of anemia control program activities for the pregnant women and lactating mothers. "Muskan Ek Abhiyan" –the initiative to improve RI services will be used as forum for extending the IFA distribution to PW and LM using RI micro plans. Village Health and Nutrition day organized in coordination with ICDS department will be utilized as the forums for counseling to PW and LM for increasing compliance, reduce the side effects and drop outs and also providing nutrition education for consumption of Iron rich food and positive effects of regular consumption of IFA on well being of fetus/child and mother during and after delivery. This will be a state wide intervention.

Adolescent girls:
In school Adolescent girls : SHSB will coordinate with HRD (Secondary School) for in school adolescent girls as HRD is implementing School Anemia Control Program in 2669 Secondary Schools (all) covering 585847 adolescent girls of class IX to XII with technical support of UNICEF Bihar since 2005-6 in 16 districts and state wide since 2008-9. SHSB will provide IFA tablets to Secondary Schools to support School Anemia Control Program in all 38 districts. This will be a state wide intervention.
Out of school Adolescent girls: As enrollment of adolescent girls in middle school and high school (IX-XII) is less then 29%, the major challenge is to cover out of school adolescent girls with weekly supplementation of IFA. SHSB will coordinate with ICDS department for registration and distribution of IFA to out of school adolescent girls through Muskan Diwas and Village Health and Nutrition Day (VHND). This will be modeled in 10 districts of the state.
Adolescent girls in Residential Bridge course school: Adolescent girls enrolled in Residential Bridge Course School and Kasturbas Gandh Balika Vidyalaya will be reached out in collaboration with Human Resource Department and Sarva Siksha Abhiyan (SSA) with technical support from UNICEF Bihar. This will be a state wide intervention.

Children 6 months to 5 years (Infant and Young Children) : As per the revised policy, children 6-59 months should receive 100 doses a year of 20 mg Iron and 100 mcg of Folic Acid. The suggested formulation is liquid IFA syrup. However, the present supply allocation through every kit A has IFA in two forms, one is in liquid syrup form 200 such bottles of 100 ml each (one dose of 1 ml) and secondly each kit is also have 6500 pediatric tablets.
Children 6-35 months will receive liquid formulation from ANM during RI day (fixed RI days and outreach sessions). Thus on RI days, all these children (6 months to 3 years) will also be mobilized, including those that are not in need of immunization, and iron syrup will be distributed. Mothers of these eligible children will receive one bottle of IFA syrup from ANM who will also counsel her on dose so that she could continue the supplementation to the child at home. This will be modeled in 10 districts of the state.
Children 3-5 years of age, the supplies in the form of pediatric tablets will be delivered to AWW by the visiting ANM on RI days. The entire quota for moth will be left with AWC and the AWW in turn will ensure that all registered children in this age group consume IFA tablets twice every week following poshahar under her supervision. This will be modeled in 10 districts of the state.

Important activities planned under Anemia control program:

- State and district level coordination committee for joint planning, review, monitoring and regular reporting. District Committee for inter sectoral Coordination under the chairmanship of District Magistrate is already operational in State for School Anemia Control Program.

This will be extended to cover entire vulnerable groups and Civil Surgeon/District RCH officer or ACMO will be nominated as nodal officer for Anemia program for vulnerable group in Bihar.

- Training of field functionaries on counseling: Training of ANM and AWW will be organized for counseling on anemia to increase compliance. All the Head masters and Nodal teachers of Secondary Schools are trained for anemia by Unicef under School Anemia Control Program in 2009.
- Social mobilization for increasing compliance: Social mobilization for increasing awareness and dealing with side effects of IFA will be taken care of as it is done under school anemia control program in all the secondary school by Unicef.
- Logistic management of IFA tablets (large and Pediatric) and IFA syrup procurement and distribution: As per the beneficiary number state will procure and supply the IFA tablets (large and pediatric) and IFA syrup under the Anemia Control Program.
- Printing of IEC and reporting and monitoring formats. IEC/BCC material and reporting and monitoring formats will be adopted from earlier used material for PW and School Anemia Control Program with special need of adolescent girls and Infant and Young children.

The detail budgetary calculation for procurement-

Summary of required Budget in 38 Districts Of Bihar

Sl.No.	Particulars	Amount [in Rupees]
1	Cost of IFA for adolescent girls [Annex 3]	**73760532**
	Total Cost	**73760532**

17.3 District Drug Warehouse

It is proposed to established rationalized and modernized District Drug Warehouses to ensure proper supply chain management system so as to ensure timely availability of quality health products at each public health facility. The upgradation would involve infrastructure upgradation, manpower deployment, training and software management. The existing District Drug Store would be upgraded and rationalization in terms of separate drug stores under for different national programmes would be consolidated under one roof.

SHSB with technical support from B-TAST is planning for the same.

Initially it is proposed to take up Drug Warehouses at the 9 Divisional Headquarters.

A tentative budget as such is being proposed –
Please note earlier under European Commission fund, Districts were provided funds for Setting up District Drug Stores

Additional Amount required -Rs.25,00,000 x 9 units = Rs.2,25,00,000/-

18. Procurement of Supplies

18.1 Provision of Quality Beds

SHSB has finalized the rates and communicated the orders to the districts. Three types of beds to be provided-Fowler Deluxe Beds, Fowler Beds and Semi Fowler Beds
It is estimated that a total of 45204 no. of beds shall be required at various levels.

Budget – Rs.37,42,89,120/- Details annexed.

19. RCH Procurement

19.1 SNCU and NSU Equipments for District Hospital

The State Health Society Bihar rate contracted equipments for SNCUs. 1300 lakhs were approved under this in SPIP 2009-10 alongwith for NSUs. It was planned to establish 26 SNCUs (23 through SHSB and 3 through NIPI), however SHSB took a precautionary decision to stagger procurement of equipments in the SHSB districts. In the 1st phase, 6 districts were initiated wherein orders have already been placed and in the next phase 7 more districts will be taken up. However as per the tender terms supply would commence 6-9 months from date of order, therefore budget is being made for 17 districts, as the supply would spill over in the next financial year. Also of the 533 NSUs, districts have been given orders for about 378 NSUs. For remaining 155 NSUs budget is being provisioned for SPIP 2010-11, with an additional spill-over amount for present NSUs as supply would fall into the next FY.

Schedule No.	Name of Equipment	Rate (Per Unit)	Total Quantity of Equipment per Setup in SNCU	Total Amount per SNCU	Fund Req. for 10 SNCUs
2.1	Bilirubinometer, total bilirubine, capillary based	226,000.00	1	226,000.00	***Rs. 4,04,13,369/-***
4.1	Open care system: radiant warmer, fixed height, with trolley, drawers, O2-bottles	49,900.00	14	698,600.00	
4.2	Oxygen hood, S and M, set of 3 each, including connecting tubes	8,500.00	14	119,000.00	
4.3	Basinet on trolley, neonatal, glass base with mattress, phototherapy under mount & single side blue light phototherapy	36,500.00	5	182,500.00	
5.1	Syringe pump, 10,20,50 ml, single phase	71,520.00	7	500,640.00	
7.1	Oxygen concentrator	41,366.00	7	289,562.00	
3.5	Glucometer	925.60	1	925.60	
	Cost of 100 strips=Rs.1200 =1200x9	10,800.00	therefore, anticipated qty. 30	10,800.00	

			nos. x30 days per unit=900 strips per month		
6.1	Pulse oxymeter, bedside, neonatal	49,890.00	7	349,230.00	
				2,377,257.60	

Total Budget –

SNCU – Rs.4,04,13,369 + NSU – Rs.4,50,00,000/- = **Rs.85413369/-**

20. De-centralised Planning

SHSB has initiated Block and district planning in the previous and current FY. In 2010-11, it is proposed to go further down and start Village Planning. This is because the VHSCs are now being constituted.

This would be a herculean task and a year long exercise. This necessitates that a Planning Cell is constituted at the State level with a Consultant-Planning and Deputy Assistant-Planning, and a District level Consultant specifically dedicated to Planning.

Budget

Head	Unit	Cost
State Health Action Plan	1	5,00,000
Planning Cell (State level)-		
Additional Director-Planning & M&E	1	50000 x12=6,00,000
Consultant-Programme Management	1	30000 x 12 =3,60,000
Asst. - Planning	1	20000 x 12=2,40,000
Computer operator-cum-Steno	1	9000 x12=1,08,000
District Health Action Plan	38	38 x Rs.1,00,000=3800000
District Planning Coordinator	38	38 x Rs.18000 x 12=82,08,000
Block Health Action Plan	533	533xRs.25000=1,33,25,000
Contingency		50000 pa

Total Budget Requirement for Planning – Rs. 2,71,91,000/-

Summary Budget of NRHM Part B

Sl. No.	Budget Head	In Lakhs	%
1	**Decentralization**		
1.11	ASHA Support System at State Level	619.21	
1.12	ASHA Support System at District Level	406.20	
1.13	ASHA Support System at Block Level	1036.15	
1.14	ASHA Support System at Village Level	0.00	
1.15	ASHA Trainings	2904.13	
1.16	ASHA Drug Kit & Replenishment	1651.47	
1.17	Motivation of ASHA	659.82	
1.18	Capacity Building/Academic Support programme	10.00	
1.19	ASHA Divas	1202.46	
	Total ASHA	8489.44	8.98
1.2	Untied Fund for Health Sub Center, Additional Primary Health Center and Primary Health Center	1379.67	
1.21	Village Health and Sanitation Committee	4053.30	
1.22	Rogi Kalyan Samiti	1078.00	
	Total Decentralization	6510.97	6.88
2	**Infrastructure Strengthening**	0.00	
2.1	Construction of HSCs	11587.50	
2.2 A	Construction of PHCs	18205.00	
2.2 B	Construction of residential quarters of 30 old for APHCs for Staff nurses.	900.00	
2.3	Upgradation of PHCs to CHC	4000.00	
2.4	Upgrading District Hospitals and Sub-Divisional Hospital as per IPHS	1500.00	
2.5	Annual Maintenance Grant	859.00	
2.6	Accreditation / ISO : 9000 certification of Health Facilities	300.00	
2.7	Upgradation of Infrastructure of ANM Training Schools	700.22	
	Total Infrastructure Strengthening	**38051.72**	40.23
3	**Contractual Manpower**	0.00	
3.1	Mobile Phone Facility for health personnel	60.51	
3.2	Block Programme Management Unit	3146.83	

3.3	Addl. Manpower for SHSB	86.66	
3.4	Addl. Manpower for NRHM-	0.00	
3.4 A	Hospital Manager in FRU	171.00	
3.4 B	Regional Programme Management Unit (RPMU)	162.00	
	Total Contractual Manpower	**3627.00**	3.83
	PPP Initiatives	0.00	0.00
4	**Referral & Emergency Transport-**		
4.1	Call 102 – Ambulance Service	40.32	0.04
4.2	1911- Doctor on Call & Samadhan	13.20	0.01
4.3	Advanced Life Saving Ambulances (Call 108)	356.04	0.38
4.4	Referral Transport in Districts	1054.80	1.12
5	American Association of Physicians of Indian Origin (AAPIO)	56.00	0.06
6	Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP) (Budgeted in Part-A)	0.00	0.00
7	Dialysis unit in various Government Hospitals of Bihar	150.00	0.16
8	Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar	360.00	0.38
9	Outsourcing of Pathology and Radiology Services from PHCs to DH	5030.00	5.32
10	Operationalising MMU	2695.68	2.85
11	Monitoring and Evaluation (State, District, Block Data Centre)	681.50	0.72
12	Generic Drug Shop	0.00	0.00
13	Hospital Maintenance	2343.60	2.48
14	Provision for HR Consultancy services	22.50	0.02
15	Strengthening of Cold Chain	389.02	0.41
16	Mainstreaming of AYUSH under NRHM	11587.60	12.25
17	Procurement and Logistics	0.00	0.00
17.1	Drug Procurement	10000.00	10.57
17.2	Controlling Iron Deficiency Anemia in Adolescent population	737.61	0.78
17.3	District Drug Warehouse	225.00	0.24
18	Procurement of Supplies	0.00	0.00
18.1	Provision of Quality Beds	1000.00	1.06

19	RCH Equipment/Instrument Procurement	0.00	0.00
19.1	Instrument for ANM In 38 districts (from Untied Fund at HSCs)	0.00	0.00
19.2	Bio metric System (Biometric Machine- Rs. 10000/-, HMS Software Rs. 5000/-, Installation Cost- Rs. 1000/-, Vat @ 1% Rs.- 640/-) = 16640/-	34.20	0.04
19.3	SNCU and NSU Equipments for District Hospital	854.13	0.90
20	De-centralised Planning	271.91	0.29
	Total	**94582.25**	**100.00**

NRHM PART- C

Routine Immunisation 2010-2011

State Implementation Plan for Strengthening Routine Immunization Services

Objective is to attain 100% immunization coverage for all Pregnant Women & children with, all available antigens under UIP

Situation analysis of the State Immunization Program

(The States/UTs should provide a brief write-up covering all the following issues)

1. Current scenario of implementation of immunization program

    a. Implementation status (Manpower/ Cold Chain/ Vaccine & Logistics / Trainings)
    b. District wise coverage levels of all antigens for 2008-09, 2009-10 till Dec'09 (including Hepatitis B & JE wherever applicable).
    c. Reporting and incidence of VPDs for 2009-10 till Dec'09.
    d. Trend of IMR of the State/UT for last 5 years.
    e. Reporting and Response to Outbreaks and AEFIs for, 2009-10 till Dec 09.

2. Supervision and Monitoring (Status of Routine Immunization cell, Review meeting and data analysis and action taken at all levels etc)

3. Status of RIMS implementation for monitoring (details of districts uploading data regularly, issues with other districts and proposed support required)

4. Co-ordination with Partners (ICDS, Public Private Partnerships, Other agencies)

5. Strategies for further improving Routine Immunization

    a. To improve the accessibility of routine immunization services (*reflected by BCG and DPT-1 coverage);* identify the districts with poor access and reasons thereof.
    b. To reduce dropouts (reflected *by DPT3 coverage*); reasons for dropout and specify steps taken for this.
    c. To create community demand for routine immunization*;(write specific steps taken)*
    d. Any other innovation started for strengthening of routine immunization in the state.

6. Additional support required to improve Routine Immunization; for any state specific need please provide a separate write-up on objective, strategy, expected output and budgetary basis for the activities.

7. Component-wise receipt & expenditure of funds received from 2005 onwards (format attached).

8. Infrastructural and manpower requirements that are essential for implementation of UIP but not admissible under Part C (Immunization) may be provisioned under the NRHM/RCH heads. (eg; Refrigerator mechanics, renovation of stores etc.). This should include district level need for godown for vaccines/logistics.

9. IEC plan for strengthening UIP; however the budget for IEC is to be provisioned under RCH.

10. ILRs, DF, Voltage stabilizers

    a. All CFC equipments supplied till 1992 has been replaced with Non CFC equipment. The expansion plan should include replacement of remaining CFC equipments supplied during the period of 93-98
    b. Plan for replacement of all condemned or non service able equipment which is beyond repair.
    c. Expansion: - Need based depending on the setting up of New PHC/ cold chain points
    d. Cold boxes, Vaccine carriers - replacement plan for expansion or replacement of condemned equipment.
    e. Insulated/Non Insulated vaccine van: Plan for supply of insulated vaccine vans against condemned vehicles and expansion plan for supply of vaccine van for newly created district.

11. Status of implementation of Procurement Management Information System (ProMIS)

Routine Immunization in Bihar: achievements in 2009-10 and plans for 2010-2011

The success of the immunization program in Bihar since the onset of NRHM has been remarkable. A combination of strong political will combined with a number of strategic interventions aimed at different aspects of program operations has paid rich dividends with the full immunization coverage in the state steadily progressing from 22.4 %(DLHS-II) in 2004 to 41.4% (DLHS - 3) in 2008.

Program components introduced earlier in 2005-06 such as alternate vaccine delivery mechanisms, auto disable syringes, data flow systems, fixed and outreach sessions, contractual manpower for vaccination, ASHAs for mobilization of beneficiaries and strong partnerships in trainings and monitoring have been further consolidated by a multi pronged program to augment immunization named "Muskan ek Abhiyan" launched in 2007. Muskan has made it evident that a program integrating increasing outreach sessions, establishing close partnerships with the ICDS, identification and tracking of beneficiaries and giving incentives to workers and mobilizers has helped in increasing both access and utilization of immunization services in the State.

In the financial year 2009-2010 a number of interventions have been undertaken in Bihar to further consolidate the gains in coverage and quality of immunization made since 2005. These are being briefly discussed below.

Revision of RI micro plans to increase reach and reduce vaccine wastage.

Micro plans for Routine Immunization were revised throughout the state.

Outreach sessions were planned on Wednesdays and Fridays at all Aganwadi centers, sub centers and additional PHCs and on all working days in PHCs and Government hospitals. To reduce vaccine wastage redundant sessions held at the Health sub center every week was limited to one or two Wednesday's a month and the remaining Wednesdays were used to cover left out areas. In areas of manpower shortage outreach sessions were planned on days other than regular RI days.

The available Polio SIA micro plans were consulted/used to ensure outreach immunization sessions were planned for all groups of habitations. Sessions frequency was planned on basis of injection load.

The micro planning exercise involved mobilizers, vaccinators and managers of the program and a software tool as well as a module was used to ensure uniformity across the state.

The micro planning process was initiated through a state level workshop on 2nd June and was completed in all districts by September 1st when the new micro plan became operational.

Capacity building among health and child care managers and providers:

Trainings were undertaken for various groups of managers and health care providers in Routine immunization as follows.

- **Training of health workers**: with the available funds for health workers in the budget allocation for the financial year 2009-10 it was possible to conduct health workers trainings in 11 districts. Following a day long refresher workshop for 33 trainers of the district, trainings were initiated at district level for contractual health workers. The health workers module of Govt. of India was printed at state level and was closely followed in the trainings. An additional day for hands-on training of contractual ANMs was also organized to enhance their skills in injection techniques and safety.

No of districts	No of batches	No of contractual ANMs trained
11	23	596

Following these trainings further training of untrained contractual ANMs have been planned in the remaining 27 districts in the months Jan-Mar 2010.

- **Training of cold chain handlers:** Following a Vaccine management assessment exercise in Bihar in 2008 a new module was prepared for cold chain handlers. This module focused not only on proper maintenance of cold chain equipment and day to day handling of vaccines and related immunization logistics, but also looked into areas of vaccine stock maintenance, indenting and distribution, emergency measures and proper record keeping. Tools like temperature recording booklets; jobs aids on maintenance of ILR, deep freezer; posters for reading of thermometer and condition of ice-packs were also supplied to PHCs for use by the cold chain handlers. The cold chain trainings were given by the Unicef consultant for cold chain and the district immunization officer. Care was taken to select and train the proper person dealing with cold chain at blocks and district level.

No of districts	No of batches	No of cold chain handlers trained
15	15	324

Trainings have been planned in the remaining 23 districts and are expected to be completed by March 2010.

- **Training of Medical Officers:**
A state level TOT for master trainers has been completed in the month of May /09 at SIHFW with technical support from NPSP/WHO for a group of 30-trainers .A training calendar has been prepared spanning over one year in batches of 20 medical Officer for around 4000 Medical officers in the state including both regular & contractual Doctors.

- **Training of data handlers:** Data needs and systems in health are rapidly evolving and while data handlers have been trained in the HMIS package in all districts and in RIMS software in 14 districts, further training of data handlers within the current financial year is envisaged wherein training on digitization of line lists of beneficiaries for immunization and other services will be undertaken.

- **Training of social mobilization network in Immunization:** Mobilizers for Polio eradication efforts through Unicef were trained in basics of Routine Immunization. Following these trainings mobilizers stationed at block and panchayat levels are expected to help in generating awareness of need for immunization and availability of immunization services in the community. The mobilizers have been trained in the use of flip chart for routine immunization which they are using to address community gatherings and forums. Around 500 community mobilization coordinators (village and panchayat level), 200 block mobilization coordinators (block level) and 50 social mobilization coordinators (district level) have been trained in routine immunization.

- **Training of Health Managers in Immunization:** A training program for all Block Health managers under NRHM was prepared by SIHFW with support of IIM Ahmedabad and Unicef. In this program a half day session was earmarked for training in Immunization for managers and delved in the aspects of micro planning, muskaan incentive calculation and distribution, logistics management and manpower management for a successful block level Routine Immunization program. All of the 401 block level health managers were trained in operational and management aspects of routine immunization through this training.

- **Training of ICDS officers and block officers in Immunization:** A session on Immunization was scheduled during the induction training of new ICDS officers and block level administrative officers. Altogether 6 batches of ICDS officers and 1 batch of administrative officers were trained in the basics of immunization and the role of CDPOs and Administrative officers in the immunization program. Each batch had 40-50 participants.

- **Training of Mamtas trainers in Immunization:** Three batches of trainers for mamtas were trained on Routine Immunization. They are expected to train the mamtas to ensure that BCG and zero doses OPV is administered to all newborns delivered in institutions and orient mothers on the benefits of fully immunizing their newborn children.

- **AEFI Surveillance in the State**

  There has been systematic improvement in the AEFI-surveillance system in the State with formation of the State-AEFI and a district AEFI committee in all 38- Districts across the State. The reporting & investigation of major AEFI has also improved over the year as shown below.

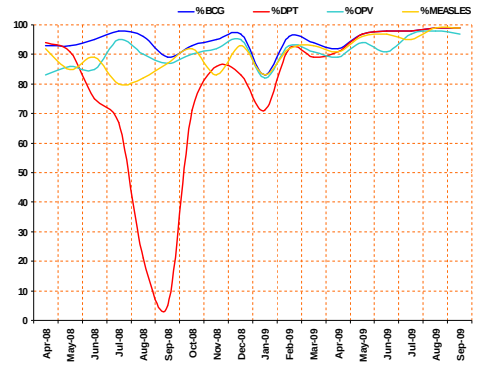
Year	2007	2008	2009
Major AEFIs Reported	3	10	19

  - **New revised Routine-Immunization /Muskan - Monitoring in the State**

Regular and systematic Monitoring of RI-session site is an ongoing process supported by partners like NPSP/WHO & UNICEF in the State. This has been recently revised based on the new-revised session-site & house to house RI-monitoring formats with SOP/Guidlines from GOI .A pilot on this new revised strategy was conducted by NPSP/WHO in the State, in 4-Districts namely, Muzafferpur, Vaishali, Buxar & Bhojpur in April-09 before being finally lunched all the districts of the State in the Month of September-09.

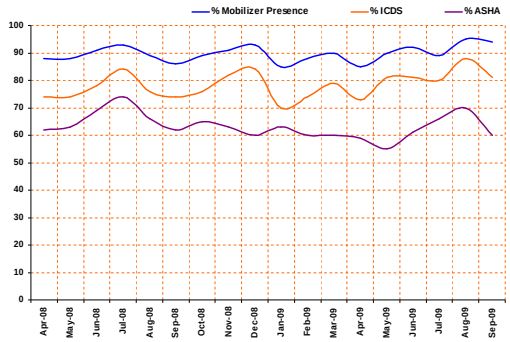
NPSP/WHO has also conducted the training/workshops for the District-Health officials as well as all Blocks/PHC's health functionarie's on the new revised RI-Monitoring Strategy, across the State in every District, so that an effective RI Monitoring System with an efficient feed back mechanism is developed in the State .This revised RI monitoring system in terms of both session-site and House to House Monitoring is definitely helping in improving Routine Immunization Quality , in terms of both service delivery as well as coverage in Bihar, as evidenced in the figures/graphs shown below.

% VACCINE AVAILABILITY AT THE SESSION SITE - BIHAR



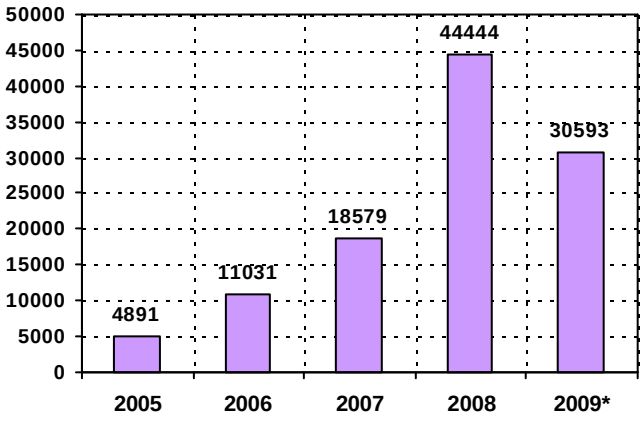
Data Source : Partners Field Units

% MOBILIZER PRESENCE, ICDS & ASHA INVOLVEMENT AT THE SESSION SITES - BIHAR

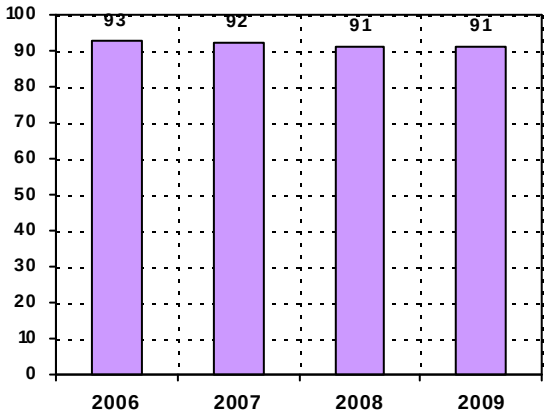


Data Source : Partners Field Units

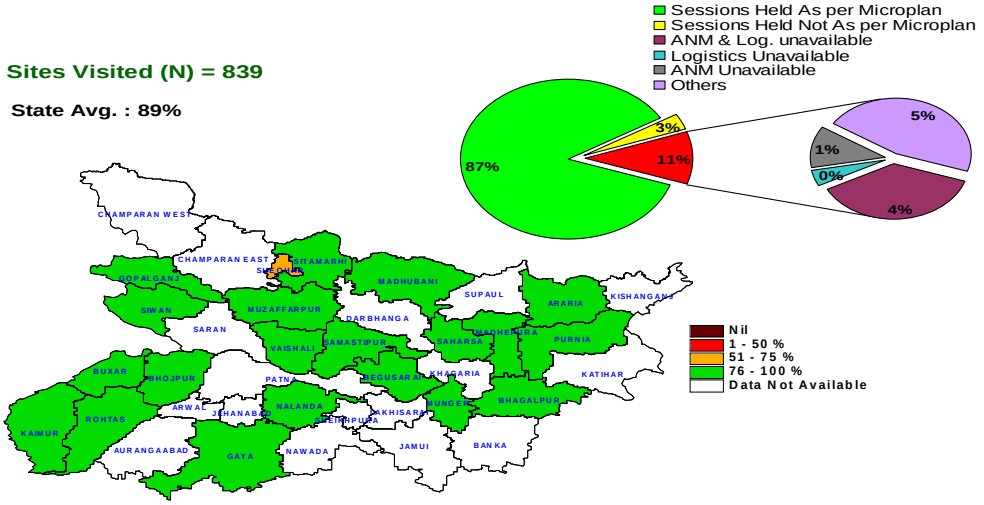
RI-Session sites monitored

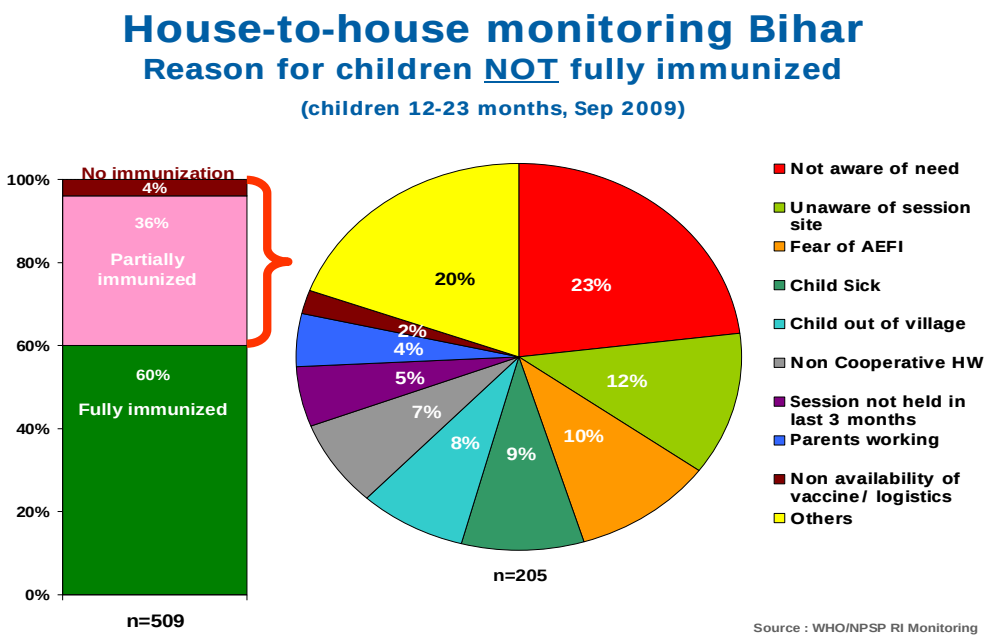


% of RI-sites held as reported



% of RI Sessions Held out of Total Sites Visited - Sep'09





- **VPD & Measles surveillance in the State**

Bihar dose not have a regular VPD/Measles surveillance system in place for the State yet. But Major Measles out-breaks are reported & investigated by the Districts on a case to case basis with technical support form Partners like NPSP/WHO & UNICEF .The State RI-Cell also maintains a line-list of Measles out-break investigation ,based on reports received from the Districts .

Muskaan ek Abhiyaan

Muskaan ek Abhiyaan is a special multipronged strategy to improve immunization services and demand in the state of Bihar and since its launch in Oct 2007, the strategy as well as the implementation of this campaign has been reviewed on a periodic basis. A strategic review of this campaign was undertaken on July 4th 2009 by the stakeholders of Routine immunization in the state in which certain changes were proposed. The new changes have become operational since September 2009.

Muskaan Oct 07 to Aug 09	Muskaan Sept 09 onwards
Immunization sessions to be based in health facilities and Aganwadi centres	Immunization sessions extended to villages and hamlets without any health facility or aganwadi centers
All beneficiaries to be registered and tracked in Muskaan tracking registers	Registration of all beneficiaries and their tracking to continue

Due-lists to be prepared by all mobilizers (ASHA and ICDS workers)	Due list preparations to continue.
Incentives to vaccinators and mobilizers based on percentage of doses administered per ICDS center against target doses in due lists.	Incentives to vaccinators and mobilizers based on number of beneficiaries vaccinated in each session.
Mahila Mandal payments through ANM	Mahila mandal meetings through Village Health and sanitation committees
Verification of achievement by ANM, Medical Officers and ICDS officers	No verification only process of certification by ANM and beneficiaries.

It is expected that the gains made by Muskaan phase 1 such as improved access of vaccination services, improved mobilization of beneficiaries through the use of line list registers and due lists will be consolidated in the second phase; whereas problems such as timely payment of incentive and difficulty in calculating and verifying achievements will be smoothened out.

An evaluation of Muskaan ek Abhiyaan as requested by GoI in its document "Record of proceedings of the NPCC for the PIP approval of Bihar…" is being planned for May/ June 2009. This evaluation will be carried out by the State Health society in consultation with Unicef and CDC Atlanta.

Quarterly review meetings at State, district and Block levels

Two sets of quarterly review meetings have been organized in Bihar using the cascade approach. These meetings had a combination of review of RI activity along with dissemination of thematic guidelines. Modules were prepared for both the series of review meetings to ensure their quality as well as their content. Timelines for district and block orientation meetings were adhered to and their quality and attendance was monitored from the RI cell at State health society on a daily basis. Facilitators from partner agencies also helped ensure quality and timeliness of these review meetings.

Quarter	1st	2nd
Theme of review meetings	Identifying left out areas and micro plan revision	Reviewing Muskaan progress and new Muskaan guidelines

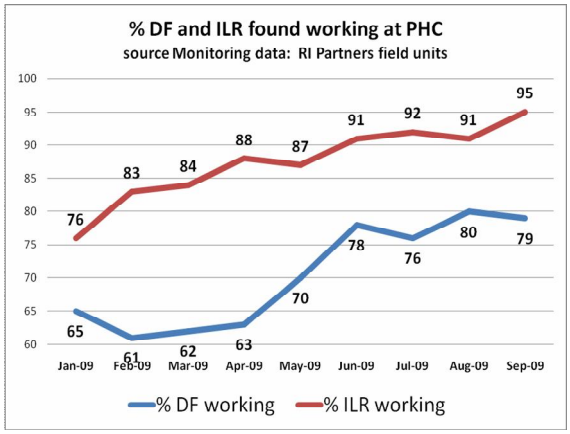
State review meetings	2nd June 2009	21st Sept 2009
Participants	P S Health, SIO, All DIOs, Partner representatives	SIO, All DIOs, Partner representatives
District review meetings	2nd to 24th June	6th Oct to 26th Nov
Participants	DM, CMO, DIO, all MOICs, BHMs, RI Nodal person, CDPOs	DM, CMO, DIO, all MOICs, all BHMs, BAMs, all CDPOs
Number (and % attendance)	1868 (95%)	1538 (78.4%)
Block level meetings	June-August 09	Oct-Nov 09
Participants	All health workers and mobilizers in small batches	All health workers and mobilizers in small batches
Outcome	Revised micro plans prepared in all blocks of all districts	Muskaan implemented as per new guidelines

A similar series of meetings at state and district levels were conducted with the support of NPSP for orientation in the new monitoring strategy. One more series of meetings based on new line listing indicators as proposed by GoI is being planned for Dec-Jan 10.

Cold chain maintenance and AMC:

Deep freezers and ILRs of Haier make as per GoI allocation have been received and installed at most locations in the State. Electrical wiring, earthing has been completed at nearly 60% of all PHC and District HQ and the work is in progress at other locations.

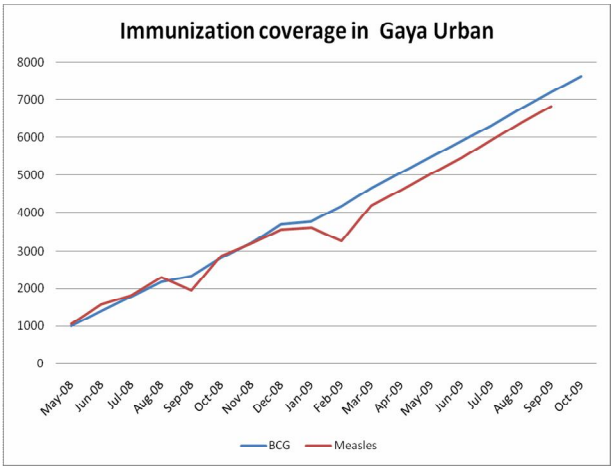
Due to poor performance, the contractor appointed for the AMC for Deep freezer and ILRs in the State during the year was terminated and the funds for repair and maintenance are being released to the Civil Surgeon to directly undertake repairs at their respective Districts. No new contractor could be finalized as there was poor response for undertaking the AMC as per the tender advertisement released during the month of November, 2009. Despite these bottlenecks in AMC the percent functional electrical cold chain equipment steadily arose in the state of Bihar (see graph) as observed during monitoring by partner agencies.

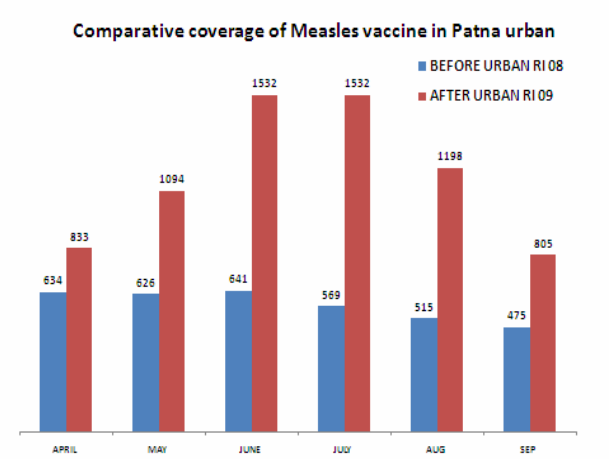


Funds have been released to all Districts who are in the process of getting the cold chain rooms refurbished. One new WIC is being installed (by UNICEF) at Saharsa which will cater to the Kosi region and Khagaria District.

Focus on urban slums and underserved areas.

With the scaling up of ICDS centers in underserved and slum areas in 2007-08 arose the opportunity and need to provide immunization services in these areas. Planned outreach urban vaccination was then initiated in 2008 and 2009 in majority of the 3565 aganwadi centers in the urban areas of Bihar. Coverage in urban areas rapidly increased two-three fold in the larger cities of Bihar (Gaya, Bhagalpur, Patna, Muzaffarpur) while such increments were not so spectacular in smaller urban areas (Hajipur, Khagaria). Further three vaccination campaigns were planned (14th Nov, 14th Dec and 18th Jan) state wide to cover left out and drop out children in urban slums. The emphasis in these campaigns was on increasing awareness and acceptability of vaccination in slums and ensuring services were delivered at the center of the slums rather than the outskirts where the ICDS centers are located.





Slum RI	Planned	Held	TT(1,2,B)	BCG	DPT1	DPT2	DPT3	Measles	Vit A
14th Nov	623	619	1316	1453	1773	1108	848	1972	1201
14th Dec	623	619	1092	1108	1322	1466	952	1230	672

Immunization waste disposal:

While immunization coverage is steadily increasing in the Bihar there is also a growing emphasis on the quality of immunization services. Safe disposal of immunization wastes is a key area where changes have recently been initiated. An assessment undertaken by Unicef revealed lack of safe practices and proper disposal of immunization wastes at all levels and reiterated on establishing habits and setting mechanisms to ensure that CPCB guidelines are closely followed. Funds for procurement of red and black bags, twin buckets, hypochlorite solutions have been given to the districts along with necessary guidelines and some districts have started procuring and using them. Safety pits have been constructed in 451 PHCs (95% of old PHCs for which funds were distributed) but only 4000 hub cutters as supplied by GoI were available for use by the existing 16901 ANMs (24% ANMs with hub cutters supplied).

VPD outbreak and response:

Major Measles outbreak is being investigated as a case to case basis by the district & State team with technical support from NPSP (WHO) and UNICEF i.e. Darbhanga Measles Outbreak Investigation carried out in Jan 2009.

JE vaccination campaign in Gaya district:

J.E. SIA Campaign has been successfully completed over a period of 2-3 weeks, during which monitoring was extensively carried out by the partners i.e. NPSP(WHO) & UNICEF. After complication of JE SIAs, J.E. Immunizations will be incorporated in to the National Immunization Schedule in Gaya district i.e. Muzaffarpur & Champaran-W.

Partnerships in Routine Immunization in Bihar:

A strong partners support in terms of R.I. monitoring led by NPSP(WHO) & UNICEF including partner's cooperation at state , division, district & block level for support in Microplanning, Health workers training, cold chain handlers training, Data handlers training & MO's training etc.

Plans for next financial year 2010-2011:

Strengthening & Improving R.I. monitoring at all levels with timely feedback and follow – up actions through an effective monitoring & supportive supervision is being needed for the State.

Generating demand and improving social mobilization for RI:
IEC at the state, district & block level, supplemented by IPC with the help of link workers i.e. ASHAs & AWWs is very essential along with quality immunization service delivery to the community.

