बिहार सरकार

DISTRICT HEALTH SOCIETY MADHEPURA

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

DISTRICT HEALTH ACTION PLAN

2011-2012

Developed & Designed By

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DHS, Madhepura

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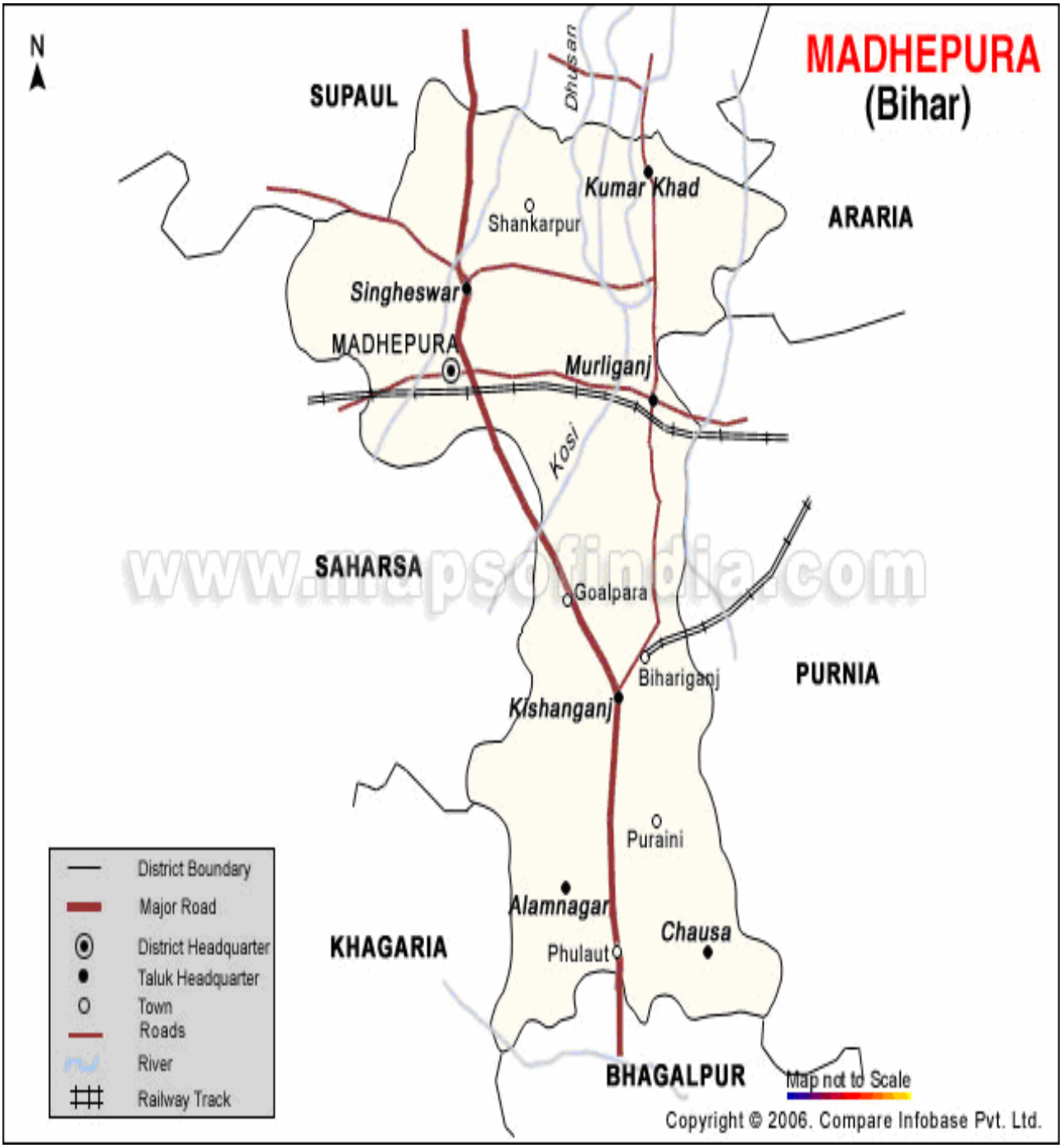
District Magistrate-cum-Chairman,
DHS, Madhepura

Map of Madhepura



Foreword

National Rural Health Mission aims at strengthening the rural health infrastructures and to improve the delivery of health services. NRHM recognizes that until better health facilities reaches the last person of the society in the rural India the social and economic development of the nation is not possible.

The District Health Action Plan of Madhepura district has been prepared keeping this vision of mind. The DHAP aims at improving the existing physical infrastructures, enabling access to better health services through hospitals equipped with modern medical facilities, and to deliver with the help of dedicated and trained manpower. It focuses on the health care needs and requirements of rural people especially vulnerable groups such as women and children. The DHAP has been prepared keeping in mind the resources available in the district and challenges faced at the grass root level. The plan strives to bring about a synergy among the various components of the rural health sector. In the process the missing links in this comprehensive chain have been identified and the Plan will aid in addressing these concerns. The plan has attempts to bring about a convergence of various existing health programmes and also has tried to anticipate the health needs of the people in the forthcoming years.

The DHAP has been prepared through participatory and consultative process wherein the opinion the community and other stakeholders have been sought and integrated. I am grateful to the Department of Health, Government of Bihar for providing the leadership in the preparation of this plan and also in the implementation of other health programmes. The medical personnel and staff of DH/PHCs/APHCs/HSCs gave vital inputs which were incorporated into this document.

I am sure the DHAP and its subsequent implementation would inspire and give new momentum to the health services in the District of Madhepura.

Dr. Birendra Pd. Yada
District Magistrate-cum-Chairman,
DHS, Madhepura

About the Profile

Even in the 21st century providing health services in villages, especially poor women and children in rural areas, is the bigger challenge. After formation of National Rural Health Mission, we are doing well in this direction. Launching Muskan- Ek Abhiyan we are try to achieve 100% immunization and Anti Natal Care. Janani Evam Bal Suraksha Yojana is another successful program that is ensuring safe institutional delivery of even poor and illiterate rural women. Like wise several other programs like RNTCP, Pulse Polio, Blindness control and Leprosy eradication are running and reaching up to last man of society. But satisfaction prevents progress. Still, we have to work a lot to touch miles stones. In this regard sometime, I personally felt that planning of any national plan made at center lacks local requirements and needs. That is why, despite of hard work, we do not obtain the optimum results. The decision of preparing District Health Action Plan at District Health Society level is good. Under the National Rural Health Mission the District Health Action Plan of Madhepura district has been prepared. From this, the situational analysis the study proceeds to make recommendations towards a policy on workforce management, with emphasis on organizational, motivational and capability building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps identified and addressed. It looks at how the facilities at different levels can be structured and reorganized.

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

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

Dr. Parshuram Prasad.
Civil Surgeon-cum-Member
Secretary, DHS, Madhepura

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Dr. J.P. Mandal
ACMO-cum-Nodal Officer
DHAP, DHS, Madhepura

STRUCTURE OF DISTRICT PLAN

PART 1:

Chapter I:

1. **Introduction, methodology and profile of the district**
    - 1.1. Introduction
    - 1.2. Planning Objectives
    - 1.3. Approach to District Planning
2. District Planning Process
    - 2.1. District Level Consultation Workshop
    - 2.2. Tools and techniques
    - 2.3. Collection of basic data for planning
3. Data analysis and plan preparation
4. Historical perspective
5. District profile
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    - 5.2. Demography and Development Indicators
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    - 5.4. Rainfall
    - 5.5. Air temperature and humidity
    - 5.6. Land and soil
    - 5.7. River system
    - 5.8. Language and culture

Chapter – I

1.1 Introduction:-

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

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

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

It is our pleasure to present the Madhepura District Health Action Plan for the year 2010-11. The District Health Action Plan seeks to set goals and objective for the district health system and delineate implementing processes in the present context of gaps and opportunities for the Madhepura district health team.

National Rural Health Mission was introduced to undertake architectural corrections I n the public Health System of India. District health action plan is an integral aspect of National Rural Health Mission. District Health Action Plans are critical for achieving decentralisation, interdepartmental convergence, Capacity building of health system and most importantly facilitating people s participation in the health system s programmes. District health Action planning provides opportunity and space to creatively design and utilise various NRHM initiatives such as flexi financing, Rogi Kalyan Samiti, Village Health and Sanitation Committee to achieve our goals in the socio-cultural context of Madhepura.

I am very glad to share that all the BHMs and MOIC of the district along with key district level functionaries participated in the planning process. The plan is a result of collective knowledge and insights of each of the district health system functionary. We are sure that the plan will set a definite direction and give us an impetus to embark on our mission.

1.2 Planning Objectives:-

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

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

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

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

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

Stakeholders in Process

- Members of State and District Health Missions
- District and Block level programme managers, Medical Officers.
- District Programme Management Unit and Block Program Management Unit Staff
- Members of NGOs and civil society groups (in case these groups are involved in the DHAP formulation)

1.3 Approach to District Planning:-

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

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

2. District Planning Process

2.1. District level Consultation Workshop:-

Planning process started with the orientation of the District level Consultation of different programme officers , MOICs , Block Health Manager, Hospital Managers and our health workers. Different group meetings were organized and at the same time issues were discussed and suggestions were taken. Simple methodology adopted for the planning process was to interact informally with the government officials, health workers, medical officers, community, PRIs and other key stake holders.

2.2. Tools and Techniques:-

Main tools used for the data collection were:

- Informal In-depth interview
- Group presentation with different district level officials
- Informal group discussions with different level of workers and community representative
- Review of secondary data

2.3. Collection of basic data for planning:-

Primary Data :- All the Medical Officers were interacted and their concern was taken in to consideration. Daily work process was observed properly and inputs were taken in account. District officials including CMO, ACMO , DIO, DMO, DLO , RCHO and others were interviewed and their ideas were kept for planning process.

Secondary Data :- **Following books, modules and reports were taken in account for this Planning Process:-**

- RCH-II Project Implementation Plan
- NRHM operational guideline
- DLHS Report
- Report Given by DTC
- Report taken from different programme societies e.g. Blindness control, District Leprosy Society, District TB Center , District Malaria Office
- Census-2001
- National Habitation Survey-2003
- Bihar State official website
- District Planning office
- District Madhepura Official website

3. Data analysis and plan preparation :-

Data Analysis:

Primary Data:-

Data analysis was done manually . All the interviews were recorded and there points were noted down. After that common points were selected out of that.

Secondary Data:

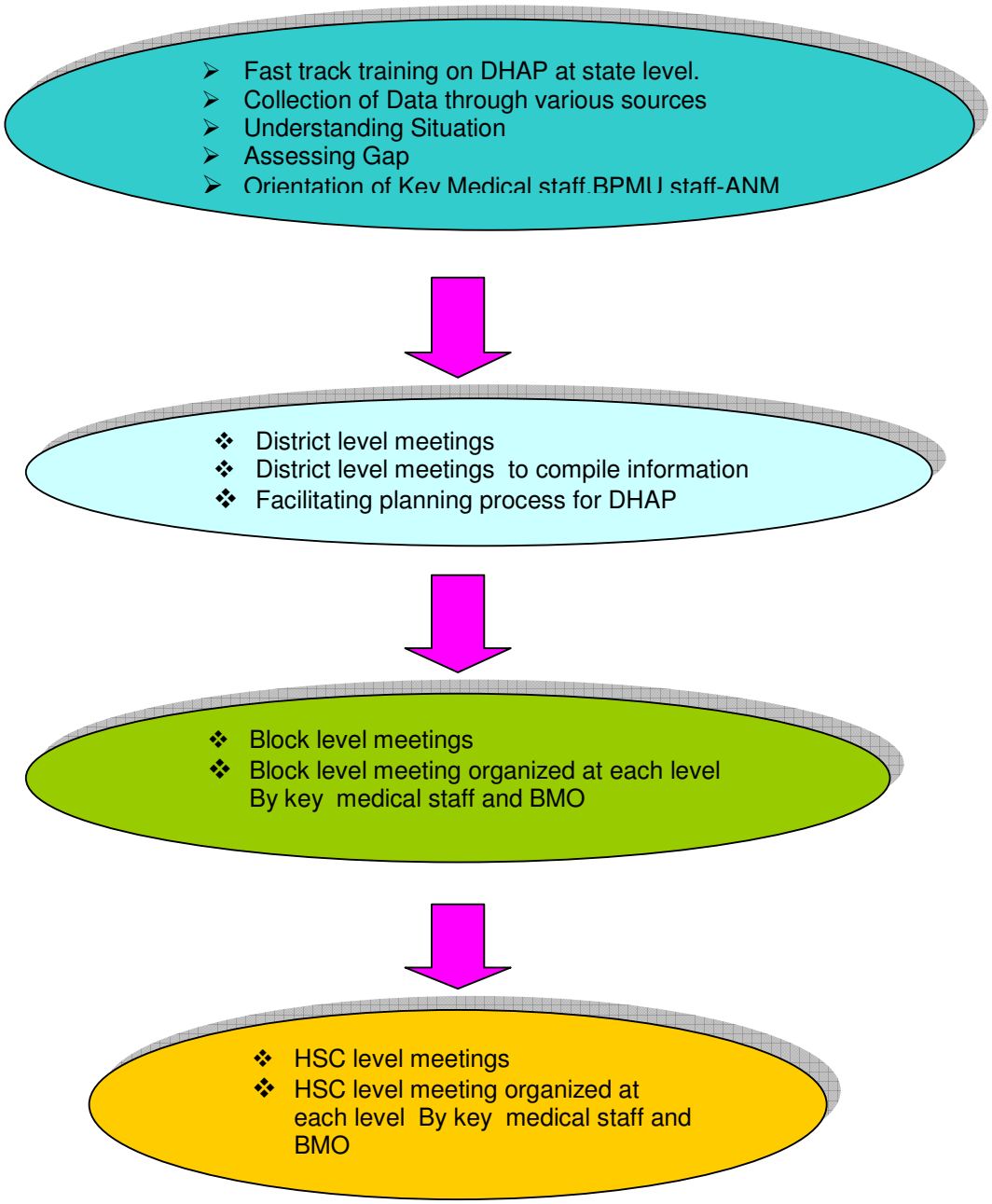
All the manuals books and reports were converted in to analysis tables and these tables are given in to introduction and background part of this plan.

Plan preparation :-

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

After a thorough situational analysis of district health scenario this document has been prepared. In the plan, it is addressing health care needs of rural poor

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



4. Historical P

erspective:-

Singheshwar sthan is also a famous pilgrimage of lord Mahadeo in the country. It is situated of the distance of 8 km from Madhepura Distt. H.Q. and is renowned for its historical and religious importance. “Maa” Bhawani is called as singheshwar and lord shiva as singheshwar here Devotes not only from Bihar but also from other parts of the country including the neighboring country Nepal come to singheshwar sthan for the worship of lord Shsiva. Some days of the week such as Sunday, Monday & Wednesday are much important for the devotees. Mahashivratri mela of singheshwar sthan is famous in Bihar and trai area of Nepal also.

There are a lot of interpolations or myths regarding the emergence of this religious place which was once upon a time the tapobhoomi of the great sringi Rishi. This place has been famous silence the emergence of idol worship in the pauranic period. Pandit Jharkhandi Jha in “Bhagalpur Darpan” has glorified the religious aspect of this place.

Reference of Singheshwar sthan has been found in Barah puran too. According to that puran once this place was infested with deep forests. Cattle roamers used to come regularly at that place with their cattle. During the course of grazing one virgin cow used to sprinkle milk from her breast on a particular place. The cattle roamers saw the & charismatic action of that cow one day a began to dash that place. After digging he got a shivlilya there if being filed up with religious feeling began to worship. Gradually people become a ware of this happening and in course of time a small temple was constructed these with the contribution of the dew tees of here Shiva.

Another reference of Barah puran is also quoted here. Once herd Vishnu, Brahma and Indra visited kailashpuri with a view to discuss some important aspect of world affairs, but unfortunately Lord Shiva was not there. They searched a lot but ultimately returned hopelessly. During the course of return journey the intuitional telepathy indicated them that Lord Shiva in the guise of a deer is residing in a lonely place of the deep forest. The omniscient Lord identified the unique dear adorned with unparalleled beater in the guise of lord Shiva and captured him after continuous attempt. The Tridevas hold the horn (sing) of the deer in three parts. Lord Indra holds the upper portion, Lord Brahma the middle and Lord is Vishnu the lower portion of that horn. But suddenly that horn broke in to three parts. Tridevas got one- one part of that horn and Lord Shiva disappeared. Then a forecast was heard that Lord Shiva will not be visible at present. Consequently Tridevas were bound to be satisfied with that very part of the horn. It is said that Lord Indra established that horn in the heaven, Lord Brahma in the same place and Lord Vishnu established that horn in Singheshwar for the welfare of the human being. Owing to that event Lord Shiva is worshipped through Vaishnav Cult here. The author of “History of Baba Mahathya of Singheshwar hat” has explained the historical and religious aspect of Shiva Temple at Singheshwar asthan.

It is also said that during the Ramayana period a purashthee Yagya was done by Raja Dashratha were as he blessed with four sons’ from the Prasad “Charu” of that mahayagya. The great Sringhi Rishi primarily worshipped Lord Shiva on the occasion of that Yagya. Seven “Havana Kunds” created of that time has been converted into a ravaged tank now. During the course of time the residential place of Sringi Rishi became famous as Singheshwar. Which later on popularly called as Singheshwar?

