STATE PROGRAMME IMPLEMENTATION PLAN

Government of Bihar

NATIONAL RURAL HEALTH MISSION

2008-09

March 2008

Preface

National Rural Health Mission offers unprecedented opportunity to improve the health of the people of Bihar. The Public Health System of Bihar, through its more than 10000 thousand ANMs, 75000 of ASHAs, 70000 of Anganwadi Workers and thousands of doctors reaches out to the people living in more than 80000 villages. The Public Health infrastructure, particularly PHCs/CHCs and hospitals ought to be the institutions where people can put their trust for good quality health services as per needs.

Though the role of Public Health system is primarily important, NRHM heralds a new beginning where the health of the people will be placed on their own hands and government will play a role of facilitator providing all round support, ensuring access to health services. The PIP has been prepared through consultation with block and district level functionaries. The plans prepared on the need based which has addressed lots of critical issues to implement the programme.

The plan is 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. Government will play the role of a facilitator and undertake new initiatives.

As planned here the capacity to manage the programme in the state is going to be significantly strengthened. There will be Programme Management Support Units at the block level, HMIS will be strengthened, and the support system also strengthened. This year also number PPP initiatives taken to reach out services to the people. It is expected that for the state of Bihar, this will be the turning point for accelerated improvement in health.

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1. Summary

The Government of Bihar has taken strong initiative in implementing the NRHM at the right earnest. The state has prepared the Plan in consultation with District and Blocks. The Plan is need based and gives significant importance on the role of private health care providers in delivery of Health system at all level.

Some of the activities, which are being implemented or are planned to be implemented are as follows:

Reproductive and Child Health:

1. Access of ANC Care service by providing Addll ANMs and New HSCs
2. Quality of ANC care will be monitored
3. Special Scheme on reducing Anemia among Pregnant Mothers and Children
4. Emphasis on Post Natal Care
5. RCH Camp will be organise Quaterly in all 533 PHC
6. Strengthening FRUs and PHCs for providing better facility for Institutional Delivery.
7. Training of SBA, EmOC, Life Saving Anesthesia Skills, RTI/STI, Safe Abortion.
8. NICUs and New Borncare Units will be set up in FRUs and PHCs.
9. Special Programme will be taken up for exclusive Breast Feeding Practices.
10. Training of IMNCI, Facility Based Newborn Care.
11. ASHAs will be involved in growth monitoring of children
12. Family Planning Programme will be strengthening by giving more emphasis o terminal method.
13. Weekly organizing mini lap at the PHC level, NSV camp at the district/sub district level.
14. IUD camps will be organised at the PHC level.
15. Training of MOs on Minilap/NSV. Trainings of ANMs on IUD unsertion
16. ARSH implementation in convergence with Bihar State AIDS Control Society.
17. Urban Health mapping will be done and 63 New Urban Health Centre Proposed.
18. Provision for incentive under MUSKAAN Programme as innovation.
19. Strengthen the SPMSU and DPMSUs. Provision for Training for programme Implementation.

NRHM Additionalities

1. ASHA Support System at State, District and Block level
2. Construction of 1000 new HSCs
3. Construction of 200 New PHCs

4. Upgradation of PHCs to CHCs
5. Upgradation of District Hospitals as per IPHS
6. Provision for Untied Fund and Annual Maintenance Grant
7. Strengthening of Rogi Kalyan Samities
8. State Health Resource Centre for Hospital Planning and Design and Procurement cell proposed to support the state.
9. PPP initiave in Emergency and Referral Service, Dialysis Unit, Implementation of Bio Medical Waste Management, Blood Storage, Hospital Maintenance, Drug Store, Pathology and Diagnostic Service, Telemedicne System.
10. Some additional scheme for supporting RCH Programme like Exclusive Breast Feeding, Nutritional Rehabilitation Centre and Anaemia Control.
11. Strengthening of Block Programme Management Unit by setting up another 138 BPMSUs.
12. Additional Manpower for State Health Society for implementating the NRHM.

Immunization:

1. Increase coverage of the routine immunization programme by strengthening Monitoring and Training of Immunization.
2. Provision for Alternative Vaccine Delivery
3. Proper handling and mainthenance of Cold Chains at all levels.
4. Role of ASHA in complete immunization. Provision for incentive for mobilization.
5. Universal coverage of 5 doses of Vitamin- A to reduce the prevalence of night blindness to below 1% and Bitots spots to below 0.5% in children 6 months to 6 years age.
6. Stregthening IEC/BCC activity for Coverage of Immunization and Vitamine A
7. More involvement of Programme Partners for strengthening the management and logistics for Immunization.

National Disease Control Programme

1. Prevention of Kala azar by strengthening the BCC/IEC activity
2. Early diagnosis and treatment of Kala azar through training of health personnels.
3. Prevention of Malaria will be strengthened by provision of DDT spray, strengthening IEC/BCC activity and Trainings.
4. IDSP will be strengthened by strengthening Peripheral Lab and monitoring activity.
5. More NGOs will be involved in supporting and implementing the RNTCP programme.
6. Training will be strengthen for RNTCP staffs.
7. Emphasis on Prevention of Disability due to Leprosy.
8. Strengthen the IEC/BCC activity and Training under NLEP.
9. Continuous NGO support for elimination of Leprosy

10. Stregthen the One Medical College, 5 District Hospital and 5 Sub Div Hospital for Eye Operation centre.
11. Provision for Eye Screening at the school.
12 Stregthen the IEC/BCC Activity
13. Provision for grants for Cataract operation.

Intersectoral Convergence

1. Convergence with ICDS for Maternal and Child Health. Incentives for ICDS functionaries.
2. Involvement of PRIs in delivering the Health Services. Provision for meeting with the Health Department at the Block Level.

SUMMARY of BUDGET for 2008-09

PART	HEAD	BUDGET 2008-09 (Rs. In Lakhs)	%
A	RCH II	30695.76	34.44
B	NRHM Additionalities	38915.39	43.66
C	Immunization	10530.67	11.82
D	NDCP	5752.92	6.45
E	Intersectoral Convergence	3232.04	3.63
	TOTAL	**89126.78**	**100.00**

2. Process of Plan Preparation

Information collected fro the District and Block level is the key in preparing the State PIP. At the block level consultation done which has been further sent to District. With the information gather from the block, district has held the consultation and prepare their priority and requirement.

The district has sent their requirement to the state which the state programme officers discussed and finalized their requirement. The state has considered the requirement of the district thoroughly and provision has been made I the PIP as per their need.

It should be mentioned that the plan has been prepare keeping in mind that private party can play a bigger role in delivering the health care services in the state.

3. Background and Current Status

3.1 Demographic and Socio-Economic Features at State and District Levels

Bihar with a population of 82.9 million is the second most populous state in India, next only to Uttar Pradesh. Despite efforts in the last few decades to stabilise population growth, the state's population continues to grow at a much faster rate (28.43%) than the national population (21.34%). The state is densely populated with 880 persons per square kilometre as against the country average of 324.The sex ratio of the state at 919 is also less favourable than the national average of 933.

Table 3.1.1: Bihar: Demographic, Socio-Economic and Health Indices

Characteristics	Bihar	India
Area	94,163 Sq. Km	
Demographic Indicators		
Population	828.8 Million	1027.0 Million
Population Density (Population / km2)	880	324
Sex Ratio	919	933
% decadal growth rate	28.43%	21.34%
Socio-Economic Indicators		
Per Capita Income (Rs.) for year 2003-04		
At constant1993-94 prices	3707	10964
At current prices	6861	20292
% decadal growth in Per capita Income	~ zero	~ 45%
Proportion of population below poverty line	42%	26%
Level of Urbanization	10.5%	27.8%
Literacy	47.5%	65.4%

Source: Census 2001, Ministry of Statistics and Program Implementation

Among the 38 districts of the state, West Champaran is the largest in terms of area (5228.00 sq. km) while the smallest is Sheikhpura (605.96 sq. km). In terms of population, Patna is the largest at 4.72 millions followed by East Champaran that has a population of 3.94 millions. Sheohar and Sheikhpura have the smallest population of 0.52 millions and 0.53 millions respectively. In terms of Sex Ratio, while districts such as

Siwan (1031) and Gopalganj (1001) have a favourable ratio, other districts like Munger (872), Patna (873) and Bhagalpur (876) have a less favourable ratio.

Bihar has total SC population of around 15.07%. However, SC population in certain districts like Gaya (29.6%) and Nawada (24.1%) is much higher than the state average. On the other hand, districts such as Kishanganj (6.6%) and Arwal (8.9%) have a relatively low proportion of SC population. After the bifurcation of the state in 2002, most of the areas with large ST population have been included in the state of Jharkhand. Therefore, the state has less than 1% ST population.

In terms of key health indicators, Bihar is among the low performing states. Though the state fares reasonably well in terms of its Infant Mortality Rate (61) as against the national average (58)), it continues to be among the poorer performing states in terms of other indicators such as TFR, MMR and NMR.

In terms of socio-economic indices too the district level variation is obvious. For literacy rates, districts such as Arwal (26%), Jehanabad (29.3%), Kishanganj (31.1%), Araria (35%) and Katihar (35.1%) are much below the even state average of 46.4%. However, there are districts - Aurangabad (57%), Bhojpur (59%), Munger (59.5%), Patna (62.9%) and Rohtas (61.3%) -that have performed better than the state average with literacy rates close to 60%. Similarly performance of districts on percentage of people living below the poverty line is varied with districts such as Araria faring the worst at 80.3%. Other poorly performing districts are Bhagalpur, Madhubani, Purnea, Sitamarhi, Supaul and Sheohar, where close to 70% of the population continues to live below the poverty line. Despite such a large number of districts having a significant proportion of their population living below poverty line, the state average of 46.2% (among the lowest in the country) is largely due to the fact that there are some districts such as Kaimur, Saharsa, Samastipur, Arwal and Jehanabad and Gopalganj where close to 80% of the population are living above the poverty line. (See table 2.1.2 for district-wise detailed data).

Table 2.1.2: Bihar: Key Demographic and Socio-economic Indicators of Districts

Sl No	Districts	Area in Sq. Km	Population			BPL (%)	SC (%)	ST (%)	Sex Ratio	Literacy Rates
			Rural	Urban	Total					
1	2	3	4	5	6	7	8	9	10	11
1	Araria	2830.00	2026257	132351	2158608	80.3	13.6	1.4	913	35.0
2	Aurangabad	3305.00	1842998	170057	2013055	61.7	23.5	0.1	934	57.0
3	Arwal	761.12	659270	52458	711728	23.36	8.9	0.05	929	26.0
4	Banka	3019.56	1552353	56420	1608773	63.4	12.4	4.7	908	42.7
5	Begusarai	1918.00	2241743	107623	2349366	65.4	14.5	0.1	912	48.0
6	Bhagalpur	2569.44	1970745	452427	2423172	70.2	10.5	2.3	876	49.5
7	Bhojpur	2474.17	1930730	312414	2243144	55.3	15.3	0.4	902	59.0
8	Buxar	1623.83	1273422	128974	1402396	46.6	14.1	0.6	899	56.8
9	Champaran (E)	3968.00	3688687	251086	3939773	54.1	13.0	0.1	897	37.5
10	Champaran (W)	5228.00	2733907	309559	3043466	47.4	14.3	1.5	901	38.9
11	Darbhanga	2279.00	3028441	267348	3295789	60.0	15.5	0.0	914	44.3
12	Gaya	4976.00	2997479	475949	3473428	69.8	29.6	0.1	938	50.4
13	Gopalganj	2033.00	2022048	130590	2152638	37.6	12.4	0.3	1001	47.5
14	Jehanabad	807.88	743433	59154	802587	26.34	10.0	0.05	929	29.3
15	Jamui	3098.27	1295552	103244	1398796	63.4	17.4	4.8	918	42.4
16	Kaimur	3361.90	1247299	41775	1289074	15.4	22.2	2.8	902	55.1
17	Katihar	3057.00	2174361	218277	2392638	49.1	8.7	5.9	919	35.1
18	Khagaria	1486.00	1204027	76327	1280354	48.8	14.5	0.0	885	41.3
19	Kishanganj	1884.00	1167340	129008	1296348	58.0	6.6	3.6	936	31.1
20	Lakhisarai	1299.01	684485	117740	802225	62.3	15.8	0.7	921	48.0

Sl.No.	Districts	Area in sq.k.m	Population			BPL (%)	SC (%)	ST (%)	Sex Ratio	Literacy Rate
			Rural	Urban	Total					
1	2	3	4	5	6	7	8	9	10	11
21	Madhepura	1788.00	1458679	67967	1526646	55.4	17.1	0.6	915	36.1
22	Madhubani	3501.00	3450736	124545	3575281	72.4	13.5	0	942	42.0
23	Munger	1418.76	819950	317847	1137797	53.0	13.3	1.6	872	59.5
24	Muzaffarpur	3372.00	3398361	348353	3746714	55.9	15.9	0.1	920	48.0
25	Nalanda	2367.00	2016899	353629	2370528	53.8	20.0	0.0	914	53.2
26	Nawada	2494.00	1671253	138443	1809696	62.0	24.1	0.1	946	46.8
27	Patna	3202.00	2757060	1961532	4718592	48.1	15.5	0.2	873	62.9
28	Purnia	3229.00	2321544	222398	2543942	70.0	12.3	4.4	915	35.1
29	Rohtas	3851.10	2123942	326806	2450748	56.8	18.1	1.0	909	61.3
30	Saharsa	1701.65	1383015	125167	1508182	14.2	16.1	0.3	910	39.1
31	Samastipur	2904.0	3271338	123455	3394793	19.5	18.5	0.1	928	45.1
32	Saran	2641.0	2950064	298637	3248701	54.1	12.0	0.2	966	51.8
33	Sheikhpura	605.96	444189	81313	525502	59.5	19.7	0.0	918	48.6
34	Sheohar	442.99	494699	21262	515961	69.8	14.4	0.0	885	35.3
35	Sitamarhi	2200.01	2529407	153313	2682720	67.1	11.8	0.1	892	38.5
36	Siwan	2219.0	2564860	149489	2714349	51.0	11.4	0.5	1031	51.6
37	Supaul	2410.35	1644370	88208	1732578	74.6	14.8	0.3	920	37.3
38	Vaishali	2036.00	2531766	186655	2718421	41.1	20.7	0.1	920	50.5
State Total		94363.00	74316709	8681800	82998509	46.2	15.07	0.9	919	46.4

3.2 Administrative Divisions

Bounded by Uttar Pradesh in the west, West Bengal on the east, Nepal on the north and Jharkhand on the south, Bihar covers an area of 94,363 square kilometers. The state has 38 districts divided into 9 administrative divisions. Tirhut and Patna divisions have 6 districts each whereas the Bhagalpur Division comprises of only two districts.

Table 3.2.1: Administrative Divisions

Sl .	Divisions	Districts
1	Patna	Patna, Nalanda, Bhojpur, Rohtas, Kaimur, Buxar
2	Magadh	Gaya, Jehanabad, Arwal, Aurangabad, Nawada
3	Tirhut	Muzaffarpur, Sitamarhi, Vaishali, Champaran East, Champaran West,
4	Saran	Saran, Siwan, Gopalganj
5	Darbhanga	Darbhanga, Madhubani, Samastipur
6	Munger	Begusarai, Jamui, Khagaria, Lakhisarai,Munger, Sheikhpura
7	Kosi	Saharsa, Madhepura, Supaul
8	Bhagalpur	Bhagalpur, Banka
9	Purnea	Purnia, Araria, Kishanganj, Katihar

In addition, the state has 101sub-divisions, 534 community development blocks, 9 urban agglomerations, 130 towns (125 statutory towns and 5 non-statutory census towns) and 37,741 villages.

Table 3.2.2: Community Development Blocks

Sl.	Districts	Community Development Blocks	
		Total	Block Name
1	Araria	9	Narpatganj, Forbesganj, Bhargama, Raniganj, Araria, Kursakatta, Sikti, Palasi, Jokihat
2	Arwal	3	Karpi, Kurtha, Makhdumpur
3	Aurangabad	11	Daudnagar, Haspura, Goh, Rafiganj, Obra, Aurangabad, Barun, Nabinagar, Kutumba, Deo, Madanpur
4	Banka	11	Shambhuganj, Amarpur, Rajaun, Dhuraiya, Barahat, Banka, Phulidumar, Belhar, Chanan, Katoria, Bausi
5	Begusarai	18	Khudabandpur, Chhorahi, Garhpura, Cheria Bariarpur, Bhagwanpur, Mansurchak, Bachhwara, Teghra, Barauni, Birpur, Begusarai, Naokothi, Bakhri, Dandari, Sahebpur Kamal, Balia, Matihani, Shamho Akha Kurha

6	Bhagalpur	16	Narayanpur, Bihpur, Kharik, Naugachhia, Rangra Chowk, Gopalpur, Pirpainti, Colgong, Ismailpur, Sabour, Nathnagar, Sultanganj, Shahkund, Goradih, Jagdishpur, Sonhaula
7	Bhojpur	14	Shahpur, Arrah, Barhara, Koilwar, Sandesh, Udwant Nagar, Behea, Jagdishpur, Piro, Charpokhari, Garhani, Agiaon, Tarari, Sahar
8	Buxar	11	Simri, Chakki, Barhampur, Chaugain, Kesath, Dumraon, Buxar, Chausa, Rajpur, Itarhi, Nawanagar
9	E. Champaran	27	Raxaul, Adapur, Ramgarhwa, Sugauli, Banjaria, Narkatia, Bankatwa, Ghorasahan, Dhaka, Chiraia, Motihari, Turkaulia, Harsidhi, Paharpur, Areraj, Sangrampur, Kesaria, Kalyanpur, Kotwa, Piprakothi, Chakia(Pipra), Pakri Dayal, Patahi, Phenhara, Madhuban, Tetaria, Mehsi
10	Champaran W	18	Sidhaw, Ramnagar, Gaunaha, Mainatanr, Narkatiaganj, Lauriya, Bagaha, Piprasi, Madhubani, Bhitaha, Thakrahan, Jogapatti, Chanpatia, Sikta, Majhaulia, Bettiah, Bairia, Nautan
11	Dharbhanga	18	Jale, Singhwara, Keotiranway, Darbhanga, Manigachhi, Tardih, Alinagar, Benipur, Bahadurpur, Hanumannagar, Hayaghat, Baheri, Biraul, Ghanshyampur, Kiratpur, Gora Bauram, Kusheshwar Asthan, Kusheshwar Asthan Purbi
12	Gaya	24	Konch, Tikari, Belaganj, Khizirsarai, Neem Chak Bathani, Muhra, Atri, Manpur, Gaya Town CD Block, Paraiya, Guraru, Gurua, Amas, Banke Bazar, Imamganj, Dumaria, Sherghati, Dobhi, Bodh Gaya, Tan Kuppa, Wazirganj, Fatehpur, Mohanpur, Barachatti
13	Gopalganj	14	Katiya, Bijaipur, Bhorey, Pach Deuri, Kuchaikote, phulwaria, Hathua, Uchkagaon, Thawe, Gopalganj, Manjha, Barauli, Sidhwalia, Baikunthpur
14	Jahanabad	12	Arwal, Kaler, Sonbhadra Banshi Suryapur, Ratni Faridpur, Jehanabad, Kako, Modanganj, Ghoshi, Hulasganj
15	Jamui	10	Islamnagar Aliganj, Sikandra, Jamui, Barhat, Lakshmipur, Jhajha, Gidhaur, Khaira, Sono, Chakai
16	Kaimur	11	Ramgarh, Nuaon, Kudra, Mohania, Durgawati, Chand, Chainpur, Bhabua, Rampur, Bhagwanpur, Adhaura
17	Katihar	16	Falka, Korha, Hasanganj, Kadwa, Balrampur, Barsoi, Azamnagar, Pranpur, Dandkhora, katihar, Mansahi, Barari, Sameli, Kursela, Manihari, Amdabad

18	Khagaria	7	Alauli, Khagaria, Mansi, Chautham, Beldaur, Gogri, Parbatta
19	Kishanganj	7	Terhagachh, Dighalbank, Thakurganj, Pothia, Bahadurganj, Kochadhamin, Kishanganj
20	Lakhisarai	6	Barahiya, Pipariya, Surajgarha, Lakhisarai, Ramgarh Chowk, Halsi
21	Madhubani	21	Madhwapur, Harlakhi, Basopatti, Jainagar, Ladania, Laukaha, Laukahi, Phulparas, Babubarhi, Khajauli, Kaluahi, Benipatti, Bisfi, Madhubani, Pandaul, Rajnagar, Andhratharhi, Jhanjharpur, Ghoghardiha, Lakhnaur, Madhepur
22	Madhepura	13	Gamharia, Singheshwar, Ghailarh, Madhepura, Shankarpur, Kumarkhand, Murliganj, Gwalpara, Bihariganj, Kishanganj, Puraini, Alamnagar, Chausa
23	Munger	9	Munger, Bariarpur, Jamalpur, Dharhara, Kharagpur, Asarganj, Tarapur, Tetiha Bambor, Sangrampur
24	Muzaffarpur	17	Sahebganj, Baruraj (Motipur), Paroo, Saraiya, Marwan, Kanti, Minapur, Bochaha, Aurai, Katra, Gaighat, Bandra, Dholi (Moraul), Musahari, Kurhani, Sakra
25	Nalanda	20	Karai Parsurai, Nagar Nausa, Harnaut, Chandi, Rahui, Bind, Sarmera, Asthawan, Bihar, Noorsarai, Tharthari, Parbalpur, Hilsa, Ekangarsarai, Islampur, Ben, Rajgir, Silao, Giriak, Katrisarai
26	Nawada	14	Nardiganj, Nawada, Warisaliganj, Kashi Chak, Pakribarawan, Kawakol, Roh, Gobindpur, Akbarpur, Hisua, Narhat, Meskaur, Sirdala, Rajauli
27	Patna	23	Maner, Dinapur-Cum-Khagaul, Patna Rural, Sampatchak, Phulwari, Bihta, Naubatpur, Bikram, Dulhin Bazar, Paliganj, Masaurhi, Dhanarua, Punpun, Fatwah, Daniawan, Khusrupur, Bakhtiarpur, Athmalgola, Belchhi, Barh, Pandarak, Ghoswari, Mokameh
28	Purnia	14	Banmankhi, Barhara, Bhawanipur, Rupauli, Dhamdaha, Krityanand Nagar, Purnia East, Kasba, Srinagar, Jalalgarh, Amour, Baisa, Baisi,
29	Rohtas	19	Kochas, Dinara, Dawath, Suryapura, Bikramganj, Karakat, Nasriganj, Rajpur, Sanjhauli, Nokha, Kargahar, Chenari, Nauhatta, Sheosagar, Sasaram, Akorhi Gola, Dehri, Tilouthu, Rohtas

30	Saharsa	10	Nauhatta, Satar Kataiya, Mahishi, Kahara, Saur Bazar, Patarghat, Sonbarsa, Simri Bakhtiarpur, Salkhua, Banma Itahri
31	Samastipur	20	Kalyanpur, Warisnagar, Shivaji Nagar, Khanpur, Samastipur, Pusa, Tajpur, Morwa, Patori, Mohanpur, Mohiuddinagar, Sarairanjan, Vidyapati Nagar, Dalsinghsarai, Ujiarpur, Bibhutpur, Rosera, Singhia, Hasanpur, Bithan
32	Saran	21	Mashrakh, Panapur, Taraiya, Ishupur, Baniapur, Lahladpur, Ekma, Manjhi, Jalalpur, Revelganj, Chapra, Nagra, Marhaura, Amnour, Maker, Parsa, Dariapur, Garkha, Dighwara, Sonepur
33	Sheikhpura	6	Barbigha, Shekhopur Sarai, Sheikhpura, Ghat Kusumbha, Chewara, Ariari
34	Sitamarhi	17	Bairgania, Suppi, Majorganj, Sonbarsa, Parihar, Sursand, Bathnaha, Riga, Parsauni, Belsand, Runisaidpur, Dumra, Bajpatti, Charaut, Pupri, Nanpur, Bokhara
35	Sheohar	5	Purnahiya, Piprarhi, Sheohar, Dumri Katsari, Tariani Chowk
36	Siwan	19	Nautan, Siwan, Barharia, Goriakothi, Lakri Nabiganj, Basantpur, Bhagwanpur Hat, Maharajganj, Pachrukhi, Hussainganj, Ziradei, Mairwa, Guthani, Darauli, Andar, Raghunathpur, Hasanpura, Daraundha, Siswan
37	Supaul	11	Nirmali, Basantpur, Chhatapur, Pratapganj, Raghopur, Saraigarh, Bhaptiyahi, Kishanpur, Marauna, Supaul, Pipra, Tribeniganj
38	Vaishali	16	Vaishali, Paterhi Belsar, Lalganj, Bhagwanpur, Goraul, Chehra Kalan, Patepur, Mahua, Jandaha, Raja Pakar, Hajipur, Raghopur, Bidupur, Desri, Sahdai Buzurg, Mahnar

3.3 RCH Outcome and Service Utilization

The government and its concerned agencies have initiated various programmes to address the health related issues of the state. However, there is considerable scope of improvement. One of the reasons for limited achievements of the programs has been the lack of quality of services. The State Health Society has paid special attention to the quality of services and aims at meeting the needs of the population leading to widespread acceptance of the service. The goal is to provide integrated reproductive health care services, including addressing the unmet need for contraception in order to improve the situation by the year 2010.

The program has made positive impact on the indicators in the state but there is still a long way to go. The current situation of the selected indictors based on NFHS-3 shows that overall the state is moving towards achieving the goals. The recent NFHS-3 has shown the improvements in health indicators in the State. IMR has reduced from 78 to 62, MMR from 389 to 371 but TFR rose from 3.7 to 4.

Important indicators reviewed during NFHS-3:

Total Fertility Rate (TFR) has increased from 3.7 to 4
Contraceptive use has increased from 24 % to 34 %
Antenatal Care has not improved at all
Institutional deliveries have increased from 15 % to 22%
IMR has declined from 78 to 62 per 1000 live births
Percentage of children under age 3 who are underweight has increased 54.3 to 58.4%

Though the State has achieved some progress in terms of output indicators, the maternal mortality, child mortality and population growth continues to be a cause of serious concern to the state's development efforts. Moreover, floods in some parts of the state make the State vulnerable to communicable diseases. Besides, the health infrastructure is inadequate to cater to the needs of the people and the upkeep of the already existing facilities is challenging.

Human resources are another major issue where the State health system is struggling to deal with. The paucity of medical professionals especially the specialists limits the public health facilities in providing much required higher levels of care to the needy. A mismatch exists in the State between the available medical and Para medical professionals and the demand for their services. More medical graduates and Para medical professionals are required to fill up this gap. To overcome this, the State has

initiated public private partnerships, out sourcing 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 state is encountering is a declining sex ratio. Several initiatives like advocacy, IEC programs and enforcement of PNDT aimed at reversing the existing sex ratio will be initiated this year.

In the coming years, the state envisions a system, which provides all the individuals specially the BPL population the ability to access health care at an affordable price by tackling the existing problems and building on its strengths and addressing its weaknesses.

3.4 Public Health Infrastructure

District wise Availability of Health Centres of Bihar State																	
Sl.	Name of Districts	No. of DH	New Constr uction	Total DH	No. of Sub Divl Hospitals exist	New Constr uction	No. of Referral Hospital upgraded in Sub Div Hospitals	Total Sub Div Hosp itals	No. of Referral Hospital s exist previou sly	No. of Referral Hospital s exist Presentl y	No. of PHCs exist	New Constr uction	No. of APHCs upgrade d into PHCs	Total No. of PHCs	No. of APHCs exist previosl y	No. of APHCs exist presentl y	No. of HSCs
1	Araria		1	1	1		1	2	3	2	9			9	30	30	200
2	Arwal		1	1				0			3			3	23	23	46
3	Aurangabad	1		1		1		1	3	3	11			11	58	58	207
4	Banka		1	1	1			1	3	3	10	1		11	24	24	227
5	Begusrai	1		1		1	1	2	2	1	11	7	2	18	31	29	288
6	Bhagalpur	1		1	1	1		2	2	2	11	5	2	16	46	44	280
7	Bhojpur	1		1		1		1	2	2	12	2	1	14	20	19	284
8	Buxar		1	1	1	1		2			7	4	1	11	20	19	158
9	Champaran (E)	1		1		1	2	3	3	1	20	7	3	27	46	43	315
10	Champaran (w)	1		1	1	1		2	2	2	16	2		18	25	25	389
11	Darbhanga					1		1	2	2	13	6	4	19	51	47	261
12	Gaya	1		1		1	1	2	2	1	19	6	4	25	49	45	439
13	Gopalganj	1		1	1			1	3	3	10	4	2	14	22	20	186
14	Jamuai		1	1	1			1	3	3	7	2	2	9	21	19	166
15	Jhanabad	1		1	1			1	2	2	4	5	2	9	25	23	81
16	Kaimur		1	1	1		1	2	2	1	9	2	1	11	40	39	107
17	Katihar	1		1			2	2	3	1	11	5	2	16	32	30	257
18	Khagaria	1		1				0	1	1	6	1	1	7	18	17	151
19	Kishanganj		1	1	1			1	2	2	7			7	8	8	136
20	Lakhisarai		1	1	1			1	1	1	4	2		6	13	13	102
21	Madhapura	1		1			1	1	1		7	6	4	13	23	19	115
22	Madhubani	1		1	1	1	1	3	2	1	19			19	76	76	430

23	Munger	1		1			1	1	1		6	3	3	9	13	10	123
24	Muzaffarpur	1		1				0	1	1	14	2		16	47	47	473
25	Nalanda	1		1	1		1	2	3	2	12	8	7	20	36	29	302
26	Nawada	1		1		1		1	2	2	10	4	3	14	27	24	129
27	Patna				3	1	1	5	4	3	16	7	6	23	70	64	418
28	Purniea	1		1		1	1	2	2	1	11	3	3	14	34	31	278
29	Rohtas	1		1	1	1		2	1	1	13	6	5	19	17	12	186
30	Saharsa	1		1		1		1			7	3		10	33	33	152
31	Samastipur	1		1	3	1		4	1	1	14	6	4	20	59	55	354
32	Saran	1		1			1	1	3	2	15	5	3	20	45	42	413
33	Sheikhpura		1	1	1			1	1	1	3	3		6	18	18	74
34	Sheohar		1	1	1			1	1	1	3	1		4	7	7	34
35	Sitamarhi	1		1		1		1	1	1	13	5	2	18	38	36	213
36	Siwan	1		1		1		1	2	2	15	4	2	19	34	32	370
37	Supaul		1	1	1	1		2	1	1	9	2	1	11	28	27	178
38	Vaishali	1		1		1		1	2	2	11	6	3	17	36	33	336
	Total	**25**	**11**	**36**	**23**	**20**	**15**	**58**	**70**	**55**	**398**	**135**	**73**	**533**	**1243**	**1170**	**8858**

Table : Bihar: Public Health Infrastructure – Personnel

Sl. No	Districts	MO		ANM		LHV		MHW		Staff Nurse		AWW	
		Sanct.	Working	Sanct.	Working	Sanct	Working	Sanct.	Working	Sanct.	Working	Sanct.	Working
1	**Araria**	117	98	273	177	41	12	102	40	17	9	1778	1631
2	**Aurangabad**	188	91	342	319	23	17	110	75	12	3	1430	1390
3	**Arwal**	62	24	78	105	4	4	59	34	0	0	631	631
4	**Banka**	97	84	275	213	45	25	124	49	12	6	1352	1044
5	**Begusarai**	117	73	352	351	24	16	33	11	8	8	1314	1296
6	**Bhagalpur**	162	127	387	385	48	27	34	32	8	8	1512	1347
7	**Bhojpur**	132	105	370	368	26	20	106	42	8	1	1658	1646
8	**Buxar**	89	77	212	212	15	11	42	19	2	2	1139	1139
9	**Champaran (E)**	237	135	364	355	35	23	48	28	12	1	2901	2895
10	**Champaran**	145	74	427	308	43	19	60	5	19	15	2263	2252
11	**Darbhanga**	172	152	363	296	29	19	131	96	8	5	2563	2315
12	**Gaya**	231	197	575	563	41	33	245	159	8	1	2427	2385
13	**Gopalganj**	106	95	250	249	20	8	30	3	12	2	1816	1592

14	**Jehanabad**	119	92	59	56	5	5	31	18	13	8	604	599
15	**Jamui**	85	61	222	222	25	12	70	31	12	8	1156	1138
16	**Kaimur**	93	74	146	146	19	11	64	20	19	9	996	993
17	**Katihar**	121	106	238	211	56	31	33	1	12	7	1716	1637
18	**Khagaria**	73	61	190	191	31	18	18	5	4	2	967	965
19	**Kishanganj**	56	37	169	115	31	15	64	27	11	5	1052	963
20	**Lakhisarai**	72	51	131	131	20	14	40	28	10	9	671	608
21	**Madhepura**	81	51	223	93	35	9	22	4	4	0	962	588
22	**Madhubani**	233	124	487	380	37	15	54	43	34	16	3437	2852
23	**Munger**	141	91	157	157	30	28	51	30	23	23	645	644
24	**Muzaffarpur**	241	223	594	592	29	21	140	82	4	4	2822	2610
25	**Nalanda**	178	167	402	402	30	30	36	21	0	0	1785	1761
26	**Nawada**	115	87	207	207	24	11	30	21	25	17	1249	1235
27	**Patna**	289	205	434	434	32	30	49	6	16	13	2481	2465
28	**Purnia**	126	100	356	275	56	29	126	67	8	2	1464	1424
29	**Rohtas**	158	129	286	270	29	12	136	48	20	10	1712	1628
30	**Saharsa**	97	55	192	169	33	15	18	1	26	21	932	825
31	**Samastipur**	192	183	475	470	30	20	29	18	4	4	2692	2512
32	**Saran**	185	133	512	386	33	29	46	17	27	10	2455	2218
33	**Sheikhpura**	53	36	109	109	16	6	18	4	4	1	357	339
34	**Sheohar**	52	34	46	26	4	1	38	13	9	1	265	265
35	**Sitamarhi**	147	127	299	289	27	9	130	82	17	13	2064	1920
36	**Siwan**	151	126	465	298	31	25	102	56	13	9	2099	1934
37	**Supaul**	85	70	206	111	44	8	60	34	2	0	1376	1230
38	**Vaishali**	126	105	421	414	25	24	33	28	8	3	1844	1608
		5124	**3860**	**11294**	**10055**	**1126**	**662**	**2562**	**1298**	**451**	**256**	**60587**	**56524**

3.5 Private and NGO Health Service

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

NGOs

The state has only 12 Mother NGOs (MNGOs) covering 22 of the 38 districts of Bihar. However the state does not have a structured procedure to assess the working of MNGOs. There is a need to improve coordination between the NGOs and the Government at all levels i.e. state, districts and sub-district levels in order to make them effective.

Further analysis of information related to NGOs in the state revealed that there are many NGOs that are engaged in the health service delivery. Although no attempts have been made to assess the functioning of these NGOs, it is important to take initiative to develop efficient NGO network in the State.

3.6 Donor Assisted Programme in the State

NIPI - Norwegian India Partnership Initiative

The NPIP has started a scheme for Institutional Delivery. They are providing one Yhoda for 4 births to monitor mothers. It has also setting up 3 NICU in three districts. A District Training Resource Centre wil be setting up in Nalanda. NIPI will also providing Child Councillor in each Blocks.

UNICEF

The Unicef is supporting the state for immunization, Nutrition and Trainings. Unicef has already initiated the implementation of iMNCI programme and supporting the oprtaionalization of Nutritional Rehabiltization Centre.

WHO

WHO is supporting the state in Pulse Polio Immunization Programme.

European Commission

In 2007-08 under the European Commission fund District Drug Store set up operationalise in all the 38 Districts of the state.

3.7 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 State level, District Level and Block Level. At the Grassroot level linkage between ASHA, ANM with AWW has been strengthened. PHED department has taken up the training of ASHA.

Trainings are being regularly conducted under different programmes in the state. The state has already started the trainings of IMNCIs. With the Unicef support the State has initiated to operationlise 12 ANM school by 2008-09. Repair and renovation of these schools are already in progress and expected to operationalise in this year.

Most the district has their own warehouse. Most of the procurement done from the district level. The state finalized the rate and quantity of items to be purchased.

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

3.8 Program Finance

The governments of India's funds are released to the state through two separate channels, i.e; through the state budget and directly through the state health society. Further the department outlay for the procurement of vaccines, drugs, equipment etc; is spent centrally and assistance to the state has been in the form of kind.

NRHM Part A
Reproductive and Child Health – II

4.1 Maternal Health

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

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

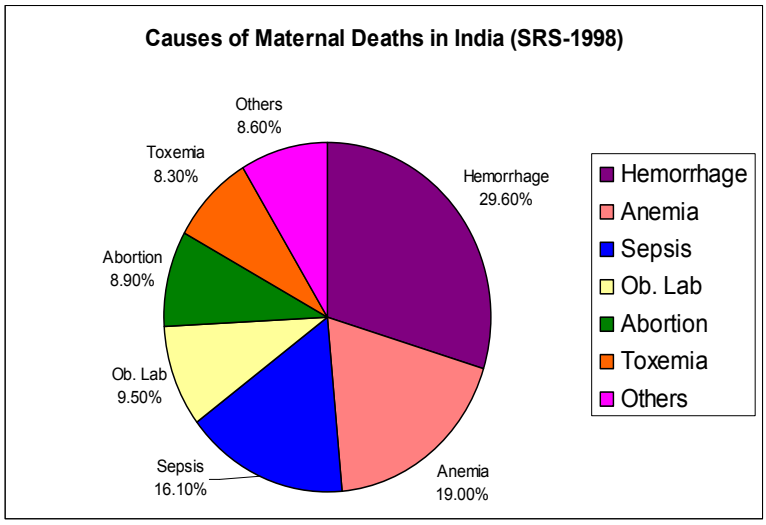
One of the very good things happen to maternal health is introduction JBSY. The institutional delivery increased and that resulted in reducing the maternal deaths in the state.

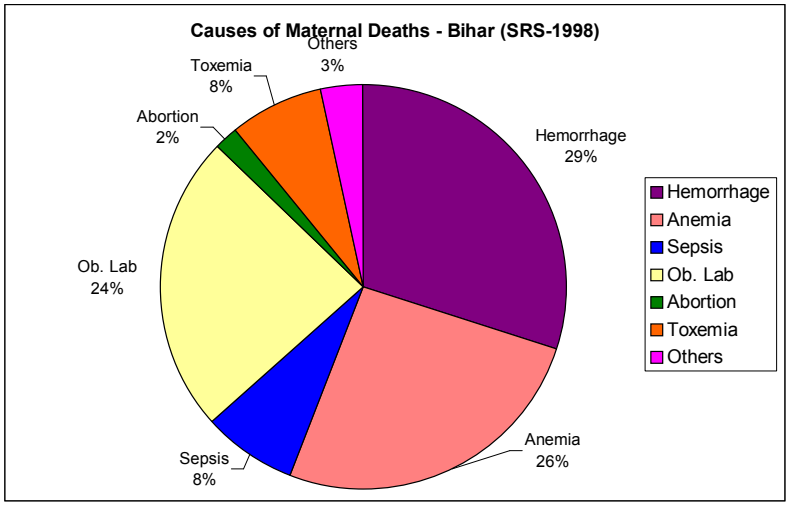
In 2007-08 24 MOs trained in CEmOC, 44 MO in Anesthesia who are now managing complicated cases.

A quality monitoring cell at the state level is monitoring all the trainings and critical services. The cell visits quarterly visits in district.

The SBA training started in the state with 179 Master Trainers. The training of 375 MOs completed. The Staff Nurse and ANM training has started in phase wise.

Causes of Maternal Deaths: Bihar and India





4.2 Child Health

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

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

Maternal Factors

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

Family Planning Services

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

Child Health Services

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

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

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

IMNCI Training: IMNCI training has successfully started in the State. The Pilot project has also successfully completed in the district of Vaishali. The project is being monitored and managed by Unicef. In phase wise rest of districts will be completed.

In 2007-08, a pilot project done on Nutritional Rehabilitation Centre by unicef. After the successful of the project the government has taken initiative to establish the Nutritional Rehabilitation Centre in each district in a phase wise. In this project special nutritious food provided to the severely malnutrition children.

4.3 Family Planning

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

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

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

- Lack of integration of the Family Planning programmes with other RCH components, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels.
- Failure of the programme to effectively undertake measures to increase median age at marriage and first childbirth.
- Inability of the programme to alter fertility preferences of eligible couples through effective behavior change communication (BCC).
- Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age groups. (Overall, sterilization accounts for 82 percent of total contraceptive use. Use rates for the pill, IUD, and condoms remain very low, each at 1 percent or less).
- Due to high prevalence of RTI/STD, IUDs are not being used by majority of women.
- Continued use of mass media to promote family planning practices despite evidently low exposure to mass media in Bihar, leading to lower exposure of family planning messages in the community, particularly among rural and socio-economically disadvantaged groups.
- Weak public-private partnerships, social marketing to promote and deliver family planning services.

These issues clearly indicate an urgent need to design and implement an effective family planning programme in the state. Such a programme would not only deliver benefits leading to limitation of population size, but also favorably impact the status of maternal and child health.

From April, 2007, 253000 sterilization conducted till Feb, 2008.

The state has quality assurance committee for family planning both at State and District level. The committee sits quarterly and report sent to state.

In the state of Bihar, 88 private hospitals and Clinics are accredited by the Quality Assurance Committee for conducting sterilization. These private facilities are monitored by the QAC on sterilization conducted in the facilities.

4.4 Adolescent Health

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

Early marriages seem to be still a key problem. Percentage of boys who are married before attaining 21 years in consistently high in most districts. The mean age of marriage for girls is 16.9. 25% pregnant mothers in the state are in the age group of 15-19 years. This is due to the reason that most of the girl's married before 18 years.

The various anecdotal evidences emerging from the community level participatory planning exercises and opinions voiced by the various levels of health officials during consultation exercise indicate that there is lack of a cohesive ARSH strategy at the state level. Possibility of bifurcating the total target into school going and out of school going adolescents have not been examined as a strategy option. Hence the current school health program by and large lacks any adolescent oriented interventions.

In the consultations with the Bihar State AIDS Control Society, it had emerged that they have several adolescent targeted intervention including using special adolescent counselors currently going actively implemented. The possibility of convergence between the RCH II program priorities and NACP priorities require to be integrated.

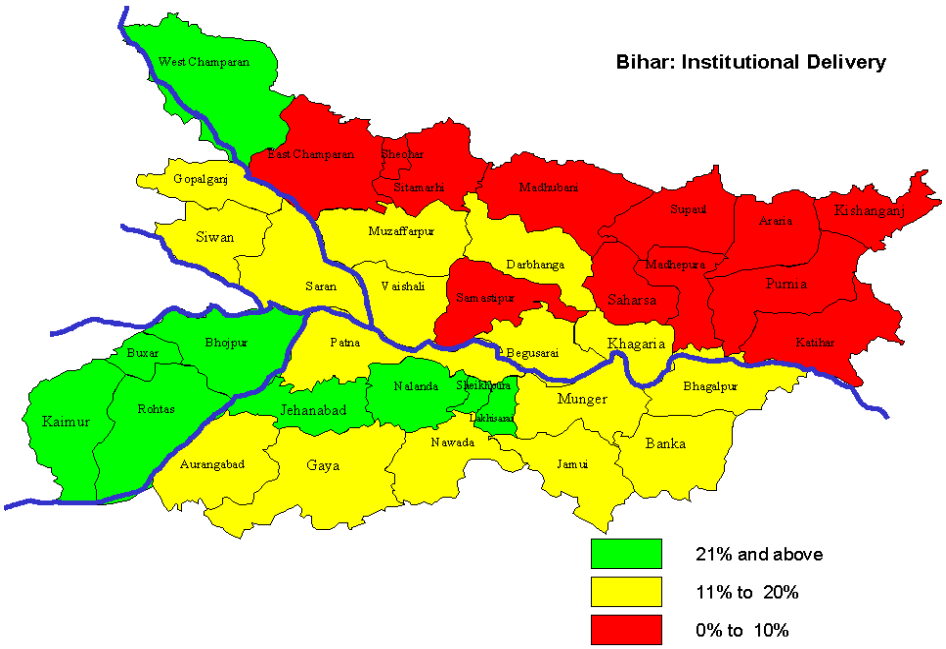
Specific capacity building initiatives to orient the health providers at various levels to specific necessities of the ARSH program like adolescent vulnerability to RTI/STI/HIV /AIDS, communication with adolescents, gender related issues, designing adolescent friendly health services, body and fertility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

4.5 District/Sub District Variations

Key indicators related to Maternal and Child Health (MCH) and Family Planning clearly show the poor status of RCH in Bihar. However, close examination of data reveals that there exist wide inter-district variations for almost all the key indicators. Listed below is the top five and lowest five performing districts for select key indicators. Data related to institutional delivery suggests that West Champaran has the highest rate of institutional delivery of 43.7%, the same for districts like Purnia and Katihar is 5.3% and 6.1% respectively. Even among the top performing districts, variations are wide and the second best performing district has a differential of more than 10 percentage points. Geographical analysis of these districts indicates that four out of five best performing districts are closer to the state capital. Among the low performers, four out of five districts are located at the periphery and the only nearby district (Samastipur) is extremely flood prone.

Table : District Level Variations in Institutional Delivery

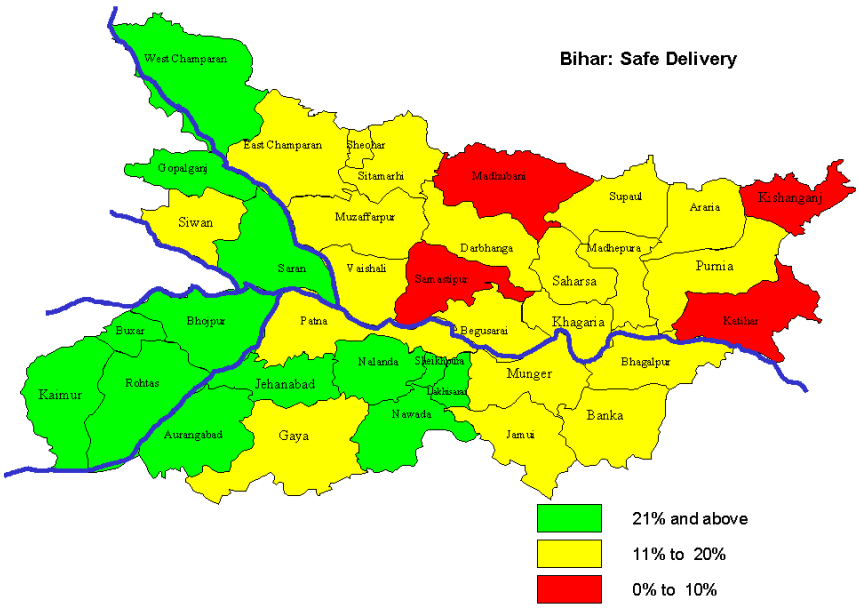
	Good Performing District	**%**	**Poor Performing District**	**%**
Institutional Delivery	West Champaran	43.7	Purnia	5.3
	Bhojpur	31.9	Katihar	6.1
	Buxar	28.3	Samastipur	6.6
	Jehanabad	26.0	Kishanganj	6.7
	Nalanda	23.2	Araria	6.8



In terms of safe delivery too the top performing districts remain similar to those who featured in as best performing districts for institutional delivery, perhaps indicating that overall delivery services in these districts are relatively better. Among the poor performing districts too, except for one, the districts remain the same as in the previous section. Madhubani, the only district that did not feature in the previous list of poor performing districts for institutional delivery, but ranked here as one of the poor performing districts for safe delivery (9.8%), also shares the geographical characteristics of other districts in this category i.e. peripheral and highly flood prone.

Table : District Level Variations in Safe Delivery

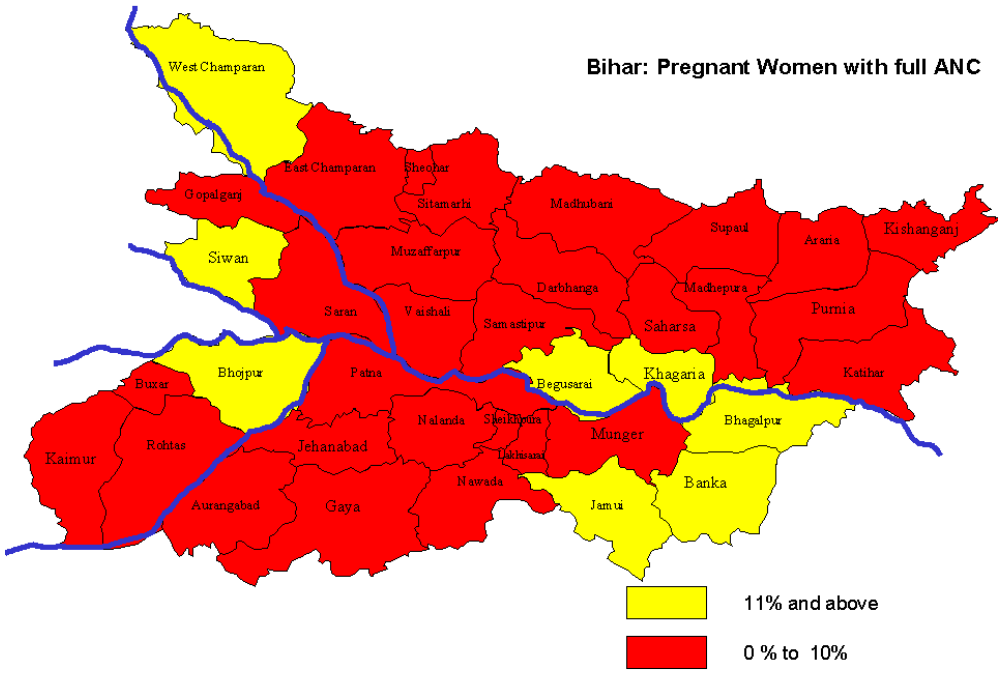
	Good Performing District	%	Poor Performing District	%
Safe Delivery	West Champaran	48.0	Samastipur	7.6
	Bhojpur	40.1	Katihar	8.0
	Buxar	29.7	Kishanganj	8.2
	Jehanabad	28.0	Madhubani	9.8
	Nalanda	27.1	Araria	10.2



The general performance in terms of ANC services in the state is abysmally low, reflecting the poor condition of public health services for women in the reproductive age group. Even the best performing district viz West Champaran is at 15.3%, which is low compared to national average. The coverage rate in the low varies between 3.3% to 4.6%.

