District Health Action Plan

Darbhanga

2012-13

District Health Society
Darbhanga
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Foreword

It has become now crystal clear for policy makers through many empirical studies that health of the common people decides the destiny of that country. If we throw light on our health system we find that they are in shambles. The District Health Society Darbhanga under the aegis of Government of Bihar is committed towards promoting the right of every citizen esp. rural woman and child to enjoy a life of health and equal opportunity and is making all round efforts in this direction. Efforts in other areas would lead us nowhere unless we pay heed towards the fine tuning of our health system. Probably this is the reason government of India launched National Rural Health Mission to fill the gap in our health system and make it be able to meet the Medicare needs of the people who can not effort Medicare at market price.

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.

This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated. The goals of the Mission are to improve the availability of and access to quality health care by people, especially for those residing in rural areas and the exclusive groups, the poor, women and children. This plan is also aimed at improving the access to comprehensive quality health care by improving the public health infrastructure to desired standards and placing the health of the people in their hands. Technical Human Resource being one of the most important resources for bringing in quality change in the programme in the District is going to be significantly strengthened. Under this Plan, the Programme Management Support Units at the block, and district level along with HMIS and other support systems shall be strengthened.

I need to congratulate the department of Health and Family Welfare and State Health Society of Bihar for their dynamic leadership of the health sector reform programme and we look forward to a rigorous and analytic documentation of their experiences so that we can learn from them and replicate successful strategies. I also appreciate their decision to invite consultants (NHSRC/ PHRN) to facilitate our DHS regarding preparation of DHAP, BHAP & VHAP.

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

(R. Lakshmanan , IAS)

DM, DARBHANGA

About the Profile

Under the National Rural Health Mission this Health Action Plan of Darbhanga district has been prepared. Through thorough situational analysis on each and every parameters of health, the study proceeds to make recommendations towards a policy on 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 how critical gaps can be identified and addressed. It looks at how the facilities at different levels can be structured and reorganized.

DPIP 2012-13 has been prepared through consultation with village, block and district level functionaries. The plans have been prepared on the needs identified and has addressed lots of critical issues and district specific innovations to implement the programme.

The information related to data and others used in this action plan is authentic and correct according to my knowledge as this has been provided by the concerned medical officers of every block and different progamme officers. I am grateful to the state level consultants (NHSRC/PHRN), ACMO, MOICs, Block Health Managers, Block Commmunity Mobilizers, ANMs, ASHAs, AWWs & entire DPMU team. Through their excellent effort we have been able to make Health Action Plan 2012-13, of Darbhanga District.

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

Dr. Laxman Prasad Singh

Asst. Chief Medical Officer
Darbhanga

Dr. Uday Kr. Choudhary

Civil Surgeon cum Member Secretary
DHS, Darbhanga

Process of Plan Preparation

The District Programme Implementation Plan 2012-13 has been framed on the basis of strategies and activities which worked in the last four years. The major bottlenecks have been identified and an attempt has been made to overcome them through alternative strategies.

Efforts have been made to plan based on evidence, consult all stake holders, incorporate lessons learnt from previous years under NRHM, set realistic objectives, develop synergies between different vertical programs and strengthen and decentralize programme management.

Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate Darbhanga, Civil Surgeon, ACMO (Nodal officer for DHAP formulation), DPM, DAM, M&EO, DPC, DCM, DDA, Data manager (IDSP), all programme officers and State level consultants of NHSRC/PHRN as well as the MOICs, Block Health Managers and ANMs, as a result of a participatory processes as detailed below. After completing the DHAP, a meeting was organized by Civil Surgeon with all MOICs & BHMs of the block and all programme officers which then discussed and displayed. Reasonable comment from participants were 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. Situational analysis component was done at four levels (village-Hsc-block-disrtict). 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.

Planning Process

- Constitution of District level team for DHAP
- Organisation of District level meeting for District team.
- Orientation of Key Medical officers & Health Functionaries of Blocks by district team on DHAP.
- Collection of Data through various sources.
- Understanding Situation
- Assessing Gap

- Constitution of Block team.
- Block level meeting of Block team.
- Orientation of ANM & health functionaries of Hsc level by Block as well as district level team.
- Division of Hsc among block team for proper monitoring.
- Collection of data through various sources.
- Situational analysis
- Gap identification.

Hsc level meeting of Hsc team.

- Orientation of Asha , Aww & PRI members at village level by Hsc level as well as block level team.
- Division of Villages among block team for proper monitoring.
- Collection of data through various sources.

- Constitution of Village level team for VHAP
- Organisation of Village level meeting for Village team.
- Orientation of ASHA, AWW & PRI through Health Functionaries of Blocks &y district on VHAP.
- Collection of Data through various sources.
- Understanding Situation
- Assessing Gap

- District level review meeting
- District level meeting to compile information

Facilitating planning process for DHAP

- Final Complation of DHAP & its approval
- Final DHAP Submission to State

The existing Health System of Darbhanga, both Public and under NRHM, through its more than 24 Staff Nurse, 468 ANMs, 212 (ANM-R), 3530 ASHAs, 3231 Aaganwadi Workers and nearly 139 regular and contractual doctors reaches out to the people living in more than 2169 villages. The Health infrastructure, particularly PHCs, APHCs and other Government hospitals ought to be the institutions where people can put their trust for good and affordable quality health services.

NRHM heralded an era where the health of the people has been placed in their own hands and government is playing a role of facilitator providing all round support and ensuring access to health services. This has also been proved by implementing decentralized planning which has given rise to village health planning. Village health planning has helped in improving community awareness, generating community perception & also helped in improving performance of the programme. Through this process it is very clear that today health of the common people is in their own hand. Thus National Rural Health Mission has offered unprecedented opportunity in improving the health of the people of Bihar.

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The DHAP, BHAP s & VHAPs consists of five major sections-

1. Reproductive & Child Health Programme-II
2. Additionalities under NRHM
3. Routine Immunization
4. National Disease Control Programmes
5. Inter Sectoral Convergence

The DPMU team was thoroughly involved in the process and their critical inputs were incorporated to make this plan more holistic, realistic and achievable. The Plan was further reviewed by the District Magistrate, chairperson, DHS and the CMO-cum-Member Secretary, and ACMO of Darbhanga.

Health Society Darbhanga, under the guidance of District Magistrate, Civil Surgeon and ACMO, has brought in a Systemic Change in the Planning process and has incorporated the Core-Concept of NRHM Mission Document-that of De-Centralisation of Planning. The Planning exercise for FY 2012-13 has been a multi-pronged process.

The District has undertaken 18 Blocks for which Block health Action Plans as per the NRHM guidelines have been prepared .Similarly blocks have undertaken HSC planning & some HSCs have taken village planning. State for the first time has selected ten districts for village planning exercise & we really feel honoured because our district is one amomg those . It is noteworthy that for the first time in Darbhanga district NRHM Village Planning exercise has been undertaken. Every district had to select five Blocks & every Block had to select five villages for this exercise. As a result 25 villages of darbhanga district, for the vary first time were involved in preparing their VHAPs (VILLAGE HEALTH ACTION PLAN).The District has constituted Village, Sub centre, Block and District Planning committee for preparing District Programme Implementation Plan under NRHM and designated nodal officers at the district ,block & village level for the same.

Village Health Action Plan

State for the first time has selected ten districts for village planning exercise & it is a matter of pride that our district Darbhanga is one among those ten. It is noteworthy that for the first time in Darbhanga district NRHM Village Planning exercise has been undertaken. As per state guideline every district is required to select five Blocks & every Block is required to select five villages for this exercise. Selection process for above two is based upon certain criteria set by state. As a result 25 villages of darbhanga district (5 each from 5 Blocks) for the vary first time were involved in preparing their VHAPs (VILLAGE HEALTH ACTION PLAN). The District has constituted Village, Sub centre, Block and District Planning committee for preparing District Programme Implementation Plan under NRHM and designated nodal officers at the village, sub centre, Block & district levels for the task.

Objective of Village health planning :

- Improved Community Awareness.
- Generate Community Perception.
- Improved performance of the program.
- Horizontal integration.
- Peoples health in peoples hand.

Promoting decentralization in governance.

Core strategies of Village health planning :

- Promote accessible & improved health care at house hold level through ASHA.
- Enhance capacity of PRI to own, control & manage public health services.
- Train frontline Workers in accessing health needs in identifying solutions at village level.
- Health plan for each village through ASHA.

Selection process of District for VHAP:

Selection of district for Village Health Action Plan was done on the basis of district ranking report (Jan-March 2011).

Selection process of Block for VHAP is based upon:

1) Geographical condition: a) Flood prone

2) Human Resource: a) Skilled, Hard working ANM available b) PHC based Doctors & Para Medical staffs

3) Disease prevalence: a) kalazar b) Malaria 3) T.B 4) JE

4) Low immunization status

5) Low coverage of ANC checkup

6) Diarrhoea Incidence

7) Low institutional delivery

8) Densly populated

Selection process of Village for VHAP is based upon:

- The village selected should have HSC in govt. building.
- PRI smember should be cooperative
- Active Self Help Group
- ANM should be trained on HMIS module
- Availability of ASHA & AWW in the village.
- Rest all the criteria's which are applicable for Block selection is applicable for village selection.

Once VHAP is prepared it is submitted at block level by Panchayat for consolidation to develop a complete Block Health Plan addressing common health problem across the block. The most important benefit of this plan is through the process of VHAP people will get a chance to reflect on their own health status & thereby will be able to contribute to a positive health status & equity.

District Planning team (DPT) at the District level has been constituted with ACMO, DPM, DAM DMEO, DPC, DCM , DDA & Dist. Data Manager (IDSP) .Capacity Building Workshops for the DPT has been held at district level under the chairmanship of ACMO. Block Planning team constitutes the MOIC, 1st MO, Block Health Manager, Block Community Mobilizer and Block Accounts Manager along with CDPO of concern block. At the district level ACMO is the Nodal Officer for Planning and at the block-the MOIC and different DPOs have been designated as Nodal Officers per block in each block for the Block Planning exercise. At village level concern ANM has been designated as the Nodal person. Capacity Building Workshop has been held at each and every level.

Resource Envelope will be communicated to the blocks based on the fund received in the district. Unit Cost for each Budget Head prepared by respective SPOs (State Programme Officer) will been communicated (covering aspects like purpose of the budget head, outcome, unit cost, responsible official, financial protocol etc).

District thereafter has conducted Capacity Building workshops for the blocks and various Consultative workshops both at the block and district level and done situational analysis and have drafted their District Plans. At the block level, consultation was done which was further sent to the District. With the information gathered from the block, district has further held consultations and prepared their priorities and requirements, which is reflected in the District Health Action Plans.

The DHAP is a consolidation of VHAPs, HSC plans, BHAPs and incorporation of district level requirements/priorities. The district presented their Plan before respective district program officers & block officers at district level workshop held in end December and based on the feedbacks received from DPOs, modified their Plans and gave final shape to the same.

District Profile

History

Darbhanga fondly remembered as the capital city of ancient Mithila has a glorious past. Mithila, observes Grierson, "is a distinct with its own traditions, its own poet and its own pride ; in a true sense everything belonging to itself." The land of the philosopher king Videh Janak, law saint poet Vidyapati, legendry scholars Yagnavalkya, Mandan of learning and scholarship. All in all, Mithila is universally known as the birth place of Goddess Sita. The splendid site of Balrajgarh, Uchchaith, Jayamanglagarh, Mahishi Bangaon and the like speak volumes of the glorious cultural heritage of Mithila, making the region potentially sound for promoting heritage tourism. Madhubani painting is rightly regarded today as the cultural ambassador of India and not that of the Mithila alone.

The history of Darbhanga dates back to the Ramayana and Mahabharat periods. According to the Vedic Sources, the Videhas of Aryan stock first migrated to the area from the banks of Saraswati in Punjab. They were guided to the east of Sadanira (Gandak River) by Agni, the God of Fire. Settlements were established and, thus, flourished the Kingdom of Vedehas- the Selfless. In course Of time vide has came to be ruled by a line of kings there was a very famous King named Mithi. To commemorate his greatness the territory was named as MITHILA. Another famous king was Janak Sirdhwaja, father of Sita.

The legends speak of various learned men patronized by Janak Sirdhwaja, who himself was an erudite scholar. Among them prominent were Yagyavalkya, who codified the Hindu law in his Yagyavalkya Smriti and Gautam, who has various valuable philosophical treatises to his credit. King Janak was himself a great philosopher and his ideas have been eternally enshrined in the Upanishads.

The name of the district has been derived from its head quarter and principal town, which is said to have been founded by Darbhangi Khan. It is also said that the name **Darbhanga** was derived from **Dwar- Banga** or **Dar-e-Bang** meaning"THE GATEWAY OF BENGAL".Darbhanga is One of the important districts of North Bihar situated in the very heart of Mithilanchal- the fertile , alluvial plains of North India. Under the British rule, Darbhanga was a part of Sarkar Tirhut upto 1875, when it was constituted into a separate district.

The Sub – divisions of the then district Darbhanga were created as earlier as Darbhanga Sadar in 1845, Madhubani in 1846 and Samastipur in 1867. Darbhanga was part of Patna Divisions till 1908, when the separate Tirhut Divisions was carved out. Darbhanga become the Divisional headquarters in 1972 When all its two sub- Divisions got the status of separate district . Thus the present Darbhanga district took shape.

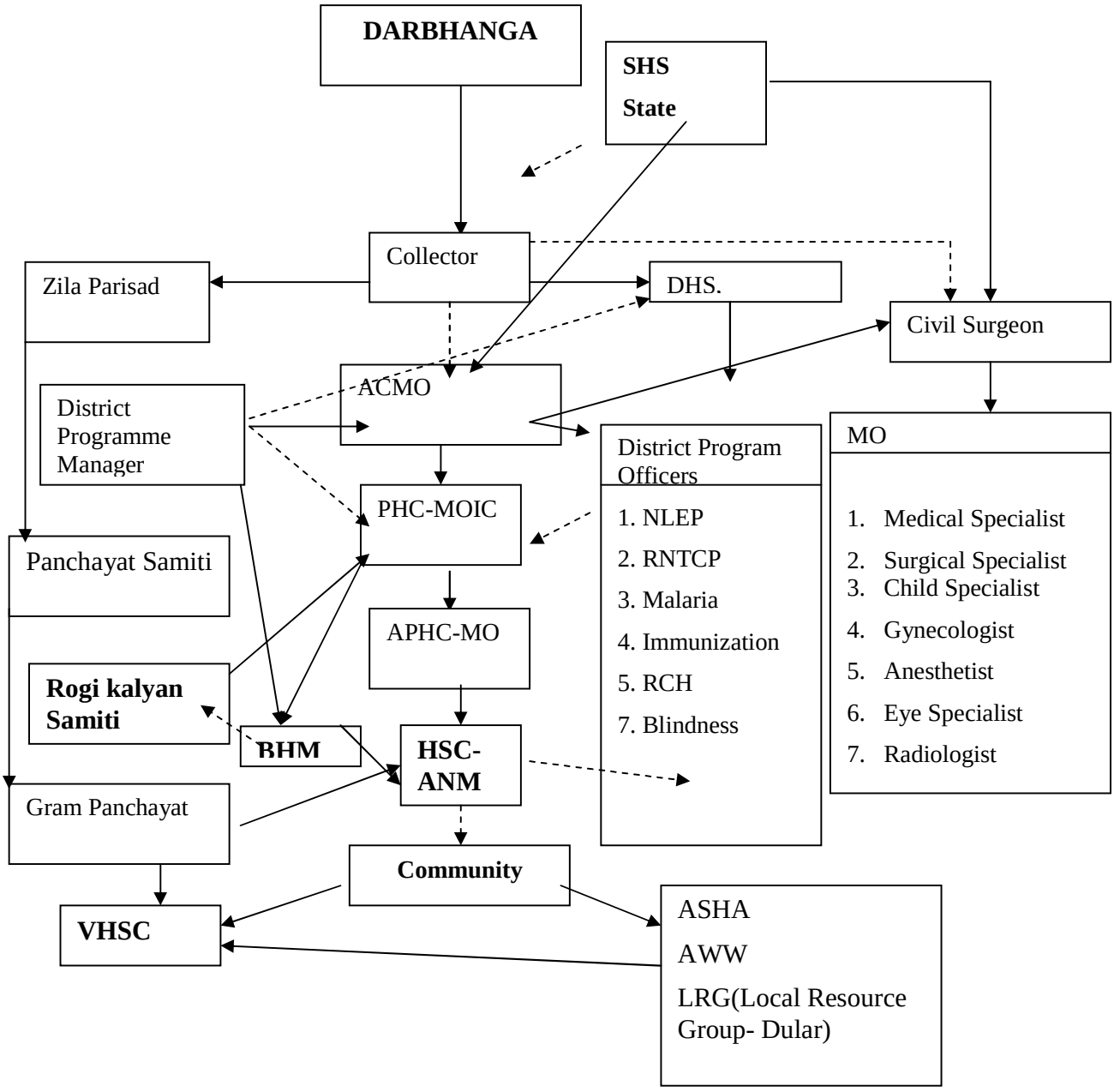
Darbhanga district is also very famous for *Paan*, *Makhan* & Varieties of *Fish.*

Geographical Location

The District is located at 26.17° North l atitude and 85.9° East longitude. The District is situated at the bank of Kamla. The District is surrounded by Madhubani in north, Samastipur in south, Muzzafarpur in west and Saharsa, Supual in East . The District is in Semi tropical Gangetic plane. The state capital Patna is linked with famous Mahatma Gandhi Setu. The District is spread over 2279 sq km area.

District Overview

District Health Administrative Setup



DARBHANGA– AT A GLANCE

AREA (Sq. Kms):- 2279				
POPULATION(CENSUS 2011)				
TOTAL	**:-**	**3921971**		
MALES	**:-**	**2053043**		
FEMALES	**:-**	**1868928**		
RURAL POPULATION				
TOTAL	**:-**	**3541846**		
MALES	**:-**	**1852977**		
FEMALES	**:-**	**1688869**		
URBAN POPULATION				
TOTAL	**:-**	**380185**		
MALES	**:-**	**200066**		
FEMALES	**:-**	**180059**		
POPULATION OF SCHEDULED CASTES				
TOTAL	**:-**	**610323**		
MALES	**:-**	**311264**		
FEMALES	**:-**	**299059**		
POPULATION OF SCHEDULED TRIBES			**:-**	
TOTAL	**:-**	**912**		
MALES	**:-**	**502**		
FEMALES	**:-**	**410**		
DENSITY OF POPULATION			**:-**	**1721 per sq.Km**
SEX RATIO			**:-**	**910 F/1000 M**

COMPARATIVE POPULATION DATA(2011 Census)

Basic Data	India	Bihar	Darbhanga
Population	1210193422	103804637	**3921971**
Density	382	1102	**1721**
Socio- Economic			
Sex- Ratio	940	916	**910**
Literacy % Total	74.04	63.82	**58.26**
Male	82.14	73.39	**68.58**
Female	**65.46**	**53.33**	**46.88**

LITERACY RATE		
TOTAL	:-	58.26%
MALES	:-	68.58%
FEMALES	:-	46.88%
BLOCKS	:-	18
SUB-DIVISION	:-	03
PANCHAYATS	:-	323
VILLAGES:-	:-	1269
POLICE STATIONS	:-	23
TOWNS	:-	01
NAGAR PARISHAD(DARBHANGA)		01
M.P CONSTITUENCY	:-	01
M.L.A. CONSTITUENCY	:-	10
HEALTH		
DARBHANGA MEDICAL COLLEGE & HOSPITAL		01
DISTRICT HOSPITAL	:-	00
REFERRAL HOSPITAL	:-	02
SUB DIVISIONAL HOSPITAL	:-	01
PRIMARY HEALTH CENTRE	:-	18
ADDITIONAL PRIMARY HEALTH CENTRE	:-	36
HEALTH SUB CENTRE	:-	261
BLOOD BANK	:-	01(DMCH)
AIDS CONTROL SOCIETY	:-	01
TRAINED NURSES	:-	516
TRAINED DOCTORS	:-	139

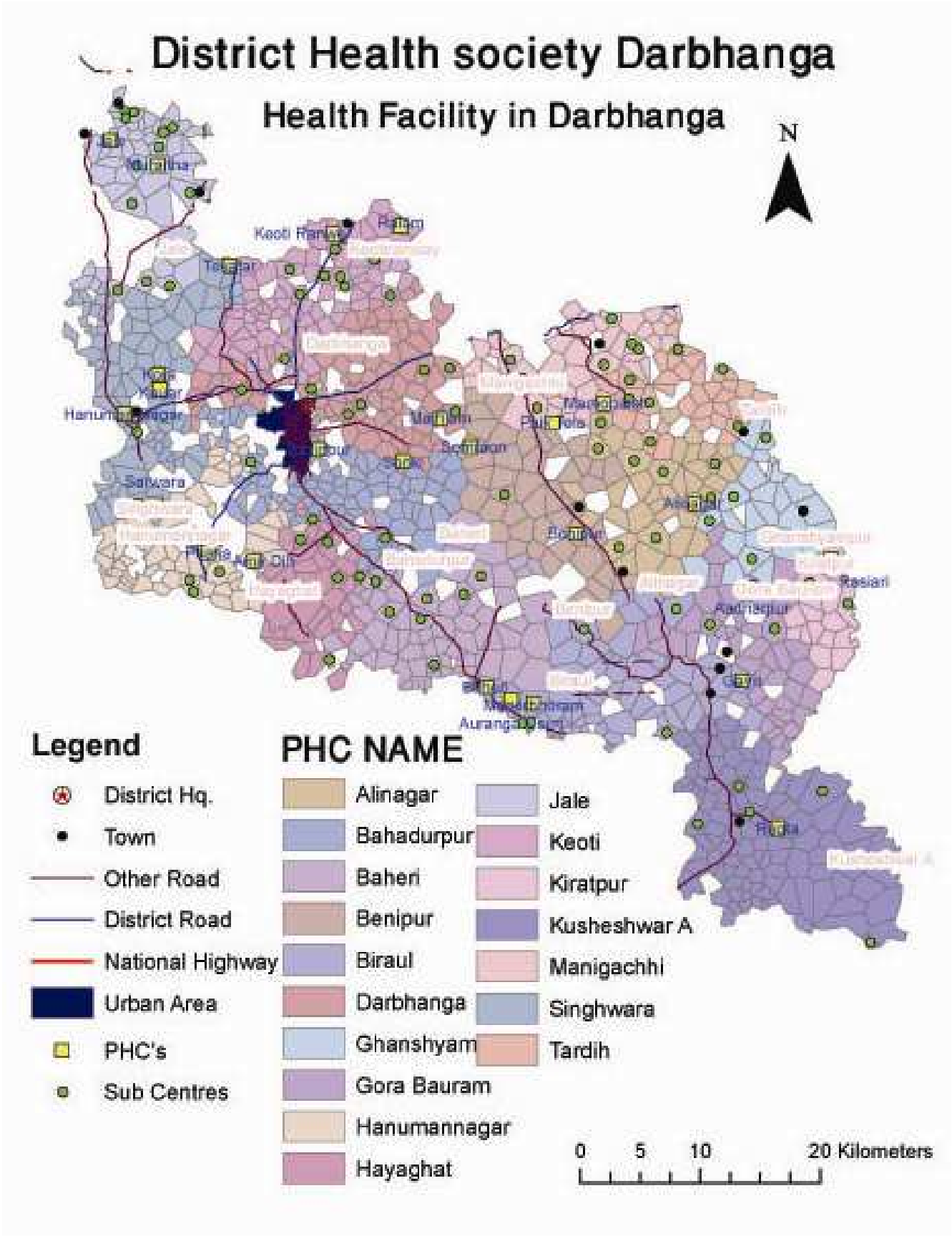
SOCIO-ECONOMIC PROFILE

Social

- Darbhanga district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Darbhanga have old social hierarchies and caste equations still shape the local development.
- 16 % of the population belongs to SC and 0.025 % to ST. Some of the most backward communities are *Mushahar, Dusadh, Chamar*, *Mallah* and *Dome*.

Economic

- The main occupation of the people in Darbhanga is Agriculture, Fisheries and daily wage labour.
- Almost 14% of the youth population migrates in search of jobs to the metropolitan cities like Kolkata, Mumbai, Delhi, Amritsar, etc.
- The main crops are Wheat, Paddy, Maize, Makhana and Mango.
- Mango, Makhana and Chilli are the major cash crop of the community residing at the bank of Kamla and Baghmati river


District Health society Darbhanga
Health Facility in Darbhanga
N
Legend
District Hq.
Town
Other Road
District Road
National Highway
Urban Area
PHC's
Sub Centres
PHC NAME
Alinagar
Bahadurpur
Baheri
Benipur
Biraul
Darbhanga
Ghanshyam
Gora Bauram
Hanumannagar
Hayaghat
Jale
Keoti
Kiratpur
Kusheshwar A
Manigachhi
Singhwara
Tardih
0 5 10 20 Kilometers

Current Status of Outcome

HEALTH STATUS AND BURDEN OF DISEASES

Table. CASE FATALITY RATE

S.No.		2010		2011	
	Disease	Case	Death	Case	Death
1	Diarrhea / Dysentery	432	0	125	2
2	Cholera	0	0	0	0
3	Meningitis	0	0	0	0
4	Jaundice	0	0	0	0
5	Tetanus	0	0	0	0
6	Kalazar	940	0	1035	0

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	Darbhanga Medical College & Hospital	1	1000
2	District Hospital	0	0
3	Referral Hospital	2	60
4	Block PHCs	18	108
5	APHCs	41	70
8	Sub-centres	261	0
9	Ayurvedic Dispensaries	0	0
10	Anganwadi Centres	3213	NAs
11	Others (Pvt. Facility accreditated)	6	210

Situational Analysis

Bird's Eye View of Progress in the District

1) District Health Society, Darbhnaga formed & registered in 2006.

2) ASHA: A total of 3530 ASHAs selected against a target of 3550.
ASHA trained in Module I, II, III and IV - 3530. Training for Module 5, 6 & 7 is going to start within couple of days.

3). DPMU & BPMU: Well oriented and functional DPMU and 18 BPMU at block level .18 Block Health Managers and 18 Block Accountants under NRHM are already in position. The orientation training for all has been completed.

4). FRU: 2 FRU are functional in darbhanga district and hospital manager for the same has been appointed. Orientation training for all has been conducted through DHS from time to time.

5) Free drug distribution of essential drugs started from 1st July 2006 and 24 hours presence of doctors ensured in all facilities up to PHC level resulting in unprecedented increase in OPD patients. 4 times increase has been reported. In the Primary Health Centres of the District, there is free Distribution of 33 drugs in OPD. Darbhanga district has 2 FRU, 1 SDH, 36 APHCs and 261 HSCs.

6).Routine Immunization: Full immunization percentage increased from 46496 in year 2007-08 to 83654 in 2010-11 .

7.) Against a total figure of 419 posts of ANM (R), 212 posts of ANM(R) have been filled up.

8) Rogi Kalyan Samitis are formed in 41 APHCs.

