District Health Action Plan

2011 – 12

District Health Society, Nalanda

Foreword

National Rural Health Mission (NRHM) was introduced to undertake architectural corrections in the public Health System of India. District Health Action Plan (DHAP) is an integral aspect of National Rural Health Mission. District Health Action Plan are critical for achieving decentralization, 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 utilize various NRHM initiatives such as flexi –financing, Rogi Kalyan Samiti, Village Health and Sanitation Committee to achieve our goals in the socio-cultural context of Nalanda.

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. 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, decentralisation 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 decentralised, pro-poor and efficient public health system. District level health planning and management facilitate improvement of health systems by 1) Addressing the local needs and specificities 2) Enabling decentralisation 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 internalises structural and social diversities such as degree of urbanisation, endemic diseases, cropping patterns, seasonal migration trends, and the presence of private health sector in the planning and management of public health systems. One area requiring major reforms is the coordinate 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 Nalanda District Health Action Plan for the financial year 2011-12. The District Health Action Plan (including the Block 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 Nalanda district health team.

I am very glad to share that Civil Surgeon/ACMO/Dy. Superintendent /MOICs and all BHMs/BCMs/Block Accountants of the district along with key district level functionaries

(DPMU –DPM-P.P.Chakhaiyar, DAM-Nirbhay Kumar & M & E Officer Kumar Manoj,DPC Abhishek Azad, District Epidemiologist Dr.Manoranjan Kumar District Health Society, Nalanda) for putting his sheer handwork with dedication to complete the Action Plan on time. 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.

Sd-

Sanjay Kumar Agarwal (IAS)
District Magistrate cum Chairman
District Health Society, Nalanda.

Acknowledgements

The commitment to bridge the gaps in the public health care delivery system, has led to the formulation of District Health Action Plan. The collaboration of different departments that are directly or indirectly related to determinants of health, hygiene and Water sanitation, will lead to betterment of health care delivery, and to make this collaboration possible actions are to be outlined in the District Health Action Plan. Thus this assignment is a shared effort between the departments of Health and Family Welfare, ICDS, PRI, Water and Sanitation, Education to draw up a concerted plan of action.

The development of a District Action Plan for Nalanda district of Bihar entailed a series of Consultative Meetings with stakeholders at various levels, collection of secondary data from various departments, analysis of the data and presentation of the existing scenario at a District-level workshop. The District level Workshop was organized to identify district specific strategies based on which the District Action Plan has been prepared by the District & Block Program Management Unit.

We would also like to acknowledge the much needed cooperation extended by the District Magistrate cum Chairman ,and Deputy Development Commissioner cum Vice Chairman ,District Health Society,Nalanda without whose support the conduct of the district level workshop would not have been possible. Our thanks are due to All the Program officers and Medical officers of the district for their assistance and full support from the inception of the project. The involvement of the all the Medical officers played a pivotal role throughout the exercise enabling a smooth conduct of consultations at block and district levels.

The present acknowledgement would be incomplete without mentioning the participation of representatives and officials from department of Integrated Child Development Services (ICDS), Panchayati Raj Institutions(PRIs), Education ,Water and Sanitation, who actively participated in consultations with great enthusiasm. Without their inputs it would not have been possible to formulate the strategic health action plan for the district. The formulation of this plan being a participatory process, with inputs from the bottom up, the participation of community members at village level proved very helpful. These consultations at grassroots level supplemented the deliberations at block and district levels, adding value to the planning process.

Finally, we would like to appreciate the efforts and supports of all those including PHRN Bihar, Team who were associated with the team for accomplishment of this task and brought the effort to fruition.

Dr.Ram Bilash Ranjan

Civil Surgeon -cum- Member Secretary

District Health Society, Nalanda.

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Decentralisation

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STRUCTURE OF DISTRICT PLAN

Executive Summary

Introduction

The District Health Society, Nalanda is committed towards promoting the right of every woman, man and child to enjoy a life of health and equal opportunity and is making all round efforts in this direction. DHS has taken steps to bring about outcomes as envisioned in the Millennium Development goals, RCH II / NRHM programme. It aims at minimizing regional variations in the areas of Reproductive and Child Health including population stabilization through an integrated, focused and participatory programme. Meeting unmet demands of the target population, and provision of assured, equitable, responsive quality services are central to the programme strategies. Based on experience gained during the implementation of RCH II, the Department anticipates that current RCH programme implementation would produce equitable reproductive and child health outcomes and contribute to raising the status of the girl child.

The Goal

The goal is to improve quality of life of the people by:

(Goals mentioned below are for the period of RCH-II i.e. to be achieved by 2011)

- Reducing Maternal Mortality Ratio (MMR) from 371 to 100 per 1,00,000 live births,
- Reducing Infant Mortality Rate (IMR) from 61 to 30 per 1000 live births,
- Reducing Total Fertility Rate (TFR) from 4.0 to 2.1 for population stabilization with enhanced satisfaction of clients with medical services.

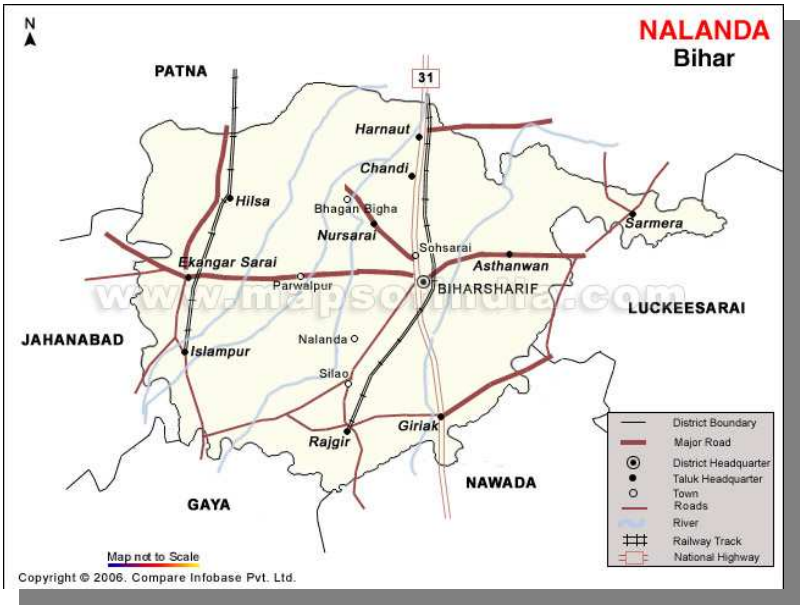
The Department is making all out efforts to reduce the IMR and has initiated an innovative program *'MUSKAAN'* for the same cause and so as to also reach the poorest of the poor with effective, quality and equitable health services. Simultaneously taking steps to effectively implement national health programme while creating synergy and convergence with RCH II.

Process of DHAP Preparation

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

DISTRICT PROFILE

Founded in the 5th centuary A.D. Nalanda is known as the ancient seat of learning. World's most ancient University lies in ruins which is 62 kms from Bodhgaya and 90 kms south of Patna. Emperor Ahoka built many monastries, temples and Viharas here. Though the Buddha visited Nalanda several times during his lifetime, this famous centre of Buddhist learning shot to fame much later, during 5th-12th centuries.



Hiuen Tsang stayed here in 7th century and has left detailed description of the excellence of education and purity of monastic life practiced here. In this first residential international university of the world, 2,000 teachers and 10,000 students from all over the Buddhist world lived and studied here. The Gupta kings patronised these monasteries, built in old Kushan architectural style, in a row of cells around a courtyard.

Nalanda (also called Bihar Sharif) district is one of the districts of Bihar, and Bihar Sharif town is the administrative headquarters of this district. Nalanda district is a part of Patna Division. The subdivision of Biharsharif in the old Patna district was upgraded to an independent district on November 9, 1972 and named Nalanda, after the famous university (the world's oldest) located here. Nalanda is 67 metres above sea level. Nalanda is referred to frequently in Jain and Buddhist scriptures. As the centre of the great Magadha Empire, the district has had a rich and glorious history extending over 2,500 years. Till its destruction by Mohammed Bin Bakhtiyar Khilji, army chief of Kutubuddin Ibak, in 1205 AD, Nalanda was the leading centre of learning in India.

The district of Nalanda is spread in an area of 2367 Sq. Kms. and a population of 2370528 has been pre-eminently an agricultural district. Bordering Patna District in north & north-west, Gaya District in South, Luckeesarai District in east, Jahanabad District in the west and Nawada district in South-east. The district is comprises of 3 sub division and 20 blocks covering 249 village panchayats.

Geography

It is located 80 km from Patna, the capital of Bihar state. It is 13 km from the ruins at Nalanda and well connected with Patna via train and buses. There is a small town located on the top of a craggy rock. The old center of the town has examples of medieval Islamic architecture, such as the Bukhari Mosque. Thousands of pilgrims of all religions visit the tombs of Makhdum Shah Sharif-ud-din, a Muslim saint of 14th century, and the saintly Syed Ibrahim Malick Biya.

DEMOGRAPHIC DETAILS: (CENSUS 2001)

	Male	Female	Total
Population	1246957	1139568	2386527
Rural Population (in %)	84.94	85.24	85.1
Literacy Rate	66.4	38.6	53.2
SC Population	20.04	19.93	20.0
ST Population	0.0	0.0	0.0
Sex Ratio	915		
Coordinates	Latitude:25° 11' 52.8324" Longitude:85° 31' 18.8256"		
Agriculture of Nalanda	Rich Paddy Fields, Potato, Onion.		
Industry of Nalanda	Handloom weaving		
Rivers of Nalanda	Phalgu, Mohane		

Block wise Population Detail as per Census 2001

Name of the CD Block	Total Population	% of Total Literates	% of Male Literates	% of Female Literates	% of SC Population	% of ST Population
KARAI PARSURAI	60127	35.88	47.60	23.03	22.27	0.00
NAGAR NAUSA	72475	39.68	51.32	27.16	24.69	0.01
HARNAUT	143922	41.46	52.46	29.26	22.48	0.00
CHANDI	125990	41.68	53.27	29.03	21.73	0.04
RAHUI	127975	40.98	52.96	27.89	23.42	0.01
BIND	56240	35.35	46.39	23.14	21.19	0.01
SARMERA	78610	35.62	46.55	23.73	22.32	0.05
ASTHAWAN	143867	38.83	49.16	27.64	24.81	0.00
BIHAR	395588	50.59	59.46	40.79	14.70	0.05
NOORSARAI	137267	41.75	53.90	28.64	23.94	0.07
THARTHARI	52039	41.22	52.73	28.49	19.43	0.04
PARBALPUR	58501	46.52	57.22	34.93	12.65	0.00
HILSA	162546	41.85	53.26	29.30	17.96	0.00
EKANGARSARAI	145479	45.94	57.80	32.88	15.52	0.04
ISLAMPUR	192113	42.57	53.34	30.75	16.62	0.08
BEN	72193	42.47	53.71	30.13	19.39	0.05
RAJGIR	109136	43.08	54.03	31.07	24.73	0.11
SILAO	122991	41.39	51.70	30.17	24.22	0.01
GIRIAK	75735	39.24	50.75	27.06	21.28	0.13
KATRISARAI	37734	41.70	53.25	29.31	22.62	0.10

HEALTH INFRASTRUCTURE

SL NO	TYPES OF INSTITUTION	NOS.
1	SUB-CENTRE	370
2	PRIMARY HEALTH CENTRE	20
3	COMMUNITY HEALTH CENTRE	03
4	FIRST REFERRAL UNIT	02
5	ANM TRAINING CENTRE	01

Block wise Health Infrastructure of Nalanda District

Sl.No.	Name of Block	Population as per census 2001	No. PHC	No. of APHC	No. of HSC
1	ASTHAWAN	167432	1	3	25
2	GIRIYAK	88140	1	2	16
3	RAJGIR	127012	1	2	13
4	HARNAUT	167496	1	4	25
5	SARMERA	91486	1	2	15
6	NOORSARAI	159751	1	2	31
7	RAHUI	148937	1	1	24
8	HILSA_PHC	145208	1	2	22
9	CHANDI	146627	1	1	26
10	EKANGARSARAI	169308	1	2	21
11	ISLAMPUR	188821	1	3	25
12	SADAR_PHC	190301	1	5	26
13	THARTHARI	60563	1	1	8
14	NAGARNAUSA	84346	1	1	16
15	KARAIPARSURAI	69976	1	2	8
16	PARWALPUR	68083	1	2	11
17	SILAO	119655	1	3	19
18	BEN	84018	1	4	15
19	KATRISARAI	43915	1	1	16
20	BIND	65452	1	0	8
TOTAL		**2386527**	**20**	**43**	**370**

DETAILS OF HEALTH INFRASTRUCTURE WITH 24 X 7 FACILITIES (EXCLUDING DH):-

SUB DIVISIONAL HOSPITAL		CHC		PHC		APHC	
TOTAL NUMBER	NUMBER OF SDH WITH 24 X 7 FACILITIES	TOTAL NUMBER	NUMBER OF CHC WITH 24 X 7 FACILITIES	TOTAL NUMBER	NUMBER OF PHC WITH 24 X 7 FACILITIES	TOTAL NUMBER	NUMBER OF APHC WITH 24 X 7 FACILITIES
1	**1**	**3**	**3**	**20**	**20**	**43**	**41**

Status of Manpower

S.No	Name of PHC	MO®			MO©			ANM®			ANM©		
		S	IP	V	S	IP	V	S	IP	V	S	IP	V
1	Distt.Hospital	17	17	0	5	5	0	3	3	0	0	0	0
2	SDH,Hilsa	8	7	1	0	0	0	0	0	0	0	0	0
3	Sadar PHC	2	1	1	4	4	0	29	29	0	26	25	1
4	Astahwan	2	1	1	4	4	0	27	27	0	26	18	8
5	Rajgir	2	2	0	4	4	0	14	14	0	13	11	2
6	Islampur	2	2	0	4	4	0	27	27	0	25	24	1
7	Ref.Hospial Asthawan	4	2	2	0	0	0	0	0	0	0	0	0
8	Ref.Hospial Rajgir	4	4	0	0	0	0	0	0	0	0	0	0
9	Ref.Hospial Islampur	5	1	4	0	0	0	0	0	0	0	0	0
10	NoorSarai	3	3	0	4	4	0	26	26	0	31	28	3
11	Chandi	3	3	0	4	4	0	21	21	0	26	21	5
12	Ekangarsarai	3	3	0	4	4	0	22	22	0	21	21	0
13	Giriyak	3	2	1	4	4	0	17	17	0	16	9	7
14	Harnaut	3	2	1	4	4	0	26	26	0	25	18	7
15	Rahui	3	2	1	4	4	0	24	24	0	24	22	2
16	Sarmera	3	3	0	4	4	0	20	20	0	15	4	11
17	Hilsa	2	2	0	4	4	0	17	17	0	22	17	5
18	Silao	3	1	2	5	5	0	22	22	0	19	14	5
19	Tharthari	3	2	1	5	5	0	10	10	0	8	7	1
20	Nagarnausa	3	2	1	5	5	0	21	21	0	16	12	4
21	Karaiparsurai	3	2	1	5	5	0	12	12	0	8	8	0
22	Parwalpur	3	2	1	5	5	0	11	11	0	11	9	2
23	Ben	3	2	1	7	5	2	21	21	0	15	11	4
24	Katrisarai	3	1	2	5	5	0	8	8	0	8	2	6
25	Bind	3	2	1	5	5	0	18	18	0	15	8	7
Total		93	70	22	95	93	2	396	396	0	370	289	81

EDUCATION DETAILS:

No. of Clusters : 187		No. of Rev. Villages : 1183	
Primary		Upper Primary	
Total Habitation	2308	Transition Rate	73.02
School Less Habitation	34	School Less Eligible Habitation	84
Government Schools	1524	Government Schools	606
Building Less	345	Building Less	4
Govt. Aided School	18	Govt. Aided School	14
Sanctioned Teachers (Post)	3909	Sanctioned Teachers	4803
Working Teacher	3905	Working Teacher	3346
Govt. Aided Teachers	34	Govt. Aided Teachers	39
Govt. Teachers	2829	Govt. Teachers	2094
Total Child Population	361295	Total Child Population	159512
Total Enrolment (All)	331537	Total Enrolment (All)	144025
Govt.+Govt. Aided		Govt.+Govt. Aided	
Total Enrollment	287821	Total Enrollment	124368
Total Girls Enrollment	133455	Total Girls Enrollment	55898
Total Boys Enrolment	154366	Total Boys Enrolment	68470
SC Boys Enrollment	37580	SC Boys Enrollment	14429
SC Girls Enrollment	31136	SC Girls Enrollment	10191
ST Boys Enrollment	0	ST Boys Enrollment	0
ST Girls Enrollment	0	ST Girls Enrollment	0
Out of School Children	29758	Out of School Children	15487
Children with Special Needs	5132	Children with Special Needs	3162
GER PRIMARY	108.43%	GER UPPER PRIMARY	48.34%
NER PRIMARY	97.70%	NER UPPER PRIMARY	43.50%
Common Toilet	1413	Girls Toilet	441 Schools
Drinking Water Facility	1830		

Source: District Plan 2009 and DICE Data

1.3 Institutional Arrangements and Organizational Development

Along with Health department the ICDS, PHED and Panchayat are helping in implementing the NRHM Programme. The coordination has been placed at District level, and Block Level. At the Grass root level linkage between ASHA, ANM with AWW has been strengthened. The state has a unique system of collecting data from each PHC level. The state has established a data centre in the state and has centers in District and at PHC. These data centers collect data from each PHC through mobile phone and feed in the computer. The computerized data is later given to the respective Programme Officers.

