DISTRICT HEALTH ACTION PLAN
2012 – 13

District Health Society

Samastipur

STRUCTURE OF DISTRICT PLAN

A	a. HMIS	
B	b. MCTS	
C	c. Other IT Initiatives	
51	Regular Monitoring Mechanisms	
52	Community Based Planning and Monitoring (CBPM)	
	Annexure:	
53	District Drug Warehouse	

Preface

Achieving the goals, amidst a number of constraints is, an acid test of an administrator because in such a situation one required excellence in managing seemingly unmanageable things.

Samastipur District, historically has seen a gap between demand, owing to increasing demographic pressure and available resources. However, the National Rural Health Mission has been considerably successful in bridging the gap between the demand and supply of health services. Basic services which were almost non-existent till a few years ago are now being provided in centers which were once considered defunct. Besides, a number of advanced services are also being delivered in the Primary Health Centres, Sub Divisional Hospitals, Referral Hospitals and District Hospital. This in turn has increased the expectations of users. In order to cope with the ever growing demands and to cater to a large population, a comprehensive District Health Action Plan is imperative. Only a systematic and organized approach can resolve the issues that need due attention. The DHS therefore, has prepared an Action Plan for the year 2012-13 keeping in mind the above factors.

The action Plan has been prepared keeping in mind the myriad of challenges to be tackled ahead specially with the limited human and material resources. The action plan if practiced in letter and spirit will ensure the people of this district a number of benefits in days and years to come. I'm sure that, with a little more effort, we will be able to achieve the goal of the Mission to ensure quality health care services especially to the disadvantaged segments of the district, who on account of poor affordability, have suffered a lot. I take this opportunity to thank every individual and especially to DHS team who contributed in preparing the action plan. I wish this Action Plan would meet the aspirations of people of Samastipur and will help us in achieving the Millennium Development Goals.

Kundan Kumar (I.A.S)
District Magistrate- Cum- Chairman
District Health Society, Samastipur

FOREWORD

This District Health Action Plan has been formulated in the face of National Rural Health Mission (NRHM). With the help of situational Analysis, the present draft action plan makes recommendations for policy decisions related to the management of workforce with focus on organisational, motivational and capacity-building dimensions. The recommendations cover and optimal utilisation of material and human resources vis-a-vis a microscopic identification and bridging of emerging critical gaps. This also throws light on the organisational and structural arrangements of the required facilities at different levels.

The information used in the process of plan formation to the best of my knowledge is correct because the Data, facts and figures have been furnished by the concerned Block Planning Team. I am grateful to the State level consultant, RPMU Darbhanga and District teams of Swasth- DFID (Dr. Sanjay Kumar Mohapatra) and Micronutrient Initiative (Miss. Pratima Shahi) for their enormous cooperation in preparing this District Health Action Plan (2012-13) for Samastipur District.

I am confident that the present District Health Action Plan would accomplish the targeted objectives.

DR. RENUKA PRADATTA SWETANKI
ACMO-CUM-NODAL OFFICER
SAMASTIPUR

DR. ANIL KUMAR CHOUDHARY
CIVIL SURGEON
SAMASTIPUR

ACKNOWLEDGEMENT

With the targets of recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system.

This District Health Action Plan (DHAP) is one of the key instruments to achieve NRHM goals. This plan is based on the changing healthcare requirements of the population of Samastipur district.

This document has been prepared on the basis of a situation analysis. The teams engaged have made an anatomy of the coverage of poor women and children. The barriers and constraints in the service process have been identified. The focus has also been given on current availability of health care infrastructure in public/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.

The goals of the Mission are to improve the availability of and access to quality health care by people, especially for the segments residing in rural areas e.g. the poor, women and children.

The department of Health and Family Welfare and State Health Society of Bihar deserve appreciation for their dynamic leadership in managing health care sector reform programme. Which virtually may provide to us backup materials for replicating strategies. I am thankful specially to our team members ACMO Dr.R.P.Swetanki, DIO Dr.S.K.Sinha, DAM Mr. A. K. Sinha, M&EO Mr. Alok Kumar, DPC Mr.Aditya Nath Jha, District Epidemiologist Mr. Arif Ali Siddiqui, DCM-Asha Ms. Anita Kumari, DDA- Suman Kumar Sinha and Data operators of DHS. I also thankful to Dr. Sanjay Kumar Mohapatra, DPO, Swasth, B-Tast DFID, for the personally attention to preparation of District Health Action Plan 2012- 13. The proposed location of HSCs, APHCs, PHCs, SDHs, Referral and Sadar Hospital and its service area reorganized with the consent of ANM, AWW, Male Health Worker and participation of community has finalized in the block level meeting.

I am sure that this excellent plan will galvanize the leaders and administrators of the primary health care system in the district, and would enable them to go into the details of implementation based on lessons drawn from this study.

Manish Kumar
District Program Manager
District Health Society, Samastipur

ABOUT THE PROFILE

The transformation of human capital sizeably rest on the two vital pillars, viz. Health and Education. It was against this backdrop that the Govt. Of India Started NRHM which made possible multi-dimensional improvements in the healthcare and Medicare facilities particularly in the rural areas of the country. Willingly or Unwillingly, we have to accept that almost five years of NRHM has engineered a sound foundation for activating the process of qualitative improvements and in the very context, it is quite natural that the general masses of the society; either living in the rural or urban area of the country nurture a high level of expectations from the second phase of national programme where we need focussed efforts for mass-sensitization for projecting the hygiene sensitibility. A number of health problems crop-up due mainly to the insensitivity to the personal hygiene problems because albeit educated segment of the society is found unaware of the problems significantly responsible for expanding the disease profile.

The present District Health Action Plan classified in six chapters is an effort to inject new life and strength to the measures helping the deprived and neglected segment of the society. The climatic condition and the geographical advantages or barriers considerably determine the successes or failures of any strategy that we formulate to achieve the target. The experiences that we have gained, the successes that we have witnessed and the failures that we have experienced have made us much more proactive to the emerging trends and evolving developments taking place during the last five years. It is in this context that we find our team perceiving the problems in a right fashion. We have been successful in establishing team leadership and promoting team culture and therefore are very optimistic to the plans formulated by us. Because we anticipate the changes and challenges, it will be easier for us to achieve the target.

I am thankful to the members of the District Planning Team and Block Planning Team for the formulation of District Health Action Plan and am confident that the administrative support that we continue to get from the different echelons would simplify our tasks of sensitising the society and promoting the Healthcare and Medicare Services. By making the healthcare communication measures effective, we will be successful in minimising the pressure on the team responsible for channelizing the Medicare services.

Aditya Nath Jha
District Planning Coordinator
District Health Society , Samastipur

Chapter I: Executive Summary, Introduction, methodology and profile of the district.

Executive Summary of Main Strategies proposed to be adopted Under Samastipur District NRHM Program:

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

Maternal Health:

 Focus on quality antenatal care to all pregnant women by increasing the access through existing Govt. facilities.
 Quality improvement of the ANC through reorientation.
 To increase awareness amongst mothers and communities about the need of ANC.
 Focus on 24-hour institutional delivery with basic emergency care in all PHCs and referral of obstetric emergencies.
 Social mobilization for institutional deliveries by involvement of *Mahila Mandals*, PRIs through orientation to motivate pregnant women and their families for institutional delivery.
 Focus on operationalisation of CHCs (across the state) inorder to help them become venues for comprehensive emergency obstetric care.
 Strengthening and upscaling transport and referral systems.
 Identification and involvement of Pvt. Sector hospitals to deliver basic & comprehensive

EmOC.

 Ensuring clean home deliveries by skilled birth attendants in difficult and inaccessible areas.
 To reduce unsafe abortion by increasing access to safe abortion in Govt. & Pvt. Facilities and promoting awareness about harmful effects of unsafe abortion amongst women, community, PRIs.
 To increase institutional delivery by continuing with the JBSY Scheme.

***Child Health**:*

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

Family Planning:

 To raise awareness amongst couples, communities and PRIs about contraceptives and advantage of small family.

 Increase the number of service delivery points and to promote contraceptive use through social marketing.

 Focus on quality male & female sterilization and conduction of sterilization camps in uncovered areas.

 To improve the number and skill of service providers by training of doctors on lap sterilization and NSV, training of GNMs to assist lap sterilization and ANMs on IUD insertion.

 Public Pvt. Partnership for increasing contraceptive use and sterilization.

Adolescent Health:

 To educate and raise awareness amongst the adolescent boys and girls about human physiology, RTI, STI, HIV/AIDS and safe sex.

 To open adolescent health clinic at block level.

Human Resource Development including Training

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

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

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

High turnover of Personnel due to low motivation- It is felt that the state needs to restrict theturnover of doctors on contract and also programme managers. It is proposed that a study may be undertaken to assess the situation and recommend remedies, however it is assumed that rural and specialist bonus will help to curb the turnover to same extent and an HR policy needs to be finalized.

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

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

Sub optimal utilization and rationalisation of trained staff – Regular evaluation and monitoring is being done and corrective steps are being taken. Placement of trained people at such facilities where infrastructure is in place. The government has taken up on priority the

placement of the trained EMoC and LSAS doctors to the FRUs where there is no such facility. Poor monitoring and evaluation framework – Regular monitoring visits by programme officers.
In 2011-12, there has been a continuous focus on the capacity building of the existing manpower in the state. Trainings as per GoI guidelines on Immunization, IMNCI, EmOC,
LSAS, SBA and Minilap/MVA etc have been taken up with full vigor, however due to poor quality of training in some centres, training fell behind schedule. It is proposed to continue these trainings in 2012-13. In addition, the state wide training on Immunization for Medical Officers, IPC skills for Breast feeding and basic training of neonatal resuscitation-shall also be taken up for various levels

Ensuring Gender Equity

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

Primary Strategies to achieve future goal-

1. Improving institutional mechanism for HR and meeting future needs

- Departmental restructuring in line with future requirement - CMO & CS system to retain specialist doctors in patient care and putting public health specialist as CMO.
- Transparent transfer policy – fixed term posting at one place.
- Rationale posting of skilled manpower – to optimally utilize services of trained manpower / specialist at appropriate facilities having adequate infrastructure and services
- Enhancing HR capacity at district and sub district levels.
- Promote doctors at techno managerial level at district and state.
- Fill up existing vacancies at both supervisory and worker cadre (See graph for existing vacancies status)
- Undertake on campus interviews to tap doctors, nurses and ANMs passing out of the existing institutions
- Establish at least 9 new government medical colleges in state to bridge the gap of doctors.
- Expansion of Nursing and Paramedic Institutions to enable an increase in the density of skilled health workers in the rural areas
- Operationalisation of ANM/GNM training schools in government hospitals
- Re open ANM training schools in each district.
- Open GNM training school in each medical college.
- Encourage private sector to open new Medical colleges, ANM /GNM training schools in state
- Creation of 9 ANM & 7 GNM schools

 Compulsory pre PG posting at rural institutions for at-least a year
 Linkages with southern state colleges for recruitment of Nurses and ANMs.
 Initiate a short term course for in service staff on administration and financial management to groom future district level officers like CMO & CS.
 Linkages with big hospitals in Bihar & other state for capacity building of service provider on clinical courses – Obs & Gyn , Anaesthesia & Paediatrics.
 Encourage medical colleges to work as training centers for clinical courses.
 Appropriate investment is needed to expand medical education infrastructure and ensure quality, with private sector involvement, if needed. Such investment is not available through NRHM funds. In addition, forward looking and transparent HR policies should be developed for the health workforce in the state.
 Provision of AYUSH doctors in HSC OPDs, Utilisation AYUSH doctors for
monitoring of ANMs, 250 APHCs to be upgraded to online computerised clinic for AYUSH, Provision for recruitment AYUSH Specialists in all the 38 districts,
Dedicated AYUSH PMU at SHSB and Provision of AYUSH drugs at APHC With the large number of human resources in the districts, the effectiveness of such addition would be more pronounced if supervisory structures and job descriptions of every worker are well established.

2. Infrastructure strengthening

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

3. Coordination with other Departments

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

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

 Design and Implement a basic package of primary health services.
 Design and Implement an essential package of hospital services.
 Track each maternal and infant death and mitigate risk of recurrence
 Provide emergency obstetric and neonatal care at all PHCs and higher facilities.
 Upgrade infrastructure to IPHS norms.
 Increase availability of doctors, nurses and specialists in facilities.

- Increase the availability of drugs and family planningservices.
- Reduce incidence of communicable diseases.
- Population Stabilization interventions
- Health System Strengthening
- Antenatal Check ups for all pregnant mothers
- Strengthening Labour Room, Operating Theatre and Blood Bank infrastructure at district and sub district level
- Provision of uninterrupted supply of medicines and logistics for maternity and family planning services
- Establishment of new facilities for maternity services to cater to outreach areas where uncomplicated deliveries could be handled by Skilled Birth Attendants (SBAs) ANMs
- Establishment of and adherence to infection prevention protocols
- Placement of trained manpower—doctors and nurses as per standards
- Recruitment of new Human Resources especially at Nurses and ANM level
- Supportive Supervision
- Conducting Maternal and Infant Death reviews
- Malaria, TB and Disease Surveillance programmes ought to be further integrated into the NRHM in such a manner that the public health challenges of infectious diseases also become fully community owned and community led.

Partner with the private sector and communities to strengthen services

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

6. Empower vulnerable groups to access affordable quality healthcare

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

7. Strengthen health systems for efficient, accountable and transparent services

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

8. Provide financial risk protection to the poor

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

9. Proactive role of the Government

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

Behaviour Change Communication

The state does not have any comprehensive BCC strategy. All the programme officers implement the BCC activity as per their respective programmes. A State IEC Plan is prepared however district specific communication plans require to be undertaken. The IEC logistics is designed, developed and procured at the district level and distributed to the PHC in an ad hoc manner. However some activity is done at the state level. There is no credible study available to identify the areas / region specific knowledge, attitudes and practices pertaining to various focus areas of interventions like breast feeding, community & family practice regarding handling of infants, etc. At present there is no impact assessment of the IEC and BCC activities. It's very important to assess the impact of IEC/BCC activities, resources and methods to undertake mid way corrective measures and prepare strategic District Communication Plan.

Convergence/Coordination

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

Private and NGO Health Service

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

Introduction:

1.1 Genesis

Establishment of small affluent islands around the vast sea of backwardness can not the motive of a development sensitive welfare state. India can not prosper when rural India suffer and rural India can not prosper unless the disadvantaged segment of society living in villages are found neglected. The process of Economic transformation remains incomplete if the process of social transformation is delayed. It was against this backdrop that Government of India launched NRHM with prime motto providing effective healthcare devices to the rural population. It is not a program indeed a mission. The multi-faceted objectives to achieve the mission are-:

- Reduction in Infant, 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
- Population stabilization and gender equity.
- Community participation in PUBLIC HEALTH FAMILY WELFARE AND RURAL SANITATION COMMITTEE popularly known as VILLAGE HEALTH SANITATION COMMITTEE (VHSC).

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 principal instrument for planning, implementation and monitoring, formulated through a participatory and bottom 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 Officer.*
- *State Programme Management Unit, District Programme Management Unit and Block Program Management Unit Staff*
- *Members of NGOs and civil society groups*
- *Support Organisation – Swasth- DFID,PHRN , NHSRC and MI, Members of Political Parties*

Besides above referred groups, this document will also be found useful for health managers, academicians, faculty from training institutes and people engaged in programme implementation, monitoring and evaluation.

1.2 Objectives of the Process

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 focus on more involvement of PRI members in Community participation with respect to health through PUBLIC HEALTH FAMILY WELFARE AND RURAL SANITATION COMMITTEE popularly known as VILLAGE HEALTH SANITATION COMMITTEE (VHSC).
- ⇨ To identify performance gaps in existing health infrastructure and find out mechanism to fight the challenges
- ⇨ Lay emphasis on concept of inter-sectoral 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

1.3 Process of Plan Development

1.3.1 Preliminary Phase

The preliminary stage of the planning comprised of reviewing the available literature and reports. Following this the research strategies, techniques and design of assessment tools were finalized. As a preparatory exercise for the formulation of DHAP, the secondary Health data were complied to perform a situational analysis. The Primary information collected by the ANM at HSC level by organizing Community Need Assessment exercise with the AWWs and ASHA workers and filled the HSC need assessment formats as per IPHS norms. Compiled at block level and added PHC need assessment formats based on IPHS norms and developed Block level plans. Based on the block level analysis and sectoral analysis of different wings under NRHM the district DHAP developed.

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

The Government of the State of Bihar is engaged in the process of re – assessing the public healthcare system to arrive at policy options for developing and harnessing the available human resources to make impact on the health status of the people. As a part of this effort the present study attempts to answer the following three questions:

1. How adequate are the existing human and material resources at various levels of care (namely from sub – center level to district hospital level) in the state; and how optimally have they been deployed?

2. What factors contribute to or hinder the performance of the personnel in position at various levels of care?

3. What structural features of the evolving health care system affect its utilization and the effectiveness?

With this in view, the study proceeds to make recommendations towards workforce management with emphasis on organizational, motivational and capacity building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps can be identified and bridged. It also recommends that how the facilities at different levels can be structured and organized.

The study used a number of primary data components which includes collecting data from field through community need assessment at HSC, and need assessment of HSC, situation analysis format of facilities that was applied on all HSCs APHC and PHCs of Samastipur district. In addition, a number of field visits and focal group discussions, interviews with senior officials, Facility Survey were also conducted. All the draft recommendations on workforce management and rationalization of services were then discussed with employees and their associations, the officers of the state, district and block level, the medical professional and professional bodies and civil society. Based on these discussions, the study group clarified and revised its recommendations and the final report was finalized.

Government of India has launched National Rural Health Mission, which aims to integrate all the rural health services and to develop a sector based approach with effective intersectoral as well as intrasectoral coordination. To translate this into reality, concrete planning in terms of improving the service situation is envisaged as well as developing adequate capacities to provide those services. This includes health infrastructure, facilities, equipments and adequately skilled and placed manpower. District has been identified as the basic coordination unit for planning and administration, where it has been conceived that an effective coordination is envisaged to be possible.

This Integrated Health Action Plan document of Samastipur district has been prepared on the said context.

1.3.3 Preparation of DHAP

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 NGOs and NHSRC/PHRN as well as the MOICs, Block Health Managers, ANMs, as a result of 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.

DHAP development District level Work shop

Focus of New DHAP:

- Mandate for De-centralized planning process.
- HMIS data 1st and 2nd Quarter-11-12.
- Gap analysis Reports as facilitate the development partners in recent past.
- The Current " census has provided district and division specific data of IMR .
- Their would be no increase in the Allocation of Resources in next financial year.
- Infrastructure and equipment can plan beyond above resources.
- Anticipated backlogs / committed expenditure should be projected in the Budget.
- Additional proposals which can be included in the plan to strengthening arrangement web enabled facility based reporting, Capacity development institution- ASHA, VHSC, RKS, PRIs, program manager unit, MIS etc.
- Proposal for over coming Adverse Gender ratio.
- Separate Chapter for Vulnerable Section, Vulnerability of Disease, Disability and Death.
- Village health Action plan for NRHM under the guideline of the VHSC- in 10 district.
- NHSRC and PHRN will support and facilitate the planning.
- The INGOs / Development partners of the district will support the planning process in different level & SWASTH/ DFID will support technically for the task.

The Process adopted for development of DHAP:

- This year the team will be focus on the in-depth situation analysis of the different sector and component of health aspects.

- The SHS prescribed format will be used as well as where ever require the team will developed some specific format as per need and generate information like Infrastructure, equipments, knowledge, skill and practices of service providers, validation of reporting verses programs service, supplies and utilization etc.

- On 18th a district planning team is formalized (in the district at present there are 4 district level nodal officer is available so, each nodal officer will be assign for leading 5 block based on the geographical distance for extensive support. Also one each Officer from the DHS will support them for the job for orientation of the functionaries, understanding formats, collection of data & information, compilation and cross checking and completing assignments.

- At the block level in the leadership of block Medical Officer In-charge a team will be constitute where all the medical officer, BHM, CDPO-ICDS, BA&MEO, BCM-ASHA, BHE and all supervisory cadre functionaries will be involved.

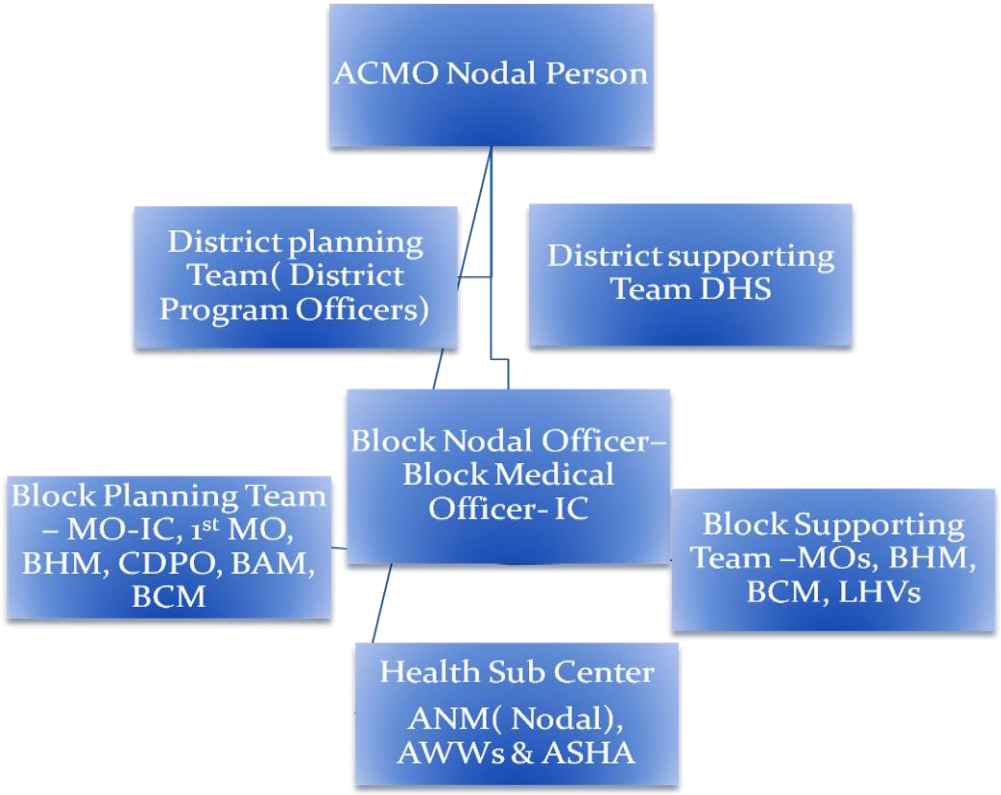
- They will support and supervise Sub- centre level process of generating Plan. The team member for HSC planning are ANM, AWWs and ASHA workers and for this purpose Rs. 1500 per HSC has been budgeted for the different expenses.

Formats Used for development of DHAP In Samastipur district:

- **Situation analysis for BHAP**
- **Situation analysis for HSC planning**
- **District Situation analysis**
- **Hospital need Assessment**
- **Sub-centre need Assessment as per IPHS.**
- **KAP Assessment.**
- **Facility assessment at different level.**
- **HMIS.**

DHAP ANM Orientation in Vidaypatinagar PHC

Core groups for development of the process:



Process Adopted for Information generation:

Hospital Need assessments:

- Organise a meeting of all Medical Officers and Paramedical staffs who working in PHC,
- Discuss the development of the PHC health services and the objective of the meeting.
- Divided them in sector specific tasks for each service room of the PHC.
- Asked them to fill the formats.
- After completion of the formats organise a meeting for cross check the information collected.
- Based on the information develop Action plan for development of the hospital.
- Keep in mind of available budgetary provision, doable activity and govt. Norms, policy & Procedure Like estimation, Quotation, tender etc.

Process of Information Generation: Health Sub Center Level

Organize Orientation of all ANM at block level with an objective to impart them the skills and understanding the formats and process of data collection.

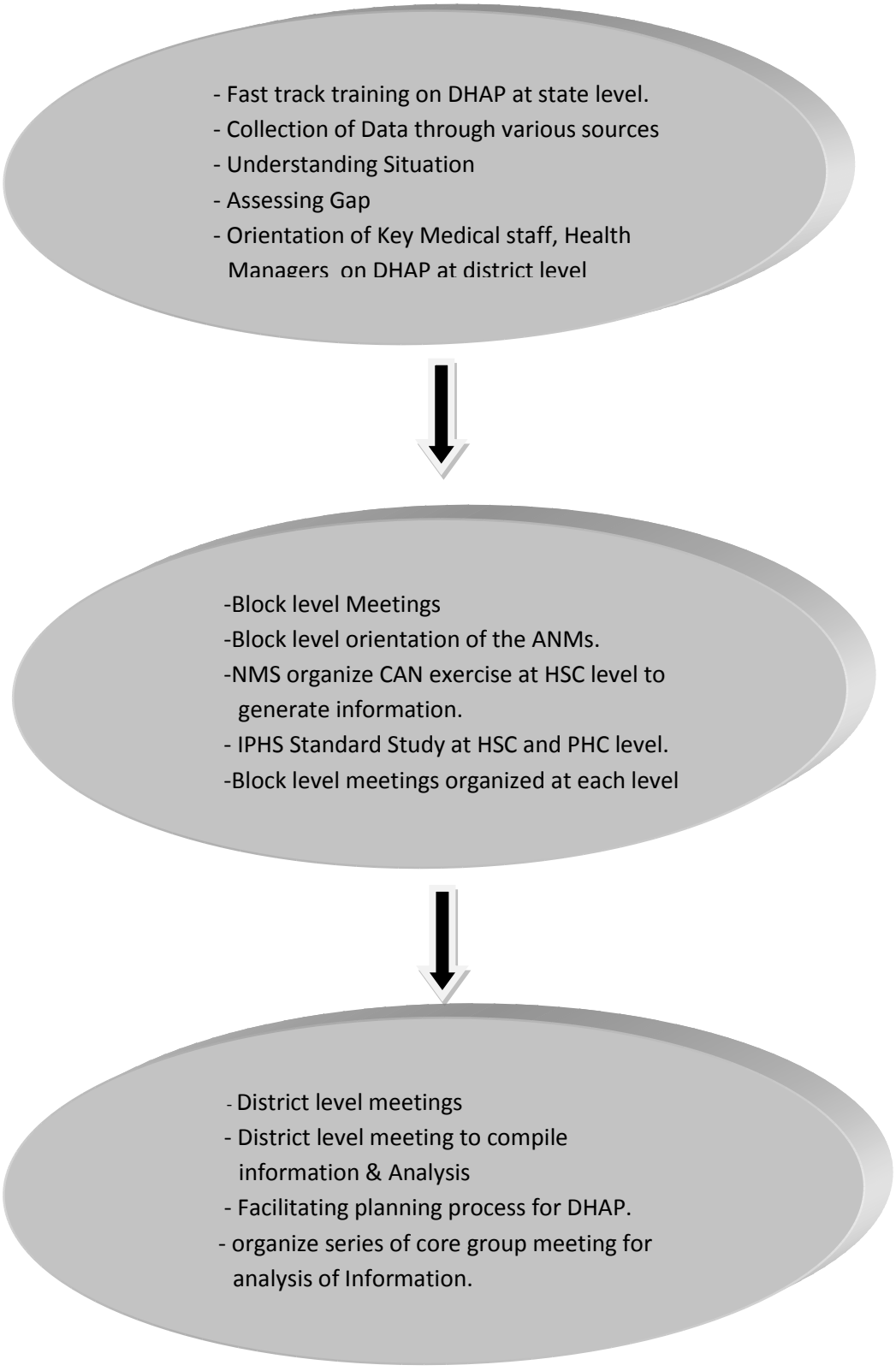
- Organize a meeting of all AWW and ASHA and generate information with the reference of the HSC register & AWC Survey registers and others registers.

- Jointly with the support of ASHA, AWW & community leaders generate all the information of village level.

Compile all the village level information and develop HSC plan.

District Health Action Plan orientation of ANMs in Bibhutipur PHC

District Health Action Plan Planning Process



Chapter:2

District Profile

2.1 District: At a Glance

Samastipur is a district in Bihar which is spread over of 2904sq.km. Samastipur is bounded on the north by the Bagmati river which separates it from Darbhanga district. On the west it is bordered by Vaishali and some part of Muzaffarpur district, on the south by the Ganges it has separated to Patna, while on its east it has Begusarai and some part of the Khagaria District. The District headquarter is located at Samastipur, The people of Samastipur mainly speak Hindi. According to the 2011 census, Population Density in the District was 1465 per sq.km. And the total population is 4354782.

The District is lacking in educational infrastructure and the Literacy rate is only 63.81 % (male 73.09, female 53.52%). The medical facilities are also not adequate but there are efforts to improve the condition.

The district comprises of 4 sub-divisions, and 20 Community Development Blocks. It has 5 towns and 1248 villages. Infrastructure wise Samastipur is very strong. It is the Divisional Headquarters of the East Central Railway. The district has direct train links with Patna, Kolkata, Delhi, Dhanbad, Jamshedpur and other places of importance. National Highway No. 28 passes through the district. Agriculture is the main economic occupation of the district and about 83 per cent of the total working population depends on it. Samastipur is noted for its fertile alluvial soil and its rabi crops. It has been the center of the indigo industry. Wheat, pulses and edible oil seeds are also grown here. Samastipur is lucky to be traversed by rivers like Budhi Gandak, Baya, Kosi, Kamla, Kareh and Jhamwari and Balan, which are both the offshoots of Budhi Gandak. The Ganges also skirts the district on the south.

2.2 HISTORY

According to Gazetteers, Darbhanga, t*he modern subdivision of Samastipur (originally Shamsuddinpur) was founded by Hazi Shamsuddin Ilyas of West Bengal.*

2.3 Administrative Unit & Location

Samastipur District : Sub-divisions/ Blocks/ Panchayat Villages

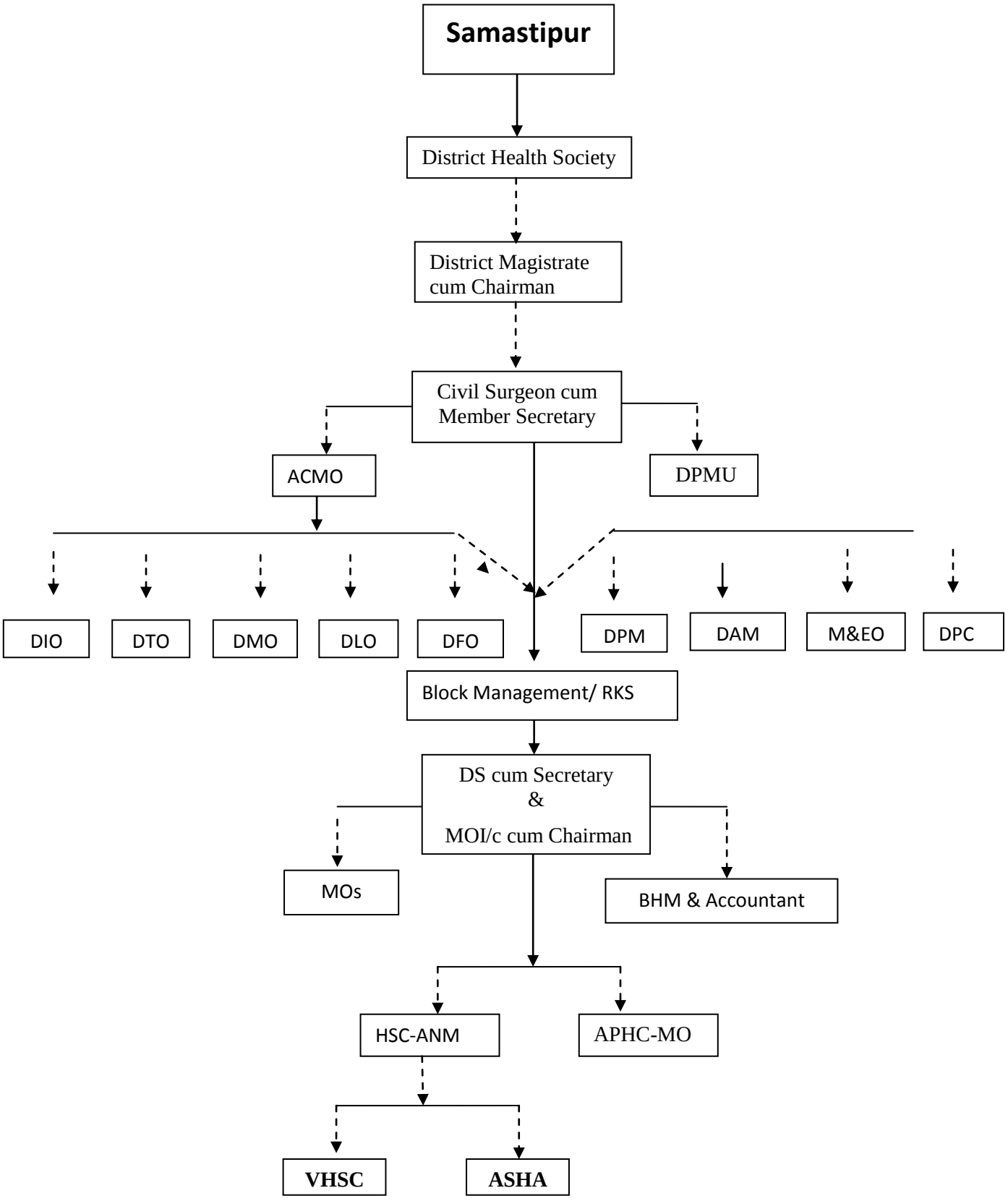
Subdivisions / Blocks

Sl. No	Subdivision Name (4)	Block Name (20)
1	Dalsinghsarai	Dalsinghsarai, Ujiyarpur, Vidyapatinagar
2	Patori	Patori, Mohanpur, Mohiuddinnagar
3	Rosera	Rosera, Hasanpur, Bithan, Sighia, Bibhutipur, Shivajinagar
4	Samastipur Sadar	Samastipur, Kalyanpur, Warisnagar, Khanpur, Pusa, Tajpur, Morwa, Sarairanjan

The District is located at 25° to 30° North latitude and 84° to 85° east longitude. The District is surrounded by river Ganga in south, Gandak in west, District Darbhanga in north ,Vaishali in west, in the south Patna and in the east Begusarai & Khagaria Districts. The District is in semi tropical Gangetic lane.

The state capital Patna is linked with famous Mahatma Gandhi Setu. The District is spread over 2904 sq km area.

2.6 District Health Administrative Setup



COMPARATIVE POPULATION DATA (2001 Census)

Basic Data	India	Bihar	Samastipur
Population	1,210,193,422	103,804,637	4,254,782
Density	382	1102	1465
Socio- Economic			
Sex- Ratio	940	916	909
Literacy % Total	74.04	63.82	53.81
Male	82.14	73.39	73.09
Female	65.46	53.33	53.52

LITERACY RATE

TOTAL :- 53.81%

MALES :- 73.09%

FEMALES :- 53.52%

VILLAGES

TOTAL :- 1239

INHABITED :- 1122

PANCHAYATS :- 381

SUB-DIVISION :- 04

BLOCKS :- 20

REVENUE CIRCLES :- 18

HALKAS :- 132

POLICE STATIONS :- 22

POLICE OUTPOSTS :- 06

TOWNS :- 04

NAGAR PARISHAD (SAMASTIPURPUR):- 01

NAGAR PANCHAYAT : - 04 (Samastipur, Rosera,Mohiuddinagar and Dalsingsarai).

M.P CONSTITUENCY :- 2 (Ujiyarpur & Samastipur)

M.L.A. CONSTITUENCY :- 10

2.7 SOCIO-ECONOMIC PROFILE

Social

- Samastipur district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Samastipur have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.
- 20.7% of the population belongs to SC and 0.02% to ST. There are at least 13% percent villages where the SC population is more than 40%. Some of the most backward communities are *Mushahar, Turha, Mallah* and *Dome*.
- The main occupation of the people in Samastipur is Agriculture, Fisheries and Daily wage labour.
- Almost 20% of the youth population migrates in search of jobs to the metropolitan cities like Kolkata, Mumbai, Pune etc.
- The main crops are Wheat, Paddy, Pulses, Oilseeds, Mango.
- Tobacco are the major cash crops of the community residing at the bank of holy river Ganges.

Demographic scenario of Samastipur district

According to Census of India 2011:

- In 2011, Samastipur had population of 4,254,782 of which male and female were 2,228,432 and 2,026,350 respectively. There was change of 25.33 percent in the population compared to population as per 2001. In the previous census of India 2001, Samastipur District recorded increase of 25.63 Percentage to its population compared to 1991.

- The initial provisional data suggest a density of 1,465 in 2011 compared to 1,169 of 2001. Total area under Samastipur district is of about 2,904 sq.km.

- Average literacy rate of Samastipur in 2011 were 63.81 compared to 45.13 of 2001. If things are looked out at gender wise, male and female literacy were 73.09 and 53.52 respectively. For 2001 census, same figures stood at 57.59 and 31.67 in Samastipur District. Total literate in Samastipur District were 2,214,498 of which male and female were 1,333,406 and 881,092 respectively. In 2001, Samastipur District had 1,211,152 in its total region.

- With regards to Sex Ratio in Samastipur, it stood at 909 per 1000 male compared to 2001 census figure of 928. The average national sex ratio in India is 940 as per latest reports of Census 2011 Directorate.

- In census enumeration, data regarding child under 0-6 age were also collected for all districts including Samastipur. There were total 784,203 children under age of 0-6 against 711,168 of 2001 census. Of total 784,203 male and female were 404,068 and 380,135 respectively. Child Sex Ratio as per census 2011 was 941 compared to 938 of census 2001. In 2011, Children under 0-6 formed 18.43 percent of Samastipur District compared to 20.95 percent of 2001. There was net change of -2.52 percent in this compared to previous census of India.

- Samastipur District population constituted 4.10 percent of total Bihar population. In 2001 census, this figure for Samastipur District was at 4.10 percent of Bihar population.

Based on these statistics one can say that Samastipur district lacks urbanization and industrialization. As elsewhere in Bihar, Samastipur suffers from lack of infrastructure facilities, lack of connectivity, and lack of social development and most people depend on small size agricultural land. Agricultural productivity is further affected adversely by recurrent floods and droughts (World Bank, 2005).

Flood effected area of the district

The district receives medium to heavy rainfall (average rainfall 1161 mm), and faces condition of severe flood. In the year 2007 the flood condition was so bad that almost 145 gram panchayats and 583 villages got marooned. Bithan, Hasanpur, Singhia, Kalyanpur, Shivajinagar, Rosera, Khanpur, and Warishnagar blocks were the worst affected blocks. According to the estimates of National Disaster Management

Department, in the year 2007, 16,00,000 people were directly affected by the floods. Crops were damaged, and there was irreparable damage to property and huge loss of lives. The economic loss due to floods this year amounts to Rs. 100 crores of crop loss, Rs. 25 crores of housing loss and Rs. 27 crore of public property loss. The district has poor drainage system and nearly 4% of the area is water logged. The district is spread over 2,036 sq km area, with no forest cover. 67% of the land is agricultural and nearly 67% of the area under cultivation is irrigated. Samastipur district is also affected by droughts. Cycles of floods and droughts severally affect the food production and food distribution system, and lead to distressful situation for most people.

2.8 HEALTH PROFILE

General Status of health in Samastipur district

In a study of 513 districts of the country ("Jansankhya Sthirata Kosh", www.jsk.gov.in) in terms of overall rank in health it was found that Samastipur district ranks 552 though on the basis of under-five mortality it ranked 313. Filaria, Malaria, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in district. Hepatitis, Diarrhea, Typhoid, Blindness and Leprosy are other high prevalence diseases. Kala-azar is an endemic problem in Bihar. As per DLHS 2002-2004 the prevalence percentage of kala-azar is 11.4% and TB is 4.3%. The overall prevalence of tuberculosis in India is 544 per 100,000 populations while in Samastipur it is reported to be close to 618 per 100,000 (RCH, Round 2).

HEALTH	
DISTRICT HOSPITAL	**1**
SUB-DIVISIONAL HOSPITAL	**2**
FRU Unit	**6**
REFERRAL HOSPITAL	**1**
PRIMARY HEALTH CENTRE	**20**
ADDITIONAL PRIMARY HEALTH CENTRE	**45**
HEALTH SUB CENTRE	**354**
GRAMIN AUSADHALAY	**3**
BLOOD BANK	**1**
BLOOD STORAGE UNIT	**2**
AIDS CONTROL SOCIETY	**1**

2.8.1 HEALTH STATUS AND BURDEN OF DISEASES

1) Table: CASE FATALITY RATE

S.No.	Year	2008	2009	2010	2011
	Disease	**Case**	**Case**	**Case**	**Case**
1	Gastroenteritis	166	17328	13259 (Including Diarrhea)	20125
2	Diarrhea/Dysentery	882	26544	13998 (Only Dysentery)	21090
3	Cholera	0	0	N/R	
4	Meningitis	0	3	0	
5	Pneumonia	0	4008	779	129
6	Malaria	0	0	1	319
7	Measles	0	228	72	14
8	A.R.I.	NA	6067	62735	111750

(b) Table : MORBIDITY DUE TO MAJOR DISEASE

S.No.	Disease	2007	2008	2009	2010	2011
1	Kala-azar	12603	5312	1172	1158	797
2	T.B. (NSP)	997	575	1586	1605	3650
3	Leprosy (PR/10000)	1.15	1.3	**0.91**	**N/A**	NA

(c) Table : BASIC HEALTH STATUS INDICATORS OF SAMASTIPUR DISTRICT

Indicators	Samastipur	Bihar
Couple Protection Rate (CPR)	33%	
Crude Death Rate (CDR)	6.9	7.2
Crude Birth Rate	28.7	26.7
Infant Mortality Rate	54	55
Maternal Mortality Rate	288	305
Total Fertility Rate (TFR)	4	3.9
Under 5 Mortality Rate	77	77
Still Birth Rate	2%	NA
Abortion rate	NA	NA

(D)Table: DENOTING PRIORITY AREAS IN EACH OF THE BLOCK

Block	Hard to Reach area
Bithan	Whole Bithan block (72 villages)
Hasanpur	2 Panchayat
Sighia	5 Panchayat
Kalyanpur	2 Panchayat
Warishnagar	2 Panchayat
Khanpur	1 Panchayat
Mohanpur	2 Panchayat

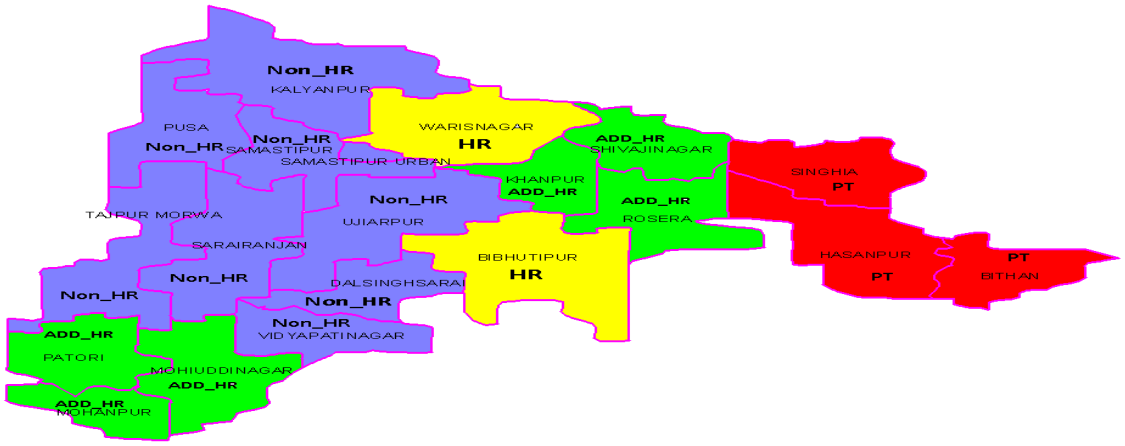
Note: During raining season i.e. From mid June to September almost 80 percent of the villages become hard to reach area.

2.2.2 PUBLIC HEALTH CARE DELIVERY SYSTEM: ORGANISATIONAL STRUCTURE AND INFRASTRUCTURE Table. HEALTH CARE INSTITUTIONS IN THE DISTRICT

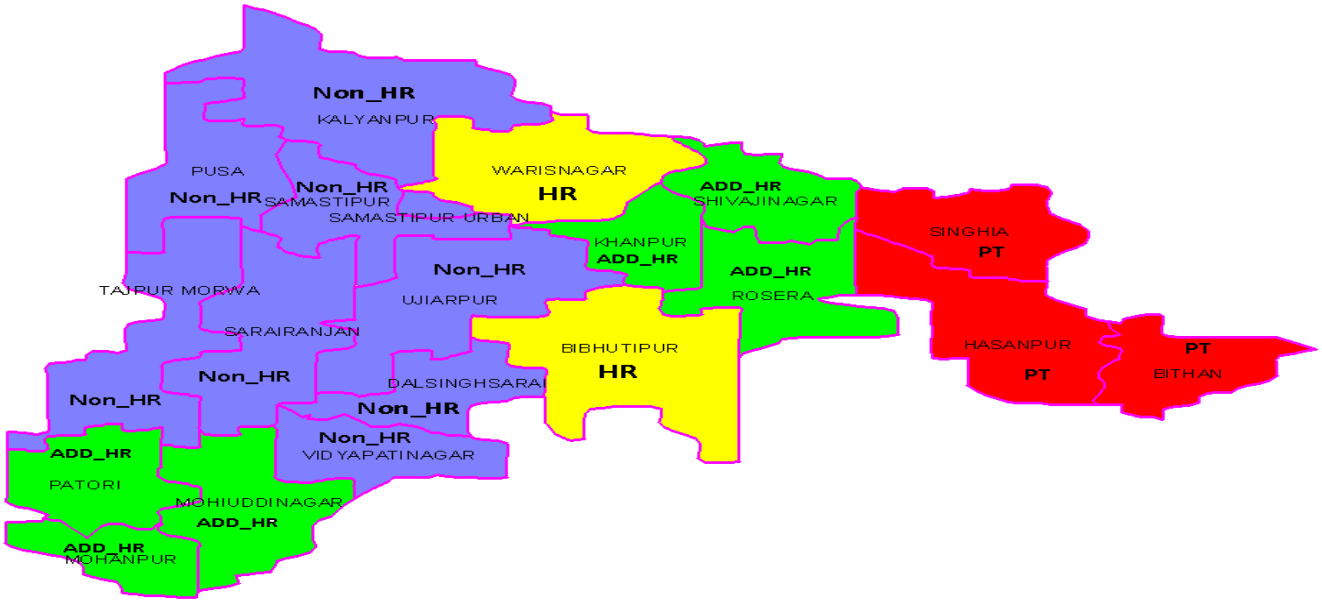
S.No.	Type of Institutions	Number	No. of Beds*
1	District Hospital	1	120
2	Sub-divisional Hospital	03	90
3	Referral Hospital	1	30
4	Block PHCs	15+5	180
5	APHCs	45	0
6	Sub-centres	354	0
7	Ayurvedic Dispensaries	03	0
8	Anganwadi Centres	3233/3433	-
9	Others (Pvt. Facility accredited)	2	27

2.8.3 Map showing BLOCK AND PHC locations

Map showing WPV 1 and WPV 3 affected BLOCK AND PHC locations



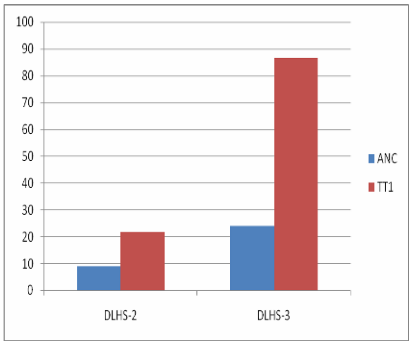
Map showing Kala azar affected BLOCK locations



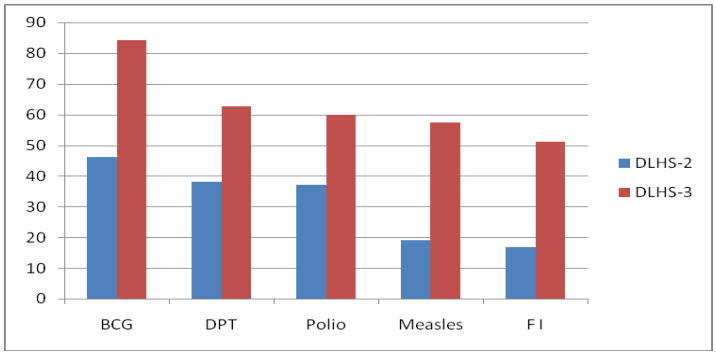
DLHS 3 Data

As per the DLHS3 (2007-08)reports the percentage of full immunization(BCG, 3 doses each of DPT and Polio and measles) coverage(12-23 months) in the district is 51.1%. And BCG coverage of the district is 83.6%. 3 doses of polio vaccine is 60%, 3 doses of DPT vaccine is 62.6% and Measles Vaccine is 57.5%. The coverage of Vit A supplementation for the children 9 months to 35 months is 97% percent.

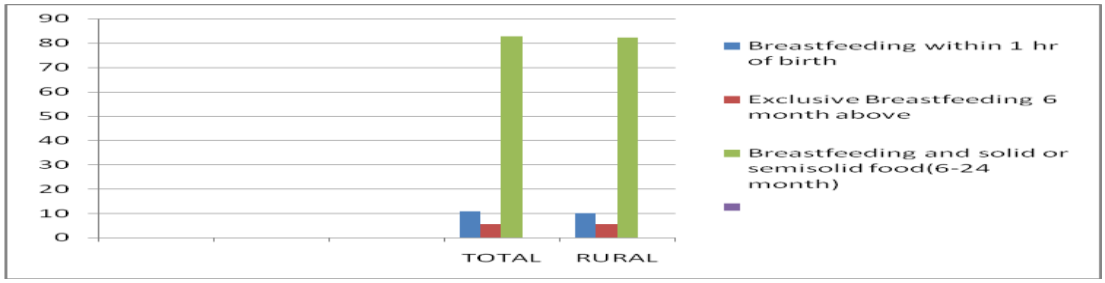
ANC in Rural Areas



Comparision of Child Immunisation Coverage



Child Breastfeeding Practices (Under 3 Yrs) according DLHS 3



Chapter 3

Situation Analysis

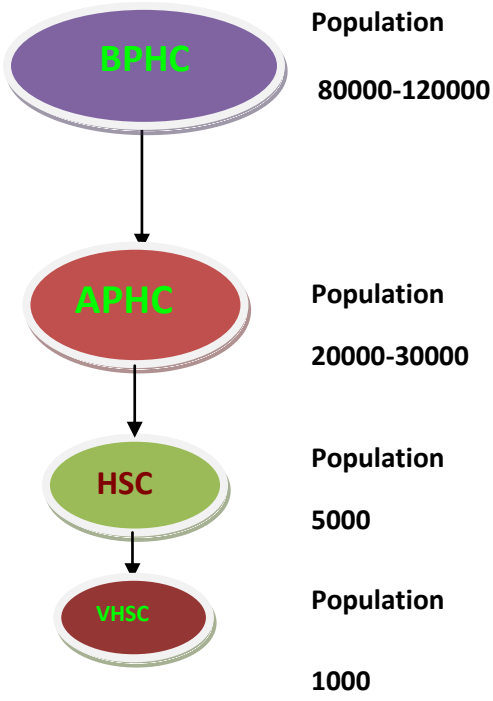
In the present situational analysis of the blocks of district Samastipur the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from census 2011, report of DHS office, Samastipur and various websites as well as other sources. These indicators help in pointing to the health scenario in Samastipur from a quantitative point of view, while they cannot by themselves provide a complete picture of the status of health in the district. However, it is useful to have outcome data to map the effectiveness of public investment in health. Further, when data pertaining to vital rates are analyzed in conjunction with demographic measures, such as sex ratio and mean age of marriage, they throw valuable light on gender dimension. Table below indicates the Health indicators of Samastipur district with respect to Bihar and India as a whole.

Table: Health Indicators

Indicator	Samastipur	Bihar	Remarks
CBR	28.7	26.7	
CDR	6.9	7.2	In recent data of NRHM Bihar – 7.2
Natural growth Rate	21.8	19.5	
IMR	54	55	In Recent data of NRHM Bihar- 47
Neonatal MR	38	35	
Post Neonatal Mortality Rate	17	19	
Under-5 MR	77	77	
MMR	288	305	
CPR	NA	34%	
TFR	4%	3.9	
Anaemia among women	NA	63.4	
Institutional Delivery	70%	NA	

a) **Sources: Censes-2011 and AHS- 2011**

3.1.1. GAPS IN INFRASTRUCTURE:



Main Constraints in Service Provision:

There are various gaps & constraints hindering the objectives of better health for the communities in Samastipur.

This chapter deals with the gaps in provisioning of equitable health services -through addressing the manpower, infrastructure, skill, equipment, facilities, drug & other supplies.

- Infrastructure Development integrated with its manpower utilization.
- Training and Capacity Building for specialization and multi-skilling.
- Opreationalizing FRUs in at least 2 blocks in one years (Definition of FRUs in this context is to be able to deliver Emergency Obstetric Care, care of sick neonates and sick children, regular FP sterilization services, safe abortion services, adolescent health care and Care for RTI/STIs) all block in five years and conversion of all PHCs to 24 hour PHCs which can perform institutional delivery.
- Strengthening routine Sub-Center functioning including the coordination of functionaries around the monthly nutrition and health day.

- Public Private Partnership to close gaps in medically underserved areas.
- NGO participation in Demand creation and service delivery.
- Community level care and improved services utilization (to bring about a halving of IMR in three years), including better provisioning of drugs and supplies for this level of care.
- Addressing the facility gaps in primary & secondary health care.
- Functionalize and regularize different health committee from village to district.
- IEC and Behavior Change Communication.

Gap Analysis:

During the MLP, data collection & analysis processes, interaction with the key stakeholders various gaps were identified that needs to be addressed in the context of the district health plan.

- The data bases at the village, block level are developed & maintained at the AWC/HSC /PHC level for reporting purposes. These data is hardly used for decision-making, tracking of the left out & drop out cases, addressing the gaps in coverage, cut off planning etc.

- The records of the AWW & ANM shows different coverage rates, enrollment on key indicators, hence matching these records is difficult.
- All beneficiaries are not tracked through the life cycle- individual service provisioning is recorded and tracked. Beneficiary wise tracking systems like follow up on services such as immunization, ANCs, PNCs, and other health services does not uniformly take place.
- Tracking system of home deliveries, quality issues on practices & skills of the skilled birth attendant, TBA / assistant are missing.
- There is no uniform roster (ATP) of the village visit by all functionaries & especially supervisory level staff, hence there is weak monitoring of coverage and its effectiveness.
- Monitoring by the ICDS and Health supervisors is often restricted to data compilation & facilitating weekly/ monthly meetings, the field visit section is weak and poorly planned to bring in a change.
- Due to lack of public / private transportation facilities villages on the fringe villages/hamlets are excluded from mainstream services, no effective & regular outreach service is planned, except the IPPI rounds.
- Developing joint plans with the Health & ICDS for 100% coverage of beneficiaries in the blocks are hardly co-ordinated.
- There are marked differences in records and actual observation during visits, this due to false reporting, inability of the workers to fulfill the desired targets.
- The record of cases maternal and infant deaths in the villages are often misleading, there is no acknowledgement of the new-born deaths as most of the birth & deaths are rarely recorded in the AWC/HSC records. The causes of the deaths are often vague & no post follow-ups are made on the same to facilitate decision-making.
- The data compilations are done at the block, little reference for planning is made addressing the sector issues & gaps in performance.
- A dis-aggregated analysis of family planning measures, birth spacing choices, strategies to promote sterilization and other permanent methods through provisions for MTP services in the CHC/PHC are missing links.
- The co-ordination in the management & monitoring plan of inter-departments (ICDS, Health, PRI, PHED, etc), the meetings are ritualistic, irregular & often attended by the nodal officers & sector staff.
- The link of the Panchayat is at best in the area of monitoring of health activities on a monthly, conducting Gram Sabha meetings, but the effective functioning of VHSC committee is missing, importance of the Gram Sachivalay is very poor among the PRI

members community members leading to poor decision making in the planning & implementation processes.

- Lack of appropriate IEC/BCC strategies, with diverse target groups, multiplicity of dialects is a major constraint.
- The lack of transparent transfer policies hinders the morale & effectiveness. Long postings in difficult conditions, poor accessibility to facilities and infrastructure cause deep resentment and affect the performance in these cases.

Suggested Plan for Addressing the Gaps:

Gender strategies:

- Undertake dis-aggregated data analysis on the gender gaps & inequities to guide decision-making.
- Facilitate male participation in BCC of target groups.
- Create conducive environment for the participation of the women representatives of Panchayat in the planning, implementation & monitoring processes.
- Move from an approach focus client based counseling to a household focused approach.
- Motivate the women from the community to form women's self help groups, initiate discussions on health issues and start regular mini savings so as to access health care in times of emergencies.
- Organizing legal awareness camps with the support of Police & ICDS for awareness building with special focus on women to help combat domestic violence and other types of harassment in the work place.

D. Training for Skill Development:

- Training to the Panchayat members for awareness building and creating active interest in the seriousness of prevailing health issues in the village.
- Training of service providers Health & ICDS at all levels to identify the existing health problems and take immediate actions to ensure prompt service delivery at the village level.
- Specific orientation to BMO's / SMO's / BEE's /CDPO's on program management skills.
- Provide training to the Sirhas, Gunias, ISMPs and RMPs to provide appropriate treatment along with carrying on with their routine rituals and practices.
- Training to all the traditional birth attendants of the village on five cleans, and identification of danger signs during and after delivery, including essential newborn care.

Addressing Exclusion

- Provision of mini Anganwadi Center through Panchayat or the Bastar Development Authority funds so as to enable reaches of basic service delivery for the women and children in the village.
- Prompt and appropriate community level care for all sick children and neonates with prompt referral where indicated.
- Motivate Panchayat to ensure four types of registration (birth registration, death registration, pregnancy registration, and marriage registration) at the village level.
- Ensure distribution of immunization cards to ensure complete immunization for the children.

Access & Control

- Identification of committed person from amongst the community (Involve Traditional Healers) for making him/ her a depot holder and training given on identification of common illnesses & diseases for first aid if required and send for referrals.
- Provision of drug kit to the trained traditional healers/ ASHA .
- Establish strong referral network of the Panchayat to provide monetary aids to any high risk pregnant woman, new born at risk, etc.
- Availability of condoms and oral pills to the identified and trained depot holder in the village to help enable birth spacing.
- Availability of bleaching powder and generic medicines for preventive care from water borne diseases to the depot holder in the village.

Behaviour Change Communication

- Folk media like Street Play, nukkad natak, etc. to generate interest among the community members.
- Wall writing on health messages, information on steps towards personal hygiene, and maintaining hygiene and sanitation in the village.
- Integrate Sector level Mela (Meet for Empowerment Learning and Advocacy) of Health and Mahila Jagriti Shivir of ICDS& RCH Camps for awareness building and community level mobilization to a wider populace.
- Provision of printed IEC materials for ASHA's, ASHA worker and other traditional healers for effective counseling.

Synergy and Convergence

- Building up community support system centered around the ASHA Program so as to improve health awareness and demand for institutional services.
- Involvement of all other stakeholders like school teachers, missionaries, NGO partners and civil society organizations to bring about greater integration and convergence of services at the village level.

- Integration with PHE for identification of defunct hand pumps for restoration / renovation and other repair works.
- Sanction and installation of new hand pumps by the PHE as per requirement in areas with no accessibility to potable drinking water. Convergence with Zilla Panchayat to ensure alternative drinking water arrangements where hand pumps installation is not possible.

Outreach / Contingency planning:

It is proposed that the health outreach sessions would be organized as mentioned below.

- Survey of beneficiaries Eligible couples, client segmentation according to parity and close counseling, registration of all births, pregnancy and Marriage for providing Maternity, Child Health & FW services in all the villages.
- The Village health registers will keep all information with Village Health committee.
- Sessions in the village once in every month with focus on improving quality of ANC check up, monitoring of Wt, HB & urine examination.
- Community ownership of sessions will be generated and the Village Health committee will take ownership for 100% immunization sessions. SHG groups will also be associated with session.
- Special camps in PHC coverage area will be carried out once in two months using Private sector and Public sector Specialists. Honorarium will be provided.
- Catch up round will be organized during the mid session to capture missed out infants and children.
- Special camping will be done for the inaccessible areas before and after rainy seasons
- It is also proposed that in every outreach sessions a gynecologist and a pediatrician will be hired from private and other trust hospitals for meeting the gap of skilled manpower.
- Mobility support will be given during the outreach sessions. Separate monetary support will be arranged for carrying out the catch up round session

6. Improve availability of drugs and medical supplies

- Improve health officers and storekeepers capability in logistics management.
- Training storekeepers and health workers on drug and medical supplies management.
- Rational distribution of essential drugs in the AWC/HSC/ depot holders .Assessments of supplies with ASHA/ Traditional healers, replenishment of stocks.
- Pre-Indenting & supply procedures needs to be rationalized as per norms.

- Monitor & Maintain the cold chain facilities, especially planning for outreach in remote PHC/HSC.
- Follow FIFO techniques in the supply systems, remove all expired drugs from the stock at all levels.
- Transportation of supplies from the PHC to the HSC needs to be strengthened.

7. RTI/STI clinic at CHC/PHC

The RTI/ STI management and treatment is an important intervention in the district Hospital under District Health Plan.

The RTI/ STI clinic is proposed is filled with posts in Gynecology & multi skilling of existing staff for providing syndromic management. OPD of CHC (Hiring of Doctors). The RTI drug kits will be supplied to all service delivery centres.

8. Strengthening IEC

- Training on communication skill.
- Health related mass media campaign.
- Awareness building on symptoms of diseases, modes of transmission and possibility and source of treatment (RTI/ STI).
- Organize Panchayat, health committee, SHGs to increase community awareness to enhance health promotion activities and to monitor health status of the community, women & children with increased male involvement.
- Provide adolescent education through school and peer education.

9. Concurrent evaluation & RAPS

The provision of concurrent evaluation will be essential to know that we are moving in the right direction and to know the efficacy of the program interventions. At Present through HMIS system all the HSC data is uploaded in block level and district level it is compiled and reviewed every months. But there is steel missing the same process at the block level with the HSC.

The district has recently initiated the Mother and child tracking system and started functional. Also the Maternal Death Review process has been initiated but it is not fully functional for collection of information, review and feedback mechanisms.

There it is suggested that RAPS (Rapid assessment of Programs) be conducted on an annual basis to gauge the program performance on an annual, this is proposed to be an independent internal assessment to be done by the Health dept., in coordination with the ICDS. The technical support for initiating this process will be sought from external agencies or SHRC.

The evaluation will be conducted by independent agency and it will help in better utilization of program funds.

11. Strengthening referral transport in rural areas

The road transport is very poor in the Samastipur and most of the first referral units are far away from the villages and in the emergency situations the referral of the pregnant mothers becomes very difficult, as no transport is available. Most of the women suffer a lot for the want of transport in villages. If the appropriate referral is made available the life of may mothers can be saved. The first referral services are available in FRUs but are Semi functional.

The referral protocol has to be developed, as presently there is lack of knowledge with the service providers for referring the cases. The community also needs awareness regarding available of funds at Panchayat level. Presently, village health societies are not even aware about the referral transportation availability.

Suggested mechanism can be as follows:

1. The funds for referral transport will be made available at the account of Panchayat and each FRU.
2. The mode of transportation for referral services will be identified by the VHC itself and will provide money.
3. The beneficiary will confirm the delivery at FRU level by producing the document provided before discharge from the institution.
4. Public Private Partnership will be encouraged with NGOs, trust hospitals.
5. Identification of first referral level public & private referral institutions and circulation to all health providers and Panchayat.
6. Strengthening of community best performers through reward system. This will motivate the community as well as increase the credibility of Health service providers

12.Strengthening Program & Financial Management Systems:

Public Health management and administration capability needs to be enhanced at all levels the district and the block. Currently most persons at this level are clinicians who are assigned public health and management functions and learn their skills on the job. The whole emergence of health administration as a separate professional domain goes unrecognized this leads to costly administrative lapses and inefficiencies and most programmes fail to expend their budgets and or deliver expected outcomes.

At the district level the district health society and the management unit need to have capability building. We also need to create and strengthen the health resource center.

At the district level we need to strengthen the district health societies and in the blocks the block medical officer. The strengthening at the district and block society level can be done by the creation of an administrative cadre and specific public health management training and by the direct recruitment of health management and social work professionals.

Strategies:

- Create administrative cadre
- Build adequate health management capabilities in district and state level in department professionals.
- Recruit as consultants and outsourcing in sourcing arrangements for performing key health management tasks.

Activities:

1. All block medical officer, Civil Surgeon, district CMO and nodal officers of vertical health programs need to be considered as health administrators.
2. All health administrators above would complete three months of a mandatory training on health management. A MOU on the same needs to be reached with management institutions for this purpose.
3. All those who are equivalent or above as block medical officer will have an opportunity to attend a 3 month course on health management. About 5 persons per year would attend the course. Costs would be shared between trainees and the government.

13. <u>Filling the Equipment gaps</u> :

1. Equip all CHC as per IPHS norms .
2. Equip all PHC as per IPHS norms.
3. Equip all HSC , fill the gaps through utilizing HSC untied funds of Rs 10000/-
4. Train all health staff on the basic equipment use at the CHC/PHC/HSC.
5. Provide cold chain facilities in all remote / cut off PHC to facilitate cold chain management to improve the coverage in the HSC & improve the efficacy rates.
6. Prepare a maintenance checklist of all equipment, carry out essential repairs as needed.

14. **Creating adequate support systems & facilities** :

1. Computerized Health Management Information Systems(HMIS) institutionalized at the block level by 2005-2006.
2. Ensure the availability of 10 computers with peripherals in the district level, each CHC having 1 each with Internet facilities with functional telephone landlines.
3. Develop customized HMIS and additional information bases. Complete training and operationalise the system by 2005-06.

15. Improved financial management systems:

1. To train one person on financial management in each block.
2. Recruit or train one finance staff at the district on accounting management to facilitate efficient financial management of the district health society.

HSC Infrastructure

Health Sub Centre is very important part of entire Health System. It is first available Health facility nearby for the people in rural areas.

We are trying to analyze the situations at present in accordance with Indian Public Health Standards.

IPHS Norms:

A Sub-centre should have its own building. If that is not possible immediately, the premises with adequate space be rented in a central location with easy access to population.

i. Location of the centre: The location of the centre should be chosen that:
   a. It is not too close to an existing sub centre/ PHC
   b. As far as possible no person has to travel more than 3 Km to reach the Sub centre
   c. The Sub Centre Village has some communication network (Road communication/Public Transport/Post Office/Telephone)
   d. Accommodation for the ANM/Male Health Worker will be available on rent in the village if necessary.
   For selection of village under the Sub Centre, approval of Panchayats as may be considered appropriate is to be obtained.

ii. The minimum covered area of a Sub Centre along with residential Quarter for ANM will vary from 73.50 to 100.20 sq. mts. depending on climatic conditions (hot and dry climate, hot and humid climate, warm and humid climate), land availability and with or without a labor room. A typical layout plan for Sub-Centre with ANM residence as per the RCH Phase-II National Programme implementation Plan with area/Space Specifications is given below

Health Sub Centers: Total population of the district as per 2001 census is 3413413. After considering two percent growth rate of the total population it comes around 4100000 (Decadal Growth Rate 2.3). After considering projected population in 2008, the district needs altogether 683(354 existing HSC AND 329 Proposed HSC) HSCs to cater not its whole population but cover 83% population, so, we need 820 HSCs our present population requirement. As per the IPHS norms (5000 population in plain area) the district still requires 466 new HSCs to be formed. Again, out of 354 established HSCs, only 121 have their own buildings and rest 242 run in rented houses or in Panchyat Bhavan. Out of 121 HSCs 67 HSCs need renovation work. All the above mentioned HSCs need equipments, drugs, furniture and stationeries.