Table : District Level Variations in % of Pregnant Women with full ANC

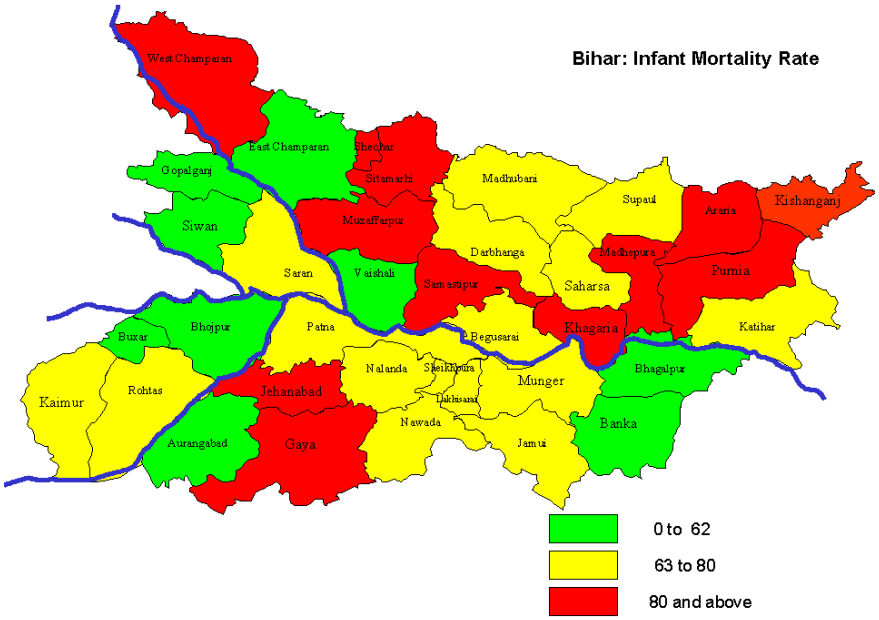
	Good Performing District	**%**	**Poor Performing District**	**%**
% of Pregnant Women with full ANC	West Champaran	15.3	Sitamarhi	3.3
	Begusarai	12.5	Samastipur	3.4
	Siwan	11.8	Madhepura	3.8
	Bhojpur	11.1	Purnia	3.9
	Bhagalpur	10.4	Aurangabad	4.6



Though the performance of the state in terms of IMR is above the national average, a large proportion of districts continue to report significantly high IMR than the state averages. Geographical analysis suggests that most of these districts such as Kishanganj, Araria, Purnea, Samastipur, and Khagaria with high IMR are either peripheral or highly prone to floods.

Table : District Level Variations in IMR

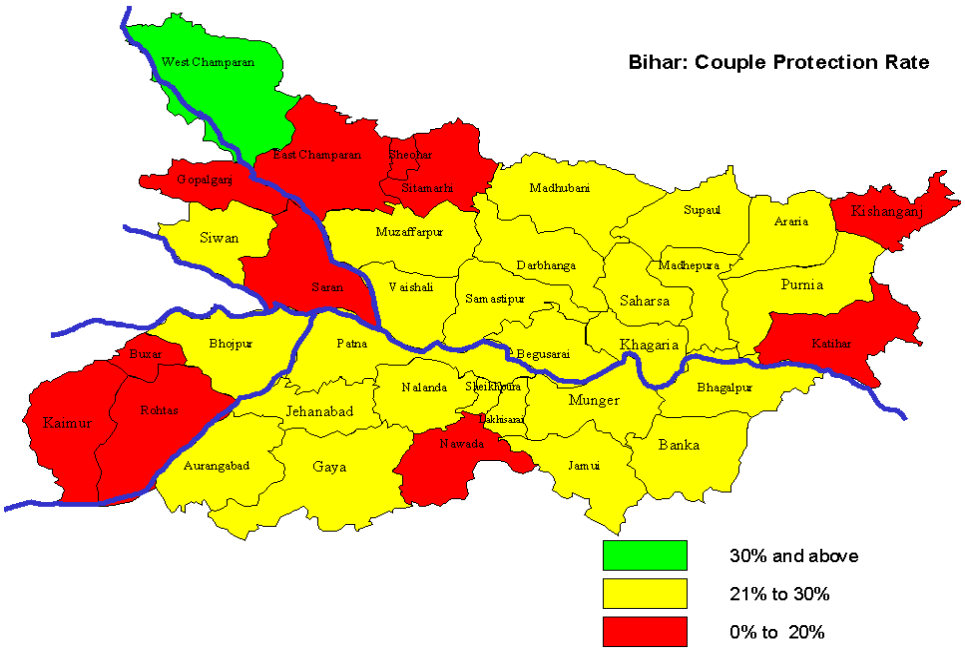
	Good Performing District		**Poor Performing District**	
IMR	Siwan	43	Kishanganj	113
	Vaishali	46	Araria	102
	Gopalganj	53	Purnia	89
	Bhojpur	55	Samastipur	87
	Buxar	55	Khagaria	85



Performance indicators for family planning in the state are not very different from those of maternal and child health. The Couple Protection Rate, one of the key indicators for family planning continues to be significantly lower than the national average. Here too, the performance of districts are varied and while districts such as West Champaran, Saharsa, Khagaria, Araria and Darbhanga report CPR in the range of 35.3% to 25.2%, the low performers such as Gopalganj, Kishanganj, Sitamarhi, Katihar and Saran have CPR in the range of 14.5% to 17.5%.

Table : District Level Variations in CPR

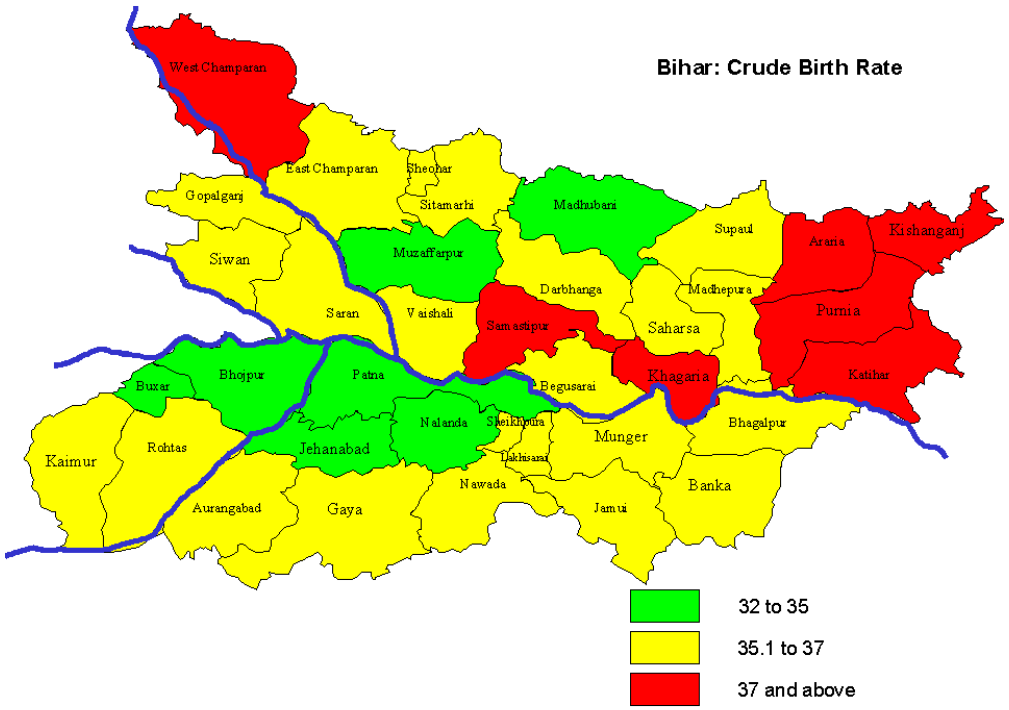
	Good Performing District	**%**	**Poor Performing District**	**%**
CPR	West Champaran	35.3	Gopalganj	14.5
	Saharsa	27.7	Kishanganj	15.5
	Khagaria	26.8	Sitamarhi	16.6
	Araria	26.5	Katihar	17.2
	Darbhanga	25.2	Saran	17.5



The poor state of Family Planning services in the state is also evident in the high Crude Birth Rate. Unlike other indicators discussed previously, the Crude Birth Rate is one of the few indicators for which inter-district variation is relatively less. Across the state, it ranges from a high of 40.7% to a low of 32.6%, for a majority of the districts (22 out of 38), the range is between 35 and 37.

Table : District Level Variations in CBR

	Good Performing District	**%**	**Poor Performing District**	**%**
CBR	Patna	32.6	West Champaran	40.7
	Madhubani	33.6	Katihar	39.5
	Jehanabad	33.7	Araria	38.8
	Nalanda	34.3	Purnia	38.1
	Muzaffarpur	34.9	Kishanganj	37.4


Bihar: Crude Birth Rate
West Champaran
East Champaran
Sheohar
Sitamarhi
Madhubani
Supaul
Araria
Kishanganj
Gopalganj
Siwan
Muzaffarpur
Darbhanga
Madhepura
Purnia
Saran
Vaishali
Samastipur
Saharsa
Bhojpur
Patna
Khagaria
Katihar
Buxar
Begusarai
Nalanda
Sheikhpura
Munger
Bhagalpur
Kaimur
Rohtas
Jehanabad
Lakhisarai
Nawada
Banka
Aurangabad
Gaya
Jamui
32 to 35
35.1 to 37
37 and above

Key Indicators of Bihar regarding health																		
S.no.	State/district	% girls marrying below legal age at marriage	% of households with low standard of living	% of households using adequate iodized salt (15ppm)	Birth order 3 and above	% women know all modern method	% husbands know NSV	% women/husbands using any family planning method	% women/husbands using any modern method of family planning	Unmet need for family planning	% women received at least three visits for ANC	% women received full ANC	% of Institutional delivery	% of delivery attended by skilled personne	% of children (age12-23 months) received full immunization	% of children (age12-23 months) did not received any immunization	% women aware of HIV/AIDS	% husbands aware of HIV/AIDS
	India	28	42.3	29.6	42	49.2	34.4	53	45.7	21.1	50	16.4	40.5	47.6	45.8	19.8	53.6	75.8
	Bihar	51.5	66.3	29.6	54.4	52.2	35.6	31	27.3	36.7	19.6	5.4	23	29.5	23	49.4	28.8	62.1
1	Araria	50.5	80.7	23.8	56.3	35.2	29	31.2	25.5	38	12	2.1	9.1	17.3	22.1	52.3	19.2	47.3
2	Aurangabad	45.6	67.1	15.7	53.7	60.8	23	25.7	24.8	34.3	19.9	1.4	21.3	26.9	28.8	47.8	20.1	59.1
3	Banka	56	74.9	31.5	54.4	56.8	28.3	36.9	26.9	31	24.1	6.4	25.4	36.2	25.3	51.7	22.7	50.4
4	Begusarai	50.6	69.3	31.9	52.6	63.4	22.7	27.6	25	41.3	18.3	2.7	15.7	20.6	17.3	60.9	26.8	59.6
5	Bhagalpur	42.6	61.4	40.3	51.9	62.9	26.8	39.6	29.9	33.1	27.9	6.2	29.2	39.4	43.4	27.6	38.1	60.3
6	Bhojpur	55.3	62.7	38	54	52.7	37.3	36.9	30.1	30.8	23.3	6.8	37.4	47.4	32.2	45.4	32.3	74.8
7	Buxar	59.2	65.4	22.1	55.1	61.9	30.3	31	25.4	36.8	16.6	3	30.4	39.8	19.5	61.3	23	63.8
8	Champaran – E	59	71.9	23	54.9	43.9	24.9	27.8	26.4	38.4	23.5	9.7	18.6	24.9	13.1	61.4	26	54.6
9	Champaran –W	63.9	80.8	1.5	57	20.1	3.2	24.6	18.9	37.2	17.5	0.8	28.6	35.8	3.5	74.4	7.7	43
10	Darbhanga	49.8	64.6	30.1	56.5	64	37.8	31.9	29.2	40	16.6	4.1	16.9	24	23.4	50.6	38.9	81.5
11	Gaya	54.7	66.9	13.3	50.5	46.8	28.4	28.4	27.4	41.1	21.3	4.7	23.6	28.9	12.4	49.4	25.2	58

12	Gopalganj	34.6	67.7	25.7	54.2	43	32.4	30.1	20.2	34.8	28.4	7	24	34.3	40.5	28.3	29.7	73
13	Jamui	64.7	74.8	33.6	49.8	46.5	28	28.9	24.3	33.2	22.7	10.3	23.5	26.4	14.7	72.6	20	48.8
14	Jehanabad	60.4	62.5	15.1	57.9	58.6	38.5	28.2	26.4	44.9	20	4.1	35.1	42.6	14.2	63.6	25.8	69.2
15	Kaimur (Bhabua)	48.6	60.5	29.3	54.5	35.9	45.3	29.2	26.9	34.4	17.8	2.1	33.6	40.3	11	60	29.8	66.4
16	Katihar	46.2	72.6	32.2	56.4	48	61.6	33.6	28.1	39.1	21.6	4.3	13.1	27.3	9.7	56.1	28.9	56.7
17	Khagaria	58.2	74.6	29.7	59.4	58.6	19.8	30.8	28	35.2	9.6	2.2	15.1	19.4	19.7	56	25	50.8
18	Kishanganj	42.6	83.6	17.3	65.6	34.8	52.6	23.1	20.3	47.3	12.4	1.8	14.1	20.1	6.3	78.6	22.4	48.7
19	Lakhisarai	57.4	62.9	24.6	50	55.3	23.6	32.6	27.4	31.6	21.9	9.3	25.4	28.8	18.4	61.8	24.3	61.5
20	Madhepura	54.3	82.6	23.9	50.4	48.1	23.4	31.5	27.2	37.9	11.7	6.3	11.8	18.3	22.4	56.6	17.3	44.5
21	Madhubani	60.8	78.2	23.9	54.7	44.9	29.6	30.4	29.9	31.8	15.5	3.5	7.7	14.6	17.4	41.9	26.2	57.5
22	Munger	48.3	56.9	38.8	50.7	53.4	36.1	38.6	30.8	35.4	22.5	4	38.8	46.8	26.9	41.3	36.8	69.5
23	Muzaffarpur	44.5	62.4	40.4	51.9	49	34.6	32.5	31.6	37.8	20.8	5.3	19.4	24.2	36.1	36.3	38.4	57.5
24	Nalanda	59.6	63.9	28.2	59.1	36.3	42	26.4	23.4	37.9	14.9	2	30.8	35.8	18.4	48.7	27	57.6
25	Nawada	58.6	64.3	21.3	55.1	64.5	52	28.8	27.9	45.9	15.4	3.9	26.1	32.3	19.6	51.9	27.3	62.8
26	Patna	44.7	42.9	45.3	48.1	68.5	48.7	36.8	33.9	34	31	12.8	45.3	47.8	39.2	33.7	47.5	74.2
27	Purnia	42.2	75.7	41	59.6	50.3	27.2	30	24	31.2	12.5	3.1	13	18.6	27.8	49.1	27.1	72.8
28	Rohtas	46.8	58.1	23.6	46.5	63	55.5	35	28.2	30.5	25.8	5.9	39.7	48.2	26.6	53.3	30.7	75.4
29	Saharsa	47.9	68.2	34.2	62.6	54.7	51.3	37.7	32.1	34.1	14.7	3.1	16.4	20.6	24.7	56.7	30.1	56
30	Samastipur	67.7	78.9	42.4	58.6	43.4	47	22.7	21.8	42.6	8.8	4.5	11.1	15.1	14.3	52	17.8	48.7

31	Saran	28.9	64.8	42.3	58.6	64.2	39.5	30.5	24.5	36.6	18.2	7.2	15.9	21.5	35.9	29.5	35.1	74.8
32	Sheikhpura	85	61.6	27.3	56.7	66.1	23.8	23.9	22.4	43.1	23	4.7	23.1	30.7	17.8	50.3	26.2	62.6
33	Sheohar	59.2	82	24.1	58.4	45.9	57	19.7	17.1	45.8	10.3	3.4	8.4	14.6	17.2	52.4	21.5	66.6
34	Sitamarhi	56	76	29.1	59.1	59.4	39	27.9	26	38.3	13.6	3.3	11.6	15.2	31	42.7	21.4	62
35	Siwan	39.5	56.9	24.2	54	53.9	19.6	23.7	21.2	45.7	22.9	4.7	24.1	32.4	38.5	35.4	27.2	64.6
36	Supaul	61.1	80.4	22.9	51.6	28	35.2	36.4	33.3	25	9.7	2.2	12.5	26	15	49.1	15.4	67.5
37	Vaishali	61.6	60.5	27.8	50	66.3	52.3	33	30.9	37	25.3	4.9	23.1	29.6	24.6	39.7	31.8	68.9

Focus Districts:

As per the guidelines issued by the Ministry of Minority Affairs, GoI regarding districts with higher percentage of the minority population, the SPIP for NRHM, attempts to provide adequate resources.

Bihar has got seven districts Araria, Kishanganj, Purnia, Katihar, Sitamarhi, West Champaran, Darbhanga in category-A which have both socio-economic and basic amenities parameters below national average while allocating available resources to the districts, we've tried to give priority to these Category-A districts. The District Magistrates of 3 (three) of these districts i.e. Araria, Purnea and Katihar have been made members of State Health Mission headed by CM. This year the rest 4 will also be included, so that the specific problems of these districts may be brought into fore.

4.6 Health Infrastructure and Facilities

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 seemed a major challenge in construction of the health care facilities. Lack of clear guidelines sometimes delayed the process.

To make the BEmOCs and CEmOCs functional, adequate staff, essential equipments and infrastructure (OT, Labour rooms, new born care area, blood storage and blood storage units) are to be taken up as a priority area.

District wise Availability of Health Centres of Bihar State

Sl.	Name of Districts	No. of DH	New Construction	Total DH	No. of Sub Divl Hospitals exist	New Construction	No. of Referral Hospital upgraded in Sub Div Hospitals	Total Sub Div Hospitals	No. of Referral Hospitals exist previously	No. of Referral Hospitals exist Presently	No. of PHCs exist	New Construction	No. of APHCs upgraded into PHCs	Total No. of PHCs	No. of APHCs exist previosly	No. of APHCs exist presently	No. of HSCs
1	Araria		1	1	1		1	2	3	2	9			9	30	30	200
2	Arwal		1	1				0			3			3	23	23	46
3	Aurangabad	1		1		1		1	3	3	11			11	58	58	207
4	Banka		1	1	1			1	3	3	10	1		11	24	24	227
5	Begusrai	1		1		1	1	2	2	1	11	7	2	18	31	29	288
6	Bhagalpur	1		1	1	1		2	2	2	11	5	2	16	46	44	280
7	Bhojpur	1		1		1		1	2	2	12	2	1	14	20	19	284
8	Buxar		1	1	1	1		2			7	4	1	11	20	19	158
9	Champaran (E)	1		1		1	2	3	3	1	20	7	3	27	46	43	315
10	Champaran (w)	1		1	1	1		2	2	2	16	2		18	25	25	389
11	Darbhanga					1		1	2	2	13	6	4	19	51	47	261
12	Gaya	1		1		1	1	2	2	1	19	6	4	25	49	45	439
13	Gopalganj	1		1	1			1	3	3	10	4	2	14	22	20	186
14	Jamuai		1	1	1			1	3	3	7	2	2	9	21	19	166
15	Jhanabad	1		1	1			1	2	2	4	5	2	9	25	23	81

16	Kaimur		1	1	1		1	2	2	1	9	2	1	11	40	39	107
17	Katihar	1		1			2	2	3	1	11	5	2	16	32	30	257
18	Khagaria	1		1				0	1	1	6	1	1	7	18	17	151
19	Kishanganj		1	1	1			1	2	2	7			7	8	8	136
20	Lakhisarai		1	1	1			1	1	1	4	2		6	13	13	102
21	Madhapura	1		1			1	1	1		7	6	4	13	23	19	115
22	Madhubani	1		1	1	1	1	3	2	1	19			19	76	76	430
23	Munger	1		1			1	1	1		6	3	3	9	13	10	123
24	Muzaffarpur	1		1				0	1	1	14	2		16	47	47	473
25	Nalanda	1		1	1		1	2	3	2	12	8	7	20	36	29	302
26	Nawada	1		1		1		1	2	2	10	4	3	14	27	24	129
27	Patna				3	1	1	5	4	3	16	7	6	23	70	64	418
28	Purniea	1		1		1	1	2	2	1	11	3	3	14	34	31	278
29	Rohtas	1		1	1	1		2	1	1	13	6	5	19	17	12	186
30	Saharsa	1		1		1		1			7	3		10	33	33	152
31	Samastipur	1		1	3	1		4	1	1	14	6	4	20	59	55	354
32	Saran	1		1			1	1	3	2	15	5	3	20	45	42	413
33	Sheikhpura		1	1	1			1	1	1	3	3		6	18	18	74
34	Sheohar		1	1	1			1	1	1	3	1		4	7	7	34
35	Sitamarhi	1		1		1		1	1	1	13	5	2	18	38	36	213
36	Siwan	1		1		1		1	2	2	15	4	2	19	34	32	370
37	Supaul		1	1	1	1		2	1	1	9	2	1	11	28	27	178
38	Vaishali	1		1		1		1	2	2	11	6	3	17	36	33	336
	Total	**25**	**11**	**36**	**23**	**20**	**15**	**58**	**70**	**55**	**398**	**135**	**73**	**533**	**1243**	**1170**	**8858**

Table : Bihar: Public Health Infrastructure – Personnel

Sl. No	Districts	MO		ANM		LHV		MHW		Staff Nurse		AWW	
		Sanct.	Working	Sanct.	Working	Sanct	Working	Sanct.	Working	Sanct.	Working	Sanct.	Working
1	**Araria**	117	98	273	177	41	12	102	40	17	9	1778	1631
2	**Aurangabad**	188	91	342	319	23	17	110	75	12	3	1430	1390
3	**Arwal**	62	24	78	105	4	4	59	34	0	0	631	631
4	**Banka**	97	84	275	213	45	25	124	49	12	6	1352	1044
5	**Begusarai**	117	73	352	351	24	16	33	11	8	8	1314	1296
6	**Bhagalpur**	162	127	387	385	48	27	34	32	8	8	1512	1347

7	**Bhojpur**	132	105	370	368	26	20	106	42	8	1	1658	1646
8	**Buxar**	89	77	212	212	15	11	42	19	2	2	1139	1139
9	**Champaran (E)**	237	135	364	355	35	23	48	28	12	1	2901	2895
10	**Champaran**	145	74	427	308	43	19	60	5	19	15	2263	2252
11	**Darbhanga**	172	152	363	296	29	19	131	96	8	5	2563	2315
12	**Gaya**	231	197	575	563	41	33	245	159	8	1	2427	2385
13	**Gopalganj**	106	95	250	249	20	8	30	3	12	2	1816	1592
14	**Jehanabad**	119	92	59	56	5	5	31	18	13	8	604	599
15	**Jamui**	85	61	222	222	25	12	70	31	12	8	1156	1138
16	**Kaimur**	93	74	146	146	19	11	64	20	19	9	996	993
17	**Katihar**	121	106	238	211	56	31	33	1	12	7	1716	1637
18	**Khagaria**	73	61	190	191	31	18	18	5	4	2	967	965
19	**Kishanganj**	56	37	169	115	31	15	64	27	11	5	1052	963
20	**Lakhisarai**	72	51	131	131	20	14	40	28	10	9	671	608
21	**Madhepura**	81	51	223	93	35	9	22	4	4	0	962	588
22	**Madhubani**	233	124	487	380	37	15	54	43	34	16	3437	2852
23	**Munger**	141	91	157	157	30	28	51	30	23	23	645	644
24	**Muzaffarpur**	241	223	594	592	29	21	140	82	4	4	2822	2610
25	**Nalanda**	178	167	402	402	30	30	36	21	0	0	1785	1761
26	**Nawada**	115	87	207	207	24	11	30	21	25	17	1249	1235
27	**Patna**	289	205	434	434	32	30	49	6	16	13	2481	2465
28	**Purnia**	126	100	356	275	56	29	126	67	8	2	1464	1424
29	**Rohtas**	158	129	286	270	29	12	136	48	20	10	1712	1628
30	**Saharsa**	97	55	192	169	33	15	18	1	26	21	932	825
31	**Samastipur**	192	183	475	470	30	20	29	18	4	4	2692	2512
32	**Saran**	185	133	512	386	33	29	46	17	27	10	2455	2218
33	**Sheikhpura**	53	36	109	109	16	6	18	4	4	1	357	339
34	**Sheohar**	52	34	46	26	4	1	38	13	9	1	265	265
35	**Sitamarhi**	147	127	299	289	27	9	130	82	17	13	2064	1920
36	**Siwan**	151	126	465	298	31	25	102	56	13	9	2099	1934
37	**Supaul**	85	70	206	111	44	8	60	34	2	0	1376	1230
38	**Vaishali**	126	105	421	414	25	24	33	28	8	3	1844	1608
		5124	**3860**	**11294**	**10055**	**1126**	**662**	**2562**	**1298**	**451**	**256**	**60587**	**56524**

District Hospitals: Out of 38 Districts 25 has only district hospital. Most of the district hospitals are not functioning up to the level due shortage of specialties and Staff Nurses. Construction of 11 District Hospitals are on full awing and expected to be completed by 2009.

Sub District Hospitals: At present there are 23 Sub District Hospital. 20 new SDH are under construction and 15 Referral Hospital are in the process of upgradation to SDH.

Referral Hospitals: There are 55 referral Hospitals. These referral hospitals get patient from PHCs, APHCs and covered by Specialised services.

Block PHCs: At present there are 398 PHCs, 135 new PHCs are under construction and will be operationalise by this year. 73 Adll PHCs will also be upgraded to PHCs. These PHCs require to be upgraded at CHC level for Specialised Services.

Adll PHCs: The total no. of Adll PHC is 1170. These adll PHCs only provide OPD services. All these PHCs require to functionalise the inpatient for providing deliver services and reduce the load of Block PHCs.

HSCs: At present there are 8858 HSCs in the state. Half of the HSCs are running from the rented place or Panchayat office. Mostly these HSCs are manned by One ANM only.

Infection Management and Environmental Plan:

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

4.7 Human Resource Development including Training

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

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

4.8 Inequity/ Gender; Vulnerable Groups Including Urban Slums & Tribal

4.8.1 Inequity and Gender

Ensuring Gender Equity

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

Gender discrimination continues throughout the life cycle, as well. Women are denied access to education, health care and nutrition. While the state's literacy rate is 47.5%, that for women in rural areas is as low as 30.03%. Abysmally low literacy levels, particularly among 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. Anaemia is a serious problem among women in every population group in the state, with prevalence ranging from 50% to 87% and is more acute for pregnant women.

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

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

4.8.2 Urban Slums

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

At present, there are 12 Urban Health Centres (UHC) in the state. However, as per the GoI guidelines, there should be one UHC for 50,000 population (outpatient). Based on the above criteria, additional 111 UHCs will be require to establish in the state. The Urban Health Centres are providing services of Maternal Health, Child Health and Family Planning. The infrastructure condition of these Urban Health Centres is not up to the mark and requires some major renovation work. The staff at each UHC comprised of 1 Medical Officer (MO), 1 PHN/LHV, 2 ANMs, 1 Lab Assistant and 1 Staff clerk with computer skills.

4.9 Logistics

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

There is provision of contingency funds for emergency drugs at the district level and health facilities. Whenever PHCs/PHSCs run out of drugs, medicines are purchased through contingency fund and supplied to the PHCs/PHSCs. The general impression is supplies arrive too late and too little. However under NRHM there is scope for huge and rapid flow of materials from the MOHFW, GOI and the State level. Also under the decentralization process the CHC, PHCs and HSCs will have larger autonomy to purchase drugs and supplies locally as per procurement guidelines to be developed by the State Government under the NRHM. District and the peripheral institutions need to be strengthened through capacity building for enhancing their capabilities of indenting, procurement, inventory management and distribution of drugs and supplies and maintenance of medical equipment and transport.

Cold Chain Vans are available in the districts for distribution of Vaccines to PHCs/ HSCs during vaccination programs and camps. Generally PHC vehicles are used to collect the drugs and supplies from the district store. Currently local purchase of drugs and supplies are not approved.

Drugs, consumables, and vaccines are directly supplied by the state to districts for HSCs, PHCs and other facilities very irregularly. There is need to streamline the process for estimation and indenting of vaccines, drugs and supply of consumables. The supply system would ensure smooth flow of indented materials as per guidelines from state to all levels of utilization.

4.10 HMIS and Monitoring & Evaluation

The National Rural Health Mission has been launched with the aim to provide effective health care to rural population. The programme seeks to decentralize with adequate devolution of powers and delegation of responsibilities has to have an appropriate implementation mechanism that is accountable.

In order to facilitate this process the NRHM has proposed a structure right from the village to the national levels with details on key functions and financial powers. To capacitate the effective delivery of the programme there is a need proper a proper HMIS system

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

For overall management of the programme, there is a Mission Directorate and a State Programme Management Unit in the state. The Unit is responsible for overall monitoring and evaluation of the programme in the state and the districts. The data gathering is being facilitated by the state, District and PHC data Centres. The numerous formats being used have been reviewed and it is found that data needs to be compiled only as per RCH ,NRHM programme and State needs. Hence the new MIES formats have been shared with all the health functionaries and it is expected that they shall be reporting in the new formats from the 3rd quarter after a brief orientation training.

At district level, there is a District Health Society who will be responsible for the data dissemination from the sub-district level to the district level. Data Manager/HMIS expert at the State level and Data Assistant at the district level will be responsible for management of HMIS.

As such, there will be a Monitoring Team constituted each at state and district level to monitor the implementation of the NRHM activities. The Team will comprise of representatives from the Mission Directorate and Programme Committee for various health programmes. The Team will also comprise of representatives from Govt. of India.

There is Hospital Management Committee/ Rogi Kalyan Samity at all PHCs and CHCs. The PHC / CHC Health committee will monitor the performance of SC under their jurisdiction and will submit the report. The PHC/ CHC health committee will monitor and evaluate the SC performance .and performance will be submitted to the District, which will compile and sent it to the state.

4.11 Behaviour Change Communication

The state does not have any comprehensive BCC strategy. All the programme officers implementing the BCC activity as per their respective programme basis.

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

There is no credible study available to identify the areas / region specific knowledge, attitudes and practices pertaining to various focus areas of interventions like breast

feeding, community & family practice regarding handling of infants, ARSH issues etc. At present there is no impact assessment of the IEC and BCC activities. It's very important to assess the impact of IEC/BCC activities, resources and methods to undertake mid way corrective measures.

4.12 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.

PHED has been entrusted to train ASHAs as per GoI norm.

Adolescent councilors are placed in each district from State AIDS Control Society. The Health department is looking to cooperate with them by giving training to these councilors for implementing ARSH programme.

The state PWD department taken care of the construction of Health department. All the construction activity for Health Institutions under NRHM already handed over to the PWD department.

4.13 Finance

In 2007-08 the GoI has approved an amount of Rs. 177.70 crore under RCH II.

5. Progress and Lessons learnt from RCH II Implementation of 05-08

5.1 Major achievement during 2005-08

1. SHSB at State level and District Health Societies (in all 38 districts) formed & registered.

2. **ASHA:** A total of 66701 ASHAs selected against the total target of 74,313.

3. **SPMU & DPM:** The State Level consultants in SHSB and DPMU staff (3 in each district) recruited in 34 out of 38 districts. The orientation training for all has been completed.

3. **Routine Immunization:** Full immunization percentage increased to 37.7 (CES 2006-07). Use of AD Syringe increased to 95%.

4. **Appointment of ANMs** - Out of 1360 vacancies of regular posts, 1092 posts of ANM had been filled earlier. Approx. 8000 applications were received for 2nd ANM. 4504 new appointments have been made till now.

5. **Rogi Kalyan Samities** formed in all health facilities till PHC level, registration of RKS completed rest in progress, so far 372 RKS have been registered.

6. **Training Programmes:** Training of EmOC, Life Saving Anaesthesia Training, IMNCI, ASHA, DPMUs, SBA training and Immunization started.

7. **Free drug distribution** of essential drugs started from 1st July 2006, 24 hours presence of doctors ensured in all facilities up to PHC level resulting in unprecedented increase in OPD patients. (10-30 times increase reported). Free drug list expanded to incorporate 21 OPD and 102 IPD drugs.

8. **ANM training Schools**-Out of 21 ANM schools 12 ANM schools were restarted after a period of more than a decade. Currently approx. 600 students enrolled.

9. **Training Policy:** The training policy for the Department of Health has been drafted with the help of NIHFW. It is expected that this policy will be adopted by Health & Family Welfare, GoB for betterment of trainings in state.

The State Programme Implementation Plan 2008-09 has been framed on the basis of strategies and activities which worked in last three years. The major bottlenecks have been identified and an attempt has been made to overcome them through alternative strategies.

5.2 Programme Management

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

i. Construction & Renovation- Slow progress in Infrastructure
ii. Procurement of RCH- Drugs & Equipments.
iii. BCC strategy formulation.
iv. High turnover of personnel in programmes.
v. The quality of training.
vi. Keeping up the motivational level of health staff at all levels.

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

viii. Mismatch of personnel and equipment.

ix. Lack of Proper of monitoring and evaluation framework.

Following strategies have been adopted to overcome the problem

- **Slow progress in infrastructure** - To overcome the problem of slow progress in infrastructure, a separate infrastructure cell has been created in State Health Society, Bihar. This year, it is proposed that two more personnel may be added to this wing to strengthen it. Moreover all the DMs have been requested to designate an agency for their district that would carry out all infrastructure-related tasks.

- **Procurement of RCH Drugs and Equipment-** Though 280 essential drugs have been rate contracted so far, the rate contract of RCH Drugs and other equipments needed for carrying out RCH activities are still to be completed. The rate contracting takes on an average 4-6 months and number of bidders are very less, resulting in single bids and no bids in many cases. The SHSB is trying to enter into a MoU with TNMSC to solve this problem for drugs and Equipments which GoI would not provide directly.

- **BCC strategy formulation-** Even after two and half years of NRHM, Bihar lacks a consolidated BCC strategy in health due to lack of technical know how. The development partners especially Packard Foundation has been asked to provide technical support for the same. Besides, some other initiatives are planned this year in areas like promotion of Breast feeding, PNDT and ARSH among others.

- **Quality Assurance committees in State and Districts-** Quality assurance committees formed in 80 % of the districts as per Quality Assurance Manual of GoI and in rest of the districts, it will be formed by 2008 March end. State Quality Assurance Cell has been formed. Quarterly monitoring visits are planned at the state level and the divisional level to monitor quality of trainings and critical services including family planning.

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

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

- **Quality of training -** Monitoring cell has been constituted at the state level and is under process at divisional level to ensure quality of training. A schedule for monitoring is being made.

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

- **Sub optimal utilization 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.

- **Poor monitoring and evaluation framework** – Regular monitoring visits by programme officers.

6. RCH II PROGRAMME OBJECTIVES AND STRATEGIES

6.1 Vision Statement:

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

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

6.2 Technical Objectives, Strategies and Activities

6.2.1 Maternal Health

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

Objectives:

1. To increase 3 ANC coverage from 16.9 % to 25% by 2008-09 and to 35% by 2009-10.
2. To increase the consumption of IFA tablets for 90 days from present level of 9.7% to 20% by 2008-9 and to 35% by 2009-10.
3. To reduce anemia among pregnant mothers from 60.2% to 52% by 2008-09 and to 40% by 2009-10

4. To increase institutional delivery from 70% to 76% by 2008-09 and to 85% by 2009-10 (MIS data)

5. To increase birth assisted by trained health personnel from 30.9% to 40%.

6. To increase the coverage of Post Natal Care from 15.3% to 24% by 2008-09 and to 35% by 2009-10.

7. To reduce incidence of RTI/STI cases

Source of data: NFHS 3 and MIS Data

Objective No. 1: To increase 3 ANC coverage from 16.9 % to 25% by 2008-09 and to 35% by 2009-10.

Strategies and Activities:

1.1 Improved Access of ANC Care

1.1.1 Provision for Additional ANMs in each Sub Centres

1.1.2 Setting up of New Sub Centres to cover more areas

1.1.3 Organizing Monthly Village Health and Nutrition Days in each Anganwadi Centres

1.1.4 Organizing RCH camp in Each Block PHC areas.

1.1.5 Tracking of Pregnant mothers by ASHAs

1.2 Ensure quality service and Monitoring of ANC Care

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

1.2.2 Involvement of PRIs in monitoring the ANMs service through convergence

1.2.3 Refresher training of ANMs on ANC care

1.2.4 Proper maintenance of ANC Register and Eligible couple register

1.3 Strengthening of Health Sub Centres

1.3.1 Repair and Renovation of Sub Centres

1.3.2 Provide equipments like BP Apparatus, Weighing machines, Heamoglobinometer etc to the Sub Centres.

1.3.3 Timely supply of Drug KitA and Kit B

1.4 Generate Awareness for ANC Service

1.4.1 Convergences meeting with AWWs, ASHAs, PRI Members, NGOs at the Grampanchayat level by ANMs. These meetings will also attended by MOs from Adll PHCs.

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

Objective No. 2: To increase the consumption of IFA tablets for 90 days from present level of 9.7% to 20% by 2008-9 and to 35% by 2009-10.

Strategies and Activities:

2.1 Purchase and Supply of IFA Tablets

2.1.1 Timely supply of IFA Tablets to the Health Institutions
2.1.2 District to purchase IFA tablets in the case of stock out
2.1.3 Convergence with ICDS for regular supply of IFA tablets through AWWCs

2.2 Awareness generation for consumption of IFA Tablets

2.2.1 Pregnant mothers will be aware for consumption of IFA tablets for 90 days
2.2.1 ASHA and AWWs will generate awareness along with ANMs at the Village level

Objective No.3: To reduce anemia among pregnant mothers from 60.2% to 52% by 2008-09 and to 40% by 2009-10

3.1 Supplementing IFA tablets consumption with other clinical strategies.

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

3.2 Other strategies

3.2.1 Refer severely Anemic Pregnant Mothers to referral centres
3.2.2 IPC based IEC campaigns emphasizing on consumption of locally available iron rich foodstuff.

Details given under Special Scheme on Anemia Control in Part B

Objective No. 4: To increase institutional delivery from 70% to 76% by 2008-09 and to 85% by 2009-10

Strategies and Activities:

4.1 Upgrading BPHCs/CHCs in to FRUs

4.1.1 Provision of Blood storage, OT and lab facility by upgrading 76 FRUs

4.1.2 Training of MOs on Obs & Gynae and Anesthesia

4.1.3 Repair and renovations of FRUs

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

4.1.5 Involve Private Anesthetist in the FRUs @ Rs.1000/- per Caesarian cases.

4.2 Operationalisation of 24x7 facility at the PHC level

4.2.1 Training of MOs and Staff Nurses of PHCs in BEmOC

4.2.2 Appointment of atleast 3 Staff Nurse in each PHCs

4.2.3 Repair and renovation of PHCs

4.2.4 Timely supply of PHC kits

4.2.5 Training of MOs, Staff Nurses on SBA

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

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

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

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

4.3.4 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 referral transport system to refer patients from home/HSCs/PHCs to referral centres.

4.4.2 Monitoring of referral transport system

4.4.3 Development of proper referral system between Health Institutions.

Objective No.5: To increase birth assisted by trained health personnel from 30.9% to 40%.

Strategies and Activities:

5.1 Ensure safe delivery at Home

5.1.1 Provision of Disposable delivery kits with ANMs and LHVs

5.1.2 Training of ANMs on SBA

5.1.3 Supply of adequate DD Kits to TBAs through ANMs, LHVs.

5.2 Provision of delivery at HSC level

5.2.1 Supply of DDkits to HSCs

5.2.2 Delivery table to be provided to the HSCs

Objective No.6: To increase the coverage of Post Natal Care from 15.3% to 24% by 2008-09 and to 35% by 2009-10.

Strategies and Activities

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

6.1.1 Refresher sessions for all ANMs on uniform guidelines to be followed for PNC care – all delivery cases to remain at facility for minimum 6 hours after normal delivery and to be recalled to facility for check up with 4 days and after 42 days.
6.1.2 Ensuring follow up PNC care through out reach services (ANM) for delivery cases where the patient does not return to facility for follow up check ups.
6.1.3 Referral of all complicated PNC cases to FRU level.
6.1.4 LHV and MO to monitor and report on PNC coverage during their filed visits

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

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

6.2.2 Counseling of all pregnant women on ANC and PNC during monthly meetings of MSS and during VHND.
6.2.3 Linking of ASHA's incentives on institutional deliveries to completion of the PNC follow-ups.

Objective No. 7: Reduce incidence of RTI/STI

Strategies and Activities

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

7.1.1 Early diagnosis of RTI / STI through early detection of potential cases through syndromic approach and referral by ANM and ASHA.
7.1.2 Conducting VDRL test for all pregnant women as a part of ANC services.
7.1.3 Implementing contact surveillance of at risk groups in convergence with Bihar AIDS Control Society.

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

7.2.1 Conducting community level RTI / STI clinics at PHCs
7.2.2 Training to all MOs at PHC / DH level in Management of RTI / STI cases in coordination with Bihar AIDS control Society.
7.2.3 Training of frontline staff, LHV, ANM and ASHA in identifying suspected cases of RTI / STI in coordination with Bihar AIDS Control Society.
7.2.4 Strengthening RTI / STI clinic of the District Hospitals

6.2.2 Child Health

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

Objectives:

1. To reduce low birth weight baby's by supplementing nutritional support to pregnant mothers
2. To increase exclusive breast feeding from 27.9% to 35% by 2008-09 and to 50% by 2009-10
3. To reduce incidence of underweight children (up to 3 years age) from 58.4% to 50% by 2008-09 and to 40% by 2009-10

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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 2009-10.
6. To increase full immunization of Children from 32.8% to 40% by 2008-09 and then to 60% by 2009-10.
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

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Strategies and Activities:

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

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

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

Objective No. 2: To increase exclusive breast feeding from 27.9% to 35% by 2008-09 and to 50% by 2009-10

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Strategies and Activities:

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

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

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

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

2.2 Increase community awareness about correct breastfeeding practices through traditional media

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

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

3. To reduce incidence of underweight children (up to 3 years age) from 58.4% to 50% by 2008-09 and to 40% by 2009-10

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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, Anganwadi centres and sub centres will have a weighing machine and enough supply of growth recording charts for monitoring the weight of all children through Untied fund of S/Cs.

3.1.1 Weighing and filling up monitoring chart for each child (0-6 years) every month during 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.

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

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

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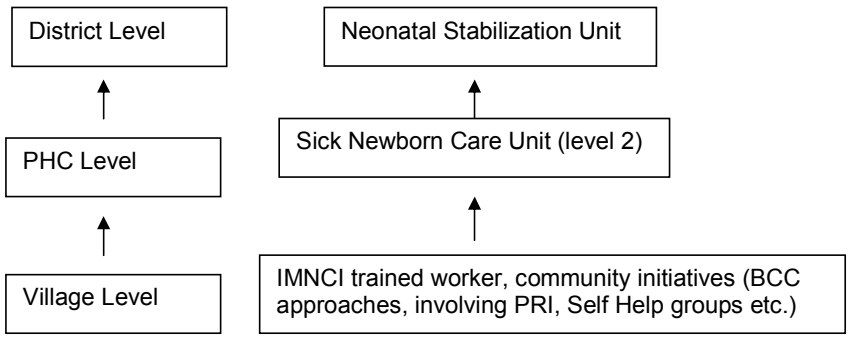
Strategies and Activities:

4.1. Strengthen institutional facilities for provision of new born care

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

MODEL FOR COMPREHENSIVE CARE OF NEWBORN



Level	Facility	Services/Activities	Training required	Equipment
1. District Level				
Near Level II Sick Newborn Care Unit ((SNCU) to provide specialized care services to sick newborns		Special care of neonates	4 days training	Equipment for SNCU and refurbishment.
2. PHC level				
Neonatal Stabilization Unit with basic care services in health facilities		Delivery services Neonatal Resuscitation Warmth	1 day training in essential newborn care	Neonatal warmer Oxygen supply Ambu bag and Mask
3. Village level				
IMNCI Trained workers in each village to provide essential child care and counseling services to community		Post natal Visits, Counseling for breastfeeding and newborn care practices, immunization timely identification, classification and treatment and referral, if needed	8 days training in IMNCI	IMNCI training module Drug Kit

Plan of action:

DISTRICT LEVEL: NEAR LEVEL II SICK NEWBORN CARE UNIT

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

It has been observed that near level II Neonatal care is

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

Establishment of near level SNCU (sick newborn care unit) in 13 districts is proposed.

REQUIREMENTS FOR ACCREDITATION

1. Location of the SNCU:
    - Should be easily accessible from entrance of the hospital
    - Should not be located on top floor
    - For units catering both inborn and outborn neonates: next to labor ward & delivery room
    - For units catering outborn neonates only: near children ward

2. Space Requirement:

1200 sq ft area for a 12 bed near Level II SNCU @ 100 sq ft per patient of which:

a. 50 sq ft would be patient care area and

b. 50 sq ft would be added up for ancillary areas

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

Item	Requirement for the unit
1. Servo controlled radiant warmer	1 for each bed (essential) +2 **Total=14**
2. Low reading digital thermometer (centigrade scale)	1 for each bed (essential) **Total=14**
3. Neonatal stethoscope	1 for each bed (essential) **Total=14**
4. Neonatal resuscitation kit:	1 set for each bed (essential)

	Total=14
5. Electrically operated pressure controlled slow suction machine	1 for 2 beds (essential) **Total=7 (5 electrical, 2 foot operated)**
6. Oxygen hood (neonatal or infant size, unbreakable)	1 for each bed (essential) **Total=14**
7. Non stretchable measuring tape (mm scale)	1 for each bed (essential) **Total=14**
9. Infusion pump or syringe pump	1 for 2 beds (essential) **Total=7**
10. Pulse oxymeter	1 for every two beds **Total=7**
11. Double outlet oxygen concentrator	1 for every two beds **Total=7**
12. Double sided blue light phototherapy	1 for every three beds **Total=2**
13. Single side blue light phototherapy	**Total=3**
13. AC (1.5 ton) split	8
14. Generator (15 KVA)	1

4. Side Laboratory Equipments:

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

5. STAFF

Manpower	**12 bed SNCU**
1. Pediatricians	2
2. Medical Officer	4
3. Sister-in-charge / PHN	1
4. Staff Nurse	6
5. ANMs	8
6. Class IV	6

6. Life Saving drugs for Emergency:

This list is not exhaustive for an Emergency situation in any Sick Newborn Care Unit

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

PHC LEVEL: NEONATAL STABLIZATION UNIT

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

FACILITIES FOR 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 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. Paeditrician will be appointed on contract basis @ Rs.26000 pm.
3. Training of MOs on Paediatrics
4. Training of MOs, Staff Nurses on Facility Based New Born care

Training and operationalization cost will be borne by the UNICEF.

GRASSROOT LEVEL IMNCI TRAINING

Details as per Annexure

4.2 Generation of awareness on new born and infant care (home-based) in community through MSS

4.2.1 Community Awareness on home-based care of new born (skin-to-skin contact, bathing after a week, not removing vermix, etc.); early recognition of danger signs - ARI, diarrhoea; proper weaning practice

The ASHAs / MPWs / AWWs at every point of contact for ANC and PNC will reinforce tenets of home-based care of new born as per IMNCI guidelines. The training will be part of IMNCI.

5. To reduce the prevalence of Anaemia among children from 87.6% to 77% by 2008-09 and to 60% by 2009-10.

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Strategies and Activities

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

6. To increase full immunization of Children from 32.8% to 40% by 2008-09 and then to 60% by 2009-10.

Strategies and Activities

6.1 Conduct fixed day and fixed-site immunisation sessions according to district microplans.

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

6.1.2 Update district microplan for conducting routine immunization sessions

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

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

6.1.5 Enlist help of AWW/ASHA in identification of new-borns and follow-up with children to ensure full immunisation during sessions. New Born tracking sysytm to be implemented

6.1.6 Replace all Cold Chain equipment, which is condemned, or more than five years old in a phased manner by the year 2007-08 and supply new Cold Chain equipment based on analysis of actual need of the health facilities

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

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

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

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

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

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

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

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

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

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

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

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

6.4 Strengthen Supervision and monitoring of immunization services

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

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

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

6.4.5 Coordinate with representatives of PRI to strengthen supervision and monitoring of immunization services.

6.4.6 Details of Immunization have been incorporated in part- C of ***PIP.***

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

Strategies and Activities:

7.1 Increase acceptance of ORS

7.1.1 Supply of ORS and ensure availability in all depots and supply of cotrimoxazole tablets.

The ASHA drug kit will have ORS and cotrimoxazole tablets which should be replenished as per need. Anganwadi centres should also be given ORS. In the absence of ORS, the use of home-based sugar and salt solution will be encouraged.

7.1.2 Orientation of ASHA for diarrhea and ARI symptoms and treatment

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

7.1.3 Organize meetings for ASHAs/AWWs for dissemination of guidelines for Home based care

ASHA and AWW will be trained and provide guidelines for Home based care. The meeting will be held at Block PHC level.

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

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

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

7.2.2 Blood slide examination of all febrile children with presumptive treatment

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

7.2.1 Strengthening of PHCs/ referral centres

6.2.3 Family Planning

Goal: Reduce TFR by 2.1 from present level of 4.3

Objectives:
1. To reduce total unmet need for contraception from 23.1 % to 15%
2. To increase Contraceptive Prevelance Rate (Any Modern Method) from 28.8% to 35% by 2008-09 and to 45% by 2009-10
3. To increase male participation in family planning
4. To increase proportion of male sterilizations from 0.6% to 1.5%.
5. Monitor the quality of service as per GoI guidelines for Sterilization

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

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Strategies and Activities

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

1.1.1. One RCH camp will be organize in each PHC/CHC where Laproscopic Ligation/Mini Lap will be done

1.1.2 Incentive to acceptors Incentive for LL operations

1.1.3 Training on LL operation, MTP and IUD Insertation

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

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

1.2.1 Update EC register with help of ASHAs and AWW

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

1.2.2 Organize monthly IUD Camps in PHCs/CHCs/SDHs

IUD camps will be organize in each PHC/CHC/SDH every month. ANM and ASHA will be informed the dates on which the camp will be held in the concern HIs.

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

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

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

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

1.3 Motivate eligible couples for permanent methods in post partum period specifically after second and third child

Efforts will be made by the service providers to motivate parents to adopt permanent methods after the birth of the second or third child.

1.3.1 Update EC register with help of ASHAs and AWW

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

1.3.2 Motivate couple after second child in Post Partal period to go in for tubectomy / NSV

After the second child is born, the couple will be motivated to adopt a permanent method of family planning preferably NSV. For this communication materials will be prepared and distributed.

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

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

1.4 Making available MTP Services in all Health Institutions.

1.4.1 MTP Services in the state is operational in all the HIs of the state. Training of MOs have been under taken during RCH-1. To further strengthen the skill of the doctors for MTP training, training shall be taken up during the year. 100 MOs will be trained in 2008-09.

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

Objective No.2: To increase Couple Protection Rate

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Strategies and Activities

2.1 Awareness generation in community for small family norm

2.1.1 Preparation of communication material for radio, newspapers, posters

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

2.1.2 Meetings with MSS, CBOs

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

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

2.2 Regularise supply of contraceptives in adequate amounts

2.2.1 Indent and supply contraceptives for all depots and subcentre/ AWCs and social outlets

Each AWC and ASHA will have at least one month's requirement of condoms and OCPs. Sub centres will have adequate supplies of IUDs also.