Another mythical story behind this place is that Goddess Maha Kali, Maha Laxmi & Maha Sarswati are assimilated into the form Goddess Durga and she being lion rider is called Singheshwari. Her counterpart Lord Brahma. Vishnu & Mahakal Sankar are assimilated into the form of eternal god is called Singheshwar. Three part of the Shivling is the expression of Trimurti. It is said that pundit Mohan Mishra was residing was and a scholarly debate on religion was held between Madan Mishra and Adi Sankaryacharya. After that debate Pt. Mandal Mishra adopted the cult sanatan. Lord Buddha’s’ statue of Awalokishwar on the southern wall of the eastern-sided temple shows the acceptance of Lord Shiva’s eternal Omnipresence.

Presently the temple’s property has been declared as the public property and its management is being locked after by a Trust committee. D.M Madhepura is the Ex. Office Chairman and SDM Madhepura is the Ex. Office Secretary of that trust Committee.

Nayanagar Durga Sthan situated at the distance of 11 K.M from Gwalpara Block HQ and at the distance of 35 KM form Madhepura Distt. HQ is not only famous for Manokamna Siddhi in Mahdepura but also in its adjacent areas. The devotees pay their floral and Bipatra offering to Goddess Durga for the fulfillment of their Manokamna. It is usually said that whose offering is accepted by Goddess his manokamna is fulfilled. The so called Bairagana Mela is held on every Monday, Wednesday & Friday and the devotees come to worship and pay their offering to Goddess from distant places. Goddess Durga is sitting on flower 'Lotus' in peaceful gesture. Animal sacrifice is being offered to the Goddess Durga on the above said days. It would be seen form religious point of view that the status of Lord Chowmukh Mahadeo. Eleven Ubhay lingas and Sun God are also available in this pious place. Where as from archaeological point of view there are only some damaged idol and stone plates. It is said that during excavations a big stone platen was found. Though there is a legend of 100 years worship and foundation of this religious place. It is also said that Raja Radeo Singh was also a devotee of this place. This pious place is spread over the area of 22 acres of land and a big pond is existing before the main Temple in which the sacrificial animals are being bathed. It is also said that the people whose manokamna is fulfilled by the grace of Goddess they sacrificed the animals before the deity for her pleasure. Some sandal trees are also available there. It is said that such type of sandalwoods is found only in that holy place and that sandal is consumed in the worship of Goddess Durga. Sandalwood is not sold here for commercial purposes. The main Temple has been constructed with contribution cooperation of the common people and a committee has been formed to look after the management of the Temple. But the communication system especially relating to roads is very poor and hazardous for the devotees. Tourism Deptt. Of Govt. is not taking interest in the upliftment of this Temple. Perhaps in has not been taken over by the Govt. as yet. The people are willing the Govt. interest for this place so that it may get proper importance from religious and archeological point of view.

नयानगर भगवती प्रतिमा

5. District Profile:-

BRIEF HISTORY OF MADHEPURA DISTRICT

Madhepura was a part of Maurya Dynasty, this fact is asserted by the Mauryan pillar at Uda-kishunganj. The history of Madhepura is traced back to the reign of Kushan Dynasty of Ancient India. The "Bhant Community" living in Basantpur and Raibhir village under Shankarpur block are the descendents of the Kushan Dynasty. In the District Singheswar Sathan has the religious significance since ancient time as this land was the meditation place of the great Rishi ,Shringi. Hence this place is considered to be the most pious for the Hindus.

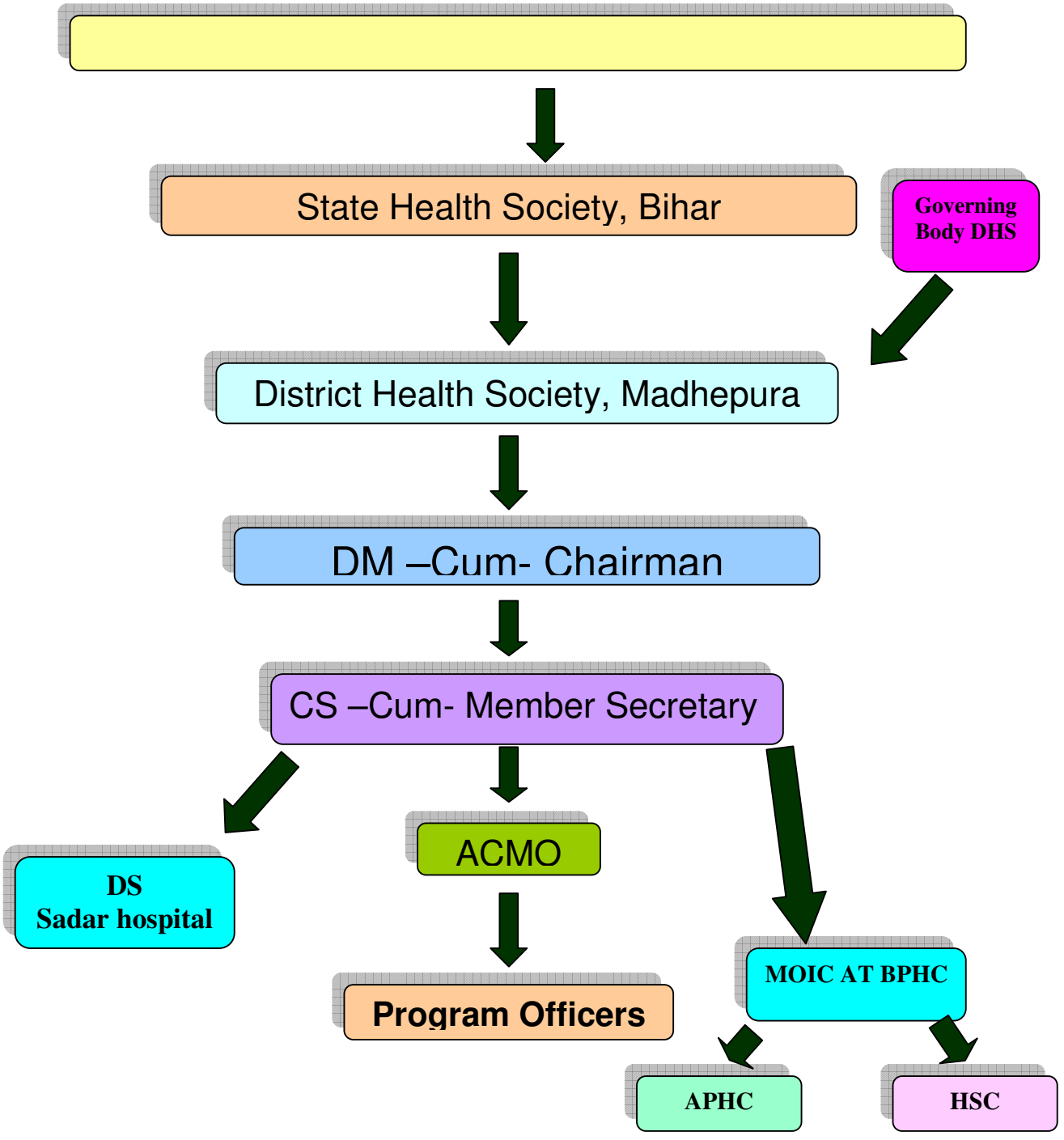
Sikandar Sah had also visited the district, which is evident from the coins discovered from Sahugarh Village. Madhepura district now consists of 2 Subdivisions : 1. Madhepura and 2. Udakishunganj. The district consists of 13 development blocks and anchals each.

The present Madhepura district had already got the status of subdivision on 09/05/1845 in which there were seven blocks. Saharsa district today was then the revenue circle of Madhepura at that time. When Saharsa became a district on 01/04/1954, Madhepura became its subdivision. Madhepura subdivision which had seven blocks at that time, was given the status of a district on 09/05/1981. On 21/05/83 Uda-kishunganj Block was upgraded and made a subdivision of Madhepura district in the name of Uda-kishunganj. Besides seven old blocks, four new blocks came in to existence in the year 1994. There were Gwalpara, Puraini, Bihariganj and Shankarpur. First three blocks come under uda-kishunganj subdivision and last one is under Madhepura subdivision. Later on two more new blocks were constituted in the name of Ghailar and Gamaharia, under Madhepura subdivision in 1999.

5.1 Administrative Setup:-

There are two sub divisions and 13 Blocks in the District. The District has 487 revenue villages and 170 Gram panchayats. A few of the newly created Blocks are still in the formation process. The newly elected Panchayati Raj is enthusiastic to play important role in the District.

District Health Administrative Setup



5.2 Demography and Development Indicators:-

The district occupies an area of 1787 km². Madhepura district is surrounded by Araria and Supaul district in the north, Madhepura and Bhagalpur district in the south, Purnia district in the east and Saharsa district in the West. It is situated in the Plains of River Koshi and located in the Northeastern part of Bihar at longitude between 25°. 34 to 26°.07' and latitude between 86° .19' to 87°.07'.

As per 2001 India census the current population of Madhepura district is 15, 24,596 and right now the population of Madhepura District in Nov. 2009 is 19,27,909 which constitute 3.01% population of the state. The annual exponential growth rate of the district as per 2001 census is 26.45%, which is higher then that of the state average 2.5%. About 4.45% of the total population lives in urban area in contrast to 11% of the state. The sex ratio of the district is 919 females per 1000 males. Males constitute 54% of the population and females 46%. Madhepura has an average literacy rate of 50.7%, lower than the national average of 64.4%: male literacy is 61%(national average:75.6%), and female literacy is 37.5%(national verage:54.2%).

HQ	**Madhepura**					
Area	**1788 km2**					
Population	**Total**	**19,27,909**	**Rural**	**18,31,513**	**Urban**	**96395**
SC Population	**Total**	**347023**	**Rural**	**288029**	**Urban**	**58994**
ST Population	**Total**	**11760**	**Rural**	**11490**	**Urban**	**270**
Sub Divisions	**Madhepura, Udakishunganj**					
Blocks	**Madhepura, Singheshwar, Gamharia, Ghailar, Shankarpur, Gwalpara, Udakishunganj, Bihariganj, Chausa, Alamnagar, Puraini, Murliganj, Kumarkhand.**					
Agriculture	**Paddy, Wheat, Maize, Jute, Oil Seeds (Sunflower, Mustard)**					
Main Horticulture	**Mango, Banana, Guava, Coconut, Litchi.**					
Industry	**Jute Factory**					
Rivers	**Koshi**					

Population & other information Block wise

Name of BLOCKS	TOTAL POPULATION	MALE POPULATION	FEMALE POPULATION	PANCAYAT	VILLAGE
Madhepura	194620	102939	91681	17	49
Singheshwar	102086	53191	48895	13	27
Gamharia	65125	33669	31456	8	12
Ghailar	73129	38300	34829	9	19
Shankarpur	82519	42767	39752	9	9
Gwalpara	95295	49257	46038	12	51
Udakishunganj	136937	71042	65895	16	44
Bihariganj	101655	52579	49076	12	22
Chausa	116471	61683	54788	13	43
Alamnagar	129226	67707	61519	14	29
Puraini	77792	40562	37230	9	31
Murliganj	164148	86126	78022	17	45
Kumarkhand	187643	97358	90285	21	71

5.3 Climate and Agro Ecological Situation:-

Irrigation facilities to 77414 hectare of land are available in the district. The total number of state boring in the district is 3018 where as, 914 borings are owned and operated by the different people of this district. The total number of state tube wells in the district is only 31.

5.4 Rainfall:-

The average rail fall in this district is 1300mm

5.5 Air temperature and humidity:-

Madhepura district is situated between 25 31 and 26 20 latitude and in the middle of 86 36 to 87 07 longitudes. The maximum temperature of this district ranges from 35 to 40 degree Celsius and the minimum temperature varies from 7 to 9 degree Celsius.

5.6 Land and soil:-

The total areas of land for cultivation is 1,36,646 Hectare. Besides these, There is 1772 hectare of famished land which can be used for cultivation. 1272 hectare of barren land is covered with sand and rest areas of barren land is 3644 hectare. Procurement areas of paddy crop is 52165 hence, wheat is grown in 31431 hectare of land, maize in 34098 hectare of land, sugarcane is 801 hectare of land and potato is grown in 1442 hectare of land. Coconut Development Board, owned by Central Government, is situated in this district.

6.7 River system:-

Madhepura District is one of the 38 administrative districts of Bihar and it has its headquarters located at Madhepura town. This district of Bihar occupies an area of 1787 sq kms

5.8 Language & Culture:-

The lingua franca is Maithili, a version of Hindi and Angika. Over the years it is in practice but due to emphasis on exclusive Hindi education, hindi language is also spoken in the district. The usage of English as form of verbal communication is looked down, very few like to communicate in English. Maithili itself has a chequered history and has been a victim of frequent political wranglings. However, it has been included in the 8th schedule of Indian Constitution in 2004, which lists India's major languages. Madhepura is the district of unity in diversity as India is. Almost all the main festivals are celebrated here irrespective of the religion & cast in a very – very cordial environment. So far attire is concern male generally like to wear Pant – Shirt or Dhoti – Kurta & female generally like to wear Salwar- kurti or Saree. Here people love eat fish-curry & rice

Transport & Communication Facility

Madhepura is connected by rail and road to other major towns in Bihar. National Highway NH – 107 connects it to Saharsha and Purnia. It does not have any air or river connectivity. The train connectivity to the city has the dubious distinction of being the victim of one of the worst train disasters in India (Bihar train Disaster). Earlier there was only a metre gauge line, but in early 2010, a much awaited broad gauge line connected it to Saharsa on the New Delhi Guwahati main line. The city is serviced by the Indian Post. Its Postal Code is: 852113. Landline telephone services have been augmented by cellular services, the quality deteriorating as one move away from the city centre. Now A lot of cyber cafe running with broad band connection.

Chapter II: SWOT analysis of Part A,B,C,D

SWOT Analysis of the District

STRENGTHS – WEAKNESSES – OPPORTUNITIES – THREATS :

1. STRENGTHS :-

- **Involvement of C.S cum CMO : -** C.S cum CMO take interest, guide in every activity of Health programme and get personally involved.
- **Support from District Administration:-** District Magistrate and Deputy Development Commissioner take interest in all health programmes and actively participate in activities. They provide administrative support as and when needed. They make involvement of other sectors in health by virtue of their administrative control.
- **Support from PRI(Panchayati Raj Institute) Members :-** Elected PRI members of District and Blocks are very co-operative. They take interest in every health programmes and support as and when required. There is an excellent support from Chairman of Zila Parishad They actively participate in all health activities and monitor ,it during their tour programme in field
- **Well established DPMU and BPMU :-** Since two year, all the posts of DPMU & BPMU are filled up. Facility for office and automation is very good. All the members of DPMU & BPMU work harmoniously and are hardworking.
- **Effective Communication: -** Communication is easy with the help of internet facility at block level and land line & Mobile phone facility which is incorporated in most of PHCs of the district.
- **Facility of vehicles: -** Under the Muskan Ek Abhiyan programme every Block have the vehicles for monitoring .
- **Support from media: -** Local newspapers and channel are very co-operative for passing messages as and when required. They also personally take interest to project good and worse things which is very helpful for administration to take corrective.

2. WEAKNESS:-

- Lack of Consideration in urban area: - Urban area has got very poor health infrastructure to provide health services due to lack of manpower. Even Urban Slum are not covered under Urban Health scheme (Urban Health Scheme is not implemented by the GOB for Madhepura district) which cover urban Population.
- Non availability of specialists at Block level: - As per IPHS norms, there are vacancies of specialists in most of the PHCs . Many a times only Medical Officer is posted, they are busy with routine OPD and medico legal work only, so PHC do not fulfill the criteria of ideal referral centers and that cause force people to avail costly private services.
- Non availability of ANMs at PHCs to HSCs level - As per IPHS norms, there are vacancies of ANMs in most of the HSCs . Out of 153 Sanctioned post of contractual ANMs only 49 ANMs are Selected so HSCs do not fulfill the criteria of ideal Health Sub Centre and that cause force people to travel up to PHCs to avail basic health services.
- Non availability of Staff Nures at APHCs level - As per IPHS norms, there are vacancies of Staff Nurses in most of the APHCs . Out of 58 Sanctioned post of contractual Staff nurses only 23 Staff Nurses are Selected so APHCs do not fulfill the criteria of ideal Additional Primary Health Centre and that cause force people to travel up to PHCs to avail basic health services.
- Apathy to work for grass root level workers: - Since long time due to lack of monitoring at various level grass root level workers are totally reluctant for work. Even after repeated training desired result has not been achieved. Most of the MO, Paramedical & other Health workers do not stay HQ. Medical Officers, who are supposed to monitor the daily activity of workers do not take any interest to do so. For that reason workers also do not deliver their duties regularly and qualitatively. Due to lack of monitoring & supervision some aim, object & program is suffering alot.
- Lack of proper transport facility and motarable roads in rural area :- There are lack of means of transport and motarable roads in rural areas. Rural roads are ruled by ‘Jogad’, a hybrid mix of Motor cycle and rickshaw, which is often inconvenient mean of transport. The fact that it is difficult to find any vehicle apart from peak hours is still the case in numerous villages.
- Illiteracy and taboos:-The literacy rate in rural area has still not reached considerable mark. Especially certain communities have constant trend of high illiteracy. This causes prevalence of various taboos that keep few communities from availing benefits of health services like immunization or ANC, institutional delivery…etc.