Health Sub Centers:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	A. Out of 354 HSCs only 130 are having own building	Inadequate facility in constructed building and lack of community ownership	Enhance visibility of HSC through hardware activity by the help of community participation .	A. **Strengthening of HSCs having own buildings**
	B. In existing 130 Buildings 56 is running in comparatively in good condition.			B.1.White washing & Repairings of doors/windows of HSC buildings. B.2.Organize adolescent girls for wall painting and plantation./hire local painter for colorful painting of HSC walls.(Regional Languages) List out all services which are provided at HSC level on the wall. B.3.Gardening in HSC premises by school children.
	C. Not even one building is having running water and electric supply.			C. Mobilize running water facility from nearby house if they have bore well and water storage facility and it could be on monthly rental. Solar Energy for power supply.
	Hire rented building of 224HSC or construct the HSC building		Availability fund for 224 HSC	**3B. Strengthening of HSCs running in rented buildings.** B2. Streamlining the payment of rent through untied fund from the month of April 2011. B3.Purchase of Furniture as per need B4 Prioritizing the

				equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries
	Hire rented building of newly sanctioned 331 HSC or construct the HSC building	Non availability of fund	Proper flow of fund	
	1. The district still needs 325 more HSCs to be formed.	1. Land Availability for new construction		**3C. Construction of new HSCs** C1. Preparation of PHC wise priority list of HSCs according to IPHS population and location norms of HSCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New HSC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector for smooth transfer of constructed HSC buildings.
	Non participation of Community in monitoring construction work	Monitoring	Ensuring community Monitoring	1. Biannual facility survey of HSCs through local NGOs as per IPHS format and Compile it to Next year DHAP 13-14 2. Regular monitoring of HSC facilities through PHC level supervisors in IPHS format. 3. Monitoring of renovation/construction

				works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4. Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 5. Monthly Meeting of one representative of VHSC/Mothers committees on construction work
	1. Lack of community ownership in the construction of Health infrastructures.	1.Community ownership	Strengthening of VHS&NCs, PRIs	1.Formation and strengthening of VHS&NCs, Mothers committees, 2.“Swasthya Kendra Chalo Abhiyan” to strengthen community ownership through(SWASTHAYA CHETNA YATRA) 3.Nukkad Nataks on Citizen’s charter of HSCs as per IPHS 4.Monthly meetings of VHS&NCs, Mothers committees

	No Proper ANC at HSC level (As per guidelines)	Improvement in quality of services like ANC, INC ,PNC, Immunization, Nutrition & Hygiene	Strengthening at least additional two HSC per PHC for institutional delivery in first quarter	1. Identification of the best HSC on service delivery 2.Listing of required equipments and medicines as per IPHS norms 3. Purchasing/ indenting according to the list prepared 4.Honouring first delivered baby and ANM
	No Proper ANC at HSC level (As per guidelines)	Improvement in quality of services like ANC, INC ,PNC, Immunization, Nutrition & Hygiene	Strengthening at least additional two HSC per PHC for institutional delivery in first quarter	1. Identification of the best HSC on service delivery 2.Listing of required equipments and medicines as per IPHS norms 3. Purchasing/ indenting according to the list prepared 4.Honouring first delivered baby and ANM
	Only 39% PW registered in first trimester PW with three ANCs is 53%, TT1 coverage is 70%, Family Planning Status Any method-43.6% Any modern method-39.8% No sterilization at HSC level IUD insertion -0.5% Pills-1.5% Condom-1.9% Total unmet need is	Improvement in quality of services like ANC, NC and PNC, Immunization and family planning	1. Phase wise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms. 2. Community focused family planning services	1 Gap identification of 39 HSCs through facility survey 2. Eligible Couple Survey 3. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 4. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 5. Training of ANMs on IUD insertion

	32.7%, for spacing-14.9,			
	Lack of counseling services	Training	Training	1. Training to ANMs on ANC, NC and PNC, Immunization and other services.
	HSC unable to implement disease control programs	Integration of disease control programs at HSC level.	Implementation of disease control programs through HSC level	1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6. (four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs
	80% of the HSC staffs do not reside at place of posting	Absence of staffs	Community monitoring	1. Submission of absentees through PRI
	Problem of mobility during rainy season	Communication and safety		1.Purchasing Life saving jackets for all field staffs of High risk blocks. 2. Providing incentives to the ANMs during rainy season so that they can use local boats.

	Lack of convergence at HSC level	Convergence	Convergence	1. Fixed Saturday for meeting day of ANM, AWW, ASHA, LRG with VHS&NCs rotation wise at all villages of the respective HSC. 2. Monthly Video shows in all schools of the concerned HSC area schools on health, nutrition and sanitation issues.
	Lack of proper reporting from field Lack of appropriate HMIS formats.	Reporting	Strengthening of reporting system	1.Training to the field staffs in filling up HMIS & MCTS reports etc. 2.Printing of adequate number of reporting formats and registers 3. Hiring consultants to develop software for reporting.

Human Resource

Source: DHS Samastipur Report.

Sub Heads	Gaps	Issues	Strategy	Activities
Human Resource	Out of 478 sanction post of regular ANM 22 post are vacant, and out of 486 post of contractual ANM only 81 seats are vacant. Out of 30 sanctioned post of LHVs only 11 are placed.	Filling up the staff shortage	Staff recruitment	1.Selection and recruitment of 81 ANMs 2.Selection and recruitment of 28 male workers
	All Contractual ANMs need training on different services.	Untrained staffs	Capacity building	1.Training need Assessment of HSC level staffs2.Training of staffs on various services
	The ANM training	Training	Strengthening of ANM	1.Analyzing gaps with

	school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities		training school	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 operationalization of allocated fund
Drug kit availability	1.No drug kit as such for the HSCs as per IPHS norms.(Drugs for delivery, drug for national disease control program (DDT, DECs) 2.No Drug kit for AWCs(@one kit per annum,) 3.No ASHA kit	Indenting (ABC & VED Basis)	Strengthening of reporting process and indenting through form 6	1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports
	Only need based emergency supply Irregular supply of drugs	Logistics		1.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2. Hiring vehicles for supply of drug kits through untied fund. 3.Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)

		Operationalization	Couriers for vaccine and other drugs supply	1 Hiring of couriers as per need 2 Payment of courier through ANMs account
			Phase wise strengthening of APHCs for vaccine / drugs storage	1.Purchasing of cold chain equipments as per IPHS norms 2. training of concerned staffs on cold chain maintenance and drug storage

Additional PHCs: -- There are 45 APHCs functioning out of 45 APHC in the district and 55 more are proposed to be established.

Additional PHC:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	1.The district altogether need 100 APHCs but there are 45 APHCs functioning in the district and 55 more are proposed to be established. 2.Out of 45APHCs only 27 are having own building 3.Existing 22 buildings are not properly maintained	Lack of facilities/ basic amenities in the constructed buildings Non payment of rent Land Availability for new construction Constraint in transfer of constructed building. Lack of community ownership	Strengthening of VHS&NCs, PRIs and uses of RKS fund for development. Strengthening of Infrastructure and	1.“Swasthya Chetna Yatra” to strengthen community ownership 2.IEC & BCC on Citizen’s charter of APHCs as per IPHS 3. Registration of RKS(Completed) 4.Monthly meetings of VHS&NCs, Mothers committees and RKS **A. Strengthening of APHCs having own buildings** A.1Rennovation of APHCs buildings A.2 Purchase of Furniture

	Lack of equipments, Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries		operationalization of construction works in Three phase	A.3 Prioritizing the equipment list according to service delivery A.4 Purchase of equipments A.5 Printing of formats and purchase of stationeries **B. Strengthening of APHCs running in rented buildings.** B1. Estimation of backlog rent and facilitate the backlog payment within two months B2. Streamlining the payment of rent through untied fund/ RKS from the month of April 09. B3.Purchase of Furniture as per need B4 Prioritizing the equipment list according to service delivery B5 Purchase of equipments as per need B6 Printing of formats and purchase of stationeries 3C. Construction of new APHC buildings as standard layout of IPHS norms. C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs C2. Community mobilization for promoting land donations at accessible locations. C3. Construction of New

			Monitoring	APHC buildings C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed APHC buildings. 4 Biannual facility survey of APHCs through local NGOs as per IPHS format 4.1 Regular monitoring of APHCs facilities through PHC level supervisors in IPHS format. 4.2 Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4.3 Training of VHS&NC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHS&NC/Mothers committees on construction work.
Human Resource	Lack of doctors, Lack of A Grade nurses, Lack of Pharmacists.	Filling up the staff shortage Untrained staffs	Staff recruitment	1.Selection and recruitment of 51 Grade A nurse/ANMs 2.Selection and recruitment of 28 male workers 3. Sending back the staffs to their own APHCs. 1.Training need Assessment of APHC level staffs 2.Training

	Untrained ANMs and male workers The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities Out of 30 sanctioned post of LHVs only 11 are placed Most of the APHC staffs are deputed to respective PHC hence APHC are defunct		Capacity building Strengthening of ANM training school	of staffs on various services 3.EmoC Training to at least one doctor of each APHC 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 operationalization of allocated fund
Drug kit availability	No drug kit as such for the APHCs as per IPHS norms.(Drugs for delivery, drug for national disease control program Only need based emergency supply Irregular supply of drugs	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 2 and 6 Couriers for vaccine and other drugs supply	1.Weekly meeting of APHC staffs at PHC for promoting APHC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three colored indenting format for the APHC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)

			Phase wise strengthening of APHCs for vaccine / drugs storage	3.1 Hiring of couriers as per need 3.2 Payment of courier through APHC account 4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage
Service performance	No institutional delivery at APHC level No inpatient facility available No lab facility No rehabilitation services No safe MTP service No OT/ dressing and Cataract operation services. Approx 80% of APHC staffs not reside at place of posting Lack of counseling services Problem of mobility during rainy season Lack of convergence at APHC level Operational gaps: There is no link between HSCs and	Operationalization of Untied fund. Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps. Integration of disease control programs at APHC level. Family Planning services Convergence Operational issues	Capacity building of account holder of untied fund Phase wise strengthening of 16 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms. Implementation of disease control programs through APHC level where APHC will work as a resource center for HSCs. At present the	1.Training of signatories on operating Untied fund /RKS account, book keeping etc 2. Assigning PHC RKS accountant for supporting operationalization of APHC level accounts 2. Timely disbursement of untied fund/ seed money for APHCs RKS. 3. 1 Gap identification of 16 APHCs through facility survey 2.strengtheing one APHC per PHC for institutional delivery in first quarter 3.Honouring first delivered baby and ANM 1 Review of all disease control programs APHC wise in existing Tuesday weekly meetings at PHC with HMIS & MCTS formats. 2.Strengthening ANMs for community based planning of all national disease control program

	APHCs and the same way there is no link between APHC and PHC		same is being done by PHC only. Community focused Family Planning services PPP Convergence	3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs. 5.Weekly meeting of the staffs of concerned HSCs (as assigned to the APHC) 1.Eligible Couple Survey 2. Ensuring supply of contraceptives with three month's buffer stock at HSCs. 3.Training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion 1. Fixed Saturday for meeting day of ANM, AWW, ASHA, LRG with VHSCs rotation wise at all villages of the respective HSC.

Primary Health centers: The district has 20 PHCs, 3 SDHs. 1 Referral hospitals and a District hospital.

PHC Bithan

Primary Health Centers:				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	All PHCs are running with 10- 15 Bed facility. At present 15 PHCs are working with average 20 delivery per day, 10 FP operation/emergency operation and 250 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility. The comparative analysis of facility survey (08-09) and DLHS3 facility survey(06-07) , the	Available facilities are not compatible with the services supposed to be delivered at PHCs. Quality of services Community participation.	Up gradation of PHCs into 30 bedded facilities. ISO certification of selected PHCs in the district.	1.Need based (Service Delivery) Estimation of cost for up gradation of PHCs 2. Preparation of priority list of interventions to deliver services. 1.Two PHCs are in process for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly

	service availability tremendously increased but the quality of services is still the area of improvement. Lack of equipments as per IPHS norms and also under utilized equipments. Lack of appropriate furniture Operation of RKS: Lack in uniform process of RKS operation. Lack of community participation in the functioning of RKS. Lack of facilities/ basic amenities in the PHC buildings		Strengthening of BPMU Ensuring community participation. Strengthening of Infrastructure and operationalization of construction works Monitoring	meeting of RKS. 2. Training to the RKS signatories for account operation. 1.Meeting with community representatives on erecting boundary, beautification etc, 2. Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS. **Strengthening of PHCs** 1.Rennovation of PHCs 2.Purchase of Furniture 3. Prioritizing the equipment list according to service delivery and IPHS norms. 4. Purchase of equipments 5. Printing of formats and purchase of stationeries 1. Biannual facility survey of PHCs through local NGOs as per IPHS format 2. Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.
Human Resource	As per IPHS norms human resource management not follow up and also local arrangement of human resource is tuff to arrange. Doctors and para medical staff are not	Staff shortage Untrained staffs	Staff recruitment	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

	posted As per IPHS norms in each PHC		Capacity building	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 programs.
Drug kit availability	Irregular supply of drugs because of lack of fund disbursement on time. Only 70 % essential drugs are rate contracted at state level. Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.	Indenting Logistics Operationalization	Strengthening of reporting process and indenting through form 7 Strengthening of drug logistic system	1.Training of store keepers on invoicing of drugs 2.Implementing computerized invoice system in all PHCs 3.Fixing the responsibility on proper and timely indenting of medicines(keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store keeper. 7. Orientation meetings on guidelines of RKS for operation.
Service performance	1. Excessive load on PHC in delivering all services i.e. 20 deliveries per day, 10	Optimum Utilization of Human Resources	Quality improvement in residential facility of	1. Hiring of rented houses from RKS fund for the residence of doctors and key

	FP operation / emergency operations and 250 OPD per day in each PHC. 2. Total 59 seats of Regular and 51 seats of contractual doctors in the district is vacant. 3. All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less (only average 65 patients per Doctor per OPD days during April 11-Nov 11, however the IPHS norms says that the OPD should be 40 per Doctor.) 4. 5 PHCs out of 20 are lacking 24 hrs services. 5. Only five PHCs provide 24 hrs BEmoC services. 6. None of the PHC provides 24 hour blood transfusion services, however PHC has been provided the equipments for blood storage unit. 7 Some PHC does not have laboratory facilities. 8 Lab services provided by PPP services have started. 9. Only one PHC provides adolescent sexual and reproductive	Epidemic outbreaks and Need based intervention in epidemic areas.	doctors/ staffs. Recruitment Proper and timely information of outbreaks	staffs. 2. Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patient's treatment. 3. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day 1.Selection and appointment of contractual doctors and staffs 1. Mapping of the areas having history of outbreaks disease wise. 2.Developing micro plans to address epidemic outbreaks 2.Assigning areas to the MOs and staffs 3.Motivating ASHA on immediate information of outbreaks 4. Purchasing folding tents, beds and equipments and medicines to organize camps in epidemic areas. 1. Repairing of all defunct Ambulances 2. Repairing of PHCs gensets and initiating their use. 3. Hiring of ambulances as per need.

	health services. 10. Referral a. No pick up facility for PW or patients. b.BPL patients are not exempted in paying fee of ambulance. c. Lack of maintenance of ambulances d. Shortage of ambulances 11. Quality of food, cleanliness (toilets, Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC. 12. In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs are reluctant to handle emergency cases. 13. Several cases of theft of instruments, computers, and submersible pumps etc at PHCs. 14. No guidance to the patients on the services available at PHCs. 15. Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in	Service Load centered at PHC Availability of AYUSH patchy. Insecurity (Staff and Properties)	Strengthening of equipments and services and increase in the number of ambulances. Strengthening of AYUSH services at PHC level in the first level. Confidence building measures	1. Appointment of one AYUSH practitioner and Yoga teacher in every PHC 1.Insurance of all properties and staffs of PHC 2.Placing one TOP in every PHC 1. Assigning mothers committees of local BRC for food supply to the patients in Govt's approved rate. 2.Lab technicians have required 3. Purchase of equipments/ instruments for strengthening lab. 4. Hiring of menial workers for cleanliness works. 1. Assigning LHV for counseling work 2. Wall writing on every section of the building denoting the facilities 3. Name plates of doctor 4. Displaying Roster of doctors with their details. 5. Gardening 6. Sitting arrangement for patients/attendents. 7. Installation of LCD TV with cable connection 8.Installation of safe drinking

	particular. 16.Lack of counseling services 17.Problem of mobility during rainy season 18.Lack of convergence	Govts existing services like lab, x-ray, generator, fooding and cleanliness services.	Strengthening of the Govts. existing services like lab, x-ray, generator, fooding and cleanliness services. Creating friendly environment HMIS and strengthening of reporting process	water equipments/water cooler, 9.Installation of solar heater system and light with the help of BDO/Panchayat 9. Apron with name plates with every doctors 10. Presence of staffs with uniform and name plates. 1.Orientation of the staffs on indicators of reporting formats

SITUATIONAL ANALYSIS OF SUB DIVISION HOSPITAL

DIAGNOSTIC CENTRE MAIN HOSPITAL

- NEW BORN CARE UNIT -1
- LABOUR ROOM -1
- DOCTOR'S DUTY ROOM-1
- KALA ZAR WARD-1
- GENERAL WARD-30 bedded
- X-RAY & ULTRASOUND -1
- BLOOD STORAGE UNIT (NON FUNCTIONAL) -1
- ADMINISTRATIVE CHAMBER - 2 Rooms
- STAFF TOILET M-1, F-1
- RUNNING WATER 24 Hrs
- IMMUNIZATION CENTER-1
- OPERATION THEATRE-1
- ANM DUTY ROOM -1
- SMALL OT-1
- PATHOLOGY LAB-1
- DATA OPERATOR ROOM-1
- LABOUR ROOM's TOILET - 1
- TOILET – M-2
- TOILET –F-2
- ELECTRIC FACILITY 24 Hrs

Gaps in Infrastructure

- At present Sub divisional hospital is working with average 25 deliveries per day, 20 FP operation/emergency operations and 300 OPD per day. This huge workload is not being addressed with only 30 beds inadequate facility.
- Lack of equipments as per IPHS norms and also underutilized equipments.

- Lack of appropriate furniture
- Operation of RKS is not on time
- Empower RKS and community participation
- Lack of facilities/ basic amenities in the SDH buildings
- Huge workload in central registration unit
- No sitting arrangement for patients.
- No safe drinking water facility.
- Half of the hospital area remains dark at night.
- Delivery room lacks beds, labour table, stretchers, and equipments.
- No proper gate and boundary wall.
- Water logging during rainy season
- No enquiry counters as such for the patients.
- No residential facilities for doctors and staffs.
- No canteen facility for out patients and attendant

Activities for Infrastructure strengthening:

- Purchase of fowler deluxe beds -100.
- Listing of required equipments as per IPHS norms and their purchase.
- Listing of required furniture and their purchase.
- Simplifying process of RKS operation.
- Computerization of registration system for the OPD/IPD patients.
- Construction of shed for waiting patients
- Installation of 3 Water cooler freezes as per requirement.
- Installation of seven vapour lights as per requirements.
- Renovation of boundary wall and gate.
- Renovation of drainage system and levelling of internal area up to the level of outer area.
- Construction of enquiry counters at the gate.
- Construction of new residential buildings.
- Hiring of rented houses from RKS fund for the residence of doctors, BMU and key staffs.
- Proper sitting arrangement for patients
- Installation of LCD TV with cable connection

GAPs in HR and Drugs

- 3 MBBS and 1 eye specialist running SDH
- Post dresser, OT assistant and ophthalmic assistant are vacant,2 A-Grade nurse and 2 ANM
- Irregular supply of drugs
- Only 70% essential drugs are rate contracted at state level.
- There is no clarity on the guideline for need based drug procurement and transportation.
- Lack of proper space, furniture and equipments for drug storage

Human Resource

- Appointment of Gynaecologist, Paediatrician, Anaesthetist, surgeon and pathologist on contract basis.
- Appointment of dresser, OT assistant, ophthalmic assistant, blood bank assistant, blood bank technician and other office assistant on contract basis.
- Motivational training to all medical or non medical staffs

- Deputation of required staffs from field.

DRUG AND SUPPLY

- Training of store keepers on invoicing of drugs
- Implementing computerized invoice system
- Enlisting of equipments for safe storage of drugs.
- Purchase of enlisted equipments.
- Ensuring the availability of FIFO list of drugs with store keeper.

Service performance Gap

- Excessive load in OPD on SDH
- Blood storage unit is present but not functional .
- 24hrs Lab facility and x Ray services are not available
- Health facility with AYUSH services is not being provided
- No pick up facility for PW or patients.
- Lack of maintenance of ambulances
- No guidance to the patients on the services available at SDH.
- Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged

SERVICE PERFORMANCE

- Operationalising APHC and strengthening adjoining PHC .
- One doctor nurse and paramedical staff designate for blood storage unit and ensure 24 hours electric supply and organise blood donation camps.
- Incentivizing doctors/ staffs on their performances and achievement especially on OPD, IPD, FP operations, Kala-azar patient's treatment.
- Organise blood donation camps
- Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day
- Strengthening VHSC for providing free ambulance services to all PW women.
- Appointment of one AYUSH practitioner
- Purchase of semi auto analyser for pathological lab.
- Displaying Roster of doctors with their details.

- Gardening and lightening in SDH
- Apron with name plates with every doctors, and organise organisational behaviour training of all staff.
- Presence of staffs with uniform and name plates.
- Out source canteen to local NGOs/ SHG

District Hospital:

District Hospital Samastipur:				
Indicators	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	1.There are 120 beds in the Sadar hospital which is not adequate as per the requirement. **Ward No of beds** Male medical ward: 20 Male surgical ward: 20 Female ward : 20 Child ward : 20 Delivery ward : 10 TB ward : 10 Infectious disease : 10 Prisoners ward : 10 **Total : 120** 2. At present District hospital is working with average 45 deliveries per day, 20 FP operation / emergency operations and 800 OPD per day. This huge workload is not being addressed with only 130 beds inadequate facility. 3. Lack of equipments as per	Lacks in infrastructure	Strengthening of infrastructure	1. Purchase of fowler deluxe beds 100. 2. Repairing of beds. 3. Listing of required equipments as per IPHS norms and their purchase. 4. Listing of required furniture and their purchase. 5. Simplifying process of RKS operation. 6. Computerization of registration system for the OPD/IPD patients. 7.Construction of shed for waiting patients 8. Installation of 3 Water cooler freezes as per requirement. 9. Installation of seven vapor lights as per requirements or a High Mask Light.

	IPHS norms and also under utilized equipments. 4.Lack of appropriate furniture 5.Operation of RKS: Delayed process of operation. Delay in disbursement of fund 6.Lack of facilities/ basic amenities in the PHC buildings 7.Huge workload in central registration unit 8. No sitting arrangement for patients. 10. No safe drinking water facility. 11. Half of the hospital area remains dark at night. 12. Delivery room lacks beds, labor table, stretchers, and equipments. 13. No proper gate and boundary wall. 14.No proper post mortem room and equipments. 15. Heavy water logging during rainy season. 16. Buildings for ICU, Causality ward are ready but due to lack of equipments, facilities are not functional. 17. No use of paying wards. 18.No enquiry counter as such for the patients. 20.No residential facilities for			10. Renovation of boundary wall and gate. 11. Construction of new Post mortem room with all facilities. 12. Renovation of drainage system and leveling of internal area up to the level of outer area. 13. Construction of enquiry counters at the gate. 14. Hiring of ambulances. 15. Construction of new residential buildings. 16.Hiring of rented houses from RKS fund for the residence of doctors, BMU and key staffs. 16.Tender for canteen facility. 17. Sitting arrangement for patients 18. Installation of LCD TV with cable connection

	doctors and staffs. 21. No canteen facility			
Human Resource	1. Post of gynecologist may be increased and pathologist is vacant. 2. Post of one dresser, one OT assistant and one ophthalmic assistant are vacant.	Lack in Staff position	Recruitment Redployment	1. Appointment of gynecologist and pathologist on contract basis. 2.**Mapping of specialist Doctors in Block as well as District** 3. Appointment of one dresser, one OT assistant and one ophthalmic assistant on contract basis. 1. Deputation of required staffs from field.
Drug kit availability	1. Irregular supply of drugs because of lack of fund disbursement on time. 2. Only 70% essential drugs are rate contracted at state level. 3. There is no clarity on the guideline for need based drug	Improper Supply and logistics	Capacity building and strengthening of reporting process and indenting through form 7	1.Training of store keepers on invoicing of drugs 2.Implementing computerized invoice system 4. Enlisting of equipments for safe

	procurement and transportation. 4. Lack of proper space, furniture and equipments for drug storage	Lack in storage facility		storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list of drugs with store keeper.
Service performance	1.Exessive load in delivering all services 2. Blood storage unit is present but not utilized 3.No 24hrs Lab facility 4. Referral a. No pick up facility for PW or patients. b. BPL patients are not exempted in paying fee of ambulance. c. Lack of maintenance of ambulances d. Shortage of ambulances 5. No guidance to the patients on the services available at DH. 6. Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.	Workload Lack in infrastructure	Motivation building Strengthening of infrastructure	1. Incentivizing doctors/ staffs on their performances especially on OPD, IPD, FP operations, Kala-azar patient's treatment. 2. Purchase of equipments for Blood storage unit, 3. IEC on blood storage unit. 4. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day 5. Repairing of all defunct Ambulances 6. Hiring of ambulances as per need. 7. Appointment of one AYUSH practitioner and Yoga teacher 8. Purchase of equipments/ instruments for strengthening lab. 9. Wall writing on every

				section of the building denoting the facilities 10. Name plates of doctor 11. Displaying Roster of doctors with their details..

Chapter 4

Setting Objectives and Suggested Action Plan

RCH Flexi pool A

Maternal Health

Child Health

Family Planning

Adolescent Reproductive and Sexual Health

PC & PNDT

Gender Main streaming

Maternal Health: Situation Analysis

3.1 MATERNAL HEALTH							
Logical Framework							
Sl.	**Goal**	**Sl.**	**Impact indicators**				
1	To improve maternal health	1.1	Reduction in MMR				
Sl.	**Objectives**	**Sl.**	**Outcome indicators**	**Sl.**	**Strategy**	**Sl.**	**Output indicators**
1	To increase institutional safe delivery by 28.2% (DLHS3) and 87% in Nov 2011 to 100% by year 2013	1.1	% of institutional delivery reported	1.1.1	To make functional PHC (24hr x7days) for institutional deliveries	1.1.1.1	% of PHC having functional OT and Labour room with equipment
						1.1.1.2	% of PHC having Obestetric First Aid medicine 24hrx 7 days
						1.1.1.3	% of Grade A nurse available 24hrx7days
						1.1.1.4	% of PHC having functional Neo-natal care units
				1.1.2	To make functional FRU for institutional deliveries	1.1.2.1	No of FRUs having functional blood storage units linkage with blood banks and 24hr ready referral transport

						1.1.2.2	No of FRUs having EmOc and CEmOc facilities
						1.1.2.3	No of FRUs having specialist doctors/ multiskilled Medical Officers
				1.1.3	To provide Referral transport services at FRU /PHC	1.1.3.1	No of pregnant women availed the referral facilities (pick up and drop)
				1.1.4	To strengthen Janani Suraksha Yojana / JSY	1.1.4.1	% of pregnant women received JBSY payments immediately after delivery
2	To increase safe delivery by trained SBA 9.6% (DLHS3) and 87% in Nov 2011 to 100% by year 2013	2.1	Proportion of birth attendant by skilled health personnel	2.1.1	To ensure support of SBA at home deliveries	2.1.1.1	% of home deliveries attended by SBA
3	To increase ANC coverage with quality 16% (DLHS3) to 53% in Nov 2011 to 100% by year 2013	3.1	% ANC reported through HMIS formats / Form -7	3.1.1	To strengthen HSC for providing outreach maternal care	3.1.1.1	% of HSCs having ANMs
						3.1.1.2	% of HSCs conducted fixed ANC and clinics (planned & held)
				3.1.2	To organize integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas	3.1.2.1	% of RCH camps planned and held

				3.1.3	To improve adolescent reproductive and sexual health	3.1.3.1	No of pregnant adolescent counseled by ANM/ AWW/ASHA
				3.1.4	To accelerate APHC for OPD and Fixed AN clinics	3.1.4.1	% of OPD clinics organized at APHC level.
4	To provide safe abortion services at all facilities	4.1	% MTP cases reported through HMIS formats / Form -7	4.1.1	To provide MTP services at health facilities	4.1.1.1	No of facilities having MTP services (public and private)
5	To increase community participation in maternal care	5.1	% of Mahila mandal meetings conducted.	5.1.1	To strengthen Monthly Village Health and Nutrition Days	5.1.1.1	% of monthly Village Health & Nutrition Days planned and held

MATERNAL HEALTH							
Sl.	**Strategy**	**Sl**	**Gaps**	**Sl**	**Activities**		
	To make functional PHC (24hr x7days) for institutional deliveries		**Infrastructure**				
A1		1.1	All PHCs are with only six bedded facility.50-60% of facilities are not adequate as per IPHS norms.(List attached, Annexure..)	1.1.1	Need based (Service delivery)Estimation of cost for upgradation of PHCs Selection of any two PHCs for ISO certification in first phase		

		1.2	At present 15 PHC are working with average 25 deliveries per day, 10 FP operation / emergency operations and 300 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	1.2.1	Preparation of priority list of interventions to deliver services.
		1.4	The comparative analysis of facility survey (08-09) and DLHS3 facility survey (06-07) , the service availability tremendously increased but the quality of services is still the area of improvement.	1.4.1	Sending the recommendation for the certification with existing services and facility detail.
		1.5	Lack of equipments as per IPHS norms and also under utilized equipments.	1.5.1	Prioritizing the equipment list according to service delivery and IPHS norms.
				1.5.2	Purchase of equipments
		1.6	Lack of appropriate furniture	1.6.1	Purchase of Furniture
		1.11	Lack of facilities/ basic amenities in the PHC buildings	1.11.1	Renovation of PHCs
	To make functional PHC (24hr x7days) for institutional deliveries	1.12	**As per IPHS norms each PHC requires the following clinical staffs:(List attached)**		
		1.12 .1	The actual position is not sufficient as per IPHS norms List of Human resource is		Selection and recruitment of Doctors on contractual basis and give priority in selection those who are living in same PHC.

			attached in Annexure.	1.12.10.1	Salary of Contractual Grade A nurses 73 Grade A Nurse
				1.12.10	Selection and recruitment of grade A nurses for conducting delivery 3 Grade A nurse for each PHC
					Selection and recruitment of dresser 19 Dresser, one for each PHC
					Selection and recruitment of Pharmacist. 19 x2 Pharmacist for each PHC
					Three month induction training of Grade A nurse under supervision of District level resource team. 100/-per day x 90 days for 86 grade A nurse
		1.13		1.13.1	Training need Assessment of PHC level staffs
					Honorarium of Block Accountants 20 Accountant @ 13200/
					Rent of Data Center 20 Data Center @ 8000/
					Honorarium of BHM 20 BHM @ 19800/-
					Mobility support to BPMU Rs 15000 per month per BPMU
		1.14		1.14.1	Appointment of Family Planning Counselors in all FRUs
					Process of all recruitments

					Trainings of FP Counselors , BHMs and BCMs on Health statistics
					Training on Program, Finance management and HMIS.
			Drug Supply		
		1.16	Irregular supply of drugs because of lack of fund disbursement on time.	1.16.1	Ensuring the availability of FIFO list of drugs with store keeper.
		1.17	Only 38 essential drugs are rate contracted at state level .	1.17.1	2.Implementing computerized invoice system in all PHCs
					Purchase of Drug invoice software Rs 10000 per PHC
			Lack of fund for the transportation of drugs from district to blocks.	1.17.2	3.Fixing the responsibility on proper and timely indenting of medicines (keeping three months buffer stock)
		1.18		1.18	4. Payment from Rogi Kalyan samiti account. Rs 2000 per month per PHC
		1.19	There is no clarity on the guideline for need based drug procurement and transportation.	1.19.1	5. Orientation meetings/ training on guidelines of RKS for operation. Rs 2000 per PHC
		1.2	Drugs are not properly stored	1.20.1	6. Enlisting of equipments for safe storage of drugs.
				1.20.2	7. Purchase of enlisted equipments. Rs 15000 per PHC
				1.20.3	8.training of store keepers on invoicing of drugs Rs 2000 per PHC

			Performance		
		1.21.1	Excessive load on PHC in delivering all services i.e. 10 deliveries per day, 10 FP operation / emergency operation and 250 OPD per day in each PHC.	1.21.1	Recruitment of Doctors on contractual basis
		1.21.2	Total 59 seats of Regular and 51 seats of contractual doctors in the district is vacant.		
		1.22	All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less (only average 23 patients per Doctor per OPD days during April 10-Nov 10, however the IPHS norms says that the OPD should be 40 per Doctor.)	1.22.1	Hiring of rented houses from RKS fund for the residence of doctors and key staffs. Rs 5000 per PHC per month
				1.22.2	Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patient's treatment. Rs 5000 per PHC per month
				1.22.3	Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day
	To make functional PHC (24hr x7days) for institutional deliveries	1.24	All PHCs has installed NBCC, it need to operationalized in future course.	1.24.1	Ensure 24 hrs new born care services in 20 PHCs. Budget in Child health care activity
		1.27	Only five PHCs provide 24 hrs BEmoC services.	1.27.1	Ensure 24 hrs BEmoC services at 10 PHC
					Training of one Doctor from each PHC on BEmoC. Rs 2000/-Per Docter
					Equipments for BEmoC 50000 per facility

		1.29	15 PHC does not have laboratory facilities on PPP based services. But 20 PHCs have T.B lab Technician. In addition to this the regular lab technician has been deputed for this purpose.		1.29.1	Deputation of 17 regular Lab tech at PHC level for providing free of cost lab services to all pregnant women and BPL families.
		1.3			1.30.1	
						Training of TB lab technician on other pathological tests. 1000/-per training
						Purchase reagent (recurring) for strengthening lab. 5000 per unit per month
						Purchase of equipments/ instruments if needed. Fund could be rooted through RKS and if it is not utilized it could be diverted to other women and child friendly activities
		1.33	**Referral Services**			
		1.33.1	No pick up facility for PW or BPL patients. It is propose by end of 2011-12	1.33.1.1	Provision for pick up & drop pregnant mothers and BPL families free of cost using existing Ambulance services at PHC level.	
					Provide EDD list of pregnant women to Ambulance driver and Number of ambulance deriver and 108 /PHC tel. No to all Pregnant women.	

		1.33.3	Lack of maintenance of ambulances	1.33.3.1	Repairing of all defunct Ambulances/ new registration and Insurance of Ambulance. 15 Ambulances @ rs 50000 per Ambulance
					Prepare list of Vehicle those are utilized in Monitoring work in PHC that can be use in pick up and dropping facility for PW.
		1.34	Quality of food, cleanliness (toilets, Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC.	1.34.1	Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate. Rs 50 per patients into 40 patients per day per PHC
					Review of Cleanliness activity in all PHC by Quality assurance committee and payment of agency should be link with it.
				1.34.2	Hiring of workers for cleanliness of OT and Labour room in PHC Two workers per PHC for maximum 30 days @ Rs 100 per day by concerned RKS
					Purchase equipments in all PHC-50,000/each PHC
					Develop mechanism for monitoring of cleanliness work
		1.35	05 PHCs have their own generator sets	1.35.1	Repairing of PHCs gensets and initiating their use. Rs 5000 per PHC
		1.8	Operation of RKS:	1.8.1	Ensuring regular monthly meeting of RKS. Confectionary costs @ Rs 500 per month per PHC
		1.9	Lack in uniform process of	1.9.1	Training to the RKS signatories for account operation. Rs 1000 per participant, Two participants from each PHC

			RKS operation.	1.9.2	Trainings of BHM and accountants on their responsibilities. Rs 1000 per participant, Two participants from each PHC
		1.1	Lack of community participation in the functioning of RKS.	1.10.1	Meeting with community (School children or other)representatives on erecting boundary, beautification etc, 5000/-per PHC
				1.10.2	Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS.
		1.36	In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases.	1.36.1	Meeting in RKS with Local Police Station in charge to handle emergency situation.
					Training local NCC/NYK/Scout & Guide/NSS etc. volunteers on identification of emergency situation. And deployment of volunteers at PHC. 5000/-per PHC
	To make functional PHC (24hr x7days) for institutional deliveries	1.37	Several cases of theft of instruments, computers, and submersible pumps etc at PHCs.	1.37.1	Insurance of all properties and staffs of PHC Rs 10000 per PHC
		1.38	No guidance to the patients on the services	1.38.1	Pictorial wall painting on every section of the building denoting the facilities and attached trained volunteers to guide patients.

			available at PHCs.		Rs 2000 per PHC	
		1.39	Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.	1.39.1	Name plates of Doctors Displaying Name Photograph and DOB of all staff of PHC and put cleanliness staff name on top of the list.	Rs 2000 per PHC
		1.41	Lack of counseling services	1.41.1	There are 22 LHV in the district we can utilize their experience in counseling work of women and adolescent girls after training. 1000 per person	
		1.42	There is no hot water facility for PW and there is no adequate lighting facility at adjoining area of PHC	1.42.1	Installation of solar heater system and light with the help of BDO/Panchayat at PHC or purchase equipments from market. 50000/-per PHC	
		1.43	Lack of convergence	1.43.1	Convergence meeting by RKS & DHS	
		1.44	Lack of timely reporting and delay in data collection	1.44.1	Orientation of the staffs on indicators of reporting formats	

		1.45	Lack of space for waiting, environmental cleanliness around PHC, provision for hospitality etc	1.45.1	Gardening Rs 5000 per PHC
				1.45.2	Sitting arrangement for patients Rs 5000 per PHC
					Construction of patients waiting shade Rs 75000/-Per PHC
				1.45.3	Installation of LCD projector for manage wait over time of OPD patients. Rs 100000/- per PHC
				1.45.4	Installation of safe drinking water equipments/water cooler, Rs 10000 per PHC
				1.45.5	Apron with name plates with every doctors Rs 250 per Doctor for total 185 doctors
				1.45.6	Presence of staffs with uniform and name plates.
	To make FRU functional and up gradation of PHC to CHC for institutional deliveries				
2		2.1	C-Section deliveries are not conducted in institution.	2.1.1	Develop Rosera, Dalsingsarai , Pusa SDH & Refferal Tajpur for C-section facility.
				2.1.2	Training of MOs of three PHCs in multi skilling. 3 Doctors from each PHC @ 2000/-per person
				2.1.5	Specialist should be posted at Sadar Hospital & above mentioned Hospitals.
				2.1.6	Incentive for C-section to PHC those who conducted 10 -15 = 10000,15-20=20000, 25-30= 50000/,C-section in a month the incentive money should be distributed among all staff of the PHC after the decision of RKS. Rs 25000 per PHC per month

				2.1.8	Need based Equipments and drugs in O.T and Labour room. List of Equipments attached (100000 per PHC)
			None of the PHC provides 24 hour blood transfusion services, however two SDH has been provided the equipments for blood storage unit.		Establishing blood storage units at Dalsingsarai, Rosera & Pusa 85000/- Per Hospital
					Training of lab technicians on management of blood storage 3 lab technicians
			Infection control protocols is not at all maintained at all facilities	2.2.2	Licensing blood storage / blood bank
				2.2.3	Meeting infrastructure requirements as per norms for Blood storage 10000 Per PHC
				2.2.4	Training of MO and lab tech/ staff nurse blood storage on grouping /cross matching and management of transfusion reactions stabilized linkages with mother blood bank. Rs 1000 per participant, Two participants from each PHC
				2.2.5	Provide free of cost Blood for pregnant women who need blood transfusion for severe anemia/ PPH on prescribed through RKS Fund

					20000/-for each PHC per month
				2.2.11	Organize Blood donation camps at all institution and mobilize community for voluntary blood donation Rs 10000 per camp per PHC for organizing two camp annually
		2.3	Welcome PW at Institution and PHC and FRU	2.3.1	Provision of food for the delivered mothers and mothers under gone in tubectomy in all the health facilities.
				2.3.2	Mobilize community Resources for providing Free food for PW at Institution.
				2.3.3	Quality indicators (clean environment, wards with clean linen, clean toilets , clean labour rooms, running waters supply, hot water and safe water for inpatients, new born corners, treatment protocols, aseptic precautions, immediate disbursement of JBSY funds
		2.4	Reporting of maternal death Maternal death reporting is usually not reported by worker	2.4.1	Training of ASHA & ANM on reporting of Maternal deaths and conduct Verbal Autopsy Rs 5000 per PHC
				2.4.2	Incentives for maternal death reporting by ASHA @ Rs 50/- per maternal death Rs 50/-per maternal death for approx 300 maternal deaths
				2.4.3	Reporting line should be in five columns – name of mother, place of death, date of death, cause of death and no. of birth.
				2.4.4	Institution and urban center also to report Maternal death to the district CS/ACMO.
				2.4.5	Maternal Death should be reported by ASHA, AWW, ANM Staff Nurse & Doctors to the district data center
				2.4.6	Investigation of maternal death by district team. And third party review(District magistrate)

				2.4.7	Training of ASHA and investigation team objective and process of investigation and review of maternal death Rs 3000 per PHC
		2.5	Biomedical waste management is not properly taken care off at all institution	2.5.1	Procurement of equipment Rs 50000 per PHC
				2.5.2	As per example Introduce color coded buckets for facilities as per IMEP
4	**To strengthen Janani Suraksha Yojana / JSY**	4.1	Tracking of pregnant women from first Trimester is not done form the register.	4.1.1	Review of early registration with 3 ANC checkup, two TT.100/200 IFA Tab. In ASHA Diwas.
		4.2	Too much documentation process. Photo required for mother and baby. It cost Rs.30/- to Rs.60/- .	4.2.1	Ensure 100 % Pregnancy Test Kit is to ASHA and regular supply. Rs 50 for 99000 pregnancies
				4.2.2	Direct transfer of funds from district to PHC through core banking / directly from DHS
				4.2.3	Finger print technology for JSY beneficiaries at facility level where computer with internet facility is available. This will help in financial monitoring.
				4.2.4	The photo system should be replaced by some other alternatives like- bank account opening of pregnant women in first trimister and directaly transfer the money to their account after delivery. Incentive to ASHA for rs 50 per PW for opening of bank account of PW for 99000 pregnancies
5	**To ensure support of SBA**	5.1	Home Delivery is	5.1.1	Home Delivery should be conducted by SBA trained Staff Nurse or ANM.

	at home deliveries		still prevailing through untrained traditional Dai's	5.1.2	Provision of Dai Delivery kit(DDK) to TBA where institution access is poor. And it should be supervised by ANM for home deliveries.
				5.1.3	Delivery kit (equipment, medicine)for ANM should be supplied Rs 10000 per PHC
				5.1.4	Supply of delivery Kits as per number of deliveries conducted in home.
		5.2	Reporting of home delivery is not done so the PNC is not provided	5.2.1	Incentive based system for reporting of home delivery by ASHA and it should be linked with ANM
6	**To strengthen HSC for providing outreach maternal care**	**Infrastructure**			
		6.1	Out of 354 HSCs only 130 are having own building	6.1.1	Strengthening of HSCs having own buildings
		6.2	In existing 130 buildings are running comparatively in good condition, 8 are in under construction, one is very poor condition and one is constructed but not handed over	6.2.1	White washing of HSC buildings. Rs 2000 per PHC
				6.2.2	Organize adolescent girls for wall painting and plantation./hire local painter for colourful painting of HSC walls.
				6.2.3	List out all services which is provided at HSC level. On the wall.
				6.2.4	Gardening in HSC premises by school children.

			to health department.		
		6.3	No one building is having running water and electric supply.	6.3.1	No one HSC are running Water supply but they have hand pump.
					Arrangement of water supply up to HSC (Wiring) from water source Rs 50000 per HSC
	To strengthen HSC for providing outreach maternal care	6.4	Lack of appropriate equipments and ANM are reluctant to keep all equipments in HSC.	6.4.1	Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/) Rs 20000 per HSC having own buildings
				6.4.2	Purchase of equipments according to services
				6.4.3	Purchase one almirah for keep all equipment safely and it could be kept in AWW / ASHA house. Rs 10000 per HSC
		6.5	Non payment of rent of 300 HSCs for more than three years	6.5.1	Strengthening of HSCs running in rented buildings.
				6.5.2	Estimation of backlog rent and facilitate the backlog payment within two months Rs 300 per HSC per month for 36 months(State fund)
				6.5.3	Streamlining the payment of rent from the month of April 09. Rs 300 per HSC per month for 12months(from State fund)
				6.5.4	Purchase of Furniture as per need where building is on rent From untied fund
				6.5.5	Prioritizing the equipment list according to service delivery
				6.5.6	Purchase of equipments as per need

					From untied fund
		6.6	The district still needs 325 more HSCs to be formed.	6.6.1	Required Construction of new HSCs. From State Govt fund
				6.6.2	Preparation of PHC wise priority list of HSCs according to IPHS population and location norms of HSCs
				6.6.3	Community mobilization for promoting land donations at accessible locations.
				6.6.5	Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings.
	To strengthen HSC for providing outreach maternal care	6.7	Non participation of Community in monitoring construction work	6.7.1	Biannual facility survey of HSCs through local NGOs as per IPHS format Rs 200 per HSC biannually
				6.7.2	Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format.
				6.7.3	Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project.
				6.7.4	Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. Rs 20000 per PHC
				6.7.5	Quarterly Meeting of one representative of VHSC/Mothers committees on construction work and other issues Rs 50 for TA to VHSC members for attending monthly meeting at PHC
		6.8	Lack of community ownership in the monitoring	6.8.1	Formation and strengthening of VHSCs, Mothers committees,
				6.8.2	"Swasthya Kendra chalo abhiyan" to strengthen community ownership

			of construction work.		One week Training of Nukkad Natak team on IPHS Rs 300 per participant per day for 85 persons for 7 days
				6.8.3	Nukkad Nataks on Citizen's charter of HSCs as per IPHS Three days performance at 354 HSCs
				6.8.4	Monthly meetings of VHSCs, Mothers committees
7		**Human Resource**			
		7.1	1.Out of 30 sanctioned post of LHVs only 11 are placed, 2.All 312 posted ANM ® are not trained enough to deliver services. 3. 174 seats of contractual ANM and 27 seats of Regular ANMs are vacant.	7.1.1	Selection and recruitment of 174 ANMs Honorarium of 174ANMs @ Rs 6000 per month for 12 months
					Honorarium of existing 312 ANMs Honorarium of existing 312 ANMs @ rs 6000 per month for 12 months
				7.1.2	Selection and recruitment of 28 male workers Honorarium of 28 male workers @ Rs 5000 per month for 12 months
				7.1.3	Training need Assessment of HSC level staffs by BHM in weekly meeting
				7.1.4	Training of staffs on various services in the PHC, Rs 1000 per participant (Total no of participants 174 new ANMs, 312 existing ANMs and 28 new male workers)
	To strengthen ANM Training School for providing regular training of ANMs.	7.2	The ANM training school situated at Sadar Hospital campus, lacks adequate number of	7.2.1	Analyzing gaps with training school
				7.2.2	Deployment of required staffs/trainers
				7.2.3	Hiring of trainers as per need
				7.2.4	Preparation of annual training calendar issue wise as per guideline of Govt of India.

			trainers, staffs and facilities	Field Placement for exposure of HSC services.	
8	**To strengthen HSC for providing outreach maternal care**	**Drug Kit Availability**			
		8.1	No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DECs)and contraceptive	8.1.1	Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports
			No Drug kit for AWCs (@one kit per annum,) . No ASHA kit, only need based emergency but that too being irregular in supply	8.1.2	Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map
				8.1.3	Hiring vehicles for supply of drug kits through untied fund. Rs 200 per HSC per month
				8.1.4	Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) Rs 2000 per PHC
				8.1.5	Hiring of couriers as per need Rs 50 per courier for 200 couriers for 8 days per month
				8.1.6	Payment of courier through ANMs account Fund for the payment of Couriers should be transferred to ANMs account.

9	**To strengthen HSC for providing outreach maternal care**	**Performance**			
		9.1	Unutilized untied fund at HSC level	9.1.1	Training of signatories on operating Untied fund account, book keeping etc Rs 100 per person for two persons for 354 HSCs
				9.1.2	Timely disbursement of untied fund for HSCs Rs 10000 per HSC per year for 354 HSCs
				9.1.3	Assigning a person at PHC level for managing accounts
		9.2	No ANC at HSC level Only 39% PW registered in first trimester PW with three ANCs is 53%, TT1 coverage is 70%,	9.2.1	Identification of the best HSC on service delivery
				9.2.2	Listing of required equipments and medicines as per IPHS norms in facility survey
				9.2.4	Honoring those ANMs who devolve women friendly HSC in given criteria. 5 ANM in a year per PHC social honoring with one shawl.
		9.3	Family Planning Status:-Any method-43.6%,Any modern method-39.8%,No sterilization at HSC level ,IUD insertion -0.5%,Pills-1.5%,Condom-1.9%,Total unmet need is 32.7%, for spacing-14.9,Lack of	9.3.1	Gap identification of 354 HSCs through facility survey
				9.3.2	Eligible Couple Survey
				9.3.3	Ensuring supply of contraceptives with three month's buffer stock at HSCs. State Fund
				9.3.4	One day training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS Rs5000 per PHC
				9.3.5	Training of ANMs on IUD insertion Rs 10000 per PHC

			counseling Skill.		
		9.4	HSC unable to implement disease control programs	9.4.1	Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.(four to five HSC per week)
	To strengthen HSC for providing outreach maternal care			9.4.2	Strengthening ANMs for community based planning of all national disease control program
				9.4.3	Reporting of disease control activities through ANMs
				9.4.4	Submission of reports of national programs by the supervisors duly signed by the respective ANMs.
		9.5	80% of the HSC staffs do not reside at place of posting	9.5.1	Submission of absentees through PRI
		9.6	Problem of mobility during rainy season	9.6.1	Purchasing Life saving jackets for all field staffs 3 units per PHC at the rate of Rs 3000 per unit
				9.6.2	Providing incentives to the ANMs during rainy season so that they can use local boats. From untied fund
		9.7	Lack of convergence at HSC level	9.7.1	Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC. from untied fund
				9.7.1	Monthly Video shows in all schools of the concerned HSC area schools on health, nutrition and sanitation issues. From untied fund
		9.8	Lack of knowledge and skill of	9.8.1	Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc

			field level staffs in data compilation in HMIS formats	9.8.2	Printing of adequate number of reporting formats and registers Discussed earlier
10	**To organize integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas**	10.1	Out reach camps are not organized in plan manner. It is totally based on demand of organization and eventually it is not reported to respective HSCs and PHCs.	10.1.1	Identifying Socially Backward, Slums & Maha Dalit Tolas.
				10.1.2	Hiring trained alternate vaccinator/ retired ANMs and Medical officer .hiring vehicle for fixed day out reach camps with drugs. Rs 10000 per PHC per month
				10.1.3	Fixed day OPD clinics at APHC level and adjoining HSC of respective APHCs. With dedicated MO and support staff.
				10.1.4	To make calendar for camps with date and identified areas. and link NGOs those who are willing to organize Camps .
				10.1.5	Community based reporting system through SMS. involve PRI members and training on reporting and Camp approach
11	**To improve adolescent reproductive and sexual health**	11.1	No training programme for adolescent particularly health and sex.	11.1.1	Multipurpose counselor can be used for adolescent care. For this services of LHV can be used. and calendar of activity could be developed.
		11.2	Preventions of anemia in adolescence girls	11.2.1	Linkage with adolescent anemia control programme in Schools with Unicef. And training to one teacher from the school Rs 5000 per PHC
		11.3	Marriage before legal age.	11.3.1	Sensitization of PRI members particularly women Rs 5000/-Per PHC

		11.4	Preventions of teen age pregnancy and abortion.	11.4.1	Adolescent pregnancy should be addressed with priority care (eclampsia, 3 ANC, anemia, 100 IFA, 100% institution delivery, low birth Wight baby, Brest feeding.PNC with in 48 hours.
		11.6	Limited interventions for empowering adolescent girls	11.6.1	Family counseling for adolescent pregnancy tracking on above mentioned through ASHA and AWW.
				11.6.2	State to develop and issue guidelines for implementation of Kishori Mandals Formation of Kishori Mandals by registration of all girls(11-18 yrs)
	To improve adolescent reproductive and sexual health			11.6.3	Prepare a monthly plan of activities for one day per week
				11.6.4	Counseling nutrition, health and social issues every week at AWCs by AWW
				11.6.5	Weekly distribution of IFA Tablets to out-of-school girls at AWCs From State
				11.6.6	Deworming adolescent every 6 months Purchase of 12lac tablets
				11.6.8	Initiate family schools for learning child care , safe motherhood life skills and Family life education Rs 10000 per Schools each in each PHC
12	**To provide MTP services at health facilities**	12.1	MTP services are not available in Public sectors	12.1.1	Selection of facilities for provision of safe abortion services
				12.1.2	Location of facility availability of trained service provider, space, equipments.
				12.1.3	To Provide appropriate equipments at all facilities and MVA syringes. 50000/-per PHC
				12.1.4	Putting the trained doctors at appropriate facilities to commence the services

				12.1.5	Training of Medical officers and Para medical staffs on Safe abortion services training including awareness about legal aspects of MVA/ EVA and Medical abortion by IPAS. One doctor and one ANM from each PHC @ Rs 2000
				12.1.6	Formation of district level committee (DLC) to accredit private sites as per GOI guide line.
				12.1.7	Develop reporting system of MTP services in private and public sector.
				12.1.8	Through training program make the govt doctors skilled to perform MTP in the approved sites.
	To provide MTP services at health facilities			12.1.9	To Involve community to aware about location of services , process and legal aspects of MTP services through - AWW, ASHA & ANM, LRG and mass media.(IEC) Rs 5000/-Per PHC
				12.1.10	The services of Pregnancy testing should be strengthened and it should be linked with MTP services.
				12.1.11	NGO's and local Practitioner should be involved for counseling and information of facility
				12.1.12	Assurance of privacy and link with family welfare services counseling at all facility.
				12.1.13	Linkage with MTP services with NGOs (PPP) those who are working in Safe abortion services. and create one modal center at district and PHC level.
				12.1.14	Training of ASHA on medical abortion. Incorporated in ASHA training
13	**To strengthen Monthly Village Health Sanitation and**	13.1	Nutrition and Counseling Component is not visible in VHSND	13.1.1	AWC should be developed as a Hub of activities (VHSND)
				13.1.2	Develop an activity plan calendar for VHSND as seasonality.

	Nutrition Days		and there is no monitoring of VHSND activity by Community.	13.1.3	Counseling of mothers on ANC, PNC, preparation for Child care ,STI/RTI, and AYUSH, adolescent Health
				13.1.4	Organize VHSND in Four Table concept regularly where One place is for registration, one is for weighing, one is for immunization and fourth is for counseling Booklet on four table concept @Rs 5 for 10000 booklets
				13.1.4	Meeting of VHSC and preparation for area specific epidemiological planning and community based monitoring.
				13.1.5	Skill development training is required to ANM , ASHA & AWW and Dular (LRG) Rs 5000 per PHC
				13.1.6	Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourished children , New born, DOTs and other services
				13.1.7	SMS reporting system of conducting VHSND and ANM collect Data from field level and compile it in weekly/Monthly formats.
B	**APHC**		**Infrastructure**		
	To form /strengthen APHC in Phase manner	1.3	Out of 45APHCs only 27 are having own building	1.3.1	Registration of RKS
		1.4	Existing 27 buildings are not properly maintained	1.4.1	Renovation of APHCs buildings from RKS Fund Rs 150000 per APHC
		1.5	Non payment of rent of 18 APHCs for more than three years	1.5.1	Payment Of Rent of APHC building From state fund

		1.6	Lack of equipments,	1.6.1	Purchase of equipment as per service need from RKS fund From state fund
		1.7	Lack of appropriate furniture	1.7.1	Purchase of Furniture from RKS fund From state fund
2			**Human Resource**		
		2.1	in the district no any APHC functioning as per IPHS norms	2.1.1	Operationalising one APHC in each PHC by conducting daily OPD by Doctor and support staff.
		2.2		2.2.1	Notification from district for operationaling APHC
3			**Drug Supply**		
		3.1	No drug kit as such for the APHCs as per IPHS norms,	3.1.1	Purchasing 23 listed OPD Drugs of PHC for APHC Rs 200000/- Per PHC for OPD drugs for one year.
5	**RTI/STI services at health facilities**	5.1	No regular clinic at all PHCs & APHCs.	5.1.1	Trained service provider on syndrome management of RTI/STI (As per GOI guide line) up to APHC level. Rs 1000/- for Two person from each PHC
				5.1.2	Logistics of setting of clinics and free drugs availability
				5.1.3	Integrated Counseling services in four public sector facilities by trained personnel.
				5.1.4	IEC/BCC for awareness available RTI/STI services at all health facilities. Rs20000 for Per PHC

Maternal & Reproductive Health:

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

Mother's Meeting

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

Samastipur Socio-economic status, traditional social ills, cultural myths on sex, reproduction and sexuality and a huge population dense of 42 lakh and marginalized people make it extremely vulnerable to reproductive related problems epidemic. In fact, the epidemic has become the most serious public health problem faced by the state.

In Samastipur, 5**3.2%** of women are literate (as compared to 73.09 % of men) with only 30% of Girls enrolled in secondary school. For most women, their low status and lack of education limit them to a life of housework and agricultural labor. The maternal and infant mortality rates are high: 288 out of every 100,000 women and 54 out of every 1,000 infants die during childbirth. These high numbers of death are due in part to the very small number of births attended to by a professional . The great majority of births occur at home with the assistance of a traditional birth attendant, which is always not recorded or registered by the health authority.

Bihar **DLHS-3**	**District : Samastipur**			
Indicators	**DLHS - 3**		**DLHS - 2**	
	Total	**Rural**	**Total**	**Rural**
Marriage and Fertility, (Jan 2004 to 2007-08)				
Percentage of girl's marrying before completing 18 years	51.4	53.1	68.0	68.7
Percentage of Births of Order 3 and above	52.7	52.5	56.2	55.9
Sex Ratio at birth	102	104	-	-
Percentage of women age 20-24 reporting birth of order 2 & above	67.5	68.6	-	-
Percentage of births to women during age 15-19 out of total births	15.8	15.7	-	-

According to reports reproductive health problems account for more than one third of the total burden of disease in women. The records prove that women die every year from complications of pregnancy, including abortion and virtually all these deaths occur in home managed deliveries . The major causes of maternal mortality are anemia, hemorrhage, eclampsia, infections, abortions, complication of obstructed labor.

Most Block of Samastipur District has a heavy burden of reproductive morbidity and mortality. The situation is aggravated by inadequate access to services among marginalized groups. The reproductive health needs of adolescent boys and girls as well as men have not been adequately addressed. The situation with respect to areas covered by reproductive health services - family planning, maternal and child health, safe abortion, reproductive tract

infections, sexually transmitted diseases and gynecological problems of older persons etc. - suggests that there continues to be cause for concern.

Underlying Causes for poor MCH services

On the basis of Focus Group discussions, Participatory assessments, Sector level analysis Team visits to PHC, APHC, Sub Health center certain basic facts emerged which are causal to poor MCH services: -

a) **Availability:** Functioning public health and health care facilities, goods and services as well as programs, have to be available in sufficient quantity & quality mechanisms in place.
b) **Accessibility**: Health facilities have to be accessible to every one without discrimination,. This has four dimensions – 1) Non-discrimination,2)Physical accessibility, 3)Economic accessibility(affordability) and 4) Information accessibility
c) **Acceptability**: All health facilities, goods, services must be respectful of medical ethics and culturally appropriate sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned.
d) **Quality**: Health facilities, goods and services must be scientifically and medically appropriate and of good quality

Systems Level

- Poor staff motivation and inadequate recognition of good performance
- Vacancy of critical positions HW-F , Lady Medical officer in PHC , Gynecologist.
- Workload on ANM is very high maximum time of her goes on meeting and reporting less time available for counseling and home visits or educating the community.
- Poor staff Knowledge and Skills: The staff training is not regular. The knowledge level and skill gap is high. It is higher in HW - F & LHV
- Lack of Supportive Supervision, Supervision is pseudo functional
- Interruptions of health supplies and supplementary nutrition supplies at the peripheral level
- Lack of co-ordination and convergence especially ICDS and Health.

- Lack of Community Participation and demand for quality Health and Nutrition services
- Panchayat role is not active and also institutional effort has not been made yet to involve them at large with Health
- linkages between Government, Community and NGOs
- Poor information available by Systems, under reporting, Poor management and record Keeping

Community Level

- Low literacy level, amongst females restricts awareness about health issues, available services and utilization of those services. There is ignorance around maternal and child health care issues.
- Decision-making rests largely with men and a poor status of women in the society and families largely influence the care and attention mother and newborn would get.
- Under reporting of births and peri-natal and/or neonatal deaths is not registered or followed up. The reasons of Infant death are also not reported. The still birth cases also have low reporting Communities consider maternal and newborn morbidity and mortality as a fairly common phenomenon. There are traditional stigmas/taboos/beliefs associated with such instances, which contribute to neglect.
- The following age-old traditions related to maternal and childcare emerged as an important barrier to positive behavior change. .
- Inadequate access to quality nutrition and health services and information
- Inadequate skills of mother for feeding and caring
- Inadequate time available to the mother due to heavy workload
- Gender inequity

Maternal Health

Maternal Mortality defined as the death of a woman while pregnant with in 42 weeks of termination of pregnancy, irrespective of the duration of pregnancy and site of pregnancy from any cause related to , or aggravated by the pregnancy or its management but not from accidents or incidental causes.

(WHO)

Causes of Maternal Mortality ;-

: Haemorrhage	-	29.7%
: Anemia	-	19%
: Sepsis	-	16.1%
: Obstructed labour	-	9.5%
: Unsafe abortion	–	8.9%
: Toxemia	-	8.3%
: Others	-	8.4%

Maternal Health:				
	Total	**Rural**	**Total**	**Rural**
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	17.0	17.6	-	-
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	23.9	23.9	8.8	8.8
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)#	86.7	86.1	21.6	21.2
Institutional births (%)	27.6	26.9	11.4	10.4
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	3.1	2.6	4.7	4.3
Mothers who received post natal care within 48 hours of delivery of their last child (%)	32.9	33.1	-	-

Some possible reasons for Maternal Mortality: -

- Non-identification of pregnant women at high risk, during health checks ups in pregnancy.
- Inability to convince mother to go to institutions for services.
- Traditional Household customs and practices
- Lack of equipment in Government Health Institutions.
- Vacancy & Lack of Trained Personals in the Health Institutions
- Lack of Blood transfusion facilities..
- Lack of transportation facilities available for referrals.

Maternal Mortality : Causes & Remedial plan.

1. **Social factors affecting MMR**
    - Poverty
    - Illiteracy
    - Ignorance
    - Lack of Women empowerment
    - Gender discrimination
    - Low Mean age of marriage & conception.
2. **Basics factors leading to high MMR**
    - Too early Pregnancies
    - Too frequently Pregnancies
    - Too late Pregnancies
    - Too Many Pregnancies
    - Heavy workload
    - High levels of anemia
    - Poor health care during the entire period, especially last trimester.
    - High risk cases not identified or followed up.

Strategies to prevent Maternal Mortality :

Care During Pregnancy

If pregnant women get even the most basic antenatal care it can make their pregnancy and birth much safer. What is done during an antenatal visit depends on the level of training of the health workers, the equipments and laboratory tests which are available with them, how often the women come to antenatal visits and the health problems, which are common in the area.

Antenatal Problems and Care:

Antenatal care (ANC) refers to pregnancy-related health care provided by a doctor or a health worker in a medical facility or at home. The safe motherhood initiative proclaims that all pregnant women must receive basic, professional antenatal care. Ideally, antenatal care should monitor a pregnancy for signs of complications, detect and treat pre-existing and concurrent problems of pregnancy, and provide advice and counseling on preventive care, diet during pregnancy, delivery care, postnatal care, and related issues. The Reproductive and Child Health Programme recommends that, as part of antenatal care, women receive two doses of tetanus toxoid vaccine, adequate amount of iron and folic acid tablets or syrup to prevent and treat anemia, and at least three antenatal check-ups that include blood pressure and other procedures to detect pregnancy complications (Ministry of Health and Family Welfare)

However, in all cases, antenatal care should aim to:

- Develop a kind and respectful relationship between each woman and the health workers, so that she will attend for antenatal care and be more likely to talk about any problems. She may also be more inclined to accept of any advice given
- Find and treat any illnesses the woman already has
- Identify which women can safely deliver at home and which women are more likely to have complications and should deliver in a health centre or hospital

Explain to women the danger signs that can occur during pregnancy, labour and deliver.

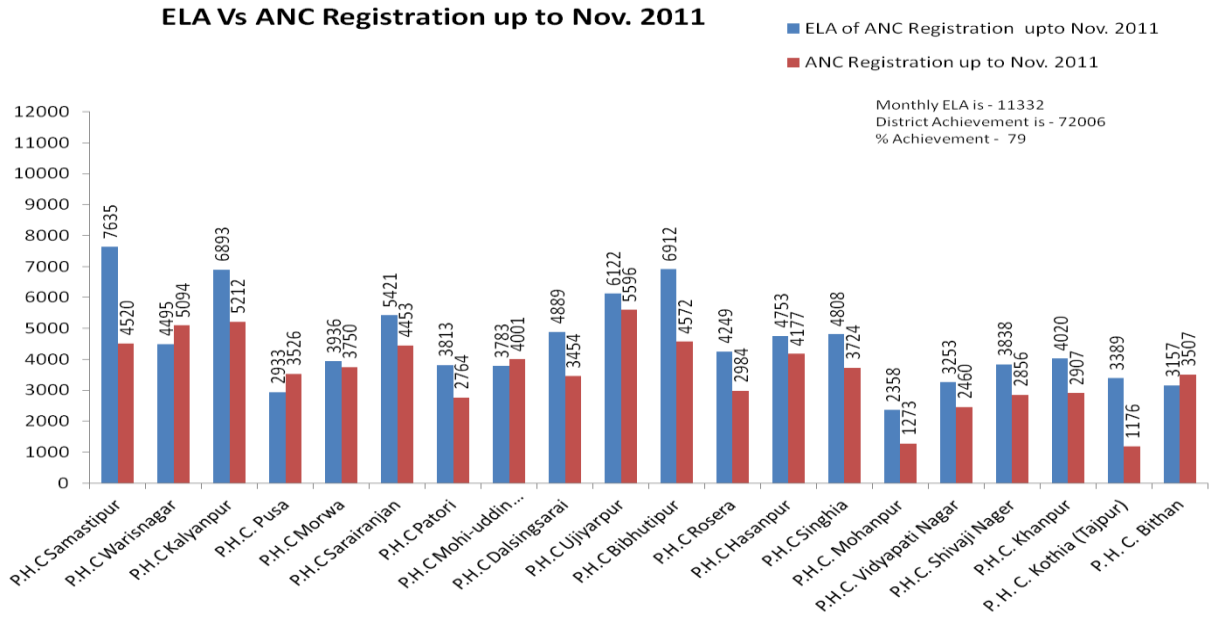
	REPRODUCTIVE AND CHILD HEALTH	
M1	**Ante Natal Care Services ANC**	Samastipur District Apr-Oct 11
1.1	Total number of pregnant women Registered for ANC	65813
1.1.1	Of which Number registered within first trimester	22369
1.2	New women registered under JSY	55867
1.3	Number of pregnant women received 3 ANC check ups	30926

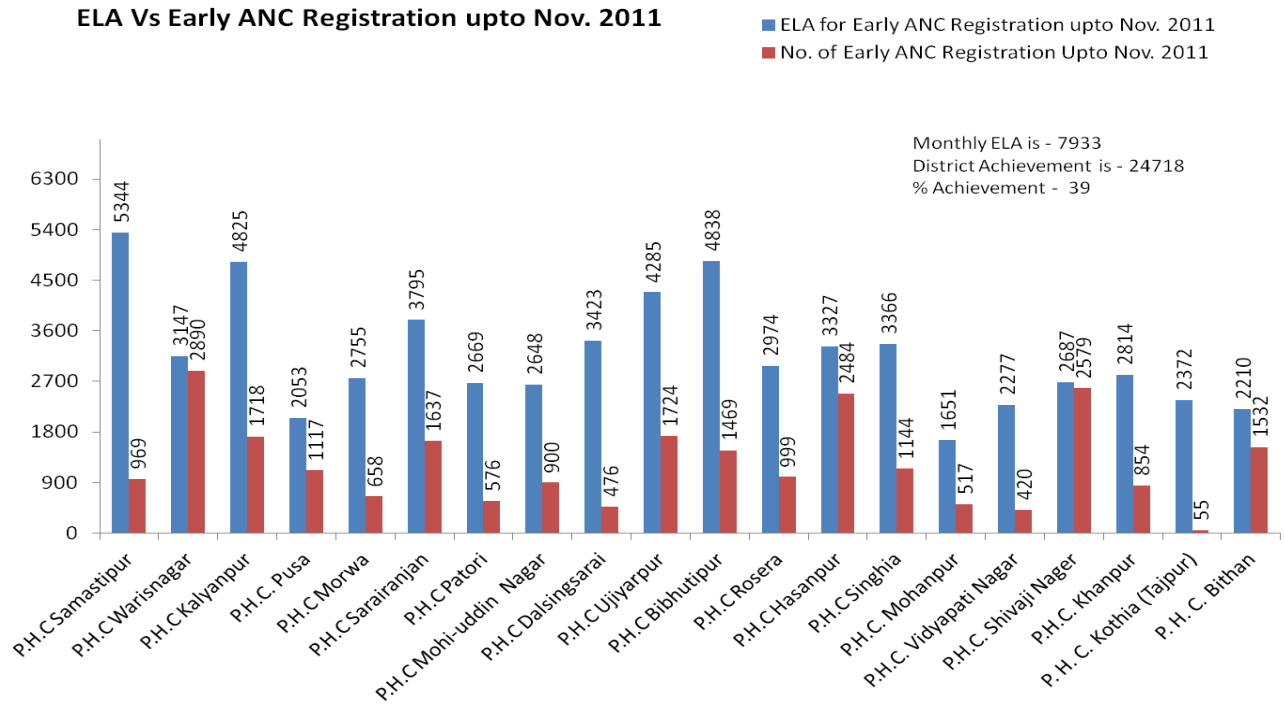
Antenatal visits:

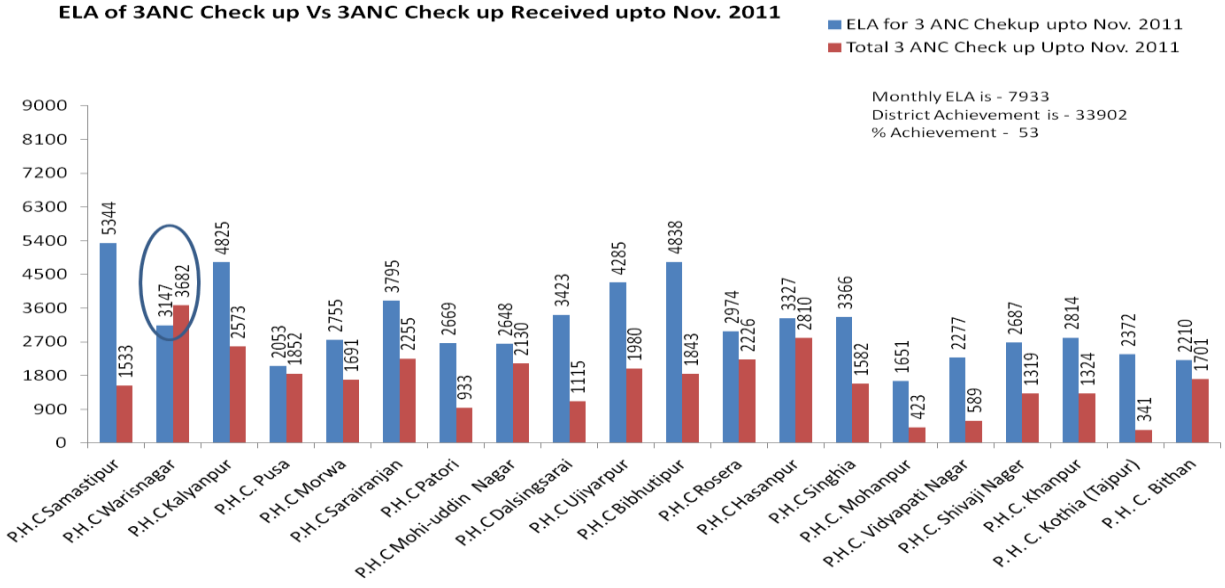
A few antenatal visits for many women are far better than many antenatal visits for a few women. It is difficult to make sure that poor women and rural women get their share of the maternity services. A real effort must be made to reach beyond the urban centers, to reach the women who need care the most. This may require mobile units, or regular visits to areas without health centers and clinics. Aim to give something to everyone; in reality, this may mean only two antenatal visit par woman.