DISTRICT FACILITY CENTRES:

NAME OF CD BLOCK	AWC	HSC	ASHA	ANM	ANM®	MAMTA	STAFF NURSE ©
ASTHAWAN	144	20	165	28	18	9	6
GIRIYAK	113	16	88	19	9	5	3
RAJGIR	109	13	127	15	11	10	4
HARNAUT	144	26	155	25	18	10	8
SARMERA	79	15	79	19	4	3	3
NOORSARAI	137	31	158	26	28	10	3
RAHUI	128	24	149	25	22	5	2
HILSA	162	29	148	17	17	9	4
CHANDI	133	19	145	21	21	9	1
EKANGARSARAI	146	30	168	21	21	6	3
ISLAMPUR	191	25	180	27	24	8	6
SADAR BIHARSHARIF	162 (R), 154 (U)	26	190	29	25	19	10
THARTHARI	63	07	61	8	7	3	1
NAGARNAUSA	81	14	76	19	12	3	2
KARAIPARSURAI	64	8	70	12	8	3	3
PARWALPUR	58	09	68	11	9	3	4
SILAO	123	16	120	21	14	4	5
BEN	72	20	84	21	11	3	8
KATRISARAI	-	8	44	10	2	3	2
BIND	56	14	59	14	8	3	2
TOTAL	**2319**	**370**	**2334**	**388**	**289**	**128**	**80**

NOTE: EVERY CD BLOCKS HAVE ITS OWN ONE PHC.

Status of Block Programm Management System of Nalanda					
Name of the Block	Status of RKS	BPMU			
		Health Manager		Accountant	
		S	IP	S	IP
Karai Parsurai	Registered	1	1	1	1
Nagar Nausa	Registered	1	1	1	1
Harnaut	Registered	1	1	1	1
Chandi	Registered	1	1	1	1
Rahui	Registered	1	1	1	1
Bind	Registered	1	1	1	1
Sarmera	Registered	1	1	1	1
Asthawan	Registered	1	1	1	1
Bihar	Registered	1	1	1	1
Noorsarai	Registered	1	1	1	1
Tharthari	Registered	1	1	1	1
Parbalpur	Registered	1	1	1	1
Hilsa	Registered	1	1	1	1
Ekangarsarai	Registered	1	1	1	1
Islampur	Registered	1	1	1	1
Ben	Registered	1	1	1	1
Rajgir	Registered	1	1	1	1
Silao	Registered	1	1	1	1
Giriak	Registered	1	1	1	1
Katrisarai	Registered	1	1	1	1

Note: S-sanctioned, IP-In Position

1.4 Program Finance

Funds are released to District through two separate channels, i.e.; through the state budget and directly through the State Health Society.

2.Situational Analysis of Key RHC Indicators

2.1 Maternal Health

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

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

- High levels of prevalence of malnutrition (anemia) among women in the reproductive age group
- Poor communication because of bad roads and a law and order situation.

One of the very good things happen to maternal health is introduction of JBSY.

2.2 Child Health

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

Maternal Factors

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

Family Planning Services

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

Child Health Services

The programme has not succeeded fully in effectively promoting colostrums feeding immediately afterbirth and exclusive breastfeeding despite almost universal breastfeeding practice in the state. In the State majority of mother breast feed children beyond six months. However both State and Unicef have taken initiative to generate awareness among mothers for exclusive breast feeding.

- High levels of child malnutrition, particularly in rural areas and in children belonging to disadvantaged socio-economic groups leading to a disproportionate increase in under five mortality.
- Persistently low levels of child immunization primarily due to non-availability of timely and quality immunization services.
- Lack of child health facilities, both infrastructure and human resource, to provide curative services for common childhood ailments such as ARI, Diarrhea, etc.
- Inadequate supply of drugs, ORS packets, weighing scales, etc.
- Lack of knowledge of basic child health care practices among the community.
- Failure to generate community awareness regarding essential sanitation and hygiene practices that impact on the health of children.

IMNCI Training: IMNCI training has successfully started in the District . In 2011-12 ,DHS Nalanda proposes to establish Nutritional Rehabilitation Centre in Nalanda district . In this project special nutritious food provided to the severel malnutrition children.

2.3 Family Planning

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 intervalsbetween pregnancies.

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

- Lack of integration of the Family Planning programmes with other RCH components, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels.
- Failure of the programme to effectively undertake measures to increase median age at marriage and first childbirth.
- Inability of the programme to alter fertility preferences of eligible couples through effective behavior change communication (BCC).
- Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age groups. (Overall, sterilization accounts for 82 percent of total contraceptive use. 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 Nalanda accredited 11 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 Nalanda made provision of fixed day family planning services at District hospitals, Sub divisional hospitals, FRUs, PHC and accredited private facilities.

2.4 Adolescent Reproductive & Sexual Health

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

Although it is a transitional phase from childhood to adulthood, it is the time that the adolescents experience critical and defining life events – first sexual relations, first marriage, first childbearing and parenthood. It is a critical period which lays the foundation for reproductive health of the individual's lifetime. Therefore, adolescent reproductive and sexual health involves a specific set of needs distinct from adult needs. The reproductive health needs of adolescents as a group has been largely ignored to date by existing reproductive health services. Many adolescents in India face reproductive and other health risks. Poor nutrition and lack of information about proper diets increase the risk of iron-deficiency anemia for adolescent girls. Young women and men commonly have reproductive tract infections (RTIs) and sexually transmitted infections (STIs), but do not regularly seek treatment despite concerns about how these infections may affect their fertility. India also has one of the highest rates of early marriage and childbearing, and a very high rate of iron deficiency anemia. The prevalence of early marriage in India poses serious health problems for girls, including a significant increase of maternal or infant mortality and morbidities during childbirth. The following facts will help understand the situation objectively.

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

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

social status of women in India. Overall for young women, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children's quality of life.

In many societies, adolescents face pressures to engage in sexual activity. Young women, particularly low income adolescents are especially vulnerable. Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting sexually transmitted diseases, including HIV/AIDS; and they are typically poorly informed about how to protect themselves.

To meet the reproductive and sexual health needs of adolescents, information and education should be provided to them to help them attain a certain level of maturity required to make responsible decisions. In particular, information and education should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction.

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

Being a sensitive and often, controversial area, adolescent reproductive and sexual health issues and information are very often difficult to handle and disseminate. Furthermore, the contents do not only deal with factual and knowledge-based information but more importantly, need to deal with attitudinal and behavioral components of the educational process. Thus it can be conclusively stated that adolescents are a diverse group, and their diversity must be considered when planning programs. Adolescents, the segment of the population in the age group of 15 -19 years, constitute about 23% of the population of the state. This group is critical to the success of any reproductive and sexual health programme, as it would remain in the reproductive age group for more than two decades. Early marriages seem to be still a key problem. Percentage of boys who are married

before attaining 21 years in consistently high in most districts. The mean age of marriage for girls is 16.9. 25% pregnant mothers in the state are in the age group of 15-19 years. This is due to the reason that most of the girl's married before18 years. The various anecdotal evidences emerging from the community level participatory planning exercises and opinions voiced by the various levels of health officials during consultation exercise indicate that there is lack of a cohesive ARSH strategy at the state level. Possibility of bifurcating the total target into school going and out of school going adolescents have not been examined as a strategy option. Hence the current school health program by and large lacks any adolescent oriented interventions.

The possibility of convergence between the RCH II program priorities and NACP priorities require to be integrated.

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

2.5 Health Infrastructure and Facilities of Nalanda

District Hospitals: Nalanda district has one District Hospital which is situated in District head quarter Biharsharif. As per IPHS norms there is a some shortage of manpower like specialties doctors and Paramedics. Dispite all constraints sadar hospital is providing all health facilities.

Sub District Hospitals: At present there are Two Sub Divisional Hospital in Nalanda district namely ***Hilsa*** and the ***Rajgir.***

Referral Hospitals: There are 3 referral Hospitals in Nalanda District namely as Asthawan,Rajgir and Islampur. Islampur referral has not good position.These referral hospitals get patient from PHCs, APHCs and are covered by specialised services.

Block PHCs: At present there are 20 in the district.These PHCs require to be upgraded at CHC level for specialised Services. These upgraded new PHC require proper building infrastructure as per IPHS norms. It is proposed in PIP 2011-12.

Additional PHCs: The total no. of Additional PHC is 44. These Additional PHCs only provide OPD services. All these APHCs require functionalizing the inpatient for providing deliver services and reduce the load of Block PHCs.

HSCs: At present there are 370 HSCs in the district. Half of the HSCs are running from the rented place or Panchayat office. Mostly these HSCs are manned by one ANM only.

Infection Management and Environmental Plan:

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

2.6 Human Resource Development including Training

Human Resource Development forms one of the key components of the overall architectural corrections envisaged by both the RCH II and NRHM programs.

Though the district has reasonable number of MBBS doctors, there is an acute shortage of specialized medical manpower. The shortage of specialists like obstetricians and Anesthetists are obstructing the district plans to operationalise all hospitals at full swing.

Trainings as per GoI guidelines on Immunization, IMNCI, EmOC, LSAS, SBA and Minilap/MVA etc have been taken up with full vigor. It is proposed to continue these trainings in 2010-11.

2.7. Inequity and Gender

2.7.1Ensuring Gender Equity

One of the broad indicators for measuring gender disparity is the sex ratio. The sex ratio in Bihar is unfavorable to women. Analysis of other indicators on the basis of gender reveals widening gaps between the sexes. While NMR for females is marginally higher than that of males, it widens further for the IMR, and even further for the under-five Mortality Rate. In conditions of absolute poverty, where resources to food and health care are severely limited, preference is given to the male child, resulting in higher female malnutrition, morbidity and mortality. Gender discrimination continues throughout the life cycle, as well. Women are denied access to education, health care and nutrition. While the state's literacy rate is 47.5%, that for women in rural areas is as low as 30.03%. Abysmally low literacy levels, particularly among women in the marginalized sections of society have a major impact on the health and well being of families. Low literacy rate impacts on the age of marriage. The demand pattern for health services is also low in the poor and less literate sections of society.

Women in the reproductive age group, have little control over their fertility, for want of knowledge of family planning methods, lack of access to contraceptive services and male control over decisions to limit family size. According to NFHS data, for 13% of the births, the mothers did not want the pregnancy at all. Even where family planning methods are adopted, these remain primarily the concern of women, and female sterilization accounts for 19% of FP methods used as against male sterilization, which is as low as 1%. In terms of nutritional status too, a large proportion of women in Bihar suffers from moderate to severe malnutrition. Anemia is a serious problem among women in every population group in the state, with prevalence ranging from 50% to 87% and is more acute for pregnant women.

In all the programmes efforts will be made to meet the needs of vulnerable groups and ensure equity. Gender sensitization shall be made part of each training. The monitoring system too will be geared for this so that we may get disaggregated data. The state of Bihar is implementing the PC- PNDT Act at right earnest. The MOs are being trained by the State Health and Family Welfare Institute. The Civil

Surgeon is the nodal person in the district in this regard. However monitoring of the activity is still a big problem and requires to improve.

2.7.2 Urban Slums

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

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

2.8 Logistics

Validation of equipments and drugs procurement is within the domain of state level decision making. The Districts generally purchase the requirements and distributed to the other Health institutes mostly Block PHCs. However stock out of drugs still a problem for concern and require insurability of drug availability in the health institutes. There should provision of contingency funds for emergency drugs at the district level and health facilities.

Under NRHM there is scope for huge and rapid flow of materials from the MOHFW, GOI and the State level.RCH Kit A & Kit B are being supplied by MOHFW, GOI.

District and the peripheral institutions need to be strengthened through capacity building for enhancing their capabilities of indenting, procurement, inventory management and distribution of drugs and supplies and maintenance of medical equipment and transport. Cold Chain Vans are available in the districts for

distribution of Vaccines to PHCs/ HSCs during vaccination programs and camps. Generally PHC vehicles are used to collect the drugs and supplies from the district store. Currently local purchase of drugs and supplies are not approved. Drugs, consumables, and vaccines are directly supplied by the districts for HSCs, PHCs and other facilities very irregularly. There is need to streamline the process for estimation and indenting of vaccines, drugs and supply of consumables. The supply system would ensure smooth flow of indented materials as per guidelines from state to all levels of utilization.

2.9 HMIS and Monitoring & Evaluation

The National Rural Health Mission has been launched with the aim to provide effective health care to rural population. The programme seeks to decentralize with adequate devolution of powers and delegation of responsibilities has to have an appropriate implementation mechanism that is accountable. In order to facilitate this process the NRHM has proposed a structure right from the village to the national levels with details on key functions and financial powers. To capacitate the effective delivery of the programme there is a need of proper HMIS system so that regular monitoring, timely review of the NRHM activities should be carried out. The quality of MIES in districts is very poor. Reporting and recording of RCH formats (Plan and monthly reporting) are irregular, incomplete, and inconsistent. Formats are not filled up completely at the sub center level. There information is not properly reviewed at the PHC level. No feedback is provided upon that information.

For overall management of the programme, there is a Mission Directorate and a State Programme Management Unit in the state. .At district level, there is a District Health Society who will be responsible for the data dissemination from the sub-district level to the district level. District M & E Officer at the district level and Accountant cum M& E Officer at block level will be responsible for management of HMIS.As such, there is a Monitoring Team constituted district level as well as block level to monitor the implementation of the NRHM activities. There is a Hospital Management Committee/Rogi Kalyan Samiti at all PHCs and CHCs. The PHC / CHC Health Committee will monitor the performance of HSC under their jurisdiction and will submit the report and evaluate the HSC performance, and will be submitted to the District, which will compile and sent it to the State.