3. OPPORTUNITIES:-

- Health indicator in Madhepura district is not satisfactory . Services like Institutional delivery, Complete Immunization , Family Planning, Complete ANC, School Health activity , Kala-azar eradication may required to be improved. So there are opportunities to take the indicator to commendable rate of above 75+% by deploying more efforts and will.
- Introduction of PPP Scheme: Through introduction of PPP Scheme we can overcome shortfall of specialist at Block level.
- Involvement of PRIs: - PRI members at district, Block and village level are very co-operative to support the programmes. Active involvement of PRI members can help much for acceptance of health care deliveries and generation of demand in community.
- improvement of infrastructure: -. With copious funds available under NRHM, there is good opportunity to make each health facility neat and clean, Well Equipped and Well Nurtured.

4. THREATS:-

- Flow of information if not properly channeled to the grass root stakeholder
- Natural calamities like every year flood adversely affected the progress of Health Programme.

Chapter – III

1.1 RCH Flexible Pool (NRHM-A):-

Vision Statement

The 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 stabilization, 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 Healthcare.

Technical Objectives, Strategies and Activities-

Maternal Health

Goals: Reduce MMR from present level 371 (SRS 2001-03) to less than 100

Objectives:

- To increase 3 ANC coverage from 26.4% to 75% by 2010-11.
- To increase the consumption of IFA tablets for 90 days from present level of 9.7% t to 35% by 2010-11.
- To reduce anemia among pregnant mothers from 60.2% to 40% by 2010-11.
- To increase institutional delivery from 70% to 85% by 2010-11
- To increase birth assisted by trained health personnel from 31.9% to 45%.
- To increase the coverage of Post Natal Care from 26% to 55% by 2010-11
- 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 75% by 2010-11.

Strategies and Activities:

- Institutionalization of Village Health and Nutrition Days (VHND)
- In collaboration with ICDS, such that the Take Home Ration (THR) distribution and ANC Happens on the same day
- This will require minor changes in the micro plans of Health and ICDS
- Policy decision and appropriate guideline under convergence between Health and ICDS need to happen as a priority Improved Access of ANC Care
- Provision for Additional ANMs in each Sub Centres (Refresher Training to ANMs on Full ANC to improve the quality of ANC)
- Setting up of New Sub Centres to cover more areas
- 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 themfor providing Community and Home based ANC to them.
- Organizing Monthly Village Health and Nutrition Days in each Aaganwadi Centres
- Organizing RCH camp in Each Block PHC areas.
- Tracking of Pregnant mothers by ASHAs
- Ensure quality service and Monitoring of ANC Care
- Strengthen the monitoring system by checking of ANMs duty rooster and visits of LHVs and MOs.
- Involvement of PRIs in monitoring the ANMs service through convergence
- Refresher training of ANMs on ANC care
- Proper maintenance of ANC Register and Eligible couple register
- Strengthening of Health Sub Centre
- Repair and Renovation of Sub Centers
- Provide equipments like BP Apparatus, Weighing machines, Heamoglobinometer etc to the Sub Centers.
- Timely supply of Drug Kit A and Kit B

- Generate Awareness for ANC Service
- Convergences meeting with AWWs, ASHAs, PRI Members, NGOs at the Gram Panchayat level by ANMs. These meetings will also attended by MOs from All PHCs.
- 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.
- 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 35% by 2010-11.

Strategies and Activities:

- Purchase and Supply of IFA Tablets
- To include IFA under essential drug list
- Timely supply of IFA Tablets to the Health Institutions (Ensuring no stock out of IFA at every Level down to Sub-Centre Level)
- District to purchase IFA tablets in the case of stock out
- 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
- Awareness generation for consumption of IFA Tablets.
- Pregnant mothers will be made aware for consumption of IFA tablets for 90 days
- ASHA and AWWs will generate awareness along with ANMs at the Village level
- Ensure utilizing the platform of Mahila Mandal meetings being held every third Wednesday

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

- Supplementing IFA tablets consumption with other clinical strategies.
- Half yearly de-worming of all adolescent girls.
- Training of ANM, AWW and ASHA on module on EDPT (Early Diagnosis and Prompt Treatment) of anemia.
- Supplementing IFA tablets consumption with AWWcs to non going school girl.
- Activities for consumption of IFA tablets as per Objective No. 2
- Refer severely Anemic Pregnant Mothers to referral centers
- IPC based IEC campaigns emphasizing on consumption of locally available iron rich food stuff. Details given under Special Scheme on Anemia Control in Part B

Objective No. 4: To increase institutional delivery from 70% to 85% by 2010-11

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.
- Upgrading Block PHCs/CHCs in to FRUs
- Provision of OT and lab facility by upgrading 76 FRUs
- Blood Bank and or Provision of Blood storage, OT and lab facility by upgrading 76 FRUs
- 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
- All CHC / PHCs have blood storage facility
- Training of MOs on Obs & Gynae and Anesthesia
- 18-week Life Saving Anesthetic Skills (LSAS) training for MBBS Doctors
- 16 week -Emergency Obstetric Skill training for MBBS doctors
- Repair and renovations of FRUs
- Appointment of Anesthetist, O&G specialist, Staff Nurses at the FRUs Incentivise the conduct of C section at FRUs @ Rs 1500 per C section for the staff involved at the FRUs.
- Accreditation of FRUs
- Operationalization of 24x7 facilities at the PHC level
- Training of MOs and Staff Nurses of PHCs in BEmOC
- Appointment of at least 3 Staff Nurse in each PHCs
- Repair and renovation of PHCs
- Availability of and timely supply of medical supplies and DDK & SBA kits
- Training of MOs, Staff Nurses on SBA
- Increase beneficiary choice for institutional delivery through IEC campaign complimented by network of link workers working on incentive basis for each institutional delivery achieved.
- Strengthening JBSY Scheme
- Improving quality: Infrastructural support to high burden facilities to avoid ‘early
- discharge’ following institutional deliveries
- Mapping of high burden facilities and proving them support for matching infrastructural up gradation to increase the hospital stay following delivery
- 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
- Design and implement an IEC campaign focusing on communicating the benefits of institutional delivery and benefits under JBSY scheme.
- Equip the ASHA network to reinforce the IEC messages through IPC interventions at village /community level.
- Provide incentives to ASHA for every institutional delivery achieved in her village / designated area.

- Involvement of PRIs for JBSY scheme to monitor and generate awareness for institutional delivery.
- Provision of Referral Support system
- Provision of a dedicated referral transport system for the newborns and pregnant women to refer them from home/HSCs/PHCs to referral centers.
- Monitoring of referral transport system
- Development of proper referral system between Health Institutions.
- 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 bloodstorage units has been proposed. Operationalising of at least one Blood Storage Units in 76 FRUs is proposed as per IPHS guidelines.

Objective No.5: To increase birth assisted by trained health personnel from 31.9% to 45%.

Strategies and Activities:

- Ensure safe delivery at Home
- Provision of Disposable delivery kits with ANMs and LHVs - Establishing full proof Supply Chain of the DD Kits
- Training of ANMs on SBA
- Providing SBA with approved drug kits, in order to deal with emergencies, like post partumhemorrhage, eclempsia, and puerperal sepsis
- Ensuring regular supply of these drugs to the SBA
- Supply of adequate DD Kits to ANMs, LHVs.
- Provision of delivery at HSC level
- Supply of DDkits to HSCs
- Delivery tables to be provided to the HSCs

Objective No.6: To increase the coverage of Post Natal Care from 26% to 55% by 2010-11.

Strategies and Activities:

- Ensuring proper practice of PNC services and follows ups at the health facility level.
- 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.
- 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.
- Referral of all complicated PNC cases to FRU level.
- LHV and MO to monitor and report on PNC coverage during their field visits
- 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.
- Utilize ASHA to ensure 3 PNC visits by the ANM for home delivery cases (1st within 2 days, 2nd within 4 days and 3rd within 42 days of delivery) and 2 follow up visits for institutional delivery cases.

- Counseling of all pregnant women on ANC and PNC during monthly meetings of MSS and during VHND.
- Linking of ASHA's incentives on institutional deliveries to completion of the PNC follow-ups.
- Basis Orientation of AWWs on identifying Post-partum and neonatal danger signs during her scheduled visits following delivery
- Basic orientation on IMNCI – in order to be able to alert the beneficiary and coordinate with ASHA and ANM (to avoid undue delay)
- 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
- Ensuring early detection through regular screenings and contact surveillance strategies.
- Early diagnosis of RTI / STI through early detection of potential cases through syndromic approach and referral by ANM and ASHA.
- Conducting VDRL test for all pregnant women as a part of ANC services.
- Implementing contact surveillance of at risk groups in convergence with Bihar AIDS Control Society.
- Strengthening the infrastructure, service delivery mechanism and capacity of field level staff for handling of RTI / STI cases.
- Conducting community level RTI / STI clinics at PHCs
- Training to all MOs at PHC / DH level in Management of RTI / STI cases in coordination with Bihar AIDS control Society.
- Training of front line staff, LHV, ANM and ASHA in identifying suspected cases of RTI / STI in coordination with Bihar AIDS Control Society.
- Strengthening RTI / STI clinic of the District Hospitals

Objective No. 8 –Reduce incidence of unsafe abortion

Strategies and activities:

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

Child Health

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

Goal: Reduce IMR from 61 (SRS 2005) to less than 30

Objectives :

- To reduce low birth weight baby's by supplementing nutritional support to pregnant mothers
- To increase exclusive breast feeding from 38.4% to 75% by 2010-11.
- To reduce incidence of underweight children (up to 3 years age) from 58.4% to 40% by 2010-11.
- To strengthen neonatal care services in all PHCs/CHCs/SDHs by setting newborn care centers & having trained manpower therein.
- To reduce the prevalence of anemia among children from 87.6% to 60% by 2009-10.
- To increase full immunization of Children from 41.4%% to 70% by 2010-11.
- 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:

- Convergence with ICDS, supplementary diet which is being given by AWW to pregnant mothers may beimproved.
- 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 under weight pregnant BPL mothers. The Scheme will be implemented in convergence with ICDS.
- Joint Monitoring by Block MO i/cs with CDPO for implementation of the scheme.

Objective No. 2: To increase exclusive breast feeding from 27.9% to 50% by 2010-11

Strategies and Activities:

- Use mass media (particularly radio) to promote breastfeeding immediately after birth (colostrums feeding)and exclusively till 6 months of age.
- Production and broadcast of radio spots, jingles, folk songs and plays promoting importance of correct breast feeding practices
- Production and broadcast of TV advertisements and plays on correct breast feeding practices MME IMPLEMENTATION PLAN- 2008-09
- Publication of newspaper advertisements, booklets and stories on correct breast feeding practices
- Increase community awareness about correct breastfeeding practices through traditional media
- 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.
- Educate adolescent girls about correct breastfeeding and complementary feeding practices through school -based awareness campaign.
- To reduce incidence of underweight children (up to 3 years age)

Strategies and Activities:

- Growth monitoring of each child
- Supply of spring type weighing machine and growth recording charts to all ASHAs, AWWs. All ASHAs, Aaganwadi centers and sub centers will have a weighting machine and enough supply of growth recording charts for monitoring the weight of all children through Untied fund of HSCs.
- Weighting 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.
- Referral for supplementary nutrition and medical care
- Training for indications of growth faltering and SOPs for referral to AWWC for nutrition supplementation and to PHC for medical care.

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:

- Strengthen institutional facilities for provision of new born care
- It is planned to develop a model for comprehensive care of the newborn at all levels, from state to the community level. PLAN- 2008-09 .To reduce the prevalence of Aneamia among children Strategies and Activities Details in special programme for “Controlling Iron Deficiency Anemia in Bihar” under Part B NRHM Additionalities.
- To increase full immunization of Children from 32.8% to 60% by 2010-11.

Strategies and Activities:

- Details in special programme for “Strenthening of Routine Immunisation ” under NRHM Part C To reduce morbidity and mortality among infants due to Diarrhea and ARI.

Strategies and Activities:

- Increase acceptance of ORS
- 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.
- 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.
- 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. A detail Action Plan for ORS submitted under Part B of NRHM Additionalities
- Strengthening of referral services for infants seeking care for life threatening diarrhoea and ARI.
- 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.

OBJECTIVE :

- Regular annual health check-up of Children registered in government primary and middle school.
- To detect any defect in progress of health and nutritional deficiencies.
- Early detection of serious illnesses and to refer them in the nearest specialized government health facilities.
- To develop good habit for better health and hygiene to remain healthy.
- To inculcate through the children habit to remain healthy among Family members and community.
- To improve quality of food supplied to children by adding micronutrients. Additionally Counseling sessions will be organized in Govt. Schools in collaboration with BSACS. Storylines and slogans will be published in text books of schools in collaboration with the Education 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.

Family Planning Population Stabilization

RCH emphasizes on the target-free promotion of contraceptive use among eligible couples, the provision to couples a choice of various contraceptive methods (including condoms, oral pills, IUDs and male and female sterilization), and the assurance of high quality care. It also encourages the spacing of births with at least three years between births. Despite RCH and previous programmes vigorously pursuing family planning objectives, fertility in Bihar continues to decline at much lower rates than the national average. Although the total fertility rate has declined by about half a child in the six-year period between NFHS-1 and NFHS-2, it has increased in NFHS-3 and is far from the replacement level. Furthermore, certain groups such as rural, illiterate, poor, and Muslim women within the population have even higher fertility than the average The persistently high fertility levels point to the inherent weakness of the state's family planning programme as well as existing socio demographic issues. High TFR is reflected by a dismal picture of women in Bihar marrying early, having their first child soon after marriage, and having two or three more children in close succession by the time they reach their late-20s. At that point, about one-third of women get sterilized. Very few women use modern spacing methods that could help them delay their first births and increase intervals between pregnancies. The major issues affecting the implementation of the Family Planning programme in Bihar are as follows. Lack of integration of the Family Planning programmes with other RCH components, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels. Failure of the programme to effectively under take measures to increase median age at marriage and first child birth. 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. Use rates for the pill, IUD, and condoms remain very low, each at 1 percent or less). Due to high prevalence of RTI/STD, IUDs are not being used by majority of women. Continued use of mass media to promote family planning practices despite evidently low exposure to mass media in Bihar, leading to lower exposure of family planning messages in the community, particularly among rural and socio-economically disadvantaged groups. Weak public-private partnerships, social marketing to promote and deliver family planning services.(Public Private Partnership is improved since 2008-09. 6 Nursing homes in districts are accredited to conduct Family planning operations . The issues mentioned above are closely interlinked with the existing socio demographic conditions of the women, specially rural, poor and illiterate. Comprehensive targeted family planning programme as well as intersectoral co-ordination on an overall female empowerment drive is needed to address the factors responsible for persistently high fertility levels in Bihar. The district has quality assurance committee for family planning. District Health Society Madhepura accredited 6 by the help of District Quality Assurance Committees for conducting sterilization in 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 district with ICICI Lombard. District Health Society Madhepura made provision of fixed day family planning services at District hospitals, Sub divisional hospitals, FRUs, PHC and accredited private facilities.

Goal: Reduce TFR by 2.1 from present level of 4.3

Objectives:

- To reduce total unmet need for contraception from 23.1 % to 15%
- To increase Contraceptive Prevalence Rate (Any Modern Method) from 28.8% to 35% by 2008-09 and to 45% by 2009-10
- To increase male participation in family planning
- To increase proportion of male sterilizations from 0.6% to 1.5%.
- 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

- Plan to organize RCH camp in each PHC/CHC once in two months.
- Creating dedicated cadre of skilled manpower
- Training of MBBS doctors on Minilap and NSV
- Training of MBBS doctors on Anesthesia
- Training on IUCD: MOs, ANMs etc.
- One RCH camp will be organize in each PHC/CHC where Laparoscopic Ligation/Mini Lap will be done
- Incentive to acceptors Incentive for LL operations
- Training on LL operation, MTP and IUD Insertion
- 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.
- Motivate eligible couples who have had their first child for spacing for condoms, OCPs or IUDs
- 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.
- Availability of FP services: IUCDs, OCPs, Emergency Pills, Condoms
- 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.

- 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
- Public Private Partnership (Social marketing): This can be taken up on an experimental basis in couple of districts, or a few blocks in these districts to pilot selling through entrusted community based institutions, volunteers, market mechanisms (like the popular pharmacist of the village, or grocery shop owner or the like) condoms and OCPs at normal or subsidized rates. This should be properly preceded by adequate awareness generation of the availability of these for price in the community itself and that the clients or the community members could buy these from specified vendors (volunteers etc.). The research has shown that the services, drugs, supplies etc. bought for fee are valued more by the user and they use them more.
- Organize monthly IUD Camps in PHCs/CHCs/SDHs IUD camps will be organize in each/CHC/SDH every month. ANM and ASHA will be informed the dates on which the camp will be held in the concern HIs.
- 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.
- Organize Contraceptive update seminars at the Block 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.
- 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.
- 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.
- 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.

Objective No.2: To increase Couple Protection Rate

Strategies and Activities:

- Awareness generation in community for small family norm
- 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.
- Meetings with MSS, CBOs Communication materials to be used for monthly MSS/CBO meetings will be prepared and distributed for use. These meetings will be scheduled during or preceding the month family planning camps are scheduled to beheld.
- Regularize supply of contraceptives in adequate amounts
- Indent and supply contraceptives for all depots and sub centre/ AWCs and social outlets: Each AWC and ASHA will have at least one month's requirement of condoms and OCPs. Sub centers will have adequate supplies of IUDs also.

Objctive No.3: To increase male participation in family planning Strategies and Activities .

- Promote the use of condoms
- 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.
- Regular supply of condoms and setting up depots which are socially accessible to all men .
- 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%.

- 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.)
- Village level meetings in which men who already underwent NSV share experiences to motivate men to undergo NSV
- Increase capacity for NSV services
- 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.