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

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Strategies and Activities

3.1 Promote the use of condoms

3.1.1 Counseling men in villages to demonstrate ease of use of condoms and for prevention of STDs

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

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

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

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

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4.1 Increase demand for NSVs

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

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

4.2 Increase capacity for NSV services

4.2.1 Training of doctors for NSV

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

4.2.2 Organise NSV camps at the Sub District Level

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

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

6.2.4 Adolescent Reproductive and Sexual Health

Objective:

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

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

3. To increase awareness levels on adolescent health issues

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Objective No.1: To reduce incidences of teenage pregnancies from present 25% to 22% by 2008-09 and to 15% by 2009-10.

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Strategies and Activities:

1.1 Improve access to safe abortions

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

MOs will be trained in MTPs

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

1.2 Ensure availability of condoms/OCPs/Emergency contraceptives

1.2.1 Depot holders among adolescent groups/youth organisations

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

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

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Strategies and Activities

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

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

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

2.1.3 Risk reduction counseling for STI/RTI

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

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

2.2.1 Training of AWW/ASHA in adolescent health issues

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

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

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

The state / district will identify NGOs or other de-addiction centres in the state 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 state/district will have an understanding with the de addiction centre on the process for referring patients to the de-addiction centres.

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

Strategies and Activities

3.1 Organizing Behavioural Change Communication campaigns on specific problems of adolescents

3.1.1 IEC activities along with take-home print material to be organized in coordination with MSS, Youth club

One of the monthly theme meetings with the MSS / CBOs will be related to adolescent health problems, signs and symptoms, treatment and referrals.

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

As part of the School Health Programme, adolescents in schools will undergo health check ups thrice in a year. Some counseling related to common adolescent problems will also be given during these check ups.

3.1.3 Orientation of VHSC on adolescent issues

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

3.1.4 Premarital counseling of adolescent girls on reproductive health issues at PHC/RH/SDH/DH

This will be part of the adolescent health session/clinics which will be regularly conducted at sub centres, PHCs and also at youth clubs.

3.2 Dissemination of ARSH Guidelines and Trainings

3.2.1 Organize dissemination of ARSH guidelines at State level.

3.2.2 Training of TOTs on ARSH

3.2.3 Training of MOs, ANMs on ARSH

6.2.5 Urban RCH

Objectives:

1. Improve delivery of timely and quality RCH services in urban areas of Bihar

2. Increase awareness about Maternal, Child health and Family Planning services in urban areas of the state

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

Strategies and Activities

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

1.1.1 Mapping of Urban Slums and existing providers of RCH services of both public and private sectors (including NGOs). **(Details in Annexure)**

1.1.2 Develop Micro-plans for each urban area for delivery of RCH services, both outreach and facility based.

1.2 Strengthen facilities of both public and private sectors (including NGOs) in urban areas

1.2.1 Setting up of 111 new Urban Health Centres **(Details in Annexure)**

1.2.2 Strengthen public sector health facilities in urban areas by upgrading Urban Health Centers, FRUs (district hospitals and SDHs), and medical colleges for delivery of quality RCH services

1.2.3 Establish partnerships with select private health facilities for delivery of facility-based RCH services e.g. institutional delivery, permanent methods of FP, curative MCH service, etc.

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

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

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

1.3.2 Develop partnerships with NGOs based in urban areas and particularly in urban slums to deliver outreach services e.g. ANC, immunisation, community based distribution of contraceptives, etc,

1.3.3 Expand outreach of RCH services by adoption of identified under-served or un-served urban areas by facility-based providers (e.g. adoption of a particular slum by a medical college or private health institute)

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

Strategies and Activities

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

2.1.1 Utililise various channels of mass media with extensive reach in urban areas such as TV, local cable networks, radio (particularly Vividh Bharti channels), cinema halls, billboards at strategic locations, etc to propagate messages related to key programme components of RCH.

2.1.2 Extensively use of print media such as newspapers (particularly local newspapers), journals and magazines for dissemination of key RCH messages.

2.2 Broad inter-sectoral coordination to increase awareness and knowledge of key messages under the RCH programme

2.2.1 Involve representatives from Urban Local Bodies (municipal corporations and municipalities), commercial associations, sports bodies, voluntary and religious organisations for intensive inter-personal communication and community-based awareness campaigns.

2.2.2 Use NGO network (MNGOs and FNGOs) with RCH to deliver key messages planned under RCH through IPC and community-based activities in urban areas, particularly in urban slums.

2.2.3 Implement school-based awareness campaign for RCH services with emphasis on adolescent health.

6.3 Infrastructure including IMEP

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 of infrastructural corrections for upgrading the facilities. These are

1. As per RCH Programme operationalisation of 76 First Referral Unit to provide emergency obstetric and newborn care 24 hrs. a day / 7 days a week. The aim is to ensure atleast two operational FRUs per district. There are 76 hospitals in the State which have been identified to be upgraded as FRUs. The main focus initially to provide remedial measures absolutely required to ensure proper functioning of the facility. Another important aims to provide appropriate specialist in each of these 76 Hospitals. It is proposed to upgrade 76 Health facilities to FRUs in 2007 – 2008. Unit cost of construction at the rate of average of 2 crores as per RCH norm. The above hospital will be well equipped with OT, electric supply, water supply, toilet, telephone services, sewerage system and disposal system for hospital infectious waste.

2. Anesthetist will be hire @ Rs.1000 per case for EmOC. A provision for 30000 cases included in the PIP.

3. Neonatal Intensive care unit will be setup in 13 districts at the district hospitals. Each Neonatal unit will cost Rs. 39,36,000/-

1	Civil & Electrical Works:	Rs. 6,86,000/-
2	Equipments for individual patient Care:	Rs. 25,00,000/-
3	General Equipments:	Rs. 2,50,000/-
4	Side Lab Equipments:	Rs. 2,00,000/-
5	Equipments for disinfection	Rs. 1,50,000/-
6	Data Collection & Recording	Rs. 1,50,000/-
Total		**Rs. 39,36,000/-**

The costs also include provision of equipments at these hospitals either as per IPHS or as required.

4. Newborn Care Unit will be set up in all the 533 PHCs @ Rs. 1,57,400/- . This includes minor civil work and purchase of Equipments.

Infection Management and Environmental Plan

The state has started a CWTF facility at IGEMS, Patna. As per the rules each CWTF should cater to all facilities in 100 Km radius, keeping this in mind, eight more CWTF are to be operationalised in each of the division except patna(which already has such a facility).All the Health facilities shall have a proper IMEP plan, as per the GoI guidelines.

Setting up a Bio-Medical Waste Management System: To implement the IMEP in a comprehensive systematic manner, a critical first step will be to undertake a thorough review of the existing situation and analysis of the current bottlenecks. The review should encompass current practices of segregation and collection of waste, disinfection and treatment methods, transportation, handling and disposal of waste both within and outside the healthcare setting, availability and use of protective devices and safety precautions followed by healthcare personnel. It will also include health and safety measures adopted by the management for healthcare workers, review of policy with respect to waste management, waste minimization, infection control, antibiotic policy and policy for disinfection procedures. An assessment of knowledge, attitude and skills of various categories of staff will help determine training needs. Based on this review, a Bio-Medical Waste Management Plan will be developed which will encompass all the key elements of the administration and implementation of infection control and bio-medical waste management in healthcare facility.

Trainings shall be provided to health care workers and officers in Infection Management and Environment Plan implementation as per GoI guidelines. The state has decided to outsource the Bio Medical Waste Management to an Agency for managing the plan comprehensively. **(Budgeted in NRHM part B)**

6.4 Institutional Strengthening

6.4.1 HMIS/Monitoring & Evaluation

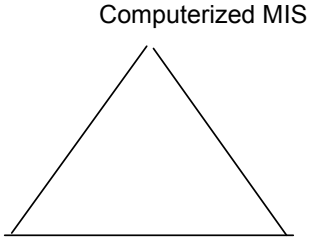
Monitoring and Evaluation is a important component in the RCH. The state has monitored the programmes on the following activities.

Activities

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

A triangulated process of Monitoring and Evaluation would enable cross checking and easy collection, entry, retrieval and analysis of data. This Triangulation monitoring will be done at block level.

Triangulation Process for Monitoring and Evaluation



The state has one data centre which collect datas from all the PHCs and District on Daily basis through landline phones and mobile phones. The collected data feed in a computerized format and sent to the respective programme officers. The collected data include al the parameters require under RCH for monitoring. Fund requires for the data Centre as a recurring cost and put under PIP.

The state conducts monitoring meetings of programmes at State and District Level. The monitoring meetings are for review the programme and sort out the issues for proper implementation of the programme.

State Rural Health Mission meets twice in a year, and State Health Society review quarterly. The District Health Society meets monthly in their respective districts.

This year the state proposes to evaluate programmes on PPP Initiatives, Janani Bal Suraksha Yojna and Family Planning Service.

6.4.2 Behaviour Change Communication

The Annual Action Plan 2007-08 for IEC/BCC has been prepared in the light of the number of initiatives taken by Deptt. of Health GoB, and State Health Society, Bihar, in the implementation of NRHM. It follows in essence, form and content, the National Communication Strategy. The National PIP for RCH and instructions and guidelines received from GoI and GoB from time to time has also been kept in mind.

The selection and implementation of set of behavior change have been adopted with a view to improve a wide range of family care-giving and care-seeking practices, and enhance supportive environments for improved household health practices at community, institutional and policy level. The IEC/BCC Programme will focus on building an environment favoring health seeking practices, preferably through low cost and no cost interventions, especially for the disadvantaged and the marginalized sections of society. This outlook will set the tone and tenor of the mobilization process for effectuating a positive change in the existing socio-cultural mores, systems and processes.

Hiring of Professionals for Developing IEC Materials: Professionals have been empanelled under three categories, namely, Category ‘A’ - Advertising, Category ‘B’ - Print Media and Category ‘C’ – BTL Media Communication. Services of these agencies will be obtained for designing, & developing of IEC materials, jingles, spots, slogans serials, cinema slides, etc., as per the need of the Society. Workshops/Competitions will

be organised to develop slogans, stories, etc., on various issues related to health. Best slogans will be awarded and used for publicity.

Publicity of Programmes:

Print & Electronic Media – Materials will be developed and publicized on different issues eg. JBSY, ANC, Promotion of Breast Feeding, Family Planning including Non Scalpel Vasectomy, Immunization, Adolescent and Sexual Reproductive Health, PNDT Act, Role of ASHA under NRHM, etc., through various priont and electronic media. Focus will be more on developing picturesque and self-depicting materials for easy consumption of the target group. Districts will be given the freedom to develop local specific materials for local use.

Outdoor Media - Hoardings, Glow Signs, Banners, posters, etc., on issues related to RCH, and NRHM will be put up at vantage points will be displayed at important locations like at District Offices, Block Offices, PHCs, Haat points, Bus Stands, Railway stations, etc. Hoardings of I&PR Dept. are being sponsored to published about health related activities. Monthly magazine brought out by the Dept. is being sponsored by SHSB. Space has been allocated in the hoardings and magazine for publicizing about health related programmes. Exhibitions, melas, functions will be organized from time to time to expand reach of different programmes. Prabhat Pheris will be organized. Folk Media will also be used as a tool for publicity.

Inter Personal Communication:

Agents of Change: ASHAs, AWWs, ANMS will act as agents of change as they are the front line workers associated with the activities of Dept. of Health.

Contact Drives - ASHA will visit every household and familiarize herself with the members of the family. Once she has won the trust of the family members, she will propagate among them the benefits of adopting a healthy life-style. She will discuss in detail, even with the male and elderly members of the family, with logic and reasoning

about the consequences and detrimental aspects of unhygienic style of living. She will support her discussions with Documents, Flip charts, pictures, etc. She will facilitate discussions among the family members and help people arrive at logical conclusions.
ASHA will discuss health related issues with the female members of Panchayat, Health & Sanitation Committees, Village Education Committees, etc.

Organizing Group Meetings:

At Community level – Once ASHA has won the confidence of the local people, she will organise local women in groups of 20 – 30, and strategically persuade them to meet at a common place, atleast once in 15 days. These group meetings will provide to the women a common forum where they will have freedom to discuss specific problems, and issues, especially those related to health. This forum will become a hub for disseminating knowledge and information to a wide range of people. Date, time, and place of meetings will be decided by the local women at their convenience. The meeting will be attended by ASHA who will act as a facilitator for initiating discussions and arriving logical conclusions.

At Anganwadi Centres – The Block Health Facilitators along with AWWs and ASHAs will organise monthly meetings with Mahila Mandals of ICDS. Members of Panchayat, VEC, Health & Sanitation Committee, Gram Sevikas, members of NGO and Self-Help Groups will be invited to attend the meetings. Focussed discussion, street plays, motivational songs, etc. will form a part of these meetings.

At the District/State level - Advocacy Programmes, workshops seminars, press conferences, etc., will be organised for different target groups including Politicians, Media Personnel, Bureaucrats, NGOs, School Children, PRIs, etc.

Adolescent Reproductive and Sexual Health (ARSH) – Separate groups of adolescent girls and boys including in school and out of school adolescents will be formed at the village level through ASHAs. ASHAs will hold monthly meetings of these groups where she will discuss various issues related to Adolescent and Reproductive Sexual Health with them. A number of activities will be taken up for awareness generation and mobilisation. Steps will be taken to integrate training of Adolescents with that of School Aids Awareness Programme conducted by Bihar State Aids Control Society.

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

Inter-Sectoral Collaboration/Convergence: No programme can run in isolation. For the sustainability & support of the programme, it is essential to collaborate with the different Govt. departments engaged in similar activities. Support from the field level functionaries under ICDS , PHED, Arts & Culture Dept., PRI Dept., Women Development Corporation,

BSACS, BSPP, Mahila Samakhya, COMFED, etc., will be sought in spreading various health related messages and best practices for a healthy living and utilization of available services and facilities. Inter-sectoral convergence with the Information & Public Relations Dept. GoB will also be made for publicizing about the programmes and schemes through other means.

Collaboration with international, national and local level NGOs having a strong field presence. Meetings and workshops will be organized to disseminate information.

Information Centre – Anganwadi Centres will be declared as the Information Centre for all health related activities. A token amount as recurring and non-recurring expense will be forwarded to these centres for its day to day functioning.

Programme Specific Interventions:
Details of programme specific interventions have been covered under the plans of respective programmes.

Awards: Award function will be organized for awarding the best performing Panchayats. Judgement will be based on parameters developed by SHSB/DHS. Advocacy Workshops will precede these competitions. Detailed Guidelines in this regard will also be issued to Panchayats.

Health Camps

The Economic Indicators of the State give enough indications that a number of families enter into debt due to health reasons. Increasing health care costs are creating further financial challenges for health care consumers, especially in the rural areas of Bihar.

A one-day health camp would be organized at every PHC, every month. The camp would be used for disseminating information on various health and family welfare issues, population control, female feticide, child care, immunization, eye care, vector borne diseases, etc. Arrangements to conduct a general eye-check-up of the visitors to the camp will be made at these centres. Free spectacles will be distributed to the needy of BPL families at these sites. This intervention will be used as a strategy to attract visitors to the camp.
Handbills and banners, posters, etc., will be placed in different localities and at public places like Panchayat Bhawan, Block Offices, Hatts, Melas, Schools, etc. Audio-video materials, print materials in the form of handbills, booklets, pamphlets, flip charts, etc. will be made use to orient the masses. Mobilisers will get in touch with the local leaders, PRI representatives, teachers and the like, a couple of days prior to the day of the camp,

and will organize the people on the actual day of the health camp. Concerted efforts will be made to attract visitors through awareness campaigns.

School Health Check-up Camps of children in Govt. Schools will be organized at the block level. One health camp will be organized every quarter. Doctors, Medical Services, Medicines, etc. will be made available by the concerned PHCs. Health Cards will be issued to children undergoing health check-ups.
Network of organisations like Mahila Samakhya, COMPFED, Pathfinder, CARE, Professional Agencies, etc., will be utilized for organizing Health Camps.

Budget for BCC		
Proposed Activity	Action Plan 2008-09	
	Details of Budget Basis of Costing (No. of Units X Unit Cost)	Proposed Budget (In Lakhs)
Print Media	Press Advertisements on Special Days – World Population Day, Health Day, Children's Day, Mother's Day, Smoking/Anti Tobacco Day, RCH/FW, Institutional Delivery etc. Press Releases on Routine Immunisation, Breast Feeding, Anti-Natal Care, Contraceptives, IUD, PNDT, etc., at DAVP Rates	50.00
Electronic Media	Spots/Quickie Production @ Rs. 25000/- x 5 spots for 60 secs.	2.50
	Sponsorship Fee for DD @ Rs. 6000/- per Prog.x120 Progs. (5 Progs. Per Week x 24 Weeks) = Rs.720000/- – Rs. 180000/-(25% commission) + Rs. 55080/-+ (service tax @ 10.2%)	5.95
Cable Network	@ Rs. 600/- per 10 sec. 60days x 4 times x Rs. 600/-	1.44
Radio	Production of Jingles in Regional Language	1.00
	Broadcasting of Jingles. – 4 types for 30 sec. Before & After Regional News Daily @ Rs. 1800/- per day x 30 days = 54000 x 2 times (morning & evening) Rs. 54000/- x 2 times x 6 months	6.48
Printing of Banners/ Folders/Booklets, etc. on various health related topics.		100.00

Budget for BCC		
Proposed Activity	Action Plan 2008-09	
	Details of Budget Basis of Costing (No. of Units X Unit Cost)	Proposed Budget (In Lakhs)
Production of Audio-Video Materials		2.00
Press Conference etc.		1.50
Hoardings/ Glow Signs etc.		150.00
Folk Programme/ Drama	Folk Media@ Rs. 500/- x 534 blocks x 2 programme	5.34
Advocacy Workshops/Seminars	for Religious Leaders, Opinion Leaders, Social Workers, NGOs, Media Personnel, PRI, Kalyani Clubs, etc. Sensitization workshop for PNDT(533X25,000+38X 50,000+ 1 cr)	153.25
Block Level Meetings of Mahila Mandals	Monthly meeting of Mahila Mandals 60 Women x 534 Blocks x Rs. 25 for Snax X 6 Months + Other expenses - 5000.00 X 534 Blocks X 6 Months	208.26
Information Centre	non recurring – expenses 10,000 X 534 Blocks Recurring - expenses 1,000 per month x 534 Blocks X 12 Months	117.48
Total		**805.15**

* Budget for IEC activities under various programmes - included in respective annual plans.

6.4.3 Quality Assurance

The state has Quality Assurance Committee for Sterilisation, Birth Control, Maternity Services, Child Survival Services, Immunization, and Case Management of Diseases in the district

Quality of health care and reproductive health services consists of the proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question and have the ability to produce an impact on client attraction & satisfaction, belief, population stabilization, inclination towards the continuation of method(s) etc.

As per the guidelines lay down by the Honorable Supreme Court of India. The State Government is in the process of constituting Quality Assurance Committees (QACs) at the State and District levels to ensure that the standards for female and male sterilization and other health services are being followed in respect of preoperative measures, operational facilities and post-operative follow-ups and other ethical diagnostic and treatment protocols.

The terms of reference for the State / District QAC are as follows:

- The District QAC shall conduct medical audit of all deaths related to sterilization, maternity deaths and deaths arising out of suspected medical negligence and send reports to the State QAC office. The State QAC shall deliberate on the report.
- Shall collect information on all hospitalization cases related to complications following sterilization as well as sterilization failure and maternity deaths and deaths arising out of suspected medical negligence.
- Shall process all cases of failure, complications requiring hospitalization, and deaths following sterilization for payment of compensation and will pursue these cases with the insurance company or otherwise.
- Shall review all static institutions i.e. Government and accredited private/NGOs and selected camps providing sterilization services and providing maternity, Child survival and other medical care for quality of care as per the standards laid down, and recommend remedial action for institutions not adhering to the standards.
- A minimum of three members shall constitute the quorum.

Presently the QAC also looking after the quality of all the trainings done under RCH.

6.5 Training

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

The training will be provided at the State Institute of H & FW , Regional training Institutes , ANM training schools , District hospital ,PHCs and also in Railways , ESI ,private sector hospitals where there is enough case load for a proper training. Some of the trainings will be contracted out to the NGOs and private players also, so that any limitation of State infrastructure is overcome easily. [Available in detail in NGO chapter]. As BCC will be a major training aspect, it has been dealt in a separate chapter.

All the technical training programmes will ensure that.along with the theoretical inputs, proper practical exposure is also provided. Apart from this each training programme will stress on the managerial aspect and on the communication with the clients.

The TOTs will ensure that the trainers not only master the contents of the training topic but also aquire skills as teachers/trainers or facilitators and motivators.The state official, trainers, professionals and functionaries who excel in implementing training programmes will be recognized through awards and citations. A rational selection criterion will be used to select the trainees for the trainings where the no. of trainees are limited.

Moreover promotion and posting policy will be linked to training and the functionary will have to undergo training to avail the promotion. There will be provision for proper rational posting so that the personnel trained, utilize their training in their day to day work.

A feedback system will be developed to assess the quality of the training. From time to time, presence of state/regional observers will be ensured to assess the quality of district level trainings and workshops. Detailed Records and data about personnel undergone training should be available with all concerned at all levels. SIHFW will coordinate and monitor this with the help of district Data Officers

Training Institutes

SIHFW

The State Institute of Health and Family Welfare (SIHFW) is the premier training institute in the state of Bihar. SIHFW needs to be further strengthened as the apex institute in the state of Bihar for co-ordination and implementation of all capacity building initiatives under RCH II program. SIHFW has the required infrastructure and facilities, which need to be reinforced further so that it can conduct the various training programs on continuous basis.

As the nodal agency for training activities in the State, SIHFW will have following major tasks:

- To develop annual training calendars based on the district action plans in close co-ordination with RHFWTCs and ANMTCs.

- To conduct clinical and non-clinical training programs for medical officers.
- To support RHFWTCs and ANMTCs to conduct timely induction and refresher training programs for ANMs and LHVs.
- To facilitate ongoing assessment of training needs of functionaries at all levels
- Co-ordinate and implement integrated skill development and specialised skill development training programs.
- Conducting TOTs with RHFWTCs and ANMTCs
- To co-ordinate with SCOVA/SHSB for need based hiring of resource persons for the training programs

At present, out of the 14 sanctioned posts of faculty at SIHFW, only 4 faculties are in position. They are for Management/OB, Communication, Gynaecologist and Paediatrician. The State proposes to fill following positions at SIHFW at earliest:

- One faculty each, for four areas - Human Resources Development, Monitoring and Evaluation, Epidemiologist & Behaviour Change Communication Strategies.
- Support staff such as one librarian, one accountant and one accounts assistant, one office assistant, one stenographer cum typist, one driver, three helpers, one housekeeper for hostel, and two security guards will be appointed preferably, on contract basis.

In addition, adequate provisions will be made for the institute to hire need based services of electricians, plumbers, carpenters, etc. on contract basis.

RHFWTCs

There are Eight Regional Health and Family Welfare Training Centers (RHFWTCs) in the state – Three for male and five for female health staff. All the sanctioned posts of trainers at these institutes are filled. However, functioning of all RHFWTCs is severely affected due to lack of proper infrastructure. The State proposes to use the facility Survey to do a detailed assessment of the needs of these training centers. Based on the report of the facility survey, adequate resources will be provided to all RHFWTCs to upgrade their respective infrastructure and maintenance support.

Location of the RHFWTCs in the State:

RFWTC Male	RFWTC Female
Patna (non residential) Muzaffarpur Bhagalpur	Patna Gaya Muzaffarpur Saran Purnea

The Facility Survey will also assess the need for new Regional Health and Family Welfare Training Centers (RHFWTCs) in the state.

ANMTCs

There are 21 ANMTCs in Bihar; the training capacity of these institutes varies from 60 to 90 participants per batch. Most of these training centers were functioning sub-optiminaly in absence of proper infrastructure and other essential support but after the facility survey was completed with the help of UNICEF, GoB has been able to restart 12 ANM schools. Based on the report of the facility survey, adequate resources will be provided for all ANMTCs to upgrade their respective infrastructure and maintenance support. Further status of faculty positions/trainers and their requirements at ANMTCs would be assessed incourse of facility survey and then adequate provisions will be made to address their needs.

Key Training Activities

The wide range of training activities to be conducted under RCH II program by various agencies and training institutes is outlined below. The trainings not mentioned in training plan would be taken up with the help of development partners .Adequate changes will be made to make all the trainings as per GOI guidelines.

Maternal Health

- Provide comprehensive skill upgradation training to frontline ANC service providers (ANMs and LHVs) to ensure delivery of quality ANC services
- Conduct training to build capacity of LHVs for effective supervision and monitoring.
- Train Anganwadi Workers and PRI members would help in identification and motivation of pregnant women for healthy antenatal care practices and for utilization of ANC services.
- Impart refresher training to Gynecologists and Obstetricians on safe delivery practices and referral procedures
- Train all ANMs, LHVs, and Nurses in identification of danger signs during delivery, referral procedures and PNC services.
- Train NGOs, Anganwadi Workers and PRI members in raising community awareness and knowledge about importance of institutional delivery, safe delivery practices at home, referral and PNC services.

Child Health

- Train frontline Health workers, Anganwadi Workers, PRIs, local NGOs and CBOs in correct breastfeeding and complementary feeding practices
- Provide comprehensive skill upgradation training to immunisation service providers (LHVs/ANMs), particularly in injection safety, safe disposal of wastes and management of adverse effects.
- Conduct training to build capacity of Medical Officers, MOICs and DIOs for effective management, supervision and monitoring of immunisation services
- Train Cold Chain handlers for proper maintenance and upkeep of Cold Chain equipment
- Train Anganwadi Workers and PRI members in identification of children eligible for immunisation, in motivation of caregivers to avail immunisation services and in follow-up of dropouts
- Identify key persons to join IMNCI master training pool
- Train members of master trainer pool in national level course
- Recruit and train district trainers (using state master trainer pool)
- Train all health and ICDS staff in a phased manner
- Train frontline health workers and Anganwadi workers in health education techniques to build community capacity for early recognition of childhood illnesses, home-based care and care-seeking

Family Planning

- Train partners such as NGO and civil society networks, religious organisations and leaders, PRIs, ICDS, Education, General Administration, Corporate Associations and Professional bodies (IAP, IMA) in promotion of Family Planning, at state, district and block levels
- (Re) train frontline health workers, Anganwadi Workers and PRIs as motivators and counselors for family planning services through IPC and counseling
- Impart technical skill-enhancement training to existing and newly appointed frontline health workers on provision of various spacing (Oral contraceptive, condom, IUD insertion, emergency contraception) and terminal (female and male sterilization) methods of Family Planning.
- Train doctors in various reversible and terminal FP procedures (MTP, Minilap, NSV and IUD).

Adolescent Health

- Conduct annual orientation and training of all health service providers on adolescent health needs at state, district and block levels
- Train/sensitise community leaders, school teachers, PRIs, NGO networks, Anganwadi Workers, towards the health needs of the adolescents
- Train NGO and civil society networks, religious organisations and leaders, PRI members and teachers in promotion of safe reproductive health practices and family planning among adolescents.
- (Re) train frontline health workers and schoolteachers as motivators and counsellors for safe reproductive health practices and family planning among adolescents through IPC and counselling
- (Re) train frontline health workers to provide RTI/STI curative services for adolescents

Urban Health

- Train representatives from Urban Local Bodies (municipal corporations and municipalities), commercial associations, sports bodies, voluntary and religious organisations in techniques for intensive inter-personal communication and community-based awareness campaigns.
- Train NGO network (MNGOs and FNGOs) with RCH in health education for RCH through IPC and community-based activities in urban areas, particularly in urban slums.

This year the state proposes to fund the medical colleges to purchase training materials for state Medical officers who will undergo training in Anesthesia, EmOC and Paediatrics. The state proposes to give Rs. 25 lacs per Medical College in this purpose.

Training Plan

Sr. No.	Name of the Training (Indicating its objective)	Target Group	Duration	Broad Course Content	Indicators/ Mechanisms for assessment of Quality/ Impact
1.	Skill upgradation Training for delivery of Quality MH Services, including SBA	ANM, LHV, Staff Nurses	15 days (staff nurse), 21 days (for ANM)	ANC, PNC, Safe Delivery, danger signs during delivery, referral procedure, MTP	MMR, Quality Assessment Survey, No. of ANCs, PNCs and safe deliveries. No, of referrals
2.	Skill upgradation, Training for quality services	ANM, LHV, Staff Nurse	5 days	FP counselling, on all spacing and terminal methods, IUD insertion, Emergency contraception (OCP, condoms, Injectables, IUDs, sterilizations, NSVs)	Quality assessment, survey of councelling sessions, client satisfaction surveys, No. of IUDs inserts. No. of ECs provided
3.	Training for effective supervision and monitoring to LHVs	LHVs	1 day	Basics of supervision, monitoring, management, preparation of workplan, work filling up of CNAA forms, effective field visits	ANMs performance
4.	Training on IPC for MH services to PRI, AWW, CBO, NGOs	PRI, AWW, ABO, NGO	3 days	IPC, MH services- ANC, PNC, safe delivery, referral services, Institutional delivery	Community awareness
5.	Training on IPC for FP services	PRI, AWW, CBO, NGO	3 days	FP Services- spacing methods, Terminal methos, Emergency contraception, Need of small family	% of FP services utilized. % of awareness about FP services in community.

6.	Training oon IPC for CH and AH services for PRI, AWW, CBO, NGO	PRI, AWW, CBO, NGO	3 days	Exclusive breast feeding, colostrums diarrhea, ARI, Immunization, Home-base neo natal care, Referral Services, Sensitization towards AH needs.	IMR, % Exclusive breast fed infants, increase in full immunization %, % referral cases, Awareness % of ARI, about ORS
7.	Refresher training for MH to gynecologists/ obstetrician including EmOC	Gynecologists or obstetrician	5 days	Safe delivery, caesarean section, EmOC referral services	% of safe deliveries, institutional deliveries, % reduction in MMR, % increase in FP services.
8.	Training on NSVs to MOs	Medical officers	5 days	NSV- councelling, IPC and NSV-technique	No. of NSVs done, client satisfaction survey
9.	ToT on safe delivery to NGOs for TBA training	MNGOs	3 days	Safe delivery, IPC, Inputs on how to train effectively	Survey of TBA who will receive training on the spot. Quality assessment of training given by NGOs to TBAs
10.	Training on safe delivery to TBAs through NGOs	TBAs	3 days	ANC, safe delivery, early detection of danger signs, referral services	% of safe delivery MMR
11.	Training for effective Mtg, supervision and monitoring for MO	MO	2 days	Basics of effective management, supervision monitoring, effective field visits, filling up of CNAA forms	Quality assessment surveys, client satisfaction surveys
12.	ToT for effective mtg, supervision, monitoring to MOICs and IOs	MOIC, DIO	2 days	How to provide effective trg, trg tools, basics of effective Mtg.	Quality assessment surveys, client satisfaction surveys

13.	Training for maintenance of cold chain equipments	Cold Chain handlers	2 days	Maintenance of cold chain, basic functioning, repair	% of cold chain equipment in working condition
14.	ToT for state level trainers in IMNCI	Distt level master trainers	10 days	Basic training tools and techniques, IMNCI including home based new born care	IMR, Decrease in deaths due to diarrhea, ARI, increase in breast feeding.
15.	ToT for district level trainers in IMNCI	Distt. Level master trainers	10 days	Basic training tools and techniques, IMNCI including home based new born care	IMR, Decrease in deaths due to diarrhea, ARI, increase in breast feeding.
16.	Training in IMNCI to ANMs, LHVs, Nurses	ANMs, LHVs, Nurses	10 days	Basic training tools and techniques, IMNCI including home based new born care	IMR, Decrease in deaths due to diarrhea, ARI, increase in breast feeding.
17.	Training of IMNCI to AWWs	AWWs	8 days	Basic training tools and techniques, IMNCI including home based new born care	IMR, Decrease in deaths due to diarrhea, ARI, increase in breast feeding.
18.	Training in IMNCI to MOs	MOs	8 days	Basic training tools and techniques, IMNCI including home based new born care	IMR, Decrease in deaths due to diarrhea, ARI, increase in breast feeding.
19.	Orientation Training for IPC for urban local bodies, NGOs, voluntary Org	Representatives of Urban local bodies, NGOs, Voluntary org. etc.	2 days	IPC, brief knowledge of MH, FP, CH and AH	% improvement in utilization of health services in urban areas
20.	Training to district level PMU	DPMs, DAMs, DM, CMOs, ACMOs, DIUs	5 days	Roles and responsibilities, brief knowledge about programme an its aspects MH, FP, CH, AH	Better monitoring at district level
21.	Training of state level PMU/SMU	SMU	6 days	State specific programme details, roles and responsibilities, results expected	Better monitoring at state level

22.	Experience sharing/ Inter state visit	SMU	7 days	Visit to a state where RCH is successfully implemented to study its implementation, problem- solving	Better monitoring at state level
23.	Training of CNAA form documentation to ANM, MPW, LHV	ANM, LHV, MPW	3 days	CNAA forms, filling up, cross checking	Better monitoring at HSC level
24.	Orientation training in AH to school teachers	School teachers			AH sensitization
25.	Training on CNAA forms for statistical personnel	statistical personnel	3 days	CNAA forms, cross checking, collation	Better monitoring at all levels
26	Training of Health personnel in Biomedical Waste management	Medical officers, staff nurses, LHV, ANM,OT attendants	1day	Segregation of waste, Colour coding, management ,disposal	Better Biomedical waste management

6.6 Equity and Gender

6.61. PNDT Act

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

In order to arrest the abhorrent & growing menace of illegal termination of pregnancies as well that of pre-natal diagnostic test ascertaining sex-selection, the Medical Termination of Pregnancy Act, 1971 read with Regulations & Rules 2003 and the pre-natal Diagnostic Techniques (Prohibition of sex selection)Act were formulated.

The misuse of modern science & technology by preventing the birth of girl child by sex determination before birth & thereafter abortion is evident also from the fact that, there has been a decline in sex ratio despite the existing laws.

The Apex court has observed that:-

"We may state that there is total slackness by the Administration in implementing the Act. Some learned counsel pointed out that even though the Genetic Counselling Centre, Genetic Laboratories or Genetic Clinics are not registered, no action is taken as provided under Section 23 of the Act, but only a warning issued. In our view, those Centres which are not registered are required to be prosecuted by the Authorities under the provision of the Act and there is no question of issue of warning and to permit them to continue their illegal activities" .The apex court accordingly directed the central as well as state Governments to implement the PNDT Act. In Bihar too the concerned authorities have been directed to implement the provisions of the both the Acts forcefully.

Following actions have been taken and planned in this regard.

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

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

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

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

6.6.1 Innovations – MUSKAAN Programme

The state has started a New Programme called MUSKAAN Programme to track Preganat women and New Born Child. Under this programme ASHA, AWW and ANMs jointly trac the pregnant mothers and New Born Child.

This programme launch in October 2007. Under this programme ASHA, AWW and ANM will hold meeting with Mahila Manadals in AWWCs. The main objective is to cover ANC coverage and Immunization. A Data Centre also placed in all the 533 PHCs to monitor this programme.

After the introduction of this programme it has been seen that the coverage of ANC and Immunization increased. The State want to continue this programme and requested the GoI to fund the programme.

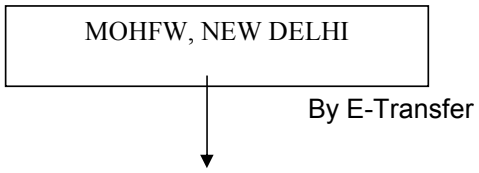
6.7 Financial Management

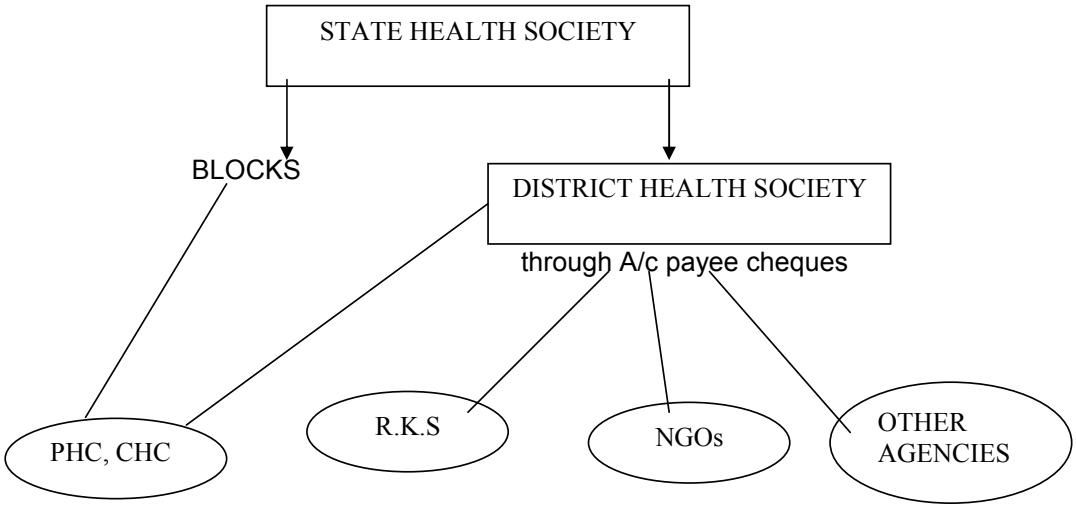
FUND FLOW MECHANISMS AT STATE

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

On the same lines of the GOI regarding transfer of funds, SHS is under the process of implementing the system of e-transfer of funds to the districts and blocks. This process is likely to be completed very soon.

FUND FLOW





OPERATION OF BANK ACCOUNTS

- The Account of State Health Society is being operated as per the delegated powers.

- The persons authorized as per the powers delegated to them are also operating the bank accounts of DHS.

ACCOUNTING PROCEDURES FOLLOWED

The State is following the Double Entry System of accounting on Cash Basis.
For the sake of convenience in consolidation of accounts districts are also instructed to follow the same system.

In addition to this for proper accounting and maintenance of books, a manual cum guidelines had been issued to the districts. Also the monthly auditor appointed at each district is reporting on the accounting procedures followed by the districts on a monthly basis, along with the deviations, if any.

FINANCIAL MANAGEMENT AT STATE

The Financial Management group at state consists of the State Finance Consultant and state accounts officer. Similarly at districts also the DAM is looking after the financial matters

FINANCIAL MONITORING

The financial monitoring is being done through the understated mechanisms-

1. Analysis of SOEs submitted by the districts and its comparison with audited expenditures on monthly basis and reconciliation of the same by the financial consultant.
2. Training cum discussion meets with all the districts officials at regular intervals.

3. AUDITS:
    a) Comprehensive audit (Annual) as per the Directions of GoI. The auditor for the F.Y 2007-08 has been appointed and they have initiated the audit of DHS's accounts.
    b) Monthly Audit is being conducted and reports are submitted to state regularly which are then reviewed.
    c) Audit by CGA officials is also going on as on date.

6.8 Convergence and Coordination

Coordination with other departments such as ICDS, PHED, Education and Panchayat Raj is important for tackling health issues. The involvement of representative of these department help the health service providers in reducing the maternal mortality, Infant Mortality and increase the coverage of Family Planning Service and Adolescent Health Service.

6.9 Role of State, District and Blocks

The role of State, District and Block are well defined. The role of each one has been clearly indicated in the workplan (Annex 3 d) as per activity wise. The decentralization process has given more roles to Districts and Blocks to perform in executing the various programs. The State mainly looking after Monitoring, Policy decisions, Centralize capital purchase, technical support etc and help the district in execute the actions planned.

6.10 Synergie with NRHM Additionalities

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

- Infrastructures for facility development,
- Manpower recruitment,

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

Would be complementing the similar efforts under NRHM.

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

6.11 Workplan

Annexure d

7. Programme Management Arrangement

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

State Health Mission

Composition

- Chairperson : Chief Minister
- Co-Chairperson : Minister of Health and Family Welfare, State Government
- Convener : Principal Secretary/Secretary (Family Welfare)
- Members :
  - Ministers in charge of Departments relevant to NRHM such as AYUSH, Women and Child Development, Medical Education, Public Health Engineering, Water and Sanitation, Panchayati Raj, Rural Development, Social Welfare, Urban Development, Planning, Finance, etc.

- Nominated public representatives (5 to 10 members) such as MPs, MLAs, Chairmen, Zila Parishad, urban local bodies (women should be adequately represented)
- Official representatives: Chief Secretary/Development Commissioners and Principal Secretaries/Secretaries in-charge of relevant departments such as Women and Child Development, Public Health Engineering, Panchayati Raj, Rural Development, Tribal Welfare, Urban Development/Affairs, Finance, Planning and Representative, MoHFW, GoI, Director (Health Services)/Director (AYUSH).
- Nominated non-official members (5 to 8 members) such as health experts, representatives of medical associations, NGOs, etc
- Representatives of Development Partners.

State Health Society

Objectives of the Society

- To provide additional managerial and technical support to the Department of H &FW, Government of Bihar for implementation of National Rural Health Mission which includes RCH –II, General Curative Care, National Disease Control Programme and AYUSH

Governing Body

Governing Body has following members.

(i.) Development Commissioner, Govt. of Bihar- Chairperson

(ii.) Finance Commissioner, Govt. of Bihar- Deputy Chairperson

(iii.) Secretary, Dept. of Health & Family Welfare, Govt. of Bihar- Chief Executive Officer

(iv.) Secretary, Dept. of Medical Education and ISM, Govt. of Bihar- Member

(v.) Secretary, Dept. of Planning- Member

(vi.) Project Director, BSACS- Member

(vii.) Director, ICDS, Bihar- Member

(viii.) Executive Director, SHSB- Member Secretary

Executive Committee

Executive Committee consists of following members.

(i.) Secretary, Dept. of Health & Family Welfare, Govt. of Bihar – To preside .

(ii.) Executive Director, SHSB- Member Secretary

(iii.) Director in Chief, Health Services, Govt. of Bihar- Member

(iv.) Joint Secretary/ Deputy Secretary, Dept. of H & FW, Govt. of Bihar- Member

(v.) Additional Director, Dept. of H & FW, Govt. of Bihar- Member

(vi.) Representative of UNICEF- Member

(vii.) Representative of WHO- Member

(viii.) Representative of European Commission- Member

(ix.) Representative of Ministry of H & FW, GOI- Member

(x.) Regional Director of H & FW, GOI- Member

Project Appraisal Committee (PAC) comprises of

(i.) Executive Director, SHSB

(ii.) Director in Chief, Health Services, Govt. of Bihar

(iii.) State Representative, UNICEF, Bihar

(iv.) Regional Coordinator, WHO

(v.) Regional Director, Regional Health Directorate, GOI

(vi.) Programme Officer- SHSB- Tuberculosis

(vii.) Programme Officer- SHSB- Kala Azar

(viii.) Programme Officer- SHSB- Leprosy

(ix.) Programme Officer- SHSB- Blindness

(x.) Assistant Engineer-PWD, Bihar

(xi.) Joint Secretary, Finance Department, Govt. of Bihar

(xii.) A representative of Vigilance Department

- A project Appraisal Committee (PAC) shall consider the district plans and other expenditure proposals.
- All proposals will be submitted to the concerned authority having delegated powers provided for final approval. In case the designated authority does not agree with the recommendations of the PAC, she/he shall record the reasons for such disagreement and may include the proposal in the full meeting of the Governing Body which shall

have the full powers to accept/ reject the recommendations of the PAC provided that the reasons for rejecting the PAC recommendations shall be recorded in the minutes of the GB.

Financial powers of the bodies/office bearers

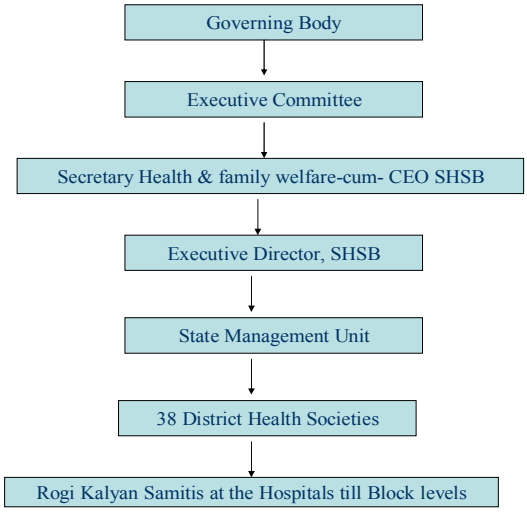
Type of Expenditure	*Extent of powers*
A. Approval of District/city plans	Full powers to the Governing Body, provided that the plan(s) have been endorsed by the Project Appraisal Committee (PAC).
B. Allocations of funds	Full powers to the Governing Body.
C. Approving programme and campaign activities under NRHM	Full powers to the Governing Body.
D. Hiring of contractual staff, including sanction of compensation package	For Staff of Category A &B of Organogram- Full powers to the Chairperson of the GB provided the contracts shall be for a period not exceeding 11 months at a time. For Staff of Category C of Organogram- Full powers to the Executive Director subject to the compensation package approved by the GB, provided the contracts shall be for a period not exceeding 11 months at a time.
E. Release of funds for implementation of plans approved by GB/EC	Full powers to the ED.
F. All related activities in pursuance of State / District plan approved by GB, such as Advertisement charges, Advance to contractors, Repayment of earnest money/security deposit, Freight charges, demurrage, Furniture & fixtures(within Budget limit),stationery, conveyance, electricity & water charges, Insurance, legal charges, postage, telephone, Fax, Repair and maintenance of equipment, Hiring of taxis, Auditors, all trainings, payment of TA/DA /Honoraria to resource persons, workshops, training material, books, TA/DA to society staff, payment related to documentation etc.	Full powers to the ED.

State Level (State Programme Management Unit):

Following are the Support staff of State Programme Management Unit

SL	Designation	No.	Salary Pm	Salary Pa
1	State Programme Manager	1	33000	396000
2	Consultant NRHM	1	30000	360000
3	Data Asstt. Cum System Analysis	1	25000	300000
4	Consultant Cold Chain	1	25000	300000
5	Consultant - Maternal Health	1	25000	300000
6	Consultant-Child Health	1	25000	300000
7	Media Expert	1	20000	240000
8	Consultant – Procurement and Logistics	1	25000	300000
9	Consultant Accounts Manager(Salary Rs.15000/- Pension Rs.Rs.7495.00)	1	7505	90060
10	Accountant	1	15000	180000
11	Store Keeper	2	8000	192000
12	Clerk cum Steno	1	11000	132000
13	Data Assistant	6	9000	648000
14	Computer Operator	1	8000	96000
15	Accountant	1	15000	180000
16	Executive Assistant	8	9000	864000
17	Computer Operator-cum-Steno	10	8000	960000
Total NRHM- (A)				**5838060**

A 10% hike in salaries per year has been recommended in the PIP and is part of RCH II budget. The Overall picture of programme management functioning is as follows



District Health Societies

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

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

Governing body of DHS

1.	District Magistrate & Collector	Chairperson
2.	District Development Commissioner (CEO Zilla	Vice Chairperson

	Parishad)	
3.	District Social Welfare Officer	Member
4.	Executive Officer, Municiplity, Saharsa	Member
5.	Addl. Chief Medical Officer	Member
6.	District RCH Officer	Member
7.	Deputy Superintendent of the District Hospital	Member
8.	Civil Surgeon	Member Secretary

Executive Body of DHS

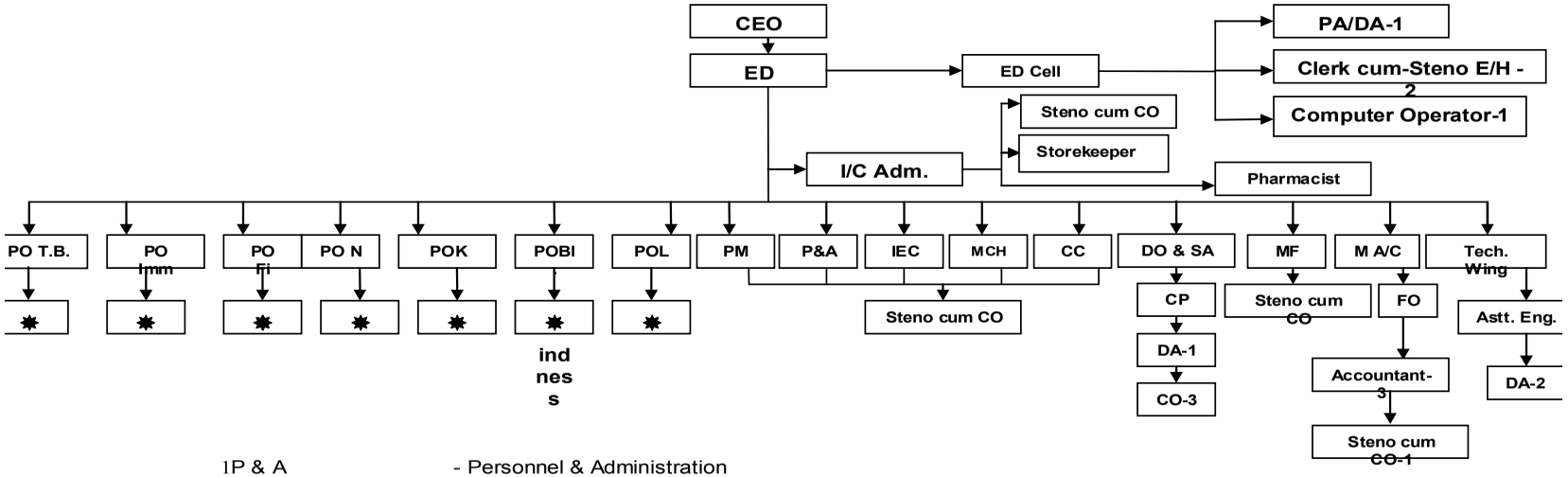
1	Civil Surgeon of the District	Chairperson
2	Additional Chief Medical Officer Cum member Sec. DBCS, Saharsa.	Member
3	District RCH Officer,	Member
4	District Leprosy Officer,	Member
5	District T.B. Officer,	Member
6	District Malaria Officer,	Member
7	District Programme Manager (ICDS)	Member
8	Chief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

District Programme Management Support unit Consist of Following Personnel:-

1. District Programme Manager

2. District Accounts Manager

3. District Data Asstts



1P & A - Personnel & Administration
2POBI - Programme Officer Blindness
3PON - Programme Officer Nutrition
4POK - Programme Officer Kala-Azar
5PO Fi - Programme Officer Filaria
6PO Imm - Programme Officer Immunization
7MF - Manager Finance
8MA/C - Manager Accounts
9PM - Programme Manager
1FO - Finance Officer
1CO - Computer Operator
1DO & SA - Data Officer & System Analyst
1POL - Program Officer Leprosy
1MCH - Maternal & Child Health
1CC - Cold Chain
1Asst. Eng - Assistant Engineer
1CP - Computer Programmer
1DA - Data Assistant
1PA - Private Assistant

8. Budget

Annex 3e and 3c

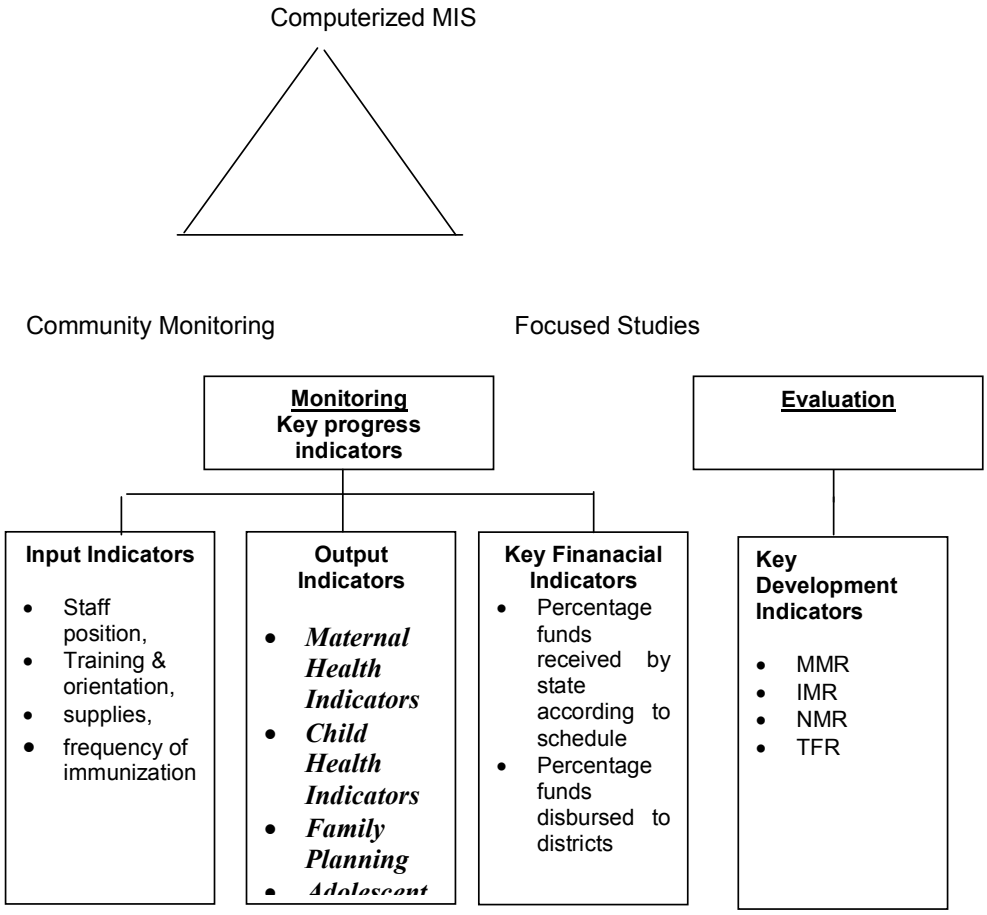
9. Monitoring and Evaluation

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

Activities

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

Triangulation Process for Monitoring and Evaluation



Key Development Indicators

The key development indicators for measuring progress in reaching the overall project development objectives for the RCH programme in the state are as follows.