Improving coverage in urban slums and underserved areas:
Special Urban Slum Immunization drive has been initiated and Urban R.I. including mobilization through paid mobilizer is being planned all across the state on different days in different districts.

Quarterly campaigns to reach most inaccessible areas:
Special post flood catch-up campaign for flood affected districts are being suggested especially the Koshi revirine area where villages are flooded one third months of a year.

Improving immunization waste management:
Waste disposable pits for disinfected sharps have been built in many PHCs and hub-cutters along with ADS is being practiced all across the state now, in every Immunization session site. Immunization safety is being taught in all Health Workers training and MO's training. Use of Red & Black plastic bags along with disinfecting twin buckets are being encouraged in the State.

Improving data flow and data for action:
Session based tally sheet reporting is in practice by ANMs/ Health Workers across the state and weekly coverage data compilation report are being sent from district to state in every week based on which state sends a UIP coverage report to National level every month. RIMS is in practice in 14 districts out of which more than 50 % are uploading regularly. HMIS revised formats are being implemented and special training for the same is being planned for the data handlers at all level.

Trainings of Medical officers and mobilizers in RI:
ToT for 30 masters trainers has been completed in May-09 with technical & organization support from NPSP (WHO). A training calendar spanning over one year for more than 4000 MOs in batches of 20 each have been prepared with a priority to high risk Koshi districts in the initial batches. Funds are in the process of being released.

Ensuring second opportunity for MCV :
With the current reported Measles coverage (2009-10) in the state less than 80%, the most appropriate method to improve MCV -2 in Bihar will be a state wide SIA campaign that needs to be planned soon.

A. Basic information of the State/UT related to Immunization

S.No	Beneficiaries	Target		
		2008-09	2009-10	2010-11
1	Pregnant women	3185540	3256578	3270958
2	0 to 1 yr infants	2895946	2960524	2973599
3	1-2 yr	2722190	2782891	2801129
4	2-5 yr	8166570	8348673	8403387
5	5 yr	2722190	2782891	2801129
6	10 yr	2722190	2782891	2801129
7	16 yr	2722190	2782891	2801129

S.No	Routine Immunization Sessions	2008-09	2009-10	2010-11
1	Session planned in Urban Areas			
2	Session planned in Rural Areas			
3	Total Sessions planned	703781	573502	
4	Total Sessions Held	623163	534776	
5	No. of session with hired vaccinators*			
6	No. of hired vaccinators*			

** No of sessions and vaccinators hired in 2008-09, 09-10 and planned in for 2010-11*

S.No	Year	IMR of the State/UT **
1	2004	61
2	2005	61
3	2006	60
4	2007	58
5	2008	56

** As per SRS released by Census.

B. Existing Support to the States

Sl No	Item	Stock (functional) as on 31st Dec'09	Requirement			Remarks
			2009-10	2010-11	2011-12	
1	**Cold Chain Equipments** -					
a)	WIC					
b)	WIF					
c)	ILR					
d)	DF					
e)	Cold Boxes					
f)	Vaccine Carrier					
g)	Ice Pack					
h)	Vaccine Van					
2	**Vaccine stock and requirement (including 25% wastage and 25% buffer)** ** ***In Vials***					
a)	TT		1804746	2197385	2225955	
b)	BCG		2860780	2860780	2860780	
c)	OPV		1209416	1235903	1241128	
d)	DPT*		2418833	2471804	2482254	
e)	Measles		967533	988721	992901	
f)	Hep B					
g)	JE (Routine)		112707	113456	115906	
3	**Syringes including wastage of 10% and 25 % buffer**					
a)	0.1 ml		4001075	4088699	4105984	
b)	0.5 ml		32808825	33527326	33669075	
c)	Reconstitution Syringes		7147934	7235556	7252841	
4	**Hub Cutters**					

**Note: DPT is to be given instead of DT at 5 yrs once the current stock of DT Vaccine is exhausted*

District –wise Coverage reports *(in numbers)*

Sl No	Name of District	Yearly Target (2008-09)		Yearly Target (2009-10)		BCG Coverage(in number)		OPV - Ist Dose Coverage in Numbers		OPV -3rd Dose Coverage (in Numbers)		DPT-1st Dose Coverage(in numbers		DPT-3rd Dose Coverage (in Numbers)	
		Infants	Pregnant Women	Infants	Pregnant Women	2008-09	2009-10	2008-09	2009-10	2008-09	2009-10	2008-09	2009-10	2008-09	2009-10
1	Araria	75317	82849	77893	85682	91753	36552	100570	46925	83482	48885	100508	46925	81861	48904
2	Arwal	24833	27316	23224	25546	12260	9329	15520	9145	14178	9923	13439	9118	13030	10267
3	Aurangabad	70239	77263	72767	80044	47821	31778	53296	32122	50374	38302	47883	32312	46684	38412
4	Banka	56133	61746	56336	61970	52743	30804	42190	26889	39814	28168	39630	29910	37463	32648
5	Begusarai	81973	90170	84470	92917	99419	34083	117415	26661	96942	26788	93281	34254	92712	34005
6	Bhagalpur	84548	93003	86612	95273	56847	38432	60077	38257	55922	39113	54077	38484	50149	38890
7	Bhojpur	78267	86094	78264	86090	56213	36478	54046	34977	44886	33298	51733	33139	43518	33255
8	Buxor	48932	53825	50575	55633	41493	24041	47543	27004	41182	26570	38455	28006	33291	27095
9	Champaran (E)	137465	151212	141955	156151	109534	72157	105899	67854	81664	59371	97911	72523	72969	64312
10	Champaran (W)	106191	116810	110580	121638	79760	67703	81695	54392	67220	55354	65924	69123	53175	49255
11	Darbhanga	114995	126495	119715	131687	92387	60561	89308	60561	73849	57510	81570	59746	67691	58520
12	Gaya	121193	133312	125629	138192	83123	44476	156267	42347	140350	48011	128201	45789	132389	52094
13	Gopalganj	75109	82620	76055	83661	40028	37969	44705	38356	41399	41339	38463	39778	36990	43885
14	Jahanabad	28003	30803	31110	34221	31033	18760	27658	16530	25328	17349	23057	15479	20413	17206
15	Jamui	48806	53687	51555	56710	45464	33799	42405	21660	39712	22953	37797	27980	36140	26444
16	Kaimur	44978	49476	46750	51425	32475	19510	28797	18775	23178	17043	28641	19087	23190	17604
17	Katihar	83483	91831	87101	95811	55425	40065	67045	46558	57943	39960	50681	44329	40532	41856
18	Khagaria	44674	49141	46087	50696	28742	30626	29193	27571	24201	26484	28277	29742	21594	28049
19	Kishanganj	45232	49755	47339	52073	38239	30085	36608	32951	26892	29232	32248	33342	23219	28903
20	Lakhisarai	27991	30790	27961	30757	17915	18844	15941	18323	11836	16552	13087	18573	10624	16308
21	Madhepura	53267	58594	55083	60591	53690	36779	63148	36757	41658	39022	62679	36359	42475	38884
22	Madhubani	124747	137222	126324	138956	110518	64326	100862	60094	90275	65883	97502	60487	88003	68294
23	Munger	39699	43669	38707	42578	31526	21930	33627	19093	24746	17185	27843	18634	24605	17802
24	Muzaffarpur	130729	143802	133003	146303	111090	70283	121357	74388	109001	73262	102669	74535	93666	72164
25	Nalanda	82711	90982	79821	87803	48831	32573	50410	33443	45093	33899	46301	34262	40436	34893
26	Nawada	63143	69457	66823	73505	30135	31513	31943	34722	24551	32530	25609	37633	20229	42075
27	Patna	164639	181103	170913	188004	68640	57658	68899	53125	55987	52158	64696	52700	52636	51709
28	Purnia	88762	97638	95035	104539	74560	57456	79066	62923	67487	65190	70361	63862	59827	66367
29	Rohtas	85510	94061	87524	96276	60402	31986	55130	28439	39828	30861	49790	30559	36598	31186
30	Saharsa	52623	57885	55616	61178	60040	36261	65033	33026	47573	34094	90914	33199	45440	35688
31	Samastipur	118449	130294	120421	132463	84482	40318	91991	40791	74784	44922	85417	54095	71463	56483
32	Saran	113352	124687	115242	126766	64996	64383	67032	70343	56563	74488	61334	70185	57244	73371
33	Sheikhpura	18336	20170	18446	20291	17502	16152	15695	14620	16514	16947	15685	14467	16064	16919
34	Sheohar	18003	19803	19342	21276	11954	9195	10298	8664	7256	7258	10412	13696	7605	13057
35	Sitamarhi	93604	102964	98308	108139	74786	45524	75988	41796	63549	39371	68840	43342	57139	40556
36	Siwan	94708	104179	95043	104547	75930	51753	151625	73994	76171	63720	154755	67657	76170	59874
37	Supaul	60452	66497	63242	69566	42404	42573	44582	35870	38216	38777	44768	37216	36173	39676
38	Vaishali	94850	104335	96146	105761	85081	49113	79129	50057	65240	51843	113353	51128	59363	53656
Total		**2895946**	**3185540**	**2977017**	**3274719**	**2219241**	**1475828**	**2421993**	**1460003**	**1984844**	**1463615**	**2257791**	**1521655**	**1822770**	**1520566**

Upto Nov 2009

Sl No	Name of District	Yearly Target (2008-09)		Yearly Target (2009-10)		Hep B- Birth Dose Coverage		Hep B- 1st Dose Coverage		Hep B- 3rd Dose Coverage(Wherever		Measles Coverage		TT2+ Booster Coverage		JE- routine (Wherever applicable)		Vit A- 1st Dose Coverage	
		Infants	Pregnant Women	Infants	Pregnant Women	2008-09	2009-10	2008-09	2009-10	2008-09	2009-10	2008-09	2009-10	2008-09	2009-10	2008-09	2009-10	2008-09	2009-10
1	Araria	75317	82849	77893	85682							81625	34037	34780	21587			63272	31223
2	Arwal	24833	27316	23224	25546							14371	11348	10707	9263			12183	10542
3	Aurangabad	70239	77263	72767	80044							46057	32529	26768	19315			37527	25677
4	Banka	56133	61746	56336	61970							45716	26480	30158	23195			21626	19383
5	Begusarai	81973	90170	84470	92917							104374	25757	50168	21101			56784	13604
6	Bhagalpur	84548	93003	86612	95273							60899	39319	44033	32028			49432	36128
7	Bhojpur	78267	86094	78264	86090							49115	30573	27989	23388			34416	18452
8	Buxor	48932	53825	50575	55633							39642	19820	25086	18999			28931	25281
9	Champaran (E)	137465	151212	141955	156151							82200	46947	51485	32970			54137	32856
10	Champaran (W)	106191	116810	110580	121638							80223	56714	42252	46299		45061	38120	20744
11	Darbhanga	114995	126495	119715	131687							77145	53887	48762	39446			49850	31767
12	Gaya	121193	133312	125629	138192							142255	44296	36865	32736			56566	35722
13	Gopalganj	75109	82620	76055	83661							42505	36925	28031	28295			36936	32334
14	Jahanabad	28003	30803	31110	34221							26580	14598	17446	19861			16646	12902
15	Jamui	48806	53687	51555	56710							42096	28012	28966	21115			48800	9695
16	Kaimur	44978	49476	46750	51425							29766	16474	27264	17062			20874	7511
17	Katihar	83483	91831	87101	95811							57097	33629	29821	27356			27461	19777
18	Khagaria	44674	49141	46087	50696							24873	27061	13328	24646			10386	12062
19	Kishanganj	45232	49755	47339	52073							26522	22204	21879	17330			18442	18151
20	Lakhisarai	27991	30790	27961	30757							15722	12425	9300	14547			8171	7771
21	Madhepura	53267	58594	55083	60591							78009	38070	19463	29295			64977	29547
22	Madhubani	124747	137222	126324	138956							99167	65312	65613	52005			85635	60789
23	Munger	39699	43669	38707	42578							28732	17772	19240	13103			23091	13330
24	Muzaffarpur	130729	143802	133003	146303							98731	58310	65242	46059		13695	78810	51439
25	Nalanda	82711	90982	79821	87803							42289	31441	27839	25327			25144	16711
26	Nawada	63143	69457	66823	73505							26512	29066	20038	20620			16928	12008
27	Patna	164639	181103	170913	188004							60270	52034	35429	39755			42455	38542
28	Purnia	88762	97638	95035	104539							74014	62056	44243	47213			48370	50295
29	Rohtas	85510	94061	87524	96276							57966	32242	35360	28964			47530	30431
30	Saharsa	52623	57885	55616	61178							75007	30145	27263	25111			61167	20411
31	Samastipur	118449	130294	120421	132463							86000	51090	54282	39815			47299	26966
32	Saran	113352	124687	115242	126766							53990	55364	37524	46201			50762	51369
33	Sheikhpura	18336	20170	18446	20291							15814	16765	10489	14139			12744	11293
34	Sheohar	18003	19803	19342	21276							8641	11588	4376	4901			5714	8482
35	Sitamarhi	93604	102964	98308	108139							65617	38771	36037	30361			39212	21442
36	Siwan	94708	104179	95043	104547							79307	52330	24566	28962			51103	52993
37	Supaul	60452	66497	63242	69566							53367	33274	23666	25161			22253	21973
38	Vaishali	94850	104335	96146	105761							71585	46821	45292	38101			64680	38823
Total		**2895946**	**3185540**	**2977017**	**3274719**							**2163801**	**1335486**	**1201050**	**1045632**		**58756**	**1478434**	**978426**

Routine Immunization Monitoring System Status

RIMS uploded for analysis and programme monitoring

Sl No	Name of District	RIMS Installed	Computer Asst. in Position	April'09	May' 09	June'09	July'09	Aug'09	Sep'09	Oct'09	Nov'09	Dec'09	Remarks
1	Banka	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	
2	Bhagalpur	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	
3	Bhojpur	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	
4	Buxar	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	
5	Champaran West	No	Yes	No	No	No	No	No	No	No	No	No	
6	Darbhanga	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	
7	Gopalganj	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	
8	Kaimur	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	
9	Kishanganj	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	
10	Madhubani	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	
11	Munger	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	
12	Saharsa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	
13	Siwan	No	Yes	No	No	No	No	No	No	No	No	No	
14	Supaul	No	Yes	No	No	No	No	No	No	No	No	No	

Data as on 15 Dec 09.

I. Budgetary Requirement												
Service Delivery: -	Norms*	Expenditure & Achievement						2009-10		2010-11		Remarks
		2005-06#	2006-07#	2007-08#		2008-09# (Dec'08)						
		Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Expenditure# (Figures based on fund allocated to dist. only)	Target	Funds requirement	Target	
Mobility support for supervision Supervisory visits by state and district level officers for monitoring and supervision of RI	@Rs.50,000 per District for district level officers (this includes POL and maintenance) per year	**4448000**	**2780000**	**985000**	No of sessions Supervised **9 divisional reviews**	**4512000**	No of sessions Supervised **38% (out of 45321 session sites monitored)**	3116000	No of sessions Supervised 9024	3648000	No of sessions Supervised 3648	**No DIOs have Govt. vehicles in working condition in Bihar ,therefore hiring cost is being included in mobility support for them @1000/- per day for 8 days a month for 12 months in order to helps them supervise in the field on all RI days.** **Target : All DIOs expected to monitor one session sites & Ten Benefeciaries (One H to H areas), on 8 days in a months for 12 months in a year (1000x(38 DIOs)X8 sessions per month X 12 months)**
	By state level officers @ Rs.100,000 /year				No of districts visited for RI review **9 divisional reviews**		No of districts visited for RI review **5 divisional reviews**		No of districts visited for RI review 38	**100000**	No of districts visited for RI review 38	**Target SIO & C.C.O. etc. to visit 3 districts per month to review & supervise RI in the field.**

I. Budgetary Requirement

Service Delivery: -	Norms*	Expenditure & Achievement						2009-10		2010-11		Remarks
		2005-06#	2006-07#	2007-08#		2008-09# (Dec'08)						
		Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Expenditure# (Figures based on fund allocated to dist. only)	Target	Funds requirement	Target	
Cold Chain maintenance	@ Rs 500 per PHC/CHC per year District Rs 10,000 per year	430737	1506300	2178635	% Funds used	727145	% Funds used	4993498	% Funds used	5770000	% Funds used	Based on earlier AMC rate @ Rs 2000/- per machine per year for 2200 machines (DFs & ILRs). Additionally maintenance of 10 WICs & 3 WIFs would cost Rs 15000/- per year & (38 + 9)=47 vaccine vans @25000/- per van per year
Focus on slum & underserved areas in urban areas:	Hiring an ANM @Rs.300/session for four sessions/month/slum of 10000 population and Rs.200/- per month as contingency per slum of i.e. total expense of Rs. 1400/- per month per slum of 10000 population.				No of sessions with hired vaccinators	1864800	No of sessions with hired vaccinators	65371600	No of sessions with hired vaccinators 17950	68448000	No of sessions with hired vaccinators 3565	Hired Vaccinators for Urban Slums in Urban R.I. A total of 3565 Urban slums will have at least one session a month which will be carried out by hired alternate vaccinators as per the given Norms =3565X1400X12 Paid Mobilizer for Urban Slums in Urban R.I. Additional Honorarium for Urban Mobilizers to mobilize benefeciaries to R.I.Sessions in Urban Slums @Rs.200/- for 3565 slums per month for 12 months. =3565X200X12

I. Budgetary Requirement

Service Delivery: -	Norms*	Expenditure & Achievement						2009-10		2010-11		Remarks
		2005-06#	2006-07#	2007-08#		2008-09# (Dec'08)						
		Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Expenditure# (Figures based on fund allocated to dist. only)	Target	Funds requirement	Target	
Mobilization of children through ASHA/mobilizers	@ Rs 150/session (for all states/UT.s)	**10292400**	**54048750**	**20410200**	No. of sessions with ASHA		No. of sessions with ASHA **64% (Out of 45321 session sites)**	**59199000**	No. of sessions with ASHA **80000**	**192000000**	No. of sessions with ASHA **80000**	**Muskan Incentives money for ASHA Rs 200/- paid as mobilization per session/ per month for one year.)**
Alternative Vaccine Delivery:					No of sessions with AVD		No of sessions with AVD 96%* out of 45321 sessions sites monitored		No of sessions with AVD		No of sessions with AVD	
NE States, Hilly terrains and geographically hard to reach areas eg. Session site>30 kms from vaccine delivery point, river crossing etc.	@ Rs.100 per session							**5400000**	**4500**	**5125200**	**4271**	**Access compromise areas/villages in Bihar including riverine & hilly areas are identified as 4271 as per dist. PIP,where upto one session per month is to be organised. (4271x100x12)**

I. Budgetary Requirement

Service Delivery: -	Norms*	Expenditure & Achievement						2009-10		2010-11		Remarks
		2005-06#	2006-07#	2007-08#		2008-09# (Dec'08)						
		Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Expenditure# (Figures based on fund allocated to dist. only)	Target	Funds requirement	Target	
For RI session in other areas	@ Rs.50 per session.	**15885400**	**53460600**	**52890500**		**55756250**	10636	**84996900**	**17000**	90539000	**17000**	**AVD for Rural R.I.** **Rs 50 X 17000 ANM X 104 days** **AVD for Urban Slums** **Rs 50 X 3565 Slums X 12**
Support for Computer Assistant for RI reporting (with annual increment of 10%)	State @Rs 12,000-15,000 p.m.								**3**	360000	**2**	**Rs.15,000/- X 2 persons X 12mths**
	Districts @ Rs 8000-10,000 p.m			**1140000**	No of C.A. in position **38**	**955000**	No of C.A. in position **19**	**3648000**	No of C.A. in position **38**	**4560000**	No of C.A. in position **38**	**Rs 10,000/- X 38 dist. X 12 mnths**
Printing and dissemination of immunization cards, tally sheets, monitoring forms, etc.	@ Rs 5 per beneficiary					**10177188**		17347710	**3154129**	18010955	**3602191**	**Rs 5/- per beneficiaries total target benef. 3602191 (including 10% buffer stock)**

I. Budgetary Requirement												
Service Delivery: -	Norms*	Expenditure & Achievement						2009-10		2010-11		Remarks
		2005-06#	2006-07#	2007-08#		2008-09# (Dec'08)						
		Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Expenditure# (Figures based on fund allocated to dist. only)	Target	Funds requirement	Target	
Review Meetings					No of meetings held		No of meetings held		No of meetings planned		No of meetings planned	
Support for Quarterly **State level** Review Meetings of district officers	@ Rs 1250/participant/day for 3 persons (CMO/DIO/Dist Cold Chain Officer)						6	**0**	**0**	570000	**4**	**Rs 1250/- x 3 persons x 38 dist x 4 meeting**
Quarterly Review & feedback meeting for exclusive for RI at **district level** with one Block MO.s, ICDS CDPO and other stakeholders	@ Rs 100/- per participant for meeting expenses (lunch, organizational expenses)	**3115000**					**1 meeting per dist. Per month**	1030000	**4**	1066000	**4**	**Rs 100/- x 5 partci. X 533 phcs x 4 meetings**
Quarterly review meeting exclusive for RI at **Block level**	@Rs 50/-pp as honorarium for ASHAs (travel) and Rs 25 per person at the disposal of MO-I/C for meeting expenses(refreshments, stationery and misc. expenses)						**one meeting per block per month (Block coordination committee meetings)**	21474600	**4**	24000000	**4**	**Rs 50 + Rs 25 = 75 x 4 x 80000 ASHAs**

I. Budgetary Requirement												
Service Delivery: -	Norms*	Expenditure & Achievement						2009-10		2010-11		Remarks
		2005-06#	2006-07#	2007-08#		2008-09# (Dec'08)						
		Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Expenditure# (Figures based on fund allocated to dist. only)	Target	Funds requirement	Target	
Trainings					No of persons trained		No of persons trained		No of persons trained		No of persons trained	**19681 HW to be trained in 984 batches in R.I. as per RCH Norms. The last training was undertaken in 2008-09 and retraining is required in 2010-11 (As per training in alternate years policy) Details of district wise Budget Attached**
District level orientation training for 2 days **ANM, Multi Purpose Health Worker (Male), LHV, Health Assistant (Male / Female), Nurse Mid Wives, BEEs & other specialist (as per RCH norms)**	As per revised RCH norms for trainings, copy attached				**6549**		**3929**	**6757800**	**9000 Health workers & 60 trainers**	**30308500**	**19681 Health workers & 114 trainers**	
Three day training of **Medical Officers on RI** using revised MO training module from GoI	As per revised RCH norms, copy attached				No of persons trained		No of persons trained	**11271800**	No of persons trained	**6265000**	No of persons trained **2000**	**Funds available for MOs training at the State Level** **Fund avaiable for MO's training on R.I. in this financial year as approved in the earlier PIP 2009-10 is in the process of being released for the training of around 3000 doctors, in the current training calender.** **Additional Fund required for MO's training (2010-11)** **Remaining 2000 MOs to be trained in 100 batches of 20 each as per the below calculations** **DA for 2000 MOs = Rs 700/- X 2000 X 3** **Honararium to 4 Guest faculty: 4 X Rs 1000/- X 3 days X 100 Batches** **Meals : 2000 Mos X Rs 200/- X 3 days** **Incidental Expenditure: 2000 MOs X Rs 250/- X 3 days** **Venue Hiring: Rs 10000/- X 100 Batches** **Institutional Overhead: 15% of total**

I. Budgetary Requirement

Service Delivery: -	Norms*	Expenditure & Achievement						2009-10		2010-11		Remarks
		2005-06#	2006-07#	2007-08#		2008-09# (Dec'08)						
		Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Expenditure# (Figures based on fund allocated to dist. only)	Target	Funds requirement	Target	
One day refresher training of **District RI Computer Assistants** on RIMS/HMIS and Immunization formats under NRHM	As per revised RCH norms , copy attached						14	**62000**	40	**88400**	40	**40 Computer Assistants to be trained in two batches** **DA for 40 CA for 2 days = Rs 400/- X 40 X 2** **Honararium: 4 Faculty X Rs 1000/- X 2 days** **Meals : 40 CA X Rs 200/- X 2 days** **Incidental Expenditure: 40 CAS X Rs 250/- X 2 days** **Venue Hiring: Rs 10000/- X 2 Batches** **Institutional Overhead: 15% of total**
One day **Cold Chain handlers training** for block level cold chain handlers by State and Distrcit Cold Chain Officers and DIO for a batch of 15-20 trainees and three trainers	As per revised RCH norms, copy attached				No of persons trained **628**		No of persons trained **423**	**696800**	No of persons to be trained **542**	**704825**	No of persons to be trained **542**	**542 Cold Chain Handlers to be trained in 28 batches** **DA for 542 CH for 1 day= Rs 400/- X 542** **Honararium: 3 Faculty X Rs 600 /- X 1 day** **Meals : 542 CH X Rs 200/- X 1 day** **Incidental Expenditure: 542 CH X Rs 250/- X 1 day** **Venue Hiring: Rs 10000/- X 28 Batches** **Institutional Overhead: 15% of total**
One day Training of **block level data handlers** by DIO and District Cold chain Officer to train about the reporting formats of Immunization and NRHM	As per revised RCH norms, copy attached				No of persons trained		No of persons trained **85**	**532750**	No of persons trained **542**	**704825**	No of persons trained **542**	**542 Data Handlers to be trained in 28 batches** **DA for 542 DH for 1 day = Rs 400 /- X 542** **Honararium: 3 Faculty X Rs 600 /- X 1 day** **Meals : 542 DH X Rs 200/- X 1 day** **Incidental Expenditure: 542 DH X Rs 250/- X 1 day** **Venue Hiring: Rs 10000/- X 28 Batches** **Institutional Overhead: 15% of total**

I. Budgetary Requirement												
Service Delivery: -	Norms*	Expenditure & Achievement						2009-10		2010-11		Remarks
		2005-06#	2006-07#	2007-08#		2008-09# (Dec'08)						
		Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Expenditure# (Figures based on fund allocated to dist. only)	Target	Funds requirement	Target	
Microplanning												
To develop sub-center and PHC microplans using bottom up planning with participation of ANM, ASHA, AWW	@ Rs 100/- per sub-centre (meeting at block level, logistic)							1690100	100% of SC/PHC/CHC/ Districts have updated microplans every year (17000 ANMs)	1700000	100% of SC/PHC/CHC/Districts have updated microplans every year (17000 ANMs)	17000 ANMs to be prepared
	For consolidation of microplan at PHC/CHC level @ Rs 1000/- block & at district level @ Rs 2000/- per district							591000		609000		533 blocks and 38 districts to consolidate MICROPLANS
POL for vaccine delivery from State to District and from district to PHC/CHCs	Rs100,000/ district/year	8636000	10401500	10734000	% Funds used	11334000	% Funds used	8680000	% Funds used	22350000		Funds required for POL (Vaccine lifting/disbursment) for vaccine delivery at all level is as follows :- For each WIC & WIF Rs 15,000/- each per month For District Rs. 10000/- each per month For PHC Rs 2500/- each per month
Consumables for computer including provision for internet access for RIMS	@ 400/ - month/ district							182400	38	182400	38	Rs 400/- per month x 38 dist x 12 months

I. Budgetary Requirement												
Service Delivery: -	Norms*	Expenditure & Achievement						2009-10		2010-11		Remarks
		2005-06#	2006-07#	2007-08#		2008-09# (Dec'08)						
		Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Expenditure# (Figures based on fund allocated to dist. only)	Target	Funds requirement	Target	
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	For consolidation of microplan at PHC/CHC level @ Rs 1000/- block & at district level @ Rs 2000/- per district							591000		609000		533 blocks and 38 districts to consolidate MICROPLANS
Injection Safety					% funds used		% funds used	1274748	% Funds used	5783700	% Funds used	
Red/Black Plastic bags etc	@ Rs 2/bags/session								17000		17000	Plastic Bags @Rs 2 per bag for 17000
Bleach/Hypochlorite solution	@ Rs 500 per PHC/CHC per year								515		533	Bleach/Hypoclorite solution @Rs 500 per PHC for 533 PHCs
Twin bucket	@ Rs 400 per PHC/CHC per year								515		533	Twin bucket @Rs 400 per PHC for 533 PHCs

I. Budgetary Requirement												
Service Delivery: -	Norms*	Expenditure & Achievement						2009-10		2010-11		Remarks
		2005-06#	2006-07#	2007-08#		2008-09# (Dec'08)						
		Expenditure	Expenditure	Expenditure	Achievement	Expenditure	Achievement	Expenditure# (Figures based on fund allocated to dist. only)	Target	Funds requirement	Target	
Any State Specific Need with justification												
Alternative Vaccinator Hiring for Urban R.I. & other HRAs	@Rs 1400/- per month									43141000	Total no. of Alternate vaccinator to be hired 2000	In addition another 1500 Alternate hired vaccinators from private sectors are being hired @ Rs 1400/- per month for 12 months for those access compromised Areas and vacant positions across the state other than Urban areas mentioned above (As per the existing GoI NORMs) For continuation of R.I.Sessions, all the contractual ANMs in the state need to be paid @Rs 1400/- for the one month break period in all districts across the state. = [(1400 X 6815) + (1400 X 2000 X 12)]
Catch up campaigns for Flood prone areas										30000000		In 2008 5 flood affected districts had supplementary emergency immunisation Campaign followed by Catch up campaign . In the coming financial year the campaign could be extended to cover a bigger area, hence State needs to have a contigency Plan for post flood R.I. Catch-up rounds for atleast 10 districts. @ Rs. 1,00,00,000/- X 3 catch up rounds per year.
AEFI Investigation by Dist. AEFI Committee.										570000		Minimum 5 Major AEFI cases are expected for every district for investigation in a year @Rs 1000/- for transportation for district AEFI committee to investigate case in the feild. @Rs.5000/ - for shipment of Specimen to lab. If required (Min. 2 samples) including travel cost, lodging & fooding etc..
POL of Generators for Cold Chain		33096000	49593000	67554000	% funds used	72984000	% funds used		% Funds used	24163000		POL for Generator running in PHCs without RKS needed along with POL for WICs Rs 600/-per day per WIC/WIF (Total -9) Rs 400/-day per PHC without RKS (152 Total no. of Sadar Hospital - 38,SDH-23+21=44 & RH-70 which have RKS independent from PHCs)
Grand Total		75903537	171790150	155892335		158310383		298316706		580767805		

DA has been calculated as per GoI Norms

These revised norms are under consideration of Empowered Programme Committee and will be sanctioned after approval of same; otherwise old norms will apply

Fund for Muskan Incentives for ANMs have been seperately budgeted in Part - A

NRHM PART- D

NDCP
2010-2011

Integrated Disease Surveillance Project (IDSP)

(Use of revised guidelines subject to approval of restructuring and extension of IDSP project)

D3.1 Introduction

The Government of India has initiated a decentralized, state based Integrated Disease Surveillance Project (IDSP) in the country in the year 2005-06.Bihar is included in phase III .started from Nov 2007.The project has been able to detect early warning signals of impending outbreaks and helped to initiate an effective response in a timely manner. It is providing essential data to monitor progress of on going disease control programs and help allocate health resources more optimally.

Criteria for including diseases in the surveillance program:

- **Burden of disease in the community,**
- **Availability of public health response and**
- **Special considerations and international commitments. Based on the information obtained from the state level workshops the following core conditions are included in the IDS program.**

The disease conditions that are included in the core list and state specific list of the surveillance program is to be reviewed once in two years based on disease burden and availability of public health action and suitably modified.

List of Core Diseases

Regular Surveillance	
Vector Borne Disease	**Malaria**
Water Borne Disease	**Acute Diarrhoeal Disease - Cholera, Typhoid**
Respiratory Diseases	**Tuberculosis**
Vaccine Preventable Diseases	**Measles**
Diseases under eradication	**Polio**
Unusual clinical syndromes	Menigoencephalitis / Respiratory Distress **(Causing death /Hospitalization; Hemorrhagic fevers, other undiagnosed conditions.**
Sentinel Surveillance	
Sexually transmitted diseases/Blood borne	HIV/HBV, HCV,STI
Other Conditions	Water Quality monitoring

Regular periodic surveys: NCD Risk Factors	Anthropometry, Physical Activity, Blood pressure, Tobacco, Nutrition, Blindness and any other unusual health condition GOG may include in a public health emergency

Objectives of IDSP

The objective is to improve the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors. Specifically, the project aims:

1. To establish a decentralized district based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the state in line of Integrated Diseases Surveillance Project.
2. To improve the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.
3. Renovate and strengthen state, district and peripheral surveillance units to cope up with the demand
4. Renovate and strengthen state, district and peripheral laboratories to cope with the demand
5. Operationalize norms and standards in the form of standard case definition, reporting formats and guidelines.
6. Strengthen the MIS by designating clear responsibilities for data collection, collation/processing, transmission, analysis and action, clear lines of information flow, standardized MIS formats and efficiency owing to use of IT (computers, software and web-based reporting system)
7. Reduce the burden of morbidity and mortality due to various diseases.
8. Develop, mobilize and optimally utilize human and financial resource and promote conductive environments for work.

The project assists in:

1. Surveillance a limited number of health conditions and risk factors;
2. Strengthen data quality, analysis and links to action;
3. Improve laboratory support;
4. Train stakeholders in disease surveillance and action;
5. Coordinate and decentralize surveillance activities;
6. Integrate disease surveillance at the state and district levels, and involve communities and other stakeholders, particularly the private sector.
7. Build capacity for outbreak response

Project activities

I. Upgradation of state, district and peripheral surveillance units
   - Renovation and furnishing of surveillance units; Providing office equipment and furniture

II. Upgradation of state, district and peripheral laboratories
   - Renovation & Furnishing of Labs; Supply of Lab. Equipments; Lab. Material and Supplies and consumables.

III. Information Technology and Communication
   - Computer Hardware and Office Equipments; Software for surveillance; Leasing of Wide Area Networking

IV. Human Resources and Development
   - Consultant / Contractual staff; Training; Information Education and Communication

V. Monitoring and Evaluation
   - Provision of syndromic, presumptive and laboratory surveillance formats
   - Establishment of web-based weekly reporting system

Current Status of Bihar

Before describing the current situation in the state MOHFW comments on IDSP has been addressed here.

Bihar

- Till date IDSP in Bihar is approved for 2009-10 financial year only
- Up gradation of peripheral labs (PHCs) is no longer encouraged under IDSP ; these labs are presently strengthened under RNTCP and NVBDCP. In contrast, there is a need to strengthen identified district level labs under IDSP.
- Two reference laboratories one at Deptt of microbiology PMCH ,Patna, & the other at Public health institute Patna are to be upgraded.

- Focus of IDSP proposal as a part of NRHM should be on :
  (i) Strengthening of the identified priority reference lab, enabling them to confirm the diagnosis of epidemic prone diseases.
    - 2 reference laboratories namely deptt of microbiology,PMCH, Patna & PHI have been identified for up gradation on priority basis during the year 2010-11.
    - One Microbiologist is to be be appointed in each of the two reference laboratories on Contractual Basis .

  (ii) All the six medical college hospitals are included as reporting unit
  (iii) Need to collect OPD data from district/medical college hospitals for analysis.
  (iv) 34 /38 districts are reporting online for IDSP.
  (v) 24 /24 (in place) epidemiologists trained for two weeks in IDSP.

  (vi) Integrate IDSP with NRHM, at least for the following :
    - **Financial management and monitoring**
      Request has been given to Program Director (NRHM) to carry outAudit with the help of NRHM appointed Chartered Accountant
    - **Training of professionals/staff**

    - **Use of contractual staff employed under different programme**

  Use of Contractual staff employed under IDSP working efficiently.

    -
    - **Monitoring and evaluation**

  ➔ State and Districts Surveillance Units are established State Nodal Officer is responsible for implementation , monitoring and supervision of IDSP from State level and Civil Surgeons are responsible for monitoring, supervision and co-ordination at district level.
  ➔ Weekly reporting system established (reporting 90%) Standard reporting formats used by all.
  ➔ IDSP Weekly Alert prepared and circulated to all Programme Officers of Health functionaries.
  ➔ Analysis and Feed-back in the form of IDSP Alert initiated at the DSU level.

Current status

Physical Progress up to December 2009

1. State and Districts Surveillance Units are established State Nodal Officer is responsible for implementation, monitoring and supervision of IDSP from state level and Chief District Health Officers are responsible for monitoring, supervision and coordination at district level.
2. 24 district level Epidemiologists are in place and received two week training.
3. One state entomologist in place and undergoing training.
4. Surveillance Programme Sub Committees are formed. at state and district level
5. Surveillance Core Group (SCG) and Surveillance Task Force (STF) are established at state and district level respectively.
6. Rapid Response Team (RRT) are formed at State and in 38 Districts. DSO of 26 districts are trained outside the state at Wardha.
7. Grant has been released to districts for renovation, procurement of equipment.

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8. Training has been imparted to the members of RRT consist of Epidemiologist, Microbiologist/Pathologist, Pediatrician/Physician, DSOs in district level as well as state level on swine flu & epidemic prone diseases with the help of WHO & NICD..
9. Standard reporting formats developed by state are used by all.
10. Weekly reporting system established (reporting 90%) Standard reporting formats used by all.
11. Integration of private, rural, urban sectors, six medical colleges and tertiary care hospitals.
12. Mechanisms for action based on data streamlined through Surveillance Core Group, Surveillance Task Force.
13. IDSP Weekly Alert prepared and circulated to all Programme Officers of Health functionaries.
14. Analysis and Feed-back in the form of EWS Alert initiated at the DSU level.
15. Three outbreaks detected & reported to CSU (Munger,Gaya,Saran)

Activities planned during second half of year 20010-11

1. Increase no. of private reporting units – Orientation workshop at district HQ for IMA, IAP, private laboratories and Grant-in-aid hospitals are planned during 4TH rd quarter of year 2009-10.
2. Catching OPD data in weekly surveillance .

Contractual posts of Microbiologist in District Public Health Laboratory (District Hospitals) is to be approved in annual plan of year 20010-11

Action Plan for Year 2010-11

Integrated Disease Surveillance System is well established in the state. Weekly surveillance data are received regularly from reporting units. Data are analyzed at state level and weekly alert is prepared which is circulated to all state and district programme officers.

