बिहार सरकार

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

National Rural Health Mission

2011-12

PROJECT IMPLEMENTATION PLAN
BIHAR

STATE HEALTH SOCIETY BIHAR

Department of Health & Family Welfare

PATNA, BIHAR

Final BIHAR NRHM SPIP 2011-12

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Bihar NRHM PIP 2011-12

MESSAGE

National Rural Health Mission (NRHM) was introduced in India with the purpose of improving the health of Children and Mothers and reaching out to meet the health needs of the people in the most remote areas of the nation. NRHM has provided the necessary impetus required in the State for focusing on Health. Implementation of NRHM in the State and in all the districts of Bihar has progressed tremendously during 2005-10. The State and District Health Societies were formed along with the establishment of the State, District and Block Programme Management Units during this period. The Societies have accomplished many tasks through their sincere and dedicated hard work and cooperation of the Programme Management Units and the work teams. Further, work plans have been chalked out to improve the health facilities and services in Bihar taking into consideration the special needs of each and every district. The future of NRHM in Bihar is very promising. Taking this opportunity, I congratulate all the concerned State level Officers including the State Executive Director and the Program Management Unit staffs, Chief Medical Officers, District Family Welfare/Immunization Officers, Concerned National Disease Program Officers, Doctors, Nurses, Village level workers, Private Partners, etc. for having played crucial roles. Lastly but not the least, I would also like to appreciate the District and Block Program Management Units for their support and hard work in planning, implementing and monitoring the NRHM activities.

09/02/11

Amarjeet Sinha
Principal Secretary, Health
Govt. of Bihar
CEO-Governing Body
State Health Society Bihar

Bihar NRHM PIP 2011-12

MESSAGE

National Rural Health Mission was launched in Bihar in the year 2005. Inorder to have a better coordination and progress, the Departments of Health and Family Welfare Services got merged at all levels. The government policy of introducing immunization days under Part "C" of NRHM, in Bihar has resulted into improved immunization coverage, the present status of fully-immunized children being 57%. With the State's focus on filling the gaps of manpower through appointment of contractual staff, the performance of the State and of the Districts is improving. As NRHM has a bottom-up approach, all the Districts have identified gaps and improvements needed in every health sphere and have reflected the same in their District Health Action Plans.

When NRHM is implemented with full commitment and sincerity, all the health needs of the people would be fulfilled; mortality and morbidity especially among the vulnerable groups like, women, children, SC, BPL families would be reduced leading to achievement of NRHM goals.

Sanjay Kumar
Executive Director, NRHM
Secretary (Health)
Govt. of Bihar
Chairman-Executive Committee,
State Health Society, Bihar

Executive Summary | Chapter - I

NRHM launched by Hon'ble Prime Minister on April 12, 2005, was a significant paradigm shift, which aimed to ensure affordable, quality health care to the poorest households in remotest areas. To enable this, NRHM proposed "architectural corrections" to make the public health system functional and importantly accountable to enable an improved health status of people in the country.

The existing Health System of Bihar under NRHM consists of its contractual staff of 1319 Staff Nurse, 7258 ANM-R, 78943 *ASHA*s and nearly 1616 contractual doctors reaches out to the people living in more than 45000 revenue villages. The Health infrastructure, particularly PHCs and other Government hospitals are being made into institutions where people can put their trust for affordable quality health services.

SPIP 2011-12 has been prepared through consultation with HSC, block and district level functionaries. The plans have been prepared on the needs identified and has addressed lots of critical issues and district specific innovations or requirements to implement the programme.

This plan is also aimed at improving the access to comprehensive quality health care by improving the public health infrastructure to desired standards, priority being operationalisation of FRUs. Technical Human Resource being one of the most important resources for bringing in quality change in the programme, the same is already being augmented and has found focus in this Plan also. Under this Plan, the Programme Management Support Units at the block, district, regional and State level along with HMIS and other support systems are also focused upon. This year the various PPP initiatives introduced earlier are re-focussed upon for ensuring quality services and better partnership.

Government's role is visualized as that of a facilitator willing to facilitate new initiatives. It is expected that for the state of Bihar, this will initiate primary and quality improvement in health.

Despite efforts of the Government some issues that continue to cause concern are:

- High IMR/MMR - These continue to be high in many rural areas and especially among poor. The chief cause for concern is that in the last few years despite varied efforts there has been no real appreciable decline in IMR/MMR in the State.
- High out of pocket expenditure- Studies indicate that high and prohibitive out of pocket expenditure is limiting access to health especially for the poor. Also, the high out of pocket expenditure is a major contributor for poverty.
- Population Stabilisation - The pace of population stabilization needs to be enhanced.
- Poorly functional public health system - The public health system over the years had suffered from weak governance, manpower shortages and ineffective service delivery – image re-building and goodwill is being developed by ensuring timely and quality services with commensurate manpower and suitable infrastructure.

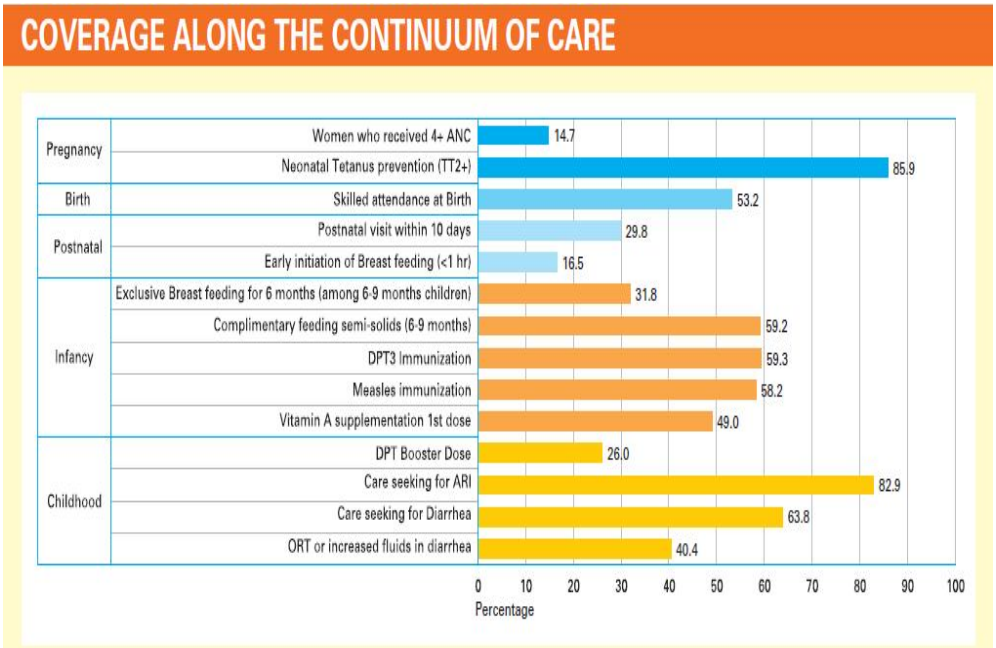
- Poor accountability -Provision of health services by the public health system is not in sync with the needs of the people at times. One of the main reasons for this is the poor involvement of the community and the PRI representatives.

NRHM in Bihar seeks to address these issues through following main strategies:

a) De-centralisation of the process of health planning and management
b) Improved management through capacity building
c) Flexible Financing
d) Innovation in human resource management: provision is being made to enable their engagement and emphasis is also on multi-skilling of staff to address the health needs in a horizontal perspective rather than a vertical one.
e) Outcome based approach: IPHS, Facility Surveys, involvement of the community is expected to be a key element in monitoring the outcomes.
f) Facilitate inter-sectoral convergence to address the key health determinants and also to ensure synergy between the AYUSH and the allopathic system.

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

NRHM State PIP presents an overview of the different activities that are to be taken in the year 2011-12 in order to boost the health scenario of the region keeping in mind the mission's main objective of making the health facilities easily available and accessible to the rural people.



Current Status of Outcome

	2003	2004	2005	2006	2007	2008	2009
CBR	30.7	30.2	30.4	29.9	29.4	28.9	28.5
IMR	60	61	61	60	58	56	52
CDR	7.9	8.1	8.1	7.7	7.5	7.3	7
TFR	4.2	4.3	4.3	4.2	3.9	3.9	3.9

Status of Important RCH indicators in Bihar vis-à-vis National figures

Important RCH indicators such as MMR, IMR and TFR are showing declining trends whereas institutional delivery in government facility, complete ANC, contraceptive use in the state has increased. The state has mapped poor performing districts and this year is now extensively focusing on them. The current situation of the selected indictors based on NFHS-3, SRS and CES shows that overall the state is moving towards achieving the goals-

Indicator	Bihar	Trend	India
Under 5 Mortality Rate (U5MR)	**72**	Improved from 105 in 1998	**69**
Infant Mortality Rate (IMR)	**52**	Improved from 61 in 2006	**50**
3+ ANC visits by mothers	**34%**	Improved from 17% in 2006	**69%**
Skilled attendance at Birth	**53.2%**	Improved from 34% in 2007	**76.2%**
Maternal Mortality Ratio (MMR)	**312**	Improved from 371 in 2002	**254**
Total Fertility Rate (TFR)	**3.9**	Worsened by 0.3 since 2002	**2.7**
Contraceptive Prevalence Rate	**28.4%**	Improved from 27% in 2005	**56%**
Full Immunisation coverage	**66.6%**	Improved from 41% in 2007	**61%**
Underweight % children (0-3 yrs)	**55%**	Worsened by 3% since 2002	**40%**
Mean age at Marriage	**17.6**	Improved from 17 in 2002	**19.7**
Institutional Deliveries pvt	**12.9%**	Improved from 11% in 2008	**26%**
Institutional Deliveries govt	**48%**	Improved from 24% in 2007	**47%**
Anaemic women in reproductive age group (15-49 yrs)	**68.2%**	Worsened from 60% in 1998	**56.2%**

Sources: NFHS 3 (2005-06), SRS 2006, 2007 and 2009, CES 2009 and FRDS 2010

Due to the various health initiatives, the **Maternal Mortality Rate** has reduced from 371 in 2001-2003 to 312 while the **Infant Mortality Rate** has decreased from 61 in year 2005 to 56 in year 2009. Similarly the **Total Fertility Rate** has decreased from 4.3 to 4.0 in the year 2007.

Bihar - Overview of Outcomes (Apr'10 to Nov'10)

ANC			
ANC Registration against Expected Pregnancies	50%	TT1 given to Pregnant women against ANC Registraion	80%
3 ANC Check ups against ANC Reigtrations	48%	100 IFA Tablets given to Pregnant women against ANC Registraion	490%
Deliveries			
Unreported Deliveries against Estimated Deliveries	66.5%	**HOME Deliveries(SBA& Non SBA) against Estimated Deliveries**	4.4%
Institutional Deliveries against Estimated Deliveries	29.1%	**HOME Deliveries(SBA& Non SBA) against Reported Deliveries**	13.2%
Institutional Deliveries against Reported Deliveries	86.8%	**C Section Deliveries against Institutional Deliveries(Pvt & Pub)**	1%
Births & Neonates Care			
Live Births Reported against Estimated Live Births	29%	**New borns weighed against Reported Live Births**	83%
Still Births (Reported)	21,845	**New borns weighed less than 2.5 kgs against newborns weighed**	22%
Sex Ratio at Birh	925	**New borns breastfed within one hr of Birth against Reported live Births**	73%
Child Immunisation(0 to 11 mnths)			
BCG given against Expected Live Births	51%	**Measles given against Expected Live Births**	43%
OPV3 given against Expected Live Births	40%	**Fully Immunised Children against Expected Live Births**	66.6%
DPT3 given against Expected Live Births	42%		
Family Plannng			
Family Plannig Methods Users (Sterilisations(Male &Female)+IUD+ Condom pieces/72 + OCP Cycles/13)	288,945	**IUD Insertions against reported FP Methods**	42%
Sterilisation against reported FP Methods	30%	**Condom Users against reported FP Methods**	18%
		OCP Users against reported FP Methods	10%
Other Services			
OPD	24,014,286	**Major Operations**	25,043
IPD	1,345,262	**Minor Operations**	208,202

Source : Bihar HMIS

The Project Implementation Plan for the year 2011-12 has the following components and consists of following sections-:

Part A: Reproductive and Child Health priority areas under RCH-II flexible pool (Sub-Components – Maternal Health, Child Health, Fmily Planning, ARSH, Urban RCH, Vulnerable Groups, Innovations/PPP/NGO, Infrastructure and Human Resources, Institutitonal Strengthening (HMIS, M&E), Training, Procurement, Programme Management).
Part B: Additionalities under NRHM (*ASHA*, Infrastructure, Contractual Manpower, PPP-Referral & Emergency Transport, Diagnostics, Data Centres, Procurement, Planning)
Part C: Routine Immunisation
Part D: National Iodine Deficiency Disorders Control Programme (NIDDCP)
Part E: Integrated Disease Surveillance project (IDSP)
Part F: National Vector Borne Disease Control Programme (NVBDCP) (Malaria, Kalazar, JE, Dengue, Chikungunya, Filaria)
Part G: National Leprosy Elimination Programme (NLEP)
Part H: National Programme for Control of Blindness (NPCB)
Part I: Revised National Tuberculosis Control Programme (RNTCP)
Part J: Inter-Sectoral Convergence
Part K: National Tobacco Control Programme (NTCP)
Part L: Non Communicable Diseases (NCD)

The State Programme Implementation Plan (SPIP) for NRHM (2011-12) for Bihar is based on the experience of implementing the NRHM Programmes during 2005-10 and provides the roadmap for the actual implementation of this programme for the next financial year 2011-12.

State's Vision, Goal and Strategy

The State's vision for the overall development, in general, and accomplishment of the desired set of goals in health sector under NRHM for the current year is as mentioned below:

- Universal Access to Primary Health Care
- Provide affordable Health Care Services
- Decentralized Health Services
- Community Participation in Health Care
- Enhanced performance of Public Health System by improving quality and ensuring client satisfaction

- Strengthen Health Management Information System
- Encourage participation of Civil Society Partners in health service delivery
- Private Sector Participation in Tertiary Health Care
- Promotion of AYUSH Services and their mainstreaming
- Mobile Medical Services for difficult areas to improve access
- Environment conservation (Bio-Medical Waste Management)

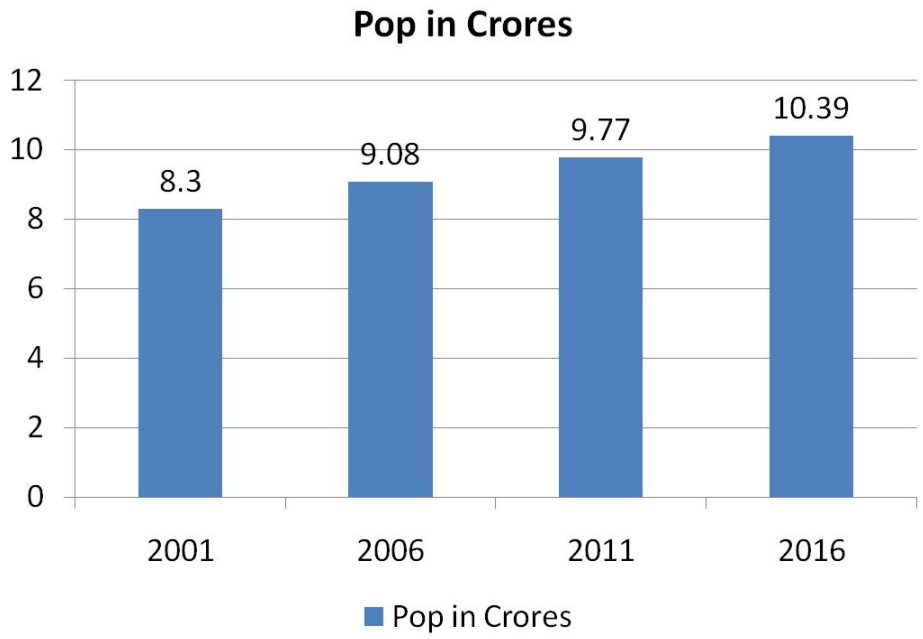
The goal is to improve quality of life of the rural people by reducing the following-

Table1: RCH Outcomes in the State: Goals				
Outcomes Indicators	Bihar		India	
	Current Status	Goal	Current Status	Goal
		2011-12		2011-12
MMR	312	200	254	<100
IMR	52	45	53	<30
NMR	31	25	39	20
TFR	4.0	3.7	2.7	2.1

Bihar State has set targets and goals of reducing IMR from 52 to less than 45, MMR from 312 to 200, TFR to 3.7 from 4.0 and improve the rate of Institutional delivery to 70% by the end of FY 2011-12. In addition, it is aimed to reduce Birth Rate from 28.5 to 27, Death Rate to 6.7 from 7 and increase CPR from 28.8 to 45.

These goals clearly indicate that the State is planning to drastically upscale availability, accessibility and utilization of RCH services. These goals will be attained by a set of processes that empower local communities to take decisions, plan and implement strategies that provide equitable access to quality affordable health care services, that are gender sensitive and that are directly or indirectly contributing to improved health indicators for the state.

Population Projection for Bihar



The State Health Society with the support of Government of Bihar is already making all round efforts towards achieving the above designated goals and the same shall be continued this year also.

Main Strategies proposed to be adopted

The strategies will be rolled out by the vast network of health care institutions and its staff under National Rural Health Mission and its yearly implementation plan.

Maternal Health:

- ✧ Focus on quality antenatal care to all pregnant women by increasing the access through existing Govt. facilities.
- ✧ Quality improvement of the ANC through reorientation.
- ✧ To increase awareness amongst mothers and communities about the need of ANC.
- ✧ Focus on 24-hour institutional delivery with basic emergency care in all PHCs and referral of obstetric emergencies.
- ✧ Social mobilization for institutional deliveries by involvement of *Mahila Mandals*, PRIs through orientation to motivate pregnant women and their families for institutional delivery.
- ✧ Focus on operationalisation of CHCs (across the state) inorder to help them become venues for comprehensive emergency obstetric care.
- ✧ Strengthening and upscaling transport and referral systems.
- ✧ Identification and involvement of Pvt. Sector hospitals to deliver basic & comprehensive EmOC.
- ✧ Ensuring clean home deliveries by skilled birth attendants in difficult and inaccessible areas.
- ✧ To reduce unsafe abortion by increasing access to safe abortion in Govt. & Pvt. facilities and promoting awareness about harmful effects of unsafe abortion amongst women, community, PRIs.
- ✧ To increase institutional delivery by continuing with the JBSY Scheme.

Child Health:

- ✧ To provide routine immunization including the booster dose to all children by strengthening sub-centre level services and increasing access through Govt. and Pvt. facilities.
- ✧ Prompt and ensure appropriate community level care for all sick children and neonates and prompt referral where indicated.
- ✧ To increase awareness amongst mothers on benefits of immediate breast feeding and need and importance of exclusive breast feeding for 6 months and supplementary feeding from 6 month onwards.
- ✧ Improve management of children with ARI and diarrhoea and reduce deaths due to it.
- ✧ Adequate referral arrangement and strengthening health facilities for treating a sick child or neonate when it requires hospitalization.
- ✧ Involvement of Pvt. Sector hospital to provide new born care services.
- ✧ To standardize case management of sick newborn and children under IMNCI.

Family Planning:

- ✧ To raise awareness amongst couples, communities and PRIs about contraceptives and advantage of small family.
- ✧ Increase the number of service delivery points and to promote contraceptive use through social marketing.
- ✧ Focus on quality male & female sterilization and conduction of sterilization camps in uncovered areas.
- ✧ To improve the number and skill of service providers by training of doctors on lap sterilization and NSV, training of GNMs to assist lap sterilization and ANMs on IUD insertion.
- ✧ Public Pvt. partnership for increasing contraceptive use and sterilization.

Adolescent Health:

- ✧ To educate and raise awareness amongst the adolescent boys and girls about human physiology, RTI, STI, HIV/AIDS and safe sex.
- ✧ To open adolescent health clinic at block level.

Programme Management arrangements:

For strengthening of planning and implementation and to build capacity at the level of State, district and below for good governance, decentralization of powers and professional management structures has been proposed as follows:

State Level:

- ✧ The State Programme Management Unit is being augmented with additional managerial manpower focusing on heading various cells representing areas of the programme like Procurement, PPP, Planning & monitoring & evaluation, Finance, MCH, Convergence, Communication, HR etc. A Corporation has been registered under the Depratment of Health for expediting the civil works and procurements under the mission and for ensuring logistic support thereafter.

District Level:

- ✧ At the district level, the District Programme Management Unit is being strenhgthened with additional manpower in areas of *ASHA*, Planning, Child Health etc and supportive manpower from different development partners. Additonally Hospital Managers have been provided in FRUs to operationalise the same, and for FY 2011-12 an accounts personnel is also proposed for the same.

Block Level:

- ✧ Programme Management unit which comprises Block Programme Manager and Accounts Manager will continue to work in co-ordination with other related departments including involving PRIs and additional manpower is being provided in programmes like *ASHA*.

Other initiatives:

- ✧ Operationalisation of the HSCs is the focal area for Bihar this year
- ✧ To improve the skills of the health manpower, various trainings have been proposed. It has also been proposed to improve the infrastructure and manpower of the lone training institute of the state, i.e., SIHFW. The Plan also highlights some of the initiative that will be implemented under the mission like construction of new PHCs, construction of Sick Newborn Care Unit-Newborn units-Neonatal Stabilisation units, model OTs, ICUs in District Hospitals.
- ✧ Various other innovative concepts like Mobile Medical Units, introduction of Health Insurance on pilot basis, conceptualizing HMIS on a broader dimension etc have again been proposed.
- ✧ Strategic interventions have also been undertaken for improving immunization with improved focus on difficult and outreach areas.
- ✧ To reduce incidence of prominent diseases like malaria, TB, Blindness various strategies has been reflected in the PIP including Eye OTs in District hospitals.
- ✧ Steps have also been initiated to ensure convergence with the key stakeholders, so as to run the programme effectively.

To achieve the above objectives, goals and targets, the state will implement the proposed PIP 2011-12 with full political and administrative commitment.

The expected allocation of fund from Government of India according to the need projected by the state is a sum of Rs.2589.65 crores for the financial year 2011-12.

Current Budget Status at a glance:

1 Provisional Unspent balance under NRHM as on 01-04-2011 – Rs.405.60 crores
2 GOI resource envelope for 2011-12 under NRHM – Rs.1122.10 crores
3 Proposed NRHM Budget FY 2011-12 – Rs.1881.47 crores
4 Committed Unspent Blanace up to 2010-11 to be revalidated in 2011-12- Rs.286.30 cr

Summary of the Proposed Budget

BIHAR NRHM BUDGET 2011-12			
PART	**HEAD**	**BUDGET 2011-12 (Rs. In lakhs)**	**%**
A	RCH II	91847.26	48.82
B	NRHM Additionalities	51160.81	27.19
C	Immunization	2891.54	1.54
D to I	NDCP	7248.37	3.85
J	Intersectoral Convergence	16230.36	8.63
K & L	NTCP & NCCD	114.51	0.06
	Direction & Administration (Treasury Route)	18655.00	9.92
	GRANT TOTAL	**188147.86**	**100.00**

Part A-

PART-A RCH Flexipool Summary Budget 2011-12			
S. No.	**Budget Head**	**Total Annual Budget (Rs. Lakhs)**	
		High focus districts	**State Total**
1	MATERNAL HEALTH		
(a)	Janani Bal Suraksha Yojana /JBSY		32695.95
(b)	Others		4061.65
	Sub Total Maternal Health	3203.06	**36757.60**
2	CHILD HEALTH	3977.41	4410.49
3	FAMILY PLANNING		
a	Sub-total Family Planning (excluding Sterilisation Compensation and NSV Camps)		2876.37
b.	Sub-total Sterilisation Compensation and NSV Camps		7275.00
	Sub Total Family Planning	10038.385	**10151.37**
4	ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH	506.97	514.75
5	URBAN RCH (focus on Urban slums)	100.44	108.00
6	TRIBAL RCH	0.00	0.00
7	VULNERABLE GROUPS	0.00	0.00
8	INNOVATIONS/ PPP/ NGO	606.54	613.25
9	INFRASTRUCTURE AND HUMAN RESOURCES	30955.46	23378.57
10	INSTITUTIONAL STRENGTHENING	4565.43	5165.56
11	TRAINING	1218.68	3008.23
12	BCC / IEC	0.00	743.92
13	PROCUREMENT	0.00	0.00
14	PROGRAMME MANAGEMENT	5482.05	6995.51
	GRAND TOTAL	**60654.44**	**91847.26**

Part B-

Sl. No.	Activities	In Lakhs	% of total budget
1	Decentralization (incl. ASHA)	15114.58	29.54
2	Infrastructure Strengthening	9077.26	17.74
3	Contractual Manpower	55.08	0.11
4	State Health System Resource Centre	100.00	0.20
5	PPP Initiatives	10166.39	19.87
6	Strengthening of Cold Chain	389.02	0.76
7	RCH Procurement and Logistics	15936.56	31.15
8	De-centralised Planning	271.91	0.53
9	Operational Research (RI)	50.00	0.10
	Total	**51160.81**	**100.00**

Part C-

Sl. No.	Activities	In Lakhs	% of total budget
1	Routine Immunization	**2891.54**	100.00
	Total	**2891.54**	**100.00**

Part D-I

Sl. N0.	Budget Head	In Lakhs	%
D	NIDDCP	18.00	0.25%
E	IDSP	543.37	7.50%
F	Kalazar	1629.11	22.48%
	Malaria	383.94	5.30%
	Dengu + Chikungunya	40.50	0.56%
	JE	20.51	0.28%
	Filaria	625.03	8.62%
G	NLEP (Leprosy)	225.00	3.10%
H	NBCP (Blindness)	1122.80	15.49%
I	RNTCP (T.B.)	2640.11	36.42%
	Total	**7248.37**	**100.00%**

Part J-

PART-J Inter-Sectoral Convergence

Sl. No.	Activities	In Lakhs	%
1	**Indian Systems of Medicine (AYUSH)**	11716.00	72.19
2	**ICDS--**		
a	Incentive to AWW for social mobilization in Muskan Abhiyan	3840.00	23.66
b	Incentive under IMNCI (Budgeted in Part-A)	0.00	0.00
c	SABLA Project	41.89	0.26
d	IFA supply (Budgeted in Part-A)		
3	**State AIDS Control Society--**	0.00	0.00
a	Training of MOs & Paramedical Staffs at Sub District Level	87.40	0.54
b	Training of ASHA Worker on HIV/AIDS	332.58	2.05
c	Integrated Counselling and Testing (ICTC) for HIV testing of ANC cases	212.50	1.31
4	Education Department (Budgeted under SHP)	0.00	0.00
5	Panchayati Raj Department (Budgeted under VHSC Part-B)	0.00	0.00
	Total	**16230.36**	**100.00**

Part K-L-

PART- K & L Priority Projects

Sl. No.	Activities	In Lakhs	%
K	NTCP		
A	Proposed budget for State Tobacco Control Cell	16.60	20.19
B	Budget for District Tobacco Control Programme	28.64	49.01
C	Additional budget for IEC and Mass Media activities	18.00	30.80
	Total	**63.24**	**55.22**
L	**NCCD**		
A	Salary	16.40	31.99
B	Development of IEC/BCC material	4.75	9.26
C	Development of training Module for ASHA and health worker	3.00	5.85
D	Training of Master trainers on NCD	2.45	4.78
E	Research on NCD	6.75	13.16
F	Community Intervention in two districts on NCD	1.56	3.04
G	Health Awareness Events	3.43	6.69
H	Community level Initiative	4.70	9.17
I	Referral of NCD patients	1.80	3.51
J	Travel	3.92	7.65
K	Office Expenses	2.02	3.93
L	Documentation	0.50	0.98
	Total	**51.27**	**44.78**
	Total (K & L)	**114.51**	**100.00**

The program has made positive impact on the indicators in the state but there is still a long way to go……

Process of Plan Preparation | Chapter - II

DECENTRALISED AND INCLUSIVE PLANNING: BIHAR HEALTH PLAN (2011-12)

Flexible, decentralized planning is the pivot on which the entire concept of NRHM revolves and the same has been adopted by State Health Society Bihar. The Planning process under NRHM in Bihar has seen significant evolution from norm based funding in 2005-06 to a bottom up process resulting in Integrated District Health Action Plans from 2009-10 and Block Health Actions Plans from 2010-11 and finally to HSC Plans for FY 2011-12.

Till the year 2008-09 SHSB disbursed funds on the basis of NRHM plans prepared at the State level (SHSB had tried to initiate de-centralised planning in 2005-06 through external consultants but the process could not be completed). From the year 2009-10 onwards detailed district PIPs were prepared and from 2010-11 Block Plans were also prepared. The district PIPs are reflected in the State PIP. Subsequent fund release is based on district requirement and Government of India approval. The concerted efforts have resulted into improved financial performance over the years.

The State Programme Implementation Plan 2011-12 has been framed on the basis of strategies and activities which worked in the last five years. The major bottlenecks have been identified and an attempt has been made to overcome them through alternative strategies.

The SPIP follows in essence, form and content, “GoI guidelines for SPIP" and the “Suggestive Guidelines for Planning Framework of SPIP in 2011-12”. The guidelines laid down comprehensive structure for the planning process and all state programme divisions have followed the basic formats for budgets and work plan within which information was required for the effective planning and implementation of NRHM.

The broad contours of the District Health Action Plan, resource allocation and norms, system of conducting situation analysis, Block level consultations, setting objectives, district planning workshop, work plan and average costs, monitoring and programme management and the structure of DHAP are in essence being followed in Bihar for NRHM planning. Efforts have been made to plan based on evidence, consult all stakeholders, incorporate lessons learnt from previous years under NRHM, set realistic objectives, develop synergies between different vertical programs and strengthen and decentralize programme management.

The Planning exercise for FY 2011-12 has been a multi-pronged process.

The State has undertaken HSC, Block and District Planning Exercise under which District Action Plans as per the NRHM guidelines have been prepared for all the 38 districts and Block Plans have been made across most of the Blocks, and for the rest this activity is expected to be completed by end of February 2011. The State Action Plan for 2011-2012 reflects the outcomes of the District Action Plans and the State level specific requirements and activities. The State has undertaken HSC level planning this year for which in

coordination between the Planning and M&E cell modules for planning through ANMs have been developed and furthermore the ANMs have been provided training on the same.

Planning Methods

Planning committees were created at district and block levels with designated nodal officers at the district and block level for the task. District Planning team (DPT) at the District level has been constituted with ACMO, DPM, DAM, 1 DPO, 1 MOIC, 1 BHM. Three Intensive (7 days) Capacity Building Workshops for the DPT has been held with the support of NHSRC and SPOs, in which District Planning in all its facets- Why, When, Where, How has been dealt with, and also sensitization done on all NRHM programmes. Block Planning team constitutes the MOIC, Block Health Manager and Block Accounts Manager. At the district level ACMO is the Nodal

Officer for Planning, at the block-the MOIC is the noal person and different DPOs have been designated as Nodal Officers per block in each district for the Block Planning exercise. At the HSC level the ANM is the nodal person for planning and the team comprises of AWW and *ASHA*s also.

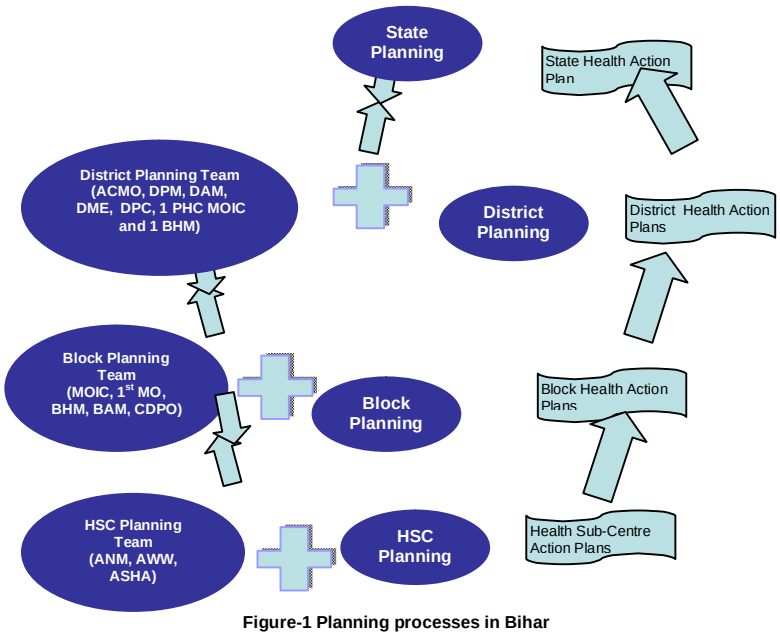


Figure-1 Planning processes in Bihar

Table-1 Steps of District 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 HMIS, by reviewing records, registers and annual reports and also from DLHS, SRS and NFHS surveys. Primary data collection involved focus group discussions, interactions and meetings in different districts. This was done to have opinion of all the programme officers, health staff, grass root workers and private partners.

It is noteworthy that for the first time in Bihar NRHM HSC Planning exercise has been undertaken. The process is still on-going and not all the HSC plans were completed as per the schedule yet some of the districts ensured incorporation of HSC Plans in their Block Plans and subsequent district plans.

Steps in Planning were-

- Capacity building of the district team on District Planning module at State level.
- Facilitation of district plans to State Nodal Officers for each district and various Development Partners
- Resource Envelop communicated to the districts and the blocks based on the district and block fund allocation in the year 2010-11 with an anticipated 25% increase from previous year's budget allocation and along with Financial Guidelines/Unit Cost for each Budget Head prepared by respective SPOs.
- Distribution of the blocks to District team members
- Orientation of Block Team on Block level planning process
- Organization of consultation with Health staff to identify the gaps in facility.
- Organisation of multi stakeholder workshop for preparing the block action Plan, Situational analysis done and drafting of Block Plans and approval of RKS
- District level workshop – Block to present the block action plan in front of the DHS
- Blocks to incorporate the suggestions from district workshop and finalize the block plan
- DHS to consolidate the findings from blocks and suggest strategies in DHAP (consolidation of BHAPs and incorporation of district level requirements/priorities).
- Districts presented their Plans before respective SHSB officials/SPOs at a State level workshop held in end December and based on the feedbacks received from SPOs, modified their Plans and gave final shape to the same.
- CS and DM endorsed the plan and submitted it to the state.
- After that, all the Civil Surgeons, District Program Managers and District Planning Coordinators were called to SHSB for presentation of DHAPs.
- Incorporation of District Plans and State level requirements/activities in the State Plan (State has considered the requirement of the district thoroughly and provision has been made in the PIP as per their need). The State level Programme Officers have chalked out their plans and requirements for FY 2011-12 which has also been consolidated into the State PIP and synchronized with district level requirements.
- After the approval of GoI, District and PHC/Facility Annual and Quarterly allocation (Financial and Physical) for Major and Minor heads to be undertaken
- Financial Guidelines (in Hindi) for each Budget Head (covering aspects like purpose of the budget head, outcome, unit cost, responsible official, financial protocol etc) to be prepared for easy implementation and clarity at the district level (prepared in consultation with district representatives)
- Subsequent sharing of allocations and guidelines with district-sub-district facilities through a district level workshop
- Followed by uploading of Block on district sites and District Plans, Allocations (District and BPHC) and Guidelines on official SHSB website www.statehealthsocitybihar.org link-PIP 2010-11
- Mid term Review of Fund utilization of each district and facility

The progress under various programmes has been analyzed to identify and prioritize the Programme interventions. Moreover, systems development interventions have been incorporated to sustain Programme gains.

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

The SPMU team was thoroughly involved in the process and their critical inputs were incorporated to make this plan more holistic, realistic and achievable. Documents available in the State regarding the health indicator issues were studied by the State Planning Team. This desk review gave the State Planning Team information regarding the various problems in the State and preventive and promotive measures which may be taken under NRHM implementation.

The Plan was further reviewed by the Executive Director, SHSB-cum-Secretary, Health and the CEO-cum-Principal Secretary, Health, Govt. of Bihar.

State level workshop was held with Development Partners for ensuring their support in planning process and for subsequent proper implementation at the district and block level and to ensure optimum fund utilisation at the district level.

District Plan as the key instrument of planning has contributed significantly in setting up of enabling institutional structures right from the village to the State level, provision of untied resources for local action, identifying areas for focused attention through facility and household surveys, convergence with wider determinants, have been some of the many achievements of decentralized planning.

Outcome Analysis of PIP of 2009-10 and 2010-11 | Chapter- III

Government of Bihar commits itself to achieving the highest attainable level of physical, mental, and social health of its citizens through processes that will empower local communities and citizens as well as lead to poverty reduction paving way for equitable and gender sensitive communities in the State. Universal access to comprehensive quality primary healthcare with adequate referral linkages would be the key strategy to realize the vision, as envisaged by the State's Vision 2020 document and the Millennium Development Goals 4, 5 & 6c.

The State will respond to the health needs of the people and will be guided by principles of transparency, accountability and community participation involving stakeholders from public and private to create a society enjoying healthy productive lives in harmony with their social responsibilities and contributing towards a progressive Bihar.

The State aims at minimizing regional variations in the areas of Reproductive and Child Health including population stabilization through a life-cycle approach by promoting informed choice, empowering women and communities, and paying special attention to reproductive and child health issues of disadvantaged populations living in remote areas. Meeting unmet demands of the target population, and provision of assured, equitable, responsive quality services are central to the programme strategies.

For all this, the state plans major interventions to strengthen the public health system as well as to improve current health programmes related to maternal health, child health, family planning, adolescent health, urban health and disease control and disease surveillance.

Recent turnaround of image

The improved governance has led to an economic revival in the state through increased investment in infrastructure, better health care facilities, greater emphasis on education, and a reduction in crime and corruption. Indian and global business and economic leaders feel that Bihar now has good opportunity to sustain its growth, economic development and as such have shown interest in investing in the state. A BBC article titled "Where 'backward' Bihar leads India" talked about how the state has made strides in the areas of women's empowerment, judiciary reforms, tax reforms, and public safety.

Health Challenges

Despite efforts in the last few decades to stabilise population growth, the state's population continues to grow at a much faster rate than the national population. The ratio of the rural and urban population is approx. 84:16. The population of Scheduled Caste households as per NFHS 3 is 18.7% and of Other Backward Class is 58.6% respectively of the state's total population. BPL population is 56.48% (Source: Deptt. of Rural Development, GOB-2007). 44% of the population in Bihar is under age 15; only 5% is aged 65 or above

(NFHS III). The growth rate of population in the state is 1.86% (Directorate of Statistics, GoB). The sex ratio of the state at 921 females per thousand males is less favorable than the national average of 933 per 1000 male (Census 2001 data).

NRHM under the Ministry of Health and Family Welfare, (MOHFW), Govt of India has recently (2008) brought out a document entitled "India Guaranteeing Quality Primary Health Care for All: An Agenda for Action". In this book, key public health challenges have been identified state wise and have been furnished in a tabular form. For Bihar the indicators where there has been higher incidence or the performance has been low and requires greater thrust are-

1 Infant Mortality
2 Maternal Mortality
3 Very high out of pocket expenditures in Government hospitals
4 High TB Cases/suspected cases, chest symptoms
5 High TFR
6 Full immunization
7 Tobacco and alcohol
8 Age at marriage
9 Spousal physical or sexual violence

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

The Hon'ble Chief Minister is the premier for the overall public health system of Bihar. The Department of Health is under the portfolio for the State Health Minister. However, the executive decisions pass through the chain of Development Commissioner and Prinicipal Secretary. The Secretary-Health is the Executive Director of SHSB. There is the Director-in-Chief who heads the National Disease Control Programme of NRHM and is the coordinating link between Health Directorate and State Health Society Bihar. Additionally in the Directorate various State Programme Officers of Joint Director and/or Director level head the various components of NDCP like TB, Leprosy, Blindness, NVBDCP. At SHSB following cadres have been approved by the Governing Body of SHSB namely Additional Director, Deputy Director, Senior Consultant, Consultant, Senior Executive and Executive. The Additional Directors head various cells of SHSB like Procurement, PPP, Inter-Convergence, Planning & Monitoring, Finance etc. Additional technical supports in SHSB in the form of State Health Resource Centre and *Asha* Resource Centre have been created. Executive Director, NRHM is the principal authority for the tasks related to the mission. Executive Director undertakes the PIP formulation and subsequent execution of the plans with well-concerted and coordinated support from several other departments besides health. The State Programme Management unit, Regional Programme Management units, District Programme Management units, Block Programme Management Units are the executive chains for successful implementation of the PIP plans. Directorate-AYUSH looks after the activities, including planning, implementation, monitoring and evaluation of the programmes related to Indian systems of medicine such as Ayurveda Yoga, Unani, Siddha and Homeopathy. The Directors are supported by several Joint Directors and Deputy Directors in effective and smooth functioning of the overall health systems. Civil Surgeon is in charge of the District Health Systems and also

is responsible for proper functioning of the district hospitals. The RPMU supports functioning of Regional Deputy Director for NRHM activities. DPMU supports the functioning of the CS while the BPMUs support the activities of the Block Medical Officers in implementation of NRHM activities.

Strategic Direction

The entire State Health Society Bihar team is working in a *mission* mode to achieve goals set-in for the state and is trying to effectively deal with the challenges. The Department has set the strategic direction that encompasses year wise objectives, technical strategies; interventions include plan for improving maternal health, child health, family planning, adolescent health etc. The state considers that strengthening institutional mechanisms, infrastructural development, ensuring adequate and trained human resources etc are fundamental requirements for getting better programme outcomes. Accordingly, the SPIP document focuses on these aspects exploring fund sourcing from NRHM or Bihar Government or Development Partners.

The State has been successful in the past few years since the inception of NRHM towards ensuring health services for the needy, in the FY 2011-12 and subsequent years the aim would be to provide quality services and ensure services right till the doorstep of the needy people.

The State through core programme strategies and special schemes such as *Muskaan, MAMTA* addressing child health, incentives to health staff; cross cutting programme strategies like Capacity building, PPP, quality assurance, gender mainstreaming, community participation, serving vulnerable community through mobile units and other innovations (some of which are district specific) and via strengthening of Institutional framework and governance mechanism by recruiting qualified human resource; through structures like functional, accountable State/District Health Societies with Governing and Executive Board; Integrated Organizational Structure of Department of Health; Functional SPMU, RPMU, DPMU, BPMU; Registration of RKS and Constitution of Village Health and Sanitation Committee for bringing in transparency and accountability by involving the community, ensuring holding of VHNDs and lastly through infrastructure development and consistent logistics support is endeavoring towards better health services.

The financial and physical progress that took place during FY 2009 – 10 and up to 31st December 2010 for FY 2010 – 11 is as under-

Sl.No	STRATEGY/ACTIVITIES	Financial (Rs. In lakh)				Physical	
		2009-10		2010-11		(2010-11)	
		Amount Approved (As per ROP)	Actual Expenditure	Amount Approved (As per ROP)	Actual Expenditure	Expected Output (as per ROP)	Achievements
RCH Flexipool							
A.1	**MATERNAL HEALTH**						
A.1.1	**Operationalise Facilities (Only Dissemination, Monitoring, and Quality)**						
A.1.1.1	Operationalise FRUs (BSU)	133.44	70.69	267.12	21.94	76	
A.1.1.2	Operationalise 24x7 PHCs	9.50	7.51				

Sl.No	STRATEGY/ACTIVITIES	Financial (Rs. In lakh)				Physical	
		2009-10		2010-11		(2010-11)	
		Amount Approved (As per ROP)	Actual Expenditure	Amount Approved (As per ROP)	Actual Expenditure	Expected Output (as per ROP)	Achievements
A.1.3	**Integrated Outreach RCH Services**						
A.1.3.1	RCH Outreach Services in Un-Served/ Under-Served Areas (Monitoring)	21.32	1.03	106.60	1.43	8858	172 (Dec. 10)
A.1.3.2	Monthly Village Health and Nutrition Days			111.83	0.66	63902	2064(Dec.10)
A.1.4	***Janani Bal Suraksha Yojana* / JBSY**						
A.1.4.1	Home Deliveries	55.00	0.36	55.00	30.48	89667	6096(Dec. 10)
A..1.4.2	Institutional Deliveries-						
A.1.4.2.1	Institutional Deliveries Rural	20,000.00	23,611.83	24,000.00	17,154.82	2051666	1052502 (Dec. 10)
A.1.4.2.2	Institutional Deliveries Urban	2,400.00	77.52	250.00	269.92	107982	22494 (Dec. 10)
A.1.4.2.3	Ceasarean Deliveries	90.00		150.00	4.13	107981	8184 (Dec. 10)
A.1.4.3	Other Activity (JBSY)	450.90		541.68	18.96		
A.1.5.1	***Maternal Death Audit***	***5.00***		***70.00***			
A.2	**CHILD HEALTH**						
A.2.1	IMNCI	36.00	70.92	36.00	4.26	456	
A.2.2	Facility Based Newborn Care/FBNC	43.00	7.19	40.00	47.89	456	
A.2.3	Home Based Newborn Care/HBNC		3.06				
A.2.4	School Health Programme	1,531.85	176.31	1,200.00	392.08	50000	23744 (Nov. 10)
A.2.6	Care of Sick Children and Severe Malnutrition (Nutritional Rehabilitation Centres)	49.34		774.90	13.63	38	
A.2.7	Management of Diarrohea, ARI and Micronutrient Malnutrition (Vitamin A Biannual Round)		34.79	114.62	13.06	76	
A.3	**FAMILY PLANNING**						
A.3.1	**Terminal/Limiting Methods-**						
A.3.1.1	Dissemination of Manuals on Sterilisation Standards & Quality Assurance of Sterilisation Services	9.50	0.54	7.50	1.78	34 distrcts	18
A.3.1.2	Female Sterilisation Camps		12.33	127.92	195.81	12792 (with 30-40 sterilisations)	5280
A.3.1.3	NSV Camps	50.00	2.28	100.00	1.46	1000	150
A.3.1.4	Compensation for Female Sterilisation	4,100.00	3,794.61	4,750.00	1,574.31	475000	216155
A.3.1.5	Compensation for Male Sterilisation	350.00	36.65	375.00	8.37	25000	4344
A.3.1.6	Accreditation of Private Providers for Sterilisation Services	1,125.00	589.14	2,250.00	566.11	150000	24000
A.3.2	**Spacing Methods-**						
A.3.2.1	IUD Camps	63.96	1.20	150.00	15.39	10000	3074
A.3.2.2	IUD Services at Health Facilities/Compensation			150.00	0.93	300000	

Sl.No	STRATEGY/ACTIVITIES	Financial (Rs. In lakh)				Physical	
		2009-10		2010-11		(2010-11)	
		Amount Approved (As per ROP)	Actual Expenditure	Amount Approved (As per ROP)	Actual Expenditure	Expected Output (as per ROP)	Achievements
A.3.2.4	Social Marketing of Contraceptives			2.00			
A.3.2.5	Contraceptive Update Seminars, Quality Assurance (Minor Procurement, Field Visit, Review Meeting Etc.)	9.75		38.00	1.51	38	24
A.3.3	**POL for Family Planning-Others**					533	533
A.3.3	POL for Family Planning-Others	100.00	6.47	92.50	5.79		
A.3.4	"Repairs of Laparoscopes	2.00					
A.3.5	"Other Strategies/Activities	4.93		198.73	1.56		
A.4	**ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH**						
A.4.1	Adolescent Services at Health Facilities.	39.05	0.18	29.30			
A.4.2	Other Strategies/activities		99.85	14.75	0.02		
A.5	**URBAN RCH**		**4.75**				
A.5.1	Urban RCH Services (Urban Health Centre Through PPP)	158.00		108.00		20	8
A.8	**INNOVATIONS/ PPP/ NGO**						
A.8.1	PNDT and Sex Ratio	150.00	4.73	145.25	0.86	534 (1 State Level)	
A.8.2	Public Private Partnerships (Chiranjeevee Scheme)		84.92	50.00		2	
A.8.4	Other Innovations(Family Friendly Hospital Certification)		223.34	20.00	1.54	10	
A.9	**INFRASTRUCTURE & HUMAN RESOURCES**						
A.9.1	**Contractual Staff & Services**						
A.9.1.1	ANMs (Budgeted in Part-B)	600.00	0.43				
A.9.1.2	Laboratory Technicians (BSU)	177.84	2.02	133.38	5.84	248	
A.9.1.3	Staff Nurses			5,400.00	1,008.09	2486	
A.9.1.4	Medical Officer and Specialists (BSU, Anesthetists, Pediatricians, Ob/Gyn, Surgeons, Physicians)	2,075.89	2.56	339.40	25.14	76	
A.9.1.5	Others	105.51	1.99	143.48	28.03		
A.9.1.5.1	Fast Track Training Cell in SIHFW				5.89		
A.9.1.5.2	Fill Vacant Position at SIHFW/Hiring Consultant at SIHFW				3.89		
A.9.1.5.3	Honorarium of Voluntary Workers					2000	
A.9.1.5.4	Consultant (18) State Level						
A.9.1.6	Incentive/ Awards Etc. to ASHA Link Worker/ SN/ MOs Etc. (Incentive for ASHA & ANM for Muskan Ek Abhiyan)	3,360.00	2,425.00	3,360.00	1,531.74	51843 ASHAs, 12000 ANMs	7258-ANM(Oct. 10)
A.9.2	**Major civil works (new construction/extension/addition)**						

Sl.No	STRATEGY/ACTIVITIES	Financial (Rs. In lakh)				Physical	
		2009-10		2010-11		(2010-11)	
		Amount Approved (As per ROP)	Actual Expenditure	Amount Approved (As per ROP)	Actual Expenditure	Expected Output (as per ROP)	Achievements
A.9.2.2	Major Civil works for operationalisation of 24 hour services at PHCs		4.38				
A.9.3	**Minor Civil Works**						
A.9.3.1	Minor Civil Works for Operationalisation of FRUs	37.50	1.11	57.50	13.86		
A.9.3.2	Minor Civil Works for Operationalisation of 24 Hour Services at PHCs	99.50	9.84	533.00	11.74	533	
A.9.4	**Operationalise IMEP at Health Facilities (Bio-Waste Management)**						
A.9.4	"Operationalise IMEP at Health Facilities (Bio-Waste Management)			510.72	159.48	36	6
A.9.5	"Other Activities (RCH-I Civil Works)		0.50	-	0.04		
A.10	**INSTITUTIONAL STRENGTHENING**						
A.10.3	**Monitoring & Evaluation / HMIS**	**50.40**	**1.31**	**259.10**	**8.55**	17531	
A.10.3.1	Upgradation and Maintenance of Web Server			-			
A.10.3.2	HMIS HR			-			
A.10.3.3	Printing of Revised HMIS Formats Prescribed Under NRHM,			-			
A.10.3.4	HMIS Training, 10.3.5: Mobility for M&E Officers			-	8.55		
A.10.3	Monitoring & Evaluation / HMIS				78.07		
A.10.4	Sub Centre Rent and Contingencies	531.00	48.47	106.20	32.68	1770	
A.10.5	Other Strategy/Activities (Operationalise FRUs Through Supportive Supervision of MCH)	5.40		22.68	0.01	180	
A_11	**Training**						
A.11.1	Strengthening of Training Institutions		**14.51**				
A.11.3	**Maternal Health Training**						
A.11.3.1	Skilled Birth Attendance / SBA	533.50	80.23	98.62	41.15		
A.11.3.1.1	SBA Trg. (Dist.) (Incl. Printing)				16.98	2520	670
A.11.3.1.3	SBA BEmOC						
A.11.3.1.4	SBA Supportive Supervision						
A.11.3.1.5	SBA in Private Facilities				2.23	288	220
A.11.3.2	EmOC Training	22.50		22.50	8.47		16(Jan 11)
A.11.3.3	Life Saving Anesthesia Skills Training	67.58		68.08	11.76		17(Jan. 11)
A.11.3.4	MTP Training	12.35		16.80	0.91	220	105 (Dec. 10)
A.11.3.5	RTI / STI Training	25.00		20.34			
A.11.3.7	Other MH Training		0.91				
A.11.5	**Child Health Training**						

Sl.No	STRATEGY/ACTIVITIES	Financial (Rs. In lakh)				Physical	
		2009-10		2010-11		(2010-11)	
		Amount Approved (As per ROP)	Actual Expenditure	Amount Approved (As per ROP)	Actual Expenditure	Expected Output (as per ROP)	Achievements
A.11.5.1	IMNCI Training	1,308.74	361.02	1,391.14	506.53	940 Batch (HW)	590 (Dec. 10)
A.11.5.2	F-IMNCI and SNCU	11.96	14.07	218.94	11.01	77 Batch (F-IMNCI), 144(SNCU)	11(Dec. 10)
A.11.5.5	Other CH Training			96.52	17.20		
A.11.6	**Family Planning Training**						
A.11.6.2	Minilap Training	16.80		36.40	8.05	38	1 State level
A.11.6.3	NSV Training	20.14		17.20		38	12 doctors
A.11.6.4	IUD Insertion Training	15.12	6.60	68.40	7.98	148	18 districts
A.11.6.5	Contraceptive Update Training			4.00	0.29		
A.11.7	"ARSH Training	28.01		13.59			
A.11.8	**Programme Management Training**						
A.11.8.1	SPMU Training	2.30		2.00			
A.11.8.2	DPMU Training	50.84	1.16	37.00	2.59	647	20
A.11.9	**Other Training** (Post Graduate Diploma in Family Medicine for MO, PGD in Public Health Mgt. for MO, DNB in Family Medicine for MO)		**1.50**	**93.00**	**14.50**		35
A.12	**BCC / IEC**						
A.12.1	Strengthening of BCC/IEC Bureaus (State and District Levels)		200.10	5.00	220.81		
A.12.2	Development of State BCC/IEC Strategy	19.00					
A.12.3	Implementation of BCC/IEC Strategy						
A.12.3.1	BCC/IEC activities for MH		1.71				
A.12.4	Other Activities (IEC)	662.89	23.40	500.00	22.89		
A_13	**PROCUREMENT**						
A.13.1	**Procurement of Equipment**						
A.13.1.1	Procurement of Equipment: MH	67.50	28.16	104.14			
A.13.1.1.1	Procurement of Equipment (MH)-Blood Storage Unit at FRUs				6.53	76	
A.13.1.1.2	Procurement of Equipment (MH)-(Procuring Equipment for the Anesthesia Departments in 6 Medical Colleges)	900.00				5	
A.13.1.1.3	Procurement of Equipment for Labour Room	1,212.46	270.27		223.31		
A.13.1.4	Procurement of equipment : IMEP		0.65				
A.13.2	**Procurement of Drugs and Supplies**		**130.37**				
A.13.2.1	**Drugs & Supplies for MH:-**			**886.39**			
A.13.2.1.1	Drug & Supplies for MH (MVA Syringes-MTP)				38.42	2356	1340 (Dec. 10)
A.13.2.1.2	Drug & Supplies for MH (Delivery Kits at HSC/ANM/ASHA)				0.99	191280	3951 (Dec. 10)
A.13.2.1.3	Drug & Supplies for MH (Availability of SBA Drug Kits				1.98	12498	807 (Dec. 10)

Sl.No	STRATEGY/ACTIVITIES	Financial (Rs. In lakh)				Physical	
		2009-10		2010-11		(2010-11)	
		Amount Approved (As per ROP)	Actual Expenditure	Amount Approved (As per ROP)	Actual Expenditure	Expected Output (as per ROP)	Achievements
	with SBA: ANMs/Nurses Etc.)						
A.13.2.1.4	Drug & Supplies for MH (ANC 3-Dose Iron Sucrose)					4165	
A.13.2.1.5	Drug & Supplies for MH (IFA Tab for Adolescents)-(pregnant &lactating mothers, (1-5) yrs. Children & adolescent girls)	1,024.08	372.02		101.71	10131942	
A.13.2.3	**Drugs & Supplies for FP:-**			**87.74**	**0.73**		
A.13.2.3.1	Drugs & Supplies for FP (Procurement of Minilap Sets)	15.00			0.39	2665	
A.13.2.3.2	Drugs & Supplies for FP (Procurement of NSV Kits)	7.60			0.20	190	
A.13.2.3.3	Drugs & Supplies for FP (Procurement of IUD Kits)	5.70			0.15	38	
A.13.2.5	General Drugs & Supplies for Health Facilities		5.81	7,000.00	1,142.01		
A_14	**PROGRAMME MANAGEMENT**						
A.14_1	Strengthening of State Society/SPMU	62.78	281.38	76.83	144.98		
A.14_2	Strengthening of District Society/DPMU	280.89	435.25	308.98	343.29		
A.14_3	Strengthening of Financial Management Systems	136.52	5.51	532.50	37.67		
A.14_4	Provision of Equipment/furniture and Mobility Support for SPMU Staff	348.95	161.09	29.50	121.16		

					(Rupees In Lakhs)		
Sl.No	**STRATEGY/ACTIVITIES**	**Financial**				**Physical**	
		2009-10		**2010-11**		**(2010-11)**	
		Amount Approved (As per ROP)	**Actual Expenditure**	**Amount Approved (As per ROP)**	**Actual Expenditure**	**Expected Output (as per ROP)**	**Achievements**
Mission Flexible Pool							
B.1	**ASHA**						
B.1.11	ASHA Support System at State Level	407.04		619.21			
B.1.12	ASHA Support System at District Level	21.60		406.20	19.89	38 (DCM) & 38 (DDA)	29 (DCM) & 31 (DDA)
B.1.13	ASHA Support System at Block Level	799.50		536.15	57.68	533	386
B.1.14	ASHA Training	2,583.95	905.74	2,000.00	27.67	87135	Modual-1-68592 & 2,3,4-52059
B.1.15	ASHA Drug Kit & Replenishment	225.56	110.68	851.47	42.60	87135	14 districts distributed
B.1.16	Motivation of ASHA- Saree & Umbrella	631.73		380.98	129.00	87135 Umbrellas, 174270 Sarees	56442 Umbrellas, 19 district
B.1.17	Capacity Building/Academic Support Program	10.00		10.00	5.17		
B.1.18	ASHA Diwas	812.30	339.64	900.00	292.36	87135	
B.1.2	Untied Fund for Health Sub Centre, Additional Primary Health Centre and Primary Health Centre	1,348.07	731.07	1,348.07	262.18	8858 HSC	
B.1.21	Village Health and Sanitation Committee	4,031.32	2,020.30	-	468.66	8462	7878 (Dec. 10)
B.1.22	Rogi Kalyan Samiti	853.00	574.00	1,078.00	452.07	684	
B.2	**Infrastructure Strenghtening**						
B.2.1	Construction of Health Sub Centre (Newly Created)	2,992.50	591.59	2,596.00	51.85	200	
B.2.2A	Construction of Primary Health Centres (APHCs) Newly Created	4,000.00	501.79	2,747.15	20.00	50	
B.2.2B	Construction of 15 Old Residential Quarters in APHC for Staff Nurses			540.00	53.94		
B.2.3	Upgradation of PHC to CHC	8,040.00	307.04	1,000.00	67.35		
B.2.4	Upgrading Dist. Hospital and SDH As Per IPHS			750.00	30.00	13 DH, 13 SDH, 2 Super Specialty	
B.2.5	Annual Maintenance Grant	820.80	161.02	470.00	133.94	637	
B.2.6	Accreditation/ISO : 9000 Certification of Health Facilities (10 PHCs, 5 SDHs & 5 DHs)	1,860.00	162.12	150.00	2.92	46	
B.2.7	Upgradation of Infrastructure of ANM Training School	700.20	6.49	350.00	83.81	27	
B.3	**Conractual Manpower**						
B.3.1	Mobile Phone Facility for Health Personnel	6,767.02	4,756.14	60.51	38.53		

B.3.2	Block Programme Management Unit	2,895.24	1,622.53	2,650.83	1,211.13	1066	
B.3.3	Addl. Manpower for SHSB	62.04		86.66			
B.3.4	Addl Manpower for NRHM :-	254.79			17.76		
B.3.4A	Addl. Manpower for NRHM: Hospital Manager in FRU			171.00	21.29	76	
B.3.4B	Addl. Manpower for NRHM: Regional Programme Management Unit			162.00		9	
B.3.5	SHSRC	100.00		100.00			
B.4	**Referral & Emergency Transport**						
B.4.1	Call - 102 Ambulance Services	40.32	162.25	40.32	74.52	6	6
B.4.2	1911 - Doctor on Call & Samadhan	8.16		162.25	13.52	6	6
B.4.3	Advance Life Saving Ambulances (Call 108)	89.01		142.41	87.26	10	10
B.4.4	Referral Transport in Districts			700.80	137.05	586	
B.5	**Americal Association of Physicians of Indian Origin (AAPIO)**						
B.5	Americal Association of Physicians of Indian Origin (AAPIO)			56.00			
B.6	**Services of Hospital Waste Treatment and Disposal in All Govt. Health Facilities Upto PHC in Bihar**	947.16		-			
B.6	Services of Hospital Waste Treatment and Disposal in All Govt. Health Facilities Upto PHC in Bihar (Budgeted in Part-A)						
B.7	**Dialysis Unit in Various Governmet Hospital of Bihar**	300.00		150.00			
B.7	Dialysis Unit in Various Governmet Hospital of Bihar						
B.8	**Setting Up of Ultra Modern Diagnostic Centre in Regional Diagnostics Centre and All Govt. Medical Colleges of Bihar**	360.00		360.00	30.14	1800000	
B.8	Setting Up of Ultra Modern Diagnostic Centre in Regional Diagnostics Centre and All Govt. Medical Colleges of Bihar						
B.9	**Outsourcing of Radiology & Pathology Services From PHC to DH**			1,000.00	274.59	767913	
B.9	Outsourcing of Radiology & Pathology Services From PHC to DH						
B.10	**Operationalising MMU**	1,600.56	30.44	1,500.00	242.06	48	38
B.10	Operationalising MMU						
B.11	**Monitoring & Evaluation (State, Dist and Block Data Centre)**	637.50	187.75	681.50	159.31	694	
B.11	Monitoring & Evaluation (State, Dist and Block Data Centre)						
B.12	**Hospital Maintenance**			-	0.15		
B_12	Hospital Maintenance						
B.13	**Provision of HR Consultancy Services**	22.50		22.50			

B.13	Provision of HR Consultancy Services						
B.14	**Strengthening of Cold Chain**					38 Cc handlers, 571 CC rooms	
B.14	Strengthening of Cold Chain	334.30	6.48	389.02	10.26		
B.15	**Mainstreaming of AYUSH Under NRHM**					1554 Doctors/ 226 Batches	1384/20 batch (Jan. 11)
B.15	Mainstreaming of AYUSH Under NRHM	3,915.85		4,272.80	215.75		
B.16	**Procurement and Logistics**						
B.16.3	District Drug Warehouse			411.94	2.81		
B.17	**Procurement of Supplies**				30.26		
B.17.1	Provision of Quality Beds				30.26		
B.18	**RCH Equipment/Instrument Procurement**						
B.18.1	Bio-Metric System- Biometric Machine, HMIS Software, Installation Cost, Vat)			34.20	2.74		
B.18.2	Procurement of SNCU Equipments for Dist. Hospital and New Born Corner Equipments for PHCs	1,300.00		854.13	174.33	411	
B.19	**De-Centralised Planning**					571	
B.19	De-Centralised Planning (Dist+State)	41.00	30.45	271.91	33.80	38 DHAPs, 533 BHAPs	38 DHAPs, 500 BHAPs
B_20	**Construction of Hostel**			20.00			
B.20	Construction of 1 STDC Hostel						
B.21	**ANMs R**					5067	
B_21	ANMs R			4,029.00	2,892.79		
B.22	**Intersectoral Convergence**					80492	
B.22	Intersectoral Convergence: Incentive for AWW Under Muskan Project			1,000.00	409.37		

		Rupees In Lakhs					
Sl.No	**STRATEGY/ACTIVITIES**	**Financial**				**Physical**	
		2009-10		**2010-11**		**(2010-11)**	
		Amount Approved (As per ROP)	**Actual Expenditure**	**Amount Approved (As per ROP)**	**Actual Expenditure**	**Expected Output (as per ROP)**	**Achievements**
	Immunization						
C	**Immunization**						
C.1	**Pulse Polio Operating Costs**						
C.1	Pulse Polio Operating Costs	7,287.00	7,526.32	7,069.08	4,185.86		
C.2	**Routine Immunization**	**2,468.00**	**1,250.05**				
C.2	Routine Immunization					More than 80% of above target	61% (N0v 10)
C.2.1	Mobility Support for Supervision and Monitoring at Districts and State Level.			20.00	7.14		
C.2.2	Cold Chain Maintenance			50.00	8.51		
C.2.3	Alternate Vaccine Delivery to Session Sites			800.64	62.20	100% as per Microplan (more than 80% of Alternate Vaccinators to be hired as per R.I. Microplan'	70% (as per process indicator)
C.2.4	Focus on Urban Slum & Underserved Areas			169.56	0.08	more than 80% of paid mobilizers to be used as per R.I. Microplan	100%
C.2.5	Social Mobilization by ASHA /Link Workers			600.00	0.04	100% of above target as per R.I. Microplan	81%
C.2.6	Computer Assistants Support at State			3.60			
C.2.7	Computer Assistants Support at District Level			45.60	0.97	100% to be in position	85-90%
C.2.8	Printing and Dissemination of Immunization Cards, Tally Sheets, Charts, Registers, Receipt Book, Monitoring Formats Etc.			163.54			
C.2.9	Quarterly Review Meeting at State Level			5.70		more than 80% DIOs review meeting on UIP expected	100%
C.2_10	Quarterly Review Meeting at District Level			10.66	0.23	100%	100%
C.2_11	Quarterly Review Meeting at Block Level			240.00	0.72	100%	100%
C.2_12	District Level Orientation for 2 Days ANMs, MPHW,LHV			100.00	0.82	100%	22% (due to non supply of H.W. Training module from GOI)
C.2_13	Three Days Training of Mos on RI			62.65			

		Rupees In Lakhs					
Sl.No	**STRATEGY/ACTIVITIES**	**Financial**				**Physical**	
		2009-10		**2010-11**		**(2010-11)**	
		Amount Approved (As per ROP)	**Actual Expenditure**	**Amount Approved (As per ROP)**	**Actual Expenditure**	**Expected Output (as per ROP)**	**Achievements**
C.2_14	One Day Refresher Training of District Computer Assistant on RIMS/HIMS			0.88	4.83	100%	
C.2_15	One Day Cold Chain Handlers Trainings			7.04	0.13	100%	
C.2_16	One Day Training of Block Level Date Handlers			7.04	0.12	100%	
C.2_17	To Develop Micro Plan at Sub-Centre Level			17.00	0.08		
C.2_18	For Consolidation of Micro Plan at Block Level(block and district level)			6.09	0.20		
C.2_19	POL for Vaccine Delivery From State to District and PHC/CHCs			38.00	1.11	100%	> 100%
C.2_20	Consumables for Computer Including Provision for Internet Access			1.82	0.02		
C.2_21	Red/Black Bags, Twin Bucket, Bleach/hypochlorite Solution			12.80	0.31	100%	100%
C.2_22	Alternative Vaccinator Hiring for Urban RI			-	5.81		
C.2_23	POL of Generators for Cold Chain			-	1.24		
C.2_24	Catch Up Campaigns for Flood Prone Areas			100.00	0.92		
C.2_25	AEFI Investigation of District AEFI Committee			5.70			
C.2_26	Supportive Supervision for 10 Top Priority Districts			-			

					(Rupees In Lakhs)
Sl.No	**STRATEGY/ACTIVITIES**	**Financial**			
		2009-10		**2010-11**	
		Amount Approved (As per ROP)	**Actual Expenditure**	**Amount Approved (As per ROP)**	**Actual Expenditure**
Disease Control Program					
IDD					
D	**IDD**	**18.00**		**18.00**	**0.18**
D.1	**IDD**			**-**	**0.18**
D	DD			-	0.18
IDSP					
E	**IDSP**	**274.00**	**114.43**	**274.00**	**72.03**
E.1	Surveillance Preparedness, Training & Staff Salary			-	72.03
E.2	Outbreak Investigation			-	
E.3	Analysis & Use of Data			-	
NVBDCP					
F	**NVBDCP**		**406.30**	**-**	
F.1.1	**Malaria**			**-**	**32.68**
F.1.1.1.	MPW Contractual Salary	300.00		300.00	
F.1.1.2	ASHA	25.00		25.00	31.69
F.1.1.3	IEC	30.00		30.00	
F.1.1.4	Training	4.00		4.00	
F.1.1.5	M&E Including NAMMIS	18.00		18.00	0.99
F.2	**KALA-AZAR (Operational Cost Including Wages, IEC, Transportation of DDT)**	**1,200.00**		**1,200.00**	**311.82**
F.2.1	KALA-AZAR (World Bank Support)	438.95		438.95	311.82
F.2.2	Human Resource	378.53		378.53	
F.2.3	Supervision	30.90		30.90	
F.2.4	State Office Strengthening				
F.2.5	Training- KALA -AZAR	29.52		29.52	
F.1.2	FILARIASIS	440.00		440.00	68.76
F.1.3	Dengue/Chikungunya	4.00		4.00	1.97
F.1.4	AES/JE	20.07		20.07	
NLEP					
G	**NLEP**		**54.56**	**-**	**33.06**
G_9	**Operating Cost**	**18.00**			
G-9	Urban Leprosy Control			18.00	
G	NLEP			-	33.06
G-1	Contractual Services	15.00		15.00	
G-2	Services Through Asha	25.00		25.00	
G-3	Office Expenses & Consumables	12.80		12.80	
G-4	Capacity Building	24.00		24.00	
G-5	Behavioural Chanage Communication	40.00		40.00	
G-6	POL/Vehicle Operation &	30.20		30.20	

					(Rupees In Lakhs)
Sl.No	**STRATEGY/ACTIVITIES**	**Financial**			
		2009-10		**2010-11**	
		Amount Approved (As per ROP)	**Actual Expenditure**	**Amount Approved (As per ROP)**	**Actual Expenditure**
	Hiring				
G-7	DPMR	24.00		24.00	
G-8	Material & Supplies	20.00		20.00	
G_10	Supervision,Monitoring 7 Review	6.00		6.00	
G_11	Cash Assistance	10.00		10.00	
NPCB					
H	**NBCP**		**161.17**	**-**	**120.96**
H.1	**Cataract Performance**			**-**	
H.1.1.	Facility			-	
H.1.2	Medical College			-	
H.1.3	District College			-	
H.1.4	CHC/Sub District Hospital			-	
H.1.5	NGOs			-	
H.1.6	Pvt. Sector			-	
H.1.7	Others			-	
H.2	**School Eye Screening**			**-**	
H.2.1	No. of Teachers Trained in Screening for Refractive Errors			-	
H.2.2	No. of School Going Children Screened			-	
H.2.3	No. of School Going Children Detected with Refractive Errors			-	
H.2.4	No. of School Going Children Provided Free Glasses			-	
H.3	**Eye Donation**			**-**	
H.3.1	No. of Eyes Collected			-	
H.3.2.	No. of Eyes Utilized			-	
H	NBCP			-	119.92
H.1	Staff Remuneration,TA/DA,POL,Meeting & Stationey - Contingencies & Consumables	14.00		14.00	
H.2	Eye Donation	5.00		5.00	
H.3	Vision Centre	25.00		25.00	
H.4	Eye Bank	30.00		30.00	
H.5	Eye Donation Centre	2.00		2.00	
H.6	Grant Ot NGOs for Strengthening /expansion of Eye Care Unit	60.00		60.00	
H.7	Training of Ophthalmic& Support Man Power	9.50		9.50	
H.8	Cataract Operation	433.21		433.21	
H.9	School Eye Screening	25.00		25.00	
H_10	Salaries of Ophthalmic Surgeon	30.00		30.00	
H_11	Salaries of Ophthalmic	19.20		19.20	

					(Rupees In Lakhs)
Sl.No	**STRATEGY/ACTIVITIES**	**Financial**			
		2009-10		**2010-11**	
		Amount Approved (As per ROP)	**Actual Expenditure**	**Amount Approved (As per ROP)**	**Actual Expenditure**
	Assistant				
H_12	Strengthening /setting Up of RIO	40.00		40.00	
H_13	Strengthening of Medical Colleges	80.00		80.00	
H_14	Strengthening of District Hospitals	140.00		140.00	1.04
H_15	Recurring GIA for District Health Societies	190.00		190.00	
H_16	IEC-Annex. 1	19.89		19.89	
RNTCP					
I	**RNTCP**		**1,076.07**	**-**	
I	RNTCP			-	
I.1	Civil Works	193.00		193.00	4.51
I.2	Laboratory Materials	58.00		58.00	22.73
I.3	Honorarium	16.20		16.20	13.43
I.4	IEC-RNTCP	36.30		36.30	7.86
I.5 A	Lab Equipment Maintenance	17.70		17.70	11.69
I.5.B	Office Equipment Maintenance			-	2.22
I.6	Training- RNTCP	20.30		20.30	3.20
I.7	Vehicle Maintenance	44.60		44.60	13.94
I.8	Vehicle Hiring	70.00		70.00	17.97
I.9	NGO/PP Support	43.50		43.50	7.62
I_10	Medical College-RNTCP	35.50		35.50	23.78
I_11	Miscellaneous-RNTCP	45.60		45.60	12.87
I_12 A	Technical & Management Assistance			-	4.48
I_12 B	Others - Contractual Services	1,035.60		1,035.60	745.15
I_13	Printing	29.00		29.00	9.68
I_14	Research & Studies			-	
I_15	Salary of Regular Staff			-	
I_16	Procurement of Drugs			-	
I_17	Procurement of Vehicles	45.50		45.50	1.33
I_18	Procurement of Equipment	3.00		3.00	0.03

Policy and Systemic Reforms in Strategic Areas | Chapter- IV

Department of Health in Bihar has many policies and protocols in place to provide quality health services to the people and improve the health of its people. As and when required the Department of Health, GOB issues necessary orders and implements new and innovative strategies to strengthen and sustain NRHM programmes.

The following table presents the status as on December 30, 2010 of the policies and systems that the State has in place/or has initiated steps for implementing with respect of the 20 management imperatives identified by MOHFW, GOI-

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
1	HR policies for doctors, nurse, paramedical staff and programme management staff	Minimizing vacancies	For the recruitment of specialists, medical officers and paramedics, the availability in the market is a problem furthermore because as against the prescribed no. of MCH and GNM/ANM school, the no. functional is very less. Every Monday walk–in–interviews are being conducted across the State and the vacancies are advertised on the official SHSB website. Online applications can be submitted which facilitates transparency. For the medical officers, MBBS doctors on Contract have been recruited have been recruited and further AYUSH doctors have been placed to ensure quality services at APHCs. GOB has already mooted a proposal for regularizing the contractual health posts of doctors, nurses and ANMs against the sanctioned posts, which would encourage further recruitment. In the process 1810 doctors have requlalised subject to two years services and qualifying in BPSC interview.
		Timely recruitment	The vacancy in the medical and paramedical has been assessed and efforts are there to fill up vacancies. Further to increase availability of medical manpower in the market more medical colleges are being established as per the standards.
		Transparent selection	Yes through panels where experts are drawn from various sectors
		Career progression and Professional	Doctors have been sent to MPH programmes in IIPH and the personnel are sent to various workshops across the country from time to

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
		development	time. HR policy has been approved by Governing Body of SHSB for the contractual manpower working under SHSB right from HSC to State level (dealt in HR section-Part A)
		Rational deployment, skill utilization	Rational deployment of LSAS and EmOC trained medical doctors is being ensured esp. in FRUs to operationalise FRUs and for optimal utilization of HR. Similarly SNCUs and NBCCs are being made functional with deployment of nurses trained in newborn care
		Stability of tenure	A policy of stable tenure is followed in the Government and contracts are signed for three years.
		Sustainability of HR under NRHM	For the position of medical and paramedical, almost all the recruited staff continues to provide the services. With regard to the staff at management units, there was a high turnover in the previous years especially at the State level which is expected to be addressed through the new HR policy introduced. Bihar Government is set to bring a legislation to protect health professionals and medical institutions in the event of violence. Draft 'Bihar Medicare Service Institutions and Persons (prevention of violence and damage to property) Bill is almost ready and likely to be tabled during the coming budget session of the state legislature.
2	Accountability and performance	Facility based monitoring	The performance is regularly monitored in the review meetings and by the State and District Monitoring Teams. State has identified nodal officers for each of the districts and additionally the Development Partners under NRHM have been given 2-3 focus districts for monitoring and facilitation. CSR is filled annually by the concerned authorities for the regular posts.
		Incentive for both the HSP and the facility based on functioning	Yes, incentives are in place under various programmes like Muskaan, Family Planning

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
		Performance appraisal against benchmarks and renewal of contracts based on performance, Incentives for performance above benchmark, Special incentives for difficult areas	For contractual staff performance based incentives have been introduced since 2009-10 based on which renewal of the contract is done. Special incentives for rural postings have been introduced and are part of this PIP also
3	Policies on drugs, procurement system and logistics management	Articulation of policy on entitlements e g free vs. charges drugs for OPD/IPD	Free distribution of medicine in OPD/IPD is done at all the health centers, PHCs, district hospitals and medical colleges On the lines of TNMSC and to streamline and expedite the drug procurement and logistics, Bihar Medical Services and Infrastructure Corporation Ltd. has been registered and is expected to be fully functional with requisite manpower etc by April 2011. From FY 2011-12 all drug procurement and thereafter logistics management shall be through this Corporation.
		Emergency patients, free vs. charged	FP accredited institutions provide free services and under the pilot Chiranjeevi Yojna, the pregnant women are catered free of charge services.
		Rational prescriptions	EDL is in place and is further being rationalized. Rational prescriptions are advocated.
		Timely procurement of drugs and consumables, Smooth distribution to facilities from DH to SC, Uninterrupted availability to patients, Minimization of out-of-pocket expenses	Rate Contracts are fixed by SHSB which the healthcare institutions are procured drugs and consumables at most times in the stipulated time. To make the system more convenient Cash and Carry mechanism has been adopted by which under the rate contracts the agencies have to open a depot at the State level. Districts place orders to the depots and within the stipulated time the manufacturer has to ensure stock of requisite orders. Districts then get a draft prepared for the order and take it

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
			to the depot and make immediate payment for collecting the orders. Apart from this, under NRHM, there are some drugs and consumables which are purchased locally at the district level which allows them flexibility, making time constraint a relatively redundant factor. The district undertakes its purchase through the standard procedures and protocols. Medicines supplied to the health centers are available for the treatment of patients. Indents are raised to the district authority by the PHCs and subdistrict facilities. Medical colleges also follow the cash and carry process for drug procurement. All the patients (BPL/APL) are entitled to free drugs in government health facilities. To minimize the burden of indoor treatment for poor patients Govt. of Bihar has implemented RSBY (Rashtriya Swasthya Bima Yojna) in some of the districts in which a family of five (maximum) receives the health insurance cover of Rs 30,000/- per year. Proposal has been mooted for accrediting Government institutions under the same also.
		Quality assurance	Drug samples are collected (from Depot and districts), and quality tested by the District Drg Licensing authoristies. In case, it fails quality test, the batches of medicine from the health facilities are collected back by the manufacturers without any additional cost to district and replaced. A proposal is under consideration for the “empanelment of testing laboratories” to have quality testing before supplied to the health facilities.
		EDL in public domain	EDL is available on the SHSB website and additionally all the health facilities are required to maintain a checklist of the same for public viewing
		Computerized drugs and logistics MIS System	Drug Logistics Information and Management System is being developed.

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
4	Equipments	Availability of essential functional equipments in all facilities, regular need assessment, Timely indenting and procurement and identification of unused/ faulty equipment. Regular maintenance and MIS	Bihar Medical Services and Infrastructure Corporation Ltd. has been registered and is expected to be fully functional with requisite manpower etc by April 2011. From FY 2011-12 all equipment procurement and thereafter logistics management shall be through this Corporation. Menawhile through SHSB rate contract, health facilities are being equipped with essential equipments like beds, labour room equipments, SCNU and NBCC equipments etc for which rate contracts are done through the SHSB.
			Assessment of needs is done with the help of IPHS norms and other standard norms with the help of development partners and expert committees.
			For the existing equipments, annual maintenance contract (AMC) and comprehensive maintenance contract (CMC) is in place.
5	Ambulance services and referral transport	Availability of ambulances for critical patients	District and sub district facilities have their own ambulances either through Govt. or Private Partners. 108 Emergency services are operational. SHSB is providing prompt quality pre hospital care to patients, trauma victims, pregnant women, for the purpose of which Emergency Network service was started under PPP in all the 38 districts of Bihar. The objective is to save lives of Road Traffic Accidents, cardiac emergencies, fire victims and other emergency cases. Initially 5 Advance Life saving Ambulances (Trauma, Critical & Cardiac Care) & 5 Basic Life saving Ambulances were made operational on 03.06.2009 which ran within Patna Municipal Corporation area and its sub urban areas, now the scheme is operational across the State in all the districts.

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
		Reliable, assured and affordable transport for pregnant women and newborn/infants. Clear policy articulation on entitlements both for mother and newborn	SPIP 2011-12 provides for free referral transport for pregnant women. Proposal has been mooted for newborn/infant transport facility for customisation of existing vehicles.
		Establishing Control Rooms for timely response and provision of services	Yes The Toll free number 102 was launched during 2006-07 and is running in all the six regional headquarters successfully. Under this scheme Ambulance for emergency transport is being provided in all the districts of Bihar. The empanelled ambulance & ambulance available in Govt. institutions are made available on receipt of calls from the beneficiaries. 108 has a 24 hours call centre.
		Drop back from village to institution and from institution to village	Yes, there is a laid down policy of free drop back to mother in SPIP 2011-12.
6	Maintenance of buildings, Sanitation, Water, Electricity, laundry, kitchen	24 x 7 maintenance and round the clock plumbing, electrical, Carpentry services	Hospital Maintenance is being provided through outsourced agencies
		Power Back Up	24 hr generator facility provided across all facilities till PHC level.
		Cleanliness and sanitation in PH facilities	Is there but needs better supervision and monitoring
		Upkeep of toilets	Being mandated to all facilities
		Electricity	24 hours electricity provided in all the facilities
		Clean linen	Bedsheets are provided daily on colour basis…7 colours for 7 days
		Diet for pregnant women	Has recently been introduced through the State fund
7	Diagnostics	Rational prescription of diagnostic test	NABL accredited institutions are providing diagnostic facility in Government hospitals right till the PHC from the MCH. SHSB intends to undertake third party evaluation of the

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
			diagnostic services to ensure quality services are being provided.
		Reliable and affordable availability to patients	Bihar Government provides free diagnostic services to all Government patients. The private partner is reimbursed through the RKS of the concerned facility. The charge list and the quality of service is regularly monitored by DHS.
		Partnerships with private service providers	Diagnostic services (Radiology & Pathology) are being provided through private partners
		Prescription audits	The same is being adhered to, and to ensure referral to Government approved diagnostic facility various orders are issued from the Prinicipal Secretary and Secretary, Health's level.
8.	Patient's feedback and grievance redressal	Feedback from patients and analysis of feedback for corrective action	In various facilities, complaint – grievance box is provided which is taken care of by MOIC, however this needs more stringent follow up.
		Expeditious grievance redressal	Grievance redressal issues are placed before RKS and RKS is expected to resolve them on consensus basis
9	Private Public Partnership (PPP)	Partnership with private providers to supplement governmental efforts in underserved and vulnerable areas for deliveries Family planning services and diagnostics etc.	SHSB has undertaken several PPP initiatives to ensure services to the public – 1. Diagnostic facility both patho-radio. Right from PHC to MCH incl. Regional Diagnostic Centres 2. Emergency transport-102, 108 3. MMU 4. Urban Health Centres 5. 110 Pvt. Nursing homes accredited to provide family planning services 6. State, Regional, District and Block data centres 7. School Health Programme 8. NRC 9. Blood Storage Units 10. Generic Drug Shops 11. Hospital Maintenance

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
10.	Inter-sectoral convergence	Effective coordination with key departments to address health determinants viz. water, sanitation, hygiene, nutrition, IYCF, gender, education, women empowerment and Convergence with SABLA, SSA, ICDS etc.	Effective convergence with education (school health programme, school health card being developed), panchayat (VHSC and Community based monitoring), water supplies (running water in facility) and ICDS department (Sabla, Muskaan & VHND) has been achieved. District Health Societies and Governing Body of SHSB comprise of the members representing the different district departments, which function under the chairpersonship of District Magistrate.
11.	Community mobilization	Active community participation	1. VHND every Wednesday is being organized in a few districts and is going to be done across the State from FY 2011-12 where ASHA worker and ANM and AWW will mobilize the beneficiaries for MCH services and the community participation shall be ensured. The Sarpanch and Mahila member of Gram Panchayat are encouraged to attend VHND. 2. Community monitoring is being focused upon for which SHSB has already initiated steps and is proposed for strengthening in FY 2011-12
		Strong VHSCs	VHSC accounts have been opened and their capacity building to be ensured.
		Social Audit.	Not yet undertaken
		Effective VHNDs	VHNDs to become fully operational from 2011-12
12.	IEC	Comprehensive communication strategy with a strong BCC component in the IEC strategy	A skeleton strategy in place, being prepared with technical support of development partners
		Dissemination in villages/ urban slums/	Partly full coverage being ensured

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
		peri urban areas	
13	Civil Registration System (CRS)	100% registration of births and deaths	State has started focusing on registration of birth across the state. Personnel from registration department address the Civil Surgeons-cum-Member Secretary, DHS w.r.t this and o generate cooperation for the same.
		Capturing of births in private institutions	Most private institutions register births and deaths occurring in their hospitals. There is collaboration with state government registry body and the private institutions enabling to capture all the births and deaths occurring in the institutions.
		Reliability to health data on institutional deliveries, Sex ratio etc.	From the year 2009, Bihar has computerized the statistical part of Form 1, 2 and 3 which is filled in by the informant to register birth/ death. This has enabled the district to capture the births/death events with an ease. On the basis of HMIS cell and information uploaded by the districts on DHIS2 portal, the state is monitoring institutional deliveries etc.
14.	Supportive Supervision	Supervision of field activities/performance Handholding Strengthening of LHVS, DPHNOS, MPHS etc.	Nine Regional Deputy Directors directly do field supervision in their respective regions. They have been provided with a RPMU for supervising district work with relation to NRHM. State and District Monitoring teams undertake supportive supervision and identify training needs.
15.	Monitoring and Review	Regular, focused reviews at different levels via CM/ Health Minister/ Health Secretary/ MD/ DHS/ officers at Block/ PHC level, use of the HMIS	The monitoring and review system is firmly established and its functioning is robust especially at the state level. The districts are monitored on the basis of 14 parameters which focus on the RCH indicators. Regular monthly review meetings are held

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
		data for reviews	with the Civil Surgeons and the DPMs under the leadership of PS, Health and Secretary, Health-cum-Executive Director. For monitoring and review, the major source of data is • HMIS • DHIS2 • Field visits State Monitoring Committee and Quality Assurance Committee visit the districts on a regular basis. In addition, the programme based review is also in place, where the feedback is given to the districts by the concerned state level officials through regular comments/ alerts/ suggestions through DO letters/ meetings/ video conference, for review. The field visits are under taken regularly by the State Nodal Officers acting as liaison officers for the respective districts.
16.	Meetings of State Health Mission/ Society/ District Health Society	Regular meetings for periodic review and future road map and Follow-up action	Regular meetings of DHS are held
17	Medical Colleges (New Colleges and Up gradation of existing ones)	Enhances supply of doctors Expansion of tertiary health care Use of medical colleges as resource centers for National Health Programmes	At present there are 6 medical colleges. The state government has planned to undertake construction of 3 more MCHs. Prosposal have been mooted for own-campus recruitment of intern student from Govt. Medical College Hospitals.
18	Nursing Schools	Augmented supply of nurses	Strengthening of Nursing schools is a priority with the State Government which would meet the requirement of manpower.
		Quality assurance	
19.	Paramedical	Availability of quality	Training is given to paramedical staff by

Sl. No	Strategic Areas	Issues that need to be addressed	Status as on 30.12.2010
	education	paramedical staff and Capacity building	SIHFW and medical colleges.
20.	Capacity building	Strengthening of SIHFW/DTC	• Full time State Training Coordinator is in place • SIHFW needs to be strengthened as a training centre- additional faculty being recruited • Networking with NIHFW • Development Partners facilitate capacity building of health personnel
			•
		Quality Assurance	• Training components are prepared on the basis of gap analysis on the skills of health functionaries and on the needs of the community • Focus is there on quality of training being imparted
		Availability of centralized training log	Training Calendar-yes
		Monitoring of post training outcomes	Participants are required to give their feedback at the end of sessions Pre and post training test are conducted to assess the level of change in the knowledge.
		Induction training for all key cadres	Induction training for all cadres are organized and conducted.
		Management training for clinicians	The officers undergo Health and hospital management training. In addition to this doctors are encouraged to undertake DPH for their professional development

Conditionalities | Chapter- V

a) Release of the first tranche of funds:

With regard to the fulfillment of specified conditions for the release of the first tranche of funds by GOI to Bihar for PIP 2011 – 12, the status against each point is presented below –

- State Health Society Bihar has a full – time Executive Director or Mission Director for NRHM who is also the Secretary, Health, Government of Bihar. ED (NRHM) does not hold any additional charge outside the Health Department
- A State Finance Manager, retired Officer from Audit is full-time in position. State Health Society Bihar has already floated an advertisement for Additional Director (Finance) and is expected to be in position by March 2010.
- The State Government has increased its Plan Budget over the years as can be seen from the Growth Rate of State Government's Budget --

State Health Budget							(Rs. In Crore)		
High Focus State	Budget 2005-06	Budget 2006-07	% Change	Budget 2007-08	% Change	Budget 2008-09	% Change	Budget 2009-10	% Change
Bihar	NO DATA	346.94	N/A	849.25	145%	695.26	-18%	1040.66	50%

For the year 2010-11, similar trend is estimated.

The State is also contemplating increase in its budgetary outlay for Health this year.

b) Release of second tranche of funds:

- HR POLICIES & SYSTEMS: The state is already in the process of ensuring rational deployment of health personnel based on their skills and requirement. Stability of tenure by way of a clear HR policy for contractual staff is already in place and has been approved by the Governing Body of SHSB. Facility based monitoring for results for its personnel shall be undertaken.
- DRUG POLICY & SYSTEMS:
  The State provides free drugs for OPD and IPD to all the Government patients.
  The State has entrusted State Health Society Bihar with rate contracting of drugs and the procurement is with the Districts. Cash and Carry mechanism is followed for drug procurement.
  The Bihar State Medical Services and Infrastructure Corporation Ltd. is already registered and would be operational on the lines of TNMSC. The Corporation is expected to be fully operational from April 2011 and has been constituted with the objective of minimizing out-of pocket expenses
- The compliance status in respect of the 31 conditionalties mentioned below is provided for the year 2010-11 in the prescribed format:

Conditionalties and Compliance status

S. No	Conditionality	Compliance Status
1	All posts under NRHM are on contract and based on local criteria. The contract should be done by the Rogi Kalyan Samiti /District Health Society. The stay of person so contracted at place of posting is mandatory. All such contracts are for a particular institution and non transferable. The contracted person will not be attached for any purpose at any place.	Complied. Further the State has issues directives that Contractual Staff cannot be transferred
2	The state agrees to credit 15% of the State share to the account of the State Health Society in two installments. The State also aggresses to enhance the over-all expenditure on health by the State Government by a minimum of 10 percent per year.	Yes. The state share is deposited every year in the Account of State Health Society. The State is also contemplating increase in its Budgetary outlay for Health and Family Welfare this year.
3.	Blended payments comprising of a base salary and a performance based component, should be encouraged.	Noted and already complied under various schemes like Muskaan, Family Planning
4.	State Government must fill up its existing vacancies against sanctioned posts, preferably by contract. Top most priority in contractual recruitments should be for backward districts and for difficult, most difficult and inaccessible health facilities.	This is a priority with the Government. Further for enlisting more contractual personnel the State is already finalizing regularizing the contractual health personnel posts vis-à-vis sanctioned posts. The priority and preference are given for posting in FRUs first. State is further working out a scheme for rural postings in backward districts.
5.	Delegation of administrative and financial powers should be completed during the current financial year. If not already done.	Complied with, delegation of financial powers districts already done and to Block Health Managers is in the pipeline.
6.	State shall set up a transparent and credible procurement and Supply chain management system and Procurement Management Information System (PROMIS) [on the lines of the Tamil Nadu Medical Services Corporation]. State agrees to periodic procurement audit by third party to ascertain progress in this regard.	Bihar State Medical Services and Infrastructure Corporation Ltd. on the lines of TNMSC already registered and expected to be fully operational from April 2011. The corporation has got the certificate of Business commencement also. State agrees to periodic procurement audit by third party.

S. No	Conditionality	Compliance Status
7.	The State shall undertake institution specific monitoring of performance of Sub Centre, PHCs, CHCs, DHs, etc.	Facility based Services and Quality Monitoring checklist already in place based on which the facilities are graded and provided feedback Monitoring Teams. Supportive supervision is provided through MCH for the FRUs. For the hospitals SPIP 2011-12 proposes monitoring their performance through Hospital Management Information System.
8.	The State shall operationalise an on-line HMIS in partnership with MOHFW.	Online HMIS has been initiated in all the 38 districts of the State. The data is uploaded regularly every month by all the 38 districts and also 90% of the Block PHCs on the HMIS and DHIS2 portal. The data is compiled at the state level regularly.
9.	The State shall take up capacity building exercise of Village Health and Sanitation Committees, Rogi Kalyan Samiti and other community /PRI institutions at all levels.	In FY 2010-11 one week was observed as RKS week for their sensitization. The same is planned for 2011-12 furthermore capacity building of VHSC and RKS members is an ongoing process.
10.	The State shall ensure regular meetings of all community Organizations /District /State Mission with public display of financial resources received by all health facilities.	Regular meetings of DHS and of Governing Body and Executive Committee of State Health Society is held. Most RKS have regular meetings too. Financial resources from State to District to Sub-District to PHC is displayed in the public domain- www.statehealthsocietybihar.org
11.	The State Govts. shall also make contributions to Rogi Kalyan Samiti and transfer responsibility for maintenance of health institutions to them.	Yes, RKS exist in all the facilities at all levels and 90% are registered. State Government contributes to RKS for hospital maintenance etc. The state government has appointed Civil Surgeon to monitor its performance in all the 38 districts.
12.	The State shall prepare Essential Drug lists of generic drugs and Standard treatment Protocols, and give it wide publicity.	Noted, EDL is already prepared and is available on the public domain. The same is further being rationalized in consultation with the districts and MCHs..
13.	The State shall focus on the health entitlements of vulnerable social groups like SCs, STs, OBCs, Minorities, Women, migrants etc.	Noted. Further special MMU provisions are made for Mahadalit tolas already.
14.	The State shall ensure timely performance based payments to ASHAs/Community Health Workers.	Noted and follow being done for payment to ASHAs
15.	The State shall encourage in patient care and fixed day services for family planning.	FP services are provided on fixed day static service on routine basis. Fixed day FP services

S. No	Conditionality	Compliance Status
		are held in all the facilities right till the PHC level. Identification of 24 X 7 PHCs, CHCs and FRUs / district hospitals to render MCH and FP services have been done. MCH centres are to be made funcational. Under PNC, a 48 hours stay is being encouraged through Family Friendly Hospital initiative (FFHI). Under FFHI, a few special services such as the mother and an accompanying person is served a meal twice a day, cloths to the mother and new born baby, a packet of sanitary napkins and home drop facility.
16.	The State shall ensure effective and regular organization of Monthly Health and Nutrition Days and set up a mechanism to monitor them.	Noted. VHND has been piloted in one district in Bihar in 2010-11 and regular VHNDs are being planned to be conducted every Wednesday, once in a month from FY 2011-12..
17.	All performance based payments/incentives should be under the supervision of Community Organizations (PRI)/RKS.	Noted to be done through RKS and VHSCs
18.	The State agrees to follow all the financial management systems under operation under NRHM and shall submit Audit Reports, FMRs, Statement of Fund Position, as and when they are due. State also agrees to undertake Monthly District Audit and periodic assessment of the financial system	Yes
19.	The State agrees to fast track physical infrastructure up gradation by crafting State specific implementation arrangements. State also agrees to external evaluation of its civil works programmes.	An SPV was established for Health in Building Construction Department, hwoever the same could not expedite the infrastructure work. The Bihar Medical Services and Infrastructure Corporation Ltd. would oversee all infrastructure related works henceforth.
20.	The State Govt. agrees to co-locate AYUSH in PHCs/CHCs, wherever feasible.	AYUSH doctors have been placed in each of the APHCs.
21.	The State agrees to focus on quality of services and accreditation of government facilities	Yes, ISO Certification and Family Friendly Hospital certification is being pursued. DH-Bhojpur has already received ISO:9001 certification.
22.	The State/UT agrees to undertake community monitoring on pilot basis	The community based monitoring is already proposed for pilot in FY 2011-12. Further school

S. No	Conditionality	Compliance Status
	wherever not tried out as yet, and scale up with suitable model wherever piloted earlier.	health programme has been initiated.
23.	The State/UT agrees to undertake continuing medical and continuing nursing education	Yes. The focus is on continuing medical and nursing education. The capacity building workshop for the doctors and nursing staff are organized to upgrade their knowledge and skill. The medical and paramedical personnel are also sent to participate in the national level and other state level trainings.
24	The State agrees to make health facilities handling JBSY, women and child friendly to ensure that women and new born children stay in the facility for 48 hours.	A Family Friendly Hospital Initiative (FFHI) has been proposed in FY 2011-12. MCH centres to be also operationalised.
25	The State Governments shall, within 45 days of the issue of the record of proceedings, issue detailed district wise approvals and place them on their website for public information	Yes. In 2010 – 11, the districts were provided with detailed Record of Proceedings (ROP) with budgetary allocation and monitorable targets and the same was put on public domain also.
26	The State agrees to return unspent balance against specific releases made in 2005-06, if any.	Noted
27	The State is entitled to engage a second ANM to the extent that it provides for MPW (Male) or the contractual amount of 2nd ANM be paid out of State Budget and Third functionary may be engaged from NRHM Fund	The state has approved MPWs from the state budget. Provision (partly) for the same has been made in NRHM FY 2011-12.
28	The State shall put in place a transparent and effective human resource policy so that difficult, most difficult and inaccessible areas attract human resources for health.	Yes
29	The State agrees to fast track physical infrastructure up-gradation by crafting State specific implementation arrangements. State also agrees to external evaluation of its civil works programmes. The State shall provide names of all facilities where civil works are undertaken and also certify that the location of these facilities is such that	The Bihar Medical Services and Infrastructure Corporation Ltd. would oversee all infrastructure related works henceforth. The construction of facilities in the backward districts and difficult areas are and shall be given special emphasis.

S. No	Conditionality	Compliance Status
	poor households can seek services from them. Prior approval of place of construction by GoI will be mandatory before taking up new construction under NRHM. Thrust must be on meeting infrastructure gap in backward districts and difficult, most difficult and inaccessible facilities	
30	The State agrees that the provision for EMRI operational cost to States will be on declining basis. For first year operational cost will be 60%, 2nd year 40%, 3rd year 20% and nil thereafter	Yes
31	The State agrees to comply with the following over a period of six months: • System for assured and affordable referral transport for pregnant women and sick children/infants. • Facility upkeep (including maintenance of building – sanitation, laundry, water, electricity, kitchen) and grievance redressal mechanisms. • Performance benchmarks for staff prior to renewal of contracts and incentives. • Availability of functional equipments at all facilities.	• Already proposed for pregnant women in FY 2011-12 NRHM PIP. Customising the vehicles for newborn to be explored. • For facility upkeep in DH/SDH, the RKS grant, untied fund and maintenance fund is being utilized. The DHS regularly monitors their work. • Hospital maintenance, generator facility, laundry, diet already being provisioned • For contractual staff, annual incentive based on performance appraisal has been approved. Parameters for the same have been developed in the districts and are further being refined. • To maintain functionality of the equipments at the health facilities, the health facilities utilize CMC/AMC/RKS/Untied grant.

Situational Analysis | Chapter- VI

NRHM Health Status of Bihar 2005-10

Physical Progress	***Financial Progress***
Block PHCs fully functional with doctor, drugs and diagnostics; Huge increase in OPD, Institutional Deliveries and IPD. Large HR augmentation through doctors, nurses and ANMs; Constitution of Bihar Medical Services Procuremen and Infrastructure Corporation; Sub Centres and APHCs still not functional; *ASHA* training weak; VHSCs being set up; slow progress on equipment provision and civil works; involvement of the Directorate of Health is weak	88.73% utilization under RCH 2005-09. 18.83% utilization under NRHM Mission Flexible Pool during the same period. State utilizing Finance Commission funds on priority, therefore under utilization of NRHM funds in initial years.

1. Increase in **health sector outlay** by 115% from Rs.154.25 crores to Rs.1700 crores for 2011-12 including for SHSB and Rural Health Scheme
2. Bihar State Medical Services and Infrastructure Corporation Ltd. has been constituted which shall ensure that logistics issues with relation to drugs and equipments is tackled and timely availability is ensured. This Corporation shall also facilitate and expedite infrastructure development including repair, renovation and new construction across the state at all levels.
3. Societies at State and District level formed & registered with regular meetings of Governing and Executive Body held.
4. Management units at State, Regional, District and Block level functional. At the State level additional recruitments are being done to ensure proper focus on programmes and expedite NRHM programmes in the State. Similarly at the district level additional manpower has been provided in the DPMU for various programmes like Child Health, Planning, *ASHA* etc to further streamline the process therein. Financial powers have been given to DPMs to streamline and expedite fund utilization in the districts. At the Regional level, a management unit with Regional Programme Manager, Regional Accounts Manager, Regional M&E officer and an HMIS supervisor, this RPMU would necessarily act in a supervisory mode. The State further proposes financial powers to BHM so as to further streamline fund utilization at block level.
5. State Level consultants in SHSB are in place, in DPMU, 6 managerial posts in each district has been provisioned and in blocks, 466 Block Health Managers and 446 Block Accountants are already in position. The orientation training for most has been completed.
6. At regional level also managerial personnel are already in place and their orientation is proposed in the year 2011-12. At the MCH level also through the Rogi Kalyan Samiti provision has been made for Hospital Manager and Accountant to oversee and manage NRHM programmes and funds being implemented and allocated. Inorder to operationalise FRUs, Hospital Managers have been provided to oversee the FRU functionality.

7. A total of 78943 *ASHA*s selected against a target of 87,135. *ASHA* trained in Module I - 68592 and trained in Module II, III, IV -52859
8. 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. 41 drugs in OPD and 193 drugs for IPD from DH to APHC and 99 drugs in OPD and 172 drugs in IPD for Medical College Hospitals is distributed free to Government patients. The process of rationalizing the Essential Drug List is already underway under the Chairmanship of Additional Director, Health and with feedback from Civil Surgeons etc.
9. There has been a remarkable increase in hospital Bed Strength in Government Institutions- from 3030 bed strength in 2005 it became 22494 in 2009.
10. Full immunization percentage has increased from 10.7 % (NFHS-I 1992-93) to 33% (NFHS 3) to 66.6 % (FRDS-2010).
11. Against a total figure of 11964 posts of ANM (R), appointment of ANM (R) - 7258 posts of ANM(R) have been filled up.
12. The State Government is contemplating regularizing the Contractual Doctors, Grade 'A' Nurses and ANM ®.
13. Rogi Kalyan Samitis formed, registered and functional in all health facilities till PHC level for better hospital management at all facilities. Many health facilities have improved their infrastructure and logistics availability due to proactive RKS. Registration of 530 against 653 RKS completed.
14. *Swasth Chetna Yatra* or camps are being held across the State to operationalise and make functional all HSCs and APHCs, to provide for treatment of minor ailments and for screening of communicable and non communicable diseases, referral treatment and follow up etc.
15. Training Programmes: Training of EmOC, Life Saving Anesthesia Training, IMNCI, *ASHA*, HMIS, DPMUs, BPMUs, SBA training, Immunization and Neonatal resuscitation started. This includes the regular monitoring and corrective actions taken.
16. ANM/GNM training Schools-Out of 22 ANM schools and 6 GNM schools, 22 ANM schools have been re-started and are fully operational. Currently approx. 600 students are enrolled. In year 2010, it is being ensured that ANM and GNM schools train students up to their optimum capacity. Besides, efforts have been made to strengthen the overall structure of these schools in the state including hiring contractual staff for filling up vacant faculty position. The posts of Deputy Director - Nursing and Asstt. Deputy Director –Nursing has been created in the Directorate. A centre of excellence for nursing is being established at Indira Gandhi Institute of Medical Sciences, Patna—the premier health institution of the State.
17. State has started a useful process of accreditation of government hospitals by bodies like ISO 9001…District Hospital, Bhojpur has been given ISO certification. This process shall be speeded up to include other units and in the subsequent years State would initiate accreditation through NABH also.
18. In the year 2010-11, New Born Corners at PHCs near Labour Rooms have been developed and up to date quality equipment and trained manpower.
19. Separate Sick Care Neonatal Units are being constructed at the District Hospital level across the State.
20. 70% deliveries in Government facilities in Bihar were conducted at PHCs.
21. In 35 districts, IDSP unit is functional.

22. Year 2011-12 is being declared as Year of Safe Motherhood subsequent to Year 2010-11 being the Year of Newborn-so that the State and District can focus on improving maternal health.
23. Free Radiology and Pathology services have been offered to all Government patients and the State Government is supporting the scheme besides NRHM.
24. Starting of several new initiatives has resulted in increase in IPD and OPD figures which reflects on the increased faith of the public on Government facilities. Such programmes which have expedited this are-
    a. Janani Evam Bal Suraksha Yojana (JBSY) which has resulted in a tremendous increase in institutional deliveries;
    b. Muskaan- Ek Abhiyaan due to which immunisation rates have considerably increasing
    c. 102 & 108 Ambulance network services.
    d. Outsourcing of generator, cleanliness/hospital manienance and kitchen services in block and district hospitals
    e. Increased availability of drugs and diagnostics for free
25. Undertaking upgradation of all hospitals to IPHS standards in a phased manner, ISO certification of various Hospitals, recruitment and placement of AYUSH doctors under contract in APHCs to operationalise APHCs and involve private sector through PPPs for various tertiary services.
26. Undertaking reforms for 'architectural correction' of health systems through the State Health Society (SHS) in organisational HR development, institutional strengthening through *ASHA*s, *MAMTA*s, procurement, monitoring, financial systems etc.
27. Working with development partners (signing of MOUs) to address health related issues in a concerted and integrated manner both at the State level and through their facilitators at the district level.
28. HMIS has been strengthened right till the HSC level and daily reporting from nearly 100% of the blocks is being ensured through the Monitoring and Evaluation Officers. A team of State Facilitators have been developed to provide HMIS support right till the block level.
29. Health Planning has become a mode of transferring power to the levels below and this year HSC Plans for NRHM have been developed.
30. Referral transport services have been upscaled through 108 services (Advanced Life Saving Ambulance service) in all the districts.
31. MMU has been provided in each of the districts and are fully functional
32. C-section, Blood Banks, SCNUs and posting of specialists is focused upon and is being ensured across all FRUs
33. As per the DLHS III, 20.3% of the ANM live in quarters where available, 64.5% of the PHCs function on 24 hour basis and 87.9% of the CHCs are designated as FRUs
34. State Health Society regularly conducts Civil Surgeon reviews on a monthly basis. The basis of review is 13 health indicators against which physical targets have been communicated to the districts. Indicators on which review is done are Total ANC Registration, Total ANC Registration in 1st trimester, No. of pregnant women given 100 IFA tablets, No. of pregnant women given TT-2 or Booster dose, Total no. of institutional delivery (public + private), Total no. of institutional delivery cases were JBSY incentive paid to mother, Total no. of C-section deliveries performed at institutions (public+private), No.of infants 0-11 months old to received OPV-0, BCG, DPT-1, DPT-3, Measles, No. of *ASHA* selected and trained with module 2,3,4, No. of

IUD insertion and OC pills distributed, No. of OPD attendance and Inpatient head count at mid night.

35. Additionally monthly ranking of the districts is undertaken on various indicators
36. SHSB also conducts monthly reviews of DPMs at the State level.

	Activity/Intervention	Specific Gain from NRHM
1	Human Resources	While it is true that human resource is one of the biggest challenges for the State, it must be acknowledged that after many years, NRHM has brough the thrust on human resources centre stage. This has involved large scale adoption of good practice and efforts at attracting doctors and nurses for government work. *ASHA*s (Community Health Workers) with *ASHA* Drug Kits; MBBS doctors; Specialists; ANMs; Staff Nurses; AYUSH doctors added to the system under NRHM
2	Physical Infrastructure	New HSC buildings; upgradation of Sub-centre buildings; new PHC buildings; upgradation of PHC buildings; upgradation of District and Sub-divisional Hospitals
3	Untied funds for maintenance and local action	All HSCs, PHCs, Sub-Divisional and District hospitals provided untied grants and annual maintenance grants to improve the facilities under the supervision of PRIs and Rogi Kalyan Samitis at the facility levels. This aided in considerably improving the maintenance of facilities all over the State.
4	Janani Evam Bal Suraksha Yojana	Extensive coverage of pregnant women
5	Mobile Medical Units	MMUs under NRHM are working to provide diagnostic and outpatient care closer to hamlets and villages in remote areas
6	Emergency Medical transport and ambulance systems	Districts have used NRHM funds to provide a variety of emergency transport systems and ambulances to improve timely attention to hospital referral for households
7	Doctor, drugs and diagnostics	NRHM has added doctors on a large scale leading to more care of patients. Availability of resources for drugs and diagnostics has improved with NRHM support to the districts.

Detailed Progress of Activities

The state government has done tremendous work in health sector in past four and a half years. Effective steps have been taken by the government to provide medical facility in remote areas of state.

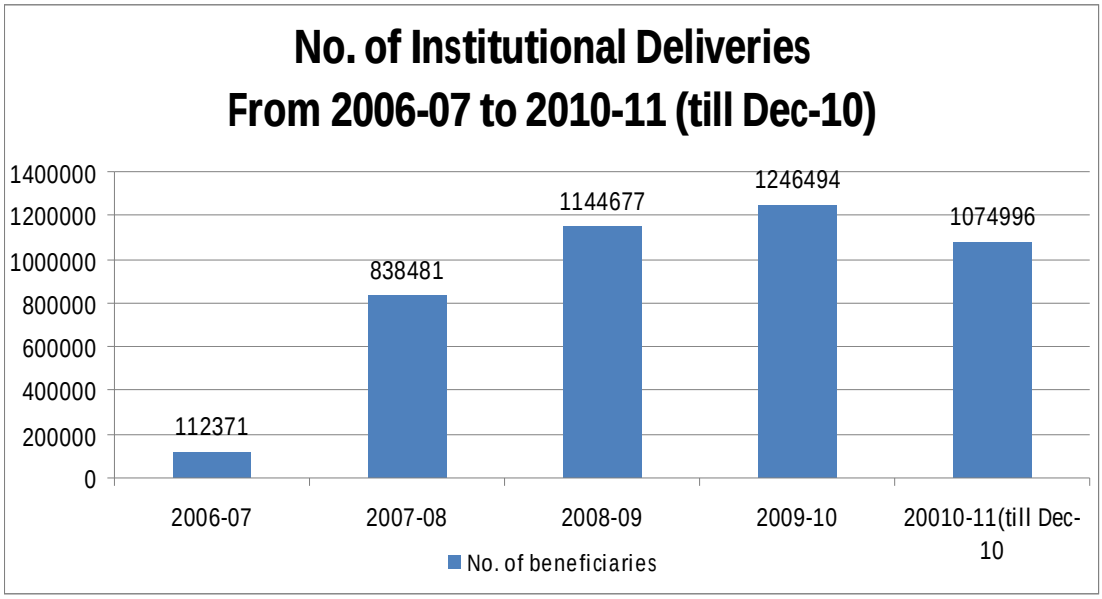
Various programmes have been initiated by the Department of Health, Government of Bihar which has improved the health scenario in the State and has made primary health care accessible and available to the rural masses. The patient load/turnout in Government hospitals has increased in the OPDs from 105 lakhs in year 2006-07 to 271 lakhs in 2010-11

(fig. till Dec 2010), similarly the load in IPDs has increased from 7.98 lakhs in 2007-08 to 15.87 lakhs in 2010-11 (fig. till Dec 2010)-Source : HMIS data.

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

Maternal Health

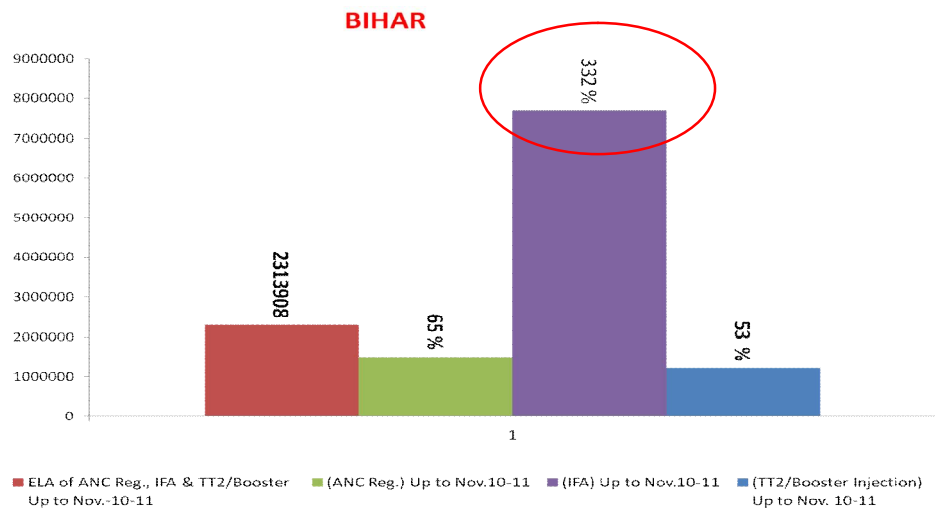
24 x 7 Health Services is available in 533 Primary Health Centres, 29 SDHs and 36 DHs of the State.
The total no. of institutional delivery has increased from 45000 in the year 2005-06 to 1074996 in 2010-11 (fig till dec 2010). The percentage of increment has been from 22% in 2005-06 to 49% in 2010-11. Average 80-90 thousand Institutional deliveries are taking place every month.



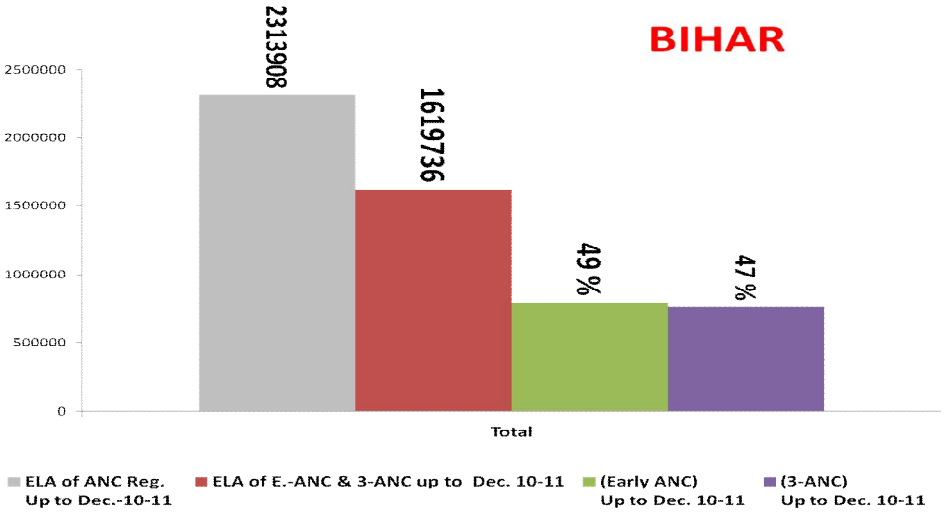
Major efforts were made for the publicity of JBSY through newspaper advertisements, hoardings, posters, pamphlets and leaflets through which messages about the monetary incentive for the beneficiaries and other benefits of institutional deliveries were publicised. The *ASHA* was the main person involved in person-to-person contacts and spreading information about the scheme at the grassroots level. All the district nodal officers and medical officers in Bihar developed detailed communication plan for involving most of the stakeholders in the publicity activities of JBSY and were monitoring IEC activities of *ASHA*s.

Antenatal Care has increased from 15.9% in 1998-99 to 47% by December 2010 (Source : HMIS Data). 663937 newborn were breastfed within 1 hour of birth from April to December 2010.

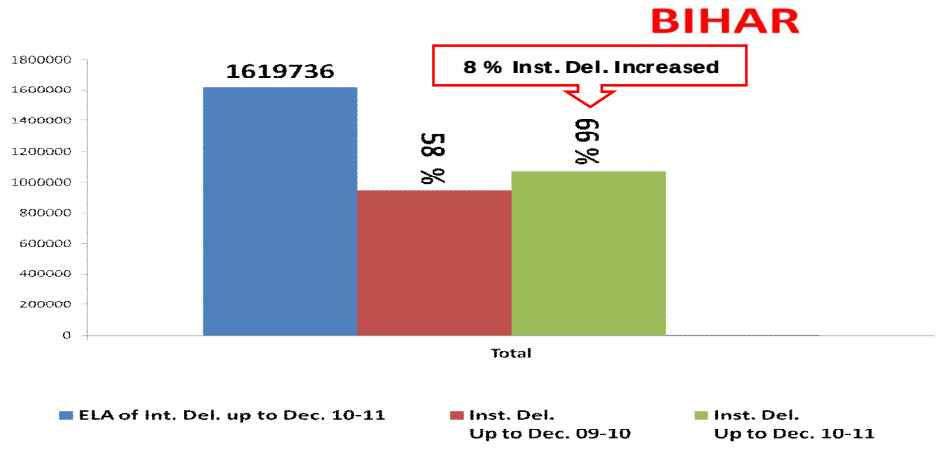
ACHIEVEMENT OF ANC REG., IFA & TT2/BOOSTER (up to December-2010-11)

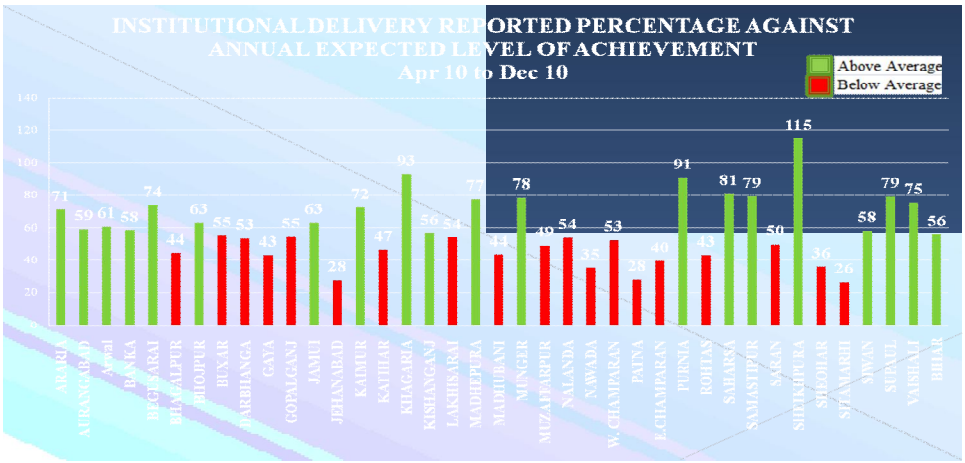


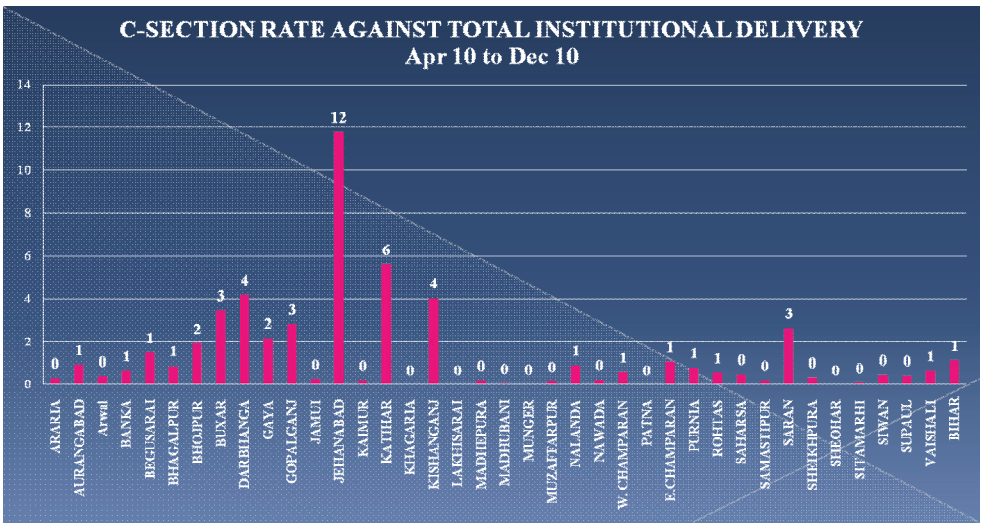
ACHIEVEMENT OF EARLY ANC & ANC-3 (upto December-2010-11)



ACHIEVEMENT OF INST. DELIVERY IN 2009-10 & 2010-11 (upto December-2010-11)





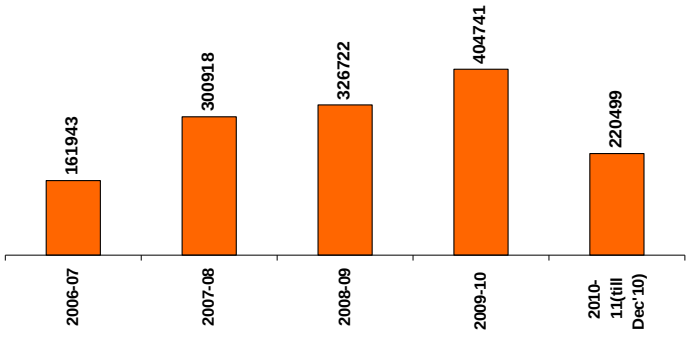


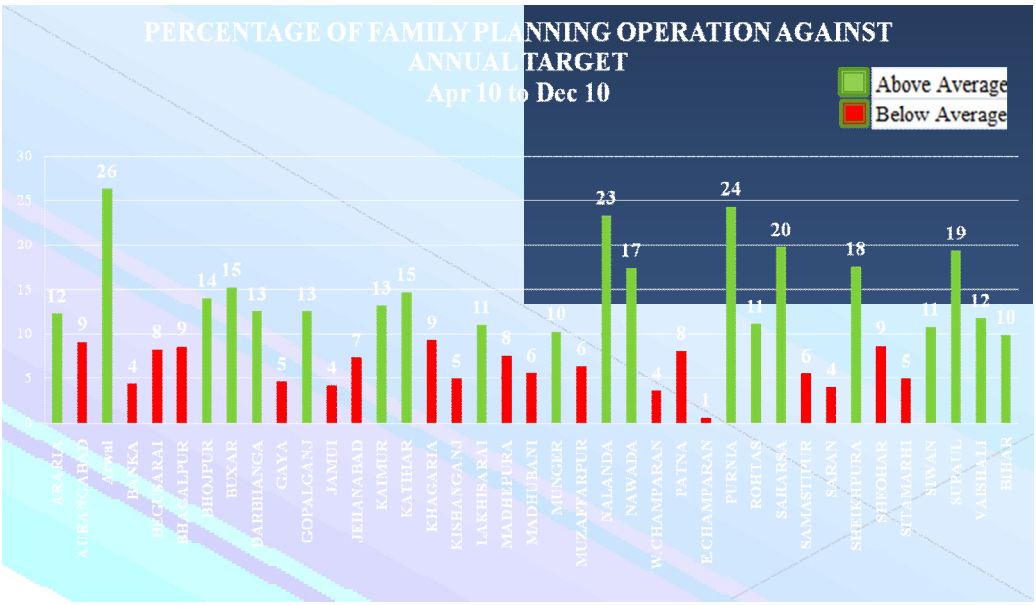
Maternal Death Audit has been initiated across the State wherein verbal autopsy is conducted, data analyzed and shared. State wide system for improving reporting of maternal deaths is planned.

Population Stabilisation

Every year about 27,00,000 children are born. The total no. of Family Planning operations has increased from 118678 in 2005-06 to 404741 in 2009-10 to 220499 (fig till Dec 2010). Contraceptive use has increased from 23.1% (NFHS-I 1992-93) to 28.4% (DLHS-III-2007-08).

Performance in FP Operation (Male+Female), Bihar





- ❖ State population council has been formed under the chairmanship of Honourable Chief Minister. A state level coordination committee under the chairmanship of Chief Secretary and district level coordination committee under the chairmanship of District Magistrate has been formed for the purpose of coordination with other departments, so that population stabilization goal can be achieved.
- ❖ To achieve the goal of population stabilization “Prerna Award” is given to BPL couples who fulfill responsible delayed marriage, spacing of children and celebration of birth of girl child.

Equipment Procurement

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

- To equip the Government Hospitals with Beds, the State Health Society is providing three types of beds- Fowler Deluxe Bed, Fowler Bed and Semi Fowler Bed.
- State Health Society has already awarded contracts for procurement of equipments for SCNUs and NBCCs.
- Establishment of the Bihar Medical Services and Infrastructure Corporation Ltd. on TNMSC model completed

Institutional Framework of NRHM

Under NRHM in Bihar out of 8462 panchayats 7878 Panchayat have formed the Village Health & Sanitation Committee and 7287 panchayats have received Rs. 280842776/- till financial year 2010-11 and the constitution of the remaining is being done on a priority basis.

Rogi Kalyan Samiti has been constituted in all hospital from District Hospital to Primary Health Centre level with a view to strengthen health related systems. Out of the 684 hospitals Rogi Kalyan Samati have been registered in 518 hospitals.

78943 *ASHA*s (Accredited Social Health Activists) have been selected for ensuring village level interventions.

De-centralised Planning

De-centralised Planning under NRHM is being practiced in Bihar since FY 2009-10 and for FY 2010-11 BHAPs were also prepared. This year for 2011-12 HSC Planning has also been undertaken. It is envisaged that once the VHSCs are strengthened, village planning shall also be initiated in the subsequent year.

Health Infrastructure Status

Bihar has combined Civil Works under NRHM with State Plan and Finance Commission resources. A total of 749 new HSCs are being constructed. 75 PHCs work has been completed out of the 138 taken up. Construction of PHCs is in progress at 31 places. Renovation of 598 Sub Centres has also been completed. Bihar Medical Services and Infrastructure Corporation Ltd. has been registered and is expected to be fully functional from April 2011 which is expected to expedite the infrastructure work in the State.

The current status is as such-

Health Institutions	**Present**
Medical Colleges	6
District Hospital	36
Sub-Divisional Hospital	40
Community Health Centre	70
Primary Health Centre	533
Additional PHC	1330
Sub-Centre	9696

- ❖ Health Sub Centre-In the year 2004-05 there were 8858 Health Sub Centres in the state. On the basis of IPHS standard it was decided to create 7765 more new Health

Sub Centres. Out of these 7765 Health Sub Centres, fund for the construction of 749 Sub Centres have been made available to Building Construction Department/District Health Societies.

- Similarly in the year 2004-05, 1243 Additional Primary Health Centres were running in the state. As per IPHS standard it was decided to create 1544 Additional Primary Health Centres in the state. Funds have been released for the construction of 213 Additional Primary Health Centres.
- Out of 8858 sanctioned Health Sub Centres 4875 Health Sub Centres had no building of their own in the beginning. Fund for the construction of 2291 Health Sub Centres have been released and construction of 457 buildings have been completed as yet.
- In the year 2004-05 only 399 Primary Health Centres were functional in the state. With a view to create one PHC in each Block, sanction for the construction of 135 new PHC building was accorded in the year 2005-06. Out of these, constructions in 89 buildings have been completed. 480 PHCs are providing 24 x 7 service to the needy people of the state.
- Similarly in the year 2004-05 only 25 Sadar Hospitals were existing in the state. The govt. accorded sanction for the creation of 12 new Sadar Hospitals. Out of these, construction work in the 9 Sadar Hospitals have been completed. Sanction was accorded for the renovation of 25 Sadar Hospitals. Out of this work in 20 Hospitals have been completed
- In the year 2004-05, 23 Sub Divisional Hospitals were existing in the state. After that 30 new Sub Divisional Hospitals were sanctioned by the government. 15 Referral Hospitals were upgraded to the status of Sub Divisional Hospital. Out of these 45 hospitals, building for 15 Hospitals have been completed.
- Moreover, the works of renovation in 22 Sub Divisional Hospitals have been started. Out of these work have been completed in 17 Sub Divisional Hospitals.

Human Resource

Manpower Management in the health sector has been undertaken vide various initiatives like re-organizing & rationalizing the existing manpower, regularization of Contractual Doctors, Staff Nurses and ANMs being undertaken, ensuring power to transfer doctors delegated to Civil Surgeons, Web enabled system to capture district level cadre information, new cadre rules providing for Specialists' cadre and timely promotion of doctors after 6, 12 and 18 years framed and approved, 7258 ANMs recruited on contract after 15 years, ANM training schools re-started after many years, 1474 Staff Nurse recruited on contract after 15 years, 1319 AYUSH doctors recruited, empanelment of private specialists on monthly or per case basis for health facilities, doctors pooled together at Block PHCs to provide guaranteed services (from District Hospitals to PHC provision of Private Specialists in Eye, ENT, Orthopedics, Pediatrics, Gynae and Surgery @ Rs.500/day/doctor is being ensured and under this renowned doctors of the regional areas are contributing towards availability of quality services), APHCs and HSCs being re-operationalised now, appointment of 1616 contractual doctors done, dynamic ACP rolled out, cadre rules notified for paramedics and health educator, OT assistant, clerks, pharmacists, lab technicians, X-ray technicians cadre

rules to be finalized soon, and draft publication readied for x-ray technicians, OT assistants and clerks.

All districts have been directed to conduct walk-in-interview on Monday every week to fill up the vacant post of all categories of contractual appointment. All formalities of appointment shall be completed on the same day of interview.

According to IPHS norms, Bihar should have at least 18 medical colleges as against 9 currently run by Government and Private. The State Government is already in the process of setting up 3 new Government MCHs, while an AIIMS like hospital has been approved through Government of India.

Child Health

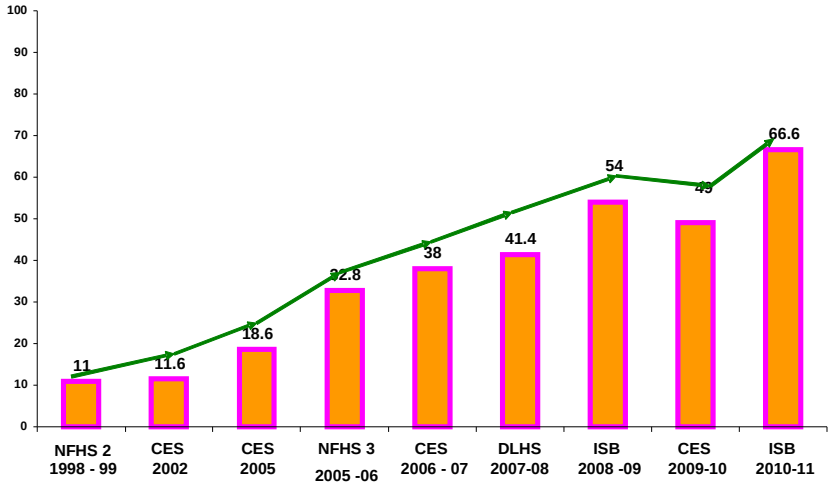
Four focused interventions by the State are -

- Newborns in the State receive home visits through IMNCi trained worker
- PHCs in the state provide essential newborn care services (newborn corners) and have *Mamta* workers
- Breastfeeding initiated in all newborns within one hour across the State
- Special Newborn Care units (SCNU) operational in at least 23 districts in 2010 and in all the 38 districts in 2011.

Introduction of Labour room registers in all facilities conducting deliveries to record information related to mother and newborns has been conceptualized and designed. MIS for SCNU set up and SCNU registers conceptualized and designed. State Government is providing Newborn kits to all mothers in Government hospitals, procurement for which has already started (baby shirt, baby bed sheet, baby blanket, baby napkin, sanitary pads for mothers)

In **Immunisation**, Full Immunization %coverage has increased from 10.7% (1992-93) to 66.6% (2010). Under Immunisation, various initiatives were introduced like alternate vaccine delivery (couriers) for reaching vaccines, 3-rounds of Mobile Hard-to-reach RI campaigns were conducted and Wednesdays and Fridays were designated as immunization days. ***Muskaan ek Abhiyaan*** was launched which included initial survey and tracking of Pregnant and Newborn till full immunization is achieved and realized partnership between ICDS and Health at all levels. There are twice weekly sessions at HSC and AWC and performance-based incentive schemes for Health Workers and Mobilisers was introduced under the scheme.

Evaluated Percentage of Fully Immunised Children in Bihar



Sick Care Neonatal Units are functional in 6 district hospitals and is further being expanded to 26 more districts. Newborn Care Corners are being established in 388 Primary Health Centres of the State of which Newborn corners have been established in 206 PHCs. Integrated Management of Neonatal Care Initiative (IMNCI) is being implemented in 24 districts and nearly 60% newborns are visited within 24 hrs by the trained worker.

Vitamin A campaign has ensured coverage increase from 8.9% in year 2004 to 94.97% in 2009.

Public Private Partnership Initiatives:

Various initiatives have been made in providing quality health services to the needy people through programmes conducted under Public Private Partnership/Outsourcing as per govt. policies-

Mobile Medical Units (MMU)

Scheme of 1 MMU per district was launched on 13th July 2009 and at present a total of 38 MMUs are functional in Bihar. In an MMU the following staff is made available -Specialist Doctor, Nurse, X-ray Tec., Lab. Attendant, Para Medic/ Pharmacist-cum Van Supervisor and OT Assistant. Services being provided per MMU are Free OPD, Free Drugs, Gynae/ANC clinic, Eye check up, ENT check up, HIV testing, Pathology, Radiological tests, IEC, Medical camps etc. A total of 477804 patients have been treated through the MMU from July 2009-Jan 2011.

Dial 108-Emergency Referral Services

Under this scheme the total number of functional units across the State are 50. A pilot project was launched in Patna under PPP for Emergency transport. It's operation started from 03 June 2009. 2 kinds of Ambulance services are being provided – 5 Advanced Life Saving and 5 Basic Life Saving ambulance services have been provided. The basic facilities that are being provided are – Drugs, Oxygen, Heart monitor, ventilator and other Supportive

Medical System. All this at a very low cost chargeable to the patient @Rs.300/- and additionally free/lower rates are charged from the poor patients. These facilities can be availed on dialing a toll free number 108. This facility is being provided by Mumbai based agency M/s Zikitsha Health Private Ltd. under PPP. This facility was inaugurated by Honorable Chief Minister of Bihar on 03-06-2009. The agency operating the facility is paid a monthly fee for the service. On calling 108, it's service is ensured within 15-20 minutes. This is a scheme which has provided a visible face to NRHM in Bihar and has added to the goodwill of the Health Department. A total of 16865 patients have utilized it's services till November 2010.

Dial 102 Services- 6 emergency control rooms have been set up in 6 divisional head quarters i.e. Patna, Gaya, Saran, Bhagalpur, Muzaffarpur and Purnia. Needy person in emergency can easily avail this facility on dialing toll free number-102 under which the nearest control room sends the ambulance to the location from where the dial has been made.

Dial 1911 Services- Patient Complain Redresal Service- This facility was launched on 03-08-2008. Under this facility any individual can register his complain against the availability of Medical Officers/ Para Medical / Sanitation/ Electricity/ Medicines etc in the hospitals on 24 x 7.

Diagnostic Services :

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

Basic Pathology Services

Private Sector Partner operates, maintains and reports through 24-hours Diagnostic centers. Coverage of this service is 19 districts at present and contract is being signed for remaining 19 districts and is for all District Hospitals, Sub-Divisional Hospitals, Referral Hospitals and PHCs of Bihar. Districts have been divided into two agencies for Pathology and agency pay nominal monthly rent for space in DH & SDH. The services to the patients are free and the reimbursement is by the RKS to the private partner. A total of 116 collection centres are functional across 19 districts of the State.

Basic Radiology Facilities

38 districts have been given to one agency to operate, maintain and generate X-ray films and Ultrasound facilities. 175 x-ray units are functional. For ultrasound (14 centres are functional), a central reporting system (CRS) has been placed at IGIMS where Radiologists shall report on USG films. Space has been provided against nominal rent. It functions under the overall supervision of the Hospital Management Society (RKS) of the respective Hospital.

Till date approx 15 lacs patients have been benefited of pathological test facilities

Radiological and Pathological test are made available to the needy patients free of costs. It is being implemented in the state since 15 July' 2009. Agencies are paid for this purpose by the state. Since 15 July' 2009 till date approx 2 lacs X-rays and 7 lacs pathological tests have been carried out.

Ultra-Modern Diagnostic facility

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

- 9 Regional Diagnostic centres have been established in the 9 divisional head quarter districts where facilities of pathology, Radiology, Biochemistry, CT Scan, M.R.I., E.C.G. etc is to be provided on 24x7 basis.
- 6 Ultra Modern Diagnostic centre have been set up in some of the Medical College and Hospitals, where facilities of Patholgy, Radiology, CT Scan, MRI, Mammography etc are/is being made available 24 x 7.

Urban Health Centres

Urban Health Centres have been established to provide support to the Government's Health Programmes under which free OPD facility is provided. 6 Urban Health Centres have been started in following districts- Bhojpur, Aurangabad, Patna, Muzaffarpur. The total number of patients seen in these Urban Health Centres is 27101 (Nov'08-Nov.'10).

Facilities of Sanitation, Diet, Generator, Laundry Services

Maintenances & Sanitation of hospitals, Patient Diet, Laundry work are being managed by the private agencies under PPP on 24 x 7.

Blood Storage Unit (BSU)

28 Blood Banks have been set up in different districts - 7 Government, 4 through PPP and 17 to Red Cross Society. 4 Blood Storage unit are functional. Equipments for Blood Storage Centres have been supplied to all FRUs. Approval Certificate has been issued for setting up 34 Blood Collection Centres in 34 FRUs.

Trauma Centre

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

Cleanliness Programme

In order to strengthen cleanliness programme in all the 38 districts from Primary Health Centres level to Medical College level, the Govt. has initiated seven coloured bed sheet programme on 15 August' 2008. This programme is being implemented by the department of the Health, Govt. of Bihar. Under the programme every day a different colour bed sheets are provided on the beds as per the given table:

Hospital Maintenance

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

Generic Drug Shop

With a view of providing quality medicines at low cost it was decided to set up three Generic Drug Shops in each Medical College and Hospitals, two shops in each district hospitals and sub divisional hospitals and one shop in each primary health centres. 188 types of drugs and some other surgical items are available in these Generic medicine shops. During 2007-08, Generic Drug Shops at 21 locations and during 2008-09, Generic Drug Shops at 14 locations were set up.

School Health Programme

Under this programme annual health- check up of all students enrolled in govt. primary and middle schools has been done by organizing camps in the schools campus through selected agencies under PPP. About 2131139 children have under gone health check up through 23744 health camps till Nov' 2011.

Institutional Arrangements and Organizational Development

Along with Health Department, ICDS, PHED and Panchayat are helping in implementing the NRHM Programme. The coordination has been placed at State, District and Block Level. At the grassroot level linkage between *ASHA*, ANM with AWW has been strengthened especially under the Muskaan programme. PHED department has taken up the training of *ASHA*. Health Camps were held across States in coordination with ICDS, Education and development partners.

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

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

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

Setting up Health Management Information System (HMIS)

With a view to uploading various reports in prescribed formats online on the web portal of Govt. of India and dissemination of information to every level for planning schemes/programmes, Data Centre at PHCs/Sub Divisional hospital/District hospital levels have been set up. This is being managed through Health Management Information System (HMIS).

State's Concerns and Strategies | Chapter- VII

The State has achieved some progress in terms of output indicators, however the maternal mortality, child mortality and population growth continues to be a cause of serious concern to the state's development efforts. In terms of key health indicators, Bihar is among the low performing states. Though the state fares reasonably well in terms of its Infant Mortality Rate (52) as against the national average (50) and NMR (42.1) as against national average of 45, it continues to be among the poorer performing states in terms of TFR and MMR.

Floods in some parts of the state make the State vulnerable to communicable diseases. Besides, the health infrastructure is inadequate to cater to the needs of the people and the upkeep of the already existing facilities is quite challenging. The delivery of services could only be improved if facilities are within reach and have minimum basic physical infrastructure to provide the basic services.

Current Challenges-

- Poor pace of infrastructure upgradation for all level of health facilities despite land, standard design and fund availability
- Huge shortage of trained professionals at medical, nursing and paramedical levels.
- Lack of transparent and rational posting policy.
- Lack of separate public health cadre (Cadre division)
- Non functional peripheral health facilities like APHC & HSC
- Weak procurement cell leading to gaps in equipment, logistics and drug supplies as per increasing need
- Non functional PRI standing committees like on Village Health and Sanitation Committee (VHSC)
- Private practice of government doctors

Human resource is a major issue where the State health system is struggling. The paucity of medical professionals especially the Specialists limits the public health facilities in providing much required higher level of care to the needy. A mismatch exists in the State between the available Medical and Para medical professionals and the demand for their services. More medical graduates and Para medical professionals are required to fill up this gap. Moreover despite number of trainings held, rationalization of manpower although focused upon is taking time in materializing.

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

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

BCC strategy formulation- Even after four years of NRHM, Bihar lacks a consolidated BCC strategy in health due to lack of technical know- how.

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

Maternal Health

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

The important ones are listed below:

- Shortage of skilled frontline health personnel (ANM) to provide timely and quality ANC and PNC services.
- The public health facilities providing obstetric and gynecological care at district and sub-district levels are inadequate.
- Mismatch in supply of essential items such as BP machines, weighing scales, safe delivery kits and their demand.
- Shortage of gynecologists, obstetricians and anesthetists to provide maternal health services in peripheral areas.
- Shortage of beds in health facilities
- Lack of knowledge about ante-natal, peri-natal and post natal care among the community especially in rural areas
- Low mean age of marriage resulting in unwanted pregnancy and difficult deliveries.
- Low levels of female literacy results in unawareness about maternal health services.
- High prevalence of malnutrition (anemia) among women in the reproductive age group

Introduction of JBSY acted as a major boost to improving maternal health. Under the Scheme institutional delivery especially at Government Hospitals has substantially increased, and there has also been a shift in deliveries from DHs to PHCs, thus easing the load on the DHs. There has been an increased utilization of ANC services which also led to high coverage of PNC, zero dose polio, BCG. The medical officers at the lower level institutions in Bihar reported that they had prepared sub-plans for additional manpower, additional equipment, drugs and additional labour rooms/operation theatres in order to meet the demand of the increased institutional deliveries. However, the minimum two day stay post delivery is not adequately ensured and there are delays in payments to beneficiaries.

JBSY is not about promoting institutional deliveries alone. Programme objectives for reduction of maternal mortality and morbidity will be achieved when women coming to facilities receive quality delivery and post partum care services. In the absence of corresponding inputs for human resources, additional labour rooms and post natal beds, drugs and other supplies, quality of services, etc. have been a major casualty. In many instances providers may not adhere to the evidence-based guidelines. Hence, it has been proposed to monitor the quality of facilities as an integral component of JBSY monitoring so that service providers and programme managers also appreciate the importance of the focus in the quality of services provided and don't see their role only as mere distributors of money.

The State had approached the Centre to permit the state to implement the Chiranjeevi Yojana (like Gujarat), approval was given for a pilot. The State had till now not taken up accreditation of private practitioners aggressively, three out of the five districts tried making efforts to enroll and accredit private hospitals. But their success was limited and only two could accredit one hospital each for JBSY activities after careful review of their infrastructure.

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

In the State 54 MOs have been trained in EmOC and 66 MOs in Life Saving Anesthetic Skills till Dec 2010 who are now managing complicated cases at their respective places of posting.

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

Child Health

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

whose mothers are illiterate, who belong to Scheduled Castes, and who are from poor households.

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

Maternal Factors

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

Family Planning Services

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

Child Health Services

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

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

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

Nutritional Rehabilitation Centre is in operation in Darbhanga and field operations are on-going in Darbhanga, Muzaffarpur and East Champaran districts. In all the 38 districts, agencies have been finalized for setting up NRCs and meanwhile through UNICEF orientation of ICDS is going on. Under the scheme special nutritious food is provided to the severely malnourished children.

Population Stabilisation

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

High TFR is reflected by a dismal picture of women in Bihar marrying early, having their first child soon after marriage, and having two or three more children in close succession by the time they reach their late-20s. At that point, about one-third of women get sterilized. Very few women use modern spacing methods that could help them delay their first births and increase intervals between pregnancies.

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

- Lack of integration of the Family Planning programmes with other RCH components, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels.
- Failure of the programme to effectively undertake measures to increase median age at marriage and first childbirth, although IEC and counseling initiatives have been introduced.
- Inability of the programme to alter fertility preferences of eligible couples through effective behavior change communication (BCC).
- Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age groups. (Overall, sterilization accounts for 82 percent of total contraceptive use. User rates for pill, IUD and condoms remains very low, each at about 2 percent or less than 1%-NFHS III).
- Due to high prevalence of RTI/STD, IUDs are not being used by majority of women (user rate at 0.6% only –NFHS III).
- Inadequate exposure of family planning messages in the community, particularly amongst rural and socio-economically disadvantaged groups.
- Weak public-private partnerships in social marketing to promote and deliver family planning services. (Public Private Partnership has improved since 2008-09. 110 Nursing homes in 19 districts are accredited to conduct Family planning operations. Accredited

Private Nursing homes are expected to conduct more than 50-60 thousand family planning operations in the state).

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

The state has quality assurance committee for family planning both at State and District level. The committee sits quarterly and report is sent to state. Also, 110 private hospitals and Clinics are accredited by the District Quality Assurance Committees for conducting sterilization in 19 districts. These private facilities are monitored by the QAC on sterilization conducted in the facilities. IUD figures for the State have considerably improved in the year 2010-11 due to persistent efforts of the state and development partners. Family planning Insurance scheme is also being implemented in the state with ICICI Lombard. Most of the Sterilizations are conducted in the last two quarters due to existing socio-demographic and programmatic reasons.

Efforts are being made to offer fixed day family planning services at District hospitals, Sub divisional hospitals, FRUs, PHCs and accredited private facilities.

Adolescent Reproductive & Sexual Health

Bihar has one of the highest rates of early marriage (69% among women aged 20-24 years) and high rate of childbearing, and a very high rate of iron-deficiency anemia.

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

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

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

Strategy for adolescents requires sensitization and handholding at all levels for proper implementation. The current school health program by and large lacks any adolescent oriented interventions.

The Bihar State AIDS Control Society has several adolescent targeted interventions including special adolescent counselors. The possibility of convergence between the RCH II program priorities and NACP priorities has been explored in this PIP.

Specific capacity building initiatives to orient the health providers at various levels to specific necessities of the ARSH program like adoleent 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.

Infrastructure Strengthening

Health Institutions	Required	Present	Shortfall
Medical Colleges	18	6	12
District Hospital	38	36	02
Sub-Divisional Hospital	67	40	27
Community Health Centre	622	70	552
Primary Health Centre	534	533	01
Additional PHC	2787	1330	1457
Sub-Centre	16623	9696	6927
ANM/GNM School	76	27	49

Out of 36 district hospitals functional the performamce is not up to the level due to shortage of Specialists and Staff Nurses. The identified PHCs require to be upgraded to CHC level for specialised services. The APHCs only provide OPD services and have to be operationalised for meeting in-patient needs and for providing delivery services, so that the load of Block PHCs is reduced. Half of the HSCs are running from the rented place or Panchayat office and are manned by one ANM only and virtually non-functional.

There is slow progress in Infrastructure as the PWD (BCD) is overloaded. To overcome the problem of slow progress in infrastructure, a separate Corporation has been created. This year, it is proposed that engineering personnel may be added to this Corporation at District and Sub-District levels for supervising and expediting the infrastructure work.

Infection Management and Environmental Plan:

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

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

The state has identified agencies for undertaking the task of Bio-Waste Management and Treatment. Necessary approval and clearance from Bihar State Pollution Control Board has been received in the month of December 2010. The waste management operations in the 30 districts through PPP are expected to be started from mid of next financial year.

In the districts under Patna division the task has been handed over to Indira Gandhi Institute of Medical Sciences, Patna which has it's own Treatment plant. The task has been operationalised in a few facilities and needs streamlining, however all the six Patna division districts' staff have been trained regarding waste management and segregation.

Human Resource Development including Training

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

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

Recruitment of Medical officers and paramedics- The process of recruitment is lengthy and takes about 04-06 months. The number of applicants is quite limited because of dearth of doctors and paramedics in the state. Moreover the consolidate remuneration is not lucrative enough. Hence from the previous year incentive for rural postings and specialist services have been provided in the SPIP.

High turnover of Personnel due to low motivation- It is felt that the state needs to restrict the turnover of doctors on contract and also programme managers. It is proposed that a study may be undertaken to assess the situation and recommend remedies, however it is assumed that rural and specialist bonus will help to curb the turnover to same extent and an HR policy needs to be finalized.
Quality of training - Monitoring cell has been constituted at the state level in State Institute of Health & Family Welfare. The trainings are being monitored at regular intervals however quality checks should also be undertaken.

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

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

In 2010-11, there has been a continuous focus on the capacity building of the existing manpower in the state. Trainings as per GoI guidelines on Immunization, IMNCI, EmOC, LSAS, SBA and Minilap/MVA etc have been taken up with full vigor, however due to poor

quality of training in some centres, training fell behind schedule. It is proposed to continue these trainings in 2010-11. In addition, the state wide training on Immunization for Medical Officers, IPC skills for Breast feeding and basic training of neonatal resuscitation-shall also be taken up for various levels.

Ensuring Gender Equity

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

Gender discrimination continues throughout the life cycle, as well. Women are denied access to education, health care and nutrition. While the state's literacy rate is 47.5%, that for women in rural areas is as low as 30.03%. Abysmally low literacy levels, particularly among3 women in the marginalised sections of society have a major impact on the health and well being of families. Low literacy rate impacts on the age of marriage. The demand pattern for health services is also low in the poor and less literate sections of society.
Women in the reproductive age group, have little control over their fertility, for want of knowledge of family planning methods, lack of access to contraceptive services and male control over decisions to limit family size. According to NFHS data, for 13% of the births, the mothers did not want the pregnancy at all. Even where family planning methods are adopted, these remain primarily the concern of women, and female sterilization accounts for 19% of FP methods used as against male sterilization, which is as low as 1%. In terms of nutritional status too, a large proportion of women in Bihar suffers from moderate to severe malnutrition. Anemia is a serious problem among women in every population group in the state and is more acute for pregnant women at 60.2% (NFHS 3).

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

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

Urban Slums

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

At present, there are 8 Urban Health Centres (UHC) in the state. However, as per the GoI guidelines, there should be one UHC for 50,000 population (outpatient). The Urban Health

Centres should provide services of Maternal Health, Child Health and Family Planning and especially cater to the Urban slums. The infrastructure condition of the existing Urban Health Centres is not up to the mark and requires some major renovation work. The staff at each UHC should comprise of 1 Medical Officer (MO), 1 PHN/LHV, 2 ANMs, 1 Lab Assistant and 1 Staff clerk with computer skills.
UHCs are being set up under PPP by SHSB under which 6 have already been made operational.

State's Focus for the next five years –

- ☞ Improved health care services for all by 2015 in Bihar
- ☞ Improving quality of services
- ☞ Improving access of services for poorest

Current Opportunities -

- Establishment of Bihar Medical Services and Infrastructure Corporation Ltd.
- Declaration of 2010 as year of Newborn and proposed declaration of 2011 as year of Safe motherhood
- Presence of Development partners and NGOs for technical support —UNICEF, BMGF, DfID, UNFPA and NIPI and assigning them different districts for holistic districts
- New cadre of contractual professionals at State, District and Sub-district level

The various roles and strategies to be focused upon by the Block, District and State under NRHM are envisaged as such-
Leadership Strategies-

- Guidance and support to Civil Surgeon's team.
- Ensuring security, water at health facilities.
- Seeking clear deliverables from health staff.
- Making Rogi Kalyan Samitis fully functional.
- Making Panchayat Swasthya Samitis active.
- Holding District Health Society Meetings.
- Organizing District Health Mission Meetings.
- Making the Red Cross Society fully active.

Governance Strategies-

- Ensuring service guarantees to the people.
- Ensuring that ANMs live at Sub Centres.
- Ensuring action against absenteeism.
- Making Additional PHCs functional.
- Effective outsourcing – generator, cleaning.
- Using services of Health Educators.
- Guaranteeing drugs, diagnostics, cleanliness.
- Doctors do surgery in Government Hospital.

Financial Strategies-

- Timely approval of payments.
- Ensuring that CS office makes timely salary payments or records reasons for non-payment. Stop open ended transactions.
- Inspection of financial records by teams.

- Full oversight of resource position and approved schemes.
- Timeliness of fund utilization – Sub Centres, ANM/GNM Nursing Schools.

Coordination strategies-

- PHED, Electricity, Building Construction Department.
- Panchayat, Social Welfare, Education Department.
- ISO 9001 Certification of Health facilities.
- Interface of health system with elected representatives.
- Involvement of NGOs in health outreach work.
- Removal of all encroachments.

Monitoring Strategies-

- Immunization, institution delivery, family planning services, TB, Kala Azar, Malaria.
- Availability of drug kits with *ASHA*s, Sub Centres, Additional PHCs, PHCs.
- Optimal utilization of human resources.
- IRS spray round starting 1st February.
- Fixed Day Family Planning Services.
- Timeliness of payments – JBSY, *ASHA*.
- Ensuring basic protocols being followed.

Planning roles-

- Inputs into the yearly planning exercise.
- Getting all priorities included in DHAP.
- Optimal utilization of available resources.
- Plan for infrastructure, human resources, equipments as per Indian Public Health Standards.
- ISO certification of institutions.
- Making all Sub Centres and Additional PHCs fully functional.
- Making Block PHCs provide surgical services.
- HR Management Strategies-
- Full use of all new skills provided on contract – Block Health Managers, DPMs, DAMs, DDMs, DCOs, etc.
- Clear job responsibilities for all staff.
- Making use of all health staff – Health Educators, Nurses, ANMs.
- Ensuring timely payments and performance assessments.
- Feedback on performance of Civil Surgeon, other doctors.

Immediate Thrust Areas-

- Every *ASHA* with drug kit by February 2011.
- Every Health Sub Centre and Additional PHC fully functional
- Cleanliness, water, electricity, drugs, diagnostics, clean linen, blankets, guaranteed services.
- Village Health and Sanitation Committees fully using the untied funds for waste disposal, cleanliness, soak-pits, etc.
- All government doctors who perform surgeries in private shall do so in government hospitals as well.

Primary Strategies to achieve future goal-

1. **Improving institutional mechanism for HR and meeting future needs**
   - ☞ Departmental restructuring in line with future requirement - CMO & CS system to retain specialist doctors in patient care and putting public health specialist as CMO.
   - ☞ Transparent transfer policy – fixed term posting at one place.
   - ☞ Rationale posting of skilled manpower – to optimally utilize services of trained manpower / specialist at appropriate facilities having adequate infrastructure and services
   - ☞ Enhancing HR capacity at district and sub district levels.
   - ☞ Promote doctors at techno managerial level at district and state.
   - ☞ Fill up existing vacancies at both supervisory and worker cadre (See graph for existing vacancies status)
   - ☞ Undertake on campus interviews to tap doctors, nurses and ANMs passing out of the existing institutions
   - ☞ Establish at least 9 new government medical colleges in state to bridge the gap of doctors.
   - ☞ Expansion of Nusring and Paramedic Institutions to enable an increase in the density of skilled health workers in the rural areas
   - ☞ Operationalisation of ANM/GNM training schools in government hospitals
   - ☞ Re open ANM training schools in each district.
   - ☞ Open GNM training school in each medical college.
   - ☞ Encourage private sector to open new Medical colleges, ANM /GNM training schools in state
   - ☞ Creation of 9 ANM & 7 GNM schools
   - ☞ Compulsory pre PG posting at rural institutions for at-least a year
   - ☞ Linkages with southern state colleges for recruitment of Nurses and ANMs.
   - ☞ Initiate a short term course for in service staff on administration and financial management to groom future district level officers like CMO & CS.
   - ☞ Linkages with big hospitals in Bihar & other state for capacity building of service provider on clinical courses – Obs & Gyn , Anaesthesia & Paediatrics.
   - ☞ Encourage medical colleges to work as training centers for clinical courses.
   - ☞ Appropriate investment is needed to expand medical education infrastructure and ensure quality, with private sector involvement, if needed. Such investment is not available through NRHM funds. In addition, forward looking and transparent HR policies should be developed for the health workforce in the state.
   - ☞ Provision of AYUSH doctors in HSC OPDs, Utilisation AYUSH doctors for monitoring of ANMs, 250 APHCs to be upgraded to online computerised clinic for AYUSH, Provision for recruitment AYUSH Specialists in all the 38 districts, Dedicated AYUSH PMU at SHSB and Provision of AYUSH drugs at APHC
   - ☞ With the large number of human resources in the districts, the effectiveness of such addition would be more pronounced if supervisory structures and job descriptions of every worker are well established.