- Maternal Mortality Rate
- Infant Mortality Rate
- Neonatal Mortality Rate
- Total Fertility Rate

Key progress indicators

Key progress indicators enable the monitoring of delivery of project inputs and the achievement of project outputs.

Table : Examples of Input Indicators				
Institutional Strengthening: Infrastructure	**Institutional Strengthening: Human Resource**	**Programme management**	**HMIS**	**Supervision**
• No. of new facilities constructed • No. of new facilities upgraded • No. of essential equipment supplied	• No. of health personnel appointed • No. of health personnel trained for capacity building	• No. of programme managers appointed at state/district levels • No. of programme managers trained at state / district levels	• Number of operational equipment such as computers supplied to reinforce HMIS	• Number of new formats developed • Percentage of work computerized

Key financial indicators

Key financial indicators help assess the project's budgetary and financial health.

- Percentage of funds received by state according to schedule
- Percentage of funds disbursed to districts
- Percentage of funds disbursed to districts according to schedule (within 15 days)

Percentage of utilization of funds against allocation by state / districts

The National Rural Health Mission has been launched with the aim to provide effective health care to rural population. The programme seeks to decentralize with adequate devolution of powers and delegation of responsibilities has to have an appropriate implementation mechanism that is accountable.

In order to facilitate this process the NRHM has proposed a structure right from the village to the national levels with details on key functions and financial powers. To capacitate the effective delivery of the programme there is a need proper a proper HMIS system

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

For overall management of the programme, there is a Mission Directorate and a State Programme Management Unit in the state. The Unit is responsible for overall monitoring and evaluation of the programme in the state and the districts. The data gathering is being

facilitated by the state, District and PHC data Centres. The numerous formats being used have been reviewed and it is found that data needs to be compiled only as per RCH, NRHM programme and State needs. Hence the new MIES formats have been shared with all the health functionaries and it is expected that they shall be reporting in the new formats from the 3rd quarter after brief orientation training.

At district level, there is a District Health Society who will be responsible for the data dissemination from the sub-district level to the district level. Data Manager/HMIS expert at the State level and Data Assistant at the district level will be responsible for management of HMIS.

As such, there will be a Monitoring Team constituted each at state and district level to monitor the implementation of the NRHM activities. The Team will comprise of representatives from the Mission Directorate and Programme Committee for various health programmes. The Team will also comprise of representatives from Govt. of India.

There is Hospital Management Committee/ Rogi Kalyan Samity at all PHCs and CHCs. The PHC / CHC Health committee will monitor the performance of SC under their jurisdiction and will submit the report. The PHC/ CHC health committee will monitor and evaluate the SC performance .and performance will be submitted to the District, which will compile and sent it to the state.

REPORTS REQUIRED FROM DHS

- Monthly Fund flow statement
- Form -9 (accurate and fully filled)
- ASHA selection and training report
- Mobile Medical unit (if working)
- Janani Evam Baal Suraksha Yojana Reports (no. of institutional deliveries, Deliveries under JBSY,No. of Pvt Institutions accredited)
- Immunization reports. Vaccine wise coverage
- Training reports of the current trainings being given in the district or being under taken by district officials
- 24 X 7 PHC working, Status of telephones working , No. of ambulance and their usage, monitoring of doctors and ANMs presence, No. of OPD patients, No. of IPD, No. of referrals, No. of deliveries being conducted
- Rogi Kalyan Samitis formation and working , meetings of RKS
- Sub centre untied funds, Joint A/c of ANM and Panchayat member (female), UCs of untied funds

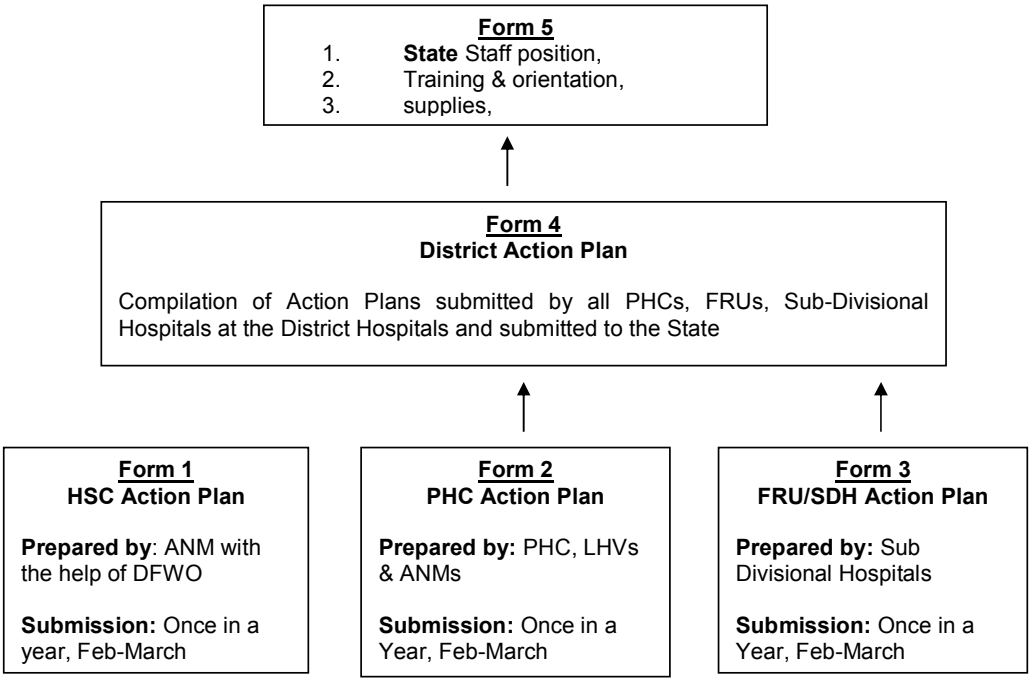
- Integration of AYUSH at PHC level
- Availability of essential drugs, Vaccines, AD syringes in DH, SDH, PHC, SC
- Contract Appointment of doctors, ANMs, Staff Nurses and other Staff
- Health melas, No. of beneficiaries
- Family planning services, male steris, female steris , IUD,
- MNGO working (if present)
- Other Special programmes specific to the district
- Quarterly Finance Management Report

The DPM along with the DAM (in financial matters) shall be responsible for compilation and timely reporting

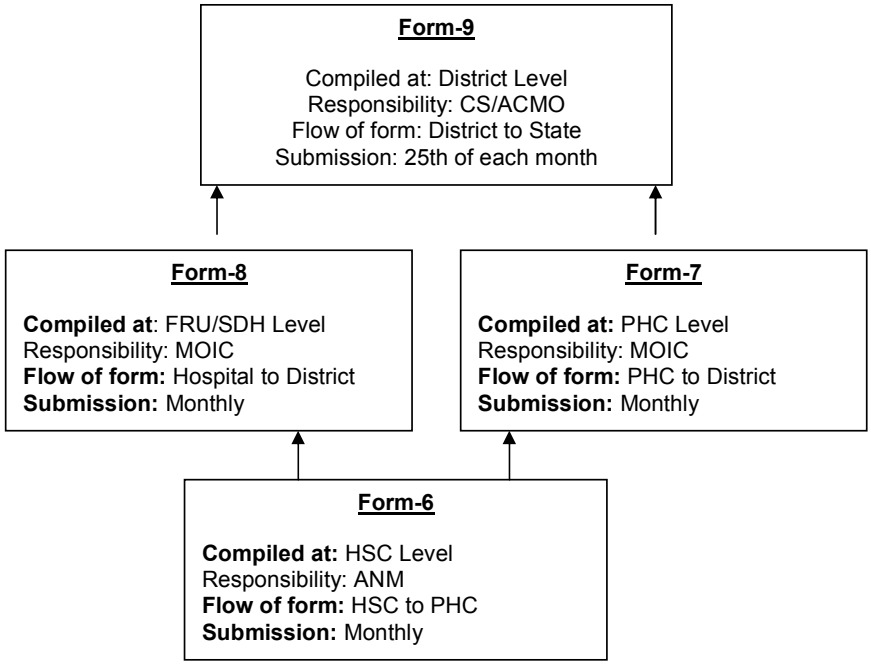
Table : HMIS Forms

Form No.	Information	Filled by
Form No.1	General information, no. of births, Cases of complicated pregnancies and deliveries, sick newborns , RTI/STD cases, oral rehydration performance data [action plan by ANM or SC]	ANM
Form No. 2	Deliveries, MTPs ,RTI/STD, Immunization, need assessment of individual ANMs [action plan for PHC]	PHC level
Form No. 3	Sterilization, ,immunization, services in obstetric care STI/RTI [action plan for FRU/Subdivision/DH]	Sub division level
Form No. 4	District action plan	District
Form No. 5	State action plan	State level
Form No. 6	Monthly report by ANM	ANM
Form No. 7	Monthly report by PHC	PHC
Form No. 8	Monthly report by FRU/Subdivision	FRU
Form No. 9	Monthly report by District	District

Action plan Forms



Reporting Forms



10. Sustainability

The usage of government services in Bihar has certainly picked up with number of patients increasing manifolds due to free drugs and availability of doctors at PHC level. Similarly there has been an unprecedented increase in number of deliveries being conducted at government health facilities under Janani Baal Suraksha Yojana This can be largely attributed to huge influx of funds under NRHM. To hedge the growth from lack of funds and for its sustainability Government of Bihar has already applied user charges for pathology and radiology services. The ambulance user charges are being determined by Rogi Kalyan Samitis. The state already has paying wards in our medical colleges and GoB is contemplating having such wards in all district hospitals too.

For sustainability of manpower incentives for specialist services and for postings in rural areas have been proposed in this Programme Implementation Plan. Government is working on Dynamic ACP and Cadre division of doctors for providing them better benefits.

Private parties are also being encouraged to make investments in Health sector so that the sector doesn't become dependent on NRHM funds. However they would be urged to take up mapping of available facilities and also analysis of demand before investing and providing services so that any duplication may be avoided. Moreover GoB is also increasing its allocation to health sector. This year the state government proposed to establish Emergency Medical Service, Dialysis Unit, Telemedicine system under PPP initiative. The state also increasing the number of Adll PHCs to be outsource to the NGOs.

NRHM Part B

NRHM Additionalities

NRHM – Part – B

1. ASHA

The concept of ASHA remains one of the core strategies of National Rural Health Mission implementation plan in Bihar. ASHA is the female health activist who would promote access to improved health care at household level.

Under NRHM, 74313 ASHA are to be selected and trained in Bihar. The first orientation training of seven days has been completed for about 57,000 ASHAs. The 2nd, 3rd and 4th round of training is to be done through PHED and its NGOs. The PHED had proposed a total cost of Rs.40.70 cr. which has now been reworked to Rs.27.15 crore.

A total number of 66701 ASHAs have been selected so far. Orientation training of seven days has been provided to 56545 till now. The ASHAs are given reading material in the form of flip charts for their better understanding and also dissemination of key health messages among villagers.
The total number of ASHA as per the rural population (Census 2001) is given in Annexure- I.

Table 1: ASHA Report

Sl.No.	Districts	No.of ASHA Selection Target	ASHA Selection till now	No.of ASHA Candidate Trained	No. of District Leve Trainer Trained	No.of Block Level Trainer Trained
1	Araria	2026	2026	2026	3	36
2	Arwal	659	653	653	3	5
3	Aurangabad	1842	1390	1224	3	33
4	Banka	1552	1535	1455	4	40
5	Begusarai	2242	2055	1591	4	61
6	Bhagalpur	1971	1971	1951	4	46
7	Bhojpur	1931	1621	1597	5	31
8	Buxer	1273	1074	946	4	50
9	Champaran East	3689	2756	2140	5	135
10	Champaran Weast	2734	2494	794	5	53
11	Darbhanga	3028	2726	2726	4	56
12	Gaya	2997	2434	2334	5	90
13	Gopalganj	2022	1846	1748	4	33
14	Jamui	1296	1270	1200	5	53

15	Jehanabad	743	769	759	3	6
16	Kaimur	1247	1247	1247	4	18
17	Katihar	2174	1590	635	4	48
18	Khagaria	1204	967	887	4	24
19	Kishanganj	1167	1024	654	4	17
20	Lakhisarai	684	562	386	4	6
21	Madhepura	1459	1459	1459	5	65
22	Madhubani	3451	2946	2574	5	70
23	Munger	820	820	769	2	26
24	Muzaffarpur	3398	2848	1949	4	70
25	Nalanda	2017	1980	1980	4	57
26	Nawada	1671	1531	1103	4	42
27	Patna	2757	2549	1955	4	70
28	Purnia	2322	2263	2002	4	34
29	Rohtas	2124	1985	1926	3	52
30	Saharsa	1383	777	777	4	46
31	Samastipur	3271	3214	3214	5	92
32	Saran	2950	2802	2109	5	59
33	Sheikhpura	444	439	439	4	30
34	Sheohar	495	431	197	5	35
35	Sitamarhi	2529	2221	980	4	65
36	Siwan	2565	2438	2218	5	75
37	Supaul	1644	1503	1472	8	19
38	Vaishali	2532	2485	2469	5	64
	State Total	74313	66701	56545	161	1812

ASHA 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 for her service mainly under the following heads. It is conceived that she will be able to earn about Rs.1,000 per month in lieu of her services.

Table 2: The compensation package of ASHA

Sl. No.	Programme & Relevant Task	Amount of Compensation
1.	Janani & Bal Surksha Yojana For Institutional Delivery and Full Immunization of the New Born	@Rs. 200/-(Only Rs.Two hundred) Per Pregnant Woman
2.	Mobilising all the Children of the village for Immunization	@ Rs. 150/-(Only Rs. One hundred fifty only) Per Month
3.	Providing DOTS under Tuberculosis Control	Rs 250 per patient.

	Program		
4.	For identifying Patient of Leprosy and accompanying him/her to PHC		@ Rs. 300/- (Only Rs. Three hundred) Per Patient
5.	Training	D.A. Per Day	@ Rs. 100/- (Only Rs. One hundred) Per Day(During the Training)
		T.A. Per Training (To & Fro)	@ Rs. 50/- (Only Rs. Fifty) Per Meeting
6.	To Participate in ASHA Divas organized at PHC		@ Rs. 50/- (Only Rs. Fifty) Per Meeting
7.	For motivating for Sterilization		@ Rs. 150/- (Only Rs. One hundred Fifty) on Completion of Surgery
8.	For motivating client for vasectomy/ NSV		@ Rs. 200/- (Only Rs. Two hundred) on Completion of Surgery

1.1 Streamlining the working and incentive payment of ASHA

⇒ For easy identification and authentication, an Identity Card with photograph shall be provided to each ASHA.

⇒ The payment of various incentives to ASHA shall be made in the Monthly Meetings at PHCs (Monthly meetings of designated village shall be called on first and third Thursday)

⇒ The ANM shall prepare the list of ASHA and the amount to be disbursed and finalize it on the village health day/sub-centre level meeting with the ASHAs.

⇒ The meeting shall also adjudge best ASHA along with the ANM. The best ASHA/ANM for the month shall be given a token reward.

1.2 Support Mechanism for ASHA

For providing support to the ASHA network an ASHA resource centre as per budgetary guidelines of GOI, shall be set up. The ASHA resource centre is envisaged to strengthen the SHSB. The ASHA resource Centre would comprise of a Project Manger (MBA), a Deputy Project Manager (MSW), one Statistical Assistant (Graduate in Statistics), a Data Assistant and Office Attendant.

At District level: The District Nodal Officer for ASHA shall to be an officer nominated by the Civil Surgeon. Each District Nodal Officer would be supported by a Community Mobiliser who would have the qualification of MSW. A Data Assistant shall also be provided to satisfactorily discharge the work.

At PHC level: There would be considerable workload at PHC level as many of the bills for payment to ASHA would be processed in that office. Since no additional manpower is provided at this level, a suitable honorarium for LHV and the Block Supervisor for ICDS is being provided as per GOI guidelines. The Block level facilitators shall be chosen from the ASHAs, who would lead and supervise other ASHAs of nearby villages.

All the appointment to the above positions shall only be on a contractual basis. The cost estimates, details of the post, qualifications, etc. are in annexure.

Budget:

Sr. No.	Particulars	Tentative Budget
	AT THE STATE LEVEL	
1	**Personnel (Hired through an Agency on contract basis)**	
	1. Project Manager (MBA/PG in HRD) - Rs.25,000/- per month x12 months = Rs.3,00,000 2. Deputy Project Manager (Master in Social Works) – Rs.17000/- per month x 12= Rs.2,04,000/- 3. Statistical Assistant (Graduate in Statistics with 6 months Basic Computer course) Rs9000/- per month x 12 months =Rs.1,08,000/- 4. Data Assistant (Graduate with Basic Computer knowledge) Rs.8,000/- per month x 12 months = Rs.96,000/- 5. Office Attendant - Rs.2,000/- per month x 12 months= Rs.24,000/- Total of (1)+(2)+(3)+(4)+(5)= Rs.7,32,000/- Agency Charges @ 5% = Rs.36,600/- TOTAL = Rs.7,68,600/-	Rs.7,68,600/-
2	Office Expenses on Telephone, Photocopy, stationary etc.	Rs.1,00,000/-
3	Development for IEC and monitoring material (IEC material, reporting format, monitoring formats and resource material for meetings)	Rs.3,00,000/-
4	Monitoring and supervision	Rs.2,00,000/-
5	Operation research and documentation	Rs.1,00,000/-
6	ASHA sammelan and exposure visits	Rs.2,00,000/-
7	Workshops, seminars and Meetings	Rs.1,00,000/-
8	Contingency	Rs.50,000/-

	Total	**Rs.18,18,600/-**
ASHA Support System at the District Level		
1	Strengthening of the District PMU for undertaking ASHA support system	
	Additional Personnel	
	(a) Community Mobiliser (Master in Social Work) Rs.20,000/- per month x 12 months = Rs.2,40,000/- Will report to District Nodal Officer	Rs.3,36,000/-
	(b) Data Assistant (Graduate with Basic Computer knowledge) - to strengthen the District PMU to take additional work…He/She will assist the existing staff of District PMU in all the work related to NRHM including ASHA related work. Rs.8,000/- per month x12 months = Rs. 96,000/-	
	(c) TA/DA to be paid from District Health Society (Programme Management Cost) for monitoring visits and collection of information Telephone, fax, computer, stationeries etc to be used from District PMU	
ASHA Support System at the Block Level		
	(A) For monthly meetings serving Tea, Snacks/ refreshment etc. during the meeting. Rs.25/- per ASHA x 130 ASHAs (Approx.) x 12 months x 533 blocks = Rs. 2,07,87,000/- (B) Block ASHA Manager in all the blocks Rs. 12000 x 533 x 12 months = Rs. 7,67,52,000.00	Rs.9,75,39,000/-
ASHA Trainings		
1	One day Orientation programme of State Level resource person	65,000.00
2	12 days training of district resource team (38 district x Rs.2,35,000/-)	89,30,000.00
3	12 days training of ASHA at Block level (2125 batches x Rs.1,20,650/-)	25,63,81,250.00
4	Documentation and Development of IEC	5,00,000.00
5	Programme Management Cost	56,60,000.00
	Sub Total	**27,15,36,250.00**
6	**Drug Kit @ Rs. 600/- for 75000 ASHA**	**4,50,00,000.00**

Total Budget under ASHA Scheme

Sl	Particulars	Amount (Rs.)
1	ASHA Support System at State Level	18,18,600/-
2	ASHA Support System at District Level	3,36,000/-
3	ASHA Support System at Block Level	9,75,39,000/-
4	Trainings of ASHAs	27,15,36,250/-
5	ASHA Drug Kit	4,50,00,000/-
Total Budget for ASHA		**41,62,29,850/-**

Work-plan for ASHA Program

Activities	**2008-09**			
	Q1	**Q2**	**Q3**	**Q4**
Development for IEC and monitoring material (IEC material, reporting format, monitoring formats and resource material for meetings)				
Monitoring and supervision				
Operation research and documentation				
ASHA sammelan and exposure visits				
Workshops, seminars and Meetings				
Trainings				

2. Untied Funds

2.1 Untied Funds for Health Sub-Centre

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

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

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

Annual Budget Provisions for Untied Funds at HSCs

Sr. No.	Particulars	Budget
1.	Total amount needed for Untied Fund in all the health sub-center ((8858 no. of existing sub center x Rs.10000)	Rs.8,85,80,000/-
2.	One - day Orientation workshop of CS from all districts at Patna - on the guidelines	Rs.1,00,000/-
3.	District level one day orientation of PHC MO by the CS of the district @Rs.20000 per district (38 districts)	Rs.7,60,000/-
4.	Quarterly review meeting of the ANMs under the chairmanship of PHC Medical Officer to monitor the usage of the fund (@Rs.1000 per meeting x 4 quarter x 38 districts)	Rs.1,52,000/-
5.	PHC level ANMs Orientation on Guidelines for Untied Funds for HSC (533 PHCs @ Rs.3000)	Rs.15,99,000/-
6.	Yearly one-day meeting at the district level under the chairmanship of the CS (@ Rs.5000 per district x 38 districts)	Rs.1,90,000/-
7.	State level one-day progress meeting (@Rs.30000)	Rs.30,000/-
	Total	**Rs.9,29,52,000/-**

2.2. Untied Funds for PHCs

Each PHC received a sum of Rs.25, 000/- as untied funds which are for being utilized as per need for local health action in the PHC area. The fund will be routed through RKS.

Annual Budget Provisions for Untied Funds at PHCs

Sr. No.	Particulars	Budget
1.	Total amount needed for Untied Fund in all the PHCs ((533 PHCs x Rs.25000)	Rs.1,33,25,000/-
2.	Quarterly Review at the District Level	
Total		**Rs.1,33,25,000/-**

3. INFRASTRUCTURE PLAN IN 2007 – 2008

3.1. CONSTRUCTION /ESTABLISHMENT OF HEALTH SUB- CENTRE

The NRHM aims to ensure Health sub-centers facility on the Govt. of India Population norms of 1 per 5000 populations in general areas and 1 per 3000 populations in tribal areas. As per 2001 Census, population of the Bihar State is approximately 8,29,98,509. Existing facility of HSCs are 8858 out of total requirement of 16623. To facilitate the above population the state required additional 7765 HSCs to achieve the total target it is proposed to create 1553 HSCs every year.

In 2007- 2008 the State proposed to take up 1000 Health Sub- Centres @ Rs.6.45 lakh per Health Sub Centre. However this year the state has revised the rate @ 9.50 lakhs as per GoI norms. The State proposes to share 25% expenses in the construction of these HSC s and land acquisition. The balance 75% the state put under this PIP for financial support from NRHM.These Health Sub Centres shall either be constructed or shall be taken up on rental basis. The cost provided also includes cost of land acquisition if Govt. land is not available. Till the time construction is complete the state shall take building for these facilities on rental also.

NRHM Action - Plan 2008- 09					
Proposed Activity	**Expected Physical Out Come**	**Proposed Budget 2008-09**	**Details of Budget Basis of Costing (No. of Units X Unit Cost)**		
Creation of HSC	Finalisation of Construction Agency & initiating construction of 500 HSC,	Rs. 6900 lakhs	Total cost at the @ Rs 9.50 lakh per unit	Contribution of GoI (75% of 7.125 lakhs i.e @7.125 lakhs per unit)	Contribution of GOB (Rs.9.50-7.125 = 2.375 lakhs per unit)
			500 x 9.50= Rs. 4750 Lakhs	Rs. 7125 Lakhs	Rs.2375 Lakhs

500 Health sub- Centres shall be taken up for construction. Rs. 26 Crores approved by GoI in year 2007-08. The balance amount require in 2008-09 for completion of work.

3.2. CONSTRUCTION OF PHC

The NRHM aims to ensure PHCs on the Govt. of India population norm of 1 per 30000 populations in general areas and 1 per 20000 population in tribal/ remote areas. As per 2001 census Population of Bihar state is approximately 82958509. The Existing facility of PHCs is 1243. Out of total requirement of 2787 PHCs. There are 121 PHCs which does not have its own building. Therefore 1665 PHCs buildings require to setup by 2010.

It is proposed to taken up 200 PHCs in 2007 - 2008. Unit cost of construction and land acquisition will be 53.15 lacs as per NRHM guidelines. Some of the facilities will be taken up on a rental basis. The total built-up area of the PHCs will be 63 hundred Sq feet, which will include 1500 sq. ft. for PHC & 4800 sq. ft. for its residential quarters. These PHCs would either be constructed or shall be taken up on rental basis. The cost provided also includes cost of land acquisition if Govt. land is not available for construction. Till the time construction is complete the state shall take building for these facilities on rental also.

NRHM Action - Plan 2008-09			
Proposed Activity	**Expected Physical Out Come**	**Proposed Budget**	**Details of Budget Basis of Costing (No. of Units X Unit Cost)**
Creation of PHC	Preparation & finalization of Maps. Finalization of Construction Agency & initiating Construction of PHCs. Funds to be released to the construction Agency	Rs. 6830 Lakhs	Unit Cost Rs.53.15 lakhs (Contribution of GoI 100%) Rs.53.15 lakhs x 200 = Rs.10630 Lakhs. Note: 200 shall be taken up for construction. Against a total estimated cost of Rs. 106.30 Crores. Rs. 38 Crores approved by GoI in year 2007-08. The balance fund require in 2008-09 for completing the work.

3.3. UPGRADATION OF COMMUNITY HEALTH CENTRE (CHC)

The NRHM aims to ensure CHCs on the Govt. of India population norm of 1 per 1.20 Lakhs populations. The Govt. of Bihar plans to upgrade all its PHCs and Referral Hospitals to CHC standards as per IPHS standards. In the state of Bihar the total no of existing PHCs are 533 and the no of Referral Hospital is 70. Hence a total of 603 units needs to be upgraded to CHC standard and converted to 30-bedded hospitals. It is proposed to upgrade facilities 200 every year. As per NRHM guideline the entire cost of construction would be borne by GOI.

It is proposed to take up upgradation of 201 PHCs to CHCs in the year 2007-08 and the balance PHCs/Referral hospitals will be upgraded to CHCs in next year. The unit cost of construction and land acquisition will be around Rs. 40 lakhs. The upgradation of hospital buildings shall be taken up from funds provided by the State Govt. The doctors and staff quarters shall be provided under the NRHM. In case adequate land is not available the fund can also be used for land acquisition. The doctors quarters would also be taken up on rental basis. The cost provided also includes cost of land acquisition if Govt. land is not available. The costs also include provision of equipment at these hospital either as per IPHS standard or as required.

Up gradation of Community Health Centre As Per IPHS NRHM Action - Plan 2008-09			
Proposed Activity	**Expected Physical Out Come**	**Proposed Budget**	**Details of Budget Basis of Costing (No. Of Units X Unit Cost)**
Creation and Up gradation of CHCs as per IPHS Standard .	➢ Preparation and Finalization of Maps. ➢ Finalization of Construction Agency & Initiating Renovation of CHCs. ➢ Funds to be released for the construction agency. ➢ Quarters for Doctors and Staffs, ➢ For the Purchase of New Surgical instruments, Equipments, Furniture,	Rs.8040.00 lacs	Unit cost @ Rs. 40 lacs (Contribution of GOI 100%) @ Rs. 40 lakhs x 201 = Rs. 8040.00 Lakhs 200 CHCs shall be taken up for upgradation. Rs. 4000 lakhs already approved by the GoI in 2007-08 and balance amount require in 2008-09.

3.4. Upgradining District Hospitals and Sub-Divisional Hospital as per IPHS

The state of Bihar has 25 District Hospitals & 23 Sub Division Hospital at present. Construction for 11 District Hospitals are under process and will be completed by 2008-09. Most of these District hospitals are 100 to 200 beded. The state has already appointed one hospital consultancy firm to carryout the situation analysis of these District Hospitals and prepares a master plan in terms of Infrastructure, Equipment and Manpower for strengthening these hospitals as per IPHS. The state also intends to develop the hospitals at Rajvanshi Nagar, Rajendra Nagar and Gardanibagh at Patna into specific speciality hospitals.

The preparation of Master Plan will be completed within six months after which the state will take up the strengthening work. The upgradation would include upgradation of Civil Infrastructure as well as provision of equipment. The cost provided also includes cost of land acquisition if Govt. land is not available. The costs also include provision of equipment at these hospital either as per IPHS standard or as required. The costs also include provision of equipment at these hospital either as per IPHS standard or as required.

Budget

Sl	Particulars	Amount (Rs.)
1	Strengthening of 25 nos. District Hospitals as per IPHS Standard	15,00,00,000/-

3.5. UPGRADATION OF INFRASTRUCTURE OF ANM TRAINING SCHOOL

It is proposed to upgrade the Infrastructure of 12 ANM Training Schools. The approximate cost of upgradation of each ANM Training Schools is expected to be Rs 50 lakhs per Unit.

ANM TRAINING SCHOOL - Plan 2007-08			
Proposed Activity	**Expected Physical Out Come**	**Proposed Budget**	**Details of Budget Basis of Costing (No. of Units X Unit Cost)**
Creation of ANM Training School	Upgradation of infrastructure of 12 ANM Training School including provision of furniture & equipment.	Rs. 300 lakhs	Unit cost Rs. 50 Lakh X 12 = Rs. 600 lakhs Note:- All 12 ANM Training School shall be taken up for upgradation. Against a total estimated cost of Rs. 600 lakhs. Rs. 300 lakhs already approaved by GoI in 2007-08. The balance fund require in 2008-09 for completion of Work.

3.6 Rental for Staff quarters:

For doctors and Paramedicals Staff from PHCs to District Hospitals quarters would be taken on rental basis.

4. District & Block Flexi-pool

These funds are meant for different activities at the district and PHC level as per GOI guidelines. In case of emergency till the regular allotment is available, this fund can be utilized for any activity in question and same can be recouped after getting the regular allotment.

A state level meeting with the Civil Surgeon can be arranged to orient them about the fund and it's utilities. The CS will further disseminate the information to all the CMOs through a one-day meeting at the district level. During the meeting the amount can be disbursed to the respective block medical officers. Utilization report against the usage of the fund need to be sent to the district in every quarter and subsequently the district will send a consolidated report to the state in every 3 months.

Budgetary

Activities	Total purposed budget
Disbursement of the fund to the CS of each district (@ Rs.20 Lakhs per district x 38 district)	Rs.760 lakhs

5. State Health Resource Centre and Procurement cell

A State Health Resource Centre already established in the SHS for Designing and Planning of Public Hospitals of Bihar. An agency has been shortlisted to provide the services. This will help to support the PWD department and health department for properly establishing and upgrading the Health Facilities.

A Procurement cell is proposed in the state on the lines of TNMSC. This cell will be responsible for procurement, logistic management and properly managing the inventory of drugs.

Table 3: Budgetary provision for State Health Resource Center and Procurement Cell

Activities	Total purposed budget (Rs.)
Total Budget Require for State Health Resource Centre for Hospital Design and Planning and Procurement Cell in the line of TNMNC	300 Lakhs

6. Emergency & Referral services

Trauma centers in 5 accident-prone zones is proposed to cater the medical needs of the patients is proposed. 102 services need to be linked with referral services and there is need to support BPL patients in form of subsidy. When implemented it will go in a long way towards actual medical support to the patients timely.

The trauma centers shall either be constructed afresh or the services of trauma centers shall be outsourced to Clinic/Private Hospitals identified for the purpose. Emergency would include a situation where doctors or staff go on strike. Under such situation services of Private Clinics shall be hired to provide health care OPD Services. This would also include provision of mobility for mobile teams, procurement of materials like ORS, Bleaching powders, Helogen Tablets and Disposable Delivery Kits at the time of floods. Any provisions made for providing health services at the time of flood would also be covered under this head.

Budget

Activities	Total Purposed Budget
Identifying the 5 accident prone zone & subsequently site for the trauma centers	Rs.5,00,00,000/-
Finalization of construction agency	
Initiating the construction process (@ Rs.1 crore per trauma center)	
Procurement of medical equipments and furniture's (@Rs.1 crore per center)	
Plan for the referral services by any consultancy agency (@ Rs.1 lakh for all trauma centers)	Rs.1,00,000/-
Provision of referral services in the trauma centers (@ Rs.15 lakh per trauma center)	Rs.75,00,000/-

Implementation of the subsidy scheme for BPL patients (@ Rs.50,000 per year per trauma center)	Rs.2,50,000/-
Yearly progress meeting at the state level to discuss the challenges and achievement of each trauma centers (@ Rs.10000 per meeting)	Rs.10,000/-
Total	**5,78,60,000/-**

Work-plan for setting up Trauma centers with Emergency & Referral service facility

Activities	2007-08			
	Q1	Q2	Q3	Q4
Identifying the 5 accident prone zone & subsequently site for the trauma centers				
Finalization of construction agency				
Initiating the construction process (1 in the first quarter and 4 in the next quarter)				
Procurement of medical equipments and furniture's (1 in the first quarter and 4 in the next quarter)				
Provision of referral services in all the 5 trauma centers				
Implementation of the subsidy scheme for BPL patients				
Yearly progress meeting at the state level to discuss the challenges and achievement of each trauma centers				

7. Dental units in all district and sub divisional hospital

Dental care is essentially linked with good health. It is proposed that at least one dental unit in one major hospital of the district preferably in district hospital with dentist on contract.

Budgetary provision for dental units in district hospitals

Activities	Total purposed budget
Plan for the dental units for all the districts	Rs.3.80 Crore (Rs.10 lakh per district*38 districts)
Initiation of the dental Unit in DH under the supervision of superintendent (Rs.4 lakh for construction of the unit)	
Recruitment of dentists on contract (@Rs.15000 per dentist per month)	
Recruitment of 2 other support staff (@ Rs.5000 per staff per month)	

Procurement of medical equipment and furniture's (Rs.3 lakh per district)	
Rendering dental services	

Work-plan

Activities	2007-08			
	Q1	Q2	Q3	Q4
Plan for the dental units for all the districts				
Initiation of the dental Unit in the DH (5 districts in the 1st quarter and 11 districts each in the next 3 quarters)				
Recruitment of dentists on contract for all the 38 Districts				
Recruitment of 2 other support staff				
Procurement of medical equipment and furniture's				
Rendering dental services				

8. Blood Storage Units in FRUs (76 FRUs in first Phase)

Lack of Blood Storage Units in the state make things complicated during emergency hence in 76 FRUs a blood storage units each has been proposed. In first phase, setting up of at least one blood Storage Units in 76 FRUs is proposed. It will also include operational cost.

Budget

Sl	Particulars	Qty	Rate (Rs.)	Amount (Rs.)
A. Capital Cost				
1	Blood Bank Refrigerator	55	65,000/-	35,75,000/-
2	Binocular Microscope with DG attachment	55	29,800/-	16,39,000/-
3	Bench Top Centrifuge	55	16,150/-	8,88,250/-
4	Incubator	55	11,350/-	6,24,250/-
			Total Capital Cost	
B. Operational Cost				
1	Salary of One Medical Officer	76	20,000/- pm	
2	Salary of 3 Lab Technician @ Rs. 6500/- pm	228	6,500/- pm	
3	Diesel	76	5,000/- pm	

4	Service and Maintenance Charge	76	5,000/- pm	
5	Misc. and Others	76	2,000/-pm	
			Total Operational Cost	2,34,84,000/-
Total Budget A Capital Cost + B Operational Cost				**2,81,31,400/-**

(Rupees Two Crore Eighty One Lakhs Thirty One Thousand Four Hundred Only)

9. Annual Maintenance Grant

During the course of up-gradation in setting up of different units in the different health facilities of the state, maintenance will also be essentially required. It is proposed that all district hospitals and sub divisional hospital @ Rs.5 lacs, Referrals/PHCs @ Rs.1 lakh

Budget

Activities	Total purposed budget
Disbursement of the Grant at the end of the meeting on the same day to the respective medical officers (district hospitals (36) and sub divisional hospital (58) @ Rs.5 lacs, Referrals/PHCs (55+533) @ Rs.1 lakh)	Rs.1058 lakhs

Rs.1058 lakhs (Rupees One Thousand Fifty Eight Lakhs Only)

10. Contractual Salaries, Incentives and Bonus

As human resources are the most important resource steps shall be taken to motivate them through various benefits and incentives like Cellphone facility for all ANMs, MOICs, Programme Officers, CDPOs etc. and rural and specialist incentives. All the doctors posted in the rural area would get an additional incentive of Rs.3000.

A provision for Rs.50,000/- per PHC per year will be given as incentive to the PHCs for better performing in services.

All the doctors performing specialist duties including the MBBS doctors trained for specialized tasks e.g. Life saving Anesthesia skills etc. will get an incentive of Rs.4000.

Budget:

Sub-Heads	@	Proposed Budget (Rs. In lakhs)
Incentive for PHC doctors & staffs @ Rs. 50,000 for better performance in implementing programmes	Rs. 50,000/ - per PHC per year	266.50
Contract Salaries for ANMs (around 8000)	Rs.6500 per month	520.00
Salaries for contractual Staff Nurses (2092 existing and 1000 new)	Rs.7500 per month	2782.80
Mobile facility for all health functionaries	District officials, PHC incharge, CDPOs and ANMs @ 500 per month	600.00
Total		**4169.30**

11. Rogi Kalyan Samities

12.1 Aims and Objectives

The objectives of the Society will be to:

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

12.2 Functions of the RKS

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

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

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

Table 4: Budget summary of Rogi Kalyan Samiti

Sub-Heads	@	Proposed Budget (in Crores)
District Hospitals, Sub-divisional hospitals	5 lacs x 38 districts	1.90
Referral hospitals	70 hospitals x 1 lac	0.70
PHCs	533 PHCs x 1 lac	5.33
Total		**7.93**

12. Setting up of Dialysis Units in Hospitals of Bihar (PPP initiative)

It is proposed to set up & operationalise Dialysis Units through Public Private Partnership (PPP) in 25 Hospitals of Bihar. This would require operation, maintenance and reporting 24-hours 7 days a week Dialysis units in Hospitals.

The State Government shall provide vacant space in the premises of the Hospital itself with additional space for washing and RO plant installation (incase it is not in-built). The space provided shall be approx. 750 sq.ft. including RO plant. The agency has to provide everything from equipments & machine, logistics, consumables etc to personnel. The agency has to ensure the installation, maintenance, functioning with provision of technical manpower round the clock. No rates shall be charged from the patients.

Tender bids have already been floated for the same. **The anticipated project cost shall be Rs.2.00 crores.** Government/SHSB shall pay a monthly rental to the agency, based on the monthly cost as projected by them in the financial bid.

Budget

Activities	Total purposed budget
Operationlaizing the Dialysis center	Rs.1 lakhs per month for 25 Dialysis Centre **= Rs.300 lakhs**

13. Infection Management and Enironmental Plan (IMEP) through PPP.

Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar

13.1 Project Description

State Health Society Bihar is implementing National Rural Health Mission (NRHM) to carry out necessary architectural correction in the basic health care delivery system. In order to provide quality services to the public, SHSB seeks Public Private Partnership in providing proper Hospital Waste Treatment and Disposal Services, in all Health facilities right from Medical Colleges to the PHCs.

13.2 Services to be provided

1. Provide Service of Hospital Waste Treatment and Disposal in all Medical Colleges, District Hospitals, Sub-Divisional Hospitals, Referral Hospitals and PHCs of the State.
2. Install, Operate and maintain appropriate Common Biomedical Waste Treatment facility, as per the Biomedical Waste (Management & Handling) Rules, 1998 and subsequent amendments in it.
3. Provide one day orientation training to all the health service providers.
4. Maintain the above-mentioned arrangement for a period of minimum 10 years. The Common Biomedical Waste Treatment facilities are proposed to be established at 8 Divisional Headquarters across the State

The state has started a CWTF facility at IGIMS, Patna. As per the rules each CWTF should cater to all facilities in 100 Km radius, keeping this in mind, eight more CWTF are to be operationalised in each of the division except Patna (which already has such a facility). All the Health facilities shall have a proper IMEP plan, as per the GoI guidelines.

- Treatment of Bio-medical waste in Patna Municipal area through IGIMS of all government hospital

13.3 Setting up a Bio-Medical Waste Management System

To implement the IMEP in a comprehensive systematic manner, a critical first step will be to undertake a thorough review of the existing situation and analysis of the current bottlenecks. The review should encompass current practices of segregation and collection of waste, disinfection and treatment methods, transportation, handling and disposal of waste both

within and outside the healthcare setting, availability and use of protective devices and safety precautions followed by healthcare personnel. It will also include health and safety measures adopted by the management for healthcare workers, review of policy with respect to waste management, waste minimization, infection control, antibiotic policy and policy for disinfection procedures. An assessment of knowledge, attitude and skills of various categories of staff will help determine training needs. Based on this review, a Bio-Medical Waste Management Plan will be developed which will encompass all the key elements of the administration and implementation of infection control and bio-medical waste management in healthcare facility.

Trainings shall be provided to health care workers and officers in Infection Management and Environment Plan implementation as per GoI guidelines.

Budget

Activities	**Total proposed budget (Rs.)**
Dissemination and Sensitization workshops on IMEP Guidelines at district and block level in every alternative year	33,000/-
Training of trainers at the state capital on bio-medical waste disposal system and IMEP guideline	66,000/-
Training of Medical Officers followed by refresher training in every two year	3,30,000/-
Training of in-house staff (ANM, Safai Karmacharis, clinical support staff) on recognizing, segregating and disposing of bio-medical wastes	60,75,000/-
Oprationalization of Biomedical Waste Management Plan @ Rs. 0.04 lacs pm per Adll PHCs (1247), Rs. 0.08 lacs pm per PHC (533), Rs. 0.12 lacs per Referral Hospital and SDH (113) and Rs. 0.30 lacs per DH (36) and Rs0.45lacs pm per Medical College (6)	14,34,96,000/-
Total	**15,00,00,000/-**

Workplan

Activities	**2007-08**			
	Q1	**Q2**	**Q3**	**Q4**
Dissemination and Sensitization workshops on IMEP Guidelines at district and block level in every alternative year				
Training of trainers at the state capital on bio-medical waste				

disposal system and IMEP guideline				
Training of Medical Officers followed by refresher training in every two year				
Training of in-house staff (ANM, Safai Karmacharis, clinical support staff) on recognizing, segregating and disposing of bio-medical wastes				
Operationalization of BMW Plan at APHCs, PHCs, SDH, Referral Hospitals, DHs and Medical Colleges.				

14. Setting Up Modern Diagnostic Centres through Public Private Partnership (PPP) in Regional Diagnostic Centres and all Government Medical College Hospitals of Bihar

State Health Society Bihar is implementing the National Rural Health Mission (NRHM) to improve the availability of and access to quality health care for people. Setting Up of Ultra-Modern Diagnostic Centres through Public Private Partnership (PPP)' in 9 Regional Diagnostic Centres (RDCs) and 6 Medical College Hospitals (MCHs) of Bihar has been started.

Project Area –Regional Diagnostic Centres in Ara, Gaya, Bhagalpur, Munger, Muzaffarpur, Motihari, Purnea, Saharsa and Chapra.

Medical College Hospitals – PMCH, NMCH, SKMCH, DMCH, ANMMCH, JLMNCH

M/s Softline, New Delhi and M/s Doyen Diagnostics, Kolkatta have been contracted to set up the Ultra-Modern Diagnostic Centres.

Project Scope– To operate, maintain and report 24-hours ***'Ultra-Modern Diagnostic Centres'*** in RDCs & MCHs and report the progress to the RDDs (who would be in-charge of monitoring the RDCs project) and the Superintendents (who would be in-charge of monitoring the MCH project) and the SHSB.

Project Condition -

- The State Government has created the buildings for Regional Diagnostic Centres at all the towns mentioned in Project Area. In the case of MCHs, space shall be provided in the premises of the MCH itself at the discretion of the Superintendent of the concerned MCH.

- The agency has to provide everything from equipments & machine, logistics, consumables etc to personnel; the said RDC/MCH will only provide space for the Diagnostic Centre along with space for storage at a nominal monthly rent payable to the DHS of the concerned district (in the case of RDC) and the Rogi Kalyan Samiti of the concerned MCH (in the case of MCH) by the agency.
- The agency has to ensure the installation, maintenance, functioning with provision of expert technical manpower round the clock.
- Rates (to be charged from the users) shall be applicable as per AIIMS, New Delhi for the basic, standard and other specialized tests under each Diagnostic head.

The project is for ten (10) years depending upon performance further extension will be considered.

Facilities that will be provided in RDCs and MCHs are→ Pathology- Bio-Chemistry, Radiology – digital x-ray, CT Scan, MRI, ECG, Mammography.

The state does not require budget in this regard. All the cost for setting up centres will be borne by the private providers.

15. Establishment of Telemedicine System in the state of Bihar

What is Telemedicine?

The European Commissions health care telematics programme defines telemedicine as:

"Rapid access to shared and remote medical expertise by means of telecommunications and information technologies, no matter where the patient or relevant information is located."

In plain speak, telemedicine is a process by which a patient is able to communicate his problems (along with, if necessary, details of medical investigations) to a doctor many miles away and receive necessary and relevant medical advice. A brief idea of telemedicine is that with the help of audio, video and data using telecommunication connectivity, a patient can get treatment or can get operated from a doctor located thousands of kilometers away. It includes the transfer of X Ray, CT SCAN, MRI, Ultrasound Images, Pathology Reports, Endoscopic Video images and other procedures on-line.

The Goal

The goal of this project is to establish a model for application of Telemedicine to address the issues of improving accessibility, more efficient use, ensure equitable distribution and enhancing the quality of available health services across the state.

The Objectives

1. To cover all the areas of the State by establishing Telemedicine Network for accessibility of healthcare service.
2. To reduce the cost of health services by providing specialize service through the network.
3. Upgrade the skills of existing Medical staff at the PHCs/DHs.

The following problems – which the Telemedicine could help in – were identified

S No	Problem	Possible Solution	How can Telemedicine Help
1	There is no access to specialist medical facilities at the PHCs.	Make specialists available at the PHCs	Specialist even at distant hospital will be instantly accessible for consultation.
2	There is no preparedness to meet medical emergencies.	Make prior arrangements for consultations and back up from hospital as per shared plan.	Institutionalize linkages between PHCs and hospitals through formal arrangements to provide instant consultation to PHCs and also honour referral cases from PHCs.
3	Patient have no idea about availability of specialized health care facilities at the PHCs.	Disseminate information about available specialized health care facilities at the PHCs.	Patient satisfaction will increase
4	Patients and staffs consider the health care facilities at PHCs to be essential.	Improve and upgrade health care services available at the PHCs.	Through linkages with specialists and hospital, PHCs will be able to cater to wider spectrum of needs/expectations of passengers/staff.

Proposed Model of Telemedicine Facilities at PHCs

Telemedicine facility at the PHCs – will comprise of computer hardware and telemedicine software.

This will need to be housed in a chamber/ medical room at the PHCs and operated by a trained health worker / general doctor. The telemedicine software is very user-friendly and a

person can be trained how to operate it within a few days. This computer will have to be connected through telephone line (preferably ISDN[1] line) to other specialist doctor sitting at Private Hospitals, District Hospitals, Medical Colleges. A choice will be available to link to many places with one or more being active at any time

Consulting Doctor/ Hospital: There will be hospital/ consulting doctor back up to each of the telemedicine centre at the PHCs.
These backup institution(s) will also have a telemedicine facility so that the PHCs could communicate with them for consultation. Prior arrangements will be done in form of commitments from such institutions to provide specialist consultations whenever needed. Along side a choice is available to link to Private Hospitals or a special pool of specialists will also be taken care of.

Technical back up: A outsource agency will provide complete technical support in terms of designing the telemedicine network for PHCs, supply of hard and software required, installation and Operationalization of telemedicine system including necessary training. The agency shall also facilitate defining and formalizing linkages between PHCs and specialist hospital(s).

The Outsource agency will work on following:

a) Supply and installation of telemedicine equipment
b) Building the capacity at PHCs as well as associated hospitals (Dist Hospitals/Medical Colleges/Private Hospitals) to operate and use the system.
c) Technical support to run the system to operationalise the project.
d) Continued technical back up for maintenance of the system.

Equipment required

For each PHCs

Telemedicine equipment (Medicon 500)	1
Tele ECG machine	1
Scanner	1
Telefax	1

For each DHs/Medical Colleges and Private Hospitals

Telemedicine equipment (Medicon 500)	1
Medical Grade Scanner	1
Tele ECG machine	1
Telefax	1
Office Computer System with Printer	1

Additional inputs required. These will be required separately for each centre: -

- ISDN (384 kbps) Line
- A Telemedicine Room

Implementation

The whole programme will be outsource. These include:

1. Operation and Maintenance of System
2. Facilitate the consultation through telemedicine
3. Setting up a centre at the State level with a pool of specialist to give back up to the Specialised consultation from the govt secondary and tertiary level hospitals.

