District Health Action Plan

Year 2009-10

District – Purnia

जिला स्वास्थ्य समिति, पूर्णियाँ।

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प्रेषक ,

सिविल सर्जन सह सदस्य सचिव
जिला स्वास्थ्य समिति, पूर्णियॉ।

सेवा में ,

कार्यपालक निदेशक,
राज्य स्वास्थ्य समिति, बिहार पटना।

पूर्णियाँ, / दिनांक 24/03/08

विषय :– राष्ट्रीय ग्रामिण स्वास्थ्य मिशन अन्तर्गत वित्तीय वर्ष 2009–10 का जिला स्वास्थ्य कार्ययोजना समर्पित करने के संबंध में।

महाशय,

उपर्युक्त विषय के संबंध में कहना है कि वित्तीय वर्ष 2009–10 का जिला स्वास्थ्य कार्ययोजना जिला पदाधिकारी सह अध्यक्ष, जिला स्वास्थ्य समिति, के अनुमोदनोपरांत आवश्यक कार्यार्थ भेजा जा रहा है।

विश्वास भाजन
सिविल सर्जन सह सदस्य सचिव
जिला स्वास्थ्य समिति, पूर्णियॉ।

Forward

The NRHM came up with the Goal to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. The District Health Action Plan of Purnia district is prepared taking into consideration the available resources under the existing RCH-II programme and all other national level programmes. The intention is to develop a fully accountable public health system through intensive monitoring and performance standard. The District Health Plan reflects the convergence with wider determinants of health like drinking water, sanitation, women empowerment, child development etc.

The plan has a special focus on rural health infrastructure development and provisioning of major RCH services in the district in this financial year. Efforts have been made to cover all the district specific needs that have been realized.

It gives us immense pleasure in putting forward the District Health Action Plan under NRHM of Purnia district for the year 2009-10. At the outset, we express our sincere gratitude to the Executive Director, State Health Society Bihar for the project based support to strengthen primary health services in the rural areas of Purnia district. Besides I am very appreciative for the effort made by Population Foundation of India and UNFPA people especially we are very thankful to Mr. Matish Kumar of Population Foundation of India who played a very important role in the process of preparation of District Health Action Plan under NRHM for Purnia district first time after launching of NRHM in the district.

We are also thankful to all district level and block level health officials especially the District Immunization officers, MOICs and disease control programme officers for their hard work in preparing the PIP. We are also very thankful to our DPMU and BHMU staffs without whom it was difficult to collect all the information for preparation of district PIP. At last, the team effort and hard work of ICDS officials, PRI representatives, PHED officials and other district and block level official for their contribution towards preparation of first PIP of the district under NRHM. We appreciate their zest and urge them to convert their vision behind District NRHM Plan into reality.

We look forward to do our speck by effective & successful implementation of the Plan to take district's health situation to the next level.

Civil Surgeon –cum – Member Secretary
District Health Society, Purnia

Content

1. Summary:

Since independence, India has created a vast public health infrastructure of Sub-centres, Primary Health Centres (PHCs) and Community Health Centres (CHCs). There is also large cadre of health care providers (Auxiliary Nurse Midwives, Male Health workers, Female Health Visitors and Health Assistant Male). Yet, this vast infrastructure is able to cater to only 20% of the population, while 80% of healthcare needs are still being provided by the private sector. Rural India is suffering from a long-standing healthcare problem. Studies have shown that only one trained healthcare provider including a doctor with any degree is available per every 16 villages. Although, more than 70% of its population lives in rural areas, but only approximately 20% of the total hospital beds are located in rural area. A countrywide study conducted a few years ago (RCH Facility Survey 1st round) found that less than 50% of primary health centres (PHCs) had a labour room or a laboratory, and less than 20% had a telephone. Less than a third of these centre stocked iron and folic acid, a very cheap but essential drug. Taking into consideration the above issues, the National Rural Health Mission (NRHM) was launched by Government of India (GOI).

The National Rural Health Mission (2005-12) was launched in **April 2005** by GOI. It seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure and Bihar is one of the EAG states.

The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It also seeks to reduce the Maternal Mortality Rate (MMR) in the country from 407 to 100 per 1,00,000 live births, Infant Mortality Rate (IMR) from 60 to 30 per 1000 live births and the Total Fertility Rate (TFR) from 3.0 to 2.1 within the 7 year period of the Mission. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care.

The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centres into functional hospitals meeting Indian Public Health Standards.

The District Action Plan (2009-10), Purnia has focused on few major issues to ensure that MMR, IMR & TFR has been achieved according to the National Goals. In this plan, the focus has been made on improvement of ANC, institutional delivery, PNC, new born care, immunisation, family planning services, health, RTI/STI management, diseases control programme, public-private partnership and strengthening of at least 30% of the PHCs and one FRU at par with IPHS guideline. The focus has also been made on mobile health units, boat ambulance, **urban health**, formation of village health and sanitation committee, village health and nutrition day, infrastructure development by strengthening health centres with adequate equipments, drugs and supplies, and most importantly selection and training. In order to increase institutional delivery attention has been given to 24x7 PHCs.

The gaps have been identified at Panchayat, block and district levels. The identified gaps have been prioritised by the planning team in consultation with different stakeholders and the most important priorities have been taken to address the public need for the financial year 2009-2010. The strategies and feasible activities have been finalised by taking into consideration of NRHM mandates and recommendations from the block and district level officials of related line departments.

A total budget proposed for the year 2009-10 under the NRHM for Purnia district is Rs. 8436.97 lakhs including all the National Health programs.

NATIONAL RURAL HEALTH MISSION

SUMMARY BUDGET -2009-2010 FOR PURNIA DISTRICT

S. No.	Particulars	2009-2010 (in Lacs)
1	Budget for RCH-II	2849.44
2	Budget for NRHM Additionalitis	5280.18
3	Immunization	37.12
4	Budget for NVBDCP	170.13
5	Budget for RNTCP	44.40
6	Budget for NLEP	20.70
7	Budget for NBCP	35
	Total Budget	**8436.97**

The detail budget is given in Annexure - I.

2. BACKGROUND AND CURRENT STATUS

2.1 Bihar at a Glance:

Bihar is located in the eastern part of the country (between 83°-30' to 88°-00' longitude). It is an entirely land–locked state, although the outlet to the sea through the port of Kolkata is not far away. Bihar lies mid-way between the humid West Bengal in the east and the sub humid Uttar Pradesh in the west which provides it with a transitional position in respect of climate, economy and culture. It is bounded by Nepal in the north and by Jharkhand in the south. The Bihar plain is divided into two unequal halves by the river Ganga which flows through the middle from west to east.

Physical Features

Latitude	21°-58'-10" ~ 27°-31'-15" N
Longitude	82°-19'-50" ~ 88°-17'-40" E
Rural Area	92,257.51 sq. Kms
Urban Area	1,095.49 sq. Kms
Total Area	94,163.00 sq. Kms
Height above Sea-Level	173 Feet
Normal Rainfall	1,205 mm
Avg. Number of Rainy Days	52.5 Days in a Year

Administrative Units

Divisions	9
Districts	38
Sub-Divisions	101
CD Blocks	534
Panchayats	8,471

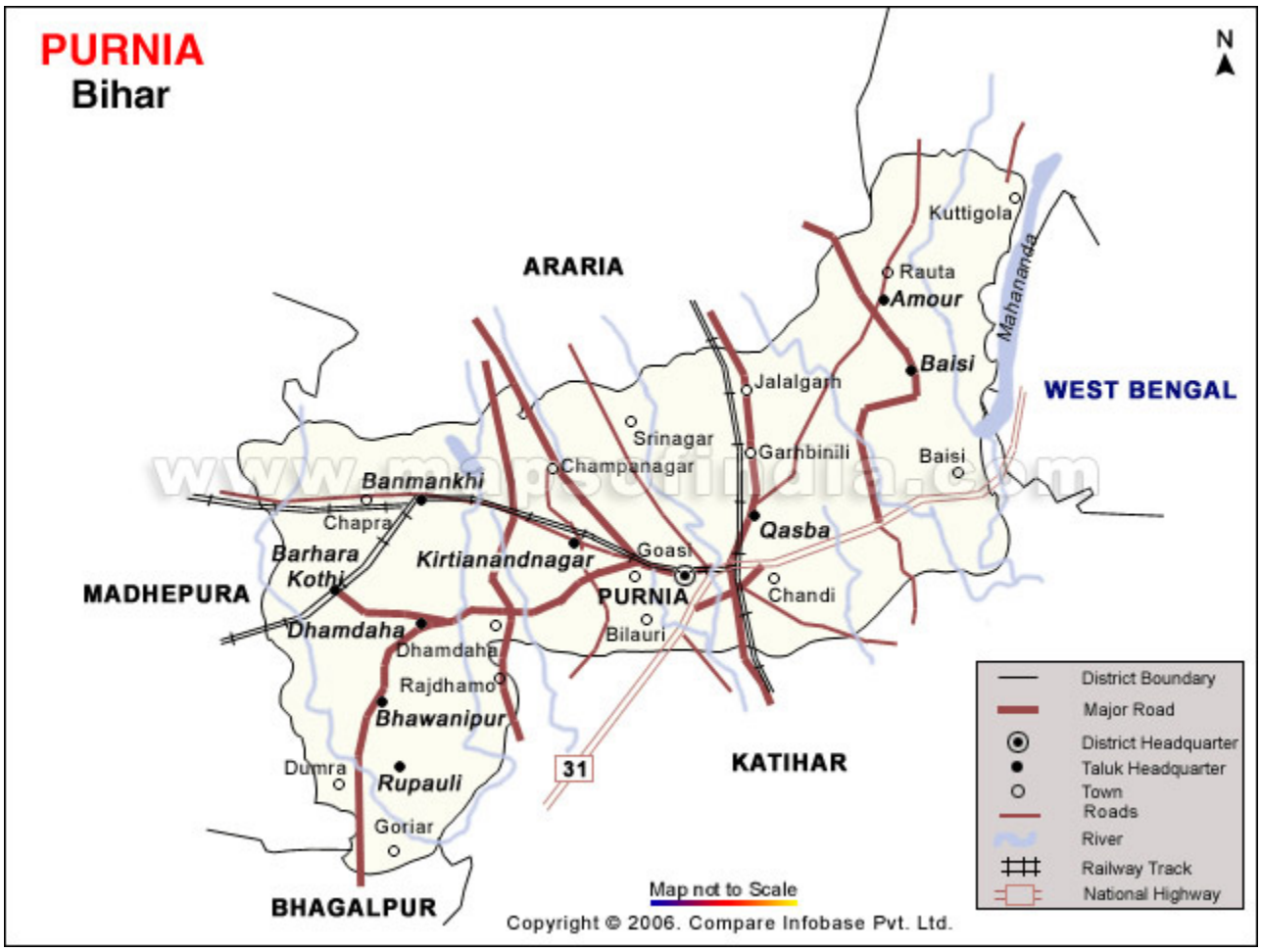
Number of Revenue Villages	45,103
Number of Urban Agglomerations	9
Number of Towns	130
- Statutory Towns	125
- Non-Statutory Towns	5
Police Stations	853
- Civil Police Stations	813
- Railway Police Stations	40
Police Districts	43
- Civil Police District	39
- Railway Police District	4

2.2 Demographic and Socio-Economic Features at District Level:

Purnia is the oldest and one of the most backward districts of Bihar. In 1912, Bihar and Orissa were carved as separate provinces out of the old Bengal Province and Purnia became the district of the new provincial unit. The district of Purnia, as it existed in 1951 with an area of 12784.64 sq. km. and a population of 25,25,231 has been pre-eminently an agricultural district. After separating the Katihar District, the area of Purnia District was 7943 sq. km. and accounts for 4.56 % of the state area. In the year 1990, the district was split into two more districts namely Araria and Kishanganj. Now the present area of the Purnia District is 3202.31 sq. kms. It lies between 25 degree 13 minutes 80 seconds and 27-degree 7 minutes 59 seconds north latitude and between 86 degree 59 minutes 6 seconds and 87-degree 52 minutes 35 seconds east longitude.

As per 2001 census, the total population of Purnia district is 2543942 of which 1328417 are male and 1215525 are female. The district is divided into 4 sub divisions, 14 Blocks, 251 Gram Panchayats, and 1296 villages. The river Kosi and Mahananda and their tributaries irrigate different parts of the district.

Since agriculture is the principal occupation of the people of Purnia. Crops grown in this region are paddy, Jute, Wheat, Maize, Moong, Masoor, Mustard linseed, Sugar cane and Potato. Jute is the major cash crop of Purnia district. Fruit plants like coconut, Banana, Mango, Guava, Lemon, Jack Fruit, Pineapple and banana are also grown here. Rearing of livestock like goat, cow and pig is very popular in Purnia. It produces the maximum number of poultry and eggs in Bihar. The Sugar mill at Banmankhi and 716 other small-scale industries provide employment to the people of Purnia.



As shown in Table 2.1 below, the population of Purnia district is around 2543942 lakh as per the 2001 Census and constitutes about 3.06 percent of the total population of the State. The annual exponential growth rate of the district during 1991-2001 is 3.03 percent. The district has a population density of 787 persons per sq. km., which is low compared to 880 persons per sq. Km. of the State. The sex ratio of the district is 916 females per 1000 males, which is lower than that of the State average of 921 females per 1000 males. The literacy rate of the

district (7yrs and above) is 35.51% percent, with 46.2 percent for males and 23.7 percent for females, which are much lower than the respective rates of the State.

Table 2.1: Basic Demographic Indicators (as per census 2001)		
Particulars	**Purnia**	**Bihar**
(1) General Information:		
Area (Sq. Km.)	3229	
% to Total States' Area	3.43	
CD Blocks	14	
Towns	3	
(2) Population (Census 2001):		
Total	2543942	82998509
Male	1328417	
Female	1215525	
% of Urban Population	8.7	
Total Population (2008-2009)	2958863	
Total Population (2009-2010)	3023960	
(a) Scheduled Castes Population:		
Total	312088	
Male	161322	
Female	150766	
Percent scheduled caste	12.5	15.7
(b) Scheduled Tribes Population:		
Total	111947	
Male	57714	
Female	54233	
Percent scheduled tribes	4.4	0.9
(3) Population in the Age Group 0-6 years:		
Total	549690	
Male	279449	
Female	270241	
(4) Estimated number of Pregnant women (2009-2010)	94684	
(5) Estimated number of Infants (0-1 year)	88766	
(6) Average annual exponential growth rate	3.03	2.5
(7) Decadal Growth Rate (1991-2001):	35.2	
(8)Population under Below Poverty Line	70%	
(9) Population Density:	787.84	881
(10) Sex Ratio (General):	915	921
(11) Sex Ration (0-6):	967	
(12) Literacy Rates:		
Total	35.51	47.0
Male	46.2	59.7
Female	23.7	33.1
(13) Total Workers:		
Total	960700	

Male	677235	
Female	283465	
(14) % of workers to Total Population:		
Total	37.8	
Male	51	
Female	23.3	
(15) Total no. of Blocks	14	
(16) Total no. of Sub-divisions	4	
(17) Total no. of Panchayats	251	
(18) Total no. of Villages	1301	
(19) Total no. of Schools		
Primary	934	
Middle	249	
High	NA	
(20) Total no. of ICDS centres	2482	
(21) Total no. of functional ICDS centres	2399	

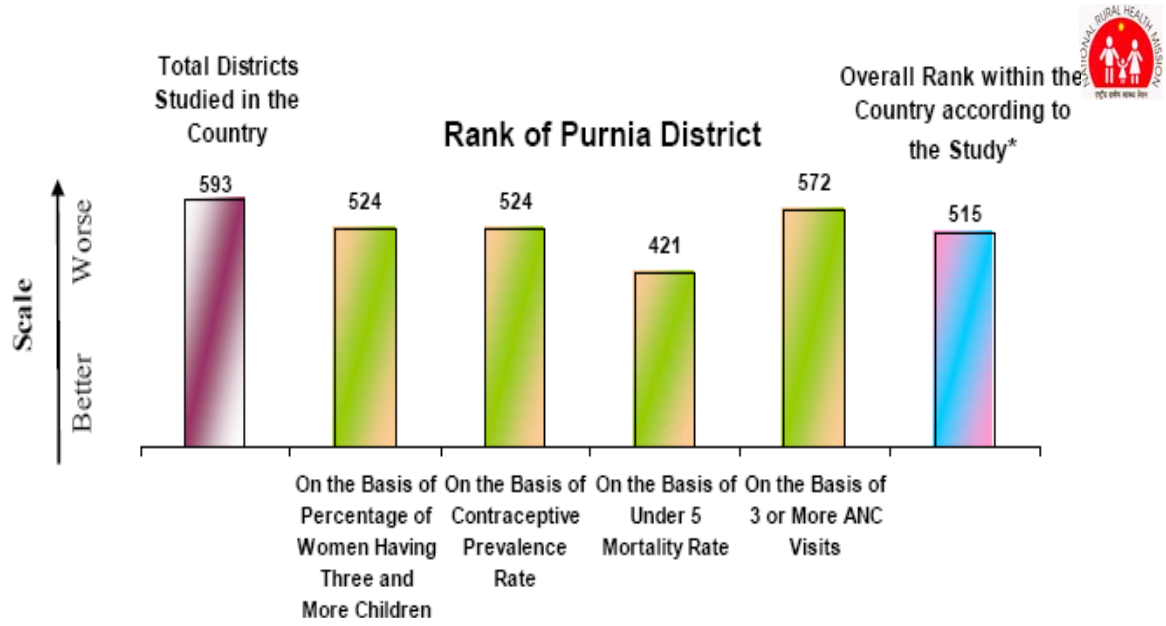
2.3 Administrative Set-up:

Purnia district is bordered by Araria district in north, Katihar and Bhagalpur district in South, Madhepura and Saharsa district in the west and West Dinajpur district of West Bengal and Kishanganj district of Bihar in east. There are four sub-divisions in the district covering all the thirteen blocks. There are 1290 villages under 251 Panchayats in the district. Following is the name of blocks of Purnia district:

Sl. No.	Name of Division	Name of the Blocks
1	Baisi	Amour, Baisa, Baisi and Dagarua
2	Sadar	Purnea East, Kritiyanand Nagar, Kasba, Jalalgarh and Srinagar
3	Damdaha	Damdaha, Bhawanipur, Barhara-kothi (B-kothi), Rupauli
4	Banmankhi	Banmankhi

2.4 Health Status of the District:

When we analyze the key health indicators of the district, we found that the performance of the district is poor. The district ranks 421 on the basis of under 5 mortality rate and on the basis of 3 or more ANC visits, it ranks 572, out of 593 districts taken for study. Following is the rank of Purnia district on the basis of selected indictors:



The district have not been covered due to unavailability of data for some districts

* Source: Ranking and Mapping of Districts, IIPS 2006

As shown in table 2.2, approximately 40.4% of the girls are marrying before attaining the age of 18 years. The total unmet need of the district is 41.2% as per the DLHS 3 data. Approximately 25.7% of the eligible couple is using any modern FP method. The male sterilisation is dismal (only 0.6%) in the district which is a major concern for the district, though the coverage of female sterilisation is 23.3%. Less than 2% of the eligible couple is using condoms, pills and IUD for spacing and delaying their child birth. Only 19% of the pregnant women are getting at least 3+ ANC services and approximately 22% of the deliveries are being conducted at the institutions. The status of child health is also deplorable as even after launching the routine immunisation programme, only 37% of the children (12-23 months) are being fully immunised. There is need to focus on promoting exclusive breast feeding as only 11.5% of the children are being given exclusive breastfeeding. There is great need to build up capacity of the ASHAs and other community health workers as hardly 5% of the target groups are being mobilsed by them to access the health services.

Table 2.2

Basic Socio-Demographic and Health Indicators of Purnia District (as per DLHS 2 & 3)

Sl. No.	Particulars	DLHS 3	DLHS 2	Sl. No.	Particulars	DLHS 3	DLHS 2
1	Percentage of girl's marrying before completing 18 years	40.4	47	E	**Treatment of childhood diseases (children under 3 years based on last two surviving children)**		

2	Sex Ratio at birth	113	NA	E.1	Children with Diarrhoea in the last two weeks who received ORS (%)	7.6	0
3	Percentage of women age 20-24 reporting birth of order 2 & above	67.8	NA	E.2	Children with Diarrhoea in the last two weeks who were given treatment (%)	77.3	0
4	Percentage of births of order 3 and above	53.6	60.4	E.3	Children with acute respiratory infection/fever in the last two weeks who were given treatment (%)	64	NA
5	Percentage of births to women during age 15-19 out of total births	10.4	NA	E.4	Children had check-up within 24 hours after delivery (based on last live birth) (%)	19.8	NA
A	**Family planning (currently married women, age 15-49)**			E.5	Children had check-up within 10 days after delivery (based on last live birth) (%)	19.3	NA
A.1	**Current Use :**			**F**	**Child feeding practices (Children under 3 years)**		
A.1.1	Any Method (%)	27.5	24.9	F.1	Children breastfed within one hour of birth (%)	13.8	NA
A.1.2	Any Modern method (%)	25.7	20.3	F.2	Children (age 6 months above) exclusively breastfed (%)	11.5	NA
A.1.3	Female Sterilization (%)	23.3	16.5	F.3	Children (6-24 months) who received solid or semisolid food and still being breastfed	85.7	NA
A.1.4	Male Sterilization (%)	0.6	0	**G**	**Knowledge of HIV/AIDS and RTI/STI among Ever married Women (age 15-49)**		
A.1.5	IUD (%)	0	0.2	G.1	Women heard of HIV/AIDS (%)	18.9	18.1
A.1.6	Pill (%)	0.8	1.5	G.2	Women who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)	29	31
A.1.7	Condom (%)	1.1	1.2	G.3	Women having correct knowledge of HIV/ AIDS (%)	89.3	NA
B	**Unmet Need for Family Planning:**			G.4	Women underwent test for detecting HIV/ AIDS (%)	3	NA
B.1	Total unmet need (%)	41.2	31.4	G.5	Women heard of RTI/STI (%)	33.8	96.6
B.2	For spacing (%)	17.5	5.9	**H**	**Knowledge of HIV/AIDS among Un-married Women (age 15-24)**		
B.3	For limiting (%)	23.7	25.5	H.1	Women heard of HIV/AIDS (%)	28.8	NA
C	**Maternal Health:**			H.2	Women who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)	35.1	NA
C.1	Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	19	NA	H.3	Women having correct knowledge of HIV/ AIDS (%)	95.9	NA
C.2	Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	19.4	9.5	H.4	Women underwent test for detecting HIV/ AIDS (%)	0	NA

C.3	Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)#	48.8	21.8	H.5	Women heard of RTI/STI (%)	11.7	NA
C.4	Institutional births (%)	21.6	8.4	**I**	**Women facilitated/motivated by ASHA for**		
C.5	Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	2.9	5.5	I.1	Ante-natal Care (%)	1.6	NA
C.6	Mothers who received post natal care within 48 hours of delivery of their last child (%)	19.9	NA	I.2	Delivery at Health Facility (%)	5.3	NA
D	**Child Immunization and Vitamin A supplementation:**			I.3	Use of Family Planning Methods (%)	2	NA
D.1	Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)	37.4	40.9				
D.2	Children (12-23 months) who have received BCG (%)	80.1	49.2				
D.3	Children (12-23 months) who have received 3 doses of Polio Vaccine (%)	49.9	52.9				
D.4	Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	48.7	51.7				
D.5	Children (12-23 months) who have received Measles Vaccine (%)	50	55.2				
D.6	Children (9-35 months) who have received at least one dose of Vitamin A (%)	46.8	NA				
D.7	Children (above 21 months) who have received three doses of Vitamin A (%)	3.6	NA				

**Source: District Level Household Survey 2002-2003 and District Level Household Survey 2008*

2.5 Status of Govt. Institutions in the District

Sl. No.	Type of Institutions	Figures
A.	**Health**	
A.1	District Hospital (DH)	01
A.2	Referral Hospital	03
A.3	Primary Health Centre (PHC)	10
A.4	Additional PHC (APHC)	24
A.5	Health Sub Centre (HSC)	278
B.	**PRI**	
B.1	Gram Panchayat Mukhiya	251
B.2	Member of Gram Panchayat	3426
B.3	Member of Panchayat Samiti	346
B.4	Member of Zila Parishad	34

B.5	Zila Parishad Chairperson	01
C.	**ICDS**	
C.1	Number of Aanganwadi Centres (Sanctioned)	2482
C.2	Number of Aanganwadi Centres (Functional)	2399
C.3	Number of CDPOs (Sanctioned)	15
C.4	Number of CDPOs (In-position)	13
C.5	Number of Supervisors (In-position)	06
C.6	Number of Anaganwadi Workers (Sanctioned)	2482
C.7	Number of Anaganwadi Workers (In-position)	2311
C.8	Number of Anaganwadi Helpers (Sanctioned)	2482
C.9	Number of Anaganwadi Helpers (In-position)	2342
D.	**Educational Institutions**	
D.1	Primary Schools	934
D.2	Middle Schools	249
D.3	High Schools	NA
E.	**Public Health Engineering Department**	
E.1	Village Health and Sanitation Committee	0

2.6 Health Programme in the District:

The Health programmes running in the umbrella of NRHM are enlisted below:

1**. R.C.H.**

- Maternal Health Services
- Child Health Services
- Immunization Services
- RTI / STI
- F.W. Services
- MTP Services

2. Vector Born Disease Control Programme
3. Revised National Tuberculosis Control Programme (RNTCP)
4. National Leprosy Elimination Programme (NLEP)
5. Integrated Disease Surveillance Programme
6. School Health Programme
7. National Polio Eradication Project
8. Iodine Deficiency Disorder Control Programme
9. Adolescent Girls Anaemia Control Project

3. DISTRICT HEALTH ACTION PLAN - PROCESS

The process of preparation of District Health Action Plan (DHAP) for Purnia involved a participatory and need based process in collaboration with the Block and District Health Society. The plan is based on the health situation analysis in the district and the priorities for 2009 – 2010. Following are the activities undertaken as part of the process of preparing the DHAP.

1. Formation of DHAP development team
2. State level Planning meeting
3. Orientation of MOICs and Block Health Managers
4. Situational Analysis
5. Block level consultations
6. District level consultation
7. District level dissemination workshop

3.1 The Team:

A district level DHAP team was constituted. The team comprise of the following;

1. Chairperson Zilla Parishad
2. District Magistrate
3. Civil Surgeon
4. DHMU
5. MOIC
6. PHED
7. Representative from Education
8. Representative from ICDS
9. Alliance for Holistic and Sustainable Development of Communities (AHSDC)
10. UNFPA
11. Population Foundation of India

3.2 State Level Planning Meeting:

Based on the consent of the State Health Society a preparatory meeting about the plan in developing the DHAP for Purnia was held on 7th January 2009 in Patna. The representatives from the State Health Society including the Executive Director, Consultant NRHM, Consultant RCH, Programme Manager, Data Manager, State Malaria Officer, State Leprosy Officer, Assistant Chief Medical Officer (ACMO) and District Programme Manager (DPM) of District Health Society from Rohtas, Vaishali, Purnia and Suapul districts of Bihar, representative of PHRN, including UNFPA, PFI, AANSVA and AHDS were present in the meeting. The UNFPA/PFI plan was presented by PFI representative in the meeting.

It was suggested by the SHS that, since the ground work was already been done by the SHS therefore PFI/UNFPA team can go straight for collecting the information from the block level taking the help of Block Health Management Unit (BHMU). SHS there after issued the letter to the District Magistrate to provide support to PFI/UNFPA in undertaking the activity to develop the DHAP.

3.3 Orientation of Medical Officer In-charge (MOICs) and Block Health Managers:

Followed to the State level meeting the team visited Purnia and had the meeting with the District Magistrate (DM)/Civil Surgeon (CS), DPMU and BHMU staffs. An orientation was undertaken for the BHMU staffs and MOICs at ANM School, Purnia on 13th January 2009 under the chairmanship of Civil Surgeon, Purnia. The MOICs and the Block Health Managers were oriented about the importance of PIP to effectively implement the NRHM activities in the blocks and the process of development of PIP. PFI facilitated the orientation meeting. The focus was made on collecting the data in the prescribed template for situation analysis at block level. Two copies of template were given to all the Block Health Managers (BHMs) and the Medical Officer In-charge (MOICs). The BHMs and MOICs were briefed about all the formats mentioned in the situation analysis template. The BHMs did an exercise on filling up the form in the groups. The meeting was ended with the vote of thanks by the Civil Surgeon, Purnia.

3.4. Situation Analysis:

After orienting all the BHMs and MOICs, the Block Health Mangers were asked to gather all the information in the given format with the help of Block Planning team. The data collection was undertaken by the BHMU in the prescribed format (Situational Analysis for District Health Action Plan) with reference to the information available at the block headquarters. They also referred the information available with ICDS, PHC, APHC, Referral Hospital, PHED, Block Education Office, PRI, ANM, ASHA, and other sources.

The filled in formats then submitted to the District Health Society. The data was analyzed by PFI for sharing at the Block and district level consultation to place the situation of the district for discussion and gather the recommendation for developing the DHAP. Though the data was collected from all the blocks of the district, however the pilot study was made in two blocks namely Kasba and B-kothi blocks based on the suggestions by the District authority of both the districts. The Block Health Managers faced difficulties while collecting the data as the strike of government employees are going on in all over Bihar. The data was validated and compiled by the District Data Manager and the present document has been prepared on the data received from the DHS and BHMUs. The template of the Situation Analysis for Block and District Level is being given in an Annexure – II and the hard copy of all the filled formats of Situation Analysis is available.

3.5 Block level consultation:

The Block level consultations at Kasba and B-kothi blocks were held on 16th and 17th January 2009, respectively. The consultations at both the blocks were chaired by BDO and Block Pramukh. The ASHAs, PRI representatives, AWWs, ANMs, Block Development Officer, officials of PHED, Education, ICDS and health service providers participated in the consultation at both the blocks. The block level consultations helped the community and the service providers to jointly identify the ways in which they could plan to effectively meet their needs under NRHM. The participants were briefed about the objectives of the block level consultation and the processes to be followed for preparation of district PIP for the district. The participants were also sensitised on the key objectives, approaches and activities under NRHM and the importance of preparation of district PIP. The major focus was given on group work. The participants were divided into five groups to undertake the discussion on

Maternal Health, Child Health, Family Planning, Infrastructure (viz. building, facilities, equipments, supplies, drugs, forms etc.) and Convergence. The participants were given seven questions for discussion e.g. what should we do for improvement, how to do, what is available, what are the requirements, how to fulfil the requirement, how to mobilize the beneficiaries and what are the constraints to improve the situation in their block. After the group work, the group came out with the prioritized issues, concerns and feasible solutions/ intervention strategy pertaining to the block. The consultation was facilitated by representatives from UNFPA/PFI and DPMU. The same process was followed in both the blocks. The report of the block level consultations including findings is given in Annexure - III.

3.6 District level consultation:

The district level consultation was held at District Magistrate Office, Purnia on 22nd January 2009 under the Chairmanship of Mr. Sridhar C., District Magistrate, Purnia. All the block and district level health officials, ICDS officials, PRI representatives and district level officials of other line departments participated in the workshop. The consultation was facilitated by the PFI. The objective, expected outcome, processes to attain the expected output was explained to the participants. The findings and recommendation of the block level consultation was also shared with the participants. The participants were divided into eight groups to undertake the discussion on maternal health, child health, family planning, infrastructure (viz. building, facilities, equipments, supplies, drugs, forms etc.), convergence, disease control programme, human resource development and monitoring. The participants were given seven questions for discussion e.g. what should we do for improvement, how to do, what is available, what are the requirements, how to fulfil the requirement, how to mobilize the beneficiaries and what are the constraints to improve the situation in their block. After the group work, the group came out with the prioritized issues, concerns and feasible solutions/ intervention strategy pertaining to the district. The report of the district level consultation including findings is given in Annexure - IV.

3.7 District level dissemination:

Based on the situational analysis, recommendation from Block and District level consultations, the draft DHAP has been prepared by the DHAP team. This would be shared

with the District officials in Purnia for their inputs and comments. The purpose of the dissemination would be to finalise the draft DHAP for Purnia. The members of the district and block level planning teams and other district level officials would be present in the meeting. The meeting would be chaired by the District Magistrate of Purnia.

4. SITUATIONAL ANALYSIS

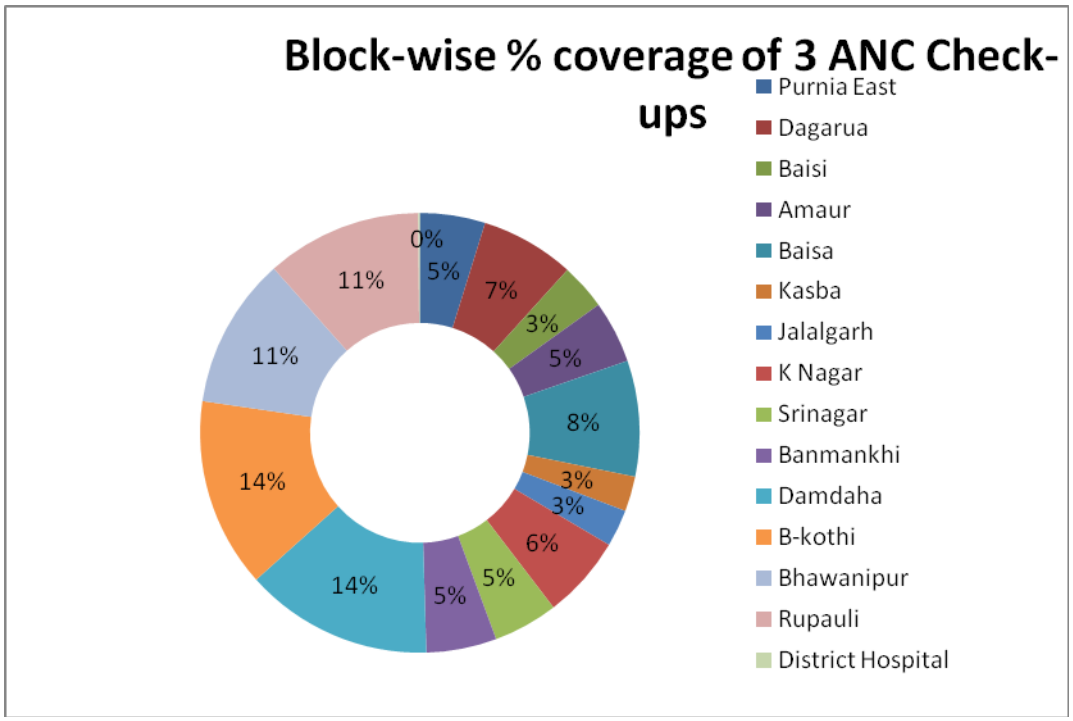
4.1 Status of Reproductive and Child Health (RCH) – II:

4.1.1 Maternal Health:

Though the status of maternal health has improved significantly after launching the NRHM, but still the district has to go miles ahead to achieve the NRHM goals. Following table depicts the district has progressed during the period of DLHS -2 and 3. The coverage of institutional delivery has improved from 8.4% to 21.6% over the period of three years. When we see the data for the last two years, the progress during the period is quite good.

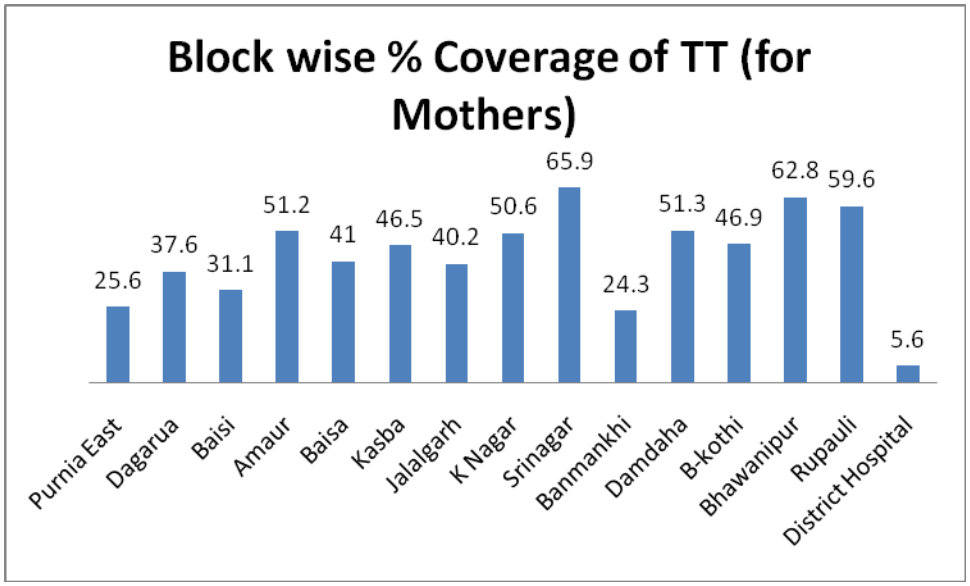
Maternal Health Indicator	DLHS – 3	DLHS – 2
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	19	NA
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	19.4	9.5
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)	48.8	21.8
Institutional births (%)	21.6	8.4
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	2.9	5.5
Mothers who received post natal care within 48 hours of delivery of their last child (%)	19.9	NA

The district has very poor performance in ante natal care services as only 19.4% of the pregnant women are receiving at least 3 ANC visits in the district. Following is the block-wise performance of the ANC check-up for the period of April 2008 to December 2008:



As per the DLHS – 3 data, the percentage coverage of mothers who got at least one TT injection during pregnancy is 48.8%, but the percentage of women receiving two doses of TT injection is only 41.2%. Following is the block-wise target and achievement against the target set for the year:

Sl. No.	Name of the Block / Centres	Target for TT
1	Purnia East	6629
2	Dagarua	6420
3	Baisi	6295
4	Amaur	8246
5	Baisa	5562
6	Kasba	5358
7	Jalalgarh	3215
8	K Nagar	6500
9	Srinagar	3026
10	Banmankhi	10406
11	Damdaha	8684
12	B-kothi	6228
13	Bhawanipur	4722
14	Rupauli	7012
15	District Hospital	6381
	Total	**94684**



The current percentage coverage of pregnant women received 100 Iron Folic Acid (IFA) tablets is only 17.37% of the total women registered for ANC. The following table shows the block-wise performance in terms of pregnant women received 100 IFA tablets:

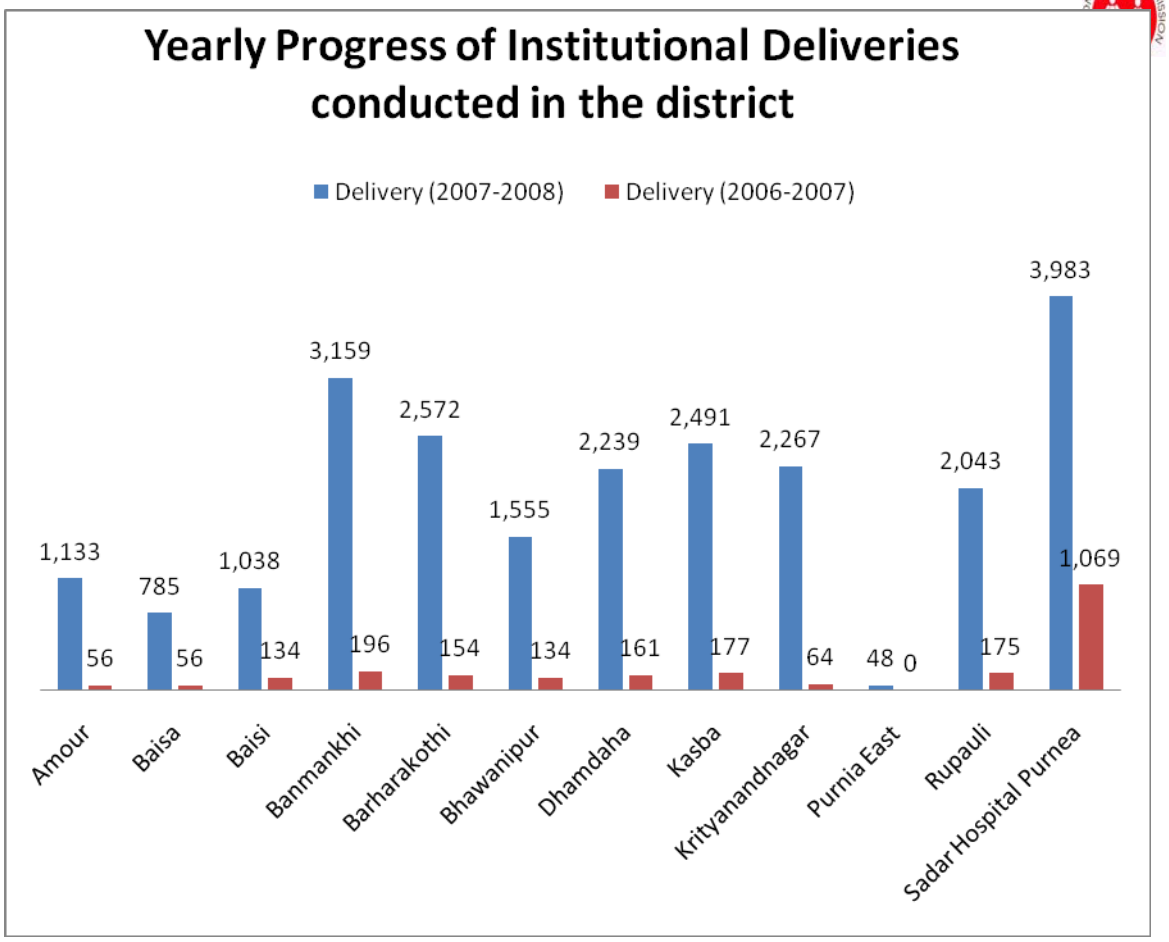
Name of the Block	**Pregnant women received 100 IFA tablets (April 2008-December 2008)**
Purnia East	155
Dagarua	291
Baisi	210
Amaur	684
Baisa	684
Kasba	469
Jalalgarh	1904
K Nagar	83
Srinagar	0
Banmankhi	635
Damdaha	0
B-kothi	1818
Bhawanipur	1105
Rupauli	1804
District Hospital	0
Total	**9842**

One of the prime goal of NRHM is to reduce MMR and IMR in the area. Though the IMR has decreasde significantly over the years due to increase in availability of health services in the

area, but still there is a great need to improve the service delivery specailly related to maternal health. Following table shows block-wise details of still birth conducted at health centres:

Block-wise Details of Still Birth (April 2008 to December 2008)			
		Still Birth	
Sl. No.	**Name of the Block/Centres**	**Male**	**Female**
1	Purnia East	0	0
2	Dagarua	33	30
3	Baisi	44	39
4	Amaur	40	24
5	Baisa	23	18
6	Kasba	33	29
7	Jalalgarh	25	12
8	K Nagar	37	32
9	Srinagar	0	0
10	Banmankhi	90	45
11	Damdaha	52	47
12	B-kothi	50	39
13	Bhawanipur	20	25
14	Rupauli	32	44
15	District Hospital	82	58
	Total	**561**	**442**

In order to reduce the cases of still birth and maternal mortality, it is very important to make all the deliveries either at institutions or at home by skilled birth attendant. The progress of the institutional delivery of the district is quite low which is only 21.6% (as per DLHS-3). Following table shows the progress of the institutional delivery at different health centres in the district during 2006-2007 and 2007 – 2008:



It can be depicted from the above graph that the total number of deliveries conducted during 2006-2007 was 2376, which increased to 23313 during 2007-2008 i.e.the total number of deliveries has increased by 10 times during the year 2007-2008.

Following table shows the status of institutional deliveries conducted at HSCs, PHCs, referrals and district hospital. The number of institutional deliveries has increased significantly in all the health centres of the district, which is very clear from the following table:

Progress of Deliveries in the District (April - 2008 to December 2008)					
Sl. No.	**Name of the Block**	**Total delivery conducted in the area**	**Deliveries conducted at Home by ANM/LHV**	**Institutional Delivery**	**Deliveries at HSC**
1	Purnia East	333	69	96	2
2	Dagarua	2705	17	2688	0
3	Baisi	1902	169	1514	2
4	Amaur	2351	247	1736	11

5	Baisa	2351	247	1082	0
6	Kasba	3994	0	3994	0
7	Jalalgarh	1869	0	1869	0
8	K Nagar	4092	423	2607	316
9	Srinagar	1573	65	1416	0
10	Banmankhi	4284	312	3449	12
11	Damdaha	3897	315	3004	60
12	B-kothi	3237	57	2969	2
13	Bhawanipur	2940	436	1921	0
14	Rupauli	3316	203	2265	211
15	District Hospital	2091	0	2091	0
	Total	**40935**	**2560**	**32701**	**616**

The total number of deliveries conducted during the period of April 2008 to December 2009 is 40935. The progress of the district is good in terms of institutional delivery as till December 2008, the district has crossed the figure of 32500. The institutional deliveries conducted at Kasba PHC are the highest around 12% of the total institutional deliveries conducted in the district. Banmankhi and Damdaha PHCs has the second and third highest performance in terms of institutional delivery which is 11% and 9%, respectively. As per the State Health Society figure (PIP 2008-2009), Purnia has the lowest percentage institutional delivery in all the districts of the state.