9). Training Programmes: Training of EmOC, IMNCI, ASHA, MCTS, HMIS,CPSM, DPMUs, BPMUs, SBA training, NBCC, Immunization and Neonatal resuscitation started. This includes the regular monitoring and corrective actions taken.

10). Institutional delivery has increased manifold.It has increased from 24933 in year 2007-08 to 42946 in year 2010-11.

11). Additionally in the year 2011 -12, establishment of new borne care corner has been achieved & out of 11 (proposed) PHCs 10 have their full flagged functional New Borne Care Corner.

12). In Darbhanga districts, IDSP unit is functional.

13). Free Radiology services have been offered by 7 PHCs.

14). Solar water system is functional at 2 PHCs.

15). Health card has been provided to almost 78% children under Nai Pidhi Swasth Guarantee Karyakaram till Dec 2011.

16).Family planning (female tubectomy as well as male vasactomy) has also increased a lot.It has increased from 12037 in year 2007-8 to 16051 in year 2010-11.

17).There has been a reduction in **IMR & MMR**.

18**). NRC** (Nutritional Rehabilitation Centre) is functional & is being run by NGO.

19).**Community Based Planning and Monitoring** Scheme is running in 2 Blocks along with 5 Panchayat each in Darbhanga District.

20).**Social marketing** keeping in mind the health of adolescent girl has been launched recently.

21). **VHSND** is celebrated once in a month at each Anganwari center.

22). **FFHI** (Family Friendly Hospital Initiative) has become functional in darbhanga district in current year (2011) & Gap analysis under FFHI has been done under 6 blocks. Gaps were identified by all the employees of the concern PHC, right from MIOC to fourth grade.

23).**Quality Assurance:** A pilot project launched currently (2011) in two district (Vaishali & Darbhanga), especially for improving quality of care in Facility Based New Borne Care (SNCU & NBCC) through supportive supervision & monitoring.This was done done by SHSB, Patna in support with UNICEF & PHFI.External & internal monitoring of all NBC corners of the district was done through SAT(Self Assesment Tool) & QAT (Quality Assesment Tool) method.

In the present situational analysis of the blocks of Darbhanga district 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, Darbhanga and various websites as well as other sources. These indicators help in pointing to the health scenario in Darbhanga 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 Darbhanga district with respect to Bihar and India as a whole.

Table 3.1: Health Indicators

Indicator	Darbhanga	Bihar	India
CBR	26.5	26.7	**22.5**
CDR	8.8	7.2	**7.6**
IMR	48	48	**50**
MMR	312	256	**301**
TFR	4.5	4.2	**3**
CPR	**31**	**34**	**35**

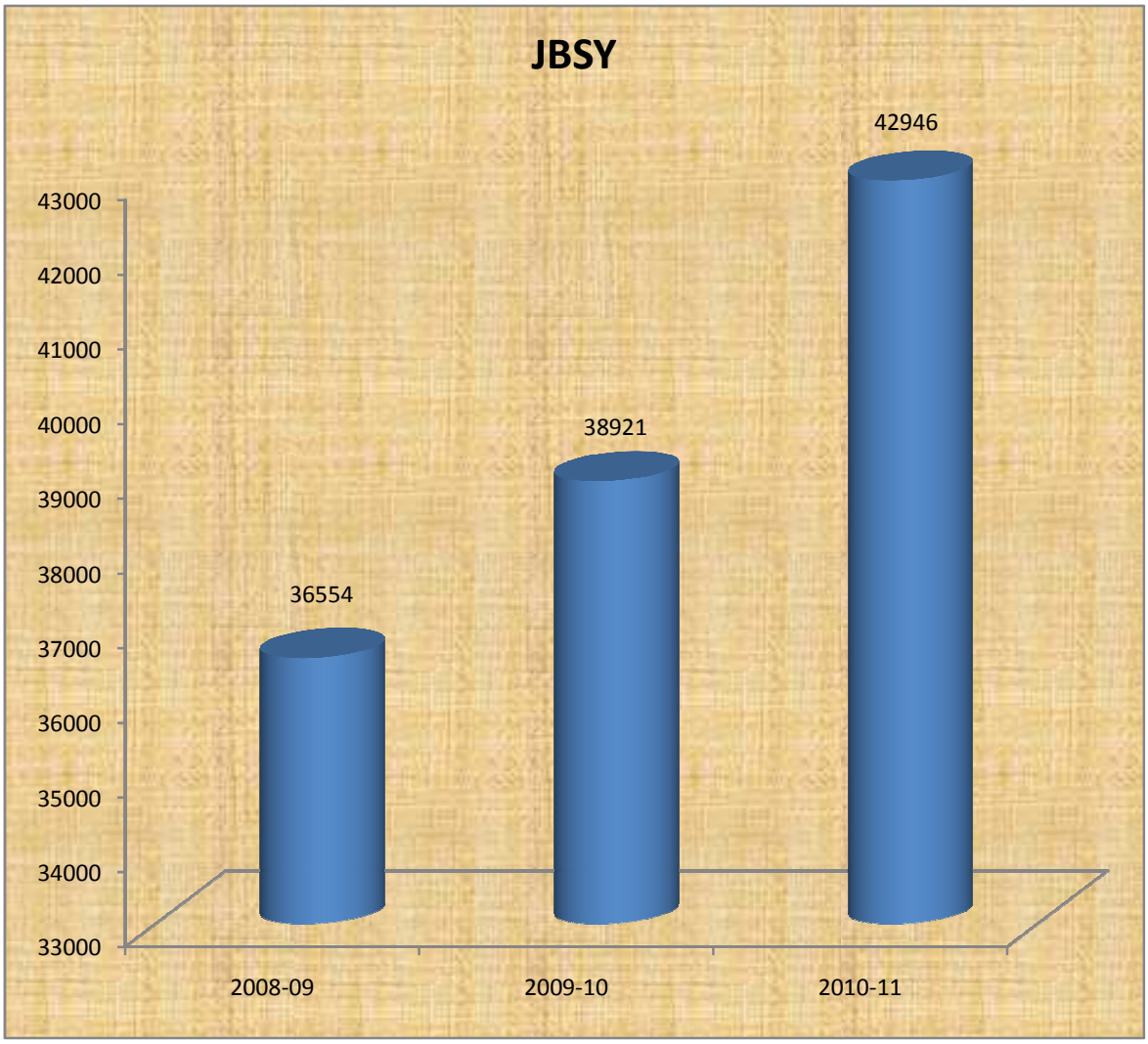
Sources: Annual Health Survey 2011-12

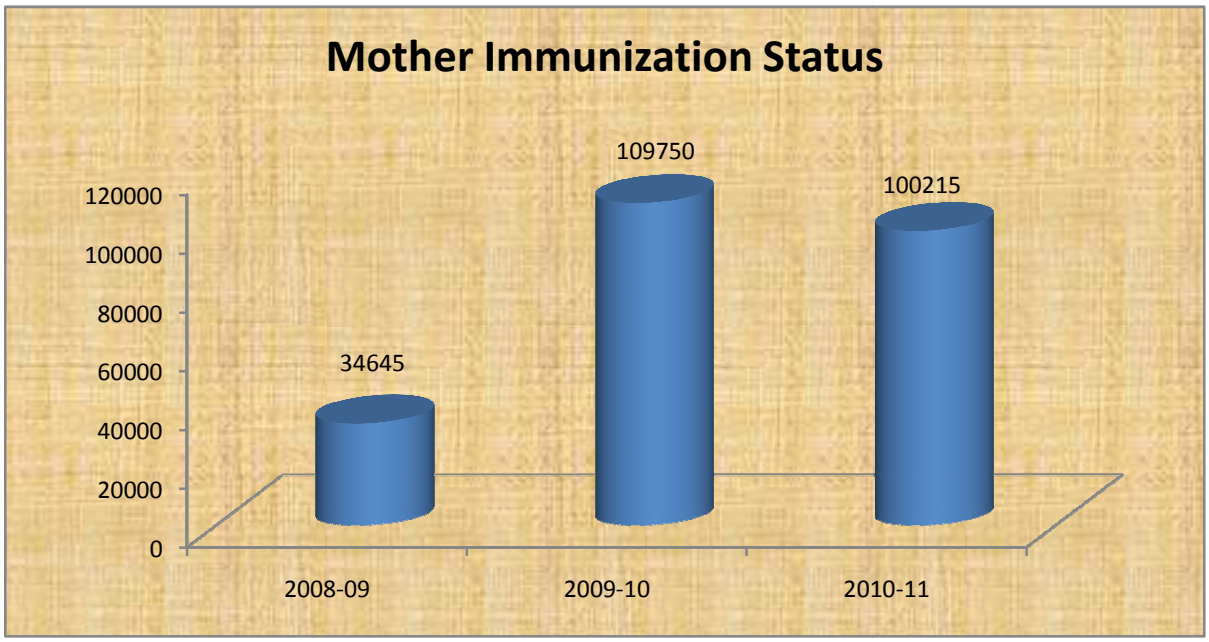
Detailed Progress of Activities

Various programmes have been initiated by the Department of Health, Government of Bihar which has improved the health scenario in the District and has made primary health care accessible and available to the rural masses. The **patient load/turnout** in PHCs has increased in the OPDs as well as in the IPDs in comprasion to previous year.

Maternal Health

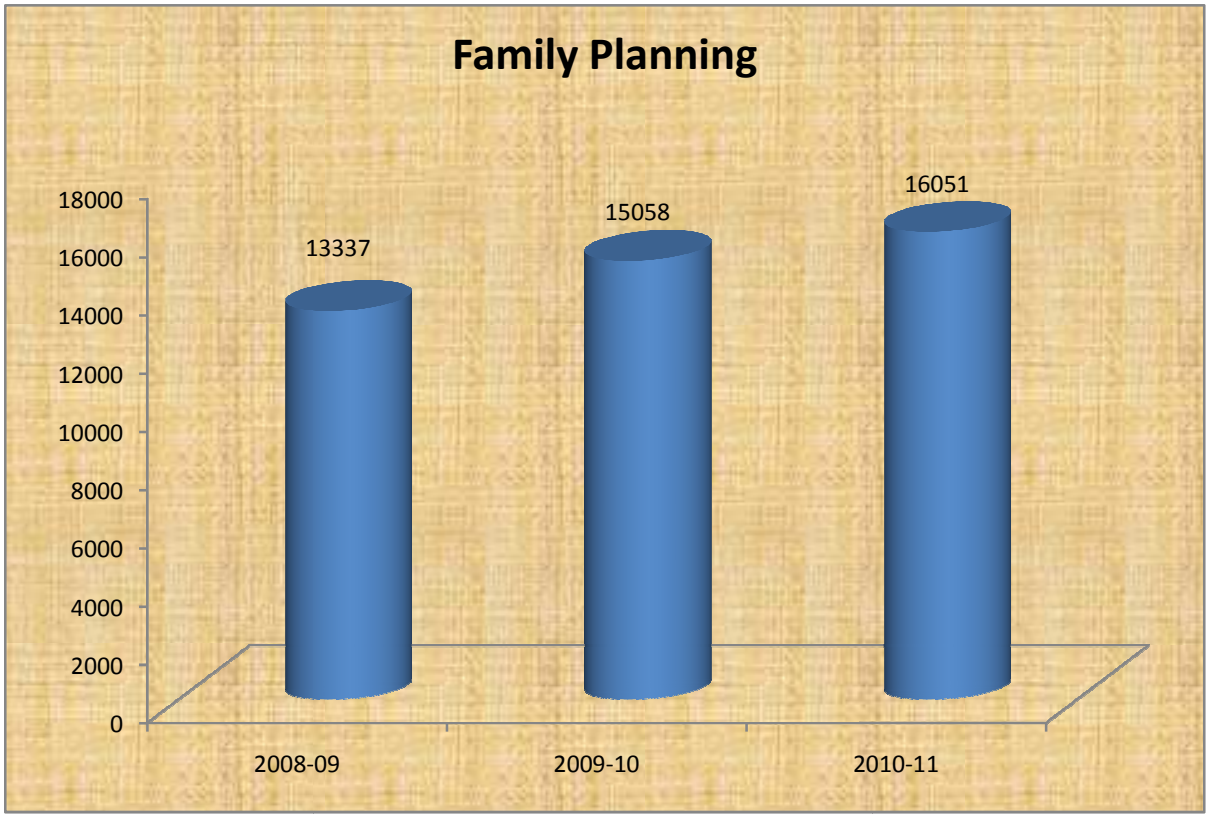
24 x 7 Health Services is available in 16 Primary Health Centres of the District.
The total no. of **institutional delivery** has increased from 38921 in the year 2009-10 to 42946 in year 2010-11.





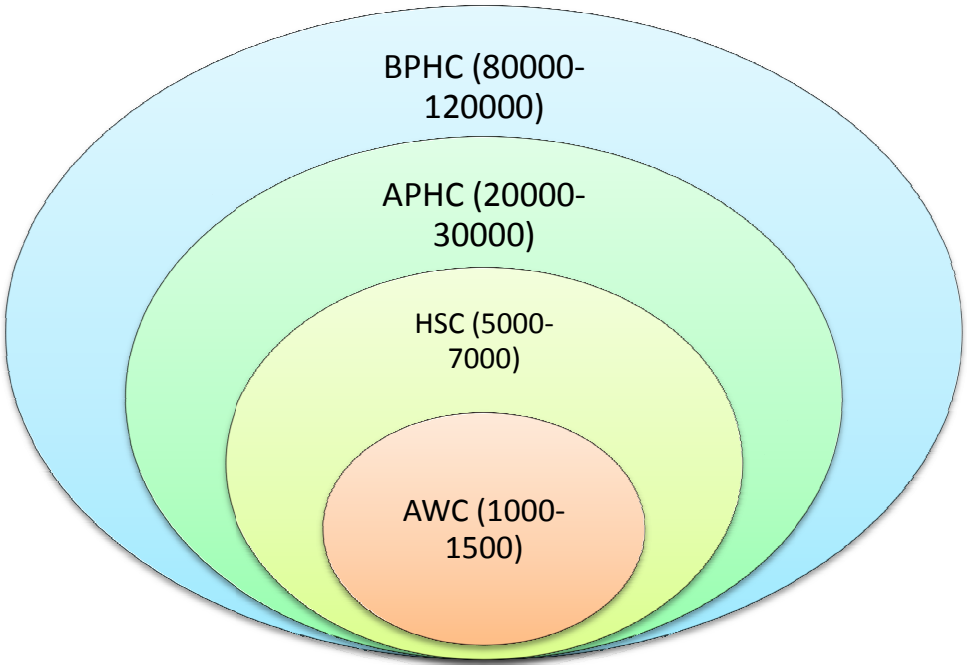
Population Stabilisation

Every year about 74000 children are born. The total no.of Family Planning operations has increased from 15058 in 2009-10 to 16051 in 2010-11.



Health Infrastructure Status

Health Institutions	Present
Medical Colleges	01
Sub-Divisional Hospital	01
Referral Hospital	02
Primary Health Centre	18
Additional PHC	41
Sub-Centre	261



INFRASTRUCTURE:

Introduction:

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.

1. **Infrastructure for HSCs:**

IPHS Norms:

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

1 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.

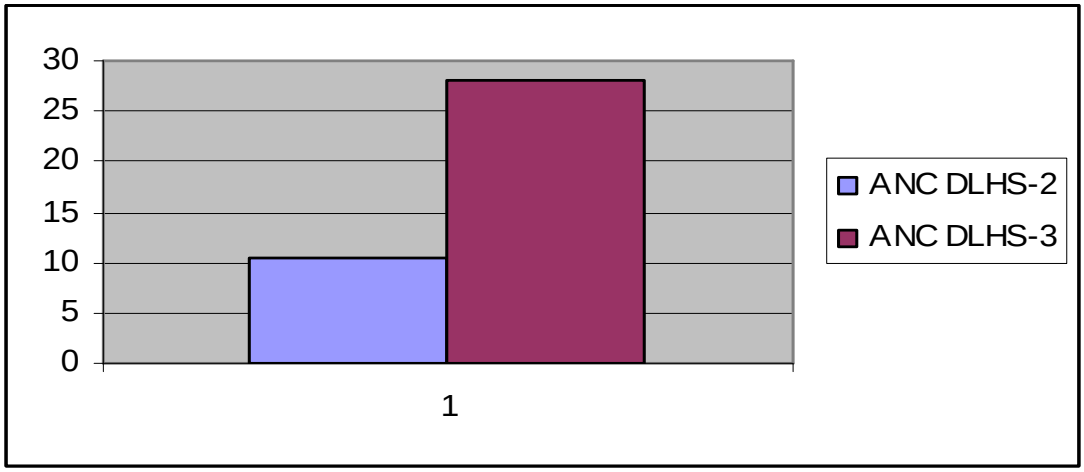
For selection of village under the Sub Centre, approval of Panchayats as may be considered appropriate is to be obtained.

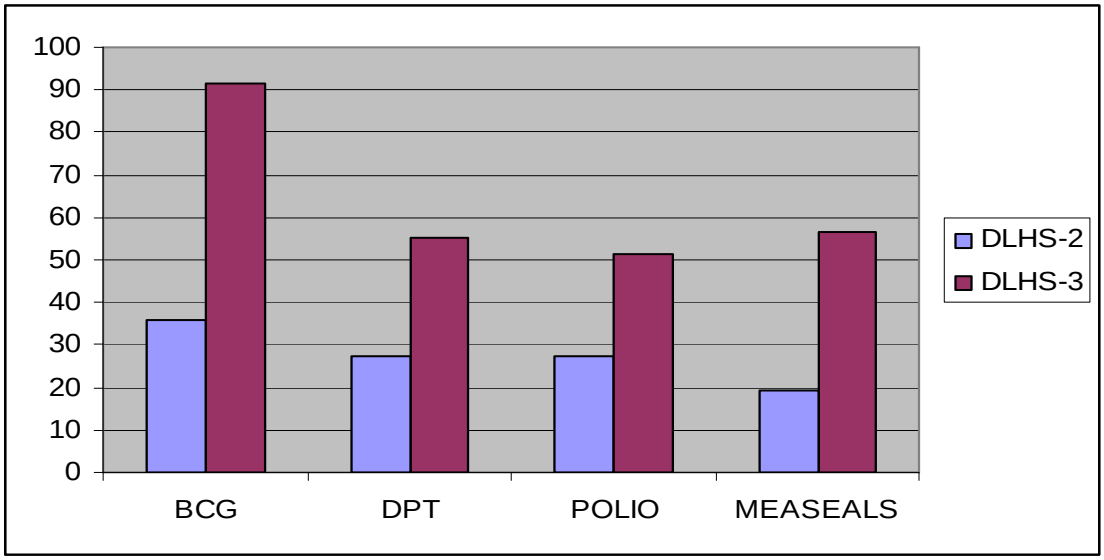
The minimum covered area of a Sub Centre along with residential Quarter for ANM will vary from 73.50 to 100.20 sq mts. depending on climatic conditions(hot and dry climate, hot and humid climate, warm and humid climate), land availability and with or without a labor room. A typical layout plan for Sub-Centre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

Services of HSCs:

As per IPHS norms a sub center provides interface with the community at the grass root level providing all the health care services. Of particular importance are the practices packages of services such as immunization, ANC, NC and PNC, prevention of malnutrition and common childhood diseases, family planning services and counseling. They also provide elementary drugs for minor ailments such as ARI, diarrhoea, fever, worm infestation etc. And carry out community need assessment. Besides the above the government implements several national health and family welfare programs which again are delivered through these frontline workers.

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 41.8%. And BCG coverage of the district is 91.5%. 3 doses of polio vaccine is 52.5%, 3 doses of DPT vaccine is 55.4% and Measles Vaccine is 72.3%. The coverage of Vit A supplementation for the children 9 months to 35 months is 63.2 percent.





Sub Heads	Gaps	Issues	Strategy	Activities
Service performance	20%Unutilized untied fund at HSC level	Operationalization of Untied fund.	Capacity building of account holder of untied fund	1.Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs 3. Hiring a person at PHC level for managing accounts
	Very few ANC at HSC level	Improvement in quality of services like ANC, NC and PNC, Immunization	Strengthening one 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 18.2% PW registered in first trimester PW with three	Improvement in quality of services like ANC, NC and PNC, Immunization and	1.Phase wise strengthening of 39 HSCs for Institutional delivery and fix	1 Gap identification of 39 HSCs through facility survey 2. Eligible Couple Survey

	ANCs is 29%, TT1 coverage is 71.94%, Family Planning Status: Any method-31.8% Any modern method-30.4% No sterilization at HSC level IUD insertion -4% Pills-1% Condom-3% Total unmet need is 30.3%, for spacing-18.5,	family planning	a day for ANC as per IPHS norms. 2. Community focused family planning services	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
	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.

			Lack of Cleaner	Recruitment of Cleaner through RKS on Contract
	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 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 VHSCs 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.
Human Resource Lack of proper reporting from field	Reporting	Strengthening of reporting system	1.Training to the field staffs in filling up HMIS Format,form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports & HMIS report etc 2.Printing of adequate number of reporting formats and registers 3. Hiring consultants to develop softwares for reporting. 4.Establish data centre at APHC which will monitor all HSC

. Manpower Management in the health sector has been undertaken vide various initiatives like re-organizing & rationalizing the existing manpower, ensuring power to transfer doctors delegated to Civil Surgeons, Web enabled system to capture district level cadre in formation, appointment of 71 contractual doctors done, dynamic ACP being rolled out, cadre modified for doctors, cadre rules notified for paramedics and health educator, OT assistant, clerks, pharmacists, lab technicians, X-ray technicians cadre rules to be finalized soon, and draft publication readied for x-ray technicians, OT assistants and clerks.

PHC

	Gaps	Issues	Strategies	Activities
Human Resource	As per IPHS norms each PHC requires the following clinical staffs General Surgeon Physician Gynecologist Pediatrics Anesthetist Eye surgeon As per IPHS norms each PHC requires the following para medical support:(List attached) But the actual position is Nurse midwife 777/468 Dresser 12./21 Pharmacist/compounders 11/21 Lab technician18./21 Ophthalmic assistant 6/18 Demotivated BPMU staffs	staff shortage Untrained staffs	Staff recruitment Capacity building	1.Selection and recruitment of Doctors 2.Selection and recruitment of ANMs/ male workers 3.Selection and recruitment of paramedical/ support staffs 1.Training need Assessment of PHC level staffs 2.Training of staffs on various services 3. Trainings of BHM, BCM and accountants on their responsibilities. 4. Trainings of BHM on implementation of services/ various National program programs.

APHC

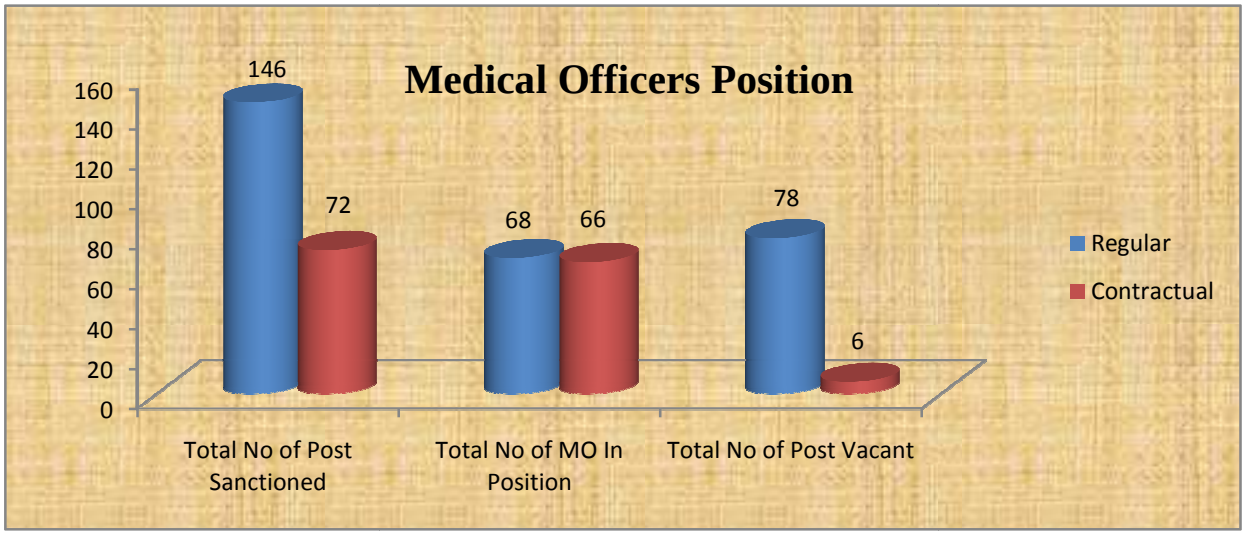
	Gaps	Issues	Strategies	Activities
Human Resource	Out of 41 all APHCs have doctors, 20 don't have A grade nurse.	Filling up the staff shortage Untrained staffs	Staff recruitment	1.Selection and recruitment of .Doctors/Grade A nurse/ANMs 2.Selection and recruitment of male workers
			Capacity building	3. Sending back the staffs to their own APHCs.
	Hospital campus, lacks adequate number of trainers, staffs and facilities Most of the APHC staffs are deputed to respective PHCS hence APHCS are defunct		Strengthening of ANM training school	1.Training need Assessment of APHC level staffs 2. Training 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

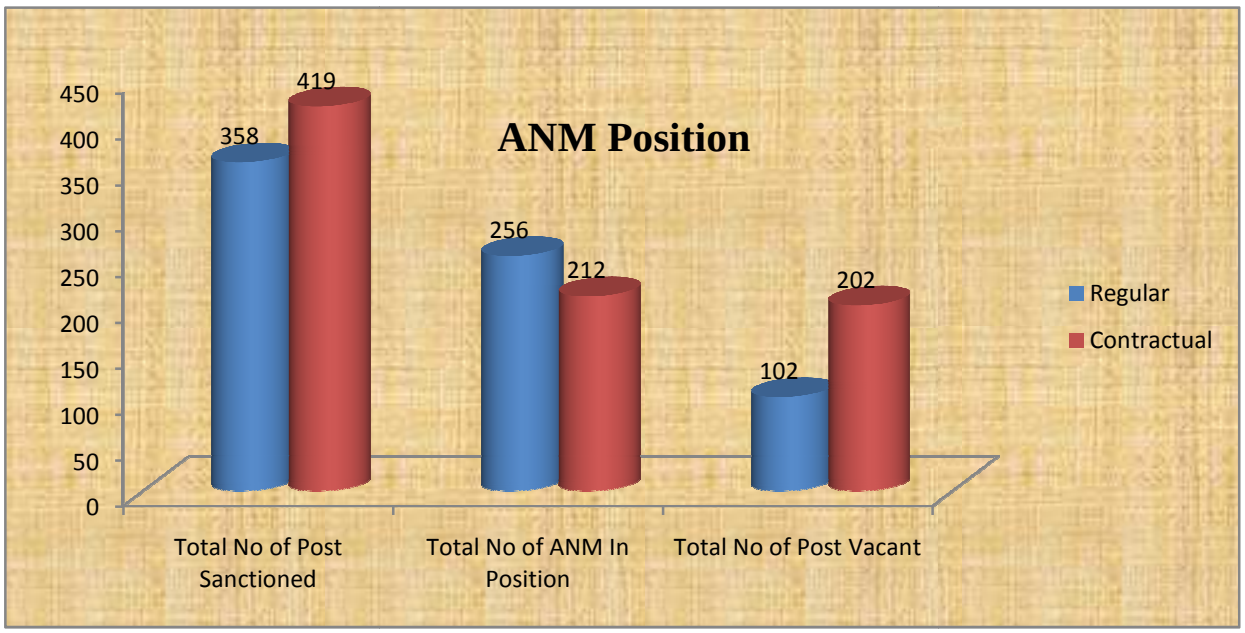
HSC

Sub Heads	Gaps	Issues	Strategy	Activities
Human Resource	1. Out of 261 HSCs 15. don't have either ANMs or Male worker, 2.Out of 25 sanctioned post of LHVs only 16 are placed	Filling up the staff shortage	Staff recruitment	1.Selection and recruitment of ANMs 2.Selection and recruitment of male workers
	1. Out of 468 ANMs 148 Are trained on different services.	Untrained staffs	Capacity building	1.Training need Assessment of HSC level staffs 2.Training of staffs on various services
	Lacks adequate number of trainers, staffs and facilities	Training	Strengthening of ANM training school	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

