DISTRICT HEALTH SOCIETY
MADHEPURA

DISTRICT HEALTH ACTION PLAN
2012-2013

Developed & Designed By

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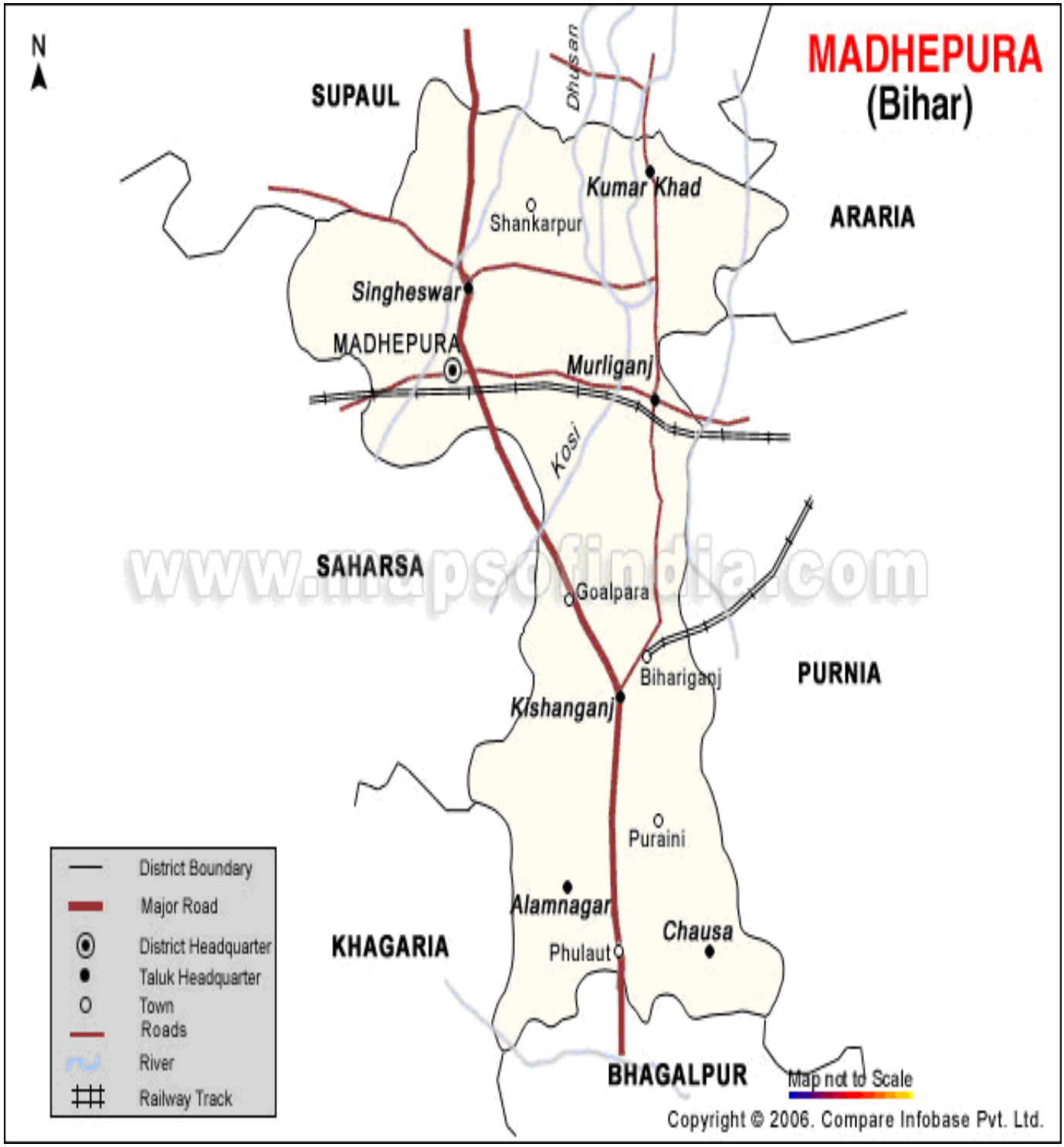
Map of Madhepura



Foreword

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

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

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

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

Md. Minhaz Alam
District Magistrate-cum-Chairman,
DHS, Madhepura

About the Profile

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

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

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

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

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

STRUCTURE OF DISTRICT PLAN

PART 1:

Chapter I:

1. Introduction, methodology and profile of the district

1.1. Introduction

1.2. Planning Objectives

1.3. Approach to District Planning

2. District Planning Process

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2.3. Collection of basic data for planning

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Chapter – I

1.1 Introduction:-

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

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

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

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

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

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

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

Goal

The goal is to improve quality of life of the people by:
(Goals mentioned below are for the period of RCH-II i.e. to be achieved by 2012)

- Reducing Maternal Mortality Ratio (MMR) from 352 to 100 per 1,00,000 live births,
- Reducing Infant Mortality Rate (IMR) from 61 to 30 per 1000 live births,
- Reducing Total Fertility Rate (TFR) from 4.0 to 2.1 for population

1.2 Planning Objectives:-

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

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

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

Core strategies of mission include decentralized public health management. This is supposed to be realized by implementation of District Health Action Plans (DHAPs) formulated through a participatory and bottom up planning process. DHAP enable village, block, district and state level to identify the gaps and constraints to improve services in regard to access, demand and quality of health

care. In view with attainment of the objectives of NRHM, DHAP has been envisioned to be the principle instrument for planning, implementation and monitoring, formulated through a participatory and bottom to up planning process. NRHM-DHAP is anticipated as the cornerstone of all strategies and activities in the district.

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

Stakeholders in Process

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

1.3 Approach to District Planning:-

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

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

2. District Planning Process

2.1. District level Consultation Workshop:-

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

2.2. Tools and Techniques:-

Main tools used for the data collection were:

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

2.3. Collection of basic data for planning:-

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

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

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

3. Data analysis and plan preparation :-

Data Analysis:

Primary Data:-

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

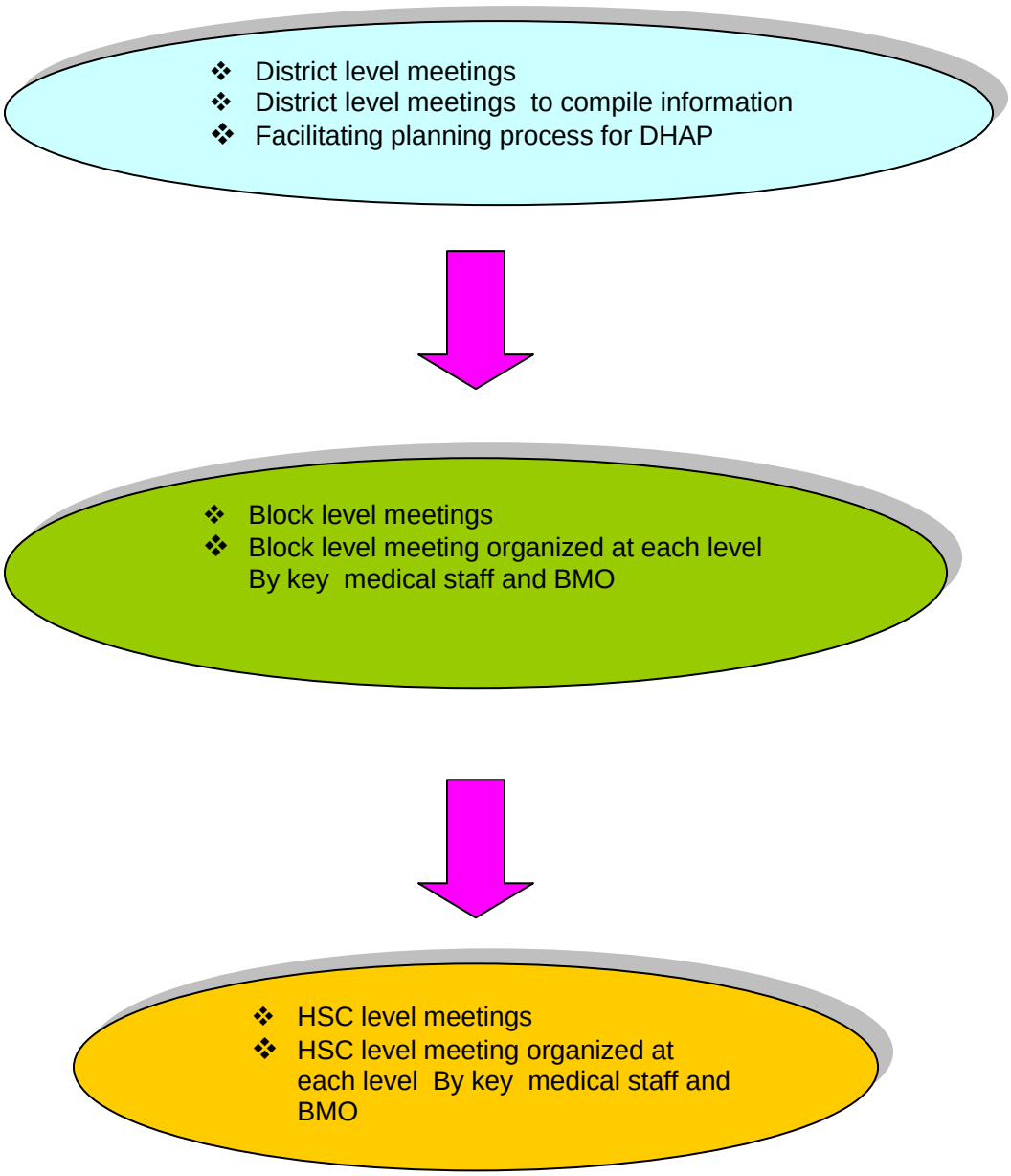
Secondary Data:

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

Plan preparation :-

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

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



4. Historical Place

Perspective:-

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

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

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

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

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

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

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

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

नयानगर भगवती प्रतिमा

5. District Profile:-

BRIEF HISTORY OF MADHEPURA DISTRICT

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

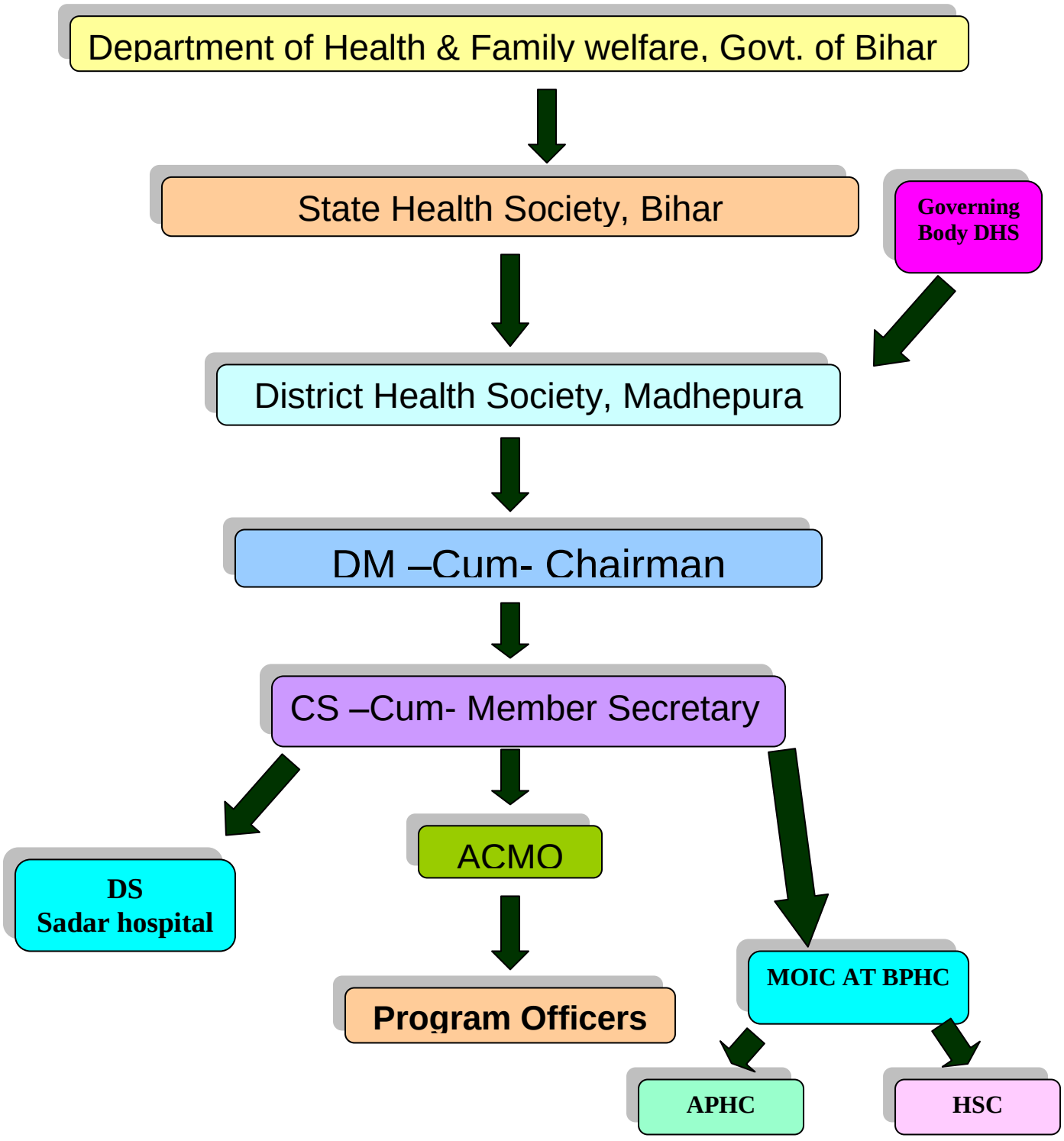
Sikandar Sah had also visited the district, which is evident from the coins discovered from Sahugarh Village. Madhepura district now consists of 2 Subdivisions : 1. Madhepura and 2. Udakishunganj. The district consists of 13 development blocks and anchals each.