Following is the current status of the maternal health in the district:

Sl. No.	Indicators	Figure
1	Number of pregnant women registered for ANC	56651 (April 2008-December 2008)
2	% of pregnant women with 3 ANC check ups	9.4%
3	% of pregnant women with anaemia	73.2%
4	% of pregnant women who received 2 TT injections	41.2%
5	% of pregnant women who received 100 IFA tablets	17.37%
6	Number of Institutional deliveries conducted	33317 (April 2008-December 2009)
7	% of institutional deliveries in which JBSY funds were given	100%
8	% of home deliveries in which JBSY funds were given	Nil
9	% of institutional delivery	40.3%
10	% of safe deliveries	42.5%

It can be analysed from the above table that the percentage of pregnant women with 3 ANC check-ups is only 9.4% which is comparatively very low. It is a major concen for the district.

4.1.2 Child Health:

The most common cause of infant mortality worldwide has traditionally been dehydration from diarrhea. Because of the success of spreading information about Oral Rehydration Solution (a mixture of salts, sugar, and water) to mothers around the world, the rate of children dying from dehydration has been decreasing and has become the second most common cause in the late 1990s. Morbidity and mortality of children 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 Diarrhea 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. 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. The Routine Immunization programme for vaccinating all the children from vaccine preventable diseases, IMNCI programme for management of new born disease and Nutritional Rehabilitation Centre to provide special nutritious food to the severely malnourished children are the three important programmes being run in the district. The bid for establishment of nutritional rehabilitation centre has been called by the SHSB but further process for establishment has not been done so far.

The child health status of the district is also very poor. The Infant Mortality Rate (IMR) of the district is 89, third highest in the state. It's a major conern for the district as well as the state as one of the goal of NRHM and MDG is to reduce IMR and MMR in the area.

Though the child health sitaution has increased in the district during the last two years but still the covergae of complete immunisation and other child care facility is very poor. Following is the progress of immunisation of mother and child during 2006-2007 and 2007-2008:

Progress of Immunization of Mother and Child				
Health Centre Name	**Mother Immunized (2007-2008)**	**Mother Immunized (2006-2007)**	**Child Immunized (2007-2008)**	**Child Immunized (2006-2007)**
Amour	5,881	1,846	36,264	13,464
Baisa	3,460	1,304	17,090	5,837
Baisi	2,058	38,087	9,298	16,191
Banmankhi	3,517	3,282	19,698	23,334
Barharakothi	4,178	1,852	25,265	19,077
Bhawanipur	1,250	664	3,763	6,025
Dhamdaha	5,635	1,594	42,925	10,637
Kasba	5,326	2,370	32,642	21,225
Krityanandnagar	1,257	1,899	5,110	10,475
Purnia East	24	914	201	8,687
Rupauli	1,317	1,211	7,084	14,771
Sadar Hospital	1,934	656	17,898	7,730
Total	**35,837**	**55,679**	**217,238**	**157,453**

Following table shows the block-wise target and achievemnt of child immunisation:

Progress of Child Immunization (from April 2008 - December 2008)						
Sl. No.	**Name of the Block**	**Target Children**	**BCG**	**DPT**	**OPV**	**Measles**
1	Purnia East	6215	60.1	51.7	60.88	62.99
2	Dagarua	6019	75.2	49.9	73.75	76.16
3	Baisi	5902	77.8	50	66.57	55.69
4	Amaur	7731	78.4	51.6	69.97	73.51
5	Baisa	5214	91.5	55.9	61.93	63.9
6	Kasba	5023	67.5	60.1	68.5	64.52
7	Jalalgarh	3014	89	54.8	68.85	59.62
8	K Nagar	6093	81.8	61.4	75.55	81.42
9	Srinagar	2837	107.8	91.4	109.4	107.5
10	Banmankhi	9755	60	39.5	47.53	90.1
11	Damdaha	8141	81.5	60.2	63.96	77.99
12	B-kothi	5839	85.8	55.8	76.98	77.03
13	Bhawanipur	4427	89.1	71.1	69.39	81.5
14	Rupauli	6574	84.9	73.1	82.64	77.87
15	District Hospital	5982	65.9	15.8	16.38	19.56
	Total	**88766**	**77.5**	**54.1**	**65.16**	**71.4**

Srinagar, Kritiyanand Nagar and Rupauli blocks have performed well while the overall performace of child immunisation of B-kothi, Rupauli and District hospital is poor. Approximately 98% of the immunisation sessions have been held against the planned.

Approximately 43% of the children are fully immunised in the district. The coverage of complete immunisation has increased during the year 2008-2009, but still its low in comparison to other better performing districts of the state.

There are 220 hard to reach areas in all the 14 blocks. Following is the detail of hard to reach areas in the district:

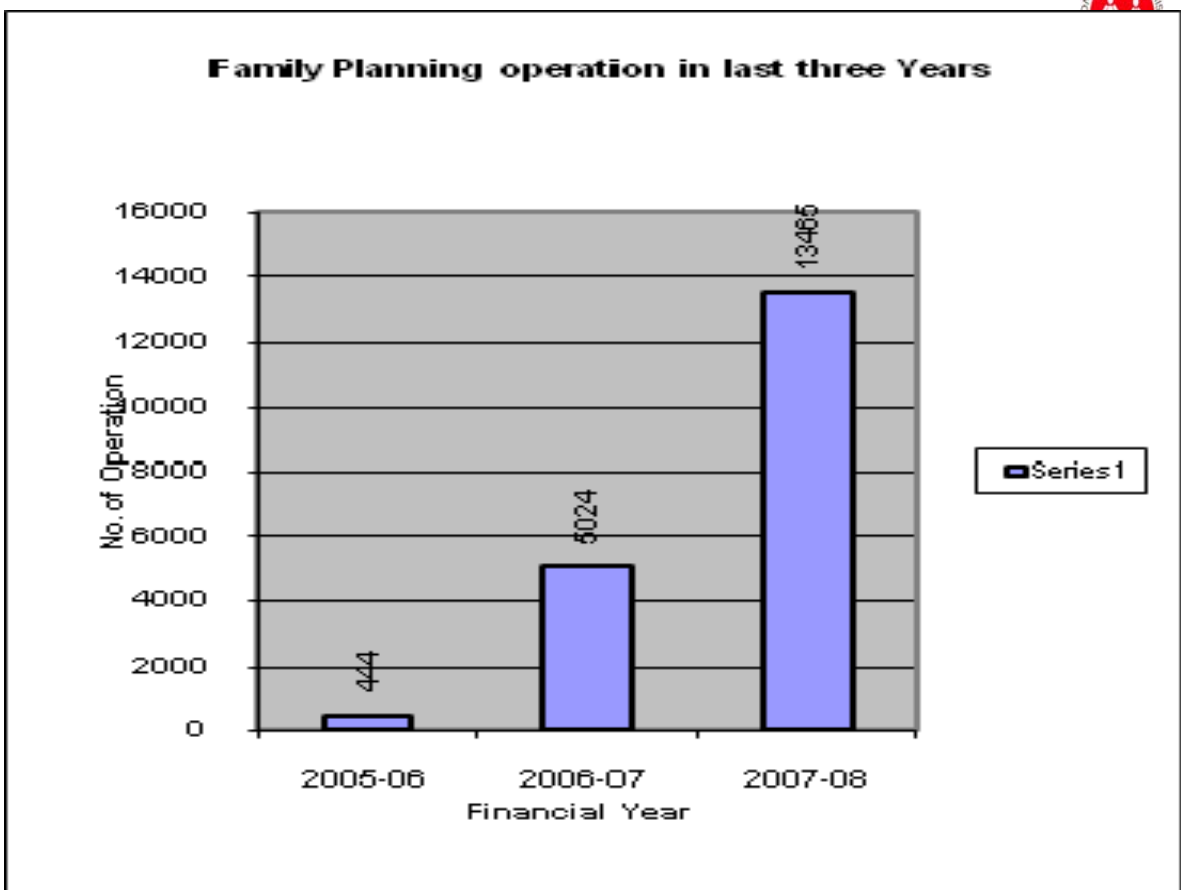
Details of Hard to Reach Areas in the District		
1	Number of Access compromised areas	220
2	Number of block with Access compromised areas	14

4.1.3 Family Planning Services:

The district is also very poor in terms of family planning services as the crude birth rate of the district is 38.1%, the fourth highest in the state. It can be depicted from DLHS – 3, the percentage of girls marrying below attaining legal age of marriage and early pregnancy rate of the district is quite high, because of poor availability and accessibility of clients over temporary contraceptive methods. Following table shows the month-wise usage of temporary contraceptive methods used:

Details of Temporary Contraceptives Used										
Sl. No.	**Type**	**April**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
1	Condom (Pieces)	163214	177636	151991	129700	128884	127221	137305	121569	122336
2	OCP (Packets)	4635	4273	4092	3765	3814	3355	3492	2696	2497
3	IUD 380 A	2402	2393	2379	2391	2483	2168	1518	1456	1453
4	Emergency Contraceptives	645	645	645	645	645	645	645	645	475
	Total temprorary Contraceptive Used	170896	184947	159107	136501	135826	133389	142960	126366	126761

In order to reduce, the TFR there is a need to improve the family planning services in the district. The performance of the district in terms of clinical permanent method is good, which can be depicted from the following graph. But performance in terms of male sterilisation is very poor.



During the financial year 2007-2008, approximately 13500 sterilisations have been conducted during the period of April 2008 to December 2009 and all of them are the female sterilisation. Following table shows the block-wise female sterilisation camps held in the district:

No. of Female Sterilization Camps											
Sl. No.	**Name of the Site**	**April**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
1	Banmankhi	0	0	2	0	0	0	2	8	9	21
2	Barharakoti	1	0	0	0	1	0	1	1	4	8
3	Bhawanipur	0	0	0	0	2		2	4	7	15
4	Rupauli	0	0	0	0	0	0	1	5	6	12
5	Damdaha	1	0	0	0	0	0	1	2	3	7
6	K.Nagar	2	0	0	1	5	8	4	6	9	35
7	Purna East	0	0	0	0	0	2	3	8	10	23
8	Kasba	0	0	0	0	0	0	0	1	2	3
9	Sri Nagar	0	0	0	0	1	1	1	2	6	11
10	Jalalgarh	0	0	0	0	0	0	1	1	2	4
11	Amour	0	0	0	0	0	1	0	1	2	4

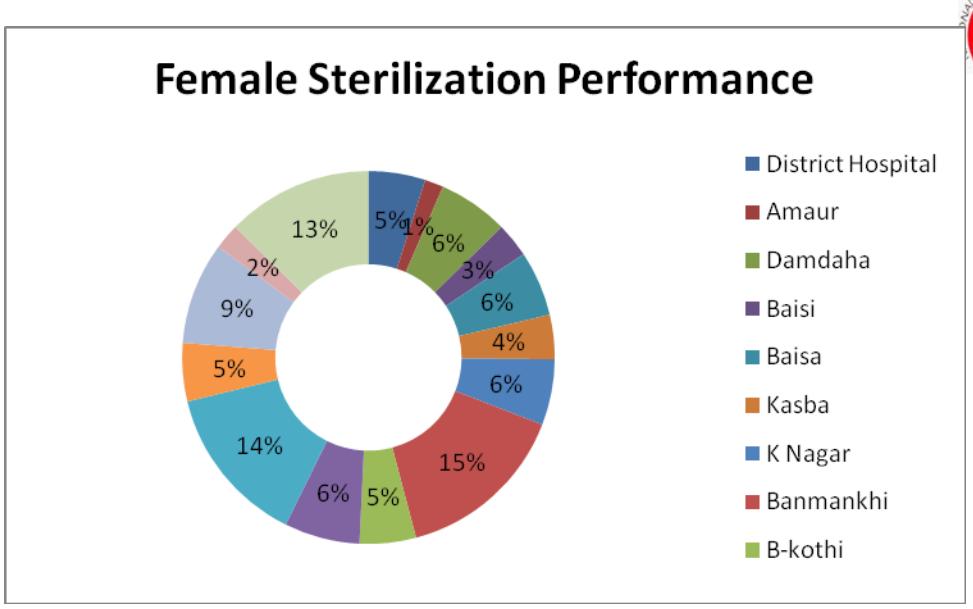
12	Baisa	0	0	0	0	1	0	0	3	4	8
13	Baisi	1	0	0	0	0	0	0	1	1	3
14	Dagaurua	1	0	1	1	2	1	5	5	6	22
15	Purnia Sadar	0	0	0	0	0	0	0	0	0	0
	Total	6	0	3	2	12	13	21	48	71	176

A total of 176 camps for sterilisation has been conducted in the district. But all of the camps held for female sterilisation. None of the camp has been held for male sterilisation in the district.

Following table shows the health centre wise details of the family planning operations conducted in the district:

Progress of Family Planning Operations (2007-2008)	
Name of the Block	**No. of Operations Conducted**
District Hospital	3036
Amaur	577
Damdaha	1142
Baisi	526
Baisa	381
Kasba	664
K Nagar	1667
Banmankhi	908
B-kothi	701
Bhawanipur	344
Rupauli	1213
Dagarua	1112
Srinagar	536
Jalalgarh	250
Purnea East	382
Total	**13439**

The percentage of male sterilisation is dismal i.e. less than 1%. Even the health centers do not have the OT facility and there is a need to strengthen the health centres to conduct quality sterilisation services at the PHCs, referral and district hospital level. The total number of family planning operations conducted during April 2008 to December 2009 is 12532. Following is the block-wise distribution of sterilisation in the district:



4.1.4 Adolscent 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 marriage seems to be still a key problem of the district. Percentage of girls who are married before attaining 18 years is 40.4% which is quite high and is a mjor concern for the district as well as the state. Approximately 10.4% of total births are from the women of age 15-19 years.

As far as adolscent health is concerned, no such special intervention has been made in the district. The school health education needs to be focussed as weel as the Anaemia control programme needs to be implemnented effectively in the district. The ARSH services is almost absent in the district. The youth based organsiations are present in the district but it needs to be strengthened for increasing the accessibility of services.

4.2 Public Health Infrastructure:

There are 1290 villages under 251 panchayats in 14 blocks of the district. Though the health centres are available in almost all the blocks but it is meagre to cater the entire population of the district. Following table shows the health facilities in the district:

HEALTH INFRASTRUTRE IN THE DISTRICT								
Sl. No.	**Name of the Block**	**No. of Health sub-centre in place**	**No. of APHCs**	**No. of PHCs**	**No. of Functional PHCs**	**Referral Unit**	**District Hospital**	**Remarks**
1	Amour	23	2	1	0	1	NA	PHC has been upgraded into FRU
2	Baisa	16	2	1	1	0	NA	
3	Baisi	15	0	1	1	0	NA	
4	Dagarua	18	2	1	1	0	NA	
5	Purnea East	13	2	1	0	0	1	PHC has been upgraded into District Hospital
6	K Nagar	22	3	1	1	0	NA	
7	Kasba	9	0	1	1	0	NA	
8	Jalalgarh	9	0	1	1	0	NA	
9	Srinagar	9	0	1	1	0	NA	
10	Damdaha	36	2	1	0	1	NA	PHC has been upgraded into FRU
11	Bhwanipur	16	2	1	1	0	NA	
12	B-kothi	31	2	1	1	0	NA	
13	Rupauli	25	5	1	0	1	NA	PHC has been upgraded into FRU
14	Banmankhi	36	2	1	1	0	NA	
	Total	**278**	**24**	**14**	**10**	**3**	**1**	

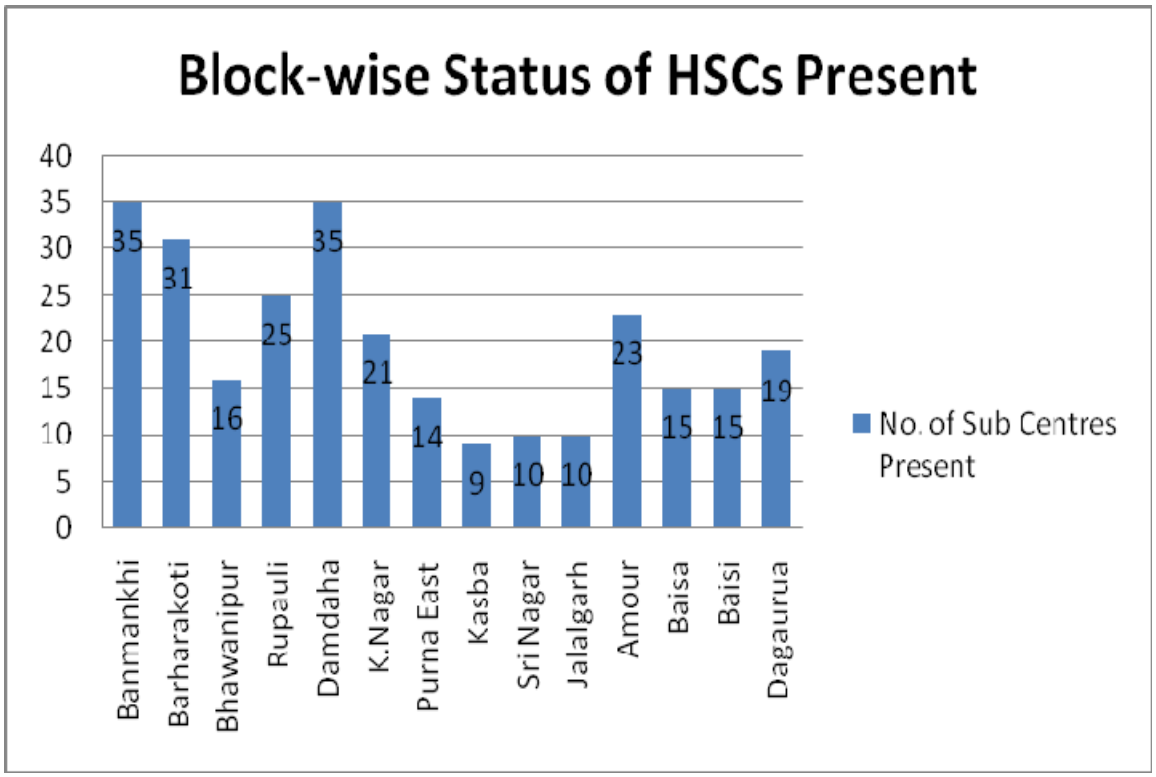
There are 278 sub-centers, 24 Additional PHCs, 10 functional PHCs, 3 referral units and 1 district hospital in the district. Three APHCs are functional and rest 21 APHCs are non-functional.

50 new APHCs and 233 new sub centres have been sanctioned for establishment. The work is in progress at few of the centres.

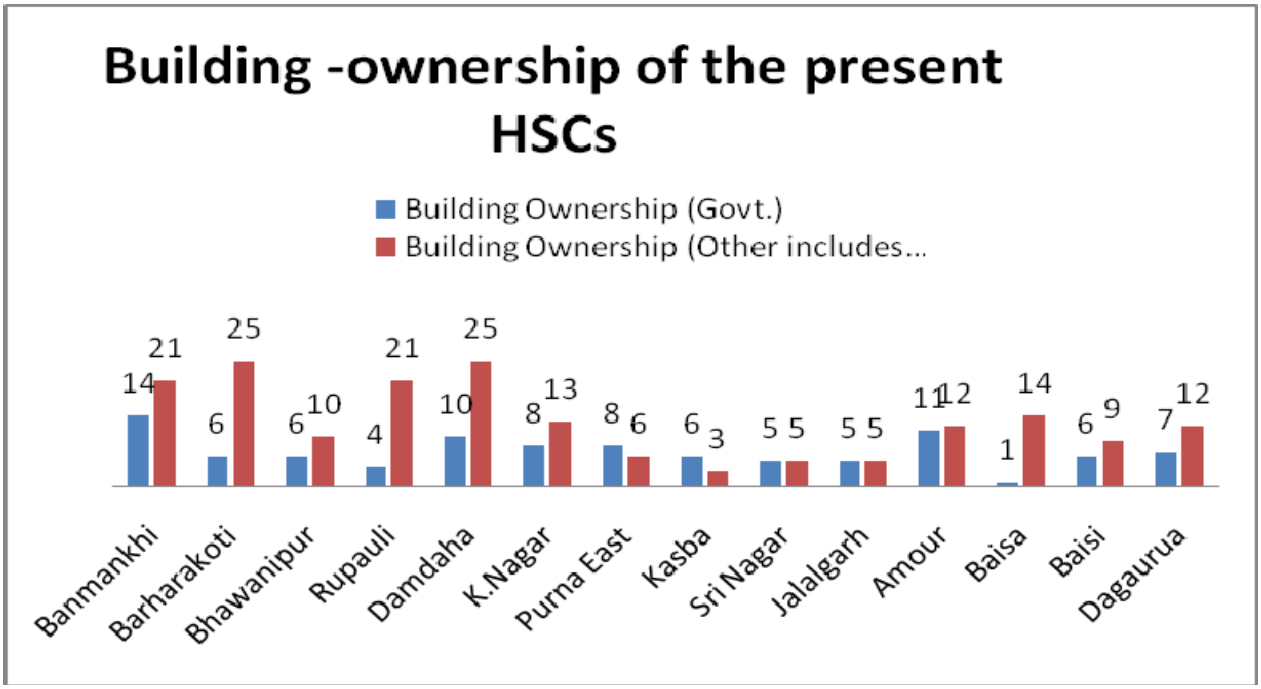
4.2.1 Infrastructure at the Sub Center level:

There are 278 health sub-centres present in the district, out of which 160 have their own land and 118 sub centres are being run in other building. All the 160 sub-centres have their own building, but there is requirement to construct the building of 118 health sub centres to make all the HSCs fully functional. 221 HSCs have been proposed and approved for establishment in the next three years, but still there is requirement to establish another 90

HSCs seeing the strength of the population of the district. Following graph shows the block wise distribution of health sub-centre in the district:



Following is the status of building ownership of HSCs present in the district:



Out of 278, sub centres, 97 HSCs have their own government building and rest 181 HSCs are being run in other buildings.

Status of Building Condition at HSCs				
Name of the block	**Building Condition (+++)**	**Building Condition (++)**	**Building Condition (+)**	**Building Condition (#)**
Banmankhi	8	5	1	21
Barharakoti	1	4	1	25
Bhawanipur	1	3	1	11
Rupauli	1	3	0	21
Damdaha	6	4	0	25
K.Nagar	2	4	2	13
Purna East	1	5	2	6
Kasba	3	3	0	3
Sri Nagar	1	3	1	5
Jalalgarh	3	2	0	5
Amour	5	6	0	12
Baisa	0	1	0	14
Baisi	2	2	2	9
Dagaurua	3	3	1	12
Purna Sadar	0	0	0	0
Total	**37**	**48**	**11**	**182**

Note: +++-good, ++-needs major repair, + - Needs minor repair, #-Needs new construction

The status of building of 37 HSCs is good, 48 HSCs need major repair, 11 HSCs need minor repair of less than Rs. 10000.00 and 182 HSCs need new building. None of the HSCs has assured running water supply. 268 HSCs do not have the water facility and only 10 HSCs have the hand pumps as a water source. Following table shows the status of water supply facility at HSCs:

Status of Assured Running Water at HSCs			
Name of the block	**Assured Running Water (Yes)**	**Assured Running Water (No) i.e. NA**	**Assured Running Water (I)**
Banmankhi	0	30	5
Barharakoti	0	31	0
Bhawanipur	0	15	1
Rupauli	0	25	0
Damdaha	0	35	0
K.Nagar	0	21	0
Purna East	0	14	0
Kasba	0	9	0

Sri Nagar	0	10	0
Jalalgarh	0	10	0
Amour	0	23	0
Baisa	0	15	0
Baisi	0	13	2
Dagaurua	0	17	2
Purna Sadar	0	0	0
Total	0	268	10

The toilet facility is also not avaliable in almost 82% of the HSCs.

Status of Toilet Facility at HSCs				
Name of the block	**Toilet Condition (+++)**	**Toilet Condition (++)**	**Toilet Condition (+)**	**Toilet Condition (#)**
Banmankhi	4	1	0	30
Barharakoti	3	0	0	28
Bhawanipur	1	0	0	15
Rupauli	0	0	0	25
Damdaha	1	0	0	34
K.Nagar	2	0	2	17
Purna East	0	3	3	8
Kasba	3	0	0	6
Sri Nagar	0	0	2	8
Jalalgarh	3	2	0	5
Amour	5	6	0	12
Baisa	0	0	0	15
Baisi	2	3	0	10
Dagaurua	3	1	0	15
Purna Sadar	0	0	0	0
Total	27	16	7	228

Note: +++-good, ++-needs major repair, + - Needs minor repair, #-Needs new construction

Only 10% of the HSCs have toilet facility in good condition, 6% of the HSCs' toilet need major repair and 3% of the HSCs' toilet need minor repair. Only 3 HScs have the electricity connection and rest 275 HSCs do not have continuous power supply. Only 11.9% of the ANMs posted at HSCs are residing in their areas and rest 88.1% of the ANMs are residing out of the area as only 11% of the HSCs have the residential facility and rest 89% of the HSCs do not the residentail facility.

4.2.2 Infrastructre at APHCs:

There are 24 APHCs in the district but out of that only 3 APHCs namely Ranipatra, Jankinagar and Mohanpur APHCs located at Purnia East, Banmankhi and Rupauli blocks are functional. Following table shows the block-wise distribution of APHCs:

Details of APHCs in the District

Sl. No.	Name of the Block	No. of APHCs required	No. of APHCs present	No. of APHCs Proposed	No. of Additional APHSc required	Availability of Land (Yes)	Availability of Land (No)	Nature of Land Ownership (Govt.)
1	Banmankhi	11	2	6	3	2	0	2
2	Barharakoti	7	2	4	1	2	0	2
3	Bhawanipur	5	2	3	0	1	1	1
4	Rupauli	7	5	2	0	5	0	5
5	Damdaha	9	2	5	2	2	0	2
6	K.Nagar	6	3	3	0	3	0	3
7	Purna East	7	2	4	1	2	0	2
8	Kasba	5	0	4	1	0	0	0
9	Sri Nagar	3	0	3	0	0	0	0
10	Jalalgarh	3	0	3	0	0	0	0
11	Amour	8	2	5	1	2	0	2
12	Baisa	5	2	3	0	2	0	2
13	Baisi	7	0	6	1	0	0	0
14	Dagaurua	7	2	5	0	2	0	2
15	Purnia Urban(Sadar)	6	0	0	6	0	0	0
	Total	96	24	56	16	23	1	23

As mentioned in the above table, there are 24 APHCs in the dirtict against the requirement of 96 APHCs. 56 APHCs have been proposed for construction in the next five year. At few places the construction of new APHCs have already been started. There is a need to establish another additional 16 APHCs to cater the present popultaion. All the APHCs have their own land except one located at Bhawanipur.

Status of Building of APHCs present in the District

Sl. No.	Name of the Block / area	Building ownership (Govt.)	Building ownership (Other)	Building Condition (+++)	Building Condition (++)	Building Condition (+)	Building Condition (#)
1	Banmankhi	2	0	0	1	1	0
2	Barharakoti	2	0	2	0	0	0

3	Bhawanipur	1	1	1	0	0	1
4	Rupauli	5	0	3	2	0	0
5	Damdaha	2	0	1	1	0	0
6	K.Nagar	3	0	1	2	0	0
7	Purna East	2	0	0	2	0	0
8	Kasba	0	0	0	0	0	0
9	Sri Nagar	0	0	0	0	0	0
10	Jalalgarh	0	0	0	0	0	0
11	Amour	2	0	1	1	0	0
12	Baisa	2	0	2	0	0	0
13	Baisi	0	0	0	0	0	0
14	Dagaurua	1	1	1	0	0	1
15	Purnia Urban	0	0	0	0	0	0
	Total	22	2	12	9	1	2

Note: +++-good, ++-needs major repair, + - Needs minor repair, #-Needs new construction

22 APHCs out of 24 APHCs have their own govt. building and 2 APHCs are being run in other buildings. The condition of building of 12 APHCs is good, 9 needs major repair, 1 needs minor repair and 2 APHCs needs another building as it is being run at other building. Following table shows the status of water and power supply at APHCs present in the district and the status of toilets at APHCs:

Status of Water and Power Supply at the Existing APHSCs

		Assured Running Water Supply			Power Supply		Toilet Condition			
Sl. No.	**Name of the Block / area**	**Yes)**	**(No)**	**(I)**	**(Yes)**	**(No)**	+++	++	+	#
1	Banmankhi	0	0	2	0	2	0	0	0	2
2	Barharakoti	0	2	0	0	2	2	0	0	0
3	Bhawanipur	1	1	0	1	1	1	0	0	1
4	Rupauli	0	2	3	0	5	3	0	0	2
5	Damdaha	0	2	0	0	2	1	1	0	0
6	K.Nagar	0	3	0	0	3	1	0	0	2
7	Purna East	0	2	0	0	2	0	2	0	0
8	Kasba	0	0	0	0	0	0	0	0	0
9	Sri Nagar	0	0	0	0	0	0	0	0	0
10	Jalalgarh	0	0	0	0	0	0	0	0	0
11	Amour	0	2	0	0	2	0	0	0	2
12	Baisa	0	2	0	0	2	2	0	0	0
13	Baisi	0	0	0	0	0	0	0	0	0
14	Dagaurua	1	1	0	0	2	1	0	0	1
15	Purnia Urban	0	0	0	0	0	0	0	0	0
	Total	2	17	5	1	23	11	3	0	10

Note: +++-good, ++-needs major repair, + - Needs minor repair, #-Needs new construction

It can be depicted from the above table that, 17 APHCs do not have the water supply, 2 APHCs have the water supply facility and 5 APHCs have the hand pumps as the water source at the APHCs. None of the APHCs have the continuous power supply except one at Bhawanipur. 11 APHCs have toilet in good condition, 3 APHCs's toilet need major repair and there is a need to construct toilets at 10 APHCs. Following table shows the infrastructre available at the APHCs:

Status of Infrastructure available at Existing APHCs

		Condition of Labour room						Condition of Residential facility					
Sl. No.	**Name of the Block / area**	+++	++	+	#	**No of rooms**	**No of beds**	+++	++	+	#	**No. of Vehicle**	**No. of Ambulance**
1	Banmankhi	0	2	0	0	9	0	0	0	0	2	0	0
2	Barharakoti	0	0	2	0	8	0	0	0	0	2	0	0
3	Bhawanipur	0	0	0	2	7	6	0	0	0	2	0	0
4	Rupauli	3	0	0	2	22	0	0	0	0	5	0	0
5	Damdaha	1	1	0	0	12	12	0	0	0	2	0	0
6	K.Nagar	1	1	0	1	16	0	0	0	0	3	0	0
7	Purna East	0	1	0	1	11	2	0	2	0	0	0	0
8	Kasba	0	0	0	0	0	0	0	0	0	0	0	0
9	Sri Nagar	0	0	0	0	0	0	0	0	0	0	0	0
10	Jalalgarh	0	0	0	0	0	0	0	0	0	0	0	0
11	Amour	0	1	0	1	5	2	0	0	0	2	0	0
12	Baisa	2	0	0	0	10	0	0	0	0	2	0	0
13	Baisi	0	0	0	0	0	0	0	0	0	0	0	0
14	Dagaurua	1	0	0	1	7	0	0	0	0	2	0	0
15	Purnia Urban	0	0	0	0	0	0	0	0	0	0	0	0
	Total	8	6	2	8	107	22	0	2	0	22		

Note: +++-good, ++-needs major repair, + - Needs minor repair, #-Needs new construction

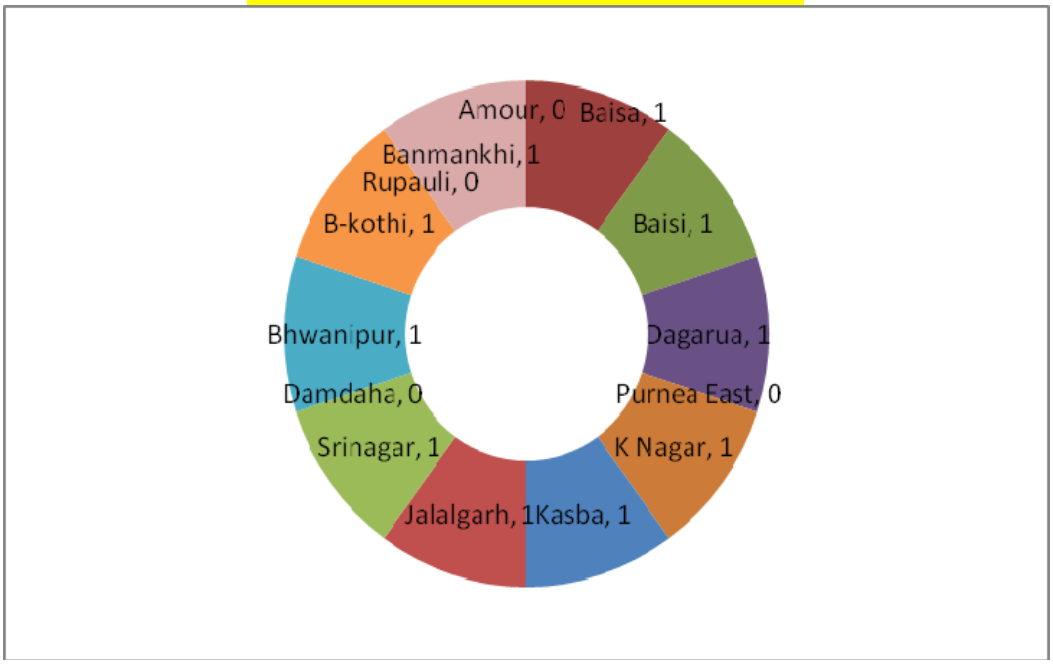
It can be analysed from the above table that, at 8 APHCs condition of labour room is good, labour rooms at 6 APHCs need major repair, at 2 APHCs it needs minor repair and at 8 APHCs there are no labour rooms to deliver the child at APHCs. There are altogether 107 rooms in all the APHCs and 22 beds are there at all APHCs. At only 2 APHCs there are residential facility for MOs which also need major repair and at 22 APHCs there is no

residential facility for MOs. None of the APHCs have their own functional vehicle and ambulance in the district.

4.2.3 Infrastructure at PHC Level:

There are 14 PHCs in the district , out of which 10 are functional, three PHCs namely Amour, Damdaha and Rupauli have been upgraded to referral hospital and one PHC at Purnia East has been upgraded to district hospital. Following graph illustrates the distribution of functional PHCs located in different blocks of the district:

Functional PHC Distribution-Block-wise



All the PHCs, Referrals and DH have their own government building.

Details of Infrastructure at PHCs/Referrals/District Hospitals

Sl. No.	Name of the Area	PHC/Referral Hospital/SDH/DH Name	Building ownership		Building Condition				Assured Running water supply			Continuous Power Supply			Toilet	
			(Govt.)	(Other)	+++	++	+	#	A	NA	I	A	NA	I	A	NA
1	Banmankhi	PHC	1	0	1	0	0	0	1	0	0	1	0	0	1	0
2	Barharakoti	PHC	1	0	1	0	0	0	0	0	1	1	0	0	1	0

3	Bhawanipur	PHC	1	0	1	0	0	0	1	0	0	1	0	0	1	0
4	Rupauli	Referral	1	0	0	1	0	0	1	0	0	1	0	0	1	0
5	Damdaha	Referral	1	0	1	0	0	0	0	0	1	1	0	0	1	0
6	K.Nagar	PHC	1	0	1	0	0	0	1	0	0	1	0	0	1	0
7	Purna East	PHC	1	0	0	1	0	0	1	0	0	1	0	0	1	0
8	Kasba	PHC	1	0	1	0	0	0	1	0	0	1	0	0	1	0
9	Sri Nagar	PHC	1	0	1	0	0	0	1	0	0	1	0	0	1	0
10	Jalalgarh	PHC	1	0	0	1	0	0	1	0	0	1	0	0	1	0
11	Amour	Referral	1	0	0	1	0	0	1	0	0	1	0	0	1	0
12	Baisa	PHC	1	0	1	0	0	0	1	0	0	1	0	0	1	0
13	Baisi	PHC	1	0	1	0	0	0	1	0	0	1	0	0	1	0
14	Dagaurua	PHC	1	0	1	0	0	0	1	0	0	1	0	0	1	0
15	Purnia Urban	District Hospital	1	0	0	1	0	0	1	0	0	1	0	0	1	0
	Total		15	0	10	5	0	0	13	0	2	15	0	0	15	0

Note: +++-good, ++-needs major repair, + - Needs minor repair, #-Needs new construction

It can be analysed from the above table that the condition of 10 buldings out of 15 centres is good and 5 health centres located at Rupauli, Purnea East, Amour and Purnia Urban needs major repair. 13 health centres have the assured running water supply but only 2 centres have the water sources but its not proper for the centre. The toilet and power suplly facility at all the centres are existing.

Status of Labour Room, OT and Transportation Facility at PHCs/Referrals/DH

Sl. No.	Name of the Area	PHC/Referral Hospital/SDH/DH Name	Functional Labour Room		Condition of Labour room				No. of Rooms	No. of Beds	Functional OT		Condition of OT				No. of Vehicles	
			A	NA	+++	++	+	#			A	NA	+++	++	+	#	Veh.	Amb.
1	Banmankhi	PHC	1	0	1	0	0	0	12	8	1	0	1	0	0	0	1	1
2	Barharakoti	PHC	1	0	1	0	0	0	12	6	1	0	1	0	0	0	0	1
3	Bhawanipur	PHC	1	0	0	1	0	0	3	6	0	1	0	0	0	1	1	1
4	Rupauli	Referral	1	0	0	1	0	0	37	30	0	1	0	0	0	1	0	1
5	Damdaha	Referral	1	0	0	1	0	0	36	35	1	0	0	1	0	0	1	2
6	K.Nagar	PHC	1	0	1	0	0	0	21	9	1	0	1	0	0	0	2	1
7	Purna East	PHC	0	1	0	0	0	1	8	8	0	1	0	0	0	1	0	1
8	Kasba	PHC	1	0	0	1	0	0	22	9	0	1	0	0	0	1	1	1

9	Sri Nagar	PHC	1	0	1	0	0	0	14	6	1	0	0	1	0	0	2	1
10	Jalalgarh	PHC	0	1	0	0	0	1	12	6	0	1	0	0	0	1	1	1
11	Amour	Referral	1	0	0	0	1	0	21	30	1	0	0	0	1	0	1	1
12	Baisa	PHC	1	0	0	1	0	0	12	8	1	0	0	1	0	0	2	1
13	Baisi	PHC	1	0	1	0	0	0	9	12	1	0	1	0	0	0	1	1
14	Dagaurua	PHC	1	0	0	1	0	0	14	9	0	1	0	0	0	1	0	2
15	Purnia Urban	District Hospital	1	0	0	1	0	0	52	240	1	0	0	1	0	0	0	2
	Total		13	2	5	7	1	2	285	422	9	6	4	4	1	6	13	18

Note: +++-good, ++-needs major repair, + - Needs minor repair, #-Needs new construction

At all the health centres, there are functional labour room except Purnea Esat and Jalalgarh PHCs. The condition of labour room at 5 health centres is good, 7 labour rooms need major repair, 1 needs minor repair and there is an urgent need to construct labour room at 2 health centres. There are altogther 285 rooms and 422 beds at all the above health centres. 9 health centres have the functional OT, out of that the condition of 4 OTs is good, 4 needs major repair and 1 need minor repair. All the above health centres have the ambulance facility which has been outsourced to external agency.

4.2.4 Infrastructure at Referral Units:

There are three referral units in the district which have been established after upgrading the PHCs located at Amour, Damdaha and Rupauli blocks. The condition of building of all the referral units is good. All the three referral units have the functional labour room, out of that 2 needs major repair and 1 referral unit located at Amour needs minor repair. Rupuali does not have the functional OT. The OT at Damdaha referral needs major repair whereas the OT at Amour needs minor repair to make the referral units fully functional. All the referral units have the ambulance facility.

4.2.5 Infrastructre at District Hospital:

There is one district hospial in the district. The PHC of Purnia East has been upgraded to the district hospital. This is a 240 bedded hospital. The district hospital has its own building with functional labour room, OT facility and other requisite facility, but its under construction. The district hospital has 240 beds and the sanction for upgrading this into 500 bedded hospital has been done by the cabinet in the month of January 2009. Now all the facilities at district

hospital need to be streangthened in order to make it a functional unit to deliver specialised qualitative services.

4.2.6 Details of the Support System to Health Facility:

As shown in the following table, all the 10 PHCs, referral units and district hospital have the ambulance facility. The regular power supply is available in all the PHCs, referral units and district hospital. The laboratory facility is not available in either the PHCs or the referral units. The housekeeping at referral units need to be initiated as it's very important for maintenance of referrals. The X-ray facility is not available at 8 PHCs and all the 3 referral units. The data centre is being run by the out-sourced agency at all the PHCs, referral units and district hospitals.

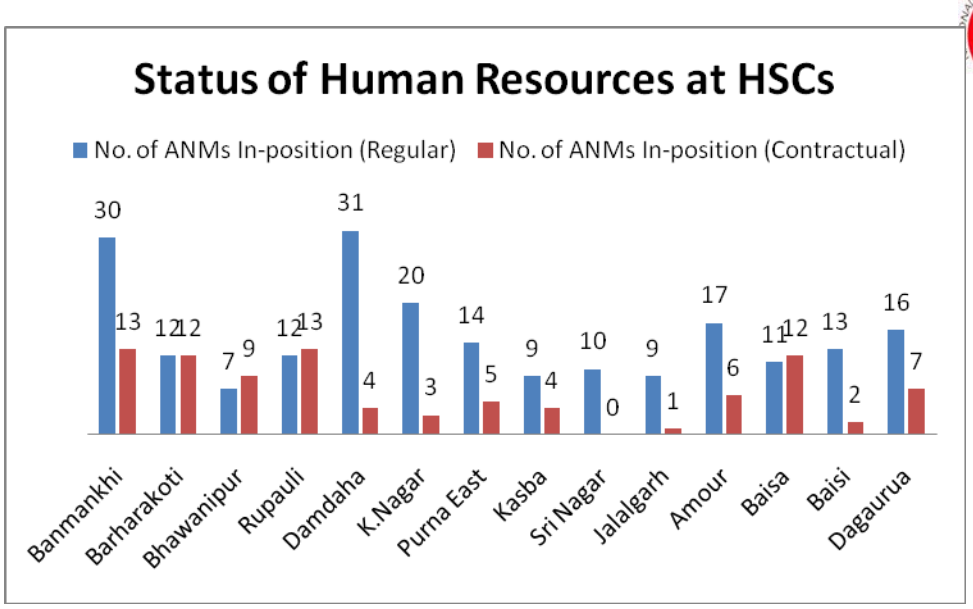
Support System to Health Facility Functioning				
Sl. No.	**Services Available**	**No. of Units available at health facility centres**		
		PHC	**Referral**	**District Hospital**
1	Ambulance (In-sourced)	0	2	1
2	Ambulance (Out-sourced)	10	1	0
3	Generator (All outsourced)	10	3	1
4	X-ray (All outsourced)	2	0	1
5	Laboratory Services	0	0	1
6	Housekeeping (All outsourced)	10	0	1
7	Data Operator (All outsourced)	10	3	2

4.3 Public Health Human Resources (HR):

The district does not have the sufficient man power to run the health centres. Even the district health society has appointed the doctors, ANMs, A Grade Nurse on contract basis, but still it's insufficient to deliver all the PHCs 24x7x365 services. The district health society and the state government has taken the issue as a priority and the ANM schools have been started to fill-up the requisite ANMs at all the health centers, but still it would take another 3-4 years to fulfil the requirement of ANMs.