Current Status of Manpower

Medical Officers	:	68
Contractual Doctors	:	71
Staff Nurses	:	24
ANM	:	256
ANM-R (Contractual)	:	212
Health Managers	:	18
Block Accountant	:	18
Block Community mob	:	15
Hospital Managers	:	02
ASHA Health worker	:	3530



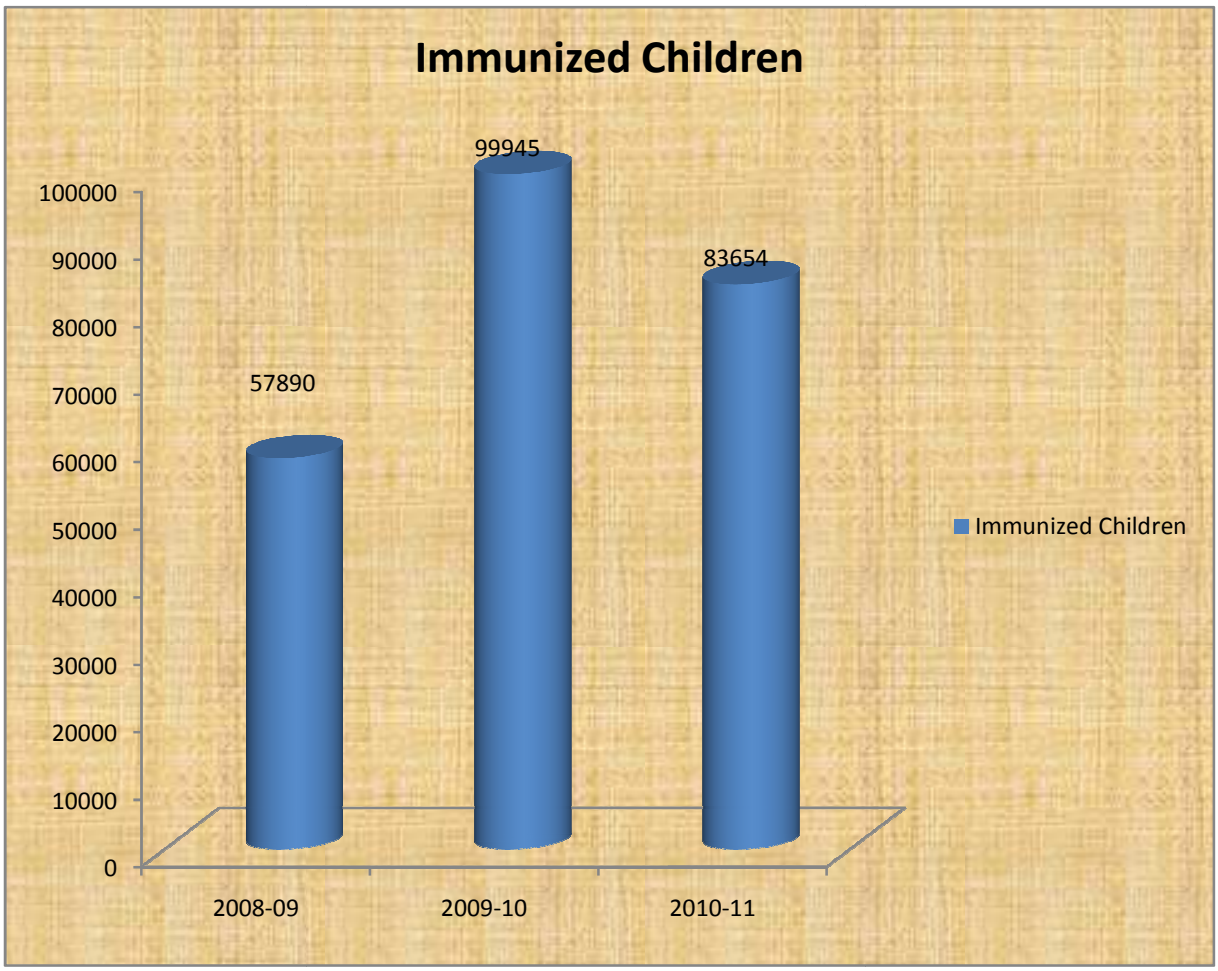


Source: DHS Darbhanga Report.

Child Health

Immunisation, Full Immunization coverage has increased from 46496(2007-08) to 57890(2008-09) and finally 99945 in 2009-10. Under Immunisation, various initiatives were introduced like alternate vaccine delivery(Couriers) for reaching vaccines site. 3-rounds of Mobile Hard-to-reach RI campaigns were conducted in early 2006 to reach communities which hitherto never had access to RI services. The Year **2006** was declared as **Immunization year** and Wednesdays and Fridays were designated as immunization days.

Furthermore in October 2008, ***Muskaan ek Abhiyaan*** was launched which included initial survey and tracking of Pregnant and Newborn till full immunization is achieved and realized partnership between ICDS and Health at all levels. There are twice weekly sessions at HSC and AWC and performance-based incentive schemes for Health Workers and Mobilisers was introduced under the scheme.



Referral transport

A pilot project was launched in Patna under PPP for Emergency transport. It started in Darbhanga in the month of Sept 2010. The basic facilities that are being provided are – Drugs, Oxygen, Heart monitor, ventilator and other Supportive Medical System.This facility is known by MMU. All this at a very low cost chargeable to the patient @Rs.300/- and additionally free/lowerrates are charged from the poor patients. The agency operating the facility is paid a monthly fee for the service. On calling 108, it's service is ensured within 15-20 minutes. This is a scheme which has provided a visible face to NRHM in Darbhanga district and has added to the good will of the Health Department.

Radiology Facilities

7 PHCs have been given to agency to operate, maintain and generate X-ray films. Space has been provided against nominal rent. It functions under the overall supervision of the Hospital Management Society (RKS) of the respective Hospital.

Ultra-Modern Diagnostic facility

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

Blood Storage Unit (BSU)

Three Blood Banks have been proposed for each two FRUs and SDH respectively. . Equipments for Blood Storage Centres have been supplied to both FRUs and SDH. These FRUs are Manigachi and Jalley and SDH is Benipur.

Bedsheets-Cleanliness Initiative

Different Coloured Bed sheets are being ensured per day in each PHCs and FRUs. Promotion of Handloom Industry by procuring only handloom bed sheets for this purpose has also been ensured. There is concept of satrangi chadar for each PHC and the bed sheets are being changed accordingly.

Hospital Maintenance

Maintenance of hospital premises, Generator Facility, Cleanliness of Hospitals, Washing etc is being ensured through private partners in each PHC.

Institutional Arrangements and Organizational Development

Along with Health department the ICDS, PHED and Panchayat are helping in implementing the NRHM Programme. The coordination has been placed at District level, Block Level and Village Level. At the Grass root level linkage between ASHA, ANM with AWW has been strengthened especially under the Muskaan programme. NGO has taken up the training of ASHA.

trainings are being regularly conducted under different programmes in the district. The district has already started the trainings of IMNCI.

The District is trying to operationalise 2 ANM schools.The District has a unique system of collecting data from each PHC level. It has established a data centre in the DHS and has centres in all PHCs. These data centres collect data from each PHC through mobile phone and feed in the computer. The computerized data is later given to the respective Programme Officers.

Financial Management

Government of India's funds are released to the district through two separate channels, i.e; through the District budget and directly through the State Health Society. Further the Department's outlay for the procurement of vaccines, drugs, equipments etc; is spent centrally and assistance to the District has been in the form of kind.

To decentralise the process, SHSB undertook the task of ' Allocation of Funds for Districts for FY 2011-12' for all the components of NRHM-RCH Flexible Pool (A), Mission Flexipool/Additionalties (B), RI and Pulse Polio (C) & Disease Control Programmes (D). The District Programme Officers were assigned the task of allocating funds for the complete year to the districts based on the unit cost and requirement of the district. The annual fund allocation was done for all the programmes which were grouped under Part A, B, and C & D. The DPMU team was then called at the State Headquarter level for a workshop and they undertook the exercise of **allocating the funds for the four quarters.**

District's Concern Strategies

The District has achieved some progress in terms of output indicators, however the maternal mortality, child mortality and population growth continues to be a cause of serious concern to the District's development efforts. In terms of key health indicators Darbhanga is among the well performing Districts.

Though the District fares reasonably well in terms of its Infant Mortality Rate (52) as against the national average (48) and NMR (35) as against national average of 33, it continues to be among the poorer performing districts in terms of TFR and MMR. Moreover, floods in some parts of the district make the district vulnerable to communicable diseases. Besides, the health infrastructure is inadequate to cater to the needs of the people and the upkeep of the already existing facilities is quite challenging. The delivery of services could only be improved if facilities are within reach and have minimum basic physical infrastructure to provide the basic services. There seems a major challenge in construction of the health care facilities. Lack of clear guidelines sometimes delays the process.

Human resource is another major issue where the District health system is struggling. The scaracity of medical professionals especially the Specialists limits the public health facilities in providing much required higher level o f care to the needy. A mismatch exists in the District between the available Medical and Para medical professionals and the demand for their services. More medical graduates and Para medical professionals are required to fill up this gap.

Moreover despite number of trainings held, rationalization of manpower is yet to take place. To overcome this, the District has initiated public private partnerships, outsourcing health facilities and programmes to private sector and NGOs, contracting specialists for specialized care, etc. There is also dearth of well- trained public health professionals and managers to effectively steer the public health and family welfare programs.

Another issue which the District is encountering is a declining sex ratio. Several initiatives like advocacy, intensive IEC programs and enforcement of PNDT is aimed at reversing the existing sex ratio is being initiated this year.Besides, some other initiatives are planned this year in areas like promotion of Breast feeding, PNDT etc.

Quality Assurance committees in the districts should be formed as per Quality Assurance Manual of GoI. District Quality Assurance committee work will be to monitor and evaluate different programs from time to time such as Family Planning, JBSY etc.

Maternal Health

Improving the maternal health scenario by strengthening availability, accessibility and utilization of maternal health services in the District is one of the major objectives of RCH. However, the current status of maternal health in the District clearly shows that the programme has not been able to significantly improve the health status of women. There has been a little improvement & we need to improve a lot.There are a lots of issues that affect maternal health services in Darbhanga.

The important ones are listed below:

Shortage of skilled frontline health personnel (ANM) to provide timely and quality ANC and PNC services. The public health facilities providing obstetric and gynecological care at district and Sub-district levels are inadequate. Mismatch in supply of essential items such as BP machines, Weighing scales, safe delivery kits, Kit A and Kit B, etc and their demand. Shortage of gynecologists and obstetricians to provide maternal health services in peripheral areas. Inadequate skilled birth attendants to assist in home-based deliveries. Weak referral network for emergency medical and obstetric care services.

Lack of knowledge about ante- natal, pre-natal and post natal care among the community especially in rural areas. Low meanage of marriage resulted in pregnancy and difficult deliveries. Low levels of female literacy results in unawareness about maternal health services. High level of prevalence of malnutrition (anemia) among women in the reproductive age group. Poor communication because of bad roads and a poor law and order situation.

Introduction of JBSY acted as a major boost to improving maternal health. Under the Scheme institutional delivery has substantially increased, and there has also been a shift in deliveries from Medical College Hospital to PHCs, thus easing the load on the Medical College Hospital. There has been an increased utilization o f ANC services which also led to high coverage o f PNC, zero dose polio, BCG. However, the minimum two day stay post delivery is not adequately ensured and there are delays in payments to beneficiaries.

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

Child Health

The child health indicators of the district reveal that the District's IMR is lower than the national average. Morbidity and mortality due to vaccine.-Preventable diseases still continues to be significantly high. Similarly, child health care seeking practices in the case of common childhood diseases such as ARI and Diarrhoea are not satisfactory. The child health scenario is worse for specific groups of children, such as those who live in rural areas, whose mothers are illiterate, who belong to Scheduled Castes, and who are from poor households is particularly appealing.

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

Family Planning Services

The Family Planning programme has partially succeeded in delaying first birth and spacing birth rates under 20 years of age and to children born less than 24 months after a previous birth.

Child Health Service

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

IMNCI Training: IMNCI training has successfully started in the District where training is given to ANM and AWW regarding management of neonatal and childhood illness.

VHSND- Village Health Sanitation and Nutrition Day is a very good platform for child health care services at Anganwari Centres

Nutritional Rehabilitation Centres is operational wherein special nutritious food is provided to the severely malnourished children. Severely malnourished children along with their mother are kept in NRC for 20 days in general. Here mother is given compensation against loss of wages.

Population Stabilisation

RCH emphasizes on the target-free promotion of contraceptive use among eligible couples, the provision of various contraceptive methods (including condoms, oral pills, IUDs and male and female sterilization), and the assurance of high quality care. It also encourages the spacing of births with at least three years between births.

Furthermore, certain groups such as rural, illiterate, poor, and Muslim women within the population have even higher fertility than the average. The persistently high fertility levels point to the inherent weakness of the District's family planning programme as well as existing socio - demographic issues. High TFR is reflected by a dismal picture of women in Bihar marrying early, having their first child soon after marriage, and having two or three more children in close succession by the time they reach their late-20s. At that point, about one-third of women get sterilized.

Very few women use modern spacing methods that could help them delay their first births and increase intervals between pregnancies Major issues affecting the implementation of the Family Planning programme in Darbhanga district are as follows:

Six Nursing homes are accredited to conduct Family planning operations. Accredited Private Nursing homes are expected to conduct more than 10 thousand family planning operations in the District. 16051 sterilizations conducted till march 2010 of which approximately 6000 are conducted by the accredited private Nursing Homes **.**

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

The District has quality assurance committee for family planning. These private facilities are monitored by the QAC on sterilization conducted in the facilities.

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 District. 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.

Commencement of puberty is usually associated with the beginning of adolescence. In some societies, adolescents are expected to shoulder adult responsibilities well before they are adults; in others, such responsibilities come later in life. Although it is a transitional phase from childhood to adulthood, it is the time that the adolescents experience critical and defining life events – first sexual relations, first marriage, first childbearing and parenthood. It is a critical period which lays the foundation for reproductive health of the individual's lifetime. Therefore, adolescent reproductive and sexual health involves a specific set of needs distinct from adult needs.

Reproductive health needs of adolescents as a group has been largely ignored to date by existing reproductive health services. Many adolescents in India face reproductive and other health risks. Poor nutrition and lack of information about proper diets increase the risk of iron-deficiency anemia for adolescent girls. (as high as 68.3% as per NFHS 3). Young women and men commonly have reproductive tract infections (RTIs) and sexually transmitted infections (STIs), but do not regularly seek treatment despite concerns about how these infections may affect their fertility.

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

Underlying each of these health concerns are gender and social norms that constrain young people – especially young women's access to reproductive health information and ser vices. Motherhood at a very young age entails a risk o f maternal death that is much greater than average, and the children of young mothers have higher levels of morbidity and mortality.

Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting sexually transmitted diseases, including HIV/AIDS; and they are typically poorly

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

In the District there was lack of a cohesive ARSH strategy at the District level and was introduced in 2009-10 Plan, however the strategy requires sensitization and handholding at all levels for proper implementation. The current school health program has adolescent oriented interventions.

Health Infrastructure Status

Health institutions	Required	present	Shortfall
Medical Colleges	1	1	**0**
District Hospital	0	0	**0**
Sub-Divisional Hospital	0	1	**0**
Community Health Centre	0	0	**0**
Primary Health Centre	0	18	**0**
Additional PHC	73	36	**37**
Sub-Centre	**600**	**261**	**339**

Darbhanga district has 18 PHCs and out of these 18 PHCs some needs to be upgraded into CHC. All the 36 APHCs except 2 (Adharpur & Kansi), provide only OPD services and have to be operationalised for meeting in-patient needs and for providing delivery services, so that the load of Block PHCs is reduced. Half of the HSCs are running from the rented place or Panchayat office and are mannaged by one ANM only.

Infection Management and Environmental Plan:

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

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

The District has identified agencies for undertaking the task of Bio-Waste Management and Treatment but necessary approval and clearance from Bihar District Pollution Control Board and Central Pollution Control Board is still awaited. Development forms one of the key components of the overall architectural corrections envisaged by NRHM. Government of Bihar also has spelt out the same as the number one priority.

Quality of training - Monitoring cell has been constituted at the District level in District Institute of Health & Family Welfare. The trainings are being monitored at regular intervals.Low mo tivational level o f health staff - The motivational level of health staff at all levels is low. Continuous communication and feedback by District 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. E.g. The government has taken up on priority the placement of the trained EMoC and LSAS doctos to the FRUs where there is no such facility. Poor monitoring and evaluation framework – Regular monitoring visits by programme officers.

In 2009-10, there has been a continuous focus on the capacity building of the existing manpower in the District. 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 o f training in some centres, training fell behind schedule. It is proposed to continue these trainings in 2010-11. In addition, the District wide training on Immunization for Medical Of ficers, IPC skills for Breast feeding and basic training o f neonatal resuscitatio n- shall also be taken up for various levels.

Ensuring Gender Equity

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

Gender discrimination continues throughout the life cycle, as well. Women are denied access to education, health care and nutrition. While the District's literacy rate is 47.5%, that for women in rural areas is as low as 30.03%. Abysmally lo w literacy levels, particularly among 3 women in the marginalised sections of society have a major impact on the health and well being of families. Low literacy rate impacts on the age of marriage. The demand pattern for health services is also low in the poor and less literate sections of society.
Women in the reproductive age group, have little control over their fertility, for want of knowledge of family planning methods, lack of access to contraceptive services and male control over decisions to limit family size. According to NFHS data, for 13% of the births, the mothers did not want the pregnancy at all. Even where family planning methods are adopted, these remain primarily the concern of women, and female sterilization accounts for 19% of FP methods used as against male sterilization, which is as low as 1%. In terms of nutritional status too, a large proportion of women in Bihar suffers from moderate to severe malnutrition. Anemia is a serious problem among women in every population group in the District and is more acute for pregnant women at 60. 2%.

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

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

Current System of drug, equipment, services and supplies

Procurement in decentralised manner with rate contracts fixed centrally by SHSB District officials directly place orders to the concerned entities using a cash and carry system Positive steps taken by DOH, GOB for improving procurement function: Transfer ring the procurement function to Bihar District Health Society which provides flexibility in functioning Guidelines for rate contracts are revised from time to time to make them more prudent and if one analyses the guidelines from initial rounds to current rounds, several points have been included to increase the transparency DoH has prioritised strengthening Warehouse Infrastructure in districts and funds have been sanctioned for construction of new warehouses Adoption of GOI's GFR to make system transparent and procedures simple for procurement by District level entities.Rate contracting and cash and carry system introduced by SHSB, resulting in increase in availability of drugs at facility level manifold and has further resulted in increase in patient using District run health facilities.

All procurement related information starting from advertisement to evaluation to final decision are posted on SHSB website, making the entire system transparent DoH keen to establish an independent procurement agency o n lines of TNMSC Issues that the present suffers from – Absence of detailed and transparent guidelines for technical evaluation of bid s by SHSB results in delayed evaluation process and leads to litigations by disqualified bidders. For a number of drugs the rates are not fixed because of limited or even no bidders Rates of drugs pro cured by SHSB are much higher than other Districts like MP and TN- due to perceived high level of corruption in the District, which results in time taken for finalisation of rate contracts and due to non-surety of the quantities to be supplied to allow the bidders to take economies of scale into account

No proper systems for drug procurement planning, demand assessment, indenting and supply of drugs at district and lower level health facilities-resulting in supply of drugs on an adhoc basis without a clear relation to actual demand No standard systems for record keeping at district and facility levels which results which results in a lack of re-conciliation of indents and actual supplies; difficulty in compiling actual stock availability at any particular point of time; difficulty in placing orders based on stock availability; and problems ensuring old stock is cleared first, once the new supplies come. Infrastructure and staff capacity (both in numbers and qualification) available at district and facility level stores remain weak, as a result of which it becomes difficult to manage the supply chain and inventory management efficiently and effectively. Due to absence of central rate contracts for a no. of drugs, the level o f local purchase of drugs by district officials remains as high as 20-30% of the district budget value. Since at district level mostly branded drugs are purchased, their cost is higher than drugs bought through centrally fixed rate contracts. Systems put in place for quality testing of drugs remain under -utilised due to a lack of capacity for monitoring and supervision. There is no system for quarantine o f supplies and most of the time the onward supply is made before receipt of the quality testing reports.

Also , where local purchases are made, quality testing of drugs is minimal. For equipments and services, the supply remains top driven and there are no proper mechanisms for demand assessment. Lack of skills at SHSB level to define detailed specification for equipments and lack of capacity at facility level to inspect the supplies also impact the procurement process. As for service contracts, in the absence of properly defined benchmarks and specifications it becomes difficult to monitor the quality o f services being delivered. There is also limited capacity within district officials to monitor the activities of different service providers, which results in provision of either sub-standard or no services at all.

There is huge requirement for physical infrastructure to be put in place at lower levels – construction activities thro ugh BCD or is directly outsourced by DHS, depending o n the nature of work. However both these organisations lack in capacity to carry out the scale of work that is required. PRI structure remains weak-open to fraudulent practices and lack of transparaency in functioning. Proposed Strategy- Establishment of Autonomous Procurement Agency Strengthen Demand Assessment and Supply C hain like development o f formats and forms for indenting and record keep ing, bu ilding capacity o f concerned officials in use of new formats District level Procu rement reforms like implementation o f Bihar District Transparency and Accountability Act (like in AP, TN) with clearly defined roles for PRIs and CSO; setting up of Bihar District Procurement Oversight Body for community monitoring Procurement Act A big leap has been taken in 2009-10 in the field of Procurement concerning Maternal and Child Health equip ments and drugs. One of the key achievements has been the finalization of rate contract for the District owned Sick Newborn Care Unit and Neonatal Stabilization Units, Labour room equipments and of quality hosp ital beds. In addition, rate contracting o f some important drugs like Misoprostol has also been ensured.

HMIS and Monitoring & Evaluation

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. In order to facilitate this process a structure right from the village to the national levels with details on key functions and financial powers is already proposed under NRHM. To capacitate the effective delivery of the programme there is a need for a proper HMIS system. In Bihar under NRHM there is lack of Proper monitoring and evaluation framework.

Regular monitoring and timely review of the NRHM activities should be carried out. The quality of HMIS in some blocks are very poor. Reporting and recording of RCH formats (Plan and monthly reporting) are irregular, incomplete, and inconsistent and few blocks are not reporting on time at all. Formats are not filled up completely at the sub center level. There information is not properly reviewed at the PHC level. No feed back is provided upon that information.

Behaviour Change Communication

The District does not have any comprehensive BCC strategy. In District PIP 2012-13 we have asked for 1 IEC consultant who will be responsible for the BCC activity in concerned District. 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 o f 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 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 ASHAs as per GoI norm. Adolescent councelors are placed in each district fro m District AIDS Control Society. The Health department is looking to cooperate with them by giving training to these councilors for implementing ARSH programme. The District PWD Department has taken care of the construction o f Health Department. All the construction activity for Health Institutions under NRHM has already been handed over to the PWD department.

PPP

Acceptance of Private Partners of district level has increased drastically and they are performing excellent in health programme specially family planning. We have accrediated 8 registered private hospital for Family Planning operation. Also as being ensured by Civil Surgeon, regular meetings should be held with the private partners to ensure that their performance is being maintained and that the obstacles being faced by the private partner is removed. Initially in the year 2008-09 the family planning operation was around 8000 which has now increased up to 12000 in the year 2012-13.

NRHM PART- A
RCH Flexible Pool
2012-13

RCH II Programme Objectives and Strategies

Vision Statement:

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

- Facilitate increased access and utilization of quality health services by all.
- Forge a partnership between the Central, District and the local governments.
- Set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.
- Provide an opportunity for promoting equity and social justice.
- Establish a mechanism to pro vide flexibility to the Districts and the community to promote local initiatives.

It also aims at developing a framework for promoting inter-sectoral convergence for promotive and preventive health care

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Technical Objectives, Strategies & Activities

1 Maternal Health

Goals: Reduce MMR from present level 312 (SRS 2007-08) to less than 100.

Objectives:

1. To increase 3 ANC coverage from 26.4% to 45% by 2009-10 and to 75% by 2011- 12. (DLHS3).
2. To increase the consumption of IFA tablets for 90 days from pr esent level of 9.7% to 20% by 2009-10 and to 35% by 2011- 12. (DLHS-3)
3. To reduce anemia among pregnant mothers from 60.2% to 52% by 2009 -10 and to 40% by 2011-12.
4. To increase institutional delivery from 70% to 76% by 2009-10 and to 85% by 2011 -12 (MIS data)
5. To increase birth assisted by trained health personnel fro m 31.9% to 45%. (DLHS-3).
6. To increase the coverage of Post Natal Care from 26% to 40% by 2009-10 and to 55% by 2011-12. (DLHS-3).
7. To reduce incidence of RTI/STI cases .
8. To reduce the no of unsafe abortions.

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

Objective No. 1: To increase 3 ANC coverage from 26.4% to 45% by 2009-10 and to 75% by 2011-12.

Strategies and Activities:

1.1. Institutionalization o f Village Health and Nutrition Days (VHND)
1.1.1 In collaboration with ICDS, such that the Take Home Ration (THR) distribution and ANC happens on the same day.
1.1.2 This will require minor changes in the microplans o f Health and I CDS.

1.1.3 Policy decision and appropriate guideline under convergence between Health and ICDS needto happen as a priority.
1.2 Improved Access o f ANC Care.
1.2.1 Provision for Additional ANMs in each Sub Centres (Refresher Training to ANMs on Full ANC to improve the quality o f ANC)
1.2.2 Setting up of New Sub Centres to cover more areas
1.2.3 Strengthening of Health Sub Centres
1.2.4 Repair and Renovation o f Sub Centres
1.2.6 Provide equipments like BP Apparatus, Weighing machines, Heamo globinometer etc to the Sub Centers.
1.2.7 Timely supply o f Drug Kit A and Kit B
1.2.8 Generate Awareness for ANC Service.