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

5.1 Administrative Setup:-

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

District Health Administrative Setup



5.2 Demography and Development Indicators:-

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

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

HQ	**Madhepura**					
Area	**1788 km2**					
Population	**Total**	**1994618**	**Rural**	**1906448**	**Urban**	**88170**
SC Population	**Total**	**347023**	**Rural**	**288029**	**Urban**	**58994**
ST Population	**Total**	**11760**	**Rural**	**11490**	**Urban**	**270**
Sub Divisions	**Madhepura, Udakishunganj**					
Blocks	**Madhepura, Singheshwar, Gamharia, Ghailar, Shankarpur, Gwalpara, Udakishunganj, Bihariganj, Chausa, Alamnagar, Puraini, Murliganj, Kumarkhand.**					
Agriculture	**Paddy, Wheat, Maize, Jute, Oil Seeds (Sunflower, Mustard)**					
Main Horticulture	**Mango, Banana, Guava, Coconut, Litchi.**					
Industry	**Jute Factory**					
Rivers	**Koshi**					

Population & other information Block wise

Name of BLOCKS	TOTAL POPULATION	MALE POPULATION	FEMALE POPULATION	PANCHAYAT	VILLAGE
Madhepura	245634	129305	116329	17	49
Singheshwar	134151	70267	63884	13	27
Gamharia	82477	42992	39485	8	12
Ghailar	91672	47566	44106	9	19
Shankarpur	106429	54977	51452	9	9
Gwalpara	126318	65516	60802	12	51
Udakishunganj	189314	98275	91039	16	44
Bihariganj	131189	68270	62919	12	22
Chausa	151399	79674	71725	13	43
Alamnagar	175391	92253	83138	14	29
Puraini	104365	54726	49637	9	31
Murliganj	213081	111629	101450	17	45
Kumarkhand	243198	126919	116279	21	71
Total	1994618	1042369	952245	170	452

5.3 Climate and Agro Ecological Situation:-

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

5.4 Rainfall:-

The average rail fall in this district is 1300mm

5.5 Air temperature and humidity:-

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

5.6 Land and soil:-

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

6.7 River system:-

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

5.8 Language & Culture:-

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

Transport & Communication Facility

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

Analysis of the District

Part.	Strength	Weakness	Opportunity	Threat
Part. A	1. Owing to decentralized Planning process MCH service is easily accessible to the community.	1. Poor infrastructure status that is not up to IPHS norms hence challenge for maternal health, child health, family planning service.	1.Decentralized planning ensured Community participation	1. Poor health service at facility that is maternal health, child health and family planning can generate chaos among the community.
	2. Strength of infrastructure and human resource provided facility to the community.	2. Earlier shortage of human resource is challenge for maternal health, child health, family planning service.	2. Optimum utilization of allocated budget that is ensured better financial absorption.	2. Poor infrastructure status and shortage of manpower leads to discontentment of community.
	3. By multi skilled trained doctor and paramedical staff provided health service for the community.	3. In adequate training session for the MO and paramedical staff.	3. HMIS assisted to make the plan realistic and implementable.	3.Unavailability of medicine and equipment can generate the dissatisfaction.

Part. B	1. Due to decentralization, strengthening of physical infrastructure, contractual manpower, referral and emergency transport under NRHM additionalties got strength for smooth functioning of health program. 2. Involvement of ASHA became threshold for the different health activities 3. Innovative schemes can be launched such as birth preparedness and construction of rest room for ASHA at health institution will add upliftment in health service.	1. Earlier there was no PPP initiatives 2. There was no concept for Decentralized planning for District Health Action Plan. 3. There was lack of fund for infrastructure strengthening.	1. Due to PPP mode health facility can be ensured to entire vulnerable section of the community to their doorstep. 2. Community got the help through ASHA/Volunteer workers for their demand. 3. Untied fund for VHSC, HSC, PHC provided better health facility for the community.	1. Hurdles in actual expenditure of allocated budget due to involvement of RKS/PRI members etc. 2. Untimely completion of government building due to different department agency. 3. Delay payment of outsourcing agency.

Part.	Strength	Weakness	Opportunity	Threat
Part. C	1. With the introduction of incentive for ASHA/ AWW/ANM under Muskan Ek Abhiyan Scheme increased the immunization coverage. 2. With the recruitment of ANMR/Outreach service has been improved sharply. 3. Budget provision for mobility support, cold chain maintenance and focused on slum and	1. Earlier there was no such incentive for AHSA/ AWW/ANM for RI program. 2. Owing to lack of paramedical staff health service was unsatisfactory. 3. RI session planned and held was not monitored.	1. By the incentive provision to ASHA/ AWW/ ANM immunization coverage has shoot up considerably. 2. Budget provision assisted in monitoring of RI session. 3. Budget provision paved the way to recruit MO and Paramedical staff.	1. Lack of monitoring and Supervision can hamper RI activities. 2. Untrained paramedical staff is challenge to injection safety. 3. AEFI can be panic if not handled in the supervision of MO or trained Paramedical staff.

	under served area in urban made the RI coverage satisfactory.			
Part. D	1. Convergence of all national program within NRHM paved the way for integration with all health programs. 2. Due to decentralization specific plan for each national program can be made. 3. Allocated expenditure of all national program can be monitored through DHS.	1. Earlier all national program were running vertically. 2. There was no opportunity to make specific plan for each program. 3. Monitoring and supervision of all national program was unsatisfactory.	1. Chance to integrate all national program under NRHM. 2. Close supervision of expenditure of all national program through DHS.	1. Poor BCC/IEC of national program can deprive the community from health facility. 2. Untrained paramedical staff can be hurdle for the program.

Chapter – III

1.1 RCH Flexible Pool (NRHM-A):-

Vision Statement

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

To achieve these goals NRHM will:

- Facilitate increased access and utilization of quality health services by all.
- Forge a partnership between the Central, state and the local governments.
- Set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.
- Provide an opportunity for promoting equity and social justice.

- Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.
- Develop a framework for promoting inter-sectoral convergence for promotive and preventive Healthcare.

Technical Objectives, Strategies and Activities-

Maternal Health

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

- To increase 3 ANC coverage from 57% to 90% by 2012-13.
- To increase the consumption of IFA tablets for 90 days from present level of 47.7% to 100% by 2012-13.
- To reduce anemia among pregnant mothers from 30% to 10% by 2012-13.
- To increase institutional delivery from 68% to 90% by 2012-13
- To increase birth assisted by trained health personnel from 10% to 45%.
- To increase the coverage of Post Natal Care from 26% to 55% by 2012-13.
- To reduce the no of unsafe abortions

Source of data: DLHS 3, NFHS 3 and MIS Data
Objective No. 1: To increase 3 ANC coverage from 57% to 90% by 2012-13.
Strategies and Activities:

- Institutionalization of Village Health Sanitation and Nutrition Days (VHSND)
- Tracking of Pregnant mothers by ASHAs and ANMs and maintaining in MCTS register. It should be uploaded on MCTS Web Portal.
- In collaboration with ICDS, such that the Take Home Ration (THR) distribution and ANC Happens on the same day
- This will require minor changes in the micro plans of Health and ICDS
- Policy decision and appropriate guideline under convergence between Health and ICDS need to happen as a priority Improved Access of ANC Care
- Provision for Additional ANMs in each Sub Centres (Refresher Training to ANMs on Full ANC to improve the quality of ANC)
- Setting up of New Sub Centres to cover more areas
- Micro planning: Identifying vulnerable groups, left out areas and communities having high percentages of BPL under each block and incorporating the same into the block micro plans to focus attention on themfor providing Community and Home based ANC to them.
- Organizing Monthly Village Health Sanitation and Nutrition Days (VHSND) in each Aaganwadi Centres
- Organizing RCH camp in Each Block PHC areas.
- Tracking of Pregnant mothers by ASHAs and ANMs.

- Ensure quality service and Monitoring of ANC Care
- Strengthening the monitoring system by checking of ANMs duty rooster and visits of LHVs and MOs.
- Involvement of PRIs in monitoring the ANMs service through convergence
- Refresher training of ANMs on ANC care
- Proper maintenance of ANC Register and Eligible couple register
- Strengthening of Health Sub Centre
- Repair and Renovation of Sub Centers
- Provide equipments like BP Apparatus, Weighing machines, Heamoglobinometer etc to the Sub Centers.
- Timely supply of Drug Kit A and Kit B
- Generate Awareness for ANC Service
- Convergences meeting with AWWs, ASHAs, PRI Members, NGOs at the Gram Panchayat level by ANMs. These meetings will also attended by MOs from All PHCs.
- Tracking of Pregnant mothers by ASHA, ANM and AWWs though organizing Mahila Mandals meeting. Incentive for ASHAs and ANMs to give for the initiative. This initiative is under MUSKAAN Programme. Incentive for ASHA will be taken care under Inter sectoral Convergence.
- Counseling by ASHAs and ANMs to the pregnant mothers, mothers and Mother in Laws.
-
- **Objective No. 2:** To increase the consumption of IFA tablets for 90 days from present level of 47.7% to 100% by 2012-13.

Strategies and Activities:

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

Objective No.3: To reduce anemia among pregnant mothers from 30% to 10% by 2012-13.

Strategies and Activities:

- Supplementing IFA tablets consumption with other clinical strategies.
- Half yearly de-worming of all adolescent girls.
- Training of ANM, AWW and ASHA on module on EDPT (Early Diagnosis and Prompt Treatment) of anemia.
- Supplementing IFA tablets consumption with AWWcs to non going school girl.
- Activities for consumption of IFA tablets as per Objective No. 2
- Refer severely Anemic Pregnant Mothers to referral centers
- IPC based IEC campaigns emphasizing on consumption of locally available iron rich food stuff. Details given under Special Scheme on Anemia Control in Part B
- **Objective No. 4:** To increase institutional delivery from 68% to 90% by 2012-13.

Strategies and Activities:

- The strategies will lead to up gradation and operationalization of the facilities to increase institutional deliveries along with providing EmOC and emergency care of sick children. These facilities will also provide entire range of Family Planning Services, safe MTPs, and RTI/STI Services.
- Upgrading Block PHCs/CHCs in to FRUs
- Provision of OT and lab facility by upgrading 2 FRUs
- Blood Bank and or Provision of Blood storage, OT and lab facility by upgrading 2 FRUs
- District Hospitals must have either its own Blood Bank, operational round the clock, or must have access to one that can be accessed in less than 30 minutes
- All CHC / PHCs have blood storage facility
- Training of MOs on Obs & Gynae and Anesthesia.
- 18-week Life Saving Anesthetic Skills (LSAS) training for MBBS Doctors
- 16 week -Emergency Obstetric Skill training for MBBS doctors
- Appointment of Anesthetist, O&G specialist, Staff Nurses at the FRUs Incentivise the conduct of C section at FRUs @ Rs 1500 per C section for the staff involved at the FRUs.
- Training of MOs and Staff Nurses of PHCs in BEmOC
- Appointment of at least 3 Staff Nurse in each PHCs
- Repair and renovation of PHCs
- Availability of and timely supply of medical supplies and DDK & SBA kits
- Training of MOs, Staff Nurses on SBA
- Increase beneficiary choice for institutional delivery through IEC campaign complimented by network of link workers working on incentive basis for each institutional delivery achieved.
- Improving quality: Infrastructural support to high burden facilities to avoid ‘early
- discharge’ following institutional deliveries

- Mapping of high burden facilities and proving them support for matching infrastructural up gradation to increase the hospital stay following delivery
- Identifying districts and blocks and communities within them, where the awareness and reach of JBSY scheme is poor and to ensure increased service utilization in these areas
- Design and implement an IEC campaign focusing on communicating the benefits of institutional delivery and benefits under JBSY scheme.
- Equip the ASHA network to reinforce the IEC messages through IPC interventions at village /community level.
- Provide incentives to ASHA for every institutional delivery achieved in her village / designated area.
- Involvement of PRIs for JBSY scheme to monitor and generate awareness for institutional delivery.
- Provision of Referral Support system
- Provision of a dedicated referral transport system for the newborns and pregnant women to refer them from home/HSCs/PHCs to referral centers.
- Monitoring of referral transport system
- Development of proper referral system between Health Institutions.
-

Objective No.5: To increase birth assisted by trained health personnel from 10% to 45%.

Strategies and Activities:

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

Objective No.6: To increase the coverage of Post Natal Care from 26% to 55% by 2012-13

Strategies and Activities:

- Ensuring proper practice of PNC services and follows ups at the health facility level.
- Refresher sessions for all ANMs on uniform guidelines to be followed for PNC care – all delivery cases to remain at facility for minimum 6 hours after normal delivery and to be recalled to facility for check up with 4 days and after 42 days.

- Ensuring follow up PNC care through out reach services (ANM) for delivery cases where the patient does not return to facility for follow up check ups.
- Referral of all complicated PNC cases to FRU level.
- LHV and MO to monitor and report on PNC coverage during their field visits
- Utilizing the ASHA network to strengthen the follow up of PNC services through tracking of cases, mobilization to facilities and providing IPC based education / counseling.
- Utilize ASHA to ensure 3 PNC visits by the ANM for home delivery cases (1st within 2 days, 2nd within 4 days and 3rd within 42 days of delivery) and 2 follow up visits for institutional delivery cases.
- Counseling of all pregnant women on ANC and PNC during monthly meetings of MSS and during VHND.
- Linking of ASHA's incentives on institutional deliveries to completion of the PNC follow-ups.
- Basis Orientation of AWWs on identifying Post-partum and neonatal danger signs during her scheduled visits following delivery
- Basic orientation on IMNCI – in order to be able to alert the beneficiary and coordinate with ASHA and ANM (to avoid undue delay)
- Basic orientation on identifying post-partum danger signs, specially, for home based deliveries, such that the she can alert ASHA, ANM or the local PHC towards avoiding undue delay
- Objective No. 7: Reduce incidence of RTI/STI
- Strategies and Activities
- Ensuring early detection through regular screenings and contact surveillance strategies.
- Early diagnosis of RTI / STI through early detection of potential cases through syndromic approach and referral by ANM and ASHA.
- Conducting VDRL test for all pregnant women as a part of ANC services.
- Implementing contact surveillance of at risk groups in convergence with Bihar AIDS Control Society.
- Strengthening the infrastructure, service delivery mechanism and capacity of field level staff for handling of RTI / STI cases.
- Conducting community level RTI / STI clinics at PHCs
- Training to all MOs at PHC / DH level in Management of RTI / STI cases in coordination with Bihar AIDS control Society.
- Training of front line staff, LHV, ANM and ASHA in identifying suspected cases of RTI / STI in coordination with Bihar AIDS Control Society.
- Strengthening RTI / STI clinic of the District Hospitals

Objective No. 8 –Reduce incidence of unsafe abortion

Strategies and activities:

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

Child Health

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

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

Objectives :

- To reduce low birth weight baby's by supplementing nutritional support to pregnant mothers
- To increase exclusive breast feeding from 85% to 100% by 2012-13.
- To strengthen neonatal care services in all PHCs/CHCs/SDHs by setting newborn care centers & having trained manpower there in.
- To increase full immunization of Children from 80% to100% by 2012-13.
- To reduce morbidity and mortality among infants due to diarrheoa and ARI

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

Strategies and Activities:

- Convergence with ICDS, supplementary diet which is being given by AWW to pregnant mothers may be improved.
- A supplementary diet comprising of rice, dal and ghee will be provided to all pregnant women.
- This will be given for the last 3 months to all under weight pregnant BPL mothers. The Scheme will be implemented in convergence with ICDS.
- Joint Monitoring by Block MOICs with CDPO for implementation of the scheme.

Objective No. 2: To increase exclusive breast feeding from 40% to 80% by 2012-13.