2. **Infrastructure strengthening**
   - ☞ De-centralization of power to hire local private construction agency for speedy work.

- ☞ Phased wise construction of CHC and PHCs to provide services.
- ☞ Construction of residential quarters for staff working at block level.
- ☞ Accelerating pace of infrastructure upgradation of health centres and hospitals through-
  - The Bihar Medical Services and Infrastructure Corporation Ltd. has been established. The necessary formalities may be completed on a fast track mode including staff appointment and then the corporation can take up the strengthening of district hospitals on a priority basis.
  - The PWD may be requested to pace up the infrastructure work which is near completion or handover the already complete buildings to the Health Department. This will help the Civil Surgeons to optimally utilize their resources.

3. Coordination with other Departments

- ☞ Establish a state level coordination committee having members from ICDS , Panchayati Raj , Education , Water and PHED under the chairmanship of Development Commissioner to seek support from other development departments in improving quality of service delivery
- ☞ Strengthening inter-departmental coordination (Health, PHED, Social Welfare) and involvement of Panchayats in organizing VHND.

4. Improving the availability and functioning of public sector health services

- ☞ Design and Implement a basic package of primary health services.
- ☞ Design and Implement an essential package of hospital services.
- ☞ Track each maternal and infant death and mitigate risk of recurrence.
- ☞ Provide emergency obstetric and neonatal care at all PHCs and higher facilities.
- ☞ Upgrade infrastructure to IPHS norms.
- ☞ Increase availability of doctors, nurses and specialists in facilities.
- ☞ Increase the availability of drugs and family planning services.
- ☞ Reduce incidence of communicable diseases.
- ☞ Population Stabilization interventions
- ☞ Health System Strengthening -
  - 〉 Antenatal Check ups for all pregnant mothers
  - 〉 Strengthening Labour Room, Operating Theatre and Blood Bank infrastructure at district and sub district level
  - 〉 Provision of uninterrupted supply of medicines and logistics for maternity and family planning services
  - 〉 Establishment of new facilities for maternity services to cater to outreach areas where uncomplicated deliveries could be handled by Skilled Birth Attendants (SBAs) ANMs
  - 〉 Establishment of and adherence to infection prevention protocols
  - 〉 Placement of trained manpower—doctors and nurses as per standards
  - 〉 Recruitment of new Human Resources especially at Nurses and ANM level
  - 〉 Supportive Supervision
- ☞ Conducting Maternal and Infant Death reviews
- ☞ Malaria, TB and Disease Surveillance programmes ought to be further integrated into the NRHM in such a manner that the public health challenges of infectious diseases also become fully community owned and community led.

5. **Partner with the private sector and communities to strengthen services**
   - ☞ Facilitate regulation of and the orderly growth of private sector health services.
   - ☞ Create a positive PPP environment and partner to upscale services.
   - ☞ Involve community and elected representatives in health service management.
   - ☞ Mainstream nutrition and sanitation issues in health delivery.
   - ☞ Harmonise funding and initiatives in the health sector.

6. **Empower vulnerable groups to access affordable quality healthcare**
   - ☞ Start new initiatives and investments in backward regions.
   - ☞ Introduce safety nets for the poor to access PPP services.
   - ☞ Empower vulnerable groups with rights based access to health services.
   - ☞ Use innovative mechanisms to reduce out of pocket expenditure on health.
   - ☞ Linkages with RSBY in government hospitals as also in provision of care in the private sector needs to be further strengthened to enable cashless services for the poor. RSBY payments can also help to incentivize service delivery in government hospitals.

7. **Strengthen health systems for efficient, accountable and transparent services**
   - ☞ Focus on developing the capacity of the departments.
   - ☞ Improve the direction utilisation and effectiveness of budget spent.
   - ☞ Enhance the availability of skilled medical, nursing and support professionals.
   - ☞ Strengthen information, monitoring and evaluation systems.
   - ☞ Enhance the capacity for strategic planning and evidence based decision making.
   - ☞ Improve governance, social accountability and transparency.

8. **Provide financial risk protection to the poor**
   - ☞ Although out-of-pocket medical expenditure is lower than national levels, the following strategies need to be focussed upon to reduce OOP expenses-
   - ☞ Ensure timely incentive to beneficiaries under JBSY
   - ☞ Increase gain through RSBY
   - ☞ Ensure free transportation facility to pregnant women

9. **Proactive role of the Government**
   - ☞ Department to be looked at as critical and important department
   - ☞ Quarterly review of progress by Hon'ble Health Minister
   - ☞ Bi –annual review of health department by Honorable CM.
   - ☞ Curbing HR indiscipline through political support and commitment
   - ☞ Fast Track roll-out of BMSIC (Bihar Medical Services and Infrastructure Corporation Ltd.)
   - ☞ Focus on capacity development of Village Health and Sanitation Committee (VHSCs) for improved local monitoring
   - ☞ Support of all elected Members on implementation and monitoring of health programs, regular visits to health facilities in their constituencies and feedback to improve the delivery of services

Current System of drug, equipment, services and supplies

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

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

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

Issues that the present suffers from –

- Absence of detailed and transparent guidelines for technical evaluation of bids by SHSB results in delayed evaluation process and leads to litigations by disqualified bidders.
- For a number of drugs the rates are not fixed because of limited or even no bidders
- Rates of drugs procured by SHSB are much higher than other states like MP and TN- due to perceived high level of corruption in the state, which results in time taken for finalisation of rate contracts and due to non-surety of the quantities to be supplied to allow the bidders to take economies of scale into account
- No proper systems for drug procurement planning, demand assessment, indenting and supply of drugs at district and lower level health facilities-resulting in supply of drugs on an ad hoc basis without a clear relation to actual demand
- No standard systems for record keeping at district and facility levels which results which results in a lack of re-conciliation of indents and actual supplies; difficulty in compiling actual stock availability at any particular point of time; difficulty in placing orders based on stock availability; and problems ensuring old stock is cleared first, once the new supplies come.

- Infrastructure and staff capacity (both in numbers and qualification) available at district and facility level stores remain weak, as a result of which it becomes difficult to manage the supply chain and inventory management efficiently and effectively.

- Due to absence of central rate contracts for a no. of drugs, the level of local purchase of drugs by district officials remains as high as 20-30% of the district budget value. Since at district level mostly branded drugs are purchased, their cost is higher than drugs bought through centrally fixed rate contracts.

- Systems put in place for quality testing of drugs remain under-utilised due to a lack of capacity for monitoring and supeervision. There is no system for quarantine of supplies and most of the time the onward supply is made before receipt of the quality testing reports. Also, where local purchases are made, quality testing of drugs is minimal.

- For equipments and services, the supply remains top driven and there are no proper mechnaisms for demand assessment. Lack of skills at SHSB level to define detailed specification for equipments and lack of capacity at facility level to inspect the supplies also impact the procurement process.

- As for service contracts, in the absence of properly defined benchmarks and specifications it becomes difficult to monitor the quality of services being delivered. There is also limited capacity within district officials to monitor the activities of different service providers, which results in provision of either sub-standard or no services at all.

- There is huge requirement for physical infrastructure to be put in place at lower levels – construction activities through BCD or is directly outsourced by DHS, depending on the nature of work. However both these organisations lack in capacity to carry out the scale of work that is required.

- PRI structure remains weak-open to fraudulent practices and lack of transparaency in functioning.

<u>Opportunity and Strategy</u>-

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

A big leap has been taken in 2010-11 in the field of Procurement concerning Maternal and Child Health equipments and drugs. One of the key achievements has been the finalization of rate contract for the state owned Sick Newborn Care Unit and Neonatal Stabilization Units, Labour room equipments and of quality hospital beds. In addition, rate contracting of

some important drugs like Misoprostol has also been ensured. Procurement of the same has already been initiated.

Behaviour Change Communication

The state does not have any comprehensive BCC strategy. All the programme officers implement the BCC activity as per their respective programmes. A State IEC Plan is prepared however district specific communication plans require to be undertaken.

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

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

Convergence/Coordination

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

Private and NGO Health Service

The State has a wide network of private health facilities in the urban areas providing Health services. In general, these private health facilities are run either by individuals/ organizations for profit or by Non-profit Charitable organization/NGOs. However, exact data on the number of these health facilities are not available with the State as the registration of private clinics and nursing homes has not yet started although the Clinical Establishment Act was passed a couple of years ago by the State. Presently these health facilities are also not regulated by the DoH. However under PNDT Act, the private clinics and nursing homes undertaking ultra sonography have been regulated and these facilities are being monitored. There is an urgent need to create a comprehensive database for private health service providers and develop appropriate regulatory mechanism for them.

NGOs

NGOs are involved in School Health Programme and Nutrition Rehabilitation Centre projects of the State.

PPP

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

Vulnerable Section/High Focus districts

In 2011-12, the state envisions a system, which provides all the individuals especially the vulnerable population (SC, OBC, BPL) the ability to access health care at an affordable price by tackling the existing problems and building on its strengths and addressing its weaknesses.

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

Scheme/Program under NRHM	Chapter - VIII

RCH Flexipool	Part A

RCH II Programme Objectives and Strategies

Vision Statement

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

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

Technical Objectives, Strategies & Activities

Maternal Health

Introduction

Maternal health indicator for Fifth Millennium Development Goal (MDG) is reduction of maternal mortality ratio to less than hundred. Bihar is celebrating the year 2011 as 'Year Of Safe Motherhood'. Towards a commitment to the human development of the state, five selected strategies have been identified. Maternal mortality ratio reduction up to 200 is one of the goals of the state for 2011-12. This shall be a step towards reaching the MDG goal by 2015. This requires a focused attention as current MMR is 312 per 100000 live births (SRS 2007-08). Therefore focused interventions within ongoing maternal health program through sustenance of the strategies have been suggested for ensuring the progress towards Goal.

Safe motherhood concept has been proposed by the state government to put in place a system and interventions through inter-sectoral coordination towards concept of holistic health aiming towards physical, mental, social and spiritual development of mother and child with life cycle approach by covering services of all pregnant women to adolescent girls. Safe motherhood has been linked with maternal health through ensuring whole gamet of quality reproductive services from early registration of ANC, Intra-natal care and post natal care.

Background:-

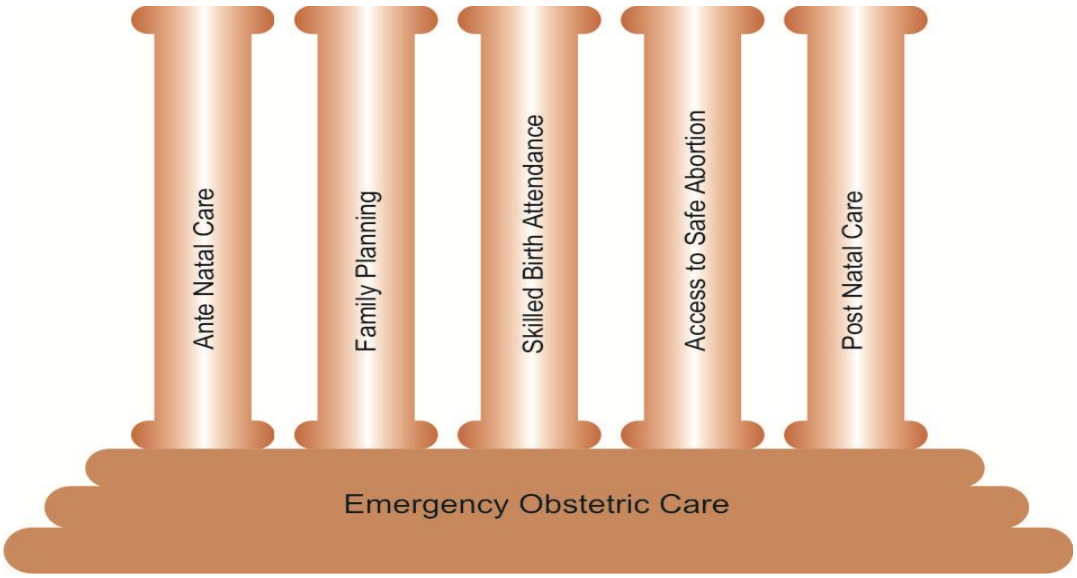
In Bihar, every hour, a lady dies while delivering a new soul for the family and the society. Each year, about 8300 mothers die while giving 2.7 million births annually. The Maternal Mortality Ratio (MMR) in Bihar is 312 deaths per 1, 00,000 LB. The rate of decline in MMR in the past decade has been close to 4 percentage points while this should have been more than 5.5 percentage points to achieve the MDG target. Bihar contributes the second highest mortality burden in the national maternal mortality disease burden. For every woman who dies from causes related to pregnancy or childbirth, it is estimated that there are 20 others who suffer pregnancy-related illness or experience other severe consequences. The number is striking: an estimated 1,66,000 women in Bihar annually who survive their pregnancies experience adverse outcomes such as pregnancy related injuries, infections, diseases and disabilities, often with lifelong consequences. The truth is that most of these deaths and conditions are preventable – research has shown that approximately 80 per cent of maternal deaths could be averted if women had access to essential and basic health-care services.

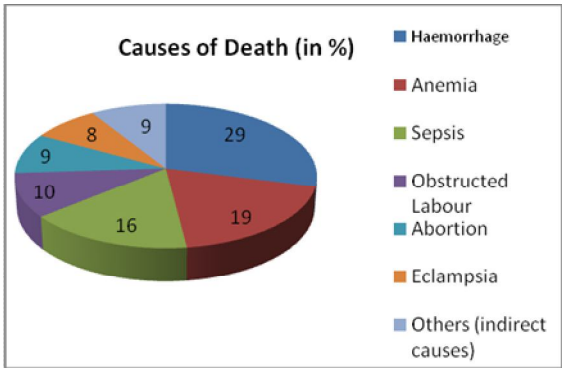
'Why do mothers die? What causes deaths of prospective mothers? What is the most critical time period in a ten and half month long pregnancy and birthing process?' are well researched questions. The Sample Registration Survey (SRS) and the verbal autopsy methods capture this information periodically. Anaemia is a major physiological condition which accentuates during pregnancy and affects severely the outcome of the pregnancy for

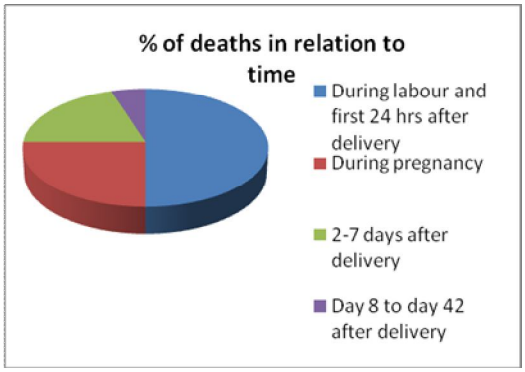
both mother and baby. There are other conditions like Haemorrhage, Eclampsia, Sepsis, Obstructed labour and Unsafe Abortion which, if left untreated or unaddressed, promote the death of the mothers. Additionally, if a lady is suffering from malaria, HIV/AIDS, cardiovascular condition or other debilitating disease and her condition worsens during pregnancy, then she is said to have died due to an indirect cause. In today's world, there

is evidence based solutions available for all the possible causes of maternal death and these are applicable even for low resource settings.

Pillars of Safe Motherhood







There are five pillars with foundation laid by the Emergency Obstetric Care. Improving availability of all the pillars of safe motherhood and access to all sections of population including the disadvantaged group promotes the reduction in maternal mortality and morbidity.

Emergency Obstetric Care (EmOC)-the foundation of safe motherhood :

To achieve the Millennium Development Goal of 75% reduction in the maternal mortality ratio between 1990 and 2015, National Rural Health Mission (NRHM) in India has facilitated the investment of more energy and resources into providing equitable, adequate maternal health services. One way of reducing maternal mortality is by improving the

availability, accessibility, quality and use of services for the treatment of complications that arise during pregnancy and childbirth. These services are collectively known as Emergency Obstetric Care (EmONC). The EmONC services can further be classified into the Basic EmONC (BEmONC) and the Comprehensive EmOC (CEmONC) services.

Type of EmONC	Three minimal essential services on a 24X7 basis	Health facilities in Bihar offering EmOC 24X7
Basic EmONC	-Safe Delivery Services -Emergency Newborn care -Referral transport	533 Block PHCs Sub divisional hospitals Referral hospitals
Comprehensive EmONC	-Caesarean section surgery, as per medical indication -Safe blood provision -Emergency Newborn care	District hospitals All medical colleges

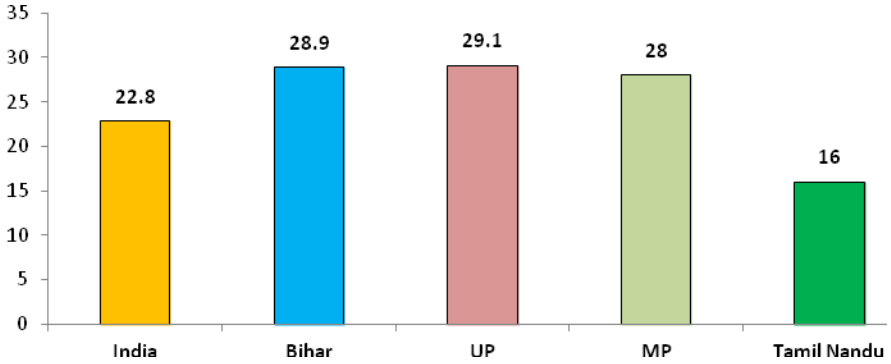
The UN process indicators and the Indian Public Health Standards state that there has to be a health facility providing CEmONC at every 5 lakhs population and a BeMOC at every 1.25 lakhs population. In Bihar, presently, there is a CeMOC centre for every 25 lakhs and a BeMOC centre for every 1.75 lakhs of population. Thus, meeting the population norms for the provision of EMOC services requires a concrete and concerted effort by all stakeholders.

Antenatal Care - the first pillar:

Fifteen percent of all pregnant mothers are at high risk due to the presence of one or many complications. The availability of standard antenatal care and access by all clients helps in the identification of high risk cases. The frontline health workers are expected to keep a close watch on such cases and put them in contact with more skilled personnel for a safe outcome of the pregnancy. The national guidelines stipulate that every pregnant mother should be examined at least four times during her antenatal period to monitor the progress of her pregnancy and facilitate the timely detection of any potential complication. In Bihar, presently, only 15% of the mothers are accessing the antenatal care services at least four times in their pregnancy. Early registration with the nearest ANM and mobilization of the pregnant mothers for regular checkup is one of the tasks of *ASHA*s but the coverage for this intervention is very poor. There are issues both on the demand and supply sides which need to be addressed to improve the antenatal care in Bihar.

Family Planning - the second pillar:

Bihar has the second highest birth rate in India at 28.5 against the national average of 22.5. Additionally, Bihar has poor contraceptive prevalence rate and high unmet need for all types of family planning methods. High incidence of early marriage despite all types of regulatory provisions leads to high adolescent birth rate in Bihar. Summarily, the availability of family planning services and access to these services is extremely poor. The State Population Council has taken a serious note of the current situation and has asked the Health Department and NRHM to step up their efforts for Population control. A Janasankhya Sthirta Kosh (JSK) has also been established to spearhead the efforts required for population control. These efforts need to continue to ensure that the unmet need for family planning is reduced to less than 10%.



Birth rate of different states of India

Skilled attendance at birth - the third pillar:

This refers to the availability of a Skilled Birth Attendant (SBA) with all necessary basic tools for the birthing process of a woman in need. After the Janani Evam Bal Suraksha Yojana-JBSY, the health facilities in the government sector are attracting high case load of deliveries but two independent coverage surveys have revealed that about 50% of the births are still occurring at home. While it may be presumed that all births at health facilities are being delivered by skilled attendants, only about three percent of the births are being attended by SBAs among the home deliveries. The availability of a SBA helps in identification of the danger signs or complications of pregnancy and finding ways to address the same. The IPHS standards clearly define the essential drugs, equipments, logistics and skills of human resources for ensuring a safe delivery at different levels of health facility, but ensuring the regular availability of these at all health facilities is a great challenge in Bihar.

Access to safe abortion - fourth pillar:

Abortion is the process of termination of pregnancy before its completion. As per Medical Termination Pregnancy (MTP) act, a pregnancy of less than 20 weeks can be legally terminated at a recognized medical center. However, the availability of such recognized centers in rural populace is almost absent. With high unmet need for family planning, there are high chances of unwanted pregnancies. When a woman or her family decides to abort the pregnancy, the unauthorized and untrained services provider is requisitioned for service more often. However, these 'quacks' end up doing more harm than good to the women in need. Unsafe abortion results in high morbidity and mortality among reproductive age group of women. Under the bouquet of family planning services, access to safe abortion services is being addressed, but not at the required scale.

Postnatal Care - the fifth pillar:

Post-natal care is the care provided to a mother after the birth of a baby. A visit by a SBA to the mother's place at least three times in the first ten days is sufficient to track any danger signs for both mother and newborn. In Bihar, the current coverage for the postnatal care, either by visit of the client to the facility or visit of an ANM to the client, is 15%. Currently, under the IMNCI program, aimed at improving the newborn and child survival, an AWW or an ANM address the needs of the newborns by undertaking three mandatory visits to record

her progress. However, there is a missed opportunity as the same workers can also ask and identify the mothers of the newborns being visited and address the referral need of mothers, if any.

Goals: ***Reduce MMR from present level 312 (SRS 2007-08) to less than 200***
Objectives:

1. To increase full Antenatal check up from 4.6 %(DLHS-III) to 50 % by 2011-12
2. To increase the consumption of 100 IFA tablets from present level of 46.5% to 80% by 2011-12 (DLHS-3)
3. To reduce anaemia among pregnant mothers from 60.2% to 52% by 2010-11 and to 40% by 2011-12.
4. To increase institutional delivery from 48% to 76% by 2011-12 and to 85% by 2012-13 (MIS data)
5. To increase birth assisted by trained health personnel from 31.9% to 45%. (DLHS-3).
6. To increase the coverage of Post Natal Care from 26% to 60% by 2011-12 and to 80% by 2012-13 (DLHS-3)
7. To reduce incidence of RTI/STI cases
8. To reduce the no. of unsafe abortions

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

Objective No. 1: To increase full Antenatal check up from 4.6 %(DLHS-III) to 50 % by 2011-12

Strategies and Activities:

1.1. Institutionalization of Village Health and Nutrition Days (VHND)
1.1.1 Collaborate with ICDS, such that the Take Home Ration (THR) distribution and ANC happens on the same day
1.2 Improved Access of ANC Care
1.2.1 Provision of Additional ANMs in each Sub Centre (Refresher Training to ANMs on Full ANC to improve the quality of ANC)
1.2.2 Setting up of New Sub Centres to cover more areas
1.2.4 Organizing Monthly Village Health and Nutrition Days in each Aaganwadi Centres
1.2.5 Organizing RCH camp in each Block PHC areas.
1.2.6 Tracking of Pregnant mothers by *ASHA*s
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.
1.3.3 Refresher training of ANMs on ANC care
1.3.4 Proper maintenance of ANC Register and Eligible Couple Register
1.4 Strengthening of Health Sub Centres
1.4.1 Repair and Renovation of Sub Centres
1.4.2 Provide equipments like BP Apparatus, Weighing machines, Heamoglobinometer etc to the Sub Centers.
1.4.3 Timely supply of Drug Kit A and Kit B
1.5 Generate awareness for ANC Service
1.5.1 Convergence meetings with AWWs, *ASHA*s, PRI Members, NGOs at the Gram Panchayat level by ANMs. These meetings will be supervised through MOs.

1.5.2 Tracking of Pregnant mothers by *ASHA*, ANM and AWWs through organizing Mahila Mandal meeting. Incentive to *ASHA*s and ANMs to given for the initiative. This initiative is under MUSKAAN Programme. Incentive for AWW will be taken care under Intersectoral Convergence.
1.5.3 Counseling by *ASHA*s and ANMs to the pregnant mothers, mothers and mother-in-laws.
1.5.4 Fixed day ANC clinic at different health facilities.

Objective No. 2: To increase the consumption of 100 IFA tablets from present level of 46.5% to 80% by 2011-12 (DLHS-3)

Strategies and Activities:
2.1 Purchase and Supply of IFA Tablets (now RCH Kits are available, yet additional provision to be made
2.1.1 To 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 AWCs 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

Objective No.3: To reduce anaemia among pregnant mothers from 60.2% to 52% by 2010-11 and to 40% by 2011-12.

Strategies and Activities:
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.

Objective No. 4: To increase institutional delivery from 48% to 76% by 2011-12 and to 85% by 2012-13 (MIS data)

Strategies and Activities:
To increase facilities for Emergency Obstetric Care (EmOC) - The strategies will lead to upgradation 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 -
- ☞ All district hospitals must have either its own Blood Bank, operational round the clock, or must have access to one that can be accessed in less than 30 minutes
- ☞ All CHC / PHCs to have blood storage facility

4.1.3 Training of MOs on Obs & Gynae and Anesthesia
- ☞ 18-weeks Life Saving Anesthetic Skills (LSAS) training for MBBS Doctors
- ☞ 16 weeks Emergency Obstetric Skill training for MBBS doctors
- ☞ 3 days training of doctors and nurses posted at FRUs for the neonatal stabilization unit

4.1.4 Repair and renovations of FRUs
4.1.5 Appointment of Anesthetist, O&G specialist, Staff Nurses at the FRUs
4.1.6 Incentivise the conduct of C section at FRUs @ Rs 1500 per C section for the staff involved at the FRUs.
4.1.7 Accreditation of FRUs
4.2 Operationalization of 24x7 facilities at the PHC level
4.2.1 Training of MOs and Staff Nurses of PHCs in BEmOC
4.2.2 Appointment of atleast 3 Staff Nurse in each PHCs
4.2.3 Repair and renovation of PHCs
4.2.4 Availability of and timely supply of medical supplies and DDK & SBA kits

4.2.5 Training of MOs, Staff Nurses on SBA
4.3 Increase beneficiary choice for institutional delivery through IEC campaign complimented by network of link workers working on incentive basis for each institutional delivery achieved
4.3.2 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.
4.4 Provision of Referral Support system
4.4.1 Provision of a dedicated referral transport system for the newborn and pregnant woman 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.

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

Strategies and Activities:

5.1 Ensure safe delivery at Home
5.1.1 Provision of Disposable Delivery Kits with ANMs and LHVs - Establishing full proof Supply Chain of the DD Kits
5.1.2 Training of ANMs on SBA
- ☞ Providing SBA with approved drug kits, in order to deal with emergencies, like post-partum hemorrhage, eclempsia, and puerperal sepsis
- ☞ 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 designated as MCH Centres

Objective No.6: To increase the coverage of Post Natal Care from 26% to 60% by 2011-12 and to 80% by 2012-13 (DLHS-3)

Strategies and Activities -
6.1 Ensuring proper practice of PNC services and follow-ups at the health facility level.
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.
6.2.2 Counseling of all pregnant women on ANC and PNC during VHND.
6.2.3 *ASHA* incentives for completion of PNC follow-ups through IMNCI.
6.3 Basic 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
Early diagnosis of pregnancy using *Nischay* pregnancy testing kits
Counselling and proper referral for termination of pregnancy in 1st trimester if the woman wishes so
8.2.1 Training of MOs and Nurses/LHV in MTP (MVA)
8.3 Making available MTP Services in all Health Institutions in a staggered manner.

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

8.3.1 MTP Services in the state is not fully operational in all the districts of the state. 105 MOs have been trained till date in 2010-11 and the target is 220. This is presently in 13 districts. To further strengthen the skill of doctors in MTP training, 212 more MOs will be trained and the training will cover 20 districts in all. This is being done through IPAS. Nursing cadre is also being oriented.

8.3.2 Plastic MVAs are to be utilized and state will purchase the same to ensure availability in health institutions. Rate contracting is being done through State Health Society.

Some Initiatives Detailed

A). Operationalising Blood Banks/Blood Storage Units in 76 FRUs

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

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

Budget Proposed –

PIP for Blood Bank/Blood Storage Unit in FRUs (2011-12)

S. No.	Budget Code	Activities	Total Amount (in Lakhs)
1	A 9.1.4.1	Salary for one Medical Officers in 34 Blood Bank (28 Running Blood Banks+6 New Blood Bank (Arwal, Araria, Banka, Supaul, E. Champaran & Sheohar) - 35000/-pmx34x12 months	142.80

2	A 9.1.2	Salary for three Laboratory Technician in 34 Blood Bank (28 Running Blood Banks+6 New Blood Bank (Arwal, Araria, Banka, Supaul, E. Champaran & Sheohar) - 3x10000/-pmx34x12 months	122.40
3	A 1.1.1.1	Fuel+Lubricant and incidental charge of generator+Miscellaneous expenditure - 24000/-pmx34x12 months	97.92
4	A 1.1.1.1	Fuel+Lubricant and incidental charge of generator+Miscellaneous expenditure - 21500/-pmx42x12 months	108.36
5	A 13.1.1	A.C. 1.5 Ton Window for 28 Running Blood Bank - 25000/- per pc	7.00
6	A 13.1.1	**Equipments for 6 New Blood Banks** Autoclave - 125000/- Bench top Centrifuge - 15000/- A.C. 1.5 Ton window - 25000/- per pc (two for every Blood Bank) Biomixer - 125000/- per pc (two for every Blood Bank) Donor Couch - 200000/- per pc (two for every Blood B	83.40
7	A 1.1.1.1	**Blood Donation Camp** 1 camp- 8000/- 12 Camp in a year by one District For 38 District- 8000/-x12x38	36.48
8	A 1.1.1.1	**Contingency Fund-** 6000/-pm per BSU For 34 Blood Banks- 6000/-pmx34x12	24.48
9	A 1.1.1.1	**State Monitoring Cell for Blood Banks/BSUs** One Pathologist-35000/-pm One Computer Operator-8000/-pm Telephone Exp.- 2000/-pm Stationary Exp.- 1000/-pm Mobility Exp.-19000/-pm Total - 65000/- pm For one year - 65000/-pmx12	7.80
		Total	**630.64**

B). Fixed Day ANC Clinic

Bihar's strategy for maternal mortality reduction focuses on complete Antenatal Care of every pregnant woman. Antenatal care is the systemic supervision of women during pregnancy to monitor the progress of foetal growth and to ascertain the well-being of the mother and the foetus. A proper antenatal check-up provides necessary care to the mother and helps identify any complications of pregnancy such as anaemia, pre-eclampsia and hypertension etc. in the mother and slow/inadequate growth of the foetus. Antenatal care allows for the timely management of complications through referral to an appropriate facility for further treatment.

Seeing the importance of Antenatal Care, Govt of Bihar has decided to have a fixed day ANC clinic in every health facility on given day.

S.N	Facility	Day
1	At Anganwadi centre	On every VHND
2.	At HSC	Every Monday
3.	At PHC, RH, SDH, DH	Every Thursday.

Availability of Equipments for Ante natal check up-

Before beginning each antenatal check-up at HSC, APHC or during the VHND, ensure that all the required instruments and equipments are available and are in working condition. These include stethoscope, blood pressure apparatus, weighing scale, inch tape, foetoscope, thermometer, watch, gloves, 0.5% chlorine solution, syringes and needles, hub cutter, spirit swabs, IFA tablets, TT injections, Haemoglobinometer and uristick.

Total budget required for Equipments-

Sl. No.	Item Description	Remarks	Quantity Required (in Numbers)	Unit Price (in Rs.)	Total Amount (in Rs.)	Requirement (per HSC-2,Total =19392	Total
	A	B	C	D	E	F	E * F
1	Stethoscope	Neonate	1	800	800	19392	15513600
2	BP Apparetus	Neonate	1	2000	2000	19392	38784000
3	Weighing Scale	5 kg.	1	350	350	19392	6787200
4	Weighing Scale	120 kg. adult	1	950	950	19392	18422400
5	Weighing Scale	20 kg. infant	1	4500	4500	19392	87264000
6	Fetoscope		1	85	85	19392	1648320
7	Thermometer	Digital	1	95	95	19392	1842240
8	Haemoglobinometer		1	650	650	19392	12604800
9	Urostic (1Urostic/pregnant women)		1pkt	350	350	9143	3200050
10	Glucometer		1	1250	1250	19392	24240000
Grand Total					**11030**		**210306610**

C). Safe Abortion Services

Abortion scenario:
Complications due to unsafe abortion are a major public health issue facing women in developing countries. In India, abortion is legal and women can access and avail safe abortion services by trained medical personnel in registered facilities. In practice, limited access to authorized abortion providers, the stigma associated with induced abortion and low level of awareness regarding the legality of the procedure bar women from receiving safe abortion services. As a result, women often go to untrained practitioners under unsafe conditions. The consequences of abortions performed under such circumstances leads to life threatening to chronic reproductive tract morbidity such as infections, chronic disability and infertility.

Official figures report that about 0.6 million induced abortion take place annually in India of which only approximately 10% of abortions conducted by qualified providers in approved institution *(Source : Regional Health Forum, Vol.8, No.2,2004)*.

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

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

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

In order to provide safe abortion services in Bihar, the doctors are being trained as per the MTP Act, 1971, with the support and facilitation of IPAS. The program includes training on new technology like Manual Vacuum Aspirations (MVA) and Medical Abortion. Till date (Oct 2002 to November 2010) Ipas facilitated training of 735 Medical Officers on Comprehensive Abortion Care (CAC) in the state (of which 147 were trained during April'10 to Nov 2010). These medical officers are placed as such- 235 in PHCs, 55 in Dist. Hospitals, 43 in Referral Hospitals, 35 in APHCs and 10 in Medical College & Hospitals.

Strategy

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

- ☞ To increase the number of approved MTP sites and service providers in private sector
- ☞ To improve the reporting system of MTP under NRHM through formation of MTP Cell at the state and district levels
- ☞ To sensitize and make the community as well as the service providers aware about the provisions of MTP act and services of safe abortion

Activities

a) To provide and improve safe abortion services at all the health facilities starting from District hospitals to PHC
b) Provide training to the doctors and other associated staff on safe abortion techniques like MVA and MA
c) Ensure logistics and supply of MVA kits and other related equipments and drugs
d) Monitor the number of MTPs being conducted by each district
e) To increase the number of approved MTP sites and service providers in private sector
f) Ensure smooth and timely implementation of Yukti Yojana (the flagship program of Govt. of Bihar for increasing access to safe abortion services) by:

- ☞ Formation/ reactivation of District Level Committee (DLC) as per the MTP act in all the districts
- ☞ Encourage private sites/ doctors to get their facilities accredited with the Yukti Yojana
- ☞ Monitor the dist. health officials and ensure their full support for coordinated effort of the public and the private sector
- ☞ Timely reporting by each dist. to the State Health Society about the implementation of the scheme.
- ☞ To improve the reporting system of MTP under NRHM through formation of MTP Cell at the state and district levels

The reporting regarding MTP (Both private & public) needs to be improved. One State Level MTP Cell will help this. The cell will comprise of three members, one will be technical person, and others will be State Training consultant and the State Data Manager. This cell will mentor district's activities. This cell will conduct review meeting on quarterly basis. This Cell will designate one district level officer as Nodal Officer for MTP at District level.

Post training monitoring system is to be strengthened. All the doctors undergoing MTP training will be followed up for 6 months post training to ensure the initiation of MTP services by the trained doctors. The MTP Cell at the respective district will do this follow up and report back to the state MTP cell on monthly basis.

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

- ☞ Organize region wise orientation program for Civil surgeon, ACMO, RCH officer, Programme Managers and service providers to make them aware about the provisions of MTP Act (particularly in places where DLC has not been formed yet).
- ☞ Sensitize Community on safe and early abortion, practices and the availability of services through banner, posters and mass media
- ☞ Orient ANMs, *ASHA* and also Community Based Organizations and NGOs about the safe abortion services

- ☞ Ensure a big wall painting (12 ft x 6 ft) at the public health facilities where doctors have been trained announcing the availability of the safe abortion facility.

Action Plan
As performing MTP needs purely technical skill, to enhance the technical skill among the doctors especially those who are posted in the health facilities including those doctors posted at the PHCs would be trained on Comprehensive Abortion Care. This year the focus will be the districts like Khagaria, Saran, Siwan, East & West Champaran, Begusarai, Purnia and Buxar. Apart from the existing 13 training sites creation of 6-7 new training sites will done this year. The exact location of the training sites will be finalized by the State and district officials in consultation with IPAS.

The State Health Society, Bihar will ensure that each and every District Hospital, Sub divisional hospital, RH and PHC have the steady supply of Manual Vacuum Expiration (MVA) Kits, Xylocaine, other medicines and basic equipments.

D). Accreditation scheme for private nursing home to provide safe abortion services 'Yukti Yojana'

Although abortion has been legal in India since 1971, safe and legal abortion services are still not readily available, especially to poor, rural women, and morbidity and mortality from unsafe abortion are still serious problems for women in Bihar. The maternal mortality ratio (MMR) of 312 in Bihar far exceeds the national ratio of 254. Approximately 5.8 lakh induced abortions occur in Bihar annually with a majority of them happening outside of government-recognized health centers, often in unhygienic conditions or by untrained abortion providers. Reducing the number of unsafe abortions will have a direct bearing on reducing the MMR of the state. Addressing the following two critical barriers can contribute to decreasing unsafe abortions:

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

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

- Inadequate number of (legal/safe/qualified) providers in rural areas
- Over-pricing of services
- Non-compliance with the law,
- Inadequate and/or inappropriate treatments,
- Excessive use of outdated technologies and/or medication

To augment service provision by the public sector and increase availability of quality comprehensive abortion care (CAC) services, Government of Bihar (GoB) intends to accredit eligible and interested private sector sites to provide free first trimester CAC services; treat abortion complications, spontaneous and missed abortion; and stabilize and refer abortion complications and second trimester abortions and be reimbursed by the government at a fair price. The accreditation system is the mechanism for GoB to buy

services from the private sector in a transparent way to ensure wider availability of CAC and family welfare services beyond the public sector.

MTP certified private and not-for-profit NGO healthcare facilities will be eligible to enlist as accredited CAC service sites and will include the 110 accredited family planning sites with MTP site certification. These sites will offer free of cost first trimester CAC services and treat post abortion complications, incomplete and missed abortion cases and stabilize and refer cases of abortion complications and second trimester induced abortions (as needed) to district hospitals or other appropriate private sites (in cases where the site is not certified to offer second trimester abortion services).

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

Accreditation Scheme for CAC services: *Yukti Yojana*

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

The accreditation scheme is known as the *Yukti Yojana* and includes provision of the following services:

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

For women seeking the above services, the participating private sites will also ensure counseling on and provision of post abortion contraception services.

The *Yukti Yojana* is a private site accreditation scheme of Government of Bihar (GoB) with the specific objective of increasing access to safe abortion services and treatment of abortion complications. Private sites accredited under this scheme are also eligible to participate in other GoB schemes involving private sector provision of reproductive health services.

E). Raksha Project - Continuum of care Model: Clinical & Community Action to Address PPH

Raksha Project addresses Postpartum Hemorrhage (PPH) – the leading cause of maternal mortality in Bihar. Raksha project aims to improve maternal health by supporting and strengthening health systems and promoting skilled attendance during birth at all levels.

Raksha Project - Background

Raksha project is training approximately 2000 service providers & 3500 front line workers (FLW) in 1400 villages and providing 2000 Non Pneumatic Anti Shock Garments (NASG)[1] as the immediate first-aid treatment for reversing hypovolumic shock in pregnant women suffering from PPH during transportation. The training is being conducted in the four intervention states to ensure sustainability of the project beyond the project duration.

Project has identified champions at every facility to coordinate Project activities, to manage all logistic support and NASG, and to report all cases of PPH morbidity and mortality.

State	Number of live births (Jan to Oct 2010)	Number of PPH Cases reported
Bihar	37,311	211

Intensive monitoring and supportive supervision system have improved the quality of data recording & reporting system. Treatment with Uterotonics and IVF transfused has increased in comparison to earlier showing that that there has been improvement in “Quality of Care”.

Pursuing New Approaches to Enduring Problems:

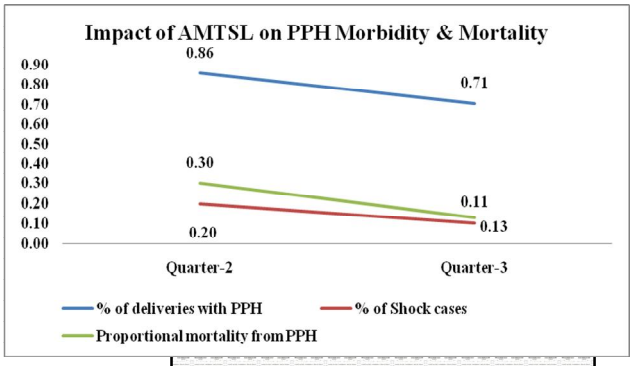
- ☞ Task Sharing- Due to shortage of Medical Officers (MO) at periphery, ANMs have become essential actors in obstetric care in peripheral areas. ANMs appear to be capable for performing AMTSL, diagnosing PPH, and providing other related services. This is a successful example of task sharing with potential for scale up to prevent PPH in a large percent of population. Pathfinder has conducted numerous orientation sessions for ANMs to build their capacity as a critical part of the clinical teams providing maternal care. Trainings included orientation of ANMs and Staff Nurses on AMSTL and diagnosis & management of PPH/shock.
- ☞ Joint Supportive supervision system (JSSS): A problem solving team comprising of District Level health officer, Clinical Consultant, Medical Officers and Pathfinder staff conduct regular, monthly monitoring visits to health facilities. This helps facilities to strengthen PPH surveillance and improve staff motivation. It provides the trainee direct feedback not only on her/his performance, but also provides the opportunity to discuss

[1] *The NASG is technical innovation that was introduced by Pathfinder in India. The NASG is a neoprene fabric that is tightly wrapped from ankles to abdomen of a woman who suffers from obstetric shock from PPH. This process shunts the blood to the upper body, preserving vital organs and stabilizing the woman for up to 50 hours so that she can be safely transported to a referral hospital for emergency obstetric care.

any startup problems or constraints to service delivery (e.g., lack of instruments, supplies or support staff).

☞ Community Mobilization activities to improve Maternal health : The objectives of the project are to increase awareness among community members on recognition of danger signs of PPH, to augment their capacity to seek medical care for PPH and to increase their ability to reach health facilities in case of emergencies. Target groups include Front Line Workers (FLWs) like ANMs, *ASHA*s, AWW, Dais; PRI (Panchayati Raj Institute) representatives, VHSC (Village health & sanitation committee) members; SHG members; local transporters; local influentials; eligible women & decision makers at household level.

☞ MIES activities: Data Collection, Quality Improvement and Ongoing Supervision & monitoring - M&E information is being collected from various target audiences to whom interventions are directed. The sources of data include household surveys, skilled and unskilled provider surveys, facility logbooks and monthly delivery statistics, supervision checklists, and specially designed forms to track each use of the NASG.



Trends of Maternal Mortality due to PPH:

In Pathfinder intervention areas PPH case fatality rate is showing a decreasing trend over the last 3 quarters (it has decreased from 7.9 % in 1st quarter to 4% in 3rd quarter). It clearly shows that the new technologies such as AMTSL, estimation of blood loss and NASG which has been used in program activities are having a positive impact in reducing the maternal mortality and morbidity due to PPH.

Raksha Interventions in Bihar (Patna & Vaishalli Districts)

The project was launched in Bihar in February 2010 and is currently being implemented in six blocks; three blocks each in Vaishalli and Patna district. The blocks are Paliganj, Dhanarua, Masaurhi, Hajipur, Mahua, & Biddupur. The project has a total of twelve intervention facilities in Patna and Vaishalli districts. The level of these facilities is given below:

Tertiary Level Facility	PMCH, & NMCH - 2
Secondary Level Facility	Paliganj –PHC, Mahua – PHC, Hajipur District Hospital, Biddupur-PHC, Dhanarua – PHC, Masaurhi – PHC & Guru Govind Singh Hospital - 7
Private Facilities	Kurji Holy Family Hospital, Tripolia Hospital & Mahavir Vatsalya - 3

One of the major components of the project is to conduct training of health care providers as well as support staff at various levels (Primary Health Centers, Additional Primary Health Centers, District Hospitals & Medical Colleges) on the use of an appropriate uterotonic,

Kelly's Pad and Non- Pneumatic Anti-Shock Garment (NASG). The training is conducted by project's Master Trainers at Medical Colleges like PMCH/NMCH. These Master Trainers have already been trained under the Training of Trainers (TOT) program. Orientation for the Doctors and staff nurse on PPH is also conducted in order to reach to a larger audience to address the issue reducing maternal mortality.

Achievements of Raksha Project:

- Letter of approval from the Bihar State Health Society for working in Patna and Vaishalli district of Bihar.
- Launch of the project done by the Honorable Health Minister of Bihar. This was attended by the Executive Director of Bihar State Health Society, senior health officials from the government and representatives of the major international NGOs working in Bihar.
- Training target of 225 providers achieved within nine months of implementation of the project. Apart from this, 476 providers were provided orientation for a day. Also, there was full attendance during the training/orientation.
- NASG has been provided to all the twelve intervention facilities. In total, eighteen NASG has been given to the intervention facilities. The two tertiary facilities (PMCH and NMCH) have been given four each while other intervention facilities have been given one each.
- Display of job-aids at all the targeted intervention facilities.
- Application of AMTSL is being done at most of the intervention facilities: -
- Use of Oxytocin within one minute of delivery at all the intervention facilities.
- Practice of uterine massage being carried out at ten intervention facilities.
- CCT being carried out at ten intervention facilities.
- Indent of Oxytocin has been done by the Civil Surgeon of Patna and is now available in the government supply at three government intervention facilities of Patna District.
- 211 cases of PPH have been recorded from January to October 2010. Seven out of twelve targeted facilities have started reporting cases of PPH. This is significant considering that none of them (except one tertiary facility) were recording PPH cases before the start of the project.
- NASG has been used 12 times, out of which life of eight patients were saved.
- 135 monitoring visits to the intervention facilities have been made for streamlining the application of project's protocols.
- Sensitization workshop has been conducted for the PG students of one of the intervention facility.
- Community Interventions has begun with the identification and finalization of NGO and selection of their staff. Letter of Notifying Award to NGO has been signed and financial training of NGO staff and their accountant has been completed.
- State level TOT for Community Intervention has been completed successfully. There were 21 participants in all – 11 Medical Officers, 5 Block Health Managers, 4 NGOs staff, 1 health Inspector.

Goal:

The Project's goal is to reduce mortality and morbidity related to PPH through the implementation of a Continuum of Care approach that extends from the community, where women are most likely to give birth at home or at facilities that are at the lowest levels of the health system, to higher level facilities where women can receive care for complications.

The Continuum of Care model incorporates an appropriate uterotonic for prevention and/or management of PPH, an appropriate tool for estimating blood loss, NASG, and community level transportation and communication networks. The project will also engage in sustained advocacy at the community, state and national levels to lay the groundwork for use of these intervention technologies on a wide scale.

Objectives of project :

- Improve the capacity of health care providers to provide high-quality, appropriate care to women with PPH
- Increase awareness and improve the capacity of community members and community level providers to make the decision to seek medical care for PPH
- Increase the ability of community members and community level providers to identify and reach SBA or facilities for obstetric emergencies and complications including PPH treatment

Strategy: Continuum of care model

- Advocacy
- Integrating technological innovation with public health system (NASG & Kelly's pad)
- Shaping demand & practices from community

After the initial success of Raksha project by Pathfinder in preventing maternal mortality, the State is planning to scale up the project.

The NASG has been proven to aid in reducing PPH related maternal morbidity and mortality in the state. Pathfinder will provide additional NASGs to support the scale-up process for NASG in the public health system as it will be instrumental in reducing maternal mortality due to PPH, in 8 high priority districts of the state- namely Patna, Vaishali, Nalanda, Gaya, Muzaffarpur, Samastipur, Katihar and Madhubani. The state wide use of NASG will ensure safe delivery and has the potential to demonstrate the impact of scale-up of this technology in saving mother's lives.

Role of SHSB in scale up-

- MoU between SHSB & Pathfinder
- NASG launch and handover function
- Letter for Customs Duty Exemption for the NASGs
- Inclusion of the Raksha project strategies in the State PIP
- Formation of the state–level core advocacy group (with Pathfinder representatives) to provide oversight to the NASG scale-up operational plan
- Training of service provider in identified facilities and logistical support
- IEC & sensitization/ training of FLW in 8 districts
- Inclusion of 108 ambulances network in the scale-up model (8 districts)
- HMIS mechanisms – centralized mechanism for monitoring NASG usage
- Support for the monitoring & documentation

Role of Pathfinder (PI) in scale up in Bihar-

- Donation of NASG for the 8 high priority districts
- Level 3 FRU with BSU & ambulances in these districts

- ☞ Training support – conducting MTOT & creating pool of trainers
- ☞ Conduct a MTOT at SIHFW Patna and three TOT at divisional level
- ☞ Technical assistance - PI representation on the NASG roll-out advisory group
- ☞ Support Documentation

Clinical Training of health care providers

The importance of training all other paramedical hospital staff because of rotation/shifting of staff to other departments/facilities is to be ensured. In addition to upgrading the skills of providers in the treatment and management of PPH, special focus will be given to improving the overall quality of care, promoting the rights and dignity of patients, and developing more accountability and teamwork across providers in the facilities.

Types of training conducted in 2010	Five day training	Orientation & Sensitization to hospital staff	Training for PG students/ resident doctor
Bihar	224	357	40

Estimated Budget for Raksha Project-

	-Total Identified Institutions 30 in 8 districts				
	-To be trained medical college- 20 each i.e total 100				
	-To be trained from other Institutions- 10 each from 25 inst. i.e total 250				
	-To be trained from 108 Ambulance Staff 50 staff				
	-Total Manpower to be Trained: 100+250+50=400				
	-Total Batches (20 px per Batch)= 20 Batches				
	-Participants - Gynecologist, MBBS Doctors ,GNM/ANM staff conducting deliveries & 108 Ambulance Staff				
	-Resource Person per Batch				
Budget of Clinical Training at District Level for 3 days- Residential					
Sl.no	Description	Px / Batches	Per	Days/time	Total Amount
1	Training Stationaries	400	50	1	20000.00
2	TA to px(as per Actual) once only	400	500	1	200000.00
3	D.A to the px inclusive of accommodation	400	500	3	600000.00
4	Working Lunch, Tea & Snacks inclusive of Resource Person	406	100	3	121800.00
5	Honorarium to Resource Person @ Rs.600 for full day teaching, Maximum 2 trainers per day i.e 6 trainers for 3 days	20	600	6	72000.00
6	Honorarium to State/ National level Guest Faculty (one per batch)	20	1000	1	20000.00
7	Contingency @ 100/- per px per day	400	100	3	120000.00
8	Honorarium to assisting staff per day Maximum 2 staff posted in Labour Room	20	200	2	8000.00
9	Providers Training Module	200	300	1	60000.00
	Total Clinical Training Budget of Residentials				1221800.00
	One day Sensitization to FLW's(*Asha* Sahyogini/ANM/Dai)				
	25 facilities except medical colleges, & Total no. of Villages attached per FRU- Approximate no-20				
	In 20 villages number of FLW is - *ASHA* 20 + AWW 20 + Dai 20 + ANM 10				
	Total FLW Participants for training= 70 FLW X 25 facilities =1750				

Budget for One day Sensitization of FLW's					
Sl.no	Description	Px / Batches	Per	Days/time	Total Amount
1	Flip Book	1750	150	1	262500.00
2	Training Mannual to each facilities except medical colleges	25	300	1	7500.00
3	Partcipation Amount	1750	100	1	175000.00
4	Tea & Snacks	1750	10	1	17500.00
5	Honorarium to Resource Person @ Rs.300 for full day teaching,	60	300	1	18000.00
	Total Community Training Budget of non residentials				480500.00
Budget for IEC/BCC (To be sourced from IEC under Part B)					
Sl.no	Description	Px /Batches	Per	Days/time	Total Amount
1	Electronic/Print per District	10	5000	1	50000.00
2	Job Aids per facility	30	100	4	3000.00
3	Birth Preparedness Calender(BPCR) per pregnant mother	15000	20	1	300000.00
	Total IEC budget				353000.00
	Total Budget for inclusion of Raksha in PIP				2055300.00

F). Special focus for management of severe anemia among pregnant women (Parental Iron sucrose (IV/IM) as therapeutic measure)

In Bihar as anemia levels are high >60% women (as per NFHS 3) are seen in the hospitals with complications of anemia with hemoglobin levels around 3-4 gms. For improving hemoglobin levels of these women within short course of time either blood transfusion or intravenous iron therapy are the probable solutions. As in the State not many institutions are well equipped for providing facility of blood transfusion intravenous iron sucrose is the next best alternative. Though studies proved that parental iron and oral iron have the same benefits, the various factors like poor compliance, poor absorption etc resulted in poor outcomes among severely anemic women even if they were given 200 IFA tablets as proposed under routine ANC care. To correct severe anemia with Hb% less than 8 gms within short period during pregnancy it is proposed to give parental iron for quick corrections in Hb% levels and better pregnancy related outcomes.

On this background state is proposing to administer Iron sucrose as IV/ IM drug for the management of severe anemia among pregnant women. The advantage with this drug is the near absence of side effects of oral iron therapy and the allergic reactions noted with other parentral iron preparations. The second important advantage is the rapidity in the correction of anemia which occurs within 5 weeks (Bangladesh study) and hence can be administered even in advanced stages of pregnancy (eight months gestational stage - 30-32 weeks).

State is proposing to develop uniform guidelines for statewide implementation in all the institutions of state so that the benefit of iron therapy reaches the targeted population. All the pregnant women who attend antenatal clinics in all CHCs/BPHCs, FRUs and district hospitals with Hb% levels less than 8 gms may be administered with Intravenous Iron Sucrose as per the protocol. The ANMs are responsible to screen pregnant women with severe anemia during antenatal checkups and refer them to CHCs, FRUs for the treatment

with Intravenous iron Sucrose. It is also proposed to make compulsory Hemoglobin estimation at 14th, 20th and 32nd weeks of pregnancy of pregnant women referred by ANM to PHC as severe anemia case.

As this is a special focus initiative to be implemented in state for the first time it is proposed to form a technical group with the senior specialists in Obstetrics, officer in charge of maternal health in State Health Society and state programme officer to prepare the state specific guidelines including method of administration of Iron Sucrose injection.

S. No.	Activities	Total Amount (in Lakhs)	Remarks
1	Parental Iron sucrose (IV/IM) as therapeutic measure to pregnant women with severe anaemia	190.00	@ 5 lac/district for 38 districts
Total		190.00	

G). Village Health Sanitation and Nutrition Days (VHSNDs)

The State Government is presently organizing monthly Village Health Sanitation and Nutrition day in every village (Anganwadi centers) with the help of AWW/ANM/ASHAs in Sadar block and Parbatta blocks of Khagaria district on pilot basis. Based on the learning of implementing the pilot project in Khagaria district, the state government has decided to implement the VHSND in the entire state.

Village Health Sanitation and Nutrition Day (VHND) aims at increasing awareness about availability of government health services in the community encourage healthy behaviours and practices and act as a platform where all health services are provided to the communities. The objectives of the VHND are:

- To create a conducive environment for health seeking behaviour
- To ensure all the community level essential health services at one place in village with special focus on:
    - Registration
    - Immunization
    - Ante-natal checkups
    - Counseling
    - Nutrition
- Strengthen convergence between frontline health care providers before, during and after VHND
- Ensure coverage of left out and drop out beneficiaries

Services to be provided:

Following are some of the services which would be provided at VHSND sites:

- All pregnant women are to be registered.

- Registered pregnant women are to be given ANC.
- Dropout pregnant women eligible for ANC are to be tracked and services are to be provided to them.
- All eligible children below one year are to be given vaccines against six Vaccine-preventable diseases.
- All dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated.
- Vitamin A solution is to be administered, to children.
- All children are to be weighed, with the weight being plotted on a card and managed appropriately in order to combat malnutrition.
- Anti-TB drugs are to be given to patients of TB.
- All eligible couples are to be given condoms and OCPs as per their choice and referrals are to be made for other contraceptive services.
- Supplementary nutrition is to be provided to underweight children.

For the current financial year (2011-2012), focus would be given on providing:

- Registration of pregnant women, children and other beneficiaries
- Immunization
- Ante-natal checkup
- Counseling
- Nutrition

On the appointed day (Wednesday and Friday), ASHAs, AWWs, and others will mobilize the villagers, especially women and children, to assemble at the nearest AWC, where the centre has been fixed during the micro planning exercise. The ANM and other health personnel would be present on time. On the VHND, the villagers can interact freely with the health personnel and obtain basic services and information. They can also learn about the preventive and promotive aspects of health care, which will encourage them to seek health care at proper facilities. Since the VHND will be held at a site very close to their habitation, the villagers will not have to spend money or time on travel. Health services will be provided at their doorstep. The VHSC comprising the ASHA, the AWW, the ANM, and the PRI representatives, if fully involved in organizing the event, can bring about dramatic changes in the way that people perceive health and health care practices.

The micro-planning for conduction of VHND will be prepared jointly by the ICDS officials, health officials, PRIs and other. The VHND will be organized once every month (preferably on Wednesdays & Friday), and for those villages that have been left out, on any other day of the same month) at the AWC in the village. This will ensure uniformity in organizing the VHSND. The AWC will be identified as the hub for service provision, and also as a platform for intersectoral convergence. VHND is also to be seen as a platform for interfacing between the community and the health system.

The ANM and the AWW will guide the ASHA during the monthly health days. The organization of the monthly Health and Nutrition Days ought to be jointly monitored by the CDPO, LHVs, and the Block Supervisor of the ICDS periodically.

A detailed state specific implementation guideline for VHND would be prepared based on the NRHM guideline and the suggestions/feedback/recommendations of development partners during a state level consultative meeting. In the current financial year, following activities would be conducted at different levels:

State level convergence meeting, workshop/ Review meeting and monitoring by state team
District level meeting under chairmanship of DM with CS+DPM+DCM+DPRO+ DPO+PHED+BDO+ MOIC+CDPO+BHM+BCM+1 HE/PHC
Block level meeting for Microplanning and Capacity building of ANM+AWW+ASHA+VHSC-PRI
VHND days Supply/repairing of (BP instrument+ Stetho + Thermometer + Wt.Machine + Preg.test kit + Hemoglobinometer + Uristics) (To be sourced from procurement of supplies under MH)
Drug supply (Procurement of drug is primary responsibility of PHC/DHS through drug procurement fund) In emergency fund can be sourced from Drug Procurement head under Part B
Logistics support at VHSND site
IEC + reporting format support (To be sourced from IEC head)
Monitoring of VHSND by Block officials (BDO/CDPO/MOIC/BHM/BCM/HE/PHED Er.)

Special focus would be given in the five identified districts, where the pilot intervention of Community based planning and monitoring process is being carried out. The capacity building of VHSC members, AWWs, ASHAs, ANMs, PRIs, VHSC members would also be done in the selected blocks. Intensive IEC/BCC activities would be conducted in the selected area for generating demand and making the services client friendly.

Child Health

Introduction

With the concern about the child health indicators reflected in NFHS III of the state, several new evidence based strategies and interventions were planned and implemented in the state in the first four years of RCH-II. The strategic approach for Child Health is reduction of neonatal and infant mortality, life cycle approach, improving service reach and coverage, inclusion of nutrition care in overall health care, skill building, public private partnership, inter-sectoral convergence, commoditization of services and effective IEC, BCC.

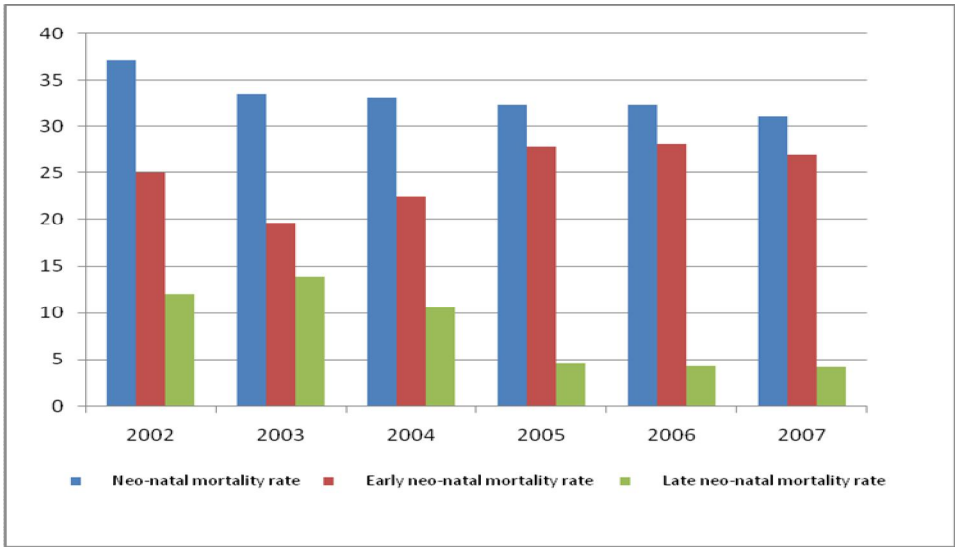
The concern of the state and with a political and administrative will about child health and survival reflected in various state initiatives like Year 2010 being declared “New Born Year in 2010”. “New Born Year” concept was to put in a system and interventions in place through inter-sectoral co-ordination towards holistic health aiming towards physical, mental, social and spiritual development of children with life cycle approach by covering services of pregnant women to Adolescent girls. Ensuring no child is left out including children in difficult terrain, girls and physically, mentally and/or socially challenged children. The aim was to introduce evidence based interventions to ensure effective outcome.

Background

Newborn period is the period of a child starting from birth to one month of life. This is the most vulnerable period of a child’s life, signifying the transition from a fully dependent existence in the mother’s womb to a more independent existence, in this world.

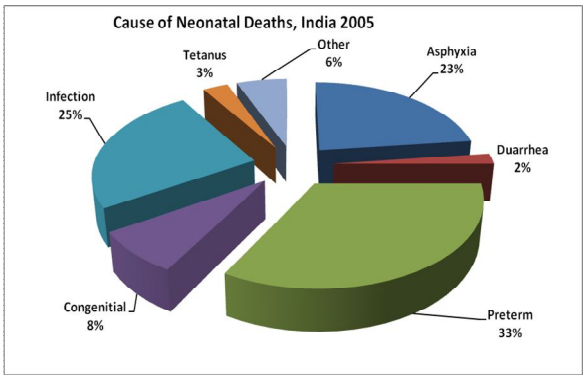
Out of about 29 lakh children born every year in Bihar, 1.68 children die before one year of life. Of these, about 2/3rd or about 90,000 children die within the first month of life. Neonatal mortality rate in Bihar is about 31/1000 live births, contributing to about 50% of all deaths in childhood.

Despite massive investments under RCH-II program and NRHM, and visible improvements in health system, the decline in IMR has been inadequate: much less that what would be required to reach the XIth plan goals of reaching IMR of 30/1000 live births by the year 2012. In India, while there has been some decline in post-neonatal period, the neonatal mortality has remained static for past seven years. The analysis of Neonatal Mortality Rate in Bihar from 2002-2007 shows a marginal decrease from 37/1000 live births to 31/1000 live births. This has largely resulted from a decrease in late neonatal deaths (7–28 days). However, there has been no change in the early neonatal deaths (0-7 days) over the same period. Hence, there is a need to focus on the first week of life or the early neonatal period.



Most deaths are caused by a few, preventable causes

Three major causes contribute to 80% of deaths in the newborn period: Birth Asphyxia (inability to breathe well at birth), infections in the newborn and pre-maturity (being born before time). In addition, hypothermia (getting cold) contributes significantly. Most of these causes can be prevented or managed by a set of interventions delivered at household, community and health facility levels



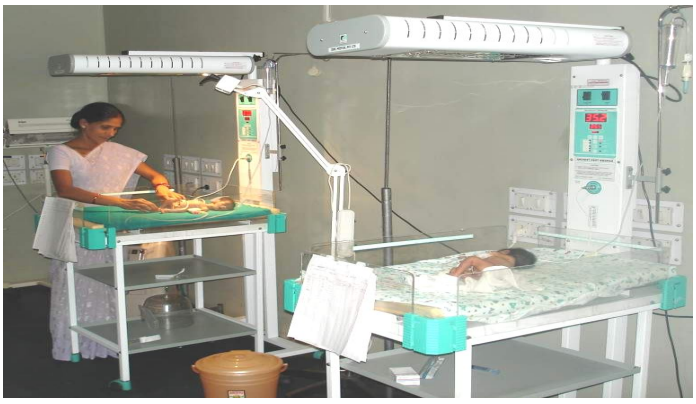
Inappropriate household practices increase the risk of newborn deaths. Besides the medical causes, certain practices at the household level increase the risk of deaths in the newborn period. Some of the key ones that are quiet prevalent in India are: a) Delayed initiation of breastfeeding- in many parts of India, breastfeeding is still delayed beyond the first hour, and in many cases beyond the first day. This increases the risk of dying by as much as 3 times. b) Delayed clothing and early bathing- babies are often not clothed adequately and bathed early: this increases the risk of baby getting cold (hypothermic) and subsequently dying. c) Not seeking care for newborns- in several parts of India, babies are often not taken out of their households for first six weeks. This even applies for sick newborns, delaying seeking of appropriate care. d) Applying material on cord-stump-in many places, families put different material ranging from oil to cow-dung to the cord stump. This increases the risk of infection and sepsis among newborns.

Major Strategies for Child health

Good news is that simple known interventions can significantly improve newborn survival. Some of the known interventions are:

- ☞ Early initiation of breastfeeding: Initiation of breastfeeding within one hour of birth has been shown to improve newborn survival significantly. At the moment, only 16% of newborns initiate breastfeeding within 1 hour of birth in Bihar.
- ☞ Ensuring Warmth: Keeping babies warm at the time of birth improves newborn survival substantially

- ☞ Newborn resuscitation: As mentioned earlier, about 1/4th of all deaths occur due to birth asphyxia. More than half of these deaths can be prevented if skilled providers resuscitate the newborns who have not cried at birth, using simple equipment.
- ☞ Appropriate care of sick newborns at health facilities: When a newborn falls sick, she often requires specialized care at health facilities.
- ☞ Program strategies to improve newborn survival:
  - Home visits to all newborns through IMNCI: in several settings in India, it has been shown that home visits by trained frontline workers can cut the newborns' deaths by half. In Bihar, under the Integrated Management of Newborn and Childhood Illnesses (IMNCI) strategy, Anganwadi workers are making home visits to all newborns three times in the first week of life. This strategy was piloted in Vaishali district by UNICEF and since then is being scaled up to 23 more districts.
  - Strengthening PHCs for newborn care: with the successful implementation of *Janani Evam Suraksha Yojana*, a large number of deliveries are happening in institutions. From less than 50,000 deliveries about 3 years ago, as of today, 11.00 lakh deliveries across the state happened in the health facilities. This has necessitated the need of strengthening PHCs or all delivery points for essential newborn care services. This includes ensuring that PHCs have the necessary equipment and health providers are equipped with requisite skills for providing essential newborn care. PHCs in Vaishali District are currently providing essential newborn care services to all newborns delivered in the facilities.
  - In addition, the Government of Bihar has also decided to scale up the existing *Mamta* programme which essentially involves provision of essential newborn care services to every newborn born at the facility by a lay worker called the *Mamta* worker. Every newborn is entrusted with one *Mamta* Worker, who is responsible for ensuring that the newborn is kept warm, is breastfed and receives the first dose of immunization. The worker receives a performance based incentive for the same.
  - Special Care Newborn Units (SCNUs): in several least developed districts of the State, Special Care Newborn Units are being set up that provide state of the art newborn care that was available only to the richest families in urban areas till now. The first such unit in Bihar was set up in Vaishali. In the last year this unit had successfully managed more than 900 seriously ill newborns. So far Government of Bihar has established 7 SCNU in different districts. 26 more SCNU is going to be established by end of this financial year.



Buoyed by the success of the roll out of the comprehensive newborn care initiative in Vaishali District the Government of Bihar has decided to upscale the model in 26 districts. UNICEF and NIPI have already committed to support the Government with technical inputs for the same. This initiative if scaled up across the state has the potential of saving 60,000 newborns from dying every single year. Declaring the year 2010 as Year of the Newborn has brought into the focus of Government machinery and decision makers at all levels on the issue of need to improving newborn health in Bihar. In addition, it has motivated and rallied all the stakeholders like media, development partners, civil society and professional bodies around the task of ensuring a healthy life for the newborns of Bihar…..

Goal: Reduce IMR from 52 (SRS 2009) to less than 45
Objectives:

1. To reduce low birth weight babies by supplementing nutritional support to pregnant mothers
2. To increase exclusive breast feeding from 38.4% to 50% by 2010-11 and to 75% by 2011-12.
3. To reduce incidence of underweight children (up to 3 years age) from 58.4% to 50% by 2010-11 and to 40% by 2011-12.
4. To strengthen neonatal care services in all PHCs/CHCs/SDHs by setting newborn care centers in all PHCs & having trained manpower therein.
5. To reduce the prevalence of anaemia among children from 87.6% to 77% by 2011-12 and to 60% by 2012-13.
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 MOICs with CDPO for implementation of the scheme.

1.1.3 Vitamin A supplementation

Objective No. 2: To increase exclusive breast feeding from 27.9% to 35% by 2011-12 and to 50% by 2012-13

Strategies and Activities:

2.1 Use mass media (particularly radio) to promote breastfeeding immediately after birth (colostrum feeding) and exclusive breastfeeding 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, 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.

Objective No. 3: To reduce incidence of underweight children (up to 3 years age) from 58.4% to 50% by 2011-12 and to 40% by 2012-13

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 *ASHA*s, AWWs. All *ASHA*s, Aaganwadi centers and sub centers will have a weighing machine and enough supply of growth recording charts for monitoring the weight of all children – provisioning of the same to be made through Untied fund for HSCs.

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

3.2 Referral for supplementary nutrition and medical care

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

3.2.2 Establishment of 38 Nutrition Rehabilitation Centres in Districts having severe problems of malnutrition (budgeted under NRHM B)

Objective No.4: To strengthen neonatal care services in all PHCs/CHCs/SDHs by setting newborn care centres & 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.

Objective No. 5: To reduce the prevalence of Aneamia among children from 87.6% to 77% by 2010-11 and to 60% by 2010-11.

Strategies and Activities

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

Objective No.6: To increase full immunization of Children from 57% to 80% by 2011-12.

Strategies and Activities

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

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

6.1.2 Update district micro plan for conducting routine immunization sessions

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

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

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

6.1.6 Replace all Cold Chain equipment, which is condemned, or more than five years old in a phased manner by the year 2011-12 and supply new Cold Chain equipment based on analysis of actual need of the health facilities

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

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

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

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

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

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

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

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

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

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

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

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

6.4 Strengthen Supervision and monitoring of immunization services

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

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

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

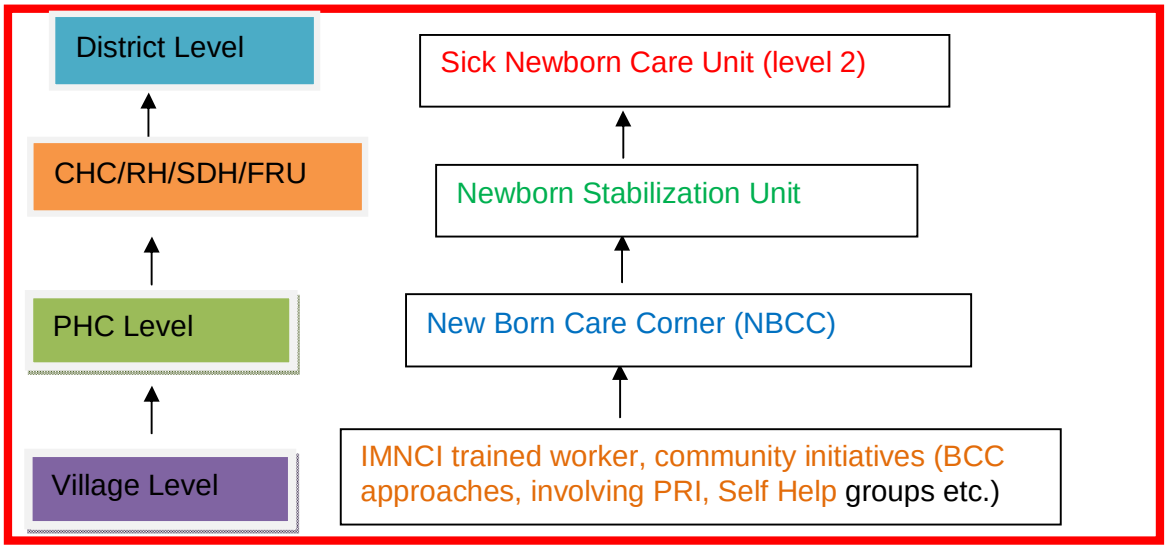
6.4.5 Coordinate with representatives of PRI to strengthen supervision and monitoring of immunization services.
6.4.6 Details of Immunization have been incorporated in part- C of PIP.

Objective No. 7: To reduce morbidity and mortality among infants due to Diarrhea and ARI

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

Some Initiatives Detailed

A). MODEL FOR COMPREHENSIVE CARE OF NEWBORN



DISTRICT LEVEL: NEAR LEVEL II SICK NEWBORN CARE UNIT

Level	Facility	Services/Activities	Training required	Equipment
1. District Level				
Near Level II Sick Newborn Care Unit ((SCNU) to provide specialized care services to sick newborns		Special care of neonates	4 days training	Equipment for SCNU and refurbishment.
2.CHC/RH/SDH level				
Out of 76 FRUs, 36 are district hospitals and the remaining 40 are SDH, RH, and BPHCs. In district hospitals we are establishing Sick New Born Care units, and in remaining 40 FRUs we are proposing to set up new born Stabilisation Unit (NBSU).		Safe and effective resuscitation of babies and for the care of sick newborns	2 days NSSK Training	Equipment for SCNU and refurbishment
3. PHC level				
New Born Care Corner with basic care services in health facilities		Delivery services Neonatal Resuscitation Warmth	2 days NSSK Training	Neonatal warmer Oxygen supply Ambu bag and Mask
4. Village level				
IMNCI Trained workers in each village to provide essential child care and counselling services to community		Post Natal Visits, Counselling for breastfeeding and newborn care practices, immunization, timely identification, classification, treatment and referral, if needed	8 days training in IMNCI	IMNCI training module Drug Kit

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

It has been observed that near level II Neonatal care is -

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

Establishment of near level SCNU (sick newborn care unit) in 23 districts through NRHM funds and 3 through NIPI funds. Unicef is extending all possible technical support in this regard.

Requirements for Accreditation

1. Location of the SCNU:
   - ☞ Should be easily accessible from entrance of the hospital
   - ☞ Should not be located on top floor
   - ☞ For units catering both inborn and out born neonates: next to labor ward & delivery room
   - ☞ For units catering out born neonates only: near children ward
2. Space Requirement:
   1200 sq ft area for a 12 bed near Level II SCNU @ 100 sq ft per patient of which:
   50 sq ft would be patient care area and 50 sq ft would be added up for ancillary areas

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

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

4. Side Laboratory Equipments:

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

5. Staff

Manpower	12 bed SCNU
1. Pediatricians	2
2. Medical Officer	4

3. Sister-in-charge / PHN	1
4. Staff Nurse	6
5. ANMs	8
6. Class IV	6

6. Life Saving drugs for Emergency:
This list is not exhaustive for an emergency situation in any Sick Newborn Care Unit

Item	Requirement for the unit
Injection adrenaline, naloxone, sodium bicarbonate, aminophylline, phenobarbitone, hydrocortisone, 10% dextrose, normal saline, ampicillin with cloxacillin, ampicillin and cefotaxime and gentamycin etc	A stock of 1 set per bed per month should always be maintained in the unit

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

CHC/RH/SDH LEVEL FACILITY- NEW BORN STABILISATION UNIT

Every FRU must have clearly established arrangement for the prompt, safe and effective resuscitation of babies and for the care of sick newborns. Most sick newborn can be stabilised at this level. In Bihar there are total 76 FRUs including District hospitals, Sub divisional hospitals, and Referral hospitals and few blocks PHCs. out of 76 FRUs, 36 are district hospitals and the remaining 40 are SDH, RH, and BPHCs. In district hospitals we are establishing Sick New born Care Units, and in remaining 40 FRUs we are proposing to set up New Born Stabilisation Unit (NBSU).

Services at a Stabilisation Unit
A Stabilisation Unit at an FRU or an equivalent facility provides the following services:

- Care at birth
- Provision of warmth
- Resuscitation
- Monitoring of vital signs
- Initial care and stabilisation of sick newborns
- Care of low birth weight newborn not requiring intensive care
- Breast feeding and feeding support
- Referral services
- Configuration of a Stabilisation Unit
  a) The stabilisation unit should be located within or in close proximity of the maternity ward
  b) Space of approximately 40-50 sq ft. per bed is needed, where four radiant warmers can be kept.
  c) Provision of hand washing and containment of infection control should be there, if is not a part of the delivery room.

Equipment and Renewable required for a Stabilisation Unit

Item No.	Item Description	Quantity
1	Open care system: radiant warmer, fixed height, with trolley, drawers, O2-bottles	4
2	Resuscitator, hand-operated, neonate, 500ml	2
3	Laryngoscope set, neonate	2
4	Scale, baby, electronic, 10kg <5kg>	1
5	Pump suction, foot operated	1
6	Thermometer, clinical, digital, 32-34C	4
7	Light examination, mobile, 220-12V	4
8	Hub Cutter, Syringe	1
9	I/V Cannula 24G, 26g	
10	Extractor, mucus, 20ml, ster, disp Dee Lee	
11	Tube, feeding, CH07, L40 cm, ster, disp	
12	Oxygen cylinder 8F	
13	Sterile Gloves	
14	Tube, Suction, CH 10, L50 cm, ster, disp	
15	Cotton wool, 500g, roll, non-ster	
16	Disinfectant, chlorhesidine, 20%	

Human resources

Staffing:-One dedicated nursing staff needs to be available round-the-clock for newborn care in the stabilisation unit. One Medical Officer skilled in newborn care of paediatrician is required for clinical care and oversight.

Training:-Doctors and nurses posted in the stabilisation unit must undergo skill-based training for 3-4 days.

Referral services- Each unit accepting sick newborns and required to make neonatal referrals should have or have access to an appropriately staffed and equipped transport service.

Cost of setting up a Stabilisation Unit

The costs mentioned below are indicative and could vary widely:

One time establishment cost	
Renovations and civil works	Rs. 3,00,000- 7,50,000
(Highly variable depending on the state of the health facility)	
Equipment and furniture	Rs.2,75,000
Capacity building	Rs. 25,000
Sub Total(A)	Rs. 6,00,000*

*Civil and electrical work has been taken at an average of Rs. 3lakh

Recurring of running cost per year (does not include the salaries of staff)	
Consumables	Rs. 25,000
Maintenance cost	Rs. 1,50,000

Sub Total (B)	Rs. 1, 75,000
Total (A+B) for 1 NBSU	Rs. 7,75,000
Total Cost for 40 NBSU	3,10,00,000

FACILITIES FOR PHC LEVEL: NEW BORN CARE CORNER (NBCC)

- Adequate warming through radiant heat source.
- Facilities for Resuscitation with self inflating resuscitation bag and well fitting neonatal face masks (at least two sizes).
- Medicines of essential newborn care
- Supply of bucket type / spring type weighing machines to all sub centres and Anganwadi Centres - many times new born and infants are not weighed or incorrectly weighed using adult type weighing machines which are usually available at sub centres and Anganwadi centres. Provision of bucket type or spring type weighing instruments will improve weight monitoring.
- Paediatrician will be appointed on contract basis @ Rs.26000 pm.
- Training of MOs on Paediatrics
- Training of MOs, Staff Nurses on Facility Based New Born Care
- Training and operationalization cost will be borne by the UNICEF.

NEWBORN CARE CORNERS in OT/ LABOUR ROOMS

Delivery rooms in Operation Theatres (OT) and in Labour rooms are required to have separate resuscitation space and outlets for newborn. Some term infants and most pre-term infants are at greater thermal risk and often require additional personnel, equipment and time to optimize resuscitation. An appropriate resuscitation/stabilization environment should be provided as provision of appropriate temperature for delivery room resuscitation of high-risk preterm infants is vital to their stabilization.

1. Services at the Corner

This space provides an acceptable environment for most uncomplicated term infants, but may not support the optimal management of newborns who may require referral to SCNU. :

- Care at birth
- Resuscitation
- Provision of warmth
- Early initiation of breastfeeding
- Weighing the neonate

2. Configuration of the corner

- Clear floor area shall be provided for in the room for newborn corner. It is a space within the labour room, 20-30 sq ft in size, where a radiant warmer will be kept.
- Oxygen, air and simultaneously-accessible electrical outlets shall be provided for the newborn infant in addition to the facilities required for the mother.
- Clinical procedures: administration of oxygen, airway suctioning.
- Resuscitation kit should be placed in the radiant warmer.
- Provision of hand washing and containment of infection control if it is not a part of the delivery room
- The area should be away from draught of air, and should have power connection for plugging in the radiant warmer.

3. Equipments and Renewables required for the Corner

Item No	Item Description	Essential	Desirable	Quantity	Installation	Training	Civil	Mechanical	Electrical
	Open care system: radiant warmer, fixed height, with trolley, drawers, O2-bottles	E		1	X	X	X	X	X
	Resuscitator, hand-operated, neonate, 500ml	E		1		X			
	Weighing Scale, spring	E		1		X			
	Pump suction, foot operated	E		1		X			
	Thermometer, clinical, digital, 32-34C	E		1					
	Light examination, mobile, 220-12 V	E		1	X				X
	Hub Cutter, syringe	E		1		X			
Renewable consumables									
	I / V Cannula 24 G, 26 G	E							
	Extractor,mucus,20ml,ster,disp Dee Lee	E							
	Tube,feeding,CH07,L40cm,ster,disp	E							
	Oxygen cylinder 8 F	E							
	Sterile Gloves	E							

4. Human Resource: No additional staffs are required for newborn care at the health facility.
5. Training : Training to staff working at NCC on NSSK will be conducted at district hospitals for two days

Timeline of Process (Total 4 months)	1	2	3	4
Finalization of site				
Equipment specification & procurement				
Minor Civil/Electrical Modifications/works				
Trainings for the staff				
NCC functioning				

B). Performance based incentives to AWWs for Post natal Check up visits in 24 IMNCI Districts

Review of the status of Postnatal Care (PNC) services based on an assessment of available monitoring and evaluated data from NFHS and DLHS pertaining to Bihar reveal that mothers & Newborn babies who received Post Natal Check-up within 2 days of delivery is 15.3 per cent as compared to 59.3 per cent of mothers who received ANC (NFHS 3). Further, according to DLHS 3, percentage of mothers & newborns who received PNC within 2 weeks of delivery is 26.2. On the other hand, percentage of home delivery is 27.7 as per the DLHS 3 which leads to an inference that most of the home deliveries are exempted from PNC services which contribute to most of the post partum deaths.

In view of the above facts and figures it is conspicuous that the current status of PNC visit is

neither adequate nor qualitative. Further, the findings suggest that PNC visit is an imperative to ensure safe motherhood and to efficiently arrest maternal and infant mortality. First week of post natal period is critical for the survival of mother and newborn. Continuum of care model for maternal and newborn health starts during the first week. An agile and responsive system and structure during PNC saves lives. Three quality PNC visits within a week of delivery by skilled workers can help in:

- Identifying danger signs of mother and newborn
- Promoting early initiation and proper breastfeeding and colostrums feeding
- Promoting kangaroo mother care for keeping baby warm
- Counseling on essential maternal and newborn health care
- Arranging for early referral to correct facility

In this connection it is noteworthy that a comprehensive PNC checklist (IMNCI 0 to 2m recording formats with addition of maternal components) is being devised in light of the social and biological causes associated with the morbidity of mother and newborn.

In view of the experience in IMNCI interventions, the proposed area for the intervention is 24 IMNCI districts. The area is characterized with most backward pockets of the state. The districts have a total number of 375 blocks and 8099 villages. A total number of 7027 AWWs are already trained in IMNCI programme.

Methodology:

AWWs are emerging as the grassroot level frontline service providers with viability to reach out to every mother and child in need. IMNCI training is imparting basic skills to them in post natal care for mother & newborn. Provisions of incentives have motivated them to render service with good coverage. This intends to increase the PNC visits through trained AWWs to ensure optimum coverage.

Incentive:

Every AWW will get Rs.100/- per 3 PNC visit to Normal NBs of >2.5kg wt & Rs.200/per 6 PNC visit to LBW babies after successful completion of required number of visits. Every AWW has to make home visits as per IMNCI protocol. She will carry the PNC checklist (0-2m IMNCI recording formats) for each house, the PNC checklist has questionnaire on newborn, mother and referral. After required number of visits she will submit the checklists to the ANM who will submit it to the MOIC of the PHC for payment @ Rs. 100/- or Rs.200/- as per PNC visits.

MOV:

Monthly PNC visit reports as part of IMNCI implementation reporting (AWWs-ANMs-LHVs-MO I/Cs-District-State)

Through IMNCI-FUS and cross checking PNC visits

Intermediate process indicators e.g Early initiation of BF within 1hr, KMC, BF with proper positioning, attachment & suckling etc.

Total Budget required for 24 IMNCI implementing districts

Total expected Delivery in 24 districts (A)	14,36,043.00
Out of 14,36,043 approximately 50 % will be covered (B)	7,18,021.50
Out of 718021 approximately 70 will be normal baby(C)	5,02,615.05
And 30 % will be low birth baby(D)	2,15,406.45

Total incentive Required for 3 PNC visit for normal baby(E)	5,02,61,505
Total incentive required for 6 PNC visit for low birth baby(F)	4,30,81,290
Total budget required(E+F)	9,33,42,795

C). IMNCI Drug KITs

All IMNCI trained workers will be provided with an IMNCI Drug Kit at the end of 8 days IMNCI training. Procurement is done in a decentralised manner with rate contracts fixed centrally by SHSB while District officials directly place orders to the concerned entities using a cash and carry system. IMNCI Kit contains drugs like-Paediatric Cotrimoxazole, PCM, Chloroquine, IFA, Gention Violet, ORS and Zinc.

Total Budget for IMNCI Drug kits

Total number of Anganwadi worker to be trained {A}	50000
Number of IMNCI kit Required(1 kit for 3 months so 4 kit for one year){B}	50000x4=200000
cost of 1 Kit	Rs-250
Total Cost	200000x250=5,00,00,000

D). Hiring of Bio medical Engineer for maintenance of SCNU, NBSU, NBCC

Term of reference for Bio Medical engineer:
Qualification- Diploma in electrical engineering
Work Exp-3-4 Years
Place of Posting-State Health Society

Monthly Remuneration – 25000/month

- Technical evaluation of equipment's i.e. pre inspection delivery.
- Support Installation of Medical Equipment's.
- Imparting training on equipments to the concerned medical staffs.
- Maintenance of Medical Equipments in co- ordination with manufacturer/ supplier.
- Inspection of electrical connections and other essentials for installation of equipments.
- Preparation of technical specification of tender document.
- Evaluation of technical specification of equipments quoted in the tender.
- Provide assistance to Procurement Expert for procuring Medical equipments.
- Designing the AMC package for the equipments procured.
- Power audit of the new sites
- Identifications of problems in the high equipment failure rate SCNU/NBC/Stabilization units.
- Liasoning with the equipment manufacturers to provide AMC
- Supervise Preventive maintainence
- Design preventive maintaince protocol and calculate average downtime of the equipment

Term of reference for Assistant Engineer to Bio Medical Engineer:

Qualification- Diploma in electrical engineering
Work Exp- 0-2 Years
Place of Posting-Divisional level at Regional Programme Management Unit (RPMU)
Monthly Remuneration – 20000/month

1. Providing assistance to Bio Medical Engineer for maintaining the equipments.
2. Providing assistance to Bio Medical Engineer for installation of Medical equipments.
3. Providing assistance to Bio Medical Engineer for Inspection of electrical connections and other essentials for installation of equipment's.

Total Budget Required

	Unit	Monthly Remuneration	Total for 9 months
Bio Medical Engineer at State Level(A)	1	25000	25000x9=225000
Bio Medical Engineer at Divisional Level(B)	9	20000	20000x9x9=1620000
Total Budget Required(A+B)			1845000 Budgeted under HR (Part A)

E). Procurement of ARI Timer:

Community-based management of pneumonia through IMNCI trained workers (AWW/*ASHA*/ANM) has been identified as one of the key strategies of child survival. To diagnose pneumonia the worker has to count the respiration of the baby. It has been observed that workers are facing a lot of problem to count Respiratory Rate properly. The main reasons are lack of watch, unable to find out the time from watch etc. For effective counting of respiration and there by diagnosing pneumonia, by IMNCI trained workers, the provision of ARI Timer to IMNCI trained workers is being proposed for 2011-12 PIP.

Unit Cost-Rs.200/- per timer, total requirement- 50000, Total cost: - 50000x200= Rs.10,00,000/-

F). School Health Programme

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

S. No.	Activities	Total Amount (in Lakhs)	Remarks
1	No. of Children in Govt. School (I to VIII)- 19093607 No. of Girls in Kasturba Gandhi Balika Vidyalaya (KGBV) -34949 Total No. of Children (Govt.+KGBV)-19128556 No. of Children examined per Camp - 100 No. of Medical Camp - 191285 Approx Exp. Per Medical Camp - 3000/- Total expected Exp. In Medical Camp- 191285x3000/-	5738.55	Calculated Budget is as per data provided by, MDM, Directrorate, Govt. of Bihar
2	**Monitoring, Supervision & Evaluation of School Health Programme** **From State Level** Monthy Visit to Different Schools of Dist. by State Level Officers		Vehicle+Fuel to be provided by the State Health Society, Bihar
	From District Level Weekly Visit to Different Schools of Dist. by District Level Officers		
	Total	5738.55	

In phase –I of 2011-12 Budget required from NRHM is 50000 camps x 3000 = 1500.00 Lakhs, remaining amount shall be proposed in supplementary PIP.

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

Introduction:

Adequate nutrition is critical to child development. Children are particularly vulnerable to growth retardation, micronutrient deficiencies, and common childhood illnesses such as diarrhoea and acute respiratory infections (ARI). Child malnutrition extracts a heavy toll on both human and economic development, contributing to about 50% of child deaths worldwide. The consequences of malnutrition are serious leading to stunting, mental and physical retardation, weak immune defense and impaired development. About 55 million underweight under-five children, i.e. one-third of world's underweight 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 %. Severe and acute malnutrition among children can be direct or indirect cause of child death by increasing the case fatality rate in children suffering from such common illnesses as diarrhea and pneumonia. The risk of death in these children is 5-20 times higher compared to well-nourished children. Severe and acute malnutrition (SAM) is defined by a very low weight for height, below -3 z* scores of the

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

median WHO growth standards, presence of visible severe wasting or 'bipedal oedema', or mid-upper arm circumference (MUAC) of <11.5 cm in children between 6-60 months.

An estimated one-third of child undernutrition in India occurs before birth and two-thirds in the first two years of a child's life. This makes the 1,000 days from conception to a child's second birthday a critical window of opportunity for intervention, one that requires a combination of facility- and home-based care to safeguard children's nutrition security. The period from birth to two years of age is important for optimal growth, health, and development.

MALNUTRITION IN BIHAR:
In Bihar, malnutrition is a serious concern with a high prevalence of 58.4 % as revealed by the National Health and Family welfare Survey (NFHS-3, 2005-06). Children suffering from severe and acute malnutrition are reported to be 8.3%. Based on population figures, it is estimated that in Bihar, 1.2 million children under five years of age are threatened to face the consequences of severe and acute 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. About 73-170/1000 of these severe and acute malnourished children die during childhood, which means around 87,600 deaths per year, or 240 deaths per day.

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 centers, 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 a therapeutic feeding programme.

A decision was thus taken to set up Nutrition Rehabilitation Centers which is a unit for the management of SAM children where they are kept under observation and provided with medical and nutritional care. In additional to medical 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.

Initial discussions with UNICEF on establishment of NRCs in the 2007 flood affected districts was productive. It was thought worthwhile to pilot NRCs for treatment of children suffering from severe forms of malnutrition in 2 flood affected districts with support from UNICEF for supervision and monitoring of activities, especially in the initial period of management of NRCs.

The NRCs were operationalized in the districts of Muzaffarpur and East Champaran during August-September 2007 and in Darbhanga in May 2010 by District Health Society - Darbhanga. The results have been very encouraging with 1772 SAM children benefitting till date, of which around 95% belonged to the socially excluded class. Based on these impressive results from these three NRCs in the management of child malnutrition, it has been decided to scale up these units in all the districts of the state. A total of eight NRCs

have already been established in the districts of Muzaffarpur, East Champaran, Samastipur, Darbhanga, Madhubani, Khagaria, Sitamarhi and Sheohar.

State plans to run NRCs in all the districts of the state either through the respective District Health Society or via a qualified Agency/Firm/NGO/Institution. State Health Society has already finalized site for NRC in all the districts of the state and selected a qualified Agency/Firm/NGO/Institution has for running the NRC in most of the districts of the state. Technical staff selection and training has already been done for currently functional NRCs.

Nutrition Rehabilitation Centers will thus be important to address severe and acute malnutrition among children needing residential care and medical treatment. However, considering the major challenge of SAM in Bihar, which is 8.3%, corresponding to 1.2 million preschool children, a special care and feeding programme for children will be promoted through ICDS along with NRC services during the scaling process.

REQUIREMENT FOR SETTING UP NRCs:

Expected Cost for Establishment of one NRC

Sl. No.	Name of the Items	Quantity	Cost for Per pc	Total Cost
	Civil Work (Minor repair work, white washing)			10000.00
	Water Tank-Sintex (1000 lt)	1	8000.00	8000.00
	Electric Motor – 1 HP	1	8500.00	8500.00
	Cots	20	2000.00	40000.00
	Bedside Locker	20	500.00	10000.00
	Mattresses	20	500.00	10000.00
	Pillow	20	80.00	1600.0
	Hand towel	40	30.00	1200.00
	Bath towel for children	40	50.00	2000.00
	Bedsheet (size – 54”x90”)	40	100.00	4000.00
	Pillow Cover	40	30.00	1200.00
	Small Blankets for Children	20	200.00	4000.00
	Large Blankets for Mothers	20	250.00	5000.00
	Plastic Mats	6	60.00	360.00
	Door Mats	6	60.00	360.00
	Mackintosh	40	100.00	4000.00
	Mosquito Nets	20	100.00	2000.00
	Nets for the Windows	10	100.00	1000.00
	Toys for Children	20	100.00	2000.00
	Warmer	6	1500.00	9000.00
	Room Coolers	3	3000.00	9000.00
	Refrigerator (200 lt)	1	6000.00	6000.00
	Voltage Stabilizer	2	750.00	1500.00
	Steel Almirah (7’x3’x2.5’)	5	3000.00	15000.00
	Table (4’x3’)	4	2000.00	8000.00
	Chair	6	300.00	1800.00
	Ceiling Fan	6	800.00	4800.00
	Exhaust Fan	4	500.00	2000.00
	Wall Clock	2	100.00	200.00
	Child friendly paintings			3000.00
	Uniform for NRC Staff (2 set per staff)	22	400.00	8800.00
Kitchen Materials Cooking Utensils				
	Kitchen Rack-large	2	800.00	1600.00
	Electronic Kitchen Balance	1	1000.00	1000.00
	Cooker – 3lt	2	700.00	1400.00

Sl. No.	Name of the Items	Quantity	Cost for Per pc	Total Cost
	Karahi	2	300.00	600.00
	Dekchi with cover	8	200.00	1600.00
	Cholni	1	30.00	30.00
	Dabbu	1	30.00	30.00
	Tawa	1	150.00	150.00
	Chakla Belan	1	150.00	150.00
	Chimta	1	30.00	30.00
	Parath	1	200.00	200.00
	Chilohi (Hasua)	1	40.00	40.00
	Knife	2	30.00	60.00
	Peeler	1	30.00	30.00
	Steel Grater	1	40.00	40.00
	Chalni ¼vkVk pkyus dh pyuh½	1	60.00	60.00
	Tea Strainer	1	30.00	30.00
	Soup Strainer	1	60.00	60.00
	Vessel Holder (laMlh½	1	50.00	50.00
	Spatula	2	40.00	80.00
	Serving Spoon	4	15.00	60.00
	Gas Stove with Gas Connection (Double Cylinder)	1	5000.00	5000.00
	Measuring Cups and Spoons	1 set	150.00	150.00
	Spoons (Large)	6	20.00	120.00
	Napkin for Kitchen Use	3	50.00	150.00
	Water purifier (Aquaguard)	1	7000.00	7000.00
	Mixer & Grinder	1	2000.00	2000.00
	Food Storage Container (5 kg capacity)	5	150.00	750.00
	Food Storage Container (2 kg capacity)	8	90.00	720.00
	Small Plastic Tubs (for washing /cutting vegetables)	4	50.00	200.00
	Plastic Basket (Medium Size)	3	20.00	60.00
	Plastic Basket (Large Size)	3	30.00	90.00
	Plastic Water Bucket/Drum with mug	2	100.00	200.00
	Water Jug (Steel 2 lt)	2	100.00	200.00
	Apron for Kitchen use	5	50.00	250.00
	Head Gears	4	50.00	200.00
	Casserole (A Set of 3)	1 set	300.00	300.00
	Container for spices (A Set of 6)	1 set	70.00	70.00
Feeding Utensils				
	Plate	40	12.00	480.00
	Katori	40	10.00	400.00
	Glasses	40	10.00	400.00
	Spoons (Small)	40	5.00	200.00
For Washing & Cleaning				
	Phenyl	1 lt	30.00	30.00
	Soap	4	10.00	40.00
	Washing Powder – 1kg	2 kg	20.00	40.00
	Dust Bin	6	40.00	240.00
	Buckets and Mugs	6	60.00	360.00
Total			58522.00	2,11,270.00

Note : These rates are as per rates during initially establishment NRCs in 2007-08. Therefore, the entire funding for establishment of an NRC is being increased by 25% to cover increase cost. The fund for establishment of one NRC = Rs.265000/-

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The total cost for establishment of 38 NRCs for 2011-12 =265000 x 38 District = Rs.1,00,70,000/-

Estimated Running Cost per Nutritional Rehabilitation Centre (NRC) with 20 Beds per month

Sl. No	Item and Quantity	Unit cost (Rs.)	Total Cost per Batch	Total Cost/ Month (Rs)	Remark
	Medicines				Will be provided by the Govt.
	Honorarium to Mobilizer	100/- per child	100/- x 20= 2000/-	4000.00	ASHA/ AWW will work as mobilizer (Responsibility- Out-sourced Agency)
	Food for child	70/- per child	70/- x 20 children x 21 days = 25200/-	42000.00	Responsibility- Out-sourced Agency
	Food for mother	50/- per mother	50/- x 20 mothers x 21 days = 12600/-	30000.00	Responsibility- Out-sourced Agency
	Loss of wages to mother	70/- per day	70/- per day x 20 mothers x 21 days = 29400/-	42000.00	(Responsibility- Out-sourced Agency)
	Transportation cost to bring children (to mother)	120/- per child	120/- x 20 = 2400/-	4800.00	Will be given to mother to bring the child to NRC (Responsibility- Out-sourced Agency)
	Transportation cost after 21 days (to mother)	100/- per child	100/- x 20 = 2000/-	2000.00	Will be given to mother during the discharge from NRC (Responsibility- Out-sourced Agency)
	Transportation cost for follow up visits (to mother)	100/- per child per visit	100/- x 4 visits x 20 children = 8000/-	12,000.00	Will be given to mother to bring the child to NRC for follow-up (Responsibility- Out-sourced Agency)
	Fuel expense for generator		12000/-	12000.00	Responsibility- Out-sourced Agency
	Miscellaneous	Bulb+Tube= 200/- Electric Bill= 600/- Telephone Bill= 500/- Register + Reporting format= 1100/- Referral Transport = 500/- Transport for Path. Investigation = 1600/- Routine Pathological Investigation = 3000/- Stationary & Photocopy = 500/- Photography of SAM children = 500/- Laundries /Washerman = 600/- Counseling Material = 300/- Phenyl, soap, mosquito repellent,		13000.00	Responsibility- Out-sourced Agency

		washing powder etc= 1100/- Emergency Expenses = 1500/- Data entry= 500/- Monthly review meeting for NRC+CBC 500/-			
	Pediatrician -1	35000/-	35000/-	35000.00	
	A-Grade Staff Nurse– 2	12000/-	12000/-X 2= 24000/-	24000.00	
	Nutrition/Feeding Demonstrator – 2	8000/-	8000/- x 2 = 16000/-	16000.00	
	Caretaker – 3	3500/-	3500/- x 3= 10500/-	10500.00	Responsibility- Out-sourced Agency
	Cook – 2	3500/-	3500/- x 2 = 7000/-	7000.00	
	Security Guards – 3	3500/-	3500/- x 3= 10500/-	10500.00	
	Sweeper/Cleaner – 2	3000/-	3000/- x 2 = 6000/-	6000.00	
	CBC Extender – 1	7500/-	7500/- x 1 = 7500/-	7500.00	
Total				278300.00	

Note : The total amount will be allotted to concerned District Health Society who will make the payment to the outsourced agency. In case, NRC is run by District Health Society (and not out-sourced) all the payment will be by District Health Society.

Therefore, the total cost for running NRC per year

= 38 x 2,78,300/- x 12 = Rs. 12,69,04,800/-

Total Budget for Orientation regarding SAM management (2011-2012)

The management of SAM children will require orientation of state level functionaries from Health and ICDS department. It will also be necessary to orient all the medical colleges (especially Pediatrics and PSM departments) in regard to the SAM management activities in the state. Even the NGOs selected to run NRCs will need to be oriented regarding various guidelines related to NRC.

Sl. No.	Orientation	Details	Total (in Rs.)
1	State level orientation meeting of CS & DPO of all 38 District.	2 (CS+DPO)x38 Dist x Rs. 150 (Rs. 100 -Lunch & Snacks, Rs. 50- Contingency)+ Rs. 3000 (Venue Hiring)	14400
2	Orientation of Pediatric and PSM department of all the medical colleges	6 (Medical Colleges) x 25 Participants (Pediatrics & PSM Dept.) x Rs. 150 (Rs. 100 -Lunch & Snacks, Rs. 50- Contingency)	22500
3	State level orientation meeting with IAP and IMA	2 (one for IMA & One for IAP) x [30 Participants x Rs. 150 (Rs. 100 -Lunch & Snacks, Rs. 50- Contingency) + Rs. 2000 (Venue Hiring)]	15000
4	State level orientation of all NGOs selected to run NRCs	38 NRCs (Selected NGO representative) x Rs. 150 (Rs. 100 -Lunch & Snacks, Rs. 50- Contingency) + Rs. 3000 (Venue Hiring)	8700
		Total	60600

Total Budget for training regarding NRC (2011-2012)

In each district, one focused block can be chosen by Civil Surgeon and the DPM, from where the SAM children can be identified by the Community Based Care Extender (new addition to NRC staff) among the various severely underweight children identified by the

AWW based on the New WHO growth standards. ASHA and/or AWW can counsel and motivate parents of these identified SAM children for stay at NRC for proper care. ASHA would also be responsible for ensuring the follow-up services of the SAM children discharged from NRC.

This year PIP proposing for 4 follow up visits for every SAM child discharged from NRC. Regarding this all the ASHA/AWW/ANM of the focused block will need to be oriented on the functioning of the NRC in the district. It will also be necessary to train all the Medical Officers of all the 38 districts in the management of Severe Acute Malnutrition.

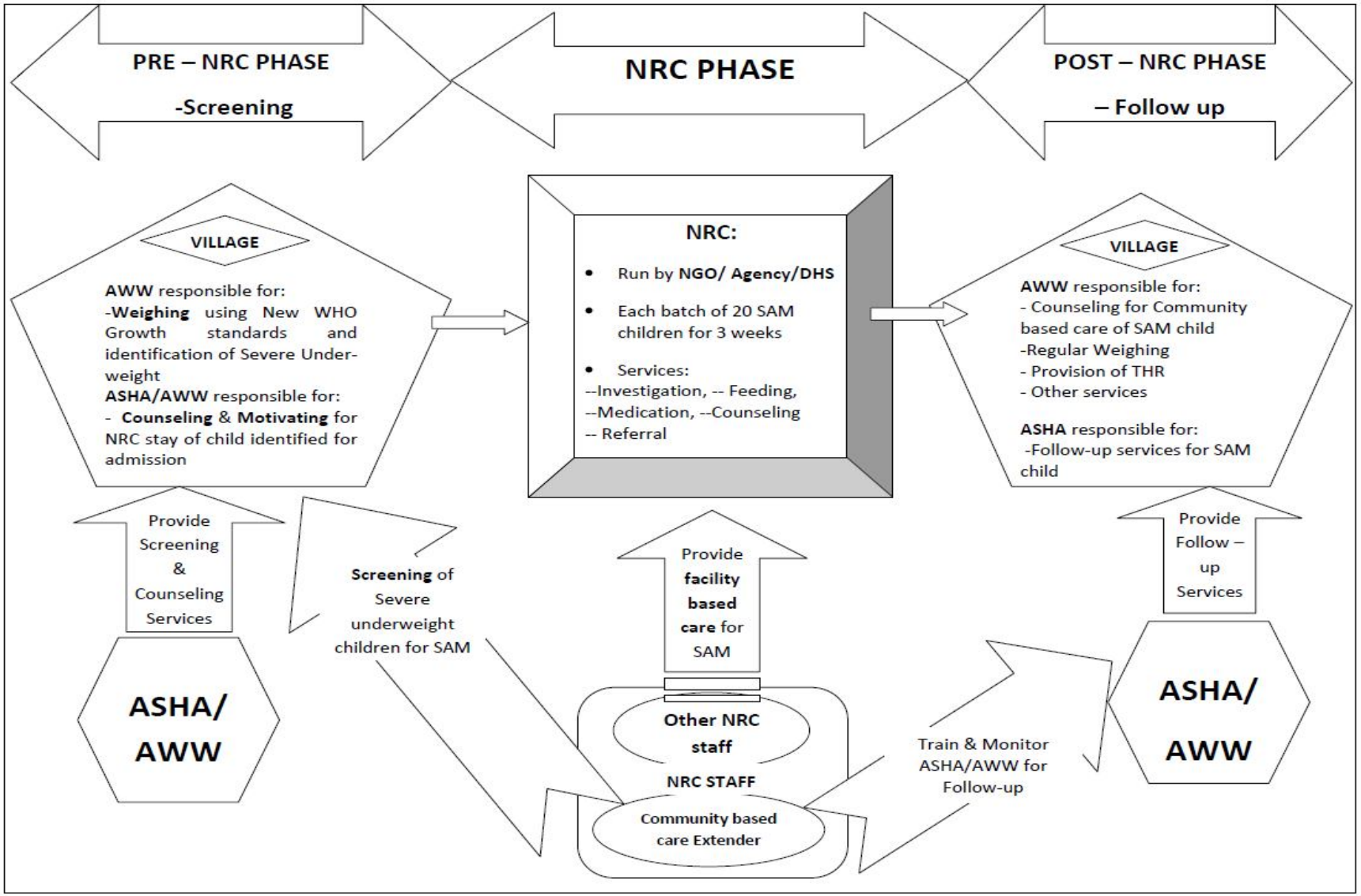
Sl. No.	Training	Details	Total (in Rs.)
1	Training of all MOs in the district on NRC	30 Medical Officers in each Dist. x38 Dist x Rs. 150 (Rs. 100 -Lunch & Snacks, Rs. 50- Contingency)	171000
2	Training of all ANM/ASHA/AWW of one focused block in each of the 38 district	38 focused blocks x 350 Participants (approx. 150 ASHA + 150 AWW + 50 Health Functionaries) x Rs. 100 (Rs. 50 -Lunch & Snacks, Rs. 50- Contingency)	1330000
Total			1501000

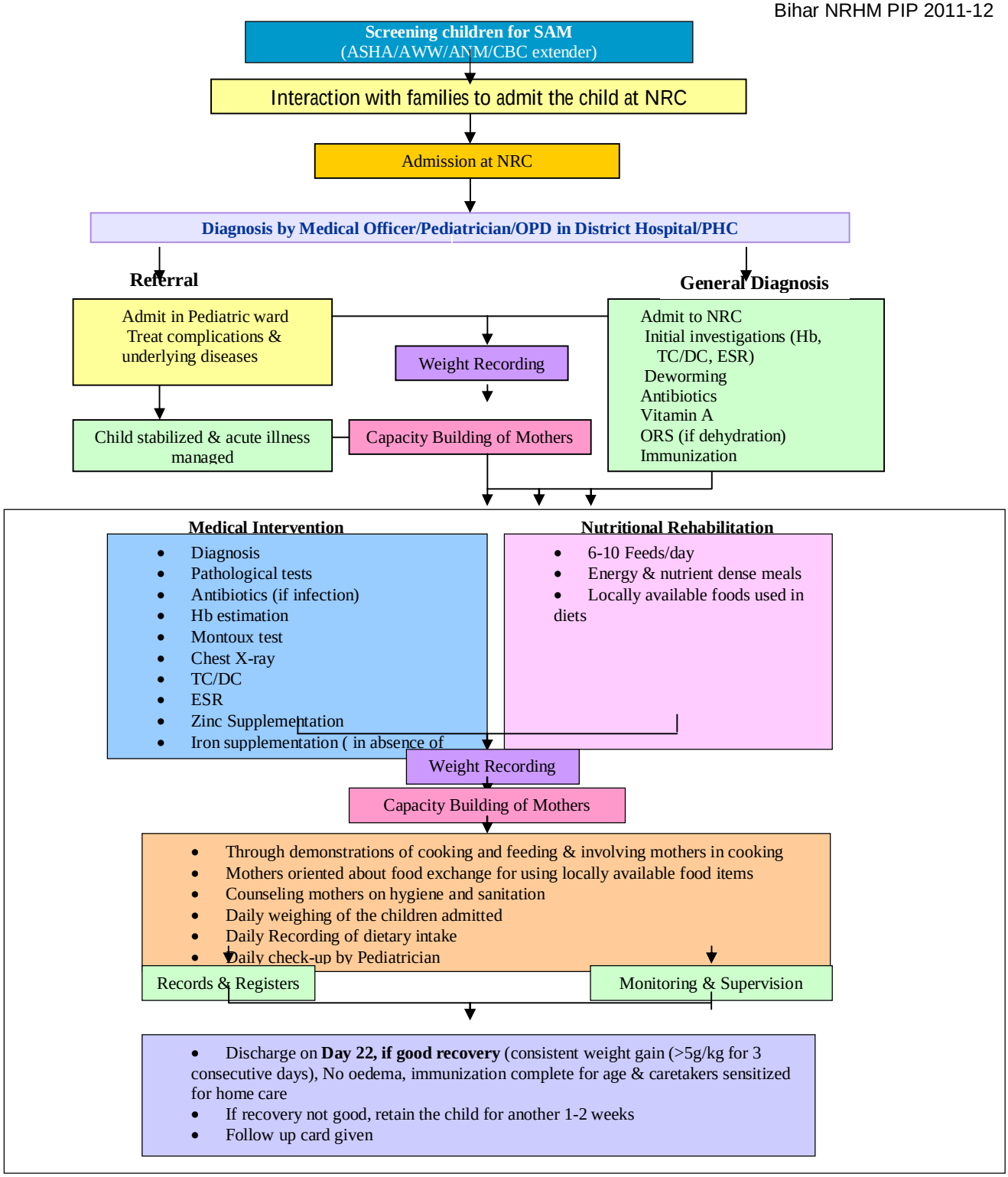
Total Budget for NRC (2011-2012)

Sl. No.	Activities	Proposed Budget for one Year (2011-2012) (in Lakhs)	Remarks
1	Estimated cost For establishment of one NRC (One time cost)= 2,65,000/- For establishment of 0 NRCs for 38 districts = 38 x 2,65,000 =10070000/-	100.70	
2	Estimated cost For running of one NRC/Month = 2,78,300/- For 38 District for 12 months = 38 Districts x 2,78,300/- per month x 12 months = 12,69,04,800/-	1269.048	One NRC is proposed to be functional in every district in 2011-12
3	Orientation Cost State level orientation meeting Orientation of Pediatric and PSM department of all the medical colleges State level orientation meeting with IAP and IMA State level orientation of all NGOs selected to run NRCs	0.606	
4	Training cost Training of all MOs in the district on NRC Training of all ANM/ASHA/AWW of the focused block in each of the 38 district	15.01	
Total		**1385.364**	

FUNCTIONING OF NRC:

The step-wise process of implementation of NRC has been described in the flow diagram below:





H). Childhood Diarrhea Management Programme in Selected Districts through Use of Zinc and Lo-ORS

Introduction:

Acute diarrhea remains a leading cause of childhood deaths – despite the undeniable success of oral dehydration therapy (ORT) over the years. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), in 1978, adopted ORT using oral rehydration salts (ORS) solution as the first line of treatment to control dehydration, Since then, the mortality rate for children under the age of five suffering from acute diarrhea has

fallen from 4.5 million to 1.8 million annually. However, in spite of this impressive achievement, acute diarrhea remains a leading cause of death among children in India and other developing countries.

On 2nd November, 2006 the Government of India released its revised policy for childhood diarrhea management; the revised recommendations aimed at significantly reducing the number of deaths due to diarrhea. These recommendations have taken into account two significant advances: -

- Demonstration of the increased efficacy of a new formulation for ORS containing lower concentrations of glucose and salt
- Success in using zinc supplementation in addition to re-hydration therapy in the management of diarrhoeal diseases.

Prevention and treatment of dehydration with ORS and fluid commonly available at home, breastfeeding, continued feeding, selective use of antibiotics and providing zinc supplementation for 14 days are the critical therapies helpful in management of diarrheal diseases.

In Bihar, the ORS use rate for children with diarrhea has increased from 13.4 %(DLHS-II 2002 – 04) to 22 % (DLHS-III (2007 – 08), that ultimately contributed an increase of the state's use rate to 8.6 percent. In 2009–10. keeping in view the above mentioned recommendations and revised guidelines for childhood diarrhea management program, SHSB in partnership with the Department of Biotechnology/ Biological Corporation Limited (BIBCOL), Ministry for Science and Technology, Government of India, has implemented a programme named "Supporting the scale up of therapeutic administration of zinc as a part of the revised diarrhea management program to reduce childhood morbidity and mortality in the State of Bihar" in eight districts namely Munger, Khagaria, Saharsa, Madhepura Araria, Purnea ,Vashali and Supaul. BIBCOL supplied Zinc tablets to all health facilities and AWCs through MI and UNICEF in the focus districts of Bihar. Under this strategy the ANMs and AWWs have administered Zinc tablets and Lo-ORS to children suffering from diarrhea.

For scale up therapeutic use of Zinc tablets with LO-ORS for child hood diarrhea management program in 18 districts, in the first phase-

For scaling up the programme, a tripartite MOC between GoB, MI and CIFF is in pipeline, the duration of MOC is for five years (2010-2015). The names of the districts that will be covered are Bhagalpur, Banka, Jehanabad, Sheikpura, Nalanda, Gaya, Munger, Khagaria, Saharsa, Madhepura, Supaul, Shamastipur,Sheohar, Sitamarhi and East Champaran These districts have been selected keeping in view a number of parameters like the size of the population, the number of children aged 9-59 months, composite index ranking (Ranking and Mapping of Districts, 2006, International Institute of Population Sciences, Mumbai), roll-out of the IMNCI programme, focus districts of partners and other players. The districts selected are part of south Bihar and fall under either the Gangetic or Kosi flood prone areas. In the subsequent phase the remaining districts will be taken up.

Objectives:

- To reduce the burden of diarrhea on child health and survival in Bihar by facilitating the scale up and mainstreaming of therapeutic zinc supplementation and oral rehydration for treatment of childhood diarrhea through public channels in Bihar.
- To enable state-wide scale up of proven approaches, lessons and good practices by integrating them into State Government plans and programs.
- To document and disseminate results and lessons to influence related diarrhea management programs within India and other developing countries.

Implementation Strategy:

- Commodity procurement – seed supply & capacity building

- Provision of seed supply/buffer stock in the selected districts
- Seasonality trend analysis
- Consultant support for procurement streamlining & logistics
- Capacity building
- Training and sensitization of district, block and field workers
- Information Education and Communication (IEC)
- Formative research
- Technical support to Government as deemed necessary by formative research
- IEC materials for health workers
- State-level launch
- State-level workshop
- Network of champions to be identified
- Program review mechanism will be institutionalized
- Technical support, advocacy, monitoring and supportive supervision at state, district, block and field levels.

Activities for scaling up Diarrhea Management Program in 15 districts:

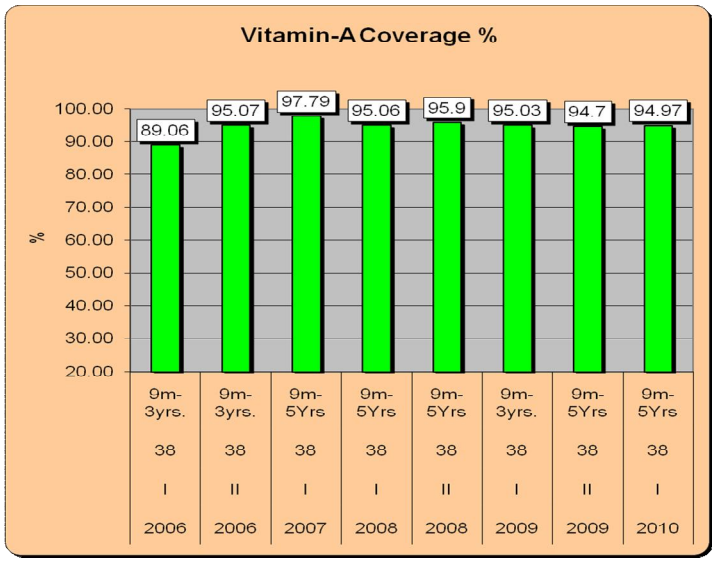
- Sensitization of State and district level functionaries
- Supply of Zinc + Lo- ORS
- Development of communication strategy and printing of IEC materials
- Printing of Training Modules
- Training of block, sector and field level functionaries of Health
- Field level monitoring
- External evaluation to assess the extent of awareness and utilization of zinc + Lo-ORS in the community
- Integrating record keeping and reporting in the existing HMIS

Budgetary Outlay

Sl.	Activity	Amount (Rs. In Lakh)
1.	IEC/ IPC/awareness of caregivers i) TV spot (For 100 day/year in 3 channels for 10 insertions/day for 20 sec each- Rs. 14.00 Lakhs) ii)Radio jingles(For 100 days/year in Vividh Bharti 10 insertions/day for 20 sec each – Rs. 7.00 lakhs) iii)Display on Govt. bus panel (For 160 days on 50 buses - 2 side panels and 1 back panel – 6X2 sq. ft & 4x 3 sq.ft.-- Rs.7.23 lakhs) iv) Hoarding size 20x10 sq. ft in the 18 district hospitals-Rs. 7.26 Lakhs	35.49 (to be sourced from IEC under Part A)

I). Addressing Under nutrition

Vitamin A biannual round – Strategy for Addressing Micronutrient Malnutrition to improve the survival of child and reduction in Under 5 Mortality (U5MR)



A biannual strategy (4 days schedule-Six months apart- June and December) was developed and implemented state wide since 2006 jointly with UNICEF, MI and ICDS. The strategy proved effective as in last rounds more then 90% children of target group (9-59 months) covered with biannual Vitamin A doses. In the present PIP it is proposed to strengthen and ensure implementation state wide in effective manner as an evidence based strategy for addressing under nutrition. During 4 days of biannual rounds two days- Wednesday and Friday as per Routine Immunization micro plan (immunization/outreach fixed site strategy) and following two days are house to house to cover the left outs. In addition to Health Sub Centres and AWCs, State has also identified additional sites during the biannual round to ensure coverage in hard to reach and socially excluded children (Mahadalit and SC/ST communities). Additional sites are also identified and created as per district needs and ASHA/volunteers are trained for Vitamin A administrating. The following table depicts the state wide achievement for Vitamin A during the round as against the annual target.

Vitamin 'A' Coverage (2006 - 2010)

Sl.	Year	Round	Total No. of District	Age	Targeted Children	Administered Children	% Coverage
1	2006	I	38	9m-3yrs.	7697186	6785215	89.06
2	2006	II	38	9m-3yrs.	7829227	7443059	95.07
3	2007	I	38	9m-5Yrs	13185616	12893873	97.79
4	2008	I	38	9m-5Yrs	13613612	12941219	95.06
5	2008	II	38	9m-5Yrs	12399842	11891271	95.90
6	2009	I	38	9m-5Yrs	14110842	13409124	95.03
7	2009	II	38	9m-5Yrs	14119368	13371279	94.70
8	2010	I	38	9m-5Yrs	14377395	13654124	94.97
9	2010	II	38	9m-5Yrs	14703606	in December	
Target for 2011							
10	2011	I	38	9m-5Yrs	14703606	Proposed	
11	2011	II	38	9m-5Yrs	14703606	Proposed	

Guidelines to specifying the role of Health and ICDS for implementing and monitoring is well defined and in place. AWWs play a key role in preparing due list of children, Vitamin A administration and house-to-house visit for tracking the left outs. ANMs ensure the micro planning, distribution of logistics (Vitamin A bottles, reporting formats and IEC materials), monitoring the additional sites and compiling the reports. Block and district level officials of Health and ICDS supports in microplanning and monitoring of the Vitamin A administration.
Microplanning and reporting formats were revised in 2009-10 to ensure proper coverage and reporting from Mahadalit areas and SC/ST children. This has facilitated in collecting the disaggregated coverage data and effective planning process. A joint orientation of Health and ICDS grass root functionaries (ANM, AWW & ASHA) will be taken up in all the blocks of the State before each round. Honorarium will be paid to each additional site volunteers, AWWs and ANM for working for 4 days during biannual round. Monitoring and supportive supervision is the key of success of any large scale campaign program. To ensure quality VAS supplementation and reporting there is a need to establish a strong monitoring and supervision system for all 4 days of campaign. At the level of Primary Health Centre, an integrated approach of supportive supervision is proposed to adopt by Medical Officer (MO) and ICDS officials. It is also proposed to have one supervisor per five sites (AWC, HSC & additional sites) to intensively monitor for supplementation, recording, reporting and social mobilisation. This will ensure 100% coverage of all targeted beneficiaries during campaign. State will also conduct joint sensitization of all MOICs and CDPOs. Additionally banners and IEC materials will be provided to all the booths for enhancing visibility of biannual rounds and display Vitamin A rich foods to improve community understanding as a long term strategy.

Requirement of vitamin A syrup would be ensured through Kit A
For additional requirement of vitamin A state will send the additional request to GOI or procure from NRHM budget.

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The budgetary outlay for biannual Vitamin A round is given ahead:

Sl.	Activity	Amount (Rs. In lacs)
1	Printing of Vitamin A biannual round guidelines, microplanning, reporting and monitoring formats & IEC (@ Rs.1,000- per block x 2 rounds/year x 534 blocks)	10.68
2	Joint orientation of Health and ICDS grass root functionaries- ANM, ASHA and AWW before each round (@ Rs 50/participant for orientation and creating child friendly sites for app 16901 ANM, 80000 AWW + 60000 ASHA & 10000 (additional site volunteers) X 2)	166.90
3	Honorarium to additional site vaccinators (volunteers/ASHA) for each round (@ Rs. 75/ day for 4 days for 10000 additional sites X2)	60.00
4	Supervisor support for all approx 1,00,000 sites (@ 100/day for 4 days for 20000 Supervisors- 1 supervisior/5sites) X 2 rounds	160.00
	Total-	**114.62**

Requirement of Vitamin-A bottles

1.	Total estimated Population-2010-11 of State (Bihar)	9,77,00,000
2.	Total estimated children (9 month to 5 years) 14% of total estimated population	1,36,78,000
3.	Under 5 mortality@72 children/ thousand live birth (source : SRS)	9,84,816
4.	Total estimated targeted children (9 month to 5 years)	1,26,93,184
5.	Total Vitamin-A supply through KIT-A (18116 kits), 12 bottles/kit by GOI	2,17,392
6.	Total requirement of Vitamin-A bottles for 2 biannual round (2,53,863 x 2)	5,07,726
7.	Gap in supply (5,07,726-2,17,392)	2,90,334
8.	Total fund require for gap supply (@ Rs. 45/bottle)	1,30,65,030

Gap supply will be procured by state from the Drug Procurement budget under Part B of NRHM in PIP-2011-2012.

Accordingly, a budgetary provision of Rs. 114.62 lakhs annually is being made for biannual Vitamin A round.

J). MAMTA Activities :

A total of 628 MAMTAs were appointed in 48 Hospitals (District and Sub Divisional Hospitals) of Biharfunded by NIPI. Number of MAMTAs required in each hospital required are calculated on the basis of average number of deliveries taking place in a hospital per day. After the recruitment of MAMTAs in all the Districts and Sub divisional Hospitals, training TOT was given to one Medical Officer and two 'A ' Grade Nurses drawn from each Sadar Hospital at SIHFW, Patna. Those who took TOT trained the MAMTAs in their respective Districts. The main component of the training was on Breast Feeding, Immunization, Family Planning options and mother and Baby Care. Each MAMTA was provided with a FLIP CHART to be used by MAMTA at the bed side of the Mother. The main purpose of MAMTA posting in the Hospital is to retain the mother for 48 hours in the Hospital and empower the mother on Breast feeding, Immunization of Baby, Family planning options and Mother and Child Care. Besides this MAMTA will facilitate a clean environment in Maternity ward and will provide all the comforts to mother during her stay at Hospital for 48 hours.

Incentives to MAMTA :
NIPI pays incentives to MAMTA every month. The basis of incentive payment is to multiply the number of Deliveries per month by Rs. 100/- and distribute amount of Rupees equally among all the MAMTAs working in the hospital.

NIPI will support the incentives of MAMTAs till June 2011 after which the incentives of MAMTA to be assessed through NRHM.

NIPI has given financial support for distributing MAMTA kit in 2010 – 2011 only in Sadar Hospitals for a period of two months. However MAMTA Kit should also be provided to every mother delivering in Health Facilities including PHCs so it is proposed to be taken over by NRHM for 2011-2012.

Components of A-septic Labour and Newborn Kit (given 1 packet per delivery)

- Baby bedsheet – 1 pc
- Baby Nappy- 2 pc

- Baby Inner (Jhabla) – 2 pc
- Towel (Baby wrap) – 1 pc
- Sanitary pad- 6 pc

BUDGET					
SI.NO.	SERVICE DELIVERY	NORMS	EXPENDITURE		REMARKS
			FUND REQUIREMENT	TARGET	
1	**DEPUTY CHILD HEALTH SUPERVISOR (District & Sub Divisional Hospital)**	DISTRICTS @ Rs. 10,000/ months	5760000	48	Purpose of Deputy child health manager to provide technomanagerial support at District level in Immunization, child health, Mamta activities, monitoring & supervision etc.
2	**CHILD HEALTH SUPERVISOR (District) (MAMTA)**	DISTRICTS @ Rs. 15,000/months (Subject to revised pay of Block Health Manager)	570000	38	To support Training , supervision of Mamta at districts & PHC level.
3	**MAMTA INCENTIVE (a) PHC Level**	Rs 100/= per delivery for 1050000 (March 2011-2012)	105000000	534 PHC	To support and empower the mother & child care at PHC level
	(b) SADAR & SUB DIVISIONAL HOSPITAL	Rs 100/= per delivery for 350000, from June 2011 (75 % of total annual incentive)	26250000	48 (38 SADAR & 10 SUB-DIVISIONAL HOSPITAL	To support & empower the mother & child care at Sadar & Sub-Divisional Hospital
4	**TRAINING**	for 3546 Mamta at PHC level i.e. 178 batch (20 participants/batch) @ 15620/batch	2780360	534 PHC	To sensitize & capacity building of Mamta at PHC level
5	**MAMTA KITS**	Rs 99/= for 14 Lacs deliveries	138600000	534 PHC	To keep the Baby warm
		Total	**278960360**		

Training for Mamta on PHC Level for All Districts of Bihar			
Duration of training : in days	2 Days		
Batch Size	20		
Participants	Mamta		
Total No. of Batches in 2010-11	178		
Unit Cost /Batch	15620/-		
Total Budget	unit cost for Batches-15620X178 = 27,80,360/-		
Trainers	3		
Venue:	Dist. Hosp. & Any other Centres		
Beak Up of Budget 2011-12			
Particular	Cost	Days X No. of Participants	Total Per Batch for 20 Participants
Per day Allowance for Mamta	Rs 200 X 2 Days X 20 Participants =		8000/-
Per day Allowance for Trainers	Rs 200 X 2 Days X 3 Trainers =		1200/-
Lunch + Snacks	Rs 100 X 2 Days X 25 Participants =		5000/-
Total			14200/-
Institutional charges 10 % of total expenses			1420/-
		So per Batch	Rs 15620/-
		So for 178 Batches	Rs 2780360/-

Training will be given @ 20 participant per batch
Total No. of Mamta on PHC level = 3546,
Total No. of batches =178
So 178 batches will be trained @ 15620 X 178 = 2780360/-

A). MCH Centres Operationalization

Background:-
The Reproductive and Child Health Plan, strengthened by its integration into the national Rural Health Mission (NRHM) is the main policy response of the nation to meeting the MDG goals 4 and 5. The NRHM was launched on 12th April 2005 throughout the country with special focus on 18 states. The NRHM operates as an umbrella programme integrating all vertical health programme and various disease control Programmes. The National Rural Health Mission has led to substantial investment and attention to revitalising public health systems, with strengthening of community processes, increase in deployment of skilled human resources and improved management and local planning. Quality of antenatal and postnatal care has been strengthened, with the ASHA (woman community health worker) providing support for increased utilization of all RCH services. One important new component of RCH-NRHM that has made a major difference is the introduction of a conditional cash transfer scheme called Janani Bal Suraksha Yojana (JBSY). This scheme has led to a huge increase in institutional deliveries within just four years, the number of beneficiaries rising from 38 thousand lakhs per year in 2005-06 to over 13 lakhs in current year. Today this scheme accounts for 47% of expenditure under reproductive and child health.

In parallel to this demand-side financing through JBSY, the RCH-NRHM programme planned for a parallel investment in strengthening public health facilities. This effort however was constrained by critical human resources shortages, slow growth of public health infrastructure, unavailability of private sector partners in under-serviced areas, and by decreased capacities to train and support and manage this sudden increase in investment and human resources. In the creation of FRUs also, we find the same difficulty of achieving the targets set, despite functionality even of those difficulty of achieving the targets set, despite scaling down targets and then a poor functionality even of those facilities which are stated to have reached the objective. Progress was also slower in the districts facing greater challenges. As a result, there is further effort needed to ensure that every institutional delivery is also a safe delivery and that the expected reduction in maternal and child morbidity and mortality is realised.

To achieve the targets for maternal and child survival by 2012 and 2015, and in view of the recommendations made in the Mid Term Appraisal Report of the Planning Commission, the Ministry of Health and Family Welfare has now mooted a five-pronged strategy with the following key elements-
Focusing on high focused districts (36 districts) except Patna. Munger, which account for a major proportion of the infant and maternal deaths and have a high TFR for planned facility development that would provide universal access to quality health care and supplement these with community health workers in home-based care;

- Improving quality of the facilities where institutional deliveries are being conducted- referred to as MCH facilities- in accordance with the standards laid down in the Maternal and Newborn Health Operational Guidelines and in the Indian Public Health Standards;
- Developing a referral transport system that ensures universal access to these select facilities chosen for development as MCH centres providing quality care.
- Providing an additional package of incentives for those facilities notified by a joint mechanism of centre and state as Inaccessible, Most Difficult or Difficult.
- Strengthening supportive supervision and capacity building in these 36 districts by placing trained public health nurses.
- Re-formulating the financing of these services based on results and performance based so as to ensure all key partners-the beneficiary-clients, the health providers and the health facility managers are all appropriately incentivized to maximize the outcomes.

Services Packages at Different Levels

Level 1 facility –Skilled Birth Attendance:

Maternal Health

ANC Package-Registration (within 12 weeks), Physical Examination, Identification of referral for danger signs, IFA for Pregnant and anaemic women.

Delivery Package-Normal Delivery with use of Partograph, ANTSL, Infection Prevention, Pre referral Management for obstetric Emergencies.

PNC Package-Minimum 6 hrs post delivery stay; Home visits for PNC check up Safe abortion Services-Counselling and Facilitation

New Born Health

Newborn Resuscitation, Warmth, Infection Prevention, Support for Breast feeding initiation, Weighing, Care of LBW<25001gm and referral of sick newborn

RTI/STI Management

Counselling and Referral

Family Planning Services

Emergency Contraceptive pills, Counselling and motivation for small family norm, Distribution of OCP, Condoms, IUD insertions, Follow up of beneficiaries.

"Assured" referral systems to higher facilities

Complete Immunisation

Counselling for feeding, Nutrition, Family Planning, Immunisation

Human Resources: Minimum Two Skilled Birth Attendants-midwives

Level 2 facilities- Basic Obstetric and Newborn Care

All services as in Level 1

PLUS

Maternal Health

ANC Package-Blood grouping, RH typing, RPR/VDRL, linkage with nears ICTC/PPTCT.

Delivery Package-All complication management other than those requiring Blood transfusion and survey: Episiotomy and suturing cervical tears, Assisted vaginal delivery, Stabilisation of patients with obstetric emergency requiring surgery before referral

PNC Package- Minimum 48hrs post delivery stay, Stabilisation of mother with Post natal complications

Safe abortion Services-MVA up to 8 weeks-desirable services as per MTP Act, Medical Methods up till 7 weeks with referral linkages.

New Born Health

Antenatal Corticosteroid to mother in case of preterm babies, Care of LBW>1800gms and other newborn complication referral where appropriate, Vit K to premature babies, Sepsis Management

RTI/STI Management

Identification and management, Wet Mount Referral linkage to ICTC

Family Planning Services

Desirables-Male sterilization-NSV, Tubectomy, IUD insertion

"Assured" referral transport linkages to higher facilities

Human Resources: One of two Medical Officers, three to 5 nu4rses of midwives with SBA training.

Level 3 facilities- Comprehensive Obstetric and Newborn Care

All services in Level II

PLUS

Maternal Health

Management of severe Anaemia, Management of Intra partum and postpartum complications including those requiring Caesarean section and blood transfusion. Blood bank storage/Bank

New Born Health

Care of sick newborn, Management of LBW babies less than 1800gms

RTI/STI Management

Identification and management, Desirable- ICTC/PPTCT services

Family Planning Services

Male sterilisation-Non Scalpel Vasectomy, Female Sterilization: Conventional Tubectomy, Minilap, Laproscopic Tubectomy, All other FP services as mentioned in Level 1 and Level 2 Plus Management of complications.

Human Resources: An obstetrician, an anaesthetist and a paediatrician...or medical officer with short term

No of MCH Centre Operationalised in Year 2011-12

Total number of MCH Centre would be Operationalised in year 2011-12 is

S.N.	Level	Facility	Total
1	LEVEL-1	2 HSC per Dist+1 APHC Per Block(533+76)	609
2	LEVEL-2	All BPHC	533
3	LEVEL-3	ALL FRU(SDH+DH+RH)	76
	Total		**1218**

Bihar -MCH Facility Development Plan-2011-12

No. of High Focus districts in the State – 36

Key Indicators	Source and Year of reference	Rate of change per year (current)	Projected value by year 2015 with current rate of change per year	Required rate of change to reach MDG/ Targets by 2015
IMR	52 (SRS 2009)	- 0.67 (SRS 2005-2008)	53	4
MMR	312 (SRS 2005)	-19.7 (SRS 2002-05)	115	21.2
TFR	3.9 (SRS 2009)	+ 0.04 (NFHS II to III)	4.42	0.19
Institutional deliveries rate	27.7% (DLHS III)	+ 1.78 (DLHS II to III)	40.2	10.3
Pregnant women 3 ANC Check up rate	26.4% (DLHS III)	+ 2.1 (DLHS II to III)	41.1	10.5
Measles immunization rate	54.2% (DLHS III)	+ 6 (DLHS II to III)	96.2	6.54
Unmet need for Family planning	37.2 (DLHS III)	- 0.22 (DLHS II to III)	35.66	5.3

State: Bihar																
District-wise : MCH Facility Identification Sheet																
No. of High Focus Districts : 36																
Districts name	District Population	Existing Institutional Deliveries % against estimated	Total No. of Health facilities in the district						Total Health Facilities in the District	No. of Facilities identified as Level-1		No. of Facilities identified as Level-2		No. of Facilities identified as Level-3		Total MCH centers
			HSC	PHC (APHC)	CHC (BPHC)	RH	SDH	DH		HSC	PHC (APHC)	PHC (APHC)	CHC (BPHC)/ RH	CHC (BPHC)/ RH	DH/ SDH	
ARARIA	27,13,305	41.10%	191	30	9	2	2	1	235	2	11	7	0	0	2	22
AURANGABAD	25,21,270	37.50%	216	58	11	3	0	1	289	2	11	7	0	3	1	24
ARWAL	7,00,282	35.50%	47	8	5	0	0	1	61	2	6	0	4	0	1	13
BANKA	20,12,437	42.10%	222	24	11	3	1	1	262	2	10	0	9	1	2	24
BEGUSARAI	29,41,305	30.60%	288	31	18	2	1	1	341	2	15	0	16	1	1	35
BHAGALPUR	30,28,448	33.10%	280	46	16	3	2	1	348	2	6	0	11	2	1	22
BHOJPUR	28,09,720	21.90%	**286**	**13**	**14**	**3**	**1**	1	318	2	12	11	0	1	1	27
BUXAR	17,53,871	14.50%	**156**	**27**	**11**	**0**	**2**	1	197	2	7	0	10	0	2	21
DARBHANGA	41,26,712	30.20%	**258**	**51**	**18**	**2**	**1**	0	330	2	10	0	11	0	3	26
GAYA	43,48,204	20.40%	441	49	24	2	0	1	517	2	24	22	0	1	2	51
GOPALGANJ	26,94,031	41.40%	186	22	14	3	1	1	227	3	13	14	3	0	2	35
JAMUI	17,50,282	18.40%	166	21	10	3	1	1	202	0	10	6	3	0	1	20
JEHANABAD	18,95,396	65.30%	88	40	7	2	0	1	138	3	3	5	0	1	1	13
KAIMUR	16,14,250	49.80%	117	17	11	2	1	1	149	0	13	7	0	1	2	23
KATIHAR	29,94,178	21.70%	295	32	16	1	0	1	345	2	13	3	15	2	2	37
KHAGARIA	16,03,025	55.30%	150	18	7	1	0	1	177	5	10	5	0	1	1	22
KISHANGANJ	16,22,498	23.50%	136	8	7	2	1	1	155	2	9	7	1	0	1	20
LAKHISARAI	10,03,919	33.70%	102	13	8	1	1	1	126	2	5	0	3	0	1	11
MADHEPURA	19,10,491	35.20%	196	23	13	0	0	1	233	2	9	0	13	1	1	26
MADHUBANI	44,74,149	33.50%	642	76	19	3	1	1	742	2	18	17	0	0	2	39
MUZAFFARPUR	46,87,926	27.60%	467	47	16	1	0	1	532	3	13	14	0	1	1	32
NALANDA	29,66,174	39.40%	261	36	20	3	1	1	322	4	18	18	0	0	0	40
NAWADA	22,63,881	26.60%	127	27	14	2	0	1	171	3	9	0	11	0	1	24
West CHAMPARAN	38,07,281	44.10%	367	25	18	2	1	1	414	4	13	12	1	1	2	33
East CHAMPARAN	49,30,676	33.90%	309	46	27	1	0	1	384	3	17	0	19	0	1	40
PURNIA	31,83,465	23.90%	278	34	14	2	0	1	329	2	12	10	2	0	3	29
ROHTAS	30,66,440	34.30%	119	40	19	2	2	1	183	2	17	17	0	0	2	38
SAHARSA	18,87,284	22.20%	162	33	10	0	0	1	206	0	0	9	1	0	1	11
SAMASTIPUR	42,39,495	61.80%	355	59	21	1	3	1	440	3	14	16	1	0	4	38
SARAN	40,62,789	37.90%	409	45	20	3	0	1	478	4	12	10	1	1	1	29
SHEIKHPURA	6,57,498	60.4%	73	18	6	1	1	1	100	3	3	0	4	1	1	12
SHEOHAR	6,46,066	17.80%	26	7	5	1	1	1	41	0	19	2	1	0	1	23
SITAMARHI	33,60,786	11.60%	204	38	17	2	0	1	262	2	16	17	0	2	1	38
SIWAN	33,97,534	38.00%	313	34	19	3	0	1	370	19	19	0	18	0	2	58
SUPAUL	21,62,548	40.80%	178	28	11	2	0	1	220	8	9	0	11	0	1	29
VAISHALI	34,02,828	46.70%	317	36	17	3	1	1	375	2	13	16	0	0	2	33

State: Bihar												
District wise : Infrastructure Gaps and Budgets												
No. of High Focus Districts : 6												
Name of the district	Physical gaps in Level I infrastructure				Physical gaps in Level II infrastructure				Physical gaps in Level III infrastructure			
	No. of Beds required	Partial Constructions *	Renovation/ Minor repair *	Staff Qrtrs.	No. of Beds required	Partial Constructions *	Renovation/ Minor repair *	Staff Qrtrs.	No. of Beds required	Partial Constructions*	Renovation /Minor repair*	Staff Qrtrs.
ARARIA	70	13 LR, 13 NBC, 25 Toilets	11 SQ	41	168	3 LR, 7 CSU, 4 NBC, 14 Toilets	15 SQ, 3 LR, 12 Toilets	41	0	1 LR, 1 OT, 1 SCNU, 2 NBC, 4 Tiolets	6 SQ, 2 Toilets, 1 OT, 1 LR	22
AURANGABAD	13	13 LR, 11 NBC, 14 Toilets	16 SQ, 4 Toilets	30	4	7 CSU, 6 NBC , 11 Toilets	30 SQ, 6 LR, 1 NBC, 6 Toilets	26	11	4 SCNU, 4 NBC, 3 BSU, 12 Toilets	10 SQ, 3 OT , 4 Toilets	46
Arwal	46	8 LR, 9 NBC, 18 Toilets	2 SQ	36	20	4 CSU, 4 NBC, 12 Toilets	4 SQ, 4 LR, 4 Toilets	20	24	1 OT, 1 LR, 2 Toilets	12 SQ, 1 LR, 1 SCNU, 1 OT, 6 Toilets	12
BANKA	72	12 LR, 12 NBC, 22 Toilets	1 SQ, 6 Toilets	44	168	6 LR, 7 CSU, 7 NBC, 21 Toilets	24 SQ, 1 LR, 3 SCNU, 3 NBC, 4 Toilets	70	0	1 OT, 1 LR, 2SCNU, 1 NBC , 3 Toilets	13 SQ, 1 OT, 1 LR, 1 NBC	Existing
BEGUSARAI	54	9 LR, 9 NBC, 9 Toilets	0	36	120	16 CSU, 16 NBC, 96 Toilets	0	107	0	2 SCNU, 2 NBC	0	30
BHAGALPUR	21	7 LR, 8 NBC, 10 Toilets	0	28	162	11 CSU, 11 NBC, 16 Toilets	15 SQ, 1 LR, 12 Toilets	40	0	1 LR, 2 SCNU, 3 NBC, 2 BSU, 3Toilets	0	Existing
BHOJPUR	64	12 LR, 14 NBC, 14 Toilets	0	60	222	1 LR, 11 CSU, 11 NBC, 6 Toilets	0	66	0	2 SCNU, 2 NBC, 1 BSU	0	Existing
BUXAR	46	9 NBC, 7 Toilets	0	32	57	2 LR, 10 CSU, 10 NBC, 25 Toilets	10 SQ, 11 Toilets	57	75	2 SCNU, 2 NBC, 2 BSU, 10 Toilets	2 Toilets	40
DARBHANGA	17	4 LR, 16 NBC, 10 Toilets	11 SQ, 12 LR, 13 Toilets	40	216	11 CSU, 10 NBC, 9 Toilets	28 SQ, 11 Toilets	47	64	3 OT, 1 LR, 3 SCNU, 3 NBC, 3 BSU, 8 Toilets	9 SQ, 2 LR, 5 Toilets	28
GAYA	130	26 LR, 26 NBC, 52 Toilets	0	104	190	5 LR, 20 CSU, 20 NBC, 61 Toilets	28 SQ, 2 LR, 1 CSU, 1 NBC, 7 Toilets	140	130	2 OT, 1 LR, 4 SCNU, 4 NBC,1 BSU, 6 Toilets	52 SQ, 1 OT, 1 LR, 1 BSU, 26 Toilets	26
GOPALGANJ	69	15 LR, 16 NBC, 26 Tlts.	6 SQ, 1 LR	58	12	3 LR, 14 CSU, 14 NBC	32 SQ, 1 LR, 56 Tlts.	68	0	2 CSU, 2 NBC, 9 Toilets	3 SQ, 3 OT, 1 LR, 2 BSU, 3 Toilets	27
JAMUI	60	10 LR, 10 NBC, 16 Toilets	0	40	0	9 CSU, 9 NBC, 11 Toilets	13 SQ, 7 LR, 18 Toilets	30	0	1 SCNU, 1 NBC	6 Toilets	15
JEHANABAD	21	2 LR, 6 NBC, 9 Toilets	4 LR	21	0	4 CSU, 3 NBC, 6 Toilets	10 SQ, 1 LR, 5 Toilets	30	65	1 SCNU, 4 Toilets	1 SQ, 2 Toilets	29
KAIMUR	102	17 LR, 17 NBC, 34 Toilets	0	68	146	7 CSU, 7 NBC, 21 Toilets	14 SQ, 14 LR, 7 Toilets	42	60	3 SCNU, 2 NBC, 2 BSU, 8 Toilets	2 Toilets	42
KATIHAR	82	15 LR, 15 NBC, 30 Tlts.	0	58	240	3 LR, 15 CSU, 15 NBC, 45 Toilets	30 SQ, 12 LR, 15 Toilets	90	270	1 SCNU, 7 CSU, 8 NBC, 4 BSU, 18 Toilets	6 SQ, 2 OT, 2 LR, 3 Toilets	44
KHAGARIA	70	15 LR, 15 NBC, 25 Toilets	0	55	96	5 LR, 5 CSU, 5 NBC	20 Toilets	40	45	2 LR, 2 SCNU, 2 NBC, 2 BSU	2 OT, 12 Toilets	30
KISHANGANJ	58	11 LR, 11 NBC, 11 Toilets	0	34	168	8 CSU, 8 NBC, 16 Toilets	0	64	0	1 SCNU, 4 Toilets	1 NBC	15
LAKHISARAI	22	5 LR, 7 NBC, 11 Toilets	1 LR	28	48	3 CSU, 3 NBC, 1 Toilets	0	24	0	1 SCNU, 1 NBC	0	12
MADHEPURA	58	11 LR, 11 NBC, 20 Toilets	0	42	180	4 LR, 13 CSU, 13 NBC, 25 Toilets	25 Toilets	93	75	1 OT, 1 LR, 1 SCNU, 1 CSU, 1 NBC, 1 BSU, 12Toilets	0	30

MADHUBANI	84	21 LR, 29 NBC, 30 Toilets	2 SQ, 1 NBC, 3 Toilets	77	286	16 CSU, 17 NBC, 37 Toilets	8 SQ, 2 LR, 1CSU, 2 NBC, 1Toilets	101	70	2 SCNU, 2 NBC, 1 BSU, 4 Toilets	2 LR	30
MUZAFFARPUR	84	16 LR, 16 NBC, 16 Toilets	0	61	336	14 CSU, 14 NBC, 8 Toilets	0	84	0	2 SCNU, 2 NBC, 1 BSU	0	36
NALANDA	110	21 LR, 21 NBC, 41 Toilets	2 SQ	103	253	4 LR, 17 SCNU, 17 NBC, 31 Toilets	19 SQ, 14 LR, 16 Toilets	117	25	2 SCNU, 2 NBC, 1 BSU, 2 Toilets	14 SQ, 3 OT, 2 LR, 1 BSU, 12 Toilets	16
NAWADA	48	10 LR, 12 NBC, 29 Toilets	0	49	192	2 LR, 11 CSU, 11 NBC, 22 Toilets	0	66	0	1 SCNU, 1 NBC	0	12
PASCHIM Champaran	8	17 LR, 17 NBC, 30 Toilets	26 SQ	34	0	3 LR, 15 CSU, 15 NBC, 45 Toilets	30 SQ, 12 LR, 15 Toilets	90	69	1 OT, 1 SCNU, 2 CSU, 3 NBC, 1 BSU, 8 Toilets	14 SQ, 3 OT, 3 LR, 2 BSU, 9 Toilets	24
PURBI CHAMPARAN	108	11 LR, 20 NBC, 31 Toilets	10 Toilets	78	456	19 CSU, 19 NBC, 57 Toilets	19 LR	152	0	1 SCNU, 1 NBC, 1 BSU, 6 Toilets	2 OT, 1 LR	6
PURNIA	18	14 LR, 14 NBC, 21 Toilets	4 LR	49	45	5 CSU, 2 NBC, 4 Toilets	9 SQ, 3 Toilets	27	160	1 OT, 1 LR, 3 SCNU, 3 NBC, 1 BSU, 6 Toilets	12 Toilets	40
ROHTAS	106	19 LR, 19 NBC, 36 Toilets	0	74	0	16 NBC, 48 Toilets	0	128	45	2 SCNU, 2 NBC, 1 BSU, 5 Toilets	0	Existing
SAHARSA	64	11 LR, 11 NBC, 22 Toilets	0	44	126	14 Toilets	20 SQ, 6 LR, 9 Toilets	51	0	1 NBC	10 SQ, 1 LR, 1 BSU, 6 Toilets	Existing
SAMASTIPUR	92	16 LR, 16 NBC, 32 Toilets	0	128	69	4 LR, 1 CSU, 1 NBC, 48 Toilets	37 SQ, 4 LR, 7 Toilets	83	90	3 SCNU,2 NBC, 1 NBC, 19 Toilets	19 SQ, 5 Toilets	48
SARAN	116	14 LR, 16 NBC, 16 Toilets	0	64	199	12 CSU, 12 NBC, 11 Toilets	0	66	0	2 SNUC, 2 NBC, 1 BSU	0	22
SHEIKHPURA	24	6 LR, 6 NBC, 6 Toilets	0	21	24	4 CSU, 1 Toilets	1 SQ, 4 LR	18	0	2 SCNU, 1 BSU, 4 Toilets	0	19
SHEOHAR	96	19 LR, 19 NBC	38 Toilets	76	51	3 CSU, 3 NBC,3 Toilets	3 SQ, 1 LR	19	50	1 SCNU, 1 NBC	6 Toilets	13
SITAMARHI	82	15 LR, 15 NBC, 28 Toilets	0	56	264	14 LR, 14 CSU, 17 NBC, 68 Toilets	0	127	131	2 OT, 1 LR, 2 SCNU, 2 NBC,2 BSU, 14 Toilets	0	45
SIWAN	152	38 LR, 38 NBC, 57 Toilets	0	133	102	5 LR, 17 CSU, 17 NBC, 17 Toilet	96 SQ, 51 Toilet	40	115	2 OT, 1 SCNU, 2 NBC, 1 BSU, 12 Toilet	3 SQ, 2 LR, 4 Toilets	13
SUPAUL	70	17 LR, 17 NBC, 34 Toilets	0	60	222	11 CSU, 11 NBC, 22 Toilets	11 LR, 22 Toilets	88	0	1 NBC, 1 BSU	2 SQ	11
VAISHALI	80	14 LR, 13 NBC, 27 Toilets	13 SQ	42	224	16 BSU, 32 Toilets	0	128	95	1 SCNU, 1 BSU, 4 Toilets	0	27

***No. of facilities requiring partial constructions or minor repairs and renovations.**

For Partial constructions take only: LR, SCNU/NBSU/NBC, OT, BSU. Toilets and other construction to be included in Minor repairs /construction

No new building construction is required.

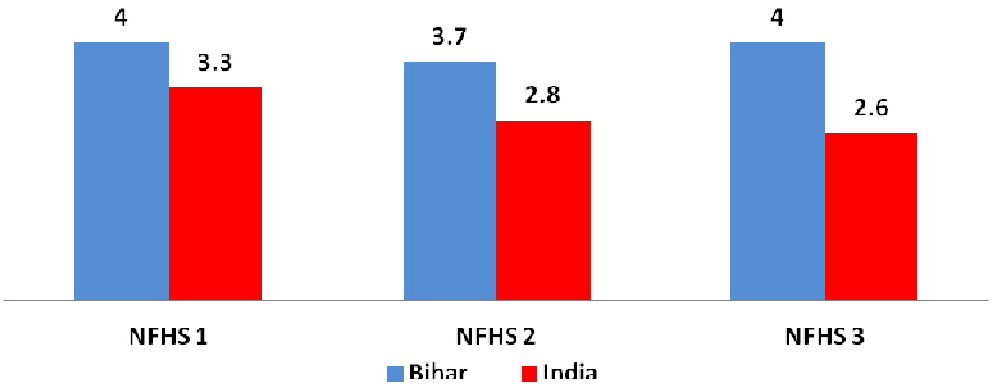
Family Planning Repositioning

Introduction

As per DLHS-3 data only 28.4 percent of eligible couples use any modern method of Family Planning in Bihar. Between the age of 20-24 years 68 percent of girls get married. 44.4 percent of reproductive age group women (having two children) want no more children.

Short birth interval adversely affects the health of mother and the chances of survival of new born. Recent research has shown that the optimal birth interval between subsequent children is 3 to 5 years for reducing neonatal mortality, infant mortality and to achieve optimal nutrition outcomes. NFHS-III data shows that the median age at first birth for women in the age group 25 to 49 years is 18.7 percent. Therefore, at least three years spacing between successive births in the state needs to be promoted vigorously in order to help reduce maternal and infant mortality rates. To reduce the high unmet need (14.4 percent for spacing methods), Government of Bihar is striving to increase the percentage of eligible couples using spacing methods.

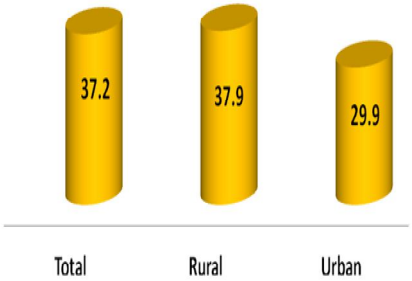
Total Fertility Rate of Bihar & India:



As per SRS 2008, TFR of Bihar is 3.9

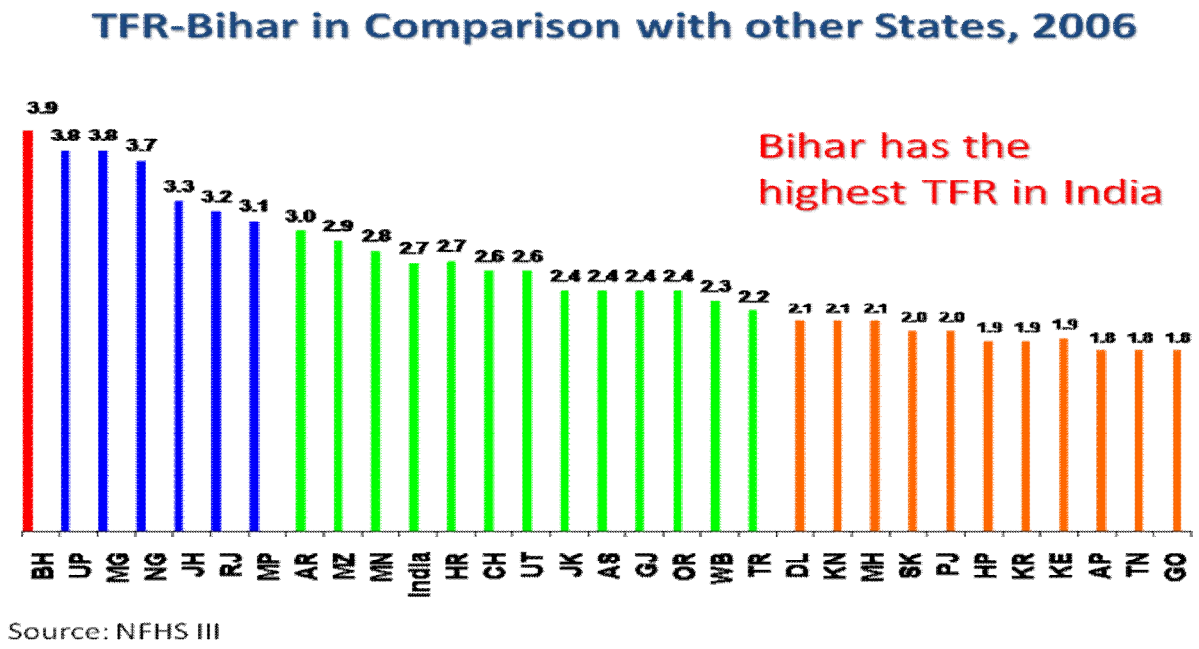
Current level of TFR Bihar State is 3.9 as per SRS data. A woman in the state will on an average give birth to 4 children during her reproductive lifetime. The decline of 0.3 was registered in TFR between NFHS 1 and NFHS 2 whereas it again witnessed a rise (of 0.3) during NFHS 3. However recent SRS data shows TFR as 3.9 and by 2012 it is expected that there may be 0.4 reduction in total TFR of Bihar.