1.2.9 Convergences meeting with AWWs, ASHAs, PRI Members, NGOs at the Gram Panchayat

Objective No . 2: To increase the consumption of IFA tablets for 90 days from present level of 9.7% to 20% by 2009-10 and to 35% by 2011-12. (DLHS-3)

***Strategies and Activities*:**

2.1 Purchase and Supply o f IFA Tablets(now RCH Kits are available)
2.1.1To include IFA under essential drug list
2.1.2Timely supply o f IFA Tablets to the Health Institutions (Ensuring no stock out of IFA at ever y level down to Sub-Centre Level)
2.1.3 District to purchase IFA tablets in the case of stock out .
2.1.4 Convergence with ICDS and Education for regular supply of I FA tablets through AWWCs .And Schools for the pregnant and lactating women, children 1 -3 years and adol escent girls.
2.2 Awareness generation for consumption of IFA Tablets .

Objective No.3: To reduce anemia among pregnant mothers from 60. 2% to 52% by 2009- 10 and to 40% by 2010-11.

Strategies and Activities:

3.1 Supplementing IFA tablets consumption with other clinical strategies.
3.1.1 Half yearly de-worming of all adolescent girls.
3.1.2 Training of ANM, AWW and ASHA on module on EDPT (Early Diagnosis and Prompt Treatment) of anemia.
3.1.3 Activities for consumption o f IFA tablets as per Objective No. 2
foodstuff.

Objective No. 4: To increase institutional delivery from 70% to 76% by 2009-10 and to 85% by 2011-12(MIS data) and to increase facilities for Emergency Obstetric Care (EmOC)

***Strategies and Activities*:**

The strategies will lead to up gradation and operationalization o f the facilities to increaseinstitutional deliveriees along with providing EmOC and emergency care of sick children. These failities will also provide entire range of Family Planning Services, safe MTPs, and RTI/STI Services.
4.1.4 Repair and renovatio ns of FRUs
4.1.5 Appointment o f Anesthetist, O&G specialist, Staff Nurses at the FRUs
4.1.6 Incentivise the conduct of C section at FRUs @ Rs 1500 per C section for the staff involved at
the FRUs.
4.1.7 Accreditation of FRUs
4.2 Operationalization of 24x7 facilities at the PHC level

4.2.2 Appointment o f at least 3 Staff Nurse in each PHCs
4.2.3 Repair and renovation o f PHCs
4.2.5 Availability of and timely supply of medical supplies and DDK & SBA kits
4.2.5 Training of MOs, Staff Nurses on SBA
4.3 Increase beneficiary choice for institutional deliver y through I EC campaign complimented by network of link workers working on incentive basis for each institutional delivery achieved
4.3.1 Strengthening JBSY Scheme

1. Improving quality: Infrastructural support to high burden facilities to avoid 'early discharge' following institutional deliveries
2. Mapping of high burden facilities and proving them support for matching infrastructural up gradation to increase the hospital stay fo llowing delivery.
3. Identifying districts and blocks and communities within them, where the awareness and reach of JBSY scheme is poor and to ensure increased service utilization in these areas .

4.3.2 Design and implement an IEC campaign focusing on communicating the benefits of institutio nal deliver y and benefits under JBSY scheme.
4.3.3 Equip the ASHA network to reinforce the IEC messages through IPC interventions at village / community level.
4.3.4 Provide incentives to ASHA for every institutional delivery achieved in her village /designated area.
4.3.5 Involvement of PRIs for JBSY scheme to monitor and generate awareness for institutional delivery.
4.4 Provision of Referral Support system.
4.4.1 Provision of a dedicated referral transport system for the newborns and pregnant women to refer them from ho me/HSC s/PHCs to referral centers. Lack of Blood Storage Units in the PHCs make things complicated during emergency hence in FRUs blood storage units has been proposed. Operatio nalising of at least one Blood Storage Units in each FRUs is proposed as per IPHS guidelines.

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

***Strategies and Activities*:**

5.1 Ensure safe delivery at Home
5.1.1 Provision of Disposable delivery kits with ANMs and LHVs - Establishing full proof Supply Chain o f the DD Kits
5.1.2 Training of ANMs on SBA

1. Providing SBA with approved drug kits, in order to deal with emergencies, like post-partum hemorrhage, eclempsia, and puerperal sep sis
2. Ensuring regular supply of these drugs to the SBA

5.1.3 Supply of adequate DD Kits to ANMs, LHVs.
5.2 Provision of delivery at HSC level
5.2.1 Supply of DDkits to HSCs
5.2.2 Delivery tables to be provided to the HSCs

Objective No.6: To increase the coverage of Post Natal Care from 26% to 40% by 2009-10 and to 55% by 2010-11. (DLHS- 3).

Strategies and Activities:

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

6.1.1 Refresher sessions for all ANMs on uniform gidelines to be followed for PNC care – all delivery cases to remain at facility for minimum 6 hours after normal delivery and to be recalled to facility for check up with 4 days and after 42 days.
6.1.2 Ensuring follow up PNC care through out reach services (ANM) for delivery cases where the patient does not return to facility for follow up check ups.
6.1.3 Referral of all complicated PNC cases to FRU level.
6.1.4 LHV and MO to monitor and report on PNC coverage during their field visits .
6.2 Utilizing the ASHA network to strengthen the follow up of PNC services through tracking of cases, mobilization to facilities and providing IPC based education / counseling.
6.2.1Utilize ASHA to ensure 3 PNC visits by the ANM for home delivery cases meetings o f MSS and during VHND.

objective No.7: Reduce incidence o f RTI/STI

Strategies and Activities:

7.1 Ensuring early detection through regular screenings and contact surveillance strategies.
7.1.1 Early diagnosis o f RTI / STI through early detection of potential cases through syndromic approach and referral by ANM and ASHA.
7.1.2 Conducting VDRL test for all prenant women as a part o f ANC services.
7.1.3 Implementing contact surveillance of at risk groups in convergence with District AIDS Contro Society.
7.2 Strengthening the infrastructure, service delivery mechanism and capacity of field level staff for handling of RTI / STI cases.
7.2.1 Conducting community level RTI / STI clinics at PHCs .
7.2.2 Training to all MOs at PHC / DH level in Management o f RTI / STI cases in coordination with District AIDS control Society.
7.2.3 Training of frontline staff, LHV, ANM and ASHA in identifying suspected cases of RTI / STI in coordination with District AIDS Control Society.
Objective No. 8 –Reduce incidence of unsafe abortio n
Strategies and activities
8.1 Early diagnosis of pregnancy using Nischay pregnancy testing kits.
8.2 Counselling and proper referral for termination of pregnancy in 1st trimester if the woman wishes so .
8.2.1 Training of MOs and Nurses/LHV in MTP (MVA)
8.2.2 Procurement and availability o f MVA at the designated facilities.

Safe Abortion Services

The causes of maternal death are multiple. Women die because complicatio ns during labour and delivery go unrecognized or are inadequate managed. They die because o f complications arising early in pregnancy, late pregnancy or even after delivery. Achieving the Millennium Development Goal of improved maternal health and reducing maternal mortality requires actions on all these fronts.

Globally, approximately 13% of all maternal deaths are due to complications of unsafe abortion and in absolute number there are 67,000 women die due to unsafe abortion. An estimated 46 million pregnancies end in induced abortions each year. Nearly 20 million of these are estimated to be unsafe.

In India, unsafe Abortion contributes 8% o f total maternal deaths but there is a big regional variance. In EAG Districts, the total % o f maternal deaths due to unsafe abortion is 10 (source:*Causes of maternal deaths from 2001-03. Special Survey of Deaths*).In Darbhanga district, It is estimated that 14,289 induced abortion take place per year (*Source: Ipas;*

Calculated based on latest population and birth rates (CBR) . Two third of these Induced Abortion are carried out in unsafe conditions in illegal manner and hence not reported. Under the MTP Act 1971, MTP up to 20 weeks in an approved facility by a registered service provider is legal. The provisions of the act is an attempt to make the services of Safe abortion available to women but the progress so far has not been satisfactory. Hence the NRHM framework recommends for providing safe abortion services in all health facilities starting from the Medical College hospital to the PHC level.

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

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Strategy

- To provide and improve safe abortion services at all the health facilities starting from Medical College Hospital to PHCs.
- To increase the number of approved MTP sites and service providers in private sector .
- To sensitize and make the community as well as the service providers aware about the provisions of MTP act and services of safe abortion .

2. Child Health

Goal: Reduce ***IMR*** from 48 to less than **30**.

Objectives:

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

2. To increase exclusive breast feeding from 38.4% to 50% by 2009-10 and to 75% by 2011 -12.

3. To reduce incidence o f underweight children (up to 3 years age) from 58.4% to 50% by 2009-10 and to 40% by 2011- 12.

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

5. To reduce the prevalence of anaemia among children from 87.6% to 77% by 2008-09 and to 60% by 2011-12.

6. To increase full immunization of Children from 41.4%% to 60% by 2009-10 and then to 70% by 2011-12.

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

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

Strategies and Activities:

1.1 Convergence with I CDS, supp lementary d iet which is being g iven by AWW to pregnant mothers may be improved.

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

1.1.2 Joint Monitoring by Block MOICs with CDPO for implementation of the scheme.

1.1.3 Vitamin A supplementation

Objective No. 2: To increase exclusive breast feeding from 27.9% to 35% by 2008-09 and to 50% by 2011-12

Strategies and Activities:

2.1 Use mass media (particularly rad io) to promote breastfeeding immediately after birth (colostrum feeding) and exclusively till 6 months o f age.

2.1.1 Production and broadcast of radio spots, jingles, folk songs and plays promo ting importance of correct breastfeeding practices.
2.1.2 Production and broadcast of TV advertisements and plays on correct breastfeeding practices.

2.1.3 Publication of newspaper advertisements, booklets and stories on correct breastfeeding practices
2.2 Increase community awareness about correct breastfeeding practices through traditional media.
2.2.2 Involve frontline Health workers, Aaganwadi Workers, PRIs, TBAs, local NGOs and CBOs in promoting correct breastfeeding and complementary feeding through IPC, group meetings, folk media and wall writing.
2.2.3 Educate adolescent girls about correct breastfeeding and complementary feeding practices through school -based awareness campaign.

Objective no 3 To reduce incidence of underweight children (up to 3 years age) from 58.4% to 50% by 2009-10 and to 40% by 2011- 12

Strategies and Activities:

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

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

Strategies and Activities:

4.1. Strengthen institutional facilities for provision of new born care .
4.1.1. It is planned to develop a model for comprehensive care of the newborn at all levels, from District to the community leve

MODEL FOR COMPREHENSIVE CARE OF NEWBORN

District Level	Neonatal Stabilization Unit
PHCs Level	Newborn Care Corner
Village Level	IMNCI trained worker, community initiatives

FACILITIES FOR PHC LEVEL: NEONATAL STABLIZATION UNIT

NEONATAL STABILIZATION

- Adequate warming through radiant heat source.
- Facilities for Resuscitation with self inflating resuscitation bag and well fitting neonatal face masks (at least two sizes).
- Medicines of essential newborn care

1. Supply of bucket type/spring type n weighing machines to all sub centres and Anganwadi centres .Many times new borns 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.

2. Pediatrician will be appointed on contract basis .
3. Training of MOs on Pediatrics
4. Training of MOs, Staff Nurses on Facility Based New Born care
5. Training and operationalization cost will be borne by the UNICEF.

3. Population stablisation

Objective No.1 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 addressin g 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 co ndoms 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.

Objective No2: To increase proportion of male sterilizations from 0.6% to 1.5%.

2.1 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 completed the procedures, 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)

2.1.1 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 member so the community about their experience and the benefits of NSV. These meetings will be repeated each month in the same batch o f Gram Panchayat or ADC Villages. NSV will be conducted o n the motivated men. The same men will then be requested to share their experiences in the next batch o f five villages for the next three months

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2.2 Increase capacity for NSV services.

2.2.1 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.

2.2.2 Organize NSV camps at the District Level.

Objective No. 3: Monitor the quality of service as per GoI guidelines for Sterilization .

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

3.2 Streamline the contraceptive supply chain & Monitoring

a. Identificatins &Renovation of Warehouse – District /District/ PHC

b. Budget allocation for transportation at every level

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

4. Adolescent Reproductive and Sexual Health

Objective:

1. To reduce incidence of teenage pregnancies from present 23% to 20% by 2009 -10 and to 13% by 2010-11.
2. To ensure the access to information on Adolescent Reproductive & Sexual Health (ARSH) through services at District Hospitals, SDH, CHCs, PHCs & HSC level.
3.To increase awareness levels on adolescent health issues

Objective No .1: To reduce incidences of teenage pregnancies from present 23% to 20% by 2009-10 and to 13% by 2011- 12.

***Strategies and Activities**:*

1.1 Improve access to safe abortions

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

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

1.2 Ensure availability of condo ms/OCPs/Emergency contraceptives
.
1.2.1 Depot holders among ado lescent groups/youth organizations.In addition to the ASHA and the AWW, youth organizations such as football clubs and o thers will havedepot holders who will provide condoms/OCPs and Emergency contraceptive pills and maintain confidentiality.

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

Strategies and Activities

2.1.Organize regular adolescent clinics/counseling camps at SC/PHC/CHC/SDH/DH .
2.1.1 Appointment of 5 nos. Adolescent Counselor for districts setting up Ado lescent clinics.
2.1.2 Adolescent health sessions/clinics will be held in each Sub Centre/ PHC / CHC/SDH and DH with service delivery & referral support .
2.1.3 Risk reduction counseling for STI/RTI
During the monthly or weekly interactions through health sessions and clinics, counseling for preventing STI/RTI will be also be done. This will include single partner sex and use o f condoms for safe sex.
2.2 ASHA/AWW to act as nodal persons at village level for identifying & referring adolescents in need of such services.

2.2.1 Training of AWW/ASHA in adolescent health issues All ASHAs and AWWs will be oriented on problems faced by adolescents, signs and symptoms of the problems and where to refer these cases.
2.3 Referrals to de-addiction centers for treating alcoholism/drug addiction
2.3.1Identification of de-addiction centers in the district .

The District / district will identify NGOs or other de-addiction centres in the District and through the health workers will refer the cases in need to these centres for treatment.
2.3.2 Circulate information on services provided at these centres and setup referral system.The District/district will have an understanding with the de addiction centre on the process for referring patients to the de-addiction centres.

Proposed Strategies and Activities for Operationalization of ARSH

1. ARSH service delivery through the public health system:

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

   b). Fixed day, fixed time approach could be adopted to deliver dedicated services to adolescents and newly married couples. A fixed day across the District, either once a month or twice a month can be declared for ARSH, and the information regarding the same should be properly disseminated in the community and properly displayed at the facilities.

   C) .A separate ARSH Cell, comprising of ANM, LHV,Health Educators etc. (perhaps on a rotatory basis) can be established at these Cells
   .
   d.) A separate ARSH Cell can be constituted at every CHCs and Referral Units, with one MO as its nodal officer (on call, sort of) and two counselors.

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

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

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

Innovations

1. Muskan Programme

The District has started a New Programme called MUSKAAN Programme to track pregnant women and New Born Child. Under this programme ASHA, AWW and ANMs jointly track the pregnant mothers and New Born Child.
This programme was launched in October 2007. Under this programme ASHA, AWW and ANM will hold meeting with Mahila Mandals in AWWCs. The main objective is to cover ANC coverage and Immunizatio . A Data Centre also placed in all the 18 PHCs to monitor this programme.

After the introduction of this programme it has been seen that the coverage of ANC and Immunization has increased.

2. Family friendly Hospital certification

Background

Access to public health services in Bihar has witnessed tremendous improvement since the inception of National Rural Health Mission.

Definition

A Family friendly Hospital is a health care facility where the practitioners who provide care for women and babies adopt quality practices that aim to protect, promote and support activities conducive for the health of mother and baby viz; antenatal care, safe delivery, exclusive breastfeeding of neonate,and postnatal care in an enabling environment
.

Procedure for certification

Once the concept note and the certification format is approved by the Executive Director and Health Secretary, Sensitization of the key stakeholders in the SHS and directorate of Health services will be ensured. This is followed by Creation of a **support group** consisting of public health experts,NHSRC, development partners, representatives from SHS, CMO/ACMO of the concerned district. A single member from a team will be identified who will provide constant support and guidance to the institutions aspiring to get certified.

3. Community based Maternal and Infant Death Review (Verbal Autopsy)

The verbal autopsy is a technique whereby family members, relatives, neighbors or other informants and care providers are interviewed to elicit information on the events leading to the death of the mother during pregnancy in their own words to identify the medical and non medical (including socio -economic) factors for the cause of death of the mother.

The main purpose of the CBMIDR is to identify the various delays and causes leading to maternal deaths, to enable the health system to take corrective measures at various levels.

Identifying maternal deaths would be the first step in the process, the second step would be the investigation of the factors/causes which led to the maternal death – whether medical, social, systemic, and the third step would be to take appropriate and corrective measures on these, depending on their amenability to various demand side and communication interventions.

The District will be the unit for undertaking Community based MIDR. The District nodal officer for MIDR 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.

The district nodal officer will be responsible for convening a district level review committee meeting, organizing necessary documentation for review by the committee and keeping a record of follow up actions initiated. District nodal person could be the RCH officer, Deputy CMO, or some other district level programme manager.

As a first step in implementation, all MOs will orient ASHAs in scheduled monthly meetings about line listing of all deaths of women in the age group of 15-49 yrs irrespective of cause or pregnancy status and a line listing o f all infant deaths in the chosen PHC area. Line listing format as given in the annexure would need to be explained and adequate copies should be made available in the local language for ASHAs to report to the nearest PHC she is attached to.If possible this can be incentivized and required resources can be reflected in the PIP.

Once the report reaches the concerned PHC, Medical officer I/C will designate a LHV/BPHN or ANM to further investigate and conduct a verbal autopsy. The designated person may be required to make 2-3 visits to the deceased women's house in order to collect complete information. It is proposed that such investigations should be completed within a fortnight of receiving information from ASHA. These visits should be made to the house as per the convenience of respondent/s.

Medical Officers should undertake orientation of nursing staff designated to undertake verbal autopsy in data collection.The standard guidelines, modules and the questionnaires would be used to undertake the verbal autopsy. At district level, the maternal death review committee should be constituted under the chairpersonship o f Distrct Health Society. Specific terms of reference for this committee could include the following:

- To review VA records for maternal deaths in the district.
- To draw inferences on causes / circumstances leading to each maternal death in the district.
- To get additional information w.r.t. institutions where maternal death took place.
- To review progress on addressing specific programmatic elements to prevent deaths in future.

4. YOGA- *The Art Of L:ife*

Yoga is the symphony of India. It is an ancient science which leads to healthy body, peaceful mind, joyful heart and liberated soul .The word Yoga is associated with "MEDITATION".

We all have come to a stage where one cannot rely exclusively on medication. To reduce stress in both personal as well as private life and to regain lost health, or to maintain it, we all nowadays are increasingly falling on yoga, which in true sense is helping us a lot. The benefits one can have through Yoga are many. The most important thing in practicing Yoga is that it doesn't cost anything, it just requires time and hence available for each classes of society.

Doing Yoga regularly gives us greater control on our body and mind. Yoga can be performed anywhere anytime, but it has to be done under the supervision of a trained person otherwise it could have adverse effect.

Keeping in mind the importance of Yoga we too need one Yoga trainer in our District .
Yoga trainer will be paid an honorarium of Rs.10,000(Ten thousand only) per month.
So total budget for this head will be **Rs. 10,000 * 12 months = Rs 1,20,000(One Lac twenty thousand only).**

5. Nai Pidhi Swasthya Garentee Karyakram

This programme is running on full flaged basis in our district and we have given health cards to more than 70% of children as well as adolescent girls falling under this programme.

6. Community Based Planning and Monitoring Scheme

Community Based Planning and Monitoring Scheme has been implemented as a pilot project in Darbhanga district covering 2 blocks named Baheri and Singhwara each having 5 panchayats with 30 villages.

7. Drug and Equipment warehouse

Since there is scarcity of space in our office specially in terms of drug and equipment warehouse so there is an urgent need of a big store room where medicines and equipments can be kept properly.For this district needs sum of rupees 20 Lakhs.

8. **Training building with atleast 3 big halls**

Training load in district has increased manifold. Every day there are numerous training programs. Since there is not a single room for carrying out different training programs.Hence one training building with at least three big rooms are required for this purpose.

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Infrastructure and Human Resource

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

1. As per RCH Programme operationalisation of 2 first Referral Unit to provide emergency obstetric and newborn care 24hrs a day / 7 days a week. There are 2 operational FRUs in Darbhanga district.

2. One APHC will be upgraded from each block & in this context 2 APHCs have been upgraded this year.

3. Several Hscs has also been taken in proposal for upgradation as well as construction.

4. Newbon Care is already established in 11 PHCs.This further needs to be established in rest 7 PHCs, 2 FRUs & 1 SDH..

Institutional Strengthening

For HRD, training of 10 regular Government doctors is being proposed in Public Health for improving their administrative skills. Further more it is proposed that for Multiskilling of Doctors they can be sent to hospitals like Safdarjung etc in New Delhi for continuing medical education.

Sub- centre rent shall be pro vided for 20% of the HSCs operational.

Quality Assurance

The District has Quality Assurance Committee for Sterilisation. Ouality assurance committee has 4 members. These members are ACMO, Civil Surgeon, DPM and one gynecologist.Further there is instruction from state for building more Quality Assyrance Committee.

Training

Successful Implementation of any programme depends on the capacity building of the personnel engaged. In RCH II also human resource base will be created by enhancing the capacities through training .The sensitization of health personnel towards various RCH interventions is one of the major focus o f the capacity building initiatives under RCH - I I . Various trainings will be provided to Block and district level managers, medical officers, nursing staff, ANMs, AWWs, ASHA and others.

Different types of training are;

Anaesthesia Training – LSAS Training.

Medical Officers' Training on SBA (BEMoC Training) ---Ten days training

Follow up training on SBA--- two days.

Medical Termination of Pregnancy (MTP) Training.

Cold chain training

Regular Immunization Training

IMNCI Training.

HMIS Training.

CPSM Training.

Mini lap Training & many more……..

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IEC/BCC

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

Appointment of ***Consultant-IEC*** at district level. IEC should be done for different programs such as-

Maternal Health

IFA/anemia
Institutional delivery
Birth preparedness and referral transport promotion

Child Health

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

Adolescent health

IFA/Anemia
HIV prevention

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

Inter Personal Communication, counseling by trained functionaries supported with various social mobilization and mass media activities will be built into communication plan for each program under NRHM.

ICC /BCC can be done either through *Mass Media* or through *Interpersonal* Communication.

1) Mass Media: Radio, television, newspaper, magazine, tin plate, bus panel, wall painting, wall writing, glow shine board etc can be used as one of the effective medium for mass media.

2) Interpersonal media: Anm, ASHA, AWW, medical officers, other health staffs, PRI members and any other volunteer can be used as medium for Interpersonal communication.

3) Community Media: Workshop, Fair (Mela), Stall organization, Folk drama, Nukkad natak, Magic show, Puppet show, Video show, AV film show, Community

meeting (with SHG, influencers, opinion leaders, PRI, youth), Health Camps and other health related activities / functions will be organized in District from time to time to expand reach of different programmes. Folk Media will also be used as a tool for publicity. Health related Posters/Banners will be displayed at entire District.

4. Campaigns: Campaing on different aspects of health can also solve the problem of ICC/BCC by bringing awarness among community regarding different programs such as

1. **Safe motherhood**
2. **Child Survival & development**
3. **Breastfeeding**
4. **Health emergencies**
5. **Family Planning**
6. **Routine Immunization**
7. **PPP and others.**

Procurement of equipment/Instrument and drug supplies

Delivery Kits at HSC/ANM/ASHA

Medical equipment &accessories: Disposable Delivery Kits consisting of the following items:

(1) Four pieces Gauze (F11) 14x16 cm, folded 4 times each;

(2) Stainless steel blade;

(3) Cotton pad

(4) Two pieces of strong thread each 25 cm);

(5) Small bar of soap;

(6) 4 pieces cotton (IP) 2.5 sq. inch each;

(7) Plastic sheet 60x60 cm.

SBA Drug Kits with SBA-ANM/Nurses

1 Misoprostol Tablet 200 µg

2. Oxytocin Injection

3 Magnesium Injection

4. Gentamycin Injection 80 mg

5. Ampicillin Capsule 500 mg

6. Metronidazole Tablet 400 mg

7. Veinflow 20 G

8. IV set

9. Disposable needles

10 (a). Syringes 5 ml

10 (b). Syringes 10 ml

Sanitary Napkins for adolescent

Instrument for ANM In Hscs

1. Stethoscope

2. B. P.Instrument (Air blood instrument Non-Mercurial sphygmomanometer)

3. Weighing Machine weighing capacity of 10 Kgs)

4. Weighing Machine Square Model (120 Kgs)

Procurement of ICU Equipment

1 Bed Side Monitor

2 Defibrillator

3 Syringe Pump

4 ECG Machine

5 ICU Ventilators

6 Air Fumigator

7 Suction Machines

8 Laryngoscopes

9 Nebuliser

10 Glucometer

11 Air Viva (Ambu Bag)

12 ICU Bed

13 Bed Side Lockers

14 Medicine Trolley

15 Transfer Trolley

16 Three Fold Stand

17 X-Ray View Box

Programme Management

Programme management arrangements have been made at district and block level. The entire NRHM at district level(DISTRICT HEALTH SOCIETY)is governed by Hon'ble District Magistrate and Civil Surgeon is the member secratory. At block level medical officer incharge is the Chairperson.

The objective of District Health Society is to provide additional managerial and technical support to programmes which includes RCH –II, General Curative Care, National Disease Control Programme and AYUSH. At district level we have DPMU(District Program Management Unit) where as at Block level we have BPMU(Block Programm management unit). Financial powers of the bodies/office bearers have been clearly defined in the Society's Financial Rules and Bye-Laws.

District Health Society

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 at District level Societies 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 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 fr om time to time including mechanism for intra and intersectoral convergence of inputs and structures. The DHS has it's o wn Governing body with the District Magistrate as the Chair man and Executive Body with the Civil Surgeon as Chair man.

District unit (DPMU)

DPMUnit consists of following personnel:-

1. District Programme Manager
2. District Accounts Manager
3. District M & E Officer
4. District Planning Co-ordinator
5. District Community Mobilizer
6. District Data Assistant

Block Unit (BPMU)

Block Programme Management Unit consists of following personnel-

1. Block Health Manager
2. Block Accountant
3. Block Community Mobilizer

Financial Management

FUND FLOW MECHANISM IN DISTRICT

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

OPERATION OF BANK ACCOUNTS

The Account of District Health Society is being operated as per the delegated powers. The persons authorized as per the powers delegated to them are also operating the bank accounts of DHS.