Strategies and Activities:

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

Strategies and Activities:

- Growth monitoring of each child
- Supply of spring type weighing machine and growth recording charts to all ASHAs, AWWs. All ASHAs, Aaganwadi centers and sub centers will have a weighting machine and enough supply of growth recording charts for monitoring the weight of all children through Untied fund of HSCs.
- Weighting and filling up monitoring chart for each child (0-6 years) every month during VHSNDs. Each child in the village will be monitored by weight and height and records will be maintained.
- Referral for supplementary nutrition and medical care
- Training for indications of growth faltering and SOPs for referral to AWWc for nutrition supplementation and to PHC for medical care.

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

Strategies and Activities:

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

Objective No.5:

- To increase full immunization of Children from 80% to100% by 2012-13.

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

Strategies and Activities:

- Increase acceptance of ORS
- Supply of ORS and ensure availability in all depots and supply of cotrimoxazole tablets. The ASHA drug kit will have ORS and cotrimoxazole tablets which should be replenished as per need. Aaganwadi centers should also be given ORS. In the absence of ORS, the use of home-based sugar and salt solution will be encouraged.
- Orientation of ASHA for diarrhea and ARI symptoms and treatment ASHAs will be specifically trained to identify symptoms of diarrhea and ARI and to provide home based care. Danger signs prompting transportation to seek medical care will also be taught to ASHAs.
- Organize meetings for ASHAs/AWWs for dissemination of guidelines for Home based care ASHA and AWW will be trained and provide guidelines for Home based care. The meeting will be held at Block PHC level. A detail Action Plan for ORS submitted under Part B of NRHM Additionalities
- Strengthening of referral services for infants seeking care for life threatening diarrhoea and ARI.
- Blood slide examination of all febrile children with presumptive treatment In endemic areas, most children are anemic due to repeated bouts of malaria. Any febrile child needs to be checked for malaria compulsorily.

Management of Childhood Diarrhea Through the Use of Zinc and ORS

1. Introduction

India has a national policy for management of diarrhoea among children that recommends the use of Zinc tablets along with ORS in the treatment of diarrhoea as per the MOHFW, GoI directive dated 2nd Nov. 2006. A high-level meeting held under the chairmanship of Dr. M.K. Bhan, Secretary, Department of Biotechnology recommends for every case of diarrhoea, a dose of 20 mg/day for 14 days for children above age 6 months and 10mg/day for children aged 2-6 months.

The high-level committee recommendations emphasize that:

a) Zinc tablets should be available in all parts of the country including Anganwadicentres..

b) An effective communication strategy be put in place

c) Health care providers including Anganwadi Workers and ASHAs are oriented and trained in the use of zinc along with ORS.

2 Situation Analysis:-

Madhepura district is a part of Kosi Division and one of the toughest topography of Bihar and most vulnerable in context of diarrhoea due to its poor geographical condition and major prone to natural calamity.

The district has 3 polio high risk blocks namely Udakishanganj, Alamnagar & Chousa. The IMR in Madhepura is highest in the state. The under-five child death stands third highest in the state. The causes of child mortality were mainly attributed to Diarrhea and ARI.The diarrhea prevalence rate in Madhepura is very high (22.9%) as compared to state average (12.1%). The ORS use rate is also very low.

Indicator	Madhepura District	Bihar State	Source
Children suffered from Diarrhea in the last two weeks prior to survey (%)	22.9	12.1	DLHS-3
Children with Diarrhea in the last two weeks who were given treatment (%)	75.1	73.7	DLHS-3
Children with Diarrhea in the last two weeks who were received ORS (%)	18.9	22	DLHS-3
Women aware of ORS (%)	11.3	23.8	DLHS-3
IMR	71	55	AHS,10-11
Under 5 Child Death	101	77	AHS,10-11

3. Progressduring the current year (2011-12):

The district implemented the childhood diarrhea management program in 2009-10. Micronutrient Initiative provided initial support in the form of training to all ANMs,

Anganwadi Workers, Medical Officers, supplied 18 lakh dispersible Zinc Tablets, Recording and Reporting formats, posters and techno-managerial support through the placement of District Extender.
In the current year (2011-12) Micronutrient Initiative (MI) has planned to provide technical and operational support to the district through the placement of Divisional Coordinator and would provide training on childhood diarrhea management to all MOs, CDPOs, BHMs, BCMs, LHVs, Staff Nurses, Pharmacists, ANMs, ASHAs and Anganwadi Workers which is scheduled in January to March, 12. MI would supply 2, 04,134 of combo kits in month of January,12 (each kit consists of two packets of ORS and 14 tablets of Zinc DT) along with recording and reporting formats, compliance cards, Inter Personal Counseling(IPC) tool for counseling.

4. Plan of Action for 2012-2013:-

4.1 Specific Objectives for 2012-13:

I) At least 2,56,662 (50% of the total expected diarrheal cases in a year) childhood diarrheal episodes treated with ORS & Zinc through public health system (Sadar Hospital, PHCs, APHCs, HSCs, ASHAs and Anganwadi Workers)

II) At least 52,528 numbers of Zinc syrup bottles and 1, 05,056 packets of ORS are procured and distributed to AWWs, ASHAs, HSCs, APHCs, PHCs & Sadar Hospital.

Population as per 2011 census	0-5 years Children (15.05% of the total population as per the CBR(30.1), Annual Health Survey, 10-11 for Madhepura)	Expected yearly Childhood diarrheal cases (@1.71 per child/annual as per NCMH, 2005, GoI)	Target for 2012-13 (At least 50% cases will be reported and treated through public health care system (At present 28.6% cases reported in government health facility as per DLHS-3, India)	No. of combo kits of Zinc and ORS would be supplied by MI in January-February, 2012	Additional number of bottles of Zinc Syrup to be procured for 2012-13 under NRHM funds (@ 1 bottle per episode)	Additional number of ORS packets to be procured for 12-13 under NRHM funds (@ 2 packets per episode)
1994618	3,00,190	5,13,325	2,56,662	2,04,134	52,528	1,05,056

4.2 Implementation Strategies for 2012-13:

- Procurement of Zinc Syrup & ORS packets at the district level.
- Distribution of Zinc syrup & ORS packets to AWWs, ASHAs, HSCs, APHCs, PHCs & District Hospital.
- Ensure no stock-out of Zinc & ORS at all levels at all times
- Training of all Medical Officers, CDPOs, ANMs, ICDS Supervisors, LHVs, Pharmacists, Staff Nurses, BHMs, BCMs, AWWs, ASHAs on childhood Diarrhea management program and recording and reporting (This training is scheduled to start in January, 2012 and will be completed by the end of March, 2012).
- Training of BCMs on supportive supervision and they will carry out supportive supervision visits to HSCs, AWCs, and ASHAs.
- Training of Data Entry Operators on recording and reporting.
- Create awareness in the community about the importance of Zinc & ORS through various BCC & Social Mobilization activities.
- Celebrate important events like ORS-Zinc day/week
- Quarterly review at district level under the chairmanship of DM/CS with key Health and ICDS officials and quarterly review at block level under the chairmanship of MOIC with the presence of Health and ICDS officials.
- Monthly review meeting with BCMs on the supportive supervision visit findings at the district level and monitoring visits by DCM to BCMs during supportive supervision visits.
- Strong coordination with the development partners.

4.3 Supports by Development Partners in 2012-13:-

Micronutrient initiative will provide the following support in 2012-13 to the district Madhepura:

1) Techno-managerial support through the placement of Divisional Coordinator
2) Supply of 2,04,134 combo kits (Each kit consists of 2 packets of ORS and 14 tablets of Zinc dispersible tablets) (MI will supply combo kits in January-February, 2012 to the district)
3) Training of all Medical Officers, ANMs, Staff Nurses, ICDS Supervisors, CDPOs, BHMs, BCMs, LHVs, Pharmacists, Staff Nurses, ASHAs and Anganwadi Workers

on childhood diarrhea management program using Zinc and ORS. (This training is scheduled to start in January, 2012 and will be completed by the end of March, 2012).

4) Training of BCMs on supportive supervision and mobility support for supportive supervision visits by the BCMs

5) Distribution of Inter personal communication (IPC) tool kit and compliance card for counseling by ANMs, Anganwadi Workers and ASHAs

6) Training of Data Entry Operators on recording and reporting

7) Support in organizing district and block level review meetings.

8) Provide prototype soft copy of poster, wall painting, and display board.

9) Supply of printed recording and reporting formats and supportive supervision checklists.

4.4 Following activities proposed under NRHM budget in 2012-13:

- Procurement of additional Zinc syrup (52,528) and ORS packets (1,05,056) for 52,528 diarrheal episodes
- Print and distribute posters and display boards at Sadar Hospital, PHCs, APHCs, HSCs, AWCs
- Mobility support for hiring vehicle for the distribution of Zinc and ORS from the district to block PHCs
- Undertake wall paintings in villages
- Mobility support for DCM to carry out monthly monitoring visits.
- Monthly Review meeting of BCMs at the district level.
- Celebrate ORS –Zinc day and week at the district and block levels

Family Planning Population Stabilization

RCH emphasizes on the target-free promotion of contraceptive use among eligible couples, the provision to couples a choice of various contraceptive methods (including condoms, oral pills, IUDs and male and female sterilization), and the assurance of high quality care. It also encourages the spacing of births with at least three years between births. Despite RCH and previous programmes vigorously pursuing family planning objectives, fertility in Bihar continues to decline at much lower rates than the national average. Although the total fertility rate has declined by about half a child in the six-year period between NFHS-1 and NFHS-2, it has increased in NFHS-3 and is far from the replacement level. Furthermore, certain groups such as rural, illiterate, poor, and Muslim women within the population have even higher fertility than the average The persistently high fertility levels point to the inherent weakness of the state's family planning programme as well as existing socio demographic issues. High TFR is reflected by a dismal picture of women in Bihar marrying early, having their first child soon after marriage, and having two or three more children in close succession by the time they reach their late-20s. At that point, about one-third of women get sterilized. Very few women use modern spacing methods that could help them delay their first births and increase intervals between pregnancies. The major issues affecting the implementation of the Family Planning programme in Bihar are as follows. Lack of integration of the Family Planning programmes with other RCH components, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels. Failure of the programme to effectively under take measures to increase median age at marriage and first child birth. Inability of the programme to alter fertility preferences of eligible couples through effective behavior change communication (BCC). Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age groups. (Overall, sterilization accounts for 82 percent of total contraceptive use. Use rates for the pill, IUD, and condoms remain very low, each at 1 percent or less). Due to high prevalence of RTI/STD, IUDs are not being used by majority of women. Continued use of mass media to promote family planning practices despite evidently low exposure to mass media in Bihar, leading to lower exposure of family planning messages in the community, particularly among rural and socio-economically disadvantaged groups. Weak public-private partnerships, social marketing to promote and deliver family planning services.(Public Private Partnership is improved since 2008-09. 6 Nursing homes in districts are accredited to conduct Family planning operations . The issues mentioned above are closely interlinked with the existing socio demographic conditions of the women, specially rural, poor and illiterate. Comprehensive targeted family planning programme as well as intersectoral co-ordination on an overall female empowerment drive is needed to address the factors responsible for persistently high fertility levels in Bihar. The district has quality assurance committee for family planning. District

Health Society Madhepura accredited 6 by the help of District Quality Assurance Committees for conducting sterilization in districts. These private facilities are monitored by the QAC on sterilization conducted in the facilities. Family planning Insurance scheme is also being implemented in the district with ICICI Lombard. District Health Society Madhepura made provision of fixed day family planning services at District hospitals, Sub divisional hospitals, FRUs, PHC and accredited private facilities.

Goal: Reduce TFR by 3.4 from present level of 3.9

Objectives:

- To increase male participation in family planning
- To increase proportion of male sterilizations from 0.6% to 1.5%.
- Monitor the quality of service as per GoI guidelines for Sterilization

Objective No.1: To increase Couple Protection Rate

Strategies and Activities:

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

Objctive No.2: To increase male participation in family planning Strategies and Activities .

Strategies and Activities:

- Promote the use of condoms
- Counseling men in villages to demonstrate easy of use of condoms and for prevention of STDs Male workers will assist the MPWs in addressing the meetings of men in villages to demonstrate the use of condoms and its benefits in family planning and prevention of STDs.
- Regular supply of condoms and setting up depots which are socially accessible to all men .
- Promote adopting NSV: as simple and convenient method of hassle free FP methods (however, it must be told that it doesn't protect from STI/RTI of HIV/ AIDS)

Objective No.3: To increase proportion of male sterilizations from 0.6% to 1.5%.

Strategies and Activities:

- Increase demand for NSVs (develop a method of satisfied NSV Client, who could be the advocates for NSV in their designated geographical areas. Orient and traind them and give them specific geographical responsibility to give roster based tasks etc to identified groups of probable clients.)
- Village level meetings in which men who already underwent NSV share experiences to motivate men to undergo NSV
- Increase capacity for NSV services
- Training of doctors for NSV While demand is being generated, a team of doctors should be trained at all the FRU level to conduct NSVs.

Objective No. 4: Monitor the quality of service as per GoI guidelines for Sterilization

Strategies and Activities:

- A quality assurance committee initiated in every district for monitoring the quality of sterilization in the respective district. The Civil Surgeon is the chairman of the committee with at least one Gynecologist.
- Streamline the contraceptive supply chain & Monitoring
- Identifications & Renovation of Warehouse – District/ PHC
- Budget allocation for transportation at every level
- Provision for report format printing and their availability at every level

Adolescent Reproductive and Sexual Health

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

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

- The median age of marriage among women (aged 20 to 24) in India is 16 years.
- In rural India, 40 percent of girls, ages 15 to 19, are married, compared to only 8 percent of boys the same age.
- Among women in their reproductive years (ages 20 to 49), the median age at which they first gave birth is 19.
- Nearly half of married girls, ages 15 to 19, have had a least one child.
- India has the world's highest prevalence of iron-deficiency anemia among women, with 40 percent to 50 percent of adolescent girls being anemic.

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

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

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

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

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

Being a sensitive and often, controversial area, adolescent reproductive and sexual health issues and information are very often difficult to handle and disseminate. Furthermore, the contents do not only deal with factual and knowledge-based information but more importantly, need to deal with attitudinal and behavioral components of the educational process. Thus it can be conclusively stated that adolescents are a diverse group, and their diversity must be considered when planning programs. Adolescents, the segment of the population in the age group of 15 -19 years, constitute about 23% of the population of the state. This group is critical to the success of any reproductive and sexual health programme, as it would remain in the reproductive age group for more than two decades. Early marriages seem to be still a key problem. Percentage of boys who are married before attaining 21 years in consistently high in most districts. The mean age of marriage for girls is 16.9. 25% pregnant mothers in the state are in the age group of 15-19 years. This is due to the reason that most of the girl's married before18 years. The various anecdotal evidences emerging from the community level participatory planning exercises and opinions voiced by the various levels of health officials during consultation exercise indicate that there is lack of a cohesive ARSH strategy at the state level. Possibility of bifurcating the total target into school going and out of school going adolescents have not been examined as a strategy option. Hence the current school health program by and large lacks any adolescent oriented interventions.