2.10 Behaviour Change Communication

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

The IEC logistic is designed, developed and procured at the district level and distributed to the PHC in an adhoc manner. However some activity is done at the state level. There is no credible study available to identify the areas / region specific knowledge, attitudes and practices pertaining to various focus areas of interventions like breast feeding, community & family practice regarding handling of infants, ARSH issues etc. At present there is no impact assessment of the IEC and BCC activities. It's very important to assess the impact of IEC/BCC activities, resources and methods to undertake mid way corrective measures.

2.11 Convergence/Coordination

Convergence with ICDS has been taken care of to cover immunization and ANC Service. ASHA, AWW and ANMs together hold monthly meetings with Mahila Mandals under MUSKAAN Programme. Government of Bihar has decided to merge "Village Health and Sanitation Committee" with "*Lok Swasthya Pariwar Kalyan and Gramin Swaschata Samiti*" constituted by Department of Panchayat Raj in Bihar.

There are 249 PRIs in Nalanda district. VH & SC are constituted in all panchayat.

3. Progress from RCH II Implementation of 2005-09

3.1 Major achievements during 2005-09

1. District Health Societies formed & registered.

2. ASHA: A total of 2334 ASHAs selected against the total revised target of 2365

3. DPM & BPMU: The district DPMU staff (DPM, DAM,DM&E) & block BPMU (HM & Accountant)have been recruited. The orientation training for all has been completed.

4. Free drug distribution of essential drugs started from 1st July 2006 and 24 hours presence of doctors ensured in all facilities up to PHC level resulting in unprecedented increase in OPD patients. Free drug list has been expanded 46 OPD and 193 IPD drugs at DH and 33 OPD and 37 drugs IPD at PHC.OPD Performance of last three is as below:-

Sl.No.	Year	No. of OPD
1	2006-07	6,02,018
2	2007-08	6,28,166
3	2008-09	7,27,278
4	2009-10	14,57,273
5	2010-11(upto Nov-10)	1530933

5. Routine Immunization: Full immunization percentage increased to 41.4% (DLHS). Use of ADSyringe increased to 95%.

Sl.No.	YEAR	BCG	DPT	POLIO	DT	VITAMIN A	TT
1	2006-07	70649	68202	67610	63057	22233	34730
2	2007-08	66055	62143	50210	45412	6945	81846
3	2008-09	53265	40723	46431	17500	35280	62025
4	2009-10	56554	62698	60528	33806	2483	42165
5	2010-11 (upto oct-09)	39184	33485	31198	1050	699	37800

6. Institutional delivery has increasesd manifold.

Sl. No.	Year	No. of Delivery
1.	2006-07	20322
2.	2007-08	28070
3.	2008-09	35388
4.	2009-10	33173
5.	2010-11(upto Nov.-10)	31736

7. Increase no. of family planning in district .

Sl. No.	Year	No. of FP
1.	2006-07	4399
2.	2007-08	5526
3.	2008-09	8089
4.	2009-10	12030
5.	2009-10(upto Nov.-10)	5143

8. Rogi Kalyan Samitis formed in all health facilities till PHC level, registration of RKS completed .

9. Establishment of labour room with latest equipment is under progress.

10. Operationalisation 24 x 7. Detail is as follow

SUB DIVISIONAL HOSPITAL		**CHC**		**PHC**		**APHC**	
TOTAL NUMBER	NUMBER OF SDH WITH 24 X 7 FACILITIES	TOTAL NUMBER	NUMBER OF CHC WITH 24 X 7 FACILITIES	TOTAL NUMBER	NUMBER OF PHC WITH 24 X 7 FACILITIES	TOTAL NUMBER	NUMBER OF APHC WITH 24 X 7 FACILITIES
1	1	3	3	20	20	43	0

11. Contractual Appointment

Sl. No.	Name of Post	No. Sanctioned	No. Selected
1.	DPM	1	1
2.	DAM	1	1
3.	DM&E	1	1
4.	Hospital Manager	2	2
5.	DPC	1	1
6.	DCM	1	1
7.	DDA	1	1
8.	Doctor	95	93
9.	Staff Nurse	88	80
10.	ANM	370	289
11.	Health Manager	20	20
12.	Accountant	20	20
13.	ASHA	2365	2351
14.	MAMTA	128	**128**

15. Constitution of VH & SC in district- There are 249 panchayat in Nalanda district . VH & SC is constituted in all 249 panchayat.

3.2 MAJOR OBASTACLE IN PATH OF PROGRESS FOR DISTRICT

Some of the things which didn't work in last three years are:-

i. Construction & Renovation- Slow progress in Infrastructure due heavy work load to working agency.

ii. BCC/IEC strategy formulation.

iii. The quality of training. It needs establishment of training cell in district with a nodal officer.

iv. Keeping up the motivational level of health staff at all levels.

v. Utilization of trained staff (It is sub optimal now).

vi. Mismatch of personnel and equipment.

vii. Lack of Proper monitoring and evaluation framework.

viii. Acceptance of Private Partners the district level

4. RCH II Programme Objectives and Strategies

4.1 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.

5 Technical Objectives, Strategies and Activities

5.1 Maternal Health

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

Objectives:

1. To increase 3 ANC coverage from 26.4% to 75% by 2010-11.

2. To increase the consumption of IFA tablets for 90 days from present level of 9.7% to 35% by 2010-11.

3. To reduce anemia among pregnant mothers from 60.2% to 40% by 2010-11.

4. To increase institutional delivery from 70% to 85% by 2010-11

5. To increase birth assisted by trained health personnel from 31.9% to 45%.

6. To increase the coverage of Post Natal Care from 26% to 55% by 2010-11

7. To reduce incidence of RTI/STI cases.

8. To reduce the no. of unsafe abortions.

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

Objective No. 1: To increase 3 ANC coverage from 26.4% to 75% by 2011-12.

Strategies and Activities:

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

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

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

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

1.2 Improved Access of ANC Care.

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

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

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

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

1.2.5 Organizing RCH camp in Each Block PHC areas.

1.2.6 Tracking of Pregnant mothers by ASHAs.

1.3 Ensure quality service and Monitoring of ANC Care.

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

1.3.2 Involvement of PRIs in monitoring the ANMs service through convergence.

1.3.3 Refresher training of ANMs on ANC care.

1.3.4 Proper maintenance of ANC Register and Eligible couple register.

1.4 Strengthening of Health Sub Centre

1.4.1 Repair and Renovation of Sub Centers

1.4.2 Provide equipments like BP Apparatus, Weighing machines, Heamoglobinometer etc to the Sub Centers.

1.4.3 Timely supply of Drug Kit A and Kit B

1.5 Generate Awareness for ANC Service

1.5.1 Convergences meeting with AWWs, ASHAs, PRI Members, NGOs at the Gram Panchayat level byANMs. These meetings will also attended by MOs from Additional PHC`s.

1.5.2 Tracking of Pregnant mothers by ASHA, ANM and AWWs though organizing Mahila Mandals meeting. Incentive for ASHAs and ANMs to give for the initiative. This initiative is under MUSKAAN Programme. Incentive for ASHA will be taken care under Intersectoral Convergence.

1.5.3 Counseling by ASHAs and ANMs to the pregnant mothers, mothers and Mother in Laws.

Objective No. 2: To increase the consumption of IFA tablets for 90 days from present level of 9.7% to 35% by 2011-12.

Strategies and Activities:

2.1 Purchase and Supply of IFA Tablets

2.1.1To include IFA under essential drug list

2.1.2 Timely supply of IFA Tablets to the Health Institutions (Ensuring no stock out of IFA at every level down to Sub-Centre Level)

2.1.3 District to purchase IFA tablets in the case of stock out.

2.1.4 Convergence with ICDS and Education for regular supply of IFA tablets through AWWCs And Schools for the pregnant and lactating women, children 1-3 years and adolescent girls.

2.2 Awareness generation for consumption of IFA Tablets.

2.2.1 Pregnant mothers will be made aware for consumption of IFA tablets for 90 days.

2.2.2 ASHA and AWWs will generate awareness along with ANMs at the Village level.

2.2.3 Ensure utilizing the platform of Mahila Mandal meetings being held every third Wednesday.

Objective No.3: To reduce anemia among pregnant mothers from 60.2% to 40% by 2011-12.

3.1 Supplementing IFA tablets consumption with other clinical strategies.

3.1.1 Half yearly de-worming of all adolescent girls.

3.1.2 Training of ANM, AWW and ASHA on module on EDPT (Early Diagnosis and Prompt Treatment) of anemia.

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

3.2 Other strategies.

3.2.1 Refer severely Anemic Pregnant Mothers to referral centers.

3.2.2 IPC based IEC campaigns emphasizing on consumption of locally available iron rich foodstuff. Details given under Special Scheme on Anemia Control in Part

B.

Objective No. 4: To increase institutional delivery from 70% to 85% by 2011-12 (MIS data) and to increase facilities for Emergency Obstetric Care (EmOC)

Strategies and Activities:

The strategies will lead to up gradation and operationalization of the facilities to increase institutional deliveries along with providing EmOC and emergency care of sick children. These facilities will also provide entire range of Family Planning Services, safe MTPs, and RTI/STI Services.

4.1 Upgrading Block PHCs/CHCs in to FRUs

4.1.1 Provision of OT and lab facility by upgrading 76 FRUs

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

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

2. All CHC / PHCs have blood storage facility

4.1.3 Training of MOs on Obs.& Gynae and Anesthesia

1. 18-week Life Saving Anesthetic Skills (LSAS) training for MBBS Doctors

2. 16 week -Emergency Obstetric Skill training for MBBS doctors

3. 3 days training of doctors and nurses posted at FRUs for the neonatal stabilization unit

4.1.4 Repair and renovations of FRUs

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

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

4.1.7 Accreditation of FRUs

4.2 Operationalization of 24x7 facilities at the PHC level

4.2.1 Training of MOs and Staff Nurses of PHCs in BEmOC

4.2.2 Appointment of at least 3 Staff Nurse in each PHCs

4.2.3 Repair and renovation of PHCs

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

4.2.5 Training of MOs, Staff Nurses on SBA

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

4.3.1 Strengthening JBSY Scheme

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

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

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

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

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

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

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

4.4 Provision of Referral Support system

4.4.1 Provision of a dedicated referral transport system for the newborns and pregnant women to refer them from Home/HSCs/PHCs to referral centers.

4.4.2 Monitoring of referral transport system

4.4.3 Development of proper referral system between Health Institutions.

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

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

Strategies and Activities:

5.1 Ensure safe delivery at Home

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

5.1.2 Training of ANMs on SBA

1. Providing SBA with approved drug kits, in order to deal with emergencies, like post-partum hemorrhage, eclempsia, and puerperal sepsis

2. Ensuring regular supply of these drugs to the SBA

5.1.3 Supply of adequate DD Kits to ANMs, LHVs.

5.2 Provision of delivery at HSC level

5.2.1 Supply of DDkits to HSCs

5.2.2 Delivery tables to be provided to the HSCs

Objective No.6: To increase the coverage of Post Natal Care from 26% to 55% by 2011-12.

Strategies and Activities

6.1 Ensuring proper practice of PNC services and follows ups at the health facility level.

6.1.1 Refresher sessions for all ANMs on uniform guidelines to be followed for PNC care – all delivery cases to remain at facility for minimum 6 hours after normal delivery and to be recalled to facility for check up with 4 days and after 42 days.

6.1.2 Ensuring follow up PNC care through out reach services (ANM) for delivery cases where the patient does not return to facility for follow up check ups.

6.1.3 Referral of all complicated PNC cases to FRU level.

6.1.4 LHV and MO to monitor and report on PNC coverage during their field visits

6.2 Utilizing the ASHA network to strengthen the follow up of PNC services through tracking of cases, mobilization to facilities and providing IPC based education / counseling.

6.2.1 Utilize ASHA to ensure 3 PNC visits by the ANM for home delivery cases (1st within 2 days, 2nd within 4 days and 3rd within 42 days of delivery) and 2 follow up visits for institutional delivery cases.

6.2.2 Counseling of all pregnant women on ANC and PNC during monthly meetings of MSS and during VHND.

6.2.3 Linking of ASHA's incentives on institutional deliveries to completion of the PNC follow-ups.

6.3 Basis Orientation of AWWs on identifying Post-partum and neonatal danger signs during her scheduled visits following delivery

6.3.1 Basic orientation on IMNCI – in order to be able to alert the beneficiary and coordinate with ASHA and ANM (to avoid undue delay)

6.3.2 Basic orientation on identifying post-partum danger signs, specially, for home based deliveries, such that the she can alert ASHA, ANM or the local PHC towards avoiding undue delay

Objective No. 7: Reduce incidence of RTI/STI

Strategies and Activities

7.1 Ensuring early detection through regular screenings and contact surveillance strategies.

7.1.1 Early diagnosis of RTI / STI through early detection of potential cases through syndromic approach and referral by ANM and ASHA.

7.1.2 Conducting VDRL test for all pregnant women as a part of ANC services.

7.1.3 Implementing contact surveillance of at risk groups in convergence with Bihar AIDS Control Society.

7.2 Strengthening the infrastructure, service delivery mechanism and capacity of field level staff for handling of RTI / STI cases.

7.2.1 Conducting community level RTI / STI clinics at PHCs

7.2.2 Training to all MOs at PHC / DH level in Management of RTI / STI cases in coordination with Bihar AIDS control Society.

7.2.3 Training of frontline staff, LHV, ANM and ASHA in identifying suspected cases of RTI / STI in coordination with Bihar AIDS Control Society.

7.2.4 Strengthening RTI / STI clinic of the District Hospitals

Objective No. 8 –Reduce incidence of unsafe abortion

Strategies and activities

8.1 Early diagnosis of pregnancy using Nischay pregnancy testing kits

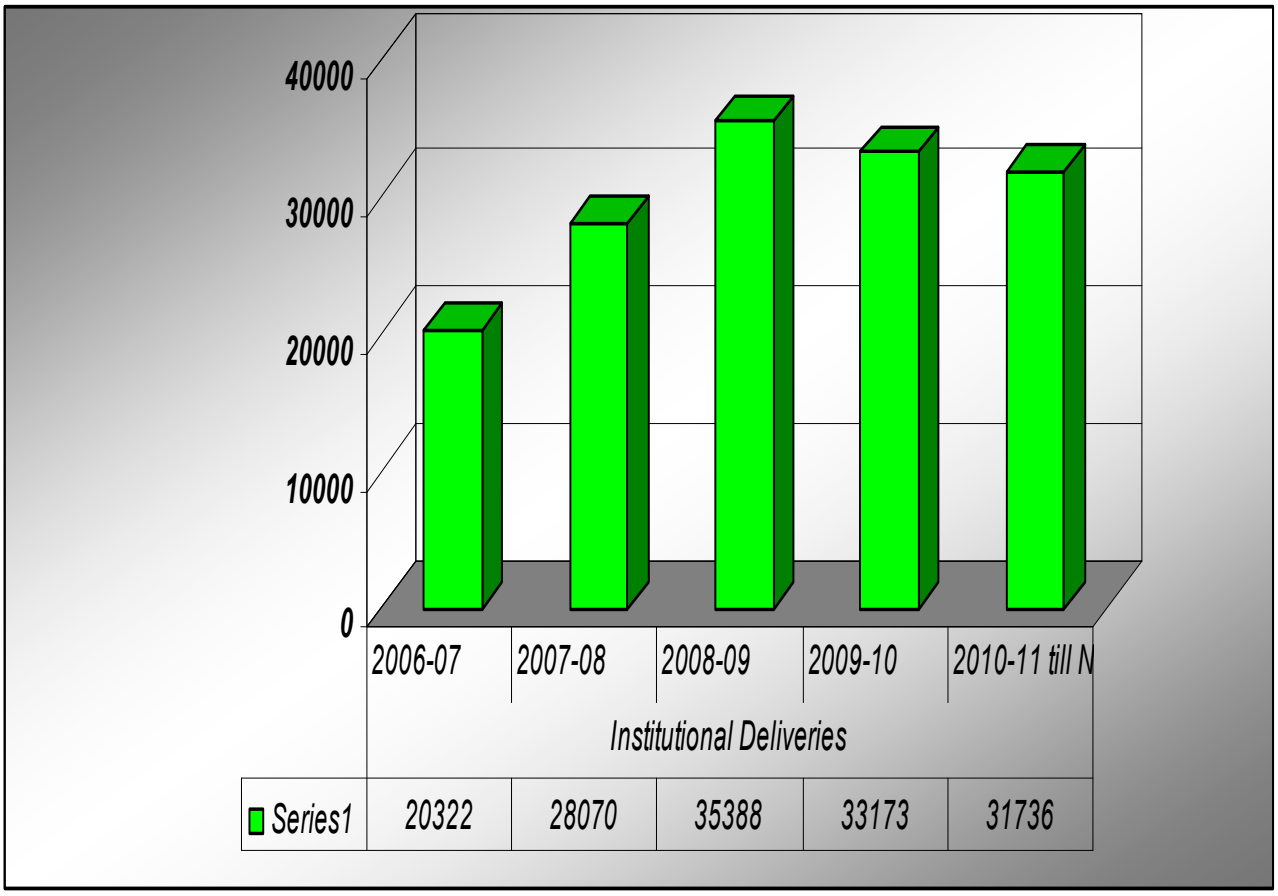
8.2 Counselling and proper referral for termination of pregnancy in 1st trimester if the woman wishes so