ACCOUNTING PROCEDURES FOLLOWED

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

FI NANCIAL MANAGEMENT AT DISTRICT

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

New Financial System was introduced in 2009. The purpose for introducing this new system was-

- De-centralisation o f Resources and Power to the blocks and below
- Transparency in the Fund allocation
- Need based fund allocation
- Better utilization of funds
- Better Fund Accountability of the Districts and PHCs

Convergence and Co-ordination

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

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

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

Monitoring and Evaluation

One of the major weaknesses of the RCH program in Bihar is the absence o f 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. A triangulated process of Monitoring and Evaluation would enable cross checking and easy collection, entry, retrieval and analysis of data.

Main Activities

A. Health Management Information System

1). HMIS at block level
2) HMIS at District level.

B. Data Centre at District Level & Block Level and SMS based Mobile Data Centre at Blocks.

A. Health Management Information System (HMIS)

As we know that NRHM aims to continuously improve and refine its strategies based on the input and feedback received from the block and from various review missions. One of our priorities is to strengthen the Health Management Information System (HIMS) in the Block and to use it for improving the quality of data for planning and programme implementation at each level.

NRHM has introduced revised HMIS formats for each and every level.
Ministry of Health & Family Welfare, Govt. of India have launched the Health MIS (HMIS) Portal (http://nrhm-mis.nic.in .) on 21October 2008 with a view to place NRHM related information in the public domain. NHSRC, New Delhi has also introduced HMIS Portal (http://bihar.nhsrc-hmis.org)

Flow of Data through HMIS in Darbhanga District

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

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

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

Flow of data from HSCs, APHCs

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

HMIS Training

HMIS training should be given to all the below mentioned :-

01. CS
02. ACMO
03. DPM
04. DAM
05. District M & E Officer (DA)
06. District Planning Coordinator
07. District Community Mobiliser
08. District Level other Programme Officer s/Consultants
09. MOIC
10. MO
11. BHM
12. BAM
13. BCM
14. Health Educator
15. ANM (Regular & contractual)
16. Grad- 'A' Nurse
17. LHV Operators

Synergie with NRHM Additionalities

NRHM is an effort to bring about rationalization of resources and simultaneously to augment the limited resources so that equity in health is ensured. The similar efforts under NRHM-

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

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The convergence approach which was mooted earlier now finds a clear policy initiative and procedural development by health and all health determinants sectors so that a joint effort is made in tandem from planning to impact evaluation / outcome to ensure investments in health reach the poor /unnerved/underserved/excluded segment of the population.

These common efforts would also strengthen gender equity through adolscent and other initiatives of both RCH & NRHM to provide a safety net to young women and girl children.

Sustainability

The usage of government services in Darbhanga district has certainly picked up with number of patients increasing manifolds due to free drugs and availability of doctors at PHC level. Similarly there has been an unprecedented increase in number o f deliveries being conducted at government health facilities under Janani Baal Suraksha Yojana. This can be largely attributed to huge influx of funds under NRHM.

To hedge the growth from lack of funds and for its sustainability Government of Bihar has already applied user charges for referral transport services. The ambulance user charges are being determined by Rogi Kalyan Samitis.

For sustainability of manpower, incentives have been proposed forspecialist services and for postings in rural areas in this Programme Implementation Plan. Government has finalized Dynamic ACP and Cadre division of doctors for providing them better benefits.Private parties are also being encouraged to make investments in Health sector so that the sector doesn't become dependent on NRHM funds.

NRHM PART- B FlexiblePool/Mission Additionalities(2012-13)

Decentralization

For effective decentralization in principle as well as practice, health societies have been established at all levels of the healthcare delivery structure. Systematic involvement of various stakeholders at all levels through these societies has helped make healthcare delivery responsive to the needs of the people via participatory planning and removal of bottlenecks at implementation levels

District Health Society provides overall guidance and supervision for effective planning and implementation, and also coordinates activities across the board. The District Health Mission, the Governing Body and the Executive Committee meet at regular intervals and take decisio ns regarding all matters. District level activities are taken care of through the District Health Society.

Rogi Kalyan Samitis at APHCs, PHCs, FRUS and SDH have been set up..The formation of societies under NRHM has given a new direction to management and overall functioning of the health department towards the achievement of its goals.

ASHA

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – 'ASHA' or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA is trained to work as an interface between the community and the public health system.

A total number of 3530 ASHAs have been selected out of 3550 so far. The ASHAs are given the copies of each module (Hindi version) and reading material in the form of flip charts for their better understanding and also dissemination of key health messages among villagers.

ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services and she will provide her service mainly under the fo llowing heads-

The compensation package of ASHA

Programme & Relevant Task	***Amount of Compensation***
1. ***Delivery and Full Immunization o f the New Born*** Woman	RURAL AREA-@Rs. 600/-(100(Registratio)+ Janani & Bal Suraksha Yoyna For Institutional 200(Transport)+ 300(B.C.G)) Pregnant URBAN AREA- @ Rs. 200 (100-Registration+100 B.C.G)
2. ***Mobilizing all the children of the village for***	5 to 10 Children = 50/- 11 to 15

Immunization(Under Muskaan Ek Abhiyaan) to be given to ASHA	Children = 100/- *16 to 20 Children* = 150/- 20 to …. Children = 200/-
3. ***Providing DOTS underTuberculosis Control Program***	Rs 250 per patient.
4. ***For identifying Patient of Leprosy and accompanying him/her to PHC***	@ Rs. 300/- P. B cases (Only Rs. Three hundred) Per Patient- Rs. 100 on confirmation of Disease and Rs. 200 on completion of treatment @ Rs. 500 M.B. cases per patient- Rs. 100 on confirmatio n of Disease and Rs. 400 on completion of treatment
5*. Training*	T.A. Per Training (To & Fro) @ Rs. 100/- (Only Rs. Hundred Per Training @ Rs. 115/- (Only Rs.

	Hundred
6. ***To participate in ASHA Divas organized at PHC***	Per Meeting (Rs.86) ASHAs and 15 for refreshment)
7. *For motivating for Sterilization*	@ Rs. 150/- (Only Rs. One hundred Fifty) on Completion of Surgery
8. *For motivating client for vasectomy/ NSV* Two	@ Rs. 200/- (Only Rs. hundred) on Comp letion of Surgery
	@ Rs. 200/- (Only Rs. Two**9.** For 6 no. home visits under HBN and IMNCI hundred) on Comp letion of the 6 th visit
9. *National Blindness Control Programme*	@ Rs. 175/- per Cataract Patient oper ation and staying till operation Rs.100/-For Bringing Kalazar Patient to the Hospital

Untied Fund for Health Sub Centre, APHC and PHC

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

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

- Cover minor modifications to sub center -curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level.
- Adhoc payments for cleaning up sub center , especially after childbirth, transport of emergencies to appropriate referral centers.
- Purchase o f consumables such as bandag es in subcenter.
- 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 fo r certain identif ied activ ities.
- 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 o f emergencies to appropriate referral centre.

Total budget under untied fund in darbhanga district is:

Untied Fund for Revenue village is Rs. 10,000 per revenue village..

Untied Fund for Sub-centre is Rs. 10,000 per sub centre.

Untied Fund for APHCs is Rs 25000 per APHC

Untied Fund for PHC is Rs 25,000 per PHC

ANM of the concern Hsc is the secretory whereas PRI member is the chairperson of this committee. Untied fund account is being operated by the joint signature of secretory as well as chairperson. Untied fund for PHC is operationalised through Medical officer incharge of the concern block.

Village Health and Sanitation Committee

Government of Bihar has decided to merge "*Village Health and Sanitation Committee*" with "*Lok Swathya Pariwar Kalyan and Gramin Swaschata Samiti"* constituted by Department of Panchayati Raj in Bihar .

There is one VHSC at each revenue village .Each revenue village has one VHSC account @ Rs .10,000. ANM of the concern Hsc is the secretory whereas PRI member of the concern revenue village is the chairperson of this committee.Untied fund account is being operated by the joint signature of secretory as well as chairperson. So if a panchyat is having say 3 or 4 revenue villages then concern ANM of panchyat will be secretory for all those VHSC account.

Darbhanga district has 963 revenue villages. Out of these revenue villages 915 have VHSC account. Very soon by the end of this financial year 12-13 we will have 100% VHSC account in our district.

Rogi Kalyan Samiti

Initially RKS was operational at SDH, Refferal units & PHCs. Today it is functional at all APHC level.

Aims and Objectives
The objectives of the RKS is :

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

Functions of the RKS

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

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

2. RKS- SDH 01
3. RKS-Referal 02
4. RKS-PHC 18
5. RKS-APHC 41

INFRASTRUCTURE PLAN

Primary Health Centers:(30 bedded)			
Gaps	**Issues**	**Strategy**	**Activities**
All PHCs are running with only six bed facility. At present 12 PHC are working with average 30 delivery per day, 2 inpatient Kala-azar, and 140 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms. • 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 area of improvement. Lack of equipments as per IPHS norms and also under utilized equipments. Lack of appropriate furniture Non availability of HMIS formats/registers and stationeries 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	Available facilities are not compatible with the services supposed to be delivered at PHCs. Quality of services Community participation.	Upgradation of PHCs into 30 bedded facilities. ISO certification of selected PHCs in the district. Strengthening of BMU Ensuring community participation. Strengthening of Infrastructure and operationalization of construction works	1.Need based (Service delivery)Estimation of cost for upgradation of PHCs 2.Preparation of priority list of interventions to deliver services. 1.Selection of any two PHCs for ISO certification in first phase. 2. Sending the recommendation for the certification with existing services and facility detail. 1. Ensuring regular monthly meeting of RKS. 2. Appointment of Block Health Managers, Accountants in all institutions 3. Training to the RKS signatories for account operation. 4. Trainings of BHM and accountants on their responsibilities. 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. **3.Strengtheing of PHCs** 1Rennovation 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 form

Gaps	Issues	Strategy	Activities
A. Out of 261 HSCs only 39 are having own building			A**Strengtheing of HSCs having own buildings**
B. In existing 39 buildings 16 are in running comparatively in good condition,	In adequate facility in constructed building and lack of community ownership	Enhance visibility of HSC through hardware activity by the help of community participation .	B.1.White washing of HSC buildings. B.2.Organize adolescent girls for wall painting and plantation./hire local painter for colure full painting of HSC walls. List out all services which is provided at HSC level. On the wall. B.3.Gardening in HSC premises by school children.
C.No one building is having running water and electric supply.			C. Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental.
D. Lack of equipments and ANM are reluctant to keep all equipments in HSC . E. Lack of appropriate furniture	. Operational problem in availability of equipment in constructed HSC		D.1.Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/) D.2. Purchase of equipments according to services Purchase one almirah for keep all equipment safely and it could be keep in AWW / ASHA house.
1.Non payment of rent of HSCs	1.Non payment of rent	Regularizing rent payment	**3B. Strengthening of HSCs 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 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
1. The district still needs 158 more HSCs to be formed.	1. Land Availability for new construction 2. Constraint in transfer of constructed building		**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 in 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 2. Regular monitoring of HSCs 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	1.Community ownership	Strengthening of VHSCs, PRI	1.Formation and strengthening of VHSCs, Mothers committees, 2.“Swasthya Kendra chalo abhiyan” to strengthen community ownership 3.Nukkad Nataks on Citizen’s charter of HSCs as per IPHS 4.Monthly meetings of VHSCs, Mothers committees

Additional PHC:				
Sub Heads	**Gaps**	**Issues**	**Strategy**	**Activities**
Infrastructure	1.The district altogether need 109 APHCs but there are 36 APHCs functioning in the district . 2. 73 more are proposed to be established. 3.Out of 36 APHCs only 19 are having own building 4.Non payment of rent of APHCs for more than three years Lack of equipments, Non availability of HMIS formats/registers and stationeries 5. PHCs doesn't have boundary walls resulting PHC Premises Safe heaven for Astray animals and trespasser	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 VHSCs, PRI and formation of RKS Strengthening of Infrastructure and operationalization of construction works in Three phase Monitoring	1."Swasthya Kendra chalo abhiyan" to strengthen community ownership 2.Nukkad Nataks on Citizen's charter of APHCs as per IPHS 3. Registration of RKS 4.Monthly meetings of VHSCs, Mothers committees and RKS **A.Strengtheing of APHCs having own buildings** A.1 Prioritizing the equipment list according to service delivery A.2 Purchase of equipments A.3 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 t he month of April 09. B3 Prioritizing the equipment list according to service delivery B4 Purchase of equipments as per need B5 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 APHC buildings C4. Meeting with local PRI

				/CO/BDO/Police Inspector in smooth transfer of constructed APHCs 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 VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 4.4 Monthly Meeting of one representative of VHSC/Mothers committees on construction work.

Upgrading Sub- Divisional Hospital as per IPHS

Darbhanga district has one SDH in Benipur which needs to be upgraded. According to IPHS norms it should be upgraded as 100 bed hospital.we have budgeted for this in our current DPIP.

3. *Upgrading First Referral Unit as per IPHS*

Darbhanga district has two FRUs which needs to be upgraded. According to IPHS norms it should be upgraded as 60 bed hospital. These FRUs are

a) Manigachi Referral hospital
b) Jalley Referral Hospital.

According to IPHS norms there should be one blood bank at each unit. Pathology as well as Radiology facility should be there. New borne corner (NBC) is an essential element for a well functioning FRU. We have budgeted for this in our current DPIP

4. *Upgrading Doctors as well as Nurses quarter as per IPHS*

According to IPHS norms all residential quarters (Both of Medical Officers as well as Nurses) needs to be upgraded. They are not in a condition for residing purpose. This is the first and fore most thing which needs deep attention.

Contractual Manpower

Programme management arrangements have been made at district and block level. The entire NRHM at district level(DISTRICT HEALTH SOCIETY)is governed by Hon'ble District Magistrate and Civil Surgeon is the member secratory. At block level medical officer incharge is the Chairperson.

The objective of District Health Society is to provide additional managerial and technical support to programmes which includes RCH –II, General Curative Care, National Disease Control Programme and AYUSH. At district level we have DPMU(District Program Management Unit) where as at Block level we have BPMU(Block Programm management unit).

The District has already established Block Programme Management Unit in all the Block PHCs. Each BPMU consists of One Block Health Manager and One Accountant. It has been observed that after the establishment of BPMUs the implementation of National Programmes has been managed efficiently and getting improved results. Financial powers of the bodies/office bearers have been clearly defined in the Society's Financial Rules and Bye-Laws.

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 intersectoral 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 unit (DPMU)

DPMUnit consists offollowing personnel:-

1 District Programme Manager
2 District Accounts Manager
3 District M & E Officer
4 District Planning Co-ordinator
5 District Community Mobilizer
6 District Data Assistant
7 District Data Operator/Assistant

Block Unit (BPMU)

Block Programme Management Unit consists of following personnel-

1. Block Health Manager

2 Block Accountant

3 Block Community Mobilizer . Apart from these people, there are ANMs, A-grades, data operators & fourth grade staffs who are posted in blocks as well as district.

Additional Manpower under NRHM

Being a big district, having 18 PHCs, 2 FRUs and 1 SDH Darbhanga requires more manpower to provide services at various facility levels and for better management of NRHM programme.

Add l. Manpower in the form of Hospital managers is being proposed for 1 Sub Divisional Hospital. Hospital managers would facilitate process of quality control and also ensure that SDH in the real sense get functional with all critical determinants.

Apart from Hospital Manager there is need of at least one additional accountant for each block. Similarly one additional data operator is required for each block for proper and timely report generation and data flow. One clerk for each Health Manager is required for timely correspondence of important letters & programe implementation. One data operator separately for DPC is required because planning itself is a very lengthy & tough exercise.

Apart from these every program at district level needs one consultant for its proper implementation. District is overburdened with programs & there are very few people at district level to handle them so The above mentioned is required a lot.

Again at district level the same is required for DPM , DAM & M&EO. District also requires one additional data operator because of increased work load in District.

Services of Hospital Waste Treatment and Disposal

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

Keeping in view the waste disposal ,every PHCs as well as SDH and FRUs have pit for waste disposal.These pits are constructed for disposal of placenta, disposable syringe and used vials.

The District has identified agencies for undertaking the task of Bio-Waste Management and Treatment but necessary approval and clearance from Bihar District Pollution Control Board and Central Pollution Control Board is still awaited. Development forms one of the key components of the overall architectural corrections envisaged by NRHM. Government of Bihar also has spelt out the same as the number one priority.

Outsourcing of Pathology and Radiology Services

Under this scheme Pathology and Radiology services have been outsourced to different Private agencies. The agencies have and/or are in the process of setting up centers/diagnostic labs/collection centers at the hospitals/facilities.

The District has taken a policy decision to provide free service under this to all Government patients and the reimbursement to the agency as per the fixed rates of SHSB and is reimbursed to RKS. The District has provided space at the hospitals to the agency for running the Pathology and Diagnostic Centre. Darbhanga district has seven PHCs rendering radiology services. In the coming days very soon we will have pathology as well as radiology service in all our18 PHCs.

Operationalising Mobile Medical Unit

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

Darbhanga district is currently having one MMU providing health facilities to exclusive groups as well as hard to reach areas.soon it will have 2 MMUs. This service in our district started in the month of Sep"2010.

The manpower to be employed for the program is to be appointed by the Private agency as such-1 Doctor, 1 Nurse,1 Pharmacist (van supervisor), 1 OT assistant , 1 X-ray technician, 1 ANM ,1 Driver(Qualification requirements annexed)

Service Areas

The Medical areas which would be handled include:

1. Free General OPD/ Doctor Consult

2. Free Drugs - Free dispensation and procurement of medicines as per the Essential Drug List prescribed by GoB for PHCs (Annexed) has to be ensured by the private agency.

3. Emergency Services during epidemics and Disasters.

4. Network and referral between PHC/CHC/Private clinics .

5. Generating health indicators and monitoring behavioral changes

6. Gynec clinic.

7. Antenatal Clinics
.
8. Post Natal Care.

9.Infants and Child Care including immunization with VitaminA supplementation (support for the same to be provided by the Government.
)
10. Diagnosis, Referral and Rehabilitation for Non-commu nicable diseases eg. CardiacDiseases, Hypertension, Diabetes,etc

11. Adolescent and Reproductive Health

12. Other Services like Treatment of Minor Injuries and Burns, Aseptic Dressing, TT immunization, Treatment of Minor burns, Minor Suturing and removal – referral etc.

13. Minor lab investigations
.

14. Eye examination

15. ENT examination
.
16. HIV testing
.
17. Promotion of contraceptive services including IUD insertion
.
18. Prophylaxis and treatment of Anemia with IFA Tablets.

19. IEC and counseling along with preventive health screening and health awareness programs.

20. Service related to different public health programmes.

21. Pathological services.

22. Radiology Services – X-ray and Ultra- sound.

23. Preventive Health Screening and Health awareness programs

24. Medical camps will have to be conducted whenever emergency need can be fulfilled..

Generic Drug Shop

Under the PPP initiative Generic Drug Stores shall be set up at all MCHs, DHs and PHCs. The Private agency has to keep 188 types of drugs at the store. The District has provided only space for this purpose to the agency and the agency shares a % revenue share with the Government. The District has also fixed rates for the Generic Drug as per MRP.No additional cost is involved.

Strengthening of Cold Chain

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

Often there is lack of storage space in the existing health stores leading to dumping of critical immunization, vaccine carriers and cold boxes in the open, exposing them to the vagaries of nature and sometimes leading to their damage. Renovation of existing stores would help in creating more organized dry space for both proper storage of material as well as proper loading, packing and unloading of Immunization related logistics. The District store in particular receives large quantities of materials and separate ware house is needed to store immunization related logistis

. The lack of dedicated support manpower for immunization logistics management and for cold chain equipment repair at all levels was observed during the aforesaid cold chain assessments and it was recommended that “At each of these facilities there should be a full time dedicated store manager.

At PHCs we often feel shortage of space for RI related machines as well as equipment. So this issue should be taken immediate cognizance. Separate room should be allotted for Immunization purpose where Deep Freezer , ILR, Voltage Stabilizer etc can be kept and temperature of room can be maintained for maintenance of Vaccines.

Mainstreaming of AYUSH under NRHM

Recognizing the importance of Health in the process o f 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 a vailability 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).*
AYUSH means-

AY *for* ***Ayurvedi***
U *for* ***Unani***
S *for* ***Siddha***
H for Homeopathy

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.

The main objective is to facilitate expansion of health care facilities of AYUSH and building up confidence of the practitioners of these systems while propagating them and establishing their strengths and potentials. In Darbhanga district there are 48 AYUSH doctors posted in different APHCs.

De-centralised Planning

SHSB has initiated village level planning in this current financial year. Initally it was up till district as well as block level .Under this head each district is allotted a sum of Rs.20,000 for preparation of concern District Health Action Plan(DHAP). A sum of Rs. 5,000 per block is allotted for preparation of Block Health Action Plan (BHAP). Similarly Rs. 1500 per HSC is provided for planning & Rs. 1000 per village is provided for preparing VHAP (Village Health Action Plan).

Keeping in view the planning process, SHS has created post of planning coordinator whose work will be to carry out the planning process of the concern district. Preparation of DHAP will be the major concern of planning coordinator.

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

The planning process	***Nodal person***
DHAP (District Health Action Plan)	***ACMO***
BHAP (Block Health Action Plan)	***Medical officer In-charge***
HSC as well as VHAP	***ANM***

The planning process	***Approving Committee***
DHAP (District Health Action Plan)	***DHS***
BHAP (Block Health Action Plan)	***RKS***
HSC as well as VHAP	***VHSC as well as Nigrani Samiti***

NRHM PART- C
Routine Immunization
2012-2013

IMMUNIZATION

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

Immunization Service Delivery

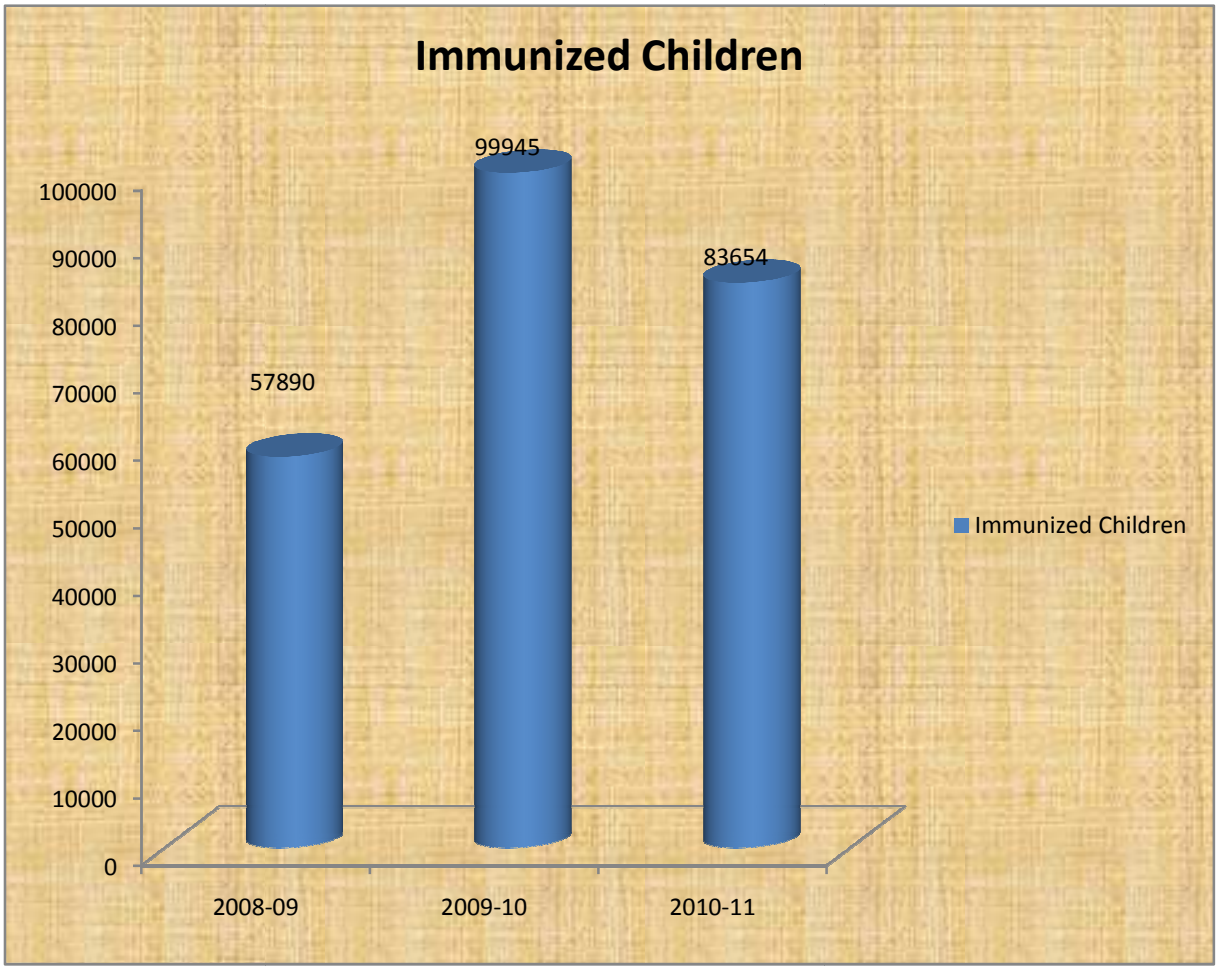
In 2001, Bihar contributed 2.6 million unimmunized infants to the pool of susceptible children: the 2nd largest in India. [Estimate from 2001 coveragesurvey and 2001 census]

Bihar is among the few states where the performance of Routine Immunization Programalso continues to be significantly below national average. The 2001-2 Coverage Evaluation Survey indicated that full immunization coverage levels among children in **Bihar** was only 13%. BCG coverage level was at 39% indicating poor access and utilization of immunization services. Coverage levels for DTP3, OPV3, measles and vitamin A were at 21.1, 21.1, 13.8%, and 11.1%. In addition Rapid household survey performed in 30 districts in Bihar in 1998-1999 and again in 2002-2003 showed that full immunization rates are decreased in 11 of the districts. These findings indicate a strong need for focusing greater efforts on strengthening immunization in the state (Ref Rapid Household Survey RCH Project: IIPS Mumbai)

Newborns in Bihar can now expect to have a healthier future as the state government, in close co-operation with UNICEF, has launched a vigorous campaign to strengthen the Routine Immunisation programme. The reinvigorated programme will ensure that every child is vaccinated against six fatal and debilitating childhood infections. These include tuberculosis, diphtheria, tetanus, whooping cough, polio and measles.

UNICEF State Representative Bijaya Rajbhandari said in a speech made before a 2,000-strong audience which included health workers, parents and top government officials, "The fact that children in Bihar have waited for so many years for this basic health assurance should give us a sense of obligation…I would like to assert that these deaths are preventable and they should be prevented, no matter what it takes," he said.

UNICEF also arranged for the participation of Mr. Shekhar Suman, Bihar's own celebrity television and film star, who made an emotional appeal to the people. "I keep 'vaccinating politicians'. But now I want to ensure that every child in Bihar is vaccinated against childhood diseases," he said in reference to his popular satirical television programme on politicians. Mr. Suman has promised to record tapes and messages to ensure that "people who love me also learn about routine immunization and other children's programmes," he said. His messages will be recorded and taken to every nook and corner of Bihar.