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

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

Goal:

- To reduce incidence of teen age pregnancies from present 20-25% by 2012-13.
- To ensure the access to information on Adolescent Reproductive & Sexual Health (ARSH)
- Through services at District Hospitals, SDH, CHCs, PHCs & HSC level.
- To increase awareness levels on adolescent health issues

Objective No.1: To reduce incidences of teenage pregnancies from present 20-25% by 2012-13.

Strategies and Activities:

- Improve access to safe abortions
- MTP services made available at all the FRUs initially & at all SDHs in subsequent years, through training of select medical officers at DH/MC.MOs will be trained in MTPs
- Manpower (Training) & logistic support to private hospital doctors and will also be trained inconducting safe abortions.
- Ensure availability of condoms/OCPs/Emergency contraceptives
- Depot holders among adolescent groups/youth organizations In addition to the ASHA and the AWW, youth organizations such as football clubs and others will havedepot holders who will provide condoms/OCPs and Emergency contraceptive pills and Maintain confidentiality.

Objective No.2:

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

Strategies and Activities:

- Organize regular adolescent clinics/counseling camps at SC/PHC/CHC/SDH/DH
- Appointment of Adolescent Counselor for districts setting up Adolescent clinics.
- Adolescent health sessions/clinics will be held in each Sub Centre/ PHC / CHC/SDH and DH with service delivery & referral support
- Risk reduction counseling for STI/RTI During the monthly or weekly interactions through health sessions and clinics, counseling for preventing STI/RTI will be also be done. This will include single partner sex and use of condoms for safe sex.
- ASHA/AWW to act as nodal persons at village level for identifying & referring adolescents in need of such services.
- Training of AWW/ASHA in adolescent health issues All ASHAs and AWWs will be oriented on problems faced by adolescents, signs and symptoms of the problems and where to refer these cases.
- Referrals to de-addiction centers for treating alcoholism/drug addiction
- Identification of de-addiction centers in the state/district The state / district will identify NGOs or other de-addiction centres in the state and through the health workers will refer the cases in need to these centres for treatment.
- Circulate information on services provided at these centres and setup referral system The state/district will have an understanding with the de addiction centre on the process for referring patients to the de-addiction centres.

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

Strategies and Activities

- Organizing Behavioral Change Communication campaigns on specific problems of adolescents
- IEC activities along with take-home print material to be organized in coordination with MSS, Youth club One of the monthly theme meetings with the MSS / CBOs will be related to adolescent health problems, signs and symptoms, treatment and referrals.
- Monthly health checkups under School Health Programme through PHC medical and paramedical staff 3.1.3 Orientation of VHSC on adolescent issues The MPWs will during their routine interactions with the VHSC members apprise them of theproblems and issues related to adolescents and what to do for treatment and referrals. (Budgeted in RCH Training along with maternal health, Child health and Family Planning)
- Premarital counseling of adolescent girls on reproductive health issues at PHC/RH/SDH/DHThis will be part of the adolescent health session/clinics

which will be regularly conducted at sub centres,PHCs and also at youth clubs.

- Dissemination of ARSH Guidelines and Trainings
- Organize dissemination of ARSH guidelines at State level.
- Training of TOTs on ARSH
- Training of MOs, ANMs on ARSH

Proposed Strategies and Activities for Operationalization of ARSH

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

- Actions are proposed at the level of sub-centre, PHC, CHC, district hospitals through routine OPDs. Separate arrangements should be done for male and female adolescents.
- Fixed day, fixed time approach could be adopted to deliver dedicated services to adolescents and newly married couples.
- A separate ARSH Cell, comprising of ANM, LHV, Health Educators etc. can be established at these Cells.
- A separate ARSH Cell can be constituted at every CHCs and Referral Units, with one MO asits nodal officer (on call, sort of) and two counselors.

2. Interventions to operationalise ARSH.

- Orientation of the service providers: Equipping the service providers with knowledge and skills is important. The core content of the orientation should be vulnerabilities of adolescents, need for services, and how to make existing services adolescent friendly.
- Environment building activities: this should include orienting broad range of gate keepers, like district officials, Panchayat members, women's group and civil society. Proper communication messages should be prepared for the same exercise. District, block and sub block level functionaries should be responsible for this.
- The MIS should at least capture information on teen age pregnancy, teen age institutional delivery and teenage prevention of STI.

Urban Health

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

Objectives:

1. Improve delivery of timely and quality RCH services in urban areas of Bihar.
2. Increase awareness about Maternal, Child health and Family Planning services in urban areas of the state. At present, there are 12 Urban Health Centres (UHC) in the state which are non-functional. However, as per the GoI guidelines, there should be one UHC for 50,000 population (out patient). The Urban Health Centre are required to provide services of Maternal Health, Child Health and Family Planning. The infrastructure condition of the Urban Health Centres is not up to the mark and requires some major renovation work. The staff at each UHC should comprise of 1 Medical Officer (MO), 1 PHN/LHV, 2 ANMs, 1 Lab Assistant and 1Staff clerk with computer skills.

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

Strategies and Activities

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

- Mapping of Urban Slums and existing providers of RCH services of both public and private sectors has been completed.
- Develop Micro-plans for each urban area for delivery of RCH services, both outreach and facility based.
- Strengthen facilities of both public and private sectors in urban areas
- Establish partnerships with select private health clinics for delivery of facility-based RCH services e.g .institutional delivery, permanent methods of FP, curative MCH service etc.
- Collaborate with health facilities managed by large public sector undertakings such as Railways, ESIS, CGHS and Military to provide RCH services to general population from identified urban areas.
- Strengthen outreach RCH services in urban areas through involvement of both public and private sector service providers
- Deliver outreach services planned under RCH through reinforced network of frontline health service providers (ANMs, LHVs)
- Expand outreach of RCH services by adoption of identified under-served or un-served urban areas by facility-based providers (e.g. adoption of a particular slum by a medical college or private health institute)
- Establish 20 Urban Health Centres on a rental basis under PPP in this financial year especially indistricts with DHs having heavy patient load

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

Strategies and Activities

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

- Utililise various channels of mass media with extensive reach in urban areas such as TV, local cable net works, radio cinema halls, billboards at strategic locations, etc to propagate messages related to key programme components of RCH.
- Extensive use of print media such as newspapers (particularly local newspapers), journals and magazines for dissemination of key RCH messages.
- Broad inter-sectoral coordination to increase awareness and knowledge of key messages under the RCH programme.

Vulnerable Groups/ intervention in High Focus District

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

Tribal Health

There are so many area of tribal family in the district of Madhepura like Murliganj, Ghailarh, Kumarkhand, Gwalpara etc. for which we will provide the special services of health like mobile medical unit.

Infrastructure and Human Resource

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

Health Facility

S.No.	Type	No. of Facilities/Institution
1	District Hospital	1 (Sadar Hospital at Madhepura)
2	RH	1 (Not Functional)
3	PHC	13
4	APHC	23
5	HSC	272

Human Resource

Manpower Management in the health sector has been undertaken vide various initiatives like **r**e-organizing & rationalizing the existing manpower, ensuring power to transfer doctors delegated to Civil Surgeons, Web enabled system to capture district level cadre in formation, appointment of 26 contractual doctors done, dynamic ACP being rolled out, cadre modified for doctors, cadre rules notified for paramedics and health educator, OT assistant, clerks, pharmacists, lab technicians, X-ray technicians cadre rules to be finalized soon, and draft publication read **Mobile Medical Unit** for x-ray technicians, OT assistants and clerks.

PHC	**Gaps**	**Issues**	**Strategies**	**Activities**
Human Resource	As per IPHS norms each PHC requires the following clinical staffs General Surgeon Physician Gynecologist Pediatrics Anesthetist Eye surgeon As per IPHS norms each PHC requires the following Para medical support:(List attached) But the actual position Is Nurse midwife 13/58 Dresser 5/41 Pharmacists 4/38 Lab technician 12/38 Ophthalmic assistant 6/14	staff shortage Untrained staffs	Staff recruitment And Capacity building	1.Selection and recruitment of Doctors. 2.Selection and recruitment of ANMs / male workers 3.Selection and recruitment of paramedical/ support staffs 1.Training need Assessment of PHC level staffs 2.Training of staffs on various services 3.Trainings of BHM and Accountants on their responsibilities. 4. Trainings of BHM on implementation of services/ various National programes.

APHC	Gaps	Issues	Strategies	Activities
Human Resource	Out of 23 APHCs 6 do not have Nurse grade “A”	Filling up the staff shortage Untrained staffs	Staff recruitment Capacity building	1.Selection and recruitment Doctors / Grade A nurse/ANMs 2.Selection and recruitment of male Workers 1. Training need Assessment of APHC level staffs 2. Training of staffs on various services 1. Analyzing gaps with training school. 2. Deployment of required staffs/trainers 3. Hiring of trainers as per need. 4. Preparation of annual training calendar issue wise as per guideline of Govt of India. 5. Allocation of fund and Operationliasation of allocated fund

HSC	Gaps	Issues	Strategies	Activities
Human Resource	1.Out of 272 HSCs 147. don’t have either own ANMs or Male worker,	Filling up the staff shortage	Staff recruitment	1.Selection and recruitment of ANMs 2.Selection and recruitment of male Workers

S.N.	Name of Units	Doctors					
		Regular			Contractual		
		Sanc.	Posted	Vac.	Sanc.	Posted	Vac.
1	Alamnagar	8	2	6	5	2	3
2	Bihariganj	8	2	6	5	1	4
3	Chousa	9	2	7	5	1	4
4	Gamharia	6	2	4	5	1	4
5	Ghailadh	10	1	9	5	1	4
6	Gwalpara	6	1	5	5	2	3
7	Kumarkhand	12	2	10	5	1	4
8	Madhepura	7	2	5	4	2	2
9	Murliganj	7	1	6	5	3	2
10	Puraini	6	2	4	5	1	4
11	Shankarpur	4	1	3	5	2	3
12	Singheshwar	5	2	3	5	1	4
13	Udakishunganj	5	2	3	5	1	4
14	Sadar Hospital	58	12	46	5	5	0
Total		**151**	**34**	**117**	**69**	**24**	**45**

S.N.	Name of Units	Nurse Grade 'A'						ANM					
		Regular			Contractual			Regular			Contractual		
		Sanc.	Posted	Vac.	Sanc.	Posted	Vac.	Sanc.	Posted	Vac.	Sanc.	Posted	Vac.
1	Alamnagar			0	4	3	1	18	3	15		4	
2	Bihariganj			0	4	0	4	12	6	6		2	
3	Chousa			0	6	0	6	15	5	10		5	
4	Gamharia			0	6	1	5	8	2	6		3	
5	Ghailadh			0	8	1	7	10	5	5		3	
6	Gwalpara			0	4	1	3	12	2	10		7	
7	Kumarkhand			0	8	3	5	24	11	13		2	
8	Madhepura			0	4	1	3	24	15	9		0	
9	Murliganj			0	4	0	4	16	12	4		1	
10	Puraini			0	4	0	4	10	3	7		4	
11	Shankarpur			0	2	0	2	11	1	10		5	
12	Singheshwar			0	2	0	2	16	8	8		5	
13	Udakishunganj	4	0	4	2	2	0	16	9	7		2	
14	Sadar Hospital	5	3	2	0	1	-1	4	9	0		0	
Total		**9**	**3**	**6**	**58**	**13**	**45**	**196**	**91**	**105**	**153**	**43**	**110**

S.N.	Name of Post	Sanc.	Posted	Vac.
1	DPM	1	1	0
2	DAM	1	1	0
3	M&E Officer	1	1	0
4	DPC	1	1	0
5	DCM (ASHA)	1	1	0
6	DDA (ASHA)	1	1	0
7	BCM (ASHA)	13	9	4
8	Data Operator	16	15	1
9	Hospital Manager	2	2	0
10	NVBDCP Consultant	1	1	0
11	Financial & Logistic Assistant	1	1	0
12	Data Operator (Kala-Azar)	1	1	0
13	KTS	6	6	0
	(IDSP)			
14	Epideomologiest	1	0	1
15	Data Manager	1	1	0
16	Accountant	1	0	1
17	Administrative Assistant	1	0	1
18	Data Operator	1	0	1

Institutional Strengthening

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

Training

Successful Implementation of any programme depends on the capacity building of the personnel engaged. In RCH – II also, human resource base will be created by enhancing the capacities through training .The sensitization of health personnel towards various RCH interventions is one of the major focus of the capacity building initiatives under RCH - II . Various trainings will be provided to State and district level managers, medical officers, nursing staff, ANMs, AWWs, ASHA and others. The training will be provided at the State Institute of H & FW , Regional training Institutes , ANM training schools , District hospital ,PHCs . Some of the trainings will be contracted out to the NGOs and private players also, so that any limitation of State infrastructure is overcome easily. .As BCC will be a major training aspect; it has been dealt in a separate chapter. All the technical training programmes will ensure that. Along with the theoretical inputs, proper practical exposure is also provided. Apart from this each training programme will stress on the managerial aspect and on

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

S.No	Name of Training	Medical Officer	Staff Nurse	ANM	AWW
1	NSSK	16	1	13	0
2	SBA	6	2	51	0
3	FIMNCI	35	0	0	0
4	IMNCI	14	05	40	796
5	IUD Insertion	1	8	24	0
6	Bemoc	0	0	0	0
7	Emoc	1	0	0	0

IEC/BCC

Madhepura is a District with high cultural heterogeneity. It has been a challenging area to address the issues of behaviour change in a heterogeneous population. Even if the language of communication differs from area to area. It indicates that no common strategy is going to work for the entire district as different areas have different dialects of communication. Use of Block BCC has been one of the key components in any health sector strategy. It is essential to modify risk prone life styles and practices to promote healthier lifestyles and practices. Appointment of ***Consultant-IEC*** at district level. IEC should be done for different programs such as-

Maternal Health

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

Child Health

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

Adolescent health

- IFA/Anemia
- HIV prevention

Vitamin –A, Pulse Polio and other different types of program.

Inter Personal Communication, counseling by trained functionaries supported with various social mobilization and mass media activities will be built into communication plan for each program under NRHM. ICC /BCC can be done either through *Mass Media* or through *Interpersonal* Communication.

1) Mass Media: Radio, television, newspaper, magazine, tin plate, bus panel, wall painting, wall writing, glow shine board etc can be used as one of the effective medium for mass media.
2) Interpersonal media: Anm, ASHA, AWW, medical officers, other health staffs, PRI members and any other volunteer can be used as medium for Interpersonal communication.
3) Community Media: Workshop, Fair (Mela), Stall organization, 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 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 District.
4. Campaigns: Campaign on different aspects of health can also solve the problem of ICC/BCC by bringing awareness among community regarding different programs such as

- Safe motherhood
- Child Survival & development
- Breastfeeding
- Health emergencies
- Family Planning
- Routine Immunization
- PPP and others.