Following major activities are planned for year 2010-11

Activities as per IDSP Guidelines

1. Renovation of peripheral surveillance units and laboratories located in sub district hospitals and community health centers
2. Procurement of equipment, reagents, consumables, furniture etc for peripheral laboratories.
3. Printing of Syndromic Surveillance, Presumptive Surveillance and Laboratory Surveillance forms
4. Printing of posters and charts on biosafety, standard operation procedures, protocols etc.
5. Orientation workshops, conferences and review meetings
6. IEC Activities

Additional activities

1. Refresher course for all categories of staff of reporting units and private hospitals
2. Support Infectious Disease hospitals
3. Provision of transport facilities to RRT in 6 Medical Colleges
4. Establishment of community surveillance system through toll free telephone
5. Use of call centers for prompt dissemination of information to avert outbreak
6. Mapping of disease incidence and prevalence through use of GIS

renovation of state and district public health laboratories and procurement of equipment, instrument, consumables and furniture have been taken up on priority basis fully utilized as this activity has been transferred to National Informatics,

Draft - Annexure 2

Budget Sheet for Other States(BIHAR)

Sub-activity	Tasks		Unit Cost	No. of Units	2010 - 11	Remarks
1. Staff Salary	1.1	Epidemiologists	30000	39	1170000 *12= 14040000	
	1.2	Microbiologists	20000	2	40000*12= 480000	
	1.3	Entomologist	20000	1	20000 * 12= 240000	
	1.4	Consultant (Finance)	14000	1	14000 * 12 = 168000	
	1.5	Consultant (Training)	28000	1	28000 * 12 = 336000	
	1.6	State Data Manger	14000	1	14000 * 12 = 168000	
	1.7	District Data Manager	13500	38	513000 * 12 = 6156000	
	1.8	Data Entry Operator	8500	45	382500 * 12 = 4590000	
		Sub Total			**26178000**	
2. Training	2.1	Training of Hospital Doctors	11000	20(Per batch)	330000	Total 30 Batch out of 550 PHC & Hospitals.
	2.2	Training of Hospital Pharmasist / Nurses	15000	20(Per batch)	450000	Total 30 Batch out of 550 PHC & Hospitals.
	2.3	Training of Data Managers	183500	39(Per batch)	**183,500**	Total 1 Batch out of 39 Data Managers Details is given below**
		Sub Total			**963500**	
3. Operational Cost	3.1	Mobility Support	5000	39	195000 * 12 =2340000	5000 Per month for Each District
	3.2	Office Expenses	5000	39	195000 * 12 =2340000	5000 Per month for Each District
	3.3	ASHA incentives for Outbreak reporting	100	120 * 38 = 4560	456000	Estimated to get 10 informations per month from volunteers a total of 120 such information in a year per district. Each informant to be given an incentive of Rs.100/-
	3.4	Consumables for District Labs	50000	38	1900000	
	3.5	Collection & transportation of	50000	38	1900000	

		samples				
	3.6	IDSP reports including alerts	20	52 * 38	39520	
	3.7	Printing of Reporting Forms	20	52 *550	572000	
	3.8	Broadband Expenses	1000	39	39000 * 12 = 468000	
	3.10	Setting up of two reference lan	1700000			
		Sub Total			**10015520**	
		TOTAL		**38857020**		

Data Manager trianing (District level) break up		
	Data Managers	
Duration of Training	**6 Days**	
Participants	39 Data Managers	
Venue	SIHFW	
Total Training Load	42	
Batch Size	39 Participants	
Trainer	2-3 Master Trainers	
Break Up of Budget 2010 – 11		
Particular	**Data Managers**	**Total**
DA for Trainees	Rs. 150 X6DaysX39 participants =	35,100.00
DA for Trainers	Rs. 600 X 6Days X 3 trainers =	10,800.00
Lunch + Snacks	Rs.200 X 6Days X 45 participants =	54,000.00
Contigency	Rs.150 X 39participants X 6 days =	35,100.00
Venue Hiring(one Hall)		5,000.00
IOH 15%		21000
TA for Trainers(as per Govt. Rule)	Rs.@1000	3,000.00
TA for Trainees(As per Govt. Rule)	Rs.@500	19,500.00
Total		**183,500.00**

National Iodine Deficiency Disorder Control Programme

Addressing Iodine Deficiency Disorders in Bihar.

Introduction :

Iodine deficiency is a world wide public health problem. It is the major cause of brain damage loss of energy, learning disability, poor motivation, poor human resource development and child survival. Thus, it remains a major threat to the health and development of school children and pregnant women. Children with iodine deficiency have intelligence (I.Q) 13.5 points less than that of children from areas where there is no iodine deficiency. The only solution to this is simple and affordable, which is consumption of iodized salt. IDD elimination Programme was launched in the late 1960s. By 1988 legislative measures were put in place to ban the sale of non-iodized salt in the entire state.
During the United Nations General Assembly Special Session for Children (2002), India has committed to eliminate IDD by 2005. Although, in national policy commitments, India commits to eliminate IDD by 2010, there is an urgent need to accelerate the strategy in India, especially when a decreasing trend, 49% to 37% (1998-99 to 2002-03), has been seen in households consuming adequately iodised salt.

Iodine Deficiency Disorders in Bihar :

In Bihar the northern part of the state lies in the sub-Himalayan region in which the existence of severe to moderate iodine deficiency in this region is well established. A recent study was undertaken in Bihar with support from UNICEF for Government of Bihar, to track progress towards sustainable elimination of IDD from the state. The results of the study reveal that iodine deficiency continues to be a public health problem. A high proportion of population (31.5%) has very low urinary iodine excretion suggesting existence of severe iodine deficiency in many pockets. As per the recent NFHS-3 63% of the households consume adequately iodized salt. As per the nation wide assessment availability of adequately iodized salt is 60% in Bihar and main transportation of iodized salt is through rail.

The findings of this study warrant instituting corrective measure to ensure that the population of Bihar has access to adequately iodized salt through salt traders and at least 80% of the households receive and use adequately iodized salt.

Goal :

- Achieve universal access to iodised salt.
- Generate district wise data on iodised salt consumption.
- Reproduction in the prevalence of iodine deficiency disorders to less than 10% by 2010.

Major Objectives:

- Creating universal demand for iodised salt at consumption level.
- Strengthening the monitoring system at the production level, distribution (retailer level) & consumption level.
- Strengthening coalition of salt traders & retailers, railways and other government department for increasing demand and supply of iodized salt.
- Urgent enforcement of legal ban reinstituted on 17th May 2006

Strategies :

- Formation of District Co-ordination Committee (DCC) for planning implementation and monitoring of activities.
    - Each District will be supported with a District Field Monitor.
    - Salt Testing Kits will be provided for monitoring salt quality.
    - Relevant IEC material will be developed and distributed to each district for advocacy.
    - Members of Salt Traders Association will support in monitoring and advocacy by utilizing their network and also by linking with DFMs to carry out specific activities in a coordinated manner.

The expected outcomes of these efforts are :

- Increase in numbers of salt traders indenting for better quality salt with Salt Department.
- Increase in availability of iodized salt in shops.
- Increase awareness on benefits of iodized salt among mothers and children.
- Increase in number of households consuming adequately iodized salt.
- Increase in use of iodized salt in Government programmes, institutions etc.

- Directives of District Administration and concerned department for :
    - Organising promotional activities with available funds if required.
    - Orientation on iodised salt consumption.
    - Discussions of IDD/USI activities in review meetings.
- State reviews held biannually with district officials.
- Provision of BCC/IEC materials to schools and AWCs.
- Coordination committee at block level with involvement of BDO, BWO, MOIC, MOs, CDPO & BEEO.
- Coordination committee at block level will ensure role at each department of ICDS, health & education in creating demand and producing awareness in the common people for use of iodised salt.

Role of Each Department :

Awareness generation among consumers is a corner stone of the strategy and all possible means to disseminate information about the benefits of consuming iodized salt and to trigger behaviour change among the population. This surely requires the contribution of stakeholders outside the Health Department. In this regard the ICDS with its extended network of AWCs is a strong link through which the vulnerable population groups in the community can be reached out. Health department could also coordinate with Railways for the proper unloading of iodized salt at Railway unloading sites and sharing information of unloading to health department to facilitate the salt sampling/testing before forward distribution by salt traders.

The priority of Iodine Deficiency Disorders should also be shouldered by the Education department. Schools provide an excellent infrastructure for promotional activities to reach out to masses through children. Teachers can be trained for encouraging students to influence their families in purchasing iodised salt highlighting the benefit of IQ difference in children with iodine deficiency. Thus, a series of activities could be organized for awareness creation among children, who in turn can be expected to serve as change agents for influencing their families.

Department of Food and Civil Supplies can encourage and support the inclusion of iodized salt in the food basket of the public distribution system (PDS).

Health:

Health is the nodal department, while ICDS, Food and Civil Supplies and Education will be the collaborating departments. These have been specified under the role of departments of ICDS, Food and Civil Supplies and Education. To begin with the district will form a co-ordination Committee to take decisions on priority actions and review the progress of work once every quarter under the chairmanship of District Magistrate. A Nodal Officer will be nominated in the district to coordinate the IDD activities and work as Member Secretary for the District Coordination Committee.

State Health Department will ensure the following:

- Formation of State Coordination Committee at state level under with Program Officer IDD as Nodal officer and member Secretary of SCC-IDD and IDD cell.
- Regular monitoring and review meeting
- State IDD cell to ensure the procurement of Salt Testing Kit (MBI Kit), printing of reporting formats and IEC material districts to distribute to AWCS, through CDPOs and to Schools through BEOs.
    - Reporting format
    - Distribution of Salt Testing Kits (MBI kits)
    - Distribution of IEC material
    - Financial Support under the NRHM part D.
- Directives to district for formation of District Co-ordination Committee to prioritize actions and review progress quarterly.
- Strengthening the salt testing laboratory in the state and ensure regular inflow and outflow of the salt samples by Food inspectors
- Directives to be issued to Medical Colleges and District hospitals, for using iodized salt in cooking meals for the patients.
- Directives to Civil Surgeon to hold meetings of lab technician and Food Inspectors in his district for

  review of salt sampling and salt testing.

Functions of District Co-ordination Committee:

1. To facilitate Orientation and Planning Meetings for awareness generation and to strengthen monitoring of salt quality
2. To support organization and implementation of awareness campaigns through schools and AWCs to reach out to the communities.
3. To monitor campaigns/activities under the 3 departments and prepare district reports
4. To institute follow-up actions in block areas with low or no iodine salt sale and consumption.
5. Initiate issue of joint letter signed by Civil Surgeon, DPO and DSE for co-ordination by the functionaries of three departments to organize and conduct joint training of ANMs and AWWs.

Advocacy :

A. Advocacy will be through mass awareness creation activities such as Rath Yatra, processions, Prabhat Pheri rallies, human chain etc. These will be organized with support from district administration and coordinated by DFM to partner with all stake holders in the district. A brief on completion of the activities will be forwarded to Civil Surgeon's office and to State Health Society, Bihar with a copy to Unicef.

B. Monitoring salt quality will be carried out at various levels using salt testing kits. Salt samples on receipt of railway racks, godowns and retail outlets and small shop keepers will be ensured from time to time. These efforts will be concerted to motivate other salt traders to indent for iodised salt and stock and sell only iodised salt. There would be meeting of salt sellers to motivate them for the above. A consolidated reporting giving the number of samples tested along with percentage of salt with 0 PPM, <15 PPM and >15 PPM will be submitted to the district (Civil Surgeon's office), SHS, Bihar and a copy to Unicef.

Education:

- Directives from DEO using iodised salt only in MDM in schools.
- District DEO to facilitate and complete training of BEOs on IDD/USI
- BEO to conduct training of Nodal Teachers along with MOIC/CDPO at the Block
- Support Nodal Teachers to prepare a plan of activities and budget for the schools.
- Submit a copy of plan and the budget of schools to DEOs office.
- All students in the school to be sensitized with the problem of IDD and the benefits of iodised salt.

Sensitizing School Children on IDD/IS

School teacher shall take a 30 minutes class, and would explain to children why iodine is important, causes of iodine deficiency disorder, and consequences of IDD with emphasis on physical and mental development. Explain that iodised salt helps bring back iodine to the body. Thus iodised salt is important, but both iodised and non-iodised salt is available. Give emphasis to the difference in the IQ points up to 13, in children with iodine deficiency thus affecting leaning and school performance which further reflects on workout put and productivity. Thus good health can be ensured only with daily consumption of iodised salt.

Activities within the school:

- Essay/Story competition -Poetry Writing
- Exhibitions -Play/Skits
- Slogan writing -Songs

-All children participating, to get a certificate and the best child/ children to get a prize.

- BEOs to ensure supply of ST Kits, IEC materials, cash assistance etc to schools

Monitoring salt for iodine content in the class room:

All children requested to bring few pinches of salt from their homes

Teacher to supervise the testing of salt using the kit, by each child. Children would be classified into two groups.
Group 1 will have children with salt samples tested with adequate iodine.
Group II will have children with salt samples tested with no iodine or inadequate iodine.

Counseling to Group I: "Your salt is of good quality and would allow you to perform well in school if you continue consuming iodised salt as you are and pay attention to your studies in the school. Insist that your parents always buy iodised salt only".

Counseling to Group II. "Your salt does not contain iodine. Your are being left out from its benefits. If this continues, you are likely to face some serious risks. Your growth can be retarded and at the same time your school performance would be negatively affected. This can happen to your brothers and sisters, as they are also consuming the same salt without iodine or less amount of iodine that is required by the body. When we have the same session repeated next month, your salt test should show blue colour which means you have convinced your parents to buy salt which is iodised.

In general, the Teacher should say, we want to see **all** children in group I and none in the other group. So our class should have children all using iodised salt.

- Prepare a monitoring plan and carry out monitoring of the planned activities in the school along with MOICs and CDPOs.
- Head Masters to facilitate organizing of activities within and outside school, Nodal Teacher to take the lead.

Activities outside the school:

- Organize Salt monitoring for advocacy in the community
- Each Nodal Teacher to choose 20 children living in different localities
- Each student to visit 15-20 houses and shops around them for monitoring and advocacy.
    - Slogans to be used for Prabhat Pheri
    - Human Chain
    - Marathon/Bicycle Race
- All children to get a certificate, and the best performer to get a prize.
- Each nodal teacher to prepare report for her class.
- Every school to prepare an Activity Report including a report on monitoring of salt
- BEO to conduct review meetings with Head Masters/Nodal Teachers on 25th and collect the report for all schools in his block 25th of every month.
- DEO to hold meeting of BEOs on 28th of every month and receive reports for all schools in his district by 28th of every month.
- These meetings also to be utilized for planning activities for the next month with time line budget and role specificity.

Plan of Action :

1. Training -

- Letter signed by Civil Surgeon, DPO and DSE for co-ordination by the functionaries of three district departments to organize and conduct joint training of ANMs and AWWs.
- Directives to be re-issued as a reminder for use of iodised salt in supplementary food at AWCs.
- DPOs/DWOs to plan and conduct the orientation of CDPOs and LS.
- CDPOs/LS to organize and carryout block level training of AWWs and the ANM along with MOICs and BEO.

2. Supply of ST Kits -

- MOIC/CDPO to ensure supply of ST Kits, IEC materials, cash assistance etc to AWCs.

3. Monitoring Plan & reporting -

- Prepare a monitoring plan and carry out monitoring of the planned activities jointly in the village or community by involving the leaders, youth or school children.
- The monitoring of the activities will be done by the block level officers of all three departments. A plan for monitoring will be ensured and will be prepared during the planning meetings.

1. Each AWC/ANM will prepare a report and forward it to MOIC, CDPO BDO.
2. The schools will prepare the activity report and forward it to BEO and BDO.
3. The MOICs will compile and send the report to CS while, the CDPO will compile and send the report to DPO/DWO with a copy to CS.
4. The BEO will compile for all schools in the block and forward it to DEO with a copy to CS.

- Civil Surgeon Office will prepare a final compiled report for the district and forward it to State Nutrition Cell, copy to Directorate ICDS and Education, Government of Bihar, Patna.
- State IDD Cell and UNICEF along with Directors of respective departments will hold review meetings to discuss progress and strengthen efforts in low consumptions areas.
- State IDD Cell with support from UNICEF will also facilitate State Task Force Meeting in end September to take stock of achievements and future course of actions.

4. Review Meeting -

- MOIC and CDPO to conduct joint review meetings with ANMs and AWWs in her/his block on 25th of every month.
- DPO/CSEO to hold meeting of BEOs on 28th of every month and receive reports for all schools in his district by 28th of every month.

These meetings also to be utilized for planning activities for the next month with time line budget and role specificity.

Total Budget : Rupees Ninety Three Lac Seventy Six Thousand only (Rs. 93,76,000)

State level activities : Rupees Four Lac Sixty Eight Thousand only (Rs. 4,68,000)

District level activities: Rupees Eighty Nine Lac Eight Thousand only (Rs. 89,08,000)

Budget for National Iodine Deficiency Disorder Control Programme for state level activities in Bihar 2010-11

SL No	Activities	Frequency	Fund allocation	total fund
1	IDD day WS at state level	1	100000	100000
2	Sensitization WS for Salt traders	2	50000	100000
3	Upgradation of salt testing laboratoy	3	50000	150000
4	Nodal officers meeting at state level	4	10000	40000
5	Training of food inspectors	1	38000	38000
6	State level meeting of state Coordination committee	2	10000	20000
7	Orientation of Railway officials on Salt unloading precautions	1	20000	20000
	Total			**468000**

Grand total : Four lac Sixty Eight thousand only

Total of district and state :- 93,76,000/-
(Ninety Three Lac Seventy Six Thousand only)

Budget for National Iodine Deficiency Disorder Control Programme in 38 Districts of Bihar 2010-11									
SL No	Name of District	No. of PHC	Training @ Rs. 3000	Community Awareness @ Rs. 2000	Activities in School @ Rs. 3000	Activaties at AWC & Communities @ Rs.3000	IEC Material @ Rs. 3000	procurment of MBI kits @ 2000	4 District level meeting @ 2500/meeting
1	Araria	9	27000	18000	27000	27000	27000	18000	10000
2	Arwal	5	15000	10000	15000	15000	15000	10000	10000
3	Aurangabad	11	33000	22000	33000	33000	33000	22000	10000
4	Banka	11	33000	22000	33000	33000	33000	22000	10000
5	Begusarai	18	54000	36000	54000	54000	54000	36000	10000
6	Bhagalpur	16	48000	32000	48000	48000	48000	32000	10000
7	Bhojpur	14	42000	28000	42000	42000	42000	28000	10000
8	Buxar	11	33000	22000	33000	33000	33000	22000	10000
9	Champaran East	27	81000	54000	81000	81000	81000	54000	10000
10	Champaran West	18	54000	36000	54000	54000	54000	36000	10000
11	Darbhanga	18	54000	36000	54000	54000	54000	36000	10000
12	Gaya	24	72000	48000	72000	72000	72000	48000	10000
13	Gopalganj	14	42000	28000	42000	42000	42000	28000	10000
14	Jamui	10	30000	20000	30000	30000	30000	20000	10000
15	Jahanabad	7	21000	14000	21000	21000	21000	14000	10000
16	Kaimur	11	33000	22000	33000	33000	33000	22000	10000
17	Katihar	16	48000	32000	48000	48000	48000	32000	10000
18	Khagaria	7	21000	14000	21000	21000	21000	14000	10000
19	Kishanganj	7	21000	14000	21000	21000	21000	14000	10000
20	Lakhisarai	7	21000	14000	21000	21000	21000	14000	10000
21	Madhepura	13	39000	26000	39000	39000	39000	26000	10000
22	Madhubani	19	57000	38000	57000	57000	57000	38000	10000
23	Munger	9	27000	18000	27000	27000	27000	18000	10000
24	Muzaffarpur	16	48000	32000	48000	48000	48000	32000	10000
25	Nalanda	20	60000	40000	60000	60000	60000	40000	10000
26	Nawada	14	42000	28000	42000	42000	42000	28000	10000
27	Patna	23	69000	46000	69000	69000	69000	46000	10000
28	Purnea	14	42000	28000	42000	42000	42000	28000	10000
29	Rohtas	19	57000	38000	57000	57000	57000	38000	10000
30	Saharsa	10	30000	20000	30000	30000	30000	20000	10000

31	Samastipur	20	60000	40000	60000	60000	60000	40000	10000
32	Saran	20	60000	40000	60000	60000	60000	40000	10000
33	Sheikhpura	7	21000	14000	21000	21000	21000	14000	10000
34	Sheohar	4	12000	8000	12000	12000	12000	8000	10000
35	Sitamarhi	17	51000	34000	51000	51000	51000	34000	10000
36	Siwan	19	57000	38000	57000	57000	57000	38000	10000
37	Supaul	11	33000	22000	33000	33000	33000	22000	10000
38	Vaishali	17	51000	34000	51000	51000	51000	34000	10000
	Total	533	1599000	1066000	1599000	1599000	1599000	1066000	380000
Grand Total - 89,08,000/- (Eighty Nine Lacs Eight Thousand Only)									

PROJECT IMPLEMENTATION PLAN

FOR

NATIONAL PROGRAMME FOR

CONTROL OF BLINDNESS

2010 – 2011

Introduction

National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100% centrally sponsored scheme with the goal of reducing the prevalence of blindness. The goal set for the terminal year of the 10th Plan is to reduce the prevalence of blindness to 0.8% by 2007 prevalence of Blindness is 1% (2006-07 Survey) and 0.3% of population by 2020.
The four pronged strategy of the programme is:

• strengthening service delivery,

• developing human resources for eye care,

• promoting outreach activities and public awareness and

• developing institutional capacity.

NATIONAL POLICY :

One of the basic human right is 'THE RIGHT TO SIGHT' we have to ensure that no citizen goes blind needlessly, or bring blind does not remain so, if by reasonable skill and resources his sight can be prevented from deteriorating, of if already lost can be restored.

National Programme for Control of Blindness
(Financial Year 2010-2011)

There are two main Programmes under National Programme for Control of Blindness:
(1) Cataract Operation
(2) School Eye Screenings Programme:

Cataract Operation:- Cataract Operations are being done in district Hospitals against the target fixed by state. In addition in the NGOs governed hospitals under the monitoring of District Health Society- Blindness Division.

The following table shows the last six year's physical record of Cataract Operation:-

Sl. No.	Year	Target	Achievement	Percentage
1.	2003-04	140000	90405	64.58
2.	2004-05	140000	102531	73.24
3.	2005-06	140000	131860	94.19
4.	2006-07	140000	129064	92.19
5.	2007-08	140000	137685	98.35
6.	2008-2009	150000	154817	103.21

School Eye Screening Programme :- Teachers are being trained, to conduct eye screening of the school children and to advise for using proper spectacles by the needy children with defective eyes is one of the main activities of the Programme. In addition to this free distribution of spectacles among the families belonging to below Poverty Line (BPL) is also a major component of the activities.

The following table shows the last four year's physical record of SES :-

Sl. No.	Year	No. of school children underwent Eye Screening
1.	2005-06	2,97,278
2.	2006-07	2,43,095
3.	2007-08	284398
4.	2008-2009	257928

Review Meeting: - A Two days Review Meeting of Additional Chief Medical Officer who is also the District Programme Officer of National Programme for Control of Blindness is proposed in near feature in which representative of Govt. of India shall also be requested to attend.

State Level Workshop:- Three days State Level Workshop of Eye specialist/Eye surgeon of district level is also proposed in which representative of Govt. of India shall also be invited to attend.

Vision Centre:- In remote rural areas where there is no facility of eye care , Govt. of India has provision for setting up vision centre by the NGOs where all facilities for eye care shall be made available.

Training :- Under the NPCB training to Medical Officer of PHC, PMOAs and Nurses shall be imparted. Medical Officers shall be trained for three days, PMOAs for five days and 28 days training to the Nurses as per Govt. of India guideline.

IEC:- In order to make aware the people about how to take care of their eyes to acquaint them where to report for eye check up in case of any vision problem through hand bill, pump let, poster, banner, cable net work, hoarding and Doordarshan etc.

Causes of Blindness in Bihar State :

Following is the table showing the causes of blindness according to their magnitude of importance in the overall situation of blindness problem.

- ☞ Cataract
- ☞ Refractive Errors
- ☞ Corneal Blindness
- ☞ Glaucoma
- ☞ Surgical Complications
- ☞ Posterior segment disorders
- ☞ Others

Emerging Causes of Blindness :

- ☞ Diabetic retinopathy
- ☞ Glaucoma
- ☞ Childhood blindness

Comparison of Prevalence of Blindness National Surveys on Blindness 1986-89 & 2001-2002

Parameter	National Survey 1986-89	National Survey 2001-2002
Estd. Prevalence of Blindness (Visual Acuity <6/60	1.49	1.1
Bihar	1.28	0.78

Plan of Action and Budgetary requirements during 2009-2010
Recurring Grants in Aid to NGOs for performing free Cataract Operation and other Intra Ocular Surgeries.

Sl.No.	ICCE	IOL	Phaco	Total
Cataract operation and other Intra Ocular Surgeries	1,50,00,000	9,00,00,000		10,50,00,000
Drug and Consumable	150	200	200	
Sutures	50	50		
Spectacles	125	125	125	
Transportation/POL	100	100	100	
Organization & Publicity	75	75	75	
Icl, Viscoelastics & Addl. Consumables	0	200	250	
Total	500	750	750	
Target:- 150000	**20%**	**80%**		**100%**

Plan of action and Budgetary requirements during 2010-2011		
Sl. No.	**Name of Activity**	**Estimated Cost. (Rupees)**
1.	Remuneration, other activities & contingencies (Annex-A)	14,00,000
2.	Grant-in-Aid other Components-)	21,10,78,750
	TOTAL:- (Twenty one crore twenty four lac(s) seventy eight thousand seven hundred fifty only.)	**21,24,78,750**

Budgetary requirement during 2010-2011

	Annexure-A	
Sl.No.	**Particulars**	**Cost p.a.**
1.	Review Meeting	80,000
2.	Flexi pool fund (for staff remuneration & other)	10,00,000
3.	TA/DA for Staff	96,000
4.	POL/Vehicle Maintenance	72,000
5.	Stationary and Consumables	52,000
6.	State level Workshop	100,000
	Total	**14,00,000**
	Annexure-B	
	Grant in Aid other components-	
1.	Recurring GIA for Eye Donation	500,000
2.	Vision Centre (50 @ 50,000/- per vision centres)	25,00,000
3.	Eye Bank 2 @ 15 Lakh	30,00,000
4.	Eye Donation Centre 2 @ 1 lakh	2,00,000
5.	Non-Recurring Grant to NGO for strengthening /expansion of eye care unit on 1: 1 sharing basis 2 @ 30 lakh	60,00,000
6.	Training of Ophthalmic & support Man power	9,50,000
7.	IEC – Annex.1	19,88,750
8.	GIA for free Cataract Operation for 38/ DHS-Blindness Division – Annex-2	10,50,00,000
9.	GIA for School Eye Screening for 38 DHS- Blindness Division	25,00,000
10.	Support towards salaries of Ophthalmic Manpower to States 1.Ophthalmic surgeon in district Hospitals for 10 dist. @ 35000/- per month 2. Ophthalmic Assistant in district Hospital in 20 dist. @ 12000/- 3. Eye Donation Counselors in eye bank in Government and NGO sector in 2 dist. @ 15000/- per month	42,00,000 28,80,000 3,60,000
11.	Strengthening /setting up of Regional Institutes of Ophthalmology (Non Recurring Assistance)	40,00,000
12.	Strengthening of Medical Colleges @ 40 Lakh for 6	2,40,00,000
13.	Strengthening of District Hospitals @ 20 Lakhs for 7 dist.	1,40,00,000
14.	Grant-in-aid to District Health Societies (Recurring Assistant) @ 5 Lakhs	1,90,00,000
15.	Back lock dues in dist.(Approx.)	2,00,00,000
	Total:- Rupees Twenty one crore ten lac(s) seventy eight thousand seven hundred fifty only.	**21,10,78,750**

Annexure-1

IEC CAMPAIGN: PROPOSED BUDGET FOR IEC ACTIVITES DURING 2009-2010

Sl.No.	IEC Materials	Tentative Quantity	Estimated Cost (Rs.)
1.	Hand Bill (For Eye)	3 Lakh	93750
2.	Hand Bill (For Children)	2 Lakh	62500
3.	Leaflet	1 Lakh	62500
4.	Poster	1 Lakh	156250
5.	Banner	5000 (Five thousand) (38 District & Head Quarter)	500000
6.	Cable	38 District & Head Quarter – 78	341250
7.	Hoarding	(38 District & Head Quarter – 78	585000
8.	Doordarshan Telecast	30 Secs. 6 T.V. Spots on Eye Care: Diabetic Retinopathy, Eye Donation, Cataract, Refractive Error, Glaucoma, Blindness	187500
	TOTAL		**19,88,750**

Annexure-2

Recurring Grants in Aid to NGOs for performing free Cataract Operation and other Intra Ocular Surgeries.

Sl.No.	Name of Dist.	Target	ICCE @500/- (20%)	ECCE/IOL@ 750/- (80%)	Phaco	Total
1.	Araria	2000	200,000.00	1,200,000.00	-	1,400,000.00
2.	Arwal	500	50,000.00	300,000.00	-	350,000.00
3.	Aurangabad	3000	300,000.00	1,800,000.00	-	2,100,000.00
4.	Banka	1500	150,000.00	900,000.00	-	1,050,000.00
5.	Begusarai	4000	400,000.00	2,400,000.00	-	2,800,000.00
6.	Bhagalpur	6000	600,000.00	3,600,000.00	-	4,200,000.00
7.	Bhojpur	6000	600,000.00	3,600,000.00	-	4,200,000.00
8.	Buxar	3000	300,000.00	1,800,000.00	-	2,100,000.00
9.	Darbhanga	6000	600,000.00	3,600,000.00	-	4,200,000.00
10.	E.Champn.	2500	250,000.00	1,500,000.00	-	1,750,000.00
11.	Gaya	23000	2,300,000.00	13,800,000.00	-	16,100,000.00
12.	Gopalganj	2000	200,000.00	1,200,000.00	-	1,400,000.00
13.	Jamui	1500	150,000.00	900,000.00	-	1,050,000.00
14.	Jehanabad	2000	200,000.00	1,200,000.00	-	1,400,000.00
15.	Kaimur	2000	200,000.00	1,200,000.00	-	1,400,000.00
16.	Katihar	4000	400,000.00	2,400,000.00	-	2,800,000.00
17.	Khagaria	1500	150,000.00	900,000.00	-	1,050,000.00
18.	Kishanganj	2000	200,000.00	1,200,000.00	-	1,400,000.00
19.	Lakhisarai	1000	100,000.00	600,000.00	-	700,000.00
20.	Madhepura	1000	100,000.00	600,000.00	-	700,000.00
21.	Madhubani	1500	150,000.00	900,000.00	-	1,050,000.00
22.	Munger	2000	200,000.00	1,200,000.00	-	1,400,000.00
23.	Muzaffarpur	11000	1,100,000.00	6,600,000.00	-	7,700,000.00
24.	Nalanda	11000	1,100,000.00	6,600,000.00	-	7,700,000.00
25.	Nawada	3000	300,000.00	1,800,000.00	-	2,100,000.00
26.	Patna	22000	2,200,000.00	13,200,000.00	-	15,400,000.00
27.	Purnia	4000	400,000.00	2,400,000.00	-	2,800,000.00
28.	Rohtas	2000	200,000.00	1,200,000.00	-	1,400,000.00
29.	Saharsa	2000	200,000.00	1,200,000.00	-	1,400,000.00
30.	Samastipur	2000	200,000.00	1,200,000.00	-	1,400,000.00
31.	Saran	3000	300,000.00	1,800,000.00	-	2,100,000.00
32.	Sheikhpura	500	50,000.00	300,000.00	-	350,000.00
33.	Sheohar	500	50,000.00	300,000.00	-	350,000.00
34.	Sitamarhi	1000	100,000.00	600,000.00	-	700,000.00
35.	Siwan	2500	250,000.00	1,500,000.00	-	1,750,000.00
36.	Supaul	1000	100,000.00	600,000.00	-	700,000.00
37.	Vaishali	3500	350,000.00	2,100,000.00	-	2,450,000.00
38.	W.Chamn.	3000	300,000.00	1,800,000.00	-	2,100,000.00
	Total	**150000**	**15,000,000.00**	**90,000,000.00**	**-**	**105,000,000.00**

RNTCP

Annual Plan for Programme Performance & Budget for the year
1st April 2010 to 31st March 2011
State: BIHAR

Objectives:
1. *To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases, and*
2. *To achieve and maintain detection of at least 70% of such cases in the population*

This action plan and budget have been approved by the STCS.

*Signature of the STO*_____
Name:- ***DR. N.M. SHARMA***_____

Section-A – General Information about the State

1	State Population (in lakh) *please give projected population for next year*	**955.28**
2	Number of districts in the State	**38**
3	Urban population	**86.62**
4	Tribal population	**8**
5	Hilly population	**7.55**
6	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums, etc.)	

(These population statistics may be obtained from Census data /State Statistical Dept/ District plans)

No. of districts without DTC: None

No. of districts that submitted annual action plans, which have been consolidated in this state plan: **38**

Organization of services in the state:

S. No.	Name of the District	Projected Population (in Lakhs)	Please indicate number of TUs of each type		Please indicate no. of DMCs of each type in the district		
			Govt	NGO	Public Sector*	NGO	Private Sector^
1	Araria	2642000	5	0	12	1	5
2	Arwal	700000	1	0	5	0	0
3	Aurangagad	2304988	5	0	17	8	0
4	Banka	1849000	3	1	11	1	3
5	Begusarai	2734139	5	0	14	1	1
6	Bhagalpur	2936063	5	0	17	1	2
7	Bhojpur	2662344	5	0	22	0	0
8	Buxar	178630	3	0	14	0	0
9	East Champaran (Motihari)	3585873	8	0	20	4	0

10	West Champaran (Betiya)	3498000	6	1	20	0	3
11	Darbhanga	3777000	7	0	20	1	4
12	Gaya	3983000	8	0	28	1	3
13	Gopalganj	2670000	5	0	20	0	2
14	Jamui	1645919	4	1	11	X	X
15	Jehanabad	1052906	2	0	8	X	X
16	Kaimur	1776808	2	1	13	0	0
17	Katihar	2788454	5	1	1	1	0
18	Khagaria	1499812	3	0	14	0	0
19	Kishanganj	1584006	2	1	9	5	0
20	Lakhisarai	921063	2	0	5	0	0
21	Madhepura	1779000	3	0	14	0	0
22	Madhubani	4166753	8	0	35	0	0
23	Munger	1507018	2	0	8	2	0
24	Muzaffarpur	4304074	7	0	18	0	0
25	Nalanda	2763707	5	0	23	0	0
26	Nawada	2080193	4	0	15	0	0
27	Patna	5528137	10	0	40	0	0
28	Purnia	3158863	5	0	25	0	0
29	Rohtash	2815000	5	0	20	2	2
30	Saharsa	1731000	4	0	11	0	3
31	Samastipur	4458912	7	1	23	0	2
32	Saran	3794291	6	0	32	0	0
33	Sheikhpura	603000	1	0	4	0	0
34	Sheohar	591247	1	0	5	0	0
35	Sitamarhi	3115000	6	0	25	0	0
36	Siwan	3314198	6	0	15	1	0
37	Supaul	2006000	4	0	11	0	2
38	Vaishali	3022077	5	0	10	0	0
	Total	**95528475**	**175**	**7**	**615**	**11**	**9**

**Public Sector includes Medical Colleges, Govt. health department, other Govt. department and PSUs i.e. as defined in PMR report*

^ Similarly, Private Sector includes Private Medical College, Private Practitioners, Private Clinics/Nursing Homes and Corporate sector

RNTCP performance indicators:

Important: Please give the performance for the last 4 quarters i.e. Oct ___ to September _____

Name of the District (also indicate if it is notified hilly or tribal district	Total number of patients put on treatment *	Annualised total case detection rate (per lakh pop.)	No of new smear positive cases put on treatment *	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year	
						Annualized NSP case detection rate	Cure rate
West Champaran	2611	72	1383	43	81	74	85
Jamui	1563	427	701	219	354	295	
Jehanabad	1344		481				
Kaimur	876		328		245		
Madhepura	734	42.3	423	33	90	70	90
Munger	1397		612				
Nalanda	1626	63	744	29	83	50	89
Nawada	1109	53	631	50	89	40	90
Purnia	3207		1662				
Vaishali	3237	108	871	27	86	60	93
Aurangabad	1428	66	656	29	75	38	86
Total							

***** *Patients put on treatment under DOTS regimens only are to be included.*

S.No.	Priority areas	Activity planned under each priority area
		1 a) Filling up of all State and District Level Contractual Staff

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

		1 b) Filling up the posts of DTOs & MOTCs
		1 c) Training of untrained DTOs & MOTCs at National and State Level and also of STS, STLS, LTs
2	Training	2 a)Training and Refresher Training of MOs & Para Medical Staff
		2 b)Training of ASHA as DOT Providers
		2 c)Training and retraining of All Contractual Staff under RNTCP
3	IEC	3 a) Printing of IEC Materials for the state
		3 b) Involvement of masses through generating awareness via the print and electronic media.
		3 c) Sensitisation of Local MLAs and PRI Members empowering the community by making them aware of the RNTCP facilities
4	Involvement of other Sectors/ NGOs/PP	4 a) Sensitisation workshop for other sectors, NGOs and PPs. On the revised schemes.
		4 b) Increased Involvement of Faith Based and Community Based organisation.
		4 c) Involving IMA in RNTCP in the State
5	Strengthening of IRL, Lab network and Implementation of EQA	5 a) Starting more DMCs especially in the APHCs with the help of NGOs.
		5 b) Visit of IRL to all the 38 districts with at least one OSE and One Panel Testing.
6	Minimizing Initial Defaulters	6 a) Ensuring in all districts – line listing of all sputum smear +ve patients diagnosed on regular basis.
		6 b) Regular data exchange for feedback within district regarding referral for treatment.