In India, the Reproductive and Child Health Programme includes the provision of at least three antenatal care visits for pregnant women. As per the programme guidelines, each pregnancy must be registered in the first 12-16 weeks (Ministry of Health and Family Welfare, 1997). Accordingly, the first antenatal check-up should take place at the latest, during the second trimester (4th Month) of pregnancy.

When antenatal care is accessible, affordable and respectful, pregnant women do attend. Women should be encouraged to start their antenatal care early in pregnancy. However, in Orissa only the health worker is the source of antenatal checkup and she only does physical checkup in the homes of pregnant mothers, providing routine antenatal care dose of IFA tablets and TT injection and advises. Also more then 30% of village areas are never visited by the ANM, some reasons due to work load, geographical locations, hilly and remoteness.

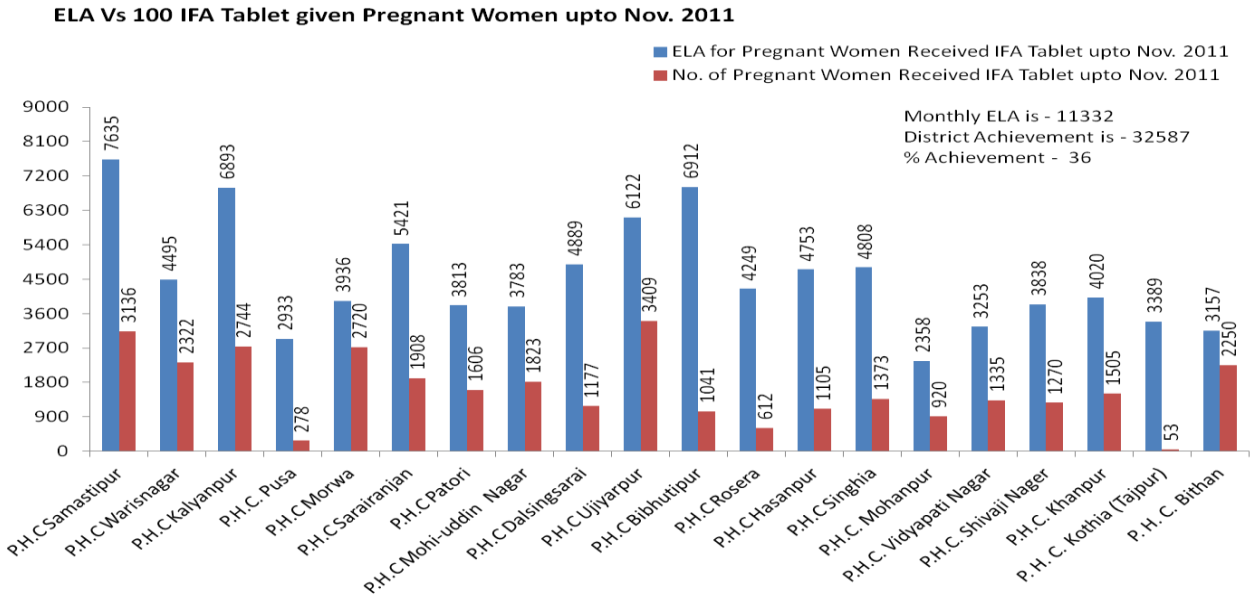



ELA Vs Early ANC Registration upto Nov. 2011
ELA for Early ANC Registration upto Nov. 2011
No. of Early ANC Registration Upto Nov. 2011
Monthly ELA is - 7933
District Achievement is - 24718
% Achievement - 39
6300
5400
4500
3600
2700
1800
900
0
5344 969
3147 2890
4825 1718
2053 1117
2755 658
3795 1637
2669 576
2648 900
3423 476
4285 1724
4838 1469
2974 999
3327 2484
3366 1144
1651 517
2277 420
2687 2579
2814 854
2372 55
2210 1532
P.H.C Samastipur
P.H.C Warisnagar
P.H.C Kalyanpur
P.H.C. Pusa
P.H.C Morwa
P.H.C Sarairanjan
P.H.C Patori
P.H.C Mohi-uddin Nagar
P.H.C Dalsingsarai
P.H.C Ujiyarpur
P.H.C Bibhutipur
P.H.C Rosera
P.H.C Hasanpur
P.H.C Singhia
P.H.C. Mohanpur
P.H.C. Vidyapati Nagar
P.H.C. Shivaji Nager
P.H.C. Khanpur
P. H. C. Kothia (Tajpur)
P. H. C. Bithan


ELA of 3ANC Check up Vs 3ANC Check up Received upto Nov. 2011
ELA for 3 ANC Chekup upto Nov. 2011
Total 3 ANC Check up Upto Nov. 2011
Monthly ELA is - 7933
District Achievement is - 33902
% Achievement - 53
9000
8100
7200
6300
5400
4500
3600
2700
1800
900
0
5344 1533
3147 3682
4825 2573
2053 1852
2755 1691
3795 2255
2669 933
2648 2130
3423 1115
4285 1980
4838 1843
2974 2226
3327 2810
3366 1582
1651 423
2277 589
2687 1319
2814 1324
2372 341
2210 1701
P.H.C Samastipur
P.H.C Warisnagar
P.H.C Kalyanpur
P.H.C. Pusa
P.H.C Morwa
P.H.C Sarairanjan
P.H.C Patori
P.H.C Mohi-uddin Nagar
P.H.C Dalsingsarai
P.H.C Ujiyarpur
P.H.C Bibhutipur
P.H.C Rosera
P.H.C Hasanpur
P.H.C Singhia
P.H.C. Mohanpur
P.H.C. Vidyapati Nagar
P.H.C. Shivaji Nager
P.H.C. Khanpur
P. H. C. Kothia (Tajpur)
P. H. C. Bithan

Nutritional deficiencies & Micro- Supplementation:

Nutritional deficiencies in women are often exacerbated during pregnancy because of the additional nutrient requirements of feotal growth. Iron-deficiency; anemia is the most common micronutrient deficiency. It is a major threat to safe motherhood and to the health and survival of infants because it contributes to low birth weight, lower resistance to infection, impaired cognitive development, and decreased work capacity. Studies in different parts of India have estimated that the proportion of births with a low birth weight (less than 2,500 grams) ranges from 15 percent in Trivandrum to 46 percent in Baroda (nutrition Foundation of India, 1993). Overall, about one-third of newborn children in India are of low birth weight, indicating that many pregnant women in India suffer from nutritional deficiencies. Improvement in a woman's nutritional status, coupled with proper health care during pregnancy, can substantially increase her child's birth weight. To this end, the provision of iron folic acid (IFA) tablets to pregnant women to prevent iron-deficiency anemia, forms an integral part of the safe motherhood services offered as part of the MCH activities of the Family Welfare Programme (Ministry of Health and Family Welfare, 1991), now offered as part of the Reproductive and Child Health Programme. The programme recommendation is that pregnant women consume 100 tablets of iron folic acid during pregnancy.



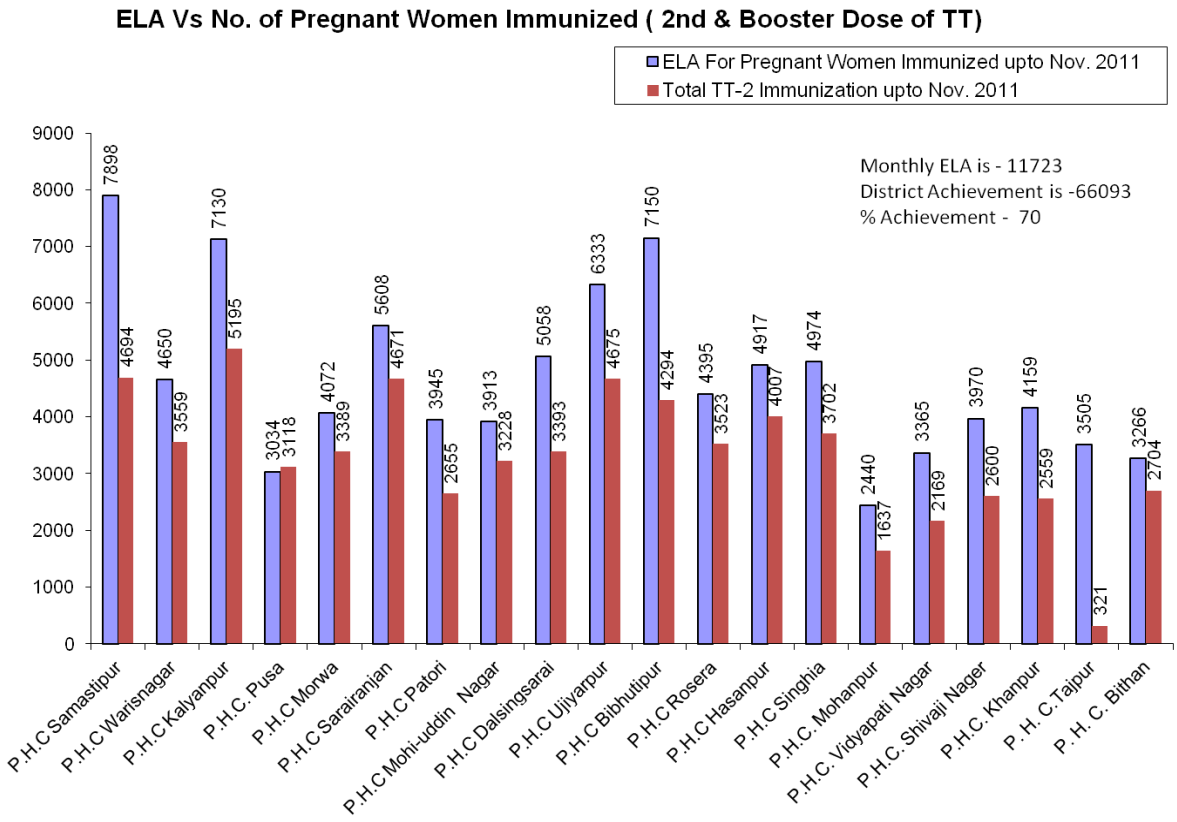
Protect against tetanus Toxoid vaccination:

In Bihar one of the major cause of death of infants is from neonatal tetanus, where newborn infants becoming infected by tetanus organisms, usually at the umbilical stump. Neonatal tetanus is most common among infants delivered in unhygienic environments and when non-sterilized instruments are used to cut the umbilical cord. Tetanus typically develops during the first or second week of delivery is fatal in 70 to 90 percent of cases.

Where expert medical help are unavailable, as is common, death due to neonatal tetanus is almost certain. Neonatal tetanus is however, a preventable disease. Two doses of tetanus toxoid vaccine given one month apart during early pregnancy is nearly 100 percent effective in preventing tetanus both in newborn infants and their mothers. Immunity against tetanus is transferred to the foetus through the placenta when the mother is vaccinated.

1.4	**Number of pregnant women given**	Samastipur District Apr-Oct 11
1.4.1	TT1	56029
1.4.2	TT2 or Booster	58135
1.5	Total number of pregnant women given 100 IFA tablets	35346
1.6	Pregnant women with Hypertension (BP>140/90)	
1.6.1	New cases detected at institution	1360
1.6.2	Number of Eclampsia cases managed during delivery	69

According to the National Immunization Schedule, a pregnant woman should receive two doses of tetanus toxoid injection, the first when she is 16-week pregnant and the second when she is 20-week pregnant (Central Bureau of Health Intelligence, 1991).



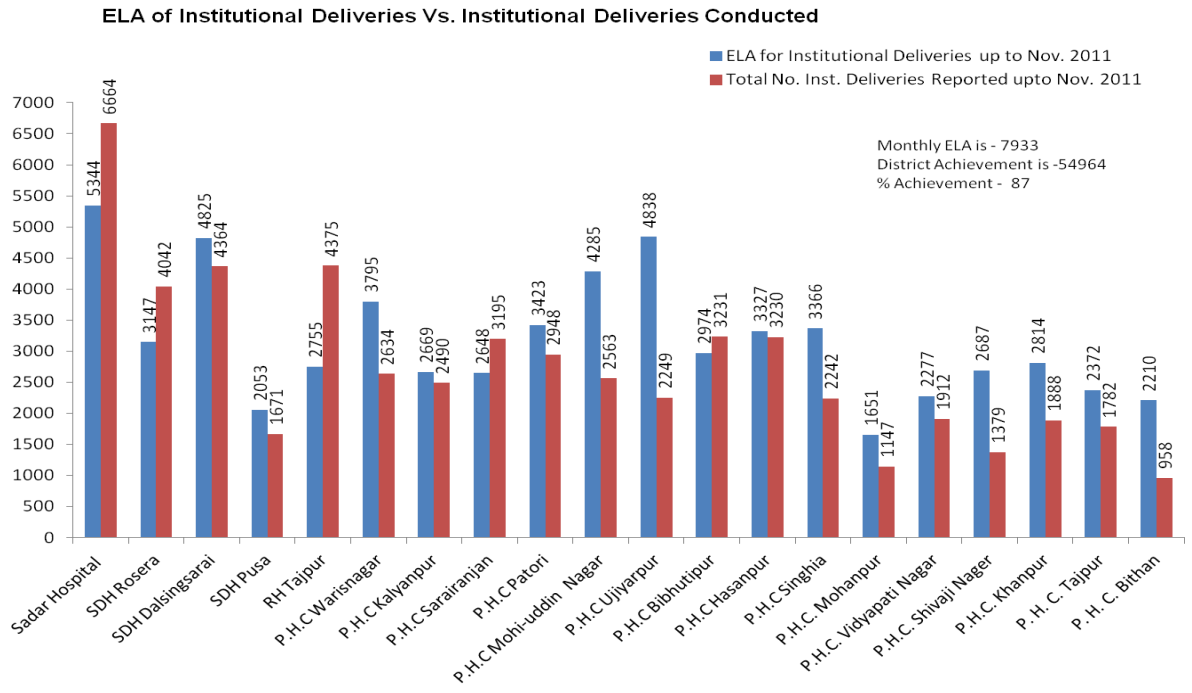
Problem and preparation for childbirth

Many unwanted deaths could be prevented if every pregnant woman were examined after the 36th week of pregnancy to determine the position of the baby. The baby should be lying in the head down position. If the baby is lying sideways, or with the shoulder coming first, somebody who knows how to do this safely should turn it around, or the woman should deliver in a hospital where a caesarean section can be performed. if the baby is lying in the breech position – with the head up – the baby should be turned if possible. Otherwise, the woman should be advised to deliver in a hospital where there is skilled help.

Reasons for advising a woman to give birth in a hospital

- Severe anemia
- Previous postpartum hemorrhage
- Previous delivery by caesarean

- Bleeding towards the end of pregnancy
- High blood pressure
- Twin pregnancy
- Baby's position is not headfirst.



In addition, if a woman is very young (16 or under) and very poor, she is at high risk.

Women who give birth at home still need a skilled helper with them; this could be a trained TBA or a midwife. Even those women who are at no special risk of having a complication during delivery can suddenly develop problems. Many risk factors are mentioned concerning childbirth however, it is not often made clear that the women whose lives are most in danger are those who live in poverty.

Food Consumption and Nutrition status of women

The consumption of a wide variety of nutritious food is important for women's health. Adequate amount of protein, fat, carbohydrates, vitamins, and minerals are required for a well-balanced diet.

The availability, access & purchasing power of communities is extremely fragile to meet the basic requirements to meet the minimum standards. The provisions of supplementary nutrition through the ICDS is the only viable option .

Due to above reasons, nutritional problems are particularly serious for expectant, lactating and nursing mothers, young women, and women from scheduled castes, and scheduled tribes.

Standard of living is negatively related to chronic energy deficiency. Women in households with a low standard of living are more than two and half times as likely to have a low body mass Index compared to women in households with a high standard of living. This results in regular and endemic anemia.

Anemia among women:

A low level of hemoglobin in the blood characterizes anemia. Hemoglobin is necessary for transporting oxygen from the lungs to other tissues and organs of the body. Anemia result from nutritional deficiency of iron, foliate, vitamin B12, or some other nutrients. This type of anemia is commonly referred to as iron deficiency anemia. Iron deficiency is the most wide spread form of malnutrition in the world, affecting more than all women.

Anemia may have detrimental effects on the health of women, and children may become an underlying cause of maternal mortality and pre-natal mortality, and results in an increased risk of premature delivery and low birth weight

Early detection of anemia can help prevent complications related to pregnancy and delivery, as well as child-development problems. Information on the prevalence of anemia can be useful for the development of health intervention programmes designed to prevent anemia, such as iron-fortification programmes.

In India, under the Government's Reproductive and child Health Programme, iron and folic acid tablets are provided to pregnant women in order to prevent anemia during pregnancy. Anemia is a serious health problem in India; pregnant women are considerably more likely to have moderate to severe anemia (34%) than non-pregnant women (16-19%).

1.7	Pregnant women with Anaemia	Samastipur District Apr-Oct 11
1.7.1	Number having Hb level<11 (tested cases)	405
1.7.2	Number having severe anaemia (Hb<7) treated at institution	13

In Samastipur, anemia is the most common and one of the most serious problems among pregnant women. Poverty and unavailability of nutrients attributes as the main cause

Antenatal care :

- Registration of ANC
- Providing ANC at least 3 visits and two dosage TT
- Detection and treatment of anemia referral of high risk cases.

To provide 100 % ANC care our district follow the "*8/8*" Rules- by launching the "*Equip*" technique.

1. Registration
1. Weight
2. Blood Pressure
3. Abdominal Checkup
4. Anemia Detection (*H.B. %)*
5. Infection Treatment
6. Immunization – (*Two dose TT*)
7. Prevention of Anemia by IFA

trition Day

Danger signs during pregnancies :

Though pregnancy is natural physiological phenomenon complication do arise even with best of ANC care. It is therefore important to recognize the danger signs.

1. Bleeding
2. Loss of fetal Movement
3. Weight gain more than 3 kg in one month.
4. High blood pressure
5. Swelling of face and feet.
6. H.B. less than 7 gm %
7. Short women less than 145 cm height
8. Previous caesarean section
9. Previous still birth

M3	Number of Caesarean C-Section deliveries performed at	Samastipur District Apr-Oct 11
3.1	**Public facilities**	
3.1.1	PHC	0
3.1.2	CHC	0
3.1.3	Sub-divisional hospital/District Hospital	75
3.1.4	At Other State Owned Public Institutions	0
3.1.5	Total {(3.1.1) to (3.1.4)}	75
3.2	Private facilities	0

Natal and post-natal Care:

The essential proper care of natal and postnatal can survive the life of both mother and child.

The health of a mother and her newborn child depends not only on the health care she receives during the pregnancy and delivery, but also on the care, she and their infants receive during the first few weeks after delivery. Postpartum check-up within two months after delivery are particularly important for birth that takes place in non-institutional setting. Recognizing the importance of postpartum checkups, the Reproductive and Child Health programme recommends three postpartum visits. This will be done by the AWW, ASHA, TBA & ANM .

Place of delivery:

Another important thrust of the Reproductive and Child Health Programme is to encourage deliveries under proper hygienic conditions supervised by trained health professionals. District has start Training of ANM on SBA to increase skilled birth attendants in institutions but due to the length of Curriculum and available of trainers and institution it is very slow.

2.2.2	**Number of cases where JSY incentive paid to**	Samastipur District Apr-Oct 11
2.2.2.a	Mothers	21398
2.2.2.b	ASHAs	13941
2.2.2.c	ANM or AWW (only for HPS States)	7
2.3	Number of Deliveries at accredited Private Institutions	0
2.3.1	**Number of institutional delivery cases where JSY incentive paid to**	
2.3.1.a	Mothers	270
2.3.1.b	ASHAs	0
2.3.1.c	ANM or AWW (only for HPS States)	0

As far as natal and postpartum complications are concerned, there are many complicacies, which are common in almost all the areas, where the services are negligible. The government has many rules, regulations and schemes but all these are not accessible in times of need. No

expert gynecologist is available not only at the village level but also at PHC, Referral Hospital, and Sub Divisional Hospitals.

In our aim for performing the delivery by 100% either institutional or supervised –

If delivery conduct at home every time use the rules of "*5*" clean

- Clean place
- Clean Hand
- Clean Blade
- Clean Thread
- Clean umbilical cord

M2	**Deliveries**	
2.1	**Deliveries conducted at Home:**	
2.1.1	**Number of Home Deliveries attended by:**	Samastipur District Apr-Oct 11
2.1.1.a	SBA Trained (Doctor/Nurse/ANM)	3021
2.1.1.b	Non SBA (Trained TBA/Relatives/etc.)	4701
2.1.1.c	Total {(a) to (b)}	7722
2.1.2	Number of newborns visited within 24 hours of Home Delivery	4132
2.1.3	Number of mothers paid JSY incentive for Home deliveries	7
2.2	Deliveries conducted at Public Institutions	48029
2.2.1	Of which Number discharged under 48 hours of delivery	23622

(d) C. Postnatal care

The postnatal period starts from delivery of child to 42days. During this period the new mother and baby is vulnerable to a new sets of risks. They are physically weak and need rest and proper nutrition to recover from the labour. Therefore the following supports are necessary for complete restoration of health of mother and baby

(a) Breast feeding

- Starts immediately after birth even before placates out.
- Feed on demand daily day & night.
- Feed should be given every 2-3 hours / 7 times / day
- Do not stop breast-feeding if baby or mother sick.

(b) Nutrition – Need more diet, Iron and vitamins , additional meals & supplementary nutrition from the AWC

(c) Hygiene: Ensure personal hygiene of the mother & child , including minimal handling of the newborn.

After delivery look for the following danger signs

- Fever
- Bad smelling discharge
- Pain in passing urine
- Abdominal pain
- Abnormal behavior
- Painful & swollen legs
- Painful breast.

Postnatal care

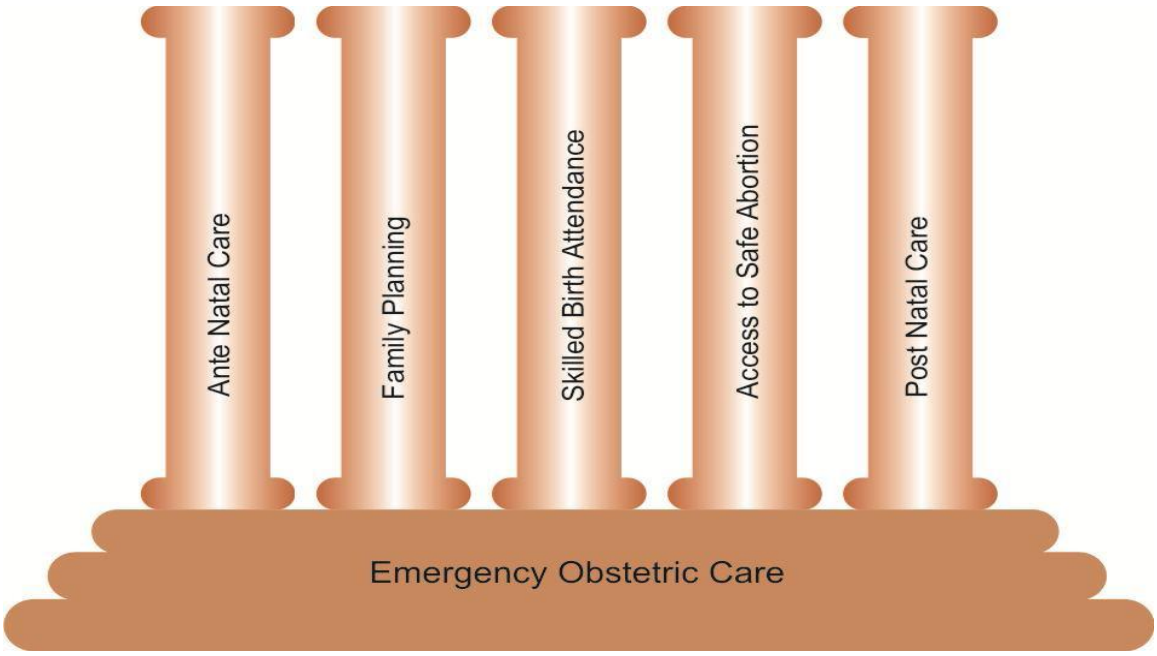
- 3 post natal checkups
- Counseling on family planning, nutrition, breast feeding meaning, immunization

M4	Pregnancy outcome & weight of new-born	Samastipur District Apr-Oct 11
4.1	**Pregnancy Outcome (in number)**	
4.1.1	Live Birth	
4.1.1.a	Male	26799
4.1.1.b	Female	25492
4.1.1.c	Total ({a} + {b})	52291
4.1.2	Still Birth	691
4.1.3	Abortion (spontaneous/induced)	41
4.2	**Details of Newborn children weighed**	
4.2.1	Number of Newborns weighed at birth	37860
4.2.2	Number of Newborns having weight less than 2.5 kg	1408
4.3	Number of Newborns breast fed within 1 hour	34571
M6	**Post - Natal Care**	
6.1	Women receiving post partum check-up within 48 hours after delivery	15762
6.2	Women getting a post partum check up between 48 hours and 14 days	7722
6.3	PNC maternal complications attended	49

Objectives: (For improving maternal health) –

1. To upgrade the all PHC & SDH for obstetric care, appoint the gynecologist & Anesthesia facilities by 2012 in the PHC,. Upgrade Obstetric care and CS facilities in all CHC.
2. Establish a blood bank in SDHS by 2012 & institutional facilities of transportation to FRU - 2012.

3. At PHC level, Surgeon & staff nurse appointment required for emergency deliveries assistance.
4. To improve TT coverage rates up to 100% by 2012 of pregnant women.
5. Establish referral mechanisms from HSC TO PHC/FRU in complicated labour.
6. 100 % registration of Maternal deaths, cause identification & follow up with the deceased.
7. Involve & orient private institutions on emergency obstetric & newborn care.



Strategic Intervention: -

For achieving the above objectives some possible interventions required will be :

1. Ensure early registration & 3 complete ANC.
2. Dietary supplementation - Anaemia , supplementary nutrition from AWC .
3. Prevention of infection & haemorrhage during puerperium.
4. Prevention of complication - eclampsia , mal presentation & ruptured uterus .
5. Treatment of medical conditions - hypertension , TB & diabetes.
6. Tetanus Prophylaxies.
7. 5 clean during delivery and hygiene practice.

8. Promote institutional delivery.
9. Promote Birth spacing.
10. Identification of every maternal deaths and screening for its cause.
11. For upgrade CHC/PHC – Manpower Increase and training for obstetric care during emergency..
12. Maternal deaths could be prevented with the help of training of SBAs.
13. Identification of High Risk Mother- Trained ANM and public awareness needs to be facilitated.
14. Increased use of BCC strategies for complete immunization.
15. High-risk identification by HW-F, facilitating referrals.
16. Maternal mortality registration not hidden because after proper registration we will provide the another services in different level.

Accreditation Scheme for CAC services: *Yukti Yojana*

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

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

following services:

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

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

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

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

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

NEWBORN CARE CORNERS in OT/ LABOUR ROOMS

Delivery rooms in Operation Theatres (OT) and in Labour rooms are required to have

separate resuscitation space and outlets for newborn. Some term infants and most pre-term infants are at greater thermal risk and often require additional personnel, equipment and time to optimize resuscitation. An appropriate resuscitation/stabilization environment should be provided as provision of appropriate temperature for delivery room resuscitation of highrisk preterm infants is vital to their stabilization.

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

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

2. Configuration of the corner

- Clear floor area shall be provided for in the room for newborn corner. It is a space within the labour room, 20-30 sq ft in size, where a radiant warmer will be kept.
- Oxygen, air and simultaneously-accessible electrical outlets shall be provided for the newborn infant in addition to the facilities required for the mother.
- Clinical procedures: administration of oxygen, airway suctioning.

- Resuscitation kit should be placed in the radiant warmer.
- Provision of hand washing and containment of infection control if it is not a part of the delivery room
- The area should be away from draught of air, and should have power connection for plugging in the radiant warmer.

3. Equipments and Renewables required for the Corner

MCH Centers Operationalization

Background:-

The Reproductive and Child Health Plan, strengthened by its integration into the national

Rural Health Mission (NRHM) is the main policy response of the nation to meeting the MDG goals 4 and 5. The NRHM was launched on 12th April 2005 throughout the country with special focus on 18 states. The NRHM operates as an umbrella programme integrating all vertical health programme and various disease control Programmes. The National Rural

Health Mission has led to substantial investment and attention to revitalising public health systems, with strengthening of community processes, increase in deployment of skilled human resources and improved management and local planning. Quality of antenatal and postnatal care has been strengthened, with the ASHA (woman community health worker) providing support for increased utilization of all RCH services. One important new component of RCH-NRHM that has made a major difference is the introduction of a conditional cash transfer scheme called Janani Bal Suraksha Yojana (JBSY). This scheme has led to a huge increase in institutional deliveries within just four years, the number of beneficiaries rising from 38 thousand lakhs per year in 2005-06 to over 13 lakhs in current year. Today this scheme accounts for 47% of expenditure under reproductive and child health.

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

To achieve the targets for maternal and child survival by 2012 and 2015, and in view of the recommendations made in the Mid Term Appraisal Report of the Planning Commission, the

Ministry of Health and Family Welfare has now mooted a five-pronged strategy with the following key elements-

Focusing on high focused districts (36 districts) except Patna. Munger, which account for a major proportion of the infant and maternal deaths and have a high TFR for planned facility development that would provide universal access to quality health care and supplement these with community health workers in home-based care;

- Improving quality of the facilities where institutional deliveries are being conducted referred to as MCH facilities- in accordance with the standards laid down in the Maternal and Newborn Health Operational Guidelines and in the Indian Public Health Standards;
- Developing a referral transport system that ensures universal access to these select facilities chosen for development as MCH centres providing quality care.

- Providing an additional package of incentives for those facilities notified by a joint mechanism of centre and state as Inaccessible, Most Difficult or Difficult.
- Strengthening supportive supervision and capacity building in these 36 districts by placing trained public health nurses.
- Re-formulating the financing of these services based on results and performance based so as to ensure all key partners-the beneficiary-clients, the health providers and the health facility managers are all appropriately incentivized to maximize the outcomes.

Services Packages at Different Levels

Level 1 facility –Skilled Birth Attendance:

Maternal Health

- ANC Package-Registration (within 12 weeks), Physical Examination, Identification of referral for danger signs, IFA for Pregnant and anaemic women.
- Delivery Package-Normal Delivery with use of Partograph, ANTSL, Infection Prevention,
- Pre referral Management for obstetric Emergencies.
- PNC Package-Minimum 6 hrs post delivery stay; Home visits for PNC check up Safe abortion Services-Counselling and Facilitation

New Born Health

- Newborn Resuscitation, Warmth, Infection Prevention, Support for Breast feeding initiation,
- Weighing, Care of LBW<2500gm and referral of sick newborn

- RTI/STI Management
- Counselling and Referral

Family Planning Services

- Emergency Contraceptive pills, Counselling and motivation for small family norm,
- Distribution of OCP, Condoms, IUD insertions, Follow up of beneficiaries.
- "Assured" referral systems to higher facilities
- Complete Immunisation
- Counselling for feeding, Nutrition, Family Planning, Immunisation
- Human Resources: Minimum Two Skilled Birth Attendants-midwives

Level 2 facilities- Basic Obstetric and Newborn Care All services as in Level 1 PLUS

Maternal Health

- ANC Package-Blood grouping, RH typing, RPR/VDRL, linkage with nears ICTC/PPTCT.
- Delivery Package-All complication management other than those requiring Blood
- transfusion and survey: Episiotomy and suturing cervical tears, Assisted vaginal delivery,
- Stabilisation of patients with obstetric emergency requiring surgery before referral
- PNC Package- Minimum 48hrs post delivery stay, Stabilisation of mother with Post natal
- complications
- Safe abortion Services-MVA up to 8 weeks-desirable services as per MTP Act, Medical
- Methods up till 7 weeks with referral linkages.

New Born Health

- Antenatal Corticosteroid to mother in case of preterm babies, Care of LBW>1800gms and other newborn complication referral where appropriate, Vit K to premature babies, Sepsis
- Management
- RTI/STI Management
- Identification and management, Wet Mount Referral linkage to ICTC
- Family Planning Services
- Desirables-Male sterilization-NSV, Tubectomy, IUD insertion
- "Assured" referral transport linkages to higher facilities
- Human Resources: One of two Medical Officers, three to 5 nu4rses of midwives with SBA training.

Level 3 facilities- Comprehensive Obstetric and Newborn Care All services in Level II PLUS

Maternal Health

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

New Born Health

- Care of sick newborn, Management of LBW babies less than 1800gms
- RTI/STI Management
- Identification and management, Desirable- ICTC/PPTCT services
- Family Planning Services
- Male sterilization-Non Scalpel Vasectomy, Female Sterilization: Conventional Tubectomy,
- Minilap, Laproscopic Tubectomy, All other FP services as mentioned in Level 1 and Level 2 Plus Management of complications.
- Human Resources: An obstetrician, an anesthetist and a pediatrician...or medical officer with short term
- No of MCH Centers Operationalized in the year 2011-2012

Sl No	Level	Facility	Total
1	Level-1	2 HSC+1 APHC	17
2	Level-2	All BPHC	14
3	Level-3	All FRU (SDH+DH+RH)	6
		Total	37

Child Health: Situation Analysis:

4.4 Chid Health							
Logical Framework							
Sl.	Goal	Sl.	Impact indicators				
1		1.1	Reduction in IMR and Under 5 Child Mortality				
	To improve Child health & achieve child survival	1.2	Child performance in the Pre school - enrolment, attendance and dropout				
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
1	To increase ORS with Zinc distribution and usage from 20.9% (DLHS3) to 50%	1.1	% increase of ORS with Zinc distribution and Use.- 50%	1.1.1			% of PHC initiated IMNCI and HBNC training.
2	To increase treatment of diarrohoea from 84.9% to 90% within two weeks		% increase of treatment of diarrohoea within two weeks- 90%				
3	To increase treatment of ARI/Fever in the last two weeks from 78.9%(DLHS3) to 90%		% increase of treatment of ARI/Fever in the last two weeks		*IMNCI,Home Based Newborn Care/HBNC*		

4	To increase of infant care with in 24hr of delivery from 29.7% (DLHS3) to 50%		% increase of infant care with in 24hr of delivery.		Strengthening of Facility Based Newborn Care/FBNC and trained workers on using equipments.		No of PHC initiated FBNC with trained MAMTA on facility based new born care..
5	To increase % of breast feeding from 33.8% to 80% within 1 hr of birth .		% increase of breast feeding within 1 hr of birth.	1.1.2	Infant and Young Child Feeding/IYCF		No of training organized in PHC on IYCF
6	To increase initiation of complimentary feeding among 6 month of children from 88.3% to 90%		% increase of complimentary feeding among 6month of children.				
7	To increase exclusive breastfeeding among 0-6 month of children from 36.4% to 80%		% increase of exclusive breastfeeding among 0-6 month of children.				
8	To increase immunization coverage from 80 to 100 %		% increase of full immunization coverage.				
9	To increase vit A coverage of received at least one dose (9 month to 35 months) from 67.3% to 90% and include up to 5 years.		To increase Vit A reported adequate coverage among (9m to 5ys)	1.1.3	Management of diarrhea, ARI and Micronutrient Malnutrition through Child survival months		Two round of Child survival Month organized in one financial year.

10	To decrease Malnutrition form 58% (NFHS III state) to 30% of the age group of (0 to 5 yrs)		% of decrease Malnutrition age group of (0 to 5 yrs)	1.1.4	Care of Sick Children and Severe Malnutrition and strengthen VHND at all AWCs		No of VHND organized vs Planned.
		2.1		2.1.1	School Health Programme		No Of school health programme organized in the PHC
Sl.	Strategy		Gaps		Activities		
	IMNCI, Home Based Newborn Care/HBNC		*Training Gaps(AWW-2328 /2476, ASHA-0,ANM-377/401,MPW-11/83,MO-47/146,CDPO-05/16,ICDS Super-05,Health supervisors-27,NGOs-06)* *No ASHA is trained on IMNCI*		*Assessment of Training load and prepare calendar of training*		
					Incorporate ASHA in IMNCI training team		
					ASHA kit regular supply and incorporate use of ASHA Kit in training curriculum.		
			Inadequate monitoring of this activity at field level		*Division of area among all trained supervisors for revision of IMNCI activity in their area.*		
					BHM will be responsible for review of health supervisors and LS(ICDS)on given format. Unicef staff will support in developing review mechanism in PHC.		
					Incorporate IMNCI reports in HIMS format		
					Encouraging mother regarding child care. in VHND		

					Frequent checkups of babies by Pediatrician. *Distribute telephone number to AWW and ANM of respective doctors those who are supervising them in the field.*
					Wednesday could be fixed a day for IMNCI related work at HSC level
					Community based Monitoring support system develop with SHG in one PHCTraining of Group membersseed money to SHG for referral services and other need based services. Rs 100000 for one PHC
	Facility Based Newborn Care/FBNC		only eight institutions have baby warmer machines but maintenance of machine is not up to the mark and district having referral six bedded SNCU		All PHCs should be equipped with baby warmer machines. Mobilizing nine units from UNICEF
			ANMs and Doctors are not trained to operate these machines		Training of Doctors and ANMs to operate baby warmer machine. Rs 5000/- for demonstration at District level
			There is no provision of stay of mothers of neonates at PHC.		Organize training program for newborn care for the nurses in the district hospitals One Nurse from each PHC Cost will be 5000/-
			Neonatal Care Unit not up to mark.		District level Supporting supervisory team should be developed with the responsibility of non functioning of neonatal care unit. Training of team on monitoring of NCU Rs.5000/-for one time training

					Colostrums feeding and breast feeding inclusively for six months. Through IMNCI Training.
			Non awareness of breast feeding and proper diet of young children.		Baby friendly hospital Training of one doctor from each Nursing hospital at District Level Rs.20000 for training program
					Two days training of one staff nurse from each private hospital on counseling skill. Rs 20000/- for training program
					Accreditation of nursing home and facility according to norms of baby friendly hospital initiatives
	Infant and Young Child Feeding/IYCF		Poor knowledge regarding new born care and child feeding practices		Development and Printing of BCC materials Rs 5 per unit for 10000 units
					Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA
					Linking JBSY with colostrums feeding
			Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding		Counseling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries in mothers meetings and VHSCs meetings
					Folk performance to promote exclusive breast feeding Included in maternal health
					Uniform message on radio from state head quarter State budget
			Lack of awareness on importance of appropriate and		Organize social events through VHSCs

			timely IYCF		Strengthening of *Mahila Mandal* meetings-fortnightly with involvement of adolescent girl
					Organize healthy baby shows, healthy mother / pregnant woman. Rs 2000 per month per PHC
					Appreciation and reorganization of positive practices in community. For this purpose hiring a documentation specialist. Rs 100000 for the whole district on community wise sample basis
					Demonstration of recipes. Rs 250 per month per AWC(Under MUSKAN program)
					Exposure visits to existing NRCs to observe different models in the country Rs 50000 for the district
	Care of Sick Children and Severe Malnutrition		There in only one Unit of Severely Malnourish children with 20 child each batch per month need to increase the unit looking in to the Malnutrition %.		Establish rehabilitation center in, FRU and one PHC and promote locally available food formula for nutritional Therapy as Hyderabad Mix Rs 1000000 per unit
	Management of diarrhea, ARI and Micronutrient Malnutrition		There is high prevalence of PEM and anemia among children because of Child nutrition is least priority among service providers.		Procurement of ,ORS , Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup. 100000 ORS packets at the rate of Rs 5 per packet.(If ORS is not provided in Kit A)IFA syrup for 800000 children at rate of Rs 4 per children
					Include coverage of Vitamin A and IFA, children in New HIMS format.

					Insure two rounds of Vitamin A and de worming for the age group of (9m to 5 yrs) & (2 yrs to 5 yers) respectively in the month of April And Oct as per GOI guide line. Rs 1500000 per round into two rounds(If Vit A is not provided in Kit A)
					Involvement of ICDS, school teachers and PRI for monitoring and evolution
	School Health Program		No Pre School Health checkup & complete Immunization card.		Half yearly health checkup camp for children in schools should be organized. Rs 2000 per PHC
			No training of school teacher for basic health care and personnel hygiene.		Training of school teacher by the medical personnel with support of administrative person. Budget incorporated in adolescent health
			No regular health checkup camp at school.		Quarterly meetings of VEC representatives by attending existing meetings of VECs representatives at block level by the concerned MOI/Cs and BHMs.
			No Training & Screening of school's teacher for eye sight test.		Linking existing 7 ophthalmic paramedics with this program and developing school wise calendar. Mobility support of Rs 10000 per PHC for moving other blocks and hard to reach areas.
			No other specific program has been formulated in the district.		School health anemia control program should be strengthened with biannually de worming. Budget incorporated in adolescent health
					Organizing competitions/Debates/Painting competitions/Essay/demonstration and model preparation of nutritional food and health. Rs 20000 per PHC
					Half yearly Health checkups and health card of all school going children.

					Printing of Health Card at the rate of Re 1 per card for the children of class 6 to 10
					Films shows on health, sanitation and nutrition issues Use LCD projector in this activity.
					Social science Lab activities. Included in adolescent health
					Rally and Prabhat Phery in epidemic areas. (Kala-azar & Malaria) Local contribution/ Untied Fund/VHSC
					Referral system for the school children for higher medical care. From RKS fund

Promoting Child Survival & Health:

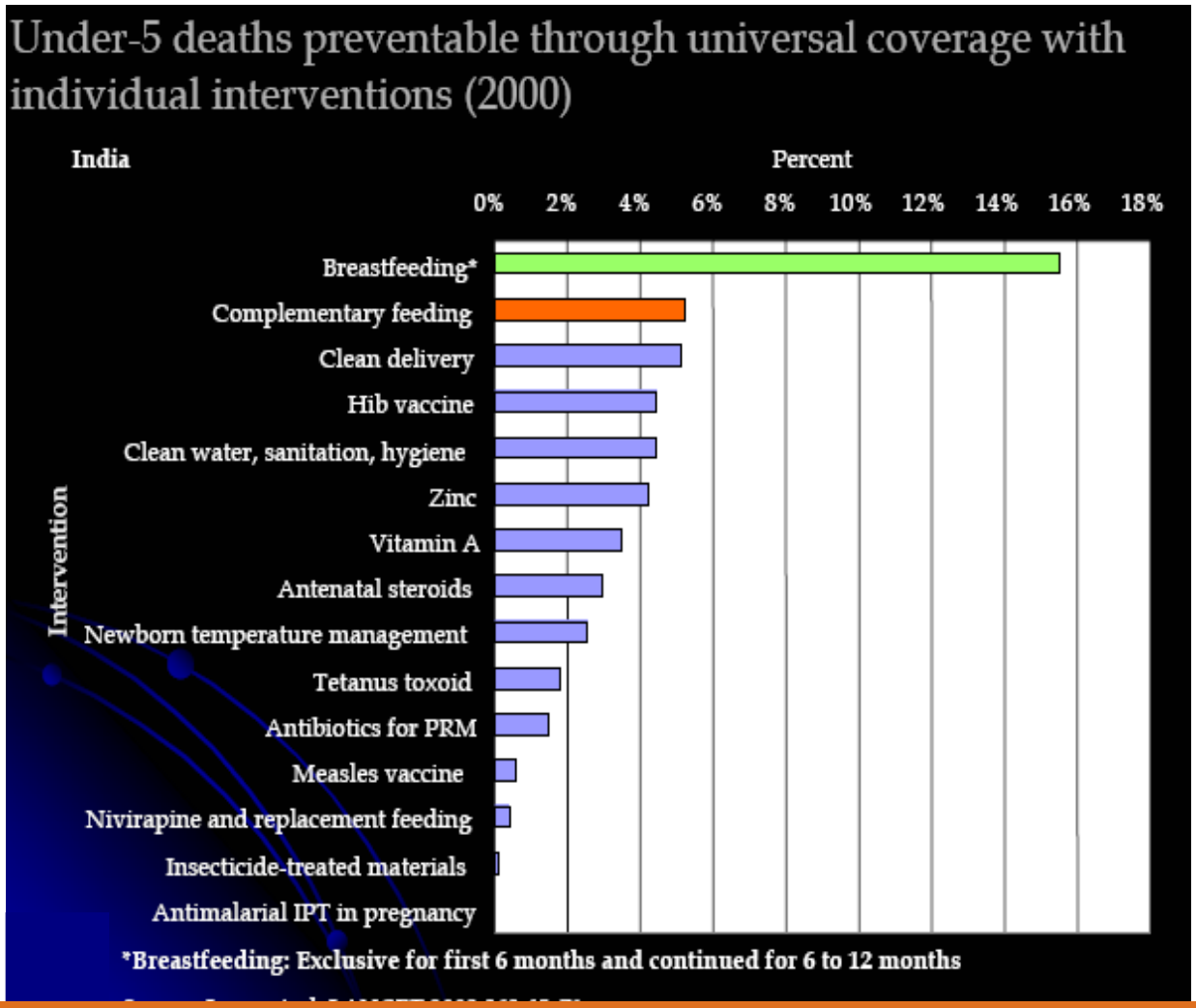
To address Child Survival & Health, addressing the issues from birth, effective planning during the newborn period is critical. Nearly three-quarters of neonatal deaths could be avoided by simple interventions, these include Tetanus Toxoid vaccinations for pregnant women, promoting clean delivery, prompt and exclusive breastfeeding, extra care for low birth- weight babies, and antibiotics for neonatal infection.

VHSND Growth Monitoring

The plan emphasis's that combining interventions into packages, which are delivered within existing maternal care and child survival programs of RCH . Despite the availability of cost-effective interventions to prevent neonatal mortality, coverage of many of these interventions is low.

"Early success in preventing neonatal deaths is possible, even in settings with high mortality and weak health systems, by improving home care practices, raising demand for skilled care and increasing care-seeking for illness through outreach services and a family-community care package.

"However, for child survival, steps need to identify by strengthening and expanding clinical care for both mothers and babies."


Under-5 deaths preventable through universal coverage with individual interventions (2000)
India
Percent
0%
2%
4%
6%
8%
10%
12%
14%
16%
18%
Intervention
Breastfeeding*
Complementary feeding
Clean delivery
Hib vaccine
Clean water, sanitation, hygiene
Zinc
Vitamin A
Antenatal steroids
Newborn temperature management
Tetanus toxoid
Antibiotics for PRM
Measles vaccine
Nivirapine and replacement feeding
Insecticide-treated materials
Antimalarial IPT in pregnancy
*Breastfeeding: Exclusive for first 6 months and continued for 6 to 12 months

CHILD HEALTH

High levels of maternal malnutrition and low levels of female literacy, particularly in rural areas increase risk of child mortality. Failure of family to properly plan their family in matters related to delaying and spacing of births leads to significantly high mortality among children. Failure of programme to effectively promote breastfeeding immediately after birth and exclusive breastfeeding is yet another factor affecting IMR. A high level of child malnutrition, particularly in rural areas and in children belonging to disadvantaged groups adds to the problem. The Anganwadi centre and Sub Centre often lacks drugs, ORS packets, weighing scales, etc. The plan for child health takes these factors into consideration.

Objectives

· To reduce IMR

· To reduce child mortality rate

· To reduce malnutrition among children

· Mamta Training

· To reduce the prevalence of anaemia among children

Essentials of Infant/Child Health & Survival

- Promotion of essential newborn care at the household level, referral care of weak & sick neonates & infants.
- Child health prevention of childhood infections, diarrhea, malaria and ARI, immunization and micronutrient supplements.
- Communication campaign conducted and lactating counseled women were benefits of breast-feeding.
- Nutritional monitoring & focus on growth promotion in all growth faltering cases. Strengthening the capacities of ICDS frontline workers to operationalise the Essential Nutrition package : Exclusive Breast feeding , Appropriate Complementary feeding with continued breastfeeding, Adequate nutritional care during illness & severe malnutrition , Adequate intake of Vitamin-A (5 doses), Adequate iron intake and Adequate iodine intake.

- 100% immunization including the booster dose by strengthening sub-center level services and its supervision.
- Prompt and appropriate community level care all sick children and neonate and prompt referral where indicated.
- Cent Percent usage of ORS with Zinc in the treatment of Childhood Diarrhea.
- Regular House visit and counseling by community level care givers fro preventive and promotive health of children and reduction of child malnutrition.
- Adequate referral arrangement and secondary care facilities for sending a sick child or neonate when it requires hospitalization.

NBCC @PHC Ujiyarpur

Activities:

1. Home based neonatal care will be done by ANM of respective HSC. This will be monitored by LHV
2. Build state IMNCI training pool – inadequate monitoring of this activity at field level is an issue. Local Resource Persons can be roped in to ensure community based monitoring.
3. Care of babies by "MAMTA" and ANM needs to be ensured. Training of MO and staff nurse in IMNCI / operation of baby warmer machines. Fixing a day in a week for IMNCI related work at HSC level.
4. (Re) train health and ICDS staff in IMNCI protocols
5. Ensure implementation of IMNCI clinical work following training

6. Community Awareness on home-based care of new born (skin-to-skin contact, bathing after a week, not removing vermix, etc.); early recognition of danger signs - ARI, diarrhoea; proper weaning practice
7. The ASHAs / MPWs / AWWs at every point of contact for ANC and PNC will reinforce tenets of home-based care of new born as per IMNCI guidelines. The training will be part of IMNCI.
8. Capacity building in the area of facility Based newborn care

Nutrition in Action:

Infant feeding Practices:

Infant feeding practices have significant effect on both mother and child. Mother is affected through the influence of breast-feeding during the period of postpartum infertility, and hence on fertility levels and the length of birth intervals. These effects vary both the duration and intensity of breast-feeding.

Proper infant feeding, starting from the time of birth, is important for the physical and mental development of the child. Breast-feeding improves the nutrition status of young children and reduced morbidity and mortality. Breast milk not only provides important nutrients but also protects the child against infections. The timing and type of supplementary foods introduced in an infant's diet also have significant effects on the child's nutritional status.

Initiation of breastfeeding immediately after childbirth is important because it benefits both the mother and the infant. As soon as the infant starts suckling at the breast, the hormone oxytocin is released, resulting in uterine contractions that facilitate expulsion of the placenta and reduce the risk of postpartum hemorrhage. It is also recommended that the first breast milk (colostrums) should be given to the child rather than squeezed from the breast and discarded, because it provides natural immunity to the child.

Nutritional Assessment District Consolidation of Under – 5 Children:

		Normal		Grade-1		Grade-2		Grade-3&4		Weigh of children	
		Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
1	Ujiarpur	775	715	905	896	1955	1949	950	895	4585	4455
2	Tajpur	0	0	2280	2170	2858	2853	912	912	6050	5935
3	Khanpur	220	220	365	275	210	317	102	70	897	882
4	Bibhutipur	12810	12429	3949	3980	4599	4664	1362	1362	22720	22435
5	Singhia	1155	1118	3060	1596	2326	2536	1135	1536	7676	6786
6	Kalyanpur	0	0	3023	3021	4155	4114	2849	2842	10027	9977
7	Bithan	1470	1238	1314	1144	1162	898	409	485	4355	3765
8	Rosera	4347	4192	4305	3859	4196	3759	1820	1709	14668	13519
9	Mohanpur	0	0	2989	2981	498	512	33	27	3520	3520
10	Morwa	0	0	1078	1084	1466	1658	941	1183	3485	3925
11	Mohiudian Nagar	0	0	4760	4810	797	766	53	74	5610	5650
12	Samastipur	2118	1731	3608	2995	3280	2689	3365	2774	12371	10189
13	Patory	1425	1282	1818	1564	1803	1595	830	838	5876	5279
14	Hasanpur	0	0	3410	3400	2285	2577	1099	796	6794	6773
15	Vidyapatinager	0	0	884	2864	2776	5932	1114	2059	4774	10855
16	Pusa	0	0	1419	902	1313	1160	635	601	3367	2663
8	Shivajinager	0	0	4520	3178	3199	3101	827	1073	8546	7352
18	Dalsingsarai	0	0	0	0	0	0	0	0	0	0
19	Warishnager	0	0	430	655	343	419	267	243	1040	1317
20	Sarairanjan	0	0	3842	5451	2583	3337	3973	3553	10398	12341
	District	24320	22925	47959	46825	41804	44836	22676	23032	136759	137618
	Percentage	17.78	16.66	35.07	34.03	30.57	32.58	16.58	16.74		

Prevalence of mild & chronic malnutrition is mainly due to

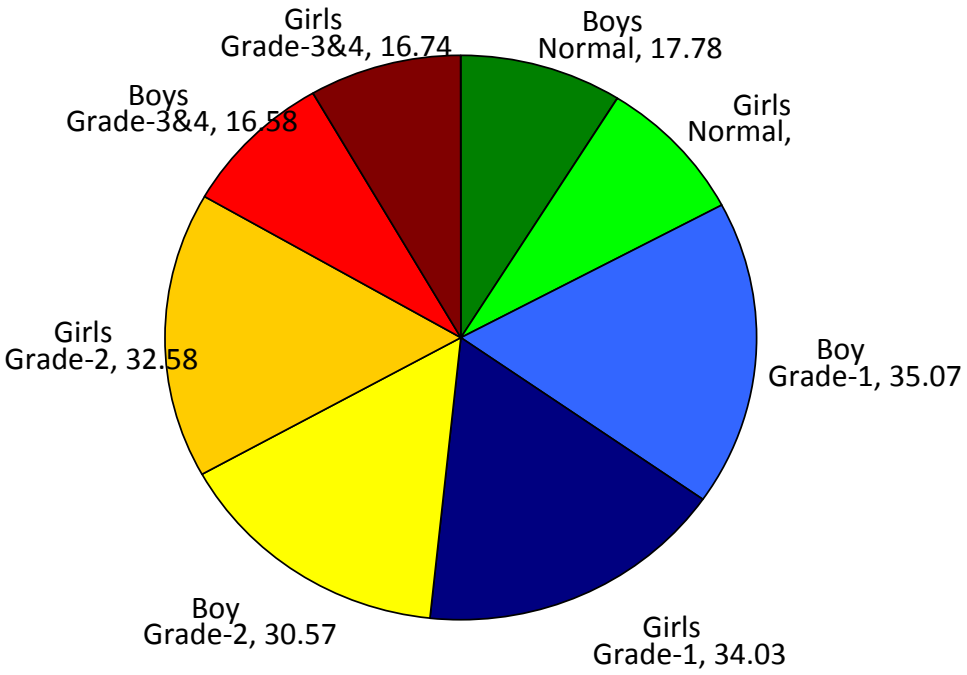
- Lack of caretakers' knowledge about nutrition.
- Cultural habits of feeding children, delayed initiation of appropriate complimentary feeding. Gaps in the Frequency, Amount, Density & Utilization levels (FADU) appropriate complimentary feeding practices.
- Low nutrition status of pregnant and nursing mothers
- Poverty (difficult to feed children with adequate nutritious food)
- Inadequate knowledge and skills of HW-M & F on nutritional counseling.
- Less awareness and knowledge of the AWW in providing nutrition services and health education.
- Lack of knowledge of the AWW in providing child growth monitoring services and nutrition education.
- High rate of migration
- Less number of Anganwadi centers (Norm more then 1000 population) and absentees in the existing AWCs.
- Vacant Position of Supervisors post ICDS , hindering the program monitoring & management processes.
- Weak coordination between ICDS and Health
- Irregular supply of RCH Kit A & B
- Lack of health and sanitation in the villages and poor personal hygiene
- Lack of sanitation and poor access to safe drinking water.
- Inadequate knowledge of health providers about proper treatment of these infectious diseases

To address the cycle of malnutrition it is proposed that composite stage wise planning be undertaken for the children up to 5 years.

Essential Nutrition package:

- Early & Exclusive Breast feeding
- Appropriate Complementary feeding with continued breastfeeding
- Adequate nutritional care during illness & severe malnutrition
- Adequate intake of Vitamin-A (9 doses)
- Adequate iron intake
- Adequate iodine
- **Rehabilitate Malnourish children.**

Nutrition Status of children 0-6 Yrs as per ICDS MPR- oct 11



Objective and Goal:

Malnutrition: The percentage of children under three years, who are under-weight, is

58.4 (all India - 45.9). The Eleventh Plan goal for the State is to reduce it to 27.2%. Similarly, anaemia among women 15 to 49 years is also higher (68.3%) than the all India figure (56.2). It is pertinent to indicate that only 9.7% mothers consumed iron and folic acid tablets for 90 days or more when they were pregnant last time. The all India figure for this is 22.3% (NFHS-3). The Eleventh Plan goal for the State is to reduce anaemia among women to 31.7%. Through a better coordination with ICDS and proper organization of monthly health days at the Angwanwadis, the State should make all out efforts to reduce malnutrition among children (0-3 years) and anaemia among women and girls to at least half its present level by the end of Eleventh Plan. Nutri candies consisting of Vitamin A, iron, folic acid and Vitamin C are currently being distributed under ICDS/Dular project. A systematic study should be conducted to access the effectiveness of such an intervention. Based on the findings of the Study, further refinements/adjustments should be introduced in the on-going programmes.

Strategies to monitor Nutritional Status:

- Emphasis on contacts (Home visit) and counseling by AWW, ANM, Asha etc.
- Emphasis on supply chain management issues of Supplementary nutrition, Micro-nutrients - IFA, Iodized salt , Vit-A.
- Effective monitoring and supervision mechanism to be developed.
- Universal access to the ICDS services. Proposals for initiating ICDS centers in each Hamlets by 2012.
- Build capacities of ICDS staff to manage & monitor the grade wise tracking of all children up to 5 years, with special focus on the U-3 years .
- Shift focus from the Grade -III & IV , to track all grades to malnutrition - promote the transfer to normal children.

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

Introduction:

Adequate nutrition is critical to child development. Children are particularly vulnerable to growth retardation, micronutrient deficiencies, and common childhood illnesses such as diarrhoea and acute respiratory infections (ARI). Child malnutrition extracts a heavy toll on both human and economic development, contributing to about 50% of child deaths worldwide. The consequences of malnutrition are serious leading to stunting, mental and physical retardation, weak immune defense and impaired development. About 55 million underweight under-five children, i.e. one-third of world's underweight children, live in India.

Nutrition Rehabilitation Center, Samastipur

In India, as revealed by the recent National Survey (NFHS-3, 2005-06), malnutrition burden in children under three years of age is 46 %. Severe and acute malnutrition among children can be direct or indirect cause of child death by increasing the case fatality rate in children suffering from such common illnesses as diarrhea and pneumonia. The risk of death in these children is 5-20 times higher compared to well-nourished children. Severe and acute malnutrition (SAM) is defined by a very low weight for height, below -3 z scores of the median WHO growth standards, presence of visible severe wasting or 'bipedal oedema', or mid-upper arm circumference (MUAC) of <11.5 cm in children between 6-60 months.

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

MALNUTRITION IN BIHAR:

In Bihar, malnutrition is a serious concern with a high prevalence of 58.4 % as revealed by the National Health and Family welfare Survey (NFHS-3, 2005-06). Children suffering from severe and acute malnutrition are reported to be 8.3%. Based on population figures, it is estimated that in Bihar, 1.2 million children under five years of age are threatened to face the consequences of severe and acute malnutrition. With the situation of nutrition among children being far from satisfactory, it will not be surprising to find that these children who have already arrived in a poor state of nutritional status, with further deterioration are at a high risk of morbidity and mortality. About 73-170/1000 of these severe and acute malnourished children die during childhood, which means around 87,600 deaths per year, or 240 deaths per day.

MEASURES TO MANAGE MALNUTRITION:

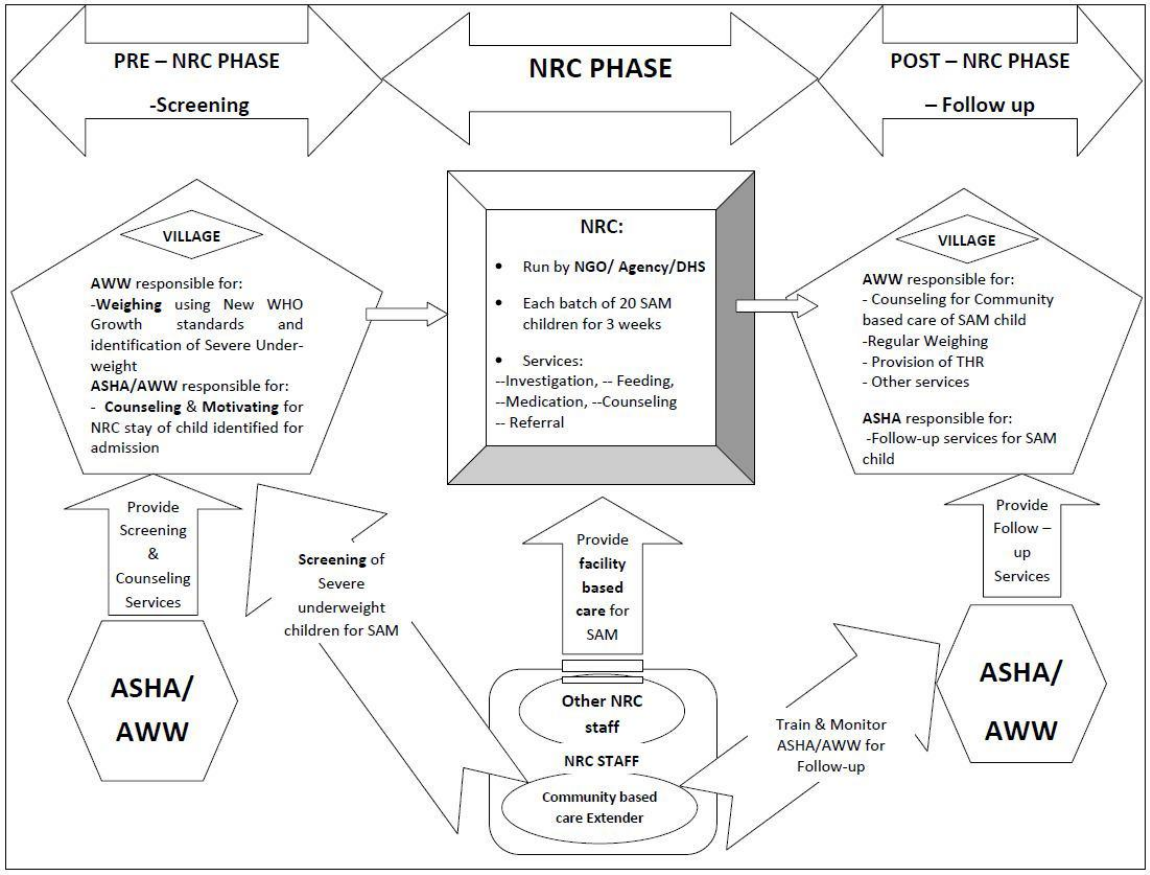
While mild and moderate forms of malnutrition in the absence of any minor or major illness among children can be addressed through Anganwadi centers, by supporting mothers to ensure service utilization and appropriate feeding and care practices at the household level; the treatment of children with severe and acute malnutrition calls for a therapeutic feeding programme.

A decision was thus taken to set up Nutrition Rehabilitation Centers which is a unit for the management of SAM children where they are kept under observation and provided with medical and nutritional care. In additional to medical care, special focus is given on timely, adequate and appropriate feeding to children. Efforts are also made to build the capacity of mothers through counseling to identify the

nutrition and health problems in their child

Principal Secretary H&FW- Amerjit Sinha Visits NRC in Samastiour

Functioning of NRC



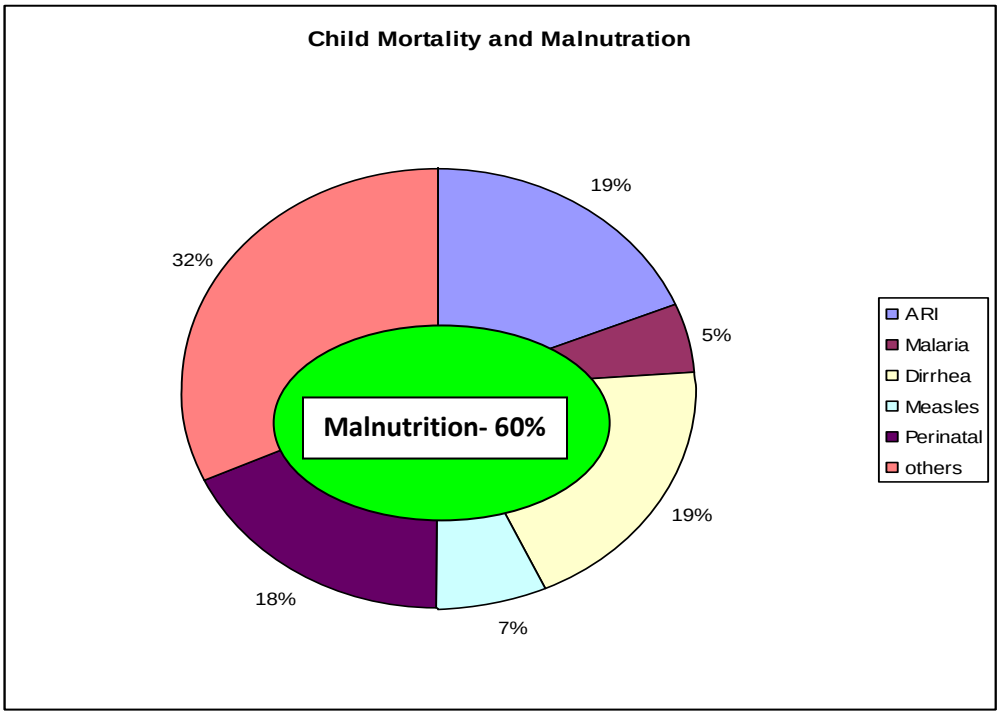
Nutrition Rehabilitation Center in Samastipur:

The NRC has been established in Sadar Hospital, Samastiput in December 2011. one batch of children has been admitted and well rehabilitate from Kalyanpur and warishnager. Every month one batch of children will be enrolled in cycle basis of different blocks. After the children discharged they will be followed up for the nutritional practices in their vicinity by the Kasturaba Mahila Vikash Kalyan Samittee staffs and if the situation of the children will not be improved then the steps will taken accordingly. The district core group in the chair of Civil Surgeons meets regularly for smooth functioning, DPO- ICDS supporting with his team of staff for the growth monitoring & screening. The District Magistrate, CS, DPC-DHS and Technical Agencies Unicef regular monitoring and provide supportive supervision the program.