The current campaign is guided by a State Plan of Action, prepared by the Department of Health with UNICEF support. The Plan has definite targets ahead and is committed to achieving no less than 100 per cent immunisation by 2010 – a target which appears to be very distant from the present figures but one "that will be made possible" assured Health Secretary Deepak Kumar.

UNICEF and the Health Department are vigorously promoting Wednesday as the day of vaccination, and under the State Plan of Action, a vaccine delivery method has been devised by which vaccines will be provided to vaccinators who will set up centres in villages to provide easy access to parents of young children.

The problem of low immunisation rate is rooted in deeper systemic issues. For example, rural electrification rate is around 10 per cent and many of the state's primary health centres (PHCs) do not have electrical connections. The ones that are electrified do not have adequate or assured electricity supply, making it difficult to preserve vaccines in order to maintain their potency.

Other problems include lack of training of vaccinators and use of safe syringes. Also,reports have indicated that people are not aware of immunization services being available. For instance, Rubina Khatun in Nalanda district of Bihar told visiting journalists two days before the launch of the campaign that she did not know that children could be protected from diseases through vaccination..

However, the strategy to improve routine immunization is comprehensive, and includes strengthening of service delivery as well as raising awareness so that available services also have takers. UNICEF has provided generator sets to the health centres that reported the worst power situation. "These will help in running refrigerators even when there is no power," said Mr. Rajbhandari.

In many areas, in the absence of disposable syringes, vaccinations were carried out using old and blunt needles, making pricks very painful and prone to abscess, thereby making vaccination unpopular. UNICEF has introduced auto-disable (AD) syringes in the state which ensure safe and less painful vaccination. AD syringe can be used only once as these get locked after use, making reuse impossible.

To keep vaccines safe and effective, 3,000 cold boxes with shoulder straps for mobility, 65 deep freezers and one large walk-in freezer have been made available as part of UNICEF's support. UNICEF is also providing technical support to train health workers "so that they know how to vaccinate and are also able to decide which arm or leg to give the shot in." UNICEF is also supporting the Government in making systemic changes "so that routine immunization becomes routine and we do not have to re-launch another campaign", adds Mr. Rajbhandari. Improving awareness levels is another area of UNICEF's attention.

The most promising aspect of the programme is the sense of urgency with which activities are being pursued. Soon, an accelerated routine immunization campaign will improve the quality of life for the children by protecting them from deadly and often fatal infections.

In Bihar the current situation of regular immunization is improving day by day. Our last year(09-10) achievement of RI was around 60% and this year(11-12) till Dec, our achievement is 59%. Uptill the end of financial year our achievement will definitely go high, say 70-75%.

Government of India (GoI) target for RCH

1. 100% children aged 12-23 months fully immunized (for Bihar, currently it is under 20%).

2. under 30 IMR by 2010 (for Bihar, currently it is 73).

3.under 100 MMR by 2010 (for Bihar, currently it is 500).

.

Goal of Govt. of Bihar*:*

All districts in Bihar provide timely and safe immunisation with all antigens (plus 2 dosages of Vitamin A) to all children between 12 –23 months (100% coverage) and all pregnant women with 2 doses of TT (100% coverage).

Objectives to be achieved by GoB

1. 100% vaccine availability as per vaccine supply schedule.

2. 100% availability of ADS
.
3. 100% availability of needle cutter
.
4. Ensure that every block has a functional microplan
.
5. 100% sessions are held as per microplan.

6. 100% involvement of Anganwadi workers in mobilizing the community and bringing beneficiaries to the sites

7. 100% trained ANMs available in all the blocks (including urban areas).

8. All districts have dedicated DIOs in place.

9. Maintaining functional cold chain status of above 90%.

10. To ensure regular quality immunization sessions are planned and held.

11. To ensure smooth functioning of state and district routine immunization cell.

12. 100% trained staff available at every level – especially, SIO, DIO, Cold chain Technician, ANMs etc.

Status of Immunization in Darbhanga district

Our achievement for current year (2010-2011 to Nov 2011) is

BCG	= 82975	68228
DPT	= 63460	55912
OPV	= 60797	46683
MEASELS	= 59550	61610
TT(Pre. Lady)	= 59017	55985

POLIO PROGRAMME

The Polio Eradication Programme in India is a collaborative effort between the Ministry of Health and Family Welfare (MOHFW), WHO's National Polio Surveillance Project (NPSP), UNICEF, Rotary International, and the U.S. Centres for Disease Control.The programme aims to eradicate polio from India by immunizing every child under 5 with the Oral Polio Vaccine (OPV). India, together with Afghanistan, Nigeria, and Pakistan, is one of the four polio-endemic countries left in the world. **Since last three years no any polio cases has been detected in darbhanga district**.

The programme aims to eradicate polio from India by immunizing every child under 5 with the Oral Polio Vaccine (OPV). India, together with Afghanistan, Nigeria, and Pakistan, is one of the four polio-endemic countries left in the world.

Tremendous progress has been made in the last several years to interrupt polio transmission in India. India is only two states away from being polio free and the virus has become increasingly localized to only 100 blocks of Uttar Pradesh and Bihar.

The total number of cases for this year in the country remains 24 (six WPV1(wild polio virus Type One) and 18 Type Three WPV3 . The most recent case had onset of paralysis on 14 June (WPV3 from West Bengal). A mop-up immunization campaign was conducted on 11 July in West Bengal, with additional technical support deployed from other areas to support the activity.

In the two endemic states of Uttar Pradesh and Bihar, no WPV1 cases have been reported since November and October 2009, respectively. Supplementary immunization activities (SIAs) are currently ongoing in Bihar, using a mix of bivalent OPV and monovalent OPV type 3 (mOPV3).

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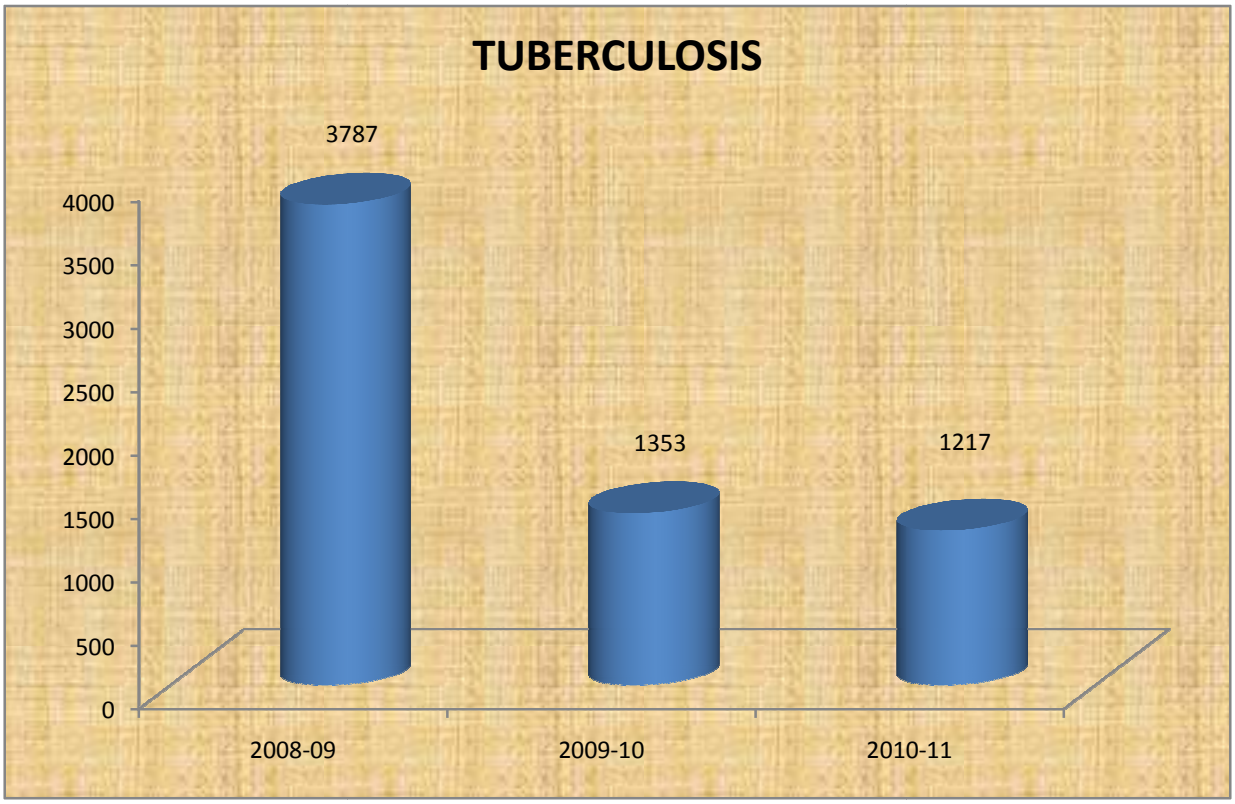
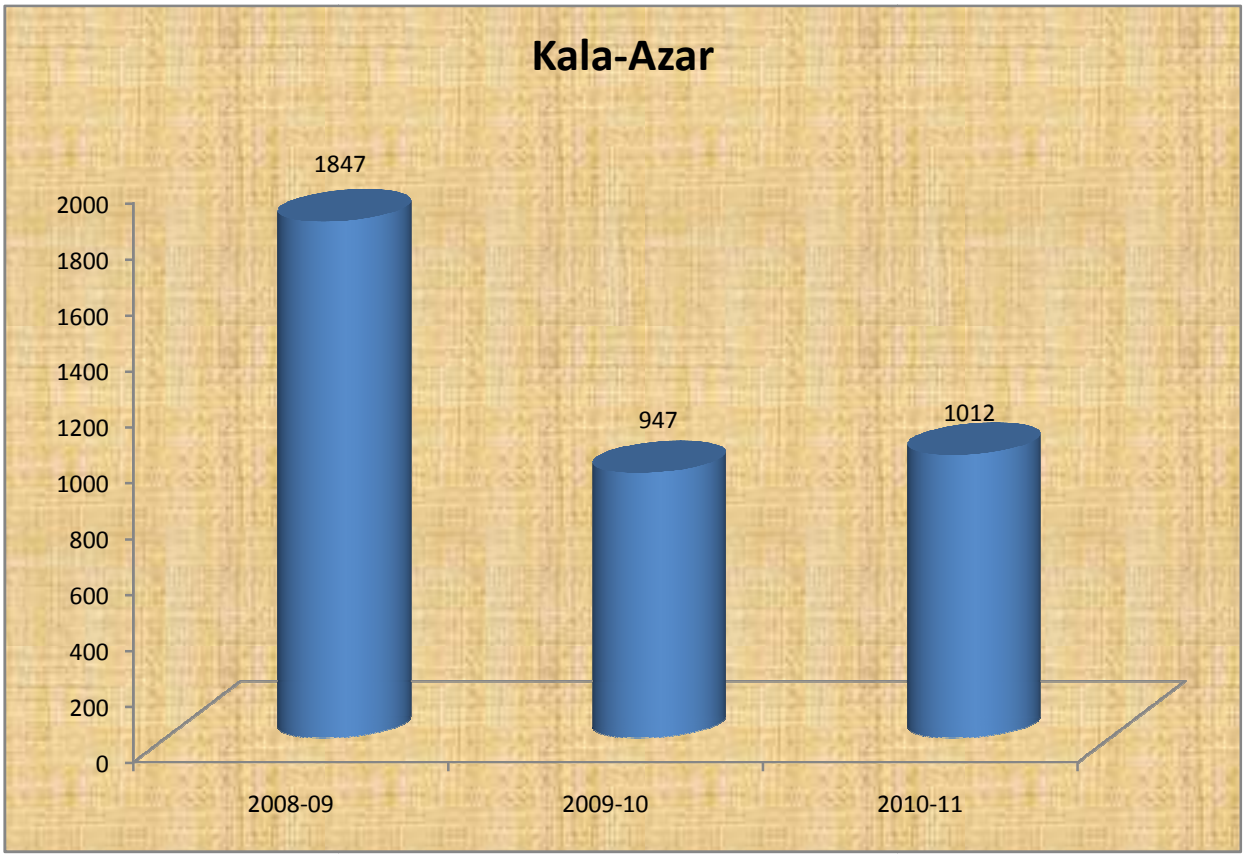
Polio Programme has started in India in 1995. In current scenario there are 18 P1 cases whereas 24 P3 cases left. P2 has been eradicated from India. In Bihar 3P1 cases left whereas 6P3 cases are found in Samastipur and Begusarai District. Our next round is going to start from 23rd jan 11.Our Darbhanga is currently Polio free.

NRHM PART- D
2012-2013


TUBERCULOSIS
3787
1353
1217
4000
3500
3000
2500
2000
1500
1000
500
0
2008-09
2009-10
2010-11


Kala-Azar
1847
947
1012
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1800
1600
1400
1200
1000
800
600
400
200
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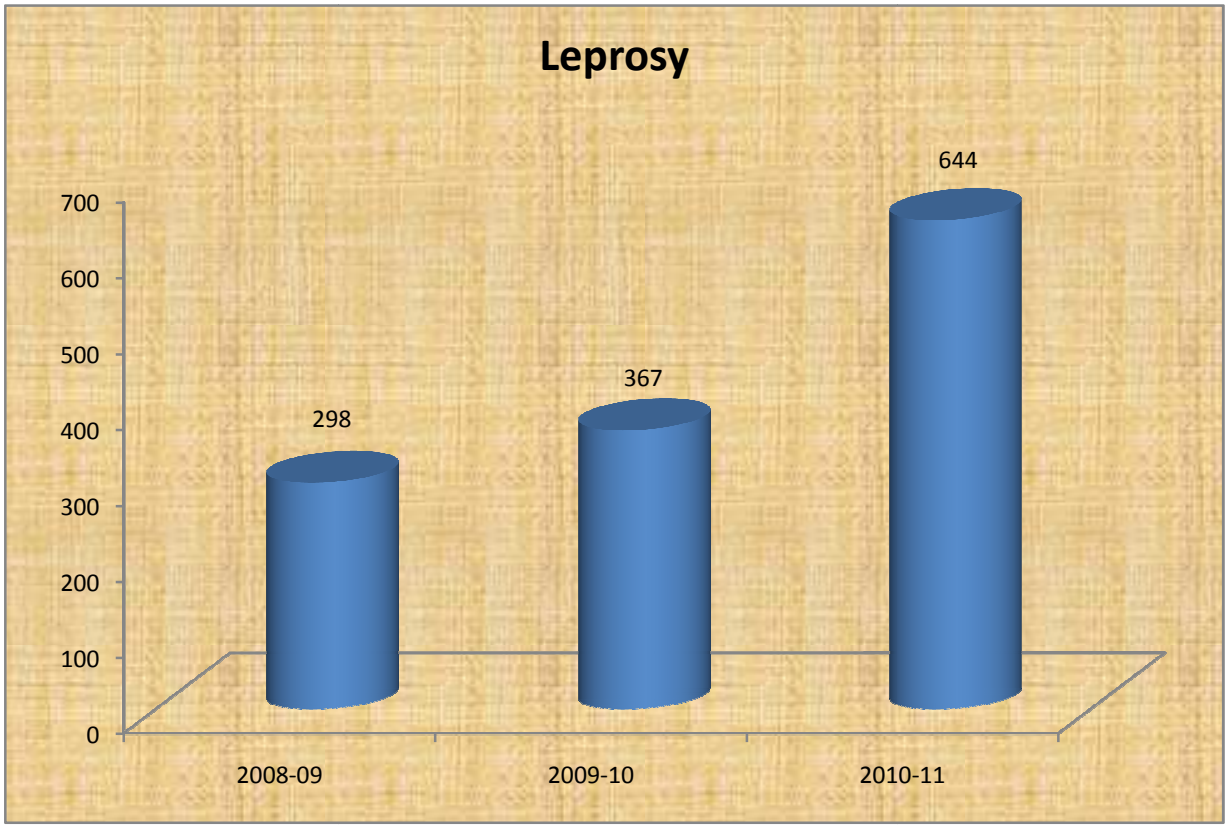
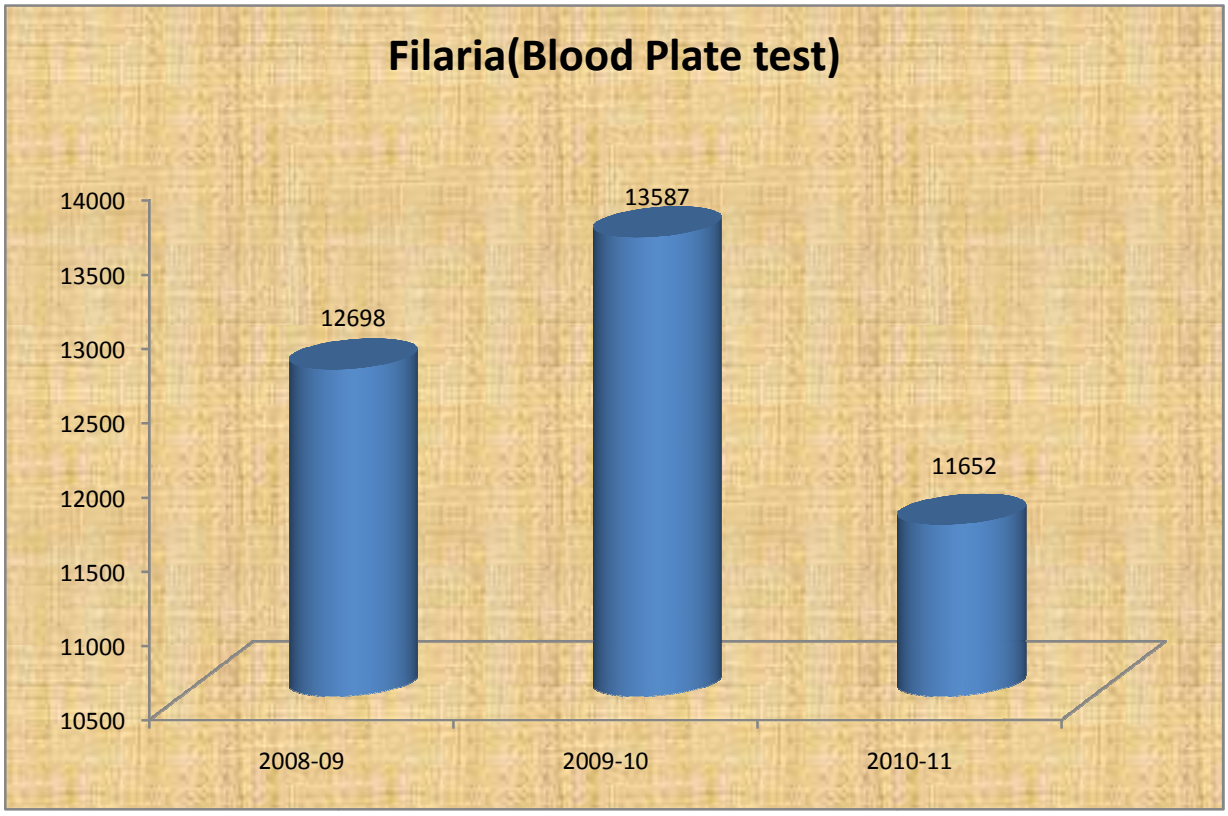
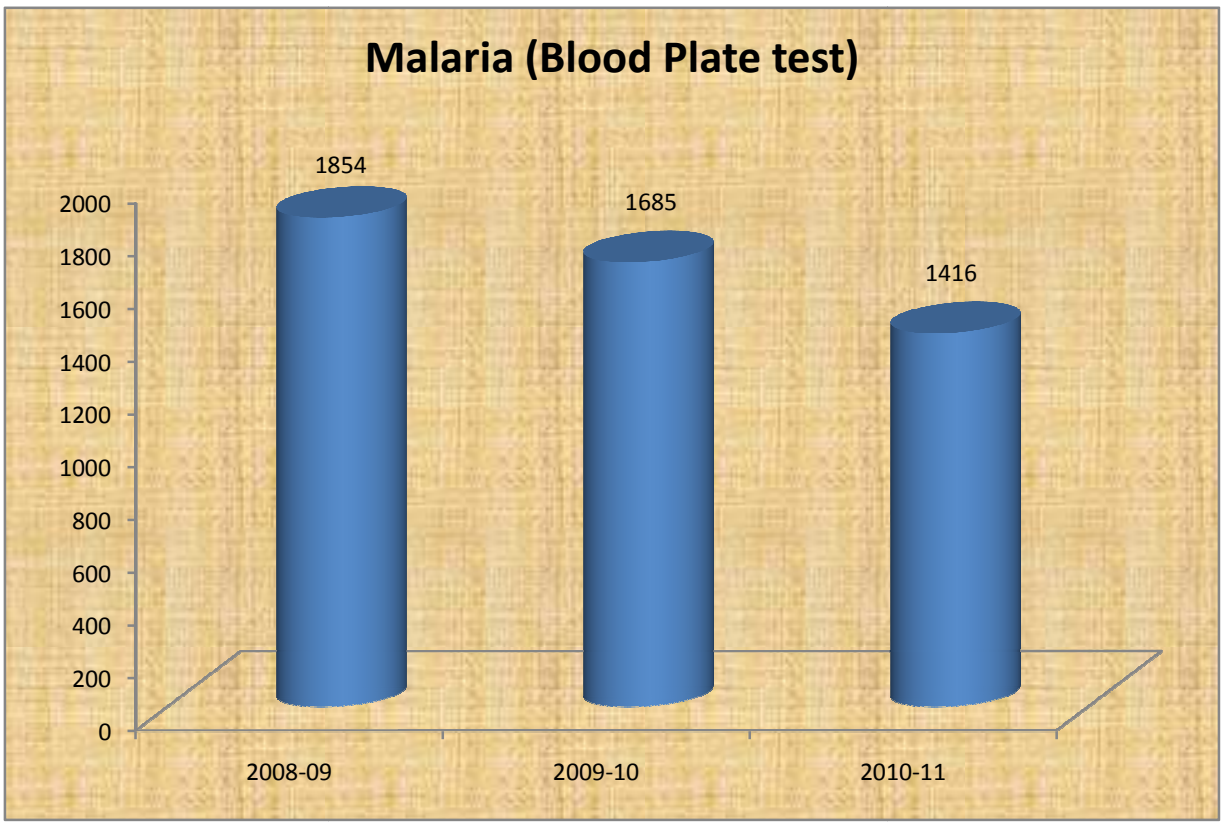
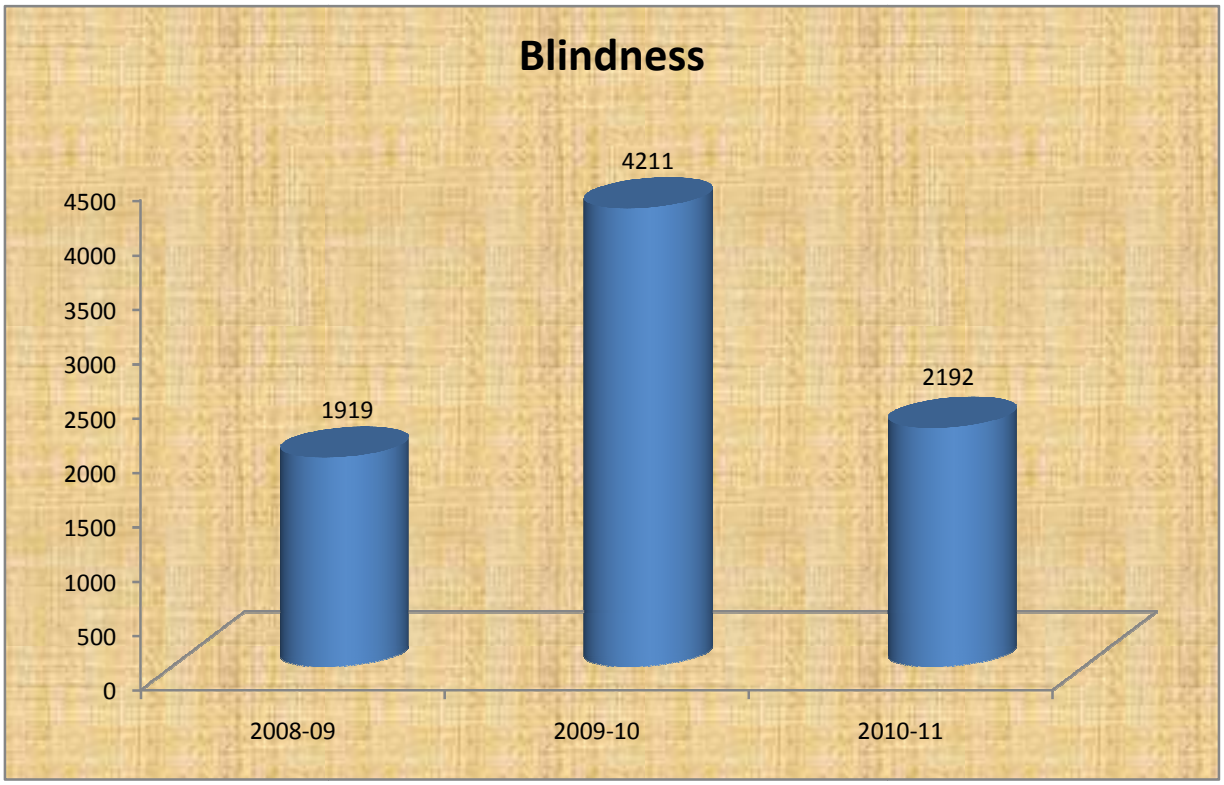
2008-09
2009-10
2010-11


Leprosy
700
600
500
400
300
200
100
0
298
367
644
2008-09
2009-10
2010-11


Filaria(Blood Plate test)
14000
13500
13000
12500
12000
11500
11000
10500
12698
13587
11652
2008-09
2009-10
2010-11


Malaria (Blood Plate test)
1854
1685
1416
2000
1800
1600
1400
1200
1000
800
600
400
200
0
2008-09
2009-10
2010-11


Blindness
4211
1919
2192
4500
4000
3500
3000
2500
2000
1500
1000
500
0
2008-09
2009-10
2010-11

Village Health Action Plan

2012-13

District Health Society, Darbhanga

VILLAGE HEALTH ACTION PLAN

Year

2012-13

ROGI KALYAN SAMITI
SADAR DARBHANGA

T.B.D.C Building Allalpatti, Darbhanga- 846001
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ग्रामीण स्वास्थ्य एवं स्वच्छता समिति, शिशो