Priority Districts for Supervision and Monitoring by State during the next year

S No	District	Reason for inclusion in priority list
1	*Supaul*	*Low Case Detection*
2	*Buxar*	Low Case Detection
3	*Bhojpur*	Low Case Detection
4	*Gaya*	Low Case Detection
5	*Madhepura*	Low Case Detection
6	*Kaimur*	Low Case Detection
7	*Saran*	Low Case Detection

1 Civil Works

Activity	No. required as per the norms in the state	No. already upgraded/ present in the state	No. planned to be upgraded during next financial year	Pl provide justification if an increase is planned in excess of norms (use separate sheet if required)	Estimated Expenditure on the activity
	(a)	(b)	(c)	(d)	(e)
STDC/ IRL	1	0	1	0	3200000
STDC Hostel	1	0	1	0	2000000
SDS	1	0	0	0	0
DTCs	38	25	2	Upgradation of DTCs	2137500
TUs	121	105	15	Upgradation of Tus	1008200
DMCs	652	489	128	Upgradation of DMCs	3948100
				TOTAL	**12293800**

2 Laboratory Materials

Activity	Amount permissible as per the norms in the state	Amount actually spent in the last 4 quarters	Procurement planned during the current financial year (in Rupees)	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
Purchase of Lab Materials by Districts					Project increase in Case Detection and also increase in cose of Lab Consumables
Lab materials for EQA activity at STDC					
			Total	**14748750**	

3 Honorarium

Activity	Amount permissible as per the norms in the state	Amount actually spent in the last 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ Remarks for (d)
	(a)	(b)	(c)	(d)	(e)
Honorarium					
	No. presently involved in RNTCP		Additional enrolment proposed for the next fin. year		Committed Honorarium to DOT Providers
Community volunteers in all the districts*	1243		10000		
			Total	**7437500**	

***** *These community volunteers are other than salaried employees of Central/State government and are involved in provision of DOT e.g. Anganwadi workers, trained dais, village health guides, ASHA, other volunteers, etc.*

4 IEC/Publicity:

Permissible budget for State and all Districts as per Norms: Rs. _____

Estimated IEC budget for all Districts, as per action plans (*please enclose consolidation summary)*: Rs. _____

Target Group/ Objective	Activities Planned at State Level						Total activities proposed during next fin. year	Estimated Cost per activity unit	Total expenditure for the activity during the next fin. Year
	Activity (All activities to be planned as per local needs, catering to the target groups specified)	No. of activities held in last 4 quarters	No of activities proposed in the next financial year, quarterwise						
			Apr-Jun	July-Sep	Oct-Dec	Jan-Mar			
Patients and General public / for awareness generation and social mobilization	Outdoors:	0	3	2	3	0	8	8000	
	- wall paintings	25	3738	40257	25243	25344	1082	7150	
	- Hoardings	10980	46	37	36	36	155	59650	
	- Tin plates	20	10091	10091	91	90	363	11300	
	- Banners	2	32	31	22	32	117	6050	
	- others	25	15	0	0	0	15	200	
	Outreach activities:	0	0	0	0	0	0	0	
	- Patient provider interaction meetings	121	183	184	185	180	732	3300	
	- Community meetings	58	43	37	42	36	158	4600	
	- Mike publicity	1	32	32	27	26	117	5300	
	- Others	15	21	21	21	21	84	500	
	Puppet shows/ street plays/etc.	0	11	11	11	11	44	5000	
	School activities	10	29	29	29	28	115	4000	
	Print publicity	0	5000	5000	10000	5000	25000	500	
	- Posters	0	200	200	200	200	800	10	
	- Pamphlets	5001	6500	1000	1000	1000	4500	7005	
	- Others	1000	2000	2000	2000	2000	8000	0	
	Media activities on Cable/local channels	0	3	2	2	3	10	11500	
	Radio	0	0	0	0	0	0	0	
	Any other activity	0	0	0	0	0	0	0	

Opinion leaders/ NGOs for advocacy	Sensitization meetings	24	14	14	14	14	56	24400	
	Media activities	0	3	6	3	6	18	9000	
	Power point Presentations / one to one interaction	5	503	503	506	506	2018	8010	
	Information Booklets/ brochures	0	1000	1000	500	500	3000	3010	
World TB Day activities		10	0	0	0	21	21	85000	
Any other public event		0	0	0	0	1	1	5000	
Health Care providers – public and private	- CMEs	0	3	2	3	3	11	2500	
	- Interaction meetings	0	8	8	7	7	30	7700	
	- one to one interaction meetings	0	1	1	1	1	4	10000	
	- Information Booklets	0	210	211	216	205	852	3005	
	- Any other	0	0	0	0	0	0	0	
Any Other Activities proposed									
	Communication Facilitators (each for 5-6 districts)	0	0	0	0	1	1	6000	
								Total Budget	**10468750**

5. Equipment Maintenance:

Item	No. actually present in the state	Amount actually spent in the last 4 quarters		Amount Proposed for Maintenance during current financial yr.		Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)		Justification/ Remarks for (d)	
	(a)	(b)	(c)	(d)	(e)				

Computer (maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)	41	323369	654700	1500000		
Binocular Microscopes	800	40800	460200	1700000		
STDC IRL Equipments				1100000		
			TOTAL	**4300000**		

6. Training:

Activity	No. in the state	No. already trained in RNTCP	No. planned to be trained in RNTCP during each quarter of next FY (c)				Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year (Rs.)	Justification/ remarks
	(a)	(b)	Q1	Q2	Q3	Q4	(d)	(e)	(f)
Training of MOs (Govt + Non-Govt)	1991	1112	275	175	168	130	504500		
Training of LTs of DMCs- Govt + Non Govt	220	205	7	0	0	0	7250		
Training of MPWs	3562	1526	74	310	60	90	49250		
Training of MPHS, pharmacists, nursing staff, BEO etc	2089	1856	95	65	70	46	700		
Training of Comm Volunteers	5375	2513	550	1325	898	1145	111150		
Training of Pvt Practitioners	1129	370	176	406	156	282	72500		
Other trainings #	1700	500	175	175	175	175	5342		
Re- training of MOs	855	482	323	339	196	252	289640		
Re- Training of LTs of DMCs	157	154	28	80	13	51	53900		
Re- Training of MPWs	849	1036	395	135	160	163	260000		
Re- Training of MPHS, pharmacists, nursing staff, BEO	1517	739	115	415	115	673	107100		
Re- Training of CVs	1338	1105	165	1168	50	1150	0		
Re-training of Pvt Practitioners	1397	270	120	650	120	557	77500		
TB/HIV Training of MO-TCs and MOs	981	252	105	358	173	236	444500		

TB/HIV Training of STLS, LTs , MPWs, MPHS, Nursing Staff, Community Volunteers etc	5586	3081	385	1997	435	1967	78670		
TB/HIV Training of STS	42	17	9	28	0	21	21300		
Provision for Update Training at Various Levels #	1490	335	125	125	25	125	40000		
Review Meetings at State Level									
Any Other Training Activity			200	200	200	240			
							TOTAL	***1175000 0***	

7. Vehicle Maintenance:

Type of Vehicle	Number permissible as per the norms in the state	Number actually present	Amount spent on POL and Maintenance in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
Four Wheelers	11	38319	184260	120000		
Two Wheelers	124	32289	1230571	2761741		
				TOTAL	**7518750**	

8. Vehicle Hiring*:

Hiring of Four Wheeler	Number permissible as per the norms in the state	Number actually requiring hired vehicles	Amount spent in the prev. 4 qtrs	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
For STC/ STDC						Proposed to increase the No. of Tus
For DTO	33	14	790830	2767400		
For MO-TC	95	37	67206	2415500		
				TOTAL	**18500000**	

** Vehicle Hiring permissible only where RNTCP vehicles have not been provided*

9. NGO/ PP Support:

Activity	No. of currently involved in RNTCP in the state	Additional enrolment planned for this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)	(f)
NGOs involvement scheme 1	1	16	0	375000		
NGOs involvement scheme 2	1	15	0	575000		
NGOs involvement scheme 3	8	8	0	0		
NGOs involvement scheme 4	1	6	0	20000		
NGOs involvement scheme 5	9	0	298000	540000		
NGOs involvement unsigned	0	0	0	0		
Private practitioners scheme 1	2	65	0	35000		
Private practitioners scheme 2A	0	103	0	20000		
Private practitioners scheme 2B	0	3	0	0		
Private practitioners scheme 3	0	1	0	0		
Private practitioners scheme 4	0	0	0	0		

Activity	No. of currently involved in RNTCP in the district	Additional enrolment planned for this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification / remarks
	(a)	(b)	(c)	(d)	(e)	(f)
ACSM Scheme: TB advocacy, communication, and social mobilization	1	7	0	97500		-
SC Scheme: Sputum Collection Centre/s	0	3	0	90000		-
Transport Scheme: Sputum Pick-Up and Transport Service	0	1	25000	53000		-
DMC Scheme: Designated Microscopy Cum Treatment Centre (A & B)	0	2	0	112000		-
LT Scheme: Strengthening RNTCP diagnostic services	2	7	36675	40000		-
Culture and DST Scheme: Providing Quality Assured Culture and Drug Susceptibility Testing Services	0	0	0	0		-

Adherence scheme: Promoting treatment adherence	0	3	0	20000		-
Slum Scheme: Improving TB control in Urban Slums	0	0	0	0		-
Tuberculosis Unit Model	1	0	298500	390241		-
TB-HIV Scheme: Delivering TB-HIV interventions to high HIV Risk groups (HRGs)	0	1	0	25000		-
				TOTAL	**13375000**	

10. Miscellaneous:

Activity*	Amount permissible as per the norms in the district	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)
(Telephone Bill ,Postage, Staff TA/DA, Office Furniture & Stationary	**10626511**	**791263**	**4210479**	**13375000**	

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

Contractual Services:

Activity	No. required as per the norms in the district	No. actually present in the district	No. planned to be additionally hired during this year	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)		(d)	(e)	
Medical Officer-DTC	Not to be filled	2	1	-	128800		
STS	125	108	25	**34657133**	10013111		
STLS	125	101	28		8381861		
TBHV	50	21	16		1124250		
DEO	25	23	3		1593575		
Accountant – part time	23	12	11		328900		
Contractual LT		243	98		18358599		
Driver		0	0		0		
					Total	**132500000**	

Printing:

Activity	Amount permissible as per the norms in the district	Amount spent in the previous 4 quarters	Expenditure (in Rs) planned for current financial year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)	(e)
Printing*	4718755	114059	2296000	**6907500**	

** Please specify items to be printed*

Research and Studies:

Any Operational Research project planned (Yes)

(Post Graduate grant for one research paper from Medical College)
(If yes, enclose annexure providing details of the Topic of the Study, Investigators and Other details)

Whether submitted for approval/ already approved? (Yes/No)
_____
Estimated Budget (to be approved by STCS)._____

Medical Colleges

Activity	Amount permissible as per norms		Estimated Expenditure for the next financial year(Rs.)	Justification/ remarks
	(a)		(b)	(c)
Contractual Staff:				PMCH & NMCH statement of Medical College have been diverted from DTO to by STO for further information, if required please contact superintendent of Medical College.
□ MO (In place: Yes/No)	0			
□ STLS (In place: Yes/No)	0			
□ LT (In place: Yes/No)	0			
□ TBHV (In place: Yes/No)	0			
Research and Studies:				
□ Thesis of PG Student				
□ Operations Research*				
Travel Expenses for attending	6000			

STF/ZTF meetings			
IEC: Meetings and CME planned	15000		
	Total	**6000000**	

** Expenditure on OR can only be incurred after due approvals of STF/ STCS/ZTF/CTD (as applicable)*

Procurement of Vehicles:

Equipment	No. actually present in the district	No. planned for this year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)
4-wheeler **	3	0	0	-
2-wheeler	71	11	0	-
		Total	**1312500**	

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

Procurement of Equipment:

Equipment	No. actually present in the district	No. planned for this year	Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)	Justification/ remarks
	(a)	(b)	(c)	(d)
Office Equipment (computer, modem, scanner, printer, UPS etc)	38	30002		-
Any Other	10	0		
		Total	**1343750**	

Section D: Summary of proposed budget for the district –

S.No.	Category of Expenditure	**Budget estimate for the coming FY 2010- 11** *(To be based on the planned activities and expenditure in Section C)*
1	Civil works	12293800

2	Laboratory materials	14748750
3	Honorarium	7437500
4	IEC/ Publicity	10468750
5	Equipment maintenance	4300000
6	Training	11750000
7	Vehicle maintenance	7518750
8	Vehicle hiring	18500000
9	NGO/PP support	13375000
10	Miscellaneous	13375000
11	Contractual services	132500000
12	Printing	6907500
13	Research and studies	0
14	Medical Colleges	6000000
15	Salaries of regular staff**	0
16	Procurement – drugs	0
17	Procurement –vehicles	1312500
18	Procurement – equipment	1343750
	TOTAL	**261831300**

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

ACTION PLAN
(2010 – 2011)

NVBDCP
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¼ftykokj fooj.kh ifjf'k"V II LrHk & 14 ,o 15 n"V0;½

¼III½ fNMdko gr MhñMhñVhñ dh <ykb ftyk Lrj l i[k.M e[;ky; rFkk i[k.M e[;ky; l xkek rd dh tkrh gA vf/kdk'kr% ftyk e MhñMhñVhñ ftyk e[;ky; e gh HkMkfjr gA yfdu dN ftyk e i[k.M Lrj ij Hkh fiNy fNMdko d ckn MhñMhñVhñ cpr gA pfd i[k.M Lrj ij HkMkj.k dk vkdMk jkT; e[;ky; e ugh gA ,lh fLFkfr e ftyk e[;ky; l i[k.M rd <ykb d fufer #i; 1]500@& ¼,d gtkj ikp lk½ ifr dkyktkj iHkfor i[k.M rFkk i[k.M l fNMdko LFky rd <ykb d fy, #i; 1000@& ¼,d gtkj½ ifr iHkfor i[k.M dh nj l jkf'k dk vkdyu fd;k x;k gA

ifr i[k.M <ykb dh jkf'k dk vkdyu ctV r;kj dh nf"V l fd;k x;k gA vd{k.k nf"V l lcf/kr ftyk d dk;Øe inkf/kdkjh ftyk e[;ky; l i[k.M dh njh d vulkj fu;eulkj ¼vuekfnr nj½ <ykb djk;x] lkFk gh i[k.Mk e miyC/k MhñMhñVhñ dk eíutj j[kr g, <ykb ij jkf'k dk 0;; djx <ykb en dh jkf'k d 0;; ij fu;=k.k j[kk tk,xkA MhñMhñVhñ <ykb dk iLrkfor jkf'k % &

ftyk e[;ky; l i[k.M rd @ Rs. 1,500/-

ifr iHkkfor i[k.M dh nj l ¼310 X 1500½ & #i; 4]65]000@&

i[k.M e[;ky; l LFky rd @ Rs. 1000/-

ifr iHkkfor i[k.M dh nj l ¼310 X 1000½ & #i; 3]10]000@&

dy &#i; 7]75]000@&

¼ftykokj fooj.kh ifjf'k"V II LrHk & 16 ,o 17 n"V0;½

¼IV½ fNMdko e 0;ogkj gkuoky fNMdko midj.kk ¼ejEefr ;kX; midj.kk d½ ejEefr gr] fNMdko d nkjku fNMdko midj.kk d ejEefr ,o LVhji iEi gr pVdh okIj] xyu lrk bR;kfn d fy, jkf'k dk iko/kku ifr fNMdko ny #i; 120@& ,o ukty VhIl d Ø; gr ifr ifr fNMdko ny #i; 400@&dh nj l jkf'k dk iko/kku fd;k x;k gA C;; C;kjk bl idkj g % &

¼d½ fNMdko midj.kk dh ejEefr ,o okIj bR;kfn d Ø; gr

ifr fNMdko ny #i; 120@& 1782 X120 & Rs. 2]13]840@&

¼[k½ ukty Vhll Ø; & 5 uktu Vhll ifr iEi @ Rs. 40/-ifr ukty Vhll
3564X 5X 40&Rs. 7]12]800@&
dy &Rs. 9]26]640@&

¼ftykokj fooj.kh ifjf'k"V IV dkye 5 rFkk 6 n"V0;½

ftyk l ikIr fNMdko midj.kk dh miyC/krk dk ftykokj fooj.k ifjf'k"V III e n'kk;k x;k gA fNMdko d vulkj mä ifjf'k"V III e LVhji iEi] okYVh] xyu etj] ik.M Ektj rFkk ukty Vhll dh vko';drk rFkk ftyk e miyC/k midj.kk dk C;kjk n'kk;h xb gA fooj.kh d voykdu l Li"V gkxk fd vf/kdk'kr% ftyk e vko';drk l T;knk midj.k miyC/k g ftu ftyk e ejEefr d mijkr Hkh vko';drk l de midj.k miyC/k gkx] mu ftyk e fopyu }kjk vU; ftyk ¼tgk vko';drk l vf/kd midj.k g½ l fNMdko midj.k miyC/k djk;k tk,xkA

¼V½ **i;o{k.k % &** jkT; d 31 dkyktkj iHkkfor ftyk d foxr ikp o"kk e dkyktkj l iHkkfor lHkh xkek e fNMdko djk;k tkuk gA fNMdko d lQy lpkyu ,o x.koÙkk i.k fNMdko dh nf"V l i;o{k.k ,o eY;kdu vko';d gAi;o{k.k ftyk Lrj ,o i[k.M Lrj d inkf/kdkjh ,o depkjh }kjk fd;k tkrk gA

fNMdko d cgrj lk;o{k.k dh nf"V l ftyk Lrj ij lHkh 31 ftyk d flfoy ltu rFkk vij e[; fpfdRlk inkf/kdkjh dk lk;o{k.k dk nkf;Ro fn;k tk jgk gA 31 dkyktkj iHkkfor ftyk e l ek= 20 ftyk e gh ftyk eyfj;k inkf/kdkjh dk in lftr gA vr% 20 ftyk dk ftyk eyfj;k inkf/kdkjh dk Hkh i.k lk;o{k.k dk nkf;Ro fn;k tk jgk gA

ftu ftyk e xkMh miyC/k g] mu ftyk e jkf'k dk mi;kx xkMh e mi;ä gku oky b/ku ij fu;ekulkj fd;k tk,xkA ftu ftyk e xkMh miyC/k ugh g o fty HkkM ij xkMh ¼jkT; Lokñ lfefr] fcgkj iVuk }kjk fu/kkfjr nj ij½ ydj i;o{k.k dk; djxA

i[k.M Lrj ij i;o{k.k gr i[k.M d fpñinkñ dk ifr fnu 650@& :Œ dh nj l 60 fnuk d fy; jkf'k miyC/k djkb tk,xhA bl fufer vko';drk d rgr HkkM ij Hkh okgu fy;k tk ldrk g] tl fd Åij mYy[k fd;k x;k gA iHkkfor i[kMk d fpfdRlk inkf/kdkjh viu {k= e 'kr ifr'kr fNMdko dk i;o{k.k djxA

31 ftyk d flfoy ltu		
nk ekg d fy;	31X 2 X 10000	& 6]20]000@&
31 ftyk d vij e[; fpñinkñ		
nk ekg d fy;	31X 2 X 10000	& 6]20]000@&
20 ftyk d ftñ eñinkñ &		
nk ekg d fy;	20 X 2 X 20000	& 8]00]000@&
31 ftyk d 310 i[k.M fpñinkñ &		
nk ekg d fy;	310X 60X 650	& 1]20]90]000@&
	dy	&Rs. 1]41]30]000@&

i[k.M Lrj dh jkf'k ftyk dk;Øe inkf/kdkjh }kjk i[k.M fpñinkñ dk miyC/k djkb tk,xhA

¼ftyk fooj.kh ifjf'k"V IV LrHk 8]9 ,oa 10 n"V0;½

¼VI½ **i;o{kh inkf/kdkjh@depkjh dk nfud HkÙkk % &**

ek=k MhñMhñVhñ fNMdko e lyXu i;o{kh inkf/kdkjh ,o depkjh dk nfud HkÙkk ¼fu;ekulkj½ fn;k tk,xkA bl fufer ifr dkyktkj iHkkfor i[k.M d fy, #i; 1]000@& dh nj l jkf'k dk vkdyu fd;k x;k gA pfd i[k.M d ek= iHkkfor xkek dk gh fNMdko fd;k tk jgk gA ij i[k.M dk ughA bl eíutj j[kr g, gh jkf'k dk vkdyu fd;k x;k gA dkyktkj ;tuk d nfud HkRrk dk 0;; dkyktkj dk; d fy, d.kkfdr g rFkk LFkkiuk ctV e ek= HkRrk en e vkofVr jkf'k eyfj;k dk; d fy; gA

iLrkfor jkf'k &iHkkfor ik- Lok- dUn dh l[;k X1]000 = 310X 1]000 = #i; 3]10]000@&

¼ftyk fooj.kh ifjf'k"V IV LrHk 11 n"V0;½

(VII) vkbñbñlhñ % & fNMdko d io tu lk/kkj.k e fNMdko d Qk;n fNMdko d frFkk dh tkudkjh dh nf"V l bl en e ifr iHkkfor i[k.M #i; 1]500@& dh nj l

jkf'k dk iko/kku fd;k x;k gA fty k Lrjh; dk;Øe inkf/kdkjh ikLVj]bR;kfn d ek/;e l ipkj&ilkj djk;xA bl en dh jkf'k i[k.M fpñinkñ dk #i; 500@& ifr i[k.M dh nj l miyC/k djkb tk,xhA i[k.M fpñinkñ iHkkfor xkek e fNMdko d io <ky fiVokdj] ekbd }kjk xk"Bh dj tul/kkj.k dk fNMdko dh frfFk dh tkudkjh nxA iLrkfod jkf'k ¼iHkkfor i[k.M X1]500½ & 310X1]500 & #i; 4]65]000@& ¼fty k fooj.kh ifjf'k"V IV LrHk 12 n"V0;½

(VIII) 7 {k=h; mi fun'kd dk fNMdko i;o{k.k gr 10]000@& ifrekg dh nj l jkf'k dk iko/kku fd;k x;k gA 7X2 X10]000 = 1,40,000/-
eyfj;k dk;Øe e pkj {k=h; eyfj;k inkñ dk in lftr gA fNMdko dh egÙkk] x.kork i.k fNMdko rFkk fNMdko d lQy lpkyu dh nf"V l {k=h; eyfj;k inkñ dk i;o{k.k dk; d eY;kdu dk nkf;Ro fn;k tk,xkA lcf/kr {k=h; mi fun'kd rFkk {k=h; eyfj;k inkñ viu v/khuLFk fty k d Hke.k dj fNMdko d lpkyu dh tkudkjh ikIr djx rFkk llrkgUr e fty kokj fLFkfr l jkT; dk;Øe inkf/kdkjh dk voxr djk;xA bl fufer xkMh HkkM ij yu vFkok ;fn ljdkjh xkMh miyC/k gk rk b/ku gr jkf'k dk iko/kku ifr {k=h; eyfj;k inkñ #i; 20]000@& dh nj l fd;k x;k gA lcf/kr inkf/kdkjh ljdkjh okgu miyC/k ugh jgu ij jkT; Lokñ lfefr }kjk vuekfnr nj ij HkkM ij xkMh ydj dk; lEiknu djxA i;o{k.k d Øe e lcf/kr inkf/kdkjh de&l&de lHkh iHkkfor i[k.Mk d nk&rhu xkek d fNMdko dk fujh{k.k ¼ fNMdko vof/k e½ fuf'pr :i l djxA

iLrkfor jkf'k

7 {k=h; mi fun'kd 7X2 X10]000 = 1,40,000/-	
4 {kh; eyfj;k ink- 4 X 20]000@&	80]000@&
dy jkf'k&	2]20]000@&

(IX) jkT; Lrj ij jkT; dk;Øe inkf/kdkjh@ mi e[; eyfj;k inkf/kdkjh ,o lgk;d fun'kd dkyktkj }kjk fNMdko dk; dk fujh{k.k fd;k tk;xkA bl fufeRr rhuk inkf/kdkjh d ft, ij pØ e HkkM ij xkMh gr ctV iko/kku fd;k tk jgk gA HkkM dh xkMh jkT; LokLF; lfefr] fcgkj}kjk vuekfnr nj d vulkj 650@& :Œ ifrfnu dh nj l & 3 X60X 650@& 1]17]000@&
Hkkjr ljdkj d i;o{kd dk {k= Hke.k d fy; 6 xkMh] 3 fnuk d fy;@ ij pØ e pkj ckj ¼iUng fnuk ij½& 4 ¼6X3X 650½ = 46]800@&
jkT; Lrj ij fty k l ikIr ifronuk dk r;kj dju d Øe e LV'kujh dh vko';drk gkxhA bld rgr ek=k 25]000@& #i; dk;kYk; 0;; en e jkT; Lrj d lk;o{kh inkf/kdkjh d ;k=k HkRrk d fufeRr Hkh jkf'k dk iko/kku fd;k x;k gA bl idkj jkT; Lrj d fy, jkf'k ¼ &

jkT; Lrj xkMh en e	&	#i; 1]17]000@&
dUnh; i;o{kd d fy, xkMh	&	:l; 46]800@&
dk;kYk; en e	&	#i; 25]000@&
;k=kk en e	&	#i; 25]000@&
dy		**#i; 2]13]800@&**

(X) Spray quality should be focused & fNMdko dh x.koÙkk lfuf'pr dju gr lHkh io{kh inkf/kdkjh ,o depkjh dk vko';d fun'k fn;k tk;xkA jkT; Lrj d io{kh inkf/kdkjh }kjk fty k d Hke.k d nkjku bl ij dMh fuxjkuh j[kh tk;xhA lcf/kr {k=h; eyfj;k inkf/kdkjh ,o fty k dk;de inkf/kdkjh dk fNMdko dh 'kr ifr'kr x.koÙkk lfuf'pr djku dk nkf;Ro fn;k tk;xkA

Qjojh&ekp] 2010 e dkyktkj MhñMhñVhñ fNMdko gr iLrkfor ctV dk ljk'k ¼ &

Øe lñ	Ekn	jkf'k	fty k dk;Øe inkñdk dkyktkj iHkkfor fty k d fooj.kh vulkj
01-	etnjh	6]12]65]160@&	rFko
02-	¼i½ dk;ky; 0;; ¼ii½ vkDlfedrk 0;;	3]56]400@& 3]56]400@&	rFko
03-	MhñMhñVhñ <ykb	7]75]000@&	rFko

04-	fNMdko midj.k	9]26]640@&	rFko
05-	i;o{k.k	1]41]30]000@&	rFko
06-	nfud HkÙkk	3]10]000@&	rFko
07-	vkbñbñlhñ	4]65]000@&	rFko
	ftyk Lrj dk ;kx	**7]85]84]600@&**	¼ ifjf'k"V II & IV dk ;kx½
08-	Lkkr {k=h; mi fun'kd ,o pkj {kñeñinkñ dk i;o{k.k gr	2]20]000@&	{k-mi-fu- iVuk@et¶Qjij@njHkxk@ exj@Hkkxyij@lgjlk ,o if.k;k {kñeñinkñ] iVuk] et¶Qjij] Hkkxyij rFkk njHkxk dk
09-	jkT; e[;ky; gr	2]13]800@&	jkT; dk;Øe inkf/kdkjh jkT; e[;ky;] iVukA

,d pØ d fy, dy : 0 7]90]18]400@& vuñ ¼ & fooj.kh I, II, III &IV
nk pØ d fy, dy : 0 15]80]36]800@&

¼[k½ **mipkjkRed dkjokb %** &
dkyktkj d jkdFkke gr fujk/kkRed dkjokb d rgr MhñMhñVhñ fNMdko dk iko/kku g] ftld fy, [k.M ^d* e enokj ctV dk iko/kku fd;k x;k gA mipkjkRed dkjokb d rgr dkyktkj jkxh d fpfdRlk lfo/kk nu ij o"k 2008 d fnlEcj rFkk 04-11-2009 d jkT; Lrjh; cBd e foLrkj l ppk gb FkhA ppk d nkjku dkyktkj d lHkh jkxh dk i.k fpfdRlk ljdjh lLFkkuk e djku d lnHk e fofHké igyvk ij fopkj fd;k x;kA foe'kkijkUr ftu e[; fcUnvk ij lgefr cuh mld vulkj lyXu ifjf'k"V V e ctV iLrko fn;k x;k gA fooj.k fuEuor g %&

¼1½ **ikRlkgu jkf'k %** &
ik;% n[kk tkrk x;k g fd lHkh jkxh dfri; dkj.kk l ljdkjh lLFkkuk e fpfdRlk ugh djk ikr g ;k vkr g rk fpfdRlk d nkjku gh py tkr gA dN jkxh ikboV fpfdRld d ikl fpfdRlk djkr gA
dkyktkj d lHkh jkxh dk ljdkjh lLFkkuk e i.k fpfdRlk djku dh nf"V l LokLF; dk;dUkk ^*vk'kk** dk ikRlkgu jkf'k d :lk e #i; 100 ifr dkyktkj jkxh dh nj l nu dk fu.k; fy;k x;k g] ftld rgr ^*vk'kk** xkeh.k {k=k d lHkkfor dkyktkj jkfx;k d ljdkjh lLFkkuk e tkp djokuk ,o dkyktkj dh fcekjh li"V gku ij i.k fpfdRlk djku dk nkf;Ro fuHkk;xA jkxh dh fpfdRlk i.k gku d mijkr mUg ikRlkgu jkf'k fn;k tk,xkA
ifjf'k"V V LrHk 4 e o"k 2009 d vuekfur dkyktkj jkfx;k dk ftykokj l[;k n'kkr g, ifr jkxh 100@& #i; dh nj l jkf'k dk vkdyu fd;k g] ftl LrHk 5 e n'kk;k x;k g %&
iLrkfor jkf'k & dkyktkj jkfx;k dh l[;kX100 ¾
33]000X100 ¾ 33]00]000@& ¼**ifjf'k"V v LrHk 5 n"V0;**½
tgk rd Hkkjr ljdkj Qeyh odj dk ikRlkgu jkf'k nu lc/kh iLrko nu dk l>ko g] rk bl fufer vk'kk dk;dUkk dk ikRlkgu jkf'k nu dk iko/kku ctV e fd;k x;k gA bld vfrfjDr vU; Health activist }kjk dkyktkj d lEHkkfor jkxh yk; tku ij jkxh dk dkyktkj jkx lEi"V gku d mijkUr i.k fpfdRlkijkUr ikRlkgu jkf'k fn;k tk;xkA

¼2½ **{kfrifrl jkf'k %** &
dkyktkj d vf/kdk'k jkxh xjhc ox d gkr g] tk etnjh dj viuk thou fuokg djr gA ,l ykx >Xxh&>kiMh e lnj ngrh bykdk e jgr g] tgk l bykt gr ljdkjh vLirky e vku e dfBukb d vfrfjä bykt djku d fy, ljdkjh vLirky e fpfdRlk d nkjku 20&30 fnuk rd jguk iMrk gA ftll mudk nfud etnjh ckf/kr gk tkrk g vkj mUg vkfFkd ldV dh nkgjh ekj gk tkrh gA nfud etnjh rk ugh feyrh] vyx l bykt ij Hkh 0;; gk tkrk gA ifj.kkeLo:l dkyktkj d ,l jkxh ljdkjh lLFkkuk e fpfdRlk vof/k ¼vf/kdre 30 fnu½ rd Je {kfrifr jkf'k nh tk,xhA
iLrkfor jkf'k & dkyktkj jkfx;k dh l[;k×fpfdRlk vof/k×{kfrifr jkf'k
¾33]000X30X50¾Rs. 4]95]00]000@& ¼**ifjf'k"V v LrHk 6 n"V0;**½

¼3½ **i;ksx{k.k %** &
Dkyktkj d fu;=k.k e io{k.k ,d egRoi.k fgLlk gA ;fn ij o"k e ftyk Lrj ,o i[k.M Lrj l l{ke io{k.k fd;k tk, rk dkyktkj d fu;=k.k dk y{; ikIr fd;k tk ldrk gA io{k.k d rgr MhñMhñVhñ fNMdko] jkfx;k dk fpfdRlk] vuJo.k] ifronuk dk lle; i"k.k bR;kfn vkr gA o"k e nk pØ MhñMhñVhñ fNMdko vof/k vFkkr 4 ekg d io{k.k dk ctV iko/kku vkbñvkjñ ,lñ d rgr fd;k x;k gA 'k"k vkB ekg d io{k.k gr mipkjkRed dkjokb e iko/kku fd;k tkuk gA
io{k.k dk nkf;Ro ftyk Lrj ij ftyk dk;Øe inkf/kdkjh ,o i[k.M Lrj ij i[k.M fpfdRlk inkf/kdkjh dk gA jkT; d 31 dkyktkj iHkkfor ftyk e ek=k 20 fty e gh ftyk eñinkf/kdkjh dk in lftr g 'k"k 11 ftyk e bUgh ftyk eyfj;k inkf/kdkjh d v/khu vkr gA lQy io{k.k dh nf"V l iR;d ftyk e ,d ftyk Lrjh; io{k.kh inkf/kdkjh gkuk pkfg,A bl fufer 20 ftyk d io{k.k dk nkf;Ro ftyk eyfj;k inkf/kdkjh dk] 9 ftyk d vij e[; fpfdRlk inkf/kdkjh dk rFkk 'k"k nk fty ¼kxfM;k vkj e/kijk½ d flfoy ltu fn;k tk jgk gA

[kxfM;k rFkk e/kijk ftyk d flfoy ltu bl en dh jkf'k dk mi;kx xkMh d b/ku ij djx ftu ftyk d vij e[; fpfdRlk inkf/kdkjh d ikl jkf'k miyC/k g o :i; 3000@& ifrekg dh nj l b/ku ij 0;; djxA ftu ftyk e xkMh miyC/k ugh g o 10]000@& dh jkf'k HkkM dh xkMh ij 0;; djxA
fNMdko vof/k ¼pkj ekg½ e io{k.k d fy, jkf'k dk iko/kku lyXu ifjf'k"V IV e fn;k x;k gA 'k"k vkB ekg d fy, jkf'k dk iko/kku lyXu ifjf'k"V V e fd;k x;k gA ifjf'k"V V d LrHk 8 e flfoy ltu e/kijk ,o [kxfM;k dk 3]000@& ifr ekg dh nj l ifjf'k"V V d LrHk 9 e vij e[; fpfdRlk inkf/kdkjh ¼vjfj;k] vjoy] ckdk] cDlj] tgkukckn] fd'kuxt] y[kh ljk;] f'kogj ,o liky½ dk #i; 10]000@& #i; ifr ekg dh nj l rFkk 'k"k 20 ftyk d ftyk eyfj;k inkf/kdkjh dk #i; 10]000@& ifrekg dh nj l jkf'k dk iko/kku fd;k x;k g lkFk gh iHkkjh fpfdRlk inkf/kdkfj;k d lg;kx l ikFkfed LokLF; dUn d {kk e 'kr&ifr'kr fNMdko lfuf'pr djxA

iLFkkfor jkf'k bl izdkj g%&

(a) nk flfoy ltu dk :- 3000@& ifrekg dh nj l 8 ekg d fy; 3000x2 x 8 = 48000@&

(b) 9 ftyk d vij e[; fpfdRlk inkf/kdkjh dk ,o 20 ftyk d ftyk eyfj;k inkf/kdkjh dk 8 ekg d fy; :- 10000@& ifrekg dh nj l%& 10000x29 x 8 = 23]20]000@
dk vkdyu ifjf'k"V V e fd;k x;k gA

¼4½ **dkykt kj dh nok ,EQkVjhlhe ohñ dk HkMkj.k 0;oLFkk % &**

dkykt kj jkfx;k d fpfdRlk gr Hkkjr ljdkj }kjk ,lh,lhth ,EQkVjhlhu oh dh nok dh vkifr dh tkrh gA ,EQkVjhlhu nok dh ,d fu/kkfjr rkiØe ¼2 l 8° C½ ij j[kk tk tkuk g] vU;Fkk nok dh {kerk d Ðgkl gku dh lHkkouk gA fu/kkfjr rkiØe ij nok HkMkj.k d fy, 'khr J[kyk@'khrxg gh mi;ä gA
ftu ftyk e 'khr J[kyk miyC/k g bu ftyk d flfoy ltu nok dk 'khr J[kyk e j[kxA ftu ftyk e 'khr J[kyk miyC/k ugh g mu ftyk e 'khr xg ¼Cold Storage½ e nok j[ku dk iLrko gA bl fufer iR;d fty dk mä nok HkMkj.k gr ¼'khr J[kyk miyC/k ugh jgu ij dkYM LVkjt HkkM ij yu gr½ #i; 500@& ifrekg dh nj l ,d o"k d fy, jkf'k dk iko/kku fd;k x;k gA jkT; Lrj ij ¼jkT; dk;Øe inkf/kdkjh½ Hkh mä nok d HkMkj.k gr 'khr xg dh vko';drk g] ftld fy, #i; 1500@& ifr ekg dh nj l jkf'k dk iko/kku fooj.kh V LrHk 12 e e fd;k x;k gA

iLrkfor jkf'k &

1½ ftyk Lrj ij HkMkj.k gr #i; 500 @& ifrekg dh nj l ,d o"k d fy, 31 X 500X 12 ¾ #i; 1]86]000@&

¼II½ jkT; Lrj ij HkMkj.k gr #i; 1]500 @& ifrekg dh nj l ,d o"k d fy, 1]500X 12 ¾ #i; 18]000@&¼vko';drkulkj½

¼ifjf'k"V V LrHk 12 n"V0;½

5- fpfdRlk dkM % &

dkykt kj jkfx;k d fpfdRlk d Øe e nh tkuokyh nok d [kjkd dk y[kk&l/kkj.k ,o fpfdRlk C;kjk d fy, fpfdRlk dkM dk mi;kx fd;k tkuk vko';d g oreku e fpfdRlk dkM dk mi;kx ftyk Lrj d vLirky l ydj i[k.kM Lrj ij ugh fd;k tk jgk g] ftld dkj.k rduhdh eY;kdu e dfBukb gkrh gA 'kh"k Lrj ij Hkh fpfdRlk dkM l/kkj.k ugh fd; tku ij fprk trkb xb gA
vr% fpfdRlk dkM d mi;kx dh egUkk dk n[kr g, ifr jkxh 2 idkj d dkM dh fu;ekulkj vko';drk gkxhA ,d dkM dh Nkb e vuekfur #i; 5-00@& 0;; gkxkA bl rjg ,d ¼,d jkxh d fy, nk dkM d fglkc l ½ ifr jkxh ij 10-00@& #i; 0;; gkxkA ifjf'k"V V LrHk 4 e o"k 2009 d lHkkfor jkfx;k dh l[;k d vulkj LrHk 13 e ftykokj jkf'k dk vkdyu fd;k x;k gA
iLrkfor jkf'k & jkfx;k dh l[;k nj ¼33]00X 10½ ¾ #i; 3]30]000@&

¼ifjf'k"V V LrHk 13 n"V0;½

6- dkykt kj jkfx;k dk lpuk l/kkj.k ith % &

dkyktkj jkfx;k d foLrr lpuk d l/kkj.k ,o {k=kh; Je {kfrifr Hkkx d l/kkj.k gr iR; dkyktkj iHkkfor i[k.M e nk jftLVj j[ku dk iko/kku fd;k x;k g rkfd 'kh"k Lrj d inkf/kdkjh }kjk Hke.k d nkjku jkfx;k dh foLrr lpuk ,o nfud Je {kfrifr jkf'k dk eY;kdu fd;k tk ldA bl fufer iR;d dkyktkj iHkkfor fty d dkyktkj iHkkfor ik- Lok- dUn dk nk jftLVj ¼,d ftLrk dk½ vuekfur dher #i; 100@& ¼pkj jftLVj½ dh nj l jkf'k dk vkdyu fd;k x;k gA

iLrkfor jkf'k & 31 ftyk d dkyktkj iHkkfor ik- Lok- dUn dh l[;k × nj 310X100 ¾31]000@&

¼ifjf'k"V v LrHk 14 n"V0;½

7- **MhñMhñVhñ dk Hk.Mkj.k ¼ &**

MhñMhñVhñ fNMdko d fy, Hkkjr ljdkj }kjk ftyk e MhñMhñVhñ dh vkifr dh tkrh gA ftyk e MhñMhñVhñ d Hk.Mkj.k dh lefpr 0;oLFkk ugh jgu d dkj.k MhñMhñVhñ {kfrxLr ¼/ki ,o ikuh l½ gku dh lHkkouk gA lefpr Hk.Mkj.k 0;oLFkk dk eíutj j[kr g, ;k rk Hk.Mkj] HkkM ij fy;k tk; ;k ftyk d miyC/k jkT; HkMkj fuxe d xknke e j[kk tk;A

Pkfd ftyk dk HkkM ij HkMkj yu e fu;ekulkj i'kklfud Lohdfr yu e dkQh dfBukb gkrh gA Qyr% tc rd HkMkj.k dh 0;oLFkk ugh gkrh gA rc rd MhñMhñVhñ dk ;=&r= j[kuk iMrk gA bl fufer HkkM ij xknke yu vFkok jkT; HkMkj fuxe ¼ftldk nj ljdkj }kjk vuekfnr g½ d xknke e HkMkj.k gr ifr ftyk ifr ekg #i; 5]000@& dh nj l ij o"k d fy, jkf'k dk iko?kku fd;k x;k gA

iLrkfor jkf'k & 31X 5000X 12 ¾ 18]60]000@&

¼ifjf'k"V v LrHk 15 n"V0;½

8- **dkyktkj [kkt lk[kokjk&**

i dkyktkj i[kokjk d cny dEi ekM e jkfx;k d [kt dju dh vu'kklk gA bl fufeRr iR;d dkyktkj iHkkfor i[k Me ifrekg nk fnu dkyktkj jkfx;k dk fo'k"k [kkt dk; djk;k tk;xkA

iR;d dEi e de l de pkj xkek dk 'kkfey fd;k tk;A bl [kkt dk;Øe d lpkyu d fy, iR;d dkyktkj iHkkfor i[kMk] iR;d ekg e nk fnu dEi d fy, ilkj okgu gr 750@& ifrfnu dh nj l jkf'k dk iko/kku gA ;d dk;Øe foRrh; o"k 2010&11 d vkB ekgk ¼eb&tu rFkk Qjojh&ekp dk NkMdj½ djk;k tk;xkA

iLrkfor jkf'k%& 310x2x8 x750 = 37]20]000

ii vkb-bl-lh-%& dkyktkj iHkkfor 31 ftyk d lHkh i[kMk e dkyktkj l cpko ,o bykt gr fHkftfofyVh c<ku gr jkf'k dk iko/kku fd;k tk jgk gA ;g jkf'k ldfyr :l l jkT;Lrj ij miyC/k jgxh ,o ipkj&ilkj lkekxh dk Hkn.k dj lHkh i[kMk dk miyC/k djk;k tk;xkA

iLrkfor jkf'k%& 338x10]000 = 33]80]000

9- **Arrest Cases of Kalazar** & o"k 2010 rd dkyktkj Elemenation y{; dk ikIr dju d fy, lHkh dkyktkj jkfx;k dk i.k mipkj fd;k tk;xk rFkk iHkkfor {k=k e fujk/kkRed dkjokb d rgr o"k e nk okj MhOMhOVh0 fNMdko djk;k tk;xkA bld vfrfjDr [kkt lk[kokjk d }kjk dkyktkj jkfx;k dh [kkt dj fpfdRlk dh tk;xhA vk'kk dk;dUkk dk dkyktkj d lEHkkfor dk ljdkjh vLirky e ykdj] dkyktkj d jkx lEi"V gku ,o i.k fpfdRlk d mijkUr ikRlkgu jkf'k nh tk;xhA bl rjg dkyktkj dl dk lekIr fd;k tk ldrk gA

10- **iLrkfor jkf'k%**& ¼ &

1-	ikRlkgu jkf'k &	33]00]000@&ftyk dk;Øe inkñ dk
2-	nfud Je {kfrifr jkf'k	4]95]00]000@& rFko
3-	lko{k.k	23]68]]000@& rFko
4-	nok dk Hk.Mkj.k	1]86]000@& rFko
		18]000@& jkT; dk;Øe inkñ dk
5-	fpfdRlk dkM	3]30]000@& ftyk dk;Øe inkñ dk
6-	lpuk l/kkj.k ith	31]000@& rFko
7-	MhñMhñVhñ dk HkMkj.k	18]60]000@& rFko

8- dkyktkj [kkt i[kokjk 71]00]000@&
dy ;kx **6]46]93]000@&**
¼N% djkM fN;kfyl yk[k frjkuo gtkj #i; ek= ½
¼ifjf'k"V V n"V0;½

1. _____ _____
_____

Rs. 50,000/-

[**VI**]

2. _____

Rs. 50,000/- Rs.
50,000 × 1 -------Rs. 50,000/-

[VI]

3. _____

Rs. 2000/-

Rs. 1000/-

_____

× Rs 20,000/-
× × Rs.60,000/-
Rs. Rs.80,000//-

[VI,]

4. _____

Rs. 25,000/-

[VI,]

5. _____

Rs. 1,50,000/-

6. _____

Rs. 15,000/-

_____ 6 × 15,000 Rs. 90,000/-

7. _____

Rs. 50,000/-

8. _____

x Rs. 1,60,000/-

Rs. 50, 000/-

[VI] Rs. 2,10,000/-

9. _____

Rs. 1,50, 000/-

Rs. 10,000/-
× 10,000 Rs. 1,20,000/-

Rs. 2,70,000/-

VI 11

10. _____

Rs. 5,00,000/-

VI 13

11. _____

_____

10,000 × 4x8 320,000/-

	50,000 × 4	2,00,000/-
	5000 × 4	20,000/-
ih Vj	000 × 4	40,000
		5,80,000/-

Rs. 50,000/-
Rs. 50,000/-
Rs. 80,000/-
Rs. 25,000/-
Rs. 1,50,000/-
Rs. 90,000/-
Rs. 50,000/-
Rs. 2,10,000/-
Rs. 2,70,000/-
Rs. 5,00,000/-
Rs. 5,80,000/-
Rs. 20,55,000/-

Elemination

VII VII

1.