Children Under nutrition rehabilitation in NRC, Samastipur

Effects of Malnutrition

- **Infant & child mortality**
- **Maternal/neonatal mortality**
- **Morbidity**
- **Growth**
- **Psychomotor & cognitive development**
- **Academic performance**
- **Adult health & productivity**



Services

- **Process facilitated by ANM/AWW/ASHA.**
- **Child identified by ANM as per criteria from the short listed underweight children by AWW/ASHA.**
- **Mothers motivated by ANM/ASHA to admit the child at NRC.**
- **ASHA's responsibility to bring child to NRC.**
- **ASHA receives incentive of Rs 100 per child on discharge of child.**
- **Child admitted in NRC for 21 days.**
- **(Transportation cost for follow-up proposed in 2011-12 PIP).**
- **Child weighed & temperature checked daily**
- **Immunization, De-wormed, vitamin A, Iron-folic acid, Zinc**
- **Paracetamol, Antibiotic**
- **Pathological tests-Treatment as per Report**
- **Referral, if needed for major complications**
- **After treatment from referral- child readmitted**
- **Child fed with special feeds F 75 in 1st week & F 100 in 2nd and 3rd weeks along with energy dense home foods in the last week.**
- **Around 8-6 feeds/ day.**
- **Counseling: feeding, health, hygiene-sanitation**
- **Weight gain of 5-15 g/day/body wt expected**
- **Child discharged after 3 weeks if criteria met**
- **If not, child is not discharged till criteria is met**
- **Mothers receive Rs 70/day- wage compensation –Rs. 1470 total amount on discharge after 21 days**

- **Mothers engaged in cooking, cleaning, feedings.**
- **Sattu and recipe demos live preparations as part of counseling**
- **Hygiene given special focus: case by case basis**

Monitoring of NRC by District Magistrate

Childhood Infections

Vitamin A:

M11	Number of Vitamin A doses	Samastipur District Apr-Oct 11
11.1	Administered between 9 months and 5 years	
11.1.1	Dose-1	33541
11.1.2	Dose-5	2158
11.1.3	Dose-9	516

Taking block data to analyze the Vitamin A administration. The Vitamin A, should be, administered in 9 doses to 9-60 months children in the gap of 6 months. It is to be noted that the 1st doze has good coverage but gradually the rest 2 doses, trickles down. There is no

monitoring of the 9 doses, to complete the schedule. Vitamin A dose and reiterates poor coverage, follow-ups and complete dozes administration of Vitamin A. In almost all the years the targets have dipped down.

The Vitamin_A administrated in two ways the regular administration is on the VHSND day / with routine immunization. The other way is on moop-up / catch-up round

Advantages of Vitamin A administration:

- Prevent Nutritional Blindness of children.
- Reduce mortality rate causes dirrhoea around 35 to 50 %.
- Reduce under -5 year Child mortality rate 23 %.
- Reduce measles mortality rate up to 50%.
- Reduce regular malaria incidence rate.

Management of Acute Diarrheal Disease (Including acute gastroenteritis)

Diarrheal diseases constitute one of the major causes of morbidity and mortality, especially in children below 5 years of age. They are responsible for morbidity & mortality. Outbreak of diarrheal diseases (including cholera) continues to occur in Samastipur due to poor environmental condition, unsafe water, food habits - includes consumption of rotten flesh out of the carcass etc , causing deaths & illness in various pockets of Samastipur. As this transmitted primarily or exclusively by the faecal-oral route may be water born, food born or direct transmission which implies an array of other faecal oral routes such as via fingers or fomites or direct which may be ingested by human.

In health institutions up to a third of total pediatric admissions are due to diarrheal diseases and exceptionally high death in indoor pediatric patents are due to diarrheal diseases.

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:

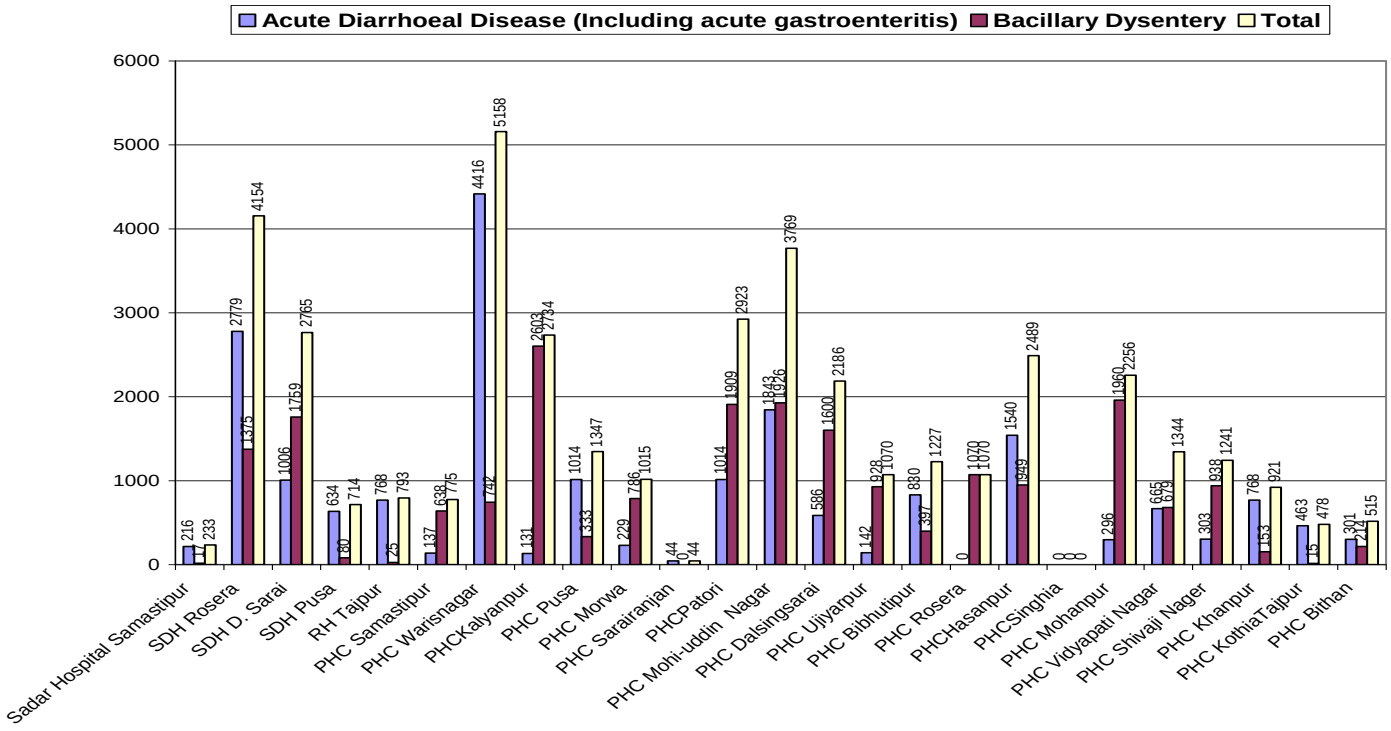
a) Zinc tablets should be available in all parts of the country including Anganwadi centers.
b) An effective communication strategy be put in place

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

(i) Current Situation

The district Samastipur is the sixth most populous district of Bihar having five polio high risk blocks namely Hasanpur, Warisnagar, Bithan, Bibhutipur & Singhia. There are 8 blocks (Kalyanpur, Dalsinghsarai, Mohanpur, Patory, Bithan, Singhia, Mohaddinnagar & Vidyapatinagar) which were severely affected due to flood in the current year (2011-12). The diarrhea prevalence is very high which is 19.9% as compared to the state average of 12.1%.

Indicator	**Samastipur District**	**Bihar State**	**Source**
Children suffered from Diarrhea in the last two weeks prior to survey (%)	19.9	12.1	DLHS-3
Children with Diarrhea in the last two weeks who were given treatment (%)	84.9	73.7	DLHS-3
Children with Diarrhea in the last two weeks who were received ORS (%)	20.9	22	DLHS-3
Women aware of ORS (%)	34.1	23.8	DLHS -3
IMR	54	55	Annual Health Survey,10-11
Under 5 Child Death	77	77	Annual Health Survey,10-11



ORS Demonstration in BCM orientation Program

Constraints in Diarrheal Control:

- Lack of caretakers' knowledge about infectious diseases and its causes
- Lack of sanitation and poor access to safe drinking water
- Poor personal hygiene leads to incomplete treatment
- Strong faith on traditional healers.
- Lack of health and sanitation in the villages
- Less coordination between line departments like PHE , ICDS and Panchayats with the Health Department
- Shortage of drugs for treatment at HSC / community level
- Low use of ORS and Zinc
- Low awareness of ORS and Zinc among the care givers in the management of childhood diarrhea
- Lack of awareness about the home management of diarrhea
- Irregular and poor quality of visits of health service providers
- Incomplete treatment seeking behavior and in continuity in follow up
- Poor referral systems

Control & Management:

- Appropriate clinical management.
    - ORS & Zinc Tablets supplies to all depot holders, Asha & AWW's
    - Availability of ORS and Zinc in all government facilities.
    - Treatment of home management of diarrhea by ANM, ASHA and AWWs and referral for severe dehydration cases.
    - Appropriate feeding during illness.
    - Chemotherapy- Follow STG of GO-Bihar norms.
- Better MCH care practices.
    - Maternal nutrition.
    - Child nutrition.
- Preventive strategy - Promotion through BCC / IEC activities.
    - Improved sanitation, Health education.
    - Immunization especially Measles vaccination
    - Vitamin A Supplementation
    - Hand washing especially before eating and after defecation.
    - Improved safe drinking water.
    - Fly control.
- Mapping of endemic pockets & formation of combat, improved communication in the management of epidemics.

Orientation on Zinc & ORC at Kalyanpur

Progress update during the current year (2011-12) :

The district implemented the childhood diarrhea management program in 2011-12. Micronutrient Initiative (MI) provided technical and operational support to the district through the placement of Divisional Coordinator and provided training on childhood diarrhea management to all MOs, CDPOs, BHMs, BCMs, LHVs, Staff Nurses, Pharmacists, ANMs, ASHAs and Anganwadi Workers. MI also supplied 2,88,000 combo kits (each kit consists of two packets of ORS and 14 tablets of Zinc DT), recording and reporting formats, compliance cards, IPC tool for counseling. Further, MI trained all Data Entry Operators in the block PHCs and District on record keeping and reporting. MI also imparted two days training to all BCMs on supportive supervision and provided printed supportive supervision checklists.

The district introduced reporting on Zinc –ORS from August, 2011 immediately after completion of training. The supply of combo kits was distributed to all AWWs, ASHAs, HSCs, PHCs and Sadar Hospital. The report for the month of August, September & October reveals that 5476 number of cases reported in which 5221 treated with both Zinc &ORS which is 95%. The BCMs have started supportive supervision visits from December 2011 as per their plan.

Specific Objectives (2012-13):

I) At least 5,22,030 (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 5,22,030 numbers of Zinc syrup bottles and 10,44,060 packets of ORS are procured and distributed to AWWs, ASHAs, HSCs, APHCs, PHCs & Sadar Hospital.

Population as per 2011 census	0-5 years Children (14.35% of the total population as per the CBR(28.7), Annual Health Survey, 10-11 for Samastipur)	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 govt. health facilities as per DLHS-3, India)	No. of bottles of Zinc Syrup to be procured for 2012-13 (@ 1 bottle per episode)	No. of ORS packets to be procured for 12-13 (@ 2 packets per episode)
42, 54,782	6,10,561	10,44,060	5,22,030	5,22,030	10,44,060

2 <u>Implementation Strategies (2012-13):</u>

- 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
- Continue the involvement of BCMs in Supportive Supervision.
- Refresher training of all ANMs, AWWs, ASHAs on childhood Diarrhea management and recording and reporting.
- Print & distribute training module for the refresher training of ANMs, AWWs, and ASHAs.
- Refresher training of Data Entry Operators on recording & reporting.
- Refresher training of BCM on Supportive supervision.

- Print & distribute registers (ANM, ASHA, AWW) reporting forms (PHC, APHC, HSC, ASHA, AWW), Supportive supervision checklist for BCMs.
- Print & distribute inter personal communication (IPC) tool kit & Compliance cards for counseling by ANM, ASHA, AWW.
- 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 & monitoring visits by DCM to BCMs during supportive supervision visits.
- Strong coordination with the development partners.
- Special camps will be organized prior to onset of monsoons with special emphasis on immunization and epidemic management
- Ensure through VHSC for supply of bleaching powder, chlorine, and other necessary drugs for immediate treatment at village level
- Awareness among the PRI members to take accountability towards monitoring and managing a congenial health environment and take immediate remedial actions , especially immediate communication to the PHC for assistance in case of epidemic outbreaks ,so that any problems and diseases if occurs do not spread beyond control.
- Coordination with PHED to repair/ renovate all defunct hand pumps before rainy seasons which are used for drinking water purposes in the villages
- PHED to allocate funds to repair/ construct platforms around the hand pumps to avoid water stagnation and prevent spread of water borne diseases
- Special campaign for improving sanitation and encourage use of safe drinking water

Supports by other Development Partners (2012-13):-

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

- Continue to provide techno-managerial support through the placement of Divisional Coordinator.
- Provide technical support in refresher training of ANMs, AWWs, ASHAs, BCMs & Data Entry Operators.

- Provide prototype soft copy of training module, Inter Personal Communication (IPC) tool kit, Compliance Cards, Registers, Reporting forms, Poster, Wall Painting & Display Board.
- Support in organizing district and block level review meetings.
- Continue to provide mobility support to the BCMs for the supportive supervision visits.

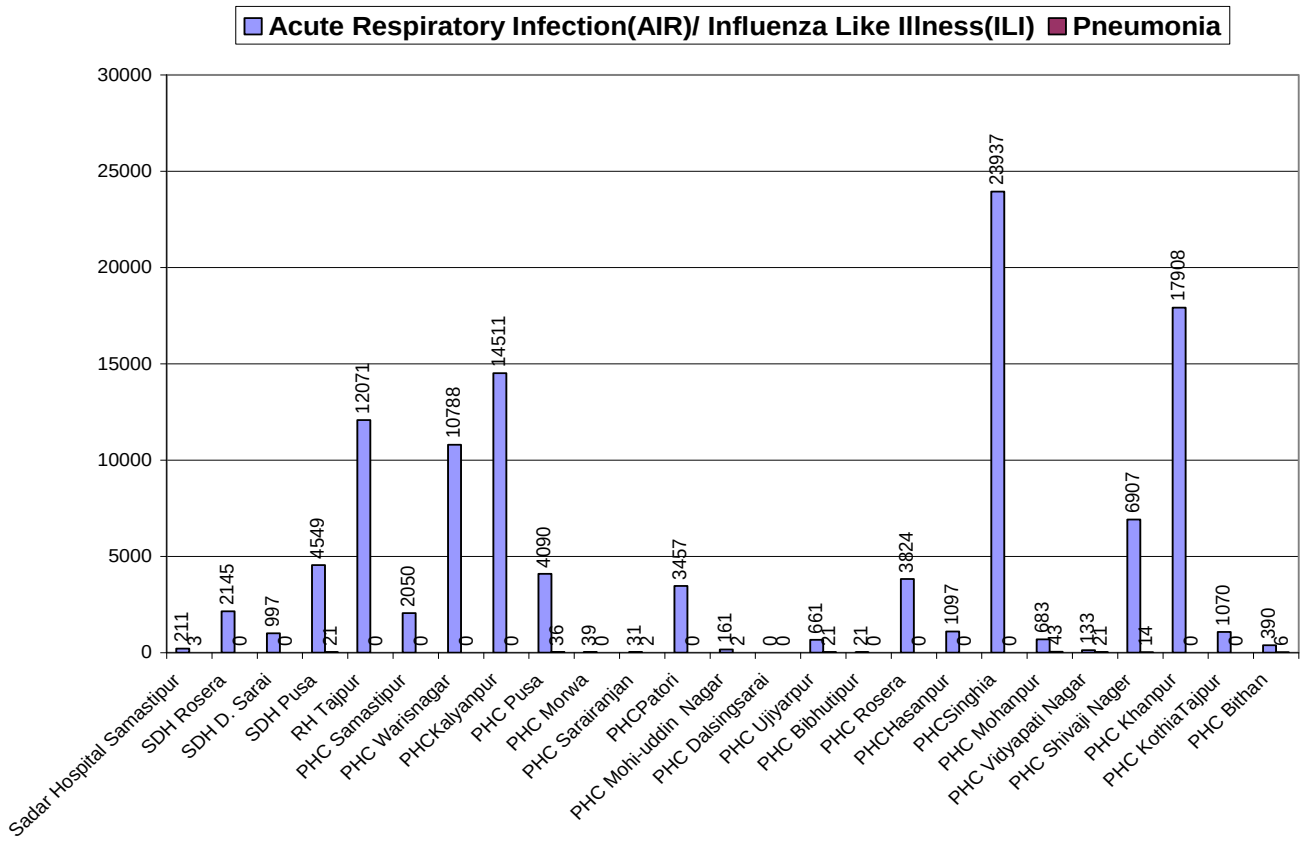
4.4 Following activities proposed under NRHM budget (2012-13):

- Procurement of Zinc Syrup (5,22,030) and ORS packets (10,44,060) for 5,22,030 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
- Print & distribute training module, Registers, Reporting forms, Supportive Supervision Checklist, Compliance Cards, Inter Personal Communication (IPC) tool kit.
- 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

ARI (Acute Respiratory Infections):

Infections of the respiratory tract are perhaps most common human aliments. While they are a source of discomforts, disability and loss of time for most adults. Acute respiratory diseases are one of the major causes of morbidity and mortality in children below 5 years of age and especially infants and neonates. It is estimated that it is about 13.6 percent of hospital admissions are 13 percent inpatients death in paediatrics wards are due to ARI. ARI particularly pneumonia are the leading causes of death. Although most of this ARI attacks are mild, self-limiting episodes, they are a frequent reason for seeking health care.

ARI consists of awareness of danger signs of pneumonia and treatment practices.



5 Institution reported More then 10,000 cases reported and highest reported by PHC Singhia more then twenty three thousand.

Possible reasons for low use of ARI services

- Home based treatment.
- Services not reached in the unapproachable villages
- Lack of infrastructure for referral services
- Lack of knowledge and awareness of ARI symptoms among household members and service providers in the HSC.
- Traditional beliefs and practices, treatment through local traditional healers .
- Lack of counseling services by service providers
- Myths and misconceptions
- Erratic drug supply at HSC level.

Control Mechanisms:

- Appropriate clinical assessment and management.
  - Appropriate feeding.
  - Chemotherapy.
- Better MCH care practices.
  - Maternal nutrition.
  - Child nutrition.
- Preventive strategy.
- Control and prevention.

Objectives

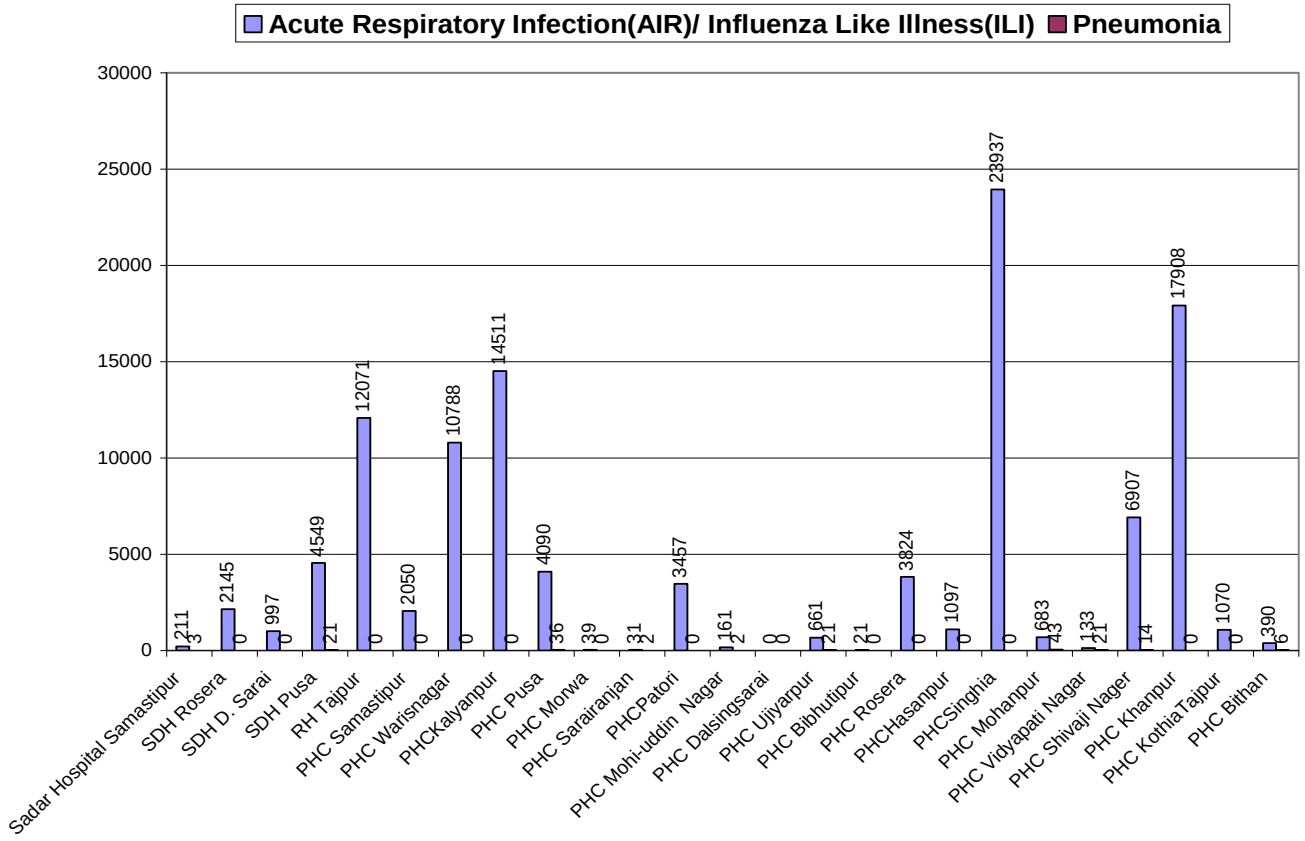
- Communication campaign for creating awareness
- Training of service providers and traditional healers for identification of high risk symptoms
- Early management of disease by strengthening referral system
- Training of AWWs in diagnosis of risk cases and giving treatment to refer cases
- Training of ASHA for identification of danger signs
- Organize special health check up camps in high risk remote areas

Strategic Interventions

- Training of all service providers
- BCC campaigns
- Ensure regular drug supply

Activities

- Create awareness about exclusive breast-feeding.
- Organize baby friendly days in the PHC/APHC/HSC.
- Develop and distribute locally developed print material (posters/folders)..
- Identification of training needs. Train all health workers/ nursing staff/ ASHA in resuscitation of newborn and essential neonatal care.
- Ensure availability of resuscitation equipment at all levels, including HSC.
- Provide weighing machine if not available
- Record weight within one week of birth.
- Create awareness about importance of newborn care among people by organizing meetings.
- Individual/group counseling and interaction.
- Train dais



5 Institution reported More then 10,000 cases reported and highest reported by PHC Singhia more then twenty three thousand.

Possible reasons for low use of ARI services

- Home based treatment.
- Services not reached in the unapproachable villages
- Lack of infrastructure for referral services
- Lack of knowledge and awareness of ARI symptoms among household members and service providers in the HSC.
- Traditional beliefs and practices, treatment through local traditional healers .
- Lack of counseling services by service providers
- Myths and misconceptions
- Erratic drug supply at HSC level.

Control Mechanisms:

- Appropriate clinical assessment and management.
  - Appropriate feeding.
  - Chemotherapy.
- Better MCH care practices.
  - Maternal nutrition.
  - Child nutrition.
- Preventive strategy.
- Control and prevention.

Objectives

- Communication campaign for creating awareness
- Training of service providers and traditional healers for identification of high risk symptoms
- Early management of disease by strengthening referral system
- Training of AWWs in diagnosis of risk cases and giving treatment to refer cases
- Training of ASHA for identification of danger signs
- Organize special health check up camps in high risk remote areas

Strategic Interventions

- Training of all service providers
- BCC campaigns
- Ensure regular drug supply

Activities

- Create awareness about exclusive breast-feeding.
- Organize baby friendly days in the PHC/APHC/HSC.
- Develop and distribute locally developed print material (posters/folders).
- Identification of training needs. Train all health workers/ nursing staff/ ASHA in resuscitation of newborn and essential neonatal care.
- Ensure availability of resuscitation equipment at all levels, including HSC.
- Provide weighing machine if not available
- Record weight within one week of birth.
- Create awareness about importance of newborn care among people by organizing meetings.
- Individual/group counseling and interaction.
- Train dais

Family Planning -:

Statistics tell us a power full story on how people and situation around them are changing. This statistical data can be used to gauge the progress in a particular sector. There is a need to percolate these information and analysis for making informed choices in respect to our programmatic decisions.

The supply of services has always played an integral role in improving the coverage rates of indicators. The core team at the district level undertook the analysis of various family planning intervention of reproductive health to achieve an increase in CPR and stable TFR. This analysis was aimed at analyzing various components of family planning in the supply chain, user trend, STI protection and its implications on the management indicator like TFR.

The district has a history of rural ethnicity, which is inherent, the untouched modernization & voice lessness of voices of community. The Family planning and Birth spacing situation in the Samastipur is moderate to low-higher on the side. The CPR of the district is 55.4, which secured 5th rank in the state. The district administration has put their region able efforts to increase the coverage of temporary method of contraception in respective of permanent method.

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

Objectives:

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

2. To increase Contraceptive Prevalence Rate (Any Modern Method) from 28.8% to 45% in 2011-12

3. To increase male participation in family planning

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

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

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

Core Strategies and Activities

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

1.1.1. Creating dedicated cadre of skilled manpower

1. Training of MBBS doctors on Minilap and NSV (fast tracking of trainees from the identified facilities- as mentioned)

2. Training of MBBS doctors on Anesthesia

3. Training on IUCD: MOs, ANMs etc.

1.1.2 One RCH camp will be organized in each PHC/CHC where Laparoscopic

Ligation/Mini Lap will be done

1.1.3 Incentive to acceptors of minilap operations

1.1.4 Training on minilap operation, MTP and IUD Insertion

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

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

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

The eligible couple register is presently being updated once a year (usually in April) as per a survey mode. It is done in a hurry and may not have complete information in many cases. With the involvement of *ASHA*s and AWWs, updates should be done preferably prior to VHNDs. This will result in better recording of information.

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

1.2.2.1 Each SDH/CHC/PHC should have static FP cell / corner, with earmarked ANM /

LHV responsible, for providing these services daily as OPD services to clients

1.2.2.2 Community Based Distribution (CBD) of Condoms and Pills: The OCPs and condoms can be provided to community based motivated volunteers, like members of Self Help Groups (for Pills) and Husbands of motivated ASHA, Satisfied NSV client, active PRI members etc. (for condoms) for community based distribution (CBD) of these. Besides these innovative ways of expending reach especially to poor communities MMU (Mobile Medical Units) will also be explored. The access could also be expanded by utilizing Generic Drug Store to sell IUDs at subsidized rate as per prevailing govt. norms. The availability of condoms and OCPs with the volunteers and their geographical responsibilities should be widely known to the potential clients / beneficiaries. Before they are made the community based distributors, they should be properly trained and mechanism developed to regularly monitor them and review their performance

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

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

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

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

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

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

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

Every event will be recorded in the EC register and thus the register will be updated.

This can be done after every event has occurred or reported to have occurred or during the VHNDs visit each month to a village.

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

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

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

Objective No.2: To increase Couple Protection Rate

Strategies and Activities

2.1 Awareness generation in community for small family norm

2.1.1 Preparation of communication material for radio, newspapers, posters:

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

2.1.2 Meetings with MSS, CBOs: Communication materials to be used for monthly

MSS/CBO meetings will be prepared and distributed for use. These meetings will be scheduled during or preceding the month family planning camps are scheduled to be held.

2.2 Regularise supply of contraceptives in adequate amounts

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

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

Strategies and Activities

3.1 Promote the use of condoms

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

3.1.2 Regular supply of condoms and setting up depots which are socially accessible to all men : It is very essential to supply condoms through depots which can be easily accessible to men and confidentiality will also be ensured. During the meetings, the sources of condoms in the village will be made known to all. It will be ensured that the client's identity will not be disclosed. The depot holder will be set up only on condition that he shall not reveal the identity of clients.

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

3.3 The male participation may also be increased by frequently exposing them to health system. This can be accomplished by health providers insisting that the male spouse be present atleast on three occasions (1) atleast one ANC check up (2) at the time of delivery and (3) atleast attending one session of child immunization.

Other innovative ways to increase their participation will be explored and adolescents will be sensitized during Nehru Yuva Kendra (NYK) meetings and Kalyani Health Clubs and organizing sports like football, kabaddi competitions and other activities.

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

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

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

4.2 Increase capacity for NSV services

4.2.1 Training of doctors for NSV

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

4.2.2 Organize NSV camps at the Sub District Level

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

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

5.2 Streamline the contraceptive supply chain & Monitoring

1. Identifications & Renovation of Warehouse – State /District/ PHC

2. Budget allocation for transportation at every level

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

Action Plan for Strengthening Sterilization Services

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

District Level Activities:

1. Undertake block-wise analysis of service utilization and work out detailed service provisions: fixed day roster based static services, camps and their schedules

2. Prepare block wise demand generation activities, separately for static services and camps

3. Prepare a list of providers not providing sterilization services and orient and reorient them and place/post them as per defined roster to the services: static services and camps

4. Finalize work plan with state to get specific need-based inputs

5. Conduct monthly review of sterilization activities at district level

District Level Actions

1. Saturate training of all available providers

2. Ensure presence of providers in all static facilities

3. Institutionalize sterilization services

4. Public private partnership

a. line listing of the same

b. dedicated pool of the same, MBBS doctors (ask them to perform surgeries at government facilities)

2. Orient block level MOs in using data for monthly review and stocktaking

Current Interventions:

a) Eligible couple survey in every Village with help of ASHA

b) Minilap training for Medical Officers and Staff Nurse

c) Training of surgeons for NSV so as to ensure at least one NSV provider per district

d) Training of ANM & MOs for IUD-380 A no touch insertion technique

e) A scheme 'Yukti' is being launched in the state to accreditation private providers

for safe abortion services as per existing rules

f) Micro planning at district level to reach all eligible couples to reduce the unmet

need .

g) Extra financial incentive planned to increase rate of sterilisation amongst couples with less than three children. Also financial incentive planned for couples accepting sterilisation after one or two girl children.

h) Planning at district level to increase IUD insertion rate among women with one child. Planned to seek services of FP motivators to motivate couples for FP services. Also planned to motivate females at the time of institutional delivery for PPFP

i) Ensure timely filing of insurance coverage in case of adverse events following sterilization

j) To make all types of sterilization services available, three types of training programs will be conducted at district level as elaborated above (Mini-lap, NSV & IUD-380 A)

k) All ASHAs are being provided drug-kits with condoms and OC pills to ensure availability of FP material at grass-root level.

l) State is developing a post partum strategy for family planning

Present Strategy of FP in the District:

Family planning (currently married women, age 15-49)	DLHS-3		DLHS_2	
Current Use :	Total	Rural	Total	Rural
Any Method (%)	34.8	34.3	23.2	22.0
Any Modern method (%)	28.9	29.3	22.4	21.1
Female Sterilization (%)	26.6	27.1	19.9	18.8
Male Sterilization (%)	0.4	0.4	0.2	0.2
IUD (%)	0.4	0.4	0.1	0.1
Pill (%)	0.7	0.6	0.9	0.7
Condom (%)	0.8	0.8	1.2	1.2
Unmet Need for Family Planning:				
Total unmet need (%)	36.3	36.2	42.7	43.2
For spacing (%)	14.0	14.2	21.6	21.8
For limiting (%)	22.3	22.0	21.1	21.4

To increase in the CPR the district administration has adopted multi sect oral achievement strategy. Which target the population according the age wise. The TFR of the district is 3.9 and targeted to reduce upto 2.7 for the stable population and Birth rate in the year 2011. The trend of TFR shows a positive picture to achieve the target of 2.7. The district health administration has formed a strategy to reach the TFR level at 2.7 which includes 50 % of Sterilization along with IUCD method and 15 % of birth spacing (OCP, Condom and other) method. The strategy adopted due to higher increase in the numbers of eligible couples (EC) over the year.

M9	Family Planning	
9.01	**Number of NSV/Conventional Vasectomy conducted**	Samastipur District Apr-Oct 11
9.1.1	**At Public facilities**	
9.1.1.a	At PHCs	6
9.1.1.b	At CHCs	1
9.1.1.c	At Sub-divisional hospitals/ District Hospitals	1
9.1.1.d	At Other State Owned Public Institutions	0
9.1.1.e	Total {(a) to (d)}	8
9.1.2	At Private facilities	0
9.03	**Number of Mini-lap sterilizations conducted**	
9.3.1	**At Public facilities**	
9.3.1.a	At PHCs	1655
9.3.1.b	At CHCs	0
9.3.1.c	At Sub-divisional hospitals/ District Hospitals	876
9.3.1.d	At Other State Owned Public Institutions	0
9.3.1.e	Total {(a) to (d)}	2531
9.3.2	At Private facilities	18
9.04	**Number of Post-Partum sterilizations conducted**	
9.4.1	**Public facilities**	
9.4.1.a	At PHCs	11
9.4.1.b	At CHCs	0
9.4.1.c	At Sub-divisional hospitals/ District Hospitals	61
9.4.1.d	At Other State Owned Public Institutions	0
9.4.1.e	Total {(a) to (d)}	72
9.4.2	Private facilities	0

PROCUREMENT AND SUPPLY

CONDOMS

Condoms are procured centrally and distributed to various States/Uts, which provide them free of cost to the beneficiaries through the Sub-Centres, PHCs, CHC, Post Partum Centres, Hospitals, Dispensaries and NGOs etc. The contraceptives were distributed by the ANM ad Male worker during the VHSND and the household visits. The depot was established in every Sub health center, which is managed by an ANM , AWW **and ASHS** has been developed as distribution point in the DS and other AWCs to facilitate the distribution. Condoms are also sold at subsidized prices through ASHA workers under Contraceptive Social Marketing Scheme.

ORAL CONTRACEPTIVE PILLS:

Oral Contraceptive Pills (OCP) are also distributed under Free Distribution as well as Social Marketing Scheme. Under free supply scheme, pills are supplied under the brand name Mala 'N'. During March – October 2011, a total of 23775 -cycles of Mala 'N' were distributed under the Free Supply Scheme.
Under the Social Marketing Scheme, introduced in 2011, OCPs are distributed under the brand name of Mala 'D' and other distributor's brands and are being sold throughout the selected pharmaceuticals companies.

The district Health department has estimating the requirements on the basis of the no of eligible couple and user rate. Following formula adopted to calculate the annual estimation of the contraceptives.

(e) Condom: 1 (beneficiaries) *10 pieces *12 month

(f) OCP: 1 (beneficiaries)*12 cycles/annum

(g) (Total 15% of the Eligible female population**)**

Reasons for low awareness of family planning methods

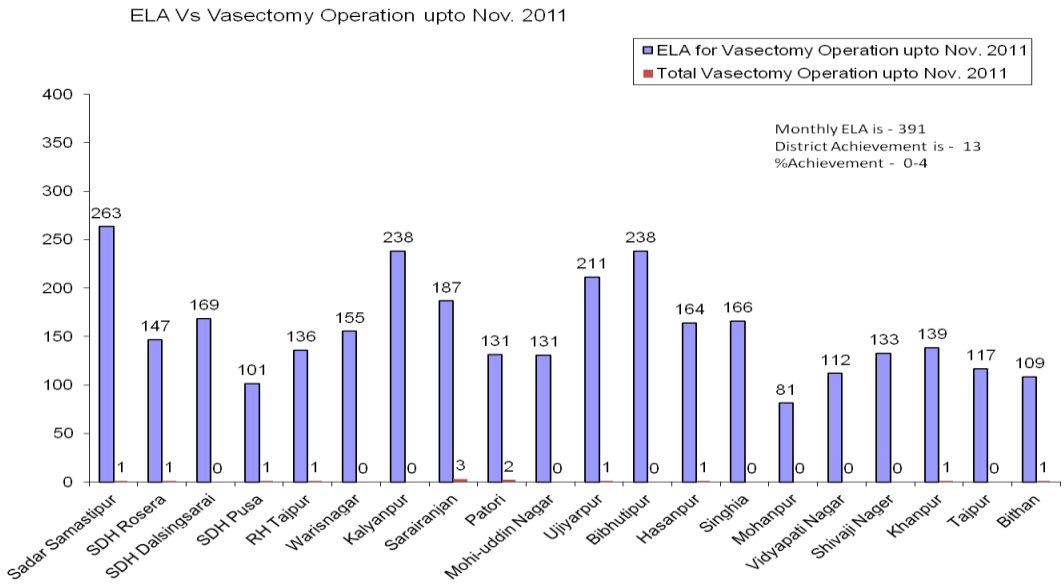
Early and repeated pregnancies due to

- Social/ family pressure and cultural habits
- Inadequate knowledge of new couples on family planning and FP methods, inhibitions and less knowledge about sources of availability
- Low social status and education level of girls and women
- Birth of children is treated as a part and parcel of a woman's life

9.05	Number of IUD Insertions	Samastipur District Apr-Oct 11
9.5.1	**Public facilities**	
9.5.1.a	At Sub-Centres	1967
9.5.1.b	At PHCs	818
9.5.1.c	At CHCs	0
9.5.1.d	At Sub-divisional hospitals/ District Hospitals	166
9.5.1.e	At Other State Owned Public Institutions	0
9.5.1.f	Total {(a) to (e)}	2951
9.5.2	Private facilities	46
9.06	Number of IUD removals	480
9.07	Number of Oral Pills cycles distributed	23775
9.08	Number of Condom pieces distributed	276154
9.09	Number of Centchroman (weekly) pills given	533
9.10	Number of Emergency Contraceptive Pills distributed	417

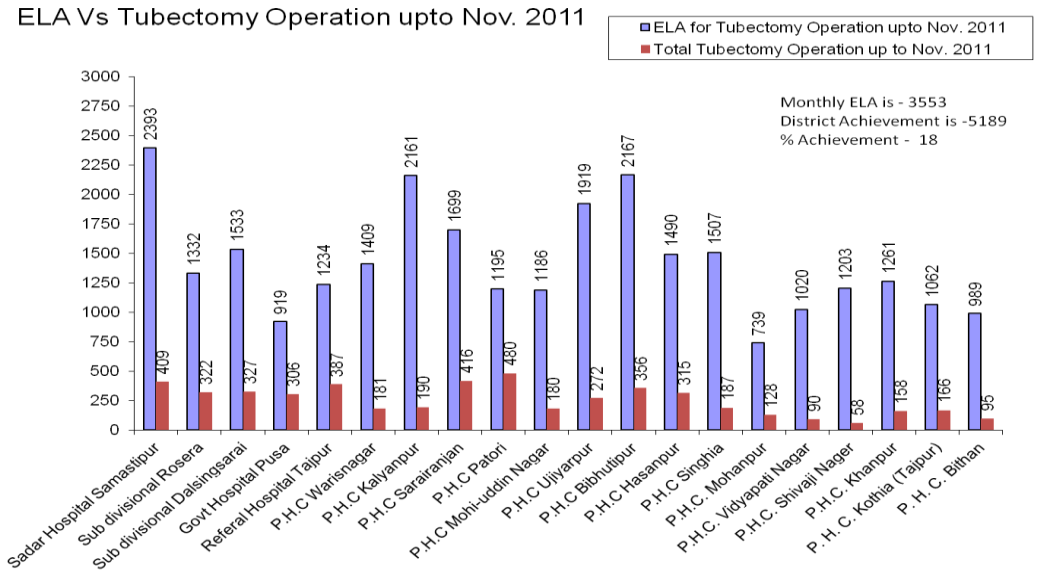
Low access to FP services mainly due to

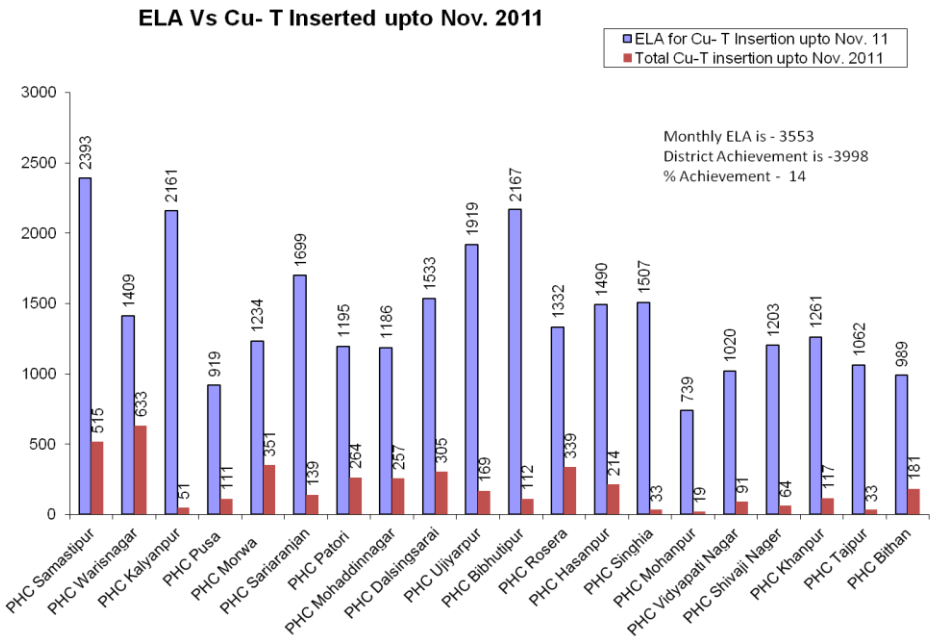
- Lack of knowledge of availability and sources of FP services
- Non-availability or shortage of contraceptives at community level
- Social/ family pressure and traditional beliefs
- Inadequate/ partial knowledge of population on FP and FP methods
- Low social status and education level of girls and women
- Preference for birth of male child
- Less number of LTT and NSVT surgeons
- Religious and caste based taboos regarding FP methods



Poor quality of FP services mainly due to

- Inadequate knowledge and skills of ANMs, Asha & AW and other service providers including communication and counseling skills
- Lack of supervision system of health staff for assuring quality of services
- Non-availability of services about infertility
- Infertility is tragic because many stigmas are attached to it, and many women are suffering from social and family pressure. Many of them lose their social standing and are divorced.
- Follow up after availing permanent FP methods is not regularly provided by the service providers
- Lack of availability of Gynecologists
- Health functionaries do not believe in some methods and do not promote them
- Service providers do not pay attention to promoting informed choices





Objectives

- Focused BCC on awareness and encourage use of family planning methods specially birth spacing
- Ensure training of service providers on modern technology of family planning methods.
- Ensure training of all health staffs on Contraceptive management and counseling.
- Establish linkage with Panchayat, Anganwadi Centres and community level volunteers like Depot holders, ASHA , Self Help Groups, etc.

Reasons for low adoption of Family planning methods

- Non availability of trained medical service providers / doctors to conduct sterilization operations
- Inadequate facilities to provide quality services
- Reluctance on part of medical professionals to provide sterilization services due to legal complications
- Inadequate infrastructure facilities as per the norm
- Son's preference and disapproval by family members
- Male involvement in family planning is very negligible
- High incidence of RTI / STI cases leading to rejection of IUD insertions
- Reluctance on part of health service providers to providers to promote birth spacing methods
- No proper follow up by service providers in the sterilization cases
- High drop out rates of oral pills, condoms and IUCD

Strategic Interventions

- Reaching to the un-reached population by atleast 80%
- Establish linkages with other agencies to improve access to services in atleast -80% of the villages
- Communication campaign to improve demand for terminal and modern spacing methods
- Organize special camps in a systematic and effective manner
- Conducting workshops and trainings to service providers on linkages between spacing of children
- Involvement of Private clinics, RMPs ,ISMPs in promoting family planning & birth spacing methods (access and demand to these methods).

(h) Recommended plan of action for Family Planning Promotion:

(i) The district has recommended the following suggestive measure to promote the family planning method, Appropriate increase in CPR rates and the reduced level of TFR by 2.7

1. A district should address the category wise eligible couples for targeting. (Ref. Table # 1)..
2. The category wise targeting will reduce the TFR level from 3.9 to 2.7 and will achieve the birth rate and the expected CPR.
3. A cadre of the old user of contraceptives will be developing to motivate the new couples for the use of contraceptives and Birth spacing.
4. ASHA, ANM and AWW will coordinate the village level intervention through community meeting and VHSND forums for better coverage of contraceptives. Also the village volunteers like, ASHA, depot holder, CBOs, community groups will facilitate the community process of family planning methods.
5. Sankalp Mela: A joint initiatives of Partner NGOs and DT to reinforce the needs of contraception and family planning in the DS. The event will organize at the DS level to address the unmet needs of contraception, personal & family counseling and referral services. This will work as a boost to increase the CPR**.**

6. The district needs to develop inter sect oral coordination among the different departments to promote and contextulize the family planning methods. The review and level of participation needs to be done on a monthly basis.
7. The core committees would facilitate the skill enhancement programmes for the service providers for correct knowledge and skill.
8. The enabling environments through various BCC strategies will be created for better participation of the community.
9. Campaign approach through health camps/Mela would facilitate and build environment among the FP users.

10. Information, education, and communication (IEC) activities:

Information, education, and communication (IEC) activities directed to potential clients are able to change individual attitudes and social norms about family planning, to increase knowledge of contraception, to promote discussion of family planning issues with family and friends, to publicize service sites and providers, to encourage people to adopt contraception, and to create demand for high-quality care. The strategy will expose during Health camp, NHD, CSG meetings, household visit and Sankalp mela. All audio/video, posters and flip charts aids will be used for the campaign.

11. Interpersonal communication and counseling

Counseling is central to family planning services, and improvements in client-provider interaction may lead to higher rates of contraceptive adoption, effective use, and continuation. Ideally, the counseling process should be client-centered. The common consensus has been developed to adopt the following measure for the ICC. All village level volunteer like, ANM, AWW, ASHA will address the need of contraception, Information on side effects and complications, Advantages and disadvantages of the methods, Method effectiveness, Proper method use once a method has been selected, The availability of emergency contraception through Individual meeting/ groups meetings and mass meetings.

World Family Planning Day Observation _ BCC activity

12. Training and revitalizing

When workers lack knowledge or skills, they need training. A continuing program of in-service training is critical for family planning providers to strengthen existing skills and teach new knowledge and skills.

District health department/ICDS and NGOs will facilitate the needs of contraception among the service providers. All BTT and DTT will develop an enabling environment for all the trainers to address the unmet need of contraception among the different age groups.

13. Logistics and contraceptive quality assurance

A sound ensures that each service delivery point has sufficient contraceptive commodities and other supplies, in good condition, to meet clients needs. There is growing concern about shortages of contraceptives and other reproductive health supplies in the village level. Rising interest in family planning and growing numbers of people of reproductive age are boosting demand for contraceptives, but supplies are limited by insufficient and poorly coordinated donor funding as well as inadequate logistics capacity in our state/countries.

14. Monitoring:

The program activities will be monitored through the regular monitoring forums. The off take of the contraceptives will be regularly monitored through field visit of the ANM/MPW, household visit by CA/RHCA and AWW. CSG members will manage the demand and supply of the contraceptives and their distribution. Consumer's register, Distribution register and eligible couples data will be updated on a regular basis at the PHC level. Program performance will be review on a sector level to keep the pace of execution. BMO and CDPO of the respective blocks will manage the block level intervention to increase in the CPR and update district health unit for the logistic supports and technical guidance. District core committees will manage all supports requires for the field implementation and ensure regular availability of contraceptives across the district.

15. Advocacy

The commitment of service provider, movement in low coverage areas and regular popular support are essential to ensuring the broad access to good-quality family planning and reproductive health services. NGO, CBOs and civil society will coordinate the advocacy initiatives in Gram sabhas, and community meeting to address the demand and supplies of the services. The situation will be review in every quarter of the month to access the efforts in increasing the CPR of the district. All RMP/PMP and community volunteer will reinforced the community needs of contraception and coordinate village level intervention for the region able increase in CPR.

Adolescent Reproductive Sexual Health

Large numbers of adolescents and young people are out of school, get married early, work in vulnerable situations, are sexually active and are exposed to peer pressure. Since there situation varies from place to place, therefore, any intervention to meet their demand should be flexible. The public health challenges for this group include pregnancy, excess risk of maternal and infant mortality, sexually transmitted diseases, reproductive tract infection, and rapidly rising incidence of HIV / AIDS. In context of reducing IMR. MMR, and TFR, addressing adolescent related health issues will pay rich dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complications, including access to early and safe abortion services and reduction of unsafe sexual behaviour. Poor infrastructure and lack of awareness are two main reasons for poor availability of services for the adolescents.

Evidence shows that teenage pregnancy, before the age of 16 years, is negatively associated with maternal nutrition, birth weight and survival of the offspring. They suffer more from malnutrition and anaemia. They may have not received tetanus immunization. All this cumulatively lead to more maternal, perinatal, neonatal and infant mortality. Lack of availability of adequate privacy and confidentiality and judgemental attitudes of service providers are two other major gaps in service availability for adolescents and young people.

Also Adolescent is a period of transmission from childhood to adulthood. It is the period of life between ages of 10 to 19 years.

This period is very crucial, since these are the formative years in the life of an individual when major physical, psychological and behavioral changes takes place. This is also an impressionable period of life. This is also the period preparation for undertaking greater responsibilities including healthy responsible parenthood. Future of a society depends on adolescents and they from a great human resource for the society.

Health problems of an adolescent are very different those of younger children and older adults. Due to lack of accurate information, adolescents are prone to various behavioral and reproductive health problems like, RTI/STI etc. the period of transmission from child hood to adult hood is hazardous for the adolescents health because they develop behavioral problem in absence of proper guidance and counseling. Health and ICDS departments have to play very important role in preventing these problems.

The state is facing many other problems related to the growing population of young people just entering or already in their reproductive years. These include high unmet need for contraception and rapid growth in the prevalence of sexually transmitted infections (STIs), including HIV, as well as reproductive tract infections (RTIs). As mentioned in the Annual Report 2000-01 of the Ministry of Health and Family Welfare, Government of India, "Till recently reproductive tract infections (RTIs) including sexually transmitted infections (STIs) were not recognized as a problem. Research conducted on the reproductive health needs of the people in India has contributed to making these infections visible and the concern about the spread of the HIV epidemic and the recognition of the role that STIs play in HIV transmission has also drawn attention to the problem. RTI/STI are known to be very common among women in the reproductive age (15-44 years). Most community based studies of gynecological morbidity conducted in India indicate the heavy burden of RTI/STI in the country."

Gaps in knowledge and behavior of Adolescents and young people and their poor

status: It is becoming widely known that Adolescents (10-19 yrs.) and young people (15- 24 yrs.) in Bihar are much in need of services, reliable information and appropriate skills to address their health and nutrition concerns, including reproductive and sexual health (RSH). A recent Youth Survey of young people, aged 15-24 years conducted by IIPS and Population Council in 2006-07 shows that only 13% young woman as against 30% young men have completed their high school in Bihar. Just 15% women and 28% men have comprehensive knowledge of HIV / AIDS and just about 12% women and 11% men have heard about STI. 46% women in the age

group 20-24 are married before the age of 15 (and 33.4% in the age group of 15-24 before). 80% of 15-24 year old married women have already experienced pregnancy. As per NFHS III data, the use of any modern contraceptive methods by married adolescent women is barely 9% and their total unmet need for Family Planning is 36% (NFHS III), with spacing needs accounting for 33%.

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

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

Economic activity and gender roles among young people: according to the Youth

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

Key Issues, Problems and barriers faced by youth in managing ARSH risks:

- Youth are unable to get need-based information and services related to Adolescent and Reproductive Sexual Health (ARSH) from qualified and trained providers hence; they have many myths and misconceptions related to Sexual and Reproductive Health (ARSH), HIV/AIDS and RTI/STI.
- They lack necessary skills (life-skills, income-generating) and educational, vocational and recreational opportunities.
- Lack of communication/good understanding between parents/teachers and youth.
- Lack of communication/good understanding related to ARSH issues between males and females.
- Lack of safe and supportive environment with no one to guide them / to turn to in case of need; adults are generally not comfortable talking about ARSH issues with youth and there are social taboos against talking about ARSH issues, particularly with unmarried people.
- Very little involvement of youth in planning and implementation of programs intended to serve their needs and priorities.
- Very little involvement of elders of the families in program activities so they do not understand the importance of ARSH education and thus refuse/restrict the participation of their daughters/sons/sisters in the project activities.
- Insufficient number of technically competent volunteers and staff who could take up the task of providing ARSH education and related health services.
- Youth hesitate in availing/or are unable to avail the existing ARSH services because they are shy to visit these centers; these services are not youth friendly, are scarce, and do not meet their needs.
- Societal and peer pressures may direct them to have risky and unsafe behavior.
- There is very few Reproductive Health services for youth and adolescents in general and unmarried in particular**.**
- Even school Principals and teachers are reluctant and sometimes very resistant in taking session on RH issues.
- Prevalent myths and misconceptions
- Young women being more vulnerable to sexual abuse and violence, getting pregnant and unsafe abortions.

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

At present there is no dedicated health and counseling services available exclusively for the adolescents and young people in the government health sector in Bihar. This fact corroborates the data above (and other data) that point to poor status of adolescents and young people in Bihar and more so women and members of marginalized communities.

They, as a group are often ignored, especially in terms of availability of dedicated health services and benefits under various government schemes and initiatives. The problem becomes much acute given the different settings where adolescents and young people live, which are very diverse: in-school, out-of school, mobile stationary, rich poor, urban rural etc. This fact

coupled with figures above makes a strong case to start dedicated and integrated adolescent and young people services, including clinical health services, counseling, and creating linkages with education, development and livelihood options for them.

Goals of ARSH Programme

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

2. To create dedicated ASRH services at all levels of health department, catering to age specific clinical, counseling and developmental needs of adolescents and young people

3. To build linkages among health, education and welfare departments on adolescent issues to provide integrated services under the same roof at different levels of government functioning on aspects of health, education and livelihood options.

Objective:

- Providing health care and counselling services through Awareness camp & campaigns.
- Incorporating Reproductive health chapters in High School curriculum and strengthening NHED sessions in AWC.
- Providing IEC materials in Schools, Health centres, Panchyats and youth clubs, alongwith initiating discussions among adolescents on reproductive health issues in various forums.
- Ensuring TT, IFA (Including bi-annual Hb tests in the AWC/HSC/School health check up camps) to all adolescent girls.
- Provision to supplementary nutrition through the AWC to all adolescent girls.
- Organizing BCC campaigns to increase awareness against early marriages and frequent pregnancies , initiate social sanctions through the Gram Sabhas & Panchayats in this regard.

Activity:

- Enabling environment
- Seeking Systemic and Social Sanction
- Training and capacity building of adolescent
- Behavior change communication**.**
- Key intervention like . Life Skills Education and Prevention of RTI/ STI/HIV..
- Establish youth resource center (health resource centers in all Gram Panchayats).
- Synergy of service providers like ICDS, Health and Education.
- Establish referral network.

- School health education Camp for adolescent.
- Health education at village and counseling campaign in all the villages in every month.
- Involve in AWC and give appropriate facility on Nutrition and health.
- Train all ICDS and Health Staffs on adolescent hoods, Personal hygiene, Counseling and adolescent problem management. Crucial role of family and community in adolescent health.

New Proposed Interventions

Adolescent Reproductive & Sexual Health

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

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

 Women aged 20-24 married by age 18 in Bihar is 60.3% (NFHS 3)

 Median age at first birth for women age 25-49 in Bihar is 18.7%

 Total fertility rate (children per women) in Bihar is 4

RTI/STI and HIV Prevention

STI/HIV is a development crisis with profound implication on future infant, children and maternal mortality, life expectancy and economic growth. These unprecedented impacts at the macro-level are matched by the intense burden of suffering among individuals and households. AIDS is unique in its devastating impact on the social, economical and demographic underpinnings of development.

Although Reproductive health care is essential part of every individual family but over a period of time It has not given serious attention that it deserves. Taboos, Misconception, Misunderstanding and Misbelieve are found more in relation to sex & reproductive health care than any other disease.

High incidence of infertility pregnancy and poor reproductive outcome is an indirect reflection of high prevalence of RTI/STI .In the MLP exercise it was evident that number of RTI cases is alarmingly high among woman. Three out of four women affected from RTI are bellow the age of 25 years.

Reproductive health is a state of complete physical, metal and social well being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes according to the World Health Organization.

In order to achieve the above, we need to create an environment whereby a woman has the freedom and empowerment to regulate the fertility with pride and dignity. This would mean the presence of a more equitable and meaningful relationship between man and women. This can be achieved by improving the status of women socially. Empowerment of women socially and economically, will enhance their ability of asserting themselves and their rights. The awareness building on the role of men and women in achieving the above mentioned is of primary importance. This would also mean a better health care for women in terms of quality, accessibility and affordability, which are totally lacking in the remote areas of the district. In order to create a sustainable Reproductive health Development, it is important for the male and female to realize the role either play in each other's lives, rights from adolescent through the adult phase of life.

Every day 7000 young people worldwide acquire the HIV virus. This means around 2.6 million new infections per year among young people. Overall, young people account for at least 50% of all those who become infected after infancy, and in some countries the figure exceeds 60%. Worldwide new infections in young people occur at a rate of 5 per minute (UNAIDS 1998). In India, current available data, limited as it is, indicates that the youth will increasingly be at the center of the epidemic, both in terms of transmission and impact. Over 50% of all new infections in India take place among young adults below 20 years.

DLHS-3

Awareness of RTI/STI and HIV/AIDS

- Eligible women heard about RTI/STI- 39.8
- Eligible women Symptoms of RTI/STI-21.5%
- Eligible women heard of HIV/AIDS-29.5%
- Women who know place to go for the testing HIV test-43.3%
- Women under went test for HIV- 2.7%

M8	RTI/STI Cases	
8.1	**Number of new RTI/STI for which treatment initiated**	Samastipur District Apr-Oct 11
8.1.a	Male	1558
8.1.b	Female	2106
8.1.c	Total {(a) to (b)}	3664
8.2	Number of wet mount tests conducted	168

Perceived needs and constraints.

Although RTI/STI affects most of the common people but poor are the prime sufferers from the infection. There is a need for compressive policies, youth-friendly health services, gender sensitive and culturally appropriate IEC materials and programs that provide holistic interventions which include integration of RTI/STI prevention with non-formal education and vocational training, where these exist, and developing linkages with other resources such as technical training canters, financial organizations for support to small enterprise development, government schemes for unemployed youth- etc. for young people so that they may have a healthy and productive future.

Health infrastructure in the district is inadequate and needs to be strengthened further. For instance, in every Block, there should be a hospital, with all health facilities having specialist Doctors and district hospitals need to maintain the standard of IPHS with special initiatives on an HIV testing, counseling & Care facility.

Traditional and pervasive gender inequalities place girls at a particular disadvantage in access to education and income, and in their ability to choose when, with whom, and under what conditions to have sexual relations and in exercising their rights for safer sex specifically among the rural populations.

This also severely compromises the position of **young girls** in these states, as they are not only biologically more vulnerable to HIV but are also 'victims' of gender discrimination which further increases their physiological vulnerability {given less food, are therefore malnourished, have an already weak immune system, do not access health facilities for even minor ailments, lack of sanitation (toilets) facilities result in gastro enteric problems, poor personal hygiene (cannot bathe as there is no water or bathroom, cannot wash and dry menstrual cloth in sunlight, as it needs to be hidden under the bed, etc.) during menstruation predisposes them to fungal and other reproductive tract infection increasing the likelihood of getting STD/HIV} and are also

socially and economically at a greater disadvantage as outlined below. Some of the main factors increasing girls/women's vulnerability are listed below:

In general following Factors influence the incidences:

- Local customs and traditions.
- Low level of education, health information and personal hygiene.
- low financial and social status.
- Multiple sex partners.
- Non-availability of Medical facility
- Investigative equipment's & experts not available.
- Private and separate department for RTI/STI lacking in Govt. sectors.
- Non availability of Proper and effective medicines for treatment.

Biological vulnerability

- Larger mucus surface; micro lesions which can occur during intercourse may be entry points for the virus; very young women even more vulnerable in this respect.
- More virus in sperm than in vaginal secretions
- As with STIs, women are at least four times more vulnerable to infection; the presence of untreated STIs is a risk factor for HIV.
- Coerced sex increases risk of micro lesions.
- Monthly menstruation and daily hygiene of genital.
- Genital and anal is situated nearby. It promotes fecal contamination.
- Infection in the female reproductive tract, which are not transmitted sexually but are a result of an overgrowth of organisms normally present in the vagina.

Economic vulnerability

- Financial or material dependency on men, that means, women cannot control when, with whom and in what circumstances they have sex
- Many women engaged in commercial sex for their well being and family responsibilities, often poor women are encouraged to inter in sex business for the livelihood security.

Social and cultural Vulnerability

- Women are not expected to discuss or make decisions about sexuality
- They cannot request, let alone insist on using a condom or any form of protection
- If they refuse sex or request for condom use, they often risk abuse, as there is a suspicion of infidelity
- The many forms of violence against women mean that sex is often coerced which is itself a risk factor for HIV infection

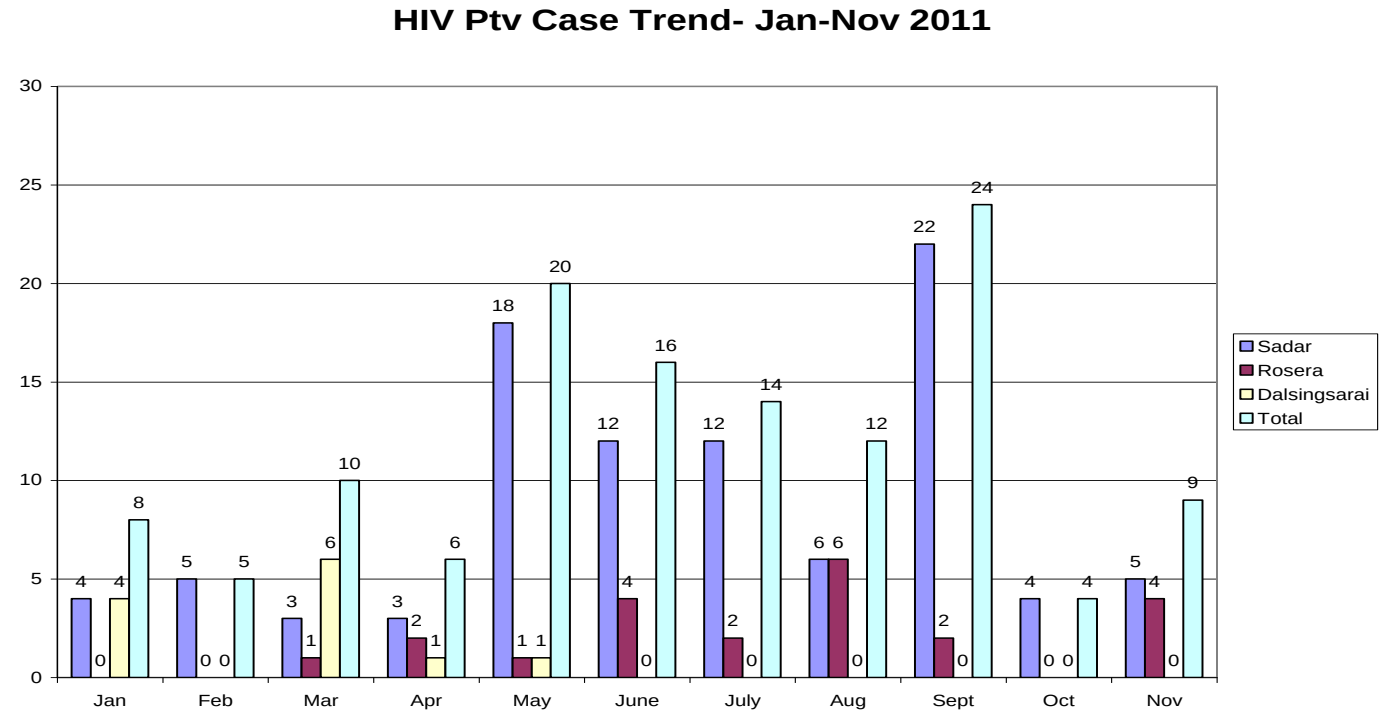
- For married and unmarried men, multiple partners (including sex workers) are culturally accepted
- Men are seeking younger and young partners in order to avoid infection and in the belief that sex with virgin cures RTI/STI/AIDS and other diseases (Source: WHO).

Sexuality remains a taboo in Indian society, and the District of Samastipur where traditional conservative views co-exist with an open and sexually permissive culture. The two polarities are difficult to bridge, especially when NGO, public and private sector organizations, decision and opinion makers, policy planners and implementers, belong to the former conservative category.

The culture of silence around sexual and reproductive health, young peoples concerns on reproductive and sexual health issues like menstruation, masturbation, homosexuality, intercourse, attractions to the opposite sex, etc. remain mostly unanswered. The situation is such that myths and misconceptions such as, masturbation makes the males weak and impotent, it is not good for girls to bathe during menstruation, once a person is 'cured' of an STD it will never recur again, sex with a virgin cures a man of STDs, using contraceptive pills or IUD (intrauterine device) will also protect from STD/HIV, etc further increase the vulnerability, particularly for girls and young women. Condoms for adolescent age group 10-19 years are not available or manufactured in India. Gender and cultural sensibilities will not allow an organization to openly talk about and promote condoms for 13-19 year age group, especially, women/young girls, more so for unmarried young people. Again fear and shame would prevent young people from asking for, purchasing and using contraceptives. Moreover, young people, particularly in India, have almost no access to sexual health information, education, and services on these issues because the issues are perceived to be socially, culturally, and politically sensitive. Along with this is the fact that the health infrastructure and investment in these two states in India is inadequate and what exists is insufficient to meet their health needs.

Young people face social, economical and health challenges that pose unprecedented threats to their sexual and reproductive health and well being in light of the HIV/AIDS. While some progress has been made in recent years in delivering youth friendly programs these are mostly confined to urban school going youth and are short-term, isolated incidents without any support services. Many do not address gender inequalities, include girls or attend to their specific needs, or reach married and/or out-of-school adolescents from rural-tribal areas. Often, the programs continue to take a narrow, vertical approach without considering young people's educational, economic, and other social needs. The information shared and given out is therefore out of the context of the life of the young person, more so if it is a girl. Therefore the present program endeavors to adopt a more comprehensive and broad based approach by placing HIV/AIDS prevention and care issues within the context of reproductive and sexual

health needs of young people and integrate it along with the socio-economic and other developmental programmes seeking to empower the youth.



The main strategies for the programme:

i) Promoting convenient, easily accessible, developmentally appropriate and culturally competent activities that address the multiple needs of young people such as peer prevention programs, popular opinion leader interventions, and network interventions, service linkages on reproductive/sexual health services and social marketing of contraceptives and sanitary pads.

ii) Encourage prevention programs with a holistic approach that promote safer behaviors and build skills (e.g., safer sex negotiation, delay first sexual intercourse), and provide service linkages with existing programmes on income generation, small savings, health and other developmental issues.

iii) Support projects and programs that can reach underserved and out of reach young people – married and unmarried, out of school youth simultaneously and specifically, through services/projects that are personalized, extensive, and that provide ongoing contact and follow-up for behaviour change and lead to sustained risk-reduction strategies.

iv) Promotion and capacity building of health staffs and NGOs on social marketing skills and techniques by facilitating development of a detailed business strategy and plan for sustaining activities through social marketing of contraceptives and sanitary pads.

Objectives

Main aim is to increase access of young people, especially young girls, to information and services on RTI/STI/HIV/AIDS prevention and related reproductive health issues.

AIMS

- Increase access of young people, especially young girls, for information and services on RTI/STI/ prevention and related sexual health issues;
- To improve the quality of sexual life.
- Sensitize & increase the awareness level of the Community and target Groups on STIs, HIV/AIDS.
- Enhance skills, capacity, knowledge of all target groups to create enabling environment.
- To prevent the STIs, HIV infection among the target groups.
- To change the risk Behavior of the Target Community
- To ensure condom out lets & increase the condom use among the Target community.
- To mobilize, facilitate regular Govt. services on Reproductive Health care, STI treatment and Condom Programming
- Promote and advocate for the development of a District specific strategic plan and contribute to public policy development on RTI/STI/HIV prevention and care for young people at district and state level through advocacy, networking and alliance building between NGOs, private and public sector organizations.

a) Specific Objectives

1. All PHCs and CHCs equipped with lab facilities and lab technicians to carry out diagnostic tests.
2. Training of all medical officer for RTI/STI services.
3. Special camps for the diagnosis of RTI/STI should be conducted in each PHCs twice in a year
4. Increased knowledge of RTI/STI symptoms from 15% to 70%.
5. The percentage of treatment for RTI/STI in women's increased from 5% to 45% .

b) Strategic Interventions: -

Strategy to meet all the felt needs for RTI/STI would include :-

- RTI/STI clinics are being set up in the FRUs and PHCs phase wise.
- Trained doctor in RTI/STI management.
- Trained ANMs, LHVs to provide RTI/STI services to the community.
- Educate the community about RTI/STI, mode of transmission and complications of infection.
- Counseling service should be provided to all RTI/STI patients.
- Partner notification & his/her sexual partner can be similarly treated and counseled.
- FRUs and PHCs should be well equipped with lab and technicians.