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

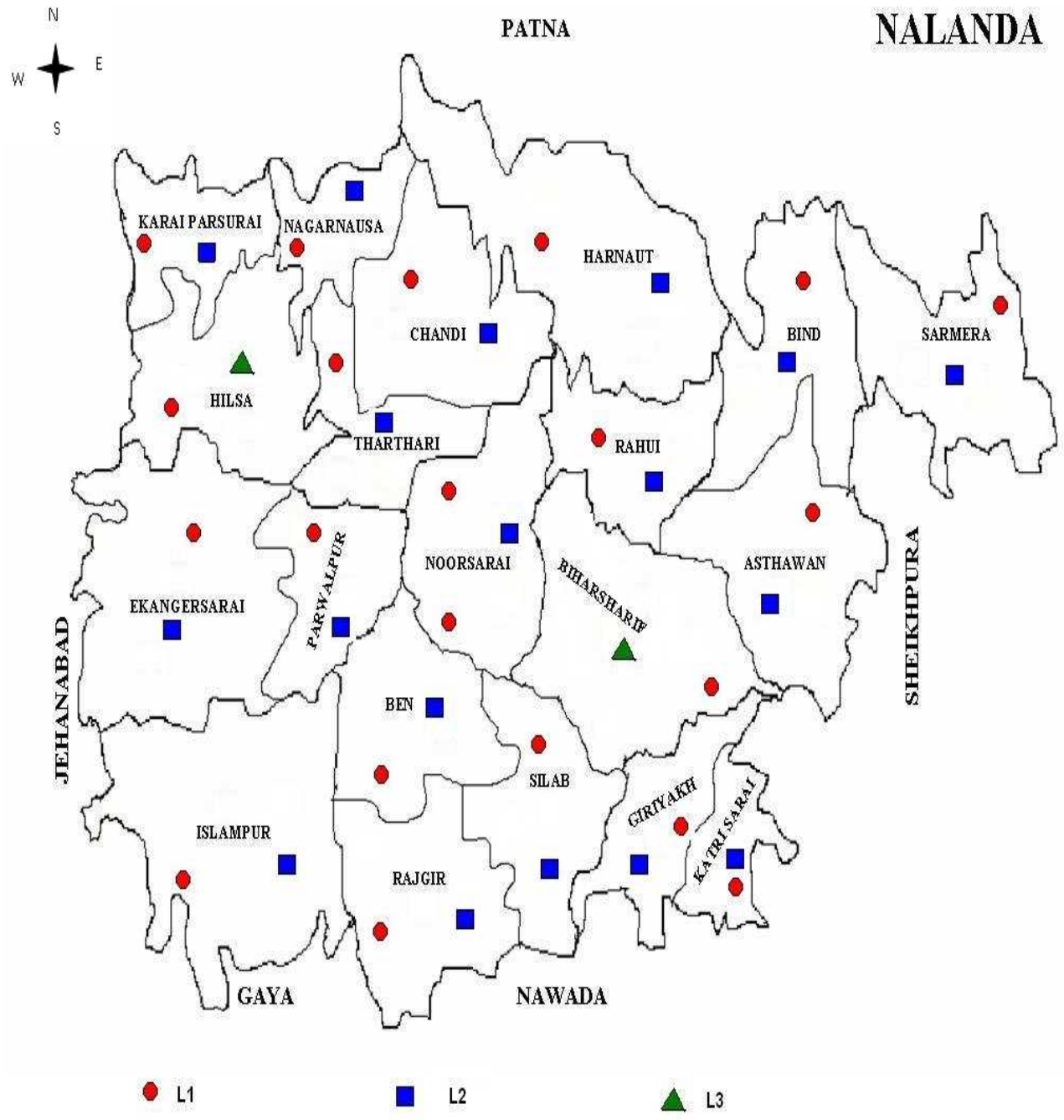
8.2.2 Procurement and availability of MVA at the designated facilities.

24 x 7 Health Services is available in 20 Primary Health Centres of the District Nalanda.

The total no. of **institutional delivery** has increased from 20322 in the year 2006-07 to 33173 in 2009-10, while the total no. of deliveries from April to November 2010 is 31736.



Level 1,2 & 3 facilities selected for 24*7 institutional delivery



L1 - HSC

L2 - PHC

L3 - District Hospital / Sub Divisional Hospital

5.2. Child Health

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

Objectives:

1. To reduce low birth weight baby's by supplementing nutritional support to pregnant mothers

2. To increase exclusive breast feeding from 38.4% to 75% by 2011-12.

3. To reduce incidence of underweight children (up to 3 years age) from 58.4% to 40% by 2011-12.

4. To strengthen neonatal care services in all PHCs/CHCs/SDHs by setting newborn care centers & having trained manpower therein.

5. To reduce the prevalence of anaemia among children from 87.6% to 60% by 2011-12.

6. To increase full immunization of Children from 41.4%% to 70% by 2011-12.

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

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

Strategies and Activities:

1.1 Convergence with ICDS, supplementary diet which is being given by AWW to pregnant mothers may be improved.

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

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

Objective No. 2: To increase exclusive breast feeding from 27.9% to 50% by 2011-12

Strategies and Activities:

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

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

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

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

2.2 Increase community awareness about correct breastfeeding practices through traditional media

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

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

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

Strategies and Activities:

3.1. Growth monitoring of each child

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

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

3.2 Referral for supplementary nutrition and medical care

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

3.2.2 Establishment of 10 Nutrition Rehabilitation Centers in Districts having severe problems of malnutrition and continue of 8 existing Centers (A Special Scheme taken up and put under NRHM B)

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

Strategies and Activities:

4.1. Strengthen institutional facilities for provision of new born care

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

5. 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 NRHMAdditionalities.

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

Strategies and Activities

Details in special programme for "**Strenthening of Routine Immunisation** " under NRHM Part C

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

Strategies and Activities:

7.1 Increase acceptance of ORS

7.1.1 Supply of ORS and ensure availability in all depots and supply of cotrimoxazole tablets. The ASHA drug kit will have ORS and cotrimoxazole tablets which should be replenished as per need.Aaganwadi centers should also be

given ORS. In the absence of ORS, the use of home-based sugar and salt solution will be encouraged.

7.1.2 Orientation of ASHA for diarrhea and ARI symptoms and treatment

ASHAs will be specifically trained to identify symptoms of diarrhea and ARI and to provide home-basedcare. Danger signs prompting transportation to seek medical care will also be taught to ASHAs.

7.1.3 Organize meetings for ASHAs/AWWs for dissemination of guidelines for Home based careASHA and AWW will be trained and provide guidelines for Home based care. The meeting will be held at Block PHC level.

A detail Action Plan for ORS submitted under Part B of NRHM Additionalities

7.2 Strengthening of referral services for infants seeking care for life threatening diarrhoea and ARI

7.2.1 Availability of referral money @ Rs.500 available for transporting of sick infants to the health institute.

7.2.2 Blood slide examination of all febrile children with presumptive treatment

In endemic areas, most children are anemic due to repeated bouts of malaria. Any febrile child needs to be checked for malaria compulsorily.

7.2.1 Strengthening of PHCs/ referral centers

School Health Programmes (Health Check up under MDM)

As part of the School Health Programme, adolescents in schools will undergo health check ups thrice in a year. Some counseling related to common adolescent problems will also be given during these check ups.Children are the asset and future of the Nation. The progress of any country and state depends upon them for which they must remain healthy. In Bihar there are about 1.5 crore children of 6-14 years age reading in government primary & middle schools. The health check-up of these children are must at least once in a year to detect any serious disease in the early stage, so that preventive and curative measures may be taken at the earliest. For this objective in mind government has decided to do medical health check-up of children reading in government primary and middle schools.

OBJECTIVE:

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

Additionally Counseling sessions will be organized in Govt. Schools in collaboration with BSACS. 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

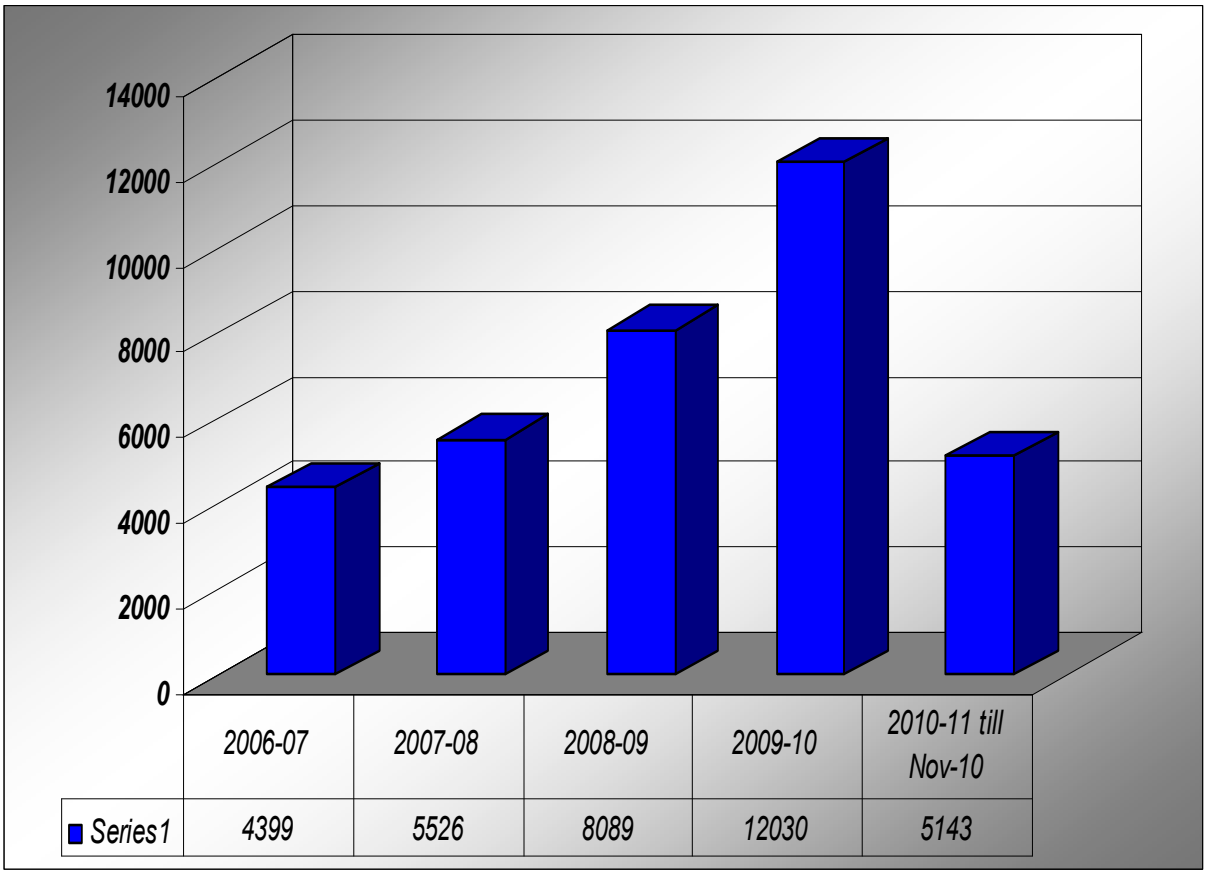
Camps will be organized for health check-ups for school children. Innovative strategies will be adopted to orient school children about healthy practices.

5.3 Family Planning

Goal: Reduce TFR by 2.1 from present level of 4.3

The total no. of Family Planning operations has increased from 4399 in 2006-07 to 12030 in 2009-10, and from Apr. to Nov. 2010 a total of 5143 operations have been done.

Family Planning/Sterilization from 2006-07 to till Nov. 2010-11



Objectives:

1. To reduce total unmet need for contraception from 23.1 % to 15%

2. To increase Contraceptive Prevalence Rate (Any Modern Method) from 28.8% to 35% by 2008-09 and to 45% by 2009-10

3. To increase male participation in family planning

4. To increase proportion of male sterilizations from 0.6% to 1.5%.

5. Monitor the quality of service as per GoI guidelines for Sterilization

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

Strategies and Activities

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

1.1.1. Creating dedicated cadre of skilled manpower

1. Training of MBBS doctors on Minilap and NSV

2. Training of MBBS doctors on Anesthesia

3. Training on IUCD: MOs, ANMs etc.

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

1.1.3 Incentive to acceptors Incentive for LL operations

1.1.4 Training on LL operation, MTP and IUD Insertion

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

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

1.2.1 Update EC register with help of ASHAs and AWW

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

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

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

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

1.2.2.3 Public Private Partnership (Social marketing): This can be taken up on an experimental basis in couple of districts, or a few blocks in these districts to pilot selling through entrusted community based institutions, volunteers, market mechanisms (like the popular pharmacist of the village, or grocery shop owner or the like) condoms and OCPs at normal or subsidized rates. This should be properly preceded by adequate awareness generation of the availability of these for price in the community itself and that the clients or the community members could buy these from specified vendors (volunteers etc.). The research has shown that the services, drugs, supplies etc. bought for fee are valued more by the user and they use them more.

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

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

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

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

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

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

1.3.1 Update EC register with help of ASHAs and AWW

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

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

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

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

1.4 Making available MTP Services in all Health Institutions.

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

1.4.1 MTP Services in the state is not fully operational in all the hospitals of the state. Training of MOs has been under taken during RCH-1. To further strengthen

the skill of the doctors for MTP training, training shall be taken up during the year. 100 MOs will be trained in 2008-09.

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

Objective No.2: To increase Couple Protection Rate

Strategies and Activities

2.1 Awareness generation in community for small family norm

2.1.1 Preparation of communication material for radio, newspapers, posters

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

2.1.2 Meetings with MSS, CBOs

Communication materials to be used for monthly MSS/CBO meetings will be prepared and distributed for use.

These meetings will be scheduled during or preceding the month family planning camps are scheduled to beheld.

2.2 Regularize supply of contraceptives in adequate amounts

2.2.1 Indent and supply contraceptives for all depots and sub centre/ AWCs and social outlets: Each AWC and ASHA will have at least one month's requirement of condoms and OCPs. Sub centers will have adequate supplies of IUDs also.

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

Strategies and Activities

3.1 Promote the use of condoms

3.1.1 Counseling men in villages to demonstrate ease of use of condoms and for prevention of STDs Male workers will assist the MPWs in addressing the meetings of men in villages to demonstrate the use of condoms and its benefits in family planning and prevention of STDs.