Procurement of Equipments/ Instruments and Drugs/Supplies

Delivery Kits at HSC/ANM/ASHA
***Medical equipment &accessories: Disposable Delivery Kits consisting of the following items*:**

- Four pieces Gauze (F11) 14x16 cm, folded 4 times each;
- Stainless steel blade;
- Cotton pad
- Two pieces of strong thread each 25 cm);
- Small bar of soap;
- 4 pieces cotton (IP) 2.5 sq. inch each;
- Plastic sheet 60x60 cm;

SBA Drug Kits with SBA-ANM/Nurses

- Misoprostol Tablet 200 µg
- Oxytocin Injection
- Magnesium Injection
- Gentamycin Injection 80 mg
- Ampicillin Capsule 500 mg
- Metronidazole Tablet 400 mg
- Veinflow 20 G
- IV set
- Disposable needles
- Syringes 5 ml
- Syringes 10 ml
- Sanitary Napkins for adolescent
-

Instrument for ANM In HSCs

- Stethoscope
- B. P.Instrument (Air blood instrument Nonmercurial sphygmomanometer)
- Weighing Machine weighing capacity of 10 Kgs) /-

- Weighing Machine Square Model (120 Kgs)

Procurement of ICU Equipment

- Bed Side Monitor
- Defibrillator
- Syringe Pump
- ECG Machine
- ICU Ventilator
- Air Fumigator
- Suction Machine
- Laryngoscope
- Nebuliser
- Glucometer
- Air Viva (Ambu Bag)
- ICU Bed
- Bed Side Lockers
- Medicine Trolley
- Transfer Trolley
- Three Fold Stand
- X-Ray View Box

Programme Management

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

District Health Societies

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

- To act as a nodal forum for all stake holders-line departments, PRI, NGO, to participate in planning, implementation and monitoring of the various Health & Family Welfare Programmes and projects in the district .
- To receive, manage and account for the funds State level Societies in the Health Sector) and Govt.of India for Implementation of Centrally Sponsored Schemes in the Districts.
- Strengthen the technical/management capacity of the District Health Administration through recruitment of individual/ institutional experts from the open market.

NRHM STATE PROGRAMME IMPLEMENTATION PLAN-

- To facilitate preparation of integrated district health development plans.
- To mobilize financial/non-financial resources for complementing /supplement the NRHM activity in the district.
- To assist Hospital Management Society in the district.
- To undertake such other activity for strengthening Health and Family Welfare Activities in the district as may be identified from time to time including mechanism for intra and inter sectoral convergence of inputs and structures.

Governing body of DHS

1. District Magistrate –cum - Chairman
2 District Development Commissioner-cum- Vice Chairman
3. District Social Welfare Officer Member
4. Civil Surgeon-cum- Member Secretary
5. Addl. Chief Medical Officer Member
6. District RCH Officer Member
7. Deputy Superintendent of the District Hospital Member

Executive Body of DHS

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

District Programme Management Support unit Consist of Following Personnel:-

1. District Programme Manager
2. District Planning Co-Ordinator
3. District Accounts Manager
3. District M & E Officer
4. District Community Mobilizer (Asha)
5. District Data Assistant (Asha)
6. VBDCP, Consultant.
7. Data Operator

Hospital Programme Management Support unit Consist of Following Personnel:-

1. Hospital Manager
2. FRU Accountant
3. Family Planning Counselor
4. Data Operator

Block Unit (BPMU)

Block Programme Management Unit consists of following personnel

1. Block Health Manager
2. Block Accountant
3. Block Community Mobilizer
4. Data Operator
5. KTS

Financial Management

FUND FLOW MECHANISM IN DISTRICT

Presently the State Health Society is getting Grants-in-Aid from GoI through electronic transfer by crediting the A/c o f SHS. These funds are transferred to District Health Society A/c as Untied funds as per their respective District Actio Plans, which then gets routed to the CHCs, PHCs, district hospitals and RKS for smooth conduct of the activities o f RCH- II.

OPERATION OF BANK ACCOUNTS

The Account of District 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 District is following the Double Entry System of accounting on Cash Basis. For the sake of convenience in consolidation of accounts Blocks are instructed to follow the same system. In addition to this for proper accounting and maintenance o f books, a manual cum guidelines had been issued to all 18 blocks as well as districts. Also the monthly auditing is being done by Civil Surgeon on Personal basis in order to trace out any sort of irregularity immediately.

FI NANCIAL MANAGEMENT AT DISTRICT

The Financial Management at District level is looked by (DAM) District Accounts Manager. DAM is accountable for all sort of financial matters under NRHM at district level and at the block level, there is the Block Accountant.

Convergence and Coordination

Coordination with other departments such as ICDS, PHED, Education and Panchayat Raj is important for tackling health issues. The involvement of representative of these departments will help the health service to achieve its goal easily.The District would take certain initiatives to ensure a synergistic effort from the community level to the District level.

Convergence with ICDS has been taken care of to cover immunization and ANC Service. ASHA, AWW and ANMs together hold monthly meetings with Mahila Mandals under MUSKAAN Programme. Government of Bihar has decided to merge "Village Health and Sanitation Committee" with " *Lok Swasthya Pariwar Kalyan and Gramin Swaschata Samiti"*constituted by Department of Panchayat Raj in Bihar. There are 170 PRIs in Madhepura district. VHSC are constituted in all panchayat.

The PHED has been entrusted to train ASHAs as per GoI norm. Adolescent councelors are placed in each district fro m District AIDS Control Society. The Health department is looking to cooperate with them by giving training to these councilors for implementing ARSH programme. The District PWD Department has taken care of the construction of Health Department. All the construction activity for Health Institutions under NRHM has already been handed over to the PWD department.

Role of State, District & Blocks

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

Monitoring and Evaluation

The National Rural Health Mission has been launched with the aim to provide effective health care to rural population. The programme seeks to decentralize with adequate devolution of powers and delegation of responsibilities has to have an appropriate implementation mechanism that is accountable. In order to facilitate this process the NRHM has proposed a structure right from the village to the national levels with details on key functions and financial powers. To capacitate the effective delivery of the programme there is a need of proper HMIS system so that regular monitoring, timely review of the NRHM activities should be carried out. At district level, there is a District Health Society who will be responsible for the data dissemination from the HSCs level to the district level. District M & E Officer at the district level and Accountant cum M& E Oficer at block level will be responsible for management of HMIS. As such, there is a Monitoring Team constituted district level as well as block level to monitor the implementation of the NRHM activities. There is a Hospital Management Committee/Rogi Kalyan Samiti at all PHCs and CHCs.The PHC / CHC Health Committee will monitor the performance of HSC under their jurisdiction and will submit the report and evaluate the HSC performance, and will be submitted to the District, which will compile and sent it to the State.

Main Activities

A. Health Management Information System

1). HMIS at block level
2) HMIS at District level.
3) Data Centre at District Level & Block Level.

A. Health Management Information System (HMIS)

As we know that NRHM aims to continuously improve and refine its strategies based on the input and feedback received from the block and from various review missions. One of our priorities is to strengthen the Health Management Information System (HIMS) in the Block and to use it for improving the quality of data for planning and programme implementation at each level. NRHM has introduced revised HMIS formats for each and every level. Ministry of Health & Family Welfare, Govt. of India have launched the Health MIS (HMIS) Portal (http://nrhm-mis.nic.in .) on 21October 2008 with a view to place NRHM related information in the public domain. NHSRC, New Delhi has also introduced HMIS Portal (http://bihar.nhsrc-hmis.org)

Flow of Data through HMIS in Madhepura District

State Programme Management Unit
(M&E Division/HMIS Cell)

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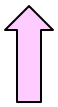
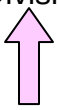


District Programme Management Unit
(M&E Division/HMIS Cell)



Block Programme Management Unit
(M&E Division/HMIS Cell)

Flow of data from HSCs, ⇨ APHCs ⇨ PHCs & DH ⇨ DHS

The HMIS system has been running well in blocks but there are several gaps in training and analysis of reports for improving the quality of data. Currently training is being imparted to all ANMS of district on HMIS so that the district can have actual data. Data operators ,BHMS as well as MOS Should also be given training in HMIS from time to time.

Synergie with NRHM Additionalities

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

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

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

Sustainability

The usage of government services in Bihar has certainly picked up with number of patients increasing manifolds due to free drugs and availability of doctors at PHC level. Similarly there has been an unprecedented increase in number of deliveries being conducted at government health facilities under Janani Baal Suraksha Yojana This can be largely attributed to huge influx of funds under NRHM. To hedge the growth from lack of funds and for its sustainability Government of Bihar has already applied user charges for referral transport services. The ambulance user charges are being determined by Rogi Kalyan Samitis. The state already has paying wards in our medical colleges and GoB is contemplating having such wards in all district hospitals too. For sustainability of manpower, incentives have been proposed for specialist services and for postings in rural areas in this Programme Implementation Plan. Government has finalized Dynamic ACP and Cadre division of doctors for providing them better benefits. Private parties are also being encouraged to make investments in Health sector so that the sector doesn't become dependent on NRHM funds. However they would be urged to take up mapping of available facilities and also analysis of demand before investing and providing services so that any duplication may be avoided. Moreover GoB is also increasing its allocation to health sector. This year the state government proposes to expand Emergency Medical Service, establish Dialysis Unit under PPP initiative. The state is also increasing the number of Urban Health Centres.

Extra inclusions in RCH (IFA)

IFA (Details Annexed)

Proposal for reduction of maternal mortality and morbidity and neonatal mortality by management of severe anaemia among pregnant women Anemia is prevalent in pregnant women is more than 60% in Bihar and UP (NFHS-3).Studies have proved that iron deficiency is responsible for > 95% of the anemias during pregnancy. The factors responsible for iron deficiency precede pregnancy and include diet poor in iron content, menstrual loss, poor oral intake of iron supplements and increasing demand of the fetus during pregnancy. Anemia directly contributes to 8% mortality and indirectly to 22% mortality of the total maternal mortality rates. It also contributes to high fetal losses and increased incidence of LBW babies and consequent infant mortality. Oral iron is given in the form of Iron Folic Acid tablets to combat anemia both as a therapeutic and preventive measure.To correct severe anemia with Hb% less than 8 gms within 6 months the women need parentral iron . Though studies proved that parentral iron and oral iron have the same benefits, the various factors like poor compliance, poor absorption etc resulted in poor outcomes among severely anemic women. In the high focus states often women are seen in the hospitals with complications of anemia and the haemoglobin levels are around 3-4 gms. When the haemoglobin levels of these women are to be improved within shorter time either blood transfusion or intravenous iron therapy is to be given. As the availability of blood transfusion facility is limited , intravenous iron sucrose is the next best alternative. Iron sucrose is administered as IV/ IM drug for the management of anemia. The advantage with this drug is the near absence of side effects of oral iron therapy and the allergic reactions noted with other parenteral iron preparations. The second important advantage is the rapidity in the correction of anemia which occurs within 5 weeks (Bangladesh study) and hence can be administered even in advanced stages of pregnancy say 30- 32 weeks. It is also important to develop uniform guidelines which can be implemented across the state

in all the institutions so that the benefit of iron therapy reaches the targeted population of the pregnant women . Accordingly guidelines have been developed for the administration of iron sucrose in all the medical institutions . All the pregnant women who attend antenatal clinics in all CHCs/BPHCs, FRUs and district hospitals with Hb% levels less than 8 gms may be administered with Intravenous Iron Sucrose as per the protocol. The ANMs would screen the women for severe anemia and refer the women to CHCs, FRUs and for the treatment with Intravenous iron Sucrose. A technical group will be formed with the senior specialist in Obstetrics, officer incharge of maternal health in State Health Society and state programme officer will prepare the state specific guidelines including method of administration of Iron Sucrose injection.

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

a. Compulsory Hemoglobin estimation at 14 weeks, 20th weeks and 32 weeks of pregnancy for all pregnant mothers.
b. De worming at 20th week of gestation (Second Trimester). (Tablet Albendazole 400mg – single dose.)
c. Iron in the form of Ferrous Sulphate is the best choice. Preventive and therapeutic form of Iron to be started after deworming.
   (Preventive dosage of Iron – 100 mg. of elemental iron- FST 0.5mg. Folic acid once daily for 100 days. Therapeutic dosage of Iron – 100 mg. of elemental iron – FST 0.5 mg. folic
   acid twice daily for 100 days)

Decentralisation

For effective decentralization in principle as well as practice, Health societies have been established at all levels of the health care delivery structure. Systematic involvement of various stakeholders at all levels through these societies has helped make healthcare delivery responsive to the needs of the people via participatory planning and removal of bottlenecks at implementation levels. State Health Society provides overall guidance and supervision for effective planning and implementation, and also coordinates activities across the board. The State Health Mission, the Governing Body and the Executive Committee meet at regular intervals and take decisions regarding all matters. District level activities are taken care of through the District Health Society. Rogi Kalyan Samitis at PHC, CHC, Sub Divisional Hospitals, District Hospitals and Medical Colleges have been progress. The formation of societies under NRHM has given a new direction to management and overall functioning of the health department towards the achievement of its goals.

ASHA

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – 'ASHA' or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA is trained to work as an interface between the community and the public health system. Under NRHM, 1500 ASHAs (revised as per the decadal growth in 2008) are to be selected and trained in Madhepura.

1.1 At the District Level

District Community Mobilizer :-

He is 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 of ASHA.

Data Assistant: He will assist the community mobilizer and existing staff of the DPMU in all the ASHA related work

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

1.2 At the Block Level

Block Community Mobilizer – An Officer will be appointed as a block level organizer for effective programme management, implementation and execution and to act as a link and network between the ASHAs and the District and will be assisted by a facilitator – 1 on every 20 ASHAs. The Facilitator will be the 21st ASHA worker. This will help in building up and developing the necessary skill required for a community health worker in a sustainable way.

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

1.3 At the Village Level

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

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

1.4 ASHA Training

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

1.5 ASHA Drug Kit and it's replenishment

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

1.6 Emergency Services of ASHA

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

1.7 Motivations for ASHA

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

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

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

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

Capacity Building/Academic Support Programme:

a) Enabling ASHA 10th pass – For up gradation of academic strength of ASHA, SHSB will provide examination fees for the 10th examination of open schooling mode/Board/IGNOU to 1000 ASHAs in 1st Phase. Fee for the same to be provided by SHSB.

b) Training for Help Desk – The person/officer involved in operationalising the ASHA help desk at District level and Block level will be trained.