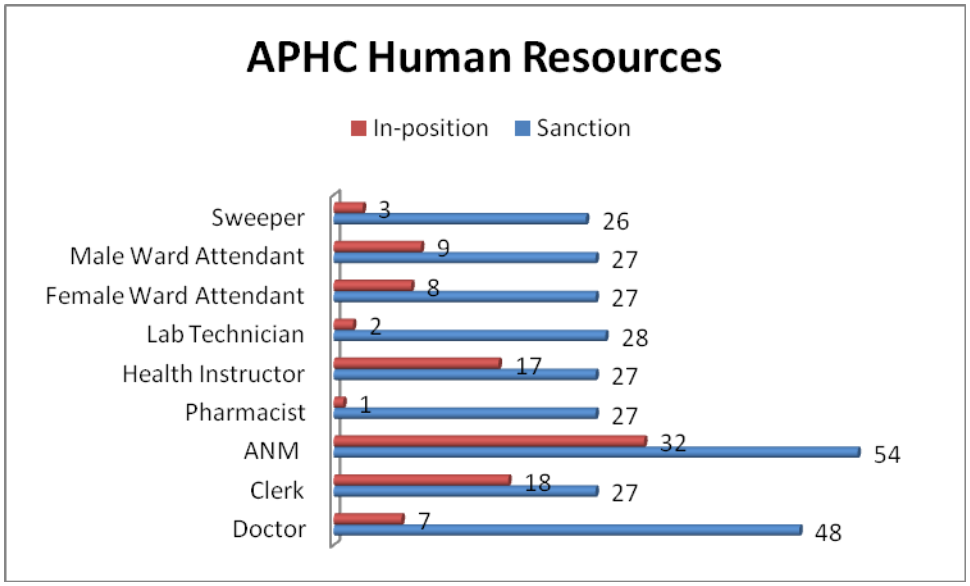
4.3.1 Status of HR at Health Sub-centre level:

As shown in the following bar-chart, there are 211 (regular) and 91 (contractual) ANMs are in position against 278 (regular and 278 (contractual) sanctioned positions.



4.3.2 Status of HR at Additional PHCs level:

Following pie-chart clearly depicts that the availability of human resources at APHCs are very dismal. The reason behind this is the non availability of human resources in the district. The human resources from the APHCs have been called to the PHCs, referral units and district hospitals to deliver their services. There is need to recruit the requisite human resources at the APHCs to make it functional.



4.3.3 Status of HR at PHC level:

The human resources at the PHCs are also not sufficient to improve the quality of services. The district health administration has placed seven doctors (including 4 specialists recruited on contractual basis). As shown in the following table, there are only 31 regular doctors in place out of the 42 sanctioned posts of doctors. Only four PHCs' have the pharmacist. There are three ophthalmic assistant at Rupauli, Damdaha and Bhawanipur PHCs each. 34 regular ANMs are in position against the sanctioned 42 posts. Following are the details of human resources available at each sanctioned PHCs in the district:

Details of Human Resources at PHCs																																						
	MOs		**Clerk**		**ANM**		**LHV**		**Block Ext. Educator**		**Health Worker**		**FP Worker**		**Basic Health Worker**		**Pharmacist**		**Sanitaory Inspector**		**Dresser**		**Computer**		**Driver**		**Male Ward Attendant**		**Female Ward Attendant**		**Orderly**		**Sweeper**		**Sweeper cum Night Guard**		**Opthalmic Assistant**	
Name of the PHCs	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**
Purnia east	3	2	2	2	3	3	4	4	1	0	3	1	3	0	11	10	1	0	1	0	0	0	1	1	1	1	0	0	0	0	1	1	1	1	3	1	0	0
Baisi	3	2	2	1	3	3	6	2	1	0	3	1	3	2	4	2	1	0	1	0	1	0	1	0	2	0	1	0	1	0	1	0	2	1	3	1	0	0
Amour	3	2	2	2	3	3	6	3	1	0	3	0	3	1	3	1	1	0	1	0	1	0	1	1	2	0	1	1	1	0	1	0	2	0	3	0	0	0
Baisa	3	3	1	1	3	1	4	2	1	0	3	2	3	1	0	0	1	0	1	0	1	1	1	1	2	1	1	1	1	0	1	0	2	0	3	0	0	0
Kasba	3	1	2	2	3	2	4	2	1	1	3	0	3	1	6	0	1	1	1	0	1	0	1	1	2	2	1	1	1	1	1	1	2	2	3	1	0	0
K. Nagar	3	3	2	2	3	3	6	2	1	0	3	0	3	1	3	2	1	0	1	1	1	0	1	1	2	1	1	0	1	1	1	0	2	1	3	3	0	0
Banmankhi	3	3	2	1	3	3	7	1	1	0	3	0	3	1	9	0	1	0	1	0	1	0	1	1	2	0	1	1	1	0	1	0	2	1	3	1	1	0
Damdaha	3	1	2	1	3	3	4	1	1	0	3	0	3	3	6	1	1	0	1	0	1	0	1	0	2	1	1	1	1	0	1	0	2	1	3	3	1	1
B-kothi	3	2	2	2	3	3	5	2	1	0	3	0	3	0	10	3	1	0	1	0	1	0	1	0	2	0	1	0	1	0	1	1	2	1	3	2	0	0
Bhawnipur	3	3	2	2	3	1	4	2	1	0	3	1	3	0	1	0	1	1	1	0	1	0	1	1	2	0	1	0	1	0	1	0	2	1	3	1	1	1
Rupauli	3	3	2	1	3	3	6	1	1	0	3	0	3	2	3	1	1	1	1	0	1	0	1	1	2	0	1	0	1	0	1	0	2	1	3	1	1	1
Sri Nagar	3	2	2	1	3	2	1	0	1	0	3	0	3	1	1	1	1	0	1	0	1	0	1	0	2	0	1	1	1	1	1	0	1	0	1	0	0	0
Jalalgarh	3	2	2	1	3	2	4	0	1	0	3	0	3	1	1	1	1	1	1	0	1	0	1	0	2	0	1	1	1	0	1	0	2	1	1	0	0	0
Dagaurua	3	2	2	1	3	2	2	0	1	0	3	0	3	2	3	3	1	0	1	0	1	0	1	0	2	0	1	1	1	1	1	0	2	0	1	0	0	0
Total	**42**	**31**	**27**	**20**	**42**	**34**	**63**	**22**	**14**	**1**	**42**	**5**	**42**	**16**	**61**	**25**	**14**	**4**	**14**	**1**	**13**	**1**	**14**	**8**	**27**	**6**	**13**	**8**	**13**	**4**	**14**	**3**	**26**	**11**	**36**	**14**	**4**	**3**

Apart from the regular posts at PHCs, 59 contractual positions of specialists have been sanctioned, out of that 35 doctors are in place at all the functional 10 PHCs.

4.3.4 Status of HR at Referral Units:

Following table clearly depicts that there is a need to place the trained human resources including medicos and para-medicos at the referral centers to make these referral units fully functional. There are only 5 regular medical officers in place against the sanction post of 12 MOs. There are only 2 A grade nurses in all the three referrals. At none of the referral there are pharmacists in place. Following is the deatil of human resources in-position against the mentioned sanctioned positions at the three referral units in the district:

Details of Human Resources at Referrals																																		
	MOs		**Clerk**		**Nurse A Grade**		**Pharmacist**		**Dresser**		**X-ray Technician**		**OT assistant**		**Lab Tech.**		**Female ward attendant**		**Male Ward Attendant**		**Orderly**		**Male Sweeper**		**Female Sweeper**		**Cook**		**Cook Assistant**		**Guard**		**Gardner**	
Name of the Referrals	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**	**S**	**IP**
Damdaha	4	2	2	2	4	0	2	0	1	0	1	0	1	0	1	0	3	0	3	0	1	0	2	0	2	0	1	0	1	0	1	0	1	0
Rupauli	4	1	2	2	4	1	2	0	1	0	1	0	1	0	1	0	3	0	3	0	1	0	2	1	2	0	1	0	1	0	1	0	1	0
Amour	4	2	2	0	4	1	2	0	1	0	1	0	1	0	1	0	3	0	3	0	1	0	2	2	2	0	1	0	1	0	1	0	1	0
Total	12	5	6	4	12	2	6	0	3	0	3	0	3	0	3	0	9	0	9	0	3	0	6	3	6	0	3	0	3	0	3	0	3	0

4.3.5 Status of HR at District Hospital level:

Though the status of human resources at the district hospital is somehow better as almost all the human resources required to deliver the services is available but as the district hospital has been decided to upgrade into a 500 bedded hospital there is a need to arrange for placing the requisite human resources at the upgraded hospital. Following graph shows the status of human resources at the district hospital:

Details of Human Resources at District Hospital							
Sl. No		**Sanction**	**In-position**	**Sl. No**	**Human Resources**	**Sanction**	**In-position**
1	MOs	5	5	17	Ward Sister	2	0
2	Clerk	2	2	18	Nursing Orderly	1	0
3	ANM	3	2	19	Night Guard	1	0
4	Pharmacist	4	3	20	Physiotheraphist	1	1
5	Dresser	1	1	21	Dentist	1	1
6	LHV	1	1	22	radiologist	1	1
7	X-ray Technician	2	0	23	Gyanaecologist	1	1
8	OT assistant	4	4	24	Eye Specialist	1	1
9	Lab Tech.	4	4	25	Skin Specialist	1	1
10	Female ward attendant	14	11	26	Child Specailist	1	1
11	Male Ward Attendant	3	2	27	Orthopedic	1	1
12	Orderly	3	2	28	Anaesthetic	1	1
13	Sweeper	15	10	29	Eye Surgeon	1	1
14	Female Sweeper	2	0	30	Gardner	1	1
15	Cook	3	2	31	Driver	2	2
16	OT assistant	1	0				
	Total					84	62

Apart from the above MOs, 5 positions of specialist doctors have been sanctioned on contractual basis at District Hospital, out of that 4 specialists have been appointed at district hospital on contractual basis.

4.4 Human Resource Development including Training:

Human resource development is one of the important components under NRHM. The district has 278 health sub-centres, 10 functional PHCs, 3 referral units and one district hospitals. The

district performance in terms of capacity building of HR is very poor. Following table shows the status of trained providers by issues in the district:

Status of Trained Providers (by issues)				
	Number Trained			
Issues	**MOs**	**LHV**	**ANM**	**Others**
Cesarean Section	2	0	0	0
Minilap	0	0	0	0
NSV	2	0	0	0
Anaesthesia	3	0	0	0
MTP / Abortion	0	0	0	0
Contraceptive updates	5	5	21	0
STI / RTI	5	4	4	0
SBA Training	4	2	28	4
IMNCI	5	2	5	3
Total	26	13	58	7

Apart from this, 1 surgeon has been trained on laparoscopic. The trainings on Skilled Birth Attendant (SBA), immunisation and IMNCI have been conducted in the district but it's insufficient to deliver the services.

4.5 Logistic Management:

To ensure proper functioning of the health system it is imperative that they have the required logistic and supplies in hand always. The district is very poor in logistic management. The stock position of IEC materials, condoms, contraceptive pills, IUD, drugs, equipments, supplies for delivering the services at health centres is not proper. There is an urgent need to set up a logistic unit at the block and district level in order to ensure the regular supply of all the supplies at health centres. A logistic consultant agency / consultants can be hired to look after the logistics at the block and district level. The use of modern information technology can be established for effective management of inventories.

4.6 Behavioural Change Communication (BCC):

As far as IEC/BCC is concerned, the district has not conducted any specific activities for it. Few IEC materials have been distributed at the PHC level. Following table shows the IEC materials used and in stock at the district:

Details of IEC materials									
Sl. No.	**Method**	**Poster**		**Handbill**		**Banner**		**Hoarding**	
		In-stock	**Displayed**	**In-stock**	**In-use**	**In-stock**	**Displayed**	**In-stock**	**Displayed**
1	Female Sterilization	0	0	53000	141850	0	0	1	1
2	NSV	0	0	20000	13000	0	0	0	0
3	Condom	0	0	36000	31000	0	0	2	2
4	OCP	0	0	0	0	0	0	1	1
5	IUD 380 A	0	0	0	0	0	0	0	0
6	Emergency Pills	5	5	0	0	0	0	0	0
7	JBSY	0	0	0	0	0	0	1	1
8	Immunization	0	0	0	0	0	0	0	0
9	IMNCI	0	0	0	0	0	0	0	0
10	RI	400	425	0	0	79	79	1	1
11	Institutional Delivery	0	0	0	0	0	0	1	1
12	Disease control Programe	0	0	0	0	0	0	1	1
	Total	405	430	109000	185850	79	79	8	8

The hoardings on institutional delivery, immunisation, family planning and disease control programme are there at the PHC, referral and district hospital level. No specific BCC activities have been held in the district. The district does not have any comprehensive BCC strategy. The health service providers (viz. MOs, ANMs and ASHAS), BHMU and DPMU needs to be trained on BCC strategy and usage of BCC in social mobilisation and changing the health related practices of the community. Major focus areas of BCC interventions are promotion of early and exclusive breast feeding, colostrums feeding, anaemia prevention, nutrition, new born care practices, family planning services, ARSH issues, JBSY scheme and national diseases control programme. The follow-up mechanism is also needed to be looked at to access the impact of the BCC/IEC. It has been realised by the district that there is a great need to recruit one IEC consultatnt at the district level to look after the IEC/BCC part of the NRHM in the district as at present there is no one to look after the IEC part.

4.7 Convergence:

Inter-sectoral convergence is one of the core strategies under NRHM. Though the degree of effective inter-sectoral convergence is not very effective, but the inter-sectoral convergence

has been established in the district. The ICDS, PHED and Panchayat Raj Institutions (PRIs) are working together in implementing the NRHM Programme. Following are the details of ICDS who plays an important role in improving maternal and child health status of the area:

Details of ICDS Human Resources									
Sl. No.	Name of the Block	Anganwadi Centres		CDPOs		Anganwadi worker		Anganwadi Helper	
		Sanctioned	Fully Functional	Sanctioned	In-position	Sanctioned	In-position	Sanctioned	In-position
1	Purnia Sadar	114	54	1	1	114	111	114	112
2	Purnia East	178	178	1	1	178	173	178	174
3	Kasba	144	144	1	1	144	144	144	144
4	Dagarua	172	168	1	1	172	156	172	167
5	Jalalgarh	86	82	1	1	86	82	86	86
6	Amour	221	219	1	1	221	112	221	112
7	Baisi	169	169	1	1	169	159	169	163
8	Baisa	149	149	1	1	149	147	149	148
9	K. Nagar	174	170	1	1	174	170	174	171
10	Sri Nagar	81	79	1	0	81	79	81	78
11	Banmankhi	279	279	1	1	279	275	279	279
12	Bhawanipur	127	127	1	0	127	124	127	126
13	Rupauli	188	183	1	1	188	185	188	186
14	B-kothi	167	167	1	1	167	164	167	164
15	Damdahaa	233	231	1	1	233	230	233	232
	Total	**2482**	**2399**	**15**	**13**	**2482**	**2311**	**2482**	**2342**

There are 2399 functional AWCs in the district. For delivering the ICDS services in the area, there are 2311 AWWs and 2342 Anganawadi helpers in the district, who also act as a mobilise for RCH services. The AWWs, AW helpers are involved in immunisation and mobilisation of community in other health programmes. The linkage between ASHA, ANM with AWW needs to be strengthened. Involvement of Public Health Engineering Department (PHED) and PRIs can be made by strengthening of Rogi Kalyan Samiti (RKS) at district hospital, referral units and PHC level and simultaneously formation and strengthening of Village Health and Sanitation Committee (VHSC) at village level. The capacity of RKS and VHSCs needs to be strengthened in order to effectively do the community monitoring, which is one of the core component of NRHM. The village health and nutrition day is not being conducted at the community level, which needs to be initiated during this financial year for improving the health status of women and children.

4.8 Community Participation:

The community participation initiative is very poor in the district. No village health and sanitation committee has been formed so far in the district. This year the focus would be made on formation and strengthening of VHSCs in all the blocks.

4.9 Public-Private Partnership:

Public-private partnership is one of the major strategies for achieving the objectives of the NRHM. The district has initiated few initiatives towards public-private partnership. The NGOs have been involved in maintenance of PHCs, referral units and district hospitals. The NGOs have also been involved in delivering the services for family planning and conducting eye camps. The district has a wide network of Mother NGOs/Field NGOs. These MNGOs/FNGOs would be involved in demand generation for increasing the accessibility of community from hard to reach areas over the existing health services. These MNGOs/FNGOs would also be engaged in other health related activities in the district. The private health facilities in different blocks are there at few of the places but the accreditation of these private facilities have not been done by the district to deliver the health services in their coverage area.

There is a need to strengthen the training institutes at the district level. Though the ANM schools have been restarted and admission of candidates for ANM has been done but the ANM schools need to be strengthened. The training equipments and other materials are not enough to run the training institute and ANM schools.

4.10 Programme Management Unit:

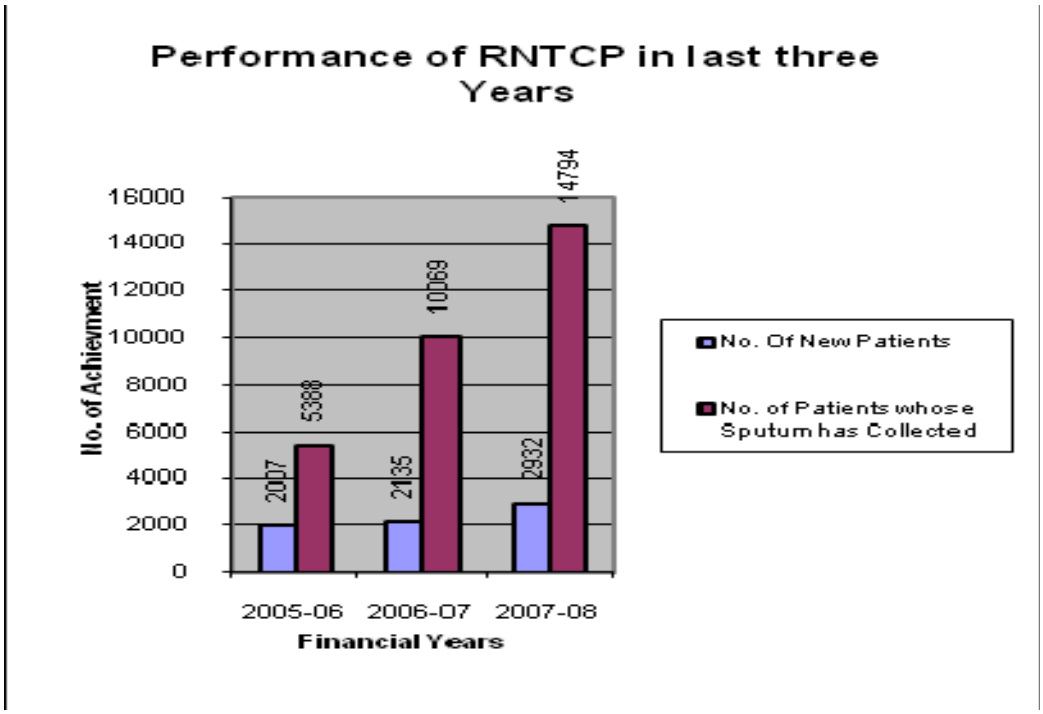
The District and Block Health Management Units have been established in all the fourteen blocks. The Block Health Managers, Block Data Manager and Block Accounts Manager are in place in all the 14 blocks of the district. None of the block has the store keeper in place. The District Health Manager, District Data Manager and District Accounts Manager are also in place. All the BHMUs and DHS are functioning well. There is a need to build up the capacity of the BHMU and DPMU regarding programme management.

4.11 Programme Finance:

The district funds under NRHM come to the district from through two separate channels, i.e; through the state budget and directly through the state health society. Further the vaccines, drugs and equipments come to the district from the state in the form of kind. The cash assistance has also been provided to the district during flood to deliver health services in flood affected blocks.

4.11 Revised National Tuberculosis Control Programme (RNTCP):

The performance of national TB control programme is also poor in the district. The facilities required for TB control is at health centres are also very poor and it needs improvement. The human resources are also not sufficient for treatment and control of tuberculosis in the district. The DOT centere are also not functioning well. Supply of drugs for TB treatment and unavailaility of human resources are the amjor concern for effective implementation of RNTCP in the district. Following is the performance of the district over the last three years:



Following table shows the details of the TB patients reported during the peiod 2006-2007 and 2007-2008:

Progress in RNTCP		
Health Centre Name	**TB Patient (2006-2007)**	**TB Patient (2007-2008)**
Amour	99	13
Baisa	37	9
Baisi	53	66
Banmankhi	122	48
Barharakothi	71	54
Bhawanipur	98	29
Dhamdaha	23	19
Kasba	74	40
Krityanandnagar	195	84
Purnia East	2	0
Rupauli	62	58
Sadar Hospital Purnea	648	108
Total	**1,484**	**528**

Following is the block-wise percentage distribution of TB patients reported during the period of April 2008 to December 2009.

Details of the RNTCP Progress in the District										
Sl. No.	**Name of TU/MC**		**Name of the Block/area**	**No. Of Sputum-Test**	**No. of + Ve Case**	**No. of - Ve Case**	**No. Of Cases to whom Medicine are Providing**			**Total Cases**
							Cat I	**Cat II**	**Cat III**	
1	TU Purnea									
	1-1	Purnea DTC	Purnea Urban	1504	201	1303	148	60	86	294
	1-2	Ranipatra MC	Purnea East	673	86	587	59	9	4	72
	1-3	Dagarua MC	Dagarua	769	97	672	88	14	54	156
	1-4	Harda MC	Purnea East	302	34	268	25	10	3	38
	1-5	Mahendrapur MC	Purnea East	229	23	206	19	3	5	27
2	TU Kasba									
	2-1	Kasba MC	Kasba	911	94	817	103	35	42	180
	2-2	Sri Nagar MC	Srinagar	538	54	484	62	8	10	80
	2-3	K- Nagar MC	K Nagar	1209	83	1126	136	50	87	273
	2-4	Champa Nagar MC	K Nagar	490	33	457	28	3	0	31
	2-5	Kajha MC	K Nagar	245	30	215	26	3	0	29
	2-6	Jalalgarh	Jalalgarh	781	71	710	61	11	24	96

		MC								
3	TU Banmankhi									
	3-1	Banmankhi MC	Banmankhi	1444	172	1272	240	82	81	403
	3-2	Sarsi MC	Banmankhi	272	29	243	37	9	4	50
	3-3	Janki Nagar MC	Banmankhi	456	45	411	64	28	19	111
	3-4	B- Kothi MC	B- Kothi	901	90	811	60	19	13	92
	3-5	Maldiha MC	B- Kothi	340	22	318	14	4	3	21
4	TU Rupouli									
	4-1	Rupouli MC	Rupuali	1136	130	1006	121	22	18	161
	4-2	Bhawanipur MC	Bhawanipur	940	107	833	77	33	20	130
	4-3	Dhamdaha MC	Damdaha	1081	147	934	141	27	57	225
	4-4	Gaddigath MC	Rupuali	338	35	303	19	11	1	31
	4-5	Tikkapatti MC	Rupuali	553	88	465	69	17	1	87
	4-6	Bishanpur MC	Damdaha	7	0	7	0	0	0	0
5	TU Amour									
	5-1	Amour MC	Amour	791	62	729	92	31	45	168
	5-2	Baisa MC	Baisa	597	45	552	40	12	5	57
	5-3	Machchhatta MC	Baisi	254	14	240	12	1	5	18
	5-4	Baisee MC	Baisi	1038	113	925	135	22	61	218
		Total		**17799**	**1905**	**15894**	**1876**	**524**	**648**	**3048**

4.12 Vector Borne Disease Control Programme:

Vector Borne Diseases viz. Kala-azar, Malaria and Filariasis is the major public health problems in the district. 13 blocks out of 14 blocks are affected by Kala-azar. Most of the kala-azar cases have been reported from rural areas. Following table shows the details of Kala-azar patients reported during 2006-2007 and 2007-2008 in the district:

Progress of Kala-azar		
Health Centre Name	**Kala-azar patient (2006-2007)**	**Kala-azar patient (2007-2008)**
Amour	56	17
Baisa	2	1
Baisi	21	5
Banmankhi	275	139
Barharakothi	99	47
Bhawanipur	73	31

Dhamdaha	424	103
Kasba	151	89
Krityanandnagar	191	69
Purnia East	7	0
Rupauli	90	42
Sadar Hospital Purnea	391	94
Total	**1,780**	**637**

1866 cases of Kala-azar has been reported during April 2008 to December 2009. The last spary of D.D.T. was done in the month of June 2008.

Overview of Kala-azar - District Level (April 2008 – December 2009)	
Kala-azar Cases	1866
Death	0
Treated	1615
Under Treatment	225
Untreated	25
P.K.D.L.	1
Last Spray of D.D.T.	June 18, 2008 for 15 days

Drug availability in the district has improved considerably. All the PHCs, referral units and district hospital are equipped with anti Kala-Azar drugs but the supply of drugs on regular basis needs to be ensured.

The National Malaria Surveillance Programme is being implemented in the state but the status of this programme is poor. Though the cases of malaria have not been reported on regular basis but five blocks are affected by Malaria. The services for treatment of malria at health centres are very poor. The drugs for malaria treatment are also not available at health centres. The human resources required for malaria treatment is also not sufficient. Following tables give an overview of malaria at the district level.

Overview of Malaria - District Level	
Annual Parasite Incidence	0
Annual Blood Examination Rate (Total 546)	100%
Plasmodium Faliparum Percentage	0
Slide Positive Rate	0
Number of Patients Receiving Treatment for Malaria	0
Number of Patients with Malaria referred	0
Number of FTP and Drug Distribution Centres (DDC)	20

Lack of human resources is a major concern for effective implementation of the programme in the affected blocks. Blood testing facility and anti-malaria drugs are absent in almost all the APHCs, PHCs and referral units.

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 performance of the district in filarial elimination is very poor. The services are almost absent in all the health centres. Lack of human resources is the major concern for the district to effectively implement the programme in the district.

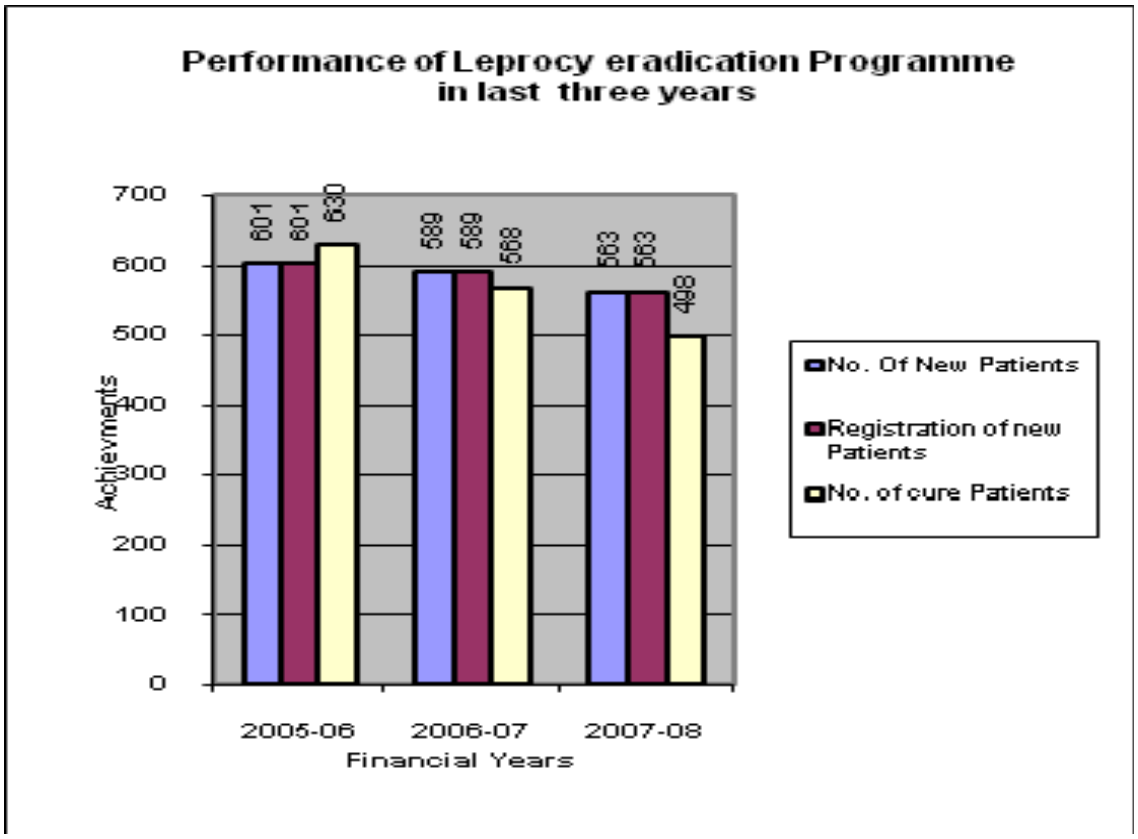
4.13 National Blindnees Control Programme:

The performance of this programme is also very poor in the district. Only two PHCs namely Damdaha and Rupuali has the eye unit but the requisite infrastructure, equipments, drugs and supplies are poor which needs to be strengthened in order to make the eye units functional. One opthalmic assistant is in place at each of these two PHCs. Following is the performance of the district in terms of NBCP over the last three years:

Performance of National Programme For Control of Blindness (April - January 2008) Against the annual target of 4000											
Cataract Operation Performance											
	Months										
Facility	**April**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Total**
District Hospital	3	6	5	0	0	2	0	11	15	5	47
NGOs	0	0	0	0	41	0	23	0	28	312	404
Pvt. sector	9	11	14	348	39	47	40	35	45	42	630
Total	12	17	19	348	80	49	63	46	88	359	1081

4.14 National Leprocy Eradication Programme:

The national leprocy redaication programme is being implemented in the district, the cases of leprocy has come down but still few cases of leprocy is there in the district. The treatment of leprocy is being done. There is lack of human resources in this programme also but the additional charges have been given to the dosctors for implementing the programme in the district. The drugs are available but the supply is not regular.



NLEP Performance (April -December 2008)				
Sl. No.	**Name of the Centre**	**No. of cases**	**PR/1000**	**No. of sub-centres providing MDT services**
1	Purnea Sadar	11	0.5	0
2	Purnea East	14	0.68	13
3	Dagarua	22	1.11	15
4	Baisi	22	0.79	20
5	Amour	25	0.94	23
6	Baisa	12	0.6	17
7	K Nagar	15	0.7	18
8	Srinagar	29	3.16	0
9	Kasba	15	0.8	18
10	Jalalgarh	15	1.69	0
11	Banmankhi	36	1.1	36
12	Rupuali	12	0.53	37
13	Bhawanipur	9	0.54	33
14	Damdaha	27	0.98	17
15	B-Kothi	27	1.34	31
	Total	**291**	**0.93**	**278**

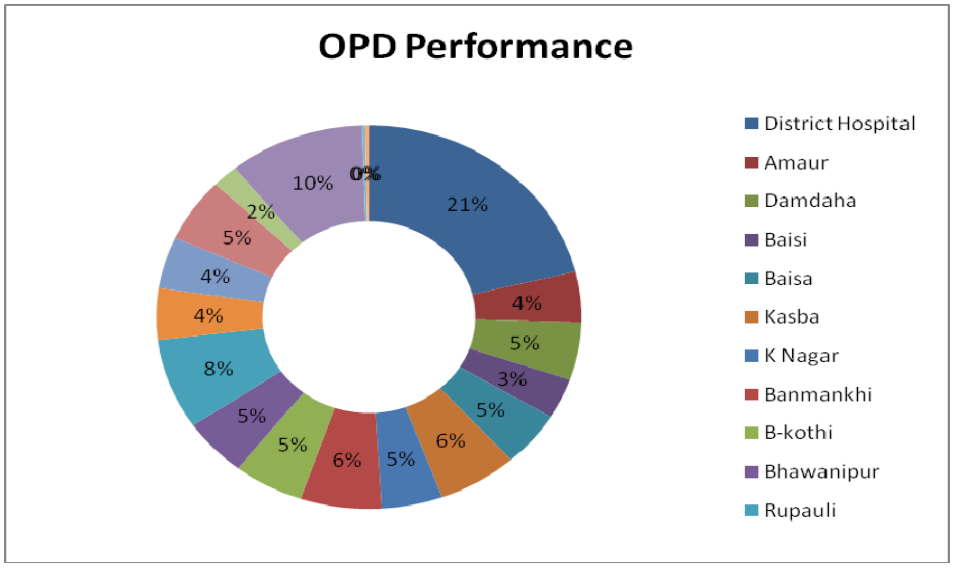
4.15 Status of In-patient, Out-patient and Referral Services:

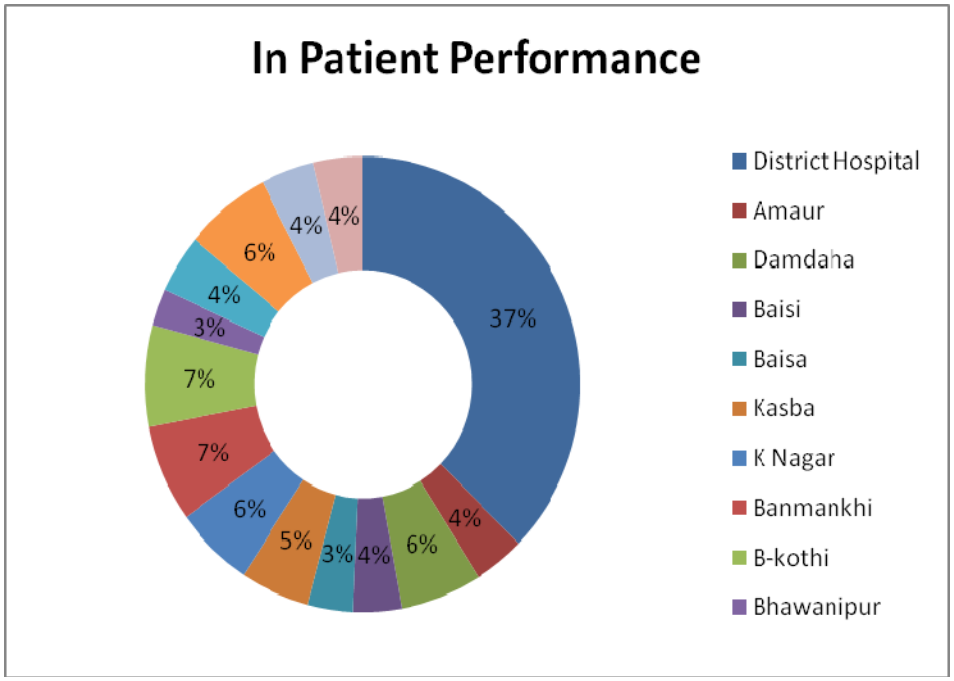
The number of in-patients and out-patients has increased significantly during the last three years. The referral services has also improved. Three referral units have been esatblished to provide the specialised services to the community. Following is the progress of few of the health services provided at the district:

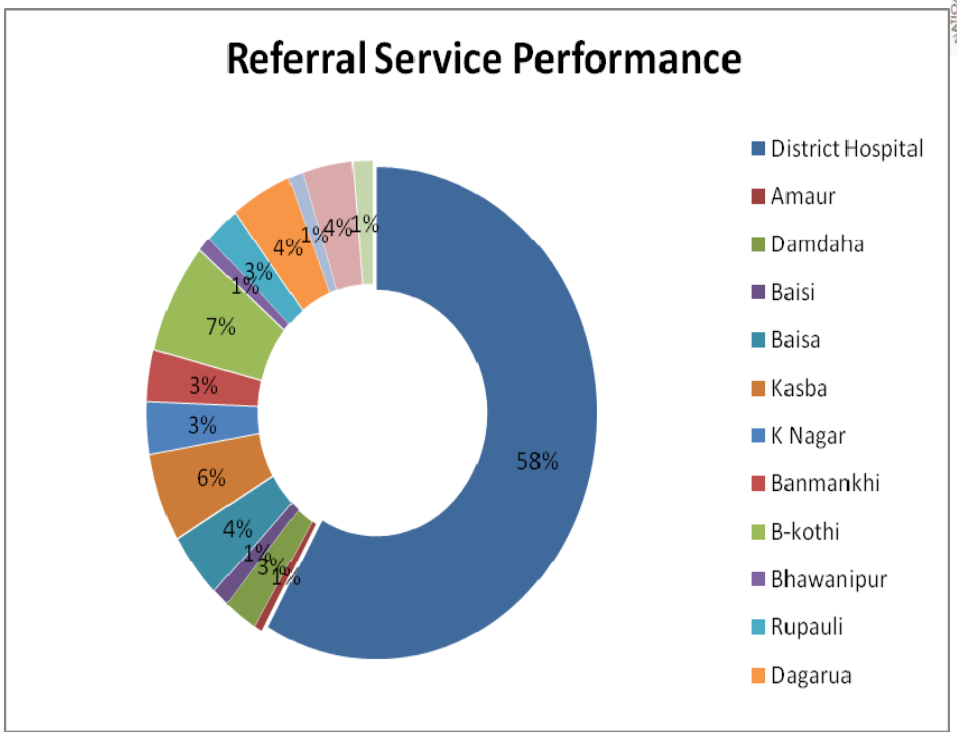
Progress of Health Services Provided at Health Centres						
Health Centre Name	**Patient Visited (2007-2008)**	**Patient Visited (2006-2007)**	**Referred (2007-2008)**	**Referred (2006-2007)**	**Operation (2007-2008)**	**Operation (2006-2007)**
Amour	14056	7,816	115	70	617	405
Baisa	29,644	10,340	708	112	865	303
Baisi	29,494	6,388	190	144	653	130
Banmankhi	42,558	8,763	730	119	507	218
Barharakothi	40,241	9,842	670	210	951	168
Bhawanipur	36,147	6,820	232	77	774	140
Dhamdaha	41,263	11,302	505	140	1,078	867
Kasba	44,623	11,892	437	158	2,735	780

Krityanandnagar	41,990	9,855	617	166	2,106	695
Purnia East	3,427	0	79	0	185	0
Rupauli	37,047	10,389	461	314	1,794	333
Sadar Hospital Purnea	215,580	59,323	4,779	883	2,378	818
Total	**589,571**	**152,730**	**9,523**	**2,393**	**14,643**	**4,857**

Following graphs show the block-wise percentage distribution of the OPD, in-patient and referral performance of the district during the period of April 2008 to December 2009:







4.16 SWOT Analysis of Public Health System at the district level:

Strengths

- High budget allocation to health
- Centrally managed human resource positioning
- Good number of public health institutions
- Accessible Health Services (Better road connectivity)
- Affordable health care
- Structured programme implementation mainly in the rural areas(Decentralization)
- Ever Improving infrastructure of health system
- Political commitment

Weakness

- Lack of sufficient health centres
- Lack of proper infrastructure, facilities, equipment, supplies and drugs to deliver the qualitative services
- Lack of skilled manpower at health centres to deliver qualitative services to the clients
- Lack of skill among MOICs regarding monitoring and programme management

- Lack of residential facility for service provider at health centres itself to make all the health centres functional
- Poor logistic management
- Lack of alternate arrangement for ambulance in flood affected areas
- Non existent of health insurance system for the rural poor
- Poor convergence and support at the lower levels of the systems
- Poor community participation
- Deficiency in quality of monitoring
- Lack of work aptitude in field staff
- Lack of concurrent supervision
- Lack of availability of lady doctor specially Obstetrics and Gynaecologist specialist at referral and district level.

Opportunities

- Improved transportation and road connectivity
- One of the highest priority districts of the state
- District Magistrate as the member of State Health Society Bihar
- Good presence of MNGOs/FNGOs and other NGOs
- Strong educational system and social awareness
- Technology boom
- Availability of human resource (medical and Para medical)
- Private participation in District health care system
- Presence of human resources and other resources in other GoB initiatives e.g. Village Resource Persons working under Dular & Muskan-Ek Abhiyan can be involved in mobilising the community and delivering few health services

Threats

- Increasing incidence of non communicable diseases
- Corporate and Private health care
- Various system of health care not complementing each other
- Natural Disasters specially the flood
- Lower pay packages
- Corruption

Challenges in the health sector at Purnia:

Despite these SWOT the District faces certain issues which need to be addressed to improve health outcomes:

- Improvement in Quality of Care
- Increase in levels of Health Financing
- Growing burden of Non-Communicable Diseases (NCDs)
- There is still a large "unfinished agenda" related to women and children's health, as well as control of communicable diseases.
- Equity Issues

Strategic Approach that will be adopted

- Increasing Access to and Utilization of Services aims to improve access to critical services with an intensive package of interventions
- Building Capacity for Oversight & Management of the Health System
- Maximizing Efficiency of the Public Sector to Deliver Essential Services

Special Recommendations from District:

Following are the special recommendations of the District Magistrate and other district officials:

- As there is lack of sufficient obstetrics and gynaecologist in the district so the lady doctor or even male doctors should be trained to substitute the position till the Obs. and Gynaecologists at health centers.
- Focus should be given on human resource development in this financial year
- Provision of two-three storied residential flats for PHC, referral and district hospital staffs rather making single floor flats for them.
- As there is unavailability of sufficient ANMs in the district and it would take time to fill up the ANMs at health centres, the local resource persons (LRP) working under Dular-Muskan programme should be involved for service delivery by building up their capacity.
- Managerial skill training should be conducted for doctors to manage and implement the programmes at health centres

- 100% registration and ANC for first time pregnant women
- Training of ANMs, ASHAs to identify the position of foetus in order to identify the high risk pregnant women.
- Ensuring 100% institutional delivery for the first time pregnant women to decrease the maternal and child mortality
- The special provision should be made for rehabilitation and tretamnet of child disables in the district as in Purnia the number of disables is quite high. The Physiotherapy centre located in the district can be given the responsibility to run the centre.
- In the first phase OT, new born care unit and laboratory facilities at PHCs, referral units and district hospitals needs to be strengthened for delivering RCH services.
- One district blood bank unit is essential for 24 hrs supply of blood at health centres.
- Regular refresher course or training should be conducted for service providers to provide qualitative health services to the clients.
- Provisioning of extra incentives for doctors who have been given the extra responsibility.
- Maternity hut should be established for flood affected areas and hard to reach areas for conducting safe deliveries.
- For flood affected areas, provisioning of boat ambulance should be there.
- Neo born care centre should be established at PHCs, referrals and district hospital
- IMNCI training should be conducted.
- NGOs should be involved for demand generation and ensuring RCH services in un-served and underserved areas.
- Formation of Village health and sanitation committee.
- Organising village health and nutrition day at village level in coordination with ICDS.
- Improving male participation in family planning services by mobilising the male for NSV.
- Regular supply of IUD for spacing between two children till 5-10 years
- The health centers at block and district level should be strengthened as per Indian Public Health Standard (IPHS) guideline.

5. Programme Objectives, Strategies and Activities

5.1 RCH-II:

The RCH II seeks to provide accessible, affordable and quality health care to both the rural and the urban population, especially the vulnerable sections. It also seeks to reduce the Maternal Mortality Rate (MMR) in the district from 451 to below 425 per 1,00,000 live births, Infant Mortality Rate (IMR) from 85 per 1000 live births to 75 per 1000 live births and decrease the Total Fertility Rate (TFR) from 4.0 to 3.8 by the year 2010.

The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower decentralization and District Management of Health Programmes, community participation and ownership of assets, induction of management and financial personnel into District Health System, and Operationalzing health facilities into functional units meeting Indian Public Health Standards. It has been realized by previous experiences that merely spending on infrastructure will not lead to a desired outcome. Therefore in last year as well as for coming year intensive focus has been planned for investing in provision of services along with infrastructure development.

Reproductive and Child Health Programme involves Maternal Health, Child Health, Immunization, Adolescent Health, RTI/STI Management, and Family Planning. In addition to this special focus is given to, Urban Health, operationalising of health facilities, and most importantly human resource and training. In order to provide quality care in PHCs attention has been given to expansion of 24x7 delivery and newborn care services.

This year's focus is on maternal and child health as well as family planning to bring down the maternal and infant mortality rate, neonatal mortality rate and decreasing the CBR. In addition to this, strengthening of institutional services at the level of First Referral Units (FRUs) will be taken up to support the referrals from primary health centres and provide decentralised specialist care thereby reducing the burden on tertiary care institutions and enable the provision of care to be cost effective. IMNCI is working as key strategy to improve child health scenario in the state. Facility and home based neonatal care is another priority for this year, which will include institutional and field based capacity building measures to decrease IMR.

Programme Management has been given a key place under RCH-II and a full-fledged DPMU in place and the process of setting up of BPMUs is also completed and it's fully functional.

Partnership with NGOs and private sector is necessary to improve the RCH Program coverage and services. It is important that NGOs initiate a sustainable health system at appropriate locations.