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

- 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.
- Streamline the contraceptive supply chain & Monitoring
- Identifications & Renovation of Warehouse – District/ PHC
- Budget allocation for transportation at every level
- Provision for report format printing and their availability at every level

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.
- To ensure the access to information on Adolescent Reproductive & Sexual Health (ARSH)
- Through services at District Hospitals, SDH, CHCs, PHCs & HSC level.
- To increase awareness levels on adolescent health issues

Objective No.2: To reduce incidences of teenage pregnancies from present 25% to 15% by 2010-11.

Strategies and Activities:

- Improve access to safe abortions
- 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
- Manpower (Training) & logistic support to private hospital doctors and will also be trained inconducting safe abortions.
- Ensure availability of condoms/OCPs/Emergency contraceptives
- Depot holders among adolescent groups/youth organizations In addition to the ASHA and the AWW, youth organizations such as football clubs and others will havedepot 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

- Organize regular adolescent clinics/counseling camps at SC/PHC/CHC/SDH/DH
- Appointment of 5 nos. Adolescent Counselor for districts setting up Adolescent clinics.
- Adolescent health sessions/clinics will be held in each Sub Centre/ PHC / CHC/SDH and DH with service delivery & referral support
- 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.
- ASHA/AWW to act as nodal persons at village level for identifying & referring adolescents in need of such services.
- 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.
- Referrals to de-addiction centers for treating alcoholism/drug addiction

- 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.
- 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

- Organizing Behavioral Change Communication campaigns on specific problems of adolescents
- 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.
- monthly health checkups under School Health Programme through PHC medical and paramedical staff 3.1.3 Orientation of VHSC on adolescent issues The MPWs will during their routine interactions with the VHSC members apprise them of theproblems 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)
- Premarital counseling of adolescent girls on reproductive health issues at PHC/RH/SDH/DHThis will be part of the adolescent health session/clinics which will be regularly conducted at sub centres,PHCs and also at youth clubs.
- Dissemination of ARSH Guidelines and Trainings
- Organize dissemination of ARSH guidelines at State level.
- Training of TOTs on ARSH
- Training of MOs, ANMs on ARSH

Proposed Strategies and Activities for Operationalization of ARSH

1. ARSH service delivery through the public health system:NRHM STATE

- 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.
- Fixed day, fixed time approach could be adopted to deliver dedicated services to adolescents and newly married couples.

- A separate ARSH Cell, comprising of ANM, LHV, Health Educators etc. can be established at these Cells.
- A separate ARSH Cell can be constituted at every CHCs and Referral Units, with one MO asits nodal officer (on call, sort of) and two counselors.

2. Interventions to operationalise ARSH

- 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 a dolescents, need for services, and how to make existing services adolescent friendly.
- Environment building activities: this should include orienting broad range of gate keepers, like district officials, panchayat members, women's group and civil society. Proper communication messages should be prepared for the same exercise. District, block and subblocklevel functionaries should be responsible for this.
- The MIS should at least capture information on teenage pregnancy, teenage institutional delivery and teenage prevention of STI.

Urban Health

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

Objectives:

1. Improve delivery of timely and quality RCH services in urban areas of Bihar
2. Increase awareness about Maternal, Child health and Family Planning services in urban areas of the state At present, there are 12 Urban Health Centres (UHC) in the state which are non-functional. However, as per the GoI guidelines, there should be one UHC for 50,000 population (outpatient). The Urban Health Centre are required to provide services of Maternal Health, Child Health and Family Planning. The infrastructure condition of the 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 1Staff clerk with computer skills.

Objectives No. 1: Improve delivery of timely and quality RCH services in urban areas of Bihar
Strategies and Activities

Identify health service providers of both public and private sectors (including NGOs) in urban areas and plan delivery of RCH services through them

- Mapping of Urban Slums and existing providers of RCH services of both public and private sectors has been completed
- Develop Micro-plans for each urban area for delivery of RCH services, both outreach and facility based.

1.2 Strengthen facilities of both public and private sectors in urban areas

- Establish partnerships with select private health clinics for delivery of facility-based RCH services e.g .institutional delivery, permanent methods of FP, curative MCH service, etc.
- 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.

1.3 Strengthen outreach RCH services in urban areas through involvement of both public and private sector service providers

- Deliver outreach services planned under RCH through reinforced network of frontline health service providers (ANMs, LHVs)
- Expand outreach of RCH services by adoption of identified under-served or un-served urban areas by facility-based providers (e.g. adoption of a particular slum by a medical college or private health institute)
- Establish 20 Urban Health Centres on a rental basis under PPP in this financial year especially indistricts with DHs having heavy patient load

Objective No. 2: Increase awareness about Maternal, Child health and Family Planning services in urban areas of the state.

Strategies and Activities

- Use Multiple channels for delivery of key RCH messages in urban areas
- Utililise various channels of mass media with extensive reach in urban areas such as TV, local cable net works, radio cinema halls, billboards at strategic locations, etc to propagate messages related to key programme components of RCH.
- Extensive use of print media such as newspapers (particularly local newspapers), journals andmagazines for dissemination of key RCH messages.

2.2 *Broad inter-sectoral coordination to increase awareness and knowledge of key messages under the RCH programme*

2.2.1 Involve representatives from Urban Local Bodies(municipal corporations and municipalities), commercial associations, sports bodies, voluntary and religious organizations for
intensive inter-personal communication and community-based awareness campaigns.

2.3. Use various channels of mass media for ensuring utilization of services of Urban Health Centres, private or Government

Vulnerable Groups/ intervention in High Focus District

Two camps shall be held in each Maha-Dalit tola where health check-up and counseling shall be done, followed by distribution of spectacles to reach out to the vulnerable sections of the Society

Tribal Health

There are so many area of tribal family in the district of Madhepura like marliganj, ghailarh, kumarkhand and etc. for which we will provide the special services of health like mobile medical unit.

Strengthening of SIHFW

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.

Infrastructure and Human Resource

Infrastructure is one of the most 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.

Institutional Strengthening

Sub-centre rent shall be provided for the HSCs operational in rented building we would like to try new infrastructure if the land is available.

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 . Some of the trainings will be contracted out to the NGOs and private players also, so that any limitation of State infrastructure is overcome easily. .As BCC will be a major training aspect; it has been dealt in a separate chapter. 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 thecommunication 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.

IEC/BCC

The Annual Action Plan 2010-11 for IEC/BCC has been prepared in the light of the number of initiatives taken by Dept. of Health, GoB, and State Health Society, Bihar, in the implementation of NRHM .It follows in essence, form and content, the National Communication Strategy. The National PIP for RCH and instructions and guidelines received from GoI and GoB from time to time has also been kept in mind.The selection and implementation of set of behavior change have been adopted with a view to improve a wide range of family care-giving and care-seeking practices, and enhance supportive environments for improved household health practices at community, institutional and policy level. The IEC/BCC Programme will focus on building an environment favoring health seeking practices, preferably through low cost 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.

Procurement of Equipments/ Instruments and Drugs/Supplies

There are two FRU in the district of Madhepura Sadar hospital Madhepura and murliganj ,both are functionable

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.

District Health Societies

The society shall direct 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. RHM STATE PROGRAMME IMPLEMENTATION PLAN-
- 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.

Governing body of DHS

1. District Magistrate & Collector Chairperson
2. District Development Commissioner (CEO Zilla Parishad) Vice Chairperson
3. District Social Welfare Officer Member
4. Executive Officer, Municiplity, Saharsa Member
5. Addl. Chief Medical Officer Member
6. District RCH Officer Member
7. Deputy Superintendent of the District Hospital Member
8. Civil Surgeon Member Secretary

Executive Body of DHS

1 Civil Surgeon of the District Chairperson
2 Additional Chief Medical Officer Cum member Sec.Member
3 District RCH Officer, Member
4 District Leprosy Officer, Member
5 District T.B. Officer, Member
6 District Malaria Officer, Member
7 District Programme Manager (ICDS) Member
8 Chief Executive Officers Nagar Nigam, Member
9 Deputy Superintendent, Sadar Hospital Member Secretary
10 Sec. IMA Member
11 Sec. Indian Red Cross Society, Member

District Programme Management Support unit Consist of Following Personnel:-

1. District Programme Manager
2. District Planning Co-Ordinator
3. District Accounts Manager
3. District M & E Officer
4. District Community Mobilizer (Asha)
5. District Data Assistant (Asha)
6. District C.A.

Convergence and 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.

There are 170 PRIs in Madhepura district. VH& SC are constituted in all panchayat.

Role of State, District & Blocks

The role of State, District and Block are well defined. The role of each one has been clearly indicated in the work plan as per activity wise. The decentralization process has given more roles to Districts andBlocks to perform in executing the various programs. The State mainly looking after Monitoring, Policy decisions, Centralize capital purchase, technical support etc and help the district in execute the actions panned.

Monitoring and Evaluation

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

Synergie with NRHM Additionalities

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

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

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

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.

Extra inclusions in RCH (IFA)

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)

Chapter IV:

Part B – NRHM Additionalities

Decentralisation

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.

ASHA

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, 2365 ASHAs (revised as per the decadal growth in 2008) are to be selected and trained in Madhepura. The previous target was 2017 (as per 2001 census). The first orientation training of seven days has been completed for about 1960 ASHAs. The 2nd, 3rd and 4th round /2, 3 & 4th module training is being done by PHED and its NGOs.

1.1 At the District Level

Additional 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.

Data Assistant: She/He will assist the community mobilizer and existing staff of the District PMU in all the ASHA related work

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ASHA Help Desk: An ASHA help desk will be formed at the district level whose overall in charge will be the community mobilizer. This will be expanded to the block level for strengthening of referral support system, to redress grievances of ASHAs, if any and to work as an information networking and management system.

1.2 At the Block Level

Block ASHA Manager/ Block Level Organizer– An Officer will be appointed as a block level organizer for effective programme management, implementation and execution and to act as a link and network between the ASHAs and the District and will be assisted by a facilitator – 1 on every 20 ASHAs. The Facilitator will be the21st ASHA worker. This will help in building up and developing the necessary skill required for a community health worker in a sustainable way.

ASHA Help Desk: An ASHA Help Desk will be formed also at the block level. Overall in-charge of Block level ASHA Help Desk will be block level organizer and MOIC. This shall be in network with the District Level ASHA Help Desk. It will act as a network integrating the Village, Block and the District. It will help in strengthening referral support system, redress grievances of ASHAs, if any, and work as an in formation networking and management system.

1.3 At the Village Level

Community Monitoring and Community Need Assessment: Community-based Monitoring ensures that the services reach those for whom they are meant, for those residing in rural areas, especially the poor, women and children. Community Monitoring is also seen as an important aspect of promoting community led action in the field of health and to understand if the work is moving towards the decided purpose. Although, ASHA hails from the same village, she may not be having knowledge and information on the health status of the village population. For this purpose, she will be advised to visit every household and undertake a sample survey of the residents of the village to understand their health status. In this way she will come to know the villagers, the common diseases which are prevalent amongst the villagers, the number of pregnant women, the number of newborn, educational and socio-economic status of different categories of people, the health status of weaker sections especially scheduled castes/scheduled tribes etc. She will be provided with a simple format for conducting the surveys. The ASHA Activity Diary will also help her keep a record of the base level. In this she should be supported by the AWW and the Village Health & Sanitation Committee. Such a review will help to identify obstacles in the work, so that appropriate changes can be made to cross the obstacles by the team of the block level organizers.

Networking with VHSC, PRI and SHGs – All ASHAs will be involved in this Village Health and Sanitation Committee of the Panchayat, as Members. ASHAs will coordinate with Gram Panchayat in developing the village health plan, along with the Block Level Organizer, Block Medical Officer and Block Facilitator. The untied funds placed with the Sub-Centre or the Panchayat will be used for this purpose. The SHGs, Woman's Health Committees, Village Health and Sanitation Committees of the Gram Panchayat will be major sources of support to ASHA. The Panchayat members will ensure secure and congenial environment for enabling ASHAs to function effectively to achieve the desired goal.

1.4 ASHA Training

The second phase of ASHA training which includes the 2nd, 3rd and 4th modules is being done by PHED and it's NGOs.

1.5 ASHA Drug Kit and it's replenishment

To ensure provision of ASHA Drug Kit to 1711 ASHAs and replenishment as it is one of the key components of NRHM

1.6 Emergency Services of ASHA

Bihar has been experiencing regular floods which have created havocs in lives of lakhs of people both economically and psychologically. During the time of floods, health related problems become extremely acute. In such a situation the role of ASHA becomes extremely crucial. Thus ASHAs will be provided intensive training/capacity building preferably of three days and would then be deputed in 16 flood prone districts or similar natural disaster areas.

1.7 Motivations for ASHA

Provision of Two Sarees to ASHA – The provision of Sarees will ensure the following:-

- The availability of Sarees will help in building up of better motivation of the ASHA workers.
- Identification in any work helps in rooting identity for the worker and the work itself. The availability of Sarees will help in doing so.
- Sarees will help in easy deliverance of work and make the worker more accessible by the community as it will help in easy identification of the ASHA worker.
- It will help in boosting the morale of the ASHA worker and shall make the relationship stronger and would help in connecting the ASHA worker and the State.

Provision of One Umbrella to ASHA– The provision of Umbrella will ensure the following:-

- The availability of Umbrella will act as an aid to the ASHA worker in extreme weather conditions,which will facilitate the health facility/services in a smooth way
- The availability of Umbrella will help her comply with her nature of work
- It will help in building up of motivation of the ASHA worker, enhance her identity.
- It will help in boosting the morale of the ASHA worker and making the relationship stronger andensure connectivity between the ASHA worker and the District

1.8 Capacity Building/Academic Support Programme:

a) Enabling ASHA 10th pass – For upgradation of academic strength of ASHA, SHSB will provide examination fees for the 10th examination of open schooling mode/Board/IGNOU to 1000 ASHAs in 1st Phase. Fee for the same to be provided by SHSB. b) Training for Help Desk – The person/officer involved in operationalising the ASHA help desk at District level and Block level will be trained.

1.9 ASHA *Divas*

ASHA *Divas* will be held per month. This will include the following components- Monthly Meetings for ASHA Divas of ASHAs, ANMs and AWWs shall provide the necessary platform to share the work experiences, identify the loop holes and work towards the same.

- Best ASHA worker and ANM worker felicitation as per their monthly performance at the
- ASHA Divas will provide motivation. The performance will be rated as per the ASHA Activity Diary.
- Provision of I-Card will be done to the newly selected ASHA workers.
- Replenishment of ASHA Drug Kit for at least the next two months. This will ensure treatment of common ailments and first level prompt care and referrals initiated based on symptoms of necessary cases. For this, effective access to basic drugs in every village should be ensured through ASHA Drug Kit.

Untied Funds for Health Sub-Centre, APHC & PHCs

The objective of the activity is to facilitate meeting urgent yet discrete activities that need relatively small sumsof 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;
- Adhoc payments for cleaning up sub center, especially after childbirth; transport of emergencies toappropriate 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.

Village Health & Sanitation Committee

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.

Rogi Kalyan Samiti

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 Gob Make 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.

1.12 Seed Money for Rogi Kalyan Summittes

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

Infrastructure Plan

2. Infrastructure Development

2.1 Construction/Establishment of Health Sub Centre (HSC)

NRHM aims to ensure HSC facility on the Govt. of India population norms of 1 per 5000 population in general areas and 1 per 3000 populations in tribal areas. As per 2001 Census, population of the Madhepura District is approximately 70,528.Exsiting no of HSCs are 272.As per IPHS norms total requirement of HSCs are 380 . To facilitate the above population the state requires additional 108 HSCs had been approved by state health society bihar to achieve the total target. It is proposed to becreated next five years.In SPIP 2009-10 State Health Society Bihar sanctioned fund for Building construction of 5 to 10 HSC @ Rs.12 lakhs per HSC.The construction work HSC is under progress. The DHS Madhepura proposes to construct additional 23 HSC building in next financial year2010-11.

Contractual Manpower

As human resources are the most important resource steps shall be taken to motivate them through various benefits and incentives like Cell phone facility for all ANMs, MOICs, Programme Officers, CDPOs etc.. All the doctors posted in the rural area would get an additional incentive of Rs.3000. State Health Society Bihar had sanctioned Rs.50,000/- per PHC per year as incentive to the PHCs for better performing in services. 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.

3.2. Block Programme Management Unit

The district has already established Block Programme Management Unit in all the 13 Block PHCs.. Each BPMU consist of One Block HealthManager 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.

Additional Manpower for District Health Society, Madhepura

NRHM being a large programme covering various components, DHS requires more manpower to run the programmes. The District Health Society requires additional manpower other than Programme Management Support to manage all the Programmes under NRHM umbrella.

PPP Initiatives

4.1 Ambulance Service Under this scheme Ambulance for emergency transport is being provided in all the DH to APHC .. The empanelled ambulance & ambulance available in Govt. institutions are made available for beneficiaries. This service has been outsourced to a private agency for Operationalisation. Requirement of Ambulance in Didtrict:-

Addl. Primary Health Centre: 23

- Primary Health Centre (PHC): 13
- Sub-Divisional Hospital (SDH):
- District Hospital: 01
- Total Ambulace: 19

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4.7. 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.

MALNUTRITION IN BIHAR:

In Bihar, malnutrition is a serious concern with a high prevalence of 58.4 % as revealed by the National Healthand Family welfare Survey (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 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. 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.

Budget

Activities Total proposed budget (in Rs.)