3.1.2 Regular supply of condoms and setting up depots which are socially accessible to all men.

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

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

4.1 Increase demand for NSVs (develop a cadre of satisfied NSV Client, who could be the advocates for NSV in their designated geographical areas. Orient and train them and give them specific geographical responsibility to give roster based talks etc to identified groups of probable clients.)

4.1.1 Village level meetings in which men who already underwent NSV share experiences to motivate men to undergo NSV

4.2 Increase capacity for NSV services

4.2.1 Training of doctors for NSV While demand is being generated, a team of doctors should be trained at all the FRU level to conduct NSVs.

4.2.2 Organize NSV camps at the Sub District Level.

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

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

5.2 Streamline the contraceptive supply chain & Monitoring

1. Identifications &Renovation of Warehouse – District/ PHC

2. Budget allocation for transportation at every level

3. Provision for report format printing and their availability at every level

5.4. Adolescent Reproductive and Sexual Health

Objective:

1. To reduce incidence of teenage pregnancies from present 25% to 22% by 2008-09 and to 15% by 2009-10.

2. To ensure the access to information on Adolescent Reproductive & Sexual Health (ARSH) through services at District Hospitals, SDH, CHCs, PHCs & HSC level.

3. To increase awareness levels on adolescent health issues

Objective No.1: To reduce incidences of teenage pregnancies from present 25% to 15% by 2011-12.

Strategies and Activities:

1.1 Improve access to safe abortions

1.1.1 MTP services made available at all the FRUs initially & at all SDHs in subsequent years, through training of select medical officers at DH/MC.MOs will be trained in MTPs

1.1.2 Manpower (Training) & logistic support to private hospital doctors and will also be trained in conducting safe abortions.

1.2 Ensure availability of condoms/OCPs/Emergency contraceptives

1.2.1 Depot holders among adolescent groups/youth organizations

In addition to the ASHA and the AWW, youth organizations such as football clubs and others will have depot holders who will provide condoms/OCPs and Emergency contraceptive pills and maintain confidentiality.

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

Strategies and Activities

2.1. Organize regular adolescent clinics/counseling camps at SC/PHC/CHC/SDH/DH

2.1.1 Appointment of 5 nos. Adolescent Counselor for districts setting up Adolescent clinics.

2.1.2 Adolescent health sessions/clinics will be held in each Sub Centre/ PHC / CHC/SDH and DH with service delivery & referral support

2.1.3 Risk reduction counseling for STI/RTI

During the monthly or weekly interactions through health sessions and clinics, counseling for preventing STI/RTI will be also be done. This will include single partner sex and use of condoms for safe sex.

2.2 ASHA/AWW to act as nodal persons at village level for identifying & referring adolescents in need of such services.

2.2.1 Training of AWW/ASHA in adolescent health issues

All ASHAs and AWWs will be oriented on problems faced by adolescents, signs and symptoms of the problems and where to refer these cases.

2.3 Referrals to de-addiction centers for treating alcoholism/drug addiction

2.3.1 Identification of de-addiction centers in the state/district

The state / district will identify NGOs or other de-addiction centers in the state and through the health workers will refer the cases in need to these centers for treatment.

2.3.2 Circulate information on services provided at these centers 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 centers.

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

Strategies and Activities

3.1 Organizing Behavioral Change Communication campaigns on specific problems of adolescents

3.1.1 IEC activities along with take-home print material to be organized in coordination with MSS, Youth club One of the monthly theme meetings with the

MSS / CBOs will be related to adolescent health problems, signs and symptoms, treatment and referrals.

3.1.2 4 monthly health checkups under School Health Programme through PHC medical and paramedical staff

3.1.3 Orientation of VHSC on adolescent issues

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

3.1.4 Premarital counseling of adolescent girls on reproductive health issues at PHC/RH/SDH/DH. This will be part of the adolescent health session/clinics which will be regularly conducted at sub centers, PHCs and also at youth clubs.

3.2 Dissemination of ARSH Guidelines and Trainings

3.2.1 Organize dissemination of ARSH guidelines at State level.

3.2.2 Training of TOTs on ARSH

3.2.3 Training of MOs, ANMs on ARSH

Proposed Strategies and Activities for Operationalization of ARSH

1. ARSH service delivery through the public health system:

a. Actions are proposed at the level of sub-centre, PHC, CHC, district hospitals through routine OPDs. Separate arrangements should be done for male and female adolescents.

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

c. A separate ARSH Cell, comprising of ANM, LHV, and Health Educators etc. can be established at these Cells.

d. A separate ARSH Cell can be constituted at every CHCs and Referral Units, with one MO assist nodal officer (on call, sort of) and two counselors.

2. Interventions to operationalise ARSH

a. Orientation of the service providers: Equipping the service providers with knowledge and skills is important. The core content of the orientation should be vulnerabilities of adolescents, need for services, and how to make existing services adolescent friendly.

b. Environment building activities: this should include orienting broad range of gatekeepers, like district officials, panchayat members, women's group and civil society. Proper communication messages should be prepared for the same exercise. District, block and subblocklevel functionaries should be responsible for this.

c. The MIS should at least capture information on teenage pregnancy, teenage institutional delivery and teenage prevention of STI.

5.5 Urban Health

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

Objectives:

1. 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 Centers (UHC) in the state which are non-functional. However, as per the GoI guidelines, there should be one UHC for 50,000 populations (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 Centers 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

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

1.1.1 Mapping of Urban Slums and existing providers of RCH services of both public and private sectors has been completed

1.1.2 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

1.2.1 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.

1.2.2 Collaborate with health facilities managed by large public sector undertakings such as Railways, ESIS, CGHS and Military to provide RCH services to general population from identified urban areas.

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

1.3.1 Deliver outreach services planned under RCH through reinforced network of frontline health service providers (ANMs, LHVs)

1.3.2 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)

1.3.3 Establish 20 Urban Health Centers on a rental basis under PPP in this financial year especially in districts 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

2.1 Use Multiple channels for delivery of key RCH messages in urban areas

2.1.1 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.

2.1.2 Extensive use of print media such as newspapers (particularly local newspapers), journals and magazines 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 Centers, private or Government

5.6 Vulnerable Groups Health Camps in Maha-Dalit Tola

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

5.7 PNDT Act

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

In order to arrest the abhorrent & growing menace of illegal termination of pregnancies as well that of prenatal diagnostic test ascertaining sex-selection, the Medical Termination of Pregnancy Act, 1971 read with Regulations & Rules 2003 and the pre-natal Diagnostic Techniques (Prohibition of sex selection)Act were formulated. The misuse of modern science & technology by preventing the birth of girl child by sex determination before birth & thereafter abortion is evident also from the fact that, there has been a decline in sex ratio despite the existing laws. The Apex court has observed that:-

"We may state that there is total slackness by the Administration in implementing the Act. Some learned counsel pointed out that even though the Genetic Counseling Centre, Genetic Laboratories or Genetic

Clinics are not registered, no action is taken as provided under Section 23 of the Act, but only a warning issued. In our view, those Centers which are not registered are required to be prosecuted by the Authorities

Under the provision of the Act and there is no question of issue of warning and to permit them to continue their illegal activities" .The apex court accordingly directed the central as well as state Governments to implement the PNDT Act. In Bihar too the concerned authorities have been directed to implement the provisions of the both the Acts force fully. Following actions have been taken and planned in this regard.

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

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

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

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

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.

5.9 Infrastructure and Human Resource

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

5.10 Institutional Strengthening

Sub-centre rent shall be provided for the HSCs operational in rented building.

5.11 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 the communication with the clients. The

TOTs will ensure that the trainers not only master the contents of the training topic but also acquire skills as teachers/trainers or facilitators and motivators.

5.12 IEC/BCC

The Annual Action Plan 2011-12 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.

PUBLICITY:

Print & Electronic Media – Materials will be developed and publicized on different issues eg. Dial 108(Ambulance Service), Dial 1911 (Doctor's Consultancy), ICU Service, JBSY, Promotion of Breast Feeding, Family Planning including Non Scalpel Vasectomy, Immunization, Urban Health, Adolescent and Sexual Reproductive Health, PNDT Act, Role of ASHA under NRHM, Role of Mamta, Importance of Super Speciality Hospitals and various PPP activities initiated by SHSB etc., through various print and electronic media.

Outdoor Media - Hoardings, Glow Signs, Laminated Board, Flex Banners, posters, etc., on issues related to RCH and NRHM will be put up at vantage points will be displayed at important locations like at District Offices, Block Offices, PHCs, Haat points, Bus Stands, Railway stations, etc. Exhibitions, Melas, Nukkad Natak functions will be organized in each block from time to time to expand reach of different programmes. Folk Media will also be used as atool for publicity.

At the District/State level - Advocacy Programmes, workshops seminars, press conferences, etc., will beorganised for different target groups including Politicians, Media Personnel, Bureaucrats, NGOs, Schoolchildren, etc.

Mobility Support: Vehicles will be hired on rent on a monthly basis at the State to provide mobility support to the IEC component.

5.13 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.

- 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, 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 Accounts Manager

3. District M & E Oficer

4.District Planning Co-Ordinator

Appointment of CA at DHS Level

Due to increase in funds flow & for maintenance of Accounts as per NRHM guidelines, all the DHS were directed to appoint C.A. at a monthly cost of Rs.20, 000/- P.M. Similarly; CA. at SHSB level is to be appointed soon.

Budget:

Activity @ Proposed Budget

Audit of DHS by CA for 2011-12 Rs. 20,000/-X 12 month = Rs. 2,40,000,-

6. Role of District and 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 and Blocks 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.

7. Monitoring and Evaluation

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

Activities

- Strengthening and up gradation of monitoring and evaluation cell
- Mobility support
- Equipping and furnishing demographic cells
- Conducting survey and concurrent evaluation
- Formation of Databank
- Revised CNAA for all levels would be persuaded and guidelines for preparation district plans
- Web/internet based computer software for use at district and state level
- Reporting formats for providing requisite information

8. 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.

PART- B NRHM Flexible Pool /NRHM Additionalities

1. Decentralization

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

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

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 Nalanda. 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.

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 2386 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 and ensure connectivity between the ASHA worker and the District

1.8 Capacity Building/Academic Support Programme:

a) Enabling ASHA 10th pass – For up gradation of academic strength of ASHA, SHSB will provide examination fees for the 10th examination of open schooling mode/Board/IGNOU to 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.

Budget:

A) ASHA Support System at the District Level

1 Strengthening of the District PMU for undertaking ASHA support system

Additional Personnel

(a) District Community Mobilizer/District Project Manager-ASHA (Master in Social Work) Rs.20, 000/- per month x 12 months =Rs.2, 40,000/- who will report to District Nodal Officer

(b) District Data Assistant (Graduate with Basic Computer knowledge) – to strengthen the District PMU to take additional work. He/She will assist the existing staff of District PMU in all the work related to

NRHM including ASHA related work. Rs.15,000/- per month x12 months = Rs. 1,80,000/-

(c) TA/DA to be paid from District Health Society (Programme Management Cost) for monitoring visits and collection of information Telephone, fax, computer, stationeries etc to be used from District PMU (4000 x 12 month = Rs.48000/-

(d) ASHA Help Desk at the district level (As In-charge Community Mobilizer) = 1000/- x 12 months =Rs.12000/-

B) ASHA Support System at the Block Level

(A) Block ASHA Manager/An officer – Block Level Organizer in all the blocks. (Rs. 12000 x 20 x 12 months = Rs. 28,80,000/-

(B) ASHA Help Desk at the Block Level (as in-charge Block Level Organizer and MOIC) = 500/- x 20 x 12= Rs1,20,000/-

C) ASHA Support System at Village Level

1Community Monitoring and Community need assessment

(20 ASHA and block facilitator, PRIs, SHG, two beneficiaries and

NGO representative.)(Rs.150/- x 249 x 12month) = Rs.4,48,200/-

(F) ASHA Drug Kit & Replenishment

1 Drug Kit @ Rs. 897.65/-* (2 Times) for 2365 ASHA ie.Rs.2800 x 2365 =Rs. 49,30,600/-

(G) Emergency Services of ASHA

1. Deputation/ engagement of ASHA in Flood and other natural calamities for flood prone district (20 days x Rs.100 per day x approx 100 ASHA= Rs.2,00,000/-

2. Capacity Building/Training of ASHA in Flood and other natural calamities for flood prone district (2 days x Rs. 100 per day x approx 100ASHA = Rs.20,000/-

(H) Motivation of ASHA

1. Provision of two Sarees to ASHAs (2365 ASHA x Rs.600(two Sarees) =Rs. 14,19,000/-

2. Provision of one umbrella to ASHAs (2365 ASHAs x Rs.125/-) =Rs. 2,95,625/-

(I) ASHA Divas

1. TA/DA for ASHA Divas @ Rs.86 per ASHAs per month

(2365 ASHA x Rs.86 x12month) = Rs.24,97,440/-

2. Best performance award to ASHAs at district level. @ Rs.2000 per block=3 ASHAs from each block @ Rs.1000 for 1st, Rs.500 for 2nd and

Rs. 300 for 3rd prize, Rs. 200 for Certificate printing and distribution

= Rs. 2000 x 20 Block) = Rs. 40,000//-

4.Identity Card (Rs. 20 x 2365) = Rs.47,300/-

1.10 Untied Fund for Health Sub Centre, APHC and PHC

The objective of the activity is to facilitate meeting urgent yet discrete activities that need relatively small sums of money at Health Sub Centers.

The suggested areas where Untied Funds can be used mentioned below:

- Cover minor modifications to sub center-curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level;
- Ad hoc payments for cleaning up sub center, especially after childbirth; transport of emergencies to appropriate referral centers;
- Purchase of consumables such as bandages in sub center;
- Purchase of bleaching powder and disinfectants for use in common areas of the village;
- Labour supplies for environmental sanitation, such as clearing/ larvicidal measures for stagnant water
- Payment/reward to ASHA for certain identified activities.

Budget

Budget Head Untied Fund

Untied fund for sub-centre	370 HSC x Rs.10,000	Rs.37,00,000/-
Untied fund for APHCs	44 APHC xRs.25,000	Rs.11,00,000/-
Untied fund for PHCs	20 PHC x Rs.25,000	Rs.5,00,000/-

PHC level ANMs:-

1.Orientation on Guidelinesfor Untied Funds for HSC

(20 PHCs x Rs.3000) Rs.60,000/-

2.Quarterly review meeting of the ANMs under the chairmanship of PHC

Medical Officer to monitor the usage of the fund

(Rs.1000 per meeting x 4quarter x 20 PHC) Rs.80,000/-

Total Rs.54,40,000/-

1.11 Village Health and 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.

Budget

Budget Head Untied Fund for VHS

Untied fund for VHSCs 1183 village Rs.10,000/-=1,18,30,000/-

Training of members of VHSC regardingfunctioning mechanism at the PHC level 20 PHCx Rs.2500 =Rs.50,000/-

1.12 Seed Money for Rogi Kalyan Samitis

Aims and Objectives

The objectives of the RKS is :

» Upgrade and modernize the health services provided by the hospital and any associated outreach services

» Supervise the implementation of National Health Programme at the hospital and other health institutions that may be placed under its administrative jurisdiction

» Organize outreach services / health camps at facilities under the jurisdiction of the hospital

» Monitor quality of hospital services; obtain regular feedback from the community and users of the hospital services

» Generate resources locally through donations, user fees and other means

Functions of the RKS

To achieve the above objective, the Society utilizes it's resources for undertaking the following activities/initiatives:

» Acquire equipment, furniture, ambulance (through, donation, rent or any other means) for the hospital

» Expand the hospital building, in consultation with and subject to any guidelines that may be laid down by the 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.