Monitoring and Evaluation being a key to assess the programme outcome has been given a key priority in the plan. The data centres are already there in place at all the PHCs in the District. A web-based portal for data management has started. Training of all level of health staff starting from PHC to block to district will be done in several phases to understand the importance of Health Management Information System (HMIS).

This plan will focus to achieve all the planed goals in a time bound manner with special consideration on benefit to poor and marginalized community.

GOALS under RCH:

Health Indicators	Current status	DLHS-2008	2010 GOALS
MMR (per lakh live birth)	451	-----	425
IMR (Per 1000 live birth)	85	-----	75

5.1.1 Maternal Health:

In order to improve the maternal health status of the women living in the area, focus should be made on ante natal care (ANC), institutional delivery and post natal care.

Health Indicators	Current status	DLHS-2008	2010 GOALS
% of women who had minimum three Ante-natal Check-up	9.4%	9.5%	40%
% of women with anaemia	73.2%	-----	60%
Institutional Delivery	39%	21.6%	50%
Safe Delivery	40.3%	24.5%	55%

5.1.1.1 ANC Service:

Objective 1: To increase the percentage coverage of minimum three ANC check-up from 9.4% to 40% in the next one year.

Strategies

- Increasing awareness in the community for improving ANC seeking during pregnancy, & community role in reaching adolescent mothers and SC/ST mothers and involvement of NGOs
- Effective implementation of village health and nutrition day
- Full ANC (3 visits+2TT+100IFA) by ANMs and FHW
- Developing linkages with private practitioners for improving early ANC registration and ANC services

Activities

- Registration of pregnant women
- ASHAs/AWW/FHW to motivate all pregnant women for ANC and prepare them for ANC and institutional delivery by visiting them in last trimester.
- Prepare a list of dais, community based health volunteers to be oriented
- Support to NGOs for improving ANC seeking during pregnancy
- Orient dais for social mobilization and support though NGOs
- Link up with AWWs and sensitization of AWWs on conducting ANC sessions
- IEC on the importance of ANC and BCC for timely health seeking behavior
- Half yearly review meeting of dais, CBHVs
- Micro-plan for Mother Child Protection activities once a month for every village & hamlets by FHW
- Village Health and Sanitation Day should be started and held regularly
- Prepare a plan for holding weekly ANC clinic
- Finalize the plan and outreach service schedule including schedule for MHU
- Propagate a schedule –inform dais, AWWs, Panchayats, CBOs etc about the fixed day and time on which the outreach services are planned

- Providing equipments, supplies and other support to the PHC, APHC and sub centre to provide ANC services to the pregnant women
- Contract ANMs, where FHWs are not available, for organizing outreach weekly ANC sessions
- Identify and finalize the private practitioners interested in holding ANC sessions especially in hard to reach areas areas, urban slums
- Provide support in terms of guideline, supplies, etc to private practitioner for holding ANC sessions
- Develop a fix day schedule for Organizing weekly ANC clinics
- Orientation of the private practitioners on quality ANC services
- Incentive support to the private practitioners on the completion of full ANC visits and care as per the guidelines

Objective 2: To reduce anaemia among pregnant and lactating mothers from 73.2% to 60% by 2010.

Strategies

- Awareness generation for consumption of IFA Tablets
- Purchase and Supply of IFA Tablets
- Supplementing IFA tablets consumption with other clinical strategies.

Activities

- ASHA and AWWs will generate awareness along with ANMs at the Village level
- Pregnant mothers will be aware for consumption of IFA tablets for 90 days
- Convergence with ICDS for regular supply of IFA tablets through AWWs
- Purchase IFA tablets in the case of stock out
- Timely supply of IFA Tablets to the Health Institutions
- Half yearly de-worming of all adolescent girls.
- Training of ANM, AWW and ASHA on module on EDPT (Early Diagnosis and Prompt Treatment) of anemia.

5.1.1. 2 Safe Delivery:

In order to reduce the MMR and IMR of the district, it is very important to conduct all the deliveries either at institutions or at home but assisted by a skilled birth attendant. The essential obstetric care services needs to be strengthened in order to reduce the maternal deaths. Essential obstetric care is the term used to describe the elements of obstetric care needed for the management of normal and complicated pregnancy, delivery and the postpartum period. Basic essential obstetric care services at the health centre level should include at least the following:

- Parenteral antibiotics
- Parenteral oxytocic drugs
- Parenteral sedatives for eclampsia
- Manual removal of placenta
- Manual removal of retained products

Comprehensive essential obstetric care services at the district hospital level (first referral level) should include the entire above plus

- Surgery
- Anaesthesia, and
- Blood transfusion.

For the services at a facility to be considered functional, the elements of care must have been provided during the 6 months previous to data collection.

Objective 1: To increase the proportion of deliveries conducted by skilled birth attendants from 42.5% to 55%.

Strategies:

- Improving service environment of the PHCs, CHCs and district hospital for institutional deliveries
- Increasing availability of skilled Birth Attendants (ANMs/SNs in 50% PHCs for 24 hrs delivery services)

- Streamlining Health Seeking behavior of community/ pregnant mothers for institutional deliveries

Activities

- Up gradation of physical infrastructure of Facilities and improve service improvements
- Provide necessary need based supplies, Other support to PHCs for improving quality of services
- Provide financial package to all for conducting deliveries at facilities decided by the government
- Link with Janani Evam Bal Suraksha Yojana & implement JBSY
- Monitor services through block officers and BPHNs
- Untied fund for district hospital (except RKS)
- Strengthening of 24X7 PHCs
- Ensure availability of Staff Nurses in identified PHCs for round the clock delivery services
- Refresher training of ANMs, SNs, MOs for conducting deliveries.
- Provide service guidelines and other necessary inputs, IEC/ BCC material
- Ensure the presence of staff nurse in the facility for 24 hours delivery services
- Provide IEC, BCC material for improving institutional deliveries
- Conduct IEC, and BCC activities on health seeking behaviors through MSS, CBOs, SHGs particularly in the outreach/hard to reach areas areas

Objective 2: To increase the number of facilities for basic emergency obstetric care.

Strategies

- Operationalizing BEmOC services in 100% referrals, 50% PHCs
- Operationalising CEmOC services in FRUs
- Developing partnership with private/trust/grant in aid hospitals for C/BEmOC
- Increasing awareness in the community regarding the availability of EmOC services particularly in the hard to reach areas areas

- Strengthening of FRUs with optimum facilities (hiring of specialists on contract, facilities for Caesarean Section, blood storage or blood bank, & newborn care).
- Operationalising CEmOC services in at least two FRUs in the next one year

Activities

- Improve the selected referrals (at least 2 referrals) for meeting IPHS
- Conduct facility need assessment by MOs
- Provide need based supplies, support, guidelines, etc
- Facility Improvement for BEmOC-LR/MW/OT/ Toilet/Water supply, waiting area, Fencing, etc
- Training of MOs & Staff Nurses on EmOC services
- Formalize referral linkages with FRUs for CEmOC
- Work out mechanisms for referral-Support with NGOs/Private/trust (referral transport)
- Provide referral transport through pvt agencies/NGOs (Integrate and Link with Janani Suraksha Yojana and referral transport plan)
- Monitor FRU & BEmOC services
- Conduct maternal death audit
- Facility improvements for CEmOC services
- Provide need based equipments, supplies, other support
- Equip the facilities for blood storage
- Develop public private partnership for supplying safe blood
- Orient specialists for CEmOC-trainers, training module, training sites, service guidelines and support
- Contract specialist, where specialists are not available , on call basis-Gynec, Anaesthetist
- Quarterly review of FRU services and meeting of staff Nurses
- Maternal death audit
- Support for referral transport-providing toll free telephone numbers for ambulance services in difficult areas for referral cases

- Identify, finalize private/trust/grant in aid hospitals
- MOU for the identified services with private providers/ facilities
- Provide service guidelines & incentive support for EmOC cases
- Training of MOs & staff Nurses on EmOC
- Formalize referral linkages with medical college for technical back stopping
- Provide referral transport on hire- toll free numbers
- Provide IEC material, involve NGOs in IEC activities
- Conduct community awareness activities through , NGOs, CBOs and other key actors

5.1.1.3 Postpartum Care:

The postpartum period covers a critical transitional time for a woman, her newborn and her family, on a physiological, emotional and social level.

Objective 1: To improve the coverage of mothers who received postpartum care within 48 hours of delivery from 19.9% to 40%.

Strategies

- Ensuring home visits (ANM, LHV) within three days of delivery in case of home delivery.
- Sensitizing the health service providers (HSPs) on the need for providing care to women and new born during post partum period and ensuring colostrums feeding to infants
- Undertaking specific BCC/IEC activities particularly related to exclusive breast feeding, nutrition and anaemia prevention specially in hard to reach areas
- Effective implementation of mamta diwas.

Activities

- Advance list will be prepared by each FHW for PNC
- Provide neonatal care, colostrums feeding and integrated mother-child care during PNC home visit as per GoI guidelines
- Link up the AWW with ANM to maximum coverage
- Use of Algorithm during PNC home visits by ANMs
- Monitoring of home visits through BHOs, BPHNs

- Information of family planning methods at the time of PNC
- Sensitization/training program for HSPs like MOs ANMs, FHWs, AWWs, etc (as a part of essential new born care training, BEmOC) on colostrums feeding, anaemia prevention and exclusive importance of breastfeeding
- Undertake specific IEC activities for exclusive breast feeding
- Undertake BCC among women and men on the need of contacting health personnel after home delivery
- Integrated communication for maternal health, exclusive breastfeeding, anaemia prevention and nutrition, child health, FP and adolescents' health through outreach healers, NGOs, HSPs especially in hard to reach areas
- Selection of Mamta (approximately 160 Mamtas would be selected in the district)
- Training of Mamta on Post Natal Care and other related services
- Need based training for Mamtas
- Mamta divas should be held regularly

Objective 2: To provide supportive supervision for facilitating block and PHC authorities in implementing various maternal health interventions.

Strategies

- Regular review meetings and visits
- Performance appraisal and monitoring

Activities

- Regular field visits followed by appropriate feedback and troubleshooting
- Development of checklist for supervision
- Performance appraisal through ranking system based on composite indicators raised from block health data

Objective 3: To ensure availability of RTI and STI services till PHC level to all clients.

Strategies

- Strengthening PHCs,CHCs, FRUs, UHC for diagnosis and treatment of RTI/STI
- Counselling for RTI/STI with special focus on adolescents.

Activities

- Provide Service guideline
- Training of MOs, staff Nurses/ANMs, Lab Technicians as per the approved manual
- Strengthen lab services
- Develop linkages with private practitioners for diagnosis and treatment
- Identification of counselling center for adolescents or provision of separate place and time for adolescents
- Training for counselling to medical officers

Objective 4: To increase Access to early and safe abortion services (Reduce deaths due to unsafe abortion practices)

Strategies

- Improving access to safe abortion services by ensuring one service centre in each block
- Increasing community awareness regarding availability of MTP services, consequences of sex selective abortions and PNDT Act.

Activities

- Training of Medical Officers/ qualified private Practitioners for MTP
- Strengthen DH, CHCs and selected PHCs For MTP
- Develop public Private partnership
- Implement quality improvement program with the support of District Quality Assurance Team
- Monitor MTP services through designated district committee
- IEC on availability of safe abortion services
- Community mobilization Particularly in the low sex ratio reported blocks/areas
- Awareness about the consequences of adverse sex ratio

5.1.2 Child Health:

Children are the building blocks of a nation. Survival of newborns and infants is directly related to the maternal health, nutrition status and the management of obstetric complications during a woman/s delivery and postnatal period. Of the nearly 8 million infant deaths each

year, around two-thirds occur during the neonatal period (the first month of life). About 3.4 million deaths occur in the first week. For every neonatal death another child is born with a physical disability. In India, every year 27 million infants are born. Around 10% of them do not survive to 5 years of age. The NRHM and the RCH II program have rightly focused on child survival strategies for saving the lives of children, many of whom today are needlessly dyeing. Presently, with 158000 infant deaths occurring annually, Bihar contributes about 9.9% to the national burden of infant deaths in India.

GOALS: for child health

- Reduce IMR from present 85 /1000 live births to 79/1000 live births by the year 2010

Health Indicators	Current status	DLHS-2008	2010 GOALS
IMR (Per 1000 live birth)	85	-----	75
Neonatal Mortality	65	-----	55
% of Children Fully Immunized	43%	37.4	60%
Children (age 6 months above) exclusive breastfed	11.5%	11.5%	30%

Objective 1: To increase access of essential care to all neonates.

Strategies

- Providing essential care to new born at community level
- Providing essential care to new born at facility level
- Effective implementation of IMNCI for home based neonatal care with the support from UNICEF

Activities

- Training of AWWs/ ANMs
- Educate the community about the danger signs,
- IEC/BCC/advocacy for promoting newborn care, exclusive breastfeeding & complementary feeding , immunization, polio eradication

- Training to SBAs, MOs, Staff Nurses and ANMs on new born care especially on danger signs
- Provide equipments, supplies and support, service guidelines, materials
- Training of ASHA/ AWW/ FHW/ MOs on the home based neonatal care package using IMNCI Approach (by UNICEF)
- Supply of diagnosis and treatment protocols (chart booklets) for implementation of the IMNCI strategy (by UNICEF).

Objective 2:

- Increase availability of neonatal services in at FRU level in this financial year.

Strategies

- Providing critical newborn care at FRU level

Activities

- Strengthen FRUs to provide NNC services
- Encourage ANMs & sensitize community on the risk symptoms and timely referral
- Link up with private practitioners in hard to reach areas/ outreach areas
- Orient paediatricians on critical new born care
- Support for paediatrician services, where specialists are not available, on call basis

Objective 3: To promote and increase the exclusive breastfeeding up to 6 months from 11.5% to 30% in this financial year and introduce complementary feeding at 6 months of age.

Strategies

- Promoting exclusive breast feeding

Activities

- Involvement ASHA and CBHVs
- IEC/BCC activities to change the behaviors and Practices, conduct communication campaign, special advocacy efforts to promote breast-feeding practices

Objective 4: Increase the complete immunization coverage of children (12-23 months) from 43% to 60% in the next one year.

Strategies

- Universalizing immunization coverage

Activities

- Block wise planning
- Organize monthly outreach sessions on fixed days
- Coordinate with AWWs and Dais
- Immunization session in the outreach areas and monitoring through BPHNs
- Support to DIOs for monitoring immunization programs under NRHM
- Organize immunization session in the remote areas through MHU
- Ensure availability of vaccines and regular immunization services
- Ensure regular supply of vaccine and maintenance of cold chain
- Awareness generation program on need for immunization
- Alternative arrangement for vaccine delivery at the center

Objective 5: To improve the treatment of diarrhoeal services in the district.

Strategies

Managing diarrhea and ARIs at the facility and community level

Activities

1. Facility level

- Provide need based supplies and other support
- Orient health personnel on prevention and management of diarrhea and ARI
- Referral of sick child to higher level of care

2. Community level

- Recognizing danger signs
- Promoting home available oral dehydration fluids
- Referral of sick child

5.1.3 Family Planning:

Goal for Family Planning: Reduce TFR to 3.8 from present level of 4.0

Health Indicators	Current status	DLHS-2008	2010 GOALS
Total Fertility Rate	4.0	------	3.8
CBR	38.1%	------	36%
% of married women (age 15-49 years) currently using any family planning method	27.5%	27.5%	35%
% of married women (age 15-49 years) currently using any Modern Method	25.7%	25.7%	33%
% of married women (age 15-49 years) currently using Female Sterilization	23.3%	23.3%	27%
% of married men (age 15-49 years) currently using Male Sterilization	0.6%	0.6%	1.5%
% of married women (age 15-49 years) currently using IUD	1.5%	0.0%	2.5%
% of married women (age 15-49 years) currently using OCP	0.8%	0.8%	5%
% of married women (age 15-49 years) currently using Condom	1.1%	1.1%	5%

Objective 1: To reduce TFR from 4.0 to 3.8 in the next one year.

Strategies

- Increasing access to non clinical contraceptives through community based distribution system and MHU

Activities

1. Strengthen distribution of contraceptives through CBD system:

    - Community health Volunteers
    - Training of trainers
    - Training of volunteers CBHVs under NRHM

- Supply & Support to CBHVs
- Half yearly meetings, reward for the best CBHVs
- Out reach contacts volunteers by health workers
- MIS

2.Strengthen distribution of contraceptives through MHU

Objective 2: To increase the availability and accessibility of the non clinical contraceptive methods in the area.

Strategies

- Improving access to non clinical contraceptives through Social Marketing

Activities

- Contract a Professional agency for social marketing
- Set benchmarks and measure performance
- Develop performance criteria
- Innovative approaches like condom vending machines in strategic locations particularly in hard to reach areas

Objective 3: To increase the percentage of IUD users from 1.5% to 7% in the next one year by improving IUD utilization and improvement in quality.

Strategies

- Popularizing D 380-A as alternative to sterilization

Activities

- Improve service environment at SCs
- Provides service guidelines
- Training of FHWs on quality IUD services
- Provide need based supplies and other support

Objective 4: To increase the percentage coverage of female sterilisation from 27.5% to 35% and male sterilisation from 0.6% to 1.5% in the year 2009-2010.

Strategy:

- Strengthening sterilization services in each 14 blocks (One facility in each block)
- Conducting issue based IEC and advocacy-age at marriage, declining sex ratio, benefits of small family etc (Popularize NSV)

Activities:

- Upgrade facilities
- Provide service guidelines
- Training of service providers- Minilap, Laparoscopic,
- Training cum services camp for MOs on NSV
- Provide need based supplies and other support
- Mobility support to lapro surgeon
- Provide support for compensation for loss of wages undergoing sterilization/IUD insertion scheme
- Provide IEC material
- Conduct IEC/ advocacy program, NSV camp
- Increase male involvement in the use of contraceptives, NSV
- Use of local resources –CBD volunteers as depot holders of IEC materials

5.1.4 Adolescent reproductive and Sexual Health (ARSH)

Objective 1: To enhance access of RH services to adolescents and contribute the RCH II goals of reduction of IMR, MMR and TFR.

Strategies

- Provision of Adolescent Friendly Health Services (AFHS) in every block at least one CHC
- Increasing awareness among the adolescents about the service availability
- Developing linkages for referral services and ASRH education and undertaking IEC and BCC on ASRH
- Controlling anaemia in adolescent girls (even in boys - attention to compliance to IFA

- Providing information to adolescents about importance of proper nutrition for proper growth and better reproductive health
- Involvement ASHA for better services and BCC.

Activities

- Provide service standards and guidelines
- Training of HSPs on ADOLSCENT FRIENDLY HEALTH SERVICES (AFHS)
- Improve service environment
- Establish referral mechanism
- Provide additional drugs and supplies
- Develop monitoring mechanisms
- Initiate services
- Monitoring of services
- Advocacy to key stake holders to create conducive environment for providing services
- Increase awareness among adolescents on RH issues
- Increase awareness in the community especially among parents
- Involve MNGOs/Other local groups for IEC/ advocacy, service; provision particularly in hard to reach areas.
- Identify and finalize the linkages
- Develop linkages with the identified centers/ facilities particularly in outreach areas
- Use of Injectable Iron to reduce Anaemia among adolescents
- IFA tablet distribution among adolescents.
- Conduct IEC/BCC activities
- Conduct IEC/ BCC activities- ASRH will have nutrition messages on importance of proper nutrition for growth and future reproductive health
- Training to ASHS for BCC
- Help of ASHA to take adolescents at AFHS Centers

5.1.5 Urban RCH:

Objective 1: To provide integrated Maternal and Child Health Services to urban poor through fully functional urban health centres.

Strategies

- Strengthening integrated and sustainable system for primary health care services in urban/ urban slum areas
- Strengthen and upgrade the existing health centers

Activities

- Appointment of required staff
- Increase access to referral units
- Encourage and provide an integrated health services
- Promote community participation through inter sect oral Coordination
- Promote convergence of efforts among multiple stakeholders
- Identify and support volunteers in urban slum-CBHVs
- Develop strategies to promote behavior change
- Strengthen referral transport
- Provide need based equipments, supplies and support
- Have linkages with the higher referral facilities

5.1.6 Vulnerable Group (Sex workers in red light areas of Purnia and labourers in Jute industry):

Objective 1: To provide sustainable system for maternal, child, adolescent and family planning services to vulnerable groups.

Strategies

- Identification and localisation of these groups with the involvement of Targeted Intervention partners of BSACS and district labour department.
- Special incentives to this group for improving institutional deliveries and family planning services

Activities

- Mapping of these groups by NGOs
- Provision of health check-up camps and benefits of JBSY to these groups

- Mobile health units (MHUs) to look after these group
- Emergency transport to take care of complications in pregnant mothers and new born

5.1.7 RCH services in unserved and underserved areas:

Objective 1: To improve the RCH services in unserved and underserved areas.

Strategies

- Improving access and generating demand for RCH services in unserved blocks

Activities

- Improve service coverage, accessibility, acceptability, utilization
- Promote community participation and inter-sect oral coordination
- Develop a sufficient number of first referral institutions capable of tackling emergencies, including obstetric emergencies
- Develop a system of referrals from primary to secondary and higher levels
- Undertake special initiatives in these areas through implementation of MNGO scheme to generate demand for quality RCH services.

5.1.8 School Health programme

Objective 1: To improve the health status of school going children

Strategies

- Providing basic health education to school going children

Activities

- Conduction of half day orientation of children in every school on basic health education
- Health Check-up camps

5.2 Infrastructure Development

Infrastructure is one of the important components for up gradation of facility to deliver the quality service. In the PIP it has been proposed a number of infrastructural corrections for upgrading the facilities. All the ten functional PHCs would be strengthened by strengthening labour rooms, OT, laboratory facility, providing mobile health units, MTP and RTI/STI centers, ARSH services and making all the PHCs with 50 beds. The supply of drugs and other

supplies for facility based services would be improved. The referral system would be improved. The logistic consultants would be appointed in the next one year. The residential facility for the service providers would be made but in order to make it cost-effective multi-storied flats would be constructed for cost saving and optimal usage of land available for health centres.

At least 3 PHCs, 1 referral units would be made as per the IPHS guideline and one PHC would be provided ISO certification in this financial year. The provision of sufficient HR would be made available to ensure 24x7 services at health centres. Seeing the lack of HR at the health centres, capacity building of available HR would be made to replace the vacant position. The selected potential local resource persons working under Dular-Muskan programme can be capacitated for replacing ANMs.

Recently a cabinet decision has been taken to upgrade Purnia District Hospital into a 500 bedded hospital hence all the requisite facilities, equipments, infrastructure, human resources, drugs and supplies need to be provided during this financial year to make it functional.

5.3 Institutional Strengthening (Health Management Information System):

Monitoring and Evaluation is an important component under NRHM. The district monitors the progress of the programme through its data centres, but still the progress is not very satisfactory. So in order to strengthen the HMIS, the DHS will implement following activities:

Activities

- Strengthen district Quality Assurance Committee
- Merger of all society under District Health society
- Strengthen training institution
- Logistics & Supply system
    - Provide training material
    - Orient district level-mid level personnel for logistics/supplies
- Monitor the activities at different levels

5.4 Quality Assurance

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 guideline, every district should have one District Quality Assurance Committee (QAC). The QAC has 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 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 district does not have any functional QAC.

Strategy:

- Mainstreaming the Quality Assurance programme in the district health system for improving quality of services

- Meeting Indian Public health Standards at least by 2 referrals and prepare path for more facilities.

Activity:

- Designate district quality assurance officer
- Activate district quality assurance committee, setting quality of care standards, indicators and outputs
- Develop guidelines & checklists for QA committee
- Provide guidelines to QA team and HSPs
- Orientation workshop for MOs on quality issues
- Upgrade CHCs as per IPHS (as a part of NRHM support)
- Strengthen existing grading system of health institutions
- Support for quality initiatives to CHC/PHC/FRU/FP services
- Conduct the feasibility of alternate models through innovative operations research
- Support for regular review meeting of quality team
- Facilitate interface between women/community groups with health systems

5.5 Human Resource Development Including Training:

Successful Implementation of any programme depends on the capacity building of the personnel engaged. The HRD is one of the major components under NRHM. As far as HRD is concerned, the performance of the district is very poor. The HR does not have the requisite technical skills to provide qualitative services to the clients. Seeing the gap in HRD, the focus would be made to strengthen the existing human resources to deliver qualitative services at health centres. There is need to provide training to all levels viz. district health hospital level, referral units level, PHC level and HSC level. The district and block level managers, medical officers, nursing staff, ANMs, LHVs, AWWs, ASHAs and Village Resource persons would be trained on different issues. The district level officials would be trained at the state level that would be used as the Master Trainers to conduct trainings at lower levels.

The training will be provided at the Regional Institute of Health and Family Welfare, ANM training schools, District hospital, PHCs. But in order to carry out all the training activities,

one district level training institute is needed exclusively for conduct HRD activities as the ANM school has been started in the district and the present batch session will continue for another 18 months. The space at RIHFW, district hospital and PHCs is not sufficient to conduct the training. Some of the trainings will be contracted out to the MNGOs/NGOs and private players, so that the gap in skill of available HR can be fulfilled. 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.

A feedback system will be developed to assess the quality of the training. The QAC members would be requested to monitor the trainings.

The wide range of training activities to be conducted under RCH II program by various agencies and training institutes is outlined below. A training calendar would be prepared in consultation with other stakeholders by organsiing a one day workshop on preprartion of district training calendar. 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. The details about the trainings required have already been discussed in the above sections and has been mentioned in the activity part against each section.

Objectives 1: To build up the capacity of human resources available at health centres in all spheres of service delivery.

Strategies:

- Organizing different trainings and workshops for HRD and Capacity Building.

Activities:

- Training of district health society staff on RCH II
- Training of Medical offices for operation management and reporting
- Training of FHWs for proper reporting

5.6 Equity and Gender

Equity and gender mainstreaming is one of the major strategy / components under NRHM. In the district, no such initiatives haves been made but in order to achieve the objectives of NRHM, the district would start the initiatives for gender equity and mainstreaming.

Objectives 1: To maintain Equity at every level in the health system

Strategy:

- Provision of AFSH services for both (male and female)
- Improving service environment to maintain equity.

Activities:

- AFHS services for both (male and female)
- Both male and female will be covered under anaemia control programme
- Training of HSPs to maintain equity
- Provide facility screening check list to make service environment gender sensitive
- Screen the facility by the medical officer
- Improve facility to be female friendly

5.7 Public Private Partnership / NGO

The district will do accreditation of Pvt. Health centres to deliver health services especially for JBSY scheme and FP services. The MNGO scheme would be implemented in the district and the MNGOs would be involved in demand generation and ensuring the health services in hard to reach areas of the district. There are one MNGO in the district namely Arthik Aatma Nirbharta Samajik Vikas Abhikaran selected as the MNGO under RCH – II programme. There are four field NGOs who are working at the grass root level. The project proposals of the MNGOs/FNGOs have been approved by the SHSB and fund would be allotted from RCH flexi pool. Other NGOs can also be involved to cater larger number of population.

Objectives 1: Increase related sectors and NGO involvement in programme implementation and community mobilization.

Strategies:

- Strengthening networking and partnership with the civil society and private sector.

- Supporting MNGO and FNGOs/ other NGOs for services and service support.

Activities:

- Inter linkage with Other departments like WCD, Education, Panchayat, Youth Affairs, etc
- Formation and functional Village Health and Sanitation Committee.
- Fully functional Rogi Kalyan samitis at PHCs
- Involve civil society, partners, NGOs in district societies
- Involvement of ASHA, AWWs in ANC, PNC, AFHS etc.
- Identification of MNGO and implementation of MNGO scheme.
- Strengthen Partnership with M/FNGOs to improve health status particularly for RTI/STI services in outreach areas

5.8 Innovations

5.8.1 MUSKAAN – Ek Abhiyan

An innovative programme called MUSKAAN Programme is being implemented to track pregnant women and new born child. Under this programme, ASHA, AWW and ANMs jointly track the pregnant mothers and New Born Child. The main objective of the programme is to cover ANC coverage and Immunization. After the introduction of this programme it has been seen that the coverage of ANC and Immunization increased.

5.8.2 Boat Ambulance:

Eight blocks of the district, namely Baisi, Baisa, Amour, Rupauli, Damdaha, Bhawanipur, Barharkothi and Banmankhi blocks are affected by flood where the large number of population does not have access over health centres to avail health services. The flood affected villages remain cut off from the rest part of the district for more than four to five months. The delivery of pregnant women has been found as one of the major concern for the district. In order to address the issue, provisioning of one boat ambulance in each of the affected blocks is one of the most feasible strategies for the district. These motor boats would be used as an ambulance and would be equipped with essential equipments and trained ANMs to conduct safe deliveries, in case it needs to conduct delivery on the way to health centres.

Strategies:

- Functional boat ambulance

Activities:

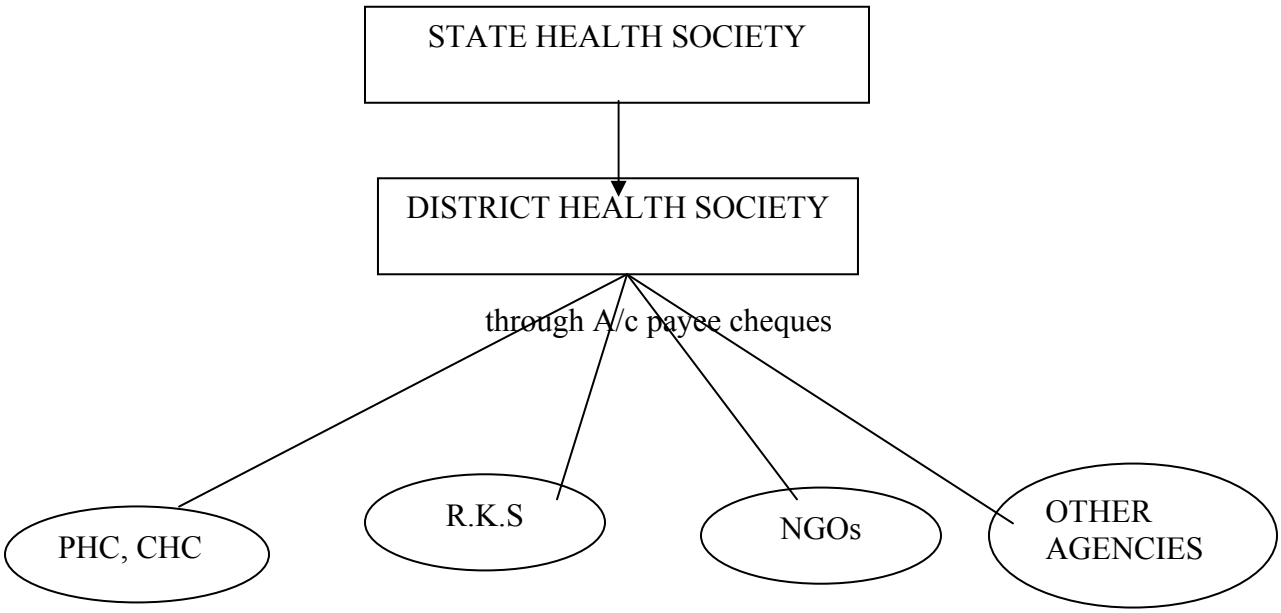
- Procurement of eight motor boats in this financial year
- Equipped the motor boat with all the essential equipments for using it as an ambulance
- Provision of one ANM and MPW at each Boat Ambulance to bring the patients at health centres and making the boat ambulance equipped for safe delivery, in case conduction of delivery is essential during journey.

5.9 Financial Management

5.9.1 Fund Flow Mechanisms at District

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.

FUND FLOW



5.9.2 Operation of Bank Accounts

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

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

5.9.3 Accounting Procedures Followed

The DHS is following the Double Entry System of accounting on Cash Basis. In addition to this for proper accounting and maintenance of books, a manual cum guidelines had been issued by the SHSB. Also the auditor has been appointed for the district.

5.9.4 Financial Management at District

The Financial Management is being done by the DHS and District Accounts Manager looks after the financial matters

5.9.4.1 Financial Monitoring

The financial monitoring is being done through the understated mechanisms-

1. Analysis of SOEs submitted by the blocks and its comparison with audited expenditures on monthly basis and reconciliation of the same by the DAM.
2. Discussion of financial issues with the districts officials in DHS meeting at regular intervals.
3. Audits:
    a) Comprehensive audit (Annual) as per the Directions of SHSB. The auditor has been appointed by the state.
    b) Monthly Audit is being conducted and reports are submitted to state regularly which are then reviewed.

5.10 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. NRHM will also enable the mainstreaming of Ayurvedic, Yoga, Unani, Siddha and homeopathy system of Health (AYUSH). The role of District and Block are well defined. The role of each one has been clearly indicated in the work plan. The district will mainstream AYUSH with the NRHM initiatives. Mainstreaming AYUSH will also help in supporting Child disability rehabilitation centres.

5.11 Synergise 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,
- Promotional efforts for demand generation and
- Improved monitoring & evaluation systems developed under RCH II
- Public Private Partnership
- Convergence & Coordination

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.

5.13 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. Similarly at the district level, the District Health Society has been established to look after the NRHM programme at the district level. The District Magistrate is the Chairperson of District Health Society.

The district health 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 District.
- 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.

5.13.1 Governing body of DHS

1.	District Magistrate & Collector, Purnia	Chairperson
2.	District Development Commissioner (CEO Zilla Parishad), Purnia	Vice Chairperson
3.	District Social Welfare Officer, Purnia	Member
4.	Executive Officer, Municiplity, Purnia	Member
5.	Addl. Chief Medical Officer, Purnia	Member
6.	District RCH Officer, Purnia	Member
7.	Deputy Superintendent of the District Hospital, Purnia	Member
8.	Civil Surgeon, Purnia	Member Secretary

5.13.2 Executive Body of DHS

1	District Magistrate, Purnia	Chairperson
2	Civil Surgeon of the District, Purnia	Member Secretary
3	Additional Chief Medical Officer Cum member Sec. DBCS, Purnia	Member
4	District RCH Officer, Purnia	Member
5	District Leprosy Officer, Purnia	Member
6	District T.B. Officer, Purnia	Member
7	District Malaria Officer, Purnia	Member
8	District Programme Manager (ICDS), Purnia	Member
9	Chief Executive Officers Nagar Nigam, Purnia	Member
10	Executive Engineer, PHED, Purnia	Member
11	Representative of Mother NGO under RCH – II	Member

District Programme Management Support unit consists of following personnel:-

- District Programme Manager
- District Accounts Manager
- District Data Assistant

Similarly in all the blocks, a Block Health Management Unit has been formed. The MOIC is the Chairperson of the unit. Block Programme Management Support unit consists of following personnel:-

- Block Health Manager
- Block Accounts Manager
- Block Data Assistant

5.14 Strengthen DPMU and BPMU

Objectives: To strengthen the DPMU and BHMU in the district

Strategies:

- Strengthen District Program Management Unit
- Improving Management of Health Management Information system (HMIS)

Activities:

- Contractual appointment of logistic consultant at district and block level.
- Support for Office/data processing equipments, hiring vehicles, POL and maintenance, contingency, annual plan formulation, consultancy, etc
- Prepare operational guidelines for district society
- Orient district health society staff , district managers
- Provide operational Support to district program
- Training program for district staff on HMIS
- Print and disseminate forms (1-9), 1-8 register , other for mate, operational manuals/ training material for computerized HMIS etc

5.15 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 at PHC level
- Revising the HMIS formats for effective implementation of the programme. It has been realised that the health workers are overloaded with the formats available for different programmes. There is a need to make it short and easy to fill up for devoting more time on delivering health services rather filling up forms.
- Training to MOs for effective supervision and monitoring
- Performance appraisal of MOs and other staffs
- Provision of performance based incentive for service providers
- Mobility support
- Concurrent monitoring and evaluation
- Running up of Data centres at block and district level
- Web/internet based computer software for use at district level (would be developed at state level)

- Road map of each health centre for easy communication
- Effective implementation of community based monitoring
- Formation and strengthening of VHSCs
- Strengthening of RKSs
- Conduction of VHSCs, RKSs and DHS meeting on regular basis for effective monitoring and supervision

5.16 Key Development Indicators

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

- Maternal Mortality Rate
- Infant Mortality Rate
- Neonatal Mortality Rate
- CBR

5.16.1 Key progress indicators

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

5.16.2 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

Regular monitoring, timely review of the NRHM activities would be carried out at the district level. The reporting and recording of RCH formats (Plan and monthly reporting) are irregular, incomplete and inconsistent. 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, 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 Assistant at the district level will be responsible for management of HMIS.

There is Rogi Kalyan Samitis at all PHCs and CHCs. The RKS will monitor the performance of PHC/CHC under their jurisdiction and will submit the report. At the panchayat level, there will be Village Health and Sanitation Committee who make the village health plan and monitor the health activities at village level and will report to RKS. The RKS will monitor and evaluate the HSC performance and performance will be submitted to the District, which will be compiled and sent it to the state.

5.17 Reports Required From Blocks / District:

Following are the reports required to come from block to district level. The DHS would compile the data collected from all the blocks and would send the compiled report to the State Health Society Bihar for monitoring.

- 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 to the SHSB.

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

Form 5

1. **State** Staff position,
2. Training & orientation,
3. supplies,

Form 4
District Action Plan

Compilation of Action Plans submitted by all PHCs, FRUs, Sub-Divisional Hospitals at the District Hospitals and submitted to the State

Form 1
HSC Action Plan

Prepared by: ANM with the help of DFWO

Submission: Once in a year, Feb-March

Form 2
PHC Action Plan

Prepared by: PHC, LHVs & ANMs

Submission: Once in a Year, Feb-March

Form 3
FRU/SDH Action Plan

Prepared by: Sub Divisional Hospitals

Submission: Once in a Year, Feb-March

Reporting Forms

Form-9

Compiled at: District Level
Responsibility: CS/ACMO
Flow of form: District to State
Submission: 25th of each month

Form-8

Compiled at: FRU/SDH Level
Responsibility: MOIC
Flow of form: Hospital to District
Submission: Monthly

Form-7

Compiled at: PHC Level
Responsibility: MOIC
Flow of form: PHC to District
Submission: Monthly

Form-6

Compiled at: HSC Level
Responsibility: ANM
Flow of form: HSC to PHC
Submission: Monthly

5.18 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.

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. The involvement of NGOs would be enhanced for sustainability of the programme.