ASHA *Divas*

ASHA *Divas* will be held per month. This will include the following components-

- Monthly Meetings for ASHA Divas of ASHAs, ANMs and AWWs shall provide the necessary platform to share the work experiences, identify the loop holes and work towards the same.
- Best ASHA worker and facilitation as per their monthly performance at the institutions.
- ASHA Divas will provide motivation. The performance will be rated as per the ASHA Activity Diary.
- Provision of I-Card will be done to the newly selected ASHA workers.
- Replenishment of ASHA Drug Kit for at least the next two months. This will ensure treatment of common ailments and first level prompt care and referrals initiated based on symptoms of necessary cases. For this, effective access to basic drugs in every village should be ensured through ASHA Drug Kit.

Untied Funds for Health Sub-Centre, APHC & PHCs

The objective of the activity is to facilitate meeting urgent yet discrete activities that need relatively small sum of money at Health Sub Centers. The suggested areas where Untied Funds can be used mentioned below:

- Cover minor modifications to sub center-curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level;
- Adhoc 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.

Village Health Sanitation & Nutrition Committee

Government of Bihar has decided to merge “Village Health and Sanitation Committee” with “Lok Swasthya Pariwar Kalyan and Gramin Swaschata Samiti” constituted by Department of Panchayat Raj in Bihar.

ANM of the concern HSC is the secretary where as PRI member of the concern revenue village is the chairperson of this committee. VHSNC account is being operated by the joint signature of secretary as well as chairperson. So if a panchyat is having say 3 revenue

villages then amount (3@10000=30000) concern ANM of panchyat will be secretary for all those VHSNC account.

Madhepura district has 170 panchayat .Out of these panchayat 153 have VHSNC account. Very soon by the end of this financial year 11-12 we will have 100% VHSNC account in our district.

Rogi Kalyan Samiti

Functions of the RKS

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

- Acquire equipment, furniture, ambulance (through, donation, rent or any other means) for the hospital
- Expand the hospital building, in consultation with and subject to any guidelines that may be laid down by the Gob Make arrangements for the maintenance of hospital building (including residential buildings), vehicles and equipments available with the hospital » Improve boarding/lodging arrangements for the patients and their attendants » Enter into partnership arrangement with the private sector (including individuals) for the improvement of support services such as cleaning services, laundry services, diagnostic facilities and ambulatory services etc » Develop/lease out vacant land in the premises of the hospital for commercial purposes with a view to improve financial position of the Society » Encourage community participation in the maintenance and upkeep of the hospital » Promote measures for resource conservation through adoption of wards by institutions or individuals » Adopt sustainable and environmental friendly measures for the day-to-day management of the hospital, e.g. scientific hospital waste disposal system, solar lighting systems, solar refrigeration systems, water harvesting and water re-charging systems etc.

Seed Money for Rogi Kalyan Samiti

Aims and Objectives

The objectives of the RKS is :

- Upgrade and modernize the health services provided by the hospital and any associated outreach services.
- Supervise the implementation of National Health Programme at the hospital and other health institutions that may be placed under its administrative jurisdiction
- Organize outreach services / health camps at facilities under the jurisdiction of the hospital
- Monitor quality of hospital services; obtain regular feedback from the community and users of the hospital services
- Generate resources locally through donations, user fees and other means

Infrastructure Plan

Construction/Establishment of Health Sub Centre (HSC):

NRHM aims to ensure HSC facility on the Govt. of India population norms of 1 per 5000 population in general areas and 1 per 3000 populations in tribal areas. As per 2001 Census, population of the Madhepura District is approximately 70,528.Exsiting no of HSCs are 272.As per IPHS norms total requirement of HSCs are 380 . To facilitate the above population the state requires additional 152 HSCs had been approved by state health society bihar to achieve the total target. It is proposed to becreated next five years. In SPIP 20011-12 State Health Society Bihar sanctioned fund for Building construction of 5 to 10 HSC @ Rs.15.57 lakhs per HSC. The construction work HSC is under progress. The DHS Madhepura proposes to construct additional 5 HSC building in financial year2011-12.

Contractual Manpower

As human resources are the most important resource steps shall be taken to motivate them through various benefits and incentives like Cell phone facility for all ANMs, MOICs, Programme Officers, CDPOs etc.. All the doctors posted in the rural area would get an additional incentive of Rs.3000. State Health Society Bihar had sanctioned Rs.50,000/- per PHC per year as incentive to the PHCs for better performing in services. All the doctors performing specialist duties including the MBBS doctors trained for specialized tasks e.g. Life saving Anesthesia skills etc. will get an incentive of Rs.4000.

Block Programme Management Unit

The district has already established Block Programme Management Unit in all the 13 Block PHCs.. Each BPMU consist of One Block Health Manager ,One Accountant and BCM. It has been observed that after the establishment of BPMUs the implementation of National Programmes has been managed efficiently and getting improved results.

New proposed – one additional Data operator for BPMU because overloaded work.

Additional Manpower for District Health Society, Madhepura

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

New proposed – Two additional Data operator for DPMU because overloaded work.

PPP Initiatives

Referral & Emergency Transport

1. 108 Ambulance Service

Under this scheme Ambulance for emergency transport is being provided in all the DH to APHC .. The empanelled ambulance & ambulance available in Govt. institutions are made

available for beneficiaries. This service has been outsourced to a private agency for Operationalisation. Requirement of Ambulance in District:-

- Primary Health Centre (PHC): 14
- District Hospital: 02

Total Ambulace: 16

Services of Hospital waste treatment and Disposal in all

4.3. Bio Medical Waste Management

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

Fund Requirement :- Rs.18 lakh

Outsourcing Pathology & Radiology Services from PHCs to District Hospital

Under this scheme Pathology and Radiology services have been outsourced to different Private agencies. The agencies are in the progress of setting up centers/diagnostic labs/collection centers at the hospitals/facilities. The state has fixed the rates . All the remaining cost for setting up centers and providing services will be borne by the private providers.

AAPIO

Services of Hospital waste treatment and Disposal in All Gov. Health Facilities up to PHC in Madhepura (IMEP)

Biomedical 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.

Keeping in view the waste disposal ,every PHCs as well as DH and FRUs have pit for waste disposal. These pits are constructed for disposal of placenta, disposable syringe and used vials. The State has identified agencies for undertaking the task of Bio-Waste Management and Treatment but necessary approval and clearance from Bihar District Pollution Control Board and Central Pollution Control Board is still awaited.

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.

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

Child malnutrition extracts a heavy toll on both human and economic development, accounting for more than 50 % of child deaths world wide. The consequences of malnutrition are serious leading to stunting, mental and physical retardation, weak immune defense and impaired development. More than one-third of worlds malnourished children live in India. In India, as revealed by the recent National Survey (NFHS-3, 2005-06), malnutrition burden in children under three years of age is 46 %. With the current population of India of 1100 million, it is expected that 2.6 million under-five would be suffering from severe and acute malnutrition which is the major killer of children under five years of age. It can be direct or indirect cause of child death by increasing the case fatality rate in children suffering from such common illnesses as diarrhea and pneumonia. The risk of death in these children is 5-20 times higher compared to well-nourished children.

MALNUTRITION IN BIHAR:

In Bihar, malnutrition is a serious concern with a high prevalence of 58.4 % as revealed by the National Healthand Family welfare Survey (NFHS-3, 2005-06). Children suffering from severe and acute malnutrition are reported to be 8.33 %. Based on population figures, it is estimated that in Bihar, 2.5 million children under five years of age are threatened to face the consequences of severe malnutrition. With the situation of nutrition among children being far from satisfactory, it will not be surprising to find that these children who have already arrived in a poor state of nutritional status, with further deterioration are at a high risk of morbidity and mortality.

MEASURES TO MANAGE MALNUTRITION:

While mild and moderate forms of malnutrition in the absence of any minor or major illness among children can be addressed through Anganwadi centres, by supporting mothers to ensure service utilization and appropriate feeding and care practices at the household level; the treatment of children with severe and acute malnutrition calls for facility-based treatment by admitting children to a health facility or a therapeutic feeding centre. This is mainly because these children generally are seen to suffer from acute respiratory infections, diarrhea and pneumonia. In additional to curative care, special focus is given on timely, adequate and appropriate feeding to children. Efforts are also made to

build the capacity of mothers through counseling to identify the nutrition and health problems in their child.

Providing Ward Management Services in District Hospitals

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

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

4.10. Provision for HR Consultant

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

Operationalising Mobile Medical Unit

The concept of MMU has emerged as to provide and supplement regular, accessible and quality primary health care services for the farthest areas in the district of Darbhanga and to provide visible face for the mission and the Government, also establishing the concept of Healthy Living among the rural mass.

Madhepura district is currently having one MMU providing health facilities to exclusive groups as well as hard to reach areas. Now 1 MMU is working. This service in our district started in the month of April 2010.

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 Staff nurse ,1 Driver(Qualification requirements annexed)

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Service Areas

The Medical areas which would be handled include:

1. Free General OPD/ Doctor Consult
2. Free Drugs - Free dispensation and procurement of medicines as per the Essential Drug List prescribed by GoB for PHCs (Annexed) has to be ensured by the private agency.
3. Emergency Services during epidemics and Disasters.
4. Network and referral between PHC/CHC/Private clinics .
5. Generating health indicators and monitoring behavioral changes
6. Gynec clinic.
7. Antenatal Clinics

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8. Post Natal Care.
9. Infants and Child Care including immunization with Vitamin-A supplementation (support for the same to be provided by the Government.)
10. Diagnosis, Referral and Rehabilitation for Non-communicable diseases eg. Cardiac Diseases,

Hypertension, Diabetes,etc

11. Adolescent and Reproductive Health
12. Other Services like Treatment of Minor Injuries and Burns, Aseptic Dressing, TT immunization, Treatment of Minor burns, Minor Suturing and removal – referral etc.
13. Minor lab investigations
14. Eye examination
15. ENT examination

.16. HIV testing

.17. Promotion of contraceptive services including IUD insertion

.18. Prophylaxis and treatment of Anemia with IFA Tablets.

19. IEC and counseling along with preventive health screening and health awareness programs.
20. Service related to different public health programmes.
21. Pathological services.
22. Radiology Services – X-ray and Ultra- sound.
23. Preventive Health Screening and Health awareness programs
24. Medical camps will have to be conducted whenever emergency need can be fulfilled..

Monitoring and Evaluation

District & Block Data Centres

The Data Centers at each and every hospital (PHC, Sadar Hospital, Sub-Divisional Hospital etc.) are being established through outsourcing. District Hospital Sub-Divisional Hospital require two Data Centre . The main purpose of these Data Centers of Hospitals is to gather and maintain health related data under RCH/NRHM programme in their computer system and they upload the gathered health related data on the web-server of SHSB on daily basis. The Data Centers contain one computer with UPS, Laser printer, Phone connection, Internet connection, Computer operator, Misc. etc. The GPRS enabled mobile sets have been given to each and every data centers. The District/Block Data Centres units are working as:

- Primary Health Centre (PHC): 13
- RCH Office : 01
- District Hospital: 01
- District Health Society: 01

Total Data Centre: 16

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 District has provided only space for this purpose to the agency and the agency shares a % revenue share with the Government. The District has also fixed rates for the Generic Drug as per MRP. No additional cost is involved.

Hospital Maintenance

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

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

Provision 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.

Strengthening of Cold Chain

Effective cold chain maintenance is the key to ensuring proper availability and potency of vaccines at all levels. With a steadily increasing immunization coverage for Routine Immunization, rise in demand for Immunization services throughout the state, the consumption of large quantities of vaccines in frequent Supplementary Immunization activities and the possibility of introduction of newer vaccines in the near future, it is necessary that the capacity of existing cold chain stores as well as the proper management of immunization related logistics be strengthened on a urgent basis. For this there is need for refurbishment of existing cold chain stores at all levels.

Main streaming AYUSH under NRHM

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

of ASHA, The additional supply of generic drugs for common ailments at SC/PHC/CHC levels under the Mission shall also include AYUSH formulations.

At the CHC level two rooms shall be provided for AYUSH practitioner and pharmacist under the Indian Public Health Standards (IPHS) model. At the same time, it has been decided to place or provision one Ayush doctor on contract at the APHCs for the purpose and to ensure complete coverage of the population. Activities Improving the availability of AYUSH treatment faculties and integrating it with the existing Health Care Service. Strategies-

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

Procurement & Logistics (Drug and Drug Store)

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	Dist. Hospital to APHC	33	112

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 452 no. of beds shall be required at various levels

Procurement of Equipment (RCH)

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. Also of the 13 Newborn Care Corners at PHCs and one SCNU is functional at Dist. Hospital also, in 2011-12.

De-centralized Planning

SHSB has initiated HSC level planning in this current financial year. Initally it was up till district as well as block level and HSC level .Keeping in view the planning process ,SHS has created post of planning coordinator whose work will be to carry out the planning process of the concern district. Preparation of DHAP will be the major concern of planning coordinator.

At Hsc level Concern ANM will be the nodal person for planning process whereas at block level concern PHCs MOIC will be the nodal person.At district level ACMO is the nodal person for preparation of DHAP.

Chapter V:

Part C – Immunization

Nearly 60 of every 1,000 children in Bihar – one of India's poorest states – do not live to celebrate their first birthday primarily because 89 out of 100 children in the state do not get protection from vaccine-preventable diseases. Bihar reported a routine immunization of 11 percent in 1998-99. However, on August 15, India's Independence Day, Bihar made an enormous effort to free itself from its past. A massive statewide campaign has been launched by the Health and Family Welfare Department in partnership with UNICEF to ensure that deaths preventable by vaccine are actually prevented.The Plan has definite targets ahead and is committed to achieving no less than 100 per cent immunisation by 2010 **Immunization Service Delivery.**

Government of India (GoI) target for RCH

1. 100% children aged 1-12 months and 12-23 months fully immunized (for Bihar, currently it is under 20%).
2. under 30 IMR by 2012-13(for Bihar, currently it is 48).
3. under 200 MMR by 2012-13 (for Bihar, currently it is 352).

Chapter VI:

Part D – National Disease Control Programmes

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 District 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

- **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.**
- **Sexually transmitted**
- **diseases/Blood borne**
- **HIV/HBV, HCV,STI**
- **Other Conditions Water Quality monitoring**

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 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 District level. Currently linkages are being established with District Head Quarter Network. This network enables enhanced Speedy Data Transfer, 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

Use of contractual staff employed under different Programme

Use of Contractual staff employed under IDSP working efficiently.

Monitoring and evaluation

- Districts Surveillance Units are established. District 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.

IDD

Objectives :-

01. Inspite of general salt all the citizens should use the iodised salt.

02. Decrease the no. of those patient who used the non iodised salt,and create awareness between the citizens about iodised salt.