The state government will appoint a nodal person to facilitate with the Outsource agency. From the district Civil Surgeons will facilitate as a nodal person from the district.

Duration of project:

The work will be allotted to the outsource agency for a period of 5 years and will be continue if the result found satisfactory.

Indicators for assessment of the utility of telemedicine system

1. Number of Online Consultations
    a. Gross Number
    b. Timings
        i. Routine
        ii. Emergency
    c. As percentage of total seen
    d. How many physically sent
    e. How saved the need for transfer
    f. Whether any dramatic savings (e.g. Life /death matters) ensued
2. Number of investigations
    a. On line Routine / Emergency investigations.
    b. Number and type of specialized investigations, waiting time and reporting time
3. Follow up visits
4. Number and type of procedures
    a. At PHCs
    b. At centres where staff is referred to.
5. Training of Health and paramedical staff in telemedicine.
    a. Number
    b. Level of skills and confidence.

Expected results:

- Improved access to specialist diagnostic/clinical services by PHC Staff
- Medical Preparedness to effectively meet emergency situations
- Medical backup for emergencies.
- PHCs enabled to be effective epidemiological surveillance centres.
- A general resource Centre for medical and health information
- Increased proportion of the referrals honored by the specialist hospital
- Creation of learning opportunities for the staff.
- Improved quality of health services.

BUDGET

Operational Cost: There are different models of telemedicines system. However **Rs. 5,00,00,000.00** is provided for setting up telemedicine system in the state.

16. PPP for Additional PHC management by NGOs

The state has started to outsource the management of Adll PHCs to the NGOs in The State. In 2007-08 the state has given 44 Adll PHCs to the NGOs for management. The result was good and it has been observed that the NGOs are properly managing the PHCs. This year the state proposes to outsource another 56 Adll PHCs to the NGOs for management.

Last year 44 PHCs were given @ Rs.80,000/- pm per Adll PHCs. This year the state proposes to provide Rs.1,00,000/- per Adll PHCs.

Budget

Sl No	Particulars	Amount (Rs.)
1	Recurring Cost for existing 44 Adll PHCs @ Rs.1,00,000/-	5,28,00,000/-
2	Cost of New 56 Adll PHCs @ Rs.1,00,000/-	6,72,00,000/-
Total		**12,00,00,000/-**

17. Controlling Iron Deficiency Anemia in Vulnerable Population in Bihar

(PIP for Iron Folic Acid Supplements: 2008-09)

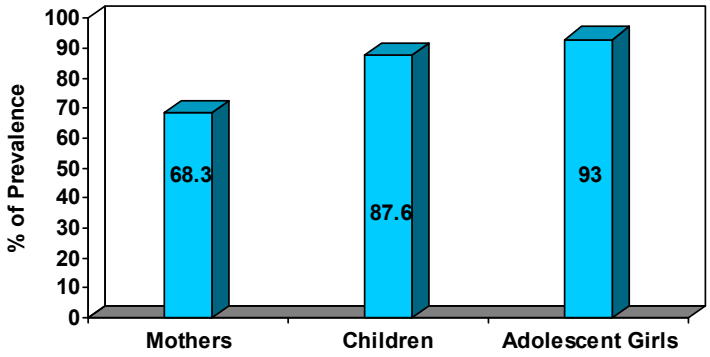
India has the highest prevalence of iron deficiency anaemia in the world affecting children, women and adolescent girls, and resulting in reduced work productivity, impaired physical capabilities and increased susceptibility to illness. Recent surveys show that in India, over 60 per cent of women, preschool children and girls in the adolescent age group are anemic (NFHS 1998-99).

The Government of India is committed to the cause of controlling anemia and has identified a 25 per cent reduction in this deficiency disease as a National Nutrition Goal (Tenth Five Year Plan). Though the national programme aiming to achieve reduction in anemia has been operational for more than three decades, no significant impact is visible and the problem continues to prevail. In pregnant women, the iron deficiency anemia can increase the risk of programme of hemorrhage, leading to maternal and neonatal mortality. There is adequate evidence to suggest that in preschool children, cognitive development is impaired and learning abilities too are affected due to low hemoglobin levels in blood. Moreover, anemic children are also highly susceptible to repeated illnesses.

Although the National Anemia Control Programme has been in operation for more than two decades, it has not made a marked impact of the prevalence of anemia. The recent National Health and Family Survey data suggests that the most vulnerable population groups are the women in pregnant and lactating stages, preschool children and adolescent girls.

In Bihar, which is at the lowest rung of the development and with nutrition-health indicators far from satisfactory, it is not surprising to find that the prevalence considerably high as shown below in Figure 1.

Figure 1: Prevalence of Anemia



Source: NFHS-3 (2005-06), and UNICEF 2005-06).

Estimates suggest that about 25-50 per cent of girls become anemic by the time they reach menarche. This may be due to factors such as menstruation, gender discrimination in intra-household food allocation and early marriage leading to early pregnancy. Early marriage and pregnancy further aggravates their pre-existing anemia. Anemia, in its severe form, is known to be an underlying cause of 20.3 per cent of maternal deaths. It is now increasingly recognized that if the problem of anemia in women is to be overcome, it must be addressed across the inter-generational cycle, i.e., beginning from the period of adolescence (UNICEF 1997).

The dietary practices and food habits as influenced by traditions, availability and family income also prevent the use of foods rich in iron to be included in the diet on daily basis.

Therefore, it is extremely important that oral supplementation of iron tablets or syrup be administered to these vulnerable groups.

The dosage is defined as under:

Beneficiaries	Dose	Duration
Women: Pregnant/Lactating	1 tablet of 100 mg/day	100 tablets in the last trimester
Children 1-5 years of age	1 tablet of 20 mg/day	100 tablets
Adolescent Girls	1 tablet of 100 mg/week	52 Tablets

Therefore, the distribution of iron tablets for pregnant and lactating mothers will be through Health sub centres, anganwadi centres for the above beneficiaries. Additionally, adolescent girls will receive iron tablets through the schools once a week as indicated above.

The requirement of tablets and budget requirement for the purchase of these supplies is given in **Annexure 1 to 5**. The cost of IFA for all beneficiaries for the year 2008-09 is estimated to be **10,00,00,000.00** [Rupees Ten Crores Only]**.**

Summary of required Budget in 38 Districts Of Bihar		
SL#	**Particulars**	**Amount [in Rupees]**
1	Cost of IFA for Pregnant & Lactating mothers [Annex 18.1]	2,01,53,109/-
2	Cost of IFA for (1-5) years children [Annex 18.2]	4,09,23,588/-
3	Cost of IFA for adolescent girls [Annex 18.3]	3,37,50,174/-
4	Cost of IEC Materials [Annex 18.4]	40,65,247/-
5	Cost of Trainings of Head Master [Annex 18.5.1]	2,36,102/-
6	Cost of Trainings Nodal Teachers [Annex 18.5.2]	8,71,780/-
Total Cost		**10,00,00,000/-**
Total Budget Rs. 10,00,00,000/- [Rupees Ten Crores Only)		

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

INTRODUCTION:

Child malnutrition extracts a heavy toll on both human and economic development, accounting for more than 50 % of child deaths world wide. The consequences of malnutrition are serious leading to stunting, mental and physical retardation, weak immune defense and impaired development. More than one-third of worlds malnourished children live in India.

In India, as revealed by the recent National Survey (NFHS-3, 2005-06), malnutrition burden in children under three years of age is 46 %. With the current population of India of 1100 million, it is expected that 2.6 million under-five would be suffering from severe and acute malnutrition which is the major killer of children under five years of age. It can be direct or indirect cause of child death by increasing the case fatality rate in children suffering from such common illnesses as diarrhea and pneumonia.

The risk of death in these children is 5-20 times higher compared to well-nourished children. Severe and acute malnutrition is defined by a very low weight for height, below -3 z* scores of the median WHO growth standards, presence of visible severe wasting' or 'bipedal Oedema', or mid-upper arm circumference (MUAC) of <11 or 11.5 cm in children between 6-60 months.

MALNUTRITION IN BIHAR:

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

MEASURES TO MANAGE MALNUTRITION:

While mild and moderate forms of malnutrition in the absence of any minor or major illness among children can be addressed through Anganwadi centres, by supporting mothers to

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

ensure service utilization and appropriate feeding and care practices at the household level; **the treatment of children with severe and acute malnutrition calls for facility-based treatment by admitting children to a health facility or a therapeutic feeding centre.** This is mainly because these children generally are seen to suffer from acute respiratory infections, diarrhea and pneumonia. A decision was thus taken to set up Nutrition Rehabilitation Centers which is a unit for the management of SAM children where they are kept under observation and provided with medical and nutritional care. In additional to curative care, special focus is given on timely, adequate and appropriate feeding to children. Efforts are also made to build the capacity of mothers through counseling to identify the nutrition and health problems in their child.

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

Thus the NRCs were established in the districts of Muzaffarpur and East Champaran during August-September 2007. Based on the results from the two piloted NRCs in the management of child malnutrition, it was decided to further scale it up to a total of 9 in the financial year of 2007-08. 8 NRCs have thus been established in the districts of Muzaffarpur, East Champaran, Samastipur, Darbhanga, Madhubani, Khagaria, Sitamarhi and Sheohar. In the currebnt financial year, it is proposed to set up 10 more NRCs. Thus the proposal will include the establishment cost of 10 and the running cost for 18 NRCs.

18.1 REQUIREMENT FOR SETTING UP NRCs:

ESTIMATED COSTS OF SETTING UP NRC WITH 20 BEDS

S. no	Item and quantity	Qty	Unit cost	Total cost	Resources
INFRASTRUCTURE					
1	Civil works – minor repairs to building (Capital Cost)		10,000-50,000		PWD may do this
2	Water source / toilet installation (Capital Cost)		10,000		PWD
3	Water tank	1	5000	5000	RCH/NRHM
4	Electric motor	1	1500	1500	RCH/NRHM

5	Cots	20	1000	20,000	RCH/NRHM
6	Bed side tables	20	500	10000	RCH/NRHM
7	Mattresses	20	500	10,000	RCH/NRHM
8	Pillows	20	80	1600	RCH/NRHM
9	Hand towels	40	30	1200	RCH/NRHM
10	Linen (bed-sheets, pillow-covers, etc.)	60	125	7,500	RCH/NRHM
11 a)	Small Blankets (for children)	20	200	5,000	RCH/NRHM
b)	Large Blankets (for mothers)	20	350	7000	RCH/NRHM
12	Plastic Mats	10	65	650	RCH/NRHM
13	Macintoshes	20	100	2,000	RCH/NRHM
14	Mosquito nets	20	100	2000	RCH/NRHM
15	Room heaters	5	1000	5,000	RCH/NRHM
16	Refrigerator	1	8000	8,000	RCH/NRHM
17	Voltage Stabilizer	1	1500	1500	RCH/NRHM
18	Weighing scale	1			UNICEF
19	Weight for height chart	1			UNICEF
20	Room coolers	2	1000	2,000	RCH/NRHM
21	Feeding charts and IEC				UNICEF
22	Almirah	2	5000	10000	RCH/NRHM
23	Table	2	3000	6000	RCH/NRHM
24	Chairs	4	1000	4000	RCH/NRHM
KITCHEN EXPENSES:					
1	Cooking utensils		5000	5,000	RCH/NRHM
2	Gas connection	1	2500	2,500	RCH/NRHM
3	Measuring cups & spoons	1	100	100	RCH/NRHM
4	Aqua guard	1	8850	8850	RCH/NRHM
5	Mixer	1	1000	1,000	RCH/NRHM
6	Food storage tins	12	100	1,200	RCH/NRHM
7	Feeding –katori, spoons,glasses,plates	20 set	125	2500	RCH/NRHM
8	Contingency – phenyl, soap, mosquito repellent, washing powder, etc			2000	RKS
9	Dust bin, door mats, plastic mats, toys for			5000	RKS

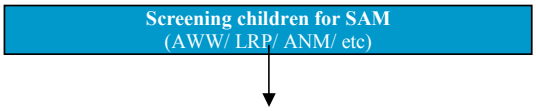
	children, curtains with rods, napkins for kitchen use, etc.				
TRAINING:					
1.	Training of medical officers on management of severely malnourished children				UNICEF
2.	Training of nutrition/ feeding demonstrator, cook, caretakers on therapeutic feeding				UNICEF
RECORDING & REPORTING MATERIALS:					
1	Record keeping registers	10	200	2,000	RCH/NRHM
2	Follow-up Cards	500	3	1500	RCH/NRHM
3	Referral Cards	100	2	200	RCH/NRHM
	TOTAL			**Rs. 1,41,800**	

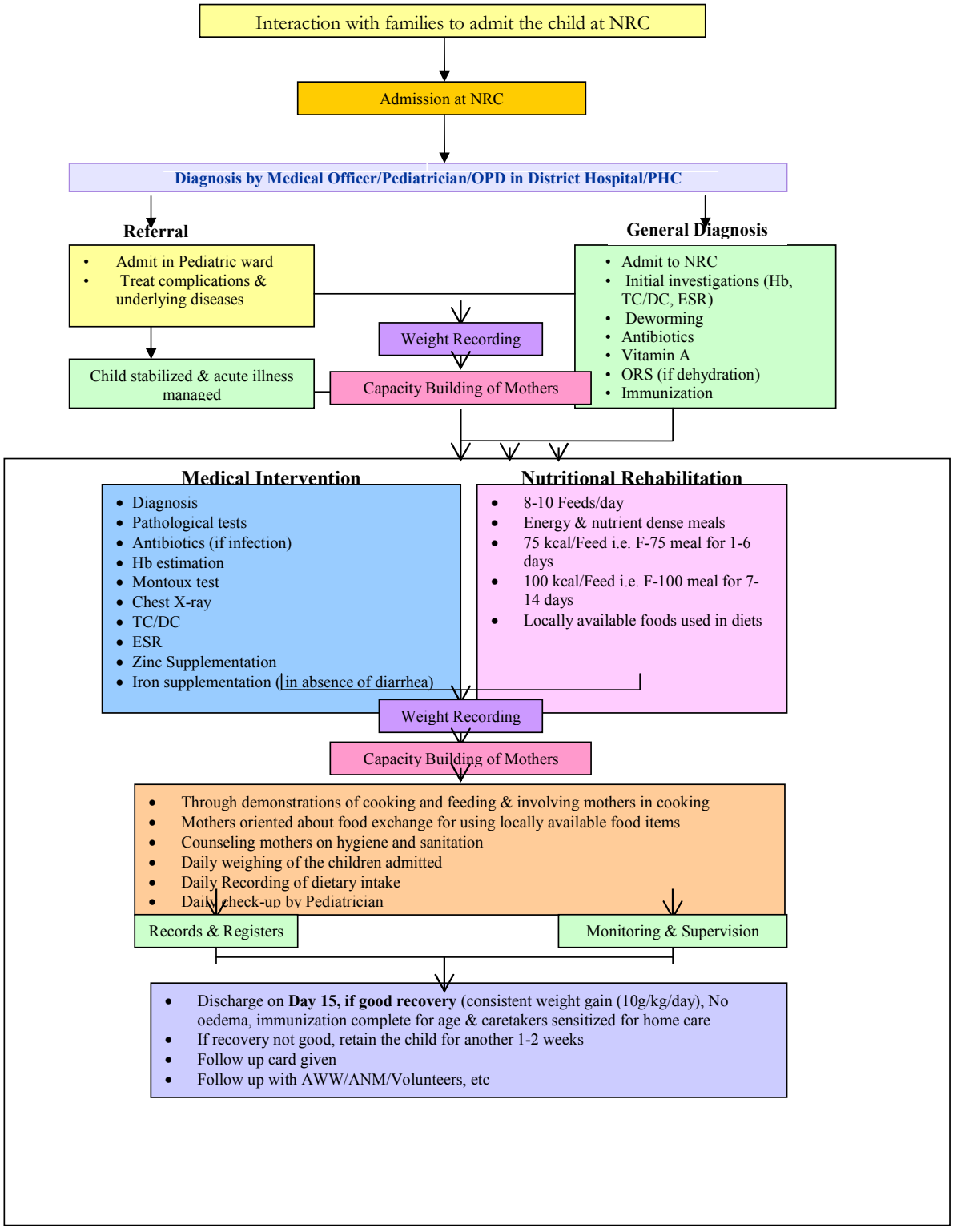
While the supplies for setting up NRCs in the ongoing 8 districts have already been supplied by UNICEF, it would be procured by the GoB for the rest 10 districts this year.

Therefore, the total cost of setting up 10 NRCs **= 1,41,800/- x 10**
= Rs. 14,18,000/-

18.2 FUNCTIONING OF NRC:

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




Interaction with families to admit the child at NRC
Admission at NRC
Diagnosis by Medical Officer/Pediatrician/OPD in District Hospital/PHC
Referral
Admit in Pediatric ward
Treat complications & underlying diseases
Child stabilized & acute illness managed
General Diagnosis
Admit to NRC
Initial investigations (Hb, TC/DC, ESR)
Deworming
Antibiotics
Vitamin A
ORS (if dehydration)
Immunization
Weight Recording
Capacity Building of Mothers
Medical Intervention
Diagnosis
Pathological tests
Antibiotics (if infection)
Hb estimation
Montoux test
Chest X-ray
TC/DC
ESR
Zinc Supplementation
Iron supplementation (in absence of diarrhea)
Nutritional Rehabilitation
8-10 Feeds/day
Energy & nutrient dense meals
75 kcal/Feed i.e. F-75 meal for 1-6 days
100 kcal/Feed i.e. F-100 meal for 7-14 days
Locally available foods used in diets
Weight Recording
Capacity Building of Mothers
Through demonstrations of cooking and feeding & involving mothers in cooking
Mothers oriented about food exchange for using locally available food items
Counseling mothers on hygiene and sanitation
Daily weighing of the children admitted
Daily Recording of dietary intake
Daily check-up by Pediatrician
Records & Registers
Monitoring & Supervision
Discharge on Day 15, if good recovery (consistent weight gain (10g/kg/day), No oedema, immunization complete for age & caretakers sensitized for home care
If recovery not good, retain the child for another 1-2 weeks
Follow up card given
Follow up with AWW/ANM/Volunteers, etc

Sl no	Item and quantity	Unit cost (Rs.)	Total cost per batch	Total cost / month	REMARKS
1	Medicines	250-500/child	10000/-	10000	
2	Honorarium to Mobilizer	100/- per child	100/- x 20 = 2000/-	4000/-	
3	Food for child	60/- per child	60/- x 20 children x 15 days = 18000/-	36000/-	NRHM/RCH
4	Food for mother	30/- per mother	30/ day x 20 mothers x 15 days = 9000/-	18000	NRHM/RCH
5	Loss of wages to mother	70/- per day	70 /day x 20 mothers x 15 days = 21000/-	42000	NRHM/RCH
6	Transportation cost to bring children	1200/vehicle	1200/- x 4 vehicles = 4800/-	9600	5 children in each vehicle with their care taker
7	Transportation cost after 14 days (to mother)	100/child	100/- x 20 = 2000/-	4000	
8	Fuel expense for generator		10000/-	10000/-	
9	Contingency – phenyl, soap, mosquito repellent, washing powder,etc		1000/-	1000	
1	Doctor - 1	District hospital/CHC/PHC			
2	Nurses - 2	3000	6000/-	6000	
3	Ward boy/ care taker - 2	2000	2000/- x 2 = 4000/-	8000	
4	Nutrition/feeding demonstrator - 2	7000	7000/- x 2 = 14000/-	28000	
5	Cook - 2	2500	2500/- x 2 = 5000/-	10000	
6	Security Guards - 2	District hospital/CHC/PHC			
7	Sweeper/cleaner- 1	1000	1000/-	1000	
8	Generator operator	2000	2000/- pm	2000	

	Total cost			**Rs. 1,39,600**	
	Total Cost / year			**Rs. 16,75,200**	

Total cost for running 8 + 10 (18) NRCs = 16,75,200/- x 18 = Rs. 3,01,53,600/-

18.3 Exposure Visit for Nutritional Rehabilitation Centers

Introduction: It is well known that in about 54% of the infant deaths, malnutrition is an underlying factor. In Bihar, about 58% of children under 3 years are undernourished. As the IMR of the state is 60, improving nutritional status of the children can have significant positive impact on the IMR. The nutritional management requires an integrated approach of the Health and ICDS departments. It is proposed to undertake a joint Exposure visit to the state of Rajasthan where similar problems are being managed by State government with UNICEF support.

The

Objectives of the exposure visit:

1. To understand the technical, administrative and financial management of the Nutritional Rehabilitation Centers.
2. To learn the cohesion of Health and ICDS in the nutritional management at different levels
3. To guide Government of Bihar for the efforts required to strengthen the policy issues towards nutrition promotion

Plan of visit: The visit is proposed in the month of April, 2008. The visit would be planned by interacting with the state programme officers of Rajasthan The State programme officer, Nutrition, eight representatives from the Paediatric and Community Medicine departments of the medical colleges and two state officials from ICDS directorate would visit Rajasthan for four days , interact with the state and district officials and visit two NRCs. The total duration of the visit would be of Five days including journey time.

Expected Outcome:

1. Facility management of severly malnourished children is better managed in the state NRCs.
2. Linkup with Home based management of such children is also strengthened.

Financial Input is approximately **Rs 1,68,000/- @ Rs 14,000 per person** (TA/DA and contingency) for a group of 12 people for 5 days.

Total Budget for NRC

Sl	Particulars	Qty	Rate (Rs.)	Amount (Rs.)
1	Establishment of NRC	10	40,000/-	4,00,000/-
2	Recurring Cost of NRC	18	5,24,000/-	94,32,000/-
3	Exposure Visit for NRC for	12	14,000/-	1,68,000/-
Total Budget				**1,00,00,000/-**

(Rupees One Crore Only)

19. Setting up of Intensive Care Unit in all the District Hospitals

An **intensive Care Unit** (ICU) is a specialised department in a hospital that provides intensive care medicine. Many hospitals also have designated intensive care areas for certain specialities of medicine, as dictated by the needs and available resources of each hospital. The naming is not rigidly standardized.

In most of the districts do not have Intensive Care Unit in any set up whether it is Private or Public. The patients have to shift either to the nearest medical colleges or to Patna for Intensive Care. In the process of transfer most of time it has been seen that patient die on transportation. The distance to the nearest ICU set up is long and most precious time waste for treatment of the patient.

Setting up of Intensive Care Unit will help to avail patient the facility in all districts so that accessibility for intensive care can be addressed. The state has proposed to establish 4 bedded ICU in all the 36 District Hospitals.

Budget Per Unit

Sl No	Item	Qty	Rate (Rs.)	Amount (Rs.)
1	Bed side Monitor - Multipara Monitor	4	1,20,000/-	4,80,000/-
2	Defibrillator (Bi-phasic)	1	1,40,000/-	1,40,000/-
3	Syringe Pump	4	45,000/-	1,90,000/-
4	ECG Machine (12 Channel)	1	1,10,000/-	1,10,000/-
5	ICU Ventilator	1	6,00,000/-	6,00,000/-
6	Air Conditioner (2 ton)	1	25,000/-	25,000/-
7	Air Fumigator	1	12,000/-	12,000/-
8	Suction Machine	1	12,000/-	12,000/-
9	Laryngoscope	1	3,000/-	3,000/-

10	Nebuliser	1	3,500/-	3,500/-
11	Glucometer	1	4,000/-	4,000/-
12	Air Viva (Ambu Bag)	1	3,000/-	3,000/-
13	ICU Bed	4	22,000/-	88,000/-
14	Bed side lockers	4	3,000/-	12,000/-
15	Medicine Trolley	4	5,000/-	20,000/-
16	Transfer Trolley	4	6,000/-	24,000/-
17	Three fold Stand	4	2,000/-	8,000/-
18	X-Ray view box	1	2,000/-	2,000/-
Budget for One ICU				**17,26,500/-**

Cost of Setting up 36 ICUs at District Hospitals = Rs.17,26,500/- x 36 = Rs.6,24,51,000/- (Rupees Six Crore Twenty Four Lacs Fifty One Thousand Only)

20. Exposure Visit to Tamil Nadu and Gujarat for the Anesthesia trainers' and State Programme Officers

Introduction: In Bihar, there is an acute shortage of anesthesia specialists. The state has six medical colleges where the Life saving Anesthetic skills training for MBBS doctors has been taken up to meet up the demand for Anesthetists. These doctors would then be posted in different FRUs wherein they support the Gynaecologists for conducting Caesarean sections. All the medical colleges of the state have trained 44 doctors till date. Dr Himanshu Bhushan, National Officer in Maternal Health have visited the state twice in the last six months and have interacted with the state programme officer, Heads of the Anesthesia departments as well as the development partner. The standard of the training was not found to be uniform as also the GoI administrative guidelines are not being followed.

Objectives of the exposure visit:

1. To understand the administrative and financial management related to this training.
2. To learn the standard curriculum and the examination process related to this training.
3. To learn the utilization of the trained doctors for saving lives at FRUs.

Plan of visit*:* The visit is proposed in the month of April, 2008. The visit would be planned by interacting with the state programme officers of Gujarat and Tamilnadu. The state programme officer, Anesthesia trainings, the state programme officer, Maternal health and one faculty member from each medical college would visit the states of Gujarat and

Tamilnadu for three days each, interact with the state and district officials and visit a few FRUs. The total duration of the visit would be of eight days including journey time.

Expected Outcome:

The training of MBBS doctors on Life saving skills is continued with improved quality in every aspect of the training.

Budget:

Sl	Particulars	No	Rate (Rs.)	Amount (Rs.)
1	Exposure Visit for Medical Officers on Life Saving Anesthesia Skill	10	40,000/-	4,00,000/-

21. AAPIO survey on Specific Disease

The Ministry of Overseas Affairs, Govt of India and American Association of Physicians of Indian Origin (AAPIO) signed an MoU at the Pravasi Bharatiya Divas in Jan 2006 to conduct a study on 5 specific diseases. Thereafter a meeting of Core Committee was held in New Delhi in this regard.

As a followup to the above activities this project was included in the Annual Plan of NRHM in 2007-08 and a provision of Rs.50 lakhs has been made in the PIP. A sum of Rs.1.56 crore for the project has already been approved. In 2007-08 as per annual plan a sum of Rs.50 lakhs released for the operation of the Project.

This year the State again proposes another installment of **Rs.50 lakh in the 2008-09 State PIP.**

22. Block Programme Management Unit

The state has already established Block Programme Management Unit in all the 398 Block PHCs. This year the state will establish the next 135 Block Programme Management Unit. Each BPMU consist of One Block Programme 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.

Budget

A. Recurring Expenses of 533 BPMUs

Sl	Particulars	Qty	Rate (Rs.)	Amount (Rs.)
1	Salary of Block Programme Manager	1	15000/- pm	1,80,000/-
2	Salary of Block Accountant	1	8000/- pm	84,000/-
3	Mobility and Office Expenses	1	25000/- pm	3,00,000/-
			Recurring Expenses Per BPMU per Year	5,64,000/-
Recurring Expenses of 533 BPMUs per Year				**30,06,12,000/-**

B. Establishment Expenses for 135 BPMUs

Sl	Particulars	Qty	Rate (Rs.)	Amount (Rs.)
1	Computer System with Printer	1	50,000/-	50,000/-
2	Furniture	1	10,000/-	10,000/-
			Establishment Expenses Per BPMU per Year	60,000/-
Establishment Expenses of 135 BPMUs				**81,00,000/-**

Total Budget for 2008-09 for Block Programme Management Unit (A + B) = Rs. 30,87,12,000/-

Rupees Thirty Crore Eighty Seven Lacs Twelve Thousand Only)

23. Additional Manpower for State Health Society, Bihar

Being the big state, Bihar requires more manpower to run the programmes. The state health society requires additional manpower other than State Programme Management Support to manage all the programmes under NRHM umbrella. This year state also proposes to put 2 nos. Executive Engineers under SHSB for monitoring the construction activity under NRHM.

The details of Manpower as follows with Budget:

Details of Staff

Sl	Post	Salary PM	Salary PA
1	Accountant (RNTCP)	15000	180000
2	Pharmacist (RNTCP)	11500	138000
3	Data Assistant (RNTCP)	9000	108000
4	Computer Operator (RNTCP)	8000	96000
5	Accountant (NBCP)	15000	180000
6	Computer Operator/Data Assistant (NBCP)	8000	96000
7	Steno-cum-LDC (NBCP)	8000	96000
8	Computer Programmer (NLEP)	15000	180000

9	Data Officer (Malaria/Kalazar)	15000	180000
10	Computer Operator (Malaria/Kalazar)	8000	96000
11	Store Keeper (Malaria /Kalazar)	8000	96000
12	Accountant (Filaria)	15000	180000
13	Computer Operator (Filaria)	8000	96000
		Total Per Annum	**1722000/-**

Details of Programme Officers

Sl.	Name	Salary Pm	Salary Pa
1	Administrative Officer- SHSB	29143	349716
2	Programme Office - TB	27983	335796
3	Programme Officer-Kalazar/IDSP	33643	403716
4	Programme Officer -Blindness	24882	298584
5	Programme Officer- IDD/Filaria	30664	367968
6	State Immunization Officer	37108	445296
7	Programme Officer-Malaria	25751	309012
8	Programme Officer - Leprosy	25000	300000
Total Salary of ProgrammeOfficers		**234174**	**2810088/-**

Details of Engineers

Sl.	Name	Salary Pm	Salary Pa
1	Executive Engineer 1 - SHSB	25000	300000
2	Executive Engineer 2 - SHSB	25000	300000
Total Salary for Engineers		**50000**	**600000/-**

Total Budget for Additional Manpower under NRHM = Rs. 51,32,088/-
(Fifty One lacs Thirty Two Thousand Eighty Eight Only)

24. PPP Initiative in State

24.1. Emergency Medical Service

Under this service a special number has been allotted as 102 to call for Ambulance for Emergency transport and call the Health Institute for emergency Service. This has been running in all the Divisional Headquater where a call centre established to manage and operation of the service.

Hospitals were accredited to provide the Emergency Services. Also private Ambulance empanelled for transportation of services. In the year 2007-08 around 7500 requisition successfully met by this service.

This service has been outsourced to a private agency for operationalization.

Budget:
Rs. 45,000/- pm per district + Rs. 25000/- pm for Telephone Charge
Total Budget for 2008-09 = Rs. 8,40,000/-

24.2. Doctor On Call: Dial 1911

A new scheme launched in the state for calling doctors and provided a special tool free number 1911. The objective of the scheme is to give medical assistance to the patient at their home.

Doctors and Specialists empanelled for this scheme. Also pathology lab can be connected to collect specimen for test from home.

A budget provision of Rs. 20000/- pm for telephone bill kept under this scheme and for 3 doctors x Rs, 20,000/- x 12 months + Ambulance in all the 38 districts has to be provision for.

Budget for 2008-09 = Rs. 2,40,000/-
Salary of Doctors = Rs. 7,20,000/-
Rental Amublance = Rs. 1,20,000/-
= Rs. 10,80,000.00

3. Pathology and Radiology Services (Outsource)

Under this scheme Pathology and Radiology service has been outsourced to Private agencies. The agency setup centre at the district hospitals and facility collect the specimen from the PHC.
The state has fixed the rates on which the agency charges from the patient.
The state has only provided space at the hospitals to the agency for running the Pathology and Diagnostic Centre.

4. Hospital Maintenance (Funded by State Govt)

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

The activities include

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

5. Generic Drug Shop

Under the PPP initiative Generic Drug Stores set up in all PHCs. The Private agency has to keep 188 types of drugs at the store. The state has provided only space for this purpose to the agency.

The state has also fixed rates for the Generic Drug as per MRP.

25. Village Health & Sanitation Committee:

In Bihar thereof 45098 Villages Village Health & Sanitation Committee will be setup in each village and Rs. 10000/- per committee per annum will be provided. The Village Health & Sanitation Committee shall prepare integrated action plan in the year 2008-09. 1000 Village Health & Santiation Committee.

NRHM PART C
IMMUNIZATION

Routine Immunization - PIP
NRHM – Part – C
(2008 – 09)

Muskaan Ek: Abhiyaan ……..

Routine Immunization: Bihar

(1). Augmentation of Routine Immunization in Bihar

Routine Immunization has become the priority programme for the State of Bihar. Since the augmentation drive from August 15, 2005, the state has been consistently performing well in all the Routine Indicators, as shown by the monitoring feedback that is continuously updating the Government on the activities. We have been able to ensure the availability of vaccines, Auto Disable syringes, Immunization cards, reporting formats and hub cutters all across the state. New micro plans have been made for the sessions as well as the Immunization weeks. Alternate vaccinators have been hired by the districts, couriers (people with a bicycle or a motorcycle who would deliver vaccines and AD syringes to the ANM at the session site and safety pits for sharps disposal have been constructed by some Primary Health Centers.

Activities such as these were not envisioned before in Bihar and has only started happening due to the renewed support by the Government of India following the submission of the PIP for Immunization as a part C of NRHM by the individual states. The support from the GoI followed by the interest shown by the government of Bihar towards improving immunization has helped tremendously in the progress made on this front. Support from the partners (WHO-NPSP and UNICEF) has also ensured that the gains in Routine Immunization are not faltered.

The year 2007 has been special because of the launch of the campaign: Muskan ….Ek Abhiyan

This campaign was launched in October, 2007 with the objective to achieve 100 % immunization of infants and pregnant women and to ensure 100 per cent institutional deliveries. The operational strategy includes convergence between ICDS and health for service delivery. The anganwadi centre is to act as the service delivery unit for immunization and as Headquarters from where AWW and ASHA operate. The ANM is the team leader of eight to ten AWCs.

The regular monthly review of progress under Muskan Campaign is done by DM. The discussion on progress of Muskan in every District Task Force Meeting is done under the chairmanship of DM.

Components

1. **Tracking of all pregnant women and newborns**

Field survey

AWW and ASHA to carry out time bound, one time cross-sectional house-to-house survey to:

- Identify all currently pregnant women
- Identify all children in 0 to 2 Years age group

After initial survey, follow-up survey from time to time to identify new pregnancies and newborns.

Tracking Registers

All identified pregnant women and 0 to 2 children to be registered in pregnancy tracking and newborn tracking registers respectively.
During initial survey, previous vaccination status of pregnant women and 0 to 3 years children to be entered in tracking registers.

2. **Immunization sessions at AWCs**

- RI sessions to be held by ANMs at sub-centers on Wednesdays as before
- Every Friday ANM to conduct RI sessions on 2 – 3 AWCs
- Microplanning for above to be done on standard microplanning formats (Form 3)
- AWW and ASHA of the session AWC to ensure all due pregnant women and children as per tracking register are mobilized to AWC for immunization
- ANM to document the immunizations in RI reporting formats and MCH/immunization register
- ASHA/AWW to update the immunizations on pregnancy tracking (Form 2) and Newborn Tracking registers (Form 1)
- Immunizations done on Wednesdays to be updated on tracking registers on Friday so that they are up-to-date.

3. Mahila Mandal Meetings

- Mahila Mandal meeting to be organized on every AWC on 3rd Friday of the month
- Meeting to be attended by all pregnant women and mothers of 0-3 years children
- Rs. 150/- per month allocated per AWC per month for Mahila Mandal Meeting Expenses.

Incentives for health workers

For AWW and ASHA

Initial survey – Rs. 200/- each for AWW and ASHA (One time)
Achievement of monthly immunization target (PW and infants)

- >90 %: Rs 200/- each for AWW and ASHA
- 80 % - 90 % : Rs. 100 each for AWW and ASHA
- 60 % - 80 %: No incentive
- < 60 %: AWW and ASHA liable for punitive action

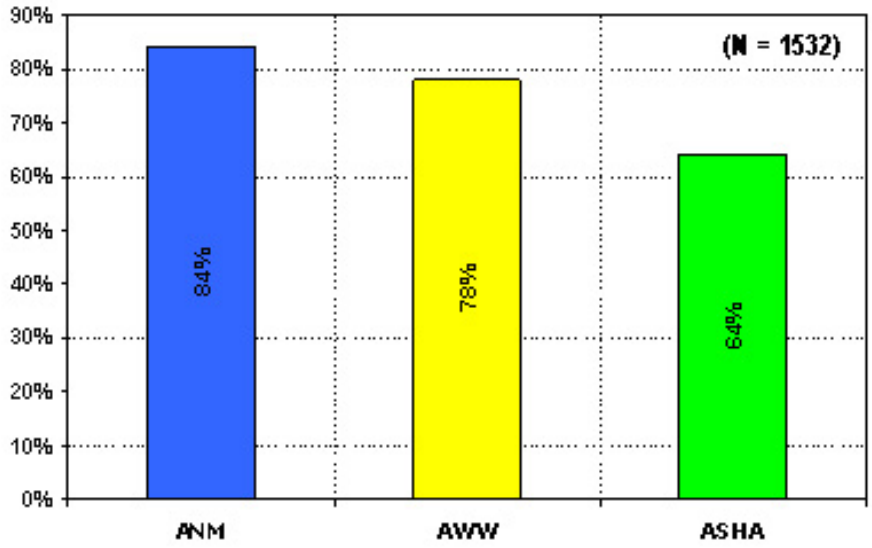
For ANM

Achievement of monthly immunization target (PW and infants)

- > 90 %: Rs. 150/- per AWC
- 80 % - 90 %: Rs 75/- per AWC
- 60 % - 80 %: No incentive
- < 60 %: ANM liable for punitive action

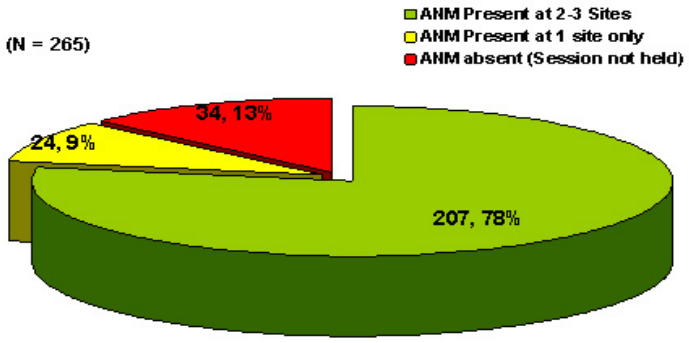
(Jan 2008 – Feb 2008)

% of ANM / AWW / ASHA presence at the session sites (only WHO)



(Jan 2008 – Feb 2008)

Percentage of 2 to 3 Sessions held by ANMs as per Muskan Microplan



The initiatives taken by the Immunization division of the State Health society, Bihar over the last Financial Year include disbursement of funds for the following activities:

1. POL for cold chain functioning so as to ensure at least 6-8 hours of continuous electricity supply. Support has been provided to the WIC/WIF level, districts and PHCs.
2. Maintenance of the cold chain - Support to the PHCs, districts and WIC/WIF points have been provided so that they could ensure that the cold chain remains functional at all times. Maintenance of cold chain has been outsourced through an annual maintenance contract given to Voltas company. The company has identified all functional and reparable electric cold chain equipment and covered for any breakdowns and non-functioning.
3. Vaccine mobility is another area that the SHSB has decided to extend its support to. Allocation of funds for this activity is of prime importance as the major purpose of ensuring the availability of vaccines at districts, PHCs and session sites can only be ensured by this activity. The PHC procures its supplies from the district stores and the district in turn gets its supply from the next higher level of WIC/WIF. This activity ensures that no stock out happens and that the sessions are not compromised.
4. Support for supervision has also been provided to the districts (all DIOs) and the State Immunization Officer (SIO) so as to ensure that all activities on Routine Immunization are being carried out in the predetermined manner. This would also provide the district and the PHC level officials the capacity to judge the work of their subordinates.
5. Mobilization of beneficiaries to the session sites is another important area of support. Special support to the ASHA (Accredited Social Health Activist) and AWW (Anganwadi Worker) has been provided so as to ensure that beneficiaries are brought to the session site and tracking of beneficiaries is ensured.
6. Couriers have benefited the programme immensely. These couriers lift vaccines from the PHCs and distribute them to the session sites during every immunization session. They also carry the AD syringes, Immunization cards, hub cutters and blank reporting formats with them for delivery to the ANM. At the end of the day, these couriers bring back the unused as well as used vaccine vials, used and unused AD syringes, hub cutters and the reporting formats duly filled by the ANM. These are delivered at the PHC for further actions.

7. Alternate vaccinators are those people who could deliver immunization services. They are recruited by the districts and paid for their efforts towards improving the immunization delivery. In urban areas, we don't have adequate trained government field health worker (ANMs) and no subcentres. Therefore large number of alternate vaccinators will be needed for urban areas.
8. Safety pits construction has been initiated in all districts where the sharps are to be disposed after due disinfection. They are being constructed according to the Central Pollution Control Board (CPCB) guidelines.
9. Ice packs are required during special activities like the Immunization weeks. During such activities, the Deep Freezers (DF) are not capable of turning out such large numbers of ice packs. They are therefore procured from outside for these special activities. A special provision was given to all blocks to freeze the icepacks from outside in instances of breakdown of electrical cold chain equipment and backup power supply.

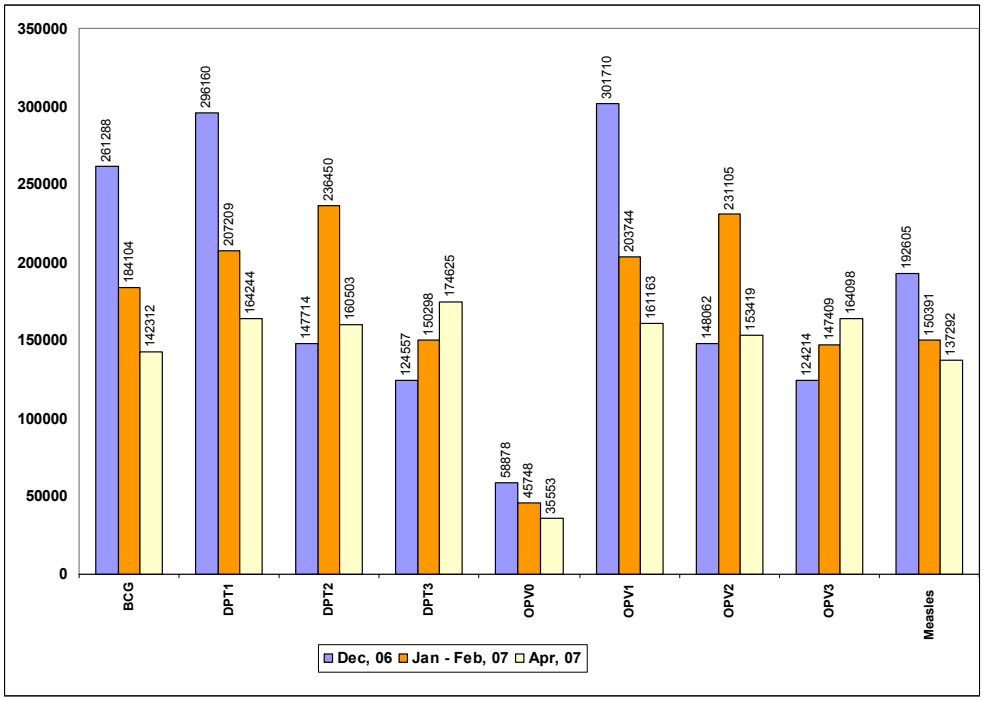
(2). Immunization Weeks

Unlike the Immunization weeks carried out during the FY 2005-06 wherein MPSD (Message Propagating Service Delivery) vans were used for reaching out to the Hard-to-Reach areas, Immunization weeks carried out during the FY 2006-07 included reaching all areas with all available ANMs.

During the Immunization weeks carried out in FY 2006-07, vans were also used for the first two weeks. These vans were solely used for IEC and not for service delivery. Approximately 60,000 sessions were carried out during each Immunization week. The third round of Immunization week was held between April 16th to 22nd, 2007.

Comparative Coverage of Immunization Weeks

(11 Dec to 16 Dec , 29 Jan 07 to 4 Feb 07 & 16 Apr to 21 Apr-07)

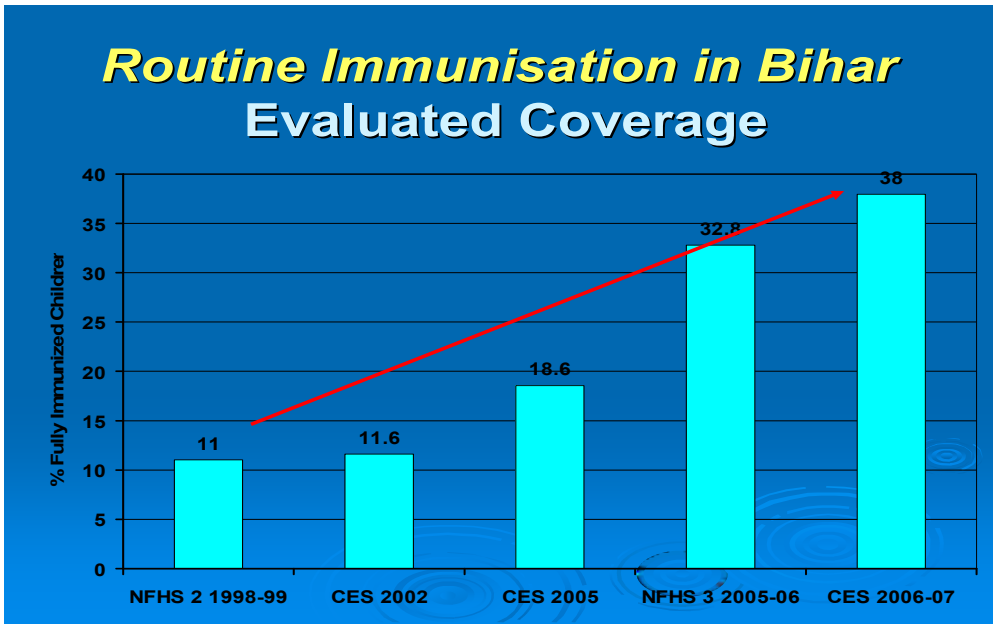


(3). Achievements in Bihar

The evaluated fully immunized percentage in Bihar has increased to 32.8 % (NFHS III April – June 2006). This is a remarkable increase from the lowly 11 % during NFHS II. CES 2005, carried out during December 2005, informed the state that FI percentage was at 18%. This was mainly due to the interventions carried out during the months of August 2005 onwards wherein the augmentation was carried out for RI. As per coverage evaluation survey 2006, the fully immunized percentage has increased to (37.7%)

A summary of Bihar's progress in Fully Immunized RI is as under:

Fully Immunized	**NFHS 2 (98-99)**	**CES 2002**	**CES 2005**	**RCES 2006**	**NFHS 3 2006**	**CES 2006-07**
	11.8	11.6	18.6	26.1	32.8	37.7



We aim to achieve an increase in percentage of FI Children to about above 90**%** during this FY.

(4). Special Activities being carried out for strengthening RI in Bihar

1. Muskan ek abhiyaan campaign was launched by the CM to strengthen routine immunization. The key features of Muskan were identification and tracking of pregnant women and new born children till they achieved full immunization status. This is to be achieved through team work and intersectoral coordination involving ASHA and anganwadi workers for mobilization and ANM for vaccination. Muskan also envisages a system of performance based incentives as well as punishments.

2. Training of health workers: Training of trainers has been conducted at state level in five batches where three to five trainers per district have been trained. Trainings of health workers have also been initiated in all districts and completed in a few. This process will continue till all health workers are trained.

3. Microplans have been remade in all districts. This was done following a fresh survey of all pregnant women and children less than three years old. The microplans

incorporated three sessions a week with special emphasis on Friday sessions as outreach sessions in two to three anganwadi centres and Wednesdays reserved for subcentres and additional PHCs.

4. Revamp in cold chain maintenance management has taken place. Its maintenance has been outsourced and the cold chain officer, SHSB and cold chain consultant, UNICEF are closely supervising repairs and replenishment. Cold chain equipment sickness rate has gone down.

5. Cold chain handlers trainings is being undertaken in all the districts of the state.

6. State level meeting for AEFI was organized with technical input from WHO-NPSP and UNICEF following which several cases of AEFI were reported and investigated.

7. State level meetings for orientation of the DIOs (District Immunization Officers) and ACMOs (Additional Chief Medical Officers) of Bihar were carried out.

8. Divisional level meetings for orientation of all MO I/Cs (Medical Officers In Charge) as well as the district functionaries were also carried out.

9. Regular monitoring of RI sessions and Immunization weeks are being carried out by GoB, Unicef and WHO-NPSP. These monitoring feedback are being sent to the Divisional commissioners (DC) and the Regional Deputy Directors (RDD) for action.

10. Medical Officers and ANMs on contractual basis have been recruited.

11. District level meetings are being undertaken on a regular basis to review immunization performance for the state.

12. Auto disable syringes (ADS) have been used for ensuring that one child – one dose – one syringe norms are followed and adhered to.

(5). Current Healthcare Infrastructure

(a) Infrastructure status-

Serial No.	***Indicator***	***Status***
1	District Hospitals	25
2	Sub divisional hospitals	23

3	Referral hospitals	76
4	PHCs	533
5	Additional PHCs	1243
6	Sub centers	9021

(b) Manpower status-

Position	**Sanctioned Posts**	**In position**	**Proposed Addition**	**Trained in last 3 years**
Medical Officers[2]	5124	3860	3376	398
LHV (Female Multi-purpose Health Supervisor)	1126	662	0	140
ANM (Female Multi-purpose Health Worker)	11294	10500	15000	2205
Male Multi-purpose Health Worker	2562	1298	0	273
Contractual ANM		2700	12000	0

(c) Cold Chain status

Cold Storage Point	**Total Number**	**Location**
State Store	3 WIC / 2 WIF	Patna
Regional Store	6 WICs	Aurangabad, Saran, Muzaffarpur, Darbhanga, Purnia and Bhagalpur
	1 WIF	Purnia
	1 WIC	Motihari (operational since 2007)

District Store	38	All districts
ILR Storage Point	442	All Blocks

(6). Purpose of this document

This document highlights the Govt. of Bihar's response to strengthen the state immunization system within the context of polio eradication and to contribute in providing high quality immunization services to all the communities in all districts (Reach Every District, RED) and Reach all Communities in order to prevent mortality, morbidity and disability from the diseases that is preventable through use of quality of vaccines that are currently available in the national system. The guiding principles of Bihar State Immunization Plan is to reach the entire population as well as the un-reached, strengthen the management and achieve and sustain high immunization coverage level throughout the state. Although this plan of action covers strategies to be implemented over the next few years, specific focus is given to activities to be undertaken in 2007-08. Inputs and objectives to be achieved are thus outlined.

(7). Goals and Objectives

a. Government of India (GoI) target for RCH under millennium development goals (by 2010):

- 100% children aged less than 1 year are fully immunized (for Bihar, currently it is **37.7%,CES-2007**).
- IMR under 30 by 2010 (for Bihar, currently it is 60, source GoI).
- MMR under 100 by 2010 (for Bihar, currently it is 500, source GoI).

b. Goal of Govt. of Bihar (GoB) by 2010:

All districts in Bihar to provide timely and safe immunization 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).

c. Objectives to be achieved by GoB by 2010:

- 100% vaccine availability as per vaccine supply schedule.