Unmet Need of FP methods in Bihar



In Bihar the unmet need for family planning methods (sexually active couples who would prefer not to have a child but are not unable to use any method of contraception) is 37.2 percent (23% for limiting and 14 % for spacing methods). An overall decline in unmet need of 1.1 was witnessed between DLHS 2 (38.3) and DLHS 3 (37.2)

Interstate Comparison:



Source: NFHS III

As per NFHS III, national average of TFR is 2.7 but that of Bihar is the highest in the country. The TFR of states like Tamil Nadu, Goa and AP are below the replacement level. Efforts are being made by the state to plan for adequate family planning interventions to attain 0.2 reduction of TFR every year.

Key Goal: - Reducing TFR from 3.9 to 3.4 by 2011-12 (NRHM)

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 45% in 2011-12
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%

Core 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 (fast tracking of trainees from the identified facilities- as mentioned)

2. Training of MBBS doctors on Anesthesia
3. Training on IUCD: MOs, ANMs etc.

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

1.1.3 Incentive to acceptors of minilap operations

1.1.4 Training on minilap 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 through condoms, OCPs or IUDs

1.2.1 Update EC register with help of *ASHA*s and AWW

The eligible couple register is presently being updated once a year (usually in April) as per a survey mode. It is done in a hurry and may not have complete information in many cases. With the involvement of *ASHA*s and AWWs, updates should be done preferably prior to VHNDs. This will result in 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. Besides these innovative ways of expending reach especially to poor communities MMU (Medical Mobile Units) will also be explored. The access could also be expanded by utilizing Genric Drug Store to sell IUDs at subsidized rate as per prevailing govt. norms. The availability of condoms and OCPs with the volunteers and their geographical responsibilities should be widely known to the potential clients / beneficiaries. Before they are made the community based distributors, they should be properly trained and mechanism developed to regularly monitor them and review their performance

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

1.2.2.4 Organize monthly IUD Camps in PHCs/CHCs/SDHs IUD camps will be organized in each PHC/CHC/SDH every month. ANM and *ASHA* will inform about the dates on which the camps will be held in the concerned HSC.

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

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

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

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

1.3.1 Update EC register with help of *ASHA*s 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.

Objective No.2: To increase Couple Protection Rate

Strategies and Activities

2.1 Awareness generation in community for small family norm

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

2.1.2 Meetings with MSS, CBOs: Communication materials to be used for monthly MSS/CBO meetings will be prepared and distributed for use. These meetings will be scheduled during or preceding the month family planning camps are scheduled to be held.

2.2 Regularise supply of contraceptives in adequate amounts

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

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

Strategies and Activities

3.1 Promote the use of condoms

3.1.1 Counseling men in villages to demonstrate ease of use of condoms and for prevention of STDs: Male workers will assist the MPWs in addressing the meetings of men in villages to demonstrate the use of condoms and its benefits in family planning and prevention of STDs. It should be stressed that condoms are easy to use and is a temporary method. Current methods of family planning which target women are not very easy to adopt while condoms can be very easily used.

3.1.2 Regular supply of condoms and setting up depots which are socially accessible to all men : It is very essential to supply condoms through depots which can be easily accessible to men and confidentiality will also be ensured. During the meetings, the sources of condoms in the village will be made known to all. It will be ensured that

the client's identity will not be disclosed. The depot holder will be set up only on condition that he shall not reveal the identity of clients.

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

3.3 The male participation may also be increased by frequently exposing them to health system. This can be accompalished by health providers insisting that the male spouse be present atleast on three occasions (1) atleast one ANC check up (2) at the time of delivery and (3) atleast attending one session of child immunization. Other innovative ways to increase their participation will be explored and adolescents will be sensitized during Nehru Yuva Kendra (NYK) meetings and Kalyani Health Clubs and organizing sports like football, kabadi competitions and other activities.

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

4.1 Increase demand for NSVs (develop a cadre of satisfied NSV Client, who could be the advocates for NSV in their designated geographical areas. Orient and train them and give them specific geographical responsibility to give roster based talks etc to identified groups of probable clients. During these talks the probable clients can be registered and they could be escorted to the nearest static facility or the camp on designated days for NSV. Once the procedures completed, then these new clients can become advocates for the same. This entire process must be fully facilitated by respective PHCs and be provided with all logistics support along with some incentives for the work or activities undertaken by them)

4.1.1 Village level meetings in which men who already underwent NSV share experiences to motivate men to undergo NSV : All the GP/ADC Villages will be chosen in the district to hold meetings in which men who have undergone NSV will tell male members of their community about their experience and the benefits of NSV. These meetings will be repeated each month in the same batch of Gram Panchayat or ADC Villages. NSV will be conducted on the motivated men. The same men will then be requested to share their experiences in the next batch of five villages for the next three months.

4.2 Increase capacity for NSV services

4.2.1 Training of doctors for NSV

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

4.2.2 Organize NSV camps at the Sub District Level

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

5.1 A Quality Assurance Committee has been initiated in every district for monitoring the quality of sterilization in the district. The Civil Surgeon is the chairman of the committee with at least one Gynecologist.

5.2 Streamline the contraceptive supply chain & Monitoring

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

Action Plan for Strengthening Sterilization Services

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

Short Term Activities

State Level Activities:

1. Service Availability

Static Services

i. Ensure that district level facilities are fully equipped with manpower and equipments
ii. Availability of Sterilization services everyday at district hospitals, separately for, Males and Females
iii. Availability of Sterilization services at PHC level on at-least 3 fixed-days a week (these days could be fixed for the entire state)
iv. Demand generation activities: wide dissemination of information on the regular (daily and on fixed days) availability of the services
    - ☞ prominent display
    - ☞ workshop of key department functionaries, who in turn would disseminate the same to their line staff, who in turn will directly inform the public about the availability of services
v. CAMPS : The number of camps needs to be planned and based on the ELA of the districts (following SOP)-
    a. Districts must plan camps in various PHCs and locations based on the need, in the beginning of the year; this should be based on the past years records etc., and these must be shared in the beginning of the year with the state
    b. These camps must be planned round the year, they must be evenly distributed through out the year and wide publicity on the venue and dates of the camps, well in advance must be disseminated through out the respective catchment areas
    c. Availability of Providers
    d. Line listing of available Providers by Geographical Areas (DHQ, PHCs, SDH etc.)
        - Gynecologist,
        - Surgeon
        - Anesthetist
        - Nursing Staff

    a. Roster for year long Static Services Providers: Based on the above line listing form Surgical Teams for male and female sterilization separately, the teams then must be provided with earmarked days of the week at static centres, like the rotation duties in Medical Colleges and big private Nursing Homes. For example Team 1 will perform on Mondays and Wednesdays; Team 2 on Tuesdays and Fridays; and Team 3 on Thursdays and Saturdays etc. and on rotation one Team can be on call for emergencies on holidays etc.
    b. Roster for year long Camp Service Providers: Similarly, by camps the teams should be identified in the beginning of the year and their year-long roster be prepared and informed to them in advance. The evenness in providers' work load should be ensured such that it is not the situation that a few providers are doing all the surgeries while the remaining are doing none.
    g. Identification of Providers for Training: Line Listing of Providers for the same. It must be prepared for every district and every PHC in the district. Before the training begins for the identified future providers, their choice must sought as to the posting to the facility they would be interested in; as far as possible this should

be entertained. Based on this they should be trained and posted to the pre-identified facility in a time-bound fashion. This exercise should be done in advance and proper notification regarding the same should be widely publicised and disseminated. This activity should be very closely monitored by the State Health Society, in order to ensure its full operationalization. Once done, the training in phased manner should happen in a time bound fashion.

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

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

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

District Level Activities:

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

Long Term Actions

State Level Actions

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

District Level Actions

1. saturate training of all available providers
2. ensure presence of providers in all static facilities
3. institutionalize sterilization services

4. public private partnership
    a. line listing of the same
    b. dedicated pool of the same, MBBS doctors (ask them to perform surgeries at government facilities)
2. orient block level MOs in using data for monthly review and stocktaking

Family planning program of the state at a glance:

Strategies:

- To increase the sterilization coverage rate, IUD insertion and retention rate per 1000 eligible couple
- Increase in number of couples with two children for sterilization and with one child for IUD
- Micro-plan to cover poor performing areas, under-served and un-served communities
- Increase the number of sites offering FP services and also service providers in both public and private institutions.
- Increase number of centers providing quality IUD services
- Quality assurance and training- Training of ANMs for IUD 380A insertion.
- Contraceptive update seminars in districts
- Mobility support for surgeons
- Social marketing of contraceptives – outsourcing through an NGO
- Accreditation of more private family planning facilities under Public Private Partnership
- Availability of FP material with grass root level workers (ASHA, AWW etc)
- Increase male participation in acceptance of FP method but at the same time devises mechanisms to screen the eligible person as per the GOI guideline
- Increase access to EC pills
- More focus on post MTP counseling for family planning
- Expand the choice of method and its accessibility and availability. Regular uninterrupted availability of contraceptives to be ensured
- Studies and operational research to guide future course of action
- Provision for monitoring of the FW Programme in the field. Support for movement is planned for district and block level functionaries and also for state level monitors.
- The state plans to roll out post partum family planning programme. For this in the first phase state plans to orient select MOs and LHV/Nurses of all district level hospitals in post partum family planning methods. The training is proposed to be conducted after preparing trainers at all six Medical Colleges.
- Integration with other existing programmes. Attempts will be made to integrate ARSH (Adolescent Reporductive and Sexual Health) and NACP (National AIDS Control Programm) programme activities with FP programme activities through joint planning. For example: traning provided by ARSH to school principals and teachers will also include training / information on FP methods suited to adolescent. This would facilitate delay of the 1st Child considering high tennage pregnancies. To provide continuum of care, FP programme and MNCH activities will be integrated for example: every contract of the women with the health system will be utilized for providing FP information and services. This includes ANC contacts, delivery care, post natal contacts, child immunization contacts and growth monitoring during VHND.

- ☞ Pooling of counseling services- ARSH and NACP have already got counselors, the FP program proposes to train health providers in FP counseling and recruit counselors for medical colleges and FRU's (as proposed in this PIP elsewhere). This pool of counselors can optimally be utilized through integrated trainings and deployment.
- ☞ Increasing the accessibility of family planning products and devices through innovative methods of community based distribution (see below).

Current Interventions:

a) Eligible couple survey in every Village with help of ASHA
b) Minilap training for Medical Officers and Staff Nurse
c) Training of surgeons for NSV so as to ensure at least one NSV provider per district
d) Training of ANM & MOs for IUD-380 A no touch insertion technique
e) A scheme 'Yukti' is being launched in the state to accreditate private providers for safe abortion services as per existing rules
f) Micro planning at district level to reach all eligible couples to reduce the unmet need
g) Extra financial incentive planned to increase rate of sterilisation amongst couples with less than three children. Also financial incentive planned for couples accepting sterilisation after one or two girl children.
h) Planning at district level to increase IUD insertion rate among women with one child. Planned to seek services of FP motivators to motivate couples for FP services. Also planned to motivate females at the time of institutional delivery for PPFP
i) Ensure timely filing of insurance coverage in case of adverse events following sterilisation
j) To make all types of sterilization services available, three types of training programs will be conducted at district level as elaborated above (Mini-lap, NSV & IUD-380 A)
k) All ASHAs are being provided drug-kits with condoms and OC pills to ensure availability of FP material at grass-root level.
l) State is developing a post partum strategy for family planning

New Proposed Interventions

A). Social Marketing:

It may be mentioned that a major factor in the forward thrust to spacing methods in the country has been the increased use of socially marketed (SM) brands. As per DLHS-3 data the use of condom and pill in Bihar is just 1.4 and 1.1 percent respectively. Hence the state government has decided to take up a select district i.e. Patna on a pilot project basis to improve family planning services among rural, urban and peri-urban slum population through innovative social marketing. Financial support will be used to implement evidence-based social marketing activities targeting couples with one or more children to space their children at least three years apart. The proposed program will improve access to, and motivate couples to adopt modern spacing method. Development Partners like Janani, PSI, PFI will help in improving access to a basket of FP/ RH products and services like condoms, emergency contraceptive (EC), oral contraceptive (OCP), intrauterine devices

(IUDs). The state also proposes to install condom dispensing machines at all PHC/ other strategic locations in the selected district.

The Proposed Program is anticipated to produce the following results:

- ☞ Ensure availability of modern spacing method in 75% of slum and peri-slum areas through condom dispensing machine.
- ☞ Increase demand through a mix of communication medium for FP/RH products during project period.

Condom Dispensing Machine: In order to strengthen the supply chain for free condoms alternate means of making condom available among community will be explored. This will also help in reducing the stock out situation at grass root level by ensuring availability through an alternative distribution window. Anecdotal evidence suggests that sometimes community members hesitate to obtain contraceptives like condom over the counter. An option like condom dispensing machine will help in addressing both the issues.

Thus to enhance current use of condoms, it is proposed that condom dispensing machines may be installed at PHC, CHC, referral hospitals and other govt. health facilities. The intervention will be taken up in one district of Bihar on a pilot basis to assess the usage and availability of condom to the community. The suggested intervention will facilitate in following manner:

- ☞ Community members will have direct access to the product (govt. supplied free condom)
- ☞ Those community members who are hesitant to ask for condom can have the access through this facility
- ☞ This also serves as an alternative means through which community members can avail modern reversible contractive method (condom)

A social marketing agency will be awarded a contract on a pilot basis in any one of the district viz. Patna, Samastipur or Bhagalpur for this purpose. It is planned that a total of 35 to 40 condom dispensing machines will be installed at various Govt. health facilities as per Civil Surgeon's opinion.

Condom dispensing machine will be installed at a certain height so that it's not within the reach of children, where as adults can avail the facility. It will also be taken care of that the machine is not been installed on the way (entry or exist point) but at a suitable location (offering reasonable privacy) within the selected facility. One person from that particular Govt. health facility will be trained on how to refill the stocks at regular intervals, operate and conduct servicing as and when required. This person will be nominated by the head of that selected Govt. health facility i.e. MOIC, CS or any other doctor who is in charge.

B). Family Planning Counsellors (FP Corners at FRU level):

Counseling is a key component of family planning services. The time dedicated to talking with clients can help ensure correct use of and satisfaction with a chosen contraceptive method.

The state is establishing FP corners at all 76 FRUs, 6 Medical Colleges & 3 pre-identified hospitals (total 85). It is proposed to base counsellors in these units who would provide

counselling services to clients (women who have delivered in the institution) and also distribute condoms and OC Pills.

Role of Family Planning Counsellors

- ☞ Educate about the benefits of using family planning methods
- ☞ Create a comfortable atmosphere for family planning users
- ☞ Have respect for the values and attitudes of users
- ☞ Present information relating to FP services and choices clearly and help allay any fears
- ☞ Encourage the formulation of questions
- ☞ Listen and observe attentively & impartially
- ☞ Ask questions in a manner that encourages clients to share information and feelings
- ☞ Facilitate effective counselor-user interaction
- ☞ Speak in the language of the clients
- ☞ Educate and allay fear about the possible side effects
- ☞ Ensure and obtain additional supply

C). Family Planning Cell at State level:

to plan, implement, monitor and manage FP activities in the state. Given the high priority that FP Program has in the State there is an urgent need to provide extra hands and infrastructural support to State and districts for efficiently implementing the FP Program. So far, there is only one person managing the entire FP Program along with other programmes at the State level without any extra support. The State has already advertised for one Consultant-FP at State level while provision is there in the current PIP and revised organogram for Deputy Director-FP. Provision can be made for two Monitoring and Evaluation Assistants at State Level. Further the state is already in the process of recruiting additional Office Assistants, one of them will be provisioned in the FP cell.

Establishment cost heads (added in second quarter) for State FP Cell:

a) Two Laptops
b) One desktop, printer and Fax machine for official use
c) Furniture for the cell

D). Family Planning Cell at District Level:

In districts there is no specific Cell and staff to undertake FP activities. The State has identified Ddistrict FP Nodal Officers in the year 2010-11. Three day training was also organised at state level for these officers but they are not able to function as per expectation because of lack of manpower and IT support. It was unanimously felt by all Nodal officers that there was a need to establish District FP cell for coordinating FP activities. Therefore, FP Assistants are proposed in all 38 districts HQ of the state to assist FP nodal officers along with operational cost for FP Cell at district level to purchase Computers, Printers, and furniture for the districts.

E). Family Planning Contraceptive Update Seminar at State Level for MOICs, PHCs:

In recent times a number of new Guidelines and techniques have evolved on FP methods and FP Program. At the same time there has hardly been any specific FP training for the Medical Officers in the state. There is an urgent need for orienting all MOICs on latest FP Planning guidelines. For FY 2011-12 the state is trying to train a maximum of 200 PHC

MOICs in 10 poor performing districts of the state. This would be conducted with the help of SIHFW.

F). Post Partum FP/ PPIUD/PPS:

IUD coverage rate with one child in Bihar state is only 2.6 percent while IUD insertion after two children is 40.8 percent and more than 2 is 58 percent. Similarly post partum sterilization achievements are low. Hence, PPFP methods needs to be emphasized.This new initiative aims to meet the objective of imparting clinical skills for PPFP and immediate PPIUD (within 48hrs) after delivery at institute to scale up the family planning services in the state and decrease the unmet need for contraception.

JBSY has resulted in increased number of deliveries at the institutes (approximately 12 lakhs) and there is increased perceived need to provide PPFP services to these eligible females before they leave institution.

The demand is expected to further mount up after the state's initiative to deploy FP counselors at each of the medical college hospital and FRUs as proposed above. The expected increased demand will be met by trained manpower at each of these facilities.

It is proposed that two Medical Officers and two ANMs/LHVs from each of the district hospital will be trained during the year at designated medical colleges on PPFP/PPIUD. The clinical training involves three days of intensive skill building trainings on pelvic models and hands on experience on clients: the master trainers from medical college will provide the PPIUD clinical trainings to district hospital staff in the Medical College. Priorty will be given to those districts that have good JSY case load including good number of Medical Termination of pregnancies being done. Within these districts priority will be given to 2-3 facilities that outperform compared to other facilities. The svice providers in these selected facilities will be fast tracked for training to speed up PPFP services in the state. The training will be completed in 13 batches of 12 participants each (4 batches will be trained in each of the first three quarter and 1 batch in the last quarter). The total budget proposed for PPFP/PPIUD trainings is Rs. 6,29,460/-.

G). Motivational Support to health team for Family Planning

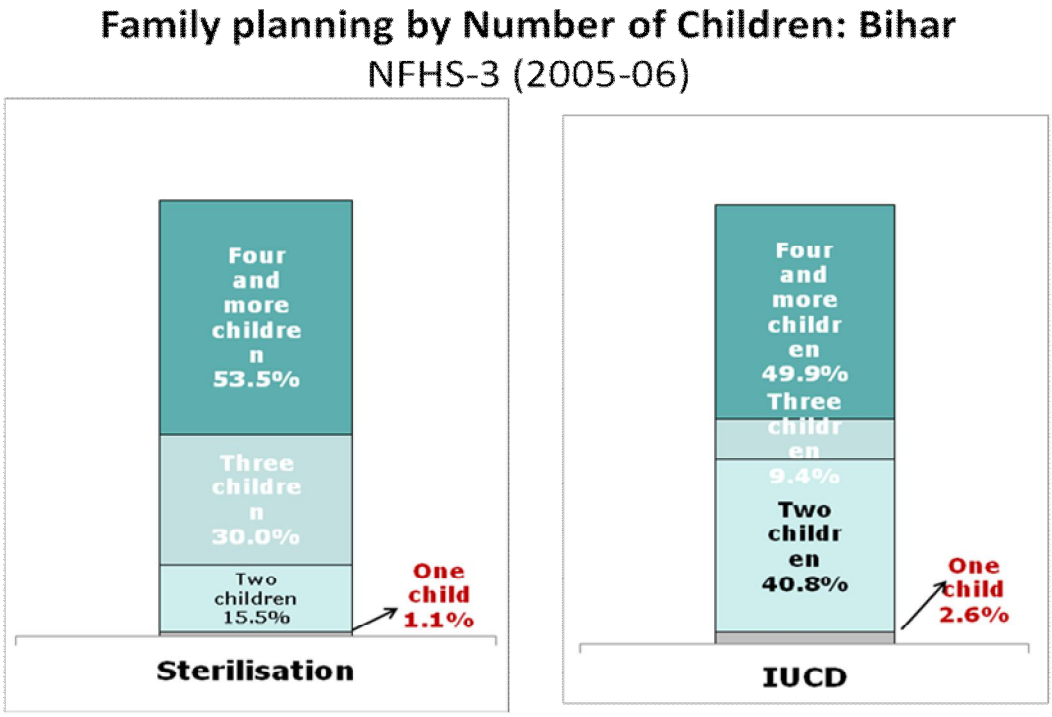
To scale up Family Planning, motivation is an important factor among the Health team and Administration and therefore it is proposed to give Prize/Award to best performing Districts, Blocks, ASHA, ANM etc. and Private Doctors also. Details are as follows:

Budget for award & prizes for Family Planning (Operation) Best performer (2010-11)			
S.N	**At State Level (Best performing District in FP)**	**Category/Description**	**Amount in Rs**
1	Award for 3 Best performing district to be given to District Magistrate & Civil surgeon	1st Prize	100000
		2nd Prize	75000
		3rd prize	50000
2	Consolation prize for two districts	Rs.40,000*2	80,000
3	2 Best performing division, to be given to Div.commissioner & RDD (Health)	Rs.1lakh/Division	200000
		Sub total (A)	**505,000**
	District level (Best performing blocks)		
4	3 Blocks in the district where no. of block is more	15*3*25000	1125000

	than 15 @ Rs. 25000/block (15 such districts)		
5	2 Blocks in the district where no. of blocks is less than 15 @ Rs. 25000/block (23 such districts)	23*2*25000	1150000
6	Best performing panchayat in each Block@10,000/panchayat	534*10000	5340000
		Sub total (B)	**7615000**
	Best performing Doctors & team		
7	Best performing team in each district @ Rs. 25000/team (Rs. 15000 to doctor & 10000 to other staff) 38 districts	38*25000	950000
8	Best performing *ASHA* per block (3 *ASHA* per block@2500, 2000 & 1500)		
	1st prize @ 2500/Block in 534 blocks	534*2500	1335000
	2nd prize @ 2000/*ASHA* in 534 block	534*2000	1068000
	3rd Prize @1500/*ASHA* in 534 block	534*1500	801000
9	Best performing ANM per block (1 ANM /Block @2500)	534*2500	1335000
		Sub Total (C)	**5489000**
	Promoting PPP in family planning, award for private doctors for best performance in each dist.		
10	1 st prize @ Rs. 25000 per districts to the surgeon performing maximum number of family planning operation but the minimum number of such operations should be more than 1000 (25 number of dist where doctors are empanelled)	25*25000	625000
11	2 nd prize @ Rs. 25000 per district to the surgeon performing more than 700 family planning operations (25 number of dist where doctors are empanelled)	25*20000	500000
12	3rd prize @ Rs. 15000 per district to the surgeon performing more than 500 family planning operations (25 number of dist where doctors are empanelled)	25*15000	375000
		Sub Total (D)	**1500000**
		Total (A+B+C+D)	**15,109,000**

H). Emphasis on Quality Work in Sterilization & IUD

Service Coverage:-Sterilization coverage per 1000 eligible couple as per state MIS have increased, while Sterilization coverage rate with two children is just 15.5 percent although 3 and more than 3 children sterilization is 85 percent. IUD coverage rate with one child in Bihar state is only 2.6 percent while IUD insertion after two Children is 40.8 percent and more than 2 is 58 percent.



Therefore, greater emphasis is needed on 2+ Sterilization. Districts which have high TFR i.e. 3.9 or > 3.9 is a major concern for population stabilisation.

Sterilization after two children in Bihar is only 15.5 percent which is of concern to achieve the replacement level. While sterilization after three children is 30 percent and after four or more children is 53.5 percent. Looking at the situation, this initiative is proposed in the PIP. Total budget proposed is Rs. 180,000,000 for 36000 proposed sterilizations :

		Amount of incentive proposed
Eligible couple for sterilization	Sterilization after one male, one female or two male child	Rs.5000/- to beneficiary

Adolescent Health

Situational Analysis

Adolescent (10 – 19 years), and particularly girls, constitute one of the most vulnerable sections of the society in Bihar. Adolescents comprises of roughly 24% of the population. As per 2001 census, the projected population of adolescents in Bihar in 2011 will be 23.4 million (24% of total population), of which 12.1 million (52%) will be male and 11.3 million (48%) female and several of them out-of-school: about 53% of 7 – 11 year olds in Bihar are not enrolled in school system (Census 2001). Adolescents, particularly girls and women, face many hardships in the society. They are the victims of neglect, ignorance and exploitation. It is therefore, pertinent to focus on their overall empowerment, development and growth, which will help evolve prosperous and healthy societies. Focusing on adolescents will also give desired push to achieving MDGs.

Large numbers of adolescents and young people are out of school, get married early, work in vulnerable situations, are sexually active and are exposed to peer pressure. Since there situation varies from place to place, therefore, any intervention to meet their demand should be flexible. The public health challenges for this group include pregnancy, excess risk of maternal and infant mortality, sexually transmitted diseases, reproductive tract infection, and rapidly rising incidence of HIV / AIDS. In context of reducing IMR. MMR, and TFR, addressing adolescent related health issues will pay rich dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complications, including access to early and safe abortion services and reduction of unsafe sexual behaviour. Poor infrastructure and lack of awareness are two main reasons for poor availability of services for the adolescents. Evidence shows that teenage pregnancy, before the age of 16 years, is negatively associated with maternal nutrition, birth weight and survival of the offspring. They suffer more from malnutrition and anaemia. They may have not received tetanus immunization. All this cumulatively lead to more maternal, perinatal, neonatal and infant mortality. Lack of availability of adequate privacy and confidentiality and judgemental attitudes of service providers are two other major gaps in service availability for adolescents and young people.

Gaps in knowledge and behavior of Adolescents and young people and their poor status: It is becoming widely known that Adolescents (10-19 yrs.) and young people (15-24 yrs.) in Bihar are much in need of services, reliable information and appropriate skills to address their health and nutrition concerns, including reproductive and sexual health (RSH). A recent Youth Survey of young people, aged 15-24 years conducted by IIPS and Population Council in 2006-07 shows that only 13% young women as against 30% young men have completed their high school in Bihar. Just 15% women and 28% men have comprehensive knowledge of HIV / AIDS and just about 12% women and 11% men have heard about STI. 46% women in the age group 20-24 are married before the age of 15 (and 33.4% in the age group of 15-24 before). 80% of 15-24 year old married women have already experienced pregnancy. As per NFHS III data, the use of any modern contraceptive methods by married adolescent women is barely 9% and their total unmet need for Family Planning is 36% (NFHS III), with spacing needs accounting for 33%.

Health problems among young people (15-24 yrs): as per the above Youth Survey, a significant minority of young people reported general, mental, and sexual problems in preceding 3 months before the survey: about 25% experienced high fever, 8% men and 22% women reported genital infection, 11% women reported menstrual problems, 20% men reported anxiety about nocturnal emission and about 16% young men and 9% young women reported symptoms indicative of mental disorders. Similarly, NFHS III (2005-06) survey shows that, 49% women vs. 28% men in the age group of 15 – 19 year are anaemic in Bihar.

Health care seeking behavior of young people (15-24 yrs.): The health seeking behavior of this group varies for different problems - while it is widespread for common ailments like high fever and injuries, it is not so for sexual and reproductive complaints. 92% men and 87% women seek treatment for high fever as against 22% men and 13% women for genital infections. Similarly, just 36% men and women seek care for menstrual disorders and anxiety associated with nocturnal emission. It is also noted that young people prefer private providers and others (including pharmacists, traditional healers etc.) over government providers / facilities for their problems, more so for sexual and reproductive complaints and even more so by women. Young women are found to be using government facility relatively less. The survey also found that a large proportion of young people were hesitant in approaching either health care provider or the medical shop for contraceptives, a finding that is significant given that 87% young women and 31% young men aged 20-24years are already married by age 20 in Bihar.

Economic activity and gender roles among young people: according to the Youth Survey, 33% of young women (63% men) are involved in paid-work, 57% (75% men) can make decision alone about spending money, and 30% (53% men) regarding buying clothes for themselves. Young women face considerable mobility restriction with only 13% (94% men) and 16% (77% men) being able to respectively move out of their village or visit a health facility unescorted. 30% young married women experience physical violence by their husbands.

Need to reach out to Adolescents, particularly girls and young women

At present there is no dedicated health and counseling services available exclusively for the adolescents and young people in the government health sector in Bihar. This fact corroborates the data above (and other data) that point to poor status of adolescents and young people in Bihar and more so women and members of marginalized communities. They, as a group are often ignored, especially in terms of availability of dedicated health services and benefits under various government schemes and initiatives. The problem becomes much acute given the different settings where adolescents and young people live, which are very diverse: in-school, out-of school, mobile stationary, rich poor, urban rural etc. This fact coupled with figures above makes a strong case to start dedicated and integrated adolescent and young people services, including clinical health services, counseling, and creating linkages with education, development and livelihood options for them.

Goals of ARSH Programme

1. To empower adolescents and young people with skills and knowledge to lead successful and satisfying lives

2. To create dedicated ASRH services at all levels of health department, catering to age specific clinical, counseling and developmental needs of adolescents and young people
3. To build linkages among health, education and welfare departments on adolescent issues to provide integrated services under the same roof at different levels of government functioning on aspects of health, education and livelihood options

New Proposed Interventions

A). Healthy Timing and Spacing of Pregnancies (HTSP) Initiative

State Concerns and Strategies

1.1 Population stabilisation

Despite RCH and previous programmes vigorously pursuing family planning objectives, fertility in Bihar continues to decline at much lower rates than the national average. Although the total fertility rate has declined by about half a child in the six-year period between NFHS-1 and NFHS-2, it has increased in NFHS-3 and again decreased as per SRS 2007 but still is far from the replacement level. Furthermore, certain groups such as rural, illiterate, poor, and Muslim women within the population have even higher fertility than the average.

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

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

- Lack of integration of the Family Planning programmes with other RCH components, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels.
- Failure of the programme to effectively undertake measures to increase median age at marriage and first childbirth.
- Inability of the programme to alter fertility preferences of eligible couples through effective behavior change communication (BCC).
- Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age groups. (Overall, sterilization accounts for 82 percent of total contraceptive use. User rates for pill, IUD and condoms remains very low, each at about 2 percent or less than 1%-NFHS III).

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

1.2 Adolescent Reproductive & Sexual Health

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

Bihar has one of the highest rates of early marriage (as per IIPS 2007, 69% among women aged 20-24 years) and high rate of childbearing. The prevalence of early marriage in India poses serious health problems for girls, including a significant increase of maternal or infant mortality and morbidity during childbirth. The following facts will help understand the situation objectively--

- Women aged 20-24 married by age 18 in Bihar is 60.3% (NFHS 3)
- Median age at first birth for women age 25-49 in Bihar is 18.7%
- Total fertility rate (children per women) in Bihar is 4

3 Background w.r.t Prachar model

Pathfinder International through its PRACHAR model highlighted family planning as a preventive intervention using the framework of "*Healthy Mothers, Healthy Babies, Healthy Families and Healthy Communities,"* to achieve significant changes in HTSP indicators in 552 villages in seven blocks each of Nalanda, Nawada and five blocks of Patna district during Phase I and 444 villages in two blocks each of Nalanda, Nawada, Patna, three blocks of Gaya and one block of Sheikhpura district of Bihar.

- By the end of 2008, the percent of women aged 15-24 using contraception increased significantly from 4.3 to 20.7 percent in intervention areas, as compared to an increase from 2.8 to 4.7 percent in non-intervention areas.
- Similarly, among women with one child, contraceptive use increased significantly from 6 to 25 percent as compared to an increase from 4 to 7 percent in comparison areas

Along with the other activities which are already being done for Population stabalisation following may also be added.

4 Technical Objectives, Strategies and Activities

The project aims to transform attitudes and behaviors to accelerate the use of and demand for contraception to delay and space pregnancies among youth and newly wed couples in three (3) districts of Bihar. Using a life stage specific behavior change communication model to change Healthy Timing and Spacing in Pregnency (HTSP) related beliefs, attitudes, and practices in areas where women and girls have traditionally been married young, faced extreme social and economic inequality, and been pressed by parents, in-laws, and the wider community to prove their fertility by bearing children immediately.

It is proposed that the project will be taken up in 3 districts in the year 2011-12 by integrating it under NRHM-

1. East Champaran
2. Khagaria
3. Darbhanga

4.1.1 Objectives

1. To delay the first pregnancy till the mother is 21 years

2. To space subsequent pregnancies by at least 36 months

4.1.2 Strategies

a. Change the beliefs held by young people between the ages of 12 and 24 regarding RH/FP, challenge traditional behavior patterns of early childbearing and inadequate spacing between children, and promote informed and healthy reproductive behavior.

b. Change beliefs held by parents of adolescents and influential community adults about RH/FP, provide them with knowledge and education to discourage early marriage of their daughters, curb the pressure that they place on young couples for early childbearing, and encourage adequate spacing of subsequent children.

c. Increase the use of contraceptives among young married couples, particularly to delay the first child until the mother is at least 21 years, and to space subsequent births by at least 3-5 years.

d. Enhance the quality of basic maternal and child care, reproductive health, and family planning services delivered by community-based traditional birth attendants (dais) and informal rural medical practitioners (RMPs).

4.1.3 Justification of the activities in the proposed HTSP initiative

Nearly 60 percent of adolescent boys of the age 15 to 17 attend school in Bihar while only 34.7 percent of girls belonging to same age group attend school. Since most of the adoloscent girls are not making use of school programs, they must be reached through community-based programs that are approved by their parents and village leaders.

Till now the family planning and contraception is driven by legitimate concerns about population, the environment, and poverty. But for the most part, those efforts have sought to motivate women who have completed their families to end childbearing altogether. Little attention has been focused on the sizeable population of adolescents just entering their reproductive years. Young couples in their peak reproductive years, who need motivation to delay and space children, have not received much guidance on how to ensure planned, happy, and healthy families. In addition, FP programs have historically targeted women, neglecting the important role that men play in decision-making about having children.

The project seeks to promote major attitude and behavior changes in youth—as well as their parents and influential community members—related to delaying a first child and spacing subsequent children. The hypothesis underlying program implementation is that if at least 80 percent of the members of each primary target

group were reached with appropriate and understandable messages, it would maximize the chances of changing the beliefs and behavior of at least 20 percent of the members of these groups. The conversion of this critical mass would ensure that the new beliefs and behaviors would be sustained and continue to grow in the community.

4.1.4 Activities

4.1.4.1A group of Master trainers will create a pool of trainers by increasing the technical capacity of government staff at the block and district level working in Reproductve Health (RH)/Family Planning (FP) to train and provide supportive supervision to frontline workers as ASHAs, ANMs and Male Communicators (MCs). The plan is to train the staff in all the aspects of HTSP, as well as in sexuality and adolescent development. Over the course of 12 months the staff has to be trained in :

a. Dealing with traditionally taboo subjects such as reproductive health, family planning, and sexuality.
b. How to conduct the group meetings and home visits required by the HTSP initiative.
c. Communication skills and the ability to translate RH/FP material learned in the classroom into messages that could be understood and accepted by communities.

4.1.4.2 A large community meeting to launch the project in each village. Government officials, teachers, landlords, medical providers, and others with community stature—including religious leaders—will be invited. This will be an opportunity to inform the broad community of the goals of the project, placing special emphasis on the health improvement and long-term family welfare of community youth. The meetings were crucial to community acceptance of the project.

4.1.4.3 Community Mapping: A database will be prepared through door-to-door canvassing; ASHA and Male Communicators (MCs) will introduce themselves and the project to the community and gathered the names, ages, and other specifics about members of targeted populations: adolescents, about-to-be-married young people, newlyweds, and young couples with one child.

4.1.4.4 Newlywed couple will be sensitised/educated/trained/counselled to promote their ability to make informed choices about the use of contraceptives to delay the first child until the wife reached the age of 21.

4.1.4.5 Couples having one child will be sensitised/educated/trained/ counselled by ASHA and MCs to have an interval of “two to three years” between children, to realize the maximum maternal and child health and survival benefits of birth spacing using home visits and group meetings. They will also be encouraged to adopt post-partum contraception within 45-90 days of delivery of the first child.

4.1.4.6 As girls enter adolescence (12-14years of age) and go through menarche, they need education on the physical and psychological changes they are experiencing, as well as information on menstrual hygiene, anemia, nutrition, and the connection between menstruation and conception. Traditionally, girls in Bihar learn about these things indirectly and piecemeal, much of the information laden with superstition and misconceptions based on beliefs passed down through generations. *(These girls will be trained using Reproductive Health Guide for Educators of 12-14 Year Old Girls. IEC materials like comic books will be distributed among the girls of this age so they understand the facts around menstruation and menstruatal hygiene.*

4.1.4.7 Older adolescents will be trained using Prachar project's well tested Reproductive Health Guide for Educators of 15-19 Year Old Adolescents by the ASHAs and MCs. Because these adolescents are at the age of marriage common in Bihar, training emphasized the dangers of early marriage and childbirth, as well as the importance of a woman postponing the birth of herfirst child until the age of 21.

4.1.4.8 As project activities are expected to increase demand for RH/FP services and products in intervention villages, local government health administrators at the district and block levels, will be work towards improving the availability of local services.

4.1.5 Monitoring Information and Evaluation System

The system of monitoring and evaluation that would provide concise and credible demonstration of the effectiveness and/or weaknesses of each component of the program needs to be created.

Key indicators are selected to measure changes in knowledge, attitudes, and behavior of specific demographic groups.

Five methods of measurement will be used used:

- **a.** Records and service statistics of ASHAs and MCs.
- **b.** Longitudinal analysis of project records and service statistics.
- **c.** Pre- and post-training tests.
- **d.** A survey to measure the effectiveness of BCC messages.

4.1.5.1 The indicators for the proposed intervention are :

- **a.** median interval between marriage and first child;
- **b.** how soon after marriage and delivering the first child couples commenced contraceptive use;
- **c.** the duration of contraception use.

4.1.5.2 Outcome indicators

- **1)** % increase in median interval between marriage and first birth
- **2)** % women using contraception for delaying first child
- **3)** % of newlywed contraceptive adopters using contraception from the consummation of marriage
- **4)** % women using contraception for spacing second child
- **5)** % first time mothers using contraception who adopt FP within 90 days of delivery
- **6)** % youth who believe that FP to delay the first child is necessary and safe
- **7)** % adults who believe that FP to delay the first child is necessary and safe
- **8)** % youth who believe that early child bearing is injurious to health of mother
- **9)** % adults who believe that early childbearing is injurious to health of mother

5 Trainings under proposed HTSP initiative

5.1 Training of ASHAs:

5.1.1 A four-day master training for selected government trainers as Master Trainers in HTSP

5.1.2 A four-days training of trainers will be conducted for MOs and DPMs to train them as trainers and for providing supportive supervision to ASHAs.

5.1.2 The trained trainers (MOs and DPMs) conduct a four- day non residential module based training focusing on communication related to HTSP for all ASHAs in batches of 25 ASHAs each. Training will be conducted at the PHCs.

5.2 Training of Male Communicators (MCs):

There is a severe shortage of male frontline health workers in the state. It is necessary to develop a public private partnership model in which selected block based NGO will indentify the required number of MCs and manage the intervention (group meetings) with men.

5.2.1 A four-days training of trainers will be conducted for MOs and DPMs to train them as trainers and for providing supportive supervision to MCs. This training can be clubbed with the TOT of ASHAs as the content is nearly the same.

5.2.2 The trained trainers (MOs and DPMs) conduct a four- day non residential module based training focusing on communication related to HTSP for all MCs in batches of 30 MCs each.

5.3 Training of Adolescents

5.3.1 ASHAs with the help of MCs will identify and mobilize the adolescents from their respective villages for training. They will also provide information on content as well as importance and benefits of training to the parents/guardians of adolescents.

5.3.2 Three days non residential module based adolescent training will be conducted by the ASHAs and MCs/ or trainers identified by the selected NGOs focusing on importance of appropriate age of marriage, delaying first birth till the woman is 21 years of age and spacing subsequent births by at least 36 months.

6 Budget

6.1 ASHA Training Budget for HTSP (District cost)

		Basis of computation	Budget(Rs)
I	Master Training of ASHAs:		
	Trainers (@ 4 trainers per block)	60	
	Training days	5	
	# of batches	4	
1	TA/DA per person	Rs. 600 x 60 persons x 5 days	180,000
2	Food (including 2 trainers)	Rs. 200 x 62 persons x 5 days	62,000
3	Training Kit (@ 4,000 per person)	Rs. 1000 x 60 participants	60,000
	TOTAL		302,000
II	Training of ASHAs		
	# of ASHAs	1,850	

	# of training batches (@ 25 ASHAs per batch)	74	
1	Training cost per batch (including, TA/DA, venue, food, stationery etc)	Rs. 100 x 25 ASHAs x 5 days x 74 batches	925,000
2	TA/DA per MT	Rs. 200 x 74 batches x 2 MTs x 4 days	118,400
	TOTAL		1,043,400
III	GRAND TOTAL		1,345,400

6.2 Adolescent training Budget for HTSP (District cost)

		Basis of computation	Budget (Rs)
I	Master Training of Adolescents:		
	Trainers (@ 1 BMC as trainers per block)	15	
	Training days	3	
	# of batches	1	
1	TA/DA per person	Rs. 200 x 15 persons x 3 days	9,000
2	Food (including 2 trainers per batch)	Rs. 200 x 17 persons x 35 days	10,200
3	Training Kit (@ 4,000 per person)	Rs. 4000 x 15 participants	60,000
	TOTAL		79,200
II	Training of Adolescents		
	# of Adolescents (15% of total population)	225,000	
	20% of Adolescents universe	45,000	
	# of training batches (@ 30 Adolescents per batch)	1500	
1	Training cost per batch (including, TA, venue, food, stationery etc)	Rs. 50 x 30 adolescents x 1500 batches x 3 days	6,750,000
2	TA/DA per MT	Rs. 200 x 1500 batches x 1 MT x 3 days	900,000
	TOTAL		7,650,000
	GRAND TOTAL		7,729,200

* Each trainer will conduct 100 batches of 3 days

6.3 MC training Budget for HTSP (District cost) to be conducted by NGO

		Basis of computation	Budget (Rs)
I	Master Training of MCs:		

	Trainers (@ 2 trainers per block)	30	
	Training days	5	
	# of batches	2	
1	TA/DA per person	Rs. 200 x 60 persons x 5 days	150,000
2	Food (including 2 trainers)	Rs. 400 x 62 persons x 5 days	217,000
3	Training Kit (@ 4,000 per person)	Rs. 4000 x 60 participants	240,000
	TOTAL		607,000
II	Training of MCs		
	# of MCs	1,500	
	# of training batches (@ 25 MCs per batch)	60	
1	Training cost per batch (including, TA/DA, venue, food, stationery etc)	Rs. 100 x 25 MCs x 5 days x 60 batches	750,000
2	TA/DA per MT	Rs. 200 x 60 batches x 2 MTs x 4 days	240,000
	TOTAL		**990,000**
	GRAND TOTAL		**1,597,000**
		Basis of computation	**Budget (Rs)**

6.4 Total Cost

	Activity	Budget (Rs)
6.1	ASHA Training	1,345,400
6.2	Adolescent training	7,729,200
6.3	MC training	1,597,000
	Total cost per district	10,671,600
6.4	**Total cost for 3 district**	**3,20,14,800**

B). ARSH Corners

1. To create and make functional ARSH Corners, providing exclusive ARSH services (clinical and counseling) at 3 district hospitals (Patna, Darbhanga, Gaya), and 63 PHCs (all PHCs of these 3 districts)
2. To build the capacity of health functionaries on ARSH at every level to make these ARSH Corners in various government facilities functional
3. To increase awareness in the masses on ARSH issues and ARSH Corners in particular

Target for financial year 2011-12

Ideally, these Corners (ARSH Corners) should be established across the state in all APHCs, PHCs, SDHs, DHs, Medical Colleges and state hospitals, but to begin with, in the first year, these centres should be established in 3 District Hospitals (Patna, Gaya and Darbhanga) and 63 PHCs (all PHCs of these 3 districts). 4 existing GoB Medical Officers

should be notified as state and district ARSH Nodal Officers (for 3 districts) to supervise state and district ARSH activities. To run these centres, minimum of these 4 Nodal Officers, 66 MOs (1 for each for 3 district hospitals and 63 PHCs) and 396 ANMs / Nurses (for 66 government facilities @ of 6 ANMs/Nurses per facility: 3 District Hospitals and 63 PHCs) should be trained on ARSH.

Broad Strategy

In the first year of the concerted effort by GoB to establish ARSH Services in the domain of NRHM, the need to reach out to adolescents and young people can be most effectively met by establishing network of dedicated ARSH Corners at government health facilities across the state and gradually making them the Centres of overall Adolescent and Young People Support, including services like counseling and providing linkages with education, development and livelihood options for adolescents and young people. Success of these centres will depend on wide publicity of these centres across the state (and districts), building proper linkages with grassroot level health infrastructure as much as it will depend on the range of quality services provided by sensitive, mature and responsive health staff, catering to the needs of the adolescents and young people.

To make this possible an ARSH Consultant is being recruited in SHSB and Nodal Officer for each of the districts to be notified and ARSH training to be provided to the earmarked doctors and Nurses / ANMs to make these facilities functional (with ARSH Corner) by the end of the financial year 2011-12. In Patna doctors have already been trained on AH. Additionally this PIP also proposes ARSH training to ASHAs, MOs & Adolescents under the Prachar project in 3 districts of Bihar. This initiative can be consolidated with ARSH Corner proposal.

Activities under specific strategies

Strategy 1: To increase access of ARSH Services (in government health facilities on a daily basis)

1. Create ARSH Corners in 3DHs (Gaya, Darbhanga, Patna)
2. Create ARSH Corners in 63 PHCs (all PHCs of 3 identified districts)
3. Notify one district ARSH Officer for each of 3 districts – 3 Nodal Officers
4. Develop a ToR for ARSH Corners for different levels of facilities
5. Develop a prototype ARSH Centre for DH, and PHCs
6. ARSH services to be provided 2 days in a week for the complete day to ensure accessibility and availability of services to Adolescnets as per their convenience

Strategy 2: To build capacity of identified health functionaries on ARSH

1. Train 4 Nodal officers (1 state and 3 district nodal officers)
2. Identify 66 MOs to manage and supervise ARSH Corners in 66 facilities identified to have ARSH Corners
3. Identify 660 ANMs / Nurses to be trained on ARSH to be posted in these ARSH Centres by rotation as per the rosters
4. Develop training calendar for training of 4 ARSH Nodal Officers, 66 MOs, and 660 ANMs/Nurses on ARSH
5. Identify the master trainers and training sites for the trainings
6. Develop budget for the training

7. Implement and monitor trainings
8. Facility/PHC MOs and ANMs/ASHAs to be placed in ARSH Corners besides their regular duty

Strategy 3: Create awareness on ARSH issues in communities and specifically on the ARSH Corners in government facilities

1. Inform about the functional ARSH Centres to all ANMs, ASHAs, AWWs, PRI members and VHSCs such that they can inform about the Centres and the availability of exclusive ARSH Services to the community
2. Develop / improvise and use IEC materials on ARSH
3. Use mass media to create awareness in the community on ARSH and availability of functional ARSH Corners – radio jingles, newspaper ads, TV spots etc.
4. Use forums like ASHA Diwas, monthly meetings of ANMs, monthly meetings of VHSCs and forums like VHND to sensitise the grass root level health functionaries on ARSH issues such that they can spread messages on ARSH in the community, with specific messages on availability of ARSH services at ARSH Corners in the government health facilities

Budget (for the year)

1. For establishing 3 ARSH Corners in 3 District Hospitals: Gaya, Patna, and Darbhanga
   Rs. 50,000/year x 3 DHs = Rs. 1,50,000
2. For establishing 63 ARSH Corners in 63 PHCs (all PHCs) of above 3 districts
   Rs. 25,000/year x 63 = Rs. 15,75,000
3. For Training (3-day training)
   a. For 4 Nodal Officers: 4 Nodal Officers x Rs. 400 x 3 days = Rs. 4,800
   b. For 64 MOs: 64 MOs x Rs.400/day x 3 days = Rs. 76,800
   c. For 396 ANMs/Nurses: 396 ANMs/Nurses x 3 days x Rs.300/day = Rs. 3,56,400
   d. Total Training (a + b + c): Rs. 4,38,000
4. **Total Budget (1+2+3)--**
   Rs.1,50,000 + Rs.15,75,000 + Rs. 4,38,000= **Rs.21,63,000**

C). Menstrual Hygiene :

A new scheme for the promotion of Menstrual Hygiene among adolescent girls (10-19 years) has been cleared by the mission streaming group of the NRHM. The reason being lack of availability of clean napkins, poor personal hygiene during menstruation and unsafe disposal of sanitary napkins in bins or in open or sometimes in the toilets themselves remains a serious issue impacting the education and health of adolescent girls. The scheme will be launched shortly through the Self Help Group at district Vaishali for the promotion of Menstrual Hygiene. After the FY the scheme will be reviewed to be expanded to other selected districts namely Gaya, Siwan, Bhojpur, Rohtas, Kaimur, Aurangabad, Buxar, Muzaffarpur & Darbhanga of the State.

Total Cost involved for sanitary napkin for 10-19 age group girls in 10 districts										
District	**Total Population**	**Girls (10-19)**	**No. of Napkin required in one year**	**COST**						**Total (in Rs.)**
				Cost of Napkin	**Cost of awareness programme**	**Cost for Channel development**	**Cost for storage**	**Cost for transportation**	**Incentive & seedmoney to Asha**	
Vaishali	2718421	299026.31	21529894.32	43059788.64	2718000	543600	430597.886	1076494.7	1484500	49312981

No. of Napkin required in one year : No. of beneficiaries x 6 x 12
Cost of Napkin : Rs. 2 / napkin
Cost for awareness programme: Rs. 1000/AWW
Cost for Channel development: Rs. 250/AW
W
Cost for Storage: 2paise/napkin
Cost of transportation : 5 paise/napkin
Incentive & seed money to Asha: No. of Asha in district x Rs. 300 one time impreset fund + 200 as cost of 12 packets of free sanitary napkin packets every year

Urban Health Programme

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

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

State Health Society Bihar is implementing phase II of RCH Programme under NRHM, a component of which is Urban Health. Though the NRHM focuses primarily on rural population, it acknowledges the condition of urban slums where proper interventions are equally important. However to focus solely on urban health, Govt. of India is planning to initiate National Urban Health Mission in near future.

As a preparation for Urban Mission, the Department of Health, GOB intends to and has already established Urban Health Centres in Bihar. The Programme aspires to address the health problems esp. problems related to RCH of vulnerable sections of urban population especially the slum dwellers. State Health Society Bihar has initiated certain measures towards Urban Health care and has been partnering with private partners like NGOs, Private Clinics for ensuring adequate primary health care delivery.

Background and Current Status

SHSB has already undertaken –

i) a separate Urban Mapping exercise under which in 37 cities all the urban slums/agglomerations have been mapped which shall be covered through scheme. Each UHC shall cater to at least 50,000 population in such a way that all the slum dwellers of that area are covered, out of which the size/magnitude of slum population would be around 20,000-30,000, including listed and unlisted slums and other vulnerable community habitations.

ii) **Focus on urban slums and underserved areas:** Till Oct 2010, against 32038 Urban sessions planned in Bihar a total of 26575 sessions held, % of session being held is 83%.

Status of Urban RI in major cties of Bihar are as follows-

Name of District	Total Urban sessions planned	Total Urban sessions held	% Sessions held
Patna	6150	5035	82%
Muzaffarpur	1915	1106	58%
Gaya	1734	1203	69%
Motihari	1255	1029	82%
Bhagalpur	788	521	66%
Begusarai	646	646	100%

Most of the sessions in Urban Patna is being done by the ANMs of the Rural blocks like Danapur, Phulwarisharif & Sadar. While in Gaya, there is a fixed set of ANMs at Sadar Hospital who perform the RI works of Urban.

In this background State Health Society invited Private Partners (Clinics) to set up Urban Health Centres which cater to particular slum areas. Urban Health Centres have been established to provide support to the Government's Health Programmes under which free OPD and facility is provided. 6 (six) Urban Health Centres have been started in following districts- Patna, Aurangabad, Bhojpur and Muzaffarpur.

Goal: To improve the health status of the urban poor community by provision of quality Primary Health Care Services, with a focus on RCH services to achieve population stabilization.

Objective: The main objective of the programme is to provide an integrated and sustainable system for primary health care service delivery, with emphasis on improved Family Planning and Child Health services in the urban areas of the state, for urban poor living in slums, be they notified or otherwise and other health vulnerable groups living in urban areas.

Specific Objectives-

- To provide and supplement primary health care services in urban areas particularly Reproductive and Child Health Services.
- To generate awareness, demand and promote behaviour change in urban population towards quality health services.

Services through UHC -

- Free Drugs, Free OPD, Immunization, Antenatal care (early registration, TT immunization, IFA supplements, nutrition counseling, Physical examination of ante-natal mothers including weighing, blood pressure, abdominal examination for position of the baby, identification of danger signs, referral services), Child Health services, including breastfeeding, immunization, management of diarrhoea and Treatment of minor ailments.
- Vaccines and drugs to be provided by respective DHS to UHC.
    - The Private Partner has the option to provide Delivery services and Family Planning services also.

Personnel per UHC: The following technically skilled, qualified personnel have to be engaged by the agency for providing the services mentioned: 1 no. Medical Officer (MBBS), Grade A Nurse/ANM (2 no.) and 1 no. other staff.

Experiences from previous years and Proposed Strategy:
SHSB with it's previous two year experiences proposes to change it's strategy of inviting expression of interests from private partners for setting up UHCs. From FY 2011-12, selection of private clinics/nursing homes/NGOs already operating hospitals or clinics shall be done through the District Magistrates and the District Quality Assurance Committees. Additionally seeing the shortage of manpower with the State Government, the provision of manpower for deputing in UHCs is being re-worked upon.

Monitoring and Evaluation: The centres shall send monthly reports to District Health Society in a prescribed format. The DHS/SHSB shall also conduct supervisory visits.

Services to be reported to DHS:

1(i) Number of children immunized
2(ii) Number of deliveries in the UHC (normal and assisted)
3(iii) Number of complicated deliveries referred
4(iv) If referred check if transport was provided/arranged
5(v) Number of live Births
6(vi) Number of FP Operations done (Male and Female)

Financial Pattern & Payment mode for UHC-

The following amount shall be payable per UHC each month→ (a)Salaries for manpower@60,000 + (b) Service Charge @15,000= Rs.75,000/-

Payment for each month shall be released to the agency by DHS on the basis of report of performance of UHC certified by the Government/SHSB staff deputed at the UHC for this purpose. The staff shall maintain registers about Attendance, OPD patients, Drug Inventory, Indoor patients, Children and Pregnant mothers immunized, Deliveries, Family Planning Operation (Male and Female) and Complicated deliveries referred.

Objective	Name of the cities identified for implementing UHPs, so far	Major urban health strategies/activities carried out	Names of the addl. cities proposed for upscaling	Urban health strategies/activities as proposed now in the State PIP under Urban RCH with list of new addl. Cities	Brief on activities being supported by external agencies
Ensure delivery of RCH services in urban areas of Bihar specifically the Urban Slums in terms of quality and timely availability	Patna, Aurangabad, Bhojpur, Muzaffarpur	Mapping of Urban Slums and existing providers of RCH services of both public and private sectors done	Araria, Arwal, Banka, Begusarai, Bhagalpur, Buxar, Darbhanga, East Champaran, Gaya, Gopalganj, Jamui, Jehanabad, Kaimur, Katihar, Khagaria, Kishanganj, Lakhisarai, Madhepura, Madhubani,	Identify health service providers of private sectors (including NGOs/Nursing Homes/ Clinics) in urban areas and plan delivery of RCH services through them through District Magistrate and District Quality Assurance Committee.	• Monitoring • Social Mobilisation
		Identified health service providers of private sectors (including NGOs) in urban areas and plan delivery of RCH services through them		Establish 33 more Urban Health Centres on a rental basis under PPP in this financial year prioritizing districts with DHs having heavy patient load	

Generate awareness about Maternal, Child health and Family Planning services in urban areas esp. Slums of the state		Established partnerships with select private health clinics/NGOs for delivery of facility-based RCH services e.g. institutional delivery, permanent methods of FP, curative MCH service, etc.	Munger, Nalanda, Nawada, Purnia, Rohtas, Saharsa, Samastipur, Saran, Sheikhpura, Sheohar, Sitamarhi, Siwan, Supaul, Vaishali, West Champaran	Utililise various channels of mass media with extensive reach in urban areas such as TV, local cable networks, radio channels, cinema halls, billboards at strategic locations, etc to propagate messages related to key programme components of RCH.	
				Use various channels of mass media for ensuring utilization of services of Urban Health Centres, private or Government	
				Extensive use of print media such as newspapers (particularly local newspapers), journals and magazines for dissemination of key RCH messages.	

Budget

Setting up of UHC @ Rs.75000 per month (Rs.60,000/- per month for Medical Officer, Grade A Nurse/ANM, other Staff + Rs.15000/- as Service Charge)

Therefore for –

Currently operational 6 UHCs = 6 x 12 months x 75000= 54,00,000/-

8 new UHCs = Rs.75000 x 9 months x 8 no. = Rs.54,00,000/-

Grand Total – Rs. 1,08,00,000/-

Innovations

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

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

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

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

Following actions have been taken and planned in this regard -

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

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

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

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

Budget Proposed-

S. No.	Budget Code	Activities	Total Amount (in Lakhs)
1	A 8.1	Working Lunch/Tea Snack in Workshop 7500/- @ 150/per person/Per Day for 50 person Health Facility For 708 Health Facilities (38 DH, 67 SDH, 70 Ref. Hosp., 533 PHC)= 7500x708	53.10
2		Honorarium to Guest Faculty/State for one Person 1000/Day per Health Facility For 708 Health Facilities (38 DH, 67 SDH, 70 Ref. Hosp., 533 PHC) =1000x708	7.08
3		Photocopy/Stationery etc. (for training material) 2000/- Rs. Per Health Facility For 708 Health Facilities (38 DH, 67 SDH, 70 Ref. Hosp., 533 PHC)= 2000x708	14.16
4		Monitoring at District level and Meeting of District level Committee 10000/- per Health Facility For 708 Health Facilities (38 DH, 67 SDH, 70 Ref. Hosp., 533 PHC)= 10000X708	70.80
		Total	**145.14**

B). MUSKAAN Programme

The state's MUSKAAN Programme tracks pregnant women and New Born Child. Under this programme ASHA, AWW and ANMs jointly track the pregnant mothers and New Born Child. This programme was launched in October 2007. Under this programme ASHA, AWW and ANM hold meeting with Mahila Mandals in AWWCs. The main objective is to cover ANC coverage and Immunization. The Data Centre placed in all the 533 PHCs to monitor this programme.

After the introduction of this programme it has been seen that the coverage of ANC and Immunization increased. The State wants to continue this programme.

C). Family Friendly Hospital Certification

Background

Access to public health services in Bihar has witnessed tremendous improvement since the inception of National Rural Health Mission. Many facilities like KAKO (Jehanabad),

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

The certification systems proposed will help 114 facilities to achieve some quality standards which will enable them to reach the ISO certification at a later date.

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

Procedure for certification

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

- The institutes aspiring to get certified will be identified and constantly supported by the support team. Once the support team is satisfied that the institute is fit for inspection, the certification team will be informed. The support group member will then facilitate inspection. If the certification team is satisfied of the facilities provided, certification is granted. The expenses needed for improving the patient amenities and training in the use of protocols will be from the RKS/annual maintenance grants. The travel cost of the support team and inspection ream could come from innovation funds or could also be supported by any development partner.
- Once the facility qualify the standard norms for certification a certificate would be issued to the institution in public function.
- The certificate would be displayed in front of the CHC/ hospital and a board will be displayed with the declaration by all the staff to ensure the fulfillment of mother and baby friendly certification norms in the institution. All the staff would sign the declaration with the assurance to provide quality services.
- The facilities would be revisited after one year for recertification.

Categories

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

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

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

Districts Proposed for FFHI– 3 facility per district through out state (except the facilities processed for ISO certification)

Process Forward

- Each District to notify two best performing service units for FFHI for the first batch – instructions for the same to be issued in April 2011. Similarly each district would notify two more facilities for next batch in Oct-Nov 2011 for next batch.
- State level one day Orientation cum Sensitization Workshop (in three batches of 13, 13 & 12 districts) to be organized in April/May 2011 for first batch and in Oct/Nov 2011 for second batch. Participants in this workshop would be CS, DPM and MOICs , BHMs & FRU Hospital Manager of the notified facilities.
- Each notified units would organize training on FFHI for its' all level of functionaries (In May/June 2011 & Nov/Dec 2011)
- The same process would be started in October/November 2011 for the 2nd batch.
- One State level Refresher training for FFHI for First batch of identified facilities would be organized in Oct/Nov. 2011-12. The budget for the same would be as follows:

Sl. No.	Head	Approved Rate with Details	Proposed Budget (in Rs.)
1	Food Expenses	Rs. 150 per day x 60participants	9,000
2	Incidental expenditure (Bag, Pen, Notebook for each participant,	Rs. 150 x 60	9000
3	Chart paper, A4 size paper, Marker, Scotch Tape, Kangaroo tape, Pen, Pencil, Photocopy, Cartridge of printer etc.)	gross amount	3,000
4	Trg. Hall Rent	@ Rs. 5000/- per day	5,000
5	Hostel Booking/ Lodging for participants	@ Rs. 500/- per day x 30 double bedrooms x 1 day.	15,000
6	PA System	Rs 500	500
7	TA to Resource persons from delhi & Other places (air travel)	10000 x 2	20,000
8	Lodging for Resource Person	@ Rs.1200 per day x 2	24,00
9	Taxi Hiring for Resource Persons (all)	2000 x 2	4000
10	Contingency		5,000
	Total	**Rs.**	**72,400**

The cost of one batch is Rupees 72,400 so the cost of 3 batches would be Rs. 2,17,200. For two batches the total cost would be Rs. 2,17,200 X 2 = Rs 4,34,400.

- Facility Level Training for selected facilities (2nd Batch) in June/July 2011. Each district to identify 2 facilities, so altogether 76 facilities would be there 1st batch as well as in 2nd batch. The budget for facility level training would be as follows:

One Facility level two day training would cost around Rs. 20,000 (consolidated) so the cost of 76 x 2 facility level training would be Rs. 20,000 X 152 = Rs. 30,40,000.

- Accreditation of the 1st Batch of facilities to start in April 2011 for first visit of the assessing team and then for the second visit the time line could range from June to July 2011 & for the second batch in first visit would be in Oct/Nov 2011 and similarly 2nd visit could be arranged in Jan/Feb 2012.

  The budget for assessing team visit would be Rs. 5,000 per team/per visit and for each selected facility two visits would be required. Thus the total budget for the assessing team visit to 76 facilities would be Rs. 5000 X 2 X 152 = Rs. 15,20,000
- Refresher Facility level training for 1st Batch of facilities in Last week of August/first week of September 2011. Follow up/Surprise visit by accreditation

team to visit these facilities in the month of Oct/Nov 2011 to check the sustainability of the Initiative for the first batch.

Refresher training for the first batch of facilities would be for a day for all 76 facilities of the first batch. One such Training would cost around Rs. 10,000 (Consolidated) so the total cost of such training at 152 first batch facilities would cost Rs. 10,000 X 152 = Rs. 15,20,000

The summary of the Family Friendly Hospital Initiative budget is as follows:

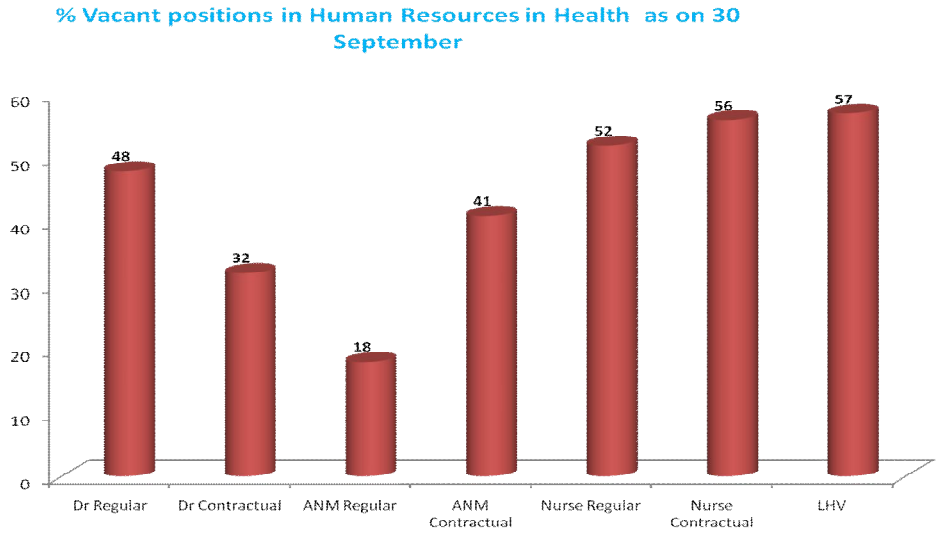
Sl. No	Activity Head	Budget
1.	State level Orientation /Sensitization meet	4,34,400.00
2.	Facility Level Two day Training	30,40,000.00
3.	Assessing Team Visit – Travel + Lodging +Fooding	15,20,000.00
4.	Refresher Training for 152 facilities	15,20,000.00
6.	Fund required for FFHI at District Level (38x4x2lakhs)	1,52,00,000.00
	Total	**2,17,14,400.00**
5.	Contingency (5% of total)	10,85,720.00
	Sub Total (FFHI)	**2,28,00,120.00**

The total budget for Family Friendly Hospital Initiative would be Rs. 2,28,00,120/

Infrastructure and Human Resource

Health Workforce Status of Bihar

The health workforce situation of the state is still in real dearth. The state is lacking in almost every category of health workforce. Worse still, the number of available nurses, doctors and specialists are below the requisite level. The condition is further worsened by the fact that the state's institutions are either insufficient or not adequately developed for meeting this demand-supply gap in human resource for health services.



Status of Contractual Staff-

- Doctors : 1624/2374
- AYUSH Doctors : 1319/1544
- Nurse Grade A : 1491/3303
- Lab. Tech : 331/680
- OT Assistant : 67/122
- Physiotherapist/Occupational Therapist: in process/132
- ANM-R : 7580/12076
- *ASHA* : 78943/87135
- *MAMTA* : 3747/4201
- DPM : 35/38
- DAM : 37/38
- M & E Officer : 37/38
- District Planning Coordinator : 29/38
- District Coordinator Mobiliser (*ASHA*) : 27/38
- District Data Assistant (*ASHA*) : 29/38
- Hospital Manager : 50/76
- Block Health Managers : 466/533
- Block Accounts Manager : 446/533
- Block Coordinator Mobiliser (*ASHA*) : 323/533

Existing Health Infrastructure in Bihar with gaps

Health Institutions	Required	Present	Shortfall
Medical Colleges	18	6	12
District Hospital	38	36	02
Sub-Divisional Hospital	101	68	33
Community Health Centre	622	70	552
Primary Health Centre	534	533	01
Additional PHC	2787	1330	1457
Sub-Centre	16576	9696	6880
ANM/GNM Schools	76	27	49

A). Sub Centre Rent/ Contingency

Presently, 9696 health sub centre are functional in the state and 7765 more health sub centre are to be set up by year 2012. Most of the health sub centres are functioning in the hired buildings. Some newly created health sub centres are also working in the building on the rent. Rent of all these building in which old and newly created health sub centre are functioning the maximum approved rate is Rs. 500/- per month. It is also possible that at some placed rent of hired building will be less than five hundred. Rent will be paid by the in charge medical officer of the concern primary health centre.

Since all the health sub centres are not functioning in rented building approx. 50% of the total functional health centre is being proposed in PIP-2011-12.

Sl. No.	No. of Sub Centre	50% of total Sub Centre	Proposed Amount (in Rs.)
1.	9696	4848	2,90,88,000

B). Voluntary Health Worker

Voluntary Health Workers are working in Primary Health Centre as voluntary worker @ Rs. 100/- per month.
2665 numbers Voluntary Health Worker are being proposed in PIP 2011-12.

Sl. No.	No. of PHC	Proposed No. of Voluntary Health Worker (No. of PHC(533) x Per PHC 5 VHWs)	Proposed Amount (in Rs.) (Rs.100 x 12 x 2665)
1.	533	2665	3198000

C). Contractual Staff Nurses

Sl. No.	Name of the post	No. of Post	Salary (PM)	Salary (PA)	Budget (Amount in Rs.)
1	Nurse Grade 'A'	Approx 5000	12000	12000 x 5000 x12 = 72,00,00,000	72,00,00,000
Recurring expenses – salaries for Contractual Staff Nurses per year					72,00,00,000

D). ANM (R)

Sub-Heads	@ ANM (R)	Proposed Budget In Rs.
Contract Salaries for ANMs (around 7580) in year 2011-12	Rs.8000 per month (12 Months Consolidated Salaries for Contractual ANMs)	72,76,80,000/-
Fund allotted in the year 2010-11 by NRHM.		40,29,00000/-
All payment will be made (Total No. of Working ANM (R) 7580 Up to Dec-2010) through NRHM. Rest of the 4496 ANM (R) will be appointed in coming year 2011-2012		
Total fund Demand in 2011-12		**72,76,80,000/-**

E). MFPW

Total no. of MFPW required – 9158
Recruitment projection for 2011-12 is 6000
The proposed MFPW will be in place by middle of 2nd Quarter.
Appointed MFPW will required a training of six months @ Rs. 3000/- per month
Budget will be Rs. 3000 x 6000 x 6 month = Rs. 10,80,00,000.00
Trained MFPW after going to District--Budget Rs. -8000 x 6000 x 3months = Rs.14,40,00,000.00
Total Budget = Rs. 25,20,00,000.00
= Rs. 25.20 Crore

F). RNTCP MO (Contractual) and LT

The Remuneration of RNTCP contractual medical officer at district level is Rs.28, 000.00 per month. It is proposed that the difference in remuneration (Rs.2000.00) vis a vis what is being paid by the State Health Society to the contractual MOs appointed in the districts be borne from NRHM, so that the remuneration is at par and it will help in checking attrition of MOs from RNTCP. Similarly it is proposed that the remuneration of Laboratory Technicians paid by RNTCP is Rs.8500.00 per month and the difference (Rs.1500.00) be borne by the State Health Society, Bihar.

Budget –
LT @Rs.1500 x 413 x 12= 7434000
Contractual MO @ Rs.2000 x 15 x 12=Rs.3,60,000
Total – Rs.77,94,000/-

G). EE, AE & JE under Bihar Medical Services and Infrastructure Corporation Ltd

BMSIC Ltd., in short State Purchase Organization, has been formed by Health Department. There is no provision for field officers and staff in it for supervision, monitoring and surveillance. Hence provision for 9 Executive Engineers one in each commissionary, 38 Assistant Engineers one in each district, 76 Junior Engineer 2 each district, along with supporting staff is being made in the PIP. These are very essential to get the work done in time as per specification and to check the bills of the contractor, its measurements and certify the expenditure.

Creation of field units of engines (9 executive engineers, One in each Commissionary, 38 Assistant engineers one in each district and 76 Junior engineers two in each district) for supervision of works, Preparation of bills, recording measurements, checking of bills and certifying the Bills for payment is essential.
Bihar Medical Services and Infrastructure Corporation as constituted does not include bove provision of field engineers. Without setting up of infra structure field unit for civil work the above corporation will not be in a position to get the construction works started.

Provision of salary of Assistant Engineer @ 22000/- & Junior Engineer @ 15000/- P.M has been made as approved in the PIP of the year 2009-10 by GOI. Salary of Executive Engineer has been provided as Rs. 25000/- P.M as mentioned in advertisement for recruitment on contractual basis. Salary of Staff has been kept as that of contractual Staff of State Health Society, Bihar

In view of above provision of 75% i.e. Rs. 234.98 Lakh is being made in infrastructure PIP for the year 2011-12 for nine months only.

Details for supervision, monitoring and surveillance of works in field:-

A. Field Unit:-

1. Executive Engineer - 9 @ Rs. 25,000 X 9X 12 = **27,00,000/-**
   (One in each Commissionary)
2. Assistant Engineer - 38 @ Rs. 22,000 X 38 X 12 =**1,00,32,000/-**
   (One in each district)
3. Junior Engineer - 76 @ Rs. 15,000 X 76 X 12 =**1,36,80,000/-**
   (Two in each district)

Sub-Total Rs = 2,64,12,000/- A

B. Supporting Staff:-

Sl. no	Officer	Data Entry Operator	Peon	Total
		No-Rate-Amount	No-Rate-Amount	
1	Executive Engineer - 9Nos.	9Nos. @ Rs. 8000/- 9 X 8000 X 12 = 8,64,000/-	9 Nos. @ Rs. 5000/- 9 X 5000 X 12 = 5,40,000/-	**Rs. 14,04,000/-**
2	Assistant Engineer- 38Nos.	38 Nos. @ Rs. 8000/- 38 X 8000 X 12 = 36,48,000/-	X	**Rs. 36,48,000/-**
3	Junior Engineer- 76Nos.	X	X	

Total- Rs. 50,52,000/- B

A = 2,64,12,000/-
B = 50,52,000/-

Grand Total = 3,14,64,000/-
75% Budget Provision = 235.98 Lakhs/-

H). HR Benefits for Contractual Staff

The Governing Body of SHSB has approved various HR benefits for the Contractual Staff under NRHM from State to HSC level.

1) Grading and Salary of the existing and new contractual human resource under SHSB

With the launch of NRHM in 2005, as a vehicle to strengthen delivery of health services especially in the rural areas consequently substantial investments have been made in all areas including augmentation of human resources. However the state capacity to absorb the additional fund flow has proved to be a major bottleneck and progress has been slow when compared with other states of the country.

In this early stage, the emphasis has been on strengthening HR management within NRHM and the State Health Society, Bihar is now poised for expansion and thus plans to recruit professional at district, regional and state level.
With opportunities growing in the state it may fast become a challenge to retain the existing trained human resource. In the past two years, 12 districts had new District Programme Managers (DPM), 18 had new District Accounts Managers (DAM) and 3 districts saw new District Monitoring and Evaluation Officers (D M&E). At present also 4 of the 38 districts are without a DPM, 3 districts are without a DAM and 2 districts do not have a D M&E. of the above 1 district is without a DPM as well as a DAM.

To ensuring that the state is able to take maximum benefit of the NRHM programme, it is important to retain the trained manpower and also attracting new talents.

Under centrally sponsored schemed, the GoI has placed several consultants at a salary structure defined by them which is in disparity with the prevailing structure.

Under the above circumstances it is important for the state to revise its salary structure to bring it at par with the other similar organisations and also grade the position for clear reporting structure.

Since SHSB does not have defined grades for the positions at present and it is recommended introducing grades which will be helpful in taking decisions in future while introducing new positions and also be help in making decisions such as salary increment, incentives, staff benefits etc.

Grades	***Positions***	***Designation***
I	Additional Directors of all departments	**Additional Director**
II	Deputy Directors of all departments	**Deputy Director**
III	Programme Managers, Regional Programme Manager, Regional Accounts Manager, Personnel Officer, State Health Finance Analyst, State Epidemiologist	**Senior Consultant**
IV	District Programme Manager, Deputy Programme Manager/Assistant Programme Managers, District Accounts Manager, Regional Manager - M&E, VBD Consultant (District), Micro Biologist – IDSP	**Consultant**
V	Hospital Manager, Assistant Manager – IT, Assistant Health Finance Analyst, Consultant Finance – IDSP, VBD Consultant – State, Training Consultant – IDSP, District Planning Coordinator, District Asha Coordinator, Coordinator – Mamta, State Planning Assistant, State Entomologist, Accountants, Audit Assistants, Finance Analysts, Data Assistants, Computer Programmer, Data Officer, Pharmacists, Monitoring & Evaluation Officers (Both State and District Based)	**Senior Executive**
VI	Block Health Managers , State Data Manager – IDSP, District Data Manager – IDSP, Store Keeper, Data Assistant, Computer Operator, Executive Assistant, Computer Operator cum Steno, Steno cum LDC, Block Accountant, Grade A Nurse Contractual, Block Community Mobilizers, Kaala Azaar Technical Supervisor, ANM (R) Contractual.	**Executive**

The starting salary for each of the positions will also have to be revised according to the salary recommendations being proposed to ensure uniformity in salary structure and also in hierarchy for the smooth functioning of the society. The starting salary for new incumbents against each of the positions will be as under:

Designation	Level	Salary Range	
Additional Director	Additional Director	50,000	60,000
Deputy Director	Deputy Director	45,000	55,000
Regional Programme Manager	Senior Consultant	43,000	53,000
Personnel Officer		40,000	50,000
State Health Finance Analyst		40,000	50,000
Programme Manager (HO)		37,500	47,500
Regional Manager Accounts		35,000	45,000
State Epedimologist		35,000	45,000
District Programme Manager	Consultant	32,000	42,000
Regional Manager - Monitoring & Evaluation		30,000	40,000
VBD Consultant (District)		30,000	40,000
Micro Biologist - IDSP		30,000	40,000
Deputy Programme Manager (HO)		28,000	38,000
District Accounts Manager		27,000	37,000
Hospital Manager	Senior Executive	25,000	35,000
Assistant Manager - IT		25,000	35,000
Assistant Health Finance Analyst		25,000	35,000
Consultant Finance - IDSP		25,000	35,000
VBD Consultant (State)		25,000	35,000
Training Consultant - IDSP		25,000	35,000
District Monitoring & Evaluation Manager		22,500	32,500
Accountant (HO)/ Data Officer/ Computer Programmer		22,500	32,500
District Planning Coordinator		20,000	30,000
District Asha Coordinator		20,000	30,000
Coordinator - Mamta		20,000	30,000
State Planning Assistant		20,000	30,000
State Entomologist		20,000	30,000
Block Health Manager	Executive	18,000	28,000
State Data Manager - IDSP		14,000	24,000
District Data Manager - IDSP		13,500	23,500
Block Accountant		12,500	22,500
Data Assistant		12,500	22,500
Computer Operator/ Steno/Executive Assistant		12,500	22,500
Grade A Nurse Contractual		12,000	22,000
Block Community Mobiliser		12,000	22,000
Kala Azaar Technical Supervisor		10,000	20,000
ANM (R) Contractual		8,000	18,000

2) Annual Increment with Annual Appraisal of contractual manpower under SHSB

Annual increment is normally given to employees to cover inflation. It is often used as a tool to motivate, acknowledge and award the contributions made by workers.

It is proposed that the society conducts an annual appraisal of its employees every year and based on the appraisal, an annual increment of 10% may be awarded.

In case due to some reason, society is not able to conduct an annual appraisal, the society will give an annual increment of a minimum of 5% to its employee on completion of year of service to all those employees who have not been marked adversely in the previous year.

Budget : Maximum of 15% of the salary budget each year.

3) Medical Facility to officers and staffs on contract of SHSB/ SPMU/ DPMU/ RPMU/BPMU

The staff engaged in the organization have been allowed Medical Allowance ` 200/- (Rupees Two Hundred only) per month for outdoor and indoor treatment. This is in line with the Bihar Government rules.

Budget : With the current staff strength from State to Block (1253) the approximate cost would be ` 30 lakhs per annum

4) Group accidental (insurance) policy for contractual manpower under SHSB (State to Sub-centre level)

Although for the effective execution of the tasks lot of travel is involved, at present the staff at SHSB is not insured against any risks. Group accidental policy for the staff has been approved

Budget : Annual Premium for all the staff under NRHM under the proposed policy- **Rs. 16,97,149/-**

5) **Appellate Authority for contractual manpower under SHSB (State to Sub-centre level)**

The state under the NRHM programme has opted for hiring doctors and even paramedic staff at state and district level on fixed term contracts with an option for renewal/extension of the contract for a further specified period to meet the existing shortage of human resource.

The arrangement will have to be continued until the Health Department is able to address to the problem of shortage of staff. It is therefore in the interest of the state to retain the contractual staff till such period.

With a motive to retain the contractual workers for a longer period it is essential to build their confidence in the current arrangement. A committee has been formed to address to the grievances of the contractual staff be it at state, district or block and may refer their concerns such as nonpayment or untimely payment of emoluments, non renewal of their contact without assigning reasons etc.

The members to the committee are:

1. Executive Director, State Health Society Bihar – Chairman
2. Administrative Officer, State Health Society, Bihar
3. Director in Chief, Health Services, Government of Bihar
4. One nominated member from the Directorate
5. Additional Director (any one), to be nominated by Executive Director, SHS, Bihar.

The committee would meet twice a month preferably on fixed dates to discuss and address the concerns of the contractual staff contributing in the effective implementation of the health programme in the state.

6) Besides the above, various ‘leaves’-casual, earned, paternity, maternity, LWP have been sanctioned and the TA/DA norms have been modified in keeping with the Bihar Government norms.

Note – The Office Order with reference to SHSB new HR Policy is provided in Annexure folder

Institutional Strengthening

Strengthening Nursing Education in Bihar

Nodal Center for PSE for Nurses at IGIMS Bihar

To achieve the NRHM goals of reducing the MMR, IMR and Child mortality in Bihar, the up- gradation of quality of Nursing training in the existing 21 ANM schools and 6 GNM training centers is a priority strategy. In the PIP for 2009-10 a sum of Rs 700.22 lacs was requested for and Rs 350 lacs was approved by GOI.

Substantial Technical Assistance will be needed to translate the strengthening process and will be a key determinant in the outcome of improved and strengthened ANMTCs in Bihar .A series of consultations have been organized by Government with partner agencies and proposals were invited . JHPIEGO was also invited to submit a proposal. JHPIEGO proposal to set up a nodal center as per the Indian Nursing Council guidelines was considered by Govt. and forwarded to Government of India for its consideration. Government of India vide letter no Z 28015/117/2010-N dated 27 September 2010 have agreed to the Government of Bihar proposal sent vide letter no 693 dated 10-08-2010 for setting up Nodal centre for Strengthening Pre -Service Education for Nursing and Midwifery under Technical Assistance from JHPIEGO and with financial assistance from UNOPS-NIPI.

The centre is to be set up at Indira Gandhi Institute of Medical Sciences. This is in synergy with the high priority accorded for upgrading Nursing Education in the state.

Objective

- Focus on Quality improvement by use of educational standards and strengthening the clinical & training skills of the tutors is the main purpose. Specifically, the strengthening of the nodal center and the ANM training centers in Bihar is proposed to be done through the use of simple, measurable performance standards which serve as a guide for better functioning schools. These performance standards (approved by the INC) provide a structure for program support and a criterion-based supportive supervision system to provide specific ongoing technical support for improving the quality of PSE in the ANMTCs
- Recent policies and programs of the Government of India focused on Maternal, Newborn and Child Health (MNCH), like the *Janani Bal Suraksha Yojana* (JBSY scheme), Integrated Management of Newborn and Childhood illnesses (IMNCI) and the focus on operationalization of 24/7 PHCs and First Referral Units; have put an increased emphasis on the role of the basic health worker in the provision of comprehensive maternal and child health services in the country, especially in rural areas. To respond to this need for development of a basic service provider who can provide quality MNCH services at the grass root level, a comprehensive initiative to strengthen the foundation of pre-service education for ANMs (Auxiliary Nurse Midwife) is being undertaken by the Indian Nursing Council (INC)
- Indian Nursing Council (INC) and Nursing Division, Government of India have developed a roadmap for improving the pre service education of GNM and ANM by strengthening ANMTC and GNMTC(including Human Resources, Infrastructure upgrade and training aids and gear) in the high focus States of India. The INC strategic approach for strengthening ANMTCs include establishment of a number of Nodal Centers (Upgraded Nursing Colleges/Training Centres) to steer the process. It is envisioned that these Nodal Centers,

besides serving as model teaching institutions, would serve as pedagogic resource centers for strengthen PSE at the ANMTCs (ANM Training Centers) in their region and also provide support in the concurrent strengthening of these ANMTCs.

JHPIEGO has been invited by Government of India and Indian Nursing Council to set up Nodal centre. Four have been set up namely in Delhi, Ludhiana, Vellore and Kolkatta.
The IGIMS Patna Nodal centre shall be the fifth in India. Technical support to this initiative includes capacity building of the existing faculty of the nursing institutions and strengthening the infrastructure of the teaching facilities and clinical sites to more sustainably address the shortage nursing staff in India and quality of their work. JHPIEGO is interested and willing to assist Bihar Government in initiating the process of strengthening the 21 ANMTCs in the State and help in setting up a Nodal Centre on same lines elsewhere.

The major activities for the proposed support will include:

- Building the capacity of schools to follow a competency and clinic-based training
- Facilitating the updating of faculty in targeted knowledge & clinical skills
- Conducting pedagogic courses for tutors and support the application of modern teaching principles
- Establishing clinical skills labs, equipped with anatomic models, computers and develop quality libraries
- Using Standards Based Management approach (SBMR) to strengthen PSE
- Networking schools to compare progress and collectively solve implementation challenges
- Developing a framework and plan for monitoring and evaluation.

The budgetary provisions as per the Nursing Council for a Nodal centre with an additionality for infrastructure improvement is as:-

Budget Criteria	Recurring in Rupees	Non Recurring in Rupees
1-Faculty and staff	9,84,000	0
2-Office and office supplies	2,58,000	1,65,000
3- Skills Lab and Computer lab	2,05,000	27,45,000
4-library	1,10,000	4,00,000
5- Faculty travel	2,50,800	0
6-Training Costs	27,84,000	0
8-Infrastructure improvement		10,00,000
Total	45,91,800	43,10,000

Grand total of both recurring and non recurring is Rs 89,01,800 for the first year. To accommodate for price escalation and rounding of the budgetary requirement for the year would be Rs 1,00,00,000 or Rupees one crore [100 lacs].

The requirement will be in addition as the Nodal center wil be a new activity in addition to ongoing activities.

To translate the Government of Bihar request into activity, the UNOPS-NIPI JPC of under the chairmanship Secy Health Government of India have approved the proposal for setting up the Nodal center. UNOPS NIPI will be supporting JHPIEGO in setting up the Nodal Center.

BCC/IEC

Bihar is a state with high cultural heterogeneity. It has been a challenging area to address the issues of behavior change in a heterogeneous population. Even if the language of communication in Bihar is Hindi / Maithili / Magahi / Angika/ Bhojpuri/ Bajjika etc the use of dialects, words and styles differs from area to area. It indicates that no common strategy will work for the entire state as different areas have different dialects of communication. Use of Social & Behavior Change Communication (SBCC) has been one of the key components in any health sector strategy.

Strategic approach to communication is imperative to improve effectiveness and sustainability of behavior and social change. A systematically developed and managed communication program supported by evidence-based strategies, state-of-the-art training and capacity building, and cutting-edge research is necessary to influence positive behaviors & practices as also to increase access, improve quality & promote demand for health services.

The NRHM in Bihar is implementing a number of programmes, each one of which needs to be complemented with adequate communication inputs to achieve desired results. The Annual Action Plan 2011-12 for IEC/SBCC has been prepared in the light of the number of initiatives taken by Dept. of Health, Government of Bihar and State Health Society Bihar in the implementation of NRHM.

Public health communication in Bihar is faced with the additional challenge of overall low exposure of the population to mainstream channels of mass media. NFHS data reveals that nearly 60% of the population in Bihar has been classified as 'not regularly exposed to media', as against a national level of approximately 35%. The challenge gets compounded when one has to reach women with critical information and messaging, as the rate of exposure falls much lower when it comes to them.

	Reads newspaper or magazine at least once a week (%)	Watches TV at least once a week (%)	Listen to radio at least once a week (%)	Visits cinema at least once a month (%)	Not regularly exposed to media (%)
Bihar	10.8	23.1	27.7	2.5	58.2
Bihar (Men)	40.4	33.4	50.7	19.4	27.3
India	22.9	55.0	28.8	5.6	34.6

It is interesting that radio is the most common source of information for both men and women in Bihar, as per NFHS data. In fact radio presents a vast potential for health related communication and may be used strategically to bring about the necessary information, attitude and behaviour change in this sector.

The PIP proposes to develop a health communication strategy for the state with support from UNICEF. All communication activities will be based on evidence based communication strategy for the state defining audiences, message approach and media mix for each issue / theme under the NRHM.

Key Activities

A). IEC Assistant cum Logistics consultant: - IEC Assistant cum Logistics consultant has been appointed in BCC Cell, to support BCC Cell activities. Assist and support BCC Cell team leader in development of IEC activities. To help state in preparing press release, media & news advertisement paper ads on specific health related days, information, recruitment notice & tender notice advertisement.

B). Mass Media Activities:-
TV / radio are best medium to reach rural and urban community. Develop the TV spot / AV spot and other for the different type of campaign. TV and radio spot will be develop for the better impact of campaign. Radio spot, TV spot & others, Press release, Media & News Paper advertisement on various healths related days, Information, Recruitment notice & tender notice advertisement for message dissemination through mass media. Series of advertisement in all Bihar editions of various newspapers is proposed to be published 3 days in a week. Series of spots and jingles in all Bihar station of various channels is proposed to be broadcast in entire year.

C). Local Media Tin plates, Bus panel, Glow Signs board & others Hoardings, Wall Painting, Bill boards, Cinema slides, Local Cable and other Wall writing/ Miking & others, Laminated Board etc., on issues related to RCH and NRHM will be place at vantage points, displayed at important locations like at District Offices, Block Offices, PHCs, Halt points, Bus Stands, Railway stations, etc. Monthly magazine brought out by the I&PR Dept. is being again sponsored by SHSB. Space has been allocated in the magazine for publicizing about health related programmes

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

E). Printing Material
Poster, Flex banner , Pannel, Banner, Striker, Leaflet, Brochures, Badhai Cards, Booklet, IPC flip card, Letter with massage, T shirts, Desk Calendar, Pocket calendar, wall calendar, health calendar, dairy, quarterly magazines Banner, Letter with massage, Rally Flag, T shirts, Flex banner and other materials will be developed and publicized on different issues eg. Dial 102 (Ambulance Service), Dial 1911 (Doctor's Consultancy), Dial 102/1911 (Samadhan: Rogi Shikayat Niwaran Wyawastha), ICU Service, JBSY, Promotion of Breast Feeding, Family Planning including Non Scalpel Vasectomy, Immunization, Adolescent and Sexual Reproductive Health, UHC, Diagnostics, PNDT Act, Role of ASHA under NRHM, Role of Mamta, Importance of Super Specialty Hospitals etc., through various print. Health Materials will be publicized on Bihar Text Book & Different types of Certificates issued by Govt. of Bihar and others. Set of 4

comics (each of 10 pages) already prepared to be distributed amongst 1000000 girl students studying in classes 9 to 12.

F). Campaigns/ Health emergencies/ Events
Many people are concerned about the influenza A H1 N1 (swine flu), and Dengue outbreak. Floods are also a big problem for most of rural population in Bihar. There is also a tradition of tableay exhibition during 26th January (Republic Day) & 15th August (Independence Day) celebrations

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

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

The capacity assessment exercise will aim to find:

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

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

H). Hiring of Public Relations Officer, SHSB for generating public awareness and dealing with Media personnel with reference to NRHM programmes and schemes.

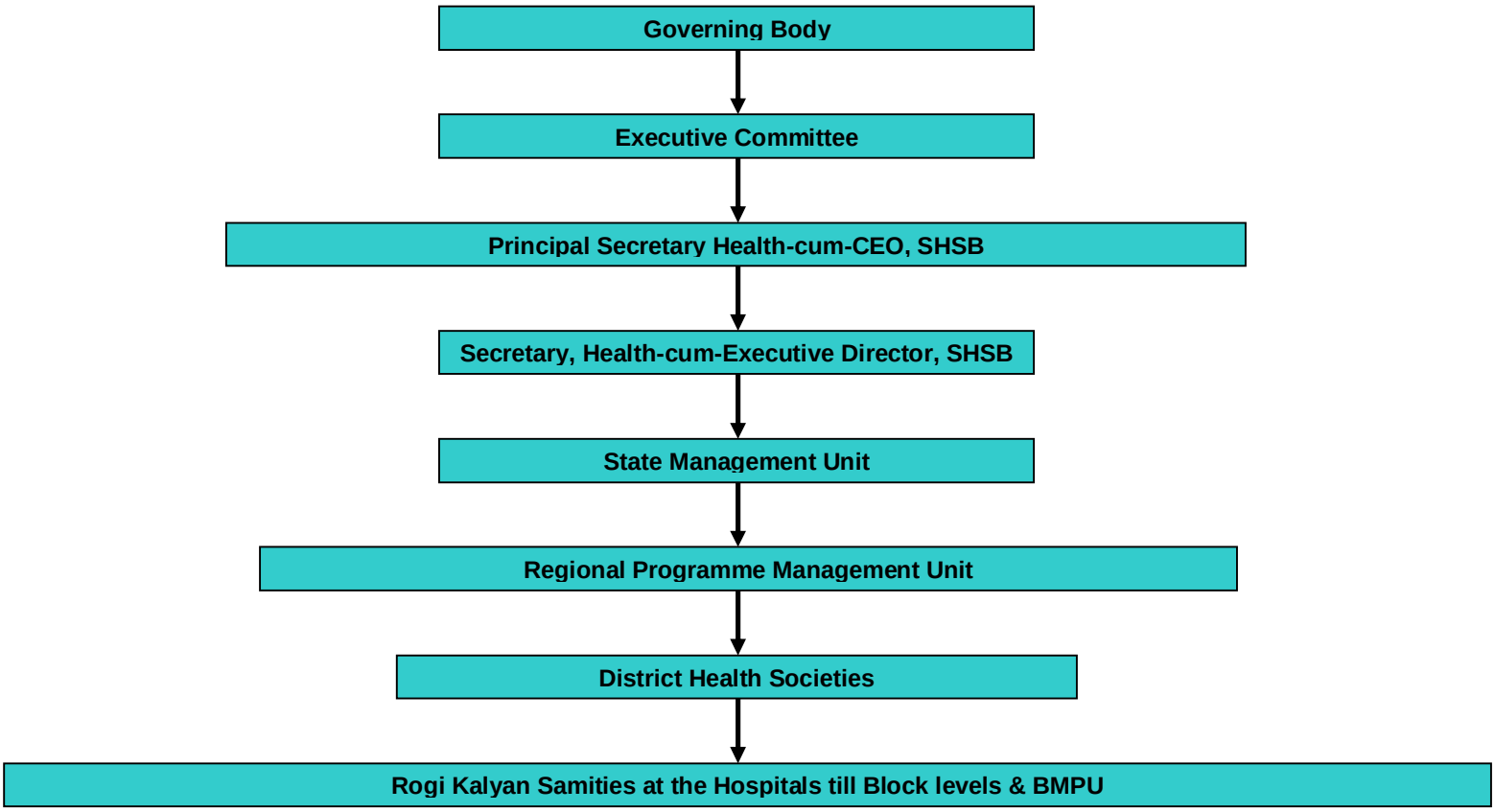
Programme Management

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

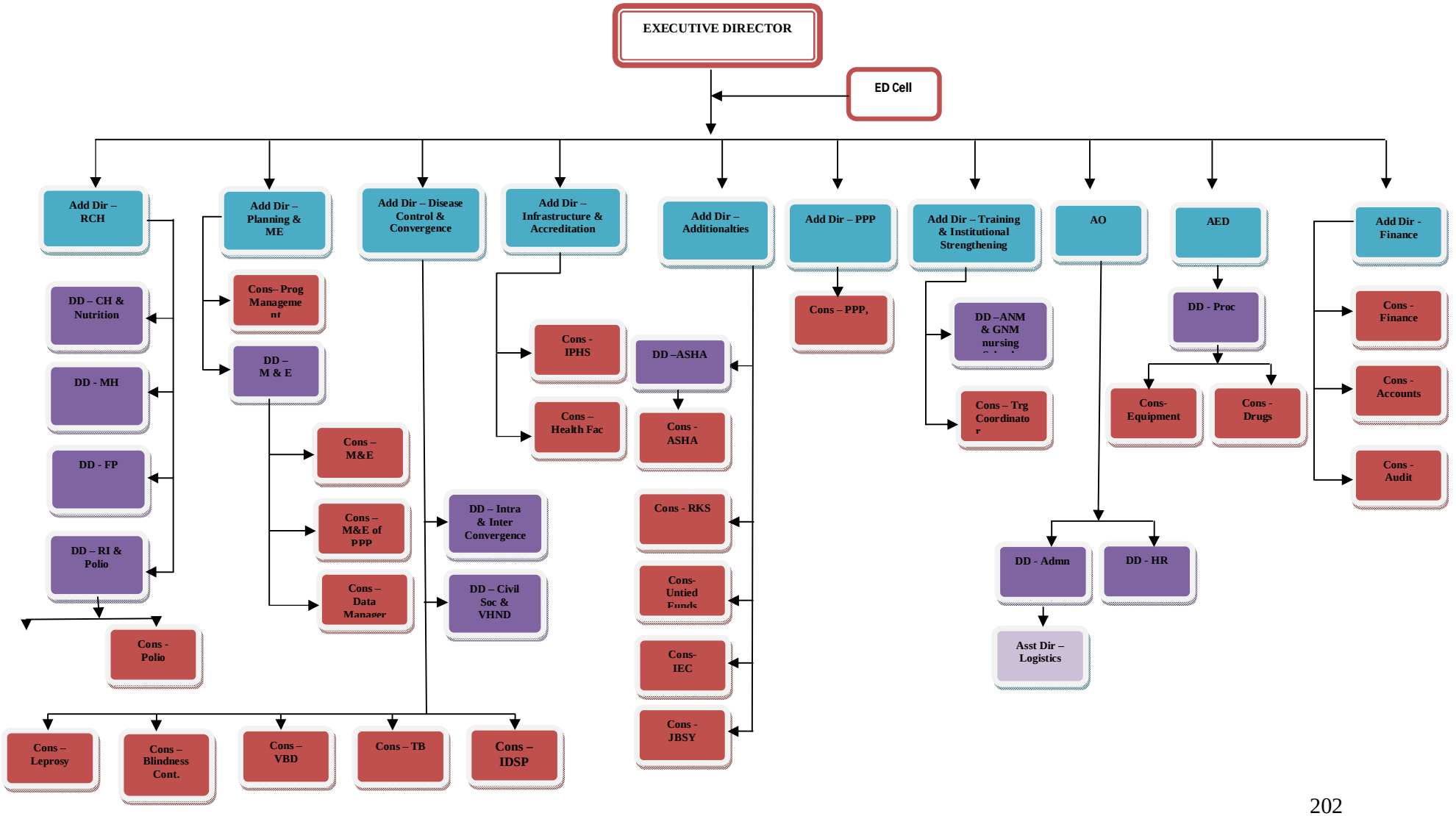
The objective of State Health Society is to provide additional managerial and technical support to the Department of Health, Government of Bihar for implementation of National Rural Health Mission which includes RCH –II, Additionalities, General Curative Care, National Disease Control Programme and AYUSH.

SHSB has a Governing Body whose Chairperson is the Development Commissioner, Govt. of Bihar and an Executive Committee whose Chairman is the Principal Secretary, Dept. of Health, Govt. of Bihar. There is a Project Appraisal Committee (PAC) whose Chairman is the Executive Director, SHSB and which has representations from Directorate, Development partners, RHO-GOI and other line departments of Bihar Government. The Committee (PAC) considers the expenditure proposals. Financial powers of the bodies/office bearers have been clearly defined in the Society's Financial Rules and Bye-Laws.

The Overall picture of programme management functioning is as follows-



Proposed Organizational Structure For State Health Society Bihar



Programme Management Units

A). State Programme Management Unit

Based on the new HR policy for Contractual Staff detailed in HR section:

Budget:

(A.1) Annual liability on salary for current staff at prevailing salary (State level):
1,16,63,340/- + 10% annual increment = Rs.1,28,29,674/-
(Current Staff includes Deputy Directors-Training, MCH, M&E; SPM; Consultants-NRHM, Cold Chain, System Analyst & Data Officer; SPO-RI & Polio; Data Officer -1; Accountant-6; Computer Programmer-1; Pharmacist-1; Storekeeper-3; Clerk-cum-Steno/Executive Assistant/Data Assistant/ -26)

Increased salaries for districts and blocks have been proposed in the relevant sections.

(A.2) Annual liability on salary of various new posts approved in SPIP 2010-11 and already advertised for and for which shortlisting is already underway. These posts would be functional before April 2011 onwards latest : Rs.2,50,56,000/-
(Addl. Directors-6 heading various cells like procurement, RCH, PPP, Training & Institutional Strengthening, Finance, Infrastructure & Accreditation; Deputy Directors-10; Consultant-21; Executive Assistants-45)

(A.3) Misc -

Sno.	Budget Head	@	Total
	Mobility and office expenses	150000 pm	18,00,000
	Meeting Expenses	25000/- pm	3,00,000
	Upgradation of SHSB office	2500000/- pa	25,00,000
	Purchase of furniture, equipments, appliances etc	500000/- pa	500000
	Total -		**51,00,000**

Grand Total – Rs.4,29,85,674/-

B). Additional Manpower for State Health Society, Bihar

With an objective of strengthening the technical and management capacity of the Directorate of Medical & Health Services in Bihar, State Health Society has been established. The objectives also include assisting the Districts Health Societies by various means including through recruitment of individual / institutional experts from the open market and mobilize financial/non-financial resources for complementing/supplementing the NRHM activities in the State.

The Society guides its functionaries towards receiving, managing (including disbursement to implementing agencies e.g. Directorate, of Medical & Public Health

District Societies, NGOs etc.) and account for the funds received from the Ministry of Health & Family Welfare, Government of India.

For proper functioning of SHSB and NRHM being a large programme covering various components, SHSB requires administrators and doctors on deputation from the Government.

For Government officials on deputation/ of retired Government officials the salary slab as such is proposed based on the revised 6th pay commission norms and for retired personnel (Pay(Basic Salary-Pension)-

Sl.	Name	Salary Pm	Salary (pa)
1	Executive Director, SHSB	102789	1233468
2	Administrative Officer- SHSB	53856	646272
3	Senior Deputy Collector-HR	44018	528216
4	Deputy Collector-Legal	39613	475356
5	State Immunization Officer	81918	983016
6	Consultant Infrastructure	42350	508200
7	State Surveillance Officer, IDSP	81918	983016
8	State Programme Officer (PMCH)	57194	686328
9	State Finance Manager (retd.)	14585	175020
10	State Accounts Manager (retd.)	12947	155364
	Total		**63,74,256**

C). Regional Programme Management Unit

In order to oversee properly and qualitatively implement NRHM in the districts, including the planning and utilisation, in SPIP 2010-11 a Regional Programme Management Unit was approved. SHSB has already selected candidates for the same and the RPMU in all the 9 Divisional Headquarters have been established with following personnel :-

1. Regional Programme Manager
2. Regional Accounts Manager
3. Regional M & E Officer
4. HMIS Supervisor

Budget

Sl. No.	Name of the post	No. of post	Salary (PM)	Salary (PA)	Budget (Amount in Rs.)
1.	Regional Programme Manager	9	43,000 (8 months) 43,000+10 % Increment = 47300 (4 months)	43000 x 8 months x 9 nos. = 30,96,000 47300 x 4 months x 9 nos. = 17,02,800 =30,96,000+17,02,800 = **47,98,800**	47,98,800
2.	Regional Accounts Manager	9	35,000 (8 months) 35,000+10% Increment = 38500 (4 months)	35000 x 8 months x 9 nos. = 25,20,000 38500 x 4 months x 9 nos. = 13,86,000 =25,20,000+13,86,000 = **39,06,000**	39,06,000
3.	Regional M & E	9	30,000	30000 x 8 months x 9	33,48,000

	Officer		(8 months) 30,000+10% Increment = 33000 (4 months)	nos. = 21,60,000 33000 x 4 months x 9 nos. = 11,88,000 =21,60,000+11,88,000 = **33,48,000**	
4.	HMIS Supervisor	9	12000+10% Increment = 13200	13200 x 12x9	14,25,600
4.	Accountant	9	10,000	10,000 x 9 x 12 months	10,80,000
Recurring expenses of 9 RPMU (Salary head) per year					
4.	Mobility and office expenses (Including computer for accounts)	9	75000/-PM	75000 x 12 months x 9 nos. = 81,00,000	81,00,000
	Meeting Expenses	9	25000/- PM	25000 x 12 months x 9 nos. = 27,00,000	27,00,000
Recurring expenses of 9 RPMU per year					**1,08,00,000**
Total expenses of 9 RPMU per year (1,45,58,400+1,08,00,000)					**2,53,58,400**

D). District Health Societies

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

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

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

District level (DPMU)

District Programme Management Support unit consists of following personnel:-
1. District Programme Manager
2. District Accounts Manager
3. District M & E Officer
4. District Planning Coordinator (budgeted in Planning portion Part B)
5. District Child Health Supervisor (budgeted through NIPI till June and thereafter through NRHM Part B)
6. District Community Mobiliser (ASHA) (budgeted in ASHA Part B)

Budget

Sl. No.	Name of the post	No. of post	Salary (PM)	Salary (PA)	Budget (Amount in Rs.)
1.	District Programme Manager	38	23000+10% Increment = 25300 (2009-10) 25300+10% Increment = 27830 (2010-11) 38962+10% Increment = 42858.20 (2011-12)	42858.20x12x38 = 1,95,43,339	1,95,43,339
2.	District Accounts Manager	38	18000+10% Increment = 19800 (2009-10) 19800+10% Increment = 21780 (2010-11) 30492+10% Increment = 33541.20 (2011-12)	33541.20x12x38 = 1,52,94,787	1,52,94,787
3.	District M & E Officer	38	15000+10% Increment = 16500 (2009-10) 19800+10% Increment = 18150 (2010-11) 27225+10% Increment = 29947.50 (2011-12)	29947.50x12x38 = 1,36,56,060	1,36,56,060
Recurring expenses of 38 DPMU (Salary head) per year					4,84,94,186
4.	Mobility and office expenses	38	55000	55000x12x38 = 2,50,80,000	2,50,80,000
	Assistant or Data Entry Operator	38x2	Rs. 8000/-PM	8000x2x12x38 = 7296000	72,96,000
	Rent of DHS Office	38	4500/- PM	4500x12x38 = 20,52,000	20,52,000
	Meeting Expenses	38	5000/- PM	5000x12x38= 22,80,000	22,80,000
	Purchase of furniture	38	20000/-PA	20000x38= 7,60,000	7,60,000
Recurring expenses of 38 DPMU per year					3,74,68,000
Total expenses of 38 DPMU per year (4,84,94,186+3,74,68,000)					8,59,62,186
Rupees Eight Crore fifty nine lacs sixty two thousand one hundred eighty six only.					

E). Block Programme Management Unit

The state has already established Block Programme Management Unit in all the Block PHCs. Each BPMU consists of One Block Health Manager, Block Accountant and Block Community Mobiliser It has been observed that after the establishment of BPMUs the implementation of National Programmes has been managed efficiently and getting improved results.

Budget --

Sl. No.	Name of the post	No. of post	Salary (PM)	Salary (PA)	Budget (Amount in Rs.)
1.	Block Health Manager	533	12000+10% Increment = 13200 (2009-10) 13200+10% Increment = 14520 (2010-11) 21780+10% Increment = 23958 (2011-12)	23958x12x533 = 15,32,35,368	15,32,35,368
2.	Block Accountant	533	8000+10% Increment = 8800 (2009-10) 8800+10% Increment = 9680 (2010-11) 14520+10% Increment = **15972** (2011-12)	15972x12x533 = 10,21,56,912	10,21,56,912
Recurring expenses of 533 BPMU (Salary head) per year					**25,53,92,280**
3.	Mobility and office expenses	533	25000	25000x12x533 = 15,99,00,000	15,99,00,000
Total Recurring expenses of 533 BPMU per year					**41,52,92,280**
Rupees Forty one Crore fifty two lacs ninety two thousand two hundred eighty only.					

F). Management Unit at FRUs --

Being a big state, Bihar requires more manpower to provide services at various facility levels and for better management of NRHM programme.

a) Hospital Managers

Addl. manpower in the form of Hospital Managers have been engaged in almost all of the 76 FRUs. Hospital Managers are facilitating process of quality control and also ensuring that FRUs in the real sense get functional with all critical determinants. Further presentably Institutional delivery is one of the main activity of operational FRU and 24 hours management of facility is a challenge, wherein these Hospital Managers would prove useful. Induction training of the HMs have already been undertaken by IIHMR, Jaipur.

b) FRU Accountant

To manage the NRHM funds at FRUs an Accountant would be required to be placed in all the 76 FRUs

Budget

Sl. No.	Name of the post	No. of post	Salary (PM)	Salary (PA)	Budget (Amount in Rs.)
1.	Hospital Manager (FRU)	76	25,000 (6 months) 25,000+10% increment = 27,500 (6months)	25000 x 6 months x 76 nos. = 1,14,00,000 27,500 x 6 months x 76 nos. = 1,25,40,000	1,14,00,000+ 1,25,40,000= 2,39,40,000
2.	Accountant (FRU)	76	15000 (9 months)	15000 x 9 x 76	1,02,60,000
Recurring expenses – Salaries at FRU per year					**3,42,00,000**

Financial Management, Monitoring & Evaluation, Convergence and Coordination

Budget has been covered under Part A NRHM for Financial Management, Part A and B for Monitoring & Evaluation and Part J for Inter-Convergence.

Write up with detailed activies may be referred to in Chapter IX, Chapter X and Part J

Role of State, District and Block

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

Synergie with Mission Flexipool

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

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

.

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

Sustainability

The usage of government services in Bihar has certainly picked up with number of patients increasing manifolds due to free drugs and availability of doctors at PHC level. Similarly there has been an unprecedented increase in number of deliveries being conducted at government health facilities under Janani Baal Suraksha Yojana This can be largely attributed to huge influx of funds under NRHM. To hedge the growth from lack of funds and for its sustainability Government of Bihar has already applied user charges for referral transport services. The ambulance user charges are being determined by Rogi Kalyan Samitis. The state already has paying wards in our medical colleges and GoB is contemplating having such wards in all district hospitals too.
For sustainability of manpower, incentives have been proposed for specialist services and for postings in rural areas in this Programme Implementation Plan. Government has finalized Dynamic ACP and Cadre division of doctors for providing them better benefits.

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

Extra Inclusions in RCH

Controlling Iron Deficiency Anemia in Vulnerable Population in Bihar (Iron Folic Acid Supplements)

Iron-deficiency anemia is the most common form of malnutrition in the world and is the ninth leading cause of disease in children, girls and women in developing countries. According to WHO 2002, estimates, India is one of the countries in the world that has highest prevalence of anemia affecting an estimated 50 per cent of the population, affecting children (under three), women and adolescent girls, and resulting in reduced work productivity, impaired physical capabilities and increased susceptibility to illness.

The Government of India is committed to the cause of controlling anemia and has identified a 25 per cent reduction in this deficiency disease as a National Nutrition Goal (Tenth Five Year Plan). The situation has taken a serious turn as can be seen from the data of NFHS-2 (1998-99) and NFHS-3 (2005-06) as per table below these efforts continue more rigorously in the Eleventh Five Year Plan. (NFHS-3, 2005-06).

Group	NFHS-2	NFHS-3
6-35 months	81%	87%
Ever married women	60.4%	68.3%

Although the National Anemia Control Programme has been in operation for more than two decades, it has not made a marked impact of the prevalence of anemia and the problem continues to prevail. The recent National Health and Family Survey data suggests that the most vulnerable population groups are the women in pregnant and lactating stages, preschool children and adolescent girls.

Anemia in Women:
In women, anemia is an important direct as well as indirect cause of maternal mortality and prenatal mortality. Anemia also results in an increased risk of premature delivery and low birth weights. Latent iron deficiency is known to alter brain iron content and neurotransmitters irreversibly in fetal life and postnatal babies. In Bihar, data from NFHS-3 (2005-06) reveals that 60.2 % of women in pregnancy period are anemic.

Anemia in Adolescents:
Apart from pregnancy and lactating stages, adolescent period (11-18 years) in girls has been recognized as a specific period in the life cycle that requires special attention. Adolescent girls' health plays an important role in determining the health of future population, as it has an intergenerational effect.
As per NFHS-3, the data shows that 66.4 % of adolescent girls in the age of 15-19 years are anemic in Bihar. This is mainly due to menstruation, social factors such as gender discrimination in intra-household food allocation and early marriage leading to early pregnancy. Considering the fact that 25 % of the adolescents in the age group 15-19 years begin early child bearing during this period. Early marriage and pregnancy further aggravates their pre-existing anemia. (NFHS-3, 2005-06).
In adolescents, the anemia leads to a fall in academic performance with a drop in memory power and concentration level. It also leads to physical exhaustion and susceptibility to infection, thus increasing the risk of morbidity.

Anemia in Children:

There is adequate evidence to suggest that anemic preschool and school aged children reveal poor cognitive functions which can lead to cumulative deficits in school performance due to impaired attention, lack of concentration and memory. Also, it is found that there is reduced ability to engage in physical activities resulting in lack of stimulus for optimum development of motor skills in this crucial period.

The data on anemia prevalence in children are inadequate; however, they confirm that it is an issue of concern as the NFHS-3 reports that 87.4 % of children 6m-35 m are anemic. While, 66.2 % of children in the older age group of 3-5 years are anemic in Bihar. In Bihar, which is at the lowest rung of the development and with nutrition-health indicators far from satisfactory, it is not surprising to find that the prevalence considerably high.

Anemia, in its severe form, is known to be an underlying cause of 20.3 per cent of maternal deaths. It is now increasingly recognized that if the problem of anemia in women is to be overcome, it must be addressed across the inter-generational cycle, i.e., beginning from the period of adolescence (UNICEF 1997). The dietary practices and food habits as influenced by traditions, availability and family income also prevent the use of foods rich in iron to be included in the diet on daily basis.

Therefore, it is extremely important that oral supplementation of iron tablets or syrup be administered to these vulnerable groups. As per the revised policy vide letter dated 23rd April 2007 from MOHFW,GOI, the supplementation under the national prophylaxis program for prevention and control of anemia, **it is recommended that adolescent girls will be given due priority**. Recommended dosage is defined as under:

Beneficiaries	Dose	Duration
Women: Pregnant/Lactating	1 tablet of 100 mg/day	100 tablets in the 2nd and last trimester and 100 tablets postpartum
Children 6-24 months	1 tsf of IFA syrup (20 mg)/day	100 doses in a year
Children 2-5 years of age	1 tsf of IFA syrup (1ml=20 mg)/day Or 1 tablet of 20 mg/day	100 doses/tablets in a year
Adolescent Girls	1 tablet of 100 mg/week	52 Tablets in a year

In 2010-11 PIP State Health Society under National Anemia Control program apart from continuing efforts of IFA supplementation to pregnant women and Lactating mothers also piloted anemia control program for preschool children (Infant and Young children) in one and out of school adolescent girls in three districts of the state. Anemia control program activities for in school adolescent girls in high schools and special schools (KGBV, minority and socially excluded groups) are scaled up state wide in present cycle. In 2011-12 PIP State Health Society apart from continuing efforts under National Anemia Control program also recommends to scale the activities state wide based on learning from pilot to out of school adolescent girls and children 6-59 months in coordination with department of Social Welfare (ICDS) and Human Resource Development (Secondary Education & SSA).

Modus operandi:

Pregnant and Lactating women: As it was implemented in earlier program cycle essential Antenatal and post natal care services under maternal health and 'Janani Suraksha Yojna' will be the major center of anemia control program activities for the pregnant women and lactating mothers. "Muskan Ek Abhiyan" –the initiative to improve RI services will be used as forum for extending the IFA distribution to PW and LM using RI micro plans. Village Health and Nutrition day (VHND) organized in coordination with ICDS department will be utilized as the forums for counseling to PW and LM for increasing compliance, reduce the side effects and drop outs and also providing nutrition education for consumption of Iron rich food and positive effects of regular consumption of IFA on well being of fetus/child and mother during and after delivery.

Adolescent girls:

***In school Adolescent girls* :** The school anemia control program (SACP) is a coordinated effort of SHSB, HRD (Secondary School) with technical support of UNICEF Bihar and in 2010-11 program cycle program implemented in approximately **2800 high schools** benefitting **9 lakh adolescent girls** studying in class IX-XII. Logistic support (tablets) was provided under NRHM, IFA tablets supplementation at schools through teachers and jointly monitored program by health, HRD and UNICEF. The same effort will be continued in present PIP 2011-12 also. It is proposed to cover the cost of printing (recording/ reporting and IEC material), capacity building and monitoring in present cycle.

***Out of school Adolescent girls*:** As enrollment of adolescent girls in middle school and high school (IX-XII) is around 50% the major challenge is to cover out of school adolescent girls with weekly supplementation of IFA. SHSB has piloted a coordinated effort with ICDS (department of social welfare), secondary School (Department of HRD) with technical support of UNICEF in three selected districts in 2010 for registration and distribution of IFA to out of school adolescent girls through 'Muskan Diwas' and Village Health and Nutrition Day (VHND). This year it is proposed to scale up anemia control program activities state wide based on learning from pilot in three districts with financial allocation to cover the cost of IFA and deworming tablets, capacity building of field staff of health and ICDS, printing (recording/ reporting and IEC material), joint reviews and monitoring. Detailed guidelines for preparation, implementation, review and monitoring based on learning of pilot and with technical support of UNICEF will be released jointly in consultation with department of HRD (Secondary school and SSA) and department of Social Welfare (ICDS) and used as guide to reach all the adolescent girls (14-19 years) in state with quality.

***Adolescent girls in special schools*:** Anemia control activities for adolescent girls enrolled in Residential Bridge Course School and Kasturbas Gandh Balika Vidyalaya and minority schools has been implemented in all such schools in collaboration with Human Resource Department and Sarva Siksha Abhiyan (SSA) with technical support from UNICEF Bihar in 2010-11 PIP cycle. The efforts will be continue in present program cycle.

Children 6 months to 5 years (Infant and Young Children) : As per the revised policy, children 6-59 months should receive 100 doses a year of 20 mg Iron and 100 mcg of Folic Acid as syrup formulation or small tablets.

SHSB has piloted a coordinated effort with ICDS (department of social welfare) with technical support of UNICEF in one district in 2010 for registration and distribution of IFA syrup/small tablets to preschool (6-59 months) children by using **AWCs as point of**

distribution through 'Muskan Diwas' and Village Health and Nutrition Day (VHND). This year it is proposed to scale up anemia control program activities state wide based on learning from pilot in one district with financial allocation to cover the cost of IFA syrup/small tablets and deworming tablets, capacity building of field staff of health and ICDS, printing (recording/ reporting and IEC material), joint reviews and monitoring. Detailed guidelines for preparation, implementation, review and monitoring based on learning of pilot with technical support of UNICEF will be released jointly in consultation with department of Social Welfare (ICDS) and used as guide to reach all the preschool (6-59 months) children in state with quality.

Children 6-35 months During piloting process (one district) IFA syrup bottle with 100 doses has been handed over to mothers with adequate counseling on feeding practices, syrup supplementation and does and donts by AWW during Musakn Day in presence of ANM and ASHA. AWW and ASHA have mobilized all the mothers with eligible children to AWC for providing counseling and IFA syrup on RI days and outreach sessions.

Children 3-5 years: During piloting process (one district) the supplies in the form of pediatric tablets has been delivered to AWW by the visiting ANM on RI days. The entire quota for moth has left with AWC and the AWW in turn has distributed IFA tablets twice every week following poshahar under her supervision to all registered children 3-5 years. The dose for one week is handed over to mothers of the children who are not registered at AWC for poshahar along with councesling messages. These mothers asked to report weekly to AWC for collecting 2 tablets of IFA for week. .

This year it is proposed to scale up anemia control program activities state wide based on learning from pilot in one district with financial allocation to cover the cost of IFA syrup/small tablets and deworming tablets, capacity building of field staff of health and ICDS, printing (recording/ reporting and IEC material), joint reviews and monitoring. Detailed guidelines for preparation, implementation, review and monitoring based on learning of pilot with technical support of UNICEF will be released jointly in consultation with department of Social Welfare (ICDS) and used as guide to reach all the preschool (6-59 months) children in state with quality.

Important activities planned under Anemia control program:

- **State and district level coordination committee** for joint planning, review, monitoring and regular reporting. District Committee for inter sectoral Coordination under the chairmanship of District Magistrate is already operational in State for School Anemia Control Program. Activities undertaken for scale up of anemia control program for the out of school adolescents and preschool children are proposed to monitor by same Coordination committee to cover entire vulnerable groups. Civil Surgeon nominate District RCH officer or ACMO as the nodal officer for Anemia program for vulnerable group in Bihar and carried out coordination in key departments (Health, HRD & Social Welfare).
- **Survey for assessing beneficiary number:** AWC wise listing through survey is proposed to carried out by AWW & ASHA for out of school adolescents' girls and preschool children using predesigned survey formats Survey as it is done in pilot districts. Based on survey findings number of beneficiaries per AWC will be assessed
- **Capacity building of field functionaries**: Training of ANM, AWW and ASHA in all districts is proposed on program implementation and counseling. UNICEF is proposed to provide techno managerial support for creating master trainers at each block for capacity building of field functionaries. Head masters and Nodal teachers of Secondary Schools are already trained for anemia by UNICEF under School Anemia Control Program is proposed to use at resource group.
- **Social mobilization**: Social mobilization for increasing awareness and dealing with side effects of IFA is proposed as it is done under model pilot districts and state wide under school anemia control program in all the secondary school by UNICEF.

- **Logistic management: S**tate is proposed to use survey findings to procure and supply the IFA tablets (large and pediatric) and IFA syrup under the Anemia Control Program. ICDS, secondary education and SSA (Sarva Shikha Abhiyan) are the distribution points for adolescent girls (AWC & High School) and preschool children (AWC) as it is already undergoing in pilot districts in 2010-11.
- **Printing of IEC and reporting and monitoring formats**: IEC/BCC material and reporting and monitoring formats developed under pilot is proposed to review and used state wide.
- **Monitoring and joint review**: State is proposing scale up of anemia control program for the out of school adolescent girls and preschool children in 2011-12 in coordination with three departments. This emphasizes the need of strong monitoring and regular joint review mechanism in place. The cost of the same is proposed to be cover under NRHM 2011-12 as health being the nodal department for this coordination.

Detail budgetary calculation based on estimates for procurement (IFA tablets (small & large) and pediatric syrup), capacity building, printing (recording/reporting/IEC material and social mobilization is given in **Annexure IV)**.

S. No.	Activities	Total Amount (in Lakhs)
1	Cost of IFA tablets for app **41,44,885** Pregnant & Lactating mothers [Annex 1]	580.2839
2	Cost of IFA small tablets and syrup for app **1,28,95,198** children (6 -59 months) [Annex 2]	967.13984
3	Cost of IFA tablets for app **55,26,513** adolescent girls (14-19 years [Annex 3]	402.33017
Total-		19,49,75,391

Budgeted under NRHM Part B

PART-A RCH Flexipool Summary Budget 2011-12						
S. No.	Budget Head	Total Annual Budget (Rs. Lakhs)		NRHM	Others (specify e.g. State Budget, Finance Commission, Development Partners etc.)	Total
		High focus districts	State Total			
1	MATERNAL HEALTH					
(a)	Janani Bal Suraksha Yojana /JBSY		32695.95	32695.95	NA	32695.95
(b)	Others		4061.65	4061.65	NA	4061.65
	Sub Total Maternal Health	3203.06	**36757.60**	**36757.60**		**36757.60**
2	CHILD HEALTH	3977.41	4410.49	4410.49	NA	4410.49
3	FAMILY PLANNING			0.00		0.00
a	Sub-total Family Planning (excluding Sterilisation Compensation and NSV Camps)		2876.37	2876.37	NA	2876.37
b.	Sub-total Sterilisation Compensation and NSV Camps		7275.00	7275.00	NA	7275.00
	Sub Total Family Planning	10038.385	**10151.37**	**10151.37**		**10151.37**
4	ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH	506.97	514.75	514.75	NA	514.75
5	URBAN RCH (focus on Urban slums)	100.44	108.00	108.00	NA	108.00
6	TRIBAL RCH	0.00	0.00	0.00	NA	0.00
7	VULNERABLE GROUPS	0.00	0.00	0.00	NA	0.00
8	INNOVATIONS/ PPP/ NGO	606.54	613.25	613.25	NA	613.25
9	INFRASTRUCTURE AND HUMAN RESOURCES	30955.46	23378.57	23378.57	NA	23378.57
10	INSTITUTIONAL STRENGTHENING	4565.43	5165.56	5165.56	NA	5165.56
11	TRAINING	1218.68	3008.23	3008.23	NA	3008.23
12	BCC / IEC	0.00	743.92	743.92	NA	743.92
13	PROCUREMENT	0.00	0.00	0.00	NA	0.00
14	PROGRAMME MANAGEMENT	5482.05	6995.51	6995.51	NA	6995.51
	GRAND TOTAL	**60654.44**	**91847.26**	**91847.26**		**91847.26**

NRHM Flexipool | Part B

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 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.

A Regional Programme Management Unit has been created under the supervision of Regional Deputy Directors to ensure regular monitoring and follow up and interface between the State and the Districts.

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

1.1. ASHA

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

Under NRHM, 87135 ASHAs (revised as per the decadal growth in 2008) are to be selected and trained in Bihar. Target was 74313 (as per 2001 census for the year 2009-10). The first orientation training of seven days has been completed for about 66996 ASHAs. The 2, 3 & 4 module training as done by PHED and its NGOs till date 52859 Asha trained. The 5th 6th & 7th module to Asha is planned for the year 2011-12.
A total number of 78943 ASHAs have been selected so far. The ASHAs are given the copies of each module (Hindi version) and reading material in the form of flip charts for their better understanding and also dissemination of key health messages among villagers.

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

Sl. No.	District	No. of ASHA Selection Target	ASHA Selection till Date
1	**Araria**	2376	2336
2	**Arwal**	773	773
3	**Aurangabad**	2160	2160
4	**Banka**	1820	1722
5	**Begusarai**	2629	2310
6	**Bhagalpur**	2311	2114
7	**Bhojpur**	2264	2137

8	**Buxar**	1493	1492
9	**Champaran(E)**	4326	3410
10	**Champaran(W)**	3206	3063
11	**Darbhanga**	3550	3546
12	**Gaya**	3514	3352
13	**Gopalganj**	2371	2126
14	**Jamui**	1520	1488
15	**Jehanabad**	871	871
16	**Kaimur**	1462	1417
17	**Katihar**	2549	2534
18	**Khagaria**	1412	1376
19	**Kishanganj**	1368	1334
20	**Lakhisarai**	802	701
21	**Madhepura**	1711	1561
22	**Madhubani**	4046	3472
23	**Munger**	961	947
24	**Muzaffarpur**	3984	3558
25	**Nalanda**	2365	2334
26	**Nawada**	1959	1959
27	**Patna**	3233	2706
28	**Purnia**	2723	2270
29	**Rohtas**	2490	2276
30	**Saharsa**	1622	1242
31	**Samastipur**	3835	3409
32	**Saran**	3459	2885
33	**Sheikhpura**	520	458
34	**Sheohar**	580	473
35	**Sitamarhi**	2965	2204
36	**Siwan**	3008	2655
37	**Supaul**	1928	1690
38	**Vaishali**	2969	2582
Total		**87135**	**78943**

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

Table 1: *The compensation package of ASHA*

Sl. No.	Programme & Relevant Task	Amount of Compensation
1.	Janani & Bal Suraksha Yojana For Institutional Delivery and Full Immunization of the New Born	RURAL AREA- @Rs. 600/-(100 (Registration)+ 200(Transport)+ 300(B.C.G)) Per Pregnant Woman URBAN AREA- @ Rs. 200 (100- Registration+ 100 B.C.G)
2.	Mobilizing all the children of the village for Immunization(Under Muskaan Ek Abhiyaan) to be given to ASHA	5 to 10 Children = 50/- 11 to 15 Children = 100/- 16 to 20 Children = 150/- 20 to …. Children = 200/-
3.	Providing DOTS under Tuberculosis Control Program	Rs 250 per patient.
4.	For identifying Patient of Leprosy and accompanying him/her to PHC	@ Rs. 300/- P.B cases (Only Rs. Three hundred) Per Patient- Rs. 100 on confirmation of Disease and Rs. 200 on completion of treatment @ Rs. 500 M.B. cases per patient-

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

Programme Description :-

Communitisation process involves empowerment of community based institutions, health activities and community managed interventions as outlined in the National Implementation Framework of NRHM. To contribute to effective facilitation of supportive structures and mechanisms at all levels of Programme implementation which essentially needs appropriate monitoring, mentoring, handholding and leadership support to the ongoing initiative in addressing health, health care and health services for the rural poor. In this context, a **State Owned Resource Centre** of its unique nature is conceptualized and proposed to facilitate health system, strengthening within the existing governance mechanism under NRHM. This would help in integrating various efforts of communitisation processes for achieving effective outcome.
This is mandated and specially designed to implement, support and facilitate community process while mobilizing appropriate technical assistance from NHSRC and partnership support involving key stakeholders from the government, NGOs , research institutions etc. ARC will operate under strategic direction and leadership of Executive Director, NRHM in the State.

Rationale:-The State of Bihar, has the population of approximately 9 crores, with prevalence of malnutrition in under 3 years Children is 58(NFHS- 3), IMR 56, (per 1000 Live birth MMR- 312 per lakh population). One of the main goals of NRHM is to reduce IMR- to 30 and MMR to 100 upto 2012. Under NRHM, ASHAs are the key functionaries with the target of selection of 87135 ASHAs and approximately 78,000 selected ASHAs. In lieu of this there is an urgent need to create a support structure for ASHAs at the grassroots level to handhold the ASHAs so as to better the efficiency of the ASHAs which is very much required for effective programme implementation. For providing regular support strong support structures needs to be built up at the State, District and Block. ASHA programme is the backbone of NRHM and reflects creation of community processes that help strengthen and empower the community towards better health care.

For creating these processes establishment of ASHA Resource Centre is an urgent requirement for the State of Bihar, so that the communitisation processes are created effectively. Since the programme is of such huge magnitude, it is very much required and essential to speed up the programmatic interventions systematically specifically the trainings.

ASHA Resource Center is to contribute in supporting for Community Processes under NRHM;

ASHA Resource Centre (ARC)

NRHM has in place several community processes, such as the ASHA programme, establishment of Village Health and Sanitation Committee (VHSC), VHND Village Health Planning, provision and management of untied funds to the sub center and VHSC, increasing public spaces for participation in health, Rogi Kalyan Samitis, and Community Monitoring. The ASHA is seen as a key figure in enabling these processes. The past few years has shown that in the absence of support and supervision to ASHA, her role in enabling such community processes remains limited.

Several reviews of the ASHA programme have demonstrated that for effective facilitation of the ASHA scheme, a supportive structure at all levels of programme implementation (State, District, Block, Village level etc.) is required for monitoring, mentoring, and handholding support to the initiative. This document lays out the Terms of Reference for establishing an Asha Resource Center at the state level.

Background:

Bihar is one of the high focus states under the NRHM. Thirty six of Bihar's districts are in the category of backward districts in the country. As of March 2010, 77,000 ASHA have been selected and an additional 7000 are now being recruited. One round of ASHA training was conducted four years ago, and covered the topics under the national Module 1. To expedite training, Modules 2, 3, and 4 have been clubbed and a combined ten day training planned. This has been completed in eight districts. ASHA training has been outsourced to PRANJAL, a set up by the Public Health and Engineering Department. With little experience in community based health interventions and limited coordination with state and district health structures, the ASHA training component lags behind the other states.

The state now wishes to establish an ASHA Resource Center (ARC) to ensure that training, monitoring and supervisory functions related to ASHA and other community processes are effectively coordinated, of high quality and move at a more rapid pace.

I. Institutional Arrangements in the ASHA Resource Center (ARC)

(i) State Level

At the State level, the ASHA Resource Centre will operate under the strategic direction and leadership of Executive Director, NRHM and in close coordination with the State Health System Resource Centre.

In each district, the ARC will have a team comprising of one District Community Mobilizer and one Data Assistant. The District Community Mobilizer will work in close coordination

with the DPMU and report to the Programme Manager/Consultant, ARC, through the DPMU.

At the Block level, the ARC will recruit a Block level Organizer, who will be assisted by the ASHA facilitator who will be the 21st ASHA. The Block Community Mobilizer/Block level Organizer will report to the District Community Mobilizer and the Block Medical officer.

Roles and Responsibilities of ARC at state, district and block levels.

The role of the State ARC is to provide technical support to the State Programme Management Unit (SPMU) and the State and District Health Societies for strategic planning, implementation, monitoring and coordination of all activities related to the community processes component of NRHM, viz: The ASHA programme, VHSC, VHND and Village Health Planning, RKS and community monitoring under NRHM. The ARC will also be responsible for coordinating with the National Health Systems Resource Centre NHSRC/SHRC for facilitation of technical assistance to strengthen programme effectiveness and capacity building on community process on a regular basis.

The broad responsibilities of the ASHA Resource Center at the state level include:

Planning, Implementation Review and Feedback to State Planning Processes

- To act as the secretariat of ASHA Mentoring Group.
- Develop annual work plans with specific deliverables and measurable outcome s
- Review and assess ongoing community processes and provide feedback to the development of the annual Project Implementation Planning (PIP).

Training and Capacity Building

- Assessment of training needs of VHSC, VHND, ASHA, ASHA facilitators, block mobilizers, and district mobilizers.
- Identifying a cadre of trainers at state, district, and block levels with the appropriate skill mix to provide quality training to ASHA
- Ensuring and maintain a stable team of district and block trainers. .
- Designing a training plan for trainers, district and block mobilizers, ASHA facilitators and ASHA.
- Designing state specific training modules and communication material
- Identifying partner NGOs and training sites (for those training components that need competency based training)
- Planning, implementing and monitoring the training programme in consultation with the districts at district, block, and sub block levels.
- Conducting training of trainers in collaboration with NHSRC and the national trainers.

Monitoring and Supervision

- Develop data base to track ASHA, VHSC & VHND through the structure at sub block, block, district and state levels to enable tracking of dropouts, payments, and to use as a planning and monitoring tool
- Developing/adapting monitoring formats and registers for ASHA, VHSC, and for the community monitoring process.

- Developing/adapting supervisory protocols and check lists for staff at various levels
- Developing monitoring formats for block, district and state ARC teams
- Develop s schedule of review and monitoring visits at the various levels
- Organizing Monthly review meeting with the Mission Director/SPMU

Coordination and Convergence

- Assist Mission Director for effective coordination among various stakeholders from the government departments and non-government sectors to strengthen community processes.
- Ensure effectiveness in programme monitoring and updating programmatic progress to the Mission Director periodically.
- Identify generic and specific impediments to the programme in districts and enable problem solving at district and state levels.
- Build partnerships with civil society organizations to serve as resources in training and capacity building of ASHA and for other community processes.
- Address issues of convergence with PRI and WCD to strengthen effectiveness of ASHA and other community processes.
- Ensure training & implementation programme on convergence for National Aids Control Programme for ASHA`s

Development of IEC/ BCC material, and Documentation

- Develop IEC/BCC/Advocacy related activities contributing to the community processes at the state level and district level.
- Documentation of successful innovations and model community processes, sharing with key stakeholders and develop scaling up strategies.

Specific Functions related to ASHA

- Review and strengthen existing selection processes, in order to recruit the full complement of ASHA required, and plan for recruitment strategy for drop out.
- Ensure role clarity and advocate for an enabling environment to improve ASHA effectiveness.
- Identify state specific issues for inclusion into future rounds of ASHA training and ensure that the requisite 23 days of training for ASHA are held each year.
- Facilitate ASHA training programmes at sub block levels through the district and block level structures.
- Facilitate timely incentive payments through regular reviews and assessments and spot checks of the situation related to payments
- Ensure distribution and refilling of drug kits to ASHA
- Strengthening the role of ASHA as an Activist through processes like Social Audit and Social Mobilization.

Responsibilities of the ARC at the District Level

The major responsibilities of District ARC (especially District Community Mobilizer) are;

- Capacity building of Block facilitator and Block Trainer's Team in coordination with District Trainer's Team
- Create and maintain district resource database for the health sector and assist in optimal allocation of resources

- Coordinate with other govt. dept. such as; WCD, Water and Sanitary, Education and PRI, at District level for intersectoral coordination, and support Block facilitator for the same at block level.
- Develop measurable performance indicators for the District and Block level ASHA support system/unit.
- Undertake periodic review meetings for ASHA programme and community processes.
- Undertake frequent field visits for supportive supervision to the activities related to community processes implementation..
- Arrange visits/meetings of ASHA Mentoring Groups at District and Block Level.

Responsibilities of the ARC at the Block Level

- Block level mobilizer will assist Block Medical Officer for the effective implementation of ASHA, VHSC, VHND and other related community processes activities in the block
- Capacity building of ASHA facilitators and ASHAs (in coordination with Block level trainer's team), review, implementation and monitoring of ASHA, VHSC and other related community processes activities.
- Coordinate for monthly meeting at PHC to discuss and sort out various issues of ASHAs relating to incentive payment, drug kit replenishment etc.
- Coordinate with other govt. department such as Health, WCD (ICDS official), Water and Sanitation, education etc. at block level for inter-sectoral coordination
- Support/guide ASHA facilitator for various coordination at village level
- Submit reports on the above activities to District ASHA Coordinator

(iv) Sub Block Level

At the sub block level, one ASHA/Block facilitator for every 20 ASHAs to assist Block level organizer as well as to provide continuous handholding support to ASHAs will be engaged. She will be the 21st ASHA herself. She will support ASHA for/in coordination with ANM, AWW, PRI, VHSC, SHG etc., and will report to Block level organizer. She will support ASHA in organizing monthly meetings, Village Health and Nutrition Day (VHND), VHSC meetings as well as monitor drug kit replenishment. It is expected that she will spend 22 days in the field to provide support ASHA in her area of operation. This has been special envisioned for empowerment and developing leadership skills of ASHA.

IV. STAFFING OF THE ARC

State ASHA Resource Centre

↓

District Asha Resource Centre

↓

Block Asha Resource Centre

↓

Village level Centre

ARC Structure State Level

ED, NRHM as Chair Person

↓

Member Secretary, Asha Resource Centre

↓

Team Leader

↓

Deputy Programme Manager, Asha

↓

9 Divisional Co-ordinator

↓

Consultants

↓

Account Assistant

↓

Data Assistant

District Level

↓

District Community Mobilizer

↓

District Data Assistant

Block Level

↓

Block community Mobilizer

Asha Facilitators

21st ASHAs

Objectives;

- Ensure the availability of state specific institutional support to Community Processes under NRHM.
- Strengthening of ARC Team capacity in undertaking training appraisals, assessments, facilitation and documentation of above outlined contributions strategically with active involvement of NHSRC/SHRC.
- Development, Training, Review and Mentoring support to District and Block level support team responsible for facilitation of Community Processes.

- Undertaking periodic review, assessment and orientation of State and District Health Officials for ensuring effective cooperation in the ongoing programmatic implementation.
- Identifying districts of innovations and less adequate functioning in undertaking corrective measures through coordination of technical assistance and mobilization of facilitation support strategically.
- Secretariat of State ASHA Mentoring Group and Secretarial Support for the visit of members of State ASHA Mentoring Group to different districts. Also, organization of AMG meeting and dissemination of recommendations of State AMG on a quarterly basis with the support of NHSRC/SHRC.
- Strategic coordination with NHSRC/SHRC for facilitation of technical assistance to contribute to program effectiveness and capacity strengthening on community process on a regular basis.

Detailed terms of Reference for ASHA Resource Center are:

S. No	Activity	Sub-activities
1	Recruitment of Staff	1. Recruiting staff like Program Officer, Research Officers for ARC 2. Recruitment of District ASHA Facilitators and Zonal Facilitators.
2	Technical backstopping in Training	3. Develop user friendly training methodology and the training modules. 4. Print the modules in prescribed time, 5. Disseminate the modules in the District. 6. The modules are being developed by MOHFW; GOI .These will be modified in the state context on the basis of functions of ASHA. 7. Work on the training modalities 8. Provide the supportive supervision to maintain quality checks and control at District and Block level.
3	Development of IEC Material	1. Developing or collecting the IEC material from different agencies for dissemination during the training. 2. Develop and disseminate the facilitation kit including flip books, chart, posters etc on different related issues. 3. Develop need based IEC material from time to time.
4	Planning of Monthly Meetings	1. Develop tentative monthly agenda for the monthly meetings including the Mentoring group;; 2. Provide required resource material and IEC material. 3. Develop the monitoring mechanism for the meetings.
5	Development of Reporting formats and registers	1. Develop the formats and orient ASHA for its utility and use. 2. Defining indicator.
6	Processing of Statistical Data and records	1. On the basis of reports and registers of ASHA and other sources of data's. ARC will compile the statistical data, analyze the data and provide the feedback of the program to the Mission.
7	Intersectoral Coordination pertaining to ASHA	1. Coordinate with different departments and facilitate empanelment of ASHAs in various other programs like Sarva Shiksha Abhiyan, Total Sanitation Campaign etc.
8	Planning, implementation and strengthening f	1. Will be done through the M & Evaluation wing/CBMP Wing for effective coordination and implementation.

	community planning and monitoring process	
9	Involving NGOs to strengthen the program	1. There could be many roles of NGOs and these roles could be identified by the ARC. In consultation of NRHM the NGOs should be involved in the program.
10	Provision of Drug Kits	1. Facilitate the procurement process and supply it to ASHA. 2. Develop the mechanism to maintain at least two months stock of medicines with ASHA. 3. Development of strategic plan for regular replenishment.
11	ASHA role in Village Health Plan	1. Capacity building of ASHA so that she could help in planning and implementation of Health Programs in the Village.
12	Organize Quarterly meeting of Mentoring Group	1. Conduct the quarterly meetings of the mentoring group. 2. Incorporate the valuable inputs provided by the group in the program.
13	Provision of services of Helpline & Grievance Redressal	Form and strengthen the helpline for the ASHA and associated functionaries. strengthen the ASHA Help Desk at the block level. 1. Respond to the queries or clarifications needed in the field. 2. Ensure the prompt help is provided to ASHA.
14	Capacity Building and academic support programme to approx 1000 ASHAs	- facilitation of the districts in identification and - Enabling ASHA 10th pass For up gradation of academic strength of ASHA, SHSB will provide examination fees for the 10th examination of open schooling mode/Board/IGNOU to 1000 ASHAs. Fee for the same to be provided by SHSB.
15	Motivations for ASHA (if the process still continues for the next year) and Identity for ASHAs	Provision of two sarees and 1 umbrella to ASHAs Best performance award to ASHAs at district level. @ Rs.200per block= 3 ASHAs from each block @ Rs.1000 for 1st, Rs.500 or 2nd and Rs. 300 for 3rd prize, Rs. 200 for Certificate printing and distribution.
16	Organizing ASHA Sammelan, Exposure visits	1. Organize such events with the help of State Health Society and District Health Society. 2. Also organize the exposure visits with in the state and outside the state.
17	Linkages of ASHA Resource Center-	1. Provide support to the districts through NRHM and all the administrative guidelines will be issued through NRHM.

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

B. At the District Level

1.11 Personnel :- District Community Mobilizer, She/He are 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, for all the Asha programme and community process.

C. At the block level.

1.12 Personnel :- The block community mobilizer, Asha She/He are appointed in the capacity of Block Community Mobilizer and will act as a Nodal person at the Block level for effective programme management, implementation and execution, for all the Asha programme and community process.

D. At Village Level:-

1.11 Block Facilitator- ASHA/Cluster facilitator:- 1 on every 2ASHAs who will be the ASHA herself. The Facilitator will be the 21st ASHA worker. This will help in building up and developing the necessary skill required for a community health worker in a sustainable wayVillage Health Planning and Monitoring Committee Revenue Village

1.12 ASHA Training

Statutes of Asha Training :- Module –I -66996**, Module 2, 3 & 4 -** 52859

No of District	No of Districts where training of ASHAs completed	No. of Districts where Districts TOTs completed	No of districts where no training has been conducted
38	30	30	8

ASHA Training on Module 6 and Module 7
Training Strategy and Plan for Roll out

I. Background:

ASHAs have now completed five rounds of training. The first four rounds have served as an introduction to health issues and built up awareness on a number of health services. The fifth round focussed on the theme of empowering ASHAs to understand her own role and the role of social mobilisation and health rights. Now as the programme moves into the fourth year, there are increasing requests from many states and from ASHAs themselves, to develop specific skills that could enable her to be more effective to respond to immediate health priorities, and which would also allow for development of selected measurable outcomes from the programme. ASHA modules 6 and 7 focuses on the development of a set of competencies (Annexure 1), the majority of which relate to improving maternal and newborn health, child health and nutrition, and selected disease control programmes.

Modules 6 and 7 will be rolled out only in those states which opt for them. Roll out of training will be undertaken on a priority basis in the EAG and NE states and in the 235 backward/poor performing districts (based on poorest indicators for health, demographic and other socio economic variables). These districts, account for about 35% of the population but contribute to over 50% of infant deaths and over 65% of maternal deaths in the country. Skilled human resources are scarce in these districts and building the skills of ASHA to address basic maternal, newborn and child health care would yield positive outcomes.

ASHA who are already trained in Modules 1-4 will be selected for training in Module 6 and 7. Rajasthan, Uttar Pradesh, Jharkhand, and Chhatisgarh have already trained

ASHA on various topics that are part of Modules 6 and 7. The training strategy will be adapted in their states based on discussions with the state team.

Roll out of Modules 6 and 7 training for ASHA necessitates that states have strong support structures in place to ensure quality control, support and supervision of the training. These include a State ASHA Mentoring Group, a state ASHA Resource Centre, District and Block Community Mobilizers and ASHA facilitators (one ASHA facilitator per 20 ASHA is recommended). Training for Modules 6 and 7 also requires a committed cadre of trainers at state and block levels, and state level training sites. Until such time as states and districts are able to meet these requirements, selected national sites across the country will serve to prepare district training teams (comprised of trainers from blocks) so that the roll out is not delayed.

II. The Four levels of Training:

a. Levels of ASHA training

The training for Modules 6 and 7 is envisaged as taking place at four levels:

Levels	Category to be trained	Site of training
Level 1	Training of ASHA	At specific training sites in the district
Level 2	Training of ASHA facilitators	At specific training sites in the district
Level 3	Training of ASHA trainers	At any one of three training sites in the state
Level 4	Training of National and State Trainers	At selected training sites across the country

b. Venue of Training :

b.1 Where will ASHA be trained?

Training of ASHA will take place in multiple sites within the district with adequate training and infrastructural facilities, close access to a community. and linkages to a health facility with an adequate caseload of newborns and children with illnesses. The training site could be managed by an NGO. Even if an organization that has an active community presence and linkages does have not the requisite infrastructural facilities, it should be able to rent such facilities on a long term basis. The caveat is that such training facilities (accommodation and training) should be close to the field operation site, and within easy access of the health facility, which could be a block PHC or CHC depending on the case load. Given the training loads, multiple training sites within the district are unavoidable, and the District Training Team with the District and Block Mobilizers and State ASHA Resource Centre will facilitate quality control and effective supervision. In all, the sites are expected to train 1800 ASHA for four rounds of training during the course of one year. Thus at least five sites are required in a district.

b.2 Where will ASHA facilitators be trained?

ASHA facilitators will also be trained in the same site that the ASHA will be trained in, although earlier in the training cycle, since they are also expected to support he ASHA trainers during the actual ASHA training. About 90 facilitators are expected to be trained within a district.

b.3 Where will the ASHA trainers be trained?

The long term strategy for training ASHA trainers is that they would be trained at specially identified sites within the state which have adequate training facilities, boarding and lodging arrangements, an active community health programme, and linkages to a health facility. The option of an active community based NGO serving as the training site, with linkages to a CHC or district hospital with adequate caseloads could also be explored. Such sites should also have personnel who will form part of the State Training

Team. The creation and strengthening of such sites would also serve as demonstration sites for future trainings. Each district will have about 25-30 individuals to be trained as ASHA trainers.
However for the short term, particularly for the 235 high focus districts in 24 states, the ASHA trainers will be trained at one of 15- 20 national training sites (Details of roll out and list of possible organizations is at Annexure 2) across the country. In any event this is to be considered an interim measure for a space of about 15 months until state level training sites are created and strengthened. Thereafter ASHA trainers will be trained in the state for subsequent training. This is the responsibility of the State ASHA Resource Centre.

b.4 Where will state level trainers be trained?

State trainers will be trained at the selected state sites (referred to in b.3). The training of state trainers will be undertaken by a cadre of National Trainers (please see b.5) Once each round of training for the state level trainers is completed, these trainers in teams of two or three, are expected to train the ASHA trainers and observe/facilitate the training of the ASHA facilitators and ASHA.

However for the short term, the state trainers will also be trained with the ASHA Trainers (please see b.3) at the national training sites. Once the state sites are ready, the state trainers can be trained at the state sites by national trainers.

b.5 Where will national and state level trainers be trained?

A cadre of about 50 National Trainers, drawn from various NGOs and other training organizations, will be trained at the national level, in sites which have full fledged community health programmes with a strong community health worker intervention, and where the staff of the organization is experienced in training of master trainers. Once each round of training for the national level trainers is completed, these trainers are expected to support the staff of the state training site in training state trainers, and should be called upon as national resource persons at the state level.

A cadre of about 35 National trainers have already been trained in Round One of the training. These trainers will now support the faculty of the national training sites in conducting the training of trainers from the states and districts.

c. Normative calculations for a state, district and block:

In a normative district of ten blocks and 18 lakh population, it is assumed that there would be 180 ASHA per block, and 1800 ASHA in a district. There would also be nine facilitators per block and thus 90 facilitators per district. Each block would nominate two trainers, making a total of twenty trainers per district In addition 3-5 District Resource Persons would also be identified who would serve as support for conduct of session or fill in when there is attrition or vacancy. Thus a typical District Training Team would have about 23-25 trainers. At the state level, a team of about nine state trainers will form a State Training Team, who would work closely with the ASHA Resource Centre in supporting the district and block level training for purposes of training, quality control and supervision. All calculations for the training roll out are based on these estimates.

III. Human Resource Definitions:

a. Who is an ASHA trainer?

An ASHA trainer is the direct trainer of the ASHA. She/he is an individual selected from within the district, preferably at the block level. Every block should have a team of two ASHA trainers. The team of two trainers from every block (twenty in total) constitute the District Training Team. One of the two trainers should have a health and clinical training and experience, such as a staff nurse, ANM or LHV or a doctor who is also motivated, interested, qualified and experienced. If such an individual is selected from within the public sector, she/he should be deputed to the training programme and relieved from other work as a priority. The other ASHA trainer should be an individual with experience of community based health interventions, drawn from an NGO, with the experience of working with communities on health issues. This trainer should be employed as a full time worker. This individual could also be the Block Community Mobilizer.

These trainers would either be already experienced community health trainers deputed by NGOs, or drawn from a pool of public health nurses, nurse tutors, or even dynamic LHVs. Staff of the training site should be preferred as ASHA trainers. Trainers would be selected based on specific criteria. The responsibility of selection of the ASHA Trainers is that of the District Community Mobilizer with the support of local NGOs and representation from the state ASHA Resource Centre and the State ASHA Mentoring Group. After each Round of training the ASHA trainers will spend at least two weeks in the field to observe ASHA functioning and identify training lacuna which can either be corrected there or be included in the subsequent round of training.

b. Who is an ASHA facilitator?

An ASHA facilitator is responsible for visiting the ASHAs in the villages, providing support, supervision, and on the job training. ASHA facilitators form the main vehicle of community mobilization and monitoring. The facilitators would also assist the ASHA trainers in the training workshop. There is one ASHA facilitator for every 20 ASHA, so there would be roughly 5 ASHA facilitators in a block.

The ideal candidate for an ASHA facilitator is a woman who is a resident of the local area (living in the cluster of villages where she supports the ASHA), with training and experience in health. A graduate in social work, or a Class XII pass individual with health experience could be considered, based on the given situation in the districts. An ASHA who has an academic qualification of Class XII and above, has demonstrated success, and is dynamic can be promoted to the role of ASHA facilitator. If she is agreeable, she could continue to be the ASHA for her area, provided there is agreement that she can manage both tasks, or anew ASHA can be appointed.

c. Who is an ASHA District Resource Person?

An ASHA district resource person is an individual, (man or woman), who is experienced in training and has an understanding of health/clinical issues. Such an individual could be deputed from the government or from an NGO, but is required to be full time and available for 18 months during the entire process of training. Every district is required to have at least three to five DRP. As far as possible, all of the DRP should have clinical experience. If not at least one should be a doctor, nurse or an LHV. The District Resource Persons also form part of the District Training Team with the ASHA trainers.

d. Who is an ASHA state trainer?

An ASHA state trainer is an individual who has substantial experience in training in community health and preferably with a clinical background. At least nine full time state trainers are required for a state. Roughly 50% of the state trainers should be drawn from organizations which serve as the training sites. Nine full time trainers with considerable past experience in training, at least half of whom are women, and preferably located and employed within an NGO or the agency which serve as the state level training site. If possible, for the period of the training, all state trainers should be affiliated to one of the three state training sites, to ensure continuity and coordination. These ASHA state trainers will also be responsible to support and facilitate the District training teams as they conduct training of ASHA facilitators and ASHA.

e. Who is a national trainer?

A national trainer is an individual who has substantial training and subject matter expertise. They will be drawn from various national mentoring organisations of the ASHA programme and other training and community based organizations. Some (about 40%) of these national trainers will become available full time whereas most remain part time. This strategy ensures that: a) There is core cadre of national trainers whose continuity in the programme is reasonably assured, and b) that whenever a state is ready for its next round of training, these national trainers can be called upon at short notice. The role of these trainers is to conduct the training of the state level trainers at the national training sites and to support the state trainers in training ASHA trainers at the state level.

IV. Sequence of Training

a. Training of national training teams

The training would be in three Rounds of 16 + 8 + 8 days.
Trainees: Their skills are developed across all training areas (classroom teaching, field practice, and clinical case demonstration).
Trainers: Faculty at national training sites
Site: The national trainers will be trained at one of the selected sites at the national level.

b. Training of state training team

The training would be in three Rounds of 16 (with additional one day for evaluation) + 8 + 6 days.
Trainees: For the state trainers, (who are all full time) the nine members of the state training team will be chosen from the state based on their credentials. At least half of them should be existing staff of the three training sites. The others should be willing to be affiliated to the organization managing the training site, for purposes of coordination and administration. All state trainers should be available to travel and supervise the training at lower levels. The state trainers will be trained at the national training sites. Once the entire cycle of three Rounds has been completed, the state trainers would receive additional seven day training at the national training sites to equip them to manage and support future training in the states.
Trainers: National Trainers
Site: National Training sites/State training sites (after they are ready)

c. Training of ASHA trainers :

Duration: 27 days: 14 + 8 + 5 days
Plus about two days per month of review and refresher training.
Trainees: Three to five district resource persons and two trainers from each block, make a total of 23-25, forming a District Training Team in each district. This is the cadre that will train the ASHA facilitator and the ASHA.
Trainers: Faculty/Resource persons at national training sites and state trainers (once the state training sites are ready)
Site of training: National Training sites (For the short term) and at state training sites (once they are ready)

Training Batch Size: 23-25.

Normative Calculations for training load for the short term strategy: Each training site will train ten DTT in one Round over five months. Thus three rounds will be completed in fifteen months.

Training of ASHA facilitators :

Duration: 22 days: 7 + 5 + 5 + 5 days in camp mode:
Plus about two days per month of review and refresher training (one with the District Training Team and one with the ASHA themselves).
Trainees: ASHA facilitators: (three batches of 30)
Trainers: Three district resource persons – plus two trainers from each block .
Site of training: Three to five sites in the district, with good support logistics, a community support network and access to health care facilities with an adequate caseload of sick children, deliveries, and newborns per month. These sites will serve as ASHA training sites subsequently
Training Batch Size: 30

Normative Calculations for training load: In a normative district of 10 blocks with 1800 ASHAs – the total number of facilitators that would have to be trained would be 90. Thus Round 1 for all three batches would be completed on one month, and the subsequent three rounds would require about 15 days each. Each Round of training would have a gap of at least four to six weeks, to enable the ASHA facilitator to participate in the ASHA training and conduct actual mentoring of ASHA, to enable field practice.
Training of ASHAs:

Duration: 20 days: Four Rounds of 5 + 5 + 5 + 5 days
The contents of the ASHA training modules 6 and 7 will be covered in four rounds over 20 days (5+5+5+5) spread over one year. The trainings are residential in nature. In addition ASHA will receive two days of structured on the job training each month, when her facilitator visits her in the field.
Trainees: ASHA
Trainers: The ASHA training will be conducted by the ASHA trainers, drawn from the District Training Team. Each batch of ASHA would be trained by two ASHA trainers supported by the District Resource Person, respective facilitators and state trainers.
Site of training: At least three to five sites in the district (each capable of running two training batches concurrently), with good support logistics, a community support network

and access to hospitals with an adequate caseload of sick children, deliveries, and newborns per month. These sites will serve as ASHA training sites subsequently
Training Batch Size: 30 ASHAs:

Normative District Calculations: In a normative district of 10 blocks and 18 lakh population one would have 1800 ASHAs in the district or 180 ASHAs per block. Thus the two trainers and 9 facilitators in a block would train 6 batches of ASHAs, sequentially, which would take 6 weeks to complete. The two trainers would spend all six weeks only on training activity on a full time basis. In the four months after the DTT is trained in Round 1, they will train the ASHA in Round 1 and 2. After they (DTT) have been trained in Round 2, they will train ASHA in Round 2, and will complete the cycle with Round 4, after they have been trained in Round 3.

v. Training Methodology:

1. The role of training sites:

Training will be done in multiple sites at state and district levels. Training for state trainers and district training team includes a period of staying in the village and actually working with ASHA in the field for one week, on all the tasks required of the ASHA.