- Ensure useful medicine in adequate quantity for RTI/STI services.
- RTI/STI services included in RCH camps.
- Private practitioner trained for RTI/STI services.
- Involvement of indigenous method, practitioners in improved IEC and early detection

Activity:

- Training and Capacity Building.
- Educational Material Development in local language.
- Create Enabling environment.
- BCC through Mela, Nukadnatak, FGD, Meetings etc.
- Condom promotion.
- Syndromic management and couples treatment at all PHC/CHC and Special with special counseling rooms.
- National Family health awareness campaign and follow-up.
- Community Based Advocacy and Lobbing.
- Monitoring and evaluation.
- Early diagnosis of RTI / STI through early detection of potential cases through syndromic approach and referral by ANM and ASHA.
- Integrated counselling services will be provided
- Conducting VDRL test for all pregnant women as part of ANC services.
- Implementing contact surveillance of at risk groups in convergence with Bihar AIDS Control Society.
- Conducting community level RTI / STI clinics at PHCs
- Training to all MOs at PHC / DH level in Syndromic Management of RTI / STI cases in coordination with Bihar AIDS control Society
- Training of frontline staff, LHV, ANM and ASHA in identifying suspected cases of RTI / STI in coordination with Bihar AIDS Control Society.
- Strengthening RTI / STI clinic at the FRUs

MEDICAL TERMINATION OF PREGNANCY - PC&PNDT

1) INTRODUCTION

Medical Termination of Pregnancy is a reproductive health measure that enables women to opt out of an unwanted unintended pregnancy without endangering her life and well being. Ensuring women's access to safe abortion services is an essential component of ensuring women's right to safeguard their health and is one of the components o Government of India's Reproductive and Child Health Program.

India legalized medical termination of pregnancy of broad socio-medical grounds through the MTP act 1971. The aim of Act was to reduce maternal mortality and morbidity due to illegal abortions.

2) Current situation Dist. Samastipur

M7	**Medical Termination of Pregnancy (MTP)**	
7.1	**Number of MTPs conducted at Public Institutions**	Samastipur District Apr-Oct 11
7.1.1	Up to 12 weeks of pregnancy	13
7.1.2	More than 12 weeks of pregnancy	0
7.1.3	Total {(7.1.1) to (7.1.2)}	13
7.2	Number of MTPs conducted at Private Facilities	0

Abortion takes place largely for reasons related to unwanted pregnancies . Unwanted pregnancies can be dealt by promoting modern contraceptive use and thereby meeting unmet demands.

Poor quality of abortions by untrained persons and traditional healers are mainly due to

- Unwanted and mistimed pregnancy
- Lack of accessibility to quality MTP service at PHC level
- Use of illegal provider who provide poor services
- Lack of knowledge of population on risk of illegal and traditional abortion
- Low social status and education level of girls and women

High risk pregnancy is mainly due to

- Early pregnancy or Due to unwanted pregnancies
- Birth spacing.
- Too many children
- Low health and nutrition status (especially adolescent anemia) of women..
- Failure of Contraceptive methods.
- Due to serious infections or disease.

Objectives

- Provide MTP services as per RCH guidelines and at least in all identified FRUs by 2012, and in the district hospital.
- BCC campaign for covering all villages for prevention of harmful effects
    - To create awareness among women/ adolescents about dangers of unsafe abortion and availability of safe MTP services.

Activity

- Provide appropriate place, necessary equipment and facility to perform MTP in the health facilities
- Train medical officers/ specialists in MTP
- To provide pre and post abortion counseling at all institutions providing MTP services
- Provide additional equipment needed for the service.
- Counseling women and adolescent pregnant women
- Interpersonal communication with users of services

Indicator

- Health facilities equipped with MTP facilities
- Health personnel trained in MTP
- Abortion cases follow up
- 2nd trimester MTP performed at the district hospitals
- Women/adolescent aware of complication of abortion

Pre Natal diagnostic techniques, prevention of misuse PNDT Act

The state has implementation prenatal diagnostic technique, prevention of misuse act for sex determination and selective female foeticide. The implementation act is very essential. There is a strong son preference in the behavior of the people and this is very essential to create awareness amongst people and implement the act fully. The appropriate authorities have been made at all district. There is a strong needs to make social activist and people aware that if any female feticide take place it should be brought to the notice of preventive action.

Workshops and seminars will be organized; print and electronic media will be used.

It is proposed that the demand of health services has to be increased. The innovative IEC has to be done to generate the demand amongst the people so as to bring about the behavioral change amongst the people.

The innovative strategy of IEC will be done for traditional healers , Panchayats at village level, newly couples at health contact visits by the HW -M& F & AWW , sensitization workshop for NGO representative at district.

The social mobilization has to be done through Panchayat and Gram Sabha and the electronic and print media and yatras sensitization of social activists, opinion leaders, traditional leaders, NGOs and newly wed couples will be involved in this.

Strategic Interventions of situation in our district are as follows.

- Need based training arrangements in MTP have been planned to be completed.
- To supplement these regular arrangements the state will also provide assistance by taking district as units for engaging doctors trained in MTP for provision of these service in PHCs once a week on fixed dated visit including ante-natal and post natal service provision.

- In view of the importance of ensuring adequate facilities for MTP in the interest of women's health, MTP equipments will be provided to well run and competent medical clinic in the non-government sectors also provided they have operation theater and trained doctors and nurses.
- Establishment of at least one MTP service unit in a health institution in each block with well trained medical officers and necessary equipment to provide MTP services.
- Identification of private clinic that do pregnancy test and invitation of action against them.
- Educate communities on availability of safe abortion in Government health institutions and harmful consequences of unsafe abortions.
- Trained medical officers on need to keep confidentially and privacy of women who seek medical termination of pregnancy services.

PNDT_Following actions have been taken and planned in this regard -

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

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

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

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

Infrastructure and Human Resource

The health workforce situation of the state is still in real dearth. The state is lacking in almost every category of health workforce. Worse still, the number of available nurses, doctors and specialists are below the requisite level. The condition is further worsened by the fact that the

state's institutions are either insufficient or not adequately developed for meeting this demand-supply gap in human resource for health services.

Incorporating Gender in Health, in Samastipur district:

The basic philosophy to addressing equity and gender issues has been the creation of a public health system that provides universal access. Universal access would thereby ensure access for the poorest and for those excluded by reasons of gender or social marginalisation. Also demand patterns seem to be lower in poorer, less illiterate sections. Informal exclusions by health care providers of most marginalized sections because of the ' cultural gap' between them and the communities they serve also limit access. Private care access is on the other hand costly and often irrational and at the village level technically illegal. These can contribute to exacerbating inequities instead of ameliorating them. Bihar state has attempted to address this problem in four ways:

a). Facilitate access by the poor and make services more accountable to the poorest by community level mobilisation. The Asha programme by selecting a women from every hamlet sees that even marginalized hamlets has a spokesperson and that too a women who facilitates service delivery to these sections. Since the Asha programme follows health rights approach accountability is addressed though perhaps not yet redressed. There has been considerable success in this but weak drug supply to Asha and poor referral services still remain a problem to her effectiveness.

b). Equity issues are sought to be addressed by improving quality of services and insisting on 100% coverage in antenatal care, immunization delivery, Access to emergency care services etc.

c). Affirmative action in the form of special programmes addressed to the needs of the poor and women and marginalized communities. Special programmes for the urban poor, for adolescent women , for rural , for RTIs etc. also seek to address equity issue.

d). Recognizing that for a number of reason the majority of people- even the poor still access private health care service, public private partnerships where the poor can get affordable care and even free care have been mooted but are yet to be operational zed (NRHM).

The afflicted world in which we live is characterized by deeply unequal sharing of the burden of adversities between women and men. Gender inequality exists in most parts of the world. However, inequality between women and men can take very many different forms. Indeed, gender inequality is not one homogeneous phenomenon, but a collection of disparate and

interlinked problems (*Sen, A. 2001).* Supporting to above statement of Nobel laureate, following kind of disparities were observed during field studies that needs to be focused under NRHM/ RCH -II Programme:

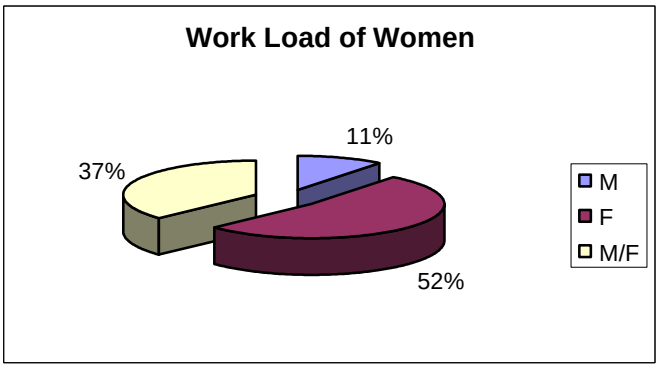
Mothers focus group Discussion and meeting

1) Mortality & Nationality inequality: As global studies reveal inequality between women and men directly involves matters of life and death, and takes the brutal form of unusually high mortality rates of women in various stats of our country. In Samastipur Girl child U-5 mortality rate is 84 where as for boy it is 70 in total it is 77. Though there is a difference mortality indicator of two difference sexes but no symptom was reported in support of any brutal attempt against girl child's death. However are some instances noted to given a preference for boys over girls that is very common in male-dominated societies. Gender inequality can manifest itself in the form of the parents wanting the newborn to be a boy rather than a girl. Similar to urban area, it is inherent wish of a tribal family to have a boy baby. Since past it was clear division of roles between tribal men and women. Women were supposed to take care of domestic and reproductive responsibilities inside the village where as men were expected to cultivate crops and hunting in forests. This is a prime cause of large sized nuclear families in the district.

(3) Basic facility inequality: Even when demographic characteristics do not show much or any anti-female bias, there are other ways in which women can have less than a square deal. There are other deficiencies in basic facilities available to women, varying from encouragement to cultivate one's natural talents to fair participation in rewarding social functions of the community. A woman equally contributes into household economy but they don't have control over expenditure. Across the district pregnancy is not considered as special state of women. Early marriages and pregnancies are most prevalent in Samastipur. Women are very shy in nature. Women and elders of the family having tendency of hiding pregnancy this results into less or late enrollment in AWCs. Women expect privacy during ANCs, consulting on RTI & STI and discussing about their case history of previous pregnancies. In AWCs during ANCs they expect themselves to be treated separately, which is not possible for ANM to provide them such required privacy. Shortage of required space was considered as one of the most neglected area, which needs urgent attention.

4) Special opportunity inequality: Even when there is relatively little difference in basic facilities including schooling, the opportunities of higher education may be far fewer for young women than for young men. The girl child is expected to educate up to primary whereas boy has no fixed criteria. Gender asymmetry can be seen in many areas of education, training and participation in a program or even accessing information. Apart getting girl child literate it is urgently required to provide facilities to access health services and information during her puberty.

(7) Household inequality: There are, often enough, basic inequalities in gender relations within the family or the household, which can take many different forms. Even in cases in which there are no overt signs of anti-female bias in, say, survival or son-preference or education, or even in promotion to higher executive positions, the family arrangements can be quite unequal in terms of sharing the burden of housework and child care. It is, quite common in tribal as well as urban communities to take it for granted that while men will naturally work outside the home, women are expected to do it combining it with various inescapable and unequally shared household duties. As a result of 'Daily activity Schedule', Women continuously work for 16- 18



hour, where as men 9-10 hour a day (Annex 1). As workload analysis of men and women reveals that women are over burdened and are engaged independently in 52% of the total household activities where as only men activities contribute 11% and 37% activities are performed jointly (Fig.1). Though men support women in cooking and child rearing if she has another new born but household core activities are sole responsibilities of women. This is called "division of labour," though women could be forgiven for seeing it as "accumulation of labour." The reach of this inequality includes not only unequal relations within the family, but also derivative inequalities in employment, choices, leadership and recognition in the outside society. Also, the established fixity of this type of "division" or "accumulation" of labour can also have far-reaching effects on the knowledge and understanding of different types of development and schemes. In the given situation where women are heavily indulge in productive as well as reproductive activities are required to shift their attention on basic health requirements. Capacity building efforts are urgently be applied to shift their attitudes from household chore activities to personal health of a women as a separate entity of community.

There is relatively little bias against women in terms of health care and social status:

However, women receive less attention and health care than men do, and particularly girls often receive very much less support than boys. Infant mortality rate in Samastipur 50 whereas for girl child it is 60. It reveals, a significant bias against women in terms of health care and other attentions relevant for survival. Problems of gender bias in life and death to other issues, which are in need of greater investigation at this time. To deal with the equity issues discussed in RCH-II document. Following issues need to be investigated that were emerged while conducting MLP exercises in 11 villages of Samastipur:

Home deliveries: Access and Quality of Reproductive Health Services:

Quality of services:

Home visits conducted by ANM & AWW were found proportionally low to the registered pregnant & lactating women. Knowledge transfer from service providers to the beneficiaries is required intensive efforts in places where ANM is not stationed. Counseling & demos of FP methods can be a part of their plan. Quality time spent during house visit, is an area of concern that need to be dealt seriously.

Technical Quality of services needs to be taken into concern on following points while making a community health plan.

- Complete ANC and counseling.
- Delivery by TBA and Immediate BF
- Ensuring first contact to the newborn.
- Immunization drop-out rate
- Experienced Contraceptive side effects
- Supply of contraceptives:

Suggested strategy for BCC:

- Counseling of Men and women during health camps.
- Family counseling through Sas-Bahu-Pati sammelan.
- Gender audits for equitable distribution of benefits from services
- Regularizing VHSND sessions for women in AWC and through Gram Panchyat.
- Counseling centers in schools for adolescents.

Summing up

By trying briefly to identify some of the principal issues. It is required to take a plural view of gender inequality, which can have many different faces. The prominent faces of gender inequality can vary from one region to another, and also from one period to the next. Gender inequality hurts the interests not only of girls and grown-up women, but also of boys and men, through biological connections (such as childhood undernourishment) and also through societal connections (including in politics and in economic and social life).

Strategic steps are suggested in various chapters of NRHM document that needs to be worked out. Special focus is given on enhancing awareness on maternal and adolescents' reproductive health. It is required urgently to focus on health requirement of men and women separately respective to their age groups. Alongwith this, community initiatives and strong actions are required to make health as a prime agenda of men and women as well as service-providers.

Setting up of Intensive Care Unit in the District Hospitals and Operational Quality Assurance Cell:

An Intensive Care Unit (ICU) is a specialized department in a hospital that provides intensive care medicine. Many hospitals also have designated intensive care areas for certain specialties of medicine, as dictated by the needs and available resources of each hospital.

Most of the districts do not have Intensive Care Unit in District Hospital. The patients have to shift either to the nearest medical colleges or to Patna for Intensive Care. In the process of transfer most of time it has been seen that patient die during transportation.

The distance to the nearest ICU set up is long and precious time is wasted for treatment of the patient.

Setting up of Intensive Care Unit will help the patient to avail the facility in all districts so that accessibility for intensive care can be addressed.

The State Government is setting up 4 bedded ICUs in different District Hospitals of Formation of State Quality Assurance Cell

A. Background:

For improving the functioning of the public health facilities and help in strengthening the processes for the providing quality public health care services throughout the District, provision for QA Cell can be done in FY 11-12. Quality Assurance intervention in NRHM will be an attempt to move forward by initiating and operationalizing programmatic interventions. It proposes to develop and institutionalize the use of the field based, practical and feasible indicators in quality assessment and to transform existing supervision practices into a more standardized and structured process. *Any sustainable change in terms of institutionalization of Quality Assurance (QA) will come from within the system and not from outside.* It is hoped that interventions from demand side (for example, community and individuals demanding better services) will also put pressure on the system to deliver quality services which will in turn give impetus for investing in QA.

B. Objective of the Quality assurance Cell

I. To facilitate the improvement of systems and processes of service delivery in the healthcare facilities to meet the laid down standards as appropriate.

II. To develop quality management systems at the hospital level, leading to enhancement in service quality and leading to certification to ISO 9001 standards.

III. The objective of the proposed Quality Assurance mechanism at state and district level is to facilitate the continuous monitoring of quality of reproductive health services/ MCH services at health facilities and consequently improve service quality by focusing on and addressing the gaps identified during the assessment process.

IV. The Quality Assurance Committee at state and district will conduct periodic assessment visits using specific tools and based on the gaps identified will help the service providers, address specific service quality elements and sub-elements.

V. This will also lead to initiating a series of actions to address the gaps and hence improvements in the quality. Subsequent visits will ensure that actions initiated have resulted in improvements in the facility score.

As per the guidelines laid down by the Honorable Supreme Court of India, *the State*

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

C. The State Quality Assurance committee (SQAC) at state level is chaired by Principal

Secretary Health, .The committee meetings should be organized by SHSB on quarterly basis. The SQAC can be used to obtain administrative approvals for the QA activities guided by the recommendations of Member's field observations and District Quality

Assurance Committee report.

D. Likewise District Quality Assurance Committee are functional at district level with the following members and expertise:-

1. District Magistrate -Chairperson

2. Civil Surgeon – Member secretary

3. ACMO – Convenor

4. Members

- Gynaecologist and/or surgeon and /or Anaesthetist and/or Paediatrician
- NGO representative
- District Nursing head
- District RCH officer/FW officer
- District Program officer, TB, Vector Borne, Blindness and leprosy
- DPM

5. Technical assistance- Two health educator (competency on computer) can be deputed to the cell by CS

6. Secretarial assistance – District M&E Officer

7. Special Invitee: Representative from Development Partners

{Full time members/ experts for MCH, Family Planning , public health and Quality

Assurance Manager may be incorporated as per the approval on the proposal.}

But the members incorporated in the State Quality assurance Committee may face time constraint and may not be able to contribute their full time support in terms of regular supportive supervision; follow-up and action taken for strengthening the programs; making plans for capacity building / trainings to service providers for improving the quality aspect of service delivery mechanisms.

Hence some more full time members may be incorporated or recruited in the

Quality Assurance Cell having expertise in Maternal health, Child Health; family Planning; public health and data analysis.

E. Scope of Quality Assessment in the District Quality Assurance Programme

In this QA intervention, the Reproductive and Child Health services to be assessed are limited to those provided at the facilities, RCH/sterilization camps and include sub-center outreach services.

RCH Service Areas	Elements of Quality Assessed
Family planning services including provision of clinical and non-clinical contraceptives B. ANC, safe delivery, Basic Emergency Obstetric Care(BEmOC) including essential newborn care C. Reproductive tract infections including sexually transmitted infection (RTI/STI) prevention and management including VCT for HIV at designated facilities D. Child Immunization	1. Service environment 2. Access 3. Equipment and supplies 4. Professional standards and technical competence 5. Continuity of care 6. Client provider interaction 7. Informed decision making 8. Privacy 9. Confidentiality 10. Informed consent 11. Proper disposal of wastes

B:NRHM Flexi Pool:

Accredited Social Health Activist

The ASHA programme builds on an extensive history of civil society and State efforts to involve communities in changing their health status by influencing the determinants of health at the household and community level as well as ensuring that health services are contextually relevant, timely, need based and accountable. In all of these experiences, wherever Community Health Workers have been appropriately identified, trained and supported, health and nutrition indicators have dramatically improved.

In fact, experience suggests that the introduction of a community-based change agent on a large scale, such as the ASHA, should be conceptualized at the heart of two interrelated processes:

(i) Strengthening of primary healthcare systems and services; and

(ii) Sustainable community-owned and driven behavioural changes.

Creating a space for such an activist – within the community, within the programme, and within the public health system – requires flexibility to both the community's and individual's needs, as well as commitment to providing continuous inputs and supportive structures. Most importantly, the health activist should occupy a unique position, one that is based in the community and yet has access to knowledge and resources from the larger programme. These are two processes considered critical for both the success of the ASHA programme as well as for ensuring the effectiveness of the health system.

The Accredited Social Health Activist (ASHA) Programme

The accredited Social Health Activist (ASHA) Programme is one of the cornerstones of the NHRM and aims to select, train and support a community-based change agent for at least every cluster of 1000 people in rural areas. This Community Health Volunteer is expected to be a locally selected woman who will catalyse a community-based process of behavioural change and facilitate better access to basic health services by poor households. She will disseminate knowledge and create awareness about health issues and their social determinants, engage closely with pregnant women, mothers, and other household members, to negotiate and adopt appropriate care practices, and mobilize her community to participate in local health planning and increase the utilization and accountability of existing health services. In addition to her primary role as a promoter of desired health practices, she could also provide a minimum package of curative care as appropriate and feasible for her profile and make timely referrals.

50. In recent times, Community Health Workers (CHWs) have received renewed attention, both nationally and internationally, as research has established and emphasized the effectiveness of community strategies and household-level practices in promoting child survival and development. For instance, three largely preventable and treatable causes – diarrhoea, pnenumonia and a limited set of

neonatal conditions – account for 82 per cent of all child deaths and that malnutrition is an underlying cause in around 52% of all cases. A number of household practices, such as improved nutrition and care during pregnancy, providing warmth and hygienic care to newborns, breastfeeding and complementary feeding, the use of Oral Rehydration Salts (ORS), hygiene practices during food preparation, and the use of insecticide treated bed nets for pregnant women and young children can have a significant impact on child mortality and malnutrition. As individual interventions, breastfeeding and ORS are especially effective: taken alone they are each capable of averting 16 per cent and 14 per cent, respectively, of all child deaths in India.

ASHA Monthly Meeting - Morwa

Most strikingly, analysis presented in The Lancet Child Survival Series estimates that actions taken at the household and family level alone can prevent over 30 per cent of child deaths and a similar proportion (up to 37 per cent) of neonatal deaths. Aware and vigilant families are also more likely to ensure that their children get prompt and appropriate facility – based clinical care, further contributing to declines in mortality. This is, therefore, clearly a priority area in high mortality resource-poor settings and requires investment in creative, contextual and decentralized strategies to work with families and communities. In this context, CHWs, such as those who are currently joining the ASHA Programme, have a vital role to play. From a review of a range of past experiences, it has been observed that wherever Community Health Workers have been appropriately identified, trained and supported, health and nutrition indicators have dramatically improved.

In addition to drawing strength from the latest scientific research, the ASHA Programme also builds on a rich history of civil society innovation in community health in India, and in many other developing countries. This is an attempt to translate earlier experiences and insights, a majority of which have emerged from smaller field-level initiatives, into large-scale processes of community participation in an ownership of health knowledge and services. Here, the critical challenge is to conceptualize and implement state-wide CHW progammes in regions with very weak health systems. Creating a space for

such an activist - within the community, within the programme, and within the public health system - requires flexibility to both the community's and individual's needs, as well as commitment to providing continuous inputs and supportive structures.

Most importantly, the health activist should occupy a unique position, one that is based in the community and yet has access to knowledge and resources from the larger programme. At this stage in particular, when States such as Bihar have already selected thousands of ASHAs across the districts, the quality of ASHA training and ongoing support must assume priority. This is also an area that lends itself to innovation and can benefit greatly from civil society expertise adapted to the challenges of large-scale programme management.

ASHA (Community Health Workers Training)

Training is an important element of the ASHA programme since it goes a long way in determining its effectiveness. Training equips motivated but untrained ASHAs to undertake their wide and complex responsibilities for preventive, promotional and curative health, as well as their role in educating and planning with the community. A large body of work exists and has been undertaken, where Community Health Worker (CHW) training has been conceptualized as a form of education for participation, empowerment and action for change.

Informed by this experience, the following have emerged as important aspects of training.

(i) Training Curriculum: This defines the abilities, knowledge and perspectives that the

ASHA needs to have, as well as training methodology, which refers to the ways in which this knowledge will be acquired. Given the ASHA's role, it is important to plan and create training modules that address health, nutrition and social issues comprehensively. In the context of Bihar, where literacy levels, especially among rural women living in poverty are significantly low, majority of the ASHAs would be from non-literate and semi-literate backgrounds. In this situation, recognizing the unique needs of this population, and addressing them in the conceptualization and implementation of training programmes, by innovating on content and methodology, is imperative for the training to be meaningful and for the ASHA programme to be effective. It is, therefore, important that the training methodology takes into account the existing learning levels and integrates significant scope for field-based training, to provide the ASHA with more confidence in her knowledge, through an ability to assess issues in reality rather than in a training centre, and act on them accordingly. Training techniques need to be innovative and be based on principles of adult learning, avoiding didactic presentations and information overload, and learning by drawing from life experiences instead. These could include elaborate explanation of the training modules using interactive techniques such as pictorial materials, story telling, skits, role plays, folk media such as Kalajathas, mass media such as local radio programmes to impart in-depth understanding about social issues, and technical health knowledge to the ASHAs.

SL NO.	Name of Block	Total Population	Target	Selected & Trained Till Last Month 2011 – 12		
				Total No. ASHAs selected	Total No. ASHAs Trained with Module 1	Total No. ASHAs Trained with Module 2,3 & 4
1	2	3	4	5	6	7
1	P.H.C Samastipur	**261462**	**261**	**214**	**207**	**134**
2	P.H.C Warisnagar	**196273**	**196**	**186**	**175**	**0**
3	P.H.C Kalyanpur	**300964**	**301**	**249**	**224**	**212**
4	P.H.C. Pusa	**128067**	**128**	**117**	**117**	**0**
5	P.H.C Morwa	**171871**	**172**	**141**	**141**	**0**
6	P.H.C Sarairanjan	**236721**	**237**	**231**	**231**	**203**
7	P.H.C Patori	**166509**	**167**	**140**	**131**	**0**
8	P.H.C Mohi-uddin Nagar	**165173**	**165**	**135**	**135**	**0**
9	P.H.C Dalsingsarai	**190194**	**190**	**179**	**150**	**0**
10	P.H.C Ujiyarpur	**267310**	**267**	**241**	**241**	**0**
11	P.H.C Bibhutipur	**301794**	**301**	**248**	**232**	**0**
12	P.H.C Rosera	**153652**	**154**	**123**	**120**	**115**
13	P.H.C Hasanpur	**207525**	**207**	**200**	**175**	**105**
14	P.H.C Singhia	**209959**	**210**	**157**	**157**	**0**
15	P.H.C. Mohanpur	**102981**	**103**	**87**	**75**	**0**
16	P.H.C. Vidyapati Nagar	**142046**	**142**	**112**	**112**	**0**
17	P.H.C. Shivaji Nager	**171778**	**172**	**159**	**130**	**0**
18	P.H.C. Khanpur	**175552**	**176**	**166**	**145**	**0**
19	P. H. C. Kothia (Tajpur)	**147959**	**148**	**120**	**120**	**0**
20	P. H. C. Bithan	**137849**	**138**	**126**	**126**	**0**
	Total :	**3835639**	**3835**	**3331**	**3144**	**769**

Training Strategy: Given the large number of ASHAs (approximately 50,000 or more) that every State is expected to have, it is important to plan how the training of such large numbers is to be organized, not just once, but continuously over a number of years. This implies detailing out the block, district and state level training structures and strategies. Additionally, it includes determining whether the training will be modular or one time, camp or field-based, its duration as well as the site of training. Specifying the profile of trainers and their support systems would be important for ensuring the continuity of training. Other important aspects include costs, monitoring and use of training materials.

Experience suggests that for effectiveness, trainings should be conducted in different rounds, gradually introducing new knowledge and constantly reinforcing learnings. Such phased training ensures time for reflection on basic concepts and does not load the individual with too much information at the same time. Importantly, the training should positively impact attitudes, build knowledge, skills and confidence. Thus, the training process should be conceptualized as part of a process of empowerment. A training strategy should aim to adapt itself to and emerge from the social and cultural context of different regions within the State.

STATUS FOR ASHA DRUG KITS, ASHA SAREE & UMBRELLA

S.L. No.	Name of Disrrict	ASHA Selection		ASHA Drug Kits		ASHA Saree	
		No. of Asha to be selected as per population	No of Asha selected	ASHA Drug Kit Received from State	Total No. of Asha Drug Kits Distributed among Asha's	ASHA Saree Received from State	Total No. of Asha Saree Distrubuted to Asha's
1	Samastipur	3835	3832	3835	3835	7670	7670

In large scale programmes, where hierarchical 'training pyramids' (in the form of a cascade approach) have been created to train ASHAs, it is important to address the issue of 'transmission losses' and hold strong training sessions at the 'senior' levels. Developing modules in the form of books has also been found to be useful for quality and standardized training in scaled programmes. At the same time there needs to be sufficient flexibility for district and block level trainers to innovate and include within their training sessions local health issues and practices and address them within the frames of regional variations of ethnicity, tribe, religion and caste that would arise in the context of Bihar.

There is, therefore, an important need to develop a contextualized training curriculum and strategy which is rooted in the socio-cultural milieu of any State.

B 4.2 JBSY Incentive Payment

Oct. 2011

Sl. No.	Hospitals	Institutional Deliveries Till last Month 2011 -12	Incentive Report				Total No. of Beneficiary Received Payment	Total No. of Asha Recived Payment
			No. of Beneficiary Received Payment Till last Month 2011 -12	No. of Asha Recived Payment Till last Month 2011 -12	No. of Beneficiary Received Payment in Reporting Month	No. of Asha Recived Payment in reporting Month		
1	**2**	**3**	**4**	**5**	**6**	**7**	**8=(4+6)**	**9= (5+7)**
1	Sadar Hospital Samastipur	**5832**	**1575**	**720**	148	0	1723	720
2	Sub divisional Rosera	**3475**	**1014**	**171**	0	0	1014	171
3	Sub divisional Dalsingsarai	**3804**	**490**	**414**	1050	1026	1540	1440
4	Govt Hospital Pusa	**1433**	**579**	**510**	49	500	628	1010
5	J.N.K.T Referal Hospital Tajpur	**3810**	**833**	**102**	1057	159	1890	261
6	P.H.C Warisnagar	**2320**	**974**	**623**	361	265	1335	888
7	P.H.C Kalyanpur	**2248**	**1256**	**75**	0	0	1256	75
8	P.H.C Sarairanjan	**2799**	**1025**	**297**	0	142	1025	439
9	P.H.C Patori	**2578**	**944**	**0**	321	82	1265	82
10	P.H.C Mohi-uddin Nagar	**2274**	**390**	**816**	169	435	559	1251
11	P.H.C Ujiyarpur	**1964**	**702**	**186**	0	0	702	186
12	P.H.C Bibhutipur	**2828**	**953**	**217**	744	12	1697	229
13	P.H.C Hasanpur	**2774**	**1660**	**0**	0	2245	1660	2245
14	P.H.C Singhia	**1911**	**608**	**205**	0	0	608	205
15	P.H.C. Mohanpur	**1017**	**256**	**139**	133	5	389	144
16	P.H.C. Vidyapati Nagar	**1693**	**0**	**0**	0	0	0	0
17	P.H.C. Shivaji Nager	**1182**	**0**	**0**	500	0	500	0

18	P.H.C. Khanpur	**1650**	**198**	**751**	456	346	654	1097
19	P. H. C. Kothia (Tajpur)	**1614**	**399**	**80**	52	38	451	118
20	P. H. C. Bithan	**831**	**1317**	**965**	1	0	1318	965
	Total :	**48037**	**15173**	**6271**	**5041**	**5255**	**20214**	**11526**

Establishment of Asha Resource Center

Responsibilities of the ARC at the District Level

- The major responsibilities of District ARC (especially District Community Mobilizer) are;
- Capacity building of Block facilitator and Block Trainer's Team in coordination with District Trainer's Team Create and maintain district resource database for the health sector and assist in optimal allocation of resources
- Coordinate with other govt. dept. such as; WCD, Water and Sanitary, Education and PRI, at District level for intersectoral coordination, and support Block facilitator for the same at block level.
- Develop measurable performance indicators for the District and Block level ASHA support system/unit.
- Undertake periodic review meetings for ASHA programme and community processes.
- Undertake frequent field visits for supportive supervision to the activities related to community processes implementation..
- Arrange visits/meetings of ASHA Mentoring Groups at District and Block Level.

Responsibilities of the ARC at the Block Level

 Block level mobiliser will assist Block Medical Officer for the effective Implementation of ASHA, VHSC, VHND and other related community processes activities in the block

 Capacity building of ASHA facilitators and ASHAs (in coordination with Block level trainer's team), review, implementation and monitoring of ASHA, VHSC and other related community processes activities.

 Coordinate for monthly meeting at PHC to discuss and sort out various issues of ASHAs relating to incentive payment, drug kit replenishment etc.

 Coordinate with other govt. department such as Health, WCD (ICDS official),

Water and Sanitation, education etc. at block level for inter-sectoral coordination

 Support/guide ASHA facilitator for various coordination at village level

 Submit reports on the above activities to District ASHA Coordinator

(iv) Sub Block Level

At the sub block level, one ASHA/Block facilitator for every 20 ASHAs to assist Block level organizer as well as to provide continuous handholding support to ASHAs will be engaged. She will be the 21st ASHA herself. She will support ASHA for/in coordination with ANM, AWW, PRI, VHSC, SHG etc., and will report to Block level organizer. She will support ASHA in organizing monthly meetings, Village Health and Nutrition Day (VHND), VHSC meetings as well as monitor drug kit replenishment. It is expected that she will spend 22 days in the field to provide support ASHA in her area of operation. This has been special envisioned for empowerment and developing leadership skills of ASHA.

Specific Functions related to ASHA

 Review and strengthen existing selection processes, in order to recruit the full complement of ASHA required, and plan for recruitment strategy for drop out.

 Ensure role clarity and advocate for an enabling environment to improve ASHA effectiveness.

 Identify state specific issues for inclusion into future rounds of ASHA training and ensure that the requisite 23 days of training for ASHA are held each year.

 Facilitate ASHA training programmes at sub block levels through the district and block level structures.

 Facilitate timely incentive payments through regular reviews and assessments and spot checks of the situation related to payments

 Ensure distribution and refilling of drug kits to ASHA.

 Strengthening the role of ASHA as an Activist through processes like Social Audit and Social Mobilization.

ASHA Engaged in different Program

Sl. No.	Name of PHC	Family Planning	Institutional Delivery	Home Delivery	R.I	Coper T	T.B Patient Serve	Leprosy Patient Serve	Kalazar Patient Serve
1	P.H.C Samastipur	707	2177	987	18557	14	105	14	0
2	P.H.C Warisnagar	756	2632	357	20489	70	91	35	42
3	P.H.C Kalyanpur	966	2044	525	19544	0	0	14	0

4	P.H.C. Pusa	539	1190	392	9219	21	35	7	0
5	P.H.C Morwa	399	1505	938	17038	0	0	0	0
6	P.H.C Sarairanjan	1057	2758	0	19600	0	112	0	42
7	P.H.C Patori	322	1673	630	15680	161	168	49	0
8	P.H.C Mohi-uddin Nagar	490	952	896	14091	49	182	0	7
9	P.H.C Dalsingsarai	63	413	21	8407	7	21	0	0
10	P.H.C Ujiyarpur	931	2443	1197	29344	224	455	28	14
11	P.H.C Bibhutipur	1211	2814	875	7868	168	63	0	21
12	P.H.C Rosera	210	1694	812	11340	56	231	14	7
13	P.H.C Hasanpur	546	3157	1897	18221	21	119	0	0
14	P.H.C Singhia	406	2044	945	15736	77	35	0	0
15	P.H.C. Mohanpur	210	756	35	5852	7	98	7	0
16	P.H.C. Vidyapati Nagar	504	1463	945	10031	35	98	49	14
17	P.H.C. Shivaji Nager	210	1358	28	11627	14	119	7	0
18	P.H.C. Khanpur	560	924	469	13293	21	0	0	0
19	P. H. C. Kothia (Tajpur)	1211	1841	350	12481	77	91	0	0
20	P. H. C. Bithan	126	679	966	11830	7	0	0	0
District		**11424**	**34517**	**13265**	**290248**	**1029**	**2023**	**224**	**147**

Asha Gap in the district:

- The Health functionaries are yet to recognize the involvement and result of the ASHA. As the focus is rather prevention it is curative focused.
- The key community stakeholders ASHA is not yet properly involved in the different regular National health programs.
- Some how it is fixed their role in RI activities and JBSY.
- There is in confuse during selection of ASHA that it will going to be permanent or govt regular post, so the selected asha who joined in this mentality were not involving her self for effective work.

- The Training and orientation of ASHA should be just after joining to understanding there role and responsibility and time to time the refresher training should be organized.
- The ASAHA were demoralized for the reimbursement of incentives as it is delayed for processing and some times the fund is not available.
- There is no supportive supervision process available during different progarmms in results Asha knows the things to do but due to un availability of the resourcious she could not be able to providing the services.
- Lack of Knowledge, skills and practices of asha in different health programs.
- In Samastipur district there is 20 Blocks with strength of 3835 ASHAs. To involve them effectively planning and monitoring need to be role out but due to unavailability of transportation provisions it is not properly administrated in the district.
- There is 20 block with 20 Block community mobilizer but due to availability of resourcious and guidance from managers they are not able to plane, implement, monitor and coordinating the things.

Steps for future action:

- Need to reinforce Asha is a volunteer and it will remain the same during selection of the ASHA.
- There is need to developed checklist for the performance appraisals.
- The ASHA incentive disbursements should be in time to encourage involvement and achievements.
- Directly or indirectly asha has been involved in different health programs with out any knowledge, so she should be well trained to get the results.
- Focused should be given for the availability of the resourcious , equipments and drugs availability.
- There is need to be district label resourcious for planning, monitoring, supportive supervision and implementation of unique interventions.
- Regularly organize monthly district level meeting of BCM to effectively involving and implementing.
- Geographical area rollout to avoid malpractice.
- Training of ASHA Facilitator.
- Training of BCM.
- ASHA MELA (Meeting for Empowerment Learning and Action)- Samillan at Block Level.
- Organize Incremental Capacity Building plan to accelerate Behaviour Change communication by monthly basis on one theme will be finalized to impart training of 2 each block functionaries (BCM and Supervisors ICDS) at district level and both the functionaries will train the ASHA on ASHA day monthly meetings and AWW on ICDS meetings. In the same Month the similar theme will be spread in the community for the changing of different practices.

ASHA MELA BUDGET AT BLOCK LEVEL -2012-13

Sl. No.	Name of Activity	Unit Cost (Rs.)	Unit No.	Total Cost (Rs.)
1	**ASHA Mela at Block Level**			
1.1	T.A.	80	3,835	3,06,800.00
1.2	Lunch/ Fooding	50	3,835	1,91,750.00
1.3	Stationery / BCC (Games/cultural programme)	100	3,835	3,83,500.00
1.4	Arrangements (Chair, Table, Tent etc.)	150	3,835	5,75,250.00
	Total			**14,57,300.00**

Incremental Capacity Building for BCM/LS

Sl.No.	Name of Activity	Unit Cost (Rs.)	Unit No.	Total Cost (Rs.)
1	**Incremental Capacity Building**			
1.1	Resource Person	500	12	6000.00
1.2	T.A. for Participants (BCM,LS/LHV) @ 1 BCM & 1 LS or LHV	100	2 x20x12	48,000.00
1.3	Stationery for participants (BCM,LS/LHV) @ 1 BCM & 1 LSor LHV	100	2 x20x12	48,000.00
1.4	Lunch for participants (BCM,LS/LHV) @ 1 BCM & 1 LS or LHV	100	2 x 20 x12	48,000.00
1.5	Venue charge	4000	12	48000.00
1.6	Printing of Hand outs& BCC Matrial for Asha and AWW	10,000	1X12	120000.000
	Total			**318000.00**

Village Health Sanitation and Nutrition Day

The NRHM guarantees better health outcomes for millions of people in rural areas, especially those belonging to marginalized and vulnerable communities. The VHSND promises to be an effective platform for providing first-contact primary health care. Quite often, program managers, service providers, community-based organizations, and PRI representatives do not share a common understanding about the activities to be undertaken and how these are to be operationalised while organizing the VHSND..

The VHSND is to be organized once every month (preferably on Wednesdays, and for those villages that have been left out, on any other day of the same month) at the AWC in the village. This will ensure uniformity in organizing the VHSND. The AWC is identified as the hub for service provision in the RCH-II, NRHM, and also as a platform for intersectoral convergence. VHSND is also to be seen as a platform for interfacing between the community and the health system. Keeping in view the significance of holding the VHSND, the important steps that need to be taken while organizing the event have been put together in this manual. The roles of the ANM, ASHA and AWW should be well defined. The quality of the VHSND needs to be improved, and hence the outcomes should be measured and monitored.

This document will help AWWs, ASHAs and PRI members to understand their respective roles in providing their services effectively to the community during the monthly VHSND and will also help in educating them on matters related to health. VHSND if organized regularly and effectively can bring about the much needed behavioural changes in the community, and can also induce health-seeking behaviour in the community leading to better health outcomes.

Program managers at district/block level should ensure availability of necessary supplies and expendables in adequate quantities during the VHSNDs. Similarly, supportive supervision by Program Managers at different levels will result in improved quality of services.

A) SERVICES TO BE PROVIDED:

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

B) ISSUES TO BE DISCUSSED WITH THE COMMUNITY:

- Danger signs during pregnancy
- Importance of institutional delivery and where to go for delivery
- Importance of seeking post-natal care
- Counselling on ENBC
- Registration for the JSY
- Counselling for better nutrition
- Exclusive Breastfeeding
- Weaning and complementary feeding
- Care during diarrhoea and home management
- Care during acute respiratory infections
- Prevention of malaria, TB, and communicable disease
- Prevention of HIV/AIDS
- Prevention of STIs
- Importance of safe drinking water
- Monthly Village Health Sanitation & Nutrition Day
- Personal hygiene
- Household sanitation
- Education of children
- Dangers of sex selection
- Age at marriage
- Information on RTIs, STIs, HIV and AIDS
- Disease outbreak
- Disaster management

C) IDENTIFICATION OF CASES THAT NEED SPECIAL ATTENTION:

- Identify children with disabilities.
- Identify children with Grade III and Grade IV malnutrition for referral
- Identify severe cases of anaemia.
- Identify pregnant women who need hospitalization.
- Identify cases of malaria, TB, leprosy, and Kala Azar.
- Identify problems of the old and the destitute.
- Pay special attention to the SC, ST, the minorities, and the weaker sections of society.

D) COLLECTION OF DATA:

- Compile data on the number of children with special needs, particularly girl children with disabilities.
- Report outbreaks of disease.
- Report/audit deaths of children and women.
- Compile data pertaining to the SCs, the STs, the minorities, and weaker sections of society that need services.

Checklist

It would be useful to have checklists for ASHAs, AWWs, and ANMs to ensure that all the activities for which they are responsible are planned properly and carried out effectively, step by step. The following checklists are to be used by these workers for organizing the VHSND.

ASHA

Actions to be taken before the Village Health and Nutrition Day:

Visit all households and get to know all the families. Make it a point to visit all poor households, especially SC/ST families.

Make a list of pregnant women.

Make a list of women who need to come for ANC for first time or for repeat visits.

Make a list of infants who need immunization, were left out or dropped-out.

Make a list of children who need care for malnutrition.

Make a list of children who were missed during the pulse polio round.

Make a list of children with special needs, particularly girl children.

Coordinate with the AWW and the ANM.

On the day:

Ensure that all listed women come for services.

Ensure that all listed children come for services.

Ensure that malnourished children come for consultation with the ANM.

Ensure supplementary nutrition to children with special needs.

Ensure that all listed TB patients collect their drugs.

Assist the ANM and the AWW.

ANC Orientation of ANMs at VHSND

Angan Wadi Worker:

Ensure that the AWC is clean.

Ensure availability of clean drinking water during the VHSND.

Ensure a place with privacy at the AWC for ANC.

Keep an adequate number of MCH cards.

Coordinate activities with the ASHA and the ANM.

ANM :

Ensure that the VHSND is held without fail. Make alternative arrangements in case the ANM is on leave.

Ensure that the supply of vaccines reaches the site well before the day's activities begin.

Ensure that all instruments, drugs, and other materials as listed in the annexure are in place.

Carry communication materials.

Ensure reporting of the VHSND to the MO in charge of the PHC.

Coordinate with the ASHA and the AWW.

PRIs

Ensure that the members of the VHSNC are available to support the sessions.

Ensure participation of schoolteachers and PRI members.

Ensure availability of clean drinking water, proper sanitation, and convenient approach to the AWC for participating in the VHSND by all.

Service package:

MATERNAL HEALTH

- Early registration of pregnancies.
- Focused ANC.
- Referral for women with signs of complications during pregnancy
- and those needing emergency care.
- Referral for safe abortion to approved MTP centres.
- Counselling on:
    - Education of girls.
    - Age at marriage.
    - Care during pregnancy.
    - Danger signs during pregnancy.
    - Birth preparedness.
    - Importance of nutrition.
    - Institutional delivery.
    - Identification of referral transport.
    - Availability of funds under the JSY for referral transport.
    - Post-natal care.
    - Breastfeeding and complementary feeding.
    - Care of a newborn.

- Contraception. Etc.

• Organizing group discussions on maternal deaths, if any that have occurred during the previous month in order to identify and analyze the possible causes.

CHILD HEALTH

Infants up to 1 year:

- Registration of new births.
- Counseling for care of newborns and feeding.
- Complete routine immunization.
- Immunization for dropout children.
- First dose of Vitamin A along with measles vaccine.
- Weighing and counseling

Children aged 1-3 years:

- Booster dose of DPT/OPV.
- Second to fifth dose of Vitamin A.
- Tablet IFA - (small) to children with clinical anaemia.
- Weighing and counseling.
- Provision of supplementary food for grades of mild malnutrition
- and referral for cases of severe malnutrition.

All children below 5 years:

- Tracking and vaccination of missed children by ASHA and AWW.
- Case management of those suffering from diarrhoea and Acute
- Respiratory Infections.
- Counselling to all mothers on home management and where to go
- in even of complications.
- Organizing ORS depots at the session site.
- Counselling on nutrition supplementation and balanced diet.
- Counselling on and management of worm infestations.

FAMILY PLANNING

Information on use of contraceptives.

Distribution - provision of contraceptive counseling and provision of non-clinic contraceptives such as condoms and OCPs.

Information on compensation for loss of wages resulting from sterilization and insurance scheme for family planning.

REPRODUCTIVE TRACT INFECTIONS AND SEXUALLY TRANSMITTED INFECTIONS

- Counseling on prevention of RTIs and STIs, including HIV/AIDS, and referral of cases for diagnosis and treatment.
- Counseling for per menopausal and post-menopausal problems
- Communication on causation, transmission, and prevention of HIV/
- AIDS and distribution of condoms for dual protection.
- Referral for VCTC and PPTCT services to the appropriate institutions.

SANITATION

- Identification of households for the construction of sanitary latrines Guidance on where to go and who to approach for availing of subsidy for those eligible to get the same under the Total Sanitation Campaign.
- Avoidance of breeding sites for mosquitoes.
- Mobilization of community action for safe disposal of household refuse and garbage.

COMMUNICABLE DISEASES

- Group communication activities for raising awareness about signs and symptoms of leprosy, suspected cases, and referrals.
- Group communication activities for elimination of breeding sites for mosquitoes, management of fever cases, i.e. importance of collection of blood film for MP and presumptive treatment.
- Awareness generation about symptoms of TB (coughing for more than three weeks), importance of continued treatment, referral of symptomatics for sputum examination at the nearest health centre.
- Provision of anti-TB drugs to patients.
- Reporting of unusual numbers of cases of any disease or disease outbreak in village.

GENDER

Communication activities for prevention of pre-natal sex selection, illegality of pre-natal sex selection, and special alert for onedaughter families.

Communication on the Prevention of Violence against Women, Domestic Violence Act, 2006.

Age at marriage, especially the importance of raising the age at marriage for girls.

HEALTH PROMOTION

Chronic diseases can be prevented by providing information and counseling on:

Tobacco chewing

Healthy lifestyle

Proper diet

Proper exercise

NUTRITION

Diseases due to nutritional deficiencies can be prevented by giving information and counseling on:

- Healthy food habits.
- Hygienic and correct cooking practices.
- Checking for anaemia, especially in adolescent girls and pregnant women; checking, advising, and referring.
- Weighing of infants and children.
- Importance of iron supplements, vitamins, and micronutrients Food that can be grown locally.
- Focus on adolescent pregnant women and infants aged 6 months to 2 years.

INSTRUMENTS, EQUIPMENT, AND FURNITURE

- Weighing scale-adult, child
- Examination table
- Bed screen/curtain
- Haemoglobin meters, kits for urine examination
- Gloves
- Slides
- Stethoscope and blood pressure instrument
- Measuring tape
- Foetoscope
- Vaccine carrier with ice packs

If these items are not available, their provision could be arranged by using the untied fund of Rs 10,000/- available with the ANM or with the VHSC.

These items should be kept under the safe custody of the ANM/ AWW/ ASHA as the case may be.

SUPPLIES

- Supplies such as vaccines, IFA tablets, Vitamin A, condoms, OCPs,
- (ECPs), ORS, and Cotrimoxazole
- Anti-helminthic drug
- Chloroquin
- Anti-TB drugs
- Paracetamol
- Stains for fixing BF
- AD syringes in sufficient quantity
- IEC material for communication and counseling

MEDIA ,METHODS AND BCC:

- Wall writings in the local language
- Hoardings at one or two prominent places in the village
- Handbills and pamphlets
- Resources for publicity activities can be accessed through the untied funds available with the VHSC or through the sub-centre joint fund

SUPERVISION AND MONITORING

The proper organization of the VHSND is the most crucial component of NRHM for guaranteeing service provision at the village level. Hence, at all program meetings at the state, district, and block levels, one should ensure the review of the VHSND and the problems encountered should be addressed promptly and effectively. Each district and block should maintain a record of the number of VHSNDs planned and the number actually held. The quality of the services offered and available during the VHSND will depend on the quality of the supervision and leadership. The LHV and the AWW Supervisor should jointly visit the pre-identified centres as per the roster and submit their joint report, which will be discussed at the monthly meeting convened by the MO in charge of the PHC.

During the supervisory visits, special attention should be given to the following elements:

1. Women and children from vulnerable communities should come forward to seek services.

2. ASHA should be available at the session site and should be engaged in the tracking of women and children, especially those from vulnerable communities, for complete coverage.

3. All resources (human resources and materials) should be in place.

4. The quality of the services available should be satisfactory.

5. Issues related to the clients' satisfaction with the services should be addressed properly and promptly.

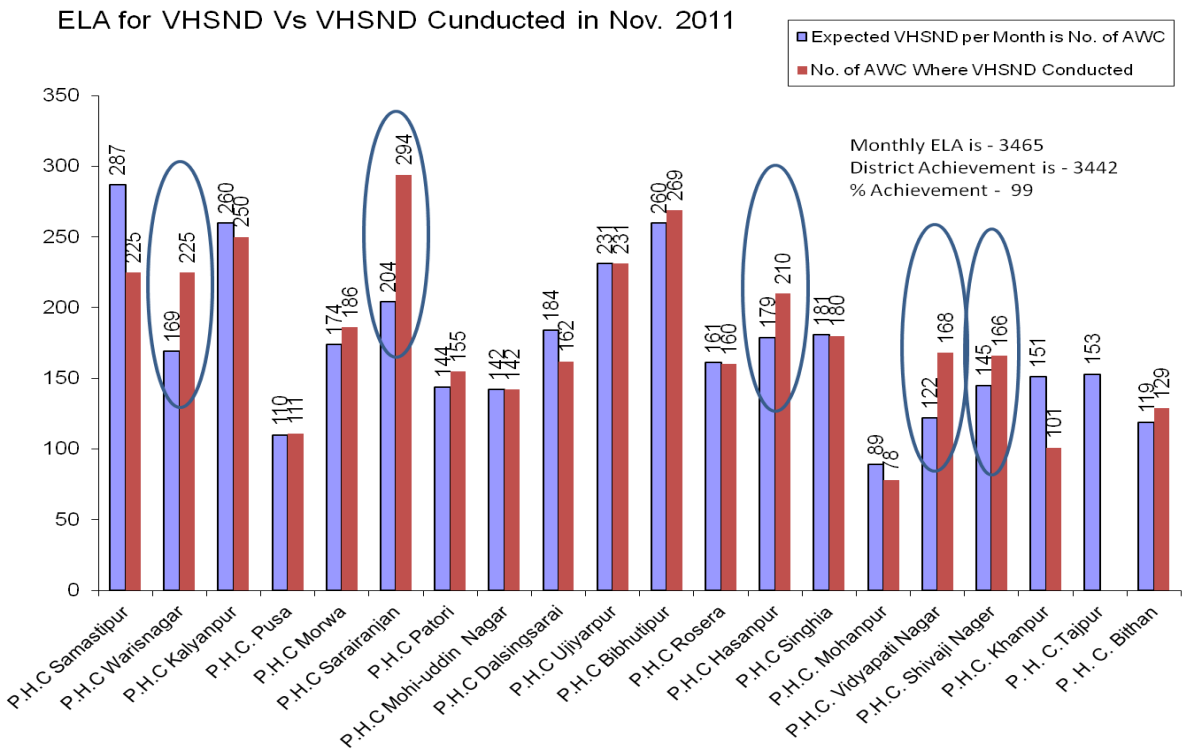
6. BCC methods should be employed.

The holding of the VHSND should be discussed at the monthly meetings convened by the MOs at the PHC level at the executive committee meetings of the District Health Society, of which the District CMO is the convener. The DPMUs will monitor it, and will also compile data on it.

OUTCOMES

The organization of the Village Health and Nutrition Day on a regular basis as per the guidelines will result in the achievement of the following outcomes:

- Hundred per cent coverage with preventive and promotive interventions, especially for pregnant women, children, and adolescents
- Preventive and promotive coverage for the National Disease Control Programs
- Increased awareness about the determinants of health such as nutrition, sanitation, timely care, etc.
- Improved knowledge about the services offered under the various Nutritional Health Programs
- Greater emphasis on the community's role in making the health system responsive to the health needs of the community and in demanding and ensuring accountability.



Findings of the VHSND in Samastipur district:

The Overall observations and findings:

- In maximum site it is observed that the Village Health day is organized but the Nutrition and sanitation is missing (AWW is available in the entire site with the responsibility of calling the community as per the due list).

- In the VHSND the Immunization, ANC and PNC is essential services which health department is providing but it is observed that only immunization is provided but ANC means only providing TT and IFA (If Available with ASHA, In maximum site the IFA Tab or syrup is not available) and PNC is negligible the functionaries are do not know what to do with PNC.

- The BP machine and stethoscope is available with many ANMs but they are not brought to site as the instrument is not functioning? In actual on observation (12 BP Instrument) found all the BP instrument is functioning but 10 of them do not know to use.

- Specifically – The Registration of New ANC Cases is low, Privacy for Bally checkup is not available, Availability of Basic Check up equipments like – Hemoglobin meter, BP Machine, Weigh Scale, Bally Check up Tables etc. And its uses are not satisfactory. The Medicines availability like IFA Tabs, Oral contraceptive Pills, condoms, ORS and disposable syringes etc. are not universal.

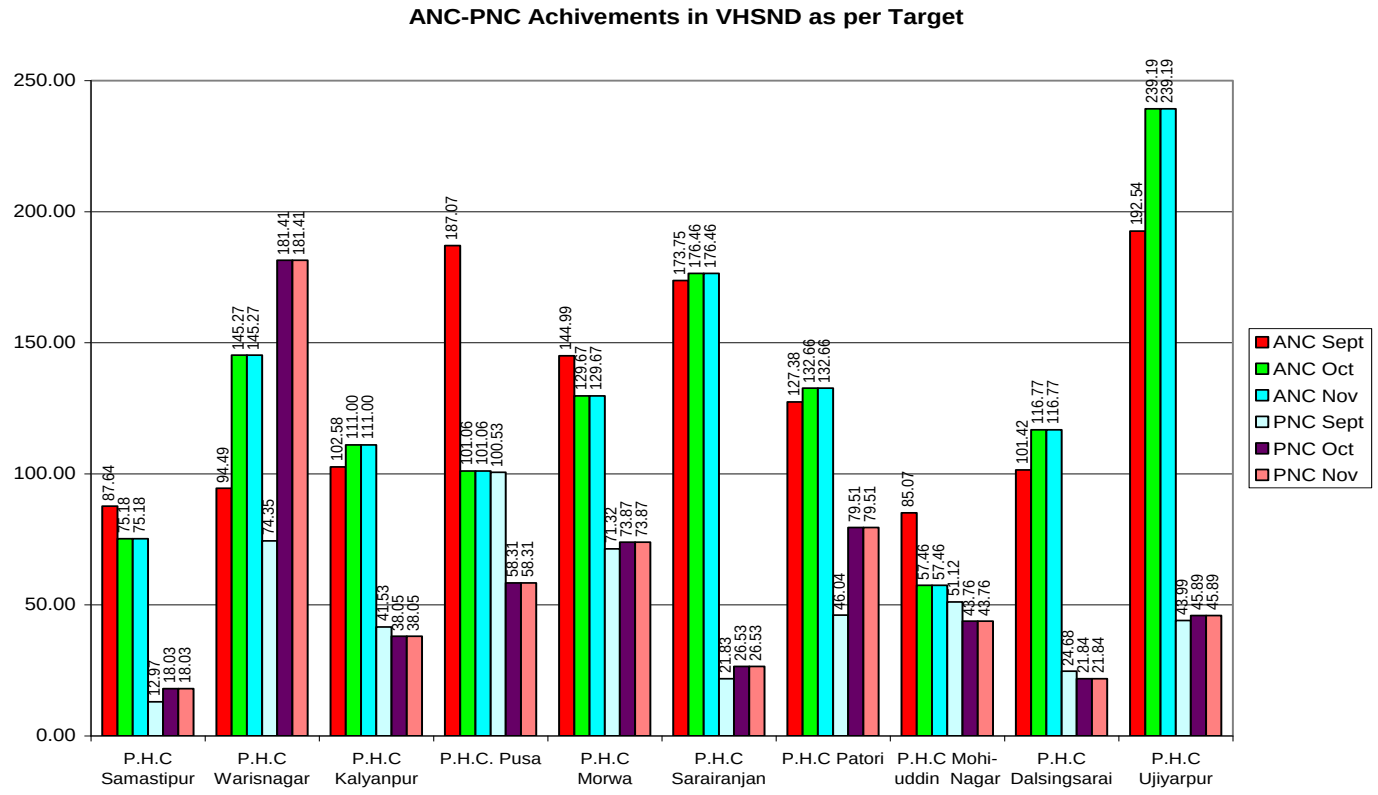
- Level of knowledge, skills for usage of equipment, & counseling skill of AMN, AWW, Asha is not appropriate level.

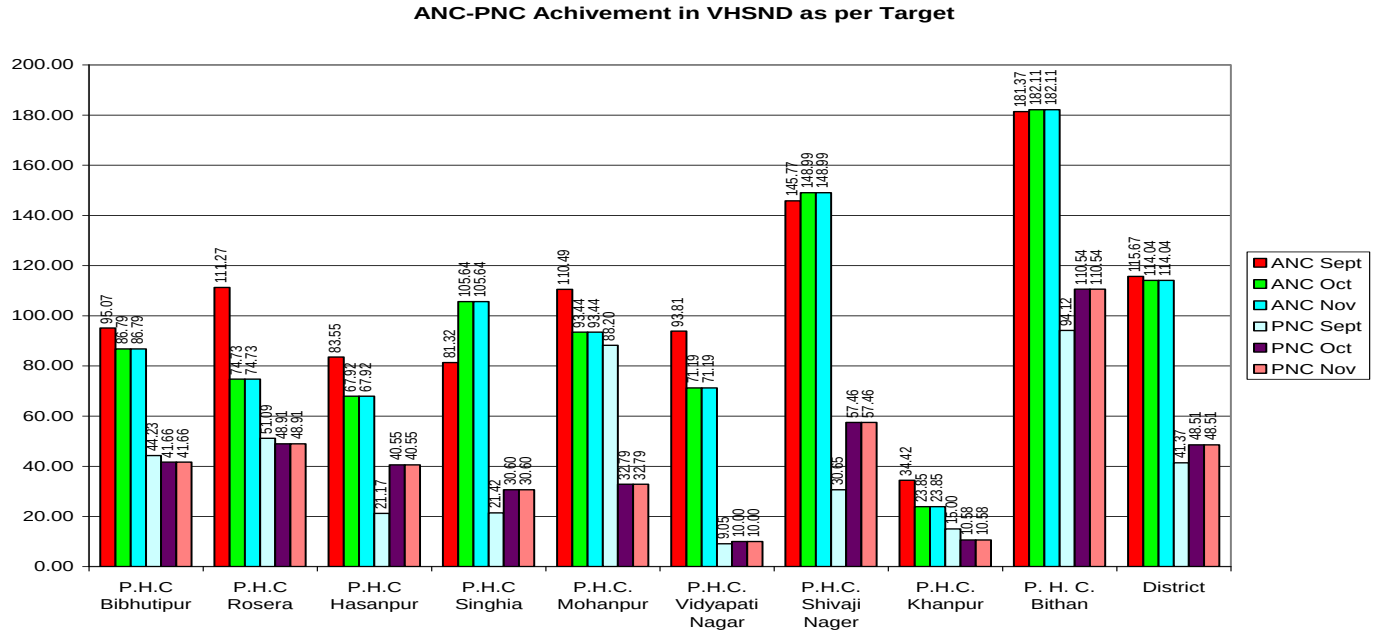
- Involvement of ASHAs and AWW is limiting to calling Stake holders for the immunization and ANC in VHSND. Rather she should have involved for the BCC activity themes provided in the VHSND guideline.
- Irregular supply of TT, Vaccine, syringe & IFA tablets results increases dropouts and misses the opportunity. The district achievement of Immunization is 72% and TT shoots is 79%.

- No home visit practices of ANMs or AWW.

- No BCC/IEC activity observed in VHSND site and no site / block found about the Topic / theme month wise decided in the VHSND guideline.

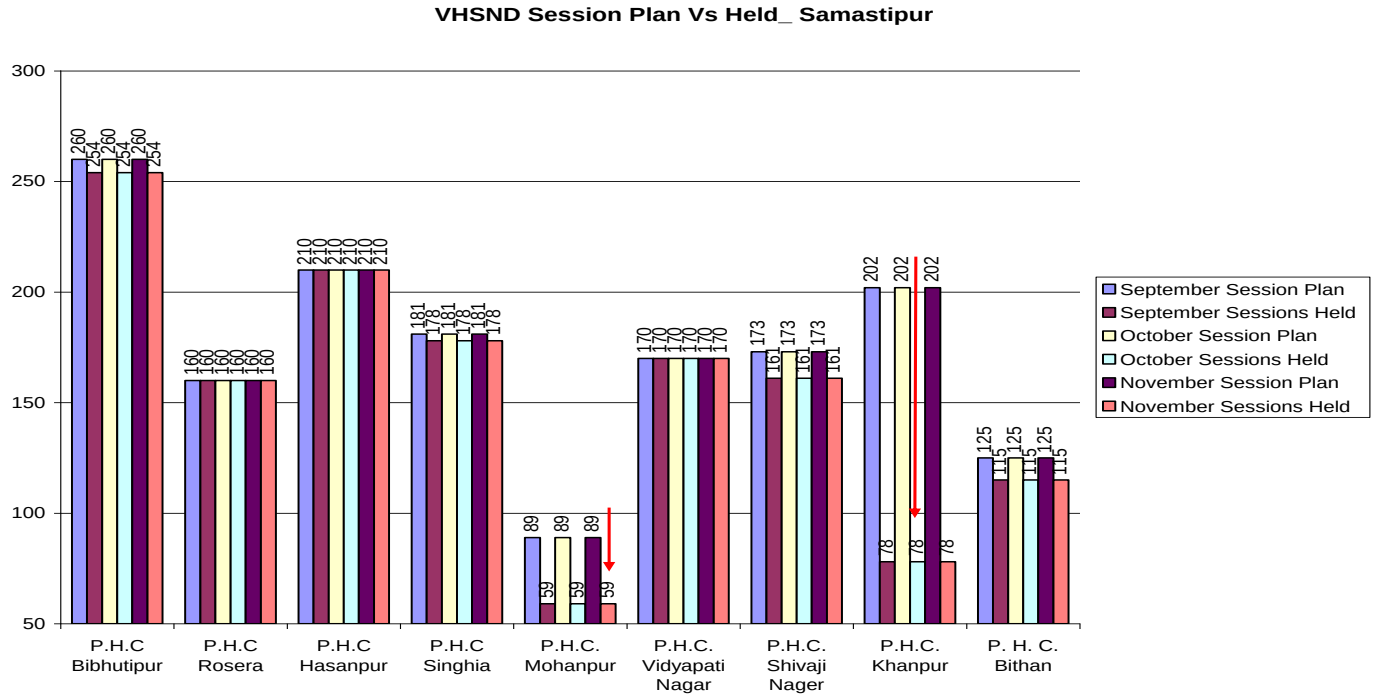
- Monitoring and Supportive supervision at Block / District level by Health & ICDS Officials is negligible.
- Documentation: In all the site the RI register, due list and to her formats are available during the visit and it is properly recording by the ANM.

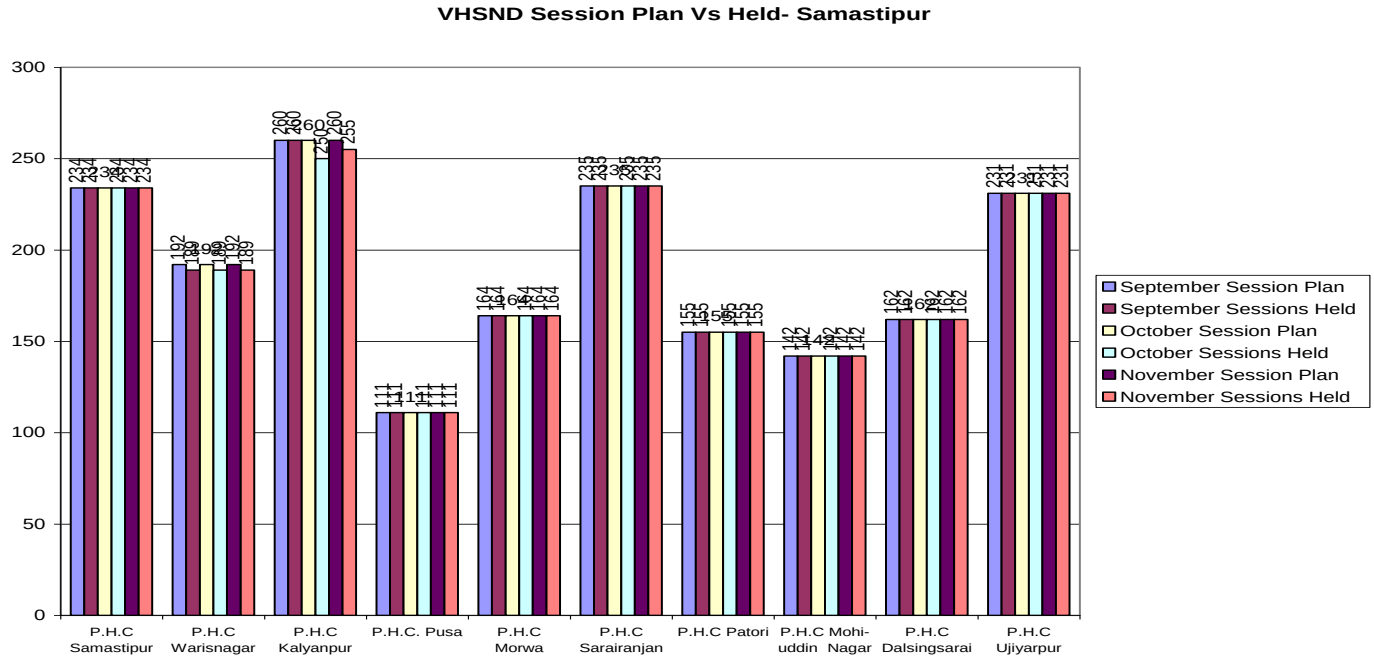




Still the Micro plan confusion has been not rectified in the reporting system as per govt. policy you

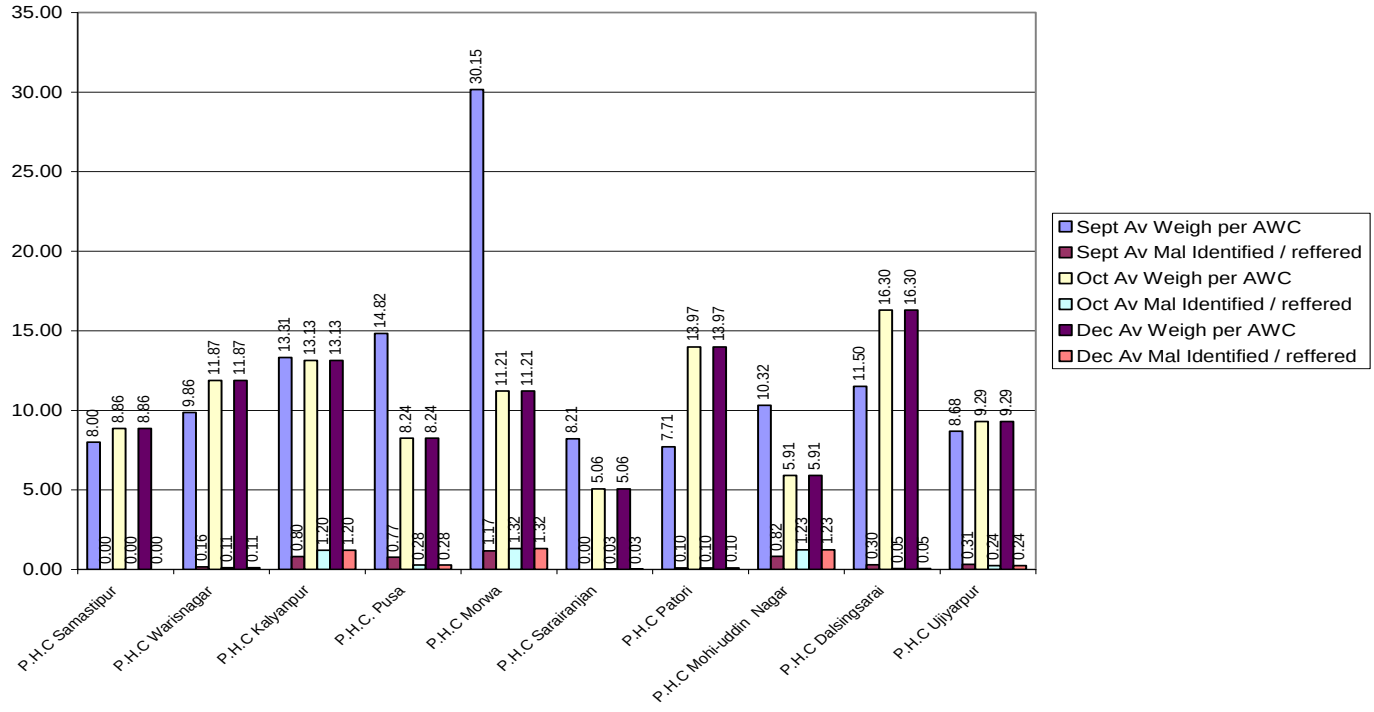
should not chage the annual target , so thare is huse different in planning verses organizing VHSND in the different Blocks.