LOGICAL FRAMEWORK ANALYSIS

Logical Framework Analysis					
Sl. No.	**Objectives**	**Strategy**	**Activities**	**Objectively verifiable indicator (OVI)**	**Means /Source of verification**
	ANC Services				
	To increase the percentage coverage of minimum three ANC check-up from 9.4% to 40% in the next one year.	a) Increasing awareness in the community for improving ANC seeking during pregnancy, & community role in reaching adolescent mothers and SC/ST mothers and involvement of NGOs	• Prepare a list of dais, community based health volunteers to be oriented • Support to NGOs for improving ANC seeking during pregnancy • Orient dais for social mobilization and support though NGOs • Link up with AWWs and sensitization of AWWs on conducting ANC sessions • IEC on the importance of ANC and BCC for timely health seeking behavior • Registration of pregnant women • ASHAs/AWW/FHW to motivate all pregnant women for ANC and prepare them for ANC and institutional delivery by visiting them in last trimester.	• % women undergoing complete ANC • dais, CBHVs identified • NGOs identified • Dais/ CBHVs oriented through NGOs • IEC material prepared for ANC • % women aware about the importance of ANC • Meetings held regularly	• Mid term and end line survey • Rapid Assessments
		b) Effective implementation of village	• Micro-plan for Mother Child Protection activities once a	• % of VHND held against the planned	• ICDS registers

		health and nutrition day	month for every village & hamlets by FHW • Village Health and Sanitation Day should be started and held regularly	session • % of pregnant women participated in VHND.	
		c)Full ANC (3 visits+2TT+100IFA) by ANMs and FHW	• Prepare a plan for holding weekly ANC clinic • Finalize the plan and outreach service schedule including schedule for MHU • Propagate a schedule –inform dais, AWWs, Panchayats, CBOs etc about the fixed day and time on which the outreach services are planned • Provide need based supplies and support to the facilities and MHU • Contract ANMs, where FHWs are not available, for organizing outreach weekly ANC sessions	• Schedule for holding ANC session is available • Weekly outreach services –ANC sessions-organized through MHU • FRUs, CHCs, PHCs, Dispensaries, UHC holding weekly ANC sessions • SCs holding weekly ANC sessions • PHCs, SCs holding weekly outreach ANC sessions	• Routine monthly performance reports from facilities • District report • Supply records
		d) Developing linkages with private practitioners for improving early ANC registration and ANC services	•Identify and finalize the private practitioners interested in holding ANC sessions especially in outreach areas, urban slums •Provide support in terms of guideline, supplies, etc to private practitioner for holding ANC sessions •Develop a fix day schedule for	• List of Private practitioners who are interested in holing ANC sessions • Guideline for holding weekly ANC sessions prepared and in position • Private Practitioners oriented on quality	• Monthly district report supply records District report

			Organizing weekly ANC clinics •Orientation of the private practitioners on quality ANC services	ANC services • Full ANC Cases Completed by the private practitioners	
	To reduce anaemia among pregnant and lactating mothers from 73.2% to 60% by 2010.	a) Awareness generation for consumption of IFA Tablets	•ASHA and AWWs will generate awareness along with ANMs at the Village level •Pregnant mothers will be aware for consumption of IFA tablets for 90 days •Convergence with ICDS for regular supply of IFA tablets through AWWs	• % increase in consumption of IFA tablets	• Registers
		b) Purchase and Supply of IFA Tablets	•Purchase IFA tablets in the case of stock out •Timely supply of IFA Tablets to the Health Institutions	• % increase in requirement of IFA tablets	• Registers
		c) Supplementing IFA tablets consumption with other clinical strategies	•Half yearly de-worming of all adolescent girls. •Training of ANM, AWW and ASHA on module on EDPT (Early Diagnosis and Prompt Treatment) of anemia.	• % of adolescents given supplementary IFA tablets • No. of health workers trained on EDPT.	• Training registers, and supply register of IFA tablets for schools
	Safe Delivery				
	1) To increase the proportion of deliveries conducted by	a) Improving service environment of the 10 PHCs, 3 referral units and district hospital for institutional deliveries	• Up gradation of physical infrastructure of Facilities and improve service improvements • Provide necessary need based supplies, Other support to PHCs for improving quality of	• PHCs and CHCs conducting delivery • No. of deliveries at facilities • Payment paid under the	• Performance report of District for PHCs and CHCs

	skilled birth attendants from 42.5% to 55%.		services • Provide financial package to all for conducting deliveries at facilities decided by the government • Link with Janani Evam Bal Suraksha Yojana & implement JBSY • Monitor services through block officers and BPHNs • Untied fund for district hospital (except RKS) • Strengthening of 24X7 PHCs	package • No of deliveries paid under JBSY • PHCs visit registers	
		b) Increasing availability of skilled Birth Attendants (ANMs/SNs in 50% PHCs for 24 hrs delivery services)	• Ensure availability of Staff Nurses in identified PHCs for round the clock delivery services • Refresher training of ANMs, MOs for conducting deliveries. • Provide service guidelines and other necessary inputs, IEC/ BCC material • Ensure the presence of staff nurse in the facility for 24 hours delivery services	• PHCs have SBAs for 24 hrs delivery services • ANMs, staff nurse, MOs trained • % deliveries attended by Skilled Birth Attendants	• Training report Performance report of PHCs
		c) Streamlining Health Seeking behavior of community/ pregnant mothers for institutional deliveries	• Provide IEC, BCC material for improving institutional deliveries • Conduct IEC, and BCC activities on health seeking behaviors through MSS, CBOs, SHGs particularly in	• Awareness about the institutions for deliveries • No. of IEC/BCC activities conducted through MSS, CBOs, SHGs	• Mid term and base line survey

			the outreach/outreach areas		
	To ensure availability of basic emergency obstetric care services at health centres	a) Operationalizing BEmOC services in 100% referrals, 50% PHCs	• Improve the selected referrals (at least 2 CHCs) for meeting IPHS • Conduct facility need assessment by MOs • Provide need based supplies, support, guidelines, etc • Facility Improvement for BEmOC-LR/MW/OT/ Toilet/Water supply, waiting area, Fencing, etc • Training of MOs & Staff Nurses on EmOC services • Formalize referral linkages with FRUs for CEmOC • Work out mechanisms for referral-Support with NGOs/Private/trust (referral transport) • Provide referral transport through pvt agencies/NGOs (Integrate and Link with Janani Suraksha Yojana and referral transport plan) • Monitor FRU & BEmOC services • Conduct maternal death audit	• Check list available for conducting the facility survey for the need assessment • FRUs and CHCs Operetionalized for BEmOC services • Trainers available for EmOC training • MOs and Staff Nurse trained for EmOC services • Interested agencies identified for providing referral services	• Monthly performance reports, Annual Health Statistics • Training report
	To increase availability and	a) Operationalising CEmOC services in FRUs	• Facility improvements for CEmOC services • Provide need based equipments, supplies, other	• Check list available for conducting the facility survey for the need assessment	• Monthly facility reports Annual Health Statistics • Training report

	accessibility of comprehensive emergency obstetric care services in all the three referral units		support • Equip the facilities for blood storage • Develop public private partnership for supplying safe blood • Orient specialists for CEmOC-trainers, training module, training sites, service guidelines and support • Contract specialist, where specialists are not available , on call basis-Gynec, Anesthetist • Quarterly review of FRU services and meeting of staff Nurses • Maternal death audit • Support for referral transport-providing toll free telephone numbers for ambulance services in difficult areas for referral cases	• Operationalized CEmOC centers at FRUs • Specialist facilities available for the supplying safe blood • Specialist trained for CEmOC • Specialist identified for the services on call basis • Meetings held • Facilities having serving of toll free telephone numbers	
		b) Developing partnership with private/trust/grant in aid hospitals for C/BEmOC	• Identify, finalize private/trust/grant in aid hospitals • MOU for the identified services with private providers/ facilities • Provide service guidelines & incentive support for EmOC cases	• Partners identified for B/CEmOC services • No. of MOU signed • % BPL families benefited from the referral services	District report

			• Training of MOs & staff Nurses on EmOC • Formalize referral linkages with medical college for technical back stopping • Provide referral transport on hire- toll free numbers		
	To increase awareness among community regarding safe delivery, availability of EmOC services in outreach areas.	a) Increasing awareness in the community regarding the availability of EmOC services particularly in the outreach areas	• Provide IEC material, involve NGOs in IEC activities • Conduct community awareness activities through , NGOs, CBOs and other key actors	• % awareness about danger signs and symptoms during pregnancy , delivery and post-partum and timely referral	• Mid term &End line survey
	Post Natal Care				
	To improve the coverage of mothers who received postpartum care within 48 hours of delivery from 19.9% to 40%.	a) Ensuring home visits (ANM, LHV) within three days of delivery in case of home delivery	• Advance list will be prepared by each FHW for PNC • Provide neonatal care and integrated mother-child care during PNC home visit as per GoI guidelines • Link up the AWW with ANM to maximum coverage • Use of Algorithm during PNC home visits by ANMs • Monitoring of home visits through BHOs, BPHNs	• % women contacted by ANM,LHV within three days of delivery and within six weeks • % new born babies weighed at birth • % PNC mothers received FP advice	• Mid term & End line survey Annual Health Statistics District report

			• Information of family planning methods at the time of PNC		
		b) Sensitizing the health service providers (HSPs) on the need for providing care to women and new born during post partum period and ensuring colostrums feeding to infants	• Sensitization/training program for HSPs like MOs ANMs, FHWs, AWWs, etc (as a part of essential new born care training, BEmOC) on colostrums feeding, anaemia prevention and exclusive importance of breastfeeding	• % women/new born contacted during post natal period by ANM/LHV • % of children given colostrums • % of children exclusively breast fed	• Mid term and line survey Rapid Assessments
		c) Undertaking specific BCC/IEC activities particularly related to exclusive breast feeding, nutrition and anaemia prevention specially in hard to reach areas	• Undertake specific IEC activities for exclusive breast feeding • Undertake BCC among women and men on the need of contacting health personnel after home delivery • Integrated communication for maternal health, exclusive breastfeeding, anaemia prevention and nutrition, child health, FP and adolescents' health through outreach healers, NGOs, HSPs	• % woman aware on care of new born during post partum period, given cholostrum and exclusively breastfed • % of lactating women taking locally available nutritious food • % of lactating women accessing services for anaemia prevention. • % of women and others accessing health services	• District report
		d)Effective implementation of mamta divas	• Selection of Mamta • Training of Mamta on Post Natal Care services • Need based training of Mamtas • Mamta divas should be held regularly	• % of Mamta selected and trained • % of Mamta divas held against planned	• Mamta registers

	STI/RTI Services				
	1	a) Strengthening PHCs,CHCs, FRUs, UHC for diagnosis and treatment of RTI/STI	• Provide Service guideline • Training of MOs, staff Nurses/ANMs, Lab Technicians as per the approved manual • Strengthen lab services • Develop linkages with private practitioners for diagnosis and treatment	• Service guideline available • Mos, ANMs and LTs trained for providing RTI/STI services • No. of Private practitioner • % increase in proportion of women with RTI/STI seeking advice and treatment	• Training reports • Reports of PHCs CHCs, FRUs, UHC • Mid term & End line survey Rapid Assessments
		b) Counseling for RTI/STI with special focus on adolescents.	• Identification of □ehaviours□ center for adolescents or provision of separate place and time for adolescents • Training for □ehaviours□ to medical officers	• No. of □ehaviours□ centers • % of adolescents □ehaviours • Trained medical officer	• District Reports
	Safe Abortion Services				
	1) To increase Access to early and safe abortion services (Reduce deaths due to unsafe abortion services).	a) Improving access to safe abortion services by ensuring one service center in each block	• Training of Medical Officers/ qualified private Practitioners for MTP • Strengthen FRUs, CHCs and selected PHCs For MTP • Develop public Private partnership • Implement quality improvement program with the support of District Quality Assurance Team • Monitor MTP services through designated district committee	• Medical officers trained in MTP • Health facilities providing safe abortion services • Partners identified for safe abortion services • MOU singed • District quality assurance team is in position • % beneficiaries	• Training report • District report • Mid term & End line survey

				benefited by services	
		b) Increasing community awareness regarding availability of MTP services, consequences of sex selective abortions and PNDT Act	• IEC on availability of safe abortion services • Community mobilization Particularly in the low sex ratio reported blocks/areas • Awareness about the consequences of adverse sex ratio	• % female aware about the availability of safe abortion services • Proportion of teenage girls availing MTP services	• Annual Health Statistics District report • Rapid Assessments
	Child Health				
	1) To increase access of essential care to all neonates.	a) Providing essential care to new born at community level	• Training of AWWs/ ANMs • Educate the community about the danger signs, • IEC/BCC/advocacy for promoting newborn care, cholostrum feeding, exclusive breastfeeding & complementary feeding , immunization, polio eradication	• AWWs/TBAs trained in essential new born care • % women aware on colostrums feeding, exclusive breastfeeding, complimentary feeding, immunization and polio eradication	• Training reports • Mid term and End line survey
		b) Providing essential care to new born at facility level	• Training to SBAs, Mos, Staff Nurses and ANMs on new born care especially on danger signs • Provide equipments, supplies and support, service guidelines, materials	• Mos, staff nurse and ANMs trained • % facilities Providing new born care	• Training report • Supply report • District reports
		Effective implementation of IMNCI for home based neonatal care with the support from UNICEF	• Training of ASHA/ AWW/ FHW/ Mos on implementation of IMNCI for home based neonatal care (by UNICEF)	• No. of health workers trained on IMNCI • % of children getting benefitted from home	• IMNCI registers • UNICEF IMNCI MIS

			• Supply of diagnosis and treatment protocols (chart booklets) for implementation of the IMNCI strategy (by UNICEF).	based neonatal care package of IMNCI • No. of chart booklets distributed	
	2) Increase availability of neonatal services in at FRU level in this financial year.	a) Providing critical newborn care at FRU level	• Strengthen FRUs to provide NNC services • Encourage ANMs & sensitize community on the risk symptoms and timely referral • Link up with private practitioners in outreach areas • Orient paediatricians on critical new born care • Support for paediatrician services, where specialists are not available, on call basis	• FRUs equipped with NNC services • Private practitioners finalize for link up • FRUs having trained doctors, staff nurses • Paediatricians available on call basis • % community aware about the new born care and availability of services related to NNC	• Supply records • District reports • Training records
	3) To promote and increase the exclusive breastfeeding up to 6 months from 11.5% to 30% in this financial year and introduce complementary feeding at 6 months of age.	a) Promoting exclusive breast feeding	• Involvement ASHA and CBHVs • IEC/BCC activities to change the □ehaviours and Practices, conduct communication campaign, special advocacy efforts to promote breast-feeding practices	• No. of ASHA and CBHVs trained • % women aware about importance of exclusive breastfeeding • % children breast fed exclusively for six months	• District reports • Mid term and End Line Survey
	4) Increase the	a) Universalizing	• Block wise planning	• Outreach sessions held	• Visit report

	complete immunization coverage of children (12-23 months) from 43% to 60% in the next one year.	immunization coverage	• Organize monthly outreach sessions on fixed days • Coordinate with AWWs and Dais • Immunization session in the outreach areas and monitoring through BPHNs • Support to DIOs for monitoring immunization programs under NRHM • Organize immunization session in the remote areas through MHU • Ensure availability of vaccines and regular immunization services • Ensure regular supply of vaccine and maintenance of cold chain • Awareness generation program on need for immunization • Alternative arrangement for vaccine delivery at the center	per month • No. of MHU are operational • Facilities having vaccines available • Facilities having functional cold chain • % children received complete immunization	• District report • Asha Cards • Mid term and line survey supply record • ICDS records • Reports from MHU •
	5) To improve the treatment of diarrhoeal services in the district.	a) Managing diarrhea and ARIs at the facility and community level	• Facility level • Provide need based supplies and other support • Orient health personnel on prevention and management of diarrhea and ARI • Referral of sick child to higher level of care	• Facility equipped with supplies and support to manage diarrhea and ARI • Health personnel oriented on prevention and management of diarrhoea and ARI • % aware of danger	• Supply report • Training program Mid term and end line survey • District report

			• Community level • Recognizing danger signs • Promoting home available oral dehydration fluids • Referral of sick child	signs for diarrhoea and ARI • % Children received ORS	
	Family Planning				
	2	a) Increasing access to non clinical contraceptives through community based distribution system and MHU	1. Strengthen distribution of contraceptives through CBD system: • Community health Volunteers • Training of trainers • Training of volunteers CBHVs under NRHM • Supply & Support to CBHVs • Half yearly meetings, reward for the best CBHVs • Out reach contacts volunteers by health workers • MIS 2. Strengthen distribution of contraceptives through MHU	• % couples knowing benefits of spacing and aware where services are available • % using non clinical contraceptives • Health personnel trained for providing contraceptive • CBD involved in distribution of contraceptive choice • MHU is Operational and have adequate stock of contraceptives	• District reports • Midline and End line survey • Rapid Assessments • Supply records • Reports from MHU
	2) To increase the availability and accessibility of the non clinical contraceptive methods in the area.	a) Improving access to non clinical contraceptives through Social Marketing	• Contract a Professional agency for social marketing • Set benchmarks and measure performance • Develop performance criteria • Innovative approaches like condom vending machines in strategic locations particularly in hard to reach areas	• % of women & men accepting non clinical contraceptives • CHCs, PHCs, UHC equipped and operationalized to provide non clinical contraceptive • % villages having non clinical contraceptive	• District reports • Midline and End line survey • Supply records • MIS • Rapid Assessments

				available through social marketing	
	3) To increase the percentage of IUD users from 1.5% to 7% in the next one year by improving IUD utilization and improvement in quality.	a) Popularizing D 380-A as alternative to sterilization	• Improve service environment at SCs • Provides service guidelines • Training of FHWs on quality IUD services • Provide need based supplies and other support	• 50% HSCs operational to provide quality IUD services • Service guideline is available in local language • ANMs /FHWs trained for quality IUD services • PHCs & SCs equipped	• Performance reports from the facilities • Training program Supply records
	4) To increase the percentage coverage of female sterilisation from 27.5% to 35% and male sterilisation from 0.6% to 1.5% in the year 2009-2010.	Strengthening sterilization services in each of the 14 blocks (One facility in each block)	• Upgrade facilities • Provide service guidelines • Training of service providers- Minilap, Laparoscopic, • Training cum services camp for Mos on NSV • Provide need based supplies and other support • Mobility support to lapro surgeon • Provide support for compensation for loss of wages undergoing sterilization/IUD insertion scheme	• No. of block equipped with-at least one facility – for regular sterilization services • % medical officers trained for conventional vasectomy, NSV, tubectomy and laparoscopic sterilization • % community aware about the sterilization methods • lapro surgeon available • % Community/beneficiaries benefited from the services	• District report • Training programs
		b) Conducting issue based	• Provide IEC material	• IEC material printed	• Mid term and

		IEC and advocacy-age at marriage, declining sex ratio, benefits of small family etc (Popularize NSV)	• Conduct IEC/ advocacy program, NSV camp • Increase male involvement in the use of contraceptives, NSV • Use of local resources –CBD volunteers as depot holders of IEC materials	and disseminated • BCC sessions conducted • % increase in male involvement in the use of FP methods • No. of CBD centers	end line Survey •
	Adolescent Health				
	1) To enhance access of RH services to adolescents and contribute the RCH II goals of reduction of IMR, MMR and TFR.	a) Provision of AFHS in every block at least one CHC	• Provide service standards and guidelines • Training of HSPs on AFHD • Improve service environment • Establish referral mechanism • Provide additional drugs and supplies • Develop monitoring mechanisms • Initiate services • Monitoring of services	• No. of facilities having standard protocols, guidelines, drugs and supplies for AFHS. • % service providers trained in providing adolescent friendly services • % facilities having essential drugs. • Rreview meetings organized for AFHS monitoring	• Facility report • Training program/reports • Reports of supervisory visits
		b) Increasing awareness among the adolescents about the service availability	• Advocacy to key stake holders to create conducive environment for providing services • Increase awareness among adolescents on RH issues • Increase awareness in the community especially among parents • Involve NGOs/Other local groups for IEC/ advocacy,	• % adolescents aware RH issues • % parents aware of RH needs among adolescents • No. of local groups/NGOs undertaking communication • Activities for adolescents	• Mid term and end line Survey • Rapid Assessments

			service, provision particularly in hard to reach areas		
		c) Developing linkages for referral services and ASRH education and undertaking IEC and BCC on ASRH	• Identify and finalize the linkages • Develop linkages with the identified centers/ facilities particularly in outreach areas	• Partners/ agencies identified and supported for referral services • % adolescents used ASRH services	• District report • Mid term and end line Survey
		d) Controlling anemia in adolescent girls (even in boys – attention to compliance to IFA	• Use of Injectable Iron to reduce Anemia among adolescents • IFA tablet distribution among adolescents. • Conduct IEC/BCC activities	• % adolescent given Injectable Iron • % adolescents girls taken IFA • % adolescent girls/ boys aware about anemia	• Mid term and end line Survey • District Report
		e) Providing information to adolescents about importance of proper nutrition for proper growth and better reproductive health	• Conduct IEC/ BCC activities- ASRH will have nutrition messages on importance of proper nutrition for growth and future reproductive health	• % adolescents aware on the importance of nutrition	• Mid term and end line Survey
		f) Involvement ASHA for better services and BCC.	• Training to ASHS for BCC • Help of ASHA to take adolescents at AFHS Centers	• % of ASHA Trained • % of adolescent referred by ASHA	• District Report • Mid term and end line survey.
	Urban Health				
	1) To provide integrated Maternal and Child Health Services to urban poor through fully functional urban	a) Strengthening integrated and sustainable system for primary health care services in urban/ urban slum areas	• Appointment of required staff • Increase access to referral units • Encourage and provide an integrated health services • Promote community participation through inter sect	• % urban poor community have access to primary health care services • CBHVs identified in urban slum	• Mid term and end line Survey • Facility report • Supply record

	health centres.		oral Coordination • Promote convergence of efforts among multiple stakeholders • Identify and support volunteers in urban slum-CBHVs • Develop strategies to promote □ehaviour change • Strengthen referral transport	• Referral hospitals identified for institutional deliveries, EmOC and terminal methods of family planning	
		b) Strengthen and upgrade the existing health centers	• Provide need based equipments, supplies and support • Have linkages with the higher referral facilities	• Health centers operational • Availability of trained medical staff	• Supply record • Training report • District report
	Vulnerable Groups		•	•	•
	1) To provide sustainable system for maternal, child, adolescent and family planning services to vulnerable groups.	a) Identification and localisation of these groups with the involvement of Targeted Intervention partners of BSACS and district labour department	• Mapping of these groups by NGOs • Linkage of these groups with BSACS's supported programme	• Listing of vulnerable groups	• Survey conducted by BSACS's supported targeted intervention partner of Purnia
	RCH services in unserved and underserved areas				
	1) To improve the RCH services in unserved and underserved areas	a) Improving access and generating demand for RCH services in unserved blocks	• Improve service coverage, accessibility, acceptability, utilization • Promote community participation and inter-sect oral coordination • Develop a sufficient number of	• CHCs, PHCs, and sub centers repaired and supplied with need based instrument/equipments • No of MHU is operational	• Facility report • District report Mid term and end line Survey

			first referral institutions capable of tackling emergencies, including obstetric emergencies • Develop a system of referrals from primary to secondary and higher levels • Undertake special initiatives in these areas through MNGOs to generate demand for quality RCH services	• Remote villages covered through MHU • % community avail the RCH services	
	School Health Programme				
	1) To improve the health status of school going children	a) Providing basic health education to school going children	• Conduction of half day orientation of children in every school on basic health education • Health Check-up camps	• No. of schools covered • No. of children orientated • No. of camps organised • % of children checked their health	• School report
	Strengthen Institutional Mechanism				
	1) To strengthen the institutional mechanism for effective implementation of RCH services in the area.	a) Strengthening institutions and support systems of infrastructure/IEC/logistics/supplies/training/QOC/MIS	• Strengthen district Quality Assurance Committee • Merger of all society under District Health society • Strengthen training institution • Logistics & Supply system • Provide training material • Orient district level-mid level personnel for logistics/supplies • Monitor the activities at different levels	• Quality Assurance Committee members in place & periodicity of meetings & minutes • Functional Integrated District Health Society • % staff trained on RCH components • Reports of monitoring activities-MIS	• QA Team report MIS reports • District Report

	Improve Quality of Care Services				
	1) To improve the quality of services for realising programme goals	a) Mainstreaming the Quality Assurance programme in the district health system for improving quality of services	• Designate district quality assurance officer • Activate district quality assurance committee, setting quality of care standards, indicators and outputs • Develop guidelines & checklists for QA committee • Provide guidelines to QA team and HSPs	• Protocol with quality assurance indicators in place • District quality assurance team is in Position • % facilities being monitored through quality assurance tools	• District report
		b) Meeting Indian Public health Standards at least by 2 CHCs and prepare path for more facilities.	• Orientation workshop for Mos on quality issues • Upgrade CHCs as per IPHS (as a part of NRHM support) • Strengthen existing grading system of health institutions • Support for quality initiatives to CHC/PHC/FRU/FP services • Conduct the feasibility of alternate models through innovative operations research • Support for regular review meeting of quality team • Facilitate interface between women/community groups with health systems •	• Mos oriented on quality issues • CHCs meeting IPHS • % facilities improving the QoC grades over the period • Minutes of meeting is available	• Annual report • QoC Team report • Financial report
	Human Resource Development Including Training:				
	1) To build up the capacity of human	a) Organizing different trainings and workshops	• Training of district health society staff on RCH II	• Availability of DTC training plan and	• Annual report • Training

	resources available at health centres in all spheres of service delivery	for HRD and Capacity Building	• Training of Medical offices for operation management and reporting • Training of FHWs for proper reporting	calendar • Reduce errors in reporting	program
	Equity and Gender				
	1) To maintain Equity at every level in the health system	a) Provision of AFSH services for both (male and female	• ADOLSCENT FRIENDLY HEALTH SERVICES (AFHS) services for both (male and female) • Both male and female will be covered under anemia control programme • Training of HSPs to maintain equity	• % of male and female • % of male covered under the programme • % HSP trained	• District Reports • Independent Survey
		b) Improving service environment to maintain equity.	• Provide facility screening check list to make service environment gender sensitive • Screen the facility by the medical officer • Improve facility to be female friendly	• No. of facilities improved to provide gender sensitive RCH services	• Facility Report • Annual Report
	Public Private Partnership / NGO				
	1) Increase related sectors and NGO involvement in programme implementation and community mobilization	a) Strengthening networking and partnership with the civil society and private sector	• Inter linkage with Other departments like WCD, Education, Panchayat, Youth Affairs, etc • Formation and functional Village Health and Sanitation Committee. • Functional Rogi Kalyan	• District Health Mission is set up • NGOs and civil society members in District Health Society • % villages having VHCs and is active • % of RKS functional at	• District Health Society Minutes • MIS • Reports

			samitis at PHCs • Involve civil society, partners, MNGOs in district societies • Involvement of ASHA, AWWs in ANC, PNC, ADOLSCENT FRIENDLY HEALTH SERVICES (AFHS) etc.	PHCs •	
		b) Supporting MNGO and FNGOs/ other NGOs for services and service support	• Implementation of MNGO scheme. • Strengthen Partnership with M/FNGOs to improve health status particularly for RTI/STI services in outreach areas	• MOUs signed with the MNGO	• Reports
	Boat Ambulance				
	To make functional boat ambulances establish in the district.	Functional boat ambulance	• Procurement of eight motor boats in this financial year • Equipped the motor boat with all the essential equipments for using it as an ambulance • Provision of one ANM and MPW at each Boat Ambulance to bring the patients at health centres and making the boat ambulance equipped for safe delivery, in case conduction of delivery is essential during journey.	• No. of boat ambulances functional • No. of blocks covered under boat ambulance services • No. of patients brought to the health centres for services	• Boat ambulance register
	Strengthen DPMU and BHMU				
	1) To strengthen the DPMU and BHMU in the district	a) Strengthen District Program Management Unit	• Contractual appointment of logistic consultant at district and block level • 2. Support for Office/data	• Fully Functional DPMU and BPMU	• District Report

			processing equipments, hiring vehicles, POL and maintenance, contingency, annual plan formulation, consultancy, etc • 3. Prepare operational guidelines for district society • 4. Orient district health society staff , district managers • 5. Provide operational Support to district program		
		b) Improving Management of Health Management Information system (HMIS)	• Training program for district staff on HMIS • Print and disseminate forms (1-9), 1-8 register , other for mate, operational manuals/ training material for computerized HMIS etc	• District staff trained on HMIS • Computer generated reports are available	• Training report Reports

NRHM Part B

NRHM Additionalities

6.1 ASHA (Accredited Social Health Activist)

6.1.1 Functionality of ASHAs

ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

The general norm will be **'**One ASHA per 1000 population'. In outreach, hilly, desert areas the norm could be relaxed to one ASHA per habitation, dependant on workload etc. ASHA must be primarily a woman resident of the village – 'Married/Widow/Divorced' and preferably in the age group of 25 to 45 years. ASHA should have effective communication skills, leadership qualities and be able to reach out to the community. She should be a literate woman with formal education up to Eighth Class. This may be relaxed only if no suitable person with this qualification is available. Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

The district will also need to work out block-wise coverage/phasing for selection of ASHAs. Fulfilment of all the roles by ASHA is envisaged through continuous training and up gradation of her skills, spread over two years or more. It is envisaged that the selection and training process of ASHA will be given due attention by the concerned Block to ensure that at least 60 percent of the envisaged ASHAs in the District are selected and given induction training in the first year as per the norms given in the guidelines. The training of second phase of ASHA is necessary for effective use of ASHAs in NRHM.

As shown in the following table, there are 2113 ASHAs has been selected in the district. At present only 2086 ASHAs are there in the district. Out of that, 2000 ASHAs have been trained

by the district. i.e. 94.65% ASHAs have been trained in the district. Following is the block wise status of ASHAs in the district:

Details of ASHAs in the District							
	Name of the Block	**Total Target**	**Total No. of ASHA selected**	**Present Status as on Jan-2009Total No. of ASHA selected**	**% of Selected Asha**	**Total No. of ASHAs Trained**	**% of Trained Asha**
1	Purnea East	179	141	138	78.77	141	100.00
2	Dagaruwa	172	145	146	84.30	142	97.93
3	Amour	222	225	225	93.71	208	92.44
4	Baisi	169	120	120	71	120	100.00
5	Baisa	149	147	146	98.66	142	96.60
6	Kasba	118	112	97	94.92	100	89.29
7	Jalalgarh	87	82	81	94.25	81	98.78
8	K-Nagar	175	163	163	93.14	149	91.41
9	Sri-Nagar	81	81	78	100	81	100.00
10	Banmakhi	254	195	194	76.77	195	100.00
11	B-Kothi	168	160	160	94.65	160	100.00
12	Bhawanipur	127	127	126	100	127	100.00
13	Dhamdaha	233	227	233	97.42	194	85.46
14	Rupouli	188	188	179	100.00	160	85.11
	TOTAL	**2322**	**2113**	**2086**	**91.00**	**2000**	**94.65**

All the ASHAs have been trained in round-1. The ASHAs are mobilising the community, but as per the DLHS-3 data, the mobilisation of women by ASHAs for seeking services is only 5%, which is a major concern and it has been found that the ASHAs needs capacity building for performing their tasks. The local resource persons are also there in the block under Dular – Muskan, project who can also be utilised for mobilising the community.

ASHA is taking steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.

She would also counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of

common infections including Reproductive Tract Infection/Sexually Transmitted Infection and care of the young child.

ASHA will mobilize the community and facilitate them in accessing health and health related services available at the village/sub-centre/primary health centres, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), sanitation and other services being provided by the government.

She will work with the Village Health & Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan. She will arrange escort/accompany pregnant women & children requiring treatment/ admission to the nearest pre identified health facility i.e. Primary Health Centre/ Community Health Centre/ First Referral Unit (PHC/CHC /FRU).

ASHA will provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme. She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.

A Drug Kit will be provided to each ASHA. She will inform about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre. She will also promote construction of household toilets under Total Sanitation Campaign.

It is conceived that she will be able to earn about Rs.1, 000.00 per month in lieu of her services. Following is the compensation package of ASHA:

Sl. No.	Programme & Relevant Task	Amount of Compensation
1.	Janani & Bal Suraksha Yojana For Institutional Delivery and Full Immunization of the New Born	@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 Program		Rs 250 per patient.
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

6.1.2 Support Mechanism for ASHA

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.

6.2 Village Health and Sanitation Committee (VHSC)

The NRHM framework support decentralized planning & monitoring up to the grass root level. Therefore it was decided to entrust village level committees of the users group, community based organization for the planning monitoring & implementation of NRHM activities into the villages of the District.

The VHSC will be the key agency for developing Village Health Plan & the entire planning of village Panchayat for NRHM. This committee comprises of Panchayat representatives, ANM, Anganwari workers, Teachers, Community health volunteers, ASHA. It is also proposed to provide Rs.10000/- to all VHSC for supporting their efforts in developing Village Health Plans. The accounts of VHSC will be opened in Nationalize banks or in post offices. No VHSCs have been formed in the district. VHSCs would be formed in every Panchayat.

VHSC will create public awareness about the essentials of health programmes, discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community, analyze key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present annual health report of the village in the Gram Sabha.

VHSC will ascertain the major health problems and health related issues in the village.
A health register will be maintained by VHSC which will be having information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc.

6.3 Janani Evam Bal Suraksha Yojana (JBSY)

Janani Evam Bal Suraksha Yojana (JBSY) under the overall umbrella of National Rural Health Mission (NRHM) is being proposed by way of modifying the existing National Maternity Benefit Scheme (NMBS). While NMBS is linked to provision of better diet for pregnant women from BPL families, JBSY integrates the cash assistance with antenatal care during the pregnancy period, institutional care during delivery and immediate post-partum period in a health centre by establishing a system of coordinated care by field level health worker. The JBSY is a 100% centrally sponsored scheme.

6.3.1 Eligibility for Cash Assistance:

All the pregnant women, aged 19 years and above preferring to deliver at home is entitled to cash assistance of Rs. 500/- per delivery and delivery at institute is entitled to get cash assistance of Rs. 1400.00. Such cash assistance would be available only up to 2 live births and

the disbursement would be done at the time of delivery. The rationale is that beneficiary would be able to use the cash assistance for her care during delivery or to meet incidental expenses of delivery.

The scheme is not of distributing cash benefit, but of providing quality maternity services to the pregnant women too. Micro-birth plan is a tool for efficient coordination of all the activities. It mainly entails – Essential activities, who would perform the activities and the desired timeline. The micro-birth plan would be drawn by the ANM. ASHA or any other link work would assist and it is essential that they know the component of the birth plan. In addition, certificates, timely submission of the completed JBSY card in the Health centre for verification by the authorized/Medical officer, arranging transport for the beneficiary to go to the Health Centre for delivery or complications, well in advance, ensuring availability of fund with the ANM/link Health worker/ASHA etc.

6.4 Indian Public Health Standard (I.P.H.S.):

Although a large number of Sub-centres, Primary Health Centres and Community Health Centres have been established to provide comprehensive promotive, preventive and curative services to the rural people in the country, most of these institutions, at present are not able to function up to the level expected of them due to varied reasons. National Rural Health Mission (NRHM), launched by the Hon'ble Prime Minister on 12 April 2005, envisages getting these institutions raised to the level of optimum availability of infrastructure, manpower, logistics etc. to improve the quality of services and the corresponding level of utilization. Through wide consultation with various stakeholders, Indian Public Health Standards (IPHS) for these centres have been framed. The key aim of the Standards is to underpin the delivery of quality services which are fair and responsive to clients' needs, which should be provided equitably and which deliver improvements in health and well being of the population. Each PHC and CHC, as part of IPHS, is required to set up a Rogi Kalyan Samiti / Hospital Management Committee, which will bring in community control into the management of public hospitals with a purpose to provide sustainable quality care with accountability and people's participation along with total transparency. To bring these centres to the level of Indian Public Health Standards, is no doubt, a challenge for most of the States

and also may require a detailed institution specific facility survey to find out the gaps. Planning is done so that all the health institutions work on the basis of IPHS. Health care delivery in India has been envisaged at three levels namely primary, secondary and tertiary. The secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral Units (FRUs) and the district hospitals. The CHCs were designed to provide referral health care for cases from the primary level and for cases in need of specialist care approaching the centre directly. 4 PHCs are included under each CHC thus catering to approximately 80,000 populations in outreach / hilly areas and 1, 20,000 population in plain areas. CHC is a 30-bedded hospital providing specialist care in medicine, Obstetrics and Gynaecology, Surgery and Paediatrics. These centres are however fulfilling the tasks entrusted to them only to a limited extent. The launch of the National Rural Health Mission (NRHM) gives us the opportunity to have a fresh look at their functioning. NRHM envisages bringing up the CHC services to the level of Indian Public Health Standards. Although there are already existing standards as prescribed by the Bureau of Indian Standards for 30-bedded hospital, these are at present not achievable as they are very resource-intensive. Under the NRHM, the Accredited Social Health Activist (ASHA) is being envisaged in each village to promote the health activities. With ASHA in place, there is bound to be a groundswell of demands for health services and the system needs to be geared to face the challenge. Not only does the system require upgradation to handle higher patient load, but emphasis also needs to be given to quality aspects to increase the level of patient satisfaction. In order to ensure quality of services, the Indian Public Health Standards are being set up for CHCs so as to provide a yardstick to measure the services being provided there. This document provides the requirements for a Minimum Functional Grade of a Community Health Centre.

6.4.1 Sub-centre:

Conduct a facility survey and identify the gaps, which have been done to ensure that all the existing Sub-centres should be posted with one ANM immediately. The vacant post may be filled up on contractual basis. There should be an in-built plan to take care of vacancies arising out of retirements, long leave, and other emergency situation so that the services of ANM are available without any interruption. Plan to conduct OPD at each sub centre by MO.

The appointment of second ANM as envisaged in the IPHS for each Sub-centre is to be made locally on contractual basis as per the demand, phase wise. The services of a Male Health Worker (MPW-M) are also necessary at the Sub centre. The arrangement has been made for utilization of untied fund for strengthening the functioning of Sub-centres. All the existing Sub-centres buildings should be made environment friendly, disabled friendly, with a good source of water supply, electricity / solar power / other alternative energy sources. This can be ensured with the help of Panchayat and related sectors. Utilization of Annual Maintenance Grant for strengthening of infrastructure and basic necessities of the Sub-centres will also be taken care of.

6.4.2 Community Health Centre (CHC)

NRHM envisages a 30-bedded fully functional block level rural hospital. The greatest challenge of bringing these CHCs to FRU / IPHS is the non-availability of the specialists especially the critical ones like obstetric/gynaecologist, anaesthetist and paediatrician. The following steps may be taken up:

Conduct an institution specific facility survey and identify the gaps. The bringing up the CHC to the level of the IPHS may be carried out in stages.

Ensuring all the CHCs provides 24x7 services with appropriate referral transport service. The basic requirement for making it 24x7 service delivery, there should be four General duty Medical Officers and seven Staff Nurses, one ANM and one LHV along with other support services and physical facilities. Once the existing gaps in relation to manpower, equipments, drugs, supplies and other support services, are filled up, the CHCs can be declared to have achieved IPHS.

IPHS facility survey has been done for all CHCs and PHCs in the district. District team has planned to develop CHCs, PHCs and Sub-Centres up to IPHS in a phased manner.

6.5 Mobile Health Unit (M.H.U.)

To reach out the marginalized communities living in far flung areas, the district has 3 Mobile health units (MHU) that are currently functioning in difficult areas. The mobile unit should

staff with one Medical Officer, one paramedic and one driver. Experiences show that the community living in remote and difficult areas better utilizes these services. These Mobile units would be re routed and strengthened to provide basic health and RCH services in remote areas, which are so far not served or difficult to cover by sub centres. These MHU will be linked with Block Health Officers so that they can monitor the services. Provision for necessary drugs and consumable, POL and staffs have been made available under this program. The guidelines, daily schedule and suggestive list of services that they need to provide will be given to them. A state level consultant has been made responsible to ensure that these services would increase RCH coverage in the marginalized communities. Periodic reviews of Mobile units are undertaken to strengthen the services. It has also planned to collect and analyze monthly performance each mobile units and coverage status of the areas. All three MHUs are not properly functioning due to unavailability of required staff.

6.5.1 Strategy to make MHU functional:

a) The mobile units in District will be made operational to cover remote areas and marginalized community with the alternative arrangement of Medical Officer. PHC Medical Officer will make arrangement to go in the field three days in a week after completing OPD at PHC. In place of Staff Nurse, FHW of the area will help Medical Officer in the work.
b) Service guidelines and list of services will be given to the MHU team. Local ANM, MPW (M), AWW, Helper, TBA ASHA of respective villages will assist the MHU team in providing services.
c) Meeting of staff of Mobile Health Units would be held every working Saturday at Block head quarters by block health officers. Medical officer will be responsible for maintaining all necessary documents like muster roll, list of beneficiaries and services provided, logbook of the vehicle and other relevant documents with the help of the other team members. Sustainability of MHU services requires strong coordination at the local/ block level, regular monitoring, backstopping of PHCs/CHCs and referral support.
d) Medicine supply would be ensured through the district health system for sustaining the demand of the MHU services. The routing and functioning of MHUs would be

reviewed periodically. As per the schedule of the MHUs, the health workers/ community volunteers/ link couples will make the clients available to the MHUs for services.

Registration of pregnant women will be done village-wise by MHUs. In every visit, they carry out regular check-ups of pregnant women in which physical examination, haemoglobin test, detection of anaemia cases will be done and provide required TT dose and IFA tablets. During follow up visits, they would also try to ascertain that women are actually taking IFA tablets. The surveillance for diseases like diarrhoea, dysentery, ARI, measles, RTI/STI will be done during OPD. The MHU teams will coordinate for postnatal visits, family planning and follow-up. Services and referrals for post-natal complications will be carried out. They will provide information on cleanliness, advantages of breast-feeding, etc. to new mothers who come to the MHUs. All the MHUs carry vaccine day carriers and the immunization days will be observed as per schedule. The service records will be shared with respective PHCs through block health officer to avoid duplications.

6.6 24X7 Primary Health Centres:

The Primary Health Centres in rural Bihar were established for the purpose of providing the full range of primary healthcare services to the community. The PHC represent the point of first contact of the community with a doctor. The provision of Maternal and Child Health services are an integral part of the service package to be provided by the PHC. According to the state vision 2010 we have to reduce maternal mortality ratio to below 350 per 100000 and Infant mortality ration to below 60 per 1000. More than 50% of the maternal deaths occur during or immediately after childbirth. Hence these deaths can be prevented by ensuring that all pregnant women deliver under the care of a skilled attendance at birth. More than two third of Infant deaths occur during the first month of life. Keeping above in mind Government of India, under its RCH programme, Phase II, Envisage the operationalisation of 50% of the PHCs and all the CHCs in each district, as health centres providing 24 hours delivery services and new born care, all seven days a week by the year 2010. As PHCs are, in effect, the point of “first referral” for the rural community, such round the clock service provision would help in increasing the percentage of institutional deliveries substantially and thus help in reduction of maternal mortality.

In Purnia 10 PHCs are functioning as 24x7 PHCs. There are some points which needs to be ensured for making the fully functional 24X7 PHCs.

1. Presence of staff and staff quarters
2. Labour room
3. Number of deliveries conducted annually
4. Referral services

6.6.1 Strategies for better operationalisation

- At least three Mos should be posted at PHC for better operation. According to the guidelines given by the Government of India there should be three staff nurses at every 24X7 PHC. So district will fill the vacant post of the staff nurses.
- As PHC is running on 24X7 bases so there should be a sweeper required at all the time and watchman in the night time for security purposes.
- Annual Maintenance grant will used to upgrade the required infrastructure through the Rogi Kalyan Samitis.

6.7 Management Information System (MIS)

Proper planning, timely execution, close supervision and continuous monitoring of the activities are the backbone for the success of any programme to have an impact. It is imperative this goes hand in hand with the implementation of the programme. Monitoring and Evaluation means measuring against previously agreed criteria in order to generate learning about the impact of interventions. All the things mentioned above are possible only through a good Management Information System. As the data available with the district and the data received from other sources (Census, DLHS etc.) is showing gaps so there is a requirement of better MIS implementation. District has setup DPMU and BPMUs for better information flow but due to high attrition rate and lack of support they are not functioning up to the mark.

6.7.1 Strategies for better information flow

- District team will give refresher training to BHOs, Mos and FHWs half yearly for better reporting and data management.
- Internet connectivity up to the PHC level

6.8 Untied Funds

6.8.1 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 enclosed as an Annexure – VII

6.8.2 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.

6.9 Infrastructure Plan in 2009 – 2010

6.9.1 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 outreach areas. The total population of Purnia is approximately 2958863 (2008-2009). There are 278 HSCs in the district and 221 new HSCs has been proposed for construction.

In this year, the district proposes to take up 100 Health Sub- Centres @ Rs.9.50 lakh per Health Sub Centre. The State proposes to share 25% expenses in the construction of these HSC s and land acquisition. The balance 75% the district 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.

6.9.2 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 populations in outreach/ remote areas. There are 10 PHCs in the district and district has proposed for construction of 56 Additional PHCs to cater the population. During this year, the district will take up construction of 14 APHCs one from each block for construction and renovation of 14 APHCs from each block. 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.

6.9.3 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. There are 3 CHCs in the district. This year these CHCs will be strengthened for delivering qualitative services to the community.

6.9.4 Upgrading District Hospitals as per IPHS

The state government has taken the decision to upgrade the district hospital to 500 bedded hospitals. The cost of up-gradation will be as per the GoI/GoB norms.

6.9.5 Establishment of One District Training Institute:

in order to carry out all the training activities, one district level training institute is needed exclusively to conduct HRD activities as the training for ANMs have already been started in ANM school and the present batch session will continue for another 18 months. The space at RIHFW, district hospital and PHCs is not sufficient to conduct the training. Hence, it is proposed to establish one training institute at district level and upgrade the infrastructure of ANM training schools and RIHFW. The approximate cost of upgradation of each ANM Training Schools is expected to be Rs 50 lakhs per Unit.

6.10 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. An amount of Rs. 20 lakh will be there as district and block flexi pool.

6.11 Blood Storage Units in Referral Units

Lack of Blood Storage Units in the state make things complicated during emergency hence in all the three referral units a blood storage units each has been proposed. The cost of establishment of blood storage unit is given as an Annexure – VII

6.12 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 the district hospital and referral hospital will get annual maintenance grant of Rs.5 lacs, and Rs.1 lakh each.

6.13 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.

6.14 PPP for Additional PHC management by NGOs

The state has started to outsource the management of Adll PHCs to the NGOs in The State. This year 14 APHCs would be given to the NGOs for running and management under PPP initiatives. An amount of Rs.1,50,000/- pm per Adll PHCs will be given to the NGO for management of APHC.

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

Child malnutrition extracts a heavy toll on both human and economic development, accounting for more than 50 % of child deaths world wide. The consequences of malnutrition

are serious leading to stunting, mental and physical retardation, weak immune defense and impaired development. More than one-third of worlds malnourished children live in India.

In 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.

While mild and moderate forms of malnutrition in the absence of any minor or major illness among children can be addressed through Anganwadi centres, by supporting mothers to ensure service utilization and appropriate feeding and care practices at the household level; the treatment of children with severe and acute malnutrition calls for facility-based treatment by admitting children to a health facility or a therapeutic feeding centre. This is mainly because these children generally are seen to suffer from acute respiratory infections, diarrhea and pneumonia. 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 □ehaviours□ to identify the nutrition and health problems in their child.

This year it is proposed to establish at least one NRC in the district as a pilot basis which will be scaled up in the next year after success.

6.16 Setting up of Intensive Care Unit at District Hospital

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 an intensive Care Unit at district hospital will help to avail patient the facility in the district so that accessibility for intensive care can be addressed. The district has established a 4 bedded ICU in the district hospital and this year it proposes to make it fully functional.

6.17 District and Block Programme Management Unit

The DHS has already established District and Block Programme Management Unit at the district and block levels. It has been observed that after the establishment of BPMUs the implementation of National Programmes has been managed efficiently and getting improved results.

6.18 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 district has provided only space for this purpose to the agency.

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

6.19 Disaster Fund:

Five blocks of the district is affected by the flood and last year, the flood situation was very grim and as the direction of Koshi has changed so it is possible that the district may again get affected by flood. So the provision of disaster fund is being made for this financial year to

continue health services during flood to the flood affected areas. It will be a contingency fund and can be used as per the need and decision taken in DHS meeting.

6.20 Child Disability Treatment Centre

It has been found that the numbers of disables in Purnia is quite high and at least one child disability treatment should be there at the district level. There are three Physiotherapy Centres in the district, which can be accredited by the district health society and the children with disability can be referred for treatment. The physiotherapists will treat the children at the centre.

6.21 Logistic Management Unit:

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.

It has been found during the situation analysis that the logistic management is very poor at the PHC and district level. In order to ensure the regular supply and distribution of all the drugs, supplies and equipments there is a need to establish a Logistic Management Unit at block and district level. The Block and District Logistic Consultant will be responsible for effective logistic management at block and district level. A consultant agency can be hired for this or the individual consultants can be placed on contractual basis.

NRHM PART C

ROUTINE IMMUNIZATION

7.1 Routine Immunisation:

Routine Immunization has become the priority programme for the State of Bihar. The programme has been given a major thrust by the govt. And other agencies to achieve the MDG – 4 stating that reduce child mortality by 2/3rd between 1990 & 2015. The IMR of the district is 89/1000 live birth, which is quite high and the RI programme would help in reducing the IMR of the district. In order to reduce the IMR, RI programme was initiated in the district. After launching of the programme, vaccines, auto disable syringes, immunization cards, reporting formats and hub cutters have been made available at all the immunisation sites. 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.
The agencies like WHO and UNICEF are also providing support to the programme for achieving the goals.

Muskan Ek Abhiyan, an innovative programme was launched by the Government of Bihar in the year 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 the District Magistrate of Purnia. The discussion on progress of Muskan-Ek Abhiyan is also being done in the meeting of District Task Force.

7.2.1 Components under Muskan Ek-Abhiyan

3. Tracking of all pregnant women and newborns

Follow-up field survey

AWW and ASHA conducted field survey to identify all currently pregnant women and children in 0 to 2 Years age group. They also do the follow-up survey to identify new pregnancies and newborns.

Tracking Registers

All identified pregnant women and 0 to 2 children has to be registered in pregnancy tracking and newborn tracking registers respectively.

4. Immunization sessions at AWCs

- RI sessions will be held by ANMs at sub-centers on Wednesdays
- Every Friday ANM will conduct RI sessions on 2 – 3 AWCs
- Micro-planning for above to be done on standard micro planning 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 will document the immunizations in RI reporting formats and MCH/immunization register
- ASHA/AWW will 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.