- 100% availability of ADS.
- 100% availability of hub cutters.
- Ensure that every district has a functional micro plan.
- 100% sessions are held as per micro plan.
- 100% involvement of ASHA and Anganwadi workers in mobilizing the community and bringing beneficiaries to the sites.
- 100% trained ANMs available in all the districts (including urban areas).
- State has a dedicated SIO in place.
- All districts have dedicated DIOs in place.
- 100% DIO trained.
- 100% ANMs trained.
- 100% Cold Chain Handlers trained by partners(UNICEF).
- Maintaining functional cold chain status above 90%.
- To ensure delivery of quality immunization services
- To ensure smooth functioning of state and district routine immunization cell.
- 100% trained staff available at every level – especially, SIO, DIO, Cold chain Technician, ANMs etc.

d. Routine programme activities and objectives for 2008-09

- The state has already been having sessions regularly over a period of 2 1/2 years now. Now with the Muskan campaign initiative, there is an expected enhancement in quality and quantity of routine immunization coverage.
- The gains made by Muskan ek abhiyan for strengthening RI is to be consolidated throughout the coming year. This would be done by close supervision and monitoring of field level workers regular review of activities at block, district and state levels and proper fund flow and data management.
- Trainings of the Health workers would be provided prime importance.
- Trainings of the MO I/Cs, DIOs and ACMOs would also be focused upon.
- RIMS would be fully operationalised in the coming financial year. This would be done through the existing network of MIS of NRHM. Data operators suitably

selected would be trained for use of RIMS software.

- Coverage evaluation survey could be undertaken in all districts by an independent agency to validate the reported coverage.
- Ensure that all SOEs (statement of expenditure) and UCs are received and submitted from the PHCs to districts and districts to state on time to streamline the fund flow in the state. There will be at least two state level training and follow up of all accounts managers from the districts in the year 2008-09 to regularize the process.
- Ensure that urban outreach vaccination is initiated to cover marginalized and slum populations.
- Ensuring that the AEFI and VPD reporting system are strengthened through training/workshops on AEFI and VPD surveillance in the state.
- Ensure that AD syringes are used and glass syringes are phased out.
- Ensure the use of hub cutters and disinfection methods all across the state.
- Ensuring that safety pits are constructed at each and every PHC across the state and they are used according to the guidelines laid down by the CPCB.
- To strengthen the Vaccine management system as well as the distribution system.
- Ensuring that the state has RIMS functioning all across.
- Ensuring that the Cold chain helpline is functional and that breakdown rate is lower than 5%.
- Ensuring that functional cold chain is above 95% at all times of the year.
- To ensure that every community of Bihar is reached by the services of immunization.

(8). Milestones achieved against set targets during 2006-07

SN	Objective	Indicators	Target 2006-07	Monitoring & Coverage Report-2007-2008 (Apr-07 TO Jan-08)
1	**100% immunization coverage for all antigens**	1. % of DPT 3 2. % of Measles immunization along with Vit A 3. % of TT2 4. Drop out rate DPT1 to DPT3, BCG to Measles	60 % for DPT3 and 50 % Measles 30 % TT2 20 % decrease in dropout	51% 50% 33% 7% DPT1 toDPT3 drop out and 9% BCG to Measles drop out
2	**100 % sessions planned are held**	% sessions planned vs. held	100 % sessions planned are also held.	92 % sessions planned were held
3	**100 % ANMs available at session site**	% sessions having ANMs at session site	100 % sessions have ANMs	96 % ANMs available at session sites
4	**100% vaccine availability as per vaccine supply schedule**	Number of districts reporting any vaccine stock out any time during the year (> 1 month no vaccine available during the year)	100 % districts monitored for vaccine availability 100 % districts with no DPT vaccine stock out	73 % districts and WIC points monitored for all vaccine availability. 100 % districts with no stock outs at district level.
3	**100% availability of ADS**	Number of districts reporting any ADS (0.5 ml and /or 0.1 ml) stock out any time during the year	100 % districts monitored for ADS supply 100 % districts with no ADS stock out	93% availability of ADS in monitored sites. 100 % districts with no ADS stock outs.
4	**100% availability of hub cutter**	Number of districts reporting hub cutter unavailability.	100 % districts monitored for hub cutter availability. 100 % districts with no hub cutter unavailability.	100%availabilty monitored for hub cutters.(but not in Working Condition)
5	**Ensure that every district has a functional new micro plan**	Number of districts having new functional micro plan	100 % blocks using newly developed micro plan	90% blocks using newly developed Muskaan micro plans
6	**100% sessions are held as per micro plan**	% sites held as per micro plan	100 % sites as per micro plan	85% sites as per micro plan

7	**100% trained ANMs available in all the districts (including urban areas)**	% districts with up to 80% ANM post filled	100 % districts up to 80 % ANM post filled	Recruitment in process.
		% ANMs received training in last 3 years	100 % ANMs received training this year	21% health workers given training on RI
8	**100% involvement of ASHA and Anganwadi workers in mobilizing the community and bringing beneficiaries to the sites**	% of ASHA and AWW working for RI	100 % ASHA / AWW working for RI	75 % mobilizers are present in sessions. 32 % ASHAs and 57 % AWW helping out in sessions.
9	**State has a dedicated SIO in place**	State has full time SIO in place with independent charge	State has full time SIO in place with independent charge	SIO in place
10	**All districts have dedicated DIOs in place**	All districts have full time and dedicated DIO in Place	All districts have full time and dedicated DIO in Place	Only 12 out of 38 District has a dedicated DIO in place
11	**100% DIO trained**	% DIO trained in last 3 years	100 % DIO trained	All functional DIOs have been trained on RI activities.
12	**Maintaining functional cold chain status of above 90%**	Number of Regional WICs functioning as 3 month depot of vaccines for the region	All WICs functional and working as regional stores	100 % functional
		% ILR functional	90 % functional	85% functional
		% DF functional	90 % functional	85% functional
		% of regions having cold chain Technician	100 %	25%
		% districts having cold chain Technician	50 %	0%
		% of PHCs having designated cold chain handler	70%	60%
		% PHCs having 1 month vaccine stock	100 %	>50%

		% of regional Technician trained	100 %	0%
		% district technician trained	40 %	
		% PHC cold chain handlers trained	70 %	68% trained in 2007-08
		% PHCs having adequate number of 20 L cold boxes	100 %	
		% PHCs having adequate number of vaccine carriers	100 %	
		% PHCs having adequate number of ice packs	75%	

Budget for Routine Immunization Program 2008 - 2010

Bihar

S. No.	Description	2008-2009 (in Rs.)	2009-2010 (in Rs.)	Whose Responsibility	Remarks
A	**Printing activities:Reporting and Recording Formats**				
1	*UIP formats*			*SHSB(RI-Cell)*	
1a	ANM tally sheet 40,000 booklets of 100 Pages each @ 50 Paisa per Page	2000000	2200000		**Tally sheets as per GOI-endrosed UIP Formats.**
1b	PHC / District reporting sheet 8,000 booklets of 50 Pages each @ 50 Paisa per Page	200000	220000		**Tally sheets as per GOI-endrosed UIP Formats.**
1c	PHC / District compilation sheet 10000 * Rs. 100 each	1000000	1100000		**As used in PHC &Dist for compilation & recording of reporting formats**
2	*Vaccine Stock register* *1000 booklets * Rs. 110 each*	110000	121000		

3	*ADS stock register* *1000 booklets * Rs. 110 each*	110000	121000		
4	Immunization cards 4000000 cards * Re.1.5 each	6000000	6600000		
5	Immunization registers 25000 registers * Rs. 40 each	1000000	1100000		**Register for tracking successive vaccine doses received maintained at ANM level as main register for reference and comparison with Muskaan tracking registers.**
6	Muskan Tracking Register (for PW and New Borns) 80211 AWCs x @Rs. 80 per set	6416880	7058568		**As per Muskaan strategy every AWC is given two registers for Tracking of Pregnant Women and children till they have achieved complete immunisation**
7	Cold chain breakdown reporting format 2000 booklets * Rs. 20 each	40000	44000		
8	**AEFI reporting format**				
8a	FIR formats 600 booklets x 50 Pages @ 50 Paisa per page	15000	16500		**AEFI reporting formats (FIR,PIR,DIR)- Ensuring that standard formats would be important**
8b	PIR format 600 booklets x 50 Pages @ 50 Paisa per page	15000	16500		

8c	DIR format 600 booklets x 50 Pages @ 50 Paisa per page	15000	16500		**for evaluation of incidence and types of AEFI as well as provide the basis of necessary data for any future action.**
9	**Vaccine Challans**			**SHSB(RI-Cell)**	
9a	Courier Indent slip 10000 booklets (of 200 pages each) * Rs. 100 each	1000000	1100000		**Vaccine challans, indent slips and supervisory challan- To ensure proper documentation of indenting of required vaccine and to ensure that the exact quantity indented is issued and reached the ANM through the vaccine courier**
9b	Vaccine indent / challan 1000 booklets (of 200 pages each) * Rs. 200 each	200000	220000		
9c	Supervisory challan 50 booklets (of 100 pages) * Rs. 100 each	5000	5500		
	Total for Reporting and Recording formats	**18126880**	**19939568**		
B	**Monitoring Tools**			**SHSB(RI-Cell)**	
1	Tickler Bag for ANMs Rs. 200 * 12000 ANMs	2400000	2640000		**Monitoring tools would help in regular assessment by individuals at various levels of their own periodic achievement. This would help them to make the right decisions and take the right actions for improvement of their performance.**
2	Monitoring chart Rs. 20 * 12000 ANMs	240000	264000		
3	RI Monitoring formats for MO's 600 booklets * Rs. 40 each	24000	26400		
4	Temperature record book for PHC/Districts 2500 Books * Rs 50 Per book	125000	137500		

Total for Monitoring tools		**2789000**	**3067900**		
C	**POL / Outsourcing of generators for Cold chain functioning**				
1	POL for WIC / WIF points Rs.600/day * 30 days * 12 months * 13 WIC/WIF points	2808000	3088800	State-RI-Cell	
2	POL for District storage points Rs.500/day * 30 days * 12 months * 38 Districts	6840000	7524000	District	
3	POL for PHC storage points @ Rs.400/day * 30 days * 12 months *533 PHCs	76752000	84427200	PHC	
Total for POL / Outsourcing of Generators		**86400000**	**95040000**		
D	**Maintenance (AMC) of Cold Chain Equipments**				
1	Maintenance of Cold chain at the WIC/WIF points Rs. 15000 / year * 13 WIC / WIF points	195000	214500	SHSB(St-RI- Cell)	
2	Maintenance of Cold chain at the PHC & District storage points by outsourcing to VOLTAS (AMC of all the electrical cold chain equipments in the field) 1500 Equipments @ 2000/- each	3000000	3300000	District & PHC	
3	Wiring & Earthing for 129 New PHC where new cold chain points to be established @ Rs 15000 each	1935000	2128500	APHC	
4	Outsourcing of Cold Chain Technician for maintenance of Cold Chain equipments at Divisional Level Rs. 18000/- per month for 9 divisions	1944000	2138400	District	

5	Wiring, replacement of electrical asseccesories & earthing for flood affected areas and other area which require to be replaced Rs 12000/- each for 250 locations	3000000	3300000	PHC	
Total for Cold Chain Manitenance		**10074000**	**11081400**		
E	**Vaccine Mobility@ Funds to be rationalized based on distances and vaccine requirements**				
1	Carrying vaccines from state WIC / WIF point to the regional WIC / WIF point Rs. 15000 / Store / month * 13 stores * 12 months	2340000	2574000	SHSB(RI-Cell)	
2	Carrying vaccines from the regional WIC / WIF point to the district Rs. 8000 / district / month * 38 districts * 12 months	3648000	4012800	District	
3	Carrying vaccines from the District storage point to the PHCs Rs. 2500 / PHC / month * 533 PHCs * 12 months	15990000	17589000	PHC	
4	Carrying vaccines from PHC to the session sites by use of couriers (persons with bicycle / motorcycle who delivers vaccines to session sites) during wednesdays and Fridays Rs. 70 / courier * 11000 Couriers * 52 Wednesdays & 52 Fridays(10,000 for Rural & 1000 for Urban areas)	72800000	80080000	PHC	**Alternate vaccine delivery by Couriors has improved immunisation coverage through good cold-chain maintainance and timely vacine & logistics delivery.**
Total for Vaccine Mobility		**94778000**	**104255800**		
F	**Mobility for supervision**			**SHSB**	
1	Mobility for state level supervision SIO Rs. 100000 / year	100000	110000	State-RI- Cell	

	Mobility for State Cold Chain Officer Rs 100000 / year	100000	110000	State-RI- Cell	
2	Mobility for district level supervision (DIO/ACMO) Rs. 50000 / year * 38 districts	1900000	2090000	District	
3	Mobility for block level supervision Rs. 2500 / month * 533 PHCs * 12 months	15990000	17589000	PHC	
4	Mobility support for 16 state level monitors Rs. 7000 / person / round * 3 rounds * 20 persons	420000	462000	State-RI- Cell	
Total for Supervision		**18510000**	**20361000**		
G	**Review Meetings**				**Setting-up Steering Committees and Regular Review Meetings -**
1	Review meeting at state for District level officers Rs. 60000 / meeting * 4 meetings	240000	264000	State_RI-Cell	**This would be vital in ensuring timely action and if necessary mid course corrections are undertaken in order to finally achieve the annual goal of individual districts, various divisions and the state as a whole.**
2	Review meeting at division for divisional level officers Rs. 30000 / meeting * 9 divisions * 4 meetings	1080000	1188000	State_RI-Cell	
Total for Review meetings		**1320000**	**1452000**		

H	**Mobilization of beneficiaries**				
1	Mobilization of beneficiaries by ASHA & AWW every Wednesday and Friday Rs. 250 / ASHA / month * (74313 ASHAs + 80211 AWWs) * 12 months	463572000	509929200	PHC	**Important component of Muskan Ek Abhiyan in which link workers are given incentive based on the coverage following their mobiliztion efforts**
Total mobilization of beneficiaries		**463572000**	**509929200**		
I	**Service Delivery**				
1	Alternate Vaccinator for Immunization Rs. 2400 / alternate vaccinator / month * 2000 centers * 12 months(1000 No.for Rural & 1000 No. Urban areas)	57600000	63360000	PHC & Urban /District/ Sub-Divisional Hospital	**Increase in Budget as compared to budget requested in PIP submitted earlier to AC (UIP), GoI on 30th April 2007(1000 alt vacinator for Rural Areas & 1000 Alt Vacinators for Urban Areas)**
2	Urban health strategy / mapping & ensuring delivery Rs. 100000 / district * 38 districts	3800000	4180000	District &	**Urban out reach needs to be established in many Towns and Urban areas to ensure coverage of Urban Benificiaries mainly in Urban slums and underserved areas.**
Total Service Delivery		**61400000**	**67540000**		

J	**Training**				
1	One dayTraining of DIOs / ACMOs at the State level (Rs. 1000 * 2 meetings / year * 76 people)+ (Rs. 100 for supplies* 76 people)	159600	175560	State-RI-cell (TA by RI- Partners)	
2	one day training on AEFI & VPD- Surveillance for all the Medical Colleges in the state(Rs.500/-*25*8 Med College)	100000	110000	State-RI-cell (TA by RI- Partners)	
3	2 day Training of Medical Officers at the district levelRs. 60000 / district * 38 districts	2280000	2508000	District,(TA by RI-Partners)	**Increase in Budget as compared to budget requested in PIP submitted earlier to AC (UIP), GoI on 30th April 2007**
4	1 day Training of Computer Assistants & Health Managers of all blocks on UIP formats and reporting at the district level (Rs. 250 * 3 Per PHC * 533 PHCs)	399750	439725	District,(TA by RI-Partners)	**This Will ensure better RI-data handling at Block & district level and regularising the SOE Process.**
5	1 day Training & follow up for all District Health Mangers, Data Managers & Computer Assistants of DIOs **RIMS** at the state level. (Rs. 600 * 3 person each district * 38 districts * 2 such trainings)	136800	150480	PHC with TA by RI-partners	**This Will ensure better RI-data handling at ,district level and regularising the SOE Process in the state.**
6	1 day training of Cold Chain Technicians of WIC/WIFs at the state level (Rs 300 * 36 Person)	10800	11880	PHC with(TA by RI-partners)	

7	1 day Training of cold chain handlers (Rs. 220 * 2 days *1100 people) + (Rs. 55 for supplies*1100 people)	544500	598950	Sub-Division/District(TA By RI-Partners	
8	2 day Training of ANMs / Health workers on Immunization at the district level (Rs. 500 * 2 days *13000 ANMs) + (Rs. 100 for supplies*13000 ANMs)(including Alternate vacinators in both Rural & Urban areas)	14300000	15730000	PHC with(TA by RI-partners)	**The HW training will include 2000 alternate vacinators for both Rural & Urban areas, (This training is being assisted by the District Training Extenders hired by UNICEF)**
9	Muskan training for ASHA & AWWs at the block level (74313 ASHAs + 80211 AWWs) * Rs 150	23178600	25496460	PHC	
Total Training		**41110050**	**45221055**		
	AEFI-Strengthening -in the State				
1	Setting-up & training of state and district-AEFI- Committee Rs.2500/- *38 districts	**95000**	**104500**	**State-RI-cell**	
2	AEFI-investigation and sample shipment to the Lab,10 cases per District /year*Rs.2500/-	**950000**	**1045000**	**District**	
	Total AEFI expenditure				
-					
K	**RI cell**				
1	Hiring of Computer operator at state Rs. 7000 * 2 person * 12 months	168000	184800	State-RI-Cell	

2	Hiring of Computer operator at district level for RIMS Rs. 7000 * 1 person * 12 months * 38 districts	3192000	3511200	District	
3	Two computer systems along with printer for computer operators(two such),Rs 40,000/-*2	80000		State-RI-Cell	
Total RI cell		**3360000**	**3696000**		
L	**Hub Cutters and Pit Construction**				
1	Procurement of Hub Cutters	5100000	5610000	GOI	**Hub Cutters are very essential requirmen at the earliest , all across the sate, as most of the Hubcutters distributed before are completely defunct & needs urgent replacement keeping Vacine safety in mind**
Total Pit construction		**5100000**	**5610000**	**PHC**	
M	**Validation by third party**				
1	Third party validation of the RI program (Outsourcing of CES)	4500000	4950000	SHSB	**Planned by the state to Review immunisation coverage quarterly.**
Total validation		**4500000**	**4950000**		
N	**Catch up campaigns for Flood prone areas**				

1	Measles Campaign for pilot in select districts	1000000	1100000	District	**Last year selected areas in 13 districts had supplementary measles imminisation Campaign,in which 139219 children (9month to 10 years) were immunised in Bihar. In the coming financial year the campaign could be extended to cover a greater geographical area.**
2	Hard to reach areas strategy	9000000	9900000	District	**Most of Bihar, particularly Northern Bihar is prone to floods during the monsoon season from June to September. Often during the floods it is not possible to conduct any routine immunization activity. Catch-up sessions planned and conducted after the monsoon would ensure immunization of eligible children in these areas through re scheduling of sessions not held during floods.**

Total Catch Up		**10000000**	**11000000**		
O	**Immunization Weeks**				
1	Ice packs for special Immunization Weeks Rs. 3 / ice pack * 4 / ANM * 11000 ANMs * 6 days / week * 3 rounds	2376000	2613600	PHC	
2	IEC for the Immunization weeks Rs. 200000 / week * 3 rounds	600000	660000	SHSB	
3	Mobilization of beneficiaries during Special Immunization weeks Rs. 50 / session * 11000 ANMs * 4 days * 3 rounds	6600000	7260000	PHC	
4	Carrying vaccines from PHC to the session sites by use of couriers (persons with bicycle / motorcycle who delivers vaccines to session sites) during special Immunization weeks Rs. 70 / courier * 11000 ANMs * 4 days * 3 rounds	9240000	10164000	PHC	
5	Mobility Support for the Block during IW (Rs. 700/- per vehicle * 2 Vehicles Per PHC * 5 days * 533 PHCs * 3 rounds)	11193000	12312300	PHC	
6	(Mobility support for the Block for AEFI-investigation)				
Total Immunization Weeks		**30009000**	**33009900**		
P	**Contingency**				
1	Rs.10000 / year * 38 districts	380000	418000	District	

2	Rs. 7000 / year * 533 PHCs	3731000	4104100	PHC	
Total contingency for the year		**4111000**	**4522100**		
Grand Total		**855159930**	**940675923**		**Increase in Budget as compared to budget requested in PIP submitted earlier to AC (UIP), GoI on 30th April 2007**

IPPI

Particulars	For 1 Round	For 8 Rounds / Year
No. of H-t-H Teams	42400	339200
No. of Transit Teams	10396	83168
No. of Mobile Teams	1512	12096
No. of Mela Teams	400	3200
Total No. of Team	54708	437664
One Man Teams	519	4152
No. of Supervisor	15448	123584
No. of Sub-Depot	4106	32848
No. of Vaccination Areas	484	3872
No. of Districts	38	304
Actifity Days (A-Team - 5 Days and 1 Day B-Team)	6	48
Per Diem to Vaccinators @ Rs. 50 per day per Vaccinators for actual working day	29744600	237956800
Per Diem to Supervisors @ Rs. 75 per day per Supervisor for actual working day	5793000	46344000
Per Diem to Cold Chain Handler per sub-depot 1, @ Rs. 50 per day for actual working day	1026500	8212000
3 Vehicles per district HQ for 6 Days and 1 vehicle per sub-depot for 5 days @ Rs. 650 per vehicle per day (hiring with POL)	13789100	110312800
4 Ice Packs per Vaccination team / Supervisor & 20 Ice Packs per Sub-Depot / Depot per day @ Rs. 3 per Ice Pack for 5 days & Rs. 3000/ for HQ	5586300	44690400
Mobility support to Supervisors @ Rs. 70 per day per supervisor for actual working day	5406800	43254400
Supplies & Logistics @ Rs. 25 per team & per Supervisor for the whole activity period	1766875	14135000
IEC & Social Mobilization (1 PA system per 10 H-t-H teams for 4 days) @ Rs. 350/- per PA system per day	5936000	47488000
Mobility Support to PHC by means other than Vehicles	50000	400000
Contingency fopr Xerox, Stationery etc. for Dist HQ Rs. 3000/- & for each PHC @ Rs. 1750/-per area for the whole activity period	961000	7688000
Per Diem to Vaccine Cold Chain Handler at Dist. HQ 5 person & at PHC 3 person(including 1 depotholder) @ Rs. 50 per person per day for 5 days	410500	3284000
Support to districts @ Rs. 2000 per dist & @ Rs. 1000 per PHC for lifiting vaccine from WIC/District	560000	4480000
Support to WIC for maintenance, vaccine transport from PHI Patna & payment of per diem to 2 vaccine handler @ Rs. 50 per day for 7 days	150000	1200000
Total A-Team Activity (in Rs.)	**71180675**	**569445400**
Orientatuion Training of Supervisor, Vaccinators and Cold-Chain Handler @ Rs. 20/- per Participant	2622620	20980960
IEC Banners & Posters per round	4657160	37257280
Total Amount for B-Team	7681289	61450312
Support to State Level IEC	760000	6080000
Purchase of Marker Pen for Vaccinators/Supervisors/Monitors etc.	1800000	14400000
Grand Total Amount (A-Team+B-Team)	**88701744**	**709613952**

Partners' contribution in Routine Immunization Strengthening

A. Strengthening of the State Routine Immunization cell:

The State Program Officer Immunization would be the overall coordinator of the RI cell and would be aided for techno managerial support by the State Routine Immunization officer-NPSP-WHO and the Senior Routine Immunization Consultant, Unicef.

Coverage as well as monitoring data pertaining to all aspects of Immunization would also be collected, collated, analyzed and acted upon at the RI Cell.

Unicef SMNET would arrange for about 210 persons to monitor Immunization sessions and activities whereas NPSP would arrange for around 300 persons. It was estimated that 38 District immunization officers, about 1000 Medical officers, 500 health managers and around 500 Child development project officers and supervisors would also monitor the Immunization sessions to evaluate Muskaan ek abhiyaan. These personnel would also be suitably trained from time to time by Unicef and NPSP.

B. Review meetings for Strengthening Immunization

Weekly meetings scheduled on Monday evenings would be organized to evaluate progress in Immunization activities, discuss future actions and plans and decide future strategies. This meeting would be chaired by the Executive Director, State Health Society and participated by the SPO-I and Representatives of NPSP WHO and Unicef.

Monthly meetings for all District Immunization officers would be organized by and at the State Health Society to review progress of Immunization strengthening activities, particularly Muskaan Ek Abhiyaan at district level. Child Survival Coordinators of Unicef would also participate in these meetings.

Divisional level meetings involving Medical Officers' in charge of various Hospitals and Health Centres would be organised on a half yearly basis. The initial set of meetings organised by the State Health Society would be to review "Muskaan ek Abhiyaan" progress at sub district level and the second round organised by Unicef would be to equip mid level managers of current knowledge and skills pertaining to Routine Immunization. NPSP WHO would be providing technical support in these meetings.

C. Printing of Formats and IEC material related to Immunization activities

The monitoring formats for sessions and trainings would be arranged to be printed by Unicef. Unicef would also arrange to provide flex scroll banners to be put up at Immunization sites, Tin plates in health sub-centres and hoardings at major Intersections at district level.

D. Special Immunization strategies

1. **Muskaan ek Abhiyaan**.

Unicef and NPSP WHO would facilitate orientation and training of workers, development of new micro plans for this campaigns in all PHCs .
Unicef would also facilitate the compilation and computerization of all micro plans.

2. **Special efforts in Difficult to Reach Areas:**

Strategies for difficult to reach and multi district border areas would be planned and executed at local level by involving local staff and officers of multiple districts and concerned persons of partner agencies involved in immunization. Both NPSP and Unicef would support this endeavor through planning and monitoring support.

2. Urban Outreach vaccination .
Unicef and NPSP were to participate in the processes of micro plan preparation and training of alternate vaccinators of Urban areas at district level.

E. Setting –up the AEFI & VPD Surveillance System in the State :-
Based on the Standard Operating Procedures on AEFI, & the letter of instruction /detail guidelines from GOI, it has been agreed upon by the State Steering Committee to constitute a state AEFI- Committee and the respective District AEFI committees which will deal with any AEFI's, reported in future from the Districts . In addition there will be a State level AEFI-Workshop for all the DIO's in the Middle of- 2008 with technical Support from NPSP/WHO & UNICEF to establish the surveillance system..

F. MIS Strengthening through operationalization of RIMs

NPSP would procure the current software and arrange for the training of state and district data operators and assistants on its use. Child Survival Coordinators of Unicef would follow up the setting up of Routine Immunization data centres at the District Immunization offices.

G. Health Workers training on Routine Immunization

Unicef has deployed District training extenders to facilitate the training process and ensure its quality. It was decided that this support would continue till the health workers' trainings were completed that would be over tentatively by the end of June 2008.

Moreover, new contractual ANMs (Rural) had been recruited throughout the state and the process of identification and hiring of Alternative vaccinators (Urban) was soon to be started. Similar training would also be given to them and the same support would be given by partners.

H. Cold chain repairs and Management of vaccine stocks

Unicef was requested to evaluate the feasibility and success of getting the vaccine carriers repaired locally until the procurement of new equipment could be worked upon.

Unicef would also initiate the training of Child Survival Coordinators and several District Immunization officers and cold chain handlers to effectively manage vaccine stocks and logistics.

I. Coverage Evaluation Survey

Unicef and NPSP WHO filed level officials wouldto monitor the training of surveyors and the survey process itself to ensure its quality.

Time line for key activities.

Key activities	**Tentative time line (end of month)**
Regularizing vaccine availability **E**stablishment of proper inventory and vaccine logistics management at every level	Has been happening since July 2005, and it would continue through 2008-09.
Foolproof Vaccine movement arrangement in place (and communicated to every level by government order) in terms of funds and proper guidelines at every level to move vaccines on fixed days every quarter, every month, and every week (depending upon the level) – vehicle/vehicle hiring/POL	Already Established such a system which is working well
Support for electricity back-up in terms of generators, fuels or funds to outsource	Already happening since August 2005 will continue through 2008-09

power backup, specially at PHC levels – system in place as Government Order and communicated to every level	
Regularising ADS and needle cutter availability **F**oolproof ADS and needle cutter movement arrangement in place (and communicated to every level by government order) in terms of funds and proper guidelines at every level to move ADS and needle cutter on fixed days every quarter, every month, and every week (depending upon the level) – vehicle/vehicle hiring/POL	Already happening, would maintain a buffer of 3 months (minimum at state level as well as at the regional level)
Fund flow to districts	Has been regularized and is being timely disbursed
Availability of staff – ANMs	Contractual ANMs are being hired as a continues process as per availability and they are being trained also
WIC revamp **N**ew WIC installed **C**old box supply **E**lectrical equipment supplied **P**roper cold chain inventory and logistics management system developed and in place **C**old chain annual maintenance contract	Happened in 2005,new WIC rinstalled in Motihari in 2007, Saharsa and Nalanda installation by 2008- 200subject to availability of equipment.. Supply subject to availability. Some done in 2005, need the others by 2006 Regularised by May 2006 In place since 2007, continuation in 2008-2008
Monitoring and supervision starts at PHC level District level Regional level State level	happening – needs qualitative- improvement happening – needs qualitative-improvement Immediately – needs quality improvement – checklist based
Printing of registers and checklists, forms	On a half yearly basis.
Training	Ongoing, continuous process in batches- expected completion July 2008
IEC **D**esigning **F**ree space at district headquarters to erect big hoardings on RI **C**ontracting out constructing steel frames for the hoardings	Ongoing process
Review meetings	Already happening at every level

VITAMINE A

PIP: 2008-09

Background

In its preamble the National Rural Health Mission (NRHM), seeks to improve access of rural people especially poor women and children, to equitable, affordable, accountable and effective primary health care. The broader vision of NRHM coincides with the RI and Vitamin A plus strategy and the objective of improving the general health status of the society by investing in child's health and by improving the survival and protection of the most vulnerable population.

The 10th 5 year plan of Government of India has the following goals:

1. Achieve universal coverage of 5 doses of Vitamin-A
2. Reduce the prevalence of night blindness to below 1% and Bitots spots to below 0.5% in children 6 months to 6 years age.
3. Eliminate Vitamin-A deficiency as public health problem.

The National Policy Guidelines on Vitamin-A Supplementation Program of MoH&FW, GoI recommends that children of age group 9 months to 5 years should receive two doses of Vitamin at 6 months interval which is considered adequate. These months would have intensive activities during which it was suggested that health sub-center level workers in close coordination with the ICDS workers and ASHAs will deliver services in the given month as per detailed micro-plans.

This recommendation is in line with the globally used REACH strategy i.e. Regular Events to Advanced Child Health which focuses on providing contact points for delivery of child friendly health services to pre-school children. The strategy of Biannual Vitamin-A Supplementation as the driver of Child Health Package of services could be an integral part of the package of NRHM driving the sessions forward.

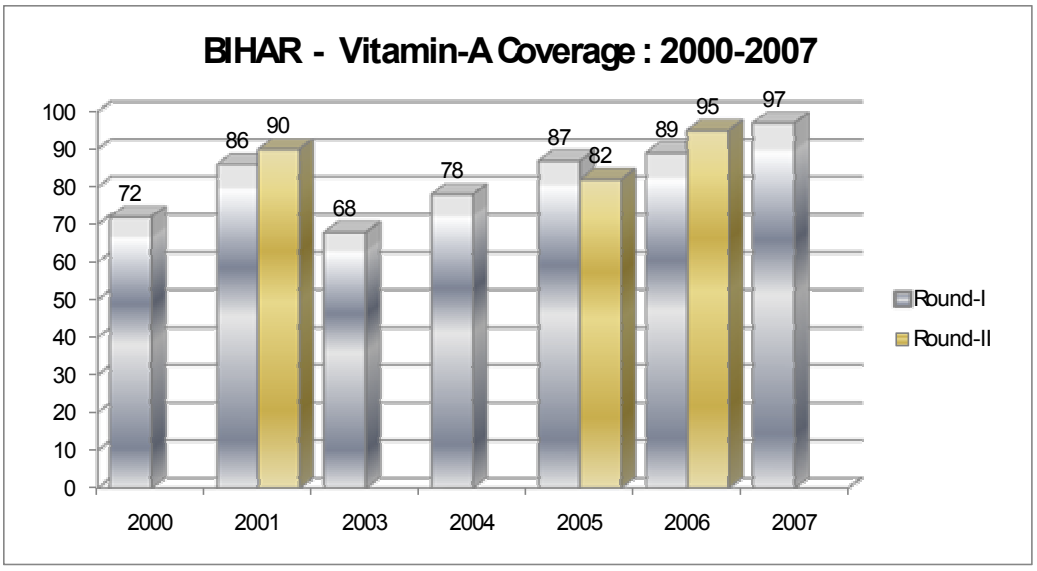
The Vitamin-A Supplementation program in India has entered a new era where many states are administering Vitamin-A during month long integrated bi-annual sessions held usually in April / May and October / November. This decision was based on the National Workshop on Micronutrients organized by ICMR on the 24-25 November 2003 which recommended that Biannual Child Health and Nutrition Promotion Months be held, six months apart which would offer a package of child health & nutrition services of which Vitamin-A supplementation of target children would be an integral part.

The Problem Statement

Vitamin and mineral deficiencies are a major public health problem in India, and in the State of Bihar, where the Infant Mortality Rate is 61 and the Under 5 Mortality Rate is 82 per 1000 live births (Source: SRS April 06) which is very high. The data on prevalence of Vitamin-A Deficiency is scant but Bitot spots in up to 7.1% children (IJMR 122, Sep 05, pp265-267) 4.7% in another study (ICMR 2002) have been reported which is way above the WHO cut of criteria of 0.5% for defining Vitamin-A Deficiency as a public health problem. Vitamin-A plays an important role in preventing nutritional blindness and in reducing childhood morbidity and mortality particularly from measles and diarrhea; contributing significantly to child health and survival (IVACG Policy Statement, 1989).

The Statement of Objective

The biannual round initiated in the year 2000-'01 by the Government of Bihar has met with success. The last reported coverage of children with 2 doses in a year was 75.32% (Source UNICEF ICO). Coverage of 97 % (Children: 9 months – 3 years) was achieved during the VAS Round -2007. The programme is targeted to approx.14 million children in the age-group of 9 months to 5 years in 38 districts in the forthcoming round and it is expected that at least 95% of them would be benefited.



This above is indicative of the fact that the programme in Bihar is functioning well and if it continues to improve and cover more than 85% of children on a sustainable basis with 2

doses a year than we can expect significant gains of reductions in Vitamin-A Deficiency and in turn in Under Five Mortality Rates (U5MR) over time.

Biannual Child Health Package of Services

1. **Vitamin-A Supplementation:** Provide prophylactic dose of Vitamin-A solution to all children between 9 months to 5 years. The recommended dosage schedule is as under:
   a. The 1st dose 1,00,000 I.U. (1 ml or half spoon) is given with routine measles immunization at 9 months completed age;
   b. The 2nd dose 2,00,000 I.U. (2ml or full spoon) is given with first DPT/OPV booster (16-18 months) and
   c. The next 7 doses (each dose 2 ml or full spoon) are given after every 6 months up to 5yrs of age.
2. **De-worming:** Worm infections contribute to Vitamin-A deficiency. De-worming reduces anemia which in turn is associated with Vitamin-A deficiency and leads to malnutrition. Tablet/ Syrup Albendazole is safe, needs single dose and are simple to administer. The doses of Albendazole are ½ dose 5ml syrup for children age-group 1-2 years and full dose 400 mg tablets for 2-5 years children. The adolescent girls (11–18 years) are the most vulnerable group suffering from anemia and are targeted to receive de-worming tablets (400mg) under life-cycle approach. It will further address the inter-generational malnutrition issues and attempt to break the vicious cycle of malnutrition.
3. **Promotion of Breast feeding and timely introduction of complementary feeding :** Accelerating community participation and BCC on components of breast-feeding, i.e.
   a. Early Initiation
   b. Exclusive Breastfeeding
   c. Introduction of Complimentary feeding at the age of 6 months
4. **Catch Up Measles Immunization:** Emphasis on immunizing all children attaining 9 months of age with first shot of measles vaccine.
5. **Piloting Zinc Supplementation for management of Diarrhea:** Organizing State level Stakeholders meeting and piloting the Zinc Supplementation in 2 districts through campaign mode.

Program Implementation

I. **Micro-plans** need to be updated, revised and refined to include all villages/hamlets under a health sub-center area as per the GoI guidelines. The primary unit for developing / revising micro-plans would be the health

sub-center level. PHC Medical Officer would provide the overall leadership for developing the health sub-center micro-plan. The Sector MOs needs to compile the sub-center micro-plans and send to the Medical Officer i/cs, who in turn compiles the micro-plans for all the HSCs in the block and sends to the district level.

- **Health Sub-center level***:* wherever possible, the sub-center micro-plans could be developed during the joint sector level meetings of AWWs, ANMs, ASHA trainers and ASHA. These meetings are ideal opportunities for categorization and prioritization of villages and planning for identification and mobilizing left-out / drop-out children. The supervisory level of ICDS should also be used to develop sub-center micro-plans. Village level functionaries and volunteers (ASHA, change agents, other volunteers) and PRI members (Village Health Committee) should also be involved in this process. Once the micro-plans are finalized, these should be shared with the AWWs, ASHA and PRI members. It is appropriate that the ANM shares the micro-plan during panchayat level meetings (Gram Sabha).

- **PHC level:** through the joint efforts of Health (LHV, Male Supervisor) and ICDS staff (Lady Supervisors). Support of any other relevant partners active in the block, such as NGOs, Industries, private providers, Panchayats, etc. could be mustered. At this level the micro plans needs to be compiled by MO i/c, shared with the CDPO and sent to the district level.

- **Urban areas:** intensive resource mapping and micro-planning is required to implement the urban health intervention. Identification of stakeholders and service providers in urban agglomerations, slums, notified areas and in migratory population would be the focus areas to prepare the micro-plans.

II. **Inter-sectoral Coordination and Convergence** among other government departments is crucial for generating demand and effective monitoring and supervision. These departments include ICDS, Education, Rural Development, Urban Local Bodies, Panchayats, NGOs, private and public sector institutions such as Railways, Industries, Mines, etc. would yield high dividends in terms of improved visibility and coverage. Administrative commitment and leadership at district levels are critical to the success of the initiative. Continuous involvement of the districts (particularly District Magistrate, CS-CMO, District Immunization Officers, District Programme Officer) is vital for the program.

A district task-force of VAS could be constituted under the aegis of the DM to plan, implement, review and direct the program at regular interval. Vehicles at districts and blocks could be pooled to monitor and supervise the biannual rounds.

III. **Urban Strategy**: Urban areas have low coverage rates as compared to rural areas. Immunization services are delivered through multiple providers, with a predominant role played by the private practitioners and hospitals. Careful planning and coordination among all players is critical for sustained improvements in the immunization program in urban areas. A Nodal officer should be identified to coordinate activities in the urban areas. The catchments area under each health facility should be clearly defined and sessions have to be continued at the same sites during subsequent Immunization days.

IV. **Capacity building of the Service Providers & Program Managers** is an ongoing process to add value to the quality of services and improve the delivery mechanism. Orientation on technical and managerial issues of the Vitamin-A supplementation program is required during the weekly meetings at the PHC level and the program managers could be sensitized during monthly meetings at the district level. Special refresher sessions are required to be organized at least a fortnight before biannual rounds.

V. **Management Information System** needs to be in place to evaluate and monitor the program concurrently. The reporting and recording formats & registers should be made available in required nos. at the site, HSC, PHC and district. The Jaccha-Baccha Raksha (MCHN) Cards could be used as a tool to record, monitor and validate the coverage reports. Orientation of service providers and the persons handling the reporting tools should be organized to streamline the MIS in the state. The coverage reports should be analysed and shared with the program mangers to identify the gaps and focus the activities to improve the coverage.

VI. **Logistics & Procurement**: Need assessment of Vitamin-A solution is a major exercise to be taken up just after the biannual round to estimate the requirement of Vitamin-A bottles for the next round. The procurement of Vitamin-A syrup could be done out of the flexi-pool funds available at the state level.

VII. **IEC / BCC**: Sensitization and Awareness generation on Vitamin-A for the family and the community has a far reaching impact on the program. Food fortification & dietary diversification including messages to promote consumption of locally available vegetables, fruits and other food items -rich source of Vitamin-A could be the addressed to the families through the mix

& match of different tools of BCC. The demand for the Vitamin-A syrup could be generated by adopting appropriate communication techniques, e.g. Interpersonal communication, Print & Electronic media, Posters, Brochures, Pamphlets, Banners-Flexes, Nukkad-Nataks, Hoardings, Wall-writings, Miking, Playcard-Rallies, Prabhat-Pherrys, etc.

VIII. **Community Participation**: It is important to put extra effort to seek community participation for the Vitamin-A Supplementation programme so that the program has the support and sustainability at the field level. The support of members of Village Health Committee, PRI, SHG, Mahila Mandals could be involved at the immunization-sites, HSC and PHC levels to provide the programmatic and logistic support during the round and would be of great help to the service providers in providing services to the hard to reach areas. The left out children could be located and covered with the help of the community.

IX. **Program monitoring and Review**: The monitoring of Vitamin-A Supplementation activities i.e. Vitamin-A supplementation sessions, Social Mobilization, display and use of IEC material, recording and reporting will be primarily carried out by supervisory level field functionaries of health and ICDS, PRA members and field extenders of UNICEF and MII. A monitoring plan will be prepared by MO I/cs and a monitoring format will be used during field visits to observe the sessions. The state level official from State Health Society and ICDS Directorate shall coordinate with district level health & ICDS officials to broadly monitor supplies, trainings and organize concurrent reviews.

The Program Partners

UNICEF being a body of United Nations is dedicated to provide support on technical and programmatic issues related to the Child Health Package of Services including Vitamin-A Supplementation in the state of Bihar. The Child Development and Nutrition Division headed by the Nutrition Specialist having a network of 38 District Field Monitors placed one in each district to coordinate at all levels and ensure the implementation of service delivery. UNICEF has been providing technical and managerial support to meet gaps in micro-planning, IEC, MIS tools, monitoring, training, need assessment, etc in coordination with Micronutrient Initiative (MI).

Micronutrient Initiative (MI) is a not for profit international organization devoted to the cause of children through elimination of vitamin and mineral deficiencies worldwide. MI is providing technical and strategic support to the VAS programme in the state through a State Technical Consultant and 9 Divisional level Consultants. The MI also provides programme support by

way of social mobilization, urban area strategy formulation and also coordinates with to technically support, orientation and training of service providers and stakeholders, concurrent monitoring, data analysis, mobilization, etc.

VITAMIN-A SUPPLEMENTATION PROGRAM : BIHAR

PIP FOR BIANNUAL VAS ROUND : 2008 -'09

Sl.No.	Activities	Unit	Total units	Unit cost for 1 Round @ Rs.	State Budget in Rs.
1	2	3	4	5	6
I.	**Micro- Planning**				
	Orientation, Stationary, Data compilation, Validation, Up-dation and Mobility cost	537 ICDS/PHCs & 139 Urban/ Municipal/ Notified area	676	1000	676,000
II.	**Inter-sectoral Co-ordination and Convergence**				
	Constitution of State and District level Task Force, and organizing meetings of District coordination committee	38 Districts	38	6000	228,000
	Constitutions Task Force, and organizing meetings of Block coordination committee	537 ICDS/PHCs	537	1000	537,000
III.	**Urban Health Intervention Strategy**				
	Strategy Planning Meetings, Orientations of Stakeholders & Volunteers, Resource Planning, Site-management	139 Municipal / Notified Area	139	5000	695,000
IV.	**Capacity Building of Service Providers & Program Managers**				
	Orientation, Workshops, Development and Production of Training manuals, Guidelines, FAQs, Refresher programs	80211 AWWs / ASHAs, 10649 ANMs, 533 MOs/BHMs & 537 CDPOs,	575	50000	28,750,000

		38 DIOs/DPMs			
	Honorarium to Volunteers, AWWs, ASHA to function as service provider	80211 AWWs/ASHAs/ and 10% of AWC-Volunteers	88232	100	8,823,210
V.	**Management Information System for Monitoring VAS Program**				
	Availability of Immunization cards [JBR Cards (**Green**)= **75,63,000** cards + Children 3-5yrs (**Orange**)= **67,23,000** cards], Reporting Formats, Record & Registers, Data analysis, Evaluations and concurrent Monitoring	537 ICDS Projects (inclusive of 533 PHCs) & 38 Districts	575	5000	2,875,000
VI.	**Logistics and Procurement**				
	Need Assessment and Procurement of Vitamin- A Syrup [Children (9m-1yr =8,40,000) + (1-5yrs = 13446000) = 1,42,86,000 children]	2,75,000 VA bottles	274,737	52	14,286,220
	Need Assessment and Procurement of De-worming Tablets (Dose: 400mg.) Children (2-5yrs)+ Ado Girls(11-18 yrs)	10,084,456 children(2-5yrs) + 10147236 Adolescent Girls (11-18 yrs)	20,231,692	0.461	9,326,811
	Mobility Support to Districts & PHCs for logistic management of Vitamin A and other programme related material.	537 ICDS Projects (inclusive of 533 PHCs) & 38 Districts	575	3000	1,725,000
VII.	**BCC/IEC**				

	Awareness & Sensitization Workshops, Posters, Banners, Flexes, Nukkad-Nataks, Wall-writings, Hoardings, Rally with Play-Cards, Phamphlets, Brochures, Print and Electronic Media, etc.	80211 AWCs, 537 ICDS/ PHCs, 139 Municipal /Notified Urban Units	80887	100	8,088,700
	Breast-feeding Promotion activities: Inter-personnel counseling, BCC activities	80211 AWCs, 537 ICDS/ PHCs, 139 Municipal / Notified Urban Units	80887	100	8,088,700
	Management of Diarrhea with ORS & Zinc: Pilot Project in 2 districts BCC & other planned interventions	36PHCs 8 Municipal /Notified area in 2 Districts	44	10000	440,000
VIII.	**Community Participation**				
	Orientation of PRIs, SHG Groups, Village Health and sanitation Committees, Mahila Mandals, etc.	80211 AWCs, 537 ICDS/ PHCs, 139 Municipal /Notified Urban Units	80887	100	8,088,700
IX.	**Program Monitoring and Review**				
	Planning Meetings for Monitoring, supportive Supervision, Reviews and related activities; Monitoring Formats, Data-entry, Data- Analysis, etc.	537 ICDS Projects (inclusive of 533 PHCs) & 38 Districts	575	1000	575,000
	Mobility Support : Hiring of Vehicles & POL	537 ICDS Projects (inclusive of 533 PHCs) & 38 Districts	575	10000	5,750,000
	TOTAL				**98,953,341**

Expenses on conducting 1 Biannual Round = Rs. 9,89,53,341

Expenses on conducting 2 Biannual Rounds = Rs. 19,79,06,682

NRHM PART D

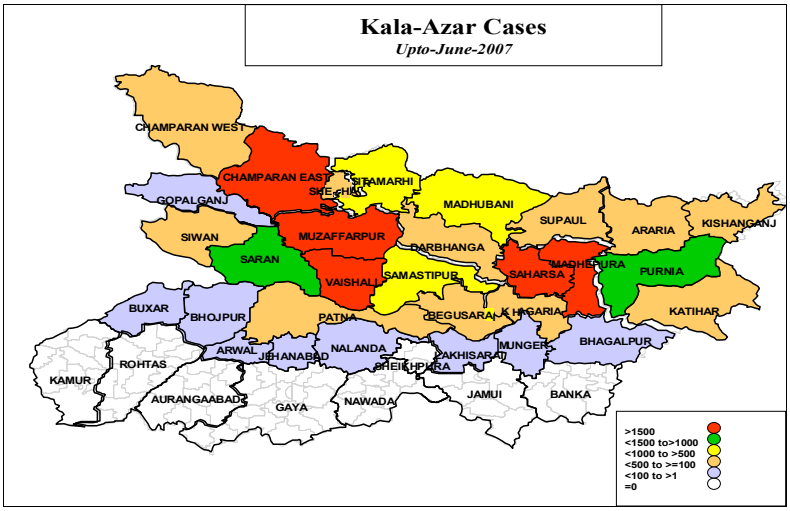
KALA-AZAR

KALA-AZAR

Kala-Azar is endemic in 31 districts of Bihar. High prevalence is seen in the districts of Gangetic plain areas. Population of 7.2 Crores in the State is at risk of the disease

Profile of Bihar

Bihar is located in the Central-East of India. It has a land with a covered area of 94,163 sq. km. It is mainly divided into two regions known as North of Ganges, and South of Ganges regions. The State is geographically classified into 38 districts and 72 sub-divisions and 533 blocks. The population of Bihar as per 2001 Census is 828.8 million with an urban population of 8681800 as the density population per sq. Km. is 880 against national figure of 324. There are 32 towns with a population of 50,000 or more and having about 40,000 villages in the state. The present sex ratio is 919 females per 1000 males (India Figure 933). The total literacy rate is 46.4%. It is mainly a rural inhabited state. The percentage of rural population is 66.08 % against India's population of 72.22%.



Total number of Cases reported in 2006 was 30,000 approximately. In the year 2006, DDT Spray was conducted in 27 districts of Bihar covering a population of approximately 5 Crores. 42 % was protected by IRS. In the year 2007, IRS was conducted in 31 districts of Bihar covering 7.2 Crores population. Coverage was approx. 92 %.