प्रस्तावना

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के प्रारम्भ वर्ष 2005 से मातृत्व मृत्यु दर एवं शिशु मृत्यु दर को कम करने हेतु केन्द्रीय प्रयास से जो स्वास्थ्य क्षेत्र की सेवा प्रदान करने की क्षमता में ऐतिहासिक वृद्धि एवं विभिन्न क्षेत्रों में खासकर सदर अस्पताल से लेकर प्राथमिक स्वास्थ्य केन्द्र तक गुणात्मक सुधार किया गया है। इसी क्रम को आगे बढ़ाते हुए यह पाया गया कि योजना एवं उसके अपेक्षित परिणाम के बीच न्यूनतम अन्तर के लिए आवश्यक है कि योजना जिस आबादी अथवा प्रक्षेत्र से सम्बन्धित है उसी ईकाई के लिए एवं उसके रहने वाले लोगों/जनप्रतिनिधि एवं सेवा प्रदाता के सहयोग से बने तो उपरोक्त अन्तर को कम किया जा सकता है। उपरोक्त वर्णित अस्पतालों में अथवा आमजन के निरोधात्मक एवं उपचारात्मक स्वास्थ्य कार्यक्रम में जो भी सुधार दिखा है वह योजना के निर्माण एवं उसके मध्य अवधि में अपेक्षित परिणाम के विशलेषण के कारण संभव हो सका है, परन्तु योजना बनाते समय सबसे सुक्ष्मतम ईकाई गॉव को योजना के लिए चुनने एवं उससे सम्बन्धित सभी निर्णायक भागदीदारों की क्षमता वर्द्धन के साथ उन्हें योजना बनाने के लिए प्रेरित करने से यह संभव हो सकेगा। ग्रामीण, माननीय जनप्रतिनिधि, ऑगनवाड़ी सेविका एवं ए0एन0एम को जागरूकता एवं अपनी सहभागिता प्रदान करने के न्यूनतम प्रतिरोध का सामना करना पड़ेगा।

योजना के निर्माण के विकेन्द्रीकरण के क्रम में राज्य से जिला, जिला से प्रखण्ड, प्रखण्ड से गॉव तक की योजना स्वास्थ्य विभाग से लेकर सभी विभागों में बनाया जा रहा है। इसी क्रम में भारत सरकार द्वारा बिहार के दस जिलों को ग्रामीण स्तर की विकेन्द्रीकृत वार्षिक कार्य योजना बनाने हेतु चयन किया गया है। यह सौभाग्य की बात है कि दस जिलों में से दरभंगा भी एक जिला है, जिसके 18 (अठारह) प्रखंडों में से 5 (पॉच) प्रखण्ड का चयन प्रखण्ड में कार्यरत ए0एन0एम, ऑगनवाड़ी सेविका, प्रखण्ड समुदाय उत्प्रेरक एवं प्रखण्ड स्वास्थ्य प्रबधंक की भागीदारी को ध्यान में रखते हुए प्रखण्डों का चयन किया गया है।

पवन रेखा देवी
ए॰ एन॰ एम॰

गीता देवी
बिरजो देवी
आशा

प्रमिला देवी
रेखा देवी
आ॰ प॰ स॰

1. रूदलराय 8
2. विजय सिंह 5
3. लाल देवी 6
4. अनीला राय 7
वार्ड सदस्य

ग्रामीण स्वास्थ्य एवं स्वच्छता समिति, शिशो

एकनौलेजमैन्ट

वित्तीय वर्ष 2012-13 के लिए ग्रामीण स्तर पर वार्षिक योजना के निर्माण की परिकल्पना करना एवं दरभंगा जिला को यह अवसर प्रदान करने के साथ इस कार्य को करने के लिए जिला स्तरीय प्रबंधन ईकाई की टीम को क्षमता विकसित करने के लिए आदरणीय कार्यपालक निदेशक, राज्य कार्यक्रम प्रबंधक, बिहार, पटना तथा सभी राज्य स्तरीय कार्यक्रम पदाधिकारी, एन0एच0एस0आर0सी0 की टीम एवं पी0एच0आर0एन0 की टीम को हार्दिक धन्यवाद देता हूँ।

राज्य से प्राप्त मार्गदर्शन एवं प्रेरणा का संप्रेषण प्रखण्ड तक करने के लिए जिला स्तरीय टीम आदारणीय जिला पदाधिकारी सह अध्यक्ष, सिविल सर्जन सह सदस्य सचिव, क्षेत्रीय कार्यक्रम प्रबंधक, जिला कार्यक्रम प्रबंधक, जिला योजना समनव्यक एवं जिला स्वास्थ्य समिति के समस्त कर्मीयों की भागीदारी के प्रति सदर प्रखण्ड की टीम अपना हार्दिक आभार प्रकट करती है।

प्रखण्ड स्वास्थ्य प्रबंधक,
प्रा0स्वा0केन्द्र, सदर

प्रभारी चिकित्स पदाधिकारी,
प्रा0स्वा0केन्द्र, सदर

आम सभा

विषय सूची

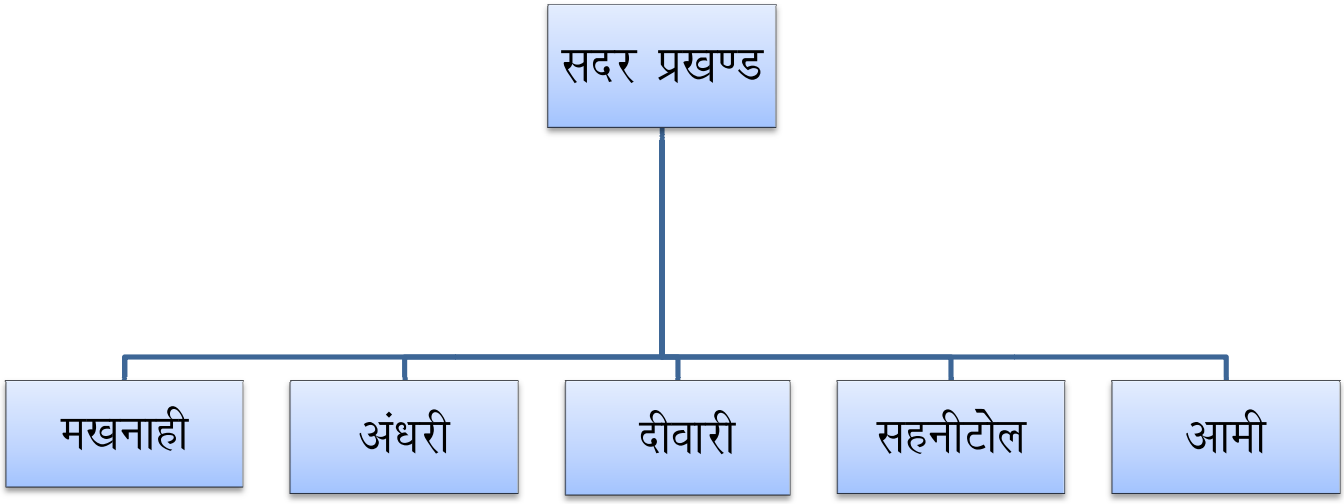
ग्रामीण स्वास्थ्य वार्षिक कार्य योजना का उद्देश्य

स्वास्थ्य कार्यक्रम जो मुख्य रूप से मातृ मृत्यु दर, शिशु मृत्यु दर को कम करने एवं स्वास्थ्य विभाग के निरोधात्मक एवं उपचारात्मक क्षमता में वृद्धि करते हुए सभी लोगों के लिए गुणवत्तापूर्ण आउट ऑफ पॉकेट मुफ्त ईलाज की व्यवस्था करना है। इस प्रयास में प्रबंधन क्षमता, आपूर्ति, कुशल मानव संसाधन एवं संचार तंत्र व प्रशिक्षण में संतोषजनक एवं गुणात्मक सुधार हुआ है जिसके कारण स्वास्थ्य विभाग से संबंधित सभी सूचकांको में सुधार परिलक्षित है। परन्तु यह सुधार अपेक्षित परिणाम से कम है जिसका मूल कारण सामुदायिक भागीदारी आपेक्षाकृत कम रहना है। इसका मुख्य कारण रहा है कि स्वास्थ्य क्षेत्र के सभी भागीदारो यथा स्वास्थ्य कार्यकर्त्ता, ग्रामीण एवं जन प्रतिनिधियों को योजना निर्माण में भागीदार नही बनाया जा सका और परिणाम यह हुआ कि उन्हे मनोविज्ञानिक स्तर पर यह लगता रहा कि उन पर योजनाएँ थोपी गयी है। यह योजना पूर्व की योजनाओं की तरह उनकी आवश्यकताओ की पूर्ति नही कर पाएगी साथ ही स्वास्थ्य संबंधित आवश्यकता एक बार फिर अनदेखी रह जाएगी।

इस विकेन्द्रीकृत योजना से पहला लाभ यह हुआ है कि सभी भगीदारो (ग्रामीण सहित) को स्वास्थ्य संबंधित सूचकांक, कार्यक्रम, वर्तमान स्थिति, आवश्यकताओं का आकलन, ढ़ाचागत निर्माण की आवश्यकता की जानकारी दी गयी है। जिसके कारण उनकी विश्लेषण क्षमता साथ ही संचालित योजनाओं में संभावित सुधार के लिए उपाय सोचने की क्षमता विकसित हुई है। इसके इतर ग्रामीण, माननीय जनप्रतिनिधि एवं स्वास्थ्य कार्यकर्ता इसे अपनी योजना, अपनी आवश्यकतानुसार बनायी गयी मान कर सेवा प्रदान करने वाली योजनाओ में उल्लेखित लक्ष्य हेतु प्रयास करेगें। ग्रामीण अपनी स्वास्थ्य संबंधित आवश्यकताओं को पूर्ण होने की अपेक्षा रखेगें साथ ही अपेक्षित परिणाम हेतु आवश्यक अनुश्रवण एवं मुल्यांकन सुनिश्चित कराएगे।

मखनाही के चुनाव की प्रक्रिया

प्रखंड सदर का राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के अन्तर्गत गॉव के स्तर से योजना निर्माण की परिकल्पना को मूर्त रूप प्रदान करने हेतु इस वर्ष ग्रामीण स्वास्थ्य कार्ययोजना निर्माण करने हेतु जिला स्वास्थ्य समिति, दरभंगा के द्वारा चयन किया गया, जिसमें बिहार राज्य स्वास्थ्य समिति, बिहार, पटना के द्वारा ग्रामीण स्वास्थ्य कार्ययोजना बनाने के लिए उदेश्य एवं चयन प्रक्रिया को ध्यान में रखते हुए पॉच गॉवो को चुना गया।



मखनाही गाँव का चयन निम्नांकित बिन्दुओं के आधार पर किया गया।

1. गाँव में उस पंचायत का स्वास्थ्य उपकेन्द्र स्थापित है।
2. गाँव में कार्यरत ए0एन0एम0, आशा एवं आंगनवाड़ी प्रशिक्षित है।
3. गाँव में स्वयं सहायता समूह कार्यरत है
4. गाँव के जनप्रतिनिधि हर दृष्टिकोण से सहयोग प्रदान करने वाले है।
5. गाँव में व्याप्त बिमारियो की सूचना संबंधित आकड़ें।

आकड़ो के चयन का माध्यम

उप स्वास्थ्य केन्द्र, शीशो के अन्तर्गत मखनाही

1. स्वास्थ्य प्रबंधक द्वारा मखनाही ग्राम का चयन ग्रामीण कार्य योजना हेतु किया गया क्योकि उक्त गाँव में हर दृष्टिकोण से स्वास्थ्य क्षेत्र में सुधार की आवश्यकता है।
2. सदर प्रखण्ड अन्तर्गत चयनित गाँव मखनाही के ग्रामीण स्वास्थ्य कार्ययोजना निर्माण हेतु आकड़ों का संकलन स्वास्थ्य प्रबंधक, ए0एन0एम0 एवं उनके उप स्वास्थ्य केन्द्र अन्तर्गत आने वाली आशा एवं ऑगनवाड़ी सेविकाओं तथा जनप्रतिनिधि, वार्ड सदस्य के द्वारा किया गया।

स्वास्थ्य उपकेन्द्र, शीशो, सदर

ग्रामीण स्वास्थ्य कार्य-योजना (2012-13)

निगरानी समिति का नाम	ग्रामीण स्वास्थ्य निगरानी समिति, शीशो
ऑगनबाड़ी सेविका का नाम	1 प्रमीला देवी 2 रेखा देवी
आशा का नाम	1 गीता देवी 2 किरण देवी
ए0एन0एम0 का नाम	1 पवन रेखा देवी
टी0बी0 डॉट् प्रोभाइडर का नाम	1 गीता देवी 2 किरण देवी

परिचय	
गॉव का नाम	मखनाही
पंचायत	शीशो
स्वास्थ्य उपकेन्द्र का नाम	शीशो
आंगनबाड़ी केन्द्र का नाम	1 मखनाही 2 छोटकी मखनाही
आबादी	2745
पुरूष	1310
महिला	1435
योग दम्पति	392
प्राथमिक स्वास्थ्य केन्द्र से दूरी	17 कि0मी0
अतिरिक्त प्राथमिक स्वास्थ्य केन्द्र से दूरी	4 कि0मी0
उपस्वास्थ्य केन्द्र से दूरी	2 कि0मी0

प्रथामिक विद्यालय से दूरी	0 कि0मी0
पेयजल के श्रोत	चापाकल 2
निकटतम प्रथम रेफरल अस्पताल से दूरी (जहॉ ब्लड भंडार की सुविधा हो) (रेफरल/अनुमंडलीय/सदर)	दरभंगा मेडिकल कॉलेज अस्पताल 09 कि0मी0
विद्युत	गॉव में बिजली है।
सड़क	गॉव में बाहर से आने के लिये पक्की सड़क है।
यातायातः	गॉव से बाहर जाने के लिए ग्रामीण टैम्पो का उपयोग करते है।
आवागमन बाधित	एक माह रहता हैं।
ग्रामीण स्वास्थ्य एवं पोषण दिवस के निर्धारित दिवस	बुधवार एवं शुक्रवार
मलेरिया की जाँच लोग कहॉ करवाते हैं	दरभंगा मेडिकल कॉलेज अस्पताल
डायरिया होने पर लोग कहॉ जाते हैं	अति0प्रा0स्वा0केन्द्र, बजार समिति
खसरा होने पर लोग कहॉ जाते हैं	अति0प्रा0स्वा0केन्द्र, बजार समिति
भवन	**प्राथमिक विद्यालय - हॉ** **सामुदायिक भवन - हॉ**
पोलियो केस नये (2010-11)	नहीं
टी0 बी0 (2010-11)	हाँ
कालाजार (2010-11)	हाँ
कुष्ठ (2010-11)	हाँ
संस्थागत प्रसव (2010-11)	119 दरभंगा मेडिकल कॉलेज अस्पताल मे
गृह प्रसव (2010-11)	33
महिला बंध्याकरण (10-11)	27
पुरूष नसबंदी (2010-11)	नहीं
निरोध प्राप्तकर्त्ता (10-11)	75
लूप निवेशन (10-11)	15
ओरल पिल प्राप्तकर्त्ता (10-11)	12

एंबुलेंस सेवायें (गाँव के स्तर पर 102)	
गाड़ी संख्या	उपलब्ध नहीं है।
ड्राईवर का नाम	उपलब्ध नहीं है।

पंचायत के वार्डवार सूचनाओं का संकलन प्रपत्र				
क्र0सं0	वार्ड संख्या	जनसंख्या	वार्ड सदस्य का नाम	मोबाईल संख्या
1	5	441	श्री विजय सिंह	9661789630
2	6	710	श्रीमति लाल देवी	9801582931
3	7	665	श्री अनिल राय	9801545301
4	8	729	श्री रूदल राय	9801498124

स्वास्थ्य सेवाएँ, कटिनाईयाँ, रणनीति, क्रियाकलाप एवं बजट

गर्भवती महिलाओं से संबंधित							
क्र0सं0	**बिन्दू**	**समस्या**	**कारण**	**समाधान**	**कौन करेगा**	**ईकाई राशि**	**बजट 12-13**
1	प्रसव पूर्व सेवाये	सभी गर्भवती महिलाओं की संख्या का पता नहीं होना।	सही ढंग से सर्वेक्षण नहीं होना	गर्भवती महिलाओं का मासिक सर्वेक्षण कराना।	आशा/आँगनवाड़ी/ए0एन0एम/स्वास्थ्य प्रशिक्षक	1000	1000
		नियमित जॉच नहीं होना।	आशाओं द्वारा सही समय पर गर्भ संबंधित जॉच नहीं करवाना।	प्रशिक्षण में साथ उपकरणों की कमी।	जिला द्वारा		
		समय पर IFA उपलब्ध नहीं होना ।	समुचित भंडारण की व्यवस्था नहीं होना।	समय पर दवा उपलब्ध कराना।	जिला द्वारा		
		प्रसूति का सही समय पर अस्पताल नहीं पहुँचना।	आशाओं द्वारा चिन्हित महिलाओं को पूर्व से रेफरल की वयवस्था नहीं किया जाना।	चिन्हित महिलाओं के लिए रेफरल की समुचित व्यवस्था करना।	आशा द्वारा स्थानीय गाड़ी मालिक से संपर्क कर ससमय अस्पताल पहुँचाना।		
2	प्रसव उपरान्त सेवाऐ	प्रसव उपरान्त एक सप्ताह तक Follow-Up नहीं होना।	आशाओं एवं ए0एन0एम द्वारा किसी भी तरह की जानकारी नहीं लेना।	आशा एवं ए0एन0एम द्वारा सही समय पर समुचित जानकारी देना	आशा एवं ए0एन0एम द्वारा की जाएगी।	मोबाईल हेतु 300 प्रति माह	3600
3	गृह प्रसव (विशेष परिस्थिति में)	प्रशिक्षित ए0एन0एम एवं दाई का सही समय पर उपलब्ध नहीं होना।	प्रसव की संभावित तिथि की जानकारी ए0एन0एम/आशा को नहीं होना।	आशा द्वारा क्षेत्र भ्रमण के दौरान चिन्हित महिलाओं का प्राथमिक स्वास्थ्य केन्द्र पर ले जाकर सही समय पर जॉच करवाना।	आशा एवं ए0एन0एम द्वारा की जाएगी।		
		आवश्यक Drug Kit का उपलब्ध नहीं होना।	समुचित दवा के संबंध में जानकारी का अभाव	समय-समय पर आशा/ए0एन0एम को दवा के उपयोग से संबंधित प्रशिक्षण देना।	जिला द्वारा		
4	नियमित टीकाकरण	पूर्ण टीकाकरण नही होना	आशा एवं आंगनवाड़ी द्वारा डीयू लिस्ट को सही नही रखना	आशा एवं आंगनवाड़ी द्वारा डीयू लिस्ट में नामित बच्चे एवं माताओं को टीकाकरण हेतु 02 दिन पूर्व सूचित करना	आशा, आंगनवाड़ी एवं ए0एन0एम0 द्वारा		

बच्चो से संबंधित							
क्र0सं0	**बिन्दू**	**समस्या**	**कारण**	**समाधान**	**कौन करेगा**	**ईकाई राशि**	**बजट 12-13**
1	कुपोषण	कुपोषण की सही जानकारी नहीं होना	आशा एवं आंगनवाड़ी के द्वारा क्षेत्र भ्रमण के समय बच्चों के सही स्वास्थ्य की जानकारी नही रखना	आशा एवं आंगनवाड़ी द्वारा क्षेत्र भ्रमण एवं टीकाकरण के समय संदिग्ध बच्चो को स्वास्थ्य जॉच हेतु अपने अधिनस्थ स्वास्थ्य केन्द्र पर भेजना	आशा , आंगनवाड़ी एवं ए0एन0एम0 द्वारा दवा उपलब्ध कराना एवं खान पान की महत्ता को बताना, आवश्यकतानुसार जिला में संचालित दुलार पोषण पुनर्वास केन्द्र (एन0आर0सी0)में भर्ती करवाना		0
योग्य दम्पति से संबंधित							
2	एफ0 डब्लू0 पी0 और आई0 यू0 डी0	योग्य दम्पति के सही आकड़े का पता नहीं होना	स्वास्थ्य विभाग द्वारा पूर्व में ए0एन0एम0 एवं बुनियादी स्वा0 कार्यकर्ता द्वारा योग्य दम्पति का वार्षिक सर्वेक्षण करवाया जाता था, ये कार्य आज के दिनो में बंद है	योग्य दम्पति के सही आकड़ो का वार्षिक सर्वेक्षण करवाना	ए0एन0एम0, स्वास्थ्य प्रशिक्षक एवं बुनियादी स्वा0 कार्यकर्ता	1000	1000
		लाभार्थी के विषय में समुचित जानकारी का आभाव होना	सभी आंगनवाड़ी केन्द्र एवं स्वास्थ्य उपकेन्द्र पर तिथि एवं जगह की सूचना उपलब्ध कराना	आशा, आंगनवाड़ी एवं ए0एन0एम0 द्वारा आपस में बैठक कर जगह एवं तिथि निर्धारित कर अपने लाभार्थीयो को सूचित करना	आशा, आंगनवाड़ी एवं ए0एन0एम0 द्वारा		0
		जनसंख्या नियंत्रण	आई0यू0डी0 कीट एवं प्रशिक्षित कर्मी का उपलब्ध नहीं होना	ए0एन0एम0 का प्रशिक्षण एवं आई0यू0डी0 कीट की उपलब्धता आवश्यकता नुसार मुहैया करवाना	जिला स्तर पर		0

अधारभूत संरचना

क्र0सं0	जरूरत	समस्या	कारण	समाधान	कौन करेगा	ईकाई राशि	बजट 12-13
1	स्वास्य उपकेन्द्र का भवन	भवन का जर्जर स्थिति	भवन का समुचित रख रखाव एवं रंगरोगन समय पर नहीं करना	अनटाईड फन्ड एवं ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के मद से आवश्यकता अनुसार ससम समय पर भवन को मरम्मती एंव रंगरोगन करवाना	ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के सदस्यों द्वारा		सरकार से संबंधित
2	पेय जल	आवश्यकतानुसार चापाकल का नही होना	जागरूकता की कमी	अनटाईड फन्ड एवं ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के मद से करवाना	ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के सदस्यों द्वारा		7000
3	शौचालय	शौचालय की समुचित व्यवस्था नहीं होना	शौचालय भवन का समुचित रख रखाव एवं रंगरोगन समय पर नहीं करना	अनटाईड फन्ड एवं ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के मद से करवाना	ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के सदस्यों द्वारा		15000
4	बिजली	बिजल की समुचित आपूर्ति नही होना	बिजली बिभाग द्वारा समय पर बिजली की आपूर्ति नही देना।	सोलर लाईट, इमरजेन्सी लाईट एवं जेनरेटर सुविधा	स्वास्थ्य प्रबंधक		25000

मानव संसाधन

क्र0सं0	जरूरत		ईकाई राशि	बजट 12-13
1	एन0एन0एम0	उपलब्ध है।		
2	एन0एन0एम0 आर0	उपलब्ध नही है।		
3	साफ सफाई कर्मी	नियुक्ति किया जाना है । (जिला द्वारा)	1500	18000
उपकरण				
1	स्टॉप वाच, थर्मामीटर, ड्रेसिंग ड्राम, आरटीफोरसेप, ब्लेड, मापने का फीता, आला	अपटाईड फन्ड से खरीद किया जाना है।		10000
कार्यालय संबंधित सामग्री				
1	टेबुल, कुर्सी, आलमीरा, मेडिसीन, जाँच करने का टेबुल, फुट स्टेप, बकेट, मग, पर्दा, रबर सीट, एप्रोन इत्यादि।	अपटाईड फन्ड से खरीद किया जाना है।		10000
			कुल	73400

ए0एन0एम0 सह सचिव
ग्रामीण स्वास्थ्य एवं स्वच्छता समिति

अध्यक्ष
ग्रामीण स्वास्थ्य एवं स्वच्छता समिति

ग्रामीण स्वास्थ्य कार्ययोजना का महत्व

समुदाय के द्वारा किये गये सामुहिक चर्चा से प्राप्त कारणो एवं उसके समाधानो से संबंधित गतिविधियो को समायोजित कर स्वास्थ्य उपकेन्द्र की कार्ययोजना में समायोजित किया जा रहा है। इसी तरह स्वास्थ्य उपकेन्द्रों की कार्ययोजनाओं को प्रखण्ड स्तरीय कार्ययोजना एवं प्रखण्ड स्तरीय कार्ययोजना को जिला स्तरीय कार्ययोजना में समायोजित किया जाएगा। फलस्वरूप विकेन्द्रीकरण की इस प्रक्रिया में एक पारदर्शी एवं सत्यतापूर्ण कार्ययोजना का निर्माण संभव हो पाएगा जो जनता द्वारा जनता को समर्पित है।

धन्यवाद सहित

District Health Society, Darbhanga
Village Health Action Plan

Year
2012-13

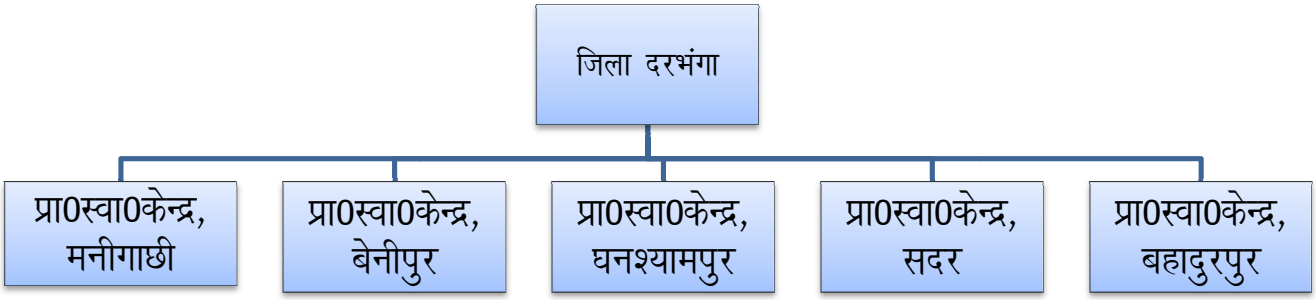
Rogi Kalyan Samiti
Manigachhi Darbhanga

T.B.D.C Building Allalpatti, Darbhanga- 846001
Tel : 06272-250162, email : www.dhs_darbhanga@rediffmail.com

प्रस्तावना

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के प्रारम्भ वर्ष 2005 से मातृत्व मृत्यु दर एवं शिशु मृत्यु दर को कम करने हेतु केन्द्रीय प्रयास से जो स्वास्थ्य क्षेत्र की सेवा प्रदान करने की क्षमता में ऐतिहासिक वृद्धि एवं विभिन्न क्षेत्रों में खासकर सदर अस्पताल से लेकर प्राथमिक स्वास्थ्य केन्द्र तक गुणात्मक सुधार किया गया है। इसी क्रम को आगे बढ़ाते हुए यह पाया गया कि योजना एवं उसके अपेक्षित परिणाम के बीच न्यूनतम अन्तर के लिए आवश्यक है कि योजना जिस आबादी अथवा प्रक्षेत्र से सम्बन्धित है उसी ईकाई के लिए एवं उसके रहने वाले लोगों/जनप्रतिनिधि एवं सेवा प्रदाता के सहयोग से बने तो उपरोक्त अन्तर को कम किया जा सकता है। उपरोक्त वर्णित अस्पतालों में अथवा आमजन के निरोधात्मक एवं उपचारात्मक स्वास्थ्य कार्यक्रम में जो भी सुधार दिखा है वह योजना के निर्माण एवं उसके मध्य अवधि में अपेक्षित परिणाम के विशलेषण के कारण संभव हो सका है, परन्तु योजना बनाते समय सबसे सुक्ष्मतम ईकाई गॉव को योजना के लिए चुनने एवं उससे सम्बन्धित सभी निर्णायक भागदीदारों की क्षमता वर्द्धन के साथ उन्हें योजना बनाने के लिए प्रेरित करने से यह संभव हो सकेगा। ग्रामीण, माननीय जनप्रतिनिधि, ऑगनवाड़ी सेविका एवं ए0एन0एम को जागरूकता एवं अपनी सहभागिता प्रदान करने के न्यूनतम प्रतिरोध का सामना करना पड़ेगा।