5. 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

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

Following is the progress of immunisation of mother and child during 2006-2007 and 2007-2008:

Progress of Immunization of Mother and Child				
Health Centre Name	**Mother Immunized (2007-2008)**	**Mother Immunized (2006-2007)**	**Child Immunized (2007-2008)**	**Child Immunized (2006-2007)**
Amour	5,881	1,846	36,264	13,464
Baisa	3,460	1,304	17,090	5,837
Baisi	2,058	38,087	9,298	16,191
Banmankhi	3,517	3,282	19,698	23,334
Barharakothi	4,178	1,852	25,265	19,077
Bhawanipur	1,250	664	3,763	6,025
Dhamdaha	5,635	1,594	42,925	10,637
Kasba	5,326	2,370	32,642	21,225
Krityanandnagar	1,257	1,899	5,110	10,475
Purnia East	24	914	201	8,687
Rupauli	1,317	1,211	7,084	14,771
Sadar Hospital	1,934	656	17,898	7,730
Total	**35,837**	**55,679**	**217,238**	**157,453**

Following table shows the block-wise target and achievemnt of child immunisation:

Progress of Child Immunization (from April 2008 – December 2009)							
Sl. No.	**Name of the Block**	**Target Children**	**BCG**	**DPT**	**OPV**	**Measles**	**Vitamin A**
1	Purnia East	6215	60.1	51.7	60.88	62.99	18.1
2	Dagarua	6019	75.2	49.9	73.75	76.16	162.3
3	Baisi	5902	77.8	50	66.57	55.69	7.7
4	Amaur	7731	78.4	51.6	69.97	73.51	106.7
5	Baisa	5214	91.5	55.9	61.93	63.9	32
6	Kasba	5023	67.5	60.1	68.5	64.52	25.6
7	Jalalgarh	3014	89	54.8	68.85	59.62	21.7
8	K Nagar	6093	81.8	61.4	75.55	81.42	45.4

9	Srinagar	2837	107.8	91.4	109.4	107.5	150.1
10	Banmankhi	9755	60	39.5	47.53	90.1	53.6
11	Damdaha	8141	81.5	60.2	63.96	77.99	57.7
12	B-kothi	5839	85.8	55.8	76.98	77.03	47.6
13	Bhawanipur	4427	89.1	71.1	69.39	81.5	77
14	Rupauli	6574	84.9	73.1	82.64	77.87	96
15	District Hospital	5982	65.9	15.8	16.38	19.56	33.2
	Total	**88766**	**77.5**	**54.1**	**65.16**	**71.4**	**77.5**

Srinagar, Kritiyanand Nagar and Rupauli blocks have performed well while the overall performace of child immunisation of B-kothi, Rupauli and District hospital is poor. Approximately 98% of the immunisation sessions have been held against the planned.

Approximately 43% of the children are fully immunised in the district. The coverage of complete immunisation has increased during the year 2008-2009, but still its low in comparison to other better performing districts of the state.

Apart from the above funds for the following activities are needed for successfully implement the programme in the district:

- POL for cold chain functioning so as to ensure at least 6-8 hours of continuous electricity supply.
- 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.
- Vaccine mobility is very important to ensure 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.
- Support for supervision is also needed and one full time Contractual District Immunisation Officer should be appointed 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.
- 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) would be provided so as to ensure that beneficiaries are brought to the session site and tracking of beneficiaries is ensured.

- 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.
- Alternate vaccinators are those people who could deliver immunization services. They have been recruited by the district 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 sub-centres. Therefore large number of alternate vaccinators will be needed for urban areas.
- Safety pits construction has been initiated in the district where the sharps are to be disposed after due disinfection. They will be constructed according to the Central Pollution Control Board (CPCB) guidelines.
- 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 has been given to all blocks to freeze the icepacks from outside in instances of breakdown of electrical cold chain equipment and backup power supply.

7.2.2 Immunization Weeks

Unlike the Immunization weeks carried out during the previous three years, this year the routine immunisation week will be observed twice in a year to cater maximum number of children for immunisation.

7.3 GOAL:

Health Indicators	Current status	DLHS-3	2010 GOALS

Infant Mortality Rate	85	-----	75
Maternal Mortality Rate	451	-----	425
Children Fully Immunized	43%	37.4%	90%
Children who have received BCG	77.5%	80.1%	95%
Children who have received DPT	54.1%	48.7%	95%
Children who have received OPV	65.16%	49.9%	95%
Children who have received Measles	71.4%	50%	95%

The district will ensure timely and safe immunization with all antigens (plus 2 dosages of Vitamin A) to all children between 12 – 23 months (95% coverage) and all pregnant women with 2 doses of TT (95% coverage). For this the district will ensure:

- 100% vaccine availability as per vaccine supply schedule.
- 100% availability of ADS.
- 100% availability of hub cutters.
- A functional micro plan will be prepared.
- 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.
- Appointing one contractual DIO
- 50% trained ANMs available in the district
- Maintaining functional cold chain status above 80%.
- Ensuring delivery of quality immunization services
- Ensuring smooth functioning of state and district routine immunization cell.
- Trainings of the MO/s, MOICs, DIO and ACMOs would also be focused upon.
- Coverage evaluation survey could be undertaken in the district by an independent agency to validate the reported coverage.
- Ensuring that all SOEs (statement of expenditure) and Ucs are received and submitted from the PHCs to districts on time to streamline the fund flow in the district.
- Ensuring 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.
- Ensuring that AD syringes are used and glass syringes are phased out.
- Ensuring 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 district and they are used according to the guidelines laid down by the CPCB.
- Ensuring that the Cold chain helpline is functional and that breakdown rate is lower than 5%.
- Ensuring that functional cold chain is above 80% at all times of the year.
- Ensuring that every community of Bihar is reached by the services of immunization.

7.3 Special Immunization strategies

7.3.1 Muskaan-ek Abhiyaan.

UNICEF and NPSP WHO would facilitate orientation and training of workers, development of new micro plans for these campaigns in all PHCs. UNICEF would also facilitate the compilation and computerization of all micro plans.

7.3.2 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 □ehaviour through planning and monitoring support. MNGOs/FNGOs would be involved in ensuring the service delivery in hard to reach areas.

7.3.3 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.

7.3.4 Setting –up the AEFI & VPD Surveillance System in the district:

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 respective District AEFI committees which will deal with any AEFI's, reported in future from the Districts .

7.3.5 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.

7.3.6 Review meetings for Strengthening Immunization

Monthly meetings for all MOICs and Mos would be organized by District 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 the meeting.

7.3.7 Health Workers training on Routine Immunization

UNICEF will conduct the training of health workers, Mos, MOICs, DIO for building up their capacity to carry out RI programme effectively in the district. New contractual ANMs will also be recruited and trained

7.3.8 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.

7.3.9 Coverage Evaluation Survey

UNICEF and NPSP WHO filed level officials would monitor the training of surveyors and the survey process itself to ensure its quality.

7.4 VITAMIN-A

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.

Vitamin and mineral deficiencies are a major public health problem in the district, where the Infant Mortality Rate is 89/1000 live births, the third highest in the state. The performance of the district in terms of Vitamin A programme is very poor. Following is the block-wise performance of the district in terms of Vitamin – A :

Progress of Vitamin A (April – 2008 to December 2008)			
Sl. No.	**Name of the Block**	**Target for Vitamin A**	**Vitamin A**
1	Purnia East	17608	18.1
2	Dagarua	17051	162.3
3	Baisi	16721	7.7
4	Amaur	21903	106.7
5	Baisa	14773	32
6	Kasba	14233	25.6
7	Jalalgarh	8541	21.7
8	K Nagar	17264	45.4
9	Srinagar	8038	150.1
10	Banmankhi	27640	53.6
11	Damdaha	23066	57.7
12	B-kothi	16543	47.6

13	Bhawanipur	12543	77
14	Rupauli	18626	96
15	District Hospital	16950	33.2
	Total	**251500**	**77.5**

It can be depicted from the above table that, overall the district has achieved 77.5% of the targets in terms of Vitamin – A coverage. Dagarua has the best performing block of the district, whereas the Baisi and Purnia Esat is the poorest performing blocks of the district.
Vitamin-A plays an important role in preventing nutritional blindness and in reducing childhood morbidity and mortality particularly from measles and diarrhoea; contributing significantly to child health and survival.

7.4.1 The Government of Bihar has initiated a biannual child health package of services; under this package following services has to be provided:

7.4.9 **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:

- The 1st dose 1,00,000 I.U. (1 ml or half spoon) is given with routine measles immunization at 9 months completed age;
- The 2nd dose 2,00,000 I.U. (2ml or full spoon) is given with first DPT/OPV booster (16-18 months) and
- The next 7 doses (each dose 2 ml or full spoon) are given after every 6 months up to 5yrs of age.

B) 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.

C) Promotion of Breast feeding and timely I ntroduction of complementary feeding:

Accelerating community participation and BCC on components of breast-feeding, i.e.

- Early Initiation
- Exclusive Breastfeeding
- Introduction of Complimentary feeding at the age of 6 months

7.4.10 Program Implementation

a) **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.

b) **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).

c) **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.

d) **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.

e) **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 level is critical to the success of the initiative.

f) **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.

g) **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.

h) **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. The coverage reports should be analysed and shared with the program mangers to identify the gaps and focus the activities to improve the coverage.

i) **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 under NRHM.

j) **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.

k) **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.

l) **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.

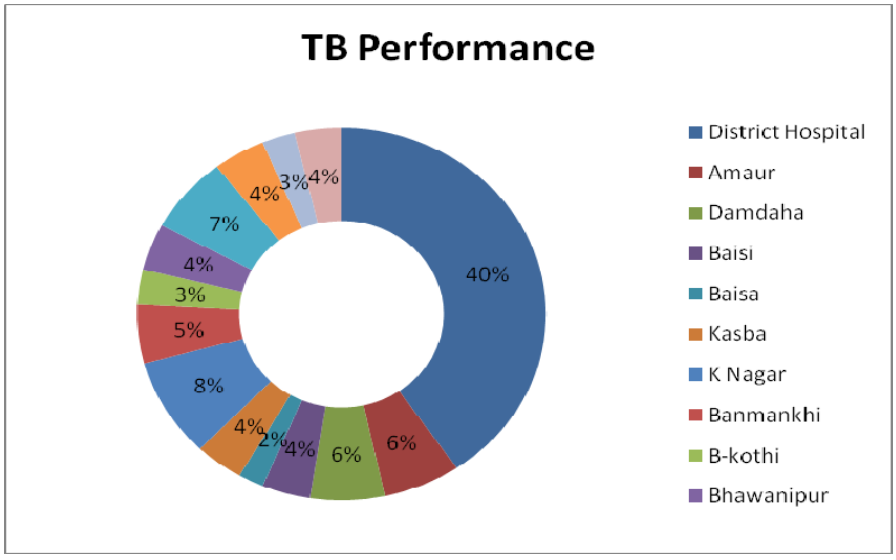
NRHM PART D

8.1 Revised National Tuberculosis Control Programme (RNTCP)

The performance of national TB control programme is also poor in the district. The facilities required for TB control is at health centres are also very poor and it needs improvement. The human resources are also not sufficient for treatment and control of tuberculosis in the district. The DOT centere are also not functioning well. Supply of drugs for TB treatment and unavailaility of human resources are the amjor concern for effective implementation of RNTCP in the district. Following table shows the details of the TB patients reported during the peiod 2006-2007 and 2007-2008:

Progress in RNTCP		
Health Centre Name	**TB Patient (2006-2007)**	**TB Patient (2007-2008)**
Amour	99	13
Baisa	37	9
Baisi	53	66
Banmankhi	122	48
Barharakothi	71	54
Bhawanipur	98	29
Dhamdaha	23	19
Kasba	74	40
Krityanandnagar	195	84
Purnia East	2	0
Rupauli	62	58
Sadar Hospital Purnea	648	108
Total	**1,484**	**528**

Following is the block-wise percentage distribution of TB patients reported during the period of April 2008 to December 2009.



8.2 Vector Borne Disease Control Programme:

Vector Borne Diseases viz. Kala-azar, Malaria and Filariasis is the major public health problems in the district. 13 blocks namely Rupouli, Bhawanipur, B. Kothi, Dhamdaha, Banmankhi, K. nagar, Purnea East, Kaswa, Srinagar, Jalalgarh, Dagaruwa, Baisi and Amour are affected by Kala-azar. Most of the kala-azar cases have been reported from rural areas.

8.2.1 Following table shows the details of Kala-azar patients reported during 2006-2007 and 2007-2008 in the district:

Progress of Kala-azar		
Health Centre Name	**Kala-azar patient (2006-2007)**	**Kala-azar patient (2007-2008)**
Amour	56	17
Baisa	2	1
Baisi	21	5
Banmankhi	275	139
Barharakothi	99	47
Bhawanipur	73	31
Dhamdaha	424	103
Kasba	151	89
Krityanandnagar	191	69
Purnia East	7	0
Rupauli	90	42
Sadar Hospital Purnea	391	94
Total	**1,780**	**637**

1866 cases of Kala-azar has been reported during April 2008 to December 2009. The last spary of D.D.T. was done in the month of June 2008.

Overview of Kala-azar – District Level (April 2008 – December 2009)	
Kala-azar Cases	1866
Death	0
Treated	1615
Under Treatment	225
Untreated	25
P.K.D.L.	1
Last Spray of D.D.T.	June 18, 2008 for 15 days

Drug availability in the district has improved considerably. All the PHCs, referral units and district hospital are equipped with anti Kala-Azar drugs but the supply of drugs on regular basis needs to be ensured.

8.2.2 Equipment and Drugs Essentially Required for Kala-azar programme:

S. No.	Name of facility	Equipment and Drug Required
1.	Kala-azar control-DDT Spray Programme (two round)	(a)stirrup pump- 100 Nos. (b)Bucket- 300Nos. (c) Gallon measure- 50 …. (d) pound Measure- 50 … (e) Nozzle Tips- 300... (F) washer- 1000… (g) DDT 50% (gov. Supply)170mt.
2.	Kala-azar search fortnight (Two round)	(a) R.K. 39 kit 32000Nos. (b) Cotton 2000pkt. (c) S.A.G. 10000 vials
3.	Malaria Month Search Programme	(a) 4 A.2 (chloroquine) 2 lac tab. (b) Malaria test kit- 31000nos. (c) 8 A. 2. (2.5 mg) 15000tab.

8.3 National Malaria Surveillance Programme:

The **National Malaria Surveillance Programme** is being implemented in the state but the status of this programme is poor. Though the cases of malaria have not been reported on regular basis but five blocks are affected by Malaria. The services for treatment of malria at health centres are very poor. The drugs for malaria treatment are also not available at health centres. The human resources required for malaria treatment is also not sufficient. Following tables give an overview of malaria at the district level.

Overview of Malaria – District Level	
Annual Parasite Incidence	0
Annual Blood Examination Rate (Total 546)	100%
Plasmodium Faliparum Percentage	0
Slide Positive Rate	0
Number of Patients Receiving Treatment for Malaria	0
Number of Patients with Malaria referred	0
Number of FTP and Drug Distribution Centres (DDC)	20

Lack of human resources is a major concern for effective implementation of the programme in the affected blocks. Blood testing facility and anti-malaria drugs are absent in almost all the APHCs, PHCs and referral units.

8.3.1 Equipment and Drugs Essentially Required for National Malaria Surveillance Programme:

S. No.	Name of facility	Equipment and Drug Required
1.	Malaria Month Search Programme	(d) 4 A.2 (chloroquine) 2 lac tab. (e) Malaria test kit- 31000nos. (f) 8 A. 2. (2.5 mg) 15000tab.

8.4 National Filaria Control Programme

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 performance of the district in filarial elimination is very poor. The services are almost absent in all the health centres. Lack of human resources is the major concern for the district to effectively implement the programme in the district. The deatil activity has to be prepared at state level as there is no concerened officials to prepare the plan.

8.5 National Blindnees Control Programme:

The performance of this programme is also very poor in the district. Only two PHCs namely Damdaha and Rupuali has the eye unit but the requisite infrastructure, equipments, drugs and supplies are poor which needs to be strengthened in order to make the eye units functional. One opthalmic assistant is in place at each of these two PHCs. Following is the performance of the district in national blindness control programme:

Performance of National Programme For Control of Blindness (April – January 2008) Against the annual target of 4000											
Cataract Operation Performance											
	Months										
Facility	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Total
District Hospital	3	6	5	0	0	2	0	11	15	5	47
NGOs	0	0	0	0	41	0	23	0	28	312	404
Pvt. Sector	9	11	14	348	39	47	40	35	45	42	630
Total	12	17	19	348	80	49	63	46	88	359	1081

8.6 National Leprocy Eradication Programme:

The national leprocy redaication programme is being implemented in the district, the cases of leprocy has come down but still few cases of leprocy is there in the district. The treatment of leprocy is being done. There is lack of human resources in this programme also but the additional charges have been given to the dosctors for implementing the programme in the district. The drugs are available but the supply is not regular. Following is the details of the performance of national leprocy eradication programme:

NLEP Performance (April –December 2008)				
Sl. No.	**Name of the Centre**	**No. of cases**	**PR/1000**	**No. of sub-centres providing MDT services**
1	Purnea Sadar	11	0.5	0
2	Purnea East	14	0.68	13
3	Dagarua	22	1.11	15
4	Baisi	22	0.79	20
5	Amour	25	0.94	23
6	Baisa	12	0.6	17
7	K Nagar	15	0.7	18
8	Srinagar	29	3.16	0
9	Kasba	15	0.8	18
10	Jalalgarh	15	1.69	0
11	Banmankhi	36	1.1	36
12	Rupuali	12	0.53	37
13	Bhawanipur	9	0.54	33
14	Damdaha	27	0.98	17
15	B-Kothi	27	1.34	31
	Total	**291**	**0.93**	**278**

Logical Framework Analysis of all Vertical Health programmes				
Objectives	**Strategy**	**Activities**	**Objectively verifiable indicator (OVI)**	**Means /Source of verification**
RNTCP				
1) To decrease the mortality and morbidity due to tuberculosis	• Strengthening DOT centres • Providing lab testing facilities at each centres	• Making all the DOT centres function • Adequate supply of drugs and other related supplies • Lab testing facilities at all the 10 functional PHCs and referral units	• Achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases of tuberculosis • Achieve and maintain detection of at least 70% of such TB cases in the population	• Program reports • HMIS
Vector Borne Disease Control programme				
7.4.11 To reduce morbidity and mortality due to malaria, Kala-azar and □ehaviou	• Strengthening PHCs for malaria, kala-azar and □ehaviou control	• Malaria and kala-azar search programme • Regular supply of anti malarial and anti kala-azar drugs • DDT Spray • Distribution of insecticide treated bed nets for the most worst blocks (priority would be given to pregnant women, children and poor population) • Organisation of Anti-Filaria week • Regular supply of anti-filarial drugs	• Reduction of mortality on account of Malaria, kala-azar, □ehaviou by half by 2010 & efficient morbidity control.	• Program reports • HMIS

National Blindness Control programme				
2) To reduce the cases of blindness in the area	• Establishment of functional eye units at all the 3 referrals	• Provision of high quality of eye care to the 3 FRUs • Conduction of cataract operations • Eye check up camps at block level	• Reduce the prevalence of blindness from 0.95% to 0.8% by 2007	• Program reports • HMIS
National Leprosy Eradication Programme				
1) To reduce the leprosy cases in the area	• Making the leprosy division functional at the block and district level • Providing regular Multi drug therapy (MDT) drugs at PHCs and referrals	• Placing of District and Block level leprosy officer on deputation (or additional charges) • Procurement and regular supply of MDT drugs	• Leprosy prevalence rate	• Program reports • HMIS

Work Plan

A. WORK PLAN (2009-2010)					
Strategy / Activity	**2009-2010**				
1. MATERNAL HEALTH	**Q1**	**Q2**	**Q3**	**Q4**	**Responsibility**
B.1.1.1. Antenatal Care					
Increase awareness in the community for improving health seeking □ehaviour for timely ANC					Dist. Immunisation Officer (DIO), Dist. Programme Officer (DPO), (ICDS)
1. List of existing dais through ANMs					
2. Selected NGOs will have list for training					
3. Finalize reorientation package for dais					
4. Reorient Dais through NGOs					
5. Monitoring the training program of dais held by NGOs					
6. Organize half yearly review meeting at PHCs for strengthening the coordination with dais					
7. Develop linkages with AWWs/Depot Holders/CBHVs					
8. Organize IEC and BCC for ANC and for timely care seeking behaviour					
9. Registration of pregnant women					
10. Meeting with pregagnt women and their family by ASHAs, AWW, FHW etc. to mobilise them for ANC and institutional delivery					
Effective implementation of village health and nutrition day					RCH Officer (RCHO), CDPO, DPO, BDO
1. Micro-plan for Mother Child Protection activities once a month for every village & hamlets by FHW					
2. Village Health and Sanitation Day should be started and held regularly					
Weekly ANC clinics will be organized to improve early ANC registration					RCHO, DIO, DPO, CDPO
1. Plan and Finalize fixed day for ANC sessions (including MHUs)					
2. Supply need based equipments/instruments					
3. Supply need based drugs and others					
4. Propagate the clinic day in the community					
5. Organize weekly ANC clinics in FRUs/ CHCs/ PHCs/PP units					
ANC sessions will be organized by ANMs on fixed days in outreach areas,					RCHO, DIO, DPC, DPO, CDPO
1. Inform women with the help of ASHA in sub centre area villages in advance and encourage to avail					

services					
2. Prepare detailed schedule of the outreach services & share at the panchayat/public places. Inform dais, AWWs, CBOs etc in advance					
3. Equip SCs for holding ANC clinics					
4. Supply of need based drugs, medicines and supplies of diagnostic kits and IFA tablets					
5. Monitor registers of ANMs and supervise to review their performance					
ANC clinic sessions will be organized in remote, outreach areas through mobile health units					DIO, RCHO, DPC, DPO, CDPO
1. Hire Staff Nurses on contract for MHUs					
2. Hire Drivers on contract for the MHUs					
3. Involve MHUs in sharing/making community aware on ANC					
4. Provide drugs and supplies to MHUs					
5. Support for POL and Maintenance for MHUs					
Linkages with private practitioners for early registration and ANC					DIO, RCHO, DPC, DPO, CDPO
1. Identify private clinics, hospitals and practitioners					
2. Recognize identified practitioners at block level					
3. Schedule weekly ANC on a fix day					
4. Provide service guidelines					
5. Orient private practitioners					
6. Provide continuous medical education on ANC and serve for timely referrals					
7. Support to private practitioner for holding ANC clinic in remote/difficult areas					
Awareness generation for consumption of IFA Tablets					CDPO, MOICs
1. ASHA and AWWs will generate awareness along with ANMs at the Village level					
2. Pregnant others will be aware for consumption of IFA tablets for 90 days					
3. Convergence with ICDS for regular supply of IFA tablets through AWWs					
Purchase and Supply of IFA Tablets					CMO, ACMO
1. Purchase IFA tablets in the case of stock out					
2. Timely supply of IFA Tablets to the Health Institutions					
Supplementing IFA tablets consumption with other clinical strategies					CMO, DPO (ICDS), RCHO
1. Half yearly de-worming of all adolescent girls.					
2. Training of ANM, AWW and ASHA on module on					

EDPT (Early Diagnosis and Prompt Treatment) of anemia					
B.1.1.2. Safe Deliveries					
Service environment of the PHCs, CHCs and Sub Centers improved for institutional deliveries					CMO, RCHO, MOICs
1. Improve Labor rooms/Maternity Wards/ toilet/ water facilities in CHCs/PHCs/HSCs					
2. Support for drugs, medicines and supplies					
3. Supply of Equipments/instruments					
4. Linkage with Janani Evam Bal Suraksha Yojana – Monetary support to pregnant woman for referral transport					
5. Utilization of Untied fund for District hospital to improve RCH services					
6. Ensure availability of Staff Nurses at PHCs (from NRHM) for 24x7					
7. Monitoring services through block medical officers and block PHNs					
Increase availability of skill birth attendant					RCHO, CMO
1. Ensure availability of staff nurses in identified PHCs (Appointed under NRHM)					
2. Refresher Training of ANMs, and Medical Officers for conducting deliveries					
3. Provide Service guideline and necessary inputs.					
4. Ensure the presence of staff nurse in the facility					
Streamline the health seeking □ehaviour of community especially pregnant mothers for institutional deliveries					RCHO, DPRO
1. Organize IEC and BCC on health seeking □ehaviours					
Operationalize BemOC facilities					CMO, RCHO, ACMO
1. Conduct facility survey					
2. Provide BemOC service guidelines					
3. Provide drugs, medicines and supplies to BemOC centers					
4. Support for facility improvement					
5. Support for repair/renovation					
6. Equip BemOC centers					
7. Training on BemOC- Medical Officers and Staff Nurses (of CHCs/FRUs)					
8. Support for referral protocols, referral cards, feedback cards, registers					
9. Develop referral linkages with FRUs for CemOC					
10. Hire transport for referral (Integrate and Linkage with Janani Evam Bl Suraksha Yojana and referral					

transport plan)					
11. Monitor FRU and BEMoC					
12. Conduct Maternal death audit					
Operationalize CemOC services					CMO, RCHO, ACMO
1. Calculating of need for CemOC services					
2. Support for Repair/renovation					
3. Equip the identified referral units					
4. Provide drugs, medicines and supplies					
5. Equip facilities for providing blood storage services					
6. Develop PPP for supplying safe blood					
7. Provide contingency support to CemOC centers					
8. Provide POL and maintenance support to B/CemOCs					
9. Training of Trainers on EmOC/New Born care (State level)					
10. Training on CemOC					
11. Training on essential new born care					
12. Provide service guidelines, referral protocols etc					
13. Support for call base services of Gynec/ anesthetist					
14. Organize quarterly review meeting of Staff Nurses of PHCs/CHCs/ EmOCs					
15. Maternal death audit					
16. Support for referral transport- support for Toll free telephone numbers for ambulance services (State level)					
Develop partnership with private hospitals, trust hospitals and grant in aid hospitals for BemOC					CMO, RCHO
1. Identify private hospitals, trust hospitals and grant in aid hospitals for BemOC and CemOC					
2. MOU with the identified service					
3. Provide guidelines for service (Integrate with – Provide service guidelines for BemOC)					
4. Training of Mos and Staff Nurses to provide BemOC services					
5. Provide referral protocols, referral cards, feedback cards, registers					
6. Incentive support for referral transport for EmOC Cases					
Increase awareness in the community regarding availability of EmOC services					DPRO, RCHO
1. Organize IEC activities for the community					

awareness					
2. Development, printing and dissemination of IEC material					
1.1.3. Post natal care					
Home visits by ANM, AWW, LHV within three days of delivery, in case of home delivery					RCHO, DPO (ICDS), CDPOs, MOICs
1. Contact dais who conducts the delivery during the home visit					
2. Provide integrated mother-child care during PNC visit					
3. Develop linkages with AWWs					
4. Referral to paediatrician under contract (PPP) in case of problem with child					
Sensitize the Mos/ANM/LHV/AWWs on the need for providing care to women and new born during post natal period					RCHO, ACMO
1. Training of medical officers					
2. Training of ANMs/FHWs					
3. Training of AWWs					
Effective Implementation of Mamta Scheme					RCHO, DPO (ICDS), CDPOs, MOICs, PRI representatives
1. Selection of Mamta					
2. Training of Mamta on post natal care and other related services					
2.Need based training of Mamtas					
2. Conduction of Mamta Diwas					
Undertake BCC/IEC related activities					RCHO, DPRO
1. BCC among women on the need of contacting health personnel after home delivery					
2. Conduct IEC activities					
B.1.1.5. Improve access to quality RTI/STI					
Strengthen all PHCs, CHCs and FRUs for diagnosis and treatment of RTI/STI					CMOO, RCHO
1. Provide Service guidelines					
2. Training of MOs to provide quality RTI/STI services and counselling					
3. Training of ANMs/Staff Nurses to provide quality RTI/STI services and counselling					
4. Training of LTs to provide quality RTI/STI services					
5. Strengthen lab services					
6. Supply of drugs, reagents, VDRL kits					
7. Develop linkages with Private Practitioners and					

Trust Hospitals					
Increase awareness regarding RTI/STI and importance of seeking timely care- BCC/IEC					DPRO, BSACS partner, RCHO
1. Provide IEC/BCC material					
2. Organize BCC activities on RTI/STI					
3. Organize IEC activities on importance of partner treatment					
4. Promote awareness regarding causes, prevention and early treatment seeking behavior for RTI/STI					
5. Identification of Counseling center for adolescent on RTI/STI					
B.1.1.4. Increase access to Early and Safe Abortion services					
Improve access to safe abortion services by ensuring one service center in each block					CMO, RCHO, MOICs
1. E-listing of MTP trained practitioners					
2. Upgrade MTP training institutes					
3. Training of Medical Officers/interested and qualified private practitioners in MTP					
4. Equip facilities to provide safe abortion services					
5. Provide drugs and supplies for safe abortion services					
6. Develop public private partnership in outreach and urban areas to provide MTP services					
7. Implement quality improvement programme in coordination with district quality assurance team					
8. Monitoring of the programme by the district team					
Increase awareness in the community regarding availability of MTP and safe delivery and services					RCHO, DPRO
1. Support for IEC and community mobilization					
B.1.1.5. Improve access to quality RTI/STI					
Strengthen all PHCs, CHCs and FRUs for diagnosis and treatment of RTI/STI					CMO, RCHO
1. Provide Service guidelines					
2. Training of MOs to provide quality RTI/STI services and counselling					
3. Training of ANMs/Staff Nurses to provide quality RTI/STI services and counselling					
4. Training of LTs to provide quality RTI/STI services					
5. Strengthen lab services					
6. Supply of drugs, reagents, VDRL kits					
7. Develop linkages with Private Practitioners and Trust Hospitals					

Increase awareness regarding RTI/STI and importance of seeking timely care- BCC/IEC					RCHO, DPRO
1. Provide IEC/BCC material					
2. Organize BCC activities on RTI/STI					
3. Organize IEC activities on importance of partner treatment					
4. Promote awareness regarding causes, prevention and early treatment seeking behavior for RTI/STI					
5. Identification of Counseling center for adolescent on RTI/STI					
B.1.2. CHILD HEALTH					
Provide essential care to new born at community level					RCHO, DIO
1. Training of AWW,ANM					
2. IEC/BCC for promotion of new born care					
Provide essential new born care at facility level					RCHO, DIO
1. Training of Medical Officers/ Staff nurses					
2. Training of FHWs					
3. Provide need based instruments					
4. Provide need based drugs, medicines					
Effective implementation of IMNCI with the support from UNICEF					UNICEF, CMO
1. Training of ASHA/ AWW/ FHW/ MOs on the home based care package using IMNCI Approach (by UNICEF)					
2. Supply of diagnosis and treatment protocols (chart booklets) for implementation of the IMNCI strategy (by UNICEF).					
Provide neonatal critical care through FRUs					CMO, RCHO, DIO
1. Support for pediatrician services on call basis					
2. Encourage ANM for timely referral					
3. Supply of equipment and instrument					
4. Supply of need based drugs, medicines and supplies					
Promotion of exclusive breast feeding					RCHO, DIO, DPRO
1. BCC activities with the help of ASHA and community based health volunteers					
Universalize immunization coverage					CMO, DIO, MOICs, DPO (ICDS), CDPOs
1. Identification of low performing block					
2. Separate planning for every block					
3. Block wise workshop to prepare immunization plan.					

4. Organize monthly outreach sessions on fixed days					
5. Co ordination with AWWs					
6. Conduct outreach immunization clinics / sessions in difficult areas through MHU					
7. Support to DIOs for immunization session					
8. Provide immunization card and other requirements					
9. Support vaccine supply for outreach immunization sessions courier services					
10. Community mobilization for immunization					
Prevent deaths due to Diarrhea and ARIs at facility and community level					RCHO, MOICs
1. Training of MOs/AWWs/ANMs/Staff Nurses on case management of diarrhea, ARI					
2. Supply of equipment and instrument (Baby warmer, neonatal respirator)					
3. Supply of need based drugs, medicines and supplies					
4. Promotion of home available oral dehydration fluids					
C.1.1. FAMILY PLANNING					
Reducing TFR					
Increase access to non clinical contraceptives through community based					CMO, ACMO, RCHO, Social mktg. agency
distribution system and MHUs					
1. Identify CBD volunteers					
2. Finalize training materials					
4. Train volunteers (CBHVs)					
5. Provide stock for CBD (Condoms, ORS, IFA, OCPs, etc)					
6. Distribution of contraceptives through CBD					
7. Provide condoms and oral pills to increase through social marketing especially in rural & urban areas					
8. Support for regular half yearly review meeting of CBHVs					
9. Rewards for PHC wise best CBHVs during the review meeting					
10. Distribution of contraceptive through MHUs					
Increase access to non clinical contraceptives through Social Marketing					CMO, RCHO
1. Develop guidelines/criteria to contract agency for social marketing					
2. Social marketing by contract agency					
3. Innovative approaches like condom vending machine, etc					

Popularize 380A-IUD as an alternative to sterilization					CMO, ACMO, RCHO, Social mktg. agency, NGOs
1. Provide guidelines in local language					
2. Provide drugs and supplies for IUD/ post IUD complications					
3. Provide 380 A IUD Insertion Kit					
4. Support for facility improvement at PHCs/SCs					
5. Training for IUD insertion ANMs/FHWs					
Strengthen sterilization services in each block					CMO, ACMO, RCHO
1. Upgrade facilities in each block					
2. Provide guidelines					
3. Training for Medical Officers on Minilap, Laproscopic etc.					
4. Provide need based equipment/ instruments to FP service center					
5. Provide need based drugs, medicines and supplies to FP service center					
6. Training cum service camp for Mos on NSV					
Popularize Non Scalpel Vasectomy- NSV					CMO, ACMO, RCHO
1. Provide guidelines in local language					
2. Conduct pre NSV camp IEC activities					
3. Training cum service camp at block level for NSV					
4. Certify the Medical Officers for NSV					
5. Supply of need based NSV Kits for regular NSV services					
6. Provide need based drugs, medicines and supplies					
IEC and advocacy for late marriage, spacing, small family, other specific advantages					CMO, ACMO, RCHO, DPRO
1. Provide IEC material to reduce unmet need for FP					
2. Organize IEC/Advocacy program for male involvement in the use of contraceptives and for NSV					
3. Use local resources (AWWs, LCs/DHs, private practitioners)					
D.1.1. ADOLESCENT HEALTH					
Improve adolescent health through provision of AFHS at					
Provision of one AFHS center in each block					CDHO, RCHO
1. Provide service standards and guidelines					
2. Identify facilities					
3. Training of the health officials on AFHS					
4. Improve service environment					

5. Provide additional drugs and supplies					
6. Establish referral mechanism					
7. Develop monitoring plan					
Undertake IEC and BCC on ASRH					RCHO, DPRO
1. Develop, print and disseminate IEC/BCC material					
2. Organize advocacy to create sensitivity on ASRH					
3. Increase awareness among the adolescents about the available services					
4. Reach out the adolescents through NGOs and other local groups					
Controlling anemia in adolescent (boys and girls)					RCHO, MOICs
1. Use of injectable iron for anemia control					
2. IFA tablet distribution.					
3. IEC/BCC at community level					
Providing information to adolescents about proper nutrition for proper growth					District Health Education Officer
1. Conduction of IEC /BCC activities					
H.1.1. Urban Health					
Strengthening integrated and sustainable system for primary healthcare in urban slums					CMO, ACMO, RCHO
1. Appointment of required staff					
2. Promote community participation					
3. Training of CBHVs					
4. IEC/BCC in urban areas					
Strengthening the existing health system					RCHO
1. Supply need based equipments, instruments and drugs					
2. Strengthen referral services					
Vulnerable Groups					
Identification and localisation of these groups with the involvement of Targeted Intervention partners of BSACS and district labour department					BSACs partner, CMO
1. Mapping of these groups by NGOs / MNGOs Linkage of these groups with BSACS's supported programme					
RCH services in unserved and underserved areas					DRCHO, MNGOs, RRCs
Improving access and generating demand for RCH services in unserved blocks					
1. Improve service coverage, accessibility, acceptability, utilization					
2. Promote community participation and inter-sect oral coordination					

3. Development of sufficient number of first referral institutions capable of tackling emergencies, including obstetric emergencies					
4. Develop a system of referrals from primary to secondary and higher levels					
5. Undertake special initiatives in these areas through MNGOs to generate demand for quality RCH services					
INSTITUTIONAL STRENGTHENING					CMO, ACMO, MOICs
1. Support to quality assurance cell					
2. Support for district societies					
3. Utilization of untied fund for PHC, CHC and sub center strengthening. (NRHM)					
4. Provision for required infrastructure with the help of annual maintenance grant (NRHM)					
Logistics & Supply System					CMO, ACMO
1. Review of logistic management system					
2. Provide training material					
3. Set up the linkage between the State and district for supply and transporting of supplies					
4. Orientation for district level - mid level personnel for logistics and supplies system					
5. Maintenance of Cold Chain Equipments					
6. Monitoring of the activities at different levels					
F.1.1. QUALITY ASSURANCE					
Mainstreaming the Quality Assurance Programme in district health system					CMO, ACMO, RCHO
1. Support for quality initiatives to CHC/ PHC/ FRU/FP Centers					
2. Provide contingency support to CHCs/ PHCs/ SCs					
3. Develop guidelines & checklists for Quality of Services					
4. Provide guidelines to QA team and to service providers					
5. Organize orientation workshop for MOs on quality issues					
6. Strengthen existing grading system of health institutions based on criteria					
8. Support for regular review meeting of quality team					
Meeting Indian Public Health Standard					DM, CMO, ACMO, MOICs
1. workshop of Medical officer on quality issue					

2. Identifying gap to meet IPHS					
3. Provide essential equipment , Instruments and drugs for IPHS					
4. Regular monitoring and correction to meet IPHS					
Human Resource Development (HRD) including Training					ACMO, CMO, RCHO
1. Organising workshop for preparation of detailed training calendar for implementation of all HRD activities in the district					
E1.1. Equity/Gender					
Provision of AFHS services for adolescents					CMO, RCHO, District Youth Dept. officials
1. Provision of equal distribution of services among adolescents boys and girls					
2. Training of HSPs to maintain equity					
Improve service environment to maintain equity					RCHO
1. Provide facility screening check list to make service environment gender sensitive					
2. Screening of facility through medical officers					
3. Improve facility to be female friendly					
4. Training of HSPs for Gender and GBV					
5. Close monitoring of the scheme					
Public Private Partnership / NGO					CMO, RCHO
Strengthening networking and partnership with the civil society and private sector					
1. Inter linkage with Other departments like WCD, Education, Panchayat, Youth Affairs, etc					
2. Formation and functional Village Health and Sanitation Committee					
3. Functional Rogi Kalyan samitis at PHCs					
4. Involve civil society, partners, MNGOs in district societies					
Supporting MNGO and FNGOs/ other NGOs for services and service support					CMO, RRC, MNGO, RCHO
1. Implementation of MNGO scheme					
2. Strengthen Partnership with M/FNGOs to improve health status particularly for RTI/STI services in outreach areas					
Boat Ambulance					RCHO, ACMO, Dist. Disaster management officials
Functional boat ambulance					

1. Procurement of eight motor boats in this financial year					
2. Equipped the motor boat with all the essential equipments for using it as an ambulance					
3. Provision of one ANM and MPW at each Boat Ambulance to bring the patients at health centres and making the boat ambulance equipped for safe delivery					
4. Functioning of boat ambulance					
PROGRAM MANAGEMENT COMPONENT					
Strengthen District Program Management Unit					DM, CMO, ACMO
1. Contracting Staff					
2. Support for contractual staff					
3. Support for office equipments					
4. Support for data processing equipments					
5. Support for hiring vehicles					
6. Support for Annual Plan Formulation					
7. Support for consultancy - Data entry outsourcing					
Training on HMIS					RCHO
1. Training program for district and block officials					
I.1.1.3. Tracking System of ANC up to Full Immunization of the children					
Every ANC will be trace till the full immunization of the new born					RCHO, DIO, MOICs, CDPOs, DPO (ICDS)
1. Identification of the pregnant women with the help of unique id given at the time of ANC					
2. Computer data base will be created at block level and district level.					
3. Follow up of pregnant mother for institutional delivery according to the expected date of delivery with the help of the data base					
4. After delivery the follow up of new born for immunization with the help of data base.					
5. Appointment of the data operator for data entry					
I.1.1.4. Honorarium to ASHA for completion of full Immunization.					
ASHA will be given honorarium after completion of full immunization of the child					CMO, RCHO
1. Training of ASHA for full immunization.					
2. Immunization with the help of ASHA					
3. Payment to ASHA after completion of full immunization of the child					
FINANCIAL MANAGEMENT					DAM
1. Meet financial reporting requirement					
2. Conduct regular internal audit at district level					

3. Conduct Annual audit					
7.9 CONVERGENCE/ COORDINATION					
Strengthening Networking and Partnership with the Civil Society and Private Sector					DM, CMO, ACMO, DPO (ICDS), Executive Engineer (PHED), DRDA Director, BDO
1. Fully functional village health and sanitation committees					
2. Involvement of AWWs in ANC, PNC, AFHS etc.					
3. Support for Annual Plan Formulation					
4. Support for consultancy - Data entry outsourcing					

B. WORK PLAN FOR NATIONAL DISEASE CONTROL PROGRAME (2009-2010)					
Strategy / Activity	**2009-2010**				
	Q1	**Q2**	**Q3**	**Q4**	**Responsibility**
A. RNTCP					District TB Officer, In-charge of TB Units
Strengthening DOT centres					
1. Making all the DOT centres function					
Providing lab testing facilities at each centres					
1. Adequate supply of drugs and other related supplies					
2. Lab testing facilities at all the 10 functional PHCs and referral units					
B. Vector Borne Disease Control programme					Dist. Malaria Officer, Dist. Kala-azar Officer, Dist. Filaria Officer, CMO
Strengthening PHCs for malaria, kala-azar and filaria control					
1. Malaria search programme					
2. Kala-azar search programme					
3. Regular supply of anti malarial drugs					
4. Regular supply of anti kala-azar drugs					
5. DDT Spray					
6. Distribution of insecticide treated bed nets for the most worst blocks					
7. Organisation of Anti-Filaria week					
8. Regular supply of anti-filarial drugs					

C. National Blindness Control programme					CMO, District BC Officer
Establishment of functional eye units at all the 3 referrals					
1. Provision of high quality of eye care to the 3 FRUs					
2. Conduction of cataract operations					
3. Eye check up camps at block level					
D. National Leprosy Eradication Programme					Dist. Leprosy Officer
Making the leprosy division functional at the block and district level					
1. Placing of District and Block level leprosy officer on deputation					
Providing regular Multi drug therapy (MDT) drugs at PHCs, referrals and DH					
1. Procurement and regular supply of MDT drugs					

ANNEXURE – III

REPORT OF THE BLOCK LEVEL CONSULTATIONS FOR PREPARARTION OF DISTRICT PIP OF PURNIA DISTRICT

The block level consultations were held at Kasba and Barhara-kothi (B-kothi) block of Purnia district on 16th January 2009 and 17th January 2009, respectively, as a part of preparation of district PIP of Purnia district. As NRHM emphasize on community participation and need-based service delivery with an improved outreach to disadvantaged communities, it was perceived that the outcome of the block level consultations would be a vital part of the information for preparation of district health action plan. Taking into consideration of bottom-up approach as the philosophy of NRHM, the district health society invited ASHAs, PRI representatives, AWWs, ANMs, Block Development Officer, officials of PHED, Education, ICDS and health service providers to participate in the consultation held at both the blocks and all of them participated in the consultation at both the blocks. Block level consultations helped the community and the service providers to jointly identify the ways in which they could plan to effectively meet their needs under NRHM. The objectives and expected outcomes of the workshop are as follows:

Objectives of the Consultation:

- Engaging wide range of stakeholders
- Identifying priorities at the grassroots
- Identify vulnerable groups, local issues and concerns with solutions/intervention
- Ensuring opportunities for inter-sectoral convergence.
- Carving out roles and responsibilities of different stakeholder in micro level planning and implementation.