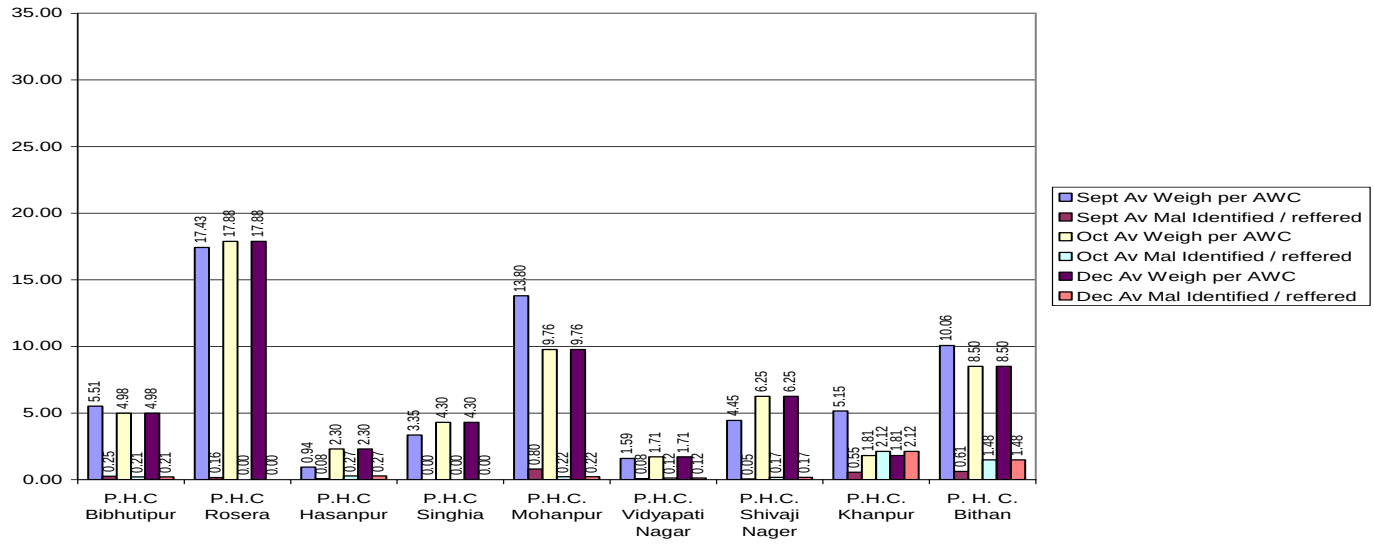


As per the VHSND Report the availability and distribution of the IFA- Small & large, Condoms, OCP, D-warming Tablets coverage is very much appreciated. In the month of September the Medicines were purchased and disbursed for usage.

Growth Monitoring, Identification of Malnurished and Referal system at VHSND



Growth Monitoring, Idendification of Malnurished & Referal System at VHSND



Issues & Recommendations	
Immunization	The district Immunization coverage is more then 82%, the back log is due to availability of drugs in the district and the supplies from the state to the district in interval. So there is need to regularized supplies the vaccines from the state to the district as per the requisitions. Supplies as per due list.
ANC	Still there is definition of ANC means providing the TT and IFA Tablets. Due to Availability of equipments and functionaries do not know how to use it. The proper ANC is not conducted in Maximum VHSND. But the reporting figure is very satisfactory.
PNC	The Govt. has assigned ASHA workers for the PNC. So there is no interest of ANM to visit Lactating mothers' house during ANC. It needs to be advocate for the visit. As it is most and should critical period.
Counseling	The Individual counseling in critical period or asking advise is been observed in maximum VHSND site but As per the prescribed theme by the govt. in VHSND guideline is not organized due to understanding and review at the block level.
Community mobilization	The Process should begin from the preparation of Due list. But with Many AWW had finished their due list register and the new register is not been reaches to them. So there is immediate action should be needed to supplies of Due list formats/ Registers. Other wise in maximum VHSND site observed the convergence of functionaries are very well to organize different activities.
Infrastructure	Big problem of space and privacy for the ANC checkup.
Instrument availability	With some ANM the BP and stethoscope is available but maximum do not know the usage of the equipments. The Hemoglobin miter is not yet seen in the district.
Role of panchayat	Still need to understand by the PRIs on health interventions.
Coordination and convergence	It is very good at the District and on site level but there is need to strengthen in the block level.

Suggestion:

- To accelerate the convergence of services there is a need of key leaders (DIO, DPO-ICDS, EE PHED) meeting at the district level to specify different activity who , how & what role and responsibility of different functionaries at village and block level. Issued a joint letter for the different activity.
- In every month block level convergence meeting (Health, ICDS, PHED & Education) should be organised

- There is a need of Revisiting Roster planning to ensure coverage, include left out area and follow all the activity define in the VHSND guideline.

- Ensure doable ANC heck-up at village level like regular weight, height, BP, sine and symptoms of Hemoglobin and Bale check-up etc.

- Ensure PNC check-up of newborns up to 45 days of births through home visit during NHDs, also generate interest among ASHA and AWW for the home contacts on day of births, 3rd day, 7th day 15th day , one months and 45 days.

- Incremental Capacity building: In the Weekly meeting of the ANM there should be compulsory for the skill development them like usage of BP instruments, Stethoscope, ANC, PNC, Growth monitoring & counseling and Behavior change communication activity etc.
- In ASHA day the them decided in the VHSND guideline should be thoroughly discussed for imparting routine BCC/IEC activity of ASHA.

Activity:

- Organizing orientations of the ANMs, AWWS and ASHA in different forum on the concept, Role, Activities and out come of the VHSND.
- Wall writing of VHSND day in AWC and Panchyat Bhaban.
- Training of ANMs on Usage of BP Instrument and all ANC checkups.
- Training of AWW on Growth monitoring and counseling skills.
- Purchasing and repairing of ANC equipment by using untied funds with ANMs.
- Establish Structured reiew meeting on Tuesday ANM Meeting.
- Joint visit of LHV and Lady Supervisors ICDS as per rosters. Submit a report to MO IC to discuss in the monthly meeting of ANM and AWW.
- Monthly Joint/ convergence meeting of MO-IC, BHM, CDPO, Jr. engineer-PHED, BEO and NGOs. At block level.
- Monthly Joint meeting of ANM, AWW and ASHA at Health Sub center level.
- Monthly joint review meeting at District level of all MO-ICs, BHMs, CDPOs and District level Officials.
- Analysis of VHSND Report and give feedback to the block for the strengthening activities.
- Re visit Micro plan / roster plan of VHSND at block level as per the AWC created/ new opened for the blocks.

Untied Fund for Health Sub Centre, APHC, PHC and SDH

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

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

- Cover minor modifications to sub center-curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level;
- Ad hoc payments for cleaning up sub center, especially after childbirth; transport of emergencies to appropriate referral centers;
- Purchase of consumables such as bandages in sub center;
- Purchase of bleaching powder and disinfectants for use in common areas of the village;
- Labour supplies for environmental sanitation, such as clearing/larvicidal measures for stagnant water
- Payment/reward to ASHA for certain identified activities.
- In PHC and APHC purchase of patient examination table, delivery table, DP apparatus, Hemoglobin meter, Cu-T insertion kit, Instruments tray, baby tray etc.
- Provision of running water.
- Transportation of emergencies to appropriate referral centre.

Districts Health Society, Samastipur-November 2011

S.N	Name of Block	Untied Expenditure		VHSC Expenditure	
		Fund Disbursed	Fund Utilized	Fund Disbursed	Fund Utilized
1	**Rosera**	280000.0	137952.0	410000.0	57500.0
2	**Dalsingsarai**	280000.0	111467.0	450000.0	0.0
3	**pusa**	230000.0	230000.0	300000.0	300000.0
4	**Samastipur**	450000.0	379613.0	740000.0	338349.0
5	**Morwa**	261279.0	241542.0	600000.0	86000.0
6	**Warishnagar**	340000.0	273100.0	360000.0	25000.0
7	**Kalyanpur**	N/A	N/A	N/A	N/A
8	**Sarairanjan**	500000.0	235613.0	340000.0	19000.0
9	**Patory**	270000.0	180000.0	90000.0	9000.0

10	**M. Nangar**	410000.0	215884.0	440000.0	61136.0
11	**Ujiyarpur**	160000.0	102675.0	165000.0	29650.0
12	**Bibhutipur**	450000.0	297233.0	400000.0	8000.0
13	**Hasanpur**	110000.0	109500.0	355000.0	265000.0
14	**Singhia**	400000.0	365600.0	290000.0	290000.0
15	**Vidyapatinagar**	100000.0	93273.0	195000.0	0.0
16	**Mohanpur**	N/A	N/A	110000.0	0.0
17	**Shivajinagar**	N/A	N/A	600000.0	250514.0
18	**Tajpur**	N/A	N/A	N/A	N/A
19	**Khanpur**	80000.0	38575.0	140000.0	0.0
20	**Bithan**	90000.0	89400.0	500000.0	481500.0
21	District	4411279.0	3101427.0	6485000.0	2220649.0

Village Health ,Sanitation& Nutrition Committee:

NRHM mandates forming Village Health, Sanitation & Nutrition Committee at revenue village level and each committee to get Rs. 10,000 as untied grant. Samastipur has 1181 revenue villages under 381 Gram panchayat.

GoB has decided to co-opt the Panchayat Committee namely “Lok Swathya Pariwar Kalyan and Gramin Swaschata Samiti” as “Village Health and Sanitation Committee”. These committees will be constituted at panchayat level and get fund according to number of revenue villages lying in their area, that is to say if one panchayat has 5 revenue villages then the said panchayat committee will get Rs.50,000 rupees. Financial power will be with Panchayat Committee, who will expend this fund per revenue village @ Rs.10000/-. There will be a monitoring committee at each revenue village, called “Nigrani Samiti”, who will monitor appropriate utilization of fund in their revenue village.

Therefore the target is to form approximately 381 panchayat committees which will act as Village Health and Sanitation Committee for 1181 revenue villages.

Each “Lok Swathya Pariwar Kalyan and Gramin Swaschata Samiti” consists of 5

members including Chairman and Secretary and every Revenue Village Samiti or "*Nigrani Samiti*" will consist of all ASHAs, AWWs, leaders of SHG & elected Ward Commissioner of panchayat These members will be required to participate in the orientation meeting program at PHC.

Rogi Kalyan Samitis (RKS)

RKS is operational in district hospital, SDH, RH & PHC. Govt. of Bihar is operationalising the APHCs this year. In light of the RKS have to be setup in all the APHCs and registered simultaneously. In Samastipur all the APHC has registered this year and start functioning.

Slno	Initiatives	Plan	Registered	Functional
1	PHC RKS	19	19	19
2	APHC-RKS	47	47	47
3	DH RKS	1	1	1
4	SDH RKS	3	3	3
5	FRU RKS	1	1	1

Rogi Kalyan Samitte Developed & maintenance of PHC

Human Resources:

District Level

Sl.No.	Post	PHC/APHC	Sanction	Posted
1	Medical Officer	PHC/SDH/DH	88	64
		APHC	88	31
2	Pharmacist	PHC/SDH/DH	27	14
		APHC	42	20
3	Dresser	PHC/SDH/DH	24	16
		APHC	39	20
4	Laboratory Technician	PHC/SDH/DH	14	1
		APHC	39	12
5	Block Extension Educator	PHC/SDH/DH	11	0
		APHC	32	22
6	ANM	PHC/SDH/DH	60	46
		APHC	88	75
7	LHV	PHC/SDH/DH	23	7
		APHC		
8	Health Inspector	PHC/SDH/DH	11	3
		APHC		
9	BHW/BHI	PHC/SDH/DH	51	32
		APHC		
10	Others	PHC/SDH/DH	163	102
		APHC		
11	Clerk	PHC/SDH/DH	36	36
		APHC	46	35
12	4th Grade	PHC/SDH/DH	144	132
		APHC	82	78
13	Ayush Doctors	PHC/SDH/DH		
		APHC	45	42
14	Nurse Grade-'A'	PHC/SDH/DH		
		APHC	88	57
15	HM / BHM	PHC/SDH/DH	23	22
		APHC		
16	Accountant	PHC/SDH/DH	20	20
		APHC		
17	Hospital Manager	PHC/SDH/DH		
		APHC		
18	BCM	PHC/SDH/DH	20	17

Programme Management

District Project Management Unit

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

The objective of State Health Society is to provide additional managerial and technical support to the Department of Health, Government of Bihar for implementation of National Rural Health Mission which includes RCH –II, Additional ties, General Curative Care, National Disease Control Programme and AYUSH.

SHSB has a Governing Body whose Chairperson is the Development Commissioner,

Govt. of Bihar and an Executive Committee whose Chairman is the Principal Secretary, Dept. of Health, Govt. of Bihar. There is a Project Appraisal Committee (PAC) whose

Chairman is the Executive Director, SHSB and which has representations from

Directorate, Development partners, RHO-GOI and other line departments of Bihar Government. The Committee (PAC) considers the expenditure proposals. Financial powers of the bodies/office bearers have been clearly defined in the Society's Financial Rules and Bye-Laws.

D). District Health Societies

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

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

Activities in the district as may be identified from time to time including mechanism for intra and inter sectoral convergence of inputs and structures.

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

District level (DPMU)

District Programme Management Support unit consists of following personnel:-

1. District Programme Manager

2. District Accounts Manager

3. District M & E Officer

4. District Planning Coordinator

Block Programme Management Unit

The state has already established Block Programme Management Unit in all the Block

PHCs. Each BPMU consists of One Block Health Manager, Block Accountant and

Block Community Mobiliser It has been observed that after the establishment of

BPMUs the implementation of National Programmes has been managed efficiently and getting improved results.

Management Unit at FRUs --

Being a big state, Bihar requires more manpower to provide services at various facility levels and for better management of NRHM programme.

a) Hospital Managers

Addl. manpower in the form of Hospital Managers have been engaged in almost all of the 3 FRUs. Hospital Managers are facilitating process of quality control and also ensuring that FRUs in the real sense get functional with all critical determinants. Further presentably Institutional delivery is one of the main activity of operational FRU and 24 hours management of facility is a challenge, wherein these Hospital Managers would prove useful.

b) FRU Accountant

To manage the NRHM funds at FRUs an Accountant would be required to be placed in all the 3 FRUs

Innovation:

The district HMIS is indicating more focus need in the Behaiviour change communication ton accerelate and achive different critical indicators like- Institutional delivery, Breast feeding, home based new born care , initiation of complemantary feeding, immunization, preventive and promiorive health etc.

Under this head district is going to give more focus on the Behaiviour change communication through ASHA intervention jointly with ICDS by organizing specific activities as follows:

- ASHA MELA (Meeting for Empowerment Learning and Action)- Samillan at Block Level.
- Organize Incremental Capacity Building plan to accelerate Behaviour Change communication by monthly basis on one theme will be finalized to impart training of 2 each block functionaries (BCM and Supervisors ICDS) at district level and both the functionaries will train the ASHA on ASHA day monthly meetings and AWW on ICDS meetings. In the same Month the similar theme will be spread in the community for the changing of different practices.

ASHA MELA BUDGET AT BLOCK LEVEL

2012-13

Sl. No.	Name of Activity	Unit Cost (Rs.)	Unit No.	Total Cost (Rs.)
1	**ASHA Mela at Block Level**			
1.1	T.A.	80	3,835	3,06,800.00
1.2	Lunch/ Fooding	50	3,835	1,91,750.00
1.3	Stationery / BCC (Games/cultural programme)	100	3,835	3,83,500.00
1.4	Arrangements (Chair, Table, Tent etc.)	150	3,835	5,75,250.00
	Total			**14,57,300.00**

Incremental Capacity Building for BCM/LS

Sl.No.	Name of Activity	Unit Cost (Rs.)	Unit No.	Total Cost (Rs.)
1	**Incremental Capacity Building**			
1.1	Resource Person	500	12	6000.00
1.2	T.A. for Participants (BCM,LS/LHV) @ 1 BCM & 1 LS or LHV	100	2 x20x12	48,000.00
1.3	Stationery for participants (BCM,LS/LHV) @ 1 BCM & 1 LSor LHV	100	2 x20x12	48,000.00
1.4	Lunch for participants (BCM,LS/LHV) @ 1 BCM & 1 LS or LHV	100	2 x 20 x12	48,000.00
1.5	Venue charge	4000	12	48000.00
1.6	Printing of Hand outs& BCC Matrial for Asha and AWW	10,000	1X12	120000.000
	Total			**318000.00**

Organizing Sankalp MELA of couples at Panchyat Level through PPP:

The event is proposed for the couples meeting organized in the center of Gram Panchyat once in the year for accelerate different RCH services through BCC Activities the Following activities will be organized .

- Infotainment of different current topics.
- Sharing of Information, discussion.
- Question and answer session (Quiz among mothers)
- Demonstration of different services including the Family planning.
- Sharing of in-gender health advantages and benefits.
- Reward and reorganization of the couples, Service providers and opinion leaders for their services.
- Counseling of Couples for Family planning and referrals.

Sl. No.	Name of Activity	Unit Cost (Rs.)	Unit No.	Total Cost (Rs.)
1	Arrangements (Chair, Table, Tent etc.)	500	381	
1.1	Stationery / BCC (Games/cultural programme)	200		
1.2	Prized for quize and Best Couples	300		
1.3	Contigency	200		
1.4				
	Total			

Installation of CC TV in all PHC/Referral and District Hospital:

It is proposed to make electronic visual mapping of all service providers who provide services in the all the district, sub-division and block level institutions. It will also helpful for the batter Monitoring of service providing , record keeping of the day services and manage security of human as well as equipments of the institutions.

In the institutions the CC TV camera will be installed around the major service providing places, OPD rest place, Indoor, out door and gate of the Hospital. The Monitoring system Visual Monitoring disk will be installed in the Medical Officers Room.

Budget:

Mainstreaming of AYUSH:

In the present data shows that the govt health services is not enough to serve the population of 42 Lakhs, even though the needy community want to avail the govt health services they do not have access and availability of services at the assigned places. Looking in to the above situation communities are bound to go for the private practitioners for the health care. The private institution is available and as it is pay by service it is accessible for the community in their door step. Even there are lots of Registered Medical Practitioners on Ayurveda, Homoeopathy, allopath, Naturopathy, Harbalism , acupuncture & presser, message and yoga therapy.

Looking in to the population, geographic, disease burden, Reproductive child health coverage there is a need to establish mainstreaming private health care service providers for the routine govt. health programs. Establish franchise, registrations, reporting of incidence and out sourcing of services.

- The Mission seeks to revitalize local health traditions and mainstream AYUSH infrastructure, including manpower, and drugs, to strengthen the public health system at all levels.
- AYUSH medications shall be included in the Drug Kit provided at village levels to ASHA.
- The additional supply of generic drugs for common ailments at Sub centre/ 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 System (IPHS) model.
- Single doctor PHCs shall be upgraded to two doctor PHCs by mainstreaming AYUSH practitioner at that level.

Recognizing the importance of Health in the process of economic and social development and for improving the quality of life of the citizens, the government of India launched the “National Rural Health Mission” for improving the availability of and access to quality heath care by people, especially for those residing in rural areas, the poor women and children and to adopt a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. One of the important aims of ***NRHM is to revitalize local health tradition and mainstream AYUSH (including manpower and drugs).***

Mainstreaming of AYUSH under NRHM:

Integration of AYUSH system including infrastructure, manpower and AYUSH medicines to strengthen the Public Health care delivery system at all levels and promote AYUSH medicines at grass-root level or village level with different national health programs. The AYUSH personnel work under the same roof of the Public Health Infrastructure.

Rational:

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 practiced by the young and old alike, to promote good health. Now days, practice of Yoga has become a part of every day life. It has aroused a world wide awakening among the people, which plays an important role in prevention and mitigation of diseases. Practice of Yoga prevents Psychosomatic disorders and improves an individual's resistance and ability to endure stressful situation. Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) are rationally recognised 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, single Doctor PHCs shall be upgraded to two Doctor PHCs by inducting AYUSH practitioner at that level.

Strategy:

- Integrate and mainstream ISM &H in health care delivery system including National Programmes.
- Encourage and facilitate in setting up of specialty centers 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

Activities:

- Improving the availability of AYUSH treatment faculties and integrating it with the existing Health Care Service Delivery System.
- Integration of AYUSH services in 314 CHC / Block PHC with appointment of contractual AYUSH Doctors.
- Appointment of 200 paramedics where AYUSH Doctors shall be posted.
- Appointment of a Data assistant to support the ISM&H Directorate.
- Strengthening of AYUSH Dispensaries with provision of storage equipments.
- Making provision for AYUSH Drugs at all levels.

Proposed activities:

- Registration of private practitioners including the RMPS and Traditional Healers (Quacks).
- Explore opportunity to involve in govt. health programs.
- Registered out sourcing of services for functioning of OT, Lab tasting, Diagnosis, eye camp, Family planning services and School Health Services etc.
- Quality control of services.
- Authorizing and legalizing institutions.

AYUSH Scheme for Hospital & Dispensaries:

- The main objective is to facilitate expansion of health care facilities of AYUSH andbuilding up confidence of the practitioners of these systems while propagating them and establishing their strengths and potentials.

- Another objective of the scheme is to provide facilities of specialized therapies of AYUSH like "Panchkarma", "Kshar-Sutra" of Ayurveda, "Regimental Therapy" of Unani, with Homoeopathy, Naturopathy and Yoga at the modern hospital where the specialized facilities are available so that the citizen have a choice of different systems of treatment under the same roof.

MONITORING AND EVALUATION

- Health MIS to be developed upto CHC level, and web-enabled for citizen scrutiny
- Sub-centers to report on performance to Panchayats, Hospitals to Rogi Kalyan Samitis and District Health Mission to Zila Parishad
- The District Health Mission to monitor compliance to Citizen's Charter at CHC level
- Annual District Reports on People's Health (to be prepared by Govt /NGO collaboration)
- State and National Reports on People's Health to be tabled in Assemblies, Parliament
- External evaluation/social audit through professional bodies/NGOs
- Mid Course reviews and appropriate correction

Information Education Communication / Behavior Change Communication (IEC/BCC):

Bihar is a state with high cultural heterogeneity. It has been a challenging area to address the issues of behavior change in a heterogeneous population. Even if the language of communication in Bihar is Hindi / Maithili / Magahi / Angika/ Bhojpuri/ Bajjika etc the use of dialects, words and styles differs from area to area. It indicates that no common strategy will work for the entire state as different areas have different dialects of communication. Use of Social & Behavior Change Communication (SBCC) has been one of the key components in any health sector strategy.

Strategic approach to communication is imperative to improve effectiveness and sustainability of behavior and social change. A systematically developed and managed communication program supported by evidence-based strategies, state-of-the-art training and capacity building, and cutting-edge research is necessary to influence positive behaviors & practices as also to increase access, improve quality & promote demand for health services.

District magistrate Innugurating Swasthya Mandap In Stapna Divash

The NRHM in Bihar is implementing a number of programmes, each one of which needs to be complemented with adequate communication inputs to achieve desired results. The Annual Action Plan 2011-12 for IEC/SBCC has been prepared in the light of the number of initiatives taken by Dept. of Health, Government of Bihar and State Health Society Public health communication in Bihar is faced with the additional challenge of overall low exposure of the population to mainstream channels of mass media. NFHS data reveals that nearly 60% of the population in Bihar has been classified as 'not regularly exposed to media', as against a national level of approximately 35%. The challenge gets compounded

when one has to reach women with critical information and messaging, as the rate of exposure falls much lower when it comes to them.

It is interesting that radio is the most common source of information for both men and women in Bihar, as per NFHS data. In fact radio presents a vast potential for health related communication and may be used strategically to bring about the necessary information, attitude and behaviour change in this sector.

The PIP proposes to develop a health communication strategy for the state with support from UNICEF. All communication activities will be based on evidence based communication strategy for the state defining audiences, message approach and media mix for each issue / theme under the NRHM.

Key Activities

A). IEC Assistant cum Logistics consultant: - IEC Assistant cum Logistics consultant has been appointed in BCC Cell, to support BCC Cell activities. Assist and support BCC Cell team leader in development of IEC activities. To help state in preparing press release, media & news advertisement paper ads on specific health related days, information, recruitment notice & tender notice advertisement.

B). Mass Media Activities:-

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

News Paper advertisement on various health's related days, Information, Recruitment notice & tender notice advertisement for message dissemination through mass media.

Series of advertisement in all Bihar editions of various newspapers is proposed to be published 3 days in a week. Series of spots and jingles in all Bihar station of various channels is proposed to be broadcast in entire year.

C). Local Media Tin plates, Bus panel, Glow Signs board & others Hoardings, Wall

Painting, Bill boards, Cinema slides, Local Cable and other Wall writing/ Miking & others, Laminated Board etc., on issues related to RCH and NRHM will be place at vantage points, displayed at important locations like at District Offices, Block Offices, PHCs, Halt points, Bus Stands, Railway stations, etc. Monthly magazine brought out by the I&PR Dept. is being again sponsored by SHSB. Space has been allocated in the magazine for publicizing about health related programmes

D). Community Media

Workshop, Fair (Mela), Stall organization, Tableau exhibit other media Folk drama,

Nukkad natak, Magic show, Puppet show, Video show, AV film show, Community meeting (with SHG, influencers, opinion leaders, PRI, youth), Health Camps and other health related activities / functions will be organized in state and each district from time to time to expand reach of different programmes. Folk Media will also be used as a tool for publicity. Health related Posters/Banners will be displayed at entire state. Video Show on different health issue will be organized at all PHC in one of the VHND district, community dialog facilitated by SHG Member of Women Development Corporation.

E). Printing Material

Poster, Flex banner , Pannel, Banner, Striker, Leaflet, Brochures, Badhai Cards, Booklet, IPC flip card, Letter with massage, T shirts, Desk Calendar, Pocket calendar, wall calendar, health calendar, dairy, quarterly magazines Banner, Letter with massage, Rally Flag, T shirts, Flex banner and other materials will be developed and publicized on different issues eg. Dial 102 (Ambulance Service), Dial 1911 (Doctor's Consultancy), Dial102/1911 (Samadhan: Rogi Shikayat Niwaran Wyawastha), ICU Service, JBSY,

Promotion of Breast Feeding, Family Planning including Non Scalpel Vasectomy,

Immunization, Adolescent and Sexual Reproductive Health, UHC, Diagnostics, PNDT

Act, Role of ASHA under NRHM, Role of Mamta, Importance of Super Specialty

Hospitals etc., through various print. Health Materials will be publicized on Bihar Text

Book & Different types of Certificates issued by Govt. of Bihar and others. Set of 4 comics (each of 10 pages) already prepared to be distributed amongst 1000000 girl students studying in classes 9 to 12.

F). Campaigns/ Health emergencies/ Events

Many people are concerned about the influenza A H1 N1 (swine flu), and Dengue outbreak. Floods are also a big problem for most of rural population in Bihar. There is also a tradition of tableay exhibition during 26th January (Republic Day) & 15th August (Independence Day) celebrations

G). Capacity building training program of DCMs, DPCs & BCM, BHM and District level officials in strategic communication.

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

To build the capacities of, DPCs, DCM & BCM, BHM and District level officials of the health department\ and that of the District Health Society, a training workshop will be organized. Inputs from tools employed during capacity assessment of State Health Society and specific need assessment for this training will be incorporated into the design of the training workshop. The capacity assessment exercise will aim to find:

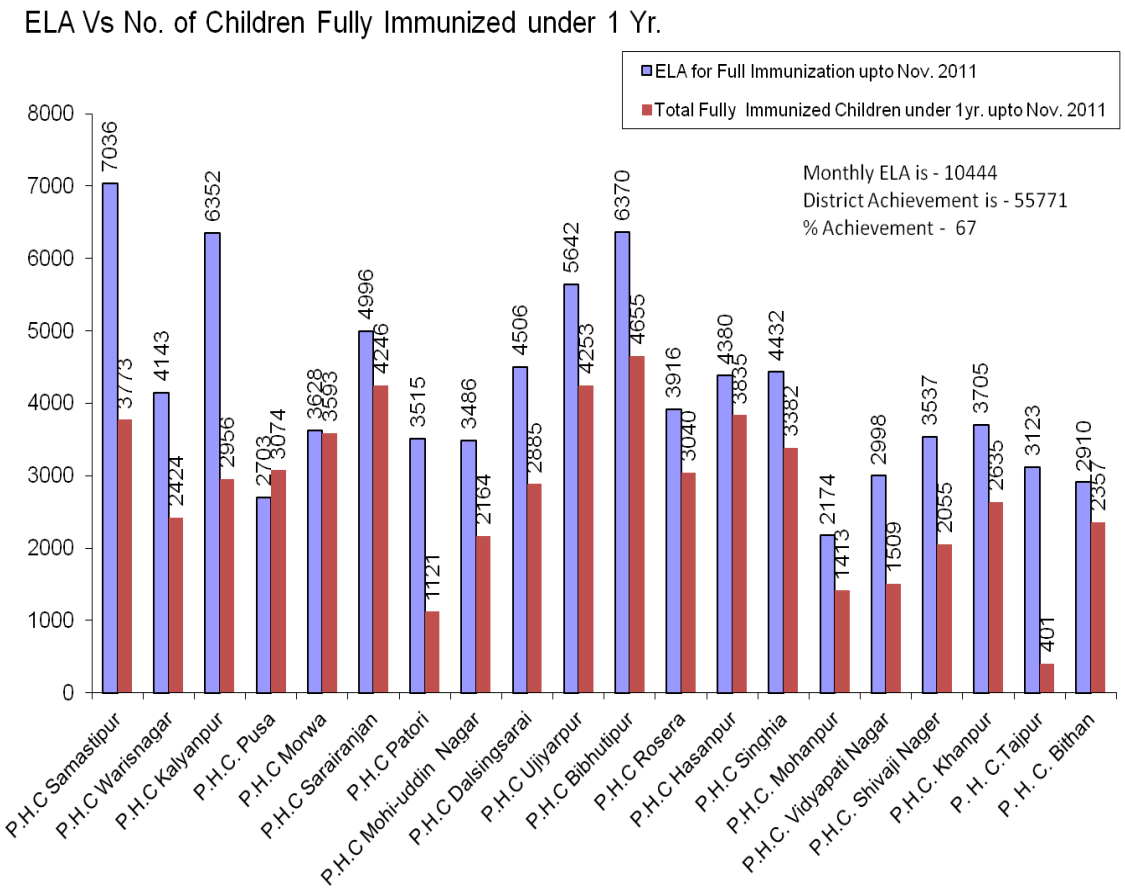
- Individual capacity of officials of DHS to carry out / implement District wide: **IEC/SBCC activities- experience & skill.**
- Capacity in designing and developing appropriate material & program
- Training skill for the use of IEC / SBCC material
- Capacity in communication monitoring- dissemination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

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

Part: C
Immunization

Immunization:

The vaccinations of children against serious but preventable diseases (tuberculosis, diphtheria, Pertusis, tetanus, poliomyelitis, measles & hepatitis -B) have been a cornerstone of the child health care system through the UIP. As part of the national health policy, the national immunization programme is being implemented on a priority basis.



The Universal Immunization program coverage has coverage of almost 70-80% as per targets. In the MLP many children were found to not receiving the vaccinations as per UIP, drop cases are rarely followed up in the village contacts with the support from the AWW, it is alarming to note that still many children's still are not immunized and at risk the target against achievements therefore gets backseat. In some blocks and sectors the immunization pattern requires our attention (Warishnagar, Hasanpur, Singhia, Bithan and Bibhutipur in particular). The sector wise data also reveals that though the achievement figures have reached but the quality of Immunization services is poor and still need to have efficient coverage. The left out population and far reached areas, forest villages the status of immunization is poor. Special area mapping of difficult & sensitive pockets needs to be identified at the block, support for the underserved pockets through a campaign / mop up approach needs to be developed.

Supply and logistic gaps:

- Insufficient supply, inaccurate estimation of quantity and delayed transfer of stock to appropriate level.
- Gaps in cold chain due to power failure and generator.
- Inadequate availability of vaccines at appropriate levels.
- Vacant positions in the HSC.
- Lack of Co-ordination with ICDS in developing visit rosters in the Village Health Sanitation and Nutrition Days.

Awareness, attitudes and beliefs of communities and service providers

- Lack of awareness about the beneficial effects of immunization and existing cultural norms or practices. About 5-10% of non-users despite a positive attitude towards immunization stated they had taken the child/children for vaccination, but did not receive it because the child was ill at the time of vaccination.
- Low literacy level, particularly among women plays a crucial role on restricting awareness about health issues (especially benefits of immunization), available services and useful programs.

S.No.	PHC	Deep Freezer Large		Deep Freezer Small		ILR Large		ILR Small		Voltage Stablizer	
		Working	Repairable	Working	Repairable	Working	Repairable	Working	Repairable	Working	Repairable
1	Dist. Vaccine Store	4	0	3	0	2	0	2	0	11	10
2	Bibhutipur	0	0	2	0	0	0	2	0	4	0
3	Bithan	0	0	1	0	0	0	1	1	2	0
4	Dalsingsarai	1	1	0	1	0	0	1	1	2	0
5	Hasanpur	1	0	1	0	0	0	2	0	2	0
6	Kalyanpur	0	0	1	2	0	0	2	0	4	0
7	Khanpur	0	0	1	0	0	0	2	0	3	0
8	Mohanpur	0	0	1	0	0	0	2	0	2	0
9	Mohiuddinagar	1	0	0	1	0	0	3	0	3	0
10	Morwa	0	0	1	0	0	0	3	0	3	0
11	Patory	0	0	0	2	0	0	1	1	1	1
12	Pusa	1	0	1	0	0	0	2	2	2	0
13	Rosera	0	0	2	0	0	0	1	1	2	0
14	Samastipur	0	0	1	0	0	0	1	0	1	0
15	Sarairanjan	1	0	1	0	0	0	1	0	3	0
16	Shivajinagar	0	0	1	0	0	0	1	1	3	0
17	Tajpur, Kothia	0	0	1	0	0	0	1	0	2	0
18	Ujiarpur	1	0	1	0	0	0	2	1	5	0
19	Vidyapatinagar	1	0	1	0	0	0	1	0	3	0
20	Warisnagar	0	0	1	0	0	0	1	0	2	0

21	**Singhia**	**1**	**0**	**1**	**0**	**0**	**0**	**3**	**s**	**2**	**0**
22	Sub. Div. Hosp. Pusa	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**1**
23	Sub. Div. Hosp. Dalsingsarai	**1**	**0**	**1**	**0**	**0**	**0**	**1**	**1**	**1**	**0**
24	Sub. Div. Hosp. Rosera	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**2**	**0**
25	Ref. Hosp. Tajpur	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**1**
Total		**13**	**1**	**24**	**8**	**2**	**0**	**37**	**11**	**65**	**13**

S.No.	PHC	Generator		Cold Boxes Large(20Lt.)		Cold Boxes Small (5Lt.)		Ice Pack
		Working	Repairable	Working	Repairable	Working	Repairable	Working
1	**Dist. Vaccine Store**	**1**	**0**	**16**	**5**	**20**	**15**	**6000**
2	**Bibhutipur**	**1**	**0**	**7**	**6**	**9**	**4**	**2780**
3	**Bithan**	**0**	**0**	**8**	**0**	**10**	**0**	**1520**
4	**Dalsingsarai**	**1**	**0**	**12**	**3**	**9**	**7**	**2060**
5	**Hasanpur**	**0**	**0**	**9**	**7**	**11**	**21**	**3240**
6	**Kalyanpur**	**0**	**1**	**8**	**10**	**6**	**13**	**2400**
7	**Khanpur**	**0**	**0**	**4**	**0**	**4**	**0**	**600**
8	**Mohanpur**	**0**	**0**	**5**	**0**	**4**	**0**	**300**
9	**Mohiuddinagar**	**0**	**1**	**10**	**3**	**2**	**8**	**1780**
10	**Morwa**	**1**	**0**	**12**	**5**	**10**	**4**	**2220**
11	**Patory**	**1**	**0**	**9**	**2**	**10**	**2**	**1389**
12	**Pusa**	**0**	**0**	**12**	**6**	**6**	**14**	**1920**
13	**Rosera**	**1**	**0**	**11**	**3**	**11**	**6**	**1860**

14	**Samastipur**	**0**	**0**	**6**	**4**	**12**	**2**	**2120**
15	**Sarairanjan**	**0**	**1**	**7**	**4**	**8**	**8**	**1200**
16	**Shivajinagar**	**0**	**0**	**6**	**0**	**6**	**0**	**492**
17	**Tajpur, Kothia**	**0**	**0**	**4**	**0**	**0**	**0**	**200**
18	**Ujiarpur**	**1**	**0**	**17**	**2**	**9**	**5**	**2120**
19	**Vidyapatinagar**	**0**	**0**	**5**	**0**	**4**	**0**	**1852**
20	**Warisnagar**	**1**	**0**	**16**	**7**	**12**	**7**	**2320**
21	**Singhia**	**0**	**1**	**10**	**3**	**10**	**7**	**2670**
22	**Sub. Div. Hosp. Pusa**	**0**	**0**	**0**	**0**	**2**	**0**	**108**
23	**Sub. Div. Hosp. Dalsingsarai**	**0**	**0**	**0**	**0**	**0**	**1**	**150**
24	**Sub. Div. Hosp. Rosera**	**0**	**0**	**0**	**0**	**1**	**0**	**350**
25	**Ref. Hosp. Tajpur**	**0**	**0**	**0**	**0**	**2**	**0**	**50**
Total		**8**	**4**	**194**	**70**	**178**	**124**	**41701**

Dropouts:

- Missed opportunity of vaccination - vaccination cards (not provided , incomplete)
- Long intervals between vaccinations.
- Infrequent / Difficult access to immunization facilities in remote pockets.
- Monitoring on vaccination rounds, rather than completing the targets of fully immunized children.

Data Quality and Monitoring

- There is also lack of accurate data to identify problems and providing target contextually appropriate solutions.

Inaccessible areas

- Another factor for low coverage rates is the fact that the immunization services scarcely reach the geographically unapproachable areas.

Population left out

- Target population not enrolled
- Left-outs within the AWC area, distant hamlets and non ICDS covered villages and, fringe areas of AWCs, block, district and state boundaries.
- Low caste/weaker or other excluded sections
- Migrant population

a) A combination of several groups of factors contributes to the low immunization coverage . Interactions with program implementers, community members and review of various reports also highlighted several factors for poor coverage. The following factors play a key role:

Systemic

- Vacant ANM positions, frequent transfers of staff, sub-optimal supervision
- Mobility difficulties of functionaries (especially ANMs)
- The policy of restricting provision of immunization services to ANM alone in rural areas
- Less children for immunization, denial of vaccination to reduce the wastage rates.
- Low motivation level of functionaries.

Immunization Session at Village Health and Nutrition Day

Low immunization efficacy is due to :

Low coverage (availability and accessibility) of routine immunization services

- Lack of knowledge of caretakers
- Poor quality of immunization sessions
- Long distances and unapproachable areas
- Lack of proper supervision & monitoring
- Lack of accountability of staff
- Lack of Immunization Skills of ANMs.
- Lack of contingency plan in remote & cut off HSC/AWC.
- Cold chain maintenance and management issues
- Delay in vaccines supply due to lack of timely transport facilities
- Less number of visits by the ANMs , due to additional workload.
- Vacant positions
- Pulse polio campaign and other programs affecting immunization schedules.
- Myths and misconceptions of side effects.
- Huge gaps in infrastructure facilities.

M10	CHILD IMMUNIZATION	
10.1	**Number of Infants 0 to 11 months old who received the following:**	Samastipur District April -Oct' 11
10.1.01	BCG	66756
10.1.02	DPT1	53827
10.1.03	DPT2	49687
10.1.04	DPT3	51016
10.1.05	OPV 0 (Birth Dose)	29335
10.1.06	OPV1	36525
10.1.07	OPV2	30541
10.1.08	OPV3	30080
10.1.09	Hepatitis-B0	2
10.1.10	Hepatitis-B1	329
10.1.11	Hepatitis-B2	0
10.1.12	Hepatitis-B3	16
10.1.13	Measles	56937
10.1.14	Measles 2nd dose	13

Objectives

- To increase the proportion of fully protected infants with 6 vaccines (DPT, BCG, Polio & Measles) to 100%
- To provide ORS to all diarrhea cases.
- Increase access to standard ARI case management at all health facilities.
- To increase coverage of children below 3 years with 5 does Vitamin A to 100%.
- To reduce diarrhea death among children by 20%.
- To eliminate neonatal tetanus in nest two years achieving Zero NNT deaths.
- To reduce case fatality rate due to ARI by 50%.

Plan to achieve 100% Immunization in Samastipur:

Goal: To ensure 100% immunization in Samastipur.

Planning processes:

- Categorization of all HSC in the PHC into three categories - A-1, A-2 & A-3.

A-1	**A-2**	**A-3**
More than 80% coverage Independent staff.	In range 70% coverage Independent staff Synergy with Asha & AWW	Less 60% Geographical reconsolidation High support in Cold Chain Mop Up with mobile Teams Synergy with Asha & AWW Reward & Recognition. Community support / PRI NGO involvement.

- Reworking the ANM / ANM rosters.
- Realign workforce - fill all vacancies in A-2 & A-3 categories on a priority basis.

- Focus on sector level co-ordination - use it as a forum for joint planning, review and monitoring.
- Focus on BCG & Measles coverage in particular. Monitor the Drop our rates BCG-Measles
- Address gaps in the understanding on the immunization protocols in the UIP.
- Updating the technical knowledge in the HSC Level.
- Quality improvement of Village Health Sanitation and Nutrition Days- integrate services ANC, THR, with specific tracking of the left out & drop out cases.
- Involvement of Panchayats - Recognize VHSC.
- Linkages with the traditional & Opinion Leaders, for supporting the Immunization days.
- Reward & recognition to performers in A-2 & A-3 on a mandatory annual basis.
- Trainings on motivation to all field staff.

▪

Part: D:- National Disease Control Programme

Situation Analysis Communicable Diseases

D1: Integrated Disease Surveillance Program (IDSP)

D2: National Vector Born Disease control Program(NVBDCP)

D2a: Kala-azar

D2b: Malaria

D3: National Leprosy eradication Program(NLEP)

D4: National program for Control of Blindness (NPCB)

D5: Revised National Tuberculosis Control Program (RNTCP)

D6: National Tobaco Controle programe (NTCP)

Communicable Diseases

Disease transmission cycle:

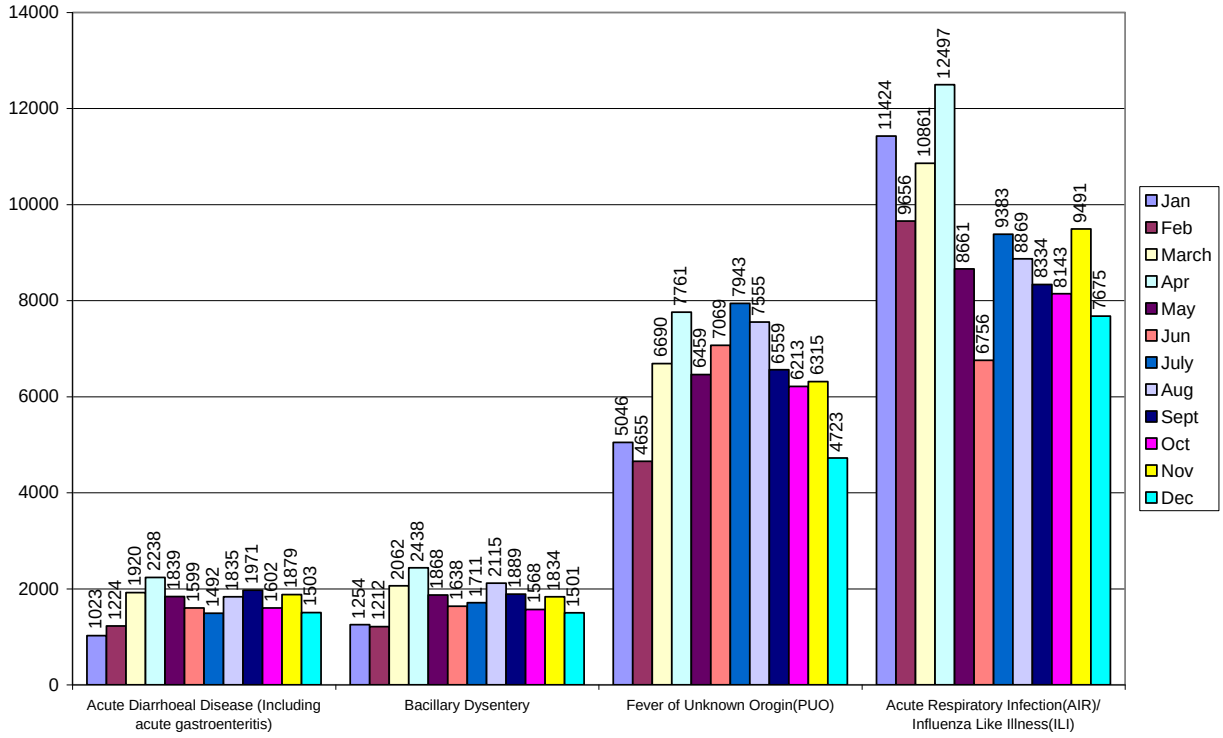
Microorganisms live everywhere in our environment. Individuals normally carry them on their Skin, respiratory, intestinal and genital tract. These micro- organisms are known as normal flora. In addition microorganisms live in animals, soil, air, plants and water. Some organisms are more pathogenic then others, i.e. there are more likely to cause the diseases. Given the right circumstances all microorganisms may cause infections. Bacteria, virus and other agents survive and spread with in the community due to the presence of certain favorable factors or conditions. The cycle of the disease transmission from reservoir to susceptible host.

Facts:

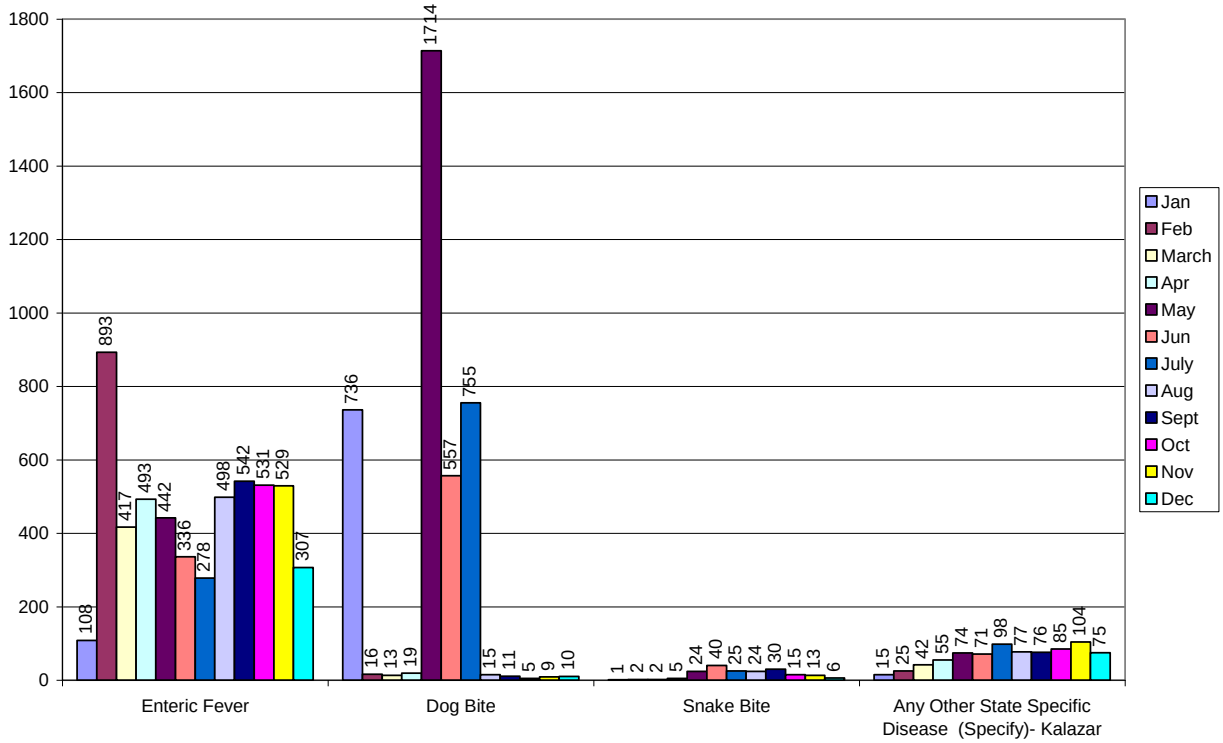
Looking in to above facts there are high chances to spread the communicable diseases as the roots are strongly supported the environment in the district like Samastipur. Also there are more people adopt the traditional treatment in which maximum infection remain untreated for a longer time. Also the incidence of the communicable diseases is prone in the district.

14.10	**Inpatient**	Samastipur District Apr-Oct 11
14.10.1	Admissions	
14.10.1.a	Male	2779
		4078
14.10.1.b	Female	2620
		53853
14.10.1.c	Total {(a) to (b)}	5399
		57931
14.12	**Outpatient**	
14.12.1	OPD attendance (All)	1793907
14.13	**Operation Theatre**	Samastipur District Apr-Oct 11
14.13.1	Operation major (General and spinal anaesthesia)	233
14.13.2	Operation minor (No or local anaesthesia)	11008
14.14	**Others (Include other services like Dental, Ophthalmology , AYUSH etc.)**	
14.14.a	AYUSH	204286
14.14.b	Dental Procedures	38254
14.14.c	Adolescent counseling services	687
M15	**Laboratory Testing**	Samastipur District Apr-Oct 11
15.1	Laboratory Test Details	
15.1.1	Hb. Tests conducted	
15.1.1.a	Number of Hb tests conducted	3574
15.1.1.b	Of which number having Hb < 7 mg	44

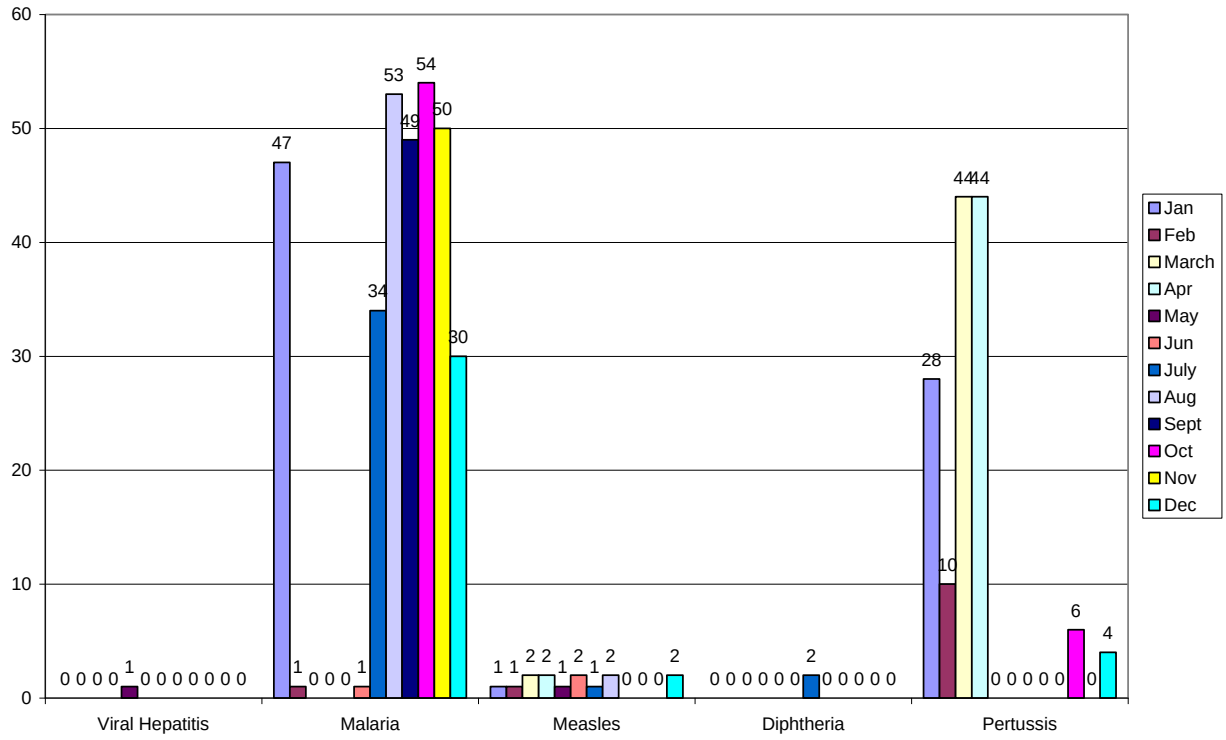
Diosease Trend, Samastipur District- Jan-Dec 2011



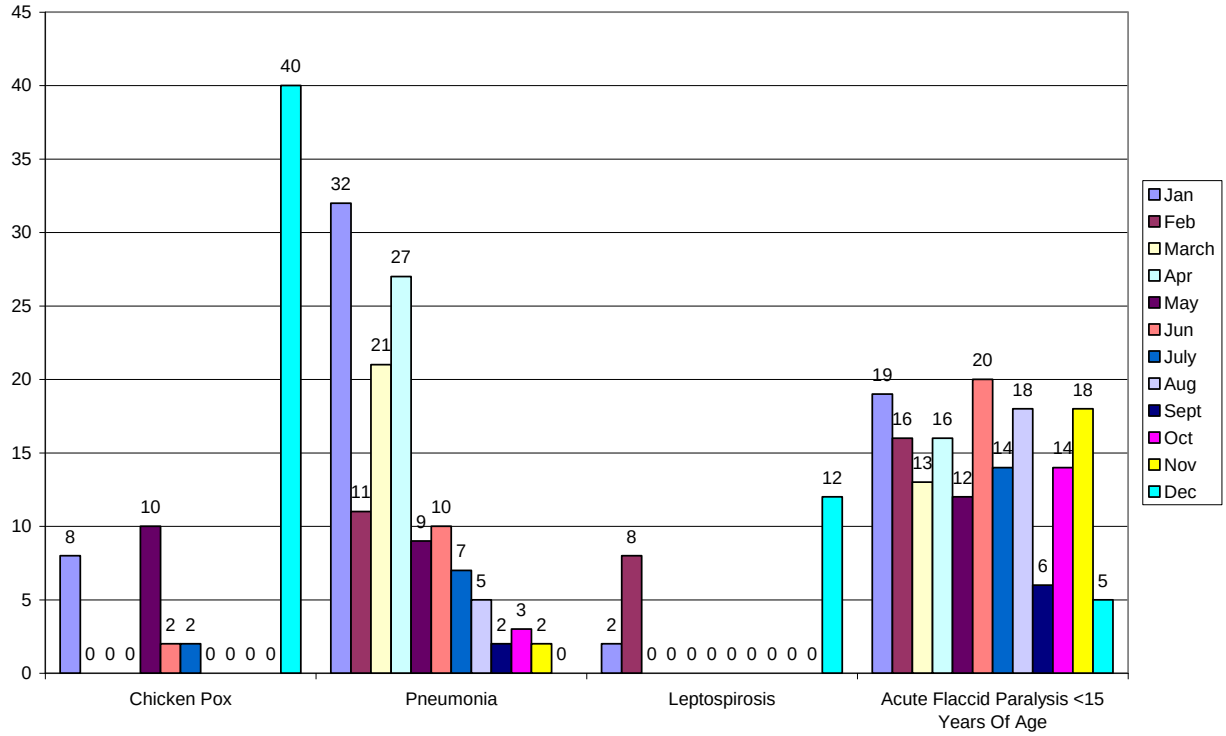
Disease Trend, Samastipur District- Jan-Dec 2011



Disease Trend- Samastipur District- Jan-Dec 2011



Disease Trend, Samastipur District- Jan-Dec 2011



Communicable diseases continue to be a major problem in Samastipur. Disease considered to be of great importance today is Kala-azar, Malaria, Tuberculosis, ARI, Diarrheal diseases, and ARI, RTI/STI/AIDS etc. The Others like Kala-azar, Viral hepatitis, enteric fever, guinea-worm diseases and other helminthic infestations are among the other important communicable diseases. The tragedy is that most of these diseases can be either preventable or treated with minimum input of sources.

D1: Integrated Disease Surveillance Program (IDSP)

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. IDSP has been identified as a flagship program of the govt. A paradigm shift is being perceived in Bihar IDSP in 2011. This is reflected in almost 100 percent, timely weekly reporting, on time outbreak detection, their analysis and transmission of information to concerned stakeholders on time etc. in spite of too little resource envelop. The state is determined to strengthen the program. Milestones are being set up to achieve the targeted goals in stipulated timeframe.

Integrated Disease Surveillance Program (IDSP) is intended to be the backbone of public health delivery system in the state. It is expected to provide essential data to monitor progress of on- going disease control programs and help in optimizing the allocation of resources. It will be able to detect early warning signals of impending outbreaks and help initiate an effective and timely response. IDSP will also facilitate the study of disease patterns in the state and identify new emerging diseases. It will play a crucial role in obtaining political and public support for the health programs in the state.

Surveillance is essential for the early detection of emerging (new) or re-emerging (resurgent) infectious diseases. In the absence of surveillance, disease may spread unrecognized by those responsible for health care or public health agencies, because many individual health care workers would see sick people in small numbers. By the time the outbreak is recognized, it may be too late for intervention measures. Continuous monitoring is essential for detecting the 'early signals' of outbreak of any epidemic of a new or resurgent disease. For disease surveillance to prevent emerging epidemics, the time taken for effective action should be short.

Criteria for including diseases in the surveillance program:

 Burden of disease in the community,

 Availability of public health response and

 Special considerations and international commitments. Based on the information obtained from the state level workshops the following core conditions are included in the IDS program.

The disease conditions that are included in the core list and state specific list of the surveillance program is to be reviewed once in two years based on disease burden and availability of public health action and suitably modified.

List of Core Diseases:

- 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

Community Meeting at Ramtola, udayapur

Regular periodic surveys:

NCD Risk Factors

Anthropometry, Physical Activity, Blood Pressure, Tobacco, Nutrition, Blindness and any other unusual health condition GOG may include in a public health emergency

Surveillance is particularly important for the early detection of outbreaks of diseases.

In the absence of surveillance, disease may spread unrecognized by the responsible health care or public health agency, because sick people would be seen in small numbers by many individual health care workers. By the time the outbreak is recognized, the best opportunity to take intervention measures might have been over. Surveillance is essential for the early detection of emerging (new) or re-emerging (resurgent) infectious diseases. In the absence of surveillance, individual health care workers may not recognize the new disease. The continuous monitoring is essential for the 'early signals' of any outbreak of any endemic, new or resurgent disease and the action loop to take effective public health action should be short and effective if disease surveillance were to prevent emerging epidemics.

Objectives of IDSP

The objective is to improve the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors. Specifically, the project aims:

1. To establish a decentralized district based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the state in line of Integrated Diseases Surveillance Project.

2. To improve the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other stakeholders so as to detect disease trends over time and evaluate control strategies.

3. Renovate and strengthen state, district and peripheral surveillance units to cope up with the demand.

4. Renovate and strengthen state, district and peripheral laboratories to cope with the demand.

5. Operationalize norms and standards in the form of standard case definition, reporting formats and guidelines.

6. Strengthen the MIS by designating clear responsibilities for data collection, collation/processing, transmission, analysis and action, clear lines of information flow, standardized MIS formats and efficiency owing to use of IT (computers, software and web-based reporting system)

7. Reduce the burden of morbidity and mortality due to various diseases.

8. Develop, mobilize and optimally utilize human and financial resource and promote conductive environments for work.

The project assists in:

1. Surveillance of a limited number of health conditions and risk factors;

2. Strengthen data quality, analysis and links to action;

3. Improve laboratory support;

4. Train stakeholders in disease surveillance and action;

5. Coordinate and decentralize surveillance activities;

6. Integrate disease surveillance at the state and district levels, and involve communities and other stakeholders, particularly the private sector.

7. Build capacity for outbreak response

STRATEGY:

Integrated Disease Surveillance Program in the state is intended to detect early warning signals of impending outbreaks and help initiate an effective response in a timely manner.

Major components of the project are:

(1) Integrating and decentralization of surveillance activities; (2) Strengthening of public health laboratories; (3) Human Resource Development – Training of State Surveillance Officers, District Surveillance Officers, Rapid Response Team, other medical and paramedical staff; and (4) Use of Information Technology for collection, collation, compilation, analysis and dissemination of data For Project implementation, Surveillance

Units have been set up at State and District level. Currently linkages are being established with all District Head Quarters and all Government Medical Colleges on a Satellite Broadband Hybrid Network. This network enables enhanced Speedy Data Transfer, Video Conferencing, Discussions, Training, Communication and in future e-learning for outbreaks and program

monitoring under IDSP. Under IDSP data is collected on a weekly (Monday– Sunday) basis. The information is collected on three specified reporting formats, namely “S” (suspected cases), “P” (presumptive cases) and “L” (Laboratory confirmed cases) filled by

Health Workers, Clinician and Clinical Laboratory staff. The weekly data gives the time

trends. Whenever there is a rising trend of illnesses in any area, it is investigated by the

Medical Officers/Rapid Response Teams (RRT) to diagnose and control the outbreak. Data analysis and action are being undertaken by respective districts and also at the state level.

Emphasis is being laid on reporting of surveillance data from major hospitals both in public and private sector and also Infectious Disease hospitals. The compilation and disease outbreak alerts has been started recently.

Disease Surveillance is the backbone of an effective Public Health Administration. It is systematic collection of data on the incidence and prevalence of various priority disease conditions for the purpose of taking appropriate action for prevention and control. It is crucial for planning, management and evaluation of Disease Control Programmes. Govt. of Bihar is planning an Integrated Disease Surveillance Project incorporating the following:-

- Integrating existing vertical & horizontal Disease Surveillance Programme.
- Surveillance of both Communicable and Non-Communicable Diseases.
- Collaboration between Govt. & Non-Govt. Health Services i.e. Private Sector and community representatives
- Action oriented and responsive to the needs of the State of Bihar.

Project activities

I. Up gradation of state, district and peripheral surveillance units

 Renovation and furnishing of surveillance units; Providing office equipment and furniture

II. Up gradation of state, district and peripheral laboratories

 Renovation & Furnishing of Labs; Supply of Lab. Equipments; Lab. Material and Supplies and consumables.

III. Information Technology and Communication

 Computer Hardware and Office Equipments; Software for surveillance; Leasing of Wide Area Networking

IV. Human Resources and Development

 Consultant / Contractual staff; Training; Information Education and Communication

V. Monitoring and Evaluation

 Provision of Syndromic, presumptive and laboratory surveillance formats

 Establishment of web-based weekly reporting system

Component wise Progress:

1. WEEKLY REPORTING:

Under the reporting system**,** four types of forms as mentioned below are being reported weekly to www.idsp.nic.in (portal of Central surveillance Unit, IDSP, New Delhi) and also to State Surveillance, IDSP, Bihar. A brief status of these are as below:

a) Presumptive (P form): 22 infectious diseases are covered under this form. Weekly reporting of the form is reported by each Block. Diseases covered under this are as below:

b) Laboratory (L Form):

At present laboratory diagnosis of diseases like Dengue, Chikungunya, JE, Measles, kala-azar, TB, HIV etc are being captured in the weekly data.

Presently 20 out of 20 Blocks are reporting on this form on regular, timely basis with completeness of data.

c) Syndromic (S form):

Under this, different syndromes like fever, diarrhea, jaundice etc with simple case definition are being captured. This form is to be reported from the Sub- Centre level by the Health Workers. Perceptible changes have been noticed in reporting of S form in spite of several constraints like unavailability of designated staff to bring the weekly formats on time to District Surveillance Unit, IDSP

Presently out of 355 Health Sub centre around 125 are submitting regularly to the district. . A proper orientation/refresher course of all the Health Workers need to be done to ensure its reporting.

d) Early Warning form (EWS form):

The objective of this form is to capture unusual increase in incidence of any disease or if there is suspected/potential outbreak. Reporting as usual is on weekly basis.

Status as on 31st December 2011: 25/25 Institutions are reporting.

2. OUTBREAK DETECTION & REPORTING:

Generation of Early Warning signals to detect Disease Outbreaks & take prompt action to mitigate the mortality & morbidity due to various diseases is the heart and soul of IDSP. The weekly data received from various reporting units are analyzed & suspected or potential outbreaks as per IDSP triggers are verified and investigated within 48 hours or as soon as possible. The concerned programme officers, relevant stake holders & partners are intimated as soon as any outbreak is detected for more prompt action.

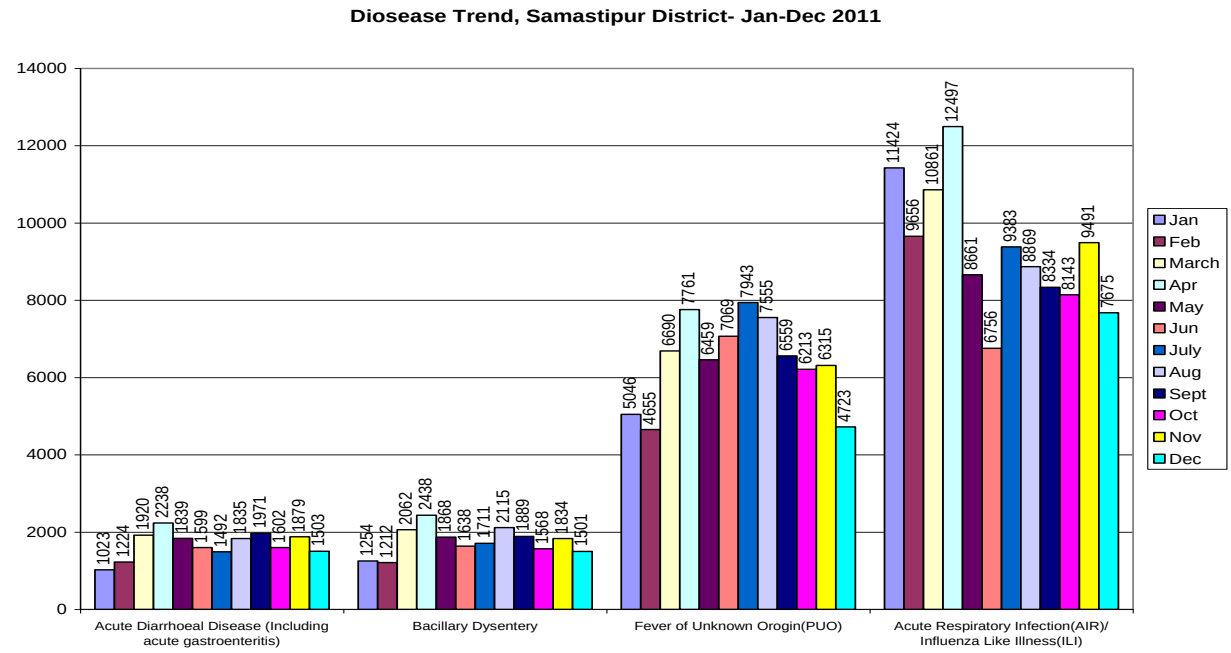
Besides undertaking the other activities under IDSP, the District Surveillance Unit is according highest priority to monitor outbreaks across the 20 Blocks in the district. The moment outbreaks are reported line listing is done on daily basis which include age wise, sex wise, date wise, disease wise, place wise mapping of data to address the problem at the onset. In last 52 Weeks 51 Out break (AFP- provisional Cases) was identified and verified lab report negative.