Running cost of one NRCs = 2,50,000/- x 12month= 30,00,000/-,

4.9. Providing Ward Management Services in District Hospitals

To enhance quality services of Indoor Patient of District Hospital, it is required a proper Ward Management in Ward of District Hospital .It is Proposed that the task shall be done under PPP, wherein the agency shall be responsible for the following servicesо Providing one ward boy for 10 or less than 10 beds and at the rate of one boy per additional 10 beds.

- Ensuring 7x24 hours services of Ward Boys.
- Shall provide one wheel chair for 10 beds or less and @ one wheel stretch for additional 20 beds.
- Deploying all Ward Boys in uniform dress bearing a unique identification no. with name.
- Assisting the nurses in the detoxification unit.
- Attending to the personal hygiene of bed-ridden patients.
- Escorting the patients to labs, other specialists & wards.
- Monitoring the visitors and checking patients for possession of drugs.
- Conducting physical exercises for the patients.
- Assisting in detoxification of toilets and ward etc.
- Daily replacement of used bed-sheets by clean bed-sheets with proper care.
- Any other task related to ward management prescribed by the authority.
- Payment shall be made on a per bed per month for all the hospitals. District Hospitals therefore initially fund is required as such –

Budget - @Rs.300/- x 300 beds x 12 months=Rs.10,08,000/-

4.10. Provision for HR Consultant

All post like doctors, nurses, paramedical staffs and other managerial and clerical staff sanctioned under NRHM is on Contract basis .SHSB advertise post Vaccany as per NRHM Guidelines. District Health Society undertakes process of selection and recruitment of doctors, nurses, paramedical staffs and other managerial and clerical staff under guidance and direction of State Health Society, Bihar. It is generally sine that process of selection is not completed in time. Hence state Health society may make provision of HR Consultant at District level.It will also enhance managerial capacity DPMU. The Consultant will be required to undertake whole process of selection for the post as per reservation roster.

Budget – Rs.20,000x12 month = Rs2,40,000/- per year

Referral & Emergency Transport

1 108 Ambulance Service

Under this scheme Ambulance for emergency transport is being provided in all the DH to APHC .. The empanelled ambulance & ambulance available in Govt. institutions are made available for beneficiaries. This service has been outsourced to a private agency for Operationalisation. Requirement of Ambulance in Didtrict:-

Addl. Primary Health Centre: 23

Services of Hospital waste treatment and Disposal in all

4.3. Bio Medical Waste Management

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.

Fund Requirement :- Rs.18 lakh

Outsourcing Pathology & Radiology Services from PHCs to District Hospital

4.4. 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 fixed the rates . All the remaining cost for setting up centers and providing services will be borne by the private providers.

4.6. Monitoring and Evaluation

District & Block Data Centres

The Data Centers at each and every hospital (PHC, Sadar Hospital, Sub-Divisional Hospital etc.) are being established through outsourcing. District Hospital Sub-Divisional Hospital require two Data Centre . The main purpose of these Data Centers 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 Centers contain one computer with UPS, Laser printer, Phone connection, Internet connection, Computer operator, Misc. etc.The GPRS enabled mobile setshave been given to each and every data centers. The total no. of Data Centers to be established is 685 and the estimated cost is Rs. 7500/- per Data Centre per month. The District/Block Data Centres units would be as such:

- Primary Health Centre (PHC): 13
- Sub-Divisional Hospital (SDH): 0
- District Hospital: 01
- District Health Society: 01

Total Data Centre: 15

Budget

Activities Total proposed budget (in Rs.)

District & Block Data Centres Rs. 7500/- x 12 x 15 =Rs. 1350000/-

Hospital Maintenance

4.8. Hospital Maintenance (Funded by State Govt)

The District has outsourced the maintenance of Hospitals to private agencies. The amount require for this purpose is borne by the state government. The activities include

- Maintenance of Hospital Premises.
- Generator Facility.
- Cleanliness of Hospitals.
- Washing
- Diet.

Strengthening of Cold Chain

Effective cold chain maintenance is the key to ensuring proper availability and potency of vaccines at all levels. 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

Main streaming AYUSH under NRHM

The Indian systems of medicine have age old acceptance in the communities in India and in most places they form the first line of treatment in case of common ailments. Of these, Ayurveda is the most ancient medical system with an impressive record of safety and efficacy.Other components such as Yoga, Naturopathy are being practised by the young and old alike, to promote good health. Now days, practice of Yoga has become a part of every day life. It has aroused a world wide awakening among the people, which plays an important role in prevention and mitigation of diseases. Practice of Yoga prevents psychosomatic disorders and improves an individual's resistance and ability to endure stressful situation.Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) are rationally recognized systems of medicineand have been integrated into the national health delivery system. India enjoys the distinction of having the largest network of traditional health care, which are fully functional with a network of registered practitioners,research institutions and licensed pharmacies. The NRHM seeks to revitalize local health traditions and mainstream AYUSH (including manpower and drugs), to strengthen the Public Health System at all levels. It is decided that AYUSH medications shall be included in the drug kit of ASHA, The additional supply of generic drugs for common ailments at SC/PHC/CHC levels under the Mission shall also include AYUSH formulations.

At the CHC level two rooms shall be provided for AYUSH practitioner and pharmacist under the

Indian PublicHealth Standards (IPHS) model. At the same time, it has been decided to place or provision one Ayush doctor on contract at the APHCs for the purpose and to ensure complete coverage of the population. Activities Improving the availability of AYUSH treatment faculties and integrating it with the existing Health Care Service.

Strategies

- Integrate and mainstream ISM &H in health care delivery system including National Programmes.
- Encourage and facilitate in setting up of Ayush wings-cum-specialty centres and ISM clinics.
- Facilitate and Strengthen Quality Control Laboratory.
- Strengthening the Drug Standardization and Research Activities on AYUSH.
- Develop Advocacy for AYUSH.
- Establish Sectoral linkages for AYUSH activities Delivery System

1. Integration of AYUSH services in 1234 APHC with appointment of contractual AYUSH Doctors.
2. Appointment of paramedics where AYUSH Doctors shall be posted.
3. Strengthening of AYUSH Dispensaries with provision of storage equipments.
5. Making provision for AYUSH Drugs at all levels.
6. Establishment of specialized therapy centers/yush wings in District Head Quarter Hospitals & Medical Colleges.
7. AYUSH doctors to be involved in all National Health Care programmes, especially in the priority areaslike IMR, MMR, JSY, Control of Malaria, Filaria, and other communicable diseases etc.
8. Training of AYUSH doctors in Primary Health Care and NDCP.
9. All AYUSH institutions will be strengthened with necessary infrastructure like building,
equipment, manpower etc.
10. Yoga trainings were held in various District hospitls to provide Yogic therapy for specific
diseases andalso as a synergistic therapy to all other systems of treatment.

Chapter V:

Part C – Immunization

The aim is to immunize all the children and pregnant mothers under Universal Immunization Programme, 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 State of Bihar has shown excellent Progress over the Years as shown in the Graphs below.

Data source-MIS

1.3 Some of the initiatives for increasing Immunization-coverage is given below.

- Micro-plans have been prepared for each District to ensure full coverage.
- Vaccines & Auto-Disposable (AD) Syringes provided free of cost to all beneficiaries.
- Alternate System of Vaccine Delivery has been put in place for delivery of Vaccines at
Immunization sites (@ Rs 50/- per session site).
- Support is being provided for POL to PHCs/Districts/WICs/WIFs for maintenance of Cold
Chain on a daily basis.
- Mobility support is given to all the Diistricts and all DIO`s for Supervision of R.I .in the field.
- Alternate Vaccinators are hired @1400/- per month where ever there is a shortage in the
Districts.

- All the Electrical Cold-chain Equipment in the Field are Under Annual Maintenance Contract, which is out-sourced by the State Health Society.
- Generators are also out-sourced in all the PHC for un-Interrupted Power Supply to allthe PHCs /ILR Points.
- Fund has been provided for the Construction of Safety-Pits in every Block-PHC for thesafe disposal of AD-Syringes.
- All the H.W. (ANM) is being trained based on the Health Workers ImmunizationModule in phases for Improving Immunization all across the State.
- Special Post Flood catch –up Immunization Campaign in the Five Most Flood AffectedDistricts of Bihar has been conducted following the massive floods.

5.8 MUSKAAN Programme

The state has started a New Programme called MUSKAAN Programme to track pregnant women and NewBorn Child. Under this programme ASHA, AWW and ANMs jointly track the pregnant mothers and NewBorn Child.This programme launch 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. After the introduction of this programme it has been seen that the coverage of ANC and Immunization increased.

2. Muskan…Ek Abhiyan

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

Objective:

- To achieve 100% immunization of Infants and Pregnant Women

Muskan … Operational Strategy

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

Components:

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

3. Technical Objectives, Strategies and Activities

Objective:-

To increase full immunization of Children from 32.8% to 60% by 2011-12.

Strategies and Activities:-

3.1 Conduct fixed day and fixed-site immunization sessions according to district/Block micro plans.

3.1.1 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.

3.1.2 Update Block micro plan for conducting routine immunization sessions

3.1.3 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.

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

3.1.5 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

3.1.6 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 3.1.7 Facilitate maintenance of Cold Chain equipment through Comprehensive annual maintenance contract with a private agency with adequate technical capacity. 3.1.8 Provide POL support to district @ Rs. 11250 per PHC per month to each PHCs for running of Gensets and minor repair 3.1.9 Issue necessary departmental instructions to re-emphasize provision of ANC services in the job description of Aaganwadi Workers and ANMs.

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

3.2.1 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.

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

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

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

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

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

3.3.3 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.

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

3.4 Strengthen Supervision and monitoring of immunization services

3.4.1 Build capacity of Medical Officers, MOICs and DIOs in supervision and monitoring of implementation of immunization services as per the micro-plan.
3.4.2 Provide mobility support to MOICs and DIOs for supervision and monitoring of implementation of immunization services.
3.4.3 Develop effective HMIS to support supervision and monitoring of implementation of immunization services.
3.4.5 Coordinate with representatives of PRI to strengthen supervision and monitoring of immunization services

Chapter VI:

Part D – National Disease Control Programmes

IDSP(Integrated Disease Surveillance Project)

Under IDSP District Survillance Unit is working in Madhepura
Salary(Epidemologist)- 30000x12=360000
Salary(Data Manager)-13500x12=162000
Salary(Data Entry operator)-8500x12=102000
Mobility-4000x12=48000
Office Expenses -2000x12=24000
Broadband Expenses-1250x12=15000
Printing of reporting formatting=12500
Collection & transportation of samples=7500
Training =30000

IDDCP

Objectives :-

01. Inspite of general salt all the citizens should use the iodised salt.
02. Decrease the no. of those patient who used the non iodised salt,and create awareness between the citizens about iodised salt.

Budget for a unit-4221/- X 13 = 54873
Training- 1250
Awareness -625
School programme-1250
Material for awreness- 471
Programme at AWC-625

NBCP

BLINDNESS CONTROL PROGRAMME	
Situation Analysis/ Current Status	Eye Care is being provided through the Sadar Hospital, There are 3 Ophthalmic Assistants in the district posted at Sadar Hospitals. The norm for GOI is 1 eye surgeon for a population of one lakh. Hence in this district at least 3 Eye Surgeons are required. The norm for Ophthalmologist to Ophthalmic Assistant is 1: 3-4 Data is not available regarding this from Private sector. The numbers of surgeries need to be at least triple to tackle the blindness due to Cataract. There is no Eye Bank or Eye donation center in District Saharsa. The nearest Eye Bank is at PMCH Patna.
Objectives	1. Reduction in the Prevalence Rate of blindness to 0.5 % **2.** Decrease in the Prevalence Rate of Childhood blindness to 0.6 % per 1000 children by 2010 **3.** Usage of IOL in 95% of Cataract operations
Strategies	1. Provision of high quality Eye Care 2. Expansion of coverage 3. Reduce the backlog of blindness 4. Development of institutional capacity for eye care services
Activities	1. Determining the prevalence of Cataract through a study by an external agency. • One time house-to-house survey for study of prevalence of vision defects and Cataract of entire population leading to referrals and appropriate case management including cataract surgeries 2. Increasing the number of Ophthalmologists either by hiring or through involvement of Private Sector. 3. Training in IOL to Ophthalmologists 4. Training of Paramedical staff and Teachers, NGOs, Patwaris and AWW for screening of school children and IEC activities. 5. AMC for all equipment will be done. 6. Equipment • Repair of Synaptophore and Operating Microscope • Purchase of Ophthalmic Chair, Slit Lamp, Operating Microscope, Synaptophore, A Scan biometry, Keratometer, Direct and Indirect phthalmoscope 7. Construction of Eye Unit in Hospitals and later PHCs 8. Supply of basic Eye medicines like eye drops, eye ointments and consumables for Primary Eye Care in PHCs/CHCs.

<table>
<tr><td></td><td>9. All PHCs and CHCs to be developed for vision screening and basic eye care
<table>
<tr><td>Eye Care centre</td><td>Vision Centre</td><td>Screening</td></tr>
<tr><td>Eye Surgeon</td><td>Primary Eye Care</td><td>Identify Blind</td></tr>
<tr><td>Treatment of eye conditions and follow-up</td><td>Vision Test</td><td>Maintain Blind Register</td></tr>
<tr><td>Training</td><td>Screening Eye Camps</td><td>Motivator</td></tr>
<tr><td>Supervision</td><td>Referral for surgery</td><td>Referral</td></tr>
</table></td></tr>
<tr><td></td><td>10. Blind Register to be filled up by the AWW, together with PRIs
11. Eye Camps with the involvement of Private sector and NGOs
12. School Eye Screening sessions
13. IEC activities</td></tr>
<tr><td>Support required</td><td>Procurement of latest equipment for hospitals by GOI
Timely Repair of equipment</td></tr>
<tr><td>Timeline</td><td>2010-11
Health Mela
Development of PHCs as Vision Centres
Development of Sadar Hospital Saharsa as Eye Unit
School Screening
Cataract Camps</td></tr>
<tr><td>Budget Against the Target of 2000.</td><td>
<table>
<tr><td>Activity / Item</td><td>2010-11</td></tr>
<tr><td>IEC</td><td>11000</td></tr>
<tr><td>School Eye Screening</td><td>149000</td></tr>
<tr><td>Cataract Camps</td><td>227500</td></tr>
<tr><td>Cataract Camps by NGO</td><td>375000</td></tr>
<tr><td>Hiring of Vehicles & POL</td><td>19000</td></tr>
<tr><td>Spectacles</td><td>2220000</td></tr>
<tr><td>Honorarium of Contractual Staff with member Secretary</td><td>45600</td></tr>
<tr><td>Miscllanious</td><td>2500</td></tr>
<tr><td>Total</td><td>1049600</td></tr>
</table></td></tr>
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T.B

Sl.No.	Indicators	Gaps	Activities	Unit Cost	Total Cost
1	Infrastructure	As per RNTCP standard one more TU is needed	Development of TU and Renovation of DMCs with Proper water supply and Eletricity connection	35000	35000
		As per RNTCP standard four more DMCs are needed	Establishment of four DMCs	22500	90000
		Six Tus need up gradation	Up gradation	1300	78000
2	HR	Four more LT is needed	Recruitment Process should be followed.	NA	0
		One more STS and STLs are needed	Recruitment Process should be followed	7500	18000
			Honorarium for 17 TB technicians	Rs.6500 per month for 13 with five percent increment and four technicians @6500/- for 12 months	1376700
		Three more TBHVs are needed	Recruitment Process should be followed.	Rs.6500/-	234000
		Constraint in selection Process of new Staff by the District Health Society	Obstacle in recruitment Process will be rectified.	NA	0
		Remuneration of Pvt. DOT Providers has not been paid	Problems in payment of remuneration will be solved	Rs. 250 per DOTS provider for 2939 units	734750

3	Drugs and Chemicals	Irregular supply of Drugs specially of Pediatric Drug Boxes (PC-13, PC-14)	To ensure regular and adequate supply of drugs and other Laboratory materials	From state budget	0
		Supply of short expiry drugs which causes difficulties in drug management	Proper care should be taken regarding short expiry drugs. Short expiry drugs may be used where there is large number of patients having DOTS.	NA	0
		Poor Retrieval of Drug Boxes of Defaulted patient	Retrieval of Drugs may be ensured by STS.	NA	0
		Irregular supply of slides and other Chemicals and other logistics	Proper supply of Slides and other Chemicals should be ensured	Rs 20000 per DMCs per month	696000
		Delay in purchasing of chemicals and other logistics at District level	Constraints in purchasing of Chemicals and other logistics will be removed. Official Process will be simplified.	NA	0
4	Service Performance	Poor quality of DOTS	Proper and Regular supervision and monitoring of programmes will be ensured.	NA	0
		ANMs providing DOTS at the HSCs do not visit the Center on DOTS day resulting irregular intake of drugs by the patient causing poor Curerate.	Motivation and Sensitization of Staffs by Refreshment training for friendly behavior with patient	NA	0
		Due to irregularities in DOTS cases of	Proper counseling of patient should be done regarding	NA	0

		MDR TB may be increased	importance of DOTS and importance of Follow-up Sputum examination		
		Not friendly behavior of Lab Technician and other staffs with patient who comes for sputum examination or for DOTS	Appointment of a Counselor at all PHC	Discussed in maternal health	0
		Case Detection I.e., <83.99%		NA	0
		Cure Rate i.e., <92%	Organizing Community meetings	NA	0
		Low Default Rate	In order to keep vigil on default rate, it is necessary to sensitize MOs at PHCs to monitor treatment card regularly. Training of MO, LT, Paramedical of PHCs are needed	NA	150000
			Medical Officers should take care of referring all chest symptomatic patients for sputum examination	NA	0
			Proper Follow-up Schedule should be maintained	NA	0
			Proper care for side effects of drugs.	NA	0
			Total Budget		**3412450**