Expected outcomes of the workshop:

- Community level health concerns, specifically those of women and vulnerable groups
- Concerns of the providers and service gaps as identified by the functionaries at the block level
- Geographical areas/panchayats requiring greater focus and attention
- Possible roles that need to be played by the panchayats and community groups such as the self-help groups
- Areas for inter-sectoral dialogue, coordination, budget and activity planning

List of Participants in both the blocks:

- Staff of DPMU
- Block Development Officer
- Block Pramukh
- MOIC
- CDPO (ICDS)
- Medical Officers

- ANMs
- ASHAs
- AWWs
- Junior Engineer, PHED
- MNGO representative
- Mukhiya
- Ward Member
- Other block officials

PFI and UNFPA representatives facilitated the block level consultation at both the blocks. The workshop was inaugurated jointly by BDO, Block Pramukh and MOIC in both the blocks. The guests addressed the participants and reiterated about the importance of preparation of district PIP under NRHM and requested all the participants to participate actively in all the sessions.

PFI/UNFPA/District Planning team briefed about the objectives of the block level consultation and the processes to be followed for preparation of district PIP for the district. The process for preparation of district PIP is as follows:

- Conducted State Level Consultation for finalization of plan at SHSB on 7th January 2009
- Finalized Format for Situation Analysis at state level
- Conducted Situational analysis for all blocks with support from block health managers, MOICs and officials of other line departments
- Conducting Block Level Consultations – in Kasba and B-kothi blocks

Thereafter a District Level Consultation would be held to come up with the district level recommendations for improving health status of the district in consultation with all the related government line departments. After that the district planning team would prepare the draft PIP which would be shared in the district dissemination workshop and then the final PIP would be submitted to the State Health Society for approval.

The participants were briefed about the key objectives, approaches and activities under NRHM and the importance of preparation of district PIP. After briefing about the NRHM, importance and processes to be followed for DHAP, all the participants were divided into five groups and were given following topics for discussion and presentation:

a) Group – 1: Maternal Health
b) Group – 2: Child Health
c) Group – 3: Family Planning
d) Group – 4: Infrastructure (viz. building, facilities, equipments, supplies, drugs, forms etc.)
e) Group – 5: Convergence

The same process was followed in Kasba and B-kothi blocks. The participants were given following common questions for discussion in all the five groups:

a) What should we do for improvement?
b) How to do?
c) What is available?
d) What are the requirements?
e) How to fulfill the requirement?
f) How to mobilize the beneficiaries?
g) What are the constraints?

Thereafter the participants were asked to come up with five suggestions / recommendations for each section. The findings/suggestions/recommendations have been compiled in the matrix form which is as follows:

Topics	Kasba	B-Kothi
1) For Maternal Health		
a) What should we do for improving Maternal Health?	• Women should take nutritious diet especially during pregnancy • Child marriage should be avoided and marriage of girls should not be done before attaining the age of 18 years • Regular ANC and PNC should be conducted of pregnant women for ensuring safe delivery. Institutional delivery should be promoted.	• Marrying girls after attaining 18 years of age. • Ensuring 3 years of spacing between two children. • Ensuring 100% institutional delivery and reducing anemia.
b) How to do?	• Women should be motivated for taking nutritional intake by using various IEC/BCC materials • All the pregnant women should be provided with all the three ante natal check ups and IFA tablets should be provided to them by ANMs, ASHAs and AWWs. • Pregnant women should be mobilized to the health centers for delivery.	• ASHA, AWW and ANMs should motivate parents, PRI members, and community influencers for marrying their daughters after attaining the age of 18 years through home visit / group meeting and other activities. • Making the people aware about different temporary contraceptive methods and ensuring regular supply of contraceptive methods for delaying the first child birth. • By making pregnant women, their husbands and in-laws aware about importance of institutional delivery and importance of nutritional intake during pregnancy. Simultaneously, strengthening of sub-centers, PHCs/CHCs should be done for ensuring quality care services for

		institutional delivery.
c) What is available?	• AWWs, ASHAs, ANMs are there in place • Hospitals are available • Ambulance, ANMs, doctors are available	• Panchayat, ASHA, AWWs, NGOs, SHGs are available. • Temporary contraceptives e.g. condom, OCPs, IUDs, Contraceptive injections, Emergency pills for delaying the first child birth • ANM, Doctors, PHCs, CHCs, HSCs, medicines, supplies, infrastructure, JBSY scheme is available
d) What are the requirements?	• Staying arrangement for ASHAs and attendant of clients is required and hygienic environment needs to be provided for quality services at health centers for safe delivery. • Women should be sensitized and mobilized to take healthy and nutritious food. 100% 3 ANC check up and PNC of pregnant women should be ensured. • Ambulance is needed for bringing the pregnant women at health centers for delivery and referral to FRUs.	• At least 60% of ANMs, ASHAs, AWWs, community influencers, religious leaders and PRI members should be trained. • Ensure regular supply of contraceptives through involvement of MNGOs, NGOs and establishment of depots at community level. • Placement of Lady doctor, para-medicos, and other human resources at PHC / CHC level, construction of separate toilets for ladies, beds, strengthening of OT, medicines and conduction of training for ANMs, ASHAs, AWWs on maternal health.
e) How to fulfill the requirement?	• Pregnant women, their husbands and in-laws should be mobilized for institutional delivery. • Information on nutritional food, awareness about food value of locally available products should be given to the community by using IEC materials.	• Through conduction of training, group meetings and mobilizing the PRI members for taking a resolution for not to marry the girls in their panchayats before attaining the age of 18 years • Conduction of group meetings, trainings of newly married couples and involving NGOs to establish depot and

	• By ensuring 100% ANC and 100% institutional delivery of first time pregnant women.	ensuing regular supply of contraceptives. • Strengthening HSCs, PHCs, CHCs, construction of toilets for ladies, placing ANMs and lady doctors, boat ambulance for flood prone areas and ensuring regular supply of drugs and supplies.
f) How to mobilise the beneficiaries?	• Community should be made aware about importance of institutional delivery • Clients should be made aware about benefits of JBSY scheme • Ensuring quality of care at health centers	• Through conduction of street play, meetings at village level, displaying banner, posters, hoardings, and taking resolution of not to marry their daughters before attaining the age of 18 years. • Enhancing knowledge, attitude and skills of beneficiaries through training, group meetings and counseling by ASHAs, AWWs and ANMS. • Enhancing timely disbursement of funds to the beneficiaries under JBSY scheme
g) What are the constraints?	• Illiteracy, social taboos • Lack of transportation facilities • Lack of qualitative health services at health centers • Lack of support from the family members to the pregnant women	• Lack of knowledge among PRI members • Lack of training and community participation • Lady doctor not in place, irregular supply of drugs and lack of proper transportation facility
2. Child Health		
a) What should we do for improvement?	• Promoting exclusive breastfeeding immediately after child birth • Complete immunization of children and ensuring qualitative services • Neo natal care services	• Child should be born at hygienic environment and proper skill development should be done for ensuring safe delivery • Promoting and ensuring exclusive breastfeeding for all the infants • 100% full immunization of children

b) How to do?	• Health workers should be trained on breast feeding. Pregnant women, lactating mothers and their family members should be made aware about importance of exclusive breastfeeding by using different BCC materials • Children should be immunized at health centers, AWCs and other places as per plan. • Service providers should be trained on new born care and making all the resources available at health centers for new born care services.	• Cord of child should be cut with new blade • Exclusive breastfeeding should be promoted. • All the mothers and in-laws should be given knowledge about importance of complete immunization.
c) What is available?	• Drugs, injections, RI card, ice pack, fridge, generator and vaccines are available at health centers and AWCs. • Health service providers, buildings, and other facilities are available • Few IEC materials are available	• Few of the equipments for delivery of child health care services are available • Cold chain and vaccines are available • Few oxygen cylinder are available
d) What are the requirements?	• IEC, BCC materials and trainings for health workers are required. • Regular and sufficient supply of vaccines, POL, ice pack and availability of trained staff are required. • Requisite equipments, supplies, drugs etc. are required for neo natal care and the health providers should be given training on identification of neo natal problems and treatment	• Hygienic place, clean clothes, proper ventilation, sterilized equipments, new blades, soaps, threads, supplies and drugs are required. • Sufficient quantity of vaccines should be made available at block and HSC level and proper cold chain management should be ensured. • Oxygen cylinder and other essential equipments should be made available

e) How to fulfill the requirement?	• By using BCC, IEC materials, mass media and conduction of training to providers for promotion of exclusive breastfeeding • Ensuring cold chain management and proper logistic management of vaccines and other supplies • Conduction of training to ANMs, ASHAs on identification of problems related to new born and ensuring regular supply of equipments, drugs, supplies and other resources for new born care services.	• All the pregnant women should be given 3 ANCs, 100 IFA tablets • Knowledge should be given to service providers and mothers for keeping their child warm after delivery and exclusive breastfeeding. • Knowledge should be given on importance of complete immunization and immunization schedule. Even the parents should be mobilized to bring their children at health centers for health checkup and immunization.
f) How to mobilise the beneficiaries?	• Conduction of group meetings, formation and strengthening of Village Health and Sanitation Committee at village level. • Involving SHGs, NGOs for demand generation. • Ensuring quality of care at health centers	• Delivering qualitative services and making the clients aware about the services available at health centres. • Through disseminating procedures for disbursement of fund to beneficiaries. • Parents should be made aware about importance of complete immunization.
g) What are the constraints?	• Lack of sufficient human resources • Lack of sufficient drugs and supplies • Lack of beds, equipments and proper knowledge	• Lack of education • Lack of awareness • Lack of trained professionals
3) Family Planning		
a) What should we do for improvement?	• Community should be made aware about importance of contraception • Community should be made aware about importance of marriage of girl child after attaining 18 years of age and delaying first child birth. • Minimum 3 years of spacing between two children.	• Mass awareness regarding temporary and permanent methods of family planning • Ensuring proper stock of condoms, OCPs, IUDs in the hard to reach areas • Ensuring availability of requisite equipments, beds, supplies at health centers for delivery of family planning services.

b) How to do?	• By making the people aware by using IEC/BCC materials • Conduction of camps • Through monthly visits of doctors, ANMs at villages for regular check ups and sensitizing the community about accessing FP services.	• To educate and make people aware about various contraceptive methods and ensuring regular supply of contraceptives at PHC/HSC/community level. • Conducting training to ANMs and ASHAs on IUD insertion and proper usage of contraceptive methods. • Mobilizing male and female for coming forward for sterilization and by strengthening the health centers to deliver quality services.
c) What is available?	• Temporary contraceptive methods • Doctors • Facilities for permanent FP methods	• PHC, doctors, equipments, ambulance, surgeon • Different family planning methods • Static centers and ANMs
d) What are the requirements?	• Regular and sufficient supply of temporary contraceptives • Counseling to eligible couples by ANMs, ASHAs for using contraceptives • Separate check up and testing centers should be there for ladies	• Building with proper infrastructure, OT facilities, requisite equipments, trained ANMs and health workers. • At least 50 beds at CHCs, one surgeon, one lady doctor, pediatrician, MD and other doctors should be there and ambulance should be available. • At least 15 beds and placement of 5 doctors and provision of family planning facilities at
e) How to fulfill the requirement?	• Through mobilization of community by ANMs, ASHAs • By educating women for using contraceptives of their choices • Strengthening static centers for ensuring quality services in family planning	• Ensuring 30 beds at PHC and 15 beds at APHC level • Renovation of PHC and APHC building with requisite furniture, equipments, supplies, drugs • Educating and mobilizing the community for accessing family planning services at PHC level.
f) How to mobilise the beneficiaries?	• By providing timely disbursement of incentives • By providing quality services • By establishing help-line for making the people informed about various contraceptive methods	• Through regular home visits by ANMs, ASHAs • Mobilizing the community through mass media • Conduction of health camps at village level and providing qualitative health

		services
g) What are the constraints?	• Lack of infrastructure • Lack of sufficient human resources • Lack of proper equipments, drugs, modern techniques etc.	• Lack of staying arrangements for ASHAs, patients and their attendants • Lack of transportation facility • Lack of trained providers
4) Infrastructure		
a) What should we do for improvement?	• Provision of safe drinking water and regular power supply at health centers • Sufficient trained human resources should be available • Availability of sufficient drugs and supplies	• Social awareness • Arrangement for land, building, staff, doctor and equipments • Ensuring regular supply of drugs, supply, and ensuring hygienic environment and transportation facilities at health centers.
b) How to do?	• Provision of separate place at pathology and diagnostic centre for ladies and construction of separate toilets for ladies. • Vehicle and ambulance facility should be made available for clients at health centres. • Strengthening OT, labour room and ensuring availability of sufficient drugs and supplies at health centres for ensuring qualitative services of all facilities.	• Making people aware through involvement of PRIs. • Improving confidence among society through involvement of ASHA, AWW, ANMs. • Conduction of meetings with community.
c) What is available?	• Ambulance • X-ray facility • Generator, building, equipments, supplies and drugs	• ANM, AWWs, ASHAs • HSC, PHC and land • Basic facilities at PHC level

d) What are the requirements?	• Building is needed for HSC and APHC. • Trained staff. • Strengthening OT, labour room, establishment of new born care centers and ensuring regular supply of drugs, supplies and equipments at health centers.	• Provision of land, building, doctors and residential facility for doctors. • Ensuring regular supply of drugs, supplies and provision of X-ray, pathology, ultrasound, incubator at PHC level. • Provision of vehicle and ambulance at HSC level.
e) How to fulfill the requirement?	• Conduction of regular trainings to the health workers. • Proper recruitment and selection of staff. • Ensuring quality services at health centers.	• Mobilizing the community. • Building, doctors, staff and other equipments. • Making provision of all basic facilities e.g. drinking water, power supply, ambulance, toilets separately for gents and ladies.
f) How to mobilise the beneficiaries?	• By using IEC/BCC materials. • Conduction of training. • Mobilising community by ASHAs, ANMs and AWWs.	• Involving PRI members for making the people aware about accessing quality services. • Mobilsing the community through regular visits and meetings by ASHAs, AWWs, ANMs. • Ensuring quality of care at all levels.
g) What are the constraints?	• Lack of skilled human resources. • Lack of vehicle. • Lack of residential facilities for ANMs and doctors.	• Lack of space/land, furniture, building, equipments. • Lack of training on different issues. • Lack of transportation facilities.
5) Convergence		
a) What should we do for improvement?	• Preparation of work plan for effective implementation of programme. • Conduction of monthly meeting for ensuring effective coordination among different stakeholders. • Developing, distribution and filling up of convergence form.	• Preparing micro plans jointly by ICDS, health services, PHED, department of social welfare, education department. • Fixing the roles and responsibilities of all the stakeholders for effective implementation of micro plan prepared jointly by involving different line departments • Making the people aware about micro plan in detail and mobilizing the community for effective implementation of micro-plan

b) How to do?	• Proper maintenance of records • By making effective coordination among ANMs, ASHAs and AWWs • Making people informed about health services through involvement of CBOs	• Making the community aware about micro-plan • Making provision of training of AWWs, ANMs, ASHAs, Junior engineers of PHED • Training and involvement of PRI members for community monitoring of NRHM activities at community level
c) What is available?	• ANMs, ASHAs, AWWs, doctors are available • Nutritional food • Drugs are available	• Health centre, MOs, health workers, ASHAs, AWWs, ANMs are available • Equipments, drugs and supplies are available but its not proper • PRIs
d) What are the requirements?	• Sufficient staff and training • Safe drinking water facility at health centers • Coordination among different line departments	• Coordination among various stakeholders • Needs to disseminate planning among community members • Needs to be informed about existing infrastructure, equipments, supplies and drugs and existing facilities to all stakeholders
e) How to fulfill the requirement?	• Making people aware about existing health services • Ensuring availability of vehicle at health centres by coordinating with different line departments • Formation of one health committee at Panchayat level for monitoring of health services at Panchayat level (Community monitoring)	• To disseminate details about micro plan on regular basis and providing training to them • By strengthening all the equipments and facilities at health centers • Formation and strengthening Village Health and Sanitation Committees
f) How to mobilise the beneficiaries?	• By organizing *nukkad natak,* puppet show • Organizing health and nutrition day at village level • Distribution of nutritional food to the beneficiaries during health and nutrition camps (Village health and nutrition day)	• To make people informed about existing health services through conduction of trainings, meetings and involving PRI members • Conduction of group meetings, home visits by involving AWWs, ASHAs, ANMs for making the clients aware about quality of care services • By using IEC and BCC materials for making the people aware about services and increasing accessibility of

		clients to health services.
g) What are the constraints?	• Insufficient supply of drugs • Lack of sufficient human resources • Lack of transportation facilities	• Lack of building, infrastructure, equipments • Lack of ladies doctors • Lack of sufficient health sub centers and transportation facilities

All the above recommendations were presented before the BDO, Block Pramukh, MOICs and other officials and all of them agreed of the recommendations.

The workshop was ended with the vote of thanks by MOICs.

ANNEXURE - IV

REPORT OF THE DISTRICT LEVEL CONSULTATIONS FOR PREPARARTION OF DISTRICT PIP OF PURNIA DISTRICT

A district level consultation was held at District Magistrate Office, Purnia on 22nd January 2009 under the Chairmanship of Mr. Sridhar C., District Magistrate, Purnia. All the block level health officials, ICDS officials and district level officials were present in the workshop. Dr R. C. Mandal, Civil Surgeon, Purnea welcomed all the participants in workshop and thanked for their cooperation and support in preparing the district PIP for Purnia. He said that the state government has taken the decision to come up with few district PIP for this financial year and for this the state has asked support from UNFPA/PFI for technical assistance in preparing the district PIP. He thanked Population Foundation of India and UNFPA to facilitate at all levels in preparation of DHAP. The workshop was organized with the following **objectives**:

- Reviewing and vetting objectives of the District Health Action Plan (DHAP).
- Assessing appropriateness and adequacy of suggested strategic interventions/and activities to meet the objectives of the DHAP.
- Sharing with a larger stakeholder group, the proposed outcomes for the District and get additional inputs.
- The purpose of this workshop is also to share with a larger stakeholder group, the proposed outcomes for the District and get a critical review and additional inputs.

The **expected outcomes** of the workshop were as follows:

- Local needs, issues, concerns and strategies identified to address NRHM programme in a holistic manner
- Monitoring processes, indicators and proper systems identified
- Inter-sectoral convergence established.
- Operational guideline to address the problem areas in convergence e.g. making functional all the village health and sanitation committee, initiation of organizing village health and nutrition days by involving PRIs/AWWs at village level. And
- Inputs and recommendations received for draft PIP:
    - SMART objectives
    - Key strategies for district PIP
    - Feasible activities

List of Participants:

- Chairperson – Zila Parishad
- District Magistrate
- Civil Surgeon
- District Planning Officer
- District Project Officer (ICDS)
- ACMO
- Officers of District Disease Control Programme
- DPMU staff
- CDPOs of all the blocks

- Civil SDO
- Block Pramukh
- MOIC
- Medical Officers
- ANMs
- AWWs
- PHED officials
- PRI representatives
- MNGO representative
- UNICEF, WHO representatives

Mr. Matish Kumar from PFI said that preparing of district PIP is one of the mandate under NRHM and since the district has not come up with the district PIP after launching of NRHM hence it has been felt by the state and district government to prepare the district PIP for the financial year 2009-2010 for effective implementation of NRHM. He said that in order to prepare the district PIP of Purnia, a state level consultation was held at SHSB on 7th January 2009 at SHS Bihar for finalizing rolling out strategy and plan and in that meting the format for situation analysis was finalized. Thereafter an orientation of MOICs, Block Health Managers and District Project Management Unit (DPMU) was conducted on 11th January and 13th January, 2009 for collecting information in the template for situation analysis. The Block Health Managers conducted situational analysis for all blocks with support from MOICs, CDPOs, PHED officials, block education officer and Block Development Officer. The block level consultation was conducted in Kasba and B-kothi blocks on 16th January 2009 and 17th January 2009, respectively. The gaps identified in Kasba and B-kothi blocks were also shared with the participants. He said that after the district consultation, the district planning team would come up with the gaps and recommendations for assessing the needs and possible intervention to incorporate in the district PIP. After assessing the needs and possible feasible interventions, the district planning team would prepare the draft PIP which would be shared in the district dissemination workshop and then the final PIP would be submitted to the State Health Society for approval. Maternal Health, Child Health, Family Planning, Infrastructure, Convergence and Disase Control Programme were suggested as the topics for group work but after getting suggestions from the District Magistrate, the participants were divided into following eight groups:

a) Group – 1: Maternal Health
b) Group – 2: Child Health
c) Group – 3: Family Planning
d) Group – 4: Infrastructure (viz. building, facilities, equipments, supplies, drugs, forms etc.)
e) Group – 5: Convergence
f) Groip – 6: Disease Control Programme
g) Group – 7: Human Resource Development
h) Group – 8: Monitoring

The participants were given following common questions for discussion in all the eight groups:

a) What should we do for improvement?
b) How to do?
c) What is available?
d) What are the requirements?
e) How to fulfill the requirement?
f) How to mobilize the beneficiaries?
g) What are the constraints?

Following is the suggestions / recommendations of the groups:

Topics	Gaps/Suggestions/Recommendations
1) For Maternal Health	
a) What should we do for improving Maternal Health?	• Encouraging for marriage of girls after attaining 18 years of age • Promoting for spacing between two children of at least 3 years • Ensuring institutional delivery
b) How to do?	• Identification of pregnant women by making regular visits and surveys through involving ASHAs, ANMs, and AWWs • Regular meetings with public representatives, ASHAs, AWWs, community representatives at village level to create awareness about antenatal care, safe delivery and post natal care • Quality of care training of AWWs, ASHAs, ANMs, MOs and ensuring quality services by regular monitoring.
c) What is available?	• Health service providers • Sub-centre, APHC, PHC building, few equipments, drugs and supplies • Medicines like IFA tablets, vaccines, contraceptives like IUD, Condoms and oral pills
d) What are the requirements?	• Proper buildings with boundary walls, regular water and power supply and residence for all MOs and health workers • Vehicles for referral services • Need for equipments for minor operations, X-rays, pathological facilities and ultra-sono facilities, proper supply of medicines, vaccines at PHC level and strengthening of referral units by making it equipped with all the facilities and HR.
e) How to fulfill the requirement?	• By creating awareness about marrying girls after attaining the age of 18 years • Counseling and ensuring regular supply of contraceptives for spacing and delaying • Focusing institutional delivery
f) How to	• Consultations and meetings by MOs, CDPOs, and BDOs at block level

mobilize the beneficiaries?	and regular group meetings ith stakeholders at village level to mobilize the community members • Proper distribution and display of IEC materials, hoardings and banners and usage of BCC materials • Disseminating information about incentives given for institutional delivery
g) What are the constraints?	• Lack of proper transport and communication facility • Lack of lady doctors, ANMs and infrastructure like buildings, proper equipments, safe drinking water supply • Lack of support by public representatives and other officials of line departments
2. Child Health	
a) What should we do for improvement?	• Promoting exclusive breast feeding • Ensuring complete immunization • Starting IMNCI programme
b) How to do?	• By motivating pregnant and lactating mothers for exclusive breast feeding • Ensure 100% immunization of children • By making women and adolescent girls aware about taking nutritional intake
c) What is available?	• Insufficient health workers • Locally available nutritious food • All types of vaccines
d) What are the requirements?	• Obs. & Gynecologist and paediatrician • Sufficient number of health worker • Ensuring nutritional diet supply at AWC
e) How to fulfill the requirement?	• To make people aware about existing health programmes, schemes and services available at health centers • Training of doctor, ANM at PHC level for neonatal resuscitation training • To make people aware about locally available nutritious food products • To mobilize parents and mothers for vaccinating their children
f) How to mobilise the beneficiaries?	• Aware parents and mothers about vaccinating their children from six vaccine preventable diseases • Ensure NGO and community participation for building up awareness among community • Mobilizing community through conduction of nukkad natak
g) What are the constraints?	• Lack of education • Lack of transportation • Insufficient number of obstetrics & gynaecologist

3) Family Planning	
a) What should we do for improvement?	• Awareness generation at community level • Providing family health education • Ensuring availability of health services at hard to reach areas
b) How to do?	• Conduction of health & family welfare camp (FP camps) at village level • Providing health education to adolescent boys and girls focusing on family planning • By using mass media e.g. TV, radio for mass awareness • Counseling lactating women and eligible couples for accessing FP services and also counseling parents when they come for immunizing their children
c) What is available?	• Different contraceptive methods • Building, staff, medicines, supplies • Few equipments for FP operations
d) What are the requirements?	• Sufficient and regular supply of contraceptives • Availability of trained health workers at all levels • Skill development for IUD insertion and availability of skilled surgeon at PHC/FRU level
e) How to fulfill the requirement?	• Sensitization for community members • Ensuring sufficient number of service providers and conduction training to health workers at all levels for IUD insertion, FP usage and sterilization • Providing extra man power, equipments, supplies at health centres and ensuring logistic management at health centers
f) How to mobilise the beneficiaries?	• Mass awareness • Efficient use of AWW, ASHA, Mamta and involving local resource person working under Muskan – Dular project • Involving adolescents, MNGOs, NGOs and CBOs
g) What are the constraints?	• Lack of awareness • De-motivated health workers e.g. AWW, ASHA, *Mamta* due to lack of proper training and orientation • Lack of sufficient resources • Existing myths, misconceptions about contraceptives
4) Infrastructure	
a) What should we do for improvement?	• Ensuring regular water and electric supply at health centers • Sufficient trained human resources • Proper planning and budgeting
b) How to do?	• Training to all HR • Separate toilet and lab facility for women • Engaging MNGOs/NGOs and public representatives • Ensuring availability of transport facility (ambulance) for referral and for bringing the patients at health centers • Improving logistic management at health centers by involving other agencies

	• Support from all concerned government line departments
c) What is available?	• Hospital and few equipments at health centers • Medicines • Ambulance
d) What are the requirements?	• Strengthening of health centers by renovating PHC building and providing adequate skilled man power • Residential building for doctors and para-medical staffs • Regular and adequate supply of equipments, supplies and drugs
e) How to fulfill the requirement?	• Providing sufficient fund for strengthening PHCs specially OT, labs, labour room and placing skilled man power • Proper and sufficient supply of drugs and other materials • Involving Local resource persons already involved in *Muskan-Dular* programme for mobilizing community and providing service delivery at the community level by building up their capacity • Strengthening *Rogi Kalyan Samiti* and making provision for providing services during disaster
f) How to mobilise the beneficiaries?	• Social mobilization by ASHA and AWW • Support from public representatives • Using IEC/BCC materials and ensuring quality of care at PHC and District Hospital
g) What are the constraints?	• Lack of trained human resources • Lack of sufficient room, OT, equipments, doctors, medicines and supplies at health centers • Lack of transportation and regular supply of electricity and safe drinking water at health centers
5) Convergence	
a) What should we do for improvement?	• By aligning micro-plans developed by different line department viz. ICDS, PHED, WCD and PRI with NRHM plans • Improving coordination among various line departments and making clarity about roles and responsibilities of various stakeholders • Sensitizing different stakeholders about strategies, activities and expected support from them to achieve common objectives
b) How to do?	• Conducting meetings with officials of different line departments at block and district level • Preparing monthly joint action plan and review of the achievements • Formation and strengthening of VHSCs by involving all the line department representatives available at community level • Execution of Village health and nutrition day at per plan in coordination with ICDS
c) What is available?	• Officers, ANMs, Doctors, AWWs, ASHAs, Local Resource persons working under Muskan - Dular project, PRI representatives, PHED,

	health centers, fund and provision of training to service providers are available • Drugs, supplies, equipments and vehicle • PRI representative and different line departments
d) What are the requirements?	• Coordination among various line departments • Sensitization of public and PRI representatives at community level • Sufficient man power, equipments, vehicle, training and orientation is required for effective operationalisation of plan at different levels
e) How to fulfill the requirement?	• Through ensuring community monitoring • Formation and strengthening of VHSCs and RKS • Through effective implementation of Village health and nutrition day • Through effective implementation of joint action plan at different levels
f) How to mobilise the beneficiaries?	• Conduction of meeting at village level (specially VHSC meeting and organizing Village health and nutrition day) and discussing health issues in PRI meeting • Through conduction of nukkad natak, using IEC/BCC materials and strengthening RKS • Involving CBOs, SHGs for mass awareness
g) What are the constraints?	• Lack of apathy of service providers and other line department officials • Lack of effective implementation of plans and programmes • Lack of coordination among various stakeholders, training, sufficient resources
6. National Disease Control Programme	
a) What should we do for improvement?	• Local resource person should be trained about the disease • Development of IEC/BCC materials for all disease control programmes • BCC strategy • Training of ASHA, AWWs and DOT providers for effective implementation of RNTCP and proper follow up of TB patients who are under treatment • Search of Kalazar and malaria patients • Strengthening laboratory facilities • Ensuring availability of drugs and supplies
b) How to do?	• All information related to it should be available at health centers • Diagnosis and management • Through treatment and awareness building for preventive measures
c) What is available?	• Manpower • Laboratory • Drugs
d) What are the requirements?	• Training to health service providers on disease control • Well equipped lab facilities • Regular spray and vehicles for follow-up
e) How to fulfill the requirement?	• Sufficient fund • Hands on training by demonstration and adopting different methods

f) How to mobilise the beneficiaries?	• Involvement of local representatives • Through IEC/BCC strategy • Regular visits by health service providers viz. ANMs, AWWs, LHVs and ASHAs
g) What are the constraints?	• Funds • Drugs and vehicles • Lack of waste disposal management system
7. Human Resource Development	
a) What should we do for improvement?	• SWOT analysis of human resources • System analysis - including skill and performance • Resource Analysis
b) How to do?	• Formulating and implementing standard operating procedures and guidelines • Need based orientation and training of human resources for delivering qualitative services
c) What is available?	• NGOs • IEC materials and activities • Logistics
d) What are the requirements?	• Training material and logistic management • Venue for training at block / district level
e) How to fulfill the requirement?	• Setting the standard operating procedures and guidelines • Need based training and orientation of human resources for conducting qualitative services, building confidence and motivation • Monitoring of quality of work, performance appraisal, Incentives for efficient staff
f) How to mobilise the beneficiaries?	• Counselling, Personal contact • Sensitization of community on services available at different levels and motivating them to increase the accessibility over the existing services • Praise the beneficiaries for his visit to health centers and acknowledgement of services
g) What are the constraints?	• Lack of coordination among different line departments • Irregular supply of fund, logistics and unavailability of resource persons • Lack of awareness, illiteracy and male dominant society
8. Monitoring	
a) What should we do for improvement?	• Proper orientation of all stakeholders on planning and monitoring and making clarity to all on their roles and responsibilities for achieving the objectives • Situation analysis • Ensuring implementation of strong and effective monitoring system

b) How to do?	• By orientation and training to service providers on programme management • By regular supervision and service assurance • Through community monitoring • Through formation and strengthening of VHSC • Strengthening and redefining existing monitoring system and strengthening logistic management
c) What is available?	• Staff • Vehicle • Fund and NRHM is in place
d) What are the requirements?	• Specific formats and registers • Vehicle and resource persons • Training and orientation of human resources for making them efficient • Doctors and Health management unit should be trained on monitoring and supervision
e) How to fulfill the requirement?	• By finding out weak points and make improvement in the system • Redefining monitoring formats • Strengthening village health and sanitation committee • Improving managerial skills of existing human resources
f) How to mobilise the beneficiaries?	• Increasing awareness, counselling among beneficiaries • Making all VHSCs functional • Providing quality services at health centers
g) What are the constraints?	• Lack of education • Non availability of trained man power • Lack of managerial skill among doctors and other health service providers • Lack of proper logistic management • Lack of coordination and cooperation among inter-sectoral and intra-sectoral departments

The group leaders of all the eight groups presented their views. The workshop was concluded by extending vote of thanks by the Civil Surgeon, Purnia.

BUDGET

ANNEXURE – I

NATIONAL RURAL HEALTH MISSION		
SUMMARY BUDGET -2009-2010 FOR PURNIA DISTRICT		
S/N	**Particulars**	**2009-2010 (in Lacs)**
1	Budget for RCH-II	2849.44
2	Budget for NRHM Additionalitis	5280.18
3	Immunization	37.12
4	Budget for NVBDCP	170.13
5	Budget for RNTCP	44.40
6	Budget for NLEP	20.70
7	Budget for NBCP	35
	Total Budget	**8436.97**

 # The total budget for Purnia district under NRHM is Rs. 8436.97 lacs (eighty four crores thirty six lacs ninty seven thousand only)

Budget Detail of (RCH Flexi Pool)

RCH II Budget 2009-2010 Purnia					
Sl. No.	Strategy/Activity	Physical Target	Rate (Rs. /unit)	Total (in Rs.)	Total # (In Lakhs)
A	**1. MATERNAL HEALTH**				
A.1	**ANC Services**				
A.1.1	Orient local health resource persons / community based health volunteers for Social Mobilization (2 from each Panchayat) {1 in each block}	14.00	7500.00	**105000.00**	**1.05**
A.1.2	Supplies for ANC sessions to the private practioners	14	50,000.00	**700000.00**	**7.00**
A.1.3	Orientation of private practicenors on quality ANC services (1 from each Panchayat)	7	5,700.00	39,900.00	0.40
A.1.4	Maternal Death Audit	1	100,000.00	100,000.00	1.00
A.1.5	Need based support to private agencies for partnership for blood bank	4	100,000.00	400,000.00	4.00
A.1.6	Selection of Mamta (including cost of advertisement for selection)	1	20,000.00	20,000.00	0.20
A.1.7	Kits for Mamta	160	500.00	80,000.00	0.80
A.1.8	Organising Monthly Mamta Diwas (1 in each block and 1 at Purnia Urban) {includes cost of fooding, TA and few unseen expenditure)	180	3,000.00	540,000.00	5.40
A.1.9	Support for counseling centres for adolescents (@ 10000/- per month per centre at PHC)	14	140,000.00	1,960,000.00	19.60

A.2	***Operationalise facilities (details of infrastructure & human resources, training, IEC/BCC, equipment, drugs and supplies in sections)***				
A.2.1	*Operationalise Block PHCs/CHCs/ SDHs/DHs as FRUs*				
A.2.1.1	Organize dissemination workshops for FRU guidelines	1	25000	25,000.00	0.25
A.2.1.2	Prepare plan for operationalisation across districts (including staffing, infrastructure, training, equipment, drugs & supplies, etc.)	1	10000	10,000.00	0.10
A.2.1.3	Monitor progress against plan; follow up with training, procurement, etc (@ 3000/- per month per block)	14	36000	504,000.00	5.04
A.2.1.4	Monitor quality of service delivery and utilization including through field visits. (@ 2000/- per month per block)	14	24000	336,000.00	3.36
A.2.2	*Operationalise PHCs to provide 24-hour services*				
A.2.2.1	Prepare plan for operationalisation across districts (including staffing, infrastructure, training, equipment, drugs & supplies, etc.)	1	10000	10,000.00	0.10
A.2.2.2	Monitor progress against plan; follow up with training, procurement, etc (@ 2000/- per month per block)	14	24000	336000	3.36
A.2.2.3	Monitor quality of service delivery and utilization including through field visits. (@ 2000/- per month per block)	14	24000	336000	3.36
A.2.3	*Operationalise MTP services at health facilities*				
A.2.3.1	Prepare plan for operationalisation across districts (including training, equipment, drugs & supplies, etc.)	1	10000	10000	0.10
A.2.3.2	Monitor progress against plan; follow up with training, procurement, etc (@ 3000/- per month per centre)	14	36000	504000	5.04
A.2.3.3	Monitor quality of service delivery and utilization including through field visits. (@2000/- per month per block)	14	24000	336000	3.36
A.2.4	*Operationalise RTI/STI services at health facilities*				

A.2.4.1	Prepare plan for operationalisation across districts (including training, equipment, drugs & supplies, etc.) @ Rs. 10,000 per district	1	10000	10000	0.10
A.2.4.2	Monitor progress against plan; follow up with training, procurement, etc (@ 2000/- per month per block)	14	24000	336000	3.36
A.2.4.3	Monitor quality of service delivery and utilization including through field visits. (@2000/- per month per block)	14	24000	336000	3.36
A.2.5	*Operationalise sub-centres*				
A.2.5.1	Prepare plan for operationalising services at sub-centres (for a range of RCH services including antenatal care and post natal care)	1	25000	25000	0.25
A.2.5.2	Monitor quality of service delivery and utilization including through field visits @ 3000/- per month per block)	1	36000	36000	0.36
A.2.6	***Referral Transport***				
A.2.6.1	Prepare and disseminate guidelines for referral transport for pregnant women and sick newborns / children	1	20000	20000	0.20
A.2.6.2	POL and maintenance to all the 24x7 PHCs functioning as first line of referral at grass root level to refer complicated cases	14	30000	420000	4.20
A.2.6.3	Support for Referral transport - Toll free telephone numbers will be provided for ambulance services in the difficult areas for referral cases	1	200000	200000	2.00
A.2.6.4	POL and Maintenance for Mobile Health Units (@ 15000/- per month for 8 MHUs)	8	180000	1440000	14.40
A.3	***Integrated outreach RCH services***				
A.3.1	*RCH Outreach Camps in un-served/ under-served areas*				
A.3.1.1	Conduction of RCH Outreach Camps in un-served/ under-served areas (4 in a year at 220 hard to reach areas @ 10000/- per camp)	880	10000	8800000	88.00

A.3.1.2	Monitor quality of services and utilization @ 3000/- as POL for each camp	880	3000	2640000	26.40
A.3.2	*Monthly Village Health and Nutrition Days at Anganwadi Centres*				
A.3.2.1	Implementation of Monthly Village Health and Nutrition Days at Anganwadi Centres (Panchayat level)	3012	100	301200	3.01
A.3.2.2	Supervision and monitoring quality of services & counseling at VHND.	3012	150	451800	4.52
A.3.2.3	Outreach referral services once a month per block by Pediatrician and gynecologist @ Rs 1500 / visit /person x 2 person x 12 months	168	3000	504000	5.04
A.4	Janani Evam Bal Suraksha Yojana / JSY : Support to pregnant woman as per Janani Evam Bal Suraksha Yojana (JSY)			0	-
A.4.1	Monitor quality and utilization of services.@ 10000/- per month per functional centres	14	120000	1680000	16.80
A.5	Support to ANM/FHW/ASHA/AWW/LHVs etc. for Completing of Early Registration to ANC or PNC Check up for Pregnant Women Rs. 100/- for case	94684	100	9468400	94.68
	Maternal Health Total			**33,020,300.00**	**330.20**
B	**CHILD HEALTH**				
B.1	***IMNCI (with the support from UNICEF)***				
B.2	***Facility Based Newborn Care/FBNC***				
B.2.1	Prepare and disseminate guidelines for FBNC.	1	20000	20000	0.20
B.2.2	Prepare detailed operational plan for HBNC across block (including training, BCC/IEC, drugs and supplies, etc.).	14	5000	70000	0.70
B.2.3	Implementation of FBNC activities at PHCs (50% PHCs and 100% referrals)	8	200000	1600000	16.00

B.2.4	Monitor progress against plan; follow up with training, procurement, etc. (@ 10000/- per month per centre)	8	120000	960000	9.60
B.3	***Home Based Newborn Care/HBNC***				
B.3.1	Prepare and disseminate guidelines for HBNC.	1	20000	20000	0.20
B.3.2	Prepare detailed operational plan for HBNC across block (including training, BCC/IEC, drugs and supplies, etc.).	14	5000	70000	0.70
B.3.3	Implementation of HBNC activities in blocks	14	100000	1400000	14.00
B.3.4	Monitor progress against plan; follow up with training, procurement, etc. (@ 10000/- per month per block)	14	120000	1680000	16.80
B.4	***School Health Programme***				
B.4.1	Prepare and disseminate guidelines for School Health Programme.	1	20000	20000	0.20
B.4.2	Prepare detailed operational plan for School Health Programme across blocks	1	20000	20000	0.20
B.4.3	Implementation of School Health Programme by blocks	14	100000	1400000	14.00
B.4.4	Monitor progress and quality of services @ 5000/- per block per month	14	60000	840000	8.40
B.5	***Care of Sick Children and Severe Malnutrition at FRUs***			0	-
B.5.1	Prepare and disseminate guidelines	1	20000	20000	0.20
B.5.2	Prepare detailed operational plan for care of sick children and severe malnutrition at referral units (including training, BCC/IEC, drugs and supplies, etc.).	3	10000	30000	0.30
B.6	***Management of Diarrhea, ARI and Micronutrient malnutrition***	14	200000	2800000	28.00

B.7	***Other strategies/activities (please specify – PPP/ Innovations/NGO to be mentioned under section 8)***				
B.7.1	Additional support for immunization (other than NRHM)	1	100000	100000	1.00
B.7.2	Transport facility for other high risk new borne	14	50000	700000	7.00
B.7.3	Activities for vulnerable population	1	1000000	1000000	10.00
B.7.4	Insecticide treated bed nets for the prevention against malaria for children & lactating mothers (for 10% of the total pregnant women belonging to most vulnerable works)	9468	200	1893600	18.94
	Child Health Total			**14,643,600.00**	**146.44**
C	**FAMILY PLANNING**				
C.1	***Terminal/Limiting Methods***				
C.1.1	Dissemination of manuals on sterilization standards & quality assurance of sterilization services.	1	20000	20000	0.20
C.1.2	Provide female sterilization services on fixed days at health facilities in blocks	14	100000	1400000	14.00
C.1.3	Mobility support to lapro/ TL surgeon and team (Rs 12,000/- block)	14	12000	168000	1.68
C.1.4	Provide NSV services on fixed days at health facilities in blocks	14	50000	700000	7.00
C.1.5	Organize female sterilization camps in blocks (6 units per block in a year)	84	20000	1680000	16.80
C.1.6	Organize NSV camps (4 units per block in a year)	56	20000	1120000	11.20
C.1.2	*Accreditation of private providers and support to provide sterilization services*	14	100000	1400000	14.00

C.1.2.1	Monitor progress, quality and audit of services through Quality Assurance Committees@10000/- per month	12	10000	120000	1.20
C.2	***Spacing Methods***			0	-
C.2.1	*Prepare operational plan for provision of spacing methods (including training, BCC/IEC, drugs and supplies, etc.).*	1	20000	20000	0.20
C.2.2	*Implementation of IUD services*			0	-
C.2.2.1	Provide IUD services at all health facilities in the district	14	100000	1400000	14.00
C.2.2.2	Organize IUD camps in blocks (4 camps per block per year)	56	20000	1120000	11.20
C.2.3	*Social Marketing of contraceptives: Social marketing-outsourcing*			0	-
C.2.3.1	Set up CBD Outlets (as revolving fund)	251	5000	1255000	12.55
C.2.4	*Organize Contraceptive Update seminars for health providers(2 seminar per block per year and 2 at district level)*	30	15000	450000	4.50
C.2.5	*Monitor progress, quality and utilization of services (@5000/- per month per block)*	14	60000	840000	8.40
C.2.6	Support to identified private FP service facilities for improving service environment	14	25000	350000	3.50
	Family Planning Total			**12,043,000.00**	**120.43**
D	**4. ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH**			0	-
D.1	***Adolescent friendly services***			0	-
D.1.1	Disseminate ARSH guidelines. (Printing and dissemination)	1	20000	20000	0.20
D.1.2	Prepare operational plan for ARSH services across districts (including training, BCC/IEC, equipment, drugs and supplies, etc.).	1	25000	25000	0.25

D.1.3	Training/Workshops for ARSH services (2 units per block per year)	28	20000	560000	5.60
D.1.4	IEC/BCC Equipments (Modules for adolescents, pamphlets etc.)	14	50000	700000	7.00
D.1.3	*Implement ARSH services in districts.*				
D.1.3.1	Setting up of Adolescent Clinics at health facilities.	14	100000	1400000	14.00
D.1.3.2	Monitor progress, quality and utilization of services @ 10000/- per block	14	10000	140000	1.40
D.1.3.3	ARSH Awareness Campaign at Panchayat level (two camps in a year)	502	1000	502000	5.02
D.2	Distribution of IFA tablets among adolescents. @Rs.95/1000 tablets. (Total 332636 adolescent girls)	19026756	0	2092943	20.93
D.3	Contingency @ Rs.10000/- per block	14	10000	140000	1.40
	ARSH Total			**5,579,943.16**	**55.80**
E	**URBAN RCH**				
E.1	***Urban RCH Services: Urban RCH***				
E.1.1	Identification of urban areas / mapping of urban slums	1	50000	50000	0.50
E.1.2	Prepare operational plan for urban RCH (including infrastructure and human resources, training, BCC/IEC, equipment, drugs and supplies, etc.).	1	20000	20000	0.20
E.1.3	Implementation of Urban RCH plan/ activities				
E.1.4	Recruitment and training of link workers for urban slums	1	50000	50000	0.50
E.1.5	Strengthening of urban health posts and urban health centres (6 in the first year)	5	100000	500000	5.00