Budget RKS:-

Budget Head Rogi Kalyan Samiti

1.District Hospitals (01 hospitals X 5 lakhs)	Rs.5,00,000/-
2.Sub-divisional hospitals (01 hospitals X 5 lakhs)	Rs.5,00,000/-
3.Referral hospitals (03 hospitals x 1 lakhs)	Rs.3,00,000/-
4.PHCs (20 PHCs x 1 lakhs)	Rs.20,00,000/-

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 Nalanda District is approximately 23,86,527.Exsiting no of HSCs are 370.As per IPHS norms total requirement of HSCs are 474 . To facilitate the above population the state requires additional 165 HSCs had been approved by state health society Bihar to achieve the total target. It is proposed to be created next five years.In SPIP 2009-10 State Health Society Bihar sanctioned fund for Building construction of 8 HSC @ Rs.9.50lakhs per HSC.The construction work HSC is under progress.

The DHS Nalanda proposes to construct additional 100 HSC building in next financial year2011-12.

Budget:-

For this an amount of Rs. 1557 lakh i.e Rs15.57 lakhs x 100 is required.

2.2 Renovation of Old Health Sub Centre (HSC) building:-

Building condition of old HSC is very poor. It is proposed to renovate 50 HSC in 2011-12.

Fund Requirement for Renovation :- Rs. 5.00 lakh x 50 =Rs. 2 Crore 50 lakhs

2.3 CONSTRUCTION OF PHC

NRHM aims to ensure PHCs on the Govt. of India population norm of 1 per 30000 populations in general areasand 1 per 20000 population in tribal/ remote areas. As per 2001 census, population of Nalanda District is approximately 2386527. The existing facility of PHCs is 20, whereas the total requirement is 79 PHCs.

There are 8 PHCs (PHC Nagarnausa, Ben, Bind, Silao, Katrisarai, Parwalpur Tharthari Karaipasurai)which do not have their own building. Therefore 7 PHCs buildings require to be setup by 2010.

Unit cost of construction and land acquisition is 53.15 lacks as per NRHM guidelines.

Budget:-

1.Fund required for Building Construction of Newly upgraded PHC

Rs. 53.15 lakh x 20=Rs. 1519.8 lakh

2. Construction of residential quarters of 3 old APHCs for Staff nurses

Construction to be done in an area of 3000 sq. ft. (1000 sq.ft. x 3 quarters) @ Rs. 30 lakhs per APHCs. **Funds required Rs.30 lakh x 20=Rs. 600 lakh**

3. Construction of building of 20 APHCs where land is available.

An amount of Rs. 75.99 lakhs x 20 = Rs.1519.8 lakh is required for the construction.

4. Construction of residential quarters for Doctors(PHC Asthawan, Sarmera, Ekangarsarai, Nagarnausa, Giriyak and Sub-Divisional Hospital Hilsa) two unit in each Institution:

Amount Requirement for Doctors Quarters = 12 X 19.08 lakh=Rs.228.96 lakh

2.4 RENOVATION OF OLD APHC:-

All APHC has been made functional . OPD and other services has been provided at APHC level. Situation of building old APHC very poor. There is need of renovation of old APHC building in phase wise manner. Initially 10 old APHC is proposed for renovation.

Fund Requirement:- Rs. 10 lakh x 15 = Rs.150 lakh

2.5 RENOVATION AND CONSTRUCTION OF BOUNDRY WALL OF APHC NALANDA:-

APHC Nalanda in Silao block of District Nalanda is situated at tourist place. Nalanda is international tourist place. There must be all health

related services . There is lack of proper infrastructure in Nalanda APHC . DHS Nalanda got an estimate prepared by Executive Engineer. Estimated cost of renovation and other civil development work is Rs. 17.40 lakh.

Fund Requirement:- Rs. 15.00 lakh

2.6 UPGRADATION OF COMMUNITY HEALTH CENTRE (CHC)

NRHM aims to ensure CHCs on the Govt. of India population norm of 1 per 1.20 Lakhs populations. The Govt.of Bihar plans to upgrade all its PHCs and Referral Hospitals below the headquarter level to CHC as per IPHS standards. In the district Nalanda total no of existing PHCs are 20 and the no of Referral Hospital is 3.

Hence a total of 23 units are needed to be upgraded to CHC standard and converted to 30-bedded hospitals. The State Health Society Bihar had Sanctioned Rs. 2.40 crore in SPIP 2010-11 for 6 PHC @Rs. 40Lakhs. The work of upgradation is under progress. The costs also include provision of equipment at these hospitals either as per IPHS standard or as required.

Fund Requirement for upgradation in 2011-12:- Rs.2.4 crore

2.7 Upgradation of Infrastructure of ANM Training Schools

In SPIP 2009-10,State Health Society Bihar had sanctioned Upgradation of Infrastructure of ANM Training Schools of Nalanda district .

Fund Requirement for upgradation in 2011-12:- Rs.50 Lacks

Sl no	Name of Scheme	No. of Physical units	Estimated cost per Physical unit per year	Requirement of fund for 2011-12 (col 4xcol5)	Remark
1	2	3	4	5	6
1	Construction of Building of PHC-CHC(Renovation of PHC into CHC)	20	40,00,000=00	8,00,00,000=00	It is proposed to convert all 20 PHC into 30 bedded CHC.
2	Construction of Building of APHC	24	75,99,000=00	18,23,76,000=00	24 APHC is running on rented building/School.
3	Construction of Building of HSC	60	15,57,000=00	9,34,20,000=00	Operationalisation of Heath sub centre for ANC services.
4	Construction of Residential Quarter of Doctors.	10	30,00,000=00	3,00,00,000=00	Residential Quarter for PHC
5	Construction of Residential Quarter for Staff Nurse	24	30,00,000=00	7,20,00,000=00	Residential Quarter for APHC staff for 24 x 7 services.
6	Construction of Residential Quarter for ACMO	1	40,00,000=00	40,00,000=00	Residential Quarter for ACMO needed.
7	Renovation /Repair of old APHC building.	19	10,00,000=00	1,90,00,000=00	Dilapidated position.
8	National Rural Health Misson(NRHM) Part A	1	20,21,37,000=00	20,21,37,000=00	Financial Year
9	National Rural Health Misson(NRHM) Part B	1	11,09,98,000=00	11,09,98,000=00	Financial Year
10	National Rural Health Misson(NRHM) Part C-RI	1	58,54,000=00	58,54,000=0	Financial Year
11	National Rural Health Misson Part C-PP	1	3,03,85,000=00	3,03,85,000=00	Financial Year
12	National Rural Health Misson(NRHM) Part D	1	1,87,45,000=00	1,87,45,000=00	Financial Year
Total			**39,22,75,000=00**	**84,89,15,000=00**	

2.8 Annual Maintenance Grant

During the course of up-gradation in setting up of different units in the different health facilities of the District ,maintenance will also be essentially required. State Health Society Bihar had approved Annual Maintenance Grant for district hospitals and sub divisional hospital @ Rs.5 lacks and Referrals/PHCs @ Rs.in SPIP 2009-10

Budget

Fund Requirement for 2011-12

1.DH & SDH(1+1)	@ Rs. 5,00,000/-	Rs.10,00,000/-
2.RH & PHC (3+20)	@Rs.1,00,000/-	Rs,23,00,000/-
3. APHC (43)	@Rs.25,000/-	Rs.10,75,000/-

3. Contractual Manpower

3.1. Incentives, Contractual Salaries and Bonus

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. Lifesaving Anesthesia skills etc. will get an incentive of Rs.4000.

Budget: **Proposed Budget Sub-Heads**

1. **Incentive for PHC doctors & staffs:-**

Incentive for PHC doctors & staffs @Rs. 50,000 for better performance in implementing programmes for 20 PHC =Rs.10,00000/-

2.Salaries for contractual Staff Nurses:-

@12000 X 88 Staff Nurse X12months=Rs.1,26,72,000/-

3.Contract Salaries for ANMs:-

@8000 x 370 ANM ® X 12 months =Rs.3,55,20,000/-

4.Mobile facility for all health functionaries

District officials, PHC in charge,

CDPOs and ANMs @ 500 per month =419 X 500 X12months=Rs.25,14,000/-

I)	**District Official– (CS,ACMO,DIO,DTO,DLO,DMO,DPM,DAM,DM&E,DPC,DCM, DDA)-12**	
II)	**MoiC Of PHC**	**-20**
III)	**CDPO**	**-20**
IV)	**One ANM per HSC**	**-370**

3.2. Block Programme Management Unit

The district has already established Block Programme Management Unit in all the 20 Block PHCs.. Each BPMU consist of One Block HealthManager, One Accountant and One Block Community Mobilizer.It has been observed that after the establishment of BPMUs the implementation of National Programmes has been managed efficiently and getting improved results.

Budget:-

Fund Requirement for Recurring Expenses of 20 BPMUs

Sl	**Particulars Qty**	**Amount (Rs.)**
1.	Block Health Manager @13200/-for 20PHC	Rs.31,68,000/-
2.	Block Community Mobilizer @ 12000/- pm for 20 PHC	Rs.28,80,000/-
2.	Block Accountant @ 8800/- pm for 20PHC	Rs.21,12,000/-

3. Mobility and Office Expenses @ 25000/- pm

for 20PHC Rs60,00,000/-

Recurring Expenses of 20 BPMUs per Year Rs. 1,7791200/-

3.3. Additional Manpower for District Health Society, Nalanda

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.

The details of Manpower as follows with Budget:

Details of Staff

Sl	Post	Salary (pa)
1	Store keeper (No.1)@5000/-pm	60,000/-
2	Computer Operators(No.2)@ 8000/-	1,92,000/-

Total Fund Required Per Annum =Rs. 2,52,000/-

3.3. Additional Manpower for FRU, Nalanda

NRHM being a large programme covering various components, Hospital Manager the implementation of each FRU has been managed efficiently and getting improved results.

The details of Manpower as follows with Budget:

Details of Addl.Manpower:

Sl	Post	Salary (pa)
1	Hospital Manager @27500/-for Each FRU (Two FRU)	Rs.6,60,000/-

4. PPP Initiatives in State

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:	44
✓ Primary Health Centre (PHC):	20
✓ Sub-Divisional Hospital (SDH):	02
✓ District Hospital:	02
Total Ambulace:	68

Budget summary of Ambulance :

400/-per day x365x 68 Rs. 99,28,000

4.2. Additional PHC management by NGOs

The state has started to outsource the management of Adll. PHCs to the NGOs. In 2008-09 the state has given 4Adll PHCs to the NGOs for management.

In mid of year 2009-10 the state decided to run all Adll PHCs through its own manpower.

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.15 lakh

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.

Fund Requirement :- Rs. 30 lakh

4.5. Operationalising Mobile Medical Unit

Operationalisation of Mobile Medical Unit in district is under progress .This project is undertaken under PPP. SHS Bihar finalize firm and rate for the project.

Scope of Work

Private Service Providers for providing mobile health care services in rural Bihar of curative, preventive and rehabilitative nature, to be provided by the service provider along with all deliverables like Mobile Clinic (each unit fitted with GPS- Global Positioning System), professional manpower, and other such services, to provide and supplement primary health care services for the far flung areas in the various districts of Bihar and to provide a visible face for the Mission.

Project Objective

To provide and supplement regular, accessible and quality primary health care services for the farthest areas in the districts of Bihar and to provide visible face for the mission and the Government, also establishing the concept of Healthy Living among the rural mass

Project Scope

The detailed roles and responsibilities of the private partners to meet the aforesaid objectives are as follows:

- ✓ Providing the requisite vehicle and equipments and software for Operationalization of the MMU.
- ✓ Install, Operate and maintain appropriate GPS facility.
- ✓ Technical manpower support to run the MMU and provide the services
- ✓ Continued technical back up for maintenance of the system.
- ✓ Ensuring Quality Standards
- ✓ Providing detailed reports and maintain database of information of MMU services as per theProformas provided at the time of signing of the contract, or as issued by the SHS from time totime.

To meet above project objective SHS Bihar had approved an amount of Rs.10.00 crores for the project in SPIP 2009-10.

Budget:-

Fund Required (in Rs.) Projected cost for 1 MMU project at district level Rs.4.68 lakhs x 12months

=Rs. 56,16,000/-

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, Laserprinter, 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 theestimated cost is Rs. 7500/- per Data Centre per month.

The District/Block Data Centres units would be as such:

- ✓ Primary Health Centre (PHC): 20
- ✓ Sub-Divisional Hospital (SDH): 02
- ✓ District Hospital: 02
- ✓ District Health Society: 01

Total Data Centre: 25

Budget

Activities Total proposed budget (in Rs.)

District & Block Data Centres Rs. 7500/- x 12 x 25 =Rs. 2250000/-

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 than50 % 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/-,

4.8. 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.

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 services-

- 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

5. Health Management Information System

(1) Web Server System

The State Health Society has established one web-server with 512 kbps leased-line connection for on-lineuploading and reporting of Health related data through web-server application of State Health Society, Bihar.

The following system shall be introduced in parallel to the existing system of Data centers:

1. Online uploading of Health related data directly from Data Centers of PHC/Hospitals.

2. Compilation and reporting of Health related data through developed application software in very less time.

3. The reports will be more accurate and consistent.

4. The DM/CS/DHS can view the different reports of Health services of district in on-line mode, therefore proper action can be taken quickly.

5. The officers/staff of state level also can view the reports of Health services of all districts in online mode, therefore proper action can be taken promptly.

6. According to requirement, any new report can be added and the information can be obtained from PHC/Hospitals in online mode quickly.

7. More security and safety of Health related database.

Therefore ,website for Nalanda districts is required to be designed, created and maintained

Budget

(2) HMIS Reports

As we know that NRHM aims to continuously improve and refine its strategies based on the inputs and feedback received from the State and from various review missions. One of our priorities is to build a robust Health Management Information System (HMIS) that is used for improving, planning and programme implementation at all levels. NRHM has introduced Revised HMIS formats and they are as follows:

6. 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

Budget

Infrastructure Strengthening for Cold Chain

Items Units Amount

Refurbishment of existing Cold chain room of districts with proper electrification,Earthing for electrical cold chain equipment and shelves and dry space for non elecrtical cold chain equipment and logistics @Rs 7 Lakhs per districtEarthing and wiring of existing Cold chain rooms in all20 PHCs @Rs 10000/- per PHC 200000

Total Requirement of fund=District +PHC

7. Mainstreaming AYUSH under NRHM

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

Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) are rationally recognised systems of medicineand have been integrated into the national health delivery system. India enjoys the distinction of having the largest network of traditional health care, which are fully functional with a network of registered practitioners,research institutions and licensed pharmacies. The NRHM seeks to revitalize local health traditions and mainstream AYUSH (including manpower and drugs), to strengthen the Public Health System at all levels. It is decided that AYUSH medications shall be included in the drug kit of ASHA, The additional supply of genericdrugs for common ailments at SC/PHC/CHC levels under the Mission shall also include AYUSH formulations.

At the CHC level two rooms shall be provided for AYUSH practitioner and pharmacist under the Indian PublicHealth Standards (IPHS) model. At the same time, it has been decided to place or provision one Ayush doctor on contract at the APHCs for the purpose and to ensure complete coverage of the population.

Activities 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.

BUDGETAYUSH - Requirement of the funds from NRHM –

1. Ayurvedic, Unani and Homeopathic dispensaries-

(i) Provision of 1 Ayush doctor at each APHC on contract

@ Rs.30,000/- x 44 APHC x 12 months =22,37,40,000.00

(ii) Salary of Paramedics @ 8000 x 44 x 12 months=

(iii) Salary of Pharmacists @12000 x 44 x 12 months=

2. Training of Ayush Doctors & Paramedical staffs w.r.t Ayush wing 4,15,00,000.00

3. IEC 1,00,00,000.00

PART- C

1. Routine Immunization

1.1 Progress of Routine Immunization in Bihar:

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.