Drug availability in the state has improved considerably. All the Govt. Hospitals are equipped with anti Kala-Azar drugs

Table 5: National Anti Malaria Programme (NVBDCP):- Staff Position

Sl.No.	Name of the Post	Sanctioned Post	Posted	Vacant
1	Chief Malaria Officer (SPO)	1	1	-
2	Assistant Director (Kala-azar)	2	2	-
3	Zonal Malaria Officer	4	4	-
4	District Malaria Officer	24	21	**3**
5	Assistant Medical Officer	24	1	**23**
6	Entomologist	1	0	**1**
7	Assistant Entomologist	3	0	**3**
8	Office Superintendent cum Accountant	1	0	**1**
9	Clerk	77	41	**36**
10	Steno-typist	3	2	**1**
11	Malaria Inspector	151	134	**17**
12	Lab. Technician	402	49	**353**
13	Basic Health Worker	1325	108	**1217**
14	Basic Health Inspector	346	132	**214**
15	Surveillance Inspector	113	28	**85**
16	Surveillance Worker	442	54	**388**
17	Motor Mechanic	24	9	**15**
18	Motor Driver	53	12	**41**
19	Insect Collector	8	2	**6**
20	Superior Field Worker	48	22	**26**
21	Field Worker	110	44	**66**
22	Peon	55	21	**34**
23	Motor Cleaner	48	13	**35**
24	Sweeper	24	12	**12**
Total		**3289**	**712**	**2577**

Table 6: Spray Coverage During 2003 to 2007

Type of insecticide	Year	Round	Population		
			Targeted	Coverage	%
D.D.T	2003	Special	2493977	2268043	90.9
		Focal	29356	29527	99.6
	2004	I	4680461	4411928	94.26

		II	5981707	5834102	
		Focal	22755	22480	
	2005	I	12891995	12206008	
		II	1028398	987355	
		Focal	177130	174315	
	2006	I	52301680	24308788	46.48
		II	Spray not done		
	2007	I	7.2 Crore	6.627	92.00

Table 7: Relation between detected cases and deaths under KALA-AZAR program

Grand Total	1997		1998		1999		2000		2001		2002		2003		2004		2005		2006	
	Cases	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*
15415	251	11837	214	10374	239	12694	127	10029	203	9505	158	13960	189	17324	115	23383	125	29711	162	

Following activities have been done in KALA-AZAR Eradication program

1. **Early Diagnosis & Complete treatment:** From 2-17th January 2006 and 1-15th December 2006. Drugs are supplied by GOI. Till now 1, 47,012 vials of SAG and 74,414 vials of Amphotericin – B has been supplied to the districts. Miltefocine & Ambisome new drugs introduced in the State. Keeping in view short supply of Amphotericin – B, rate contract of the same has been done by SHSB. Districts have been authorized to purchase Amphotericin – B and SAG as per the requirement of districts and Medical colleges.
2. **Preventive measures –** DDT Spray in April - July 2006 among 27 districts, coverage was 42% however from February – May 2007 – in 31 districts the coverage has improved to 92%. Pre and Post vector density estimation being done by RMRI – Funds were provided to the Institute.
3. **Training to Health Functionaries** (32000) by Rajendra Memorial Research Institute, Patna in January 2007. Fund was provided to the Institute.
4. **Other Initiatives –**
   - » Daily reporting of coverage is obtained telephonically
   - » State level Task Force Constituted
   - » K-39 rapid diagnostic kits for Kala-azar introduced in 16 high endemic districts

- » All the Kala-azar cases are being provided cash assistance of Rs. 50 per day as compensation to loss of wages. This is being provided through funds available with the Rogi Kalyan Samiti
- » All the Kala-Azar cases and one attendant to be provided diet during the period of hospitalization
- » Pukka houses for Mushar Kala-azar patients in 216 identified villages of high endemic districts

Future Preventive Measures

As per directives of the Government of India and NVBDCP, a new strategy has been developed for subsequent rounds of IRS. Village level data of Kala-azar endemicity has been compiled and in addition to 9 high endemic districts, 7 more districts have been identified. Villages of the districts have been divided in to certain categories depending upon number of cases reported during the last 3 years. High focused IRS is been planned in the high priority villages to contain the diseases spread. A micro plan based on this revised strategy has been developed and submitted to NVBDCP for approval.

For other districts where cases are being reported, all the cases will be covered by focal spray. Capacity building in form of community participation has been planned, and a proposal for the same is being submitted. Based on the past experiences of IRS, special emphasis has been given on the part of monitoring and supervision. Monitoring from state level to districts level and PHC level has been planned.

Table 8: KALA AZAR Budget summary for the FY 2008-09

A.	IRS - First Round		Budget
1	No of districts	16	
2	No. of PHC	141	
3	No. of Villages	1278	
4	Population to be covered	5800000	
5	Estimated Expenditure		11200000
B.	IRS – Second Round		11200000
C.	Focal Spray in other affected areas for approximately 25000 cases @ Rs.536 per case		13400000
D.	Capacity Building and related activity of link workers		13000000
	(i) Training of Health functionaries		
	(ii) Training of Spray workers		
	(iii)Training of Mushar community		
E.	State level expenditure for hiring vehicle/POL/Contingency/storage of DDT		2600000
F.	Hiring of vehicles for 31 DMOs @ Rs.10000 pm		37200000
G.	Drugs		50000000
G.	IEC (Twelve Kala-azar Search fortnights @ Rs.80,00,000 * 12)		9600000
	Total		148200000

FILARIA & MALARIA

Elimination of Lymphatic Filaria – Filaria is a debilitating disease of major health importance. It entails immense personal trauma to the affected persons and is also associated with social stigma. The National Health Policy (2002) envisages elimination of Lymphatic Filariasis in India by 2015.

This Vector Borne disease is prevalent in all the 38 districts of the state. The estimated population at risk is 7.5 crore. The prevalence of this disease is more in the districts located in upper gangetic northern part of the state & sub Himalayan Terai region.

The details of the persons examined for micro filaria and the micro filaria rate in the state during the period 2000 to 2006 is shown in the following tables.

Table 9: Under Filaria Control Programme, targeted Night Blood Sample Collection is 6, 75,000 year wise:

Year	Target	Achievement	MF+	No. of Patient	Treated	% of Achievement
2000&01	675000	403000	1707	5680	7387	51.12%
2001&02	675000	407539	1260	3107	4367	58.39%
2002&03	675000	411076	2216	4497	6713	60.90%
2003&04	675000	381523	427	3059	3486	56.52%
2004&05	675000	342078	408	4092	4495	50.67%
2005&06	675000	389194	464	6212	6676	57.65%

To achieve the goal set by GOI for elimination of lymphatic filariasis, the state has initiated Mass Drug Administration in all the 38 endemic districts in the year 2004.

The State could not achieve the desired coverage of MDA in 2004 due to lack of motivation of the PHC staff at field level. This matter has been sorted out by issuing necessary administrative order after the MDA 2004 round.

During 2005, the desired 85% coverage was nearly achieved by the state under MDA. It can be seen in the following table.

The 2006 round had been deferred due to the non availability of DEC tab. from GOI. The MDA program had been rescheduled from 29th to 31st of May 2007 after procurement of DEC Tab. from Government of India. The programme was launched successfully.

Table 10: Provisional report of Mass Drug Administration 2007 round: Mass Drug Administration (MDA '07) Coverage: 28 Nov. 2007

Sl N.	**Name of the Districts**	**Date(s) of MDA**	**Total Population of Districts**	**Eligible Population for MDA**	**No. of People received Drug**	**Covered Population**	**% Coverage**
1	Araria	28th – 30th	2379520	2011540	1715475	1715475	85.28%
2	Arwal		630726	576196	552792	552792	95.94%

3	Aurangabad	Nov. 07	2325137	2092623	1875743	1875743	89.64%
4	Banka		1757632	1625908	1421227	1421227	87.41 %
5	Begusarai		2583916	2196329		0	NR
6	Bhabhua, (Kaimur)		1453379	1023583	894931	894931	87.43%
7	Bhagalpur		2645279	2177494	2001558	2001558	91.92%
8	Bhojpur		2505895	2207470	1999952	1999952	90.60%
9	Buxar		1512838	1344274	1195566	1195566	88.94 %
10	Darbhanga		3486960	2330810	2909758	2909758	92.09 %
11	Gaya		3759756	3571769	2907104	2907104	81.39%
12	Gopalganj		2305641	2089301	1745913	1745913	83.56%
13	Jahanabad		1127119	1015398	681983	681983	67.16%
14	Jamui		1621070	1421846	1303207	1303207	91.66%
15	Katihar		2638238	2242502	1668275	1668275	74.39 %
16	Khagaria		1431394	1303437	1096109	1096109	84.09%
17	Kishanganj		1542914	1098224	957045	957045	87.14%
18	Lakhisarai		950363	845823		0	NR
19	Madhepura		1720296	1460665		0	NR
20	Madhubani		4065022	3205176	2862737	2862737	89.32%
21	Munger		1250145	961129	787045	787045	81.89%
22	Muzafferpur		4192294	3398942	3058699	3058699	89.99%
23	Nalanda		2686588	2365816	1900168	1900168	80.32%
24	Nawada		1923876	1895408	1662405	1662405	87.71 %
25	W.Champaran, (Betiah)		3241186	2657401	1667405	1667405	62.75 %
26	Patna		5030781	4296966	3682162	3682162	85.69%
27	E.Champaran, (Motihari)		4622657	3698125	3261837	3261837	88.20%
28	Purnea		2771865	2633272	2257858	2257858	85.74%
29	Rohtas, (Sasaram)		2629431	2348762	1521086	1521086	64.76%
30	Saharsa		1724651	1554136	1318880	1318880	84.86%
31	Samastipur		3493203	2736759	2391149	2391149	87.37%
32	Saran		3536621	3094056	2456826	2456826	79.40%
33	Sheikhpura		607453	571006	352838	352838	61.79 %
34	Sheohar		573042	475624		0	NR
35	Sitamarhi		2912138	2358029		0	NR
36	Siwan		2708846	2344474		0	NR
37	Supaul		1923975	1673081	1513460	1513460	90.46 %
38	Vaishali		2771960	1916226	1579647	1579647	82.44%
	Total		**91043807**	**77648591**	**57200840**	**57200840**	**73.67 %**
NOTE - NR - Not reported							

<u>Mass Drug Administration (MDA)</u> :-

The strategies for Lymphatic Filariasis elimination are annual Mass Drug Administration (MDA) for 5 years or more for the eligible population to interrupt transmission of disease. During the year 2006-07, Mass Drug Administration with annual single recommended dose of DEC for Elimination of Lymphatic Filariasis has planned for implementation in all 38 districts with total targeted population of 7.5 crores.

Strategies : Mass Drug Administration campaign has been launched broadly under three strategies:-

(1) 1. IEC – This is the mainstay of our program, in which a massive IEC campaign is to be launched through Print Media, Electronic Media & Radio.

District Level –

a. Wall painting
b. Banners
c. Posters
d. Handbills and
e. Prabhat Pheris

(2) Mass Mobile Van Campaign: - Mass Mobile Van Campaign is to be planned.

(3) House to House approach: - We have planned to train Drug distributors & Supervisors for which we will ask the total numbers for the same to cover all the eligible population of the state.

Table 11: Name of Programme :- MDA (Mass Drug Administration) : Proposed Budget for FY-- 2008-09

Sl. No.	Activity	Amonut in Rs.
A. State Level		
1	Training of District Officers	50000
2	IEC (State Level)	3800000
3	Mass Drug Administration Assessment	342000
4	Petrol allowance	304000
	Sub Total	***4496000***
B. Districts Level (38 districts)		
1	District Coordination Meeting (3 meeting per district @ Rs.10000 per meeting for 38 districts)	1140000
2	IEC for Districts Level (Rs.10 lakh per district for 38 districts)	38000000
3	Line Listing of Filaria Cases Mopping, Morbidity Management & Operational Cost (Rs.50000 per district)	1900000
4	Training for MO of PHC (Rs.50000 per district)	1900000
5	Training for Paramedical Staff (Rs.50000 per district)	1900000
6	Night Blood Survey (Rs.47000 per district)	1786000
7	Petrol allowance (Rs.80000 per district)	3040000
8	Training of Drug Distributors (@ Rs.50 per person * 260000 drug distributors in the whole state)	13000000
9	DA of Drug Distributors (@ Rs.50 per person * 260000 drug distributors in the whole state)	13000000
10	Training to Supervisors (@ Rs.50 per person * 26000 supervisors in the whole state) 1 supervisor for every 10 distributors	1300000
11	DA of Drug Supervisors (@ Rs.75 per person * 26000 supervisors in the whole state)	1950000
	Sub Total	***78916000***
	Total	**83412000**

STATE PROJECT IMPLEMENTATION PLAN FOR NATIONAL VECTOR BORN DISEASE CONTROL PROGRAMME: MALARIA 2008-09

Burden of Vector Borne Diseases: - Vector Borne Diseases viz. Filariasis & Kala-azar are still major public health problems in the State. This accounts for a major portion of morbidity & mortality. Malaria is only reported in the seven districts of Bihar namely – Kaimur, Rohtas, Aurangabad, Gaya, Nawada, Sheikhpura & Jamui. These are bordering districts of Bihar which spread from South-East to South-West, bordering Jharkhand. Few cases have also been reported from East and West Champaran.

National Malaria Control Programme: - The programme was started in 1953. Two rounds of DDT Spray in affected areas gave very positive results and the number of cases decreased considerably. It led to beginning of National Malaria Eradication Programme in 1958. Under this programme surveillance of fever cases along with examination of blood slides were included. In 1977, a revised National Malaria Eradication Programme was launched. Under this scheme, certain parameters have been defined for DDT Spray so that no death occurs due to Malaria. The Govt. of India provides drugs, DDT and some equipment where as Govt. of Bihar looks after establishment, spray etc.

For successful implementation of the programme certain number of posts were sanctioned, which as per available data, is 3289. Against this sanctioned strength, 712 persons are working with vacancy gap of 2577. So at a glance, we can say that there is a vacancy gap of 78.3%. This huge gap reflects badly in implementation of the programme. Due to this gap there is –

1. Poor Surveillance
2. Poor Blood Slide Collection rate
3. Collected Blood Slides are not examined
4. Distribution of anti-malaria drugs is also not done properly

These staff not only look after the National Malaria Eradication Programme but they are also responsible for other Vector Borne Disease Control Programmes such as Kala-azar, Dengue, J.E. etc.

National Anti Malaria Programme (NVBDCP):- Staff Position

Sl.No.	Name of the Post	Sanctioned Post	Posted	Vacant
1	State Programme Officer	1	1	**X**
2	Assistant Director (Kala-azar)	2	2	**X**
3	Zonal Malaria Officer	4	4	**X**
4	District Malaria Officer	24	21	**3**
5	Assistant Medical Officer	24	1	**23**

6	Entomologist	1	X	**1**
7	Assistant Entomologist	3	X	**3**
8	Office Supritendent cum Accountant	1	X	**1**
9	Clerk	77	41	**36**
10	Steno-typist	3	2	**1**
11	Malaria Inspector	151	134	**17**
12	Lab.Technician	402	49	**353**
13	Basic Health Worker	1325	108	**1217**
14	Basic Health Inspector	346	132	**214**
15	Surveillance Inspector	113	28	**85**
16	Surveillance Worker	442	54	**388**
17	Motar Mechanic	24	9	**15**
18	Motar Driver	53	12	**41**
19	Insect Collector	8	2	**6**
20	Superior Field Worker	48	22	**26**
21	Field Worker	110	44	**66**
22	Peon	55	21	**34**
23	Motar Cleaner	48	13	**35**
24	Sweaper	24	12	**12**
Total		**3289**	**712**	**2577**

Strategy for the Control of Malaria Programme-

- Identification of Malaria Cases & complete treatment
- To prevent the spread of Malaria two rounds of DDT Spray in one year

Medicine – The Anti Malarial Drugs are freely available in all the Govt. Hospital, Primary Health Centre and Fever Treatment Centre & Drug Distributor Centre.

Following are the status of Malaria Reported Cases in 2006 – (Provisional)		Status of the Malaria Cases in 2007: Report up to November (Provisional)	
B.S. Collection	188060	B.S. Collection	134599
B.S. Examination	179059	B.S. Examination	130654
No. of +ve. Cases	2411	No. of +ve. Cases	1451
No. of PF Cases	754	No. of PF Cases	615
Radical Treatment	191235	Radical Treatment	1414
No. of Deaths	3 (Expected)	No. of Deaths	0

Spray of DDT – To prevent the Malaria menace the DDT Spray are taken twice in a year. The First round of spray from 1st of May 2008 to 15th of July 2008 and the Second round spray from 16th of July 2008 up to 30th September 2008 is proposed.

Malaria Month – To create awareness among the masses the Malaria month is organized from 1st June to 31st June every year in which the people are made aware how to prevent malaria through information, education & communication.

Target & Achievement

Year	Population	Physical Target of Blood Collection	Blood Collection	No. of +ve patients	PF Patient	Death Confirm	Expected Death	Complete T/t of the patient
2003	85238863	8523886	371481	2652	1080	12	11	2652
2004	87223995	8722399	297810	2466	250	0	22	2466
2005	88968475	8896847	250354	2744	428	1	5	2741
2006 Provisional	89727827	8972782	188060	2411	754	0	3	2396

Table 12: MALARIA PROGRAM: Proposed Budget for FY-- 2008-09

Sl. No.	Activities	Amount in Rs.
	Total population to be covered - 5 million approx	
	DDT requirement - 750 MT (Two rounds)	
1	Wages (For two round)	16736800
2	For monitoring and supervision, hiring of vehicles for DMO and ACMO of 7 districts (Rs.10000 per month)	1680000
	Sub Total	***18416800***
3	IEC Activities	2000000
4	Training	600000
5	Meeting	400000
	Sub Total	***3000000***
	Total	**21416800**


IDSP

Surveillance is essential for the early detection of emerging (new) or re-emerging (resurgent) infectious diseases. In the absence of surveillance, disease may spread unrecognised by those responsible for health care or public health agencies, because many individual health care workers would see sick people in small numbers. By the time the outbreak is recognized, it may be too late for intervention measures. Continuous monitoring is essential for detecting the 'early signals' of outbreak of any epidemic of a new or resurgent disease. For disease surveillance to prevent emerging epidemics, the time taken for effective action should be short.

Integrated Disease Surveillance Program (IDSP) is intended to be the backbone of public health delivery system in the state. It is expected to provide essential data to monitor progress of on- going disease control programs and help in optimizing the allocation of resources. It will be able to detect early warning signals of impending outbreaks and help initiate an effective and timely response. IDSP will also facilitate the study of disease patterns in the state and identify new emerging diseases. It will play a crucial role in obtaining political and public support for the health programs in the state.

Profile of Bihar : Bihar is located in the North East – of India. It has a land with a covered area of 94,163 Sq. Km. It is mainly divided into two regions known as North of Ganges, and south of Ganges regions. The State is geographically classified into 38 districts and 72 Sub divisions and 533 blocks. The population of Bihar as per 2001 Census is 828.8 million with a urban population of 8681800 as the density population per Sq. Km. is 880 against national figure of 324. There are 32 towns with a population of 50,000 or more and having about 40,000 villages in the state. The present sex ratio is 919 females per 1000 males (India Figure 933). The total literacy rate is 46.4%. It is mainly a rural inhabited state. The percentage of rural population is 66.08% against the India's population of 72.2%.

Diseases conditions under the surveillance program

(i) Regular Surveillance***:***

Vector Borne Disease:	***Malaria & Kala-azar***
Water Borne Disease:	***Acute Diarrhoeal Disease (Cholera) & Typhoid***
Respiratory Diseases:	***Tuberculosis***
Vaccine Preventable Diseases:	***Measles***
Diseases under eradication:	***Polio***
Other Conditions:	***Road Traffic Accidents***

Table 13: Integrated Disease Surveillance Program: Proposed Budget for FY- 2008-09

IDSP (Integrated Disease Surveillance Program)				
S.N.	**Heads**	**Units**	**Unit Cost**	**Total**
1	**Infrastructure**			
a	State Surveillance Cell at DMS & DHS	1	1,500,000	1,500,000
b	District Level Laboratory	39	300,000	11,700,000
c	Manuals	1	500000	500,000
2	**Laboratory**			
a	Equipment	39	300000	11,700,000
b	Reagents and consumables	39	200000	7,800,000
3	**Communication**			
a	Telephone & Fax	39	10000	390,000
b	Quality Assurance	39	10000	390,000
4	**Salary**			
a	Data Entry Operator	39	6000	234,000
b	Accounts Assistant	39	5000	195,000
5	**Social Mobilization**	39	100000	3,900,000
6	**Monitoring & Evaluation**	39	50000	1,950,000
7	**Training**	39	100,000	3,900,000
8	**Operational expenses**	39	100000	3,900,000
9	**NCD Surveillance**	39	500,000	19,500,000
10	**Biological Waste Management**	39	30770	1,200,030
11	**5% overhead expenses**			3,618,897
	GRAND TOTAL			72,377,927

Elimination of Iodine Deficiency Disorders: A priority in Bihar

Iodine deficiency is a world wide public health problem. It is a essential micronutrient with an average daily requirement of 100-150 micrograms for normal human growth and development. Inadequate or poor intake of iodine can result in physical and mental-retardation. It affects people of all ages, both sexes and of different socio economic background. The effect of IDD is most critical during pregnancy and childhood. For iodine deficiency in pregnant mother can resulting abortions still birth and the birth of mentally retarded babies. Other adverse effects include deaf mutism, dwarfism, squint, cretinism and even milder neuro motor defects. Children with iodine deficiency have intelligence (IQ) 13.5 points less than that of children from areas where there is no iron deficiency. Thus, it remains a major threat to the health and development of school children and pregnant women. The only solution to this disorder is very simple and affordable, which is consumption of only iodized salt and discarding the use of non-iodized salt.

Iodine Deficiency Disorders is Bihar: According to public health standard, an area is declared to be iodine deficient, if 5% or more of school going children are suffering from Goitre (enlargement of the thyroid gland situated in the neck) From this point of view all district in Bihar have the problem of iodine deficiency.

Survey: In Bihar a study was undertaken in 2004 with support from UNICEF to track progress towards sustainable elimination of IDD from the state. The results of the study reveal that iodine deficiency continues to be a public health problem with a high proportion of population (31.5%) having very low urinary iodine excretion. Thus, suggesting that existence of severe iodine deficiency exists in many pockets. Only 40.1% of the households consume adequately iodized salt. The findings of this study warrant instituting corrective measure on a war footing to ensure that the population of Bihar has access to adequately iodized salt and at least 80% of the households receive and use adequately iodized salt.

A. Following measures taken to reduce IDD Prevalence rate below 5%

- **Setting up of IDD Cell in State:** A separate nutrition and IDD Cell has been set up in State Health Society, Bihar under the Department of Health, Government of Bihar
- **Setting up of IDD monitoring lab. in State**: A State level monitoring lab has been set up in Public Health Institute, Patna
- **Setting up of IDD monitoring lab. at district level** : It has to be set up in near future

B. Activities under IDD Control Programme:

- Organization of second State Level Task Force under the chairmanship of Health Secretary with heads of different supportive department like Education, ICDS.
- Formation of District Level Co-ordination Committee of supportive department like ICDS, Education/General Administration, NGO.

- Monitoring of Quality of Salt.
- Distribution of Salt Testing Kits (STK).
- Analysis of Iodized Salt Samples tested with STK

Summary of Activity

- Mobility in Districts – C.S./ ACMO & MOI/C PHC will visit AWC & random village school for supervising the salt testing done by AWW, ANM & AWS etc.
- SPO will visit any districts, villages and schools to supervise by hired vehicle on random basis.
- State HQ (SHSB) will grant additional fund to any districts if required from its fund to establish /strengthening state level testing lab.
- Contingency - State Programme Officer will meet the offices expenses from contingency fund of SHSB.
- Training of AWW, ANM, School teachers, food inspector, ICDS supervisor will be done by MOI/C PHC at PHC HQ.
- Training of MOI/C of PHC and ICDS Supervisor will be done at State HQ by SHSB.
- IEC material – i.e. Poster Banner and Pamphlet & Newspaper Ad. will be done by SHSB centrally. Celebration of Global IDD Day for mass awareness.
- Meeting/Training of Salt Traders and others i.e. food inspector and ICDS Supervisors will be done by SHSB.
- Monitoring of salt testing lab. Set up/ to be set up will be done by SHSB. Penal action against traders selling salt having Nil Iodine Contents and less than 15PPM may be recommended. Destruction/Seizing of salt containing nil iodine.
- Arrangement will be made for supply of salt testing kits by SHSB.

Table 14: NIDDCP: Proposed Budget for FY-2008-09

Sl.No.	Activity	Amount
1	IEC	2,00,000
2	Procurement of Salt testing kits 20 x 1050 x 38 =79800 (rounded off)	8,00,000
3	Training / Orientation	1,00,000
4	Setting of Lab.	1,00,000
	Total	**12,00,000**


RNTCP

Annual Plan for Programme Performance & Budget for the year

1st April 08 to 31st March 09

State: _Bihar (World Bank)_

Objectives:

1. *To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases, and*
2. *To achieve and maintain detection of at least 70% of such cases in the population*

This action plan and budget have been approved by the STCS.

*Signature of the STO*_____

*Name: Dr. (Major.)K.N. Sahai*_____

Section-A – General Information about the State

1	State Population (in lakh) *please give projected population for next year*	273.85
2	Number of districts in the State	8
3	Urban population	35.07
4	Tribal population	0.85
5	Hilly population	0
6	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums, etc.)	1.51

(These population statistics may be obtained from Census data /State Statistical Dept/ District plans)

No. of districts without DTC: 8

No. of districts that submitted annual action plans, which have been consolidated in this state plan: __8_

Organization of services in the state:

S. No.	Name of the District	Projected Population (in Lakhs)	Please indicate number of TUs of each type		Please indicate no. of DMCs of each type in the district		
			Govt	NGO	Public Sector*	NGO	Private Sector^
1.	Katihar	26.6	5	0	24	1	2
2.	Purnia	12.7	2	0	9	2	1
3.	Samstipur	41.7	8	0	22	2	4
4.	E. Champaran	52.5	10	0	42	9	5
5.	Muzaffarpur	43.8	9	0	25	1	3
6.	Patna	28.3	6	0	22	0	3
7.	Vaishali	38.0	7	1	22	2	3

8.	Munger	30.2	6	0	22	0	3
	Total	**273.8**	**53**	**1**	**188**	**17**	**24**

**Public Sector includes Medical Colleges, Govt. health department, other Govt. department and PSUs i.e. as defined in PMR report*

Section B – List Priority areas at the State level for achieving the objectives planned:

^ Similarly, Private Sector includes Private Medical College, Private Practitioners, Private Clinics/Nursing Homes and Corporate sector

RNTCP performance indicators:

Important: Please give the performance for the last 4 quarters i.e. Oct 2005 to September2006

Name of the District (also indicate if it is notified hilly or tribal district	Total number of patients put on treatment *	Annualised total case detection rate (per lakh pop.)	No of new smear positive cases put on treatment *	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year	
						Annualized NSP case detection rate	Cure rate
Katihar	1888	72	994	38	80.12	70%	85%
Purnia	915	72	346	27	65%	70%	85%
Samstipur	4110	100	1413	46	82%	70%	90%
E. Champaran	6196	118	1811	35	84%	80%	85%
Muzaffarpur	1793	41	585	14	56.79%	50%	85%
Patna	1950	70	839	41	74%	90%	85%
Vaishali	2451	66	709	22	62.71%	55.00%	82.86%
Munger	3423	117	827	27	86.00%	61%	90%
Total	22726	83	7524	27	70%	70%	85%

****** Patients put on treatment under DOTS regimens only are to be included.*

S.No.	Priority areas	Activity planned under each priority area
1	Training	1 a) Retraining of all DTOs, MOTCs, MOs, STSs,STLSs, LTs. (eg TB-HIV coordination)
		1 b) Training of remaining STLS, LT, in EQA
		1 c) Training of DTO, MOTC in revised strategy for Monitoring & Supervision.
2	IEC	2 a) Appointment of communication facilitators
		2 b) Implementation of IEC action plan
		2 c) Appointment of IEC Officer
		2 d) NGO Forum Meeting and Advocacy forum meeting
		2 e) Community interaction meeting
		2 f) Sensitisation of Zila Parisad, MLA and Mukhias
3	Involvement of other sectors/ NGOs/PP/Medical Colleges	3 a) Sensitisation workshop for other sectors, NGOs, PPs.

		3 b) Training for Doctors, LTs, DOT Providers from private sectors.
		3 c)
4	Implementation of EQA	4 a) OSE, RBRC, feedback to DMC, in districts every month.
		4 b) IRL visits to districts any six months.
		4 c) Arrangement of NRI visits.
5	Minimizing Initial Defaulters	5 a) Ensuring in all districts – line listing of all sputum smear +ve patients diagnosed on regular basis
		5 b) Regular data exchange for feedback within district regarding referral for treatment.
		5 c) Patient provider interaction meeting

Priority Districts for Supervision and Monitoring by State during the next year

S No	**District**	**Reason for inclusion in priority list**
	East_ Champaran	**Sustained Low case Detection Rate**

Section C – Consolidated Plan for Performance and Expenditure under each head, including estimates submitted by all districts, and the requirements at the State Level

1. Civil Works

Activity	*No. required as per the norms in the state*	*No. already upgraded/ present in the state*	*No. planned to be upgraded during next financial year*	*Pl provide justification if an increase is planned in excess of norms (use separate sheet if required)*	*Estimated Expenditure on the activity*	*Quarter in which the planned activity expected to be completed*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
STDC/ IRL	*1*	*1*	*1*	*IRL civil works*	*Rs.10,00,000/-*	*By 3rd Quarter 2008.*
SDS	*1*	*1*	*1*	*Need to expand*	*Rs.4,00,000/-*	*By 2nd Quarter of 2008*
DTCs	*8*	*8*	*0*	*Maintenance civil works*	*(8 x Rs.4,500)* *Rs.36,000/-*	*3rd Quarter 2008*
TUs	*55*	*42*	*9*	*Up gradation + maintenance civil works*	*(6 x Rs.35,000/) Rs.2,10,000/-* + (50 x Rs.1000) Rs.50,000	*3rd Quarter 2008*
DMCs	*274*	*230*	*35*	*Up gradation + maintenance civil works*	*(30 x Rs.30,000/) Rs.9,00,000/-* *+ (250 x Rs.1000)* *Rs. 2,50,000*	*4th Quarter 2008*
				TOTAL	*Rs.28,46,000/-*	

2. Laboratory Materials

Activity	*Amount permissible as per the norms in the state*	*Amount actually spent in the last 4 quarters*	*Procurement planned during the current financial year (in Rupees)*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Purchase of Lab Materials by Districts	4107721	959554	1732692	Rs.41,07,750	
Lab materials for EQA activity at STDC					*For two quarters.*

3. Honorarium

Activity	*Amount permissible as per the norms in the state*	*Amount actually spent in the last 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Honorarium	766774.6	0	565000	**Rs.**30,00,000/-	

	No. presently involved in RNTCP	*Additional enrolment proposed for the next fin. year*
*Community volunteers in all the districts**	*749*	*10,000*

** These community volunteers are other than salaried employees of Central/State government and are involved in provision of DOT e.g. Anganwadi workers, trained dais, village health guides, ASHA, other volunteers, etc.*

4. IEC/Publicity:

Permissible budget for State and all Districts as per Norms: Rs. (10,00,000 + 18,65,860) = Rs. 28,65,860/-

Estimated IEC budget for all Districts, as per action plans (*please enclose consolidation summary)*: Rs. 18,65,860.

Estimated IEC activities and Budget at the State level (excluding districts) for the next financial year proposed as per action plan detailed below: Rs.10,00,000.

Target Group/ Objective	Activities Planned at State Level						Total activities proposed during next fin. year	Estimated Cost per activity unit	Total expenditure for the activity during the next fin. Year
	Activity (All activities to be planned as per local needs, catering to the target groups specified)	No. of activities held in last 4 quarters	No of activities proposed in the next financial year, quarter wise						
			Apr-Jun	July-Sep	Oct-Dec	Jan-Mar			
Patients and General public / for awareness generation and social mobilization	Outdoors: - wall paintings - Hoardings - Tin plates - Banners - others	2							**Rs.**2,00,000/-
	Outreach activities: - Patient provider interaction meetings - Community meetings - Mike publicity - Others	1							**Rs.**40,000/-
	Puppet shows/ street plays/etc.	1							**Rs.**1,00,000/-
	School activities								
	Print publicity - Posters - Pamphlets - Others								**Rs.**1,00,000/-
	Media activities on Cable/local channels Radio	2	1	1				1,50,000	**Rs.**3,00,000/-
	Any other activity								
Opinion	Sensitization meetings								

leaders/ NGOs for advocacy	Media activities	2	1		1		2	10,000	**Rs.**20,000/-
	Power point Presentations / one to one interaction								
	Information Booklets/ brochures								
	World TB Day activities					1	1	10,000	**Rs.**10,000/-
	Any other public event								
Health Care providers – public and private	- CMEs - Interaction meetings - one to one interaction meetings	4	1	1	1	1	4	25,000	**Rs.**1,00,000/-
	- Information Booklets - Any other								
Any Other Activities proposed	Communication Facilitators (each for 5-6 districts)	2							**Rs.**1,30,000
								Total Budget	**Rs.10,00,000/-**

4 (b). IEC/Publicity:(Consolidated sheet for District)

Permissible budget for State and all Districts as per Norms:

Estimated IEC budget for all Districts, as per action plans (*please enclose consolidation summary)*: Rs. 18,65,000/-

Estimated IEC activities and Budget at the State level (excluding districts) for the next financial year proposed as per action plan detailed below: Rs.10,00,000.

Target Group/ Objective	Activities Planned at State Level						Total activities proposed during next fin. year	Estimated Cost per activity unit	Total expenditure for the activity during the next fin. Year
	Activity (All activities to be planned as per local needs, catering to the target groups specified)	No of activities held in last 4 quarters	No of activities proposed in the next financial year, quarter wise						
			Apr-Jun	July-Sep	Oct-Dec	Jan-Mar			

Patients and General public / for awareness generation and social mobilization	Outdoors: - wall paintings - Hoardings - Tin plates - Banners - others								**Rs.**3,00,000/-
	Outreach activities: - Patient provider interaction meetings - Community meetings - Mike publicity - Others								**Rs.**20,000/- **Rs.**6,00,000/-
	Puppet shows/ street plays/etc.								
	School activities								
	Print publicity - Posters - Pamphlets - Others								**Rs.**4,30,760/-
	Media activities on Cable/local channels Radio								**Rs.**65,000/-
	Any other activity								
Opinion leaders/ NGOs for advocacy	Sensitization meetings								**Rs.**2,00,000/-
	Media activities								
	Power point Presentations / one to one interaction								
	Information Booklets/ brochures								
	World TB Day activities								**Rs.**1,00,000/-
	Any other public event								
Health Care providers – public and private	- CMEs - Interaction meetings - one to one interaction meetings								**Rs.**1,00,000/-

	- Information Booklets - Any other								
Any Other Activities proposed	Communication Facilitators (each for 5-6 districts)								
								Total Budget	**Rs.18,15,760/-**

5. Equipment Maintenance:

Item	*No. actually present in the state*	*Amount actually spent in the last 4 quarters*	*Amount Proposed for Maintenance during current financial yr.*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Computer *(Maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)*	*8*	*15600*	*136500*	*Rs.2,40,000/-*	
Photocopier *(includes AMC, toner etc.)*	*8*	*37,310*	*42,000*		
Fax	*5*	*0*	*6500*		
OHP	*5*	*0*	*12,500*		
Binocular Microscopes	*220*	*0*	*1,12,500*	*Rs.3,75,000/-*	
STDC/ IRL Equipment	*-*	*-*	*-*	*-*	*-*

Any Other (pl. specify) State equip.					
			TOTAL	*Rs.6,15,000/-*	

6.(a) Training: State Level Rs.930000/- + Rs. 650000/- = Rs.15,80,000/-

Activity	*No. in the state*	*No. already trained in RNTCP*	*No. planned to be trained in RNTCP during each quarter of next FY (c)*				*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*Q1*	*Q2*	*Q3*	*Q4*	*(d)*	*(e)*	*(f)*
Training of DTOs (at National level)			*7*	*9*	*2*	*2*		*Rs.2,00,000/-*	
Training of MO-TCs			*15*	*15*	*15*	*15*		*Rs.3,00,000/-*	
Training of MOs (Govt + Non-Govt)									
Training of LTs of DMCs- Govt + Non Govt			*30*	*15*	*10*	*5*		*Rs.2,50,000/-*	
Training of MPWs									
Training of MPHS, pharmacists, nursing staff, BEO etc									
Training of Comm Volunteers									
Training of Pvt Practitioners									
Other trainings #									
Re- training of MOs									
Re- Training of LTs of DMCs									

Re- Training of MPWs									
Re- Training of MPHS, pharmacists, nursing staff, BEO									
Re- Training of CVs									
Re-training of Pvt Practitioners									
TB/HIV Training of MO-TCs and MOs			*40*	*40*	*40*	*40*		*Rs.1,20,000/-*	
TB/HIV Training of STLS, LTs , MPWs, MPHS, Nursing Staff, Community Volunteers etc									
TB/HIV Training of STS									
Provision for Update Training at Various Levels # Review Meetings at State Level			1	1	1	1		**Rs.**60,0000/-	
Any Other Training Activity									

 # Please specify **TOTAL Rs. 8,10,000/-**

(b)Training: Consolidated sheet of District.Activity	*No. in the state*	*No. already trained in RNTCP*	*No. planned to be trained in RNTCP during each quarter of next FY (c)*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
			Q1 Q2 Q3 Q4			

	(a)	*(b)*					*(d)*	*(e)*	*(f)*
Training of DTOs (at National level)									
Training of MO-TCs									
Training of MOs (Govt + Non-Govt)									
Training of LTs of DMCs- Govt + Non Govt									
Training of MPWs									
Training of MPHS, pharmacists, nursing staff, BEO etc									
Training of Comm Volunteers									
Other trainings #									
Re- training of MOs									
Re- Training of LTs of DMCs			*150*	*150*	*150*	*150*		*Rs.200000/-*	
Re- Training of MPWs									
Re- Training of MPHS, pharmacists, nursing staff, BEO			*1000*	*1500*	*2000*	*4000*		*Rs.300000/-*	

Re- Training of CVs									
Re-training of Pvt Practitioners			*75*	*100*	*80*	*120*		*Rs.150000/-*	
TB/HIV Training of MO-TCs and MOs									
TB/HIV Training of STLS, LTs , MPWs, MPHS, Nursing Staff, Community Volunteers etc									
TB/HIV Training of STS									
Provision for Update Training at Various Levels #									
Review Meetings at State Level									
Any Other Training Activity									

 # Please specify

TOTAL Rs. 6,50,000/-

7. Vehicle Maintenance:

Type of Vehicle	*Number permissible as per the norms in the state*	*Number actually present*	*Amount spent on POL and Maintenance in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
Four Wheelers	*3*	500000	132751.4	377500	**Rs.**445000/-	
Two Wheelers	*53*	1325000	301072.9	1125500	**Rs.**1325000/-	
				TOTAL	*Rs.17,70,000/-*	

8. Vehicle Hiring*:

Hiring of Four Wheeler	*Number permissible as per the norms in the state*	*Number actually requiring hired vehicles*	*Amount spent in the prev. 4 qtrs*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
For STC/ STDC	*1*	*1*	*0*	*0*	*Rs.2,10,000/-*	*For monitoring by STDC Medical Officers*
For DTO	*1*	840000	73500	389000	**Rs.**823000/-	
For MO-TC	*53*	3116400	41425	565500	**Rs.**1073200/-	
				TOTAL	*Rs.21,06,200/-*	

** Vehicle Hiring permissible only where RNTCP vehicles have not been provided*

9. NGO/ PP Support:

Activity	*No. of currently involved in RNTCP in the state*	*Additional enrolment planned for this year*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
NGOs involvement scheme 1 State District	0	4	0	75000	**Rs.**100000/-	
NGOs involvement scheme 2 State *District*	9	11	0	205000	**Rs.**450000/-	
NGOs involvement scheme 3						
NGOs involvement scheme 4	1	18	0	300000	**Rs.**265000/-	
NGOs involvement scheme 5	0	1	0	0	**Rs.**480000/-	
NGOs involvement unsigned	32	0	0	600000	**Rs.**0/-	
Private practitioners scheme 1	0	84	0	20000	**Rs.**81200/-	
Private practitioners scheme 2A	0	334	0	8000	**Rs.**160500/-	
Private practitioners scheme 2B						
Private practitioners scheme 3						
Private practitioners scheme 4						
				TOTAL	*Rs. 15,36,700/-*	

10. Miscellaneous:

*Activity** e.g. TA/DA, Stationary, etc	*Amount permissible as per the norms in the state*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
District Level	*41,07,721*	*3,95,972*	*9,41,346*	*Rs.23,14,000/-*	
State Level	*7,00,000/-*			*Rs.6,00,000/-*	
			TOTAL	*Rs.29,14,000/-*	

** Please mention the main activities proposed to be met out through this head*

11. Contractual Services:

Category of Staff	*No. permissible as per the norms in the state*	*No. actually present in the state*	*No. planned to be additionally hired during this year*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current fin. year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*		*(d)*	*(e)*	
TB/HIV Coord.	-	-	-	-	-	*Rs.1,92,000/-*	
Urban TB Coord.	-	-	-	-	-	-	
MO-STCS	*1*	-	-	-	-	-	
State Acct	*2*	*1*	*2*	*0*	*0*	*Rs.360000/-*	
State IEC Offr	*1*	*0*	*1*	*0*	*0*	*Rs.180000/-*	
Pharmacist	*1*	*1*	*1*	*102000*	*10200*	*Rs.102000/-*	
Secretarial Asst	*1*	*1*	*1*	*84000*	*84000*	*Rs.84000/-*	
MO-DTC	*6*	*3*	*6*	*1152000*	*1152000*	*Rs.1152000/-*	

STS	*53*	*40*	*53*	*2548605*	*3039000*	*Rs.4770000/-*	
STLS	*53*	*34*	*53*	*2042717*	*2781000*	*Rs.4770000/-*	
TBHV	*30*	*2*	*30*	*49000*	*258000*	*Rs.2160000/-*	
DEO State District	1 8	1 5	1 8	84000 250499	84000 324600	**Rs.**84000/- **Rs.**576000/-	
Accountant – part time	*8*	*4*	*8*	*48000*	*86000*	*Rs.192000/-*	
Contractual LT	*120*	*88*	*105*	*2618189*	*3961000*	*Rs.8190000/-*	
Driver- State	*8*	*5*	*5*	*250000*	*250000*	*Rs.270000/-*	
Any other contractual post approved under RNTCP							
TOTAL						*Rs.2,30,82,000/-*	

12. Printing:

Activity	*Amount permissible as per the norms in the state*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
*Printing-State level:**	*Rs.4107721 /-*	*Rs.2300000/-*	*Rs.2300000/-*	*Rs.35,00,000/-*	
*Printing-Distt. Level:**		*Rs.200780/-*	*Rs.415000/-*		

** Please specify items to be printed in this column*
List attached

13. Research and Studies (excluding OR in Medical Colleges):

Any Operational Research projects planned (Yes/No) **Yes**
(If yes, enclose annexure providing details of the Topic of the Study, Investigators and Other details)

Whether submitted for approval/ already approved? (Yes/No) ___No_____
Estimated Total Budget Rs.400000/-

14. Medical Colleges

Activity	*Amount permissible as per norms*	*Estimated Expenditure for the next financial year(Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*
Contractual Staff: ▪ *MO-Medical College (Total approved in state ___)* ▪ *STLS in Medical*	3 3 3	**Rs.**576000/- **Rs.**270000/- **Rs.**234000/-	

Colleges (Total no in state ___) ▪ *LT for Medical College (Total no in state ___)* ▪ *TBHV for Medical College (Total no in state___)*	3	**Rs.**216000/-	
Research and Studies: ▪ Thesis of PG Students ▪ Operations Research*		*Rs.60000/-*	
Travel Expenses for attending STF/ZTF/NTF meetings		*Rs.31200/-*	
IEC: Meetings and CME planned		*Rs.80000/-*	
Equipment Maintenance at Nodal Centres		*Rs.80000/-*	
Total		*Rs.15,47,200/-*	

** Expenditure on OR can only be incurred after due approvals of STF/ STCS/ZTF/CTD (as applicable)*

15. Procurement of Vehicles:

Equipment	*No. actually present in the state*	*No. planned for procurement this year (only if permissible as per norms)*	*Estimated Expenditure for the next financial year for whih plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
*4-wheeler ***	*4*	*0*	*0*	
2-wheeler	*41*	*34*	*Rs.1088000/-*	

*** Only if authorized in writing by the Central TB Division*

16. Procurement of Equipment:

Equipment	*No. actually present in the state*	*No. planned for this year (only as per norms)*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
Computer	*8*	*3*	*Rs.105000/-*	
Photocopier	*7*	*3*	*Rs.135000/-*	
OHP	*3*	*5*	*Rs.72000/-*	
Any Other - (LCD & Laptop for STC)		*1+1*	*Rs.1,40,000/-*	
Total			*Rs.4,52,000/-*	

Section D: Summary of proposed budget for the state –

Category of Expenditure	Budget estimate for the coming FY 2008 to 2009 (To be based on the planned activities and expenditure in Section C)
1. Civil works	Rs.28,46,000/-
2. Laboratory materials	Rs.41,07,750/-
3. Honorarium	*Rs.30,00,000/-*
4. IEC/ Publicity	Rs.28,15,760/-
5. Equipment maintenance	Rs.6,15,000/-
6. Training	Rs.15,80,000/-
7. Vehicle maintenance	Rs.17,70,000/-
8. Vehicle hiring	Rs.21,06,200/-
9. NGO/PP support	Rs.15,36,700/-
10. Miscellaneous	*Rs.29,14,000/-*
11. Contractual services	Rs.2,30,82,000/-
12. Printing	Rs.35,00,000/-

13. Research and studies	Rs.4,00,000/-
14. Medical Colleges	Rs.15,47,200/-
15. Procurement –vehicles	Rs.10,88,000/-
16. Procurement – equipment	Rs.4,52,000/-
Total	**Rs.4,89,09,910/-**

** *Only if authorized in writing by the Central TB Division*

Items to be printed at state level

Sr No	Items name	Quantity (No of copies)	No of pages for print including cover (back and front)
1	TB Register	334	200 + 2
2	Lab Register	1696	200 + 2
3	Treatment Card	258552	2
4	Identity Card	129276	2
5	Lab form for Sputum Examination	692550	1
6	TB Transfer form	6464	1
7	Referral for treatment form	12928	1
8	CF TU qtrly report	2672	1
9	SC TU qtrly report	2672	1
10	RT TU qtrly report	2672	1
11	PMR TU qtrly report	2672	4
12	PHI monthly Report	24422	2
13	Supervisory Registers (triplicate paging no)	1272	7 + (80 x 3) = 247
14	Desk Referance	18468	1
15	RNTCP at a glance	18468	26 + 2
16	EQA coding (blinding) register	76	100 + 2
17	EQA - RBRC roaster for STLSs rechecking and umpire rechecking	38	100 + 2
18	EQA - Register for Quality control of prepared reagents	76	100 + 2
19	EQA reporting format - annexure M (for TU)	15264	1
20	EQA reporting format - annexure M (for district)	1170	1
21	EQA reporting format - annexure E (for district)	1170	1
22	**EQA** reporting format - annexure B	20352	1
23	**EQA** reporting format - Annexure C	20352	1
24	**EQA** reporting format - Annexure D	20352	1
25	**EQA** reporting format - checklist for	20352	7

	STLS		
26	**EQA** reporting format - annexure F	380	1
27	**EQA - IRL visit to DTC - OSE**	100	10
28	District Issue voucher **(DIV)**	16032	1
29	District worksheet for Reporting Drug Requirement **(WRDR)**	16032	1
30	TU report for Reconstitution of Drugs	1670	1
31	Drug Stock Register	410	200 + 2
32	Line list of VCTC	9120	1
33	VCTC monthly report	912	1
34	Health provider guide (Local language)	18468	1
35	PP module	9234	76
36	Revised Strategy for monitoring and supervision	281	74 + 2
37	EQA Module - RNTCP Laboratory Network guidelines for Quality Assurance of smear microscopy for diagnosing TB.B60	256	91 + 2
38	Mycobacterial Culture Sensitivity forms	6464	1
39	NGO Guidelines	334	40 + 2
40	PP guidelines+B20	334	40 + 2
41	District Drug Store Manual	410	89 + 2
42	Reconstitution Register	38	200 + 2
43	Additional Drug Request	380	1
44	Referral for treatment Register	205	200 + 2
45	**RNTCP Modules** with Exercise book and answer book for training of MO (1-4 Module)	4617	190 + 2
46	**RNTCP** MO training Exercise (E1, E2, E3) and answer books (EA1-3)	167	(13+2) + (19+2) + (22+2) + (32+2) = 94
47	**RNTCP Modules** for training of MO-TC (5-9 Module)	167	254 + 2
48	**RNTCP Modules** for training of STS with Exercise book	167	(131+2) + (26+2)
49	**RNTCP Modules** for training of STLS	167	120 + 2
50	**RNTCP Modules** for training of LT	923	74 + 2

51	**RNTCP Modules** for training of Medical college faculty	1150	
52	**RNTCP Modules** for training of MPWs	18468	54 + 2
53	Modules for training in **TB-HIV** of MO	668	97 + 2
54	Modules for training in **TB-HIV** of STS & STLS	334	63 + 2
55	Modules for training in **TB-HIV** of VCTC counsellor	200	66 + 2
56	District PMR report	760	6
57	Strategy document for the supervision and monitoring	281	85 + 2
58	Guidelines for quality assuarance of smear microscopy for diagnosing tuberculosis	334	91 + 2
59	Technical & operational guidelines	923	150 + 2
60	One page Display for DOT Provider	18468	1
61	One page Display for DOT Provider pead PWB	18468	1
62	Financial Management Manual for state & district societies norms and basis of costing	190	83 + 2
63	Pages for Training in pediatric PWBs (Hindi)	18468	3
64	Pages for Training in pediatric PWBs (English)	3040	3
65	Programme review checklist for DMs & CMOs	950	2
66	Quarterly report - Medical College	96	3
67	IE - Form 1: Review of TU reports and TB registers & Worksheet for form 1	200	1
68	IE - Form 1: Worksheet for form 1	500	1
69	IE - Form 2: Data collection at the district level	200	3
70	IE - Form 3: Data collection at the DMC level	500	1
71	IE - Form 4: Data collection at the DOT Centre	1000	1
72	IE - Form 5:Patients Interview	500	1
73	IE - Form 6 :Triangulation	200	1
74	IE - Form 8: Form for interview of non-NSP patients	200	1
75	IE - Form 9: Form for observations at the TU Drug store	100	1

76	IE - Form 11: for review of the Medical College during Internal Evaluation	25	1
77	IE - Form 12: Check List For Financial Management	500	1
78	Physical Verification Sheet (PVS)	430	1
79	Adequacy of Drug Stocks (ADS)	430	1
80	Expiry Age Analysis of Drug Stocks (EAADS)	430	1
81	Training certificates	2770	1
82	Enrolment certificate (NGOs & PPs)	462	1
83	Certificate of appreciation	308	1
84	Pamphlets	92340	1
85	Posters (Sputum Microscopy)	4617	1
86	Posters (diagnosis)	9234	1
87	Posters (Treatment)	9234	1
88	Posters (DOTS)	9234	1
89	Plastic digital printed boards for Approved DOT centers	9234	1
90	Plastic digital printed boards for designated Pvt Sputum Microscopy centre	114	1
91	Table Flip type calendars	2770	24
92	Flip charts	2884	
93	Banners for workshop	38	1
94	Banners for training	38	1
95	Digital printed banners DOTS	4617	1
96	Digital printed banners diagnosis	4617	1
97	Digital printed banners Treatment	4617	1
98	RNTCP diary	4617	200
99	Car bumper stickers Plastic coated	9234	1

Annual Plan for Programme Performance & Budget for the year
1st April 08 to 31st March 09
State: BIHAR (GFATM)

Objectives:
3. *To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases, and*
4. *To achieve and maintain detection of at least 70% of such cases in the population*

This action plan and budget have been approved by the STCS.

*Signature of the STO*_____
*Name Dr.(Major) K.N. Sahai*_____

State level expenditure has been encorporated in Action pan of World Bank districts hence not enlisted in this action plan

Section-A – General Information about the State

1	State Population (in lakh) *please give projected population for next year*	650
2	Number of districts in the State	30
3	Urban population	49
4	Tribal population	8
5	Hilly population	6
6	Any other known groups of special population for specific interventions (e.g. nomadic, migrant, industrial workers, urban slums, etc.)	