NLEP

LEPROSY

Objectives	Eradication of Leprosy	
Strategies & Activities	1. Detection of New cases 2. House to house visit for detection of any cases 3. IEC for awareness regarding the symptoms and effects of Leprosy 4. Prompt treatment to all cases 5. Rehabilitation of the disabled persons 6. Distribution of Medicine kit and rubber shoes 7. Honorarium to ASHA for giving MDT	
Support required	Availability of regular supply of drugs	
Budget	**Activity / Item**	**2011-12**
	Urban Leprosy Control Programe	**47000**
	DPMR Plan	**44100**
	IEC for information on the disease to be spread all over the rural outposts Through	**160250**
	Training	**134525**
	Procurement Plan	**25000**
	Contractual Services	**6000**
	Incentive to ASHA	**74000**
	NLEP Monitoring & Review	**20000**
	Vehicle Operation & Hiring	**124000**
	Office Expenses & Consumables	**25000**
	Total-	**659875**

Kalazar

Sl. No.	Gaps	Issues	Strategy	Activities	Unit Cost	Total Budget
1	Poor coverage of DDT spray	Vector control through insecticide spray in the attack area	To increase the coverage of DDT spray in the endemic zone, there should be proper monitoring by the supervisors, capacity building of the sprayer, supervisors and other health care professionals	1. Ensure planning for timely spray of DDT in Feb-March and May-June for 45 days in each block	NA	0
			Monitoring of the spraying squad by MOIC	2. Identification of Houses with Kala-Azar patient by ANM & ASHA @ 50/ per village.	Rs. 50 for 449 village twice in a year	44900
				3. Two round of spraying scheduled in Feb-March and May-June should be strictly observed	NA	0
				4. DDT spray should be at the rate of 1gm/sq. meter up to the height of 6 feet.	NA	0
		Less time spent on spraying DDT	Training and capacity building for proper spraying	Regular capacity building training on prescribed module for the sprayer to ensure that very corner of the house is properly spray up to height of six feet from ground level.	Rs. 5000 per PHC	65000
		Poor condition of Sprayer, pump and nozzles etc No of Pumps available-	Regular checking of the spraying pumps for better functioning and timely replacement of	Fund allocation and timely release for : maintenance of old sprayer pumps, Purchase of new pumps and	Rs 150000 for the district	150000

		294, No of bucket savailable-279, No of buckets required-225, No of gallon available-127, No of gallon required-45, No of pond measure available-127.	the faulty pieces.	other articles needed-buckets, mugs etc.		
		Inadequate stock of DDT, DDT available-45mt, DDT required-127 mt	Making available DDT during spraying round	Ensure adequate Stock of DDT through proper & timely indenting to improve the quality of spray	DDT Carriage	45000
		Faulty payment plan	Appropriate fund allocation for the payment of the spraying of DDT	Fund would be allocated for regular payment of wages (126 SFW to be used and 630 FW to be used for monitoring and spraying work)	126SFW x Rs 113 x 45 days	640710
					630FW x Rs 92 x 45 Days	2608200
2	Poor rate of case detection of Kalazar	Early diagnosis and treatment through PHC system	Case detection rate should be increased with appropriate diagnostic test	Increase efficiency of case detection through training of Community workers on signs and symptoms of Kala-azar: 1) three weeks persistent fever not responding to antibiotics, malaria being excluded, with palpable spleen.2) Ensure availability of Alde Hyde test at PHC level:3) Purchase of RK 39 kit for detection of Kalazar	Purchase of 50000 units of RK39 @ Rs 25 per unit	1250000
		Reduction of kala-azar	Early diagnosis and treatment	1. Ensuring availability of	Purchase of 2400 vials of	156000

		mortality and morbidity	through PHC system	Amphotoricin at all level	Amphotoricin A @ Rs 65 per unit	
				Loss of wages for KZ patients (case detection in year 2007-3275)	Rs 50 for 22 days for 3200 patient	3520000
				2. Replacing of medicines on priority based	NA	0
				3. Training of ANMs and ASHA for IM injection	Rs 5000 per PHC	90000
3	Lack of monitoring and supervision mechanism,		Monitoring and supervision mechanism	Preparation of of Monthly visit plan for supervision :- Checking spray schedule – For supervision & treatment follow up	Mobility support for CS, ACMO and DMO	45000
					Mobility for MOIC 15x 40days x Rs100	600000
					Mobility for Supervisor 33x 40days x Rs100	132000
				Office expenses	25000 for the district	25000
4	Lack of appropriate BCC & Community Mobilization	Increasing awareness for prevention of Kala-azar	Community participation in reducing mortality and morbidity due to Kala-azar	1. Fund allocation for training activities	NA	0
				2. Identification of NGO/Private partner as trainer	NA	0
				3. Knowledge sharing with the community on signs and symptoms of Kala-azar through VHSC	NA	0
				4. Training of VHSC/PRI and community health worker on sign & symptom of Kala-aza	NA	0
				5. Regular monitoring of IEC activities	NA	0
				6. IEC activities through nukkad natak, Kalajatha mass media like radio	Rs.10000 per PHC	180000

				7. Activity for surveillance like polio surveillance	NA	0
				8. Wall painting of Treatment protocol and provisions for patients in PHC in Hindi.	Above mentioned	0
				IEC van for each PHC	15x 40x 750	450000
				Total Budget		**9594110**

Malaria

S.No.	Gaps	Issue	Strategy	Activities
1	Poor quality of Management of Malaria Cases	Persistence of Malaria in the region	1.Early Case Detection & treatment	1. Provide facility at the APHC level for Thick & thin smear test for Malaria Parasite, Repid diagnostic test
				2. Ensure functionality of FTDs & DDCs at 1000 population with support of ASHA
				3. Regular supply of Malaria drugs in the district
				4. Use of prophylactic measures in suspected cases
			2. Strengthening of Referral system	1. Ambulance facility at the APHC level for referring the Falciparum cases
				2. Training & sensitization of Professionals at sub centre, APHC, PHC, DH
				3. Strengthening of case detection & ensuring fortnightly visits to all villages
			3. Epidemic Preparedness & Repaid Response	1. Early response to the incidence of malaria cases in the district
				2. Earliest response to the area having increase in malaria by double in last two years

2	Poor vector control mechanism	1.Integrated Vector Control	1. Indoor residual insecticide spray in rural areas.	1. Ensuring availability of sprayers fogging machines and buckets in adequate number
			2. Training of the spraying squad	2. Ensuring regular supply of DDT and insecticides
				1. Regular training of the spraying team for dissolving DDT, filling, carrying and spraying process
				2. Supervision by the supervisors to get the feedback of training
				3. Follow up survey : First survey after 21 day of control and second survey after 22 days of first survey
			2. Use of Insecticide treated bed nets	1. Space spray for 7-10 days, residual insecticidal spraying to be started simultaneously as per district micro plans
				2. Supply of Insecticide treated bed nets to suspected patients free of cost
			3.Anti larval measures	1. Promotion of use of larvivorous fishes like gambusia in the natural water tank

Chapter VII:

BUDGET

NRHM Part A – RCH II

Activities	2011-2012		
	Tentative Unit Cost (2011-12)	**Budget Planned (including spill over amount) {(AP x A) ± E} = BP**	**Remarks**
1.1Operationalise facilities (dissemination, monitoring & quality) (details of infrastructure & human resources, training, IEC / BCC, equipment, drug and supplies in relevant sections)			
1.1.1 Operationalise Block PHCs/ CHCs/ SDHs/ DHs as FRUs			This yr we have decided to start two new FRU
Monthly review meeting at FRUs	10000	360000	
Two workshop per year at FRUs	50000	300000	

1.1.1 Operationalise FRUs (Diesel, Service Maintenance Charge, Misc. & Other costs) 1.1.1.1 Operationalise Blood Storage units in FRU	420000	1260000	
1.1.2 Operationalise 24x7 PHCs (Organise workshops on various aspects of operationalisation of 24x7 services at the facilities @ Rs. 25,000 / year / district)			
Monthly review meeting at PHCs	5,000	780,000	
MTP services at health facilities			
RTI/STI srvices at health facilities	1	420000	A MO (Skin specialist will be appointed on Contarct basis @35000/Month
Operationalise Sub-centres			
1.2 Referral Transport			
1.2.1. To develop guidelines regarding referral transport of the pregnant women and sick new born / children and dissemination of the same @ Rs. 50,000 for the state			
1.2.2. Payment to Ambulances for all PHCs @ Rs. 200 / case of pregnancy for Jehanabad district (Pilot basis)			
1.3. Integrated outreach RCH services			
1.3.1. RCH Outreach Camps in un-served/ under-served areas	833	259896	NA
1.3.2. Monthly Village Health and Nutrition Days at AWW Centres		172800	NA
1.4. Janani Evam Bal Suraksha Yojana/JBSY			
1.4.1 Home deliveries (500/-)	500	250000	no
1.4.2 Institutional Deliveries			
1.4.2.1 Rural (A) Institutional deliveries (Rural) @ Rs.2000/- per delivery for 10.00 lakh deliveries			NRHM fund requierd for year 2011-12=53400000 + backlog of the year 2006 to 2009=40000000 + asuumtion for 2010-11=16000000
1.4.2.2 Urban (B) Institutional deliveries (Urban) @ Rs.1200/- per delivery for 2.00 lakh deliveries	1200	5520000	

1.4.2.3 Caesarean Deliveries (Facility Gynec, Anesth & paramedic) 10.3.1 Incentive for C-section(@1500/- (facility Gynec. Anesth. & paramedic)	1500	300000	
1.4.3 Other Activities(JSY) 1.4.3. Monitor quality and utilisation of services and Mobile Data Centre at HSC and APHC Level and State Supervisory Committee for Blood Storage Unit		1800000	no For the Fy 2010-11=540000 + For the FY 2011-12=1260000
Total (JSY)			
1.5 Other strategies/activities			
1.5.1 Maternal Death Audit 1.1.3 Survey on maternal and perinatal deaths by verbal autopsy method (in two districts) @ 850 per death		0	0
Sub Plan of Maternal Health			
Level1		56,854,264	
Level2		85,983,241	
Level3		46,083,639	
2. Child Health			
2.1. Integrated Management of Neonatal & Childhood Illness/IMNCI (Monitor progress against plan; follow up with training, procurement, review meetings etc) 2.1. IMNCI (details of training, drugs and supplies, under relevant sections) 2.1.1. Monitor progress against plan; follow up with training, procurement, review meetings etc			
2.2 Facility Based Newborn Care/FBNC in districts (Monitor progress against plan; follow up with training, procurement, view meeting etc.) 2.2.1. Implementation of FBNC activities in districts. (Monitor progress against plan; follow up with training, procurement, etc.)		180344	no
2.3 Home Based New born care/HBNC			
2.4 School Health Programme (Details annexed)	1700	3726400	0
2.5 Infant and Young Child Feeding/IYCF			

2.6 Care of sick children & severe malnutrition		1758070	
2.7 Management of Diarrhoea, ARI and Micro nutrient		300000	
3.Family Planning			
3.1.Terminal/Limiting Methods			
3.1.1. Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services		25000	
3.1.2 Female Sterilisationcamps			
3.1.3 3.1.2.2. NSV camps (Organise NSV camps in districts @Rs.10,000 x 500 camps)			
3.1.4 Compensation for female sterilisation 3.1.2.3. Compensation for female sterilisation at PHC level in camp mode 3.1.2.1. Provide female sterilisation services on fixed days at health facilities in districts (Mini Lap)			
3.1.5 Compensation for male slerilisation 3.1.2.4. Compensation for NSV Acceptance @50000 cases x1500	1500	750000	
3.1.6 Accreditation of private providers for sterilisation services 3.1.3.1 Compensation for sterilization done in Pvt.Accredited Hospitals (1.50 lakh cases)	1500	2250000	
3.2. Spacing Methods			
3.2.1. IUD Camps	1500	360000	
3.2.2 IUD services at health facilites/compensation	50	365854	
Accreditation of private providers for IUD insertion services			
Social Marketing of contraceptives			
3.2.5 3.2.2. Contraceptive Update Seminars (Organise Contraceptive Update seminars for health providers (one at state level & 38 at district level) (Anticipated Participants-50-70)			
3.3 POL for Family Planning for 500 below sub-district facilities	283500	283500	–
3.4 Repair of Laproscopes (Rs. 5000 x 40 nos.)			

3.5 Other strategies/activities 3.1.4. Monitor progress, quality and utilisation of services 3.5. Establishing Community Based Condom and OCP Distribution Centres (pilot in one district/1 PHC)			
4. Adolescent Reproductive and Sexual Health (ARSH)			
(Details of training, IEC/BCC in relevant sections)			
Adolescent services at health facilites. 4.1.1. Disseminate ARSH guidelines.4.1.2. Establishing ARSH Cells in Facilities 4.1.2.1. Developing a Model ARSH Cell for the facilities 4.1.2.2. Establishing ARSH Cell at Patna District Hospital 4.1.2.3. Establishing ARSH Cell is 50% PHCs of Patna District 4.2 Conducting ARSH Camps at all PHCs for a week (as ARSH Week) 4.2.2 Establishing Youth friendly health clinics in Urban Area/ Universities Campus / Market Place	25000	25000	
4.2 Other strategies/activities			
5. Urban RCH			
5.1. Urban RCH Services (Development of Micro-plans for each urban area already mapped for delivery of RCH services, both outreach and facility based through private agencies/institutions/organisations-50lakhs & Operationalising 20 UHCs through private clinics @540000/- pm			
6 Tribal Health			
Tribal RCH services			
Other strategies/activities			
7. Vulnerable Groups			
7.1 Services for Vulnerable groups			
7.1 Services for Vulnerable groups			
7.2 Other strategies/activities			
8. Innovations/PPP/NGO			

8.1.PNDT and Sex Ratio 8.1.1. Orientation programme of PNDT activities, Workshop at State, District and Block Level (1+38+533)(amount Rs.50 Lakhs) 8.1.2 Monitoring at District level and Meetings of District level Committee (100 Lakhs)	2500	350000	
Public Private Partnerships			
NGO Programme			
Other innovations (if any)			
INFRASTRUCTURE & HR			
Contracutal Staff & Services			
9.1.1 ANMs 10.1.1.2. Hiring of 1000 Retired ANMs or ANMs from other states for out reach services @ Rs. 5000 / month / ANM	8000	456000	
9.1.2 Laboratory Technicians	10000	720000	
Staff Nurses	12000	8352000	
9.1.4 Doctors and Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians) Hiring Specialists 1.1.1.1 Operationalise Blood Storage units in FRU -Salary of Medical Officer - 1,82,40,000/-; 10.1.2.1. Empeanelling Gynaecologists for gynaecology OPD in under or un served areas @ Rs. 1000/- week x 52 weeks ; 10.1.2.3. Empanelling Gyaneocologists for PHCstoprovide OPD services @ Rs. 300/- weekx 52 weeks; 10.1.2.4 Hiring Anaesthetist positions @ Rs.1000 per case x 120000; 10.1.2.5. Hiring Paediatrician for facilities where there are vacant Paediatricians positions @ Rs. 35,000/- month (2 per district); 10.1.2.6 Hiring Gynaecologists for facilities that have vacant positions @ Rs. 650 per case x 75000 cases	35000	15120000	0
Other contractual Staff 9.1 Fast-Track Training Cell in SIHFW 9.2 Filling Vacant Position at SIHFW/Hiring Consultant at SIHFW 10.1.1 Honorarium of Voluntary Workers @ of 1200/- PA x 3106 No.			
ACCOUNTANT FOR SADAR HOSPITAL AND FRU	12000	576000	
FOURTH GRADE & SWEEPER	3000	936000	

PEON FOR DHS	5000	180000	
SECURITY GUARD	3000	1404000	
Incentive/Awards etc. 8.2.1 Incentive for ASHA per AWW center (80000x200 per month) and Incentive toANMs per Aganwari Centre under Muskan Programme (@80000 x Rs.150 Per Month		4596000	
9.2. Major civil works (new construction/extension/addition)			
9.2.1 Major Civil works for operationalisation of FRUS		9500000	
9.2.2 Major Civil works for operationalisation of 24 hour services at PHCs		31500000	
9.3 Minor Civil Works			
9.3.1 Minor civil works for operationalisation of FRUs 10.4.1 Facility improvement for establishing New Born Centres at 76 FRUs across the state - @ Rs. 50,000 / per FRU		31500000	
9.3.2 Minor civil works for operationalisation of 24 hour services at PHCs 10.4.2. Facility improvement for establishing New Born Centres at PHCs across the state - @ Rs. 25,000 / per PHC	30000	210000	
9.4 Operationalise IMEPat health facilites			
CIVIL WORK AT LEVEL I		71514000	
9.5 Other Activities			
10. Institutional Strengthening			
10.1 Human Resource Development			
10.2 Logistics management/improvement			
10.3 Monitoring Evaluation/HMIS 11.3 Monitoring & evaluation through monitoring cell at SIHFW		2839400	Support for Resourse person=2150400 + Mobility for M&E Officer=144000 + Backup=50000 + Format Printing=15000 + One two KB online Ups=150000 + Laptop with Internet=40000 + HMIS Data Operator =900000 + HMIS Training to MPW=200000
10.4 11.4 Sub-centre rent and contingencies @ 1770 no. x Rs.500/- x 60 months	500	138000	