69,500/-

1 × 6 × 69, 500/- Rs. 4,17,000/-

VII

2.

1,25,000/-

2 × 1,25, 000 Rs. 2,50,000/-

Re Orientation

75,620/-

Orientation 2 × 75, 620 Rs. 1,51,240/-

Rs. 4,01,240/-

VII 6, 7

3. _____

30,000

5 × 30, 000 Rs. 1,50,000/-

VII

4. _____

30,000/-

30,000 × 8 Rs. 2,40,000/-

VII

5. _____

VIII

1,20,000/-

× 1,20,000 Rs. 24,00,000/-

VIII

6. _____

IX

277 × 2000 Rs. 5,54,000/-

IX

7.

214 × 2000 Rs. 4,28,000/-

X

8.

X

1112 × 2000 Rs. 22,24,000/-

X

9.

Rs. 4,17,000/-
Rs. 4,01,240/-
Rs. 1,50,000/-
Rs. 2,40,000/-
Rs. 24,00,000/-
Rs. 5,54,000-
Rs. 4,28,000/-
Rs. 22,24,000/-
Rs. **68,14,240**/-

Rs. 15]80]36]800=00
Rs. 6]46]93]000=00
Rs. 20,55,000=00
Rs. 68,14,240 = 00
Rs. **23,15,99,040=00**

(

District Infrastructure of Kala-Azar Affected Districts									Anexure - I					
Sl. No.	Name of Districts	Total No. of							Total No. of Affected					
		PHC	HSC	Block	Panchyat	Revenue Village	Urban Ward	Population	PHC	HSC	Panchyat	Village	Ward	Population
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	Araria	9	109	9	221	757	54	2,670,845	9	88	165	563	0	2,153,592
2	Arwal	3	64	0	0	335	0	651,717	3	7	0	18	0	41,144
3	Banka	10	0	11	185	1681	40	0	1	1	1	2	0	12,719
4	Begusarai	11	288	18	257	1064	36	2,900,088	11	51	154	245	0	999,274
5	Bhagalpur	11	280	17	242	1929	62	2,948,451	7	0	0	62	0	145,797
6	Bhojpur	12	304	14	228	1457	100	2,292,652	9	64	0	120	0	210,106
7	Buxar	7	167	11	142	993	60	1,458,493	4	16	0	16	0	104,052
8	Darbhanga	14	306	19	306	1522	48	3,442,496	14	206	206	455	0	1,602,617
9	E.Champaran	20	318	27	387	1716	20	46,78,325	20	268	302	817	0	2,620,283
10	Gopalganj	10	186	14	234	1499	12	2,398,707	10	107	0	261	0	693,562
11	Jehanabad	5	81	12	161	947	52	1,029,742	5	15	0	36	0	37,257
12	Katihar	18	257	16	238	1737	45	2,687,203	18	192	0	543	0	1,134,049
13	Khagaria	6	0	7	129	306	18	0	6	0	0	119	0	348,271
14	Kishanganj	7	79	7	118	761	28	1,554,007	6	36	63	323	0	712,592
15	Lakhisarai	4	102	7	80	496	18	895,678	2	19	19	29	18	101,437
16	Madhepura	7	196	13	170	838	41	1,669,001	7	139	0	384	0	1,431,240
17	Madhubani	18	430	21	399	1072	75	4,094,575	18	294	294	366	0	1,376,642
18	Munger	6	134	9	101	837	104	1,349,751	6	33	30	52	0	97,035
19	Muzaffarpur	14	527	16	387	1937	49	4,561,521	14	459	0	1273	0	2,703,171
20	Nalanda	12	0	20	249	1183	122	0	11	0	0	91	0	315,421
21	Patna	16	0	23	331	1455	72	4,062,216	16	244	0	422	0	1,060,285
22	Purnea	14	151	14	237	1075	0	3,174,330	13	107	191	764	0	2,258,220
23	Saharsa	7	152	10	164	435	43	1,802,298	7	130	0	379	0	1,381,124
24	Samastipur	14	0	20	381	1250	61	3,860,729	14	331	329	701	0	1,904,426
25	Saran	15	413	20	0	1813	0	3,551,306	15	0	0	597	0	1,437,022
26	Sheohar	2	0	5	54	207	15	0	2	0	0	48	0	212,868
27	Sitamarhi	13	0	17	273	846	79	3,009,938	13	186	212	433	38	1,807,046
28	Siwan	15	351	16	293	1458	51	3,100,210	14	219	0	509	0	1,481,302
29	Supaul	11	178	11	180	688	0	1,968,535	11	0	0	245	0	809,393
30	Vaishali	11	339	16	292	1680	45	3,250,683	11	0	278	751	0	2,054,842
31	W.Champaran	16	369	18	354	2220	121	3,495,552	13	140	123	190	0	1,147,023
Total		338	5,781	438	6,793	36,194	1,471	67,880,724	310	3,352	2,367	10,814	56	32,393,812

Dist. Wise Sqad,DDT,Wages,Office Exp.,Contigency,Transportation of DDT For Kala Azar Spray One Round — Annexure -II

Sl. No.	Name of Districts	Total No. of Affected		Total No. of Sqad (55 Sqad /10 Lakhs Population	Total No. of Workers		DDT 50% Status (In Meric Ton)			WAGES			Office Expenses (@ Rs 200/- Per Sqad	Contigency (@ Rs. 200/- Per Sqad	Contigency At State HQ.	Transportation of DDT			Grand Total (13+14+15+16+18)
		PHC	Population		SFW	FW	Require.	Available	Balance Require.	SFW(Rs. 113/-Per SFW For 60 Days)	FW(Rs.92/-Per FW For 60 Days)	Total				District To PHC(RS. 1500/- Aff. PHC)	PHC To Village (Rs.1000/- PHC)	Total	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	**Araria**	9	2,153,592	118	118	590	80.76	116.00	**-35.24**	800,040	3,256,800	4,056,840	23,600	23,600	0	13,500	9,000	22,500	4,126,540
2	**Arwal**	3	41,144	2	2	10	1.54	0.00	**1.54**	13,560	55,200	68,760	400	400	0	4,500	3,000	7,500	77,060
3	**Banka**	1	12,719	1	1	5	0.48	0.00	**0.48**	6,780	27,600	34,380	200	200	0	1,500	1,000	2,500	37,280
4	**Begusarai**	11	999,274	55	55	275	37.47	36.00	**1.47**	372,900	1,518,000	1,890,900	11,000	11,000	0	16,500	11,000	27,500	1,940,400
5	**Bhagalpur**	7	145,797	8	8	40	5.47	2.00	**3.47**	54,240	220,800	275,040	1,600	1,600	0	10,500	7,000	17,500	295,740
6	**Bhojpur**	9	210,106	12	12	60	7.88	25.00	**-17.12**	81,360	331,200	412,560	2,400	2,400	0	13,500	9,000	22,500	439,860
7	**Buxar**	4	104,052	6	6	30	3.90	5.00	**-1.10**	40,680	165,600	206,280	1,200	1,200	0	6,000	4,000	10,000	218,680
8	**Darbhanga**	14	1,602,617	88	88	440	60.10	99.00	**-38.90**	596,640	2,428,800	3,025,440	17,600	17,600	0	21,000	14,000	35,000	3,095,640
9	**E.Champaran**	20	2,620,283	144	144	720	98.26	128.00	**-29.74**	976,320	3,974,400	4,950,720	28,800	28,800	0	30,000	20,000	50,000	5,058,320
10	**Gopalganj**	10	693,562	38	38	190	26.01	24.00	**2.01**	257,640	1,048,800	1,306,440	7,600	7,600	0	15,000	10,000	25,000	1,346,640
11	**Jehanabad**	5	37,257	2	2	10	1.40	0.00	**1.40**	13,560	55,200	68,760	400	400	0	7,500	5,000	12,500	82,060
12	**Katihar**	18	1,134,049	62	62	310	42.53	34.00	**8.53**	420,360	1,711,200	2,131,560	12,400	12,400	0	27,000	18,000	45,000	2,201,360
13	**Khagaria**	6	348,271	19	19	95	13.06	19.00	**-5.94**	128,820	524,400	653,220	3,800	3,800	0	9,000	6,000	15,000	675,820
14	**Kishanganj**	6	712,592	39	39	195	26.72	4.00	**22.72**	264,420	1,076,400	1,340,820	7,800	7,800	0	9,000	6,000	15,000	1,371,420
15	**Lakhisarai**	2	101,437	6	6	30	3.80	2.00	**1.80**	40,680	165,600	206,280	1,200	1,200	0	3,000	2,000	5,000	213,680
16	**Madhepura**	7	1,431,240	79	79	395	53.67	47.00	**6.67**	535,620	2,180,400	2,716,020	15,800	15,800	0	10,500	7,000	17,500	2,765,120
17	**Madhubani**	18	1,376,642	76	76	380	51.62	113.00	**-61.38**	515,280	2,097,600	2,612,880	15,200	15,200	0	27,000	18,000	45,000	2,688,280
18	**Munger**	6	97,035	6	6	30	3.64	16.00	**-12.36**	40,680	165,600	206,280	1,200	1,200	0	9,000	6,000	15,000	223,680
19	**Muzaffarpur**	14	2,703,171	149	149	745	101.37	116.00	**-14.63**	1,010,220	4,112,400	5,122,620	29,800	29,800	0	21,000	14,000	35,000	5,217,220
20	**Nalanda**	11	315,421	17	17	85	11.83	33.00	**-21.17**	115,260	469,200	584,460	3,400	3,400	0	16,500	11,000	27,500	618,760
21	**Patna**	16	1,060,285	58	58	290	39.76	50.00	**-10.24**	393,240	1,600,800	1,994,040	11,600	11,600	0	24,000	16,000	40,000	2,057,240
22	**Purnea**	13	2,258,220	124	124	620	84.68	132.00	**-47.32**	840,720	3,422,400	4,263,120	24,800	24,800	0	19,500	13,000	32,500	4,345,220
23	**Saharsa**	7	1,381,124	76	76	380	51.79	66.00	**-14.21**	515,280	2,097,600	2,612,880	15,200	15,200	0	10,500	7,000	17,500	2,660,780
24	**Samastipur**	14	1,904,426	105	105	525	71.42	68.00	**3.42**	711,900	2,898,000	3,609,900	21,000	21,000	0	21,000	14,000	35,000	3,686,900
25	**Saran**	15	1,437,022	79	79	395	53.89	82.00	**-28.11**	535,620	2,180,400	2,716,020	15,800	15,800	0	22,500	15,000	37,500	2,785,120
26	**Sheohar**	2	212,868	12	12	60	7.98	4.00	**3.98**	81,360	331,200	412,560	2,400	2,400	0	3,000	2,000	5,000	422,360
27	**Sitamarhi**	13	1,807,046	99	99	495	67.76	87.00	**-19.24**	671,220	2,732,400	3,403,620	19,800	19,800	0	19,500	13,000	32,500	3,475,720
28	**Siwan**	14	1,481,302	81	81	405	55.55	56.00	**-0.45**	549,180	2,235,600	2,784,780	16,200	16,200	0	21,000	14,000	35,000	2,852,180
29	**Supaul**	11	809,393	45	45	225	30.35	36.00	**-5.65**	305,100	1,242,000	1,547,100	9,000	9,000	0	16,500	11,000	27,500	1,592,600
30	**Vaishali**	11	2,054,842	113	113	565	77.06	95.00	**-17.94**	766,140	3,118,800	3,884,940	22,600	22,600	0	16,500	11,000	27,500	3,957,640
31	**W.Champaran**	13	1,147,023	63	63	315	43.01	41.00	**2.01**	427,140	1,738,800	2,165,940	12,600	12,600	0	19,500	13,000	32,500	2,223,640
	State HQ.	0	0	0	0	0	0	0	0	0	0	0	0	0	25000	0	0	0	25,000
Total		**310**	**32,393,812**	**1,782**	**1,782**	**8,910**	**1,215**	**1,536**	**-321**	**12,081,960**	**49,183,200**	**61,265,160**	**356,400**	**356,400**	**25,000**	**465,000**	**310,000**	**775,000**	**62,777,960**

Dist. Wise Status of Spray Equipments pf Kala Azar DDT Spray **Annex. III**

Sl. No.	Name of Districts	Total No. of Sqad (55 Sqad /10 Lakhs Population	Districwise Status of Spray Equipment of K..A D.D.T Spray																Nosal Tip
			Stirrup Pump				Bucket				Gallan Measure				Pound Measure				
			Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	Araria	118	236	237	80	-1	472	319	0	153	118	115	0	3	118	120	0	-2	590
2	Arwal	2	4	0	0	4	8	0	0	8	2	0	0	2	2	0	0	2	10
3	Banka	1	2	0	0	2	4	0	0	4	1	0	0	1	1	0	0	1	5
4	Begusarai	55	110	258	0	-148	220	508	0	-288	55	107	0	-52	55	85	0	-30	275
5	Bhagalpur	8	16	250	40	-234	32	400	9	-368	8	140	5	-132	8	140	0	-132	40
6	Bhojpur	12	24	40	193	-16	48	450	50	-402	12	100	10	-88	12	100	10	-88	60
7	Buxar	6	12	0	0	12	24	0	0	24	6	0	0	6	6	0	0	6	30
8	Darbhanga	88	176	294	0	-118	352	279	0	73	88	127	0	-39	88	127	0	-39	440
9	E.Champaran	144	288	286	177	2	576	507	138	69	144	197	23	-53	144	193	20	-49	720
10	Gopalganj	38	76	234	20	-158	152	438	40	-286	38	97	20	-59	38	97	20	-59	190
11	Jehanabad	2	4	234	20	-230	8	438	40	-430	2	97	20	-95	2	97	20	-95	10
12	Katihar	62	124	180	104	-56	248	354	120	-106	62	142	0	-80	62	142	0	-80	310
13	Khagaria	19	38	110	50	-72	76	200	116	-124	19	79	0	-60	19	79	0	-60	95
14	Kishanganj	39	78	50	50	28	156	240	0	-84	39	56	0	-17	39	42	0	-3	195
15	Lakhisarai	6	12	40	58	-28	24	150	46	-126	6	49	0	-43	6	49	0	-43	30
16	Madhepura	79	158	252	0	-94	316	324	0	-8	79	81	0	-2	79	81	0	-2	395
17	Madhubani	76	152	526	0	-374	304	820	0	-516	76	225	0	-149	76	225	0	-149	380
18	Munger	6	12	140	0	-128	24	200	0	-176	6	40	0	-34	6	40	0	-34	30
19	Muzaffarpur	149	298	375	0	-77	596	647	0	-51	149	186	0	-37	149	175	0	-26	745
20	Nalanda	17	34	257	3	-223	68	502	10	-434	17	100	0	-83	17	130	0	-113	85
21	Patna	58	116	293	130	-177	232	519	112	-287	58	193	20	-135	58	172	2	-114	290
22	Purnea	124	248	190	80	58	496	413	50	83	124	130	0	-6	124	82	0	42	620
23	Saharsa	76	152	150	20	2	304	350	20	-46	76	75	0	1	76	75	0	1	380
24	Samastipur	105	210	224	0	-14	420	300	0	120	105	90	0	15	105	90	0	15	525
25	Saran	79	158	135	101	23	316	425	135	-109	79	105	0	-26	79	105	0	-26	395
26	Sheohar	12	24	0	0	24	48	0	0	48	12	0	0	12	12	0	0	12	60
27	Sitamarhi	99	198	105	65	93	396	295	68	101	99	111	0	-12	99	117	0	-18	495
28	Siwan	81	162	124	104	38	324	439	60	-115	81	178	5	-97	81	170	5	-89	405
29	Supaul	45	90	0	0	90	180	0	0	180	45	0	0	45	45	0	0	45	225
30	Vaishali	113	226	217	49	9	452	362	59	90	113	115	4	-2	113	102	0	11	565
31	W.Champaran	63	126	280	105	-154	252	380	65	-128	63	120	7	-57	63	118	4	-55	315
Total		**1,782**	**3,564**	**5,481**	**1,449**	**-1,917**	**7,128**	**10,259**	**1,138**	**-3,131**	**1,782**	**3,055**	**114**	**-1,273**	**1,782**	**2,953**	**81**	**-1,171**	**8,910**

Statement Showing The Expenditure ,Repair,Mobility, DA Supervision & IEC For Kala Azar Spray **Annex. IV**

Sl. No.	Name of Districts	Total No. of Affected		Total No. of Sqad (55 Sqad /10 Lakhs Population	Repair of Spray Equipments Including Nozal Tips			District Mobility For **C.S Vehicle** @10000 /month for two month	District MobilityFor **ACMO Vehicle** @10000 /month for two month	District Mobility **DMO Vehicle** @ Rs.2000 0/month for two month	Mobility For PHC **MO**.@ RS.650/ days for two month	**State HQ.** Mobility @650/Day for Three Officers For Two months(3x60x650= 1,17,000 .00)	Mobility of **Central Team** @650/Day for Six Officers four times For Two months { 4(6x3x650 = 46,800)}	Mobility of 7 **RDDH** @10,000/Months for Two months (7x2x10000= 1,40,000)	**Four ZMO** Mobility @10,000/Month for Two months(4x2x10000= 80000)	DA For Supervision @ Rs. 1000 Per Affected PHC	IEC @ Rs. 1500/- Per Affected PHC per Round	**Total**	**Remarks**
		PHC	**Village**		**Repair(RS.120/-Per Sqad)**	**Purchase(Per Sqad Rs.400/)**	**Total**												
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
1	**Araria**	9	563	118	14160	47200	61360	20000	20,000	0	351000	0	0	0	0	9000	13500	**474,860**	
2	**Arwal**	3	18	2	240	800	1040	20000	20,000	0	117000	0	0	0	0	3000	4500	**165,540**	
3	**Banka**	1	2	1	120	400	520	20000	20,000	0	39000	0	0	0	0	1000	1500	**82,020**	
4	**Begusarai**	11	245	55	6600	22000	28600	20000	20,000	40,000	429000	0	0	0	0	11000	16500	**565,100**	
5	**Bhagalpur**	7	62	8	960	3200	4160	20000	20,000	40,000	273000	0	0	0	0	7000	10500	**374,660**	
6	**Bhojpur**	9	120	12	1440	4800	6240	20000	20,000	40,000	351000	0	0	0	0	9000	13500	**459,740**	
7	**Buxar**	4	16	6	720	2400	3120	20000	20,000	0	156000	0	0	0	0	4000	6000	**209,120**	
8	**Darbhanga**	14	455	88	10560	35200	45760	20000	20,000	40,000	546000	0	0	0	0	14000	21000	**706,760**	
9	**E.Champaran**	20	817	144	17280	57600	74880	20000	20,000	40,000	780000	0	0	0	0	20000	30000	**984,880**	
10	**Gopalganj**	10	261	38	4560	15200	19760	20000	20,000	40,000	390000	0	0	0	0	10000	15000	**514,760**	
11	**Jehanabad**	5	36	2	240	800	1040	20000	20,000	0	195000	0	0	0	0	5000	7500	**248,540**	
12	**Katihar**	18	543	62	7440	24800	32240	20000	20,000	40,000	702000	0	0	0	0	18000	27000	**859,240**	
13	**Khagaria**	6	119	19	2280	7600	9880	20000	20,000	0	234000	0	0	0	0	6000	9000	**298,880**	
14	**Kishanganj**	6	323	39	4680	15600	20280	20000	20,000	0	234000	0	0	0	0	6000	9000	**309,280**	
15	**Lakhisarai**	2	29	6	720	2400	3120	20000	20,000	0	78000	0	0	0	0	2000	3000	**126,120**	
16	**Madhepura**	7	384	79	9480	31600	41080	20000	20,000	0	273000	0	0	0	0	7000	10500	**371,580**	
17	**Madhubani**	18	366	76	9120	30400	39520	20000	20,000	40,000	702000	0	0	0	0	18000	27000	**866,520**	
18	**Munger**	6	52	6	720	2400	3120	20000	20,000	40,000	234000	0	0	0	0	6000	9000	**332,120**	
19	**Muzaffarpur**	14	1273	149	17880	59600	77480	20000	20,000	40,000	546000	0	0	0	0	14000	21000	**738,480**	
20	**Nalanda**	11	91	17	2040	6800	8840	20000	20,000	40,000	429000	0	0	0	0	11000	16500	**545,340**	
21	**Patna**	16	422	58	6960	23200	30160	20000	20,000	40,000	624000	0	0	0	0	16000	24000	**774,160**	
22	**Purnea**	13	764	124	14880	49600	64480	20000	20,000	40,000	507000	0	0	0	0	13000	19500	**683,980**	
23	**Saharsa**	7	379	76	9120	30400	39520	20000	20,000	40,000	273000	0	0	0	0	7000	10500	**410,020**	
24	**Samastipur**	14	701	105	12600	42000	54600	20000	20,000	40,000	546000	0	0	0	0	14000	21000	**715,600**	
25	**Saran**	15	597	79	9480	31600	41080	20000	20,000	40,000	585000	0	0	0	0	15000	22500	**743,580**	
26	**Sheohar**	2	48	12	1440	4800	6240	20000	20,000	0	78000	0	0	0	0	2000	3000	**129,240**	
27	**Sitamarhi**	13	433	99	11880	39600	51480	20000	20,000	40,000	507000	0	0	0	0	13000	19500	**670,980**	
28	**Siwan**	14	509	81	9720	32400	42120	20000	20,000	40,000	546000	0	0	0	0	14000	21000	**703,120**	
29	**Supaul**	11	245	45	5400	18000	23400	20000	20,000	0	429000	0	0	0	0	11000	16500	**519,900**	
30	**Vaishali**	11	751	113	13560	45200	58760	20000	20,000	40,000	429000	0	0	0	0	11000	16500	**595,260**	
31	**W.Champaran**	13	190	63	7560	25200	32760	20000	20,000	40,000	507000	0	0	0	0	13000	19500	**652,260**	
	State HQ.	0	0	0	0	0	0	0	0	0	0	117000	46,800	140,000	80,000	25000	0	**408,800**	
Total		**310**	**10,814**	**1,782**	**213,840**	**712,800**	**926,640**	**620,000**	**620,000**	**800,000**	**12,090,000**	**117,000**	**46,800**	**140,000**	**80,000**	**335,000**	**465,000**	**16,240,440**	

Budget Provision For Qurative Measures of Kala Azar — Annex. V

Sl. No.	Name of Districts	Total No. of PHC	Total No. of Affected PHC	Estimated ProjectedCase For 2009-2010	Incentive ASHA(Rs. 100/-Per Projected Case For Complete Treatment)	Loss Of Wages Rs.50/-For Maximum 30 Days Per Projected Case During Treatment Period(For SSG,Ampho-B & Miltofosine)	Mobility For Officers & MI,POL & Maintenance For 8 Months(Excluding IRS Periods)		Storage Of Drugs		Treatment Card @Rs.5.00 Per Treatment Card For 2 Diff.Types of Each Card For Projected Case	Register For Line Listing / Loss Of Wages/Asha Record /Drug Record@ Rs.50/-For 4 Register Per Aff.PHC	Hiring of Warehouse at Dist. Level for Storage of DDT @ Rs. 5000/-Per Month For 12 Months	Kala Azar Search Programme Per Affected PHC@Rs.750/-for 8 Months(Two Days in amonth)	IEC for Visibility @ Rs. 10000/- Per PHC	Grand Total
							Mobility For 2 CS Khagariya & Madhepura @ Rs. 3000/- Per Month for POL,for 8 Months(Excluding Spray Period)	Mobility For 20 DMO & 9 ACMO For Max.RS 10,000/- Per Month for 8 Months (Excluding Spray Period)	Emphoteracin Storage In District Level @ Rs. 500/-Per Month For 12 Months	Emphoteracin Storage In State Level @ Rs. 1500/- Per Month For 12 Months =Rs. 18,000/-						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	Araria	9	9	2,500	250,000	3,750,000	0	80,000	6,000	0	25,000	900	60,000	108,000	90,000	4,369,900
2	Arwal	3	3	20	2,000	30,000	0	80,000	6,000	0	200	300	60,000	36,000	30,000	244,500
3	Banka	10	1	20	2,000	30,000	0	80,000	6,000	0	200	100	60,000	12,000	100,000	290,300
4	Begusarai	11	11	600	60,000	900,000	0	80,000	6,000	0	6,000	1,100	60,000	132,000	110,000	1,355,100
5	Bhagalpur	11	7	150	15,000	225,000	0	80,000	6,000	0	1,500	700	60,000	84,000	110,000	582,200
6	Bhojpur	12	9	40	4,000	60,000	0	80,000	6,000	0	400	900	60,000	108,000	120,000	439,300
7	Buxar	7	4	40	4,000	60,000	0	80,000	6,000	0	400	400	60,000	48,000	70,000	328,800
8	Darbhanga	14	14	1,550	155,000	2,325,000	0	80,000	6,000	0	15,500	1,400	60,000	168,000	140,000	2,950,900
9	E.Champaran	20	20	2,000	200,000	3,000,000	0	80,000	6,000	0	20,000	2,000	60,000	240,000	200,000	3,808,000
10	Gopalganj	10	10	1,200	120,000	1,800,000	0	80,000	6,000	0	12,000	1,000	60,000	120,000	100,000	2,299,000
11	Jehanabad	5	5	30	3,000	45,000	0	80,000	6,000	0	300	500	60,000	60,000	50,000	304,800
12	Katihar	18	18	650	65,000	975,000	0	80,000	6,000	0	6,500	1,800	60,000	216,000	180,000	1,590,300
13	Khagaria	6	6	650	65,000	975,000	24,000	0	6,000	0	6,500	600	60,000	72,000	60,000	1,269,100
14	Kishanganj	7	6	300	30,000	450,000	0	80,000	6,000	0	3,000	600	60,000	72,000	70,000	771,600
15	Lakhisarai	4	2	50	5,000	75,000	0	80,000	6,000	0	500	200	60,000	24,000	40,000	290,700
16	Madhepura	7	7	2,000	200,000	3,000,000	24,000	0	6,000	0	20,000	700	60,000	84,000	70,000	3,464,700
17	Madhubani	18	18	1,100	110,000	1,650,000	0	80,000	6,000	0	11,000	1,800	60,000	216,000	180,000	2,314,800
18	Munger	6	6	100	10,000	150,000	0	80,000	6,000	0	1,000	600	60,000	72,000	60,000	439,600
19	Muzaffarpur	14	14	3,600	360,000	5,400,000	0	80,000	6,000	0	36,000	1,400	60,000	168,000	140,000	6,251,400
20	Nalanda	12	11	100	10,000	150,000	0	80,000	6,000	0	1,000	1,100	60,000	132,000	120,000	560,100
21	Patna	16	16	250	25,000	375,000	0	80,000	6,000	0	2,500	1,600	60,000	192,000	160,000	902,100
22	Purnea	14	13	2,050	205,000	3,075,000	0	80,000	6,000	0	20,500	1,300	60,000	156,000	140,000	3,743,800
23	Saharsa	7	7	2,500	250,000	3,750,000	0	80,000	6,000	0	25,000	700	60,000	84,000	70,000	4,325,700
24	Samastipur	14	14	1,900	190,000	2,850,000	0	80,000	6,000	0	19,000	1,400	60,000	168,000	140,000	3,514,400
25	Saran	15	15	1,700	170,000	2,550,000	0	80,000	6,000	0	17,000	1,500	60,000	180,000	150,000	3,214,500
26	Sheohar	2	2	150	15,000	225,000	0	80,000	6,000	0	1,500	200	60,000	24,000	20,000	431,700
27	Sitamarhi	13	13	1,000	100,000	1,500,000	0	80,000	6,000	0	10,000	1,300	60,000	156,000	130,000	2,043,300
28	Siwan	15	14	900	90,000	1,350,000	0	80,000	6,000	0	9,000	1,400	60,000	168,000	150,000	1,914,400
29	Supaul	11	11	50	5,000	75,000	0	80,000	6,000	0	500	1,100	60,000	132,000	110,000	469,600
30	Vaishali	11	11	2,800	280,000	4,200,000	0	80,000	6,000	0	28,000	1,100	60,000	132,000	110,000	4,897,100
31	W.Champaran	16	13	3,000	300,000	4,500,000	0	80,000	6,000	0	30,000	1,300	60,000	156,000	160,000	5,293,300
***	State Level	0	0	0	0	0	0	0	0	18000	0	0	0	0	0	18,000
Total		338	310	33,000	3,300,000	49,500,000	48,000	2,320,000	186,000	18,000	330,000	31,000	1,860,000	3,720,000	3,380,000	64,693,000

Annex- VI

Sl.No.	State Level Component Activity	Financial Cost
1	Computer Desktop One for Chief Malaria Office	50,000.00
2	Laptop One for KA Technical Cell including AMC)	50,000.00
3	Mobile Phone For Officer & Staff At State Level Office Including Monthly Recharge Coupen.	80,000.00
4	Laser Printer (Phone+Fax +Scanner included)	25,000.00
5	Digital Xerox Machine	150,000.00
6	Meeting With Officers of Dist. Level (Alternate Month) @ Rs.15000 Per Meeting	90,000.00
7	Strengthininh Of Computer & Internet Facility	50,000.00
8	Supervision Of Dist. At State Level	210,000.00
9	Generator with fuel	270,000.00
10	IEC	500,000.00
11	Supervision Of Four ZMO for eight months	320,000.00
12	Strengthininh Of ZMO Office,Computer,Internet etc. (All Four ZMO)	260,000.00
Total RS.		**2055000**

State - Bihar | Kala -Azar Action Plan 2009-2010 , Training Part I | Annexure --VII

Sl. No.	Name of Districts	Training Of Malaria Inspector		Training (Induction & Re-Orientation) Of LT				Training Of Health Supervisor			Training Of Health Worker					Grand Total of Training From Annex. VII
		Total No. Of MI	TRG Cost Of MI TwoRounds	Total No. Of LT	TRG Cost Of LT (Induction TRG)	TRG Cost Of LT (Re-Orientation TRG)	Grand Total Induction & Re-orientation	Total No. Of BHI	Total No. Of SI	TRG Cost Of Health Supervisor	Total No. Of BHW	Total No. Of SW	Total No. Of FW	Total No. Of SFW	TRG Cost Of Health Worker	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	Araria	0	Total No.of Malaria Inspectors114 .Total Provision of Training of 114 MI . Provision of 20 Participant in each Batch =6 Batches (One Round) @0.695 Lakhs per Batch =4.17 Lakhs As Per NVBDCP Guideline. One Round.	0	Total No.of 47 Lab Technecian .Total Provision of Induction Training of 47 Lab Technecian. Provision of 20 Participant in each Batch =2 Batches @1.25 Lakhs per Batch for 10 Days =2.5 Lakhs As Per NVBDCP Guideline .One Time	TRG of all 47 Lab Technecian Induction .Total Provision of Induction Training of 47 Lab Technecian. Provision of 20 Participant in each Batch =2 Batches @0.7562Lakhs per Batch for 5 Days =1.5124 Lakhs As Per NVBDCP Guideline .One Time	TRG of all 47 Lab Technecian Induction & Re-Orientation Grand Total. As Per NVBDCP Guideline .One Time	0	0	Total No.of BHI =118 +SI 18 Total 136 .Total Provision of Training of 136 Health Supervisor . Provision of 25 Participant in each Batch =5 Batches For 2 Days @ 0.30 Lakhs per Batch =1.50 Lakhs As Per NVBDCP Guideline. One Round.	0	0	0	0	Total No.of BHW =103 +SIW= 33 +FW=43 +SFW=19 Total 198 .Total Provision of Training of 198 Health Worker . Provision of 25 Participant in each Batch =8 Batches For 2 Days @ 0.30 Lakhs per Batch =2.40 Lakhs As Per NVBDCP Guideline. One Round.	The Amount of Training for ML,LT,Health Supervisor & Health Worker Kept in State Level .
2	Aurangabad	4		0				1	0		3	0	1	0		
3	Arwal	0		0				0	0		0	0	0	0		
4	Banka	0		0				0	0		0	0	0	0		
5	Begusarai	3		1				3	0		7	0	1	2		
6	Bhagalpur	2		1				11	1		6	0	1	2		
7	Bhojpur	5		1				8	0		1	0	4	2		
8	Buxar	0		0				0	0		0	0	0	0		
9	Darbhanga	4		0				4	2		4	2	4	0		
10	E.Champaran	7		2				12	1		5	5	1	2		
11	Gaya	4		8				8	0		7	0	3	1		
12	Gopalganj	2		2				0	0		0	0	3	1		
13	Jamui	0		0				0	0		0	0	0	0		
14	Jehanabad	0		0				0	0		0	0	0	0		
15	Kaimur	0		0				0	0		0	0	0	0		
16	Katihar	3		0				2	0		6	0	0	0		
17	Khagaria	0		0				0	0		0	0	0	0		
18	Kishanganj	0		0				0	0		0	0	0	0		
19	Lakhisarai	0		0				0	0		0	0	0	0		
20	Madhepura	0		0				0	0		0	0	0	0		
21	Madhubani	8		0				5	6		0	9	2	0		
22	Munger	5		3				4	3		11	5	2	0		
23	Muzaffarpur	4		1				7	0		3	0	3	0		
24	Nawada	2		2				1	1		0	1	2	0		
25	Nalanda	3		3				8	0		2	0	3	0		
26	Patna	10		11				11	0		9	0	5	2		
27	Purnea	9		0				6	1		7	0	3	0		
28	Rohtas	6		1				1	2		9	5	0	0		
29	Saharsa	6		3				6	0		3	0	0	0		
30	Samastipur	5		1				3	0		0	0	0	1		
31	Saran	6		1				6	0		4	0	0	1		
32	Sheikhpura	0		0				0	0		0	0	0	0		
33	Sheohar	0		0				0	0		0	0	0	0		
34	Sitamarhi	3		2				4	0		3	0	0	0		
35	Siwan	3		1				3	0		6	0	1	1		
36	Supaul	0		0				0	0		0	0	0	0		
37	Vaishali	5		1				4	0		5	0	3	2		
38	W.Champaran	5		0				0	1		2	6	1	2		
	ZMO Office (All 4)	0		2				0	0		0	0	0	0		
Total		114	417,000	47	250,000	151,240	401,240	118	18	150,000	103	33	43	19	240,000	1,208,240