(These population statistics may be obtained from Census data /State Statistical Dept/ District plans)

No. of districts without DTC: 3

No. of districts that submitted annual action plans, which have been consolidated in this state plan: 30

Organization of services in the state:

S. No.	Name of the District	Projected Population (in Lakhs)	Please indicate number of TUs of each type		Please indicate no. of DMCs of each type in the district		
			Govt	NGO	Public Sector*	NGO	Private Sector^
1	Araria	23.7	5	0	12	1	5
2	Arwal	6.8	1	0	5	0	0
3	Aurangabad	22.3	5	0	14	2	2
4	Banka	17.9	3	1	11	1	3
5	Begusarai	26.1	5	0	18	1	3

6	Bhagalpur	27.1	5	0	21	1	3
7	Bhojpur	24.9	5	0	21	0	3
8	Buxar	15.6	3	0	14	0	1
9	Darbhanga	36.6	7	0	20	1	4
10	Gaya	38.6	8	0	28	1	3
11	Gopalganj	23.9	5	0	20	0	2
12	Jamui	15.6	4	1	15	0	2
13	Jehanabad	10.1	2	0	8	0	1
14	Kaimur	14.3	2	1	12	0	1
15	Khagaria	14.2	3	0	13	0	1
16	Kisanganj	14.4	2	1	10	0	2
17	Lakhisharai	8.9	2	0	6	0	1
18	Madhepura	17.0	3	0	14	1	1
19	Madhubani	39.8	8	0	23	1	2
20	Nalanda	26.4	5	0	20	0	3
21	Nawadah	20.2	4	0	15	0	2
22	W.Champaran	33.9	6	1	20	0	3
23	Rohtas	27.3	5	0	20	2	2
24	Saharsa	16.8	4	0	11	0	3
25	Saran	36.2	6	0	29	0	3
26	Sheikhpura	5.9	1	0	4	0	0
27	Sheohar	5.7	1		4		0
28	Sitamarhi	29.7	6	0	26	0	3
29	Siwan	30.2	6	0	20	0	3
30	Supaul	19.4	4	0	11	0	2
	Total	649.6	126	5	465	12	64

**Public Sector includes Medical Colleges, Govt. health department, other Govt. department and PSUs i.e. as defined in PMR report*

^ Similarly, Private Sector includes Private Medical College, Private Practitioners, Private Clinics/Nursing Homes and Corporate sector

RNTCP performance indicators:

*Important: Please give the performance for the last 4 quarters i.e. Oct 04_ to September __05_*

Section B – List Priority areas at the State level for achieving the objectives planned:

Name of the District (also indicate if it is notified hilly or tribal district	Total number of patients put on treatment *	Annualised total case detection rate (per lakh pop.)	No of new smear positive cases put on treatment *	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year	
						Annualized NSP case detection rate	Cure rate
Araria	1275	53.9	472	19.9	63.63	120	90%
Arwal	369	54.4	107	15.8		40%	85%
Aurangabad	1407	63.0	424	19.0			
Banka	349	19.5	142	7.9		60%	85%
Begusarai	1030	39.5	227	8.7		99%	85%
Bhagalpur	2371	87.6	627	23.2	59.75	70%	85%
Bhojpur	912	36.7	314	12.6			
Buxar	708	45.3	235	15.0		70%	85%
Darbhanga	1601	43.7	751	20.5		52.50%	85%
Gaya							
Gopalganj	575	24.0	174	7.3		70%	
Jamui	498	32.0	161	10.3		0	0
Jehanabad	633	63.0	202	20.1	74.19%		
Kaimur	476	33.3		0.0			
Khagaria	326	22.9	128	9.0		60%	85%
Kisanganj							
Lakhisharai							
Madhepura							
Madhubani	1499	37.7	568	14.3	NA	45%	85%
Nalanda							
Nawadah	863	42.8	339	16.8		40%	90%
W.Champaran	1011	29.8	458	13.5			85%
Rohtas	738	27.0	231	8.5			
Saharsa							
Saran							
Sheikhpura	220	37.6	47	8.0	61%	72%	85%
Sheohar	180	31.4	51	8.9		85%	70%
Sitamarhi	1689	56.8	420	14.1			
Siwan	679	22.5	215	7.1	72%	70%	85%
Supaul	489	25.2	137	7.0			
Total	19898	30.6	6430	9.9	72%	70%	85%

***** *Patients put on treatment under DOTS regimens only are to be included.*

S.No.	Priority areas	Activity planned under each priority area
1	Training	1 a) Retraining of all DTOs, MOTCs, MOs, STSs,STLSs, LTs. (eg TB-HIV coordination)
		1 b) Training of remaining STLS, LT, in EQA
		1 c) Training of DTO, MOTC in revised strategy for Monitoring & Supervision.
2	IEC	2 a) Appointment of communication facilitators
		2 b) Implementation of IEC action plan
		2 c)
3	Involvement of other sectors/ NGOs/PP/Medical Colleges	3 a) Sensitisation workshop for other sectors, NGOs, PPs.
		3 b) Training for Doctors, LTs, DOT Providers from private sectors.
		3 c)
4	Implementation of EQA	4 a) OSE, RBRC, feedback to DMC, in districts every month.
		4 b) IRL visits to districts any six months.
		4 c) Arrangement of NRI visits.
5	Minimizing Initial Defaulters	5 a) Ensuring in all districts – line listing of all sputum smear +ve patients diagnosed on regular basis
		5 b) Regular data exchange for feedback within district regarding referral for treatment.
		5 c)

Priority Districts for Supervision and Monitoring by State during the next year

S No	District	Reason for inclusion in priority list
	West Champaran	*Sustained low case detection rate*
	Siwan	*Sustained low case detection rate*
	Gopalganj	*Sustained low case detection rate*
	Supaul	*Sustained low case detection rate*
	Lakhisarai	*Sustained low case detection rate*
	Begusarai	*High NSN : NSP ratio*

Section C – Consolidated Plan for Performance and Expenditure under each head, including estimates submitted by all districts, and the requirements at the State Level

1. Civil Works

Activity	*No. required as per the norms in the state*	*No. already upgraded/ present in the state*	*No. planned to be upgraded during next financial year*	*Pl provide justification if an increase is planned in excess of norms (use separate sheet if required)*	*Estimated Expenditure on the activity*	*Quarter in which the planned activity expected to be completed*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*

STDC/ IRL						
SDS						
DTCs	*30*	*27*	*3*	*Upgradation of DTCs*	*(3 x Rs.4,00,000/-) Rs.12,00,000/- + (30 x Rs.4500/-) Rs.1,35,000*	*3rd Quarter 2008*
TUs	*130*	*114*	*13*	*Up gradation of TUs +* Maintenance of TUs	(11 x Rs.35,000/-) Rs.3,85,000/- (120 x Rs.1,300/-) Rs.1,56,000/-	*3rd Quarter 2008*
DMCs	*650*	*513*	*74*	*Up gradation of DMcs + maintenance civil works of DMCs*	*(70 x Rs.30,000)* Rs.21,00,000/- (390 x Rs.1,000/-) Rs.3,90,000/-	*4th Quarter 2008*
				TOTAL	*Rs.43,66,000/-*	

2. Laboratory Materials

Activity	*Amount permissible as per the norms in the state*	*Amount actually spent in the last 4 quarters*	*Procurement planned during the current financial year (in Rupees)*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Purchase of Lab Materials by Districts	Rs.97,43,279/-	Rs.29,55,158/-	Rs.53,42,164/-	Rs.97,50,000/-	
Lab materials for EQA activity at STDC					

3. Honorarium

Activity	*Amount permissible as per the norms in the state*	*Amount actually spent in the last 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Honorarium	Rs.18,18,745/-	Rs.0/-	Rs.8,99,844/-	Rs.1,50,00,000/-	

	No. presently involved in RNTCP	*Additional enrolment proposed for the next fin. year*
*Community volunteers in all the districts**	*1315*	*40,000*

** These community volunteers are other than salaried employees of Central/State government and are involved in provision of DOT e.g. Anganwadi workers, trained dais, village health guides, ASHA, other volunteers, etc.*

4. IEC/Publicity:

Permissible budget for State and all Districts as per Norms: Rs.10,00,000/- + Rs.48,71,64,000/-
Estimated IEC budget for all Districts, as per action plans (*please enclose consolidation summary)*: Rs. 36,68,351/-
Estimated IEC activities and Budget at the State level (excluding districts) for the next financial year proposed as per action plan detailed below: Rs. _____

Target Group/ Objective	Activities Planned at **District Level**						Total activities proposed during next fin. year	Estimated Cost per activity unit	Total expenditure for the activity during the next fin. Year
	Activity (All activities to be planned as per local needs, catering to the target groups specified)	No. of activities held in last 4 quarters	No of activities proposed in the next financial year, quarterwise						
			Apr-Jun	July-Sep	Oct-Dec	Jan-Mar			
Patients and General public / for awareness generation and social mobilization	Outdoors: - wall paintings - Hoardings - Tin plates - Banners - others								Rs.15,00,000/-
	Outreach activities: - Patient provider interaction meetings - Community meetings - Mike publicity - Others								Rs.15,00,000/-
	Puppet shows/ street plays/etc.								
	School activities								Rs.2,00,000/-
	Print publicity - Posters - Pamphlets - Others								Rs.4,00,000/-
	Media activities on Cable/local channels Radio								
	Any other activity								
Opinion leaders/ NGOs for	Sensitization meetings								2,00,000/-
	Media activities								

advocacy	Power point Presentations / one to one interaction								
	Information Booklets/ brochures								
	World TB Day activities								Rs.3,28,700/-
	Any other public event								
Health Care providers – public and private	- CMEs - Interaction meetings - one to one interaction meetings								Rs.2,00,000/-
	- Information Booklets - Any other								
Any Other Activities proposed	Communication Facilitators (each for 5-6 districts)								
								Total Budget	**Rs.43,28,700/-**

5. Equipment Maintenance:

Item	*No. actually present in the state*	*Amount actually spent in the last 4 quarters*	*Amount Proposed for Maintenance during current financial yr.*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ Remarks for (d)*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
Computer *(maintenance includes AMC, software and hardware upgrades, Printer Cartridges and Internet expenses)*	*30*	*Rs.86,154/-*	*Rs,9,00,000/-*	*Rs.9,00,000/-*	

Photocopier *(includes AMC, toner etc.)*	*28*	*Rs.1,15,921/-*	*Rs.1,66,584/-*		
Fax	*27*	*Rs.8,500/-*	*Rs.46,344/-*		
OHP	*22*	*Rs.13,500/-*	*Rs.14,466/-*		
Binocular Microscopes	*504*	*Rs.16,000/-*	*Rs.3,02,872/-*	*Rs.8,25,000/-*	
STDC/ IRL Equipment					
Any Other (pl. specify)					
			TOTAL	***Rs.17,25,000/-***	

6. Training:

Activity	*No. in the state*	*No. already trained in RNTCP*	*No. planned to be trained in RNTCP during each quarter of next FY (c)*				*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
			Q1	*Q2*	*Q3*	*Q4*			
	(a)	*(b)*					*(d)*	*(e)*	*(f)*
Training of DTOs (at National level)									
Training of MO-TCs									
Training of MOs (Govt + Non-Govt)									
Training of LTs of DMCs- Govt + Non Govt									
Training of MPWs									
Training of MPHS, pharmacists, nursing staff, DEO etc			*4000*	*3000*	*1500*	*2500*			
Training of Comm Volunteers			*2000*	*4000*	*6000*	*1000*			
Training of Pvt Practitioners			*500*	*1000*	*1500*	*200*			
Other trainings #									
Re- training of MOs			*400*	*400*	*400*	*200*			
Re- Training of LTs of DMCs			*50*	*25*	*55*	*25*			
Re- Training of MPWs									
Re- Training of MPHS, pharmacists, nursing staff, BEO			*500*	*600*		*800*			
Re- Training of CVs									

Re-training of Pvt Practitioners									
TB/HIV Training of MO-TCs and MOs									
TB/HIV Training of STLS, LTs , MPWs, MPHS, Nursing Staff, Community Volunteers etc			*800*	*700*	*400*	*200*			
TB/HIV Training of STS									
Provision for Update Training at Various Levels #									
Review Meetings at State Level									
Any Other Training Activity									

 # Please specify **TOTAL Rs.24,41,460/-**

7. Vehicle Maintenance:

Type of Vehicle	*Number permissible as per the norms in the state*	*Number actually present*	*Amount spent on POL and Maintenance in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted* *(Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
Four Wheelers	*0*	*0*	*Rs.9,040/-*	*Rs.2,00,000/-*	*Rs.1,25,000/-*	
Two Wheelers	*130*	*113*	*Rs.2,84,200/-*	*Rs.16,29,000/-*	*Rs.24,75,000/-*	
				TOTAL	***Rs.26,00,000/-***	

8. Vehicle Hiring*:

Hiring of Four Wheeler	*Number permissible as per the norms in the state*	*Number actually requiring hired vehicles*	*Amount spent in the prev. 4 qtrs*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
For STC/ STDC						
For DTO	*30*	*30*	*Rs.8,89,987/-*	*Rs.27,85,400/-*	*Rs.30,00,000/-*	
For MO-TC	*130*	*130*	*Rs.36,100/-*	*Rs.29,98,700/-*	Rs.30,00,000/-	
				TOTAL	***Rs.60,00,000/-***	

** Vehicle Hiring permissible only where RNTCP vehicles have not been provided*

9. NGO/ PP Support:

Activity	*No. of currently involved in RNTCP in the state*	*Additional enrolment planned for this year*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*
NGOs involvement scheme 1	3	19	0	Rs.161000	Rs.4,42,500/-	
NGOs involvement scheme 2	5	76	0	Rs.454000	Rs.14,09,000/-	
NGOs involvement scheme 3	2	5	0	0	Rs.1,50,000/-	
NGOs involvement scheme 4	3	15	0	Rs.300000	Rs.7,52,500/-	
NGOs involvement	1	5	0	Rs.425313	Rs.24,00,000/-	

scheme 5						
NGOs involvement unsigned						
Private practitioners scheme 1	0	160	10	Rs.10000	Rs.2,33,000/-	
Private practitioners scheme 2A	134	527	0	Rs.71000	Rs.3,51,250/-	
Private practitioners scheme 2B	0	59	0	0	Rs.9,55,000/-	
Private practitioners scheme 3	0	250	0	0	Rs.1,05,000/-	
Private practitioners scheme 4	0	3017	0	Rs.10000	Rs.1,80,000/-	
				TOTAL	***Rs. 69,78,250/-***	

10. Miscellaneous:

*Activity** e.g. TA/DA, Stationary, etc	*Amount permissible as per the norms in the state*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
	Rs.97,43,279/-	Rs.8,74,802/-	Rs.43,77,501/-	Rs.87,84,550/-	
			TOTAL	***Rs.87,84,550/-***	

** Please mention the main activities proposed to be met out through this head*

11. Contractual Services:

Category of Staff	*No. permissible as per the norms in the state*	*No. actually present in the state*	*No. planned to be additionally hired during this year (Total)*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current fin. year*	*Estimated Expenditure for the next financial year (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*		*(d)*	*(e)*	
TB/HIV Coord.							
Urban TB Coord.							
MO-STCS							

State Acctt							
State IEC Offr							
Pharmacist							
Secretarial Asst							
MO-DTC	*6*	*6*	*6*	*Rs.8,48,550/-*	*Rs.4,89,000/-*	*Rs.11,52,000/-*	
STS	*130*	*98*	*126*	*Rs.40,00,279/-*	*Rs.62,00,614/-*	Rs.1,13,40,000/-	
STLS	*130*	*90*	*126*	Rs.35,61,978/-	Rs.54,59,372/-	*Rs.1,13,40,000/-*	
TBHV	*49*	*22*	*47*	Rs.7,52,265 /-	Rs.7,27,500 /-	*Rs.33,84,000/-*	
DEO	*30*	*20*	*30*	Rs.8,51,596/-	*Rs.1199873 /-*	*Rs.20,88,000/-*	
Accountant – part time	*30*	*13*	*30*	*Rs.71,000/-*	*Rs.1,38,000/-*	*Rs.6,48,000/-*	
Contractual LT	*290*	*172*	*290*	*Rs.25,34,048/-*	*Rs.55,99,000/-*	*Rs. 21,60,000/-*	
Driver	*0*						
Any other contractual post approved under RNTCP							
					TOTAL	***Rs.3,21,12,000****/-*	

12. Printing:

Activity	*Amount permissible as per the norms in the state*	*Amount spent in the previous 4 quarters*	*Expenditure (in Rs) planned for current financial year*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*

	(a)	(b)	(c)	(d)	(e)
*Printing-State level:**	Rs.97,43,279/-			*Rs.5200000/-*	
*Printing- Distt. Level:**		Rs.15,47,528/-	Rs.48,13,170/-		

** Please specify items to be printed in this column*

13. Research and Studies (excluding OR in Medical Colleges):

Any Operational Research projects planned (Yes/No) Yes
(If yes, enclose annexure providing details of the Topic of the Study, Investigators and Other details)

Whether submitted for approval/ already approved? (Yes/No) No
Estimated Total Budget Rs.6,00,000/-

14. Medical Colleges

Activity	*Amount permissible as per norms*	*Estimated Expenditure for the next financial year(Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*
Contractual Staff: ▪ *MO-Medical College (Total approved in state 3)* ▪ *STLS in Medical Colleges (Total no in state 3)* ▪ *LT for Medical College (Total no in state 3)* ▪ *TBHV for Medical College (Total no in state 3)*	*Rs.12,96,000/-*	*Rs.12,96,000/-*	
Research and Studies: ▪ Thesis of PG Students ▪ Operations Research*		*Rs.1,00,000/-*	
Travel Expenses for attending			

STF/ZTF/NTF meetings		Rs.50,000/-	
IEC: Meetings and CME planned		*Rs.50,000/-*	
Equipment Maintenance at Nodal Centres		*Rs.14,96,000/-*	

** Expenditure on OR can only be incurred after due approvals of STF/ STCS/ZTF/CTD (as applicable)*

15. Procurement of Vehicles:

Equipment	*No. actually present in the state*	*No. planned for procurement this year (only if permissible as per norms)*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
*4-wheeler ***	*-*	*-*	*-*	
2-wheeler	*119*	*11*	*Rs.3,85,000/-*	

*** Only if authorized in writing by the Central TB Division*

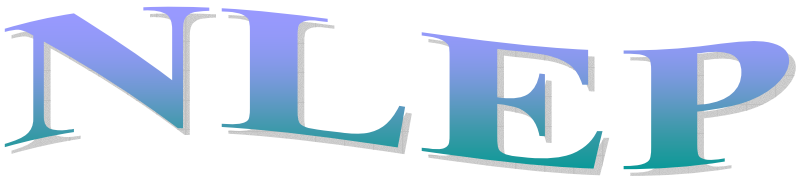
16. Procurement of Equipment:

Equipment	*No. actually present in the state*	*No. planned for this year (only as per norms)*	*Estimated Expenditure for the next financial year for which plan is being submitted (Rs.)*	*Justification/ remarks*
	(a)	*(b)*	*(c)*	*(d)*
Computer	*30*	*0*	*-*	
Photocopier	*22*	*5*	*Rs.3,95,000/-*	
OHP	*19*	*11*	*Rs.1,65,000/-*	
Total			*Rs.5,60,000/-*	

Section D: Summary of proposed budget for the state –

Category of Expenditure	Budget estimate for the coming FY 2008 - 2009 (To be based on the planned activities and expenditure in Section C)
1. Civil works	Rs.43,66,000/-
2. Laboratory materials	Rs.97,50,000/-
3. Honorarium	*Rs.1,50,00,000/-*
4. IEC/ Publicity	Rs.43,28,700/-
5. Equipment maintenance	*Rs.17,25,000/-*
6. Training	Rs.24,41,460/-
7. Vehicle maintenance	Rs.26,00,000/-
8. Vehicle hiring	Rs.60,00,000/-
9. NGO/PP support	*Rs.69,78,250/-*
10. Miscellaneous	*Rs.87,84,550/-*
11. Contractual services	Rs.3,21,12,000/-
12. Printing	*Rs.52,00,000/-*
13. Research and studies	Rs.6,00,000/-
14. Medical Colleges	Rs.14,96,000/-
15. Procurement –vehicles	*Rs.3,85,000/-*
16. Procurement – equipment	Rs.5,60,000/-
Total	Rs.10,23,26,960/-

** *Only if authorized in writing by the Central TB Division*


NLEP

NLEP STATE ACTION PLAN (2008 – 2009)

- Bring down the prevalence in community below 1/10000 Population.
- All under treatment leprosy patients will be treated regularly
- To prevent leprosy associated disabilities
- To reduce the stigma in the society
- To reduce Prevalence rate of Leprosy in high PR districts & Blocks
- To maintain achievement in elimination of Leprosy in those districts & Blocks who have achieved the elimination goal.
- To implement urban Leprosy programme with the help of Municipal Corporation and stake holders
- Strengthening of integration of Leprosy so that GHS can provide quality MDT services
- To provide quality disability care to Leprosy patients and treated disabled persons
- To emphasize upon providing quality leprosy services at each level and thus to reach the goal of leprosy elimination at the State , districts and blocks level.
- To provide quality care services to leprosy patients and disability cases through GHCS by implementing Disability Prevention and Medical Rehabilitation (DPMR).
- To strengthen the close monitoring and supervision at State, District and PHC level

Strategy:

- Identifying high endemic and SC/ST villages and intensified IPC and IEC, to encourage voluntary reporting
- Involvement of GHS staff in IEC & IPC
- Provision of quality MDT services at all health facilities
- IEC & IPC by Doordarshan, Akashwani and with involvement of health workers
- Provision of better disability care to the leprosy patient and disable leprosy cured persons
- Development of Referral system to deal with complications of leprosy

Background

- The Leprosy Prevalence Rate (PR) at the beginning of Multi Drug Therapy was more than 50 per 10,000 populations.
- The whole state was covered under MDT in Nov, 1996 & till date more than 15 lakhs patients treated with MDT.
- The PR reduced to 14.2 per 10,000 populations in year 1999.
- Leprosy Services were integrated into General Health Care System in 2000-2001.
- Five rounds of modified Leprosy Elimination campaigns and four rounds of Block Leprosy awareness campaigns have been already successfully conducted in the state during the period 1998 to 2007-08. These activities resulted in detection of more than 4 lakh cases

MDT in Bihar

- MDT started in Bihar in phased manner.
- In first phase MDT was started in two districts in year 1982 (Bhagalpur & Rohtas)
- 13 more districts added in 1994
- MDT was inducted in whole state in year 1996-97
- PR / 10000 population at the beginning of MDT= 17.3

Current Status

- Now the State is on the verge of elimination with current PR of 1.14 as on December 2007 (PR was 1.06 in March 2007)
- 13 Districts reached elimination, 25 districts have PR between 1 & 2
- At present the NLEP is fully integrated into General Health Care System from Sub center to District Hospital / Medical Colleges.
- District Nucleus is formed at 30 out of 38 districts to monitor & supervise program
- The IEC activities including Inter Personal Communication (IPC) are continued and therefore the stigma has significantly come down. At present most of leprosy deformed patient are living with their family and leprosy patient coming at health institutions voluntarily.

The treatment compliance has always remained more than 95%.

B. STRATEGY:

The main strategies being followed at present is planned to be continued. The five basic components of the Annual plan strategy are –

1. Integrated Leprosy Services and Special initiatives
2. Disability Prevention & Medical Rehabilitation
3. Information, Education & Communication
4. Training
5. Infrastructure maintenance

Integrated Leprosy Services and Special initiatives -

- Integrated Leprosy Services through all the Primary Health Care facilities will continue to be provided in the rural areas.
- All the urban areas will be covered under the urban leprosy control programme integrating services from all the partners available in the area, including the private practitioners.
- Involvement of the Multi-purpose Health functionaries, ASHA in villages and selected NGOs in urban areas are to be engaged for case follow up during treatment to ensure

regular MDT collection and consumption, so that all the cases put under treatment gets cured in shortest possible time.

- Emphasis will be laid on providing best quality leprosy services through GHC system. This means easy availability of services on all working days to all patients, correct diagnosis and adequate counseling to patient and family members, provide MDT to patient whenever approached, regular monitoring of the patient during treatment. Treatment completion by all patients will be desired outcome of the programme.
- The system of referral of difficult cases to the District hospital for diagnosis and management, which has already been started, will be further strengthened with capacity building of persons involved at PHC as well as District Hospital level.
- The laboratory facilities at the District Hospitals for smear examination to diagnose difficult cases will be strengthened.
- Desegregated data for Female, Schedule Tribe and Schedule Caste patients are to be maintained.
- Regular monitoring and surveillance at State, District and Block level will be continued to locate weak areas, so that needed plan for corrective action can be taken in time.

Disability Prevention and Medical Rehabilitation (DPMR) -

More emphasis will be given on Disability prevention among new leprosy cases and Re-constructive Surgery (RCS) services for leprosy deformed cases.

Prevention of Disability:

- Health workers will suspect cases of lepra reaction, relapse and insensitive hands & feet and will refer to PHC, Medical Officer for diagnosis & treatment.
- PHCs will diagnose and treat leprosy cases with reaction and Neuritis, provide counseling to patient on self care practices and also provide protective footwear to needy patients. Prednisolone tabs will be available in sufficient quantity at all PHCs to provide full course treatment to needy patient.
- Severe/complicated cases and all Grade – II deformity cases will be referred by PHC Medical Officer to District Hospitals/District Nucleus.
- PHCs will provide follow up treatment to all patients referred back from secondary & tertiary level.
- Grade-I & II will be referred to PHCs/Districts by peripheral institutions. Types of services as per DPMR guidelines will be provided to such cases. The adequate logistic supports will be available at every service points.

Training Plan

Leprosy Training to GHC staffs (New Entrants): To improve the quality of leprosy diagnosis, complications management, DPMR and programme monitoring the key medical and paramedical staffs will be provided training:

- 900 newly appointed MOs will be provided three days modular training on Leprosy and NLEP.
- 5000 newly appointed ANMs will be provided one day training on Leprosy and NLEP.

5 Days Training for Lab. Technicians:

- 45 Lab. Tech., one from each district will be provided training in techniques of smear taking and examination so that referred difficult to diagnose cases can be diagnosed on finding of skin smear.

Refresher Training of PHC Medical Officers (1day) & Para medicals:

- 3000 MO from PHCs will get refreshers training for 1 day at District level
- 1500 nos. of Pharmacists, supervisors and LHVs will be trained (1day) at District

Interactive Meeting with the faculties of SPM, Skin &VD Dept., Medicine, Ortho and Plastic Surgery with support of ILEP

Other Training and Workshops

- Quarterly Review & Planning Meeting of DLOs, MO Dist. Nucleus & ACMOs four times.
- Three days training of district nucleus team members about physiotherapy and POD under DPMR.
- One day POD and physiotherapy training of NMS/NMAs attached to PHCs under DPMR programme will be conducted.
- Training of private practitioners, dermatologists and other registered medical practitioners with support of ILEP.
- 1 day orientation training of ASHA(remaining ASHA). ASHA training is continued in year 2007-08.

IEC

- Radio spots and Doordarshan
- Political Advocacy, for MLA, MLC/Mukhiya.
- 10025 wall paintings in all districts(25 wall paintings per blocks)
- 401 health melas, one in each block.
- 6015 nos. Quiz in 15 Schools in each block will be organized.

- 33% villages of Bihar state will be considered(15000 villages) for IPC about leprosy awareness among community members.
- Organisation of State level and district level anti leprosy day function on 30th January 2009.

DPMR

- 2280 pairs of MCR footwear will be distributed as per the requirements of districts so that procurement of MCR footwear has taken in procurement plan.
- 200 nos. of RCS operations at Medical Colleges/TLM Hospital Muzaffarpur @ Rs. 5000 + Rs.5000/- per Operations.

Urban Leprosy Control

Only 11% of Bihar's population lives in urban area. Since masses lived in rural areas urban leprosy control plan was not a priority. Now with integration, rural leprosy services are well established and it is time to shift the thrust on urban leprosy elimination plan. The strategies are to focus on:

- Women groups
- Marginalized community (slums)
- School children
- Industrial townships

Annexure - 1: Budget for Year 2008-2009

Sl. No.	Category of Expenditure : Component & Sub Component wise	DHS (Leprosy)	SHSB (Leprosy)	WHO support
1	**Materials & Supplies :**			
1.1	Supportive Medcine Rs. 20000/- per dist per year	760000		
1.2	MCR & Other Footwear 60 pairs per district for 38 districts @ Rs.200/- per pair		456000	
1.3	Splints/Crutches etc @ Rs.10000/- per district / year		380000	
1.4	Patient Welfare @ Rs.6000/- per dist/year		228000	
1.5	Laboratory reagents and equipments @ 12000/- per district per year	456000		
1.6	State level Review Meeting, Four/year @ 35000*4		140000	
2	**Printing (SIS & MDT Indent)**			
2.1	Printing of reporting forms, indent forms, registers etc for PHC/Dist/State @ Rs. 10000 per dist(state)/ year		380000	
3	**IEC :**			

3.1	Radio Spots/Doordarshan		1000000	
3.2	Meeting (Political Advocacy, for MLA, MLC/Mukhiya)		250000	
3.3	Hoarding@ Rs.12000/- per block	4812000		
3.4	Bus panel@Rs.1900/- per unit(3 units per district)	216600		
3.5	Posters@ Rs.5/- per unit(20 posters per block)		40100	
3.6	Cable Spot@ Rs.15000/- per district	570000		
3.7	Wall panting@ Rs.200/- per unit(25 units per block)	2005000		
3.8	Rallies (including banners etc.)@ Rs.5000/- per district	190000		
3.9	School Quiz@Rs.500/-per block(15 quiz per block)	3007500		
3.1	Cinema slides@Rs.3000/-per unit(3 unit per district)	114000		
3.11	Folk Shows in haats@Rs.3000/-per show(2 per block)	2406000		
3.12	IPC Workshops (HW & Mos)@Rs.6000/- per workshop(2 workshop per district)	456000		
3.13	Meeting with Zilla Parishad@Rs.3000/- per unit(1 per district)	114000		
3.14	Orientation camp for NGO and Mahila Mandals	304000		
3.15	Village level IPC for 15000 villages(33% villages of state) @ Rs. 200/- per village, 15000*200	3000000		
3.16	Press Advertisement@Rs.12000/- per unit(4 units per district)		1824000	
3.17	Dignostic Cards 200 cards per block(Rs.5/- per unit)		401000	
3.18	Health Mellas/Fairs@Rs-4000/-(1 mela per block)	1604000		
3.19	IPC for influnecial leaders involving AWW and ASHA@Rs.500/-per unit(10 units per block)	2005000		
4	**Contractual Services (Annexure-2)**	5422600	361800	
4.1	District Nucleus staff (1 MO @ 15000/- pm + 2 NMS @ 7000/- each pm + 1 PT @ 10000/- pm on rainingal Basis for one year in districts with no existing district nucleus/ alternative NLEP structure in 9 districts	4212000		
5	**Urban Leprosy Elimination Activities (24Cities/ townships@47000/city/year& five @Rs100000/- per city & 1@200000/-)**	1828000		
6	**Training**			
6.1	3 day training for Mos @ 60000/-per batch of 30 Mos x 30 batches(Fresh appointment in 2007-08)		1800000	
6.2	1 day reorientation training for Medical Officers at Distt./PHC @ 8000/- per batch of 30 Mos x 100 batches	800000		
6.3	1 day training for 5000 newly appointed ANMs at PHC @ 7000/- per batch of 30 ANMs * 167 batches	1169000		

6.4	Refreshal training for one day for Health Supervisors/LHV/Pharmacists @ 7000/- per batch of 30 x 50 batches	350000		
6.5	5 days training of lab technicians @ 10000/- per batch of 15 LTs x 3 batches		30000	
6.6	2 days refresher training of MO district nucleus for 1 batch o 38 Mos from 38 districts		30000	
7	**Disability Prevention and Medical Rehabilitation (DPMR)**			
7.1	DPMR preparation and patient mobilization @ 40000/- per district per year	1520000		
7.2	RCS @ 5000/- per RCS for 150 operations at Dept of PMR, Patna Medical College, Patna and 50 operations at Darbhanga Medical College, Darbhanga		100000	
7.3	Welfare allowance for RCS patients @ 5000/- per patient for 200 patients		100000	
7.4	3 days DPMR training of Dist Nucleus Staff (1MO DN/DLO + 2 NMS DN + 1 PT DN) 38x4 = 152 participants in 5 batches @ 25000/- per batch		125000	
7.5	1 day DPMR training of NMA and NMS @ 8000/- per batch for 30 batches	240000		
7.6	Self-care kits for 5000 Leprosy patients and cured leprosy affected persons @ Rs.200/- per kit.	1000000		
	Total of Investment cost	**38561700**	**7645900**	
8	**RECURRENT COST**			
8.1	Consumables : Stationery etc.@ Rs. 15000/- per dist/year	570000	30000	
8.2	Rent/Telephone/Electricity, P&T Chrges/Miscellaneous @ Rs.20000/- per dist/year	760000	40000	
8.3	Equipment and maintenance		30000	
8.4	Vehicle Operation, POL / Hiring for 78 vehicle @ Rs. 100000/- per year	7600000	200000	
8.5	Maintenance of equipment and & contigency			144000
	Total of Recurrent cost	**8930000**	**300000**	**144000**
9	**Incentive for ASHA and NGOs (Urban) for completion of treatment by Leprosy affected persons**			
9.1	Expected no. of new PB cases in 2008-09=11640. @ Rs.300/- per PB pt	**3492000**		
9.2	Expected no. of new MB cases in 2008-09=9524.@ Rs.500/ per MB pt.	**4762000**		

	Total of Recurrent cost	**8254000**		
	Grand Total	**55745700**	**7945900**	**144000**
	Total Budget for year 2008-09	**63835600**		

Annexure -2: Details of Expenditure of Contractual Staff of State Health Society Bihar / District Health Society (Leprosy Division)

Sno.	Category of Staff	Honorarium per month	No of peronnel	Expenditure per annum
(A.) State Health Society (Leprosy)				
A.1	Computer Programmer	15000.00	1	180000.00
A.2	Computer Operator -cum-steno	8000.00	1	96000.00
A.3	Driver (SHS)	3850.00	1	46200.00
A.4	Peon	3300.00	1	39600.00
	Total State Health Society			**361800.00**
(B.) District Health Societies (Leprosy)				
B.1	Honorarium for DLS accounts work	400.00	38	182400.00
B.2	Audit Fees			190000.00
B.3	DA to District Nucleus Staff as @ 100/- Per Day for 1 DLO/MO, 75/- Per Day for 1 NMS, 50/- per day for 1 Driver for 15 days in a month for 12 months	40500.00	38	1539000.00
B.4	Driver (DHSs)	3850.00	76	3511200.00
	Total District Health Society			**5422600.00**
	Grand Total Contractual Services Rs.(SHS+DHS)			**5784400.00**

BLINDNESS CONTROL PROGRAMME

Introduction: National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100% centrally sponsored scheme with the goal of reducing the prevalence of blindness. The goal set for the terminal year of the 10th Plan is to reduce the prevalence of blindness to 0.8% by 2007 and 0.3% by 2020.

National Policy:One of the basic human right is 'THE RIGHT TO SIGHT' we have to ensure that no citizen goes blind needlessly, or bring blind does not remain so, if by reasonable skill and resources his sight can be prevented from deteriorating, of if already lost can be restored.

National Programme for Control of Blindness (Financial Year 2008-2009)

There are two main Programmes under National Programme for Control of Blindness:

(1) Cataract Operation
(2) School Eye Screenings Programme:

Cataract Operation:- Cataract Operations are being done in district Hospitals against the target fixed by state. In addition in the NGOs governed hospitals under the monitoring of District Health Society- Blindness Division.
The following table shows the last five year's physical record of Cataract Operation :-

Sl. No.	Year	Target	Achievement	Percentage
1.	2003-04	140000	90405	64.58
2.	2004-05	140000	102531	73.24
3.	2005-06	140000	131860	94.19
4.	2006-07	140000	129064	92.19
5.	2007-08 (Upto Dec. 07)	140000	75103	53.65

School Eye Screening Programme :- Teachers are being trained , to conduct eye screening of the school children and to advise for using proper spectacles by the needy children with defective eyes is one of the main activities of the Programme. In addition to this free distribution of spectacles among the families belonging to below Poverty Line (BPL) is also a major component of the activities.

The following table shows the last two year's physical record of SES :-

Sl. No.	Year	No. of school children underwent Eye Screening
1.	2005-06	2,97,278

2.	2006-07	2,43,095
3.	2007-08 (Up to Dec. 07)	1,95,410

Review Meeting: - A Two days Review Meeting of Additional Chief Medical Officer who is also the District Programme Officer of National Programme for Control of Blindness is proposed in near feature in which representative of Govt. of India shall also be requested to attend.

State Level Workshop:- Three days State Level Workshop of Eye specialist/Eye surgeon of district level is also proposed in which representative of Govt. of India shall also be invited to attend.

Vision Centre:- In remote rural areas where there is no facility of eye care , Govt. of India has provision for setting up vision centre by the NGOs where all facilities for eye care shall be made available. Proposal received from Araria, Siwan, Kaimur, Patna and Banka have been finalized fund to these district had already sent . Fund will be released remaining districts generally.

Training :- Under the NPCB training to Medical Officer of PHC, PMOAs and Nurses shall be imparted. Medical Officers shall be trained for three days, PMOAs for five days and 28 days training to the Nurses as per Govt. of India guideline.

IEC:- In order to make aware the people about how to take care of their eyes to acquaint them where to report for eye check up in case of any vision problem through hand bill, pump let, poster, banner, cable net work, hoarding and Doordarshan etc.

EYE CARE HUMAN RESOUURCES & INFRASTRUCTURES

Sl. No	Name of Eye care Units	Nos.	No. of Eye Surgeons	Eye Beds Strength
1.	IGIMS, Patna	1	13	60
2.	Medical Colleges	6	30 (Teaching Faculty)	306
3.	Medical Colleges, Central Mobile Unit	3	6 (Patna, Darbhanga, Nalanda)	
4.	District Hospital	37	i) Dist. Eye Surgeon : 23 ii) Mobile Unit Eye Surgeon : 25	No Permanent Eye Beds have been marked in Eye deptt. In district hospital
5.	Up graded referral hospital	9	No post	
6	Up graded PHC	113	No post	

Eye Department, Medical Colleges of Bihar and RIO, IGIMS, Patna

Sl. No	Name of the Medical Colleges & Hospitals	Strength of Bed
1	Patna Medical College & Hospital, Patna	101
2	Central Mobile Unit, Patna	0
3	Darbhanga Medical College Hospital, Darbhanga	75
4	Central Mobile Unit , Darbhanga	0
5	Jawahar Lal Nehru Medical College , Bhagalpur	75
6	Nalanda Medical College & Hospital, Patna	60
7	A.N. Medical College & Hospital , Gaya	40
8	Sri Krishna Memorial Medical College & Hospital, Muzaffarpur.	36
9	Regional Institute of Ophthalmology, IGIMS, Patna	60

Comparison of Prevalence of Blindness (1986-89 & 2001-2002)

Parameter	National Survey 1986-89	National Survey 2001-2002
Estd. Prevalence of Blindness (Visual Acuity <6/60	1.49	1.1
Bihar	1.28	0.78

Plan of action and Budgetary requirements during 2008-2009
Requirement of Funds

Name of the State :
BIHAR

Sl. No.	Name of Activity	Estimated Cost. (Rupees in Lakhs)
1.	SBCS Remuneration, other activities & contingencies (Annex-A)	10.00
2.	Grant-in-Aid other Components-SBCS (Annex-B)	308.50
3.	Cash Grant for Salaries & SOC	30.00
	TOTAL:-	348.50

Annexure-A

Budgetary requirement during 2008-2009

Recurring Assistance for State Health Society, Bihar- Blindness Division (Remuneration, other activities and Contingencies etc.)

Sl.No.	Particulars	Cost p.a.
1.	Review Meeting	60,000.00
2.	Flexi pool fund (for staff remuneration)	6,00,000.00
3.	TA/DA for Staff	96,000.00
4.	POL/Vehicle Maintenance	72,000.00
5.	Stationary and Consumables	52,000.00
6.	State level Workshop	120,000.00
	Total:-	10,00,000.00

Annexure-B

Grant in Aid other components-
SHSB-BD

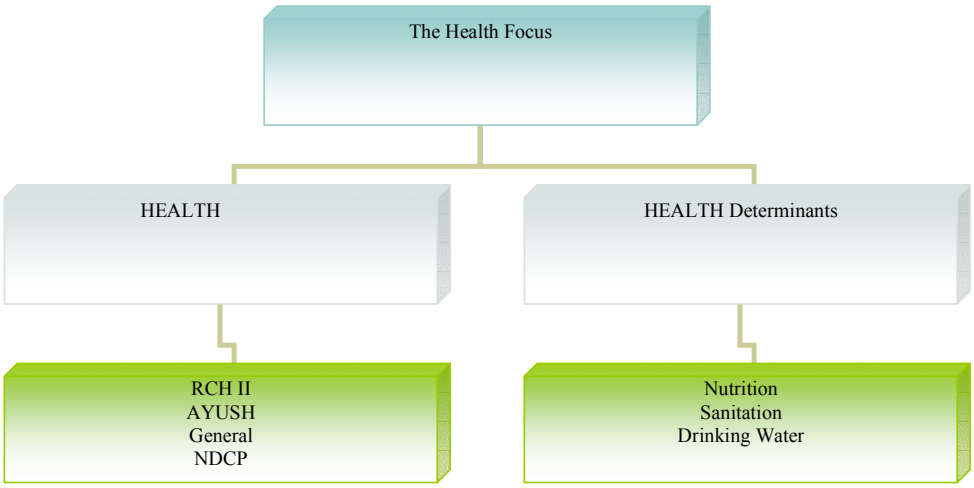
1.	Recurring GIA for Eye Donation	5,00,000.00
2.	Vision Centre (50 @ 25,000/- per vision centres)	12,50,000.00
3.	Non recurring GIA to Eye Bank	10,00,000.00

4.	Non recurring GIA to Eye Donation Centre	1,00,000.00
5.	Training	5,00,000.00
6.	IEC	5,00,000.00
7.	GIA for free Cataract Operation for 38/ DHS-Blindness Division	2,50,00,000.00
8.	GIA for School Eye Screening for 38 DHS- Blindness Division	20,00,000.00
9.		
	Total:-	**3,08,50,000.00**

NRHM PART E
CONVERGENCE

INTERSECTORAL CONVERGENCE

The National Rural Health Mission (NRHM) seeks to adopt a sector wide approach and subsumes key national Programs such as: The Reproductive & Child Health Program (RCH-II), the National Disease Control Program (NDCP) and the Integrated Disease Surveillance project (IDSP). NRHM will also enable the mainstreaming of Ayurvedic, Yoga, Unani, Siddha and homeopathy system of Health (AYUSH). Given that health is so critically linked with nutrition, water and sanitation, NRHM includes strategies for operational convergence to ensure that there is demonstrable synergy between these sectors.



CONVERGENCE WITH NUTRITION AND RELATED PROGRAMS

Currently the Anganwadi Centre (AWC) functions as a centre where children (0-6 years) are being provided with nutrition and health services. The AWC would continue to serve as the focal point for all health and nutrition services. As part of the NRHM, a Health Day is proposed to be fixed every month at the AWC to provide antenatal, postnatal family planning and child health services. An ANM and preferably a Medical Officer from the PHC will be in attendance. With active support from Community Groups such as Self Help Groups (SHGs) to motivate the AWW and ASHA could mobilize women and children and motivate to access services, Services to be provided on the Health Day (by the ANM or PHC MO would include ANC, Newborn check up, Postnatal Care, Immunization of mothers and children, IFA and

Vitamin A administration, growth monitoring, treatment for minor ailments, and health education, AWW and ASHA would
provide counseling to the community regarding the importance of institutional deliveries and facilitate referral. AWW and ASHA will also counsel communities on the importance of balanced diets and promote the use of locally available foodstuffs, particularly for micronutrient supplementation.

Involvement of PRIs

Monitoring and supervising the services of health (and related) functionaries providing services to the masses is important and hence involvement of elected representatives is imperative. Under the program, the PRIs will be involved. PRIs will be sensitized and oriented towards issues relating to women and reproductive health issues, child health issues, family planning and gender. The nodal agency for PRIs, the Indira Gandhi Panchayati Raj Sansthan will also be strengthened so that training/orientation of PRIs can be imparted in an improved manner.

Panchayati Raj Institutions will be responsible for the selection of ASHA and ASHA will be responsible to the Gram Panchayat. At the village level, the Village Health and Sanitation Committee will be guided by the Gram Panchayat. A joint account with the female member of panchayat and ANM is being opened for keeping the untied funds.

CROSS CUTTING ISSUES

Involvement of other sectors in the implementation of activities envisaged under National Rural Health Mission is critical for the success of the programs. This is important at all levels right from the Ministry level to the operational grassroots level. The ANMs are expected to work in close coordination with the Anganwadi Workers (AWWs) – the target population served by both these functionaries comprises mainly women and children. With recruitment of ASHA, the convergence will become still more important for the success of the program. The AWWs, ASHA and ANM will form the core of the Village Health Team and all three will work together to draw the village health plan in consultation with dais, other stakeholders and local opinion leaders. The AWWs will be the core institution for activities relating to delivery of health, family welfare and nutrition services at the village level. It will also serve as the institutional set up for ASHA at village level. A comprehensive Health Camp will be organized once a month at every Anganwadi Centre for providing comprehensive health services related to maternal and child health care and nutrition services. For these camps, functionaries will work in coordination. Funds for these activities have already been budgeted in the RCH Program under the activities.

Intersectoral collaboration		
Sub-Heads	**@**	**Proposed Budget (Rs.)**
Mahila Mandal Meetings at AWCentres	Rs.250 per month per AWC (80000 AWCs)	19,20,00,000/-
Incentive for 100% immunization	Rs.200 per month for 80000 AWC	12,80,00,000/-
PRI Meetings with Health Department at Block Level Twice in a Year	Rs. 3000/- per meeting for 534 Blocks	32,04,000/-
	Total -	**32,32,04,000/-**

BUDGET 2008-09

NRHM PART A : RCH II

Sl	Budget Head	Rs. lakhs	%
1	Maternal Health		
a	JBSY	17360.00	
b	Maternal Health Others	21.32	
	Sub total of Maternal Health	17381.32	**56.62**
2	Child Health	79.50	**0.26**
3	Family Planning		
a	Sterilisation compensation	3100.00	
b	NSV acceptance	150.00	
c	Family Planning Others	397.88	
	Sub total of Family Planning	3647.88	**11.88**
4	Adolescent Reproductive and Sexual Health	0.25	**0.00**
5	Urban RCH	506.77	**1.65**
6	Innovations / PPP/ NGO	1609.40	**5.24**
7	Infrastructure and Human Resources	2000.00	**6.52**
8	Institutional strengthening (HRD practices, logistics, M&E/ HMIS, QA)	958.80	**3.12**
9	Training	1534.00	**5.00**
10	BCC/ IEC	805.14	**2.62**
11	Procurement	1324.00	**4.31**
12	Programme Management	848.70	**2.76**
	TOTAL	**30695.76**	
	Total excluding JSY, Sterization and NSV compensation	**10085.76**	**100.00**

NRHM PART B : NRHM ADDITIONALITIES

S.N.	Budget Heads	Total Budget (Rs. In lacs	%
1.1	ASHA support System at the state level	18.19	0.05
1.2	ASHA Support System at the District Level	3.36	0.01
1.3	ASHA Support System at the Block Level	371.37	0.95
1.4	ASHA Training	1715.36	4.41
1.5	ASHA Drug Kit	450.00	1.16
2.1	Untied Funds at HSCs	929.52	2.39
2.2	Untied Fund for PHCs	133.25	0.34
3.1	Construction of Health Sub Centre	3000.00	7.71

3.2	Construction of Primary Health Centre	3000.00	7.71
3.3	Up-gradation of Community Health Centre As Per IPHS	8040.00	20.66
3.4	Upgrading District Hospitals as per IPHS	900.00	2.31
3.5	Up-gradation of 12 ANM Training School including provision of furniture & equipment	300.00	0.77
3.6	Rental of Staff quarters for doctors & paramedicals Staff from PHCs to District Hospitals.	100.00	0.26
4	District & Block Flexi Pool	380.00	0.98
5	State Health Resource Center and Procurement Cell	200.00	0.51
6	Setting up 5 Trauma centers with Emergency & Referral service.	500.00	1.28
7	Dental units in 38 district hospitals	280.00	0.72
8	Blood Storage Units in 38 FRUs in the first phase	281.31	0.72
9	Annual Maintenance Grant	1058.00	2.72
10	Contractual staffs - salaries & Incentives	8919.00	22.92
11	Rogi Kalyan Samiti	693.00	1.78
12	Setting up Dialysis Unit in 25 selected DH through PPP initiative	300.00	0.77
13	Implementation of IMEP through PPP initiative	1000.00	2.57
14	Stting up of Diagnostic Centre through PPP	0.00	0.00
15	Telemedicine Service in Bihar	300.00	0.77
16	Adll PHC Operation and Management through PPP	1100.00	2.83
17	Special Scheme on controlling Iron Deficiency Programme in Vulnarable Population	900.00	2.31
18	Nutrition Rehabilitation Centre for Severe and Acute Malnutrition	100.00	0.26
19	Setting up of ICU in all District Hospitals	624.51	1.60
20	Exposure visit for Anesthesia Trainers and State Programme Officers	4.00	0.01
21	AAPIO Survey for Specific Disease	50.00	0.13
22	Block Programme Management Unit	2200.00	5.65
23	Additional Manpower for SHSB of Bihar	45.32	0.12
24.1	Emergency Medical Service 102 Call	8.40	0.02
24.2	Doctor on call Dial 1911	10.80	0.03
24.3	Pathology and Radiology Service (Outsourced)	0.00	0.00
24.4	Hospital Maintenance (Funded by State)	0.00	0.00
24.5	Generic Drug Shop (Outsourced)	0.00	0.00
25	Village Health & Sanitation Committee	1000.00	2.57
	Total	**38915.39**	**100.00**

NRHM PART C: IMMUNIZATION

Sl	Budget Head	Tota Budget (Rs. In lakhs)
1	Routine Immunization	8551.60
2	Vitamin A	1979.07
Total		**10530.67**

NRHM PART D – NATIONAL DISEASE CONTROL PROGRAMME

Sl	Budget Head	Total Budget (Rs. In Lakhs)
1	KALA-AZAR	1482.00
2	Filaria and Malaria	1048.28
3	IDSP	723.78
4	IDD	12.00
5	RNTCP	1500.00
6	NLEP	638.36
7	NBCP	348.50
	Total	**5752.92**

NRHM PART E – INTERSECTORAL CONVERGENCE

E	**Intersectoral Convergence**	**3232.04**

SUMMARY of BUDGET

PART	HEAD	BUDGET 2008-09 (Rs. In Lakhs)	%
A	RCH II	30695.76	34.44
B	NRHM Additionalities	38915.39	43.66
C	Immunization	10530.67	11.82
D	NDCP	5752.92	6.45
E	Intersectoral Convergence	3232.04	3.63
	TOTAL	**89126.78**	**100.00**