10.5. Other strategies/activities TA & DA for the 30 days contact programme			
11 Training			
11.1 Strengthening of Training Institutions			
11.2 Development of training packages			
11.3 Maternal Health Training			
11.3.1 Skilled Birth Attendance /SBA 12.1.2 Skilled Attendance at Birth / SBA--Two days Reorientation of the existing trainers in Batches 12.1.3 Strengthening of existing SBA Training Centres 12.1.4 Setting up of additional SBA Training Centre- one per district 12.1.5 Training of Staff Nurses in SBA (batches of four) 12.1.6 Training of ANMs / LHVs in SBA (Batch size of four) 20 batches x 38 districts x Rs.59,000/-	88110	2202750	
EmOC Training 12.1.3 EmOc Training of (Medical Officers in EmOC (batchsize is 8)			
11.3.3 Life Saving Anaesthesia Skills training 12.1.5 Training of Medical Officers in Life Saving Anaesthesia Skills (LSAS)			
11.3.4 MTP Training 12.1.6.1 Training of nurses/ ANMs in safe abortion 12.1.8 Training of Medical Officers in safe abortion		50000	
11.3.5 RTI/STI Training	25000	50000	
Dai Training			
Other MH Training			
IMEP Training			
11.5 Child Health Training			
11.5.1 IMNCI 12.2.1.1. TOT on IMNCI for Health and ICDS worker 12.2.1.2. IMNCI Training for Medical Officers (Physician) 12.2.1.3. IMNCI Training for all health workers 12.2.1.4. IMNCI Training for ANMs / LHVs/ AWWs 12.2.1.6 Followup training (HEs,LHVs)	134760	6738000	

11.5.2 Facility Based Newborn Care 12.2.2.1 SNCU Training 12.2.2.2.NSU (TOT)	199600	399200	
11.5.3 Home Based Newborn Care			
11.5.4 Care of Sick Children and severe malnutrition			
11.5.5 Other CH Training (Pl. Specify)		5217585	
11.6 Family Planning Training			
12.6.1 Laproscopic Sterilisation Training			
11.6.2 Minilap Training12.3.2.1. Minilap training for medical officers/staff nurses (batch size of 4)	70240	702400	
11.6.3 NSV Training 12.3.3 Non-Scalpel Vasectomy (NSV) Training	67800	474600	
11.6.4 IUD InsertionTraining 12.3.4 IUD Insertion (details in Annexure) 12.3.4.1 State level (TOT for the districts) 12.3.4.2 District level training (one district total) 12.3.4.3 PHC level training (for one district only)	84725	254175	
Contraceptive Update Training			
Other FP Training			
11.7 ARSH Training 12.4.1 ARSH training for medical officers 12.4.3 One Day ARSH Orientation by the MOs of 25% ANMs 12.4.4 One Day ARSH Orientation of PRI by the MOs of50% ANMs			
11.8 Programme Management Training			
11.8.1 SPMU Training 12.5.4 State PMU to be trained/attend workshops in various areas like HR, Procurement & Logistics, PPP, FRU review and/or undertake study of various programmes in one good and one poor performing districts			
11.8.2 DPMU Training 12.5.1 Training of DPMU staff @ 38 x Rs.10,00012.5.2. Training of SHSB/DAM/BHM on accounts at Head Quarter level @ 6x1500x12=1,08,000/- +DAM= 38x1500x4 + BHM=538x1500x4 12.5.3 Training for ASHA Help Desk to DPMs (38), Block level organisers (533) and MOICs (533), @ 1104 x 1000/-		137500	90000

Other Training			
11.9.1 Continuing Medical & Nursing Education 11.2 Training of 20 (for total state) regular Government doctors in Public Health at Public Health Institute, Gujarat or at Wardha institute or Vellore institute to increase their administrative skills @ Rs.50,000/-			
12. BCC/IEC (for NRHM Part A, B & C)			
12.1 Strengthening of BCC/IEC Bureaus (State and District Levels)			
12.2 Development of State BCC/IEC strategy 13.3 Concept and material development workshops by State BCC/IEC Cell 13.8 Establishment cost of the State BCC/IEC Cell 13.10 Technical support at District level		0	
12.3 Implementation of BCC/IEC stretegy			
12.3.1 BCC/IEC activities for MH			
BCC/IEC activities for CH			
12.3.3 BCC/IEC activities for FP			
12.3.4 BCC/IEC activities for ARSH			
12.4 Other activities 13.4 State Level events 13.5 District Level events (Radio, TV, AV, Human Media as per IEC strategy dissemination) 13.6 Printed material (posters, bulletin, success story reports, health calendar,Quarterly magazines & diaries etc) 13.7 Block level BCC interventions (Radio, kalajattha and for IEC strategy dissemination) 13.11 Media Advertisements on various health related days 13.12 Various advertisements/tender advertisements/EOIs in print media at State level 13.13 Developing Mobile Hoarding Vans and A V Van for State and District 13.14 Hiring an IEC Consultancy at state level for operationation of BCC Strategy. (@ Rs. 50000 x 1 x 12) 13.16 Implementation of specific interventions including innovations of BCC strategy/plans block level 13.17 Implementation of specific interventions including innovations of BCC strategy/plans District level (Rs.		0	

5000 x 38 x 12) 13.18 Implementing need based IEC Activities in Urban Areas (Support for Organization of need based IEC Activities in Urban Areas) (Rs.50000 x 9 x 2) 13.19 Capacity building of frontline functionaries (ANM, ASHA) in IPC skills building 13.20 Research, M&E, IEC prototypes etc			
Sub-total IEC/BCC			
Procurement			
13.1 Procurement of Equipment			
13.1.1 Procurement of equipment 14.2. Equipments for EmOC services for identified facilities (PHCs, CHCs) @ Rs 1 Lac / facility / year (in two districts - kishanganj and jehanabad) 14.4. Equipments / instruments for Blood Storage Facility / Bank at facilities 14.6. Equipments / instruments, reagents for STI / RTI services @ Rs. 1 Lac per district per year	18600	37200	
13.1.2 Procurement of equipment : CH		95640	
13.1.3 Procurement of equipment : FP		61240	
13.1.4 Procurement of equipment : IMEP			
13.2 Procurement of Drugs & supplies			
13.2.1 Drugs & Supplies for MH		70680	
13.2.2 Drugs & Supplies for CH			
13.2.3 Drugs Supplies for FP			
13.2.4 Supplies for IMEP			
General drugs & supplies for health facilities			
14. Prog. Management			
Strengthening of State Society/SPMU 16.1. Strengthening of State society/State Programme Management Support Unit 16.1.1. Contractual Staff for SPMU recruited and in position 16.5.1. Last pay drawn – Pension = Approx exp of Rs.20,000/-PM @ 20,000x6x12			

14.2 Strengthening of District Society/DPMU 16.2.1. Contractual Staff for DPMSU recruited and in position	163427	1444800	
14.3 Strengtheningof Financial Management Systems 16.3.1.Training in accounting procedures 16.3.2. Audits 16.3.2.1. Audit of SHSB/ DHS by CA for 2009-10 16.4 Appointment of CA 16.4.1 At State level 16.4.2 At District level 16.5 Constitution of Internal Audit wing at SHSB			
14.4 Other activities (Programme management expenses,mobility support to state,district, block) 16.1.2. Provision of mobility support for SPMU staff @ 12 months x Rs.10.00 lakhs Updgration of SHSB Office 16.2.2.Provision of mobility support for DPMU staff @ 12 months x 38 districts x Rs.69945.17/-		1049177	
Total Prog. Mgt.			
Others/Untied Funds			
Total RCH II Base Flexi Pool			
Total JSY, Sterilisation and IUD Compensation, and NSV Camps			
Grand Total RCH II			
		408584355	90000

NRHM Part B – Additionalities

Activities	2011-2012 FY		
	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	**Budgetary Source (other than NRHM source)**	**Remarks**
ASHA Support system at State level			
ASHA Support System at District Level	1090400		DCM@ 20000x1x12=240000, DDA@ 15000x1x12=180000, ASHA Help Desk @ Dist Level=150X4X13X12 =50400, Office Exps. @ 10000X12-120000, asha sammelan 500000

ASHA Support System at Block Level	2059200		
ASHA Support System at Village Level	0		
ASHA Trainings	0		
ASHA Drug Kit & Replenishment	3422000		
Motivation of ASHA - Saree & Umlbrella	1240475		
Emergency Services of ASHA	321650		Torch /ASHA @150./Year Motivation prize @5000/Per PHC/Year
Capacity Building/Academic Support programme	0		
ASHA Divas	32029920		
Untied Fund for Health Sub Center,Additional Primary Health Center and Primary Health Center	1691000		HSC@10000x350=3500000, APHC@25000x39=975000, PHC@ 25000x13= 325000, Meeting @ Dist. Level@ 2000 p.a., @ block Level Rs. 3000X13= 39000
Village Health and Sanitation Committee	3840000		
Rogi Kalyan Samiti	2650000		PHC@150000 x13=1950000 DH@700000x1=700000
Infrastrure Strengthening	0		
Construction of HSCs	15570000		
Construction of residential quarters of old APHCs for Doctor & staff nurse	30000000		Budget for FY 2011-12 is Rs. 30000000
Construction of building of APHCs where land is available(5315000/APHCs)	37995000		
2.3 Up gradation of CHCs as per IPHS standards	142149000		
Doctor & Staff Nurse Quarter for CHC	63000000		
Infrastructure and service improvement as per IPHS in 48 (DH & SDH) hospitals for accreditation or ISO : 9000 certification	400000		
Boundary wall of PHCs	9100000		
Annual Maintenance Grant	2950000		DH @ Rs. 1000000 and PHC @ Rs. 150000

Upgradation of ANM / GNM Training Schools	50000000		
TOTAL INFRASTRUCTURE strengthening	0		
Contractual Manpower	0		
Incentive for PHC doctors & staffs	0		
Salaries for contractual Staff Nurses	0		
Contract Salaries for ANMs	0		
Mobile facility for all health functionaries	0		
Block Programme Management Unit	9204000		BHM@19800x13x12=3088800/- BAM@13200x13x12=2059200/- Mobility and other@25000x13x12=3900000/-
Addl. Manpower for NRHM-Hospital Manager in FRUs	330000		
Addl. Manpower for NRHM-Regional Programme Management Unit	0	0	
PPP Initiativs	0		
Referral Transport in Districts & PHCs	0		
102-Ambulance service (state-806400) @537600 X 6 Distrrict	0		
1911- Doctor on Call & Samadhan	1152000		
Ambulance - 108	3120000		
Advanced Life Saving Ambulance & Basic Life Saving ambulance	1186800		
Dhanwantri Rath	0		
Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP)	0		
Dialysis unit in various Government Hospitals of Bihar	0		

Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar	0		
Outsourcing of Pathology and Radiology Services from PHCs to DHs	7740000		
Operationalising MMU	5616000		
Monitoring and Evaluation (State , District & Block Data Centre)	1920000		Data centre @10000/PHC/Month
Advanced Life Saving Ambulance	0		
Equipment for Labour Room	0		
Hospital Beds	0		
Earthing and wiring of existing Cold chain rooms in all PHCs @Rs 10000/- per PHC x 533 PHCs	800000		
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 300000 Lakhs per district x 38 districts	0		
Mainstreaming Ayush under NRHM	8424000		Ayush@18000/Month
Ayush Pharmacist at APHC	0		
Ayush MPW	0		
Ayush Specialist doctors @ Sadar and Sub divisional Hospital	0		
Furniture, etc at APHC for AYUSH	0		
Bio Metric system	235000		
Procurement of SCNU equipments for DH & Newborn Corner equipments for PHCs	1952888		

De-Centralized Planning	1334000		PHC@40000x13x12=520000 District@150000/ Salary of DPC=30000x12=360000/- Laptop with internet@40000/ Mobility =12000/month Data operator=10000x12=120000/
Honorarium of ANM (R)	40800000		
Inter Sectoral Convergence -			
Incentive for AWW under Muskan Project	4208750		
Procurement of Equipments/ instruments for Anesthesia	0		
Equipment for ICU	0		
Grand Total NRHM-B	**487532083**		

NRHM Part C – Immunization

Sl.No.	District	Name of Activities	Budget
01	**Madhepura**	ANM	138
02		Alternate Vaccinator	383
03		Number of immunisation Site	107
04		AWC	1526
05		ASHA	1459
06		HSC	272
07		APHC	29
08		Slums	46
09		Under served Areas	150
10		PHC	13
11		WIC/WIF	2074
12		No of Sessions per month	230
13		No. of Session in per R.I.Day as per Microplan	150
14		H to R	0
15		Alternate vaccinator for Urban	0
16		No. of Urban AWCs	46
17		C.1Mobility Support - Mobility Support for Supervision & Monitoring at District level (Rs. 50000 per year per district	50000
18		C.2Cold chain maintenance -Maintenance of Cold Chain equipments ILR & DFs Rs. 12000/- per districts & Rs. 3000/- per PHCs	51000

19		C.3Alternative vaccine delivery to Session Sites	
20		C.3.1-Alternative vaccine delivery in NE States, Hilly terrains & geograhically from vaccine delivery point, river crossing etc.hard to reach areas in per month @ Rs. 100 per session for 12 months	**180000**
21		C.3.2-Alternative Vaccine Deliery in other areas @ Rs. 50 per session sites for Approx 14000 Session sites in a month & AVD for Urban Areas	1223600
22		C.4Focus on slum & underserved areas in urban areas:	
23		C.4.1-for 3645 slums @ Rs. 200 per month per Mobilizer per session	110400
24		C.4.2 Alternate vaccinators honorarium for urban @ Rs 1400 per month for 12 months for under served areas	0
25		C.5 Social Mobilization of Children through ASHA/ Link workers & paid mobilizers for Under served areas & Hard to Reach area @ Rs 200/- per month for mobilization (for 12 months)	720000
26		C. 6. Computer Assistants support	
27		C. 6.2 Computer Assistants support for District level @ Rs.10000 per person per month for one computer assistant in each 38 districts	120000
28		C. 7. Printing & Dissemention	**0**
29		C.8. 1 State Level Review meetings	**0**
30		C.8.2 Quarterly review meetings exclusive for RI at district level with one Block Mos, CDPO, and other stake holders @ Rs. 100 per participants for 5 participants per per PHCs 533	26000
31		C. 8.3 Quarterly review meetings exclusive for RI at block level @ Rs. 50/- PP as honorarium for ASHAs and Rs. 25 per persons for meeting expenses for 73629 ASHAs	437700
32		C.9 Trainings (separate annexure attached with details)	
33		C. 9. 1 District level orientation for 2 days for ANMs MPHW, LHV Health Assistants Nurse, Mid wife Bees and other specialist as per traning norm of RCH for 9000 persons in 600 batches	2600
34		C.9.2 MO's training	**0**
35		C.9.3 One day training for Computer Assistant on RIMS/HMIS	**0**
36		C.9.4 One day cold chain handlers training for block level cold chain hadlers for 542 + 38 Sadar Hosp. cold chain handlers	14605
37		C.9.5 One day training of block level data handlers for 533 person.	13628
38		C.10 Microplanning	
39		C.10.1 To develop microplan at sub-centre level @ Rs 100/- per sub - centre	13500

40		C.10.2 For consolidation of microplans at block level @ Rs. 1000 per block/ PHC(533) and at district level @ Rs. 2000 per district for38 districts.	15000
41		C.11 POL for vaccine delivery	
42		C.11 POL for vaccine delivery from State to district and from district to PHC/CHCs (@ Rs. 20000/- per WIC/WIF point & Rs. 20000/- per Districts + Rs. 5500/- for each PHC per year),	91500
43		C.12 Consumables	
44		C.12 Consumables for computer including provision for internet access for RIMs Rs. 400 per month per district for 38districts.	4800
45		C. 13 Injection safety	
46		C.13 1- Red & 1-Black plastic bags etc. @.90 paise per session for 12 months	22399
47		C.14 Catch-up Campaign	
48		C. 16 For major AEFI cases investigation for every district in a year. @Rs 1000/- for mobility in the field and @ 5000/- for specimen shipment to lab including travel cost, lodging & fooding etc.	15000
Total			**3111732**

NRHM Part D

IDSP

Sl.No.	District	ROP approved amount allocation (in Rs. lakhs)	Committed Expenditure amount Allocation (in Rs. lakhs)	Total District Annual Allocation (FY 2011-12) (in Rs. lakhs)
01	Madhepura	**583000**	0	**583000**
	Total	**583000**	0	**583000**

NIDDCP

Sl.No.	District	ROP approved amount allocation (in Rs. lakhs)	Committed Expenditure amount Allocation (in Rs. lakhs)	Total District Annual Allocation (FY 2011-12) (in Rs. lakhs)
01	Madhepura	**43902**	0	**43902**

Sub Plan for the Financial Year 2011-12

Annual Budget: Level - I

Budget Head	Additional Requirement	Unit Cost (in Rs.)	Amount in Rs.	Amount by State	Additional amount from Centre	Remarks
Human Resource						
Medical Officer	Redeployment					
Staff Nurse	0		0			
LT	Redeployment					
ANM	Redeployment					
Supportive Supervision [Clinical supervisor + Nonmedical supervisor]						Supervised by Block MOIc. & BHM weekly one days each
Mobility support for supervision	11	96000	12672000			Hiring Private Vehicle maxium @ Rs. 800/- per Day to minimun 10 Days for 12 months
One Fourth grade & one Sweeper	22	36000.00	792000.00			one fourth grade & one Sweeper for each Facility Centre @ Rs. 3000/ Month
Security Guard	33	36000.00	1188000.00			3 guards per facility X 12 months @3000 per month
Sub-total 1:	66	168000	**14652000**			
Training						
SBA	33	28000	924000			28000 each participants
BEmOC (MO)		15000				15000 each participants
NSSK	44	117050	234100			117050 per 32 participants
F-IMNCI	11	288250	288250			288250 per 16 participants
IMNCI	33	100800	201600			100800 per 24 participants
IUCD	33	63102	441714			63102 per 5 participants
Any Other (Please Specify)	0	0	0			
Sub-total 2:		612202				