1.2 Situational Annalysis :-

R.I ACTIVITY COMPILATION FOR BUDGET AND PLANNING										
S.No	Location (Mention all ILR points e.g PHC. SD Hospital, Sadar Hospital, Urban Hospitals and District HQ)	Total Population	Annual Target pregnent women	Annual Target infants (0-1yrs)	Number of Villages	Number of Mahadalit Villages	Number of Planned RI sesssion a month	Number of Planned Outreach RI sesssion a month	Number of planned Mobile sessions a month	Number of Aganwadi centers
1	Ekangarsarai	153894	5195	4731	230	8	188	185	0	146
2	Bind	63786	2130	1940	58	2	63	62	0	56
3	Islampur	158136	5331	4859	298	61	243	185	0	191
4	Nagarnausa	88727	2986	2721	112	3	110	110	0	81
5	Parwalpur	64836	2175	1977	88	20	71	68	0	58
6	Rahui	154802	5200	4732	145	0	178	178	0	128
7	Sarmera	93990	3137	2855	71	21	84	71	0	79
8	Karaiparsurai	65853	2225	2026	103	0	102	48	0	64
9	Tharthari	59340	1996	1816	84	8	66	80	0	63
10	Silao	159996	5368	4881	157	107	163	0	0	123
11	Asthawan	164256	5506	5012	117	7	177	172	0	142
12	Ben	108018	3612	3286	105	54	107	0	0	72
13	Giriyak	82566	2770	2526	177	11	96	97	0	76
14	Biharsharif Sadar	196644	6571	5995	189	15	200	189	0	162
15	Chandi	145152	4855	4419	144	8	68	79	0	133
16	Rajgir	147834	4952	4508	167	67	149	139	0	109
17	Hilsa	140814	4742	4335	215	12	222	98	0	162
18	Noorsarai	163854	5407	4915	180	8	200	180	0	137
19	Harnaut	158174	5219	4745	141	45	215	379	48	144
20	Katrisarai	43908	1468	1337	39	15	43	9	0	37
	Total	**2414580**	**80845**	**73616**	**2820**	**472**	**2745**	**2329**	**48**	**2163**

1.3 Vaccine Management:-

VACCINE MANAGEMENT													
S.No	**Location** (Mention all ILR points e.g PHC,SD Hospital, Sadar Hospital, Urban Hospitals and District HQ)	**Monthly Requirement of Vaccine, Diluent vials and Vitamin A**									Monthly Syringe Requirement		
		T.T	BCG	BCG Diluent	DPT	OPV	Measles	Measles Diluent	DT	Vitamin A	ADS 0.1 ml	ADS 0.5ml	Reconstitution 5ml.
1	Sadar PHC	263	196	196	437	247	247	247	196	208	780	5368	631
2	Noorsarai	248	186	186	382	236	236	236	186	197	686	4591	602
3	Chandi	187	135	135	315	181	181	181	135	142	562	3919	448
4	Ekangarsarai	274	234	234	411	267	267	267	234	237	725	4512	730
5	Hilsa	248	213	213	380	238	238	238	213	221	673	4215	662
6	Rajgir	184	138	138	312	173	173	173	138	145	575	3996	446
7	Asthawan	250	170	170	371	220	220	220	170	175	669	4574	560
8	Islampur	273	230	230	425	268	268	268	230	242	748	4708	726
9	Sarmera	119	80	80	189	111	111	111	80	89	342	2441	262
10	Giriyak	117	92	92	199	114	114	114	92	97	347	2322	298
11	Rahui	236	178	178	366	214	214	214	178	181	653	4352	569
12	Tharthari	94	80	80	152	92	92	92	80	81	262	1675	251
13	Nagarnausa	137	110	110	227	130	130	130	110	114	391	2555	350
14	Karaiparsurai	116	99	99	179	110	110	110	99	103	316	1976	307
15	Parwalpur	91	74	74	157	88	88	88	74	76	270	1810	232
16	Silao	206	158	158	341	190	190	190	158	163	636	4359	505
17	Ben	150	107	107	232	138	138	138	107	110	427	2941	349
18	Bind	85	60	60	140	78	78	78	60	66	250	1726	198
19	Katrisarai	57	40	40	94	55	55	55	40	42	168	1177	135
20	Harnaut	271	214	214	446	249	249	249	214	216	800	5348	677
	Total	**3606**	**2794**	**2794**	**5755**	**3399**	**3399**	**3399**	**2794**	**2905**	**10280**	**68565**	**8938**

1.4 Cold Chain Status:-

COLD CHAIN STATUS																										
S.No	Location (Mention all ILR points e.g PHC, SD Hospital, Sadar Hospital, Urban Hospital and District HQ)	Deep Freezer			ILR			Stablizer			Thermometer			Cold Box			Vaccine Carrier			Ice Pack			Hub Cutter		
		F	NF	BR	F	NF	BR	F	NF	BR	F	NF	BR	F	NF	BR	F	NF	BR	F	NF	BR	F	NF	BR
1	Asthawan	1	1	1	1	1	-	3	-	-	3	-	-	6	3	4	160	-		800	400	-	-	-	-
2	Biharsharif	-	1	1	2	-	1	2	-	-	3	-	-	20	13	5	300	125	4	2800	2200	-	10	29	-
3	Chandi	1	-		1	-	1	2	-	-	2	-	-	15	13	-	195	50	5	1200	200	-	12	39	-
4	Noorsarai	1	1		2	-	-	2	-	-	3	-	-	6	4	-	101	34	-	525	-	100	9	24	-
5	Rahui	1	-		1	1	-	2	-	-	2	-	-	6	5	-	80	40	-	500	100	-	10	20	-
6	Giriyak	-	-		1	2	-	1	-	-	1	-	-	7	-	4	60	19	-	400	100	-	-	-	-
7	Ben	1	-		-	-	-	1	-	-	-	-	-	-	-	-	-	-	4	-	-	-	-	-	-
8	Bind	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
9	Karaiparsurai	-	-	-	1	-	-	1	-	-	1	-	-	-	-	-	36	-	-	-	-	-	8	-	-
10	Nagarnausa	-	-	-	1		-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-	6	-	-
11	Parwalpur	-	-	-	1	-	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
12	Hilsa	-	-	-	2	1	1	2	-	-	3	-	-	10	10	4	150	15	-	800	-	-	1	-	-
13	Ekangarsarai	-	-	-	2	-	-	2	-	-	1	-	-	10	-	-	125	-	4	550	-	-	10	-	
14	Katrisarai	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
15	Harnaut	1	1	1	2	-	-	1	1	-	2	-	-	13	5	5	115	25	25	550	50	50	22	10	10
16	Rajgir	2	-	-	2	-	-	2	-	-	4	-	-	15	4	-	217	50	30	1200	-	200	-	-	-
17	Sarmera	1	-	-	1	1	1	1	-	-	2	2	-	3	7	-	62	2	8	470	150	-	6	18	-
18	Tharthari	-	-	-	1	-	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
19	Silao	-	-	-	1	-	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
20	Islampur	200	1	-	1	1	-	1	1	-	1	-	-	9	-	-	150	-	-	1000	-	-	30	-	-
	District Total	12	5	3	23	7	4	29	2	0	32	2	0	120	64	22	1751	360	80	10795	3200	350	124	140	10

1.5 Routine Immunization Achievement:- Full immunization percentage increased to 41.4% (DLHS). Use of ADSyringe increased to 95%.

Sl.No.	YEAR	BCG	DPT	POLIO	DT	VITAMIN A	TT
1	2006-07	70649	68202	67610	63057	22233	34730
2	2007-08	66055	62143	50210	45412	6945	81846
3	2008-09	53265	40723	46431	17500	35280	30903
4	2009-10	56554	62698	60528	33806	2483	42165
5	2010-11 (upto oct-09)	39184	33485	31198	1050	699	37800

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 ofVaccines 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.
- ✓ Generator 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.

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. 9000 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

SWOT ANALYSIS OF THE DISTRICT:

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

District:

Strength	Weakness	Opportunity	Threat
All hospitals under nalanda district connected with main roads which caters a large population. **All health centers provides 24*7 services with diet to all in patients and having uninterrupted electricity and water supply.** **Rogi Kalyan Samiti is constituted at every health centers which regulates and controls over functioning of health centers and gives suggestion/feedback for smooth and effective delivery of services further.**	**As per IPHS norms there is shortage of doctors/Paramedics.** **Lack of motivation among medical and paramedical staffs hospital is not attracting vast population who chooses private doctors clinics.** **Lack of physical infrastructure does not support medical and paramedics in order to get optimum patient load.** **There is no suggestion/complain cell so sometimes it shows that lack of transparency.**	**Hospital administration can do study related to satisfaction level of patients.** **Availability of the space construction of new building.** **As per IPHS norms hospital can get ISO 9001 certification.** **By the vertical and horizontal transfer of hospital staffs it is possible that these transfer can accelerate health services.** **Public-Private partnership can be strengthen.**	**Despite giving health services still hospital is not stands at par of private health services.** **To get faith of people in government hospital is very big challenges in spite of giving all facilities as compare to private.**

Budget:-

Sl.NO	Name Of Head	Annual Target
1	Mobility Support to District Officials Rs 50000 per District	60,000
2	Cold Chain maintenance	25000
3	For 3565 slums snd 14385 underserved area	714000
4	Alternative vaccine delivery in hard to reach areas	60000
5	Computer Assistant support for District level	96000
6	Quaterly review meeting exclusive for RI at district level with one Block	50000
7	One day training of block level data handlers by DIOs District cold chain officer	24375
8	POL for vaccine delivery from state to district and from district to PHC/CHCs	125000
9	Twin bucket@ Rs.400per PHC/CHCper year for 20 PHCs	14000
10	Bleach/Hypochlorite solution	12500
11	Honorarium+TA to participants	21000
12	Honorarium+TA to participants	11000
13	Honorarium for trainers/faculty	750
14	working lunch and refreshment	5750

Annexure: All Block level compile format

DISTRICT PROFILE:

Nalanda (also called Bihar Sharif) district is one of the districts of Bihar, and Bihar Sharif town is the administrative headquarters of this district. Nalanda was a part of Patna Division. The subdivision of Biharsharif in the old Patna district was upgraded to an independent district on November 9, 1972 and named Nalanda, after the famous university (the world's oldest) located here. Nalanda is 67 metres above sea level. It is referred to frequently in Jain and Buddhist scriptures. As the centre of the great Magadha Empire, Nalanda has had a rich and glorious history extending over 2,500 years. Till its destruction by Mohammed Bin Bakhtiyar Khilji, army chief of Kutubuddin Ibak, in 1205 AD, Nalanda was the leading centre of learning in India.

ADMINISTRATIVE SET – UP:

The district of Nalanda is spread in an area of 2367 Sq. Kms. and a population of 2370528 has been pre-eminently an agricultural district. Bordering Patna District in north & north-west, Gaya District in South, Luckeesarai District in east, Jahanabad District in the west and Nawada district in South-east. The district is comprises of 3 sub division and 20 blocks covering 249 village panchayats.

PARTICULARS	NUMBER
Number of Sub-Division	03
Number of Blocks	20
Number of Municipality	01
Number of Nagar Panchayat	04
Number of Gram Panchayat	249
Number of Police Station	20
Number of Inhibited Villages	1001

S.No	Sub-Division	No. of Anchals	No. of Halkas	No. of Revenue Villages
1.	Bihar Sharif	7	51	429
2.	Hilsa	8	22	198
3.	Rajgir	5	46	457
	Total	**20**	**119**	**1084**

DISTRICT DEMOGRAPHY AND DISTRICT DEVELOPMENT INDICATORS:

The main features of the population demography of the district are…

- The entire population of the district has been living in 360797 households whose average size is of 7.0 persons.
- Heavy concentration of population, male and female both, in rural areas, is an indicator of the population depending mostly on agriculture and allied activities in the rural centre.
- Scheduled Tribes population in the district is miserably low
- The percentage of literacy rate-differences between male and female is excessively high
- The features of land, the district possesses, vis-à-vis the land possessed by the state of Bihar, show that the district has certain favorable features regarding the use of land.

POPULATION	MALE	FEMALE	TOTAL
Rural Population (in %)	84.94	85.24	85.1
Literacy Rate	66.4	38.6	53.2
SC Population (in %)	20.04	19.93	20.0
ST Population (in %)	0.0	0.0	0.0
BPL Population	3, 40,576 (50.28%)		
Sex Ratio	Females per 1000 males		(0 – 6 years)
	915		941

Population Growth (1991 – 2001)	18.75		
Population Density (person per sq km)	1007		
Number of Household	Total	Rural	Urban
	360797	310799	49998
Total workers (number)	80922		
Main workers (number)	62723		
Marginal workers (number)	18199		
Non – workers (number)	1467384		
Total workers to total population (%)	38.1		
Workers in HH industries to total workers (%)	4.47		
Number of Health Sub Centre	370		
Number of Additional Primary Health Centre	44		
Number of Primary Health Centre	20		
Number of Sub-divisional hospital	02		
Number of villages having Paved approach road	37.69		
Average size of operational holding	0.6 Ha.		
Normal Rain Fall	977.9		
Actual rain Fall	1150.7		
Percentage of cultivable land to total geographical area 2006-07	79.38		
Percentage of area under commercial crops to gross cropped area 2006-07	2.94		
Percentage of net area sown to geographical area 2006-07	78.3		
Cropping intensity	1.21		
Percentage of gross irrigated area to gross area sown 2006-07	86.16		
Percentage of net irrigated area to net area sown 2006 – 07	78.12		
Consumption of fertilizer in kg/hectare of gross area sown 2006-07	0.4 Kgs./Ha		
Average yield of food grains 2006-07 (kg/ha)	1545 Kgs./Ha		
Percentage of area under bhadai crops	1.93		
Percentage of area under agahani crops	47.15		
Percentage of area under garma crops	1.34		
Percentage of area under rabi crops	49.59		
Length of highways and major district roads (mdrs) per lakh population (km) 31st march 2005	21.17		
Length of highways and major district roads (mdrs) per thousand sq km in area (km) 31st march 2005	213.17 KM		
Length of rural roads per lakh population (km) 2004-05	42.74 KM		
Length of rural roads per thousand sq km in area (km) 2004 – 05	430.23 KM		
Number of branches of scheduled commercial banks 2008 – 09	130		
Credit deposit ratio 2008	24.59		
Density of livestock per sq km 2003	177		
Density of poultry per sq km 2003	167		
Average livestock population served per veterinary	17449		

hospital/dispensary 2003	
District wise fish production 2007 – 08	9500 MT
Share of districts in total milk production 2007 – 08	2.69

Key Indicators	District Rapid Household Survey (RHS- RCH), 1998-99	District Level Health Survey _ RCH _ MHFW (2002 - 04)
% of Girls marrying below 18 years	59.2	59.6
Mean Age at Marriage (Female)		16.0
% of Births of order 3 and above	53.8	
CPR	25.6	
% Pregnant women with any ANC	41.4	33.2
% Pregnant women with full ANC	9.6	02.0
Pregnant women who had 2 or more TT injection		76.3
% of Women who received adequate IFA Tablet		05.5
% of Women who consumed 2 or more IFA Tablet regularly during pregnancy		06.0
% of Institutional Delivery	23.1	30.8
% of Safe Delivery	36.1	38.0
% of women who had delivery at home		69.0
% of Children (12-23 months) with Complete Immunization	13.1	18.4
% of Children (12-23 months) with No Immunization	57.6	48.7
% of Children (12-35 months) with Complete Immunization		21.8
% of Children (12-35 months) with No Immunization		49.6
Children under 3 initiated Breastfeeding within 2 hours of birth		05.0
Anemia among pregnant		0.0
Use of Iodized Salt (Adequately Iodized Salt)		28.2
Women whose child under 3 years suffered from Diarrhoea treated with ORS		0.0
% of females with symptoms of RTI /STI	31.9	38.1
% of males with symptoms of RTI/STI	10.6	
% of females aware of HIV / AIDS	18.4	
% of males aware of HIV / AIDS	56.8	
Vital Demographic Indicators		
IMR (q1)	73	
CBR	35.09	
TFR	5.05	
Nutritional Status of Children SD Classification		
Under Weight	57.3	
Prevalence of Under Weight (Moderate & Severe)		50.4
Prevalence of Under Weight (Severe)		24.2
Stunted	57.7	
Wasted	30.3	

LAND USE PATTERN:

The favourable features for the land use-pattern in the district are…

- The barran and uncultivable land in the district is lesser in percentage than the state of Bihar as a whole.
- Land used for no-agricultural purposes in the district is approximately equal, in percentage to the percentage of Bihar state – nearly one percent lesser than the percentage figure for Bihar.
- Cultivable wasteland in the district is lesser in percentage than the percentage figure for Bihar State.
- The percentage of current follow land in the district is lesser than the same figure for the state of Bihar, and so is with the other follow land.
- The total uncultivable land in the district is in lesser percentage than the percentage figure for the state of Bihar.
- The percentage figures for net sown area, cropped area and the area sown more than once of district are higher than the percentage figure in this head for the state of Bihar.