Training of Medical Officer | Annexure VIII

Sl. No.	Name of Districts	TRG OF MEDICAL OFFICERS						
		Govt.Medical College	Govt.Hospital	Referal Hospital	Sadar Hospital	Sub. Hospital	PHC	TRG Cost of MO
1	2	3	4	5	6	7	8	9
1	**Araria**	0	0	3	0	1	9	**TRG of all Govt. Medical College Medical Officer @ 2 MO For 6 Med.Coll =12,Gont.Hospital @ 2 x 7= 14,Referal Hospital@1x7=70, Sadar Hospital @ 2x24 =48, Sub Divisional Hospital @ 1x22 =22, PHC @1x336=336 .Total Provision of Training of 502 Medical Officers.Provision of 25 particepents in each batch =20 Batch @ 1.2 Lakhs per Batch for three days =24.0 Lakhs as per NVBDCP Guide line .**
2	**Aurangabad**	0	0	3	1	0	0	
3	**Arwal**	0	0	0	0	0	3	
4	**Banka**	0	0	3	0	1	10	
5	**Begusarai**	0	0	2	1	0	11	
6	**Bhagalpur**	1	0	2	1	1	11	
7	**Bhojpur**	0	0	2	0	0	12	
8	**Buxar**	0	0	0	0	1	7	
9	**Darbhanga**	1	0	2	0	0	14	
10	**E.Champaran**	0	0	3	1	0	20	
11	**Gaya**	1	0	2	1	0	0	
12	**Gopalganj**	0	0	3	1	1	10	
13	**Jamui**	0	0	3	0	1	0	
14	**Jehanabad**	0	0	2	1	0	5	
15	**Kaimur**	0	0	2	0	1	0	
16	**Katihar**	0	0	3	1	0	18	
17	**Khagaria**	0	0	1	1	0	6	
18	**Kishanganj**	0	0	2	0	1	7	
19	**Lakhisarai**	0	0	1	0	1	4	
20	**Madhepura**	0	0	1	1	0	7	
21	**Madhubani**	0	0	2	1	1	18	
22	**Munger**	0	0	1	1	0	6	
23	**Muzaffarpur**	1	0	1	1	0	14	
24	**Nawada**	0	0	2	1	0	0	
25	**Nalanda**	0	0	3	1	1	12	
26	**Patna**	2	7	4	0	3	16	
27	**Purnea**	0	0	2	1	0	14	
28	**Rohtas**	0	0	1	1	1	0	
29	**Saharsa**	0	0	0	1	0	7	
30	**Samastipur**	0	0	1	1	3	14	
31	**Saran**	0	0	3	1	0	15	
32	**Sheikhpura**	0	0	1	0	1	0	
33	**Sheohar**	0	0	1	0	1	0	
34	**Sitamarhi**	0	0	1	1	0	13	
35	**Siwan**	0	0	2	1	0	15	
36	**Supaul**	0	0	1	0	1	11	
37	**Vaishali**	0	0	2	1	0	11	
38	**W.Champaran**	0	0	2	1	1	16	
	ZMO Office (All 4)	0	0	0	0	0	0	
Total		**6**	**7**	**70**	**24**	**22**	**336**	**2,400,000**

Training of PRI Members					Annexure -IX
Sl. No.	Name of Districts	Advocasy Workshop & Training of PRI			
		Block	Panchyat	Zila Parishad Members(Per Dist.15 Members)	Total Cost Of PRI Members
1	2	3	4	5	6
1	Araria	9	221	15	Total No.of Blocks =438 x15 BDC Members Per Blocks=6570 Persons +Total No. Of Panchyats =6825 = 6825 Mukhiya +31 Districts x15 Zila Parishad Members =465 Members= Total 13860 Members .Total Provision of Training of PRI Members 13860 . Provision of 50 Participant in each Batch =277 Batches For 1 Days @ 0.02 Lakhs per Batch =5.54 Lakhs As Per NVBDCP Guideline. One Round.
2	Aurangabad	0	0	0	
3	Arwal	0	0	15	
4	Banka	11	185	15	
5	Begusarai	18	257	15	
6	Bhagalpur	17	242	15	
7	Bhojpur	14	228	15	
8	Buxar	11	142	15	
9	Darbhanga	19	329	15	
10	E.Champaran	27	387	15	
11	Gaya	0	0	0	
12	Gopalganj	14	234	15	
13	Jamui	0	0	0	
14	Jehanabad	12	161	15	
15	Kaimur	0	0	0	
16	Katihar	16	238	15	
17	Khagaria	7	129	15	
18	Kishanganj	7	118	15	
19	Lakhisarai	7	80	15	
20	Madhepura	13	170	15	
21	Madhubani	21	399	15	
22	Munger	9	101	15	
23	Muzaffarpur	16	387	15	
24	Nawada	0	0	0	
25	Nalanda	20	249	15	
26	Patna	23	331	15	
27	Purnea	14	246	15	
28	Rohtas	0	0	0	
29	Saharsa	10	164	15	
30	Samastipur	20	381	15	
31	Saran	20	0	15	
32	Sheikhpura	0	0	0	
33	Sheohar	5	54	15	
34	Sitamarhi	17	273	15	
35	Siwan	16	293	15	
36	Supaul	11	180	15	
37	Vaishali	16	292	15	
38	W.Champaran	18	354	15	
Total		438	6,825	465	554,000

Training of Spray Worker & ASHA					Annexure -X A			Amount Of Training Kept At State Level				Annex. X B
Sl. No.	Name of Districts	Training Of Spray Worker			Training Of MPW (ASHA) Contractual		Grand Total Of Training Of Annex. X	Total of Training From Annex. VII	Total of Training From VIII	Total of Training From Annex.IX	Total of Training From Annex.X A	Grand Total of Training From Annex.VII, VIII, IX & XA
		Total No. Of SFW	Total No. Of FW	TRG Cost Of Spray Worker	Total No. Of ASHA	TRG Cost Of MPW (ASHA)						
1	2	3	4	5	6	7	8					
1	Araria	118	590	Total No.of Spray Worker FW=8910 +SFW=1782 Total 10692 .Total Provision of Training of 10692 Spray Worker . Provision of 50 Participant in each Batch =214 Batches For 1 Days @ 0.02 Lakhs per Batch =4.28 Lakhs As Per NVBDCP Guideline One Round.	2026	Total No.of MPW(ASHA)Contractual 55570.Total Provision of Training of 55570 MPW(ASHA)Contractual . Provision of 50 Participant in each Batch =1112 Batches For 1 Days @ 0.02 Lakhs per Batch =22.24 Lakhs As Per NVBDCP Guideline One Round.	The Amount of Training for Spray Worker & ASHA Kept in State Level .	The Amount of Training for MI,LT,Health Supervisor & Health Worker Kept in State Level .	TRG of all Govt. Medical College Medical Officer @ 2 MO For 6 Med.Coll =12,Gont.Hospital @ 2 x 7= 14,Referal Hospital@1x7=70, Sadar Hospital @ 2x24 =48, Sub Divisional Hospital @ 1x22 =22, PHC @1x336=336 .Total Provision of Training of 502 Medical Officers.Provision of 25 particepents in each batch =20 Batch @ 1.2 Lakhs per Batch for three days =24.0 Lakhs as per NVBDCP Guide line ,One Time	Total No.of Blocks =438 x15 BDC Members Per Blocks=6570 Persons +Total No. Of Panchyats =6825 = 6825 Mukhiya +31 Districts x15 Zila Parishad Members =465 Members= Total 13860 Members .Total Provision of Training of PRI Members 13860 . Provision of 50 Participant in each Batch =277 Batches For 1 Days @ 0.02 Lakhs per Batch =5.54 Lakhs As Per NVBDCP Guideline. One Round.	The Amount of Training for Spray Worker & ASHA Kept in Dist. Level .	At State Level Grand Total Of Annex. VII,VII & IX
2	Arwal	2	10		653							
3	Banka	1	5		1552							
4	Begusarai	55	275		2245							
5	Bhagalpur	8	40		1966							
6	Bhojpur	12	60		2049							
7	Buxar	6	30		1318							
8	Darbhanga	88	440		2357							
9	E.Champaran	144	720		2686							
10	Gopalganj	38	190		1868							
11	Jehanabad	2	10		769							
12	Katihar	62	310		2174							
13	Khagaria	19	95		313							
14	Kishanganj	39	195		1027							
15	Lakhisarai	6	30		581							
16	Madhepura	79	395		1403							
17	Madhubani	76	380		3034							
18	Munger	6	30		951							
19	Muzaffarpur	149	745		3398							
20	Nalanda	17	85		1980							
21	Patna	58	290		2634							
22	Purnea	124	620		2263							
23	Saharsa	76	380		676							
24	Samastipur	105	525		3143							
25	Saran	79	395		3178							
26	Sheohar	12	60		495							
27	Sitamarhi	99	495		464							
28	Siwan	81	405		2618							
29	Supaul	45	225		1538							
30	Vaishali	113	565		1477							
31	W.Champaran	63	315		2734							
Total		1,782	8,910	428,000	55,570	2,224,000	2,652,000	######	2,400,000	554,000	2,652,000	6,814,240

State & District Wise Fund Allocation - Kala-Azar, Bihar 2009-2010							
	Name of Districts	One Round Amount			Two Round Amount	From Annex. V	Total (Column 6+7)
		From Annex. II	From Annex. IV	Total Amount For One Round	Total Amount For Two Round Spray i.e (Anneex.II+ Annex.IV)		
1	2	3	4	5	6	7	8
1	**Araria**	4,105,740.00	161,450.00	4,267,190.00	8,534,380.00	5,072,950.00	13,607,330.00
2	**Arwal**	73,860.00	9,700.00	83,560.00	167,120.00	1,008,250.00	1,175,370.00
3	**Banka**	36,180.00	2,800.00	38,980.00	77,960.00	1,016,150.00	1,094,110.00
4	**Begusarai**	1,923,900.00	86,250.00	2,010,150.00	4,020,300.00	2,119,550.00	6,139,850.00
5	**Bhagalpur**	287,940.00	27,300.00	315,240.00	630,480.00	1,289,100.00	1,919,580.00
6	**Bhojpur**	429,660.00	42,000.00	471,660.00	943,320.00	1,136,650.00	2,079,970.00
7	**Buxar**	214,080.00	13,400.00	227,480.00	454,960.00	1,066,400.00	1,521,360.00
8	**Darbhanga**	3,072,840.00	140,250.00	3,213,090.00	6,426,180.00	3,686,450.00	10,112,630.00
9	**E.Champaran**	5,023,920.00	234,550.00	5,258,470.00	10,516,940.00	4,493,000.00	15,009,940.00
10	**Gopalganj**	1,332,840.00	78,150.00	1,410,990.00	2,821,980.00	3,068,500.00	5,890,480.00
11	**Jehanabad**	76,860.00	16,400.00	93,260.00	186,520.00	1,052,400.00	1,238,920.00
12	**Katihar**	2,177,160.00	148,450.00	2,325,610.00	4,651,220.00	2,298,150.00	6,949,370.00
13	**Khagaria**	667,920.00	39,350.00	707,270.00	1,414,540.00	2,005,550.00	3,420,090.00
14	**Kishanganj**	1,361,520.00	79,950.00	1,441,470.00	2,882,940.00	1,503,800.00	4,386,740.00
15	**Lakhisarai**	211,080.00	11,350.00	222,430.00	444,860.00	1,050,350.00	1,495,210.00
16	**Madhepura**	2,750,220.00	111,100.00	2,861,320.00	5,722,640.00	4,254,350.00	9,976,990.00
17	**Madhubani**	2,662,680.00	128,900.00	2,791,580.00	5,583,160.00	2,952,400.00	8,535,560.00
18	**Munger**	217,080.00	22,800.00	239,880.00	479,760.00	1,178,800.00	1,658,560.00
19	**Muzaffarpur**	5,188,320.00	293,450.00	5,481,770.00	10,963,540.00	6,976,700.00	17,940,240.00
20	**Nalanda**	606,060.00	44,150.00	650,210.00	1,300,420.00	1,321,050.00	2,621,470.00
21	**Patna**	2,035,440.00	124,300.00	2,159,740.00	4,319,480.00	1,628,050.00	5,947,530.00
22	**Purnea**	4,319,820.00	202,600.00	4,522,420.00	9,044,840.00	4,410,900.00	13,455,740.00
23	**Saharsa**	2,646,180.00	108,850.00	2,755,030.00	5,510,060.00	5,044,850.00	10,554,910.00
24	**Samastipur**	3,662,400.00	185,650.00	3,848,050.00	7,696,100.00	4,248,200.00	11,944,300.00
25	**Saran**	2,762,220.00	159,050.00	2,921,270.00	5,842,540.00	3,941,250.00	9,783,790.00
26	**Sheohar**	419,160.00	17,200.00	436,360.00	872,720.00	1,202,850.00	2,075,570.00
27	**Sitamarhi**	3,452,820.00	140,450.00	3,593,270.00	7,186,540.00	2,721,650.00	9,908,190.00
28	**Siwan**	2,830,080.00	144,850.00	2,974,930.00	5,949,860.00	2,647,200.00	8,597,060.00
29	**Supaul**	1,577,100.00	81,250.00	1,658,350.00	3,316,700.00	1,168,800.00	4,485,500.00
30	**Vaishali**	3,935,340.00	191,150.00	4,126,490.00	8,252,980.00	5,650,550.00	13,903,530.00
31	**W.Champaran**	2,204,340.00	86,000.00	2,290,340.00	4,580,680.00	6,011,650.00	10,592,330.00
	Total	**62,264,760.00**	**3,133,100.00**	**65,397,860.00**	**130,795,720.00**	**87,226,500.00**	**218,022,220.00**
	State Level Activity						
1	Training At State Level From Annex. VII,VIII,IX & X						**7,089,240.00**
2	State Level Activity From Annex. VI						**1,473,440.00**
3	SPO & ZMO Mobility During Spray Period 145000.00 x2 =290000.00						**290,000.00**
4	Storage of Amphoteracin B.At State Level						**18,000.00**
	Grand Total Of Kala-Azar Programme ,BIHAR						**226,892,900.00**

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Master Trainer NVBDCP TOT

@ 25,000/- =

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National Anti Malaria Management Information System (NAMMIS) Web based

NAMMIS Software Internet Report

- Action Plan

Computer CD/DVD Writer

computer CD/DVD writer CD/DVD writer 1500/-

2 × 1500 Rs. = 3000.00

Computer System 2GB RAM, 250 GB Hard Disk

System MB RAM GB Hard Disk

2GB RAM GB

Hard Disk

AMC Annual Maintence Cost

AMC

× 6,000/-

NAMIS Internet

Broad Band/USB Broad Band Broad Band

= × Broad Band Installation charge

System

9600 + 4500 = 14100 = 00

Comptuer Cartridage, CD/DVD, Xerox Paper, UPS

NAMMIS State Component Plan

50,000-00

NAMMIS 50,000-00

Dist.Wise Malaria Affected Population , No. of Sqad,DDT Requirement ,Wages,Contegency,Equipment Repair,Mobility & Transportation of DDT of Malarial DDT Spray for 2009-2010

Sl. No.	Name of Districts	Total No. of Malaria Affected			Total No. of Sqad (44 Sqad /10 Lakhs Population	Total No. of Workers		DDT 50% Status (In Meric Ton)		EXPENDETURE FOR I ROUND											EXPENDETURE FOR II ROUND	FOGGING	MOBALITY FOR SEVEN MONTH	GRAND TOTAL
										WAGES			Office Expenses (@ Rs 300/- Per Sqad	Contigency At Dist. Level (@ Rs. 2000/- Per Dist.	Repair of Spray Equipments Including Nozal Tips @ Rs. 500/- Per Sqad	District Mobility DMO Vehicle @ Rs.650/- Per Affected Dist. For 50 Days	Transportation of DDT		IEC @ Rs.15000/- Per Dist.	Total (Column No. 13 to 20)				
		PHC	HSC	Population		SFW	FW	Require.	Available	SFW(Rs. 113/-Per SFW Per Day For 75 Days)	FW(Rs .92/- Per FW Per Day For 75 Days)	Total					For @ Rs. 25,000 /- Per Dist.	Storage of DDT @ RS. 500/- Per Month For 12 Months						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	22
1	Munger	1	26	154,135	8	8	40	12	10	67,800	276,000	343,800	2400	2000	4000	32500	25000	6000	15000	430,700	861400	1000000	0	1861400
2	Jamui	5	47	548,070	24	24	120	42	30	203,400	828,000	1,031,400	7200	2000	12000	32500	25000	6000	15000	1,131,100	2262200	1000000	70000	3332200
3	Nawada	2	11	106,942	5	5	25	5	50	42,375	172,500	214,875	1500	2000	2500	32500	25000	6000	15000	299,375	598750	0	70000	668750
4	Rohtas	2	15	192,106	9	9	45	15	30	76,275	310,500	386,775	2700	2000	4500	32500	25000	6000	15000	474,475	948950	1000000	70000	2018950
5	Kaimur	2	12	153,035	7	7	35	12	30	59,325	241,500	300,825	2100	2000	3500	32500	25000	6000	15000	386,925	773850	1000000	70000	1843850
6	Aurangabad	1	3	630,194	28	28	140	48	40	237,300	966,000	1,203,300	8400	2000	14000	32500	25000	6000	15000	1,306,200	2612400	0	70000	2682400
7	Gaya	5	12	140,000	7	7	35	11	20	59,325	241,500	300,825	2100	2000	3500	32500	25000	6000	15000	386,925	773850	0	0	773850
Total		**18**	**126**	**1,924,482**	**88**	**88**	**440**	**145**	**210**	**745,800**	**3,036,000**	**3,781,800**	**26,400**	**14,000**	**44,000**	**227,500**	**175,000**	**42,000**	**105,000**	**4,415,700**	**8,831,400**	**4,000,000**	**350,000**	**13,181,400**
STATE LEVEL		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
1	Curarive	**Purchage of Blood Slide & Reagent**																						**3,250,000**
		Purchase of Motorcycle for Supervision																						**408,000**
		Transportation & Purchase of Bednets																						**25,050,000**
2	Training	**MI**																						**139,000**
		LT																						**200,620**
		BHI & SI																						**30,000**
		Health Worker																						**60,000**
3	NAMMIS																							**1,196,100**
Grand Total Of Malaria Programme																								**43,515,120**

Malaria Control Programme , State & District Level - 2010-2011								
Sl. No.	Name of Districts	Training Of Malaria Inspector, State Level		Need based training State Level	NAMMIS Training State Level	NAMMIS State Level	IEC District & State Level	Grand Total Malaria
		Total No. Of MI	TRG Cost Of MI TwoRounds					
1	2	3	4	5	6	7	8	9
1	Aurangabad	4	Total No.of Malaria Inspectors 21 .Total Provision of Training of 21 MI . Provision of 20 Participant in each Batch =1Batches (Two Round) @0.695 Lakhs per Batch = 1.39 Lakhs As Per NVBDCP Guideline. Two Round. For seven malarial Districts as Aurangaba,Gaya,Jamui,Kaimur,Munger,Nawada & Rohtas	Provision of need based Training at state lavel =10,000 Rupee .Forseven malarial Districts as Aurangabad,Gaya,Jamui,Kaimur,Munger,Nawada & Rohtas	Provision of NAMMIS Training at State Level@Rs.25000/-Per Batch For 12 particepent in each batch for two days.Total provision of two batch =Rs.50,000.00 Forseven malarial Districts as Aurangabad,Gaya,Jamui,Kaimur,Munger,Nawada & Rohtas	Provision of Computer Strengthening for NAMMIS at State Level Rs. 50000/-for various activities as per detail sheet.	43000	43000
2	Gaya	4					43000	43000
3	Jamui	0					43000	43000
4	Kaimur	0					43000	43000
5	Munger	5					43000	43000
6	Nawada	2					43000	43000
7	Rohtas	6					43000	43000
8	Banka	0					43000	43000
9	Arwal	0					18000	18000
10	Araria	0					18000	18000
11	Begusarai	0					18000	18000
12	Bhagalpur	0					18000	18000
13	Bhojpur	0					18000	18000
14	Buxar	0					18000	18000
15	Darbhanga	0					18000	18000
16	E.Champaran	0					18000	18000
17	Gopalganj	0					18000	18000
18	Jehanabad	0					18000	18000
19	Katihar	0					18000	18000
20	Khagaria	0					18000	18000
21	Kishanganj	0					18000	18000
22	Lakhisarai	0					18000	18000
23	Madhepura	0					18000	18000
24	Madhubani	0					18000	18000
25	Shekhpura	0					18000	18000
26	Muzaffarpur	0					18000	18000
27	Nalanda	0					18000	18000
28	Patna	0					18000	18000
29	Purnea	0					18000	18000
30	Saharsa	0					18000	18000
31	Samastipur	0					18000	18000
32	Saran	0					18000	18000
33	Sheohar	0					18000	18000
34	Sitamarhi	0					18000	18000
35	Siwan	0					18000	18000
36	Supaul	0					18000	18000
37	Vaishali	0					18000	18000
38	W.Champaran	0					18000	18000
	State Level	21	139,000	11,000	50,000	50,000	1,500,000	1,750,000
Total			1,39,000	11,000	50,000	50,000	2,384,000	2,634,000

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1- Mx ,o fpdufxfu;k dh jkdFkke ,o mipkjkRed mik; gr jkT; d ANMMCH x;k dk Sentinel survelliance Hospital d :Ik e p;fur dk iLrko gA sentinel survelliance Hospital d strengthening gr 50,000@& :0 dh jkf'k LohÑr dh xb gA
2- Monitoring and Evaluation and rapid response d rgr 1 yk[k :i; dh jkf'k jkT; Lrjh; dk;ky; ij j[kk x;k g rkfd vko';drk iMu ij fdlh fty e ;g jkf'k [kp dh tk ldA
3- Epidemic Prepardness (logistics+operational cost) d :i e jkT; Lrjh; dk;ky; ij 4 yk[k 20 gtkj :i; j[kk x;k gA tk egkekjh d fLFkfr l fuiVu l lcf/kr fty l [kp fd;k tk ldA
4- Training /workshop- Training ,o NVBDCP }kjk fn, x, fun'k d vkykd e dkjok;h dh tk,xh] bl fufer 2 yk[k :i; dk iko/kku fd;k x;k gA

Dy jkf'k&

1-Sentinel Survellaince hospital. ANMMCH-Gaya.	50,000=00
2.Monitoring & Evaluation & rapid Response, State level.	1,00,000=00
3.Epidenmic preparedness (logistic+operational cost) State level	4,20,000=00
4-Training/workshop, state level	2,00000=00
	dy 7,70,000=00

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Dengu & Chikungunya Dist.Wise Plan 2010-2011 Annex. I

Sl.No.	Name of Institution	Sentinal Surveillance Hospital	Monitoring & Evaluation &Rapid Response	Epidemic Preparedness (Logistic +Operational Cost)	Training & Workshop	Grand Total
1	ANMMCH Gaya	50000	0	0	0	50000
2	State Level	0	100000	420000	200000	720000
	Total	**50000**	**100000**	**420000**	**200000**	**770000**
	Quarter Wise Activity (2010-2011)					
	Activity	Ist Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
1	Sentinal Surveillance Hospital	50000	0	0	0	50000
2	Monitoring & Evaluation &Rapid Response	50000	0	0	50000	100000
3	Epidemic Preparedness (Logistic +Operational Cost)	20000	0	0	400000	420000
4	Training & Workshop	0	0	0	200000	200000
5	Grand Total	**120000**	**0**	**0**	**650000**	**770000**

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1. Diagnostics and Management %& bl en d vrxr fcgkj d nk efMdy dkyt & ANMMCH x;k ,o PMCH iVuk dk p;fur fd;k x;k gA Diagnostic and Management en e nkuk efMdy dkyt dk :0 15&15 yk[k ifr dk iLrko j[kk x;k gA
2. Training %& NVBDCP d fun'ku e if'k{k.k dk; liUu djk;k tkuk gA bl en e 20 yk[k :Ik; dk iLrko j[kk x;k gA bl jkf'k dk jkT; Lrjh; dk;ky; ij j[kk x;k gA
3. IEC %& tkikuh blQykbfVl dh jkdFkke gr ipkj&ilkj d :Ik e 20 yk[k :Ik; j[kk x;k gA mRrj in'k l lV fcgkj d fty ;Fkk𝔠k] ekfrgkjh] etQQjij] lhoku] xkikyxt ,o tkikuh blQykbfVl l iHkkfor vU; fty ;Fkk&x;k] uoknk] vkjxkckn] tgkukckn ,o vjoy dy - 10 ftyk e IEC en 20.00 yk[k :Ik; j[kk x;k gA bl jkf'k dk jkT; Lrj ij j[kk x;k gA

4. Technical Malathion %& jkT; Lrj ij Technical Malathion en e 2 yk[k :Ik; j[kk x;k gA bl lc/k e mRrj in'k l lV fcgkj d fty ;Fkk𝔠k] ekfrgkjh] etQQjij] lhoku] xkikyxt ,o tkikuh blQykbfVl l iHkkfor 2009 e vU; fty ;Fkk&x;k] uoknk] vkjxkckn] tgkukckn ,o vjoy dy - 10 fty tkikuh blQykbfVl iHkkfor jg gA
5. Monitoring & Evaluation tkikuh blQykbfVl l iHkkfor 10 ftyk e Monitoring & Evaluation en e jkT; Lrj ij 10 yk[k :l; j[kk x;k g rkfd Epidemic dh fLFkfr e bldk vuJo.k ,o vko';d dkjokb dh fd;k tk ldA
6. Lab Support & Equipment Supply &&PMCH iVuk ANMMCH e t0 b0 d i;kx'kkyk ,o sentinel site d l'kfDrdj.k gr 50 yk[k :i; dk ctV ikDdyu fd;k x;k g A
7. Lab Support (Furnishing of virology Lab & Equipment Supply) && bl en e PMCH Sentinel Site gr 20 yk[k :i; dk ctV ikDdyu fd;k x;k g A (vuyXud I voykdukFk)
8. Staff for Strengthening of Lab at PMCH-- PMCH iVuk e Sentinel Site d l'kfDrdj.k gr lfonk ij ,d Data Entry Operator ,d Lab Technician ,,d cleaner gr bl en e dy 3.00 yk[k :i; dk ctV ikDdyu fd;k x;k g A bu ink ij jkT; LokLF; lfefr }kjk fu/kkfjr ekinM d vu:i lfonk vk/kkfjr fu;fDr fd;k tkuk g A
9. JE d dVht Ulh en e dy 3.00 yk[k :i; dk ctV ikDdyu fd;k x;k g A

10. Hkkjr ljdkj l ikIr fun'k d vkykd e Mobility Support ,o Malathion Fogging d Operational Cost d [kp dk Hkkj jkT; ljdkj dk djuk g Abl lc/k jkT; ljdkj l jkf'k dh ekx fd;k tkuk g A

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Sl.No.	Activity Detail	Amount in Rs.(In Lakhs)
1.	Diagnotics & Management, (ANMMCH Gaya , & PMCH ,Patna)	30.00
2	Training (At State Level)	20.00
3.	IEC(At State Level)	20.00
4.	Technical Malathion	2.00
5.	Monitoring & Evaluation(At State Level)	10.00
6.	Lab Support & Equipment Supply (ANMMCH Gaya , & PMCH ,Patna)	50.00
7.	Lab Support (Furnishing of Virology Lab& Equipment Supply) At PMCH ,Patna	20.00
8.	Staff for strengthening of Lab at PMCH	3.00
9.	Other Chatges(Contengency)	2.00
	Total	**157.00 Lakhs**

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JE Dist.Wise Plan 2009-2010 Annex. I (Part I)											
Sl.No.	Name of Dist.	Diagnostics & Management @ Rs. 15.0 Lakhs Per District	Training	IEC At State Level	Technical Malathion Fogging	Monitoring & Evaluation	Lab Support & Equipment SupplyFor Sentinel Sites	Lab Support (Furnishing of Virology Lab At PMCH,Patna) for Sentinel Site	Staff for Strengthening of Lab at PMCH,Patna,Sentinel Site	Other Charges(Contingency)	Grand Total
1	2	3	4	5	6	7	8	9	10	11	12
1	Gaya	0	0	0	0	0	0	0	0	0	0
2	Siwan	0	0	0	0	0	0	0	0	0	0
3	Muzaffarpur	0	0	0	0	0	0	0	0	0	0
4	W.Champaran	0	0	0	0	0	0	0	0	0	0
5	Nawada	0	0	0	0	0	0	0	0	0	0
6	Aurangabad	0	0	0	0	0	0	0	0	0	0
7	Jehanabad	0	0	0	0	0	0	0	0	0	0
8	Arwal	0	0	0	0	0	0	0	0	0	0
9	East Champaran	0	0	0	0	0	0	0	0	0	0
10	Gopalganj	0	0	0	0	0	0	0	0	0	0
11	ANMMCH Gaya	1500000	0	0	0	0	2500000	0	0	0	1500000
12	PMCH Patna	1500000	0	0	0	0	2500000	2000000	300000	0	1500000
13	State Level	0	2000000	2000000	200000	100000	0	0	0	200000	4300000
	Total	**3000000**	**2000000**	**2000000**	**200000**	**1000000**	**5000000**	**2000000**	**300000**	**200000**	**15700000**

JE Dist.Wise Plan 2009-2010 Annex. I (Part II)						
Quarter Wise Activity (In Lakhs)						
Sl.No.	Activity	Ist Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
1	Diagnostics & Management @ Rs. 15.0 Lakhs Per District	3000000	0	0	0	**3000000**
2	Training	0	0	1000000	1000000	**2000000**
3	IEC At State Level	0	1000000	500000	500000	**2000000**
4	Technical Malathion Fogging	0	200000	0	0	**200000**
5	Monitoring & Evaluation	0	500000	0	500000	**1000000**
6	Lab Support & Equipment SupplyFor Sentinel Sites	5000000	0	0	0	**5000000**
7	Lab Support (Furnishing of Virology Lab At PMCH,Patna) for Sentinel Site	2000000	0	0	0	**2000000**
8	Staff for Strengthening of Lab at PMCH,Patna,Sentinel Site	75000	75000	75000	75000	**300000**
9	Other Charges(Contingency)	100000	0	0	100000	**200000**
6	Grand Total	**10175000**	**1775000**	**1575000**	**2175000**	**15700000**

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8		2180000
9		2180000
10		1744000
11		1744000
12		1270000
13		1744000
14		14432550
15		24141720
16		1574340
17		2965007
		56777817

STATE BIHAR NAME OF PROGRAMMEMASS DRUG ADMINISTRATION (BUDGET FOR 2010-2011).																
Sl. No.	NAME OF THE INSTITUTION	No of PHC DIIST HQ.	District HQ	Total PHC Dist HQ	Training of Dist officer &state	Training for PHC Mos (Rs.5000)/per PHC&Dist. HQ.	Training for Paramedical staff & PHC Level (Rs.4000)/per PHC & Dist. HQ.	Co-ordination meeting (two round) at state HQ.(@Rs. 10000/- per meeting)&Dist. level@5000/-per meeting	IEC activity @ 5000/ PHC & one Dist.HQ+State HQ 2000000	Line Listing@4000/- PHC+Dist. HQ	Night Blood survey @ 4000/ PHC & Dist. HQ	POL		Office Expenditure for State & Dist. HQ@1000&PHC @500	Total (A)	Remarks
												State HQ&Dist HQ. @ 2000/- Dist.A	PHC @3000/- PHC(B)			
1	2	3	4	5	6	7	8	9	10	11	12	13A	13B	14	15	16
1	State level	0	0	0	40200	0	0	20000	20,00,000	0	0	100000	0	25000	2185200	
2	Araria	9	1	10	0	50000	40000	10000	50000	40000	40000	2000	27000	5500	264500	
3	Aurangabad	11	1	12	0	60000	48000	10000	60000	48000	48000	2000	33000	6500	315500	
4	Arawal	3	1	4	0	20000	16000	10000	20000	16000	16000	2000	9000	2500	111500	
5	Banka	10	1	11	0	55000	44000	10000	55000	44000	44000	2000	30000	6000	290000	
6	Begusarai	11	1	12	0	60000	48000	10000	60000	48000	48000	2000	33000	6500	315500	
7	Bhaga;[ir	11	1	12	0	60000	48000	10000	60000	48000	48000	2000	33000	6500	315500	
8	Bhojpur	12	1	13	0	65000	52000	10000	65000	52000	52000	2000	36000	7000	341000	
9	Buxar	7	1	8	0	40000	32000	10000	40000	32000	32000	2000	21000	4500	213500	
10	Darbhanga	13	1	14	0	70000	56000	10000	70000	56000	56000	2000	39000	7500	366500	
11	E. Champaran	20	1	21	0	105000	84000	10000	105000	84000	84000	2000	60000	11000	545000	
12	Gaya	19	1	20	0	100000	80000	10000	100000	80000	80000	2000	57000	10500	519500	
13	Gopalganj	10	1	11	0	55000	44000	10000	55000	44000	44000	2000	30000	6000	290000	
14	Jamui	7	1	8	0	40000	32000	10000	40000	32000	32000	2000	21000	4500	213500	
15	Jahanabad	4	1	5	0	25000	20000	10000	25000	20000	20000	2000	12000	3000	137000	
16	Kaimur	9	1	10	0	50000	40000	10000	50000	40000	40000	2000	27000	5500	264500	
17	Katihar	11	1	12	0	60000	48000	10000	60000	48000	48000	2000	33000	6500	315500	
18	Khagaria	6	1	7	0	35000	28000	10000	35000	28000	28000	2000	18000	4000	188000	
19	Kishanganj	7	1	8	0	40000	32000	10000	40000	32000	32000	2000	21000	4500	213500	
20	Lakhisarai	4	1	5	0	25000	20000	10000	25000	20000	20000	2000	12000	3000	137000	
21	Madhipura	7	1	8	0	40000	32000	10000	40000	32000	32000	2000	21000	4500	213500	
22	Madhubani	19	1	20	0	100000	80000	10000	100000	80000	80000	2000	57000	10500	519500	
23	Munger	6	1	7	0	35000	28000	10000	35000	28000	28000	2000	18000	4000	188000	
24	Muzaffarpur	14	1	15	0	75000	60000	10000	75000	60000	60000	2000	42000	8000	392000	
25	Nawada	10	1	11	0	55000	44000	10000	55000	44000	44000	2000	30000	6000	290000	
26	Nalanda	12	1	13	0	65000	52000	10000	65000	52000	52000	2000	36000	7000	341000	
27	Patna	16	1	17	0	85000	68000	10000	85000	68000	68000	2000	48000	9000	443000	
28	Purna	11	1	12	0	60000	48000	10000	60000	48000	48000	2000	33000	6500	315500	
29	Rohatas	13	1	14	0	70000	56000	10000	70000	56000	56000	2000	39000	7500	366500	
30	Saharsa	7	1	8	0	40000	32000	10000	40000	32000	32000	2000	21000	4500	213500	
31	samastipur	14	1	15	0	75000	60000	10000	75000	60000	60000	2000	42000	8000	392000	
32	Saran	15	1	16	0	80000	64000	10000	80000	64000	64000	2000	45000	8500	417500	
33	Sheikhapura	3	1	4	0	20000	16000	10000	20000	16000	16000	2000	9000	2500	111500	
34	Sheohar	3	1	4	0	20000	16000	10000	20000	16000	16000	2000	9000	2500	111500	
35	Sitamari	13	1	14	0	70000	56000	10000	70000	56000	56000	2000	39000	7500	366500	
36	Siwan	15	1	16	0	80000	64000	10000	80000	64000	64000	2000	45000	8500	417500	
37	Supaul	9	1	10	0	50000	40000	10000	50000	40000	40000	2000	27000	5500	264500	
38	Vaishali	11	1	12	0	60000	48000	10000	60000	48000	48000	2000	33000	6500	315500	
39	W. Champaran	16	1	17	0	85000	68000	10000	85000	68000	68000	2000	48000	9000	443000	
	Total:-	**398**	**38**	**436**	**40200**	**2180000**	**1744000**	**400000**	**4180000**	**1744000**	**1744000**	**176000**	**1194000**	**262000**	**13664200**	

STATE BIHAR NAME OF PROGRAMMEMASS DRUG ADMINISTRATION BUDGET FOR 2010-2011											
Sl. No.	**State & Name of District**	**No. of House in District**	**No. of Drug Distributor in District**	**No. of Supervisor**	**Training of Drug Distributor in District (@ Rs. 55/- each)**	**Hononarium of Drug Distributor in District(@92/- each)**	**Training of Supervisor @Rs. 60/-each**	**Hononarium of Supervisor in District @ Rs. 113/- each**	**Total (B)**	**Total(A)From Previous Sheet**	**Grand Total(A+B)**
1	2	3	4	5	6	7	8	9	10	11	12
1	State level	0	0	0	0	0	0	0	0	2185200	2185200
2	Araria	416693	8400	838	462000	772800	50280	94694	1379774	264500	1644274
3	Aurangabad	359820	7240	724	398200	666080	43440	81812	1189532	315500	1505032
4	Arawal	99698	2000	200	110000	184000	12000	22600	328600	111500	440100
5	Banka	271286	5450	545	299750	501400	32700	61585	895435	290000	1185435
6	Begusarai	379947	7650	765	420750	703800	45900	86445	1256895	315500	1572395
7	Bhaga;[ir	424352	8510	851	468050	782920	51060	96163	1398193	315500	1713693
8	Bhojpur	347780	7000	700	385000	644000	42000	79100	1150100	341000	1491100
9	Buxar	213834	4300	430	236500	395600	25800	48590	706490	213500	919990
10	Darbhanga	508044	10200	1020	561000	938400	61200	115260	1675860	366500	2042360
11	E. Champaran	538386	10750	1075	591250	989000	64500	121475	1766225	545000	2311225
12	Gaya	563963	11300	1130	621500	1039600	67800	127690	1856590	519500	2376090
13	Gopalganj	345846	6930	693	381150	637560	41580	78309	1138599	290000	1428599
14	Jamui	215571	4320	432	237600	397440	25920	48816	709776	213500	923276
15	Jahanabad	124264	2500	250	137500	230000	15000	28250	410750	137000	547750
16	Kaimur	199007	4000	400	220000	368000	24000	45200	657200	264500	921700
17	Katihar	417984	8380	838	460900	770960	50280	94694	1376834	315500	1692334
18	Khagaria	274709	5520	552	303600	507840	33120	62376	906936	188000	1094936
19	Kishanganj	217089	4360	436	239800	401120	26160	49268	716348	213500	929848
20	Lakhisarai	134852	2700	270	148500	248400	16200	30510	443610	137000	580610
21	Madhipura	255280	5320	532	292600	489440	31920	60116	874076	213500	1087576
22	Madhubani	563734	11300	1130	621500	1039600	67800	127690	1856590	519500	2376090
23	Munger	187522	3750	375	206250	345000	22500	42375	616125	188000	804125
24	Muzaffarpur	573302	11500	1150	632500	1058000	69000	129950	1889450	392000	2281450
25	Nawada	288581	5800	580	319000	533600	34800	65540	952940	290000	1242940
26	Nalanda	330598	6620	662	364100	609040	39720	74806	1087666	341000	1428666
27	Patna	679619	13600	1360	748000	1251200	81600	153680	2234480	443000	2677480
28	Purna	456118	9140	914	502700	840880	54840	103282	1501702	315500	1817202
29	Rohatas	394415	7900	790	434500	726800	47400	89270	1297970	366500	1664470
30	Saharsa	226070	4540	454	249700	417680	27240	51302	745922	213500	959422
31	samastipur	462681	9270	927	509850	852840	55620	104751	1523061	392000	1915061
32	Saran	467382	9350	935	514250	860200	56100	105655	1536205	417500	1953705
33	Sheikhapura	85238	1710	171	94050	157320	10260	19323	280953	111500	392453
34	Sheohar	35956	1720	172	94600	158240	10320	19436	282596	111500	394096
35	Sitamari	400483	8020	802	441100	737840	48120	90626	1317686	366500	1684186
36	Siwan	398768	8000	800	440000	736000	48000	90400	1314400	417500	1731900
37	Supaul	288596	5790	579	318450	532680	34740	65427	951297	264500	1215797
38	Vaishali	415794	8320	832	457600	765440	49920	94016	1366976	315500	1682476
39	W. Champaran	488581	9250	925	508750	851000	55500	104525	1519775	443000	1962775
	Total:-	**13051843**	**262410**	**26239**	**14432550**	**24141720**	**1574340**	**2965007**	**43113617**	**13664200**	**56777817**