NBCP

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

<table>
<tr><td></td><td>
Purchase of Ophthalmic Chair, Slit Lamp, Operating Microscope, Synaptophore,
A Scan biometry, Keratometer, Direct and Indirect phthalmoscope
7. Construction of Eye Unit in Hospitals and later PHCs
8. Supply of basic Eye medicines like eye drops, eye ointments and consumables for Primary Eye Care in PHCs/CHCs.
9. All PHCs and CHCs to be developed for vision screening and basic eye care
<table>
<tr><td>Eye Care centre</td><td>Vision Centre</td><td>Screening</td></tr>
<tr><td>Eye Surgeon</td><td>Primary Eye Care</td><td>Identify Blind</td></tr>
<tr><td>Treatment of eye conditions and follow-up</td><td>Vision Test</td><td>Maintain Blind Register</td></tr>
<tr><td>Training</td><td>Screening Eye Camps</td><td>Motivator</td></tr>
<tr><td>Supervision</td><td>Referral for surgery</td><td>Referral</td></tr>
</table>
</td></tr>
<tr><td></td><td>10. Blind Register to be filled up by the AWW, together with PRIs
11. Eye Camps with the involvement of Private sector and NGOs
12. School Eye Screening sessions
13. IEC activities</td></tr>
<tr><td>Support required</td><td>Procurement of latest equipment for hospitals by GOI
Timely Repair of equipment</td></tr>
<tr><td>Timeline</td><td>2012-13
Health Mela
Development of PHCs as Vision Centres
Development of Sadar Hospital Madhepura as Eye Unit
School Screening
Cataract Camps</td></tr>
</table>

RNTCP (TB)

Sl.No.	Indicators	Gaps	Activities
1	Infrastructure	As per RNTCP standard one more TU is needed	Development of TU and Renovation of DMCs with Proper water supply and Eletricity connection
		As per RNTCP standard four more DMCs are needed	Establishment of four DMCs
		Six Tus need up gradation	Up gradation
2	HR	Four more LT is needed	Recruitment Process should be followed.
		One more STS and STLs are needed	Recruitment Process should be followed
			Honorarium for 17 TB technicians
		Three more TBHVs are needed	Recruitment Process should be followed.
		Constraint in selection Process of new Staff by the District Health Society	Obstacle in recruitment Process will be rectified.
		Remuneration of Pvt. DOT Providers has not been paid	Problems in payment of remuneration will be solved
3	Drugs and Chemicals	Irregular supply of Drugs specially of Pediatric Drug Boxes (PC-13, PC-14)	To ensure regular and adequate supply of drugs and other Laboratory materials
		Supply of short expiry drugs which causes difficulties in drug management	Proper care should be taken regarding short expiry drugs. Short expiry drugs may be used where there is large number of patients having DOTS.
		Poor Retrieval of Drug Boxes of Defaulted patient	Retrieval of Drugs may be ensured by STS.
		Irregular supply of slides and other Chemicals and other logistics	Proper supply of Slides and other Chemicals should be ensured
		Delay in purchasing of chemicals and other logistics at District level	Constraints in purchasing of Chemicals and other logistics will be removed. Official Process will be simplified.
4	Service Performance	Poor quality of DOTS	Proper and Regular supervision and monitoring of programmes will be ensured.
		ANMs providing DOTS at the HSCs do not visit the Center on DOTS day resulting irregular intake	Motivation and Sensitization of Staffs by Refreshment training for friendly behavior with patient

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

NLEP

LEPROSY

Objectives	Eradication of Leprosy	
Strategies & Activities	1. Detection of New cases 2. House to house visit for detection of any cases 3. IEC for awareness regarding the symptoms and effects of Leprosy 4. Prompt treatment to all cases 5. Rehabilitation of the disabled persons 6. Distribution of Medicine kit and rubber shoes 7. Honorarium to ASHA for giving MDT	
Support required	Availability of regular supply of drugs	

NVBDCP

Vector borne diseases, viz Kala-Azar, Malaria, Filariasis , J.E, and Dengue are major public health concerns. Approximately 12 lac pupation at risk in 13 PHCs of the Kala-Azar endemic District MADHEPURA (BIHAR)

The goal :-

The goal of elimination of kala-Azar by 2015. Elimination of kala-azar will promote equity and poverty reduction and lead to socio-economic development of targeted areas and strengthen the capacity of the health system.

Objectives :-

- Impact - Reducing kala-azar including other vector bornedisease in the vulnerable. Poor and unreached populations in endemic areas.
- Reducing cases fatality rates from Kala-Azar
- Reducing cases of PKDL to interrupt transmission of Kala-Azar and
- Preventing the emergence of kala-azar / HIV / TB Coinfaction in areas.

Process :-

- To Enhance capacity building at all levels in Kala-Azar
- To Ensure early diagnosis and complete case management of Kala-Azar
- To Undertake disease prevention and control by integrated Vector management through selective stratified **IRS,** Insecticide treated net and environment with Community participation and intersectoral collaboration.

Target :-

Target for 2012-13

- To bring down case load of Kala-Azar by 50% as compared to 2011.
- To Prevent any death due to Kala-Azar
- To achieve more than 80% coverage of the targeted Population during **IRS.**

Programme Achievement of 2011

Within three Years of intensification (2009, 2010, 2011)

*** 0.08% Case decline in annual incidence in year ending 2011.**

Total Population :

Population at risk :

STATUS OF HEALTH FACILITIES

S.No.	Health Facility	Number	No. endemic for Kala-azar
01	**02**	**03**	**04**
01	District Hospital	01	
02	Block PHCs	13	13
03	Add PHCs / Mini PHCs	23	23
04	Subcentre	272	272
05	Villages	449	377

HUMAN RESOURCE

S.No.	Health facility	Sanctioned	In – Position	Trained
01	**02**	**03**	**04**	**05**
01	DMO (Full Time)	Nil	Nil	Nil
02	AMO	NIL	NIL	NIL
03	MO	NIL	NIL	NIL
04	VBD Consultant	01	01	Trained
05	Malaria Inspector	06	02	Trained
06	Finacial & Log. Asst. For kala-azar	01	01	Untrained
07	Kala-Azar Data Operator	01	01	Untrained
08	Lab Technician	07	01	Trained
09	Health supervisor (M)	07	01	Trained
10	Health supervisor (F)	NIL	NIL	Nil
11	MPW (M)	21	01	Trained
12	MPW (F)	NIL	NIL	NIL
13	ASHA	1711	1500	400

Chapter VII:

BUDGET

NRHM Part -A

FMR Code	Budget Head/Name of activity	Financial Requirement (in Rs.)	Committed Fund requirement (if any in Rs.)	Remarks
		Total Annual proposed budget (in Rs.)		
Part-A				
A.1.1.1.1	Operationalise FRUs	1412000	100000	250000 for Soundless Genset 24000/month for Fuel 6000/month for Contigency Fund 8000/month IEC + Light Refreshment of Blood Donner+other Expences
A.1.1.1.2	Monitor progress and quality of service delivery	50000		
A.1.1.2	Operationalise 24x7 PHCs(Mch-APHC)	325000		
A.1.1.5	Operationalise Sub centres	100000		
A.1.3.1	RCH Outreach camps / others	182000		
A.1.3.2	Monthly Village Health & Nutrition Days	467200		@2500/Quarter District Level Review Meeting+ (AWW x 100 x 3 times visits) POL for Monitoring of VHSND by Block Officials
A.1.4.1	Home Deliveries	125000		
A.1.4.2.a	Rural	73000000		
A.1.4.2.b	Urban	1470000		
A.1.4.2.c	C-Section	270000		
A.1.4.3	Administrative Expences	576453		
A.1.5	Maternal Death Review	97500		
	Child Health	0		
A.2.1.1	Implementation of IMNCI activities in districts	50000		

A.2.1.3	Incentive for HBNC to ASHA/ AWWs (state initiative) 3 PNC for normal baby	600000		
A.2.1.4	Incentive for HBNC to ASHA/AWWs(state imitative) 6PNC for low birth baby	600000		
A.2.2	Facility based New born Care/FBNC (Operationalise 40 NBSUs)	775000	775000	
A.2.6	Management of Diarrhoea,ARI and micronutrient malnutrition (38 Nutritional Rehabilitation Centres)	4332000		MD (Paed.)- @35000, Staff Nurse-2 @ 20000, Feeding demonstrator-2 @ 9000, Cook-2 @ 3800, Caretaker-3 @3800, Security Guard-3 @ 3800, Sweeper-2 @ 3300, CBC Extender-9500,
A.2.6.1	Managenent Childhood Diarrhea through the Use of Zinc and ORS	1052657		
A2.7	Vit.A biannual round	200840		
Family Planing		0		
A.3.1.1	Dissemination of manuals on sterilisation standards & QA of sterilisation services	20000		
A.3.1.2	Female Sterlization Camps	1800000		
A.3.1.3	NSV Camps	20000		
A.3.1.4	Compensation for female sterilisation	12000000		
A.3.1.5	Compensation for male sterilisation (Compensation for NSV acceptance)	375000		
A.3.1.6	Accreditation of private providers for sterilisation services	3750000		
A.3.3	POL for family Planning (for district level + State level Monitoring)	221000		
A.3.5.4	Provide IUD Services at health facility (IUD camps)	60500		
ARSH		0		
A.4.1	ARSH (Adolesecent Services at Health Facilities)	1211556		
A.4.2	School Health	5520000	1200000	

	Programme(NPSGK)			
Total —		0		
A.7.2	Other PNDT Activities (Monitoring of Sex Ratio at Birth)	100000		
Infrastructure (Minor civil work)Human Resource(Except ayush)		0		
A.8.1.1	ANMs, Staff Nurses, Supervisory Nurses (Salary of Contractual ANM/Contractual SN)	35034000	2919500	
A.8.1.2	Laboratory Technicians (Laboratory Technicians in Blood Banks)	720000	30000	
A.8.1.5	Medical Officers at CHCs / PHCs---(Salary of MO's in Blood Banks)	840000		
A8.1.7	FP Counsellors	360000		
A.8.1.8	Incentive/ Awards etc. to SN, ANMs etc. (Muskaan Programme - Incentive to ASHA and ANM)	2900456	241705	
A.8.2.1	Minor civil works for operationalisation of FRUs	500000		
A.8.2.2	Minor civil works fo operationalisation of 24x7 Sevices at PHCs	1300000	500000	
Training		0		
A.9.3.1	Skilled Attendance at birth	881100	176220	
A.9.3.4	MTP training	86940		
A.9.3.7	Other MH Training (any integrated training, etc.) --- Training of MOs and Paramedics Staffs at Sub District Level (Convergence with BSACS)	230000		
A.9.5.1	IMNCI	2695600	673800	
A.9.5.2	F-IMNCI	0		
A.9.5.5.3	NSSK Training (SN/ANM)	211600		
A.9.6.2	Minilap Training	280960		
A.9.6.4.1	Training of Medical officers in IUD insertion	55300		
A.9.6.4.2	Training of ANMs/LHVs/SN in IUD insertion	88275		
A.9.7.1	ARSH Training (MOs, ANM/Nurses, AYUSH)	0		

A.9.7.2	ARSH Training (BCM, BHM & ASHA) Block Level	286550		BCM, BHM, and ASHA*@150, contigency @2000/ PHC
A.9.8.2	DPMU Training	50000		
A.9.9	Mamta Training	97625		
A.9.11	Training Other Health Personel	15600		BCM, BHM, BAM, Data Operator*@200, contigency @4000
A.9.12	RCH Flexipul			
A.10.1.5	Mobility Support for (District Malaria Office)	180000		
		0		
A.10.2.1	Contractual Staff for DPMU recruited and in position	1940000	161667	Salary DPM (38720*12) DAM (232670*12) M&E (27225*12) DPC (22000*5+24200*7) DEO (10000*2*12) Office Assistant (10000*2*12),
A.10.2.2	Provision of equipment/furniture and mobility support for DPMU Staff	986000		Recuring Expence
A.10.3	Strengthening of Block PMU	9657180	804765	Salary BHM (21780*12*13) BAM (15125*12*13) Mobility (15000*12*13) Office expence (10000*13*12),
A.10.4.2	Renewal (Upgradation)	8100		
A.10.4.3	AMC (State, Regional & DHS)	22500		
A.10.4.5	Training on Tally	22500		
A.10.4.9	Management unit at FRU (Hospital Manager & FRU Accountant)	1058500	88208	Salary HM (27500*5*2+30250*7*2) Accountant(15000*12*2)
A.10.5.1	Annual audit of the programme (Statutory Audit)	45000		
A.10.6	Concurrent Audit (State & District)	240000		
	Total —	171557492	7670865	

NRHM Part -B

FMR Code	Budget Head/Name of activity	Financial Requirement (in Rs.)	Committed Fund requirement (if any in Rs.)	Remarks
		Total Annual proposed budget (in Rs.)		
Part-B				
B1.1.1	Selection & Training of ASHA	1412000		
B1.1.2	Procurement of ASHA Drug Kit & Replenishment	50000	500000	For Rest Asha Drug Kits (546*2186)+ Replacement of Drug (1165*500+ 546*250)
B1.1.3	Other Incentive to ASHAs (TA/DA for ASHA Divas)	325000		
B1.1.4.A	Best performance Award to ASHAs at district level.	100000		
B1.1.4.C	Identity Card to ASHA	182000		
B1.1.4.D	Two Saree for each Asha	467200		
B1.1.5	ASHA Resource Center/ASHA Mentoring Group	125000	307116	Salary DCM (22000*5+24200*7) DDA (16500*5+18150*7) BCM (13200*5*9+14520*7*9+12000*4*12) Asha Facilitator (150*7*12*83) Recuring Expense (Laptop) 35000, Non Recuring Expense 3000*12
Total		73000000		
		1470000		
B2.2.A	Untied Fund for PHCs	270000		
B2.2.B	Untied Fund for APHCs	576453		
B2.3	Untied Fund for Sub Centres	97500		
B2.4	Untied Fund for VHSCs	0		
B.3.2	Annual Maintenance Grant for PHCs	50000		
B.3.2.A	Annual Maintenance Grant for APHCs	600000		

B.3.3	Annual Maintenance Grant for Sub Centres	600000		
B.4.1.B	Upgradation of DH by increase no. of Beds	775000		
B.4.1.3	Construction of Residential Quarter for Doctors/ Staff Nurse in APHCs (PHC)	4332000		For Murliganj, Alamnagar, Chousa, Kumarkhand,Bihariganj,Gwalpara
B.4.2.A	Installation of solar water system	1052657	282000	
B.4.2.B	Accredation/ISO:9000 certification of DH and 2 PHC	200840		For DH and 2 PHC (Singheshwar and Murliganj)
B.5.2.A	Construction of APHCs	0	7600000	
B.5.2.C	Strengthening of cold chain(Refurbishment of existing Cold chain room for district stores and Earthing and wiring of existing Cold chain rooms in all PHCs	20000		
B.5.3	SHCs/Sub Centres	1800000	5775000	
B.5.7	Major Civil Works for Operationalisation of FRU	20000		FRU Murliganj
B.5.8	Major Civil Works for Operationalisation of 24 houre services at PHC	12000000		For Shankarpur
B.5.10.2	GNM Training Institution/School	375000		
B.6	Corpus Grants to HMS/RKS	3750000		
B.6.1	District Hospitals	221000		
B.6.2	CHCs (SDH)	60500		
B.6.3	PHCs	0		
B.6.4	Other (APHC)	1211556		
B.7	District Action Plans (Including Block, Village)	5520000		HSC Plans (272*1500) BHAP (13*5000) DHAP (50000)Laptop (35000) Mobile Recharge (500*12) Computer Assistant (6000*12)
B.8.1	Constitution and Orientation of Community leader & of VHSC,SHC,PHC,CHC etc	0		