Each state would develop three state training sites and five sub district training site, preferably one where there is an NGO led community health training programme. Each district training site would serve two blocks.

The field situation should be conducive to trainers spending time in the community during the training period. The choice of site does not imply that the NGO is the nodal agency for the entire state training team or that they would be responsible for the state training. The state training team would be a composite of more than one NGO and government institutions like the State ASHA resource centers. Nevertheless, such field sites are required both as inspirational models, and to serve as a field practice areas.

Organizations which have the potential to serve as such sites would be identified in each of the states and districts. In states where there are no such sites, a block level ASHA programme which has proven to be effective, could be supported to serve as a field site, or an NGO or training agency or medical institution with community outreach programmes could be funded to support and train ASHAs in one block plus hire three persons to serve as state trainers.

There is conscious effort to move **away** from a model where in the national level gynaecologists and paediatricians are trained in huge tertiary care hospitals who then train medical officers in a secondary care hospital who then train nurses in a primary care hospital etc...From the beginning the training of ASHA trainers and facilitators must be based in the community and the same trainers must be available at every stage to follow up and evaluate subsequent training stages.

2. The technology of training:

The core of the training syllabus is contained in modules six and seven, which would be made available in every language as a take-away book for ASHAs. This would be supplemented by training aids packed as a training kit that would include an animation

film, posters, situation cards and a trainer's manual. This training kit would include protocols for on the job training and village visits.

3. The pedagogy of training:

There would be some short lecture- presentations. Most sessions would have practice of skills and/or small group discussions and small assignments to be carried out. There would be field visits during the training programme. The training programme would also include examination of newborns and children as part of the practicum and this will be done during the field work that would be undertaken by ASHA and the ASHA facilitators between the training rounds. Clinical and field situations with problem solving exercises would also be demonstrated using films and situation cards. Training evaluation for every batch of trainees is mandatory.

4. Accreditation of Trainers and Certification of ASHAs.

Trainers will be certified for training as soon as they have completed each round and accredited by a suitable agency once they have completed the full course. Though by this time the full training of ASHAs will also be nearing completion, accredited trainers would be a resource for training fresh ASHAs and for future rounds of training and even the development of training institutions which could train VHSCs, PRI members, SHG groups, etc.

The process of certification of ASHAs would involve documentation of her field work over the last six months and the training evaluation of the last two rounds of training. The needs of externality would be achieved by an external agency representative being present and monitoring the training evaluation of the last round of training and collecting and correcting these papers. A separate one day evaluation session may be organized where this opportunity has been missed. (Where literacy levels are low, the evaluation would need to be assisted. Encouragement and linkages for achieving fluent literacy should also be integrated into the training programmes for ASHAs).

The certifying agency could include any agency other than the one which provided the training. Government staff, trained for this purpose could also be appointed. It is not so much who evaluates, but if she/he has clarity on the standards to be achieved in the modules, and high quality training in the tools of evaluation, that would contribute to effective evaluation and certification.

VI. MANAGEMENT OF TRAINING AND POST TRAINING SUPPORTIVE SUPERVISION:

At the National level, NHSRC will work closely with NRHM, the Training Division and the National ASHA Mentoring Group, to ensure selection and orientation of national training sites, training of national trainers, and enabling states to coordinate with the national training sites. They will also ensure that the modules, training material, and training aids are supplied to the national training sites. They will also review and support the training at the national sites.

At the state level, the State ASHA Resource Center will provide oversight and monitoring of the training, including selection of state trainers, trainers of the District Training Team, ensuring that support structures in the district are in place, identification and

strengthening of the state training sites, coordinating the logistics of nominating of state trainers and district trainers, to the training at the national sites (until their own sites are ready). The State ASHA Resource Center should also draw upon members of the State ASHA Mentoring Group and other NGOs/institutions in the state as appropriate to support this process. The state ARC is also expected to ensure timely supply of the translated modules, training material and other training aids to the district sites. The State ARC should maintain a data base of the district training which will serve as a monitoring tool to enable early diagnosis of lacuna in training schedules, drop outs among trainees and trainers between rounds, and training quality.

A meeting of the District Training Team (DTT) including the District Community Mobilizers will be held once a month at the district level in collaboration with District Health Society, to review quality of training, logistics and other training related issues. The block team will hold monitoring meetings for the facilitators on a fortnightly basis to review the ASHA functioning problem solving, MIS data collection and distribution of drugs and supplies.

Monitoring of ASHA training, records, support and supervision will be the responsibility of the facilitators and the trainers. This is to be supported and supervised by the State ASHA Resource Centers in collaboration with the District and Block Community Mobilizers.

The facilitators will visit the ASHA in the field, review their records (Maternal and New born cards, diary and village health register), conduct home visits to families of children with newborns and socially marginalized families. This will form the basis of monitoring at the field level. The ASHA should be encouraged to maintain the Maternal and Newborn Card. The facilitator will use a set of standardized protocols and checklist for ASHA. The facilitators would collate the data from the ASHA and submit to the Block Community Mobilizers for input into the block Management Information System. This data would provide information on the key outcomes and enable block and district managers to assess quality of inputs and identify issues that need to be resolved.

Every ASHA must be visited on the job at least twice if not thrice a month. At least one of these visits should be in the hamlet where she provides services. The other one or two could be in a local- GP level/sector level/block level- meeting- which in many places is being held as the ASHA divas. The ASHA facilitator will be responsible for making the visit. The ASHA facilitator is also to be held accountable for ensuring refill of the drug kits- provided drugs are made available to her at the block level.

VII. DELIVERABLES-

ASHAs in a block will be skilled and certified in areas of Newborn care, First Contact Care for the sick child, Infant and Young Child Feeding, Immunization and support to VHND, Support to Pregnant Woman and the Village Health and Sanitation Committee.

Key Outcomes:

1. Increase in proportion of babies breastfed early and exclusively.
2. Increase in proportion of newborns weighed at birth

3. Increase in proportion of infants being provided complementary foods at the appropriate time. (both of the above should find reflection in malnutrition levels in children less than three years).
4. Increase in proportion of mothers who are able to identify signs of a sick newborn
5. Increase in proportion of children with diarrheoa being given ORS by mother
6. Increase in appropriate care seeking for children with ARI.
7. Increase in number of families with pregnant women who have consciously planned how to reach the appropriate institution or access a SBA in time.
8. Increase in number of pregnant women and children sleeping under a bednet and who are tested for malaria when they have fever.

Consequent to the above this is expected to contribute to the reduction of maternal and child mortality.

VIII. THE BUDGET AND FINANCIAL FLOWS:

The budget package for a normative block for financing training and supervision would include funds for

- a 20 day training programme every year plus
- One visit once a month to every ASHA on the job training and support
- two ASHA meetings every month
- One review meeting of facilitators
- One mobilisation event every quarter.

The normative block – 180,000 population; 180 ASHAs, nine facilitators, and two block trainers who are full time until the ASHA training is completed.

Training Competencies

The training competencies needed for these activities and outcomes are given in the table below. About 20 days training is required over a one year period to achieve these competencies.

Competencies	Knowledge required	Skill required
General competencies	• Knowledge about qualities that need to be inculcated to successfully work as ASHA • Knowledge about village and its dynamics • Clear understanding of role and responsibilities • Understanding of who are the marginalized and the specific role in ensuring that they are included in health services	• Conducting a village level meeting • Communication skills – especially interpersonal communication and communication to small groups • Skill of maintaining diary, register and drug kit stock card. • Tracking beneficiaries and updating MCH/Immunization card.
Maternal Care	• Key components of antenatal care and identification of high risk mothers • Complications in pregnancy that require referral • Detection and management of anaemia • Facility within reach, provider availability, arrangement for transport, escort and payment	• Diagnosing pregnancy using Nishchay kit • Determining the Last Menstrual Period (LMP) and calculating Expected Date of Delivery (EDD) • Tracking pregnant women and ensuring updated Maternal

	• Understanding labour processes (helps to understand and plan for safe delivery) • In malaria endemic areas, identify malaria in ANC and refer appropriately • Understanding obstetric emergencies and readiness for emergencies including referral	Health Cards for all eligible women • Developing birth preparedness plans for the pregnant woman. • Screening of pregnant woman for problems and danger signs and referral • Imparting a package of health education with key messages for pregnant women • Attend and observe delivery and record various events • Recording pregnancy outcomes as abortion, live births, still birth or newborn death) • Recording the time of birth in Hrs, Min and Seconds, using digital wrist watch
Home Based Newborn care	• Components of Essential Newborn Care • Importance of early and exclusive breastfeeding • Common problem of initiating and maintaining breastfeeding which can be managed at home • Signs of ill health or a risk in a newborn	• Provide normal care at birth (dry and wrap the baby, keep baby warm and initiate breastfeeding) • Observation of baby at 30 seconds and 5 minutes for movement of limbs, breathing and crying • Conduct examination of new born for abnormality. • Provide care of eyes and umbilicus • Measure newborn temperature • Weigh newborn and assess if baby is normal or low birth weight • Counsel for exclusive breastfeeding • Ability to identify hypothermia and hyperthermia in newborns • Keep newborns warm
Competencies	**Knowledge required**	**Skill required**
Sick New Born Care	• Knowledge of risks of preterm and low birth weight. • Knowledge of referral of sick newborns – when and where?	• Identify low birth weight and preterm babies. • Care for LBW, Pre-term babies • Identify birth asphyxia (for home deliveries) and manage with mucus extractor • Manage breastfeeding problems and support breastfeeding of LBW/Preterm babies • Identification of signs of sepsis and symptomatic management. • Diagnose newborn sepsis and

		manage it with cotrimoxazole
Child care	• Immunisation schedule • Child's entitlements in ICDS services • Weaning and adequacy in complementary feeding • Feeding during an illness • Causes of diarrhoea and prevention of diarrhoea • Knowledge of signs of Acute Respiratory Infections (ARI) – fever, chest in drawing, breath counting; and ability to manage mild Vs moderate ARI with CTM, and refer the severe ones.	• Planning the home visits- which child to visit and at what frequency • Child immunisation tracking skills to ensure complete immunisation in the community. • Weighing of children below five years of age- assessing grades of malnutrition. • Analysis of causes of malnutrition in a specific child- the role of feeding practices, role of illnesses, of familial and economic factors and of access to services. • Diagnosis of dehydration and ability to ascertain if referral is required • Skill to make adaption of the message of six essential feeding advice to each household • Skill in preparing and demonstrating ORS use to the mother/caregiver • Signs of Acute Respiratory infections (ARI) – fever, chest in drawing, breath counting; and ability to manage mild Vs moderate ARI with CTM, and refer the severe ones. • Skill in counselling the mother for feeding during diarrhoeal episode • Testing for anaemia and ensuring appropriate treatment.
Abortion, Family Planning, RTI/STI and HIV/AIDS	• Understanding contraceptive needs of women/couples in various categories • Knowledge of contraceptives in public sector programmes • Knowledge of availability of safe abortion services. • Knowledge of post abortion complications and referral • Knowledge of types and causes of RTI/STI, including HIV/AIDS • Knowledge of referral facilities for women/men suspected of RTI/STI	• Counsel for delay in age of marriage, delay in age of first child bearing and in spacing the second child • Helping vulnerable and marginalized women access contraception. • Supporting women in need of such services to access safe abortion services. • Counsel for post abortion contraceptive use • Counsel on safe sexual behaviours • Counsel for partner treatment in case of STI

For High Malaria areas or high prevalence of TB	• Knowledge about Malaria and its prevention • Protecting pregnant women and the young child from malaria • How to prevent tuberculosis, • Suspecting tuberculosis and knowledge of further referral	• Managing fever in the young child- when to suspect malaria, how and when to test, when to refer, when and how to treat. • Being a provider of Directly Observed Therapy- Short Course (DOTS)) for TB
Village Health Planning	• Knowledge of key components of village plans • Understanding of steps in preparing village health plans • Understanding of methods of data collection and PRA	• Interpret and use basic data, • Identify priorities for the village based on data • Conduct Participatory Rural Appraisal • Include specific actions to ensure coverage of marginalized and vulnerable women and children with services

Work and Time Frame:-

Sl. No.	Issues in Planning in ASHA	Current Status as per evidence from data triangulation	Activities to be undertaken to achieve targets	Outputs to be achieved	Time Frame for 2011-12
1	Human Resource in place needs orientation and regular trainings	- ASHA Resource Center 5 personnel's recruited needs more personnel's at the state. - ASHA Resource centre not registered. - At District and Block level one DCM /DATA assistant, Block community mobiliser are in place without any orientation and training, - At the Cluster level ASHA facilitator (1 ASHA for 20 ASHA) had sanctioned in last PIP in some district they have selected one ASHA as facilitator total number at the State is not available.	-ARC Registration - Bank Account Opening - Constitution of 2nd Governing Body and executive committee. - Induction Training/ Orientation of the ARC Personnel's at all level.	Human Resource in place With proper orientation training for effective implementation of the programme	1st Quarter
2	ASHA Selection	78237/ 87135 ASHAs	Selection of 8898 ASHAs	Target selection to be completed	Till 2nd Quarter
3	1. ASHA Trainings- Lagging and Qualitative Issues **2.**	69402- Module 1 52859- Module 2, 3 and 4	• Signing of Tripitied MoU between SHSB/NHSRC/ State Training Site • Selection of district training Sites and NGOs/Agencies	Completion of Module 5,6 &7 trainings of ASHA. Which has the components of Module 1,	1st and 2nd Quarter completion of entire State and District ToTs and

	Technical backstopping in Training		• Printing of modules and communication material for ASHAs in prescribed time. • Disseminate the modules in the District. • Work on the training modalities • Provide the supportive supervision to maintain quality checks and control at District and Block level.	2, 3 & 4. ASHAs to develop competency in care of sick new born & pregnant women.	at the same time training of ASHAs by 4th quarter
4	ASHA Drug Kit	- Kit bag available to ASHAs not adequate (at some districts bags and many medicines are missing)	- Provision of Drug Kit Bag to ASHAs - Strengthening of distribution process at the ASHA level Develop the mechanism to maintain at least two months stock of medicines with ASHA. - Training of ASHAs on stock keeping of drug & maintaining of registers. - Strengthening the process of ASHA drug kit replenishment	- Better health Care of the community - Self- Help Mechanism will be developed	Provision of Drug kit 1st quarter/ 2nd , 3rd & 4th quarter replenishment of the drugs
5	Capacity Building and Academic support Programme	This was inbuilt in last years PIP but data not available	- develop a guideline - and regular follow-up	-Academic knowledge enhancement of ASHAs - An good opportunity for ASHAs to try for ANM	2nd Quarter
6	HMIS- no data management	In Lack of an integrated Data System, The data was asked through individual telephonic calls which was practically not feasible	- Recruitment of HMIS Officer under ARC - Data formats to be developed and channelized at all the levels - An integrated management of data systems and database	- the data received will help develop a feedback mechanism at the lowest level for mid-term corrections and take corrective measures	All 4 quarters

Budget: 2011-12

Sr. No.	Particulars	Tentative Budget
	ASHA RESOURCE CENTRE	
	(A) ASHA Support System at State Level	
1	**Personnel on contract** 1. Team Leader – Rs.50,000/- per month x 12 months = Rs.6,00,000/- 2. Deputy Asha Programme Manager – Rs.35,000/- per month x 12 months = Rs.4,20,000/- 3. Consultant Communication & Documentation – Rs. 25,000/- per month x 12 months = Rs. 3,00,000/- 4. Account Assistant – Rs. 12,000/- per month x 12 month = Rs. 1,44,000/- 5. Data Assistant – Rs. 12,000/- per month x 12 month = Rs. 1,440,00/- 6. 9 Divisional Co-ordinator (ASHA) = Rs. 30,000 per month x 12 month x 9 = Rs. 32,40,000/- 7. Consultant Training – Rs. 30,000/- per month x 12 month = Rs. 3,60,000/-	**52,08,000/-**
2	**ASHA Mentoring Group** District travel, Out side State travel, Meeting organizing at State lavel)	**2,50,000/-**
3	**BCC and IEC Wing** 1. Development of IEC and monitoring materials (ASHA flip chart, ASHA Activity Diary, ASHA Register, IEC material, reporting format, monitoring formats and resource materials for meetings) = Rs. 200 x 87135 = Rs.17427000/-	**1,74,27,000/-**
4	**Office Expenses** Computer Set = 15 (6 State Level & 9 Divisional Office) (Rs. 25,000/- (One Time) x 15 = Rs. 375000/-) Printer, Scanner with fax = Rs.7000/- (One Time) x 10 (9 Divisional & 1 State) = Rs. 70,000/-) Internet = [Rs. 500 x 9 Divisional x 12 month = Rs. 54,000/-] Internet = Rs. 5000 State level x 12 month = Rs. 60,000/- Maintains (All electronic equipments) = Rs.500/- x 12 months x 15 = Rs. 90,000/- Xerox Machine – (1 State Level) = Rs. 50,000/- Telephone landline – 1 set with bill – Rs. 1000 x 12 month = Rs. 12,000/- Mobile for All Staff (ARC) = Rs. 1500/- X 6 = Rs. 9,000/- Recharge Coupon Rs. 500/- X 15 X 12 = Rs. 90,000/-	**8,10,000/-**
5	**Miscellaneous –** Rs. 25,000/- x 12 month = Rs. 3,00000/-	**3,00,000/-**
6	**Infrastructure** – **(One Time at State Level)** Table – 10 = 3 table @ Rs. 15,000/- & 7 table @ Rs. 5,000/- = Rs. 80,000/- Chair – 25 = 3 Chair @ Rs. 5,600/- & 5 Chair @ Rs. 2,600/- & 17 Chair @ Rs. 1000/- = Rs. 46,800/- Notice-Board – 1 = Rs. 2,000/- White Board – 1 Rs. 2,000/- Display board – 2 @ Rs. 2000/- X 2 = Rs. 4,000/- Electricity - Rs. 4000/- X 12 Months = Rs. 48,000/- Room Rent - Rs. 15,000 X 12 Months = Rs. 1,80,000/- (Ac + Stabilizer (4 + 2) 4 window @ Rs. 25,000/- & 2 split @ Rs. 30,000/- with annual maintenance) = Rs.1,60,000/- Plasma TV – 32 inch – Rs. 35,000/-	**5,57,800/-**
7	**Meeting State Level (4 times)**	**1,00,000/-**

	T.A/Allowances (Divisional & District level) as per SHSB norms	
8	**Monitoring and supervision** **Travel for State level Officers** - Travel out side State - Travel in side State	**2,00,000/-**
9	**Operation research and documentation**	**2,00,000/-**
	Total (A)	**2,50,52,800/-**
	(B) ASHA Support System at the District Level	
1	**Personnel On Contract** (i) **District Community Mobilizer =** Rs.20,000/- per month x 12 months x 38 District = Rs.91,20,000/- who will report to District Programme Manager. (ii) **District Data Assistant** - Rs.15,000/- per month x12 months x 38 District = Rs. 68,40,000/- **(iii) Office Expenses** Computer Set = Rs. 25,000/-(One Time) x 38 District = Rs. 9,50,000/- Printer, Scanner with fax = Rs.7000/- (One Time) x 38 District = Rs. 2,66,000/-) Internet = [Rs. 500 x 38 District x 12 month = Rs. 2,28,000/-] Maintainence (All electronic equipments) = Rs.500/- x 12 months x 38 Districts = Rs. 2,28,000/- **(iv) Stationary** = Rs. 500 x 12 months x 38 District = Rs. 2,28,000/- **(v) Travel expenses – (DHS Norms)** Rs. 1500 X 12 month X 38 District = Rs. 6,84,000/- **Miscellaneous Contingency = (Mobile Coupon Charge etc**.) Rs. 200 X 12 months X 38 District X 2 member = Rs. 1,82,400/-	**1,87,26,400/-**
	Total (B)	**1,87,26,400/-**
	(C) ASHA Support System at the Block Level	
1.	**Personnel on Contract** (i) **Block Community Mobilizer (BCM)** in all the blocks. (Rs.12000/- x 450 (BCMs till July) x 9 months = Rs. 4,86,00,000/-) **(ii) Asha Facilitators –** (Every 21st Asha) i.e 4150 Asha Facilitators (up till Sept 2011, 1500 ASHA facilitators in place @ Rs. 150 X 7 days field visit X 9 months = Rs. 1,41,75,000/-	**6,27,75,000**
	Total (C)	**6,27,75,000**
	(D) ASHA Trainings	
1	**Asha Training Module 5, 6 & 7 for six days** @ Rs. 69350/- each X 2905 batch = Rs. 20,14,27,075/- X 4 Phase for two financial years = Rs. 80,57,08,300/- Divided by 2 Years = Rs. 402854150/- (-) Rs. 10,000000/- (Fund available at State) = **Rs. 30,28,54,150/-**	**45,52,31,900/-**
2	Training equipment cost @ Rs. 2500/- Divided by 2 years = Rs. 1250 X 87135 (Asha) = Rs. 10,89,18,750/-	
3	Master trainer & District trainer Cost. Rs. 10,30,500/- X 38 District = Rs. 3,91,59,000/-	
4	DCM & DDA Asha Training = Rs. 43,00,000/-	
	Total (D)	**45,52,31,900/-**
	(E) ASHA Drug Kit & Replenishment	
1	Drug Kit for 87135 ASHA Rs. 250/- x 1 Time x 87135 (Asha) = 2,17,83,750**/-** (Replenishment)	**2,17,83,750/-**
	Total (E)	**2,17,83,750/-**
	(F) Motivation of ASHA	
1	Provision of one Torch (Rechargeable) to Asha (One time) - @ Rs. 200 X 87135 (Asha) = Rs. 1,74,27,000/-	**1,74,27,000/-**

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 534) = 10,68,000/- (For this activity the administrative system/procedure shall be chalked out with support of Development Partners)	**10,68,000/-**
3	Identity Card (Rs. 20 x 10% of total Asha = 1,74,270/-	**1,74270/-**
	Total (F)	**1,86,69,270/-**
(G) Capacity Building/Academic Support Programme		
1	Approx. 1000 ASHAs in the State to be enrolled into 10th grade or Bachelor's Preparatory Programme through Open Schools or IGNOU. Fee for the same to be provided by SHSB. The amount being requested is less more shall be requested in case of god response to the proposal. @ Rs.1000 x 1000 students =Rs. 10,00,000/- **(Fund available at State)**	**10,00,000/-**
(H) ASHA Divas		
1	TA/DA for ASHA Divas @ Rs.86/- per ASHAs per month (87135 Asha x Rs.86 x 12 Month) = 8,99,23,320/-	**8,99,23,320/-**
	Total (H)	**8,99,23,320/-**
	Grand Total (A+B+C+D+E+F+H)	**Rs.94,90,75,440.00**

Total Budget Under ASHA Scheme

S. No.	Particulars	Amount (Rs.)
1	Asha Support System at State Level	2,50,52,800
2	Asha Support System at District Level	1,87,26,400
3	Asha Support System at Block Level	**6,27,75,000**
4	Asha Training	455231900
5	Asha Drug Kit & Replenishment	21783750
6	Motivation of ASHA	18669270
7	Capacity Building/Academic Support Programme	10,00,000
8	Asha Divas	89923320
	Total Budget for ASHA	**693162440**

1.2. Untied Fund for Health Sub Centre, APHC, PHC and SDH

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 are as mentioned below:

- Cover minor modifications to sub center-curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level;
- Ad hoc payments for cleaning up sub center, especially after childbirth; transport of emergencies to appropriate referral centers;
- Purchase of consumables such as bandages in sub center;
- Purchase of bleaching powder and disinfectants for use in common areas of the village;
- Labour supplies for environmental sanitation, such as clearing/larvicidal measures for stagnant water
- Payment/reward to ASHA for certain identified activities.
- In PHC and APHC purchase of patient examination table, delivery table, DP apparatus, Hemoglobin meter, Cu-T insertion kit, Instruments tray, baby tray etc.
- Provision of running water.
- Transportation of emergencies to appropriate referral centre.

Facility level	**No. of facilities**	**Total amount released so far**	**Total amount utilized**	**Unspent balance**
Untied fund for SCs	8858 (10-11)	8,85,80,000	2,03,04,000	6,82,76,000
Untied fund for PHCs/APHCs	533+1243 (10-11)	4,44,00,000	17,10,000	4,26,90,000
Untied fund for SDHs	40	No fund in FY 2010-11		

Budget

Budget Head	Untied Fund	
Sub-Heads	@	Proposed Budget (in Rupees)
Untied Fund for sub-centre	Rs. 10,000 x 9696 no.	9,69,60,000
Untied fund for APHCs	1330 APHC x 25,000	3,32,50,000
Untied fund for PHCs	533 PHC x 25,000	1,33,25,000
Untied fund for SDHs	40 SDHs x 50000	20,00,000
Qtr. review meeting at District level	Rs. 1500 x 38 district x 4 Qtr	1,82,400
Qtr. review meeting at PHC level	533 PHCs x Rs. 2000 x 4 Qtr	42,64,000
	Total	**14,99,81,400.00**

1.3. Village Health and Sanitation Committee

NRHM mandates forming Village Health & Sanitation Committee at revenue village level and each committee to get Rs. 10,000 as untied grant. Bihar has approx. 40,970 revenue villages under approx. 8462 panchayat.

During 2005-2008, Bihar was not able to constitute VHSC due to various reasons. GoB has now decided to co-opt the Panchayat Committee namely “Lok Swathya Pariwar

Kalyan and Gramin Swaschata Samiti" as "Village Health and Sanitation Committee". These committees will be constituted at panchayat level and get fund according to number of revenue villages lying in their area, that is to say if one panchayat has 5 revenue villages then the said panchayat committee will get Rs.50,000 rupees. Financial power will be with Panchayat Committee, who will expend this fund per revenue village @ Rs.10000/-. There will be a monitoring committee at each revenue village, called "Nigrani Samiti", who will monitor appropriate utilization of fund in their revenue village.

Therefore the target is to form approximately 8462 panchayat committees which will act as Village Health and Sanitation Committee for approx. 40,970 revenue villages.

Each "Lok Swathya Pariwar Kalyan and Gramin Swaschata Samiti" consists of 5 members including Chairman and Secretary and every Revenue Village Samiti or "*Nigrani Samiti*" will consist of all ASHAs, AWWs, leaders of SHG & elected Ward Commissioner of panchayat These members will be required to participate in the orientation meeting program at PHC.

Activity	**Cumulative Achievements so till Nov.2010**
No. of revenue villages	40970
No. of VHSCs constituted	7852 (Target-8462)
No. of joint account opened	7852
Total fund released to VHSCs	39,16,62,500
Total amount spent by VHSCs so far	27,57,14,000
Total unspent balance	11,59,48,500
No. of VHSC members trained	Nil

This financial year we would like to propose following activities as follows:

- Rs.100 per VHSC to organized monthly meeting.
- Capacity building of District/Regional officials.
- Capacity building of Block officials.
- Capacity building of VHSC members.
- Monitoring of District and Block officials.
- Monthly review meeting at Block level and
- Qtr. review meeting at district level.

Budget

Budget Head	**Untied Fund for VHSC**	
Sub-Heads	@	**Proposed Budget (in Rs)**
Untied Fund for 40970 revenue villages	40,970 villages x 10,000	40,97,00,000
VHSC meeting per month	8462 panchayat x Rs.100 x 12 month	1,01,54,400
Capacity building at state level for district/regional official		2,00,000
Capacity building at District level for PHC official	3 person x 533 PHC x Rs 50	79,950
Capacity building at PHC level for VHSC members	5 person x 8462 Panchayat x Rs.130	2,75,01,500
Monitoring of Block official to	Rs. 100 / VHSC monthly meeting	25,38,600

attend VHSC monthly meeting at panchayat		
State level activities (IEC+Monitoring+need based training for VHSC members in 5 CBPM focus districts)		10,00,000
	Total	**45,11,74,450**

1.4. Rogi Kalyan Samitis (RKS)

RKS is operational district hospital, SDH, RH & PHC. Govt. of Bihar is operationalising the APHCs this year. In light of the RKS have to be setup in all the APHCs and registered simultaneously.

Budget

Sl. No.	Initiative	Number proposed	@ Rate Proposed	Total Amount (Amount in Rs.)
1.	RKS-DH	37	5,00,000	1,85,00,000
2.	RKS-SDH	44	1,00,000	44,00,000
3.	RKS-Referral	70	1,00,000	70,00,000
4.	RKS-PHC	533	1,00,000	5,33,00,000
5.	RKS-APHC	1330	1,00,000	13,30,00,000
Total				**21,62,00,000**

RKS Capacity Building & Strengthening:

A detailed Capacity Building Program is being planned for RKS members in 2011-12, in a cascade model. A training module would be developed for this and distributed to all RKSs. Each Disticts would get 10 copies of trainings module, each RKS would get 5 copies & each resource person would get 1 copy of the training module. Thus the total training module required for this would be approximately (10X38+ 5X528+ 5X 500APHCs + 80 + 400extra = 6000). Each Copy would cost around Rs. 40 thus the total cost would be 6000 copies X Rs. 40 = 2,40,000.

For this a resource pool would be developed at state level from the resource persons from SHSRC, ARC, development partners & state level NGOs engaged in Capacity building or Community Based work. State level two days TOT would be organized for the resource pool. The budget for the same would be Rs. 1,81,000. Details of the budget is as follows:

Sl. No.	Head	Approved Rate with Details	Proposed Budget (in Rs.)
1	Food Expenses	Rs. 250 per day x 60participants x 2 days	24,000
2	Incidental expenditure (Bag, Pen, Notebook for each participant,	Rs. 300 x 60	18000
3	Chart paper, A4 size paper, Marker, Scotch Tape, Kangaroo tape, Pen, Pencil, Photocopy, Cartridge of printer etc.)	gross amount	3000
4	Trg. Hall Rent	@ Rs. 50000/- per day x 2 days	10,000
5	Hostel Booking/ Lodging for participants	@ Rs. 1000/- per day x 30 double bedrooms x 2 days.	60,000
6	PA System	Rs 500 x 2 days	1,000
7	TA to Resource persons from delhi & Other places (air travel)	10000 x 3	30,000
8	Lodging for Resource Person	@ Rs.1800 per day x 4 x 2	14,400
9	Taxi Hiring for Resource Persons (all)	2500 x 4	10,000
10	Contingency		10,600
	Total	**Rs.**	**1,81,000**

The Resource Persons would be responsible to transact the training at the district level which would be organized by DHS. At district level the participants of the training would be DPM, DCM, one dist Program Officer (nodal officer for RKS), Chairperson of RKSs, BHMs & BCMs. The budget for the district level TOT would be **Rs. 18400** for each Districts.

Break up

Activity	Unit Cost (Rs.)		Total per Batch
TA	Actual		2000.00
DA	100	/day	7200.00
Honorarium	500	/day	1500.00
Food	100	/person/day	2900.00
Hall	800	/day	2400.00
Stationary and Trg. Books	100	/day	2400.00
Total			18400.00

Thus the total budget for all districts would be Rs. 18400 X 38 = 6,99,200 only.

The persons trained at district level would then organize & transact the trainings at their facilities. All the members of the RKS & some members of the PRI & local NGOs would

be participant of the trainings at the facilities. The budget for the facility level trainings would be Rs. 5000 for each Facilities thus the total budget would be Rs. 5000 (Consolidated) X 528 = 26,40,000 only.

Similarly the state intends to streamline the setting up of APHCs level RKSs for realizing the objective of making all APHCs functional. In the next FY 2011-12 we intend to put in place at least 500 such RKSs for APHCs. For these RKSs too, facility level training would be organized and the budget for the same would be Rs. 3000 X 500 = 15,00,000 only.

The summary of the Capacity Building program budget is as follows:

Sl. No	**Activity Head**	**Budget**
1.	Printing of Training Module @ Rs. 40 X 6000 copies	2,40,000
2.	State Level TOT	1,81,000
3.	District level TOT Rs. 18400 X 38 = 699200	6,99,200
4.	Facility Level training of RKS members etc @ Rs. 5000 X 528 = 26,40,000	26,40,000
3.	APHC level Training for newly constituted RKS members Rs. 3000 X 500 = 15,00,000	15,00,000
	Total	**52,60,200**

Moreover, two weeks in the FY 2011-12 would be observed as “Rogi Kalyal Saptah”. During this district level workshops would be organized to recognize three best performing RKSs in every district. These RKS would be asked to present their accomplishments in the workshop and prizes would be given to such RKS from the DHS side. For this 1st week of May 2011 & 1st week of November 2011 would be slated as “Rogi Kalyan Saptah”.

For this each district would be given rupees 25000 and each PHC/SDH/RH would get Rupees 5000. At state level for Organizing TOT for Resource Pool & their TA/DA during RK Saptah a consolidated sum of Rupees 3 Lakhs would be kept.

The total budget for RK *Saptah* would be as follows:

Sl. No	Activity Head	Budget
1.	State level TOT & TA/DA of Resource persons Consolidated amount	3,00,000
2.	District level Consolidated fund for organizing dist level workshop – Venue, stationeries, LCD Projector, prizes for three best performing RKSs etc @ Rs. 25,000 X 2 X 38 =38,00,000	19,00,000
3.	Consolidated amount to be given to existing RKSs at PHCs/SDHs/RHs/DH @ Rs. 5000 X 528 = 26,40,000	26,40,000
	Total	48,40,000

Thus the combined Budget for Capacity Building & Rogi Kalyan Saptah for the FY 2011-12 would be 52,60,200 +48,40,000 = Rs. 1,01,00,200/-

2. INFRASTRUCTURE PLAN

2.1. CONSTRUCTION /ESTABLISHMENT OF HEALTH SUB- CENTRE

The NRHM aims to ensure Health sub-centers facility on the Govt. of India Population norms of 1 per 5000 populations in general areas and 1 per 3000 populations in tribal areas. As per 2001 Census, population of the Bihar State is approximately 8,29,98,509. Existing facility of HSCs are 8858. Out of this 4875 are without building. State government has taken up construction of 2350 nos. from 15% state share fund and loan from R.I.D.F. To facilitate the above population the state requires total 16,576 HSC. Thus there is a need of additional 7765 HSCs. To achieve the total target it was proposed to create 1553 HSCs every year. But this could not be achieved mainly because the agency, Building Construction Department and its corporation could not come up to the expectation. Another reason being unavailability of land. Govt. of Bihar has approved creation of own corporation in the name of Bihar Medical Services and Infrastructure Corporation in short it is called State Purchase Organization to meet the challenge of construction works of health facilities and procurement etc. The corporation is likely to start functioning within shortly.

Govt. of Bihar is also actively considering to purchase land for this purpose. It is expected that this also may be decided in near future.

In view of above, construction 76 HSC (two in each district) is proposed during 2011-12-

In 2007- 2008 the State took up construction of 751 Health Sub- Centres @ Rs.6.48. During 2009-10 state revised the rate as 9.50 lakhs each. Again Building Construction Department has revised the rate as 15.57 lakhs this year. Government has accordingly accorded Administrative Approval vide its letter no. 304(10), dt. 31.08.2010. Therefore cost of construction of 76 units will be Rs. 1183.32 lakh. The State proposes to share 25% expenses. Provision for the balance 75% is being made in this PIP for financial support from NRHM. Till the time of construction the state will take buildings for these facilities on rental basis.

Proposed Activity	**Expected Physical Out Come**	**Proposed Budget 2011-2012**	**Details of Budget Basis of Costing (No. of Units X Unit Cost)**		
Creation of 76 **HSCs**	Construction of 76 HSC Buildings	**Rs. 887.49 lakhs**	**Total cost** at the @ Rs 15.57 lakh per unit	**Contribution of GoI** @75% will be	**Contribution of GOB** @ 25% will be
			Rs. 1183.32 Lakhs	**Rs. 887.49 Lakhs**	**Rs. 295.83 Lakhs**

76 Health Sub- Centres shall be taken up for construction during 2010-11. Contribution of GoI will be Rs.887.49 lakhs. The budget amount is the same.

2.2.1 CONSTRUCTION OF APHC (PHC) buildings in Bihar

The NRHM aims to ensure APHC/PHCs on the Govt. of India population norm of 1 per 30000 populations in general areas and 1 per 20000 population in tribal/ remote areas. As per 2001 census Population of Bihar state is approximately 82958509. Total requirement of APHC (PHC) will be 2787 nos. The Existing facility of PHCs (APHCs) is 1243. Further requirement is of 1544 PHCs(APHCs). There were 121 building less APHC. Thus total 1665 nos. were to be constructed

within five years i.e upto 2012. Therefore Government of Bihar decided to construct 331 per year. Works were allotted to Building construction department which could not construct. It was therefore decided to take back works which could not be started. All these works will be taken up by the newly created Bihar Medical Services and Infrastructure Corporation which is being activated.

It is proposed to take up new construction of 36 APHCs building in 2011-2012. Unit cost of construction was Rs. 53.15 lakh which has been revised by state govt. vide its letter no. 304(10), dt. 31.08.2010 as Rs. 75.99 lakh. Building Construction Department has revised the Unit as Rs. 75.99 Lakhs vide letter no. 10570 dt. 17.12.09 due to increase in rates of labour and cost of materials.

Total cost of construction will be Rs. 2747.15 lakh. Therefore proposed Budget for financial year 2011-12 will be Rs. 2747.15 lakh. Till the time, the construction is completed, the state may take buildings for these facilities on rental basis.

Proposed Activity	**Expected Physical Out Come**	**Proposed Budget 2011-12**	**Details of Budget Basis of Costing (No. of Units X Unit Cost)**
Construction of **36 APHCs Buildings.**	Construction of 36 APHC Buildings.	**Rs.** 2747.15 **Lakhs**	**Unit Cost Rs.75.99 lakhs** Contribution of GoI 100% 36 nos. X 75.99 lakh as expained above.

2.2.2 Construction of residential quarters for Doctors & Staff nurses in 38 old APHC

Most of the quarters of existing APHCs are damaged. Good number of existing APHCs are without quarter. It is proposed to construct residential quarters for Doctor & Staff Nurse in 18 old APHCs @ Rs. 30.00. lakh each as sanctioned during 2011-2012 at a total cost of Rs. 540.00 lakh

NRHM Action - Plan 2010-11			
Proposed Activity	**Expected Physical Out Come**	**Proposed Budget**	**Details of Budget and Basis of Costing (No. of Units X Unit Cost)**
Construction of residential quarters for Doctor & Staff nurses in 18 old APHC. (1 doctor and 3 Sraff Nurses Quarters)	18 nos. Quarters.	**Rs. 540 lakh**	18 Quarters @ Rs. 30.00 lakh per quarters. (30 x 18) as explained above.

The entire cost of construction is to be born by Govt. of India. Hence the budgeted amount is Rs. 540.00 lakh.

2.3 UPGRADATION OF PHCs to CHC (Construction of 3 Doctor and 4 Staff Nurse Quarters)

The NRHM aims to ensure CHCs on the Govt. of India population norm of 1 per 1.20 Lakhs populations. The Govt. of Bihar plans to upgrade all its PHCs to CHC as per IPHS standard. In the state of Bihar the total no of existing 6 bedded PHCs are 534. Up gradation of 399 PHCs building have been sanctioned by GoB in-different phases. Doctor and Staff Quarters will be needed for these upgraded CHCs. Hence in total 399 PHC, Doctors & Staff Quarters will be needed. It is proposed to construct 38 quarters during 2011-12.

4 nos. of Doctor Quarter and 4 nos. of Staff Nurse quarters are needed for one CHC as per IPHS. Cost for construction of quarters for 4 **Doctors** in one CHC will be around Rs 50.00 lakh on the basis of provision made in sanctioned revised estimate of CHC. During the year 2009-10 & 2010-11 provisions for doctor and staff nurse quarter was approved by GoI @ Rs 40.00 Lakh each. Accordingly provision amounting to Rs 50,00,000 is being made in this PIP @Rs.50 lakhs each unit. The entire cost is to be born by Govt. of India under NRHM. The quarters would be taken up on rental basis till the construction of quarters is completed.

Up gradation of 6 bedded PHCs to 30 bedded Community Health Centre As Per IPHS (NRHM Action Plan 2010-11)			
Proposed Activity	**Expected Physical Out Come**	**Proposed Budget**	**Details of Budget, Basis of Costing (No. Of Units X Unit Cost)**
Up gradation of 20 PHCs to CHC.	Construction of Quarters for 4 Doctors in 20 CHC.	**Rs.1000.00 lakh**	Construction of quarter for 3 Doctors and 4 Staff Nurses @ Rs. 50 lakh Total Cost 20 X 50 = Rs. 1000.00 Lakhs (Contribution of GOI 100%)

2.4.1. Strengthing and Upgrading District Hospitals (Construction of SCNU buildings)

The state of Bihar has 36 District Hospitals at present. Construction of 24 SCNU in 24 District Hospitals is under process (21 under NRHM and 3 from NIPI). The state has already appointed TCIL a Govt. of India Enterprises for construction of these SCNU buildings on turnkey basis. Unit cost of construction in Non-NIPI district is Rs 44,70,500/= (Fortyfour Lakh Seventy Thousand Five Hundred) as per T.S accorded by Building construction department vide its letter no. 4162, dt. 27.05.2010. This amount is on the basis of old schedule of rate of GoB. Expenditure upto 10% above the estimated cost has been allowed. 8% Centage charge and Service Tax extra has also been allowed. Thus unit cost works out to Rs. 58.58 lakh. Anticipating 20% increase the present unit cost it is expected to be Rs 64.30 lakh approx.

It is proposed to construct SCNU in 23 DHS during 2011-12. The total cost of construction will then be Rs 1478.90 Lakh. Provision in the budget is being made accordingly under NRHM.

In one DHS i.e vaishali SCNU building has been constructed with co-operation of UNICEF. It is already functioning satisfactorily.

B**udget**

Sl. No.	Particulars	Amount (Rs.)
1	Strengthening and Upgrading of 23 nos. District Hospitals by providing separate SCNU buildings attached with DHS building.	23 X 64.30 = 1478.90 lakh.

2.4.2. Strengthing and upgradation of Health Facilities (Installation of Solar Water Heater System)

There are 36 DHS, 58 SDHS, 70 Ref. Hospitals & 534 PHCs total 698 health facilities in Bihar where pregnant women are taken care of. This includes 76 FRUs. There is need of hot water for both mother and child at the time of delivery. Pregnant woman may come to hospital at any time. Electricity is required to provide hot water. There is acute shortage of power supply in Bihar. Electric supply is available for a few hours only. Supply of electricity through Generator for major portion of the 24 hrs. is very costly. Therefore alternative source of electricity is essentials so that health facilities can serve for 24 x 7 days.

In this context Solar Water Heater System seems to be one alternative at cheaper cost to provide hot water to delivering mother in times of need. TATA B.P. Solar India Ltd., Room No 424, 4th Floor, Ashyana Harniwas Complex, Dak Bunglow Road, Patna-800001, is one private institution who has the expertise in this field. This System is supplied and installed by them on D.G.S. & D. Work order has been issued to them for the same vide Letter No. 22236, Dated 16.12.2010 on rate approved by D.G.S. & D.. They have been asked to install the system and commission them in 36 DHs, 25 SDHs, RH & 74 PHCs total 148 health facilities including 38 FRUs by the end of Feb. 2011.
It is proposed to upgrade 25 SDHs, 10 R.H.s and 150 PHCs totalling 185 health facilities during 2011 – 12 on approved rates of D.G.S. & D. This includes remaining 38 FRUs.

There is need of hot water for both mother and child at the time of delivery. Pregnant woman may come to hospital at any time. Electricity is required to provide hot water. There is acute shortage of power supply in Bihar. Electric supply is available for a few hours only. Supply of electricity through Generator for major portion of the 24 hrs. is very costly. Therefore alternative source of electricity is essential so that health facilities can serve for 24 x 7 days.

Final names of Health facilities from high focus districts are in process of selection.

The amount involved in this work will be following:-

(i) 25 SDHS 200 lit. per day
(ii) 10 Referral Hospital 200 lit. per day
(iii) 150 PHCs 200 lit. per day

Total 185 nos. 200 lit. per day @ Rs. 38,500/- = Rs 71,22,500/-
For other associated works = Rs 1,50,000/-
Total = Rs 72,72,500/-
(Say 72.72 lakh)

This expenditure is to be met under NRHM. Hence provision is being made in the PIP of 2011-12.

Budget – 2011-12

Sl. No	Particulars	Budget Provision
1	Installation and commissioning of Solar Water System in 185 Health Facilities as detailed above.	72.72 lakh as explained above.

2.4.3. -Up gradation of 5 DHs (Increase in number of Beds)

Govt. of Bihar has sanctioned increase in bed strength of 5 District Hospital as mentioned below :-

Sl. No.	Name of District Hospitals	Present bed Strength	Revised bed Strength
1	Purnea - District Hospitals	300	500
2	Supaul - District Hospitals	100	300
3	Begusarai - District Hospitals	100	300
4	Munger - District Hospitals	100	300
5	Sheikhpura-District Hospitals	100	200
Total		700	1600
Increase in bed strength = 900			

Estimated cost of construction of 100 bedded sub-divisional hospital building is Rs. 1385 lakh as technically approved vide building department letter no. 8377, Dated 29.10.10. Per bed cost will be Rs. 1.385 Lakh. Hence cost involved for 900 bed strength will be around Rs. 1246.5 lakh. This expenditure is proposed to be met from NRHM. Therefore Rs.50.00 lakhs is being provided in the PIP 2011 – 12 as below.

Sl. No.	Particulars	Total Cost	Budget Provision
1	Up gradation of 5 D.H.s and by increasing number of beds by 900	900 x 1.385 lakh = Rs. 1246.5 lakh as explained above.	Rs.50 lakhs (Lumpsum)

2.4.4 – Upgrading 2 Hospitals as Super Speciality Hospital.

GoB has decided to upgrade the status of 4 health facilities i.e Rajendra Nagar Eye Hospital, JPN Hospital and Gru Govind Singh Hospital, Patna city in super speciality hospital in different fields. There is one Jai Prabha Hospital in Kankarbagh, Patna which is to be a super speciality hospital. Provision for upgradation of 2 hospitals into super speciality sanctioned during 2010-11 is being made.

It is proposed to take up upgradation of 2 Health Facilities during 2011-12 as below:-

Sl. No	Particulars	Budget amount
1	Up gradation of 2 Health Facilities into Super Speciality as per IPHS. (1) Rajendra Nagar Eye Hospital. (2) Lok Nayak Jay Prakash Narain Hospital, Rajbanshi Nagar	50.00 Lakh

2.5 Upgradation of Infrastructure of ANM Training Schools

In year 2008-09, a State coordination committee for the strengthening ANM and GNM schools has been activated under the chairmanship of the Additional Commissioner,

Health. The Executive Director, SHSB, officers from the Directorate and SHSB and UNICEF are its members. The committee has chalked a comprehensive strategy for the rejuvenation of the ANM and GNM schools.

Key decisions made till now include

- Streamlining the student intake in all ANM and GNM schools up to their full capacity
- Ensuring that the vacant faculty and staff positions in all the schools are filled through contractual appointments to undertake teaching assignment sas per INC norms
- Finalizing five ANM schools in PPP mode
- Formulation of the managing committee at respective ANM and GNM schools to look after the local management affairs
- Strengthening the hands of the principals of these institutes
- Reviewing the progress on a regular basis

Initiatives have been taken in Operationalisation of 22 ANM schools in terms of -

- site assessment,
- basic renovation,
- provision of kitchen items, audiovisual equipments, lab equipments
- provision of study material,
- capacity building of faculty,
- standard curriculum development for the ANMs and GNMs
- Facilitation in accreditation from Nursing Council of India.

It is proposed to upgrade the Infrastructure of 22 ANM and 6 GNM Training Schools. In addition, the state is willing to open up more ANM and GNM schools as per the GoI's letter in this regard. The approximate cost of up gradation of each ANM/GNM Training Schools is expected to be Rs 50 lakhs per Unit. It was proposed to upgrade the Infrastructure of 12 ANM Training Schools in 2008-09 PIP and a fund for the same to the tune of Rs.3.00 crores is available.

Additional funds are requested for the remaining 9 ANM schools and 6 GNM schools. The state is preparing a separate proposal to upscale the standards of nursing education. Additionally under PPP 5 ANM schools are proposed to be operationalised.

M.Sc/B.Sc. nursing faculty for nursing school to be taken from hindi speaking states like MP, Pondicherry, for which Govt of India shall be approached for coordinating the same.

Budget

Annexure 2: PROJECT:-AUXILLARY NURSING & MIDWIFERY SCHOOL & GNM SCHOOL						
SUMMARY OF COST						
Sl.No.	**ITEM**	**School**	**Hostel**	**Residential Accommodation**		**Grand Total**
				Teaching Staff Quarters	**Non-Teaching Staff Quarters**	
Upgradation of infrastructure of 1 ANM/GNM school sper Feedback ventures study						
1	CIVIL WORK	2717875	4757054	2592467	2592467	12659863
2	ELECTRICALS	193839	269126	245830	245830	954625
3	P.H.E.	138477	239779	211416	211416	801088
4	TOTAL	3050191	5265959	3049713	3049713	14415576
5	ADD 10% FOR	305019	526596	304971	304971	1441557

	ADMINISTRATIVE AND SUPERVISION CHARGES (					
6	ADD 0.5% FOR CONTINGENCY	15251	26330	15249	15249	72079
	TOTAL for 1 ANM school	3370461	5818885	3369933	3369933	15929212
	GRAND TOTAL (for 21 ANM and 6 GNM Schools)					430088724
	Amount proposed for release initially for Infrastructure and subject to utilization further release may be done *					60022000
Strengthening of Nursing cell in the GoB						5000000
Hiring of additional faculty for all ANM and GNM schools						5000000
	GRAND TOTAL					**70022000**

** UNICEF to provide for equipments, teaching aids and furnitures*

Budget to be provisioned from State Share

2.6 District Drug Warehouse

It is proposed to established rationalized and modernized District Drug Warehouses to ensure proper supply chain management system so as to ensure timely availability of quality health products at each public health facility. The upgradation would involve infrastructure upgradation, manpower deployment, training and software management. The existing District Drug Store would be upgraded and rationalization in terms of separate drug stores for different national programmes would be consolidated under one roof.

These Drug Warehouses would also house the Drug Control Office of the district and infrastructural provision would be made for them also.

SHSB with technical support from B-TAST is planning for the same.

Initially it is proposed to take up Drug Warehouses at the 9 Divisional Headquarters and upscale to other districts in the next financial year.

Procurement Management Information System (ProMIS) Implementation

ProMIS is being introduced to strengthen and streamlining the procurement porcess and stock and supply for 5 centrally sponsored schemes (CSS).

These schemes are 1) Family Planning 2) Immunization 3) Tuberculosis 4) Malaria 5) RCH.

3 day training is planned in each district for 22 participants (inclusive of Store Keepers, Programme Officers, District M & E Officer, Cold Chain handler etc). The training would include hands on training on software with the help of computers.

A. Monitoring & Evaluation							
Break up Budget							
Particular	**Unit**	**Programmes (CSS)**	**Districts**	**Units required**	**Cost per Unit**	**Total per Batch (Rs.)**	**Remarks**
Salary of Computer Assistant	One each CSS	5	38	190	10000	1900000	
MIS Report etc	Rs.85/- per book	5		2400	85	204000	For 200 Books per month
Quarterly Workshop/Training on warehouse information system	For 120 participants to be trained in batches of 30			4	25000	100000	Rs.500/- Per participants per day + Rs.500/- honorarium to trainer per day + contingency Rs.100/- per participants + overhead 15 % of total amount
Halfyearly one day training for senior management	For 30 persons			2	37500	75000	
Total amount						**2279000**	

B. Purchasing of Computers including Monitor, CPU, Printer & UPS for warehouse in all 38 districts							
Particular	**Unit**	**Programmes (CSS)**	**Districts**	**Units required**	**Cost per Unit**	**Total per Batch (Rs.)**	**Remarks**
Purchasing of Computers/Software	Monitor, CPU, Printer & UPS	5	38	190	60000	11400000	
Consumable for computers with internet access	Internet, Consumables items	5	38	190	4800	912000	Rs.400/- per month/per warehouse/per programme
Total amount						**12312000**	

C. Operationalising ProMIS till the district level					
Particular	**Unit**	**Total Unit**	**Cost per Unit**	**Total per Batch (Rs.)**	**Remarks**
Training of Staff	batch	1	60000	60000	
Unskilled labourers for reorganising warehouse 5 labourer per CSS per district	38	190	980	186200	
Printing of expiry and stock register	38	190	300	57000	
Others	38	190	20000	3800000	
Total amount				**4103200**	
Modernization of warehouse		9 Divisional Headqtrs.	25.00 lakhs		Under European Commission fund, Districts were provided funds for Setting up District Drug Stores.The Additional

					Amount is required from NRHM
A. Monitoring & Evaluation				**2279000**	
B. Purchasing of Computers				**12312000**	
C. Operationalising ProMIS till the district level				**4103200**	
D. Modernization of warehouse				**22500000**	
Grand Total				**41194200**	

Total B=Rs. One Crore Eighty Six Lac Ninty Four Thousand Two Hundred Only

Budget to be provisioned from State Share for procurement and infrastructure

2.7 Setting up of Intensive Care Unit in all the District Hospitals

An Intensive Care Unit (ICU) is a specialized department in a hospital that provides intensive care medicine. Many hospitals also have designated intensive care areas for certain specialties of medicine, as dictated by the needs and available resources of each hospital.

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

Setting up of Intensive Care Unit will help the patient to avail the facility in all districts so that accessibility for intensive care can be addressed.

The State Government is setting up 4 bedded ICUs in 23 different District Hospitals of the State.

Break Up of Budget	
Setting of ICU in 23 district hospitals.	
Construction of each ICU as escalated rate	40 lakhs
Equipments cost in each ICU *	20 lakhs
Training of Medical Officer and Para Medics*	5 lakhs
Total Cost for one ICU	65 lakhs
Total Cost for 23 ICUs 65 lacs x 23 districts	

	*** Equipments for ICUs**
1	Bed Side Monitor
2	Defibrillator
3	Syringe Pump
4	ECG Machine
5	ICU Ventilator
6	Air Fumigator
7	Suction Machine
8	Laryngoscope
9	Nebuliser
10	Glucometer
11	Air Viva (Ambu Bag)

12	ICU Bed
13	Bed Side Lockers
14	Medicine Trolley
15	Transfer Trolley
16	Three Fold Stand
17	X-Ray View Box

To complete the ICUs in the District Hospitals an additional amount @ Rs. 20.00 lakhs per ICU and Rs.5.00 lakhs per ICU for training is proposed so as to operationalise the facility.

Therefore total budget requirement –

Training - Rs.500000 x 17 districts = Rs.85.00 lakhs
Equipment Procurement – Rs.20,00,000 x 20 districts = Rs.400 lakhs
GrandTotal- Rs.4.85 crores

The equipment procurement shall expedited through Procurement Corporation. .
Remaining fund for completing construction work to be sourced from State Government.

The status of NRHM fund provided earlier and fund provided from State Government is given in the table below.

Further Budget to be provisioned from State Share

Status of ICU in District Hospital (New construction)

Sl. No.	Districts	Fund received for ICU construction (in Rs.)	Source of fund (Bihar Govt./ SHSB)	Fund expenditure done till 31st December 2010 (as against 'a')	Status of ICU construction (1) ICU constructed / (2) Partially constructed, if partially constructed-what has been done/ (3) Already operational, is being used)	If not operational (Reasons for not being yet operational)	ICU equipment procured (Y/N)	Manpower trained to work in ICU available in the district (Y/N) If yes, specify number
		(a)	(b)	(c)	(d)	(e)	(f)	(g)
1	Patna (Rajvanshi Nagar)	2000000	SHSB	0	Not Operational	Not operational-Amt. advanced to IGIMS Patna as per the direction of SHSB	Not procured	No training for manpower to work in district ICU
2	West Champaran	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
3	Saran	3411000	GOB	3411000	Constructed	Not hand over	No	No
4	Purnea	3411000	GOB	3409500	Functioning	NA	Not Available	Not Available
5	Nalanda	3411000	SHSB	3060000	work completed & handed over	Built ICU is handed over to proposed Medical College, Nalanda	No	Yes, two Dr. being trained
6	Aurangabad	3411000	GOB	3327022	Partially constructed, only Building has been constructed, earthing wiring , water supply etc. remaining	Not Available	Yes	Yes
7	Bhojpur	3411000	GOB	520600	Partially, constructed, wards 6 beded constructed, grill door ok	Ramp, Bathroom, hatrine, store for ICU not constructed	N	N
8	Gopalganj	3411000	Bihar Govt.	3214300	ICU constructed	ICU equipment not available	Not procured	Yes
9	Siwan	3450000(SHSB 3411000 + Bank Interest 39000)	SHSB	3450000	ICU constructed	Not handed over and lack of manpower	no	Yes (1) MO
10	East	3411000	Bihar	3069900	Constructed but finishing	Finishing work of	Yes, limited	Yes

	Champaran		Govt.		work not completed	building not completed	equipments procured	
11	Samastipur	3411000	GOB	3411000	constructed	ICU equipments not available	N	N
12	Madhepura	3400000	Bihar Govt. 3400000/- +from DHS 807450/- flexipool	4218450	ICU constructed	No	No	No
13	Rohtas	3411000	GOB	3394128	Completed	Not operational	No	No
14	Munger	3411000	GOB	0	Not constructed	estimate given by Agency	-	-
15	Sitamarhi	3411000	GOB	2555500	Roof level complete & finishing under process	Building division not active	No	No
16	Katihar	3411000	SHSB	3070000	ICU Constructed	Inaugration of 15th Jan.	No	No
17	Khagaria	3411000	Bihar Govt.	3411000	ICU constructed	Lack of specialist Doctors & equipments	N	N
18	Madhubani	3411000	SHSB	2204732	Already functional		Yes	Yes-8
19	Vaishali	3410000	SHSB	3410000	ICU constructed	SNCU functioning	N	N
20	Nawada	3411000	GOB	1705500	Plinth level		N	Y
		273000	SHSB	262752	Completed		Y	Y
21	Begusarai	3411000	GOB	2000000	partially constructed, finishing has not been done. Only structure has been done	Building is not prepared	N	N
22	Saharasa	3411000	GoB	3069900	ICU Building is under construction & is likely to complete very soon	-	N	N
23	Jehanabad	3411000	GOB	2035788	ICU constructed	-	No	No

2.8. Annual Maintenance Grant

For the Financial Year 2010-11 Rs. 829.00 lakhs was sanctioned under Budget Code NRHM B.5.2 (Annual Maintenance Grant) and released to all the health institutions in time. Against this approval Rs. 111.55 Lakhs has already been spent as per FMR up to November 2010 and remaining amount is likely to be spent in F.Y. 2010-11. During 2010-11 provision of fund for day to day maintenance of Referral Hospital under this head was not made but it consider necessary to provide fund under this head to Referral Hospital also. As the patient load is very high and caesarean section is also operational for which Annual Maintenance Grant is required. As the maintenance of institution is to be carried out as and when required during the year 2011-12, thus provision of fund under this head is absolutely necessary as per details given below:-

Institution	Total No.	Proposed Budget (Rs. in Lakh)
District Hospital	36	180.00
SDH	45	45.00
Referral Hospital	70	70.00
PHC	533	266.50
APHC	1330	665.00
HSC	9696	969.60
	Total	**2196.10**

2.9. Accreditation : ISO Certification of Health Facilities

State has proposed improvement in quality management system of 90 Health facilities (15 DH, 15 SDH, 10 Referal Hospital and 50 PHC) resulting in accreditation ISO Certification during 2011-12 at a cost of Rs. 826.50 lakhs. This was inclusive of minor quality improvement required in infrastructure amounting to Rs. 400 Lakhs. The work was proposed to be under taken through NHSRC.

It has been suggested to take up this work through state level and district level quality assurance cell. In this regard it is to say that the above cell has been proposed and is under formation. Primary work has also been done, but some time is required in setting up the same.

Proposed PIP 2011-12

Hence it is requested that a token additional amount of for Rs. 294.80 lakhs may be allowed during the financial year 2011-12 on account of establishment of junior consultants and minor improvement in infrastructure works.

Formation of State Quality Assurance Cell

A. Background:

For improving the functioning of the public health facilities and help in strengthening the processes for the providing quality public health care services throughout the State, provision for QA Cell can be done in FY 11-12. Quality Assurance intervention in NRHM will be an attempt to move forward by initiating and operationalizing programmatic interventions. It proposes to develop and institutionalise the use of the field based, practical and feasible indicators in quality assessment and to transform existing supervision practices into a more standardized and structured process. *Any sustainable change in terms of institutionalisation of Quality Assurance (QA) will come from within the system and not from outside.* It is hoped that interventions from demand side (for example, community and individuals demanding better services) will also put pressure on the system to deliver quality services which will in turn give impetus for investing in QA.

B. Objective of the Quality assurance Cell

I. To facilitate the improvement of systems and processes of service delivery in the healthcare facilities to meet the laid down standards as appropriate.

II. To develop quality management systems at the hospital level, leading to enhancement in service quality and leading to certification to ISO 9001 standards.

III. The objective of the proposed Quality Assurance mechanism at state and district level is to facilitate the continuous monitoring of quality of reproductive health services/ MCH services at health facilities and consequently improve service quality by focusing on and addressing the gaps identified during the assessment process.

IV. The Quality Assurance Committee at state and district will conduct periodic assessment visits using specific tools and based on the gaps identified will help the service providers, address specific service quality elements and sub-elements.

V. This will also lead to initiating a series of actions to address the gaps and hence improvements in the quality. Subsequent visits will ensure that actions initiated have resulted in improvements in the facility score.

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

C. The State Quality Assurance committee (SQAC) at state level is chaired by Principal Secretary Health,.The committee meetings should be organized by SHSB on quarterly basis. The SQAC can be used to obtain administrative approvals for the QA activities guided by the recommendations of Member's field observations and District Quality Assurance Committee report.

The State Quality Assurance Committee formed at the state level (at present)comprises of the following members:-

1. Principal Secretary, Health & Family Welfare, Bihar - Chairman
2. Executive Director, State Health society, Bihar - Vice-Chairman
3. Director-in-Chief - Member Secretary

Members:

4. Additional Director- Family Welfare.
5. Professor & Head, Dept. of Obstetrics & Gynaecology, PMCH.
6. Professor & Head, Dept. of Paediatric, DMCH.
7. Professor & Head, Dept. Of Anaesthesia, ANMCH.
8. Training In-charge, SIHFW.
9. State Nursing Head.
10. State Program Officer, T.B.
11. State program officer, Vector Borne Diseases.
12. Additional Director- Planning, Monitoring & Evaluation, SHSB.
13. Two Accredited Private organizations

Technical Assistance:

14. Deputy Director- Monitoring & Evaluation, SHSB; Additional Director-Training, SHSB; Additional Director-RCH, SHSB.

Secretarial Assistance:

15. One (1) representative of State Data officer and one (1) from HMIS cell, SHSB.
    Special Invitee:
16. Representative from Development partners-UNICEF, WHO,DFID,BMGF,UNFPA.
17. Quality Assurance Expert of National Repute.

{Full time members/ experts for MCH, Family Planning , public health and Quality Assurance Manager may be incorporated as per the approval on the proposal.}

D. Likewise District Quality Assurance Committee are functional at district level with the following members and expertise:-

1. District Magistrate -Chairperson
2. Civil Surgeon – Member secretary
3. ACMO – Convenor
4. Members
   - oGynaecologist and/or surgeon and /or Anaesthetist and/or Paediatrician
   - oNGO representative
   - oDistrict Nursing head
   - oDistrict RCH officer/FW officer
   - oDistrict Program officer, TB, Vector Borne, Blindness and leprosy
   - oDPM
5. Technical assistance
   - oTwo health educator (competency on computer) can be deputed to the cell by CS
6. Secretarial assistance – District M&E Officer
7. Special Invitee: Representative from Development Partners

{Full time members/ experts for MCH, Family Planning , public health and Quality Assurance Manager may be incorporated as per the approval on the proposal.}

The TOR of the state and district Quality Assurance Committees is given as Annexure X.

But the members incorporated in the State Quality assurance Committee may face time constraint and may not be able to contribute their full time support in terms of regular supportive supervision; follow-up and action taken for strengthening the programs; making plans for capacity building / trainings to service providers for improving the quality aspect of service delivery mechanisms.

Hence some more full time members may be incorporated or recruited in the Quality Assurance Cell having expertise in Maternal health, Child Health; family Planning ; public health and data analysis.

E. Scope of Quality Assessment in the District Quality Assurance Programme

In this QA intervention, the Reproductive and Child Health services to be assessed are limited to those provided at the facilities, RCH/sterilization camps and include sub-center outreach services.

RCH Service Areas	Elements of Quality Assessed
A. Family planning services including provision of clinical and non-clinical contraceptives B. ANC, safe delivery, Basic Emergency Obstetric Care(BEmOC) including essential newborn care C. Reproductive tract infections including sexually transmitted infection (RTI/STI) prevention and management including VCT for HIV at designated facilities D. Child Immunization	1. Service environment 2. Access 3. Equipment and supplies 4. Professional standards and technical competence 5. Continuity of care 6. Client provider interaction 7. Informed decision making 8. Privacy 9. Confidentiality 10. Informed consent 11. Proper disposal of wastes

i. *Family Planning*:

Assess quality of service provision for all modern family planning methods available at health facilities.

Family Planning Services Components	**Elements of Quality Assessed**
a. Method specific counselling of men and women for FP method b. Provision of Oral Contraceptive Pills (OCPs) c. Provision of Condoms d. Cu-T 380 insertion e. Tubal Ligation: Laparoscopy/mini-lap f. Emergency contraception g. Vasectomy: Traditional/No-scalpel vasectomy h. Management of contraceptive side-effects i. Follow-up services j. Record keeping	1. Facility infrastructure 2. Equipment inventories including functionality 3. Supplies inventories 4. Staff – availability, training 5. Staffing – knowledge and skills 6. Availability of standards 7. Tracking follow-ups 8. Communication aids for IPC 9. Confidentiality 10. Privacy 11. Informed consent 12. Proper disposal of wastes

ii. Safe Motherhood Services and Newborn Care

Assess all components of antenatal care, safe delivery, basic emergency obstetric care services, postpartum care and essential newborn care provided at the facility. Assess the necessary stabilization of client before transportation, and arrangements for transfer of woman to the nearest Comprehensive Emergency Obstetric Care (CEmOC) facility in the district.

Maternal and Newborn Care Services	Elements of Quality Assessed
a. Antenatal care b. Management of normal labour	1. Facility Infrastructure: Consultation

c. Postpartum care d. Essential newborn care e. Basic emergency obstetric care f. Referral of obstetric and newborn complications	rooms, laboratory, labour Room, ward, OT 2. Transport – availability and functionality arrangements 3. Communications: Functional telephone 4. Equipment inventories including functionality 5. Service equipment 6. Supplies inventories, including EmOC drugs 7. Staffing- training 8. Staffing – knowledge and skills 9. Availability of protocols 10. Privacy and confidentiality 11. Proper disposal of wastes

iii. Management of Reproductive Tract Infections and Sexually Transmitted Infections.

Assess the RTI and STI case management services. Currently these services at the health facilities are being provided on the basis of laboratory diagnosis. These health facilities are expected to be staffed with trained MO, nursing staff and a laboratory technician and have reagents and supplies and equipment to conduct simple tests to detect common RTI/STI pathogens and drugs for their treatment.

RTI/STI Services (Common RTIs/STIs only)	Elements of Quality Assessed
For all common RTI/STIs a. History taking, clinical examination b. Lab investigations c. Treatment d. Partner management e. Counselling f. Follow-ups and referrals	1. Facility infrastructure including laboratory 2. Equipment 3. Supplies inventories 4. Staffing- availability 5. Staffing – knowledge and skills, training 6. Records maintenance for partner management and follow-ups 7. Availability of treatment protocols 8. Privacy 9. Confidentiality 10. Informed Consent 11. Proper disposal of wastes

iv. Child Immunization Services

This element, as far as possible has to be assessed on an immunization day when the immunization session is being conducted at the sub-center or at an outreach facility. However, this may not be feasible every time at the CHC/PHC level when the facility is being visited on non-immunization days. If the facility is offering immunization services on all working days and there is a child availing of the immunization service during the visit, then the steps suggested in the checklist should be followed. In case, it is not so, the QAG member should review the maintenance of cold-chain equipment, logbook, vaccines and examine the stock register and MIS records.

Child Immunization Services	Elements of Quality Assessed
a. Immunization session schedule – planned and conducted b. Functioning of cold-chain equipment c. Adherence to vaccine quality norms d. Infection prevention and safe-injection practices e. Stock situation of vaccines	1. Facility infrastructure 2. Equipment and instruments 3. Cold-chain maintenance 4. Supplies inventories 5. AD syringe use and disposal and safe injection practices 6. Staffing–knowledge and skills 7. Log-book maintenance and updating of immunization cards 8. Availability of protocols

F. Activities under Quality Assurance:-

- Develop process and system for certification to ISO 9001 standards.
- Strengthening of already existing QA committees at State level and District level.
- Formation of Quality Assessment Groups for Assessing the Health Facilities.
- *QA Orientation Workshops:* Prior to launch of QA program in the state and district, and the training of SQAC & DQAC members, the states will organise one day orientation workshops, one for the state officials at state headquarters and another for the district officials at district headquarters. In addition to these, a one-day orientation workshop for Medical Officers of participating facilities will be organised at district level to make them aware of the indicators on which their facility will be assessed during QA visits. This will be done prior to starting QA visits to selected facilities and after DQAG has been trained.
- Workshop to Review the QA Tools- Pretesting of the Tools.
- Identification of Health Facilities for QA Interventions.
- Training/ capacity building of hospitals (service providers) on quality of care and quality system procedure for clinical support, administrative and patient related processes.
- Supportive supervision.
- Review the findings and corrective actions/ preventive actions.

Budget:

S.No.	Particulars	units	Unit cost (Rs.)	Total (Rs.)
1.	Recruitment of Personnel at state quality assurance cell: a. Full time expert on Maternal and child Health expert (MBBS or public health). b. Full time Family Planning expert (MBBS or public health). c. Quality assurance Manager (MBA) d. Data entry Operator	1 1 1 1	40,000/ month 40,000/ month 30,000/ month 15,000/ month	4,80,000 4,80,000 3,60,000 1,80,000
	Sub –total 1.			**15,00,000**
2.	Capital expenditure:- a. Desktops	5	35,000	1,75,000

	b. laptops c. Internet facility or data card (purchase + monthly recharging)	3 3	50,000 2000 per month	1,15,000 72,000
	Sub-total 2.			**3,62,000**
3.	**State & district level workshop and capacity building trainings**			
a.	Orientation workshop at State Level on QA	1	50,000	50,000
b.	Orientation workshop at district Level on QA	38	50,000	1,90,000
c.	Workshop to Review the QA Tools (at state level)	1	50,000	50,000
d.	Training/ capacity building of hospitals (service providers) on quality of care and quality system procedure for clinical support, administrative and patient related processes (for 46 facilities identified for ISO certification)	46 facility x 2 batch /facility x 15 person per batch x Rs.1000 per person		13,80,000
	Sub-total 3.			**16,70,000**
4.	Supportive supervision visits (mobility support)	-		2,00,000
	Sub-total 4.			**2,00,000**
5.	**Travel and lodging expenses of special invitee members of SQAC**			
a.	Travel cost for 2 invitee members of SQAC @ Rs. 15,000/members	4	30,000	1,12,000
b.	Lodging for 2 invitee members of SQAC @ Rs. 3000/day	4	30,000	1,12,000
	Sub-total 5.			**2,24,000**
6.	Quarterly SQAC meetings @Rs.150/participant x 4 quarters x 30 participants	4	18,000	72,000
	Sub-total 6.			**72,000**
7.	**ISO certification**			**2, 00,00,000**
8.	**Documentation**			**50,000**
	Grand Total (Sub-total 1+2+3+4+5+6+7+8)			**2,40,78,000**

Total budget= Rs. Two crores forty lakhs and seventy eight thousand only.

3. Incentives to and Monitoring of Contractual Staff and Health Personnel---

As human resources are the most important resource under Health, steps shall be taken to motivate them through various benefits and incentives. This would ensure timely information generation like cellphone facility for all MOICs, Programme Officers, CDPOs etc. and rural and specialist incentives.

All the doctors posted in the rural area would get an additional incentive of Rs.3000. All the doctors performing specialist duties including the MBBS doctors trained for specialized tasks e.g. Life saving Anesthesia skills etc. will get an incentive of Rs.4000.

3.1 Purchase of 830 mobile handsets from BSNL/By Tender Process

BSNL CUG/RTMS mobile facility has been provided to Health Officials upto Block level. Initially 830 connections with Nokia make 1208 make mobile hand set were taken from BSNL @ 1350/- during last month of year 2008 and warranty of the mobiles has expired.

There has been complain that several mobile hand set are not working properly which needs to be replaced.
Hence it is proposed that approval for purchase of 830 mobile handsets upto the range of ` 2000/- may be obtained which can be purchased from BSNL/ By Tender Process.
Total financial implication involved will be around ` 1660000/- (Sixteen Lacs Sixty Thousand Only)

3.2 Payment of monthly bill to BSNL

Approximately 900 BSNL post paid CUG/RTMS mobile facility has been provided to Health Officials upto Block level. Approximately ` 500000/- is paid to BSNL as monthly bill (900 * ` 551.50: - ` 500 as monthly rent + ` 51.5 as ST).
For monthly payment of the bills, total financial implication involved in year 2011-2012 will be around ` 600000/- (Sixty Lacs Only). Kind approval may be obtained.

3.3 Biometric System for Attendance

Fund for set up of Bio metric system for attendance at 523 locations (PHC, SDH, Sadar Hospital) was sent during 2008-2009 (@ ` 16640/- per location). The machines which were established have gone beyond the warranty period hence districts are demanding fund for AMC and also there has been increase in number of locations. Current list of locations is attached which is 609.
Fund Requirement:

For new locations (609-523) = 86 * 166640.00= ` 1431040
Approx amount for AMC (20% ` 16640=` 3328* 546): ` 1817088
Total financial implication (` 1431040 + ` 1817088) = ` 3248128

4. State Health System Resource Centre

Governing body of SHSB, have approved the formation of SHSRC under the supervision and control of SHSB. The selection of consultants for these seven positions is under process with NHSRC, New Delhi --Team leader, Consultant-Public health planning, Consultant-Health care financing, Consultant-HMIS, Consultant-Quality Improvement, Consultant-HRD and Team leader community process.

Budget proposed- Rs. 1 Crore for FY-2011-12 for establishing and making functional SHSRC in Bihar.

5. PPP Initiatives in State

5.1. Referral & Emergency Transport

5.1.1 Emergency Medical Service /102 – Ambulance Service

The Toll free number 102 was launched during 2006-07 and is running in all the six regional headquarters successfully. Under this scheme Ambulance for emergency transport is being provided in all the districts of Bihar. The empanelled ambulance & ambulance available in Govt. institutions are made available on receipt of calls from the beneficiaries.

This service has been outsourced to a private agency for operationalisation. The telephone charges for the free toll free number is paid to BSNL by SHSB. The amount required would be for payment of incoming calls received from the beneficiaries.

In the year 2010-11 (figures till 20 December 2010) 29644 requisitions have been successfully met by this service.

Budget summary of 102 :

Budget Head	**102 Emergency Service**	
Sub-Heads	@	**Proposed Budget (in Crores)**
Control Room (including office rent, salary of staff (24x7), stationary, 2 outgoing telephones for compliance of 102 & for reporting to Headquarter)	Rs. 41,000.00 x 6 units = Rs, 246000.00 x 12 months =Rs. 29,52,000.00 + Per Control Room Rs. 15,000.00 pm x 6 = 90,000.00 x 12 months	**40,32,000.00**
Total		**40,32,000.00**

5.1.2. Doctor on Call & *Samadhan*: Dial 1911

A scheme is operational in the state wherein patients can dial a number and call for doctors. For this a special toll free number of 1911 has been provided to the people w.e.f. 01.3.2008. The objective of the scheme is to give medical assistance to the patients at their home at any time as well as act as a Samadhan of Rogi Shikayat.

Doctors and Specialists have been empanelled for this scheme. Pathology labs have also been attached to collect samples for tests from patient's home.

Budget summary of 1911:

Budget Head	**1911 Doctor on Call service**	
Sub-Heads	@	**Proposed Budget (in Crores)**
Control room	3,500 per person (Four persons) = 14,000.00 per control room is being paid to the outsourced agency. Rs. 14,000.00 x 6 = Rs. 84,000 x 12 months	1008000.00
Telephone bill	Each control room is being paid telephone bill (i) Doctors conferencing Rs. 1,500.00 x 12 months = 18,000 x 6 control rooms = 1,08,000.00 & (ii) Rogi Jan Shikayat Rs. 2,000.00 x 12 months = 24,000 x 6 control rooms = Rs. 1,44,000.00.	252000.00
Provision of Annual Maintenance of EPBAX	Rs. 10,000.00 per annum x 6 control rooms.	60000.00
Total		**1320000.00**

5.1.3 Advanced Life Saving Ambulances (108)

SHSB is providing prompt quality pre hospital care to patients, trauma victims, pregnant women, for the purpose of which Emergency Network service is being piloted under PPP in all the 38 districts of Bihar. The objective is to save lives of Road Traffic Accidents, cardiac emergencies, fire victims and other emergency cases.

Description

Initially 5 Advance Life saving Ambulances (Trauma, Critical & Cardiac Care) & 5 Basic Life saving Ambulances were made operational on 03.06.2009 which run within Patna Municipal Corporation area and its sub urban areas. Every Ambulance is manned by a Driver, an Emergency Medical Technician and trained Helper to provide basic care during transportation of patients. For each trip made by the Ambulance to anywhere within the limits of Patna Municipal Corporation and its sub-urban areas, a charge of Rs. 300/- is collected by the outsourced agency from the patients. Free Blood pressure & Blood sugar (Random) check-up camps are also organized for 20 days in a month for two hours in morning time (5.30 am to 7.30 am) in different locations of Patna Municipal Area by these ambulances. Apart from these 10 ambulances, 40 ambulances out of 45 received so far from the Prime Minister's Relief Fund have also been made operational in all the 38 districts of Bihar with provision of two ambulances in seven districts namely Patna, Bhagalpur, Gaya, Darbhanga, Kishanganj, Muzaffarpur & Nalanda. The operational cost (OPEX) per ambulance per month is estimated to be Rs. 130,000.00. Moreover agreement for one Advance Life saving & one Basic Life Saving ambulance each for nine divisional headquarters namely Bhagalpur, Darbhanga, Gaya, Munger, Muzaffarpur, Patna, Purnia, Saharsa & Saran has been done where the capital (CAPEX) & operational (OPEX) cost together will be Rs. 98,900/- per ambulance per month. The agency has set up a Control Room in Patna which operates for 24 hours in 3500 sq. ft. area through dedicated toll free three digit telephone numbers (108). The agency has provided 100 parallel lines, 16 voice recording lines & 60 terminals with hunting facilities both from BSNL & Airtel companies. The Control Room receives emergency calls related to Medical Services and from Police and Fire Fighting Services to cater to Medical Emergencies. The agency provides GIS (Geographic Information System) maps, GPS (Global positioning systems) / AVLT (Automatic Vehicle Location Track) and all the other necessary hardware/software for Computer Telephonic Integration. The agency keeps a record of the contact numbers and location of each of the 50 Ambulances, all Hospitals of city which can provide medical emergency, all the Police Stations, Police Control Room, Police Head-quarters and Fire Services in the city. The agency bears all expenses relating to hire of space, water, electricity charges, furniture, furnishing etc in running the Control Room. The Control Room has battery / generator backup facility so that services could be provided un-interrupted round the clock.

Support activities- The agency has to also undertake the following-listing of Govt and private hospitals which can provide emergency services round the clock. Necessary training of hospital personnel to take up Emergency cases. Dissemination of the scheme and the toll free numbers for police, fire, health, education and general public so that this service can be utilized.

Budget-

Sl. No.	*Items*	*Amount (Cost/month)*
1.	Cost of Emergency service network in Patna (annual cost for running 10 ambulances)	989000.00 x 12= 11868000.00
2.	Cost of Emergency service network in 9	1780200.00x12 = 21362400.00

	divisional headquarters (annual cost for running 18 ambulances)	
3.	Cost for running 45 ambulances received from Prime Minister Relief Fund	5850000.00x12 = 70200000.00
4.	Free Blood Pressure & Blood Sugar (Random) Checkup	1000000.00
	Total	**104430400.00**

Fund required from GOI - Out of the 73 life saving ambulances, 10 started functioning from the 6th June 2009. So, 20% of OPEX of these 10 ambulances may be managed from State. Out of remaining 63 ambulances, 40 started functioning from September 2010. Even one year is not complete of their functioning and rest 23 are to be made functional in this financial year. So, in total 100% OPEX for 63 life saving ambulances required.

5.1.4 Referral Transport in Districts

Taking into consideration the demand from different districts, the State Health Society, Bihar is exercising the process for launching medium sized ambulances in all the 533 PHCs & 76 FRUs. Every ambulance will be manned by 5 staff (2 Drivers, 2 Emergency Medical Technicians and 1 Back-up staff) and will be operational 24 hours on 12 hr rotation basis. These ambulances will be managed by one state headquarter control room. The service will be free for accident & natural calamities victims, BPL patients, sick children with their parents pregnant mothers & senior citizens. It is proposed to bring the one time capital (CAPEX) cost of 609 ambulances & forty percent of their operational (OPEX) cost under NRHM as this would fall under the ambit of Emergency Referral Transport.

The anticipated one time capital cost for 609 ambulances is-

Budget : Rs. 700000/- x 609 nos. = Rs. 426300000/-

The anticipated operational cost per month:-

1	Staff	35,000
2	Fuel	15,000
3	Management & CDC Staff	5,000
4	Medicine / Consumables	10,000
5	Others (Marketing, HO expense, telephone, conveyance, mobile exp in ambulances, staff OT, Tax, insurance, pollution, etc.)	8,000
	Total	**73,000**

Hence, the anticipated operational cost for 12 months:-

Budget : Rs. 73000/- x 609 nos. x 12 = Rs. 533484000/-
40% of operational cost i.e. = Rs. 213393600/- **from NRHM**

The break-up of operational cost is realistic and as follows:-

1	Staff (2 drivers + 2 EMTs + 1 Back up staff)	35,000
2	Fuel	15,000
3	Management & CDC Staff	5,000
4	Medicine / Consumables	10,000
5	Others (Marketing, HO expense, telephone, conveyance, mobile exp in ambulances, staff OT, Tax, insurance, pollution, etc.)	8,000
	Total	**73,000**

60% of operational cost = Rs. 32,00,90,400/- **from transportation head of JBSY.**
Mechanism will be established to ensure that the women who do not use the referral transport and come by their own means would be given their due referral component of JBSY.

Grand Total – Rs.95,97,84,000/-
(Operational Cost Budgeted in Part A under Referral Transport)

5.2. Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP)

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

Strategy/Project Description

State Health Society Bihar is implementing National Rural Health Mission (NRHM) to carry out necessary architectural correction in the basic health care delivery system. In order to provide quality services to the public, SHSB has sought Public Private Partnership in providing proper Hospital Waste Treatment and Disposal Services, in all Health facilities right from Medical Colleges to the PHCs.

Services to be provided

1. Provide Service of Hospital Waste Treatment and Disposal in all Medical Colleges, District Hospitals, Sub-Divisional Hospitals, Referral Hospitals and PHCs of the State.
2. Install, Operate and maintain appropriate Common Biomedical Waste Treatment facility, as per the Biomedical Waste (Management & Handling) Rules, 1998 and subsequent amendments in it.
3. Provide one day orientation training to all the health service providers.
4. Maintain the above-mentioned arrangement for a period of minimum 10 years. The Common Biomedical Waste Treatment facilities are proposed to be established at various locations across the State

Setting up a Bio-Medical Waste Management System:

1. The state has started a CWTF facility at Indira Gandhi Institute of Medical Sciences, Patna (autonomous institute). The facility has been approached for undertaking waste treatment for all PHCs to DHs in all the six districts of Patna division. Services have already been initiated in all these districts.

   Status – Registration of the health facilities with IGIMS and with Bihar State Pollution Control Board being ensured. Anticipated to be fully functional across all facilities in all the six districts by end of March 2011.

2. As per the rules each CWTF should cater to all facilities in 100 Km radius, keeping this in mind, more CWTF are to be operationalised in each of the division except Patna (which already has such a facility).

   To implement the IMEP in a comprehensive systematic manner, Private Parties have been invited through National Open Tender. SHSB has already finalized two agencies and signed contracts for undertaking the BWM project that would set up CBWM Treatment facilities at various locations in the State and cater to all the PHCs to DHs to MCHs in all the Divisions except Patna.

The agency shall ensure segregation and collection of waste, disinfection, treatment, transportation, handling and disposal of waste both within and outside the healthcare setting; also ensure use of protective devices and safety precautions. The objective being to ensure waste management, waste minimization and infection control.

Trainings to be provided to health care workers and officers in Infection Management and Environment Plan implementation by the respective agencies. Payment is to be made on a per bed Per day monthly basis to both IGIMS and the Private Agencies.

Status-

The two PPP agencies have received –

- Contract signed
- NOC from Bihar State Pollution Control Board
- Government land in Bhagalpur for setting up the facility
- One agency has procured land from BIADA (Bihar Industrial Area Development Authority) in Muzaffapur for setting up another CBWTF facility
- Land being provided by Government in Gaya
- Services expected to start from July-September 2011

Budget

Activities	Total proposed budget (in Rs.)
Dissemination and Sensitization workshops on IMEP Guidelines at divisional levels	10,00,000/-
Training of in-house staff (ANM, Safai Karmacharis, clinical support staff) on recognizing, segregating and disposing of bio-medical wastes	10,00,000/-
Operationalization of Biomedical Waste Management	5,00,72,000/-
Total (Budgeted in Part-A under IMEP)	

Work plan

Activities	2010-11			
	Q1	Q2	Q3	Q4
Dissemination and Sensitization workshops on IMEP Guidelines at divisional level				
Training of in-house staff (ANM, Safai Karmacharis, clinical support staff) on recognizing, segregating and disposing of bio-medical wastes				

Sno.	Deliverables	Time Period
1	Setting up the required infrastructure along with acquisition of land and acquiring necessary clearances from the respective Governmental and/or Municipal Departments and PCB/ boards	Within 8 months of signing the contract, expected from April-June 2011
2	Conducting sessions to orient and train health professionals across the public and private hospitals in the district by private partner	April-June 2011
3	Initiation and commissioning of Biomedical waste management, disposal and treatment services, as per agreed protocols	Within 270 days of signing the contract, expected to be initiated in 30 districts from July 2011

5.3. Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar

Ultra-Modern Diagnostic Centres through Public Private Partnership (PPP)' in 9 Regional Diagnostic Centres (RDCs) and 6 Medical College Hospitals (MCHs) of Bihar have been or are in the process of being set up.

M/s Doyen Diagnostics, Kolkata is the private partner in this initiative for MCH. For identifying Private Partners for setting up UMDCs, advertisement is to be floated.

Project Area –Regional Diagnostic Centers in Ara, Gaya, Bhagalpur, Munger, Muzaffarpur, Motihari, Purnea, Saharsa and Chapra. Government Medical College Hospitals – PMCH, NMCH, SKMCH, DMCH, ANMMCH, JLMNCH

Project Scope- To operate, maintain and report 24-hours 'Ultra-Modern Diagnostic Centers' in RDCs & MCHs and report the progress to the RDDs (who would be in-charge of monitoring the RDCs project) and the Superintendents (who would be in-charge of monitoring the MCH project) and the SHSB.

Project Condition -

- The State Government has created the buildings for Regional Diagnostic Centers at all the towns mentioned in Project Area. In the case of MCHs, space is provided in the premises of the MCH itself.
- The agency shall provide everything from equipments & machine, logistics, consumables etc to personnel; the said RDC/MCH provides space for the Diagnostic Centre along with space for storage at a nominal monthly rent payable to the DHS of the concerned district (in the case of RDC) and the Rogi Kalyan Samiti of the concerned MCH (in the case of MCH) by the agency.
- Rates (charged from the users) is as per AIIMS, New Delhi for the basic, standard and other specialized tests under each Diagnostic head.
- The project is on a revenue sharing model

The project is for ten (10) years depending upon performance further extension will be considered.

Facilities that are being/are to be provided in RDCs and MCHs are→ Pathology- Bio-Chemistry, Radiology – Digital x-ray, CT scan, MRI, ECG, Mammography.

GOI had approved an allocation of Rs.3.60 cr in the SPIP 2010-11 for reimbursement through RKS to BPL patients.

The state again requires budget in this regard only for reimbursement to the Private Parties by the RKS of the concerned hospital for providing free services to BPL patients. All the remaining cost for setting up centers will be borne by the private providers.

Budget

Activities	Total proposed budget
Reimbursement cost to the Private Parties by the RKS of the concerned hospital for providing free services to BPL patients	Rs.200 x 1000 BPL patients x 12 months x 15 units= Rs.3.60 Crores

5.4. 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 taken a policy decision to provide free service under this to all Government patients and the reimbursement to the agency as per the fixed rates of SHSB and is reimbursed to RKS. The state has provided space at the hospitals to the agency for running the Pathology and Diagnostic Centre.

However under the project service expansion has been done and Ultrasound facility is also being provided at various locations at DHs and SDHs. For this purpose of establishment of Central Reporting System (CRS) for X-ray and Ultrasound Units is being done at IGIMS, Patna. The purpose being CR system will connect all the Ultrasound and X-ray centers of IGEMS set up in Government Hospitals under this contract, with Tele-radiology in a phased manner.

The Agency has provided all necessary hardware, software and manpower for establishing the network between IGIMS and each of its Radiology unit having X-Ray and Ultrasound facilities for running the Tele-Radiology service.

SHSB has to provide radiologist (preferably retired persons) to report on the Ultrasound and X-Ray images, telephone line with broad band connection and necessary power connections. All the remaining cost for setting up centers and providing services is being borne by the private providers.

Budget

Activities	Total proposed budget
Reimbursement fee to private partners for providing free diagnostic services to patients (through RKS)	10,46,00,000
Recurring expenses for running CRS	Rs. 25,000 x 12 months = 3,00,000
Sourcing of private radiologists to report on the Ultrasound and X-Ray images through the CRS at IGIMS incase of non-availability of Government radiologists @ Rs. 35000 per month for 2 radiologists	35000x2x12=8,40,000
Total	**10,57,40,000/-**

5.5. Operationalising Mobile Medical Unit

SHS, Bihar on behalf of the Department of Health, Government of Bihar invited Private Service Providers for providing Mobile Medical Units (each unit fitted with GPS- Global Positioning System) to provide primary health care facilities in the hard to reach rural areas of various districts of Bihar.

Three agencies have been awarded the contract for operationalising mobile medical units in all the districts.

Scope of Work

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

care services for the far flung areas in the various districts of Bihar and to provide a visible face for the Mission.

Project Objective

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

Project Scope

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

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

Vehicle Type for MMU

- Brand new GPS fitted, fully Air Conditioned TATA 709 chasis or equivalent vehicle of similar dimension from reputed manufacturers for MMU
- An accompanying vehicle of TATA Sumo or Mahindra Bolero or equivalent specification make vehicle for Carriage of Medical persons and also to be used as ambulance for transporting patients in case of emergency. The body of vehicle should be suitably modified to serve this dual purpose.
- Mobile Van should be designed keeping in mind the following criteria -ease of deployment, female privacy, community acceptance and cost.
- Web enabled MIS has to be ensured along with a Control room at Patna or Commissioner HQ.
- Temporary shed facility shall have to be ensured at the site for the patients in waiting.

Manpower

The manpower to be employed for the program is to be appointed by the Private agency as such-1 Doctor, 1 Nurse, 1 Pharmacist (van supervisor),1 OT assistant , 1 X-ray technician, 1 ANM , 1 Driver (Qualification requirements annexed)

Equipments being provided in the MMU

Medical Equipments -Semi Auto-Analyzer, Portable X ray unit, Portable ECG, Microscope, Screen, Stretcher, O.T Table with standard accessories, Stools, Dressing Trolley/Instrument trolley, Dressing drums, Oxygen Cylinder, Suction Machine., Ophthalmoscope, Refraction set, Horoscope, Mobile light or Ceiling light (OT Light),Centrifugal Machine, Hemoglobin meter, Glucometer, Autoclave, Incubator, Urine Analyzer, Vaccine carrier, Weighing machines-adult and infant, Stethoscope, BP Instrument, Kits like Suture removal kit, Pregnancy test kit, IUD insertion kit, Starter, Regent kit, HIV testing kit, General Instrument kit, First Aid kit, various, tests and surgery kits, Normal Ambulance appliances or accessories like foldable furniture, waste basket, linen, mattress, mackintosh sheets, fire extinguisher etc

Silent DG set, Audio-Visual Equipment with projection system for IEC especially with, 40" LCD, P&A System, Cell phone

Service Areas

The Medical areas which would be handled include:

1. Free General OPD/ Doctor Consult
2. Free Drugs - Free dispensation and procurement of medicines as per the Essential Drug List prescribed by GoB for PHCs (Annexed) has to be ensured by the private agency
3. Emergency Services during epidemics and Disasters
4. Network and referral between PHC/CHC/Private clinics
5. Generating health indicators and monitoring behavioral changes
6. Gynae clinic
7. Antenatal Clinics
8. Post Natal Care
9. Infants and Child Care including immunization with Vitamin A supplementation (support for the same to be provided by the Government)
10. Diagnosis, Referral and Rehabilitation for Non-communicable diseases eg. Cardiac Diseases, Hypertension, Diabetes, etc
11. Adolescent and Reproductive Health
12. Other Services like Treatment of Minor Injuries and Burns, Aseptic Dressing, TT immunization, Treatment of Minor burns, Minor Suturing and removal – referral etc
13. Minor lab investigations
14. Eye examination
15. ENT examination
16. HIV testing
17. Promotion of contraceptive services including IUD insertion.
18. Prophylaxis and treatment of Anemia with IFA Tablets.
19. IEC and counseling along with preventive health screening and health awareness programs
20. Service related to different public health programmes.
21. Pathological services.
22. Radiology Services – X-ray
23. Preventive Health Screening and Health awareness programs
24. Medical camps will have to be conducted whenever emergency need be

Commissioning Period- 2 months from the date of contract signing.

Budget

Activities	Total proposed budget (in Rs.)
Projected cost for 1 MMU project at district level	Rs.4.68 lakhs x38 units x 12 months =21,34,08,000/-
Projected cost for 1 MMU for MahaDalit Tolas of the State (on a pilot basis)	Rs.4.68 lakhs x 10 units x 12 =5,61,60,000
Total	**26,95,68,000/-**

5.6 Monitoring and Evaluation (Data Centre)

The budget is given in compiled sheet of NRHM Part B budget, the write up may be referred to in Chapter IX of this SPIP document.

5.7. Generic Drug Shop

Under the PPP initiative Generic Drug Stores shall be set up at all MCHs, DHs and PHCs. The Private agency has to keep 188 types of drugs at the store. The state has provided only space for this purpose to the agency and the agency shares a % revenue share with the Government. The state has also fixed rates for the Generic Drug as per MRP.
No additional cost is involved.

5.8. Hospital Maintenance

The state has outsourced the cleanliness, diet and maintenance of Hospitals to private agencies.
The activities include -

- Maintenance of Hospital Premises @Rs.15000 per facility per month
- Generator Facility @Rs.10,000 per facility per month
- Washing- Rs.5000 per month per facility

The amount required for this purpose is borne by the state government.

5.9. Outsourcing of HR Consultancy Services

Under this scheme SHSB has contracted M/s First Select (P) Ltd. Gurgaon for assisting SHSB in selection and recruitment of doctors, nurses, paramedical staffs and other managerial and clerical staff.

Budget : Rs. 11,00,000 per year

6. Strengthening of Cold Chain

Effective cold chain maintenance is the key to ensuring proper availability and potency of vaccines at all levels. However the recently concluded Vaccine Management assessment (VMAT) in Bihar in 2008 and the National Cold chain assessment (July 2008) observed several deficiencies in cold chain storage and management in Bihar.
With a steadily increasing immunization coverage for Routine Immunization, rise in demand for Immunization services throughout the state, the consumption of large quantities of vaccines in frequent Supplementary Immunization activities and the possibility of introduction of newer vaccines in the near future, it is necessary that the capacity of existing cold chain stores as well as the proper management of immunization related logistics be strengthened on a urgent basis.
For this there is need for refurbishment of existing cold chain stores at all levels, particularly at the level of the larger state, 9 regional and 38 district stores. Often there is lack of storage space in the existing health stores leading to dumping of critical immunization related logistics like AD syringes, vaccine carriers and cold boxes in the open, exposing them to the vagaries of nature and sometimes leading to their damage. Renovation of existing stores would help in creating more organized dry space for both proper storage of material as well as proper loading, packing and unloading of Immunization related logistics. The state store in particular receives large quantities of materials and a separate ware house is needed to store immunization related logistics. Provision to hire storage space on arrival of large quantities of material should also exist. In all stores across the state there is also a need for proper electrification and wiring to ensure longevity of electrical cold chain equipment and for reducing their frequent breakdown.

The lack of dedicated support manpower for immunization logistics management and for cold chain equipment repair at all levels was observed during the aforesaid cold chain assessments and it was recommended that “At each of these facilities there should be a full time dedicated store manager. Where the load of operations is high (SVS and RVS) the store manager should have adequate support staff to help him.” (VMAT Bihar 2008) The National cold chain assessment also recommended that a there should be a cold chain technician along with a cold chain handler at all district stores and a cold chain handler at all PHCs. Since provision of regular staff in these positions is not possible it is envisaged that contractual persons be hired for these activities.

Budget

B-14 Infrastructure Strengthening for Cold Chain		
Items	**Units**	**Amount**
Refurbishment and integration of existing Warehouse facilities for R.I. as well as provision for hiring external storage space for (during Immunization Campaigns) Logistics at State HQ @Rs 15,00,000/-	1	1500000
Cold Chain handlers@Rs.12000	38	5472000
Refurbishment of existing Cold chain room for district stores in all districts with proper electrification, Earthing for electrical cold chain equipment and shelves and dry space for non electrical cold chain equipment and logistics @ Rs 8 Lakhs per district	38	30400000
Earthing and wiring of existing Cold chain rooms in all PHCs @ Rs 3000/- per PHC	533	1599000
Total	**572**	**38971000**

7. RCH Procurement and Logistics

7.1 Drug Procurement

The State Government has taken a policy decision to provide Free Essential Drugs right from PHC to MCH from 1st July 2006 which also resulted in unprecedented increase in OPD and IPD patients. State has it's own EDL for each level of health facility which is as such and the same is further being rationalized under the Chairmanship of Additional Director, Health and with feedback from Civil Surgeons etc. Furthermore with Bihar State Medical Services and Infrastructure Corporation Ltd already registered and expected to be fully functional from April 2011, it is expected that the Drug Procurement and Logistics would be further streamlined -

Sl no.	Health Facility	OPD	IPD
1	DH to APHC	41	193
2	Medical College Hospitals	99	172

SHSB undertakes rate contracting of the Drugs-

Year	Drug Tender round	No of drugs
2006	1	38
2006	2	89
2007	3	225
2008	4	46
2009	5	282
2009	6	152 out of 253finalised

The expenditure pattern in State has been as such –

FY	Expenditure on Drugs (in Crores)	Source
2004-05		State Government
2005-06		
2006-07	39	
2007-08	62	
2008-09	68	
2009-10	68	
2010-11	Approx. 150	NRHM + State Government

The per capita expenditure on drugs of Bihar is Rs.7/- as compared to Rs. 29/- in Tamil Nadu.

NRHM approved an expenditure of Rs.70 cr in FY 2010-11 under Drugs from NRHM as the requirement of drugs has increased due to increase in institutional delivery and OPD patients, it is essential that smooth and timely drug supply is ensured.

Budget Proposed – Rs.90.00* crores (Drug Procurement (incl. addl. Requirement of Vitamin A bottles as mentioned under CH of Part A + District level support manpower at DHS level)
* Addl.fund to be sourced through State Government incase expenditure exceeds

7.2 Procurement of Supplies--

Provision of Quality Beds
SHSB had finalized the rates and communicated the orders to the districts. Three types of beds to be provided-Fowler Deluxe Beds, Fowler Beds and Semi Fowler Beds
It is estimated that a total of 1284 no. of beds shall be required at various levels (Status in Annex. 8.

Total fund required = Rs. 1,06,31,520 @ Rs. 8280/- per bed—for financial year 2011-12 (Details in Annexure 8)

Budgeted in Part A under Procurement of Drugs and Supplies

7.3 Procurement of Equipments (RCH)--

7.3.1 SCNU in District Hospital and Newborn Care Corners in PHC

Year 2010 was declared as the Year of Newborn. SHSB had undertaken rate contract of equipments for SCNUs and NBCCs. 1300 lakhs was approved under this in SPIP 2009-10 alongwith for NBCCs. It is planned to establish 26 SCNUs (23 through SHSB and 3 through NIPI), however SHSB took a precautionary decision to stagger procurement of equipments in the SHSB districts. In the 1st phase, 6 districts were initiated wherein procurement was done, the next phase in 2010-11 17 more districts were taken up. However as per the tender terms supply commences 6-9 months from date of order, the procurement in the districts is taking some time besides delay in payment from the districts (status as on 28.02.2011 may be seen in Annex.7)

Therefore anticipating spill over of procurement and seeing the current payment scenario in the districts the supply and payment would spill over in 2011-12, budget is being provisioned for 2011-12 for SCNUs.

Also of the 533 Newborn Care Corners at PHCs, in 2010-11 it was expected to set up 388 NBCCs. Again as per the status at Annex.7 spill over of supply and payment is expected in 2011-12. Budget is being provisioned for such pending districts, as such - districts have been given orders for about 391 nos. in which 253 are in the process of being set up and expenditure of the same shall be made in FY 2010-11. For remaining 138 + 142 (Total 280) NBCC budget is being provisioned for SPIP 2011-12, with an additional spill-over amount for present NSUs as supply would fall into the next FY.

Schedule No.	Name of Equipment	Rate (Per Unit)	Total Quantity of Equipment per Setup in SNCU	Total Amount per SCNU	Total Amount per NBC
2.1	Bilirubinometer, total bilirubine, capillary based	226,000.00	1	226000	0
4.1	Open care system: radiant warmer, fixed height, with trolley, drawers, O2-bottles	49,900.00	14	698600	49900
4.2	Oxygen hood, S and M, set of 3 each, including connecting tubes	8,500.00	14	119000	0
4.3	Basinet on trolley,	36,500.00	5	182500	36500

	neonatal, glass base with mattress, phototherapy under mount & single side blue light phototherapy				
5.1	Syringe pump, 10,20,50 ml, single phase	55,520.00	7	388640	0
7.1	Oxygen concentrator	41,366.00	7	289562	41366
3.5	Glucometer	925.6	1	926	926
	Cost of 100 strips=Rs.1200 =1200x9	10,800.00	therefore, anticipated qty. 30 nos. x30 days per unit=900 strips per month	10800	10800
6.1	Pulse oxymeter, bedside, neonatal	49,890.00	7	349230	0
	Total			**2265258**	**139492**

Total Budget Proposed–

SCNU = Rs. 2265258 x 22 SCNU= Rs. 4,98,35,676/-
Newborn corner (In all Labour Rooms) = Rs.139492 x (280NBC in PHC) = Rs. 3,90,57,760.00
Total = Rs. 8,88,93,436/-

7.3.2 Equipments for Labour Room

Rate contract of equipments for Labour Room was done in the year 2009-10. Procurement and supply of the same has been underway in 2009-10 and 2010-11. However it is expected that purchase process in some of the districts will spill over in 2011-12 also.

The list of equipments rate contracted for Labour Room are-
Steriliser, Instrument Trolley, Labour Table, Transfer Trolley, Mayo's Instrument Trolley, Revolving Stool, Steriliser, Instrument Trolley with SS Bowl, IV Stand, Suction Machine and OT Light.

Therefore against a budget of **Rs. 13,94,39,332/-,** in SPIP 2011-12 for Phase-I an amount of **Rs. 7.00 Crores** is proposed. (details in annexure)

7.3.3 Dental Chair Procurement for DH, SDH and RH

Dentist have been recruited for across the States for various levels of Health facilities. Full utilization of this cadre can only be done if there is provision is Dental Chair at the Health facility.

Total Budget **= 36+23+70+= 129 x Rs. 400000/- = 5,16,00,000/-**

8. De-centralised Planning

SHSB has initiated HSC, Block and District planning from 2009 onwards. In 2011-12, it is proposed to go further down and start Village Planning. This is because the VHSCs are now being constituted and strengthened.

This would be a herculean task and a year long exercise. A Planning Cell is being constituted at the State level with Additional Director-Planning and Assistant-Planning (advertisement floated, shortlisting underway, expected to be in position from March 2011). At the District level Consultant specifically dedicated to Planning in the form of District

Planning Coordinator is already in place in 90% of the districts and in the rest recruitment process in underway.

Induction training of the DPCs has already been conducted with technical support from NHSRC, UNICEF and PHRN.

In FY 2011-12, SHSB intends going further down to the Village level and undertaking Village Planning for FY 2012-13 as capacity building of VHSCs is already in the ambit. Further the ANMs have all received training on Village Planning Module developed in 2010 by SHSB.

Budget

Head	Unit	Cost
State Health Action Plan incl. capapity building of State and District Planning cell on 'Planning'	1	5,00,000
Asst. – Planning	1	22000 x 12=2,64,000
Asst.- Finance (Planning)	1	20000x9= 180000
District Health Action Plan	38	38 x Rs.25,000=9,50,000
District Planning Coordinator	36	36 x Rs.22000 x 12=9504000
Block Health Action Plan	533	533xRs.3000=1599000
HSC Planning	9696	9696 x Rs.2000=14544000
Laptops for District Planning Cell (for top five best performing districts for planning)	2	2 x Rs.48,500/-=97000

Total Budget Requirement for Planning –Rs.2,76,38,000 /-

Budget of NRHM Part B

Sl. No.	Activities	Unit Cost (in Rs.)	Physical Targets	In Lakhs	% of total budget
1	**Decentralization**				
	ASHA Support System at State Level			250.53	0.50
	ASHA Support System at District Level			187.26	0.37
	ASHA Support System at Block Level			536.15	1.06
	ASHA Support System at Village Level			0.00	0.00
	ASHA Trainings			4552.32	9.01
1.1	ASHA Drug Kit & Replenishment	250	87135	217.84	0.43
	Motivation of ASHA			186.69	0.37
	Capacity Building/Academic Support programme	1000	1000	10.00	0.02
	ASHA Divas	1032	87135	899.23	1.78
	Total ASHA			**6840.02**	13.54
1.2	Untied Fund for Health Sub Center, Additional Primary Health Center and Primary Health Center			1499.81	2.97
1.3	Village Health and Sanitation Committee			4511.74	8.93
1.4	Rogi Kalyan Samiti			2263.00	4.48
	RKS Capacity Building & Strengthening				
	Total Decentralization			**15114.58**	29.93
2	**Infrastructure Strengthening--**			0.00	0.00
2.1	Construction/Establishment of HSCs	1557000	76	887.49	1.76
2.2.1	Construction of APHCs(PHC)	7599000	36	2747.15	5.44
2.2.2	Construction of residential quarters for Doctors & Staff nurses in 38 old APHC	3000000	18	540.00	1.07
2.3	Upgradation of PHCs to CHC (Construction of 3 Doctor and 4 Staff Nurse Quarters)	5000000	20	1000.00	1.98
2.4.1	Strengthening and Upgrading District Hospitals (Construction of SCNU buildings)	6430000	11	707.30	1.40
2.4.2	Strengthening and upgradation of Health Facilities (Installation of Solar Water Heater System)	38500	185	72.72	0.14
2.4.3	Up gradation of 05 DHs by Increase number of Beds 900 Lumpsum	138500	900	50.00	0.10
2.4.4	Upgrading 2 Hospitals as Super Speciality Hospital Lumpsum	2500000	2	50.00	0.10
2.5	Upgradation of Infrastructure of ANM Training Schools			0.00	0.00
2.6	District Drug Warehouse (Only for Procurement + Infrastructure)			0.00	0.00
2.7	Setting up of Intensive Care Unit in all the District Hospitals			0.00	0.00
2.8	Annual Maintenance Grant			2196.10	4.35
2.9	Accreditation / ISO : 9000 certification of Health Facilities			826.50	1.64
	Total Infrastructure Strengthening			**9077.26**	17.97

3	**Incentives to and Monitoring of Contractual Staff and Health Personnel--**			0.00	0.00
3.1	Purchase of 830 mobile handsets from BSNL/By Tender Process	2000	830	16.60	0.03
3.2	Payment of monthly bill to BSNL	6618	900	6.00	0.01
3.3	Biometric System of Attendance			32.48	0.06
	Total Incentive to & Montioring of Contractual Manpower & Health Personnel			**55.08**	0.11
4	**State Health System Resource Centre**			**100.00**	0.20
5	**PPP Initiatives--**			0.00	0.00
5.1	Referral & Emergency Transport-			0.00	0.00
5.1.1	Emergency Medical Service /102 – Ambulance Service	672000	6	40.32	0.08
5.1.2	1911- Doctor on Call & Samadhan	220000	6	13.20	0.03
5.1.3	Advanced Life Saving Ambulances (Call 108)	1631725	64	1044.30	2.07
5.1.4	Referral Transport in Districts	700000	609	4263.00	8.44
5.2	Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP) (Budgeted in Part-A)			0.00	0.00
5.3	Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and all Government Medical College Hospitals of Bihar	200	180000	360.00	0.71
5.4	Outsourcing of Pathology and Radiology Services from PHCs to DH	2646579	38	1057.39	2.09
5.5	Operationalising MMU	5616000	48	2695.68	5.34
5.6	Monitoring and Evaluation --			0.00	0.00
	State Data Centre		1	23.66	0.05
	District & Block Data Centre	90000	680	612.00	0.00
	Divisional Data Centrre at RPMU	509328	9	45.84	0.00
	Community Based Planning and Monitoring (CBPM)				0.00
	Quality Assurance and Supportive Supervision (Budgeted in Part-A)			0.00	0.00
5.7	Generic Drug Shop			0.00	0.00
5.8	Hospital Maintenance			0.00	0.00
5.9	Outsourcing of HR Consultancy Services			11.00	0.02
	Total PPP Initiatives			**10166.39**	
6	**Strengthening of Cold Chain**	**68131**	**572**	**389.02**	0.77
7	**RCH Procurement and Logistics**			0.00	0.00
7.1	**Procurement of General Drugs ---**				
7.1.1	Drug Procurement			7000.00	13.86
7.1.2	Parental Iron sucrose (IV/IM) as therapeutic measure to pregnant women with severe anaemia			190.00	0.38
7.1.3	IFA tablets for Pregnant & Lactating mothers			589.28	1.17
7.1.4	IFA small tablets and syrup for children (6 - 59 months)			967.14	1.92

7.1.5	IFA tablets for adolescent girls (14-19 years)			402.33	0.80
7.1.6	IMNCI Drug Kit	1000	50000	500.00	0.99
7.2	**Procurement of Supplies--**			0.00	0.00
7.2.1	Provision of Quality Beds	8280	1284	107.20	0.21
7.2.2	Procurement of ARI timer	200	50000	100.00	0.20
7.2.3	ANC instruments 2 pieces each at Subcentre			2103.07	4.16
7.2.4	Procurement of Minilap set (FP)	3000	2670	80.10	0.16
7.2.5	Procurement of NSV Kit (FP)	1100	190	2.09	0.00
7.2.6	Procurement of IUD Kit (FP) (PHC level)	5000	114	5.70	0.01
7.2.7	Mamta Kits	99	1400000	1386.00	2.74
7.3	**Procurement of RCH Equipments --**			0.00	0.00
7.3.1	Equipments of SCNU equipments for District Hospital and Newborn Corners in PHCs	4040610	302	888.93	1.76
7.3.2	Equipments for Labour Room			700.00	1.39
7.3.3	Dental Chair Procurement	400000	129	516.00	1.02
7.3.4	Equipments (Blood Bank/BSU)			0.00	0.00
7.3.5	Equipments for 6 new Blood Banks			83.40	0.17
7.3.6	A.C. 1.5 Ton Window for 28 Running Blood Bank			7.00	0.01
7.4	POL for vaccine delivery from State to District and to PHC/CHC			308.32	0.61
	Total RCH Procurement and Logistics			**15936.56**	
8	**De-centralised Planning**			**271.91**	0.54
9	**Operational Research (RI)**			**50.00**	0.10
	Total			**51160.81**	**100**

Routine Immunisation | Part C

Objective is to attain 100% immunization coverage for all Pregnant Women & children with, all available antigens under UIP

Routine Immunization in Bihar: achievements in 2010-11 and plans for 2011-2012

The success of the immunization program in Bihar since the onset of NRHM has been remarkable. A combination of strong political will combined with a number of strategic interventions aimed at different aspects of program operations has paid rich dividends with the full immunization coverage in the state steadily progressing from 22.4 %(DLHS-II) in 2004 to 41.4% (DLHS - 3) in 2007-08 to 66.6% (FRDS) in 2010 while CES 2009 shows 49%.

Program components introduced earlier in 2005-06 such as alternate vaccine delivery mechanisms, auto disable syringes, data flow systems, fixed and outreach sessions, contractual manpower for vaccination, ASHAs for mobilization of beneficiaries and strong partnerships in trainings and monitoring have been further consolidated by a multi pronged program to augment immunization named “Muskan ek Abhiyan” launched in 2007. Muskan has made it evident that a program integrating increasing outreach sessions, establishing close partnerships with the ICDS, identification and tracking of beneficiaries and giving incentives to workers and mobilizers has helped in increasing both access and utilization of immunization services in the State.

All the interventions which were in the financial year 2009-2010 had been consolidated in 2010-11. These are being briefly discussed below :

- **Revision of RI micro plans to increase reach and reduce vaccine wastage.**
- Micro plans for Routine Immunization were revised throughout the state.
- Outreach sessions were planned on Wednesdays and Fridays at all Aganwadi centers, sub centers and additional PHCs and on all working days in PHCs and Government hospitals.
- To reduce vaccine wastage redundant sessions held at the Health sub center every week was limited to one or two Wednesday’s a month and the remaining Wednesdays were used to cover left out areas.
- In areas of manpower shortage outreach sessions were planned on days other than regular RI days.
- In Urban areas, the ANMs (mobilised from rural areas) conducted the sessions on Mondays & Saturdays.
- The available Polio SIA micro plans were consulted/used to ensure outreach immunization sessions were planned for all groups of habitations. Sessions frequency was planned on basis of injection load.
- The micro planning exercise involved mobilizers, vaccinators and managers of the program and a software tool as well as a module was used to ensure uniformity across the state.

New initiatives for current financial year are –

- 2nd dose of Measles vaccine were started in 5 districts of Magadh division (viz. Arwal, Aurangabad, Jehanabad, Gaya & Nawada) in campaign mode from 13th Dec 2010.
- All the MOICs of 41 HR blocks had undergone training on RI at SIHFW.
- Training of all the AYUSH (1384) doctors on the monitoring aspect of RI by the technical support of WHO-NPSP in Jan-Feb 2011.
- **Capacity building among health and child care managers and providers :** Trainings were undertaken for various groups of managers and health care providers in Routine immunization as follows.

- **Training of health workers**: The training was provided at district level to both the regular & contractual health workers.

No of districts	No of regular health workers trained	No of contractual health workers trained
13	340	1036

The new training module for health workers will be available by Jan 11, so all the health workers to undergo training in RI as per new module.

- **Training of Medical Officers:** During current financial year, 482 medical officers including 41 MOICs of HR blocks had been trained. All these trainings have been done in 22 batches at SIHFW, Patna. From next financial year it has been planned to conduct at decentralised venues, mostly at divisional level.
- **Training of DIOs:** All the 38 DIOs of the State were trained in 2 batches (First week of Oct 2010) on RI with the technical support from WHO-NPSP.
- **Training of data handlers:** State is putting its best effort to operationalise HMIS. For this new booklet has been printed and training has been done at State, District & block level.
- **Training of social mobilization network in Immunization:** Mobilizers for Polio eradication efforts through Unicef were trained in basics of Routine Immunization. Following these trainings mobilizers stationed at block and panchayat levels are expected to help in generating awareness of need for immunization and availability of immunization services in the community. The mobilizers have been trained in the use of flip chart for routine immunization which they are using to address community gatherings and forums. Around 500 community mobilization coordinators (village and panchayat level), 200 block mobilization coordinators (block level) and 50 social mobilization coordinators (district level) have been trained in routine immunization.
- **Training of Pulse Polio vaccinators for RI :** All the Pulse Polio vaccinators had been sensitised for tracking of RI status of newborns. Also these Polio vaccinators has a Newborn booklet in which they have the details of session site details for RI.

➢ **AEFI Surveillance in the State :**

There has been systematic improvement in the AEFI-surveillance system in the State with formation of the State-AEFI and a district AEFI committee in all 38-Districts across the State. The reporting & investigation of major AEFI has also improved over the year as shown below.

Year	2007	2008	2009	2010
Major AEFIs Reported	3	10	18	22 (including 1 cluster of 12 children)

Due to ongoing measles campaign the AEFI identification & reporting has been improved in the 5 districts of Magadh division. In all these 5 districts all PHCs has prepared their AEFI kits to handle any anaphylaxis.

➢ **New revised Routine-Immunization /Muskan - Monitoring in the State :**

The monitoring for RI is being done for session sites to check the presence of ANMs & Alternate Vaccine Delivery Services. While to check the mobilisation efforts of the AWWs & ASHAs the House to House monitoring has been strengthened in 2010. This house to house monitoring has helped to identify the reasons for left outs & drop outs in RI, especially the aspect of demand generation by the mobilisers.

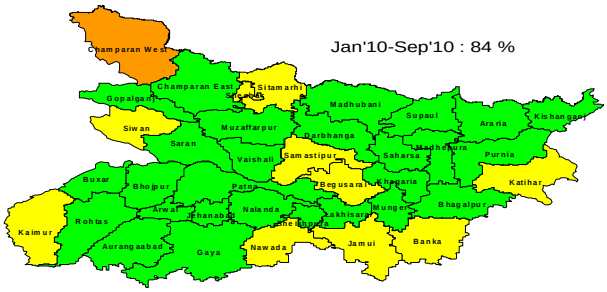
PRIORITIZATION OF DISTRICTS BASED ON BOTH REPORTED & EVALUATED COVERAGE (DATA ANALYSIS)

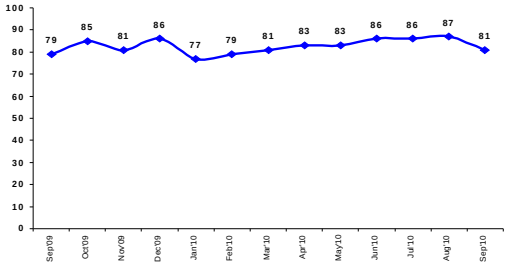
Ranking with poor performers on top	District name	Total unimmunised (Left outs & drop outs
1	Gaya	33502
2	Patna	27522
3	Madhubani	27190
4	Samastipur	25449
5	Champaran (E)	23395
6	Darbhanga	21140
7	Bhagalpur	20518
8	Rohtas	20148
9	Saran	19152
10	Muzaffarpur	19092
11	Sitamarhi	18571
12	Nawada	17301
13	Gopalganj	16596
14	Siwan	15921
15	Begusarai	15864
16	Nalanda	15236
17	Bhojpur	11786
18	Banka	10156
19	Aurangabad	9784
20	Kaimur	8806
21	Buxor	8788
22	Vaishali	8690
23	Araria	8434
24	Katihar	8012
25	Saharsa	7083
26	Madhepura	5847
27	Munger	5636
28	Arwal	5181
29	Supaul	3523
30	Kishanganj	2919
31	Khagaria	2576
32	Champaran (W)	2448
33	Sheohar	2126
34	Lakhisarai	1899
35	Sheikhpura	1715
36	Jahanabad	1312
37	Jamui	0
38	Purnia	0

Coverage data till Apr-Sep 2010
Fully Immunised as per DLHS III - 2008

Sl. No.	District (Poorest ones on top)	Fully immunised (%)
1	Jamui	19.1
2	Kishanganj	23.6
3	Kaimur	24.9
4	Champaran West	27.1
5	Sheohar	27.4
6	Araria	33.3
7	Bhojpur	33.3
8	Buxar	33.3
9	Katihar	34.8
10	Gaya	35.7
11	Lakhisarai	36.6
12	Sitamarhi	36.8
13	Champaran East	37.3
14	Banka	37.6
15	Patna	39.1
16	Purnia	39.4
17	Begusarai	41
18	Rohtas	41.5
19	Supaul	41.5
20	Saharsa	43
21	Madhubani	43.1
22	Munger	43.2
23	Sheikhpura	44.4
24	Jehanabad	44.7
25	Madhepura	45.2
26	Darbhanga	45.8
27	Nawada	46.5
28	Samastipur	47.8
29	Bhagalpur	49.7
30	Siwan	51.8
31	Khagaria	52.3
32	Muzaffarpur	54.9
33	Nalanda	55.2
34	Gopalganj	57.4
35	Vaishali	59.3
36	Aurangabad	60.7
37	Saran	67

%Sessions Where all RI Vaccines & A D Syringes were available



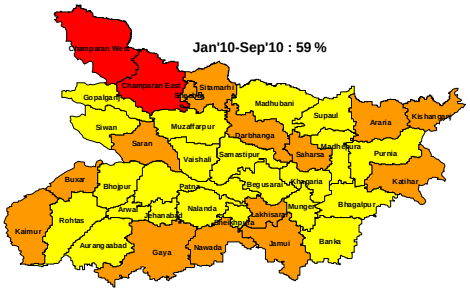


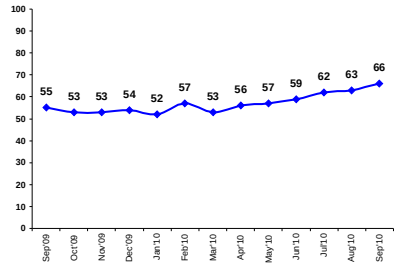
Sep'10 : 81 %

- Nil
- 1 - 30 %
- 31 - 59 %
- 60 - 79 %
- >= 80 %
- Data Not Available

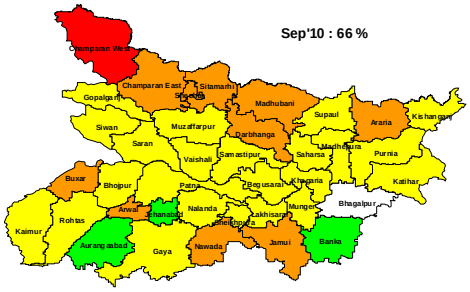
Held [N] (Jan'10-Sep'10) : 18546 Sites
(Sep'10) : 1551 Sites

%Full Immunization Status out of Children Monitored [12-23 Months]



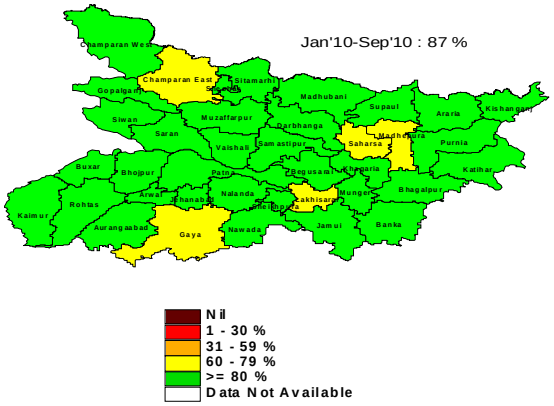


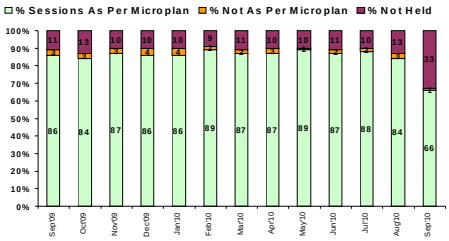
- 0 - 20 %
- 21 - 40 %
- 41 - 60 %
- 61 - 80 %
- 81 - 100 %
- Data Not Available



Children Monitored [N]
(Jan'10-Sep'10) : 49184
(Sep'10) : 5546

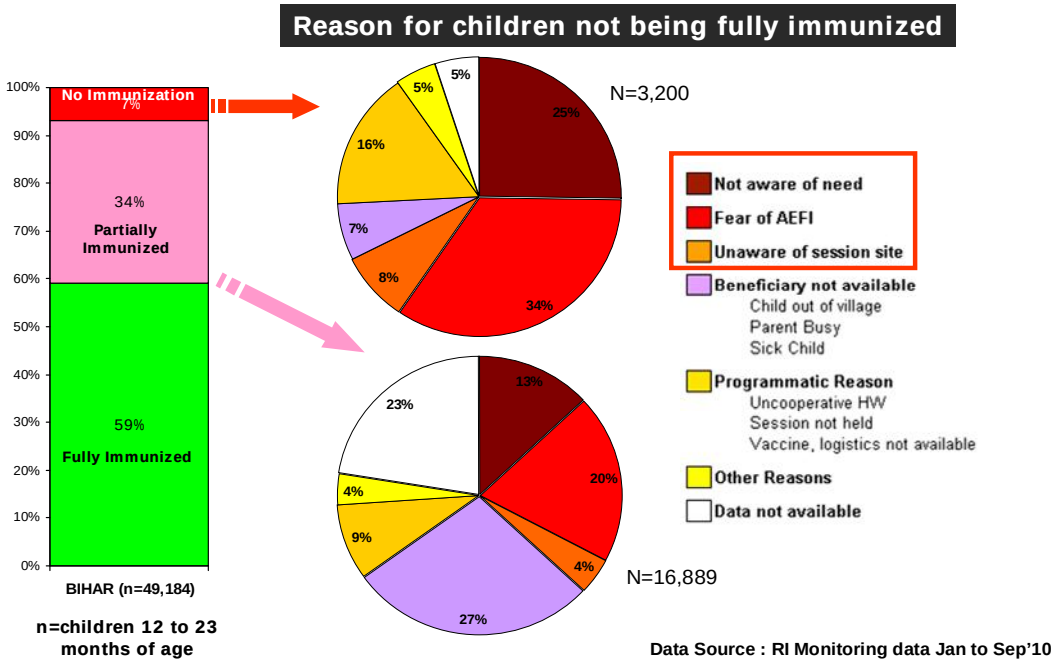
% of Sessions Held out of Session Sites Monitored





Visited [N] (Jan'10-Sep'10) : 21341 Sites

Immunization status of monitored children – January to September 2010 - BIHAR



Data Source : RI Monitoring data Jan to Sep'10

- **VPD & Measles surveillance in the State :** Bihar dose not have a regular VPD/Measles surveillance system in place for the State yet. But Major Measles out-breaks are reported & investigated by the Districts on a case to case basis with technical support form Partners like NPSP/WHO & UNICEF .The State RI-Cell also maintains a line-list of Measles out-break investigation ,based on reports received from the Districts. In 2010, two measles outbreak has been investigated at Gaya & one at Nawada. In Gaya, all the 5 blood samples sent to IOS Kolkata were found positive for Measles.

- **Muskaan ek Abhiyaan :** Muskaan ek Abhiyaan is a special multipronged strategy to improve immunization services and demand in the state of Bihar and since its launch in Oct 2007, the strategy as well as the implementation of this campaign has been reviewed on a periodic basis. A strategic review of this campaign was undertaken on July 4th 2009 by the stakeholders of Routine immunization in the state in which certain changes were proposed. The new changes have become operational since September 2009 but still some gaps are persisting in especially in incentive distribution to AWWs & ASHAs.

Muskaan Oct 07 to Aug 09	Muskaan Sept 09 onwards
Immunization sessions to be based in health facilities and Aganwadi centres	Immunization sessions extended to villages and hamlets without any health facility or aganwadi centers
All beneficiaries to be registered and tracked in Muskaan tracking registers	Registration of all beneficiaries and their tracking to continue
Due-lists to be prepared by all mobilizers (ASHA and ICDS workers)	Due list preparations to continue.
Incentives to vaccinators and mobilizers based on percentage of doses administered per ICDS center against target doses in due lists.	Incentives to vaccinators and mobilizers based on number of beneficiaries vaccinated in each session.
Mahila Mandal payments through ANM	Mahila mandal meetings through Village Health and sanitation committees
Verification of achievement by ANM, Medical Officers and ICDS officers	No verification only process of certification by ANM and beneficiaries.

It is expected that the gains made by Muskaan phase 1 such as improved access of vaccination services, improved mobilization of beneficiaries through the use of line list registers and due lists will be consolidated in the second phase; whereas problems such as timely payment of incentive and difficulty in calculating and verifying achievements will be smoothened out.

- **Quarterly review meetings at State, district and Block levels:** Three DIOs review meetings had been done at State level in April, June & Oct 2010. In these meetings, the Partner agencies NPSP-WHO & UNICEF also play important role by providing their monitoring data.
- **Focus on urban slums and underserved areas:** Till Oct 2010, against 32038 Urban sessions planned in Bihar a total of 26575 sessions held, % of session being held is 83%.

Status of Urban RI in major cities of Bihar are as follows-

Name of District	Total Urban sessions planned	Total Urban sessions held	% Sessions held
Patna	6150	5035	82%
Muzaffarpur	1915	1106	58%
Gaya	1734	1203	69%
Motihari	1255	1029	82%
Bhagalpur	788	521	66%
Begusarai	646	646	100%

Most of the sessions in Urban Patna is being done by the ANMs of the Rural blocks like Danapur, Phulwarisharif & Sadar. While in Gaya, there is a fixed set of ANMs at Sadar Hospital who perform the RI works of Urban.

- **Immunization waste disposal:** The ongoing measles campaign has strengthened the immunisation waste disposal especially in the 5 districts of Magadh division of Bihar. In all 5 districts the practice of use of hub cutters, red bags, black bags, disinfection of waste with sodium hypochlorite & disposal of sharps in the safety pit has been operationalised. Further, the State has procured about 16000 hub cutters to supply one each to all ANMs. These hub cutters has already been distributed to the districts. On site verification is showing that many of the safety pits are now not usable any more (in 65 blocks of Magadh division 20 blocks don't having usable safety pits). Also district hospitals are missing safety pits in whole Bihar, which is needed to be addressed on priority basis.

- **VPD outbreak and response:** Major Measles outbreak is being investigated as a case to case basis by the district & State team with technical support from NPSP (WHO) and UNICEF. In Dec 2010 during Measles SIA catch up campaign, 3 measles outbreak had been investigated in Gaya & Nawada. All samples sent from Gaya Sadar were found positive for Measles.

- **JE vaccination campaign in Gaya district:** JE vaccination has been incorporated in RI schedule in Gaya, Muzaffarpur & Champaran West. While in next financial year, JE SIA will be done at Nawada, Siwan & Gopalganj.

Partnerships in Routine Immunization in Bihar:

A strong partners support in terms of R.I. monitoring led by NPSP(WHO) & UNICEF including partner's cooperation at state , division, district & block level for support in Microplanning, Health workers training, cold chain handlers training, Data handlers training & MO's training etc. exists in the state.

Plans for next financial year 2010-2011:

- Strengthening & Improving R.I. monitoring at all levels with timely feedback and followup actions through an effective monitoring through out the state at all levels.
- In this strengthening exercise, all the AYUSH doctors to be involved in monitoring & supervision at PHC level.
- **2nd Opportunity for Measles Vaccine** : In 2010, 5 districts undergone for Measles SIA campaign, in next financial year all the districts south of Ganges will be covered (Sep-Dec 2011).
- **Launch of Hepatitis B vaccine in RI schedule** : The Hepatitis-B vaccine to be incorporated in the RI schedule of Bihar. For this DIOs workshop to be done in Jan 11.
- **Process Indicator** : Process Indicator has been in use since April 2010. The efforts will be put to collect quality data in this format from each district on timely manner. The data available in Process indicator are very useful for the Review Meeting of CS & DIOs at the state level.
- **Supportive Supervision** : Due to strike of Health Staffs at PHC level & district level from Aug to Oct 2010 the process of Supportive supervision could not be completed. Further elections & Measles campaign affected this exercise. The same exercise is also being planned in 2011-12 for the 10 top priority / high risk districts based on data analysis of Reported, Evaluated & Monitoring Findings.

Supportive supervision proposed as a pilot project through State Government & partners in 2011-12

Objective:
To strengthen routine immunization and nutrition services in 10 districts of the state by instituting a sustainable supportive supervision system which will help boost RI in the state.

Project area-
10 districts have been chosen in consultation with health department, based on various factors including unimmunized children from reported, evaluated (dlhs 3) & monitoring findings. These 10 districts are as follows:

S. No.	10 TOP PRIORITY DISTRICTS, BIHAR
1	PATNA
2	GAYA
3	CHAMPARAN EAST
4	SITAMARHI
5	CHAMPARAN WEST
6	BEGUSARAI
7	DARBHANGA
8	SAMASTIPUR
9	SAHARSA
10	KHAGARIA

Project Activities: The project will have four areas-

- Improving immunization service delivery
- Increase community mobilization
- Reducing malnutrition and improving counselling services
- Strengthening monitoring and evaluation system

Key Deliverables:

1. **Strengthened Supervisory Skills** of the entire supervisory cadre staff in the selected districts
2. **Capacity of frontline health staff** built on providing quality immunization services and nutrition counselling.
3. **Demonstrable Skills Enhancement of primary health care and front line health care staff** to deliver quality immunization services and effective counselling for maternal and child nutrition.
4. **Demand** for Immunization and nutrition services increased
5. **Increased attendance of pregnant women** and children for immunization at the Immunization Session days organized at the anganwadi centers.
6. **Institutionalization of regular MIS and reporting** for immunization and nutrition services with a two-way feedback and problem solving approach

Outcome Measures:

We propose to measure the success of above deliverables for the project through the following set of proxy indicators. These indicators would be a combination of process and outcome indicators.

1. **Strengthened Supervisory Skills** of the entire supervisory cadre staff in the selected division and districts

Indicators:

- All Civil Surgeons, DIOs, ACMOs, MOs sensitized and trained in supportive supervision
- 75% PHC supervisors trained in supportive supervision in the 10 pilot districts.

2. Supportive supervision system established by involving district and division level health functionaries**:**

Indicators:

- At least 4 Supportive supervision visits by DIO in a month.
- At least **4** Supportive supervision visits by PHC supervisors in a month

Supervision is important component of any programme. To have biannual supportive supervision in 10 districts, a provision of 10,00,000/- (@ 50,000/- per round of Supportive supervision with 2 such rounds in 10 identified high risk districts per year) has been budgeted in PIP under NRHM**.**

In this supervision exercise all developmental partners along with government officials will visit CHC, Cold storage points, session site and gives on the job hands on training**.**

- **Generating demand and improving social mobilization through effective IEC & IPC for RI:** IEC at the state, district & block level, supplemented by IPC with the help of link workers i.e. ASHAs & AWWs is very essential along with quality immunization service delivery to the community.

- **Improving coverage in urban slums and underserved areas:** Special Urban Slum Immunization drive has been initiated and Urban R.I. including mobilization through paid mobilizer is being planned all across the state on different days in different districts.

- **Quarterly campaigns to reach most inaccessible areas:** Special post flood catch-up campaign for flood affected districts are being suggested especially the Koshi revirine area where villages are flooded one third months of a year.

- **Improving immunization waste management:** Waste disposable pits for disinfected sharps have been built in many PHCs and hub-cutters along with ADS is being practiced all across the state now, in every Immunization session site. Immunization safety is being taught in all Health Workers training and MO's training. Use of Red & Black plastic bags along with disinfecting twin buckets are being encouraged in the State.

- **Improving data flow and data for action:** Session based tally sheet reporting is in practice by ANMs/ Health Workers across the state and weekly coverage data compilation report are being sent from district to state in every week based on which state sends a UIP coverage report to National level every month. HMIS training has been done in all the districts which will certainly improve the data flow at all levels.

- **Trainings of Medical officers and mobilizers in RI:** In this financial year, all the remaining MOs has been planned to be trained. For this decentralised venues at divisional level to be selected to complete these trainings.

- **Focus on 41 HR blocks :** Blocks with persistent transmission of WPV have been selected to be made as excellent examples of better RI coverage with least left outs & drop outs.

- **Better Management of Stock Positions of vaccine & Syringes :** All the PHCs to have a white board for better management of Stock position of all the vaccines & syringes in their PHCs.

- **The tally sheet for RI missing Hepatitis B vaccine schedule:** Printing of new tally sheets to incorporate the Hepatitis B vaccine in the schedule will be necessary for next financial year.

- **Training of all the health workers:** New training module will be available by Jan 11. So, all the health workers to be trained on RI based on new module.

A. Basic information of the State/UT related to Immunization Programme

Position	Name & Designation	Contact No./Email
State Immunization Officer	Dr Gopal Krishna	9771493836/7277939697 ribihar@gmail.com
State Cold Chain Officer	Dr MP Sharma	
State Level Data Assistant	Shashi Shekhar/ Shiwangi Biswas/ Chandra Kant Sinha	
District Immunization Officers (DIO)	No. of Districts…38	No. of DIOs in position… 38

What are the systems of ensuring stability of tenure for these key officers?

_____

_____

_____

S.No	Beneficiaries	Target		
		2009-10	2010-11	2011-12
1.	Pregnant women	3256578	3270958	3284786
	0 to 1 yr infants	2960524	2973599	2986169
	1-2 yr	2782891	2801129	2818944
	2-5 yr	8348673	8403387	8456832
	5 yr	2782891	2801129	2818944
2.	10 yr	2782891	2801129	2818944
3.	16 yr	2782891	2801129	2818944

The following information is to be filled based on the RI micro-plans. Please provide the details of held sessions for 2009-10 & 10-11, while for 2011-12 the number of planned sessions is to be provided:

S.No	Routine Immunization Sessions	2009-10	2010-11	2011-12
1.	Total Sessions planned		**758553 (Apr – Oct 10)**	14,06,112

2.	Total Sessions Held		**667670**	
3.	No. of Outreach Sessions			1405388
4.	No. of Fixed site sessions			724
5.	No. of Sessions in Urban Areas		26575	42,780
6.	No. of Sessions in Rural Areas		641095	13,63,332
7.	No. of sessions in hard to reach areas			4271
8.	No. of session with hired vaccinators*			2000 (Approx)
9.	No. of hired vaccinators*			1500 (Approx)
10.	No. of villages where sessions are held monthly			51184
11.	No. of villages (smaller) where sessions are held on alternate months			
12.	No. of villages where sessions are held quarterly			

States to provide separate targets, quarter-wise, for 2012 for high focus districts (consolidated) and State total

B. Existing Support to the States

Sl No	Item	Stock (functional) as on 31st Dec'10	Requirement			Remarks
			2009-10	2010-11	2011-12	
1	**Cold Chain Equipments** -					
a)	WIC	10		10	10	
b)	WIF	3		2	2	
c)	ILR	Large : 150, Small : 574		L:247, S:261	L:259, S:253	
d)	DF	Large : 143, Small : 364		L:339, S:340	L:334, S:295	
e)	Cold Boxes	Large : 4073, Small : 2820		L:1095,S:1464	L:1035,S:1151	
f)	Vaccine Carrier	59043		17109	20773	
g)	Ice Pack	6,55,913		2,72,672	2,61,684	
h)	Vaccine Van	38 Old vans in very poor condition		Refrigerated-11 Insulated : 38	Refrigerated-11 Insulated : 38	
2	**Vaccine stock and requirement (including 25% wastage and 25% buffer)**					
a)	TT	1804746		2178891	2225955	
b)	BCG	2860780		2860780	2860780	
c)	OPV	1209416		1214885	1241128	
d)	DPT*	2418833		2429771	2482254	
e)	Measles	967533		971909	992901	
f)	Hep B				1985803	
g)	JE (Routine)	112707		113455	115906	
3	**Syringes including wastage of 10% and 25 % buffer**					
a)	0.1 ml		4001075	4019170	4105984	
b)	0.5 ml		32808825	32957201	33669075	
c)	Reconstitution Syringes		7147934	7166029	7252841	
4	**Hub Cutters**			19000	24000	

**Note: DPT is to be given instead of DT at 5 yrs once the current stock of DT Vaccine is exhausted*

C. Additional Support required by the State

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
Mobility support for supervision	@Rs.50,000 per District for district level officers (this includes POL and maintenance) per year	**3116000**	No of sessions Supervised	**250000**	No of sessions Supervised	**1900000**	No of sessions Supervised	Out of 38 DIOs only Two are having Official Vehicle to move around in their respective district. For effective supervision they are expected to do field visit atleast for a 12 days in a month (8 days for R.I. monitoring & 4 days for other administrative purpose). Therefore hiring cost is being included in mobility support for them @ Rs. 1500 per day – for 12 days a month. (Rs 1500 X 38 DIOs X 12 days X 12 months). *Budgeted in Part A under Institutional Strengthening*
Supervisory visits by state and district level officers for monitoring and supervision of RI			**9024**		**1500**		**3648**	
	By state level officers @ Rs.100,000 /year		No of districts visited for RI review	**26000**	No of districts visited for RI review	**100000**	No of districts visited for RI review	**Target : SIO/SPO/CCO & others to visit 3 district per month to review and supervise RI in field**
					20		**38**	
Cold Chain maintenance	@ Rs 500 per PHC/CHC per year District Rs 10,000 per year		% Funds used		% Funds used	**5000000**	% Funds used	Based on earlier AMC rate @ Rs 1650/- per machine per year for approx. 2200 machines (DFs & ILRs). Additionally maintenance of 10 WICs & 3 WIFs would cost Rs 15000/- per year & (38 + 9)=47 vaccine vans @25000/- per van per year
Focus on slum & underserved areas in urban areas:	Hiring an ANM @Rs.300/session for four sessions/month/slum of 10000 population and Rs.200/- per month as contingency per slum of i.e. total expense of Rs. 1400/- per month per slum of 10000 population.	**65371600**	No of sessions with hired vaccinators	**2340000**	No of sessions with hired vaccinators	**16956000**	No of sessions with hired vaccinators	**<u>Hired Vaccinators for Urban Slums in Urban R.I. :</u> A total of 500 Urban slums will have at least one session a month which will be carried out by hired alternate vaccinators as per the given Norms =500X1400X12**
			17950		**1500 session sites with hired vaccinators 3565 Paid mobilisers**		**500 Alternate vaccinators**	

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
							to be hired & 3565 total urban RI sites for mobilisation	**Paid Mobilizer for Urban Slums in Urban R.I. Additional Honorarium for Urban Mobilizers to mobilize benefeciaries to R.I.Sessions in Urban Slums @Rs.200/- for 3565 urban AWC/slums/Other Urban RI Sites per month for 12 months. =3565X200X12**
Mobilization of children through ASHA/ mobilizers	@ Rs 200/session (for all states/UT.s)	**59199000**	No. of sessions with ASHA 960000	**9834000**	No. of sessions with ASHA 960000	**21120000**	No. of sessions with ASHA 1045092	**Mobilization per session/ per month for one year.) Total no. of ASHAs for (under served + H to R) i.e. (4500+4300) aaprox 8800 X 200 X 12**
Alternative Vaccine Delivery:	Geographically hard to reach areas (eg. Session site>30 kms from vaccine delivery point, river crossing etc.) @ Rs 100 per RI session **Note- GOI in the Sub group meeting has said that NORMS to be revised**		No of sessions with AVD		No of sessions with AVD		No of sessions with AVD	
	NE States and Hilly terrains @100 per RI session **Note- GOI in the Sub group meeting has said that NORMS to be revised**	**5400000**	**4500**	**2210000**	**4271**	**5125200**	**4271**	**Access compromise areas/villages in Bihar including riverine & hilly areas are identified as 4271 as per dist. PIP,where upto one session per month is to be organised. (4271x100x12)**
	For RI session in other areas @ Rs.50 per session. **Note- GOI in the Sub group meeting has said that NORMS to be revised**	**84996900**	**17000**	**10220000**	**14000 session sites/ RI day**	**74039000**	**14000 RI session sites per RI day**	**AVD for Rural R.I. (based on Revised RI Microplan) Rs 50 X 14000 Session Sites per day X 104 days AVD for Special Urban Slums RI Drive Rs 50 X 3565 Slums X 12 (EVEN IN PULSE POLIO, THE MINIMUM PER DIEM IS RS 50.)**
Support for Computer Assistant for RI reporting (with annual increment of	State @Rs 16335 p.m.			**49000**	1	784080	4	**Rs.16335/- X 4 persons X 12mths (incl. 10% hike for 11-12)**

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
10% w.e.f. from 2010-11)								**In 2010-11, the state level 3 computer assistants were funded by UNICEF but from 2011-12 UNICEF is withdrawing the support.**
	Districts @ Rs 8800 p.m	3648000	No of C.A. in position **38**	630000	No of C.A. in position **38**	4012800	No of C.A. in position **38**	**Rs 8800/- X 38 dist. X 12 months**
Printing and dissemination of immunization cards, tally sheets, monitoring forms, etc.	@ Rs 5 per beneficiary	**17347710**	**3154129**	**2256000**	**2701643**	**18304010**	**3660802**	**Rs 5/- per beneficiaries Total target beneficiaries 3660802(including 10% buffer stock)**
Review Meetings	Support for Quarterly State level Review Meetings of district officers @ Rs 1250/participant/day for 3 persons (CMO/DIO/Dist Cold Chain Officer)		No of meetings held 0	**79000**	No of meetings held 4	**570000**	No of meetings held 4	**Rs 1250/- X 3 persons X 38 district X 4 meeting**
	Quarterly Review & feedback meeting for exclusive for RI at district level with one Block MO.s, ICDS CDPO and other stakeholders@ Rs 100/- per participant for meeting expenses (lunch, organizational expenses)	**1030000**	**4**	**147000**	3	**1068000**	4	**Rs 100/ X 5 participant X 534 X 4**
	Quarterly review meeting exclusive for RI at Block level @Rs 50/-pp as honorarium for ASHAs (travel) and Rs 25 per person at the disposal of MO-I/C for meeting expenses(refreshments, stationery and misc. expenses)	**21474600**	**4**	**3312000**	3	**26127300**	4	**Rs 50 + Rs 25 = 75 X 4 X 87091**
Trainings			No of persons trained	**1380000**	No of persons trained	**37662031**	No of persons trained	**24450 HW to be trained in 1223 batches in RI as per RCH norms. As new training module has been devised so there is need to train all the health workers. (Details of district wise budget attached herewith**
District level orientation training for 2 days **ANM, Multi Purpose Health Worker (Male), LHV, Health Assistant (Male / Female), Nurse Mid Wives, BEEs & other specialist (as per RCH norms)**	As per revised norms for trainings under RCH				1376		24450 Health workers & 114 trainers	
Three day training of **Medical Officers on RI** using revised MO training module	As per revised norms for trainings under RCH	**11271800**	No of persons trained	**865000**	No of persons trained 460	**16219600**	No of persons trained 3100	Earlier the trainings were done at the State level only. In coming financial year (2011-2012) the training has

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
								been planned at district/divisional level. Target : DA for 3100 MOs(Regular, Contractual & AYUSH) = 700 X 3100 X 3 Honararium to 4 Guest faculty: 4 X Rs 1000/- X 3 days X 155 Batches Meals : 3100 Mos X Rs 200/- X 3 days Incidental Expenditure: 3100 MOs X Rs 250/- X 3 days Venue Hiring: Rs 10000/- X 155 Batches Institutional Overhead: 15% of total
One day refresher training of **District RI Computer Assistants** on RIMS/HMIS and Immunization formats under NRHM	As per revised norms for trainings under RCH			**12000**	30	110400	40	40 Computer Assistants to be trained in two batches DA for 40 CA for 2 days = Rs 400/- X 40 X 2 Honararium: 4 Faculty X Rs 1000/- X 2 days Meals : 40 CA X Rs 200/- X 2 days Incidental Expenditure: 40 CAS X Rs 250/- X 2 daysVenue Hiring: Rs 10000/- X 2 Batches Institutional Overhead: 15% of total
One day **Cold Chain handlers training** for block level cold chain handlers by State and District Cold Chain Officers and DIO for a batch of 15-20 trainees and three trainers	As per revised norms for trainings under RCH		No of persons trained 423	**97000**	No of persons trained 110	625898	No of persons trained 533	**533 Cold Chain to be trained in 33 batches (20 for each batch) DA for 533 CH for 1 day= Rs 400/- X 533 Honorarium: 3 Faculty X Rs 600 /- X 1 day X 33 Meals : 533 CH X Rs 200/- X 1 day Incidental Expenditure: 533 CH X Rs 250/- X 1 day Venue Hiring: Rs 10000/- X 33 Batches Institutional Overhead: 15% of total**

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
One day Training of **block level data handlers** by DIO and District Cold chain Officer to train about the reporting formats of Immunization and NRHM	As per revised norms for trainings under RCH		No of persons trained	**97000**	No of persons trained 110	625898	No of persons trained 533	533 Data to be trained in 33 batches DA for 533 DH for 1 day = Rs 400/-X533 Honorarium: 3 Faculty X Rs 600 /- X 1 day X 33 Meals : 533 DH X Rs 200/- X 1 day Incidental Expenditure: 665 DH X Rs 250/- X 1 day Venue Hiring: Rs 10000/- X 33 Batches Institutional Overhead: 15% of total
Microplanning							100% of SC/PHC/CHC /Districts have updated microplans every year (17000 ANMs)	Total of 17000 ANMs (both contractual & Regular to be involved in the microplan review process)
To develop sub-center and PHC microplans using bottom up planning with participation of ANM, ASHA, AWW	@ Rs 100/- per subcentre (meeting at block level, logistic)			**235000**	No.of Districts have updated microplans this year 17000 ANMs	**1700000**	No. of Districts have updated microplans this year	
	For consolidation of microplan at PHC/CHC level @ Rs 1000/- block & at district level @ Rs 2000/- per district			**84000**		**610000**		**534 blocks and 38 districts to consolidate MICROPLANS**
POL for vaccine delivery from State to District and from district to PHC/CHCs	Rs100,000/ district/year		% Funds used	**525000**	% Funds used	**3800000**	% Funds used	Funds required for POL (Vaccine lifting/disbursement) for vaccine delivery at all level is as follows :- For each WIC & WIF Rs 20,000/- each per month for 9 WICs/WIFs For District Rs. 15000/- each per month For PHC(534) Rs 4000/- each per month. Districtr/Block has to send

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
								their vehicles many a times to State/District due to irregular supply of vaccine and AD syringes. **(Under this head no fund is available at district from any other source)**
Consumables for computer including provision for internet access for RIMS	@ 400/ - month/ district			**25000**	**38 dist**	**182400**	**38**	**Rs 400/- per month x 38 dist x 12 months**
Injection Safety			% funds used		% Funds used		% Funds used	**Plastic Bags @Rs 3 for 2bags (1 red & 1 black) for 14000 session per day for 104 days. Bleach/ Hypochlorite solution @Rs 500 for 665 PHCs + D.H.+Sub.DH.+RH. Twin bucket @Rs 400 per 665 PHCs + D.H.+Sub.DH.+RH**
Red/Black Plastic bags etc	@ Rs 2/bags/session			**176000**		**4966500**	**14000**	
Bleach/Hypochlorite solution	@ Rs 500 per PHC/CHC per year						**665**	
Twin bucket	@ Rs 400 per PHC/CHC per year						**665**	
Safety Pits						**6650000**	**665**	GoI Specification :- Shape should be rectangular or Circular Depth :- 2-5 mtrs. Breadth : 1-2 mtrs The lining of the Pit should be made of brick. Masonry or concrete ring can be also used. The Pit should be covered with heavy concrete slab which is penetrated by a galvanised Steel pipe projecting one meter above the slab within internal diameter of 5 centimetres. The Top opening of the steel pipe should have a provision of locking. (The Estimated cost of PIT construction is 10,000/- rupees.) The fund for safety pits were supplied 3 years back. Now there is requirement of new safety pits in all **PHCs +**

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
								D.H.+Sub.DH.+RH (665) @ Rs 10000/Safety pit
Alternative Vaccinator Hiring for Urban R.I., Nomads, Brick kilns & other HRAs	@Rs 1400/- per month					25200000	Alternate vaccinator for ACAs 1500	**In addition, another 1500 Alternate hired vaccinators from private sectors are being hired @ Rs 1400/- per month for 12 months for those access compromised Areas and vacant positions across the state other than Urban areas mentioned above (As per the existing GoI NORMs)**
Catch up campaigns for Flood prone areas						9999000		**In 2008 5 flood affected districts had supplementary emergency immunisation Campaign followed by Catch up campaign . In the coming financial year the campaign could be extended to cover a bigger area, hence State needs to have a contingency Plan for post flood R.I. Catch-up rounds for atleast 10 districts. @ Rs. 33,33,000/- X 3 catch up rounds per year.**
AEFI Investigation by Dist. AEFI Committee.				79000	10	570000		**Minimum 5 Major AEFI cases are expected for every district for investigation in a year @Rs 1000/- for transportation for district AEFI committee to investigate case in the field. @Rs.5000/ - for shipment of Specimen to lab. If required (Min. 2 samples) including travel cost, lodging & fooding etc..**
POL of Generators for Cold Chain						5000000		**POL for Generator running in PHCs without RKS needed along with POL for WICs (131 Total no. of Sadar Hospital - 38,SDH-23 & RH-70**

Service Delivery: -	Norms*	Expenditure & Achievement						Remarks
		2009-10		2010-11(till Dec)		2011-12		
		Expenditure	Achievement	Expenditure	Achievement	Funds requirement	Target	
								which do not have RKS)
State Vaccine Logistic Manager	State Position 1 Remuneration Rs.30,000/- per month District Position – 38 Remuneration Rs.25,000/- per month					**0**		**Vaccine & Logistic Manager are required to be placed at State and Districts level for effective Stock Management of Vaccine & other Logistic related with R.I. This position has already been approved in Orissa PIP year 2010-11. IPHS also recommend to have this position for smooth Management of Vaccines & other logistics movement within the State.**
Additionality for State								
Assessment of New Initiative taken for enhancing R.I. Coverage						**0**		**New Initiative (Muskan Ek Abhiyaan) has helped enhance R.I. Coverage to a great extent i.e. % of Fully Immunized children has increased from 11.6 to 66.7. Assessment is required to improve it further.**
Grand Total						**289128117**		

District –wise Coverage reports *(in numbers)*

S. No	Name of District	Yearly Target (2010-11)		BCG Coverage (in Numbers)		OPV - 1st Dose Coverage (in Numbers)		OPV - 3rd Dose Coverage (in Numbers)		DPT - 1st Dose Coverage (in Numbers)		DPT - 3rd Dose Coverage (in Numbers)	
		Infants	Pregnant Women	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*
	Araria	85430	77664	34962	74898	35704	74898	33277	74898	35092	74898	34120	74898
	Arwal	28168	25607	10787	24695	8832	24695	8221	24695	8728	24695	8253	24695
	Aurangabad	79670	72427	31683	69848	27392	69848	27735	69848	27436	69848	27651	69848
	Banka	63669	57881	17627	55821	14902	55821	15378	55821	15827	55821	17161	55821
	Begusarai	92980	84527	24709	81517	20298	81517	19544	81517	23000	81517	22589	81517
	Bhagalpur	95900	87182	31753	84077	27764	84077	26491	84077	28690	84077	27096	84077
	Bhojpur	88776	80705	36241	77831	33634	77831	29740	77831	31824	77831	29891	77831
	Buxor	55502	50456	23696	48659	19364	48659	17286	48659	20454	48659	18268	48659
	Champaran (E)	155922	141747	64488	136700	59475	136700	47074	136700	61674	136700	48824	136700
	Champaran (W)	120450	109500	66752	105601	54052	105601	49189	105601	62526	105601	48881	105601
	Darbhanga	130436	118578	42713	114355	39390	114355	37933	114355	39617	114355	36989	114355
	Gaya	137466	124969	28778	120519	24286	120519	25613	120519	28117	120519	32615	120519
	Gopalganj	85194	77449	20580	74691	21864	74691	23226	74691	23827	74691	25554	74691
	Jahanabad	31764	28876	15719	27848	12989	27848	12365	27848	13068	27848	12517	27848
	Jamui	55360	50327	33625	48535	20469	48535	22589	48535	25410	48535	24153	48535
	Kaimur	51017	46379	17613	44728	13622	44728	12787	44728	15421	44728	13913	44728
	Katihar	94692	86084	37331	83018	34109	83018	32391	83018	33241	83018	32545	83018
	Khagaria	50672	46065	30984	44425	25801	44425	21772	44425	28049	44425	24170	44425
	Kishanganj	51305	46641	22575	44980	20668	44980	17843	44980	20667	44980	17875	44980
	Lakhisarai	31749	28863	11955	27835	12736	27835	14769	27835	14864	27835	17169	27835
	Madhepura	60420	54927	27125	52971	22102	52971	22393	52971	22102	52971	22387	52971
	Madhubani	141497	128634	45189	124053	43358	124053	46243	124053	43462	124053	46697	124053
	Munger	45030	40936	25455	39479	24919	39479	17220	39479	20573	39479	17399	39479
	Muzaffarpur	148282	134802	64411	130001	64995	130001	61212	130001	67182	130001	63145	130001
	Nalanda	93817	85288	36479	82251	31399	82251	27906	82251	34309	82251	30084	82251
	Nawada	71621	65110	14354	62792	17023	62792	11599	62792	15021	62792	14763	62792
	Patna	186745	169768	62795	163723	52389	163723	51759	163723	52389	163723	51759	163723
	Purnia	100680	91527	70614	88268	61071	88268	55834	88268	62239	88268	56922	88268
	Rohtas	96991	88174	22176	85035	19932	85035	21938	85035	19725	85035	22386	85035
	Saharsa	59688	54262	25607	52330	20973	52330	22259	52330	21624	52330	23072	52330
	Samastipur	134354	122140	42141	117790	44421	117790	43253	117790	47719	117790	47025	117790
	Saran	128572	116884	30682	112721	32741	112721	34419	112721	32384	112721	34687	112721
	Sheikhpura	20798	18907	8840	18233	7088	18233	6930	18233	7093	18233	7812	18233
	Sheohar	20420	18564	6785	17903	5585	17903	5162	17903	7082	17903	6643	17903
	Sitamarhi	106173	96521	40318	93083	33713	93083	28832	93083	37000	93083	31399	93083
	Siwan	107424	97658	30955	94181	28208	94181	30144	94181	32874	94181	30144	94181
	Supaul	68570	62336	32438	60116	26417	60116	25428	60116	28914	60116	27930	60116
	Vaishali	107586	97805	55880	94323	51418	94323	47035	94323	53543	94323	48730	94323
				1246815	2879834	**1115103**	2879834	**1054789**	2879834	**1162767**	2879834	**1103218**	2879834

S. No	Name of District	Measles Coverage		TT2+Booster Coverage		Hep B - Birth Dose Coverage (Wherever applicable)		Hep B - 1st Dose Coverage (Wherever applicable)		Hep B - 3rd Dose Coverage (Wherever applicable)		JE-routine (Wherever applicable)	
		2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*	2010-11	2011-12*
	Araria	32203	74898	28653	87275							0	
	Arwal	9549	24695	10722	28776							0	
	Aurangabad	29918	69848	27981	81390							0	
	Banka	17638	55821	21512	65045							0	
	Begusarai	23791	81517	24997	94988							0	
	Bhagalpur	30278	84077	26556	97972							0	
	Bhojpur	31214	77831	31098	90693							0	
	Buxor	18775	48659	17447	56701							0	
	Champaran (E)	45292	136700	31448	159290							0	
	Champaran (W)	64858	105601	45902	123052							20603	
	Darbhanga	37922	114355	34559	133253							0	
	Gaya	28199	120519	27184	140435							408	
	Gopalganj	24743	74691	23221	87034							0	
	Jahanabad	13876	48535	15877	56555							0	
	Jamui	30055	27848	25960	32450							0	
	Kaimur	15231	44728	16457	52119							0	
	Katihar	29279	83018	30043	96737							0	
	Khagaria	24845	44425	23232	51766							0	
	Kishanganj	15337	44980	18265	52413							0	
	Lakhisarai	15472	27835	22021	32435							0	
	Madhepura	23033	52971	24590	61724							0	
	Madhubani	44497	124053	38095	144553							0	
	Munger	19968	39479	19485	46003							0	
	Muzaffarpur	59304	130001	51946	151484							15933	
	Nalanda	32718	82251	33111	95843							0	
	Nawada	12426	62792	19085	73169							0	
	Patna	52032	163723	47947	190779							0	
	Purnia	58810	88268	58915	102854							0	
	Rohtas	26731	85035	26890	99087							0	
	Saharsa	25567	52330	25251	60977							0	
	Samastipur	45437	117790	44471	137256							0	
	Saran	29091	112721	26401	131349							0	
	Sheikhpura	8177	18233	10019	21247							0	
	Sheohar	5389	17903	15115	20862							0	
	Sitamarhi	27990	93083	29070	108466							0	
	Siwan	33425	94181	24458	109745							0	
	Supaul	26821	60116	32264	70050							0	
	Vaishali	46546	94323	40886	109910							0	
		1116437	2879834	**1071134**	3355737							**36960**	

[#] Coverage for 2010-11 till Dec'10

District –wise VPD reports in 2010-11 (in numbers) As per Process indicators (OCT 2010)

Sl No.	District Name	Diptheria		Pertusis		Neonatal Tetanus		Tetanus Other		Measles		Polio		AES	
		Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
1	Araria	0	0	0	0	0	0	0	0	45	0	0	0		
2	Arwal	0	0	0	0	0	0	0	0	0	0	0	0		
3	Aurangabad	0	0	0	0	0	0	0	0	0	0	0	0		
4	Banka	0	0	0	0	0	0	0	0	0	0	0	0		
5	Begusarai	0	0	0	0	0	0	0	0	0	0	1	0		
6	Bhagalpur	0	0	0	0	0	0	0	0	6	0	0	0		
7	Bhojpur	0	0	0	0	0	0	0	0	0	0	0	0		
8	Buxor	0	0	0	0	0	0	0	0	0	0	0	0		
9	Champaran (E)	0	0	0	0	0	0	0	0	0	0	3	0		
10	Champaran (W)	0	0	0	0	0	0	0	0	0	0	0	0		
11	Darbhanga	0	0	0	0	0	0	0	0	48	0	0	0		
12	Gaya	0	0	0	0	0	0	0	0	0	0	0	0		
13	Gopalganj	0	0	0	0	0	0	0	0	0	0	0	0		
14	Jahanabad	0	0	0	0	0	0	0	0	0	0	0	0		
15	Jamui	0	0	0	0	0	0	0	0	0	0	0	0		
16	Kaimur	0	0	0	0	0	0	0	0	12	0	0	0		
17	Katihar	0	0	0	0	0	0	0	0	0	0	0	0		
18	Khagaria	0	0	0	0	0	0	0	0	1	0	0	0		
19	Kishanganj	0	0	0	0	0	0	0	0	0	0	0	0		
20	Lakhisarai	0	0	0	0	0	0	0	0	0	0	0	0		
21	Madhepura	0	0	0	0	0	0	0	0	0	0	0	0		
22	Madhubani	0	0	0	0	0	0	0	0	0	0	0	0		
23	Munger	0	0	0	0	0	0	0	0	1	0	0	0		
24	Muzaffarpur	0	0	0	0	0	0	0	0	6	0	0	0		
25	Nalanda	0	0	0	0	0	0	0	0	0	0	0	0		
26	Nawada	0	0	0	0	0	0	0	0	0	0	0	0		
27	Patna	0	0	0	0	0	0	0	0	74	0	0	0		
28	Purnia	0	0	0	0	0	0	0	0	0	0	0	0		
29	Rohtas	0	0	0	0	0	0	0	0	18	0	0	0		
30	Saharsa	0	0	0	0	0	0	0	0	0	0	0	0		
31	Samastipur	0	0	0	0	0	0	0	0	98	0	5	0		
32	Saran	0	0	0	0	0	0	0	0	0	0	0	0		
33	Sheikhpura	0	0	0	0	0	0	0	0	12	0	0	0		
34	Sheohar	0	0	0	0	0	0	0	0	7	0	0	0		
35	Sitamarhi	2	0	0	0	0	0	0	0	76	0	0	0		
36	Siwan	0	0	0	0	0	0	0	0	0	0	0	0		
37	Supaul	0	0	0	0	0	0	0	0	0	0	0	0		
38	Vaishali	0	0	0	0	0	0	0	0	0	0	0	0		

PART-C Summary Budget- Routine Immunization (2011-12)					
S.no.	**Activity**	**Unit Cost**	**Requirement under NRHM**	**Budget (in lakhs)**	%
C.1 Immunization					
1	Mobility Support for Supervision & Monitoring at District & State level (remainder amount in Part A)	50000 per district+100000 at State	2000000	20.00	0.69
2	Cold Chain Maintenance		5000000	50.00	1.73
3	Focus on slum & Underserved Areas in Urban Areas	Rs1400/- & Rs 200/-	16956000	169.56	5.86
4	Mobilization of Children through ASHA/moblizers	Rs 200/-	60000000	600.00	20.75
5	Alternate Vaccine Delivery to Session Sites			0.00	0.00
	NE States & Hilly terrains	Rs 125/-	6406500	64.07	2.22
	R.I.Session in other Areas	Rs 75/-	73593000	735.93	25.45
6	Printing and dissemination of Immunization Cards formats etc.	Rs 5/-	18304010	183.04	6.33
7	Review Meeting			0.00	0.00
	Review meeting at State level	Rs 1250/-	570000	5.70	0.20
	Review meeting at district level	Rs 100/-	1066000	10.66	0.37
	Review meeting at Block level	Rs 75/- (50 + 25)	24000000	240.00	8.30
8	Microplan			0.00	0.00
	Develop Microplan at Sub Centre level	Rs.100/-	1700000	17.00	0.59
	Consolidation of microplan at Block Level	Rs. 1000/- & Rs.2000/-	609000	6.09	0.21
9	POL for Vaccine delivery from State to district and from district to PHC/CHC (Addl. Amount Budgeted under Part B)	100000	3800000	38.00	1.31
10	Consumbles for Computer including provision for Internet access	Rs 400/-	182400	1.82	0.06
11	Injection Safety			0.00	0.00
	Red/Black Plastic Bags etc	Rs.3/-	4368000	43.68	1.51
	Bleach/Hypochlorite Solution	Rs.500/-	332500	3.33	0.11
	Twin Bucket	Rs.400/-	266000	2.66	0.09
12	Red/ Black Bags, Twin Bucket,Bleach/Hypochorite Solution			0.00	0.00
13	Safety Pits	Rs 10000/-	6650000	66.50	2.30
14	Supportive supervision for 10 top priority districts				
15	Alternative vaccinator hiring for urban RI.Nomads, bricklins & ors	Rs 1400/-	25200000	252.00	8.72
16	Strengthening of record keeping of Block & District Cold Chain room				
17	Catch - up Campaigns for flood prone Areas	Rs.1,00,00,000/-	10000000	100.00	3.46
18	AEFI investigation of district AEFI committee	Rs 10000/- & 5000/-	570000	5.70	0.20
19	POL of Generators for Cold Chain	Rs.3817/-	5000000	50.00	1.73
20	Establishing Measles Surveillance & Measles Outbreak Investigation				

C. 2 Salary of Contractual Staffs				0.00	0.00
21	District Data Assistants	Rs 8800/- (incl. 10% hike for FY 11-12)	4012800	40.13	1.39
22	State Data Assistants	Rs 16,335/- (incl. 10% hike for FY 11-12)	784080	7.84	0.27
23	State Vaccine Logistic Manager (Budgeted in Part A)				
24	Janitorial Support to R.I.Cell				
C.3 Training under Immunization				0.00	0.00
25	District level orientation training for 2 days ANM,MPH, LHV etc	As per RCH Norms	10000000	100.00	3.46
26	One day Refresher training of DA's	As per RCH Norms	110400	1.10	0.04
27	One Day Cold Chain Handlers training	As per RCH Norms	704000	7.04	0.24
28	One Day Block level data Handlers training	As per RCH Norms	704000	7.04	0.24
29	Three Days training for MO's	As per RCH Norms	6265000	62.65	2.17
C.4 Assessment of New Initiative taken for enhancing R.I. Coverage (Budgeted in Part B)					
Grand Total			**289153690**	**2891.54**	**100.00**

NIDDCP	Part D

National Iodine Deficiency Disorder Control Programme (NIDDCP)

Addressing Iodine Deficiency Disorders in Bihar.