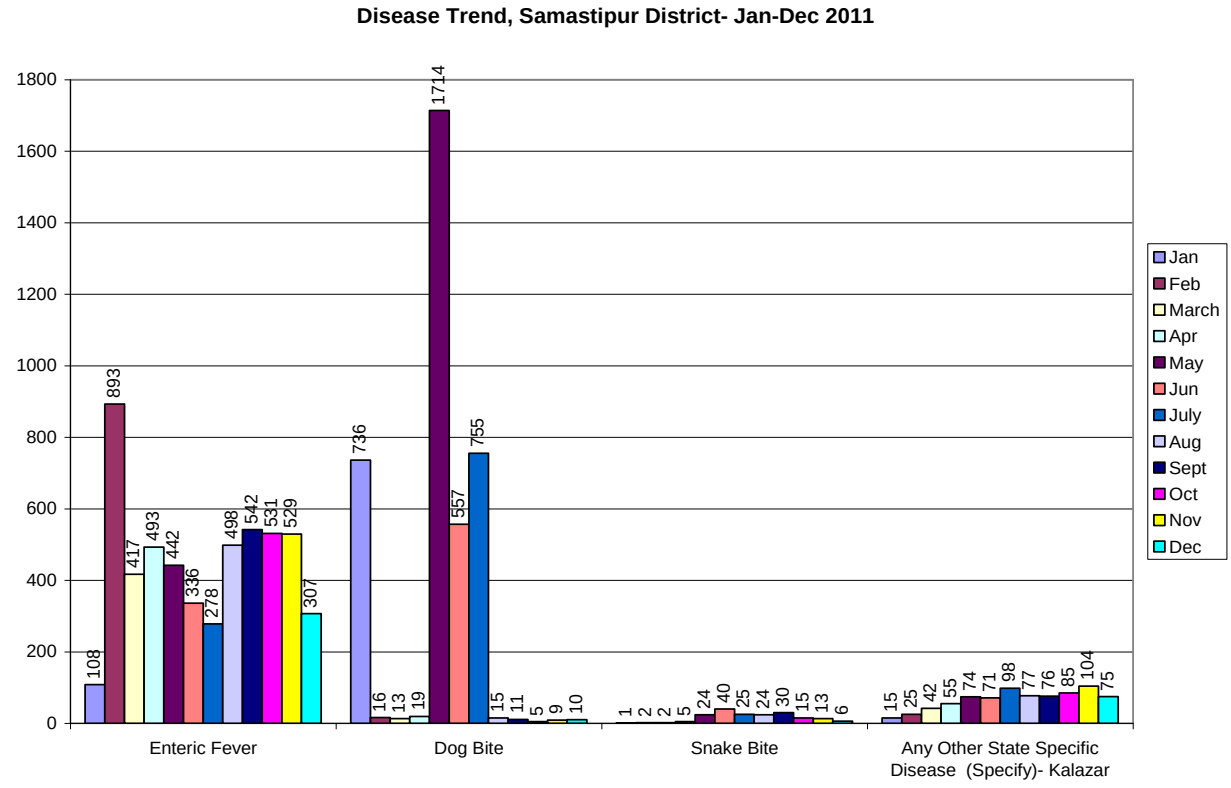
Steps under taken during the year 2011

- One day District level Training of all the Medical Officer completed during the months of March 2011.
- The Medical Officer in charge orient the ANMs, weekly reviewing reporting in PHC & give hand holding support and coaching for correct & timely reporting.
- Introduced formats Form-P, Form-L, Form-S, form EWS, form-CBHI-2A,3A, Apda & Sukhad (Disaster reporting).
- Media Scanning verification.
- Data Up load in web portal and data analysis and feedback to concerned institutions authority.
- Suggest Municipality to reduce incidence of Dog biting.
- Introducing line listing of incidences.
- Establish convergence with line departments & INGOs (WHO, Unicef, DFID & Care).
- Support DHS in capturing & give prioritize on disease incidences.

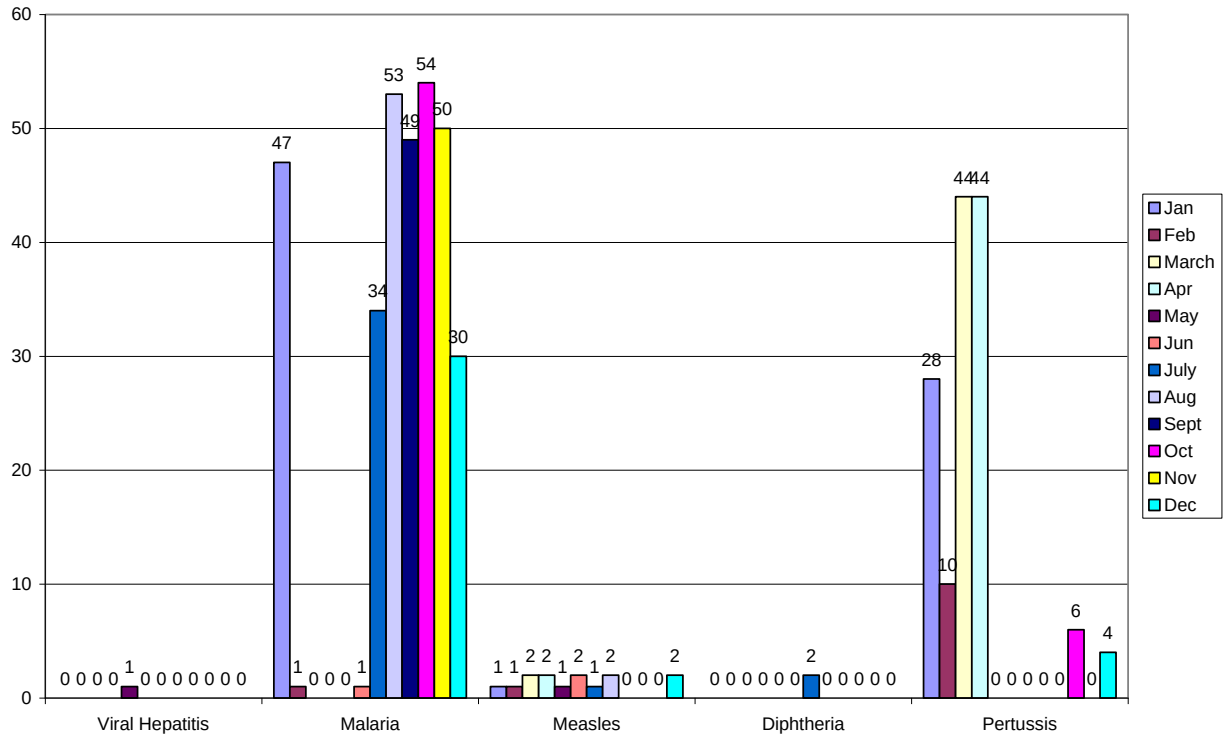
Support in development of District health Implementation plan and included specific chapter on IDSP data collection intervention, Analysis, Dissemination

At glance of different disease in Samastipur District:

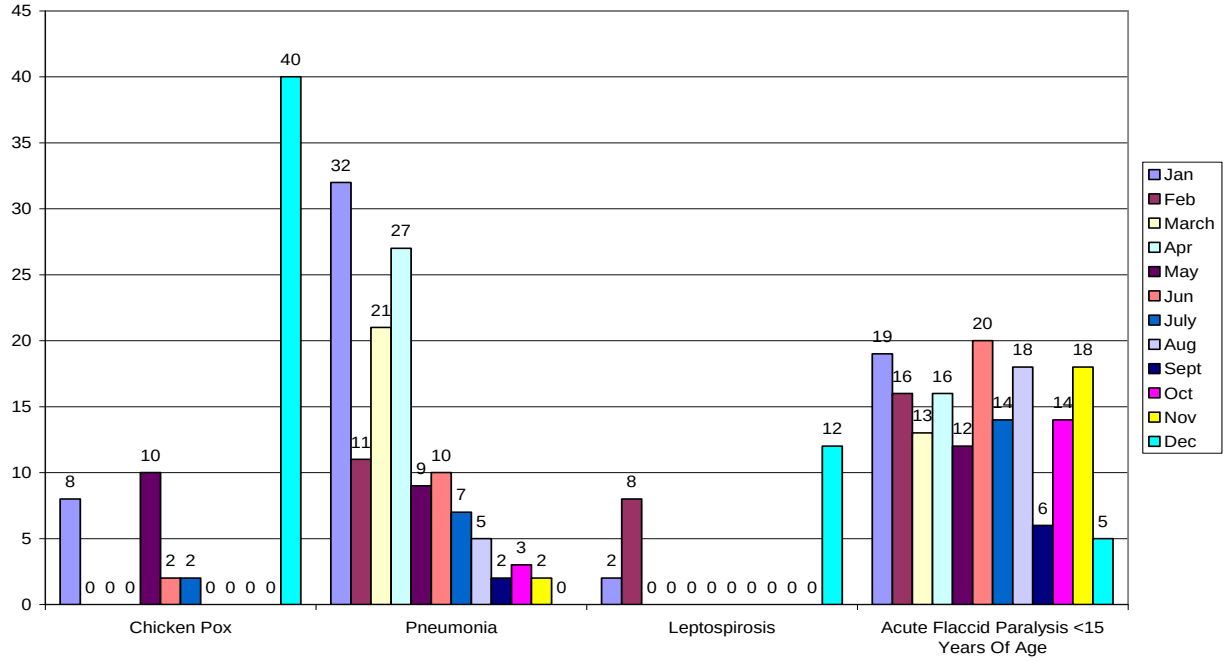




Disease Trend- Samastipur District- Jan-Dec 2011



Disease Trend, Samastipur District- Jan-Dec 2011



District Geographical at glance of different disease

- The Geographical at glance shows the generic reporting system of different Institutions.
- The reports shows that in some of the institution are only reporting actual and accurate report but others are need to understand the reality and importance of the data.

Problem faced / Issues

- Availability of Lab Facility in different Institutions.
- Availability of Human Resource in Facilities.
- Monitoring of 1st hand data collection, feedback.
- Timely report reaching to District.
- Mal practice of data(different data / information given to different line authority).
- Lack of Data Manager in district HQ- in IDSP.
- Constants of Mobility & Communication.
- Availability of formats.
- Some Institution reports static to 2 (Singhia) to 3 disease.
- Physicians are do not mentioning diagnosis in OPD Registers.
- As per IDSP guideline 22 diseases should be reported under surveillance but Samastipur district is reporting 18 Diseases during 2011.
-

Suggestion for strengthening:

- Strengthen District level PHC wise Monthly data review at ACMO/CS level.
- Monitoring of reporting and Supportive supervision to Block under reporting.
- Establish equitable, correct and consistence reporting system through regular review at PHC level.
- Focus given to the high risk blocks identified in the analysis for preventive action, ready for risk reduction & responding curative action to the needy.
- Include high incidence disease prevention and control program in DHAP.

D2: National Vector Born Disease control Program(NVBDCP)

D2a: Kala-azar

The sand fly that transmits the disease multiplies in the cow dung villagers use liberally to plaster their shanties or as cow dung cakes for fuel. The flies survive on the sap in banana and bamboo groves and the decomposed cow dung heaps. They make their home in the straw thatches of houses.

The disease is characterized by fever, weight loss, swelling of the spleen and liver and leads to cardiovascular complications resulting in death. Early this year, the Bihar government set up the task force on kala-azar headed by Thakur to suggest measures to eradicate the disease by 2010. In Samastipur district The Mushar community are residing having a small hamlets in most of the villages but till November 2012 the most effected village number is 510 and mostly the age group of 6 years to 15 years are effecting with this incidence. The population covers 1953341 are affected from Kala-azar.

STRATEGY: THREE

- VECTOR CONTROL
    - Indoor Residual Spraying with DDT up to 6 feet height from the ground twice annually.
    - Hygiene and environmental Sanitation Advocacy / Promotion for use of Insecticide - treated bed nets.
- PARASITE ELIMINATION- Early case detection and complete treatment

- PARASITE ELIMINATION :
    - Introduction of Kala-azar rapid test - rk39 for use at peripheral level
    - Introduction of oral drug – Miltefosine on pilot basis as first line treatment
    - Strengthening of referral services

- SUPPORTING INTERVENTIONS:
    - Communication for Behaviour Impact
    - Inter-sectoral collaboration
    - Capacity Building
    - Operational research
    - Close monitoring and supervision with periodic reviews/evaluations

Technical Guidelines

- Diagnosis & Treatment
- Vector Control
- Kala-azar Fortnight
- Road-Map
- Use of rK39
- Use of Miltefosine
- IEC Tool Kit / Prototypes
- Patient Coding Scheme
- Training Modules
- For ASHA / Kala-azar Activist/ Health Worker / Medical Officer /
- Private Practitioner / AWW / NGOs / CBOs /FBOs

Financial

•Cash assistance

•Release of Operation cost on spray men wages

•Incentive to patient and attendant

•Incentive to Kala-azar activist / ASHA

Capacity Building

•Medical Officers

•Para-medical staff

•Spray men

•Private Practitioners

Supervision and Monitoring

•Central Monitoring Teams

• State Mobile Teams

•District monitoring teams

•Block level monitoring supervision- KTS/Malaria Inspectors

January				February			
Age Group	**Case**	**population**	**Incidence Rate-Case/Pop*10000**	**Age Group**	**Case**	**population**	**Incidence Rate-Case/Pop*10000**
0-5	8	528310	0.151	0-5	9	528310	0.170
6-15	21	919181	0.228	6-15	39	919181	0.424
16-25	11	816309	0.135	16-25	20	816309	0.245
26-35	7	506419	0.138	26-35	10	506419	0.197
36-45	3	422928	0.071	36-45	7	422928	0.166
46-55	0	334056	0.000	46-55	3	334056	0.090
56+	1	385110	0.026	56+	0	385110	0.000

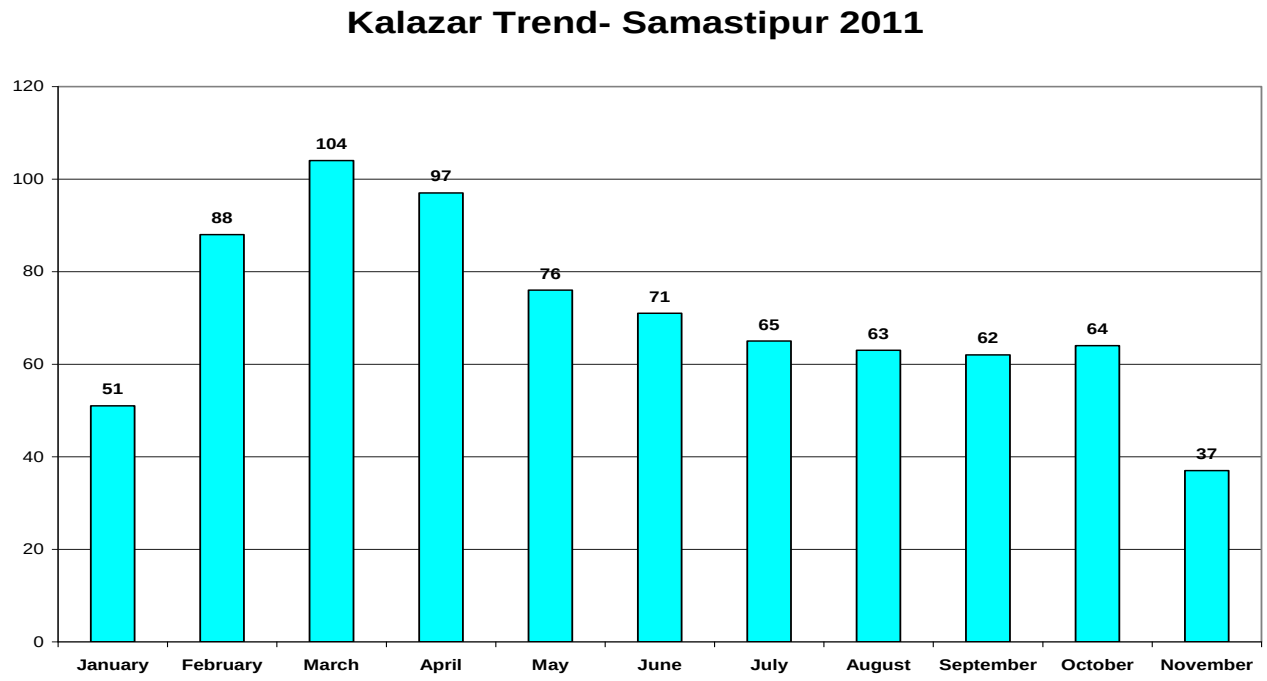
March				April			
Age Group	**Case**	**population**	**Incidence Rate-Case/Pop*10000**	**Age Group**	**Case**	**population**	**Incidence Rate-Case/Pop*10000**
0-5	8	528310	0.151	0-5	13	528310	0.246
6-15	41	919181	0.446	6-15	44	919181	0.479
16-25	19	816309	0.233	16-25	15	816309	0.184
26-35	13	506419	0.257	26-35	18	506419	0.355
36-45	14	422928	0.331	36-45	2	422928	0.047
46-55	6	334056	0.180	46-55	2	334056	0.060
56+	3	385110	0.078	56+	3	385110	0.078

July				August			
Age Group	**Case**	**population**	**Incidence Rate-Case/Pop*10000**	**Age Group**	**Case**	**population**	**Incidence Rate-Case/Pop*10000**
0-5	8	528310	0.151	0-5	8	528310	0.1514
6-15	28	919181	0.305	6-15	25	919181	0.2720

16-25	12	816309	0.147	16-25	14	816309	0.1715
26-35	8	506419	0.158	26-35	6	506419	0.1185
36-45	3	422928	0.071	36-45	3	422928	0.0709
46-55	3	334056	0.090	46-55	3	334056	0.0898
56+	3	385110	0.078	56+	4	385110	0.1039

September				**October**			
Age Group	**Case**	**population**	**Incidence Rate-Case/Pop*10000**	**Age Group**	**Case**	**population**	**Incidence Rate-Case/Pop*10000**
0-5	3	528310	0.057	0-5	1	528310	0.0189
6-15	17	919181	0.185	6-15	26	919181	0.2829
16-25	9	816309	0.110	16-25	10	816309	0.1225
26-35	17	506419	0.336	26-35	19	506419	0.3752
36-45	11	422928	0.260	36-45	5	422928	0.1182
46-55	4	334056	0.120	46-55	2	334056	0.0599
56+	1	385110	0.026	56+	1	385110	0.0260

November				**December**			
Age Group	**Case**	**population**	**Incidence Rate-Case/Pop*10000**	**Age Group**	**Case**	**population**	**Incidence Rate-Case/Pop*10000**
0-5	0	528310	0	0-5	2	528310	0.037856561
6-15	14	919181	0.152309502	6-15	14	919181	0.152309502
16-25	11	816309	0.134752894	16-25	11	816309	0.134752894
26-35	7	506419	0.138225462	26-35	6	506419	0.118478967
36-45	2	422928	0.047289373	36-45	2	422928	0.047289373
46-55	3	334056	0.089805302	46-55	5	334056	0.149675504
56+	0	385110	0	56+	0	385110	0



Weakness:

- Lack of supervision and monitoring at all levels of implementation.
- Delay in release in funds at State to Districts / PHCs level.
- Delay in submission of SOEs & UCs by District.
- Very Poor Advocacy for community awareness.
- Delayed Spray Schedules.
- Route chart not followed up.
- Active case search not done on regular basis.
- Proper case management is needed.

Constraints:

- Inadequate dedicated staff
- Lack of interest by PHC Medical Officers
- Prolonged treatment schedules
- Non-compliance by the patients
- Development of resistance
- Inadequate information on vector born disease
- Asymptomatic carriers

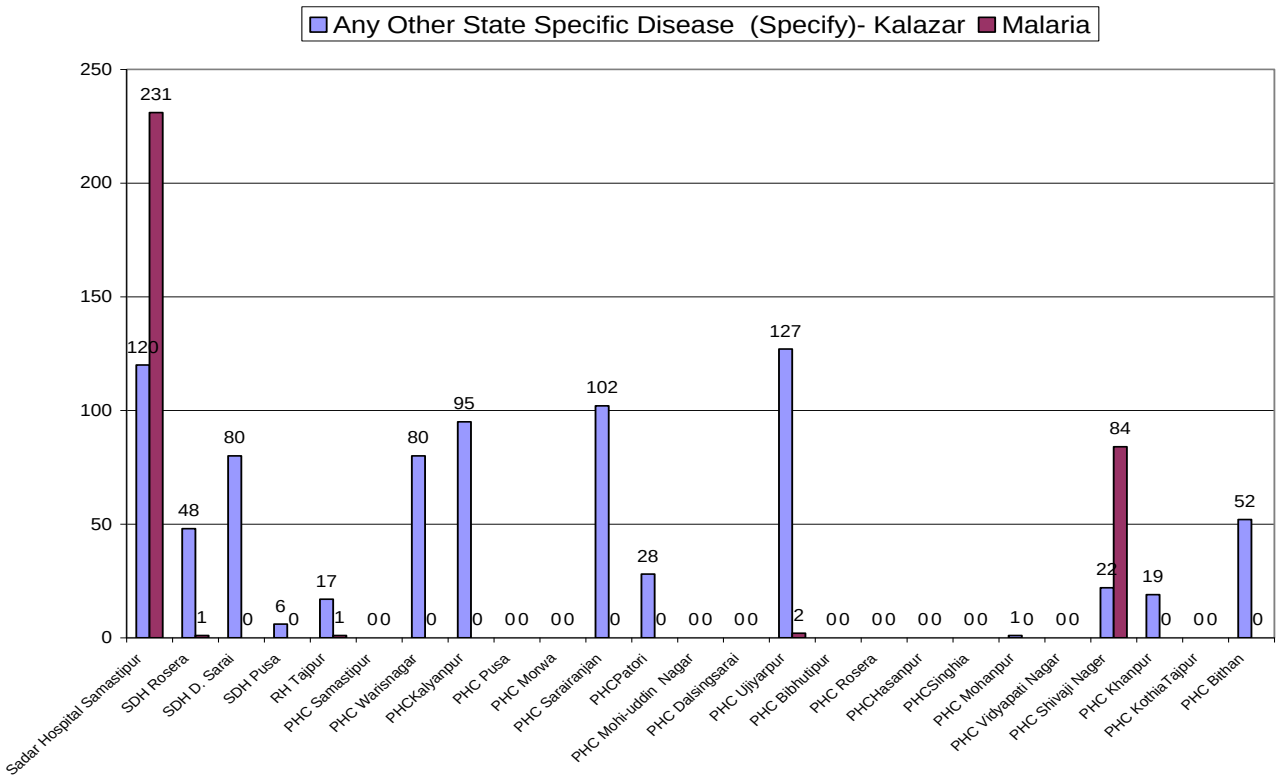
Activities:

- New Tools i.e.RK39 - diagnostic kit & oral drug Miltofosine introduced.
- Arrears of spray wages given.
- Free diet to patient and one attendant.
- Incentive to patient **@Rs. 50/-** per day towards loss of wages during treatment. Incentive to kala-azar activist for referring a case and ensuring complete treatment.
- Construction of pucca houses for mushar community in collaboration with Ministry of Rural Development.
- Patient Coding Scheme
- Guidelines on Diagnosis and treatment, vector control, roadmap, kala-azar fortnight, use of rK39 and Miltofosine
- GIS mapping for focused interventions.
- Identification of Kala-azar activist for involvement in cases detection and IRS.
- Regular BCC activity in VHSND site and through ASHA in Mushar Hamlets.

D2: National Vector Born Disease control Program(NVBDCP)

D2b: Malaria

Malaria's challenge is a development issue, not a health issue. Malaria keeps societies poor. It is a worsening threat, serious epidemics are being reported. Climate changes and population movements increase the threat. Adding to the problem, the parasite is resistant to commonly used drugs in much of the areas.
Malaria primarily affects all in the district but it is not prone to community. There are several cases reported in the district during the this years 2011.



Strategy

Malaria is a killer disease resulting in most deaths each year. With inappropriate cases reported annually, the disease is a primary cause of debilitating morbidity proportions. The scope of the problem is magnified by the fact that a disproportionate number of malaria victims are pregnant women and children, who are particularly vulnerable to the disease.

- Achieve better coordination among Multi stakeholders involvement especially NGOs ASHA, AWW , Panchayats & Traditional healers.
- Strengthen existing health facilities.

- Set up prevention and control measures that will stand up over time.
- Develop and promote new tools to combat malaria effectively, including new drug combinations and personal protection measures such as treated nets.
- Make effective and affordable drugs available to communities in need.
- Encourage the development of even more effective anti-malarial drugs , through efficacy trial studies.

There are six elements of the intervention strategy:

1. Evidence Based Decisions
2. Early Diagnosis, Rapid Treatment
3. Multiple Prevention strategy
4. Well Coordinated Action
5. Dynamic Movement
6. Focused Research

Malaria Case Management

The objectives of Malaria case management:

- To ensure early diagnosis and treatment of malaria by significantly increasing caregivers' recognition of fever in children under five years of age and caregivers' prompt and effective action.
- To improve coverage and quality of malaria case management and preventive services offered to vulnerable groups in communities by health volunteers, public and private sectors, and traditional healers.

- Improving the quality of aftercare information given to caregivers attending clinics, on the importance of compliance with treatment regimes, actions in the event of treatment failure, information on malaria prevention and general health promotion.
- Strengthening monitoring, evaluation and supervision systems to identify and rectify problems and improve service response to the local health situation.
- Supporting management systems (including equipment and procurement) to ensure that health facilities meet minimum standards for provision of quality and integrated health services.

- Behavior change is the key to successful reduction in malaria-associated morbidity and mortality in children and pregnant women. District Health Department strives to understand community perceptions of malaria (particularly severe malaria) through knowledge, practice and coverage surveys (KPC), and formative research.

Key health messages for malaria recognition include the prompt malaria treatment of children under five with fever, and the prompt referral of children with signs of severe malaria to health facilities.

Communication strategies employed include interpersonal contact, the use of local media such as radio, social events such as church gatherings, and malaria awareness days. It is important to work

through community groups, and for volunteers to work with clusters of 20 or fewer households. In a few instances, malaria health promotion has been integrated with literacy training.

ACTIVITY PLAN :

- Conducting situational analysis.
- Mapping malaria burden and access to health care.
- Improving health system response.
- Malaria surveillance and management of epidemics.
- Treating malaria in complex emergencies.
- Utilizing insecticide treated materials.
- Managing vector control issues.
- Improving case management.
- Increasing advocacy for RBM: catalyzing the social movement.
- Heightening awareness of the economic, poverty and gender dimensions of RBM.
- Improving the monitoring and evaluation procedures.
- Managing capacity development issues.
- Malaria Control and Behavior Change

Preventive behavior:

- Antenatal care: seek antenatal care at least twice during pregnancy and take adequate amounts of iodine and folate.
- Usage of micro-nutrients: correctly use micronutrient interventions.
- Use of bed nets, ensure that all young children in malaria endemic areas sleep under insecticide treated bed nets all year round.

Curative behavior:

- Recognition and treatment seeking: take the child to an appropriate health care provider if the child has a fever lasting more than one day in spite of household treatment.
- Treatment/compliance: give appropriate home management including full compliance with instructions for the use of drugs.

Sustaining behavior:

- Community support: organize, manage and give labor and other resources to support effective mechanisms for improved access to needed health products and services; support ready access to services for sick children.
- Focus behavior change resources only on efforts, which can be realistically implemented, and which are proven to be effective.

D3: National Leprosy eradication Program (NLEP)

Even though new case detection rate and prevalence rate are going down, **yet new cases continue to come up in large numbers in state.** The promotion of self reporting is now crucial to case detection, as case finding campaigns become less and less cost effective. It is important to identify and remove barriers that may prevent new cases coming forward and a greater emphasis on the assessment of disability diagnosis, so that those at particular can be recognized and managed appropriately.

 Leprosy being a disease associated with poverty, it is presumed there are still hidden cases among the underprivileged. Under special initiatives, to promote self reporting, focus will be on wide dissemination of key messages of leprosy i.e. curable, early signs, no need to be feared and support, in the urban and rural areas. This will reduce stigma & discrimination against persons affected with leprosy. The key messages along with proactive involvement of the community will bring about health behavior at individual, household and community level.

 The out come of strategy will be to promote further integration with general health care system by providing operational and technical skill in job training. The better equipped and motivated GHC system will provide quality leprosy services on all working days to the affected Persons, following the principles of equity and social justice in the community.

Background:

National Leprosy Control Programme was started by Govt. of India in 1955 based on

Dapsone Monotherapy through units implementing survey, education and treatment activities. It was only in 1970s that a definite cure was identified in the form of Multi Drug Therapy. The MDT came into wide use from 1982, following the recommendation by WHO study Group, Geneva in October 1981. Government of India established a high power committee under chairmanship of Dr. M. S. Swaminathan in 1981 for dealing with the problem of leprosy. Based on its recommendations the National Leprosy Eradication Programme (NLEP) was launched in 1983 with objective to arrest the disease activities in all the known cases of leprosy.

In order to strengthen the process of eradication, the World Bank supported the project in two phases. The first phase was started in 1993 – 94 and ended on 31st

March 2000. The second phase started in year 2001 – 2002 and ended on 31st

December 2004. Now since 2005 the project is being continued with GOI funds. The cost of infrastructure is borne by the state funds. Additional support is received from

World Health Organisation and ILEP (International Federation of Anti-Leprosy Associations). Multi Drug Therapy (MDT) was supplied free of cost by Novartis through WHO.

 In Bihar whole state was covered under MDT in November 1996.

 In Bihar till date more than 15 lakhs patients treated with leprosy.

 The PR reduced to 14.2/10000 populations in year 1999.

 Integration of leprosy services in to general health care system started in 2000 – 01

and fully integrated in 2003 -04.

 Five rounds of Modified Leprosy Elimination Campaigns (MLECs) and four rounds of

Block Level Awareness campaigns have been already successfully conducted in the

state during the period 1998 to 2008. These activities resulted in detection of more

than 4 lakh cases.

The situation of the Samastipur district is also meeting the above pathology trends and more believe on the traditional treatment for the disease. It's a common factor for any individual infected by leprosy, relating it to the wrath of Gods.

The district Leprosy prevalence rate of the district is 1.43/10000 populations but the P>R> is high in some pockets of the district it is 2.58.

Sl. No.	Hospitals	No. of patients carried over from last 10 - 11	No. of patients registerd till last Month 2011 - 12	No. of patients registered in reporting month	Total	No. of patients completely treated and cured (RFT)	Balance	No. of patients visited for the test in reporting month	Incentive Amount distributed
1	2	3	4	5	6 = (4 + 5)	7	8 = (6 - 7)	9	10
1	Sadar Hospital Samastipur	7	**4**	0	**11**	4	**7**	2	0.00
6	P.H.C Samastipur	20	**10**	2	**32**	20	**12**	5	0.00
7	P.H.C Warisnagar	11	**15**	3	**29**	13	**16**	0	0.00
8	P.H.C Kalyanpur	23	**14**	2	**39**	19	**20**	3	0.00
9	P.H.C. Pusa	14	**6**	2	**22**	7	**15**	3	0.00
10	P.H.C Morwa	27	**10**	0	**37**	24	**13**	5	0.00
11	P.H.C Sarairanjan	17	**9**	2	**28**	11	**17**	5	0.00
12	P.H.C Patori	16	**10**	1	**27**	15	**12**	4	0.00
13	P.H.C Mohi-uddin Nagar	8	**9**	0	**17**	7	**10**	2	0.00
14	P.H.C Dalsingsarai	18	**8**	1	**27**	12	**15**	2	0.00
15	P.H.C Ujiyarpur	14	**13**	2	**29**	14	**15**	8	0.00
16	P.H.C Bibhutipur	16	**12**	4	**32**	11	**21**	8	0.00
17	P.H.C Rosera	21	**12**	0	**33**	17	**16**	2	0.00
18	P.H.C Hasanpur	29	**17**	0	**46**	23	**23**	8	0.00
19	P.H.C Singhia	15	**22**	2	**39**	19	**20**	4	0.00

20	P.H.C. Mohanpur	7	**4**	1	**12**	5	**7**	2	0.00
21	P.H.C. Vidyapati Nagar	13	**8**	0	**21**	8	**13**	4	0.00
22	P.H.C. Shivaji Nager	16	**9**	2	**27**	10	**17**	7	0.00
23	P.H.C. Khanpur	18	**12**	2	**32**	13	**19**	3	0.00
24	P. H. C. Kothia (Tajpur)	20	**8**	0	**28**	18	**10**	6	0.00
25	P. H. C. Bithan	25	**14**	1	**40**	21	**19**	4	0.00
	Total	**355**	**226**	**27**	**608**	**291**	**317**	**87**	**0**

SWOT analysis:

After analysis following are strengths, weaknesses, opportunities and threats in state.

Strengths:

1. trained district nucleus

2. Trained experienced & motivated staff

3. Better awareness and reduced stigma

4. Adequacy of MDT

5. Adequacy of fund form GOI and ILEP

6. Better comprehensive infrastructure from subcentre to Medical college

7. Integration of leprosy services with GHCs staff

8. Training materials are available

9. Regular NLEP staff meetings and monitoring

10. Good coordination – State Health System, WHO & ILEP

11. Enough people willing to work for the cause.

Weakness:

1. Large state with many districts

2. Reduction in ILEP support

3. No WHO State & Zonal coordinators

4. Complicated procedures for fund utilization for leprosy work at district level

5. Inadequacy of fund for vehicle operation and complicated procedure for hiring of vehicle

6. Less support from public opinion leaders

7. Poor POD services

8. Leprosy being last priority of health programme

9. Inadequate funds for rehabilitation and mobility aids

10. Inadequate coordination between staff

11. Vehicles – Using in other programmes by DM and Civil Surgeons

12. Inadequate training of NGOs/local practitioners

13. Incomplete data of deformities

14. Less effective counseling

Opportunities:

1. Integration with NRHM

(a) Support from ASHA

(b) Additional flexible funds

(c) Better monitoring and supervision

(d) Better infrastructure and man power

2. Integration with GHS

3. Involvement of Medical Colleges/Hospitals/NGOs

4. Full utilization of dermatologists, physicians and orthopaedic surgeons for

diagnosis and rehabilitation

5. Support of ILEP/NGOs/WHO

Threats:

1. Complacency among staff and less political commitment

2. Priority to other programmes

3. Transfer of programme officers at state and district

4. Public stigma

5. No self dependence of sufferer

State will use this SWOT analysis for making strategies and plans in NLEP.

National Leprosy Eradication Programme

(11th five year plan 2007 – 2012)

Objectives:

 To further reduce the leprosy burden

 Provision of high quality leprosy services for all persons affected by leprosy, through general health care system including referral services for complications and chronic care.

 Enhanced Disability prevention and Medical Rehabilitation (DPMR) services for deformity in leprosy affected persons.

 Enhanced advocacy in order to reduce stigma and stop discrimination against leprosy affected persons and their families.

 Capacity building among health service personal in integrated setting both for rural and urban areas.

 Strengthen the monitoring and supervision component of the surveillance system.

Strategy:

(1) Integrated Leprosy Services and Special initiatives.

(2) Disability Prevention and Medical Rehabilitation (DPMR)

(3) Information, Education and Communication

(4) Training and capacity building.

(5) Supervision, monitoring and review.

(6) Infrastructure maintenance

Activities as per objectives and strategy:

I. Integrated Leprosy Services and Special initiatives –

1.1 Integrated Leprosy Services through all Primary Health Care facilities will continue to be provided in the rural areas.

1.2 All the urban areas will be covered under urban leprosy control programme integrating services from all the partners available in the areas, including private practitioners.

1.3 Involvement of multipurpose health functionaries, ASHA in villages, and selected NGOs in urban areas are to be engaged for case follow up during treatment to ensure regular MDT collection and consumption, so that all the cases put under treatment gets cured in shortest possible time.

1.4 Emphasis will be laid on providing best quality leprosy services through the GHC system. This means easy availability of services on all working days to all patients, correct diagnosis and adequate counseling to patients and family members, provide

MDT to patients whenever approached, regular monitoring of patient during treatment.

Treatment completion by all under treatment patients will be desired outcome of the

programme.

1.5 The system of referral of difficult cases to the district hospital for diagnosis and management, which has already been started, will be further strengthened with capacity building of persons involved at PHC as well district Hospital level.

1.6 The laboratory facilities at District Hospitals for smear examination to diagnose difficult cases will be strengthened.

1.7 Desegregated data for female, schedule tribe and schedule caste patients are to be maintained.

1.8 Regular monitoring and surveillance at state, District and Block level will be continued to locate weak areas, so that needed plan for corrective action can be taken in time.

Indicator of performance:

- # of cases treated.
- # of cases detected
- # of default cases.
- # of case complete treatment.
- # of complicated cases.
- # Refereed

D4: National program for Control of Blindness (NPCB)

Blindness is one of the most significant social problems in India. It is estimated that there is an annual incidence of 2 million cataract-induced blindness in country. Approximately 3 million eyes need cornea transplantation. According to NPCB-WHO survey 8 states have highest prevalence of blindness one of them is Bihar

In Samastipur the specialized ophthalmologist is available in maximum hospitals in the district , hospital available, but in general the available medical officers are supporting as per their skills. Time to time the cataract operation camps are organised in cluster of blocks and Vitamin A prophylaxis programme for Children under 5 years is going on.

Bihar is 3rd largest populated State in India having estimated population of about ten crores. Density of population is much higher than the Indian average of 89.5%.

National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a centrally sponsored scheme with the goal to reduce the prevalence of blindness to 0.3% of the population by 2020 from the existing prevalence rate of 0.8%.

The goal of eliminating avoidable blindness can be achieved through the following broad strategies.

• strengthening service delivery,

• developing human resources for eye care,

• promoting outreach activities and public awareness and

• developing institutional capacity.

Causes of Blindness:

The main diseases recognized as responsible for visual impairment and blindness.

The three great eye health problems are

- Cataract,
- Trachoma
- Malnutrition.

Prevention of blindness:

The concept of avoidable blindness has gained increasing reorganization during recent years. A great many of the causes of blindness land themselves to prevention and/or control- where by improving nutrition, by treating cases of infectious diseases, or by controlling the organisms which cause infection, or by improving safety conditions- particularly on the roads at work or in the home.

The components of the national programme for the prevention of blindness comprise of follows:

- Initial assessment of blindness
- Methods of Intervention.
    - Primary eye care.
    - Secondary eye care.
    - Tertiary eye care
    - Specific programme
        - Trachoma control.
        - School eye health service.
        - Vitamin A prophylaxis
        - Occupational eye health service.
- Long term measures (improving the quality of life)
- Evaluation.

OBJECTIVE :

Our main objective is to be combat blindness through community eye care, and providing a mix of preventive, curative and rehabilitative eye care interventions with a greater focus on curative service as to bring about significant reduction in blindness.

National Programme for Control of Blindness

(Financial Year 2011-2012)

Activities under National Programme for Control of Blindness are:

(1) Cataract Operation

(2) School Eye Screenings Programme:

(3) Diabetic retinopathy

(4) Glaucoma

(5) Childhood blindness

(6) Eye Donation Awareness

(7) Establishing Vision Centre

(8) Strengthening of RIO/Medical College/ Govt. Hospital

(9) Support to NGOs

Cataract Operation:- Cataract Operations accounts for 62.6% of blindness in India.

Cataract operations are being done in district Hospitals and by NGOs in each district of the State. In addition to that Medical Colleges/ RIO also offer these services.

The achievement of last five year against the target fixed in cataract operation is as follows. The following table shows the last six year's physical record of Cataract Operation:-

School Eye Screening Programme :- School Eye Screening is aimed mainly for community eye care. In this it is ensured that school children are screened on regular basis through the help of para medical ophthalmic assistant and teachers who are trained by them. Free spectacles are provided to families who are below poverty line.

Diabetic Retinopathy:- Diabetic Retinopathy is emerging as a major threat for blindness in India. Since Awareness of the disease and its treatment modalities among the community is low hence specialized training of ophthalmologists to diagnose and treat diabetic retinopathy thus becomes a key aspect of blindness prevention. The current need is for a holistic model inculcating awareness creation, community screening, service delivery and training to deal with the problems of diabetic retinopathy for the community.

Review Meeting: - A Review Meeting of Additional Chief Medical Officer who is also the District Programme Officer of National Programme for Control of Blindness is proposed in every quarter at state Level. Representative of India shall also be requested to attend. An exclusive meeting of PMOAs will be organized at state head quarter.

IEC:- Community eye care and Universal coverage can be ensured through IEC activities. In order to make aware the people aware about different activities done by NPCB, IEC could prove to be instrumental in this regard.

Activities :

- Generate patient demand for surgery through outreach camps and promotional campaigns.
- IEC activities at three levels
- Monitor the administration of 5 doses of Vitamin-A to all children by 3years, pregnant & lactating mothers.
  i) **Central Level:** Hoarding in all four hospitals where the operations camps is held. On every hoarding full details about blindness project will be given.
  ii) **Block level:** health workers and Government workers IEC Rath disseminate BCC activities.
  iii) **Community Level:** BCC about cataract in Gram Sabhas and the meetings of people's representatives.
- Filtering of patients up to block level by ophthalmic assistants and then by MO for operations camps.

Indicator:

- # of cataract case detected.
- # of cases registered.
- # of cases operated.
- # enlisted with eye problem
- # of camps organized

D5: Revised National Tuberculosis Control Program (RNTCP)

Tuberculosis is a specific infectious diseases caused by *M. tuberculosis*. The disease primarily affects lungs and causes pulmonary tuberculosis. It can also affect intestine, meninges, bones and joints, lymph glands, skin and other tissues of the body. The disease is usually chronic with varying clinical manifestations.

The disease also affects animals like cattle; this is known as 'bovine tuberculosis, which may sometimes be communicated to man. Pulmonary tuberculosis, the most important from of tuberculosis, which affects man, will be considered here.

Tuberculosis is a social disease with medical aspects. It has also been described as a barometer of social welfare. The social factors include many non-medical factors such as poor quality of

life, poor housing, and overcrowding, population explosion, under nutrition, lack of education, large families, early marriages, lack of awareness of causes of illness, etc. All these factors are interrelated and contribute to the occurrence and spread of tuberculosis.

Prevalence of Infection: The overall prevalence of infection (as judged by the standard tuberculin test) was about 30 %: Male 35% and Female 25%.

The prevalence of bacteriological confirmed disease was 4 cases per 1000 population, four times as high as incidence.

Infection of new cases:

The incidence of new cases of tuberculosis (confirmed by culture) was about 1 per 1000 (excluding below the age of 5 years).

Pulmonary tuberculosis is the states biggest public health problems. The number of cases of any one time has been estimated to be at list 1.5 percent of the population suffering from radio logically active tuberculosis, with about one forth of the cases being sputum positive or infection.

Sl. No.	Hospitals	No. of patients registered till last month 2011	No. of patients registered in reporting month	Total	No. of DOTs providers	Cat - 1		Cat - 2	
						(+) ve Smear	(-) ve Smear / X - ray Positive	(+) ve Smear	(-) ve Smear / X - ray Positive
1	**2**	**3**	**4**	**5 = (3 + 4)**	**6**	**7**	**8**	**9**	**10**
1	Sadar Hospital Samastipur	**157**	14	**171**	2	5	3	5	1
2	Sub Divisional Dalsingsarai	**12**	0	**12**	1	0	0	0	0
3	Referal Hospital Tajpur	**35**	3	**38**	3	0	2	1	0
4	P.H.C Samastipur	**20**	0	**20**	149	0	0	0	0
5	P.H.C Warisnagar	**179**	17	**196**	38	3	6	6	2
6	P.H.C Kalyanpur	**187**	10	**197**	42	2	5	2	1
7	P.H.C. Pusa	**121**	13	**134**	208	4	6	1	2

8	P.H.C Morwa	**92**	9	**101**	25	2	6	0	1
9	P.H.C Sarairanjan	**207**	19	**226**	35	12	2	5	0
10	P.H.C Patori	**224**	11	**235**	55	3	3	1	4
11	P.H.C Mohi-uddin Nagar	**246**	26	**272**	47	6	16	0	4
12	P.H.C Dalsingsarai	**170**	21	**191**	1	4	10	1	6
13	P.H.C Ujiyarpur	**219**	16	**235**	222	9	4	0	3
14	P.H.C Bibhutipur	**223**	26	**249**	29	4	17	4	1
15	P.H.C Rosera	**368**	36	**404**	42	13	9	11	3
16	P.H.C Hasanpur	**118**	11	**129**	90	3	4	4	0
17	P.H.C Singhia	**100**	7	**107**	105	5	0	2	0
18	PHC Bithan	**118**	7	**125**	53	2	2	1	2
19	Distt. Jail Samastipur	**4**	0	**4**	1	0	0	0	0
20	Rly Hospital Samastipur	**37**	3	**40**	1	2	0	1	0
21	APHC Karpurigram	**17**	2	**19**	3	2	0	0	0
22	PHC Vidyapati nagar	**52**	5	**57**	2	2	3	0	0
23	PHC Tajpur	**8**	6	**14**	1	5	1	0	0
24	PHC Mohanpur	**2**	4	**6**	25	3	0	1	0
25	APHC Chatauna	**4**	6	**10**	2	3	0	3	0
	Total	**2920**	**272**	**3192**	**1182**	**94**	**99**	**49**	**30**

Objectives:

- To detect early cases by sputum examination.
- To put the detected cases on treatment to prevent the spread of infections.

The control of tuberculosis:

The control of tuberculosis means reduction in the prevalence and incidence of the disease in the community. The control major consists two parts i.e. curative means case findings and treatment and preventive means BCG vaccination. These are the two fundamental weapon of the National tuberculosis control programme. The most powerful weapons how ever are the combination of CASE findings and TREATMENT through DOTS.

- CASE Findings:
- The CASE.
- Target group.
- Case finding tools.
    - Sputum examination.
    - Mass miniature radiography.
    - Tuberculin test.
- Chemotherapy.
- Anti -tuberculosis drugs.
- BCG Vaccination.

Activities:

- Increase case detection through active search.
- Improve follow up of cases.
- Monitoring continuity of the treatment.
- Imparting training for better diagnosis and management of cases.
- Improve surveillance.
- Organizing health camp to improve case detections and to raise awareness in the community.

Indicator:

- # of cases treated.
- # cases complicated referred.
- # Cases completed treatment.
- # of sputum slides made and examined.
- # slide positive.
- # defaulters.

D6- NATIONAL TOBACCO CONTROL PROGRAMME (NTCP), Samastipur, Bihar.

Executive Summary:

Tobacco use is the leading preventable cause of deaths and diseases in the world. Globally, tobacco causes 5.4 million deaths or an average of one death in every 6 seconds and accounts for one in 10 adult deaths worldwide. The death toll is projected to reach more than 8 million by 2030 if current trends continue. In India, the tobacco related deaths are currently range between 9-10 lakh per year.

Tobacco use is increasing in India, but there are considerable changes in the types and methods by which it is used. The Ministry of Health and Family Welfare, Govt. of India has taken clear steps to deal with the menace of tobacco use. Variety and popularity of forms of tobacco consumption in India, both smoked and smokeless, are causing terrible increases in cancer deaths. Oral cancer rates are occurring at a very high incidence with the popularity of gutka, khaini, zarda, mishri, and other chewing tobacco.

The Framework convention on Tobacco Control (FCTC) is the first international treaty negotiated under the auspices of the WHO aimed at curbing tobacco related deaths and diseases. India was the first country to ratify the FCTC on **5th February '2004** and is now a party to the convention and therefore, has to implement all provisions of this international treaty. Accordingly, the Tobacco Control Act, 2003 was introduced.

The Govt. of India proposed a pilot Programme for effective implementation of the anti-tobacco legislation and to create awareness about the adverse health consequences of tobacco consumption. The Ministry of Health & Family Welfare, Govt. of India launched a pilot programme for effective implementation of the anti-tobacco legislation and to create awareness about the adverse health consequences of tobacco use and hence, a National Tobacco Control Programme (NTCP) had been commenced in 2007.

Background:

According to Global Adult Tobacco Survey (GATS-2010), currently there are ***274.9***

million tobacco user, age 15 and above in India. Among them, ***197.0 million*** are males and ***77.9 million*** are females. In Bihar currently **53.5%** of the people are tobacco users and **66.2%** of **man** & **40.1%** of **female** are using tobacco in either smoking or smokeless form. More than **50**% school and college students are addicted to tobacco use. Currently about one- fifth of all worldwide deaths attributed to tobacco occur in India, more than 9,00,000 people die and 12 million people become ill as a result of tobacco use each year . The deaths attributable to tobacco, in India, are expected to rise from 1.4% of all deaths in 1990 to 13.3% in 2020. It is estimated that 5,500 adolescents start using tobacco.

Situation Analysis

Bihar produces 1.6 % of raw tobacco of total production in India. High prevalence of tobacco use in Bihar is known across the years. As per Global Adult Tobacco Survey (GATS- 2010) and National Family Health Survey (NFHS-2), Prevalence of tobacco use between men and women age 15-49 years, depicted in the table below :

Sl No	Indicator	Male		Female	
		India	Bihar	India	Bihar
1	Tobacco users	48%	66.2%	20%	40.1%
2	Smokers	15%	26.3%	2%	6.2%
3	Chewers	24.%	51.8%	17%	6.7%
4					

Global Youth Tobacco Survey (GYTS):

The India - Bihar GYTS includes data on prevalence of cigarette and other tobacco use as well as information on five determinants of tobacco use: ***access/availability and price, environmental tobacco smoke/second hand smoke exposure (ETS/SHS), cessation, media and advertising,*** and ***school curriculum.*** These components India could include in a comprehensive tobacco control program.

The India – Bihar GYTS was a school-based survey of students in standard 8-10, conducted in the year 2000. The school response rate was 100%, the student response rate was 70.1%, and the overall response rate was 70.1%. A total of 2636 students participated in the India – Bihar GYTS.

Highlights of GYTS:

 59% of students currently use any form of tobacco; 14% currently smoke cigarettes;

46% currently use other forms of tobacco.

 ETS exposure is high – 3 in 10 students live in homes where others smoke; half are exposed to smoke in public places; almost 4 in 10 have parents who use smoke, chew, or apply tobacco.

 Almost 6 in 10 students think smoke from others is harmful to them.

 7 in 10 students think smoking should be banned in public places.

 Almost 7 in 10 smokers want to stop.

 Over 9 in 10 students saw antismoking media messages in the past 30 days; over 9 in

10 students saw pro-cigarette ads in the past 30 days.

National Tobacco Control Programme:

A beginning has been made in the form of National Tobacco Control Programme

(NTCP), by the Ministry of Health & Family Welfare, Govt. of India in 2007, under the 11th five year plan; NTCP aims to build capacity of the states to effectively implement the Tobacco Control Laws and also to bring greater awareness about the ill effects of tobacco use. In 1st pilot phase (2007-08) of the program 9 states & 18 districts has been covered. In 2nd phase (2008-09) the programme has been expanded to 12 more states & 24 districts.

Main components of NTCP:

- Setting up of the State Tobacco Control Cell.
- District Tobacco Control Programme.
- Anti-tobacco Public Awareness Campaign.
- Establishment of tobacco testing labs.
- Research and Training.
- Monitoring and Evaluation.

NTCP Work shop in Samastipur

E: Inter-Sectoral Convergence & Social Development of Health

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

ED,SHSB,Bihar,Patna Inaugurating DOYEN Diagnostic Centre in Sadar Hospital Samastipur.

Convergence can be defined as the complementary working of departments or agencies that can result in the achievement of a common objective because the beneficiaries with whom they work are common and their activities can enhance the possibility of achievement of the goals and objectives. Multiple sectors with different strategies, programs and programs increasingly develop proximate focus on the needs of the beneficiaries. This offers enormous scope for results accruing through such synergies.

The departments that have close synergy with the RCH are:

- Indian Systems of Medicine (AYUSH)
- State AIDS Control Society
- Women and Child Development Department
- Education Department
- Panchayati Raj Department

Situational Analysis:

Public health peripheral and extension services and its linkage with facility based services started less than a century in the country. The said services have developed many folds during the last sixty years initially on the recommendation of the Bhor Committee and subsequently on the basis of reviews and recommendations of several expert committees. It has achieved commendable results despite poor funding and lack of a uniform system of command. It is now increasingly understood larger fund allocation would increase the resources within the health administrative set up but to achieve the desired outcomes, sectors administering the determinants of health must work in tandem with common objectives. The NRHM rightly emphasized the need to develop a convergent system between the Department of Health and other sectors governing the areas of several health determinants. The NHRM also recognizes the need to develop ownership of partners / stakeholders in tackling local endemic issues to ensure better quality of life in all sections of the population. Considering the diversity and prevailing inequity amongst the people it is rightly considered that leadership must be provided at every level of governance to solve the health problems amongst the poor and the excluded. Governance at every level can only be provided by the Rural Local Self Governance and in the State of Bihar it is the three tiers Panchayat Raj Institution. The other sectors which directly administer the issues of health determinants are;

- Department Social Welfare administers ICDS
- Department of Education administers school and higher education,
- Public Health Engineering Department and Panchayat administer supply of drinking water and environmental sanitation including solid waste management.

NRHM also seeks partnership from Indian System of Medicine like Aurveda, Unani, Yoga, Sidda and Homeopathy now jointly named AUYSH. The NRHM also seeks involvement of Non Government

Organizations (NGO) and For Profit Private Sector as partners in the public health services by developing local need specific Public Private Partnership schemes. It also visualizes the need to involve expert consultants and agencies in strengthening the Department of Health and development of a State Heath Resource Centre to provide Technical Support in carrying forward the Management of Change for efficient utilization of resources and effective delivery of health services.

Coordination with ICDS

The DPO is a member of the District Health Society & District Core Group (under NRHM) and thus the health department has been able to utilize his/her services for community mobilization at the grassroots level. Through coordinated effort of the ANM and the Anganwadi worker mothers and children are being mobilized for antenatal check up, institutional deliveries and immunisation.

 Now the coordination is to be extended to organize VHNDs (Village Health nutrition

Days) at every AWC all over the district every month.

 Muskaan Abhiyaan is a special multipronged strategy to improve immunization services and demand in the state of Bihar and since its launch in Oct 2007, the strategy as well as the implementation of this campaign has been reviewed on a periodic basis. A strategic review of this campaign was undertaken on July 4th 2009 by the stakeholders of Routine immunization in the state in which certain changes were proposed. The new changes have become operational since September 2009 but still some gaps are persisting in especially in incentive distribution to AWWs & ASHAs.

Convergence with NRHM:

The convergence framework of National Rural Health Mission (NRHM) provided the directions for synergizing the strategies for prevention, control and management for RTI/STI services under Phase II of Reproductive and Child Health Programme

(RCH II) and Phase III of National AIDS Control Programme (NACP III).

The Objectives of the STI/RTI prevention and management component of

NACP III & RCH II

 To contain STIs/RTIs and thereby HIV transmission through provision of accessible and good- quality STI/RTI services to both general populations and high-risk groups.

 The RCH draws its mandate from the National Population Policy (2000) which makes a strong reference “to include STI/RTI and HIV/AIDS prevention, screening and management in maternal and child health services”.

Elements of NACP-NRHM Convergence on STI:

A) Capacity Building:

– NACO has developed curriculum for Medical Officer, staff nurse and lab technician.

–– Training for Staff nurse and lab tech Completed. Training for Mos(District Resource Persons) to be done in last Wk,Dec,10

– Comprehensive training plan, training calendar and training curriculum have to be prepared for rolling out the training at the sub district level using the existing available resource.

B) Provision of color coded drug Kits:

– Color coded STI/RTI drug kits sent from NACO sent to all the designated STI/RTI clinics at Sadar Hospitals and 6 Govt Medical College Hospitals.

– NACO has rate contracted **Color coded STI/RTI drug kits** for which under NRHM procurement is being done. Kits received to the Districts are yet to be supplied at sub district health facilities.

C) Monitoring and Evaluation:

– At present there is access to data on STI/RTI from NRHM but suboptimal reporting is being done from most of the districts on STI/RTI.

– Reporting formats at the sub district level different than that of NACO CMIS.

- Mechanisms have to be put in place to ensure timely reporting and consolidation from SHS to BSACS.

- Consolidation of RTI/STI format from sub-ditrict with DHIS2 of SHSB is to be done also

D). Infrastructure Strengthening for Sub-District RTI/STI services:

- Each of the Health facilities to have audio visual privacy (partition), facility for examination (examination table, flexi lamp etc), instruments (speculum, proctoscope) and infection control mechanism. Fund for health facility to be assessed for infrastructure strengthening and accordingly existing gap to be filled from Untied Fund for PHCs and from Annual Maintenance Grant for PHCs

- Directive in this regard to be issued from NRHM

E). IEC and Job Aids :

- Leaflets, posters and other education material to be budgeted for the

patients. Job aids like syndromic wall posters, anaphylaxis chart, STI

counseling flip book, infection control chart etc

- Funds for printing of IEC materials and job aids to be sourced from IEC

under NRHM Part A.

F). Syphilis Screening :

- To be ensured from outsourced Pathology services under NRHM and reimbursement to private agency for the same to be done through NRHM budget for Diagnostics.

- Directive in this regard to be sent to all private partners for undertaking

Syphilis Screening and to RKS for necessary reimbursement

Convergence with Education

Issues / Areas	Areas of Convergent Action
Support in School Health Programme	Due to shortage of manpower in the health department, plans to examine school children should be prepared jointly with the education department so that larger schools are covered first or priority should be set for village schools which have not been covered recently or threats/incidences of diseases/malnutrition are more.
Support in immunization programme for provision of TT booster at the age of 10 years.	During the school health programme visits, the booster Tetanus Toxoid needs to be given to 10 year olds in the schools. This should be worked out with the Education department and visits planned accordingly.

Coordination with PRI

The state is undergoing through the process in the decentralisation of Panchayat Raj System. Thus to strengthen and monitor the performance of the APHC and PHC, this institution has been brought under the manifold of the Panchayat president and Zilla

Panchayat members of the respective areas. Further the Panchayat presidents or the members are ex officio chairman of the Village Health and Sanitation committee, to have a direct involvement in the health issues of the community. Joint bank account of Panchayat president and ANM has been opened for HSC untied fund. These processes paved the way for taking initiative in implementation in various health programmes under NRHM.

Chapter-5

Monitoring and Evaluation

a. HMIS
b. MCTS
c. Other IT Initiatives
d. Regular Monitoring Mechanisms

Monitoring and Evolution:

One of the major weaknesses of the RCH I program in Bihar was the absence of an effective Monitoring and Evaluation system that would provide accurate and reliable information to program managers and stakeholders and enable them to determine whether or not results are being achieved and thereby assist them in improving program performance.

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

Under NRHM a triangulated process of Monitoring and Evaluation was introduced which aimed to enable cross checking and easy collection, entry, retrieval and analysis of data.

In order to facilitate this process a structure right from the village to the national levels with details on key functions and financial powers was made operational under NRHM. To capacitate the effective delivery of the programme there is a need for a proper HMIS system.

SHSB has strengthened HMIS right from HSC to State level in the FY 2011-12 and data from PHCs is uploaded on a daily basis and can be reviewed even at the State level. All ANMs have received training on HMIS.

The quality of MIES in districts and from blocks has considerably improved due to regular follow up. Reporting and recording of RCH formats (Plan and monthly reporting) is now regular, complete, and consistent, some districts are irregular and the State is ensuring handholding through group of resource persons. Review of data at the state level is regular and is shared with the Civil Surgeons and DPMU on a monthly basis, however proper review at the district and PHC level is still lacking. Feedbacks are provided to the districts on their data inputs.

HMIS and M&E Unit in the State are responsible for overall monitoring and evaluation of the programme in the state and the districts. The data gathering is being facilitated by the State, Regional, District and PHC Data Centres. Additionally all the districts have been provided training in uploading information in the GOI HMIS and NHSRC HMIS portals.

At district level, there is a District Health Society which is responsible for the data dissemination from the sub-district level to the district level. District M&E Officer at the district level is responsible for

management of HMIS and HMIS Supervisor and Regional M&E are responsible for the same at the regional level.

Bithan-Block Health Review by DPM

Main Activities

I. Health Management Information System (HMIS)- The main objective of Health Management Information System is to provide accurate and reliable information on time to program managers and stakeholders for appropriate decision making. It acts as tool for monitoring and evaluation of the program and on the basis of the information available, appropriate planning can be done and can be executed for the people in need. The state aims to build its HMIS as the main frame for integrating all other information and communication technology for health initiatives.

1. Strengthening of Health Management Information System (HMIS) including the

Human Resources Information System (HRIS)

2. Establishment of Hospital Information Management System and Tele-Medicine.

3. Mobile based data uploading system from HSC level.

Background

As we know that NRHM aims to continuously improve and refine its strategies based on the input and feedback received from the state and from various review missions. One of our priorities is to build and to strengthen the Health Management Information System (HMIS) in the State and to use it for improving the quality of data for planning, program implementation and making decisions at each level. Revised HMIS formats introduced by NRHM are being used in all 38 districts of Bihar for reporting at every level of health facilities. In order to further improve its programmatic efforts, the state is in the process of

strengthening its human resources information systems (HRIS) for health. A web based information system is being set up and the data collection process is underway. The HRIS is developed as an integrated component of HMIS with support from the National Health Systems Resource Centre and the Vistaar Project of Intra Health International Inc. The state has taken the integrated health systems perspective to establish inter-linkages among different information systems developed by the State Health Society. The data flow in HRIS will be similar to the one followed in the HMIS. To strengthen the use and management of HRIS, capacity building workshops will be organized at all levels as a sub-component of the HMIS.

State Health Society, Bihar is using HMIS Portal (http://bihar.nhsrc-hmis.org) with the technical support of NHSRC, New Delhi known as DHIS2 which is a state specific portal. It is being used for facility wise reporting through the data centre established at the facilities. The data entry made in the DHIS2 by the facility gets consolidated in the system for the district. The consolidated report is generated by M&E officer of the district and uploaded on the NRHM Portal of GoI (http://nrhm-mis.nic.in) Govt. of India has been focusing on importance of HMIS and emphasized on quality of data so that the reports generated from the HMIS Portal can facilitate evidence-based decision making process. State has taken various initiatives to improve the quality of data and among them one of the major initiatives is to conduct HMIS training (including Mother and Child Tracking Formats) of ANMs, LHVs, data centre operators at block level on recording and reporting. For that state health society has developed training module and reference material for health workers. The main content of the same is HMIS formats , definition of data element, difference between recording and reporting register/ formats, MCTS reporting formats, use of data for HSC level planning and technique of data validation. This training module is printed in local dialect with user's friendly methodology Flow up Information:

Present Status of HMIS in Samastipur:

One source of data

DHS has accepted HMIS as one source of data for monitoring as well as the basis for planning.

Data Uploading

Data Centers at Block Level as well as District/Sub-Divisional level hospitals have been fully operational and functioning well in all districts . Almost all 20 Block of the district are uploading monthly MIS report on the web portal of NRHM, GoI by generating reports (In Excel Format) from DHIS2 web portal of Bihar which is being used for online entry of monthly MIS and FMR from Block Level as well as District/sub-00divisional level hospitals.

Financial monitoring in Warishnagar PHC By DAM

Use of Information

The information available in the system is being used in the formulation of PIP for the

FY 2012-2013. To make use of it in the monitoring of health services, state has developed 14 core indicators which is being used for the assessment of program performance of districts.

Feedback process

Feedback mechanism is in practice for which we have identified the denominators of different services and on the basis of which service utilization is being monitored.

State has calculated expected level of achievement for above mentioned indicators.

District is supposed to submit reasons for variance and the strategies to overcome from the deviance on the monthly basis. This strategies has dramatically improved the data quality in the state and civil surgeons are made accountable for the data uploaded in HMIS.

Mother and Child Tracking System (MCTS)

Tracking of Pregnant mothers and children has been recognized as a priority area for providing effective healthcare services to this group. As a major initiative in this regard, the Mother and Child Tracking system (MCH) is name based pregnant mother and child tracking system. It is a management tool to reduce MMR/IMR/TFR and track the health service delivery at the individual level.

MCH is a generic system which aims to provide information of different health services received at the individual level, by monitoring all the encounters that an individual undergoes in his/her health program. This system aims to help the service provider (health worker or Doctor) by categorizing various health services the individual person has to get (with due date) and missed services. It also provides for effective monitoring of different health services drilling down to the individual patient information.

MCTS District Level Workshop

In December 2011 The Block level Managers, Dataentry Operators and Functionaries are trained. The data collection and up loding process also started at the field level. In the up coming months the capacity building programme of ANM will be organised so that the proper data and information can be collected and used the information for the program interventions.

In the next financial years the data analysis ,monitoring, review and feed back mechanisms will be strengthened.

Maternal Death Review:

In Samastipur district the MDR concept circulate to all PHC for implementation but due to clarity and understanding of the importance this intervention is not getting priority in implementation. Need require to re-initiation this process.

Objectives

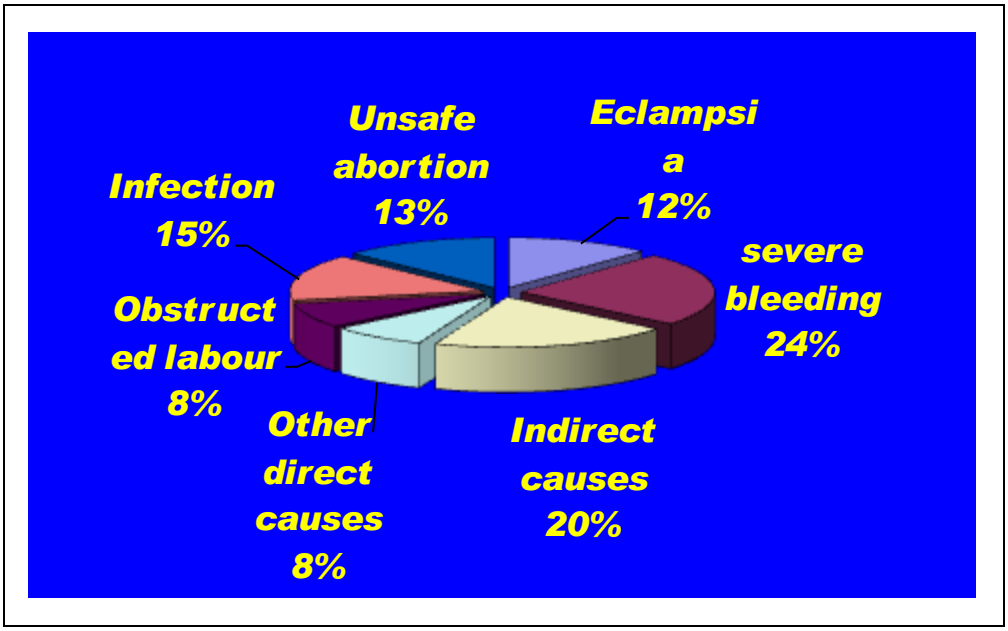
- To establish operational mechanisms/ modalities for undertaking MDR at selected institutions and in community level in all districts
- To disseminate information on data collection tools, data/information flow, analysis
- To develop systems for review and remedial follow up actions

Key Points in MDR:

- Implementation of MDR should be supported by a State Govt order
- Notification of Maternal Deaths
- **Facility based audit**
- **Community based audit**
- All health functionaries have a role in MDR
- District Collector to conduct monthly MDR with the relatives of the deceased and service providers
- No punitive action against service providers

Community Based MD Review:

The main purpose of the CBMDR is to identify the various delays and causes leading to maternal deaths, to enable the health system to take corrective measures at various levels.



MDR Steep:

Step 1

Identifying maternal deaths would be the first step in the process- notification

Step 2

Investigation of the factors/causes which led to the maternal death – whether medical, social, systemic,

Step 3

To take appropriate and corrective measures

District CS/ CMO to nominate a nodal officer – eg. Dist RCH officer/ ACMO/ DPM

Role of District Nodal officer

- The District nodal officer will be responsible for organizing the district level review committee meeting to be chaired by the District CMO every month.
- He will be also responsible for organizing necessary documentation for review by the committee and keeping a record of follow up actions initiated.

- The District nodal officer for MDR will organize a one- day orientation programme for all MOs of the primary health care institutions, focused on the processes to be adopted and formats to be used for data collection.