But there are certain disquieting features also, which can be mentioned as…

- The percentage of permanent water area in the district is lower that the same figure for the state of Bihar.
- The percentage figure for temporary water area in the district is higher than the same figure for the state of Bihar.
- The availability of forest area in the district is lesser than the average percentage figure for the state of Bihar.

All these aforesaid demographic features of the district of Nalanda are indicators of the fact that there is paucity of cultivable barran land, forest and water land in the district, consequently the development of the agricultural sector of the district depends mostly on the modernization of the agricultural, by the application of modern technique instead of the enlargement of the net sown area. Secondly its Rabbi cultivation requires wide ranged irrigation net work because the temporary water land cannot provide adequate irrigational facilities to Rabbi Cultivation. The need for irrigational net work required by the district agriculture can be substantiated by the rain fall.

CLIMATE AND AGRO ECOLOGICAL SITUATION:

Nalanda district is lying in III-B zone of Bihar state whose majority population earns its livelihood from agriculture. The district has 183377 hectares of net sown areas and the areas in which sowing activities are done more than once include 75258 hectares. The percentages net sown area and the area sown are more than once comprises 78.79 and 23.34 percent respectively of the total areas of the state. Taking these two areas together the total cropped areas of the district aggregates to 7992279 hectares or 111.13 percent. This cultivation scenario of the district, if compared with the average of the state of Bihar is higher by 18 and 8 percent respectively, but when its productivity is compared with the developed states of India like Punjab, Andhra pradesh, Tamilnadu, U.P. etc. the district lags far behind, in some cases by

double. It is however, satisfactory that oil seed production in the district is higher than the average of Bihar state and all India both for Nalanda district oil seed production average is 860 kg. per hectare while the same figure for Bihar state is 808 kg. per hectare and for all India 856 kg. per hectare.

Of its total cropped areas the district has 25 to 26 percent non-irrigated land and these irrigated are mostly by tube-wells (85.26).

The odd part of the district agriculture is its slow rate of seed replacement ratio, which has been calculated merely being 10 percent, whereas it has been calculated that this figure should have been at least 33 percent.

In general perusal the agricultural scenario of the district cannot be said to have been fully satisfactory, rather it requires improvement to comply with the productivity ratio of developed states agriculture. To bring the district agriculture to have higher rate of productivity improved variety of paddy requires to be adopted by the peasants for their upper land. There is need for soil testing, which can enable the cultivators to have greater yields by less use of fertilizers. To develop agricultural farms, administrative device there are need to assure the actual cultivators that the benefits earned by the development of agriculture will positively go to them, and in technical devices, mechanization and plant protection are the two major areas which require special cares.

Besides all these constraints there are several others whose removal is a sign-qua-non to give the agriculture in Nalanda district an impetus to achieve higher goals in production.

SOCIAL STRUCTURE:

The district is a hub of mixed population and having 30% as SC population. Around 50% of the rural population is under BPL category.

Block	AREA	House holds	Population			Scheduled Caste			Scheduled Tribes		
			Total	Male	Female	Total	Male	Female	Total	Male	Female
KARAI PARSURAI	6481	9456	60127	31461	28666	13388	6987	6401	1	1	0
NAGAR NAUSA	7532	11946	72475	37543	34932	17891	9283	8608	5	2	3
HARNAUT	18159	22554	143922	75709	68213	32356	17085	15271	1	0	1
CHANDI	13110	20245	125990	65769	60221	27374	14347	13027	46	29	17
RAHUI	12169	19847	127975	66836	61139	29974	15871	14103	17	10	7
BIND	7260	8378	56240	29543	26697	11919	6346	5573	5	1	4
SARMERA	12374	11997	78610	40948	37662	17543	9131	8412	39	15	24
ASTHAWAN	14143	21125	143867	74813	69054	35688	18754	16934	4	3	1
BIHARSHARIF	15294	25046	163517	85690	77827	38180	19951	18229	143	77	66
NOORSARAI	12487	21570	137267	71239	66028	32866	17176	15690	98	53	45
THARTHARI	6276	8343	52039	27335	24704	10109	5317	4792	21	14	7
PARBALPUR	6300	8913	58501	30422	28079	7402	3869	3533	0	0	0
HILSA	13156	19347	124771	64692	60079	24508	12891	11617	0	0	0
EKANGARSARAI	13442	22351	145479	76222	69257	22576	11717	10859	64	34	30
ISLAMPUR	21613	24335	162245	84806	77439	29136	15228	13908	145	72	73
BEN	10082	11328	72193	37780	34413	13996	7320	6676	36	19	17
RAJGIR	11139	11360	75398	39185	36213	18230	9475	8755	5	5	0
SILAO	11536	15516	102814	53611	49203	26079	13827	12252	9	6	3
GIRIAK	8091	11316	75735	38957	36778	16114	8276	7838	102	54	48
KATARISARAI	4227	5826	37734	19530	18204	8536	4435	4101	36	20	16
Total	**224871**	**310799**	**2016899**	**1052091**	**964808**	**433865**	**227286**	**206579**	**777**	**415**	**362**

As per Census 2001

The social category of the Class and caste wise classification viz. APL, BPL and community based demography of Mahadalits of the district is as hereunder.

Block Name	Total Family	B.P.L.	A.P.L.	Surveyed Number of Caste Wise Mahadalit Families								
				Dom	Mushhar	Nut	Turi	Pasi	Dhobi	Halkhor	Razwar	Total
BIHARSHARIF	133874	49987	83887	10	413	0	0	212	19	0	0	654
ASHTHAWAN	38228	18074	20154	51	800	42	0	1324	103	14	0	2334
BIND	15273	11095	4178	9	72	13	0	132	40	0	0	266
SARMERA	23603	13713	9890	14	1718	0	0	325	187	0	0	2244
RAHUI	37358	21107	16251	77	404	0	0	685	104	0	0	1270
NOORSARAI	34862	20884	13978	20	1559	19	0	623	111	0	0	2332
HARNAUT	46945	30540	16405	48	2193	4	0	528	134	0	0	2907
SUB TOTAL	**330143**	**165400**	**164743**	**229**	**7159**	**78**	**0**	**3829**	**698**	**14**	**0**	**12007**
RAJGIR	21764	12382	9382	3	1425	0	0	678	108	0	1523	3737
SILAO	30098	1508	28590	0	0	0	0	0	0	0	0	0
GIRIYAK	19300	9525	9775	18	2362	6	0	534	514	31	53	3518
KATRISARAI	9896	4973	4923	5	1300	0	0	324	39	0	56	1724
BEN	17542	11388	6154	0	1205	4	31	379	126	0	0	1745
SUB TOTAL	**98600**	**39776**	**58824**	**26**	**6292**	**10**	**31**	**1915**	**787**	**31**	**1632**	**10724**
ISLAMPUR	46577	27692	18885	46	1919	126	8	1521	268	0	82	3970
PARWALPUR	17230	8945	8285	27	568	55	0	171	83	0	0	904
KARAIPARSURAI	15656	8780	6876	0	0	0	0	0	0	0	0	0
NAGARNAUSA	26194	13244	12950	10	1215	13	0	641	94	0	0	1973
HILSA	42221	24040	18181	70	1420	0	0	939	130	0	0	2559
EKENGARSARAI	45693	15949	29744	32	286	78	0	596	126	0	3	1121
CHANDI	37593	25859	11734	88	2011	12	0	415	62	1	0	2589
THARTHARI	17486	10891	6595	15	952	30	0	176	28	0	0	1201
SUB TOTAL	**248650**	**135400**	**113250**	**288**	**8371**	**314**	**8**	**4459**	**791**	**1**	**85**	**14317**
TOTAL	**677393**	**340576**	**336817**	**543**	**21822**	**402**	**39**	**10203**	**2276**	**46**	**1717**	**37048**

FACT SHEET OF BLOCKS AND URBAN LOCAL BODIES:

Name of the Blocks	Total Population	No. of GP	No. of Revenue Village	% of Total Literates	% of Male Literates	% of Female Literates	% of SC Population	% of ST Population	Sex Ratio
KARAI PARSURAI	60127	7	45	35.88	47.60	23.03	22.27	0.00	911
NAGAR NAUSA	72475	9	47	39.68	51.32	27.16	24.69	0.01	930
HARNAUT	143922	17	81	41.46	52.46	29.26	22.48	0.00	901
CHANDI	125990	15	71	41.68	53.27	29.03	21.73	0.04	916
RAHUI	127975	16	66	40.98	52.96	27.89	23.42	0.01	915
BIND	56240	7	35	35.35	46.39	23.14	21.19	0.01	904
SARMERA	78610	9	35	35.62	46.55	23.73	22.32	0.05	920
ASTHAWAN	143867	19	59	38.83	49.16	27.64	24.81	0.00	923
BIHAR	163517	20	92	50.59	59.46	40.79	14.70	0.05	905
NOORSARAI	137267	17	62	41.75	53.90	28.64	23.94	0.07	927
THARTHARI	52039	7	30	41.22	52.73	28.49	19.43	0.04	904
PARBALPUR	58501	6	23	46.52	57.22	34.93	12.65	0.00	923
HILSA	124771	15	60	41.85	53.26	29.30	17.96	0.00	910
EKANGARSARAI	145479	18	90	45.94	57.80	32.88	15.52	0.04	909
ISLAMPUR	162245	20	91	42.57	53.34	30.75	16.62	0.08	911
BEN	72193	9	32	42.47	53.71	30.13	19.39	0.05	911
RAJGIR	75398	9	55	43.08	54.03	31.07	24.73	0.11	912
SILAO	102814	14	54	41.39	51.70	30.17	24.22	0.01	919
GIRIAK	75735	10	44	39.24	50.75	27.06	21.28	0.13	944
KATRISARAI	37734	5	14	41.70	53.25	29.31	22.62	0.10	932

The basic amenities coverage across all villages of the district are as…

Block	Road	Agriculture	Drinking water		Power	Education		Health	Employment
	% villages having paved approach road	% land irrigated	% villages with safe source of drinking water	% villages with adquate safe drinking water	% villages with electricity	% literate people	% villages with primary education facility	% village with any healthcare facility	% main worker to total worker
Karai Parsurai	5.48	62.09	100.00	65.00	100.00	44.00	98.90	78.00	78.89
Nagar Nausa	27.78	65.79	100.00	67.00	94.40	49.00	98.91	85.00	69.06
Harnaut	81.82	50.64	100.00	68.00	83.00	51.00	99.00	92.00	72.22
Chandi	28.57	78.63	100.00	62.00	95.90	51.00	97.00	92.42	74.83
Rahui	75.41	65.03	100.00	65.00	97.79	51.00	98.80	94.25	78.29
Bind	30.00	80.60	100.00	63.00	89.60	44.00	100.00	79.00	70.30
Sarmera	45.00	32.56	100.00	66.00	76.80	44.00	98.10	72.00	71.75
Asthawan	45.00	68.01	100.00	68.50	96.90	48.00	99.00	93.00	65.20
Biharsharif	90.00	73.04	100.00	66.00	91.43	61.00	97.70	98.00	83.83
Noorsarai	80.00	74.24	100.00	67.00	100.00	52.00	100.00	97.45	80.14
Tharthari	24.59	84.42	100.00	68.50	100.00	50.00	100.00	78.50	77.72
Parbalpur	17.00	61.42	100.00	66.00	100.00	57.00	100.00	77.90	76.67
Hilsa	18.00	70.28	100.00	64.00	100.00	47.00	99.90	82.00	71.11
Ekangar sarai	19.00	90.76	100.00	66.00	100.00	56.00	100.00	83.25	81.32
Islampur	18.40	56.31	100.00	65.00	98.05	52.00	100.00	81.32	77.44
Ben	75.00	70.18	100.00	64.00	93.75	52.00	99.00	76.45	75.31
Rajgir	70.50	52.08	100.00	69.00	97.91	53.00	100.00	93.25	76.84
Silao	75.50	89.24	100.00	66.00	100.00	51.00	98.39	82.35	85.78
Griyak	75.00	52.70	100.00	64.00	95.00	49.00	100.00	82.50	83.08
Katari Sarai	52.60	76.20	100.00	65.50	85.71	51.00	100.00	73.25	73.95

BLOCK WISE STATUS OF CREDIT AGENCY						
Sl No.	Block	Agriculture Cooperative Society	Non-Agriculture Cooperative Society	Central Cooperative	Nationalized Bank	RRBs
1	KARAI PARSURAI	7	4	1	1	1
2	NAGAR NAUSA	9	6	1	2	1
3	HARNAUT	17	40	1	1	5
4	CHANDI	15	38	1	2	4
5	RAHUI	16	10	1	2	4
6	BIND	7	2	1	1	-
7	SARMERA	9	27	1	1	2
8	ASTHAWAN	19	-	1	2	6
9	BIHAR	20	237	2	12	8
10	NOORSARAI	17	39	1	2	3
11	THARTHARI	7	2	1	0	2
12	PARBALPUR	6	3	-	1	3
13	HILSA	15	60	2	3	4
14	EKANGARSARAI	18	24	1	2	6
15	ISLAMPUR	20	23	1	3	5
16	BEN	9	4	1	-	1
17	RAJGIR	9	43	1	2	4
18	SILAO	14	13	1	2	4
19	GIRIAK	10	20	1	2	2
20	KATRISARAI	5	2	-	1	1

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	KARAI PARSURAI	8160	2182	6973	239
2	NAGAR NAUSA	11027	2406	11858	122
3	HARNAUT	26339	5105	19195	276
4	CHANDI	23244	4472	13171	169
5	RAHUI	17672	4687	16808	78
6	BIND	7849	2854	3895	36
7	SARMERA	10233	2797	9211	173
8	ASTHAWAN	13122	5244	19658	215
9	BIHAR	18789	5765	28768	414
10	NOORSARAI	17107	5059	16979	66
11	THARTHARI	8469	1687	6378	124
12	PARBALPUR	7470	2030	8213	58
13	HILSA	17849	4570	14192	132
14	EKANGARSARAI	19816	5175	24385	101
15	ISLAMPUR	25309	5798	22397	282
16	BEN	9200	2644	6157	12
17	RAJGIR	10622	2868	11477	46
18	SILAO	11834	3910	11278	50
19	GIRIAK	6969	2811	10134	62
20	KATRISARAI	3731	1130	5000	49