Introduction:

Iodine deficiency is a world wide public health problem. It is the major cause of brain damage, loss of energy, learning disability, poor motivation, poor human resource development and child survival. Thus, it remains a major threat to the health and development of preschool, school children and pregnant women. Children with iodine deficiency have intelligence (I.Q) 13.5 points less than that of children from areas where there is no iodine deficiency. The only solution to this is simple and affordable, which is consumption of iodized salt. IDD elimination Program was launched in the late 1960s. By 1988 legislative measures were put in place to ban the sale of non-iodized salt in the entire state.

During the United Nations General Assembly Special Session for Children (2002), India has committed to eliminate IDD by 2005. In national policy commitments, India commits to eliminate IDD by 2012. , there is an urgent need to accelerate the strategy in India, especially when a decreasing trend, 49% to 37% (1998-99 to 2002-03), has been seen in households consuming adequately iodized salt.

Iodine Deficiency Disorders in Bihar:

In Bihar the northern part of the state lies in the sub-Himalayan region in which the existence of severe to moderate iodine deficiency is well established. A recent study (2003-04) was undertaken in 14 districts of Bihar with support from UNICEF for Government of Bihar, to track progress towards sustainable elimination of IDD from the state. The results of the study reveal that prevalence of IDD is more then 10% and iodine deficiency continues to be a public health problem. A high proportion of population (31.5%) has very low urinary iodine excretion suggesting existence of severe iodine deficiency in many pockets. In recent NFHS-3, 66% of the households consume adequately iodized salt. As per the nation wide assessment availability of adequately iodized salt is 60% in Bihar and main transportation of iodized salt in state is through rail.

The findings of this study warrant instituting corrective measure to ensure that the population of Bihar has access to adequately iodized salt through salt traders and at least 80%of the households receive and use adequately iodized salt.

Goal:

- Achieve universal access (100%) to iodized salt.
- Generate district wise data on iodized salt consumption rate.
- Assess the prevalence of Iodine Deficiency Diseases (IDD survey) in state among school children (Goiter prevalence, Urinary Iodine Excretion and household consumption of iodized salt).

- Reduction in the prevalence of Iodine Deficiency Diseases to less than 10% by 2012.
- Generate awareness in the masses about IDD and consumption of adequate iodized salt.

Major Objectives:

- Creating universal demand for iodized salt at consumption level.
- Strengthening the monitoring system at the production level, distribution (retailer level) & consumption level for adequate iodization.
- Strengthening coalition of salt traders & retailers, railways and other government department for increasing demand and supply of iodized salt.
- Urgent enforcement of legal ban reinstituted on 17th May 2006.
- Strengthening iodine testing laboratory in state (up gradation of existing lab in State HQ)

Strategies:

Following main strategies would be adopted:

1. **Program planning and inter departmental coordination:** by strengthening **IDD cell** at state level
2. **Establishment of IDD monitoring lab:** by strengthening and upgrading existing lab in state HQ
3. **Health Education and publicity:** awareness generation activities among school children, salt traders and retailers, field functionaries of health, ICDS and community members
4. **IDD surveys:** IDD prevalence survey in 5 selected districts for: Goiter prevalence, Urinary Iodine Excretion and household consumption of adequate iodized salt.

1. Program Planning and inter departmental Coordination:

State level:

IDD cell is functional at State Health Society Bihar and one Program Officer is responsible for coordinating IDD activities. It is proposed to strengthen the cell by appointing the specific posts (Technical Officer-IDD, Statistical Assistant and LDC/Typist) for 'IDD cell' from NRHM and or state budget. Health as a nodal department will be the collaborating with ICDS, Food and Consumer Protection and Education departments for carrying out activities. State Coordination Committee at state level under Program Officer IDD as Nodal officer and member Secretary of SCC-IDD and IDD cell is already exits.

Progress in 2010-11:

- Monitoring of salt testing at household, wholesalers, railway unloading stations by food inspector and ASHA/AWW.
- Distribution of 10000 salt kits per districts
- Reporting formats printed and distributed for use at village/block and district level with help of UNICEF
- Guidelines and other support provided to districts for organizing IDD activities in each districts.

- Directives to Civil Surgeons for regular review of salt testing activities by food inspector
- Directives issued to all DPO and DSE for using only adequately iodized salt at AWC & MDM
- Roll out of revised reporting format for collecting disaggregated information has been completed in present PIP and BHM and supply focal point have been trained with support of UNICEF in April 2010.

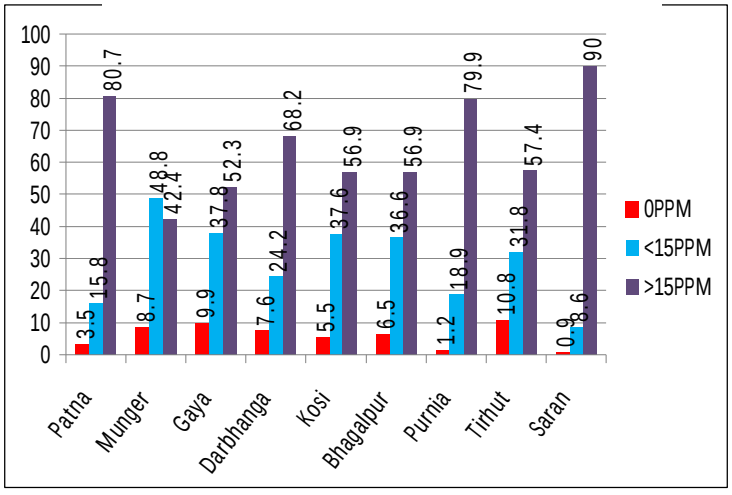
It will continue to perform following functions in current year as per PIP.

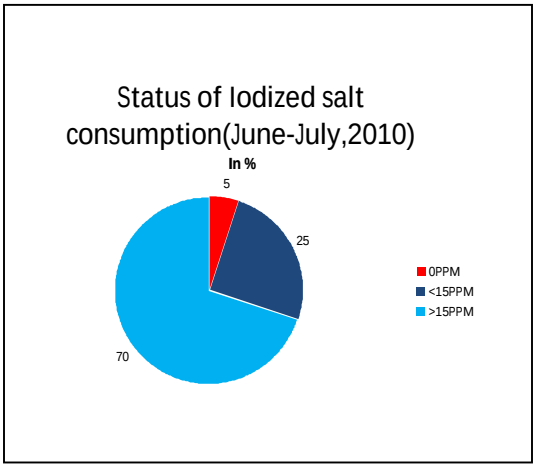
- Regular monitoring and inter departmental review meeting on periodic basis (biannual)
- Procurement/distribution of Salt Testing Kit (MBI Kit) for ASHA as well AWW.
- Printing of reporting formats and IEC material for districts to distribute to AWCS, through CDPOs and to Schools through BEOs.
- Financial Support to district to carry out awareness generation activities under the NRHM part D.
- Reinforce the directives to district for strengthening IDD activities at district level
- Reinforce directives to Civil Surgeon to hold meetings of lab technician and Food Inspectors in his district for review of salt sampling and salt testing.
- Reinforce directives from DEO to ensure exclusive use of iodized salt in MDM.
- Reinforce directives from DPO (ICDS) to ensure exclusive use of iodized salt at AWC
- Directives to be issued to Medical Colleges and District hospitals, for using iodized salt in cooking meals for the patients.
- State level study to understand state-based slat trade system and KAP of these partners.

District level

In last program year (2010-11)district co-ordination Committees meetings were organized in all district under the chairmanship of District Magistrate and nodal officer IDD as member secretary to take decisions on priority actions and review the progress of work once every quarter. Following activities were completed in 2010-11 PIP. I.

Division wise Status of Iodized Salt Consumption





- Salt Testing Kits distributed to all ASHA for monitoring salt quality..
- Relevant IEC material distributed to each district for awareness generation and used during IDD month.
- Support of members of Salt Traders Association have taken for monitoring and advocacy by utilizing their network and also linked with ICDS and Health department to carry out specific activities in a coordinated manner.
- Orientation and Planning Meetings for health and ICDS field functionaries carried out for awareness generation and to strengthen monitoring of salt quality.
- Awareness campaigns through schools and AWCs carried out to reach out to the communities..Reporting formats for submitting the reports of regular salt testing by ASHA to PHC to district to state have been provided.
- District are collecting disaggregated data of iodized salt use through revised formats and the same will be reviewed to ensure equity based utilization of services.

All these activities will be continued in present PIP period and quality ensured by regular follow up and monitoring by

- Institutionalizing follow-up actions in block areas with low or no iodine salt sale and consumption. This will be achieved through review of salt testing reports coming from blocks with help of District MIS Assistant at DHS.
- Identify schools and undertake school-based activities in prioritized salt trading districts/blocks to promote consumption of packaged adequately iodized salt through regular testing of salt samples from homes of school children and markets of the block.
- Networking with district supply officers of food and consumer protection department

The expected outcomes of these efforts are:

- Increase in numbers of salt traders indenting for better quality salt with Salt Department.
- Increase in availability of iodized salt in retailers shops.
- Increase awareness on benefits of iodized salt among mothers and children and communities.
- Increase in number of households consuming adequately iodized salt (> 15 ppm).
- Increase in use of iodized salt in Government program, institutions etc.

2. **Establishment of IDD monitoring lab:**

Presently Bihar is having one Food and Drug testing Laboratory at Patna which caries out testing of salt samples received from the district. In present PIP 2010-11 critical post of Public Analyst has been filled on contractual basis resulted in regular testing of slat by titration method and follow up action.

Following activities are proposed under NRHM PIP 2010-11.

- Filing of key posts: Under NRHM state is proposed to upgrade the laboratory and continue to fill up the key positions on contract or regular basis from NRHM budget and or from state allocation. The positions to be supported by this means are Public Analyst (One), Laboratory Technician (one) and Laboratory Assistant (one).

- Regular salt sample collection for testing: A plan of action for regularly receiving salt samples from districts through food inspector is developed and implemented last year. Same plan of action will be reinforce with quality component..
- Orientation of Food inspector for institutionalizing salt testing (salt sample collection, transportation and dissemination of results) for reducing sale and consumption of non iodized salt in the state is planned for this PIP 2011-12. As this activity was dropped sue to non allocation of funds under PIP 2010-11
- Monitoring salt quality will be continued to carried out at various levels using salt testing kits as it was done in present program cycle. Salt samples on receipt of railway racks, godowns and retail outlets and small shop keepers was carried out in present program cycle to ensure influx of adequately iodized salt in state. These efforts will be concerted in next program cycle (PIP-2011-12) to motivate other salt traders to indent for iodized salt and stock and sell only iodized salt.

3. **Health Education and publicity**:

- Awareness generation among consumers is a corner stone of the strategy and all possible means to disseminate information about the benefits of consuming iodized salt and to trigger behavior change among the population. This surely requires the contribution of stakeholders outside the Health Department. In this regard the ICDS with its extended network of AWCs is a strong link through which the vulnerable population groups in the community can be reached out.
- Health department could also coordinate with Railways for the proper unloading of iodized salt at Railway unloading sites and sharing information of unloading to health department to facilitate the salt sampling/testing before forward distribution by salt traders.
- Schools provide an excellent infrastructure for promotional activities to reach out to masses through children. Teachers can be trained for encouraging students to influence their families in purchasing iodized salt highlighting the benefit of IQ difference in children with iodine deficiency. Thus, a series of activities could be organized for awareness creation among children, who in turn can be expected to serve as change agents for influencing their families.
- Department of Food and Consumer Protection can encourage and support the inclusion of iodized salt in the food basket of the public distribution system (PDS).
- **Advocacy :**

A. Advocacy will be through mass awareness creation activities such as Rath Yatra, processions, Prabhat Pheri rallies, human chain etc. These will be organized with support from district administration and coordinated with other departments and to partner with all stake holders in the district. A brief on completion of the activities will be forwarded to Civil Surgeon's office and to State Health Society, Bihar with a copy to UNICEF. In present program cycle 'Iodine Jagrukata Rath' was moved in 8 southern districts with help of UNICEF for networking with salt traders association.

B. There would be meeting of salt sellers to motivate them for the above. State has also planned to map salt wholesalers and identify the priority districts. Meeting of salt traders will be organized to sensitize and equip them to monitor and procure only adequately iodized salt. A consolidated reporting giving the number of samples tested along with percentage of salt with 0 PPM, <15 PPM and >15 PPM

will be submitted to the district (Civil Surgeon's office), SHS, Bihar and a copy to Unicef. This activity was not carried out in present program cycle as budget was not approved. This activity is proposed for PIP 2011-12 as important advocacy activity with salt traders to support sale of adequately iodized salt in Bihar as their moral responsibility.

Special activities for school children

a) All students in the school to be sensitized with the problem of IDD and the benefits of iodized salt.

School teacher shall take a 30 minutes class, and would explain to children why iodine is important, causes of iodine deficiency disorder, and consequences of IDD with emphasis on physical and mental development. Explain that iodized salt helps bring back iodine to the body which has not been received through food. Thus iodized salt is important, but both iodized and non-iodized salt is available in market. Give emphasis to the difference in the IQ points up to 13, in children with iodine deficiency thus affecting leaning and school performance which further reflects on workout put and productivity. Thus good health can be ensured only with daily consumption of iodized salt.

b) Head Masters to facilitate organizing of activities within and outside school, Nodal Teacher to take the lead.

Activities within the school:

- Essay/Story competition -Poetry Writing
- Exhibitions -Play/Skits
- Slogan writing -Songs

All children participating, to get a certificate and the best child/ children to get a prize.

Activities outside the school:

- Organize Salt monitoring for advocacy in the community
- Each Nodal Teacher to choose 20 children living in different localities
- Each student to visit 15-20 houses and shops around them for monitoring and advocacy.
- Slogans to be used for Prabhat Pheri
- Human Chain
- Marathon/Bicycle Race
- All children to get a certificate, and the best performer to get a prize.
- Each nodal teacher to prepare report for her class.
- Every school to prepare an Activity Report including a report on monitoring of salt

c) Monitoring salt for iodine content in the class room:

All children requested to bring few pinches of salt from their homes
Teacher to supervise the testing of salt by each child using the kit. Children would be classified into two groups.
Group 1 will have children with salt samples tested with adequate iodine.
Group II will have children with salt samples tested with no iodine or inadequate iodine.

Specific counseling on based on iodine content in the salt sample will be carried out in school by nodal teachers in groups. Group with adequate iodized salt would be informed that salt is of good quality and would allow them to perform well in school if they continue consuming iodized salt. To continue as they are and pay attention to studies in the school they should insist their parents always buy iodized salt only". Group II students to be informed that their

salt does not contain iodine so they are being left out from its benefits. If this continues, they are likely to face some serious risks i.e. growth can be retarded and at the same time school performance would be negatively affected. This can happen to all the family members as they are also consuming the same salt without iodine or less amount of iodine that is required by the body. This way student would be used as agent for change in family behavior for using adequately iodized salt. In general, the nodal teacher should emphasize that all children in group I as everyone use iodized salt.

4. IDD Survey:

The important activity proposed under NRHM Part D is carrying out Iodine Deficiency Disorder (IDD) survey in five selected districts. This was not carried out in present program cycle so it will be carried out in next PIP in 10 districts. Following activities are proposed under this

- Goiter prevalence survey: Based on revised policy guidelines on National Iodine Deficiency Disorders Control Programs by GOI, state is proposing goiter prevalence survey among school children and out of school children using the survey methodology described in operational manual through an agency.
- Monitoring salt for iodine content in the school students: Every 5th child selected in the goiter survey is proposed to cover for collection of salt samples b y visiting corresponding houses.
- Urinary Iodine Excretion survey: Urinary iodine excretion will be tested in alternate child selected for salt sample in earlier step.

<table>
<tr><th>S.N.</th><th colspan="4">Activities proposed</th><th>Budget in lacs</th><th>Remark</th></tr>
<tr><td>1</td><td colspan="4">Establishment of IDD cell</td><td></td><td></td></tr>
<tr><td rowspan="6">a</td><td colspan="4">Salary of the contractual staff at IDD cell</td><td rowspan="6"></td><td rowspan="6"></td></tr>
<tr><td>Sl. No.</td><td>Staff</td><td>Remuneration per Month</td><td>Fund requirement for one year</td></tr>
<tr><td>1</td><td>one Technical Officer</td><td>15000</td><td>180000</td></tr>
<tr><td>2</td><td>one Statistical Assistant</td><td>12000</td><td>144000</td></tr>
<tr><td>3</td><td>one Data Entry Operator</td><td>10000</td><td>120000</td></tr>
<tr><td colspan="3">Total</td><td>444000</td><td>4.44</td></tr>
<tr><td>2</td><td colspan="4">Establishment of IDD monitoring Lab</td><td></td><td></td></tr>
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<table>
<tr><td>a</td><td colspan="4">Salary of the contractual staff at IDD Monitoring cell</td><td></td><td></td></tr>
<tr><td></td><td>Sl. No.</td><td>Staff</td><td>Remuneration per Month</td><td>Fund requirement for one year</td><td></td><td></td></tr>
<tr><td></td><td>1</td><td>one Laboratory Technician</td><td>10000</td><td>120000</td><td></td><td></td></tr>
<tr><td></td><td>2</td><td>One Laboratory Assistant</td><td>9000</td><td>108000</td><td></td><td></td></tr>
<tr><td></td><td colspan="3"></td><td>Total</td><td>228000</td><td>2.28</td></tr>
<tr><td>b</td><td colspan="4">Up gradation of Laboratory (Infrastructure and human resources)</td><td>1.0</td><td></td></tr>
<tr><td>c</td><td colspan="4">Salt testing Kits (MBI Kits)</td><td>0</td><td>@10 kits/ASHA and @10 kits/AWW = 600000 for ASHA and 800000 for AWW <u>(Will be provided by GOI)</u></td></tr>
<tr><td>3</td><td colspan="4">Health education and publicity</td><td></td><td></td></tr>
<tr><td>a</td><td colspan="4">Awareness generation activities and competitions in the schools</td><td>5.34</td><td>Rs.@1,000/block for total 534 blocks</td></tr>
<tr><td>4</td><td colspan="4">IDD survey</td><td></td><td></td></tr>
<tr><td></td><td colspan="4">In 10 districts of the state using the manual under revised guidelines</td><td>5.00</td><td>Rs. @50,000/districts for 10 selected districts</td></tr>
<tr><td></td><td colspan="4">Grand Total</td><td>18.06</td><td></td></tr>
</table>

IDSP | Part E

D3.1 Introduction

The Government of India has initiated a decentralized, state based Integrated Disease Surveillance Project (IDSP) in the country in the year 2005-06.Bihar is included in phase III started from Nov 2007.The project has been able to detect early warning signals of impending outbreaks and helped to initiate an effective response in a timely manner. It is providing essential data to monitor progress of on going disease control programs and help allocate health resources more optimally.

Criteria for including diseases in the surveillance program:

- Burden of disease in the community,
- Availability of public health response and
- Special considerations and international commitments. Based on the information obtained from the state level workshops the following core conditions are included in the IDS program.

The disease conditions that are included in the core list and state specific list of the surveillance program is to be reviewed once in two years based on disease burden and availability of public health action and suitably modified.

List of Core Diseases

Regular Surveillance	
Vector Borne Disease	**Malaria**
Water Borne Disease	**Acute Diarrhoeal Disease - Cholera, Typhoid**
Respiratory Diseases	**Tuberculosis**
Vaccine Preventable Diseases	**Measles**
Diseases under eradication	**Polio**
Unusual clinical syndromes	Menigoencephalitis / Respiratory Distress **(Causing death /Hospitalization; Hemorrhagic fevers, other undiagnosed conditions.**
Sentinel Surveillance	
Sexually transmitted diseases/Blood borne	HIV/HBV, HCV,STI
Other Conditions	Water Quality monitoring

Regular periodic surveys: NCD Risk Factors	Anthropometry, Physical Activity, Blood pressure, Tobacco, Nutrition, Blindness and any other unusual health condition GOG may include in a public health emergency

Surveillance is particularly important for the early detection of outbreaks of diseases. In the absence of surveillance, disease may spread unrecognized by the responsible health care or public health agency, because sick people would be seen in small numbers by many individual health care workers. By the time the outbreak is recognized, the best opportunity to take intervention measures might have been over. Surveillance is essential for the early detection of emerging (new) or re-emerging (resurgent) infectious diseases. In the absence of surveillance, individual health care workers may not recognize the new disease. The continuous monitoring is essential for the 'early signals' of any outbreak of any endemic, new or resurgent disease and the action loop to take effective public health action should be short and effective if disease surveillance were to prevent emerging epidemics.

Objectives of IDSP

The objective is to improve the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors. Specifically, the project aims:

1. To establish a decentralized district based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the state in line of Integrated Diseases Surveillance Project.
2. To improve the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.
3. Renovate and strengthen state, district and peripheral surveillance units to cope up with the demand.
4. Renovate and strengthen state, district and peripheral laboratories to cope with the demand.
5. Operationalize norms and standards in the form of standard case definition, reporting formats and guidelines.
6. Strengthen the MIS by designating clear responsibilities for data collection, collation/processing, transmission, analysis and action, clear lines of information flow, standardized MIS formats and efficiency owing to use of IT (computers, software and web-based reporting system)
7. Reduce the burden of morbidity and mortality due to various diseases.
8. Develop, mobilize and optimally utilize human and financial resource and promote conductive environments for work.

The project assists in:

1. Surveillance of a limited number of health conditions and risk factors;
2. Strengthen data quality, analysis and links to action;

3. Improve laboratory support;
4. Train stakeholders in disease surveillance and action;
5. Coordinate and decentralize surveillance activities;
6. Integrate disease surveillance at the state and district levels, and involve communities and other stakeholders, particularly the private sector.
7. Build capacity for outbreak response

STRATEGY:

Integrated Disease Surveillance Program in the state is intended to detect early warning signals of impending outbreaks and help initiate an effective response in a timely manner. Major components of the project are:

(1) Integrating and decentralization of surveillance activities; (2) Strengthening of public health laboratories; (3) Human Resource Development – Training of State Surveillance Officers, District Surveillance Officers, Rapid Response Team, other medical and paramedical staff; and (4) Use of Information Technology for collection, collation, compilation, analysis and dissemination of data For Project implementation, Surveillance Units have been set up at State and District level. Currently linkages are being established with all District Head Quarters and all Government Medical Colleges on a Satellite Broadband Hybrid Network. This network enables enhanced Speedy Data Transfer, Video Conferencing, Discussions, Training, Communication and in future e-learning for outbreaks and program monitoring under IDSP. Under IDSP data is collected on a weekly (Monday–Sunday) basis. The information is collected on three specified reporting formats, namely "S" (suspected cases), "P" (presumptive cases) and "L" (Laboratory confirmed cases) filled by Health Workers, Clinician and Clinical Laboratory staff. The weekly data gives the time trends. Whenever there is a rising trend of illnesses in any area, it is investigated by the Medical Officers/Rapid Response Teams (RRT) to diagnose and control the outbreak. Data analysis and action are being undertaken by respective districts and also at the state level. Emphasis is being laid on reporting of surveillance data from major hospitals both in public and private sector and also Infectious Disease hospitals. The compilation and disease outbreak alerts has been started recently.

Disease Surveillance is the backbone of an effective Public Health Administration. It is systematic collection of data on the incidence and prevalence of various priority disease conditions for the purpose of taking appropriate action for prevention and control. It is crucial for planning, management and evaluation of Disease Control Programmes. Govt. of Bihar is planning an Integrated Disease Surveillance Project incorporating the following:-

_ Integrating existing vertical & horizontal Disease Surveillance Programme.
_ Surveillance of both Communicable and Non-Communicable Diseases.
_ Collaboration between Govt. & Non-Govt. Health Services i.e. Private Sector and community representatives
_ Action oriented and responsive to the needs of the State of Bihar.

Project activities

I. Up gradation of state, district and peripheral surveillance units
   - Renovation and furnishing of surveillance units; Providing office equipment and furniture

II. Up gradation of state, district and peripheral laboratories
   - Renovation & Furnishing of Labs; Supply of Lab. Equipments; Lab. Material and Supplies and consumables.

III. Information Technology and Communication
- Computer Hardware and Office Equipments; Software for surveillance; Leasing of Wide Area Networking

IV. Human Resources and Development
- Consultant / Contractual staff; Training; Information Education and Communication

V. Monitoring and Evaluation
- Provision of Syndromic, presumptive and laboratory surveillance formats
- Establishment of web-based weekly reporting system

Current Status of Bihar

Before describing the current situation in the state MOHFW comments on IDSP has been addressed here.

Up gradation of peripheral labs (PHCs) is no longer encouraged under IDSP; these labs are presently strengthened under RNTCP and NVBDCP. In contrast, there is a need to strengthen identified district level labs under IDSP.

- One reference laboratory at Deptt. Of microbiology PMCH, Patna, is to be upgraded.
- Focus of IDSP proposal as a part of NRHM should be on :
  - (i) Strengthening of the identified priority reference lab, enabling them to confirm the diagnosis of epidemic prone diseases.
    - One reference laboratory namely Deptt. Of Microbiology, PMCH, Patna has been identified for up gradation on priority basis during the year 2010-11.
    - Two Microbiologists one at the State & other for District to be appointed and posted in PMCH microbiology department.
  - (ii) All the six medical college hospitals are included as reporting unit
  - (iii) Need to collect OPD data from district/medical college hospitals for analysis.
  - (iv) 32 /38 districts are reporting online for IDSP.
  - (v) 24 /38 (in place) epidemiologists trained for two weeks in IDSP.
  - (vi) Integrate IDSP with NRHM, at least for the following :
    - **Financial management and monitoring**
      Request has been given to Program Director (NRHM) to carry out Audit with the help of NRHM appointed Chartered Accountants and Monthly, Quarterly & Yearly Financial Monitoring Report, analyze by State Consultant Finance and account section.
    - **Use of contractual staff employed under different Programme**
      Use of Contractual staff employed under IDSP working efficiently.
    - **Monitoring and evaluation**

    ➔ State and Districts Surveillance Units are established. State Nodal Officer is responsible for implementation, monitoring and supervision of IDSP from State level and Civil Surgeons are responsible for monitoring, supervision and co-ordination at district level.

    ➔ Weekly reporting system established (reporting 90%) Standard reporting formats used by all.

- ➔ IDSP Weekly Alert prepared and circulated to all Programme Officers of Health functionaries.
- ➔ Analysis and Feed-back in the form of IDSP Alert initiated at the DSU level.

Physical Progress up to December 2010

1. State and Districts Surveillance Units are established. State Nodal Officer is responsible for implementation, monitoring and supervision of IDSP from state level and Chief District Health Officers are responsible for monitoring, supervision and coordination at district level.
2. 22 district level Epidemiologists are in place and received two week training.
3. One state entomologist in place.
4. Surveillance Programme Sub Committees are formed at state and district level
5. Surveillance Core Group (SCG) and Surveillance Task Force (STF) are established at state and district level respectively.
6. Rapid Response Team (RRT) is formed at State and in 38 Districts. Till date 62 participants (DSO, Epidemiologists and RRT members) trained in Wardha for TOT. This would increase up to 150 at the end of March 2011.
7. Grant has been released to districts for renovation but due to difficulty at district level, many districts have not been able to utilize the fund for the same. The same is being demanded through NRHM flexi pool.
8. Training has been imparted to the members of RRT consist of Epidemiologist, Microbiologist/Pathologist, Pediatrician/Physician, DSOs in district level as well as state level on swine flu & epidemic prone diseases with the help of WHO & NICD.
9. Standard reporting formats developed by state are used by all.
10. Weekly reporting system established (reporting 90%) Standard reporting formats used by all.
11. Integration of private, rural, urban sectors, six medical colleges and tertiary care hospitals.
12. Mechanisms for action based on data streamlined through Surveillance Core Group, Surveillance Task Force.
13. IDSP Weekly Alert prepared and circulated to all Programme Officers of Health functionaries.
14. Analysis and Feed-back in the form of EWS Alert initiated at the DSU level.
15. Nineteen outbreaks detected & reported to CSU.
16. IRS activities (for Malaria) in Jamui, Present status of Kala-azar in Patna & Darbhanga, Outbreak investigation in Muzzafarpur (JE like disease) Lakhisarai and Munger (Malaria), Begusarai & Gopalganj (Dengue) was investigated and monitored by State Entomologist.
17. Initiation of Kala-azar State Task Force by SSU, Bihar.

Activities planned/ Action Plan during 2011-12

Integrated Disease Surveillance System is well established in the state. Weekly surveillance data are received regularly from reporting units. Data are analyzed at state level and weekly alert is prepared which is circulated to all state and district programme officers.

Following major activities are planned for year 2011-12

1. Increase no. of private reporting units – Orientation workshop at State and district HQ for IMA, IAP, private laboratories is planned.
2. Catching OPD data in weekly surveillance.
3. Social Mobilization & inter-sectoral coordination to be strengthened. Social Mobilization Group to be formed at the State Headquarters. (To be operational at PHC level)
4. Community Based Surveillance to be started (To be operational at Sub-centre level)
5. Integration of Medical Colleges.
6. Case based study reports to be started in all the districts.
7. Formation of State Surveillance Committee.

Activities as per IDSP Guidelines

1. Renovation of peripheral surveillance units and laboratories located in sub district hospitals and community health centers
2. Procurement of equipment, reagents, consumables, furniture etc for peripheral laboratories.
3. Printing of Syndromic Surveillance, Presumptive Surveillance and Laboratory Surveillance forms
4. Printing of posters and charts on biosafety, standard operation procedures, protocols etc.
5. Orientation workshops, conferences and review meetings

Additional activities

1. Support Infectious Disease hospitals
2. Provision of transport facilities to RRT in 6 Medical Colleges
3. Establishment of community surveillance system through toll free telephone
4. Use of call centers for prompt dissemination of information to avert outbreak
5. Mapping of disease incidence and prevalence through use of GIS

ACTIVITY DESCRIPTION CORRESPONDING TO BUDGET

Part I: STAFF SALARY:

The staff salary of state health & District Health Societies of other programmes has been increased upto 50%. Moreover, proposed level of salary is already in vogue in other programs like Kala-azar, NTCP, JSK etc. Accordingly, revised salary of IDSP staffs has been proposed as given in the budget. The hike in salary will greatly help motivate the staffs & contribute more productively.

Since, new staffs including Consultants- Training, Consultant- Finance, Data Managers have started to contribute in IDSP, the program is under consolidation.

Part II: ACTIVITIES:

1) Under the training part, orientations of Medical Officers have been rolled out & training in other districts is in progress. The last 3 batches of TOT is being conducted at SIHFW, Patna & will be completed by mid March 2011. 38_batches of training of Medical Officers/doctors taking 1 batches from each district have been proposed which will be needed to scale up the program and strengthen the surveillance system.

2) Training of Hospital Pharmacists/Nurses is due. This is proposed to be held in April-May 2011. As they are important persons in strengthening the surveillance system. This would help in compilation of data & dissemination of information/data to next higher level, too. A Total 7 Batch out of 44 major Hospitals & PHCs, 20 per batch will be undertaken in this.

3) Training of Data Managers has been planned in May last week as the recruitment of data operators is in process. Simultaneously, training of both DMs & DEOs has been planned in 2011-12 to keep them updated about data quality & recent software for making the data more effective. Two day Training for 2 Batches 22 persons per batch will be conducted at SSU level.

4) In 2011, Community based surveillance is going to be started in Bihar. In the first phase, Workshops at State & district level has been planned. This is supposed to provide sensitization of community regarding IDSP. This is to be held One (1) batch in each Distt.

5) Workshops & meetings, both at the state & district level have been planned for social mobilization & inter sectoral coordination. This would greatly help in formulating the strategies for further actions. Workshops & meeting at an interval of every 3 months for stakeholders including NGOs (38 DSU & 1 SSU).

6) Since completeness & timelineness of data being reported from PHCs & districts is essential, monthly meetings of data managers have been planned. They would be multi-skilled for optimum utilization.

7) Since operationaliztion of the programme is dependent on DSOs/Epidemiologists, monthly meetings with them at the state level would be very beneficial.

8) There are different stake-holders under the IDSP programme for various activities; monthly meetings would be very beneficial for pushing the programme forward.

Part III: OPERATIONAL ACTIVITIES:

Mobility support: for surveillance is of utmost important for case based study reports, community based surveillance, outbreak investigations. The same is being proposed to support these activities.

Office expenses: for smooth functioning of day to day activities under IDSP are very essential.

Contingency: A provision of this is needed for unforeseen activities/expenses.

TA/DA: Since field based investigations are an important component under IDSP, TA/DA provision for the concerned officials are required.

Part IV: OUTBREAK INVESTIGATION & RESPONSE:

1) ASHAs are to be involved in disease surveillance for which there is plan for giving incentives to them for surveillance activities. They would also play a key role in community based surveillance. Incentives alone will serve our purpose as they are

already being supported by other programs. This will be economical as well as effective.

2) Renovation & consumables for district labs has also been proposed for entire districts. This would greatly help in strengthening the labs for early diagnosis.

3) Collection & transportation of samples for quick response is also very urgent in preventing outbreaks & the same is being proposed.

Part V: ANALYSIS AND USE OF DATA:

1) Broadband connectivity is the most essential component for data transmission whose regular service is required.

2) IDSP reports including alerts are to be generated at district & state level for keeping an update about the disease situation.

3) Reporting formats are to be printed & provided to PHCs & Sub-Centres to ensure regular reporting.

4) TA for private sector reporting is essential to ensure timelineness & regularity of the reports & this would help them in motivating them to be associated with IDSP.

***Financial descriptions (Budget) are as follows:* ……..**

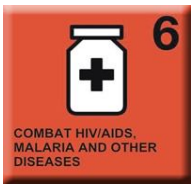
Budget Sheet for Bihar under NRHM Part -D (IDSP)

FY: 2011-12

	Sl.	Staff Salary / Remunaration	Unit Cost	No. of Units	Month	Amount (in Rs)	Remarks
Part I	1	State Epidemiologist	45000.00	1	12	540000.00	Salary has been revised by SHSB,PATNA office order No. 22884 dt. 17.01.2011
	2	Distt. Epidemiologists	40000.00	38	12	18240000.00	
	3	Microbiologists	40000.00	2	12	960000.00	
	4	State Entomologist	35000.00	1	12	420000.00	
	5	Consultant (Finance)	35000.00	1	12	420000.00	
	6	Consultant (Training)	35000.00	1	12	420000.00	
	7	State Data Manager	24000.00	1	12	288000.00	
	8	District Data Manager	23500.00	38	12	10716000.00	
	9	Data Entry Operator	10000.00	45	12	5400000.00	
		Total	**.**	**128**		**37404000.00**	
Part II	**Sl.**	**Training/Meeting/Workshop Activities**		**Unit Cost**	**Batch**	**Amount (in Rs)**	**Remarks**
	1	Training of Hospital Doctors		32000	38	1216000.00	Total 38 Batch out of 38 Distt. (Hospitals & PHCs,

						20 per batch, 1 batch per distt.) Per head training cost = 1600/-
	2	Training of Hospital Pharmacist / Nurses	20000	7	140000.00	Total 7 Batch out of 44 major hospitals (132 Person) 20 per batch
	3	Training of Data Managers/DEO	59600	2	119200.00	Two day Training for 2 Batch (22 per batch), Computer hiring 15000/- Trainer Charges 5000/-
	4	Workshop for Community Based surveillance	30000	38	1140000.00	One (1) batches in each distt.
	5	Workshops, state & district level meetings for Social mobilization & Intersectoral coordination to improve disease surveillance	7000	156	1092000.00	Workshops & meeting at an interval of every 3 months for stakeholders including NGOs (38 DSU & 1 SSU).
	6	Monthly Meeting of District Data Managers at SSU	10000	12	120000.00	
	7	Monthly Meeting of Epidemiologist/DSO at SSU	15000	12	180000.00	
	8	Monthly Meeting of IDSP stakeholders	15000	12	180000.00	
		Total			**4187200.00**	
Part III	**Sl.**	**Operational Activities**	**Unit Cost**	**Unit**	**Amount (in Rs)**	**Remarks**
	1	Mobility Support	180000	44	7920000.00	Visit of Epidemiologist and RRT for surveillance activity (Reporting unit 44 @ 15000/- month)
	2	Office Expenses			1398000.00	(Rs. 6500/- per month for SSU and Rs. 2500/- for 44 Reporting unit)
	3	Contingency			822000.00	(Rs. 2500/- per month for SSU and Rs. 1500/- for 44 Reporting unit)

	4	Office establishment & Strenthning	40000	5	200000.00	
	5	TA/DA/Perks and others (DSU)	12000	44	528000.00	Visit of Epidemiologist and RRT for surveillance activity. (1000/- per month)
	6	TA/DA/Perks and others (SSU)	24000	1	24000.00	Visit of SSU staffs for various activities relating to IDSP (2000/- per month)
		Total			**10892000.00**	
Part -IV	**Sl.**	**Outbreak investigation & response**	**Unit Cost**	**Unit**	**Amount (in Rs)**	**Remarks**
	1	ASHA incentives for Outbreak reporting	12000	38	456000.00	Rs. 100/- per ASHA for 10 Nos. per month for outbreak reports of 38 Distt.
	2	Renovation & Consumables for District Labs	200000	1	200000.00	
	3	Collection & transportation of samples	5550	38	210900.00	
		Total			**866900.00**	
Part-V	**Sl.**	**Analysis and use of data**	**Unit Cost**	**Unit**	**Amount (in Rs)**	**Remarks**
	1	Broadband Expenses	1000	45	45000.00	
	2	IDSP reports including alerts	1200	45	54000.00	
	3	Printing of Reporting Forms	3000	45	135000.00	
	4	TA for private sector reporting	100	7540	754000.00	
		Total			**988000.00**	
	GRAND TOTAL				**54338100.00**	



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ftu ftyk e ;g vuikr vf/kd g ogk l?ku fNMdko djk;k tk;xkA tgk vuikr de g ogk ukHkdh; fNMdko djku dk iLrko g]A ukHkdh; fty&1- vjoy] 2- ckdk] 3- cxljk;] 4- Hkkxyij] 5- Hkktij] 6- cDlj] 7- tgkukckn] 8- fd'kuxt] 9- y[khljk;] 10- exj] 11- ukynk] 12- uoknk] 13- iVuk] 14- i- pEikj.k A

Lk?ku fNMdko oky fty g & 1- vjfj;k] 2- njHkxk] 3- i- pEikj.k] 4- xkikyxt] 5- dfVgkj] 6- [kxfM;k] 7- e/kijk] 8- e/kcuh] 9- etQQjij] 10- if.k;k] 11- lgjlk] 12- leLrhij] 13- lkj.k] 14- f'kogj] 15- lhrke<h] 16- lhoku] 17- liky ,o 18- o'kkyh A ukHkdh; fNMdko d rgr iR;d ihfMr d vkl&ikl d 50 xgk e fNMdko djk;k tk;xk tcfd l?ku fNMdko d rgr ol lEi.k xkek dh tul[;k e fNMdko djk;k tk;xk tgk l ,d Hkh jkxh ifrofnr gkx A

¼[k½ dkyktkj ihfMrk dh [kkt dEi ekM e fd;k tk;xkA bld rgr jkT; d 31 dkyktkj iHkkfor ftyk d iR;d ik- Lok- dUn e iR;d ekg ¼dy 8 ekg& 4 ekg fNMdko dk; dk NkMdj½ ihfMrk dh l[;k d vk/kkj ij ikFkfedrk r; djr g, xke@mi&dUn Lrj ij ihfMrk dh [kkt dju gr ,d fnolh; dEi vk;kftr fd; tk;x A iR;d dEi gr ,d ny dk xBu fd;k tk;xk ftle lcf/kr ik- Lok- dUn d fp- ink-] LFkkuh; ,-,u-,e-] ,d i;kx'kkyk ikof/kd] eyfj;k fujh{kd] vk'kkogu **BHI/BHW** rFkk ,d prFk oxh; deh lnL; gkx A bl dEi e ipk;rh jkt lnL;k] xkeh.k ;okvk] f'k{kd] vkxuokMh dk;dÙkk

vkfn l lg;kx fy;k tk;xk A iR;d ik- Lok- dUn e ,d cDlk j[kk tk;xk ftl dEi ckDl dgk tk;xkA bl ckDl e dEi l lcf/kr lkekfx;k ;Fkk nok vkfn ljf{kr j[kk tk;xkA dEi dk ekbfdx rFkk cuj d ek/;e l ipkj&il kj fd;k tk;xkA

¼x½ vk'kk dk;dÙkk dk iR;d dkyktkj jkxh d [kkt rFkk mld i.k mipkj d fy, 100 :- ekun; d LFkku ij 200 :- ekun; d Hkxrku dk iLrko gA vk'kk ogu iR;d dkyktkj ihfMr d fy, MkV dk;Øe d vu:Ik nok viu ikl j[kxh rFkk fu/kkfjr [kjkd mUg miyC/k djkuk lfuf'pr djxh A

¼?k½ lEifr jkT; e dkyktkj ihfMrk dk mipkj vof/k dky ¼30 fnu½ e Je {kfrifr d :I e 50 :- ifrfnu dh nj l Hkxrku fd;k tk jgk gA bl jkf'k dk c<kdj 100 :- ifrfnu dju dk iLrko g D;kfd jkT; e U;ure etnjh dh nj 118 :- ifrfnu g A

¼M-½ iR;d dkyktkj ihfMr dk ^Li'ky QM liyheUV* nu dk iLrko g A dkyktkj ihfMr vf/kdk'kr% dikf"kr gkr gA Qyr% mud ifrj{k.k {kerk e deh d dkj.k nokvk d ifr mudk lonu de gkrk gA jkT; d o'kkyh ftykUrxr ,e-,l-,Q- uked dk;jr ,d xj ljdkjh lxBu }kjk dkyktkj ihfMrk dk Li'ky QM liyheUV fn;k tk jgk g ftld mRlkgo/kd urht lkeu vk; g A bld rgr iR;d dkyktkj ihfMr dk mipkj vof/k ¼30 fnu½ rFkk mipkjkijkr 15 fnuk rd ,d QM liyheUV iR;d fnu fn;k tk;xk A

¼p½ fNMdko d nkjku i[kM Lrj ij ftyk Lrj ij ink-@i;o{kh dfe;k dk lyl ikfy;k d leku iR;d fnu l/;k dkyhu fcQhx d vk;ktu dk iLrko gA bl gr 150 ifrfnu j[kk x;k g A

fujk/kkRed [k.M
ctV x.kuk

¼d½ MhoMhoVh o fNMdko dk;kfUo; %& ,d pØ 60 fnu d fy, A

Hkkx & I – 18 l?ku fty ¼fooj.kh vuqlkj½

(i) 18 l?ku ftyk d 249 ik- Lok- dUn e dy 2]90]68]816 ¼nk djkM uCc yk[k vMlB gtkj vkB lk lkyg½ tul[;k e Mh-Mh-Vh- fNMdko djku dk iLrko g A ¼ifjf'k"V **I** dk LrEHk 15 n"V0;½

(ii) etnjh %& dy nyk dh l[;k & 1599
dy J"B {k- dk;dÙkk & 1599
dy {k- dk;dÙkk & **1599 × 5 = 7995**
J"B {k- dk;dÙkk dh etnjh & **1599 × 145 × 160 = 1,39,11,300** :-
{k- dk;dÙkk dh etnjh & **7995 × 118 × 60 = 5, 66, 04, 600**
dy etnjh & 7]05]15]900 = 00
¼lkr djkM ikp yk[k iUng gtkj uk lk½ ¼ifjf'k"V& **II** dk LrEHk 13½

(iii) cdk;k etnjh & foxr o"kk e ftyk e Mh-Mh-Vh- fNMdko djk;k x;k FkkA dfri; dkj.kk l dN ftyk e vkf'kd @ i.k etnjh cdk;k jg x;kA
cdk;k etnjh & 20]00]000 :- vkdfyr gA
dy cdk;k etnjh & 20]00]000 :- ¼ifjf'k"V **II**½

(iv) dk;ky; 0;; ,o vkdfLedrk %& iR;d fNMdko ny dk fNMdko d nkjku vko';d lkekfx;k ;Fkk x: feVVh] jftLVj] lknk dkxt] iu] Nuuk diMk] xyCl vkfn dh vko';drk iMrh gA bl gr iR;d fNMdko ny ij 250@& dk;ky; 0;; ,o 250 :- vkDlfedrk fu/kkfjr dh xb g A ftyk eyfj;k ink-@vij e[; fp- bl jkf'k l nyk dk vko';d lkekfx;k miyC/k djk;x A

dk;ky; 0;; & **1599 × 250 = 3,99,750 = 00**
vkdfLedrk & **1599 × 250 = 3,99,750 = 00**
e[;ky; d fy, = **25,000 = 00**
dy **8,24, 500=00**
¼ifjf'k"V **II** dk LrEHk 14 ,o 15½

(v) Mh-Mh-Vh-<ykb & ftyk e[;ky; l fNMdko LFky rd Mh-Mh-Vh- igpku e gku okyk 0;; A
& ftyk e[;ky; l i[kM Lrj & 2000 :@iHkkfor i[k.M
& **249 × 2000 = 4,98, 000** :-
& i[k.M Lrj l fNMdko LFky & 1500@iHkkfor i[k.M
& **249 × 1500 = 3,73, 500** :-
dy 0;; & **8, 71, 500** :- ¼vkB yk[k bdgrj gtkj ikp lk :- ek=½
¼ifjf'k"V **II** dk LrEHk 17] 18 rFkk 19½

;g jkf'k ftyk dk ,d e'r miyC/k gkxhA ftyk eyfj;k ink- dk ;g foodkf/kdkj ikIr gkxk fd o jkf'k dk mi;kx ¼fu/kkfjr nj l brj½ vko';drkulkj e[;ky; l njh d

vulkj dj ldx A vUrj ftyk Mh-Mh-Vh- fNMdko midj.k d gFkyu&fopyu d fy, jkT; e[;ky; Lrj ij 5]00]000 :- dk iko/kku fd;k x;k gA

(vi) iEi ejEefr %& fNMdko l io fNMdko e i;Dr gku oky iEik dh lfoflx@ejEefr djk;h tkrh g bl gr pVdh ok'kj] xyu lrk vkfn dh vko';drk iMrh gA bld fy, ifr ny 150 :- fu/kkfjr gA bld vfrfjDr fNMdko dh x.kork cuk; j[ku d fy, fNMdko d nkjku iEi dk ukty Vhi cnyuk gkrk gA ukty Vhi d fy, ifr iEi 8 ukty Vhi ¼,d pØ d fy,½ 50 :- dh nj l fu/kkfjr dh xb g&

iEi ok'kj ,o ejEefr ij 0;; & **1599 × 150 = 2,39,850 = 00**

ukty Vhi Ø; & **1599 × 2 × 8 × 50**

1599 × 800 = <u>12,79,200 = 00</u>

dy 0;; **15,19,050 = 00**

¼iUng yk[k mUuhl gtkj ipkl½

¼ifjf'k"V **IV** LrEHk 6] 7 ,o 8½

(vii) i;o{k.k %& fNMdko d cgrj i;o{k.k d fy, ftyk d flfoy ltu] vij e[; fp-ink- ieMy d {k= mi fun'kd ftyk eyfj;k ink- rFkk lHkh iHkkjh i[k.M fp- in- dk i;o{k.k dk nkf;Ro fn;k tk jgk gA

18 ftyk e l ek=k 13 ftyk e ftyk ey- ink- inLFkkfir gA bUg 20]000 ifrekg dh nj l 60 fnuk d fy, 40]000@&:- fn;k x;k gA

18 flfoy ltu **18 × 2 × 10,000** = **3,60,000 = 00**

18 vij e- fp- ink- **18 × 2 × 10,000** = **3, 60, 000 = 00**

13 ftyk ey- ink- **13 × 2 × 20,000** = **5, 20, 000 = 00**

249 i[k.M fp- ink- d 650 :@fnu dh nj l 60

fnu d fy, okgu ij 0;; & **249 × 650 × 60** = **97,11,000**

5 {k- mi fun'kd d **5 × 10,000 × 2** = **1,00,000 = 00**

4 {k- eyfj;k ink- **4 × 10,000 × 2** = **80,000 = 00**

¼ifjf'k"V **IV** LrEHk 9] 10] 11] 12 ,o 15] 16½

bld vfrfjDr jkT; e[;ky; rFkk dUnh; Vhek d i;o{k.k gr ,d e'r jkf'k&

jkT; e[;ky; & **3, 06, 000 = 00**

nk okgu ¼12 :@fdykehVj 200 fdykehVj vf/kdre $ 150 :- ifr jkf= foJke½

dUnh; Vhe d fy, <u>& **2,97,000 = 00**</u>

¼nk okgu iR;d fnu½

dy 0;; **1,17,34,000 = 00**

¼ifjf'k"V **IV** dk LrEHk 13 ,o 14½

dy 0;; = **1, 17,34,000** ¼,d djkM lrjg yk[k pkrhl gtkj½

(viii) i;o{kh ink-@dfe;k dk nfud HkUkk %& Mh-Mh-Vh- fNMdko e lyXu eyfj;k LFkkiuk d i;o{kh ink- ,o dfe;k dk nfud HkUkk ¼fcgkj ;k=k HkkUkk fu;ekoyh d vulkj½ fn;k

tk,xkA bl fufeÙk ifr dkyktkj iHkkfor i[k.M d 2000@& :- dh nj l jkf'k ikDdfyr dh xb g] bl jkf'k dk Hkxrku ek= dkyktkj dk; e g, 0;; d fo:) fd;k tk ldxkA

249 × 2000 = 4,98,000 = 00 :-

¼ifjf'k"V **IV** dk LrEHk 17½

(ix) l/;k dkyhu fcfQx %& dkyktkj d fo:) Mh-Mh-Vh- fNMdko d nkjku iR;d fnu] lyl ikfy;k dk;Øe e gku oky l/;kdkyhu fcfQx dh gh rjg iR;d ik- Lok- dUn ¼tgk fNMdko gk jgk g½ rFkk ftyk e[;ky; e fp- ink- rFkk fNMdko e lyXu i;o{kh dfe;k dh l/;k dkyhu fcfQx dk iLrko gA bl d fy, iR;d ik- Lok- dUn ,o ftyk e[;ky; dk iR;d fnu dy 60 fnuk d fy, 150 :- ifrfnu dh nj jkf'k ikDdfyr dh xb gA

(249 + 18) × 150 × 60 = 24, 03. 000 = 00

¼ifjf'k"V **IV** dk LrEHk 18½

(x) vkb-b-lh- & fNMdko d io tu lk/kkj.k e fNMdko d Qk;n fNMdko d frFk dh tkudkjh dh nf"V l bl en e ifr iHkkfor i[k.M #i; 2000@& dh nj l jkf'k dk iko/kku fd;k x;k gA ftyk Lrjh; dk;Øe inkf/kdkjh ikLVj]bR;kfn d ek/;e l ipkj&ilkj djk;xA bl en dh jkf'k i[k.M fpñinkñ dk #i; 500@& ifr i[k.M dh nj l miyC/k djkb tk,xhA i[k.M fpñinkñ iHkkfor xkek e fNMdko d io <ky fiVokdj] ekbd }kjk xk"Bh dj tulk/kkj.k dk fNMdko dh frFk dh tkudkjh nxA iLrkfor jkf'k

249 × 2000 = 4,98,000 = 00

¼ifjf'k"V **IV** dk LrEHk 19½

Lk?ku 18 ftyk e Mh-Mh-Vh- fNMdko ,o vu"kxh vU; dk;k dk ctV lkjk'k%

(i)	fNMdko gr dy tul[;k	=	**2, 90, 68, 816**
(ii)	,d pØ d fy, dy ny	=	**1599**
(iii)	dy J- {k- dk-	=	**1599**
(iv)	dy {k- dk-	=	**7995**
(v)	J- {k- dk- dh etnjh	=	**1,39,11,300** :-
(vi)	{k- dk- dh etnjh	=	**5,66,04, 600** :-
(vii)	cdk;k etnjh	=	**20,00,000** :-
(viii)	dk;ky; 0;; $ vkdfLedrk 0;;		**8,24,500** :-
(ix)	Mh-Mh-Vh-<ykb	=	**8,71,500** :-
(x)	gFkyu fopyu	=	**5,00,000** :-
(xi)	iEi ejEefr $ ukty Ø;	=	**15, 19,050** :-
(xii)	i;o{k.k	=	**1,17,34,000** :-
(xiii)	nfud HkÙkk	=	**4, 98, 000** :-
(xiv)	fcfQx	=	**24, 03, 000** :-
(xv)	ipkj&ilkj	=	**4,98, 000 :-**
	dy	=	**91363950** :-

Hkkx &II % 14 ukHkdh; fty%

1- 14 ukHkdh; ftyk d iHkkfor 108 ikFkfed LokLF; dUnk d dy 225750 ¼nk yk[k iPph l gtkj lkr lk ipkl½ tul[;k e MhŒMhŒVhŒ fNMdko djku dk iLrko g ¼ifjf'k"V 1 Qkdy dk LrEHk 15½

2- etnjh %&

dy nyk dh l[;k & 55
dy J"B {k- dk;dÙkk & 55
dy {k- dk;dÙkk & 55 × 5 = 275
J"B {k- dk;dÙkk dh etnjh & 55 × 145 × 188 = 14,99,300 :-
{k- dk;dÙkk dh etnjh & 275 × 118 × 188= 61,00,600
dy etnjh & 75]99]900=00
¼ipgÙkj yk[k fuukuo gtkj uk lk½
¼ifjf'k"V IIF dk LrEHk 14½

3- dk;ky; 0;; ,o vkdlfedrk %& iR;d fNMdko ny dk fNMdko d nkjku vko';d lkekfx;k ;Fkk x: feVVh] jftLVj] lknk dkxt] iu] Nuuk diMk] xyCl vkfn dh vko';drk iMrh gA bl gr iR;d fNMdko ny ij 200@& dk;ky; 0;; ,o 200 :- vkDlfedrk fu/kkfjr dh xb g A ftyk eyfj;k ink-@vij e[; fp- bl jkf'k l nyk dk vko';d lkekfx;k miyC/k djk;x A
dk;ky; 0;; & 55 × 200 = 11000 = 00
vkDlfedrk & 55 × 200 = 11000 = 00
e[;ky; d fy, = 10,000 = 00
dy 32, 000=00
¼ifjf'k"V IIF dk LrEHk 14 ,o 15½

4- Mh-Mh-Vh-<ykb & ftyk e[;ky; l fNMdko LFky rd Mh-Mh-Vh- igpku e gku okyk 0;; A
& ftyk e[;ky; l fNMdko LFky & 1500 :@iHkkfor i[k.M
& 108 × 1500 = 1,62,000 :-
¼,d yk[k ckjlB gtkj :lk;½
¼ifjf'k"V IIF dk LrEHk 18 ½
;g jkf'k ftyk dk ,d e'r miyC/k gkxhA ftyk eyfj;k ink- dk ;g foodkf/kdkj ikIr gkxk fd o jkf'k dk mi;kx ¼fu/kkfjr nj l brj½ vko';drkulkj e[;ky; l njh d vulkj dj ldx A

5- iEi ejEefr %& fNMdko l io fNMdko e i;Dr gku oky iEik dh lfoflx@ejEefr djk;h tkrh g bl gr pVdh ok'kj] xyu lrk vkfn dh vko';drk iMrh gA bld fy, ifr ny 150 :- fu/kkfjr gA bld vfrfjDr fNMdko dh x.kork cuk; j[ku d

fy, fNMdko d nkjku iEi dk ukty Vhi cnyuk gkrk gA ukty Vhi d fy, ifr iEi 8 ukty Vhi ¼,d pØ d fy,½ 50 :- dh nj l fu/kkfjr dh xb g&

iEi ok'kj ,o ejEefr ij 0;; & **55 × 150 = 8, 250 = 00**

ukty Vhi Ø; & 1]56]800= **00**

dy 0;; **1,65,050 = 00**

¼,d yk[k ilB gtkj ipkl½

¼ifjf'k"V **IV**F LrEHk 7 8 ,o 9½

6- i;o{k.k %& fNMdko d cgrj i;o{k.k d fy, ftyk d flfoy ltu] vij e[; fp- ink- ieMy d {k= mi fun'kd ftyk eyfj;k ink- rFkk lHkh iHkkjh i[k.M fp- in- dk i;o{k.k dk nkf;Ro fn;k tk jgk gA

14 ftyk e l ek= 08 ftyk e ftyk ey- ink- inLFkkfir gA bUg 20]000 ifrekg dh nj l fNMdko d fnolk d lekuikfrd jkf'k dk vkoVu fd;k tk jgk g A

11 flfoy ltu **67,000 = 00** (tgk fNMdko 5 fnuk l de g ogk flfoy ltu dk jkf'k ugh nh xb g rFkk jkf'k 10000 @ ifrekg dh nj l fNMdko d fnuk d yxHkx lekuikfrd fn;k x;k g)

14 vij e- fp- ink- **70,000 = 00** ¼jkf'k 10000@ifrekg dh nj l fNMdko d fnuk d yxHkx lekuikfrd fn;k x;k g)

08 ftyk ey- ink- 90,**000 = 00** ¼jkf'k 20000 @ ifrekg dh nj l fNMdko d fnuk d yxHkx lekuikfrd fn;k x;k g)

iHkkfor i[k.M d fp- ink- dk ckgu gr 650 :@fnu dh nj l :Œ 1]22]200= **00**

ukV%&ftyk eyfj;k inkf/kdkjh iHkkjh fpfdRlk inkf/kdkjh dk mud i[k.M e gku oky fNMdko d fnolk e vko';drkulkj lk;o{k.k gr okgu miyC/k djk;x A

06 {k- mi fun'kd **45,000 = 00**¼jkf'k 10000 @ ifrekg dh nj l fNMdko d fnuk d yxHkx lekuikfrd fn;k x;k g)

4 {k- eyfj;k ink- **4 × 10,000** = **40,000 = 00**

bld vfrfjDr jkT; e[;ky; rFkk dUnh; Vhek d i;o{k.k gr ,d e'r jkf'k&

jkT; e[;ky; & **72, 000 = 00**

nk okgu ¼12 :@fdykehVj 200 fdykehVj vf/kdre $ 150 :- ifr jkf= foJke½

dUnh; Vhe d fy, <u>& 1,**44,000 = 00**</u>

¼nk okgu iR;d fnu½

6,50,200 = 00

dy 0;; = 6,**50,200 = 00** ¼N% yk[k ipkl gtkj nk l½

¼ifjf'k"V **IV**F LrEHk 10] 11] 12 ,o 13]14 15 16 17½

7- i;o{kh ink-@dfe;k dk nfud HkÙkk %& Mh-Mh-Vh- fNMdko e lyXu eyfj;k LFkkiuk d i;o{kh ink- ,o dfe;k dk nfud HkÙkk ¼fcgkj ;k=k HkkÙkk fu;ekoyh d vulkj½ fn;k tk,xkA bl fufeÙk 150@& :- ifr fnu ifr iHkkfor i[k.M dh nj l jkf'k ikDdfyr

dh xb g] bl jkf'k dk Hkxrku ek= dkykt kj dk; e g, 0;; d fo:) fd;k tk ldxkA

70,750 = 00 :-

¼dy 0;; lÙkj gtkj lkr lk ipkl :lk;)

¼ifjf'k"V **IVF** dk LrEHk 18½

8- l/;k dkyhu fcfQx %& dkykt kj d fo:) Mh-Mh-Vh- fNMdko d nkjku iR;d fnu] lyl ikfy;k dk;Øe e gku oky l/;kdkyhu fcfQx dh gh rjg iR;d ik- Lok- dUn ¼tgk fNMdko gk jgk g½ rFkk ftyk e[;ky; e fp- ink- rFkk fNMdko e lyXu i;o{kh dfe;k dh l/;k dkyhu fcfQx dk iLrko gA bl d fy, iR;d ik- Lok- dUn ,o ftyk e[;ky; dk fNMdko d fnuk d fy, 150 :- ifrfnu dh nj jkf'k ikDdfyr dh xb gA

dy ikDdfyr jkf'k = 2]40]450=**00**

¼ifjf'k"V **IVF** dk LrEHk 19½

9- vkb-b-lh- & fNMdko d io tu lk/kkj.k e fNMdko d Qk;n fNMdko d frfFk dh tkudkjh dh nf"V l bl en e ifr iHkkfor i[k.M #i; 500@& dh nj l jkf'k dk iko/kku fd;k x;k gA ftyk Lrjh; dk;Øe inkf/kdkjh ikLVj]bR;kfn d ek/;e l ipkj&ilkj djk;xA i[k.M fpñinkñ iHkkfor xkek e fNMdko d io <ky fiVokdj] ekbd }kjk xk"Bh dj tulk/kkj.k dk fNMdko dh frfFk dh tkudkjh nxA

iLrkfor jkf'k **108 × 500 = 54,000. 00**

¼ifjf'k"V **IVF** dk LrEHk 20½

ukHkdh; 14 ftyk e Mh-Mh-Vh- fNMdko ,o vu"kxh vU; dk;k dk ctV lkjk'kh

1-	fNMdko gr dy tul[;k	=	**2,25,750**
2-	,d pØ d fy, dy ny	=	**55**
3-	dy J- {k- dk-	=	**55**
4-	dy {k- dk-	=	**275**
5-	J- {k- dk- dh etnjh	=	**14,99,300** :-
6-	{k- dk- dh etnjh	=	**61,00,600** :-
7-	dk;ky; 0;; $ vkDlfedrk 0;;	=	**32,000** :-
8-	Mh-Mh-Vh-<ykb	=	**1,62,000** :-
9-	iEi ejEefr $ ukty Ø;	=	**1,65,050** :-
10-	lk;o{k.k	=	**650200** :-
11-	nfud HkÙkk	=	**70750** :-
12-	fcfQx	=	**240450** :-
13-	ipkj&ilkj	=	**54000** :-
	dy	=	**89,74,350** :-

¼dy uckl h yk[k pkgÙkj gtkj rhu lk ipkl½

MhOMhOVhO fNMdko ,d pd 2011&12 dk lkjk'k				
de lO	fooj.k	Hkkx 1 l?ku	Hkkx 2 ukHkdh;	dy ;kx
1	fNMdko gr dy tul[;k	29068816	225750	29294566
2	,d pØ d fy, dy ny	1599	55	1654
3	dy J- {k- dk-	1599	55	1654
4	dy {k- dk-	7995	275	8270
5	J- {k- dk- dh etnjh	**13911300**	**1499300**	15410600
6	{k- dk- dh etnjh	56604600	**6100600**	62705200
7	**etnjh ;kx**	70515900	7599900	78115800
8	cdk;k etnjh	2000000	0	2000000
9	dk;ky; O;; $ vkDlfedrk O;;	824500	32000	856500
10	Mh-Mh-Vh-<ykb	871500	162000	1033500
11	gFkyu fopyu	500000	**0**	500000
12	iEi ejEefr $ ukty Ø;	**1519050**	**165050**	1684100
13	lk;o{k.k	11734000	650200	12384200
14	nfud HkÙkk	498000	70750	568750
15	fcfQx	2403000	240450	2643450
16	ipkj&ilkj	498000	54000	552000
	dy ;kx	91363950	8974350	100338300
	nk pd d fy, dy ;kx		:lk;	198676600

:lk; mUuhl djkM fN;klh yk[k fNgÙkj gtkj N% lk ek=

mipkjkRed [k.M

dkykrkj d fu;=.kkFk fd, tku oky leLr dk;k dk fujk/kkRed ,o mipkjkRed dk; e foHkkthr fd;k tkrk g A fujk/kkRed dk; vrxr iHkkfor {k=k e MhñMhñVhñ fNMdko ,o vU; vu"kxh dk; vkr g A tcfd mipkjkRed dk; vrxr ihfMrk dh [kkt mudk lEi.k mipkj ,o vU; vu"kxh dk; vkr g A fujk/kkRed dk; dk enokj ctV ikDdyu fujk/kkRed [k.M e fd;k x;k g A mipkjkRed ,o vU; vu"kxh dk; dk ctV ikDdyu 'kh"kokj fuEuor g%&

¼1½ **ikRlkgu jkf'k** % &

dkykrkj fu;=.kkFk ;g vko';d g fd loiFke ;g ekye gkuk pkfg, fd jkT; e ihfMrk dh l[;k fdruh g ik;% ;g n[kk tkrk g fd lHkh jkxh dfri; dkj.kk l ljdkjh lLFkkuk e fpfdRlk ugh djk ikr g ;k vkr g rk fpfdRlk d nkjku gh py tkr gA bld ihN ihfMrk dk feyu okyh ljdkjh lfo/kkvk ,o jkx d ifr vKkurk e[; dkj.kk e l ,d g A io l ihfMrk dh [kkt ,o mud lEi.k fpfdRlk d mijkUr vk'kk dk;drkvk dk 100 :lk; ifr ihfMr dh nj l jkf'k Hkxrku dk iko/kku g A bl okj vk'kk dk;drkvk dk ;{ek dk;de d **MkV** uhfr d leku dkykrkj jkfx;k dk Hkh nok f[kyku dh uhfr viuku dk iLrko g A vr,o 100 :lk; ifr ihfMr ikRlkgu jkf'k dk blckj c<kdj 200 :lk;k ifr ihfMr dju dk iLrko g A

iLrkfor jkf'k & ,d frgkb dkykrkj jkfx;k dh l[;k X 200 ¾
7106 X 200 ¾ 14]21]200@&
¼ifjf'k"V V LrHk 6 n"V0;½

tgk rd Hkkjr ljdkj Qeyh odj dk ikRlkgu jkf'k nu lc/kh iLrko nu dk l>ko g] rk bl fufer vk'kk dk;dÙkk dk ikRlkgu jkf'k nu dk iko/kku ctV e fd;k x;k gA bld vfrjDr vU; Health activist }kjk dkykrkj d lEHkkfor jkxh yk; tku ij jkxh dk dkykrkj jkx lEi"V gku d mijkUr i.k fpfdRlkijkUr ikRlkgu jkf'k fn;k tk;xkAjkf'k dh x.kuk e ;g ekuk x;k g fd jkT; e dy ifrofnr dkykrkj jkfx;k e l ,d frgkb jkfx;k dh [kkt vk'kk cguk d }kjk fd;k tk;xkA

¼2½ **{kfrifrl jkf'k** % &

dkykrkj d vf/kdk'k jkxh xjhc ox d gkr g] tk etnjh dj viuk thou fuokg djr gA ,l ykx >Xxh&>kiMh e lnj ngrh bykdk e jgr g] tgk l bykt gr ljdkjh vLirkyk e vku e dfBukb d vfrjä bykt djku d fy, ljdkjh vLirky e fpfdRlk d nkjku 20&30 fnuk rd jguk iMrk gA ftll mudk nfud etnjh ckf/kr gk tkrk g vkj mUg vkfFkd ldV dh nkgjh ekj gk tkrh gA nfud etnjh rk ugh feyrh] vyx l bykt ij Hkh 0;; gk tkrk gA ifj.kkeLo:lk dkykrkj d ,l jkxh ljdkjh lLFkkuk e fpfdRlk vof/k ¼vf/kdre 30 fnu½ rd Je {kfrifr jkf'k nh tkrh g A io e ;g jkf'k 50 :l; ifr fnu dh nj l Hkxr; Fkh Ablckj bl c<kdj 100 :lk; dju dk iLrko g A mYy[kuh; g fd fcgkj e U;ure etnjh nj lEifr 118 :lk; ifrfnu g A

iLrkfor jkf'k & ifrofnr dkykrkj jkfx;k dh l[;k × fpfdRlk vof/k × {kfrifr jkf'k
¾21]318X30X100¾Rs. 6]39]54]000@& ¼ifjf'k"V V LrHk 7 n"V0;½

¼3½ dk;ky; 0;;%&

fNMdko d pkj ekg ¼Qjojh&ekp ,o vihy&eb½ d vfrjDr o"k d vkB ekg d nkjku ftyk Lrj ij dkykrkj fu;=.kkFk fd; tku oky dk;k e ;Fkk dk;;ktuk cukuk]lh0Mh0]QDl]bR;kfn dk;k e dk;ky; 0;; gkrk gA bl gr iR;d ftyk dk mud iHkkfor i[k.Mk d vulkj 2000@&:0@i[k.M dh nj l ,d eLr jkf'k dk iko/kku fd;k tk jgk gA

iLrkfor jkf'k&357X2000¾7]14]000
ftykokj fooj.kh ifjf'k"V V LrHk 9

¼4½ **i;lo{k.k %** &

dkykt kj d fu;=.k e i;o{k.k ,d egRoi.k fgLl k gA ;fn ij o"k e fty k Lrj ,o i[k.M Lrj l l{ke i;o{k.k fd;k tk, rk dkykt kj d fu;=.k dk y{; ikIr fd;k tk ldrk gA io{k.k d rgr MhñMhñVhñ fNMdko] jkfx;k dk fpfdRlk] vuJo.k] ifronuk dk lle; i"k.k bR;kfn vkr gA nk pØ MhñMhñVhñ fNMdko vof/k vFkkr 4 ekg d io{k.k dk ctV iko/kku vkbñvkjñ ,l ñ d rgr fd;k x;k gA o"k 'k"k 8 ekg d io{k.k gr mipkjkRed dkjokb e iko/kku fd;k tkuk gA i;o{k.k dk nkf;Ro fty k Lrj ij fty k dk;Øe inkf/kdkjh ,o i[k.M Lrj ij i[k.M fpfdRlk inkf/kdkjh dk gA jkT; d 32 dykt kj iHkkfor fty k e ek=k 21 fty e gh fty k eñinkf/kdkjh dk in lftr g 'k"k 11 fty k bUgh fty k eyfj;k inkf/kdkjh d v/khu vkr gA lQy io{k.k dh nf"V l iR;d fty k e ,d fty k Lrjh; i;o{kh inkf/kdkjh gkuk pkfg,A bl fufer 21 fty k d i;o{k.k dk nkf;Ro fty k eyfj;k inkf/kdkjh dk] 9 fty k d vij e[; fpfdRlk inkf/kdkjh dk rFkk 'k"k nk fty ¼[kxfM;k vkj e/kijk½ d flfoy l tu fn;k tk jgk gA

[kxfM;k rFkk e/kijk fty k d flfoy l tu bl en dh jkf'k dk mi;kx xkMh d b/ku ij djx ftu fty k d vij e[; fpfdRlk inkf/kdkjh d ikl xkMh miyC/k g o :i; 3000@& ifrekg dh nj l b/ku ij 0;; djxA ftu fty k e xkMh miyC/k ugh g o 10]000@& dh jkf'k HkkM dh xkMh ij 0;; djxA

fNMdko vof/k ¼pkj ekg½ e io{k.k d fy, jkf'k dk iko/kku ly Xu ifjf'k"V IV e fn;k x;k gA 'k"k vkB ekg d fy, jkf'k dk iko/kku ly Xu ifjf'k"V V e fd;k x;k gA ifjf'k"V V d LrHk10 e flfoy l tu e/kijk ,o [kxfM;k dk 3]000@& ifr ekg dh nj l ifjf'k"V V d LrHk 11 e vij e[; fpfdRlk inkf/kdkjh ¼vjfj;k] vjoy] ckdk] cDlj] tgkukckn] fd'kuxt] y[khljk;] f'kogj ,o liky½ dk #i; 10]000@& #i; ifr ekg dh nj l rFkk 'k"k 20 fty k d fty k eyfj;k inkf/kdkjh dk #i; 10]000@& ifrekg dh nj l jkf'k dk iko/kku fd;k x;k g lkFk gh iHkkjh fpfdRlk inkf/kdkfj;k d lg;kx l ikFkfed LokLF; dUn d {kk e 'kr&ifr'kr fNMdko lfuf'pr djxA

iLFkkfor jkf'k bl idkj g%&

¼d½ nk flfoy l tu dk :- 3000@& ifrekg dh nj l 9 ekg d fy;

3000 x 2 x 8 = 48000.00

¼[k½ 9 fty k d vij e[; fpfdRlk inkf/kdkjh dk ,o 21 fty k d fty k eyfj;k inkf/kdkjh dk 8 ekg d fy; :- 10000@& ifrekg dh nj l %&

10000 x 30 x 8 = 24,00,000-00

dy ;kx %& 24,48,000-00

dk vkdyu ifjf'k"V V LrHk 10]11 n"V0;½ e fd;k x;k gA

¼5½ **dykt kj dh nok ,EQkVjh lhe ohñ dk HkMkj.k 0;oLFkk %** &

dykt kj jkfx;k d fpfdRlk gr Hkkjr ljdkj }kjk ,l ñ,l ñth ñ ,EQkVjh lhu oh0 nok dh vkifr dh tkrh gA ,EQkVjh lhu nok dk ,d fuf'pr rkiØe ½2 l 8° C½ ij j[kk tk tkuk g] vU;Fkk nok dh {kerk d gkl gku dh l Hkkouk gA fu/kkfjr rkiØe ij nok HkMkj.k d fy, 'khr J[kyk@'khrxg gh mi;ä gA

ftu fty k e 'khr J[kyk miyC/k g mu fty k d flfoy l tu nok dk 'khr J[kyk e j[kxA ftu fty k e 'khr J[kyk miyC/k ugh g mu fty k e 'khr xg ¼Cold Storage½ e nok j[ku dk iLrko gA bl fufer iR;d fty dk mä nok HkMkj.k gr ¼'khr J[kyk miyC/k ugh jgu ij dkYM LVkjt HkkM ij yu gr½ #i; 500@& ifrekg dh nj l ,d o"k d fy, jkf'k dk iko/kku fd;k x;k gA jkT; Lrj ij ¼jkT; dk;Øe inkf/kdkjh½ Hkh mä nok d HkMkj.k gr 'khr xg dh vko';drk g] ft ld fy, #i; 1500@& ifr ekg dh nj l jkf'k dk iko/kku fooj.kh V LrHk 12]13 e e fd;k x;k gA

iLrkfor jkf'k &

¼1½ fty k Lrj ij HkMkj.k gr #i; 500 @& ifrekg dh nj l ,d o"k d fy, 31 X 500X 12 ¾ #i; 1]86]000@&

¼II½ jkT; Lrj ij HkMkj.k gr #i; 1]500 @& ifrekg dh nj l ,d o"k d fy, 1]500 X 12 ¾ #i; 18]000@& ¼vko';drkulkj½

¼ifjf'k"V V LrHk 12]13 n"V0;½

6- **fpfdRlk dkM** % &

dkyktkj jkfx;k d fpfdRlk d Øe e nh tkuokyh nok d [kjkd dk y[kk&l/kkj.k ,o fpfdRlk C;kjk d fy, fpfdRlk dkM dk mi;kx fd;k tkuk vko';d g oreku e fpfdRlk dkM dk mi;kx ftyk Lrj d vLirky l ydj i[k.M Lrj ij ugh fd;k tk jgk g] ftld dkj.k rduhdh eY;kdu e dfBukb gkrh gA 'kh"k Lrj ij Hkh fpfdRlk dkM l/kkj.k ugh fd; tku ij fprk trkb xb gA

vr% fpfdRlk dkM d mi;kx dh egÙkk dk n[kr g, ifr jkxh 2 idkj d dkM dh fu;ekulkj vko';drk gkxhA ,d dkM dh Nikb e vuekfur #i; 5-00@& 0;; gkxkA bl rjg ,d ¼,d jkxh d fy, nk dkM d fglkc l ½ ifr jkxh ij 10-00@& #i; 0;; gkxkA ifjf'k"V V LrHk 13 e o"k 2009 d lHkkfor jkfx;k dh l[;k d vulkj LrHk 12 e ftykokj jkf'k dk vkdyu fd;k x;k gA

iLrkfor jkf'k & #i; 2]13]180@&

¼ifjf'k"V V LrHk 14 n"V0;½

7- dkyktkj jkfx;k dk lpuk l/kkj.k ith % &

dkyktkj jkfx;k d foLrr lpuk d l/kkj.k ,o nfud Je {kfrifr fd jkf'k l/kkj.k gr iR; dkyktkj iHkkfor i[k.M e nk jftLVj j[ku dk iko/kku fd;k x;k g rkfd 'kh"k Lrj d inkf/kdkjh }kjk Hke.k d nkjku jkfx;k dh foLrr lpuk ,o nfud Je {kfrifr jkf'k dk eY;kdu fd;k tk ldA bl fufer iR;d dkyktkj iHkkfor fty d dkyktkj iHkkfor ik- Lok- dUn dk nk jftLVj ¼,d ftLrk dk½ vuekfur dher #i; 100@& ¼pkj jftLVj½ dh nj l jkf'k dk vkdyu fd;k x;k gA

iLrkfor jkf'k & 32 ftyk d dkyktkj iHkkfor ik- Lok- dUn dh l[;k × nj 357X100 ¾35]700@& ¼ifjf'k"V V LrHk 15 n"V0;½

8- MhñMhñVhñ dk Hk.Mkj.k % &

MhñMhñVhñ fNMdko d fy, Hkkjr ljdkj }kjk ftyk e MhñMhñVhñ dh vkifr dh tkrh gA ftyk e MhñMhñVhñ d Hk.Mkj.k dh lefpr 0;oLFkk ugh jgu d dkj.k MhñMhñVhñ {kfrxLr ¼/ki ,o ikuh l½ gku dh lHkkouk gA lefpr Hk.Mkj.k 0;oLFkk dk eíutj j[kr g, ;k rk Hk.Mkj] HkkM ij fy;k tk; ;k ftyk d miyC/k jkT; HkMkj fuxe d xknke e j[kk tk;A

Pkfd ftyk dk HkkM ij HkMkj yu e fu;ekulkj i'kklfud Lohdfr yu e dkQh dfBukb gkrh gA Qyr% tc rd HkMkj.k dh 0;oLFkk ugh gkrh gA rc rd MhñMhñVhñ dk ;=&r= j[kuk iMrk gA bl fufer HkkM ij xknke yu vFkok jkT; HkMkj fuxe ¼ftldk nj ljdkj }kjk vuekfnr g½ d xknke e HkMkj.k gr ifr ftyk ifr ekg #i; 5]000@& dh nj l ij o"k d fy, jkf'k dk iko?kku fd;k x;k gA

iLrkfor jkf'k & 31X 5000X 12 ¾ 18]60]000@&

¼ifjf'k"V V LrHk 16 n"V0;½

9 dkyktkj [kkt dEi ekM &

dkyktkj i[kokjk d cny dEi ekM e jkfx;k d [kkt dju dk iLrko gA bl fufeÙk iR;d dkyktkj iHkkfor fty d i[k.M e ifrekg ,d fnu dkyktkj jkfx;k dk fo'k"k [kkt dk; djk;k tk;xkA

iR;d dEi e de l de pkj xkek dk 'kkfey fd;k tk;A bl [kkt dk;Øe d lpkyu d fy, iR;d dkyktkj iHkkfor ftyk d i[kMk e iR;d ekg e ,d fnu dEi d fy, okgu gr 750@& ifrfnu dh nj l jkf'k dk iko/kku gA ;g dk;Øe foÙkh; o"k 2011&12 d vkB ekg ¼Qjojh&ekp dk NkMdj½ djk;k tk;xkA

iLrkfor jkf'kk& **397 x 8 x 750 = 23]82]000-**

iR;d dEi d fy, ,d dEi ckDl ,o 5 ouj dk iko/kku j[kk x;k g bl gr 1000@:0 ckDl ,o 150@:0 ifr ouj jkf'k x.kuk dh xb gA

397X **1750 =694750**

dEi d ipkj ilkj d fy, vxy&cxy d xkek e ekbfdx fd;k tkuk gAbl gr 500@:0 ifr dEi@ik0 Lok0 dUn rFkk dEi oky fnu **250:**0@dEi@ik0 Lok0 dUn tyiku gr j[kk x;k gA

397 x 750 x 8 = 23]82]000

¼ifjf'k"V V LrHk 17 18 19 n"V0;½

10- Li'ky QM liyheUV %&

vf/kdk'k dkykt kj ihfMr xjhc J.kh d ykx gkr g vkj dikf"kr gkr g A dik"k.k d dkj.k mud ifrjk/kh {kerk dk gkl gvk jgrk g A Qyr% nokvk d ifr mudk lonu de gkrk g A iLrko g fd iR;d dykt kj ihfMr dk fpfdRlk vof/k ¼30 fnu½ rFkk Bhd gku d ckn 15 fnuk rd Li'ky QM liyheUV fn;k tk, A ,d Li'ky QM liyheUV dk eY; 35 :Ik; vuekfur fd;k x;k g A

dykt kj ihfMrk dh l[;k **x 35 x 45** fnu

21318 x 35 x 45 = 33575850.00

¼ifjf'k"V V LrHk 8 n"V0;½

mipkjkRed [k.M dk ctV lkjk'k %&

1-	ikRlkgu jkf'k &	14]21]200@& ftyk eyfj;k inkñ dk
2-	nfud Je {kfrifr jkf'k	6]39]54]000@& rFko
3-	dk;ky; 0;;	7]14]000@
4-	lko{k.k	24]48]]000@& rFko
5-	nok dk Hk.Mkj.k	2]04]000@& rFko
6-	fpfdRlk dkM	2]13]180@& ftyk eyfj;k inkñ dk
7-	lpuk l/kkj.k ith	35]700@& rFko
8-	MhñMhñVhñ dk HkMkj.k	18]60]000@& rFko
9-	dykt kj [kkt	54]58]750@&
10-	Li'ky QM liyheUV	3]35]75]850@& iHkkjh fp0 ink0 dk
	dy ;kx%	**10,98,84,680@&**

¼ifjf'k"V V n"V0;½

(x) jkT; Lrjh; dEikuUV % ¼jkT; dk;Øe inkf/kdkjh dk;ky; d fy,½

1- jkT;Lrj ij cBd vk;kt u %&

dk;Øe d lpkyu e ftyk eyfj;k inkf/kdkjh d lkFk leh{kkRed cBd djuk vko';d gkrk g A cBd e dk;Øe d lc/k e ftykokj foLrr leh{kk dh tkrh g rFkk dk;Øe d lpkyu d lc/k e vxrj dkjokb gr Hkh fn'kk fun'k r; fd;k tkrk g A bld vfrfjDr jkT; Lrj ij fo'k"kKk dh cBd Òh vkgr dh tkrh gA ,lh cBdk dk le;≤ ij vk;kt u vko';d gkrk gA bu cBdk d ek/;e l dk;uhfr e l/kkj rFkk ,Mokdlh "h dh tkrh gA ,lh cBdk d fy, vfrfjDr 1,10,000:0 dk iko/kku fd;k t k jgk gA

jkT; Lrj ij o"k e de l de N% ckj cBd vk;kftr dju dk iLrko g A iR;d cBd e **Rs.15,000/-**0;; gku dh lHkkouk g A bl fufer jkf'k dk iko/ku ctV e fd;k x;k g A

iLrkfor jkf'k ----------	6 × 15,000 ----------	Rs. 90,000/-
----------	2× 55,000----------	Rs. 1,10000/-
		Rs. 2,00000/-

fooj.kh VI,

2- bUVjuV lfo/kk ,o dE;Vj d;%&

jkT; e[;ky; Lrj ij inkf/kdkjh gr nk yiVki ¼ipkl gtkj dh nj l ,d yk[k :Ik;½dk;de d lpkyu gr ,d MkLd Vki iPkkl gtkj :Ik; dk pkj ytj fiVj pkj {k=h; eyfj;k dk;ky; gr ¼12500 X 4¾50000 :Ik;½ ckMcUM ,o MVk dcy d d; gr 15000 :Ik; ,o bUVjuV gr ekfld 0;; jkf'k 50]000 dk iko/ku j[kk x;k gA

iLrkfor jkf'k---------- Rs.2, 65,000/-

fooj.kh VI,

3- **ekckby Qku%&**
dkykt kj dk; dh lxerk ,o depkjh ink- d chp lh/kk lEid dh nf"V l ekckby Qku d ifrekg diu ij gku oky 0;; ij ifr ekckby Rs. 600/ dh nj l 12 ekg d jkf'k dk iLrko gA
iLrkfor jkf'k &
ekckby ij ekfld 0;;------ 10 × 600 × 12 ------ Rs.72,000/-
dy Rs. Rs.72,000//-

fooj.kh VI,

4- **Ik;o{k.k%&** jkT; Lrj ij jkT; dk;de inkf/kdkjh dk;ky; e inLFkkfir rhu inkf/kdkfj;k }kjk fty dk vuJo.k ,o Ik;o{k.k fd;k tkuk g A bld vfrfjDr le;≤ ij dUnh; Vhek }kjk Hkh jkT; d fofHkUu fty dk Hke.k fd;k tkrk g A jkT; e[;ky; e ,d xkMh miyC/k g tk ijkuh gA vr,o HkkMk ij xkMh dh 0;oLFkk djuh gkxh ,o miyC/k xkMh dh ejEefr Hkh djkuh gkxh A bld fy, iLrkfor jkf'k
jkT; Lrjh; inkf/kdkjh $ dUnh; Vhek d fy, ckgu 0;oLFkk & 3]00]000@&
{k=h; eyfj;k ink0 d fy, &3]20]000@&
dy Rs. 6,20,000/-

5- jkT; e[;ky; dk lnf<dj.k ,o dkYM pu :e dh 0;oLFkk &jkT; e[;ky; d lnf<dj.k d fy, dfe;k d fy, Voy dlh dYdyVj tujVj b/ku gr jkf'k dh vko';drk gA nokvk d HkMkj.k d fy, ,d dkYM pu :e dh 0;oLFkk dh vko';drk gA bl gr :e d fy, pkj ,lh ¼nk Vu ifr dk½ dh vko';drk gkxhA
dy jkf'k & **1200000@&** :Ik; 0;; gku dh lHkkouk gA

6 ipkj& ilkj %& jkT; e[;ky; e ipkj ilkj ;Fkk ouj]ikLVj] gMfcy] nhoky y[ku] njn'ku ,o jfM;k ij ipkj io lpuk dkM rFkk v/;;u lkexh dh Nikb gr
& 500000

fooj.kh VI,

fooj.kh VI,

jkT; Lrjh; dEikuUV dk ctV lkjk'k %&

1- cBd (jkT; Lrjh;)	----------	Rs. 2,00,000/-
2- bUVjuV lfo/kk$ dEI;Vj d;	----------	Rs. 2,65,000/-
3- Ik;o{k.k okgu	----------	Rs. 6,20,000/-
4- ekckby Qku	----------	Rs. 72,000/-
5- jkT; e[;ky; dk lnf<dj.k ,o dkYM pu :e&		Rs.12,00,000/-
6- ipkj& ilkj	&&&&&&&&	Rs.500000/&
dy;kx		Rs. 28,57,000/-

fooj.kh VI

(?k) **if'k{k.k** & dkykt+kj Elemination y{; 2015 dh ikfIr dh nf"V l jkT; d lHkh Lrj d LokLF; foHkkx e inLFkkfir fp- inkf/kdkfj;k] eyfj;k ;ktuk e dk;jr lHkh Lrj d ikjk efMdy dfe;k dk if'k{k.k vko';d irhr gkrk g rkfd fujk/kRed ,o mipkjkRed dkjokb e mudk lfØ; lg;kx fey ld A bld vfrfjDr LokLF; lox d dN vU; ikjk efMdy dfe;k ipk;fr jkT; d lnL;k ,o cgnf'k; dk;dUkk (vk'kk) Hkh fujk/kkRed ,o mipkjkRed dkjokb d fy, if'kf{kr djuk vko';d irhr gkrk gA

bl nf"V dk.k lHkkjr ljdkj }kjk fn; x; fn'kk fun'k d vulkj if'k{k.k dk;Øe dh :ij[kk r;kj dh xb g] ftl lyXu ifjf'k"V VII e n[kk tk ldrk g A ifjf'k"V VII e ftykokj eyfj;k ;ktuk ljdkjh vLirky d fpfdRldk ,o vU; LokLF; lEox d ikjk efMdy dfe;k ipk;rh jkT; d lnL;k d if'k{k.k dk ctV ikdyu r;kj fd;k x;k g A if'k{k.k iLrko foLrr fooj.k bl idkj g &

1- **eyfj;k fujh{kdk dk if'k{k.k&**

jkT; d 31 dkykt+kj iHkkfor ftyk e dy 114 e- fu- dk;jr g A bl o"k 80 eyfj;k fujh{kdk dk if'k{k.k fn;k tk;xk A 20 eyfj;k fujh{kd ifr op dh nj l dy nk fnolh; 4 op if'k{k.k vk;kftr fd;k tk;xk A ifr op 69500 :0 0;; vuekfur gA vof/k 2 fnuk dh gkxh A

,d cp d if'k{k.k ij dy 0;; 69,500/- :- gkxkA

bl rjg ij o"k e 4 cp dk if'k{k.k ij dy 0;;

4 × 69, 500/---------- Rs. 278000/-

(ifjf'k"V VII LrEHk 4 n"V0;)

2- **cfu;knh Lok- fujh{kd ,oa fuxjkuh fujh{kd%&**

jkT; d 31 dkykt+kj iHkkfor ftyk e eyfj;k ;ktuk d 118 cfu;knh Lok- fujh{kd ,o 18 fuxjkuh fujh{kd dk;jr g A bl o"k 100 if'k{k.kFkh dk if'k{k.k fn;k tk;xkA 25 ifr op dh nj l nk fnolh; 4 op dk vk;ktuk fd;k tk;xk ;g if'k{k.k nk fnuk dk gkxk A if'k{k.k ij ifr op 30,000 :- 0;; dk iLrkfor g A

iLrkfor jkf'k----------4 × 30, 000 ---------- Rs. 1,20,000/-

(ifjf'k"V VII LrEHk 7 n"V0;)

3- **Lok- dk;dÙkkZ dk if'k{k.k&**

jkT; d eyfj;k ;ktukUrxr 31 dkykt+kj iHkkfor ftyk e dy 103 cfu;knh Lok- dk;dÙkkZ] 33 fuxjkuh dk;dÙkkZ] 43 {k=h; dk;dÙkkZ rFkk 19 J- {k- dk;dÙkkZ dk;jr gA bl o"k dy 125 dk;dRrk dk if'kf{kr fd;k tkuk g A 25 if'k{k.kFkh ifr op dh nj l 5 op e if'k{k.k fn;k tk;xkA if'k{k.k vof/k nk fnuk dh gkxh A if'k{k.k ij ifr op 30,000/- :- 0;; gkxk

iLrkfor jkf'k & 30,000 × 5 Rs. 150,000/-

(ifjf'k"V VII LrEHk 12 n"V0;)

4- **fpfdRlk ink- dk if'k{k.k&**

jkT; d 31 dkykt+kj iHkkfor ftyk e ik0 Lok0 dUn Lrj ij dk;jr 1 fpfdRlk ink0]iR;d fpfdRlk egkfo|ky;] ljdkjh vLirky lnj vLirky l 2&2 fp0 ink0 ,o jQjy vLirky ,o vue.Myh; vLirky l 1&1 fpfdRlk ink0 dy 559 fp0 ink0 dk if'kf{kr fd;k tkuk g bl o"k dy 125 fp0 ink0 dk if'kf{kr fd;k tkuk gA 25 ifr op d nj l 3 fnolh; 5 op if'k{k.k vk;kftr fd;k tk;xkA if'k{k.k vof/k rhu fnuk dh gkxh ,d op d if'k{k.k ij dy 1,20,000/- :- 0;; iLrkfor g A

fp- ink- d if'k{k.k dy iLrkfor 0;; 5 × 1,20,000 = Rs. 6,00,000/-

(ifjf'k"V VIII LrEHk 9 n"V0;)

5- **ipk;rh jkT; d lnL;k dk if'k{k.k&**

jkT; e ipk;rh jkT; d ykx gk tku l bld lnL;k dk ljdkjh dk; d n[k&j[k dk nkf;Ro fn;k x;k A dkykt+kj d djhc 90 ifr'kr jkxh xkek l gh vkr g vr% ipk;r Lrj d lnL;k dk dkykt+kj d fujk/kkRed ,o mipkjkRed dkjokb l :&c&: voxr djku dh nf"V

l if'k{k.k dk iLrko fn;k tk jgk g A lyXu ifjf'k"V VII d LrHk 6 e ipk;rh jkTk d lnL;k dk ftyokj vkdMk fn;k x;k g bl o"k 8900 ipk;rh lnL;k dk if'k{k.k nuk gA bl gr 50 lnL; ifr op dh nj l 178 op dk vk;ktu djuk gA ifr op 2000@&dk 0;; fu/kfjr gA

iLrkfor 0;; 178 × 2000 ---------- Rs. 3,56,000/-

(ifjf'k"V IX LrEHk 6 n"V0;)

6- fNMdko dfe;k dk if'k{k.k %&

fNMdko dk; e 1654 J0{k0 dk;drk rFkk 8270 {k0dk;drk lyXu gkx A bUg fNMdko 'k: gku d ,d fnu io lcf/kr ikFkfed Lok0 dUn ij fNMdko rduhd lc/kh if'k{k.k fn;k tk;xkA if'k{k.k d fnu d fy, bUg ;Fkk ;kX; ,d fnu dk ikfjJfed n; gkxk tk etnjh en l Hkxr; gkxkA if'k{k.k gr LFky]n'; J0; ek/;e ¼;Fkk VhOHkh0 ekbd vkfn½ dh 0;oLFkk gr ifr 50 deh ,d cp dh nj l 2000 :0 vfrfjDr 0;oLFkk dh tk jgh g A dy 199 cp dk vk;ktu fd;k tk;xkA

iLrkfor jkf'k%& 199x2000= 398000=00

(ifjf'k"V XA LrEHk 5

7- **cgíf'k; dk;dÙkk@]vk'kk dk if'k{k.k%&**

dk;Øe d lpkyu e vk'kk dk;dÙkk dk Hkh 'kkfey fd;k x;k g A vr% dkyktkj d mipkjkRed dkjokb d lc/k e if'k{kr fd;k tkuk g A ifjf'k"V X d LrEHk 6 e ftykokj vk'kk dk;dÙkk dh l[;k n'kk;h xb g A bl o"k 25000 vk'kk dk;drkvk dk if'k{k.k fn;k tk;xkA if'k{k.k gr ftyk eyfj;k ink0 ol i[k.Mk e inLFkkfir vk'kkvk dk ikFkfedrk nx tgk dkyktkj T;knk gA 50 vk'kk ifr op dh nj l 1 fnolh; 500 op if'k{k.k vk;kftr fd;k tk;xkA ifr op 2000@& 0;; fu/kfjr gA

dy iLrkfor 0;; -- - 500 × 2000 -------- Rs. 10,00,000/-

(ifjf'k"V XA LrHk 7 n"V0;)

if'k{k.k ij dy 0;; dk lkjk'k

1- eyfj;k fujh{kd	----------	Rs. 2,78,000/-
2- c-Lok- fu- ,o fu- fu-	----------	Rs. 1,20,000/-
3- Lok- dk;dÙkk	----------	Rs. 1,50,000/-
4- fp- ink-	----------	Rs. 6,00,000/-
5- ipk;rh jkt	----------	Rs. 3,56,000-
6- fNMdko deh	----------	Rs. 3,98,000/-
7- cgíf'k; dk;Ùkk (vk'kk)	----------	Rs. 10,00,000/-
dy		Rs. **29,02,000/-**

(ifjf'k"V XB n"V0;)

DBS **ctV dk lkjk'k**

[k.M d	&fNMdko dk;kUo;u¼l?ku$Qkdy½	&	Rs. 19,86,76,600=00
[k.M [k	& mipkjkRed dkjokb	&	Rs. 10,98,84,680=00
[k.M x&	jkT; e[;ky; dEikuUV&		Rs. 28,57,000=00
[k.M ?k&	if'k{k.k	&	Rs. 29,02,000 = 00
	dy		**Rs. 31,43,20,280=00**

oYM cd [k.M

¼1½ekuo lalk/ku&	**4]13]46]000**
¼2½dfilhVh fofYMx&	**37]10]000**
¼3½ekchyhVh&	**59]54]400**
	5]10]10]400
DBS **ctV + oYM cd [k.M &**	**36]53]30]680@&**

State- Bihar, Budget Plan 2010-11 **District Infrastructure of Kala-Azar Affected Districts** **Anexure - I-**

Sl. No.	Name of Districts	Total No. of							Total No. of Affected					
		PHC	HSC	Block	Panchyat	Revenue Village	Urban Ward	Population	PHC	HSC	Panchyat	RevenueVillage	Ward	Population
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	**Araria**	9	109	9	221	757	54	2,940,061	9	88	189	518	0	2,222,962
2	**Darbhanga**	15	306	19	315	1517	48	3,736,220	15	206	192	492	0	1,688,211
3	**E.Champaran**	20	318	27	387	1716	20	4,949,859	20	280	302	686	0	2,758,170
4	**Gopalganj**	14	186	14	234	1499	12	2,465,871	14	107	0	315	0	938,807
5	**Katihar**	18	257	16	238	1737	45	2,762,445	18	192	0	582	0	1,334,615
6	**Khagaria**	7	193	7	129	306	18	1,611,914	6	0	0	119	0	358,023
7	**Madhepura**	13	272	13	170	838	41	1,906,056	13	139	0	294	0	1,446,588
8	**Madhubani**	18	430	21	452	1072	75	4,293,826	18	301	294	366	0	1,806,247
9	**Muzaffarpur**	16	527	16	387	1937	49	4,689,244	16	444	370	1138	0	2,690,606
10	**Purnea**	14	151	14	252	1075	69	3,215,359	14	107	219	764	27	2,375,268
11	**Saharsa**	10	152	10	164	475	43	1,882,199	10	130	140	436	0	1,672,656
12	**Samastipur**	20	354	20	329	1250	61	4,275,362	20	331	329	568	0	1,799,987
13	**Saran**	16	413	20	0	1813	0	3,650,743	16	413	0	597	0	1,538,939
14	**Sheohar**	5	0	5	54	207	15	0	5	0	0	48	0	218,828
15	**Sitamarhi**	13	0	17	273	846	79	3,094,216	13	186	212	524	38	1,944,860
16	**Siwan**	19	370	16	293	1458	51	3,329,983	18	227	0	431	0	1,317,809
17	**Supaul**	11	178	11	180	511	0	2,023,654	8	101	0	214	0	747,846
18	**Vaishali**	16	339	16	292	1680	45	3,341,702	16	0	278	720	0	2,208,394
		254	**4,555**	**271**	**4,370**	**20,694**	**725**	**54,168,713**	**249**	**3,252**	**2,525**	**8,812**	**65**	**29,068,816**

District Infrastructure of Kala-Azar Affected Districts FOCAL/Hot spot spray 11-12															Anexure - I
Sl. No.	Name of Districts	Total No. of							Total No. of Affected						
		PHC	HSC	Block	Panchyat	Revenue Village	Urban Ward	Population	PHC	HSC	Panchyat	Village	Ward	K.A Cases-2009	Population(50 house Around Each case 5 persons in each house)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	15
1	Arwal	4	64	0	0	335	0	651,717	4	15	8	18	0	2	500
2	Banka	10	0	11	185	1681	40	2,000,889	2	1	1	4	0	2	500
3	Begusarai	11	288	18	257	1064	36	2,767,787	11	179	178	283	0	272	68,000
4	Bhagalpur	11	280	17	242	1929	62	2,948,451	8	112	0	174	0	47	11,750
5	Bhojpur	12	304	14	228	1457	100	2,536,179	9	64	0	71	0	7	1,750
6	Buxar	7	167	11	142	993	60	1,458,493	2	50	0	244	0	50	12,500
7	Jehanabad	7	81	12	161	947	52	1,029,742	6	8	8	15	0	19	4,750
8	Kishanganj	7	79	7	129	761	28	1,634,220	7	36	64	129	0	128	32,000
9	Lakhisarai	4	102	7	80	496	18	959,511	2	19	19	28	18	3	750
10	Munger	9	136	9	101	837	81	1,349,751	5	21	30	46	8	40	10,000
11	Nalanda	20	0	20	249	1183	122	0	16	98	0	107	0	13	3,250
12	Nawada								1	1	1	1	1	61	15,250
13	Patna	23	418	23	332	1408	72	4,062,216	22	242	0	398	0	133	33,250
14	W.Champaran	16	369	18	315	1606	121	3,147,569	13	145	132	357	0	126	31,500
Total		141	2,288	167	2,421	14,697	792	24,546,525	108	991	441	1,875	27	903	225,750

State-Bihar,Budget Plan 2010-11	Dist. Wise Sqad,DDT,Wages,Office Exp.,Contigency,Transportation of DDT For Kala Azar Spray One Round																		Annexure -II
Sl. No.	Name of Districts	Total No. of Affected		Total No. of Sqad (55 Sqad /10 Lakhs Population	Total No. of Workers		DDT 50% Status (In Meric Ton)			WAGES			Office Expenses (@ Rs 250/- Per Sqad	Contigency (@ Rs. 250/- Per Sqad	Contigency At State HQ.	Transportation of DDT			Grand Total (13+14+15+16+19)
		PHC	Population		SFW	FW	Require.	Available (April2011) After Ist Round FEB-Mar-2011	Balance Require.	SFW(Rs. 145/-Per SFW For 60 Days)	FW(Rs.118/-Per FW For 60 Days)	Total				District To PHC(RS. 2000/- Aff. PHC)	PHC To Village(Rs.1500/-PHC)	Total	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	**Araria**	9	2,222,962	122	122	610	83.36	6.240	**77.12**	1,061,400	4,318,800	5,380,200	30,500	30,500	0	18,000	13,500	31,500	5,472,700
2	**Darbhanga**	15	1,688,211	93	93	465	63.31	9.770	**53.54**	809,100	3,292,200	4,101,300	23,250	23,250	0	30,000	22,500	52,500	4,200,300
3	**E.Champaran**	20	2,758,170	152	152	760	103.43	18.295	**85.14**	1,322,400	5,380,800	6,703,200	38,000	38,000	0	40,000	30,000	70,000	6,849,200
4	**Gopalganj**	14	938,807	52	52	260	35.21	17.656	**17.55**	452,400	1,840,800	2,293,200	13,000	13,000	0	28,000	21,000	49,000	2,368,200
5	**Katihar**	18	1,334,615	73	73	365	50.05	16.548	**33.50**	635,100	2,584,200	3,219,300	18,250	18,250	0	36,000	27,000	63,000	3,318,800
6	**Khagaria**	6	358,023	20	20	100	13.43	8.040	**5.39**	174,000	708,000	882,000	5,000	5,000	0	12,000	9,000	21,000	913,000
7	**Madhepura**	13	1,446,588	80	80	400	54.25	11.230	**43.02**	696,000	2,832,000	3,528,000	20,000	20,000	0	26,000	19,500	45,500	3,613,500
8	**Madhubani**	18	2,690,606	148	148	740	100.90	10.050	**90.85**	1,287,600	5,239,200	6,526,800	37,000	37,000	0	36,000	27,000	63,000	6,663,800
9	**Muzaffarpur**	16	2,375,268	131	131	655	89.07	13.879	**75.19**	1,139,700	4,637,400	5,777,100	32,750	32,750	0	32,000	24,000	56,000	5,898,600
10	**Purnea**	14	1,672,656	92	92	460	62.72	14.043	**48.68**	800,400	3,256,800	4,057,200	23,000	23,000	0	28,000	21,000	49,000	4,152,200
11	**Saharsa**	10	1,806,247	99	99	495	64.48	6.274	**-2.81**	861,300	3,504,600	4,365,900	24,750	24,750	0	20,000	15,000	35,000	4,450,400
12	**Samastipur**	20	1,799,987	99	99	495	67.50	2.614	**64.89**	861,300	3,504,600	4,365,900	24,750	24,750	0	40,000	30,000	70,000	4,485,400
13	**Saran**	16	1,538,939	85	85	425	57.71	5.398	**52.31**	739,500	3,009,000	3,748,500	21,250	21,250	0	32,000	24,000	56,000	3,847,000
14	**Sheohar**	5	218,828	12	12	60	8.21	10.747	**-2.54**	104,400	424,800	529,200	3,000	3,000	0	10,000	7,500	17,500	552,700
15	**Sitamarhi**	13	1,944,860	107	107	535	72.93	18.614	**54.32**	930,900	3,787,800	4,718,700	26,750	26,750	0	26,000	19,500	45,500	4,817,700
16	**Siwan**	18	1,317,809	72	72	360	49.42	12.107	**37.31**	626,400	2,548,800	3,175,200	18,000	18,000	0	36,000	27,000	63,000	3,274,200
17	**Supaul**	8	747,846	41	41	205	28.04	6.270	**21.77**	356,700	1,451,400	1,808,100	10,250	10,250	0	16,000	12,000	28,000	1,856,600
18	**Vaishali**	16	2,208,394	121	121	605	82.81	5.858	**76.96**	1,052,700	4,283,400	5,336,100	30,250	30,250	0	32,000	24,000	56,000	5,452,600
19	**State HQ.**	0	0	0	0	0	0	0.000	0	0	0	2,000,000	0	0	25000	0	0	500,000	2,525,000
Total		**249**	**29068816**	**1599**	**1599**	**7995**	**1087**	**194**	**832**	**13911300**	**56604600**	**72515900**	**399750**	**399750**	**25000**	**498000**	**373500**	**1371500**	**74711900**

Note:- Rs.2000000 for back Arear Wages & Rs.500000 for inter district transpotation of DDT & Spray Equipment

Dist. Wise Sqad,DDT,Wages,Office Exp.,Contigency,Transportation of DDT For Kala Azar Spray One Round FOCAL SPRAY-11-12 **Annexure -II F**

Sl. No.	Name of Districts	Total No. of Affected		Total No. of Sqad (55 Sqad /10 Lakhs Population	Total Spray Days	Total No. of Workers		DDT 50% Status (In Kg.)			WAGES			Office Expenses (@ Rs 200/- Per Sqad	Contigency (@ Rs. 200/- Per Sqad	Contigency At State HQ.	DDT Trnspotation Total @1500/ Affected PHC	Grand Total (14+15+16 +17+ 18)
		PHC	Population			SFW	FW	Require.	Available (April2011) After Ist Round-2011(FEB -Mar)	Balance Require.	SFW(Rs. 145/-Per SFW	FW(Rs.118/-Per FW	Total					
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1	**Arwal**	4	500	1	2	1	5	0.02	5.26	**-5.24**	290	1,180	1,470	200	200	0	6,000	7,870
2	**Banka**	2	500	1	2	1	5	0.02	5.42	**-5.40**	290	1,180	1,470	200	200	0	3,000	4,870
3	**Begusarai**	11	68,000	9	30	9	45	2.55	6.04	**-3.49**	39,150	159,300	198,450	1,800	1,800	0	16,500	218,550
4	**Bhagalpur**	8	11,750	4	12	4	20	0.44	3.56	**-3.12**	6,960	28,320	35,280	800	800	0	12,000	48,880
5	**Bhojpur**	9	1,750	1	7	1	5	0.07	9.07	**-9.00**	1,015	4,130	5,145	200	200	0	13,500	19,045
6	**Buxar**	2	12,500	2	25	2	10	0.47	9.49	**-9.02**	7,250	29,500	36,750	400	400	0	3,000	40,550
7	**Jehanabad**	6	4,750	3	6	3	15	0.18	6.30	**-6.12**	2,610	10,620	13,230	600	600	0	9,000	23,430
8	**Kishanganj**	7	32,000	4	30	4	20	1.20	15.59	**-14.39**	17,400	70,800	88,200	800	800	0	10,500	100,300
9	**Lakhisarai**	2	750	1	3	1	5	0.03	1.51	**-1.48**	435	1,770	2,205	200	200	0	3,000	5,605
10	**Munger**	5	10,000	4	10	4	20	0.38	5.23	**-4.86**	5,800	23,600	29,400	800	800	0	7,500	38,500
11	**Nalanda**	16	3,250	2	7	2	10	0.12	1.99	**-1.87**	2,030	8,260	10,290	400	400	0	24,000	35,090
12	**Nawada**	1	15,250	2	30	2	10	0.57	0.00	**0.57**	8,700	35,400	44,100	400	400		1,500	46,400
13	**Patna**	22	33,250	11	12	11	55	1.25	20.82	**-19.57**	19,140	77,880	97,020	2,200	2,200	0	33,000	134,420
14	**W.Champaran**	13	31,500	10	12	10	50	1.18	7.52	**-6.34**	17,400	70,800	88,200	2,000	2,000	0	19,500	111,700
	State HQ.	0	0	0	0	0	0	0.00	0	0	0	0	0	0	0	10000	0	10,000
Total		**108**	**225,750**	**55**	**188**	**55**	**275**	**8**	**98**	**-89**	**1,499,300**	**6,100,600**	**7,599,900**	**11,000**	**11,000**	**10,000**	**162,000**	**7,793,900**

Dist. Wise Status of Spray Equipments pf Kala Azar DDT Spray **Annex. III**

Sl. No.	Name of Districts	Total No. of Sqad (55 Sqad /10 Lakhs Population	Districwise Status of Spray Equipment of K..A D.D.T Spray																Nosal Tip
			Stirrup Pump				Bucket				Gallan Measure				Pound Measure				
			Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	**Araria**	126	252	237	80	15	504	319	0	185	126	115	0	11	126	120	0	6	630
2	**Arwal**	2	4	0	0	4	8	0	0	8	2	0	0	2	2	0	0	2	10
3	**Banka**	1	2	0	0	2	4	0	0	4	1	0	0	1	1	0	0	1	5
4	**Begusarai**	75	150	258	0	-108	300	508	0	-208	75	107	0	-32	75	85	0	-10	375
5	**Bhagalpur**	26	52	250	40	-198	104	400	9	-296	26	140	5	-114	26	140	0	-114	130
6	**Bhojpur**	13	26	40	193	-14	52	450	50	-398	13	100	10	-87	13	100	10	-87	65
7	**Buxar**	23	46	0	0	46	92	0	0	92	23	0	0	23	23	0	0	23	115
8	**Darbhanga**	95	190	294	0	-104	380	279	0	101	95	127	0	-32	95	127	0	-32	475
9	**E.Champaran**	156	312	286	177	26	624	507	138	117	156	197	23	-41	156	193	20	-37	780
10	**Gopalganj**	53	106	234	20	-128	152	438	40	-286	53	97	20	-44	53	97	20	-44	265
11	**Jehanabad**	3	6	234	20	-228	12	438	40	-426	3	97	20	-94	3	97	20	-94	15
12	**Katihar**	75	150	180	104	-30	300	354	120	-54	75	142	0	-67	75	142	0	-67	375
13	**Khagaria**	20	40	110	50	-70	80	200	116	-120	20	79	0	-59	20	79	0	-59	100
14	**Kishanganj**	27	54	50	50	4	108	240	0	-132	27	56	0	-29	27	42	0	-15	135
15	**Lakhisarai**	6	12	40	58	-28	24	150	46	-126	6	49	0	-43	6	49	0	-43	30
16	**Madhepura**	82	164	252	0	-88	328	324	0	4	82	81	0	1	82	81	0	1	410
17	**Madhubani**	102	204	526	0	-322	408	820	0	-412	102	225	0	-123	102	225	0	-123	510
18	**Munger**	5	10	140	0	-130	20	200	0	-180	5	40	0	-35	5	40	0	-35	25
19	**Muzaffarpur**	152	304	375	0	-71	608	647	0	-39	152	186	0	-34	152	175	0	-23	760
20	**Nalanda**	17	34	257	3	-223	68	502	10	-434	17	100	0	-83	17	130	0	-113	85
21	**Patna**	59	118	293	130	-175	236	519	112	-283	59	193	20	-134	59	172	2	-113	295
22	**Purnea**	134	268	190	80	78	536	413	50	123	134	130	0	4	134	82	0	52	670
23	**Saharsa**	95	190	150	20	40	380	350	20	30	95	75	0	20	95	75	0	20	475
24	**Samastipur**	102	204	224	0	-20	408	300	0	108	102	90	0	12	102	90	0	12	510
25	**Saran**	87	174	135	101	39	348	425	135	-77	87	105	0	-18	87	105	0	-18	435
26	**Sheohar**	12	24	0	0	24	48	0	0	48	12	0	0	12	12	0	0	12	60
27	**Sitamarhi**	110	220	105	65	115	440	295	68	145	110	111	0	-1	110	117	0	-7	550
28	**Siwan**	75	150	124	104	26	300	439	60	-139	75	178	5	-103	75	170	5	-95	375
29	**Supaul**	42	84	0	0	84	168	0	0	168	42	0	0	42	42	0	0	42	210
30	**Vaishali**	125	250	217	49	33	500	362	59	138	125	115	4	10	125	102	0	23	625
31	**W.Champaran**	71	142	280	105	-138	284	380	65	-96	71	120	7	-49	71	118	4	-47	355
Total		**1971**	**3,942**	**5,481**	**1,449**	**-1,539**	**7,824**	**10,259**	**1,138**	**-2,435**	**1,971**	**3,055**	**114**	**-1,084**	**1,971**	**2,953**	**81**	**-982**	**9,855**

State-Bihar,Budget Plan-2011-12 **Dist. Wise Status of Spray Equipments of Kala Azar DDT Spray** **Annex. III**

Sl. No.	Name of Districts	Total No. of Sqad (55 Sqad /10 Lakhs Population	Districwise Status of Spray Equipment of K..A D.D.T Spray																
			Stirrup Pump				Bucket				Gallan Measure				Pound Measure				Nosal Tip
			Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	**Araria**	122	244	237	80	7	488	319	0	169	122	115	0	7	122	120	0	2	610
2	**Darbhanga**	93	186	294	0	-108	372	279	0	93	93	127	0	-34	93	127	0	-34	465
3	**E.Champaran**	152	304	286	177	18	608	507	138	101	152	197	23	-45	152	193	20	-41	760
4	**Gopalganj**	52	104	234	20	-130	152	438	40	-286	52	97	20	-45	52	97	20	-45	260
5	**Katihar**	73	146	180	104	-34	292	354	120	-62	73	142	0	-69	73	142	0	-69	365
6	**Khagaria**	20	40	110	50	-70	80	200	116	-120	20	79	0	-59	20	79	0	-59	100
7	**Madhepura**	80	160	252	0	-92	320	324	0	-4	80	81	0	-1	80	81	0	-1	400
8	**Madhubani**	148	296	526	0	-230	592	820	0	-228	148	225	0	-77	148	225	0	-77	740
9	**Muzaffarpur**	131	262	375	0	-113	524	647	0	-123	131	186	0	-55	131	175	0	-44	655
10	**Purnea**	92	184	190	80	-6	368	413	50	-45	92	130	0	-38	92	82	0	10	460
11	**Saharsa**	99	190	150	20	40	380	350	20	30	95	75	0	20	95	75	0	20	475
12	**Samastipur**	99	198	224	0	-26	396	300	0	96	99	90	0	9	99	90	0	9	495
13	**Saran**	85	170	135	101	35	340	425	135	-85	85	105	0	-20	85	105	0	-20	425
14	**Sheohar**	12	24	0	0	24	48	0	0	48	12	0	0	12	12	0	0	12	60
15	**Sitamarhi**	107	214	105	65	109	428	295	68	133	107	111	0	-4	107	117	0	-10	535
16	**Siwan**	72	144	124	104	20	288	439	60	-151	72	178	5	-106	72	170	5	-98	360
17	**Supaul**	41	82	0	0	82	164	0	0	164	41	0	0	41	41	0	0	41	205
18	**Vaishali**	121	242	217	49	25	484	362	59	122	121	115	4	6	121	102	0	19	605
Total		**1599**	**3,190**	**3,639**	**850**	**-449**	**6,324**	**6,472**	**806**	**-148**	**1,595**	**2,053**	**52**	**-458**	**1,595**	**1,980**	**45**	**-385**	**7,975**

Dist. Wise Status of Spray Equipments pf Kala Azar DDT Spray **(Focal 2011-12)** **Annex. III F**

Sl. No.	Name of Districts	Total No. of Sqad (55 Sqad /10 Lakhs Population	Districwise Status of Spray Equipment of K..A D.D.T Spray																
			Stirrup Pump				Bucket				Gallan Measure				Pound Measure				Nosal Tip
			Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required	Available in Good Condition	Repairable	Balance Required	Required	Availalble in Good Condition	Repairable	Balance Required	Required
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
1	**Arwal**	1	2	0	0	2	4	0	0	4	1	0	0	1	1	0	0	1	5
2	**Banka**	1	2	0	0	2	4	0	0	4	1	0	0	1	1	0	0	1	5
3	**Begusarai**	9	18	258	0	-240	36	508	0	-472	9	107	0	-98	9	85	0	-76	45
4	**Bhagalpur**	4	8	250	40	-242	16	400	9	-384	4	140	5	-136	4	140	0	-136	20
5	**Bhojpur**	1	2	40	193	-38	4	450	50	-446	1	100	10	-99	1	100	10	-99	5
6	**Buxar**	2	4	0	0	4	8	0	0	8	2	0	0	2	2	0	0	2	10
7	**Jehanabad**	3	6	234	20	-228	12	438	40	-426	3	97	20	-94	3	97	20	-94	15
8	**Kishanganj**	4	8	50	50	-42	16	240	0	-224	4	56	0	-52	4	42	0	-38	20
9	**Lakhisarai**	1	2	40	58	-38	4	150	46	-146	1	49	0	-48	1	49	0	-48	5
10	**Munger**	4	8	140	0	-132	16	200	0	-184	4	40	0	-36	4	40	0	-36	20
11	**Nalanda**	2	4	257	3	-253	8	502	10	-494	2	100	0	-98	2	130	0	-128	10
12	**Nawada**	2	4	4	0	0	8	8	0	0	2	2	0	0	2	2	0	0	10
13	**Patna**	11	22	293	130	-271	44	519	112	-475	11	193	20	-182	11	172	2	-161	55
14	**W.Champaran**	10	20	280	105	-260	40	380	65	-340	10	120	7	-110	10	118	4	-108	50
Total		**55**	**110**	**1,846**	**599**	**-1,736**	**220**	**3,795**	**332**	**-3,575**	**55**	**1,004**	**62**	**-949**	**55**	**975**	**36**	**-920**	**275**

Statement Showing The Expenditure ,Repair,Mobility, DA Supervision & IEC For Kala Azar Spray **Annex. IV**

Sl. No.	Name of Districts	Total No. of Affected		Total No. of Sqad (55 Sqad /10 Lakhs Population	Repair of Spray Equipments Including Nozal Tips			District Mobility For **C.S Vehicle** @10000 /month for two month	District MobilityFor **ACMO Vehicle** @10000 /month for two month	District Mobility **DMO Vehicle** @ Rs.20000/month for two month	Mobility For PHC **MO**.@ RS.650/days for two month	**State HQ.** Mobility @ 12 Rs. / km (Max. 200 km/ day) for 60 days+Rs. 150/Night holt 30 night	Mobility of **Central Team** @12/KM Max.200 km /Day for 60 days(Two Vehicle / day)+ Rs 150/Night holt	Mobility of 7 **RDDH** @10,000 /Months for Two months (7x2x10000= 1,40,000)	**Four ZMO** Mobility @10,000/ Month for Two months(4x2x10000 = 80000)	DA For Supervision @ Rs. 2000 Per Affected PHC	Evening -Briefing @ Rs. 150 per affected PHC & Dist.HQ.for 60 Days(During Spray Period)	IEC @ Rs. 2000/- Per Affected PHC per Round	**Total**	**Remarks**
		PHC	**Village**		**Repair(RS.150/- Per Sqad)**	**Purchase(Per Sqad Rs.800/)**	**Total**													
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**
1	**Araria**	9	563	126	18900	100800	119700	20000	20,000	0	351000	0	0	0	0	18000	90000	18000	**546,700**	
2	**Arwal**	4	18	2	300	1600	1900	20000	20,000	0	156000	0	0	0	0	8000	45000	8000	**213,900**	
3	**Banka**	2	2	1	150	800	950	20000	20,000	0	78000	0	0	0	0	4000	27000	4000	**126,950**	
4	**Begusarai**	11	245	75	11250	60000	71250	20000	20,000	40,000	429000	0	0	0	0	22000	108000	22000	**624,250**	
5	**Bhagalpur**	8	62	26	3900	20800	24700	20000	20,000	40,000	312000	0	0	0	0	16000	81000	16000	**448,700**	
6	**Bhojpur**	9	120	13	1950	10400	12350	20000	20,000	40,000	351000	0	0	0	0	18000	90000	18000	**479,350**	
7	**Buxar**	2	16	23	3450	18400	21850	20000	20,000	0	78000	0	0	0	0	4000	27000	4000	**147,850**	
8	**Darbhanga**	15	455	95	14250	76000	90250	20000	20,000	40,000	585000	0	0	0	0	30000	144000	30000	**815,250**	
9	**E.Champaran**	20	817	156	23400	124800	148200	20000	20,000	40,000	780000	0	0	0	0	40000	189000	40000	**1,088,200**	
10	**Gopalganj**	14	261	53	7950	42400	50350	20000	20,000	40,000	546000	0	0	0	0	28000	135000	28000	**732,350**	
11	**Jehanabad**	6	36	3	450	2400	2850	20000	20,000	0	234000	0	0	0	0	12000	63000	12000	**300,850**	
12	**Katihar**	18	543	75	11250	60000	71250	20000	20,000	40,000	702000	0	0	0	0	36000	171000	36000	**925,250**	
13	**Khagaria**	6	119	20	3000	16000	19000	20000	20,000	0	234000	0	0	0	0	12000	63000	12000	**317,000**	
14	**Kishanganj**	7	323	27	4050	21600	25650	20000	20,000	0	273000	0	0	0	0	14000	72000	14000	**366,650**	
15	**Lakhisarai**	2	29	6	900	4800	5700	20000	20,000	0	78000	0	0	0	0	4000	27000	4000	**131,700**	
16	**Madhepura**	13	384	82	12300	65600	77900	20000	20,000	0	507000	0	0	0	0	26000	126000	26000	**676,900**	
17	**Madhubani**	18	366	102	15300	81600	96900	20000	20,000	40,000	702000	0	0	0	0	36000	171000	36000	**950,900**	
18	**Munger**	5	52	5	750	4000	4750	20000	20,000	40,000	195000	0	0	0	0	10000	54000	10000	**299,750**	
19	**Muzaffarpur**	14	1273	152	22800	121600	144400	20000	20,000	40,000	546000	0	0	0	0	28000	135000	28000	**826,400**	
20	**Nalanda**	16	91	17	2550	13600	16150	20000	20,000	40,000	624000	0	0	0	0	32000	153000	32000	**784,150**	
21	**Patna**	22	422	59	8850	47200	56050	20000	20,000	40,000	858000	0	0	0	0	44000	207000	44000	**1,082,050**	
22	**Purnea**	14	764	134	20100	107200	127300	20000	20,000	40,000	546000	0	0	0	0	28000	135000	28000	**809,300**	
23	**Saharsa**	10	379	95	14250	76000	90250	20000	20,000	40,000	390000	0	0	0	0	20000	99000	20000	**600,250**	
24	**Samastipur**	20	701	102	15300	81600	96900	20000	20,000	40,000	780000	0	0	0	0	40000	189000	40000	**1,036,900**	
25	**Saran**	16	597	87	13050	69600	82650	20000	20,000	40,000	624000	0	0	0	0	32000	153000	32000	**850,650**	
26	**Sheohar**	5	48	12	1800	9600	11400	20000	20,000	0	195000	0	0	0	0	10000	54000	10000	**266,400**	
27	**Sitamarhi**	13	433	110	16500	88000	104500	20000	20,000	40,000	507000	0	0	0	0	26000	126000	26000	**743,500**	
28	**Siwan**	18	509	75	11250	60000	71250	20000	20,000	40,000	702000	0	0	0	0	36000	171000	36000	**925,250**	
29	**Supaul**	8	245	42	6300	33600	39900	20000	20,000	0	312000	0	0	0	0	16000	81000	16000	**423,900**	
30	**Vaishali**	16	751	125	18750	100000	118750	20000	20,000	40,000	624000	0	0	0	0	32000	153000	32000	**886,750**	
31	**W.Champaran**	13	190	71	10650	56800	67450	20000	20,000	40,000	507000	0	0	0	0	26000	126000	26000	**706,450**	
	State HQ.	0		1971	295650	1576800	0	0	0	0	0	153000	297,000	140,000	80,000	0	0	0	**2,544,421**	
Total		**354**	**10,814**	**1,971**	**591,300**	**3,153,600**	**1,872,450**	**620,000**	**620,000**	**800,000**	**13806000**	**153,000**	**297,000**	**140,000**	**80,000**	**708,000**	**3,465,000**	**708,000**	**21,678,871**	

Statement Showing The Expenditure ,Repair,Mobility, DA Supervision & IEC For Kala Azar Spray **Annex. IV**

Sl. No.	Name of Districts	Total No. of Affected		Total No. of Sqad (55 Sqad /10 Lakhs Population	Repair of Spray Equipments Including Nozal Tips			District Mobility For **C.S Vehicle** @10000 /month for two month	District MobilityFor **ACMO Vehicle** @10000 /month for two month	District Mobility **DMO Vehicle** @ Rs.20000/month for two month	Mobility For PHC **MO**.@ RS.650/days for two month	**State HQ.** Mobility @ 12 Rs. / km (Max. 200 km/ day) for 60 days for Two Vehicle+ Rs. 150/Night holt 60 night	Mobility of **Central Team** @12/KM Max.200 km /Day for 60 days(Two Vehicle / day)+ Rs 150/Night holt	Mobility of 5 **RDDH** @10,000 /Months for Two months (7x2x10000= 1,40,000)	**Four ZMO** Mobility @10,000 /Month for Two months(4x2x10000= 80000)	DA For Supervision @ Rs. 2000 Per Affected PHC	Evening - Briefing @ Rs. 150 per affected PHC & Dist.HQ.for 60 Days(During Spray Period)	IEC @ Rs. 2000/- Per Affected PHC per Round	**Total**	**Remarks**
		PHC	**Village**		**Repair(RS.150/-Per Sqad)**	**Purchase(Two Nozal Rs.50/Nozal/Squad/Week)**	**Total**													
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**
1	**Araria**	9	563	122	18300	97600	115900	20000	20,000	0	351000	0	0	0	0	18000	90000	18000	**632,900**	
2	**Darbhanga**	15	455	93	13950	74400	88350	20000	20,000	40,000	585000	0	0	0	0	30000	144000	30000	**957,350**	
3	**E.Champaran**	20	817	152	22800	121600	144400	20000	20,000	40,000	780000	0	0	0	0	40000	189000	40000	**1,273,400**	
4	**Gopalganj**	14	261	52	7800	41600	49400	20000	20,000	40,000	546000	0	0	0	0	28000	135000	28000	**866,400**	
5	**Katihar**	18	543	73	10950	58400	69350	20000	20,000	40,000	702000	0	0	0	0	36000	171000	36000	**1,094,350**	
6	**Khagaria**	6	119	20	3000	16000	19000	20000	20,000	0	234000	0	0	0	0	12000	63000	12000	**380,000**	
7	**Madhepura**	13	384	80	12000	64000	76000	20000	20,000	0	507000	0	0	0	0	26000	126000	26000	**801,000**	
8	**Madhubani**	18	366	148	22200	118400	140600	20000	20,000	40,000	702000	0	0	0	0	36000	171000	36000	**1,165,600**	
9	**Muzaffarpur**	16	1273	131	19650	104800	124450	20000	20,000	40,000	624000	0	0	0	0	32000	153000	32000	**1,045,450**	
10	**Purnea**	14	764	92	13800	73600	87400	20000	20,000	40,000	546000	0	0	0	0	28000	135000	28000	**904,400**	
11	**Saharsa**	10	379	99	14850	79200	94050	20000	20,000	40,000	390000	0	0	0	0	20000	99000	20000	**703,050**	
12	**Samastipur**	20	701	99	14850	79200	94050	20000	20,000	40,000	780000	0	0	0	0	40000	189000	40000	**1,223,050**	
13	**Saran**	16	597	85	12750	68000	80750	20000	20,000	40,000	624000	0	0	0	0	32000	153000	32000	**1,001,750**	
14	**Sheohar**	5	48	12	1800	9600	11400	20000	20,000	0	195000	0	0	0	0	10000	54000	10000	**320,400**	
15	**Sitamarhi**	13	433	107	16050	85600	101650	20000	20,000	40,000	507000	0	0	0	0	26000	126000	26000	**866,650**	
16	**Siwan**	18	509	72	10800	57600	68400	20000	20,000	40,000	702000	0	0	0	0	36000	171000	36000	**1,093,400**	
17	**Supaul**	8	245	41	6150	32800	38950	20000	20,000	0	312000	0	0	0	0	16000	81000	16000	**503,950**	
18	**Vaishali**	16	751	121	18150	96800	114950	20000	20,000	40,000	624000	0	0	0	0	32000	153000	32000	**1,035,950**	
19	**State HQ.**	0	0	0	0	0	0	0	0	0	0	306000	297,000	100,000	80,000	0	0	0	**783,000**	
Total		**249**	**9,208**	**1,599**	**239,850**	**1,279,200**	**1,519,050**	**360,000**	**360,000**	**520,000**	**9,711,000**	**306,000**	**297,000**	**100,000**	**80,000**	**498,000**	**2,403,000**	**498,000**	**16,652,050**	

Statement Showing The Expenditure ,Repair,Mobility, DA Supervision & IEC For Kala Azar Spray **(Focal 2011-12)** **Annex. IV F**

Sl. No.	Name of Districts	Total No. of Affected		Total No. of Sqad (55 Sqad /10 Lakhs Population	Total Spray Days	Repair of Spray Equipments Including Nozal Tips			District Mobility For **C.S Vehicle** @10000 /month	District Mobility For **ACMO Vehicle** @10000 /month	District Mobility **DMO Vehicle** @ Rs.20000/month	Mobility For PHC **MO**.@ RS.650/days	**State HQ.** Mobility @ 12 Rs. / km (Max. 200 km/ day) for 60 days+Rs. 150/Night holt 30 night	Mobility of **Central Team** @12/KM Max.200 km /Day for 60 days(Two Vehicle / day)+ Rs 150/Night holt	Mobility of 6 **RDDH** @10,000 /Months	**Four ZMO** Mobility @10,000/Month	Supervision Cost @ Rs. 50/ Day / Affected PHC	Evening -de-Briefing @ Rs. 150 /Day/ Affected PHC &@ Rs. 150 /Day/ Dist.HQ.(During Spray Period)	IEC @ Rs. 500/- Per Affected PHC per Round	**Total (Column 9 To 20)**
		PHC	Village			Repair(RS. 150/- Per Sqad)	Purchase of Nosal Tip @ Rs. 50 Per Nosal	Total												
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**
1	**Arwal**	4	18	1	2	150	100	250	0	1000	0	1300	0	0	0	0	400	1500	2000	**6,450**
2	**Banka**	2	4	1	2	150	100	250	0	1000	0	1300	0	0	0	0	200	900	1000	**4,650**
3	**Begusarai**	11	283	9	30	1350	3000	4350	10000	10000	20,000	19500	0	0	0	0	16500	54000	5500	**139,850**
4	**Bhagalpur**	8	174	4	12	600	800	1400	5000	5000	10,000	7800	0	0	5000	0	4800	16200	4000	**59,200**
5	**Bhojpur**	9	71	1	7	150	100	250	3000	3000	6,000	4550	0	0	0	0	3150	10500	4500	**34,950**
6	**Buxar**	2	244	2	25	300	600	900	10000	10000	0	16250	0	0	0	0	2500	11250	1000	**51,900**
7	**Jehanabad**	6	15	3	6	450	300	750	3000	3000	0	3900	0	0	10000	0	1800	6300	3000	**31,750**
8	**Kishanganj**	7	129	4	30	600	1600	2200	10000	10000	0	19500	0	0	10000	0	10500	36000	3500	**101,700**
9	**Lakhisarai**	2	28	1	3	150	100	250	0	1000	0	1950	0	0		0	300	1350	1000	**5,850**
10	**Munger**	5	46	4	10	600	800	1400	3000	3000	8,000	6500	0	0	10000	0	2500	9000	2500	**45,900**
11	**Nalanda**	16	107	2	7	300	200	500	3000	3000	6,000	4550	0	0	0	0	5600	17850	8000	**48,500**
12	**Nawada**	1	1	2	30	300	800	1100	10000	10000	20,000	19500	0	0	0	0	1500	9000	500	**71,600**
13	**Patna**	22	398	11	12	1650	2200	3850	5000	5000	10,000	7800	0	0	5000	0	13200	41400	11000	**102,250**
14	**W.Champaran**	13	357	10	12	1500	2000	3500	5000	5000	10,000	7800	0	0	5000	0	7800	25200	6500	**75,800**
15	**State HQ.**	0	0	0	0	0	0	0	0	0	0	0	72000	144000	0	40,000	0	0	0	**256,000**
Total		**108**	**1,875**	**55**	**188**	**8,250**	**156,800**	**165,050**	**67,000**	**70,000**	**90,000**	**122,200**	**72,000**	**144,000**	**45,000**	**40,000**	**70,750**	**240,450**	**54,000**	**1,180,450**

Statement Showing The Grand Total Expenditure(Annex. II & IV For Kala Azar Spray (Focal 2011-12) Annex. V F							
Sl. No.	**Name of Districts**	**Total No. of AffectedPHC**	**Total No. of Affected Population**	Grand Total (14+15+16+17+ 18) Annex.II	Total (Column 9 To 20)	Grand Total(5+6)	Remarks
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
1	**Arwal**	4	500	6,870	6,250	13,120	
2	**Banka**	2	500	6,870	4,650	11,520	
3	**Begusarai**	11	65,250	202,750	113,750	316,500	
4	**Bhagalpur**	8	11,750	41,880	55,600	97,480	
5	**Bhojpur**	9	1,750	10,545	32,500	43,045	
6	**Buxar**	2	12,500	42,550	51,900	94,450	
7	**Jehanabad**	6	4,750	19,430	30,550	49,980	
8	**Kishanganj**	7	32,000	104,800	94,200	199,000	
9	**Lakhisarai**	2	750	7,605	5,850	13,455	
10	**Munger**	5	9,500	36,000	39,400	75,400	
11	**Nalanda**	16	3,250	21,090	43,600	64,690	
12	**Nawada**	1	15,250	49,900	73,100	123,000	
13	**Patna**	22	32,500	121,420	95,250	216,670	
14	**W.Champaran**	13	31,500	112,200	69,200	181,400	
	State HQ.	0	0	10,000	396,000	406,000	
Total		**108**	**221,750**	**7,689,680**	**4,016,500**	**11,706,180**	

Budget Provision For Curative Measures of Kala Azar for the year-2011-2012 — Annex. V

Sl. No.	Name of Districts	Total No. of PHC	Total No. of Affected PHC	Kala-azar cases Based on 2009	Incentive ASHA(Rs. 200/- Per Case For Complete Treatment) as Dot. Programme	Loss Of Wages Rs.100/-For Maximum 30 Days Per Projected Case During Treatment Period(For SSG,Ampho-B & Miltofosine)	Food Suppliment for K.A Patient @ Rs.35/Patient for 45 days	Contigency for eight month for DMO/ACMO @2000/Affected PHC one time	Mobility For Officers & MI,POL & Maintenance For 8 Months(Excluding IRS Periods)		Storage Of Drugs		Treatment Card @Rs.5.00 Per Treatment Card For 2 Diff.Types of Each Card For Projected Case	Register For Line Listing / Loss Of Wages/ Asha Record /Drug Record @ Rs.50/- For 4 Register Per Aff.PHC	Hiring of Warehouse at Dist. Level for Storage of DDT @ Rs. 5000/-Per Month For 12 Months	Kala Azar Search Programme Per PHC@Rs.750/-for 8 Months(One Day in amonth)	5 Bannner &1 Box for Camp @ Rs. 1750/- Per PHC (BOX-Rs-1000+Banner Rs.-150/Banner	2 days Mikinng & Refreshment for Camp @ 750/= per camp/ PHC (Mikking Rs.-500 + Ref Rs.-250)	Grand Total
									Mobility For 2 CS Khagaria & Madhepura @ Rs. 3000/- Per Month for POL,for 8 Months(Excluding Spray Period)	Mobility For 21 DMO & 9 ACMO For Max.RS 10,000/- Per Month for 8 Months (Excluding Spray Period)	Amphoteracin Storage In District Level @ Rs. 500/- Per Month For 12 Months	Amphoteracin Storage In State Level @ Rs. 1500/- Per Month For 12 Months =Rs. 18,000/-							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	Araria	9	9	1,575	105,000	4,725,000	2,480,625	18,000	0	80,000	6,000	0	15,750	900	60,000	54,000	15,750	54,000	7,597,025
2	Arwal	4	4	2	200	6,000	3,150	8,000	0	80,000	6,000	0	20	400	60,000	24,000	7,000	24,000	210,770
3	Banka	10	2	2	200	6,000	3,150	4,000	0	80,000	6,000	0	20	200	60,000	60,000	17,500	60,000	293,070
4	Begusarai	11	11	272	18,200	816,000	428,400	22,000	0	80,000	6,000	0	2,720	1,100	60,000	66,000	19,250	66,000	1,563,670
5	Bhagalpur	11	8	47	3,200	141,000	74,025	16,000	0	80,000	6,000	0	470	800	60,000	66,000	19,250	66,000	516,745
6	Bhojpur	12	9	7	400	21,000	11,025	18,000	0	80,000	6,000	0	70	900	60,000	72,000	21,000	72,000	344,395
7	Buxar	7	2	50	3,400	150,000	78,750	4,000	0	80,000	6,000	0	500	200	60,000	42,000	12,250	42,000	475,100
8	Darbhanga	15	15	947	63,200	2,841,000	1,491,525	30,000	0	80,000	6,000	0	9,470	1,500	60,000	90,000	26,250	90,000	4,758,945
9	E.Champaran	20	20	1,365	91,000	4,095,000	2,149,875	40,000	0	80,000	6,000	0	13,650	2,000	60,000	120,000	35,000	120,000	6,772,525
10	Gopalganj	14	14	767	51,200	2,301,000	1,208,025	28,000	0	80,000	6,000	0	7,670	1,400	60,000	84,000	24,500	84,000	3,907,795
11	Jehanabad	7	6	19	1,200	57,000	29,925	12,000	0	80,000	6,000	0	190	600	60,000	42,000	12,250	42,000	331,165
12	Katihar	18	18	532	35,400	1,596,000	837,900	36,000	0	80,000	6,000	0	5,320	1,800	60,000	108,000	31,500	108,000	2,869,920
13	Khagaria	7	6	309	20,600	927,000	486,675	12,000	24,000	0	6,000	0	3,090	600	60,000	42,000	12,250	42,000	1,624,215
14	Kishanganj	7	7	128	8,600	384,000	201,600	14,000	0	80,000	6,000	0	1,280	700	60,000	42,000	12,250	42,000	838,430
15	Lakhisarai	4	2	5	400	15,000	7,875	4,000	0	80,000	6,000	0	50	200	60,000	24,000	7,000	24,000	224,525
16	Madhepura	13	13	1,591	106,000	4,773,000	2,505,825	26,000	24,000	0	6,000	0	15,910	1,300	60,000	78,000	22,750	78,000	7,670,785
17	Madhubani	18	18	732	48,800	2,196,000	1,152,900	36,000	0	80,000	6,000	0	7,320	1,800	60,000	108,000	31,500	108,000	3,800,320
18	Munger	9	5	40	2,600	120,000	63,000	10,000	0	80,000	6,000	0	400	500	60,000	54,000	15,750	54,000	456,250
19	Muzaffarpur	16	16	2,329	155,200	6,987,000	3,668,175	32,000	0	80,000	6,000	0	23,290	1,600	60,000	96,000	28,000	96,000	11,201,265
20	Nalanda	20	16	13	800	39,000	20,475	32,000	0	80,000	6,000	0	130	1,600	60,000	120,000	35,000	120,000	483,005
21	Patna	23	22	133	8,800	399,000	209,475	44,000	0	80,000	6,000	0	1,330	2,200	60,000	138,000	40,250	138,000	1,083,055
22	Purnea	14	14	2,138	142,600	6,414,000	3,367,350	28,000	0	80,000	6,000	0	21,380	1,400	60,000	84,000	24,500	84,000	10,285,230
23	Saharsa	10	10	2,150	143,400	6,450,000	3,386,250	20,000	0	80,000	6,000	0	21,500	1,000	60,000	60,000	17,500	60,000	10,285,650
24	Samastipur	20	20	1,158	77,200	3,474,000	1,823,850	40,000	0	80,000	6,000	0	11,580	2,000	60,000	120,000	35,000	120,000	5,809,630
25	Saran	16	16	1,055	70,400	3,165,000	1,661,625	32,000	0	80,000	6,000	0	10,550	1,600	60,000	96,000	28,000	96,000	5,275,175
26	Sheohar	5	5	110	7,400	330,000	173,250	10,000	0	80,000	6,000	0	1,100	500	60,000	30,000	8,750	30,000	727,000
27	Sitamarhi	13	13	726	48,400	2,178,000	1,143,450	26,000	0	80,000	6,000	0	7,260	1,300	60,000	78,000	22,750	78,000	3,703,160
28	Siwan	19	18	660	44,000	1,980,000	1,039,500	36,000	0	80,000	6,000	0	6,600	1,800	60,000	114,000	33,250	114,000	3,479,150
29	Supaul	11	8	386	25,600	1,158,000	607,950	16,000	0	80,000	6,000	0	3,860	800	60,000	66,000	19,250	66,000	2,093,460
30	Vaishali	16	16	1,883	125,400	5,649,000	2,965,725	32,000	0	80,000	6,000	0	18,830	1,600	60,000	96,000	28,000	96,000	9,126,555
31	W.Champaran	16	13	126	8,400	378,000	198,450	26,000	0	80,000	6,000	0	1,260	1,300	60,000	96,000	28,000	96,000	953,410
32	Nawada	1	1	61	4,000	183,000	96,075	2,000	0	80,000	0	0	610	100	0	6,000	1,750	6,000	377,535
***	State Level	0	0	0	0	0	0	0	0	0	0	18000	0	0	0	0	0	0	18,000
Total		397	357	21,318	1,421,200	63,954,000	33,575,850	714,000	48,000	2,400,000	186,000	18,000	213,180	35,700	1,860,000	2,382,000	694,750	2,382,000	109,156,930

Note:- for Nawada 61 cases reported in 2009

State-Bihar,Budget Plan 2010-11	**Annex- VI**		
Sl.No.	**State Level Component Activity**		**Financial Cost**
1	Mobile Phone Monthely Recharge Coupen for Officer & Staff At State Level Officefor (12 Months @ Rs 7,200 /Mobile for 10 Mobile)	----	**72000**
2	Meeting With Officers of Dist. Level (Alternate Month) and Expert committee Meeting	----	**2,00,000**
2A	Meeting With Officers of Dist. Level (Alternate Month)	90,000	**0**
2A	Expert Committee Report	1,10,000	**0**
3	Strengthining Of Computer & Internet Facility	----	**2,65,000**
3A	2 Laptpo for Officers(Dy.CMO & AD -KA)	1,00,000	**0**
3B	One Desk Top for KA Programme	50000	**0**
3C	Four Printer for Four ZMO Office & One Printer for SPO Office @ Rs. 10,000/-	50000	**0**
3D	Internet Connection (Three Laptop Plug to Surf) &One Broad Band Connection)One time Purchage	15000	**0**
3E	Internet Connection Rent for 12 Months.	50000	**0**
4	Supervision Of Dist. At State Level &Central Team	----	**620000**
5	IEC (Printing for Banner/Poster/hand bill,Wall painting/Audio Vedeo Massage/Prior intimation card/Study materials, etc	----	**500000**
6	Infrastructure Strengthening of Chief Malaria Office i.e, chair table,calculator,generator + fuel etc. & Developing a Cold Chain Room	----	**1200000**
6A	Chair ,Table,Calculator & Other Official Equipment	2,00,000	**0**
6B	POL for Generator .	1,00,000	**0**
6C	Developing a Cold Chain Room	9,00,000	**0**
Total (From Column 1 to 6)RS.		----	**2392000**

State - Bihar | Revised Training 2011-12 | Annexure --VII

Sl. No.	Name of Districts	Training Of Malaria Inspector		Training Of Health Supervisor			Training Of Health Worker					Grand Total of Training From Annex. VII
		Total No. Of MI	TRG Cost Of MI TwoRounds	Total No. Of BHI	Total No. Of SI	TRG Cost Of Health Supervisor	Total No. Of BHW	Total No. Of SW	Total No. Of FW	Total No. Of SFW	TRG Cost Of Health Worker	
1	2	3	4	5	6	7	8	9	10	11	12	17
1	Araria	0	Proposed No.of Malaria Inspectors for Training are 80 .Total Provision of Training of 80 MI . Provision of 20 Participant in each Batch =4 Batches (For 2 Days) @0.695 Lakh per Batch =2.78 Lakh As Per NVBDCP Guideline.	0	0	Proposed Training of BHI+ SI =100 .Total Provision of Training of 100 Health Supervisor . Provision of 25 Participant in each Batch =4 Batches For 2 Days @ 0.30 Lakhs per Batch =1.2 Lakh. As Per NVBDCP Guideline.	0	0	0	0	Total No.of BHW =103 +SIW= 33 +FW=43 +SFW=19 Total 198 in position.Proposed Training of 125 Health Worker . Provision of 25 Participant in each Batch =5 Batches For 2 Days @ 0.30 Lakhs per Batch =1.5 Lakh .As Per NVBDCP Guideline. One Round.	The Amount of Training for MI,Health Supervisor & Health Worker Kept in State Level .
2	Aurangabad	4		1	0		3	0	1	0		
3	Arwal	0		0	0		0	0	0	0		
4	Banka	0		0	0		0	0	0	0		
5	Begusarai	3		3	0		7	0	1	2		
6	Bhagalpur	2		11	1		6	0	1	2		
7	Bhojpur	5		8	0		1	0	4	2		
8	Buxar	0		0	0		0	0	0	0		
9	Darbhanga	4		4	2		4	2	4	0		
10	E.Champaran	7		12	1		5	5	1	2		
11	Gaya	4		8	0		7	0	3	1		
12	Gopalganj	2		0	0		0	0	3	1		
13	Jamui	0		0	0		0	0	0	0		
14	Jehanabad	0		0	0		0	0	0	0		
15	Kaimur	0		0	0		0	0	0	0		
16	Katihar	3		2	0		6	0	0	0		
17	Khagaria	0		0	0		0	0	0	0		
18	Kishanganj	0		0	0		0	0	0	0		
19	Lakhisarai	0		0	0		0	0	0	0		
20	Madhepura	0		0	0		0	0	0	0		
21	Madhubani	8		5	6		0	9	2	0		
22	Munger	5		4	3		11	5	2	0		
23	Muzaffarpur	4		7	0		3	0	3	0		
24	Nawada	2		1	1		0	1	2	0		
25	Nalanda	3		8	0		2	0	3	0		
26	Patna	10		11	0		9	0	5	2		
27	Purnea	9		6	1		7	0	3	0		
28	Rohtas	6		1	2		9	5	0	0		
29	Saharsa	6		6	0		3	0	0	0		
30	Samastipur	5		3	0		0	0	0	1		
31	Saran	6		6	0		4	0	0	1		
32	Sheikhpura	0		0	0		0	0	0	0		
33	Sheohar	0		0	0		0	0	0	0		
34	Sitamarhi	3		4	0		3	0	0	0		
35	Siwan	3		3	0		6	0	1	1		
36	Supaul	0		0	0		0	0	0	0		
37	Vaishali	5		4	0		5	0	3	2		
38	W.Champaran	5		0	1		2	6	1	2		
	ZMO Office (All 4)	0		0	0		0	0	0	0		
Total		114	278,000	118	18	120,000	103	33	43	19	150,000	548,000