E.1.6	Provide Maternal Health services (ANC, Delivery,PNC)	5	200000	1000000	10.00
E.1.7	Provide Child Health services (Immunization)	5	200000	1000000	10.00
E.1.8	Provide Family Planning services (IUD TL,)	5	200000	1000000	10.00
E.1.9	Provide ARSH services	5	50000	250000	2.50
E.1.10	Monitor progress, quality and utilization of services (@ 5000/- per month per centre)	5	60000	300000	3.00
	Urban RCH Total			**4,170,000.00**	**41.70**
F	**VULNERABLE GROUPS**				
F.1	Need based health activities targeting vulnerable communities such as sex workers living in the red light areas, laborers working in Jute industry, SCs, STs, and BPL populations living in urban and rural areas	12	20000	240000	2.40
F.2	***Services for Vulnerable groups***				
F.2.1	Mapping of vulnerable groups	1	25000	25000	0.25
F.2.2	Prepare operational plan for vulnerable groups (including infrastructure and human resources, training, BCC/IEC, equipment, drugs and supplies, etc.).	1	20000	20000	0.20
F.3	Implementation of activities				
F.3.1	Provide Maternal Health services	1	500000	500000	5.00
F.3.2	Provide Child Health services	1	500000	500000	5.00
F.3.3	Provide Family Planning services	1	500000	500000	5.00
F.3.4	Provide ARSH services	1	200000	200000	

					2.00
	Vulnerable Groups Total			**1,985,000.00**	**19.85**
G	**INNOVATIONS/ PPP/ NGO**			0	-
G.1	***PNDT and Sex Ratio***			0	-
G.1.1	Orientation of programme managers and service providers on PC & PNDT Act	2	40000	80000	0.80
G.1.2	Monitoring of Sex Ratio at Birth	1	100000	100000	1.00
G.1.3	Other PNDT activities	1	500000	500000	5.00
G.1.4	IEC for PNDT to improve sex Ratio	14	50000	700000	7.00
G.2	***NGO Programme***			0	-
G.2.1	Support for NGO programmes- Rs 20,000/ per block (other than MNGOs and FNGOs)	14	20000	280000	2.80
G.2.2	MNGO scheme support (as per the MNGO scheme guideline of GoI)	1	1500000	1500000	15.00
	Total Innovations/PPP/NGO			**3,160,000.00**	**31.60**
H.1	Support to district quality assurance committee for quality improvement initiatives (Rs 2 lac x 1 Quality Cells)	1	200000	200000	2.00
H.2	Distribution of Vit.A @ Rs.1.20 per lactating mother for post natal care	136078	1.20	163294	1.63
	Total others			**363,293.60**	**3.63**
I	**Logistic Management**				
I.1	***Logistics management/ improvement***			0	-
I.1.1	Logistics consultant(s) recruited and in position at District level	1	180000	180000	1.80

I.1.2	Logistics consultant(s) recruited and in position at block level	14	120000	1680000	16.80
I.1.3	Training of staff in logistics management	3	25000	75000	0.75
I.1.4	Strengthening of warehousing facilities (construction/ repair/ renovation, furniture, computers, software, etc.)	14	100000	1400000	14.00
I.1.5	Data processing equipments, maintenance and non expendables at District level	1	100000	100000	1.00
	Toatl Logistic Management			**3,435,000.00**	**34.35**
J	***Institutional Strengthening***				
J.1	***Monitoring & Evaluation / HMIS***			0	-
J.1.1	Strengthening of M&E Cell	15	50000	750000	7.50
J.1.3	Review of existing registers	1	50000	50000	0.50
J.1.4	Printing of new forms	1	500000	500000	5.00
J.1.5	Printing and dissemination of referral protocols, referral cards, feedback cards, registers, immunization cards, other reporting formats	1	1000000	1000000	10.00
	Institutional Strengthening Total			**2,300,000.00**	**23.00**
K	**TRAINING**				
K.1	2 day's Training of ANM, AWW and ASHA on module of EDPT of anemia	14	8,700.00	121,800.00	1.22
K.2	Training of Mamta for Post natal and other related services (for 160 Mamtas)	6	14,900.00	89,400.00	0.89
K.3	Need based training of Mamta	6	7,900.00	47,400.00	0.47

K.4	Training for counseling to Mos				
K.5	*Maternal Health Training*			0	-
K.5.1	*Skilled Attendance at Birth / SBA*			0	-
K.5.1.1	Training of Medical Officers in SBA	5	20000	100000	1.00
K.5.1.2	Training of Staff Nurses in SBA	3	20000	60000	0.60
K.5.1.3	Training of ANMs / LHVs in SBA	14	25000	350000	3.50
K.5.2	*EmOC Training*			0	-
K.5.2.1	Training of Medical Officers in EmOC	1	25000	25000	0.25
K.5.2.2	Training of staff nurses in BEmOC	3	20000	60000	0.60
K.5.2.3	Training of MO in CEmOC	4	25000	100000	1.00
K.5.3	*MTP Training*			0	-
K.5.3.1	TOT on MTP using MVA (to be conducted by SHSB)			0	-
K.5.3.2	Training of Medical Officers in MTP using MVA & MA	4	25000	100000	1.00
K.5.4	*RTI / STI Training*				
K.5.4.1	Training of laboratory technicians in RTI/STI	1	20000	20000	0.20
K.5.4.2	Training of Medical Officers in RTI/STI	4	25000	100000	1.00
K.5.4.3	Training of Staff Nurses in RTI/STI (Rs. 21,450 per batch of 25 participants x 10 batch)	1	20000	20000	0.20
K.5.4.4	Training of ANMs / LHVs in RTI/STI	3	20000	60000	0.60
K.5.5	Orientation of Local health resource persons on safe delivery	14	20000	280000	2.80

K.5.6	Other need based maternal health training	1	50000	50000	0.50
K.5.7	Awareness generation for component of RCH for PRIs/Opinion leaders/Women Group.	14	20000	280000	2.80
K.6	***Child Health Training***			0	-
K.6.1	*IMNCI Training (pre-service and in-service)*			0	-
K.6.1.1	IMNCI Training (to be conducted with support from UNICEF)			0	-
K.6.2	*Facility Based Newborn Care / FBNC*			0	-
K.6.2.1	TOT on FBNC	1	40000	40000	0.40
K.6.2.2	Training on FBNC for Medical Officers	2	30000	60000	0.60
K.6.2.3	Training on FBNC for staff nurses / LHV	4	25000	100000	1.00
K.6.3	*Home Based Newborn Care / HBNC*				
K.6.3.1	TOT on HBNC	1	25000	25000	0.25
K.6.3.2	Training on HBNC for ASHA / Local health resource persons	14	20000	280000	2.80
K.6.3.3	Care of sick children and severe malnutrition	1	100000	100000	1.00
K.6.4	***Family Planning Training***				
K.6.4.1	Training on laparoscopic sterilization to MOs	1	30000	30000	0.30
K.6.4.2	Minilap training for medical officers	1	20000	20000	0.20
K.6.4.3	NSV training for MOs	1	20000	20000	0.20
K.6.4.4	Training of Medical officers in IUD insertion	2	20000	40000	0.40

K.6.4.5	Training of staff nurses in IUD insertion @ Rs. 4600 per batch of 2 persons x 300 batches.	1	20000	20000	0.20
K.6.4.6	Training of ANMs / LHVs/FHW/LRPs in IUD insertion	14	15000	210000	2.10
K.6.4.7	Contraceptive Update Training	2	25000	50000	0.50
K.6.5	***Adolescent Reproductive and Sexual Health/ARSH Training***				
K.6.5.1	ARSH training for medical officers	2	25000	50000	0.50
K.6.5.2	ARSH training for ANMs/LHVs/LRPs	14	20000	280000	2.80
K.6.5.3	ARSH training for AWWs	14	20000	280000	2.80
	Training Total			**3,468,600.00**	**34.69**
L	**BCC / IEC**				
L.1	***Strengthening of BCC/IEC Bureaus***				
L.1.1	Contractual IEC consultant @15000 per month	1	180000	180000	1.80
L.1.2	Audio visual and other IEC equipment & its maintenance	1	50000	50000	0.50
L.1.3	Developing, printing and dissemination integrated BCC/ IEC material at district level	1	500000	500000	5.00
L.1.4	IEC, communication activities and mass media campaigns, etc at block level - Celebration of Days/ Events, etc	14	25000	350000	3.50
L.2	***implementation of BCC strategy (for RCH)***				
L.2.1	*BCC/IEC activities/campaigns for maternal health*				
L.2.2	BCC/IEC activities for maternal health interventions (except JSY)	14	50000	700000	7.00
L.2.3	BCC/IEC activities for JSY	14	50000	700000	

					7.00
L.2.4	*BCC/IEC activities/campaigns for child health*	14	50000	700000	7.00
L.2.5	*BCC/IEC activities/campaigns for family planning*	14	50000	700000	7.00
L.2.6	*BCC/IEC activities/campaigns for ARSH*	14	30000	420000	4.20
L.2.7	*Developing, printing and dissemination integrated BCC/ IEC material at district level*	1	100000	100000	1.00
L.2.8	Support to communication van for BCC/ IEC materials, POL and maintenance, BCC/IEC equipments, etc. @ 2000 per month per block	14	24000	336000	3.36
	BCC/ IEC Total			**4,736,000.00**	**47.36**
	Procurement of Equipments, drugs and supplies				
M	***Procurement of Equipment***				
M.1	*Procurement of equipment for Maternal Health*				
M.1.1	Procurement of equipment of skills based services (anesthesia, EmOC, SBA)	14	100000	1400000	14.00
M.1.2	Equipment/ Instrument for identified facilities (CHCs/ PHCs/ DHs) for BEmOC services	15	100000	1500000	15.00
M.1.3	Equipment/ instrument for CEmOC centres	3	200000	600000	6.00
M.1.4	Equipments/ instruments for other related services	14	50000	700000	7.00
M.1.5	Equipment/ Instrument for safe abortion center	3	200000	600000	6.00
M.1.6	Procurement of equipment of blood storage facility	3	500000	1500000	15.00
M.1.7	Procurement of MVA/EVA equipment for health facilities	4	300000	1200000	12.00

M.1.8	Procurement of RTI/STI equipment for health facilities: Equipment/ Instrument, reagents, etc for RTI/ STI services	14	30000	420000	4.20
M.2	*Procurement of equipment for Child Health*				
M.2.1	Procurement of equipment for facility based newborn care	14	200000	2800000	28.00
M.2.2	Equipment/ Instrument for child care at DH/CHCs/ PHCs	15	100000	1500000	15.00
M.2.3	Procurement of equipment for care of sick children and severe malnutrition	14	200000	2800000	28.00
M.3	*Procurement of equipment for Family Planning*				
M.3.1	Procurement / repair of Laparoscopes / Laprocators	14	50000	700000	7.00
M.3.2	Procurement of abdominal TL set	14	2000	28000	0.28
M.3.3	Procurement of NSV kits: NSV Kits	14	5000	70000	0.70
M.3.4	Repairing/ maintenance of Laproscopes, Leprocators, FP instruments, etc	14	20000	280000	2.80
M.3.5	Procurement of IUDs	14	50000	700000	7.00
M.3.6	Procurement of operating microscopes/accessories for recanalisation services	14	30000	420000	4.20
M.3.7	Equipments/instruments to FP Service Centers	14	5000	70000	0.70
M.4	Equipment/ Instrument for ANC at health facilities other than SCs	1	50000	50000	0.50
M.5	Equipment/ Instrument for ANC at SCs	278	5000	1390000	13.90
M.6	Equipment/ Instrument and its maintenance for referrals	3	100000	300000	3.00
N	***Procurement of Drugs and supplies***			0	-

N.1	Procurement of IFA tablets for pregnant and lactating mother (@ 110.00 per 1000 tablets for 136078 beneficiaries)	14968602	0.11	1,646,546.22	16.47
N.2	Procurement of drugs and supplies for maternal health (@1 lakh per month per centre)	14	1200000	16800000	168.00
N.3	Procurement of drugs and supplies for child health (@1 lakh per month per centre)	14	1200000	16800000	168.00
N.4	Procurement of drugs and supplies for family planning (@75 thousand per month per centre)	14	900000	12600000	126.00
N.5	Procurement of general drugs and supplies for health facilities @ 300000 per month	14	3600000	50400000	504.00
	Procurement Total			**117,274,546.22**	**1,172.75**
O	**PROGRAMME MANAGEMENT**			0	-
O.1	***Strengthening of District society/District Programme Management Support Unit***			0	-
O.1.1	Contractual Staff for DPMU			0	-
O.1.2	District Program Manager @25000/- per month	1	300000	300000	3.00
O.1.3	District Accounts Manager @ 20000/- per month	1	240000	240000	2.40
O.1.4	District Data Manager @18000/- per month	1	216000	216000	2.16
O.1.5	District Accounts Assistant @12000/- per month	1	144000	144000	1.44
O.1.6	District Office Assistant @ 6000/- per month	1	72000	72000	0.72
O.1.7	Messenger @ 4000/- per month	1	48000	48000	0.48
O.1.8	TA/DA to District PMU staff -Rs 5,000/pm	12	5000	60000	0.60

O.2	Provision of equipment/furniture and mobility support for DPMSU staff			0	-
O.2.1	Hiring vehicles at DPMUs - Vehicles will be hired on annual contract basis. (Monthly fixed rent)	12	20000	240000	2.40
O.2.2	POL and maintenance	12	10000	120000	1.20
O.2.3	Contingency at District level	12	5000	60000	0.60
O.3	***Strengthening of Financial Management systems***			0	-
O.3.1	Training in accounting procedures	1	10000	10000	0.10
O.4	*Audits*			0	-
O.4.1	Annual audit of the programme	1	50000	50000	0.50
O.4.2	Concurrent audit	12	10000	120000	1.20
O.5	Facility improvement -Support for District Health Society	1	25000	25000	0.25
O.5.1	Accounting software maintenance / computer maintenance	1	10000	10000	0.10
	Programme Management Total			**1,715,000.00**	**17.15**
	TOTAL (In Lakhs): (Excluding JSY, Compensation for NSV and female Sterilization)			**207,894,282.98**	**2,078.94**
	RCH-II TOTAL			**228944283**	**2,289.44**
	Other (not included in RCH II)			0	
	Sterilization Compensation (for Public sector)	15000	1500	22500000	225.00
	NSV acceptance (for Public sector)	500	1000	500000	

					5.00
	Sterilization Compensation (for Private sector)	21000	1500	31500000	315.00
	NSV acceptance (for Private sector)	1000	1500	1500000	15.00
	Sterilization Compensation (Male/Female) Total			**56,000,000.00**	**560.00**
	Total (others)				
	GRAND TOTAL RCH-II FLEXIPOOL + OTHERS			***284,944,282.98***	***2,849.44***

BUDGET DETAIL OF NRHM FLEXI POOL

NRHM Additionalities Budget Format for the year 2009-10							
Sl. No.	**STRATEGY/ACTIVITIES**	**Unit of Measure**	**Budget 2009-10**				
			Qty.	**Rate**	**Amount**	**Amt. in lacs**	**Total Amount**
B1	***ASHA***						
B1.1	Support for ASHA- training, monthly orientation, materials, travel expense, etc at district level- Rs 1,000/ ASHA x 1043 no of ASHAs	No of ASHA to be trained in 2009-10	1043.00	1000.00	1043000.00	10.43	
							10.43
B 2	***Community Initiatives***						

B2.1	Formation and Orientation of Community leader & of VHSC,SHC,PHC,CHC etc (14-phc*12=168 251 -vhsc*2=596 278 -sc*1=278)	no of orientation prog.	1042.00	2000.00	2084000.00	20.84	
B2.2	Registers and other need based requirement of VHSCs for its functioning	no. of VHSCs	278.00	1000.00	278000.00	2.78	
							23.62
B3	***JBSY***						
B3.1	Janani Evam Bal Suraksha Yojna	no. of pregnant women (75% of pregnant women)	71013.00	2000.00	142026000.00	1420.26	
							1420.26
B4	***Mobile Medical Units (Including recurring expenditures)***						
B4.1	Support to Mobile Medical Units at Block and District Level	no of Mobile Units	8.00	500000.00	4000000.00	40.00	
							40.00
B5	***Untied Funds***						
B5.1	Untied fund for CHCs for local health activity- Rs 1,50,000/ CHC x no of CHCs.	no of CHC	3	150000.00	450000.00	4.50	
B5.2	Untied fund for PHCs for local health activity- Rs 1,00,000/ PHC x no of PHCs.	no of PHC	14	100000.00	1400000.00	14.00	
B5.3	Untied fund for APHCs for local health activity- Rs 50,000/ PHC x no of APHCs.	no. of APHCs	24	50000.00	1200000.00	12.00	

B5.4	Untied fund for SCs for local health activity- Rs 25,000/ SC x no of SCs	no of SC	278	25000.00	6950000.00	69.50	
B5.5	Untied grants to Village Health and Sanitation Committees- Every revenue village @ of Rs. 10,000/- VHCS x no of VHCS	no of VHCS	251	10000.00	2510000.00	25.10	
							125.10
B6	***New Constructions/ Renovation and Setting up***						
B6.1	Renovation of 4 old PHCs	no of PHC	4.00	500000.00	2000000.00	20.00	
B6.2	Renovation of 11 old APHCs	no. of APHCs	11.00	300000.00	3300000.00	33.00	
B6.3	Renovation of old HSC	no of SC	59.00	200000.00	11800000.00	118.00	
B6.4	Construction of new Born centres at each 14 PHCs @ Rs. 5,00,000/- NBCs	no of NBC	14.00	500000.00	7000000.00	70.00	
B6.5	Construction of New quarters for Doctors at PHCs (Quarter will be ground + first floor and will have four no. of flats)	no. of PHCs	7.00	6000000.00	42000000.00	420.00	
B6.6	Construction of New quarters for staffs at PHCs (Quarter will be ground + two floors and will have eight no. of flats)	no. of PHCs	7.00	5000000.00	35000000.00	350.00	
B6.7	Renovation of District Leprosy office		1.00	500000.00	500000.00	5.00	
B6.8	Renovation of \Facility improvement, civil work, BemOC and CemOC centers	no of centres	15.00	500000.00	7500000.00	75.00	
							1091.00
B7	***Up gradation of CHCs, PHCs, Dist. Hospitals, to IPHS other than construction)***						
B7.1	District Hospitals	no of DH	1	2500000.00	2500000.00	25.00	

B7.2	CHCs	no of CHC	3	2000000.00	6000000.00	60.00	
B7.3	PHCs	no of PHC	14	500000.00	7000000.00	70.00	
B7.4	APHCs	no. of APHCs	24	300000.00	7200000.00	72.00	
B7.5	Sub Centers	no of SC	278	50000.00	13900000.00	139.00	
							366.00
B8	***Training Institutes***						
B8.1	Up gradation of ANM school	no of Nursing school	1.00	500000.00	500000.00	5.00	
B8.2	Establishment of one new district training institute	no. of training institute	1.00	2000000.00	2000000.00	20.00	
							25.00
B9	***Training and Capacity Building Under NRHM***						
B9.1	Training/meeting of Staff Nurse @ Rs.5000 x no of Staff Nurse	no of Staff Nurse	11.00	5000.00	55000.00	0.55	
B9.2	Training of ANMs,AWW @ of Rs. 4000/- on various issues	no of ANM-362, AWW-251	15.00	4000.00	60000.00	0.60	
B9.3	Training of Administrative staff specially MOICs on hospital management (Hospital/Health Management)	no of training	5.00	25000.00	125000.00	1.25	
B9.4	Other training and capacity building programmes for DPMU, BHMU etc.	no. of training	4.00	25000.00	100000.00	1.00	
							3.40
B10	***Annual Maintenance Grants***						
B10.1	Maintenance of physical infrastructure of CHC @ Rs.1,00,000/CHC x no of CHCs. Ensure quality services through functional physical infrastructure.	no of CHC	3.00	100000.00	300000.00	3.00	

B10.2	Maintenance of physical infrastructure @ Rs.50,000/PHC x no of PHCs. Provision for water, toilets, their use and their maintenance, etc.has to be priorities.	no of PHC	14.00	50000.00	700000.00	7.00	
B10.3	Maintenance of physical infrastructure @ Rs.10,000/SC x no of SCs. Provision for water, toilets, their use and their maintenance, etc has to be priorities. This can also be utilized for premise on rent, where SC building is not available.	no of SC	278.00	10000.00	2780000.00	27.80	
							37.80
B11	***Contractual Salaries, Incentives and Bonus***						
B11.1	Remuneration of Staff Nurse at PHC/referral units level @ Rs.7500/month*12 months x no of staff nurses*	no of Staff Nurse	110.00	90000.00	9900000.00	99.00	
B11.2	Support for Contractual ANMs @ Rs. 6000 per ANM x ANMs, where post of ANM is filled to meet IPHS norm*	no of ANM	304.00	72000.00	21888000.00	218.88	
B11.3	Additional Allowances to MOs at PHC, CHC, DH (46 regular MOs and 39 contractual MOs) @ 3000/- per month for best performing MOs for rural area only	no of MOs	85.00	36000.00	3060000.00	30.60	

B11.4	Selection, training and remuneration of Specialists (Gynecologists, Anesthetists, Pedisterian, Radiologist, Sonologist, Pathologist, Dental Surgeons.) at CHC level- Rs. 22,000/pm x 12 x 3 referrals x 7 staffs at each referrals)	no of Specialists	21.00	264000.00	5544000.00	55.44	
B11.5	Selection and remuneration of Pharmacist at PHCs, CHCs, DH @ 8000/- per month	no. of pharmacists at health centres	15.00	96000.00	1440000.00	14.40	
B11.6	Additional Allowances to anesthetics for referral units	no. of referral units	3.00	48000.00	144000.00	1.44	
B11.7	Additional incentive to PHCs for better performance	no. of PHCs	14.00	50000.00	700000.00	7.00	
							426.76
B12	***PPP for Additional PHC management by NGOs***						
B12.1	Running and management of 14 APHCs by NGOs/ MNGOs	no. of APHCs	14.00	1800000.00	25200000.00	252.00	
							252.00
B13	***Nutrition Rehabilitation Centres***		4.00	1000000.00	4000000.00	40.00	
							40.00
B14	***Strengthening of Intensive Care Unit at District Hospital***		1.00	1726500.00	1726500.00	17.27	
							17.27
B15	***District and Block Programme Management Unit (Detail in annexure - III)***						
B15.1	Strengthening of Block Health Management Unit				8568000.00	85.68	

B15.2	Strengthening of District Programme Management Unit				2172000.00	21.72	
							107.40
B16	***Generic Drug Shop***						
B16.1	Establishment of generic drug shop at each health centres		14.00	200000.00	2800000.00	28.00	
							28.00
B17	***Disaster Fund***		8.00	500000.00	4000000.00	40.00	
							40.00
B18	***Child Disability Treatment Centre***		1.00	500000.00	500000.00	5.00	
							5.00
B19	***Logistic Management and Warehousing***						
B19.1	Strengthening of logistic management by appointing logistic consultant at block/district level @ 15000/- per month		15.00	180000.00	2700000.00	27.00	
B19.2	Strengthening of supplies and drug warehousing unit by appointing store keeper at block/district level @ 10000/- per month		15.00	120000.00	1800000.00	18.00	
							45.00
B20	***Corpus Grants to HMS/RKS***						
B20.1	Rogi Kalyan Samitis/ Hospital Management Committees at District Hospitals @ Rs. 5,00,000/District Hospital	no of DH	1.00	500000.00	500000.00	5.00	
B20.2	Rogi Kalyan Samitis/ Hospital Management Committees at CHC @ Rs. 1,00,000/CHC	no of CHC	3.00	100000.00	300000.00	3.00	

B20.3	Rogi Kalyan Samitis/ Hospital Management Committees at PHC @ Rs. 1,00,000/PHC	no of PHc	11.00	100000.00	1100000.00	11.00	
							19.00
B21	***IEC-BCC NRHM (as an Annexure - II)***			410300.00	5953600.00	59.54	
							59.54
B22	***Mobile Medical Units (Including recurring expenditures)***						
	Support to Mobile Medical Units at Block and District Level	no of Mobile Units	7.00	500000.00	3500000.00	35.00	
							35.00
B23	***Referral Transport***						
B23.1	POL and maintenance support to Ambulances for CHCs- Rs 7,000/pm/ PHC x 12 months x 10 functional PHCs	no of PHCs	10.00	84000.00	840000.00	8.40	
B23.2	POL and maintenance support to ambulances of Referral units/District Hospitals- Rs 7,000/ pm/ FRU x4 units	no of referral units and DH	4.00	84000.00	336000.00	3.36	
							11.76
B24	***Mainstreaming of AYUSH***						
B24.1	Support for AYUSH department (Including Salary of AYUSH Doctors. (See Annexure - I)	no of AYUSH Doctors					
B24.2	Selection, training and remuneration of Medical Officers at PHCs/ CHCs - AYUSH (See Annex-I)	no of AYUSH Doctors					
B24.3	TA/DA to AYUSH -I (as an Annexure - I)	no of AYUSH Doctors					
	Total		14.00	101000.00	1414000.00	38.78	

							38.78
B25	***PPP/ NGOs***						
B25.1	Grants in aid to NGOs at districts levels (other than MNGO, FNGO, SNGO)	no of NGOs	14.00	1000000.00	14000000.00	140.00	
							140.00
B26	***Community Monitoring (Visioning workshops at Dist, Block level)***						
B26.1	District level-Support for Monitoring system @ 20000/- per month		1.00	240000.00	240000.00	2.40	
B26.2	Block level-Support for Monitoring system @ 10000/- per month per block		14.00	120000.00	1680000.00	16.80	
							19.20
B27	***Quality Assurance***						
B27.1	Support to Quality Assurance Committee at District level @ 20000/- per month		1.00	240000.00	240000.00	2.40	
B27.2	Mobility Support to District Hospital @ 10000/- per month		1.00	120000.00	120000.00	1.20	
							3.60
B28	***Procurements***						
B28.1	Drugs (all essential and emergency drugs)		15.00	2000000.00	30000000.00	300.00	
B28.2	Equipments (all equipments for making health centres functional for treatment including provisioning of MVA apparatus)		15.00	1000000.00	15000000.00	150.00	
B28.3	Others (IFA, ORS, Contraceptives, vaccines, disposable delivery kits, dignity kits for adolescent girls, ASHA kits, ANM kits, SBA kits, IUD kits, Kits A and B		15.00	600000.00	9000000.00	90.00	

							540.00
B29	***PNDT Activities***		1.00	2000000.00	2000000.00	20.00	
							20.00
B30	***Monitoring and Evaluation***						
B30.1	Support for Monitoring system at District and block level @ 100000/- per unit		15.00	100000.00	1500000.00	15.00	
							15.00
B31	***Innovations***						
B31.1	**Muskan - Ek Abhiyan (details in RI section of the PIP)**				23827200	238.27	
							238.27
B31.2	***Boat Ambulance***						
B31.2.1	Procurement of motor boats		8.00	150000.00	1200000.00	12.00	
B31.2.2	Strengthening of motor boat with essential equipments and supplies		8.00	75000.00	600000.00	6.00	
							18.00
B33	***NRHM Management Costs/ Contingencies***						
B27.5	Audit Fees (RKS &VH&SC)	No. of RKS and VHSCs	265.00	2000.00	530000.00	5.30	
B27.6	Concurrent Audit system		12.00	10000.00	120000.00	1.20	
B27.7	Telephone and Mobile phone, Contingencies expenses		25.00	1000.00	300000.00	3.00	
B27.8	Mobility Support to BMO/MO/Others				0.00	0.00	
B27.9	Support for contingencies/operational support to health centres - Contingencies		14.00	10000.00	140000.00	1.40	
B27.10	Other Expenditures (Power Backup, Convergence etc)		12.00	10000.00	120000.00	1.20	

							18.00
	Total NRHM Cost (Additionalities)						**5280.18**

DETAIL BUDGET OF IMMUNISATION

BUDGET FOR ROUTINE IMMUNISATION					
A.	**Training Budget for (Remaining) Health workers training in Immunization**				
S. No.	**Activity Head**	**Norm**	**Requirement for year 09-10**		
1	No. of Trainers	3 trainers per district	3		
2	No. of Training Batches	30 persons per batch	15		
3	Honorarium plus TA for Participants	Rs. 250 for 2 day training	105000		
4	Honorarium for Trainers	Rs. 600 for 2 day training	27000		
5	Contingency	Rs. 100 participant per day (inct. Of refreshment, venue, TV/LCD hiring and logistics	135600		
	Total		267600		
B. Budget requirement for Muskan ek Abhiyaan					
S. No.	**Activity Head**	**Norm**	**Requirement for year 09-10**		
A	Incentive Money				
	for ANM	Rs. 150/- per month per AWC for 12 months	4467600		

	for AWW	Rs. Per months per AWC for 12 months	5956800		
	for ASHA	Rs. Per months per AWC for 12 months	5956800		
B.	Mahila Mandal	Rs. 250 per AWC	7446000		
	Total for Muskan ek Abhiyaan		23827200		
C. Budget details and requirement Regular RI					
S.No.	**Activity Head**	**Norm**	**Requirement for year 09-10**		
A.	Printing activities: Reporting and Recording Formats				
	All RI formats	Rs. 4 per beneficiary (pregnant women)	378736		
B.	POL for cold chain				
	At WIC/WIF	Rs.600 per day	219000		
		Rs.300 per day	109500		
		Rs.400 per day	2044000		
C.	Vaccine and Logistics Mobility				
	For WIC and WIF Points		120000		
	For Districts	Rs. 5000 per month	60000		
		Rs. 1500 per month	21000		
D.	Mobility For Supervision				
	For RDD	Rs. 5000 per month	60000		

	For DIO	Rs. 4000 per month if Govt.Vehicle is functional, Rs. 10000 if Govt. vehicle is non functional/ nor available	120000		
E.	Usage of Courier				
	For APHC and HSC+ AWC	Rs. 50 per session day per APHC and HSC+AWC	1600600		
	For Urban Sessions	Rs. 50 per Vaccinator per session day	48000		
F	Hiring of Computer operator at district level for RIMS	Rs. 5000*1 person*per district	60000		
G.	Catch up Campaigns (subjects to approval by GOI)				
1	Measles Campaign for pilot in select district	Details in measles section	2212350		
2	Hard to reach strategy	Details in Hard to reach areas			
3	RI catch up campaign	Details in RI Catch up campaign			
H.	Other separate activities proposed under RI (subject to approval)				
1	Zinc & ORS		2111200		
2	Albendazole tab		1584100		
3	Vit. A		78750		
	Total		**10827236**		
D. 1 Measles Break Up					
Measles Mortality Reduction		**For Surveillance, expenses to be calculated for 1 financial year and for SIA expenses to be calculated for 1 round of 14 days**			

A	Survellance for Measles	Details of activity	Expected Expenditure		
1	Training for Medical Officers	1 day training of 1 MO per block for Measles surveillance	14000		
2	Meeting of Epidemic response teams	1 Meeting per month per district	12000		
3	Travel expenses for case investigation per outbreak	Each out break has to be investigated by One Medical Officer and team of Health workers undertaking house to house search of cases: (calculate cost of investigation of 1 outbreaks per block per year	280000		
4	Shipment cost of lab specimen	Cost of collection of blood specimen, separation of serum in local lab and shipment of nearest medical college.(calculate cost 5 specimens collected per block per year and 1 shipments made)	42000		
5	Outbreaks response	All children affected with measles to be administered 2 doses of vitamin A and treated for complications if any. Cost involved if any	20000		
	Totals for measles Surveillance		**368000**		
D.2 Break –up of Measles Supplimentary Immunization					

B	Measles Supplimentary Immunization	Requirement	Rate suggested	Unit	Estimated Cost
1	No. of teams formed	1 vaccinator to form 1 team		435	
2	District workshop	1 per district	Rs. 5000 per district		5000
3	IEC	given as per team	Rs.500 per team for entire activity		217500
4	Training of vaccinators and mobilisers	Training cost of all mobilisers and vaccinators	Rs.75/- per person trained inclusive trainer and arrangement costs		218775
5	ice pack Freezing	4 icepacks per team for 21 days	Rs. 3 per icepacks		109620
6	Vaccine & Logistic Mobility	For WIC /WIF points	Rs. 12000/-		12000
		For Districts	Rs. 7500		7500
		For PHCs	Rs. 4500/- per PHC		63000
7	Usage of Couriers (Alternate Vaccine Delivery)	1 courier per team for 21 days	Rs.50 per courier per day		456750
8	Vehicle/boat/tractor/labour for teams for Hard to reach activity	1 Vehicle for 2 team for 7 days	Rs. 650 per vehicle per day		814450
9	Perdiem for workers and mobilizers	3 days per ASHA and AWW	Rs. 50 per person per day		711750
10	Perdiem for workers and vaccinators	21 days per trained vaccinator	Rs.75/-per person per day		685125
11	perdiem for Supervisors	1 supervisor per 3 teams for 21 days	Ra.100 per person per day		304500

12	Alternate vaccinators	Number of trained manpower available Vs shortfall	Ra.100 per person per day		537600
13	Miscellaneous & contingencies etc.	for entire activity	Net Rs. 3500/- per block and Rs. 6000/- district		55000
	Total				4198570
Mobility Support for immunization					
Sl. No.	**Type of Mobility**	**Estimated cost per Unit per day of use**	**Number needed for 1 session day in all hard to reach villages combined**	**Total costs for 4 sessions**	
1	Tractor	2000	10	80000	
2	Jeep/ vehicle	750	22	66000	
3	Boat	1000	23	92000	
4	Labour	125	55	27500	
5	Others	5000		20000	
	Total			**285500**	
E. Details of RI catch up campaign					
Sl No.	**Actibity**	**Norm**		**Estimated Cost**	
1	No. of team formed	1 vaccinator to form 1 team	358		
2	District Task force meeting	1 per district	Rs. 1000 per district	1000	
3	ice pack freezing	4 ice pack per team for 7 days	Rs. 3 per ice packs	30072	

4	Vaccine & Logistic Mobility	for WIC /WIF points	Rs. 5000	5000	
5		For Districts	Rs. 2500	2500	
6		For PHCs	Rs. 1750/- per PHC	24500	
7	Usage of Couriers (Alternate Vaccine Delivery)	1 courier per team for 14 days	Rs. 50 per Courier per days	250600	
8	Vehicle/boat/ tractor/ labour for teams for Hard to reach activity	1 vihicle for 2 team for 4 days	Rs. 650/- per ehavio per day	465400	
9	Perdieum for workers and mobilisers	3 days per ASHA and AWW	Rs. 50 per person per day	711750	
10	perdiem for Supervisors	7 days per trained vaccinator	Rs. 75/- per person per day	187950	
11	Alternate vaccinators	1 supervisor per 3 team for 7 days	Rs. 100 per person per day	83534	
12	Miscellenous & Contingencies etc.	Number of trained manpower available Vs shortfall	Rs. 100/- per person per day	125300	
13		for entire activity	Net Rs. 1750/- per block and Rs. 3000/- District	27500	
	Total for 1 round of catch up			**1915106**	
	Grand Total for RI: Rs. 37122642 (Rs. Three crore seventy one lakh twenty two thousand six hundred forty two only)				

DETAIL BUDGET OF DISEASE CONTROL PRGRAMMES

A. BUDGET FOR NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

A.1 Budget for Kala-azar (2009 - 2010)				
Sl. No.	**Particulars**	**Unit Cost**	**Units**	**Total Cost**
A.1. 1 KALA-AZAR CONTROL DDT SPRAY PROGRAMME (Two round)				
1	Wages	494360	1	4,94,360.00
2	Office exp.	18300	1	18,300.00
3	Contingency	18300	1	18,300.00
4	Transportation of DDT	2033	15	30,500.00
5	Equipment repair	24400	1	24,400.00
6	Dist. Mobility	30000	1	30,000.00
7	D.A. for supervision	147000	1	1,47,000.00
8	Organization of training (Medical officer/Paramedical staff/spray workers & ASHA)	284406	1	2,84,406.00
9	I.E.C. Van	585000	1	5,85,000.00
10	I.E.C. Material & Printing etc.	20000	15	3,00,000.00
	Total (in 1st round spray)			**56,32,266.00**
	Total (in 2nd round spray)			**56,32,266.00**
	Grand total of required fund			***1,12,64,532.00***
A.1.2 KALA-AZAR SEARCH FORTNIGHT				
1	Protashahan Rashi (for 1075 villages)	1075	500	5,37,500.00
2	Office expenditure	80000	1	80,000.00
3	Organization of training	214500	1	2,14,500.00
4	I.E.C. Van	157500	1	1,57,500.00
5	Dist. Mobility	30000	1	30,000.00
6	I.E.C. material & printing	10000	15	1,50,000.00
	Total in 1st round k.z. search fortnight			**11,69,500.00**
	Total in 2nd round k.z. search fortnight			**11,69,500.00**

	Grand Total of fund required			**2,339,000.00**
	Grand Total of Kala-azar Programme			**13,603,532.00**
A.1.3 BUDGET FOR MALARIA (2009-2010)				
Sl. No.	**Particulars**	**Unit Cost**	**Units**	**Total Cost**
1	Wages (254 panchayat* 30 days*Rs.113 daily wage)	254	3390	8,61,060.00
2	Office exp.	160000	1	1,60,000.00
3	Organization of training	214500	1	2,14,500.00
4	I.E.C. Van (@ Rs. 10000.00 per block per month * 14 blocks * 12 months)	120000	14	16,80,000
5	Dist. Mobility	60000	1	60,000.00
6	D.A. to supervisor (Rs. 175*10 days * 14 supervisor*12 months)	175	1680	294,000.00
7	I.E.C. Material & printing	10000	14	1,40,000.00
	Grand Total for Malaria Month			**3,409,560.00**
	Grand Total for NVBDCP			**17,013,092.00**
B. Budget - RNTCP (2009-2010)				
Sl. No.	**Particulars**	**Unit Cost**	**Units**	**Total Cost**
1	Civil works / Renovation	400000	1	400000.00
2	Purchase of laboratory materials	1500000	1	1500000.00
3	Honorarium to DOT providers	800000	1	800000.00
4	IEC/Publicity	300000	1	300000.00
5	Equipments maintenance	500000	1	500000.00
6	Training	200000	1	200000.00
7	Vehicle hiring charges	240000	1	240000.00
8	Contractual Services	500000	1	500000.00
	Total Cost			**4440000.00**

C. National Leprosy Eradication Programme				
Sl. No.	**Particulars**	**Unit Cost**	**Units**	**Total Cost**
1	Contractual staffing (Night Guard and Sweeper etc.)	10000	12	120000
2	Office maintenance at leprosy unit level (@Rs. 1000.00 per month per unit x 12 months)	12000	15	180000
3	Office maintenance at District Level	10000	12	120000
4	Mobility at leprosy unit level	12000	15	180000
5	Mobility at District level	10000	12	120000
6	Training	200000	1	200000
7	Procurement (Medicines, items for deformity patients, patients welfare)	200000	1	200000
8	IEC activities	250000	1	250000
9	Survey	20000	15	300000
10	Incentive to ASHA for MB and PB cases	200000	1	200000
11	Programme Monitoring	200000	1	200000
	Total Cost			**2070000**
D. National Programme for Control of Blindness				
	Particulars	**Unit Cost**	**Units**	**Total Cost**
1	Cataract operation at district level			
	i) By government sector	500000	1	500000
	ii) By NGO sector	500000	1	500000
	iii) By Private Sector	500000	1	500000
E. 2	Establishment of vision centre at district level	1000000	1	1000000
E. 3	Contractual Staff (including District NPCB Officer)	1000000	1	1000000
	Total			**3500000**

BUDGET DETAIL FOR AYUSH

	Mainstreaming AYUSH at PHCs/ CHCs (Annex I) Purnia district				
	Mainstreaming AYUSH at PHCs/ CHCs (Annex I)				
Sl. No.	**Activity**	**2009-2010**			
		Qty-Q	**Rate- R**	**QxR**	**Amt**
1	Contractual Appointment of 14 AYUSH doctors- Rs 12,000/pm/doctor x 12 months	14	12,000	168,000	20.160
2	Support for TA/ DA to AYUSH doctors- Rs 3000/ pm/ AYUSH x 12 months	14	3,000	42,000	5.040
3	AYUSH Medicines Rs 25,000/unit x 14 units	14	25,000	350,000	3.500
4	Equipments/ Instruments and its maintenance for AYUSH unit- Rs 10,000/ unit x 14 units	14	10,000	140,000	1.400
5	Support for contingencies and non expendables at AYUSH unit- Rs 1,000/ unit/ pm x 14 units x 12 months	14	1,000	14,000	1.680
6	Support to AYUSH unit for Diagnostic camps - Rs 50,000/per unit	14	50,000	700,000	7.000
	Total	**14**	**101,000**	**1,414,000**	**38.78**

BUDGET DETAIL FOR IEC

	Strengthening IEC Activity (Annex II)				
Sl. No.	**Activity**	**2009-2010**			
		Qty-Q	**Rate-**	**QxR**	**Amt**

			R		
1	Outsourcing Vehicle for IECO @ 20000 pm	1	20,000	240,000	2.400
2	IEC activity through hoardings & Banner	14	20,000	280,000	2.800
3	Drama Groups	251	1,000	251,000	2.510
4	Wall writing (2 wall writing in each villages)	2,602	300	780,600	7.806
5	District level BCC strategy workshop on breastfeeding, family planning, institutional delivery, ARSH services	4	20,000	80,000	0.800
6	Block level workshop on BCC strategy on breastfeeding, family planning, institutional delivery, immunisation, ARSH services	14	10,000	140,000	1.400
7	Village health melas at Panchayat level (once a quarter)	251	6,000	1,506,000	15.060
8	Celebration of different Health days @ 2000/- per block	12	28,000	336,000	3.360
9	IEC activity through Print media (pamphlets & advertisement etc)	12	20,000	240,000	2.400
10	TV & Other media	12	10,000	120,000	1.200
11	Meeting & conferences at different level (2 in each block and at district level)	30	5,000	150,000	1.500
12	Instrument & equipment for IEC activity	1	100,000	100,000	1.000

13	Developing, printing and dissemination integrated BCC/ IEC materials	14	100,000	1,400,000	14.000
14	Block specific IEC	14	20,000	280,000	2.800
15	others & contingency	1	50,000	50,000	0.500
	Total		**410,300**	**5,953,600**	**59.54**

BUDGET DETIAL FOR DPMU AND BHMU

Strengthening District Program Management Unit (Annex III)					
Sl. No.	**Activity**	**08-09**			
		Qty-Q	**Rate- R**	**Q X Rate**	**Amt**
1	Salary to District Programme Manager	1	30000	360,000.00	3.60
2	Salary to District Data Manager	1	25000	300,000.00	3.00
3	Salary to District Accounts Manager	1	22000	264,000.00	2.64
4	Honorarium to Office Assistant (Data)	1	10000	120,000.00	1.20
5	Honorarium to Office Assistant (Accounts)	1	8000	96,000.00	0.96
6	Honorarium to Office Assistant	2	8000	192,000.00	1.92
7	Strengthening district level field monitoring- Hiring vehicles for DPMUs -Rs. 30,000/pm x 12 months	1	30,000	360,000.00	3.60

8	Support for strengthening DPMU Office- Operational support/ Contingency/ out sourcing/ data entry/ non expendables, TA/DA to DPMU staffs etc	1	40,000	480,000.00	4.80
	Total		**173,000.00**	**2,172,000.00**	**21.72**
Note: The current salary structure of DPM, DAM, District Data Assistant is 23000, 18000 and 15000, respectively but the calculation has been made as per the revised proposed salary structure of DPMU staffs.					
Strengthening Block Health Management Unit (Annex III)					
Sl. No.	**Activity**	**08-09**			
		Qty-Q	**Rate- R**	**Q X Rate**	**Amt**
1	Salary to Block Health Manager	14	15000	2,520,000.00	25.20
2	Salary to Block Accounts Assistant	14	10000	1,680,000.00	16.80
3	Support for TA/ DA to Block PMU staff	28	500	168,000.00	1.68
4	Strengthening block level field monitoring- Hiring vehicles for BHMUs -Rs. 20,000/pm x 12 months x 14 blocks	14	20,000	3,360,000.00	33.60
5	Support for strengthening BHMU Office- Operational support/ Contingency/ out sourcing/ data entry/ non expendables, etc (Rs 5,000/ pm/ per block x 2 blocks)	14	5,000	840,000.00	8.40
	Total	**2**	**50,500**	**8,568,000.00**	**85.68**

Note: The current salary structure of BHM, Block Accounts Manager is Rs. 12000 and Rs. 8000, respectively but the calculation has been made as per the revised proposed salary structure of BHMU staffs.