Infrastructure						
Staff Quarters : New	42	750000	31500000			
Repair /Rennovation	0	200000	0			
Beds for patient: New	58	8200	475600			
Repair /Rennovation	0	0	0			
Labour Room: New	11	400000	4400000			
Repair /Rennovation	0	200000	0			(including water cost)
New Born Corner: New	To be supplied by state					
Repair /Rennovation	0	0	0			
Toilets: New	20	40000	800000			
Repair /Rennovation	0	20000	0			
Equipments	To be supplied by state					
Delivery Drug + Delivery Kit	11	87000	957000			Delivery Kit + Dilivery Drug for per Benificiaries @ Rs. 290 X 25 Benificiaries X 12 Month
Outsourcing of Generator for Electricity	11	180000	1980000			It is @ 15000 per mnth for 1 year
Any Other (Please Specify)						
Subtotal 3:	153	1,885,200	40,112,600			
Grand Total		**2,665,402**				

Annual Budget: Level - II

Budget Head	Additional Requirement	Unit Cost (in Rs.)	Amount in Rs.	Amount by state	Extra from Centre
Human Resource					
Medical Officer	Redeployment				
ANM	Redeployment				
Staff Nurse	19	12000	2736000		
LHV / PHN	0				
LT	Redeployment				

Supportive Supervision [Clinical supervisor + Nonmedical supervisor]	2	40000.00	960000.00		Clinical Supervision by Mobile Trainer one each for 5- 6 blocks @ 40000 per month & Non- Clinical Supervision by DPC for 10 days a month
Mobility support for supervision	2	=(180000 x additional requirement) +96000	456000.00		Hiring Private Vehicle maxium @ Rs. 800/- per Day for minimun 10 Days in Month and 15000 per month for mobile trainer
Sub-total 1:	23		**4152000**		
Training					
SBA	54	28000	1512000		28000 each participants
BEmOC (MO)	65	15000	975000		15000 each participants
MTP	26	95795	670565		95795 per 4 participants
NSSK	117	117050	468200		117050 per 32 participants
F-IMNCI	104	288250	2017750		288250 per 16 participants
IMNCI	26	100800	100800		100800 per 24 participants
Mini-Lap	26	71240	498680		71240 per 4 participants
Laparoscopy	13	71240	213720		71240 per 4 participants
NSV	26	32600	228200		32600 per 4 participants
IUCD	65	63102	820326		63102 per 5 participants
Sub-total 2:	**522**	**883077**	**7505241**		
Infrastructure					
Staff Quarters : New	93	750000	69750000		
Repair /Rennovation	0	200000	0		
Beds for patient: New	180	8200	1476000		
Repair /Rennovation	0	0	0		
Toilets: New	25	40000	1000000		
Repair /Rennovation	25	20000	500000		
Labour Room: New	4	400000	1600000		
Repair /Rennovation	0	130000	0		
Stabilisation Unit: New	To be supplied by state	To be supplied by state			

Repair /Rennovation	0				
New Born Corner: New	To be supplied by state	To be supplied by state			
Repair /Rennovation	0				
Cold chain equipments- ILR/ DF	To be supplied by state	**To be supplied by state**			
Equipments					
Any Other (Please Specify)					
Subtotal 3:	327	1548200	74326000		
Grand Total	872	2431277	85983241		

Annual Budget at a Glance Level III					
Budget Head	**Additional Requirement**	**Unit Cost (in Rs.)**	**Amount in Rs.**	**Amount by state**	**Remarks**
Human Resource					
Specialists:					
Obs. / Gynaec.	2	35000	840000		
Anaesthetist	1	35000	420000		
Paediatrician	1	35000	420000		
Medical Officer	Redeployment				
ANM	Redeployment				
Staff Nurse	17	12000	2448000		
LHV / PHN	0				
LT	Redeployment				
Supportive Supervision [Clinical supervisor + Nonmedical supervisor]	0	0	0		Supervised by supertaindent & Hospital management
Mobility support for supervision	0	0	0		
Trainer for skill Lab	1	480000	480000		
Sub-total 1:	21	597000	4608000		
Training					
SBA	31	28000	868000		28000 per person
LSAS	1	136000	136000		136000 per participants
EmOC	2	138000	276000		138000 per participants

MTP	4	95795	95495		95495 per 4 participants
NSSK	45	117050	117050		117050 per 32 participants
F-IMNCI	8	288250	576500		288250 per 16 participants
IMNCI	16	100800	100800		100800 per 24 participants
Mini-Lap	4	71240	71240		71240 per 4 participants
Laparoscopy	2	71240	71240		71240 per 4 participants
NSV	4	32600	32600		32600 per 4 participants
IUCD	37	63102	441714		63102 per 5 participants
Any Other (Please Specify)	0	0	0		
Sub-total 2:	154	1142077	2786639		
Infrastructure					
Staff Quarters : New	30	750000	22500000		
Repair /Rennovation	0	200000	0		
Beds for patient: New	75	8200	615000		
Repair /Rennovation	0	0	0		
Toilets: New	12	40000	480000		
Repair /Rennovation	0	20000	0		
OT: New	1	3000000	3000000		
Repair /Rennovation	0	0	0		
Labour Room: New	1	400000	400000		
Repair /Rennovation	0	130000	0		
Child Stabilisation Unit: New	To be supplied by state				
Repair /Rennovation	0				
New Born Corner: New	To be supplied by state				
Repair /Rennovation	0				
SNCU: New	2	5700000	11400000		
Repair /Rennovation	0				
Blood Bank: New	To be supplied by state				
Repair /Rennovation	0				
Blood Storage (BSU): New	1	294000	294000		
Repair /Rennovation	0				

Any Other (Please Specify)	0				
Cold chain equipments- ILR/ DF	To be supplied by state				
Equipments	To be supplied by state				
Skill Lab to be stablised at District Hospital	1	1500000	1500000		
Subtotal 3:	122	10542200	38689000		
Grand Total	297	12281277	46083639		

Summary of Budget

Sl.No.	Head	Total Budget for the year 2011-12	Remarks
01	NRHM- A	408584355	Including sub plan with Budget for the year2011-12
02	NRHM- B	487532083	Including sub plan with Budget for the year2011-12
03	NRHM- C (R.I)	3889665	25% Increased by last year budget
04	NRHM- C (P.P)	25810344	25% Increased by last year budget
05	NRHM- D	17443874	25% Increased by last year budget
	Total-	**943260321**	

ADMINISTRATIVE SET – UP:

PARTICULARS	NUMBER
Number of Sub-Division	02
Number of Blocks	13
Number of Municipality	02
Number of Gram Panchayat	170
Number of Police Station	19
Number of Inhibited Villages	384
Number of Uninhibited Villages	56
Number of Villages	449

DISTRICT DEMOGRAPHY AND DISTRICT DEVELOPMENT INDICATORS:

Population	Male	Female	Total
Rural Population (in %)	52.2	47.8	95.5
Literacy Rate	48.8	22.11	36.07
SC Population (in %)	16.8	17.32	17.06
ST Population (in %)	0.58	0.64	0.61
BPL Population	235255		
Sex Ratio	Females per 1000 males 915	(0 – 6 years) 927	
Population Growth (1991 – 2001)	348940		
Population Density (person per sq km)	854		
Number of Household	Total 267179	Rural 256040	Urban 11139
Household Size			
Type of house (%)	Pucca 6.4	Kuchha 93.6	
Per Capita Income	6007		
Total workers (number)	37392		
Main workers (number)	19430		
Marginal workers (number)	3242		
Non – workers (number)	14720		
Total workers to total population (%)	44.80		
Cultivators to total workers (%)	76.42		
Agriculture laborers to total workers (%)	1.36		
Workers in HH industries to total workers (%)	1.72		
Main workers to total population (%)	72.86		
Marginal workers to total population (%)	12.16		
Non workers to total population (%)	1.25		
Number of villages having drinking water facilities	449		
Number of villages having safe drinking water facilities	383		
Number of electrified villages	168		
Number of villages having primary school			
Number of villages having middle schools			
Number of villages having secondary/sr. secondary schools			
Pupil Teacher Ratio (Primary School)	39.89		
Pupil Teacher Ratio (Middle School)	50.97		
Out of School children			
Number of villages having any health care facilities	143		

Number of Health Sub Centre	272
Number of Additional Primary Health Centre	23
Number of Primary Health Centre	13
Number of Sub-divisional hospital	0
Number of hospitals/dispensaries per lakh population 2007 – 08	1.77
Number of beds in hospitals/dispensaries per lakh population 2007 – 08	18.89
Percentage of children having complete immunization 2007 – 08	39.70
Percentage of women having safe delivery 2007 – 08	21
Number of villages having post office facility	8 Per Lakh Population
Number of villages having Paved approach road	37.05
Number of villages having mud approach road	19.91
Average size of operational holding	
Normal Rain Fall	1230.50
Actual rain Fall	1094.30
Percentage of cultivable land to total geographical area 2006-07	76.42
Percentage of area under commercial crops to gross cropped area 2006-07	6.07
Percentage of net area sown to geographical area 2006-07	0.56
Cropping intensity	1.58
Percentage of gross irrigated area to gross area sown 2006-07	68.27
Percentage of net irrigated area to net area sown 2006 – 07	67.16
Consumption of fertilizer in kg/hectare of gross area sown 2006-07	0.22
Average yield of food grains 2006-07 (kg/ha)	1586
Percentage of area under bhadai crops	12.21
Percentage of area under agahani crops	41.26
Percentage of area under garma crops	0.02
Percentage of area under rabi crops	46.52
Length of highways and major district roads (mdrs) per lakh population (km) 31st march 2005	19.91
Length of highways and major district roads (mdrs) per thousand sq km in area (km) 31st march 2005	170.07
Length of rural roads per lakh population (km) 2004-05	37.90
Length of rural roads per thousand sq km in area	323.60

(km) 2004 – 05	
Number of branches of scheduled commercial banks 2008 – 09	66
Credit deposit ratio 2008	26.47
Density of livestock per sq km 2003	207
Density of poultry per sq km 2003	80
Average livestock population served per veterinary hospital/dispensary 2003	18521
District wise fish production 2007 – 08	9000
Share of districts in total milk production 2007 – 08	1.37

TOPOGRAPHY:

CLIMATE AND AGRO ECOLOGICAL SITUATION: Madhepura district is situated between 25 31 and 26 20 latitude and in the middle of 86 36 to 87 07 longitudes. The maximum temperature of this district ranges from 35 to 40 degree Celsius and the minimum temperature varies from 7 to 9 degree Celsius. The average rail fall in this district is 1300mm.

RAINFALL: The average rail fall in this district is 1300mm.

AIR TEMPERATURE AND HUMIDITY: The maximum temperature of this district ranges from 35 to 40 degree Celsius and the minimum temperature varies from 7 to 9 degree Celsius.

LAND AND SOIL: The total areas of land for cultivation is 1,36,646 Hectare. Besides these, There is 1772 hectare of famished land which can be used for cultivation. 1272 hectare of barren land is covered with sand and rest areas of barren land is 3644 hectare. Procurement areas of paddy crop is 52165 hence, wheat is grown in 31431 hectare of land, maize in 34098 hectare of land, sugarcane is 801 hectare of land and potato is grown in 1442 hectare of land. Coconut Development Board, owned by Central Government, is situated in this district.

FACT SHEET OF BLOCKS AND URBAN LOCAL BODIES:

Name of the Blocks	Total Population	No. of GP	No. of Revenue	% of Total Literates	% of Male Literates	% of Female	% of SC Population	% of ST Population	Sex Ratio
Madhepura	Madhepura	194620	17	65	36.39	25.11	11.29	17.84	
	Murliganj	164148	17	45	30.04	20.90	9.14	20.01	
	Kumarkhand	187643	21	71	25.72	18.39	7.23	19	
	Singheshwar	102086	13	43	28.82	20.85	7.96	13.16	
	Shankarpur	82519	09	08	25.25	18.75	6.51	21.61	
	Gamharia	65125	08		29.45	21.20	8.24	15.49	
	Ghailarh	73129	09		28.76	21.84	6.95	15.74	
Udakishunganj	Gwalpara	95295	12	23	31.84	21.62	10.22	16.51	
	Uda Kishunganj	136937	16	44	26.56	18.19	8.34	15.71	
	Bihariganj	101655	12	23	29.84	20.27	9.58	15.48	
	Alamnagar	129226	14	29	23.31	16.99	6.33	16.82	
	Puraini								
	Chausa	116471	13	43	25.26	18.28	6.98	11.54	

BLOCK WISE STATUS OF DRINKING WATER

Sl No.	Block	Total no. of habitation	Habitation having safe drinking water	Functional source of drinking water	Category wise functional sources		
					HP	Tube Well	Piped water
1	Madhepura	168	168	1574	1574	-	-
2	Murliganj	126	126	1626	1626	-	-
3	Kumarkhand	186	186	2115	2115	-	-
4	Singheshwar	233	233	315	315	-	1
5	Shankarpur	145	145	863	863	-	-
6	Gamharia	137	137	682	682	-	-
7	Ghailarh	103	103	148	148	-	-
8	Gwalpara	205	205	865	865	-	-
9	Uda Kishunganj	388	388	1191	1190	-	1
10	Bihariganj	169	169	687	687	-	-
11	Alamnagar	201	201	1271	1271	-	-
12	Puraini	226	226	911	911	-	-
13	Chausa	267	267	1247	1246	-	1

BLOCK WISE SCHOOL INFRASTRUCTURE

Sl No.	Block	Total no of school	% of schools without own building	%of school without Drinking water facility	%of school without toilet facility	%of school Without playground	% of school without kitchen for mid□day meal
1	Madhepura	190	21	63.13	41	97.36	45.78
2	Murliganj	156	17.94	61.27	48	95.21	20.51
3	Kumarkhand	188	27.12	62.76	75	96.26	29.25
4	Singheshwar	100	49	57	6	96	22
5	Shankarpur	81	8.64	48.14	10	96.26	13.58
6	Gamharia	70	30	52	6	97	20
7	Ghailarh	70	15.71	61.42	12	97	2.85
8	Gwalpara	106	4.71	58.49	29	96.22	16.03
9	Uda Kishunganj	141	34.75	51	31	94.27	20.56
10	Bihariganj	87	22.98	51.72	34	93.10	10.24
11	Alamnagar	123	16.26	55.28	22	93.49	10.56
12	Puraini	74	14.86	52.70	30	85.13	12.16
13	Chausa	99	5	69.69	11	86.86	14.14

BLOCK WISE STATUS OF PDS BENEFICIARIES

Sl No.	Block	No. of BPL Cards	No. of AAY Cards	No. of APL Cards	No. of Annapurna Cards
1	Madhepura	27535	3903	18895	164
2	Murliganj	29986	3705	10397	241
3	Kumarkhand	30411	4895	17879	206
4	Singheshwar	17904	2658	15448	215
5	Shankarpur	15931	2147	12013	160
6	Gamharia	10861	1701	7606	155
7	Ghailarh	15262	1914	5792	135
8	Gwalpara	14979	2485	10832	170
9	Uda Kishunganj	23392	3516	13142	210
10	Bihariganj	16985	2649	13613	123
11	Alamnagar	20004	3367	15760	236
12	Puraini	11322	2023	10470	99
13	Chausa	18703	3034	13667	248

BLOCK WISE NUTRITIONAL STATUS OF CHILDREN (0-6 YEAR)

Sl No.	Block	Total no. of AWC	Total no. of children (0-6 year)	Total no. of children weighed	% of children weighed	Normal grade children (%)	Grade I children (%)	Grade II children (%)	Grade III children (number)	Grade IV children (number)	Total (Grade III + Grade IV)	% of severely malnourished
1	**Madhepura**	195	33610	7039	21	32.3	26.3	8	1998	342	2340	
2	**Murliganj**	164	29215	14875	35	29	21	15.13	1639	612	2251	
3	**Kumarkhand**	187	33210	10866	19	24	20	16.18	2119	144	2263	
4	**Singheshwar**	101	18973	7410	41	38	14.6	16.39	1111	104	1392	
5	**Shankarpur**	82	15071	5670	37.62	21.56	53	11.64	572	211	783	
6	**Gamharia**	65	13544	5612	41.43	38	32.23	15.88	748	32	780	
7	**Ghailarh**	73	14297	6411	44.84	34	30	22.28	848	32	880	
8	**Gwalpara**	95	23530	7611	32.34	32	33	20	999	141	1140	
9	**Uda Kishunganj**	137	31476	10640	33.80	23	32.88	25.37	1115	948	2063	
10	**Bihariganj**	102	25672	7561	29.45	31	39	16	1185	39	1224	
11	**Alamnagar**	129	30242	5331	17.62	30	34	4	925	629	1554	
12	**Puraini**	78	17776	11052	22.79	9.15	13.43	9.15	612	331	943	
13	**Chausa**	116	29405	4749	16.15	36.3	10.15	10	1181	211	1392	

Md.Salam
District Data Centre
District Health Society,
Madhepura