Community Based MDR Process:

ASHA/Health worker

- ASHA to notify all deaths of women between 15-49 years within 24 hours to block PHC MO
- Line listing of all maternal deaths once in a month in the format to block PHC MO

Block Medical Officer

- Block PHC MO to notify maternal deaths to CMO, DM and state DG/DHS within 24 hours of receipt of information and send the details in the Primary Informer format

Investigation of maternal deaths

- ANM,LHV,PHN team to meet the relatives of the deceased in the village and complete the investigation form within 3 weeks
- All confirmed maternal deaths are recorded in the register in the block PHC
- Block PHC MO prepare individual case summary in the format and send to CMO

Maternal death review at District level

1. District maternal death review :

Once in a month under the Chairmanship of CMO (ACMO, Medical officer nominated by the CMO/CS as nodal officer, Medical officer in charge of Obstetrics & Gynaecology, Anaesthetist, Officer in charge of blood bank/blood storage centre, Senior nurse nominated by the CMO/CS & Invited members from the facilities

2. The MDR committee under the Chief medical officer (CMO) will receive two types of MDR reports-

a) Community based maternal death review reports from the block medical officers

b) Facility based maternal death review from the Medical College Hospitals, District Hospitals and other Referral Hospitals .

Community Based Planning and Monitoring (CBPM)

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

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

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

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

Keeping this in view, the State Government initiated the process of CBPM in the three selected districts as pilot intervention. In the FY 2010-2011, a State Technical Advisory

Group for Community Action (SAGCA) has been formed for providing advisory support to the state for implementing the process in the state. Based on the SAGCA recommendations, a State Technical Assistance Group (STAG) has also been formed for providing technical assistance to the state for the process.

Population Foundation of India (PFI) has been given the responsibility to be the State Nodalcum-Technical Agency for facilitating the process in the State as PFI is the National

Secretariat for implementing the project on Community Based Monitoring and has experience on implementing a pilot project on Community Monitoring in the nine states of India with the support from the Ministry of Health & Family Welfare, Govt. of India. The foundation has been providing technical assistance and even facilitating the process of CBPM in the state.

Currently, the CBPM process has been initiated in the three districts namely Bhagalpur,

Darbhanga and Nawada taking two blocks from each district for pilot intervention. The villages from five selected Panchayats have been taken for implementation of CBPM process. In the next financial year, the CBPM process would be implemented in the two additional districts i.e. altogether in five districts. The five panchayats and all the villages from the selected blocks would be taken for implementing the process.

In these selected blocks, focus would be given on convergence. The different convergent activities would also be implemented in order to improve the health outcomes. More focus would be given on strengthening VHSND, VHSCs and quality of care. The CBPM committees would be formed at different level under the guidance of SAGCA and with the facilitation of State Nodal-cum-Technical Agency. In order to resolve the grievance raised at different level for improving the health outcomes, a grievance redressal mechanism may be explored in consultation with the development partners and other govt. line departments.

Objectives of Community Planning and Monitoring

Following are the objectives of Community Planning and Monitoring

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

Process of Community Planning and Monitoring

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

Some of the frameworks on which Community Based planning and Monitoring and which are included within the Samastipur NRHM are as follows

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

Annexure:

District Drug Warehouse

It is proposed to establish rationalized and modernized District Drug Warehouses to ensure proper supply chain management system so as to ensure timely availability of quality health products at each public health facility. The up-gradation would involve infrastructure up-gradation, manpower deployment, training and software management.

The existing District Drug Store would be upgraded and rationalization in terms of separate drug stores for different national programmes would be consolidated under one roof.

These Drug Warehouses would also house the Drug Control Office of the district and infrastructural provision would be made for them also.

SHSB with technical support from B-TAST is planning for the same.

Initially it is proposed to take up Drug Warehouses at the 9 Divisional Headquarters in 2011-12 and upscale to other districts 2012-13 in the next financial year.

Procurement Management Information System (ProMIS) Implementation

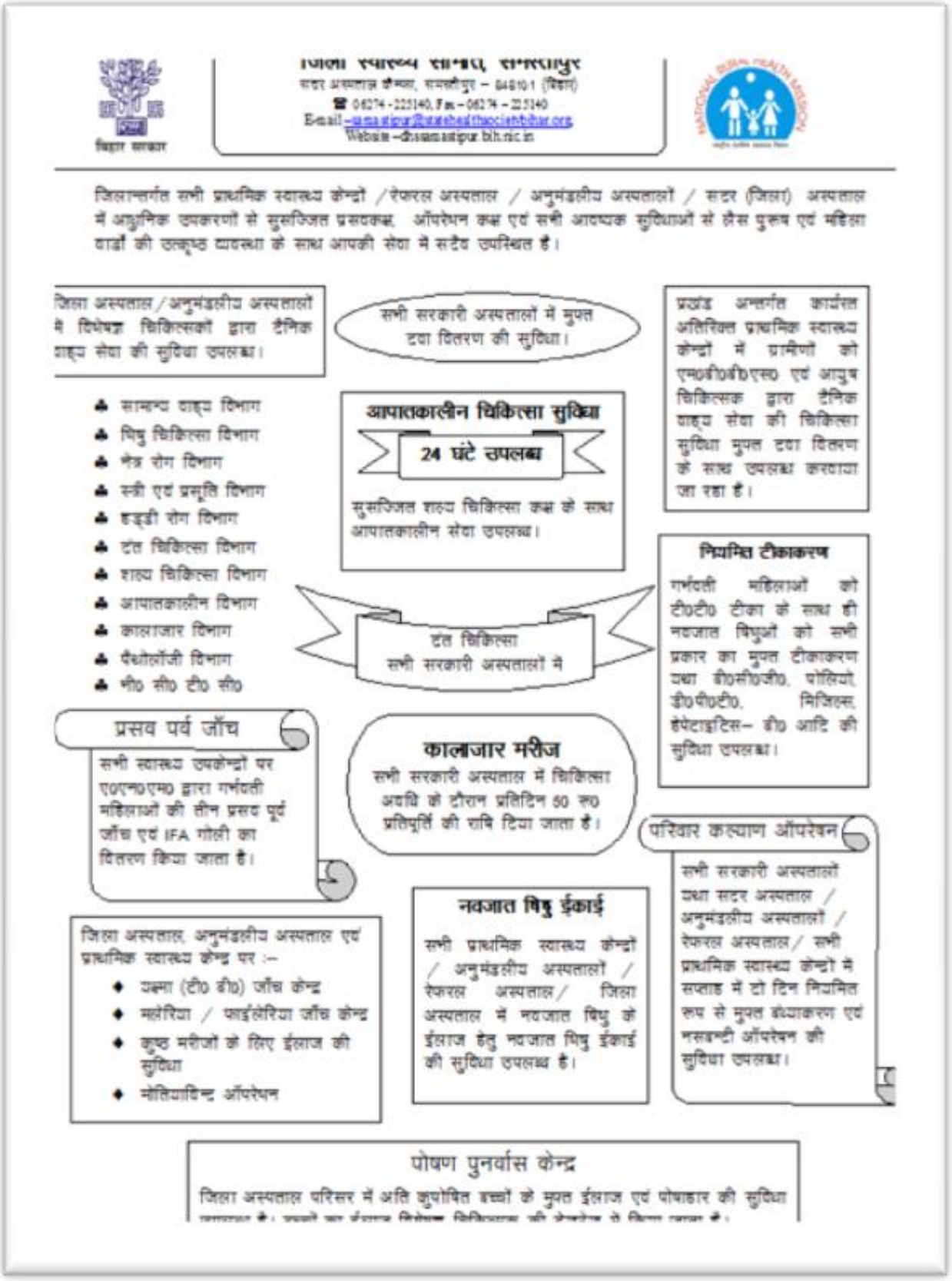
ProMIS is being introduced to strengthen and streamlining the procurement process and stock and supply for 5 centrally sponsored schemes (CSS).

These schemes are 1) Family Planning 2) Immunization 3) Tuberculosis 4) Malaria 5) RCH.

3 day training is planned in each district for 22 participants (inclusive of Store Keepers,

Programme Officers, District M & E Officer, Cold Chain handler etc). The training would include hands on training on software with the help of computers.

BCC Materials Developed by DHS:


बिहार सरकार
जिला स्वास्थ्य समिति, समस्तीपुर
सदर अस्पताल कैम्पस, समस्तीपुर – 848101 (बिहार)
☎ 06274-225140, Fax – 06274 – 225140
Email –samastipur@statehealthsocietybihar.org
Website –dhssamastipur.bih.nic.in
जिलान्तर्गत सभी प्राथमिक स्वास्थ्य केन्द्रों / रेफरल अस्पताल / अनुमंडलीय अस्पतालों / सदर (जिला) अस्पताल में आधुनिक उपकरणों से सुसज्जित प्रसवकक्ष, ऑपरेशन कक्ष एवं सभी आवश्यक सुविधाओं से लैस पुरुष एवं महिला वार्डों की उत्कृष्ट व्यवस्था के साथ आपकी सेवा में सदैव उपस्थित है।
जिला अस्पताल / अनुमंडलीय अस्पतालों में विशेषज्ञ चिकित्सकों द्वारा दैनिक बाह्य सेवा की सुविधा उपलब्ध।
सभी सरकारी अस्पतालों में मुफ्त दवा वितरण की सुविधा।
प्रखंड अन्तर्गत कार्यरत अतिरिक्त प्राथमिक स्वास्थ्य केन्द्रों में ग्रामीणों को एम0बी0बी0एस0 एवं आयुष चिकित्सक द्वारा दैनिक बाह्य सेवा की चिकित्सा सुविधा मुफ्त दवा वितरण के साथ उपलब्ध करवाया जा रहा है।
सामान्य बाह्य विभाग
शिशु चिकित्सा विभाग
नेत्र रोग विभाग
स्त्री एवं प्रसूति विभाग
हड्डी रोग विभाग
दंत चिकित्सा विभाग
शल्य चिकित्सा विभाग
आपातकालीन विभाग
कालाजार विभाग
पैथोलॉजी विभाग
पी0 सी0 टी0 सी0
आपातकालीन चिकित्सा सुविधा
24 घंटे उपलब्ध
सुसज्जित शल्य चिकित्सा कक्ष के साथ आपातकालीन सेवा उपलब्ध।
दंत चिकित्सा
सभी सरकारी अस्पतालों में
नियमित टीकाकरण
गर्भवती महिलाओं को टी0टी0 टीका के साथ ही नवजात शिशुओं को सभी प्रकार का मुफ्त टीकाकरण यथा बी0सी0जी0, पोलियो, डी0पी0टी0, मिजिल्स, हेपेटाइटिस– बी0 आदि की सुविधा उपलब्ध।
प्रसव पर्व जाँच
सभी स्वास्थ्य उपकेन्द्रों पर ए0एन0एम0 द्वारा गर्भवती महिलाओं की तीन प्रसव पूर्व जाँच एवं IFA गोली का वितरण किया जाता है।
कालाजार मरीज
सभी सरकारी अस्पताल में चिकित्सा अवधि के दौरान प्रतिदिन 50 रू0 प्रतिपूर्ति की राशि दिया जाता है।
परिवार कल्याण ऑपरेशन
सभी सरकारी अस्पतालों यथा सदर अस्पताल / अनुमंडलीय अस्पतालों / रेफरल अस्पताल / सभी प्राथमिक स्वास्थ्य केन्द्रों में सप्ताह में दो दिन नियमित रूप से मुफ्त बंध्याकरण एवं नसबन्दी ऑपरेशन की सुविधा उपलब्ध।
जिला अस्पताल, अनुमंडलीय अस्पताल एवं प्राथमिक स्वास्थ्य केन्द्र पर :–
यक्ष्मा (टी0 बी0) जाँच केन्द्र
मलेरिया / फाईलेरिया जाँच केन्द्र
कुष्ठ मरीजों के लिए इलाज की सुविधा
मोतियाबिन्द ऑपरेशन
नवजात शिशु ईकाई
सभी प्राथमिक स्वास्थ्य केन्द्रों / अनुमंडलीय अस्पतालों / रेफरल अस्पताल / जिला अस्पताल में नवजात शिशु के ईलाज हेतु नवजात शिशु ईकाई की सुविधा उपलब्ध है।
पोषण पुनर्वास केन्द्र
जिला अस्पताल परिसर में अति कुपोषित बच्चों के मुफ्त ईलाज एवं पोषाहार की सुविधा

BUDGET
PIP
2012-13

PIP of District Health Society, Samastipur (2012-13)

Proposed Budget:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)		Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB Name of Development Partner)
					Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)		
		HFD *	State Total		HFD	HFD	HFD	HFD	HFD		HFD	HFD	HFD	HFD	HFD		
A	RCH Flexipool																
A.1	MATERNAL HEALTH																
A.1.1	Operationalise Facilities																
A.1.1.1	Operationalise FRUs-																
A.1.1.1.1	Generator & Fuel			1						24000	216000	216000	216000	216000	864000		
A.1.1.1.2	Monitor Progress and Quality of Service Delivery			4	1	1	1	1	4	12500	12500	12500	12500	12500	50000		
A.1.1.2	Operationalise 24x7 PHCs (Mch Center- Aphc)			20	20	0	0	0	20	25000	500000	0	0	0	500000		
A.1.1.3	MTP Services at Health Facilities								0						0		
A.1.1.4	RTI/STI Services at Health Facilities			2	0	2	0	0	2	50000	0	100000	0	0	100000		
A.1.1.5	Operationalise Sub-Centres (MCH Center-Hsc)			2	1	1	0	0	2	50000	50000	50000	0	0	100000		
A.1.2	*Referral Transport*								0						0		
A.1.3	Integrated Outreach RCH Services								0						0		
A.1.3.1	RCH Outreach Camps/ Others			60	20	20	20	0	60	7000	140000	140000	140000	0	420000		
A.1.3.2	Monthly Village Health and Nutrition Days			3700					0	531	1113850	262850	262850	262850	1902400		
A.1.4	Janani Suraksha Yojana / JSY								0						0		
A..1.4.1	Home Deliveries			1600	400	400	400	400	1600	500	200000	200000	200000	200000	800000		
A_1.4.2	Institutional Deliveries								0						0		
A.1.4.2.A	Institutional Deliverie-Rural			90000	25000	30000	20000	15000	90000	2000	50000000	60000000	40000000	30000000	180000000	90000000	
A.1.4.2.B	Institutional Deliveries-Urban			500	150	150	150	50	500	1200	180000	180000	180000	60000	600000		
A.1.4.2.C	Institutional Deliveries-C-Sections			400	100	100	100	100	400	1500	150000	150000	150000	150000	600000		
A.1.4.3	Administrative Expenses								0		338154	338154	338154	338154	1352616		
A.1.5	Maternal Death Review			269	68	68	68	65	269	750	51000	51000	51000	48750	201750		
A.1.6	Other Strategies/Activities (ICTC for HIV Testing of ANC Cases)								0		0	0	0	0	0		
A.2	CHILD HEALTH								0		0	0	0	0	0		
A.2.1	IMNCI																
A.2.1.1	Implementation of IMNCI Activities in Districts								0		12500	12500	12500	12500	50000		
A.2.1.2	Monitor Progress Against Plan; Follow Up with Training, Procurement, Etc								0		0	0	0	0	0		
A.2.1.3	Incentive for HBNC to ASHA/AWWs(State Iniative) 3 PNC for Normal Baby			12000	3000	3000	3000	3000	12000	100	300000	300000	300000	300000	1200000		
A.2.1.4	Incentive for HBNC to ASHA(State Iniative) 6PNC for Low Birth Baby			6000	1500	1500	1500	1500	6000	100	150000	150000	150000	150000	600000		
A.2.2	Facility Based Newborn Care/FBNC (Operationalise 40 NBSUs)			3		3	0	0	3	775000	0	2325000	0	0	2325000		
A.2.3	Home Based Newborn Care/ HBNC								0		0	0	0	0	0		
A.2.4	Infant and Young Child Feeding/ IYCF								0		0	0	0	0	0		
A.2.5	Care of Sick Children and Severe Malnutrition																

A.3	**FAMILY PLANNING**								0		0	0	0	0	0		
A.3.1	**Terminal/ Limiting Methods**								0		0	0	0	0	0		
A.3.1.1	Dissemination of Manuals on Sterilisation Standards & QA of Sterilisation Services			1					1		0	20000	0	0	20000		
A.3.1.2	Female Sterilisation Camps			625	50	100	200	275	625	5000	250000	500000	1000000	1375000	3125000		
A.3.1.3	NSV Camps			5	1	1	1	2	5	5000	5000	5000	5000	10000	25000		
A.3.1.4	Compensation for Female Sterilisation			25000	3000	5000	10000	7000	25000	1000	3000000	5000000	10000000	7000000	25000000	17000000	
A.3.1.5	Compensation for Male Sterilisation (Compensation for NSV Acceptance)			400	50	50	150	150	400	1500	75000	75000	225000	225000	600000		
A.3.1.6	Accreditation of Private Providers for Sterilisation Services			4000	500	700	1500	1300	4000	1500	750000	1050000	2250000	1950000	6000000	750000	
A.3.2	**Spacing Methods**								0		0	0	0	0	0		
A.3.2.1	IUD Camps								0		0	0	0	0	0		
A.3.2.2	IUD Services at Health Facilities								0		0	0	0	0	0		
A.3.2.3	Accreditation of Private Providers for IUD Insertion Services								0		0	0	0	0	0		
A.3.2.5	Contraceptive Update Seminars								0		0	0	0	0	0		
A.3.3	POL for Family Planning (for District Level + State Level Monitoring)			20					20	17000	20000	100000	120000	100000	340000		
A.3.4	Repairs of Laparoscopes								0		0	0	0	0	0		
A.3.5	**Other Strategies/ Activities**								0		0	0	0	0	0		
A.3.5.1	State Level Worshop/Review for FP								0		0	0	0	0	0		
A.3.5.2	Orientation								0		0	0	0	0	0		
A.3.5.3	Family Planning Incentive/Award to Best Performer District/other Personel								0		0	0	0	0	0		
A.3.5.4	Provide IUD Services at Health Facility (IUD Camps)			61	1	10	25	25	61	1500	1500	15000	38000	37500	90500		
A.3.5.5	Social Marketing of Contraceptives								0		0	0	0	0			
A.4	**ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH**								0		0	0	0	0	0		
A.4.1	Adolescent Services at Health Facilities (ARSH Corners in 3 DHs and PHCs)								0		0	0	0	0	0		
A.4.2	School Health Programme (NPSGY)			26					0		5000000	0	4568000	0	9568000	6000000	
A.4.3	Other Strategies/ Activities (Menstrual Hygiene)																
A.5	**URBAN RCH**								0		0	0	0	0	0		
A.5	URBAN RCH(Urban Health Center Through PPP)								0		0	0	0	0	0		
A.6	**TRIBAL RCH**								0		0	0	0	0	0		
A.6	TRIBAL RCH								0		0	0	0	0	0		
A.7	**PNDT & Sex Ratio**								0		0	0	0	0	0		
A.7.1	Support to PNDT Cell								0		0	20000	40000	40000	100000		
A.7.2	Other PNDT Activities (Monitoring of Sex Ratio at Birth)			1					1	100000	25000	25000	25000	25000	100000		

A.8	**INFRASTRUCTURE (Minor Civil Works) & HUMAN RESOURCES (Except AYUSH)**																
A.8.1	**Contractual Staff & Services**																
A.8.1.1	ANMs, Staff Nurses, Supervisory Nurses (Salary of Contractual ANM/ Contractual SN)			125+165					125+450	20000/11500	23265000	23265000	23265000	23265000	92100000	20000000	
A.8.1.2	Laboratory Technicians/(LT in Blood Banks)			3					3		270000	270000	270000	270000	1080000	270000	
A.8.1.3	Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians, Dental Surgeons, Radiologist, Sonologist, Pathologist, Specialist for								0		0	0	0	0	0		
A.8.1.4	PHNs at CHC, PHC Level								0		0	0	0	0	0		
A.8.1.5	Medical Officers at CHCs / PHCs (Salary of MOs in Blood Banks)			1					1	35000	105000	105000	105000	105000	420000		
A.8.1.6	Additional Allowances/ Incentives to M.O. of PHCs and CHCs								0		0	0	0	0	0		
A.8.1.7	Others - FP Counsellors			6					6	15000	270000	270000	270000	270000	1080000		
A.8.1.8	Incentive/ Awards Etc. to SN, ANMs Etc. (Muskaan Programme-Incentive to ASHA and ANM)								0		1427265	1427265	1427265	1427265	5709060	5000000	
A.8.1.9	Human Resources Development (Other Than Above)																
A.8.1.10	Other Incentives Schemes (Pl. Specify)																
A.8.2	**Minor Civil Works**																
A.8.2.1	Minor Civil Works for Operationalisation of FRUs																
A.8.2.2	Minor Civil Works for Operationalisation of 24 Hour Services at PHCs/APHCs			25						200000	3000000		2000000		5000000		
A.9	**TRAINING**																
A.9.1	**Strengthening of Training Institutions (Repair/renovation of Training Institutions)**																
A.9.1	Strengthening of Training Institutions (Repair/renovation of Training Institutions)			1					1		0	200000	0	0	200000		
A.9.2	**Development of Training Packages**								0		0	0	0	0	0		
A.9.2	Development of Training Packages								0		0	0	0	0	0		
A.9.3	**Maternal Health Training**								0		0	0	0	0	0		
A.9.3.1	Skilled Attendance at Birth			40	10	10	10	10	40	88110	881100	881100	881100	881100	3524400		
A.9.3.2	Comprehensive EmOC Training (Including C-Section)								0		0	0	0	0	0		
A.9.3.3	Life Saving Anaesthesia Skills Training								0		0	0	0	0	0		
A.9.3.4	MTP Training								0		0	150000	0	0	150000		
A.9.3.5	RTI / STI Training								0		0	0	0	0	0		
A.9.3.6	BEMOC Training								0		0	0	0	0	0		
A.9.3.7	Other MH Training (Any Integrated Training, Etc.)- Training of MOs and Paramedics at Sub-District Level (Convergence with BSACS)			2					2	115000	0	115000	115000	0	230000		
A.9.4	IMEP Training								0		0	0	0	0	0		
A.9.5	**Child Health Training**								0		0	0	0	0	0		
A.9.5.1	IMNCI			60	10	15	20	15	60	134760	1347600	2021400	2695200	2021400	8085600		
A.9.5.2	F-IMNCI								0		0	0	0	0	0		
A.9.5.3	Home Based Newborn Care								0		0	0	0	0	0		
A.9.5.4	Care of Sick Children and Severe Malnutrition A.9								0		0	0	0	0	0		
A.9.5_5	**Other CH Training (Pl. Specify)**								0		0	0	0	0	0		
A.9.5.5.1	TOT on FBNC								0		0	0	0	0	0		
A.9.5.5.2	Training on FBNC for Medical Officers								0		0	0	0	0	0		
A.9.5.5.3	NSSK Training (SN/ANM)			6					6		0	200000	200000	0	400000		
A.9.6	**Family Planning Training**								0		0	0	0	0	0		
A.9.6.1	Laparoscopic Sterilisation Training								0		0	0	0	0	0		
A.9.6.2	Minilap Training			1		1			1	70237	0	70237	0	0	70237		
A.9.6.3	NSV Training			1		1			1	33900	0	33900	0	0	33900		
A.9.6_4	**IUD Insertion Training**								0		0	0	0	0	0		
A.9.6.4.1	Training of Medical Officers in IUD Insertion			1				1	1		0	0	0	55289	55289		
A.9.6.4.2	Training of ANMs / LHVs/SN in IUD Insertion			3		1	1	1	3	29420	0	29420	29420	29420	88260		
A.9.6.5	Contraceptive Update								0		0	0	0	0	0		
A.9.6_6	**Other FP Training (Pl. Specify)**								0		0	0	0	0	0		
A.9.6.6.1	Post Partum Family Planning (With Emphasis on IUCD Insertion) Master Trainers at All 38 Districts Hospitals								0		0	0	0	0	0		
A.9.6.6.2	Training of Family Planning Counsellors								0		0	0	0	0	0		
A.9.7	ARSH Training (MOs, ANM/Nurses, Nodal Officers)								0		0	0	0	0	0		
A.9.8	**Programme Management Training**								0		0	0	0	0	0		
A.9.8.1	SPMU Training								0		0	0	0	0	0		
A.9.8.2	DPMU Training			1					1		0	0	50000	50000	100000		
A.9.9	**Other Training (Pl. Specify)**								0		0	0	0	0	0		
A.9.9.1	Continuing Medical and Nursing Education								0		0	0	0	0	0		
A.9.9.2	Post Graduate Diploma in Family Medicine for MO								0		0	0	0	0	0		
A.9.9.3	DNB in Family Medicine for MO								0		0	0	0	0	0		
A.9.9.4	PGD in Public Health Management for MO (IIPH)								0		0	0	0	0	0		
A.9.9.5	PGD in Public Health Management for Health and Management Personnel (IIPH at SIHFW)								0		0	0	0	0	0		
A.9_10	**Training (Nursing)**								0		0	0	0	0	0		
A.9.10.1	Strengthening of Existing Training Institutions/ Nursing School			1					0	1317415	0	1317415	0	0	1317415		
A.9.10.2	New Training Institutions/ School								0		0	0	0	0	0		
A.9_11	**Training (Other Health Personnel)**								0		0	0	0	0	0		
A.9.11.1	Promotional Training of Health Workers Females to Lady Health Visitor Etc.								0		0	0	0	0	0		
A.9.11.2	Training of ANMs, Staff Nurses, AWW, AWS								0		0	0	0	0	0		
A.9_11_3	**Other Training and Capacity Building Programmes**								0		0	0	0	0	0		
A.9.11.3.1	Training of Faculty / Post Basic B.Sc / Basic B.Sc								0		0	0	0	0	0		
A.9.11.3.2	Community Visit for Students & Teachers								0		0	50000	50000	0	100000		

A 10	PROGRAMME / NRHM MANAGEMENT COSTS								0		0	0	0	0	0		
A.10.1	Strengthening of SHS/ SPMU (Including HR, Management Cost, Mobility Support, Field Visits)								0		0	0	0	0	0		
A.10.1.1	Liability on Current Staff at Prevailing Salary								0		0	0	0	0	0		
A.10.1.2	Additional Manpower Under SHSB								0		0	0	0	0	0		
A.10.1.3	State Monitoring Cell for Blood Banks/BSUs								0		0	0	0	0	0		
A.10.1.4	Provision of Equipment/furniture and Mobility Support for SPMU Staff								0		0	0	0	0	0		
A.10.1.5	Mobility Support (District Malaria Office)								0		0	65000	65000	65000	195000		
A.10.1.6	Strengthening of Directorate								0		0	0	0	0	0		
A.10.1.7	Liability on Various New Posts Approved in PIP 2010-11, Already Advertised and Shortlisting Underway								0		0	0	0	0	0		
A.10.2	Strengthening of DHS/ DPMU (Including HR, Management Cost, Mobility Support, Field Visits)																
A.10.2.1	Contractual Staff for DPMU Recruited and in Position			3					4		420000	420000	420000	420000	1680000	120000	
A.10.2.2	Provision of Equipment/furniture and Mobility Support for DPMU Staff			1					1	120000	360000	360000	360000	360000	1440000	120000	
A.10.3	Strengthening of Block PMU			20					0	70000	4200000	4200000	4200000	4200000	16800000		
A.10.4	Strengthening (Others)								0		0	0	0	0	0		
A.10.4.1	Tally Purchase for RAM								0		0	0	0	0	0		
A.10.4.2	Renewal (Upgradtion)								0	8100	0	8100	0	0	8100		
A.10.4.3	AMC (State, Regional & DHS)			1					1	22500	0	22500	0	0	22500		
A.10.4.4.	AMC (Block Level)			20					20	2700	0	54000	0	0	54000		
A.10.4.5	Training on Tally								0		0	0	0	0	0		
A.10.4.6	Training in Accounting Procedures								0		0	0	0	0	0		
A.10.4.7	Capacity Building & Exposure Visit of Account Staff								0		0	0	0	0	0		
A.10.4.8	Regional Programme Management Unit								0		0	0	0	0	0		
A.10.4.9	Management Unit at FRU (Hospital Manager & FRU Accountant)			6					6	42500	765000	765000	765000	765000	990000		
A.10.5	Audit Fees								0		0	0	0	0	0		
A.10.5.1	Annual Audit of the Programme (Statutory Audit)								0		0	24000	24000	24000	72000		
A.10.5.2	Internal Auditor								0		0	0	0	0	0		
A.10.5.3	TA for Internal Auditor								0		0	0	0	0	0		
A.10.5.4	Training of Internal Audit Wing								0		0	0	0	0	0		
A.10.6	Concurrent Audit (State & District)			1					1	20000	60000	60000	60000	60000	240000		
A.10.7	Mobility Support to BMO/ MO/ Others																
	Total														392597850	139260000	531857850

PIP of District Health Society, Samastipur (2012-13)

Proposed Budget:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)		Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/Name of Development Partner)
					Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)		
		HFD *	State Total		HFD	HFD	HFD	HFD	HFD		HFD	HFD	HFD	HFD	HFD		
B	Mission Flexible Pool																
B.1	ASHA																
B.1.1	ASHA COST																
B.1.1.1	Selection & Training of ASHA										10000000	3000000	4800000	0	17800000		
B.1.1.2	Procurement of ASHA Drug Kit & Replenishment			3835						250	958750	0	0	0	958750	958750	
B.1.1.3	Other Incentive to ASHAs (TA/DA for ASHA Divas)			3835					3835	100	1150500	1150500	1150500	1150500	4602000	1150500	
B.1_1.4	Awards to ASHA's/ Link Workers								0		0	0	0	0	0		
B.1.1.4.A	Best Performance Award to ASHAs at District Level			20					0	2000	0	40000	0	0	40000		
B.1.1.4.B	Rechargeable Torch to ASHA			3835					3835	200	0	0	0	0	0	767000	
B.1.1.4.C	Identity Card to ASHA (Plastic ID Card (Corporate Type)			3835						50	191750	0	0	0	191750		
B.1.1.5	ASHA Resource Centre/ ASHA Mentoring Group								0		2000810	2000810	2000810	2000810	8003240	663000	
B.2	Untied Funds								0		0	0	0	0	0		
B.2.1	Untied Fund for SDH/CHC			4	4	0	0	0	4	50000	200000	0	0	0	200000		
B.2.2.A	Untied Fund for PHCs			20	20	0	0	0	20	25000	500000	0	0	0	500000		
B.2.2.B	Untied Fund for APHC			68	68	0	0	0	68	25000	1700000	0	0	0	1700000		
B.2.3	Untied Fund for Sub Centres			486	486	0	0	0	486	10000	4860000	0	0	0	4860000		
B.2.4	Untied Fund for VHSC			1122	1122	0	0	0	1122	10000	11220000	0	0	0	11220000		
B.3	Annual Maintenance Grants								0		0	0	0	0	0		
B.3.1	DH			1	0	1	0	0	1	500000	0	500000	0	0	500000		
B.3.1.A	SDH			4	0	4	0	0	4	300000	0	1200000	0	0	1200000		
B.3.2	PHCs			15	0	15	0	0	15	200000	0	3000000	0	0	3000000		
B.3.2.A	APHC			20	0	20	0	0	20	100000	0	2000000	0	0	2000000		
B.3.3	Sub Centres			354	0	354	0	0	354	10000	0	3540000	0	0	3540000		
B.4	Hospital Strengthening								0		0	0	0	0	0		

B4.1	**Up Gradation of CHCs, PHCs, Dist. Hospitals to IPHS)**								0		0	0	0	0	0		
B.4.1.1	**District Hospitals**								0		0	0	0	0	0		
B.4.1.1.A	Construction of SNCU in District Hospitals								0		0	0	0	0	0		
B.4.1.1.B	Up Gradation of 05 DHs by Increase Number of Beds 900								0		0	0	0	0	0		
B.4.1.2	CHCs (Hospital Strengthening)								0		0	0	0	0	0		
B.4.1.3	PHCs (Construction of 3 Doctors & 4 Staff Nurse Quarters in 38 PHCs)\								0		0	0	0	0	0		
B.4.1.4	Sub Centres(Hospital Strengthening)								0		0	0	0	0	0		
B.4.1.5	Others (Up Gradation of 2 Health Facilities (Rajendra Nagar) Eye Hospital & Lok Nayak Jay Prakash Narayan Hospital) Into Super Speciality As Per IPHS								0		0	0	0	0	0		
B4.2	Strengthening of Districts, Sub-Divisional Hospitals, CHCs, PHCs								0		0	0	0	0	0		
B4.2.A	Installation of Solar Water System in 25 SDH, 10 RH and 150 PHC			6	2	2	2		6	38500	77000	77000	77000	0	231000		
B4.2.B	Accreditation / ISO : 9000 Certification of 90 Health Facilities (15 DH+15 SDH+ 10 RH+ 50 PHC)										0	0	0	0	0		
B.4.3	Sub Centre Rent and Contingencies			346					0	6000	2076000	2076000	2076000	2076000	8304000		
B.4.4	Logistics Management/ Improvement (G2P Bihar Health Operations Payment Engine HOPE)								0		0	0	0	0	0		
B.5	**New Constructions/ Renovation and Setting Up**								0		0	0	0	0	0		
B.5.1	**CHC**								0		0	0	0	0	0		
B.5.1	CHC								0		0	0	0	0	0		
B5.2	**PHCs**								0		0	0	0	0	0		
B5.2.A	Construction of APHC (PHC)			20	5	5	5	5	20	8000000	40000000	40000000	40000000	4E+07	160000000		
B5.2.B	Construction of Residential Quarters for Doctors & Staff Nurses in 38 Old APHC			15	0	5	5	5	15	3000000	0	15000000	15000000	1.5E+07	45000000		
B5.2.C	Strengthening of Cold Chain (Refurbishment of Existing Cold Chain Room for District Stores and Earthing and Wiring of Existing Cold Chain Rooms								0		0	0	0	0	800000	800000	
B_5_10	**Infrastructure of Training Institutions**								0		0	0	0	0	0		
B.5.10.1	Strengthening of Existing Training Institutions/Nursing School(Other Than HR)-Strengthening of Nursing Education- at IGIMS Bihar								0		0	0	0	0	0		
B.5.10.2	New Training Institutions/School(Other Than HR)			1	1				1	2000000	2000000	0	0	0	2000000		
B5.3	SHCs/Sub Centres			50	15	15	15	15	60	1557000	23355000	23355000	23355000	2.3E+07	93420000		
B5.4	Setting Up Infrastructure Wing for Civil Works (9 Executive Eng, 38 Asst. Eng & 76 JE Under Bihar Medical Services and Infrastructure Corporation Ltd)								0		0	0	0	0	0		
B5.5	Govt. Dispensaries/ Others Renovations								0		0	0	0	0	0		
B5.6	Construction of BHO, Facility Improvement, Civil Work, BemOC and CemOC Centers\								0		0	0	0	0	0		
B.5.7	Major Civil Works for Operationalisation of FRUS			2	2	0	0	0	2	1000000	2000000	0	0	0	2000000		
B.5.8	Major Civil Works for Operationalisation of 24 Hour Services at PHCs								0		0	0	0	0	0		
B.5.9	Civil Works for Operationalising Infection Management & Environment Plan at Health Facilities								0		0	0	0	0	0		
B.6	**Corpus Grants to HMS/RKS**								0		0	0	0	0	0		
B6.1	District Hospitals			1	1	0	0	0	1	500000	500000	0	0	0	500000		
B6.2	CHCs (SDH)			6	6	0	0	0	6	500000	3000000	0	0	0	3000000		
B6.3	PHCs - RKS			20	20	0	0	0	20	100000	2000000	0	0	0	2000000		
B6.4	Other (APHC)			46	46	0	0	0	46	100000	4600000	0	0	0	4600000		
B.7	**District Action Plans (Including Block, Village)**								0		0	0	0	0	0		
B.7	District Action Plans (Including Block, Village)			26	0						92400	1121400	92400	92400	1398600		

B.8	**Panchayati Raj Initiative**								0		0	0	0	0	0		
B8.1	Constitution and Orientation of Community Leader & of VHSC,SHC,PHC,CHC Etc			381					0		0	571500	0	0	571500		
B.8.2	Orientation Workshops, Trainings and Capacity Building of PRI at State/Dist. Health Societies,			20+381					0		0	250650	0	0	250650		
B.8.3	Others State Level Activities (IEC+Monitoring+Need Based Training for VHSC Members in 5 CBPM								0		0	0	0	0	0		
B.9	**Mainstreaming of AYUSH**								0		0	0	0	0	0		
B.9.1	**Medical Officers at DH/CHCs/ PHCs (Only AYUSH)**								0		0	0	0	0	0		
B.9.1	Medical Officers at DH/CHCs/ PHCs (Only AYUSH)			73					73	20000	4380000	4380000	4380000	4380000	17520000	1260000	
B.9.1.A	AYUSH Specialists																
B.9.2	Other Staff Nurse/ Supervisory Nurses (for AYUSH)								0		0	0	0	0	0		
B_9.3	**Activities Other Than HR**								0		0	0	0	0	0		
B.9.3.1	Training of AYUSH Doctors & Paramedical Staffs W.R.T AYUSH Wing and Establishment of Head Quarter Cost								0		0	0	0	0	0		
B_10	**IEC-BCC NRHM**								0		0	0	0	0	0		
B.10	**Strengthening of BCC/IEC Bureaus (State and District Levels)**								0		0	0	0	0	0		
B.10.1	Development of State BCC/IEC Strategy								0		1000000	1500000	0	0	2500000		
B_10.2	**Implementation of BCC/IEC Strategy**								0		0	0	0	0	0		
B.10.2.1	BCC/ IEC Activities for MH								0		500000	0	0	0	500000		
B.10.2.2	BCC/ IEC Activities for CH								0		500000	0	0	0	500000		
B.10.2.3	BCC/ IEC Activities for FP								0		200000	0	0	0	200000		
B.10.2.4	BCC/ IEC Activities for ARSH								0		200000	0	0	0	200000		
B.10.3	Health Mela								0		0	100000	0	0	100000		
B.10.4	Creating Awareness on Declining Sex Ratio Issue.								0		50000	0	0	0	50000		
B.10.5	Other Activities								0		0	0	0	0	0		
B_11	**Mobile Medical Units (Including Recurring Expenditures)**								0		0	0	0	0	0		
B_11	Mobile Medical Units (Including Recurring Expenditures)			1	1	1	1	1	0	468000	1404000	1404000	1404000	1404000	5616000	1872000	
B_12	**Referral Transport**								0		0	0	0	0	0		

B.12.1	**Ambulance/ EMRI/Other Models**								0		0	0	0	0	0		
B.12.1	Ambulance/ EMRI/Other Models								0		0	0	0	0	0		
B.12.2	**Operating Cost (POL)**								0		0	0	0	0	0		
B.12.2.A	Emergency Medical Service/102- Ambulance Service								0		0	0	0	0	0		
B.12.2.B	1911- Doctor on Call & Samadhan								0		0	0	0	0	0		
B.12.2.C	Advanced Life Saving Ambulance (Call 108)			20					0	2557300	7671900	7671900	7671900	7671900	30687600		
B.12.2.D	Referral Transport in Districts			240	60	60	60	60	240	10000	600000	600000	600000	600000	2400000		
B_13	**PPP/ NGOs**								0		0	0	0	0	0		
B.13.1	**Non-Governmental Providers of Health Care RMPs/TBAs**								0		0	0	0	0	0		
B.13.1	Non-Governmental Providers of Health Care RMPs/TBAs								0		0	0	0	0	0		
B.13.2	Public Private Partnerships								0		0	0	0	0	0		
B_13.3	**NGO Programme/ Grant in Aid to NGO**								0		0	0	0	0	0		
B.13.3.A	Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and All Government Medical College Hospitals of Bihar								0		0	0	0	0	0		
B.13.3.B	Outsourcing of Pathology and Radiology Services From PHCs to DH			160	40	40	40	40	160	200000	8000000	8000000	8000000	8000000	32000000	4000000	
B.13.3.C	Outsourcing of HR Consultancy Services								0		0	0	0	0	0		
B.13.3.D	IMEP(Bio-Waste Management)								0		476000	476000	476000	476000	1904000		
B_14	**Innovations**								0		0	0	0	0	0		
B.14.A	Innovations(If Any) (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls Or SABLA)\								0		0	0	0	0	0		
B.14.B	YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services			1150					1150		100000	100000	100000	100000	400000		
B_15	**Planning, Implementation and Monitoring**								0		0	0	0	0	0		
B.15.1	**Community Monitoring (Visioning Workshops at State, Dist, Block Level)**								0		0	0	0	0	0		
B15.1.1	State Level								0		0	0	0	0	0		
B15.1.2	District Level (Purchase of 830 Mobile Handsets From BSNL/By Tender Process)								0		0	0	0	0	0		
B15.1.3	Block Level								0		0	0	0	0	0		
B15.1.4	Other								0		0	0	0	0	0		
B.15.2	**Quality Assurance**								0		0	0	0	0	0		
B15.2	Quality Assurance								0		0	0	0	0	0		
B.15.3	**Monitoring and Evaluation**								0		0	0	0	0	0		
B.15.3.1	**Monitoring & Evaluation/HMIS/MCTS (State, District , Block & Divisional Data Centre)**								0		0	0	0	0	0		
B15.3.1.A	State, District, Divisional, Block Data Centre			312	78	78	78	78	312	10000	780000	780000	780000	780000	3120000	160000	
B15.3.1.B	CBPM								0		0	0	0	0	0		
B.15.3.2	**Computerization HMIS and E-Governance, E-Health (MCTS, RI Monitoring, CPSMS)**								0		0	0	0	0	0		
B.15.3.2.A	MCTS and HRIS								0		0	300000	300000	0	600000		
B.15.3.2.B	RI Monitoring								0		50000	50000	50000	50000	200000		
B.15.3.2.C	CPSMS								0		0	0	0	0	0		
B.15.3.2.D	Hospital Management System, Telemedicine and Mobile Based Monitoring								0		0	0	0	0	0		
B.15.3.3	**Other Activities (HMIS)**								0		0	0	0	0	0		
B.15.3.3.A	Strengthening of HMIS (Up-Gradation and Maintenance of Web Server of SHSB)			1		1			1	150000	0	150000	0	0	150000		
B15.3.3.B	Plans for HMIS Supportive Supervision and Data Validation								0		100000	100000	100000	100000	400000		
B_16	**PROCUREMENT**								0		0	0	0	0	0		
B.16.1	**Procurement of Equipment**								0		0		0	0	0		
B.16.1.3	**Procurement of Equipment: FP**																
B16.1.3.A	Procurement of Minilap Set (FP)			100	0	100	0	0	100	3000	0	300000	0	0	300000		
B16.1.3.B	Procurement of NSV Kit (FP)			8	5	3			8	1100	5500	3300	0	0	8800		
B16.1.3.C	Procurement of IUD Kit (FP) (PHC Level)			1	1				1	15000	15000	0	0	0	15000		
B16.1.4	Procurement of Equipment: IMEP								0		0	0	0	0	0		

B16.1.5	**Procurement of Others**								0		0	0	0	0	0		
B16.1.5.A	Dental Chair Procurement			10	0	10	0	0	10	283500	0	2835000	0	0	2835000		
B16.1.5.B	Equipments for 6 New Blood Banks (Genset)			1					0	250000	250000	0	0	0	250000		
B16.1.5.C	A.C. 1.5 Ton Window for 28 (Running Blood Banks)								0		0	0	0	0	0		
B16.1.5.E	POL for Vaccine Delivery From State to District and to PHC/CHC								0		0	0	0	0	0		
B.16.1.1	Procurement of Equipment: MH (Labour Room)								0		0	0	0	0	0		
B.16.1.1A	Procurement of Bed, ANC Instrument and ARI Timer								0		0	0	0	0	0		
B 16.1.2	Procurement of Equipment : CH (SCNU- NBCC)								0		0	0	0	0	0		
B 16.2	**Procurement of Drugs and Supplies**								0		0	0	0	0	0		
B16.2.1	**Drugs & Supplies for MH**								0		0	0	0	0	0		
B16.2.1.A	Parental Iron Sucrose (IV/IM) As Therapeutic Measure to Pregnant Women with Severe Anaemia			1	0	1	0	0	1	500000	0	500000	0	0	500000		
B.16.2.1.B	IFA Tablets for Pregnant & Lactating Mothers			165409	0	165409	0		0		0	0	2351620	0	2351620		
B16.2.2	**Drugs & Supplies for CH**								0		0	0	0	0	0		
B.16.2.2.A	Budget for IFA Small Tablets and Syrup for Children (6 -59 Months)			514604					0		2500000	2000000	2000000	2500000	9000000		
B16.2.2.B	IMNCI Drug Kit			11000	3000	3000	2000	3000	11000	250	750000	750000	500000	750000	2750000		
B16.2.3	Drugs & Supplies for FP			4254782					0		5000000	5000000	5000000	5000000	20000000		
B16.2.4	Supplies for IMEP								0		0	0	0	0	0		
B16.2.5	General Drugs & Supplies for Health Facilities								0		0	0	0	0	0		
B_17	**Regional Drugs Warehouses (PROMIS to Be Established and Implemented in District Drug Warehouse)**								0		0	0	0	0	0		
B.17	Regional Drugs Warehouses (PROMIS to Be Established and Implemented in District Drug Warehouse)			1					0	5000000	0	5000000	0	0	5000000		
B_18	**New Initiatives/ Strategic Interventions (As Per State Health Policy)/ Innovation/ Projects (Telemedicine, Hepatitis, Mental Health, Nutrition Programme for Pregnant Women, Neonatal) NRHM Helpline) As Per Need (Block/ District Action Plans)**								0		0	0	0	0	0		
B.18	New Initiatives/ Strategic Interventions (CCTV for Monitoring & Security)			20					0	750000	0	15000000	0	0	15000000		
B_19	**Health Insurance Scheme**								0		0	0	0	0	0		
B.19	Health Insurance Scheme								0		0	0	0	0	0		
B_20	**Research, Studies, Analysis (Research Study to Be Conducted on Assessment of New Initiative Taken for Enhancing R.I. Coverage)**								0		0	0	0	0	0		
B.20	Research, Studies, Analysis (Research Study to Be Conducted on Assessment of New Initiative Taken for Enhancing R.I. Coverage)								0		0	0	0	0	0		
B_21	**State Level Health Resource Centre(SHSRC)**								0		0	0	0	0	0		
B_21	State Level Health Resource Centre(SHSRC)								0		0	0	0	0	0		
B_22	**Support Services**								0		0	0	0	0	0		
B.22.1	Support Strengthening NPCB								0		0	0	0	0	0		
B.22.2	Support Strengthening Midwifery Services Under Medical Services								0		0	0	0	0	0		
B.22.3	Support Strengthening NVBDCP								0		0	0	0	0	0		
B.22.4	Support Strengthening RNTCP			25					0		100000	100000	100000	100000	400000		
B.22.5	Contingency Support to Govt. Dispensaries								0		0	0	0	0	0		
B.22.6	Other NDCP Support Programmes								0		0	0	0	0	0		
B_23	**Other Expenditures (Power Backup, Convergence Etc)-**								0		0	0	0	0	0		
B.23.A	Payment of Monthly Bill to BSNL			25	5	5	5	10	25	3405	17025	17025	17025	34050	85125		
	Total														**541934635**	**11631250**	**553565885**

PIP of District Health Society, Darbhanga (2012-13)

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)		Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/Name of Development Partner)
					Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in		
		HFD *	State Total		HFD	HFD	HFD	HFD	HFD		HFD	HFD	HFD	HFD	HFD		
C	Routine Immunisation & PP																
C.1	Routine Immunisation																
C.1.a	Mobility support for supervision for DIOs			120	30	30	30	30	120		12500	12500	12500	12500	50000		
C.1.c	Printing & Dissemination of Immunisation formats, tally sheets, Monitoring format			146726	73363	0	73363	0	146726	6	440178	0	440178	0	880356		
C.1.e	Quaterly Review Meetings exclusive for RI at district Level @ 100 RS for 5 Participants per Block			4	1	1	1	1	4	10000	10000	10000	10000	10000	40000		
C.1.f	Quaterly Review Meetings exclusive for RI at Block t Level @ 50 RS PP for as travel for ASHA & 25 Per Person for meeting Expences			4	1	1	1	1	4		243450	243450	243450	243450	973800		
C.1.g	Focus on slum & under surved areas in urban areas/ alternate Vaccinator For slum areas			876					876		85800	85800	85800	85800	343200		
C.1.h	Mobilization of children through ASHA under Muskan ek Abhiyan			80000	20000	20000	20000	20000			350000	350000	350000	350000	1400000	450000	
C.1.i	Alternate Vaccine delivery in hard to reach areas			374							125000	125000	125000	125000	500000		
C.1.j	Alternate Vaccine delivery in otherareas			4792							750000	750000	750000	750000	3000000		
C.1.k	To Develop Microplan at sub centre level			856						100	0	85600	0	0	85600		
C.1.l	For consolidation of Microplan at block Level			20							0	22000	0	0	22000		
C.1.m	POL for Vaccine & Logistic delivery from District to Block			20							50000	50000	50000	50000	200000		

C.1.n	Consumable for Computer including provision for internet access			1							3000	3000	3000	3000	12000		
C.1.o&p	Red/ Black plastic bags etc. Bleach/ Hypoclorite solution / twin bucket			5000							75000	0	75000	0	150000		
C.1.q	Saftey Pits for Hospitals where there is no pit or is not in working condition			5						5000	0	25000	0	0	25000		
C.1.r	Alternate vaccinator hiring for Access compromised areas, POL for Generators for Cold chains, For serious AEFI cases investigation for every district			150						16000	600000	600000	600000	600000	2400000		
C.2.b	Computer assistant support for district level @ Rs 10000 per person per month for one computer assistant			1						10000	30000	30000	30000	30000	120000		
C.3a	District Level orientation training including Hep. -B, Measles for ANM, MHW & LHV			1000							400000	400000	400000	400000	1600000		
C.3d	One Day Cold Chain Handler Training for Block Level			20						1500	0	30000	0	0	30000		
C.3.e	One Day Training of block level data handler			20						1500	0	30000	0	0	30000		
C.4	Cold Chain Maintenance											40000	40000	0	80000		
C.5	ASHA Incentive				0	0	0	0	0		0	0	0	0	0		
C.6	**PPI Operation Cost**				0	0	0	0	0		0	0	0	0	0		
C.6	PPI Operation Cost				0	0	0	0	0		9844660	9844660	9844660	9844660	39378640		
	Others (Tickler Bag for RI Site+AWC+HSC+PHC)			4342					4342	250	1085500	0	0	0	1085500		
	Total														**52406096**	**450000**	**52856096**

PIP of District Health Society, Samastipur (2012-13)

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)		Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/ Name of Development Partner)
					Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in		
		HFD *	State Total		HFD	HFD	HFD	HFD	HFD		HFD	HFD	HFD	HFD	HFD		
D	IDD				0	0	0	0	0		0	0	0	0	25000		
D.1	Establishment of IDD Control Cell				0	0	0	0	0		0	0	0	0	0		
D.1	Establishment of IDD Control Cell				0	0	0	0	0		0	0	0	0	0		
D.1.A	Technical Officer				0	0	0	0	0		0	0	0	0	0		
D.1.B	Statistical Officer / Staffs				0	0	0	0	0		0	0	0	0	0		
D.1.C	LDC Typist				0	0	0	0	0		0	0	0	0	0		
D.2	Establishment of IDD Monitoring Lab				0	0	0	0	0		0	0	0	0	0		
D.2	Establishment of IDD Monitoring Lab			12	3	3	3	3	12	8000	24000	24000	24000	24000	96000		
D.2.A	Lab Technician			12	3	3	3	3	12	12000	36000	36000	36000	36000	144000		
D.2.B	Lab Assistant			12	3	3	3	3	12	8000	24000	24000	24000	24000	96000		
D.3	IEC/ BCC Health Education and Publicity			20					0	500	0	10000	0	0	10000		
	Awareness generation activities & Competitions in the School			20					20	1000	0	20000	0	0	20000		
D.4	IDD Surveys/Re-Surveys				0	0	0	0	0		0	50000	0	0	50000		
D.5	Supply of Salt Testing Kit (Form of Kind Grant)				0	0	0	0	0		0	0	0	0	0		
D2.1A	Coordination Meeting									50000		50000			50000		
	Review Meeting									10000		10000			10000		
D	Orientation of Field functionaries			20					20	2000	0	40000	0	0	40000		
	Total IDD														541000		

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)		Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/ Name of Development Partner)
					Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in		
		HFD *	State Total		HFD	HFD	HFD	HFD	HFD		HFD	HFD	HFD	HFD	HFD		
E.1	**Operational Cost**				0	0	0	0	0		0	0	0	0	0		
E.1.1	Mobility Support			12	3	3	3	3	12	20000	60000	60000	60000	60000	240000		
E.1.2	Lab Consumables			20	5	5	5	5	20	2000	10000	10000	10000	10000	40000		
E.1.3	Review Meetings			4	1	1	1	1	4	5000	5000	5000	5000	5000	20000		
E.1.4	Field Visits				0	0	0	0	0		0	0	0	0	0		
E.1.5	Formats and Reports			224640	56160	56160	56160	56160	224640	1	56160	56160	56160	56160	224640		
E.2	**Human Resources**			12	3	3	3	3	12	40000	120000	120000	120000	120000	480000		
E.2.1	Remuneration of Epidemiologists				0	0	0	0	0		0	0	0	0	0		
E.2.2	Remuneration of Microbiologists				0	0	0	0	0		0	0	0	0	0		
E.2.3	Remuneration of Entomologists				0	0	0	0	0		0	0	0	0	0		
E.3	**Consultant-Finance**				0	0	0	0	0		0	0	0	0	0		
E.3	Consultant-Finance				0	0	0	0	0		0	0	0	0	0		
E.3.1	Consultant-Training				0	0	0	0	0		0	0	0	0	0		
E.3.2	Data Managers			12	3	3	3	3	12	15000	45000	45000	45000	45000	180000		
E.3.3	Data Entry Operators			12	3	3	3	3	12	10000	30000	30000	30000	30000	120000		
E.3.4	Others				0	0	0	0	0		0	0	0	0	0		
E.4	**Procurements**				0	0	0	0	0		0	0	0	0	0		
E.4.1	Procurement -Equipments				0	0	0	0	0		0	0	0	0	0		
E.4.2	Procurement -Drugs & Supplies				0	0	0	0	0		0	0	0	0	0		
E.5	**Innovations /PPP/NGOs**				0	0	0	0	0		0	0	0	0	0		
E.5	Innovations /PPP/NGOs				0	0	0	0	0		0	0	0	0	0		
E.6	**IEC-BCC Activities**				0	0	0	0	0		0	0	0	0	0		
E.6	IEC-BCC Activities				0	0	0	0	0		0	0	0	0	0		
E.7	**Financial Aids to Medical Institutions**				0	0	0	0	0		0	0	0	0	0		
E.7	Financial Aids to Medical Institutions				0	0	0	0	0		0	0	0	0	0		
E.8	**Training**				0	0	0	0	0		0	0	0	0	0		
E.8	Training				0	0	0	0	0		0	71250	0	0	71250		
E	IDSP				0	0	0	0	0		0	0	0	0	**0**		
	Total				0	0	0	0	0		0	0	0	0	**1375890**		

PIP of District Health Society, Samastipur (2012-13)

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)		Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/ Name of Development Partner)
					Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in		
		HFD *	State Total		HFD	HFD	HFD	HFD	HFD		HFD	HFD	HFD	HFD	HFD		
F	NVBDCP				0	0	0	0	0		0	0	0	0	0		
F.1	DBS (Domestic Budgetary Support)				0	0	0	0	0		0	0	0	0	0		
F.1.1	Malaria				0	0	0	0	0		0	0	0	0	0		
F.1.1	Malaria				0	0	0	0	0		0	0	0	0	0		
F.1.1.A	MPW (F)				0	0	0	0	0		0	0	0	0	0		
F.1.1.B	ASHA Honorarium				0	0	0	0	0		20000	20000	20000	20000	80000		
F.1.1.C	Operational Cost				0	0	0	0	0		0	0	0	0	0		
F.1.1.D	Monitoring , Evaluation & Supervision & Epidemic Preparedness Including Mobility				0	0	0	0	0		0	0	0	0	0		
F.1.1.E	IEC/BCC				0	0	0	0	0		20000	0	0	0	20000		
F.1.1.F	PPP / NGO Activities				0	0	0	0	0		0	0	0	0	0		
F.1.1.G	Training / Capacity Building				0	0	0	0	0		0	0	0	0	0		
F.1.1.H	Any Other Activities (Pl. Specify)				0	0	0	0	0		0	0	0	0	0		
F.1.2	Dengue & Chikungunya				0	0	0	0	0		0	0	0	0	0		
F.1.2	Dengue & Chikungunya				0	0	0	0	0		5000	5000	5000	0	15000		
F.1.2.A	Strengthening Surveillance (As Per GOI Approval)				0	0	0	0	0		0	0	0	0	0		
F.1.2.A (I)	Apex Referral Labs Recurrent				0	0	0	0	0		0	0	0	0	0		
F.1.2.A. (Ii)	Sentinel Surveillance Hospital Recurrent				0	0	0	0	0		0	0	0	0	0		
F.1.2.B	Test Kits (Nos.) to Be Supplied by GoI (Kindly Indicate Numbers of ELISA Based NS1 Kit and Mac ELISA Kits Required Separately)				0	0	0	0	0		0	0	0	0	0		
F.1.2.C	Monitoring/Supervision and Rapid Response				0	0	0	0	0		0	0	0	0	0		
F.1.2.D	Epidemic Preparedness				0	0	0	0	0		0	0	0	0	0		
F.1.2.E	IEC/BCC/Social Mobilization				0	0	0	0	0		0	0	0	0	0		
F.1.2.F	Training/Workshop				0	0	0	0	0		0	0	0	0	0		
F.1.3	Acute Encephalitis Syndrome (AES)/ Japanese Encephalitis (JE)				0	0	0	0	0		0	0	0	0	0		
F.1.3	Acute Encephalitis Syndrome (AES)/ Japanese Encephalitis (JE)				0	0	0	0	0		0	0	0	0	0		
F.1.3 .A	Strengthening of Sentinel Sites Which Will Include Diagnostics and Management. Supply of Kits by GoI				0	0	0	0	0		0	0	0	0	0		
F.1.3.B	IEC/BCC Specific to J.E. in Endemic Areas				0	0	0	0	0		0	0	0	0	0		
F.1.3.C	Training Specific for J.E. Prevention and Management				0	0	0	0	0		0	0	0	0	0		
F.1.3.D	Monitoring and Supervision				0	0	0	0	0		0	0	0	0	0		
F.1.3.E	Procurement of Insecticides (Technical Malathion)				0	0	0	0	0		0	0	0	0	0		

F.1.4	**Lymphatic Filariasis**				0	0	0	0	0		0	0	0	0	**0**		
F.1.4	Lymphatic Filariasis				0	0	0	0	0		0	150000	0	0	150000		
F.1.4.A	State Task Force, State Technical Advisory Committee Meeting, Printing of Forms/registers, Mobility Support, District Coordination Meeting, Sensitization of Media Etc., Morbidity Management, Monitoring & Supervision and Mobility Support for Rapid Response Team				0	0	0	0	0		0	0	0	0	0		
F.1.4.B	Microfilaria Survey				0	0	0	0	0		50000	0	0	0	50000		
F.1.4.C	Post MDA Assessment by Medical Colleges (Govt. & Private)/ ICMR Institutions.				0	0	0	0	0		10000	0	0	0	10000		
F.1.4.D	Training/sensitization of District Level Officers on ELF and Drug Distributors Including Peripheral Health Workers				0	0	0	0	0		503200	0	0	0	503200		
F.1.4.E	Specific IEC/BCC at State, District, PHC, Sub-Centre and Village Level Including VHSC/GKS for Community Mobilization Efforts to Realize the Desired Drug Compliance of 85% During MDA				0	0	0	0	0		225000	0	0	0	225000		
F.1.4.F	Honorarium to Drug Distributors Including ASHA and Supervisors Involved in MDA				0	0	0	0	0		0	800000	0	0	800000		
F.1.5	**Kala-Azar**				0	0	0	0	0		0	0	0	0	0		
F.1.5	KALA-AZAR - PART I				0	0	0	0	0		0	702650	0	0	**702650**		
F.1.6	KALA-AZAR - PART II											215000			**215000**		
	KALA-AZAR - PART III											6000			**6000**		
F.2	**Externally Aided Component (EAC)**				0	0	0	0	0		0	0	0	0	0		
F.2.A	World Bank Support for Malaria				0	0	0	0	0		250000	250000	250000	250000	1000000		
F.2.B	Human Resource(VBD Consultant& KTS Supervisor, Logistics Assiatant& Data Operator Salary)				0	0	0	0	0		321000	321000	321000	321000	1284000	50000	
F.2.C	Training /Capacity Building				0	0	0	0	0		0	0	0	0	0		
F.2.D	Mobility Support for Monitoring Supervision & Evaluation & Review Meetings, Reporting Format (for Printing Formats)				0	0	0	0	0		0	0	0	0	0		
F.3	**GFATM Project**				0	0	0	0	0		0	0	0	0	0		
F .3	GFATM PROJECT				0	0	0	0	0		0	0	0	0	0		
F.4	**Any Other Item (Please Specify)**				0	0	0	0	0		0	0	0	0	0		
F.4	Any Other Item (Please Specify)				0	0	0	0	0		0	0	0	0	0		
F.5	**Operational Costs (Mobility, Review Meeting,Communication,Formats & Reports)**				0	0	0	0	0		0	0	0	0	0		
F.5	Operational Costs (Mobility, Review Meeting,Communication,Formats & Reports)				0	0	0	0	0		0	0	0	0	0		
F.6	**Cash Grant for Decentralized Commodities**				0	0	0	0	0		0	0	0	0	0		
F.6.A	Chloroquine Phosphate Tablets				0	0	0	0	0		0	0	0	0	0		
F.6.B	Primaquine Tablets 2.5 Mg				0	0	0	0	0		0	0	0	0	0		
F.6.C	Primaquine Tablets 7.5 Mg				0	0	0	0	0		0	0	0	0	0		
F.6.D	Quinine Sulphate Tablets				0	0	0	0	0		0	0	0	0	0		
F.6.E	Quinine Injections				0	0	0	0	0		0	0	0	0	0		
F.6.F	DEC 100 Mg Tablets				0	0	0	0	0		0	0	0	0	0		
F.6.G	Albendazole 400 Mg Tablets				0	0	0	0	0		0	0	0	0	0		
F.6.H	Dengue NS1 Antigen Kit				0	0	0	0	0		0	0	0	0	0		
F.6.I	Temephos, Bti (for Polluted & Non Polluted Water)				0	0	0	0	0		0	0	0	0	0		
F.6.J	Pyrethrum Extract 2%				0	0	0	0	0		0	0	0	0	0		
F.6.K	Any Other (Pl. Specify)				0	0	0	0	0		0	0	0	0	0		
F	NVBDCP				0	0	0	0	0		0	0	0	0	0		
	Total														**5060850**		

G	NLEP				0	0	0	0	0		0	0	0	0	0		
G.1	NLEP				0	0	0	0	0		0	0	0	0	0		
G.1	Contractual Services				0	0	0	0	0		0	0	0	0	0		
G.10	NGO-SET Scheme				0	0	0	0	0		0	0	0	0	0		
G.11	Supervision, Monitoring & Review				0	0	0	0	0		0	0	0	0	0		
G.12	Specific-Plan for High Endemic Districts				0	0	0	0	0		0	0	0	0	0		
G.13	Others (Maintenance of Vertical Unit, Training & TA/DA of Vertical Staff)				0	0	0	0	0		0	0	0	0	0		
G.2	Services Through ASHA				0	0	0	0	0		0	0	0	0	0		
G.3	Office Expenses & Consumables				0	0	0	0	0		0	0	0	0	0		
G.4	Capacity Building (Training)				0	0	0	0	0		0	0	0	0	0		
G.5	BCC/IEC(NLEP)				0	0	0	0	0		0	0	0	0	0		
G.6	POL/Vehicle Operation & Hiring				0	0	0	0	0		0	0	0	0	0		
G.7	DPMR(MCR Footwear, Aids and Appliances, Welfare to BPL Patients for RCS, Support to Govt. Institutions for RCS				0	0	0	0	0		0	0	0	0	0		
G.8	Material & Supplies				0	0	0	0	0		0	0	0	0	0		
G.9	Urban Leprosy Control				0	0	0	0	0			0	0	0	0		
G	NLEP				0	0	0	0	0		0	0	0	0	400000		
	Total														**400000**		

H	NPCB				0	0	0	0	0		0	0	0	0	0		
H.1	**Recurring Grant-in Aid**				0	0	0	0	0		0	0	0	0	0		
H.1	Recurring Grant-in Aid				0	0	0	0	0		0	0	0	0	0		
H.1.1	For Free Cataract Operation and Other Approved Schemes As Per Financial Norms				0	0	0	0	0		200000	200000	300000	300000	1000000		
H.1.2	Other Eye Diseases				0	0	0	0	0		0	0	0	0	0		
H.1.3	School Eye Screening Programme				0	0	0	0	0		0	100000	100000	0	200000		
H.1.4	Blindness Survey				0	0	0	0	0		0	0	0	0	0		
H.1.4.A	Private Practitioners As Per NGO Norms				0	0	0	0	0		0	0	0	0	0		
H.1.5	Management of State Health Society and Distt. Health Society Remuneration(Salary/ Review Meeting, Hiring Vehicles and Other Activities & Contingency)				0	0	0	0	0		0	0	0	0	0		
H.1.6	Recurring GIA to Eye Donation Centres				0	0	0	0	0		0	0	0	0	0		
H.1.7	Eye Ball Collection and Eye Bank				0	0	0	0	0		0	0	0	0	0		
H.1.8	Eye Ball Collection				0	0	0	0	0		0	0	0	0	0		
H.1.9	Training PMOA				0	0	0	0	0		0	0	0	0	0		
H.1_10	IEC (Eye Donation Fortnight, World Sight Day & Awareness Programme in State & Districts)				0	0	0	0	0		0	0	0	0	0		
H.1_11	Procurement of Ophthalmic Equipment				0	0	0	0	0		0	0	0	0	0		
H.1_12	Maintenance of Ophthalmic Equipments				0	0	0	0	0		0	0	0	0	0		
H.1_13	Grant-in-Aid for Strengthening of 1 Distt. Hospitals.				0	0	0	0	0		0	0	0	0	0		
H.1_14	Grant-in-Aid for Strengthening of 2 Sub Divisional. Hospitals				0	0	0	0	0		0	0	0	0	0		

H.2	**Non Recurring Grant -in-Aid**				0	0	0	0	0		0	0	0	0	0		
H.2.1	For RIO (New)				0	0	0	0	0		0	0	0	0	0		
H.2.2	For Medical College				0	0	0	0	0		0	0	0	0	0		
H.2.3	For Vision Centre				0	0	0	0	0		0	300000	0	0	300000		
H.2.4	For Eye Bank				0	0	0	0	0		0	0	0	0	0		
H.2.5	For Eye Donation Centre				0	0	0	0	0		0	0	0	0	0		
H.2.6	For NGOs				0	0	0	0	0		0	0	0	0	0		
H.2.7	For Eye Ward & Eye OTS				0	0	0	0	0		0	0	0	0	0		
H.2.8	For Mobile Ophthalmic Units With Tele Network				0	0	0	0	0		0	0	0	0	0		
H.3	**Contractual Man Power**				0	0	0	0	0		0	0	0	0	0		
H.3.1	Ophthalmic Surgeon				0	0	0	0	0		0	0	0	0	0		
H.3.2	Ophthalmic Assistant				0	0	0	0	0		0	0	0	0	0		
H.3.3	Eye Donation Counsellors				0	0	0	0	0		0	0	0	0	0		
H	NPCB				0	0	0	0	0		0	0	0	0	0		
	Total				0	0	0	0							1500000		

I	**RNTCP**				0	0	0	0	0		0	0	0	0			
I.1	**RNTCP**				0	0	0	0	0		0	0	0	0			
I.1	Civil Works				0	0	0	0	0		0	0	0	0			
I.2	Laboratory Materials				0	0	0	0	0		0	0	0	0			
I.3.A	Honorarium/Counselling Charges				0	0	0	0	0		0	0	0	0			
I.4	IEC/ Publicity				0	0	0	0	0		0	0	0	0			
I 5	Equipment Maintenance				0	0	0	0	0		0	0	0	0			
I.6	Training (RNTCP)				0	0	0	0	0		0	0	0	0			
I.7	Vehicle Maintenance				0	0	0	0	0		0	0	0	0			
I.8	Vehicle Hiring				0	0	0	0	0		0	0	0	0			
I.9	NGO/PPP Support				0	0	0	0	0		0	0	0	0			
I.3.B	Incentive to DOTs Providers				0	0	0	0	0		0	0	0	0			
I_10	Miscellaneous				0	0	0	0	0		0	0	0	0			
I_11	Contractual Services				0	0	0	0	0		0	0	0	0			
I_12	Printing (RNTCP)				0	0	0	0	0		0	0	0	0			
I_13	Research and Studies				0	0	0	0	0		0	0	0	0			
I_14	Medical Colleges				0	0	0	0	0		0	0	0	0			
I_15	Procurement –vehicles				0	0	0	0	0		0	0	0	0			
I_16	Procurement – Equipment				0	0	0	0	0		0	0	0	0			
I_17	Tribal Action Plan				0	0	0	0	0		0	0	0	0			
I_18	Any Other Item (Salary Of Mo & LT)																
	Total														6500000		
	Grand Total (D To I)														14861740		