Revised Training of Medical Officer							Annexure VIII
Sl. No.	Name of Districts	TRG OF MEDICAL OFFICERS					
		Govt.Medical College	Referal Hospital	Sadar Hospital	Sub. Hospital	PHC	TRG Cost of MO
1	2	3	5	6	7	8	9
1	Araria	0	3	0	1	9	TRG of 1 MO each affected PHC,Govt. 2 MO from Medical College 2 MO from Govt.Hospital,2 MO from Sadar Hospital ,1-1 MO from Sub Divisional Hospital & Referral Hospital.Total Provision of Training of 125 Medical Officers.Provision of 25 particepents in each batch =5 Batch @ 1.2 Lakhs per Batch for three days =6.0 Lakh as per NVBDCP Guide line .
2	Aurangabad	0	3	1	0	0	
3	Arwal	0	0	0	0	3	
4	Banka	0	3	0	1	10	
5	Begusarai	0	2	1	0	11	
6	Bhagalpur	1	2	1	1	11	
7	Bhojpur	0	2	0	0	12	
8	Buxar	0	0	0	1	7	
9	Darbhanga	1	2	0	0	14	
10	E.Champaran	0	3	1	0	20	
11	Gaya	1	2	1	0	0	
12	Gopalganj	0	3	1	1	10	
13	Jamui	0	3	0	1	0	
14	Jehanabad	0	2	1	0	5	
15	Kaimur	0	2	0	1	0	
16	Katihar	0	3	1	0	18	
17	Khagaria	0	1	1	0	6	
18	Kishanganj	0	2	0	1	7	
19	Lakhisarai	0	1	0	1	4	
20	Madhepura	0	1	1	0	7	
21	Madhubani	0	2	1	1	18	
22	Munger	0	1	1	0	6	
23	Muzaffarpur	1	1	1	0	14	
24	Nawada	0	2	1	0	0	
25	Nalanda	0	3	1	1	12	
26	Patna	2	4	0	3	16	
27	Purnea	0	2	1	0	14	
28	Rohtas	0	1	1	1	0	
29	Saharsa	0	0	1	0	7	
30	Samastipur	0	1	1	3	14	
31	Saran	0	3	1	0	15	
32	Sheikhpura	0	1	0	1	0	
33	Sheohar	0	1	0	1	0	
34	Sitamarhi	0	1	1	0	13	
35	Siwan	0	2	1	0	15	
36	Supaul	0	1	0	1	11	
37	Vaishali	0	2	1	0	11	
38	W.Champaran	0	2	1	1	16	
	ZMO Office (All 4)	0	0	0	0	0	
Total		6	70	24	22	336	600,000

Revised Training of PRI Members					Annexure -IX
Sl. No.	Name of Districts	Advocasy Workshop & Training of PRI			
		Block	Panchyat	Zila Parishad Members(Per Dist.15 Members)	Total Cost Of PRI Members
1	2	3	4	5	6
1	Araria	9	221	15	Proposed Training for PRI Members are :-total No.15 BDC Members Per Blocks + Total No. Of 1 Mukhiya per Panchyats + 15 Zila Parishad Members per districts. Total Provision of Training of PRI Members are 8900.Provision of 50 Participant in each Batch =178 Batches For 1 Days @ 0.02 Lakhs per Batch =3.56 Lakh .Selection of PRI Members from Highly Endemic Blocks/PHC . As Per NVBDCP Guideline. One Round.
2	Aurangabad	0	0	0	
3	Arwal	0	0	15	
4	Banka	11	185	15	
5	Begusarai	18	257	15	
6	Bhagalpur	17	242	15	
7	Bhojpur	14	228	15	
8	Buxar	11	142	15	
9	Darbhanga	19	329	15	
10	E.Champaran	27	387	15	
11	Gaya	0	0	0	
12	Gopalganj	14	234	15	
13	Jamui	0	0	0	
14	Jehanabad	12	161	15	
15	Kaimur	0	0	0	
16	Katihar	16	238	15	
17	Khagaria	7	129	15	
18	Kishanganj	7	118	15	
19	Lakhisarai	7	80	15	
20	Madhepura	13	170	15	
21	Madhubani	21	399	15	
22	Munger	9	101	15	
23	Muzaffarpur	16	387	15	
24	Nawada	0	0	0	
25	Nalanda	20	249	15	
26	Patna	23	331	15	
27	Purnea	14	246	15	
28	Rohtas	0	0	0	
29	Saharsa	10	164	15	
30	Samastipur	20	381	15	
31	Saran	20	0	15	
32	Sheikhpura	0	0	0	
33	Sheohar	5	54	15	
34	Sitamarhi	17	273	15	
35	Siwan	16	293	15	
36	Supaul	11	180	15	
37	Vaishali	16	292	15	
38	W.Champaran	18	354	15	
Total		438	6,825	465	356,000

Revised Training of PRI Members					Annexure -IX
Sl. No.	Name of Districts	Advocasy Workshop & Training of PRI			
		Block	Panchyat	Zila Parishad Members(Per Dist.15 Members)	Total Cost Of PRI Members
1	2	3	4	5	6
1	Araria	9	221	15	Proposed Training for PRI Members are :-total No.15 BDC Members Per Blocks + Total No. Of 1 Mukhiya per Panchyats + 15 Zila Parishad Members per districts. Total Provision of Training of PRI Members are 8900.Provision of 50 Participant in each Batch =178 Batches For 1 Days @ 0.02 Lakhs per Batch =3.56 Lakh .Selection of PRI Members from Highly Endemic Blocks/PHC . As Per NVBDCP Guideline. One Round.
2	Aurangabad	0	0	0	
3	Arwal	0	0	15	
4	Banka	11	185	15	
5	Begusarai	18	257	15	
6	Bhagalpur	17	242	15	
7	Bhojpur	14	228	15	
8	Buxar	11	142	15	
9	Darbhanga	19	329	15	
10	E.Champaran	27	387	15	
11	Gaya	0	0	0	
12	Gopalganj	14	234	15	
13	Jamui	0	0	0	
14	Jehanabad	12	161	15	
15	Kaimur	0	0	0	
16	Katihar	16	238	15	
17	Khagaria	7	129	15	
18	Kishanganj	7	118	15	
19	Lakhisarai	7	80	15	
20	Madhepura	13	170	15	
21	Madhubani	21	399	15	
22	Munger	9	101	15	
23	Muzaffarpur	16	387	15	
24	Nawada	0	0	0	
25	Nalanda	20	249	15	
26	Patna	23	331	15	
27	Purnea	14	246	15	
28	Rohtas	0	0	0	
29	Saharsa	10	164	15	
30	Samastipur	20	381	15	
31	Saran	20	0	15	
32	Sheikhpura	0	0	0	
33	Sheohar	5	54	15	
34	Sitamarhi	17	273	15	
35	Siwan	16	293	15	
36	Supaul	11	180	15	
37	Vaishali	16	292	15	
38	W.Champaran	18	354	15	
Total		438	6,825	465	356,000

Revised Training of Spray Worker & ASHA Anex. X A							Total of Training From Annex. VII,VIII,IX & XA (Annex. XB)				
Sl. No.	Name of Districts	Training Of Spray Worker			Training Of MPW (ASHA) Contractual		Total of Training From Annex. VII	Total of Training From VIII	Total of Training From Annex.IX	Total of Training From Annex. XA	Grand Total of Training From Annex.VII, VIII, IX & XA
		Total No. Of SFW	Total No. Of FW	TRG Cost Of Spray Worker	Total No. Of ASHA	TRG Cost Of MPW (ASHA)					
1	2	3	4	5	6	7	9	10	11	12	13
1	Araria	1654	8270	Total No.of Spray Worker FW=8270 +SFW=1654 Total 9924 .Total Provision of Training of 9924 Spray Worker . Provision of 50 Participant in each Batch =199 Batches For 1 Days @ 0.02 Lakhs per Batch =3.98 Lakh. As Per NVBDCP Guideline One Round.	2026	Total No.of MPW(ASHA) Contractual 55570.Total Provision of Training of 25000 MPW(ASHA) Contractual in First Phase . Provision of 50 Participant in each Batch =500 Batches For 1 Days @ 0.02 Lakhs per Batch =10.00 Lakh As Per NVBDCP Guideline One Round.	The Amount of Training for MI(2.78 Lakh),Health Supervisor(1.20 Lakh) & Health Worker(1.50 Lakh) Total 5.48 Lakh,Kept in State Level .	TRG of 1 MO each affected PHC,Govt. 2 MO from Medical College 2 MO from Govt.Hospital,2 MO from Sadar Hospital ,1-1 MO from Sub Divisional Hospital & Referral Hospital.Total Provision of Training of 125 Medical Officers.Provision of 25 particepents in each batch =5 Batch @ 1.2 Lakhs per Batch for three days =6.0 Lakh as per NVBDCP Guide line .	Proposed Training for PRI Members are :- total No.15 BDC Members Per Blocks + Total No. Of 1 Mukhiya per Panchyats + 15 Zila Parishad Members per districts. Total Provision of Training of PRI Members are 8900.Provision of 50 Participant in each Batch =178 Batches For 1 Days @ 0.02 Lakhs per Batch =3.56 Lakh .Selection of PRI Members from Highly Endemic Blocks/PHC . As Per NVBDCP Guideline. One Round.	The Amount of Training for Spray Worker 4.48 Lakh)& ASHA (10.00 Lakh)Kept in State Level .	At State Level Grand Total Of Annex. VII,VIII , IX & XA =29.52 Lakh.
2	Arwal				653						
3	Banka				1552						
4	Begusarai				2245						
5	Bhagalpur				1966						
6	Bhojpur				2049						
7	Buxar				1318						
8	Darbhanga				2357						
9	E.Champaran				2686						
10	Gopalganj				1868						
11	Jehanabad				769						
12	Katihar				2174						
13	Khagaria				313						
14	Kishanganj				1027						
15	Lakhisarai				581						
16	Madhepura				1403						
17	Madhubani				3034						
18	Munger				951						
19	Muzaffarpur				3398						
20	Nalanda				1980						
21	Patna				2634						
22	Purnea				2263						
23	Saharsa				676						
24	Samastipur				3143						
25	Saran				3178						
26	Sheohar				495						
27	Sitamarhi				464						
28	Siwan				2618						
29	Supaul				1538						
30	Vaishali				1477						
31	W.Champaran				2734						
Total		1,654	8,270	398,000	55,570	1,000,000	548,000	600,000	356,000	1,398,000	2,902,000

Revised Training of Spray Worker & ASHA Anex. X A							Total of Training From Annex. VII,VIII,IX & XA (Annex. XB)				
Sl. No.	Name of Districts	Training Of Spray Worker			Training Of MPW (ASHA) Contractual		Total of Training From Annex. VII	Total of Training From VIII	Total of Training From Annex.IX	Total of Training From Annex. XA	Grand Total of Training From Annex.VII, VIII, IX & XA
		Total No. Of SFW	Total No. Of FW	TRG Cost Of Spray Worker	Total No. Of ASHA	TRG Cost Of MPW (ASHA)					
1	2	3	4	5	6	7	9	10	11	12	13
1	Araria	1654	8270	Total No.of Spray Worker FW=8270 +SFW=1654 Total 9924 .Total Provision of Training of 9924 Spray Worker . Provision of 50 Participant in each Batch =199 Batches For 1 Days @ 0.02 Lakhs per Batch =3.98 Lakh. As Per NVBDCP Guideline One Round.	2026	Total No.of MPW(ASHA)Contractual 55570.Total Provision of Training of 25000 MPW(ASHA)Contractual in First Phase . Provision of 50 Participant in each Batch =500 Batches For 1 Days @ 0.02 Lakhs per Batch =10.00 Lakh As Per NVBDCP Guideline One Round.	The Amount of Training for MI(2.78 Lakh),Health Supervisor(1.20 Lakh) & Health Worker(1.50 Lakh) Total 5.48 Lakh,Kept in State Level .	TRG of 1 MO each affected PHC,Govt. 2 MO from Medical College 2 MO from Govt.Hospital ,2 MO from Sadar Hospital ,1-1 MO from Sub Divisional Hospital & Referral Hospital.Total Provision of Training of 125 Medical Officers.Provision of 25 particepents in each batch =5 Batch @ 1.2 Lakhs per Batch for three days =6.0 Lakh as per NVBDCP Guide line .	Proposed Training for PRI Members are :- total No.15 BDC Members Per Blocks + Total No. Of 1 Mukhiya per Panchyats + 15 Zila Parishad Members per districts. Total Provision of Training of PRI Members are 8900.Provision of 50 Participant in each Batch =178 Batches For 1 Days @ 0.02 Lakhs per Batch =3.56 Lakh .Selection of PRI Members from Highly Endemic Blocks/PHC . As Per NVBDCP Guideline. One Round.	The Amount of Training for Spray Worker 4.48 Lakh)& ASHA (10.00 Lakh)Kept in State Level .	At State Level Grand Total Of Annex. VII,VIII , IX & XA =29.52 Lakh.
2	Arwal				653						
3	Banka				1552						
4	Begusarai				2245						
5	Bhagalpur				1966						
6	Bhojpur				2049						
7	Buxar				1318						
8	Darbhanga				2357						
9	E.Champaran				2686						
10	Gopalganj				1868						
11	Jehanabad				769						
12	Katihar				2174						
13	Khagaria				313						
14	Kishanganj				1027						
15	Lakhisarai				581						
16	Madhepura				1403						
17	Madhubani				3034						
18	Munger				951						
19	Muzaffarpur				3398						
20	Nalanda				1980						
21	Patna				2634						
22	Purnea				2263						
23	Saharsa				676						
24	Samastipur				3143						
25	Saran				3178						
26	Sheohar				495						
27	Sitamarhi				464						
28	Siwan				2618						
29	Supaul				1538						
30	Vaishali				1477						
31	W.Champaran				2734						
Total		1,654	8,270	398,000	55,570	1,000,000	548,000	600,000	356,000	1,398,000	2,902,000

World Bank Suported Programme (Salary and T.A , DA and other Activity of Contractual Staff) ANNEX- I (World Bank)

Sl. No.	Name of Districts	Name of post - KTS		Name of post-VBDC		Name of post		Name of post		Name of post		Name of post		Grand Total Salary	Mobility	D.A	Mobility Total	Training	Training	Training Total	Total
		No. of K.T.S	Salary @ 10000/Month for 12 month	No. of VBD in District /State	Salary @ 30000/Month for 12 month	No. of Data operator in District	Salary @6500/Month for 12 month	No. of Logistic & Financial Assistant in District	Salary @8000/Month for 12 month	No. of Acountant in State	Salary @10000/ Month for 12 month	No. of Insect Collector in State	Salary @8000/Month for 12 month		Mobility for District VBD & State VBD, Insect Collector	D.A For District & State Consultant, Insect Collector		Training For District & State Consultant, Insect Collector	Training For KTS		
1	2	3	4	5	6	7	8	9	10	11	12	13	14		15	16		17	18		19
1	Araria	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
2	Arwal	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
3	Banka	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
4	Begusarai	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
5	Bhagalpur	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
6	Bhojpur	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
7	Buxar	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
8	Darbhanga	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
9	E.Champaran	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
10	Gopalganj	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
11	Jehanabad	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
12	Katihar	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
13	Khagaria	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
14	Kishanganj	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
15	Lakhisarai	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
16	Madhepura	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
17	Madhubani	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
18	Munger	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
19	Muzaffarpur	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
20	Nalanda	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
21	Patna	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
22	Purnea	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
23	Saharsa	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
24	Samastipur	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
25	Saran	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
26	Sheohar	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
27	Sitamarhi	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
28	Siwan	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
29	Supaul	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
30	Vaishali	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
31	W.Champaran	6	720000	1	360000	1	78000	1	96000	0	0	0	0	1254000	86400	36000	122400	17000	102000	119000	1495400
***	State Level	0	0	6	2160000	0	0	0	0	1	120000	2	192000	2472000	2016000	144000	2160000	21000	0	21000	4653000
Total		**186**	**22320000**	**37**	**13320000**	**31**	**2418000**	**31**	**2976000**	**1**	**120000**	**2**	**192000**	**41346000**	**4694400**	**1260000**	**5954400**	**548000**	**3162000**	**3710000**	51010400

State-Bihar Expenditure(Financial Performance)-Budget proposal 2011-12			
Major Head & Sub Activity	**2010-11(Expenditure)**	**2011-12 (Proposed)* (Rs. In Lakhs)**	**Support to be met from NVBDCP/GOI or State Resources or NRHM Flexi Fund**
Malaria			
DBS			
MPW		66,168,000.00	
ASHA		75,000.00	
Operational Cost including Spray Wages(By GOB)		0.00	
NAMMIS		1,800,000.00	
IEC,BCC & PPP		1,695,000.00	
Training		1,079,790.00	
Additional Support under World Bank (If applicable)		0.00	
Human Resource		0.00	
Capacity Building in Project Area		0.00	
Mobility Support		660,000.00	
Additional Support Under GFATM(If Applicable)		0.00	
Capacity Building		0.00	
Establishment State Society		0.00	
Human Resource		0.00	
Monitoring & Evaluation		0.00	
BCC/PPP/Soc.Mkt.		0.00	
Drugs		0.00	
ChloroquinePhosphate Tablets		800000 No.	
Primaquine Tablets 2.5 mg		16500 No.	
Primaquine Tablets 7.5 mg		38400 No.	
Quinine Sulphate Tablets		1000 No.	
Quinine Injection		0 No.	
Sulphadoxine+Pyremethamine Tablets		0 No.	
Diagnostics		0.00	
IRS (By GOB)		0.00	
Wages		0.00	
Human Resource		0.00	
Monitoring & Evaluation		0.00	
Bed Nets		0.00	
Impregnated Mosquito Nets		0.00	
LLIN		0.00	
Insecticides		0.00	
DDT 50%		0.00	
Synthetic Pyrethroid		0.00	
Malathion 25% Technical		0.00	
UMS-Larvicides		0.00	
For Polluted Water		0.00	
For Non Polluted Water		0.00	
Pyrethrum Extract 2%		0.00	
Total Malaria		**71,477,790.00**	
Dengue/Chikungunya		0	
Grant in respect of Dengu & Chikungunya		0	
Strengthening Surveillance(As per GOI Approval)		2.00	
Apex Referral Labs Recurrent @ Rs/-1.00 Lakh		0.00	
Sentinet Survelliance Hospital Recurrent @ Rs. 0.50 Lakhs		0.00	

Test Kit(No.) to be supplied by GOI		0.00	
Monitoring/Supervision & Rapid Response		2.00	
Epidemic Prepardness		28.00	
IEC/BCC/Social Mobilisation(Amount kept in Epidemic Prepardness Head)		0.00	
Training/Workshop		2.00	
Total Dengue/Chikungunya		**34.00**	
AES/JE		0	
Diagnostic & Management		6.00	
ELISA Kits		3.00	
IEC/BCC		5.00	
Training		1.01175	
Monitoring & Supervision		7.50	
Technical Malathion		15.50	
Total AES/JE		**38.01175**	
Kala-Azar (Bihar)		0	
DDT 50%		2251 MT	
Ambhotericin-B		25964 Vials	
Miltofosine 10 mg.		4,80,480 Cap.	
Miltofosine 50 mg.		7,34,624 Cap.	
RDK for KA		54239 No.	
Case Search	RS.	5,458,750.00	As Camp Mode
Spray Pumps		0.00	
Operational Cost including Spray Operational Cost for spray including spray wages	Rs.	172,804,200.00	For Two round
Wages	RS.	78,115,800.00	For One round
Back wages	RS.	2,000,000.00	
Office Expance + Contigency	RS.	856,500.00	For One round
DDT Transpotation	RS.	1,533,500.00	For One round
Pump repair+ Nossel Purchase	RS.	1,684,100.00	For One round
D.A for Supervision	RS.	568,750.00	For One round
Daily Evening Brifing	RS.	2,643,450.00	For One round
Mobility /POL	RS.	27,836,400.00	
During Spray(Four Months)	RS.	24,768,400.00	For Two round
For other Eight Month	RS.	2,448,000.00	For Dist.
Head Quarter for Eight months	RS.	620,000.00	Head Quarter
Training for spraying for regular Staff & Mos,PRI & Asha	RS.	2,902,000.00	
BCC/IEC	RS.	1,604,000.00	
IEC during Spray	RS.	1,104,000.00	For Two round
IEC for head Quarter(Printing Materials etc.)	RS.	500,000.00	
Monitoring & Evaluation	RS.	200,000.00	
Metting at State level(DMO/ACMO+VBD)	RS.	90,000.00	
Expert Committee Mettinng	RS.	110,000.00	
Asha Incentive	RS.	1,421,200.00	
Wage Loss K.A Patients	RS.	63,954,000.00	
Drug Storage	RS.	204,000.00	
At District Level	RS.	186,000.00	
At State Level	RS.	18,000.00	
Treatment Card	RS.	213,180.00	
Information collection Register	RS.	35,700.00	
DDT Storage at District level	RS.	1,860,000.00	
Spl food supliment for K.A Pateints	RS.	33,575,850.00	

Office Expance + Contigency for districts for eight month	RS.	714,000.00	
Infrastructure developments of SPO office	RS.	1,537,000.00	
Internet + Computer Purchage	RS.	265,000.00	
Mobile	RS.	72,000.00	
Chair + Table	RS.	100,000.00	
Generator+ Fuel	RS.	500,000.00	
Cold Chain room with four Ac	RS.	600,000.00	
Kala-Azar sub total (DBS)		**314,320,280.00**	
KA World Bank Project Assistance		0.00	
Human Resource		41,346,000.00	
Capacity Building		3,710,000.00	
Mobility		5,954,400.00	
KA Sub Total(World Bank Project Assistance)		**51,010,400.00**	
Kala-Azar Total		**365,330,680.00**	
Grand Total			
Activity not listed & require for programme is as follow :-			
Malaria			
Artheter Injection		1003 No.	
Malaria RDT Kits		28750 No.	
Bed Nets		100000 No.	
Combi Blister Pack(ACT)		1000 No.	
Dengue/Chikungunya			
Platelets Seperator		15.00	
ELISA Reader		42.00	
Ward Strengthening		14.00	
Blood Bank Strengthening		14.00	
Mosquito Net		5.00	
Total Additional Requirement		**90.00**	
Reqiurement mentioned as above(As DBS)		**34.00**	
Grand Total Dengu/Chikungunya		**124.00**	
AES/JE			
Incentive of ASHA		0.40	
Total Additional Requirement		**0.40**	
Reqiurement mentioned as above(As DBS)		**38.01175**	
Grand Total AES/JE		**38.41175**	

State & District Wise Fund Allocation - Kala-Azar, Bihar 2009-2010							
	Name of Districts	One Round Amount			Two Round Amount	From Annex. V	Total (Column 6+7)
		From Annex. II	From Annex. IV	Total Amount For One Round	Total Amount For Two Round Spray i.e (Anneex.II+ Annex.IV)		
1	2	3	4	5	6	7	8
1	**Araria**	4,105,740.00	161,450.00	4,267,190.00	8,534,380.00	5,072,950.00	13,607,330.00
2	**Arwal**	73,860.00	9,700.00	83,560.00	167,120.00	1,008,250.00	1,175,370.00
3	**Banka**	36,180.00	2,800.00	38,980.00	77,960.00	1,016,150.00	1,094,110.00
4	**Begusarai**	1,923,900.00	86,250.00	2,010,150.00	4,020,300.00	2,119,550.00	6,139,850.00
5	**Bhagalpur**	287,940.00	27,300.00	315,240.00	630,480.00	1,289,100.00	1,919,580.00
6	**Bhojpur**	429,660.00	42,000.00	471,660.00	943,320.00	1,136,650.00	2,079,970.00
7	**Buxar**	214,080.00	13,400.00	227,480.00	454,960.00	1,066,400.00	1,521,360.00
8	**Darbhanga**	3,072,840.00	140,250.00	3,213,090.00	6,426,180.00	3,686,450.00	10,112,630.00
9	**E.Champaran**	5,023,920.00	234,550.00	5,258,470.00	10,516,940.00	4,493,000.00	15,009,940.00
10	**Gopalganj**	1,332,840.00	78,150.00	1,410,990.00	2,821,980.00	3,068,500.00	5,890,480.00
11	**Jehanabad**	76,860.00	16,400.00	93,260.00	186,520.00	1,052,400.00	1,238,920.00
12	**Katihar**	2,177,160.00	148,450.00	2,325,610.00	4,651,220.00	2,298,150.00	6,949,370.00
13	**Khagaria**	667,920.00	39,350.00	707,270.00	1,414,540.00	2,005,550.00	3,420,090.00
14	**Kishanganj**	1,361,520.00	79,950.00	1,441,470.00	2,882,940.00	1,503,800.00	4,386,740.00
15	**Lakhisarai**	211,080.00	11,350.00	222,430.00	444,860.00	1,050,350.00	1,495,210.00
16	**Madhepura**	2,750,220.00	111,100.00	2,861,320.00	5,722,640.00	4,254,350.00	9,976,990.00
17	**Madhubani**	2,662,680.00	128,900.00	2,791,580.00	5,583,160.00	2,952,400.00	8,535,560.00
18	**Munger**	217,080.00	22,800.00	239,880.00	479,760.00	1,178,800.00	1,658,560.00
19	**Muzaffarpur**	5,188,320.00	293,450.00	5,481,770.00	10,963,540.00	6,976,700.00	17,940,240.00
20	**Nalanda**	606,060.00	44,150.00	650,210.00	1,300,420.00	1,321,050.00	2,621,470.00
21	**Patna**	2,035,440.00	124,300.00	2,159,740.00	4,319,480.00	1,628,050.00	5,947,530.00
22	**Purnea**	4,319,820.00	202,600.00	4,522,420.00	9,044,840.00	4,410,900.00	13,455,740.00
23	**Saharsa**	2,646,180.00	108,850.00	2,755,030.00	5,510,060.00	5,044,850.00	10,554,910.00
24	**Samastipur**	3,662,400.00	185,650.00	3,848,050.00	7,696,100.00	4,248,200.00	11,944,300.00
25	**Saran**	2,762,220.00	159,050.00	2,921,270.00	5,842,540.00	3,941,250.00	9,783,790.00
26	**Sheohar**	419,160.00	17,200.00	436,360.00	872,720.00	1,202,850.00	2,075,570.00
27	**Sitamarhi**	3,452,820.00	140,450.00	3,593,270.00	7,186,540.00	2,721,650.00	9,908,190.00
28	**Siwan**	2,830,080.00	144,850.00	2,974,930.00	5,949,860.00	2,647,200.00	8,597,060.00
29	**Supaul**	1,577,100.00	81,250.00	1,658,350.00	3,316,700.00	1,168,800.00	4,485,500.00
30	**Vaishali**	3,935,340.00	191,150.00	4,126,490.00	8,252,980.00	5,650,550.00	13,903,530.00
31	**W.Champaran**	2,204,340.00	86,000.00	2,290,340.00	4,580,680.00	6,011,650.00	10,592,330.00
Total		**62,264,760.00**	**3,133,100.00**	**65,397,860.00**	**130,795,720.00**	**87,226,500.00**	**218,022,220.00**
State Level Activity							
1	Training At State Level From Annex. VII,VIII,IX & X						**7,089,240.00**
2	State Level Activity From Annex. VI						**1,473,440.00**
3	SPO & ZMO Mobility During Spray Period 145000.00 x2 =290000.00						**290,000.00**
4	Storage of Amphoteracin B.At State Level						**18,000.00**
Grand Total Of Kala-Azar Programme ,BIHAR							**226,892,900.00**

i=kkd %&

i"kd]
MkO ,l0 d0 veu]
iHkkjh jkT; dk;Øe inkf/kdkjh]lg
mi e[; eyfj;k inkf/kdkjh
e[; eyfj;k dk;ky; fcgkj] iVuk
lok e]
dk;ikyd fun'kd]
jkT; LokLF; lfefr]
fcgkj]iVuk

iVuk]fnukd%----------

fo"k;%& eyfj;k fu;=.kkFk foÙkh; o"k 2011&12 ctV ikdyu d i"k.k d lc/k eA egk'k;]

mi;ä fo"k;d eyfj;k fu;=.kkFk foÙkh; o"k 2011&12 dk ctV ikdyu foLrr fooj.kh fuEuor g&

jkT; d 38 ftyk e l lkr fty] ;Fkk jkgrkl] dej] x;k vkjxkckn] teb] uoknk rFkk exj] eyfj;k l vfèkdÙke iHkkfor g A bu lkr ftyk d eyfj;k iHkkfor {k=kk e o"k 2011 e Mh-Mh-Vh- fNMdko dk ctV ikoDyu jkT; ljdkj dk Hktk x;k g A

mijkDr lkr ftyk e fNMdko d vfrfjDr vU; xfrfofèk;k ;Fkk lfonk d vkèkkj ij fu;Dr gku oky ,e-ih-MCy d oru] vk'kk d }kjk eyfj;k jkfx;k dh [kkt@igpku mipkj gr ikRlkgu jkf'k] ipkj ilkj] i;o{k.k] if'k{k.k] oVuV ,o ukfel ij gku oky 0;; dk ctV ikoDyu iLrr fd;k tk jgk g A

(1) **ogmf'k; dk;dkrk (,e-ih-MCy**)%&eyfj;k d fu;=k.kkFk Hkkjr ljdkj }kjk 919 ,e-ih-MCy dk in LohÑr g] ftld fu;fDr dh ifØ;k jkT; Loko lfefr fcgkj iVuk }kjk dh tk jgh g A ,e-ih-MCy dk 6000@&:o ifr ekg oru n; g A ,e-ih-MCy d o"k 2011&12 d oru ij

0;; & 919x12x6000 --------- Rs, 6,61,68,000=00

(2) **vk'kk**

xkeh.k {k=kk e vk'kk tu lkèkkj.k dk LokLF; lok l tkMu dh lcl egÙoi.k dMh g A eyfj;k ;ktuk e vk'kk dk mi;kx fuxjkuh] fujkèkkRed] mipkjkRed ,o oh-lh-lh- ,tU;V d :i e ck[kh l fd;k tk ldrk g A

(I) lkr eyfj;k iHkkfor ftyk e vk'kk d 14066 in lftr g ftle 13597 dk;jr g A vk'kk Toj ihfMr jkfx;k dh igpku dj mUg DykjkDohu dk ,d [kjkd f[kkyk;xh lkFk gh mudk jDriV lxg djxh ;k vkj-Mh- d }kjk Lo; tkp djxh A tkpkijkUr èkukRed jkfx;k dk mipkj djxh ftld fy, ifr jkxh 30@&:o ikRlkgu jkf'k fn;k tk;xk A

foxr rhu o"kk e ifrofnr vkIr eyfj;k jkfx;k dh l[;k 2372 g A vk'kk dk bl dk; ij yxk; tku l ifro"k 2500 jkfx;k dk vkèkkj ekudj ctV dk vkdyu fd;k x;k g A

vk'kk dk dy ikRlkgu jkf'k & 2500x30----------Rs. 75000=00

(II) vk'kk dk eyfj;k jkfx;k dh igpku ,o mipkj gr if'kf{kr fd;k tkuk g A lkr eyfj;k iHkkfor ftyk e dk;jr 13597 vk'kk dk 50 d cp e ,d fnolh; if'k{k.k fn;k tk;xkA if'k{k.k d nkjku mUg eyfj;k d jkdFkke lcèkh ekx nf'kdk ,o pk; bR;kfn ij ifr vk'kk 50@& :o 0;; dk vkdyu fd;k x;k g A

vk'kk d if'k{k.k ij iLrkfor 0;; &&& 13597x50----------Rs. 6,79,850=00

(3) **ipkj ilkj**

lkr eyfj;k iHkkfor ftyk e fNMdko d io ,o fNMdko d njE;ku vke turk dk fNMdko lcèkh vko';d tkudkjh ,o fNMdko dh frFk dk fNMdko gr r;kj jgu dh tkudkjh ikLVj] iEiyV] ipk;r xk"Bh ,o <ky fiVokdj nh tkrh g A bl fufer 7 ftyk dk ifr ftyk 25]000 :o dh nj l jkf'k miyC;k djkb tk;xh A

fNMdko lcèkh ipkj&ilkj d fy, iLrkfor jkf'k & 7x25,000----------Rs. 175,000=00 (II) Hkkjr ljdkj d fun'kkulkj iR;d o"k ekg tu e eyfj;k ekg euku dk ikoèkku g A eyfj;k ekg d nkjku eyfj;k l cpko lcèkh egÙoi.k tkudkjh ikLVj] iEiyV] ipk;r xk"Bh d ekè;e l vke turk dk nh tkrh g A bl fufer iR;d fty dk 20000@&:o dh nj l jkf'k miyC;k djk;h tk;xh A

eyfj;k ekg d nkjku ipkj ilkj gr iLrkfor jkf'k&38x20000 --------Rs. 7,60,000/-

(III) jkT; Lrj l Hkh fNMdko ,o eyfj;k ekg d nkjku 0;kid ipkj ilkj fd;k tk;xk ftld fy, ekbd ;Dr okgu HkkM ij fy;k tk;xk A bl fufer vuekfur 0;; (ifr ftyk Rs. 20,000/-) dk vkdyu fd;k x;k g A

jkT; Lrj l ipkj ilkj gr iLrkfor jkf'k& 38x20,000----------Rs. 7,60,000=00

(4) **i;o{k.k&**

(I) **ftyk Lrjh;%&** eyfj;k d fu;=kk.kkFk jkT; d lkr ftyk e iR;d nk pØ Mh-Mh-Vh-fNMdko djku dk ikoèkku g A fNMdko d liQy lpkyu ,o x.koÙkk i.k fNMdko dh nf"V l i;o{k.k vR;Ur vko';d g A vr% fNMdko d i;o{k.k gr iR;d fty dk 20]000@&:o ifr ftyk ifr ekg fd nj l 4 ekg d fy, jkf'k miyC;k djk;h tk;xh A lcfèkr fty i;o{k.k gr ftyk Lrj ij vuekfnr nj d vulkj HkkM ij xkMh yx A ftu ftyk e okgu miyC;k g] o fty bl jkf'k dk mi;kx bèku bR;kfn ij djx A

fNMdko d i;o{k.k gr iLrkfor jkf'k&7x20000x4 ---------- Rs. 5,60,000=00

(II) **jkT; Lrjh;%&** fNMdko dk i;o{k.k jkT; Lrj d inkfèkdkfj;k ;Fkk jkT; dk;Øe ink0] mi e[; eyfj;k inko] lgk;d fun'kd dkykt kj ,o {k=kh; eyfj;k inko iVuk ie.My iVuk] }kjk fd;k tkrk g A bl fufer HkkM d okgu dk mi;kx fd;k tkrk g A

,d pØ d nkjku mDr jkT;Lrjh; inkfèkdkfj;k }kjk iR;d fty dk nk ckj i;o{k.k fd;k tk;xk A

vr% jkT; d inkfèkdkfj;k d HkkM dh jkf'k d fy, dy iLrkfo jkf'k%& Rs. 1,00,000=00

(5) **if'k{k.k%&**

eyfj;k d fu;=k.kkFk fuxjkuh dk; dh xfr c<ku dh nf"V l lcfèkr fty d ftyk eyfj;k inko@vij e[; fpfdrlk inko (ftu ftyk e ftyk eoinko dk in lftr ugh g)] eyfj;k fujh{kd] i;kx'kkyk ikofèkd] cfu;knh Loko dk;dÙkk] fuxjkuh dk;drk rFkk {k=kh; dk;dÙkk dk if'kf{kr fd;k tk;xk A

(I) lkr ftyk d ftyk e0 ink0@vij e[k fpfdRlk ink0 14 eyfj;k fujh{kd (iR;d fty l nk) dk ,d cp e nk fnolh; if'k{k.k fn;k tk;xk A if'k{k.k ij ifr cp 1]20]000@& :o 0;; gkxk A

bl idkj mijkDr 21 if'k{k.kFkh d ,d cp e if'k{k.k ij dy 0;;%&Rs. 1,20,000/-

(II) lkr ftyk d i;kx'kkyk ikofèkd dk 5 fnolh; if'k{k.k fn;k tk;xk A ble iR;d ftyk d N% ioiko Hkkx yx A bl idkj dy if'k{k.kFkk dk nk cp e if'k{k.k fn;k tk;xk A if'k{k.k e ifr cp 75620@& :0 0;; gkxkA

i;kx'kkyk ik0 d if'k{k.k ij dy 0;;&75]620 x 2---------- Rs. 1,51,240=00

(III) lkr ftyk d cgnf'k; dk;dÙkk];Fkk cfu;knh LokLF; dk;dÙkk](29)]fuxjkuh fujh{kd ¼Survillence inspector½ (16) rFkk {k=kh; dk;dÙkk (11) dk if'kf{kr fd;k tk;xk A mDr 56 if'k{kk.kkFkk dk ,d fnolh; if'k{k.k nk cp e fn;k tk;xk A ,d cp d if'k{k.k ij 64]350@& : 0;; gkxk A

cgnf'k; dk;dÙkk d if'k{k.k ij dy 0;; -------- (64350x2) -------- Rs. 1,28,700/-

(6) **M & E including NAMIS**:- bld rgr dk;Øe dk bUVjuV d ekè;e l ftyk dk jkT; e[;ky; l tkMdj dk;Øe lcèk lHkh idkj d ifronuk@lpukvk dk ldfyr fd;k tkuk g A foÙkh; o"k 2010&11 e bl en e LohÑr ROP e vBkjg yk[k :i; Hkkjr ljdkj }kjk LohÑr fd;k x;k g A jkT; d 38 ftyk e iR;d fty e ,d&,d rFkk jkT; e[;ky; e nk dEI;Vj dy 40 dEI;Vj miyC;ek g A ukeh l d vrxr fuEukfdr xfrfofèk;k dk j[kk x;k g%&

1 -**lh-Mh-@Mh-oh-Mh- jkbVj%&** jkT; e miyC;ek 39 dEI;Vj e lh-Mh-@Mh-oh-Mh- jkbVj ugh yxk g ftld dkj.k dk; dk lpk: :i e lpkyu e dfBukb gkrh g A bl fufer ifr dEI;Vj 1500@& dh nj l jkf'k dk ikoèkku fd;k x;k g 1500x39 = 58,500/-

2- **jle ,oa gkM fMLd%&** jkT; e miyC;ek 40 dEI;Vj e 256 ,e-ch- je ,o 40 th-ch- gkM ftLd yxk gvk g tk dk;ck> dk n[kr g, cgr de g A bl ukfer ifr dEI;Vj 2 th-ch- je gr 2000@& rFkk 160 th-ch- gkM fMld 25000@& 0;; dk ikoèkku fd;k x;k g A

(i) 2 GB RAM - 40x2000 =---------- 80000/-
(ii) 160 GB HD = 40x2500 = 100000/-
dy%& 180000/-

3- **okf"kd j[k&j[kko%&** jkT; e miyCèk 40 dEI;Vj dk ikVl lfgr ,-,e-lh- (okf"kd j[k&j[kko 0;;) dk ikoèkku vko';d gA ,e-,e-lh- ifr dEI;Vj 5000@&0;; vuekfur g A

40X5000 = 200000@&

4- **bUVjuV%&** ukeh l dk;Øe ,d oolkbV dk;Øe g A jkT; e miyCèk lHkh dEI;Vj dk bVjuV l tkMuk vko';d g] ftll ftyk l vko';d lpuk;@ifronu le; ij miyCèk gk ldA vr% bVjuV duD'ku gr ifr dEI;Vj 4500@&:o 0;; dk ikoèkku fd;k x;k g A ckM cM d vufyfeVM Ldhe gr ifr ekg ifr dEI;Vj :o 800 dh nj l ij o"k d 0;; dk ikoèkku fd;k x;k A

(i) ckM cM dufDVx pkt vku ykbu 39x4500 = 175500/-
(ii) ekfld jVy 0;; 39x800x12 = 374400/-
dy 549900/-

5- **dEI;Vj d ikVl%&** fty e miyCèk dEI;Vj d j[k&j[kko ;Fkk ;-ih-,l- dk cVh] LV'kujh] iu Mkbo] dkVt bR;kfn dh vko';drk gkrh g A bl fufeÙk ifr dEI;Vj vuekfnr
:o 11000@& dk ikoèkku fd;k x;k g rFkk jkT; Lrj d nk dEI;Vj gr ifr dEI;Vj :o25000@& dh nj l 0;; dk ikoèkku fd;k x;k g A

38 x 11000 = 418000/-
2 x 25000 = 50000/-
dy 46800/-

6- **jkT; Lrj gr yi&Vki%&** jkT; Lrj ij ukeh l dk&vkfMuVj gr 2 yi Vki dh vko';drk gkxh A yi&Vki miyCèk jgu l cBd bR;kfn e dk;Øe lcèkh lHkh lpuk, miyCèk jgxh A bl nf"V l nk yi&Vki rFkk yi&Vki d ;-,l-ch-] bVjuV duD'ku dk ikoèkku fd;k x;k g] ftlij gkuoky 0;; dk fooj.k fuEuor g A

(i) **nk yi&Vki%&** 50000@& ifr dh nj l 2 x 50000 = 100000/-
(ii) ;-,l-ch- bVjuV lfoèkk gr ifr yi&Vki 16000@&dh nj l 2 x 16000 =32000/-
dy 132000/-

(7) **if'k{k.k%&** fty e miyCèk dEI;Vj d liQy lpkyu gr dEI;Vj ij dk; djuoky deh ;Fkk eyfj;k fujh{kd ,o MkVk bVh vkijVj dk if'k{k.k vko';d g A 38 fty d ,d ,d eyfj;k fujh{kd rFkk ,d&,d MkVk bVh vkijVj dy 76 ifrHkkfx;k dk pkj cp (ifr cp 20) e if'kf{kr fd;k tk;xk A if'k{k.k ij ifr cp :o 50000@& vuekfur g A
if'k{k.k ij 0;; 50000 x 4 =200000/-

(8) **jkT;Lrj ij vkijfVx [kp%&** miyC/k dEI;Vj d vkijfVx 0;; gr jkf'k dh 0;oLFkk dh tk jgh g] ftld fy, 11600@& j[kk x;k g A bud ukfel in d 0;; dk fooj.k bl idkj g%&

(1)	lh-Mh-@Mh-oh-Mh jkbVj	58]500&00
(2)	je ,o gkM fMLd	180000&00
(3)	okf"kd j[k&j[kko	200000&00
(4)	bVjuV	549900&00
(5)	dEI;Vj ikVl	468000&00
(6)	yi&Vki	132000&00
(7)	if'k{k.k	200000&00
(8)	jkT; Lrjh; vkijfVx 0;;	11]600&00
	dy	1800000-00

REVISED NAMMIS ACTIVITY 2010-11				
Sl. No.	**Activity**	**Unit Cost**	**Total No.**	**Total Cost**
1	CD/DVD Writer	1500	39	58500
2-A	2 GB RAM	2000	40	80000
2-B	160 GB Hard Disk	2500	40	100000
3	AMC (With Parts)	5000	40	200000
4	Internet			
4-A	Broad Band Installation Charge	4500	39	175500
4-B	Broad Band Monthly Rental Charge	800	39	374400
5-A	For District H.Q.:- System Maintenance, UPS Battery, Stationary, Pen Drive, CD/DVD, Cartridge, Paper etc.	11000	38	418000
5-B	For State H.Q.:- System Maintenance, UPS Battery, Stationary, Pen Drive, CD/DVD, Cartridge, Paper etc.	25000	2	50000
6-A	For State H.Q.:- 2 Laptop for 2 State NAMMIS Co-Ordinator	50000	2	100000
6-B	For State H.Q.:- 2 USB Plug to Surf Internet Connection for 2 Laptops	16000	2	32000
7	Training (38 MI+38 Data Operator) 4 Batches, Each Batch consist of Participants	50000	4	200000
8	State Level Operating Expenses			11600
	Total Cost	**168300**	**285**	**1800000**

(8) **jkT;Lrj ij vkijfVx [kp%&** miyC/k dEI;Vj d vkijfVx 0;; gr jkf'k dh 0;oLFkk dh tk jgh g] ftld fy, 11600@& j[kk x;k g A bud ukfel in d 0;; dk fooj.k bl idkj g%&

(1)	lh-Mh-@Mh-oh-Mh jkbVj	58]500&00
(2)	je ,o gkM fMLd	180000&00
(3)	okf"kd j[k&j[kko	200000&00
(4)	bVjuV	549900&00
(5)	dEI;Vj ikVl	468000&00
(6)	yi&Vki	132000&00
(7)	if'k{k.k	200000&00
(8)	jkT; Lrjh; vkijfVx 0;;	11]600&00
	dy	1800000-00

i=kd %&

i"kd]

Mk0 ,l0 d0 veu]
iHkkjh jkT; dk;Øe inkf/kdkjh]lg
mi e[; eyfj;k inkf/kdkjh
e[; eyfj;k dk;ky; fcgkj] iVuk

lok e]

dk;ikyd fun'kd]
jkT; LokLF; lfefr]
fcgkj]iVuk

iVuk]fnukd%----------

fo"k;%& Mx ,o fpduxhuh;k fu;=.kkFk foÙkh; o"k 2011&12 ctV ikdyu d i"k.k d lc/k eA egk'k;]

mi;ä fo"k;d Mx ,o fpduxhuh;k fu;=.kkFk foÙkh; o"k 2011&12 dk ctV ikdyu foLrr fooj.kh fuEuor g&

1- **Sentinel Surveillance Hospital:-**

Mx ,o fpdufxfu;k dh jkdFkke ,o mipkjkRed mik; gr jkT; d ANMMCH x;k ,o PMCH iVuk dk p;fur fd;k x;k gA bu Sentinel Site d Strengthening gr ,d&,d yk[k :i; iR;d dk ctVh; iko/kku fd;k x;k gA
dy iLrkfor jkf'k &2 yk[k :i;A

2- **Monitoring/Supervision and Rapid Response:-**

bld rgr 2 yk[k :i; dh jkf'k jkT; Lrj ij j[kk x;k g rkfd vko';drk iMu ij bl jkf'k dk [kp fd;k tk ldA

3- **Epidemic Prepardness (Including IEC/BCC/Social Mobilisation :-**

fofnr gk o"k 2010 d flrEcj eghu e Mx d idki l jkT; d 14 fty iHkkfor jg gA ble lcl T;knk iHkkfor exj] cxljk; ,o if.k;k jg gA bu rhu ftyk e 3&3 yk[k iR;d ftyk ,o 11 'k"k ftyk e ,d yk[k iPphl gtkj :i; iR;d ftyk dh nj l ctVh; iko/kku j[kk x;k gA

¼d½ vfriHkkfor rhu ftyk d 3 yk[k :i; dh [kp fooj.kh fuEuor g&

(I)	vkikrdkyhu RDT Kits dk Ø;	& 1-00 yk[k :i;A
(II)	By-tex dk Ø;	& 0-10 yk[k :i;A
(III)	VDuhdy eykfFk;ku dk Ø;	& 0-10 yk[k :i;A
(IV)	Qkfxx dk Operational Cost	& 0-50 yk[k :i;A
(V)	IEC/BCC	& 0-25 yk[k :i;A
(VI)	dk;ky; dVut Ulh 0;;	& 0-25 yk[k :i;A
		&&&&&&&&&&&&&&&&&&&&&
	dy	& 3-00 yk[k :i;A

vfriHkkfor rhu ftyk e dy ctVh; jkf'k& 9-00 yk[k :i;A

¼[k½ de iHkkfor 'k"k 11 ftyk ¼;Fkk liky] vkjxkckn] x;k] if.k;k] vjfj;k] njHkxk] uoknk] Hkktij] xkikyxt] i0 pikj.k ,o Hkkxyij e 1 yk[k iPphl gtkj :i; dh fooj.kh fuEuor g&

(I) vkikrdkyhu RDT Kits dk Ø; & 0-2 yk[k :i;A
(II) By-tex dk Ø; & 0-36 yk[k :i;A
(III) VDuhdy eykFk;ku dk Ø; & 0-05 yk[k :i;A
(IV) Qkfxx dk Operational Cost & 0-25 yk[k :i;A
(V) IEC/BCC & 0-15 yk[k :i;A
(VI) dk;ky; dVutUlh 0;; & 0-24 yk[k :i;A

&&&&&&&&&&&&&&&&&&&&

dy & 1-25 yk[k :i;A

de iHkkfor 'k"k 11 ftyk e dy ctVh; jkf'k & 13-75 yk[k :i;A

¼x½ Mx dh jkdFkke ,o mipkjkRed mik; gr jkT; d Sentinel Sites ANMMCH x;k ,o PMCH iVuk dk Monitoring- Evaluation and Rapid Response en e ,d&,d yk[k :i; iR;d dk ctVh; iko/kku fd;k x;k gA

dy ctVh; jkf'k & 2-00 yk[k :i;A

¼?k½ bld rjg jkT; Lrj ij 3-25 yk[k :i; j[kk x;k gA

bl en e dy ctVh; jkf'k ¼d + [k + x + ?k½ & 28-00 yk[k :i;A

4 Training / Workshop:-

Mx fu;=.kkFk Mx iHkkfor ftyk e fpfdRlk inkf/kdkjh] MI. ANM,ASHA dk if'k{k.k@dk;'kkyk gr 2 yk[k :i; dk iko/kku fd;k x;k gA

5 Platelets Separator:-

lokf/kd Mx iHkkfor nk fty ;Fkk& exj ,o cxljk; e Platelets Separator dh vko';drk egll dh tk jgh gA bl uhfer lnj vLirky exj ,o cxljk; e Platelets Separator gr 7-5 yk[k dh nj l 15 yk[k :i; dk iko/kku fd;k x;k gA

6 ELISA Reader :-

Mx iHkkfor lHkh 14 ftyk d lnj vLirky e ELISA Reader LFkkfir dju gr ctVh; iko/kku fd;k x;k gA bl uhfer ifr ftyk 3&3 yk[k dh nj l 42 yk[k :i; dk ctVh; iko/kku fd;k x;k gA

7 Ward Strengthening:-

14 Mx iHkkfor ftyk e lnj vLirky d Ward Strengthening gr 1&1 yk[k :i; ifr fty dh nj l 14 yk[k :i; dk iko/kku fd;k x;k gA

8 Blood Bank Stengthening:-

14 Mx iHkkfor ftyk e Blood Bank Strengthening gr 1&1 yk[k :i; ifr fty dh nj l 14 yk[k :i; dk iko/kku fd;k x;k gA

9 Mosquito Net:-

Mx iHkkfor ejhtk dk fuh'kYd Mosquito Net dk ctV iko/kku fd;k x;k gA o"k 2011 e yxHkx 2000 Mx Confirmed Cases d vueku d vkykd e 250@&:0 ifr ejht ifr ePNjnkuh dh nj l&

2000 x 250 = 5]00]000@& ikp yk[k :i; dk iko/kku fd;k x;k gA

Mx ctV dh lefdr fooj.kh fuEuor g&

(I)	Sentinel Surveillance Hospital	& 2-00 yk[k
(II)	Monitor & Evaluation	& 2-00 yk[k
(III)	Epidemic Preparedness	& 28-00 yk[k
(IV)	Training /Workshop	& 2-00 yk[k
(V)	Platelets Separator	& 15-00 yk[k
(VI)	ELISA Reader	& 42-00 yk[k
(VII)	Ward Strengthening	& 14-00 yk[k
(VIII)	Blood Bank Strengthening	& 14-00 yk[k
(IX)	Mosquito Net	& 5-00 yk[k
	dy ctVh; jkf'k	**& 124-00 yk[k**

i=kd %&

i"kd]

MkO ,lO dO veu]

iHkkjh jkT; dk;Øe inkf/kdkjh]lg

mi e[; eyfj;k inkf/kdkjh

e[; eyfj;k dk;ky; fcgkj] iVuk

lok e]

dk;ikyd fun'kd]

jkT; LokLF; lfefr]

fcgkj]iVuk

iVuk]fnukd%----------

fo"k;%& AES/JE fu;=.kkFk foÙkh; o"k 2011&12 ctV ikdyu d i"k.k d lc/k eA

egk'k;]

mi;ä fo"k;d AES/JE fu;=.kkFk foÙkh; o"k 2011&12 dk ctV ikdyu foLrr fooj.kh fuEuor g&

(1) Diagnostic & Management:-

bl en e fcgkj d rhu Medical College ;Fkk 1- PMCH iVuk] 2- ANMMCH x;k ,o 3- SKMCH, et¶Qjij dk p;fur fd;k x;k gA mDr rhuk dkytk dk bl en e 2&2 yk[k :i; iR;d dk iLrko j[kk x;k gA ble mDr rhuk Medical College dk Sentinel Site d :i e Strengthening dju dk iLrko gA

dy iLrkfor jkf'k& 6-00 yk[kA

(2) ELISA Test Kits:-

ELISA Test Kits dh vkifr NIV i.k }kjk jkT; ljdkj dk dh tkrh gA Epidemic dh fLFkfr e bld LFkkuh; Ø; gr mDr of.kr rhuk Medical Colleges dk 1&1 yk[k iR;d dh nj l 3 yk[k dk ctVh; iko/kku j[kk x;k gA

dy iLrkfor jkf'k& 3-00 yk[kA

(3) IEC/BCC:-

JE/AES iHkkfor 10 fty fcgkj e g ftle mÙkj in'k jkT; l lV&1 ioh pikj.k 2- if'peh pikj.k 3- et¶Qjij 4- floku ,o 5- xkikyxt 'kkfey gA 'k"k ikp fty ;Fkk& 1- x;k 2- tgukckn 3- vjoy 4- vkjxkckn ,o 5-uoknk 'kkfey gA bu ftyk e IEC/BCC xfrfof/k;k gr 50 gtkj ifr ftyk dh nj l dy 5-00 yk[k dk iLrko gA bld vrxr IEC, d rgr ikLVj] cuj] gMfcy l ilkj&ipkj djuk] BCC d rgr& vketuk e ln'k dk i"k.k fd;k tkuk gA ble fcekjh dh jkdFkke gr ePnjnkuh dk i;kx] ?kj l nj lvjk d j[ku dk LFkku fu/kkfjr djuk] tyh; if{k;k dk ?kj l nj j[kuk] ?kj d vkl&ikl d {k=k e lkQ&lQkb dk /;ku j[kuk rFkk /kku dh [krh d le; fo'k"k lrdrk cjru lc/kh lpukvk dk i"k.k djuk gA

dy iLrkfor jkf'k&5-00 yk[kA

(4) if'k{k.k:-

(I) fpfdRlk inkf/kdkjh%& bld rgr 10 JE/AES iHkkfor ftyk d lHkh PHC d 2nd Medical officer dk ,d fnolh; xj vkoklh; if'k{k.k gr p;fur fd;k tk ldrk gA lkFk gh ftyk Lrj l 2&2 fpfdRlk inkf/kdkjh;k dk iR;d fty l p;fur fd;k tkuk gAdy PHC dh l[;k =145 dy ifrHkkxh=145+20=155]dy cp =6

bldk ctV fuEuor j[kk x;k g%&

1- iR;d fpfdRlk inkf/kdkjh dk ekun;& 200-00] 155x200=31300 :i;
2- vYikgkj ,o Logistics = 50-00] 155x50=7750 :i;
3- if'k{kd dk ekun; ifr cp = 500-00] 6x500=3000 :i;
4- Contingency ifr cp = 500-00] 6x500=3000 :i;
5- T-A- dk 0;; viu&viu LFkkiuk l fd;k tkuk gA
6- ,d cp e 25 fpfdRlk inkf/kdkjh dk if'k{k.k fn;k tkuk gA
dy iLrkfor ctV = 44750 :i;

(II) eyfj;k fujh{kd%& JE/AES iHkkfor 10 ftyk e dk;jr lHkh eyfj;k fujh{kdk dk ,d fnolh; xj vkoklh; if'k{k.k dk iLrko gA dy MI =34A ,d cp e lHkh MI dk if'k{k.k fn;k tkuk gA
dy cp= 1 cp
bldk ctV fuEuor g&
1-ifr eyfj;k fujh{kdk dk ekun; =125-00]34x125=4250 :i;
2- ifr MI vYikgkj ,o Logestics= 50-00]34x50=1700 :i;
3-if'k{kd dk ekun; ifr cp =300-00]1x300=300 :i;
4-Contingency ifr cp =500-00]1x300=300 :i;
5-TA- viu&viu LFkkiuk l
dy iLrkfor ctV = 6750 :i;

(III) ANM dk if'k{k.k%& JE/AES iHkkfor 10 ftyk e dk;jr lHkh PHC l ,d&,d ANM dk ,d fnolh; xj vkoklh; if'k{k.k dk iLrko gA
dy PHC = 145] dy ANM = 145] dy cp = 6
bldk ctV fuEuor g&
1 ifr ANM dk ekun; = 125-00]145x125=18125 :i;
2 ifr ANM vYikgkj Logetic = 50-00]145x50=7250 :i;
3 if'k{kd dk ekun; ifrcp = 300-00]6x300=1800 :i;
4- Contingency = 500-00]6x500=3000 :i;
5. TA viu&viu LFkkiuk lA
dy iLrkfor ctV = 30175 :i;

(IV) ASHA dk if'k{k.k%& foxr o"k 2009 e JE/AES d 365 dl ifrofnr g, gA bu lHkh vØkr ejhtk d Line-Listing d vk/kkj ij lcf/kr ejhtk d xko dh ASHA dk if'k{k.k fn;k tkuk gA bld rgr 350 ASHA dk p;fur dj if'k{k.k fn;k tkuk gA dy ASHA = 400] dy cp = 10 cp
bldk ctV fuEuor g&
1- ifr ASHA vYikgkj ,o Logestics = 50-00] 400x50=17500 :i;
2- if'k{kd dk ekun; ifrcp = 200-00] 10x200=2000 :i;
dy iLrkfor ctV = 19500 :i;

(I) fpfdRlk inkf/kdkjh dk if'k{k.k %& 44]750 :i;
(II) eyfj;k fujh{kd dk if'k{k.k %& 6]750 :i;
(III) ANM dk if'k{k.k %& 30]175 :i;
(IV) ASHA dk if'k{k.k %& 19]500 :i;
dy %& 101175

(5) Montitoring & Supervision:-

JE/AES d Monitering & Supervision en e jkT; Lrj ij 2-5 yk[k :i; dk iko/kku j[kk x;k gA 10 iHkkfor fty e ifr ftyk 50 gtkj :i; ifr dh nj l 5 yk[k :i; dk iko/kku j[kk x;k g rkfd Epidemic dh fLFkfr e bldk vuJo.k ,o eY;kd.k fd;k tk ldA

dy iLrkfor jkf'k&

jkT; Lrj ij = 2-5 yk[k :i;

ftyk Lrj ij = 5-00 yk[k :i;

½50 gtkj :i; ifr ftyk dh nj l 10 ftyk gr½

dy iLrkfor ctV 7-50 yk[k :i;

(6) Technical Malathion:-

Technical Malathion d Ø; gr 5-00 yk[k :i; dk ctVh; iko/kku j[kk x;k gA Technical Malathion d Operational cost en e x;k] i0 pikj.k ,o et¶Qjij fty dk ,d&,d yk[k :i; j[kk tku gA 'k"k lkr ftyk e 50 gtkj :i; iR;d dh nj l 3-5 yk[k :i; dk iko/kku j[kk x;k gA

eykfFk;ku Ø; = 5-00 yk[k :i;

Operational cost = 10-50 yk[k :i;

&&&&&&&&&&&&&&&&

dy = 15-50 yk[k :i;

(7) Incentive of ASHA:-

JE/AES iHkkfor ftyk e JE/AES d ejhtk dk ftyk vLirky e ykdj lefpr fpfdRlk 'k: djku gr ASHA dk ikLrkgu jkf'k d :i e 100 :0 ifr ejht fn; tku dk ctVh; iko/kku j[kk x;k gA foxr o"k 2009 e JE/AES d 365 ejht ifrofnr g, gA o"k 2010 e yxHkx 400 lHkkfor ejhtk d vk/kkj ij bl en e 400 ASHA dk ikLrkgu jkf'k fn; tku dk iLrko j[kk x;k gA

dy iLrkfor jkf'k = 400 x 100 = 40]000 :i;

(8) JE vaccination:-

fcgkj d 10 JE/AES iHkkfor ftyk e foxr o"kk e et¶Qjij] i0 pikj.k ,o x;k e JE Vhdkdj.k fd;k tk pdk gA o"k 2010 e xkikyxt] uoknk ,o lhoku e JE Vhdkdj.k iLokfor gA 'k"k vkjxkckn] tgkukckn] vjoy ,o ioh pikj.k e Vhdkdj.k Hkfo"; e fd;k tkuk gA

JE ctV dh lefdr fooj.kh fuEuor g&

(I)	Diagnostic & Management:-	& 6.00 yk[k
(II)	ELISA Test Kits	& 3.00 yk[k
(III)	IEC/BCC	& 5.00 yk[k
(IV)	Training	& 1.01175 yk[k
(V)	Monitoring & Supervision	& 7.50 yk[k
(VI)	Technical Malathion	& 15.50 yk[k
(VII)	Incentive Of ASHA	& 0.40 yk[k
(VIII)	JE Vaccination (By GOI)	& 0.00 yk[k
	dy ctVh; jkf'k	**& 38.41175 yk[k**

i=kad ———————————@

i`"Bkd% MkW0 ,l0 dS0 veu
jkT; dk;Zdze inkf/kdkjh
iQkby§;k[fcgkj] iVuk

lsok esa funs'kd
jk"Vªh; oSDVj tfur jksx fu;a=k.k dk;Zdze
22&'kkeukFk ekxZ] fnYYkh&54
iVuk fnukad ——————

fo"k;% iQkby§;k fnol eukus gsrq foRrh; o"kZ 2011&2012 dk ctV iLrkoyu Hkstus ds lca/k esaA

mi;ZqDr fo"k;d o"kZ 2011&2012 dk ctV iLrkoyu (vkSicaf/kd) bl i=k ds lkFk layXu fd;k tk jgk gSA orZeku ctV iLrkoyu 6]25]03]450@& (N% djksM+ iPphl yk[k rhu gtkj pkj lkS ipkl :0) ek=k dk gSA iLrkoyu dk fuekZ.k dk vko';Drk ,oa vk/kkj dk fuEu :i ls enokj vkadyu fd;k x;k gSA

ctV iLrkoyu dqy iFkfed LokLFk; dsUnzksa 493 ,oa 38 ftyk eq[;ky;ksa esa jg jgs yxHkx 10 djksM+ tul[;k dks iQkby§;k fu;a=k.k dk;Zdze ds rgr vkPNkfnr djus ds mís'; ls r;Sokj fd;k x;k gSA ftl ds vUrxZr ,d fu/kkZfjr frfFk dks nez ds fgl kc ls fu/kkZfjr ek=kk esa Mh0 bZ0 lh0 f[kykus dk dk;Zdze djk;k tk;sxk ,oa mDr fnol dks Nqfs gq, tuekul dks vxys nks fnu rd ekWi&vi pdzpykus dk dk;Zdze r;Sokj fd;k x;k gSA ctV iLrkoyu jkT; Lrj ,oa ftyk Lrj ij O;; gksus okyh jkf'k foojk.kh [k.e esa n'kkZ;h x;h gSA

iz'k{k.k &

1 (d) jkT; Lrj ij lHkh ftyk eq[;ky;ksa ls nks fpfdRlk inkf/kdkjh (38x2 = 76) dqy 76 fpfdRlk inkf/kdkjh bl dk;ZØe ds lHkh igyqvksa ij iz'k{k.k fd;k tk;sxk A tks vius& vius ftys esa tkdj eq[; iz'k{kd dk dk;Z djsaxs ,oa ftyk Lrjh; ,oa iz[k.M Lrjh; ftyk inkf/kdkjh dks iz'kf{kr djsaxsA bl en esa 40000@& :i;k iLrkfyr gSA foojk.kh 1 dkWye &6 nz"VO;A

([k) iz[k.M Lrj ,oa ftyk Lrjh; fpfdRlk inkf/kdkjh;ksa dk iz'k{k.k % jkT; Lrj ls iz'kf{kr fpfdRlk inkf/kdkjh;ksa }kjk vius ftys ds ftyk eq[;ky; ,oa iz[k.M Lrjh; fpfdRlk inkf/kdkjh;ksa dk iz'k{k.k dk;ZØe ftyk eq[;ky; esa vk;ksftr fd;k tk;sxk A rFkk bl en esa dqy vkdyu 536600@& i;s fd;k x;k gSA ftyokj iLrkoyu foojk.kh 1 dkWye&7 esa iznf'kZr gSA

(x) i[zk.M Lrjh; ,oa ftyk Lrjh; ikjkesfMdy dfeZ;ksa dk i[zk{k.k %i[zk.M Lrj ,oa ftyk eq[;ky; esa inLFkkfir ikjk esfMdy ,oa ftyk eq[;ky; dqy 1332500@& jkf'k vkadfyr dh xbZ gSA foo j.kh 1 dkWyMdk&8 esa iznf'kZr gSA ;g jkf'k i[zk{k.k LFky] dkslZ esfVfj;y ,oa vU; [kpksZa vkfn dsfy, gSA

2 ftyk leUo; lfefr dh cSBd %;g cSBd iz;sd ftys esa nks ekg ij fd;k tkuk gSA ftlesa MDA dk;ZØe dslaiQyrk dsfy, lHkh laca/kr egRoiw.kZ foHkkxksa ,oa Lo;a lsoh laxBuksa dk iHkkjh fpfdRlk inkf/kdkjh dsleUo; cSBd ftyk Lrj ij fd;k tkuk gSA ftldsfy, izfr cSBd 10000@& i;s izfr cSBd dh nj ls,oa jkT; Lrj ij leUo; lfefr dj cSBd gsrq 20000@& (chl gtkj) :i;s vf/kdre jkf'k dk vkadyu fd;k x;k gSA dqy O;; 400000@& (pkj yk[k) :i;s vkadfyr fd xbZ gSA laca/kr C.S. vko';drkuqlkj jkf'k dk O;; djsaxsA foo j.kh 1 dkWye & 9 esa iznf'kZr gSA

3 izpkj & izlkj %dh en esa jkT; eq[;ky; dsfy, 2000000@& (chl yk[k) :i;s izfr i[zk.M ,oa ftyk eq[;ky; dsfy, 5000@& izfr dsnj lsjkf'k dk vkadyu foo j.kh 1 dqy jkf'k 3332500@& iznf'kZr gSA dkWyMdk 10 esa dh xbZ gSA

4 ykbu fyLVhax %dh dsvUrxZr i[zk{kr ikjk esfMdy LVkiQ vFkok vk'kk dk;ZdRkkZ }kjk ?kj & ?kj tkdj iQkbysfj;k dsfofHkUu Jsf.k;ksa (fyEQksMhe] gkbMªksly) vkfn dh igpku dh tkuh gSftldsfy, nqwgsa 50@& (ipkl) :lk;sdh nj lsiksRlkgu jkf'k Hkqxrs gksxsA bl en esa foo j.kh 1 dkWyMdk 11 esa 4000@& (pkj gtkj) :lk;s izfr i[zk.M ,oa ftyk eq[;ky; dsfy, jkf'k vkadfyr dh xbZ gSftlesa dqy 1332500@& iznf'kZr gSA

5 jksxh jDr iV laxzg %lHkkfor iQkbysfj;k dsfofHkUu Jskh dsjksfx;ksa dsfuf'pr igpku gsrq jksxh jDr iV laxzg i[zk{kr ikjk esfMdy LVkiQ ,oa vk'kk dk;ZdRkkZ }kjk fd;k tk;sxk rFkk iz;ksx'kkyk esa tkap dsmijkUr fpfUgr jksfx;ksa dks nok forj.k fd;k tk;sxkA ftldsfy, 50@& (ipkl) :lk;siksRlkgu jkf'k nqwgsa Hkqxrs gksxsA ftlds fy, izfr i[zk.M ,oa ftyk eq[;ky; dsfy, 4000@& (pkj gtkj) :lk;sdh nj ls foo j.kh 1 dkWye 12 esa dqy 1332500@&) iznf'kZr gSA

6 ih0 vks0 ,y0 %,e0 Mh0 ,0 dk;ZØe dslk;Zdrkzk.k gsrqokgu ,o bZa/u en esa jkT; eq[;ky; ls,oa {ks=h; mi funsZkd dsfy, eq[;ky; Lrj ij 100000@&(,d yk[k) :lk;s ftyk Lrj ij 2000@&(nks gtkj) :lk;s ,oa i[zk.M Lrj dsfy, 3000@& (rhu gtkj) :lk;s vkadfyr gSA tks foo j.kh 1 dkWye 13 esa iznf'kZr gSA bl en esa dqy 'k% 100000 :lk;s,oa 471150@& lk;s iznf'kZr gSA

7 foo/ O;; %1]23]715@& State level +PHC+Dist H.Q @500 +Rs 100/PHC (Col : XIV)

8 dk;kZy; O;; %dh en esa M.D.A dk;ZØe dsfy, LVs'kujh] iQksVksLVsV] LVkWa vkfn vU; ;ku dk;ksaZ gsrq jkT; eq[;ky; dsfy, 25000@& (ipphl gtkj) :lk;s,oa ftyk eq[;ky; rFkk i[zk.M Lrj dsfy, dqy 'k% 1000@& (,d gtkj) :lk;s,oa 500@&

(ikp lk§S : Ik;sifr dh nj lsjkf'k dk vkadyu fooj.kh&1 dkWye 15 esafd;k x;k gSA dqy jkf'k 329500@& : Ik;s ikLrkfor gSA

9 State Office Strengthing Amount 2,71,000/- Col XVI

10 nok forj.kdRrkZ, oaLk;ZlsOkd dsizf'k{k.k ,oa ekuns;%fooj.kh 2 ds dkWye dk 3 esaM.D.A dk;Zde gsrq dqy 13051843 (,d djksM+ rhl yk[k ,Ddkou gtkj vkB lkSrsrkyhl) ?kjksa dk vkadyu fd;k x;k gSA ftlds fy, fooj.kh 2 dkWye dk 4 ,oa 5 esa dze'k% nok forj.kdRrkZ (262410 ,oa Lk;ZlsOkd 26239) dh vko';drk vkadfyr dh xbZ gSA nok forj.kdRrkZ, oa Lk;ZlsOkdksa ds izf'k{k.k ,oa ekuns; dk vkadyu fuEu : Ik lsfd;k x;k gSA

(d) nok forj.kdRrkZ dk izf'k{k.k % nok forj.kdRrkZvksa dks ifr ftyk fpfUgr dh l[;k esa vk/ksfnu dk izf'k{k.k fn;k tk;sxk ftlds fy, mUgsa 50@& ifr nj lsjkf'k dk vkadyu fooj.kh & 2 dkWye dk 6 esa fd;k x;k gSA dqy O;; 13120500@& : Ik;s ikLrkfor gSA

([k) ekuns; % fpfUgr nok forj.k dRrkZvksa dks 118@& ifr ds nj ls ftykokj jkf'k vkadfyr dh xbZ gS ftlesa 30964380@ Ik;s fooj.kh 2 dkWye dk 7 esa ikLrkfor gSA

(x) Ik;ZlsOkdksa dk izf'k{k.k % bl en esa ftykokj fpfUgr Ik;ZlsOkdksa dh l[;k ds vk/kkj ij vk/ksfnu ds izf'k{k.k dk;Z ds fy, 50@& (ipkl) : Ik;s ifr nj lsjkf'k vkadfyr dh xbZ gS fooj.kh 2 dkWye dk 8 esa dqy ikLrkfor jkf'k 1311950@& : Ik;s ikLrkfor gSA

(?k) Ik;ZlsOkd ekuns;% Lk;ZlsOkdksa ds fy, 145@& : Ik;s dh nj ls ekuns; jkf'k dk vkadyu ftykokj fpfUgr ejhtksa ds l[;k ds vk/kkj ij fooj.kh 2 dkWye dk 9 esa fd;k x;k gSA ftlesa dqy 3804655 : Ik;s ikLrkfor gSA

(M) gkbMªksly jksx;ksa dk vkWijs'ku % ,e0 Mh0 ,0 dk;Zde 2011&12 ds vUrxZr gkbMªksly jksx;ksa ds vkWijs'ku gsrq ftyk eq[;ky; ,oa ikFkfed LokLF; dsUnzLrj ij ,d yk[k : i;s ifr ftyk ds nj ls dqy 38]00]000@& (vM+rhl yk[k : i;s) O;; fd, tkus dk ikzLrko gS fooj.kh dkWye &10

bl izdkj dqy 6]25]03]450@& Ik;s dk O;; ij ct V ikLrkfdyu vkids vxzj dk;Zokbz gsrq Hksk tk jgk gSA ct V ikLrkfdyu lkjka'k fooj.kh 3 esa layXu gSA

,e- Mh- ,- dk izLrkfor ctV iwDdyu foRrh; o"kZ 2011&2012

Lka fu-

jk"Vªh; iQkbysfj;k fnol 2011&2012 esa eukus gsrq fofHkUu enksa dk vyx&2 rS;kj fd;k tkjgk gS] ftldk C;kSjk fuEu izdkj gSA

dzekad	Ekn dk uke	izLrkfor jkf'k
1	jkT; Lrj ij ftysdsfpfdRlk inkf/kdkjh dk izf'k{k.k gsrq	40000
2	jkT; Lrj ij vkbZ bZ lh- gsrq	2000000
3	jkT; Lrj ij leUo; lfefr dh cSBd gsrq	20000
4	jkT; Lrj ij dk;kZy; O;;	25000
5	ftykLrj ij ,oa izkFkfed LokLF; dsUnz ij dk;kZy; O;;	304500
6	jkT; Lrj ij iSjkfyfQ ,oaY;wcjhdsV	100000
7	ftykLrj ij lEcU/kh; lfefr dk cSBd nksfnukad dk	380000
8	ftykLrj ij vkbZ bZ lh0 gsrq	1332500
9	ftykLrj ij fpfdRlk inkf/kdkjh dk izf'k{k.k gsrq	536600
10	ftykLrj ij iSjkesfMdy LVkQ dk izf'k{k.k gsrq	1332500
11	ftykLrj ij ykbu fyLV cukus gsrq	1332500
12	ftykLrj ij iSjkfyfQ ,oaY;wdksjhdsV gsrq	371150
13	jkf=kjDr iVlaxzg gsrq	1332500
14	ftykLrj ij nok forjdksa dk izf'k{k.k gsrq	13120500
15	ftykLrj ij nok forjdksa dk ekuns; gsrq	30964380
16	ftykLrj ij i;ZoS{kdksa dk izf'k{k.k gsrq	1311950
17	ftykLrj ij lk;ZoS{kdksa dk ekuns; gsrq	3804655
18	fofo/k O;;	123715
19	**State office Strengthing**	271000
20	gkbZMªksdhy vkWijs'ku	3800000
21	dqy jkf'k	62503450

jkT; dk;Zdze inkf/kdkjh
iQkbysfj;k] fcgkj] iVuk

jk"Vªh; iQkbysfj;k dk;ØZe eq[;ky; fcgkj] iVuk dk lq<hdj.k ct V o"kZ 2011&2012

Øekad	fo"k;	vnn	jkf'k	vH;qfDr
1-	dEI;wVj	1 ihl	50]000-00	
2-	fiazVj eYVhijil	1 ihl	25]000-00	
3-	eksMse	2 ihl	4]000-00	
4-	dwyu	2 ihl	12]000-00	
5-	,0 lh0	1 ihl	40]000-00	
6-	xksnjst vyekjh	1 ihl	20]000-00	
7	xkM+h	1 vnn	1]20]000-00	
	Vksvy %&	9 ihl	2]71]000-00 (nks yk[k ,dgrj gtkj :i;s)	

jkT; eq[;ky; lq<hdj.k dsfy, lekuksa dk ct V o"kZ 2011&2012

(1) dEI;wVj %& mijksDr dk;ØZe jkT; Lrj ij ,d vnn dEI;wVj dh vko';drk gS ftl dh ykxr eWY; yxHkx 50]000@& (ipkl gtkj) :i;s gSA

(2) fiazVj eYVhi;wl %& 1 (,d) vnn fiazVj eYVhijil dh vko';drk gS ftl dh ykxr eWY; yxHkx 25]000@& (ipPhl gtkj) :i;s gSA

(3) eksMse %& 2 (nks) vnn eksMse dh vko';drk gS ftl dk ykxr eWY; 2]000@& izfr dh nj ls 4]000@& (pkj gtkj) :i;s gSA

(4) dwyu %& 2 (nks) vnn dwyu dh vko';drk gS ftl dk ykxr eWY; ,d efguk esa 500@& rks 12 ekg esa 6000 x (2) eksMse dk ykxr eWY; 12]000-00 :i;s gSA

(5) ,0 lh0 %& 1 (,d) vnn ,0 lh0 dh vko';drk gS ftl dk ykxr eWY; 40]000@& :i;sa gSA

(6) xksnjst %& 1 (,d) vnn xksnjst vkyekjh dh vko';drk gS ftl dk ykxr eWY; 20]000@& :i;sa gSA

(7) xkM+h %& 1 (,d) vnn iz;{k.k gsrq HkkM+s dk xkM+h dh vko';drk gS ftl dk ykxr eWY; 1]20]000@& :i;sa gSA

uksV %& (Øekad 1 ls 7 rd dk [k.M ^d* dk dqy dk&16 esa dqy jkf'k 2]71]000@&(nks yk[k ,dgrj gtkj) :i;s izLrkfor gSA

State : Bihar Name of Programme-Mass Drug Administration Budget for 2011-12											POL					
Sl No.	State & Name of Dist	No of PHC & Distt HQ	No of Mo's	Training of Distt Level Officer at State	Training for Mo's @Rs 300 Each trainee @200 each	Training for Para Medical Staff	Cordination meetin(two round) atSHQ @10000 P.M.	IEC activities @2500 PHC @ one dist HQ+ SHQ 200000	Line Listing @2500 PHC &DHQ	Night blood Survey	State level 1Lakh &PHC+ Distt H.Q @500+ each PHC & Each Distt Officer Expenditure	Mislleno us Head	State level 25000 & PHC+ Distt HQ @ 500+ 1000 PHC & Each Distt Officer Expenditure	State Off Of Strengt hnieng	Total (A)	Remark
1	2	3+4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1	**State Level**			40000	0	0	20000	2000000			100000	123715	25000	271000	2579715	
2	**Araria**	8+1=9	56	0	11400	22500	10000	22500	22500	22500	6500		5500		123400	
3	**Aurangabad**	10+1=11	57	0	11600	27500	10000	27500	27500	27500	7800		6500		145900	
4	**Arawal**	4+1=5	21	0	4400	12500	10000	12500	12500	12500	3900		3500		71800	
5	**Banka**	10+1=11	63	0	12800	27500	10000	27500	27500	27500	7800		6500		147100	
6	**Begusarai**	17+1=18	69	0	14000	45000	10000	45000	45000	45000	12350		10000		226350	
7	**Bhagalpuir**	15+1=16	51	0	10400	40000	10000	40000	40000	40000	11050		9000		200450	
8	**Bhojpur**	13+1=14	84	0	17000	35000	10000	35000	35000	35000	9750		8000		184750	
9	**Buxar**	10+1=11	54	0	11000	27500	10000	27500	27500	27500	7800		6500		145300	
10	**Darbhanga**	17+1=18	68	0	13800	45000	10000	45000	45000	45000	12350		10000		226150	
11	**E. Champaran**	25+1=26	83	0	16800	67500	10000	67500	67500	67500	18200		14500		329500	
12	**Gaya**	23+1=24	116	0	23400	60000	10000	60000	60000	60000	16250		13000		302650	
13	**Gopalganj**	13+1=14	52	0	10600	35000	10000	35000	35000	35000	9750		8000		178350	
14	**Jamui**	9+1=10	29	0	6000	25000	10000	25000	25000	25000	7150		6000		129150	
15	**Jahanabad**	6+1=7	58	0	11800	17500	10000	17500	17500	17500	5200		4500		101500	
16	**Kaimur**	10+1=11	38	0	7800	27500	10000	27500	27500	27500	7800		6500		142100	
17	**Katihar**	15+1=16	81	0	16400	40000	10000	40000	40000	40000	11050		9000		206450	
18	**Khagaria**	6+1=7	26	0	5400	17500	10000	17500	17500	17500	5200		4500		95100	
19	**Kishanganj**	6+1=7	28	0	5800	17500	10000	17500	17500	17500	5200		4500		95500	
20	**Lakhisarai**	6+1=7	32	0	6600	17500	10000	17500	17500	17500	5200		4500		96300	
21	**Madhipura**	12+1=13	42	0	8600	32500	10000	32500	32500	32500	9100		7500		165200	
22	**Madhubani**	19+1=20	94	0	19000	50000	10000	50000	50000	50000	13650		11000		253650	
23	**Munger**	8+1=9	47	0	9600	22500	10000	22500	22500	22500	6500		5500		121600	
24	**Muzaffarpur**	15+1=16	98	0	19800	40000	10000	40000	40000	40000	11050		9000		209850	
25	**Nawada**	19+1=20	84	0	17000	50000	10000	50000	50000	50000	13650		11000		251650	
26	**Nalanda**	13+1=14	52	0	10600	35000	10000	35000	35000	35000	9750		8000		178350	
27	**Patna**	22+1=23	259	0	52000	57500	10000	57500	57500	57500	15600		12500		320100	
28	**Purinea**	13+1=14	72	0	14600	35000	10000	35000	35000	35000	9750		8000		182350	
29	**Rohatas**	17+1=18	104	0	21000	47500	10000	47500	47500	47500	13000		10500		244500	
30	**Saharsa**	9+1=10	57	0	11600	25000	10000	25000	25000	25000	7150		6000		134750	
31	**samastipur**	19+1=20	124	0	25000	50000	10000	50000	50000	50000	13650		11000		259650	
32	**Saran**	19+1=20	88	0	17800	50000	10000	50000	50000	50000	13650		11000		252450	
33	**Sheikhapura**	5+1=6	36	0	7400	15000	10000	15000	15000	15000	4550		4000		85950	
34	**Sheohar**	4+1=5	30	0	6200	12500	10000	12500	12500	12500	3900		3500		73600	
35	**Sitamari**	16+1=17	73	0	14800	42500	10000	42500	42500	42500	11700		9500		216000	
36	**Siwan**	18+1=19	51	0	10400	47500	10000	47500	47500	47500	13000		10500		233900	
37	**Supaul**	10+1=11	72	0	14600	27500	10000	27500	27500	27500	7800		6500		148900	
38	**Vaishali**	15+1=16	125	0	25200	40000	10000	40000	40000	40000	11050		9000		215250	
39	**W. Champaran**	17+1=18	71	0	14400	45000	10000	45000	45000	45000	12350		10000		226750	
	Total	**493+38=531**	**2645**	**40000**	**536600**	**1332500**	**400000**	**3332500**	**1332500**	**1332500**	**471150**	**123715**	**329500**	**271000**	**9501965**	

STATE BIHAR NAME OF PROGRAMME MASS DRUG ADMINISTRATION BUDGET FOR 2011-2012												
Sl. No.	**State & Name of District**	**No. of House in District**	**No. of Drug Distributor in District**	**No. of Supervisor**	**Training of Drug Distributor in District (@ Rs. 50/- each)**	**Hononarium of Drug Distributor in District(@118 /- each)**	**Training of Supervisor @Rs. 50/- each**	**Hononarium of Supervisor in District @ Rs. 145/- each**	**Hydrosil Operation District @ Rs. 1,00,000/-**	**Total (B)**	**Total(A)From Previous Sheet**	**Grand Total(A+B)**
1	2	3	4	5	6	7	8	9	10	11	12	13
1	**State level**	0	0	0	0	0	0	0	0	0	2579715	2579715
2	**Araria**	416693	8400	838	420000	991200	41900	121510	100000	1674610	123400	1798010
3	**Aurangabad**	359820	7240	724	362000	854320	36200	104980	100000	1457500	145900	1603400
4	**Arawal**	99698	2000	200	100000	236000	10000	29000	100000	475000	71800	546800
5	**Banka**	271286	5450	545	272500	643100	27250	79025	100000	1121875	147100	1268975
6	**Begusarai**	379947	7650	765	382500	902700	38250	110925	100000	1534375	226350	1760725
7	**Bhagalpur**	424352	8510	851	425500	1004180	42550	123395	100000	1695625	200450	1896075
8	**Bhojpur**	347780	7000	700	350000	826000	35000	101500	100000	1412500	184750	1597250
9	**Buxar**	213834	4300	430	215000	507400	21500	62350	100000	906250	145300	1051550
10	**Darbhanga**	508044	10200	1020	510000	1203600	51000	147900	100000	2012500	226150	2238650
11	**E. Champaran**	538386	10750	1075	537500	1268500	53750	155875	100000	2115625	329500	2445125
12	**Gaya**	563963	11300	1130	565000	1333400	56500	163850	100000	2218750	302650	2521400
13	**Gopalganj**	345846	6930	693	346500	817740	34650	100485	100000	1399375	178350	1577725
14	**Jamui**	215571	4320	432	216000	509760	21600	62640	100000	910000	129150	1039150
15	**Jahanabad**	124264	2500	250	125000	295000	12500	36250	100000	568750	101500	670250
16	**Kaimur**	199007	4000	400	200000	472000	20000	58000	100000	850000	142100	992100
17	**Katihar**	417984	8380	838	419000	988840	41900	121510	100000	1671250	206450	1877700
18	**Khagaria**	274709	5520	552	276000	651360	27600	80040	100000	1135000	95100	1230100
19	**Kishanganj**	217089	4360	436	218000	514480	21800	63220	100000	917500	95500	1013000
20	**Lakhisarai**	134852	2700	270	135000	318600	13500	39150	100000	606250	96300	702550
21	**Madhepura**	255280	5320	532	266000	627760	26600	77140	100000	1097500	165200	1262700
22	**Madhubani**	563734	11300	1130	565000	1333400	56500	163850	100000	2218750	253650	2472400
23	**Munger**	187522	3750	375	187500	442500	18750	54375	100000	803125	121600	924725
24	**Muzaffarpur**	573302	11500	1150	575000	1357000	57500	166750	100000	2256250	209850	2466100
25	**Nawada**	288581	5800	580	290000	684400	29000	84100	100000	1187500	251650	1439150
26	**Nalanda**	330598	6620	662	331000	781160	33100	95990	100000	1341250	178350	1519600
27	**Patna**	679619	13600	1360	680000	1604800	68000	197200	100000	2650000	320100	2970100
28	**Purniea**	456118	9140	914	457000	1078520	45700	132530	100000	1813750	182350	1996100
29	**Rohatas**	394415	7900	790	395000	932200	39500	114550	100000	1581250	244500	1825750
30	**Saharsa**	226070	4540	454	227000	535720	22700	65830	100000	951250	134750	1086000
31	**samastipur**	462681	9270	927	463500	1093860	46350	134415	100000	1838125	259650	2097775
32	**Saran**	467382	9350	935	467500	1103300	46750	135575	100000	1853125	252450	2105575
33	**Sheikhapura**	85238	1710	171	85500	201780	8550	24795	100000	420625	85950	506575
34	**Sheohar**	35956	1720	172	86000	202960	8600	24940	100000	422500	73600	496100
35	**Sitamari**	400483	8020	802	401000	946360	40100	116290	100000	1603750	216000	1819750
36	**Siwan**	398768	8000	800	400000	944000	40000	116000	100000	1600000	233900	1833900
37	**Supaul**	288596	5790	579	289500	683220	28950	83955	100000	1185625	148900	1334525
38	**Vaishali**	415794	8320	832	416000	981760	41600	120640	100000	1660000	215250	1875250
39	**W. Champaran**	488581	9250	925	462500	1091500	46250	134125	100000	1834375	226750	2061125
	Total:-	**13051843**	**262410**	**26239**	**13120500**	**30964380**	**1311950**	**3804655**	**3800000**	**53001485**	**9501965**	**62503450**

Format for ROP in respect of NVBDCP, Bihar-2011-12							
S. No.	**Component (Sub- Component)**	**Unit Cost (wherever applicable)in Rs**	**Physical target**	**Amount proposed by the state (Rs. in Lakhs)**	**Amount Approved by GoI (Rs. in Lakhs)**	**Remarks**	**Functional head as per NRHM**
1	**Domestic Budget Support (DBS)**						
1.1	**Malaria**						
1.1.1	**MPW**	0.06	919	330.84		Salary for 6 Months	Human Resource
1.1.2	**ASHA Honorarium**			0.75			Honorarium & Incentives
1.1.3	**Operational Cost**						
	Spray Wages - for NE states and UTs without legislation			0			Operating Cost
	Impregnation of Bed nets- for NE states			0			Operating Cost
	Monitoring , Evaluation & Supervision & Epidemic Preparedness including mobility.(Including NAMMIS)			24.6			Operating Cost
1.1.4	**IEC/BCC**			16.95			IEC & BCC
1.1.5	**PPP / NGO activities**			0			PPP/NGO
1.1.6	**Training / Capacity Building**			10.7979			Training
	Total Malaria (DBS)			**383.9379**			
1.2	**Dengue & Chikungunya**						
1.2.1	**Strengthening surveillance (As per**			0			Financial

	GOI approval)						aid/grant to institutions
	Ø Apex Referral Labs recurrent @ Rs.1.00 lakh per lab.			0			
	Ø Sentinel surveillance Hospital recurrent @ Rs. 0.50 lakhs per lab.			0			
	Test kits (Nos.) to be supplied by GoI (kindly indicate numbers of ELISA based NS1 kit and Mac ELISA Kits required separately)		10	10		For purchage by Medical College during Epidemic situation	Not applicble
1.2.2	**Monitoring/Supervision and Rapid Response**			0.5			Operating cost
1.2.3	**Epidemic Preparedness**			28			Operating cost
1.2.4	**IEC/BCC/Social Mobilization**			0			IEC
1.2.5	**Training/Workshop**			2			Training
	Total Dengue/Chikungunya			**40.5**			
1.3	**Acute Encephalitis Syndrome (AES)/ Japanese Encephalitis (JE)**						
1.3.1	**Strengthening of Sentinel Sites which will include diagnostics and management. Supply of kits by GoI**			6			Procurement
1.3.2	**IEC/BCC specific to J.E. in endemic areas**			2.5			IEC
1.3.3	**Training specific for J.E. prevention and management**			1.01175			Training
1.3.4	**Monitoring and supervision**			1			Operatinc cost
1.3.5	**Procurement of insecticides (Technical Malathion)**			10			Procurement
	Total AES/JE			**20.51175**			

1.4	**Lymphatic Filariasis**						
1.4.1	**State Task Force, State Technical Advisory Committee meeting, printing of forms/registers, mobility support, district coordination meeting, sensitization of media etc., morbidity management, monitoring & supervision and mobility support for Rapid Response**			50.1565			Operating cost
1.4.2	**Microfilaria survey**			26.65			Operating cost
1.4.3	**Post MDA assessment by medical colleges (Govt. & private)/ ICMR institutions.**			.---			Operating cost
1.4.4	**Training/sensitization of district level officers on ELF and drug distributors including peripheral health workers**			164.503			Training
1.4.5	**Specific IEC/BCC at state, district, PHC, sub-centre and village level including VHSC/GKS for community mobilization efforts to realize the desired drug compliance of 85% during MDA & Office Strengthening**			36.035			IEC/BCC
1.4.6	**Honorarium to drug distributors including ASHA and supervisors involved in MDA**			347.69			Honorarium & incentives
	Total Lymphatic Filariasis			**625.035**			
1.5	**Kala-azar**						
1.5.1	**Case search**			**42.6775**			Operating cost
1.5.2	**Spray Pumps**			0			Procurement
1.5.3	**Operational cost for spray including spray wages**			1577.9118			Operating cost

1.5.4	**Mobility/POL**			0		By WB Assistance	Operating cost
1.5.5	**Monitoring & Evaluation**			2			Operating cost
1.5.6	**Training for spraying**			0		By WB Assistance	Training
1.5.7	**BCC/IEC**			6.52			IEC
	Kala-azar			0			
	Total (DBS)			**1629.1093**			
2	**Externally aided component**						
2.1	**World Bank support for Malaria (Andhra Pradesh, Chattisgarh, Jharkhand, Madhya Pradesh, Orissa, Gujarat, Karnataka & Maharashtra)**						
2.1.1	Human Resource						Human Resource
2.1.2	Training /Capacity building						Training
2.1.3	Mobility support for Monitoring Supervision & Evaluation & review meetings, Reporting format (for printing formats)						Operating Cost
2.2	**GFATM support for Malaria (NE states except Sikkim)**						
2.2.1	Project Management Unit including human resource of N.E. states and erstwhile GFATM states viz., Jharkhand, Orissa and West Bengal						Human Resource
2.2.2	Training/Capacity Building						Training
2.2.3	Planning and Administration(Office expenses recurring expenses, Office automation , printing and stationary for running of project)						Operating Cost

2.2.4	Mobility support for Monitoring Supervision & review meetings,(including travel expenses, operational research, project evaluation etc)						Operating Cost
2.2.5	Infrastructure and Other Equipment (Computer Laptops, printers, Motor cycles for MTS)						Infrastructure
2.3	**Kala-azar World Bank assisted Project**						
2.3.1	**Human resource**			374.62			Human Resource
2.3.2	**Capacity building**			25.46			Training
2.3.3	**Mobility**			154.322			Operating cost
	Total : EAC component			**554.402**			
	Grand total for cash assistance under NVBDCP (DBS + EAC)						
3	**Cash grant for decentralized commodities**						
3.1	**Drugs**						
3.1.1	Chloroquine phosphate tablets	1	800000	8			Procurement
3.1.2	Primaquine tablets 2.5 mg	1	16500	0.165			Procurement
3.1.3	Primaquine tablets 7.5 mg	1	38400	0.384			Procurement
3.1.4	Quinine sulphate tablets	5	1000	0.05			Procurement

3.1.5	Quinine Injections			0			Procurement
3.1.6	Sulphadoxine + Pyremethamine tablets			0		By GOI	Procurement
3.1.7	ACT (For Non Project states)		1000	0		By GOI	Procurement
3.1.8	DEC 100 mg tablets			0		By GOI	Procurement
3.1.9	Albendazole 400 mg tablets			0		By GOI	Procurement
3.2	**Diagnostics**			0		By GOI	
3.2.1	RDT Malaria (For Non Project states)		100000	0		By GOI	Procurement
3.2.2	Dengue NS1 antigen kit			0		By GOI	Procurement
3.3	**Larvicides**			80		.@ Rs. 20000 Per 10 Lt x 4000	
3.3.1	Temephos, Bti (for polluted & non polluted water)			0		By GOI	Procurement
3.3.2	Pyrethrum extract 2%			0		By GOI	Procurement
	Total grant for decentralized commodities			88.599		By GOI	
	Grand Total for grant-in-aid under NVBDCP					By GOI	
	Total cash assistance required under NRHM flexi fund					By GOI	
						By GOI	

	Commodities to be supplied by NVBDCP					By GOI	
	Insecticides						
	DDT 50% wdp		2251Mt	Supplied by GOI		For Two Round	
	Synthetic Pyrethroid - for UT without legislation			Supplied by GOI			
	Malathion 25% wdp / Technical			Supplied by GOI			
	Amphotericin-B		25964	Supplied by GoI			
	meltifosine 50mg		734624				
	Miltefosine(10mg)		480480	Supplied by GoI			
	RDK for Kala-azar		54239	Supplied by GoI			
	Procurement of Bednet / LLIN			Supplied by GOI			
	Commodity grant total -						

NLEP | Part G

National Leprosy Eradication Programme
(11th five Year Plan 2007 – 2012)

State Action Plan 2011 – 2012
BIHAR

Executive Summary:

- Even though new case detection rate and prevalence rate are going down, **yet new cases continue to come up in large numbers in state.**

- The promotion of self reporting is now crucial to case detection, as case finding campaigns become less and less cost effective. It is important to identify and remove barriers that may prevent new cases coming forward and a greater emphasis on the assessment of disability diagnosis, so that those at particular can be recognized and managed appropriately.

- Leprosy being a disease associated with poverty, it is presumed there are still hidden cases among the underprivileged.

- Under special initiatives, to promote self reporting, focus will be on wide dissemination of key messages of leprosy i.e. curable, early signs, no need to be feared and support, in the urban and rural areas. This will reduce stigma & discrimination against persons affected with leprosy. The key messages along with proactive involvement of the community will bring about health behavior at individual, household and community level.

- The out come of strategy will be to promote further integration with general health care system by providing operational and technical skill in job training. The better equipped and motivated GHC system will provide quality leprosy services on all working days to the affected Persons, following the principles of equity and social justice in the community.

Background:

- National Leprosy Control Programme was started by Govt. of India in 1955 based on Dapsone Monotherapy through units implementing survey, education and treatment activities. It was only in 1970s that a definite cure was identified in the form of Multi Drug Therapy. The MDT came into wide use from 1982, following the recommendation by WHO study Group, Geneva in October 1981. Government of India established a high power committee under chairmanship of Dr. M. S. Swaminathan in 1981 for dealing with the problem of leprosy. Based on its recommendations the National Leprosy Eradication Programme (NLEP) was launched in 1983 with objective to arrest the disease activities in all the known cases of leprosy.

- In order to strengthen the process of eradication, the World Bank supported the project in two phases. The first phase was started in 1993 – 94 and ended on 31st March 2000. The second phase started in year 2001 – 2002 and ended on 31st December 2004. Now since 2005 the project is being continued with GOI funds. The cost of infrastructure is borne by the state funds. Additional support is received from World Health Organisation and ILEP (International Federation of Anti-Leprosy Associations). Multi Drug Therapy (MDT) was supplied free of cost by Novartis through WHO.

- In Bihar whole state was covered under MDT in November 1996.
- In Bihar till date more than 15 lakhs patients treated with leprosy.
- The PR reduced to 14.2/10000 populations in year 1999.
- Integration of leprosy services in to general health care system started in 2000 – 01 and fully integrated in 2003 -04.
- Five rounds of Modified Leprosy Elimination Campaigns (MLECs) and four rounds of Block Level Awareness campaigns have been already successfully conducted in the state during the period 1998 to 2008. These activities resulted in detection of more than 4 lakh cases.

MDT in Bihar:

- MDT started in Bihar in phased manner.
- In composite state of Bihar, first phase MDT was started in two districts in 1982 (Bhagalpur & Rohtas).
- 13 more districts added in 1994.
- MDT was launched in whole state in 1996 – 97.

Current status:

- From 1996 – 97 onwards when entire state was brought under MDT, a steady decline in PR was recorded. The PR of 17.3/10000 populations in 1996-97 declined to 1.08/10000 populations on 31st March 2010.
- PR < 1 - 13 districts,
  PR >1- <2 - 25 districts
- At present the NLEP is fully integrated into General Health Care System from sub centre to District Hospitals/Medical Colleges.
- District Nucleus is formed in all 38 districts to monitor and supervise the programme.
- The IEC activities including Inter Personal Communication are continued and therefore stigma has significantly come down. At present most of leprosy affected deformed patients are living with their family and leprosy patients are coming at health institutions voluntarily.
- Although the State PR has reduced to 1.08 as on 31st March 2010, 49 blocks in 23 districts have been identified as high endemic blocks where special activities have to be carried out to reduce disease burden. DLOs of 23 districts to be directed to form a team to visit these blocks and to identify the problems for high endemicity. Regular IEC / BCC activities to be carried out in the villages reporting more cases by involving local leaders, ASHA & AWW to mobilize the community and to encourage self reporting. School IEC programme to be organized in these pockets with emphasis on high endemicity and the need to increase community awareness.

DLOs are being directed to monitor the activities regularly and to organize special drive like mini MLEC in the identified high endemic villages and report to be submitted to the state programme Officer.

Endemicity in the PHCs

0 > 1 PR - 232 PHC
1 > 2 PR- 239 PHC
2 > 4 PR- 47 PHC
4 < PR- 2 PHC

STATE PROFILE

Bihar is the third largest populated state in the country. There are 38 districts in the state. Bihar is divided in two geographical areas- North and south areas

POPULATION (2001 census)* **Estimated Population as on March 2010*	829988509 *103504258*
MALES	54169163
FEMALES	49335095
SEX RATIO (females/1000 males)	921
DENSITY OF POPULATION (Persons/ Square Km)	880
URBAN POPULATION %	10.47
LITERACY RATE (census 2001) in %	47
MALE LITERACY in %	59.7
MALE LITERATE in numbers	20644376
FEMALE LITERACY in %	33.1
FEMALE LITERATE in numbers	10465201
BIRTH RATE (PER 1000)	30.9
DEATH RATE (PER 1000)	7.9
District Hospital	24
Sub- Divisional Hospital	23
Referral Hospital	71
Primary Health Centre (PHCs)	533
Additional Primary Health Centre (APHCs)	1243
Health Sub-Centre	8858
No. of Villages	45100

Leprosy Staff Position

	Sanctioned	In Position
Regular DLOs	13	9
PT	28	22
MSW (NMS)	265	128
HE	22	9
NMA (PMW)	1379	687
LT	60	16
MOs in LCU / MLCU	58	31
EST Unit	2	1
SSAU	1	Nil

Thirteen districts have sanctioned post of regular DLOs in which 4 DLOs are required to be posted. The Government is being communicated on this matter. 25 posts of regular DLOs are to be created so that DLOs can be posted in these districts. At present all these districts are having In-charge DLOs. State Programme Officer incharge of leprosy programme may request the Govt. to sanction a regular post of the State Leprosy Officer and 25 posts of regular DLOs in the districts where regular post of DLO has not been created yet or to upgrade the LCUs / MLCUs in the districts to district Leprosy offices and shift these upgraded district units, in the districts, where regular posts of DLOs do not exist.

Situational Analysis – As on November 2010 / Districts / Blocks /Urbans

Indicators recommended by GOI for Monitoring & Supervision:
The Government of India has recommended the following three indicators:-

(I) Major indicators:
(1) Annual New Case Detection Rate(ANCDR) per 100000 population
(2) Treatment Completion Rate
(3) Prevalence Rate

(II) Additional Indicators:
(1) Proportions of Grade I disability among new cases
(2) Grade II disability rate among new cases / 100000
(3) Proportions of child cases among new cases
(4) Proportions of female cases among new cases
(5) Proportions of MB cases among new cases

(III) Indicators for patient management and follow up:
(1) The proportion of new cases correctly diagnosed
(2) The proportion of treatment defaulters
(3) Number of relapse reported during year
(4) The proportion of patients who develop new or additional disabilities during MDT.

Shift in focus from PR to ANCDR:
Since 2008-09 a shift in focus from PR to ANCDR was introduced, as it is a better indicator for epidemiological analysis.:- as on October 2010

Sl. No.	District	Active Balance case at the end of Oct. 2010	Female (%)	Defor-mity % Grd. II	MB %	PR/ 10,000	ANCDR per 100,000
1	Aurangabad	349	35.26	0.91	33.74	1.39	23.04
2	Bhojpur	257	33.19	1.68	38.24	0.92	14.56
3	Buxar	184	26.32	0.00	36.84	1.05	15.75
4	Bhagalpur	424	40.25	1.26	36.48	1.40	17.73
5	Banka	416	40.35	0.00	46.49	2.07	28.12
6	Darbhanga	551	47.34	0.76	49.43	1.34	20.13
7	Katihar	220	40.40	1.01	36.87	0.74	10.66
8	Muzaffarpur	377	51.46	1.35	31.69	0.81	14.63
9	Nawadah	379	49.12	1.76	27.35	1.68	24.38
10	Patna	700	35.50	2.30	47.15	1.19	18.94

11	Purnia	387	35.04	0.81	40.70	1.22	20.83
12	Kishanganj	564	34.32	0.00	43.39	3.49	42.76
13	Araria	497	33.01	0.64	19.81	1.87	34.90
14	Rohtas	467	35.32	0.85	33.40	1.53	25.57
15	Kaimur	363	25.12	3.79	50.24	2.26	22.19
16	Siwan	434	40.67	3.56	31.03	1.28	21.99
17	Sitamarhi	459	53.24	1.89	34.05	1.38	17.45
18	Sheohar	126	38.55	0.00	26.51	1.96	23.35
19	W.Champaran	363	36.10	3.64	31.17	0.96	16.71
20	Begusarai	249	41.58	2.11	34.74	0.85	11.82
21	E.Champaran	454	39.07	1.27	27.81	0.92	14.88
22	Gaya	619	36.08	1.29	33.33	1.43	22.53
23	Gopalganj	236	40.38	0.00	31.70	0.88	14.68
24	Jehanabad	214	40.72	0.90	44.34	1.85	30.69
25	Arwal	120	41.48	0.00	37.78	1.64	29.41
26	Khagaria	121	27.43	0.00	31.86	0.76	10.54
27	Madhubani	819	43.01	1.26	37.36	1.84	24.24
28	Madhepura	298	38.31	0.81	38.71	1.57	20.06
29	Munger	176	33.14	0.00	40.12	1.24	17.07
30	Sheikhpura	95	47.87	0.00	44.68	1.45	20.74
31	Jamui	150	27.70	0.00	47.97	0.86	14.95
32	Lakhisarai	223	39.00	0.00	56.50	2.23	32.18
33	Nalanda	485	39.07	1.06	39.07	1.64	24.01
34	Saharsa	194	44.44	3.70	45.68	1.03	14.46
35	Supaul	333	38.37	0.00	31.72	1.53	24.23
36	Samastipur	378	36.53	2.58	46.13	0.89	10.77
37	Saran	553	25.83	2.33	48.50	1.36	22.39
38	Vaishali	476	39.64	1.78	49.41	1.41	15.65
Total		13710	38.37	1.34	38.02	1.32	19.71

ANCDR: (19.71/100000)

ANCDR(quarterly) of 17 districts is > 20/100000 of population. These districts are Bhojpur, Buxar, Bhagalpur, Begusarai, Gopalganj, Jamui, Khagaria, Katihar, Muzaffarpur, Patna, East Champaran, Munger, Saharsa, Samastipur,Sitamarhi, West Champaran and Vaishali. Therefore overall ANCDR of state is also > 20/100000 population

Performance under NLEP-

Indicators	2006-07	2007-08	2008-09	2009-10	2010-11 (till date)
No. of New cases detected (ANCDR)	21350 (22.21)	19041 (19.33)	20086 (19.33)	21431 (20.71)	12787 (19.71)
No. of cases on record at year end (PR)	10158 (1.06)	10262 (1.04)	10771 (1.07)	11221 (1.08)	13710 (1.32)
No. Gr. II disability among new cases (%)	484 (2.27)	459 (2.41)	421 (2.10)	421 (1.96)	171 (1.34)
Treatment Completion Rate	-	94.03	PB-96.63 MB-91.22	PB-94.82 MB-91.34	- -
Re-constructive Surgery conducted	-	149	89	104	37

SWOT analysis:

After analysis following are strengths, weaknesses, opportunities and threats in state.

Strengths:

1. trained district nucleus
2. Trained experienced & motivated staff
3. Better awareness and reduced stigma
4. Adequacy of MDT
5. Adequacy of fund form GOI and ILEP
6. Better comprehensive infrastructure from subcentre to Medical college
7. Integration of leprosy services with GHCs staff
8. Training materials are available
9. Regular NLEP staff meetings and monitoring
10. Good coordination – State Health System, WHO & ILEP
11. Enough people willing to work for the cause.

Weakness:

1. Large state with many districts
2. Reduction in ILEP support
3. No WHO State & Zonal coordinators
4. Complicated procedures for fund utilization for leprosy work at district level
5. Inadequacy of fund for vehicle operation and complicated procedure for hiring of vehicle
6. Less support from public opinion leaders
7. Poor POD services
8. Leprosy being last priority of health programme
9. Inadequate funds for rehabilitation and mobility aids
10. Inadequate coordination between staff
11. Vehicles – Using in other programmes by DM and Civil Surgeons
12. Inadequate training of NGOs/local practitioners
13. incomplete data of deformities
14. Less effective counseling

Opporunities:

1. Integration with NRHM
   (a) Support from ASHA
   (b) Additional flexible funds
   (c) Better monitoring and supervision
   (d) Better infrastructure and man power
2. Integration with GHS
3. Involvement of Medical Colleges/Hospitals/NGOs
4. Full utilization of dermatologists, physicians and orthopaedic surgeons for diagnosis and rehabilitation
5. Support of ILEP/NGOs/WHO

Threats:

1. Complacency among staff and less political commitment
2. Priority to other programmes
3. Transfer of programme officers at state and district
4. Public stigma
5. No self dependence of sufferer

State will use this SWOT analysis for making strategies and plans in NLEP.

National Leprosy Eradication Programme
(11th five year plan 2007 – 2012)

Objectives:

- To further reduce the leprosy burden
- Provision of high quality leprosy services for all persons affected by leprosy, through general health care system including referral services for complications and chronic care.
- Enhanced Disability prevention and Medical Rehabilitation (DPMR) services for deformity in leprosy affected persons.
- Enhanced advocacy in order to reduce stigma and stop discrimination against leprosy affected persons and their families.
- Capacity building among health service personal in integrated setting both for rural and urban areas.
- Strengthen the monitoring and supervision component of the surveillance system.

Strategy:

(1) Integrated Leprosy Services and Special initiatives.
(2) Disability Prevention and Medical Rehabilitation (DPMR)
(3) Information, Education and Communication
(4) Training and capacity building.
(5) Supervision, monitoring and review.
(6) Infrastructure maintenance

Activities as per objectives and strategy:

I. <u>Integrated Leprosy Services and Special initiatives</u> –

1.1 Integrated Leprosy Services through all Primary Health Care facilities will continue to be provided in the rural areas.
1.2 All the urban areas will be covered under urban leprosy control programme integrating services from all the partners available in the areas, including private practitioners.
1.3 Involvement of multipurpose health functionaries, ASHA in villages, and selected NGOs in urban areas are to be engaged for case follow up during treatment to ensure regular MDT collection and consumption, so that all the cases put under treatment gets cured in shortest possible time.
1.4 Emphasis will be laid on providing best quality leprosy services through the GHC system. This means easy availability of services on all working days to all patients, correct diagnosis and adequate counseling to patients and family members, provide MDT to patients whenever approached, regular monitoring of patient during treatment. Treatment completion by all under treatment patients will be desired outcome of the programme.
1.5 The system of referral of difficult cases to the district hospital for diagnosis and management, which has already been started, will be further strengthened with capacity building of persons involved at PHC as well district Hospital level.
1.6 The laboratory facilities at District Hospitals for smear examination to diagnose difficult cases will be strengthened.

1.7 Desegregated data for female, schedule tribe and schedule caste patients are to be maintained.

1.8 Regular monitoring and surveillance at state, District and Block level will be continued to locate weak areas, so that needed plan for corrective action can be taken in time.

1. Contractual Services:

- As per annexure 1

2. Services through ASHA:

After sensitization of ASHA in Leprosy they will be involved to refer a suspected case of leprosy from their villages for diagnosis at PHC and after diagnosis to follow up the patients for completion of their treatment, ASHA will be entitled to receive incentive as below-

(i) On confirmed diagnosis of cases brought by them – Rs 100/-

(ii) On completion of full course of treatment within specified time –

PB Leprosy case – Rs. 200/-

MB Leprosy case – Rs. 400/-

Number of new leprosy cases detected cases in 2009-10 –21431

37.53% MB cases – 8043

62.47% PB cases – 13388

2.1 Incentive to ASHA / USHA

Budget:

For MB cases = Rs.500.00*2400 cases

= Rs. 1200000.00

For PB cases = Rs. 300.00*3500

= Rs. 1050000.00

Total incentive to ASHA / USHA = Rs.22,50,000/-

2.2 Training of ASHA / USHA @ Rs. 2225/ per Batch 30 participants for 500 Batch

- **Budget** – for one batch of 30 participants

Honorarium to resource persons PHC's Medical Officer @ Rs.150/- for 1MO

Rs.150 x 1= Rs.150/-

Honorarium to NMA / NMS @ Rs.75/- for One

Rs.75/- x 1 =Rs.75/-

Transportation & Refreshment @ Rs.50/- for 35 persons

50 x 35 = Rs.1750/-

Stationary and miscellaneous = Rs.250/-

Total = Rs.2,225/- for one batch.

Grand Total for 500 batches = 2225 x 500 = Rs.11,12,500/-

Total Cost of services through ASHA = Rs.33,62,500.00

3. Office expenses:

- For SHS (leprosy) Rs.38000/- and for DHS (leprosy) Rs.18000/- per district will be provided (Rent, telephone, electricity, P&T charges and Miscellaneous).

Consumables:

- For SHS (leprosy) Rs.28000/- and for DHS(leprosy) Rs.14000/- per district will be provided.

4. Training Plan (training and capacity building):

4.1 Leprosy training to GHC staff (new entrants)

To improve quality of leprosy diagnosis, complications management, DPMR and programme monitoring the key medical and paramedical staffs will be provided trainings.

1400 newly appointed contractual MOs will be provided four days modular training on leprosy and NLEP (including DPMR).

Budget –

Venue – District head quarter training hall.
Trainers (2trainers) TA/DA @ Rs.300/- per day for two days
Rs.300.00 x 2 days x 2 trainers = Rs.1200/-
TA for trainees @ Rs.80/- per day for 30 trainees for 2days
Rs.80.00 x 30 trainees x 2 days = Rs.4800/-
DA for trainees @ Rs.80/- per day for 30 trainees for 2 days.
Rs.80.00 x 30 trainees x 2 days = Rs.4800/-
Working lunch & tea @ Rs.100/- for 40 persons for 2 days
Rs100.00 x 2 days x 40 = Rs.8000/-
Learning materials, stationary etc @ Rs.100/- per head for 35 trainees.
Rs.100.00 x 35 = 3500/-
Miscellaneous – Rs.500/- per batch.
Total expenditure for 2 days training of new MOs for one batch
= Rs.22,800/-
Total number of batches in all districts of Bihar – 38
Total Expenditure – Rs.22800.00 x 38 batches
= Rs.8,66,400/-

4.2 One day refresher training of PHC medical officers:

Total number of regular MOs in position – 2712
Total number of batches – 90(batches distributed district-wise)
Trainers (2trainers) DA @ Rs.200/- for 2 Trainers
Rs.200.00 x 2 trainers = Rs.400/-
DA for trainees @ Rs.150/- for 30 trainees.
Rs.150.00 x 30 trainees = Rs.4500/-
Working lunch & tea @ Rs.100/- for 40 persons
Rs100.00 x 40 = Rs.4000/-
Learning materials, stationary etc @ Rs.75/- per head for 30 trainees.
Rs.75.00 x 30 = 2250/-
Miscellaneous – Rs.500/- per batch.
Total number of batches in all districts of Bihar – 90
Total Expenditure – Rs.11650.00 x 90 batches
= Rs.10,48,500/-

4.3 One day Orientation training of supervisors, HW, ANM, LHVs and Pharmacists:

- 1500 numbers of Pharmacists, supervisers, HW, ANM and LHVs will be given one day refresher training at district level.
- Budget – for one batch of 30 participants
  Honorarium to resource persons @ Rs.200/- for two person
  200 x 2 = Rs.400/-

Honorarium to participants @ Rs.100/- for 30 persons
100 x 30 = Rs.3000/-
Refreshment @ Rs.100/- for 40 persons
100 x 40 = Rs.4000/-
Stationary and miscellaneous = Rs.750/-
Total = Rs.8,150/- for one batch.
Grand Total for 70 batches = 8150 x 70
= Rs.5,70,500/-

4.4 Training of 9 DLOs & 1 SLO in Central Institution sponsored by GOI

Budget- TA & DA @ Rs.10000/- x 10
=Rs. 1,00,000/-

Total cost of Training and capacity building = Rs.25,85,400/-

II. Information, Education & Communication:

Introduction –

Leprosy is an age old disease. As there was no known remedy for the disease in the earlier days, the viciousness of disease, disfigurement and disability caused by the disease resulting in making the affected persons heavily, led to a number of myths, misconceptions, apprehensions and inhibitions in the minds of people. This resulted in to developing such a high degree of stigma against the disease that the community wanted to avoid all contacts with such persons. The leprosy affected persons were forced to leave their home and live in segregated areas. This is the only disease where sufferer had to live in separate colonies, villages and in distant islands.

At present the situation has changed to a greater extent. Now there is cure for leprosy and patient can live in their home during treatment. Because of early treatment deformities and disabilities have reduced. Many discriminatory laws have been repealed all over the world. Yet there is discrimination against the person affected by leprosy, which need to be removed from the public mind, so that these persons can lead normal life like any other human being.

Determinants of stigma:

Stigma is perpetuated by (1) Lack of knowledge (2) Attitude (3) Fear (4) Blame & shame

Intervention strategies:

Spreading awareness: Spread the demystifying messages and its interpretations, mainly regarding nature of disease, whether leprosy cases are untouchable, role of immunity in occurrence of leprosy, what is burnt case and so on. However, mere information and education, to all and sundry about the signs and symptoms of leprosy and its curability, shall not work. It is imperative to break the barrier between persons affected by leprosy and the rest of the society, by appealing to the people's emotions and their ability to empathies with those they feared and shunned.

With reducing number of leprosy cases in community, awareness about curability of disease, lessening number of deformity due to leprosy, stigma associated with the disease has become slightly less. The effective way to deal with this difficult challenge of stigma removal is to embark on intensive inter personal communication (IPC) with the target groups

The strategy involves, coordinates and facilitated by (1) civil societies (2) social activists (3) Health service providers (4) Community/opinion leaders (5) Corporate sectors (6) Media (7) Institutions under NRHM such as ASHA and other health functionaries, Rogi Kalyan Samities and Village Health & Sanitation Committees, Health Melas at district and block level etc.

An IEC campaign towards achieving "Leprosy free India" recommended by GOI will be followed on following concept –

- The effort to further reducing leprosy burden in the communities have to be prioritized so that visible deformity in newly detected cases is reduced to minimum.
- Early reporting and complete treatment of leprosy cases prevent disability.
- Quality of services provided to leprosy affected persons be at optimum level to reduce suffering and prevent consequences in all cases put on treatment.
- Leprosy patients will not be stigmatized and discriminated and would lead to a socially and economically productive life.

5. Behavioral Changes and Communication (IEC):

Budget and norms

5.1 School quiz @ Rs.500/- for one quiz.

In each block 7 school quiz will be conducted.

Budget – Rs.500.00 x 533 blocks x 7

= Rs.18,65,500/-

5.2 Sensitisation meetings with PRI members @ Rs.4000/- for one meeting and one meeting in every Block will be conducted.

Budget – Rs.4000.00 x 533 districts

= Rs.21,32,000/-

5.3 One Health Mela per district @ Rs. 4000/- per mela

Budget – Rs. 4,000/- x 38 district

= Rs. 1,52,000/-

5.4 Celebration of Leprosy Day in every District & State

Budget – Rs. 10,000/- x 38 district + Rs.20,000/- (State)

= Rs. 4,00,000/-

5.5 Wall-writing three per PHC

Budget- Rs.700/- x 3 x 533

=Rs.11,19,300/-

5.6 Three days Special IEC Campaign for high endemic PHC / Block having PR more than 2 in 49 PHCs (as per annexure)

Budget- Rs.17,500/- x 49 PHCs / Block in 23 Districts

=Rs.8,57,500/- (Norms- 25 ASHA/AWW / Local NGO@ Rs.50/- per day for 3days + Hand bill-Rs.5500/- + Tent –Rs. 3000/- for 3days +Miking & Riksha – Rs.700/- per day for five days + Misc. – Rs.1750/-)

Total cost of Behavioral Changes and Communication (IEC)

= Rs.65,26,300/-

6. Vehicle Operation & Hiring:

- Vehicle operation/POL/Hiring for SHS (leprosy) Rs.85000/- for two vehicles and for DHS (leprosy) Rs.75000/- one vehicle for one district will be kept.

7. Drugs, Materials & supplies:

7.1 For supportive medicine Rs.25000/- per district.
7.2 For laboratory reagents- Rs.12000/- per year per district.

Printing:

- Required numbers of DPMR registers, formats and other formats will be printed at state head quarter and supplied to districts.
  (State Officers and WHO/ILEP Coordinators will also monitor the supply of different logistics at each level)

III. <u>Disability Prevention and Medical Rehabilitation</u> -

More emphasis will be given on Disability prevention among new leprosy cases and RCS services for deformed persons due to leprosy.

III.1 Prevention of Disability:

- Health workers will suspect cases of leprosy reaction, relapse, insensitive hands and feet and refer to PHC for diagnosis. They will also empower patients with self care procedure for prevention of deformity.

- All PHC Medical Officers will diagnose cases of reaction/neuritis, provide counseling and treat them. Severe reaction/neuritis cases will be referred to the District Hospital if not responded within two weeks of starting treatment.

- Service and care for impairment such as ulcers, cracks and wounds, septic hand or feet etc. will be available from all the health facilities routinely. Complicated ulcer cases will be referred to District Hospital.

- Microcellular Rubber (MCR) footwear are to be provided to all needy patients (under treatment and RFT) by the District nucleus staff at the concerned health facility. An appropriate system of need assessment, procurement and supply will be maintained and improved.

- PHC will provide follow up treatment to all patients referred back by the secondary and tertiary level units for reaction, complication or post surgery care.

- Operational guidelines on DPMR for primary and secondary level have been distributed to all districts and PHCs.

III.2 Medical Rehabilitation:

- Enlisting of disability cases has been completed in 24 districts and in remaining 14 districts enlisting is under process.
- In districts the patients fit for RCS are being referred to identified RCS units (Department of PMR at PMCH, Patna and DMCH Darbhanga).
- An estimated 100 RCS will be done during this year. Budget for RCS support and patient welfare for 100 patients is kept.
- In addition to this TLM Hospital Muzaffarpur will continue to do RCS with ILEP support.
- It is planned to start RCS in Magadh Medical college, Gaya in this year

Leprosy Colonies

There are 48 identified Leprosy Colonies in the state. 972 LAPs live in these colonies with their families. The total population is 2664. some activities like formation of self care groups and providing aids and appliance to the needy LAPs have been initiated with the help of ILEP partners.

DLOs of the concerned districts have been directed to make a person responsible to look after the activities in the leprosy colonies. These persons have to visit regularly in these colonies and have to form and supervise self care groups and to assess the needs of LAPs and make arrangement to provide them self care Kit. DLOs have been asked to monitor these activities and to report regularly.

Incentive to patients undergoing RCS:

- Provision to patients undergoing RCS @ Rs. 5000.00 to offset wage loss to BPL families as recommended by GoI. It is proposed that the above provision may be applied for surgical Nerve Decompression also. Further it is suggested that leprosy is a disease associated with poverty, the provision of Rs. 5000.00 to offset wage loss may be given to all leprosy patients undergoing RCS/Nerve decompression surgery.

Incentive to Institutions:

- Provision to support Government Medical Colleges/PMR centers in the form of Rs. 5000.00 per RCS case has been kept for procurement of supply and material and other ancillary expenditure.

Need based supply of **MCR footwear** to the needy patients will continue during year through District Societies, NGOs and concerned institutions. As grade –I patients with insensitive feet have been included under DPMR plan for MCR supply the number of foot wear requirement will increase.

8. Budget:

8.1 MCR foot wear- 4560 pairs of MCR foot wears @ Rs.250.00
4560 x Rs.250.00 = Rs. 1140000.00

8.2 Aids and appliances @ Rs. 8000/- per district x 38
= Rs. 304000/-

8.3 Provision to compensate wage loss to BPL persons affected with leprosy undergoing Reconstructive / Nerve Decompression surgery – around 100 persons are expected to be operated. The reimbursement of Rs. 5000.00 is sought to be provided for –

Incentive @ Rs.100.00 per person*2*20 days = Rs. 4000.00
Transportation for 2 persons(4-5 times) = Rs. 1000.00
Total (one RCS) = Rs. 5000.00
For 100 RCS- 5000.00*100 = Rs.500000.00

8.4 Provision of incentive to Govt. institutions-
For 100 RCS – 5000.00*100 = Rs. 500000.00
Total cost of DPMR = 2444000.00

Professional Services:

- Audit fees will be met by State Health & FW Society for centralized audit of 38 DLS & SLS head quarter for preparation of consolidation Audit Report.

9. Urban Leprosy Control :

- Total number of town ships selected for ULCP – 24
- Total number of medium city(I) selected for ULCP – 6
- Budget – Rs.51000/- for one town ship x 24 = 1224000/-
  Rs.100000/- for one medium city (I) x 6 = Rs.600000/-

Total cost of Urban Leprosy Control = 1824000/-

NLEP Monitoring and Review :

- Monitoring of:
  - NCDR,TCR,PR & other NLEP indicators
  - Regularity of treatment & timely RFT
  - Reports(MPR,MDT indents, Tour reports etc)
  - Implementation of DPMR trainings with support of ILEP, RCS & other referral & IEC activities.
  - On the job training on DPMR formats, modified SIS & MDT stock management up to sub centre level
- DPMR/SIS/MDT management & monitoring of
  -MDT stock situation in patient month BCPs
  -MDT indenting
  -MDT supply
  -Availability of prednisolone at PHCs.
  - Review Meetings of DLOs and members of District nucleus four times in one year at State level.
  - Cost of organizing State level review meeting and Travel Expenses of State Programme Officer attending country level meeting called by GOI.
  - Review meeting at District level.

Annexure 1

STATE HEALTH SOCIETY (Leprosy), BIHAR				
Budget Proposal under NLEP for the Year 2011-2012				
Sl. No.	**Category of Expenditure : Component & Sub Component wise**	**DLS**	**SHSB (Leprosy)**	**Total of activities**
1	**Under SHS(Leprosy) NLEP contractual services (staff) (Need to be revised)**			
1.1	20 Drivers for 19 districts & for State Leprosy Cell @ Rs.4500/-PM	1026000	54000.00	1080000.00
1.2	DEO at State Leprosy Cell @ Rs.8000/-	0	96000.00	96000.00
1.3	Administrative Assistant in State Leprosy Cell @ Rs.7000/-per month	0	84000.00	84000.00
1.4	SMO (Surveillance Medical Officer @ Rs. 20000/- per month	0	240000.00	240000.00
	Total contratual services(1.1 to 1.4)	**1026000.00**	**474000.00**	**1500000.00**
2	**Services through ASHA/ USHA**			
2.1	Insentive to ASHA / USHA	2250000.00		2250000.00
2.2	Training of ASHA / USHA @ Rs. 2225/ per Batch 30 participants for 500 Batch	1112500.00		1112500.00
	Total Services through ASHA/ USHA	**3362500.00**	**0.00**	3362500.00
3	**Office expences**			
3.1	SHS (leprosy) for rent,telephone,electricity, P & T charges, miscellaneous-Rs.38,000/- per year		38000.00	38000.00
3.2	DLS (leprosy) for rent,telephone,electricity, P & T charges, miscellaneous-Rs.18000/- per district/ year	684000.00		684000.00
3.3	Consumables for SHS & DHS (leprosy) : Stationery etc.@ Rs. 28000/- per year & @ Rs. 14000/- respectively	532000.00	28000.00	560000.00
	Total - Office expences(3.1 to 3.3)	**1216000.00**	**66000.00**	**1282000.00**
4	**Capacity Building**			
4.1	Two days modular training of new entrant MOs @ Rs. 22,800/- per Batch for 38 batches	866400.00		866400.00
4.2	One day Orientation training of Mos @ Rs. 11650/- per Batch for 90 Batches	1048500.00		1048500.00
4.3	One day training of Health Supervisor , HW & ANM & others @Rs. 8150/- per Batches for 70 Batches	570500.00		570500.00
4.4	Training of 9 DLOs + SPO in Central Institution @ Rs.10000/- per DLO		100000.00	100000.00
	Total Capacity Building (4.1to 4.4)	**2485400.00**	**100000.00**	2585400.00
5	**Behavioral Changes and communication**			
5.1	School Quiz-Rs.500/-per quiz (7 quiz per block for 533blocks))	**1865500.00**		**1865500.00**
5.2	Sensitisation meetings with PRI members at Rs. 4000/- per meeting at Block level	**2132000.00**		**2132000.00**

5.3	Health Melas @ Rs. 4000/- per mela (one health mela per District)	**152000.00**		**152000.00**
5.4	Leprosy Day Function	**380000.00**	**20000.00**	**400000.00**
5.5	Wall-writing three per PHC @ Rs.700/- for 533 PHCs	**1119300.00**		**1119300.00**
5.6	Three days Special IEC in 49 PHCs / Blocks in 23 districts @Rs.17500/-	**857500.00**		**857500.00**
	Total Behavioral Changes and communication	**6506300.00**	**20000.00**	**6526300.00**
6	**Vehicle operation/hiring & POL/Maintenance**			
6.1	One vehicle for each DHS(leprosy)-@ Rs.75000.00 per vehicle/district	2850000.00		**2850000.00**
6.2	Two vehicles for SHS(Leprosy)-Rs.85000/- per vehicle		170000.00	**170000.00**
	Total - Vehicle operation(6.1 to 6.2)	**2850000.00**	**170000.00**	**3020000.00**
7	**Drugs, materials & supplies**			
7.1	Supportive medicines-Rs. 25000/-per district/year	950000.00		**950000.00**
7.2	Laboratory reagents & equipments-Rs.12000/-per district/year	456000.00		**456000.00**
7.3	Printing of SIS forms / registers etc		1000000.00	**1000000.00**
	Total - Drugs,materials & supplies(7.1 to7.3)	**1406000.00**	**1000000.00**	**2406000.00**
8	**Disability Prevention and Medical Rehabilitation (DPMR)**			
8.1	MCR & other footwears-4560 pairs @ Rs.250/- per pair		1140000.00	1140000.00
8.2	Aids & appliances-Rs.8000/- per district	304000.00		304000.00
8.3	Welfare allowance for RCS patients @ Rs.5000/- per patient for 100 patients	500000.00		500000.00
8.4	Incentive to institution for RCSRs.5000/- per RCS for 100 RCS	500000.00		500000.00
	Total - DPMR(8.1 to 8.5)	**1304000.00**	**1140000.00**	**2444000.00**
9	**Urban Leprosy Control Programme:**			
9.1	For 24 townships-Rs.51000/- per town	**1224000.00**		**1224000.00**
9.2	For 6 medium I cities-Rs.100000/- per medium city	**600000.00**		**600000.00**
	Total -Urban leprosy control(9.1 to 9.2)	**1824000.00**		**1824000.00**
10	**Review meetings**	**228000.00**	**200000.00**	**428000.00**
11	**Cash Assistance**		**3000000.00**	**3000000.00**
	Grand Total	**21980200.00**	**6050000.00**	**28030200.00**
	(Rs. Two Crore eighty lac thirty thousand & two hundred only)			

Action plan based on Logical frame work for 2011-12			
Over all goal :	Reduced burden of Leprosy in Society		
Specific objective:	1. Proportion of health facilities with integrated services for PAL	DNT Quarterly supervission report	
	2. Proportion of district where NGO cooperation is available for referral and Rehabilitation	DPMR reports	
	3. Increased fund utilization by districts- 25% increase annually	From SOE	
Leprosy affected persons are diagnosed, treated and rehabilitated effectively-			
Results	**Objectively verifable indicators**	**Means of verifcation**	**Activities**
1. Increased attention of decision makers	1.1 Timely release of funds	Financial guide line and SOE	Advocacy meeting & good coordination & rapport building
	1.2 Monitoring meetings involving District, Regional and State Programme Officers quarterly	Official letters from the state and minutes of the meeting	Organizing of meeting at Regional Level
	1.3 Annual meeting at state level for review of progress with decision makers	-do-	Organizing of meeting at state level
	1.4 Appointment of full time Programme Officer	-do-	Notification
	1.5 State leprosy cell made fully functional by appointing contractual staff	SPO & State Health Society	Notification
	1.6 Equal distribution of leprosy unit in the districts	Official letters from the state and minutes of the meeting	Issue order by DHS Govt. of Bihar
2. Early case detection improved	2.1 10% increase in new case detection (at present annually about 19000 to 20000 cases are being detected)	MPR & Master register	i) Lobbying with cooperation partners & meeting with cooperation partners ii) Special IEC drive through wall painting, posters & rallies, sensitization of contacts of patients under treatment, School quiez, health melas, folk media, Advocacy with PRI members
	2.2 20% reduction of disability among new cases (at present no. of disabilities as on march 2010 = 421)	MPR & Master register	i) Sensitization of ASHA /AWW ii) Sensitization of community stakeholders iii)Capacity building of GHS
	2.3 All district will have at least one trained LT in skin smear to diagnose difficult cases & lab reagents will be supplyed to all LTs.		Training of LT in skin smear & procurment of reagents
3. Improved case manegement	3.1 All PHCs will maintain up-to-date master registers	verification of master register during review meetings	Counseling of all patients Timely RFTof all patients One persone made responsible for the

			maintenance of register at PHC
	3.2 At least 35% increase in treatment completion rate of MB cases (TCR at present as on 31st Oct. 2010 TCR is 60 %)	TCR report and analysis of report	Follow up of irregular patients with the help of ASHA / ANM Provide AMDT to deserving patients
	3.3 All newly detected cases will undergo nerve function assessment (NFA) by march 2012	NFA recording on forms	Training of GHS in nerve Functional assessment Printing of DPMR Form & registers
	3.4 Zero % disability among patient under treatment	Master register, NFA recording form and DPMR reports	Maintain adequate supply of MDT
	3.5 All PHCs have adequate supply of MDT & prednisolone by June 2011	MPR & drug stock register	Procurement of MDT and Prednisolone in time
	All district will submit monthly progress report (MPR) in time	State Leprosy cell	
4. Improved Disability Prevention & Medical Rehabilitation (DPMR) services management	4.1 At least 50 % of disabled cases are practicing self care by the end of dec 2011	ASHA supervissory report & DNT Report	Sensitization of ASHA/ ANM Prepared list of disabled pts. Gr-I & Gr-II To organize POD camps at PHC involving GHS, pts for self care Do the disability assessment of all patients and to assess requirement of Aids and appliances vocational training and RCS Procurement and distribution of Aids and appliances with cooperation of distt welfare officer To send patients and dependents needing vocational training and with the help of ILEP To train GHS staff in diagnosis and management of LEPRA reaction Maintain adequate supply of prednisolone To Maintain record of NFA of cases and follow up for high risk cases To follow up RFT pts. Specially high risk Regular follow up of self care by ASHA and submitting report To supervisor follow up of RCS patients -Referring complicated cases and maintaining records
	4.2 No. of districts where reaction cases are effectivly managed at PHC level to be increased from 50 % to 80 % by december 2011	Reaction Register & DPMR reports	
	Proportion of needy cases refered for surgical treatment increased 25 % in 2011 and 50 % in 2012	RCS rererral register & follow-up records	
	Proportion of patient s who received medical rehabilitation (RCS, assistive devices, physical Therapy) that experience and improvement in physical functioning to the minimum of 70 %	-do-	
5. Supervission system	Use of supervission check list & submission of	Tour diary and visit report	Preparation of checklist

improved	supervisory report by all PHCs quarterly,		Plan for training Training of supervisory staff PHC level – 2 batches Plan of monthly supervision PHC / dists. Mobility for supervision with consultation of DHS Hiring of vehicle Review supervision activity during meeting Submission of supervision report to MO/IC / DNT / CMO DNT to prepare tour plan for six month with priority to problem area DNT attend PHC review meeting quarterly DNT to review supervision report monthly Submission of report to CMO /SPO ILEP partner monthly
	Proportion of DNT preparing visit report of their supervission increases from 40% to 80 % by dec. 2011	Supervission register and tour diary	
	SLO visit to districts every month	SLO visit report	
6. State and District NLEP Managemnet improved	Fund utilization at state level increased to 80 % as per quarterly targets of allocated fund	SOE	Preparation of annual plan at PHC level Preparation of annual plan of dist level Coordination meeting at various path at dist. level Training of pharmacist and storekeepers on MDT mgmt.. Infrastructure of DLO officer Demand of MCR, aid and appliances Ensure F/U, monitoring of PR index, RCS pts
	Timely receiving of SOE from the district every month	State Leprosy cell	
	Fully equiped and functional SLO and DLO office by Second quarter 2011-2012	Estabilishment report	
	Review meetings will be conducted at all levels as per schedule	Minutes of the meeting	

Annexure -IA

Estimated Budget

Special Case detection Campaign		Sl. No.	Particulars	Amount		Total Amount
				State Level	District Level	
Preparatory Phase	**Meetings**	**1**	**State Level meeting of one day for DLOs**			
			Venue Cost (Rs. 2500/- x 1)	2500		
			Refreshment (Rs. 150/- x 50)	7500		
			Misc. Expenses	500		**10500**
	Tanning	**2**	**District level Meeting (Half day)**			
			Venue Cost (Rs. 500/- x 38)		19000	
			Refreshment for 1MO per PHC (Rs. 50/- x 540)		27000	
			Refreshment for DLO, assisting staff (Rs.50/-x 4 x 38)		7600	
			Misc. Expenses (Rs. 200/-x38)		7600	**61200**
		3	PHC Level Meeting			
			Refreshment for searcher (ASHA /AWW /HG) (Rs. 30/- x 70000)		2100000	
			Misc. Expenses (Rs. 200/- x 540)		108000	**2208000**
	IEC	**4**	**IEC material**			
			Hand bill (50000 per district) (50x Rs.400x38)		760000	
			Poster 2000 per district (2x Rs. 3000/-x 38)		228000	
			Banner 4'x2' (3000X Rs.200/-)		600000	
			Flash card 750000 (no. of search teamx2x @Rs. 5/-) (75000x2xRs.5)		750000	
			Wall writing 3 per PHC (540x3x600)		972000	**3310000**
		5	Printing of Forms			

			Survey Forms 850000 (12 Forms each search team) (70000x12) (850 X Rs.400)		340000	
			Suspected cases form 150000 (2 Forms each search team) (150xRs. 400)		60000	
			referral shlip for suspected cases 1400000 (1400 x Rs.100/-)		140000	
			PHC reporting forms for confirmed cases 6000Form (10 forms each PHC) (6xRs.400)		2400	
			District reporting forms (By Xerox) to be met from Misc. Expenses		0	**542400**
			State level reporting forms (By Xerox) to be met from Misc. Expenses			
Implementation Phase			**Meeting with PRI member(3000/540PHC)**		1620000	**1620000**
			Radio jinggle Relay 5 days (to be done by govt. of India			
	Active search Phase		Incentive to Searchers @ Rs.125/- for 3 days (70000xRs.125/- x3)		26250000	**26250000**
			One village volunteer (70000 x 3 x Rs.100/-)		21000000	**21000000**
			House marking (Geru)@Rs.20/- per searchar team (70000xRs.20/-)		1400000	**1400000**
			Incentive to sector Incharge (@Rs.125/- per day for 3 days)(No. of sectors 2300 each sector covering area 50-60 thousands population) (Rs.125 x 3)		2587500	**2587500**
			Misc. Expenses at district level (@Rs. 5000/- per district for 38 district)		190000	**190000**
			Mobility & Supervision			
			SPO (TO BE BORN BY FUND AVAILEBLE IN NLEP FUND (SHS)}			
			DISTRICT LEVEL SUPERVISION			

			CS {TO BE BORN BY FUND AVAILEBLE IN NLEP FUND (DHS)}			
			ACMO {TO BE BORN BY FUND AVAILEBLE IN NLEP FUND (DHS)}			
			DLO {TO BE BORN BY FUND AVAILEBLE IN NLEP FUND (DHS)}			
			PHC LEVEL			
			2 MO (DA + MOVEBILITY @Rs.300/- PER DAY)(540x2xRs.300x3)		972000	**972000**
			SECTOR SUPERVISION supervisory staff of PHC(DA + MOVEBILITY @Rs.200/- PER DAY/3day)(540x4x3xRs.200)		1296000	**1296000**
			ILEP SUPERVION (TO BE BORN BY ILEP)			
			DISTRICT LEVEL SUPERVISION			
			CS {TO BE BORN BY FUND AVAILEBLE IN NLEP FUND (DHS)}			
			ACMO {TO BE BORN BY FUND AVAILEBLE IN NLEP FUND (DHS)}			
			DLO {TO BE BORN BY FUND AVAILEBLE IN NLEP FUND (DHS)}			
		Total	**Rs.**	**10500**	**61437100**	**61447600**

NPCB	Part H

Introduction

Bihar is 3rd largest populated State in India having estimated population of about ten crores. Density of population is much higher than the Indian average of 89.5%.
National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a centrally sponsored scheme with the goal to reduce the prevalence of blindness to 0.3% of the population by 2020 from the existing prevalence rate of 0.8%.
The goal of eliminating avoidable blindness can be achieved through the following broad strategies.

• strengthening service delivery,

• developing human resources for eye care,

• promoting outreach activities and public awareness and

• developing institutional capacity.

OBJECTIVE :
Our main objective is to be combat blindness through community eye care, and providing a mix of preventive, curative and rehabilitative eye care interventions with a greater focus on curative service as to bring about significant reduction in blindness.

National Programme for Control of Blindness
(Financial Year 2011-2012)

Activities under National Programme for Control of Blindness are:

(1) Cataract Operation
(2) School Eye Screenings Programme:
(3) Diabetic retinopathy
(4) Glaucoma
(5) Childhood blindness
(6) Eye Donation Awareness
(7) Establishing Vision Centre
(8) Strengthening of RIO/Medical College/ Govt. Hospital
(9) Support to NGOs

Cataract Operation:- Cataract Operations accounts for 62.6% of blindness in India. Cataract operation are being done in district Hospitals and by NGOs in each district of the State. In addition to that Medical Colleges/ RIO also offer these services.

The achievement of last five year against the target fixed in cataract operation are as follows. The following table shows the last six year's physical record of Cataract Operation:-

Sl. No.	Year	Target	Achievement	Percentage
1.	2005-06	140000	131860	94.19
2.	2006-07	140000	129064	92.19
3.	2007-08	140000	137685	98.35
4.	2008-09	150000	154817	103.21
5.	2009-10	150000	169955	113.30

School Eye Screening Programme :- School Eye Screening is aimed mainly for community eye care. In this it is ensured that school children are screened on regular basis through the help of para medical ophthalmic assistant and teachers who are trained by them. Free spectacles are provided to families who are below poverty line.

The following table shows the last four year's physical record of SES:-

Sl. No.	Year	No. of school children underwent Eye Screening
1.	2005-06	2,97,278
2.	2006-07	2,43,095
3.	2007-08	284398
4.	2008-09	257928
5.	2009-10	468817

Diabetic Retinopathy:- Diabetic Retinopathy is emerging as a major threat for blindness in India. Since Awareness of the disease and its treatment modalities among the community is low hence specialized training of ophthalmologists to diagnose and treat diabetic retinopathy thus becomes a key aspect of blindness prevention. The current need is for a holistic model inculcating awareness creation, community screening, service delivery and training to deal with the problems of diabetic retinopathy for the community.

Review Meeting: - A Review Meeting of Additional Chief Medical Officer who is also the District Programme Officer of National Programme for Control of Blindness is proposed in every quarter at state Level. Representative of India shall also be requested to attend. An exclusive meeting of PMOAs will be organized at state head quarter.
State Level Workshop:- State Level Workshop/Refresher training of Eye specialist/Eye surgeon posted in district/district head quarter as well as private practicenor is proposed.
Vision Centre:- In remote rural areas where there is no facility of eye care , Govt. of India has provision for setting up vision centres. Our aim is to establish at least three vision centre in every districts. Involvement of NGOS may be taken in this regard.
Training :- Under the NPCB training to Medical Officer of PHC, PMOAs and Nurses shall be imparted. Medical Officers shall be trained for three days, PMOAs for five days and 28 days training to the Nurses as per Govt. of India guideline. As per GOI guide line Para Medical Ophthalmic assistant are sent out side state for refresher training. Medical officer are also sent out side state for specialized training.

IEC:- Community eye care and Universal coverage can be ensured through IEC activities. In order to make aware the people aware about different activities done by NPCB, IEC could prove to be instrumental in this regard.

Causes of Blindness in Bihar State :

Following is the table showing the causes of blindness according to their magnitude of importance in the overall situation of blindness problem.

- Cataract
- Refractive Errors
- Corneal Blindness
- Glaucoma
- Surgical Complications
- Posterior segment disorders
- Others

Emerging Causes of Blindness :

- Diabetic retinopathy
- Glaucoma
- Childhood blindness

Comparison of Prevalence of Blindness National Surveys on Blindness 1986-89 & 2001-2002

Parameter	National Survey 1986-89	National Survey 2001-2002
Estd. Prevalence of Blindness (Visual Acuity <6/60	1.49	1.1
Bihar	1.28	0.78

Plan of Action and Budgetary requirements during 2011-2012
Recurring Grants in Aid to NGOs for performing free Cataract Operation and other Intra Ocular Surgeries.

Sl.No.	ECCE	IOL	SICS/ Phaco	Total
Cataract operation and other Intra Ocular Surgeries	**11,250,000**	**101,250,000**	-	**11,25,00,000**
Drug and Consumable	200	200	200	
Sutures	50	50		
Spectacles	125	125	125	
Transportation/POL	100	100	100	
Organization & Publicity	75	75	75	
Icl, Viscoelastics & Addl. Consumables	200	200	250	
Total	**750**	**750**	**750**	
Target:- 150000	**10%**	**90%**		**100%**

Plan of action and Budgetary requirements during 2011-2012		
Sl. No.	**Name of Activity**	**Estimated Cost. (Rupees)**
1.	Remuneration, other activities & contingencies (Annex-A)	14,00,000
2.	Grant-in-Aid other Components-) Annexure-B	37,88,06,600
	TOTAL:- (Thirty eight crore two lakhs six thousand six hundred only)	**38,02,06,600**

Budgetary requirement during 2011-2012

	Annexure-A	
Sl.No.	**Particulars**	**Cost p.a.**
1.	Review Meeting	240000
2.	Flexi pool fund (for staff remuneration & other)	600000
3.	TA/DA for staff and officers	90000
4.	POL/Vehicle Maintenance	200000
5.	Stationary and Consumables	50,000
6.	State level Workshop	220000
	Total	**14,00,000**

	Annexure-B	
	Grant in Aid other components-	
1.	Vision Centre (100 @ 50,000/- per vision centres)	50,00,000
2.	Eye Bank 1 @ 15 Lakh each	15,00,000
3.	Eye donation Centre 1 @ 1 lakh each	1,00,000
4.	Training of Ophthalmic & support Man power	5,00,000
5.	IEC – Annex.1	81,53,600
6.	GIA for free Cataract Operation for 38/ DHS-Blindness Division – Annex-3	11,25,00,000
7.	GIA for School Eye Screening for 38 DHS- Blindness Division @ 2 lakh per district	76,00,000
8.	For Eye Ward and eye OTs@Rs75Lakhs for six district	4,50,00,000
9	**Support towards salaries of Ophthalmic Manpower to States** **A. Demand for Manpower** 1. Fifty Ophthalmic Assistant in district Hospital/PHC @ 15000/- per month **B. Recurring expenditure towards salaries of Ophthalmic surgeon & Ophthalmic Assistant :-** **1. 10 (Ten)** Ophthalmic surgeon :- 35000 X10X12=42,00,000 **2. 20 (twenty)** Ophthalmic Assistant:- 8000 X 20 X 12=19,20,000	90,00,000 61,20,000
10.	Strengthening /setting up of Regional Institutes of Ophthalmology (Non Recurring Assistance for pediatrics ophthalmology)	40,00,000
11.	Strengthening of Medical Colleges @ 40 Lakh for 6 Medical Colleges	2,40,00,000
12.	Strengthening of District Hospitals @ 20 Lakhs for 12 dist.	2,40,00,000
13	Grant-in-aid to District Health Societies (Recurring Assistant) @ 5 Lakhs	1,90,00,000
14	Back lock dues in dist.(Approx.)	4,00,00,000
15.	Non –recurring GIA for maintenance of Ophthalmic equipment @ 5 lakhs per unit (45 X5 lakh)	2,25,00,000
16.	Procurement of Ophthalmic Equipments and Instruments(Annexure-2)	4,98,33,000
	TOTAL:- **Rupees thirty seven crore eighty eight lacks six thousand six hundred only.**	**37,88,06,600**

Annexure-1

IEC CAMPAIGN: PROPOSED BUDGET FOR IEC ACTIVITES DURING 2009-2010

Sl.No.	IEC Materials	Tentative Quantity	Estimated Cost (Rs.)
1.	Tin Plate Poster & wall painting	At PHC, dist. And State Level	9,88,800
2.	Doordarshan Telecast, scroll for TV channels, slogan & broadcasting in Radio channels	T.V. Spots on Eye Care, Diabetic Retinopathy, Eye Donation, Free Cataract operation , Refractive Error, Glaucoma	27,64,800
3.	**IEC activities for:-** 1. eye donation fortnight, 2. world sight day 3. world glaucoma day	 @ Rs. 1,00,000X38 in 38 district @ Rs. 1,00,000X6 in 6 medical colleges.	 38,00,000 6,00,000
	TOTAL:-		**8153600**

Annexure-2

Sl.No.	Name of Ophthalmic Equipment/ Instruments	Tentative Quantity	Estimated Cost (Rs.)
1.	Operating Microscope @ 577800 per piece	(for 20 districts)	1,15,56,000
2.	A-Scan Biometer @ 558750 per piece	(for 20 districts)	1,11,75,000
3.	Auto Refractor with Keratometer @ 476000 per piece	(for 20 districts)	95,20,000
4.	Slit Lamps @ 879100 per piece	(for 20 districts)	1,75,82,000
		Total:	**4,98,33,000**

Annexure-3

Recurring Grants in Aid to NGOs for performing free Cataract Operation and other Intra Ocular Surgeries.

Sl.No.	Name of Dist.	Target	ICCE @750/- (10%)	ECCE/IOL@ 750/- (90%)	Phaco	Total
1.	Araria	2000	150,000.00	1,350,000.00	-	1,500,000.00
2.	Arwal	500	37,500.00	337,500.00	-	375,000.00
3.	Aurangabad	3000	225,000.00	2,025,000.00	-	2,250,000.00
4.	Banka	1500	112,500.00	1,012,500.00	-	1,125,000.00
5.	Begusarai	4000	300,000.00	2,700,000.00	-	3,000,000.00
6.	Bhagalpur	6000	450,000.00	4,050,000.00	-	4,500,000.00
7.	Bhojpur	6000	450,000.00	4,050,000.00	-	4,500,000.00
8.	Buxar	3000	225,000.00	2,025,000.00	-	2,250,000.00
9.	Darbhanga	6000	450,000.00	4,050,000.00	-	4,500,000.00
10.	E.Champn.	2500	187,500.00	1,687,500.00	-	1,875,000.00
11.	Gaya	23000	1,875,000.00	16,875,000.00	-	18,750,000.00
12.	Gopalganj	2000	150,000.00	1,350,000.00	-	1,500,000.00
13.	Jamui	1500	112,500.00	1,012,500.00	-	1,125,000.00
14.	Jehanabad	2000	150,000.00	1,350,000.00	-	1,500,000.00
15.	Kaimur	2000	150,000.00	1,350,000.00	-	1,500,000.00
16.	Katihar	4000	300,000.00	2,700,000.00	-	3,000,000.00
17.	Khagaria	1500	112,500.00	1,012,500.00	-	1,125,000.00
18.	Kishanganj	2000	150,000.00	1,350,000.00	-	1,500,000.00
19.	Lakhisarai	1000	75,000.00	675,000.00	-	750,000.00
20.	Madhepura	1000	75,000.00	675,000.00	-	750,000.00
21.	Madhubani	1500	75,000.00	675,000.00	-	750,000.00
22.	Munger	2000	150,000.00	1,350,000.00	-	1,500,000.00
23.	Muzaffarpur	11000	825,000.00	7,425,000.00	-	8,250,000.00
24.	Nalanda	11000	825,000.00	7,425,000.00	-	8,250,000.00
25.	Nawada	3000	225,000.00	2,025,000.00	-	2,250,000.00
26.	Patna	22000	1,650,000.00	14,850,000.00	-	16,500,000.00
27.	Purnia	4000	300,000.00	2,700,000.00	-	3,000,000.00
28.	Rohtas	2000	150,000.00	1,350,000.00	-	1,500,000.00
29.	Saharsa	2000	150,000.00	1,350,000.00	-	1,500,000.00
30.	Samastipur	2000	150,000.00	1,350,000.00	-	1,500,000.00
31.	Saran	3000	225,000.00	2,025,000.00	-	2,250,000.00
32.	Sheikhpura	500	37,500.00	337,500.00	-	375,000.00
33.	Sheohar	500	37,500.00	337,500.00	-	375,000.00
34.	Sitamarhi	1000	75,000.00	675,000.00	-	750,000.00
35.	Siwan	2500	187,500.00	1,687,500.00	-	1,875,000.00
36.	Supaul	1000	75,000.00	675,000.00	-	750,000.00
37.	Vaishali	3500	225,000.00	2,025,000.00	-	2,250,000.00
38.	W.Chamn.	3000	150,000.00	1,350,000.00	-	1,500,000.00
	Total	**150000**	**11,250,000.00**	**101,250,000.00**	**-**	**112,500,000.00**

***

RNTCP | Part I

Annual Plan for Programme Performance & Budget for the year

1st April 2011 to 31st March 12

State: BIHAR

Objectives:

1. *To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases, and*
2. *To achieve and maintain detection of at least 70% of such cases in the population*

This action plan and budget have been approved by the STCS.

Signature of the STO

Name: Dr. A.K.Jha

Section-A – General Information about the State

1	State Population (in lakh) *please give projected population for next year*	**977.2 Lakhs**
2	Number of districts in the State	**38**
3	Urban population	**88.83 Lakhs**
4	Tribal population	
5	Hilly population	
6	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums, etc.)	