योजना के निर्माण के विकेन्द्रीकरण के क्रम में राज्य से जिला, जिला से प्रखण्ड, प्रखण्ड से गॉव तक की योजना स्वास्थ्य विभाग से लेकर सभी विभागों में बनाया जा रहा है। इसी क्रम में भारत सरकार द्वारा बिहार के दस जिलों को ग्रामीण स्तर की विकेन्द्रीकृत वार्षिक कार्य योजना बनाने हेतु चयन किया गया है। यह सौभाग्य की बात है कि दस जिलों में से दरभंगा भी एक जिला है, जिसके 18 (अठारह) प्रखंडों में से 5 (पॉच) प्रखण्ड का चयन प्रखण्ड में कार्यरत ए0एन0एम, ऑगनवाड़ी सेविका, प्रखण्ड समुदाय उत्प्रेरक एवं प्रखण्ड स्वास्थ्य प्रबधंक की भागीदारी को ध्यान में रखते हुए निम्नांकित प्रखण्डों का चयन किया गया है :-



एकनौलेजमैन्ट

वित्तीय वर्ष 2012-13 के लिए ग्रामीण स्तर पर वार्षिक योजना के निर्माण की परिकल्पना करना एवं दरभंगा जिला को यह अवसर प्रदान करने के साथ इस कार्य को करने के लिए जिला स्तरीय प्रबंधन ईकाई की टीम को क्षमता विकसित करने के लिए आदरणीय कार्यपालक निदेशक, राज्य कार्यक्रम प्रबधंक, बिहार, पटना तथा सभी राज्य स्तरीय कार्यक्रम पदाधिकारी, एन0एच0एस0आर0सी0 की टीम एवं पी0एच0आर0एन0 की टीम को हार्दिक धन्यवाद देता हूँ।

राज्य से प्राप्त मार्गदर्शन एवं प्रेरणा का संप्रेषण प्रखण्ड तक करने के लिए जिला स्तरीय टीम आदारणीय जिला पदाधिकारी सह अध्यक्ष, सिविल सर्जन सह सदस्य सचिव, क्षेत्रीय कार्यक्रम प्रबंधक, जिला कार्यक्रम प्रबंधक, जिला योजना समनव्यक एवं जिला स्वास्थ्य समिति के समस्त कर्मीयों की भागीदारी के प्रति मनीगाछी की टीम अपना हार्दिक आभार प्रकट करती है।

प्रखण्ड स्वास्थ्य प्रबंधक,
प्रा0स्वा0केन्द्र, मनीगाछी

प्रभारी चिकित्स पदाधिकारी,
प्रा0स्वा0केन्द्र, मनीगाछी

विषय सूची

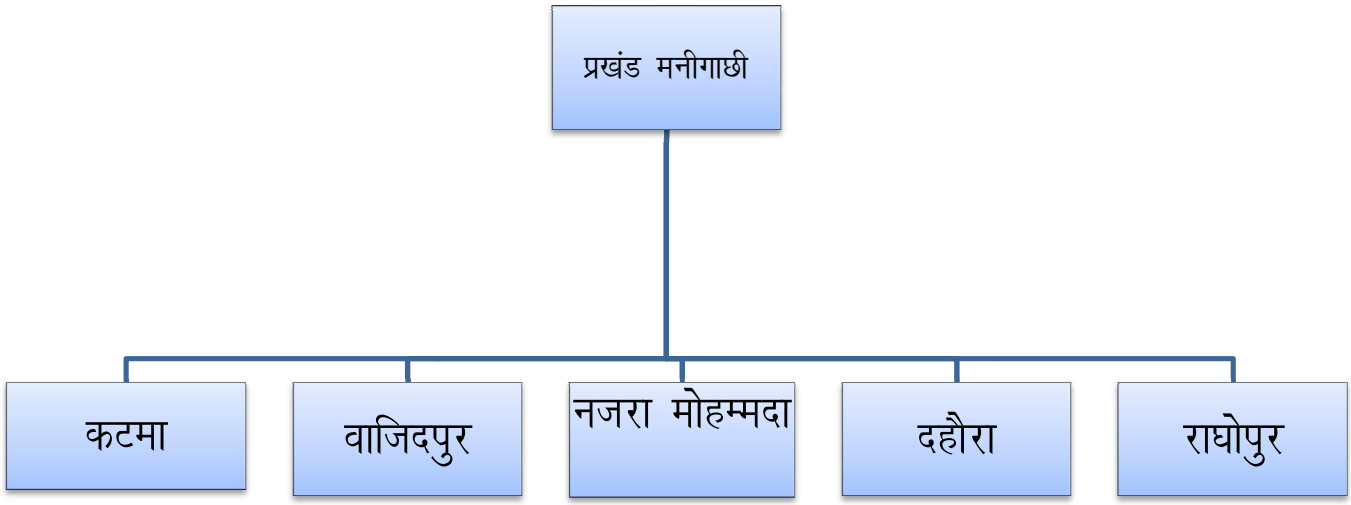
ग्रामीण स्वास्थ्य वार्षिक कार्य योजना का उद्देश्य

स्वास्थ्य कार्यक्रम जो मुख्य रूप से मातृ मृत्यु दर, शिशु मृत्यु दर को कम करने एवं स्वास्थ्य विभाग के निरोधात्मक एवं उपचारात्मक क्षमता में वृद्धि करते हुए सभी लोगों के लिए गुणवत्तापूर्ण आउट ऑफ पॉकेट मुफ्त ईलाज की व्यवस्था करना है। इस प्रयास में प्रबंधन क्षमता, आपूर्ति, कुशल मानव संसाधन एवं संचार तंत्र व प्रशिक्षण में संतोषजनक एवं गुणात्मक सुधार हुआ है जिसके कारण स्वास्थ्य विभाग से संबंधित सभी सूचकांको में सुधार परिलक्षित है। परन्तु यह सुधार अपेक्षित परिणाम से कम है जिसका मूल कारण सामुदायिक भागीदारी आपेक्षाकृत कम रहना है। इसका मुख्य कारण रहा है कि स्वास्थ्य क्षेत्र के सभी भागीदारो यथा स्वास्थ्य कार्यकर्त्ता, ग्रामीण एवं जन प्रतिनिधियों को योजना निर्माण में भागीदार नही बनाया जा सका और परिणाम यह हुआ कि उन्हे मनोविज्ञानिक स्तर पर यह लगता रहा कि उन पर योजनाएँ थोपी गयी है। यह योजना पूर्व की योजनाओं की तरह उनकी आवश्यकताओ की पूर्ति नही कर पाएगी साथ ही स्वास्थ्य संबंधित आवश्यकता एक बार फिर अनदेखी रह जाएगी।

इस विकेन्द्रीकृत योजना से पहला लाभ यह हुआ है कि सभी भगीदारो (ग्रामीण सहित) को स्वास्थ्य संबंधित सूचकांक, कार्यक्रम, वर्तमान स्थिति, आवश्यकताओं का आकलन, ढ़ाचागत निर्माण की आवश्यकता की जानकारी दी गयी है। जिसके कारण उनकी विश्लेषण क्षमता साथ ही संचालित योजनाओं में संभावित सुधार के लिए उपाय सोचने की क्षमता विकसित हुई है। इसके इतर ग्रामीण, माननीय जनप्रतिनिधि एवं स्वास्थ्य कार्यकर्ता इसे अपनी योजना, अपनी आवश्यकतानुसार बनायी गयी मान कर सेवा प्रदान करने वाली योजनाओ में उल्लेखित लक्ष्य हेतु प्रयास करेगें। ग्रामीण अपनी स्वास्थ्य संबंधित आवश्यकताओं को पूर्ण होने की अपेक्षा रखेगें साथ ही अपेक्षित परिणाम हेतु आवश्यक अनुश्रवण एवं मुल्यांकन सुनिश्चित कराएगे।

राघोपुर गाँव के चुनाव की प्रक्रिया

प्रखंड मनीगाछी का राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के अन्तर्गत गॉव के स्तर से योजना निर्माण की परिकल्पना को मूर्त रूप प्रदान करने हेतु इस वर्ष ग्रामीण स्वास्थ्य कार्ययोजना निर्माण करने हेतु जिला स्वास्थ्य समिति, दरभंगा के द्वारा चयन किया गया, जिसमें बिहार राज्य स्वास्थ्य समिति, बिहार, पटना के द्वारा ग्रामीण स्वास्थ्य कार्ययोजना बनाने के लिए उदेश्य एवं चयन प्रक्रिया को ध्यान में रखते हुए पॉच गॉवो को चुना गया।



राघोपुर गाँव का चयन निम्नांकित बिन्दुओं के आधार पर किया गया।

1. गाँव में उस पंचायत का स्वास्थ्य उपकेन्द्र स्थापित है।
2. गाँव में कार्यरत ए0एन0एम0, आशा एवं आंगनवाड़ी प्रशिक्षित है।
3. गाँव में स्वयं सहायता समूह कार्यरत है
4. गाँव के जनप्रतिनिधि हर दृष्टिकोण से सहयोग प्रदान करने वाले है।
5. गाँव में व्याप्त बिमारियो की सूचना संबंधित आकड़ें।

आकड़ो के चयन का माध्यम

उप स्वास्थ्य केन्द्र, राघोपुर के अन्तर्गत राघोपुर गाँव

1. स्वास्थ्य प्रबंधक द्वारा राघोपुर ग्राम का चयन ग्रामीण कार्य योजना हेतु किया गया क्योकि उक्त गाँव में हर दृष्टिकोण से स्वास्थ्य क्षेत्र में सुधार की आवश्यकता है।
2. मनीगाछी प्रखण्ड अन्तर्गत चयनित गाँव राघोपुर के ग्रामीण स्वास्थ्य कार्ययोजना निर्माण हेतु आकड़ों का संकलन स्वास्थ्य प्रबंधक, ए0एन0एम0 एवं उनके उप स्वास्थ्य केन्द्र अन्तर्गत आने वाली आशा एवं ऑगनवाड़ी सेविकाओं तथा जनप्रतिनिधि, वार्ड सदस्य के द्वारा किया गया।

स्वास्थ्य उपकेनद्र, राघोपुर, मनीगाछी

ग्रामीण स्वास्थ्य कार्य-योजना (2012-13)

निगरानी समिति का नाम	ग्रामीण स्वास्थ्य निगरानी समिति, राधोपुर
ऑगनबाड़ी सेविका का नाम	1 नीलम देवी 2 रामदाई देवी 3 पुतुल देवी
आशा का नाम	1 नीलम देवी
ए0एन0एम0 का नाम	1 अंजनी कुमारी
टी0बी0 डॉट् प्रोभाइडर का नाम	1. नीलम देवी 2 रामदाई देवी

परिचय	
गॉव का नाम	राघोपुर
पंचायत	राघोपुर
स्वास्थ्य उपकेन्द्र का नाम	राघोपुर
आंगनबाड़ी केन्द्र का नाम	1 राघोपुर यादव टोल 2 राघोपुर दक्षिणी 3 बरही टोल
आबादी	8322
पुरूष	4310
महिला	4012
योग दम्पति	2080
प्राथमिक स्वास्थ्य केन्द्र से दूरी	15 कि0मी0
अतिरिक्त प्राथमिक स्वास्थ्य केन्द्र से दूरी	4 कि0मी0
उपस्वास्थ्य केन्द्र से दूरी	1 कि0मी0

प्रथामिक विद्यालय से दूरी	1 कि0मी0
पेयजल के श्रोत	चापाकल 2
निकटतम प्रथम रेफरल अस्पताल से दूरी (जहॉ ब्लड भंडार की सुविधा हो) (रेफरल/अनुमंडलीय/सदर)	15 कि0मी0
विद्युत	गॉव में बिजली है।
सड़क	गॉव में बाहर से आने के लिये खरंजा एवं पक्की सड़क है।
यातायातः	गॉव से बाहर जाने के लिए ग्रामीण बस, मिनी बस, टैम्पो/जीप/कार पब्लिक ट्रान्सपोर्ट का उपयोग करते है।
आवागमन बाधित	कभी नहीं रहता हैं।
ग्रामीण स्वास्थ्य एवं पोषण दिवस के निर्धारित दिवस	सेमवार, बुधवार, शुक्रवार
मलेरिया की जाँच लोग कहॉ करवाते हैं	प्राथमिक स्वास्थ्य केन्द्र
डायरिया होने पर लोग कहॉ जाते हैं	प्राथमिक स्वास्थ्य केन्द्र
खसरा होने पर लोग कहॉ जाते हैं	प्राथमिक स्वास्थ्य केन्द्र
भवन	**प्राथमिक विद्यालय - हॉ** **ऑगनबाड़ी केन्द्र का - हॉ** **सामुदायिक भवन - हॉ**
पोलियो केस नये (2010-11)	नहीं
टी0 बी0 (2010-11)	हाँ
कालाजार (2010-11)	हाँ
कुष्ठ (2010-11)	हाँ
संस्थागत प्रसव (2010-11)	213
गृह प्रसव (2010-11)	26
महिला बंध्याकरण (10-11)	59
पुरूष नसबंदी (2010-11)	नहीं
निरोध प्राप्तकर्त्ता (10-11)	हाँ
लूप निवेशन (10-11)	35
ओरल पिल प्राप्तकर्त्ता (10-11)	25

एंबुलेंस सेवायें (गाँव के स्तर पर 102)	
गाड़ी संख्या	उपलब्ध नहीं है।
ड्राईवर का नाम	उपलब्ध नहीं है।

पंचायत के वार्डवार सूचनाओं का संकलन प्रपत्र				
क्र0सं0	वार्ड संख्या	जनसंख्या	वार्ड सदस्य का नाम	मोबाईल संख्या
1	1	1035	जगदीश साहु	
2	2	1190	मनोज साहु	
3	4	925	सुधीर झा	
4	5	1035	सुबोध सहाय	
5	7	1125	रंजीत ठाकुर	
6	3	1025	पतासिया देवी	
7	6	1000	जानकी देवी	
8	9	987	मोहन झा	

स्वास्थ्य सेवाएँ, कटिनाईयाँ, रणनीति, क्रियाकलाप एवं बजट

गर्भवती महिलाओं से संबंधित							
क्र0सं0	**बिन्दू**	**समस्या**	**कारण**	**समाधान**	**कौन करेगा**	**ईकाई राशि**	**बजट 12-13**
1	प्रसव पूर्व सेवाये	सभी गर्भवती महिलाओं की संख्या का पता नहीं होना।	सही ढंग से सर्वेक्षण नहीं होना	गर्भवती महिलाओं का मासिक सर्वेक्षण कराना।	आशा/आँगनवाड़ी/ए0एन0एम/स्वास्थ्य प्रशिक्षक	1000	1000
		नियमित जॉच नहीं होना।	आशाओं द्वारा सही समय पर गर्भ संबंधित जॉच नहीं करवाना।	प्रशिक्षण में साथ उपकरणों की कमी।	जिला द्वारा		
		समय पर IFA उपलब्ध नहीं होना ।	समुचित भंडारण की व्यवस्था नहीं होना।	समय पर दवा उपलब्ध कराना।	जिला द्वारा		
		प्रसूति का सही समय पर अस्पताल नहीं पहुँचना।	आशाओं द्वारा चिन्हित महिलाओं को पूर्व से रेफरल की वयवस्था नहीं किया जाना।	चिन्हित महिलाओं के लिए रेफरल की समुचित व्यवस्था करना।	आशा द्वारा स्थानीय गाड़ी मालिक से संपर्क कर ससमय अस्पताल पहुँचाना।		
2	प्रसव उपरान्त सेवाऐ	प्रसव उपरान्त एक सप्ताह तक Follow-Up नहीं होना।	आशाओं एवं ए0एन0एम द्वारा किसी भी तरह की जानकारी नहीं लेना।	आशा एवं ए0एन0एम द्वारा सही समय पर समुचित जानकारी देना	आशा एवं ए0एन0एम द्वारा की जाएगी।	मोबाईल हेतु 300 प्रति माह	3600
3	गृह प्रसव (विशेष परिस्थिति में)	प्रशिक्षित ए0एन0एम एवं दाई का सही समय पर उपलब्ध नहीं होना।	प्रसव की संभावित तिथि की जानकारी ए0एन0एम/आशा को नहीं होना।	आशा द्वारा क्षेत्र भ्रमण के दौरान चिन्हित महिलाओं का प्राथमिक स्वास्थ्य केन्द्र पर ले जाकर सही समय पर जॉच करवाना।	आशा एवं ए0एन0एम द्वारा की जाएगी।		
		आवश्यक Drug Kit का उपलब्ध नहीं होना।	समुचित दवा के संबंध में जानकारी का अभाव	समय-समय पर आशा/ए0एन0एम को दवा के उपयोग से संबंधित प्रशिक्षण देना।	जिला द्वारा		
4	नियमित टीकाकरण	पूर्ण टीकाकरण नही होना	आशा एवं आंगनवाड़ी द्वारा डीयू लिस्ट को सही नही रखना	आशा एवं आंगनवाड़ी द्वारा डीयू लिस्ट में नामित बच्चे एवं माताओं को टीकाकरण हेतु 02 दिन पूर्व सूचित करना	आशा, आंगनवाड़ी एवं ए0एन0एम0 द्वारा		

बच्चो से संबंधित							
क्र0सं0	बिन्दू	समस्या	कारण	समाधान	कौन करेगा	ईकाई राशि	बजट 12-13
1	कुपोषण	कुपोषण की सही जानकारी नहीं होना	आशा एवं आंगनवाड़ी के द्वारा क्षेत्र भ्रमण के समय बच्चों के सही स्वास्थ्य की जानकारी नही रखना	आशा एवं आंगनवाड़ी द्वारा क्षेत्र भ्रमण एवं टीकाकरण के समय संदिग्ध बच्चो को स्वास्थ्य जॉच हेतु अपने अधिनस्थ स्वास्थ्य केन्द्र पर भेजना	आशा , आंगनवाड़ी एवं ए0एन0एम0 द्वारा दवा उपलब्ध कराना एवं खान पान की महत्ता को बताना, आवश्यकतानुसार जिला में संचालित दुलार पोषण पुनर्वास केन्द्र (एन0आर0सी0)में भर्ती करवाना		0
योग्य दम्पति से संबंधित							
2	एफ0 डब्लू0 पी0 और आई0 यू0 डी0	योग्य दम्पति के सही आकड़े का पता नहीं होना	स्वास्थ्य विभाग द्वारा पूर्व में ए0एन0एम0 एवं बुनियादी स्वा0 कार्यकर्ता द्वारा योग्य दम्पति का वार्षिक सर्वेक्षण करवाया जाता था, ये कार्य आज के दिनो में बंद है	योग्य दम्पति के सही आकड़ो का वार्षिक सर्वेक्षण करवाना	ए0एन0एम0, स्वास्थ्य प्रशिक्षक एवं बुनियादी स्वा0 कार्यकर्ता	1000	1000
		लाभार्थी के विषय में समुचित जानकारी का आभाव होना	सभी आंगनवाड़ी केन्द्र एवं स्वास्थ्य उपकेन्द्र पर तिथि एवं जगह की सूचना उपलब्ध कराना	आशा, आंगनवाड़ी एवं ए0एन0एम0 द्वारा आपस में बैठक कर जगह एवं तिथि निर्धारित कर अपने लाभार्थीयो को सूचित करना	आशा, आंगनवाड़ी एवं ए0एन0एम0 द्वारा		0
		जनसंख्या नियंत्रण	आई0यू0डी0 कीट एवं प्रशिक्षित कर्मी का उपलब्ध नहीं होना	ए0एन0एम0 का प्रशिक्षण एवं आई0यू0डी0 कीट की उपलब्धता आवश्यकता नुसार मुहैया करवाना	जिला स्तर पर		0

अधारभूत संरचना

क्र0सं0	जरूरत	समस्या	कारण	समाधान	कौन करेगा	ईकाई राशि	बजट 12-13
1	स्वास्य उपकेन्द्र का भवन	भवन का जर्जर स्थिति	भवन का समुचित रख रखाव एवं रंगरोगन समय पर नहीं करना	अनटाईड फन्ड एवं ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के मद से आवश्यकता अनुसार ससम समय पर भवन को मरम्मती एंव रंगरोगन करवाना	ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के सदस्यों द्वारा		सरकार से संबंधित
2	पेय जल	आवश्यकतानुसार चापाकल का नही होना	जागरूकता की कमी	अनटाईड फन्ड एवं ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के मद से करवाना	ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के सदस्यों द्वारा		7000
3	शौचालय	शौचालय की समुचित व्यवस्था नहीं होना	शौचालय भवन का समुचित रख रखाव एवं रंगरोगन समय पर नहीं करना	अनटाईड फन्ड एवं ग्रामीण स्वास्थ्य एवं स्वच्छता समिति के मद से करवाना	स्वास्थ्य प्रबंधक		15000
4	बिजली	बिजल की समुचित आपूर्ति नही होना	बिजली बिभाग द्वारा समय पर बिजली की आपूर्ति नही देना।	सोलर लाईट, इमरजेन्सी लाईट एवं जेनरेटर सुविधा	स्वास्थ्य प्रबंधक		25000

मानव संसाधन

क्र0सं0	जरूरत		ईकाई राशि	बजट 12-13
1	एन0एन0एम0	उपलब्ध है।		
2	एन0एन0एम0 आर0	उपलब्ध नही है।		
3	साफ सफाई कर्मी	नियुक्ति किया जाना है । (जिला द्वारा)	1500	18000
उपकरण				
1	स्टॉप वाच, थर्मामीटर, ड्रेसिंग ड्राम, आरटीफोरसेप, ब्लेड, मापने का फीता, आला	अपटाईड फन्ड से खरीद किया जाना है।		10000
कार्यालय संबंधित सामग्री				
1	टेबुल, कुर्सी, आलमीरा, मेडिसीन, जाँच करने का टेबुल, फुट स्टेप, बकेट, मग, पर्दा, रबर सीट, एप्रोन इत्यादि।	अपटाईड फन्ड से खरीद किया जाना है।		10000
			कुल	73400

ए0एन0एम0 सह सचिव
ग्रामीण स्वास्थ्य एवं स्वच्छता समिति

अध्यक्ष
ग्रामीण स्वास्थ्य एवं स्वच्छता समिति

ग्रामीण स्वास्थ्य कार्ययोजना का महत्व

समुदाय के द्वारा किये गये सामुहिक चर्चा से प्राप्त कारणो एवं उसके समाधानो से संबंधित गतिविधियो को समायोजित कर स्वास्थ्य उपकेन्द्र की कार्ययोजना में समायोजित किया जा रहा है। इसी तरह स्वास्थ्य उपकेन्द्रों की कार्ययोजनाओं को प्रखण्ड स्तरीय कार्ययोजना एवं प्रखण्ड स्तरीय कार्ययोजना को जिला स्तरीय कार्ययोजना में समायोजित किया जाएगा। फलस्वरूप विकेन्द्रीकरण की इस प्रक्रिया में एक पारदर्शी एवं सत्यतापूर्ण कार्ययोजना का निर्माण संभव हो पाएगा जो जनता द्वारा जनता को समर्पित है।

धन्यवाद सहित

Abbreviations

ANM	**Auxiliary Nurse Midwife**
ARI	**Acute Respiratory Infection**
AWC	**Aaganwadi Centre**
ASHA	**Accredited Social Health Activist**
AWW	**Aaganwadi Worker**
AYUSH	**Ayurved Unani Siddha and Homeopathy**
BEmONC	**Basic Emergency Obstetric Neonatal Care**
BHAP	**Block health Action Plan**
BPL	**Below Poverty Line**
CBO	**Community Based Organization**
CEmONC	**Comprehensive Emergency Obstetric Neonatal Care**
CH	**Civil Hospital**
CHC	**Community Health Centre**
CS	**Civil Surgeon**
CMR	**Child Mortality Rate**
CSO	**Civil Society Organization**
DFID	**Department for International Development**
DH	**District Hospital**
DHAP	**District Health Action Plan**
APHC	**Additional Primary Health Centre**
SDH	**Sub-Divisional Hospital**
DP	**Development Partners**
FNGO	**Field Non-Governmental Organization**
GOI	**Government of India**
HMIS	**Health Management Information System**
HRD	**Human Resource Development**
ICDS	**Integrated Child Development Scheme**
IEC	**Information Education and Communication**
IFA	**Iron Folic Acid**
IMNCI	**Integrated Management of Neonatal and Childhood Illnesses**
IMR	**Infant Mortality Rate**
IPHS	**Indian Public Health Standards**
IUCD	**Inter Uterine Contraceptive Devices**
JBSY	**Janani Evam Bal Suraksha Yojana**
LHV	**Local Health Visitor**
M&E	**Monitoring and Evaluation**
MDG	**Millennium Development Goals**
MOHFW	**Ministry of Health and Family Welfare**
MoU	**Memorandum of Understanding**
MPW	**Multi-Purpose Worker**
MTP	**Medical Termination of Pregnancy**
NACO	**National AIDS Control Organization**
NACP	**National AIDS Control Programme**
NFHS	**National Family Health Survey**
NMR	**Neonatal Mortality Rate**
OBC	**Other Backward Class**
OPD	**Outdoor Patient Dispensary**

PG	**Post Graduate**
PHC	**Primary Health Centre**
PHED	**Public Health Engineering Department**
PIP	**Programme Implementation Plan**
PMU	**Programme Management Unit**
POL	**Petrol Oil and Lubricant**
PRI	**Panchayati Raj Institution**
RCH	**Reproductive and Child Health**
RHS	**Rapid Household Survey**
RKS	**Rogi Kalyan Samiti**
RMP	**Registered Medical Practitioner**
RTI	**Reproductive Tract Infection**
SBA	**Skilled Birth Attendant**
SC	**Scheduled Caste**
SHC	**Sub Health Centre**
SNGO	**Service Non-Governmental Organization**
SPMU	**District Programme Management Unit**
ST	**Scheduled Tribe**
STI	**Sexual Tract Infection**
TBA	**Traditional Birth Attendant**
TFR	**Total Fertility Rate**
TT	**Tetanus Toxoid**
U5M	**Under 5 Mortality**
UIP	**Universal Immunization Programme**
UNFPA	**United Nations Population Fund**
UT	**Union Territory**
VHAP	**Village Health Action Plan**
VHSC	**Village Health and Sanitation Committee**
VO	**Voluntary Organization**

BUDGET PART - 2012-2013