ACTION PLAN
(2010 – 2011)
National Leprosy Eradication Programme
(NLEP) – BIHAR

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ctV @ ,Q0,e0vkj0'kh"k& vk'kk dk;dÙkkvk dh d"B mUeyu dk;Øe e mudh l'kDr Hkkxhnkjh gr mUg if'kf{kr fd;k tk jgk gA
dk;Øe dk lpkyu & ftyk Lrj
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- xke Lrj ij dk;jr vk'kk dk;dÙkkvk dh d"B mUeyu dk;Øe e mudh l'kDr Hkkxhnkjh gr mUg if'kf{kr fd;k tk jgk gA
- ;g if'k{k.k i[k.M Lrj v} fnolh; gkxk A iR;d cp e 40 ifrHkkxh gkx A
- ifr cp 1800@& :i; dk iko/kku g A
- vYikgkj& 30 X 45 = 1350
- ik0 Lok0 dUn d fp0 ink0 dk ekun;& 150
- ik0 Lok0 dUn d NMA/NMS dk ekun;& 100
- fofo/k [kp & 200
- i[kM d fp0 ink0]ftyk d"B ,o i[kM d NMA if'k{k.k dk lEiUUk djk;x A

vk'kk ekun;%&

- vk'kk }kjk lnfHkr lfnX/k d"B jkxh d ik0 Lok0 dUn ij if"V gku ij ,o ml jkxh d lQyrkiod bykt i.k dju ij fuEu ekun; nu dk iko/kku g%&
- ih0 ch0 jkxh& 300 :i; ¼ 100 :i; jkx dh if"V gku ij ,o 200 :i; bykt i.k dju ij½
- ,e0 ch0 jkxh& 500 :i; ¼ 100 :i; jkx dh if"V gku ij ,o 400 :i; bykt i.k dju ij½
- **vk'kk dh ekun; dh fy, iR;d** ftyk dk i[kM ikFkfed LokLF; dUn dk nu gr 3000 gtkj :i; ifr i[kM inku fd;k tk;xkA

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3-1 & dk;ky; [kp & iR;d ftyk d"B dk;ky; dk VyhQku] QDl] ikLVy ,o VyhxkQ ,o fofo/k [kp gr 18000@& :i; dk okf"kd C;; dk iko/kku gA

3-2 & lkexh & LVªkujh bR;kfn dh en e iR;d fty dk 14000@& :i; dk okf"kd C;; dk iko/kku gA

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dk;Øe dk lpkyu & fty Lrj

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4-1 & nk fnolh; u;s fpfdRlk inkf/kdkfj;k dk ekM;yj if'k{k.k %&

- **iR;sd cp 30 if'k{kvk dk gkxk A**
- **,d cp ij 16700@& :i;s fd jkf'k vkofVr g ftldk fooj.kh fuEu g%&**

& if'k{kdk dk ekun; 300@& :i;s ifr if'k{kd ¼2X300=600½

& if'k{kvk dk ekun; 320@& :i;s ¼320x30=9600½

& vYikgkj 100@& :i;s ifr 0;fDr ¼100x30x2=6000½

& fofo/k [kp 500@& :i;s

4-2 & igys l if'kf{kr fpfdRlk inkf/kdkfj;k dk ,d fnolh; re-orientation training

- **iR;sd cp 30 if'k{kvk dk gkxk A**
- **,d cp ij 8000@& :i;s fd jkf'k vkofVr g ftldk fooj.kh fuEu g%&**

& if'k{kdk dk ekun; 200@& :i;s ifr if'k{kd ¼2X200=400½

& if'k{kvk dk ekun; 150@& :i;s ¼150x30=4500½

& vYikgkj 50@& :i;s ifr 0;fDr ¼40x50=2000½

& nk lgk;dk dk ekun; 75@& :i;s ¼75x2=150½

& LV'kujh ,o fofo/k [kp 950@& :i;s

4-3 & 'kgjh {k= d fpfdRlk inkf/kdkfj;k dk nk fnolh; if'k{k.k ¼mu ftyk e tgk Urban Leprosy Control **ykx gA½**

- **;g if'k{k.k ctV Øe l[;k 4-1 d vuqlkj gkxkA**

4-4 & ,d fnolh; gYFk ijokbtj dk if'k{k.kA

- **dy 70 cp ftyk e vuqyXud &1 d vuqlkj ckVs x;s gA**
- **iR;sd cp 30 if'k{kvk dk gkxk**
- **,d cp ij 6500@& :i;s fd jkf'k vkofVr g ftldk fooj.kh fuEu g%&**

& if'k{kdk dk ekun; 200@& :i;s ifr if'k{kd ¼2X200=400½

& if'k{kvk dk ekun; 100@& :i;s ¼100x30=3000½

& vYikgkj 50@& :i;s ifr 0;fDr ¼40x50=2000½

& nk lgk;dk dk ekun; 75@& :i;s ¼75x2=150½

& LV'kujh ,o fofo/k [kp 950@& :i;s

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	dk;Øe dk lpkyu & ftyk Lrj dk;;ktuk dh vof/k& -2009-2010 5-1 & Ldy fDoht ifr;kfxrk mÌ'; & Ldy d cPPkk ,o v/;kidk dk d"B jkx d ckj e tkx:d djuk rkfd o bl tkudkjh dk viu ifjokj ,o lekt e crk;s vkj d"B jkx d y{k.kk oky 0;fDr;k dk fudV d LokLF; dUn ij tkp ,o e¶r bykt d fy, ifjr djsA i)fr & ,uŒ,eŒ,Œ@,eŒ,uŒ,lŒ Cykd d Ldyk dk fpfUgr dj l{edkj ;ktuk cukdj Ldyk e tk;sx ,o fgUnh e d"B lc/kh tkudkjh nu d i'pkr i'u iNx ,o lcl vf/kd mÙkj nuoky rhu cPpk dk v/;kid dh lgk;rk l fpfUgr djsxA mUg iFke f}rh; ,o rrh; ?kkf"kr djd uxn ijLdkj nx vkj jlhn y yxA & iFke ijLdkj & 200@& :i;s & f}rh; ijLdkj & 150@& :i;s & rrh; ijLdkj & 100@& :i;s & fofo/k [kp & 50@& :i;s • iR;sd fty d gj i[kM e bl idkj d nl fDoht lhiUu djk;s tk;sxA 5-2 & LokLF; eyk & ifr eyk 4000@& :i;s & ,d eyk ifr ftyk iR;sd fty e ,d LokLF; eyk yxkdj mld LVkY dk ipkj ijkj dh lkexh l ltkdj ,o ,eŒMhŒVhŒ nok dk dkmVj Hkh j[kxA jkfx;k dk funku gku d ckn mudk jftLVªku djd rRdky ,eŒMhŒVhŒ }kjk bykt ikjHk dj nxA • ;g eyk vU; LokLF; dk;sØek d LokLF; eyk e lefdr fd;k tk ldrk gA 5-3 & ipk;r lnL;k dk d"B jkx d ckj e lofnr djukA • iR;sd fty d iR;sd i[kM e 4000@& :i;s ifr i[kM ifr cBd fu/kkfjr gA
	ctV Øe l[;k& 6 ctV @ ,Q0,e0vkj0'kh"k& bZ/ku@fdjk;s ij xkMh dk;Øe dk lpkyu & ftyk Lrj dk;;ktuk dh vof/k& -2009-2010 d"B mUeyu dk;Øe dk lpk: :i l lpkfyr dju gr Monitoring ,o Supervision vfr vko';d g A vr iR;sd fty dk okgu d bZ/ku] j[k&j[kko ;k fdjk;s ij okgu yu gr iR;sd fty dk 75000@& :i;s ,d okgu gr ifro"k nu dk iko/kku gA
	ctV Øe l[;k& 7 ctV @ ,Q0,e0vkj0'kh"k& fodykxrk dh jkdFkke ,o fpfdRlh; iuokl dk;Øe dk lpkyu & ftyk Lrj dk;;ktuk dh vof/k& -2009-2010

List of Supportive Medicines for treatment of leprosy patients

Besides the Anti leprosy drugs forming basic components of MDT, the following drugs/material essential to treat the following conditions should be available:

1. Reactions
2. Disabilities
3. Eye complications
4. Commonly associated general conditions

1. Anti-reaction drugs
   1. Prednisolone
   2. Inj. Dexamethasone
   3. Clofazimine (higher doses needed to treat reactions)
   4. Chloroform
   5. Aspirin

2. Material needed for disability cases
   1. Acriflavin Powder 25 gm
   2. Cotton
   3. Roller bandage
   4. Chlorhexidine gluconate (savlon)
   5. Gauze pieces
   6. Adhesive plaster
   7. Zink tapes
   8. Vaseline
   9. Splints of various type
   10. Antibiotic ointment
   11. Sulphonilamide power 250 gm
   12. POP

3. Material for ophthalmic conditions

1. Atropine eye ointment
2. Chloramphenicol (eye applicaps) 50x100
3. Sulphacetamide eye drops 10 ml.
4. Prednisolone eye drops

4. Drugs needed for general use.

1. Tab. Avil 25 mg
2. Tab. Paracetamol
3. Tab. B. Complex
4. Tab. Iron with Folic Acid
5. Tab. Diiodoquine Hydrochloride
6. Tab. Mebaendazole
7. Cap. Vit. A & D
8. Tab. Brufen
9. Tab. Septran
10. Tab. Aluminium Hydroxide
11. Cap. Teatracycline
12. Tab. Spasmindon
13. Furazolidone
14. Benzyl Benzoate 450 ml
15. Tab. Multi Vitamin
16. Inj. Avil
17. Inj. 'B' Complex
18. Inj. Imferon
19. Inj. Mephentine
20. Whitfield ointment 450 gm
21. Tincture Benzoin co. 450 ml
22. Tincture Iodine 450 ml
.

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10oha iapo"khZ; ;kstuk esa Hkkjr ljdkj }kjk 'kgjh {ks=ksa dk d"B fuokj.k gsrq fo'ks"k ctV dk izko/kku fd;k x;k gS D;ksafd 'kgjh {ks=ksa esa xzkeh.k {ks=ksa dh rjg Infrastructure dk vHkko gSA vr% 'kgjh {ks=ksa esa d"B mUewyu gsrq vfrfjDr /ku jkf'k dk izko/kku fd;k x;k tks 11oha iapo"khZ; ;kstuk esa Hkh tkjh gSA

'kgjh {ks= dk pkj Js.kh;ksa esa foHkkftr fd;k x;k gSA

Sl. No.	Type of urban area	Number	Located in State/UT *
1	Township	354	28
2	Medium Cities – I	55	19
3	Medium Cities – II	5	5
4	Mega Cities	8	7
Total		422	28

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ftyk jkaph esa 24 Township ,oa 6 Medium City 1 fpfUgr fd;s x;s gSA

8-2 & ¼vuqyXud&1½ vFkdeZ ,oa midj.k & 90 izfr'kr d"B jksxh dks y{k.kks ls gh funku dj dk;Z ;kstuk & ¼'kgjh d"B mUewyu dk;ZØe½ jk"Vªh; d"B mUewyu dk;ZØe ds i=kad ,y{k.k 16011/7/2000 Lep. (Coord.) of May 2008

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1- Lfdu Lfeh;j dh tkWp
2- ,Ok dh igpku djuk
3- mipkj djuk

jksxh dks fy, ,oa jksx dks Qsyus ls jksdus ds fy, ,oa ftyk i;Z'kkslu ,eMhÃVhÃ lsok fuxjkuh djus gsrq e[; dUnz bl ee esa 12000@& :i;s izfr ftyk izfro"kZ vkofVr gSA

4- lanuhdj.k cBd dk vk;kstu A

5- 'kgjh d"B mUewyu lfefr dk xBu A

6- izfronuks ds j[k&j[kko dk r= fodflr djuk A

7- ,eMhÃVhÃ nok dh fu;fer vkiwfrZ ,oa ejhtks rd miyC/krk A

Township ds fy, vkoVu 51000@& :i;s izfr Township izfro"kZ

1- lgk;d nok,sa & 9000@& :i;s

2- 'kgjh d"B mUewyu dk;ZØe dh leh{kkRed cBd o"kZ esa 4 ckj gksxh] ftlds fy, 4000@& :i;s izfr cBd O;; dh jkf'k vkcafVr gS A ¼4x4000=16000½ A

3- i;Zos{k.k gsrq okgu bZ/ku ,oa j[k&j[kko & 10000@& :i;s izfro"kZ A

4- vkbZ,eÃ,Ã ds fpfdRldksa dk lanuhdj.k ¼50 izfrHkkxh 1 cSp & 5000@&½

5- vkbZihÃlhÃ odZ'kki & vkxuokMh ,oa vU; xSj ljdkjh laxBuksa ds Lo;alsoh ds fy, 5 cSp ¼40 izfrHkkxh izfr cSp½ ds fy, 2000@& :i;s izfr cSp 2000x5=10000

6- fofo/k [kp 1000@& :i;

dy [kp 51000@& :i;

Medium City 1 d fy, vkoVu 100000@& :i; ifr Medium City 1 ifro"k

1- lgk;d nok, & 18000@& :i;

2- 'kgjh d"B mUeyu dk;Øe dh leh{kkRed cBd o"k e 4 ckj & 6500@& :i; ifr cBd ¼4x6500=26000½

3- i;o{k.k gr okgu b/ku ,o j[k&j[kko & 25000@& :i; ifro"k A

4- vkbZ,eŒ,Œ d fpfdRld dk lonuhdj.k ¼100 ifrHkkxh 2 cp e & 5000@& ifr cp½ 5000x2=10000

5- vkbZihŒlhŒ od"kkZi & vkxuokMh ,o vU; xj ljdkjh lxBuk d Lo;lsoh d fy, 10 cp ¼40 ifrHkkxh ifr cp½ d fy, 2000@& :i; ifr cp 2000x10=20000

6- fofo/k [kp 1000@& :i;

dy [kp 100000@& :i;

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STATE HEALTH SOCIETY (Leprosy), BIHAR

Budget for Year 2010-11

Head No.	Category of Expenditure : Component & Sub Component wise	DLS	SHSB (Leprosy)	Total of activities	Remarks
1	Under SHS (Leprosy) NLEP Contractual Services (Staff)				
1.1	20 Drivers for 19 Districts & for State Leprosy Cell @ Rs.4500/-PM	1026000	54000	1080000	
1.2	DEO at State Leprosy Cell @ Rs.8000/-	0	96000	96000	
1.3	Administrative Assistant in State Leprosy Cell @ Rs.7000/- per month.	0	84000	84000	
1.4	SMO (Surveillance Medical Officer) @ Rs. 20000/- per month	0	240000	240000	
Total Contractual Services (1.1 to 1.4)		**1026000**	**474000**	**1500000**	
2	Services Through ASHA/USHA	2136000	0	2136000	
	Total - Services Through ASHA	**2136000**	**0**	**2136000**	
3	Office Expences & Consumables				
3.1	Telephone, Fax, P & T Charges, Miscellaneous @ Rs.47500/- per year at State & Rs.22500/- District per year)	855000	47500	902500	
3.2	Consumables : Stationary etc. (@ Rs.35000/- per year at State & Rs.17500/- District per year)	665000	35000	700000	
Total - Office Expences (3.1 to 3.2)		**1520000**	**82500**	**1602500**	
4	Capacity Building				
4.1	Two days modular training of new entrant Mos @ Rs.25000/- per batch for 49 batches	1225000	0	1225000	
4.2	One day reorientation training of Mos @ Rs 12650/- per batch for 90 batches	1138500	0	1138500	
4.3	Two day training of Urban Mos	750000	0	750000	
4.4	One day training of Health Supervisors @ Rs. 12500/- per batch for 70 batches	875000	0	875000	
Total - Capacity Building (4.1 to 4.4)		**3988500**	**0**	**3988500**	
5	Behavioral Changes & Communication				
5.1	School Quiz @ Rs.500/- per quiz (100 quiz per blocks)	2420000	0	2420000	
5.2	Health Melas/Fairs @ Rs.4000/- per mela (One Health Mela/District)	152000	0	152000	
5.3	Sensitisation meetings with PRI members @ Rs.4000/- per meeting at block level	1936000	0	1936000	
Total - Behavioral Changes & Communication (5.1 to 5.3)		**4508000**	**0**	**4508000**	
6	**POL/Vehicle Operation & Hiring**				

	POL/ Vehicle Operation, hiring & maintenance (One Vehicle per district @ Rs. 75000/- per year & Rs.85000/-/ Vehicle per year for two vehicles at State)	**2850000**	**170000**	**3020000**	
7	**DPMR**				
7.1	Aids & appliances @ Rs.12500/- per district	475000	0	475000	
7.2	Reconstructive Surgery (RCS)	1875000	0	1875000	
7.3	MCR & other footwears 4560 pairs @ Rs.250/- per year	0	1140000	1140000	
7.4	Printing of DPMR formats & registers	0	375000	375000	
Total - DPMR (7.1 to 7.4)		**2350000**	**1515000**	**3865000**	
8	Material & Supplies				
8.1	Supportive medicines @ Rs. 25000/- per year	950000	0	950000	
8.2	Laboratory reagents & equipments @ Rs.12000/- per year	456000	0	456000	
8.3	Printing of SIS formats & registers	0	600000	600000	
Total - Material & Supplies (8.1 to 8.3)		**1406000**	**600000**	**2006000**	
9	Urban Leprosy Control (Rs.51000/- for 24 Towns & Rs. 1,00,000/- for 6 Medium Cities)	**1824000**	**0**	**1824000**	
10	NGO - SET Scheme	0	0	0	
11	Supervision, Monitoring & Review			0	
	Review meetings and Travel Expenses	0	800000	800000	
12	Cash Assistance	0	3000000	3000000	
	Grand Total	**21608500**	**6641500**	**28250000**	

(Rs. Two Crore Eighty Two Lacs Fifty Thousand Only)

(Dr. N. M. Sharma)
Joint Director, Health Services,
State Leprosy Office, Bihar, Patna-6

Fund Allocation to District Health Society (Leprosy) 2010-11

Sl. No.	District	Population March 2008 (Est.)	Number of Block PHCs	Number of ASHAs	Contractual Services	Services through ASHA			Office Expenses @ Consumables		Capacity Building (Trainings)								Behavioral Change Communication (IEC)			POL/Vehicle Operation & hiring
					Driver's Remuneration @ Rs. 4500/- per month	Performance based incentive to ASHA @ Rs. 300/- for new PB case & Rs. 500/- for new MB case (Rs. 3000/- per Block)	Sensitization of ASHA (half day) @ Rs. 1800/- per batch of 40 participants		Office expences for rent, telephone, electricity, P & T charges, miscellaneous (Includes Rs. 500/- per month Honararium for Account Work)- @ Rs. 18000/- per district year	Consumables : Stationary etc. @ Rs. 14000/- per year	Two days modular training of newentrant Mos @ 16700/- per batch for 49 batces		One day reorientation training of Mos @ Rs. 8000/- per batch for 90 batches		Two days training of Urban Mos		One day training of health supervisors @ Rs.6500/- per batch for 70 batches		School Quiz @ Rs. 500/- per quiz (10 quiz per Blocks)	Health Melas/ Fairs @ Rs.40000/- per mela (One health mela/ Districts)	Sensitisation meetings with PRI members @ Rs.40000/- per meeting at block level	POL/Vehicle Operation, hiring & Maintenance
							No. of Batch	Amount			No. of Batch	Amount	No. of Batch	Amount	No. of Batch	Amount	No. of Batch	Amount				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1	Aurangabad	2442850	11	1552	0	33000	11	19800	22500	17500	1	25000	2	25300	1	25000	2	25000	55000	4000	44000	75000
2	Bhojpur	2721199	13	1621	0	39000	10	18000	22500	17500	2	50000	3	37950	1	25000	2	25000	65000	4000	52000	75000
3	Buxar	1709982	8	1074	0	24000	6	10800	22500	17500	1	25000	2	25300	1	25000	2	25000	40000	4000	32000	75000
4	Bhagalpur	2961123	13	1971	54000	39000	11	19800	22500	17500	2	50000	3	37950	1	25000	2	25000	65000	4000	52000	75000
5	Banka	1960140	10	1535	0	30000	10	18000	22500	17500	1	25000	2	25300	0	0	2	25000	50000	4000	40000	75000
6	Darbhanga	4003029	18	2890	54000	54000	13	23400	22500	17500	2	50000	3	37950	1	25000	2	25000	90000	4000	72000	75000
7	Katihar	2911413	13	1866	54000	39000	11	19800	22500	17500	1	25000	2	25300	1	25000	2	25000	65000	4000	52000	75000
8	Muzaffarpur	4561500	14	2848	0	42000	13	23400	22500	17500	2	50000	3	37950	1	25000	2	25000	70000	4000	56000	75000
9	Nawada	2204609	14	1591	54000	42000	10	18000	22500	17500	1	25000	2	25300	1	25000	2	25000	70000	4000	56000	75000
10	Patna	5738496	23	2549	54000	69000	13	23400	22500	17500	2	50000	7	88550	1	25000	2	25000	115000	4000	92000	75000
11	Purnea	3095704	11	2263	0	33000	11	19800	22500	17500	1	25000	2	25300	1	25000	2	25000	55000	4000	44000	75000
12	Kishanganj	1576690	7	1024	54000	21000	6	10800	22500	17500	1	25000	1	12650	1	25000	1	12500	35000	4000	28000	75000
13	Araria	2588901	9	2026	54000	27000	13	2340	22500	17500	1	25000	2	25300	0	0	2	25000	45000	4000	36000	75000
14	Rohtash	2983578	19	2030	0	57000	11	19800	22500	17500	1	25000	2	25300	1	25000	2	25000	95000	4000	76000	75000
15	Kaimur	1565130	10	1247	0	30000	6	10800	22500	17500	1	25000	1	12650	0	0	1	12500	50000	4000	40000	75000
16	Siwan	3300459	15	2538	54000	45000	13	23400	22500	17500	1	25000	2	25300	1	25000	2	25000	75000	4000	60000	75000
17	Sitamarhi	3252998	14	2221	54000	42000	11	19800	22500	17500	1	25000	3	37950	1	25000	2	25000	70000	4000	56000	75000
18	Sheohar	626610	3	464	54000	9000	10	18000	22500	17500	1	25000	1	12650	0	0	1	12500	15000	4000	12000	75000
19	W.Champaran	3707653	18	2494	0	54000	12	21600	22500	17500	1	25000	3	37950	1	25000	2	25000	90000	4000	72000	75000
20	Begusarai	2854704	18	2091	0	54000	10	18000	22500	17500	2	50000	2	25300	1	25000	2	25000	90000	4000	72000	75000
21	E. Champaran	4792753	20	2756	54000	60000	13	23400	22500	17500	2	50000	4	50600	1	25000	2	25000	100000	4000	80000	75000
22	Gaya	4221745	22	2440	54000	66000	13	23400	22500	17500	2	50000	3	37950	1	25000	2	25000	110000	4000	88000	75000
23	Gopalganj	2618766	14	1846	54000	42000	10	18000	22500	17500	1	25000	2	25300	1	25000	2	25000	70000	4000	56000	75000
24	Jehanabad	1128356	7	743	54000	21000	6	10800	22500	17500	1	25000	2	25300	1	25000	2	25000	35000	4000	28000	75000
25	Arwal	713145	5	658	0	15000	6	10800	22500	17500	1	25000	1	12650	0	0	1	12500	25000	4000	20000	75000
26	Khagaria	1555507	7	967	54000	21000	6	10800	22500	17500	1	25000	1	12650	0	0	1	12500	35000	4000	28000	75000
27	Madhubani	4350491	18	3034	0	54000	13	23400	22500	17500	1	25000	3	37950	1	25000	2	25000	90000	4000	72000	75000
28	Madhepura	1857573	7	1459	54000	21000	10	18000	22500	17500	1	25000	2	25300	1	25000	2	25000	35000	4000	28000	75000
29	Munger	1383495	9	820	0	27000	6	10800	22500	17500	1	25000	2	25300	1	25000	2	25000	45000	4000	36000	75000
30	Sheikhpura	639829	6	439	54000	18000	6	10800	22500	17500	1	25000	2	25300	0	0	2	25000	30000	4000	24000	75000
31	Jamui	1702687	6	1270	0	18000	6	10800	22500	17500	1	25000	1	12650	1	25000	2	25000	30000	4000	24000	75000
32	Lakhisarai	976152	4	568	0	12000	6	10800	22500	17500	1	25000	1	12650	0	0	1	12500	20000	4000	16000	75000
33	Nalanda	2885577	20	2017	54000	60000	10	18000	22500	17500	2	50000	3	37950	1	25000	2	25000	100000	4000	80000	75000
34	Saharsa	1835424	12	777	0	36000	10	18000	22500	17500	1	25000	2	25300	1	25000	2	25000	60000	4000	48000	75000
35	Supaul	2126197	11	1533	54000	33000	10	18000	22500	17500	1	25000	2	25300	1	25000	2	25000	55000	4000	44000	75000
36	Samastipur	4158912	23	3214	0	69000	13	23400	22500	17500	2	50000	5	63250	1	25000	2	25000	115000	4000	92000	75000
37	Saran	3961606	15	2825	0	45000	13	23400	22500	17500	1	25000	3	37950	1	25000	2	25000	75000	4000	60000	75000
38	Vaishali	3304782	17	2532	0	51000	12	21600	22500	17500	2	50000	3	37950	1	25000	2	25000	85000	4000	68000	75000
Total		100979765	484	67793	1026000	1452000	380	662940	855000	665000	49	1225000	90	1138500	30	750000	70	875000	2420000	152000	1936000	2850000

Sl. No.	District	DPMR				Material & Supplies		Urban Leprosy Control	Total Fund Allocation to Districts	Quarterly Fund Allocation to District			
		Aids & appliances @ Rs. 12500/- per district	Reconstructive Surgery (RCS)			Supportive medicines @ Rs.25000/- per year	Laboratory reagents & equipments @ Rs.12000/- per year	Townships @ Rs.510000/- per town & medium city 1 @ Rs.1000000/- per medium city		First Quarter April 2010 to June 2010	Second Quarter July 2010 to September 2010	Third Quarter October 2010 to December 2010	Fourth Quarter January 2011 to March 2011
			No. of RCS	Welfare Allounce for RCS patients (Rs.5000/- per RCS)	Incentive to institution for RCS (Rs. 5000/- per RCS)								
1	2	24	25	26	27	28	29	30	31	32	33	34	35
1	Aurangabad	12500	0	0	0	25000	12000	51000	471600	117900	117900	117900	117900
2	Bhojpur	12500	0	0	0	25000	12000	51000	531450	132863	132863	132862	132862
3	Buxar	12500	0	0	0	25000	12000	51000	426600	106650	106650	106650	106650
4	Bhagalpur	12500	0	0	0	25000	12000	100000	636250	159063	159063	159062	159062
5	Banka	12500	0	0	0	25000	12000	0	381800	95450	95450	95450	95450
6	Darbhanga	12500	35	175000	175000	25000	12000	100000	1049850	262463	262463	262462	262462
7	Katihar	12500	0	0	0	25000	12000	51000	549600	137400	137400	137400	137400
8	Muzaffarpur	12500	85	425000	0	25000	12000	100000	1022850	255713	255713	255712	255712
9	Nawada	12500	0	0	0	25000	12000	51000	559800	139950	139950	139950	139950
10	Patna	12500	110	550000	550000	25000	12000	100000	1910450	477613	477613	477612	477612
11	Purnea	12500	0	0	0	25000	12000	100000	520600	130150	130150	130150	130150
12	Kishanganj	12500	0	0	0	25000	12000	51000	443450	110863	110863	110862	110862
13	Araria	12500	0	0	0	25000	12000	0	429200	107300	107300	107300	107300
14	Rohtash	12500	0	0	0	25000	12000	51000	567600	141900	141900	141900	141900
15	Kaimur	12500	0	0	0	25000	12000	0	349450	87363	87363	87362	87362
16	Siwan	12500	0	0	0	25000	12000	51000	577200	144300	144300	144300	144300
17	Sitamarhi	12500	0	0	0	25000	12000	51000	574250	143563	143563	143563	143563
18	Sheohar	12500	0	0	0	25000	12000	0	326650	81663	81663	81663	81663
19	W.Champaran	12500	0	0	0	25000	12000	51000	570050	142513	142513	142513	142513
20	Begusarai	12500	0	0	0	25000	12000	51000	578800	144700	144700	144700	144700
21	E. Champaran	12500	0	0	0	25000	12000	51000	687500	171875	171875	171875	171875
22	Gaya	12500	0	0	0	25000	12000	100000	747850	186963	186963	186963	186963
23	Gopalganj	12500	0	0	0	25000	12000	51000	559800	139950	139950	139950	139950
24	Jehanabad	12500	0	0	0	25000	12000	51000	468600	117150	117150	117150	117150
25	Arwal	12500	0	0	0	25000	12000	0	289450	72363	72363	72363	72363
26	Khagaria	12500	0	0	0	25000	12000	0	367750	91863	91863	91863	91863
27	Madhubani	12500	0	0	0	25000	12000	51000	571850	142963	142963	142963	142963
28	Madhepura	12500	0	0	0	25000	12000	51000	475800	118950	118950	118950	118950
29	Munger	12500	0	0	0	25000	12000	51000	438600	109650	109650	109650	109650
30	Sheikhpura	12500	0	0	0	25000	12000	0	380600	95150	95150	95150	95150
31	Jamui	12500	0	0	0	25000	12000	51000	389950	97488	97488	97488	97488
32	Lakhisarai	12500	0	0	0	25000	12000	0	277450	67363	67363	67363	67363
33	Nalanda	12500	0	0	0	25000	12000	51000	669450	167363	167363	167363	167363
34	Saharsa	12500	0	0	0	25000	12000	51000	481800	120450	120450	120450	120450
35	Supaul	12500	0	0	0	25000	12000	51000	523800	130950	130950	130950	130950
36	Samastipur	12500	0	0	0	25000	12000	51000	682150	170538	170538	170538	170538
37	Saran	12500	0	0	0	25000	12000	51000	535850	133963	133963	133963	133963
38	Vaishali	12500	0	0	0	25000	12000	51000	583050	145763	145763	145763	145763
	Total	475000	230	1150000	725000	950000	456000	1824000	21608800	5400135	5400135	5400128	5400128

PART- E

Intersectoral Convergence

2010-2011

Situational Analysis:

Public health peripheral and extension services and its linkage with facility based services started less than a century in the country. The said services have developed many folds during the last sixty years initially on the recommendation of the Bhor Committee and subsequently on the basis of reviews and recommendations of several expert committees. It has achieved commendable results despite poor funding and lack of a uniform system of command. It is now increasingly understood larger fund allocation would increase the resources within the health administrative set up but to achieve the desired outcomes, sectors administering the determinants of health must work in tandem with common objectives. The NRHM rightly emphasized the need to develop a convergent system between the Department of Health and other sectors governing the areas of several health determinants. The NHRM also recognizes the need to develop ownership of partners / stakeholders in tackling local endemic issues to ensure better quality of life in all sections of the population. Considering the diversity and prevailing inequity amongst the people it is rightly considered that leadership must be provided at every level of governance to solve the health problems amongst the poor and the excluded. Governance at every level can only be provided by the Rural Local Self Governance and in the State of Bihar it is the three tiers Panchayat Raj Institution. The other sectors which directly administer the issues of health determinants are;

- Department Social Welfare administers ICDS
- Department of Education administers school and higher education,
- Public Health Engineering Department and Panchayat administer supply of drinking water and environmental sanitation including solid waste management.

NRHM also seeks partnership from Indian System of Medicine like Aurveda, Unani, Yoga, Sidda and Homeopathy now jointly named AUYSH. The NRHM also seeks involvement of Non Government Organizations (NGO) and For Profit Private Sector as partners in the public health services by developing local need specific Public Private Partnership schemes. It also visualizes the need to involve expert consultants and agencies in strengthening the Department of Health and development of a State Heath Resource Centre to provide Technical Support in carrying forward the Management of Change for efficient utilization of resources and effective delivery of health services.

(a) Coordination with Panchayat /Village Council.

The state is undergoing through the process in the decentralisation of Panchayati Raj System. Thus to strengthen and monitor the performance of the PHSC and PHC, this institution has been brought under the manifold of the Panchayat president and Zilla Panchayat members of the respective areas. Further the Panchayat presidents or the members are ex officio chairman of the Village Health Water and Sanitation committee, to have a direct involvement in the health issues of the community. Joint bank account of Panchayat president and ANM has been opened for PHSC untied fund. These processes paved the way for taking initiative in implementation in various health programmes under NRHM

Department has good relationship with the Village Council and through coordination with the Village Council most of the health programmes are being implemented at the community level with satisfaction.

(b) Coordination with ICDS

The DPO is a member of the District Health Society & District Core Group (under NRHM) and thus the health department has been able to utilize his/her services for community mobilization at the grassroots level. Through coordinated effort of the ANM and the Anganwadi worker mothers and children are being mobilized for antenatal check up, institutional deliveries and immunisation. Now the coordination is to be extended to organize VHNDs (Village Health nutrition Days) at every AWC all over the district every month.

Issues / Areas	Areas of Convergent Action
Support in School Health Programme	Due to shortage of manpower in the health department, plans to examine school children should be prepared jointly with the education department so that larger schools are covered first or priority should be set for village schools which have not been covered recently or threats/incidences of diseases/malnutrition are more.
Support in immunisation programme for provision of TT booster at the age of 10 years.	During the school health programme visits, the booster Tetanus Toxoid needs to be given to 10 year olds in the schools. This should be worked out with the Education department and visits planned accordingly.
Support in the adolescent health programme	Problem villages to be identified in which ASRH services can be provided on priority basis.

(c) Coordination with PRI

Issues / Areas	Convergent actions
Drainage system in villages	List of villages with major drainage problems to be shared by the Health and ICDS department with the Rural Development department for annual prioritization of resources
Garbage disposal in villages	The system of disposal of garbage (solid waste) needs to be set up and larger villages prioritized as per list submitted by ANMs and AWWs. The operational aspects need to be managed by the VHWSC as per guidelines.
Emergency transportation services	Standard Operation Procedure (SOPs) and operation of emergency transportation services in villages with support from the block are in process.