B.8.2	Orientation Workshops, Trainings and capacity building of PRI at State/Dist. Health Societies, CHC,PHC	100000		
Total —		0		
B.9.1	Mainstreaming of AYUSH Medical Officers at DH/CHCs/ PHCs (only AYUSH)	35034000	480000	
B.9.2	Mission Flexipul	720000	480000	
B.10.1	Development of State BCC/IEC Strategy	840000		
B.10.3	Health Mela	360000		
B.11	Mobile Medical Units (Including recurring expenditures)	2900456	468000	
B.12.2.A	Emergency Medical Service/ 102 Ambulance service	500000		Maintanance of 102 Ambulance
B.12.2.C	Advanced Life Saving Ambulance (Call 108)	1300000	150000	
B.13.2.D	Refral Transport in District	0		
B.13.3.B	Outsourcing of Pathology and Rediology Services from PHCs to DH	881100	70000	
B.13.3.D	Operationalise Infection management & Enviornment plan at health facilities. Training of in house-Staff (ANM,safaikarmacharies,clinic support staff)on recognizing,segregating and desposing of bio-medical waste,Organise disseminationworkeshops for IMEP Guidelines.	86940		
B.14.B	YUKTI yojana Acceditation of public and private sector for providing safe Abortion services	230000		
B.15.1.2	Purchase of Mobile Handset	2695600		
B.15.2	Capacity Building Training for Quality Assurance	0		
B.15.2.a	Tow Days District level orientation on quality improvement of health facilities & service + FFHI/I (For all Staff od DHS including CS, superintendent, deputy superintendents) 1 Unit	211600		

B.15.2.b	Refesher Training on QA & new initiative on QA (For all Staff od DHS including CS, superintendent, deputy superintendents) 1 Unit	280960		
B.15.2.c	District level training on quality improvement of health facilities & services + FFHI/ISO (MOIC, MO1, HoBHM, DCM, BCM, 2 Staff Nurses or ANMs) {Batch Size may be 100}	55300		
B.15.2.d	Refesher Training on QA & new initiative on QA (MOIC, MO1, HoBHM, DCM, BCM, 2 Staff Nurses or ANMs) {Batch Size may be 100}	88275		
B.15.2.e	Block level/ Facilities based training on FFHI for all staff of facility including 4th grade staff (only for facilities selected for FFHI certification)	0		
B.15.2.f	one day activity- conducting facility level gap analysis exercise (only for the facilities selected for FFHI certification)	286550		
B.15.3.1.A	State,District,Divisional,Block Data Centre.	50000		
B.15.3.2.A	MCTS and HRIS	97625		
B.15.3.2.B	RI Monitoring	15600		
B.15.3.3.A	Strengthening of HMIS (up-gradation and maintenance of Web server of SHSB)			
B.15.3.3.b	Plans for HMIS supportive supervision and data validation	180000		
B.16.1.1	Procurement of equipment: MH (Labour room)	0		
B.16.1.2	Procurement of equipment: CH (SCNU & NBCC equipment)	1940000	300000	Due to increase in no. of instutional delivary, there is a need of New Born setup
B.16.1.3.A	Procurement of Minilap Set: FP	986000		
B.16.1.3.B	Procurement of NSV Kit (FP)	9657180		
B.16.1.3.C	Procurement of IUD Kit (FP)	8100		

	(PHCLevel)			
B.16.1.3.D	Procurement of OT equipments	22500		There is a vast need of OT equipment in all the L1 and L2 institation because of day by day increase in no. of petaints
B.16.1.5.A	Dental Chair Procurement	22500		
B.16.1.5.B	Equipment for 6 new Blood banks	1058500		
B.16.1.5.C	A.C.1.5 ton Window for 28	45000		For FRU murliganj
B.16.2.1.A	Parental Iron sucrose (IV/IM) as therapeutic measure to pregnant women with sever Anemia	240000		
B.16.2.1.B	IFA Tablets for pregnant & Lactating mothers	171557492		
B.16.2.2.A	Budget for 1.IFA small Tablets and syrup for children 6-59 months)	2000000		
B.16.2.2.B	IMNCI Drug Kit	1176000		
B.16.2.5	General Drugs & Supplies for health facilities	9000000		
B.22	Incentive for AWW Muskan Ek Abhiyan	2289000		
B.23.A	Payment of monthly bill to be BSNL	50000		
	Total —	720805101	16412116	

NRHM Part- C

FMR Code	Budget Head/Name of activity	Financial Requirement (in Rs.)	Committed Fund requirement (if any in Rs.)	Remarks
		Total Annual proposed budget (in Rs.)		
Part-C				
C.1.a	Mobility Support for Supervision for DIO	50000		
C.1.c	Printing & dissemination of Immunization formats,tally sheets, monitoring forms etc.	400000		
C.1.e	Quarterly review meetings exclusive for RI at district level with MOIC, CDPO, and other stake holders	40000		
C.1.f	Quarterly review meetings exclusive for RI at block level	513300		
C.1.g	Focus on slum & underserved areas in urban areas/ Alternate Vaccinator for slums	168000		
C.1.h	Mobilization of Children through ASHA under Muskan Ek Abhiyaan	400000		
C.1.i	Alternative vaccine delivery in hard to reach areas	240000	60000	
C.1.j	Alternative Vaccine Delivery in other areas	1600000	150000	
C.1.k	To develop microplan at sub-centre level	27200		
C.1.L	For consolidation of microplans at block level	30000		
C.1.m	POL for vaccine & Logistics delivery from State to district and from district to PHC/CHCs	220800		
C.1.n	Consumables for computer including provision for internet access for RIMs Rs. 1000 per month per district for 38districts.	12000		
C.1.o	Red/Black Plastic bags etc. Bleach/Hypchlorite Solution/twin bucket.	60000		
C.1.q	Safety Pits for those PHC /Hospitals where there is no Pit or is not in working condition	150000		

C.1.r	Alternate vaccinator hiring for Access Compromised Areas, POL of Generators for Cold Chain and For serious AEFI cases investigation for every district	2669400		
C.2.b	Computer Assistants support for District level	120000	10000	
C.3.a	District level Orientation training including Hep-B,Measles,JE for 2 days ANM,MHW,LHV & ors staffs etc.	586500		
C.3.d	One day cold chain handlers training for block level cold chain hadlers	15468		
C.3.e	One day training of block level data handlers for 533 person.	15468		
C.4	Cold Chain Maintenance	58000		
	Total —	7376136	220000	

NRHM Part D

FMR Code	Budget Head/Name of activity	Financial Requirement (in Rs.)	Committed Fund requirement (if any in Rs.)	Remarks
		Total Annual proposed budget (in Rs.)		
Part-D	**IDD (IDCP)**	72000		
E	**IDSP**	1369920		Epidiomologist @ 39900, Data Manager@ 17955, Data entry Operator @ 11305,/Month, Rs. 300000 for Video confrensing Setup
F.1	**Malaria**	584000		
F.1.2.a	**Dengue**	200000		
F.1.2.b	**Chikungunya**	200000		
F.1.3	**JE**	200000		
F.1.4	**Falaria**	2545300		
F.1.5	**Kalazar**	7042400		
G	**Leprosy**	0		

G.1	DEO, Administrative Asst., Driver	294000		
G.2.1	Sensitization of ASHA, Honorarium to ASHA	90000		
G.2.2	Honorarium to ASHA (Rs. 300/- PB & Rs. 500/- MB) @ 3000/PHCs	39000		
G.3.1	For rent, Telephone, electricity, P & T charges, Misc. Rs.- 25000/- per district year	25000		
G.3.2	Consumable Expenses (Stationary & ect.) @ Rs. 14000/- Per Year	15000		
G.4.1	Two days modular Training of new entrant Mos @ Rs. 18425/- Per Batch	18425		
G.4.2	One day Orientation Training of Supervisors, HW, ANM, LHVs & Pharmacists @ Rs. 7025/- per batch for 70 Batchs	7025		
G.4.3	One day Refresher training of PHC Medical Officer @ Rs. 10,000/- Per Batch	10000		
G.5.1	School Quiz @ 500/- Per Quiz (7 Quiz Per PHCs/ Blocks)	45500		
G.5.2	Health Mela/ Fares @ 4000/- Per mela	4000		
G.5.3	Wall Writing- 2 Wall Writing Per PHC @ 700/- Per Wall Writing	18200		
G.5.4	Celebration of Leprosy day in every District @ Rs. 10000/- Per District	10000		
G.6	Vehicle Operation / Hiring, POL & Maintenance 7500/- Per Vehicle Per District	7500		
G.7.2	Aids & appliances @ Rs. 8000/- per district	8000		
G.8.1	Supportive Medicines @ Rs. 25000/- per Year	25000		
G.8.2	Laboratory Reagents equipments @ Rs. 12000/- per year	12000		
G.9	Urban Leprosy control Programme for 24 Twon Ship @ Rs. 100000/- Per City	100000		
H	**Blindness**			
H.1.1	Free Catract Operation each 750/per cases	750000		

H.1.3	School Eye Screening Program	200000		
H.1.5	Contingencies & Vhicle Hireing	420000		
H.1.9	Recurring GIA for Training	120000		
H.1.10	Recurring GIA for IEC	50000		
H.1.11	Recurring GIA for Maintenece of Opthalmic equipments	100000		
H.1.12	Non-Recurring GIA for Vision Center	300000		
H.1.13	Recurring GIA for Strengthing of District Hospital	300000		
H.3.2	Opthalmic Assistant	1440000		
I	**RNTCP (TB)**	**0**		
I.1	Civil Work	172400		
I.2	Lab Consumbles	270000		
I.3.a	Honorarium	345000		
I.1.4	IEC	135000		
I.1.5	Equipments Maintenance	52500		
I.1.6	Training	193400		
I.1.7	Vhicle Maintennce	75000		
I.1.8	Vhicle Hireing	313000		
I.1.9	NGO/PP Support	168000		
I.1.10	Misc.	270000		
I.1.11	Cotractual Servises	2202000		
I.1.12	Printing	1000000		
I.1.16	Procurement of equipment	650000		
	Total —	22468570		

Summary Head Wise

FMR Head	Financial Requirement (in Rs.)	Committed Fund requirement (if any in Rs.)
	Total Annual proposed budget (in Rs.)	
NRHM Part-A	**171534992**	**7670865**
NRHM Part-B	**715045101**	**15932116**
NRHM Part-C	**7376136**	**220000**
NRHM Part-D	**22468570**	**0**
Total —	**916424799**	**23822981**

ADMINISTRATIVE SET – UP:

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

DISTRICT DEMOGRAPHY AND DISTRICT DEVELOPMENT INDICATORS:

Population	Male	Female	Total
Rural Population (in %)	52.2	47.8	95.5
Literacy Rate	48.8	22.11	36.07
SC Population (in %)	16.8	17.32	17.06
ST Population (in %)	0.58	0.64	0.61
BPL Population	235255		
Sex Ratio	Females per 1000 males 915	(0 – 6 years) 927	
Population Growth (1991 – 2001)	348940		
Population Density (person per sq km)	854		
Number of Household	Total 267179	Rural 256040	Urban 11139
Household Size			
Type of house (%)	Pucca 6.4	Kuchha 93.6	
Per Capita Income	6007		
Total workers (number)	37392		
Main workers (number)	19430		
Marginal workers (number)	3242		
Non – workers (number)	14720		
Total workers to total population (%)	44.80		
Cultivators to total workers (%)	76.42		
Agriculture laborers to total workers (%)	1.36		
Workers in HH industries to total workers (%)	1.72		
Main workers to total population (%)	72.86		
Marginal workers to total population (%)	12.16		

Non workers to total population (%)	1.25
Number of villages having drinking water facilities	449
Number of villages having safe drinking water facilities	383
Number of electrified villages	168
Number of villages having primary school	
Number of villages having middle schools	
Number of villages having secondary/sr. secondary schools	
Pupil Teacher Ratio (Primary School)	39.89
Pupil Teacher Ratio (Middle School)	50.97
Out of School children	
Number of villages having any health care facilities	143
Number of Health Sub Centre	272
Number of Additional Primary Health Centre	23
Number of Primary Health Centre	13
Number of Sub-divisional hospital	0
Number of hospitals/dispensaries per lakh population 2007 – 08	1.77
Number of beds in hospitals/dispensaries per lakh population 2007 – 08	18.89
Percentage of children having complete immunization 2007 – 08	39.70
Percentage of women having safe delivery 2007 – 08	21
Number of villages having post office facility	8 Per Lakh Population
Number of villages having Paved approach road	37.05
Number of villages having mud approach road	19.91
Average size of operational holding	
Normal Rain Fall	1230.50
Actual rain Fall	1094.30
Percentage of cultivable land to total geographical area 2006-07	76.42
Percentage of area under commercial crops to gross cropped area 2006-07	6.07
Percentage of net area sown to geographical area 2006-07	0.56
Cropping intensity	1.58
Percentage of gross irrigated area to gross area sown 2006-07	68.27
Percentage of net irrigated area to net area sown 2006 – 07	67.16
Consumption of fertilizer in kg/hectare of gross area sown 2006-07	0.22

Average yield of food grains 2006-07 (kg/ha)	1586
Percentage of area under bhadai crops	12.21
Percentage of area under agahani crops	41.26
Percentage of area under garma crops	0.02
Percentage of area under rabi crops	46.52
Length of highways and major district roads (mdrs) per lakh population (km) 31st march 2005	19.91
Length of highways and major district roads (mdrs) per thousand sq km in area (km) 31st march 2005	170.07
Length of rural roads per lakh population (km) 2004-05	37.90
Length of rural roads per thousand sq km in area (km) 2004 – 05	323.60
Number of branches of scheduled commercial banks 2008 – 09	66
Credit deposit ratio 2008	26.47
Density of livestock per sq km 2003	207
Density of poultry per sq km 2003	80
Average livestock population served per veterinary hospital/dispensary 2003	18521
District wise fish production 2007 – 08	9000
Share of districts in total milk production 2007 – 08	1.37

TOPOGRAPHY:

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

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

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

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

BLOCK WISE STATUS OF DRINKING WATER

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

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

BLOCK WISE STATUS OF PDS BENEFICIARIES

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

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

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


Thanking You