(These population statistics may be obtained from Census data /State Statistical Dept/ District plans)

No. of districts without DTC: NIL

No. of districts that submitted annual action plans, which have been consolidated in this state plan: **38 Districts**

Organization of services in the state:

S. No.	Name of the District	Projected Population (in Lakhs)	Please indicate number of TUs of each type		Please indicate no. of DMCs of each type in the district: To be changed		
			Govt	NGO	Public Sector	NGO	Private Sector
1	Aurangabad	2449678	4	0	17	0	0
2	Araria	2471203	4	0	11	0	0
3	Arwal	708425	1	0	6	0	0
4	Bhagalpur	2826503	5	0	17	0	3
5	Begusarai	2,762,551	4	0	23	0	1

6	Bhojpur	2597488	4	0	22	0	0
7	Banka	1871027	3	1	14	7	0
8	Buxar	1632243	3	0	14	0	0
9	Purba Champaran	4574864	9	0	28	1	0
10	Paschim Champaran	3539095	6	1	24	0	0
11	Darbhanga	38,73,807	6	0	33	0	0
12	Gopalganj	2508165	5	0	19	0	0
13	Gaya	4205182	7	0	27	3	0
14	Jehanabad	1049357	2	0	8	0	0
15	Jamui	1625278	5	0	9	0	0
16	Khagaria	1484790	3	0	14	0	0
17	Kishanganj	1505010	2	1	6	3	0
18	Kaimur	1499028	2	1	13	0	0
19	Katihar	2779055	5	0	19	0	1
20	Lakhisarai	931773	2	0	5	0	1
21	Madhubani	**42,10,052**	7	0	35	0	0
22	Madhepura	1773123	3	0	14	0	0
23	Munger	1320598	2	0	9	1	0
24	Muzaffarpur	4354125	9	0	22	0	0
25	Nalanda	2763697	5	0	23	0	0
26	Nawada	2104382	4	0	16	0	0
27	Purnia	2964960	5	0	25	0	0
28	Patna	5477611	10	0	40	7	4
29	Rohtas	2847939	5	0	18	1	0
30	Saharsa	1751982	4	0	10	0	0
31	Samastipur	43,69,457	6	1	23	0	0
32	Saran	3794291	6	0	26	0	0
33	Sheohar	598123	1	0	3	0	0
34	Sitamarhi	31,47,987	5	0	24	0	0
35	Sheikhpura	612806	1	0	5	0	0
36	Supaul	2029535	3	0	18	1	0
37	Siwan	3161067	5	0	16	0	0
38	Vaishali	3154540	5	0	16	0	0
39	**Total**	81729494	168	5	672	24	10

**Public Sector includes Medical Colleges, Govt. health department, other Govt. department and PSUs i.e. as defined in PMR report*

^ Similarly, Private Sector includes Private Medical College, Private Practitioners, Private Clinics/Nursing Homes and Corporate sector

RNTCP performance indicators:

Important: Please give the performance for the last 4 quarters i.e. Oct 2009 to September 2010

Name of the District (also indicate if it is notified hilly or tribal district	Total number of patients put on treatment*	Annualised total case detection rate(per lakh pop.)	No of new smear positive cases put on treatment *	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year		Proportion of TB patients tested for HIV	No. of MDR TB suspects identified and subjects to C/DST of sputum	No. of MDR TB cases diagnosed & put on treatment
						Annualized NSP case detection rate	Cure rate			
Aurangabad	1436	61	659	28	77%	38	85%			
Araria	1675	68	777	31	87%	38	87%			
Arwal	631	89	282	40	84%	48	85%			
Bhagalpur	3569	126	1421	50	83%	60	85%			
Begusarai	3267	120	1353	50	93%	60	93%			
Bhojpur	1393	54	477	18	70%	38	85%			
Banka	1443	77	589	31	71%	38	85%			
Buxar	892	55	387	24	89%	38	89%			
Purba Champaran	2254	49	1135	25	91%	38	91%			
Paschim Champaran	2467	70	1629	46	91%	55	91%			
Darbhanga	2983	78	1241	32	82%	40	85%			
Gopalganj	1875	75	889	35	84%	42	85%			
Gaya	3544	88	964	24	74%	38	85%			
Jehanabad	1129	108	465	44	80%	53	85%			
Jamui	1542	95	548	34	57%	41	85%			
Khagaria	947	64	547	37	81%	45	85%			
Kishanganj	1181	78	640	43	84%	52	85%			
Kaimur	959	64	358	24	81%	38	85%			
Katihar	2466	89	1457	52	79%	65	85%			
Lakhisarai	672	72	284	30	86%	38	86%			
Madhubani	2821	68	1762	42	82%	52	85%			
Madhepura	1078	61	608	34	89%	42	89%			
Munger	1541	117	675	51	83%	62	85%			
Muzaffarpur	5395	124	1738	40	76%	50	85%			
Nalanda	1904	69	975	35	88%	45	88%			
Nawada	1183	56	617	29	91%	38	91%			
Purnia	3375	114	1749	59	80%	70	85%			
Patna	6343	116	1932	35	84%	45	85%			
Rohtas	1835	64	1092	38	88%	45	88%			
Saharsa	1521	87	630	36	73%	45	85%			
Samastipur	4368	110	1856	47	82%	57	85%			
Saran	2151	57	872	23	63%	38	85%			
Sheohar	695	116	202	34	63%	40	85%			
Sitamarhi	3067	98	1508	48	74%	58	85%			
Sheikhpura	630	103	171	28	70%	38	85%			
Supaul	1081	53	419	21	65%	38	85%			
Siwan	3171	100	1243	39	75%	50	85%			
Vaishali	3207	102	895	28	84%	38	85%			
Total	81691	85	35046	36	81%	46	85%			

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

Patients put on treatment under DOTS regimens only are included.

S.No.	Priority areas	Activity planned under each priority area
1	Human Resource	1 a)Filling up of District level RNTCP contractual vacancies as and when it arises along with a reserve panel of candidates for filling vacancies which might arise later on.
		1 b)Sanctioning of post of DTO by Health Department in Araria, Arwal,Darbhanga, Lakhsarai, Sheohar , Sheikpura and Supaul . Filling up of MOTCs positions. ..
		Placement of MD microbiology at TBDC Patna by Health Department, Government of Bihar against the existing government position. Placement of 3 Laboratory attendants by Director TBDC Patna.
2	Programmatic Management of Drug Resistant Tuberculosis	2 a) Rolling out of PMDT services in the district in the first 2 phases as per the PMDT action plan. Phase I:(Patna, Begusarai, Darbhanga, Bhagalpur,Purnea,Samastipur). Phase II :(Katihar, Madhubani, Munger, Nalanda, Paschim Champaran , Sitamarhi) Appointment of DOTS Plus and TB HIV supervisors in Phase I and II districts at state level. Appointment of all RNTCP contractual positions which are lying vacant in the districts to be done at the state level.
		Up gradation of the State and the District Drug stores for storing CAT-IV drugs as per specified guidelines in priority in phase 1 and II districts and later in all the districts of the state.
3	Training	Identifying the master trainers for DOTS Plus module from medical College and reputed private physicians and nominate them for national level training.
		Training of additional Laboratory Technicians in sputum smear microscopy who have been recruited by the State Health Society and will be utilised subsequently for establishing more DMCs .
		3) Re-training of all the STS at STDC Patna in STS Module, TBHIV and Training of the STS, STLS, MO-TC and MO-DTC of 12 districts (Phase I and II) of PMDT at STDC Patna. d) Training/Re-training of all MOs,STS,STLS and VCTC counsellors on TB-HIV.
		3 e) Training of all concerned in PMDT requirements and regular update on the same
		3 b)Establish at least 20 more Tuberculosis Units which will help in better supervision of patients put on DOTS and also improved supervision on the quality of microscopy services offered.

		3 **Additional 15 TUs** planned in the districts of Aurangabad, Bhagalpur, Begusarai, Darbhanga, Gaya, Madhubani, Purnia, Rohtas, Samastipur, Saran, Sitamarhi, Siwan, Vaishali, Patna, Bhojpur **A total of 165 DMCs** : Aurangabad-7, Bhagalpur-8, Begusarai – 4, Banka-4, Purbi Champaran- 5, Darbhanga-6, Gaya- 12, Jamui- 2, Khagaria-1, Kishanganj-3, Kaimur- 2, Lakhisarai- 1, Katihar-3, Madhubani- 7, Madhepura-3, Munger-3, Muzzafarpur-12, Nalanda-5, Nawada- 6, Purnia-4, Rohtas-4 , Saharsa-2, Samastipur- 19, Saran-6, Sitamarhi-6, Siwan-3, Vaishali- 16, Bhojpur-4, Up gradation of 12 district drug store and State Drug Store in the current financial year)
5	Intermediate Reference Laboratory, Lab network and strengthening of EQA	4 a) Accreditation of IRL and initiation of Mycobacterial culture and drug susceptibility testing. For developing a sustainable transport mechanism under PPP model for Sputum samples of MDR suspects to be tested at IRL – Ranchi/Patna/RMRI Patna To procure the packing materials and Falcon tubes for sputum transport of MDR suspects.
6	Strengthening Supervision and Monitoring	6 a)At least 2 districts per quarter to be visited by the STO, Director STDC and MO-STDC and feed back to be submitted to the State TB Cell with a copy to Executive Director ,State Health Society and Principal Secretary Health & Family Welfare.
		6 b)A minimum of 2 Internal evaluations to be conducted by STDC every quarter. Vehicle hiring for STC and STDC for supervision by the state TB cell and IRL.
		6 c)Timely implementation of suggestions received from the Central IE/State IE/NRL OSE visits and all concerned within the specified time period.
7	Involvement of other sectors and NGOs/PPs	7 a)The NGOs and PPs who are already involved in the programme there timely payment of grant in aid and renewal of MOU based on there performance.
		7 b)Sensitisation of other sectors, NGOs and PPs in the newer schemes for diagnosis,treatment adherence, sputum collection and transport and for special groups and there involvement.
		7 c)Increased involvement of Faith Based and community based organisations.
8	Minimizing Initial Defaulters	8 a) Ensuring in all districts – line listing of all sputum smear +ve patients diagnosed on regular basis and their follow up.
		b) Regular data exchange for feedback within district regarding referral for treatment.
9	TB- HIV Coordination	9 a)Constitution of State Coordination committee and district coordination committee's.
		9 b)Initiation of reporting of cross refferals from RNTCP to ICTC and vice versa
		9 c) Re-Training of all ART staff in the state.

Priority Districts for Supervision and Monitoring by State during the next year

S No	District	Reason for inclusion in priority list
1	*Supaul*	*Low Case Detection*
2	*Buxar*	Lowest Case Detection and no STLS
3	*Bhojpur*	Low Case Detection
4	*Gaya*	Low Case Detection
5	*Madhepura*	Low Case Detection
6	*Kaimur*	Low Case Detection
7	*Saran*	Low Case Detection
8	*Araria*	*Low Case Detection*
9	*Sheohar*	*Low cure rate*
10	*Vaishali*	*No contractual supervisory staff in the District*

Section C – Consolidated Plan for Performance and Expenditure under each head, including estimates submitted by all districts, and the requirements at the State Level

1. Civil Works

Activity	*No. required as per the norms in the state*	*No. already upgraded/ present in the state*	*No. planned to be upgraded during next financial year*	*Pl provide justification if an increase is planned in excess of norms (use separate sheet if required)*	*Estimated Expenditure on the activity*	*Quarter in which the planned activity expected to be completed*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
STDC/ IRL	*2*	*1**		*For Maintenance*	***75000.00***	*Dec'2011*
SDS	*1*			*Upgradation of SDS for storing Second line Anti TB Drugs in the current Financial year as per the specifications.*	*150000*	
DTCs	*38*	*38*	*12 District Drug store will be upgraded for Cat-IV drugs.*	In addition to routine maintenance, district drug store is to be upgraded in all the districts for storing Second line anti TB drugs.	***171000.00(For maintenance)*** **1140000** (For upgradation) **2412000.00****	*Dec'2011*
TUs	*196*	*173*	*15*	*The TUs are being increased in 15 districts vis a vis population norms.*	***254800.00****(only maintenance cost)* **525000.00**(For new TUs) $ **140000.00**	*Dec'2011*
DMCs	*977*	*706***	*165*	*The DMCs will help in providing the sputum microscopy services to a larger population and make it more accessible.*	***706000.00****(For maintenance)* **4950000.00** (For new DMCs)	*Dec'2011*
DOTS Plus site	*8*	*0*	*3#*	*1 Site in Patna will be completed in the current financial year. Second site is proposed in the current action plan*	***3000000.00***	*Dec'2011*
				TOTAL	***13523800.00***	

***1 STDC at Patna is functioning with the IRL . TBDC Darbhanga is functioning as DTC Darbhanga**

** Araria , Bhagalpur, Banka, Madhubani, Munger, Purnea, Saharsa, Samastipur : Major Civil work and renovation

$ Munger,Saharsa, Lakhisarai , saran

Patna, Bhagalpur, Darbhanga

2. Laboratory Materials

Activity	*Amount permissible as per the norms in the state*	*Amount actually spent in the last 4 quarters*	*Procurement planned during the current financial year (in Rupees)*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Purchase of Lab Materials by Districts	*15918932.00*	*3807454.00*	*4200000.00*	*12800000.00*	*With finalisation of rate contract and expected increase in case detection in the state, the expenditure will increase*
Lab materials for EQA activity at STDC (eg. Lab consumables for trainings, preparation of Panel slides etc)		*-*		*100000.00*	
Lab materials & consumables for Culture/DST activity at IRL and other Accredited Culture & DST labs in Govt. sector including Medical Colleges		*-*		*1447176.00*	*The state will be starting CDST in 2011 and the expected expenditure has been based on assumptions.*
Total		***3807454.00***	*4200000.00*	***14347176.00***	

3. Honorarium

Activity	*Amount permissible as per the norms in the state*	*Amount actually spent in the last 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Honorarium for DOT providers (both tribal and non tribal districts)	*5472000.00*	***3173663.00***	*2978500.00*	*13321810.00*	*The amount is for committed expenditure and for current expenditure in the year*
Honorarium for DOT providers of Cat IV patients				*100000.00*	*Estimated on the assumption that by 2012, a total of 56 patients will be receiving second line drugs.*
Total		***3173663.00***	*2978500.00*	*13421810.00*	

	No. presently involved in RNTCP	*Additional enrolment proposed for the next fin. Year*
*Community volunteers in all the districts**	*13496***	*64567***

***** *These community volunteers are other than salaried employees of Central/State government and are involved in provision of DOT e.g. Anganwadi workers, trained dais, village health guides, ASHA, other volunteers, etc.*

****** The numbers proposed

Annual Action Plan Format Advocacy, Communication and Social Mobilization (ACSM) for RNTCP**

1) Information on previous year's Annual Action Plan
   - **a)** Budget proposed in last Annual Action Plan: **726.64 Lakhs**
   - **b)** Amount released by the state: **36.3 Lakhs**
   - **c)** Amount Spent by the district- **10.64 Lakhs**
   - **d)** Amount Spent at state level; **4.5lakhs**

Permissible budget as per norm : 8327500.00

2) Budget for next financial year for the districts: 36.63 Lakhs
3) Budget for next financial year for the State : 10 Lakhs
4) **Total Budget for ACSM: 46.63 Lakhs**

Comments, if any:- Details of activity will be planned in consultation with State IEC Officer (selection process completed).
Prepared by:-

5. Equipment Maintenance:

Item	*No. actually present in the state*	*Amount actually spent in the last 4 quarters*	*Amount Proposed for Maintenance during current financial yr.*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Computer (Maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)	*41*	*361841.00*	*130991.00*	*1230000.00*	
Binocular Microscopes (RNTCP)	*848*		*2000000.00*	*1272000.00*	
STDC/ IRL Equipment				*1000000.00*	*The amount proposed for maintenance of IRL equipments for the coming financial year is based on assumption*
Any other (pl. specify)					
TOTAL		***361841.00***	*2130991.00*	***3502000.00***	

6. Training:

Activity	*No. in the state*	*No. already trained in RNTCP*	*No. planned to be trained in RNTCP during each quarter of next FY (c)*				*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*Q1*	*Q2*	*Q3*	*Q4*	*(d)*	*(e)*	*(f)*
Training of DTOs (at National level)	*38*	*25*	*10*	*3*	*0*	*0*			*The DTOs as and when posted will be nominated for training at National institutes*
Training of MO-TCs	*155**	*109*	*20*	*20*	*20*	*15*		*1254400.00*	
Training of MOs (Govt + Non-Govt)	*3400*	*2717*	*170*	*170*	*170*	*170*		*284000.00*	
Training of LTs of DMCs- Govt + Non Govt	*632*	*572*	*15*	*15*	*15*	*15*		*390000.00*	
Training of MPW,MPHS, pharmacists, nursing staff, BEO etc	*9927*	*7920*	*500*	*500*	*500*	*500*	***1900000***	*1910000.00*	
Training of Community Volunteers	*18182*	*14316*	*966*	*966*	*968*	*968*		*3647700.00*	
Training of Pvt Practitioners									
Other trainings #									
Re- training of MOs	*3400*	*2717*	*136*	*136*	*136*	*136*		*1571400.00*	
Re- Training of LTs of DMCs	*632*	*572*	*28*	*29*	*28*	*29*		*156000.00*	
Re- Training of MPWs MPHS, pharmacists, nursing staff, BEO	*9927*	*7920*	*400*	*400*	*400*	*400*		*1528000.00*	
Re- Training of CVs	*18182*	*14316*	*720*	*720*	*720*	*720*		*2750400.00*	
TB/HIV Training of MO-TCs and MOs	*3400*	*0*	*850*	*850*	*850*	*850*			
TB/HIV Training of STLS, LTs , MPWs, MPHS, Nursing Staff, Community Volunteers etc	*978*	*0*	*244*	*244*	*244*	*244*		*792000.00*	
TB/HIV Training of STS	*173*	*0*	*43*	*43*	*43*	*43*			
Training of MOs and Para medicals in DOTS Plus for management of MDR TB	**	*0*						*9258400.00*	
Provision for Update Training at Various Levels #	***4***								
Review Meetings	**4**								

at State Level									
Retraining of STS, DTC Pharmacists **PMDT**			*106*	*107*					*All the training for PMDT will be at the state level except for DOT Provider*
						TOTAL	***1900000***	***30874967***	

 # DOTS PLUS, TB HIV
$ Full and part time DTOs
***MOs,STS,STLS,TBHV,CV*

6. Vehicle Maintenance:

Type of Vehicle	*Number permissible as per the norms in the state*	*Number actually present*	*Amount spent on POL and Maintenance in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
Four Wheelers		*1*			*200000*	
Two Wheelers	*188**	*169*	*2771765.00*	*3000000.00*	*4700000*	*The estimated expenditure includes for 2-wheelers which will be procured for the new TUs*
Total			*2771765.00*	*3000000.00*	*4900000*	

*Including the new Proposed TUs

8. Vehicle Hiring*:

Hiring of Four Wheeler	*Number permissible as per the norms in the state*	*Number actually requiring hired vehicles*	*Amount spent in the prev. 4 qtrs*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
For STC/ STDC	*2*	*2*	*0*	*0*	*450000*	*One for IRL/STDC visit and other for Transportation of Specialists from PMCH to DOTS PLUS Site TBDC, Agamkuan Patna.*
For DTO	*30*	*38***	*2829882.00*	*3000000.00*	*8550000.00*	*The programme vehicles are non-functional and therefore hiring of vehicles for DTO will strengthen supervision.*
For MO-TC	*173*	*173*			10899000	
TOTAL			***2829882.00***	*3000000.00*	19899000	

** Vehicle Hiring permissible only where RNTCP vehicles have not been provided*

9. NGO/ PP Support:

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

Activity	*No. of currently involved in RNTCP*	*Additional enrolment planned for this year*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
ACSM Scheme: TB advocacy, communication, and social mobilization	1	17		0	1510000	
SC Scheme: Sputum Collection Centre/s	2	25		60000	1820000	
Transport Scheme: Sputum Pick-Up and Transport Service	2	25		318000	54000	
DMC Scheme: Designated Microscopy Cum Treatment Centre (A & B)	12	10		1352000	3300000	
LT Scheme: Strengthening RNTCP diagnostic services	0	0		0	0	
Culture and DST Scheme: Providing Quality Assured Culture and Drug Susceptibility Testing Services	0	0	**1889144**	0	0	
Adherence scheme: Promoting treatment adherence	16	0		0	640000	
Slum Scheme: Improving TB control in Urban Slums	0	0		0	0	
Tuberculosis Unit Model	3	0		1388000	2418000	Payment to Contractual MO-TC, STS, STLS as per Revised Financial Norms applicable since April 2009
TB-HIV Scheme: Delivering TB-HIV interventions to high HIV Risk groups (HRGs)	0	0		0	0	
TOTAL	36	75	**1889144**	3118000	9742000	

10. Miscellaneous:

*Activity** e.g. TA/DA, Stationary, etc	*Amount permissible as per the norms in the state*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
State	700000	*1921362*	*3000000*	700000	
Districts	14658000			9891500	
Transportation of Sputum sample of MDR Suspects				3200000	*DOTS PLUS to be started from 4th Quarter 2010/ 1st Quarter 2011*
Falcon tubes & packing material for sputum samples & Category-IV drugs for MDR TB Patients					
N-95 Respirator for Laboratory & Health staffs working in MDR-TB Ward					*For inherent occupational risk and bio-safety precautions applicable to MDR-TB lab and ward.*
Office Furniture for I.R.L.STDC & State TB Cell				*1500000*	*All contractual staffs (STC/IRL) appointment completed and Office needs to be organized properly.*
TOTAL	15358000	***1921362***	*3000000*	15291500	

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

11. Contractual Services:

Category of Staff	*No. permissible as per the norms in the state*	*No. actually present in the state*	*No. planned to be additionally hired during this year*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current fin. year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification / remarks*
Epidemiologist	*1*	*0*	*0*	*0*	120000	480000.00	*Appointment of all the state level contractual posts completed.*
MO STC	*1*	*0*	*1*	*0*	90000	360000.00	
TBHIV Coordinator	*1*	*0*	*1*	*0*	105000	420000.00	
DOTS PLUS Site MO	*1*	*0*	*1*	*0*	90000	360000.00	
DOTS PLUS Site Stastical Assistant	*1*	*0*	*1*	*0*	45000	180000.00	
Microbiologist	*1*	*0*	*1*	*0*	120000	480000.00	
Sr. LT IRL	*1*	*0*	*1*	*0*	45000	180000.00	
IEC Officer	*1*	*0*	*1*	*0*	54000	216000.00	
Accounts Officer	*1*	*0*	*1*	*0*	54000	216000.00	
Secretrial Assistant	*1*	*0*	*1*	*0*	25500	102000.00	
Pharmacist (Store Keeper)	*1*	*0*	*1*	*0*	36000	144000.00	
Store Assistant (State Srug Store)	*1*	*0*	*1*	*0*	24000	96000.00	
DEO State TB Cell	*1*	*0*	*1*	*0*	30000	120000.00	
DEO IRL	*1*	*0*	*1*	*0*	30000	120000.00	
Driver	*1*	*0*	*1*	*0*	21000	84000.00	
MO-DTC	*7*	*1*	*6*	***49750413***	**82637403**	2469600	
*STS**	*188*	*148*	*40*			28425600	
*STLS**	*188*	*146*	*42*			28425600	
TBHV	*29*	*29*	*0*			2923200	
DEO (Districts)	*38*	*33*	*38*			4069800	
Accountant – part time	*38*	*38*	*0*			1436400	
LT	*413*	*346*	*67*			44232300	
				49750413		**115540500**	

*15 STS and STLS are to be recruited for the additional TU proposed in the coming financial year.

12. Printing:

Activity	*Amount permissible as per the norms in the state*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
*Printing-State level:**		***1179388***	*2500000*	7329000	*7.40 Lakh paid in October 2010 and 4 Lakh is committed .*
*Printing- Distt. Level:**					*Order has been given modules (Revised) to be printed*
Total	14658000	***1179388***		7329000	

** Please specify items to be printed in this column*

13. Research and Studies (excluding OR in Medical Colleges):

Any Operational Research projects planned Yes
Estimated Total Budget **500000**

14. Medical Colleges

Activity	*Amount permissible as per norms*	*Estimated Expenditure for the next financial year(Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*
Contractual Staff: *MO-Medical College (Total approved in state 8)* *STLS in Medical Colleges (Total no in state 1)* *LT for Medical College (Total no in state 6)* *TBHV for Medical College (Total no in state 6)*	*2688000* 144000 612000 630000	*2688000* 144000 612000 630000	*3 Private Medical Colleges are planned to be involved under RNTCP* *-Mata Gujri Medical College (Kishnaganj),* *-Katihar Medical College (Katihar),* *- Narayan Medical College, Rohtas* **The salary of contractual MO, LT and TBHV, to be appointed, included.**
Research and Studies: ▪ Thesis of PG Students ▪ Operations Research*	*180000** 1500000	*180000** 1500000	
Travel Expenses for attending STF/ZTF/NTF meetings	*500000*	*500000*	
IEC: Meetings and CME planned	*40000*	*40000*	
Equipment Maintenance at Nodal Centres	*0*	*0*	
Total	**6294000**	6829880 *	

15. Procurement of Vehicles:

Equipment	*No. actually present in the state*	*No. planned for procurement this year (only if permissible as per norms)*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
*4-wheeler **				
2-wheeler	*169*	*61*	3060000	For New TU 13 For Replacement of Unusable Motorcycle 48
			3060000	

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

16. Procurement of Equipment:

Equipment	*No. actually present in the state*	*No. planned for this year (only as per norms)*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
Office Equipment (Computer, modem, scanner, printer, UPS etc.)	*40*	*1*	***590000***	Computer, Photocopier, Scanner and Inverter etc in districts 440000 Scanner for STDC Computer 10000 SDS Computer 60000 LCD Projector for STDC/STC 80000
Any Other			***590000***	

Section D: Summary of proposed budget for the state –

Category of Expenditure	Budget estimate for the coming FY 2011- 12 (Based on the planned activities and expenditure detailed in Section C)
1. Civil works	**13523800**
2. Laboratory materials	**14347176**
3. Honorarium	**13421810**
4. IEC/ Publicity	**4663000**
5. Equipment maintenance	**3502000**
6. Training	**30874967**
7. Vehicle maintenance	**4900000**
8. Vehicle hiring	**19899000**
9. NGO/PP support	**9742000**
10. Miscellaneous	**15291500**
11. Contractual services	**115540500**
12. Printing	**7329000**
13. Research and studies	**500000**
14. Medical Colleges	**6829880**
15. Procurement – (Two Wheelers)	**3060000**
16. Procurement – equipment	**590000**
	264014633

Additionality Funds from NRHM-Details of the activities with justification for which Additionality Funds are proposed to be sought.

a) **Biomedical Waste Management:**
It is proposed that a comprehensive Bio medical waste management system(National Guidelines for Hospital Waste Management,MOH & FW March,2002) be developed from the funds available under NRHM at all the Health Institutions which will not only help RNTCP which generates biological, sharp and plastic waste , which is presently being disposed at a smaller scale in these institutes but also help the institution to dispose its waste in a proper manner.

b) **Difference In Remuneration of RNTCP and State Health Society Bihar contractual staffs :**

The Remuneration of RNTCP contractual medical officer at district level is Rs.28, 000.00 per month. **It is proposed that the difference in remuneration (Rs.2000.00) vis a vis what is being paid by the State Health society to the contractual MOs appointed in the districts be borne from NRHM**, so that the remuneration is at par and it will help in checking attrition of MOs from RNTCP. **Similarly it is proposed that the remuneration of Laboratory Technicians paid by RNTCP is Rs.8500.00 per month and the difference (Rs.1500.00) be borne by the State Health Society, Bihar.**

c) **Civil works in newly constructed Health infrastructures in the Districts:**

The new PHC buildings which have been constructed and also the new hospitals, though a laboratory has been identified in these buildings, there are no slab and sink for doing the laboratory work. It is suggested that a slab be constructed in these rooms along with sink and provision of water for doing laboratory work. This will facilitate the sputum microscopy for TB along with other microscopy/laboratory investigations to be conducted from the same premises. At present, the sputum microscopy centers are not functioning in these facilities.

d) **Civil works at TBDC, Agamkuan Complex.**

e) **Hiring of vehicles:**

The rate as per the financial guidelines for hiring of 4 wheelers is Rs 750/day(For a distance of 80 Km and duration of 8 hours).Additional cost towards extra milage or duration is on pro-rata basis of Rs.7.50 every additional kilometerand Rs.25 every extra hour. As the rates for hiring proposed by the State/District health socities is higher, the vehicle providers are not willing to provide vehicles as mentioned in the financial guidelines of the RNTCP.

It is proposed that the difference in the hiring rates between the Health society and RNTCP be borne from funds available in NRHM for both at the districts and also at the state.

Inter-Sectoral Convergence | Part J

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

Convergence can be defined as the complementary working of departments or agencies that can result in the achievement of a common objective because the beneficiaries with whom they work are common and their activities can enhance the possibility of achievement of the goals and objectives. Multiple sectors with different strategies, programs and programs increasingly develop proximate focus on the needs of the beneficiaries. This offers enormous scope for results accruing through such synergies.
The departments that have close synergy with the RCH are:

- Indian Systems of Medicine (AYUSH)
- State AIDS Control Society
- Women and Child Development Department
- Education Department
- Panchayati Raj Department

Situational Analysis:

Public health peripheral and extension services and its linkage with facility based services started less than a century in the country. The said services have developed many folds during the last sixty years initially on the recommendation of the Bhor Committee and subsequently on the basis of reviews and recommendations of several expert committees. It has achieved commendable results despite poor funding and lack of a uniform system of command. It is now increasingly understood larger fund allocation would increase the resources within the health administrative set up but to achieve the desired outcomes, sectors administering the determinants of health must work in tandem with common objectives. The NRHM rightly emphasized the need to develop a convergent system between the Department of Health and other sectors governing the areas of several health determinants. The NHRM also recognizes the need to develop ownership of partners / stakeholders in tackling local endemic issues to ensure better quality of life in all sections of the population. Considering the diversity and prevailing inequity amongst the people it is rightly considered that leadership must be provided at every level of governance to solve the health problems amongst the poor and the excluded. Governance at every level can only be provided by the Rural Local Self Governance and in the State of Bihar it is the three tiers Panchayat Raj Institution. The other sectors which directly administer the issues of health determinants are;

- Department Social Welfare administers ICDS
- Department of Education administers school and higher education,
- Public Health Engineering Department and Panchayat administer supply of drinking water and environmental sanitation including solid waste management.

NRHM also seeks partnership from Indian System of Medicine like Aurveda, Unani, Yoga, Sidda and Homeopathy now jointly named AUYSH. The NRHM also seeks involvement of

Non Government Organizations (NGO) and For Profit Private Sector as partners in the public health services by developing local need specific Public Private Partnership schemes. It also visualizes the need to involve expert consultants and agencies in strengthening the Department of Health and development of a State Heath Resource Centre to provide Technical Support in carrying forward the Management of Change for efficient utilization of resources and effective delivery of health services.

(a) Coordination with ICDS

The DPO is a member of the District Health Society & District Core Group (under NRHM) and thus the health department has been able to utilize his/her services for community mobilization at the grassroots level. Through coordinated effort of the ANM and the Anganwadi worker mothers and children are being mobilized for antenatal check up, institutional deliveries and immunisation.

- Now the coordination is to be extended to organize VHNDs (Village Health nutrition Days) at every AWC all over the district every month.
- Muskaan Abhiyaan is a special multipronged strategy to improve immunization services and demand in the state of Bihar and since its launch in Oct 2007, the strategy as well as the implementation of this campaign has been reviewed on a periodic basis. A strategic review of this campaign was undertaken on July 4th 2009 by the stakeholders of Routine immunization in the state in which certain changes were proposed. The new changes have become operational since September 2009 but still some gaps are persisting in especially in incentive distribution to AWWs & ASHAs.

Muskaan Oct 07 to Aug 09	Muskaan Sept 09 onwards
Immunization sessions to be based in health facilities and Aganwadi centres	Immunization sessions extended to villages and hamlets without any health facility or aganwadi centers
All beneficiaries to be registered and tracked in Muskaan tracking registers	Registration of all beneficiaries and their tracking to continue
Due-lists to be prepared by all mobilizers (ASHA and ICDS workers)	Due list preparations to continue.
Incentives to vaccinators and mobilizers based on percentage of doses administered per ICDS center against target doses in due lists.	Incentives to vaccinators and mobilizers based on number of beneficiaries vaccinated in each session.
Mahila Mandal payments through ANM	Mahila mandal meetings through Village Health and sanitation committees
Verification of achievement by ANM, Medical Officers and ICDS officers	No verification only process of certification by ANM and beneficiaries.

It is expected that the gains made by Muskaan phase 1 such as improved access of vaccination services, improved mobilization of beneficiaries through the use of line list registers and due lists will be consolidated in the second phase; whereas problems such as timely payment of incentive and difficulty in calculating and verifying achievements will be smoothened out.

Incentive to AWW for social mobilization in Muskan Abhiyan

@ 80000 no.X Rs.400 X 12 months = Rs.38,40,00,000/-

- **Incentive under IMNCI:**
  Every AWW will get Rs.100/- per 3 PNC visit to Normal NBs of >2.5kg wt & Rs.200/per 6 PNC visit to LBW babies after successful completion of required number of visits. Every AWW has to make home visits as per IMNCI protocol. She will carry the PNC checklist (0-2m IMNCI recording formats) for each house, the PNC checklist has questionnaire on newborn, mother and referral. After required number of visits she will submit the checklists to the ANM who will submit it to the MOIC of the PHC for payment @ Rs. 100/- or Rs.200/- as per PNC visits.

- **SABLA Project** -The Ministry of Women and Child Development, Government of India, in the year 2000, came up with a scheme called *Kishori Shakti Yojana (KSY),* which was implemented using the infrastructure of the Integrated Child Development Services Scheme (ICDS). The objective of this scheme was to improve the nutrition and health status of girls in the age-group of 11 to 18 years, to equip them to improve and upgrade their home-based and vocational skills, and to promote their overall development, including awareness about their health, personal hygiene, nutrition and family welfare and management. Thereafter, the Nutrition Programme for Adolescent Girls (NPAG) was initiated as a pilot project in the year 2002-03 in 51 identified districts across the country to address the problem of under-nutrition among AGs.

Though both these schemes have influenced the lives of AGs to an extent, but have not shown the desired impact. Moreover, the extent of financial assistance and coverage under them has been limited and they both had similar interventions and catered to more or less similar target groups. Therefore, a new comprehensive scheme, called Rajiv Gandhi Scheme for Empowerment of Adolescent Girls or SABLA, merging the erstwhile KSY and NPAG schemes has been formulated to address the multidimensional problems of AGs.

SABLA will be implemented initially in **12 districts** of Bihar namely using the platform of ICDS –Katihar, Vaishali, W Champaran, Banka, Gaya, Saharsa, Kishanganj, Patna, Buxar, Sitamarhi, Munger and Aurangabad

One of the **objectives** of the scheme is to improve their nutrition and health status wherein NRHM shall coordinate with ICDS.

Target Group-
The scheme aims at covering AGs in the age group of 11 to 18 years under all ICDS projects

The scheme focuses on all out-of-school AGs, who would assemble at the Anganwadi Centre (AWC) as per timetable and frequency to be decided by the State Governments /UTs concerned. The others, *i.e.*, school-going girls, would meet at the AWC at least twice a month, and more frequently (once a week) during vacations/holidays. Here they will receive life skills education, nutrition and health education, awareness about socio-legal issues, etc. This will provide an opportunity for mixed group interaction between school-going and

out-of-school girls, motivating the latter to also join school and help the school going to receive the life skills.

Kishori Diwas is going to be celebrated as a special health day, celebrated once in three months on a fixed day. On this day, the AWWs with the help of health functionaries, including Medical Officer, Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA), will mobilize AGs and their families, especially mothers, to assemble at the AWC.

ICDS infrastructure will be used for implementation of SABLA. AWC will be the focal point for delivery of services under the scheme.

IFA Supplementation

Prevalence rates for anemia are high among AGs in India. Over 70% of girls in the age group of 10 to 19 years suffer from severe or moderate anemia (DLHS-RCH 2004).
Evidence suggests that IFA supplementation helps in combating anemia and enhancing adolescent growth. RCH-II scheme under the National Rural Health Mission (NRHM) has covered children (6-10 years) and adolescents (11-18 years) under the National Nutritional Anemia Prophylaxis Programme (NNAPP).

Activities: ICDS in convergence with NRHM is to ensure adult tablets of IFA for each beneficiary of Sabla. Out-of-school AGs attending AWC may be given two adult IFA tablets per week when they come to the AWC for other services. The AGs should preferably consume the IFA tablets at the AWC itself. Sakhi and Sahelis may counsel AGs for this. Distribution and consumption has to be recorded on Kishori Cards. ANM/AWW will give information to AGs on food fortification, dietary diversification, advantages of supplementation by IFA tablets and its consumption with food for combating IFA deficiency.

Service Provider: Department of Health and Family Welfare under NRHM

- Supply of IFA Tablets : As part of School Health Programme or separately through the Annual State Project Implementation Plans for NRHM
- Convergence to be ensured with ICDS
- Supply of IFA tablets to each AWC will be ensured by CDPOs/Supervisors in coordination with the PHCs.
- The IFA tablets may be made available to AWCs through CDPOs and to Supervisors during the sectoral meetings.

Health check-ups and referral services will be provided through the grassroots-level healthcare system, *i.e.*, through ASHAs and ANMs. The Medical Officer at the PHC will be responsible for the health check-ups which will be ensured by the CDPO.

Activities:

(a) A general health check-up of all AGs at least once in every three months, preferably on Kishori Diwas, will be organised. For this, the ICDS Supervisor, in close collaboration with the ANM and other health functionaries, will draw a schedule for the village/ward level.

(b) AWW, assisted by Sakhi and Saheli, will ensure recording of height, weight and BMI of AGs on Kishori Cards, in order to keep a close watch on the status of growth of AGs. Adult weighing scales provided to AWCs under ICDS would be used for weighing AGs. The weighing scales provided in the kit of the ASHA / ANM may also be used for weighing AGs.

(c) ANM / AWW / ASHA would ensure discussion and clarification of general queries of AGs on issues related to health and hygiene on a regular basis.

(d) The Medical Officer/ANM will provide de-worming tablets to AGs as per guidelines.issued by SHSB.

(e) In case of AGs having problems requiring specialized treatment, Medical Officers would refer the AGs, with a referral slip, to the District Hospital / PHC / CHC / Maternal & Child Health (MCH) Sub–Centre. All referrals would be followed up on / tracked on the day when the next Kishori Diwas or VHND is organized.

Nutrition and Health Education (NHE)

Adolescent girls require nutritious food, coupled with correct and relevant information on nutrition and health, as their bodies get geared up physically for motherhood. In order to address this requirement, the CDPO / Supervisor will ensure nutrition and health education (NHE) for all AGs attending AWCs. Sustained information on these issues will result in better health of AGs, leading to overall improvement in family health, and will also help in breaking the vicious intergenerational cycle of malnutrition. Mothers of AGs may also be motivated for joining in the NHE sessions for improved impact.

Major activities under this component of the scheme may include:

(a) Promoting healthy cooking, eating habits, balanced diet and locally available Nutritious food.

(b) Sensitizing about nutrient deficiency disorders, prevention, nutritional requirements during pregnancy and lactation, etc.

(c) Promoting use of safe drinking water and sanitation.

(d) Educating on personal hygiene, onset of puberty and related changes.

(e) Informing about common ailments, home remedies, first aid, personal hygiene, exercise, etc.

(f) Educating on avoiding drugs and alcohol abuse, stress management, etc.

Service Provider:

- AWW along with health functionaries like ANM and ASHA,
- Resource persons / field-trainers, including those drawn from NGOs.
- Food and Nutrition Board's (FNB)'s Community Food & Nutrition Extension Units and Mobile Food & Extension Units may be utilized for training, demonstration and education on nutrition
- Queries and concerns raised by AGs will be addressed by ICDS and health functionaries during Kishori Diwas as well as during the course of interaction of AGs with the AWC/PHC/CHC.
- SHSB may organize specialized short duration courses on nutrition and health education, in collaboration with the FNB, National Institute of Nutrition (NIN) and voluntary organizations.

Adolescent Reproductive and Sexual Health (ARSH)

Orientation and training modules for ARSH, being utilized under the RCH II scheme ofNRHM, will be made available to Resource Persons for training on ARSH. Under NRHM dedicated ARSH services are offered on fixed days and at fixed timings at the PHC andCHC levels

Kishori Diwas

Kishori Diwas will be a celebrated as a special health day, celebrated **once in three months on a fixed day, as decided by health/ICDS**. On this day, the AWWs with the help of health functionaries, including Medical Officer, ANM, and ASHA, will mobilize AGs and their families, especially mothers, to assemble at the AWC. For better coordination, health/ICDS may choose to combine Kishori Diwas with the corresponding month's Village Health and Nutrition Day (VHND). However, care should be taken that the overall aim of the Kishori Diwas is not lost and that it is not overshadowed by the

Health department will ensure that health personnel specially the Medical Officers/ANM will present on Kishori Diwas. On Kishori Diwas, AGs and their families will be able to interact freely with ICDS and health personnel to obtain basic services and information. The ICDS and health functionaries will be responsible for educating AGs and their families about the preventive and promotive aspects of nutrition and healthcare, for encouraging them to adopt healthy behavior as well as seeking healthcare from proper healthcare facilities. Village Health and Sanitation Committees (VHSCs), comprising ASHA, AWW, ANM and PRI representatives, will be involved in organizing the event. Adequate publicity of Kishori Diwas should be ensured to maximize participation.

On Kishori Diwas, the following services are to be provided:

(a) General health check-up, including recording of height, weight, Body-Mass Index (BMI) for all AGs, by the Medical Officer / ANM

(b) Filling up of Kishori Cards for every AG, marking major milestones

(c) Referral to specialized healthcare facilities, as required specially for conditions like malnutrition (BMI < 18.5), menstrual problems, frequent headaches, prolonged acne, worm infestation, etc.

(d) Organizing of special health camps

(e) Providing nutrition and health education

(f) Demonstration of preparing nutritious recipes (FNB may be involved for these)

(g) Holding counseling / behavior change communication (BCC) sessions with AGs and their families for promoting good practices

(h) Imparting information, education and communication (IEC) to community, parents, siblings etc.
(i) Mobile Health Units (where existing) may be utilized.

Kishori Card

A card for each AG to be called "**Kishori Card**", will be maintained at the AWC. This will contain information regarding the weight, height, Body Mass Index (BMI)4, Iron Folic Acid (IFA) Supplementation, referrals and services received under SABLA. The card will also contain important milestones in the girl's life like joining school, leaving school, marriage, etc. which will be marked as and when they are achieved. AWW will help the girls in maintenance of Kishori Cards. Sakhi and Sahelis will assist the AGs in filling up the Kishori Cards, after which the AWW will countersign it.

Convergence with the Health System

Four of the seven services under the scheme will be provided in convergence with the schemes of the Departments of Health & Family Welfare and AIDS Control. These are:

i. IFA supplementation, including supply of IFA tablets
ii. Health check-up and referral services
iii. Nutrition and Health Education
iv. Family welfare and ARSH services

Convergence is sought with the Reproductive & Child Health II (RCH-II) programme of the Department of Health & Family Welfare. Action to be taken in respect of each of these services has been discussed in the preceding section 3.4. In States / UTs where the menstrual hygiene programme is being implemented through the Water & Sanitation Department, the convergence with the respective programme may be sought.

Proposed Budget for 2011-12

Sl.	Activities	Proposed Amount	Remarks
1	Requirement of IFA Tabs (100 tabs/Yrs.)	00.00	IFA tabs is already incorporated in School/Out of School Anemia control program . If needed extra IFA tabs, supplementary budget will be raised
2	Requirement of Poster	89,282.00	
3	Radio/TV Spots	300000.00	
4	Training of District/Block level official and health field functionary	36,99,225	
5	Paper Advertisement / Media advocacy	100000.00	
TOTAL		**41,88,507.00**	

Rs. Forty one lakhs eighty eight thousand five hundred seven only

BUDGET FOR RGSEAG-SABLA
Years 2011-12

			TARGET	Field functionaries Staff			REQUIREMENT			BUDGET		
Sl.	District Name	Population	No. of Adolsecent Girls (11% of total population	No. ASHA	No. of AWW	No. of ANM	Requirement of IFA Tabs (100 tabs/Yrs.)	Requirement of Health Card	Requirement of Poster (1 poster/AWC)	Cost of IFA tabs (@ Rs. 0.14/tab)	Cost of Haealth Card tabs (@ Rs. 4.50/card)	Cost of Poster tabs (@ Rs. 3.50/poster)
1	Kishanganj	1523079	167539	1106	1230	128	16753900	184293	1230	2345546	829318	4305
2	Katihar	2638237	290206	2498	2271	318	29020600	319227	2271	4062884	1436520	7949
3	West Champaran	3359291	369522	2624	2885	600	36952200	406474	2885	5173308	1829134	10098
4	Sitamarhi	3006026	330663	2153	2310	340	33066300	363729	2310	4629282	1636782	8085
5	Vaishali	3001539	330169	2532	2410	373	33016900	363186	2410	4622366	1634337	8435
6	Aurangabad	2277583	250534	1890	1982	338	25053400	275587	1982	3507476	1240143	6937
7	Gaya	3784223	416265	3266	3315	655	41626500	457892	3315	5827710	2060512	11603
8	Munger	1285731	141430	949	1032	248	14143000	155573	1032	1980020	700079	3612
9	Banka	1757632	193340	1820	1609	498	19334000	212674	1609	2706760	957033	5632
10	Buxar	1548352	170319	1455	1223	224	17031900	187351	1223	2384466	843079	4281
11	Saharsa	1660586	182664	683	1419	191	18266400	200930	1419	2557296	904187	4967
12	Patna	5477549	602530	2612	3823	789	60253000	662783	3823	8435420	2982524	13381
Total		**31319828**	**3445181**	**23588**	**25509**	**4702**	**344518100**	**3789699**	**25509**	**48232534**	**17053646**	**89282**

BUDGET BREAK UP FOR RGSEAG-SABLA
Years 2011-12

								Participants		Refreshment		Stationayfor		Contingency		TA		Total Amount
Sl.	District Name	PHC	MOIC	CDPO	MO	No. ASHA	No. of ANM	No of Participants at district level	No of Participants at block level	Refreshment for district level participant (Trainees + 3 Persons) @Rs. 50	Refreshment for block level participants(Trainess + 3 Persons) @RS. 40	Stationayfor district level participants @RS. 50	Stationayfor block level participants @Rs. 25	Contingency for district level participants @RS. 1000/ district	Contingency for block level participants @Rs. 500/block	TA for district level trainees @Rs. 200/Person	TA for block level trainees @RS. 50	
1	Kishanganj	8	8	8	24	1106	128	40	1234	2150	49480	2000	30850	1000	4000	8000	61700	159180
2	Katihar	17	17	17	51	2498	318	85	2816	4400	112760	4250	70400	1000	8500	17000	140800	359110
3	West Champaran	18	18	18	54	2624	600	90	3224	4650	129080	4500	80600	1000	9000	18000	161200	408030
4	Sitamarhi	17	17	17	51	2153	340	85	2493	4400	99840	4250	62325	1000	8500	17000	124650	321965
5	Vaishali	17	17	17	51	2532	373	85	2905	4400	116320	4250	72625	1000	8500	17000	145250	369345
6	Aurangabad	11	11	11	33	1890	338	55	2228	2900	89240	2750	55700	1000	5500	11000	111400	279490
7	Gaya	23	23	23	69	3266	655	115	3921	5900	156960	5750	98025	1000	11500	23000	196050	498185
8	Munger	9	9	9	27	949	248	45	1197	2400	48000	2250	29925	1000	4500	9000	59850	156925
9	Banka	11	11	11	33	1820	498	55	2318	2900	92840	2750	57950	1000	5500	11000	115900	289840
10	Buxar	9	9	9	27	1455	224	45	1679	2400	67280	2250	41975	1000	4500	9000	83950	212355
11	Saharsa	11	11	11	33	683	191	55	874	2900	35080	2750	21850	1000	5500	11000	43700	123780
12	Patna	34	34	34	102	2612	789	170	3401	8650	136160	8500	85025	1000	17000	34000	170050	460385
Total		**185**	185	185	555	**23588**	**4702**	925	28290	46400	1131720	46250	707250	**12000**	92500	185000	1414500	3635620

BUDGET For IEC RGSEAG-SABLA
Years 2011-12

			TARGET	Field functionaries Staff			REQUIREMENT			
Sl.	**District Name**	**Population**	**No. of Adolsecent Girls (11% of total population**	**No. ASHA**	**No. of AWW**	**No. of ANM**	**Requirement of IFA Tabs (100 tabs/Yrs.)**	**Requirement of Health Card**	**Requirement of Poster (1 poster/AWC)**	**Cost of Poster (@ Rs. 3.50/ poster)**
1	Kishanganj	1523079	167539	1106	1230	128	16753900	184293	1230	4305
2	Katihar	2638237	290206	2498	2271	318	29020600	319227	2271	7949
3	West Champaran	3359291	369522	2624	2885	600	36952200	406474	2885	10098
4	Sitamarhi	3006026	330663	2153	2310	340	33066300	363729	2310	8085
5	Vaishali	3001539	330169	2532	2410	373	33016900	363186	2410	8435
6	Aurangabad	2277583	250534	1890	1982	338	25053400	275587	1982	6937
7	Gaya	3784223	416265	3266	3315	655	41626500	457892	3315	11603
8	Munger	1285731	141430	949	1032	248	14143000	155573	1032	3612
9	Banka	1757632	193340	1820	1609	498	19334000	212674	1609	5632
10	Buxar	1548352	170319	1455	1223	224	17031900	187351	1223	4281
11	Saharsa	1660586	182664	683	1419	191	18266400	200930	1419	4967
12	Patna	5477549	602530	2612	3823	789	60253000	662783	3823	13381
Total		**31319828**	**3445181**	**23588**	**25509**	**4702**	**344518100**	**3789699**	**25509**	**89282**

Health card will be provided by ICDS

(b) Convergence with BSACS

STI/RTI SERVICE DELIVERY:

Sexually Transmitted infection and reproductive tract infection (STI/RTI) are an important public health problem in India .Studies suggested that 6% of the adult population in India is infected with one or more STI/RTI. Individuals with STI/RTI have significantly higher chance of acquiring and transmitting HIV. Controlling STI/RTI helps decrease HIV infection rate and provide a window of opportunity for counseling about HIV prevention and reproductive health. Provision of STI/RTI care service is a very important strategy to prevent HIV transmission and promote sexual and reproductive health under the National AIDS Control Programme and RCH (II) of the NRHM.

Bihar accounts for 8.07% of the total population of the country. This is the state with poverty and the health care infrastructure being in a very dilapidated condition. The availability and accessibility of health care services is very low to the marginal population, added with the gap in knowledge and awareness about RH services. In Bihar Population prone for risky behaviour is 1.9% as per National BSS, 06 data. In Bihar, Percentage of respondents who were aware of STDs were 17.7% as compared to national average of 37.7%The percentage of population who have the knowledge about the linkage between STDs and HIV/AIDS were 14.7% as compared to national average of 23.5%.Hence there is great need for heavy mass media and inter personal communication for demand generation so that people go for the treatment. Simultaneously, the percentage of respondents seeking the treatment also emphasizes that the service delivery system needs to be strengthened so that they are accessible, available and friendly for men and women.

State	Proportion of respondents who had ever heard of STD	Proportion of respondents aware of linkage between STD and HIV/AIDS	Proportion of respondents reporting at least 1 STD symptom in last 12 months	Proportion of respondents reporting STD treatment in a Govt Hospital/Clinic during last episode	Proportion of respondents who reported having sex with any non-regular partner in last 12 months
BIHAR	17.7%	14.7%	2.5%	19.2%	1.9%
All India(2006)	37.7	23.5	5.1%	25.7%	5.8%

In terms of the availability of centers providing the RTI/STI counseling and treatment, Bihar State AIDS Control Society and the State has the following details.

Number of existing STI clinics in Bihar reporting to BSACS

BSACS supported TI(NGO) clinics	Number of Dist Hospitals with Designated STD Clinics	Number of Medical college with Designated STD Clinics(Dept of Skin, STD & Gynaecology)	Designated STD clinics
45	36	6	36+6= 42

Convergence with NRHM:

The convergence framework of National Rural Health Mission (NRHM) provided the directions for synergizing the strategies for prevention, control and management for RTI/STI services under Phase II of Reproductive and Child Health Programme (RCH II) and Phase III of National AIDS Control Programme (NACP III).

The Objectives of the STI/RTI prevention and management component of NACP III & RCH II

- To contain STIs/RTIs and thereby HIV transmission through provision of accessible and good- quality STI/RTI services to both general populations and high-risk groups.
- The RCH draws its mandate from the National Population Policy (2000) which makes a strong reference "to include STI/RTI and HIV/AIDS prevention, screening and management in maternal and child health services".

Elements of NACP-NRHM Convergence on STI:

A) Capacity Building:

- NACO has developed curriculum for Medical Officer, staff nurse and lab technician.
- TOT for State Resource Faculty done (at Kolkatta).
- Training for Staff nurse and lab tech Completed. Training for Mos(District Resource Persons) to be done in last Wk,Dec,10
- Comprehensive training plan, training calendar and training curriculum have to be prepared for rolling out the training at the sub district level using the existing available resource.

B) Provision of color coded drug Kits:

- Color coded STI/RTI drug kits sent from NACO sent to all the designated STI/RTI clinics at Sadar Hospitals and 6 Govt Medical College Hospitals.
- NACO has rate contracted **Color coded STI/RTI drug kits** for which under NRHM procurement is being done. Kits received to the Districts are yet to be supplied at sub district health facilities.

C) Monitoring and Evaluation:

- At present there is access to data on STI/RTI from NRHM but sub-optimal reporting is being done from most of the districts on STI/RTI.
- Reporting formats at the sub district level different than that of NACO CMIS.
- Mechanisms have to be put in place to ensure timely reporting and consolidation from SHS to BSACS.
- Consolidation of RTI/STI format from sub-ditrict with DHIS2 of SHSB is to be done also

D). Infrastructure Strengthening for Sub-District RTI/STI services:

- Each of the Health facilities to have audio visual privacy (partition), facility for examination (examination table, flexi lamp etc), instruments (speculum, proctoscope) and infection control mechanism.

- Fund for health facility to be assessed for infrastructure strengthening and accordingly existing gap to be filled from Untied Fund for PHCs and from Annual Maintenance Grant for PHCs
- Directive in this regard to be issued from NRHM

E). IEC and Job Aids :

- Leaflets, posters and other education material to be budgeted for the patients. Job aids like syndromic wall posters, anaphylaxis chart, STI counseling flip book, infection control chart etc
- Funds for printing of IEC materials and job aids to be sourced from IEC under NRHM Part A.

F). Syphilis Screening :

- To be ensured from outsourced Pathology services under NRHM and reimbursement to private agency for the same to be done through NRHM
  budget for Diagnostics.
- Directive in this regard to be sent to all private partners for undertaking Syphilis Screening and to RKS for necessary reimbursement

Key Intervention Strategies:

(A)Sub-district level:

- Health workers (HW), Accredited Social health Activists (ASHA) and AYUSH practitioners will conduct STI/RTI prevention and health promotion activities and refer.
- STI/RTI clinical services will be provided at these locations using the syndromic management and counselling approach.
- Laboratory services wherever available will be used to corroborate syndromic diagnosis.
- All activities will be done in convergence with NACO and with RCH II of the NRHM.

(B)District hospitals and medical colleges:

- The services will be provided through specialists and trained physicians at designated STI/RTI clinics.
- These locations will also serve as referral sites for STI/RTI services besides participating as resources for STI/RTI training, monitoring and supervision.
- This service delivery will be entirely supported by NACO through State AIDS Control Societies (SACS) and District AIDS Prevention and Control Units (DAPCUs).

(C) High-risk population groups:

- STI/RTI services will be provided through targeted interventions (TIs) to high-risk groups (HRGs) through specified clinic settings.
- There are three recommended kinds of clinic settings:
  - TI-owned static clinics for locations with >1,000 sex workers
  - Fixed-day, fixed-time outreach clinics for locations with smaller number of sex workers
  - Referral linkage with government and private STI/RTI service providers in locations with <200 sex workers

- TI owned STI/RTI clinics should have either on site laboratory facilities or link up with the nearest government laboratory performing syphilis screening.

STI/RTI services in the private sector:

- Identified private sector service providers, including those qualified in modern medicine, AYUSH and other health care providers will be involved by NACO, SACS and DAPCU through a franchising approach both at the sub-district and district levels to provide STI/RTI service to the general population and HRGs (High Risk Groups).

STI/RTI SERVICE DELIVERY UNDER NACO-NRHM CONVERGENCE FRAMEWORK:

As per the Convergence framework of NACO-NRHM for STI/RTI service delivery, uniform service delivery protocol guidelines ,training packages & resources, jointly developed by NRHM & NACO are to be followed for provision of STI/RTI services at all public health facilities including CHC and PHC.

As per joint implementation plan agreed upon, NACO/SACS would provide training, quality supervision and monitoring of STI/RTI services at all health facilities, thus overseeing the implementation. For tracking access, quality progress and bottlenecks in STI/RTI program implementation, common information and monitoring system jointly developed by NACO and NRHM would be followed. In order to ensure standardized service package, colour coded STI/RTI drug kits for syndromic case management have been centrally procured and supplied at BSACS as well as at the district level (CMO/ Civil Surgeons).

As a step to take forward this convergence, NACO has conducted a series of regional 'STI Training of Trainers' workshops'' and created a resource pool in every state so as to enable roll out training for service providers. The training curriculum for doctor, staff nurse and laboratory technicians, operational guidelines and IEC material and job aids for STI/RTI services have also been disseminated so as facilitate the training roll out at state and district level.

A one day sensitization for all Civil Surgeons-cum-CMOs has to be organised and finalize the roll out plan so as to ensure that standardized STI/RTI services are rolled out through all the public health facilities in our state through the availability of colour coded syndromic STI/RTI drug kits, trained services providers and regular reporting and monitoring.

BUDGET FOR TRAINING OF MOs & PARAMEDICAL STAFFS AT SUB-DISTRICT HEALTH FACILITIES:

As per Operational Guidelines Medical Officers and Paramedical staffs (Staff Nurses/ANMs and Lab Technicians) at NRHM Sub-district level health facilities have to be trained on STI/RTI. Duration of induction training for MOs and Paramedical staffs will be of two days and one day respectively. SHS, Bihar under NRHM would bear expenses for training of MOs & paramedical at sub-district health facilities.

In the light of above an estimated budget of **Rs 87.40 lacs** [MOs training = 38 x 2(batches) x 65,000(Estimated Unit cost) + Paramedical staff training = 38 x 2(batches) x 50,0000(Estimated unit cost] is proposed in the SPIP for FY 2011-12 for carrying out these activities.

Training of ASHA Worker on HIV/AIDS - 2011-12

Total Budget for Roll out the ASHA Training on HIV/AIDS

S.NO.	Particular	Amount Rs.
1	Total Cost of 3 Days TOT at State Level (Annx-I)	471600
2	Total Cost of 2 Days TOT at Dist. Level (Annx-II)	1470600
3	Total Cost for ASHA Training (Annx.-III)	28687500
4	Documentation of the Programme	200000
5	Travelling & Monitoring of the Programme	200000
6	**Total**	31029700
7	Miscellaneous 10%	2227970
	Grand Total	**33257670**

Annexure - I

Total Budget for 3 Days TOT at State level (2 Participants from each Dist.)

S.No.	Pariticulars	No. of Pariticpants	Unit Rate	No. of Day	Amount
1	Hall hiring for training	..	2000	3 Days	6000
2	LCD and laptop	..	2000	3 Days	6000
3	Accommodation for particiapants	**82** (76 participants + 6 Trainer)	750	3+ 1 Days	246000
4	TA for participants	**82** (76 participants + 6 Trainer)	1000	...	82000
5	Lunch, Dinner & Tea	**82** (76 participants + 6 Trainer)	300	3+1 days	98400
6	Training material (Chart paper, Marker etc.)	**One Time**	2000	One time	2000
7	Stationery for participants (Bag, Pad, Pen etc.)	**82** (76 participants + 6 Trainer)	100	One time	8200
8	Honorarium to the Recourse persons	6 Resource Persons	1000	3 Days	18000
9	Miscellaneous				5000
Total					**471600**

Annexure - II

Total Budget for 2 Days TOT at Dist. Level (10 Participants)

S.No.	Pariticulars	No. of Pariticpants	Unit Rate	No. of Day	Amount
1	Hall hiring for training	..	1000	2 Days	2000
2	LCD and laptop	..	1500	2 Days	3000
3	Accommodation for particiapants	**12** (10 participants +2 Trainer)	500	2 + 1 Days	18000

4	TA for participants	**12** (10 participants +2 Trainer)	150	**…**	1800
5	Lunch, Dinner & Tea	**12** (10 participants +2 Trainer)	200	2+1 days	7200
6	Training material (Chart paper, Marker etc.)	**One time**	500	One time	500
7	Stationery for participants (Bag, Pad, Pen etc.)	12 (10 participants +2 Trainer)	100	One time	1200
8	Honorarium to the Recourse persons	2 Recourse Person	500	2 Days	2000
9	Miscellaneous				3000
Total					**38700**
Total Cost for Dist. Level TOT					
Total Dist.		**Total No. of Dist.**		**Total Cost per of One Dist. Level ToT**	**Total Cost.**
38		**38**		**38700**	**1470600**

Annexure - III

Budget for Training Per Batch 35 Person			
Particulares	**No. of Paricipants/day**	**Unit Cost**	**Amount (Rs.)**
Travelling (fixed cost inclucing all travel & DA) Per Porson	35 paricipants	100	3500
Working Lunch & Tea,per Person	37(35 paricipant+2 Faculty	75	2775
Training material & Documentation(chart pepar,Marker,Photography)	..	200	200
ASHA Honorarium @ 100 per Day	35	100	3500
Honorarium of Faculty(2 faculty per batch)	2	350	700
Travelling of Faculty (2 faculty per batch)	2	150	300
Miscellaneous			500
Total cost of one day training for			**11475**

Total Cost for Dist. & Block level ASHA Training					
Total Dist.	**Total ASHA to be trained**	**Total No. of ASHA/ Batch**	**Total Training batches**	**Total cost per batch**	**Total Cost.**
38	87135	35	2500	11475	28687500

Integrated Counselling and Testing (ICTC) for HIV testing of ANC cases in Bihar under NRHM-NACP Convergence

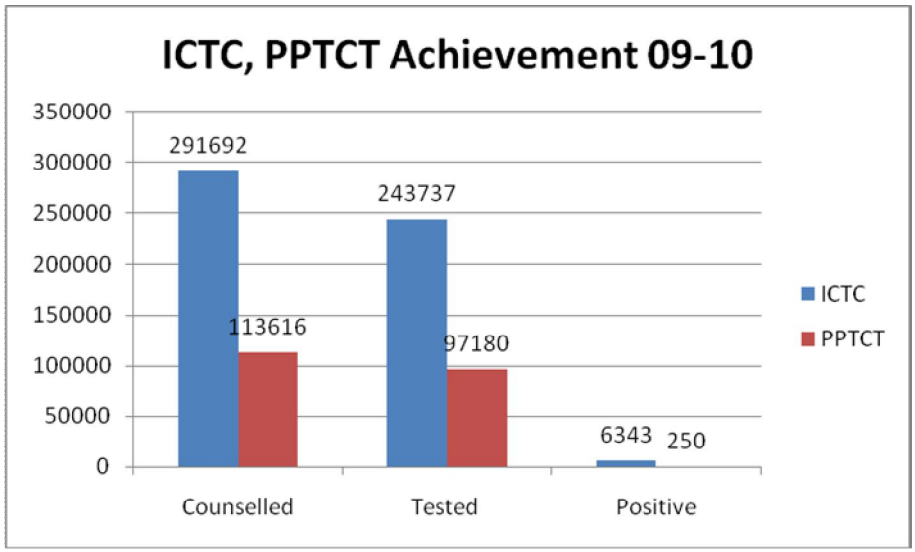
Introduction

ICTC is one of sub component of Basic Services under NACP III to provide a comprehensive package of information, counseling and testing. Apart from providing counseling and testing, this is the first place where information regarding positive prevention is imparted to general people and PLHIVs. This is the center reaching out to maximum population with HIV messages through inter personal communication methods.

207 ICTCs were established in 38 districts of Bihar. 11 are located in Govt. Medical Colleges, 36 are in District Hospitals having 2 centers (General + PPTCT) i.e. 72 ICTC, 12 are in Sub Divisional Hospital level, 14 are in Referral Hospitals, 85 are in Block PHCs, 2 are in Specialized Institutes, 3 are in Red Cross Society and 8 are in Private Hospitals (4 in MC & 4 in other Private Hospitals). Six ICTC were initiated during the year 09-10 under PPP 2 each 'A' and 'B' category districts.

All the 207 ICTCs have 1 counselor and 1 Laboratory Technician except in Medical Colleges 2 counsellors. The program is funded under GFATM Round VI in NACP III

The proposed target for FY 2010-11 for ICTC (General clients) was 300000 (Three lacks) and for PPTCT 250000 (Two lacks fifty thousand). Out of this (April 09 to December 2009), total **291692** general clients were counseled and **243737** tests were conducted. Total **6343** clients were found HIV positive among general clients. Among pregnant women **113616** were counseled and **97180** were tested. **250** women were detected HIV positive.



Due to irregular supply of 1st test kit by the NACO the testing was hampered many times in current financial year.

BSACS is having one mobile ICTC, but due to some administrative issues, in the current financial year, the service of this could not be used fully. Steps have been taken to repair the mobile ICTC and utilize it this year. There are some remote areas where a large no of migrants, FSWs and IDUs are prevalent and it is very difficult to bring these people to the nearby services centers. The mobile ICTC may provide services at the door steps as a out reach program.

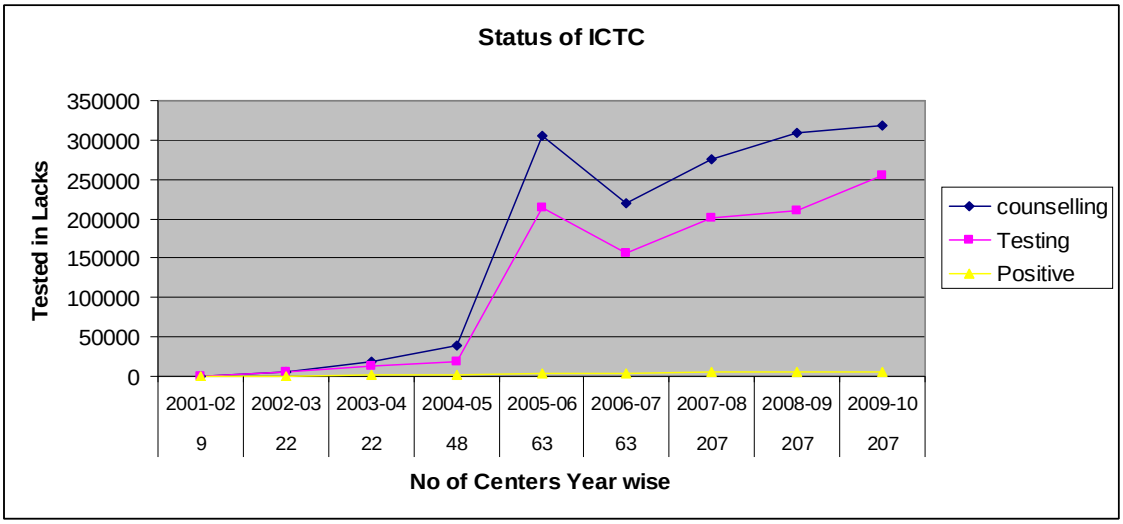
Expansion of ICTC services to the 24 hour PHCs:

At present 84 ICTC centers are functional at CHCs (Block PHC) level of A and B Categories and high priority districts. Under the NRHM collaboration we are planning to initiate ICTC services in 24X7 PHCs to achieve the maximum coverage of ANC

testing find out the maximum number of HIV infected pregnant mother, so that the vertical transmission can be reduced to a large extend.

Approx 30 centers of ICTC/PPTCT which are running either in District Hospitals or Private Medical institutions are low performing since last one year. BSACS is planning to relocate these to other hospital in the next FY 2010-11 for optimum use of the trained man power and maximum identification of HIV cases.

District wise categorization as per prevalence rate:



Performance of ICTCs (including PPTCT & General Clients) (Up to Dec. 09)

Center	Year	counselling	Testing	Positive
9	**2001-02**	**261**	230	27
22	**2002-03**	**6487**	5876	683
22	**2003-04**	**18097**	13209	1266
48	**2004-05**	**38858**	18935	1207
63	**2005-06**	**305840**	213527	2867
63	**2006-07**	**220291**	156164	4362
207	**2007-08**	**274892**	200862	5323
207	**2008-09**	**308600**	211014	6304
207	**2009-10**	**291962**	243737	6398

No of existing centers	Physical Performance of VCTC.										Positivity
		Counselled			Tested			Positive			
	Period	Male	Female	Total	Male	Female	Total	Male	Female	Total	
9	**01-02**	167	94	**261**	145	85	**230**	19	8	**27**	11.7
22	**02-03**	4104	2383	**6487**	3642	2234	**5876**	465	218	**683**	11.6
22	**03-04**	11562	6535	**18097**	8262	4947	**13209**	850	416	**1266**	9.6
48	**04-05**	22871	15987	**38858**	11625	7310	**18935**	798	409	**1207**	6.4
63	**05-06**	183583	122257	**305840**	130988	82539	**213527**	1781	1086	**2867**	1.3

63	**06-07**	85771	80021	**165792**	55857	60657	**116514**	2650	1583	**4233**	3.6
207	**07-08**	104618	94630	**199248**	73548	69308	**142856**	3198	1954	**5152**	3.6
207	**08-09**	116722	105310	**222032**	76833	77028	**153861**	3767	2360	**6127**	4.0
207	**09-10**	93857	84489	**178346**	76022	70535	**146557**	3775	2373	**6148**	4.2
Grand Total:		**623255**	**511706**	**1134961**	**436922**	**374643**	**811565**	**17303**	**10407**	**27710**	**3.4**
	Apr-09	9719	8308	**18027**	7155	6500	**13655**	403	255	**658**	4.8
	May-09	10375	7495	**17870**	8332	6303	**14635**	449	295	**744**	5.1
	Jun-09	10887	8871	**19758**	8707	7233	**15940**	490	294	**784**	4.9
	Jul-09	11318	8786	**20104**	8972	7309	**16281**	420	305	**725**	4.5
	Aug-09	11265	9381	**20646**	9426	7857	**17283**	430	247	**677**	3.9
	Sep-09	10531	9294	**19825**	9026	7734	**16760**	397	245	**642**	3.8
	Oct-09	10355	9710	**20065**	8710	8232	**16942**	413	288	**701**	4.1
	Nov-09	9970	12045	**22015**	8059	10513	**18572**	413	242	**655**	3.5
	Dec-09	9437	10599	**20036**	7635	8854	**16489**	360	202	**562**	3.4
Total:		**93857**	**84489**	**178346**	**76022**	**70535**	**146557**	**3775**	**2373**	**6148**	**4.2**

Physical Performance of P.P.T.C.T

	Period	ANC Registration	Direct Delivery	Counselled	Tested	Positive
	2005	24475	2566	16862	10314	**39**
	2006	66439	8505	54459	39650	129
	2007	88928	17091	75644	58006	171
	2008	264615	193000	86568	57153	177
	Jan-09	13844	16863	6213	4345	9
	Feb-09	24525	28368	9539	8137	35
	Mar-09	22759	28859	10409	8460	36
	Total	**505585**	**295252**	**259694**	**186065**	**596**
	Apr-09	23848	11166	10949	8677	25
	May-09	14056	6058	10751	9267	23
	Jun-09	15312	6814	12543	10145	24
	Jul-09	15835	6910	13901	11824	30
	Aug-09	19185	8633	15090	14817	36
	Sep-09	15801	9300	14580	12873	27
	Oct-09	16805	9823	11971	10759	23
	Nov-09	15282	8154	12585	10352	22
	Dec-09	14132	7871	11246	8466	40
	Total	**150256**	**74729**	**113616**	**97180**	**250**
Grand total:		**655841**	**369981**	**373310**	**283245**	**846**

Prevention of Parent to Child Transmission (PPTCT)

- As per the NRHM data 2.5 million deliveries are happening per year in Bihar and out of that 48% of deliveries are institutional. (36% of deliveries are catered by the Govt. health institutions and 12.9% under Private institutions)
- ANC coverage is very poor as compared to any other states in the country.

The PPTCT programme in the state started in 2005 the above data shows the progress in accessing the services. So far 3.7 lakh pregnant women are tested and 846 positives identified. The client load in some of the centers are very poor and due to none availability of infrastructural support some of the district hospitals doctors are not entertaining any deliveries and patients are referred to nearby bigger hospitals like medical colleges or Pvt. Hospitals. There is a need to expand access to PPTCT

services particularly in the border districts where the large number of positives are identified through ICTC centers. Greater linkage is planned in the coming years with NRHM to improve the status of testing among pregnant women.

BSACS has already taken various steps to increase the percentage of counseling and testing in Bihar, few initiatives in this regard has already been are taken. An instruction was issued to all the centers that, in ANC clinic doctor will attend the case only after the HIV test. Instructions were also issued to all ASHAs and ANMs regarding the same. Even NRHM is planning to have incentive systems to ASHAs for PPTCT coverage.

The ANM and Staff Nurses of the A & B categories district has also been trained on HIV rapid whole blood test to cover the pregnant women who are coming in labor room directly or late night deliveries.

The constant review programs and frequent visits to the PPTCT/ICTC centers increase the coverage of MB pair in the state. But still it needs to go a long way ahead.

Safe Delivery Kit: Total 1000 kit has been distributed to all 207 ICTCs as per their requirements.

Early Infant Diagnosis:

Roll out of EID as per NACO guideline including clotrimazole prophylaxis in the state. This would include capacity building and supply chain management. This will lead to increased coverage of MBP and exposed infants

Gaps in the Program

No detailed analysis has been made yet to assess the gaps in the program. BSACS in collaboration with SHS (NRHM) is planning to convergence the ICTC/ANC program in the state including the capacity assessment of peripheral unit. Few major gaps identified during the current year through informal; discussions with ICTC/PPTCT team members during the review meetings are listed below:

- Irregular supply of test kits hamper the testing process.
- Use of test kit in operation/ Ligation which is breach of protocol of testing policy.
- Non availability of trained staffs who are willing to work for HIV testing..
- Poor infrastructure availability and non cooperation from the health systems
- Need for more separate register for new and old ANC cases.
- Training curriculum needs to be improved to cater the needs of staff.

Coverage Targets for ICTC

Dist.	Popln of Dist	Category	Sexually Active Popln in Dist (~50% of popln)	Popln prone for risky behavior (6% of sexually active popln)	No of HRG covered by TI project in dist.= 'X'	Target for 2010-11: (50% of population prone for risky behavior in A & B district and 10-25% in C & D district)	Target for counseling and testing of HRG in 2010-11 = 'X'	Annual Pregnancy in dist (3.38 of population (B)	% of institutional delivery in dist. 'P' (42%)	ANC prevalence as per SS 'Q' (0.36)	Estimated Number of HIV+ve pregnant women 'R'	Target for counseling and testing of pregnant women for 2010-11:	Target for NVP administration for 2010-11: P *R (No of L)	Target for referrals at ICTC - RNTCP for 2009-10:	No of registered TB cases in RNTCP 2009	Target for referrals from RNTCP - ICTC centers for 2010-11:	Total targets for cross referrals between ICTC and RNTCP (M+N)
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Araria	2158608	A	1079304	64758	0	32379	0	72961	30644	0.36	110	22983	110	3238	1	0.7	3239
Lakhisarai	802225	A	401113	24067	292	12033	292	27115	11388	0.36	41	8541	41	1203	6	4.2	1208
Katihar	2392638	B	1196319	71779	800	35890	800	80871	33966	0.36	122	25474	122	3589	4	2.8	3592
Purnia	2543942	c	1271971	76318	900	7632	900	85985	36114	0.36	130	9028	130	458	0	0	458
Banka	1608773	C	804387	48263	0	4826	0	54377	22838	0.36	82	5710	82	290	0	0	290
Begusarai	2349366	C	1174683	70481	800	7048	800	79409	33352	0.36	120	8338	120	423	3	0.6	423
Bhojpur	2243144	C	1121572	67294	800	6729	800	75818	31844	0.36	115	7961	115	404	0	0	404
Darbhanga	3295789	C	1647895	98874	0	9887	0	111398	46787	0.36	168	11697	168	593	1	0.2	593
Gaya	3473428	C	1736714	104203	600	10420	600	117402	49309	0.36	178	12327	178	625	0	0	625
Gopalgunj	2152638	C	1076319	64579	600	6458	600	72759	30559	0.36	110	7640	110	387	6	1.2	389
Jamui	1398796	C	699398	41964	500	4196	500	47279	19857	0.36	71	4964	71	252	0	0	252
Jehanabad	802587	C	401294	24078	0	2408	0	27127	11394	0.36	41	2848	41	144	0	0	144
Kaimur (Bhabhua)	1289074	C	644537	38672	500	3867	500	43571	18300	0.36	66	4575	66	232	8	1.6	234
Khagaria	1280354	C	640177	38411	0	3841	0	43276	18176	0.36	65	4544	65	230	24	4.8	235
Kishanganj	1296348	C	648174	38890	1300	3889	1300	43817	18403	0.36	66	4601	66	233	0	0	233
Madhepura*	1526646	C	763323	45799	0	4580	0	51601	21672	0.36	78	5418	78	275	61	12.2	287
Madhubani	3575281	C	1787641	107258	500	10726	500	120844	50755	0.36	183	12689	183	644	8	1.6	645
Munger	1137797	C	568899	34134	600	3413	600	38458	16152	0.36	58	4038	58	205	11	2.2	207
Muzaffarpur	3746714	C	1873357	112401	1800	11240	1800	126639	53188	0.36	191	13297	191	674	2	0.4	675

Nawada	1809696	C	904848	54291	600	5429	600	61168	25690	0.36	92	6423	92	326	21	4.2	330
Paschimi Champaran	3043466	C	1521733	91304	700	9130	700	102869	43205	0.36	156	10801	156	548	5	1	549
Patna	4718592	C	2359296	141558	300	14156	300	159488	66985	0.36	241	16746	241	849	24	4.8	854
Purbi Champaran	3939773	C	1969887	118193	0	11819	0	133164	55929	0.36	201	13982	201	709	27	5.4	715
Rohtas	2450748	C	1225374	73522	0	7352	0	82835	34791	0.36	125	8698	125	441	0	0	441
Saharsa	1508182	C	754091	45245	0	4525	0	50977	21410	0.36	77	5353	77	271	0	0	271
Samastipur	3394793	C	1697397	101844	700	10184	700	114744	48192	0.36	173	12048	173	611	0	0	611
Saran	3248701	C	1624351	97461	600	9746	600	109806	46119	0.36	166	11530	166	585	6	1.2	586
Sheohar	515961	C	257981	15479	250	1548	250	17439	7325	0.36	26	1831	26	93	32	6.4	99
Sitamarhi	2682720	C	1341360	80482	0	8048	0	90676	38084	0.36	137	9521	137	483	9	1.8	485
Supaul	1732578	C	866289	51977	0	5198	0	58561	24596	0.36	89	6149	89	312	0	0	312
Vaishali	2718421	C	1359211	81553	0	8155	0	91883	38591	0.36	139	9648	139	489	0	0	489
Arwal	2013055	D	1006528	60392	0	6039	0	68041	28577	0.36	103	7144	103	362	5	1	363
Aurangabad	711728	D	355864	21352	1400	2135	1400	24056	10104	0.36	36	2526	36	128	5	1	129
Bhagalpur	2423172	D	1211586	72695	800	7270	800	81903	34399	0.36	124	8600	124	436	0	0	436
Buxar	1402396	D	701198	42072	0	4207	0	47401	19908	0.36	72	4977	72	252	35	7	259
Nalanda	2370528	D	1185264	71116	1100	7112	1100	80124	33652	0.36	121	8413	121	427	0	0	427
Sheikhpura	525502	D	262751	15765	0	1577	0	17762	7460	0.36	27	1865	27	95	0	0	95
Siwan	2714349	D	1357175	81430	0	8143	0	91745	38533	0.36	139	9633	139	489	24	4.8	493
State Total	**82998509**		**41499255**	**2489955**	**16442**	**313237**	**16442**	**2805350**	**1178247**	**13.68**	**4242**	**332561**	**4242**	**22006**	**328**	**71.1**	**22077**

(75% of institutional delivery in A & B district and 25% in C & D district) (10% of ICTC general clients in Cat A & B category districts and 6% in C & D category districts) (M)/ (70% of registered TB cases in Cat A & B category districts and 20% in C & D category districts) (N)

Note: Total annual delivery is approx 28 lacks and out of this only 12 lacks is institutional delivery approx (42%). Out of 12 lacks 3 lacks ANC will be covered by the BSACS and rest 9 lacks will be covered by NRHM.

Total Budget for ICTC

S. No	Details of Activity	@ rate of per test	Total Cost (2010-11)	Source of Fund
1	Total eight lacs approx annual pregnancy 50% (4 lacs) will be covered by the NRHM (1st test) Whole Blood test	Rs. 50/-	200.00 Lacs	NRHM
2	Training of Staff nurses on counseling and testing (total no of nurses 4000 No. approx	Rs. 1000/-	40.00 Lacs	NACO
3	Consumable for 9 lacs pregnancy testing at Center. (for 1257 Center)@ 100 Rs. Pm per center)	Rs. 1200/-	15.00 Lacs	NACO
4	Contingency per (101 Sub. Div + 622 CHC+ 534 PHC=1257center (one time)	Rs. 1000/-	12.50 Lacs	NRHM
Total Budget			**267.50 Lacs**	

Total NRHM Budget – Rs. 212.50 Lakhs

c) **Mainstreaming of AYUSH under NRHM (2011-12)**

Introduction

Recognizing the importance of Health in the process of economic and social development and for improving the quality of life of the citizens, the government of India launched the "National Rural Health Mission" for improving the availability of and access to quality heath care by people, especially for those residing in rural areas, the poor women and children and to adopt a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. One of the important aims of ***NRHM is to revitalize local health tradition and mainstream AYUSH (including manpower and drugs).***

Mainstreaming of AYUSH under NRHM:

Integration of AYUSH system including infrastructure, manpower and AYUSH medicines to strengthen the Public Health care delivery system at all levels and promote AYUSH medicines at grass-root level or village level with different national health programs. The AYUSH personnel work under the same roof of the Public Health Infrastructure. (Guidelines in Annexure 2)

AYUSH Scheme for Hospital & Dispensaries:

- The main objective is to facilitate expansion of health care facilities of AYUSH and building up confidence of the practitioners of these systems while propagating them and establishing their strengths and potentials.
- Another objective of the scheme is to provide facilities of specialized therapies of AYUSH like "Panchkarma", "Kshar-Sutra" of Ayurveda, "Regimental Therapy" of Unani, with Homoeopathy, Naturopathy and Yoga at the modern hospital where the specialized facilities are available so that the citizen have a choice of different systems of treatment under the same roof.

1. Profile of AYUSH in Bihar.

AYUSH is being administered under Directorate - Indian System of Medicine (ISM), of Health Department, Bihar Government. Since the systems of AYUSH are widely practiced in Bihar, an emphasis on them in this state will go a long way in improving the health system.

Current Scenario of AYUSH in Bihar is:

1. State Level:
   - Separate Directorate for Indian System of Medicine with Director (ISM).
   - 3 Deputy Directors: one each for Ayurveda, Unani and Homeopathy.
   - for the Mainstreaming of AYUSH in the state using the ISM infrastructure which will be headed at state level by Director (ISM) and assisted by Program In-charge Officer (AYUSH) at State Health Society Bihar..
2. District Level:
   - Out of 38 districts in Bihar, in 26 districts there is Joint Hospitals(ISM) with OPD services of Ayurveda, Unani and Homeopath systems. Under Central sponsored scheme of AYUSH depart. Govt of India a 100 bedded specialized hospital is proposed at these 26 districts.

- Bihar has 26 District Medical Officers (ISM) at these Joint Hospitals to control the functioning of all government ISM dispensaries in the concerned districts.
- Guidelines are currently being prepared for the Mainstreaming of AYUSH in all the districts using the ISM infrastructure which will be headed at district level by District Medical Officer (ISM).

3. Total 127 Rural Dispensaries are functional under ISM
   - Ayurvedic: 69
   - Unani: 30
   - Homeopathic: 28
4. 20 AYUSH dispensaries are functional in different sectors (i.e., Welfare Department, Labor Department and Rural Development Department under Government of Bihar)
5. A 10 bedded government Homeopathy hospital is functional in Patna.
6. AYUSH Teaching and Research Facilities:
   - 4 Government Ayurvedic colleges (one out of these has also got PG facility and is in process of being converted to Model College with financial support of Department of AYUSH, GoI)
   - 1 Government Unani College (is in process of being converted to Model College with financial support of AYUSH Department, GoI)
   - 1 Government Homoeopathic College (is in process of being converted to Model College with financial support of AYUSH Department, GoI)
   - 1 Regional Research Institute of Ayurveda is being run by Central Government of India with panchkarma and specialized Eye hospital.
   - 1 Regional Research Institute of Unani is being run by Central Government of India.
   - 1 State Ayurvedic Unani Pharmacy for manufacturing and supply of Ayurvedic and Unani medicine to Government Ayurvedic and Unani Medical College Hospitals in Patna respectively. In this premise a State level Drug Testing Laboratory is proposed for testing of Ayurvedic and Unani medicine with the financial support of Department of AYUSH, GoI.
7. ISM staff profile:
   - Doctors: 195 Ayurvedic doctors, 90 Unani Doctors and 85 Homeopathic regular doctors and newly appointed contractual 1384 ayush doctors are currently working in the state's Joint Hospitals, Rural dispensaries and co-located additional APHCs under ISM.
   - Paramedics and Pharmacists: Approximately 85 Ayurvedic paramedics and pharmacists each, 56 Unani paramedics and pharmacists each and 55 Homeopathic paramedics and pharmacists each are currently working in the state's Joint Hospitals and rural dispensaries under ISM.

2. AYUSH Facilities Co-location

429 Additional Primary Health Centre (APHCs) under health system have been co-located for AYUSH, **before the launch of NRHM**.

The numbers of APHCs co-located under different systems of ISM are:

- Ayurvedic: 215
- Unani: 88
- Homeopathic: 126

- Under NRHM 1384 APHC IS CO LOCATED (704 AYR. 428 HOM. 252 UNA)

No Co-location of the AYUSH facilities has occurred till date in District Hospitals, Sub divisional Hospitals and PHCs.

3. Progress of Implementation of Mainstreaming of AYUSH

Till 2008-09, no PIP was prepared for Mainstreaming of AYUSH in Bihar.

In 2009-10 for the first time AYUSH State PIP is being prepared which includes the AYUSH component added for the first time in the State PIP for NRHM.

4. Utilization Status

As no PIP has been submitted till 2008-09, no fund available under Mainstreaming of AYUSH till 2008-09. Approximately Rs 82 lakh has been received for medicine procurement from Department of AYUSH for 272 Additional PHCs and 127 Rural Dispensaries. This fund has been kept for expenditure in 2009-10.(PROCURMENT OF MEDICINE is done Utilisation is under process.)

2009.10 From NRHM Rs 39.15 Crores sanctioned, for salaries, IEC& TRAINING. APOINTMENT ISIN PROCESS. (nearly 0.80 crores expender)

2009-10 FROM AYUSH DEPARTMENT; RS. 25 crorores for 250 APCH infrastrucrs @10.00 lacks each. And RS. 11.17 crorors for 471 aphc's medicine supply @ Rs. O.25 lack. Each for Procurement of AYUSH DRUGS, process in progress.

2010-11 30.4 crores fro NRHM for ayush doctors appointed and taraining and other expenses. 1384 ayush doctor appointed. And 38 ayush specialized doctors, at DH level and Training and other activity is going on.

5. Proposal for the year 2011-12

Part A: Proposal for the requirement of funds from NRHM

Part B: Proposal for the requirement of funds from Department of AYUSH

- **Part B (I): for AYUSH Dispensaries and Hospitals**

Part A	Part B (I)	Total
117.16 Crores	**202.34 Crores**	**319.50 Crores**

5. A <u>Co-location</u>: Number of AYUSH facilities to be under taken for co-location (system-wise) separately at District Sadar hospital (DHs), Sub-Divisional Hospital (SDHs), PHCs. (24x7) primary health centers & APHCs. One of the targets for mainstreaming AYUSH in the state is to co-locate each DH, SDH, PHC with one Ayurveda, one Unani, and one Homoeopathy wing in each, and one Naturopathy & Yoga unit in 10 DHs only.

Sr.No	System	DH(2 doctors)		SDH (2 doctors)		PHC (1 doctor)		APHC (1 doctor)		Total		
		Upto-2010-11	New for 2011-12	Upto-2010-11	New for 2011-12	Upto-2010-11	New for 2011-12 (50% lady doctors are proposed)	Upto-2010-11	New for 2011-12	Upto-2010-11	New for 2011-12	Cumulated
1	Ayurveda	19			22		266	704	**331**	**723**	**353**	**1076**
2	Unani	8			10		107	252	**133**	**260**	**143**	**403**
3	Homoeopathic	11			10		160	428	**198**	**439**	**208**	**647**
4	Naturopath, yoga	0	5	-	5	-		-			**10**	**10**
Total		**38**	**05**		**47**		**533**	**1384**	**662**	**1422**	**714**	**2136**

5. B <u>Appointments:</u> Number of AYUSH doctors, Pharmacists, Nursing Staff/ MPW, proposed for contractual hiring during 2009-10.

Sr. No.	Category of staff	Recruitment up to-2010-11	Recruitment proposed 2011-12
1	Medical officers	1422	714
2	Pharmacists		1422
3	Multipurpose worker (MPW)		
5	AYUSH Consultant	01	
6	Program manager PMU ((MBA)	01	
7	PMU (Fin.)	01	
8	Account Manager	01	
9	(Data OPRATOT)/ASST	02	
10	STATE Program/ OFFICER Doctor I/C	01	
11	PMU (Attendant)		02
12	District program manager AYUSH		38
13	Data operator at district level;		38

5. C <u>Training</u>: Number of trainings proposed to be imparted to AYUSH Doctors & paramedical staffs on Mainstreaming of AYUSH and OTHERS National Health Programs at National/ State/ District/Block levels.

6. D <u>IEC/BCC</u>: Awareness programs and IEC campaign on strengths of AYUSH and Mainstreaming, Awareness of Allopath Doctors with AYUSH systems, Organization of

Health Fair & Health camps, School boys Health checkup, Awareness of Medicinal plants to the school and college level students.

7. **5. E Centrally Sponsored Schemes (AYUSH):** Following Centrally Sponsored Schemes proposed for 2009-10.

    1. Geriatric Care unit at Govt. Ayurvedic college hospital & Govt. Unani college hospital at Patna.
    2. Panch Karma unit at Govt. Ayurvedic hospital and Regimental therapy unit at Govt. Unani college hospital at Patna.
    3. Special Care units on mother and child care at 10 bedded Homoeopathy hospitals at Patna.
    4. Organize 04 ROTP Program of each Unani, Ayurveda, Homoeopathy at respective Govt. colleges and one ROTP (mixed path, Unani, Ayurveda, Homoeopath And Naturopath & Yoga) for Allopathic and AYUSH Doctors at Directorate level
    5. 2 CME and 2 State level seminars at Directorate level at Patna.
    6. Established AYUSH library at State Medicinal Plants Board office at Patna.

5. F Proposal for reviving LHT: Reviving of Local Health Traditions (LHT) in West Champaran and Bhagalpur planned in 2009-10.

5. G Others:

- Proposal to conduct special project for
    - Prevention of Malaria & Kalaazar in Muzaffarpur and Tirhut Region
    - Eradication of iron deficiency and worm infestation by Unani Medicines in Champ ran Region
- Strengthening of AYUSH cell with AYUSH consultant, I/c Doctors & PMU - Contractual recruitment of MBA, Financial Manager, Accountant & Computer Personnel along with one attendant.

Medicinal plants board: A separate action plan is to be prepared and sent in due course.

National campaigns: Department of AYUSH, Ministry of Health and Family Welfare, Government of India has launched National campaigns on various strengths of AYUSH Systems to sensitize all stake holders, i.e. Policy Makers, Program Evaluators, Opinion Makers, AYUSH doctors, Allopathic doctors and other physicians and NGOs regarding the strengths of AYUSH systems. State may also organize these campaigns with financial assistance from Dept. of AYUSH, (MOHFW), and New Delhi.

Budget Proposal for 20011-12

Part –A: Proposal for the requirement of funds from NRHM:

A-1; SALARY OF AYUSH CO-LOCATION HOSPITALS.

No. of ayush doctors and other to be appointed

Sr. No	System	DH()		SDH ()		PHC (1 doctor)		APHC (1 doctor)		Total		
		Upto-2010-11	New for 2011-12	Upto-2010-11	New for 2011-12	Upto-2010-11	New for 2011-12 (50% lady doctors are propose d)	Upto-2010-11	New for 2011-12	Upto-2010-11	New for 2011-12	Cumulated
1	Ayurveda	19			22		266	704	**331**	**723**	**353**	**1076**
2	Unani	8			10		107	252	**133**	**260**	**143**	**403**
3	Homoeopathic	11			10		160	428	**198**	**439**	**208**	**647**
4	Naturopath, yoga	0	5	-	5	-		-			**10**	**10**
Total		**38**	**5**		**47**		**533**	**1384**	**662**	**1422**	**714**	**2136**

Amount required for Ayush personals.

Sr No.	Components	Up to 2010-11	For new 2011-12	Cumulated	Amounts cumulated
1	**Manpower for Ayurvedic, Unani and Homeopathic , Co located**	No.	No.	No.	(Rs.in Lacks)
1.I	Provision of 1 AYUSH doctor on contract @ Rs.20,000/- x 2096 x 12 months	**1384**	**712**	**2096**	6288.00
	Provision of 1 AYUSH specialist doctor on contract @ Rs.35,000/- x 90 SDH,DH x 12months	38	52	90	378.00
1.II	Salary of Pharmacists @ Rs.6500 x 1422 x 12 months		1422	1422	1109.16
2	**Training** of AYUSH Doctors & Paramedical staffs w.r.t AYUSH wing and establishment of head quarter cost	1000	1000		415.00
3	**IEC**				100.00
	Program management unit at district level @ 25000x 38x12			38	114.00
4	**Data operator @ 6500 x 40**			40	31.2
5	**Management unit cost and mobility at aphc and district and head quarters at APHC @ 2000 X 3000 X12=**				720.00
6	**AT HEAD QURTER AND DISTRICT LEVEL 25000 X2 X12=6 38 X12 X12000=57.72**				63.72
7	**Up gradation of 250 APHC Infrastructure & Video Conferencing, repurtation & Support @ 10.00 Lacks- (Anx-Ayush Gram)**				2500.00
					11715.98

117.16 Crores

A-2; REVITALISATION OF LOCAL HEALTH AND TRADITIO (LHT);

In this program 250 APHC which is co-located will be up graded with modern web supported AYUSH OPD facility and expected to cover at least one VILLAGE of their periphery to" ***AYUSH GRAM***"

In THIS PROGRAM

A); one village is covered for "***health for all***". Which cover up? Sensation, vaccination, prophylaxis measure for vector bond diseases and all programs of diseases control is adopted with regular heath checkup, child and mother care. Villagers are trained to identify field near by Medicinal plants and their benefits, and cultivation.

b); survey of total Traditional Practitioners, and they are trained for NRHM schemes AND latter on they will be involved in all health programs as promoter and supporting staff on basis of referral incentives.

C) APHC will be connected by web to central UNITE at PATNA and others Govt and private specialized medical facility centre (a separate project is attached)
Cost of each APHCs; @ 10.00 lacks total cost will be= **10 x 250 = 2500 lacks**.

Total Part A = 117.16 Crores

This proposed budget for Part – A (117.16 Crore) is required from the AYUSH head in NRHM PIP 20011-12 (Flexi pool - Part B-)

Part –B: <u>Proposal for the requirement of funds from AYUSH Department:</u>

Part B (I): <u>Requirement of the funds from the AYUSH Department - for AYUSH Dispensaries and Hospitals</u>

1- <u>Procurement of Medicines:</u>

1. a. Procurement of Medicines for Dispensaries;

Sr. No.	Type of Dispensary	Total number 2010-11of units	No. of Units new for 2011-12	No. of Units for which fund is required	Amount (Rs. in Lacks)
1	New Add PHCs. Sanctioned for AYUSH@ 50,000/-	1384	1835	3119	1559.50
2	Rural Dispensaries@ 50,000/-	127		127	63.50
3	District Joint Hospitals@ 50,000/-	26 x 3	0	78	39.00
4	Upgraded APHCs @ 3.0 lacks	250		250	750.00
Sub Total (1.a)					**2412.00**

2- Infrastructures strengthening of co-located Institutions

Sr. No.	**Components** (one time)	Cost per Unit	Units	Amounts (Rs. In Lacks)
1.1	Building Repair, addition, alteration, partitioning etc Equipments, furniture	APHCs.@ Rs.15.00 L	500	7500.00
1.2		PHC.@ Rs.15 L	300	4500.00
1.3		SDH.@ Rs.25.0L	30	750.00
1.4		DH.@ Rs.30.0 L	35	1050.00
3.1	Medicine & diets	APHCs.@ Rs.3 L	500	1500.00
3.2		PHC.@ Rs.5 L	300	1500.00
3.3		SDH.@ Rs.5 L	30	150.00
3.4		DH.@ Rs.5.0 L	35	175.00
4.1	Lump sum contingency fund for plan period	APHCs.@ Rs.0.3 L	500	150.00
4.2		PHC.@ Rs.0.5 L	300	150.00
4.3		SDH.@ Rs.0.7 L	30	21.00
4.4		DH.@ Rs.0.7 L	35	24.50
Sub. Total (2)				**17470.50**

Total for Infrastructure strengthening of co-located Institutions = **174.705 Crores**

3- Special Schemes for AYUSH.

Sr. No.	Scheme	Number of Units	Rate per Unit (Rs. in Lacks)	Amount (Rs. in Lacks)
1	Specialized AYUSH facility in govt territories medical college hospitals ppp mode (02 ayr.01 unani)	3	95	285.00
2	State level Seminar	4	4	16
Sub. Total (3)				**301.00**

Total for Special Schemes for AYUSH = **3.01 Crores**
(Annexure 6)

4- <u>Other AYUSH Schemes</u>.

Sr. No.	Schemes	Financial (Rs. in Lacks)
1- Proposal to conduct special project: Identified area: Muzaffarpur and Vaishali for Kalazar, Chapra and Siwan for Malaria.		
2.1	Incentive & TA for MOs	4.00
2.3	Medicines Rs.2.0 L x 2 systems	8.00
2.4	Hiring of 4 vehicles for four districts for 6 months @ Rs.0.2 L / month	4.80
2.5	Contingency for period	1.00
2.6	IEC activities	2.20
Sub. Total (4.2)		**20**
2- Strengthen of AYUSH Cell: With AYUSH consultant, I/c Doctors & PMU(Contractual recruitment of MBA, Financial Manager, Accountant & Computer Personnel along with one attendant)		
3.1	One MBA qualified personnel @ 0.25 L / month x12	3.00
3.2	Finance manager @ Rs.0.25 L / month x 12	3.00
3.3	Accountant @ RS. 0.15 L / month x12	1.80
3.4	4-Computer personnel @ 0.065 L / month x12	3.12
3.5	Office Assistant cum PA for I/C doctor @ 0.065 L / month x 12	0.78
3.5	4 Office Attendant cum helper @ 0.045 L / month x 2 x 12	2.16
3.6	Office setup: Furniture for office – Rs. 4 L, 6 desk top with accessories @ 0.5 L, 1 laptop @ 0.5 L, 1 projector @ 1 L & Internet, fax, Xerox, Printer and telephones facility @ Rs. 1.5 L	10.00
3.7	Hiring of two vehicle for monitoring of AYUSH OPDs & other works @ Rs.0.30 x2 x12	7.20
Sub. Total (4.3)		**31.06**

Total for Other Schemes= **0.20 + 0.3106 = Rs. 0.5106 Crores**

Total Part B (I): from the Department of AYUSH – for AYUSH Dispensaries and Hospitals includes:

1- **Total** for Procurement of Medicines **2412.00** =**24.12 Crores**
2- Total for Infrastructure strengthening - co-located Institutions **17470.50**=**174.70 Crores**
3- Total for Special Schemes for AYUSH **301.00** = **3.01 Crores**
4- Total for Other Schemes 51.06 **= 0.51 Crores**

Total Part B (I) = (1) 24.12 + (2) 174.70 + (3) 3.01 + (4) 0.51 = 202.34Crores

Part A	Part B (I)	Total
117.16 Crores	**202.34 Crores**	**319.50 Crores**

8. Proposed Time frames

a. **Time frame for implementation** of activities is one year - FY 2010-11.
b. The **expected out comes** of the initiatives are:
   - Development & effective utilization of AYUSH medicines by the population.
   - Availability of accessible, quality and affordable AYUSH services at public health institutions.
   - Promotion of preventive & curative treatment facility.
   - Availability of qualified AYUSH practitioners, in the public health facilities.
   - Availability of AYUSH medicines which are accessible to the rural poor.

Performa for Preparation of Budget

Training OF Doctors, No of Trainees – 30 in each batch. At Districts. Level
Name of the Programme/AYUSH Training for Doctors FMR Part B Code 15
No of Participates 30 No. of Total Batch 40 Date of Training/Meeting.....

Sl. No	Budget Heads	Approved Rate	Proposed Budged
1	Number of Participants'	30	
2	DA to Group B & Equivalent Participants'	200x25=5000.00	5000.00
2	DA to Group A Participants' officers & equivalent	300x05=1500.00	1500.00
4	Honorarium to Districts & Sub-district guest faculty	600x3x3=5400.00	5400.00
5	Hon to guest faculty comes at state/Regional/ National level	1000x1x3=3000.00	3000.00
6	Working lunch Tea & snacks (per day)	200x40x3=24000.00	24000.00
7	Lodging	200x30x3=18000.00	18000.00
8	Incidental expenditure Photocopy, Job Cards, flip chart	200x30x3=18000.00	18000.00
9	Venue Hiring	600x3=1800.00	1800.00
10	T.A. to participants	1000x30=30000.00	30000.00
11	T.A. & D.A. to resource person	18000.00	18000.00
12	LCD/Mic & others	2000.00	2000.00
13	Others/Mobility/H. Ex. & Program Co-coordinator @1000x3	10000.00	10000.00
	Total=	**136700.00**	**1,36,700.00**
	GRAND TOTALS	**136700X40**	**54,68,000.00**

Annuxer-2

Performa for Preparation of Budget

Training OF paramedical, No of Trainees – 30 in each batch. At Districts. Level

Name of the Programme/AYUSH Training, Paramedical .FMR Part B Code 15

No of Participates 30 No. of Total Batch 40 Date of Training/Meeting.....

Sl. No	Budget Heads	Approved Rate	Proposed Budged
1	Number of Participants'	30	
2	DA to Group C & Equivalent Participants'	150x30=4500.00	4500.00
2	DA to Group A Participants' officers & equivalent		
4	Honorarium to Districts & Sub-district guest faculty	600x3x3=5400.00	5400.00
5	Hon to guest faculty comes at state/Regional/ National level	1000x1x3=3000.00	3000.00
6	Working lunch Tea & snacks (per day)	200x40x3=24000.00	24000.00
7	Lodging	200x30x3=18000.00	18000.00
8	Incidental expenditure Photocopy, Job Cards, flip chart	200x30x3=18000.00	18000.00
9	Venue Hiring	600x3=1800.00	1800.00
10	T.A. to participants	1000x30=30000.00	30000.00
11	T.A.& D.A. to resource person	18000.00	18000.00
12	LCD/Mic & others	2000.00	2000.00
13	Others/Mobility/H. Ex. & Program Co-coordinator @1000x3	10000.00	10000.00
	Total=	**134700.00**	**134700.00**
	GRAND TOTALS	**134700X40**	**5388000.00**

Annuxer-3

Performa for Preparation of Budget
Training OF Ashas/ANM/ Local health traditional parishioners
, No of Trainees – 30 in each batch. At Districts. Level

Name of the Programme/AYUSH Training, Ashas/ANM/ Local health traditional practioners

FMR Part B Code 15 No of Participates 30 No. of Total Batch 150 Date of Tra ining/Meeting.....

Sl. No	Budget Heads	Approved Rate	Proposed Budged
1	Number of Participants'	30	
2	DA to Group D & Equivalent Participants'	100x30=3000.00	3000.00
2	DA to Group A Participants' officers & equivalent		
4	Honorarium to Districts & Sub-district guest faculty	600x3x3=5400.00	5400.00
5	Hon to guest faculty comes at state/Regional/ National level	1000x1x3=3000.00	3000.00
6	Working lunch Tea & snacks (per day)	200x40x3=24000.00	24000.00
7	Lodging	200x30x3=18000.00	18000.00
8	Incidental expenditure Photocopy, Job Cards, flip chart	200x30x3=18000.00	18000.00
9	Venue Hiring	600x3=1800.00	1800.00
10	T.A. to participants	1000x30=30000.00	30000.00
11	T.A. & D.A. to resource person	18000.00	18000.00
12	LCD/Mic & others	2000.00	2000.00
13	Others/Mobility/H. Ex. & Program Co-coordinator @1000x3	10000.00	10000.00
	Total=	**1,33,200.00**	**1,33,200.00**
	GRAND TOTALS	**133200X150**	**1,99,80,000.00**

1. Kits Distribution Cost (Five Kits every Year /Asha)

Every Asha evry Kits	200x5	1000
Cost of Kits	3000x5	15000
Doctor Intensive	100x5	500
Kits, transportation and Other Costs	100x5	500
Total		17000x30x38=19380000.00

2. Head Quarter Monitoring Cost

Program Consultant	25000x9	225000.00
Data Operator	6000x9	54000.00
Instrument , Office Cost, Mobility and other cost	500000	500000
Guard	4500x9	40500.00
Transportation	25000x2x12	600000.00
Total		1419500.00

3. Printing & Advertisement Cost = 3000000.00

4. I.E.C. Cost = 12,94,500.00

Total Cost = 1,93,80,000 + 14,19,500 +30,00000+12,94,500 = 2,50,94,000.00

Project - AYUSHMAAN

Hewlett-Packard Using Technology in HealthCare Service at APHC
[Type the company address] Anup Kumar Sinha
A d m i n i s t r a t i v e O f f i c e : IDEAS Foundation, Behind Vaidya Niwas, Chitragupta Nagar
M - 1 9 , S K N a g a r , Patna New Colony, Patna – 800020Phone: +91 612 3200685
[E-mail- **ideas.foundation@rediffmail.com**) Mobile: +91 94308 31834

11. Financial Requirement – Summary

Ayushman						
Indicative Budget for Year 1						
SN	**Particulars**	**Units**	Unit Cost	Amount	TOTAL	**Remarks**
A	**Application Software**					
1	Software Application Development	1	50,00,000	50,00,000	50,00,000	For the entire project
B	**Capital Expenses - APHC Level**					
1	Computers and accessories	250	40,000	1,00,00,000		
2	Printer with cartriges	250	19,000	47,50,000		
3	Furniture	250	35,000	87,50,000		
4	Site Preparation (Including exterior wall and painting of consultation rooms at APHC)	250	1,10,000	2,75,00,000		
5	Digital Remote Medical Devices for tele consultation	250	60,000	1,50,00,000		
6	Power back up (Solar System for teleconsultation and basic lighting at APHC)	250	1,05,000	2,62,50,000		
7	Installation cost for Internet Connection	250	2,500	6,25,000		
8	Installation cost for Telemedicine equipments and software at APHC	250	14,000	35,00,000	9,63,75,000	
9	Insurance for Software & Hardware at APHC	250	700	1,75,000		

C	**Capital Expenses - Central Unit**					
1	Computers and accessories	5	40,000	2,00,000	Computers and accessories	
2	Power back up	1	3,00,000	3,00,000		
3	Lease Line Installation Charges	1	2,00,000	2,00,000		
4	Printer with cartriges	2	19,000	47,50,000		
5	Digital Medical Devices for tele consultation	5	40,000	2,00,000		
6	LCD for display of consultations	5	52,000	2,60,000		
7	Furniture and Furnishing of Central Unit	1	7,50,000	7,50,000		

8	Installation cost for Telemedicine equipments and software at Central Unit	1	60,000	60,000	20,08,000	For 5 operators @ Rs 12,000/- per operator
9	Insurance Coverage for C.U.	1	5,000	5,000	Insurance Coverage for C.U.	
D	**Training Cost**					
1	Doctors	250	5,000	12,50,000		
2	Assistant	250	4,000	10,00,000	22,50,000	
E	**Operating Costs**					
1	Human Resource					
1.1	*At APHC*					
1.1.1	Assistant (to operate the devices)@ Rs. 3,000/- PM	250	36,000	90,00,000		
1.2	*At Central Unit*					
1.1.1	Assistant (to operate the devices)@ Rs. 3,000/- PM	250	36,000	90,00,000		
1.2.1	Project Manager	1	4,20,000	4,20,000		
1.2.2.	I.T. Head	1	4,20,000	4,20,000		
1.2.3	I.T. Assistants - Field Operation	10	1,44,000	14,40,000		
1.2.4	Electrical Assistant	2	60,000	1,20,000		
1.2.5	Office Assistant	5	60,000	3,00,000		
1.2.6	Peon	2	36,000	72,000		
1.2.7	Security Guards	3	48,000	1,44,000		
2	Rent	12	75,000	9,00,000	assumption: @ Rs 30/sft for 2500 sft space	
3	Stationery at APHC	250	12,000	30,00,000		
4	Stationery at Central Unit	1	60,000	60,000		
5	Fuel for Genset Central Unit	12	10,500	1,26,000		Assumption: 4 Hours/day; 3lts/Hour; 25days/month; @Rs 35/-/ltr
6	Travelling Expenses	250	14,000	35,00,000		assumption: @ Rs 2,000/- Per visit/centre/7 visit in a year
7	Repairs and Maintenance Central Unit	12	5,000	60,000		assumption: Rs 5,000/ Month
8	Miscellaneous Expenses	12	5,000	60,000		assumption: Rs 5,000/ Month

9	Electricity for Central Unit	12	5,000	60,000		assumption: Rs 5,000/ Month
10	Internet Charges APHC	250	14,400	36,00,000		
11	Lease Line Charges Central Unit	1	4,20,000	4,20,000	2,37,02,000	
12	Project Overheads (5% of the project cost)			64,75,750	64,75,750	
	Grand Total (Total Project Cost for year 1)			13,59,90,750	13,58,10,750	

	Operating Cost for next 2 years			
S.N.	**Particulars**	**1st Year**	**2nd Year**	**3rd Year**
1	**Operating Cost 250 APHC & C.U.**	**23702000**	**23702000**	**26072200**
2	**AMC for Computers(255)**	**Nil**	**459000**	**504900**
3	**AMC for Medical Device(255)**	**Nil**	**459000**	**504900**
4	**Insurance (APHC & C.U.)**	**180000**	**180000**	**198000**
5	**Software Maintanance**		**500000**	**550000**
6	**Overhead**	**Nil**	**506000**	**506000**
			25806000	**28336000**

Cost of Maintenance has been calculated with inflation rate over the corresponding year

d) Convergence with Education

Issues / Areas	Areas of Convergent Action
Support in School Health Programme	Due to shortage of manpower in the health department, plans to examine school children should be prepared jointly with the education department so that larger schools are covered first or priority should be set for village schools which have not been covered recently or threats/incidences of diseases/malnutrition are more.
Support in immunisation programme for provision of TT booster at the age of 10 years.	During the school health programme visits, the booster Tetanus Toxoid needs to be given to 10 year olds in the schools. This should be worked out with the Education department and visits planned accordingly.

e) Coordination with PRI

The state is undergoing through the process in the decentralisation of Panchayati Raj System. Thus to strengthen and monitor the performance of the APHC and PHC, this institution has been brought under the manifold of the Panchayat president and Zilla Panchayat members of the respective areas. Further the Panchayat presidents or the members are ex officio chairman of the Village Health and Sanitation committee, to have a direct involvement in the health issues of the community. Joint bank account of Panchayat president and ANM has been opened for HSC untied fund. These processes paved the way for taking initiative in implementation in various health programmes under NRHM

Monitoring & Evaluation | Chapter- IX

One of the major weaknesses of the RCH I program in Bihar was the absence of an effective Monitoring and Evaluation system that would provide accurate and reliable information to program managers and stakeholders and enable them to determine whether or not results are being achieved and thereby assist them in improving program performance.

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

Under NRHM a triangulated process of Monitoring and Evaluation was introduced which aimed to enable cross checking and easy collection, entry, retrieval and analysis of data.

In order to facilitate this process a structure right from the village to the national levels with details on key functions and financial powers was made operational under NRHM. To capacitate the effective delivery of the programme there is a need for a proper HMIS system.

SHSB has strengthened HMIS right from HSC to State level in the FY 2011-12 and data from PHCs is uploaded on a daily basis and can be reviewed even at the State level. All ANMs have received training on HMIS.

The quality of MIES in districts and from blocks has considerably improved due to regular follow up. Reporting and recording of RCH formats (Plan and monthly reporting) is now regular, complete, and consistent, some districts are irregular and the State is ensuring handholding through group of resource persons. Review of data at the state level is regular and is shared with the Civil Surgeons and DPMU on a monthly basis, however proper review at the district and PHC level is still lacking. Feedbacks are provided to the districts on their data inputs.

HMIS and M&E Unit in the State are responsible for overall monitoring and evaluation of the programme in the state and the districts. The data gathering is being facilitated by the State, Regional, District and PHC Data Centres. Additionally all the districts have been provided training in uploading information in the GOI HMIS and NHSRC HMIS portals.

At district level, there is a District Health Society which is responsible for the data dissemination from the sub-district level to the district level. District M&E Officer at the district level is responsible for management of HMIS and HMIS Supervisor and Regional M&E are responsible for the same at the regional level.

Main Activities

I. Health Management Information System (HMIS)- (Budgeted in Part-A)

The main objective of Health Management Information System is to provide accurate and reliable information on time to program managers and stakeholders for appropriate decision making. It acts as tool for monitoring and evaluation of the program and on the basis of the information available, appropriate planning can be done and can be executed for the people in need. The state aims to build its HMIS as the main frame for integrating all other information and communication technology for health initiatives.

Main Activities

1. Strengthening of Health Management Information System (HMIS) including the Human Resources Information System (HRIS)

2. Establishment of Hospital Information Management System and Tele-Medicine.

3. Mobile based data uploading system from HSC level.

Background

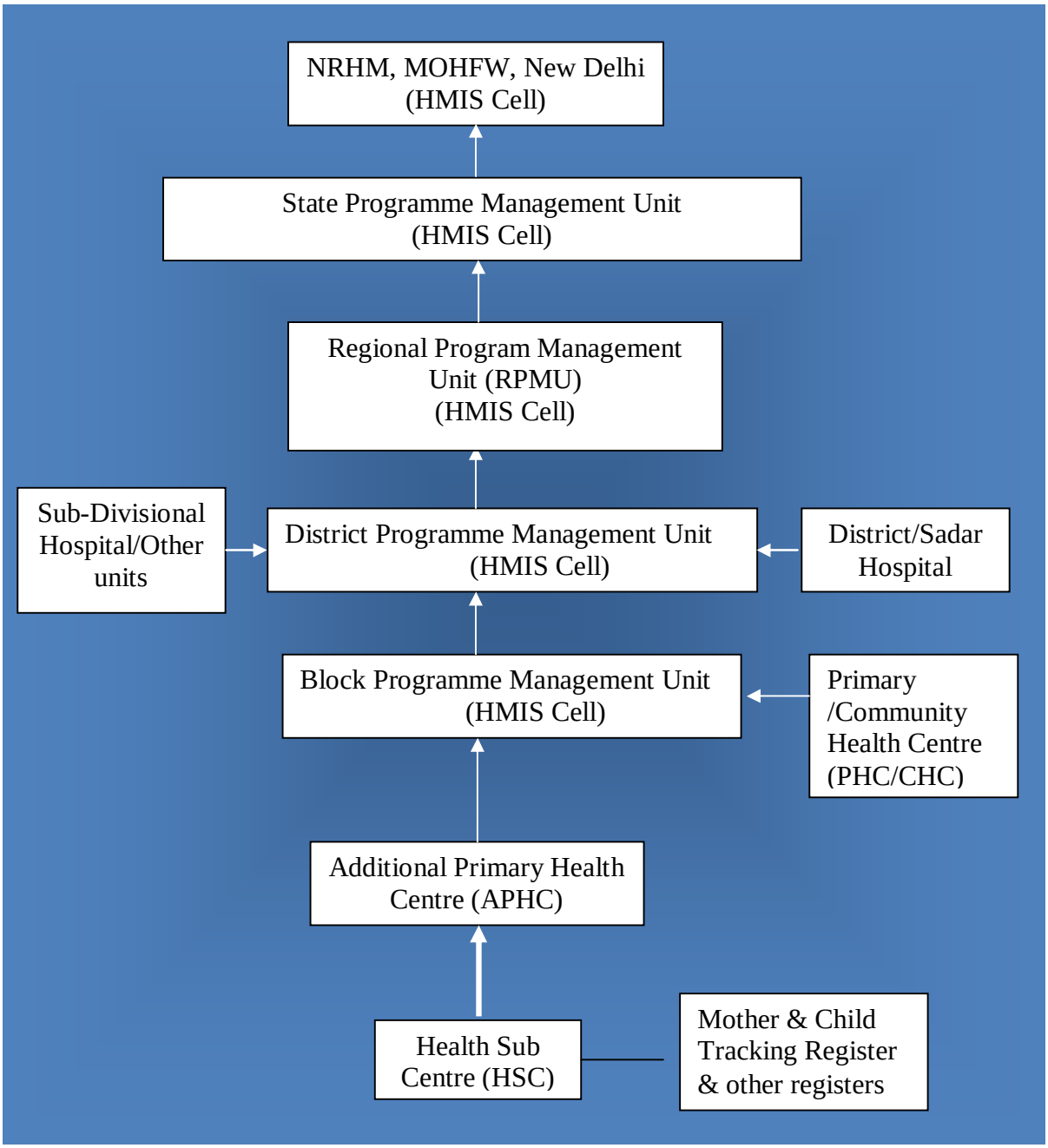
As we know that NRHM aims to continuously improve and refine its strategies based on the input and feedback received from the state and from various review missions. One of our priorities is to build and to strengthen the Health Management Information System (HMIS) in the State and to use it for improving the quality of data for planning, program implementation and making decisions at each level. Revised HMIS formats introduced by NRHM are being used in all 38 districts of Bihar for reporting at every level of health facilities. In order to further improve its programmatic efforts, the state is in the process of strengthening its human resources information systems (HRIS) for health. A web based information system is being set up and the data collection process is underway. The HRIS is developed as an integrated component of HMIS with support from the National Health Systems Resource Centre and the Vistaar Project of IntraHealth International Inc. The state has taken the integrated health systems perspective to establish interlinkages among different information systems developed by the State Health Society. The data flow in HRIS will be similar to the one followed in the HMIS. To strengthen the use and management of HRIS, capacity building workshops will be organised at all levels as a sub-component of the HMIS.

State Health Society, Bihar is using HMIS Portal (http://bihar.nhsrc-hmis.org) with the technical support of NHSRC, New Delhi known as DHIS2 which is a state specific portal. It is being used for facility wise reporting through the data centre established at the facilities. The data entry made in the DHIS2 by the facility gets consolidated in the system for the district. The consolidated report is generated by M&E officer of the district and uploaded on the NRHM Portal of GoI (http://nrhm-mis.nic.in)

Govt. of India has been focusing on importance of HMIS and emphasized on quality of data so that the reports generated from the HMIS Portal can facilitate evidence-based decision making process. State has taken various initiatives to improve the quality of data and among

them one of the major initiatives is to conduct HMIS training (including Mother and Child Tracking Formats) of ANMs, LHVs, data centre operators at block level on recording and reporting. For that state health society has developed training module and reference material for health workers. The main content of the same is HMIS formats , definition of data element, difference between recording and reporting register/ formats, MCTS reporting formats, use of data for HSC level planning and technique of data validation. This training module is printed in local dialect with user's friendly methodology.

- **Flow of Information:-**



➢ **Present Status of HMIS in Bihar:**

- **One source of data**

  State has accepted HMIS as one source of data for monitoring as well as the basis for planning.

- **Data Uploading**

Data Centers at Block Level as well as District/Sub-Divisional level hospitals have been fully operational and functioning well in all 38 districts of Bihar. Almost all 38 districts of the state are uploading monthly MIS report on the web portal of NRHM, GoI by generating reports (In Excel Format) from DHIS2 web portal of Bihar which is being used for online entry of monthly MIS and FMR from Block Level as well as District/sub-divisional level hospitals.

Status of Data Uploading on Portals:-

Period	District reporting(on NRHM portal)	Facility wise reporting (up to BPHC level) (On DHIS2)
FY 2008-09	450/456 (38 districts X 12 months	-----
FY 2009-10	450/456 (38 districts X 12 months	480 facilities reported every month(Nov 2009-march 2010)
FY 2010-11(up to Nov)	303/304 (38 districts X 8 months)	547 facilities reported every month

- **Use of Information**

  The information available in the system is being used in the formulation of PIP for the FY 2011-2012. To make use of it in the monitoring of health services, state has developed 14 core indicator which is being used for the assessment of program performance of all 38 districts.

- **Feedback process**

  Feedback mechanism is in practice for which we have identified the denominators of different services and on the basis of which service utilization is being monitored. State has calculated expected level of achievement for above mentioned indicators. District is supposed to submit reasons for variance and the strategies to overcome from the deviance on the monthly basis. This strategies has dramatically improved the data quality in the state and civil surgeons are made accountable for the data uploaded in HMIS.

> **HMIS Training**

- **Present Status of HMIS Training**

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

In continuation with the past training programs, following orientation and trainings have been completed in the current FY 2010-11:

A. Formation of HMIS Resource Pool and three days training at State Level

For successful completion of HMIS training for ANMs, LHVs and Data Centre Operators at block level, a HMIS resource Pool was constituted at the State level through standard procedures of selection. A three days residential training for these resource pool members was organized in two batches. These resource pool members have actively facilitated in the block level trainings and also supported the existing team of trainers at the block level. Representatives of ROHFW, Patna and PRC, Patna have also participated in the three days residential training of HMIS Resource Pool members.

B. One Day State Level Orientation

A one day Orientation program at the State level for all the District M&E Officers have been organized in two batches on two different dates. The members of HMIS Resource Pool have been also participated in this orientation. Representatives of ROHFW, Patna and PRC, Patna have also participated in this orientation program.

C. One Day District Level Orientation

The Master trainers who have attended the State level orientation have further completed the district level one day orientation in all 38 districts with the support of NHSRC and IIHMR (UNFPA) resource persons.

D. Two Days HMIS Training at the Block Level

Further the Block level trainers including the MOICs, BHMs, BAMs and BHEs have conducted the actual block level two-days training at the blocks for ANMs, LHVs and Data Center Operators. The two day HMIS training on revised NRHM Format at HSC level, data element and the MCTS registers have been completed in all the 533 BPHCs of Bihar State.

Two Days HMIS Training at the Block Level

E. **Two Days State level HMIS Training for AYUSH Doctors:**

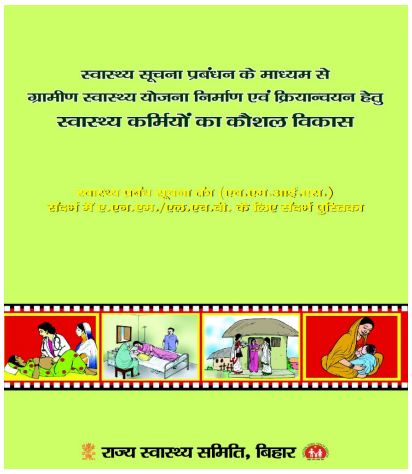
One of the aims of NRHM is to mainstream the AYUSH Department in the state. It was proposed that HMIS training should be given to all the AYUSH doctors so that they can contribute to the HMIS at the APHC and HSC level. They could also do some monitoring and provide handhold support to the ANMs in sending the proper report to the PHCs. In this direction a two days ToT program on HMIS of AYUSH doctors have been given at the state level with the support of SIHFW, Patna, IIHMR (UNFPA) and NHSRC. These doctors will work as Master Trainers at the district level trainings and train all the newly appointed doctors.

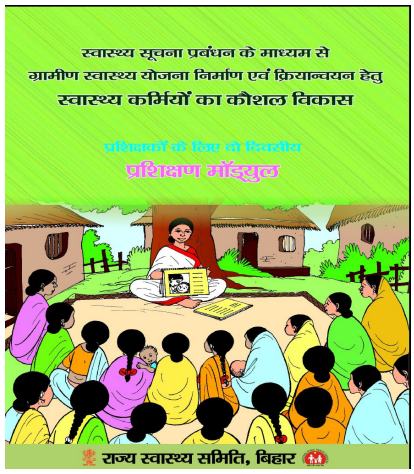
F. Monitoring and Feedback of District Level Orientation

The district level orientation on HMIS was also monitored by the State level officials and the development agencies.

G. Monitoring and Feedback for the Block Level Two Days HMIS Training

The Block level two days training on HMIS for ANMs, LHVs, and Data Center Operators has been successfully completed in all the 533 BPHCs of 38 districts with the active support of HMIS Resource Pool members as facilitators. For quality check and providing feedback, these trainings have continuously been monitored by the SHSB officials and the officials of IIHMR (UNFPA) and NHSRC.





- **Plans for FY 2011-12**

The HMIS system is operational in the State but there are several gaps in the training and analysis of reports for improving the quality of data. Therefore the following activities must be performed in the next financial year 2011-12. Further the state health society will develop guidelines related to data security, safety and privacy

1. Strengthening of Health Management Information System (HMIS)

1.1.Up-gradation and Maintenance of web server of State Health Society

State Health Society, Bihar has its own web server with 2 MBPS leased line connection from BSNL. The following applications are running on this web server-

a) DHIS2 (District Health Information System-2)
b) Online doctor appointment management system
c) Online daily reporting system
d) Website of SHSB

SHSB is in process of developing the following new application-

a) Human Resource Information System (HRIS) with support of NHSRC & Intra Health
b) Drug Inventory Management System
c) Geographical Information System (GIS) of health facilities
d) Other applications as like Online ANM & Nurse appointment management system, Radiology & Pathology Monitoring System etc
e) Customization of DHIS2 for FMR uploading from existing Tally system.
f) Integration of IDSP data in DHIS2

Hence it is very essential to upgrade and maintain the web-server of SHSB.

The detail budget of up gradation and maintenance are as follows:-

S. No.	Items	Amount (Rs.)
A	Up-gradation of Lease line from 2 MBPS to 4MBPS	20,00,000
B	Up gradation of Server with blade server (2 blades), back -up system, UPS, additional hardware/software and miscellaneous	20,00,000
C	Software Development as per local needs	2,00,000
D	Designing, Creation, Maintenance, Registration, Hosting of state web site	1,00,000
E	External Hard Disk: For maintaining the Data Back-up at district level, each district should be given external hard disk @ Rs. 4000/- per year	1,52,000
Total		44,52,000/-

Note: The existing resources available at NIC State HQ will also be utilized as per requirements.

1.2 Plans for the HMIS supportive supervision & data validation in FY 2011-12

The training on HMIS has been completed from state level to the Health Sub Centre level in the FY 2009-2010 & 2010-11. Now for further strengthening of HMIS, continuous hand holding support & monitoring is very essential. Therefore the following activities are required to be performed in FY 2011-2012.

1. The HMIS training for frontline health workers up to HSC level has been completed last year. It has been observed that the reporting and quality of HMIS data has improved substantially after the training. In continuation with the last year activities, State has initiated the strengthening of MCTS implementation with the support of NIC and ICDS. This activity requires continuous handholding and monitoring support in the field. Data validation has to be done by the divisional and district level officials.

2. For handholding support and on the spot orientation of local Health Workers including ANMs, LHVs and Data Center Operators on HMIS, the HMIS Resource Pool members will make visits to the HSC, APHC & BPHC for validation of data and provide feedback to Medical officer in charge & submit the report to the State. The resource person will also provide feedback in state level quarterly meeting in which M&E officer will also be the part of it. One resource person will cover 4 PHC in the frequency of three months and for that one day honorarium @ Rs. 1000/ day will be provided for the same and TA will be provided as actual up to Rs. 1000 & lodging-fooding for one day as per actual up to Rs 1000/day.

3. **Development & Printing of training module on data validation:** A training module will be developed for M&E and BHM on data validation under the 5 components of outreach coverage evaluation such as accessibility, availability, coverage, adequate coverage, effective coverage.

4. **Technical Support in District Level review meeting:** For necessary review of HMIS and assuring the data quality in HMIS, state has initiated to review Civil surgeons on 14 indicators. This initiative has improved data quality substantially in the state. Further, it has been envisioned to extend this initiative at district level. For this, one facilitator from State/divisional level will attend the district level meeting and orient block level managers on data validation. Facilitator would also provide feedback to district magistrate and civil surgeon on block level data analysis. One facilitator will cover at least one district in one quarter. The facilitator may be provided one day honorarium @ Rs. 1000/ and travelling cost @Rs. 2000/ visit & lodging-fooding for one day as per actual up to RS 1000/day.

5. **One day state level quarterly review workshop on HMIS data quality:** For quality movement of HMIS in the State, it is further proposed that the state data quality workshop will be organized on quarterly basis in which all district monitoring and evaluation officers as well as state level resource pool person will participate.

6. Printing of registers and formats : To reduce the duplicity of data recording, State health society has decided that as per the need of programs at the Health Sub Centre, 5 registers may be printed which are 1.Couple survey register ,2.RCH register (MCH , FAMILY PLANNING & RI)3.OPD register,4. Disease control consolidated registers and 5 Administrative register Total Budget: Printing of HMIS Revised Formats and Registers: Rs. 2775252

Detail of the budget

Activity	**Unit cost/ visit (in Rs)**	**Details**	**Total cost in Rs**
Mobility Support to M&E Officers	1000	4 Visits per month per district = 1824	18,24000
Hand holding support	3000	4 visits of each PHC- 533X 4= 2132	6396000
Technical Support in District Level review meeting	4000	152 (1 district / quarter)	608000
Development & Printing of training module on data validation	50	1000	50000
Development charge in Rs	25000		25000
One day quarterly state level review workshop on HMIS data quality	2,00000	4 meetings X 2,00000	8,00000
Printing of registers	Rs. 200 for 5 registers	10666 (9696+10% extra)	21,33,200

Printing of revised NRHM formats	Rs. 1 per page	Revised NRHM formats for HSC, PHC, SDH, DH,DHQ, SHQ etc.	642052
Total Rs			1,24,78,252

1.3 Additional Human resources for HMIS cell at State level

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

SN	Designation of Staff	No. of Staff	Positioned at	Salary (Rs.) per month	Total Salary per year (Rs.)	Total
A	Network Engineer	1	State level	25000	3,00,000	Rs.6, 60,000/-
B	Consultant-MCTS	1	State level	30000	3,60,000	

2. **Establishment of Hospital Information Management System and Tele-Medicine**

A. Establishment of Hospital Management System in all 2 DHs & 2 Govt. Medical Colleges & Hospitals of Bihar.

NRHM has helped the state to increase the service availability at the facilities by which service utilization has increased substantially. Increased service utilization leads to increased patient load in the facilities. Management is now facing to manage the different processes of facility for which electronic intervention is required. By adopting electronic medium, state aims to streamline the processes of facilities and increase the optimal utilization of available resources. Therefore, State Health Society, Bihar has decided to establish Hospital Management System in all 9 DHs and 6 Medical College and Hospitals.

- NRHM has helped the state to increase the service availability at the facilities by which service utilization has increased substantially. Increased service utilization leads to increased patient load on the facilities. This leads to difficulty in managing the processes of facility for which electronic intervention is required. By adopting electronic medium, state aims to streamline the processes of facilities and increase the optimal utilization of available resources.
- Tele-Medicine/Tele-consultation is also essential to provide specialized health care consultation to patients in remote locations. Remote Doctors can have a Tele-Consultation about a patient with the Specialist Doctors available in Medical College & Hospitals. It also gives the facility of video-conferencing among health care experts for better treatment & care and training.
- Hence, as **discussed in the NPCC meeting on 29th March, 2011** we propose that the Hospital Management System and Tele-Medicine/ Consultation may be started in at least 2 District Hospitals which are located remotely and poor performing will be connected to 2 Medical College and Hospitals separately.

B. Establishment of Tele-Medicine/Tele-Consultation in all 2 DHs to 2 Govt. Medical Colleges & Hospitals further connected to AIIMS New Delhi.

- *Healthcare service all over the world is going through phase of transition with globalization and innovation in information technology. Hence use of Information Technology in Healthcare service has been inevitable.*

- *Connected care system reduced to its simplest form is connecting geographically separate health care facilities via telecommunications, video, and information systems –*

    - ***Tele-Consultation:*** *To provide specialized health care consultation to patients in remote locations, Remote Doctors can have a Tele-Consultation about a patient with the Specialists either with or without the presence of the patient.*

    - ***Tele-Surgery:*** *To facilitate video-conferencing among health care experts for better treatment & care, Remote Doctor can have consult expert surgeon in conducting operation.*

    - ***CME Program/ Educational / Public Awareness:*** *To provide opportunities for continuing education of health care personnel, continuing medical education for the Doctors / Specialists which includes seminars & workshops*

The main reasons for a need of Telemedicine/Tele-consulting in the state of Bihar

- ✓ Routine need for medical consultation for citizen centric care
- ✓ Shortage of workforces in PHC and specialists in secondary hospitals
- ✓ Need for cost effective and appropriate healthcare delivery mechanism
- ✓ Better technical infrastructure available for telemedicine
- ✓ 85% population lives in Rural
- ✓ Increased number of cases with AIDS, TB, Cancer and Cardiovascular diseases
- ✓ Inadequate accessibility of specialized healthcare services for a large size of population (85% lives in rural areas)
- ✓ Patients are forced to travel long distances to reach hospitals
- ✓ Low coverage of immunization facilities.

The proposed Integrated budget details for Hospital Information Management System & Tele-medicine/Tele-Consultation System are as follows :-

For 2 Medical College & Hospitals and IGIMS, Patna

Particulars	**Unit cost (in Rs.)**	**Number of units**	**Total Cost for 2 Medical College and Hospitals (in Rs.)**
Hardware	1,70,00000	2	34000000
Software (50 Users)	1,50,00000	2	30000000
Implementation	50,00000	2	10000000
Training	10,00,000	2	2000000
Support Per year (recurring)	3400000	2	6800000
Total Cost in Rs.			**82800000**

For 2 District Hospitals

Particulars	Unit cost (in Rs.)	Number of units	Total Cost for District (36 District Hospitals)
Hardware	70,00,000	2	14000000
Software (10 Users)	30,00,000	2	6000000
Implementation	20,00,000	2	4000000
Training	400000	2	800000
Support (recurring for one year)	1500000	2	3000000
Total cost in Rs.			**27800000**

Leased line /SWAN for complete network connectivity in the state.

Leased line /SWAN for network connectivity of all these 5 Hospitals.

Particulars	Unit cost (in Rs.)	Number of units	Total Cost
Leased line/SWAN	300,000	4	**1200000**

Total Budget for this activity = **Rs. 111800000/-**
Therefore, the total amount of **Rs. 111800000/- (Rs. Eleven Crore eighteen Lacs only)** for Piloting of Hospital Management System and Tele-medicine/Tele-consultation in 2 District Hospitals connected to 2 Medical College & Hospital may be kindly approved.

3. Mobile based data uploading system from HSC level

ANM in health sector is the key person for providing MCH and other basic health services at village level and also for capturing, recording and reporting of health activities. If they are provided a mobile with software they will able to report the MCTS and other data on real time basis. Thus, the services provided by them could also be tracked through this system and accuracy of the report will also be improved.

In view of that the SHSB has planned to implement the system and before that it has sought proposal for doing pilot in two districts (Nalanda & Bhojpur) from BSNL, Patna. The total cost of piloting is Rs.1,39,71,186/- Hence the cost of piloting may be approved so that in future it could be implemented in all over the state.

Sn	Item (CAPEX)	Periodicity	Numbers	Basic Cost	Service Tax 10.3%	Total Cost (Basic Cost + Service Cost)
1	Handset Cost a.) Nokia model no. 2700 @Rs 3364/- or	One time	1,495	Rs.5,029,180/-	Rs.0/-	Rs.5,029,180/-
	b.) Nokia model no.5130 @ Rs.4327/-			Rs.6,467,370/-	Rs.0/-	Rs.6,467,370/-
2	SIM cost- one time @Rs 50/- per SIM	One time	1,495	Rs.74,750/-	Rs.7,699/-	Rs.82,449/-
3	BSNL short-code charge	One time	-	Rs.50,000/-	Rs.5,150/-	Rs.55,150/-
4	Training cost –per man-day for a batch size of 30	One time	-	Rs.10,000/-	Rs.1,030/-	Rs.11,030/-
5	ANM Mobile & Web application cost	One time	-	Rs.1,800,000/-	Rs.185,400/-	Rs.1,985,400/-
6	Monthly Connection Charge	Monthly	Rs.1,49500/- for 1,495 mobile connection @Rs.100/-per connection per month		Rs.15,399/-	Rs.164,899/-
7	CUG-Charge @Rs 60/-	Monthly	1,495	Rs.89,700/-	Rs.9,239/-	Rs.98,939/-
8	Server storage cost	Monthly	-	Rs.12,000/-	Rs.1,236/-	Rs.13,236/-
9	Operation & maintenance cost per month for pilot project	Monthly	2 staff in each dist.	Rs.57,600/-	Rs.5,933/-	Rs.63,533/-
10	Bulk SMS Charge	Monthly billing	-	Rs.0.10/- per SMS to be billed at actual	-	-
11	SMS Cost i) MO ii) MT	Monthly billing	-	i) Covered in monthly connection charge. ii) Rs.0.10/- per SMS to be billed at actual	-	-
	Total cost in Rs.					Rs.1,39,71,186/-

4. Training on Mother and child Tracking System (MCTS) and HRIS

- In the present FY 2011-12, the MCTS training has to be completed. For this, the State has already taken steps such as mapping of all the HSCs and revenue villages has been completed. A state level training on MCTS was conducted for the district level officials at SHSB, Patna and it is already implemented in the state with effect from April 1, 2011. An office order has been sent to all the block PHCs for entry and update of MCTS data from the village level since April, 2010.

- For further improvement and strengthening the quality of MCTS data, a two days training is required for all the health staffs up to HSC level. This training platform may also be used for providing training on HRIS and the refresher HMIS training including the NRHM format.

- Therefore in FY 2011-12, Training on Mother and child Tracking System (MCTS) is required for all the health officers and staffs such as State Level Officers/ Consultants, CS, ACMO, DPM, DAM, District M & E Officer, District Level other Programme Officers/Consultants, MOIC, BHM, BAM, Health Educator, Grade "A" Nurses, ANM and LHV etc. The total cost of the training is Rs **1,44,40,800/-**

The details are as follows:-

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

Budget

(i) TA/DA Cost for Trainees (for 2 days)- Rs. 200/- per day per trainee x 2 x 24068	Rs. **9627200/-**
(ii) Miscellaneous for Trainees (for 2 days) = Rs. 100/- Per day Per trainee x 2 days x 24068	Rs. **4813600/-**
Total	**Rs. 1,44,40,800/-**

Final Budget sheet:-

Sub -head	Total budget (Rs.)
B15.3.2: Computerization HMIS and e-governance, e-health	
Activity 1: Establishment of Hospital Management System and Establishment of Tele-Medicine/Tele-Consultation	111800000
Activity 2: Mobile based data uploading system from HSC level	13971186
Activity 3: Training on MCTS and Human Resource Information System (HRIS)	14440800
RI monitoring	6293000
CPSMS	100000
B15.3.3: Other M&E	
Activity 1: Strengthening of HMIS (up-gradation and maintenance of Web server of SHSB)	4452000
Activity 2: Plans for HMIS supporting supervision and data validation	12478252
Total	**16,35,35,238/-**

II. Data Centre (PPP) – Budgeted in Part-B

A. STATE DATA CENTRE :

State Health Society, Bihar is implementing various health programmes under National Rural Health Mission in the State. Further, each programme has several components of activities. In order to formulate the effective plan of schemes, monitoring and evaluation of the on-going programme requires various data/information from time to time.
At state level, State Data Centre has been set up in State Health Society, Bihar through outsource. The State Data Centre collects data/information from Health Institution/Hospital of all 38 districts on monthly/as per need basis through Fax/E-Mail. The Collected data are stored and maintained in a computerised format and they are then sent to respective Programme Officers according to their requirements. The collected data includes all the parameters required under RCH/NRHM for monitoring. The State Data centre has the following facilities:-

Supervisor-1 (One), Computer Opreators-4 (Four),Computers with UPS -5(Five),Laser Printers with Fax & Photo Copy Facility -1(One), Fax Machine with Auto Sending & Receiving Facility -1 (One), Telephone connection (with Broadband connection) -4(Four), EPABX-Telephone Network System, All necessary furnitures- As Required

With the increasing load of different programme's, uploading of data/information of patient load (IPD & OPD) on daily basis, capturing attendance of Medical Personnel from PHC to State, assessing OPD load in APHCs and to capture performance of AYUSH doctor posted at APHC, extra manpower and equipments is required for State Data Centre. In order to accomplish the task the existing State Data Centre needs further upgradation /expansion . As

the same time new Data Centre at APHC also shall have to be setup .Proposal for setting up Data Centre at APHC has been dealt in following section separately. For maintenance of quality/accuracy of data/information, Programmer, Supervisor and Computer Operator of State Data Centre will now have pre defined requisite qualification and experience .Therefore it is proposed that skilled & experienced Programmer, Supervisor and Computer Operator of State Data Centre will be paid enhanced wages. So the outsource agency will pay not less than Rs. 12,000/- (Rupees Twelve Thousand Only), Rs. 10,000/- (Rupees Ten Thousand Only) and Rs.8,000/- (Rupees Eight Thousand Only) per month for Programmer, Supervisor and Computer Operator respectively. The State Data Centre will be connected to Divisional Data Centres (R.P.M.U.) through Video Conferencing. The Structure of upgraded State Data Centre is being proposed as follows:
Programmer-1(One), Supervisor-2 (Two), Computer Opreators-10 (Ten), Laptop /Computers with UPS -12 (Twelve), Necessary software, Laser Printers with Scanner, Fax & Photo Copy Facility -2 (Two), Fax Machine with Auto Sending & Receiving Facility -1 (One), Telephone connection (Broadband connection) -8 (Eight), EPABX- Telephone Network System, All necessary furniture, accessories and others miscellaneous .
Estimated Budget

(a) for State Data Centre
Rs.190,000/- X 7 Month =Rs.13,30,000/-+50,000x5 = 1,50,000 = **15,80,000**/-
(b) Micellaneous Expenses at State level
Rs. **5,06,048**/- (Rupees Five Lacs Only)

Total Budget for State Level: (a) + (b)

Rs. 15,80,000/- + Rs 5,60,000/-= Rs. 20,86,048/-

B. DISTRICT & BLOCK DATA CENTRE :
At District and Block level, District & Block Data Centre have been set up through outsourcing. The main purpose of these Data Centres is to gather and maintain health related data under RCH/NRHM programme .The Data Centres enter and upload the monthly MIS reports and FMR in revised HMIS formats on Web-portals of Government of India. The payment of these Data Centre are performance based. Performance of these Data Centre will be reviewed by a three/ four membered committee of the concerned Offices or Hospitals. These Data Centres are of following structure.
Computer with UPS:- (P-IV, 1 GB RAM, 1 Web Camera with UPS)
Laser Printer with Scanner
Telephone
Internet Connection (with unlimited uploading & downloading facilities through GPRS or Data Card)
Computer Operator Salary
Misc. (Pen Drive, Etc, CD, Travelling, others)

Presently provision of following number of Data Centres in diference Hospital / Offices are as follows:-

Primary Health Centre (PHC)	533 X 1 = 533
Sub-Divisional Hospital (SDH)	40 X 1 = 40
District Hospital (DH)	36 X 1 = 36

Office of Divisional Commissioner	9	X	1	= 9
District Health Society (DHS)	38	X	1	= 38
Medical Colleges Hospitals	6	X	4	= 24

(Each Medical Colleges Hospitals 4 DC each)

Total No. of District & Block Data Centre 625

Proposed for FY 2011-12
Estimated Budget for District & Block Data Centre

625 District & Block Data Centre X Rs.7,500 X 12 Month = **Rs. 5,62,50,000 /-**

C. DIVISIONAL DATA CENTRE AT R.P.M.U. :

State Health Society, Bihar is implementing various health programmes under National Rural Health Mission in the State. Further, each programme has several components of activities. In order to formulate the effective plan of schemes, monitoring and evaluation of the on-going programme requires various data from time to time.

For strengthening Monitoring & Supervision of State & Division, Divisional Data Centre at 9 Divisional Headquarters i.e. Patna, Gaya, Muzaffarpur, Bhagalpur, Purnia, Chapra, Saharsa, Darbhanga and Munger have been set up under outsourcing by a agency, selected through open tender. Divisional Data Centre is located in the Regional Programme Management Unit (R.P.M.U.).

Divisional Data Centre has the following facilities :

(1) Supervisor- 1 (One)-
Minimum qualification:- PGDCA/ PGDIT/ BCA from recognized University with 5 years of Experience in the Government Sector / International Agencies. Excellent communication skill.

(2) Computer Operators- 4 (Four)
Minimum qualification:- DCA/ DIT/ BCA with 3 years Experience.

(3) Computer with UPS - 5 (Five)
Minimum requirement:- Intel Core 2 duo processor, DVD Writer, 320 GB HDD, 2 GB RAM,19'' TFT Monitor

(4) Laser Printers with Fax, Scanner & Photo Copy Facility - 1 (One)

(5) Telephone connection (with Broadband connection) - 4 (Four)

(6) All necessary furniture's - As Required

Estimated Budget

(a) Divisional Data Centre (R.P.M.U.)

9 Divisional Data Centre X Rs.42,444 X 12 Month = **Rs. 45,83,952/-**

Summary of Estimated Budget

S.No	Component	Estimated Budget Rs.
1	STATE DATA CENTRE+ Miscellaneous Expens.	**20,86,048/-**
2	DISTRICT & BLOCK DATA CENTRE	**5,62,50,000**
3	DIVISIONAL DATA CENTRE AT R.P.M.U.	**45,83,952/-**
	Total Rs.	**6,29,20,000/-**

III. Community Based Planning and Monitoring (CBPM)

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

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

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

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

Keeping this in view, the State Government initiated the process of CBPM in the three selected districts as pilot intervention. In the FY 2010-2011, a State Technical Advisory Group for Community Action (SAGCA) has been formed for providing advisory support to the state for implementing the process in the state. Based on the SAGCA recommendations, a State Technical Assistance Group (STAG) has also been formed for providing technical assistance to the state for the process.

Population Foundation of India (PFI) has been given the responsibility to be the State Nodal-cum- Technical Agency for facilitating the process in the State as PFI is the National Secretariat for implementing the project on Community Based Monitoring and has experience on implementing a pilot project on Community Monitoring in the nine states of India with the support from the Ministry of Health & Family Welfare, Govt. of India. The foundation has been providing technical assistance and even facilitating the process of CBPM in the state.

Currently, the CBPM process has been initiated in the three districts namely Bhagalpur, Darbhanga and Nawada taking two blocks from each district for pilot intervention. The villages from five selected Panchayats have been taken for implementation of CBPM process. In the next financial year, the CBPM process would be implemented in the two additional districts i.e. altogether in five districts. The five panchayats and all the villages from the selected blocks would be taken for implementing the process.

In these selected blocks, focus would be given on convergence. The different convergent activities would also be implemented in order to improve the health outcomes. More focus would be given on strengthening VHSND, VHSCs and quality of care.

The CBPM committees would be formed at different level under the guidance of SAGCA and with the facilitation of State Nodal-cum-Technical Agency. In order to resolve the grievance raised at different level for improving the health outcomes, a grievance redressal mechanism may be explored in consultation with the development partners and other govt. line departments.

Objectives of Community Planning and Monitoring

Following are the objectives of Community Planning and Monitoring

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

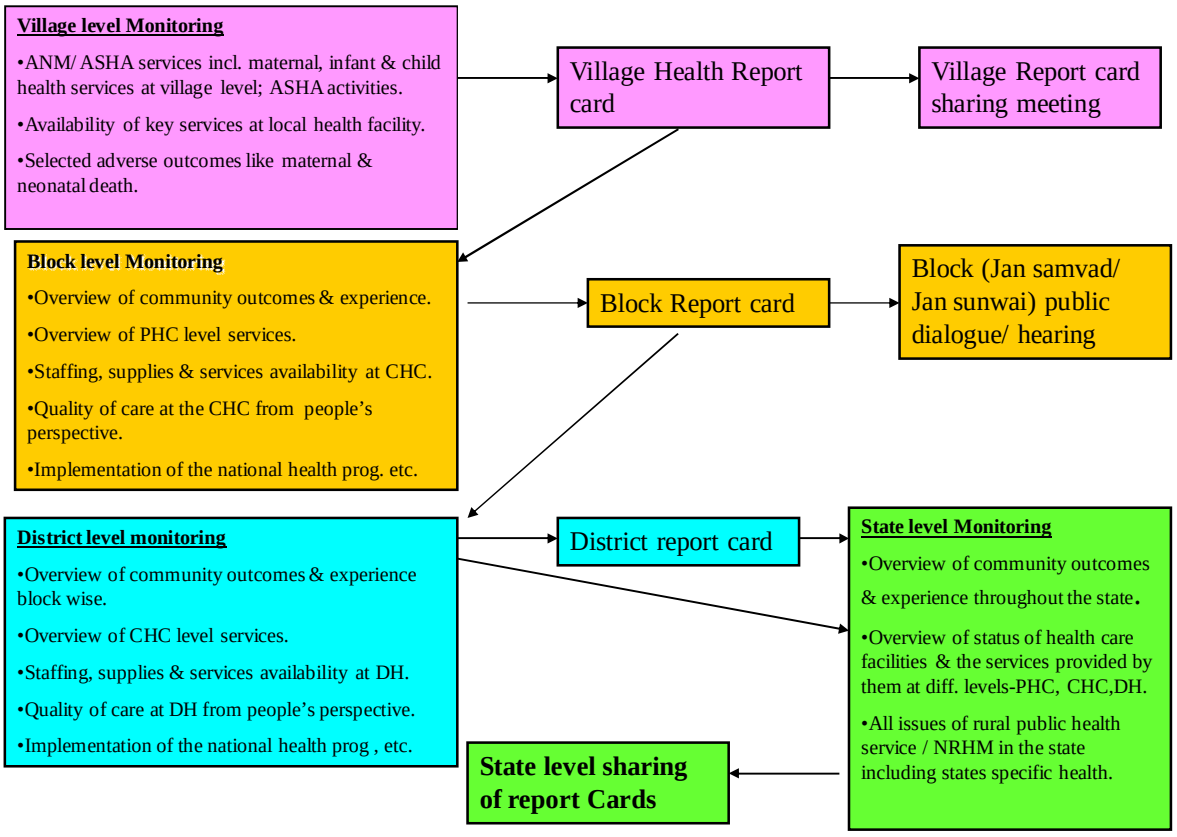
context of the public health system.

- It can also be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

Process of Community Planning and Monitoring

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

Issues & Process of CBPM at different levels



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

- Village Health Plan

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

Levels of Planning and Monitoring Committees

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

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

State Level Advisory Group on Community Action

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

Composition

The Committee will comprise of

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

Roles and Responsibilities

- Conceiving and planning the entire intervention.
- Periodic review.

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

State Level Technical Assistance Group-:

The state level technical assistance group for community action has been formed with following objectives:-

a. Providing technical assistance on the following four core components of Community Based Planning and Monitoring (CBP&M) of health services under NRHM in Bihar

  - Developing strategy for community mobilization & intervention
  - Developing training modules for various capacity building initiatives for different stakeholders at village, block, district and state level
  - Developing specific IEC/ BCC materials and manuals
  - Concurrent monitoring & supportive supervision at village, block and district level for effective implementation of CBP&M

- Coordinate efforts including liaisoning to strengthen communitisation in health services.

<u>STAG will perform following tasks related to CBPM:</u>

- Suggest strategies for CBPM intervention at different levels.
- Providing technical inputs for developing training modules for different stakeholders, IEC / BCC materials, report card, facility card,etc.
- Regular field visits to monitor the progress and feedback sharing with the State Health Society, Bihar.
- Regular meeting to review the progress of program implementation at different levels and to provide suggestions for gearing up the programme.
- Suggest new interventions in upcoming years PIP for improving the implementation of CBP&M program.

State Health Monitoring and Planning Committee

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

Secretary would be one of the CSO coalition representatives.

Roles & Composition of Planning & Monitoring Committees at Different level

Planning & Monitoring committees	Role of committees	Composition
STATE HEALTH PLANNING AND MONITORING COMMITTEE	1. Discuss programmatic and policy issues. 2. Review and contribute to State Health Plan & NRHM Perspective plan. 3. Issues arising from District Health Committees relating to state action. 4. Institute a Health rights redressal mechanism. 5. Assessing progress made in implementing the recommendations of the NHRC, to actualize the Right to health care at the state level. 6. Proactive role to share information received from GOI	1. 30% members be elected reps in legislative body (MLAs /MLCs) or Convenors of Health committees of ZPs by rotation 2. 15% be non-official members of District committees, by rotation 3. 20% members be representatives from State Health NGO coalitions 4. 25% members would belong to State Health Department incl Secretary HFW, Commissioner Health, officials from Dt. of Health Services, NRHM Mission Director) along with experts from SHRC / SPMU 5. 10% members be officials belonging to other related departments 6. The Chairperson be one of the elected members (MLAs). 7. The executive chairperson would be the Secretary HFW. 8. The secretary be one of the NGO representatives.

Power(s) of the committee

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

Yardsticks for Monitoring at State Level

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

Tools for Monitoring at State Level

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

District Health Monitoring and Planning Committee

The committee constituted at the district level would contribute to the development of District Health Plan. This committee would have members drawn from service providers, representatives of Panchayat and Block level planning and monitoring committees and

representative of panchayts.

Planning & Monitoring committees	Role of committees	Composition
DISTRICT HEALTH PLANNING AND MONITORING COMMITTEE	1. Discuss Health committees from lower levels, Financial reporting and solving blockages in flow of resources. 2. Monitoring of physical resources at all District Health facilities 3. Progress report of Health facilities esp referral utilisation. 4. Charting out Integrated District Health Aaction Plan 5. Ensuring proper functioning of the RKS. 6. Discussion on Health Policy of the state level – local relevance. 7. Initiate action on instances of denial of right to health care.	1. 30% members be representatives of the Zilla Parishad (esp. convenor and members of its Health committee) 2. 25% members be district health officials, including DHO/ CMO/ Civil Surgeon and representatives from DPMUs 3. 15% members be non-official representatives of block committees, with annual rotation. 4. 20% members be representatives from NGOs / CBOs 5. 10% members be representatives of RKSs in the district 6. The chairperson be one of the ZP representatives, preferably convenor of the Zilla Parishad Health committee. 7. The executive chairperson be CMO / CMHO / DHO . 8. The secretary be one of the NGO / CBO representatives

Yardsticks for Monitoring at District Level

- Charters of Citizens Health Rights
- District Action Plan
- NRHM guidelines
- Indian Public Health Standards

Tools for Monitoring at the District Level

- Report from the Block Health Planning and Monitoring committee
- Report of the District Mission committee
- Public Dialogue (Jan Samvad)

Block Health Planning and Monitoring Committee –

Planning & Monitoring committees	Role of committees	Composition
BLOCK HEALTH MONITORING AND PLANNING COMMITTEE	1. Consolidation of village health plans 2. Charting out the annual health action plan & a PHC Health Plan 3. Disseminate Charter of citizen's health rights 4. Monitoring of physical resources at PHC 5. Coordinate with local CBOs and NGOs 6. Review functioning of Sub-centres operating under the PHC 7. Initiate action on instances of denial of right to health care.	1. 30% members : representatives of Panchayati Raj Institutions (Panchayat Samiti member from the area; two or more sarpanchs) 2. 20% members - non-official representatives from VHSCs with annual rotation to enable representation from all the villages 3. 20% members representatives from NGOs / CBOs in the area 4. 30% members representatives of providers, MO, ANM. 5. The chairperson be one of the Panchayat representatives, 6. The executive chairperson be Medical officer of PHC. 7. The secretary be one of the NGO / CBO representatives

Powers of the committee

- Contribute to annual performance appraisal of Medical officer/other functionaries at the PHC and CHC.
- Take collective decision about the utilization of the special funds given to PHC for the repairs, maintenance of equipments, health education etc and any other aspects, which will facilitate the improvement of access to health care services. The MO/ACMO can utilize this fund after the discussion and approval from the committee.

Yardsticks for Monitoring at Block level

- IPHS or similar standards for PHC (this would include continuous availability of basic outpatient services, indoor facility, community outreach services, referral services, delivery and antenatal care, drugs, laboratory investigations and ambulance facilities).
- Charter of Citizens Health Rights for PHC CHC
- Block Health Plan.

Tools for Monitoring at Block level

- Village health registers/calendars
- PHC records
- Discussions with and interviews of the PHCRKS members
- Report of Public dialogue (Jan Samvad)
- Quarterly feedback from village and PHC Health Committees

- Periodic assessment of the existing structural and functional deficiencies

Community based planning and monitoring at Village Level:-

Planning & Monitoring committees	Role of committees	Composition
Village Health Planning and Monitoring Committee (VHSC)	1. Create Public Awareness about the health programs. 2. Discuss and develop Village Health Plan manage health fund. 3. Participatory Rapid Assessment: to ascertain major problems 4. Maintenance of a village health register and health information board/calendar 5. Ensure that ANM and MPW visit the village on fixed days 6. Get bi-monthly health delivery report from service providers 7. Discuss every maternal & neonatal death in village	1. Gram Panchayat members from the village 2. ASHA, Anganwadi Sevika, ANM. 3. SHG leader, the PTA Secretary, village representative of any Community based organisation working in the village, user group representative 4. The chairperson would be the Panchayat member 5. Convener would be ASHA / Anganwadi Sevika of the village. 7. Formed at level of revenue village (more than one such villages may come under a single Gram Panchayat).

Powers of the Committee

- The Committee would monitor that Rs. 10000.00 is used for development works by the PRI committee.
- Planning and Monitoring

Yardsticks for Monitoring at Village Level

- Village Health Plan
- NRHM indicators translated into Village health indicators.

Tools for Monitoring at Village Level

- Village Health Card, Facility Score Card, Report Card etc.
- Village Health Register.
- Records of the ANM
- Village Health calendar
- Infant and maternal death audit
- Public dialogue (Jan Samvad)

In other states, as envisioned under NRHM, a Village Health and Sanitation Committee (VHSC) has been formed as the institutional mechanism at the village level. A Policy decision

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

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

Geographical Coverage:

In the current financial year, the state would implement the CBPM process in the five selected districts of the state. In the FY 2010-2011, the state has initiated the process in the two selected blocks from each of the three already piloted districts namely Bhagalpur, Darbhanga and Nawada. Two additional districts would be taken for implementing the process in the current financial year. From each of the five districts, two blocks and five panchayats would be selected for implementing the process. PFI would provide the technical and managerial support to the state for implementing the CBPM process.