(d) Coordination with AYUSH

There are few practitioners of ISM that are in government employment. The service rules related to them are not well defined. However, practitioners of traditional systems are there. Before a strategy can be worked out as to how to mainstream or integrate this, a study need to be carried out to identify the points of common interest such as rational management of common diseases, communicable diseases control Programme and disease surveillance

Outcome /Output: Effective coordination exists between health dept. and other line departments	
Objectively Verifiable Indicators (OVI): Increased participation of all the line departments with the health department	
1.1 – Strategy : • Constitute State level inter department standing committee to initiate policy review for convergence and develop implementation procedures • Constitute District level inter department committee under the Chairmanship of DM and involvement of the District Level PRI to ensure PHC level committees are constituted and implementing the directives of the State Level Standing Committee • SHRC and TSU can facilitate by providing Technical Assistance and Support	
Activities:	**MoV**
1.1.1 Develop convergence platform at all levels with NRHM line departments by constituting the committees	Committees constituted
1.1.2 Develop policy framework and procedural guidelines / manual	Guidelines / manual
1.1.3 Develop linkage with other departments like WCD, Urban & Rural	Minutes of the

	Development, Education, Panchayat, Youth Affairs, etc at all levels by ensuring the committees are functioning as per guidelines	meeting
1.1.4	Involve civil society, partners, NGOs in district health society	Membership list
1.1.5	Establish convergent committee in all PHCs chaired by BDO	Committees constituted
1.1.6	PRI s to actively involve in health development activities	Membership list
1.1.7	Joint Action with the line departments at different levels	Joint plans and monitoring and review documents
1.1.8	Formation and effective functioning of Rogi Kalyan Samiti (RKS) at PHC level which will also function as convergence committee	RKS constituted
1.1.9	Joint Planning, monitoring, evaluation by ANM, AWW ASHA FNGO/NGO, VHWSC and PRI representatives in VHWSC meeting.	Joint plan documents
1.1.10	Regular information sharing among converging departments and joint review of progress.	Minutes of meeting
1.1.11	Key officials of NRHM related departments at State level to be actively involved in monitoring at all levels	Joint monitoring and review documents
1.1.12	Preparation of joint monitoring plan in consultation with all line departments	Joint monitoring plan document
1.1.13	Review and monitoring of activities jointly.	Joint monitoring and review documents

Programme wise convergence

Strategies/Activities	MoV
1. Maternal Health	
1.1 Organize VHNDs at each and every AWC once a month to deliver ANC services.	Consolidated report of the PHC & district hospital
1.1 Organize once in two months RCH camps in all PHC and District Hospital areas within the district.	Consolidated report of PHC & district
1.2 Involvement of community representative of Gram Sabha through VHWSCs & MSS for identifying & referring complicated cases to facilities	Supervision and monitoring reports
1.3 Involvement of AWWs and PRIs to identify and track each pregnant woman and motivate them to avail ANC services. Regular updation of EC register and quarterly population survey of her coverage area.	Supervision and monitoring reports
1.4 Collection of blood and urines samples of pregnant women and send it to PHC for examination and report back with in 24 hours	VHND Report
1.5 ASHA, AWW and ANM to be involved in observed consumption of IFA tablets by moderately and severely anemic pregnant mothers through regular home visits and follow ups.	Monitoring and supervision report of LHV/ MO/DRCHO/PRI
1.6 Observed consumption of Iron Follifer Tabs by Girls students in schools	School Health Programme report
1.7 De-worming of all pregnant and adolescents girls (Half Yearly)	Programme report
2. Child Health	
2.1 Organize VHNDs at each and every AWC once a month to deliver child health and nutrition services.	Consolidated report of the PHC & district hospital
2.2 Organize RCH camps once in two months in all PHCs	Consolidated report of PHC & district
2.3 Involvement of community representative of Gram Sabha through VHWSCs & MSS for identifying & referring malnourished cases to facilities	Supervision and monitoring reports
2.4 Supervision & Monitoring on all VHNDs by PRI representatives	Supervision and monitoring reports
2.5 Regular organization of VHNDs at every AWCs in co-ordination of ANMs, ASHAs and PRIs	Programme report
2.6 Estimation and registration of children under the age group of 0-5 yrs	List of children

2.7 Growth monitoring of each child during VHNDs, at PHSC & in other facilities	Supervision and monitoring reports of PRIs/Department
3. Family Planning	
3.1 Ensure distribution of OCPs, emergency pills, condoms and IUD insertion to eligible couple through ASHAs , AWCs and ANMs	Stock Register
4. Adolescents Health	
4.1 To provide weekly dose of observed IFA and bi-annual dose of deworming to adolescents girls in school by teachers	List of girls provided IFA % deworming
4.2 To provide weekly dose of observed IFA and bi-annual dose of deworming to adolescents girls in school by AWWs and ASHAs	List of girls provided IFA % deworming
4.3 Training of school teachers, AWWs, ASHAs and female PRI representatives on following issues: • Hygiene and menstrual hygiene and genital cleanliness • Adolescents growth and development • Communicating with adolescents • Sexual and reproductive health concerns of boys and girls • Nutrition and anemia in adolescents • Contraception for adolescents • RTIs/STIs and HIV/AIDS in adolescents • Child bearing • Birth preparedness and parenting • Safe abortion	Report of training
4.4 Awareness development amongst adolescents girls by school teachers, AWWs, ASHAs and female PRI representatives on all issues mentioned above by community	Report of counseling session
5. Immunization	
ASHA , AWW and ANM to conduct Home Visits to trace out the Un-immunized children and Drop outs	List of children
Provision of Immunization during regular VHNDs organized at every AWCs	Performance report
6. National Disease Control Programme	
IDSP	
Symptomatic identification of diseases covered under IDSP and refer to nearest health facility	Report of cases

Treatment all referral cases	Performance report
RNTCP	
Symptomatic detection of cases by ANMs, AWWs, ASHAs, PRIs and refer to nearest DOTS centre	report of cases
Awareness development at community level regarding signs and symptoms of reportable cases for early detection, isolation and seeking treatment through mass media,, IPS, & counseling	Report of BCC activities
Developing and dissemination of IEC material, including leaflets and posters to the community	Display and availability of BCC material
IPC through convergent approach	Report of key functionaries
Blindness	
Create awareness at the community level through effective mass media for screening camps to be organized by BCC activities	Report of BCC activities
Awareness development at community level regarding signs and symptoms of reportable diseases for early detection and seeking treatment.	Report of BCC activities
Developing and dissemination of IEC material, including leaflets and posters	Leaflets and posters in place
IPC through convergent approach	Report of key functionaries
Leprosy	
Involving ASHA, AWWs and PRIs to ensure accessible and uninterrupted MDT services available to all patients through flexible and patient friendly drug delivery system	Clinic during conventional timing
6.5 National Vector Borne Disease Control Programme	
6.5.1 Convergence with Panchayat/PHED for environmental sanitation and safe drinking water supply by detecting location with problems	List of sites
6.6 Water borne diseases	
6.6.1 **Drainage system in villages**	
List of villages with major drainage problems to be shared by the Health and ICDS department with the Rural Development department for annual prioritization of resources	List of villages
6.6.2 Garbage disposal in villages	
The system of disposal of garbage (solid waste) needs to be set up and larger villages prioritized as per list submitted by ANMs and AWWs. The operational aspects need to be managed by the VHWSC as per guidelines.	List of villages and locations

Work Plan

Goal:

Effective coordination exists between health dept. and other line departments

Strategy / Activity	Timeline						Responsibility State/District
	2009-10				2010-11	2011-12	
	Q1	Q2	Q3	Q4			
Inter-sectoral Coordination							
Strategy: Refer to LFA above							
Activities:							
1.1.1 Develop convergence platform at all levels with NRHM line departments by constituting the committees							State
1.1.2 Develop policy framework and procedural guidelines / manual							State
1.1.3 Develop linkage with other departments like WCD, Urban & Rural Development, Education, Panchayat, Youth Affairs, etc at all levels by ensuring the committees are functioning as per guidelines							State/District
1.1.4 Involve civil society, partners, NGOs in district health society							District
1.1.5 Establish convergent committee in all PHCs chaired by BDO							District
1.1.6 PRIs to actively involve in health development activities							District
1.1.7 Joint Action with the line departments at different levels							State/District
1.1.8 Effective functioning of Rogi Kalyan Samiti (RKS) at PHC level which will be also function as convergence committee							District
1.1.9 Joint Planning, monitoring, evaluation by ANM, AWW ASHA FNGO/NGO, VHWSC and PRI representatives in VHWSC meeting.							District
1.1.10 Regular information sharing among converging departments and joint review of progress.							State/District
1.1.11 Key officials of NRHM related departments at							State

Strategy / Activity		Timeline						Responsibility State/District
		2009-10				2010-11	2011-12	
		Q1	Q2	Q3	Q4			
	State level to be actively involved in monitoring at all levels							
1.1.12	Preparation of joint monitoring plan in consultation with all line departments							State/District
1.1.13	Review and monitoring of activities jointly.							State/District

NRHM PART A : RCH II

Sl. No.	Budget Head	Rs. lakhs	%
1	Maternal Health		
1.1.1.1	Operationalise FRUs-BSUs (Generator, Fuel, Misc @24000 pm x 76 x 12 mths) , Blood Donation Camp @ 38 x 12 x 8000 , Contingency Fund @6000 x 76 and State Monitoring Cell @60000 x 12	267.12	
1.3.1.	RCH Outreach Camps in un-served/ under-served areas	21.32	
1.3.2	Monthly Village Health and Nutrition Days at AWW Centres	111.83	
1.4.1	Home deliveries (500/-)	1375.00	
1.4.2.1	1.4.2.1 Rural (A) Institutional deliveries (Rural)	24000.00	
1.4.2.1	Urban (B) Institutional deliveries (Urban)	2710.82	
1.4.2.3	Caesarean Deliveries (Facility Gynec, Anesth & paramedic) - Incentive for C-section(@1500/-(facility Gynec. Anesth. & paramedic)	1500.06	
1.4.3	Chiranjeevi yojna in Bihar(Pilot in two districts-Gopalganj and Kishanganj)	50.01	
1.4.4	1.4.4 Other Activities(JSY) 1.4.4.1 Monitor quality and utilisation of services	591.68	
1.5	1.5 Other strategies/activities	50.00	
1.5.1	Instititutional base death review	20.00	
	Sub total	**30697.84**	39.36
2	Child Health	4288.18	5.50
3	Family Planning	8963.36	11.49
4	Adolescent Reproductive and Sexual Health	89.05	0.11
5	Urban RCH	108.00	0.14
6	Vulnerable Groups	0.00	0.00
7	Tribal Health	0.00	0.00
8	Innovations/PPP/NGO	165.25	0.21
9	Infrastructure and Human Resource	25156.61	32.25
10	Institutional Strengthening	156.60	0.20
11	Training	2518.72	3.23
12	BCC/IEC (for NRHM Part A, B & C)	2542.08	3.26
13	Procurement of Equipments/Instruments	1612.14	2.07
14	Procurement of Drugs and Supplies	241.65	0.31
15	Programme management	1270.98	1.63
	Other/Untied Fund/Flexipool for District	190.00	0.24
	TOTAL	**78000.46**	**100.00**

PART- B

Sl. No.	Budget Head	In Lakhs	%
1	**Decentralization**		
1.11	ASHA Support System at State Level	619.21	
1.12	ASHA Support System at District Level	406.20	
1.13	ASHA Support System at Block Level	1036.15	
1.14	ASHA Support System at Village Level	0.00	
1.15	ASHA Trainings	2904.13	
1.16	ASHA Drug Kit & Replenishment	1651.47	
1.17	Motivation of ASHA	659.82	
1.18	Capacity Building/Academic Support programme	10.00	
1.19	ASHA Divas	1202.46	
	Total ASHA	8489.44	8.98
1.2	Untied Fund for Health Sub Center, Additional Primary Health Center and Primary Health Center	1379.67	
1.21	Village Health and Sanitation Committee	4053.30	
1.22	Rogi Kalyan Samiti	1078.00	
	Total Decentralization	6510.97	6.88
2	**Infrastructure Strengthening**	0.00	
2.1	Construction of HSCs	11587.50	
2.2 A	Construction of PHCs	18205.00	
2.2 B	Construction of residential quarters of 30 old for APHCs for Staff nurses.	900.00	
2.3	Upgradation of PHCs to CHC	4000.00	
2.4	Upgrading District Hospitals and Sub-Divisional Hospital as per IPHS	1500.00	
2.5	Annual Maintenance Grant	859.00	
2.6	Accreditation / ISO : 9000 certification of Health Facilities	300.00	
2.7	Upgradation of Infrastructure of ANM Training Schools	700.22	
	Total Infrastructure Strengthening	**38051.72**	40.23
3	**Contractual Manpower**	0.00	
3.1	Mobile Phone Facility for health personnel	60.51	
3.2	Block Programme Management Unit	3146.83	
3.3	Addl. Manpower for SHSB	86.66	
3.4	Addl. Manpower for NRHM-	0.00	

3.4 A	Hospital Manager in FRU	171.00	
3.4 B	Regional Programme Management Unit (RPMU)	162.00	
	Total Contractual Manpower	**3627.00**	3.83
	PPP Initiatives	0.00	0.00
4	**Referral & Emergency Transport-**		
4.1	Call 102 – Ambulance Service	40.32	0.04
4.2	1911- Doctor on Call & Samadhan	13.20	0.01
4.3	Advanced Life Saving Ambulances (Call 108)	356.04	0.38
4.4	Referral Transport in Districts	1054.80	1.12
5	American Association of Physicians of Indian Origin (AAPIO)	56.00	0.06
6	Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP) (Budgeted in Part-A)	0.00	0.00
7	Dialysis unit in various Government Hospitals of Bihar	150.00	0.16
8	Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar	360.00	0.38
9	Outsourcing of Pathology and Radiology Services from PHCs to DH	5030.00	5.32
10	Operationalising MMU	2695.68	2.85
11	Monitoring and Evaluation (State, District, Block Data Centre)	681.50	0.72
12	Generic Drug Shop	0.00	0.00
13	Hospital Maintenance	2343.60	2.48
14	Provision for HR Consultancy services	22.50	0.02
15	Strengthening of Cold Chain	389.02	0.41
16	Mainstreaming of AYUSH under NRHM	11587.60	12.25
17	Procurement and Logistics	0.00	0.00
17.1	Drug Procurement	10000.00	10.57
17.2	Controlling Iron Deficiency Anemia in Adolescent population	737.61	0.78
17.3	District Drug Warehouse	225.00	0.24
18	Procurement of Supplies	0.00	0.00
18.1	Provision of Quality Beds	1000.00	1.06
19	RCH Equipment/Instrument Procurement	0.00	0.00

19.1	Instrument for ANM In 38 districts (from Untied Fund at HSCs)	0.00	0.00
19.2	Bio metric System (Biometric Machine- Rs. 10000/-, HMS Software Rs. 5000/-, Installation Cost- Rs. 1000/-, Vat @ 1% Rs.- 640/-) = 16640/-	34.20	0.04
19.3	SNCU and NSU Equipments for District Hospital	854.13	0.90
20	De-centralised Planning	271.91	0.29
	Total	**94582.25**	**100.00**

NRHM Part: C

Sl	Budget Head	Total Budget (Rs. In lakhs)	%
1	**Routine Immunization**	5807.68	100
Total		**5807.68**	

NRHM PART D – NATIONAL DISEASE CONTROL PROGRAMME

Sl. N0.	Budget Head	In Lakhs	%
1	IDSP	388.57	4.32%
2	NIDDCP	93.76	1.04%
3	Blindness	2124.79	23.63%
4	NLEP	282.50	3.14%
5	RNTCP	2618.31	29.12%
6	Kalazar	2315.99	25.76%
7	Malaria	435.15	4.84%
8	Dengu + Chikungunya	7.70	0.09%
9	JE	157.00	1.75%
10	Filaria	567.78	6.31%
	Total	**8991.55**	**100.00%**

SUMMARY of BUDGET

PART	HEAD	BUDGET 2010-11 (Rs. In lakhs)	%
A	RCH II	78000.46	41.63
B	NRHM Additionalities	94582.25	50.48
C	Immunization	5807.68	3.10
D	NDCP	8991.55	4.80
	TOTAL	**187381.93**	**100.00**
	GRANT TOTAL	**187381.93**	

Development Partners with SHSB

UNICEF Bihar -

The indicative budget for one year is USD 2 million. However, if the measles campaign is held next year, then the indicative budget would add up by USD 1.8 million.

S No	UNICEF Intermediate results	Part of PIP
1	Health Managers at block, district, state and national level can manage UIP resources (prediction, stock control and distribution)	C
2	Frontline Health workers have capacity to implement RI and supportive supervision according to set standards	C
3	Parents have increased knowledge on the importance of RI	C
4	Health Managers at block, district and state level can manage health system resources for maternal and child health	C
5	State Governments can implement prioritized interventions for accelerating access to and participation of excluded communities in health and nutrition services	A
6	NRHM and ICDS and TSC managers at block, district and state level know how to use Village Health and Nutrition Days (VHND) for convergence of maternal and child survival, growth and development programmes	A
7	Parents of all children <5 in SMNet high risk areas have knowledge about improved hygiene practices, exclusive breastfeeding, and the managements of diarrhea	A
8	Health Managers at block, district and state level can manage health system resources for maternal and child health	A
9	Frontline health and ICDS workers can offer essential services for the Integrated Management of Neonatal and Childhood Illnesses	A
10	Frontline health and ICDS workers have interpersonal communication skill	A
11	Managers of child survival and development programmes at all levels can guide the collection and analysis of routine data and its use for program design, planning, implementation and monitoring	A
12	Educational and training institutions provide training of health professionals in public health programmes for maternal and child health as per national standards	A
13	To scale up a model programme for the integrated management of severe acute malnutrition (IM-SAM) in children	A
14	Health managers, workers and communities at state, district, block and village level can use Maternal Perinatal Death Inquiry (MAPEDIR) and facility based maternal death reviews for improving maternal health services	A
15	Health managers and communities at state, district, block and village level can use referral-transport services	A
16	Managers of child survival and development programmes at all levels can guide the collection and analysis of routine data and its use for program design, planning, implementation and monitoring	
17	Auxiliary Nurse Midwives (ANMs), staff nurses and doctors can provide IMNCI, skilled birth attendance (SBA), ante-natal care (ANC) and post-natal care (PNC)	A

	according to set standards	
18	Health facilities can implement ANC, F-IMNCI, PNC and EmOC and specialized newborn care according to set standards	A
19	Census and surveys and other data systems (including routine monitoring systems of Flagship programmes) fill in data gaps, improve quality and disseminate data in time	A
20	Gap analysis of flagship programmes informs policy changes and improves implementation	A
21	Dissemination of the contents of the Policy for Newborn & Child Health at all levels	A
22	Health Managers at block, district and state level can manage the malaria control programme	
23	UNICEF Health specialists/officers guide the fulfillment of UNICEF's CCC in Health	
24	Health managers at block, district and state level, can assess and respond during emergencies.	
25	A Comprehensive policy addressing Anemia in Children, adolescent girls and women of reproductive age is drafted and ready for dissemination	A
26	Strengthened convergence with other sectors to integrate Child-friendly framework norms into SSA and RTE plans	A
27	State AIDS Control Societies (SACS) are able to plan and operationalise quality PPTCT services up to appropriate level	A
28	To scale up Infant and Young Child Feeding (IYCF) practices for infants and young children (0-23 months old) including for children who are sick;	
29	To scale up a model programme for improved complementary foods and feeding practices in infants and young children (6-23 months old)	
30	To scale up an integrated model programme for the control of **anemia in children with emphasis on infants and young children 0-23 months old**	
31	To scale up an integrated programme to improve women's nutrition, with emphasis on the control of **anemia in adolescent girls, pregnant women, and lactating mothers**	
32	State government departments (HFW and WCD) can scale up a programme to deliver preventive vitamin A supplementation and deworming bi-annually for children under five years old	
33	Increased awareness and knowledge of communities on critical practices related to child survival and development (IYCF, Immunization, Diarrhea Management, Early Danger signs and handwashing) in Vaishali	
34	Families and communities have the basic knowledge to care for and support women during pregnancy, child birth and post-partum period in Vaishali	
35	Communication units in Rural Development/PHED/DDWS, Information and Broadcasting, Health and WCD Departments at national/state level are able to plan, implement and monitor behaviour change communication strategies	

UNFPA Bihar -

UNFPA has been in operations in Bihar since last one year (2009). UNFPA Bihar office has two professionals, one Finance Assistant and a Driver. Since November 2009, a Consultant has also been placed in Bihar Office to coordinate the work of Population Policy development in the state. In last one year, the office has been successful in properly positioning UNFPA in the state as a nodal UN agency on Population and Development, including Family Planning, Maternal Health, ARSH, Gender and Social Equity. In year 2009, apart from providing technical support to Government of Bihar (GoB) on above areas, Bihar office initiated two NGO partnerships on HMIS and meeting the unmet needs of adolescents and young couples. Apart from these, the office participated, provided inputs and supported other UNFPA initiatives like 'Sapno ko Chali Chune' with Dianik Jagaran (a popular Hindi Newspaper) and addressing declining sex ratio in Bihar, with WPC. On the request of GoB, the state office is providing two state Consultants: one for Family Planning and another for Maternal Health. UNFPA will also support SHS, GoB with State Level FP IEC Consultant and PCPNDT (need based) Consultant.

For year 2010, UNFPA Bihar's proposed budget is approximately 1.15 million dollars.

Together with the initiatives begun last year, this year's – 2010 – AWP for Bihar will include the following:

1. Technical Assistance to GoB

   UNFPA through its Office in Patna and with support from the New Delhi Office will provide assistance, as per the request of GoB, to Health, Education, Women's Development and Panchayati Raj Departments based on its mandate and competencies. We envisage support related to development of PIPs at the State and in selected Districts, and providing inputs in the implementation of the same. UNFPA would be pleased to undertake assessments and evaluations of interventions undertaken by different social sector departments. The Technical Assistance will also include increasing the Pool of Skilled Family Planning Providers in Bihar, particularly on Non-Scalpel Vasectomy (NSV). At present Bihar does not have enough NSV Providers. In partnership with an agency of national repute (National NSV Association of India), UNFPA Bihar will work towards increasing the pool of Certified State NSV Trainers and subsequently the NSV Providers. UNFPA Bihar will continue supporting GoB with State Consultants on Maternal Health and Family Planning. Apart from these, in 2010, the state office also plans to provide a State FP IEC Consultant and a PCPNDT Consultant to GoB.

2. Facilitating MIS implementation in the State

   MOHFW has recently launched the web based MIS for the country. The initial focus is to ensure that all the districts in the country start sending their service statistics through the new computerized MIS system. In the second phase, MOHFW intends to focus on development of competencies among the statistical staff at State, District and sub-district levels to ensure quality in reporting, analysis and interpretation of data.

   UNFPA would continue supporting Government of Bihar on effective functioning of its MIS. To facilitate this, UNFPA started a project with IIHMR, Jaipur in 2009. This project will continue in year 2010 too.

3. Meeting the unmet demand for family planning

The state has a relatively high unmet demand for FP. The share of spacing method use is also very low. The MOHFW is emphasizing on a set of key strategies for meeting this demand. Technical assistance of UNFPA is visualized both for the government system and also through the NGOs. Support will be provided through state office for accelerating pace of clinical trainings in contraception and for Operationalisation of QOC in family planning. Inputs for improving the quality of PIPs would be provided for increasing access, improving quality of services and monitoring plan implementation. Additionally alternative service delivery interventions such as community based contraceptive programmes through NGOs and social franchising for contraceptive services will also be explored. The effort would be to provide a comprehensive set of inputs, both technical and establishing pilots that can be up-scaled using NRHM resources. In this regard, UNFPA started a Community Based project with Pathfinder to address high unmet needs of the youth and the young couples, aiming at encouraging them to have children at appropriate age and increasing space between two births. This project will continue this in year 2010 too.

4. Addressing adolescents Life Skills Development and RH needs

Based on the experiences in other States, it is evident that life skills development of adolescents, both in school and out of school is an important area of intervention. Young married adolescents girls form a significant proportion of population in Bihar.

a. **In-School**: Possibilities exist in terms of improving pedagogy in teaching of life skills by the B.Ed students; revision of curriculum, in-service training of teachers through partnership with the Education Department. Interventions for this group could also be contemplated through NGOs. Based on the interest and feasibility, interventions through the Department of Education and NGOs will be initiated.
b. **Out-of-School**: In order to address adolescent and reproductive health need of out of school adolescents, projects will be initiated in both rural and urban settings, through NGOs with linkages with government.

5. Strengthening Midwifery Infrastructure in Bihar

UNFPA Bihar will explore the possibility of providing 2 ANM Schools in Bihar, full-fledged support for improving the quality of teaching, courses and the capacity building skills of the faculties. The likely support will include providing quality teaching staff, support staff, educational materials, teaching aids, computer facilities etc.

6. UN Systems Convergence Plan and Support for 5 Districts

As part of the UN Systems Convergence Plan, UNFPA is providing specific intervention in 5 convergence districts: Baghalpur, Gaya, Nalanda, Supaul and Purnea.

UNFPA is providing support to two districts, Supaul and Purnia, in developing their DHAPs. As part of the joint UN effort, UNFPA is providing programme planning, implementation and monitoring inputs on UNFPA mandated areas. In continuation with UNFPA's specific contribution to enhance data use capability of senior, middle and front line officials of key development departments, at state and district levels, UNFPA will conduct the trainings on the same for the district level officials from these

departments in year 2010. In 2009, UNFPA organized similar training for senior level state and district (5 convergent districts) officials at ISEC, Bangalore.

7. Creating awareness on Population Issues

In partnership with Media Group, Dainik Jagaran (Jagaran Pahal), UNFPA will create awareness on population issues at community level through village level melas (*Haat)* in the state.

NPSP/WHO Bihar -

WHO-NPSP supports various activities related to polio eradication and other vaccine preventable diseases (VPDs) in Bihar through a network of Medical Officers. A total of 82 Surveillance Medical Officers (SMOs) are deployed in the districts. Most districts have one Surveillance Medical Officer while some high risk districts have additional SMOs posted in them. The NPSP SMOs are supervised and supported by Sub-Regional Team Leaders positioned at the divisional level and a Team Leader at the state headquarters. NPSP also provides support at the PHC level through a network of 421 Field Volunteers.

Role of NPSP in Polio Eradication

A. **Supporting a highly sensitive surveillance system to detect wild poliovirus transmission in all districts of the State**

- Establishing, sensitizing and maintaining a network of reporting sites: NPSP SMOs play a critical role in establishment and maintenance of a large network of reporting sites for reporting cases of Acute Flaccid Paralysis (AFP) More than 637 disease reporting units report weekly, including zero reports, to the network in Bihar. These reporting units are comprised of government and private hospitals and health centers. In addition, 3221 Informing Units of Bihar comprised of medical practitioners and traditional healers report Acute Flaccid Paralysis (AFP) cases.

- Case-Investigation, follow-up, stool sample collection & shipment to WHO accredited Lab & sharing of result at all levels: More than 11655 AFP cases were reported and investigated in 2008 from Bihar. Stool specimens collected from AFP cases are tested in one of the WHO-accredited poliovirus laboratories in the network. In 2008, 22566 specimens were collected, shipped and processed by the laboratory network. The NPSP SMOs ensure timely AFP case detection, immediate reporting and investigation through ongoing analysis of health facility contacts of patients, advocacy, sensitization and orientation of reporting sites, and training and capacity building of district immunization staff. Although the district immunization officers are responsible for all case investigations, a vast majority of AFP cases are examined and reviewed personally by the SMOs. SMOs closely monitor and track specimen collection, handling, and shipment to laboratories.

- Data Management and Analysis: Data on cases and system performance are managed and analyzed at the district level by SMOs for local feedback, dissemination and action. NPSP has established an electronic surveillance data base throughout the country that generates real time data on cases under investigation and those confirmed as polio. Analyzed data are shared by NPSP, every week with the state. Key programme decisions are taken and strategies designed/modified based on these data.

B. **NPSP Role in Polio Immunization Campaigns**

- Support micro planning and training for the polio campaigns: NPSP is involved with the formulation of the guidelines for micro planning and supporting the district and PHC Medical Officers in the implementation of these guidelines. NPSP has also been providing support for training support for vaccinators and supervisors by developing training modules and conducting trainings of trainers to ensure high quality polio campaigns.

- Monitoring polio campaigns: Through its extensive network of Field Volunteers and additional temporarily hired monitors in Bihar, NPSP undertakes extensive monitoring of the planning and implementation of polio vaccination campaigns. Data generated through the NPSP monitoring is extensively used by the state, district and sub-district governments to take corrective actions and improve the quality of the polio campaigns. NPSP provides technical and organizational support for the District Task Force & Block level Task Force Meeting for Polio campaigns.

NPSP role in activities beyond Polio Eradication

A. Strengthening Routine Immunization: NPSP has been assisting the Bihar Government with improving routine immunization coverage through its flagship programme - Muskan. The key areas of NPSP support to the routine immunization strengthening include:

- formulation of policies, strategies and guidelines for improving the reach of the existing vaccines under Muskan
- developing training materials for immunization staff, supporting training of trainers and evaluating training activities
- developing and disseminating guidelines for surveillance of adverse events following immunization (AEFI),
- monitoring immunization sessions and coverage through its extensive network of Field Volunteers and using the monitoring data to identify gaps in the implementation of the routine immunization programme so that corrective actions can be taken to improve coverage.

B. Other Areas of support:

- Support in investigation of selected outbreaks of measles
- Strategic technical and monitoring support during floods and major epidemics
- Supporting the state for Epidemic and Pandemic Preparedness Response
- Monitoring JE immunization campaigns

NIPI Bihar -

In order to achieve MDG-4 (Reduction in IMR), NIPI (Norway- India Partnership Initiative) - UNOPS (United Nations Office for Project Services) has joined hands with State Health Society, Bihar through an MoU signed in (Dec. 2007). The vision of NIPI is to provide catalytic, strategic support that would make a vital and sustainable difference to the rapid scaling up of quality and equitably delivered child health services in India under the National Rural Health Mission (NRHM). SHSB is the executing body of the programme in the State.

In Bihar, based on the existing status of health indicators, three districts viz. Nalanda, Sheikhpura and Jehanabad have been selected for focused attention of NIPI.

Interventions:

(a) **MAMTA:** Services of lady workers, known as MAMTA, have been engaged to achieve following outcomes:

- retention of mother and the newborn for 48 hours in the hospital of birth,
- promote breast feeding,
- weighing the baby,
- impart basic knowledge to the mother regarding warming up the baby,
- health and hygiene of the mother and newborn,
- counsel on small family norms,
- Immunization- BCG & 0-dose polio.

Services of fairly experienced lady has been engaged in Darbhanga Medical College Hospital, All Sadar Hospitals (Total: 24) and all Sub Divisional Hospitals (Total: 23) of the State (Total-48).

N.B. "MAMTA" is not an employee but a voluntary worker.

1. **Criteria for selection:**
    - A local woman living near the hospital area
    - Preferably a mother of children who are not being breastfed
    - She agrees to work as a volunteer without intimidation of caste/creed
    - Free from communicable diseases, subject to clearance by the Medical Officer
    - Willing to work on rotational basis including night duties.
    - Belongs to Ravidas community.
    - Education at least up to 8^{th} standard.
    - Age- between 25-50 years.

For every 4/5 births one MAMTA is to be engaged per shift of eight hours plus 20% as buffer to meet the contingency- absence of MAMTA from duty.

2. **Training:** MAMTA is given two days orientation training in the facility itself, by a team consisting of medical officer and A-grade nurse, about the practices she has to observe during the duty. Subsequently she will receive induction training and refresher training to ensure continuous updating of her knowledge and skills.
4. **Honorarium:** Rs. 100/- delivery care.
5. **Supervision:** One Dy. Child Health Supervisor (DCHS) has been engaged, on contract, to aid, assist and supervise the functioning of MAMTA.
6. **MAMTA kits:** MAMTA will present an aseptic kit to every mother after the delivery, the kit will consist of:
    - Newborn blanket
    - Plastic sheet
    - Sanitary pad for mother
    - Contraceptive pills
    - Pack of condoms

7. **Performance:** 224921 deliveries took place during Jan.-Oct. 2009 in 48 facilities, MAMTAs have attended the mother and the child very enthusiastically, and they have extended due care and counsel that they were trained in.
8. **Impact:** There is visible impact on promotion of breast feeding, weighing the baby, immunization (BCG & 0-dose polio) and reception to the pregnant lady in the hospital.

(b) **Home- Based Newborn Care (HBNC):** The newborn, whether the birth takes place in the facility or in home, needs care and supervision at least for 42 days from the birth. In Bihar, 60% of the total deliveries take place in homes; mostly attended by traditional birth attendants who are not exposed to update knowledge and skills. Timely identification of danger clinical signs and immediate interventions for these sick babies are key factors for reduction in neonatal mortality. NIPI has addressed this crucial factor through specially designed Home-Based Newborn Care system, in three focused districts-Nalanda, Jehanabad and Sheikhpura.

Under this initiative ASHA will visit every home of newborn six times, at recommended intervals, during first 42 days. She has been properly trained to identify the danger signs, given a kit, PNC card for the home visits, referral cards so as to refer the newborn immediately after the danger signs are identified, and Rs. 1000/- so that the baby is immediately transported to the nearest facility.

1. **Training:** For up gradation of skills and imparting details of the scheme, ASHAs need proper, both theoretical and practical training. For this two tier training has been designed. In tier I, a team of one medical officer, one ANM and one LHV, where LHV is not available two ANMs, from each PHC in the three focused districts received three days ToT in the State Institute of Health and Family Welfare, Patna. This team then organizes two days training for the ASHAs of the PHC at the PHC headquarter. The two tier training has been completed in all 33 PHCs before launching the scheme. During the training following components are covered in detail-
    a) Care during pregnancy;
    b) Breast feeding;
    c) Care of the newborn;
    d) Care of the mother;
    e) Care of the underweight baby;
    f) Additional counseling;
    g) Care during delivery.

Subsequently a five days pilot training will be given to these ASHAs at the PHC level. Experts form National Neonatology Forum, New Delhi, All India Institute of Medical Sciences, New Delhi, NIPI Secretariat, New Delhi and from SIHFW, Patna will participate in this pilot training. A training need assessment for the ASHAs of the PHC will be conducted to ensure that the pilot training is need specific.

2. **Incentive:** Every ASHA will get Rs. 200/- per delivery after successful completion of required number of visits. Every ASHA has to make 5 visits incase of delivery in the facility and six visits incase of home delivery. She will carry the PNC card for each house, the PNC card has questionnaire on newborn, mother and referral. After required number of visits she will submit the card to the ANM who will submit it to the MOIC of the PHC for payment @ Rs. 200/- per PNC card/ delivery.

3. **ASHA kit:** ASHA will be given a kit which contains spring balance, thermometer, gentian violet and some OTC drugs; she will carry this kit during her home visits and ensure that the baby is weighed and temperature is read whenever the baby seems to be sick.
4. **Referral fund:** Every ASHA has been given Rs. 1000/- (one thousand only) so as to refer the newborn to the nearest hospital, immediately after the danger signs are identified. Guidelines, how to use this fund and account for, has been issued by the State Health Society. It is expected that above provision will help in avoiding delay in decisions, delay in reaching hospitals and delay in proper treatments. This will have an impact on infant mortality rate of the districts.

State Health Society, Bihar has issued detail guidelines on different component of the scheme (Letter No: SHSB/RI/222/08/12475, Dated: 14/10/09, Letter No. SHSB/RI/187/07/II/12778, Dated: 03/11/09, Letter No. SHSB/RI/292/09/1236, Dated: 07/10/09)

(c) **Sick Newborn Care Unit (SNCU):** Bihar contributes about 9.9 per cent to the national burden of infant deaths in India. To ensure immediate emergency treatment to the sick newborn, NIPI will set up SNCU in Sadar hospitals of all the three focused districts (Nalanda, Sheikhpura and Jehanabad). SNCU will focus on providing early detection and treatment to critical neonatal cases. It will provide for controlled environment, individual warming and closed monitoring devices equipped with modern life saving equipments.

(d) **Techno-managerial support:** NIPI will provide techno-managerial support to PHCs in three focused districts, 48 facilities (Sadar and Sub-divisional hospitals), SIHFW (Set up State Child Health Resource Centre) and State Health Society, Bihar (Child Health Consultant and Financial Analyst)

In addition to above, NIPI is assisting in setting up an update Financial Management Information System in State Health Society, Bihar, it has further engaged Mr. V. Srinivas, IAS as consultant to State Health Society, he will study the system, identify the short comings and suggest improvements so as to improve flow of fund and register sizable increase in utilization of funds released by NRHM.

In view of our experiences so far, we intended to utilize the services of MAMTAs engaged in the Sadar/ Sub-divisional hospitals of the State to the full, shall ensure better mentoring of MAMTAs and more homely and informal care of the baby & mother and counseling the mother and the wards which will have calculable impact on IMR/MMR of the Districts.

Since HBNC was launched, in focused districts, in the fag end of the calendar year, it will be fully operational during current year. The ASHA will be given kits so that they make effective 5/6 visits to every home of newborn. Proper monitoring of visits, analysis of PNC cards submitted by her will be ensured. This will have impact on the infant mortality of the blocks and district.

DFID Supported "Sector Wide Approach to Strengthen Health (SWASTH)" Bihar -

Government of Bihar has initiated the DFID supported programme Sector wide approach for strengthening health (SWASTH) in Bihar, with the goal of improving the health and nutritional status of the people of Bihar. The programme takes an integrated approach and spans the three prime government departments of Health and Family Welfare, Social Welfare, and Public Health Engineering.

The purpose of SWASTH is to increase access to better quality health, nutrition, and water and sanitation services for underserved groups. SWASTH will achieve its purpose through prioritizing and delivering an Essential health, nutrition, water and sanitation Service Package (ESP).

The Essential Service Package includes services that need to be provided at the facility as well as community level. This also includes activities and processes to empower the community to adopt safe health, nutrition, water, sanitation and hygiene practices and demand quality services. Suggested components of ESP to improve maternal and child health and nutrition conditions are:

Maternal health:

Facility level: a) Strengthening of District Hospitals to provide quality Comprehensive Obstetric Care, including safe abortion care and BPHCs to provide quality Basic Obstetric Care; b) Improving referral networks between communities and health facilities, and between BPHCs and District Hospital; c) Equipping block level health facilities to manage unwanted pregnancies and Reproductive Tract Infections and Sexually Transmitted Infections; and d) Improving Infection Prevention and Environmental Management practice (IPEM).

Community level: Implementation of proven community based initiatives to manage pregnancies, space births, improve access to reversible family planning methods; prevent unwanted pregnancies, prevent/ manage anaemia, malaria and other conditions, and buy time for women with complications during pregnancy and childbirth by timely / prompt transportation to the nearest specialized facility (BPHC or District Hospital).

Child Health:

Facility level: Strengthening District Hospitals and Block level PHCs to manage complications during pregnancy, delivery and early childhood (i.e., provisioning of sick and new-born care); b) Improving water and sanitation facilities at public institutions such as hospitals, AWCs and schools; and c) Improving hygiene practices in children in AWCs and schools.

Community level: Implementation of proven community based initiatives to: a) manage childhood pneumonia/respiratory infections and diarrhea; b) detect and treat malaria and Kala Azar; c) improve child immunization, d) prevent micronutrient deficiencies and malnutrition e) improve coverage of households with safe water and sanitation facilities; and f) improve household level practice related to safe drinking water, safe disposal of excreta (feces), washing hands with soap at appropriate times, food safety and hygiene.

Nutrition

Community level: Enhancing skills of frontline workers (ANMs, Anganwadi workers and ASHAs) to focus on proven, essential nutrition interventions, the timely initiation of breastfeeding within one hour of birth, exclusive breastfeeding during the first six months of life, the timely introduction of age-appropriate complementary foods at six months (adequate in terms of quality, quantity and frequency), hygienic cooking and child feeding practices, improved nutrition for women (especially adolescent girls, pregnant women and lactating mothers), focusing on iron and folic acid supplements, de-worming, vitamin A and timely, and care for all children with severe acute malnutrition along with high quality therapeutic feeding.

Water and Sanitation

Community level: Improve access to safe water and sanitation, particularly by rehabilitating borewells, creating sustainable water sources, testing of water quality, and promoting Total Sanitation Campaign and hygiene.

Outputs

SWASTH will achieve its purpose through the realization of six cross cutting and mutually beneficial outputs.

1. Increased scale and functionality of nutrition, health and water and sanitation services,
2. Community level initiatives undertaken to manage, demand and monitor nutrition, health and water and sanitation services.
3. Availability, capacities and accountability of staff providing services improved.
4. Institutions established and systems strengthened to achieve better efficiency and effectiveness of service provision.
5. Capacity to work with non-government actors enhanced to deliver essential nutrition, health and water and sanitation services.
6. Quality and use of health, nutrition and water and sanitation monitoring and evaluation systems improved.

Programme Activities: DFID support will be spent on achieving the six BHSRP outputs through mutually agreed milestones and activities. Six monthly and annual reviews will measure progress against the milestones.

Technical Assistance

The DFID financial assistance is being complemented with Technical Assistance and a Technical Assistance Support Team (BTAST) has been appointed by DFID to provide technical and managerial support to the GoB to achieve its health and nutrition goals, specifically to support the design and implementation of the State Health Sector Plan. TAST is managed by a consortium of CARE, Options Consulting and IPE Global. The team consists of international and national consultants.

Abbreviations

ANM Auxiliary Nurse Midwife
ARI Acute Respiratory Infection
AWC Aaganwadi Centre
ASHA Accredited Social Health Activist
AWW Aaganwadi Worker
AYUSH Ayurved Unani Siddha and Homeopathy
BEmONC Basic Emergency Obstetric Neonatal Care
BPL Below Poverty Line
CBO Community Based Organization
CEmONC Comprehensive Emergency Obstetric Neonatal Care
CH Civil Hospital
CHC Community Health Centre
CS Civil Surgeon
CMR Child Mortality Rate
CSO Civil Society Organization
DFID Department for International Development
DH District Hospital
APHC Additional Primary Health Centre
SDH Sub-Divisional Hospital
DP Development Partners
FNGO Field Non-Governmental Organization
GOI Government of India
HMIS Health Management Information System
HRD Human Resource Development
ICDS Integrated Child Development Scheme
IEC Information Education and Communication
IFA Iron Folic Acid
IMNCI Integrated Management of Neonatal and Childhood Illnesses
IMR Infant Mortality Rate
IPHS Indian Public Health Standards
IUCD Inter Uterine Contraceptive Devices
JBSY Janani Evam Bal Suraksha Yojana
LHV Local Health Visitor
M&E Monitoring and Evaluation
MDG Millennium Development Goals
MOHFW Ministry of Health and Family Welfare
MoU Memorandum of Understanding
MPW Multi-Purpose Worker
MTP Medical Termination of Pregnancy
NACO National AIDS Control Organization
NACP National AIDS Control Programme
NFHS National Family Health Survey
NMR Neonatal Mortality Rate
OBC Other Backward Class
OPD Outdoor Patient Dispensary
PG Post Graduate
PHC Primary Health Centre
PHED Public Health Engineering Department
PIP Programme Implementation Plan
PMU Programme Management Unit
POL Petrol Oil and Lubricant

PRI Panchayati Raj Institution
RCH Reproductive and Child Health
RHS Rapid Household Survey
RKS Rogi Kalyan Samiti
RMP Registered Medical Practitioner
RTI Reproductive Tract Infection
SBA Skilled Birth Attendant
SC Scheduled Caste
SHC Sub Health Centre
SNGO Service Non-Governmental Organization
SPMU State Programme Management Unit
ST Scheduled Tribe
STI Sexual Tract Infection
TBA Traditional Birth Attendant
TFR Total Fertility Rate
TT Tetanus Toxoid
U5M Under 5 Mortality
UIP Universal Immunization Programme
UNFPA United Nations Population Fund
UT Union Territory
VHSC Village Health and Sanitation Committee
VO Voluntary Organization

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State Health Society, Bihar