Role of Civil Society Organisations

Civil Society Organisations i.e. Community Based Organisations (CBOs) and Non Governmental Organisations (NGOs) have three kinds of roles in the process of community based planning and monitoring: Members of the monitoring committees: Social organisations working in close, regular contact with communities on health related issues, especially from a rights-based perspective, would be able to present in the monitoring committees at different levels.

Resource groups for capacity building and facilitation: NGOs and CBOs will have the responsibility for overall facilitation of the initial process of committee formation and capacity building of community monitoring committee members about the process of community based monitoring. It includes the roles of members at different levels, including peripheral committees at Panchayat and village levels.
Based on national model material, training modules and materials for orientation of community monitoring committee members would be adapted and published at state level and used for this capacity building process at different levels. All three types of members –

Panchayat representatives, civil society organisations and health system functionaries would benefit from such capacity building. NGOs and CBOs would contribute to the collection of information relevant to the monitoring process at all levels from the village to state level. In these processes, an element of community mobilization may be involved. Specific teams would dialogue with communities and would collect and process community-based information.

There would be one State Nodal –cum- Technical Agency which would engage the CSOs at district and block level in close coordination with the State Health Society Bihar. The State would adopt the process of engaging district and block level CSOs based on the implementation framework of Community monitoring carried out in the nine states of India as the framework was agreed by the Govt. of India, State Governments of the respective states and the implementing partners.

State Level Nodal-cum-Technical Agency for facilitating CBPM:

Population Foundation of India (PFI) will provide technical as well as managerial support to the state for implementation of Community Based Planning and Monitoring at State / District / Block level. During the current financial year, PFI will extend its support to the state for implementing the CBPM process in the five selected districts (three currently pilot districts namely Bhagalpur, Darbhanga and Nawada and two new districts selected by the state).

Roles and Responsibilities of the State Nodal-cum-Technical Agency

- Coordinating and facilitating activities of the State preparatory phase, which includes developing tools, model curriculum, workshops, awareness materials and documentation formats for the programme.
- Assist the SAGCA members and the state NRHM Directorates and CSO networks for the state preparatory and implementation stage.
- Arrange for technical and resource support to district/block level NGOs.
- Facilitate process documentation and review of the pilot implementation phase in consultation with SAGCA members.
- Provide progress, process and financial reports and documents to State Health Society Bihar on a regular basis.
- Facilitate in conducting quarterly review of SAGCA for review of the pilot programme.
- Facilitate in conducting monthly meeting of STAG for strengthening the pilot programme.
- Assist in implementing the decisions taken at the CBPM Commitees at different levels.
- Facilitate in arranging for technical and managerial support to district/block level CSOs.
- Support the process of adaptation, translation and publication state level materials/manuals.
- Financial support and disbursement to district level and block level processes.
- Facilitate and supervise progress and support processes/activities at the district, block and community levels.

District Nodal Agency

- Assist in implementing decisions taken by State and District level monitoring / mentoring group.
- Arrange for technical and resource support to district/ block level NGOs.
- Support process of adaptation, translation and publication state level materials/manuals.
- Supervise community level documentation processes.
- Coordinate with State Level Nodal-cum-Technical Agency.
- Coordinate with district officials – Civil Surgeon; Zilla Parishad, District Monitoring Team.
- Mobilisation and capacity building at district level.
- Collation of records and reports.
- Financial management.
- Mobilisation and capacity building at district and block level.
- Declaring, dissemination – health entitlements within rights based approach.
- Reflect community/spokespersons of community concerns, experiences.
- Form committees at the village, Panchayat and block if such committees have not been formed.

Block Level Agency:

At the block level, there would be a Block Nodal Agency in coordination with District Nodal NGO. The block level NGOs will be involved for the execution of community based planning and monitoring at block, panchayat and village level. Following would be the role of the block level nodal agency:

- Mobilisation and capacity building atblock level.
- Form committees at the village, panchayat and block if such committees have not been formed.
- Coordinate with- Block Medical Officer; village Panchayat, Panchayat Samitis, District monitoring team.
- Supervise block facilitators for the execution of the Community Monitoring at block and village level.
- Community mobilisation at village level.
- Encouraging participation of all stakeholders in community monitoring process.
- Conduct Jan Samvad at village, Panchayat and block level.
- Supervise community level documentation processes.
- Organize VHSC and other community level trainings/orientations.
- Handholding of VHSC members for community inquiry and preparation of report card

BUDGET FOR IMPLEMENTATION OF COMMUNITY BASED PLANNING AND MONITORING INITIATIVES		
Sl. No.	**Activity**	**Total Budget (in Rs.)**
1	Quarterly meeting of SAGCA	104000
2	Monthly meeting of STAG members	60000
3	State Level Training of Trainers (including orientation of State Level Planning and Monitoring Committee members) by AGCA/STAG/State Nodal -cum - Technical Agency	54000
4	State level workshop to finalize the modalities of village level intervention (*with AGCA members, STAG,State Planning and Monitoring Committee members and developmental partners*)	69000
5	Advertisement for CSOs selection at Block Level to facilitate the process at village level	150000
6	District level ToT for Block Level Trainers Resource Pool (3 Days')(includes Stae Level resource person, 10 persons from each block etc.)	344500
7	Skill Development training for DCM, BCM and District trainers to strengthen the community process in NRHM	114500
8	Two days' State Level Consultative workshop for preparation of training module for Kalajatthas, Village Plannning and Monitoring Committee and CSOs- for facilitation and Orientation of Village Planning and Monitoring Committee.	71000
9	Development and printing of BCC / IEC Materials	1025000
10	State level ToT for Kalajatta team	36000
11	Conduction of Kalajatha at village level	900000
12	Formation of Village level Planning and Monitoring Committee by CSO	1500000
13	Two rounds of Orientation cum Training of Village Planning and Monitoring Committee at Panchayat level	1530000
14	Data Collection and analysis of Village level report cards, health facility card, preparartion of village health plans	1500000
15	Conduction of Quarterly Block Level Jan Samvad in each of the pilot blocks	800000
16	Orientation of block level Planning and Monitoring Committee by CSO at district level	47500
17	Orientation of District level Planning and Monitoring Committee	57500
18	Orientation of State level Planning and Monitoring Committee	11100
19	Quarterly meeting of block level Planning and Monitoring Committee by CSO	37500
20	Meeting of District level Planning and Monitoring Committee	30000
21	Meeting of State level Planning and Monitoring Committee	10000

22	Block level consultative meeting with blcok level officials and CSOs for exploring the grievance redressal mechansim for CBPM	45000
23	District level consultative meeting with district officials and CSOs for exploring the grievance redressal mechansim for CBPM	27500
24	District Level Dissemination and planning Workshop on Community Planning and Monitoring	158500
25	Facilitation cost to State Nodal-cum-Technical Agency (including HR, technical and managerial support, monitoring, reporting, documentation etc.)	1000000
26	Concurrent Monitoring Visits by State Planning and Monitoring Members / State Advisory Group for Community Action Members	600000
27	Documentation including process documentation (including reports, case studies, success stories, designing, composing and editing)	100000
28	Documentary (multilocation of 30 minutes as per Govt. approved rate of Dept of Public Relation)	200000
29	Coordination Expenses (per block) for CSOs (including HR and other admin and programme supporting expenses) (Rs. 150000/- per block for 10 blocks)	1500000
30	District level Contingency(Rs.4000/- Per month per District x 12 months)	240000
31	Contigency State Level	500000
	Total Cost	***12822600***

WORK PLAN FOR IMPLEMENTATION OF COMMUNITY BASED PLANNING AND MONITORING INITIATIVES													
Sl. No.	**Activity**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Jan-12**	**Feb-12**	**Mar-12**
1	Quarterly meeting of SAGCA												
2	Monthly meeting of STAG members												
3	Field Visit of SAGCA/STAG Members												
4	Consultative meeting with DM/CS by State representative at district level (two additional) for selection of blocks and Panchayats												
5	Consultative meeting with MOIC/BHM by State representative at district level for orientation of the CBM process												
6	State Level Training of Trainers (including orientation of State Level Planning and Monitoring Committee members) by AGCA/STAG/State Nodal -cum - Technical Agency												
7	State level workshop to finalize the modalities of village level intervention (*with AGCA members, STAG,State Planning and Monitoring Committee members and developmental partners*)												
8	Advertisement for CSOs selection at Block Level to facilitate the process at village level												
9	Selection of Nodal NGOs at Block level												
10	District level ToT for Block Level Trainers Resource Pool (3 Days')(includes Stae Level resource person, 10 persons from each block etc.)												
11	Skill Development training for DCM, BCM and District trainers to strengthen the community process in NRHM												

12	Identification of State Level Community Planning and Monitoring Group members ; identification of trainers and other members													
13	Identification of Kalajatta team / agency													
14	Two days' State Level Consultative workshop for preparation of training module for Kalajatthas, Village Plannning and Monitoring Committee and CSOs- for facilitation and Orientation of Village Planning and Monitoring Committee.													
15	State level ToT for Kalajatta team													
16	Identification of Community Level Artists for Kalajattha performances by CSO													
17	Conduction of Kalajatha at village level													
18	Formation of Village level Planning and Monitoring Committee by CSO													
19	Formation of block level Planning and Monitoring Committee by CSO													
20	Formation of District level Planning and Monitoring Committee													
21	Formation of State level Planning and Monitoring Committee													
22	Monthly meeting of Village level Planning and Monitoring Committee by CSO													
23	Quarterly meeting of block level Planning and Monitoring Committee by CSO													
24	Quarterly meeting of District level Planning and Monitoring Committee													
25	Quarterly meeting of State level Planning and Monitoring Committee													

26	Orientation of block level Planning and Monitoring Committee by CSO												
27	Orientation of District level Planning and Monitoring Committee												
28	Orientation of State level Planning and Monitoring Committee												
29	Filling up of Village Health Card												
30	Filling up of Village Facility Card												
31	Data gathering and preparation of Report Card												
32	Preparation of Village Health Plan												
33	Conduction of Report Sharing Meeting at Panchayat level												
34	Conduction of Jan Samvad at Block level												
35	Block level consultative meeting with blcok level officials and CSOs for exploring the grievance redressal mechansim for CBPM												
36	District level consultative meeting with district officials and CSOs for exploring the grievance redressal mechansim for CBPM												
37	District Level Dissemination and planning Workshop on Community Planning and Monitoring												
38	District level monthly review meeting with CSO partners and block level health officials												
39	Monitoring Visits by State Level Planning and Monitoring Group members / STAG/SAGCA Members												
40	Documentation including process documentation												
41	Preparation of Documentary												

BUDGET FOR IMPLEMENTATION OF COMMUNITY PLANNING AND MONITORING IN SELECTED FIVE DISTRICTS OF BIHAR							
							Amount in Rs.
Sl No.	**Particulars**	**Unit Cost**	**Units**	**Total Cost**	**Gross Total**	**Level from where the funds will be utilized**	**Level wise approved amount**
1	**One Day State Level Advisory Group Meeting (4 times)**				**104000**	State	104000
	Lunch for Participants (As per actual)	200	20	4000			
	National Level Resource person (one) travel (Reimbursement of Economy Class Air Fare/ IInd AC) (As per actual)	15000	1	15000			
	Honorarium to Resource Person (one)	1000	1	1000			
	Lodging and Fooding for Resource Person (one resource person for 2 days) (As per actual)	2500	2	5000			
	Stationary for Participants	50	20	1000			
	Total budget for 1 Advisory Group Meeting			26000			
	Total amount for conducting 2 Advisory Group Meeting	**26000**	**4**	**104000**			
2	**Monthly Meeting of State Level Technical Assistance Group**						
	Lunch for Participants (As per actual)	200	20	4000	**60000**	State	60000
	Stationary for Participants	50	20	1000			
	Total budget for 1 STAG Meeting			5000			
	Total amount for conducting 12 STAG Meeting	**5000**	**12**	**60000**			
3	**State level ToT (2 Days') at SIHFW (includes Stae Level planning and**				**54000**	State	54000

	monitoring committee members, AGCA members)						
	Banner	500	2	1000			
	Hall Charges	2000	2	4000			
	PA System	1000	2	2000			
	LCD (from SHSB)	1000	2	2000			
	Fooding 200/- per person x 35 participants x 2 Days (including organisers and trainers)	7000	2	14000			
	National Level Resource person (one) travel (Reimbursement of Economy Class Air Fare/ IInd AC) (As per actual)	15000	1	15000			
	Honorarium to Resource Person (one)	1000	2	2000			
	Lodging and Fooding for Resource Person (one resource person for 2 days) (As per actual)	3000	3	9000			
	Stationary for ToT including photocopy etc.	100	25	2500			
	Stationary for Participants	100	25	2500			
	Sub Total			**54000**			
3	**State Level Workshop to finalise the modalities of village level interventions State Health Society, Bihar (includes AGCA Members, Stae Level planning DPM, MOIC, ACMO) {4 representatives from each district)**				**69000**	State	69000
	Banner	500	1	500			
	Hall Charges	2000	1	2000			
	PA System	500	1	500			
	LCD (from SHSB)	1000	1	1000			
	Travel 1000/- per person bus/train fare x 12 (4 persons from each district) (As per actual)	1000	12	12000			
	Food 200/- per person x 40 participants (including organisers and trainers)	200	40	8000			
	National Level Resource person (one)	15000	1	15000			

	travel (Reimbursement of Economy Class Air Fare/ IInd AC) (As per actual)						
	Honorarium to Resource Person (one)	2000	1	2000			
	Lodging and Fooding for District People (participants will come one day prior) Rs. 400/- per participant per day x 20 participants x 3 days	8000	2	16000			
	Lodging and Fooding for Resource Person (one resource person for 2 days) (As per actual)	2500	2	5000			
	Stationary for Workshop including photocopying	75	40	3000			
	Stationary for Participants	100	40	4000			
	Sub Total			**69000**			
4	**2 days' State Level Consultative workshop for preparation of Module for training of Kalajatthas, Village Plannning and Monitoring Committee and CSOs**				**71000**	State	71000
	Banner	500	2	1000			
	Hall Charges	2000	2	4000			
	PA System	500	2	1000			
	LCD (from SHSB)	1000	2	2000			
	Travel 800/- per person bus/train fare x 20 (4 CSO/BCM/DCM members from each district) (As per actual)	800	20	16000			
	Fooding 200/- per person x 35 participants x 2 Days (including organisers and trainers) (As per actual)	7000	2	14000			
	Honorarium to Resource Person (one)	2000	2	4000			
	Lodging and Fooding for District People (participants will come one day prior) Rs. 400/- per participant per day x 20 participants x 3 days	8000	3	24000			

	Stationary for Consulttaive meeting including photocopy etc.	100	25	2500			
	Stationary for Participants	100	25	2500			
	Sub Total			**71000**			
5	**Selection of NGOs**				**150000**	State	150000
	Advertisement (in 3 leading newspaper)	150000	1	150000			
	Sub Total			150000			
6	**District level ToT for Block Level Trainers Resource Pool (3 Days')(includes Stae Level resource person, 10 persons from each block etc.)**				**344500**	State (Rs. 142000/-) & District (40500/- per district)	State (Rs. 142000/-) & District (40500/- per district)
	Hall Charges	2000	3	6000			
	LCD and PA System	1500	3	4500			
	Fooding 250/- per person x 30 participants x 3 Days (including organisers and trainers) (As per actual)	7500	3	22500			
	Stationary for Participants	150	30	4500			
	Local Conveyance for State Level Resource Persons (Two Vehicle for 3 days)	4800	3	14400			
	Honorarium to Resource Person (Two) @ Rs. 1000/- per day per resource person as per Govt. norms	2000	3	6000			
	Lodging and Fooding for Resource Person (Two resource person for 4 days @ Rs. 1000/- per day per resource person) (As per actual Govt. Rate)	2000	4	8000			
	Miscellaneous	3000	1	3000			
	Total Cost for Organising one District Level ToT			**68900**			
	Total Cost for Organising Three District Level ToT in three districts	**68900**	**5**	**344500**			
7	**4 day's Skill Development training for DCM, BCM and District trainers to strengthen the community process in NRHM (State level)**				**114500**	State	114500

	Hall Charges	2000	4	8000			
	PA System	500	4	2000			
	LCD (from SHSB)	1000	4	4000			
	National Level Resource person (one) travel (Reimbursement of Economy Class Air Fare/ IInd AC) (As per actual)	15000	1	15000			
	Lodging and Fooding for Resource Person (one resource person for 2 days) (As per actual)	2500	4	10000			
	Travel 1000/- per person bus/train fare x 15 (2 persons from each block & 2 person from district level) (as per actuals)	1000	15	15000			
	Fooding 200/- per person x 25 participants (As per actual) x 4 days	5000	4	20000			
	Honorarium to Resource Person (Two) @ Rs. 2000/- per day per resource person	2000	4	8000			
	Lodging and Fooding for District People (participants will come one day prior) Rs. 400/- per participant per day x 15 participants x 5 days	6000	5	30000			
	Stationary for Participants	100	25	2500			
	Sub Total			**114500**			
8	**Development and printing of BCC / IEC Materials**				**1025000**	State	1025000
	Development of BCC Materials @ 50000/- (at state level)	50000	1	50000			
	Printing of BCC Materials @ 75000/- per district	75000	5	375000			
	Printing of Manuals	100000	1	100000			
	Printing of Report Cards / Facility Cards @ 100000/- per district	100000	5	500000			
	Sub Total			1025000			

9	**State level ToT for Kalajatta team (2 Days') at SIHFW**				**36000**	State	36000
	Hall Charges	2000	2	4000			
	PA System	1000	2	2000			
	LCD from SHSB	1000	2	2000			
	Fooding 200/- per person x 20 participants x 2 Days (including organisers and trainers) (As per actual)	4000	2	8000			
	Travel Cost for Resource Person Team from State Govt. Agency (Dept of Public Relations) (As per Govt. norms)	2000	2	4000			
	Honorarium to Resource Persons (Team of 3 persons) (As per Govt. norms)	3000	2	6000			
	Incidental expenditure, photocopying, job aids, flip charts, etc.	500	20	10000			
	Sub Total			**36000**			
10	**Conduction of Kalajatha at Village level @ Rs 3000/- per show (five Districts) { approx. 6 villages would be taken from each panchayats i.e. 5 districts x 2 blocks x 5 panchayts x 6 villages = 300)**	3000	300	**900000**	**900000**	District @ 180000/- per district	900000
	Sub Total			**900000**			
11	**Activity Cost for formation of Village Planning and Monitoring Committee (including travel cost for facilitators and meeting cost at village level) {approximately 6 villages will be there in each panchayat for 5 Panchayats in a block}**	5000	300	1500000	**1500000**	District (Rs. 300000.00 per district)	1500000
	Sub Total			**1500000**			

12	**Two rounds of Orientation cum Training of Village Planning and Monitoring Committee at Panchayat level (6 members from each village level monitoring committee x 300 committees i.e. approx total 1800 members will be there and will heve batch size of 30 persons i.e. total no. of batches will be approximately 60)**				**1530000**	District (Rs. 306000/- per district)	1530000
	Food expenses (per batch) Rs. 100 per person x 30 persons x 2 days (As per actual)	3000	2	6000			
	Logistics	2500	1	2500			
	Total expenses for one training			**8500**			
	Total expenses for conducting trainings of approx 60 batches (one round)	**8500**	**60**	**510000**			
	Total expenses for conducting two rounds of training at Panchayat level	**510000**	**3**	**1530000**			
13	**Data Collection and analysis of Village level report cards, health facility card, preparartion of village health plans**	5000	300	1500000	**1500000**	District (Rs. 300000/- per district)	1500000
	Sub Total			**1500000**			
14	**Conduction of Quarterly Block Level Jan Samvad in each of the pilot blocks (in units total units will be 4 Block Jan Samvad per block x 10 blocks = 40 units)**				**800000**	District (Rs. 160000.00 per district)	800000
	Block Jan Samvad (5 panelists / experts, 200 participants) {20000/- per block per Jan Samvad}	20000	40	800000			
	Sub Total			**800000**			
15	**Orientation of block level Planning and Monitoring Committee by CSO at district level**				**47500**	District (Rs. 9500.00 per district)	**47500**
	LCD and PA System	1000	1	1000			

	Fooding 100/- per person x 15 participants x 1 day (including organisers and trainers) (As per actual)	1500	1	1500			
	Stationary for Participants	50	15	750			
	Honorarium to Resource Person (Two) @ Rs. 1000/- per day per resource person as per Govt. norms	1000	1	1000			
	Miscellaneous	500	1	500			
	Sub Total for Organising one block level orientation			***4750***			
	Total Cost for Organising block level orientation in ten blocks	***4750***	***10***	***47500***			
16	**Orientation of District level Planning and Monitoring Committee**				**57500**	State (35000/-) District (4520/- per district)	**State (35000/-) District (4520/- per district)**
	LCD and PA System	1000	1	1000			
	Fooding 150/- per person x 15 participants x 1 day (including organisers and trainers) (As per actual)	2250	1	2250			
	Stationary for Participants	50	15	750			
	Local Conveyance for State Level Resource Persons (One Vehicle for 2 days)	2000	2	4000			
	Honorarium to Resource Person @ Rs. 1000/- per day per resource person as per Govt. norms	1000	1	1000			
	Lodging and Fooding for Resource Person (Two resource person for 4 days @ Rs. 1000/- per day per resource person) (As per actual Govt. Rate)	1000	2	2000			
	Miscellaneous	500	1	500			
	Sub total for Organising one district			***11500***			

	level orientation						
	Total Cost for Organising district level orientation in five districts	***11500***	***5***	***57500***			
17	**Orientation of State level Planning and Monitoring Committee**				**11100**	State	**11100**
	LCD and PA System	1000	1	1000			
	Fooding 250/- per person x 20 participants x 1 day (including organisers and trainers) (As per actual)	5000	1	5000			
	Stationary for Participants	100	20	2000			
	Honorarium to Resource Person (Two) @ Rs. 1000/- per day per resource person as per Govt. norms	1000	1	1000			
	Miscellaneous	2000	1	2000			
	Total Cost			***11100***			
18	**Quarterly meeting of block level Planning and Monitoring Committee by CSO @ 2500/- per quarter for 3 times**	2500	3	**7500**	**37500**	District (7500/- per district)	**37500**
	Sub total for Organising one block level meeting			**7500**			
	Total Cost for Organising block level meeting in five districts	7500	5	**37500**			
19	**Meeting of District level Planning and Monitoring Committee @ 3000/- per quarter for 2 times**	3000	2	**6000**	**30000**	District (6000/- per district)	**30000**
	Sub total for Organising district level meeting			**6000**			
	Total Cost for Organising distirct level meeting in five districts	6000	5	**30000**			

20	**Meeting of State level Planning and Monitoring Committee @ 5000/- per quarter for 2 times**	5000	2	**10000**	**10000**	State	**10000**
	Total Cost			**10000**			
21	**Block level consultative meeting with blcok level officials and CSOs for exploring the grievance redressal mechansim for CBPM**				**45000**	District (9000/- per district)	**45000**
	Fooding 100/- per person x 20 participants x 1 day (including organisers and trainers) (As per actual)	2000	1	2000			
	Stationary for Participants	50	20	1000			
	Honorarium to Resource Person (Two) @ Rs. 1000/- per day per resource person as per Govt. norms	1000	1	1000			
	Miscellaneous	500	1	500			
	Sub Total for Organising one block level orientation			**4500**			
	Total Cost for Organising block level orientation in ten blocks	4500	10	**45000**			
22	**District level consultative meeting with district officials and CSOs for exploring the grievance redressal mechansim for CBPM**				**27500**	District (5500/- per district)	**27500**
	Fooding 150/- per person x 20 participants x 1 day (including organisers and trainers) (As per actual)	3000	1	3000			
	Stationary for Participants	50	20	1000			
	Honorarium to Resource Person (Two) @	1000	1	1000			

	Rs. 1000/- per day per resource person as per Govt. norms						
	Miscellaneous	500	1	500			
	Sub Total for Organising one district level orientation			**5500**			
	Total Cost for Organising block level orientation in ten blocks	5500	5	**27500**			
23	**District Level Dissemination and planning Workshop on Community Planning and Monitoring**				**158500**	District (Rs. 18500/- per district) & at State level (66000/- will be kept at state level)	District (Rs. 18500/- per district) & at State level (66000/- will be kept at state level)
	Hall Charges	2000	1	2000			
	LCD and PA System	1500	1	1500			
	Fooding 250/- per person x 40 participants x 1 Day (including organisers and trainers) (As per actual)	10000	1	10000			
	Stationary for Participants	125	40	5000			
	Local Conveyance for State Level Resource Persons (Two Vehicle for 2 days)	3600	2	7200			
	Honorarium to Resource Person (Two) @ Rs. 1000/- per day per resource person	2000	1	2000			
	Lodging and Fooding for Resource Person (Two resource person for 2 days @ Rs. 1000/- per day per resource person) (As per actual Govt. Rate)	2000	2	4000			
	Miscellaneous	2750	1	2750			
	Sub Total			**31700**			
	Total Cost for Organising District Level Dissemination and planning Workshop on Community Planning and Monitoring in five districts	**31700**	**5**	**158500**			

24	**Facilitation cost to State Nodal-cum-Technical Agency (including HR, technical and managerial support, monitoring, reporting, documentation etc.)**	**1000000**	**1**	**1000000**	**1000000**	State	**1000000**
	Total			**1000000**			
25	**Concurrent Monitoring Visits by State Planning and Monitoring Members / State Advisory Group for Community Action Members (Rs. 10000/- per month per block for 12 months)**	50000	12	600000	**600000**	State	600000
	Sub Total			**600000**			
26	**Documentation including process documentation (including reports, case studies, success stories, designing, composing and editing)**	100000	1	100000	**100000**	State	100000
	Sub Total			**100000**			
27	**Documentary (multilocation of 30 minutes as per Govt. approved rate of Dept of Public Relation)**	200000	1	200000	**200000**	State	200000
	Sub Total			**200000**			
28	**Coordination Expenses (per block) for CSOs (including HR and other admin and programme supporting expenses (Rs. 150000/- per block for 10 blocks)**	150000	10	1500000	**1500000**	District (Rs. 300000/- per district)	1500000
	Sub Total			**1500000**			
29	***District level Contingency(Rs.4000/- Per month per District x 12 months)***	20000	12	240000	**240000**	District	240000
30	***Contigency State Level**			**500000**	**500000**	State	500000
	Grand Total				**Rs. 12,822,600.00**		

IV. Quality Assurance and Supportive Supervision (Budgeted in Part-A)

Goal: To ensure Quality in Health Service delivery and strengthening the delivery mechanism.

Objective:

a. To strengthen the existing health facilities.
b. To strengthen the monitoring & Evaluation division.
c. To assess the capacity of existing manpower in terms of skills possessed and skills required for delivering quality service.
d. To ensure action oriented supportive supervision at block, district and state level.
e. To ensure quality in health service delivery and its delivery mechanism at different level.

Introduction

Quality Assurance is a systematic and planned approach to assess, monitor and improve the quality of health services on a continuous basis. It promotes confidence, improves communications and allows clearer understanding of community needs and expectations.

1. Quality Assurance is oriented towards meeting the needs and expectations of the patient and the community.
2. Quality Assurance focuses on the way we work, our activities, and processes of health care delivery.
3. Quality assurance uses data to analyze how we are working and delivering health services.
4. Quality assurance encourages a multi-disciplinary team approach to problem solving and quality improvement.

In practice Quality Assurance is a continuous process and the quality assurance cycle can be used to guide the activities being implemented. There are various different stages in the Quality Assurance Cycle. which includes following steps:

- Preparing for QA in the health facilities.
- Forming a quality assurance committee at state & district level.
- Deciding the focus of QA plan.
- Statement of the quality that is expected.
- Selecting indicators (indicator = measure of a quality factor)
- Selecting information source (clinic records etc.)
- Data collection & validation.
- Implementing monitoring.
    - Identifying *areas for quality improvement* using the monitoring information or identifying areas of local collective concern.
- Agree on and state the problem (as a team)
- Assign appropriate people to work on the problem
- Understand what is causing the problem
- Suggest ways of correcting the problem

Quality Assurance Committees (QAC)

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

Functioning of Quality Assurance Committees (QAC)

To ensure quality service delivery through the network of public health facilities in the state and for smooth implementation and regular review of Quality Assurance activities, State Quality Assurance committee (SQAC) chaired by Principal Health Secretary is being constituted at State level to give highest priority to address quality issues in service delivery. The committee meetings should be organized by SHSB on quarterly basis. The SQAC can be used to obtain administrative approvals for the QA activities guided by the recommendations of Member's field observations and District Quality Assurance Committee report.

4.1. a. State Quality Assurance Committee (SQAC) consists of :

1. Principal Secretary, Health & Family Welfare, Bihar - Chairman
2. Executive Director, State Health society, Bihar - Vice-Chairman
3. Director-in-Chief - Member Secretary

Members:

Additional Director- Family Welfare.
Professor & Head, Dept. of Obstetrics & Gynaecology, PMCH.
Professor & Head, Dept. of Paediatric, DMCH.
Professor & Head, Dept. Of Anaesthesia, ANMCH.
Training In-charge, SIHFW.
State Nursing Head.
State Program Officer, T.B.
State program officer, Vector Borne Diseases.
Additional Director- Planning, Monitoring & Evaluation, SHSB.
Two Accredited Private organizations

Technical Assistance:

Deputy Director- Monitoring & Evaluation, SHSB; Additional Director-Training, SHSB; Additional Director-RCH, SHSB.

Secretarial Assistance: One (1) representative of State Data officer and one (1) from HMIS cell, SHSB.

Special Invitee:

Representative from Development partners-UNICEF, WHO,DFID,BMGF,UNFPA.
Quality Assurance Expert of National Repute.

Note: It is desirable to have adequate number female representatives in the committee.

Scope of Work of the Committee

The State Quality Assurance Committee (SQAC) will review the performance of different health institutions in respect of QA in the state, formulate strategies and provide guidance for strengthening the QA at all level.

The committee should hold a meeting once every quarter.

The Chairman of the Committee if need arises can invite a person as special invitee whenever required for the betterment of the programme. In case the Chairman is not available for the meeting, a nominee of the chairperson may preside over the deliberations.

The terms of reference for the SQAC are as follows:

1. Review the report and recommendations of member's field observations and District Quality Assurance Committee (DQAC) and take administrative decisions.
2. Formulate strategies for the Quality Improvement at each level of health institution e.g. Sub Centers, PHCs, RHs, SDHs, District Hospitals and Medical College as well as for outreach based programmes
3. Review the report from cases of adverse outcomes/complications in maternal, neonatal health & child health/maternal, infant & child deaths, deaths & complications following sterilization, cases of conception due to failure of sterilization in the State in the state.
4. Give directions on the implementation of measures for improving the quality of maternal, neonatal, child health & family planning (including sterilization services) in the state.
5. The Committee would provide guidelines on standard protocols in maternal, neonatal, child health & family planning services as well as for disease control programme implementation in tune with national guidelines, determine quality indicators in these areas and review the progress against the indicators quarterly/six-monthly as appropriate.
6. The Committee would nominate members and representatives of DPs to undertake Quality Assurance visits to districts at regular intervals using Checklists for reviewing facilities, community based interventions, implementation of schemes like JBSY and review quality of ongoing training programmes and the feedback would be shared with Facility in-charges and the district quality Assurance Committee apart from presentation in SQAC quarterly meeting
7. Review the quality of training programmes being organized at state & district level
8. Review of Different community based interventions and schemes like JBSY.
9. Meet once every three months.
10. A minimum of half + one members shall constitute the quorum.

The State Co-ordination Committee (QA) should adopt the following procedures:

1. District-level committees will submit quarterly reports in the prescribed formats to the state committee.
2. The SQAC will also have a supervisory role in the functioning of the district-level committees. The state committee will organize orientation programmes for the members of the district-level committees initially followed by refresher sessions at a regular interval of time as per requirement.

3. The members as technical and secretarial assistance of SQAC, co-ordinated by Addl. Director, Planning and M&E, will meet every quarter before the schedule meeting of SQAC to review the reports being received from the districts. The members may ask for additional information from the district committees if needed.
4. Dy. Director, M&E will be responsible for coordinating the committee's activities, preparing quarterly reports and recommendations, and conducting selective investigations. S/He will be assisted by technical and secretarial assistance members to complete the task.
5. The SQAC meet every 3 months will review the report and recommendations member's field observations and District Quality Assurance Committee (DQAC) and take administrative decisions.
6. Member Secretary, SQAC will be responsible for co-ordinating the SQAC's activities and preparing and organizing meetings, reports. The technical and secretarial assistance members will assist Member Secretary to carry out the activities.
7. Members of SQAC will make visits to the district on a regular periodic basis and evaluate the QA in the district using standardised format.
8. To make field visits 4 teams will be constituted with each team comprising 2 key members of SQAC, 2 representatives of development partners and 2 representatives from neighbouring district health officials (e.g. CS/DS/ ACMO/ District Program officers).
9. Each team shall visit at-least one district per quarter using standard format. The visit must be for four days and try to cover a sample of health facilities, undertake exit interviews of users at health facilities and home visits of randomly selected beneficiaries.
10. The elements of quality to be assessed by the team would broadly cover - Service environment, Access, Equipment and supplies, Professional standards and technical competence, Continuity of care, Client provider interaction & Informed decision making by clients/users
11. Monitor the Quality Improvement programme at each level e.g. Sub Centres, PHCs, RHs, SDHs, District Hospitals and Medical College and assess whether the essential service package is being delivered as per standards and also assess general service environment including cleanliness, infection control measures and look into aspects of client/user-provider relations..
12. Visit both public and private facilities providing family planning services and safe abortion services in the State to ensure implementation of national standards.
13. Review (desk review / field visit, if required) cases of death / complications following sterilization and cases of conception due to failure of sterilization in the state.
14. Review the cases of maternal and infant deaths/any adverse outcomes in maternal, neonatal & child health.
15. Review & monitor the quality of trainings under RCH II/National disease control programmes organized at state & district level and undertake follow-up of selected sample of trainees during field visits.
16. Give directions to districts on the implementation of measures for improving the quality of maternal, neonatal, child health & family planning services including sterilization services and disease control programme service delivery in the state.

District QA Committee consists of :

1. District Magistrate –Chairperson
2. Civil Surgeon – Member secretary
3. ACMO – Convenor

4. Members
    a. Gynaecologist and/or surgeon and /or Anaesthetist and/or Paediatrician
    b. NGO representative
    c. District Nursing head
    d. District RCH officer/FW officer
    e. District Program officer, TB, Vector Borne, Blindness and leprosy
    f. DPM

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

Note: It is desirable to have adequate number of female representation in the committee.

1. Monitor the Quality Improvement programme and track progress based on identified quality indicators at each level e.g. Sub Centres, PHCs, RHs, SDHs, District Hospitals and Medical College. And whether the facilities are providing the essential service package as per standards and protocols being adhered to.
2. Conducting medical audits from time to time of all maternal & infant deaths and deaths related to sterilization and sending reports to the State QAC office.
3. Review the cases of maternal & infant deaths and report from cases of adverse outcomes/complications in maternal, neonatal health & child health
4. Collecting information on all hospitalization cases related to complications following sterilization as well as sterilization failure.
5. Processing all cases of failure, complications requiring hospitalization, and deaths following sterilization for payment of compensation, and pursuing these cases with the insurance company or otherwise.
6. Reviewing all static institutions, i.e. government and accredited private / NGOs and selected camps providing sterilization services and safe abortion services, for quality of care as per the standards laid down, and recommending remedial action for institutions not adhering to the standards.
7. Review & monitor the quality of trainings under RCH II/National disease control programmes organized at state & district level and undertake follow-up of selected sample of trainees during field visits.
8. Review of Different community based interventions like outreach camps and schemes like JBSY
9. Give directions to blocks on the implementation of measures for improving the quality of maternal, neonatal, child health & family planning services including sterilization services and disease control programme service delivery in the state.
10. Meeting once every month.
11. A minimum of half + one members shall constitute the quorum including one female member.
12. Plans QAC visits to facilities and communicates visit schedule to members of the Quality Assurance Committee in advance
13. Make necessary preparations for visit – transport, at least three members per visit, adequate supplies of QA forms.

14. Make visits to facilities and uses the standardized QA Checklists to conduct the assessment and Debriefs the Medical Officer In-charge of the facility with guidance on what actions needs to be taken
15. Compiles findings during the visits at the district level and distributes the District Summary Report and discusses these at the monthly meeting with medical officers. Forward the minutes of the monthly QAC meeting and actions to be taken to the concerned officials
16. Keeps a record of follow-up and actions taken so that these can be reviewed on subsequent visits to the facility.
17. Shares the district visit reports with the State Committee on monthly basis and initiates actions based on recommendations from state committee

Burt, it is very important that the state should focus its attention on all 3 dimensions as mentioned below and not just concentrate on one aspect.

This is the availability and quality of resources, management systems and policy guidelines. These things are quite easy to measure, but are not always very informative unless they can be related to processes and outcomes.

This is the actual process of health care delivery. *The measurements of services provided are* more difficult to make, but this information is more useful because it tells us what happened to the patient.

This is the end result of health care; the outputs and health status. Outcome measures include things such as mortality, patient satisfaction, coverage, attendance levels etc.

Activities

In order to ensure quality of care at health centers, following major activities needs to be conducted:

(1) ***Assessment of existing health facilities: FRU/DH/SDH/PHC-*** To identify the gaps in the existing health facilities and developing plan of action for improving their status and assuring quality of services of existing health facilities (in terms of infrastructure, HR,services,supplies,etc) , assessment of the health facilities must be done. The outcome of the assessment will act as base for taking corrective measures and developing perspective plan for strengthening infrastructure and service delivery.
For this service of external agencies will be hired (no.-4).The agencies will be responsible for:-

1. Developing Formats for assessment in consultation with state and health official.
2. Twice visit by the agencies { once for base line assessment and next for assessing improvements} The agencies will be sensitizing the health service providers ;conducting gap analysis of the health facilities; and prepare a complete plan of action for the facility .
3. Report submission to the state.

Time line for completion of the activity: - 3-4 months

(2). ***State level dissemination meeting with SQAC***: The collated recommendation of the assessment studies conducted by the identified agencies would be presented before

the State Quality Assurance Committee. Based on the SQAC recommendations, a state plan of action would be prepared, which can be implemented in phase-wise manner.

(3).***Capacity building of Health service providers on quality of care (in Five districts in which Community based Planning & Monitoring activities will be conducted - Special intervention)***. The institution having experience on quality of care can be involved in building capacities of the service providers and managers.

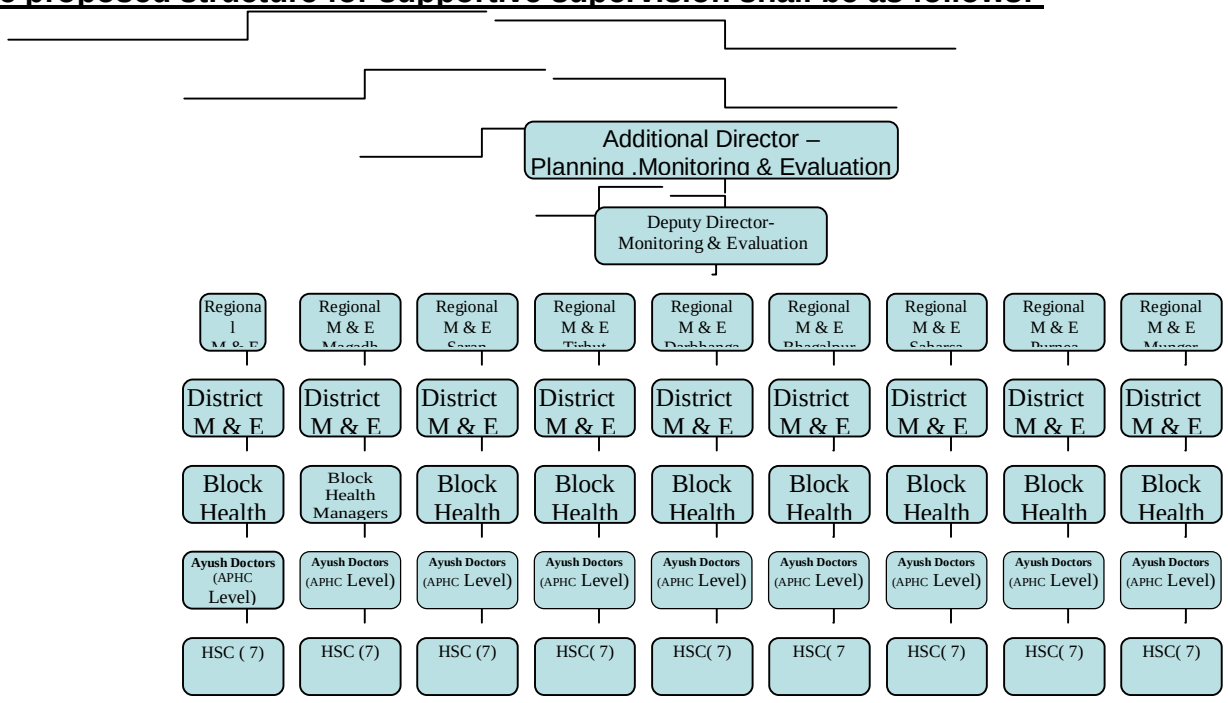
a. The MOIC's, MO's, Hospital Managers from two identified blocks in five districts where CBPM would be implemented, would be imparted training on Quality of care so that they can provide quality services for improving patient's satisfaction.

(4).**Capacity building of Managers**- The BHMs; BCM;DCM;DPMs, district M &E and selected CSO representatives would be given training on Quality of care so that they can provide quality services for improving patient's satisfaction.

(5). ***Involvement of Ayush Doctors in supportive supervision (Cluster approach)-*** The Ayush Doctors placed at APHC's will be identified as nodal persons for supportive supervision at APHC level. Each Ayush doctor shall be assigned 7 HSC on an average (as per the existing facilities) for regular supervision and strengthening capacities of the frontline service providers. For performing the task the capacities of the Ayush Doctors shall also be strengthened.

***Revision of Supportive Supervision tools*:** Inspection formats developed for supervision of health facilities by SHSB for inspecting health facilities will be revised in consultation with state officials and development partners.

The proposed structure for supportive supervision shall be as follows:-



Budget

S.No	Activities	No. of units	Total budget (in Rs.)
1	Assessment of existing health facilities: FRU/DH/SDH/PHC (Services of four (4) agencies will be hired)	-	15000000
	State level dissemination meeting with SQAC on outcome of assessment		3000
	Sub total 1.		**1,50,03,000**
2.	**Capacity building trainings:-**	1	
A	The MOIC's, MO's, Hospital Managers would be imparted training on Quality of care so that they can provide quality services for improving patient's satisfaction (for 5 districts in which CBPM will be implemented)-2 days@60,000per dist	1	86,000
b.	Capacity building of Managers- The BHMs; BCM;DCM;DPMs, district M &E and selected CSO representatives would be given training on Quality of care so that they can provide quality services for improving patient's satisfaction (for 5 districts in which CBPM will be implemented)	1	1,10,000
	Sub total 2		**1,96,000**
3.	Facilitation cost for external agency specialized in quality of care for capacity building of MOIC's, MO's, Hospital Managers ; Managers (for 5 districts in which CBPM will be implemented)		2,00,000
	Sub total 3		**2,00,000**
4.	**Refreshment cost**		
a	Quarterly SQAC meetings @Rs. 150/participant x 4 quarters x 30 participants	4	18,000
	Sub total 4		**18,000**
5.	Travel cost for invitee members of SQAC @ Rs. 15,000/members	4	60,000
	Sub total 5		**60,000**
6.	Lodging for invitee members of SQAC @ Rs. 3000/day	4	12,000
	Sub total 6		**12000**
7.	**Mobility for supportive supervision**		
a.	District For M & E officials		-
b.	For Ayush doctors *{supportive supervision of 7 HSC per Ayush doctor -1day per HSC per month}* @ Rs. 200/HSC/day x7 daysx12 months x1330 Ayush Doctors		2.23 crores
	Sub total 7		**223.000 lakhs**
9.	Documentation & publication of best practices & innovative practices under NRHM. (half yearly)	2	2,00,000
	Sub total 9.		**2,00,000**
10.	Research & impact assessment studies	-	10,00,000
	Sub total 10		**10,00,000**
	GRAND TOTAL		**684.58 lakhs**

Financial Status

Flexible, decentralized planning is the pivot on which the entire concept of the Mission revolves. Till the year 2005, central funding to Bihar was on normative basis. Thereafter decentralized planning became the basis of fund release.
Government of India's funds are released to the state through two separate channels, i.e; through the state budget and directly through the State Health Society. Further the Department's outlay for the procurement of vaccines, drugs, equipments etc; is spent centrally and assistance to the state has been in the form of both cash and kind.

In 2010-11 GoI had approved an amount of Rs. 1273.88 crores under RCH II. To decentralise the process, SHSB undertook the task of 'Allocation of Funds for Districts for FY 2010-11' for all the components of NRHM-RCH Flexible Pool (A), Mission Flexipool/Additionalties (B), RI and Pulse Polio (C) & Disease Control Programmes (D). The State Programme Officers were assigned the task of allocating funds for the complete year to the districts based on the unit cost and requirement of the district. The annual fund allocation was done for all the programmes which were grouped under Part A, B, C & D. The DPMU team was then called at the State Headquarter level for a workshop and they undertook the exercise of allocating the funds for the four quarters. In this workshop each State Programme Officer detailed the districts on the unit costs for each district, which assisted the districts in allocating funds for the quarters.

This quarterly allocation was then taken back to the districts and after necessary corrections and vetting by the concerned District Programme Officers, necessary approval of the District Magistrate and Civil Surgeon was taken. This was then communicated to the State. Based on the requirement from the districts and the final approval from Government of India, the fund allocation was finalised for the 4 quarters and the annual targets for the districts were finalized. The physical targets were uploaded on the DHIS 2 portal for reporting by the districts.

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

In this process streamlining of the financial system was undertaken with the following purpose -

- De-centralisation of Resources and Power to the Districts and even Blocks from the State level itself with district participation
- Transparency in the Fund allocation
- Need based fund allocation
- Better utilization of funds

- Better Fund Accountability of the Districts and PHCs

The salient features of this system are –

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

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

Further for better monitoring of the flow of funds and internal control purposes various financial management initiatives have been undertaken like-

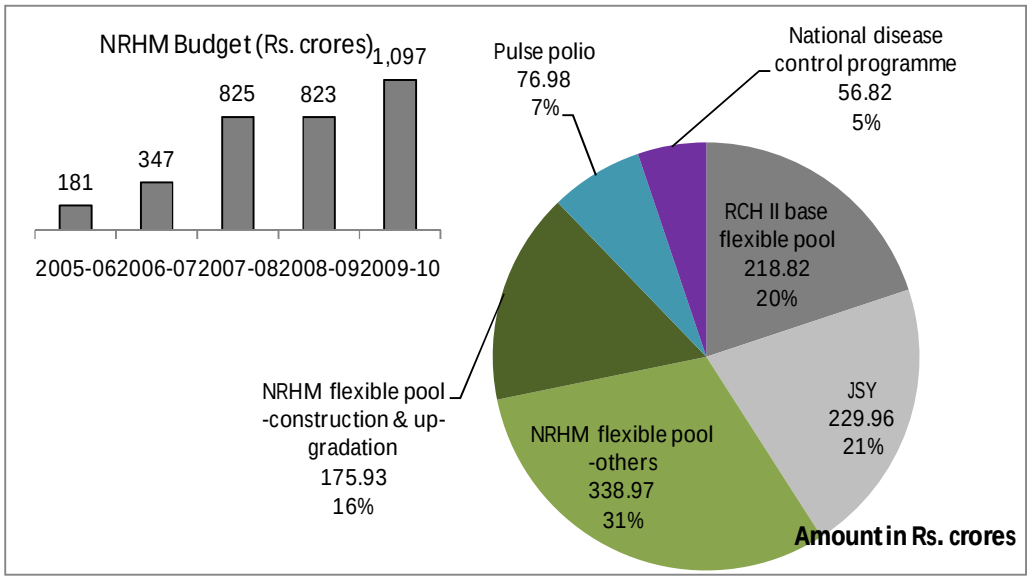
- ✓ Implementation of customized latest version of Tally ERP.9 for NRHM accounting
- ✓ Concurrent audit system through CA firms
- ✓ System of open tender system in the selection of Statutory Auditor for annual audit of district health societies
- ✓ Timely submission of Financial Monitoring Reports (FMRs) from districts
- ✓ Follow-up with districts for implementation of electronic transfer of Funds
- ✓ Payment through Cheque for any NRHM expenditures at all levels
- ✓ Establishment of Internal Audit Wing
- ✓ Increased focus on accurate and timely reporting of SOEs and UCs resulting in improved status of outstanding funds with the State
- ✓ Augmentation of accounting manpower at the level of PHCs

Status of Funds (FY 2010-11)

(Rs. In Crore)

	Approved Budget	**O.B**	**Fund. Recd.**	**Total**	**Release upto 31.12.10**	**Exps. Upto 31.12.10**
NRHM-A	593.64	98.19	275.54	373.73	225.64	250.81
NRHM-B	337.96	5.36		5.36	96.60	100.64
NRHM-C	97.55	54.82	46.82	101.64	49.00	51.06
Total	1029.15	158.37	322.36	480.73	371.24	402.51

NRHM budget



FUND FLOW MECHANISM AT STATE

Presently the State Health Society is getting Grants-in-Aid from GoI through electronic transfer by crediting the A/c of SHS. These funds are transferred to District Health Society A/c as Untied funds as per their respective District Action Plans, which then gets routed to the CHCs, PHCs, district hospitals and RKS for smooth conduct of the activities of RCH- II.

On the lines of the GOI regarding transfer of funds, SHS and DHS has implemented the system of electronic transfer of funds to the districts.Districts have been directed

OPERATION OF BANK ACCOUNTS

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

ACCOUNTING PROCEDURES FOLLOWED

The State is following the Double Entry System of accounting on Cash Basis.

For the sake of convenience in consolidation of accounts districts are also instructed to follow the same system.

In addition to this for proper accounting and maintenance of books, a manual cum guidelines had been issued to the districts. Also the monthly auditor appointed at each district is reporting on the accounting procedures followed by the districts on a monthly basis, along with the deviations, if any.

FINANCIAL MANAGEMENT AT STATE

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

FINANCIAL UPDATE

1.	Tally	:	Tally in all the 38 districts has already been installed & is working satisfactorily as per report received from district and is being made functional in blocks also by end of month
2.	R.T.G.S.	:	The funds are being released electronically from 01-12-2009 to all the districts, furthermore all the districts are in the process of getting the RTGS and IFSC code for e-transfer to PHCs also. Some districts in blocks also
3.	Need based allocation to districts	:	Funds are being released on the basis of reported expenditure of 80% or more.
5.	Expenditure as per activity hence forth in FMR	:	All the districts have already been instructed to report the expenditure as per activity wise in FMR. Additionally the FMR has now been synchronized with the ROP heads and communicated to the districts.
6.	Specific time line for Concurrent Audit e-banking etc.	:	In 36 districts concurrent auditor has already been appointed. D.M of the remaining districts have already been requested to complete the recruitment process by the end of this month. Consolidated con report upto sep to hq
8.	FMR uploading regularly	:	Already complied and the District and State FMRs are available on SHSB website – www. statehealthsocietybihar.org

FINANCIAL MONITORING

Financial monitoring is being done through the understated mechanisms-

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

Appointment of CA at SHSB & C.A. Level

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

Constitution of Internal Audit wing at SHSB:

Internal Audit wing has been constituted with 3 internal auditors in place from Recognised Audit & Accounts Services who are well versed in audit work.

For the Financial Year 2010-11 Rs. 532.50 lakhs was sanctioned under Budget NRHM - Strengthening of Financial Management. Against this approval Rs. 385.85 lakh has already

been spent for purchase of Tally ERP-9 Multi User for District Level and 496 Desktop with Printer and UPS and Tally ERP – 9 Single User for Block Level and remaining amount is likely to be spent by March 2010-11.

Besides this orientation of capacity building of DAM was conducted. Customization of Tally as per ROP was also carried out. In addition Income Tax Consultant and PF Consultant (both part time) have also been engaged from F. Y. 2010-11. Desktop Computer and Tally as block level is to be installed by the end of the February 2011. Customization of Tally as per ROP, provision of tables and chairs, Electricity provisions, Orienting of capacity building of Block Accountant provision of Computer with Tally ERP – 9 Multi user for RAM is to be carried out during 2011-12. In addition Tally already installed during 2010-11 is required to be upgraded in 2011-12 and AMC of Tally at State, District and Block level is to be carried out during 2011-12 for which necessary proposal of fund has been made in the budget estimate of 2011-12.

Government to Person (G2P) Health Payments

1. Background

The State Health Society in Bihar with the support of the International Finance Corporation (IFC), the World Bank, and the Bill and Melinda Gates Foundation (BMGF) commissioned a diagnostic to analyse government to person (G2P) health payments in Bihar. The objective was to analyse (i) the payments processes associated with health programmes and (ii) the payment and financial inclusion environment. The diagnostic provides the basis for recommendations to the SHS on measures to improve the efficiency and transparency of these payments.

The state–wide diagnostic was conducted in September 2010 with field visits in five districts - Begusarai, East Champaran, Gaya, Patna and Sheikhpura. Three programmes were analysed – Janani Evam Bal Suraksha Yojna (JBSY), Muskan Ek Abhiyan (MEA) and the Revised National Tuberculosis Control Programme (RNTCP). Interviews and Focus Group Discussions were conducted with over 280 people including health officials at the state, district and block level, health workers, health programme beneficiaries, private providers, technical experts, development organisations, and financial service providers.

Based on inputs from key participants in the current health payments system, the current process flows for the three health programmes were studied in detail and various inefficiencies in the current payment processes were identified. The key findings include (i) significant time of the Medical Officer In–Charge (MOIC) is spent on payments-related administrative issues – estimated at between 25-30%; (ii) actual payments to recipients depend on efficiency and interest of block health officials; (iii) block health officials are uneven in their understanding of administrative processes and programme (especially financial) guidelines; (iv) District Health Society (DHS) and block workers are overburdened and de-motivated due to inefficient payment mechanisms; and (v) there is heavy reliance on local bank branches for payment services, and constraints to timely payments include cheque book availability, inter-bank clearing delays, etc. Delays in payments of incentives range from long-term (2+ years) and state-wide delays for RNTCP; short–term state-wide delays for MEA (2-12 months); and widely varied delays for JBSY (2 months to 2 years). Given delayed payments, health workers (ASHAs, ANMs and AWWs) are losing motivation. Further, as delays mount, the chance of leakages and costs increase, as it becomes more difficult to find recipients who may migrate to other locations in the state or beyond.

Most of the health workers and some of the beneficiaries are already banked. This category of recipients is keen on having access to a broader range of financial services. Even among the non-banked, the demand for banking services is palpable.
There is a strong momentum for increasing the efficiency and effectiveness of public health services in Bihar. Examples include (i) SHS's state-wide IT initiatives like the Health Management Information System (HMIS) and e-MAMTA and (ii) decentralised planning. These health sector reforms and the current financial inclusion initiatives in the state provide the right platform for implementing the proposed alternative payment system – Bihar Health Operations Payments Engine (HOPE), detailed below.
Bihar HOPE will reduce administrative burden and release capacity for health services, improve motivation for health workers and providers through timely payments, save government the costs of leakages at various points and hence improve impact of the health programmes. This will have an obvious impact on achievement of the NRHM goals, especially the ones related to reduction in infant mortality rate and maternal mortality ratio; achievement of universal immunisation; and prevention and control of communicable diseases.

2. Solution Framework

Findings from the diagnostic study and global and national good practices in G2P programmes were used to define the solution framework. The current decentralised decision making on budgeting and use of funds is working well and should be retained. The process of recording approvals, however, will need to be changed from the current paper-based mechanism. The current process of medical service provision, interaction with health workers, MIS reporting and overall programme management needs no change. Under the proposed approach, programme management would benefit from availability of enhanced MIS and system-based enforcement of programme rules.

A limited number of changes are proposed to the existing system for payments. Currently, payments to end-beneficiaries and health workers are predominantly by cheque with a small number of payments like transport incentives and the MEA incentives being made in cash. A significant portion of the end-beneficiaries are un-banked and are experiencing difficulties and delays in encashing cheques. The SHS has already directed all ASHAs to open bank accounts and many of the ASHAs have already complied. ASHAs can encourage and assist the end-beneficiaries in opening bank accounts. Given these developments and the other ongoing financial inclusion initiatives in Bihar, it would be viable to shift from cheque and cash payments to direct Electronic Funds Transfer (EFT) into the bank accounts of end-beneficiaries and health workers. The health service providers under the PPP programme, all businesses with existing banking relations, can move easily from cheque payments to EFT. In addition to banks, the payment services offered by the post office and other Payment Service Providers (PSP) (including cards or mobile phone-based approaches) could also be leveraged.

Decentralised approvals and processing of payments is adding to the administrative workload of the MOICs, estimated to be around 25-30% of an MOIC's time. This decentralised processing of payments makes them susceptible to various localised issues like availability of cheque books and MOICs availability to sign cheques. Decentralised

processing should be replaced by a centralised and automated payment execution process, which is triggered by completion of current payment approval processes.

Record keeping of all events related to payments for health workers and end-beneficiaries is manual and paper-based, which limits ability to track and monitor timeliness and accuracy in payment processing. These recordings of programme events need to be moved to the centralised and automated system mentioned above.

The profile of beneficiaries with respect to literacy levels, familiarity and experience with electronic payment instruments, and access to bank branches/service locations varies significantly amongst the broad categories of health workers and beneficiaries. These variations have a bearing on which access channel and payment instrument would be most effective in meeting their needs, and hence the system will need to support multiple payment instruments, banks and PSPs.

The proposed solution framework meets these requirements. The key aspect of the solution is to implement a centralised payments entitlement engine that manages the payments processes across all the stages of beneficiary enrolment, recording of events, payment execution, and finally monitoring and evaluation of health programmes. The centralised payments entitlement engine (HOPE) would be a web-enabled system which would be accessible from the blocks, DHS and SHS through a standard web browser without need for any additional software deployment in the user's desktops. HOPE would exchange payment processing information with an optimal number of banking and PSP partners to process payments to the health workers and end-beneficiaries. Banking partners and PSP partners would be responsible for providing recipients with convenient access and would be governed by service-level agreements with the SHS. The block staff will record the various health programme events and record approvals for payment for those events in the HOPE system. HOPE would interface with the proposed e-MAMTA system to capture the health programme events that would be recorded by it. The HOPE system would also exchange information with the existing MIS systems – HMIS and SHS MIS. The HOPE system would provide a variety of MIS to the SHS, DHS and block staff to monitor the programme implementation, including the status of the payments in various health programmes.

This solution framework would be flexible to accommodate changes to the existing programmes and integrate with new banking and PSP partners. The solution framework is also extensible to support future health and other social welfare programmes to workers and beneficiaries, as the design of the HOPE would enable configuration of new programmes.

3. Implementation Steps

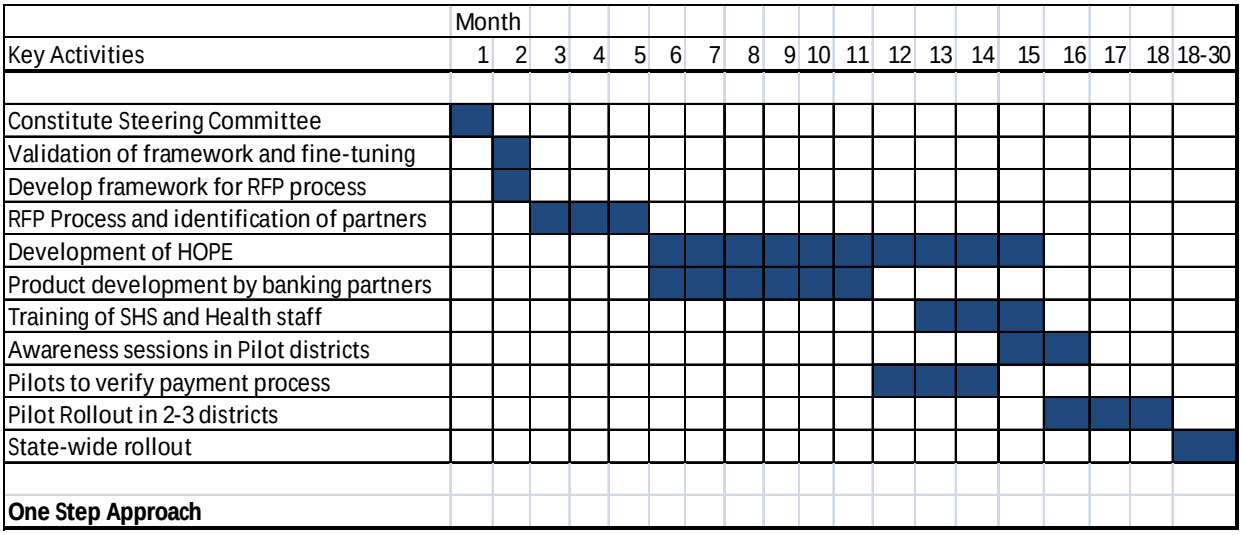
The implementation of the proposed solution would have the following high level tasks:

- Project initiation, consisting of launching the project, constituting a steering committee to guide and oversee the project and developing the detailed project implementation plan
- Designing, development, and implementation of the HOPE system for processing payment transactions
- Contracting with the banks and PSPs

- Development of the payment products and opening accounts for payment recipients by the banks and PSPs
- Training of the SHS, DHS and block staff
- Conducting awareness sessions for the health workers and end-beneficiaries
- Piloting the HOPE system in selected districts
- Rolling out the HOPE system to all districts in Bihar

The projected implementation timelines are depicted in the chart below.

Chart 1: Estimated implementation time



4. Implementation costs

The cost estimate for the project rollout is INR 134,347,185. Implementation is estimated at approximately 30 months, with costs estimated below.

Initial estimate: Proposed payment solution

Implementation Costs	Amount	Proposed Source of Funds
Project Initiation	INR 750,000	BMGF
HOPE System Development		
Development costs	INR 9,673,250	BMGF
System (hardware) costs	INR 4,375,000	SHS
Consulting Support		
World Bank Group Staff	INR 24,100,340	50% WBG + 50% BMGF
Consultants	INR 24,850,584	BMGF
Change Management	INR 5,424,375	BMGF
Travel and Lodging	INR 16,500,000	BMGF
Pilot Rollout (assumes 3 month pilot)	INR 6,625,000	70% BMGF + 30% SHS
System Rollout (assumes 12 month rollout)	INR 7,500,000	50% BMGF + 50% SHS
HOPE system training	INR 2,412,500	SHS

Outreach and change management	INR 15,700,000	SHS
Monitoring and Evaluation	INR 5,500,000	BMGF
Miscellaneous	INR 6,225,553	BMGF
Administrative expenses	INR 4,710,572	BMGF
Total implementation costs	**INR 134,347,185**	

This second phase of the G2P payments programme is contingent on co-funding by the SHS, IFC/World Bank, and the BMGF and is therefore indicative. Final budget will depend on decisions by BMGF and the IFC/World Bank and final negotiations with the SHS.

The budget estimate for Year 1 is robust, although some changes may be needed for Years 2-3 in overall amount and/or allocation of funding by SHS, BMGF and/or IFC/WB. Based on the current budget estimates presented in the table above, the total one-time funding requirement from SHS over a three-year period would be INR 28,225,000. The break-up for each year would be:

Year 1: INR 6,362,500
Year 2: INR 10,448,750
Year 3: INR 11,413,750

Ongoing operational costs consist of fees to banks accepting payment transactions from the HOPE system, personnel costs, and data centre costs for supporting the HOPE system. Fees to banks are assumed as one percent of the total amount processed by the system. In addition the banking partner might require the SHS to maintain their bank accounts with them.

It is expected that HOPE will be able to take advantage of the technology infrastructure put in place by the GoB. In this scenario, annual ongoing operational costs will be limited, as estimated in the following table.

Initial estimate: Ongoing annual operational costs for proposed payment solution

Recurring Costs for SHS	Amount
HOPE Support	INR 7,500,000
Banking Charges[2] (assuming 1% fee) (2nd year onwards)	INR 28,426,000
Total per year	**INR 35,926,000**

Operations support staff are estimated at three people providing back-office and help desk support to the districts to resolve operational issues with the HOPE system.
These recurring operational costs would start from Year 2 onwards, when the HOPE system goes live after state-wide rollout starts.
In the event the implementation of HOPE moves faster, then some of Year 2 costs would need to be incurred in Year 1. Under this scenario, the additional cost for Year 1 is estimated as 30 percent of Year 2 costs, 30 percent of the HOPE ongoing support costs and 20 percent

[2] The cost estimate assumes a 1 percent transaction fee to be paid by SHS for all health payments processed by banks or other payment service providers. This expense is calculated based on estimates of total annual volume of health payments to health workers, health providers, and health beneficiaries.

of the bank charges. This translates to a total Year 1 SHS contribution of INR 17,432,325."

5. Anticipated support from SHS

Successful piloting and implementation of HOPE in Bihar would depend to a large extent on the support from the SHS, with anticipated assistance in the following areas:

- Commitment of top management at SHS and DHS for implementation of HOPE
- Budgetary support for a portion of the costs, detailed in section 4.
- Facilitating the constitution of the project steering committee
- Provision of adequate space for housing the central server(s)
- Provision of an estimated three dedicated personnel at the state level for managing the system
- Provision of office space for the local project coordinator
- Provision of the requisite hardware at district and block levels
- Computerisation of data at the district/block level
- Training of staff at the BPHC
- Training of health workers by the block health manager or ASHA manager
- Sensitisation of beneficiaries by health workers
- Enforcement of HOPE and notifications to staff at the state, district, and block levels to comply
- Mandate for opening bank accounts for all health workers and beneficiaries
- Integration of HOPE with other relevant programmes of NRHM and other partners like e-MAMTA, DFID programme with ICDS, and PPPs under the programme supported by the Foundation.

Central Plan Scheme Monitoring System (CPSMS)

CPSMS is to be implemented as the Financial management Information System (FMIS). This will provide Bihar with state of the art financial management system which, apart from providing completely new financial management solutions, will make available all necessary FMRs to the State authorities and also to MoHFW, Government of India, thus eliminating the need for investing separately on developing financial MIS.

Notional budget has been provisioned under NRHm Part A ‘Monitoring and Evaluation’ for covering expenditures likeTraining and workshops for implementation, travel for CPSMS implementation, addl. Infrastructure cost, Misc. cost.

CPSMS implementation expected to start in Bihar in a month's time, savings under other heads may be allowed to be utilised for implementation

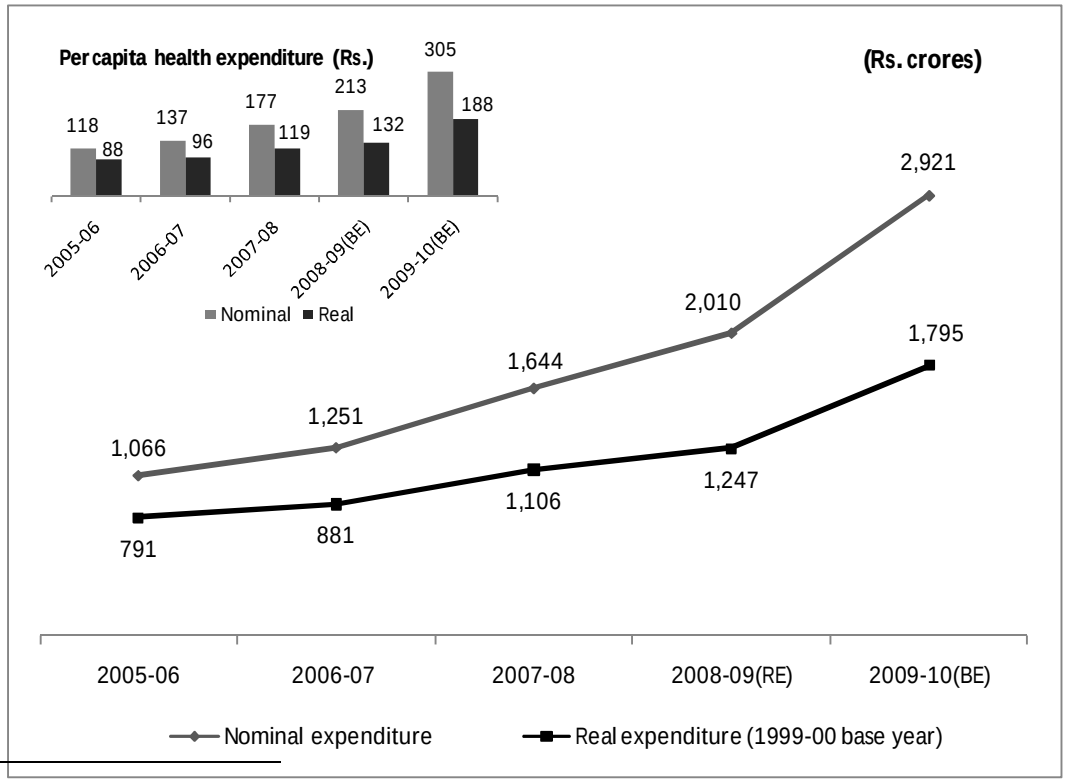
Financial Overview and Commitment

The NSS 61st round (2004-05) provides insight into per capita medical expenses by the households. The sample survey data reveals that per capita medical expenditure (out-of-pocket expenditure) in Bihar is much less than the all-India average. In rural areas, per capita medical expenditure is Rs. 167 as compared to all-India average of Rs. 444[3]. Similarly, out-of-pocket expenditure by the urban population is Rs. 307 per person per year vis-à-vis all-India average of Rs. 655. Relatively lower per capita medical expenditure possibly reflects inability of the people to spend on health due to low per capita income (over 40 percent of the population belong to BPL category). Though in absolute terms per capita medical expenditure is higher in urban areas compared to rural areas, both the rural and urban population allocate almost the same percentage, 3 to 4 percent, of the total consumption budget for medical treatment

Annual medical exp per person (Rs.)	Rural	Urban
Bihar	167	307
% to total expenditure	*3.3*	*3.7*
India	444	655
% to total expenditure	*6.6*	*5.2*
Note: Figures are calculated annualizing monthly medical expenditure		

State Government Source (Bihar)

Nominal and real growth of public health expenditure



Trends in health expenditure

On-Budget & Off-Budget Heads of Expenditure	2005-06		2006-07		2007-08		2008-09 (RE)		2009-10 (BE)	
	Rs. crores	Share (%)	Rs. crores	Share (%)	Rs. crores	Share (%)	Rs. crores	Share (%)	Rs. crores	Share (%)
Medical Services	814	82	951	84	1198	87	1426	81	1451	81
Urban Health Services-Allopathy	257		305		290		499		508	
UHS-Other system of medicine	7		7		6		10		12	
UHS-Capital expenditure	36		81		65		64		54	
Urban Health Services	300	30	392	35	361	26	573	33	574	32
RHS - Allopathy	371		397		544		559		623	
RHS -Other System of Medicine	6		5		6		8		9	
RHS-Capital expenditure	54		73		173		66		46	
Rural Health Services	430	43	475	42	724	52	633	36	679	38
METR	71		75		106		183		168	
METR-Capital expenditure	13		10		6		38		30	
METR	84	8	85	7	112	8	220	13	199	11
Public Health	32	3	37	3	30	2	95	5	76	4
Family Welfare	114	11	137	12	145	10	220	13	248	14
General	36	4	8	1	11	1	16	1	17	1
Total(excluding secretariat)	996	100	1133	100	1383	100	1756	100	1792	100
Secretariat	1	0	1	0	1	0	2	0	2	0
Total on-budget expenditure (A)	**997**	100	**1,135**	100	**1,384**	100	**1,758**	100	**1,794**	100
Share of on-budget (%)	94		91		84		87		61	
NRHM (off-budget)	**49**		**110**		**254**		**246**		**1,098**	
Share of NRHM (%)	5		9		15		12		38	
NACP III	**21**		**6**		**6**		**6**		**29**	
Share of NACP III (%)	2		0.5		0.4		0.3		1	
Total off-budget expenditure (B)	**69**		**116**		**260**		**252**		**1,127**	
Share of off-budget (%)	6		9		16		13		39	
Total health spends (A+B)	**1,066**		**1,251**		**1,644**		**2,010**		**2,921**	
Per capita expenditure (Rs.)	118		137		177		213		305	
Health spends as % of GSDP	1.3		1.3		1.6		1.7		2.3	
Share of primary sector (%)	59		61		70		59		72	
Memo Item										
GSDP at current prices (Rs. Crores)	80,157		98,957		105,148		115,083		129,433	
Mid-year population (in millions)	90.0		91.5		92.9		94.3		95.7	

State Budget (2009-10 to 2014-15)

Sl. No.	*(Rs. Crores)*	Total (6 Years)	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
1	**Budget Estimate**	24,750	3,136	3,848	4,147	4,160	4,527	4,931
1.1	Urban health services-allopath	4,186	562	678	718	682	741	805
1.2	Rural health services-allopath	10,730	1,341	1,631	1,774	1,821	1,989	2,174
1.3	ISM&H	467	60	71	78	79	86	94
1.4	METR	1,541	199	236	256	259	282	308
1.5	Public Health	1,398	180	214	232	235	257	280
1.6	Family welfare	6,002	774	918	997	1,009	1,102	1,202
1.7	General	148	19	22	24	25	28	30
	Sub-total (1.1 - 1.8)	24,472	3,136	3,770	4,078	4,110	4,484	4,894
1.9	DFID funded initiatives	278		78	69	50	43	38
2	**Resource Envelop**	24,750	3,136	3,848	4,147	4,160	4,527	4,931
2.1	**State's own resource**	13,947	1,739	2,254	2,406	2,319	2,510	2,720
2.1.1	Non-Plan	11,037	1,416	1,775	1,925	1,816	1,969	2,135
2.1.2	State Plan	2,632	323	401	411	452	498	547
2.2	DFID funding	278		78	69	50	43	38
2.3	**Government of India**	10,803	1,397	1,594	1,742	1,841	2,018	2,211
2.3.1	On-budget (CSP)	1,678	214	293	311	267	286	307
2.3.2	Off-budget (NRHM)	8,900	1,153	1,269	1,396	1,535	1,689	1,858
2.3.3	Off-budget (NACP III)	226	29	32	35	39	43	47
3	**Resource surplus (+)/gap(-)**		nil	nil	nil	nil	nil	nil
			Share (%)					
1	**Budget Estimate**	100	100	100	100	100	100	100
1.1	Urban health services-allopath	17	18	18	17	16	16	16
1.2	Rural health services-allopath	43	43	42	43	44	44	44
1.3	ISM&H	2	2	2	2	2	2	2
1.4	METR	6	6	6	6	6	6	6
1.5	Public Health	6	6	6	6	6	6	6
1.6	Family welfare	24	25	24	24	24	24	24
1.7	General	1	1	1	1	1	1	1
	Sub-total (1.1 - 1.8)	99	100	98	98	99	99	99
1.9	DFID funded initiatives	1	0	2	2	1	1	1
2	**Resource Envelop**	100	100	100	100	100	100	100
2.1	**State's own resource**	56	55	59	58	56	55	55
2.1.1	Non-Plan	45	45	46	46	44	43	43
2.1.2	State Plan	11	10	10	10	11	11	11
2.2	DFID funding	1	0	2	2	1	1	1
2.3	**Government of India**	44	45	41	42	44	45	45
2.3.1	On-budget (CSP)	7	7	8	7	6	6	6
2.3.2	Off-budget (NRHM)	36	37	33	34	37	37	38
2.3.3	Off-budget (NACP III)	1	1	1	1	1	1	1
3	**Resource surplus (+)/gap(-)**		nil	nil	nil	nil	nil	nil

	Total (6 years)	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Budget estimate (Rs. Crores)	24,750	3,136	3,848	4,147	4,160	4,527	4,931
% of GSDP	2.4	2.4	2.7	2.6	2.4	2.3	2.3
Per capita expenditure (Rs.)	417	328	396	422	417	449	483
Memo items							
GSDP at current market prices (Rs. Crores)		129,433	143,024	158,757	176,220	195,604	217,121
Estimated mid-year population (in millions)		95.71	97.05	98.37	99.65	100.91	102.13

Source : Planning Department

Other sources (Development Partners in Health)

Bill & Melinda Gates Foundation and its partner organizations in Bihar – BBC World Service Trust, CARE, the International Finance Corporation, PRAXIS and World Health Partners

A summary of the planned initiatives that the partners will start implementing in Bihar under the framework of the Memorandum of Cooperation (MoC) signed between the Government of Bihar and the Gates Foundation in May 2010. Under the MoC, the Government of Bihar and the Gates Foundation have committed themselves to a set of share health outcomes in the state by 2015. The planned initiatives for 2011-12 will be aligned with these outcomes and with the state's NRHM goals.

Under the objectives laid out in the 2010 MoC with the Government of Bihar the foundation will support the state as below:

- To reduce maternal and child mortality and improve key nutrition and health outcomes (including tuberculosis and VL control) by developing innovative solutions, based on programs in a set of eight focus districts[4], using the public and private sectors to improve the reach, coverage and quality of:
    - essential primary health and nutrition services for children under five years and women and men of reproductive age especially pregnant women, newborns and children under 2 years; and
    - Diagnostic and disease control services for specific disease conditions – namely pneumonia, diarrhea, tuberculosis and Kala-azar.

Under the terms of the MoC the foundation will also work with the Government of Bihar to enable state-wide scale up of proven approaches, lessons and good practices and will also help document and disseminate results and lessons to inform influence health and nutrition programs nationally and globally.

Programme elements and initiatives

In order to achieve the stated objectives, we believe there is need to focus on a set of high impact program elements as identified in the MoC. These include:

1. Improved design and implementation of interactions between health workers and individuals and families;
2. Improved design and implementation of health-worker and demand side incentives;
3. Use of data for improved management and supervision of frontline health worker performance to raise utilization and coverage of essential interventions;
4. Appropriate engagement and integration of private sector (formally qualified and less than formally qualified practitioners) in diagnosis, referrals and service delivery for select disease conditions;
5. Interventions for change of intra-household behaviors and social norms;
6. Design and implementation of innovative demand creation, social marketing, and behavior change efforts.

[4] The eight focus districts identified by the Government of Bihar include West Champaran, East Champaran, Gopalganj, Patna, Begusarai, Khagaria, Saharsa and Samastipur.

7. Facilitate introduction of new and under-utilized life saving technologies (including vaccines and improved technologies for point-of-care diagnostics and detection of infectious diseases);
8. Mechanisms to strengthen community groups to shape social norms supportive of priority health outcomes and to monitor and raise the social accountability of service providers;

Accordingly, the Gates Foundation in consultation with the Government of Bihar has identified a set of programmatic grants that will provide catalytic and technical support to the state government and its partners to help the state achieve its goals. The Gates Foundation grants are fully aligned with the state's NRHM goals and targets and most of their implementation will take place by leveraging government investments in the existing health system. The following programmes and supporting activities are envisaged in Bihar starting 2011-12:

Programme description	Lead partners	Focus districts	Status	NRHM priority areas addressed
Major initiatives already approved for funding				
Family health initiative to increase the availability, quality, and utilization of priority family health services and interventions, including nutrition and immunization	Consortium of partners led by CARE	Primary focus on eight focus districts; lessons will be scaled-up statewide through Government of Bihar	Funding approved in late November 2010; staffing underway; programme activities to commence in Q1 2011	Capacity building of frontline workers Name-based tracking Robust monitoring (supportive field supervision) Training and skill development Social and gender equity Optimizing appropriate supply and demand-side incentives Public-private partnerships
Engagement of private providers to improve the delivery of timely diagnosis and appropriate care for tuberculosis, pneumonia, diarrhea, and VL	World Health Partners	Will cover over 15,000 private health providers and 12,000 chemist shops in 25 districts of Bihar	Funding approved in late November 2010; staffing underway; programme activities to commence in Q1 2011	Innovations in public-private partnerships Improved diagnostics Demand creation Infectious disease control

Programme description	Lead partners	Focus districts	Status	NRHM priority areas addressed
				Optimizing appropriate supply-side incentives
Behavior change communications and demand generation to shape demand and shift social norms and promote appropriate health practices	Consortium of partners led by the BBC World Service Trust	Mass media will cover the entire state; mid-media and inter-personal communication will cover the eight focus districts; lessons will be scaled-up statewide through Government of Bihar	Funding approved in December 2010; staffing underway; programme activities to commence in Q1 2011 Contextual analysis of barriers and conducive factors for eight priority behaviours currently being conducted by Population Council – results expected by March-April 2011	IEC Demand creation Innovations in communication (Flexipool related) Social and gender equity Community mobilization Capacity building especially for inter-personal communication Optimizing appropriate supply and demand side incentives
Major initiatives in design phase				
Community mobilization to strengthen /create community based organizations to leverage for social norm change and strengthen grassroots mechanisms for communities to monitor and hold service providers accountable to ensure timely and predictable delivery of health services across public and private sectors	Partners to be identified	Anticipated primary focus on eight focus districts; lessons will be scaled-up statewide through Government of Bihar	Expected to be approved by Q3, 2011; currently PRAXIS is implementing a scoping study of community-based groups in Bihar to inform grant design and scope; study results will be available by February 2011	Community mobilization Accountability and performance of providers
Measurement, learning and evaluation (MLE) activities cutting across all the initiatives – will include analysis of available data sources, supplementary data collection and surveys and impact evaluation	Mathematica Policy Research; the Center for Global Health Research, University of Toronto; and the COHESIVE consortium	Will cover all districts where foundation-supported initiatives are implemented; sampling frame for evaluation still under discussion	Expected to be approved by Q2, 2011; currently Mathematica and CGHR implementing contracts to define the framework for MLE and identify baseline data sources; additional	Impact measurement Cost effectiveness

Programme description	Lead partners	Focus districts	Status	NRHM priority areas addressed
	(World Bank, Duke University, Sambodhi and others)		baseline data collection expected to be completed by Q2, 2011	
Other special studies				
Study of existing government to people (G2P) health payment systems in Bihar to identify challenges and propose solutions to increase efficiency, timeliness and targeting of payments including salaries, incentives, allowances and reimbursements	International Finance Corporation	The study covers health payments related to the JSBY, Muskaan Ek Abhiyaan and the RNTCP in five districts (Patna, Begusarai, Gaya, East Champaran and Sheikhpura)	The field work has been completed and findings have been shared with the SHS. Feedback from SHS officials is being incorporated. The next version of the report is expected in January 2011. At the request of the SHS, IFC will start work on a follow up project to support the Government of Bihar to implement the results of the study – this is expected to commence by Mar-April 2011	Management systems (especially health payments including salaries, incentives, allowances and reimbursements)
Studies to strengthen routine immunization delivery • Analysis of the routine immunization system to identify strengths, gaps and opportunities for improvement • Identification of low-cost innovations to improve targeting and delivery of vaccines for routine immunization	RI analysis – PATH Vaccine delivery innovations – Center for Knowledge Societies	RI analysis covered Kishanganj, Muzzafarpur, Patna and Gaya Vaccine delivery innovation study covered Kishanganj, Muzzafarpur, Patna, Gaya and Saharsa	Findings from the RI study are being finalized and will be available in Q1 2011 The vaccine delivery innovation findings were presented to the SHS in August 2010; a potential follow up study to further develop promising concepts identified during the first phase is currently under discussion	Systems strengthening Innovations for service delivery

In addition, a separate study is also proposed to analyze the current status of health monitoring systems in the state including formats, data flows, ICT platforms etc. The results of this study might be useful in reference to the NRHM 2011-12 priorities related to operationalizing the HMIS up to facility level.

UNFPA Bihar -

Background: UNFPA is closely working with State Health society Bihar and Department of Health & Family Welfare since last two years for providing the technical support in planning, implementation and monitoring of NRHM intervention in the state. The main focus of the support in the state from UNFPA is on following thematic areas

- Annual Planning for NRHM
- Family planning
- PC & PNDT Act implementation in the state
- ARSH
- Monitoring and Evaluation
- Maternal Health

UNFPA is directly providing technical inputs to State Health Society through its state office while few projects are being implemented through various implementing agencies in line with NRHM goals and objectives.

UNFPA support for year 2011 -12: UNFPA will continue supporting State Health Society for effective implementation of NRHM interventions at state and districts level and following would be planned support for the said year

a. Technical support through UNFPA office

UNFPA state office will provide direct support to the state health society through Technical Assistance AWP for the year 2011 and following support would be extended for effective implementation of NRHM.

1. ***Support to family planning program*** : UNFPA's main focus area for the state being family planning as state is one of the highest on TFR and focused support is required in order to reach population stabilization goals. UNFPA will provide following assistance for family planning program in the state under NRHM

    - Regular technical support would be given in routine planning and monitoring of FP program activities in the state through state office.
    - State office will provide technical and financial support in regular review meetings and capacity building of the district family planning nodal officers
    - UNFPA will provide dedicated HR support to the state level family planning cell through hiring of one state level family planning consultant.
    - Two regional family planning consultants would be provided for Muzaffarpur and Chhapra region for supporting the districts falling under these two regions for effective planning, implementation and monitoring of interventions planned under family planning program and PIP.
    - UNFPA will support in increasing the service providers network for male sterilization services mainly for NSV through refresher training of medical officers trained in NSV and also provide support to the state health society in monitoring the NSV trainings planned under NRHM PIP for the year 2011 -12.
    - UNFPA has supported assessment of reimbursement mechanism for accredited private providers for family planning services and has come out with Bihar specific

model to improve the payment systems to private providers and also to involve more and more private providers to support in providing family planning services. UNFPA would support implementation of the PPP model for one year, subject to approval from government to field test the model on pilot basis.

2. ***Support for population & development policy formulation and dissemination***: UNFPA is providing support to government of Bihar in formulating a comprehensive policy on population and development which tries to link effects of population growth on development and future direction for government to address population stabilization and overall development of the state population.

   - UNFPA will support technical experts for drafting the sectoral papers which would act backbone for policy formulation.
   - UNFPA will support hiring of experts for drafting the policy document in close collaboration with senior government officials.
   - UNFPA will provide support in dissemination of policy among various stakeholder and at various levels through organizing workshops to share the policy and actions recommended.

3. ***Support to three districts for NRHM***: State Health society has allotted three backward districts to UNFPA for providing support in effective planning, implementation and monitoring of NRHM PIP interventions.

   - One district facilitator would be placed from UNFPA in each of three allotted districts for supporting implementation of interventions planned under NRHM PIP for the year 2011 -12.
   - The district facilitator would provide active support in preparing the operational plan for the interventions.
   - District facilitator would provide technical support in preparing the NRHM District PIP for year 2012 -13.

4. ***Support in development of communication material***: UNFPA will provide support to state health society in development of communication and resource materials related to UNFPA mandated areas. UNFPA will develop the prototype of the requested material while printing cost would be taken up by state health society from NRHM funds.

5. ***Support for undertaking rapid assessments and surveys***: UNFPA will provide technical and financial support to small rapid assessments and surveys requested by the state health society to know the status and effectiveness various interventions or schemes implemented under NRHM. The support for such assessments would be given for UNFPA mandated areas.

6. ***Support in effective implementation of PC & PNDT Act***: UNFPA being the lead agency in the country in promoting effective implementation of PC & PNDT Act, would

extend its technical expertise and assistance in improving the implementation of act in the state. following support would be provided

- Providing resource and communication material developed by UNFPA on the subject.
- Technical support in capacity building of various stakeholders on PC & PNDT Act. (Session plans , resource persons and material)
- Sharing of best practices from other parts of the country

b. ***Projects contributing to NRHM goals and objectives:*** UNFPA is supporting few project implementations in the state which are directly contributing to the goal and objective of NRHM program. The projects supported by UNFPA are approved by various ministries of Government of Bihar and working in close collaboration with the health department. Following projects are implemented in the state with UNFPA support

1. ***Promoting change in reproductive behavior:*** UNFPA has collaborated with Pathfinder International who has previous successful experience of implementing intervention with youths in delaying the age at first birth and spacing subsequently. PRACHAR –III is implemented in 8 blocks of Gaya district to showcase PPP model can be utilized in promoting the behavior change in reproductive health among youth. The project aims to impact youth fertility and sexual and reproductive health practices among adolescents and youths in the project area.
2. ***Strengthening HMIS systems in Bihar:*** UNFPA is in partnership with Institute of Health Management and Research ,Jaipur for strengthening the HMIS system in Bihar. HMIS is one of the critical area in managing various programs under health sector and also can contribute greatly in improving the program performance. The project aims to build the capacity of health functionaries at all levels across 38 districts on HMIS and various data elements through structured training programs in close collaboration with state health society.
3. ***Development of two model ANM training schools:*** Reviving and strengthening ANM training school is focus are for majority of the states in order to meet the increased demand for the field functionaries to provide basic health care services. In past several studies highlighted gaps in basic trainings organized for ANMs mainly in terms of adequate exposure to clinical practices and also changing program needs. UNFPA partnered with ANSWERs , having vast experience in improving midwifery skills of field functionaries in AP. The project aims to develop two ANM training schools based at Gaya and Saharasa as model trainings schools which would be replicated across the state based on the experience gained from the project.
4. ***Mainstreaming of AEP program through SCERT:*** It is evident from various surveys and studies that youth, which would be backbone of the future of India and States have very limited knowledge on reproductive health hence indulge in wrong practices. It is very important to build the skills of the youths in order to take informed decisions

about their reproductive life. Looking at the need , UNFPA has partnered with CEDPA with great experience of working with adolescents on reproductive health to develop extra curriculum on reproductive health which can be taken up through school teachers in enhancing the knowledge and skills of school going adolescents. The project is implemented in collaboration with Ministry of HRD and SCERT. The project on pilot basis would be implemented in 822 schools from nine districts (one district per region).

Approximate budget for UNFPA support - Bihar

Sl. No.	Particulars	Approximate Budget (INR)
1	Support to the State Health Society for Family Planning	3,900,000.00
2	Support to focused districts for implementation of NRHM activities	3,800,000.00
3	Meetings / Assessments / reviews / process documentation	1,550,000.00
4	Printing of advocacy and Communication Material	500,000.00
5	Strengthening of HMIS in Bihar	84,74,079.00
6	UMANG - Reaching out to Youth in Secondary Schools in Bihar with Information & Skills for Improved Health and Well Being	1,07,74,581.00
7	Enhancing The Quality of Midwifery Education & Practice in India Models in Andhra Pradesh and Bihar	2,03,69,175.00
8	PRACHAR: Promoting Change in Reproductive Behaviour in Bihar	2,28,50,000.00
	Total	**7,22,17,835.00**

NPSP/WHO Bihar -

WHO-NPSP supports various activities related to polio eradication, Routine Immunization and Measles in Bihar through a network of Medical Officers. A total of 82 Surveillance Medical Officers (SMOs) are deployed in the districts. Most districts have one Surveillance Medical Officer while some high risk districts have additional SMOs posted in them. The NPSP SMOs are supervised and supported by Sub-Regional Team Leaders positioned at the divisional level and a Team Leader at the state headquarters. NPSP also provides support at the PHC level through a network of 441 Field Monitors and a pool of 555 External Monitors.

Role of NPSP in Polio Eradication:
WHO-NPSP provides support to the polio eradication through technical inputs at all levels, support in microplanning/ operations, monitoring & feedback, data management and AFP surveillance.

A. **Supporting a highly sensitive surveillance system to detect wild poliovirus transmission in all districts of the State**

a. ***Establishing, sensitizing and maintaining a network of reporting sites:*** NPSP SMOs play a critical role in establishment and maintenance of a large network of reporting sites for reporting cases of Acute Flaccid Paralysis (AFP). ***675 disease reporting units*** report weekly, including zero reports, to the network in Bihar. These reporting units are comprised of government and private hospitals and health centers. In addition, ***3634 Informing Units*** of Bihar

comprised of medical practitioners and traditional healers report Acute Flaccid Paralysis (AFP) cases.

b. ***Case-Investigation, follow-up, stool sample collection & shipment to WHO accredited Lab & sharing of result at all levels: 13509 AFP cases*** were reported and investigated in 2009 from Bihar. Stool specimens collected from AFP cases are tested in one of the WHO-accredited poliovirus laboratories in the network. In 2009, ***26184 specimens*** were collected, shipped and processed by the laboratory network. The NPSP SMOs ensure timely AFP case detection, immediate reporting and investigation through ongoing analysis of health facility contacts of patients, advocacy, sensitization and orientation of reporting sites, and training and capacity building of district immunization staff. Although the district immunization officers are responsible for all case investigations, all AFP cases are examined and reviewed personally by the SMOs. SMOs closely monitor and track specimen collection, handling, and shipment to laboratories.

c. ***Data Management and Analysis:*** Data on cases and system performance are managed and analyzed at the district level by SMOs for local feedback, dissemination and action. NPSP has established ***an electronic surveillance data base throughout the country that generates real time data on cases under investigation and those confirmed as polio.*** Analyzed data are shared by NPSP, every week with the state. Key programme decisions are taken and strategies designed/modified based on these data.

B. **NPSP Role in Polio Immunization Campaigns**

- ***Support micro planning and training for the polio campaigns:*** NPSP is involved with the formulation of the guidelines for micro planning and supporting the district and PHC Medical Officers in the implementation of these guidelines. NPSP has also been providing support for training support for vaccinators and supervisors by developing training modules and conducting trainings of trainers along with monitoring the sessions to ensure high quality polio campaigns.

- NPSP provides ***technical and organizational support for the District Task Force & Block level Task Force Meeting*** for Polio campaigns.
- ***Support in Data management at all levels:*** NPSP provides support in collection, compilation, analysis and transmission of program data.
- ***Support in Vaccine, cold chain and logistic management:*** NPSP provides technical support in management of vaccine and logistic chain.
- ***Monitoring polio campaigns:*** Through its extensive network of Field Monitors and additional temporarily hired monitors in Bihar, NPSP undertakes extensive monitoring of the planning and implementation of polio vaccination campaigns. NPSP monitors polio activity at house to house, Transit sites, Basas, and other special sites like brick kilns, nomads, construction sites etc. Data generated through the NPSP monitoring is extensively used by the state, district and sub-district governments to take corrective actions and improve the quality of the polio campaigns.

NPSP role in activities beyond Polio Eradication

A. Strengthening Routine Immunization:

WHO-NPSP has been assisting the Bihar Government with improving routine immunization coverage through its flagship programme - Muskan. The key areas of WHO-NPSP support to the routine immunization strengthening include:

- ***Technical Support:*** Support in formulation of policies, strategies and guidelines for improving the reach of the existing vaccines under Muskan
- ***Support in Capacity building:*** Support in developing training materials for immunization staff, supporting training of trainers, training of DIOs, facilitating training of MOs and evaluating training activities
- ***AEFI:*** developing and disseminating guidelines for surveillance of adverse events following immunization (AEFI). Provides technical assistance in conducting district and state level workshops, AEFI surveillance monitoring and feedback
- ***Monitoring:*** Monitoring immunization sessions and coverage through its extensive network of Field Monitors and using the monitoring data to identify gaps in the implementation of the routine immunization programme so that corrective actions can be taken to improve coverage.
- Facilitating regular review of Routine Immunization activity at district level (weekly) and state level (Monthly).

B. Measles:

- ***Technical assistance*** to the state for the effective planning and implementation of Measles catch-up campaign.
- WHO-NPSP is providing technical ***support in microplanning*** for Measles campaign through its network of district and block level field personnale.
- ***Capacity building:*** WHO-NPSP has supported training for Measles SIA at state, district and block level. It has also facilitated deployment of DIOs and MOs from all Non SIA districts to SIA districts for their capacity building.
- Provided technical assistance for ***District Task Force Meetings*** held for Measles SIA.
- ***Monitoring:*** WHO-NPSP is monitoring Measles SIA campaign through its network of Field Monitors and External Monitors and provides concurrent feedback at appropriate levels for corrective actions
- ***Data Management:*** WHO-NPSP is supporting data collection, compilation, transmission and analysis of Data.
- Provides technical assistance and lab support to district and IDSP for investigating selected ***major outbreaks of measles***

C. Other areas of support:

- Strategic technical and monitoring support during floods and major epidemics
- Supporting the state for Epidemic and Pandemic Preparedness Response
- Monitoring JE immunization campaigns

WHO RNTCP Technical Assistance Project

The World Health Organisation provides technical support to the Revised National Tuberculosis Control Programme and is not providing any financial assistance directly. The consultancy to the states is being provided by a network of consultants covering 10 to 15 million populations.

Technical Assistance Includes:

(1) Provide technical support to RNTCP for planning, training, surveillance and monitoring;
(2) Assist the State and district authorities in establishing good practices in all activities under RNTCP, including quality assurance, supervision and monitoring;
(3) Provide technical assistance in timely and complete electronic reporting of activities and information, using the standardized recording and reporting system;
(4) Assist RNTCP in validating reported data by promoting triangulation of records and reports, and facilitating internal evaluations of districts by the State and the Central TB Division;
(5) Facilitate uninterrupted drug supply at all levels by building capacity for drug stock management and prompt reporting of low stocks to State and the Central TB Division;
(7) Assist in coordination among government and non-government sectors including involvement of non-governmental organizations (NGOs), private physicians, medical colleges and health facilities under other health sectors;
(8) Liaise with State and District level authorities and Chairpersons of the Health Societies with a view to enhance political and administrative commitment for TB control;
(9) Assist in scaling up of all components of the 2006 Stop TB Strategy, including TB/HIV collaborative activities, laboratory strengthening and management of MDR-TB;
(10) Support to national efforts to monitor the implementation of the Global Plan to stop TB, 2011-2015 by routine evaluation through the use of standard recording and reporting systems and through the development of new indicators to permit evaluation of the implementation of new technology (e.g. new diagnostics).
(11) Mainstreaming DOTS into the regular curriculum and activities of medical colleges, and promoting operational research.

Major activities for the financial year 2011-12:

- Initiation of Programmatic Management of Drug Resistance Tuberculosis in the state
- Initiation of process of Accreditation of Intermediate Reference Laboratory at STDC Patna and RMRI, Patna.
- Initiation of TB HIV collaborative activities in all the districts of the state
- Facilitating evaluation of at least 8 districts by financial year end.

NIPI Bihar -

Situation Analysis and Financial Support of UNOPS-NIPI Programme in Bihar :

1. MAMTA Activities :

A total of 628 MAMTAs were appointed in 48 Hospitals (District and Sub Divisional Hospitals) of Biharfunded by NIPI. Number of MAMTAs required in each hospital required are calculated on the basis of average number of deliveries taking place in a hospital per day. After the recruitment of MAMTAs in all the Districts and Sub divisional Hospitals, training TOT was given to one Medical Officer and two 'A ' Grade Nurses drawn from each Sadar Hospital at SIHFW, Patna. Those who took TOT trained the MAMTAs in their respective Districts. The main component of the training was on Breast Feeding, Immunization, Family Planning options and mother and Baby Care. Each MAMTA was provided with a FLIP CHART to be used by MAMTA at the bed side of the Mother. The main purpose of MAMTA posting in the Hospital is to retain the mother for 48 hours in the Hospital and empower the mother on Breast feeding, Immunization of Baby, Family planning options and Mother and Child Care. Besides this MAMTA will facilitate a clean environment in Maternity ward and will provide all the comforts to mother during her stay at Hospital for 48 hours.

Incentives to MAMTA :

NIPI pays incentives to MAMTA every month. The basis of incentive payment is to multiply the number of Deliveries per month by Rs. 100/- and distribute amount of Rupees equally among all the MAMTAs working in the hospital.

Budget for MAMTA Activities :

NIPI will support the incentives of MAMTAs till June 2011 after which the incentives of MAMTA will be given by NRHM. NIPI has given financial support for distributing MAMTA kit in 2010 – 2011 only in Sadar Hospitals for a period of two months. However MAMTA Kit should also be provided to every mother delivering in Health Facilities including PHCs so it will be taken over by NRHM for 2011-2012.

Home Based Post Natal Care (HBPNC) :

Three Districts have been identified as NIPI Focused Districts (i.e. **Jehnabad, Nalanda** and **Sheikhpura**) where Home Based Post Natal Care (HBPNC) is being implemented. Whether a baby is born in a Health Facility or in the Home will be visited by ASHA 5 to 6 times till 42 days of birth of the Baby. ASHAs are filling up a Post Natal care Card **(PNC Card)** and submitting it to PHC after completion of 6 Visits During her visit if she founds a Sick Baby she will immediately refer the Baby to a Health Facility for treatment. Ideally the Baby should be referred to a **SNCU (Sick New Born Care Unit).** Since in these three District SNCU has not yet been established, ASHAs are referring the sick new Born Babies to their respective PHCs. It is expected that SNCU will be established in these three Districts by June 2011.

Incentives to ASHA :

NIPI is paying an incentives of Rs. 200. 00 to ASHA after completion of 6 Visits of ASHA to a New Born Baby and submitting the PNC Card to the PHC. NIPI will continue to pay incentives to ASHAs of three NIPI focused Districts (i.e. Nalanda, Jehnabad and Seikhpura District) in 2011-2012.

SICK NEW BORN CARE UNIT (SNCU) :

NIPI will facilitate the establishment of SNCU in Nalanda, Jehnabad and Seikhpura Districts by providing all the required Equipment of the SNCU. State Health Society has already offered the tender to TCI India to construct the SNCU in these three Districts. It is expected that the construction of SNCU will be completed by June 2011.

Budget : NIPI will pay for the equipment of the SNCU of Nalanda, Jehnabad and Seikhpura District.

2. TECHNOMANAGERIAL SUPPORT :

NIPI has funded to appoint staffs both at State and District Level. Four Consultants at State level (i.e. HR consultant, IT Consultant, Finance Consultant and State MAMTA coordinator) are appointed and at District level, 12 Deputy Child Health Managers , 7 Junior Child Health Managers, 10 Child Supervisors and 35 Deputy Child health Supervisors at present working in different districts of Bihar. Further appointments of Junior Child Health Managers are in process at present. In NIPI focused Districts there are 33 PHCS and each PHC will have a Deputy Child Health Supervisor to monitor and supervise the Home Based New Born Care (HBPNC) by ASHA.

NIPI will continue to pay for the already appointed persons at State level staffs appointed by NIPI Fund. However at District level NIPI will continue to pay the salary only of Junior Child Health Managers in NIPI Focused Districts. The salary of Deputy Child Health Managers, Child Health Supervisors and Deputy Child health Supervisors at District level will be paid by NRHM from June 2011-2012.

3. Support to SIHFW :

NIPI will provide fund of 60 Lacs of Rupees a Year to SIHFW for the State Child Health Resource Center and District Child Health Centers at Nalanda. Both the Resource center will be under the direct supervision of Director SIHFW. All the required staffs will be appointed by Director SIHFW by utilizing the NIPI Fund. Already 4 staffs (i.e. Mangement Consultant, Documentation Consultant, ANM Consultant and Data entry operator have been appointed for State Child health resource Center. Establishment of District Child Health Resource center is under process.

4. OUT SOURCING AGENCY FOR SUPPORTIVE SUPERVISION OF HBPNC :

AN Sinha Institute which is a Social Science institute under Ministry of Education, Govt. of Bihar has been out sourced for supportive supervision of HBPNC and skill building of ASHA for carrying out the Home Based Post Natal Care (HBPNC). The Supervisors of AN Sinha Institute are accompanying the ASHAs to the house of New Born Babies and helping the ASHAs to carry out the HBPNC work and correctly filling up the PNC card. Funding has been provided by NIPI to AN Sinha Institute for the supportive supervision of HBPNC and have been working since April 2010

Budget : NIPI will continue to give Financial Support to AN Sinha Institute for carrying out the supportive supervision and hand holding activities of ASHA for HBPNC in 2011 -2012

NB: The detailed budget for NIPI interventions, the training plan and training budget given in annexure-1&2.

DFID Supported "Sector Wide Approach to Strengthen Health (SWASTH)" Bihar - *SWASTH*

Sector wide approach for strengthening health (*SWASTH*) is a Government of Bihar initiative supported by DFID. SWASTH is a holistic and integrated approach to health and nutrition, spanning three government departments of Health and Family Welfare, Social Welfare, and Public Health Engineering.

Goal and Purpose

The goal of *SWASTH* is to improve the health and nutritional status of the people of Bihar. *SWASTH* will achieve this goal by reducing maternal deaths, child deaths, under-nutrition and unwanted pregnancies/fertility.

The purpose of the Programme is to ensure access to better quality health, nutrition, water and sanitation services especially for underserved groups.

Outputs

SWASTH will achieve its purpose through the realization of six cross cutting and mutually beneficial outputs.

1. Increased scale and functionality of nutrition, health and water and sanitation services,
2. Community level initiatives undertaken to manage, demand and monitor nutrition, health and water and sanitation services.
3. Availability, capacities and accountability of staff providing services improved.
4. Institutions established and systems strengthened to achieve better efficiency and effectiveness of service provision.
5. Capacity to work with non-government actors enhanced to deliver essential nutrition, health and water and sanitation services.
6. Quality and use of health, nutrition and water and sanitation monitoring and evaluation systems improved.

Programme Activities

DFID support will be spent on achieving the six outputs through mutually agreed milestones and activities. Six monthly and annual reviews will measure progress against the milestones. The programme will focus on the following

- Essential Health Care Package for Primary and Hospital Services;
- Quality assurance mechanisms for health, nutrition and water sanitation services;
- Establishment of a State Nutrition Authority incorporating ICDS and other central, state and donor supported programmes;

- Raising community awareness on safe health, nutrition and hygiene through an integrated state level campaign;
- Establishing/upgrading Nursing Schools and Colleges;
- Setting up a Bihar Medical Supplies Corporation under Department of Health.
- Establishing a state of the art Management Information System for Health, Nutrition and Water and Sanitation Departments;
- Establishing 8471 nodal Anganwadi (Village Nutrition) Centres across the state - one AWC in each Panchayat to support 11-12 Anganwadi Centres;
- Research using randomised controlled Trials (RCTs) approach, which will provide high quality data to inform key Bihar decision-makers.
- Mechanisms to strengthen convergence between the three departments.

Financial Assistance and Phasing

DFID will provide assistance of 145 million pounds (about 1000 crores) over 6 years, this includes technical assistance through B-TAST and a pool of Technical Cooperation (TC) funds. DFID and partner departments from GoB (DoH, SWD and PHED) will agree an action plan for the utilisation of TC prior to incurring expenditure. *SWASTH* is being implemented in a phasewise manner

- The design phase –*(Jan to Jul 2009)*
- Interim phase – *(Aug 09 to March 2010)* (Technical assistance provided)
- Implementation Phase *(Year 2 – 7)*

Status of *SWASTH*

The programme was launched in January 2009, with an aim to prepare the design for implementation. A technical Assistance support team (B-TAST[5]) was provided by DFID to support GoB to prepare the design for the programme. A series of consultations (between BTAST, GoB and DFID) and field visits were undertaken in this phase have been the basis of the following.

- A detailed diagnostic report of the Health, Nutrition, water and sanitation services in the state has been prepared.
- Human resources and organization development and Procurement processes reviewed and key issues identified for action
- Strategies and operational plans for Health, Nutrition and WATSAN (water and sanitation) prepared
- Based on the above specific goals, indicators and activity matrix for *SWASTH* were framed *and* lastly a Programme Memorandum was drafted.
- During the interim phase support, was provided in the areas of – Procurement, HR &OD, Financial management, MIS, Addressing Violence Against Women and preparing modules for Water, sanitation and hygiene for frontline workers.

[5] BTAST is managed by a consortium of CARE UK, Options Consulting UK and IPE Global India.

Programme Implementation Team:
Besides a team of cross sectoral experts at the State level for providing techno managerial support to the state, under the programme the state has been divided in 6 clusters with each cluster comprising of 6-7 districts, each of the cluster offices are manned by skilled professionals with expertise and experience in health, nutrition and WATSAN . Besides these, a coordinator has been placed in each of the 38 districts.

PFI initiatives in Bihar –
Population Foundation of India (PFI) set up by a group of industrialists led by the late J R D Tata in 1970 is a national level non-governmental foundation dedicated to promote effective formulation and implementation of gender sensitive population and development policies, strategies and programmes with a focus on Reproductive and Child Health issues. PFI addresses the critical issues of population, health and sustainable development for better quality of life, by increased access to quality services, promotion of advocacy programs, capacity building at various levels and facilitating an enabling environment for optimal utilization of resources. It is committed to serving the economically weaker and marginalized sections living in socio-demographically backward districts of the country. PFI considers a rights-based framework and gender sensitivity as cross cutting approaches in all its population programs. PFI's network and reputation in India is well recognized, including at the policy level. Its work spans several states and includes projects in women's health, reproductive and child health, adolescent reproductive and sexual health, community based distribution of services, and media advocacy and communication. PFI works in partnership with the government and NGOs, and relies heavily on community planning, monitoring and participation.

PFI's strategic partnerships involve working with central and state governments; community based voluntary organizations, initiatives led by the corporate sector, and the media. PFI for the past four years has been undertaking various programmes as a technical support agency towards improving RCH and HIV/AIDS status in the state of Bihar. In RCH, PFI has been notified by the Government of India (GOI) as the Regional Resource Centre for Bihar to work towards improving access to quality Reproductive and Child Health services from the public health system in un-served/ underserved areas of the state. As an RRC in the state, PFI provides technical support for effective RCH programme management, advocates for appropriate changes in programmes and policies for ensuring policy implementation with district, state and central government and to network with the state/district officials and MNGOs to strengthen linkages.

Under NRHM, PFI has been identified by the GOI to serve as the National Secretariat for the Advisory Group for Community Action (AGCA), a statutory group of experts from the civil society identified by the GOI. Under AGCA, PFI also served as the Secretariat for a nine-state pilot on the community monitoring component in NRHM.

In Bihar, PFI has been identified as the State Nodal-cum-Technical Agency by the SHS Bihar to provide technical and managerial support for facilitating the community based planning and monitoring (CBPM) process in the state. PFI is facilitating the CBPM process in the selected pilot district of the state working in close collaboration with SHSB and other development partners.

PFI provides technical support to the state for strengthening family planning initiatives in the state. PFI is one of the members of the State Advisory Group for Family Planning initiatives and the State ASHA Mentoring Group. PFI provides technical support to the ASHA cell for strengthening the ASHA programme in the state. It also provides technical support to the monitoring and evaluation cell of SHS Bihar for strengthening monitoring & evaluation system and ensuring quality of health care services in the state. PFI is also providing technical support to the state for planning and implementation of village health, sanitation and nutrition day.

During the next financial year, PFI would continue supporting the NRHM initiatives in the State by providing all the technical and managerial support for successful implementation of CBPM process, FP initiatives, quality assurance, ASHA programme and implementation of VHSND in the State.

IPAS

Ipas, a not for profit non-governmental organization, was founded with the unique mission to reduce abortion related maternal death and injury and increase women's ability to exercise their sexual and reproductive rights. Ipas begins its operation in India since 2001, takes a comprehensive approach to advancing women's access to safe, women centred comprehensive abortion care. Major initiatives include strengthening training systems and service delivery in primary health care settings, promoting early abortion technologies such as Manual Vacuum Aspiration and Medication Abortion, conducting research on abortion issues and advocating for policies that support women's health and rights.

In order to provide safe abortion services in Bihar, the doctors are being trained as per the MTP Act, 1971, with the support and facilitation of IPAS. The program includes training on new technology like Manual Vacuum Aspirations (MVA) and Medical Abortion. Till date (Oct 2002 to November 2010) Ipas facilitated training of 735 Medical Officers on Comprehensive Abortion Care (CAC) in the state (of which 147 were trained during April'10 to Nov 2010). These medical officers are placed as such- 235 in PHCs, 55 in Dist. Hospitals, 43 in Referral Hospitals, 35 in APHCs and 10 in Medical College & Hospitals.

IPAS will continue facilitating MTP training as per its own annual plan and also continue providing technical support to the Government of Bihar on all issues of MTP.

Micronutrient Initiative

Micronutrient Initiative (MI) is an international, not- for-profit organization dedicated to ensuring vitamins and minerals needed for survival of the women and children of developing countries. Its mission is to develop, implement and monitor innovative, cost effective and sustainable solutions for hidden hunger, in partnership with International agencies, Central and State governments and industries. MI supports and promotes food fortification and supplementation programmes in Asia, Africa and South America and provides technical and operational support those countries where vitamin and mineral deficiencies are most prevalent.

Keeping in mind the National Policy and MDG goals, the Government of Bihar in collaboration with MI and UNICEF has been conducting two rounds of Vitamin A in a year 6 months apart. The round activities are carried by health department in close coordination with ICDS department. However MI is also providing technical and financial support in terms of capacity building, IEC, monitoring and other round related activities.

In Bihar MI is providing technical and programmatic support to Department of Health, State Health Society, and Directorate of ICDS in implementation of vitamin –A biannual round at six months apart every year, Childhood Diarrhea Management Programme, and Wheat Flour Fortification Programme.

In Bihar the vitamin –A Supplementation Programme started in the year 2000 as standalone programme. In 2001 the programme was carried by the name of Netra Jyoti Abhiyan, however, from 2003 the supplementation activity was carried out along with immunization under RI Plus.

The biannual rounds are of four days starting from Tuesday and concluding on Friday. At the govt. health facilities services provided are routine immunization, vitamin A supplementation and counseling of caregivers. However since 2005 the programme starts from Wednesday and concludes on Saturday.

Major activities undertaken during the year

Sl.No	Particulars	Expenditure (in lakhs)
1	Capacity Building	
1.1	State level training of instructors of 49 Aganwadi Training Centers	1.30
1.2	State level training of Block Health Manager of 47 low performing PHCs	1.36
1.3	PHC level PHC level training of 263 batches of ANMs & AWWs of low performing PHCs	19.19
2	IEC/BCC activities	
2.1	T.V spot containing VA message in prominent channels such as Mahua for 5 days ,Saharsa for 10 days	1.37
2.2	Bus flex in 50 buses of Bihar Transport Department covering important routes of Bihar for one month.	1. 45
2.3	Hoarding in 11 important places of Patna urban areas before VAS round-I for one week	0.63
2.4	Hoarding in 4 districts for one month for VAS round-II	2.72
2.5	PHC flex containing VA message in 275 PHCs	1.54
3	Community Mobilization Activities	
3.1	Nukkar-Natak in 10 districts of Bihar covering 960 villages.	15.84
3.2	Organized 6156 group meetings in 13 districts of Bihar	12.30
4	Supply and Logistic	
4.1	Supply of Vitamin-A bottles, markers and posters in 99 PHCs of 8 districts for VAS round-II, 2010.	0.90
4.2	Procurement of 110943 markers for avoiding overdosing of VA during VAS round for all urban and rural sites for round-II, 2010.	17.53
5	Programme Implementation Support and Monitoring	
5.1	Mobility support to SIO for 7 days and DIO for 4 days in 32 districts for monitoring of VAS round.	2.03
6	Data analysis, reporting and documentation	
6.1	Coverage evaluation study for Patna urban areas	4.00
Total Expenditure		80. 71

Childhood Diarrhea Management Program

In Bihar, MI in support with the Department of Biotechnology and Biological Corporation Limited (BIBCOL), a central public sector company under the Department of Biotechnology (DBT), Government of India in partnership with Government of Bihar has piloted the "Supporting the scale up of therapeutic zinc as a part of the revised diarrhea management program to reduce childhood morbidity and mortality in the State of Bihar" in five districts of Bihar namely Munger, Khagaria, Saharsa, Madhepura and Supaul. MI in support of BIBCOL ensured supply of Zinc tablets to all health facilities and ICDS centers in all intervention

districts of Bihar. Under this strategy the ANMs and AWWs administered Zinc tablets and ORS to children suffering from diarrhea.
Major Activities undertaken during the year

Sl.No	Particulars	Expenditure
1	Advocacy	
1.1	District level Awareness & Sensitization Workshops for members of PRIs - Pramukh, District Board - Chairperson, Parishad & Municipal Corporations - CEO, Mayor	0.35
1.2	PHC/ Block level joint planning meeting of Program Managers of Health & ICDS of 51 PHCs	0.18
1.3	IEC for State level Launch	0.14
2	Capacity Building	
2.1	District level refresher Training of Trainers (MOI/Cs/ MOs, CDPOs)	0.50
2.2	PHC level training of ANMs and AWWs for 50 PHCs	5.56
2.3	Sensitization workshop for ASHAs	5.06
2.4	District level training of district and PHC level MOs	0.55
2.5	PHC level orientation of AWWs and ANMs on reporting formats and registers	0.36
3	IEC/BCC	
3.1	Development & printing of leaflet for caregivers	3.98
3.2	Information booklet for ANMs & AWWs on diarrhea management	3.28
3.3	Poster printed for AWCs, HSCs, PHCs and district offices on benefits of Zinc	0.41
3.4	Printing and distribution of compliance card	10.35
4	Monitoring and MIS	
4.1	Development, printing & distribution of PHC/ AWC-Project-District level monthly reporting formats	2.09
4.2	Development, printing and distribution of monitoring formats	0.50
5	Evaluation	
5.1	District level orientation of DPM, BHMs & Data Entry Operators of PHCs on data entry & data analysis of monthly reports	0.32
5.2	Process documentation	1.50
Total Expenditure		35.13

Scaling up Childhood Diarrhea Management Programme:

The Childhood Diarrhea Management Programme will be scaled up in all districts in phased manner over 2-3 years for which MI- CIFF will provide technical and programmatic support to Department of Health, GoB.
For scale up therapeutic use of Zinc tablets with LO-ORS for childhood diarrhea management program in 15 districts, in the first phase, a tripartite MOC between GoB, MI and CIFF is in pipeline, the duration of MOC is for five years (2010-2015). The names of the districts that will be covered are Bhagalpur, Banka, Jehanabad, Sheikpura, Nalanda, Gaya, Munger, Khagaria, Saharsa, Madhepura, Supaul, Shamastipur,Sheohar, Sitamarhi and East Champaran These districts have been selected in consultation with the State Government

keeping in view a number of parameters like the size of the population, the number of children aged 9-59 months, composite index ranking (Ranking and Mapping of Districts, 2006, International Institute of Population Sciences, Mumbai), roll-out of the IMNCI programme, focus districts of partners and other players. The districts selected are part of south Bihar and fall under either the Gangetic or Kosi flood prone areas. In the subsequent phase the remaining districts will be taken up.

Objectives:

To reduce the burden of diarrhea on child health and survival in Bihar by facilitating the scale up and mainstreaming of therapeutic zinc supplementation and oral rehydration for treatment of childhood diarrhea through public channels in Bihar.

To enable state-wide scale up of proven approaches, lessons and good practices by integrating them into State Government plans and programs.

To document and disseminate results and lessons to influence related diarrhea management programs within India and other developing countries.

Activities for scaling up Diarrhea Management Program in 15 districts:

Sensitization of State and district level functionaries

Supply of Zinc + Lo- ORS

Development of communication strategy and printing of IEC materials

Printing of Training Modules

Training of block, sector and field level functionaries of Health

Field level monitoring

External Evaluation to assess the extent of awareness and utilization of zinc + Lo- ORS in the community

Integrating Record keeping and reporting in the existing HMIS

Budgetary Outlay

Sl.	Activity	Amount (Rs. In Lakhs)
1.	Provision of seed supply/buffer stock of co-packaged Zinc- (Rs. 127.85 lakhs for estd. 17.88 lakhs episodes) + ORS (Rs. 173.91 lakhs for estd. 17.88 lakhs episode)+ cost of Co-packaging(Rs. 17.09 Lakhs)	319.00
2.	State level workshop for scale up Zinc and LO-ORS	0.97
3.	Training of of MOs, CDPOs,	3.94
4.	Training of ANMs	8.21
5.	Training of BHMs	2.99
6.	Training of Supervisors	6.56
6.	Sensitization workshop for ASHAs	31.53
7.	Sensitization workshop for AWWs	19.71
9.	Formative research	8.60
9.	IEC/ IPC/awareness of caregivers	24.51
10.	District level workshops	1.31
11	Monitoring and Evaluation	5.90
	Total	433.23

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NTCP

NATIONAL TOBACCO CONTROL PROGRAMME (NTCP), Bihar

Executive Summary:

Tobacco use is the leading preventable cause of deaths and diseases in the world. Globally, tobacco causes 5.4 million deaths or an average of one death in every 6 seconds and accounts for one in 10 adult deaths worldwide. The death toll is projected to reach more than 8 million by 2030 if current trends continue. In India, the tobacco related deaths are currently range between 9-10 lakh per year.

Tobacco use is increasing in India, but there are considerable changes in the types and methods by which it is used. The Ministry of Health and Family Welfare, Govt. of India has taken clear steps to deal with the menace of tobacco use. Variety and popularity of forms of tobacco consumption in India, both smoked and smokeless, are causing terrible increases in cancer deaths. Oral cancer rates are occurring at a very high incidence with the popularity of gutka, khaini, zarda, mishri, and other chewing tobacco.

The Framework convention on Tobacco Control (FCTC) is the first international treaty negotiated under the auspices of the WHO aimed at curbing tobacco related deaths and diseases. India was the first country to ratify the FCTC on **5th February '2004** and is now a party to the convention and therefore, has to implement all provisions of this international treaty. Accordingly, the Tobacco Control Act, 2003 was introduced.

The Govt. of India proposed a pilot Programme for effective implementation of the anti-tobacco legislation and to create awareness about the adverse health consequences of tobacco consumption. The Ministry of Health & Family Welfare, Govt. of India launched a pilot programme for effective implementation of the anti-tobacco legislation and to create awareness about the adverse health consequences of tobacco use and hence, a National Tobacco Control Programme (NTCP) had been commenced in 2007.

Background:

Bihar is geographically located at Latitude: 25.110 N Longitude: 85.320 E, covering area of **94,163 sq. km**. and a population of **82.9 million**. There are 9 divisions, 38 districts, 101 sub divisions, 533 blocks and 45,098 villages. The State has population density of 881 per sq. km. (as against the national average of 312) with a sex ratio of 921 women per 1000 men.

According to Global Adult Tobacco Survey (GATS-2010), currently there are ***274.9 million*** tobacco user, age 15 and above in India. Among them, ***197.0 million*** are males and ***77.9 million*** are females. In Bihar currently **53.5%** of the people are tobacco users and **66.2%** of **man** & **40.1%** of **female** are using tobacco in either smoking or smokeless form. More than **50**% school and college students are addicted to tobacco use.

Currently about one- fifth of all worldwide deaths attributed to tobacco occur in India, more than 9,00,000 people die and 12 million people become ill as a result of tobacco use each year . The deaths attributable to tobacco, in India, are expected to rise from 1.4% of all deaths in 1990 to 13.3% in 2020. It is estimated that 5,500 adolescents start using tobacco

every day in India, joining the 4 million young people under the age of 15 who already regularly use tobacco.

Situation Analysis

Bihar produces 1.6 % of raw tobacco of total production in India. High prevalence of tobacco use in Bihar is known across the years. As per Global Adult Tobacco Survey (GATS-2010) and National Family Health Survey (NFHS-2), Prevalence of tobacco use between men and women age 15-49 years, depicted in the table below :

S. No.	Indicator	Males (%)		Females (%)	
		India	Bihar	India	Bihar
1.	**Tobacco users**	48.0	66.2	20.0	40.1
2.	**Smokers**	15.0	26.3	2.0	6.2
3.	**Chewers**	24.0	51.8	17.0	6.7

Global Youth Tobacco Survey (GYTS):

The India - Bihar GYTS includes data on prevalence of cigarette and other tobacco use as well as information on five determinants of tobacco use: ***access/availability and price, environmental tobacco smoke/second hand smoke exposure (ETS/SHS), cessation, media and advertising,*** and ***school curriculum.*** These components India could include in a comprehensive tobacco control program.

The India – Bihar GYTS was a school-based survey of students in standard 8-10, conducted in the year 2000. The school response rate was 100%, the student response rate was 70.1%, and the overall response rate was 70.1%. A total of 2636 students participated in the India – Bihar GYTS.

Highlights of GYTS:

- 59% of students currently use any form of tobacco; 14% currently smoke cigarettes; 46% currently use other forms of tobacco.
- ETS exposure is high – 3 in 10 students live in homes where others smoke; half are exposed to smoke in public places; almost 4 in 10 have parents who use smoke, chew, or apply tobacco.
- Almost 6 in 10 students think smoke from others is harmful to them.
- 7 in 10 students think smoking should be banned in public places.
- Almost 7 in 10 smokers want to stop.
- Over 9 in 10 students saw antismoking media messages in the past 30 days; over 9 in 10 students saw pro-cigarette ads in the past 30 days.

Plan of Action for the year 2011-12:

1. To follow up with the Govt. to notify Enforcement agencies and mechanism of the Gazetted Officers as Enforcement Squad for compliance of the rules of the Tobacco Control Act, monitor violations and imposing penalty.
2. At present NTCP is functioning in the state capital, Patna and Munger District. In the year 2011-12, proposed to be covered all the districts under the tobacco control program.
3. Convergence into all health programs/ vertical programmes of National Rural Health Mission.

4. BCC/ IEC development- Print , Audio, Audio-visual, Electronic Media
5. Trainings/ Workshop – Health professional, Teachers, Students, Media, Police, Law enforcers, community at large and other stake holders.
6. Programs in Educational Institutes (including Colleges & Schools)
7. State level Survey/ Intervention on Tobacco Control.
8. Constant monitoring of the implementation of the Tobacco Control Act (COTPA-2003).
9. Tobacco Cessation Centres to be established in all the district hospitals.
10. Signature campaign would be organized at state level for the mass level awareness on tobacco control.

Activities conducted under NTCP, Bihar:

The major activities are being carried out by the State Tobacco Control Cell, State Health Society, Bihar from 1st of June-10 to December-2010 so far:

- State Tobacco Control Cell collected the law of various states and submitted to a lawyer for drafting own legislation for the state. It will be presented before the state govt. for final approval.
- Meeting with HRIDAY and Socio Economic and Educational Development Society (SEEDS-NGO) representative on tobacco control issues in the state.
- One day meeting on **19th of June-10** on tobacco control organized by Bihar Voluntary Health Association.
- The State Tobacco Control Cell, State Health Society, Bihar (SHSB) organized a meeting of State Tobacco Control Committee at the conference hall of SHSB on the **7th September 2010**.The meeting was chaired by Mr. Sanjay Kumar, Executive Director – State Health Society and was attended by Director in –Chief, Drug Controller, Asstt. Drug Controller- Department of Health, Govt. of Bihar, Principal Investigator of Tobacco Cessation Centre, PMCH, Patna, representatives from Bihar Voluntary Health Association, Socio Economic and Educational Development Society (SEEDS), Bihar, HRIDAY, New Delhi, besides all the State Programme Officers and Consultants of SHSB.
- A letter and draft guidelines had been prepared and signed by Secretary, Health-cum-Executive Director, SHSB, sent to District Magistrate and Civil Surgeon of **Patna** & **Munger** to set up DTCC and Monitoring/Steering Committee at district level.
- Meeting on tobacco control with Socio Economic and Educational Development Society (SEEDS) on **20th October-2010**.
- State Tobacco Control Cell, SHSB organized a meeting on **24th of September-2010** with Director in-chief, Municipal Counsellor, Civil Surgeon and Head of department of Biochemistry- Patna Medical College & Hospital of Patna district. The purpose of the meeting was to launch the two months special health check up camp on Hypertension and Diabetes for urban poor with emphasis on tobacco and alcohol consumption.
- State Health Society has developed and distributed 4000 **"No Smoking Area-Smoking Here is an Offence"** signage to display in the entire state specially the

offices of District Magistrate, Regional Deputy Directors, Civil Surgeon, Civil hospitals and Medical Colleges etc.

- A letter to all the Vice Chancellor of universities in Bihar to put up the '***No Smoking'*** tin plates at prominent places in the university and colleges premises. The signage has been provided by SHSB.
- A letter has been sent to District Magistrates and Civil Surgeons of **Darbhanga, Bhojpur, Samastipur, Vaishali** and **Katihar** on **3rd September-10**, for providing necessary support and cooperation to Socio Economic and Educational Development Society (SEEDS)-NGO for carrying out the tobacco control activities in these districts.
- A detail power point presentation on tobacco control issues in the Civil Surgeon meeting of 38 districts on **5th August-10** at hotel Maurya, Patna. Distributed the hard copies of the presentation and Tobacco Control Act-2003.
- State Consultant visited the different institutions/offices on **17th August-10** and hold discussion on Tobacco Control Act-2003 and National Tobacco Control Programme such as Bihar Voluntary Health Association, Socio Economic and Educational Development Society and Tobacco Cessation Centre, Patna.
- A letter from Secretary, Health-cum-Executive Director, SHSB, has been sent to Director in Chief, Health Services, Govt. of Bihar on **19th October-10** for integration of tobacco control activities into TB control trainings.
- Visited the Regional Cancer Centre (RCC), Indira Gandhi Institute of Medical Science (IGIM), Patna. Met Dr. Rajeev Nandan- Head of RCC, discussed with him on tobacco control and cessation issues. He said that the IGIM is planning to open a Tobacco Cessation Centre. Visited the Cancer Awareness Society (NGO), discuss on tobacco program. They are working on tobacco control issues in Bihar.
- Two days visit to Munger district on **15-16th November-10**. Meeting with District Magistrate, Civil Surgeon, Deputy Superintendent of Sadar Hospital, District Programme Manager and other staff of District Health Society.
- Meeting on 16th of November -2010 in the chairmanship of District Magistrate, Munger. State Consultant presented a detailed presentation on tobacco control issues and district tobacco control programme. 30-40 higher officials were presented in the meeting including Civil Surgeon, Drug Inspector, Medical Officer and Nodal Officer of tobacco control.
- The Tobacco Control Act "***Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act' 2003"*** has been uploaded on the official website of SHSB (www.statehealthsocietybihar.org)
- Prepared one page note on tobacco control program and initiatives taken by the state, to be presented before Chief Minister of Bihar.
- The District Tobacco Control Cells (DTCC) has been established in the district of Patna & Munger. The Nodal Officer has been notified for tobacco control activities at district level.

- The district level monitoring/ steering committee has been formed in Munger and Patna under the chairmanship of District Magistrate including the members from Health, Education, Police, Academicians and civil societies in the list.
- Recruitment of district level staff is in the process. They would be placed at DTCC Patna & Munger under District Health Society.
- The Guidelines for Law Enforcers and Health Worker Guide are being developed by SHSB, file processed.
- The State Health Society are developing appropriate IEC materials for effective tobacco control at grass root level, three designs of poster and pamphlets.
- Meeting with Drug Inspectors and Licensing Authority on **10th December-2010** at the conference hall of Directorate of Health Services, Govt. of Bihar.
- Letter to all the District Magistrate for setting up District level steering/ monitoring committee for tobacco control.
- Letter to all the Civil Surgeons for notifying the Nodal Officer for better implementation of tobacco control programme and Tobacco Control Laws at the district and grass root level.

National Tobacco Control Programme:

A beginning has been made in the form of National Tobacco Control Programme (NTCP), by the Ministry of Health & Family Welfare, Govt. of India in 2007, under the 11th five year plan; NTCP aims to build capacity of the states to effectively implement the Tobacco Control Laws and also to bring greater awareness about the ill effects of tobacco use. In 1st pilot phase (2007-08) of the program 9 states & 18 districts has been covered. In 2nd phase (2008-09) the programme has been expanded to 12 more states & 24 districts. Bihar is the 2nd phase state and the programme is being implemented in **Patna** & **Munger**.

Main components of NTCP:

- Setting up of the State Tobacco Control Cell.
- District Tobacco Control Programme.
- Anti-tobacco Public Awareness Campaign.
- Establishment of tobacco testing labs.
- Research and Training.
- Monitoring and Evaluation.

State Tobacco Control Cell:

The State Tobacco Control Cell (STCC) has been established under the State Health Society, Bihar. The STCC manned by State Consultant, will build the capacity of the state in effective enforcement of the Anti-tobacco laws and also to coordinate the district tobacco control programme. It is proposed that Programme Assistant may be appointed in the STCC for smooth and successful execution of the program.

District Tobacco Control Programme:

The District Tobacco Control Programme put up in place for bringing about public awareness against ill - effects of tobacco use. School programmes, effective monitoring/ enforcement of anti tobacco provisions and providing support to tobacco cessation are included in the activities. Two districts namely, **Patna** and **Munger** have been identified for

setting up the District Tobacco Control Cells (DTCC). It is proposed that District Tobacco Control Units will be set up in District Government Hospitals. The Nodal Officer will coordinate all activities of the tobacco control program.
The Nodal Officer will also conduct tobacco control activities with support from DTCC personnel in collaboration with local NGOs. The DTCC personnel are 1 Psychologist, 1 Social Worker and 1 Data Entry Operator, will be engaged on contractual basis to carry out the tobacco control activities.
The District Tobacco Control Programme comprises of the following components:

a. **Implementation and Monitoring on tobacco control laws**
b. **Training and Sensitization**
c. **IEC/BCC activities**
d. **School Programme**
e. **Tobacco Cessation Centre (TCC)**
f. **Identifying partnerships with NGOs/PRIs and Urban Level Bodies**

a. <u>Implementation and Monitoring Tobacco Control Laws</u>:

A small team of trained personnel at every level would be formed with a view to ensuring various provisions of Indian Tobacco Control Act-2003 are properly implemented. Small teams of trained school teachers, health workers, law enforcers, women SHG, and other civil society organizations would be formed to cover small areas of each district. These groups with local NGOs would report violations back to the Nodal Officer for ensuring proper implementation of law.

b. <u>Training & Sensitization</u>:

The DTCC will conduct training workshop among the School Teachers, Health Workers, Law Enforces, Self-Help-Groups and other civil society organization etc. training on tobacco control will be provided by identified GOI institutions/TCC on tobacco epidemic, tobacco control laws and implementation of the same.

c. <u>IEC/BCC activities</u>:

State and District level campaigns would be carried out through local cable TV channel, Radio, Street shows, exhibitions, Mela etc. in regional language. Awareness programs on tobacco control proposed to be carried out by the women SHG/NGO in community, villages, slums etc. IEC materials will be developed and disseminated in local languages.

d. <u>School Programme</u>:

The school programme is aimed at creating awareness among the school teachers/children, who will also become the ambassadors for the cause. In the 2nd phase of pilot project at least 40-50 Government and Private schools per district would be taken up under the School Programme. Some schools in the district may be declared as **'Tobacco Free School'** based on some criteria.

e. <u>Tobacco Cessation Centre (TCC)</u>:

For tobacco cessation activities there would be Tobacco Cessation Centre in the District Tobacco Control Cells. These TCC would provide counselling and pharmacotherapy to tobacco users for quitting the tobacco addiction besides TCC will develop community outreach programmes and conduct training and awareness programme at schools and colleges.

f. Identifying partnerships with NGOs/PRIs and Urban Level Bodies

Local NGO/Civil Society Group may involve in implementation of the district level components and forward the message to the community/grass root level for greater awareness and effectiveness of the programme.

Proposed Budget for the National Tobacco Control Programme, Bihar

Proposed Budget for establishment of State Tobacco Control Cell

S. No.	Activities Proposed	Budget in Lakhs	Remarks
1.	Remuneration: State Consultant@Rs.40000/- x 1 person x 12 months	4.80	To support the daily activities, one State Consultant and one Programme Assistant may be recruited.
2.	Remuneration: Programme Assistant @ Rs. 15,000/- x 1 person x 12 months	1.80	
3.	IEC materials Printing of Brochure, Poster and Pamphlet etc. Radio Jingles and modules/ guidelines would be developed.	5.00	This is very important activities for tobacco control
4.	Training/ Workshop/Meeting	2.00	Multi sectoral coordination, workshop and training with different stakeholders such as education, police, transport other departments would be organised.
5.	Monitoring the tobacco control laws	2.00	
6.	Contingency Expenditure	1.00	
Total		**16.60**	

Total estimated budget for State Tobacco Control Cell = **Rs. 16.60/-**

Budgetary estimate for one District Tobacco Control Cell

S. No.	Details	Budget in Lakhs	Remarks
1.	Remuneration: a. Psychologist/Counsellor @ Rs.15, 000/- x 1person x 12 months. =180000/- b. Social Worker @ Rs.13, 000/- x 1person x 12 months. = 156000/- c. Data Entry Operator @ Rs. 8,000/- x 1 person x 12 months.= 96000/-	4.32	
2.	Training	2.00	
3.	IEC development	2.00	
4.	School Programme	4.00	
5.	Monitoring the tobacco control laws & reporting	1.00	
6.	Contingency	1.00	
Total		**14.32**	

Total budget for two District Tobacco Control Cell = **Rs. 14.32 lakhsx2 = 28.64/- (Twenty eight lakh sixty four thousand only)**

Additional budget required for IEC and Mass Media activities to be conducted in all 36 Non-NTCP districts of Bihar. The fund may provided as **Rs. 50000/ x 36 = 18, 00, 000/- (Eighteen lakh only)**

Summary of Budget:

S. No.	Details	Amount (Rs. In Lakh)	Remarks
1.	Proposed budget for State Tobacco Control Cell	**Rs. 16.60**	
2.	Budget for District Tobacco Control Programme	**Rs. 28.64**	
3.	Additional budget for IEC and Mass Media activities	**Rs. 18.00**	It would be conducted in except pilot districts, Patna & Munger.
Grant Total		**Rs. 63.24**	

Total budget = Rs. 63.24 /-

NCCD

Technical Assistance for Human and Institutional Capacity Building on Non Communicable Chronic Disease

Introduction

India is in the midst of an epidemiological and demographic transition – with the attendant problems of increased chronic disease burden and a decline in mortality and fertility rates leading to an ageing of the population. Non-communicable diseases such as cardio-vascular diseases, diabetes, obesity, kidney disease and tobacco use related illnesses have imposed the chronic diseases burden on the already over- stretched health care system in the country. Pre-mature morbidity and mortality from chronic diseases can be a major economic and human resource loss for India. The large disparity across India places the burden of these conditions mostly on the poor and on women, scheduled castes and tribes especially those who live in the rural areas of the country.

The World Health Report of 2002 states that cardiovascular diseases (CVD) will be the largest cause of death and disability in India by 2012. Non Communicable diseases (NCDs), especially cardiovascular diseases, diabetes mellitus, cancer, stroke and chronic lung diseases have emerged as a major public health problem in India, due to an ageing population and environmentally driven changes in behavior. It is estimated that in 2005 NCDs accounted for 5,466,000 (53%) of all deaths (10,362000) in India.

The Mission document of National Rural Health Mission (2005-2012) clearly states that prevention and control of communicable and non communicable diseases is one of the key goals of NRHM and the core strategy being adopted is promoting healthy lifestyles and reduction in consumption of tobacco and alcohol.

According to Price Water House Coopers-Associated Chambers of Commerce India Report, 2007, deaths due to chronic diseases in India accounted for 53% of all deaths and 44% of disability adjusted life years (DALYs) in 2005. In 2008 the **World Health Assembly adopted the 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non Communicable diseases** where the focus is on promoting action to reduce the main common modifiable risk factors for NCDs: ***tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol***.

National Family Health Survey-3(2005-06) points out the fact that more than 2/3rd of the men in 11 states of India use tobacco and the tobacco use is as high as 61% the tobacco consumption increases with age specially among the lowest quintile specially in rural areas. NFHS-3 points out the fact that 1/3rd of the men in 20 states use alcohol and it is as high as 31% in rural areas. The total cost of the three major diseases caused due to tobacco use in India was Rs. 308 billion in 2002-03(Report on Tobacco Control in India, Ministry of Health and Family Welfare, 2004)

There is evidence based information that NCDs are preventable through integrated and comprehensive interventions. Cost effective interventions exist, and have worked in many countries: the most successful strategies have employed a range of population-wide approaches combined with interventions for individuals.

Disease Burden

Program for Integrated Prevention and control of Non Communicable Disease

There is an urgent need for an integrated programme for Cardiovascular Disease, Diabetes and stroke since these diseases have a common modifiable risk factors of unhealthy diet, lack of physical activity or sedentary lifestyle, use of tobacco and alcohol and obesity. The programs focus would be on the prevention and reduction of risk factors common to these diseases. The approach to the program would address the following:

- Biological Risk approach through individual based approaches
- Behavioural risk factors through community based approaches

Population based approach for both the strategies above for promoting health behaviours would result in modest but meaningful reductions in many risk factors across the whole population yielding high cumulative benefit and would be more sustainable as well as cost effective.

Affordable solutions exist to prevent 40 to 50% of premature deaths from non communicable diseases and the need of the hour is to identify gaps in the existing system and pool together resources and focus on objectives which are achievable and affordable as per the need of the state. The urban population has high and rising rates of overweight, central obesity, diabetes, high blood pressure, however such trends also exists in rural population but of a lesser magnitude. Recent studies have shown that highest prevalence is shifting from an affluent to less affluent section of the society. For example Tobacco consumption is now universally more common among the lower socioeconomic groups and hypertension is more common in poor in Chennai and diabetes is emerging as a major disease in urban slums and obesity is now common in school going children in urban and semi- urban areas in Delhi NCR region.

Objectives

a) Primary Prevention of major non communicable disease through health promotion and intervention
b) To effectively use research for prevention and control of NCD in the population.
c) Capacity enhancement of health professionals for appropriate management of NCDs and their risk factors.
d) To build and promote partnership for prevention and control of NCD

Technical Assistance Component of Chronic Care Foundation

a. Primary Prevention through Health Promotion and Intervention

CCF with its vast repertoire of knowledge relating to technical and management support and monitoring and evaluation in the health sector and is placed in a strong position to meet the objectives of the study with a minimal learning curve. Based on the information available in designing and undertaking similar assignments carried out for various sector projects in different states of India, lessons learnt from such assignments, and the insights, knowledge and skills gained by its team members in these assignments, the following approach to the assignment is proposed.

We also understand the need for intensive consultative and participatory approach for success of the services to be provided under the support, and the need to give clear and relevant deliverables relevant to the assignment within specified time periods.

We would help the Department in designing **Health Communication Material**:

- **Media package development**
- **Strengthen IEC/IPC for Community awareness and behavior Change**
- **IEC targeted for specific setting like schools, rural, urban and peri-urban areas**.

We would help to design the health communication material as per the need of state and field test the material in different settings to make them contextual and incorporate the changes as per the feedback received from the community and people from the department of Health.

b. Research for Primary prevention and control of NCCD

A validated and nationally representative estimate of Non Communicable diseases for the Eastern India is not available. Existing data sources are very heterogeneous making comparison difficult. There is an urgent need of having regional information focusing on Eastern India to create a valid database of prevalence of NCD and lay the foundation for planning specific interventions as per the database. Chronic Care Foundation with its experience of research would provide technical assistance in the following area:

- Development of Research Design and Methodology for surveillance of risk factors of NCD
- Randomized controlled trials (RCTs) of lifestyle interventions for the prevention of Non Communicable Chronic Disease.

c. Capacity enhancement of health professionals

Chronic Care Foundation has experience of institutional and human capacity development initiatives and use learning from previous projects for capacity development of health workers. CCF would provide technical assistance to the government for:

- Development of training module for health worker and ASHA.
- CCF would provide technical assistance and support for development of pool of trainers for capacity building of health workers using TOT strategy.

d. Build and Promote partnership for prevention of NCD

Chronic Care Foundation (CCF) would provide technical support for partnership with the non government organizations and private sector for their involvement in the prevention of NCD. The technical assistance would be provided for partnership for using NGO and the private sector for operational research and formation of network of NGOs to work on the issue of NCD.CCF would provide managerial support to manage partnership with NGOs and private sector.

Phases of Technical Support

The technical and managerial support would be provided to the government for a period of 3 years consisting of three phases:

Stage One Stage Two Stage three

Diagnostic Phase

Transition Phase

6months

Implementention Phase

24 months

Diagnostic Phase

5 months

CCF Proposed Budget				
Sl No	**Activity**	**Budget Detail**		**Total**
A	**Salary**			
	Project Director	10%of time for 12 months		240000
	Program Manager	1 PM for twelve months@50000/month	50000.00	600000.00
	M&E Officer	1M&E for twelve months@30000/month	30000.00	360000.00
	Public Health Expert on NCCD	10days@10000/day	100000.00	100000.00
	Lead Researcher	10days@10000/day	100000.00	100000.00
	District Coordinator	2 DC for 12 months@10000/month	120000.00	240000.00
			Total(A)	**1640000.00**
B	**Development of IEC/BCC material**			0
	Field survey and need assement	50,000/district	100000	100000
	BCC Expert for IEC development	1BCC expert for 3 months every year @ 40000/month (short term contract)		120000
	Meeting with IEC head and DPM of pilot districts			15000
	Development of IEC/BCC material			220000
	Field testing of IEC			20000
			Total(B)	**475000**
C	**Development of training Module for ASHA and health worker**			0
	Analysis of training need of ASHA/health worker	20,000/district		40000
	Development of training module for ASHA			200000
	Meeting with CS/DPM of pilot district			20000
	Field testing of Module	20,000/district		40000
			Total (C)	**300000**
D	**Training of Master trainers on NCD**			0
	Meeting with SHS for identification of MT			15000
	Development of NCD module for Master trainers	honrarium of CB expert, travel,module development		150000
	Training of 20 Master Trainers in two day training			80000
			Total (D)	**245000**
E	**Research on NCD**			0
	Development of Research Design for surveiallamce of risk factors in 7 districts			50000
	Orientation of Field researchers			75000
	Data collection			350000
	Data compilation			50000
	Report preparation			150000
			Total (E)	**675000**
F	**Community Intervention in two districts on NCD**			
	Orientation of 30 PRI members on NCD	30 X 100 X 1 day	3000.00	6000.00
	Orientation of 100 ASHA on NCD	100 X 100 X 2 days	20000.00	40000.00
	Orientation of 100 AWW on NCD	100 X 100 X 2 days	20000.00	40000.00
	Orientation District Health Officials on NCD	30 X 400 X 1 day	12000.00	24000.00
	Orientation of 25 Village Health forum	25 X 300 X 1 time	3000.00	6000.00
	Orientation of ANM 100 ANM	100 X 100 X 2 days	20000.00	40000.00

			Total (F)	**156000.00**
G	**Health Awareness Events**			
1	Five Health awareness events in each block per month	5600 X 2 event X 12 months	134400.00	268800.00
	(Magic shows/Street Theatre/Puppet show/Display of short film etc)			
2	Quiz show in Schools/Colleges	3000 X 4 time	12000.00	24000.00
3	Sport event (1 in each district)	15000 X 1 time	15000.00	30000.00
4	Rally by students(1 in each district)	10000 X 1 time	10000.00	20000.00
			Total (G)	**342800.00**
H	**Community level Initiative**			
	Formation of 25 Village health forum for NCD	1000 X 25 VHF X 1 time	25000.00	50000.00
	Monthly meeting of VHF	20 X 12 members X 25 VHF X 12 months	72000.00	144000.00
	Coordination meeting with exisitng 20 SHG	200 X 20 X 12 months	48000.00	96000.00
	Monthly Coordination meeting with schools	200 X 30 Schools X 12 months	72000.00	144000.00
	Monthly Coordination meeting with colleges	500 X 1 College X 12 months	6000.00	12000.00
	Bi monthly review at district level	1000 X 12 months	12000.00	24000.00
			Total (H)	**470000.00**
I	Referral of NCD patients			
	Incentive of @Rs300/month for referral by 25 ASHA	300 X 25 ASHA X 12months	90000.00	180000.00
			Total (I)	**180000.00**
J	**Travel**			
	District Coordinator	1500 X 2DCs X 12 months	36000.00	72000.00
	Programme Manager	5000 X 1 X 12 months	60000.00	120000.00
	M & E Officer	3000 X 1 X 12 months	36000.00	72000.00
	Health Expert/Researcher	8000X2X4months	64000.00	128000.00
			Total (J)	**392000.00**
K	**Office Expenses**			
	Rent Electricity & Maintenance	10000 X 12 months	120000.00	120000.00
	Xerox & Stationaries charges	1200 X 12 months	18000.00	18000.00
	Postage & Courier Charges	1000 X 12 months	12000.00	12000.00
	Books & Periodicals	800 X 12 months	9600.00	9600.00
	Telepnone & Fax charges	2000 X 12 months	24000.00	24000.00
	Misc. Expenses	1500 X 12 months	18000.00	18000.00
			Total (K)	**201600.00**
L	**Documentation**			**50000.00**
			G.Total	**5127400.00**

Direction & Administration (Treasury Route)

Name of the Collection Head:- Sponsored Plan under Main Head-2211 (Pariwar Kalyan Kendra)

Under this Budget fund is required for – Directorate, Directorate State F&W Bureau, Directorate District F&W Bureau, ANM/LHV School, Village F&W Services, Health Sub-centre, Urban F&W Centre, Regional Health and F&W Training Centre & Training of Multri Purpose Worker.

Total Budget- 186.55 Lakhs

NRHM BUDGET OVERVIEW

SUMMARY of BUDGET

PART	HEAD	BUDGET 2011-12 (Rs. In lakhs)	%
A	RCH II	91847.26	48.82
B	NRHM Additionalities	51160.81	27.19
C	Immunization	2891.54	1.54
D to I	NDCP	7248.37	3.85
J	Intersectoral Convergence	16230.36	8.63
K & L	NTCP & NCCD	114.51	0.06
	Direction & Administration (Treasury Route)	18655.00	9.92
	GRANT TOTAL	**188147.86**	**100.00**

NRHM PART A : RCH II

PART-A RCH Flexipool Summary Budget 2011-12						
S. No.	**Budget Head**	**Total Annual Budget (Rs. Lakhs)**		**NRHM**	**Others (specify e.g. State Budget, Finance Commission, Development Partners etc.)**	**Total**
		High focus districts	**State Total**			
1	MATERNAL HEALTH					
(a)	Janani Bal Suraksha Yojana /JBSY		32695.95	32695.95	NA	32695.95
(b)	Others		4061.65	4061.65	NA	4061.65
	Sub Total Maternal Health	3203.06	**36757.60**	**36757.60**		**36757.60**
2	CHILD HEALTH	3977.41	4410.49	4410.49	NA	4410.49
3	FAMILY PLANNING			0.00		0.00
a	Sub-total Family Planning (excluding Sterilisation Compensation and NSV Camps)		2876.37	2876.37	NA	2876.37
b.	Sub-total Sterilisation Compensation and NSV Camps		7275.00	7275.00	NA	7275.00
	Sub Total Family Planning	10038.385	**10151.37**	**10151.37**		**10151.37**
4	ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH	506.97	514.75	514.75	NA	514.75
5	URBAN RCH (focus on Urban slums)	100.44	108.00	108.00	NA	108.00
6	TRIBAL RCH	0.00	0.00	0.00	NA	0.00
7	VULNERABLE GROUPS	0.00	0.00	0.00	NA	0.00
8	INNOVATIONS/ PPP/ NGO	606.54	613.25	613.25	NA	613.25
9	INFRASTRUCTURE AND HUMAN RESOURCES	30955.46	23378.57	23378.57	NA	23378.57
10	INSTITUTIONAL STRENGTHENING	4565.43	5165.56	5165.56	NA	5165.56
11	TRAINING	1218.68	3008.23	3008.23	NA	3008.23
12	BCC / IEC	0.00	743.92	743.92	NA	743.92
13	PROCUREMENT	0.00	0.00	0.00	NA	0.00
14	PROGRAMME MANAGEMENT	5482.05	6995.51	6995.51	NA	6995.51
	GRAND TOTAL	**60654.44**	**91847.26**	**91847.26**		**91847.26**

PART- B

PART-B NRHM Flexipool

Sl. No.	Activities	In Lakhs	% of total budget
1	Decentralization (incl. ASHA)	15114.58	29.54
2	Infrastructure Strengthening	9077.26	17.74
3	Contractual Manpower	55.08	0.11
4	State Health System Resource Centre	100.00	0.20
5	PPP Initiatives	10166.39	19.87
6	Strengthening of Cold Chain	389.02	0.76
7	RCH Procurement and Logistics	15936.56	31.15
8	De-centralised Planning	271.91	0.53
9	Operational Research (RI)	50.00	0.10
	Total	**51160.81**	**100.00**

NRHM Part: C

Sl. No.	Activities	In Lakhs	% of total budget
1	Routine Immunization	**2891.54**	100.00
	Total	**2891.54**	**100.00**

NRHM PART D to I – NATIONAL DISEASE CONTROL PROGRAMME

PART- D to I (National Disease Control Programm)

Sl. N0.	Budget Head	In Lakhs	%
D	NIDDCP	18.00	0.25%
E	IDSP	543.37	7.50%
F	Kalazar	1629.11	22.48%
	Malaria	383.94	5.30%
	Dengu + Chikungunya	40.50	0.56%
	JE	20.51	0.28%
	Filaria	625.03	8.62%
G	NLEP (Leprosy)	225.00	3.10%
H	NBCP (Blindness)	1122.80	15.49%
I	RNTCP (T.B.)	2640.11	36.42%
	Total	**7248.37**	**100.00%**

NRHM PART J – Inter-Sectoral Convergence

PART-J Inter-Sectoral Convergence

Sl. No.	Activities	In Lakhs	%
1	**Indian Systems of Medicine (AYUSH)**	11716.00	72.19
2	**ICDS--**		
a	Incentive to AWW for social mobilization in Muskan Abhiyan	3840.00	23.66
b	Incentive under IMNCI (Budgeted in Part-A)	0.00	0.00
c	SABLA Project	41.89	0.26
d	IFA supply (Budgeted in Part-A)		
3	**State AIDS Control Society--**	0.00	0.00
a	Training of MOs & Paramedical Staffs at Sub District Level	87.40	0.54
b	Training of ASHA Worker on HIV/AIDS	332.58	2.05
c	Integrated Counselling and Testing (ICTC) for HIV testing of ANC cases	212.50	1.31
4	Education Department (Budgeted under SHP)	0.00	0.00
5	Panchayati Raj Department (Budgeted under VHSC Part-B)	0.00	0.00
	Total	**16230.36**	**100.00**

Part K-L-

PART- K & L Priority Projects

Sl. No.	Activities	In Lakhs	%
K	NTCP		
A	Proposed budget for State Tobacco Control Cell	16.60	20.19
B	Budget for District Tobacco Control Programme	28.64	49.01
C	Additional budget for IEC and Mass Media activities	18.00	30.80
	Total	**63.24**	**55.22**
L	**NCCD**		
A	Salary	16.40	31.99
B	Development of IEC/BCC material	4.75	9.26
C	Development of training Module for ASHA and health worker	3.00	5.85
D	Training of Master trainers on NCD	2.45	4.78
E	Research on NCD	6.75	13.16
F	Community Intervention in two districts on NCD	1.56	3.04
G	Health Awareness Events	3.43	6.69
H	Community level Initiative	4.70	9.17
I	Referral of NCD patients	1.80	3.51
J	Travel	3.92	7.65
K	Office Expenses	2.02	3.93
L	Documentation	0.50	0.98
	Total	**51.27**	**44.78**
	Total (K & L)	**114.51**	**100.00**

Abbreviations

ANM Auxiliary Nurse Midwife
ARI Acute Respiratory Infection
AWC Aaganwadi Centre
ASHA Accredited Social Health Activist
AWW Aaganwadi Worker
AYUSH Ayurved Unani Siddha and Homeopathy
BEmONC Basic Emergency Obstetric Neonatal Care
BPL Below Poverty Line
CBO Community Based Organization
CEmONC Comprehensive Emergency Obstetric Neonatal Care
CH Civil Hospital
CHC Community Health Centre
CS Civil Surgeon
CMR Child Mortality Rate
CSO Civil Society Organization
DFID Department for International Development
DH District Hospital
APHC Additional Primary Health Centre
SDH Sub-Divisional Hospital
DP Development Partners
FNGO Field Non-Governmental Organization
GOI Government of India
HMIS Health Management Information System
HRD Human Resource Development
ICDS Integrated Child Development Scheme
IEC Information Education and Communication
IFA Iron Folic Acid
IMNCI Integrated Management of Neonatal and Childhood Illnesses
IMR Infant Mortality Rate
IPHS Indian Public Health Standards
IUCD Inter Uterine Contraceptive Devices
JBSY Janani Evam Bal Suraksha Yojana
LHV Local Health Visitor
M&E Monitoring and Evaluation
MDG Millennium Development Goals
MOHFW Ministry of Health and Family Welfare
MoU Memorandum of Understanding
MPW Multi-Purpose Worker
MTP Medical Termination of Pregnancy
NACO National AIDS Control Organization
NACP National AIDS Control Programme
NFHS National Family Health Survey
NMR Neonatal Mortality Rate
OBC Other Backward Class

OPD Outdoor Patient Dispensary
PG Post Graduate
PHC Primary Health Centre
PHED Public Health Engineering Department
PIP Programme Implementation Plan
PMU Programme Management Unit
POL Petrol Oil and Lubricant
PRI Panchayati Raj Institution
RCH Reproductive and Child Health
RHS Rapid Household Survey
RKS Rogi Kalyan Samiti
RMP Registered Medical Practitioner
RTI Reproductive Tract Infection
SBA Skilled Birth Attendant
SC Scheduled Caste
SHC Sub Health Centre
SNGO Service Non-Governmental Organization
SPMU State Programme Management Unit
ST Scheduled Tribe
STI Sexual Tract Infection
TBA Traditional Birth Attendant
TFR Total Fertility Rate
TT Tetanus Toxoid
U5M Under 5 Mortality
UIP Universal Immunization Programme
UNFPA United Nations Population Fund
UT Union Territory
VHSC Village Health and Sanitation Committee
VO Voluntary Organization

Referral Hospital,Chandi-Nalanda

NRHM 2011-12 SPIP